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Scrutiny Committee

Agenda

Date:	**Tuesday, 14th June, 2022**
Time:	**10.30 am**
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**

   To receive any apologies for absence.

2. **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.

3. **Minutes of Previous Meeting** (Pages 5 - 12)

   To approve as a correct record the minutes of the previous meeting held on 21 March 2022.

4. **Public Speaking/Open Session**

For requests for further information
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There is no facility to allow questions by members of the public at meetings of the Scrutiny Committee. However, a period of 10 minutes will be provided at the beginning of such meetings to allow members of the public to make a statement on any matter that falls within the remit of the committee, subject to individual speakers being restricted to 3 minutes.

5. **Feedback on Quality Accounts: Cheshire & Wirral Partnership NHS Foundation Trust** (Pages 13 - 14)

For the Committee to provide commentary on the Cheshire and Wirral Partnership (CWP) Quality Accounts which will be incorporated into the final document before it is published on June 30th 2022, as per NHS England and NHS Improvement recommendations to allow scrutiny and comment.

6. **Feedback on Quality Accounts: Mid Cheshire Hospitals NHS Foundation Trust** (Pages 15 - 128)

For the Committee to provide commentary on the Mid Cheshire NHS Foundation Trust (MCNHSFT) Quality Accounts which will be incorporated into the final document before it is published, as per NHS England and NHS Improvement recommendations to allow scrutiny and comment.

Cover Report- to follow

7. **Feedback on Quality Accounts: East Cheshire NHS Trust** (Pages 129 - 138)

For the Committee to provide commentary on the East Cheshire NHS Trust Quality Accounts which will be incorporated into the final document before it is published, as per NHS England and NHS Improvement recommendations to allow scrutiny and comment.

8. **Update from East Cheshire NHS Trust** (Pages 139 - 146)

To receive an update from representatives of East Cheshire NHS Trust following a six-week engagement period with the public on the subject of how clinical teams are being supported in working together to develop a joint clinical strategy that sets out new, single clinical pathways, and innovative solutions to best meet the growing care needs of local populations.

9. **Pharmaceutical Needs Assessment (PNA)** (Pages 147 - 172)

To update the Committee on the progress of the Pharmaceutical Needs Assessments (PNA) production.

10. **Place Partnership Board Update** (Pages 173 - 200)

For the Committee to note the progress on the new governance arrangements for local Health and Care services, to consider and comment on the proposed joint scrutiny arrangements for Cheshire & Merseyside and approve the amended 'Protocol for the establishment of Joint Health Scrutiny Arrangements in Cheshire and Merseyside'.

Comments from the Adults & Health Committee- to follow

11. **Work Programme** (Pages 201 - 204)

To consider the Work Programme and determine any required amendments.

Membership: Councillors L Anderson, R Bailey, D Brown, S Carter, L Crane, D Marren, B Murphy, D Murphy (Vice-Chair), L Roberts, M Simon, L Smetham, R Vernon and L Wardlaw (Chair)

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CHESHIRE EAST COUNCIL

Minutes of a meeting of the **Scrutiny Committee**
held on Monday, 21st March, 2022 in the The Capesthorne Room - Town Hall, Macclesfield SK10 1EA

PRESENT

Councillor L Wardlaw (Chair)
Councillor D Murphy (Vice-Chair)

Councillors L Anderson, D Brown, C Naismith, M Simon, L Smetham, R Vernon, P Redstone and A Critchley

OFFICERS IN ATTENDANCE

Helen Davies- Democratic Services
Katie Small- Democratic Services (via Microsoft Teams)

ALSO PRESENT

Graham Urwin- Chief Executive of the Cheshire and Merseyside Integrated Care Board (ICB) (via Microsoft Teams)
David Flory- Chair of the ICB (via Microsoft Teams)
Clare Watson- Accountable Officer of the Cheshire Clinical Commissioning Group (CCG) and Assistant Chief Executive of the ICB (via Microsoft Teams)
Karen James OBE- Chief Executive of Tameside & Glossop Integrated Care NHS Foundation Trust and Stockport NHS Foundation Trust
Ged Murphy- Acting Chief Executive at East Cheshire NHS Trust
Katherine Sheerin- Director of Transformation and Partnerships at East Cheshire NHS Trust
Maddy Lowry- Associate Director at Cheshire and Wirral Partnership (CWP) NHS Foundation Trust (via Microsoft Teams)

24 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Councillors Brendan Murphy, Sarah Pochin, Lloyd Roberts, Rachel Bailey (Councillor Patrick Redstone was substituting) and Joy Bratherton (Councillor Anthony Critchley was substituting).

25 **DECLARATIONS OF INTEREST**

In the interests of openness Councillor Liz Wardlaw declared that in respect of agenda item six, the update from Cheshire and Wirral Partnership NHS Foundation Trust, she occasionally works for Cheshire and Wirral Partnership NHS Foundation Trust.

26 **MINUTES OF PREVIOUS MEETING**

Councillor Anderton noted that the initial was missing from her name in the Members listed as present for the last meeting.

RESOLVED:

That with the amendment above, the minutes be received as a correct and accurate record.

27 **PUBLIC SPEAKING/OPEN SESSION**

There were no members of the public who wished to speak.

28 **UPDATE FROM THE INTEGRATED CARE BOARD (ICB)**

Graham Urwin, Chief Executive of the Cheshire and Merseyside Integrated Care Board (ICB) attended the meeting via Microsoft Teams. Clare Watson (current Accountable Officer of the Cheshire Clinical Commissioning Group (CCG) was also present on the Teams call in her new capacity as Assistant Chief Executive of the ICB).

The Committee were shown a presentation that covered the new integrated care structure, Place development, staff consultation, the close down and transition of the CCG (the ICB will have the statutory functions of the NHS), staff transfers (in total there will be 1200 officers transferred to the ICB and includes 9 CCGs plus Cheshire and Merseyside Healthcare Partnerships, and preparation for Day One of the ICB on the 1 July 2022 including the risk and governance.,

Most of the Executive Team are appointed or in place for the ICB.

The Chief Executive explained to the Committee that the current default position weas that if something could be done at a Place level then it should be done at a Place level. The ICB would work with partners in most effective way possible and the integration of Care boards and integration of Government White Papers would join up local services unlike ever before.

Some things will not be done at Place level for example, post-pandemic the long waits for treatment, the catch up for operations would mean hospitals working together on waiting list management unlike ever before.

The appointment of ICB chair was taking place, until now David Flory had supported the ICB as interim Chair. Interviews had taken place and had included two Local Authority representatives on the panel. A recommendation for preferred candidate was made to the Secretary of State who would be making the final decision.

The Committee asked questions related to the 1200 staff within the Cheshire and Merseyside footprint. The Chief Executive advised there could be no Transfer of Undertakings (Protection of Employment) (TUPE) of staff until the bill is passed through Parliament, and then there will be a

full scale consultation. Employment was guaranteed for those beneath senior level.

Where possible the ICB will work to avoid any form of redundancies.

The Committee were advised that there would be a continuation of the hybrid working model, sometimes in-person and sometimes remotely.

The voluntary and community sector were acknowledged as an important ally within the health system and whilst there was no formal seat on ICB there was room for observation at a strategic level and the right to address the Board. Infrastructures were being planned to enable the public voice to be heard and represented.

