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Health and Adult Social Care and Communities Overview and Scrutiny Committee

Agenda

Date:	**Thursday, 13th June, 2019**
Time:	**2.00 pm**
Venue:	**Committee Suite 1,2 & 3, Westfields, Middlewich Road, Sandbach CW11 1HZ**

The agenda is divided into 2 parts. Part 1 is taken in the presence of the public and press. Part 2 items will be considered in the absence of the public and press for the reasons indicated on the agenda and at the foot of each report.

It should be noted that Part 1 items of Cheshire East Council decision making and Overview and Scrutiny meetings are audio recorded and the recordings will be uploaded to the Council's website

PART 1 – MATTERS TO BE CONSIDERED WITH THE PUBLIC AND PRESS PRESENT

1. **Apologies for Absence**

2. **Minutes of Previous meeting** (Pages 3 - 6)

   To approve the minutes of the meeting held on 11 April, 2019.

3. **Declarations of Interest**

   To provide an opportunity for Members and Officers to declare any disclosable pecuniary and non-pecuniary interests in any item on the agenda.

4. **Declaration of Party Whip**

   To provide an opportunity for Members to declare the existence of a party whip in relation to any item on the Agenda

For requests for further information
Contact: Joel.Hammond-Gant
Tel: 01270 686468
E-Mail: joel.hammond-gant@cheshireeast.gov.uk with any apologies

5. **Public Speaking Time/Open Session**

A total period of 15 minutes is allocated for members of the public to make a statement(s) on any matter that falls within the remit of the Committee.

Individual members of the public may speak for up to 5 minutes, but the Chairman will decide how the period of time allocated for public speaking will be apportioned, where there are a number of speakers.

Note: in order for officers to undertake and background research, it would be helpful if members of the public notified the Scrutiny Officer listed at the foot of the Agenda at least one working day before the meeting with brief details of the matter to be covered.

6. **Summary of Health Scrutiny Regulations** (Pages 7 - 10)

7. **Update on Progress of Referral to Secretary of State for Health and Social Care**

To receive an oral update from the Scrutiny Officer.

8. **Working Together Across Cheshire** (Pages 11 - 16)

9. **2018/19 Quality Accounts - Cheshire and Wirral Partnership NHS Foundation Trust** (Pages 17 - 60)

10. **2018/19 Quality Accounts - East Cheshire NHS Trust** (Pages 61 - 148)

11. **2018/19 Quality Accounts - Mid Cheshire Hospitals NHS Foundation Trust** (Pages 149 - 242)

12. **Improved Accesss - Eastern Cheshire Clinical Commissioning Group** (Pages 243 - 248)

13. **Forward Plan** (Pages 249 - 262)

To review the Council's Forward Plan of Key Decisions and consider whether any items within the remit of this Committee should be added to its work programme.

14. **Work Programme** (Pages 263 - 276)

To review the current work programme and amend (add new items or delete existing ones) as required.

CHESHIRE EAST COUNCIL

Minutes of a meeting of the **Health and Adult Social Care and Communities Overview and Scrutiny Committee** held on Thursday, 11th April, 2019 at Committee Suite 1,2 & 3, Westfields, Middlewich Road, Sandbach CW11 1HZ

PRESENT

Councillor S Gardiner (Chairman)
Councillor B Dooley (Vice-Chairman)

Councillors Rhoda Bailey, S Brookfield, L Durham, S Edgar, C Green, L Jeuda, D Mahon, A Moran and J Rhodes

PORTFOLIO HOLDERS IN ATTENDANCE

Councillor L Wardlaw, Deputy Leader and Portfolio Holder for Health
Councillor J Clowes, Portfolio Holder for Adult Social Care and Integration

OFFICERS IN ATTENDANCE

Jill Broomhall, Director of Adult Social Care
John Wilbraham, Chief Executive Officer (East Cheshire NHS Trust)
Neil Evans, Director of Commissioning (NHS Eastern Cheshire Clinical Commissioning Group)
Linda Couchman, Acting Strategic Director of Adult Social Care and Health

109 APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors C Andrew, G Baxendale and G Hayes.

110 MINUTES OF PREVIOUS MEETING

RESOLVED –

That the minutes of the previous meeting held on 7 March 2019 be approved as a correct record and signed by the Chairman.

111 DECLARATIONS OF INTEREST

Councillor L Durham declared a non-pecuniary interest in Minute Nos. 114 and 115.

112 DECLARATION OF PARTY WHIP

No declarations of a party whip were received.

113 PUBLIC SPEAKING TIME/OPEN SESSION

No members of the public were present.

114 CESSATION OF SPECIALIST ORTHODONTIC AND ORAL SURGERY SERVICES AT MACCLESFIELD GENERAL HOSPITAL

Consideration was given to written and verbal updates on the cessation of specialist orthodontic and oral surgery services at Macclesfield General Hospital, submitted by NHS England North (Cheshire and Merseyside) and John Wilbraham, Chief Executive of East Cheshire NHS Trust, respectively.

Mr John Wilbraham accepted that consultation with the committee should have taken place immediately after the Trust served notice on the two contracts, and expressed sincere apologies on behalf of the Trust for this.

The committee were provided with more detail to explain why notice had been served on the contracts, including that the services were small-scale and considered clinically fragile and that providing the services from other providers could be more sustainable.

Members asked questions and put comments in relation to;

- how many patients had been, or were on a waiting list to be, transferred to new service providers to date;
- whether there is confidence that the services could be provided from Macclesfield in the future;
- concerns for patients (and their families, carers or friends) who would be required to travel further for appointments; and
- concern about the future of Macclesfield District General Hospital and whether more services would also transferred to other providers in the future.

After giving consideration to the informal advice provided by the Independent Reconfiguration Panel regarding the committee's decision to refer this matter to the Secretary of State for Health and Social Care, the committee deliberated whether or not to continue with its referral in the light of the updates received.

It was proposed and seconded that the committee would continue with its referral. Of the eleven members present, nine voted in favour of the proposal and the Chairman and Vice-Chairman abstained from the vote.

RESOLVED –

1 That the committee refer the matter to the Secretary of State for Health and Social Care.

2 That a further update on this matter be submitted to the committee's meeting on 13 June 2019.

115 CLOSURE OF PARKINSON'S DISEASE SUPPORT SERVICE AT MACCLESFIELD GENERAL HOSPITAL

Consideration was given to a report submitted by NHS Eastern Cheshire Clinical Commissioning Group regarding changes to the provision of nursing services that supported people with Parkinson's Disease within the locality.

The committee asked questions in relation to;

- how quickly the patients would develop positive relationships with the new Parkinson's Disease nurse support service;
- what the range of benefits would be following the establishment of the new service;
- when the new service would likely commence;
- whether the total number or proportion of Parkinson's Disease diagnoses had increased in Cheshire East; and
- whether people were increasingly living longer with Parkinson's Disease.

RESOLVED –

That the committee be made aware of the new service provider once it has become public knowledge.

116 **FORWARD PLAN**

Consideration was given to the council's forward plan of key decisions, for the period until …

RESOLVED –

That the forward plan be noted.

117 **WORK PROGRAMME**

Consideration was given to the committee's current work programme and whether any new or existing items needed to be added or deleted respectively.

RESOLVED –

That the Scrutiny Officer liaise with the relevant officers and partners to obtain more information on the Transformation Board, One for You service, and the range of clinically fragile services provided by Cheshire East hospitals, to ultimately allow the committee to make an informed decision to add any additional items to its work programme.

The meeting commenced at 10.03 am and concluded at 11.20 am

Councillor S Gardiner (Chairman)

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Agenda Item 6

Cheshire East Council

Working for a brighter future together

Version Number: 1

BRIEFING REPORT

Health and Adult Social Care and Communities Overview and Scrutiny Committee

Date of Meeting: 13 June 2019

Report Title: Local Authority Health Scrutiny Powers and Regulations – A Summary

Portfolio Holder: Councillor L Jeuda – Portfolio Holder for Adult Social Care and Health

Councillor J Rhodes – Portfolio Holder for Public Health and Corporate Services

Councillor M Warren – Portfolio Holder for Communities

Author: Joel Hammond-Gant – Scrutiny Officer

Senior Officer: Mark Taylor – Interim Executive Director of Corporate Services

1. Introduction and Policy Context

1.1. This report presents a summary of the regulations and legislation surrounding local authority health scrutiny, including the specific responsibilities and powers that a health scrutiny committee has (in addition to those bestowed on all overview and scrutiny committees.)

2. Background

2.1. This report is intended to introduce councillors new to health scrutiny to, and refresh the knowledge of councillors with pre-existing experience of, the general regulations and powers relating to local authority health scrutiny.

2.2. This report will be supplemented by induction training being held for all members of the committee prior to its first meeting of the 2019/20 council year on 13 June, 2019.

3. Briefing Information

3.1. Since the introduction of the Local Government Act 2000 (which came into force in 2001,) local authorities operating executive governance arrangements have been required to establish and maintain an overview and scrutiny function.

3.2. In addition to this, all councils whether operating executive arrangements or a committee system of governance, have a statutory responsibility to review or scrutinise any matter relating to the planning, provision and operation of health services in their respective areas.

What is health scrutiny?

3.3. The primary aim of health scrutiny is to strengthen the voice of local people, ensuring that their needs and experiences are considered as an integral part of the commissioning and delivery of health services, and that those services are both effective and safe.

3.4. It provides a means by which democratically elected councillors can voice the views of their constituents, and hold relevant NHS bodies and health service providers to account. It is therefore imperative that health scrutiny functions operate in a transparent manner, so that local people have the opportunity to see and hear proceedings, and can be involved in local health service matters in their area.

3.5. Health scrutiny has a strategic role in taking an overview of the longer term commissioning and delivery plans and strategies of its local health partners. For many local authorities in recent years, this strategic role has involved overviewing how well health, public health and social care services are being integrated; a growing necessity in an increasingly challenging financial climate.

3.6. At the same time, health scrutiny has a role in proactively seeking information about the performance of local health services, in challenging the information provided to it by commissioners and service providers, and in testing this information by drawing on different sources of intelligence.

3.7. Effective health scrutiny requires open and honest engagement from relevant NHS bodies and health service providers, and the establishing of strong, effective working relationships between these and local authority health scrutiny bodies.

Specific Powers

3.8. Upper tier local authorities in England (i.e. unitary authorities, county councils, and metropolitan borough/district councils) have the power to:

3.8.1. Review and scrutinise matters relating to the planning, provision and operation of the health service in the area. This can include scrutinising the finances of local health services.

3.8.2. Require information to be provided by certain NHS bodies about the planning, provision and operation of health services.

3.8.3. Require officers of certain NHS bodies to attend before them to answer questions.

3.8.4. Make reports and recommendations to certain NHS bodies and expect a response to these within 28 days.

3.8.5. Set up joint health scrutiny committees with other local authorities and delegate health scrutiny functions to an overview and scrutiny committee of another local authority.

3.8.6. Refer significant developments or variations of local health service provision to the Secretary of State for Health and Social Care. The power to refer such matters is explained in more detail below.

Referring Matters to the Secretary of State for Health and Social Care

3.9. NHS bodies are statutorily required to consult with local authorities and the public about any proposals they have that could be considered a significant development or variation to the local health service provision.

3.10. Upon consultation, a local authority health scrutiny body will decide whether or not it considers a particular proposal to be ‘significant’. It will also recommend to the responsible NHS bodies what length of formal consultation with the public it feels would be appropriate.

3.11. A local authority health scrutiny body can refer significant developments or variations (SDVs) to the Secretary of State for Health and Social Care if it considers that:

- The consultation carried out on any substantial reconfiguration proposal has been inadequate (either in terms of content or the amount of time allowed)
- The NHS body has not given adequate reasons why it has not consulted

3.12. Although SDVs are not formally set out in any legislation, there is an agreed practice that is followed. More specific detail on these types of proposals and the role of health scrutiny bodies in them can be found in the Department of Health's 2014 guidance on Local Authority Health Scrutiny.

Making Reports and Recommendations

3.13. Under the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013, when scrutinising a particular health matter, the local authority undertaking the review must:

(1) Invite interested parties to comment on the matter, and

(2) Take account of all the relevant information available to it (i.e. information referred to it from its local Healthwatch body.)

3.14. The following information must be included in any report or recommendation made by a local authority health scrutiny body to relevant NHS bodies and health service providers:

- An explanation of the matter reviewed or scrutinised.
- A summary of the evidence considered.
- A list of the participants involved in the review or scrutiny.
- An explanation of any recommendations on the matter reviewed or scrutinised.

3.15. Where a local authority health scrutiny body requests a response form a relevant NHS body or health service provider to which it has made a report or recommendation, there is a statutory requirement for the body/provider to provide a response in writing within 28 days of this request.

4. Implications

4.1. Legal Implications

4.1.1. There are no legal implications arising from this report.

4.2. Financial Implications

4.2.1. There are no financial implications arising from this report.

4.3. Human Resources Implications

4.3.1. There are no human resources implications arising from this report.

TO: **Health and Adult Social Care and Communities Overview & Scrutiny Committee**

DATE: **13th June 2019**

SUBJECT: **Working Together Across Cheshire**

1.0 BACKGROUND

1.1 The Governing Bodies of the four Cheshire Clinical Commissioning Groups (CCGs) have all supported recommendations around strengthening collaborative commissioning arrangements, unified commissioning, and the development of a Joint Commissioning Committee between the four CCGs.

1.2 All the CCGs are progressing engagement with their GP Memberships and Stakeholders to support a proposal to consolidate the shared responsibilities and resources of the four Cheshire CCGs through merging and establishing a single Cheshire CCG from 01 April 2020. A major programme of work is underway between the four CCGs, called Working Together Across Cheshire (WTAC), which is progressing the alignment of functions, resources and governance arrangements so as to better enable the four CCGs to work as one, reduce avoidable repetition and to free up resources to further progress integrated or joined up care and, ultimately, improve patient care and experience.

1.3 The four CCGs in October 2018 appointed Clare Watson as single Accountable Officer (Chief Officer) and further a single executive team has been appointed which took effect from 1st June 2019.

1.4 The four Cheshire CCGs are working in partnership with the three local (Cheshire) acute hospital trusts, Cheshire and Wirral Partnership NHS Foundation Trust, GP Federations, the two local authorities in Cheshire and other key stakeholders in developing two integrated care partnerships (ICPs). The two ICPs cover the geographic place of either Cheshire East Council or Cheshire West and Chester Council. It is envisaged that, in time, both ICPs (and the partners within) will be responsible for both commissioning and/or delivery of the majority of health and care services for the population of Cheshire.

1.5 Care Communities are being developed across Cheshire East Council and Cheshire West and Chester Council. Care communities which will form the foundations of delivering integrated care across the whole of Cheshire.

2.0 RECOMMENDATIONS

2.1 The committee's views are invited on the proposals to merge the four Cheshire Clinical Commissioning Groups in parallel to (and to support) the development of two Integrated Care Partnerships (one in Cheshire West and One in Cheshire East) and care communities.

2.2 That the committee receives future reports on progress.

3.0 SUMMARY OF MAIN ISSUES

3.1 Nationally and regionally there is a direction of travel to move towards place-based care, with 'Place' locally being identified as local authority geographic boundaries. We have been working closely with Cheshire West and Chester Council and Cheshire East Council colleagues to consider what this would mean for the four Cheshire CCGs.

3.2 There are a number of challenges that we need to address. Funding for health and care services is tight and significant system-wide pressures mean Cheshire CCGs, and their partners, face an increasingly difficult annual challenge to balance the books and continue to ensure access to high quality, clinically safe and sustainable health and care services. With demand for services rising faster than available resources, positive transformative change is needed to maintain and improve the quality of care that the people of Cheshire have every right to experience.

3.3 The WTAC programme is striving to create the optimum environment for the four CCGs to support and enable the shared cross-system ambition to join up care via the development of ICPs within the local authority boundaries of Cheshire East and Cheshire West and Chester. ICPs are designed to join up the commissioning and delivery of hospital, primary and community based care (health and social care), mental and physical health and care services, for the benefit of local communities. Through the WTAC programme, CCGs will support the phased transfer of commissioning responsibilities for services from the CCGs to the two ICPs, whilst also working towards establishing a single strategic CCG for Cheshire.

3.4 In Cheshire East, the WTAC programme supports the ambitions of the Cheshire East Place Partnership, whose membership of this inter-partnership forum consist of all NHS partners and the local authority. At the centre of the integrated care plans of local authorities and NHS partners is the development of care communities based on footprints of circa 30,000-50,000 people. Each CCG is working with partners to develop these care communities which will form the foundations of delivering integrated care across the whole of Cheshire.

3.5 There are 17 care communities proposed across Cheshire: 9 in Cheshire West and Chester (2 in Vale Royal and 7 in West Cheshire) and 8 within the boundary of Cheshire East Council (3 in South Cheshire CCG and 5 in Eastern Cheshire CCG).

3.6 The approach of integrated care planning and delivery within the Care Communities of Cheshire East will focus particularly on services and support for older adults at first but would then be expanded to include services and support for children and other vulnerable groups of people. Introduction of the care communities started in 2018 as part of a five-year plan that will culminate

in having a single integrated care system fully operational by 2022-23. The care communities will be run by health and social care professionals including GPs, community nurses and therapists, providers of mental health services for older people, social care workers and staff providing intermediate care as an alternative to hospital admission or to patients recently discharged from hospital. Over this five year period, providers of community and voluntary services will be brought on board while arrangements will be made for the care communities to work closely with providers of regional specialist services such as acute and hyper-acute care, treatment for major injuries and long-term complex mental health care.

3.7 Intended benefits of the care communities will include improved health, increased patient and staff satisfaction, fewer avoidable hospital visits and admissions, and more efficient use of taxpayers' money. People will have a better understanding of how to stay well and manage their long-term conditions, and there will be more non-emergency services available 24/7.

3.8 In aligning the four Cheshire CCGs to work and act as one, and with the intent to establish a single Cheshire CCG, a more powerful voice for Cheshire will emerge in championing the needs of local people and local organisations at both regional and national level, maximising the opportunities for commissioning at scale for the c750,000 of Cheshire and supporting collaborative commissioning with partners as part of the Cheshire and Merseyside Health Care Partnership and others surrounding Cheshire's borders.

3.9 It is imperative that the development of integrated care is done in parallel with the development of a single Cheshire CCG. It is envisaged that a single CCG will operate in a significantly different way and require a lower level of resource / staff to that currently required of the existing CCGs. This is because many of the functions (and therefore resource) of a CCG will be delegated to the emerging integrated care partnerships in Cheshire.

3.0 QUALITY AND PATIENT EXPERIENCE

4.1 Our shared ambition to develop integrated care across Cheshire is driven by a commitment to enable people to live well for longer. When they do need to access care, this will be available as close to home as is possible and regardless of where they live will be expected to be delivered to the same high standard level (quality, safety and experience). The ambition is to ensure that the best possible outcomes are attained for the local population regardless of where they live and who they are.

4.2 The development of a single Cheshire CCG, and through our partnership work with Cheshire West & Chester and Cheshire East Councils to further develop Integrated Care, will enable us to commission services using a common outcomes framework for both integrated care and each of our 17 care communities.

4.0 FINANCE

5.1 The four CCGs across Cheshire are committed to commissioning (buying, planning and monitoring) the best possible high quality safe care within the available resources that are nationally allocated to them by NHS England (NHSE). This continues to present a significant challenge and the development of a single Cheshire CCG is expected to improve our ability to plan and commission care services equitably, based on need and all the while meeting our statutory obligation to live within our financial allocations.

5.2 It is expected that there will be both short and long term financial savings for the Cheshire CCGs through the implementation of the programmes of work and strategic direction outlined within this paper. In collapsing and streamlining the operational and governance arrangements for the four CCGs, financial savings are likely to be realised through a number of areas both in relation to running costs associated with operating CCGs (e.g. estates, licences, contracts, staffing costs) and in undertaking their business (e.g. governance structures, meeting arrangements).

5.3 Demonstrating how CCGs are optimising the use of their administrative resources is a key assessment criterion for NHSE when assessing applications by CCGs requesting approval to merge. CCGs also have a responsibility to ensure that they continue to maximise the amount of funding available for direct patient care, which means constantly challenging ourselves to ensure that management and administration functions are delivered in as efficient a way as possible. At the end of 2018, CCGs were also mandated by NHSE to reduce administration costs by 20% by 2020/21. This 20% reduction has also been adopted by NHSE and NHS Involvement.

5.4 The adoption of a single way of doing things across the four CCGs and the establishment of a single Cheshire CCG is also expected to maximise the opportunity for making efficiencies in contracting arrangements and service delivery, which in turn frees up resource to be invested elsewhere.

6.0 CONSULTATION AND ENGAGEMENT

6.1 The merging of CCGs does not require a formal consultation with members of the public or stakeholders, however we are committed to seeking the views of members of the public / stakeholders on such matters and this has been done across the country where CCGs have already merged.

6.2 The CCGs launched a survey on 23rd May 2019 seeking the public's opinion on whether the CCGs should merge or not. The survey will be open for a period of 4 weeks and in the first 24 hours there were 30 plus responses.

6.3 The CCGs haves sourced support from the voluntary sector to promote the survey and encourage responses from across Cheshire and the diverse

communities. This includes the offers of presentations to various groups and committees.

6.4 The CCGs have used social media platforms to promote the survey widely and sourced additional support to make sure this happens.

6.5 The CCGs have previously presented to Overview Scrutiny Committees and Health and Wellbeing Boards in Cheshire East and are committed to updating these committees throughout the programme.

6.6 Ahead of submitting any CCG merger application to NHSE, CCGs will need to have provided evidence and assurance to the CCG Governing Body(s), GP Membership(s) and stakeholders that a move to a larger geographical footprint is not at the expense the new CCG's ability to engage with GPs and local communities at locality level.

6.7 NHS England also requires evidence and assurance with regards the extent to which the CCG(s) has/have sought the views of the local authority(s) whose area covers the whole or any part of the CCG's area; any other person or body which in the CCG's view might be affected by the CCGs intentions to merge and the extent to which the CCG has sought the views of patients and the public.

6.8 There will be a need for ongoing engagement with members of the public and other stakeholders regarding the development of the care communities and the emerging ICPs. This will also include engagement on the implementation of the NHS Long Term Plan.

Contact Person: **Matthew Cunningham**

Email: **matthew.cunningham@nhs.net**

Service Area: **Governance and Corporate Development**

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Cheshire and Wirral Partnership
NHS Foundation Trust

Quality Account 2018/19

Quality at CWP
2018/19 in pictures

#cwpQI

Working in partnership to improve health and well-being by providing high quality, person-centred care

Introduction

Our *Quality Account* is an annual report to the people we serve about the quality of services we provide. They offer an opportunity to understand what we are doing to improve the care and treatment we provide.

All Quality Accounts require providers of NHS services to describe quality in the following ways:

Patient safety
This means delivering care in a way which increases safety, by using effective approaches that reduce unnecessary risks.

Clinical effectiveness
This means delivering care that is based on evidence and people's needs and results in improved health outcomes.

Patient experience
This means delivering care which people can easily access and that takes into account their preferences and their needs.

At CWP, we also use international ways of defining quality to help us to better show where we are making real improvements, for example is the care that we deliver affordable, sustainable, acceptable and accessible. To help us deliver care which is more equitable and person-centred, we place an emphasis on co-production, which is about the people who deliver and support the delivery of our services, people who access our services, their families and the people we serve, playing more of an active role in planning, improving and delivering services.

The aim in reviewing and publishing performance about quality is to enhance *public accountability* by *listening* to and *involving* the public, partner agencies and, most importantly, *acting* on feedback we receive.

To help meet this aim, we produce *Quality Improvement Report*s three times a year.

This *Quality Account*, and 'easier read' accessible versions of the *Quality Account* and our *Quality Improvement Report*s, are published on our website.

Part 1.
Statement on quality from the Chief Executive of the NHS Foundation Trust

I am delighted to introduce this year's Quality Account, to look back with pride on another year of significant success and achievement, and to look ahead to developments at CWP in the coming year.

Following the Care Quality Commission (CQC) inspection of our services in August and September 2018, we were really pleased to have been rated as 'Outstanding' for Care, making us the only trust in the local area, and the only mental health trust in the north west, with this rating. We were rated as 'Good' overall. This is a tremendous testimony to the hard work and dedication of our staff and our commitment to the care that we provide. But we are not complacent and we are making continuous improvements, including in the areas identified by the CQC. As we look to build on our CQC rating, and to help us be the best we can be, we are looking forward to further embedding our Quality Improvement strategy into our work. Dr Sivananthan goes on to talk more about this in her foreword on the following pages.

This year's Quality Account sets out some of our key achievements in improving the quality of our services. These include:

- Launch of a new advice line for young people, parents/ carers, and organisations across Cheshire and Wirral who may have concerns about a young person's mental health.
- Opening of the Coronation Road workplace hub, a new integrated workspace for health and care services in Ellesmere Port.
- 40 graduates from the University of Chester have completed a two-year work-based programme and are now Registered Nursing Associates.
- Launch of a brand new All Age Disability service in Wirral, aiming to improve experiences for people in the area with a disability or mental health condition.
- Being recognised as a top performer nationally in the 2018 Community Mental Health Survey, including being one of the top three trusts nationally for 'organising your care', 'NHS therapies' and 'your health and social care workers'.
- Being placed at the top of the North West mental health table, based on the last three years of national NHS Staff Survey results, for staff recommending CWP as a place to work or receive care.
- Collaborative working between the Neston and Willaston Community Care team and services provided by partner organisations to improve the well-being of people in these communities, including improving understanding of support available and offering self-care tips on issues like pressure ulcer care and preventing falls.
- Approval of plans to improve the model of care of more than 7,000 people in Eastern Cheshire, South Cheshire and Vale Royal, who need support every year with serious, long-term mental health problems. The enhanced community services will include a new dementia outreach service and 24/7 crisis care, alongside modern inpatient facilities for those that require hospital care.

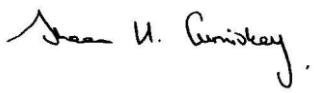
In relation to the last development listed above, this is one example of the positive relationships we have with our partners and how we provide services alongside them. Our clinical services are building on this

partnership working over the coming year, and we are looking forward to working together to further integrate our services. This will include co-producing and delivering models of care that reflect the needs of the people we serve. We are delighted that our local plans in this respect reflect the NHS Long Term Plan that was published this year. The NHS Long Term Plan was developed in partnership with those who know the NHS best – frontline health and care staff, patients and their families and other experts. It is a 10-year plan to make the NHS fit for the future for patients, their families and staff. Among the many opportunities that the Long Term Plan affords us, it also provides us with the opportunity to continue to build on our great working with valued partners and stakeholders across our footprint. A joined-up, safe, local healthcare system is vital for the NHS going forward, something that the Long Term Plan alludes to.

All things considered, this has been a successful year for CWP and there are interesting, as well as challenging times ahead. Ultimately, I am hopeful it will be another positive year for the Trust. I am also confident that we will meet any challenges head-on, as we at #TeamCWP continue our dedication to providing outstanding care.

On behalf of the Board, to the best of my knowledge, the information presented in this report is accurate. I hope you enjoy reading our Quality Account.

Sheena Cumiskey



Chief Executive
Cheshire and Wirral Partnership NHS Foundation Trust

Statement from the Medical Director – Executive lead for quality

At CWP, we continue to be committed to providing high quality care for the people we serve. Our Quality Improvement strategy was launched in 2018, setting out how we will build on this commitment and dedication to providing outstanding care. As Sheena mentioned in her foreword, this year I'd like to share with you what we have achieved over the past year, and what our plans are for further embedding our Quality Improvement strategy over the coming year.

Ultimately, Quality Improvement is about understanding the needs of the people we serve and using helpful techniques to provide safe, effective, person-centred care with great experience. We want to make it easier to provide the best care. Our Quality Improvement strategy is a way to help us do this. It is based on a principle of organisations, staff and people who access health and care services working together to improve care and outcomes for the population. Quality improvement looks at what we currently do and the ways in which we can do things better. Lots of people in #TeamCWP have great ideas to improve care. The Quality Improvement strategy will support us in implementing good ideas and improvements – whether these are big or small, they will all make a difference. The quality improvement priorities we identified in last year's Quality Account are one example of this, which you can read more about in Part 2 of this report. Our Quality Committee has agreed that we continue to focus on these priorities this year, by refining them further with the aim of making further improvements and, just as importantly, demonstrating our commitment to continuous improvement. Our other achievements in implementing our Quality Improvement strategy this year include:

- Delivering a further 63 Quality Improvement projects, this is in addition to the 275 Quality Improvement projects we have delivered since 2014 when we launched our Zero Harm quality strategy.
- Development of a Quality Improvement 'hub' as an intranet resource for our staff to help them take forward their ideas for change and improvement.
- Establishment of our Quality Improvement twitter feed, entitled #cwpQI, to share our Quality Improvement successes. Already we currently have over 250 followers.
- Establishment of a Quality Improvement faculty to bring together the support for Quality Improvement. The faculty has helped to promote Quality Improvement and ensure that learning and good practice is shared.

To help us with our future plans, we've recently trained 15 Quality Improvement Experts. Our Experts are based across all clinical and clinical support services, and they will support people within their service areas to consider what may need to be improved/ changed, and to support this change using the new skills they have developed. Our Experts will use their knowledge and skills of Quality Improvement methodology to give all colleagues the confidence to drive forward the change they want to see.

Every year, I always like to give a mention to our Big Book of Best Practice! Our flagship publication contains all of the very best innovative work that has been taking place at CWP. The Big Book itself is a great example of our commitment to Quality Improvement, but it also supports learning and good practice being spread throughout our organisation. The Big Book for 2018/19, our sixth edition, was launched in October, the same day as our Annual Members Meeting. We invited all of our staff that had been selected to be a part of the Big Book to come along and showcase their work to members of the

public, governors and our stakeholders including commissioners and other public service partners. Yet again, we were thrilled with the response from our staff, with a brilliant 40 stalls being established on the day to celebrate some outstanding work.

Our Big Book of Best Practice has also been getting some national attention this year. The Big Book is a way for us to share our successes, not just throughout our organisation, but also with colleagues across the wider NHS and beyond. At the start of this year, alongside a number of our other best practice examples, the Big Book was published in a new NHS Improvement publication, which aims to help mental health trusts across the country improve services. CWP, alongside eight other mental health trusts, partnered with NHS Improvement to pull together learning and good practice in improvement. CWP shared a total of nine case studies – the most to appear in the document – and a number of resources and helpful quotes to support those looking to implement change. Then, at the end of this year, we were delighted to hear that the Big Book had been shortlisted for a prestigious national award. It has been nominated in the Communications Initiative category of the Health Service Journal (HSJ) Value Awards. The awards take place in May.

I hope you enjoy reading our Quality Account.

Dr Anushta Sivananthan

Medical Director & Consultant Psychiatrist
Cheshire and Wirral Partnership NHS Foundation Trust

Part 2.
Priorities for improvement and statements of assurance from the board

Priorities for improvement

Quality improvement priorities from 2018/19

CWP has made significant improvements towards the priorities set in last year's *Quality Account*.

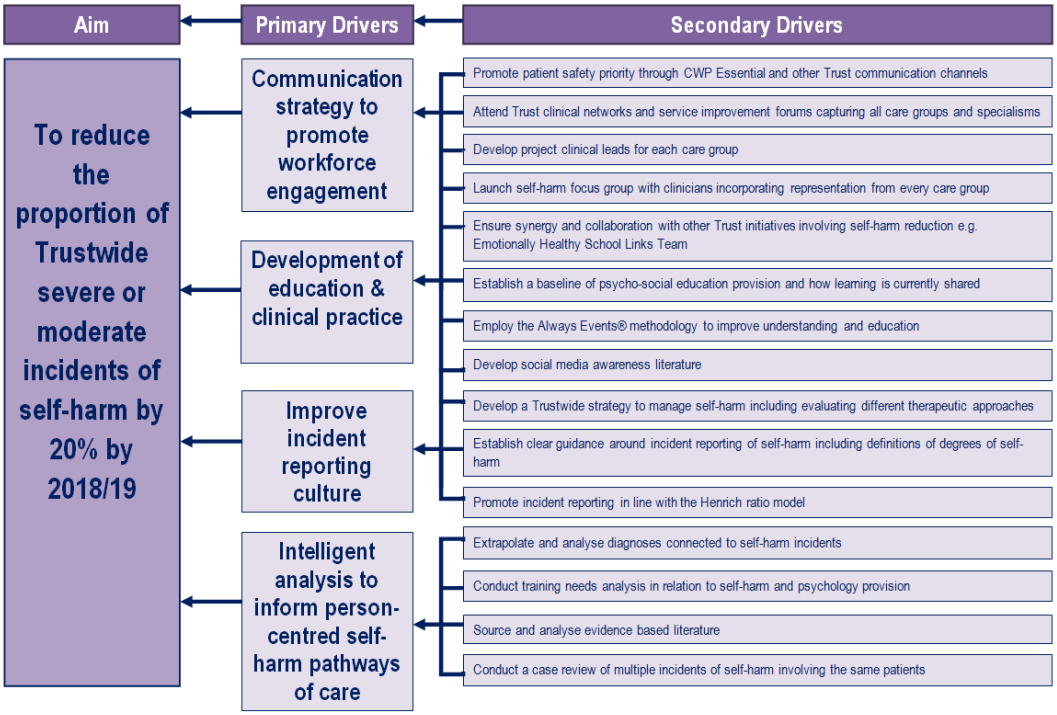
Below is a summary of our improvements, which are presented at the Trust's Board meetings and are available on the CWP website. Our *Quality Improvement Report*s, which are available on our website, have reported on progress throughout the year. Edition 3 of our *Quality Improvement Report* provides further detail on how we have made improvements in addition to the summary below.

We have included a glossary of some of the terms used in the report. *Annex A* explains these terms.

Patient safety priority for 2018/19

We wanted to:
Demonstrate a reduction in the severity of the harm sustained by those people accessing CWP services that cause harm to themselves.

This is because the evidence shows us that self-harm is strongly linked to poor safety outcomes, such as death by suicide, depression and anxiety.



How we have delivered improvements:

✓ We established a group, including experts on this subject matter, to deliver improvements in this area using quality improvement approaches. This also included regular engagement with other related areas of work such as suicide prevention.

✓ Promotion of this quality improvement work at clinical networks and quality improvement events to gather feedback on this area.

✓ We produced a 'share learning' bulletin to clarify the definition of self-harm in line with best evidence and NICE guidance. Our 'Safe Services' team also made changes to the incident reporting process for self-harm incidents to improve the consistency with which we capture these incidents and to help improve feedback and learning following self-harm incidents when they are reported.

✓ In-depth analysis of self-harm data to identify themes and specific areas/ opportunities for improvement.

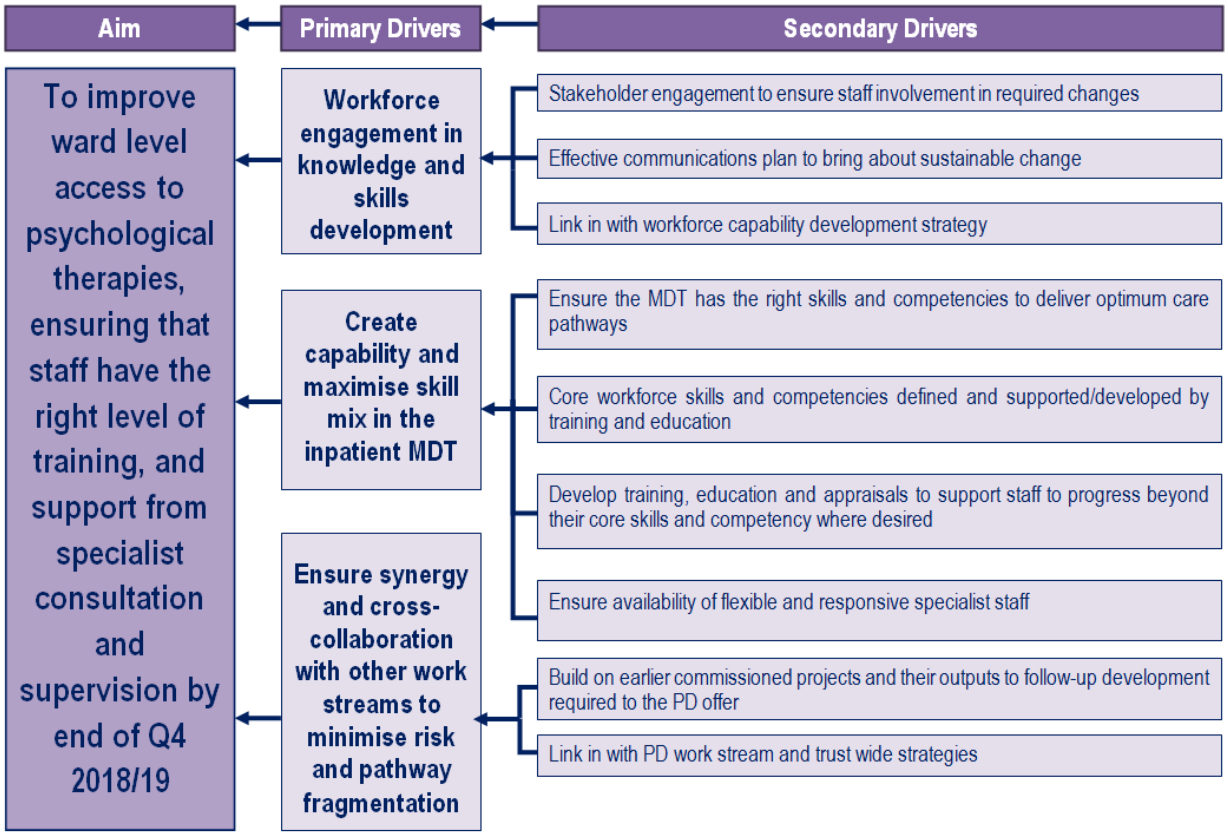
We have made significant progress in reducing moderate and severe incidents of self-harm, achieving a **12% reduction**.

Clinical effectiveness priority for 2018/19

We wanted to:

Improve access to psychological therapies in our inpatient units.

This is because clinically effective care includes access to a minimum psychological therapeutic service offer.



How we have delivered improvements:

✓ We established a multi-disciplinary group, including experts on this subject matter, to deliver improvements in this area using quality improvement approaches. This focused on the application of psychology skills on wards.

✓ We reviewed national standards for psychology and engaged with related areas of work, such as personality disorder, to develop Trustwide guidelines to support the capability of staff in this area.

✓ Promotion of this quality improvement work at clinical networks and quality improvement events to gather feedback on this area.

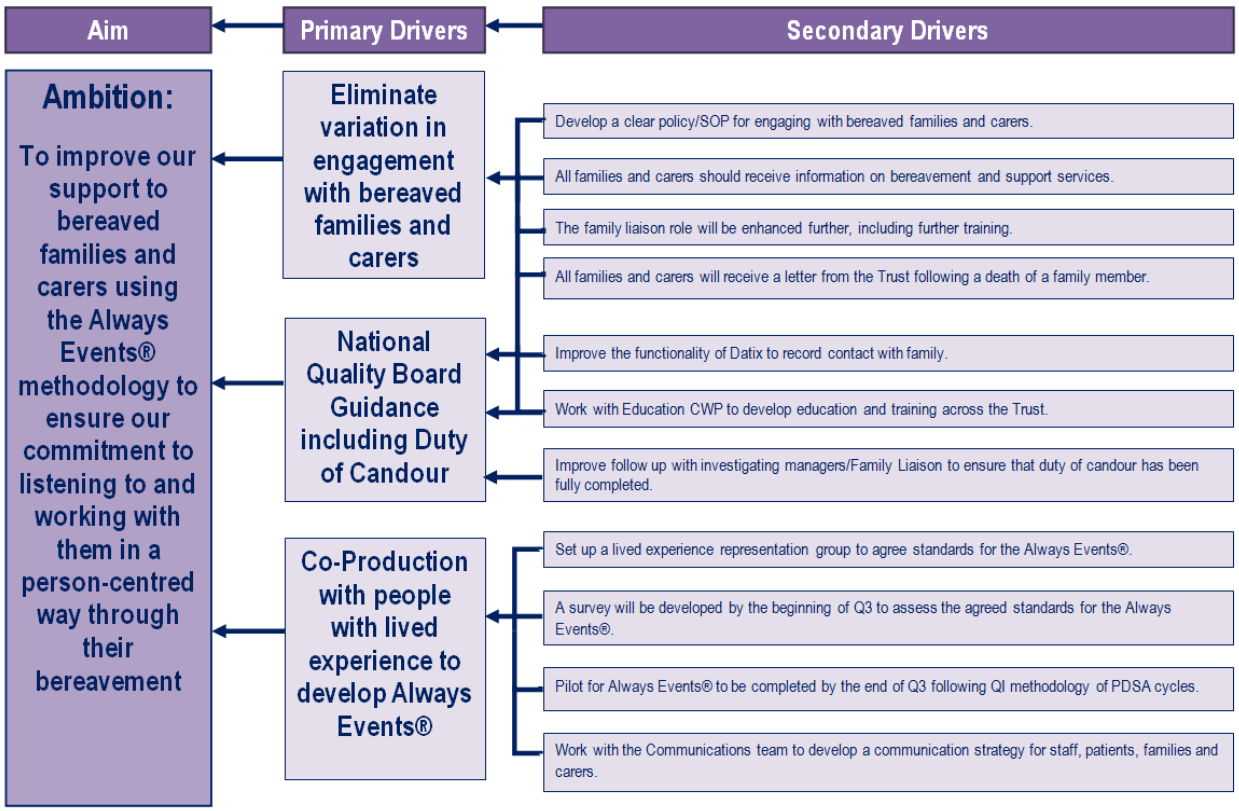
Having **demonstrated the scope for improvement that we can make to the access to psychological therapies for inpatients**, we are developing plans to help with delivering continuous improvements in this area.

Patient experience priority for 2018/19

We wanted to:

Improve engagement with bereaved families and carers.

This is because delivering a consistent level of timely, meaningful and compassionate support and engagement at every stage, from notification of the death to an investigation report and its lessons learned and actions taken, strengthens learning from deaths and improves the experience of bereaved families and carers.



How we have delivered improvements:

✓ We have developed a set of standards and principles, engaging with a lived experience representation group. This group has helped to agree fundamental principles, such as all families and carers receive information on bereavement and support services, and the development of person-centred communication. The group has also commenced work to co-produce a survey to seek views on the experience of bereaved families and carers.

✓ Further training has been provided to the Trust's family liaison officers to enhance the support provided to bereaved families and carers.

✓ Our 'Safe Services' team also made changes to the incident reporting process to help deliver the principles of the 'Duty of Candour', which includes the key aim of supporting bereaved families and carers.

We have **improved our offer to bereaved families and carers**, by now providing more information, that is as person-centred and as supportive as possible, ensuring they are able to provide feedback on their experiences so we can learn from what we do well and to improve where we have scope to do so.

Quality improvement priorities for 2019/20

Our Quality Committee oversees our Trustwide quality improvement priorities. It has agreed that we continue to focus on these priorities this year, by refining them further with the aim of making further improvements and, just as importantly, demonstrating our commitment to continuous improvement.

These priorities have been set out in our plans, including how they link to our organisational objectives. This allows them to be consistently consulted on and effectively communicated across the Trust and wider stakeholder groups.

Our Quality Improvement Reports, which are available on our website, will report on progress with our quality improvement priorities for 2019/20 throughout the year. This report is also presented at and monitored by our Quality Committee and our Board.

Our approach to Quality Improvement

Our Quality Improvement strategy builds on our successful Zero Harm quality strategy that we have reported on in previous Quality Accounts. It was launched in April 2018 and sets out an initial three year plan to help us deliver person-centred health care that responds to the needs and preference of people who access our services, with a compelling ambition to work in partnership to deliver the best outcomes nationally for the population we serve. In developing our Quality Improvement strategy and our ambition, we sought feedback from our Board, Quality Committee, Clinical Engagement and Leadership Forum, Governors, and via focus groups with partners and stakeholders.

Institute for Healthcare Improvement guidance has encouraged us to assess and monitor quality, using a broader definition than as defined in 2008 by the Department of Health. This will help us to better identify and prioritise areas for improvement. Together with World Health Organization definitions and our Person-centred Framework, we have defined quality as described in our Quality Framework:

Q U A L I T Y					
Patient safety	**Clinical effectiveness**			**Patient experience**	
Safe	**Effective**	**Affordable**	**Sustainable**	**Acceptable**	**Accessible**
Achieving **Equity** and **Person-centred Care** through **CO-PRODUCTION, CO-DELIVERY, QUALITY IMPROVEMENT & WELL-LED SERVICES**					
Delivering care in a way which increases safety by using effective approaches that mitigate unwarranted risks	Delivering care that follows an evidence base and results in improved health outcomes, based on people's needs	Delivering care in a way which maximises use of resources and minimises waste	Delivering care that can be supported within the limits of financial, social and environmental resources	Delivering care which takes into account the preferences and aspirations of people	Delivering care that is timely, geographically reasonable, and provided in a place where skills and resources are appropriate to meet people's needs

Our patient safety priority for 2019/20

Measure		Reduction in the number of incidents of people accessing CWP services that have caused harm to themselves	**Specialist Mental Health services**	✓
			Learning Disability, Neuro Developmental Disorders & Acquired Brain Injury services	✓
			Children, Young People & Families services	✓
			Neighbourhoods & integrated care services	✓
Rationale	**Locally**	We want to demonstrate continuous improvement in the number of reported incidents of self-harm, to complement the 12% decrease in incidents of moderate and severe self-harm that we have achieved during 2018/19 (Source: Trustwide 'Learning from Experience' reports, 2018/19)		
	Nationally	There is a wide variation between services in the frequency of self-harm (Source: Care Quality Commission 'State of Care' report 2016/17)		
Baseline		2018/19 National Reporting and Learning System data – CWP ranks 37th out of 50 (the lowest 25%) of other mental health trusts		
Improvement target		Trustwide incident reports of self-harm to be comparable with the middle 50% of peer reporters (other mental health trusts) to the National Learning and Reporting System		
Source		Incident reporting data as published by the National Reporting and Learning System and reported in the Trustwide 'Learning from Experience' report		

Our clinical effectiveness priority for 2019/20

Measure		Improvement in access to psychological therapies for people accessing acute care services (*this priority will also aim to improve access for people accessing community and primary care services*)	**Specialist Mental Health services**	✓
			Learning Disability, Neuro Developmental Disorders & Acquired Brain Injury services	✓
			Children, Young People & Families services	✓
			Neighbourhoods & integrated care services	✓
Rationale	**Locally**	Gaps and variation in the current psychological therapeutic offer to people accessing care across each inpatient unit (Source: Internal review commissioned by the Board, undertaken by the acute care nurse consultant)		
	Nationally	Health care organisations should be assured that they are providing effective care that includes psychological interventions (Source: Care Quality Commission 'State of Care' report 2016/17)		
Baseline		Access to psychological therapies = variable per ward		
Improvement target		Delivery of a minimum, consistent psychological therapeutic service offer to people accessing care across each inpatient unit by the end of 2019/20		
Source		Quality improvement project reporting		

Our patient and carer experience priority for 2019/20

Measure		Improvement in engagement with bereaved families and carers	**Specialist Mental Health services** ✓ **Learning Disability, Neuro Developmental Disorders & Acquired Brain Injury services** ✓ **Children, Young People & Families services** ✓ **Neighbourhoods & integrated care services** ✓
Rationale	**Locally**	Variation in the delivery of consistent levels of support and engagement with bereaved families and carers (Source: Outputs of scoping work undertaken by a lived experience representation group 2018/19)	
	Nationally	Health care organisations should prioritise working more closely with bereaved families and carers and ensure that a consistent level of timely, meaningful and compassionate support and engagement is delivered and assured at every stage, from notification of the death to an investigation report and its lessons learned and actions taken (Source: National Quality Board 'National Guidance on Learning from Deaths' report 2017)	
Baseline		Baseline to be determined end of quarter 2 2019/20 following completion of engagement events to agree minimum bereavement support interventions (in addition to person-centred principles)	
Improvement target		By the end of 2019/20, delivery of agreed minimum support offer to people who have been bereaved 9families and carers of people who have accessed CWP's services)	
Source		Reporting data as published in the Trustwide 'Learning from Experience' report	

Statements of assurance from the board

The purpose of this section of the report is to provide formally required evidence on the quality of CWP's services. This allows readers to compare content that is common across all *Quality Account*s nationally.

Common content for all *Quality Account*s nationally is contained in a shaded double line border like this. We are required to use certain wording.

Information on the review of services

We are commissioned to provide the following services:

- NHS Bolton CCG – Eating Disorder services.
- NHS England – CAMHS Tier 4, Specialised Eating Disorder, Low Secure, school age immunisations programmes, Child Health Information Systems, and Specialist Community Peri-natal Mental Health services.
- NHS Eastern Cheshire CCG – Mental Health, Learning Disability, CYP, and Eating Disorder services.
- NHS South Cheshire and Vale Royal CCGs – Mental Health (including IAPT services), Learning Disability, CYP, and Eating Disorder services.
- NHS South Sefton and NHS Southport and Formby CCGs – IAPT services.
- NHS Trafford CCG – Eating Disorder services and Learning Disability services.
- NHS Western Cheshire CCG – Mental Health (including IAPT services), Learning Disability, CYP, and Community services.
- NHS Wirral CCG (and co-commissioners) – Mental Health, Learning Disability, Eating Disorder, CYP, and ASD services.
- Betsi Cadwaladr University Health Board – Emergency Mental Health services.
- Wirral Metropolitan Borough Council – Nurse Practitioner for the Homeless, and All Age Disability services.

- Cheshire East Council – Substance Misuse services* (until 31 October 2018) and Emotionally Healthy Schools.
- Cheshire West and Chester Council – Starting Well (0-19 services), and Infection, Prevention and Control services.

We also deliver various CCG commissioned specialist services to support people with Autism of all ages and abilities.

During 2018/19 Cheshire and Wirral Partnership NHS Foundation Trust provided and/ or sub contracted 81 NHS services, as outlined within the Trust's contract with its commissioners. The income generated by the relevant health services reviewed in 2018/19 represents 94.4 per cent of the total income generated from the provision of relevant health services by Cheshire and Wirral Partnership NHS Foundation Trust for 2018/19.

We have reviewed the data on the quality of our services in the following ways during the year.

Contract review and monitoring

We work together with our commissioners to review and update the quality requirements in our contracts to ensure that they reflect changes in best practice and emerging national or local good clinical or good healthcare practice. To support this work, a joint Cheshire and Wirral contract setting out quality requirements (a quality 'schedule') was developed during 2018/19, with reporting shared across our five main CCG commissioners.

Reviewing the results of surveys

We have engaged people who access our services, carers, people who deliver our services, and other partners in a wide variety of survey activity to inform and influence the development of our services.

The NHS Staff Survey is used to review and improve the experience of the people who deliver our services. The results also inform local and national assessments of the quality and safety of care, and how well organisations are delivering against the standards set out in the *NHS Constitution*. Trusts are asked to provide the following specific survey results, to demonstrate progress against a number of indicators of workforce equality linked to the Workforce Race Equality Standard (WRES):

Q13C – Percentage of staff who have not experienced harassment, bullying or abuse from other colleagues

White	86.7%
Black and minority ethnic	90.8%

Q14 – Percentage of staff believing that the trust provides equal opportunities for career progression or promotion

White	89%
Black and minority ethnic	81.8%

Further information can be found at:
http://www.nhsstaffsurveyresults.com/wp-ontent/uploads/2019/05/NHS_staff_survey_2018_RXA_full.pdf

The WRES detailing the NHS Staff Survey results for 2018 will be published on our website in July 2019.

Learning from experience – examples

Learning from a **complaint** has brought about improvement in the information we provide for those families who are supporting and caring for a loved one who is dying. This information includes the care and treatment that can be provided and the support that is available.

Learning from an **incident** has improved person-centred care, through collaborative working with people accessing our services and the multi-disciplinary team, in order to achieve timely interventions. This includes exploring new coping strategies using a 'traffic light' system to reduce or avoid further incidents and mitigate the risk of harm.

Learning from a **clinical claim**, where a person died by suicide, identified that a formal psychiatric assessment by a consultant psychiatrist should have taken place for this person. Clinical reflection at an individual and at multi-disciplinary team level has increased awareness of ensuring people are involved in the 'triangle of care', are more supported and are informed of care plans.

Learning from deaths monitoring

In March 2017, the *National Quality Board* published guidance on "Learning from Deaths" which requires all NHS trusts to increase the number of deaths they can learn lessons from by reviewing deaths that they were not previously required to review, such as expected deaths. Since this guidance, we have been increasing the reporting and review of deaths that do not meet the serious incident criteria set out by *NHS England* to help us identify more learning. This work is being reported in our Learning from Experience report and is being monitored by our Quality Committee.

The National Health Service (Quality Accounts) (Amendment) Regulations 2018/19 require all NHS trusts to report on the following information.

During 2018/19 980 of Cheshire and Wirral Partnership NHS Foundation Trust's patients died*. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 272 in the first quarter;
- 244 in the second quarter;
- 272 in the third quarter;
- 192 in the fourth quarter.

By March 2019, 568 case record reviews and 92 investigations have been carried out in relation to 980 of the deaths included above. In 92 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 88 in the first quarter;
- 139 in the second quarter;
- 159 in the third quarter;
- 182 in the fourth quarter.

One (1) representing 0.2% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in care provided to the patient. In relation to each quarter, this consisted of:

- One (1) representing 1.2% for the first quarter;
- Zero (0) representing 0% for the second quarter;
- Zero (0) representing 0% for the third quarter;
- Zero (0) representing 0% for the fourth quarter.

These numbers have been estimated using the multi-disciplinary team assessment of the case record reviews**.

Cheshire and Wirral Partnership NHS Foundation Trust has learnt the following from case record reviews in relation to the patient deaths during the reporting period (these have been reported to the Board). The actions taken and the impact of these are summarised below.

- Shortfalls identified in formulating plans of care and the quality of documentation has led improvements in this area.

Zero (0) case record reviews and zero (0) investigations were completed after April 2018 which related to deaths which took place before the start of the reporting period.

Zero (0) representing 0% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in care provided to the patient. This number has been estimated using the multi-disciplinary team assessment of the case record reviews.

Zero (0) representing 0% of the patient deaths during 2018/19 are judged to be more likely than not to have been due to problems in the care provided to the patient.

* includes deaths of people who were discharged from CWP's care within 6 months of their death

** For investigations into serious incidents, there is currently no nationally agreed or validated tool, for mental health or learning disability services, to determine whether deaths are due to problems in care provided. The Royal College of Psychiatrists is developing a tool which CWP will review as part of its commitment to implement the best evidence in conducting reviews of learning from deaths. The information above is from the bespoke tool that CWP has developed in 2018/19, using quality improvement approaches – this tool uses a multi-disciplinary team assessment of case records.

Speaking up

We are committed to creating an open and honest learning culture that is responsive to feedback so that we can continually improve. We meet the statutory requirement, set out by NHS England, of having Freedom to Speak Up Guardians available to support any staff member to raise a concern that they may have, including around quality of care, patient safety or bullying and harassment.

Our speaking up policy and processes have been reviewed and are up-to-date and in line with recommendations of the National Guardian's Office. This includes standards around promoting ways in which staff can speak up, how feedback is given to those who speak up, and ensuring that staff who do speak up do not suffer detriment. Our Freedom to Speak Up Guardians have a clear understanding of their roles and responsibilities and have the time and support needed to undertake them.

Our Director of Nursing, Therapies and Patient Partnership is the Executive Lead for speaking up. We also have a Non Executive Director Freedom to Speak Up Champion, who provides alternative support to the Freedom to Speak Up Guardians, scrutinises our approach, and is able to robustly challenge speak up governance.

The Board receives regular reports in relation to speak up that provides ongoing assurance that the Trust adheres to good practice and that appropriate speak pp arrangements are in place.

Feedback from people who access the Trust's services

We welcome compliments and comments from people who access our services, their families and carers, and use the feedback to act on suggestions, consolidate what we do well, and to share this best practice across the Trust.

Our *Learning from Experience* report, which is produced three times a year, reviews learning from incidents, complaints, concerns, claims and compliments, including Patient Advice and Liaison Service (PALS) contacts. Reviewing them together, with the results of clinical audits, helps to identify trends and spot early warnings, so that actions can be taken to prevent potential shortfalls in care. Sharing learning is key to ensuring that safety is maintained and that action can be taken to prevent recurrence of similar issues. These *Learning from Experience* reports are shared with the public, via our Board meetings, our partner organisations and via our website.