The Committee had some concerns about the perception of the Cheshire and Merseyside model becoming Merseyside-centric and wanted to ensure the services being delivered across Cheshire East would be maintained. The Chief Executive gave assurances that the NHS had a very clear funding formula for the allocation of resources this could be broken down to show each part of Cheshire and Merseyside to show a fair-share of national resources. There was the acknowledgement that it would not always be possible to meet the needs of Cheshire East residents in Cheshire East alone. Some residents would receive services from Liverpool Alderhey or Manchester Christie for example which are outside of the Cheshire and Merseyside footprint.

The Committee were advised that the Secretary of State would be reviewing the ICB model formally after 2-years in implementation. This was unclear how it would be rolled out, but it was known that this would be a formal review point to review fairness and equity.

The Committee raised the issue of reducing waiting lists and were advised that some patients being treated at Macclesfield would have gone to Wythenshaw or Stockport- 100 patients who should have gone to The Countess of Chester have gone to Leighton- there had been some movement to match capacity in the system. The target was to identify those who had waited too long on a list but also to assess strategic risk, to reach those most quickly who will suffer detrimentally as a result e.g. those in constant daily pain.

RESOLVED:

That the Chief Executive and Deputy Chief Executive be thanked for their attendance and contributions to the Committee.

29 **UPDATE FROM EAST CHESHIRE NHS TRUST**

Karen James OBE, Chief Executive of Tameside & Glossop Integrated Care NHS Foundation Trust and Stockport NHS Foundation Trust; Ged Murphy, Acting Chief Executive at East Cheshire NHS Trust; and Katherine Sheerin, Director of Transformation and Partnerships at East

Cheshire NHS Trust all attended the meeting to present the item to the Committee and answer any questions.

The Committee heard that four parties: Stockport NHS Trust, Stockport and Cheshire CCGs and East Cheshire NHS Trust had circulated a statement of intent to all partners that outlined the continued intention to work collaboratively for acute services with NHS partners, and support clinical teams to continue working together to develop a joint clinical strategy that would set out new, single clinical pathways, as well as innovative solutions to best meet the growing care needs of local populations. Especially post-pandemic, when specifically reviewing the services provided and how people access those and the impact of covid.

Partners had embarked on a six-week engagement exercise with the public, staff and partners, to gather peoples' experiences of the trusts acute services based on some specific services; Cardiology; Critical Care and Anaesthetics; Diabetes and endocrinology; Gastroenterology and endoscopy, General Surgery; Imaging (X-ray and radiology); Trauma and orthopaedics; Urgent and Emergency Care and Women's and children's services along with broader experiences of planned care and community services.

The Committee were given the example of The Christie at Macclesfield as positive partnership working as a direct response to consultation.

There was an awareness that some patients do prefer the hybrid model of working but others could be disadvantaged through digital exclusion for a number of reasons.

There was an opportunity for the Committee to ask questions, there was some discussion on:

- The challenges of deciding when to roll out consultation exercises during/post-pandemic;
- GPs had reported activity levels being 10% more than pre-pandemic and the same being seen at A&E level and Mental Health demand. This had created a lot of pressure in the system;
- The importance of understanding communities especially those hard-to-reach or facing inequality with health outcomes; and
- Some Committee Members noted the engagement questions were generic and difficult to answer meaningfully.

RESOLVED: That the officers from East Cheshire Trust be thanked for their attendance and update to the Committee and that they return after the six-week engagement period with the consultation results and planned next steps.

30 **UPDATE FROM NHS CHESHIRE CLINICAL COMMISSIONING GROUP**

Clare Watson attended the meeting via Microsoft Teams in her current role as Accountable Officer of the Cheshire Clinical Commissioning Group (CCG), and acknowledged her new role moving forwards would be the Deputy Chief Executive Officer at the Integrated Care Board (ICB).

The Committee were advised that the current priorities were the safe and legal closure of the CCGs notwithstanding the ongoing statutory and year-end responsibilities for 2022/23.

The CCG had made a commitment to ensuring an evergreen offer in respect of Covid-19 vaccinations. Figures showed over 870,000 people vaccinated across Cheshire East and whilst the unvaccinated figures were 20%, this was still relatively low given the large number of those vaccinated. The CCG maintained a priority to offer vaccination and were targeting engagement and communication including:

- Working with Local Authorities and Cheshire and Wirral Partnership (CWP) on roving models and pop-up clinics;
- Invitations for those eligible for fourth dose vaccinations and roll out of the autumn booster programme;
- A focus on engagement with families over the summer holidays.

Flu Vaccination,

Cheshire is top of the Cheshire and Merseyside league table for flu vaccinations. Whilst flu had not been prevalent in last couple of years it was still important to vaccinate and plan for future campaigns. Pregnant women were a cohort with lower than expected vaccinations for both flu and covid-19.

The CCG reported a balanced outturn for the current financial year.

The Committee were particularly interested in vaccine-hesitancy and motivation to move people towards vaccination. The Accountable Officer advised that targeted community work in those areas with lower uptake was being carried out. The Committee requested further information and facts on vaccine-hesitancy at a ward level to assist Members in their role as Community Champions.

RESOLVED:

That the Accountable Officer be thanked for her presentation and update to the Committee.

31 **UPDATE FROM CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST**

Maddy Lowry, Associate Director at Cheshire and Wirral Partnership (CWP) NHS Foundation Trust attended the meeting via Microsoft Teams

to update the Committee on the item of eating disorders and the work being carried out with veterans.

The presentation began with a trauma trigger acknowledgement, in light of all the media coverage on the unfolding war between Russia and the Ukraine that this update was not a knee-jerk response but had been on the Work Programme for some time.

CWP became aware of the needs of veterans from those delivering front-line services and now have a dedicated intranet site for veterans and reservists. There has been the development of a passport that enables raising of issues and the access of mental health services quickly.

CWP have linked with Operation Courage. If someone needed an intensive offer outside the usual perimeters, CWP could refer to that person to specialist help and support.

CWP was now part of the Defence Employer Recognition Scheme (ERS) that encourages employers to support defence and inspire others to do the same. The scheme encompasses bronze, silver and gold awards for employer organisations that pledge, demonstrate or advocate support to defence and the armed forces community, and align their values with the Armed Forces Covenant.

The Committee were advised that CWP would need formal accreditation to achieve the silver award, evidence would be submitted before July 2022 with a range of feedback from partners including within the submission. The Committee asked to be kept up to date with progress on this matter.

In November 2021, CWP launched the Electronic Patient Record and were still in the early stages of data gathering. The Committee requested that in the meantime, CWP submit short, recorded Digital Stories of patients and their lived experiences to showcase the patients and the patient journey directly to the Committee.

The Associate Director at Cheshire and Wirral Partnership (CWP) NHS Foundation Trust then moved onto the Eating Disorders presentation update first with services for children then adults.

In terms of the national picture there had been significant increase in demand during the pandemic. CWP were able to meet the increased demand, and was meeting national access targets, through enhancing the capacity with extra posts.

Across Cheshire East there were two community support service for children and young people presenting with an eating disorder with 1-week waiting times for emergency referral and 4-weeks for routine appointments. After this stage, referrals moved to The Cheshire and Merseyside Adolescent Eating Disorder Service (CHEDS) for hospital avoidance. The CHEDs service covered a broad range of complex eating disorders and the outpatient service was less disruptive to family life and

less traumatic for patients sharing a ward with patients presenting complex mental health needs.

The Committee requested quantitive data to demonstrate the number of patients accessing services, success over time and referral trends specifically the journey for the child and family.

In terms of Adults with eating disorders this had been prioritised across Cheshire and Merseyside, there was the First episode and Rapid Early intervention for Eating Disorders (FREED model) aimed at 16-25 for those with eating disorder for 3 years or less.

CWP had been working with Beet, a national eating disorder charity with telephone support over 12-weeks for those with binge eating.

There was some discussion by the Committee on the role of this Committee and mental health needs within the community. The Associate Director at Cheshire and Wirral Partnership (CWP) NHS Foundation Trust agreed to return to the Committee to update on the Cheshire and Merseyside commissioned group for patients specifically prone to suicidal tendencies. The crisis offer was accessed in different ways by different people in the community and this could be presented to this Committee at a later date.

RESOLVED: That the Associate Director at Cheshire and Wirral Partnership (CWP) NHS Foundation Trust be thanked for her attendance and contributions to the Committee and that the areas of work identified for further updates be scheduled within the Work Programme.

32 **WORK PROGRAMME**

The Democratic Services Officer (DSO) advised the Committee that since the last formal Scrutiny Committee meeting, Members had met, via Microsoft Teams in January, to discuss potential areas of review for the Work Programme. That information had been collated and the DSO was in the process of liaising with relevant Directors to establish clear themes for the Committee to focus overview and scrutiny.

The Chair noted that any scrutiny of flooding must be done strategically with as many partners as possible in the room together, and also that the outcome from the Stockport/Macclesfield engagement exercise, by the East Cheshire NHS Trust, will be added to the Work Programme for further discussion with the representatives who had attended committee earlier in the agenda.

There was some discussion about where the potential overlap for Service Committees and the Scrutiny Committee lay when scrutinising within the remit of its own Terms of Reference. There was still wide scope for this Committee to determine value for money and the perspective of external agencies back to the local authority.

RESOLVED:

That the Work Programme be received and noted.

The meeting commenced at 10.30 am and concluded at 1.06 pm

Councillor L Wardlaw (Chair)

TO: **Cheshire East Overview and Scrutiny Committee**
DATE: *14th June 2022*
SUBJECT: *CWP's Draft Quality Account 2021-22*

1.0 Why is this item before the Scrutiny Committee?

CWP's Quality Account is an annual report to the people we serve about the quality of services we provide. We would like to present a high-level overview of what we have achieved over the past year 2021-22, to improve the quality of care and treatment we deliver and our ambitions for the coming year.

2.0 What is Scrutiny being asked to do?

Provide commentary on our Accounts which will be incorporated into the final document before it is published on June 30th 2022, as per NHS England and NHS Improvement recommendations to allow scrutiny and comment. Any comments made by the Health Overview and Scrutiny Committee will be incorporated (as previous years) within an additional annex "Comments on CWP Quality Account".

3.0 RECOMMENDATIONS

The aim in reviewing and publishing information about quality is so that CWP can demonstrate public accountability by listening to and involving the public, partner agencies and, most importantly, acting on feedback we receive. To help us meet this aim, we don't just produce this report, we also produce Quality Improvement Reports three times a year. Quality Accounts and our Quality Improvement Reports are published on our website.

4.0 SUMMARY OF MAIN ISSUES

A Quality Account is a report about the quality of services offered by an NHS healthcare provider. The reports are published annually by each provider, including the independent sector, and are available to the public.

Quality Accounts are an important way for local NHS services to report on quality and show improvements in the services they deliver to local communities and stakeholders. The quality of the services is measured by looking at patient safety, the effectiveness of treatments patients receive, and patient feedback about the care provided.

The Department of Health and Social Care requires providers to submit their final Quality Account to the Secretary of State by uploading it to the NHS website each year. The requirement is set out in the Health Act 2009. Amendments were made in 2012, such as the inclusion of quality indicators according to the Health and Social Care Act 2012.

5.0 How will this review by Scrutiny make a difference to those living or working in the Borough?

We are determined to work in partnership to deliver the best outcomes nationally for the population we serve.

6.0 How does this review link to the Council's priorities?

CWPs Quality Account and ambitions fully support the Council's priority to enable residents to benefit from good health and wellbeing. We are delighted that many of our Quality Improvement projects reflect the aims of the National Patient Safety Strategy and the NHS Long Term Plan – which we are working in partnership with local authority colleagues to deliver. At CWP, patient safety is central to all that we do, as reflected in the work we are doing with our patient safety leaders.

Contact Officer:
Service Area(s):
Tel:
Email:
Service Area:

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

Quality Account

2021-22

Because you matter

Statement on Quality from the Chief Executive

Welcome to the Quality Account Report for Mid Cheshire Hospitals NHS Foundation Trust for 2021/22.

The National Health Service has endured a uniquely challenging period since the spring of 2020 and there is no doubt the impact of COVID-19 will be long-lasting. As I reflect on another challenging but productive year at Mid Cheshire Hospitals NHS Foundation Trust (MCHFT), I am delighted to share some of our work through the Quality Account for the period of April 2021 to March 2022.

Mid Cheshire Hospitals NHS Foundation Trust 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 (General Practitioner) Alliance, we also deliver Community services across several community locations.

As Chief Executive, I am proud to lead an organisation with such committed and passionate staff. At Mid Cheshire Hospitals NHS Foundation Trust, our top priority remains to provide the highest quality care and experience for our patients and to ensure the wellbeing of our dedicated staff, who have been exemplary throughout the pandemic. As a Trust we have committed to deliver further year-on-year improvements and ensured our patients and our staff remained safe and supported during this time.

One of the key challenges we have faced during 2021/22 remains our response to the Coronavirus Pandemic (COVID-19). The Trust has at pace, implemented many changes to the core function of the organisation in accordance with the requirements set down by Public Health England and NHS England/Improvement. In response to COVID-19 the Trust has worked within the principles of both the National Outbreak Policy and Emergency Preparedness Pandemic Policy to implement changes to support patients and staff either suspected or confirmed as COVID-19 positive. Throughout the COVID-19 pandemic, our Trust has evolved our response to support the very best possible care for those impacted. Some of these changes have included increasing Critical Care Capacity, redefining ward areas to ensure strict infection prevention and control and continually providing staff with the correct level of Personal Protective Equipment and training.

Moving forward, as a Trust, we recognise how the impact of the last year may have affected the health and wellbeing of our staff. In response the Health & Wellbeing Group have worked tirelessly to ensure that staff health and wellbeing remains an absolute priority. Enhanced psychological support has been a focus for staff at all levels through the Mental Health First Aid Service, Employee Assistance Programme, Freedom to speak up Guardian, Professional Nurses Advocates, and implementation of Pastoral Nurses.

As a result of the coronavirus pandemic a number of monitoring elements have remained suspended under the quality and safety priorities. Despite the suspension of monitoring requirements, we have continued to make good progress on our quality and safety improvements. In response to the COVID-19 pandemic the Trust has continued to ensure the highest standards of Infection Prevention and Control measures are in place.

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 Trust's ambitious aims to continue to reduce harm across our organisation. Our

Quality and Safety Improvement Strategy, aligned with the third strategic aim of the National Patient Safety Strategy: Improvement, is the vehicle by which we have steered the direction of travel for quality and safety focusing on the four indicators below:

- Preventing deterioration and sepsis
- Medicines safety
- Maternal and neonatal safety
- End of life care

For the year 2021/22, the Trust continued to deliver a high quality, timely service to our patients. We are now working hard to restore these services fully whilst operating in this new world challenged by the threat of COVID-19 infection.
Key achievements for the Trust in 2021/22 include:

- The Trust is committed to ensuring that fair and equitable healthcare provision is available and supported for the local population and service users. As a Trust, we understand the importance of hospital visiting and the impact restrictions have had on both patients and relatives, and we are currently working to a phased approach to lifting visiting the hospital following national guidance.