Examples of feedback from people who access our services, their families and carers, includes:

"I always like hearing your calm and friendly voice when I ring and seeing your smiling face when I come to Rosemount! It makes a big difference!"
Learning Disability, Neuro-Developmental Disorder & Acquired Brain Injury services

"Excellent care of our mother – compassionate keeping her dignity, treating her with respect, and us her family, with understanding and care. We felt supported during a very difficult time."
Joint Therapy services

"Thank you for being so kind and lovely to me. You really make me laugh. Thank you for all the support you have given me over the past month."
Children, Young People & Families services

"I have felt so supported. It has been so helpful to be able to talk and rationalise my thoughts and feelings. I have been able to see my progress in a positive way and ask for help when needed."
Specialist Mental Health – Place Based services

"Thanking staff nurse for support during admission. Staff nurse gave patient so much time and help, how she listened, held her hand, mopped up her tears. Gave support in darkest moments and made patient feel safe, understood and cared for. She can never thank staff member enough for her support and care".
Specialist Mental Health – Bed Based services

"Thank you for all the help and support you provided for me and my husband in the last few days of his life. The CART team and all DNs have been amazing. Cannot fault the service."
Neighbourhoods and Integrated Care services

"We would be lost without you and appreciate everything you do everyday to help me to get him to school. Though at times things are challenging you all smile and do such a wonderful job. You are all kind and patient and that means so much to us and although our son cannot express it, I'm sure if he could, he would say a massive thank you too!"
All Age Disability services

Duty of Candour

All health and care professionals have a duty of candour, which is professional responsibility to be honest with people who access health and care services, their advocates, carers and families when things go wrong. Providers of these services are regulated on how they deliver this responsibility. A key requirement is for individuals and organisations to learn from events to change and improve the safety and quality of care. We take a continuous improvement approach to being open and transparent, including reviewing the effectiveness of the role of our family liaison officers who support people affected by serious incidents. We aim to continually improve our communication and connection with people who access our services, their families and carers, ensuring that they are central to reviews of the care we have provided and that their feedback is acted upon and incorporated into our responses. Learning is reported through our Learning from Experience report, which is monitored by our Quality Committee.

Reviewing the results of clinical audit

Clinical audit is used to check that standards of care are of a high quality. Where there is a need for improvement, actions are identified and monitored. The next section describes this is greater detail.

Information on participation in clinical audits and national confidential enquiries

National clinical audits and national confidential enquiries

National clinical audits

We take part in national audits in order to compare findings with other NHS trusts to help us identify necessary improvements to the care we provide and deliver to people accessing our services.

National confidential enquiries

National confidential enquiries are nationally defined audit programmes that ensure there is learning from the investigation of deaths that have occurred in specific circumstances (taken from a sample of deaths that have happened nationally) in order to improve clinical practice.

During 2018/19 nine national clinical audits covered relevant health services that Cheshire and Wirral Partnership NHS Foundation Trust provides. During 2018/19 the Trust participated in 82% of national clinical audits which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Trust was eligible to participate in during 2018/19 are as follows:

- National Prescribing Observatory for Mental Health: Topic 6d: Assessment of the Side Effects of Depot/ Long-Acting Injectable Antipsychotic Medication.
- National Prescribing Observatory for Mental Health: Topic 7f: Monitoring of patients prescribed lithium.
- National Prescribing Observatory for Mental Health: Topic 18a: The Use of Clozapine.
- NHS England/ Royal College of Psychiatrists: Early Intervention in Psychosis Self-Assessment Audit.
- NHS England/ Royal College of Psychiatrists: National Clinical Audit of Psychosis including National CQUIN: Physical health assessment of patients with severe mental illness; also Communication with General Practitioners.
- University of Bristol: Learning disability mortality review programme.
- National Clinical Audit of Anxiety and Depression.
- National Clinical Audit of Anxiety and Depression: Psychological Therapies Spotlight audit.

The national clinical audits that the Trust participated are listed below alongside the number of cases submitted to each audit.

	Cases submitted (as a percentage of registered cases within CWP)	
National clinical audits		
National Prescribing Observatory for Mental Health: Topic 6d: Assessment of the Side Effects of Depot/ Long-Acting Injectable Antipsychotic Medication	**181 (91%)**	Data submitted; report awaiting publication. Action planning will then follow.
National Prescribing Observatory for Mental Health: Topic 7f: Monitoring of patients prescribed lithium	**78 (58%)**	Data submitted; report awaiting publication. Action planning will then follow.
National Prescribing Observatory for Mental Health: Topic 18a: The Use of	**129 (51%)**	Data submitted; report awaiting publication. Action planning will then

	Cases submitted (as a percentage of registered cases within CWP)		
National clinical audits			
Clozapine			follow.
National Clinical Audit of Anxiety and Depression (Core Audit)	**90 (100%)**		Data submitted; report awaiting publication. Action planning will then follow.
National Clinical Audit of Anxiety and Depression: Psychological Therapies Spotlight audit	**83 (70%)**		Data submitted, report awaiting publication. Action planning will then follow.
National Clinical Audit of Psychosis Mental Health CQUIN 3a for Community Patients and Inpatients	**110 (99%)**		Report to be published June 2019.
Early Intervention in Psychosis Network/ Royal College of Psychiatrists: Early Intervention in Psychosis Self-Assessment Audits: Wirral, West, Central and East Cheshire	**Central & East**	**77 (100%)**	Reports to be published in June 2019. Action planning will then follow.
	West	**55 (100%)**	
	Wirral	**120 (100%)**	
NHS England: Physical health assessment of patients with severe mental illness: Communication with General Practitioners	**Central & East**	**40 (100%)**	Report provided to commissioners April 2019. An improvement plan has been developed, including standardising the use of the cardio-metabolic screening form to avoid duplication of recording.
	West	**40 (100%)**	
	Wirral	**40 (100%)**	
Learning disability mortality review programme (LeDeR)	**49 (100%)**		Ongoing data submission.

	Percentage of cases submitted
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness	
Sudden unexplained death in psychiatric inpatients	**No cases**
Suicide	**100%**
Homicide	**100%**
Victims of homicide	**No cases**

Local CWP clinical audits

The reports of nine completed local clinical audits were reviewed in 2018/19 and Cheshire and Wirral Partnership NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Title of local clinical audit	Good practice identified	Action/s taken
1. Compliance with Trust CPA policy documentation (perinatal services)	▪ The audit demonstrated that all patients had care co-ordinator allocated within 4 weeks of initial contact.	▪ Development of the electronic clinical record to help practitioners better comply with CPA standards. ▪ Enhanced local training has been implemented around CPA documentation standards.
2. Structural neuroimaging in dementia	▪ People in the memory clinic were assessed as per NICE dementia clinical guideline (CG42) for dementia.	▪ Identification of a re-audit to review practice in line with the new NICE clinical guideline (CG97).

Title of local clinical audit	Good practice identified	Action/s taken
3. Respiratory tract infections – Antibiotic prescribing (re-audit)	▪ Re-audit demonstrated improvement in advice given to people with regards to the antibiotic strategy.	▪ Promotional activities around patient information leaflets.
4. UTI in children (re-audit)	▪ Re-audit has demonstrated almost full compliance with best practice guidance on standards for UTI in children.	▪ Promotional activities to help strengthen clinical documentation detailing the duration of antibiotic treatment.
5. Audit of junior doctor and nursing staff on-call duties within CWP – Venepuncture and electrocardiogram	▪ 100% completion of routine venepuncture and ECG duties within 72 hours at Springview Hospital.	▪ Identification of a re-audit to assure full compliance is being sustained.
6. Patient step-down from PICU to general adult open wards	▪ Compliance with standards demonstrating efficient and effective patient care, and continued progression towards recovery and discharge from inpatient stays.	▪ Service improvement meetings have been held to identify changes and improvements to facilitate more timely transfers from PICU to general adult open wards.
7. Feverish illness in children – Out of hours service) (re-audit)	▪ Good compliance with NICE clinical guideline 160. ▪ Achievement of 100% in recognising sick children and transferring them urgently to secondary care/ specialist care. ▪ Achievement of 100% in treating feverish children appropriately and only prescribing antibiotics if indicated.	▪ Improvement to the design of the 'child assessment' template within the clinical record.
8. DNA rates at CMHT response team	▪ There is a proactive overview of DNA rates by consultant and team manager.	▪ Implementation of a text reminder service.
9. Record keeping	▪ The majority of the records audited were contemporaneous and whenever possible made immediately after contact with the patient. ▪ High compliance in relation to documented risk assessments. ▪ High compliance in relation to legible prescription sheets/ charts containing adequate details, i.e. patient identifier, dosage and signature.	▪ Conducted record keeping standards staff awareness campaign for ward based staff. ▪ Revision of audit tool for collection of results by care groups. ▪ Revision of audit tool to improve clarity of questions and remove questions which are no longer applicable.

National and local CWP clinical audits are reviewed as part of the annual healthcare quality improvement programme (which incorporates clinical audit), and are reported to our *Clinical Practice & Standards Sub Committee*, chaired by the Medical Director (Executive Lead for Quality).

We have an infection prevention and control (IPC) audit programme, to ensure cleanliness of the care environment, identify good IPC practice and areas for improvement. We also analyse patient safety standards, including use of the national safety thermometer tool, to monitor the degree to which we provide harm free care in relation to areas such as pressure ulcer care and falls through our Learning from Experience report, presented at our Quality Committee, which identifies areas for improvement.

Information on participation in clinical research

The NHS Constitution states that research is a core part of the NHS, enabling the NHS to improve the current and future health. Our staff are recognised internationally for their pioneering work through their involvement in research to discover best practice and innovative ways of working.

The number of patients that were recruited during that period to participate in research approved by a research ethics committee was **1066**.

Cheshire and Wirral Partnership NHS Foundation Trust was involved in conducting **24** clinical research studies in all of its clinical services during 2018/19.

There were **214** clinical staff participating in approved research during 2018/19. These staff participated in research covering **8** medical specialties.

The number of principal investigators in CWP has increased over the last year and more clinicians are actively involved in research. CWP has been associated with **19** research publications, the findings from which are used to improve patient outcomes and experience across the Trust and the wider NHS.

During 2018/19, CWP successfully recruited 3 participants to a Phase 3 study examining the efficacy and safety of a new drug for Alzheimer's Disease, and 106 patients and carers were recruited to a study investigating cognitive aids for those with mild to moderate dementia. CWP have also been participating in a study investigating the effect of Vitamin D in those diagnosed with First Episode Psychosis.

NICE guidance

The *National Institute for Health and Care Excellence* (*NICE*) provides national guidance and advice that helps health, public health and social care professionals to deliver the best possible care based on the best available evidence. Many of our specialists are involved in the production of national guidelines for *NICE*.

Information on the use of the CQUIN framework

The *Commissioning for Quality and Innovation* (*CQUIN*) payment framework enables commissioners to reward excellence, by linking a proportion of our income to the achievement of local, regional, and national quality improvement goals. *CQUIN* goals are reviewed through the contract monitoring process.

A proportion of Cheshire and Wirral Partnership NHS Foundation Trust's income in 2018/19 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2019/20 available by request from the Trust's Effective Services Department: email lynndavison@nhs.net

The maximum income available in 2018/19 was £3,238,994, including a further £1,723,068 for meeting technical requirements stipulated by NHS Improvement and NHS England. Cheshire and Wirral Partnership NHS Foundation Trust received £2,913,166 for the *CQUIN* goals achieved (for 2017/18 this was £1,902,417). The total monies available in 2019/20, upon successful achievement of all the agreed *CQUIN* goals, is forecast to be £1,721,002, based on the NHS Improvement and NHS England new CQUIN payment framework.

Information relating to registration with the Care Quality Commission and periodic/ special reviews

Independent assessments of CWP and what people have said about the Trust can be found by accessing the Care Quality Commission's website. Here is the web address of CWP's page: http://www.cqc.org.uk/directory/rxa

Cheshire and Wirral Partnership NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is **registered and licensed to provide services**. The Trust has no conditions on its registration.

The Care Quality Commission has **not** taken enforcement action against the Trust during 2018/19.

Cheshire and Wirral Partnership NHS Foundation Trust has participated in **1** investigation or review by the Care Quality Commission during 2018/19, relating to the following:

A routine regulatory assessment of the 'well-led question', including targeted inspections focused on individual services and their leadership.
The individual services assessed were:

- Wards for older people with mental health problems
- Acute wards for adults of working age and psychiatric intensive care units
- Child and adolescent mental health wards
- Forensic inpatient/secure wards
- Community health services for children, young people and families
- GP out of hours service
- Primary medical services

Following this inspection, the Trust's rating has been sustained, remaining as "Good" overall with "Outstanding" for care.

The Trust intends to take the following action to address the conclusions or requirements reported by the Care Quality Commission:

- Update registration with the Care Quality Commission to enable the regulated activity of minor surgery to be carried out at Westminster Surgery.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care at Westminster Surgery.
- Enhance systems to improve complaints management at Westminster Surgery.
- Ensuring effective systems and processes are in place to monitor and manage staff access to clinical supervision.
- Ensuring patients' privacy, dignity and safety is not compromised as a result of breaches in relation to guidance on mixed sex accommodation.
- Making sure that each patient who requires one has a personal emergency evacuation plan in place.
- Supporting staff to maintain compliance with mandatory training.
- Ensuring that physical health monitoring takes place and policy and national guidance followed after the administration of rapid tranquilisation to a patient in the service.
- Supporting staff to consistently record their responsibilities under the Mental Health Act Code of Practice relating to seclusion and reasons are given if staff need to depart from the code.
- Supporting staff to consider, and record discussions, around the differing thresholds and responsibilities between seclusion and long-term segregation.
- Carrying out audits relating to seclusion and rapid tranquilisation

The Trust has made the following progress by 31 March 2019 in taking such action:

- A quality improvement plan was developed in response to the conclusions and requirements identified by the Care Quality Commission. All of the identified improvement actions are either completed or are on track for completion by the end of May 2019. Cheshire and Wirral Partnership

NHS Foundation Trust meets with the Care Quality Commission on a quarterly basis to provide updates on the progress made in taking the actions required.

Overall rating for services at this Provider	Good
Are Services safe?	Requires improvement
Are Services effective?	Good
Are Services caring?	Outstanding
Are Services responsive?	Good
Are Services well-led?	Good

Information on the quality of data

NHS number and general medical practice code validity

The patient *NHS number* is the key identifier for patient records. Improving the quality of NHS number data has a direct impact on improving clinical safety by preventing misidentification.

Accurate recording of a patient's *general medical practice code* is essential to enable transfer of clinical information about the patient from a Trust to the patient's GP.

Cheshire and Wirral Partnership NHS Foundation Trust submitted records during 2018/19 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage (to one decimal point) of records in the published data which included the patient's valid NHS number was:
99.8% for admitted patient care;
100.0% for outpatient care.

The percentage of records (to one decimal point) in the published data which included the patient's valid General Medical Practice Code was:
100.0% for admitted patient care; and
100.0% for outpatient care.

Information Governance Toolkit attainment levels

The Information Quality and Records Management attainment levels assessed within the Information Governance Toolkit provide an overall measure of the quality of data systems, standards and processes within an organisation.

The Data Security & Protection Toolkit, which replaced the Information Governance toolkit in May 2018, is subject to annual internal audit. This was recently completed and a significant/ substantial assurance opinion was issued for the seventh consecutive year.

Clinical coding error rate

Cheshire and Wirral Partnership NHS Foundation Trust was **not** subject to the *Payment by Results* clinical coding audit during 2018/19 by the *Audit Commission*.

Statement on relevance of data quality and actions to improve data quality

Good quality information underpins the effective delivery of the care of people who access NHS services and is essential if improvements in quality of care are to be made.

Data quality

Cheshire and Wirral Partnership NHS Foundation Trust will be taking the following actions to improve data quality:

- Continue to implement the Trust's data quality improvement framework during 2019/20, this will involve improvements in the notification of data quality issues to our clinical teams.
- Implement the improvement actions identified in response to recommendations arising from the independent audit of the mandated and local indicators identified in Part 3.
- Delivery of the Trustwide data quality (data capture, flow and production) strategic risk treatment plan to progress mitigating actions identified.

Performance against key national quality indicator targets

We are required to report our Trustwide performance against a list of national measures of access and outcomes, against which we are judged as part of assessments of our governance. We report our performance to the Board and our regulators throughout the year. These performance measures and quality outcomes help us to monitor how we deliver our services.

We have successfully met all required organisational performance levels for the quality indicator targets detailed below. Performance against all targets from NHS Improvement's Single Oversight Framework 2018/19, including our local indicator chosen by the council of governors as described in Part 3, is detailed in our Annual Report 2018/19.

Individual teams benchmark against each other and other services in the Trust to identify how they can continuously improve their performance.

Performance against key* national quality indicator targets from *NHS Improvement*'s Single Oversight Framework 2018/19

Indicator	Required Trustwide performance threshold	**Trustwide
Care Programme Approach (CPA) patients, comprising:	95.0%	**96.5%**
▪ Receiving follow-up contact within seven days of discharge		
▪ Having formal review within 12 months	95.0%	**96.5%**
Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral	50.0%	**68.7%**
Improving access to psychological therapies (IAPT): ▪ Proportion of people completing treatment who move to recovery	50%	**50.0%**
▪ People with common mental health conditions referred to the IAPT programme will be treated within 6 weeks of referral	75%	**85.2%**
▪ People with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral	95%	**99.5%**
Minimising mental health delayed transfers of care	≤7.5%	**3.7%**
Admissions to inpatient services that had access to crisis resolution/ home treatment teams	95.0%	**96.3%**

*Additional national quality indicator targets are detailed in Part 3 of this Quality Account – see section "An overview of the quality of care offered by CWP – performance in 2018/19"

**Trustwide includes all relevant services (see section above entitled "Information on the review of services")

Performance against quality indicators: 2017/18 – 2018/19

*Quality Account*s are required to report against a core set of quality indicators provided by *NHS Digital*. This allows readers to compare performance common across all *Quality Account*s nationally. These are detailed in the following table.

		Reporting period					
		2018/19			2017/18		
Quality indicator	**Related NHS Outcomes Framework domain**	**CWP performance**	**National average**	**National performance range**	**CWP performance**	**National average**	**National performance range**
Care Programme Approach (CPA) patients receiving follow-up contact within seven days of discharge from psychiatric inpatient care	Preventing people from dying prematurely Enhancing quality of life for people with long-term conditions	Quarter 1 **97.9%**	Quarter 1 **96.4%**	Quarter 1 **73.4% – 100%**	Quarter 1 **98.9%**	Quarter 1 **95.4%**	Quarter 1 **69.2% – 100%**
		Quarter 2 **95.3%**	Quarter 2 **95.7%**	Quarter 2 **83% – 100%**	Quarter 2 **98.1%**	Quarter 2 **96.7%**	Quarter 2 **87.5% – 100%**
		Quarter 3 **96.5%**	Quarter 3 **95.5%**	Quarter 3 **81.6% – 100%**	Quarter 3 **97.2%**	Quarter 3 **95.4%**	Quarter 3 **69.2% – 100%**
		Not available until June 2019	Not available until June 2019	Not available until June 2019	Quarter 4 **99.2%**	Quarter 4 **95.5%**	Quarter 4 **68.2% – 100%**
		Cheshire and Wirral Partnership NHS Foundation Trust considers that this data is as described because the Trust's data is checked internally for consistency and accuracy by the responsible staff in line with internal gatekeeping processes. The Trust's external auditors have verified the processes for production of this data. The Trust has achieved the performance target for this quality indicator, as required by the Department of Health and NHS Improvement (target for 2018/19 is **achieving at least 95.0%** rate of patients followed up after discharge, CWP performance for 2018/19 is 96.4%*). The Trust has taken the following action to improve this percentage, and so the quality of its services: targeting work with services and teams demonstrating areas of underperformance by offering support through dedicated analysts.					
Admissions to acute wards for which the crisis resolution home treatment team acted as a gatekeeper	Enhancing quality of life for people with long-term conditions	Quarter 1 **96.6%**	Quarter 1 **98.1%**	Quarter 1 **85.1% – 100%**	Quarter 1 **98.1%**	Quarter 1 **98.5%**	Quarter 1 **91.4% – 100%**
		Quarter 2 **100%**	Quarter 2 **98.4%**	Quarter 2 **81.4% – 100%**	Quarter 2 **95.4%**	Quarter 2 **98.6%**	Quarter 2 **94.0% – 100%**
		Quarter 3 **97.4%**	Quarter 3 **97.8%**	Quarter 3 **78.8% – 100%**	Quarter 3 **97.8%**	Quarter 3 **98.7%**	Quarter 3 **88.9% – 100%**
		Not available until June 2019	Not available until June	Not available until June 2019	Quarter 4 **97.7%**	Quarter 4 **98.7%**	Quarter 4 **88.7% – 100%**

		Reporting period					
		2018/19			2017/18		
Quality indicator	**Related NHS Outcomes Framework domain**	**CWP performance**	**National average**	**National performance range**	**CWP performance**	**National average**	**National performance range**
			2019				
		Cheshire and Wirral Partnership NHS Foundation Trust considers that this data is as described because the Trust's data is checked internally for consistency and accuracy by the responsible staff in line with internal gatekeeping processes. The Trust's external auditors have verified the processes for production of this data. The Trust has achieved the performance target for this quality indicator, as required by the Department of Health and NHS Improvement (target for 2018/19 is **achieving at least 95.0%** of all admissions gate kept, CWP performance for 2018/19 is 96.3%*. The Trust has taken the following action to improve this percentage, and so the quality of its services: targeting work with services and teams demonstrating areas of underperformance by offering support through dedicated analysts.					
The percentage of patients aged (i) 0 to 14; and (ii) 15 or over, readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period	Helping people to recover from episodes of ill health or following injury	**(i) 0.0%** **(ii) 7.4%**	**Not available via NHS Digital indicator portal***		**(i) 0.0%** **(ii) 10.3%**	**Not available via NHS Digital indicator portal***	
		Cheshire and Wirral Partnership NHS Foundation Trust considers that this data is as described because using information that is held on internal information systems. Readmission rates help to monitor success in preventing or reducing unplanned readmissions to hospital following discharge. The Trust has taken the following action to improve this percentage, and so the quality of its services: targeting work with services and teams demonstrating areas of underperformance by offering support through dedicated analysts.					
Staff employed by, or under contract to the Trust who would recommend the Trust as a provider of care to their family or friends	Ensuring that people have a positive experience of care	**72%**	**70%**	**36% – 95%**	**72%**	**70%**	**42% – 93%**
		Cheshire and Wirral Partnership NHS Foundation Trust considers that this data is as described because it is administered and verified by the National NHS Staff Survey Co-ordination Centre. The Trust has taken the following action to improve this percentage, and so the quality of its services: developing an action plan to address areas of improvement identified in the survey.					
"Patient experience of community mental health services" indicator score with regard to a patient's experience of contact with a health or social care worker	Enhancing quality of life for people with long-term conditions Ensuring that people have a positive	**75%**	**"About the same"**	**40% – 80%**	**80%**	**"About the same"**	**64% – 81%**
		Cheshire and Wirral Partnership NHS Foundation Trust considers that this data is as described because the survey is administered and verified externally on behalf of the Care Quality Commission. The Trust has taken the following action to improve this percentage, and so the quality of its services, by sharing results with services and teams to support their work to develop actions plans to address priority areas for improvement.					

Quality indicator	Related NHS Outcomes Framework domain	Reporting period					
		2018/19			2017/18		
		CWP performance	National average	National performance range	CWP performance	National average	National performance range
	experience of care						
Incidents (i)The number and, where available, rate (per 1,000 bed days) of patient safety incidents reported within the Trust during the reporting period and the number and percentage of such patient safety incidents that resulted in (ii) severe harm or (iii) death	Treating and caring for people in a safe environment and protecting them from avoidable harm	**** (i) 2859/ 53.6**	**** (i) 3381/ 55.4**	**** (i) 16 – 9204/ 24.9 – 114.3**	***(i) 4330/ 41.2**	***(i) 3153/ 51.4**	***(i) 13 – 15518/ 14.9 – 126.5**
		**** (ii) 60/ 2.1**	**** (ii) 11/ 0.3**	**** (ii) 0 – 129/ 0 – 2.1**	***(ii) 82/ 1.9**	***(ii) 10/ 0.3**	***(ii) 0 – 210/ 0 – 2.1**
		**** (iii) 47/ 1.6**	**** (iii) 26/ 0.9**	**** (iii) 0 – 110/ 0 – 2.3**	***(iii) 86/ 2.0**	***(iii) 24/ 0.9**	***(iii) 1 – 221/ 0 – 3.9**
		Cheshire and Wirral Partnership NHS Foundation Trust considers that this data is as described because the Trust's data is checked internally for consistency and accuracy by the responsible staff in line with internal gatekeeping processes. The data is analysed and published by NHS Improvement. The national data stated relates to mental health trusts only. The Trust has taken the following action to improve this number/ percentage, and so the quality of its services: encouraging the reporting of incidents through its "learning from experience" report produced for staff three times a year. The national average data includes all mental health trusts that have provided partial or full data. *Represents full 2018/19 data hence the difference in reporting in the Quality Account 2017/18. **Represents data for 01/04/2018 to 30/09/2018, data for 01/10/2018 to 31/03/2019 will be available in April 2020.					

(*) denotes:

Performance for 2018/19 (and 2017/18 where applicable) is not available or is not available at the time of publication of the report from the data source prescribed in *The National Health Service (Quality Accounts) Amendments Regulations 2012.*

The data source is *NHS Digital*.

The data source of the performance that is stated as Trust performance where *NHS Digital* data is not available is the Trust's information systems.

Part 3.
Other information

An overview of the quality of care offered by CWP – performance in 2018/19

Below is a summary of our Trustwide performance, during 2018/19, against previous years' quality improvement priority areas. The performance compares historical data where this is available. These priorities were selected because they are national quality indicator targets.

Quality improvement priority area	Year identified	CWP performance		
		2016/17	2017/18	2018/19
Patient safety				
1. Inappropriate out of area placements	2015/16	0	0	1*
2. Admissions to adult facilities of patients under 16	2015/16	0	1**	0
3. CPA follow up – proportion of discharges from hospital followed up within 7 days	2015/16	98.0%	97.3%	96.4%
Clinical effectiveness				
1. % of clients in employment	2015/16	11%	7.3%	7.7%
2. Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas:	2015/16			
Inpatient wards		92%	92%	90%
Early intervention in psychosis services		99%	71%	97%
Community mental health services (people on care programme approach)		69%	60%	N/R
3. IAPT – proportion of people completing treatment who move to recovery	2016/17	53.7%	51.1%	50.0%
Patient experience				
1. Referral to treatment % of incomplete referrals waiting less than 18 weeks (1st DNA) 18 week - incomplete	2016/17	97.2%	87.6%	92.5%
2. People with a first episode of psychosis begin treatment with a NICE recommended care package within two weeks referral	2016/17	85.0%	79.8%	69.5%
3. IAPT waiting times to begin treatment	2016/17			84.0%
▪ 6 weeks		88.9%	89.8%	
▪ 18 weeks		98.4%	99.5%	99.5%

* This person was categorised as "away from home" therefore in line with national guidance, for CWP as the receiving organisation, this instance is defined as an "appropriate out of area placement"

** Admission in the person's best interests, agreed with commissioners

N/A = Not Available

N/R = Not Received (available June 2019)

NHS Improvement requires mental health foundation trusts, for external assurance of their *Quality Accounts*, to ensure a review by independent auditors of two mandated indicators and at least one local indicator chosen by the council of governors. The independent auditor's report, at *Annex D*, details the findings of the review of the mandated indicators.

Mandated indicators

- Early Intervention in Psychosis: people experiencing a first episode of psychosis treated with a NICE approved package within two weeks of referral.
- Improving Access to Psychological Therapies: waiting time to begin treatment.

Locally selected indicator

- Child Eating Disorders – patients commencing NICE-concordant treatment within 4 weeks (routine cases).
- Child Eating Disorders – patients commencing NICE-concordant treatment within 1 week (urgent cases).

Additional information on improving the quality of CWP's services in 2018/19

Below is a selection of the work over the past year that some of our services have undertaken to improve the quality of the services we provide. Our *Quality Improvement Report*s, published three times a year, provide more information about this throughout the year.

Improving **patient safety**

Non-medical prescribing (NMP) contributes to the delivery of high quality and person-centred services. It also supports the delivery of Care Quality Commission essential standards and enables organisations to achieve access targets. A member of the pharmacy team in Central & East Cheshire, was enrolled onto the NMP course and has now qualified; further members of the pharmacy team in other areas plan to also undertake the training.

The immediate results were that the NMP within the Central & East pharmacy team has been able to help with the writing of new prescriptions and clarifying unclear prescriptions by re-writing them in a timely manner when no medical staff were available. This has **reduced the risk of medication errors** that could have occurred while waiting for the availability of medical staff. The NMP has also been able to undertake patient reviews with the Home Treatment team and facilitate the issuing of prescriptions at the point of patient review rather than having to rely on duty doctors following it up at a later date, which delays the implementation of the necessary interventions.

Our Emotionally Healthy School (EHS) Links Team have been supporting schools with children and young people who harm themselves intentionally. It was identified that schools required a clear pathway for self-harm. The team, with primary mental health colleagues, met with school leads in Cheshire East to identify what information they would find useful to support their response to self-harm. The information was collated and a review of good practice was conducted to identify existing toolkits and pathways that could be adapted. The self-harm pathway has been rolled out to all schools and colleges via the EHS Links mental health awareness training, which is posted on the Trust's MyMind website and the EHS programme landing page on Middlewich High School's website. School staff have reported feeling **more confident and equipped to respond appropriately to children and young people who have harmed themselves** deliberately. School staff attending training have found the pathway informative and easy to use and have valued the scripted questions that can be found in the document to drive questions around an individual's risk to themselves. They report in feedback that the self-harm pathway component of the training is the one they value the most.

Safety huddles are brief and routine meetings for sharing information about potential or existing safety problems. We have identified wards with the highest numbers of increased therapeutic observations for the longest durations and introduced safety huddles.

Since the introduction of safety huddles, there has been a **significant reduction in level 3 and level 4 observations**, with only one person requiring this (before accessing ECT). Level 2 observations have been reviewed daily and there has also been a noticeable reduction in the number of people requiring 5 or 10 minute observations. Staff have engaged well with

the safety huddle and have noticed the benefit of this being a multi-disciplinary team approach and staff report that they feel supported in making decisions in relation to therapeutic observations.

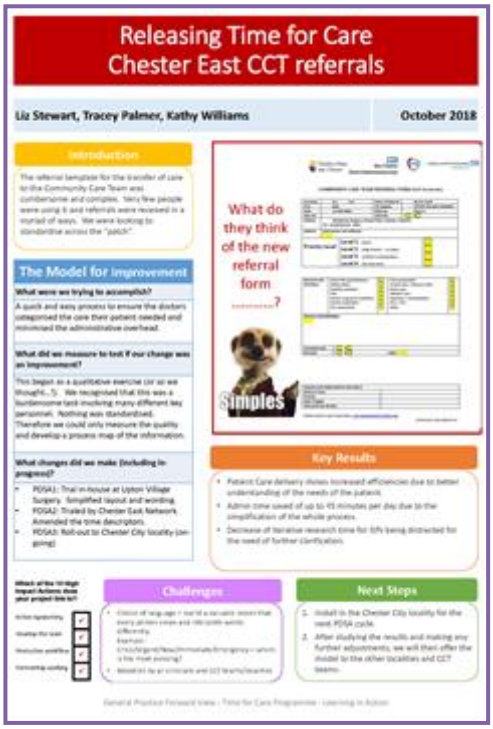
As a specialist eating disorder unit, Oaktrees ward has seen an expansion of access to and the use of social media and the effect it has on people accessing the service. The ward decided to create a social media initiative; the aim was to find out more about what sites people were using and how this impacted on their mental health, helping them identify how the negative social media was empowering their eating disorder and to provide them with a space to discuss this with a lead nurse.

The ward has set up a self-help shelf in the communal area and provided self-help books for people who struggle to use social media sites. Also they have found some of the blogs and pages identified on the ward's social media board **helpful in safety improving the management of their eating disorder**, people are also informing staff of sites they have found helpful to put on the board.

Improving **clinical effectiveness**

The Red2Green project has been running for over a year and the next stage is now focussed on the sustainability of the project and embedding it within the culture of the wards in CWP. Red2Green aims to **optimise patient flow through the identification of wasted time in a person's journey, and reduce internal and external delays**. The emphasis is on people receiving active and timely care in the most appropriate setting and for no longer than required, so that people do not lose one more day of community living than is absolutely necessary. For inpatient settings, this is vital in improving quality of care and freeing up capacity within the system by reducing length of stay. A steering group for the future of the Red2Green project has been planned to support the continuous improvement of flow through inpatient services and ensure consistency in the approach across the Trust. Administration support has been identified as being vital and is being allocated to support 'board rounds' on the wards. The criteria was redeveloped to be applicable to an organic ward.

Red2Green has successfully spread to nine wards within CWP, including acute and organic wards and is being trialled within community intensive support services in Wirral. The engagement and motivation from staff in the project has maintained and been the driver for the continued success of the project. It has been particularly successful on Meadowbank, an organic ward, where the average length of stay has reduced from 73.6 to 47.3 days.



There are nine community care teams (CCTs) across the Trust, three of which are in Chester and includes East CCT. The team identified that there was insufficient information being received at the point of referral which was impacting on time, resource and person-centredness, as a referral can be made for a huge variety of reasons reflected by the multi-disciplinary nature of the team. The team developed a new referral form, ensuring that a triage system or priority assessment was included to ensure timely access to the service. The team were very keen to ensure that the form was piloted and undertook a PDSA cycle, collaborating with one of the GP cluster practices, gathering feedback on any areas on which to improve before spreading the initiative to the rest of the cluster.

The results have been very encouraging; everybody in the cluster feels **the form is more efficient, streamlined and effective and has impacted positively on the delivery of patient care**. There is a greater awareness and understanding of the person's needs on referral, which precipitates an improved timeliness to a person's access to the appropriate service. Furthermore, through the PDSA cycle, the team have identified that the administration time within the GP practices and CCT has, on average, saved 45 minutes a day.

The Older People's Mental Health Service in Chester has been providing Cognitive Stimulation Therapy (CST) for several years and over that time have **developed the intervention in accordance with best practice**. The team wanted to build on the foundation of current CST sessions to spread the programme further, making it accessible to more people and gaining feedback from carers in order to evaluate the impact of the therapy.

Initially people attended seven weekly sessions; as the team's skills and confidence developed, they were extended to ten weekly sessions. The team are now in the position to deliver a programme of fourteen hourly sessions, held twice weekly for up to eight people at a time. Sessions, run by two staff members, are structured and always include discussion on current affairs and activity relating to a specific topic, for example childhood memories, creative activity, sounds or word games. The principles of reality orientation and reminiscence therapy are incorporated into the sessions in a helpful and sensitive way though the emphasis is on enabling people to give their opinions rather than having to give factual information which they may find difficult to recall.

Historically, there have been significant waiting lists for people accessing speech and language therapy in community learning disability services in West Cheshire; as a result the team have looked at innovative ways for those people referred to access support in a more timely way. The service wanted to provide person-centred training in relation to speech and language therapy using 'Total Communication' workshops in order to reduce waiting times for people who access services and their families. The team wanted to ensure that people received the right care, at the right place, at the right time.

A ‘Total Communication’ workshop was developed and delivered, which involved speech and language therapeutic training and support in a group setting. People, which included the patient, family and care team, were trained in how to use a Total Communication approach and how to create a person-centred plan to ensure the person receives good quality support.

The project has **significantly reduced waiting times for Speech and Language Therapy support** using a Total Communication approach. This support is now offered within two months of referral compared to a previous wait of approximately six months.

Improving **patient experience**

Cheshire and Wirral was one of the first 11 pilot sites across the country selected by Health Education England to pioneer nursing associate training in England.

Nursing associates are trained to work with people of all ages, in a variety of settings, and enable registered nurses to focus on more complex clinical duties by **helping meet the changing health and care needs of patients**. Nursing associates support, not substitute, registered nurses, creating better educated and skilled support staff that allow improved use of graduate registered nurse resources.

40 graduates have completed a two-year work-based programme in the beginning of 2019 and are now Registered Nursing Associates.

Recognising that carers can feel very isolated looking after a loved one with dementia, the staff at Bowmere Hospital have launched a Memory Café supported by the Alzheimer’s Society.

Links were built with an Alzheimer’s Society representative who supported the development of the Memory Café within the Oasis Café at Bowmere Hospital. The sessions include informal carer support and a supportive environment with social activities, including quizzes and reminiscence items available for carers to engage in with the person they care for or with other carers/ facilitators. **Carer support can be identified and addressed immediately** due to Alzheimer’s Society representation. The session is open to all and the location was chosen to encourage and support attendance of those who have current or who have had previous involvement within the inpatient or community older adult services in Chester. This allows for graded involvement, with the hope of links being built, followed by continued support and attendance following discharge from these services.

The Trust’s Millbrook Unit, based in Macclesfield, developed a well-being group facilitated by various staff, adopting a collaborative, multi-disciplinary approach to **aid recovery for people within their acute adult mental health and dementia wards**.

The well-being sessions were developed as a joint effort between members of the therapy team, once identified that Mindfulness and Tai Chi could have positive benefits. The mindfulness section of the session is facilitated by an art therapist and the Tai Chi exercises are facilitated by a physiotherapist. The Occupational Therapy staff also support the session by helping to identify and encourage people who may benefit from attendance, and by helping to co-facilitate the session.

The therapeutic activity timetable has a better balance of activities and opportunities, encompassing daily living skills sessions, social groups, well-being sessions and gym. As the well-being session is available to people across three wards, it enables them to mix with different people and is an efficient use of workforce. Staff have also improved skills and awareness of Tai Chi and Mindfulness interventions.

A brand new All Age Disability service has been launched in Wirral, aiming to improve experiences for people in the area with a disability or mental health condition. The service, provided by CWP has brought together teams historically split between CWP and Wirral Council, under one banner, ensuring a **more streamlined and person-centred experience**. Those who access the service are supported to live as independently as possible and enjoy the best quality of life they can, with collaborative support from both social care and healthcare staff.

CWP has launched a new advice line for young people, parents/ carers and organisations across Cheshire and Wirral who may have concerns about a young person's mental health. It **provides access to a mental health service for children and young people, their families and concerned professionals outside of usual hours**.

There is a high incidence of over 65 year old females living alone in the Neston area, and as part of compassionate communities, Neston and Willaston Community Care team have built collaborations with the third sector to improve wellbeing, especially for this demographic.

The team have engaged with Healthbox, who have started up initiatives in the Neston area such as introducing foodbanks and combatting social isolation. The team also engage with Live at Home which is an initiative that arranges events for local people who may be socially isolated and aims to offer lunches, outings and guest speakers. The team met with representatives from both initiatives and arranged for their therapy assistant to attend a session and deliver a talk on falls prevention. In addition, one of the community nurses has been identified to deliver a talk on the importance of looking after your skin, especially in pressure areas.

The results so far are demonstrating cohesive and collaborative working with the third sector to **improve the patient experience within the local area**, with lots of positive feedback from many different stakeholders.

Annex A: Glossary

ASD
Autism Spectrum Disorder – a neurodevelopmental disorder that impairs a child's ability to communicate and interact with others.

All Age Disability
Working alongside people with disabilities of all ages.

Board
A Board (of Directors) is the executive body responsible for the operational management and conduct of an NHS Foundation Trust. It is includes a non-executive Chairman, non-executive directors, the Chief Executive and other Executive Directors. The Chairman and non-executive directors are in the majority on the Board.

Care pathways
A pre-determined plan of care for patients with a specific condition.

Care plan
Written agreements setting out how care will be provided within the resources available for people with complex needs.

Care Programme Approach – CPA
The process mental health service providers use to co-ordinate care for mental health patients.

Care Quality Commission – CQC
The Care Quality Commission is the independent regulator of health and social care in England. It regulates health and adult social care services, whether provided by the NHS, local authorities, private companies or voluntary organisations.

Carer
Person who provides a substantial amount of care on a regular basis, and is not employed to do so by an agency or organisation. Carers are usually friends or relatives looking after someone at home who is elderly, ill or disabled.

Clinical audit
Clinical audit measures the quality of care and services against agreed standards and suggests or makes improvements where necessary.

Clinical commissioning group – CCG
Clinical Commissioning Groups are clinically-led statutory bodies that are responsible for designing and commissioning/ buying local health and care services in England.

Clinician
A health professional. Clinicians come from a number of different healthcare professions, such as psychiatrists, psychologists, nurses, occupational therapists etc.

Commissioners
Commissioners are responsible for ensuring adequate services are available for their local population by assessing needs and purchasing services. Clinical commissioning groups are the key organisations responsible for commissioning healthcare services for their area. They commission services (including acute care, primary care and mental healthcare) for the whole of their population, with a view to improving their population's health.

Commissioning for Quality and Innovation – CQUIN
High Quality Care for All included a commitment to make a proportion of providers' income conditional on quality and innovation, through the Commissioning for Quality and Innovation payment framework.

Community physical health services
Health services provided in the community, for example health visiting, school nursing, podiatry (foot care), and musculo-skeletal services.

Crisis
A mental health crisis is a sudden and intense period of severe mental distress.

CST
Cognitive Stimulation Therapy, an adaptable approach which can benefit people with a wide range of dementia.

Department of Health
The Department of Health is a department of the UK Government but with responsibility for Government policy for England alone on health, social care and the NHS.

Driver diagram
A visual display of what “drives” the achievement of a project aim.

Duty of Candour
This is Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20. The intention of this regulation is to ensure that providers are open and transparent with people who access services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment.

ECT
Electroconvulsive Therapy, a procedure done under general anaesthesia in which small currents pass through the brain to treat certain mental health illnesses.

Electrocardiogram (ECG)
A test to check a heart rhythm.

Forensic
Forensic mental health is an area of specialisation that involves the assessment and treatment of those who have a mental disorder or learning disability and whose behaviour has led, or could lead, to offending.

Foundation Trust
A type of NHS trust in England that has been created to devolve decision-making from central government control to local organisations and communities so they are more responsive to the needs and wishes of their local people. NHS Foundation Trusts provide and develop healthcare according to core NHS principles – free care, based on need and not on ability to pay. NHS Foundation Trusts have members drawn from patients, the public and staff, and are governed by a Council of Governors comprising people elected from and by the membership base.

Health Act
An Act of Parliament is a law, enforced in all areas of the UK where it is applicable. The Health Act 2009 received Royal Assent on 12 November 2009.

Healthcare
Healthcare includes all forms of care provided for individuals, whether relating to physical or mental health, and includes procedures that are similar to forms of medical or surgical care but are not provided in connection with a medical condition, for example cosmetic surgery.

Hospital Episode Statistics
Hospital Episode Statistics is the national statistical data warehouse for England of the care provided by NHS hospitals and for NHS hospital patients treated elsewhere.

Improving Access to Psychological Therapies – IAPT
A national programme to implement NICE guidelines for people suffering from depression and anxiety disorders.

Information Governance Toolkit
The Information Governance Toolkit is a performance tool produced by the Department of Health. It draws together the legal rules and central guidance set out above and presents them in one place as a set of information governance requirements.

Mental Health Act 1983
The Mental Health Act 1983 is a law that allows the compulsory detention of people in hospital for assessment and/ or treatment for mental disorder. People who are detained under the Mental Health Act must show signs of mental disorder and need assessment and/ or treatment because they are a risk to themselves or a risk to others. People who are detained have rights to appeal against their detention.

Multi-disciplinary Team (MDT)
A group of professionals from diverse disciplines who come together to provide care, e.g. psychiatrists, psychologists, community psychiatric nurses, occupational therapists etc.

MyMind
An NHS website run by CWP for everyone interested in the mental health and well-being of children and young people across Cheshire and Wirral.

National Confidential Enquiry into Patient Outcome and Death – NCEPOD
NCEPOD undertakes confidential surveys and research to assist in maintaining and improving standards of care for adults and children for the benefit of the public.

National Confidential Inquiry into Suicide and Homicide by People with Mental Illness
A research project funded mainly by the National Patient Safety Agency that aims to improve mental health services and to help reduce the risk of similar incidents happening again in the future.

National Institute for Health and Care Excellence – NICE
The National Institute for Health and Care Excellence is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health.

National prescribing observatory for mental health
Run by the Health Foundation, Royal College of Psychiatrists, its aim is to help specialist mental health services improve prescribing practice through quality improvement programmes including clinical audits.

National Staff Survey
An annual national survey of NHS staff in England, co-ordinated by the Care Quality Commission. Its purpose is to collect staff satisfaction and staff views about their experiences of working in the NHS.

NHS Commissioning Board Special Health Authority
Responsible for promoting patient safety wherever the NHS provides care.

NHS Constitution
The principles and values of the NHS in England. It sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities, which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively.

NHS Improvement
The independent regulator responsible for authorising, monitoring and regulating NHS Foundation Trusts.

Patient Advice and Liaison Services – PALS
Patient Advice and Liaison Services are services that provide information, advice and support to help patients, families and their carers.

PDSA
PDSA stands for Plan Do Study Act. It is an evidence-based approach that involves a repetitive four-stage model for continuous improvement.

Perinatal
The perinatal period extends from when pregnancy begins to the first year after the baby is born.

Person-centred care
Connecting with people as unique individuals with their own strengths, abilities, needs and goals.

Providers
Providers are the organisations that provide NHS services, for example NHS Trusts and their private or voluntary sector equivalents.

Psychiatric Intensive Care Unit (PICU)
Takes care of patients who cannot be cared for on an open (unlocked) ward due to their needs.

Public health
Public health is concerned with improving the health of the population rather than treating the diseases of individual patients.

Quarter
One of four three month intervals, which together comprise the financial year. The first quarter, or quarter one, means April, May and June.

Registration
From April 2009, every NHS trust that provides healthcare directly to patients must be registered with the Care Quality Commission.

Regulations
Regulations are a type of secondary legislation made by an executive authority under powers given to them by primary legislation in order to implement and administer the requirements of that primary legislation.

Research
Clinical research and clinical trials are an everyday part of the NHS. The people who do research are mostly the same doctors and other health professionals who treat people. A clinical trial is a particular type of research that tests one treatment against another. It may involve either patients or people in good health, or both.

Secondary care
Secondary care is specialist care, usually provided in hospital, after a referral from a GP or health professional. Mental health services are included in secondary care.

Secondary Uses Service – SUS
The Secondary Uses Service is designed to provide anonymous patient-based data for purposes other than direct clinical care such as healthcare planning, commissioning, public health, clinical audit and governance, benchmarking, performance improvement, medical research and national policy development.

Serious untoward incident
A serious untoward incident (SUI) includes unexpected or avoidable death or very serious or permanent harm to one or more patients, staff, visitors or members of the public.

Service users/ patients/ people who access services
Anyone who accesses, uses, requests, applies for or benefits from health or local authority services.

Single Oversight Framework
An NHS Improvement framework for assessing the performance of NHS trusts.

Special review
A special review is a review carried out by the Care Quality Commission. Special reviews and studies are projects that look at themes in health and social care. They focus on services, pathways of care or groups of people. A review will usually result in assessments by the CQC of local health and social care organisations. A study will usually result in national level findings based on the CQC's research.

Stakeholders
In relation to CWP, all people who have an interest in the services provided by CWP.

Strategy
A plan explaining what an organisation will do and how it will do it.

The Health and Social Care Information Centre
The Health and Social Care Information Centre is a data, information and technology resource for the health and care system.

Triangle of Care
A working collaboration, or "therapeutic alliance" between the person accessing health and care services, the professional and the person's family/ carer/ advocate that promotes safety, supports recovery and sustains well-being.

Urinary Tract Infection (UTI)
An infection of the urinary system, usually caused by bacteria.

Venepuncture
Process of obtaining the persons veins to access for blood sampling

Zero Harm
A strategy which aims to reduce unwarranted avoidable harm and embed a culture of patient safety in CWP.

Annex B: Comments on CWP Quality Account 2018/19

Statement from Governors

A statement from the Lead Governor is in the foreword of the Annual Report. At the Council of Governors meeting held on 18 April 2019 it was agreed that the Child Eating Disorders – patients commencing NICE-concordant treatment within 4 weeks (routine cases) and the Child Eating Disorders patients commencing NICE-concordant treatment within 1 week (urgent cases) would be the locally selected indicator. Governors have continued to play a key role in influencing and informing Trust strategy and have been fully involved in the development of the Trust strategic plan and operational plan and fully support the Trust as it seeks to achieve its ambitions and objectives. Furthermore, the Governors agree to continue to focus on the same Quality Improvement priorities as last year. By refining the priorities further, this will help bring about further improvements. It was a pleasure to read the Quality Account and to confirm support the priorities that the Trust has identified for the next year. The theme running throughout is that of improved person-centred care and the quality improvement strategy and agenda. I am particularly impressed with the establishment of a Quality Improvement faculty to bring together the support for Quality Improvement. The faculty has helped to promote Quality Improvement and ensure that learning and good practice is shared.

Comments by CWP's commissioners

NHS South Cheshire Clinical Commissioning Group, NHS Vale Royal Clinical Commissioning Group and NHS Eastern Cheshire Clinical Commissioning Group commentary
Feedback was requested on 15/05/2019, but has not been received

NHS West Cheshire Clinical Commissioning Group commentary
Feedback was requested on 15/05/2019, but has not been received

NHS Wirral Clinical Commissioning Group commentary
Feedback was requested on 15/05/2019, but has not been received

Statement from Scrutiny Committees

Statement from Wirral Metropolitan Borough Council

The Adult Care and Health Overview & Scrutiny Committee are responsible for the discharge of the health scrutiny function at Wirral Council. The Committee established a task and finish group in May 2019 in order to review the Quality Account of the Cheshire and Wirral Partnership NHS Foundation Trust for 2018/19 and were grateful for the opportunity to comment on the draft report.

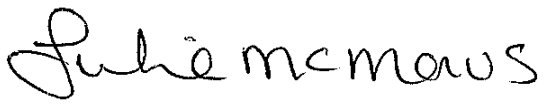
Within the three priority areas of patient safety, patient experience and clinical effectiveness, Members note that the Trust have gone some way to implementing quality improvement initiatives and have made progress. The Trust's aim to reduce the severity of harm by those that cause harm to themselves has seen significant development, with a 12% reduction reported for moderate and severe incidents of self-harm. Although this did not meet the Trust's target of 20%, Members expect that the continuous improvements in this area will have an impact, and welcome the steps taken; particularly the analysis of self-harm data and collaborative working with the Safe Services team. Members are also pleased to note the work undertaken towards improved engagement with bereaved families and carers, principally the enhancement of the family liaison role. As a national priority, the person-centred approach to bereavement is welcomed as a positive way to support those affected by loss, whilst learning from their experiences in order to provide better care.

It is noted that there have been a number of initiatives implemented to improve inpatient access to psychological therapies, with Members recognising that there have been achievements in response to this priority. There is, however, ongoing concern in relation to the current picture of Child and Adolescent Mental Health Services (CAMHS). It is understood that there has been an increase in demand for these services nationally, and that this trend is reflected in Wirral. However, Members are disheartened to learn that there are an estimated 7000+ children with diagnosable mental health conditions who are not supported by local services. Members appreciate that the Trust are part of a wider structure of mental health service provision and anticipate that the number of children and young people reached will improve over the coming year through partnership working with commissioners.

Members are pleased to learn that these priorities will be continued into 2019/20 so that the positive work started in 2018/19 can be developed and monitored over an extended period. It is expected that improvements and action plan sustainability in all priority areas will be evidenced over the forthcoming year.

Staff engagement is tremendously important in any organisation, and it is clear that there is some work to be done within the Trust in order to strengthen workforce participation and communication. The results of the NHS Staff Survey undertaken by the Trust show key areas of necessary improvement; notably, only 30% of staff feel senior managers try to involve them in decision making. In addition, only 37% of staff feel that communication between senior management and staff is effective – with both of these results falling below the national average. It is encouraging to hear that the Trust has already taken steps to address these areas. For example, through introduction of measures such as culture surveys to identify themes of staff disengagement and to look at ways to mitigate them.

The Adult Care and Health Overview & Scrutiny Committee look forward to continued partnership working with the Trust during the forthcoming year and note its priorities for 2019/20.



Councillor Julie McManus
Chair, Adult Care and Health Overview & Scrutiny Committee
Wirral Borough Council

Cheshire East Health and Adult Social Care Overview and Scrutiny Committee

Feedback was requested on 17/05/2019, but has not been received

Cheshire West Health and Adult Social Care Overview and Scrutiny Committee
Feedback was requested on 17/05/2019, but has not been received

Statement from Healthwatch organisations

Healthwatch Wirral
Feedback was requested on 16/05/2019, but has not been received

Healthwatch Cheshire
Feedback was requested on 16/05/2019, but has not been received

Annex C: Statement of Directors responsibilities in respect of the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 as amended to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS Foundation Trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that Foundation Trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the Quality Report is prepared in all material respects in line with the criteria set out in the NHS Improvement publications the NHS Foundation Trust Annual Reporting Manual 2018/19 and Detailed requirements for quality reports for foundation trusts 2018/19;
- the Quality Report is consistent in all material respects with the sources specified in the NHS Improvement guidance.

The indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are reasonably stated in all material respects in accordance with the NHS Improvement Detailed requirements for quality reports for foundation trusts 2018/19 and the six dimensions of data quality set out in the Detailed Requirements for external assurance for quality reports for foundation trusts 2018/19 (the Guidance'). The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered.

- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice; these control measures include implementation of the improvement actions identified in response to recommendations arising from the independent audit of the mandated and local indicators identified in the independent auditor's report;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with NHS Improvements annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report. We will continue to strive to improve the quality of data the Trust collects.

By order of the Board at the meeting held on 22 May 2019.

Signatures to be inserted once independent auditor has provided corresponding report at Annex D.

Annex D: Independent Auditor's Report to the Council of Governors of Cheshire and Wirral Partnership NHS Foundation Trust on the Quality Report

To be provided by independent audit prior to approval of Quality Account

East Cheshire
NHS Trust

QUALITY ACCOUNT 2018/19

Contents

About the trust

Our mission is to provide high-quality, integrated services delivered by highly-motivated staff.

We provide safe, effective and personal care to our patients. As a community and acute trust serving a large population of over 200,000 our vision is to deliver the best care in the right place. We have over 2,500 staff who work across our community settings and our three hospital sites. The hospital locations can be seen here: www.eastcheshire.nhs.uk/Contact%20Us/Location-Directions.html

The trust consists of three hospitals providing inpatient services at Macclesfield and Congleton and outpatient services at Knutsford. Further outpatient and community services are delivered from other sites in the region.

Our community health services are delivered from locations including Knutsford and Congleton hospitals, clinics, GP premises and patients' own homes. They include child health, district nursing, intermediate care, occupational health and physiotherapy, community dental services, speech and language therapy and palliative care.

Acute services provided at Macclesfield District General Hospital include A&E emergency care and emergency surgery, elective surgery in many specialities, maternity and cancer services.

We also provide a number of hospital services in partnership with other local trusts and private providers, including pathology, urology, cancer services and renal dialysis services. For more information about the trust visit our website: www.eastcheshire.nhs.uk

Chairman's Statement

We are pleased to present our Quality Account for 2018/19. Throughout the year, our focus has remained on delivering the best care in the right place, providing safe, quality, integrated services delivered by highly motivated and compassionate people. The improved experience patients have, as evidenced by feedback from the 'Family and Friends' surveys, incidents, the many communications of thanks for care received and the reducing number of complaints, collectively demonstrates that we are on the right path.

As a partner within the Cheshire East Place, we are making our contribution to broader integration by investing resources and people into the development of Care Communities alongside others, for patient benefit with an improved experience and outcomes. Underpinning this progress has been a consistent focus on timely and person centred interventions in the right place. These are incremental steps towards the transformation necessary to realign services so they are closer to the patient, fit for our population and more clinically and financially sustainable for our local population.

These developments, together with a renewed focus on prevention as outlined within NHS England's NHS Long Term Plan, link with strategic regional plans across Cheshire and Merseyside and Greater Manchester, together with local and regional priorities. This approach remains clinically-led and underpinned by the same quality standards expected of all licenced health care provision.

Learning from experience and feedback, we will continue to work with our patients, carers, partners and our workforce to innovate care models that deliver safe care, balanced with the need to make the most of every NHS pound. This is supported by patient and staff stories to Trust Board and Safety, Quality and Standards committee, demonstrating the values and behaviours we expect of everyone.

Despite another challenging winter, we have prepared well and continue to enjoy strong people engagement which has resulted in improved delivery of harm-free care. Throughout the year I have seen many examples of outstanding care, against the backdrop of the pressures faced both from demand on services and the financial climate. I am immensely proud of the care provided here and the resilience of our teams.

It is my privilege to share thanks with our outstanding teams, valued volunteers, staff and partners whom have worked tirelessly and continue to demonstrate their commitment and dedication to patients through compassion, care and with the courage to challenge. I look forward to another exciting, dynamic year of achievement and transformation. Thank you to everyone.

Lynn McGill
Chairman

Why are we producing a Quality Account?

We believe it is important to be open about the quality of the services we provide. This report sets out how we are performing and takes into account the views of our patients.

It also describes how we are continuously improving our services through clinical audit and innovation and assesses opportunities to improve further.

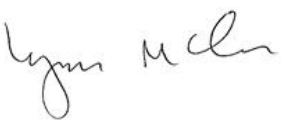
Statement of directors' responsibilities in respect of the Quality Account

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

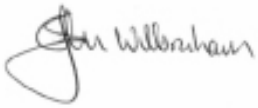
In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- The Quality Account presents a balanced picture of the trust's performance over the period covered
- The performance information reported in the Quality Account is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- The Quality Account has been prepared in accordance with Department of Health guidance. The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account. By order of the board.