- The Trust was part of a collaborative within Cheshire and Merseyside that implemented a tendering process for interpreting and translation services across the region. DA Languages Limited were appointed in September 2021 and the Trust was one of the initial organisations to transfer provider as of 1st December 2021. The new service incorporates video interpreting services in addition to telephone and face-to-face interpreting that were already in place to enhance patient experience.

- The Trust COVID-19 vaccination programme continued to the end of 2021 with 93% of staff having now received their first COVID-19 vaccination, 91% their second vaccination and 78% of all staff receiving their Booster (subject to change).

- Despite managing two waves of COVID-19, the management of infection prevention control continued to effectively manage other organisms effectively, the overarching safety of patients and staff was not compromised by the pandemic diversion in terms of infection. The Trust saw a reduction in hospital associated MRSA (Methicillin Resistant Staphylococcus Aurea) colonisation (93 cases compared to 137) and no MRSA bacteraemia isolates (blood stream infections) for two years

- Working in collaboration, the Quality Team and Estates and Facilities Team utilise a live database to ensure clinical need of air mattress allocation is met while maintaining stock levels. This allows daily monitoring and assessment of stock levels to support clinical demand as bed capacity increases across the Trust by way of escalation beds. Since this implementation lapses in care because of lack of mattress availability has been eliminated since July 2021.

- In February 2022, the Rt Hon Sajid Javid MP, Secretary of State for Health and Social Care opened our newly completed Emergency Department. Covering 4,000m^2 this has increased our Resuscitation and Paediatric capacity which is designed to support a better patient experience. In addition, Mid Cheshire has also recently invested in increased capacity for the Critical Care Unit at Leighton, with the number of available beds rising from 14 to 18 in January 2022.

- Victoria Infirmary in Northwich received £1.7 million to become one of 40 new Community Diagnostic Centres in England. VIN has already carried out more than 4,000 diagnostic tests in the space of a few months.

In relation to our mortality rates, the latest publication of our mortality data for the reporting period October 2020 to September 2021 demonstrates a Summary Hospital Level Mortality Indicator (SHMI) and the Trust remains positively in the 'as expected' range. We know that our ongoing focus to drive improvements through our Learning from Deaths Programme and being aligned with the health care needs of our patients, has contributed to this achievement.

I hope this Quality Account provides you with a clear picture of how important quality improvement, safety and patient experience are to us at MCHFT. 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 to always give of their best.

I can confirm that the Board of Directors have reviewed the 2021/22 Quality Account and I am pleased to share they agree that this is a true and fair reflection of our performance. 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, and in particular during the global pandemic. 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.

James Sumner

Chief Executive

Date 6 April 2022

Please note, as of May 2022, Russ Favager, Interim Chief Executive was appointed and therefore provides the final signoff of the Quality Account 2021-22 by order of the Board.

Part 2: Priorities for improvement and statements of assurance from the Board

At Mid Cheshire Hospitals NHS Foundation Trust (MCHFT), we want 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. As a Trust, we are committed to the delivery of our Trust Strategy 2021-26.

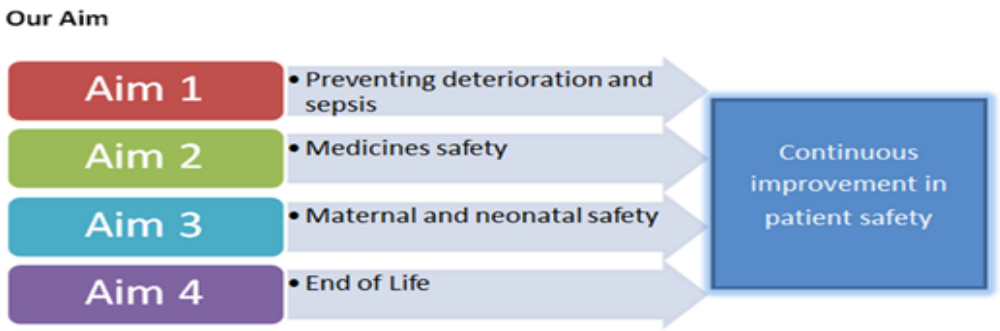
The purpose of the Trust Strategy 2021-26 is to support the delivery of the organisation's mission. The values and behaviours developed with our staff underpin delivery and success of the Trust's strategy. We recruit and nurture our staff so that we always see these values and behaviours.

Following the completion of the first year of the 2020/21 Quality & Safety and Improvement Strategy and the impact of COVID-19, whilst aligned to The National Patient Safety Strategy 2019, the Trust agreed to continue the 2020/21 strategy for a second year through 2021/22.

The NHS Patient Safety Strategy, published jointly by NHS England and NHS Improvement in July 2019, describes how a focus on three strategic aims (**Insight, Involvement, and Improvement**) will support delivery of the NHS safety vision of **continuously improving patient safety**.

Mid Cheshire Hospitals NHS Foundation Trust Quality Safety and Improvement strategy equally sets out the local vision for continuously improving quality and patient safety. We have aligned our priorities with the ambition of the third national strategic aim: **Improvement**.

The first three programme aims of work are aligned to those areas already identified nationally as the areas of care delivery where most harm is seen. End of life care is a Trust priority, and so warrants its own priority programme for our 2020/22 Strategy.



It is envisaged that delivery of the priority programmes will be supported by information and learning derived from the Trust's internal patient safety systems, and that of the local healthcare system; intelligent use of clinical incident data, complaint's themes and learning from our collective experience will inform the decisions we make to identify positive change, with an aim to drive continuous improvement in patient safety.

The Quality & Safety Improvement Strategy 2020/22 progress is monitored through the Quality & Safety Improvement Strategy Steering group monthly. Each work stream of the strategy delivers a detailed update of progress to the committee for approval and monitoring. Progress is escalated to the Trust's Quality Group (TQG) and then escalated to the Trust's 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) 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 is reported in the annual Quality Account. This report will be made available to the public on the Trust's website. The Trust is making good progress in the development of our Quality and Safety Improvement Plan for 2022-2023 which will replace the Quality & Safety Improvement Strategy 2020-2022. Our absolute obligation to engagement is paramount. Stakeholder events have ensured full involvement from Staff, Patients and Relatives across all sites in the focus for improvement for 2022-23.

Priorities for improvement 2021/22

Seven-Day Hospital Services

The COVID-19 pandemic has challenged all services to become more responsive to patient needs and although the programme for development of seven-day services was stood down as the pandemic progressed, the Trust maintains a firm commitment to the principles and standards of Seven-Day Hospital Services and will look to build appropriate capacity over the next year.

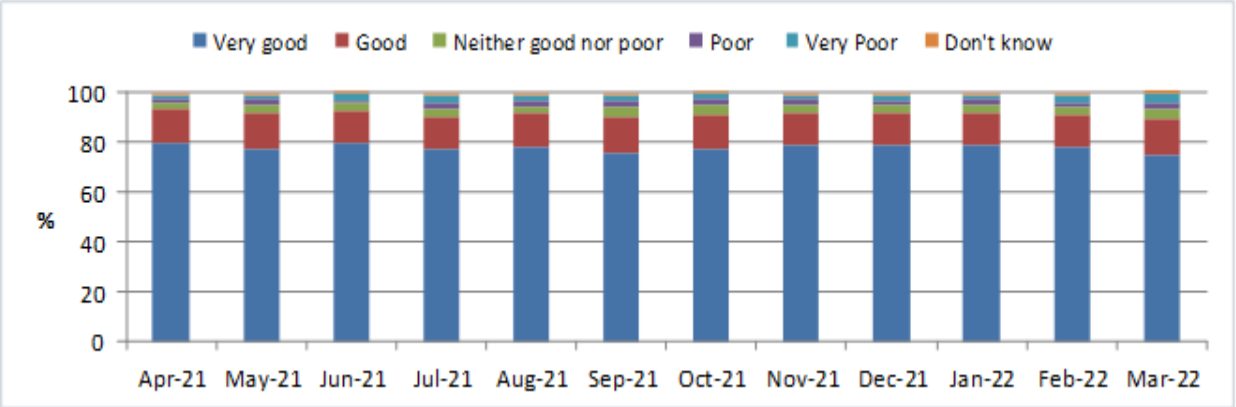
Patient feedback

The Trust actively seeks feedback from patients and values patient opinion and engagement as a direct means of improving services and providing the best possible experience for patients. A variety of patient feedback methods are available to make the feedback process as quick and easy as possible for patients and relatives. Work to enhance and expand on methods of feedback is ongoing.

Friends and Family Test

The Trust has continued to collect Friends and Family Test (FFT) responses throughout the COVID-19 pandemic and completed monthly submissions to the national system throughout 2021/22. Submission rates have increased slightly through the year, with ongoing work to ensure the capture of appropriate samples and the response rate now remained consistent at 12% at the latter end of the year. The Trust has developed QR codes (machine readable optical labels containing information about an attached item) to support an increase in responses, particularly in community health. Manual completion of cards is also still available where technology may be problematic.

During 2021/22 the Trust received 60,859 responses with 91% noting good or very good care.



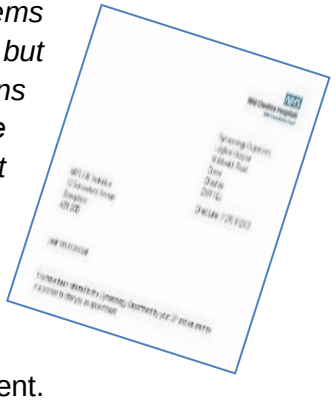
Examples of positive and negative comments received through the FFT include:

"I gave you a number 1 rating for my recent visit to Leighton Hospital. The best rating I could give. There was nothing better the team could have given me, excellent friendly attention, I was very well looked after and kept informed all the way through the long 8 hour's treatment. Well happy with everything" (Treatment Centre)

"My experience with the service at the hospital was second to none. All the staff were amazing. Nurses, cleaners, surgeons, carers, porters. All of them. Admitted at midday and in for an operation at 8pm. I can't thank them all enough. Wonderful. 10 out of 10" (Ward 11)

"My 5-year-old son broke his collar bone. Northwich Victoria Infirmary staff were amazing with him, and he was seen by an amazing nurse, x-rayed, and put in a sling within an hour. I can't thank them enough for the whole experience." (Minor Injuries Unit, VIN)

You said: "*The staff are fantastic. So friendly and helpful. My only problems were with the lack of parking spaces - I arrived early to my appointment but ended up late due to driving around looking for a space. Also, the signs aren't very clear inside the building either. I couldn't see anywhere where I was supposed to go, and a nurse ended up having to walk me to the right place."*



We did: Gynaecology Outpatient letters have been amended to include more detailed directions and signage updated by the Estates Department.

You said: "*Communication - The main reason I put good was because you are not booking into a reception in the eye clinic, you are having to leave your letter in a post box which I didn't feel was obvious as I sat waiting myself. Lots of people were wandering round looking for it because it is against the wall, and you are actually looking where you are walking. That was my main reason for putting good. Seating was fine, you were sat socially distanced, but because you are not actually speaking to a member of staff when you check in you've no idea how long the wait is likely to be, can be hard to ascertain."*

We did: A poster has been displayed above the post box in the Eye Care Centre to indicate where patients are to put their appointment letters.

National Surveys

NHS England produces and uses a range of different surveys as a valuable source of feedback directly from patients and service users about the care that they receive. The Trust participated in four of these national patient surveys in 2021/22.

National surveys for the Trust are supported by an approved supplier which provides a full service including, but not limited to, notification of sample requirements and dissent, review and submission of samples, facilitation of surveys and collation and analysis of results.

Survey	Detail
Urgent and Emergency Care 2021 **(results received July 2021)**	The survey responses incorporated Type 1 attendances at the Emergency Department (ED), Leighton Hospital and Type 2 attendances at the Minor Injuries Unit, Victoria Infirmary. The response rate was 31% for Type 1 attendances and 38% for Type 2 attendances. There was an increase seen in the average overall score for both types of attendance from previous results with Type 1 up to 77.8% (from 75.2%) and Type 2 up to 84% (from 83.1%). There were no regulator concerns raised. Improvement actions that have been taken within Urgent and Emergency care include: • Audient speaker system installed to support communication • Civility and psychological safety work underway • ED newsletter developed • Coded safe installed for storage of patient property • The Trust was an early implementer site for 111 First • A Clinical Assessment Service (CAS) has been implemented
National Children & Young People Survey 2020 **(results received in September 2021)**	The Trust response for the survey was 23%, in line with the national average of 24%. Benchmark results showed the Trust to be better than expected in 11 of 63 questions, about the same in 50 of 63 questions and somewhat worse than expected in 2 questions. The overall patient experience was 8.4 out of 10, with no regulator concerns raised. Areas identified for improvement, which have been affected by the ongoing impact of the COVID-19 pandemic, include: • Activities and things to do whilst in hospital • Parental access to facilities for food

	These areas will be addressed in the Trust roadmap for post COVID-19 care.
National Adult Inpatient Survey 2020 **(results received in October 2021)**	A different sampling method was used for the 2020 survey which is not comparable with previous surveys. The Trust response rate for the survey was 50%. Benchmark results showed the Trust to be better than expected in 1 of 45 questions and about the same in 44 of 45 questions, with the overall patient experience being 8.4 out of 10. There were no regulator concerns raised. Areas identified for improvement work were: • patient feedback • lighting in ward areas • provision of discharge information Several projects are ongoing to address the areas identified including: • FFT QR codes, new digital platform, and Trust internet • Quality Improvement (QI) project as part of a learning cohort with the Trust QI partners, the Advancing Quality Alliance (AQuA) around learning from feedback • Business case for Patient Safety Partners as part of the Patient Safety Strategy • Continuation of the June 2021 Trust Shhhhh Campaign to support patients during admission • 7 days no delays project to support improvements and initiatives in relation to capacity and patient flow • Criteria-led discharge project as part of the Alliance 16 Programme
National Maternity Survey 2021 (results received in January 2022)	The survey is split into three sections that ask questions about: Antenatal care, labour and birth and postnatal care. The Trust response rate for the survey was 49%. Out of the 50 questions, the benchmark results showed the Trust to be better than expected in 2 questions, about the same in 47 questions and somewhat worse than expected in 1 question. No areas of concern from a regulator perspective. Areas identified for improvement work were: • Mothers being given enough support for their mental health during pregnancy • Midwives or the doctor appearing to be aware of mothers' medical history during antenatal check-ups • Mothers being given a choice about where their postnatal care would take place • Midwives listening to mothers during antenatal check ups At the start of their pregnancy, mothers being given enough information about coronavirus restrictions and any implications for their maternity care

National Cancer Patient Experience Survey 2021	Participation in 2021 survey was optional due to demands and pressures of the COVID-19 pandemic. The Trust did not participate.

Local Surveys

The process for undertaking local patient surveys has been updated and support has been provided from the Patient and Public Involvement Team to enable clinical staff to use electronic methods of data collection where this may be more effective.