Lynn McGill
Chairman



John Wilbraham
Chief Executive



Chief Executive's Statement

We strive to provide the best care in the right place for the patients who need us. The development of services in the community as part of the "care communities" development is critical in this ambition. These teams of staff from health and social care organisations are working to provide integrated services for those in most need within the towns of East Cheshire.

The quality of care both in and out of hospital is shared in this report against our four high level themes of:

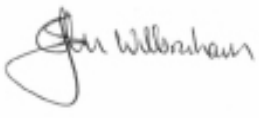
- Harm-free Care
- Improving Outcomes
- Listening and Responding
- Integrated Care

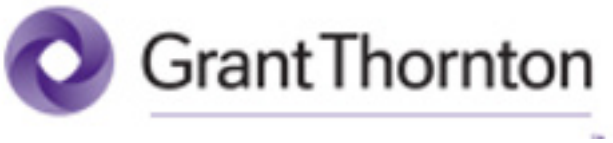
I believe we have delivered improvements cross all of these areas during the 2018/19 and hope that you will see the evidence of these improvement as you read through this document.

Patient safety is integral to our organisation and the continual quality improvement alongside this cornerstone is the key behind continued high levels of patient satisfaction.

I hope you enjoy reading about the care provided by our staff to our patients.

John Wilbraham
Chief Executive





Independent Practitioner's Limited Assurance Report

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

We have been engaged by the Board of Directors of East Cheshire NHS Trust to perform an independent assurance engagement in respect of East Cheshire NHS Trust's Quality Account for the year ended 31 March 2019 ("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 and as subsequently amended in 2011, 2012, 2017 and 2018 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to the limited assurance engagement consist of the following indicators:

- rate of clostridium difficile infections; and
- percentage of patient safety incidents resulting in severe harm or death.

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

Respective responsibilities of the Directors and Practitioner

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health and NHS Improvement 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 and NHS Improvement 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 the Department of Health 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 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 1 April 2018 to 28 May 2019;
- papers relating to quality reported to the Board over the period 1 April 2018 to 28 May 2019;
- feedback from commissioners dated 10 May 2019;
- feedback from local Healthwatch organisations dated 10 May 2019;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and National Health Service Complaints (England) Regulations 2009, dated 7 May 2019;
- the national patient surveys dated June 2018, September 2018 and January 2019;
- the national staff survey dated 26 February 2019;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated May 2019;
- the annual governance statement dated 28 May 2019;
- the Care Quality Commission's inspection report dated 12 April 2018; and
- the results of the Payment by Results coding review dated January 2019.

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.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for 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, except 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;
- limited testing, on a selective basis, of the data used to calculate the indicators tested against 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

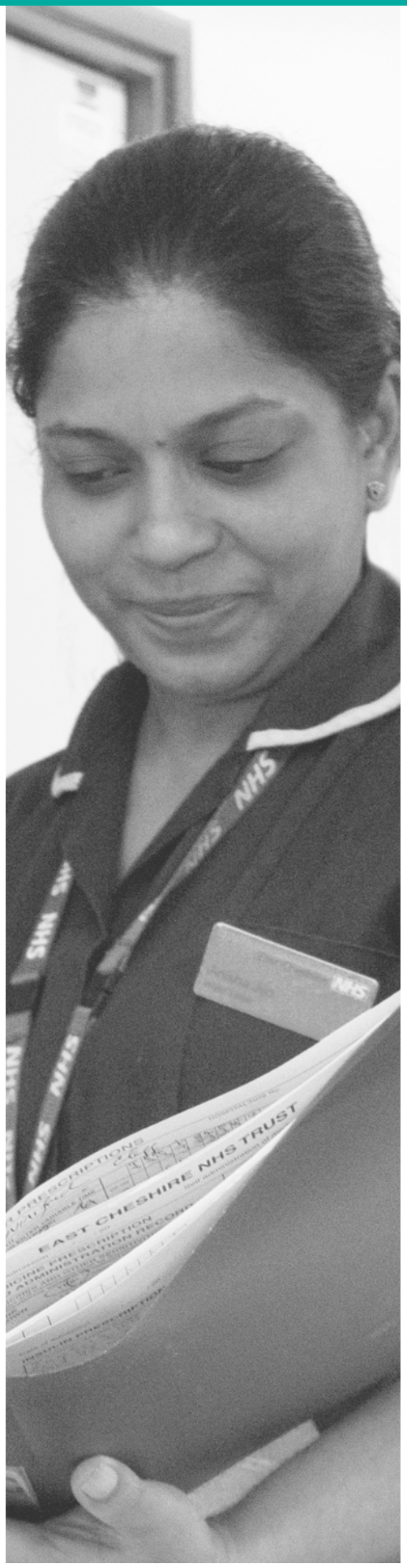
Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques that can result in materially different measurements and can affect 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 of these criteria, 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 and NHS Improvement. 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 limited assurance work has not included governance over quality or non-mandated indicators which have been determined locally by East Cheshire NHS Trust.

Our audit work on the financial statements of NHS Trust is carried out in accordance with our statutory obligations and is subject to separate terms and conditions. This engagement will not be treated as having any effect on our separate duties and responsibilities as East Cheshire NHS Trust's external auditors. Our audit reports on the financial statements are made solely to East Cheshire NHS Trust's Directors, as a body, in accordance with



the Local Audit and Accountability Act 2014. Our audit work is undertaken so that we might state to East Cheshire NHS Trust's Directors those matters we are required to state to them in an auditor's report and for no other purpose. Our audits of East Cheshire NHS Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such Directors as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than East Cheshire NHS Trust and East Cheshire NHS Trust's Directors as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Conclusion

Based on the results of our procedures, as described in this report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- 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 identified as having been 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
Chartered Accountants

Manchester
28 May 2019

Performance against 2018/19 priorities

Quality Strategy overview and performance against 2018/19 priorities

Quality improvement at ECT is about continuously improving standards to ensure we provide safe care, better outcomes and positive experiences for the people who access our services and in 2019 we have refreshed our Quality Strategy to build on the final year achievements of the 2015/19 strategy.

The NHS Long Term Plan sets out a number of ambitions and the trust's Quality Strategy demonstrates our commitment to deliver safe, effective and personal care whilst working in partnership to develop innovative and integrated ways of working that drive quality improvement. This will support the trust in achieving its vision to provide the best care in the right place.

As a trust rated overall 'Good' following our CQC inspection we will continue to have a strong focus on demonstrating compliance with regulatory safety requirements. Achieving improvement in patient access standards is a key priority for the trust. A culture of continuous learning from incidents, complaints and good practice is fundamental to patient safety, engaging with people for whom we provide care or services.

The Eastern Cheshire area has a high elderly population compared to the national average, with a high percentage of people aged over 65 and over 85. This is expected to increase further in the future, which will result in rising demands on health and care services. It is therefore essential that we work with partners to make best use of all available resources. Many patients are living well with one or more long-term conditions and our ability to treat the person rather than their condition is something that has been at the forefront of our work with health, care and third sector partners as we develop our five care communities within our catchment area.

We recognise that the best place for care is often in the person's own home and enabling people to maintain their independence is a high priority. When people require essential hospital treatment our aim is to provide timely and responsive care and we will continue to ensure that our staff have the necessary knowledge, skills and competence.

We are proud of what has already been achieved and look forward to working with key stakeholders and staff as we further develop and transform services across Eastern Cheshire.

Performance against 2018/19 priorities

Domain	Action focus	Progress
Harm Free Care (Evidence of significant improvement)	**Reduction in falls with harm**	• The injurious falls rate per 1000 occupied bed days for 2018/19 has been achieved at 1.7% against a target of 2.5%.This equates to 13% reduction in the total number of injurious falls reported when compared to last year (193 compared to 222) • There has been one fall resulting in moderate harm • There have been two reported falls resulting in severe harm which is a significant reduction when compared to the 8 severe harm falls reported in the previous year. • The trust has commenced participation in the new 2018 national falls and fragility fracture audit programme. Part 1 has been completed (outcome pending)
	Reduction in pressure ulcers associated with lapses in care	• Overall there have been 53 pressure ulcers reported on StEIS during 2018/19 of which 21 have been have been undeclared as there have been no lapses in care. • Of the 32 remaining - 22 have been deemed as avoidable and 10 are currently under investigation. • There have been 2 Category 4 and 10 Category 3 pressure ulcers which have been confirmed as hospital acquired pressure ulcers. The remaining confirmed avoidable relate to 2 Category 4 and 8 Category 3 pressure ulcers which have been reported as developed on community nursing caseloads. • *End of year figures may change once the 10 current investigations have been completed. • Pressure ulcer prevention training is now delivered as part of the face to face clinical statutory and mandatory training.

Domain	Action focus	Progress
Harm Free Care (Evidence of significant improvement)	**Reduction of Clostridium difficile infection**	• Overall reduction in number of Clostridium difficile infections - eleven cases in year against national trajectory of 13 cases
	Full implementation of Sepsis Care bundle	• Implementation of evidence-based tools • Clinical consistency of critical care outreach • Outreach sepsis champion • Red sepsis grab boxes • Mandated e-learning • Named sepsis nurse per shift in ED • Grand round presentation
	Improved management of Intravenous lines	• Review of current process for peripheral cannula care • New Peripheral Cannulation Policy developed • Planned audits using the National Saving Lives Peripheral Care Tool.
Improving outcomes (Evidence of significant improvement)	**Improved patient's understanding of possible side effects of medications including improved antimicrobial stewardship**	• Consultant microbiologist presented Grand Round presentation in May which included a section on red flag sepsis and also the importance of reviewing antibiotics • Shared decision making pages on medication uploaded to the trust website to support patients
	Embedding Personalised Care Plans	• Frailty dementia care bundle has been created • EMIS system has been improved to enable personalized care to be documented electronically
	Improve patient flow	• Launched "Improving Patient Flow" (Flo) with an internal event • Produced a video to demonstrate the initiative which went on to win a regional award and featured local NHS and social care staff

Domain	Action focus	Progress
Listening & responding (Evidence of significant improvement)	**Improving Care Environment within Medical Wards**	• Relocated the Discharge Lounge to support patient flow • New clinical equipment purchased including 70 new electronic beds • Increased the number of computer workstations • Improved sluice environments and installed new flooring on some wards
	Skill mix review of acute ward areas	• Registered nurse vacancies and retention rates improved • First cohort of nursing associates commenced on the wards • Increased the health care assistant pool • Introduced a flexible registered nurse pool
	Reduction of outpatient clinic cancellations	• Monthly data has been monitored to provide assurance regarding the rationale for any clinic cancellations • The annual leave policy for medical staff has been updated to provide a clear and equitable process • Further work is ongoing to streamline processes from the point of request to action by the booking team so that any impact on patient care is minimized.
	Friends and Family Test	• Overall positive Friends and Family test results throughout the year
Integrated care (Evidence of significant improvement)	**Develop integrated community care teams effectively aligning health and social care professionals**	• Five Care Communities fully established • Development of a Community Dashboard with key quality metrics • Trusted assessor pathway implemented for all seven nursing homes who support intermediate care patients
	Improve End of Life Pathway in Hospital and Community	• Trust received “Outstanding” rating for the CQC Caring Domain in Community End of Life Care.

Achievements - year at a glance

APRIL

The trust was rated 'Good' by the Care Quality Commission (CQC) following inspections of the trust's services and leadership. The trust underwent a major inspection of its services followed by a 'well-led' inspection of its leadership team in January and February 2018.

MAY

The trust once again took part in International Nurses' Day. The day was very well attended by staff who said it appeared the best-attended year so far. Colleagues on the Aston Unit at Congleton War Memorial also dressed in vintage nursing uniforms and brought in nursing memorabilia which proved a great hit with nostalgic patients!

JUNE

Karen Clayton, Macmillan Lung Cancer Lead Nurse with East Cheshire NHS Trust, was given the Queen Elizabeth the Queen Mother's Award for Outstanding Service at a recent Queen's Nursing Institute ceremony. Karen, who is based at Macclesfield Hospital, was one of just five nurses nationally to receive the award.

OCTOBER

The trust celebrated the first ever National Allied Health Professionals Day with a range of stalls and representatives from Podiatry, Occupational Therapy, Speech & Language Therapy, Radiology, Pharmacy, Dietetics, Audiology, Plaster Technicians and Physiotherapy.

NOVEMBER

The Tissue Viability Team and 'Pressure Ulcer Super Hero' Stephen performed a trolley dash around Macclesfield Hospital, to increase awareness about the damaging impact of pressure ulcers. This event was part of Stop the Pressure Day – a national campaign aimed at the prevention of pressure ulcers.

DECEMBER

NEWS2 - England's new standardised early warning system for identifying acutely ill patients - was officially launched at MDGH. North West Ambulance Service is already using NEWS2 along with peers at local hospital trusts including Stockport NHS Foundation Trust.

JULY

On Thursday, July 5th staff from all around the trust joined in with the national 70th birthday celebrations for the NHS. Colleagues helped to celebrate by decorating their departments, hosting tea parties, reminiscing with old medical instruments and eating lots of cake!

AUGUST

Staff nurse Barbara Morton won colleague of the month for being the main gardener in a project to revamp Ward 10's garden. The garden now gives a more private area for patients and their visitors to sit and staff and patients can spend time there together.

SEPTEMBER

The trust and its partners launched the 'Helping Flo' campaign aimed at highlighting the ways in which members of the public can help free up hospital beds for those who really need them. The campaign featured a video starring local NHS and social care staff along with a fictitious patient called Flo.

JANUARY

Sue Brown, management facilitator for Acute and Integrated Care, received recognition for her role in helping the trust hit a 75% flu vaccination figure. Sue performed the important and ongoing task of checking staff lists are accurate and up-to-date to ensure good data quality.

FEBRUARY

A poster produced by the Bollington, Disley and Poynton (BDP) Care Community was voted the best on display at a national cardiovascular disease conference. The poster coincided with work the trust is taking part in to support patients with heart failure.

MARCH

Nine trust nursing associates were among the first-ever cohort to graduate from the University of Chester in this month. The nine are now working within community teams, Ward 9, MAU, ED and Ward 11.

"The staff are so friendly and kind in their approach. They are both caring and compassionate."

WARD 8

Data Quality

Secondary Uses Service Data Quality Dashboard

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 Data Quality Dashboard which provides data quality reports 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.

Under figures for April 2018 to November 2018, the Secondary Uses Service Data Quality Dashboard was at 97.6%, against 96.6% nationally. Meanwhile, for a valid NHS number being present in the data, the scores are above the national average.

Admitted patient care was at 99.8% against 99.4%, outpatients was showing 100% against 99.6%, and accident and emergency was significantly above the national average of 97.5%, at 98.3%.

For a valid Healthcare Resource Group version 4 code, the scores are 99.9% for the trust against national scores of admitted patient care at 97.9%, outpatients at 100% against national figures of 99.1% and accident and emergency at 100% against national figures of 97.9%.

For a valid general medical practice code under figures for April 2018 to November 2018 the scores are above the national average. Admitted patient care was at 100% against 99.9%, outpatients was showing 100% against 99.8%, and accident and emergency was significantly above the national average of 99.3%, at 100%.

Clinical coding

Clinical coding translates the medical terminology written by clinicians to describe the patients' diagnosis and treatment into standard, recognised codes. The accuracy of this coding is a fundamental indicator of the accuracy of the patient records. Clinical coding is carried out using the full patient case note supplemented by electronic systems, such as histopathology and radiology, which is considered best practice. The clinical coding staff attend all mandatory clinical coding training as required, as well as clinical coding specialty workshops. Annually, the trust undergoes an information governance toolkit audit, which is a national requirement. In January 2019 the annual external clinical coding audit illustrated a consistently high level of accuracy as shown in the table below:

	Correct (%) 2016/17	Correct (%) 2017/18	Correct (%) 2018/19
Primary Diagnosis	93.50	95.50	95.00
Secondary Diagnosis	94.60	94.89	94.35
Primary Procedure	95.21	97.65	96.88
Secondary Procedure	91.64	96.07	97.54

Counter-fraud

The trust operates a local anti-fraud policy available for all staff. Close links with anti-fraud organisations and robust provision of staff information including case studies of fraud helps to mitigate against fraudulent activity. Fraud information is also available on the trust website: www.eastcheshire.nhs.uk/Our-Services/Counter-fraud.htm

The trust is committed to reducing the level of fraud, bribery and corruption within both the trust and the wider NHS and aims to eliminate all such activity as far as possible. The trust has an established anti-fraud service provided by Mersey Internal Audit Agency (MIAA), with a nominated anti-fraud specialist (AFS) who undertakes a variety of activities in accordance with the Standards for Providers for Fraud, Bribery and Corruption.

The trust ensures compliance in accordance with its contractual requirements under the NHS Standard Contract in respect of anti-fraud, bribery and corruption as required by NHS Protect's Standards for Providers and has an Anti-Fraud, Bribery and Corruption Policy in place which encourages anyone having reasonable suspicions of fraud, bribery or corruption to report them.

The trust is committed to embedding an anti-fraud culture throughout the organisation which is fully supported by the Board and monitored on a regular basis by the trust's Audit Committee. The trust takes all necessary steps to ensure that NHS funds and resources are protected and safeguarded against those minded to commit fraud, bribery and corruption and that appropriate measures to combat fraud, bribery and corruption are put in place.

Being open and duty of candour

The trust has policies and processes in place to ensure openness and compliance with its regulatory and statutory responsibilities for duty of candour. This means that when staff engage with patients or their families and carers they are properly communicated with and informed about all of their treatment and care.

Where harm occurs they are notified and, if this is moderate or severe in nature, the findings and learning from investigations are shared and discussed with them. The Trust Board monitors compliance with its duty of candour via its governance arrangements. In this way, we provide assurance to our patients that we are doing everything we can to keep them safe and are promoting a safety culture dedicated to learning and improvement that continually strives to reduce avoidable harm. The trust's policy on duty of candour can be seen on it's website: www.eastcheshire.nhs.uk/About-The-Trust/policies/D/Duty%20of%20Candour%20SOP%20ECT2625.pdf

Data Security and Protection Toolkit

In January 2018, to improve data security and protection for health and care organisations the Department of Health and Social Care, NHS England and NHS Improvement published a set of 10 data and cyber security standards – the 17/18 Data Security Protection Requirements (2017/18 DSPR) – that all providers of health and care must comply with.

The Data Security and Protection Toolkit is an online self-assessment tool that enables organisations to measure and publish their performance against the National Data Guardian's ten data security standards. All organisations that have access to NHS patient data and systems must use this toolkit to provide assurance that they are practising good data security and that personal information is handled correctly.

For 2018/19 the trust published its final toolkit submission with an assessment status of "Standards Met".

Review of services

During 2018/19 East Cheshire NHS Trust provided and/or sub-contracted 10 NHS service types encompassing 11 regulated activities. 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 2018/19 represents 100% per cent of the total income generated from the provision of NHS services by East Cheshire NHS Trust for 2018/19. See www.eastcheshire.nhs.uk/Downloads/The%20Trust/Quality%20and%20performance/Statement%20of%20Purpose.pdf

The trust systematically and continuously reviews data related to the quality of its services. It uses its integrated Quality, Safety and Performance Scorecard to demonstrate this. Reports to the Trust Board, Safety Quality and Standards Committee, Finance, Performance and Workforce Committee, Clinical Management Board, Executive Management Team and the Performance Management Framework all include data and information relating to our quality of services.

Freedom to Speak Up

The trust has a Freedom to Speak Up Guardian in place whose role is to promote speaking up across the trust, to establish a range of routes through which staff can raise concerns and to ensure that an appropriate management response is provided to address concerns. Arrangements are in place to provide the Trust Board with assurance on speaking up matters and a three-year strategic plan has been developed and approved. Learning and actions as a result of investigation of speaking up matters is shared trust-wide via staff communications, the Infonet and via governance structure.

During 2018/19 a total of 23 concerns were raised with, or overseen by, the Guardian. This is in addition to those concerns raised and managed locally within services. The two key themes arising from speaking up this year relate to effective communication and valuing and respecting people in line with the trust's values and behaviours. Examples of improvements made as a result of concerns raised include; strengthened communication with front line staff during periods of operational pressure, management staff have increased understanding of the important role seeking feedback and listening plays in making staff feel valued and individuals have reflected and increased their self-awareness of the impact of their behaviour and communication style on others. During the year, 39 staff volunteered to be Freedom to Speak Up Ambassadors, and are starting to play a key role in supporting and promoting a speaking up culture across the organisation.

Specified indicators 2018-19

In line with national guidance for quality accounts, external auditors test two indicators annually according to the nature of the trust's activities. For 2018/19 these indicators are Clostridium difficile and Severe Harm.

Clostridium difficile	East Cheshire NHS Trust did not exceed its allocated trajectory of 13 cases of Clostridium difficile toxin positive cases during the financial year 2018-19. The trust came in below trajectory with eleven cases. Learning from post infection reviews continues, as does the trust's focus on appropriate antibiotic stewardship in order to continue to work towards reducing instances of Clostridium difficile infection further. The trust has received an unqualified opinion on this specified indicator.*
Severe Harm incidents reported via NRLS	Trust staff report patient safety incidents and near misses via the electronic DATIX incident reporting system and this data is exported to the National Reporting and Learning System (NRLS) in line with mandatory requirements. All incidents are reviewed and assigned to handlers for information or investigation and as part of this process the grade of actual harm attributed to each incident is verified to ensure consistency in practice and procedure. A procedure is in place which defines harm levels, which may be death, severe harm, moderate harm, low harm or no harm dependent upon the nature of the incident and impact on the patient. A sample of incidents with a range of harm levels reported via the NRLS during 2018/19 have been reviewed against the health record of the patients concerned to determine appropriateness and accuracy of harm grading . In addition, a sample of complaints records for the same period were reviewed to determine whether the systems for incident reporting and complaints management correlated. The trust has received an unqualified opinion on this specific indicator *.

*Full audit opinion can be found on page 9 of this report

Core indicators

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

Quality indicator	Trust data	Comparison	Reason	Action to improve
1: Preventing people from dying prematurely. Summary Hospital-Level Mortality Indicator (SHMI):				
A: SHMI value and branding (July 2017 - June 2018)	1.1201 (band 2 as expected)	15 trusts higher than expected. 16 trusts lower than expected. Lowest = 0.6982 Highest = 1.2572	The trust performs within the expected range for this indicator	
SHMI value and branding (October 2017 - September 2018)	1.15		Trust performed higher than expected	
2: Enhancing quality of life for people with long-term conditions				
B: Percentage of patient deaths with palliative care coded at either diagnosis or specialty level	17.9%	National average = 33.1%	The trust performs better than the national average for this indicator.	
3. Helping people to recover from episodes of ill-health or following injury. Patient reported outcome for:				
i) Groin hernia surgery	Latest data available from NHS Digital at time of print April 2016-March 2017 EQ5D Index: 49.2%	Latest data available from NHS Digital at time of print England EQ5D Index: 51.4%		
ii) varicose vein surgery iii) Total hip replacement surgery iv) Total knee replacement surgery	* 92.4% 83.5%	* 89.8% 82.6%	* No data available from NHS digital	
3a. Helping people to recover from episodes of ill-health or following injury. Emergency readmissions to hospital within 28 days of discharge:				
i) The percentage of patients aged 0-15 re-admitted within 28 days of discharge - NHS Digital no longer publishes these figures as part of it's Quality Accounts.				
ii) The percentage of patients aged 16+ re-admitted within 28 days of discharge - NHS Digital no longer publishes these figures as part of it's Quality Accounts.				

Quality indicator	Trust data	Comparison	Reason	Action to improve
4. Ensuring that people have a positive experience of care				
Responsiveness to inpatients' personal needs.	70.2 (2017/18) 67.8 (2016/17) 69.0 (2015/16) 67.4 (2014/15) 65.6 (2013/14)	England: 68.6 (2017/18) 68.1 (2016/17) 69.6 (2015/16) 68.9 (2014/15) 68.7 (2013/14)	Average weighted score of 5 questions relating to responsiveness to inpatients' personal needs (score out of 100) taken from inpatient survey.	
Percentage of staff who would recommend the provider to friends or family needing care (July - Sept 2018)	Trust: 76%	England: 81%		
Percentage of patients who would recommend the provider to their friends and family (Nov 2018)	Trust: A&E: 87% Inpatients: 97% Outpatients: 95%	England: A&E:87% Inpatients: 95% Outpatients: 94%	The trust performs in line with or better than the national average for this indicator	
5. Treating and caring for people in a safe environment and protecting them from avoidable harm				
Percentage of admitted patients risk-assessed for venous thromboembolism (Jul-Sept 2018)	Trust: 94.84%	England: 95.49%	The trust performs within the expected range for this indicator.	
Rate of C Difficile - hospital only (April 2017-March 2018) - rate per 100,000 bed days	Trust: 8.3	England: 13.7	The trust performs better than the national average for this indicator.	
Rate of patient safety incidents and percentage resulting in severe harm or death (Oct 2017 – Mar 2018) (April 18- Sept 18)	47.57 incidents per 1000 bed days Incidents involving severe harm = 6 Incidents involving death = 2 57.04 incidents per 1,000 bed days Incidents involving severe harm = 8 Incidents involving death = 3		The trust performs within the expected range for this indicator. There is no significant change to previous year	

Please note all figures are the latest available from NHS Digital systems at the time of publication.

"The staff are so very good. They are also very helpful with all my needs a credit to the ward. Thank you all."

WARD 9

Our performance 2018/19

Care Quality Commission (CQC)

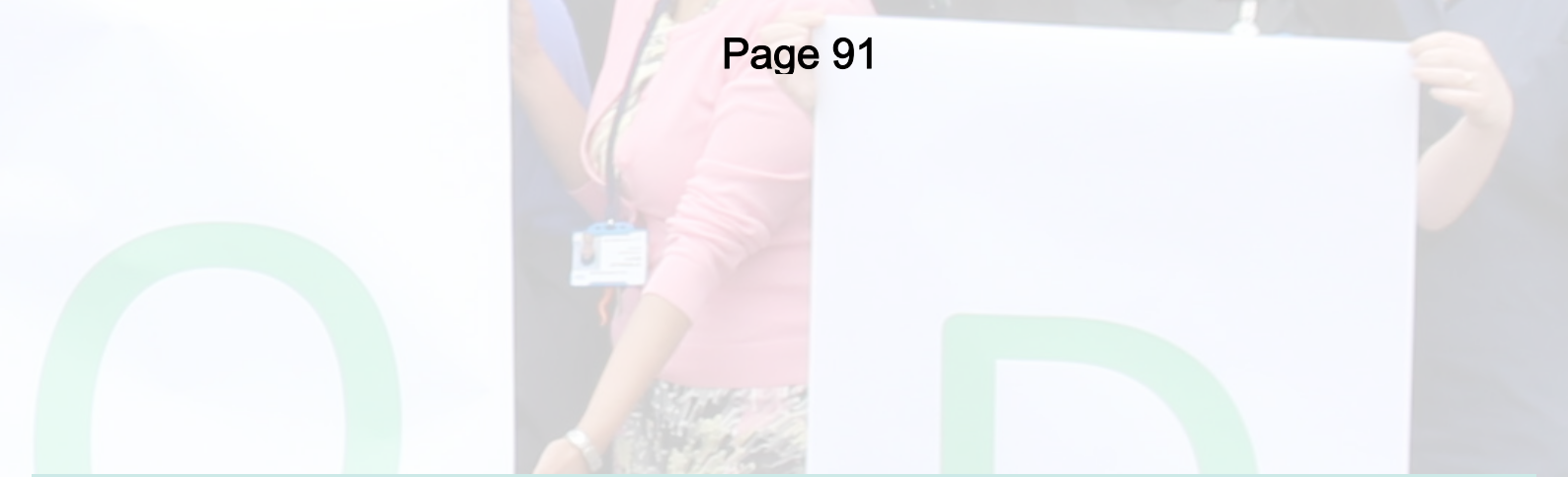
A proportion of the income received at East Cheshire NHS Trust in 2018/19 was conditional on achieving quality improvements and innovation goals agreed between the trust and its commissioners. The goals agreed can be found through the trust website: www.eastcheshire.nhs.uk. East Cheshire NHS Trust has reviewed all of the data on the quality of care in 2018/19 and the reports, achievements and improvements planned can be seen throughout this report.

Registration under the Health and Social Care Act 2008 (Regulated Activity) Regulations 2009 and the Care Quality Commission (Registration) Regulations 2009. During 2013/14 all NHS healthcare providers were required by law to register with the Care Quality Commission (CQC) and declare compliance against 28 regulations. Of these, 16 regulations relate to quality and safety of care received by patients. Following inspection, any areas of non-compliance are responded to with an action plan, which is reviewed and monitored by the CQC. Registration can be issued with 'no condition' or 'with conditions'. The trust was not involved in a CQC special review during the year.

East Cheshire NHS Trust has been rated 'Good' by the Care Quality Commission (CQC) following inspections of the trust's services and leadership during January and February 2018.

Among the inspectors' findings, they identified multiple areas of outstanding practice.

This rating shows our patients can be assured that they are receiving high-quality care delivered by professional and caring staff. It is a testament to the 2,500 hard-working and caring staff who make our organisation what it is. The report also highlighted opportunities for improvement. We will continue to work to improve what we do for our patients. Please see our full report at: www.cqc.org.uk/location/RJN71/reports



Quality performance

The trust is measured on its performance against the Department of Health NHS Performance Framework, which provides a dynamic assessment of the performance of NHS providers that are not NHS foundation trusts.

The assessments are across four key domains of organisational function - finance, quality of service, operational standards and targets, and quality and safety. Performance is assessed quarterly.

The trust's performance against national targets can be seen on page 35 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

The considerable pressures facing all types of NHS and social care organisations continued throughout 2018/19, mainly as a result of an ageing population many of whom are frail older people with complex health and social care needs. These challenges were exacerbated during the year by a continuing national nurse staffing shortage and difficulty in recruiting to some medical specialist areas.

Learning from deaths in line with national guidance

The mortality governance policy, which describes how the trust learns from deaths of patients who die under its management and care, was implemented in April 2017 in line with the national guidance "Learning From Deaths". At implementation all deaths were systematically reviewed and any learning shared with the patient's consultant and the directorate's Safety, Quality and Standards meetings. The trust collects and publishes on a quarterly basis specified information on deaths through a paper and an agenda item to a public board meeting, the minutes of which are available on the trust's website here: http://www.eastcheshire.nhs.uk/About-The-Trust/Trust-Board/trust-board-meetings.htm

Evaluation of the revised guidance for mortality governance

Following local evaluation of mortality governance the process for reviewing all patient deaths was changed in 2018-19. Building on our learning from thematic analysis the trust implemented a change to the deaths reviewed in line with national guidance. Specific criteria are now used to select deaths for mortality review, with a minimum of 20% of all deaths being subject to comprehensive mortality review every month.

Patient deaths 2018/19

The number of inpatients who died during 2018/19 was 604; quarter one- 134 deaths, quarter two- 143, quarter three- 149 and quarter four- 178.

During 2018-19 129 deaths were subject to systemic case note review. Mortality review of one case prompted a root cause analysis investigation.

The number of deaths per quarter for which a case record review was carried out was; quarter one- 30, quarter two- 33, quarter three- 33 and quarter four- 33.

Three of the patient deaths during the reporting period were judged as potentially avoidable using the Royal College of Physician's avoidability of death judgement score, although this is a highly subjective assessment.

Learning identified from mortality reviews has highlighted gaps in clinical documentation, care bundle implementation and assessments not being fully completed in line with best practice. Any learning is shared with each consultant who was caring for the patient and it is their responsibility to share this learning with their teams to ensure individual learning and reflection occurs where appropriate. A summary of findings from mortality reviews is produced quarterly and cascaded from the mortality sub-committee to each directorate.

As a result of the mortality reviews there has been an evaluation of some specific documentation including the end-of-life care pathway, sepsis pathway and consent forms. Learning from mortality reviews has also driven improvements in clinical documentation and diagnostic pathways.

Clinical standards for seven-day hospital working

The 7-day Services programme is designed to ensure patients who are admitted as an emergency receive high quality consistent care, whatever day they enter hospital. Four of the 10 clinical standards were identified as priorities for ECT. These are:

- Standard 2 – Time to first consultant review
- Standard 5 – Access to diagnostic tests
- Standard 6 – Access to consultant-directed interventions
- Standard 8 – Ongoing review by consultant twice daily if high dependency patients, daily for others

The trust's compliance with these standards is assessed by a regular survey. Future audits of compliance are planned for May 2019.

A number of changes have been implemented at the trust to support the delivery of 7-day services and ensure that emergency admissions receive high quality care regardless of day of admission.

- 7 day consultant physician presence in the hospital for a minimum 12 hours per day 08:00-20:00 7 days a week
- On site ED consultant presence 7 days per week; 12 hours on weekdays and 8 hours at the weekends
- Increase in physiotherapy, OT and social worker cover over weekend to support frailty service and promote prompt discharge and admission avoidance
- Rescheduling pharmacy access hours at weekends and bank holidays to facilitate discharges
- Job planning of anaesthetists to provide twice daily ward rounds on ICU/HDU 7 days per week including bank holidays
- Appointment of additional respiratory, diabetic and emergency medicine consultants

The trust will continue to work alongside NHS Improvement and NHS England to ensure, where practicable and possible within a small local DGH, that all priority standards are met.

Commissioning for Quality and Innovation (CQUIN)*

A proportion of the trust's income in 2018/19 was conditional on achieving quality improvement and innovation goals agreed between Eastern Cheshire Clinical Commissioning Group and NHS England for the provision of NHS choices through the Commissioning for Quality and Innovation payment framework. Achievements against these goals can be seen below.

NHS England CQUINS	
Diabetic eye adult screening programme communication review	On target
Dental e-referral and audit	On target
Breast screening programme - clinical staff development (health promotion role)	On target
Dose banding chemotherapy	Achieved
CCG CQUINS	
Acute and community	
Improvement of health and wellbeing of NHS staff	Partially achieved
Healthy food for NHS staff, visitors and patients	Achieved
Improving the uptake of flu vaccinations for front line staff	Achieved
Improving the assessment of wounds	Achieved
Acute	
Improving services for people with mental health needs who present to A&E	Achieved
Reduction in antibiotic consumptions per 1,000 admissions	Partially achieved
Timely identification of sepsis in emergency departments and acute inpatient settings	Achieved
Timely treatment of sepsis in emergency departments and acute inpatient settings	Partially achieved
Antibiotic review	Not achieved
Offering advice and guidance	Not achieved
Preventing ill health by risky behaviours - Tobacco screening	Achieved
Preventing ill health by risky behaviours - Tobacco brief advice	Achieved
Preventing ill health by risky behaviours - Tobacco referral and medication offer	Achieved
Preventing ill health by risky behaviours - Alcohol screening	Achieved
Preventing ill health by risky behaviours - Alcohol brief advice or referral	Achieved

	Metric	Target	18/19 figures as at 30/4/19
Mortality	Risk Adjusted Mortality Index 2017 - Rolling 12 months - Latest Peer (Jan 18 - Dec 18 : 85.19)	< Latest peer (85.19)	82
	Summary Hospital Mortality Indicator (HSCIC) - Latest Figure (Oct 17 - Sep 18)	Within expected range	"Higher than expected 1.15"
Infection	Ecoli - hospital - 18/19 Total	< 25 (previous years performance)	11
	Hospital MRSA bacteraemia - 18/19 Total	0	1
	Hospital Acquired Clostridium Difficile - 18/19 Total	<=13	11
	Incidence of newly-acquired cat 3 and 4 pressure ulcers - hospital - 18/19 Total	20% reduction in Cat 2, 3 and 4	18
	Incidence of newly-acquired cat 3 and 4 pressure ulcers - out of hospital - 18/19 Total	20% reduction in Cat 2, 3 and 4	17
Incidents	Medication errors causing serious harm - 18/19 Total	0	0
	Never Events - 18/19 Total	0	2
	Patient Safety: Falls resulting in patient harm per 1000 Occupied bed days - 18/19 whole year Rate	2.5	1.7
Complaints	No. complaints with HSO Recommendations - 18/19 Total	0	1
	Number of complaints - 18/19 Total	<=140	134
Experience	Ward Family and Friends Test % response - 18/19 Total	20%	37.4%
	ED Family and Friends Test % response - 18/19 Total	20%	22.5%
	Mixed Sex Accommodation breaches - 18/19 Total	0	394
Access	18 week - Incomplete Patients - March 18 Figure	92%	78.1%
	Diagnostic 6 week Wait - 18/19 Total	>=99%	86.7%
	ED: Maximum waiting time of 4 hours - 18/19 Total	95%	82.5%
	ED: The recording of a completed handover, (HAS) - 18/19 Total	85%	88.9%
Cancer	2 Weeks maximum wait from urgent referral for suspected cancer - 18/19 Total	93.0%	91.4%
	2 Weeks maximum wait from referral for breast symptoms - 18/19 Total	93.0%	70.6%
	31 days maximum from decision to treat to subsequent treatment - Surgery - 18/19 Total	96.0%	98.1%
	31 day wait from cancer diagnosis to treatment - 18/19 Total	94.0%	99.4%
	62 day maximum wait from urgent referral to treatment of all cancers - 18/19 Total	85.0%	76.7%
	62 days maximum from screening referral to treatment - 18/19 Total	90.0%	95.0%
DTOC	Delayed transfers of care - Acute - 18/19 Total		3.49%
	Delayed transfers of care - Non Acute - 18/19 Total		9.28%
Staff	Core Staff in Post (FTE) - March 18 Figure	2316.2	2214.91
	Sickness Absence - Rolling year - 18/19 Total	4.95%	4.7%
	Statutory and Mandatory Training - Rolling 3 year period (Apr 16 - Mar 19)	90%	91.5%
	Corporate Induction attendance - Rolling year - 18/19 Total	90%	97.6%
	Appraisals and Personal Development Plans - Rolling year - 18/19 Total	90%	91.7%
	Information Governance training - 18/19 Total	95%	95.3%
	Safeguarding - Level 1 Compliance - March 18 Figure	85%	91.5%
	Safeguarding Children - Level 2 - March 18 Figure	85%	89.7%
	Safeguarding Adults - Level 2 - March 18 Figure	85%	89.7%
	Safeguarding Children - Level 3 - March 18 Figure	85%	90.8%
Finance	Total Pay Expenditure (£000) - 18/19 Total	£106,810k	£110,084k
	Bank Staff Expenditure (£000) - 18/19 Total	£4,922k	£6,729k
	Agency Staff Expenditure (£000) - 18/19 Total	£7,325k	£6,483k
	Cash (£000's) - March 18 Figure	£3,000k	£9,463k
	2018/19 EBITDA (£000)	(£13,521k)	(£9,842k)
	2018/19 Deficit	(£17,932k)	(£14,472k)

"The professionalism and caring manner of every member of the Holmes Chapel team are a credit to the NHS"

COMMUNITY NURSING

Improving patient care

GP Out of Hours

The total number of patients streamed by the Emergency Department through GPOOH during 2018/19 was 893. North West Ambulance Service (NWAS) has 24 hour/ 365 day direct referral access to the GPOOH service at the trust which resulted in 1672 admission avoidances during 2018. The 23 GP surgeries in East Cheshire also have direct clinical access to GPOOH whereby as opposed to referring their patient to the ED, the surgery can request an urgent visit from the Acute Visiting Service (AVS). 308 patients were visited by the AVS in 2018 see below for details. Additionally any vulnerable, palliative or unstable patients who are at high risk of admission can be referred for continuation of care out of hours. This group of patients is clinically assessed and seen within an agreed care plan avoiding the need for the patients to access medical support via NHS111 or ED.

GP OOH and the surgeries are working together with the shared bookable appointments systems in cases where patients can safely wait until the following day to be seen.

Patient feedback:

- “Overall very good. Drs always helpful and always listened”
- “Seen as soon as arrived. Would recommend the service”
- “Definitely improved since my visit a few years ago”
- “Very professional and calm nurse”
- “Fast and efficient service from friendly people”
- “The Dr I saw was brilliant and a real asset to the NHS.

The Acute Visiting Service

A new service was implemented in GPOOH in 2018. When a patient calls 111 and is advised to attend ED, an alert is sent to GPOOH and a further triage assessment is carried out to avoid an inappropriate ED attendance. Over the year this service extended to NWAS. When a 999 call is made - NWAS will, where appropriate, telephone through to GPOOH to allow the triage nurse to do a further assessment and again avoid an inappropriate dispatch of an emergency paramedic.

Helping Flo

The trust introduced the #helpingflo campaign to help manage winter pressures in 2018. The campaign was developed with system partners in response to the regional NHSI winter programme ‘Action on A&E’ aiming to empower staff and public to assist with keeping hospital beds free for those who really needed them over the challenging winter.

Our animated patient ‘Flo’ video launched at a staff event in September and was featured on social media and in local press. #helpingflo has proved to be an engaging and effective way of helping everyone to understand what can make a difference when services are under pressure. The Flo videos have had almost 3000 views and have been shared widely with stakeholders.

We have continued to use Flo to help us launch patient flow initiatives, with Flo’s Perfect Christmas and Flo’s Cracking Easter. The #helpingflo campaign has successfully grabbed the imagination of our organisation and has become synonymous with improving patient flow. The organisation will continue to work with Flo over the coming year.

Emergency Department

ED has participated in many new initiatives as part of the #HelpingFlo campaign, one of those being the introduction of a Rapid Access and Diagnostics (RAD) pilot. Walk-in majors patients and patients presenting by ambulance are assessed by a senior nurse supported by a healthcare assistant and ED consultant. This immediate assessment allows for earlier diagnostics to be ordered and reported on to improve the patient journey. This will now be embedded into the ED system.

ED has also been involved with:

- Processes to reduce ambulance turnaround and handover times
- Fit2sit - stopping patients lying down on trolleys and stretchers if they are well enough to sit or stand
- Piloting new streaming processes such as: utilising primary care for minors patients to release capacity in ED for major patients; review of signage and queue management
- Developing new roles such as first trainee advanced nurse practitioner
- Securing funding for an electronic waiting time display which will display live waiting times and can be accessed by the public via smart phone from home and thus support them in making the right choice for their treatment.

ED has also recruited two new consultants; Dr Tom Bartram and Dr Chetan Kashinath making an invaluable contribution to the team and adding additional educational sessions to enhance staff learning and good practice.

Patient feedback:

“The triage system at Macclesfield General A&E department from arrival to being treated is fabulous - the last few times we’ve had to use it have seen us triaged, assessed and treated in a very efficient and speedy manner without compromising on any of the quality we’ve come to expect (we are there a lot with my son who as well as having a long term health condition requiring A&E on occasion is also a tad clumsy!).

I know there’s always somebody that has a story of how awful the experience was but I can honestly say that even when we’ve had to wait the care and treatment we’ve had at Macc A&E has always been excellent. All the staff in this department are helpful, compassionate and professional. As a nurse sister myself (different hospital) I would be proud to work within this team.”

Critical Care

- East Cheshire NHS Trust was the first trust in the North West to deliver the Safe Critically Ill Transfer Training (SCITT). The programme has been accessed by medical staff from Critical Care, Theatres and The Emergency Department and contributes to ensure all our patients are transferred safely by competent staff. The accredited programme has had a number of attendees from outside the organisation from as far afield as Italy.
- Following a patient's relative's feedback the Critical Care Team wanted to make it easier for staff and relatives to be able to recycle waste and therefore purchased some new 'green' bins. These were placed in the staff room, relative's room and in clinical areas with an almost immediate reduction in non-recyclable waste.

Critical Care took part in various audits throughout the year in order to develop and improve quality of care for patients. The following are just a few examples of the studies they have been a part of or have initiated locally:

- DecubICUs, an international one-day point prevalence study of pressure-related injuries in ICU.
- The Cheshire and Mersey Quality Standards Audit encompasses the care bundles and elements from the Critical Care Service Specification that are used to inform our peer review
- A local audit of pressure-related damage from tape used to secure endotracheal tubes. The results from this audit resulted in a change in practice which has reduced the incidence of pressure damage to the face
- Ongoing studies include oral care and noise at night

Surgery

- **Theatre refurbishment:**Towards the last quarter of 2018/19 the main theatre suite underwent major refurbishment. This included upgrades to three main theatres, replacement furniture, flooring, lighting and new surgeons' panels. This benefits theatre users and staffing by providing a more modern environment and has also helped reduce infection risk, while staff are now able to control the theatre temperature, the laminar flow and the operating and canopy lighting. All theatre department main doors have also been replaced, providing a more secure environment and improvements in security for theatres via restricted swipe access.
- **Improvements in medical rotas**: In February 2019 a new rota for F2 junior doctors was introduced within Planned Care. The main benefit of this was to provide an additional F2 grade doctor over a weekend - there is now a surgical doctor and an orthopaedic doctor on shift across each day at the weekend. This benefits patients by providing more hours to enable them to be seen and treated in a more timely way in the ward areas and gives an improved response rate for patients awaiting specialty assessment in ED.
- **Straight to the test:** In 2018 the trust introduced a service called Straight to Test (STT) which supports a new GP referral pathway for patients with a suspected cancer who require a diagnostic colonoscopy/ combined gastroscopy and colonoscopy, depending on their symptoms. The GP referral is triaged by the duty consultant for the day and the patient is assessed at that point for their suitability to go Straight to Test which avoids the need for the patient to attend an outpatient appointment.
- **Addison's Pathway:** In 2018 the Pre-operative Assessment Service agreed to provide an emergency medical pack to patients with a diagnosis of Addison's or Secondary Adrenal Insufficiency.

The Buurtzorg model

Community nurses in Holmes Chapel have taken delivery of a new cycle in order to reach patients in a healthy and environmentally-friendly way. The bike is available to all types of community nurses operating from the base and was a result of discussions around the Buurtzorg model of nursing.

Denise Baillie, Care Community Coach for Congleton and Holmes Chapel, explained: “The new bike will be a great, environmentally-friendly way for the team to get around the village. Holmes Chapel often gets quite congested so having the bike should help ensure we can get to patients without delays and improve our own health at the same time.

“Holmes Chapel is quite flat and we won’t be covering great distances, so team members of all fitness levels should be able to use it and I’m sure it will attract a lot of interest from our patients!”

Representatives of the Buurtzorg programme visited the trust in September to provide further support as the trust begins to embed principles of the Dutch approach to community care.

Elements of Buurtzorg are being introduced to the recently-created Care Communities.

The Buurtzorg model is patient-focused and based around small, self-managing teams of community nurses who have access to a coach for support when needed.

NEWS 2

- The consultant nurse and service improvement lead focussed their efforts on the implementation of the National Early Warning Score 2 (NEWS2) in an effort to improve the recognition and response to the sepsis patient. This included training and education across all disciplines with the support of L&D and the rigorous & relentless testing of the electronic VitalPac. The project was concluded in December 2018 and as per national guidelines, all acute ward electronic systems and paperwork were upgraded.
- An E-learning package for sepsis and NEWS2 is now mandated and embedded into the ESR matrix and is available for all patient-facing staff.
- All grades of staff are educated at statutory and mandatory training sessions and this occurs weekly. One to one ward-based training is given to all disciplines of staff (if required) by the critical care outreach team.

Maternity

The maternity services at East Cheshire NHS Trust continue to provide quality ante, intra and post- partum care in line with latest evidence based practice and recommendations.

The CQC (Care Quality Commission) report produced in April 2018 demonstrated that maternity services were good in all of the assessed domains.

Better Births -A Five Year Forward View for Maternity Care(2016) identified that better postnatal and perinatal mental health care was required, recognising that this can have a significant impact on the life chances and wellbeing of the woman, baby and family. In order to address this, in 2018 the post of perinatal mental health midwife was introduced at East Cheshire to provide expertise and continuity for women with mental health issues. A joint antenatal clinic with the mental health services has improved multidisciplinary care and the mental health team are now providing staff training on the multidisciplinary mandatory training days.

Also in line with Better Births, continuity of care was introduced in March 2019. The target of 20% of women being booked in this model of care has been exceeded in the first month with 40% of women booked on the continuity of care pathway in midwifery team system. The expected benefits are: women are 16 per cent less likely to lose their baby, 19 per cent less likely to lose their baby before 24 weeks and 24 per cent less likely to experience pre-term birth. This work will continue in line with national targets over future years.

The local maternity system has provided funding to focus upon the Saving Babies Lives Care Bundle. The initiative is a bold step towards introducing many evidence-based and policy recommendations in maternity care towards the goal of reducing stillbirth in the UK by 50% by 2025. From 2016/17 the stillbirth rate at East Cheshire has seen a year-on-year reduction from 4.7 to 3.0 per 1000 births and the latest 2018/19 figures are 2.6 per 1000 births, remarkably below the latest national average of 4.2 per 1000.

2019 has seen East Cheshire NHS Trust being successful in the application to become 1 of only 16 trusts chosen to develop the new Royal College of Obstetricians and Gynaecologists (RCOG)/Royal College of Midwives (RCM) Each Baby Counts: Learn and Support Programme. The engagement of our local development leads to work with the multidisciplinary teams to introduce, test and evaluate interventions that focus on the behaviours, team work and safety culture, will contribute to improving safety and quality in the maternity unit. We embrace the challenge and are excited to influence not only regionally but nationally this latest initiative.

Children's Ward

Over the last year the Children's ward has developed ward activities including:

- Part of the local Tesco 'token' collection receiving £4000 worth of toys, games and activities including sensory toys for children and young people with learning difficulties.
- Funding from Medequip for Kids, a children's entertainer 'Loubie Lou' who visits the ward each month.
- A donation of 15 iPads set up with games for the children.
- A departmental 'you said we did' board to respond to patients and parents feedback and display feedback from the National Friends and Family Test. (Typically above 95%)
- A band 6 nurse on every shift to enable leadership and support for staff resulting in a positive effect on staff morale and patient care.
- An Advanced Paediatric Life Support trained nurse on every shift to support medical staff during emergencies.
- A breast feeding link nurse role, established to improve breast feeding facilities and care provided to mothers. Working alongside a parent a dedicated fundraising effort has resulted in the donation of two breast pumps and breastfeeding comfort packs.
- The introduction of a new nutritional tool to identify children at risk of malnutrition at an early stage. 'STAMP' enables this identification and allows us to then work closely with dieticians to develop an effective management plan. Monthly auditing will ensure compliance is maintained.

Children's Community

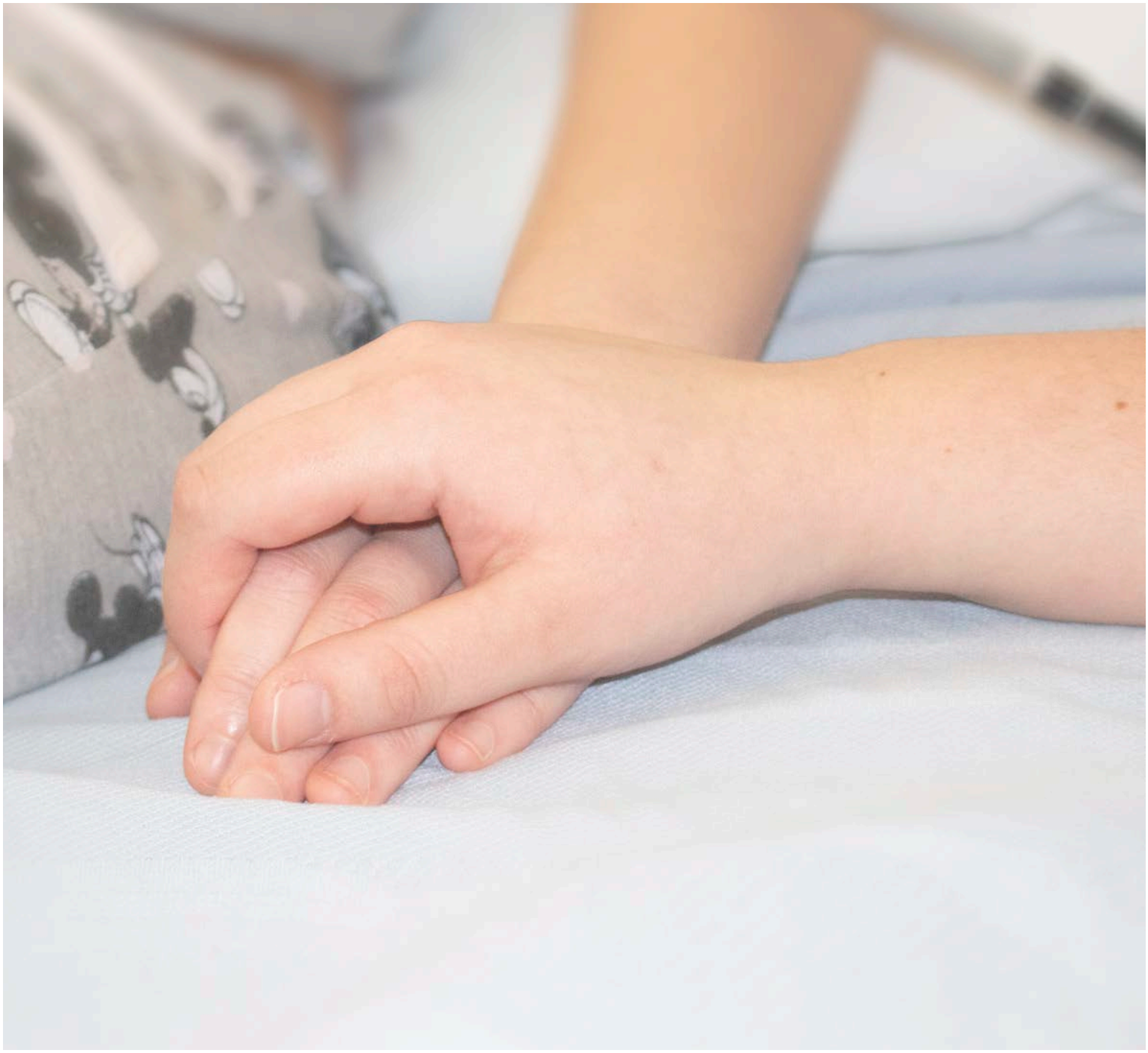
Following a joint CQC and OFSTED inspection, the paediatric department have been working closely with the CCG and the therapies department to design a pathway for autism assessment for under 5s. A pilot model helped to diagnose over 27 children. It is hoped that following evaluation, the model will be commissioned.

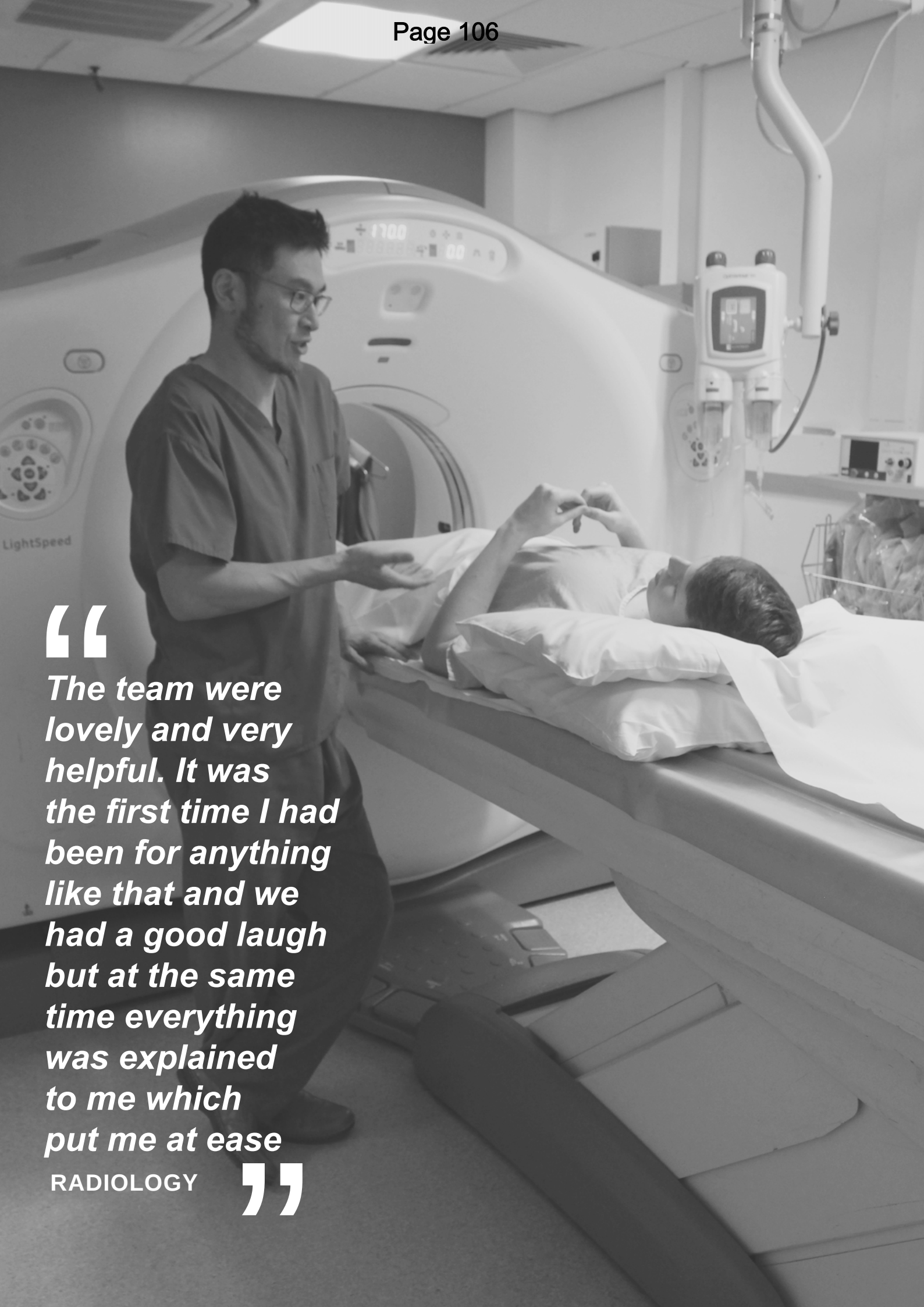
The paediatric allergy service continues to go from strength to strength with the development of new staff and succession planning.