Examples of local surveys that have taken place include:

Survey	Detail
Podiatry Service Patient Survey 2021	Overall, the survey showed a positive response to the quality of care patients receive. Patients felt involved with their care, staff were seen to introduce themselves, explain benefits/risks and allow chance for patients to ask questions. 90% of respondents rated the service as good. The appointment system was noted to be tricky to navigate, reflecting the lengthy waiting list for podiatry review. The booking system and appointment times have been changed and staff numbers have been increased to address this.
Colposcopy Clinic Repeat Patient Survey 2021	Overall, this survey showed a positive response with all findings above 92% positive, including: length of time between test result and appointment; staff introductions; personal privacy during appointment; cleanliness; feeling listened to and respected by staff; recommending the service. The provision of information around Human Papilloma Virus (HPV) was highlighted as an area that could be improved which has been addressed with an HPV information booklet and links to Jo's Trust. Access to drinking water in the clinic was also raised and patients are now made aware that water facilities are available.
Paediatric Refraction Drops at Home Patient Survey 2021	This survey was undertaken following the implementation of a new clinic to assess parental response to the process. All results were 96% positive or higher, with all parents happy to attend the 'drops at home' clinic again. The replenishment of cyclopentolate 'To Take Out' (TTO) stock from pharmacy was raised as an issue. This was found to be a problem with supply and has been addressed through Pharmacy.
Local Inpatient Survey 2021	The local inpatient survey is undertaken monthly to assess patient views of elements of their care and experience on discharge from hospital. Results across 2021/22 showed a positive increase in the following areas: • Patients not being bothered by noise/staff noise at night (following the Shhhh Campaign) • Patients being treated with respect and dignity

- Patients being able to keep in touch with family and friends during restrictions on visiting.

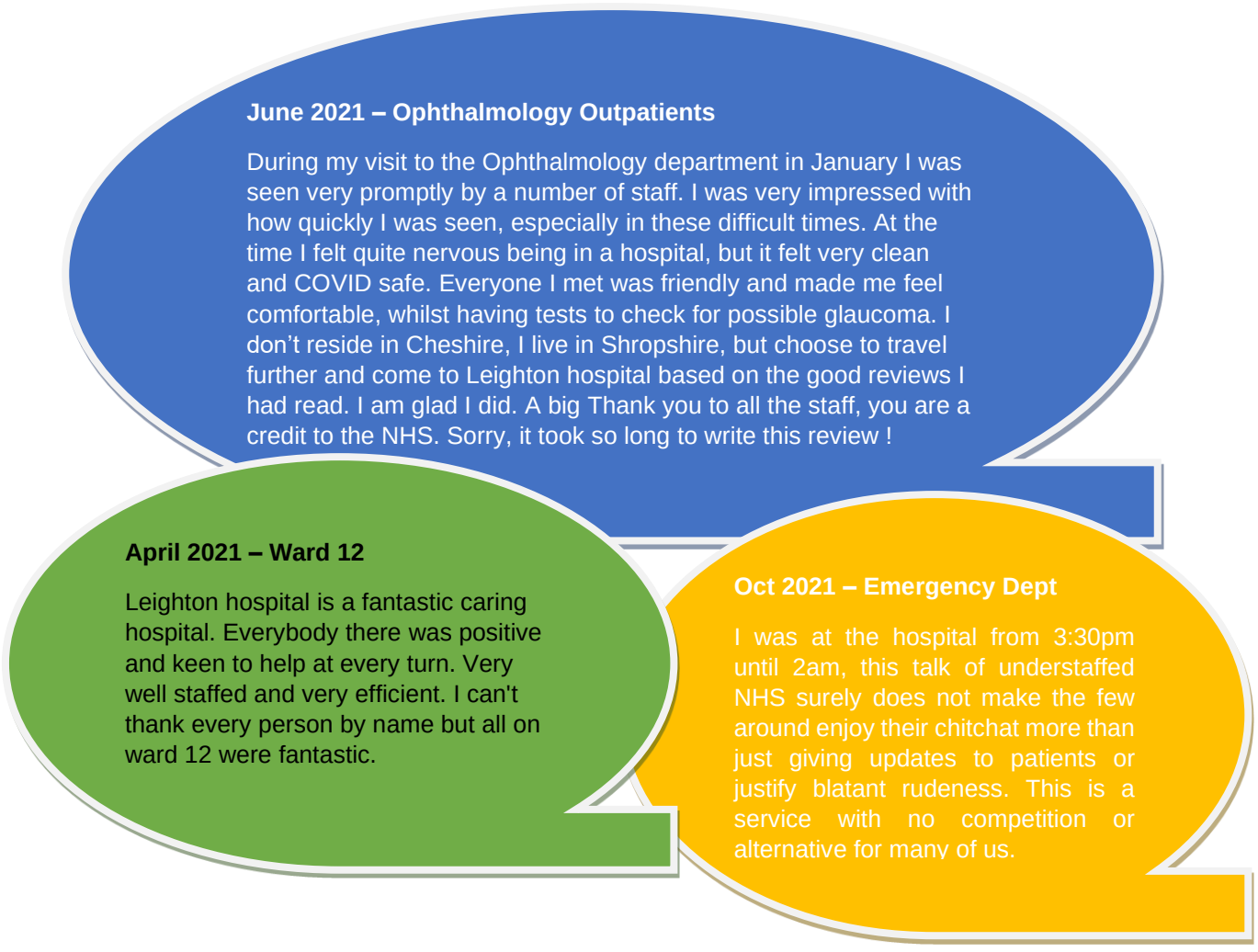
Areas that decreased in results, which have been addressed in ward areas, include:

- Staff introducing themselves
- Discussion around discharge

NHS Choices

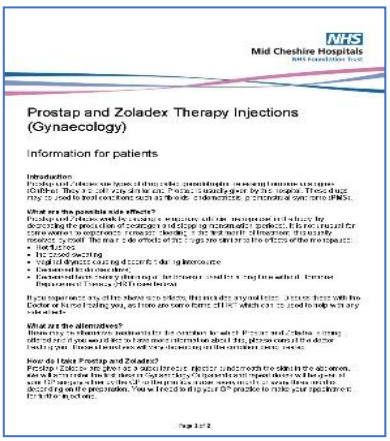
NHS Choices feedback collates information in relation to compliments, comments or complaints regarding the services provided by the Trust. This information is shared with the Divisions to help improve the services at the Trust and ensure that positive comments are fed back to the staff.

During 2021/22, 27 postings were made in relation to care and services at the Trust, with 78% positive comments and 22% negative.



Patient Information

The Trust has a Patient Information Group made up of multidisciplinary staff and patient representatives to allow co-production of Trust patient information leaflets. Ensuring that leaflets are informative for patients, meet national and local guidance for the provision of information and enabling accessibility is a key priority for the group.


NHS
Mid Cheshire Hospitals

Prostap and Zoladex Therapy Injections (Gynaecology)

Information for patients

In 2021/22, the group developed and/or reviewed 46 leaflets, with examples including:

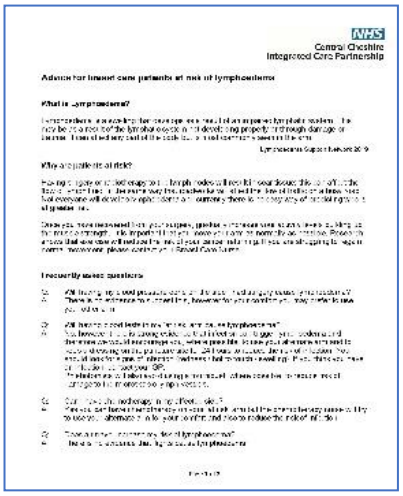
- Female Trial without Catheter (TWOC): frequently-asked questions – Urology Department
- Prostap and Zoladex Therapy Injections – Gynaecology Department
- Post COVID-19 Recovery Service – Post COVID-19 Recovery Service

To support this, the Trust has an active Readers' Panel with 74 members who review patient information on a monthly basis. The role 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, 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.