Productivity in paediatric outpatients has been a focus. Reviews of clinic availability have ensured the right clinics are available to meet demand.
The community nursing team have been working in the children's observation area to promote continuity of care, carrying out blood tests, reducing waiting times and improving discharge rates. This also means children see the same nurse at home which improves the patient and family experience.

Improving patient care: A patient story

Background	A patient of the trust and resident of the David Lewis Centre in Cheshire has profound learning disabilities and multiple medical diagnoses. Over recent years he has been admitted to the trust a number of times per year, each time to a different ward, sometimes for prolonged periods. The patients family felt care was fragmented, of varying quality and that they kept having to repeat themselves and felt they were not always kept informed. This led to multiple complaints by the family, poor patient experience and difficult situations for ward staff to manage. Stakeholder relationships consequently became challenging due to communication issues. The patient requires intense medical and nursing treatment for a spectrum of conditions including seizures and unusual dietary requirements and often requires invasive procedures such as nasal tubes, intravenous lines and the administration of oral medication which is challenging to carry out.
What went well?	The matron for medicine produced an action plan that was agreed by all departments that the patients comes into contact with such as medicine, the ED and the ward along with the family and carers this enables early notification of the need for admission, a clear management plan while in hospital and agreed parameters for discharge. Copies are retained on his case notes and in digital format. The patient now spends minimal time in ED, always moves to a side room on Ward 4 and is cared for by the same consultant and nursing staff on each admission. An agreement was reached with dietetics and kitchens to provide a diet which permanently meets the patient's needs without the need for further assessment. The patient now receives alternative therapy solutions and has a bespoke care plan in place. Relationships with the patient's parents are positive and full discussions are held via telephone due to the parents living away from the area. Parents are now confident that their son is well cared for and we all have the same goal. Relationships with the patient's GP practice are much improved and a clear focus and agreement has been reached on this care plan moving forward. The reasonable adjustments care plan for this patient is now used by both parties to prevent duplication.
The Future	The next steps in the improvements of this patients pathway is to hold a professionals' meeting to discuss strategy for ongoing care in case of clinical deterioration while at his current place of residence.





"The team were lovely and very helpful. It was the first time I had been for anything like that and we had a good laugh but at the same time everything was explained to me which put me at ease"

RADIOLOGY

Patient feedback

Health Matters public lectures

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 from both the trust and partner organisations and put questions directly to them. The Health Matters series covers a range of popular clinical areas and has been an outstanding success in delivering key messages directly from senior trust staff to the community they serve. For a full programme, see the Health Matters page on the trust's website: www.eastcheshire.nhs.uk/News-Events/Health-matters.htm

We also film Health Matters lectures to help reach a wider audience. These videos can be viewed on our YouTube channel.

Topics covered by Health Matters lectures in 2018/19 included:

- Managing common general surgical emergencies
- Basic life support and resuscitation
- Bowel cancer
- Advances in breast surgery
- 'Your back pain, your brain and you'
- Parkinson's disease: an update
- An A-Z of respiratory disease
- Recent advances in knee surgery

Healthwatch

This year the trust has worked with Healthwatch Cheshire CIC, which provides Healthwatch services in Cheshire East and Cheshire West. Healthwatch is an organisation which champions local people's views on health and social care.

Enter and view visits:

Three enter and view visits have taken place this year to wards 9 and 10 and to Outpatient Therapies. Positive feedback on the staff approach is a common theme across all areas. As well as comments about staff being caring and attentive, knowledgeable and enthusiastic, and positive comments about the environment, Healthwatch representatives praised the initiatives undertaken to improve the patient stay where staff went the extra mile.

Improvements made as a result of visits are:

- Improved website information for all areas
- Ward 9: Improved ward storage
- Ward 10: Improved communication with patients and relatives following board rounds
- Outpatient therapies: Updated clinic information and the exploration of outdoor space for rehabilitation - staff do already utilise the hospital grounds, in particular for a back class which includes a supervised walking route outdoors.

Healthwatch have also been involved in the following over the past year:

- Engagement visits across the trust to ascertain priorities for east Cheshire residents
- Participation in the Complaints Scrutiny Group
- Commenting on the trust's Quality Account.

Patient-Led Assessments of the Care Environment (PLACE)

The aim of the PLACE assessments is to provide a snapshot of how an organisation is performing against a range of non-clinical activities which impact on the overall patient experience. Non-clinical activities that form part of the assessment are as follows:-

- Cleanliness
- Food and hydration
- Privacy, dignity and wellbeing
- Condition, appearance and maintenance
- Dementia
- Disability

	National average	MDGH	CWMH
Cleanliness	98.47%	99.86%	99.44%
Food	90.22%	95.09%	93.71%
Privacy, dignity and wellbeing	84.16%	86.33%	87.75%
Condition, appearance and maintenance	94.33%	96.91%	89.58%
Dementia	78.89%	88.67%	86.22%
Disability	84.19%	96.18%	87.38%
Average	80.82%	94.15%	91.44%

All of the scoring was awarded from volunteer patient assessors who were recruited locally. During the assessment, the patient assessors received help and guidance from Infection Prevention & Control, departmental managers and Estates & Facilities.

Patient assessors' summary

At the end of each assessment, the patient assessors complete a summary report which is sent to the Health & Social Care Information Centre giving their own feedback on each area visited. Below is a snapshot of their findings:

Macclesfield

- There is clear evidence during the assessment that patients are being treated with dignity and respect in all areas
- A fairly modern hospital where cleanliness standards are very high
- Quality of food is good
- Colour coded meal tray system is in place for patients who need support with feeding
- The hospital is well regarded within the community and benefits from dedicated friendly and efficient staff at all levels
- All the staff within the Emergency Department were approachable, caring and helpful
- The patient assessors praised the new flooring, the installation of LED lights and the new configuration of the Emergency Department
- Even though the wards and departments were busy, there was a huge sense of calm and professionalism from staff which must be reassuring for the patients
- There is a need for more storage as the corridors were cluttered with equipment and beds
- The hospital needs more car parking spaces

Congleton

- Patients' privacy and dignity was respected , despite the limitations presented by an ageing building
- An old building where there are challenges maintaining the fabric of the building, but some of the challenges have been addressed over the last year i.e. guttering
- Standards of cleanliness is very high
- Quality of food is very good
- The food service in the dining room on Aston Unit allows patients to socialise in an uplifting area
- Carpeting in the main corridors need to be replaced

Trust summary

- The trust has scored higher than the national average for the fifth consecutive year in a row
- Congleton has one score below the national average for condition, appearance and maintenance but with the hospital being built in 1928 this is reflected in the scoring
- The assessment demonstrated that the privacy and dignity of patients is being maintained; however, limitations of ward design have restricted the opportunity of totally segregating patients
- There were lots of comments about the staffing in all areas of each hospital and the patient assessors were in full agreement that the staff work hard to ensure that our patients are cared for in a calm and soothing environmental

Local patient surveys

The trust carries out patient feedback work across both acute and community settings. Patient feedback is vital as it enables the trust to ensure that its services are meeting the needs and expectations of patients and their families and to identify areas for improvement.

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

Area	Examples of improvements
Children's Ward	• Increased range of activities for older children • Updated nursing documentation to ensure children involved as much as possible in discussions about care and treatment • New 'finger food' menu • New range of child friendly cutlery • Mobile phone charging facilities for parents • Ward and parents room redecorated and the provision of new curtains
Colposcopy	• Updated appointment letter and information leaflet to further raise awareness of the opportunity to bring a friend / relative to the appointment for support
Emergency Department	• Introduction of a numbered queuing system for seeing the streaming nurse • Frosted glass and privacy screen around streaming nurse to improve patient privacy • Pain assessment undertaken at streaming to reduce wait for analgesia
Endoscopy	• Staff reminded to ensure all patients receive a full explanation of their proposed procedure during the admissions process • Review of admission information booklet • Staff to ensure information about delays communicated
Macmillan	• Information board updated every 30 minutes in relation to delays in clinic
Pulmonary Rehabilitation	• All patients now receive an information leaflet about the service and what to expect prior to attending their first appointment

Quarterly audits

The trust also undertakes quarterly audits on wards, outpatient areas and community areas which cover key elements of the patient experience including cleanliness and environment, privacy and dignity, provision of information and overall quality of care.

The table below details key results for 2018/19 (percentage of patients responding positively to audits):

	Inpatient	Outpatient	Community Nursing
Rated the cleanliness of the ward/ dept as 'very clean' / 'excellent'	84%	68%	Not applicable
Stated that they were 'definitely' involved in decisions about their care and treatment	66%	83%	80%
Said staff 'definitely' checked they were comfortable and had everything that they needed on a regular basis	83%	Not applicable	Not applicable
'Always' had enough privacy when discussing their condition / treatment	75%	Not applicable	Not applicable
'Always' had enough privacy when being examined or treated	91%	97%	Not applicable
Said they were 'always' treated with dignity and respect	96%	98%	99%
Said they were 'definitely' treated with care and compassion	**93%**	**94%**	**98%**
Rated the overall level of care as 'excellent'	**77%**	**84%**	**83%**
Stated that the nurse 'always' arrived as planned for their visits	Not applicable	Not applicable	**95%**
Said they 'definitely' felt supported in managing their condition	Not applicable	Not applicable	**88%**

National patient surveys

The trust undertakes national surveys across a range of departments on an annual basis. Results from these surveys inform future learning and benchmark the trust against its peers.

NATIONAL SURVEY	Results
2018 National Maternity Survey	Full report available to view at www.cqc.org.uk/publications/surveys/surveys The survey sample was drawn from women aged 16 or over who had a live birth at the trust / home birth between 1st January and 28th February 2018. The survey asked women about their experiences of care during labour and birth, as well as the quality of antenatal and postnatal support received. The trust's results were 'better than expected' in relation to women knowing how to contact the midwifery team when at home following the birth. The trust was classed performing 'as expected' for all remaining criteria and there were no areas where the trusts results were 'worse than expected'
2017 National Cancer Survey	Full report available to view at www.ncpes.co.uk/index.php/reports/2017-reports The trust was classed as performing 'higher than expected' for 3/52 criteria and 'as expected' for 49/52 criteria. The trust was not classed as performing 'lower than expected' for any criteria. The criteria where the trust was classed as performing 'higher than expected' were: • Patient found it easy to contact their clinical nurse specialist. • Patient was able to discuss worries or fears with staff during their hospital visit. • Hospital staff gave family or someone close all the information needed to help with care at home.
2017 National Adult Inpatient Survey	Full report available to view at www.cqc.org.uk/publications/surveys/surveys The trust was classed as performing 'better than other trusts' (green) for two criteria: • Patients receiving an explanation in relation to how an operation / procedure had gone • Staff doing everything possible to control any pain • The trust was classed as performing 'the same as other trusts' in 58 categories (amber) The trust was not classed as performing 'worse than other trusts' (red) in any categories.

The trust undertook four additional surveys during 2018 these are National Adult Inpatient Survey, Emergency Department Survey, Children and Young People's Survey and National Cancer Survey results are due to be published in 2019.


POST PROCEDURE CARE
Handed over to Recovery staff ☐ Yes ☐ No
Nil by mouth until ..... N/A
ETU Recovery Notes – Entries to be signed for.
Care required post ERCP
for possible discharge
throat spray used. NBM for 1 hour post procedure, otherwise start clear fluids
when awake. If tolerated well, introduce normal diet.
deterioration - Increasing or persistent abdominal pain, pyrexia, altered
contact medical/surgical team immediately.
care to be added by endoscopy team
☐ Yes ☐ No
☐ Yes ☐ No
ward staff
completed
ETU recovery

All the staff on the ward were very friendly. They worked so well as a team and were very helpful.

WARD 1

Clinical audits and research

Participation in clinical audits

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

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

The following section summarises the clinical audit activity participated in by East Cheshire NHS Trust during 2018/19.

National clinical audits

During 2018/19, the trust participated in 38 national clinical audits and three national confidential enquiries. This equated to 90.5% and 100% respectively of the audits in which it was eligible to participate.
The national clinical audits and national confidential enquiries that the trust participated in, and for which data collection was completed during 2018/19, are listed below alongside the percentage or number of cases submitted to each audit or enquiry.

National clinical audit / programme	Participation	% Data submission
Planned Care Services		
General Surgery		
Elective Surgery (National PROMs Programme)	Yes	Data collection ongoing
National Emergency Laparotomy Audit (NELA)	Yes	Data collection ongoing
Orthopaedics		
NJR Hip Knee shoulder elbow	Yes	Data collection ongoing
Maternity		
National Maternity and Perinatal Audit (NMPA)	Yes	Data collection ongoing
Maternal, Newborn and Infant Clinical Outcome Review Programme (MMBRACE)	Yes	Data collection ongoing
Neonates		
National Neonatal Audit Programme – Neonatal Intensive and Special Care (NNAP)	Yes	Data collection ongoing
Sexual health		
Faculty of Sexual and Reproductive Healthcare -Emergency contraception audit	Yes	100%
British HIV Association - Partner notification of HIV positive patients audit	Yes	100%
British Association for Sexual Health and HIV - national audit of HIV monitoring and assessment in older adults	Yes	100%
Allied Heath and Clinical Support Services		
Cancer Services		
National Oesophago-gastric Cancer (NAOGC)	Yes	Data collection ongoing
National Prostate Cancer Audit	Yes	Data collection ongoing
National Audit of Breast Cancer in Older People	Yes	Data collection ongoing
National Bowel Cancer Audit (NBOCA)	Yes	Data collection ongoing
National Lung Cancer (NLCA)	Yes	Data collection ongoing
Clinical Haematology		
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance	Yes	Data collection ongoing
National Comparative Audit of Blood Transfusion programme* Massive Haemorrhage	Yes	Data collection ongoing

National clinical audit / programme	Participation	% Data submission
Palliative Care (End of Life)		
National Audit of Care at the End of Life (NACEL)	Yes	100%
Acute and Integrated Community Care		
Acute Paediatrics		
National Audit of Seizures and Epilepsies in Children and Young People	Yes	Data collection ongoing
Cardiology		
Myocardial Ischaemia National Audit Project (MINAP)	Yes	100%
National Audit of Cardiac Rehabilitation	Yes	100%
National Heart Failure Audit	Yes	100%
Emergency Medicine		
Feverish Children (care in emergency departments)	Yes	Data collection ongoing
National Comparative Audit of Blood Transfusion programme	Yes	100%
Vital Signs in Adults (care in emergency departments)	Yes	Data collection ongoing
VTE risk in lower limb immobilisation (care in emergency departments)	Yes	Data collection ongoing
Elderly Care		
National Audit of Dementia	Yes	Data collection ongoing
Intensive Care		
Case Mix Programme (CMP)	Yes	100%
Respiratory		
National Lung Cancer Audit (NLCA)	Yes	Data collection ongoing
Adult Community Acquired Pneumonia	Yes	Data collection ongoing
National Asthma and COPD Audit Programme*	Yes	Data collection ongoing
Diabetes		
National Inpatient Diabetes Audit – Adults (NaDIA)	Yes	100%
National Inpatient Diabetes Audit – Adults-Harms (NaDIA- Harms)	Yes	Data collection ongoing
Rheumatology		
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)	Yes	Data collection ongoing
Corporate		
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)*	Yes	100%
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	Yes	Data collection ongoing
Surgical Site Infection Surveillance Service	Yes	Data collection ongoing
Seven Day Hospital Services	Yes	100%

The following national clinical audits were not participated in during 2018/19;

National Clinical Audit/ Programme	Reason for non-participation
Planned Care Services	
National Bariatric Surgery Registry (NBSR)	The trust does not provide this service
Major Trauma Audit	The trust is not a major trauma centre
National Ophthalmology Audit	Unable to participate due to IT incompatibility.
BAUS Urology Audit	Urology service is provided on an outpatient basis by an external provider
Allied Health and Clinical Support Services	
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	The trust is not a major trauma centre so therefore does not have a specialist rehab centre
Acute and Integrated Care	
Paediatric Intensive Care (PICANet)	The trust does not provide this service
Falls and Fragility Fractures Audit Programme (FFFAP)	There is currently no orthogeriatrician in post at the trust
Adult Cardiac Surgery	The trust does not provide this service
Cardiac Rhythm Management (CRM)	The trust does not provide this service
National Audit of Percutaneous Coronary Interventions (PCI)	The trust does not provide this service
National Congenital Heart Disease (CHD)	The trust does not provide this service
National Vascular Registry	The trust does not provide this service
Inflammatory Bowel Disease programme / IBD Registry	Completion would require additional unavailable funding.
National Diabetes Foot Care Audit	The trust does not provide this service
National Core Diabetes Audit	East Cheshire provides data for this audit but data is collated and analysed by Eastern Cheshire CCG
National Diabetes Transition	The trust does not provide this service
Sentinel Stroke National Audit programme (SSNAP)	The trust does not provide this service
National Audit of Pulmonary Hypertension	Patients with this condition are not treated by East Cheshire NHS Trust
Non-Invasive Ventilation - Adults	The trust does not meet the minimum number of cases to participate
National Cardiac Arrest Audit (NCAA)	Resuscitation team participate in a local audit programme which explores issues in real time and highlights actions specific to ECT
UK Cystic Fibrosis Registry	The trust does not provide this service
National Pregnancy in Diabetes Audit	The trust did not provide a diabetes service during data collection period
National Audit of Intermediate Care	Unable to participate due to unavailable resource for completion
Corporate	
National Mortality Case Record Review Programme	East Cheshire provides data for this audit but data is collated and analysed by Eastern Cheshire CCG

The following national audit reports have been issued during 18/19 but relate to previous financial years;

National Clinical Audit/ Programme
Planned Care Services
General Surgery
National Emergency Laparotomy Audit (NELA)
Trauma & Orthopaedics
National Hip Fracture Database
NJR Hip Knee shoulder elbow
Maternity
National Maternity and Perinatal Audit (NMPA)
Maternal, Newborn and Infant Clinical Outcome Review Programme (MMBRACE)
Neonates
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)
Allied Heath and Clinical Support Services
Cancer Services
Systemic Anti-Cancer Therapy (SACT)
National Audit of Breast Cancer in Older Patients (NABCOP)
National Bowel Cancer Audit (NBOCA)
National Oesophago-gastric Cancer (NAOGC)
Acute Oncology Outcome measures (including Cancer of Unknown Primary)
National Lung Cancer (NLCA)
National Prostate cancer (NPCA)
Clinical Haematology
National Comparative Audit of Blood Transfusion programme Re-audit of the 2016 audit of red cell and platelet transfusion in adult haematology patients
National Comparative Audit of Transfusion Associated Circulatory Overload (TACO)
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme
Adult Therapies
UK Parkinson's Audit – Neurophysiotherapy
Radiology
Audit of the Provision of Imaging of the Severely Injured Patient
Acute and Integrated Community Care
Acute Paediatrics
Growth Hormone
National Paediatric Diabetes Audit (NPDA)
Respiratory
National COPD Audit

National clinical audit outcomes

The reports of 28 national clinical audits were reviewed by the trust in 2018/19 and ECT intends to take the following actions to improve the quality of healthcare provided: Examples of action from nine of 28 audits. A full list of actions can be found at www.eastcheshire.nhs.uk/Our-Services/clinical-audit.htm

Myocardial Ischaemia National Audit Project (MINAP)

The trust aims to support initiatives to mitigate known risk factors, publicise the signs and symptoms of heart attack, and encourage prompt responses at the onset of symptoms and continue to ensure nSTEMI patients at moderate to high risk have access to timely angiography.

Mandatory Surveillance of Bloodstream Infections and Clostridium Defficile Infection (CDI)

All cases of MRSA BSI and CDI are subject to a post infection review as per NHS England's requirements to ensure outpatients are receiving good quality care. These reviews enable a targeted approach to improve practice by identifying how the infection occurred and if there are any elements of the patient's pathway which may have contributed to the infection. Factors considered for MRSA BSI include management of invasive devices and appropriate screening. In relation to CDI, factors which have been identified included antimicrobial prescribing, patients with multiple underlying co-morbidities which increase the risk of developing CDI and staff understanding of when to take a stool specimen. This learning has been addressed by supporting clinical staff in training and focusing on a robust antimicrobial prescribing campaign.

UK Parkinson's Audit - Neurophysiotherapy

We performed well in this audit. Three improvement areas were identified and the trust has developed an evidence-based Parkinson's disease information file to improve information and understanding of Parkinson's disease to new starters and rotational physiotherapists, in addition to the development of weekly high intensity interval training and group exercise sessions delivered in the neuro-gym.

National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)

Following the results a series of local audits have been planned to review the process of liaison with the obstetrician if the opportunity to give steroids is missed. A records review ensured documentation included whether parents were present for the ward round. Training has also been delivered around the recording of culture, signs and results on Badgernet (digital maternity system).

National Maternity and Perinatal Audit (NMPA)

We performed well in this audit, scoring in the top three trusts nationally for detection of small gestational babies when using GAP/GROW. The trust will continue to review its practices in line with the introduction of new guidelines and national recommendations aimed at reducing avoidable stillbirths.

National Comparative Audit of Blood Transfusion programme (Re-audit of the 2016 audit of red cell and platelet transfusion in adult haematology patients)

The audit results show three areas for which national recommendations have been identified for improvement. The trust already meets two of these recommendations and is currently compliant with three of four clinical practice recommendations with additional processes in place for reviewing results and treatment planning within a small staff team.

National Emergency Laparotomy Audit (NELA)

We have achieved local improvements in all parameters compared with last year's data. Actions implemented this year by the trust's NELA lead have led to improvements to data collection, anaesthetic consultant participation, possum scoring and case logging by specialty doctors.

National Paediatric Diabetes Audit (NPDA)

The report shows further improvement on last year performing above average compared with North West and England averages regarding HbA1c levels. The department continues to work in line with NICE guidelines and will be participating again in next year's national audit.

National COPD Audit

The audit data suggests three key improvement targets, based on a strong evidence base for their effectiveness in improving outcomes. An additional three care processes were identified that would also benefit from further collaborative improvement work. The trust has reviewed relevant NICE guidance and remains fully compliant with all recommendations.

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

The following four NCEPOD audits were participated in during 2018/19, with progress reported to Clinical Audit and Research Effectiveness (CARE) Group at each meeting.

A summary of the NCEPOD studies participated in during 2018/19 is given below:

NCEPOD Audit Reviewed	Participation	% Data submission
Pulmonary embolism	Yes	100%
Long Term Ventilation	Yes	100%
Acute Bowel Obstruction	Yes	100%
Dysphagia in people with Parkinson's Disease	No	Not required to submit any information

The outcomes of these studies are not yet concluded. On conclusion reports are issued to the trust by NCEPOD, these reports are then cascaded through the organisation.

Local clinical audits

As at the 31st March 2019 the trust registered 53 local clinical audits (100% of the approved forward plan). Progress against the forward plan and a summary of audit outcomes are monitored at the monthly Clinical Audit and Research Effectiveness Group. Completed audits are presented to specialty audit meetings. The trust action plan to improve the quality of healthcare provided includes:

General Surgery

With the aim to improve intravenous (IV) fluid prescribing practice in adult surgical patients we undertook an audit to compare current practice against NICE guideline standards. Following the audit, teaching sessions were conducted aimed towards junior doctors and new NICE IV fluid algorithm posters were displayed in appropriate locations (including doctor's mess and nursing stations). A re-audit was planned within four months to review the impact of these actions. Results from the IV fluids re-audit showed improvement in some areas. In order to keep improving, the trust implemented prescription charts with new IV fluid charts to aid prescribers in following the NICE guidance. The inclusion of IV fluid teaching for junior doctors was well received and is now standard practice. A further re-audit has been planned for next year.

Orthopaedics

An audit on anticoagulants in fractured neck of femur (NOF) surgery aimed to identify the number of patients presenting with NOF fractures who are on anticoagulants. To assess how each anti-coagulant agent affected both waiting time for surgery and length of stay in hospitals. It concluded that there was no difference in transfusion rates in early surgery groups. Most trauma centres will not delay surgery due to anticoagulants. Due to the outcomes of this audit the trust is now developing a new guideline in order to improve the quality of healthcare provided.

Haematology

The trust undertook the Obtaining valid consent for Blood Transfusions' audit. This audit aims to to identify if valid consent is obtained and documented appropriately for patients receiving blood transfusions at MDGH and then use this information to drive a trust-wide improvement of clinical practice in gaining and documenting valid informed consent for those receiving blood transfusions. Simple changes implemented as part of the audit process demonstrated a serial increase in the levels of valid consent obtained for transfusions. This quality improvement project will now form the basis for a yearly audit cycle to ensure practice is maintained at a high level and consent for blood transfusions training is to be incorporated as part of the trust's statutory and mandatory training package.

Gastroenterology

An Oesophageal Cancer Stenting Audit was undertaken to assess the quality of upper GI endoscopy with oesophageal stenting in oesophageal carcinoma as per British Society of Gastroenterologists (BSG) guidelines. Conclusions made from the audit were that both direct and fluoroscopic stent insertion can be done safely and effectively. Both methods offer similar outcomes. As per European guidelines photographic documentation and mandatory imaging is completed during the procedure. The trust is now looking to formalise a follow up post stenting protocol.

Paediatrics

The Paediatric Early Warning Score (PEWS) audit was undertaken to ascertain whether the new early warning score was being used effectively on the Children's Ward and any improvement that has been made since the introduction of the new tool. The results indicated improvements in each category in comparison to previous years. The trust has implemented training sessions for nursing staff and health care assistants on the importance of PEWS on admission, including the importance of accurate scoring. In addition PEWs competencies are to be completed on paediatric essentials annually for staff nurses.

Paediatric Therapy

After identifying gaps in the transition from children to adult services the Paediatric Therapies Team formulated an audit to unite these multiple disciplines together with the aim to identify whether the team are having early discussions around transition to adult therapy services and to evaluate if young people are provided with information relating to adult therapy services and available support groups prior to discharge.
In order to achieve this the trust will be creating a transition pathway for therapists for reference and guidance. A transition section is to be added within the therapy Education, Health and Care Plan (EHCP) template in order to prepare patients and families as early as possible about what to expect in adult services. The team now also provides patient and family transition leaflets with information about the process, what to expect, local networks and charities who offer support and stating where there is no equivalent service up to a year prior to transition.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Participation in clinical research

Participation in clinical research demonstrates the trust's ambition to improve the quality of care offered and make a contribution to wider health improvement. It provides patients with opportunities to participate in trials, and also meets the obligations set out in the NHS Constitution that research is core business for the NHS.

We are part of the Greater Manchester Clinical Research Network, one of 15 local clinical research networks that make up the National Institute for Health Research (NIHR). The network coordinates and supports the delivery of research.

For the financial year 2018/19, 51 clinical research studies were active to recruitment, 20 of which were opened during the year. Of these studies, 8 studies were interventional (so could potentially change the patient's treatment). In addition these 'actively recruiting' studies a further 105 studies were in follow-up.

The trust continues to excel with patient participation, reaching our NIHR recruitment target during quarter four of the year with a total of 516 patients recruited to clinical research studies during 2018/19 (over 218 % of our local NIHR target).

A wide range of research was carried out last year, covering specialties such as oncology, children, dementia and neurodegenerative diseases, musculoskeletal disorders, cardiovascular, gastroenterology, health service and delivery research, stroke, hepatology, surgery, diabetes, ophthalmology, reproductive health and childbirth, respiratory, sexual health, respiratory, critical care, dermatology, haematology, injuries and emergencies, orthopaedics, pharmacy, speech and language therapy and urology.

We used the nationally-recommended systems and protocols to manage these studies and to ensure that the results were translated into practice in a timely and safe manner where appropriate.

“This is the third visit to Ophthalmology, sent for a scan. I was always treated with courtesy and had everything explained.”

OPTHALMOLOGY

Quality priorities 2019/20

Quality priorities 2019/20

Our quality priorities for 2019/20 are informed by a number of sources including patient representative groups, commissioners and clinical leads.

For East Cheshire NHS Trust, quality encompasses four areas of focus:

- **Harm-free care**

  Care that is safe and a commitment to deliver a year-on-year reduction in patient harm

- **Improving outcomes**

  Care that is clinically effective, providing the best possible evidence-based care

- **Listening and responding**

  Care that provides a positive experience for patients, carers and families, further improving patient experience by listening to feedback and responding to concerns

- **Integrated person-centred care**

  Care which is coordinated and based around individual needs through collaboration and co-operation

Confirmed quality priorities for 2019/20 include:
Enhance falls and pressure ulcer prevention with improved risk assessment, care planning and documentation
Review and enhance safe staffing and skill mix
Full implementation of saving babies lives care bundle
Improve dementia care
Full compliance with sepsis care bundle and NEWS2
Improve discharge planning
Further development of care communities
Improve end-of-life care
Achievement of autism hospital accreditation standards

Our Quality Improvement Model*

Our Quality Improvement Model provides a framework for high quality person-centred care by ensuring that we listen and respond to patient and staff feedback to improve outcomes and prevent harm. This integrated person-centred approach aims to empower service users and staff with the knowledge and skills needed to lead long and healthy lives.

*Adapted from the National Quality Board 'Shared commitment to quality' publication NHSE May 2017

Harm-Free Care

To deliver a year-on-year reduction in avoidable patient harm.

A focus on safety is central to everything the trust does. We will continue to ensure that as we transform services that safety remains our top priority for all age groups.

Focus for 2019/20		Expected Outcome
Infection Prevention Control	Participation in a health economy approach to ensure a reduction in avoidable healthcare associated infections in line with national requirements including MRSA bloodstream infections, Clostridium difficile and gram negative organisms. This includes learning from post-infection reviews to improve practice and reduce the risk of reoccurrence.	• MRSA blood stream infections and Clostridium Difficile remain within agreed trajectories - MRSA 0, CDiff 27 (healthcare and community onset) • Continue our contribution to the reduction in gram-negative bloodstream infections by 50% by 2021 aligned with wider health economy plans
Maternity Services	Embed Saving Babies' Lives care bundle: • Implement 36 week carbon monoxide monitoring for all women • Ensure all smokers are commenced on growth scan surveillance pathway • Ensure compliant with all areas of reduced fetal movement guideline – includes completion of reduced fetal movements assessment tools • Develop CTG competency package to ensure all staff undertake assessment • Reduce preterm births • Implement continuity of carer to meet the national ambition to reduce rates of stillbirth, neonatal death, maternal death and brain injury during birth by 20% by 2020	• Saving Babies' Lives care bundle fully implemented to support national ambition.
Falls	Improve care for patients by reducing inpatient falls and associated harms: Continue to align fall prevention work with national priorities to support a reduction in falls and harms relating to falls : • NICE guidance • The Falls and Fragility Fracture Audit Programme (FFFAP) • National Safety Strategy Create / implement a local integrated (hospital and community) falls working group designed to improve engagement/collaboration and undertake the improvement work.	• Target reduction in injurious falls from 2.5 per 1000 bed days to 1.8 in 2019/20

Focus for 2019/20		Expected Outcome
Pressure Ulcers	Continue embedding strategic /national initiatives to support a reduction in avoidable harms caused through pressure ulcer development. • Stop the Pressure • React to Red approaches Participate in the national pressure ulcer improvement collaborative and align pressure ulcer strategy /reduction work with the National Safety Strategy. Rollout of the government initiative to align the terminology and reporting of pressure ulcers Create of a local integrated pressure ulcer working group designed to improve engagement and focus on improvement work to be undertaken.	• 10% reduction in number of grade 2, 3 and 4 pressure ulcers from 2018/19 baseline. • Zero avoidable grade 4 pressure ulcers by March 2020
Deteriorating patient NEWS 2	• Continue to embed national early warning score in all acute wards and work with community staff to embed NEWS 2 into community and GP settings • Continue working with Manchester patient safety collaborative and AQUA to progress NEWS 2	• Decreased mortality rates. • Full compliance with sepsis care bundle.
Safer Staffing	Undertake baseline assessment re: updated NICE guidance Review and agree local, organisational response re: NICE red flags Monitor Safe Care compliance - review nurse sensitive indicators and ward quality dashboards Review of all wards' WTE funded staff establishments inclusive of skill mix and roles based upon bi-annual Safer Nursing Care Tool Audit analysis	• Registered nurse rolling annual turnover to remain less than 10% by March 2020 • In year reduction in registered nurse vacancies by 10% from March 2019 baseline • Skill mix meets the needs of patients and national guidelines
Discharge Planning	To reduce inappropriate time spent in hospital. Smooth transition of patient discharge: • Strengthen board rounds and long stay patient reviews. • Support development of trusted assessor across care homes • Shared decision making framework for complex patient. • Trusted assessor model across all care homes • Reduce the number of patient moves at night	• Reduction in patients with a prolonged length of stay in hospital bed from 2018/19 baseline. • Improved National Adult Inpatient Survey results in relation to discharge questions • To meet the delayed transfers of care trajectory of 3.5% in line with national target • Improved patient experience and patient survey results

Integrated Person-centred Care

We want to ensure services are effectively coordinated and based around an individual's needs by collaboration and cooperation. 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 in a holistic way.

To address this we aim to further develop our Care Communities to work in a more integrated way to deliver personalised care in the right place at the right time by people with the right skills.

Focus for 2019/20		Expected Outcome
Further Development of Care Communities	To empower people to take responsibility for their own health and wellbeing putting them in control of the support available to meet their needs Establish neighbourhood care team model across East Cheshire building on work in Holmes Chapel Develop & agree vision for personalised care including social prescribing across all Care Communities Improved access designed to deliver high quality responsive services, support and appropriate information that provides everyone with the opportunity to have the best health and wellbeing throughout their life Collaborative patient care between the acute and community and mental health care.	• An increase in the number of people returning to their usual place of residence following a hospital stay. • A reduction in avoidable hospital admissions • Improved patient and staff satisfaction results • Care Communities working in an integrated to way to deliver personalised care • Improved patient satisfaction measured via Friends and Family tests • 30% of staff trained in social prescribing skills in 2019/20 • Improved collaborative working between partner organisations to ensure seamless transition of care. • A reduction in hospital readmissions by 10%.
Social Isolation	Improved training for carers, volunteers and third sector Population profiling & identification processes developed To develop a new volunteer role to provide support to patients on the wards and encourage carers to participate where appropriate in supporting care	• Community staff have a greater understanding of the range of local initiatives to reduce social isolation • Better recognition and understanding of loneliness across all age groups. • An increase of recruited volunteers for this role • Greater carer involvement in ward-based care

Focus for 2019/20		Expected Outcome
Children's Services	Ensure trust remains compliant with national guidance in terms of staffing levels, skill mix and paediatric life support training Further roll out of the use of EMIS to all paediatric community specialities, to improve contemporaneous record keeping, releasing time for care. Improve the pathway to diagnosis for children with autism spectrum condition The Children's Ward to achieve UNICEF breastfeeding accreditation	• Safer staffing levels maintained and all staff up to date with statutory and mandatory training • Improved record keeping • Improved experience for children with autism spectrum condition • East Cheshire contribution to increasing national breast feeding rates by maintaining at least 74% 2019-2022
Dementia Care	To improve care for patients living with dementia by appointing an admiral nurse and work in partnership with Dementia UK, end of life and frailty to ensure the best possible experience for patients in our care at all times To develop a local trust dementia strategy and a delirium pathway	• Dementia-friendly environments in all areas • Staff supported when caring for patients with dementia • More opportunities to facilitate reminiscence therapy

It is envisaged that Care Communities will continue to bring wider health and social care teams together to deliver a wide range of services that not only treat illness but promote wellness, self-care and behavioural change.

This will continue to involve a cohesive and comprehensive response from community services, social and primary care, hospital specialists, mental health and support from public health and preventative services. Input from the voluntary and community sector will be central to the success of this approach.

All the Care Communities are evolving to support the following principles:

- Optimise self-care and family/carers support to enable people to stay at home for as long as possible, independently and safely
- Pro actively identify people at high risk of requiring access to services through early intervention and prevention
- Help people live as independently as possible whilst managing one or more long term conditions
- Focus on improved condition management to avoid unnecessary admissions
- Co-ordinate delivery of services from all providers, with teams of multi- skilled professionals based in each of the Care Communities
- Help prevent people from having to move to a residential or nursing home (24 hour care) until they really need this level of care
- Move care and support closer to home
- Improve recruitment and retention into general practice and community services

Improving outcomes

We want to provide the best possible evidence-based care

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.

Focus for 2019/20		Expected Outcome
Clinical Audit	Develop and implement annual clinical audit programme. Participation in National Falls Audit Participation in Care of the Dying Audit Ensure a more streamlined approach to audit to prevent duplication and release time to care.	• Evidence of service improvements and better outcomes for patients.
Clinical Research	Increase awareness of the benefits of research for patients and the trust by publicising on intranet and induction. Increase awareness of what research activity is carried out within the trust by informing staff, visitors, patients and the wider public. Ensure research continues to be carried out in a safe, effective manner whilst being a positive experience for patients taking part.	• Improved research awareness and implementation of evidence based practice. • Increase the number of participants recruited into NIHR CRN Portfolio studies and increase number of research articles published.
Implement the UNICEF Baby Friendly Initiative UK	A standardised programme of training and auditing of NHS staff to provide evidence based infant feeding information which includes guidelines, leaflets and practical advice. The overall aim is to increase breastfeeding figures nationally and therefore increase the health of the nation.	• East Cheshire contribution to increasing national breast feeding rates by maintaining at least 74% 2019-2022
Releasing Time to Care and better utilisation of IT	Review and refinement of nursing documentation Removing the need for fax machine referrals	• More efficient and effective working and more time to care and increased productivity
Delivering Clinical Standards	To deliver all clinical standards within the operational plan including RTT, cancer screening and diagnostics	• Patients receive timely care, procedures and investigations in line with national standards

Listening and Responding

To further improve patient experience by listening to feedback and responding to concerns

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

Focus for 2019/20		Expected Outcome
Safety Culture	Ensuring a safety culture is fostered, by encouraging and supporting staff to report incidents. Ensure the trust is listening and responding to staff concerns through implementation of the Freedom to Speak Up Strategic Plan. Further promotion of excellence reporting	• Maintain trust position in top quartile of peer group for incident reporting via the National Reporting and Learning System. • Increase the number of Freedom to Speak Up ambassadors. • Improved staff survey results in relation to staff confidence in reporting incidents.
Autism	Pilot of the autism hospital accreditation standards.	• Achievement of autism hospital accreditation standards in six areas
Learning Disabilities	Ensuring that people with disabilities feel involved in decisions about their care and treatment Identify reasons via patient interviews carried out by members of the trust's Disability Equality Group	• Parity of esteem for patients with learning disabilities. • At least 20% of community staff to have received autism and learning disabilities awareness training
Patient Representative Groups	To ensure groups of individuals truly reflect the demographic of the local population Introduce feedback groups for people with learning disabilities and/or autism. Ensure mechanisms for the involvement of children and young people.	• Patient representative groups to become more reflective of the population we serve •
Continued work in ensuring patients die in their preferred place, with a focus on more patients dying in their own home.	Better access to domiciliary support for end of life care. A review of documentation including care plans for both hospital and community. Further roll out of the use of EPACCs to ensure patients' preferences are recorded and this information is shared.	• More patients dying at their preferred place of death. • Improved percentage of patients who have their care supported by a care plan in both hospital and community settings.

We would highly recommend. All the staff have been amazing and we have felt very well looked after for our whole stay.

MATERNITY

Statements of assurances

East Cheshire NHS Trust response to partners comments on the Quality Account

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 Clinical Commissioning Group and Healthwatch can be found on the following pages. The Health and Adult Social Care and Communities Overview and Scrutiny Committee, Cheshire East were invited to comment on the report however owing to the 2019 local elections and the scheduling of committee meetings, the Health and Adult Social Care and Communities Overview and Scrutiny Committee was unable to provide an opinion on East Cheshire NHS Trust's Quality Account for 2018/19."

The trust would like to thank the CCG and Healthwatch for the time taken to comment on this document and for their recognition and positive comments regarding the quality of care provided at the trust. We look forward to working with our partners on implementing our quality improvements in 2019/20.

14th May 2019

NHS
Eastern Cheshire
Clinical Commissioning Group

East Cheshire NHS Trust Quality Account 2018/2019 commentary on behalf of NHS Eastern Cheshire Clinical Commissioning Group

East Cheshire NHS Trust Quality Account 2018/2019

Thank you for the opportunity to comment on East Cheshire Trust's draft quality account 2018/19. The CCG's Clinical, Quality and Performance Committee has reviewed the document and noted the key achievements against the Trusts priorities.

The CCG acknowledges the strategic direction set out in the NHS Ten Year Plan and Quality Strategy but we also note the additional efforts required to address and improve current patient access standards. We recognise the staffing challenges faced and the steps taken by the Trust to address this locally including additional efforts put in place to retain staff, and participate in the Nursing Associates programme.

Furthermore we would also like to recognise the Trust's commitment to providing support to the wider health economy, including other hospital trusts in times of difficulty. The CCG would particularly like to acknowledge the challenges experienced over the winter period. We recognise the Trust's commitment to keeping patients safe, the innovative approaches developed including the award winning 'Helping Flo campaign' (Improving patient flow) and to take this opportunity to formally acknowledge the contribution of all the East Cheshire NHS Trust staff.

In closing, the CCG is of the opinion that this account provides a balanced picture of the Trust's performance during 2018/1019,and would like to wish you every success in implementing planned quality improvements in 2019/20.

Alex Mitchell
Deputy Accountable Chief Officer & Chief Finance Officer
NHS Eastern Cheshire CCG
10th May 2019

Healthwatch Cheshire CIC welcomes the opportunity to comment on the East Cheshire NHS Trust (ECT) Quality Account 2018/2019

HEALTHWATCH CHESHIRE CIC – 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 ECNHST have involved and listened to their consumers views (patients and their families).

We would like to acknowledge the importance the Trust have with regard to PLACE visits and improving the patient experience; we are pleased to contribute to this aim as key partners.

Having read the Quality Account document as presented to us we note and commend the trust on its recent work in particular –

- Its continued ambitions in relation to care closer to home carried forward from the last Quality Account
- Its commitment to invest resources and people into the development of five Care Communities
- Renewed focus on prevention in line with the NHS Long Term Plan

In regard to the presentation and look of the document it appears to be logical, clear and easy to read.
In relation to the fine detail we are pleased to read that the trust received an “Outstanding” rating for the CQC Caring Domain in Community End of Life Care, which demonstrates the quality of the work done around enabling people to maintain their independence.

Additional comments on detail:

- Freedom to Speak Up Guardian has been appointed to allow staff to raise concerns
- We note that mortality reviews have highlighted gaps in clinical documentation and that steps are being taken to improve the situation
- Healthwatch commends the four quality areas of focus in particular in relation to Listening and Responding.

We recognise that there have been significant challenges for the Trust during 2018/2019 and value the relationship that Healthwatch Cheshire CIC and the Trust have. We look forward to continue working with the Trust during 2019-2020 to enable our community to have a powerful voice helping to shape and improve these services for the future.

HEALTHWATCH CHESHIRE CIC – MAY 2019


East Cheshire NHS
Lesley Cork

Glossary

A&E - Accident and Emergency
ACS - Acute Coronary Syndrome
ACP - Association of Child Psychotherapists
AHP - Allied Health Professional
AKI - Acute Kidney Injury
AQ - Advancing Quality
AMi - Acute Myocardial Infarction
AMT- Abbreviated Mental Test
ANC - Antenatal Clinic
APLS - Advanced Paediatric Life Support
AVS - Acute visiting service
BDP - Bollington, Disley and Poyton
CARE - Clinical Audit Research and Effectiveness
CCG - Clinical Commissioning Group
CCR - Cheshire Care Record
CDiff - Clostridium *Difficile*
CGA - Comprehensive geriatric assessment
CNST - Clinical Negligence Scheme for trusts
COPD - Chronic Obstructive Pulmonary Disease
CPR - Cardiopulmonary Resuscitation
CQC - Care Quality Commission
CQUIN - Commissioning for Quality And Innovation
CTG - Cardiotocography
CWMH- Congleton War Memorial Hospital
Datix - Internal incident reporting system
DH - Department of Health
DNACPR - Do Not Attempt Cardiopulmonary Resuscitation
DTOC - Delayed Transfers of Care
DVT - Deep Vein Thrombosis
ECCCG - East Cheshire Clinical Commissioning Group
ECT - East Cheshire NHS Trust
ED - Emergency Department
EDD - Expected Day of Discharge
EDNF - Electronic Discharge Notification Form
EMIS- Electronic Medical Information Systems
EPaCCS - Electronic Palliative Care Co-ordination Systems
EOL - End of life
ETU - Endoscopy Treatment Unit
FFT - Friends and Family Test
GMC - General Medical Council
GP - General Practitioner
GPOOH - GP Out-of-Hours
HCA - Healthcare Assistant
HDU - High Dependency Unit

HITS - Home Intravenous Therapy Team
ICU - Intensive Care Unit
CRN - Clinical Research Nurse
IG - Information Governance
IT - Information technology
MAPLE - Mental and Physical-Led Exercises
MAU - Medical Assessment Unit
MDGH - Macclesfield District General Hospital
MDT - Multi-Disciplinary Team
MRSA - Methicillin-Resistant Staphylococcus Aureus
MINAP - Myocardial Ischaemia National Audit Project
NEWS2 - National Early Warning Score 2
NHS - National Health Service
NHSI - NHS Improvement
NHSLA - NHS Litigation Authority
NHSP - Newborn Hearing Screening Programme
NICE - National Institute of Clinical Excellence
NIHR - National Institute for Health Research
NCEPOD - National Confidential Enquiry into Patient Outcome and Death
NOF - Neck of Femur
NRLS- The National Reporting and Learning System
NSF - National Service Framework
NWAS - North West Ambulance Service
OT - Occupational Therapist
OFSTED- Office for Standards in Education
PCI - Percutaneous Coronary Interventions
PE - Pulmonary Embolism
PLACE - Patient-Led Assesment of Care Environment
PPC/D- Preferred Place for Care/Death
PROMS - Patient-Reported Outcome Measures
QIPP - Quality, Innovation, Productivity and Prevention
RAD - Rapid Access and Diagnostics
RCN - Royal College of Nursing
RCM - Royal Colleage of Midwives
RCOG - Royal College of Obstetricians and Gynaecologists
SHMI - Summary Hospital-level Mortality Indicator
SNCT - Safer Nursing Care Tool
SPCT - Specialist Palliative Care Team
SQS - Safety, Quality Standards
StEIS- Strategic Executive Information System
TARN - Trauma Audit and Research Networks
TNA - Trainee Nursing Associate
UTI - Urinary Tract Infection
VTE - Venous Thromboembolism

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

By post

East Cheshire NHS Trust

Macclesfield District General Hospital

Victoria Road

Macclesfield

Cheshire

SK10 3BL

By telephone

01625 421000 - main trust switchboard

01625 661184 - Communications Department

Via our website

www.eastcheshire.nhs.uk

Mid Cheshire Hospitals
NHS Foundation Trust

Quality Account 2018/19

Quality and Safety at Heart
Mid Cheshire Hospitals NHS Foundation Trust

Quality Account 2018/19


"Mid Cheshire Hospitals NHS
Foundation Trust prides itself
on the quality and safety
of care it delivers
to users
and carers"

Statement on Quality from the Chief Executive

It has been a very eventful year at Mid Cheshire Hospitals NHS Foundation Trust, and I am delighted to share some of our work through our Quality Account for the period of April 2018 to March 2019.

Mid Cheshire Hospitals NHS Foundation Trust (MCHFT) is the organisation that runs Leighton Hospital in Crewe, Victoria Infirmary in Northwich and Elmhurst Intermediate Care Centre in Winsford. In partnership with Cheshire and Wirral Partnership NHS Foundation Trust and South Cheshire and Vale Royal GP Alliance, we also deliver Community Services across a number of community locations.

Patient safety and quality are at the heart of everything that we do. As Interim Chief Executive I am incredibly proud of what we, at MCHFT, have achieved so far and the Trust is committed to deliver further year-on-year improvements. We hope that you find this Quality Account describes our achievements to date and our plans for the future

Throughout 2018/2019 we have continued to make good progress on our Quality and Safety Improvement Strategy; progress which has largely been achieved collaboratively as a result of the hard work, commitment and dedication of all our staff. We have continued to see and treat an increasing number of patients with more complex needs on both an elective and non-elective basis.

For the year 2018/19 the Trust delivered four of the five of the NHS Improvement Standard Oversight Framework performance indicators. The standard not achieved was the four hour access standard, (nationally known as the A&E Target) which delivered 83.63% in 2018/19. A full programme of improvement work is underway during 2019/20 to improve this performance

Following the successful integration of community services we are proud that the programme of continuous improvement and transformation for these services has continued. The development of 5 care communities sets the future direction of patient centred care across geographical footprints and supports closer working relationships between partner organisations and enhances holistic patient pathways.

MCHFT was named nationally within the top five combined acute and community Trusts for the annual staff survey results in 2018/19. This is a continued achievement that every one of our staff can be proud of.

Key achievements in 2018/19 include:

- The Surgical Ambulatory Care Unit winners of the Integration and Continuity of Care category for the Patient Experience Network Awards (PENNA) 2018. The Surgical Ambulatory Unit focusses around the teams launch and delivery of this new service which has been successful in reducing unnecessary hospital admissions and has consistently received positive patient feedback
- The Virtual Fracture Clinic were also winners at PENNA 2018.The team won the Innovative Use for Technology and Social Media Category for streamlining the process for the fracture clinic patients and avoiding unnecessary hospital attendances
- The Trust were successful winners of the National Wounds UK Award 2018 for the most innovative abstract in work to reduce moisture associated skin damage
- The bespoke phlebotomy clinic for adults with learning disabilities continues to support patients and obtain samples in a non-threatening environment. The clinic was recently shortlisted for a Nursing Times Award 2018
- A continued reduction of the number of patients having E-coli infections and the improvement of Patient Screening and treatment for Sepsis

We recognise that providing health care is not without risk and that sometimes patients can be unintentionally harmed in the care of hospitals. You will read throughout this Quality Account of the Trusts ambitious aims to continue to reduce harm across our organisation. Our Quality and

Safety Improvement Strategy is the vehicle by which we have steered the direction of travel for quality and safety focusing on the 9 indicators below;

- Reducing serious harm
- Reducing hospital or community acquired avoidable pressure ulcers
- Reducing inpatient falls
- Reducing mortality figures
- Reducing hospital acquired infections
- Reducing inappropriate inpatient moves
- Recognising and responding to the deteriorating patient
- Recognising and treating sepsis
- Improving end of life care

Patients want to know that they will be provided with the best treatment and care available, based on up-to-date evidence and by well trained staff. This report also demonstrates that the Trust has a number of assurance mechanisms in place which demonstrate how we scrutinise the quality of the care that we deliver. Examples of these include our extensive audit program and the nursing acuity tool that is used to ensure the planned required levels of staffing is in place.

We are proud that our C-difficile infection rates have fallen from 3 avoidable cases to 2 avoidable cases in 2018/19. Overall we had 24 C-difficile infections against an objective of 23. Importantly, of those, 19 were deemed to have been unavoidable following in-depth analysis with our commissioners. The remaining 4 have not yet been assigned and are awaiting review. Although we did not achieve the objective of no MRSA blood stream infections this year having identified 4 patients, we have implemented a robust focused approach to reduce the risk of occurrence in other patients to ensure the risk of Health Care Associated Infections is minimised.

With regard to our mortality rates; the latest publication for our mortality data for the period October 17 to September 2018 demonstrates a SHMI of 105.48 and the Trust remains in the 'as expected' range.

I hope you will enjoy reading about the many examples of the improvement work that teams across the organisation are pursuing. We strive to deliver high quality, safe, cost-effective and sustainable healthcare services that meet the high standards that our patients deserve. We want MCHFT to continue to be the health care provider that patients trust to provide those highest standards of care - and the organisation that staff have pride in and are willing always to give of their best.

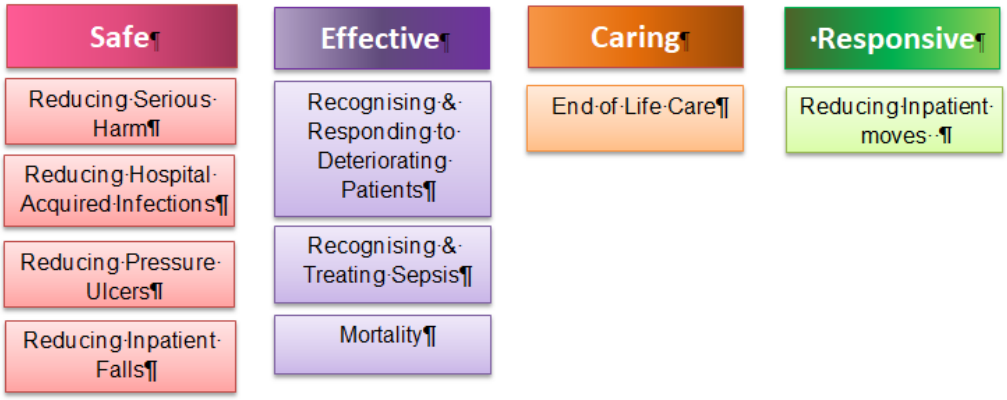
I am pleased to confirm that the Board of Directors has reviewed the 2018/19 Quality Account and agree that it is a true and fair reflection of our performance. We hope that this Quality Account provides you with a clear picture of how important quality improvement and patient safety are to us at MCHFT.

Finally, I want to take this opportunity to thank our staff who are highly skilled, dedicated and committed .They work hard to deliver safe and compassionate care to our patients day in and day out, sometimes in difficult circumstances. I would also like to extend my appreciation to our Governors, Volunteers, Members, Patient Representatives and other Stakeholders who have helped shape our quality programme by taking time out to support and advise us.

Dr Paul Dodds
Interim Chief Executive
Date: 23 April 2019

Priorities for improvement and statements of assurance from the Board

Following the successful completion of the 2018/19 Quality Strategy, the Trust conducted an extensive engagement programme to inform the development of the 2019/20 Quality and Safety Improvement strategy. The nine key priorities identified will continue in 2019/20.



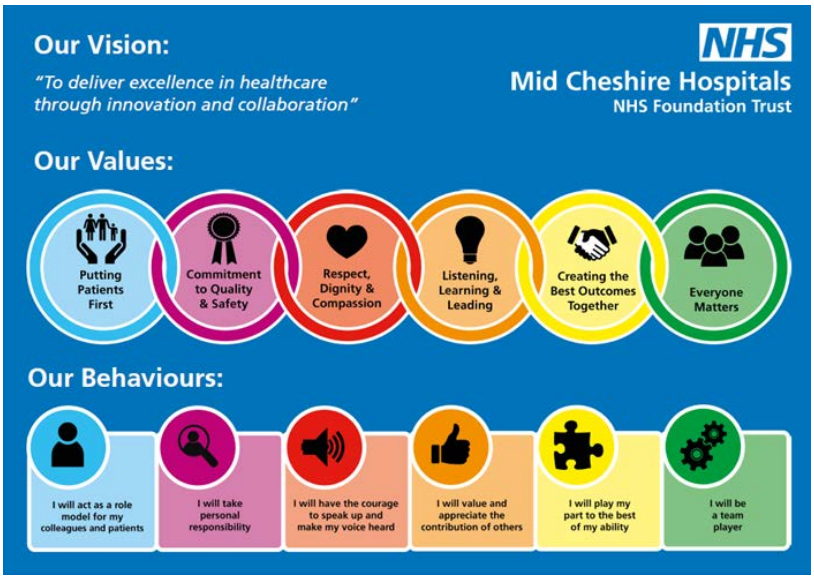
The overall purpose of the new strategy is to support the delivery of the organisation's vision and mission:

"***To deliver excellence in healthcare through innovations and collaboration"***

The Trust will be a provider that:

- Delivers Outstanding Clinical Quality, Safety & Experience
- Is A leading Partner in a Progressive Health Economy
- Strives for Outstanding Organisational Effectiveness
- Aspires to Excellence in Practice through our Workforce
- Creates a 21st Century Infrastructure for Transformative health and Social Care

The strategy links closely with other key strategies such as the Trust Strategy and Our Workforce Matters Strategy 2018-21; it is when these work hand in hand that collectively the Trust can deliver the vision and mission of the organisation.



The strategy is based on views from people from Vale Royal, South Cheshire and the surrounding areas who told the Trust what they wanted from their hospital. In addition, staff, governors and other stakeholders also contributed to the development of the strategy.

The values and behaviours developed with Trust staff underpin the delivery and success of the strategy. The Trust recruits, supports and develops its staff so that these values and behaviours are observed by all staff.