In 2021/22, the Readers' Panel has reviewed 11 leaflets such as:

- Advice for breast care patient at risk of lymphoedema – Lymphoedema Service
- IV at Home Service patient agreement – IV at Home Service
- Exercise and Advice Following Latissimus Dorsi Reconstruction – Physiotherapy.


NHS
Central Cheshire
Integrated Care Partnership

Advice for breast care patients at risk of lymphoedema

What is Lymphoedema?

Why am I at risk of lymphoedema?

Frequently asked questions

Patient/Staff Stories

The Trust actively encourages patient and staff stories at Board Level and within Trust Groups. Listening to patients and staff stories of their experiences and journeys through our system enables redesign and improvements in care according to patients' needs, allowing every step in the patient journey to be examined and improved.

Stories are also used to promote the achievements of service improvement activity using tangible evidence from the stories provided by the patients' themselves. Sharing the lessons learned and the processes for successful implementation of improvements is a valuable way of spreading the learning throughout the organisation.

Examples of digital stories that have been created in-conjunction with patients/relatives are provided below.

Emergency Department, Medical Wards, Rehabilitation Ward

A patient's husband told his experience about his wife's inpatient stay across several Trust services and wards. Key aspects of the story included:

- After a few weeks the patient's husband was able to visit his wife and it was then he noticed her rings were missing. The ward staff were extremely helpful, telephoning everywhere to try and trace them
- His wife celebrated her 90th birthday whilst on a Medical Ward and the nursing staff were wonderful. They put all thirty-six birthday cards up on the wall of her room, took photographs of her cutting her cake and gave him printed copies to take home
- His wife was in a side room which was good for privacy but sadly there was no television or radio, so no stimulation at all and his wife spent most of her time sleeping.
- The patient's husband was full of praise at what the wards were able to do for his wife.

Chronic Pain Service

The patient told their positive experience and outcomes of using the Pain Management Programme run in the community health services. Key aspects of the story included:

- This was an experience that had changed the patient's life
- The exercise hugely helped with pain and boosted the patient's confidence
- The patient was able to significantly reduce pain medication
- The one-to-one support provided was noted to be 'fantastic' and the service 'brilliantly run' and 'well executed'
- When the programme finished, the patient felt they were left to their own devices
- With the help of the Pain Management Team, the Thrive Chronic Pain Support Group has been set up offering mindfulness and exercise classes to staff and patients who had previously been on the programme.

All patient stories are shared with the specific areas of care concerned or involved and are also shared through Trust groups and committees to support wider learning and cross service development.

Ecards

The Trust has a website facility for family and friends to send ecards to patients, which was part of a previous quality improvement project for junior medical staff. Patients can receive a message from their family or friends in the form of a card produced from the website post and delivered to the ward. 2021/22 has seen the ecard service being well used by family and friends keen to send messages of support to their loved ones during difficult times. A total of 259 messages have been received and delivered by patient experience staff.

Interpreting and Translation

In 2021/22 the Trust was part of a collaborative within Cheshire and Merseyside that implemented a tendering process for interpreting and translation services across the region. Issues arising around interpreting were noted to be similar across organisations and were incorporated into the bid requirements.

The successful bidder for interpreting and translation services was DA Languages Limited, who were appointed in September 2021 and the Trust was one of the initial organisations to transfer service provider as of 1st December 2021. The new service incorporates video interpreting services in addition to telephone and face-to-face interpreting that were already in place.

To support the transition of services, the previous service provider has remained in place in parallel and a further service for more specialised language support, particularly in relation to maternity services for the local population is also available. The Trust is committed to ensuring that fair and equitable healthcare provision is available and supported for the local population and service users.

Customer Care Team

The Customer Care Team provides advice, information and support for patients and relatives if they have concerns regarding care and services they have experienced at the Trust. The team can also support patients when dealing with issues about NHS care and provide advice, information and signposting for other local health and support services.

The Customer Care Team aims to respond to concerns and issues in a timely and effective manner, irrespective of whether this involves an informal concern, advice or a formal complaint. Most concerns can usually be resolved directly by staff that are caring for patients, however, sometimes patient or family members/carers prefer to talk to someone who is not directly involved in their care and the Customer Care Team are able to help. The Team can be contacted by telephone, email, in writing and in normal circumstances face to face, however, the latter has been minimal in 2021/22 due to ongoing restrictions and social distancing.

Complaints Process

Trust Policy and process for handling complaints reflects 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 (PHSO). The Trust is committed to providing an accessible, fair and efficient service for patients and service users who express concerns or make a complaint about the care, treatment or services they have experienced with independent support signposted through the Healthwatch Advocacy Service and the PHSO.

In 2021/22 the Trust continued to strengthen the triangulation and learning from complaints, patient safety incidents and claims following a successful merger of Teams into the Quality Governance Team. Improved scrutiny and investigation around concerns and issues involving patient care and more cohesive lessons learned and actions enables more opportunities for the team to work together. To support this process a weekly Triangulation Group is in place to review all new complaints, patient safety incidents and claims and highlight potential themes.

The process for formal complaint responses including acknowledgement by the Customer Care Team, divisional and service investigation, and a two-stage quality assurance process prior to executive sign-off has ensured that acknowledgement of formal complaints remains high (above 95%) and that re-opened formal complaints have remained consistently low throughout 2021/22 (below 5%).

Timely processing of formal complaints is monitored through key performance indicators for acknowledging formal complaints within three working days and complaint responses being completed within forty working days. This has been a challenging target throughout the

COVID-19 pandemic with complaints paused locally at some points during 2021/22 because of demands on clinical services and staff. Complainants have been updated in relation to delays around complaint responses and cautious recovery towards the working day target is anticipated in-conjunction with reductions in the backlog of responses. A risk assessment has been undertaken around the backlog resulting in an increase in staff resources to provide further support.

The Trust received 278 formal complaints in 2021/22 and dealt with 1195 informal concerns and enquiries for advice that were logged on Trust systems. Both formal complaints and informal concerns have remained considerably higher than pre COVID-19 pandemic due to the impact on Trust services and staffing levels and restrictions remaining in place affecting staff, patients, and families. Improvement actions taken because of issues raised through formal complaints and informal concerns include, but are not limited to:

- Enhanced bereavement training and improved accessibility to further training through the End-of-Life Partnership
- Increased numbers of Health Care Assistants have been recruited to the Emergency Department
- Updated processes within the Ear Nose and Throat service to support patient accessibility to their clinic letters
- Targeted and specialised training provided by the Parkinson Specialist Nurse to increase awareness of the impact of Parkinson's disease on patients and their families
- Service transfer by the Irritable Bowel Disease (IBD) service from Lloyds Pharmacy to Healthnet Homecare, who support an electronic system accessible to the IBD service and patients and enables tracking of prescriptions
- IBD patient reviews moved from twelve weeks to six months to reduce unnecessary delays for patients
- Further education for Emergency Nurse Practitioners in relation to the use of x-rays and provision of safety netting information to come back to the department
- Further education around the rheumatoid pathway for clinical staff to support continuation of care
- Charitable funding for installation of coded safes in medical, surgical and rehabilitation ward areas to support safer storage of patient's valuable property.