The Quality and Safety Improvement Strategy for 2018/19 includes the three key elements of quality; experience, effectiveness and safety however also has focus on the quality domains set by the Care Quality Commission (CQC);

Safe

Reducing Serious Harm – To reduce patient safety serious incidents by 10% in the acute Trust when compared to the previous financial year by the end of March 2019 and reduce patient safety serious incidents by 10% in CCICP when compared to the previous financial year by the end of March 2019.

Reducing Hospital Acquired Infections – Reduction in avoidable HCAI in line with National Objectives with specific focus on MRSA Blood Stream Infections, Avoidable Cases of CDI, E.Coli and MSSA

Pressure Ulcers – For both the acute Trust and CCICP the target is to reduce hospital acquired pressure ulcers by 20% when compared to the previous financial year by the end of March 2019.

Falls – The target is to reduce inpatient falls by 10% when compared to the previous financial year by the end of March 2019.

Responsive

Reducing Inpatient Moves – The number of ward moves is 2 or less for all patients. Data will be analysed for those patients moved more than twice. Moves beyond this will be analysed for clinical necessity for example a move to critical care would be excluded.

Effective

Deteriorating Patient - Mid Cheshire Hospitals NHS Foundation Trust will reduce adult avoidable patient harm (measured by reductions in cardiac arrests, severity of patient harm incidents and high risk admissions to critical care) by improving the recognition of the response to the acutely deteriorating patient by 50% by the end of March 2019.

Sepsis –Mid Cheshire Hospitals NHS Foundation Trust aims to screen 90% of patients for sepsis who have signs of infection in ED, admission areas and inpatient areas and we will deliver intravenous antibiotics to 90% of patients who develop high risk (red flag) sepsis signs in ED, admission areas and inpatient areas.

Mortality – Mid Cheshire Hospitals NHS Foundation Trust's Summary Hospital-Level Mortality Indicator (SHMI) is to be within the "as expected" bracket and the Hospital Standardised Mortality Ratio (HSMR) is to be within the "as expected" bracket

Caring

End of Life – Mid Cheshire Hospitals NHS Foundation Trust will ensure patients who are identified as dying in the hospital are cared for according to the 5 priorities for care of the dying person, with appropriate use of individualised care plans for end of life.

Well-Led

The Quality & Safety Improvement Strategy 2019-20 will be monitored through the Quality & Safety Improvement Strategy Steering group on a monthly basis. Progress will be escalated to the Executive Quality Governance Group (EQGG).

The Executive Quality Governance Group (EQGG) is responsible for providing information and assurance to the Board of Directors that the Trust is safely managing the quality of patient care, the effectiveness of quality interventions and patient safety.

The Executive Quality Governance Group (EQGG) will review the quality goals at its meetings to ensure progress is being made in relation to the key areas for improvement.

In addition, progress against the quality goals will also be reported in the annual Quality Account. This report will be made available to the public on the Trust's website, NHS choices and will also be included in the Trust's Annual Report

Priorities for improvement in 2018/19: Feedback from patients

Local patient surveys

Annual patient and public involvement programmes are compiled at divisional level and agreed at Trust level. These divisional programmes comprise of a list of patient and public involvement surveys, identified as key areas of interest.

In the financial year 2018/2019, 42 surveys were undertaken. These surveys were completed by patients in various settings including whilst they are receiving treatment on the wards, in outpatient clinics and in the community.

Additionally, 4 core surveys are collected each quarter in inpatient areas, and an open and honest monthly patient survey which is collected by face to face interviews with inpatients. These core surveys collect patient feedback on key focus areas including communication, privacy and dignity, infection control and nutrition and hydration.

Three of the local surveys that have taken place in 2018/2019 are detailed below:

Orthopaedic Patient Satisfaction Survey

The second round of this annual survey was conducted in July-September 2018.
Paper questionnaires were distributed to inpatients seen by the orthopaedic physio team. 100 questionnaires were available for distribution. 59 completed questionnaires were returned giving a response rate of 59%.

Responses were very positive including 100% of patients who answered were treated with kindness, compassion, dignity and respect, honesty and understanding and 98% of patients who answered said they felt the therapist listened to their views about their treatment. The results for this survey were fed back to staff at team meeting. A patient leaflet has been designed in conjunction with the patient experience team, which will explain the patient's right to a second opinion

Macmillan Patient Satisfaction Survey

The Macmillan team conducted a generic patient satisfaction survey enquiring about patient experiences of the care and treatment they received whilst attending the Macmillan Unit. In total 83 responses were received out of a possible 100 surveys that were distributed, giving a response rate of 83%. Reponses were overwhelmingly positive with 100% of patients rating the level of care they received from the staff in the unit as good / very good or excellent.

Antenatal Screening Survey

A survey was conducted to obtain feedback on women's experiences attending the antenatal clinic for ultrasound scans. 84 questionnaires were completed by women who attended the Antenatal Clinic.
Overall the responses received were positive including 99% of respondents indicated that they felt they had enough verbal and/or written information to help them decide whether or not to have a scan / screening test and 99% of respondents indicated that they felt they had enough time to ask questions.
Results of this survey were shared with all Obstetric Medical Staff and staff within the Antenatal Clinic.
A Maternity Voices Partnership has been set up to enable women to provide further feedback on their experiences of maternity care, including antenatal screening and to seek views on the improvements being considered.

National Surveys

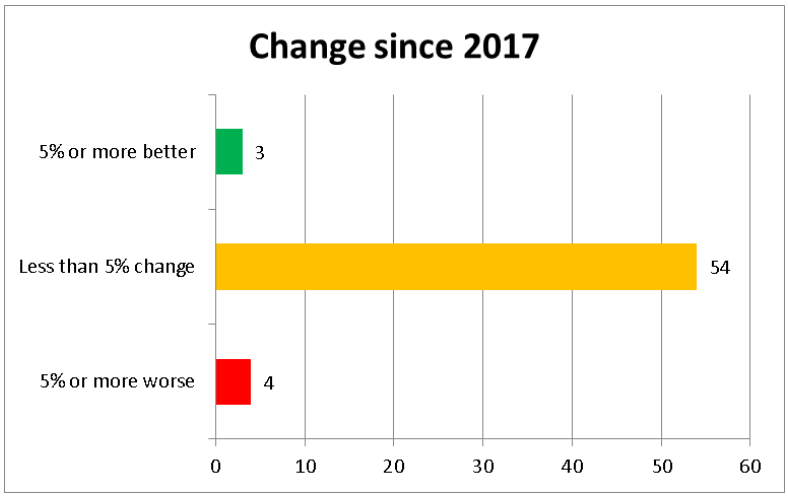
National Inpatient Survey

The survey was distributed to patients admitted in July 2018. With 691 surveys returned completed, the Trust had a response rate of 59% an increase of 6%.
The results include patients' perceptions of their hospital stay including:

- Admission to hospital,
- The quality of communications between medical professionals (doctors and nurses) and patients and care from non-clinical staff,
- Choice of food and rating and help provided, if needed, at meal times,
- Being involved in decisions about their care and treatment and
- Information provided.

The Trust scored an average score of 74.7% which is slightly higher than in 2017.
Compared with the 2017 survey, the Trust showed a 5% or greater improvement on 3 question scores and a 5% or greater reduction in score on 4 questions.

What has changed since the 2017 Inpatient Survey?



As part of this survey, a large amount of qualitative data is collected. Over 700 free text comments were analysed and themed. 61% of the comments received were positive

What has changed since the last inpatent survey?

The trust has significantly improved on the following questions :

- Staff helping patients to eat meals (12% improvement on 2017)
- Doctors: not talking in front of patients as if they weren't there; giving understandable answers to important questions

A workshop including all members of the multi disciplinary working group was established to review the outcome and to identify themes to develop an action plan to ensure continuous improvement. Results are shared widely across the organisation and at public meetings. A poster was distributed to wards and departments with examples of comments made by patients from the survey when asked what was particularly good about their care.

Based on the previous inpatient survey the Trust agreed to focus on the following areas:

Delays at Discharge and Medications Side effects

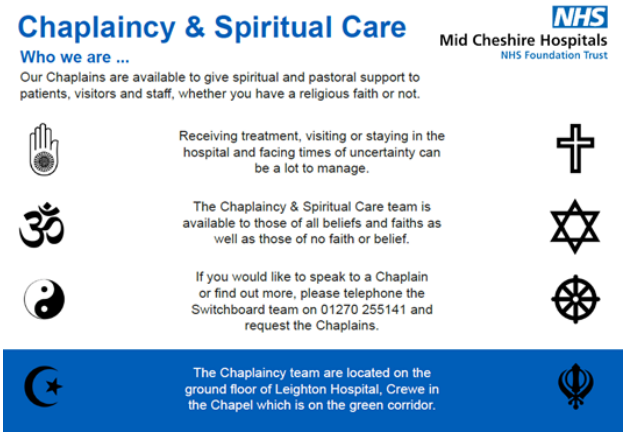
To Take Out (TTO) labelling machines are now in place on three wards to enable ward prescribing and reduce delays associated with waiting for take home medications. This is being rolled out to other wards. Early Discharge Facilitators have been appointed on core wards. A prescription tracker system is being introduced within the pharmacy department.

Emotional Support

The working group linked in with the chaplaincy team for assistance with emotional support for patients. There is a large team of chaplains both paid and volunteer chaplaincy visitors, who can provide emotional support to patients. A trust spiritual strategy was launched in October 2018 with two launch events at the crossroads talking to staff and patients. A poster has been developed to promote the chaplaincy team.

Support at meal times

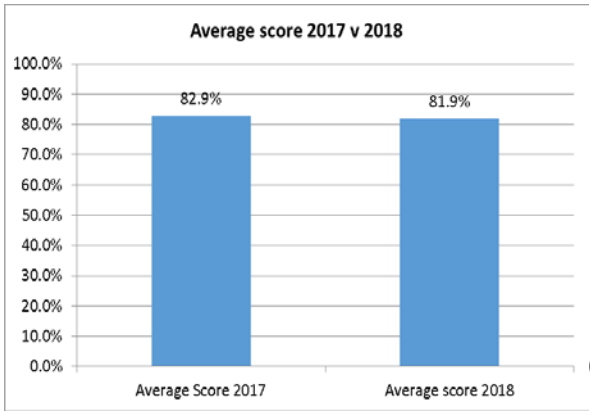
Volunteers were appointed and trained in 2018 to assist with helping patients to eat meals. Currently we have 20 trained volunteers to liaise with the dieticians to ensure they are reaching the wards and areas where the demand for assistance at mealtimes is at its highest. A dining companion role has been compiled and is now advertised on our Trust internet volunteer page.

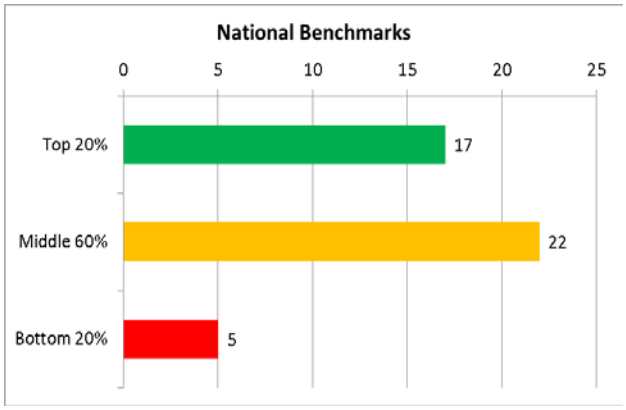


National Maternity Survey

The 2018 national survey looks at women's experiences of maternity care. It asked women about their experiences during labour and birth and the quality of antenatal and postnatal support. The survey for Mid Cheshire includes responses from 112 women who gave birth in February 2018.

300 surveys were posted and there was a 37% response rate. The average Mean Rating Score, across all questions, was 81.9% which is slightly lower than in 2017.





Patient satisfaction scores from women included:

- 97% reported that they had skin to skin contact with their baby shortly after birth
- 100% reported that a midwife or health visitor ask them how they were feeling emotionally
- 90% reported that in the six weeks after birth that they received help and advice from health professionals about their baby's health and progress

Areas showing at least a 5% improvement from 2017:

- Were you offered a choice of hospital
- Were you offered a choice of giving birth in a midwife led unit or birth centre?
- Were you offered a choice of giving birth in a consultant led unit?
- If you raised a concern during labour and birth, did you feel that it was taken seriously?

Areas where we have performed better than other trusts:

The survey looked at how the Trust performed against the national average for each question and across eight different areas. The trust performed better than the national average for two sections 'Feeding' and 'Care after Birth' and individual questions the Trust performed better than the national average for:

- Skin to skin contact with baby shortly after birth
- Midwives and other health professionals gave you consistent advice about feeding you baby
- Midwives that saw you appear to be aware of the medical history of you and your baby
- Midwives take your personal circumstances into account when giving you advice
- In the first 6 weeks after birth did you receive help and advice from a midwife or a health visitor about feeding your baby
- In the 6 weeks after birth did you receive help and advice from health professionals about your baby's health and progress

There were six questions which scored up to 5% lower than results from 2017 and the issues are included in an action plan.

Action Plan

A working group is progressing actions on the following themes:

- Discharge Delays – the work that was done last year will not have been captured in the results of this survey so we are anticipating an improvement in next year's survey results.

- Homebirth – promoting home birth choice. An audit will also be undertaken to ensure homebirth option is offered to women
- Post-natal care and information which will include a review of current information with women to identify any areas for improvement
- Explore choice and venues for women to access post-natal care.
- Identify what type of information women need about their own physical recovery after giving birth.

National Cancer Survey

The survey is designed to monitor national progress on cancer care and provides information to drive local quality improvements. This was the 7th year and 49 of the 50 questions relating directly to patient experience have been summarised as a percentage score for the patients who reported a positive experience only.

http://www.ncpes.co.uk/reports/2017-reports/national-reports-2/3579-cpes-2017-national-report/file

Patients were sent the postal questionnaire (with 2 reminders) and had the option to complete the survey online. The sample included all adult (aged 16 and over) NHS patients with a confirmed primary diagnosis of cancer (ICD10 codes). The sample included patients discharged from an NHS Trust after an inpatient episode or day case attendance for cancer related treatment between April and June 2018. A Freephone helpline was available for respondents to ask questions, receive support and for translation / interpreting facility where first language was not English.

Patients affected or distressed by the survey were given a Freephone number to the Trust Survey Contractor, who contacted the Trust Survey Lead (Cancer Services Manager) with queries / concerns.

The Trust had a 63% response rate (England national average 63%).

What has changed since the last inpatient survey?

- Respondents gave an average rating of **8.9** for the Trust where the scale was zero (very poor) to 10 (very good). The national average was **8.8**
- Patient experience at the Trust was better than national average in 39 questions including the overall rating (26 in 2016)
- The same for 4 questions (7 in 2016)
- Patient experience at the Trust scored lower than the national average in 9 questions (19 in 2016)
- **95%** Received all the information needed about the test
- **91%** Hospital staff gave information about support groups (83% in 2016)
- **77%** Possible side effects explained in an understandable way (73% in 2016)
- **64%** Hospital staff gave information on getting financial help (54% in 2016)
- **88%** Patient had confidence and trust in all doctors treating them (81% in 2016)

- **79%** Hospital staff definitely did everything to help control pain (85% in 2016)
- **86%** Beforehand patient had all information needed about chemotherapy treatment though **only 68%** given information about whether chemotherapy was working (76% in 2016)
- Only **40%** Colorectal patient felt always / nearly always enough nurses on duty
- **65%** Always / nearly always enough nurses on duty (60% in 2016).

Six questions from Phase 1 of the Cancer Dashboard developed by Public Health England and NHS England

National Cancer Dashboard	MCHFT Score 2016	National Average Score 2016	MCHFT Score 2017	National Average Score 2017
Patient definitely involved in decisions about care and treatment	83%	78%	↓81%	79%
Patient given the name of the CNS who would support them through their treatment	93%	90%	↔93%	91%
Patient found it easy to contact their CNS	88%	86%	↓87%	86%
Always treated with respect and dignity by hospital staff	87%	88%	↑92%	89%
Staff told patient who to contact if worried post discharge	97%	94%	↓96%	94%
Practice staff definitely did everything they could to support patient	70%	62%	↓69%	60%

Actions Taken

- Analyse the tumour specific differences
- Interpret narrative feedback comments when published
- Develop action plan in collaboration with respective Divisions
- Monitor progress through Cancer Governance Group.

PEN Awards

The Trust had three applications shortlisted for the national Patient Experience

The Virtual Fracture Clinic application led by consultant orthopaedic surgeon Mr Nicholas Boyce-Cam, was shortlisted under the 'Innovative Use of Technology/social digital media' Category. This entry documented how this new system was introduced to streamline the process for fracture clinic patients and avoid unnecessary hospital attendances.

CCICP were shortlisted for their application from the advanced community matrons, documenting how they have transformed services to better meet the challenges and needs of the population they serve.

The Surgical Ambulatory Unit were shortlisted under two categories – strengthening the foundation and integration and continuity of care. This application was led by Matron Helen Williamson and focussed around the teams launch and delivery of this new service which has been successful in reducing unnecessary hospital admissions and has consistently received positive patient feedback.

The Trust is pleased to announce that the Surgical Ambulatory Care Unit and the Virtual Fracture Clinic both successfully won the awards in their category for the Patient Experience Network Awards (PENNA) 2018.

NHS Choices

The NHS choices website provides an opportunity for patients to provide comments about their recent experience in hospital.

There were a total of 87 new postings on the NHS choices website in 2018/2019.
There have been 66 positive postings and 21 negative.

Leighton Hospital is currently achieving a star rating of 4.5 stars out of a maximum of 5 stars and the Victoria infirmary, Northwich is achieving 5 stars out of 5.

The Trust, wherever possible, can respond to the posting thanking patients for feedback and providing information on how their comments can be shared with teams or acted on to improve services.

Examples of comments posted on NHS choices include:

Specialty	Patient Posting	Trust Response from department lead.
Women's & Children Maternity – Early Pregnancy Assessment	**EPAU review - dignity respect and outstanding care.** My partner and I were seen several times at EPAU for early pregnancy scans and then management of our miscarriage. We must say the care, dignity and respect we were shown was truly first rate and made all the difference. Everything was explained to us very clearly,	In response to the posting via NHS choices, Firstly I would like to thank you for taking the time to make this post. It's so nice

Unit (EPAU)	prompt actions were taken and the team did everything they could to be extremely thorough and careful with such a delicate situation. We were mainly treated by one particular member of staff and she was so caring and great at her job. She made us feel very involved, well cared for and in very safe experienced hands. We can't thank this member of staff and the EPAU team enough for the difference this made to our experience.	to hear the kind words you have for the staff working in the Early Pregnancy Assessment Unit (EPAU) and that your care and treatment at this sensitive time was dealt with respect and dignity. I will ensure the team are aware of your positive experience and the great work they are doing. Many thanks.
Diagnostics and Clinical Services – Medical Imaging	I had an MRI scan for a knee injury. My appointment was at 5:45 on a Wednesday and having been to Leighton before, I was anxious about finding a parking space. It was very easy at that time of day. The nurse/ admin person in the department read out various questions relating to my health for me to answer. As I was a nervous patient I asked the person to slow down as they rattled through the questions too fast! The person operating the scanner was very reassuring, gave me a buzzer in case of problems and played "you tube" music for me, at my request. However the scanner was so noisy I couldn't really hear the music through the headphones, but it was a nice touch. During the scan, the person checked that I was okay.	Thanks you for leaving your feedback on NHS Choices .I will feedback your comments to the Medical Imaging staff.
Surgery and Cancer - Gynaecology	I visited the Treatment Centre yesterday 23/11/18 for a Hysteroscopy, polypectomy and to have some biopsies taken. I was extremely anxious after a worrying few weeks leading up to this. I would like to thank the amazing team on duty yesterday for making me feel at ease from start to finish. From arrival to going home, I was treated with care, compassion, respect and dignity and I felt extremely looked after, even though it was clear, whilst I was in the recovery department, that they were short staffed and under pressure. Please can you pass on my heartfelt thanks to the amazing team who looked after me so well. We are so lucky to have access to such amazing healthcare on our doorstep.	Thank you very much for taking the time to positively comment on the care and treatment you recently received whilst attending the Treatment Centre. I will pass on your comments to the staff involved. Thank you again.
Medicine and Emergency Care	I attended the Out of Hours Unit which referred me to A&E on the evening of 11 August. The GP in the Out of Hours Unit gave me a very thorough examination before referring me to A&E after asking that I be seen by a Doctor from the Orthopaedics Department. I was seen by a Doctor and a Registrar from Orthopaedics who again gave me a very thorough looking over and were very reassuring in that I thought I had had a DVT when I had not. All concerned explained fully what they were doing and the conclusions they reached. I could not have asked for better treatment.	Thank you so much for your kind comments regarding your recent visit to the GP Out of Hours Service. I will ensure your comments are shared with my team and the orthopaedic team and we hope you have made a full recovery
CCICP	I attended the Out of Hours Unit which referred me to A&E on the evening of 11 August. The GP in the Out of Hours Unit gave me a very thorough examination before referring me to A&E after asking that I be seen by a	Thank you so much for your kind comments regarding your recent visit to the GP Out of

	Doctor from the Orthopaedics Department. I was seen by a Doctor and a Registrar from Orthopaedics who again gave me a very thorough looking over and were very reassuring in that I thought I had had a DVT when I had not. All concerned explained fully what they were doing and the conclusions they reached. I could not have asked for better treatment.	Hours Service. I will ensure your comments are shared with my team and the orthopaedic team and we hope you have made a full recovery

Friends and Family Test

The NHS Friends and Family Test (FFT) helps the Trust understand whether patients are happy with the service provided, or where improvements are needed. It is a quick and anonymous way to give patient views after receiving care or treatment. This simple survey is run in areas across the Trust ensuring patients have an opportunity to provide feedback on the care received. Responses are mainly collected through text messaging or automated voice messages and postcards.

Trust results

Over 48,000 patients have responded to the Friends and Family Test, which is 10,000 patients more than last year with 91% of patients indicating that they are likely to recommend services or treatment to their friends or family.

One of the key benefits of the Friends and Family Test is that results are quickly available to staff, enabling them to take swift action where poor experiences have been identified.

Areas/wards are being encouraged to display up to date FFT information and patient feedback on their quality and safety boards.

Examples of actions taken as a result of feedback from the Friends and Family Test include:

- ❖ Provision of juice and biscuits in the Children's Outpatient department and toys are constantly checked and renewed
- ❖ Improved monitoring of hand sanitizers to ensure they are full and in working order in outpatients
- ❖ Fault highlighted with baby changing area in the emergency department and promptly actioned
- ❖ Letters for patients attending the Treatment Centre have been reviewed in response to feedback

Maternity Facebook comments

The Maternity Facebook page aids in promoting Leighton Hospital Maternity Services and making information accessible via social media. The number of followers of the Facebook page has risen to 3694 followers.

The Facebook page raises the profile of the services offered and provides current evidence based information to women and their families. Recent posts by the Maternity Unit include

- Promoting parent education sessions which include topics of labour and birth, infant feeding, safe sleeping, early days with a newborn and a great chance to meet other parents.
- Pregnancy Advice - Making sure your body is ready for pregnancy is vitally important for the long term health of you and your baby. Take this quick quiz to see if you are 'pregnancy ready'. https://www.tommys.org/planning-for-pregnancy-tool
- Friends of Freya - Staff on our Neonatal Unit Leighton Hospital Ward 22 Neonatal Unit were extremely grateful for the donation of filled wash bags from Friends of Freya. This will make the stay for parents who are not prepared for their baby being admitted to the unit a little easier.

The page is also used to post messages of thanks from mothers. Feedback has shown that mothers find the page an easy way of thanking staff during this busy time in their life. All staff mentioned are then put forward for Maternity Employee of the Month and a winner is chosen at random and receive a certificate for their portfolio. All messages are also forwarded to the staff members for them to keep.

Some examples of the messages left are below:

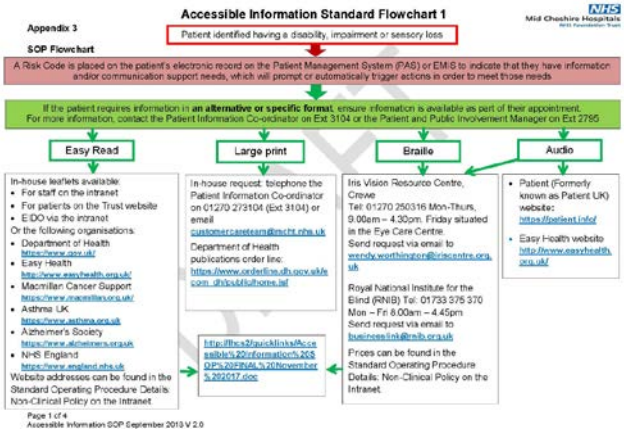
- ❖ Just a quick message to say thank you to the lovely Alana who delivered our third baby at Leighton. Our Armistice baby was delivered a few minutes past 11am on the 11th November. Alana was everything a midwife should be and the care we received from her and all the members of the Maternity team was exceptional. Thank you again, Sarah & Steve Porter xx.
- ❖ I just want to say a big thank you to Heather who delivered my baby. My husband and I only arrived at the hospital at 3.10am, and my daughter (Rosie) decided she didn't want to hang about, and was delivered in the triage room! A little bit of a shock being quicker than we expected, but thank you for bringing her into the world safe and well. She's now just over one and is running around everywhere, full of life. Thank you again! X

Other patient and public involvement programme activities

Patient Information Group

The group meets on a monthly basis with a membership of 11 including two patient representatives and a multi-disciplinary group of staff. In 2018/19, the group reviewed 26 leaflets reviewed, including Personal Wheelchair Budgets; know your numbers, Vague Symptoms

A flow chart has been developed to support the work being undertaken to meet the Accessible Information Standard. This aims to ensure staff are proactive in the approach to meeting the information needs of patients and are supported in being able to provide alternative types of information.



Readers Panel

The Trust continues to have an active reader's panel with 78 members to review patient information on a monthly basis. The aim of the Readers' Panel is to ensure:

- Patients and the public provide a user perspective in relation to the content and production of patient literature by being involved in the development of the written information
- Patient information is accessible to patients, their carers' and visitors
- The language used in leaflets is user-friendly, simple and easy to understand
- There is a consistent approach to patient information across the Trust ensuring a high standard of production

Leaflets reviewed by the Patient Information Group included: Personal Wheelchair budgets, Musculoskeletal Single Point of Access Service and general patient advice leaflets on self-help including tennis elbow and carpal tunnel.

Leaflets produced in other formats:

The Trust has a number of initiatives in place to ensure it meets the standard for Accessible Information. The aim of the accessible information standard is to make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need.

The Trust has produced guidance to assist staff to identify and record information and communication needs for patient's service users, carers and parents, where those needs relate to a disability, impairment or sensory loss.

Staff follow a booking in procedure which asks patients if they have any disabilities or communication methods other than normal practice e.g. Braille, signing for hard of hearing, interpreters due to language barrier.

Information produced this year includes large print maps, a stroke leaflet and patient leaflets for condition and specific treatments.

Easy Read

Information produced in an easy read format includes a review of the leaflet for patients attending the Minors Unit in the Emergency Department which is aimed at making the visit less stressful for the patient.

You will then have to book in at the reception desk.

The person on the front desk will ask your name, address and what is wrong with you.

Patient Register Group

The register group met twice in 2018 at local venues in the community. The meetings were attended by governors, volunteers, patient representatives and with an open invitation to members of the public. The group aims to provide information about new developments in the Trust and also an opportunity to seek patient and public views.

Topics covered have included an overview of the new Virtual Fracture Clinic system, presented by Mr Nic Boyce-Cam, Consultant Orthopaedic Surgeon, and the Surgical Transformation Project, documenting the launch of the Surgical Ambulatory Care Unit and the benefits this has brought to patients. The physiotherapy team manager Michelle Kaey also came to talk to the group about the trust wide led work around EndPJparalysis, a simple concept that encourages patient to get up, dressed and moving while in hospital, which can prevent the complications of being immobile, including chest infections, muscle degeneration, clotting; as well as shifting patient's perceptions 'I'm sick' to 'I'm getting better'

Voluntary Services

Annual Volunteers' Celebration Evening

The Nightingale Choir

A major highlight during National Volunteers' week (first week of June) is our Annual Volunteers' Celebration Evening. Held again this year at Nantwich Football club, the evening was very well attended, with volunteers representing all areas of the Trust and covering a multitude of volunteer roles. The evening is a chance for the Trust to thank our family of volunteers who make such a valuable contribution to the hospital. It also gives volunteers a chance to meet one another, perhaps catching up with old friends, or making new. The musical entertainment on the night was provided by the Nightingale choir. The Volunteers' evening is an ideal opportunity to congratulate and present long service awards, to those reaching particularly momentous anniversaries. The awards were presented by Trust Chairman, Dennis Dunn MBE and Chief Executive Tracy Bullock. This year we proudly recognised 12 volunteers reaching milestone anniversaries, between 10 and 46 years.

Partnership Working - Hospital Garden Space

There has once again seen a great deal of activity in the hospital gardens. The official opening of the beautiful Urology Outpatient garden was held. This event was a fitting celebration after all the dedication, hard work and fundraising efforts. There has been a programme of ongoing maintenance throughout the year here and across other garden areas around the hospital, including the Therapy Garden and Ward 1 courtyard. Such projects continue to be coordinated by Trust volunteers and supported by volunteers from Barclays Bank (Gadbrook Park). Barclays Bank have adopted the Urology garden and will therefore continue to maintain this for us. Discussions have begun already regarding 2019/20 garden projects with Barclays Bank, who have confirmed the excellent news that they will double their involvement, allocating two department teams of volunteers to the hospital.

The MacMillan garden has continued to be maintained by volunteers from Bentleys. Their group of volunteers now called 'Give back gardeners', support the local community and have confirmed their commitment to the MacMillan unit for the year ahead.

Neo Natal Unit - Peer Support volunteers

The first three volunteers were recruited this year into the new role of Volunteer Peer Supporters, for the Neonatal Unit. These volunteers have first-hand experience of having a premature baby cared for on the unit and felt they could provide support to other parents going through this difficult journey.

Dining Companions

This year Voluntary services in conjunction with the RVS, have promoted Patient Feeding training to volunteers. This has led to an increase in the number of volunteers that are trained and can now assist patients at meal times. This help is proven to make a significant difference to patients' wellbeing and recovery.

50 Years of Hospital Radio

Leighton Hospital Radio celebrated their 50th Anniversary on 14th November. The station, which is volunteer led, started life at Coppenhall Hospital in 1968. It later moved to the Memorial and Barony hospitals, before making Leighton hospital its base in 1987. The 50th birthday was marked

with a display in the Outpatients department, presenting photos and memorabilia from over the five decades, which Chairman Bob Squirrel and many of the radio volunteers helped to bring together. Chief Executive Tracy Bullock, presented the broadcasters with a certificate to commemorate half a century in broadcasting in South Cheshire and two special radio programmes presented by Stewart Green and Angela McCully-Jackson were also aired.

Chief Executive Tracy Bullock, celebrating 50 years with Hospital Radio volunteers, Stewart Green, Bob Squirrel (chair) and Anthea Taylor.

Christmas Community Activities

Bags of Joy – As in previous years, hundreds of Christmas 'Bags of Joy' were delivered to the hospital. These had been kindly made and donated by volunteers from Elim Church and contained such items as toiletries, chocolates and socks, along with a small message. They also donated many "mermaid blankets" to the Children's ward. The bags were added to the gifts already generously donated by staff and distributed by ward staff to patients over Christmas.

Carol singers – Volunteer Carol singers from the churches of Audlem Baptist, Wheelock Heath Baptist and St Andrews, Aston provided Christmas cheer to the wards in December, enjoyed by patients and staff. Many patients requested their favourite carols and joined in with the singing.

Pets As Therapy (PAT)

We are fortunate to now have regular visits from three PAT dogs, visiting a wide variety of wards, across the hospital. These visits allow patients the chance to chat with the volunteers and stroke the dogs. Staff enjoy the visits as much as the patients and it is wonderful to see how patients engage with our canine friends. One of our PAT dogs Brann, wearing his Christmas antlers with pride, visited the Children's ward over the festive season. This brought smiles to many faces.

Royal Voluntary Service (RVS) Befriending Service

The RVS Befriending service currently has 11 active volunteers based at Leighton hospital, with a further 9 in the recruitment process. The service spans the week and is currently across 5 wards (4, 6, 7, 10, and 19). Most recently they have introduced volunteers to the Clinical Decision Unit. The RVS support staff by engaging patients in activities including; reading, discussing news

headlines and completing puzzles. More recently some Volunteers have undertaken additional training to assist with supporting patients at meal times. They are also being trained to use a digital therapy system RITA for older patients with cognitive impairment, such as dementia.

Compliments / Complaints

Customer Care Team

The role of the Customer Care Team is to provide on-the-spot advice, information and support for patients and relatives if they wish to raise concerns. The team can also support patients when dealing with issues about NHS care and provide advice and information about local health services. The Customer Care Team aims to respond to patients concerns and issues in a timely and effective manner, irrespective of whether they have been raised as an informal concern or a formal complaint. The majority of concerns can usually be resolved swiftly by those staff who are caring for patients. However, sometimes patients or a family may want to talk to someone who is not involved in their care and the Customer Care Team are then able to help.

In January 2019 a new Customer Care Team office was opened in the main entrance to promote the support the Customer Care Team can offer and improve access for patients and their families if they need support.

The Customer Care Team also receives Ecards from relatives who chose to send messages in this way. This year, 10 Ecards were delivered to patients in the Trust between April 2018 and March 2019.

Compliments

4779 (figure to date) formal compliments were received by the Trust during 2018/19 which expressed thanks from patients and families about the care received. This is a significant increase compared with previous years. This increase is in part due to a change in the method of collating all thank you letters, emails and compliments inclusive of various social media.

All compliments are shared with the relevant teams who are identified.

	2015/16	2016/17	2017/18	2018/19
Number of compliments received	1727	1,872	1913	4779

Overview of compliments received by the Trust

Complaints

209 formal complaints were received by the Trust during 2018/2019 which is a 3% reduction compared to 2017/2018.

	2015/16	2016/17	2017/18	2018/19
Number of complaints received	264	283	215	209

Overview of complaints received by the Trust

Review of complaints

The Trust adheres to the Local Authority Social Services and National Health Service Complaints Regulations (England) 2009 and follows the Principles of Good Complaint Handling outlined by the Parliamentary and Health Service Ombudsman.

The Trust is committed to providing an accessible, fair and efficient service for patients and service users who wish to express their concerns or make a complaint with regard to the care, treatment or services provided by the Trust. The Trust promotes the Healthwatch advocacy service to anyone making a complaint to highlight the independent support available. The Trust also promotes the Healthwatch service by supporting the use of community Healthwatch stands within the Trust premises to encourage engagement with the public in regarding the support and advice the Heathwatch service provides.

The Trust recognises the importance of having a robust and flexible process for the management of complaints to ensure complainants receive a timely and person-centred response to the issues they have raised. In October 2018 key performance indicators for the management of complaints were agreed with all divisions within the Trust to ensure that concerns raised are responded to in a timely manner.

The complaints policy clarifies that the Chief Executive is the 'responsible person' with overall accountability for the complaints process. The Chief Executive ensures compliance with the regulations, that complaints are fully responded to and actions are implemented in the light of the outcome of the complaint review.

The complaints review group is chaired by the Patient Experience Manager and has a Governor and patient representative amongst its members. The panel reviews individual cases of closed complaints and follows best practice, as recommended by the Patient's Association, in monitoring progress against action plans and undertaking detailed reviews.

All complaint meetings are recorded and a copy of the CD is given to the complainant at the end of the meeting. The Trust is also able, with the consent of the complainant, to provide copies of the disc to external bodies such as the Coroner's Office and The Parliamentary Health Service Ombudsman to assist them in their information gathering.

The Customer Care Team continues to seek the views of their service users and send out surveys to complainants in order to gain feedback to support an improvement in the way that the service is delivered. However as the Trust has identified that current response rates to the survey are relatively low the Trust is completing a review of surveys used by other Trusts and in addition is reviewing the recommendations of the NHS England survey. It is planned to redesign and relaunch the survey offered to complainants in the 2018/2019.

Some of the key themes of complaints received in 2018/19 were in regards to nursing medication delays and concerns regarding nutrition, communication face to face with patients and relatives, medical adverse outcomes and medical diagnosis. Examples of these are summarised in the table below together with actions taken to address the concerns raised.

Themes	Actions Taken
Inpatient Wards: **Concerns were raised with regards to identifying patients who need support to maintain appropriate nutrition.**	The wards have implemented the new nutritional screening tool in October 2018 to support early recognition of patients who need support with maintaining good nutritional levels for recovery.
Trust Staff: **Concerns were raised with regard to the effectiveness of staff communication with patients and relatives**	A programme of communication workshops has been developed for all grades of staff which is now available bi-annually. Staff have been reminded of the importance of good communication with patients and their families and progress against this improvement is monitored by means of the divisional communication surveys and complaint analysis.
Trust medical and nursing staff: **Concerns were raised with regards to medical adverse outcomes and diagnosis problems.**	Action plans have been agreed divisionally to address issues raised by patients and families and the feedback received from the complaint investigations has been shared with relevant staff to ensure lessons were learnt from the incidents and actions were taken to improve care. The Deteriorating Patient Group has been developed to improve recognition of the deteriorating patient for all staff, which has implemented the National Earning Warning Score to improve care of the deteriorating patient in the clinical areas. .

Learning disability access

People admitted to hospital with a learning disability (LD) need to be supported, assessed and treated by competent and compassionate staff, who have had access to appropriate education and training.

Mid Cheshire Hospitals NHS Foundation Trust (MCHFT) works exceptionally hard to ensure the care we provide to people with a LD is of a high quality, enabling good clinical outcomes and an enhanced patient and carer experience.

People with a learning disability are more likely to develop physical and mental health problems compared with the general population. Learning disability statistics demonstrate that:

- People with a LD have an increased risk of early death compared to the general population
- People with a LD are less likely to receive regular health checks
- People with learning disabilities are 2.5 times more likely to have health problems than other people
- The prevalence of dementia is much higher amongst older adults with LD compared to the general population
- Prevalence rates for schizophrenia in people with LD are approximately 3 times greater than for the general population

(Mental Health Foundation, 2018)

To address these issues and support our patients who have learning disabilities, we have introduced a number of initiatives at MCHFT. These are:

- Every quarter we hold a LD Phlebotomy Clinic. The clinic is held out of hours to minimise distress for patient's and provide a calm and non-threatening environment. The clinic is always fully booked, with double appointments so we can take our time and not rush our patients. The cakes and chocolates afterwards always go down particularly well! The service was recently shortlisted for a Nursing Times Award

- We have a large library of easy read information for our LD patients and carers to access. Recent additions include updated versions of our Emergency Department information leaflet, both from a minor and majors perspective

- The Trust's Dignity Matron continues to visit LD patients in their own home to plan elective admissions to hospital. This enables reasonable adjustments to be made such as:

  - Carers accompanying patient's into the anaesthetic room and recovery area after surgery
  - Double appointments
  - Tours prior to admission
  - Completion of Hospital Passports
  - Easy read information
  - Make the most of our opportunities i.e. when a patient is having a general anaesthetic, try to incorporate all health checks such as blood tests, podiatry, flu jabs.
  - Home visit(s) to take blood, perform ultra sounds if patients are reluctant to come into hospital.

The Dignity Matron also visits patients who have been admitted to the hospital via the emergency department. The Matron acts as a liaison between patients, carers, staff and community teams and helps to facilitate best interest and pre-discharge meetings.

- Every week the Dignity Matron works alongside the Pre-Operative Assessment (POAC) Nurses, to provide a clinic specifically for patients who lack capacity to consent to procedures themselves. These clinics enable the consent process to be completed and reasonable adjustments to be highlighted at an early stage. Areas of concern can be discussed with patients and their carers, to alleviate worries and fears and improve the overall patient/carer experience

- The Trust holds a LD development group, which has representation from Trust and community services. The group shares patient feedback, local and national best practice and reviews LD deaths

- All deaths of patients with a learning disability are reviewed from a clinical perspective as well as a LD perspective. Lessons learnt are shared across Divisions and potentially into primary care; if there are issues for the wider learning disabled community

- Patient stories from an LD and carer perspective have been shared at a senior level including the Trust Executive Board and the Local Safeguarding Adults Board

- We have recently taken part in an NHSI Learning Disabilities Standards project. The aim of the project is to gather data in relation to LD patients, carers and the organisation itself, with a view to highlighting improvement opportunities.

Seven Day Hospital Services

The Trust's has continued its risk based approach to investment in the multi-disciplinary teams ready for 2019/20 to make progress towards complying with the four priority clinical standards with the seven-day services programme.

Significant work has taken place which includes a focus on the infrastructure, medical staffing, nursing and therapy support to deliver services across seven-days. With this aim, business cases in General Surgery and Urology have been presented to the Trust's Board of Directors in 2018/19 which contain investment proposals to help improve our services over the week and 'out of hours'. Further business cases are being developed to improve the level of services within Therapies and Acute Medicine.

In line with other Trusts, the consistent delivery of the 'First Consultant Review within 14 hours of an Emergency Admission' (Standard 2) remains a challenge, although there are plans in place, down to speciality level, as to how this could be achieved. The Trust will continue to develop networked arrangements with neighbouring Trusts to deliver Consultant-directed interventions, (e.g. interventional endoscopy, stroke thrombolysis) out of hours. The Trust achieves the seven-day services standards relating to 'access to diagnostic tests' (standard 5) and 'ongoing consultant-directed reviews'

Freedom to Speak Up

An outcome of the Freedom to Speak Up review, an independent review into creating an open and honest reporting culture in the NHS, led by Sir Robert Francis QC, was that NHS Trusts should appoint Freedom to Speak Up Guardians. The Guardian is someone whose role it is to act as an independent and impartial source of advice to staff, with access to anyone in the organisation, including the CEO, or if necessary outside the organisation, where concerns are identified which affect patient care. The Guardian ensures that the primary focus is on the safety issue; that the case is handled appropriately, investigated promptly and issues addressed; and that there are no repercussions for the person who raised it.

Speaking up should be something that everyone does and is encouraged to do. There is a shared belief across the Trust that raising concerns is a positive action and staff need to feel safe to raise concerns, confident that they will be listened to and the concerns raised will be acted upon. Mid Cheshire Hospitals NHS Trust is committed to supporting and encouraging all those who raise honestly held concerns about safety, with a focus on learning rather than blame.

The Director of Nursing and Quality is the Trust's Freedom to Speak Up Guardian and therefore is committed to providing confidential advice and support to staff in relation to concerns staff have about patient safety and/or the way their concern has been handled. Whilst the Guardian does not investigate the concerns raised, they help to facilitate the raising concerns process where needed, ensuring Trust policies are followed correctly.

The Trust have implemented a 'Raising Concerns' policy which has been adopted in line with recommendations of the review by Sir Robert Francis into whistleblowing in the NHS.

The Freedom to Speak Up Guardian regularly attends the National Guardian Freedom to Speak Up Conferences and update sessions which are an opportunity to share learning with peers from other organisations and to hear from the National Guardian's Office on best practice.

Additional ways staff can raise concerns

- Employee Support Advisers/Speak Up Champions – The Employee Support Advisors are trained staff volunteers who provide an opportunity for individuals to discuss any concerns in an informal forum and help to identify the range of options and support available. Quarterly information update sessions are held between the Guardian and the Employee Support Advisors and Champions to share knowledge and good practice

- Staff are able to leave a confidential message raising any concerns using the Staff Voicemail Service which is managed by the Human Resources Department

- A dedicated email address was set up in 2018 as another mechanism for staff to report any concerns

- A Freedom to Speak Up box has recently launched to provide staff with an additional way to raise concerns. The box was piloted during quarter three and quarter four at the Patient Safety Summit Meeting which is held fortnightly. Staff are able to anonymously submit concerns via the box which may affect patient safety. Any feedback on the issues raised is given at the following meeting. A review will be undertaken at the end of the financial year to assess the effectiveness and to explore whether the approach is to be rolled out across other areas

- Some concerns are raised locally and dealt with by local managers as part of their day-to-day work. These concerns would not be logged onto the whistleblowing log.

Staff are able to utilise any of these forums if they have concerns over quality of care, patient safety or bullying and harassment within the Trust.

Feedback is an important part of the process. Where concerns raised are not done so anonymously, face to face feedback is provided by an appropriate manager. Where concerns are raised anonymously, feedback on improvements or process changes, as a result of the concern raised, is communicated across the relevant division using a 'you said, we did' approach. The Trust are currently considering the promotion of positive outcome cases.

The Trust uses staff survey results to benchmark itself against peer organisations on indicators relevant to raising concerns. The Trust's overall staff engagement score was 7.2 out of 10 in 2018 compared to the national average of 7.0 as the national average for Acute and Community Trusts.

The Trust uses staff survey results as shown below to assess whether the arrangements in place for raising concerns are effective. The Trust score better than the national average when compared to other comparable trusts on the following key findings in the 2018 staff survey:

- My organisation treats staff who are involved in an error, near miss or incident fairly

- When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again

- We are given feedback about changes made in response to reported errors, near misses and incidents
- I would feel secure raising concerns about unsafe clinical practice
- I am confident that my organisation would address my concern
- My organisation acts on concerns raised by patients / service users.

Feedback from staff

The NHS staff survey is undertaken by all NHS Trusts on an annual basis and continues to be recognised as an important way of ensuring the views of staff working in the Trust inform local improvements and outcomes for both staff and patients. The results from all Trusts are made available and allow the Trust to be benchmarked. The survey is undertaken on behalf of the Trust by Quality Health (an independent contractor) using the nationally specified criteria.

The 2018 NHS Staff Survey saw changes introduced to the reporting of the results. In previous years trusts have been benchmarked against 32 Key Findings, however based on the outcome of a review by the National Staff Survey Co-ordination Centre these Key Findings have now been replaced by Ten Themes.

The following table provides an overview of the scores achieved by the Trust against the Ten Themes

Theme	2017 (Scores out of 10)	2018 (Scores out of 10)	Combined Acute and Community Trust Average	Trust Performance (when compared with all combined acute and community trusts in 2018)
Equality, Diversity and Inclusion	9.3	9.4	9.2	Above Average
Health and Wellbeing	6.4	6.1	5.9	Above Average
Immediate Managers	6.8	6.8	6.8	Average
Morale	No data	6.5	6.2	Best
Quality of Appraisals	5.3	5.6	5.4	Above Average
Quality of Care	7.7	7.6	7.4	Above Average
Safe Environment – Bullying and Harassment	8.2	8.3	8.1	Above Average
Safe Environment – Violence	9.4	9.6	9.5	Above Average
Safety Culture	6.9	6.9	6.7	Above Average
Staff Engagement	7.1	7.2	7.0	Above Average

* There is no comparative data prior to 2017 due to the significant organisational change that took place in 2016 with the inclusion of Central Cheshire Integrated Care Partnership (CCICP), which resulted in the organisation moving from an ‘Acute’ to a ‘Combined Acute and Community Trust’.

Staff Survey Data

Equality and Diversity	2017	2018	National 2018 average for combined acute and community Trusts	Best 2018 Score for combined acute and community Trusts
Q14 Percentage of staff believing the organisation provides equal opportunities for career progression and promotion *(% of staff electing 'Yes')*	92.3%	90.5%	85.5%	91.5%
Violence, harassment and bullying	**2017**	**2018**	**National 2018 average for combined acute and community Trusts**	**Best 2018 Score for combined acute and community Trusts**
Q13b. In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers? *(% of staff saying that they have experienced at least one incident)*	10.5%	9.3%	12.1%	8%
Q13c. In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from other colleagues? *(% of staff saying that they have experienced at least one incident)*	18.2%	16.1%	18.4%	14.4%

The Quality Account Reporting Arrangements require the Trust to report on the responses for the following questions for the Workforce Race Equality Standard:

- **The percentage of staff who report that they have experienced harassment, bullying or abuse from staff in the last 12 months.**

The scores for White and Black and Minority Ethnic (BME) staff as required for the Workforce Race Equality Standard are as follows:

Key Finding		2017	2018
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White	21.5%	20.2%
	Black and Minority Ethnic	32.3%	32.1%

The national Trust average in the reporting category in 2018 was 23.6% for white staff and 29.9% for BME staff which puts the Trust in a slightly better than average position for white staff, however the results are slightly worse than the national Trust average for BME staff.

- **The percentage of staff who believe the Trust provides equal opportunities for career progression or promotion**

90.5% of staff who completed the 2018 staff survey believe that the Trust provides equal opportunities for career progression and promotion. The national average for combined acute and community Trusts in 2018 was 85.5% with the best score being 91.5%.

The scores for White and BME staff as required for the Workforce Race Equality Standard can be found in the table below:

Key Finding		2017	2018
Percentage of staff believing the organisation provides equal opportunities for career progression and promotion	White	92.9%	91.2%
	Black and Minority Ethnic	84.2%	86.4%

The national Trust average in the reporting category in 2018 was 87.2% for white staff and for BME staff 74.2%, which puts the Trust in an above average position.

Action plans will be developed in 2019 to address any areas of concern highlighted in the staff survey.

Statements of assurance from the Board

Review of services

During 2018/19 the Trust provided and/or sub-contracted 40 relevant health services.

The Trust has reviewed all the data available to them on the quality of care in all of these relevant health services.

The income generated by the relevant health services reviewed in 2018/19 represents 100% of the total income generated from the provision of relevant health services by the Trust for 2018/19.

Participation in Clinical Audits and Research

Clinical audit evaluates the quality of care provided against evidence based standards and is a key component of clinical governance and quality improvement. Mid Cheshire Hospitals NHS Foundation Trust (MCHFT) produces an annual programme for clinical audit and quality improvement, incorporating national, regional and local projects, which is informed and monitored using priority levels.

National Clinical Audit

During 2018/19, 50 national clinical audits/other projects and 8 national confidential enquiries (Clinical Outcome Review Programmes) studies covered NHS services that MCHFT provides.

During that period, MCHFT participated in 96% of national clinical audits and 100% of national confidential enquiries (Clinical Outcome Review Programmes) of the national clinical audits and national confidential enquires (Clinical Outcome Review Programmes) which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Trust was eligible to participate in during 2018/19 are shown in the table below.

The national clinical audits and national confidential enquires that the Trust participated in during 2018/19 are shown in the table below.

The national clinical audits and national confidential enquires that the Trust participated in, and for which data collection was completed during 2018/19, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Clinical Audit Participation 2018/19

National Clinical Audit and Clinical Outcome Review Programme	Participation	Data submission
BAUS Urology Audits: Female stress urinary incontinence	Yes	27 cases*
BAUS Urology Audits: Percutaneous Nephrolithotomy	Yes	13 cases*
Case Mix Programme (CMP)	Yes	100%
Elective Surgery (National PROMs Programme)	Yes	See PROMs section of this report

Falls and Fragility Fractures Audit programme (FFFAP):		
National Inpatient Falls	Yes	NA
National Hip Fracture Database	Yes	100%*
Feverish Children (care in Emergency Departments)	Yes	100%
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit	Yes	43 cases*
Learning Disability Mortality Review Programme (LeDeR Programme)	Yes	100%
Major Trauma Audit	Yes	100%
Mandatory Surveillance of bloodstream infections and clostridium difficile infection	Yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme:		
Perinatal Mortality Surveillance	Yes	100%
Perinatal Morbidity and Mortality Confidential Enquiries	Yes	100%
Maternal Mortality Surveillance and Mortality Confidential Enquiries	Yes	100%
Maternal Morbidity Confidential Enquiries	Yes	100%
Medical & Surgical Clinical Outcome Review Programme:		
Pulmonary Embolism	Yes	100%
Acute Bowel Obstruction	Yes	100%
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP):		
Adult Asthma Secondary Care	Yes	NA
Chronic Obstructive Pulmonary Disease (COPD) Secondary Care	Yes	188 cases*
Pulmonary Rehabilitation - *Community*	Yes	NA
National Audit of Breast Cancer in Older Patients (NABCOP)	Yes	100%
National Audit of Cardiac Rehabilitation	Yes	Partial*
National Audit of Care at the End of Life (NACEL)	Yes	100%
National Audit of Dementia (care in general hospitals)	Yes	100%
National Audit of Intermediate Care (NAIC)	Yes	689 patients*
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	Yes	NA
National Cardiac Arrest Audit (NCAA)	Yes	100%
National Cardiac Audit Programme:		
Myocardial Ischaemia National Audit Project (MINAP)	Yes	100%
National Heart Failure Audit	Yes	75%*
National Comparative Audit of Blood Transfusion Programme:		
Use of Fresh Frozen Plasma and Cryoprecipitate in neonates and children	Yes	100%
Management of Massive Haemorrhage	Yes	100%
National Diabetes Audit – Adults:		
National Diabetes Foot Care Audit - *Community*	Yes	NA
National Diabetes Inpatient Audit (NaDIA)	Yes	100%
NaDIA Harms (reporting on diabetic harms)	Yes	100%
National Core Diabetes Audit	Yes	100%
National Diabetes in Pregnancy	Yes	100%
National Audit of Rheumatoid and Early Inflammatory	Yes	36 cases*

Arthritis		
National Emergency Laparotomy Audit (NELA)	Yes	100%
National Gastrointestinal Cancer Programme:		
Oesophago-gastric Cancer (NAOGC);	Yes	81-90%
National Bowel Cancer Audit (NBOCA)	Yes	100%
National Joint Registry (NJR)	Yes	100%
National Lung Cancer Audit (NLCA)	Yes	100%
National Maternity and Perinatal Audit	Yes	100%
National Mortality Case Record Review Programme	Yes	See Learning from Death section of this report
National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)	Yes	100%
National Ophthalmology Audit	Yes	99%*
National Paediatric Diabetes Audit (NPDA)	Yes	38 cases*
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis):		
Antibiotic Consumption	Yes	100%
Antibiotic Stewardship	Yes	30 cases per Quarter
Sentinel Stroke National Audit programme (SSNAP)	Yes	100%
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Yes	100%
Seven Day Hospital Services Self-Assessment Survey	Yes	100%
Surgical Site Infection Surveillance Service	Yes	100%
Vital Signs in Adults (care in Emergency Departments)	Yes	100%
VTE risk in lower limb immobilisation (care in Emergency Departments)	Yes	100%

* Based on most recent report or online data

NA Data submission in progress or due to commence

Non-Participation

National Clinical Audit and Clinical Outcome Review Programme	Reason for Non-Participation
National Adult Community Acquired Pneumonia (CAP) Audit	Lack of clinical resource
National Adult Non-Invasive Ventilation (NIV) Audit	Lack of clinical resource

The reports of 28 national clinical audits were reviewed by the provider in 2018/19 and the Trust intends to take the following actions to improve the quality of healthcare provided:

National Clinical Audit Participation 2018/19 – Actions

National Clinical Audit and Clinical Outcome Review Programme	Actions taken / to be taken
Case Mix Programme (CMP)	Quarterly reviews of all ICNARC/Critical Care activity at the multidisciplinary team meeting and all individual cases discussed with any issues being taken forward by the clinical lead as part of the governance strategy.
Elective Surgery (National PROMs Programme)	See Patient Reported Outcome Measures Scores section of this report.
Falls and Fragility Fractures Audit programme (FFFAP):	
National Hip Fracture Database	Trust results remain good and above national figures. Ongoing work is continuing around relevant assessments; therapy provision at weekends to support early mobilisation; nerve block training for advanced practitioners and anaesthetic supervision of trauma lists
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit	Review of report in progress
Major Trauma Audit	The trust compares favourably with Trauma Hospitals in the Network. Work is in progress around transfer of patients for CT Scan in a timely manner; administration of transexamic acid within 3 hours; and trauma calls for consultant review.
Maternal, Newborn and Infant Clinical Outcome Review Programme:	
Perinatal Mortality	Compliance for standardised review and accurate data was good. Further work is underway in regard to a focus on 'quality of cause of death coding'; post mortem counselling and information for parents and placental histology for stillbirths
Saving Lives, Improving Mothers Care	Trust Guidelines around Induction of Labour, Obstetric Haemorrhage and Management of Venous Thromboembolism (VTE) in pregnancy have been updated to accommodate recommendations and an audit of VTE risk score is planned
Topical Study: Perinatal Mortality Surveillance Enquiry - Term, Singleton, Intrapartum Stillbirth and Intrapartum Related Neonatal Death	On review, the Trust was compliant with all recommendations, except documentation of discussion and the agreed management plan for labour and birth following previous caesarean section. A Vaginal Birth after Caesarean Section (VBAC) clinic is being set up with relevant guidance and pro-forma.
Medical & Surgical Clinical Outcome Review Programme:	

Acute Heart Failure	Existing pathway of care is being developed further to incorporate location, 24 hour review, initial investigations and bloods, access to echocardiograms and immediate treatments. All Heart Failure nurses are being trained as specialists in palliative care as part of the multidisciplinary team. A checklist is being developed to support escalation decision making with patients.
Cancer in Children, Teens and Young Adults	Review of report in progress
Perioperative Diabetes	Review of report in progress
National Audit of Breast Cancer in Older Patients (NABCOP)	Trust results are in line with national results. A crib sheet with performance score has been developed for clinics and the multidisciplinary team. The system for getting her2 results back for the multidisciplinary team has been improved and the cancer services department aim to get data for staging for all cancers.
National Audit of Cardiac Rehabilitation	Review of report in progress
National Audit of Care at the End of Life (NACEL)	Review of report in progress
National Audit of Dementia (care in general hospitals)	Issues with inconsistency of reported data were highlighted on review, thus no further action was taken with this report.
National Audit of Intermediate Care (NAIC) - *Community*	Intermediate Care Teams / Point of Care Hubs (PoCH) have been implemented and work is commencing around integration of health and social care teams to facilitate early discharge and prevention of unavoidable hospital admission.
National Cardiac Arrest Audit (NCAA)	Rate of cardiac arrest is lower than national figures and data submission remains good. A review of resuscitation stopped due to 'futility' in regard to pre-arrest factors relating to DNACPR is underway
National Cardiac Audit Programme:	
Myocardial Ischaemia National Audit Project (MINAP)	Work is ongoing to support direct admission to Cardiology or Coronary Care unit; checklist of medications depending on eligibility and pre-discharge angiography at partnership site.
National Heart Failure Audit	Work is underway to revise the acute heart failure pathway including location of care on a specialist unit; arrangements for heart failure review within 24 hours; initial investigations required to diagnose acute heart failure, including a standard protocol for the use of BNP/NT pro BNP and Echocardiography and immediate treatments
National Diabetes Audit – Adults:	
National Audit of Inpatient Diabetes (NADIA)	A diabetic alert system has been established along with an electronic system for identification of hypo/hyperglycaemia. Weekly multidisciplinary foot clinic implemented using a network diabetic foot pathway and twice weekly 'hot foot' clinic for direct access to medical/vascular care.
National Emergency Laparotomy Audit (NELA)	A pathway been developed for ortho-geriatrician support of elderly laparotomy patients, with review of patients as required. Review of surgical admission pro forma to collect pre and post-op p-possum (mortality risk).
National Gastrointestinal Cancer Programme:	
Oesophago-gastric Cancer (NAOGC);	Review of report in progress
National Bowel Cancer Audit (NBOCA)	Review of report in progress
National Joint Registry (NJR)	A review of revision of primary knee replacements

	was undertaken by the clinical lead and all planned cases for revision are now discussed at local multidisciplinary team prior to surgery. The Trust is involved in QIST, a national project aiming on optimising patients prior to surgery by identifying and treating anaemia.
National Maternity and Perinatal Audit	Infant feeding policy and skin to skin contact compliance through audit already achieved. Electronic maternity system, maternity dashboard, midwifery led unit guidelines, fit for birth programme and information on healthy eating in pregnancy all in place and business as usual in the Trust.
National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)	Patient information around pre-term labour a pro-forma for counselling pre-term parents introduced as part of the preterm pathway. Multidisciplinary developed care bundle in place for admission of pre-term babies. Work is in progress to work with local parent representatives to improve the attendance of parents on ward rounds and parental involvement in decision making.
National Ophthalmology Audit	Trust results favourable against national standards. Work is ongoing to improve mechanisms for obtaining post-operative refractions and to assess the use of post-operative Bromfenac to reduce complications.
Seven Day Hospital Services Self-Assessment Survey	See Seven Day Hospital Services section of this report.

Local Clinical Audits

The reports of 71 local clinical audits were reviewed by the provider in 2018/19 and the Trust intends to take/has taken the following actions to improve the quality of healthcare provided in the sample of projects below:

Local Clinical Audit	Actions Taken / To Be Taken
Monitoring of Vital Signs for Patients who are Acutely Unwell or at Risk of Clinical Deterioration	This audit was performed to highlight any issues in regards to accuracy of the use of our current track and trigger system. It was designed to highlight compliance with EWS documentation and the correct score being documented as this result will affect the appropriate clinical escalation. Our findings were the accuracy of EWS was poor due to the compliance of fluid balance monitoring where only 88% of patients had an accurate recording of their EWS. A comparison was done between EWS and NEWS2, this highlighted NEWS2 would have detected more patients to escalate early by its sensitivity, hence detecting acutely unwell patients early. NEWS2 was launched in the Trust in November 2018 and a further audit will be undertaken to assess accuracy in recording of the parameters.
An Audit to Assess the Implementation and Perceived Benefit of Group Therapy Sessions on Ward 6 (Stroke Rehab) to Establish a Local Standard	This audit was undertaken to review the pilot implementation of Group Therapy Sessions for stroke patients. Out of 17 possible groups, 15 sessions were actually held equating to 750 extra minutes of treatment and 60 extra treatments, 57 of which were in addition to patient individual sessions. All sessions ran for 45 minutes or longer therefore adhering to national guidelines. 12 of the sessions focused on upper limb exercises, 3 focused on bed exercises and all sessions included gait re-education and transfers (bed to chair, chair to chair). Following these results groups will be run 5 times a week, with assigned staff to ensure responsibility and consistency. Sessions will be pre-planned at set times daily and become ward routine with regular training sessions and assistant support for staff.
Compliance with NICE Guidance in the	The audit was carried out to assess compliance with NICE Guidance, for which compliance was 100% around patient assessment and stepped care plan,

Diagnosis and Management of Atopic Eczema in the Under 12's	assessment and documentation of severity and timely and appropriate referral. Areas for requiring improvement included provision of evidence based information, measurement of disease impact on Quality of Life / psychological impact, prescription of emollients. Standardised evidence based educational material/ supporting information has been developed as part of an atopic eczema pack, shared with paediatrics and will be given to all patients on all sites and the Dermatology internet site will be updated accordingly. Work on prescription of sufficient emollient, improved identification/ assessment of infection and standardising assessment processes to routinely capture all recommended criteria is currently in progress.
Audit of Nasal Trauma Referrals to ENT Emergency Clinics in MCHT	This audit highlighted a delay in seeing patients in clinic from trauma and issues with referral letters at clinic appointments. As a result of this the process for the administration team and medical staff to book and see patients is within 10 days of trauma and medical staff review all referrals and specify a timeframe for review based on the trauma date.
Management of Vaginal Birth after Caesarean	This audit was commenced to assess the management of Vaginal Birth After Caesarean (VBAC) using the existing Trust management pro-forma. Poor documentation highlighted a potential issue with discussion around risks and benefits and plan for labour. A midwife led VBAC clinic has now been set up and guidelines for management of women having VBAC in the latent phase of labour or with pre-labour spontaneous rupture of membranes has been developed. The VBAC management pro-forma has also been updated.

Participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by the Trust in between 01/04/18 and 28/02/2019 that were recruited during the period to participate in research approved by a research ethics committee was 611

Commissioning for Quality and Innovation (CQUIN)

The CQUIN framework was introduced in April 2009 as a national framework for locally agreed quality improvement schemes. These schemes require the development of clear plans and goals through agreement between providers and commissioners.

A proportion of the Trust's income in 2018/19 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2018/19 and for the following 12 month period are available electronically at:

http://www.mcht.nhs.uk/information-for-patients/why-choose-us/quality/

The overall financial value of CQUIN schemes is currently 2.5% of the provider's contract value.

The financial value of the 2018/19 CQUIN scheme for the acute Trust was £4,254,800. The total amount the Trust received in payment for the CQUIN scheme was £3,637,480

The financial value of the 2017/18 CQUIN scheme for the Trust was £4,274,560

The financial value of the 2018/19 CQUIN scheme for CCICP was £718,540. The total amount the Trust received in payment for the CQUIN scheme was £718,540

For 2018/19 there are **seven** National goals of which **four** apply to MCHFT, **two** apply to CCICP and **one** apply to both.

Public Health England has agreed **two** goals which relate to the breast and bowel screening programmes.

The North of England Specialised Commissioners has negotiated **two** goals in relation to chemotherapy banding and medicines optimisation.

Key CQUIN results for 2018/19:

Achieved 

Partially Achieved 

Partially

Not achieved 

Goal	Goal Name	Financial Value of the goal (£)	Status
Goal 1: PART A	Improvement of health and wellbeing of NHS staff	£137,574	 **Partially**
PART B	Healthy food for NHS staff, visitors and patients	£137,574	
Part C	Improving the uptake of flu vaccinations for front line staff within Providers	MCHFT £137,574 CCICP £137,180	
Goal 2: PART A	Timely identification of sepsis in emergency departments and acute inpatient settings	£103,181	 **Partially**
PART B	Timely treatment for sepsis in emergency departments and acute inpatient settings	£103,181	 **Partially**
PART C	Antibiotic review	£103,181	 **Partially**
PART D	Reduction in antibiotic consumption per 1,000 admissions	£103,181	
Goal 4:	Improving services for people with mental health needs who present to A&E.	£412,723	 **Partially**
Goal 6:	Offering advice and Guidance (A&G)	£412,723	
Goal 9:			
PART A	Tobacco screening	£20,636	 **Partially**
PART B	Tobacco brief advice	£82,545	 **Partially**
PART C	Tobacco referral and medication offer	£103,181	 **Partially**
PART D	Alcohol screening	£103,181	

PART E	Alcohol brief advice or referral	£103,181	✗
Goal 10:	Improving the assessment of wounds **Community Only**	£137,180	✓
Goal 11:	Personalised Care and Support Planning **Community Only**	£137,180	✓
Public Health England			
	Breast Screening Programme Clerical Staff Development (Health Promotion role)	£14,969	✓
	Cancer Screening Programmes – reducing professional stress and building resilience	£23,288	✓
North of England Specialised Commissioning			
	Nationally Standardised Dose Banding for Adult Intravenous Systemic Anticancer Therapy (SACT)38	£41,167	✓
	Hospital Pharmacy Transformation and Medicines Optimisation	£61,749	✓

The table above briefly describes the goals included in this year's CQUIN and the Trust's performance against each of the CQUIN goals.

Feedback from Care Quality Commission (CQC)

CareQuality Commission

The Trust is required to register with the Care Quality Commission (CQC) under section 10 of the Health and Social Care Act 2008 and its current registration status is unconditional which means there are no conditions on its registration.

The Trust's registration includes the services provided at Leighton Hospital, Victoria Infirmary in Northwich, Elmhurst Intermediate Care Centre in Winsford and the community services within the

Central Cheshire Integrated Care Partnership (CCICP), and the Statement of Purpose was updated accordingly.

The Care Quality Commission has not taken enforcement action against the Trust during the period April 2018 to March 2019.

Following the CQC Comprehensive Inspection in May 2018 the Trust received an overall rating of 'Good'. The inspectors identified, overall that the Trust was rated good for effective, caring, responsive and well led with safe rated as requires improvement.

Mid Cheshire Hospitals NHS Foundation Trust

Overall rating for this trust	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

In response to the inspection an improvement plan to address compliance actions was developed. The improvement plan evidences the completion and ongoing monitoring, where required, of the 'Must Do's' and 'Should Do' actions required to improve services and patient safety within the Trust. The Trusts CQC improvement plan is managed by the Quality Summit Group and monitored by the Executive Quality Governance Group. Escalation and assurances is provided to the Quality Governance Committee, a Board sub-committee with delegated authority from Trust Board to oversee matters relating to quality care and the maintenance of unconditional registration with the CQC. The improvement plan provides a progress update to the Quality Summit bi-monthly on the areas identified for improvement and provides identified monitoring and assurance routes to embed improvements into a business as usual approach.

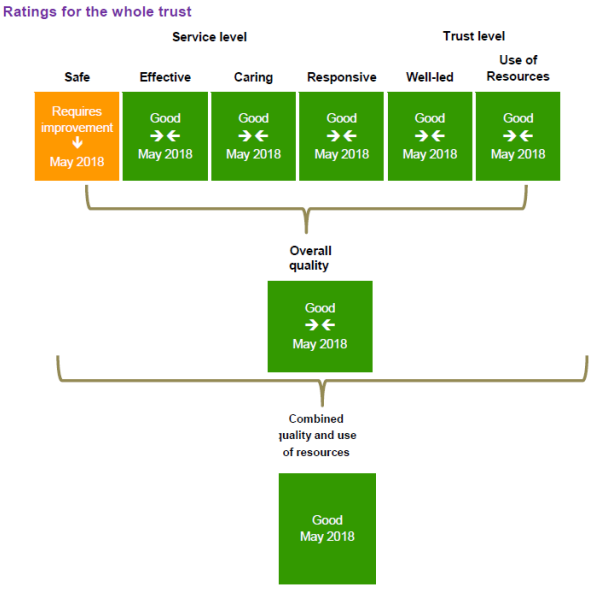
As part of the Trusts 'commitment to Quality' and journey from 'Good to Outstanding', the Executive Quality Governance Group oversees the strengthening of the Trust's local quality governance and assurance systems and processes, including the position in each division and Community Services (CCICP) against each of the CQC domains. Subsequent escalation and assurances will be via the committee structure to the Quality Governance Committee, and ultimately the Trust Board, maintaining a 'Ward to Board' approach.

The Trust has maintained its quarterly meetings with its designated CQC Relationship Manager. These quarterly Relationship meetings have a defined structure and format to ensure a consistent approach to relationship management. These meetings assist the Relationship Manager in developing an understanding of the organisation and, additionally, they will inform the CQC's regulatory planning.

The NHS Improvement Use of Resources assessment is an additional sixth key question which has been introduced in to the CQC inspection process and is combined with the Trusts overall quality rating for safe, effective, caring, responsive and well-led. The Use of Resources assessments are designed to improve understanding of how effectively and efficiently trusts are

using their resources. Analysis is followed by a qualitative assessment by a team from NHS Improvement during a one-day site visit to the trust. Aspects such as finances, workforce, estates and facilities, technology and procurement and the outcome of this assessment will be published alongside the Trusts CQC Inspection report.

In September 2018 the CQC Use of Resources assessment demonstrated an overall rating of 'Good' against Trust's Use of Resource, combined with the Trusts overall quality rating.



The Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Data Quality Assurance

NHS and General Practitioner registration code validity (April 17 – November 17 From NHS Digital SUS dashboard)

The Trust submitted records during 2018/19 to the secondary uses service for inclusion in the Hospital Episodes Statistics which are included in the latest published data.

The percentage of records in the published data which included the patient's valid NHS number was:

- 99.6% for admitted patient care;
- 99.9% for outpatient care;
- 98.5% for accident and emergency care.

The percentage of records in the published data which included the patient's valid General Medical Practice code was:

- 100% for admitted patient care;
- 100% for outpatient care;
- 100% for accident and emergency care

Data Security and Protection Toolkit attainment

The Trust has completed its 2019/20 Data Security and Protection Toolkit submission, achieving 99 of 100 mandatory assertions, resulting in a 'Standards Not Met' overall assessment. An improvement plan will be developed and monitored to support the Trust in achieving the required training compliance by July 2019.

Clinical coding error rate

In 2018/19 the Clinical Coding department were subject to a Data Security Protection (DSP) Toolkit audit, this has replaced the Information Governance Toolkit audit. The results of the DSP audit are listed in the table below. The IG toolkit level requirements have also been included as a point of reference, for the standard attained by the Clinical Coding department, in this year's DSP audit.

The accuracy results give Mid Cheshire Hospital NHS Foundation Trust a performance Level 2,

CODING FIELD	PERCENTAGE CORRECT	IG LEVEL 2	IG LEVEL 3
Primary Diagnosis	94.00%	90.00%	95.00%
Secondary Diagnosis	94.03%	80.00%	90.00%
Primary Procedure	95.24%	90.00%	95.00%
Secondary Procedure	96.48%	80.00%	90.00%

The Trust was not subject to the Payment by Results clinical coding audit during 2018/19 by the Audit Commission.

The Trust will continue to take the following actions to improve data quality:

- Deliver a robust annual coding audit programme to ensure that staff maintain and enhance their skills in line with the National Clinical Coding Standards.
- Action any recommendations from the Clinical Coding Audits, escalating to the Data Quality Group where appropriate.
- Continue to support and deliver an internal training programme for the Novice Clinical Coders, through the mentorship programme delivered by the Clinical Coding Team Leaders.
- Continue to deliver required training to all Clinical Coders and support them in their professional development.
- The Clinical Coding Management team will continue to develop the clinician engagement programme to promote the importance of accurate clinical data.
- Continually review coding resources and performance

Performance against quality indicators and targets

National quality targets

	2014-15	2015-16	2016-17	2017-18	2018-19	Target	Achieved
Clostridium Difficile infections	10 avoidable cases	10 avoidable cases	3 avoidable cases	2 avoidable cases	2 avoidable case	23	✖
Percentage of patient who wait 4 hours or less in A&E	92.30%	93.40%	90.25%	87.12%	84.20%	95%	✖

The percentage of patients waiting 6 weeks or more for a diagnostic test	0.37%	0.55%	0.34%	0.31%	0.37%	1%	
Summary Hospital-level Mortality Indicator		100	103.85	104.9	105.48		
Venous thromboembolism (VTE) risk assessment		96.11%	96.09%	95.50%	95.30%	95%	
Percentage of patients receiving first definite treatment for cancer within 62 days of an urgent GP referral for suspected cancer	89.34%	91.22%	90.98%	93.70%	89.62%	85%	
Percentage of patients receiving first definite treatment for cancer within 62 days of referral from an NHS Cancer Screening Service	95.94%	97.94%	93.67%	97.09%	94.03%	90%	
The percentage of Referral to Treatment (RTT) pathways within 18 weeks for incomplete pathways	94.41%	95.02%	94.82%	95.90%	92.63%	92%	

National quality indicators

Since 2012/13, all Trusts have been required to report performance against a core set of indicators using data made available to the Trust by NHS Digital.

For each indicator the numbers, percentages, values, scores or rates of each of the NHS foundation Trust's indicators should be compared with:

- the national average for the same and
- NHS Trusts and NHS foundation Trusts with the highest and lowest for the same

The value and banding of the summary hospital-level mortality indicator ('SHMI')

Indicator	Measure Description			
SHMI	A) The value and banding of the summary hospital-level mortality indicator ('SHMI') for the Trust for the reporting: and			
Period	**Trust Performance**	**National Average**	**95% Upper Limit**	**95% Lower Limit**

January 2016 - December 2016	104.24	100	112.09	89.22
April 2016 – March 2017	103.85	100	112.31	89.04
July 2016 –June 2017	102.97	100	112.37	88.99
October 16 - September 17	103.71	100	112.05	89.25
January 17 - December 17	104.12	100	112.47	88.91
April 17 - March 18	104.39	100	112.57	88.84
July 17 - June 18	104.75	100	112.51	88.88
October 17 - September 18	105.48	100	112.72	88.72

The Trust considers that this data is as described for the following reasons:

- For the reporting period October 2017 to September 2018, the SHMI is currently 105.48 and is in the 'as expected' range. This currently places the Trust 88 out of 131.

- The month on month changes to the Trust SHMI and HSMR is caused by a number of different factors but mainly driven by natural variation in admissions resulting in death across the whole country. Using these models, the Trust has maintained a mortality rate that is 'within the expected range' for each month and quarterly release.

The Trust has taken the following actions to improve this result, and so the quality of its service, by:

- The Trust has a well-established Hospital Mortality Reduction Group (HMRG) led by the Medical Director. This group monitors the mortality reduction improvement plans across the Trust. On a quarterly basis the HMRG meets with the divisional mortality reduction groups to ensure a unified approach to mortality reduction across the Trust and to share learning opportunities.

- The HMRG developed a reducing hospital mortality rates driver diagram, which has been reviewed and approved by HMRG. There are five primary drivers:

    - **R**eliable Clinical Care
    - **E**ffective Clinical Care
    - **M**edical Documentation, Clinical Coding and Data Quality
    - **E**nd of life Care
    - **L**eadership

Percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust

Indicator	Measure Description
SHMI	B) The percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust for the reporting period.

Period	Trust Performance	National Average	95% Upper Limit	95% Lower Limit
July 16 - June 17	0.88%	1.06%	2.18%	0.41%
October 16 - September 17	0.91%	1.08%	2.27%	0.42%
January 17 - December 17	0.95%	1.11%	2.28%	0.46%
April 17 - March 18	0.96%	1.14%	2.19%	0.49%
July 17 - June 18	0.91%	1.14%	2.89%	0.44%
October 17 - September 18	0.88%	1.14%	2.83%	0.48%

This is an indicator designed to accompany the Summary Hospital-level Mortality Indicator (SHMI) and represents the percentage of deaths reported in the SHMI indicator where the patient received palliative care.

The SHMI makes no adjustments for palliative care. This indicator presents the crude percentage rates of death that are coded with palliative care either in diagnosis or treatment speciality.

The Trust's patient reported outcome measure scores for hip replacement surgery and knee replacement surgery during the reporting period.

Indicator	Measure Description				
PROM	The Trust's patient reported outcome measure scores for hip replacement surgery and knee replacement surgery during the reporting period.				
Date	**Measure**	**Trust performance**	**National Average**	**Highest Result**	**Lowest Result**
Hip Replacement					
2016-2017	EQ5D	0.415	0.437	0.533	0.328
2017-2018	EQ5D	0.448	0.458	0.550	0.357
2016-2017	VAS	12.768	13.112	20.183	7.893
2017-2018	VAS	11.567	13.877	18.514	7.991
2016-2017	OXFORD HIP	20.441	21.379	25.044	15.968
2017-2018	OXFORD HIP	21.682	22.210	25.045	18.000
Knee Replacement					
2016-2017	EQ5D	0.308	0.322	0.398	0.237
2017-2018	EQ5D	0.328	0.334	0.406	0.254
2016-2017	VAS	6.098	6.850	14.443	0.465
2017-2018	VAS	7.169	8.153	13.985	1.752
2016-2017	OXFORD KNEE	15.858	16.393	19.686	12.231
2017-2018	OXFORD KNEE	17.830	17.102	20.394	12.899

The data demonstrates an overall improvement in patient reported outcome measure results in hip and knee surgery compared to 2016/17 data. This improvement does not include the visual analogue score (VAS) which is reported at a lower rate.

The Trust considers that these results are as described for the following reasons:

- Trust performance data represents the adjusted average health gains which have been calculated using statistical models which account for the fact that each provider organisation deals with patients with different case-mixes

- Data allows for fair comparisons between providers and England as a whole. Random variation in patients mean that small differences in averages, even when case-mix adjusted, may not be statistically significant
- Case mix adjusted figures are calculated only where there are at least 30 modelled records.

The Trust intends to take / has taken for the following actions to improve this result, and therefore the quality of its service, by:

- Continuing to monitor feedback from patients at their follow-up clinic appointments
- Reviewing the results on a case by case basis for those patients who feel they did not have a good outcome against the outcome recorded in the clinical records
- Continuing to use information leaflets which describe the process and value of the information collected through the use of the PROMS questionnaire
- Undertaking phone calls to patients at home 48 hours following discharge from their hip and knee replacement surgery.

The percentage of patients aged 0 to 14 readmitted to a hospital which forms part of the Trust within 28 days of being discharged.

Indicator	Measure Description	
Readmission Rates	The percentage of patients aged 0 to 14 readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.	
Period	**Trust per HED**	**Peer Group av HED**
Jan 2014 – Dec 2014	11.40%	10.90%
Jan 2015 – Dec 2015	11.40%	10.40%
Jan 2016 – Dec 2016	12.14%	10.44%
Jan 2017 - Dec 2017	12.41%	10.69%
Jan 2018 - Sep 2018	13.74%	11.06%

The Trust considers that these results are as described for the following reasons:

- Readmission rates for patients aged 0 – 14 have been increasing both nationally and locally. Paediatric admissions generally have a high rate of readmission due to the offer extended to the child and family to return straight to ward should there be a worry once back home.

The Trust intends to take / has taken for the following actions to improve this result, and therefore the quality of its service, by:

- Further work to understand other key influences of this increasing rate is ongoing and consideration will then be given as to how actions can be effectively implemented to improve the rate

The percentage of patients aged 15 and over readmitted to a hospital which forms part of the Trust within 28 days of being discharged

Indicator	Measure Description	
Readmission Rates	The percentage of patients aged 15 and over readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.	
Period	**Trust per HED**	**Peer Group av HED**
Jan 2014 – Dec 2014	8.60%	7.70%
Jan 2015 – Dec 2015	7.90%	7.10%
Jan 2016 – Dec 2016	8.23%	7.73%
Jan 2017 - Dec 2017	9.04%	8.16%
Jan 2018 - Sep 2018	9.09%	8.40%

The Trust considers that this data is as described for the following reasons:

- There has been a significant increase in short stay emergency admissions which will have an impact on a Trust's readmission rate. In spite of this dramatic increase, the rate of readmissions has only increased 0.05% year to date at Mid Cheshire. This is set against an increase at peer Trusts of an average of 0.25% year to date.

The Trust has taken the following actions to improve this result, and so the quality of its service, by:

- Focusing efforts to bring the readmissions down further this year through closer working with system partners such as CCICP (Central Cheshire Integrated Care Partnership). By working closer together with care in the community, deterioration/exasperations can be prevented, thus reducing the readmissions.
- The Trust has undertaken a review of all divisional and specialities readmission rates and no theme have been identified. To further support this work a further "deep dive" relating to readmissions was carried out at Elmhurst, the summary of the review highlighted that the readmission related to co-morbidities and a complex patient cohort. No earlier interventions or alternatives to admission were identified to support.

The Trust's responsiveness to the personal needs

Indicator	Measure Description			
Responsiveness to patient needs	**Trust Performance 2016/2017**	**2017/2018**	**National Average**	**2017-18 95% confidence interval**
Access and Waiting	83.3	79.3	83.5	0.19
Safe, high quality, coordinated care	65.7	67.3	72.6	0.23
Better information, more choice	63.6	66.3	68.6	0.27
Building closer relationships	85.0	87.5	85.8	0.15
Clean, comfortable,	78.7	78.7	81.4	013

friendly place to be				
Inpatient overall patient experience score	75.6	77.5	78.4	0.14

If patients reported all aspects of their care as 'good', we would expect a score of at least 60. If they reported all aspects as 'very good', we would expect a score of at least 80

Source: NHS Patient Survey Programme, Care Quality Commission
Further details of the methodology can be found in the methodology paper at: http://www.england.nhs.uk/statistics/statistical-work-areas/pat-exp/

The Trust considers that this data is as described for the following reasons:

Access and Waiting

Three survey questions, domain score reducing from 83.3 to 79.3. This domain captures information about how frequently admission dates are changed, how long patients wait for treatment (higher scores for shorter waits) and how long patients wait after arriving to be allocated a bed. For this domain, all three questions scores have reduced. The Trust has scored worse than the national average for this section.

Safe, high quality, co-ordinated care

This domain includes questions about whether patients were given consistent messages by different members of staff and whether there were delays in discharge from hospital. Of the two questions in this domain, one score has decreased and one score has improved with fewer patients reported experience of delayed discharges (score increasing from 65.7 to 67.3).

Better information, more choice

This domain captures feedback on whether patients were involved as much as they wanted to be in decisions about their care and treatment and whether staff clearly explained the purpose and side effects of medicines. Two questions that form this domain have shown improved scores and one remains the same.

- More patients were satisfied with their involvement in decisions about their care and treatment (score increasing from 69 to 74).
- More patients reported being told about medication side effects to watch for at home (score increasing from 41 to 44).
- More patients received an explanation of the purpose of the medications they were to take at home (score remains the same at 81).

Building closer relationships

Four survey questions, domain score increasing from 85 to 87.5
This domain assesses whether doctors or nurses provided information to patients in a way they could understand and whether doctors or nurses spoke about patients as if they weren't there. Three of the four questions included in this domain improved scores and one remains the same.

- Fewer health professionals spoke in front of patients as if they weren't there (for doctors the score increased from 85 to 89 and for nurses the score remains the same at 90.0).
- More health professionals gave information to patients in a way they could understand (for doctors the score increased from 82 to 86 and for nurses the score increased from 83 to 85).

Clean, comfortable, friendly place to be

Seven survey questions, domain score remains the same at 78.7. This domain captures feedback on whether patients were disturbed by noise at night, asking patients what they thought about the cleanliness of their hospital room or ward and how patients felt they were treated by staff, including how much privacy they were given, whether they were helped to manage their pain and if they felt that they were treated with dignity and respect. There has been an improvement in two of the seven question scores. Two scores are reduced – noise and cleanliness.

- Patients' opinions of cleanliness of the room or ward stayed the same (score reduced from 89 to 87).
- Patients' reporting of whether they were treated with respect and dignity stayed the same (score remaining at 90).
- The score rating for hospital food increased from 57 to 60.

The Overall Score has improved from 75.6 to 77.5

The Trust has taken the following actions to improve this result, and so the quality of its service, by:

- To reduce unnecessary noise at night re-launch Quiet Protocol and to include "Invest to Rest" Campaign
- Improve ward cleanliness
- Continue to improve efficiency of patients being discharge from hospital by extending system of ward labelling of medication and support from ward based pharmacy staff and the ward discharge co-ordinators.

Scores have been included from Survey Contractor as the CQC Benchmark report is not available until June 2019.

Staff employed by the Trust who would recommend the Trust as a provider of care to their family or friends (scores out of 5)

Indicator	Measure Description			
Friends & Family	Staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.			
Period	**Trust Performance**	**National Average**	**Upper Limit**	**Lower Limit**
2017 staff survey	75%	70.2%	89.3%	48%
2018 staff survey	77.5%	69.9%	90.3%	49.2%

The Trust considers that this data is as described for the following reasons:

- The 2018 results place the Trust in the reporting category of combined acute and community trusts, instead of solely acute trust for the second year

The Trust has taken the following actions to improve this result, and so the quality of its service, by:

- Creating action plans within divisions and Central Cheshire Integrated Care Partnership (CCICP) which focus on delivering sustainable improvement in the experience of our staff.
- Involving staff in decision-making and keeping them informed of changes and developments across the organisation.
- Taking an open and honest approach in ensuring staff are informed about the Trust's performance and key decisions being made, as well as giving staff the opportunity to put

forward any views or suggestions about how we can improve the experience of our patients, services users and staff

- Working with seven staff Governors who make a valuable contribution to the governance and development of the organisation.
- Delivering a new Trust induction programme which is the first step in helping new staff to get to know more about the Trust and how we involve and engage them in our decision-making.
- Delivering 'Employee of the Month' and 'Team of the Month' schemes which provide staff with recognition for going above and beyond what is expected.
- Using a range of well-established forums for consulting with and engaging staff and their representatives, including:
    - Regular Executive and Non-executive ward safety visits;
    - Executive Director walkabouts
    - Regular formal and informal meetings with our Trade Union representatives, (Joint Local Negotiating Committee and Joint Consultation & Negotiation Committee)
    - Weekly CEO Brief
    - Regular Trust Briefings, (Trust Update and Payday Press)
    - CEO drop-in surgeries
    - CEO Engagement Events
    - Forward thinking events.
    - Staff Focus Groups
    - Bright Ideas Scheme
    - All Together Newsletter

The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE).

Indicator	Measure Description			
VTE	The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.			
Period	**Trust Performance**	**National Average**	**95% Upper Limit**	**95% Lower Limit**
January 2016 - March 2016	95.44%	96.00%	100.00%	78.06%
April 2016 – June 2016	95.56%	96.00%	100.00%	80.61%
July 2016 – October 2016	96.52%	96.00%	100.00%	72.14%
October 2016 - December 2016	96.17%	96.00%	100.00%	76.48%
January 2017 - March 2017	95.61%	96.00%	99.87%	63.02%
April 2017 – June 2017	95.58%	96.00%	99.97%	51.38%
July 2017 - October 2017	95.55%	No data available	No data available	No data available
October 2017 - December 2017	95.31%	No data available	No data available	No data available
January 2018 - March 2018	94.59%	No data available	No data available	No data available
April 2018 - June 2018	95.07%	No data available	No data available	No data available

July 2018 - September 2018	95.57%	No data available	No data available	No data available
October 2018 - December 2018	95.24%	No data available	No data available	No data available

The Trust considers that this data is as described for the following reasons:

- The Trust continues to achieve the 95% target for the completion of VTE risk assessment by implementing a number of actions as described below.

The Trust has taken the following actions to improve this result, and therefore the quality of its service, by:

- Monthly monitoring of the percentage of patients risk assessed for VTE by the clinical divisions
- Quarterly monitoring of the percentage of patients risk assessed for VTE through the Executive led quarterly divisional quality assurance reviews
- Regular review of the VTE risk assessment tool to ensure it continues to be compliant with National Institute for Health and Clinical Excellence (NICE) guidance. The tool is included within the Trust admission proforma to ensure it is completed in a timely manner at admission and the appropriate VTE prevention interventions are implemented
- Continued education for medical staff on induction on the importance of VTE assessment.

The rate per 100,000 bed days of cases of C.difficile infection reported within the Trust amongst patients aged 2 or over

Indicator	Measure Description			
C.Difficile	The rate per 100,000 bed days of cases of C.difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period.			
Period	**Trust Performance**	**National Average**	**95% Upper Limit**	**95% Lower Limit**
2014-2015	13.8	15.1	62.2	0
2015-2016	22.2	15.1	67.2	0
2016-2017	12.2	14.92	82.6	0
2017-2018	11.1	13.65	90.3	0
2018-2019	21.54	Not yet published	Not yet published	Not yet published

The Trust considers that this data is as described for the following reasons:

- The Trust continues to have a robust Post Infection Review (PIR) process in place for all cases of Clostridium difficile (CDI) including a secondary review with our Commissioners, this facilitates the opportunity to review the case and establish if any "lapse of care" has occurred either contributing or not contributing to the development of CDI. This is a learning opportunity aimed at implementing/strengthening procedures to reduce the risk of CDI developing in other patients

The Trust has taken the following actions to improve this result, and therefore the quality of its service, by:

- The Trust objective for 2018/19 was 23 cases. The Trust reported 24 cases of C.Difficile for 2018/19, of which 2 have been identified as avoidable cases, the remaining cases have been identified as unavoidable.

- Antimicrobial stewardship is closely monitored in line with Trust policy ensuring a focus on antimicrobial prescribing and feedback to medical staff
- Multi-disciplinary bedside reviews of all CDI positive patients throughout their stay
- IPC team now has dedicated clinical areas assigned to them.
- Shared learning via the divisions quality forums.

The number of patient safety incidents reported within the Trust.

Indicator	Measure Description			
Patient Safety Incidents	The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period.			
Period	**Trust Performance**	**National Average**	**95% Upper Limit**	**95% Lower Limit**
April 2014 – September 2014	2,814	2,052	4,301	908
October 2014 –March 2015	2,767	4,539	12,784	443
April 2015 – September 2015	3,159	4,647	12,080	1,559
October 2015 – March 2016	3,116	4,818	11,998	1,499
April 2016 – September 2016	3,348	4,955	13,485	1,485
April 2017 – September 2017	3485	5226	15,228	1133
October 2017- March 2018	3462	5449	19,897	1,311

The Trust considers that this data is as described for the following reasons:

- Nationally, it is viewed that being a high reporter of incidents is a positive position as it demonstrates a risk aware culture within the Trust and highlights that staff are not afraid to report patient safety incidents.
- The majority of the incidents reported resulted in no harm to the patient, which again demonstrates a positive risk aware culture within the Trust.

The Trust has taken the following actions to improve the reporting of patient safety incidents and therefore the quality of its service:

- Patient Safety Summit is a twice monthly meeting led by clinical teams. The Summit provides an opportunity for cross-divisional / CCICP learning and sharing of immediate learning following incidents. All moderate and above patient safety incidents are discussed at the Summit and clinical teams are encouraged to attend to promote learning and improvement. The Patient Safety Summit is chaired by the Medical Director.
- Following each Patient Safety Summit a 'Safety Matters' newsletter is developed and distributed across the organisation. The newsletter contains learning from incidents, mortality case note reviews, local or national updates and Summit messages of the week.
- Incident report training for all new staff to the Trust. This training ensures that all staff in the Trust knows how to report a patient safety incident and they also understand the importance of incident reporting.
- Direct feedback to all staff on the outcome of the incidents they have reported to demonstrate the changes in practice that have been made as a result of the incident.
- Sharing of learning from reported incidents through safety alerts, lessons learned episodes of care, individual patient stories and Safety Matters.

The number and percentage of such patient safety incidents that resulted in severe harm or death.

Indicator	Measure Description			
Patient Safety Incidents	The number and percentage of such patient safety incidents that resulted in severe harm or death.			
Period	**Trust Performance**	**National Average**	**Highest Result**	**Lowest Result**

April 2014 – September 2014	3	15	51	0
October 2014 –March 2015	6	23	128	2
April 2015 – September 2015	6	20	89	2
October 2015 – March 2016	18	19	94	0
April 2016 – September 2016	18	18	111	0
April 2017 – September 2017	19	19	121	0
October 2017- March 2018	18	19	99	0

The Trust considers that this data is as described for the following reasons:
The Trust has a positive reporting culture and is a high reporter of incidents. Nationally this is seen as positive. The Trust has undertaken a number of actions as described below to reduce the harm caused to patients and learn from our incidents.

The Trust has taken the following actions to improve the reporting of patient safety incidents and therefore the quality of its service:

- Undertaking a comprehensive investigation for all incidents, which result in severe harm or death. An Executive led review meeting is held following the incident investigation to ensure that lessons are learned and improvement plans are implemented to prevent a reoccurrence
- Reporting all incidents which result in severe harm or death to the Board of Directors to ensure openness within the Trust
- Implementation of the Trust's *Being Open* (including Duty of candour) policy which ensures that, if an incident occurs which results in severe harm or death, the patient and / or their family are informed and the lessons learned and improvement plans from the comprehensive investigation are shared with them.

Learning from Deaths

During 2018/19 938 of Mid Cheshire Hospitals NHS Foundation Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:
213 in the first quarter;
225 in the second quarter;
223 in the third quarter;
277 in the fourth quarter

By 31/03/2019, 832 case record reviews (using the Trust Mortality Review Tool) and 94 investigations (using the Structured Judgement Review process) have been carried out in relation to 938 of the deaths included above.

In 94 cases a death was subjected to both a case record review and an investigation using the Structured Judgement Review process. The number of deaths in each quarter for which a case record review or an investigation was carried out was:
223 in the first quarter;
214 in the second quarter;
240 in the third quarter;
249 in the fourth quarter
0 representing 0% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient using either the Trust Mortality Review Tool or the Structured Judgement Review Process

In relation to each quarter, this consisted of:

0 representing 0% for the first quarter;
0 representing 0% for the second quarter;
0 representing 0% for the third quarter;
0 representing 0% for the fourth quarter.
These numbers have been estimated using the Trust Mortality Review Tool or the Structured Judgement Review process.

Six avoidable deaths in 2018 / 19 were identified and reported following comprehensive incident investigations. Action plans were developed following each of the Executive Led incident reviews.

The SJR process was developed by the Royal College of Physicians (RCP). Structured judgement review blends traditional, clinical-judgement based review methods with a standard format. The approach requires reviewers to make safety and quality judgements over phases of care and to make explicit written comments about care for each phase. The result is a relatively short, but rich, set of information about each case in a form that can also be aggregated to produce knowledge about clinical services and systems of care.
The objective of the review method is to look for strengths and weaknesses in the caring process, to provide information about what can be learnt about the hospital systems where care goes well and to identify points where they may be gaps, problems or difficulty in the care process.
The SJR produces two types of data:

1. A score from 1 to 5 identifies very poor - excellent care respectively in a number of phases of care
2. Qualitative data in the form of explicit statements about care using free text

The phases of care which are reviewed are:

- Admission and initial care - first 24 hours
- Ongoing care
- Care during a procedure
- Perioperative/procedure care
- End of life care
- Assessment of overall care

The overall quality of care is assessed during the SJR process. Care scores are recorded after the judgement comments have been written. One score is given to each phase of care. The reviewers then judge their overall decision on the overall quality of care. The SJR process commenced at the Trust in April 2018.

The Trust's Learning from Deaths Policy has built upon the Mortality Case Note Review Standard Operating Procedure, which outlined the existing embedded process for reviewing all in-hospital deaths.

All in-patient deaths are reviewed on a weekly basis by a team of Consultants, led by the Lead Consultant for Patient Safety. A short mortality case note review form is completed and, if a death is identified where clinical care could potentially have been more appropriate, the case is referred for a Structured Judgement Review (SJR).

SJRs are undertaken by a cohort of senior medical and nursing staff trained in the SJR Process.

In addition to the escalations from the weekly reviews, in line with national guidance, the Hospital Mortality Reduction Group (HMRG) has agreed a number of other clinical conditions / criteria that result in an in-patient death undergoing a SJR. These are reviewed on an annual basis and currently include:

- Acute Cerebrovascular Accident (at the weekend)
- Pneumonia (at the weekend)
- Intestinal obstruction without hernia
- Alcohol related liver disease
- Infectious diseases (CQC Insight metric)
- Relevant elective deaths
- All deaths where families, carers or staff raise concerns
- Concerns raised by the Coroner
- Concerns raised at the Patient Safety Summit

Organisational learning from this process must be dynamic, with immediate actions and improvements undertaken in a timely manner to prevent reoccurrence. Short - medium term improvements, identified through organisational learning, are introduced through the Trust's governance structure. In the longer term organisational learning will take place through the triangulation and theming of data and information. The Trust's incident reporting, investigation and organisational learning processes describe our approach to organisational learning.

The learning from these reviews is collated and shared in a quarterly newsletter, 'Learning from our Mortality Reviews'
The Trust has a well-established HMRG led by the Medical Director. This group leads the Trust's mortality reduction programme and, on a quarterly basis, meets with the Divisional Mortality Reduction Groups to ensure a unified approach to mortality reduction across the Trust and to share learning opportunities.

The Trust's mortality reduction programme is succinctly described in a driver diagram that was most recently updated in March 2019. The five primary drivers to reducing the Trust's mortality rates are:

- **R**eliable Clinical Care
- **E**ffective Clinical Care
- **M**edical Documentation, Clinical Coding and Data Quality
- **E**nd of life Care
- **L**eadership

Summary of Learning

Below are a number of the positive comments made during the reviews.

- Excellent care provided
- Multi-specialty working
- Excellent prescribing of anticipatory medications
- Excellent communication with the family
- Risks of surgery well documented
- Excellent set of clinical records
- Good documentation and use of the fractured neck of femur pathway
- Good evidence of both nursing and medical reviews
- Medical review in Emergency Department well completed with a thorough history taken, medication and allergies recorded. Chest and abdominal examination recorded. VTE risk assessment completed
- Good documentation of discussions with relatives regarding end of life care and ceilings of care
- Good assessment of patient's capacity and requirement for a DoLs

The SJRs undertaken have identified the following learning themes:

- Poor completion of pathways including acute kidney injury, sepsis management and pneumonia
- Clinical observations not recorded in line with Trust guidance
- Failure to identify, and respond to, the deteriorating patient
- Delay in medical review
- Poor completion of fluid balance monitoring

Actions and Assessment of Impact

Following a large scale training programme across the organisation, the National Early Warning Score 2 (NEWS2) was launched in the Emergency Department and in-patient ward areas on the 5 November 2018. NEWS2 has been launched in Theatres, Treatment Centre, Ambulatory Care Unit, Planned Interventions Unit, Outpatients Department and Elmhurst as part of the roll out programme in April 2019.

The revised vital signs chart includes the NEWS2 chart, neurological observation chart, sepsis and AKI guidance and SBAR information to ensure accurate handover in the clinical settings. This is currently being audited to assess impact.

A care pathway group chaired by the Executive team monitors the compliance with care pathways.

Clinical leads have been identified for each of the pathways and monitoring is undertaken by the Care Pathway Group, reporting to the Quality and Safety Improvement Strategy Group with escalation to the Executive Quality Governance Group and assurances to the Quality Governance Committee.

Improvements in compliance of the use of care pathways are being demonstrated through the AQ reporting process.

Review of quality performance

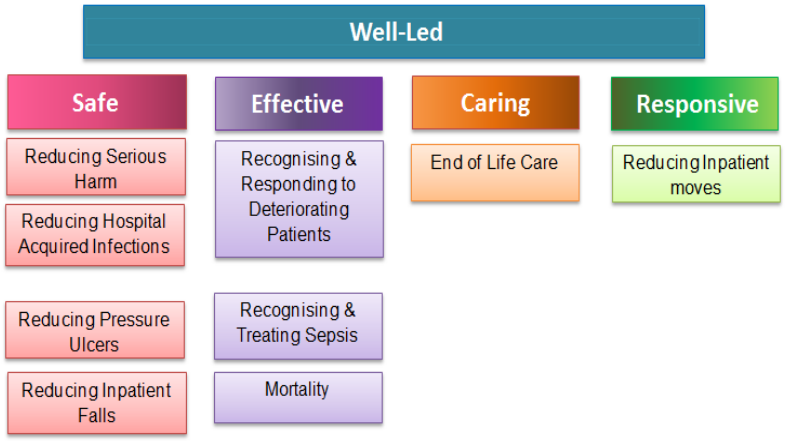
Priorities for 2018-19

The Trust wants to be sure that everyone in our local community who may use our services has absolute confidence that our care and treatment is completely patient centred. The Trust is committed to the delivery of our Quality and Safety Improvement Strategy 2018-19.

In 2018-19, the Trust aims to deliver the CQC domains as part of our Quality and Safety Improvement Strategy. These are key drivers in the elements of quality care.

The Trust held a programme of both staff and public engagement sessions to engage with the local community. The engagement sessions gave the opportunity to share achievements and obtain ideas of what the Trust should focus on in the 2018-19 strategy.

The common themes that emerged from the engagement sessions were:



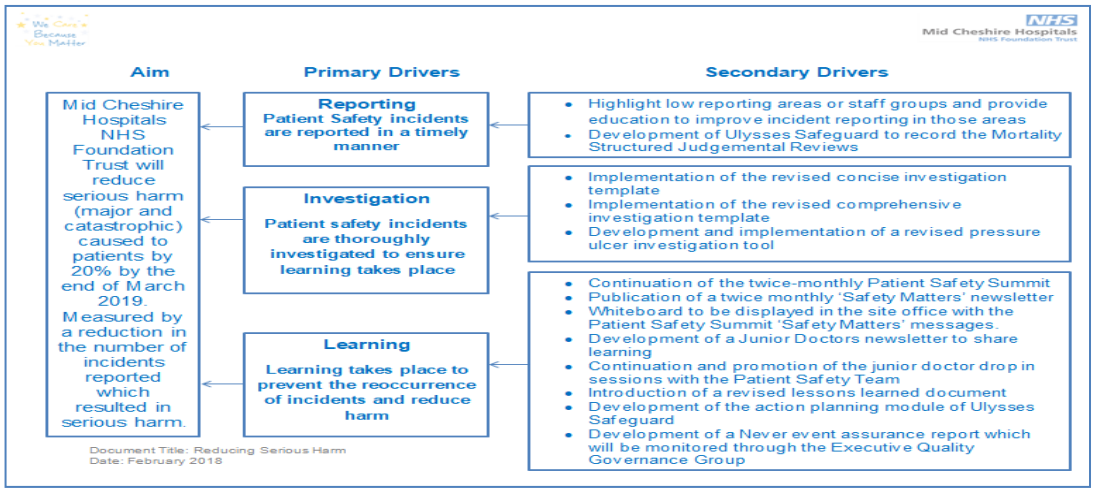
Reducing Serious Harm

Our aim is to reduce serious harm (major and catastrophic) caused to patients by 20% by the end of March 2019.

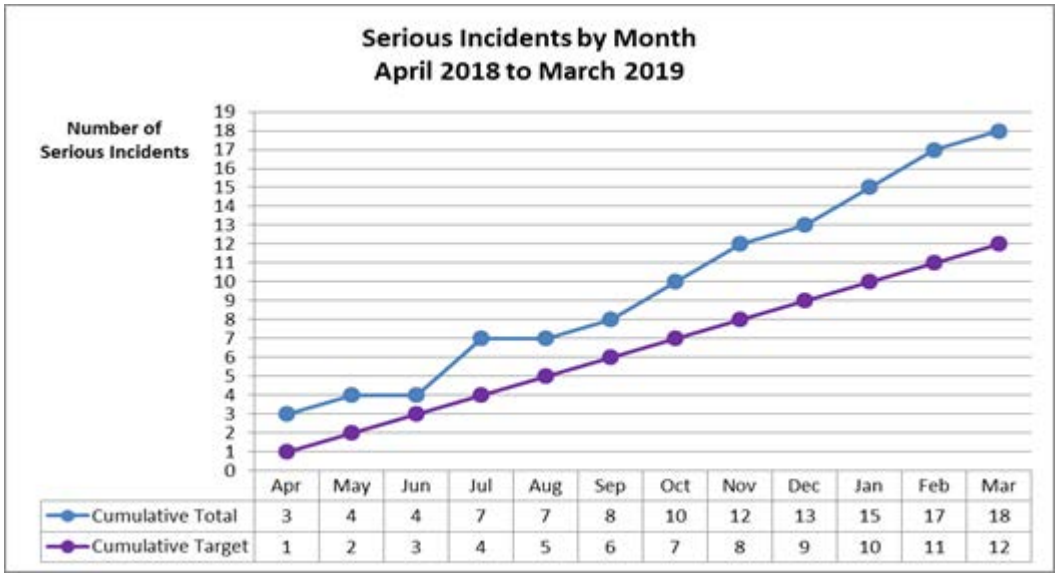
Why is it important?

Robust reporting, investigating and learning from our incidents will reduce the chance of the same incident reoccurring and causing serious harm to another patient.

Reduction in serious harm driver diagram



Serious incidents by month April 2018 to March 2019



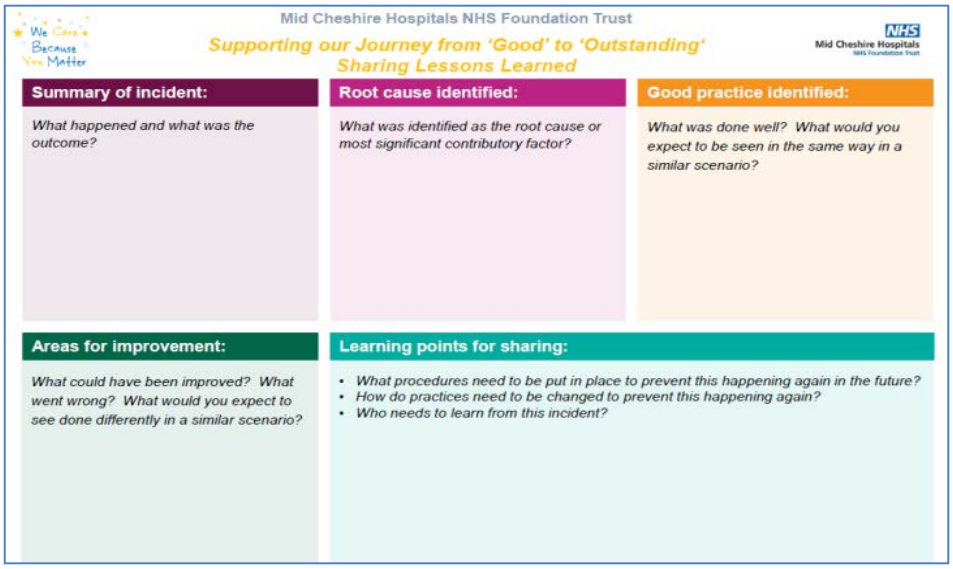
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Totals	Shift
Cumulative 2018/19	3	4	4	7	7	8	10	12	13	15	17	18	18	+38.%
Cumulative 2017/18	0	3	4	7	8	9	10	10	11	11	12	13	13	

The Trust has reported 18 serious incidents in the period April 2018 to March 2019 against a target of 12.
The incidents reported in the period include:
Delay in commencing a patient on Non-Invasive Ventilation x 1
Delay in referring a patient to the Critical Care Outreach Service x 1
Delay in access to hospital care x 1
Failure to provide appropriate nutrition and hydration for a patient x 1
Patient fall resulting in fractured neck of femur x 10
Failure to provide appropriate treatment to a stroke patient x 1
Cardiac arrest x 1
Neonatal death x 1
Never Event retention of guidewire x 1

There has been a 38.5% increase in the number of incidents reported which resulted in serious harm in 2018/19 compared to the previous financial year.

A comprehensive investigation was undertaken for all the incidents in line with the Trust Incident Reporting, Investigation, Learning and Improvement Policy and national guidance. A review meeting was held following each investigation and an improvement plan developed.

The concise and comprehensive investigation templates have been revised in line with national guidance to further develop the quality of the incident investigations conducted. Further specific tools have been developed for the investigation of hospital acquired pressure ulcers and venous thromboembolism.
A revised lesson learned template has been developed to share learning from the investigations.



Mid Cheshire Hospitals NHS Foundation Trust

Supporting our Journey from 'Good' to 'Outstanding'
Sharing Lessons Learned

Summary of incident:	Root cause identified:	Good practice identified:
What happened and what was the outcome?	*What was identified as the root cause or most significant contributory factor?*	*What was done well? What would you expect to be seen in the same way in a similar scenario?*

Areas for improvement:	Learning points for sharing:
What could have been improved? What went wrong? What would you expect to see done differently in a similar scenario?	• *What procedures need to be put in place to prevent this happening again in the future?* • *How do practices need to be changed to prevent this happening again?* • *Who needs to learn from this incident?*

The lessons learned which are shared following each comprehensive investigation highlight the root cause of the incident, good practice which was identified, areas for improvement and the learning points that the review panel wish to share.

Learning from all investigations is also shared by the divisions at the two-weekly Patient Safety Summit. Patient Safety Summit is a two weekly meeting led by clinical teams. The Summit provides an opportunity for cross divisional / CCICP learning and sharing of immediate learning following incidents. All moderate and above patient safety incidents are discussed at the Summit and clinical teams are encouraged to attend to promote learning and improvement. The Patient Safety Summit is chaired by the Medical Director.

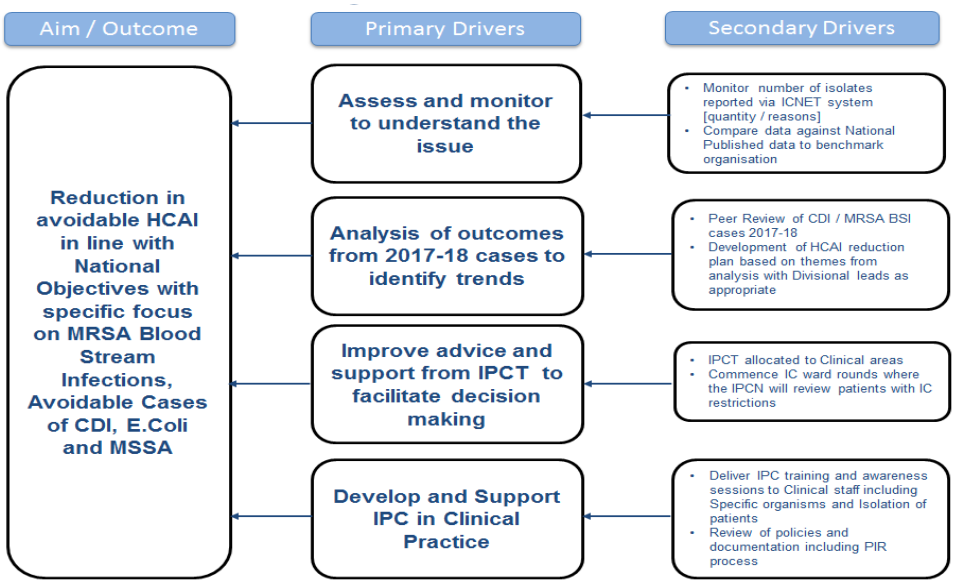

Summit 'Safety Matters'

Following Patient Safety Summit the Safety Matters Newsletter is shared across the organisation to further share the learning from incident investigation, complaint investigations and mortality reviews. Both paper and hard copies of the newsletter are distributed.

Reducing Hospital Acquired Infections

Reducing the risk of Health Care Associated Infection remains a priority as part of delivering safe quality care to our health population. This year the trust has continued to focus on reducing Clostridium difficile infections (CDI), preventing the occurrence of MRSA blood stream infections and participating in a health economy approach to reducing gram negative bacteraemia in particular ECOLI.

Reduction in Hospital Acquired Infections Driver Diagram



CDI -Despite a year on year reduction both locally and nationally, Clostridium difficile infection (CDI) is an unpleasant and potentially severe or fatal illness especially for our elderly and vulnerable population. It is acknowledged that this reduction has slowed over recent years and this may be due to factors outside of the organisations control for example antibiotics prescribed due to private medical treatment.
Learning from cases is important to establish any "Lapse in Care'' which either directly or indirectly contributed to a case, identifying any measures which can be implemented to prevent CDI in other patients.

Progress

NHS England sets all trusts an annual objective to support a year on year reduction in CDI the Trust have been set an objective of no more than 23 cases, this year the trust reported 24 cases. From the completed reviews only 2 of the cases were identified as avoidable with a contributing factor relating antimicrobial prescribing. 22 cases were identified as unavoidable.

As part of a commitment to learning from incidents of infection each case of CDI is reviewed at a Post Infection Review, this is a multidisciplinary team approach to identify any factors which could have prevented the case of CDI occurring or used as a learning exercise to reduce the risk to other patient ensuring that robust systems and processes are in place to ensure rapid identification of any case.

What have we learnt?

All the patients reviewed had increased risk factors for the development of CDI including their age and other comorbidities this is in line with the regional and national picture.
Many of the patient's clinical pathways require multiple antibiotics which increases the risk of CDI. Two of the cases reviewed antibiotics could have been selected differently and therefore this contributed to the development of CDI
A new improved stool chart has been launched to support the staff in earlier identification of when the patient's bowel habit changes, this triggers a prompt to send samples sooner, this has also been supported by the launch of the new CDI policy.

MRSA BSI

Progress

The Trust continues to support the national objective of a zero tolerance approach to MRSA BSI. This year 4 cases have been identified from blood cultures taken within the organisation. A PIR was undertaken on all the cases with representation from clinical areas and the

commissioners. As part of this process some clinical learning was identified which has resulted in a robust plan to implement system wide change.

What we have learnt

To provide more detailed information on where the patient was colonised with MRSA there has been a change to screening sites required the IPCT are supporting the clinical areas in implementing this change.
A 90 day improvement programme to review ANTT within the organisation against the latest national standards.
A new MRSA policy and Care plan reflective of local requirements and changes to national guidance.

ECOLI Reduction.

NHS England have set a target of a 50% reduction by 2020 (this is a CCG target). To ensure this is a collaborative across the health economy the Trust is a key stakeholder in a new HCAI reduction group. This group includes CCG's across South and Vale Royal and East Cheshire, representatives from Cheshire East council, East Cheshire NHS Trust, CWP and Midlands Partnership Trust.

Progress

Following an analysis of the data collected by the Trust the indication, is in line with the national profile and that although there are no clear themes to focus on individually adopting a multi-facetted approach will improve the outcomes for our patient population including the ongoing work on antimicrobial prescribing across the acute and community settings and improving the message on hydration for patient with multiple health needs not only during periods of warm weather but throughout the year.
Although there is no objective for acute organisations the trust has seen a reduction of acute attributable cases (although many of these cases are unavoidable due to clinical picture of the patient) with 27 cases reported in 2017/18 and 25 cases in 2018/1. In the community the number of cases reported has also seen a reduction with 180 cases in 2017/18 compared to 148 cases 2018/19.

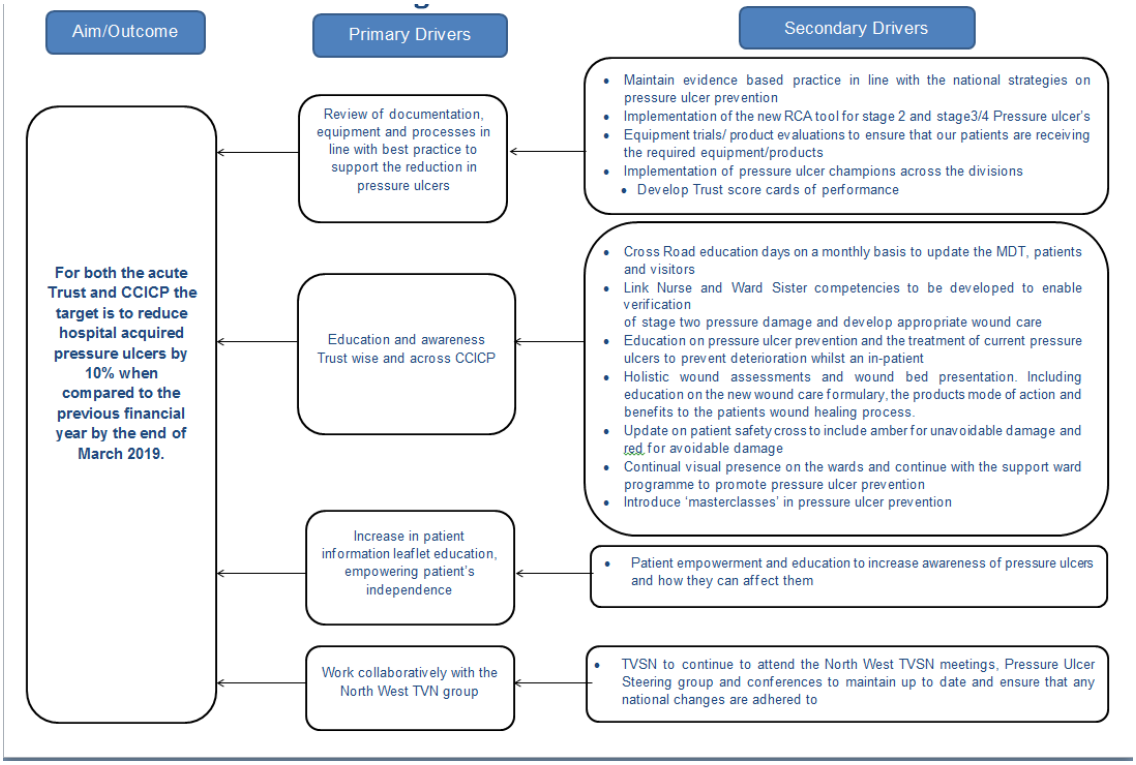
What are we doing to reduce Health Care Associated infections (HCAI)?

- IPCT supporting the clinical areas in managing patients with infections including but not limited to CDI, MRSA BSI, Gram negative BSI this includes correct isolation, hand washing, the use of PPE and accurate documentation.
- Multi-disciplinary Post infection reviews as appropriate
- A focus on antimicrobial stewardship supported by Consultant Microbiologist antimicrobial ward rounds and clinical advice.
- A review of documentation including care plans, stool charts to ensure they provide the relevant information for all staff.
- Continual review of data to extract key themes and ensure learning is implemented as appropriate.
- A commitment to ensure that all the new policies are user friendly and provide easily accessible information.
- Working a cross the Health Economy to improve patients hydration in their own home especially patients with UTI's
- Rolling out a Urinary Catheter Care Passport to ensure consistency in care for patients in any health care environment.

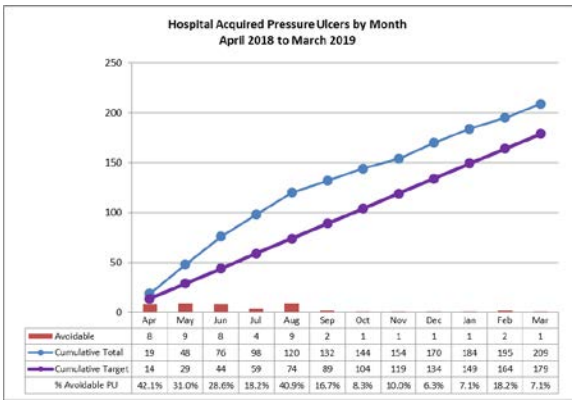
Reducing Pressure Ulcers

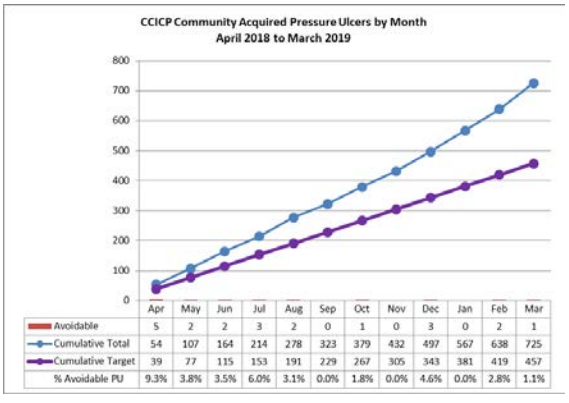
Following a review of the strategy in March 2018, the Trust's aim was to reduce pressure ulcers in both the acute Trust and CCICP. The target was to reduce hospital acquired pressure ulcers by 10% when compared to the previous financial year by the end of March 2019.

Pressure Ulcer Prevention Driver Diagram



Acquired Pressures Ulcers by month April 2018 to March 2019





Financial Year	Hospital acquired pressure ulcers (MCHFT)	Hospital acquired avoidable pressure ulcers (MCHFT)	Developed on caseload pressure ulcers (CCICP)	Developed on caseload avoidable pressure ulcers (CCICP)
2017/18	187	37	510	29
2018/19	209	47	725	21

Unfortunately the Trust did not achieve its aim to reduce hospital acquired avoidable pressure ulcers by 10% when compared to the previous financial year.

In response to the number of reported pressure ulcers the Trust continues to invest to reduce the number of hospital acquired avoidable pressure ulcers.

Within the Trust the investment is delivered by;

- The Tissue Viability Specialist Nurse reviews all reported hospital acquired pressure ulcers and Deep Tissue Injuries to ensure all appropriate interventions are in place and to determine the category of the pressure ulcer. In addition, a ward based investigation is undertaken for all hospital acquired category two and unstageable pressure damage, so that staff can understand what led to the development of the pressure ulcer and implement corrective action to eliminate gaps in care. Outcomes of the investigation are undertaken by the ward manager and matron for the area to ensure senior support and fed into the Pressure Ulcer Panel Meeting if confirmed avoidable damage

- The Clinical Quality and Outcomes Matron maintains senior leadership within the Trust to focus on the elimination of avoidable pressure ulcers

- The Trust's skin care group continues to meet monthly and is chaired by the Clinical Quality and Outcomes Matron. The group has a multidisciplinary, cross divisional review. The agenda has been updated to include updates from both MCHFT and CCICP on pressure ulcer prevention strategies and initiatives

- Staff education remains a priority within the Trust and CCICP to eliminate avoidable pressure ulcers. Tissue Viability Link Nurse Study days are held quarterly for MCHFT and CCICP staff. The number of link nurses within each ward/base remains that of a 'link team' which includes support from both Registered Nurses and Health Care Assistants

- Photographing of all pressure ulcers to ensure accurate documentation within the Trust is becoming embedded into everyday clinical practice. This supports the recognition of any deterioration or improvement in reported pressure ulcers, as well as accurate categorisation of pressure ulcers

- A number of pressure relieving equipment trials are being undertaken within the Trust to support the patient's care journey. This includes the trials of a Heel off-loading device, ED trolley toppers and friction prevention garments, which are currently in process

- The Trust is in the process of entering the procurement process in relation to the Hybrid mattress evaluation that has concluded

- The Trust has implemented the use of KerraPro silicone sheet to redistribute the pressure to patients at risk areas, such as Sacrum, elbows, heels, etc. This is embedded within everyday practice and the product is widely used within the Trust

- Tissue Viability Specialist representation from MCHFT and CCICP attend the quarterly Tissue Viability North West region meetings. This is a forum that meets and discusses best practice within the holistic patient care delivery and pressure ulcer prevention, as well as being up to date with both local and national initiatives

- The Tissue Viability Specialist Nurses attend the quarterly North West Pressure Ulcer Steering Group meetings. This is a forum that meets and discusses best practice within

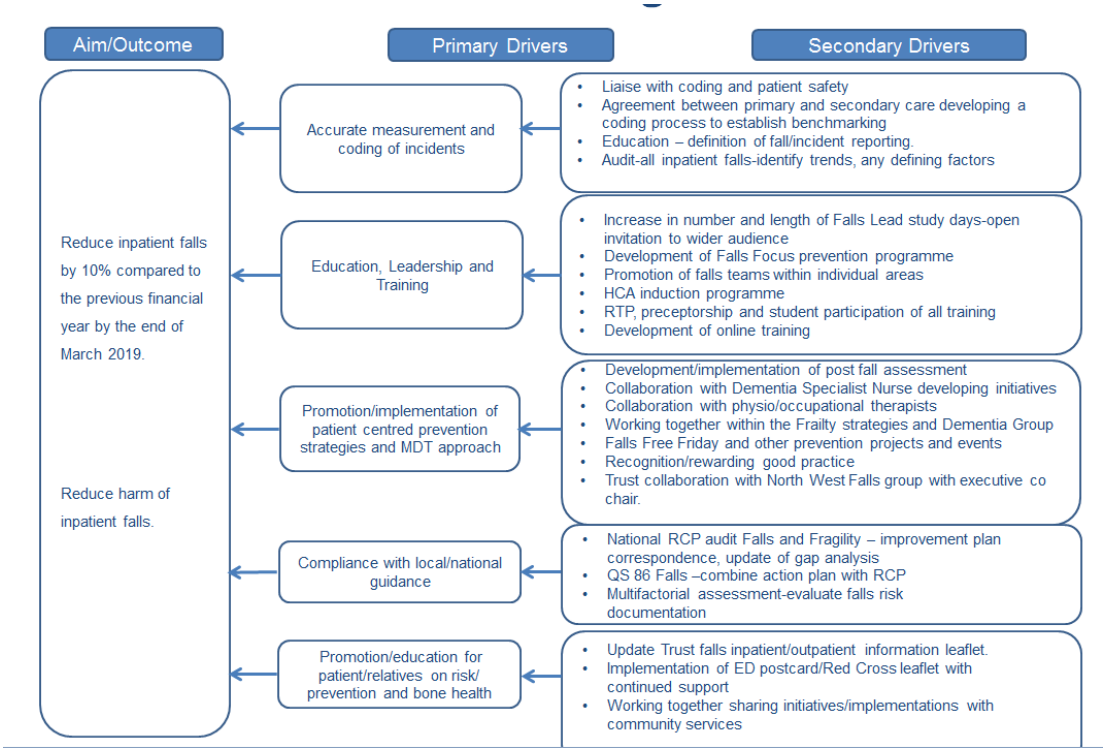
the holistic patient care delivery and pressure ulcer prevention, as well as being up to date with both local and national initiatives. The group is currently developing regional patient information leaflets and regional Policy in relation to Pressure Ulcer Prevention and Treatment in line with the National Health Service Improvement Pressure Ulcer changes

- Ward staff competency workbooks for Pressure Ulcer Prevention and categorisation has been reviewed and updated. This booklet is in the process of being added to an e-learning training package for health care assistance and registered nurses within the Trust
- The Tissue Viability Specialist Nurse continues to deliver the teaching education programme around Pressure ulcer prevention and delivers training to the Health Care Assistant induction students, Quality Matters sessions, preceptor students, pre-preceptor students, student nurses, pre- registration students, as well as adhoc ward based training as identified
- The Trust documentation has been reviewed by the Tissue Viability Specialist Nurse and has been updated in-line with the National NHS Improvement plan
- React 2 Red has been re-launched within the Surgery and Cancer division and is led by a division Matron
- The Tissue Viability Specialist Nurse is working within a Critical Care work stream with National Health Service Improvement to devise national guidance in relation to pressure ulcer prevention and treatment within the specific area
- The Trust has launched monthly multidisciplinary, cross divisional Pressure Ulcer Panel meetings to discuss all avoidable category 2 and unstageable pressure damage and establish lessons learnt and develop action plans as required. This meeting also reviews all category 3 or 4 investigations tools to determine avoidability
- The Tissue Viability Specialist Nurse has reviewed the moisture associated skin damage products that the Trust had in place in relation to prevention and treatment and has made changes to the product selection following this review
- The Tissue Viability Specialist Nurse has reviewed both the care rounds and repositioning documentation and changes have been made to make the documents more user friendly and capturing the information that is required. These have been rolled out to all wards
- The Tissue Viability Specialist Nurse won an award at the National Wounds UK conference for the ‘most innovative’ abstract submitted for the work that has been done within the Trust in relation to the reduction of moisture associated skin damage.

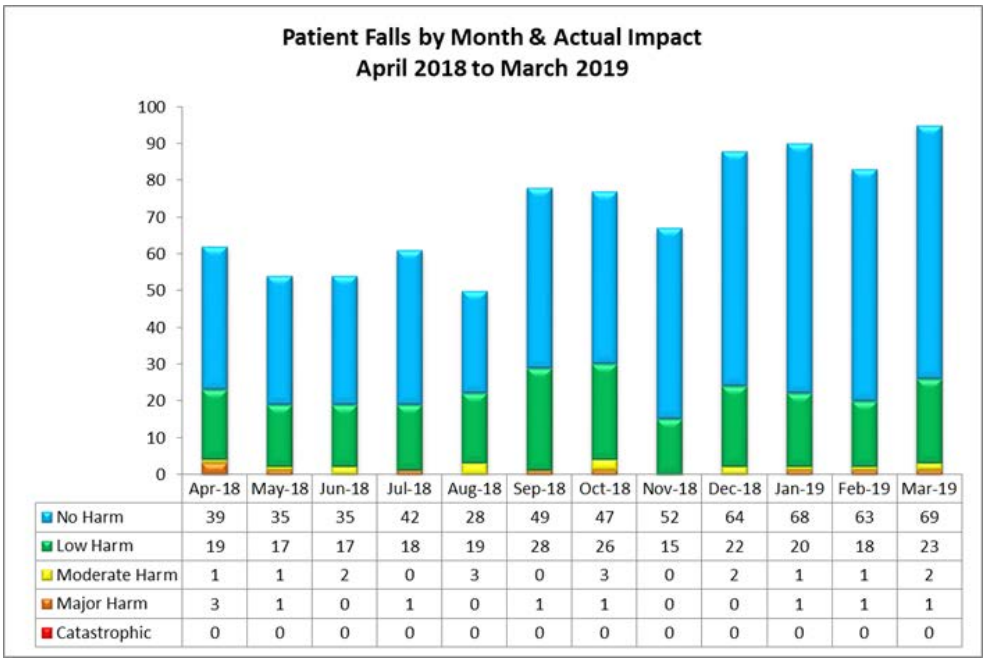
Reducing Inpatient falls

The Trust's aim is to reduce inpatient falls by 10% compared to the previous financial year by the end of March 2019

Falls Driver Diagram



Number of patient falls reported by month April 2018 to March 2019



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
No Harm	39	35	35	42	28	49	47	52	64	68	63	69
Low Harm	19	17	17	18	19	28	26	15	22	20	18	23
Moderate Harm	1	1	2	0	3	0	3	0	2	1	1	2
Major Harm	3	1	0	1	0	1	1	0	0	1	1	1
Catastrophic	0	0	0	0	0	0	0	0	0	0	0	0

Incident Type	2015/16	2016/17	2017/18	2018/19
Patient Falls	833	767	729	859

There has been a 18% increase in the number of reported inpatient falls in 2018/19 compared to the previous financial year

In order to achieve a reduction in falls there has been a number of actions undertaken or in development:

- Post fall assessments are completed by the Falls Specialist Nurse providing an individual prevention plan
- Falls Focus Programme - bespoke education, training and support is delivered by the Falls Specialist Nurse in individual areas
- Falls resulting in harm result in a Concise or Comprehensive review, with a focus to learn and implement improvements
- Falls prevention days increased in order to reach a wider audience
- Development of Falls Teams in all areas which include nursing staff and health care assistants
- A Fall Prevention guide has been created in order to support staff with appropriate interventions
- Community links established regarding falls prevention and support for patients
- Traffic light system commenced in rehabilitation areas which aids in safe mobilisation whilst rehabilitating
- Display boards in individual areas which are used as communication for staff, patients and relatives
- Signage in bays and toilets for patients as a reminder on how to call for assistance
- Promotional events held in the Trust and community to raise awareness.

The falls service has developed significant improvements since May 2018. Many patients now receive a complex, detailed assessment post fall by the Falls Specialist Nurse and an individualised prevention plan including assessment for frailty is then provided for the patient with a view to reducing the risk of further falls. We also encourage patients and their families to be involved in care planning whenever possible.

We continue to implement and promote the previous work for the 'One Step Ahead' collaborative which is across all ward areas. The specific elements of this collaborative are;

- Toilet/commode tagging
- Cohort higher risk patients
- Staff Placement/Changes to staff base
- Safety crosses

The Falls Specialist Nurse continues to evaluate and promote these initiatives within the ward areas with the inclusion of the Falls Teams. In addition educational sessions, workshops and

promotional events are held within the Trust. Care rounds continue in all inpatient areas and trials of assessment notifications at bay entrances are taking place across the divisions highlighting at risk patients.

A Concise or Comprehensive investigation is undertaken where moderate or severe harm has occurred due to a fall. Outcomes of investigations are shared with staff at ward level and discussed at the Trust falls group. As a result of these investigations actions are taken in order to implement improvements.

All inpatients continue to be assessed for their risk of falls in hospital using the NICE guideline 161. Focus remains on individual risk factors such as falls history, lying/standing blood pressure, urinalysis and medications. Cognitive impairment is one of the largest risk factors which are supported by the Royal College of Physicians. We have established links with the Trust Dementia Nurse Specialist in order to support these patients in reducing falls risk. Part of this involves raising awareness of Delirium, treatments to consider and appropriate interventions to minimise the risk.

The Trust's Falls group continue to meet monthly and is chaired by the Clinical Quality and Outcomes Matron. The group has multidisciplinary and cross divisional representation inclusive of CCICP Falls lead.

Staff education continues to remain priority. Falls Education study days are held twice a year. This was open to the Falls Leads although invitation has recently extended to all staff members within the Trust. Falls Prevention training also forms part of the Quality Matters and Preceptorship programmes. The number of link nurses within each ward has increased to produce a 'falls prevention team' which includes support from both registered nurses and health care assistants. Links have also been developed with the community who now have representation on the Falls Group.

There is now a much improved provision of mobility aids utilised in the ward areas and improved communication system within the physiotherapy department which facilitates prompt ordering of aids. In addition individualised areas are using a traffic light system in order to highlight the appropriate walking aid required and the support needed to mobilise.

The Trust participated in the second Royal College of Physicians National Falls audit in May 2017. Results were received in November and work is currently underway via a Gap analysis to identify areas for improvement. We have also since signed up to the new continual audit by the Royal College of Physicians which commenced in January 2019.

The Community Rehabilitation Team introduced a pilot in June 2017 providing a new seven days falls service. The therapist and paramedic offer an alternative response to emergency calls. As a partnership team, the therapist and paramedic are able to rapidly assess and respond to patients needs in their home. They can provide immediate advice, equipment and support to help prevent further falls.

There is an acknowledgement that we are not going to eliminate falls altogether, and we do have to balance the encouragement of independence with the management of risk. However, we know that there are many risk factors that can be mitigated. The Trust is working hard to reduce falls and any harm caused from falls.

Recognising & Responding to Deteriorating Patients

Our aim is for Mid Cheshire Hospitals NHS Foundation Trust to reduce adult avoidable patient harm (Measured by reductions in cardiac arrests, severity of patient harm incidents and high risk admissions to Critical Care) by improving the recognition of and the response to the acutely deteriorating patient by 50% by the end of March 2019

Why is it important?

Improving the recognition of, and the response to, the acutely deteriorating patient can reduce in-hospital cardiac arrests, serious harm to patients and high risk admissions to Critical Care.

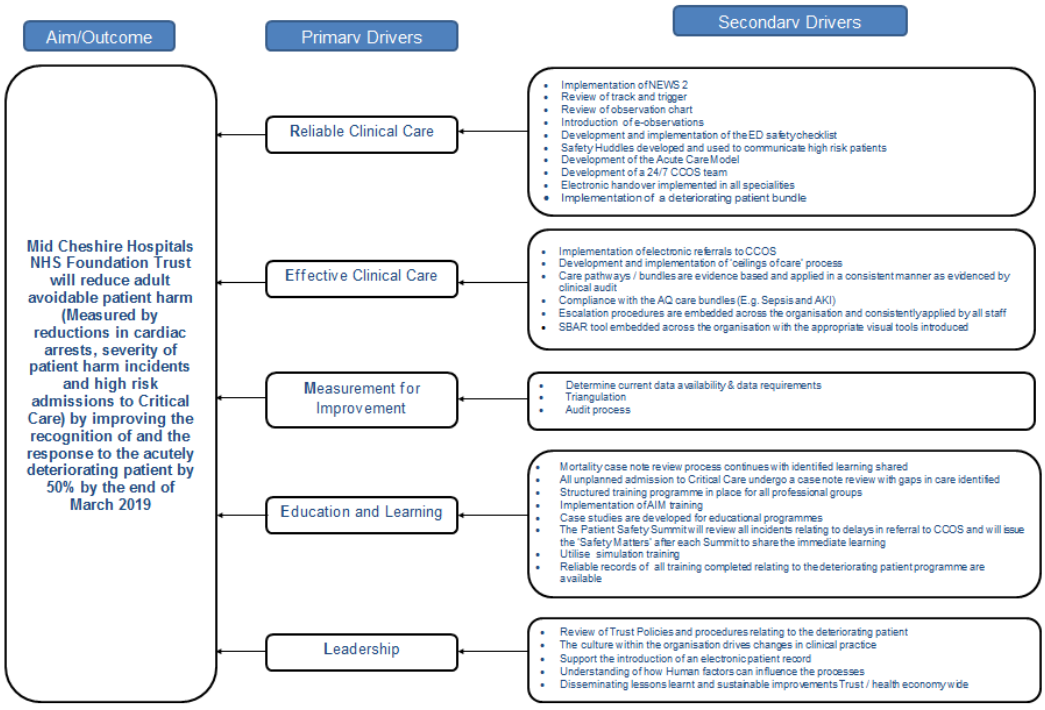
Progress

The Executive Led Deteriorating Patient Steering Group was formed in November 2017. The group has cross-divisional representation, is chaired by the Medical Director and reports to the Trust Mortality Reduction Group and up through the committee structure to Board as appropriate.

The group has six work streams with a nominated lead for each:

- Acute Care Model
- Unplanned Admissions to the Critical Care Unit
- Education and Training
- Quality Improvement Projects
- Policy
- Lines

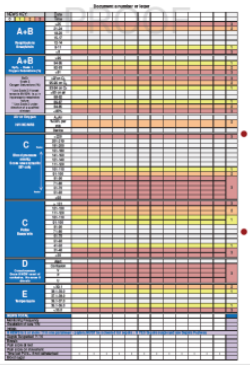
Deteriorating Patients Driver Diagram

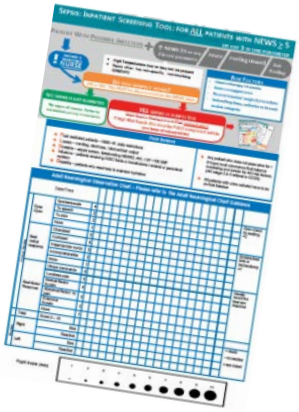


The National Early Warning Score (NEWS 2) was launched in the Trust on the 5 November 2018. The revised vital signs chart has been developed to incorporate NEWS2 and approved by the Deteriorating Patient Steering Group. The revised vital signs chart includes the

Safe
Effective
Caring
Responsive
Well-Led

NEWS2 chart, neurological observation chart, sepsis and AKI guidance and SBAR information to ensure accurate handover in the clinical settings.





The Trust vital signs policy has been rewritten to include the use of NEWS2. The divisional teams have updated their local admission proforma's and documents to again incorporate NEWS2.
The organisation has attended the AQuA Deteriorating Patient Collaborative which commenced on the 12 July 2018. The Trust also joined the NHS England NEWS2 Champion Network.
A training implementation plan was developed and approved by the Deteriorating Patient Steering Group. The training programme is being led by the Critical Care Outreach Service Lead Nurse.

The 2018 Mid Cheshire Hospitals NHS Foundation Trust Quality Improvement Session which was held on the 19 October focused on the care of the deteriorating patient and the launch of NEWS 2.

All unplanned admissions to Critical Care are reviewed by a clinical team using the Structured Judgement Review methodology. Learning from these reviews is taken forward through the Governance structure with lessons learned produced.

The Critical Care Matron has taken forward a piece of work relating to the insertion and management of lines. A competency passport for staff has been developed along with a patient passport. A decision tool to aid in selecting the correct line to use is being developed.

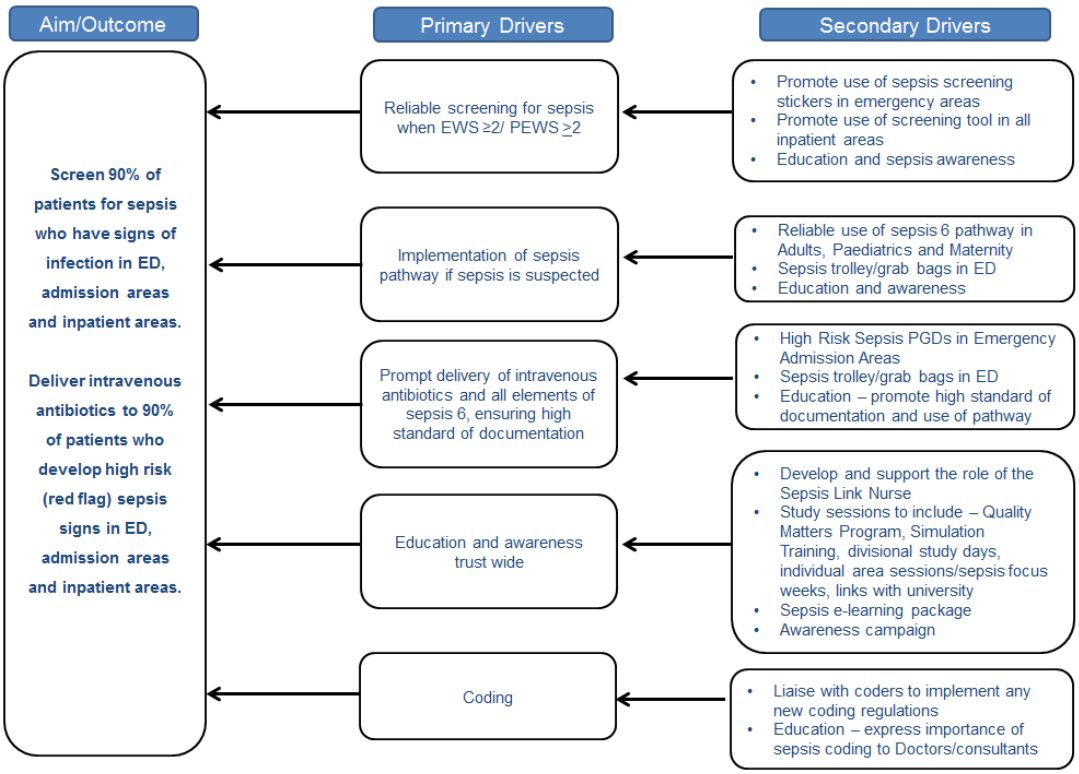
The Critical Care Outreach Service Lead Nurse has implemented an AIM training programme within the organisation.

Following the launch of NEWS2 in November 2018 data collection has been commenced to show the impact of NEWS2 on the measures within the driver diagram aim. This data is now being collated and will be presented at the Deteriorating Patient Steering Group in 2019/20.

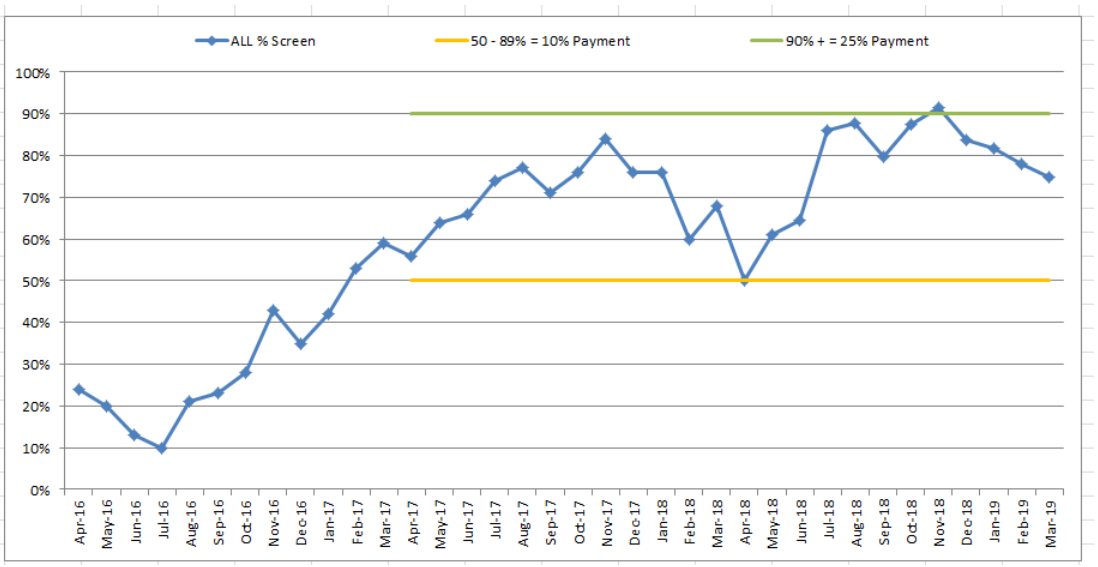
Recognising & Treating Sepsis

There are a number of strategies in place to improve performance as the sepsis team continue to work with the aim to achieve the National target of 90% for both part 2A (sepsis screening) and part 2B (antibiotic administration) of the CQUIN

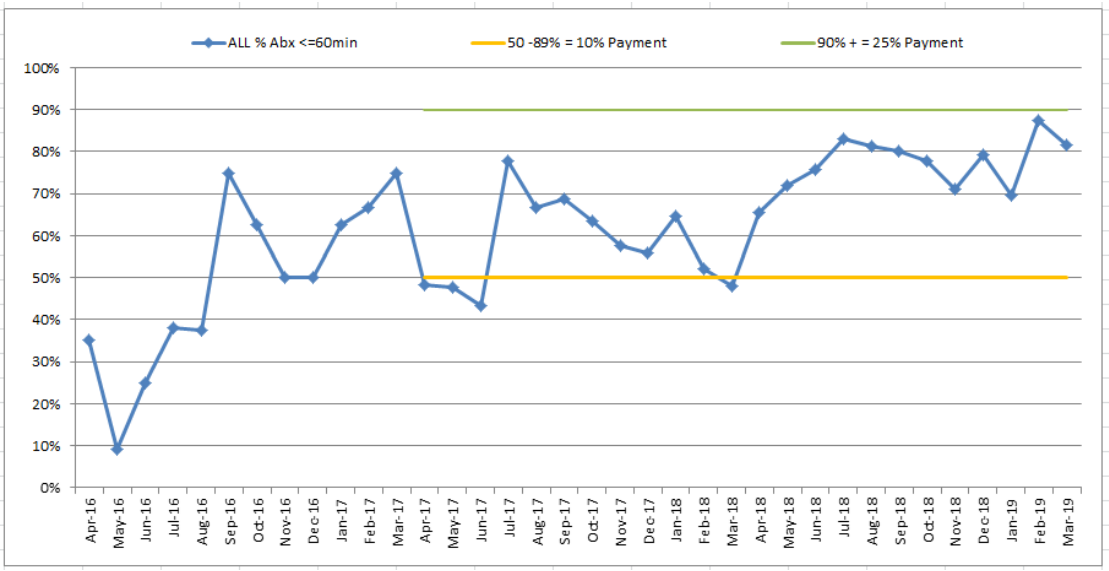
Sepsis Driver Diagram



The results below demonstrate progress to date for screening in the Emergency Department, inpatients and combined for 2018/2019. The final quarter 4 combined screening results is 78% against a target of 90%



The results below demonstrate progress to date for delivery of antibiotics in the Emergency Department inpatient's and combined for 2018/2019. The final quarter 4 result is 79% against a target of 90%



The table below shows the end of quarter 4 results for each year:

	Year 16/17	Year 17/18	Year 18/19
Combined Screening	51%	67%	78%
Combined antibiotic delivery	69%	57%	79%

Education and awareness of sepsis screening, recognition and treatment of sepsis with all staff remains key. Training with link nurses and wards remains on-going, staff can contact the sepsis nurse at any time to have training needs updated or refreshed. All wards have sepsis link nurses; the link nurses are educated on sepsis and aware of their roles and responsibilities which include teaching the staff in their area. Each ward is reminded each month to submit their monthly audit of sepsis screening, this highlights area's where improvement is needed.

Education continues via many avenues including the Quality Care Delivery Programme, preceptorship training, link nurse training, spontaneous visits to wards to check screening. Sessions are also booked in with the school of nursing for the return to practice nurses. Extra training for the launch of NEWS2 has also included education on the new way to screen patients for sepsis. The sepsis E-learning package remains in progress with several members of staff completing it. In December the quality team completed a quality week which promoted sepsis, awareness and recognition along with other quality domains. This was completed at the hospital cross roads and afterwards each ward and department was visited to ensure staff were happy with all aspects of sepsis care. Staff were also given edible goodies and drinks to thank them for their continuous sepsis care and recognition.

The launch of NEWS2 was rolled out in November, as a part of this all staff were trained on the new chart and how to identify sepsis and screening for sepsis. Results since the launch have improved sepsis screening for inpatients.

The Acute Medical Unit re-launched a triage area which has significantly increased screening results; this has continually remained a huge improvement on their sepsis screening. In November both inpatients and the Emergency Department met their target of 90% screening.

This is the highest yet. Presence in ED and the inpatient areas has decreased over the last few months due to the sepsis team becoming 1 nurse; however this does not seem to have impacted on results to date. ED has had new staff starting, after discussing with senior staff in ED a roll out of training is to commence February/March to capture all staff that need updates and all new staff that need training on sepsis recognition and treatment.

During quarter 2 the sepsis team were in communication with computer services department about having a mandatory screening box on the triage screen in ED, unfortunately this is not possible so staff remain screening the patients using the sepsis screening stickers. The new Emergency Department cas card has now been launched. The screening sticker is incorporated into the cas card, next month's audit with prove if this is working or not and highlight if changes are needed.

During November the Trust held their a Celebration of Achievement Awards Ceremony; the sepsis team won the Outstanding Contribution to Quality and Safety award for improvement of sepsis care and recognition throughout the Trust.

The patient Group Direction (PGD) is in use in the Emergency Department now and the Ambulatory Care Unit. A new training programme is to be rolled out in the Emergency Department to capture new starters and refresh those that need an update in using the PGD. The staff also have access to the sepsis trolley which has all the equipment and medication on to be able to deliver the sepsis 6 to patients with sepsis and suspected sepsis, the PGD and high risk check list are available on the trolley so staff can administer antibiotics if needed without delay. The sepsis policy is readily available to staff to read and refer to, this is on the intranet for ease of access.

The sepsis nurse continues to audit the use of the pathway. This allows effectiveness of the pathway to be determined alongside the antibiotics delivery compliance. Education on the pathway use across all divisions including maternity and paediatrics continues, promoting the importance of the sepsis six. The pathway and all documents have now been update in line with the NEWS2 launch.

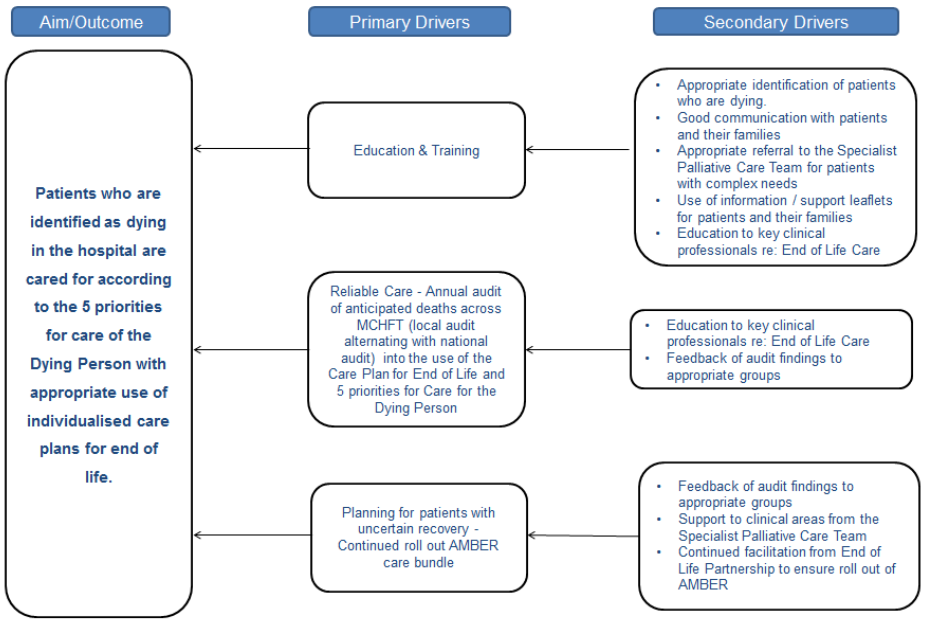
The collection of the AQ data continues. This helps to identify how the Trust is achieving compared to other Trusts. This looks at patients treated for moderate – high risk sepsis. The sepsis steering group continues to meet on a monthly basis. Representation from all divisions is requested to ensure sepsis care is delivered the same through the Trust.

Central Cheshire Integrated Care Partnership (CCICP) now has a developed sepsis pathway that ensures community nursing staff appropriately assess at risk patients. CCICP have worked in partnership with the acute Trust in order to design their robust pathway. Prior to the launch of the pathway all staff were trained in the use of the early warning scores for patients at risk of developing sepsis.

End of Life Care

Nearly half of all deaths in England occur in hospitals. For this reason, it is a core responsibility of hospitals is to deliver high quality care for patients in their final days and appropriate support to their careers. There is only one opportunity to get it right and to then create a positive lasting memory for relatives and carers. The Trust aims to provide the best possible care for patients at the end of life, whatever their disease. We strongly believe that high quality care consists of the five priorities for end of life care being embedded in everybody's clinical practice. The use of individualised care plans helps to focus care around the needs of the patient and their family and provides documentation and evidence that we are doing so.

End of Life Driver Diagram



Progress:

Education and training – The Trust now has a new Educator Facilitator in post for End of Life Care 2 days a week. End of Life Care Education is established within junior doctor's medical education programme, the nursing preceptorship and 'Return to Practice' programmes. Bespoke support is provided for clinical areas and individual staff members. There are 8 Macmillan Education study days available throughout the year funded places are available for all healthcare professions working locally within both primary and secondary care.

As part of the End of Life Care and Bereavement Group we now work collaboratively with the Customer Care Team to be able to monitor complaints and respond with education appropriately.

Audit - During 2018 The national NHS Benchmarking audit 'National Audit of Care at the End of Life' has been undertaken. This consisted of an Organisational Audit / Clinical Case note Review / Hospital site Audit and Quality Bereavement Survey. The clinical case note review looked at all deaths in hospital during April 2018. The data collection for this has been completed and submitted.

The results of this audit are produced nationally and will be available publically May 2019.

NHS Benchmarking have announced that this audit will be repeated during 2019.

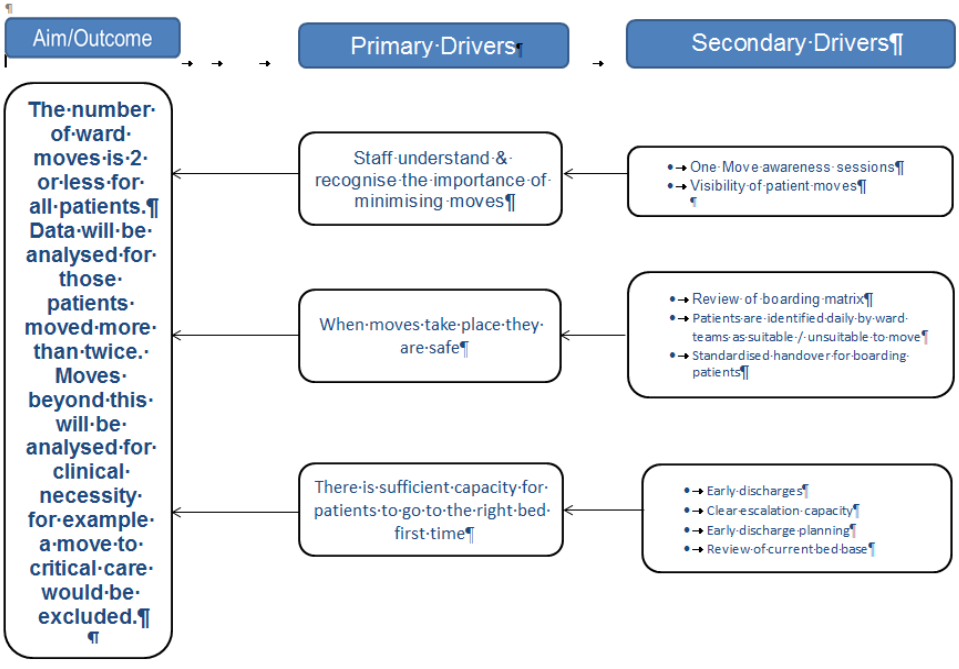
Planning for patients with uncertain recovery – Continued roll out of the AMBER Care Bundle is ongoing.

- Amber Care Bundle aiming to go live on wards 2 and 3 at the Trust in April 2019. A baseline audit being completed
- Working with medical consultants who are championing its use within clinical areas
- Amber Care training on wards 2 & 3 commenced on 31st Jan, weekly sessions for 6 weeks. Education resources / folders created for each clinical area.

Reducing Inpatient Moves

The Trust is committed to reducing inpatient moves throughout the organisation, especially when this occurs for non-clinical reasons. The national evidence suggests that patient moves are associated with extended length of stay and lack of continuity of care. As an organisation we have reviewed our current policies and procedures related to patient moves/ boarding to ensure that patient moves are kept to minimal level and clinically appropriate patients are moved to suitable areas. The introduction of the flex bundle has been a clinically led protocol designed to ensure a holistic assessment of the patients' needs are considered.

Reducing Inappropriate Inpatient Moves Driver Diagram



Safe
Effective
Caring
Responsive
Well-Led

The following work streams are in place to support the reduction of patient moves and improve the quality and safety when patients are moved:

- Trust-wide bed modelling review to assess capacity & demand
- The National Emergency Intensive Support Team (ECIST) are providing assistance with the safe admission and discharge processes in the Trust.
- Implementation of the safe flex bundle which supports a holistic assessment criteria
- Live visibility around patient moves to support decision making

It is unlikely we can eliminate the practice of medical outliers / patient moves entirely however the Quality programme in 18/19 has developed safe procedures and identified long term plans to support the overall reduction of this metric. It is fair to say that there are further aspects of improvement work required for the success of this quality measure which will be carried into the Quality programme 19/20.

Governors' choice of indicator

Mortality

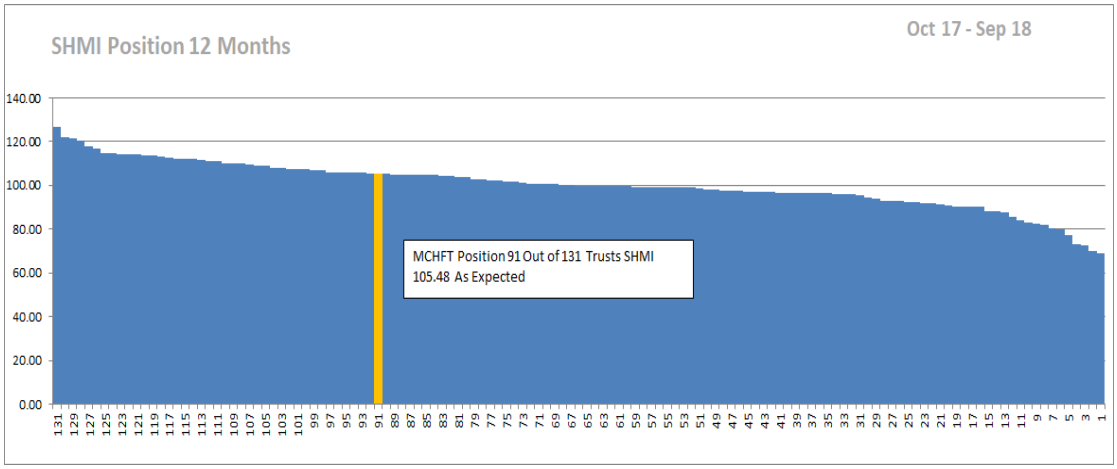
Our aim is for from April 2015, Mid Cheshire Hospitals NHS Foundation Trust's Summary Hospital-Level Mortality Indicator (SHMI) will remain at or below 1.0 and its Hospital Standardised Mortality Ratio (HSMR) will remain at or below 100

Why is it important?

SHMI and HSMR are indicators which report on mortality at Trust level across the NHS in England. These measures are important because high mortality rates may be an indication of problems with the quality and safety in a hospital.

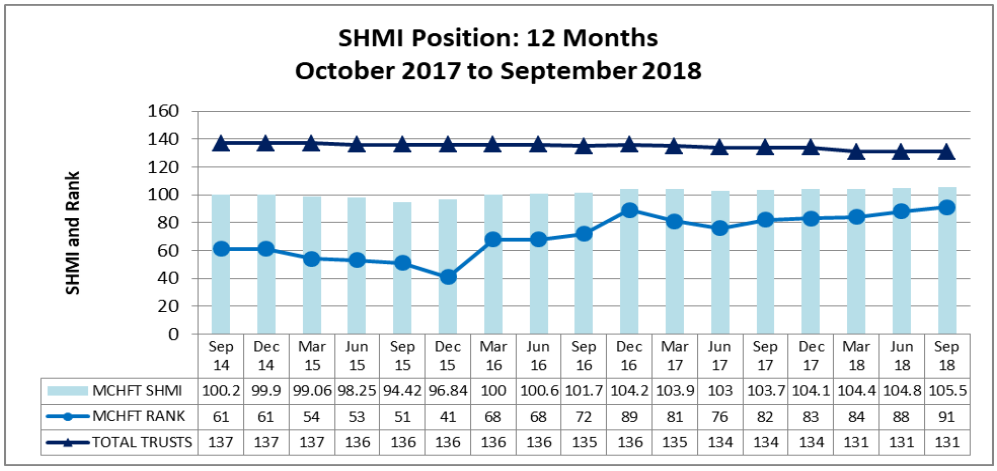
Progress

Summary Hospital-level Mortality Indicator (SHMI) October 2017 - September 2018



(Source NHS Digital, 2018)

The above chart demonstrates the SHMI position for the reporting period October 2017 - September 2018. The SHMI is currently 105.48 and is in the 'as expected' range. This currently places the Trust 91 out of 131 Trusts.

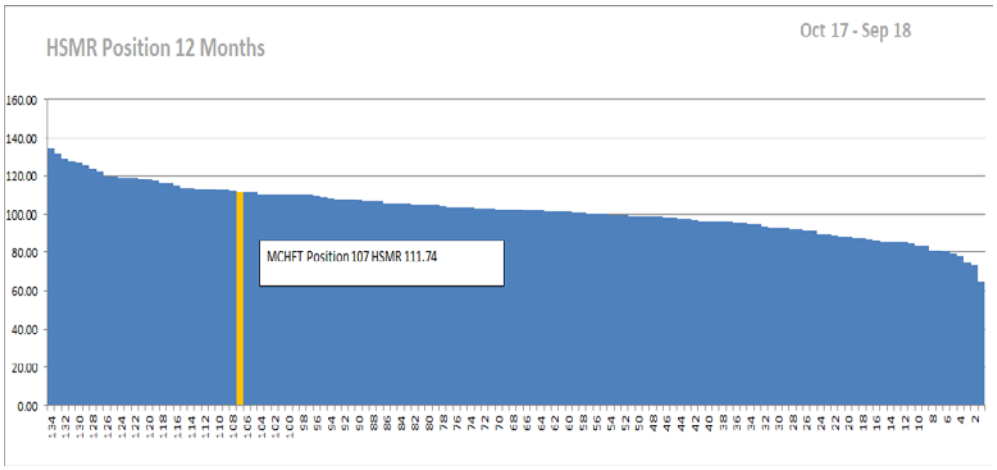


	Sep 14	Dec 14	Mar 15	Jun 15	Sep 15	Dec 15	Mar 16	Jun 16	Sep 16	Dec 16	Mar 17	Jun 17	Sep 17	Dec 17	Mar 18	Jun 18	Sep 18
MCHFT SHMI	100.2	99.9	99.06	98.25	94.42	96.84	100	100.6	101.7	104.2	103.9	103	103.7	104.1	104.4	104.8	105.5
MCHFT RANK	61	61	54	53	51	41	68	68	72	89	81	76	82	83	84	88	91
TOTAL TRUSTS	137	137	137	136	136	136	136	136	135	136	135	134	134	134	131	131	131

(Source NHS Digital, 2018)

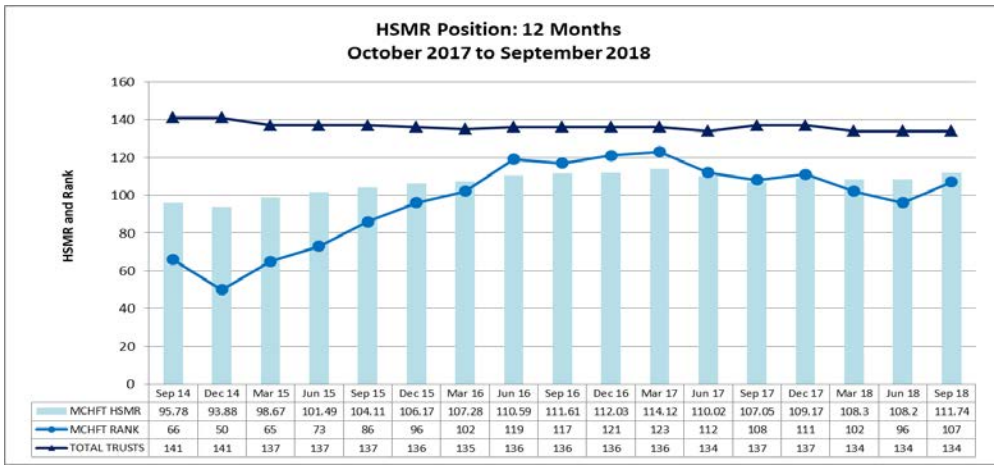
The above chart demonstrates the SHMI and rank of the Trust over time, up to latest reporting period.

Hospital Standardised Mortality Rate (HSMR) October 2017 – September 2018



(Source HED, 2019)

The above chart demonstrates the HSMR position for the reporting period October 2017 - September 2018. The HSMR is currently 111.74 and places the Trust 107 out of 134 Trusts.



	Sep 14	Dec 14	Mar 15	Jun 15	Sep 15	Dec 15	Mar 16	Jun 16	Sep 16	Dec 16	Mar 17	Jun 17	Sep 17	Dec 17	Mar 18	Jun 18	Sep 18
MCHFT HSMR	95.78	93.88	98.67	101.49	104.11	106.17	107.28	110.59	111.61	112.03	114.12	110.02	107.05	109.17	108.3	108.2	111.74
MCHFT RANK	66	50	65	73	86	96	102	119	117	121	123	112	108	111	102	96	107
TOTAL TRUSTS	141	141	137	137	137	136	135	136	136	136	136	134	137	137	134	134	134

(Source HED, 2019)

The above chart demonstrates the HSMR and rank of the Trust over time, up to the latest reporting period.

The month on month changes to the Trust SHMI and HSMR is caused by a number of different factors but mainly driven by natural variation in admissions resulting in death across the whole country. Using these models, the Trust has maintained a mortality rate that is 'within the expected range' for each month and quarterly release.

Learning from Deaths and Improvements

The Trust Learning from Deaths Policy built upon the Mortality Case Note Review Standard Operating Procedure, which outlined the existing embedded process for reviewing all in-hospital deaths.

All in-patient deaths are reviewed on a weekly basis by a team of consultants led by the Lead Consultant for Patient Safety. A short mortality case note review form is completed and if a death is identified where clinical care could potentially have been more appropriate, the case is referred for a Structured Judgement Review.

The Medical Director and Clinical Lead for Patient Safety undertook two sessions to educate a cohort of senior medical and nursing staff on how to undertake the Structured Judgement Review Process.
The clinical conditions that were included within the Structured Judgement Review Process for 2018/19 were agreed by the HMRG in line with national guidance. The clinical conditions selected included:

- Acute Cerebrovascular Accident (at the weekend)
- Pneumonia (at the weekend)
- Intestinal obstruction without hernia
- Alcohol related liver disease
- Infectious diseases (CQC Insight metric)
- All deaths where families, carers or staff raise concerns
- Concerns raised by the Coroner
- Concerns raised at the Patient Safety Summit
- Concerns raised during the Friday mortality screening process
- Relevant elective deaths

The Structured Judgement Review Process commenced in April 2018.

Organisational learning from this process must be dynamic, with immediate actions and improvements undertaken in a timely manner to prevent reoccurrence. Short - medium term improvements identified through organisational learning are introduced through the Trust's governance structure. In the longer term organisational learning will take place through the triangulation and theming of data and information

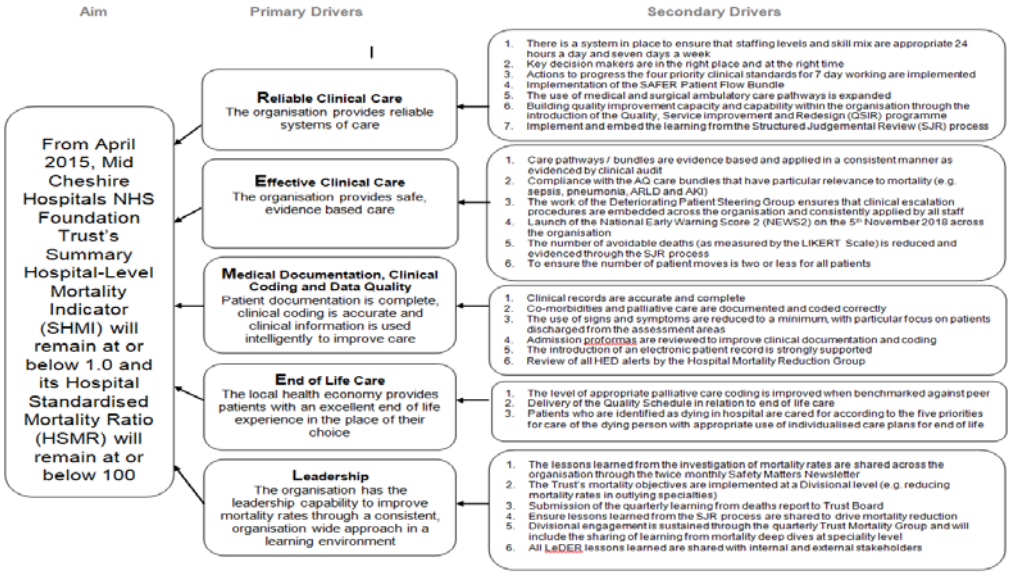
The Divisional Mortality Reduction Groups undertake mortality case note reviews in line with their terms of reference.
The Trust has a well-established Hospital Mortality Reduction Group (HMRG) led by the Medical Director. This group monitors the mortality reduction improvement plans across the Trust. On a quarterly basis the HMRG meets with the divisional mortality reduction groups to ensure a unified approach to mortality reduction across the Trust and to share learning opportunities.

Quarterly deep dives are undertaken to understand the mortality data further. To date deep dives have been completed on the following topics and the detail included in the quarterly Learning from Deaths Report.

- Gynaecology Mortality Rates
- Gastroenterology Mortality Rates
- Palliative Care Mortality Rates
- Paediatrics
- Cardiology

The HMRG developed a reducing hospital mortality rates driver diagram. There are five primary drivers are:

- Reliable Clinical Care
- Effective Clinical Care
- Medical Documentation, Clinical Coding and Data Quality
- End of life Care
- Leadership



The main areas of focus from the driver diagram currently are:

Actions to progress the four priority clinical standards for 7 day working included:

- Submitting data from the March / April 2018 survey centrally.
- Development of a business case for general surgery to support seven day working for presentation at Trust Board
- The NHS England team visited the paediatric department and discussed the process for the robust documentation of time to admission. They also discussed and provided clarity around the exclusion criteria in relation to the 7 day services data submission.
- NHS Improvement published a guidance document on the challenges and solutions for 7 day services. The divisional teams reviewed this to identify any learning to implement locally.

Actions to implement the Structured Judgement Review Process in line with national guidance:

- The Structured Judgement Review Process commenced in April 2018.
- The learning from these reviews has been collated and included in a quarterly newsletter
- A deep dive into the Structured Judgement Review Process has been completed and reported in the quarterly Trust Learning from Deaths Report

Actions to implement learning lessons

- The structure of the twice monthly Patient Safety Summit has been reviewed to include specific sections for each Division to feedback on learning from incident investigations and case note reviews.

Actions to progress the use of care pathways / bundles which are evidence based and applied in a consistent manner, as evidenced by clinical audit and include:

- The Trust re-joined the Advancing Quality (AQ) programme in April 2017 and has signed up for a further year in 2018/19. The four pathways chosen are:
- Sepsis
- Alcohol related liver disease (ARLD)
- Pneumonia
- Acute Kidney Injury (AKI)
- Clinical leads have been identified for each of the pathways and monitoring is undertaken by the Care Pathway Group, reporting to the Quality and Safety Improvement Strategy Group with escalation to the Executive Quality Governance Group and assurances to the Quality Governance Committee

Annex 1 - Statements from commissioners, local Healthwatch organisations and overview and scrutiny committees.

Council of Governors

The Council of Governors (CoG) welcomes the opportunity to comment on the 2018/19 Quality Account for Mid Cheshire NHS Foundation Trust. The council of governors, collectively, is the body that binds a foundation trust to its patients, service users, staff and stakeholders and consists of elected members and appointed individuals who represent members and other stakeholder organisations. As Governors, we receive assurances about the quality and performance of the trust during the year and we are also involved in a range of other events, such as patient safety walkarounds, patient and carer surveys, public meetings, committee meetings and committee observations. All of these activities enable us to scrutinise the quality of care that is being provided and we hear first-hand from staff, patients and carers about the care they receive across all areas of the trust. We also hear through patient stories, staff feedback, reviews of incidents and complaints and reports to Council of the many ways that staff are working to improve quality – all of which reflect the Trust's ongoing commitment deliver the best possible care.

2018/19 was a challenging year for the Trust which, like other healthcare providers, has witnessed increased demand for its services as a result of an ageing population and evolving healthcare needs. In addition, wider social and economic pressures along with system reconfiguration have meant that maintaining high quality, safe care can at times be difficult for any provider of health and social care. Despite these challenges, feedback from patients about the standard of care they received is consistently high (as evidenced in both national and in local surveys) and the actions taken following previous surveys demonstrate that care has improved in some key areas. We were particularly pleased to see the significant improvements achieved in respect of staff helping patients to eat meals (12% improvement on 2017) and in the area of doctor:patient communication. Specific projects aimed at improving delays at discharge, emotional support and the suite of actions in place to enhance the care provided to maternity patients and patients with cancer should also lead to improvements in patient experience and the CoG will be interested to track the impact of these during 2019/20. We were also impressed with the work being done by the Patient Information Group to ensure that the trust meets the information needs of patients and that alternative types of information are provided and also by the Trust's approach to planning for the seven day service, the aim to reduce length of stay and the ways in which patients with a learning disability are supported should they require care/treatment.

The Trust's achievements are recognised not only by the CoG, by staff and by other stakeholders, but also at national level. The three national awards in the areas of surgical ambulatory care, fracture clinics and wound management, along with other projects shortlisted for national awards, reflect the innovative and creative ways in which services are being developed and it is hoped that the learning from these projects can be shared so as to support improvements across the sector. Participation in the national clinical audit programme also evidences the quality of care provided by the trust when compared to other trusts involved in these national programmes. Again the detailed action plans evidence a concern to learn and improve as do the actions taken by the Hospital Mortality Reduction Group to ensure a unified approach to mortality reduction across the Trust and to share learning opportunities. As these actions embed, the CoG would be keen to see the Trusts overall position (currently 88/131) improve - although it is recognised that the current position is in the 'as expected' range.

The pride that staff have in their services and their commitment to delivering high quality care is evident from our patient safety walkarounds, from discussions of patient stories at Board / Council

and in other CoG activities and this is testament both to the motivation of individual staff and also to the quality of leadership at all levels of the organisation. This is reflected in particular by the outcomes from the Friends and Family Test, in the staff survey and was recognised by the CQC in its review of the trust (May 2018) which we were delighted to see rated leadership of the trust as 'good'.

The CoG was delighted that the Trust achieved an *overall* rating of 'Good' following the comprehensive CQC inspection. It was disappointing therefore that the outcome for 'safe' was lowered to 'requires improvement' following the inspection. During their visit, the CQC observed failures to follow infection and control procedures within some clinical areas and they also had concerns regarding the ways in which compliance with infection control procedures were monitored. We recognise that the Trust has implemented an improvement plan in respect of this during 2018/19, progress of which is reported to the local CCGs on a quarterly basis.

The CoG also notes with concern the challenges experienced in year regarding achievement of some of the key indicators within the NHS Improvement Standard Oversight Framework and a decline in the standards relating to MRSA infections and pressure ulcers. Whilst 4/5 indicators within the NHS Improvement Standard Oversight Framework were consistently met, the standard not achieved was the four hour access standard, (nationally known as the A&E Target) which delivered 83.63% in 2018/19. Whilst many trusts across England failed to meet this target, the potential impact for patients and on staff is significant and as such this is an area that governors will continue to focus on during 2019/20. We are also keen to better understand the opportunities across the locality to reduce avoidable admissions and also to ensure staff wellbeing during periods of significant pressure. In addition to our focus on patient and staff experience within A&E, the CoG is keen to see progress on the 9 key priority areas within the Quality and Safety Improvement Strategy (which includes reductions in MRSA and pressure ulcers) and on the actions within the Workforce Matters Strategy. As a CoG we were pleased to see the commitments made within these strategies across Mid Cheshire NHS Foundation Trust and CCICP to supporting staff, reducing harm and on improving patient's experiences of care, and especially patient's experiences of end of life care given the impact of an ageing population both now and in the future.

Throughout the Quality Account key priorities are discussed, data on 2018/19 performance is presented clearly and actions / learning discussed. The commitment 'to deliver excellence in healthcare through innovations and collaboration' is clear and as a CoG we are confident that the 2018/19 Quality Account reflects a fair, representative and balanced overview of the quality of care across MCHFT and CCICP.

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Quality Accounts NHS South Cheshire and NHS Vale Royal CCG Statement – Mid Cheshire Hospitals NHS Foundation Trust

Note this response is written based on an incomplete draft

General Overview

NHS South Cheshire Clinical Commissioning Group (CCG) and NHS Vale Royal Clinical Commissioning Group (CCG) welcome the opportunity to comment on Mid Cheshire Hospitals Foundation Trust (MCHFT) Quality Account 2018/19.

We can confirm that we have reviewed the content of the Quality Account and this reflects a fair, representative and balanced overview of the quality of care in MCHFT and includes the mandatory elements required.

NHS South Cheshire CCG and NHS Vale Royal CCG endorse MCHFT's clear vision 'to deliver excellence in healthcare through innovations and collaboration' which is underpinned by agreed values and behaviours.

The priorities MCHFT identified in the Quality Account continue to build on a strong patient focus, supported by staff values and behaviours which underpin the quality agenda. In particular, we would like to highlight the on-going engagement with partners based on feedback from carers and patients.

Patient and Public Engagement

The CCGs note the continued collaborative approach which includes working with partners, local communities and working relationships relating to the quality of care delivered to patients at MCHFT, examples of which are the Readers Panel and the accessibility of information and leaflets to inform patient experience. We congratulate them on the continued achievements for a significant number of the quality indicators.

It was pleasing to see the involvement of voluntary services in a number of initiatives across the trust which is reflected in the national inpatient survey

Clinical Priorities

MCHFT continues to have a focus on a number of clinical areas to drive quality and safety forward and to improve outcomes for patients. Of particular note is the development of multidisciplinary teams in readiness for the seven day service which is hoped to improve quality outcomes, and the timely & effective delivery of services.

The aim to reduce inpatient moves will improve patient experience and support reduced length of stay. The CCG support the Trust's view that further work is required in 2019/20 to improve this quality measure.

The CCGs acknowledge that MCHFT work hard to ensure that care they provide to people with a Learning Disability is of a high quality and have introduced a number of initiatives to improve access.
The CCGs also recognise the work that the Trust has put into place to implement the 'Learning from Deaths' guidance and the commitment to learn from deaths and improve services.

The Trust has not achieved their targets that the Summary Hospital-Level Mortality Indicator (SHMI) will remain at or below 1.0 or that the Hospital Standardised Mortality Ratio (HSMR) will remain at or below 100. However, the Trust remains in the 'as expected' range for mortality.

Overall, the Trust's delivery of services to support people with cancer is making positive progress driving quality and safety forward – MCHFT remain above the National average in the Public Health England and NHS England Cancer Dashboard, although there has been a slight decrease but overall they remain above the national average.

CQC Inspection

The CCGs congratulate the Trust for the overall rating of 'Good' following the CQC Comprehensive Inspection in May 2018. The CQC is responsible for ensuring health and social care services meet essential standards of quality and safety.

It was therefore disappointing to see that the rating for 'safe' was downgraded to 'requires improvement'.

This is because the CQC observed failures to follow infection and control procedures across wards and areas within urgent and emergency care, maternity care and medicine services. The CQC also found a lack of adequate assurance that there was an effective process for overseeing and monitoring compliance with infection control procedures.

The CCGs recognise that the Trust implemented a comprehensive improvement plan, progress of which has been reported to the contract and quality meetings on a quarterly basis.

However, the CCGs are concerned that there has been an increase in infection control issues within the Trust despite the completion of the CQC improvement plan.

Quality and Safety

It is disappointing to note that there has been an increase in a number of areas relating to safety:

1. Following a long period without MRSA Bacteraemia infections, the Trust has reported four cases in the last quarter. In line with national guidance of acute trusts to have zero tolerance of MRSA bacteraemia, the CCGs have taken contractual action to support the Trust to learn from these outbreaks and to ensure safe care for patients.

   MCHFT has identified learning for all four cases and has developed comprehensive improvement plans for implementation across the Trust and workforce. The Trust has continued to take responsibility and be accountable for continuous quality improvement in relation to infection prevention and control, and this is reflected in the Quality Account.

2. The CCG acknowledge that the Trust has been working to reduce the incidence of serious harm. This has resulted in a target to reduce the numbers of Serious Incidents (SI). The CCGs have worked with the Trust to highlight that numbers of SIs alone should not be a performance target. This is to encourage the reporting of incidents and a robust learning culture.

3. Despite a target to reduce the numbers of pressure ulcers, the Trust has seen an increase in the number of hospital acquired and community acquired pressure ulcers.

   The CCGs recognise and acknowledge the positive work that has been undertaken to date which is described in the Quality Account.

   The CCGs have raised with the Trust that in line with the NHS Improvement Pressure Ulcer Guidance 2018, the new definitions of Pressure Ulcers should be used and the language of 'avoidable' and 'unavoidable' should not be used.

   MCHFT and the Central Cheshire Integrated Partnership (CCICP) have committed to work with the CCG and local partners and we look forward to working together in 2019/20 to improve the occurrence of pressure ulcers across the health economy.

The CCGs would like to recognise the following:

1. The Trust participation in a Health Economy approach to reduce Gram negative bacteraemia infections, specifically ECOLI. This group is led by the CCGs and MCHFT has contributed significantly to the analysis of data, this has enabled the multi-agency steering group to

identify an improvement plan which has resulted in a reduction of infections in this health economy.

2. The positive work to reduce the numbers of inpatient falls which has seen a slight reduction since 2015.

3. The work to recognise the deteriorating patient and improve screening and treatment for Sepsis, which the Trust has also acknowledged in their Celebration of Achievement Awards.

4. The CCGs note that there was one Never Event in 2018, however the Trust has demonstrated an open and honest approach and a robust learning culture in its management of the case.

As commissioners of the services, the CCGs support the work of MCHFT and the on-going commitment to continue to improve the quality and safety of all of their services. We look forward to working with the Trust as they work towards their priorities for 2019-20.

Healthwatch Cheshire CIC Response to Quality Account 2018/19

We recognise that there have been significant challenges for the Trust during 2018/2019 and value the relationship that Healthwatch Cheshire CIC and the Trust have, as noted in this document. We have noted and welcome the extensive use of patient surveys. The improvement in the National Inpatient Survey for 2018 compared to 2017 and the large increase in compliments received by the Trust is to be commended.

We look forward to continue working with the Trust during 2019-2020 to enable our community to have a powerful voice helping to shape and improve these services for the future".

Healthwatch Cheshire CIC
April 2019

Annex 2 - Statement of Directors' responsibilities for the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation Trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation Trust boards should put in place to support the data quality for the preparation of the quality report.

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

- the content of the Quality Report meets the requirements set out in the NHS foundation Trust annual reporting manual 2018/19 and supporting guidance detailed requirements for quality reports 2018/19

- the content of the Quality Report is not inconsistent with internal and external sources of information including:

    - board minutes and papers reported to the board over the period 1 April 2018 to 31 March 2019
    - papers relating to the quality reported to the board over the period 1 April 2018 to 31 March 2019
    - feedback from commissioners dated 09.04.18
    - feedback from governors dated 25.04.19
    - feedback from local Healthwatch organisations dated 11.04.19
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 20.06.19
    - the (latest) national patient survey 01.07.2018-31.07.8
    - the (latest) national staff survey 01.04.19
    - the Head of Internal Audit's annual opinion of the Trust's control environment dated 15.05.2018
    - CQC report relating to inspection dated 20.03.18 – 10.05.18

- the Quality Report presents a balanced picture of the NHS foundation Trust's performance over the period covered

- the performance information reported in the Quality Report is reliable and accurate

- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, 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 Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and

- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts

regulations) as well as the standards to support data quality for the preparation of the Quality report.

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

By order of the board

……Date……Chairman

……Date……Chief Executive

Appendix 1 - Glossary and abbreviations

Terms	Abbreviation	Description
Acute Kidney Injury	AKI	A sudden episode of kidney failure or kidney damage that happens within a few hours or a few days. AKI causes a build-up of waste products in the blood, making it hard for the kidneys to keep the right balance of fluid in the body.
Advancing Quality	AQ	A programme which rewards hospitals which improve care in a number of key areas – heart attacks, pneumonia, hip and knee replacements, heart failure and heart bypass surgery – when compared to research which identifies what best care constitutes.
Advancing Quality Alliance	AQuA	A north west NHS health and care quality improvement organisation.
Antimicrobial resistance & stewardship		A coordinated program that promotes the appropriate use of antimicrobials, improves patient outcomes, reduces microbial resistance and decreases the spread of infections caused by multidrug-resistant organisms.
Board (of Trust)		The role of Trust's board is to take corporate responsibility for the organisation's strategies and actions. The chair and non-executive directors are lay people drawn from the local community and are accountable to the Secretary of State. The chief executive is responsible for ensuring that the board is empowered to govern the organisation and to deliver its objectives.
Care Quality Commission	CQC	The independent regulator of health and social care in England. Its aim is to make sure better care is provided for everyone, whether in hospital, in care homes, in people's own homes, or elsewhere.
Central Cheshire Integrated Care Partnership	CCICP	A collaboration between Mid Cheshire Hospital Foundation NHS Trust and the South Cheshire and Vale Royal GP Alliance.
Clinical Commissioning Group	CCG	This is the GP led commissioning body who buy services from providers of care such as the hospital.
Clostridium Difficile	C-diff	A naturally occurring bacterium that does not cause any problems in healthy people. However, some antibiotics that are used to treat other health conditions can interfere with the balance of 'good' bacteria in the gut. When this happens, C-diff bacteria can multiply and cause symptoms such as diarrhoea and fever.
Commissioner		A person or body who buy services.

Terms	Abbreviation	Description
Commissioning for Quality and Innovations	CQUIN	CQUIN is a payment framework developed to ensure that a proportion of a providers' income is determined by their work towards quality and innovation.
Deprivation of Liberty Safeguards	DOLs	The Mental Capacity Act allows restraint and restrictions to be used but only in a person's best interest. Extra safeguards are needed if the restrictions and restraints used will deprive a person of their liberty. These are called the Deprivation of Liberty Safeguards.
Duty of Candour		A legal duty to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. It aims to help patients receive accurate truthful information from health providers.
Endoscopy		A nonsurgical procedure used to examine a person's digestive tract using an endoscope – a flexible tube with a light and camera attached to it.
Health Service Ombudsman		The role of the Health Service Ombudsman is to provide a service to the public by undertaking independent investigations into complaints where the NHS in England have not acted properly or fairly or have provided a poor service.
Hospital Evaluation Data	HED	This is an on-line solution delivering information which enables healthcare organisations to drive clinical performance in order to improve patient care and deliver financial savings
Intrahepatic Cholestasis		A condition that impairs the release of a digestive fluid called bile from liver cells. As a result, bile builds up in the liver, impairing liver function.
John's campaign		A campaign for extended visiting rights for family carers of patients with dementia in hospital.
Methicillin-Resistant Staphylococcus Aureus	MRSA	Staphylococcus aureus is a bacterium which is often found on the skin and in the nose of about 3 in 10 healthy people. An infection occurs when the bacterium enters the body through a break in the skin. A strain of this bacterium has become resistant to antibiotic treatment and this is often referred to as MRSA.
National Joint Registry		Set up by the Department of Health and Welsh Government in 2002 to collect information on all hip, knee, ankle, elbow and shoulder replacement operations and to monitor the performance of joint replacement implants and effectiveness of different types of surgery.

Terms	Abbreviation	Description
National Patient Surveys		Co-ordinated by the CQC, they gather feedback from patients on different aspects of their experience of care they have recently received, across a variety of services/settings: Inpatients, Outpatients, Emergency care, Maternity care, Mental Health services, Primary Care services and Ambulance services.
National Safety Standards for Invasive Procedures	NatSSIPs	A set of national safety standards to support NHS hospitals to provide safer surgical care.
Nephrotoxic		Damage to the kidneys
Never Event		Serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented.
Oncology		The study of cancer. An oncologist manages a person's care and treatment once he/she is diagnosed with cancer.
Patient Reported Outcome Measures	PROMs	A programme in which patients complete a questionnaire on their health before and after their operation. The results of the two questionnaires can be compared to see if the operation has improved the health of the patient. Any improvement is measured from the patient's perspective as opposed to the clinicians.
Percutaneous Nephrolithotomy		A minimally invasive procedure to remove stones from the kidney by a small puncture wound through the skin.
Preceptorship		A period transition for newly qualified nurses during which time they are supported by a mentor.
Quality Account		This is a statutory annual report of quality which provides assurance to external bodies that the Trust Board has assessed quality across the totality of services and is driving continuous improvement.
Re-admission Rates		A measure to compare hospitals which looks at the rate at which patients need to be readmitted to hospital after being discharged (leaving hospital).
Sepsis		A life threatening condition that arises when the body's response to an infection injuries its own tissue and organs.
Sign up to Safety		A national initiative to help NHS organisations and their staff achieve their patient safety aspirations and care for their patients in the safest possible way.

Terms	Abbreviation	Description
Sigmoidoscopy		A minimally invasive medical examination of the large intestine from the rectum using an instrument called a sigmoidoscope.
Submucosal tie		The posterior tongue-tie, hidden under the mucus lining of the tongue/mouth.
Summary Hospital level Mortality Indicator	SHMI	SHMI is a hospital level indicator which measures whether mortality associated with hospitalisation was in line with expectations. The SHMI value is the ratio of observed deaths in a Trust over a period of time divided by the expected number given the characteristics of patients treated by that Trust Depending on the SHMI value, Trusts are banded between 1 and 3 to indicate whether their SHMI is low (3), average (2) or high (1) compared to other Trusts. SHMI is not an absolute measure of quality. However, it is a useful indicator for supporting organisations to ensure they properly understand their mortality rates across each and every service line they provide.
To Take Out	TTO	Medication given to patient on discharge from hospital.
Venous Thrombo-Embolism	VTE	This is a blood clot which can develop when a person may not be as mobile as they are usually or following surgery. The blood clot itself is not usually life threatening, but if it comes loose it can be carried in the blood to another part of the body where it can cause problems – this is called a Venous Thromboembolism (VTE).
Workforce Race Equality Standards		Standards to ensure the Trust addresses race equality issues.

Appendix 2 - Feedback form

We hope you have found this Quality Account useful. To save costs, the report is available on our website and hard copies are available on request.

We would be grateful if you would take the time to complete this feedback form and return it to:
Clinical Quality and Outcomes Matron
Mid Cheshire Hospitals NHS Foundation Trust
Leighton Hospital
Middlewich Road
Crewe
Cheshire
CW1 4QJ
Email: quality.accounts@mcht.nhs.uk

How useful did you find this report?

Very useful □
Quite useful □
Not very useful □

Did you find the contents?

Too simplistic □
About right □
Too complicated □

Is the presentation of data clearly labelled?

Yes, completely □
Yes, to some extent □
No □

If no, what would have helped?

_____
_____

Is there anything in this report you found particularly useful / not useful?

_____
_____
_____

Independent auditor's report to the Council of Governors of Mid Cheshire Hospitals NHS Foundation Trust on the quality report

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NHS Eastern Cheshire Clinical Commissioning Group

NHS South Cheshire Clinical Commissioning Group

Health and Adult Social Care and Communities Overview and Scrutiny Committee

Date of Meeting: 13 June 2019

Report of:
Dean Grice (Primary Care Commissioning Manager, NHS Eastern Cheshire Clinical Commissioning Group)
Amanda Best (Service Delivery Manager, NHS South Cheshire Clinical Commissioning Group)

Subject/Title: Implementation of the Extended Access Service as part of the NHS Improved Access to General Practice Programme

1. Report Summary

1.1. A growing national population combined with an ageing population has resulted in increasing demands on general practice over recent years. In addition to a heavier workload, GPs are seeing increasing complexity and intensity of work. This has led to national recognition that patient access capacity to general practice needs to be improved.

1.2. Extended Access in South Cheshire CCG went live from July 2015 as part of a government sponsored pilot GP Access Fund.

1.3. Extended Access in Eastern Cheshire CCG went live from October 2018 as part of the General Practice Forward View Improved Access programme of work.

1.4. The Extended Access services provide a minimum additional 30 minutes per week consultation capacity per 1000 population.

1.5. The Extended Access services provide this additional General Practice appointment capacity outside of core hours of 08:00-18:30 Monday to Friday, with additional appointments available weekday evenings and at weekends.

1.6. A mixture of general practice appointment types are offered as part of the services. These include appointments with GPs, Advanced Nurse Practitioners, Practice Nurses, Health Care Assistants, Physician Associates, Clinical Pharmacists, and Phlebotomists.

1.7. Utilisation of the Extended Access appointments is currently 97% in South Cheshire and 83% in Eastern Cheshire, with the difference in uptake attributable to the maturity of each service. Both services are now providing much needed additional General Practice appointment capacity for Cheshire East residents.

1.8. Both CCGs continue to work closely with the service providers to monitor, refine and improve the Extended Access service for NHS patients residing within Cheshire East. Ongoing work with the Eastern Cheshire GP practices continues, to further increase awareness and utilisation of the Extended Access service.

2. Recommendations

2.1. The committee is asked to note the implementation of the Extended Access Service as part of the NHS Improved Access to General Practice Programme across the two Cheshire East CCGs resulting in improved access to general practice for residents of Cheshire East.

3. Background

3.1. Public satisfaction with general practice remains high, but in recent years patients have increasingly reported, through the GP Patient Survey, more difficulty in accessing services including a decline nationally in good overall experience of making an appointment in general practice. It is noted that according to the July 2018 GP Patient Survey published findings, 74% of respondents in Eastern Cheshire CCG and 69% of respondents in South Cheshire CCG said they had a good experience of making an appointment compared to the national average of 69%.

3.2. In October 2013, the Prime Minister announced a new £50 million Challenge Fund to help improve access to general practice and stimulate innovative ways of providing primary care services. In April 2014 twenty pilot sites were selected to participate in the Challenge Fund, covering 1,100 general practices and 7.5 million patients. Each scheme chose its own specific objectives, innovations and ways of organising services. Further funding of £100 million was announced by the Prime Minister in September 2014 for a second wave, known as the GP Access Fund. This second wave of 37 schemes was announced in April 2015.

3.3. South Cheshire CCG was part of a successful GP Access Fund bid, with a scheme that aimed to deliver five interlinked elements of service for nearly 224,000 patients across 23 practices and four localities in South Cheshire and Vale Royal with an aim of delivering extended opening and improved access through existing practices, existing staff, with minimum spend.

3.4. Extended Access in South Cheshire CCG went live initially in July 2015, with the remaining practices offering this service going live in September 2015, with the service offering additional general practice appointments between 07:00-20:00 on Mondays to Fridays, 09:00-14:00 Saturdays and 10:00-14:00 on Sundays, creating additional appointment capacity for Cheshire East residents registered with a GP Practice in the South Cheshire CCG area.

3.5. In April 2016, following a national review of the Challenge Fund and GP Access Fund pilot sites, NHS England published the General Practice Forward View, setting out plans to enable all CCGs to commission and fund additional general practice to ensure that by 2020 everyone has improved

access to general practice services. This was achieved nationally by the end of 2018-19.

3.6. NHS funding was made available to the Eastern Cheshire CCG in April 2018, enabling the CCG to implement an Extended Access service from October 2018.

4. Core National Extended Access Requirements

There are seven core national requirements required for Extended Access. These are:

4.1. Timing of appointments

- Commissioning of weekday provision of access to pre-bookable and same day appointments to general practice services in evenings (after 18:30) – to provide a minimum additional 1.5 hours a day,
- Commissioning of weekend provision of access to pre-bookable and same day appointments on both Saturdays and Sundays to meet local population needs.

4.2. Capacity

- Commissioning of a minimum additional 30 minutes per week consultation capacity per 1000 population.

4.3. Measurement

- Use of nationally commissioned tools, as they become available, to automatically measure appointment activity, both in-hours and in extended hours, to enable improvements in matching capacity to times of high demand.

4.4. Advertising and ease of access

- Ensuring that services are advertised to patients,
- Ensuring ease of access for patients including:
    - All practice receptionists able to direct patients to the service and offer appointments to extended hours service on the same basis as appointments to non-extended hours services
    - Patients offered a choice of evening or weekend appointments on an equal footing to core hours appointments.

4.5. Digital

- Use of digital approaches, as they become available, to support new models of care in general practice.

4.6. Inequalities

- Issues of inequalities in patients' experience of accessing general practice identified by local evidence and actions to resolve put in place.

4.7. Effective access to wider whole system services

- Facilitation of effective patient connection to other system services enabling patients to receive the right care from the right professional, including access from and to other primary care and general practice services such as urgent care services.

5. Implementation and Performance in South Cheshire CCG

5.1. The commissioned service started July 2015, with the South Cheshire & Vale Royal GP Alliance leading and supporting the South Cheshire GP practices to provide a service to 100% of the patient population within the CCG area.

5.2. The commissioned service provides an additional minimum of 30 minutes per week per 1,000 population, equating to an additional 94 hours per week, based on a South Cheshire registered population of 188,595. Service provision regularly exceeds the commissioned hours requirement in South Cheshire.

5.3. GP Practices within the three Care Community footprints of South Cheshire provide the Extended Access service to allow a greater number of patients to access general practice services in South Cheshire outside of existing core hours of 08:00-18:30 on Mondays to Thursdays, e.g. early morning and evening appointments.

5.4. South Cheshire GP Practices have formed a GP Hub at the Gresty Brook Surgery in Crewe, providing a centralised weekend service - 09:00-14:00 on Saturdays and 10:00-14:00 on Sundays.

5.5. A mixture of general practice appointment types are offered as part of the service. These include appointments with GPs, Advanced Nurse Practitioners, Practice Nurses, Health Care Assistants, Clinical Pharmacists, and Phlebotomists. It is noted that approximately 75% of the appointments available via the Extended Access service are GP appointments.

5.6. Patients are able to book Extended Access appointments via their own GP practice, with patients encouraged to contact their own GP practice to facilitate the patient obtaining the best available appointment from across core and Extended Access service provision. Appointment booking via NHS 111 has been piloted in the South Cheshire CCG area, aiding future national role out of this additional access route for patients.

5.7. Current utilisation of the Extended Access appointments in South Cheshire is 97%.

6. Implementation and Performance in Eastern Cheshire CCG

6.1. The commissioned service started 01 October 2018, with the local Eastern Cheshire GP Federation (Vernova Healthcare CIC) leading and supporting the Eastern Cheshire GP practices to provide a service to 100% of the patient population within the CCG area.

6.2. The commissioned service provides an additional minimum of 30 minutes per week per 1,000 population, equating to an additional 105 hours per week, based on an Eastern Cheshire registered population of 209,638.

6.3. GP Practices within the five Care Community footprints of Eastern Cheshire provide the Extended Access service to allow a greater number of patients to access general practice services in Eastern Cheshire outside of existing core

hours of 08:00-18:30 on Mondays to Thursdays, e.g. early morning and evening appointments.

6.4. Vernova Healthcare CIC provides a centralised service between 18:30-20:00 on Mondays to Fridays, based out of the Waters Green Medical Centre in Macclesfield.

6.5. Vernova Healthcare CIC provides a centralised service between 09:00-12:00 on Saturdays, and between 10:00-12:00 on Sundays, based out of the Waters Green Medical Centre in Macclesfield.

6.6. A mixture of general practice appointment types are offered as part of the service. These include appointments with GPs, Advanced Nurse Practitioners, Practice Nurses, Health Care Assistants, Physician Associates, Clinical Pharmacists, and Phlebotomists. It is noted that approximately 65% of the appointments available via the Extended Access service are GP appointments.

6.7. Patients are able to book Extended Access appointments via their own GP practice, with patients encouraged to contact their own GP practice to facilitate the patient obtaining the best available appointment from across core and Extended Access service provision. Appointment booking via Vernova Healthcare CIC is also available during Extended Access service provision hours.

6.8. Current utilisation of the Extended Access appointments in Eastern Cheshire is 83%.

7. Next Steps

7.1. Both CCGs continue to work closely with the service providers to monitor, refine and improve the Extended Access service for NHS patients residing within Cheshire East. Ongoing work with the Eastern Cheshire GP practices continues, to further increase awareness and utilisation of the Extended Access service.

7.2. Additional types of Extended Access appointment types are being looked at with the aim of providing services based on local need, e.g.

- Weekend appointments with primary care physiotherapists
- Monthly weekend cervical smear clinics
- Monthly weekend childhood immunisation clinics

7.3. Further service improvements are being reviewed regarding the ability of patients to be able to directly book Extended Access appointments online in the same way as they have access to core hour appointments. Technology barriers within the existing clinical systems need to be overcome nationally in order for the CCGs to progress this functionality.

7.4. General Practice is now commissioned to work at scale within defined local GP Networks. From April 2021, funding for the Extended Access service will be passed directly to GP Networks, with the Extended Access service

requirements becoming a core requirement of the national GP Network enhanced service. The CCGs do not foresee this realignment having any significant impact on the provision of the service, however it will allow for optimisation with existing historic extended hour enhanced services, allowing for a simpler commissioning model but with no reduction in the existing levels of service provision.

End of paper

FORWARD PLAN FOR THE PERIOD ENDING 30TH SEPTEMBER 2019

This Plan sets out the key decisions which the Executive expects to take over the period indicated above. The Plan is rolled forward every month. A key decision is defined in the Council's Constitution as:

> "an executive decision which is likely –
>
> (a) to result in the local authority incurring expenditure which is, or the making of savings which are, significant having regard to the local authority's budget for the service or function to which the decision relates; or
>
> (b) to be significant in terms of its effects on communities living or working in an area comprising one or more wards or electoral divisions in the area of the local authority.
>
> *For the purpose of the above, savings or expenditure are "significant" if they are equal to or greater than £1M."*

Reports relevant to key decisions, and any listed background documents, may be viewed at any of the Council's Offices/Information Centres 5 days before the decision is to be made. Copies of, or extracts from, these documents may be obtained on the payment of a reasonable fee from the following address:

Democratic Services Team
Cheshire East Council
c/o Westfields, Middlewich Road, Sandbach Cheshire CW11 1HZ
Telephone: 01270 686472

However, it is not possible to make available for viewing or to supply copies of reports or documents the publication of which is restricted due to confidentiality of the information contained.

A record of each key decision is published within 6 days of it having been made. This is open for public inspection on the Council's Website, at Council Information Centres and at Council Offices.

This Forward Plan also provides notice that the Cabinet, or a Portfolio Holder, may decide to take a decision in private, that is, with the public and press excluded from the meeting. In accordance with the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012, 28 clear days' notice must be given of any decision to be taken in private by the Cabinet or a Portfolio Holder, with provision for the public to make representations as to why the decision should be taken in public. In such cases, Members of the Council and the public may make representations in writing to the Democratic Services Team Manager using the contact details below. A further notice of intention to hold the meeting in private must then be published 5 clear days before the

meeting, setting out any representations received about why the meeting should be held in public, together with a response from the Leader and the Cabinet.

The list of decisions in this Forward Plan indicates whether a decision is to be taken in private, with the reason category for the decision being taken in private being drawn from the list overleaf:

1. Information relating to an individual
2. Information which is likely to reveal the identity of an individual
3. Information relating to the financial or business affairs of any particular person (including to authority holding that information)
4. Information relating to any consultations or negotiations, or contemplated consultations or negotiations, in connection with any labour relations matter arising between the authority or a Minister of the Crown and employees of, or office holders under the authority
5. Information in respect of which a claim to legal and professional privilege could be maintained in legal proceedings
6. Information which reveals that the authority proposes (a) to give under any enactment a notice under or by virtue of which requirements are imposed on a person; or (b) to make an order or direction under any enactment
7. Information relating to any action taken or to be taken in connection with the prevention, investigation of prosecution of crime

If you would like to make representations about any decision to be conducted in private at a meeting, please email:

Paul Mountford, Executive Democratic Services Officer
paul.mountford@cheshireeast.gov.uk

Such representations must be received at least 10 clear working days before the date of the Cabinet or Portfolio Holder meeting concerned.

Where it has not been possible to meet the 28 clear day rule for publication of notice of a key decision or intention to meet in private, the relevant notices will be published as soon as possible in accordance with the requirements of the Constitution.

The law and the Council's Constitution provide for urgent key decisions to be made. Any decision made in this way will be published in the same way.

Forward Plan

Key Decision and Private Non-Key Decision	Decisions to be Taken	Decision Maker	Expected Date of Decision	Proposed Consultation	How to make representation to the decision made	Private/ Confidential and paragraph number
CE 18/19-51 ASDV Programme Update	To authorise officers to take all necessary actions to implement the recommendations made in the ASDV Review report approved by Cabinet on 12th March 2019.	Portfolio Holder for Planning	May 2019			Fully exempt - paras 3 & 4
CE 18/19-49 Crewe Hub Station	To take all necessary actions to progress the Crewe Hub, including land acquisition and preparation of an evidence base for an Enterprise Zone.	Cabinet	11 Jun 2019			N/A
CE 18/19-57 Re-Procurement of Food Contracts for Fresh Meat	To seek approval for the re-procurement of fresh meat and poultry products and to authorise the Executive Director of People in consultation with the Portfolio Holder for Children and Families to award contracts following evaluation. The new contract term will run from October 2019 for two years, with an option to extend.	Cabinet	11 Jun 2019		Mark Bayley, Head of Service for Education Infrastructure and Outcomes	N/A

Key Decision	Decisions to be Taken	Decision Maker	Expected Date of Decision	Proposed Consultation	How to make representation to the decision made	Private/ Confidential and paragraph number
CE 18/19-58 Malbank School and Sixth Form College - Authority to Enter into a Contract	To seek approval to delegate to the Executive Director People authority to enter into a construction contract for additional places at Malbank School, Nantwich.	Cabinet	11 Jun 2019		Mark Bayley, Head of Service for Education Infrastructure and Outcomes	N/A
CE 18/19-59 Tatton Vision 2 - Arrival and Stableyard	To seek delegated authority for the Executive Director Place, in consultation with the Portfolio Holder for Environment, to implement the Arrival and Stableyard project at Tatton Park, including procuring and entering into all necessary contractual arrangements.	Cabinet	11 Jun 2019		Brendan Flanagan, Head of Rural and Cultural Economy	N/A
CE 18/19-61 Cheshire and Warrington LEP Urban Development Fund	To take all necessary actions to progress the Urban Development Fund, including the creation of the structures and governance to allow the fund to commence.	Cabinet	11 Jun 2019		Aaron Lecroy	N/A
CE 18/19-63 ASDV Directorships	To consider a report in relation to ASDV Directorships.	Cabinet	11 Jun 2019		Frank Jordan, Acting Deputy Chief Executive and Executive Director of Place	Fully exempt by virtue of Exemption para 3

Key Decision	Decisions to be Taken	Decision Maker	Expected Date of Decision	Proposed Consultation	How to make representation to the decision made	Private/ Confidential and paragraph number
CE 18/19-65 SMDA Infrastructure Procurement Strategy	In accordance with the authority delegated by Cabinet to the Executive Director of Place on 8th May 2018: To procure the infrastructure, utilities and ground stabilisation works at South Macclesfield Development Area; to enter into any contracts or agreements required under the SCAPE Civil Engineering and Infrastructure Framework; and to utilise an NEC ECC Type C construction contract with Early Contractor Involvement.	Executive Director Place	Not before 12th Jun 2019			N/A

Key Decision	Decisions to be Taken	Decision Maker	Expected Date of Decision	Proposed Consultation	How to make representation to the decision made	Private/ Confidential and paragraph number
CE 18/19-66 SMDA Infrastructure and Funding Agreement	In accordance with the authority delegated by Cabinet to the Executive Director of Place on 8th May 2018: To enter into a funding agreement (infrastructure agreement) with the principal landowner in respect of the Council's landholding at South Macclesfield Development Area.	Executive Director Place	Not before 12th Jun 2019			Partly exempt by virtue of paras 3 and 5.

Key Decision	Decisions to be Taken	Decision Maker	Expected Date of Decision	Proposed Consultation	How to make representation to the decision made	Private/ Confidential and paragraph number
CE 18/19-69 Acquisition of the Willows, Macclesfield	In accordance with Chapter 2, Part 6, Paragraph 52 of the constitution of Cheshire East Borough Council dated 12th February 2019: To approve the acquisition of the property known as The Willows, Macclesfield, Cheshire SK11 8LF and to instruct the Council's Legal Officers to proceed to legal completion of the purchase and any related legal documentation on terms and conditions to be determined by the Assets Manager and the Director of Governance and Compliance.	Executive Director Place	Not before 19th Jun 2019			Fully exempt under para 3

Key Decision	Decisions to be Taken	Decision Maker	Expected Date of Decision	Proposed Consultation	How to make representation to the decision made	Private/ Confidential and paragraph number
CE 18/19-50 Environment Strategy	To seek approval for the draft Environment Strategy and agreement that a borough wide public consultation takes place seeking views on the draft Environmental Strategy, with the decision on all final consultation materials being delegated to the Executive Director of Place. The outcomes of the consultation and any resultant changes to the draft strategy will be reported to and approved by Cabinet in due course.	Cabinet	9 Jul 2019		Paul Bayley	
CE 18/19-52 Cheshire East Economic Strategy	To approve the draft economic strategy for public consultation. The outcome of the consultation will be reported to Cabinet in due course.	Cabinet	9 Jul 2019			N/A

Key Decision	Decisions to be Taken	Decision Maker	Expected Date of Decision	Proposed Consultation	How to make representation to the decision made	Private/ Confidential and paragraph number
CE 18/19-53 Site Allocations and Development Policies Document - Public Consultation	To seek approval to publish a Publication Draft of the Cheshire East Site Allocations and Development Policies Document, along with its supporting evidence, for a further six weeks' public consultation.	Cabinet	9 Jul 2019		Jeremy Owens	N/A
CE 18/19-55 Sandbach School - Authority to Enter into a Grant Agreement	To seek approval to delegate authority to the Executive Director People to authorise the entering into of a grant agreement to facilitate the creation of additional pupil places at Sandbach School.	Cabinet	9 Jul 2019		Jacky Forster, Director of Education and 14-19 Skills	N/A
CE 18/19-56 Proposed Expansion of Park Lane School, Macclesfield	To approve the proposed expansion of Park Lane School, Macclesfield from 82 places to 122 places for implementation in September 2020, having given due consideration to the response to the statutory proposal notice.	Cabinet	9 Jul 2019		Jacky Forster, Director of Education and 14-19 Skills	N/A

Key Decision	Decisions to be Taken	Decision Maker	Expected Date of Decision	Proposed Consultation	How to make representation to the decision made	Private/ Confidential and paragraph number
CE 18/19-62 Next Generation WAN Contract	To authorise the officers to take all necessary steps to enter into a contract with a new Wide Area Network supplier for up to 10 years and maximum value of £25M. The current contract ends on 21st February 2021.	Cabinet	9 Jul 2019		Gareth Pawlett, ICT Manager	N/A
CE 19/20-1 A500 Dualling - CPO Powers to Acquire Land	To authorise the use of compulsory purchase powers to undertake the acquisition of land and new rights required for the construction of the scheme.	Cabinet	9 Jul 2019		Chris Hindle	N/A
CE 19/20-2 Middlewich Eastern Bypass - CPO Powers to Acquire Land	To authorise the use of compulsory purchase powers to undertake the acquisition of land and new rights required for the construction of the scheme.	Cabinet	9 Jul 2019		Chris Hindle	N/A

Key Decision	Decisions to be Taken	Decision Maker	Expected Date of Decision	Proposed Consultation	How to make representation to the decision made	Private/ Confidential and paragraph number
CE 18/19-44 Local Transport Plan	Cheshire East Council as the Local Transport Authority has a duty to produce, and keep under review, a Local Transport Plan (LTP) in accordance with the Local Transport Act 2008. Council will be asked to approve the LTP for adoption following consideration by Cabinet.	Council	18 Jul 2019		Richard Hibbert	N/A
CE 18/19-64 Framework for Domestic Repairs and Adaptations	To approve the establishment of a framework to commission low value domestic repairs and adaptations on behalf of vulnerable residents, and to authorise the Executive Director Place in consultation with the Portfolio Holder for Housing, Planning and Regeneration to award and enter into a framework.	Cabinet	10 Sep 2019		Karen Whitehead	N/A

Key Decision	Decisions to be Taken	Decision Maker	Expected Date of Decision	Proposed Consultation	How to make representation to the decision made	Private/ Confidential and paragraph number
CE 18/19-67 Macclesfield Town Centre Regeneration - Strategic Regeneration Framework and Future Programme	Taking into account the outcome of a public consultation on a draft Strategic Regeneration Framework for Macclesfield Town Centre, to approve a final version of the Framework and agree further actions stemming from its recommendations.	Cabinet	10 Sep 2019		Jo Wise	N/A
CE 18/19-54 Crewe Station Hub Area Action Plan - Public Consultation	To seek approval for a further six week consultation period on the Crewe Station Hub Area Action Plan.	Cabinet	8 Oct 2019		Adrian Fisher, Head of Planning Strategy	N/A
CE 18/19-60 The Minerals and Waste Development Plan	To seek approval to consult on the first draft of the Minerals and Waste Development Plan.	Portfolio Holder for Planning	November 2019		Adrian Fisher, Head of Planning Strategy	N/A
CE 18/19-68 Medium Term Financial Strategy 2020-24	To approve the Medium Term Financial Strategy for 2020-24, incorporating the Council's priorities, budget, policy proposals and capital programme. The report will also include the capital, treasury management, investment and reserves strategies.	Council	20 Feb 2020		Alex Thompson, Head of Finance and Performance and Interim Section 151 Officer	N/A

Key Decision	Decisions to be Taken	Decision Maker	Expected Date of Decision	Proposed Consultation	How to make representation to the decision made	Private/ Confidential and paragraph number

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Cheshire East Council

Working for a brighter future together

Version Number: 1

Health and Adult Social Care and Communities Overview and Scrutiny Committee

Date of Meeting: 13 June 2019

Report Title: Work Programme

Portfolio Holder: Councillor L Jeuda – Portfolio Holder for Adult Social Care and Health

Councillor J Rhodes – Portfolio Holder for Public Health and Corporate Services

Councillor M Warren – Portfolio Holder for Communities

Senior Officer: Interim Executive Director of Corporate Services

1. Report Summary

1.1. To review items in the work programme listed in the schedule attached, together with any other items suggested by committee members.

2. Recommendation

2.1. That the work programme be approved, subject to agreement from the committee to add new items or delete items that no longer require any scrutiny activity.

3. Reason for Recommendation

3.1. It is good practice to regularly review the work programme and update it as required.

4. Other Options Considered

4.1. N/A.

5. Background

5.1. The committee has responsibility for updating and approving its own work programme. Scrutiny liaison meetings – held between the Chairman and Vice-Chairman of the committee, alongside the portfolio holders and key senior officers – ensure that portfolio holders and officers keep the committee abreast of upcoming policies, strategies and decisions.

5.2. The schedule attached was most recently approved by the previous membership of the committee on 11 April 2019. It was updated following a scrutiny liaison meeting held on 30 May 2019.

5.3. To review items in the work programme listed in the schedule attached, together with any other items suggested by committee members.

5.4. When selecting potential topics, members should have regard to the Council's three year plan and to the criteria listed below, which should be considered to determine whether scrutiny activity is appropriate.

5.5. The following questions should be considered by the committee when determining whether to add new work programme items, or delete existing items:

- Does the issue fall within a corporate priority?
- Is the issue of key interest to the public?
- Does the matter relate to a poor or declining performing service for which there is no obvious explanation?
- Is there a pattern of budgetary overspends or underspends?
- Is it a matter raised by external audit management letters and or audit reports?
- Is there a high level of dissatisfaction with the service?

5.6. The committee should not add any items to its work programme (and should delete any existing items) that fall under any one of the following:

- The topic is already being addressed elsewhere by another body (i.e. this committee would be duplicating work)
- The matter is sub-judice
- Scrutiny would not add value to the matter
- The committee is unlikely to be able to conclude an investigation within a specified or required timescale

6. Medium Term Financial Strategy

6.1. At the suggestion of the council's Corporate Leadership Team, the council's Medium Term Financial Strategy 2019-22 will be used as an additional tool to support the forward planning and work programming of matters by the four overview and scrutiny committees.

6.2. Published alongside this covering report and the work programme itself are the areas of planned work within the corporate priorities related to this committee's remit

7. Implications of the Recommendations

7.1. There are no implications to legal or financial matters, equality, human resources, risk management, or for rural communities, children and young people or public health.

8. Ward Members Affected

8.1. All.

9. Access to Information

9.1. The background papers can be inspected by contacting the report author.

10. Contact Information

10.1. Any questions relating to this report should be directed to the following officer:

Name: Joel Hammond-Gant

Job Title: Scrutiny Officer

Email: joel.hammond-gant@cheshireeast.gov.uk

Work Programme **Health and Adult Social Care and Communities Overview and Scrutiny Committee** Updated 05.06.19

13.06.19	01.08.19	12.09.19	10.10.19	07.11.19	05.12.19
10.00am	10.00am	10.00am	10.00am	10.00am	10.00am
Committee Suite, Westfields	Committee Suite, Westfields	Committee Suite, Westfields	Committee Suite, Westfields	Committee Suite, Westfields	Committee Suite, Westfields

16.01.20	06.02.20	05.03.20	09.04.20	07.05.20
10.00am	10.00am	10.00am	10.00am	10.00am
Committee Suite, Westfields	Committee Suite, Westfields	Committee Suite, Westfields	Committee Suite, Westfields	Committee Suite, Westfields

Item	Purpose	Lead Officer	Portfolios	Suggested by	Scrutiny role	Corporate priorities	Date
Provision of Orthodontic and Oral Surgery Services in Cheshire East	(1) To be updated on the progress of the committee's referral of the matter to the Secretary of State for Health and Social Care. (2) To be updated on the future plans for the undertaken of a needs assessment and the development of a new model of care for the services in	East Cheshire NHS Trust / NHS England	Health	Committee	Follow up on recommendations made and determine next steps for committee involvement	People live well and for longer	13.06.19

	Cheshire East.						
Working Together Across Cheshire	The four Cheshire Clinical Commissioning Groups are planning to merge into one single CCG by April 2020.	Eastern/South CCGs	Adult Social Care and Health	CCGs	To provide formal feedback on the proposed merger of the four Cheshire Clinical Commissioning Groups.	People live well and for longer	13.06.19
Improved Access – Eastern Cheshire CCG	To consider a report on the effectiveness and impact of NHS Eastern Cheshire CCG's work to improve access to services; new ways of working were introduced in October 2018.	Director of Commissioning (Eastern Cheshire CCG)	Adult Social Care and Integration Health	Committee	Performance monitoring	People live well and for longer	13.06.19
2018/19 Quality Account – Mid Cheshire NHS Trust	To consider the 2018/19 Quality Account.	Mid-Cheshire NHS Trust	Health	Committee	Performance monitoring	People live well and for longer	13.06.19
2018/19 Quality Account – East Cheshire NHS Trust	To consider the 2018/19 Quality Account.	East Cheshire NHS Trust	Health	Committee	Performance monitoring	People live well and for longer	13.06.19
2018/19 Quality Account – Cheshire and Wirral Partnership	To consider the 2018/19 Quality Account.	CWP	Health	Committee	Performance monitoring	People live well and for longer	13.06.19

Congleton Minor Injuries Unit	To consider a report on the impacts to the Congleton Minor Injuries Unit Impact of national review of urgent care services with a required specification of service standards for the provision of facilities. Findings of the review and its impact on the unit to be considered.	Kath Senior (NHS East Cheshire Trust) / Director of Commissioning (Eastern Cheshire CCG)	Health	Committee	Performance monitoring Monitoring developments or variations in service provision	People live well and for longer	01.08.19
CCG Operational Plans	To consider a report on CCG operational plans	Eastern/South CCGs	Health	CCGs	Performance monitoring	People live well and for longer	01.08.19
Health and Adult Social Care and Communities Performance Scorecard (Quarter 3)	To consider performance data for council services in the committee's remit for quarter 3 of 2018/19.	Acting Executive Director of People	Adult Social Care and Integration Health	CLT	Performance monitoring	People live well and for longer Our local communities are strong and supportive	01.08.19
Impact of 2018 Winter Pressures on Delayed Transfers of Care	To consider performance relating to delayed transfers of care during the 2018/19 winter months.	CEC / Eastern Cheshire CCG / South Cheshire CCG	Adult Social Care and Integration Health	Committee	Performance monitoring	People live well and for longer	01.08.19

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Recommissioning of Assistive Technology	To consider a report providing detail on performance following the recommissioning of assistive technology	Director of Commissioning	Health	Committee	Monitoring developments or variations in service provision	Our local communities are strong and supportive People live well and for longer	TBD - Autumn
Early Help Framework	Performance review following implementation in October 2018.	Director of Commissioning	Adult Social Care and Integration Health	Committee	Performance monitoring	People live well and for longer	12.09.19
Connected Communities	To consider a progress report on performance of the Council's Connected Communities Centres against key strategies and objectives	Director of Public Health	Adult Social Care and Integration	Committee	Performance monitoring	People live well and for longer Our local communities are strong and supportive	12.09.19
Health and Adult Social Care Performance Scorecard – Quarter 4, 2018/19	To keep the committee informed of progress made within the health and adult social care sections, against key performance indicators.	Director of Adult Social Care	Adult Social Care and Integration Health	Corporate Leadership Team	Performance monitoring	People live well and for longer	12.09.19

Performance scorecard – Quarter 1, 2019/20	To keep the committee informed of progress made within the health and adult social care sections, against key performance indicators.	Acting Executive Director of People	Adult Social Care and Integration Health	CLT	Performance monitoring	Our local communities are strong and supportive People live well and for longer	12.09.19
North West Ambulance Service (NWAS) Performance Update	To consider a performance report from NWAS, approximately 12 months on from the last report to the committee.	NWAS	Health	Committee	Performance monitoring	People live well and for longer	07.11.19
Everybody Sport and Recreation Annual Performance Report 2018/19	To consider the annual performance of ESAR in 2018/19.	CEO of ESAR	Health	Committee	Information / performance monitoring	People live well and for longer Our local communities are strong and supportive	07.11.19

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Performance scorecard – Quarter 2, 2019/20	To keep the committee informed of progress made within the health and adult social care sections, against key performance indicators.	Acting Executive Director of People	Adult Social Care and Integration Health	CLT	Performance monitoring	Our local communities are strong and supportive People live well and for longer	16.01.20
Review of Autism Screening at Cheshire's Custody Suites	To consider a report from the Cheshire and Wirral Partnership (CWP) on autism screening at Cheshire's custody suites, following a campaign to identify suspects with, or suspected of having, a condition on the Autistic Spectrum.	CWP	Health	Committee (following CWP Quality Account 2016/17)	Performance monitoring	People live well and for longer	16.01.20
Delayed Transfers of Care	To consider a report outlining performance on delayed transfers of care approximately 12 months on from the last report to committee in February 2019.	CEC / CCGs / CWP	Adult Social Care and Integration Health	Committee	Performance monitoring	People live well and for longer	06.02.20

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Performance scorecard – Quarter 3, 2019/20	To keep the committee informed of progress made within the health and adult social care sections, against key performance indicators.	Acting Executive Director of People	Adult Social Care and Integration Health	CLT	Performance monitoring	Our local communities are strong and supportive People live well and for longer	07.05.20
Performance scorecard – Quarter 4, 2019/20	To keep the committee informed of progress made within the health and adult social care sections, against key performance indicators.	Acting Executive Director of People	Adult Social Care and Integration Health	CLT	Performance monitoring	Our local communities are strong and supportive People live well and for longer	July/Aug 2020

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Items to be scheduled into the work programme

Item	Purpose	Lead Officer	Portfolios	Suggested by	Scrutiny role	Corporate priorities	Date
Improving physical and mental health and wellbeing in areas of greater deprivation within Cheshire East	To consider a report outlining the work undertaken by the Council and partners focused in areas of higher deprivation in the borough, to improve peoples' physical and mental wellbeing.	Director of Public Health / CEO of ESAR	Health	Committee	Overview	People live well and for longer Our local communities are strong and supportive	TBD
Impacts to Cheshire East Adult Social Care Services Following Decision on Millbrook Unit	To consider a report highlighting the impacts to Cheshire East Council adult social care services following the implementation of the new model of mental health services in eastern Cheshire. (This will be brought to the committee following the implementation of new ways of working to ensure sufficient data and evidence for effective scrutiny.)	NHS Eastern Cheshire CCG / CWP / CEC	Adult Social Care and Integration Health	Director of Adult Social Care / Director of Public Health	Performance monitoring	People live well and for longer	TBD
On-line Slimming Products	To investigate the licensing/control mechanisms in place to regulate the sale of slimming products on line and to review the mental impacts of rapid weight loss achieved through such products.	Director of Public Health	Health	Chairman	Policy Development	People live well and for longer	TBD

Outcomes from Consultation on Option 2 Plus	To consider information from the Eastern Cheshire CCG, Cheshire and Wirral Partnership and South Cheshire and Vale Royal CCG on the consultation carried out for the newly proposed Option 2 Plus for the redesign of mental health services in Cheshire East.	Associate Director of Commissioning (Eastern Cheshire CCG)	Adult Social Care and Integration Health	Committee	Establish a clear role for monitoring the implementation of changes and the performance of the new service arrangements	People live well and for longer	TBD
Cheshire East Mental Health Strategy	To consider the Cheshire East Mental Health Strategy prior to a decision being made by Cabinet.	Director of Commissioning Corporate Manager – Health Improvement	Health	Chairman	Pre-decision, strategy/policy development	People live well and for longer	TBD

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