Complaints Review Group

The Complaints Review Group meets bi-monthly and is responsible for providing information and assurances to the Trust Patient Experience Group that it is effectively managing all issues relating to the Trust complaints framework and national complaints agenda. During 2021/22 the Group has recruited a further two volunteer patient representatives through consultation with Healthwatch. The Terms of Reference for the Group have been reviewed at each meeting

and membership has been extended to incorporate a wider representation of disciplines to support cross service and discipline learning from complaints.

Parliamentary Health Service Ombudsman (PHSO)

The Trust has received one proposal for potential investigation of a closed formal complaint in 2021/22. In addition, one formal complaint investigated by the PHSO has been reported on and was not upheld.

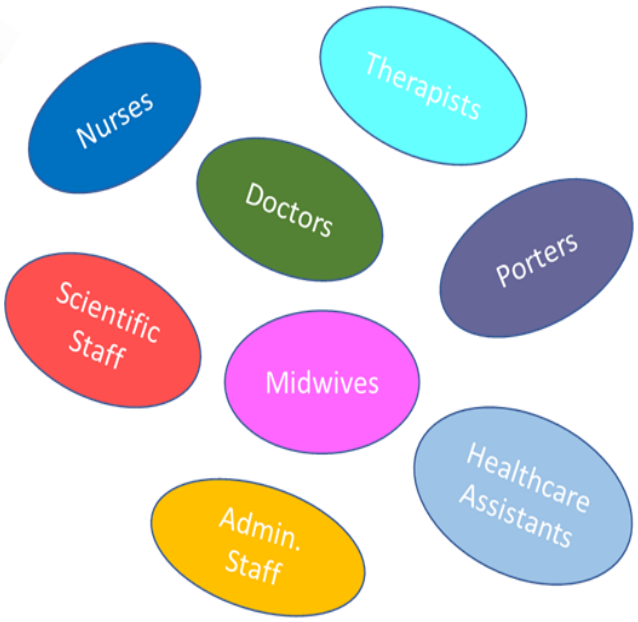
Compliments

The Trust received 282 compliments through the Customer Care Team in 2021/22 that were logged on Trust systems. Compliments are shared with relevant staff across the Trust to ensure that their dedication and hard work is recognised, something which has been of particular importance this year for the Trust as a whole. Compliments have been recorded for numerous staff groups within the Trust, including but not limited to:

"Would you please convey my appreciation to your team. I supported with the transfer of a patient recently to another hospital. During my time on the ward the staff were friendly, helpful, organised and showed a strong team ethic in achieving what was best for the patient.

It made my role so much easier as I felt supported in ensuring all the relevant information was transported with the patient.

It was a fantastic team effort"



"My mother was taken to AE following a 111 call with an AE disposition. As her daughter I drove her and from the time she was assessed until her discharge she was extremely well cared for. Mum described the consultant specialist as a remarkably kind and gentle man who took time to listen and inform her of the next steps and outcomes from her CTPA scan and blood tests. She noted that the doctor treated her as an individual with intelligence not as an older lady with impaired hearing. The care she felt was exemplary. She was in AE for a while but so well cared for and supported. She was on oxygen and being monitored. The nurses in all areas she found to be kind and considerate in particular the Algerian Nurse on AE and the ward nurses. Not to forget the hospital food, which is so often critiqued, mum found it delicious and felt it worthy of note. We wanted to say thank you, it will never be enough but thank you anyway. Mum is recovering now at home after being so scared with shortness of breath. She is very grateful for the care provided and the energy and kindness extended."

Trust Health & Wellbeing 2021/22

The pressures on NHS staff throughout the pandemic are well documented and these continued to persist during the past twelve months. Not only did staff have to continue to contend with the pandemic, but they also faced overwhelming workload and capacity issues, in addition to personal stories of anxieties relating to trauma, bereavement and family issues. The Health & Wellbeing Project Board recognised just how important it was that staff were supported to remain resilient and well, both whilst at work and in their home lives.

To reinforce the Trust's commitment to maintaining and improving staff wellbeing, the Director of People was confirmed as the Executive Lead for Health & Wellbeing and a Non-Executive Director was appointed as the Trust's Wellbeing Guardian. Furthermore, in October, a senior manager was seconded into the newly created position of Head of Health and Wellbeing.

A wide range of wellbeing activities were used throughout this period and at times, many of these interventions simply focused on meeting the basic needs of staff such as ensuring they remained hydrated and had the opportunity to receive a hot meal. On other occasions, interventions were focused on lifting spirits and boosting morale through small treats or rewards or a free back massage!

Some examples of the workstreams the Health & Wellbeing Project Board implemented include:

- 17 new wellbeing rooms/areas for staff to rest, rehydrate and refuel
- Delivery of our first remote Schwartz Round attended by over 50 individuals
- Increased out of hours food and drink provision
- Enhanced staff kitchen facilities with equipment such as microwaves, fridges, kettles, and sandwich toasters to ensure staff can make and store hot and cold food
- Provision of free bottled water to key areas to help staff stay hydrated whilst in full PPE
- Improvements in staff work life balance and the easing of car parking challenges through flexible and agile working arrangements including increased home working
- 24/7 counselling and bereavement support for all staff including enhanced support services for senior leaders through the Listening Ear Service
- Free drinks vouchers
- Temporary Paid Special Leave – 2 weeks
- Bereavement Leave extension to 2 weeks
- Additional 30 staff trained as Mental Health First Aiders
- Removal of car parking charges
- Closed Facebook group for comms
- Public transport options reviewed regularly
- Green Circle Walking Route
- Outdoor seating
- Snack bags
- School liaison role and advice to support childcare provision
- Free complimentary massage therapy
- Wellbeing Squads
- On-site Counselling
- Regular Treats for Ward Staff

- Staff Wellbeing Events (Leighton, VIN, Eagle Bridge, Infinity House.)
- Menopause Cafes
- Launch of CURE – smoking cessation support for patients and staff
- Hydration Stations
- Mental Health Drop in Sessions
- Regular Wellbeing Events aligned with the national wellbeing dates
- Resilience Workshops Free access for NHS staff to wellbeing apps
- Signposting to regional and national resources (NHS Employers & NHS Improvement)
- Free staff vaccinations – COVID-19 and Flu

In addition, the Trust's COVID-19 vaccination programme continued through to the end of 2021 with the rollout of the Booster vaccination for staff. With 93% of staff having now received their first COVID-19 vaccination, 91% their second vaccination and 78% of all staff having received their Booster dose, (please note this may be subject to further change).

To ensure the Trust Health & Wellbeing offer reflects the current needs of our people, an external audit was commissioned via Mersey Internal Audit Agency in late November 2021. Although the pace of this audit was impacted by the Omicron variant, the findings will be published in March 2022 and alongside the results of the NHS staff survey and Pulse Surveys, will provide an important foundation in informing the future Health & Wellbeing strategy for the Trust.

Whilst people come to terms with living with the COVID-19 virus, our staff now face the momentous challenge of helping the NHS move from pandemic to recovery phase. With no respite in sight for staff, it remains vitally important that both the physical and psychological wellbeing of our people remains a priority for the Trust. This will, therefore, continue to be a clear focus for the Health & Wellbeing Project Board.

Learning Disabilities and Dementia

Learning Disabilities Access

There are 1.5 million people with a learning disability (LD) in the UK. The health inequalities experienced by people with a LD are partly caused by poor quality health care. In addition, there are several health conditions that people with a learning disability are more likely to experience, including epilepsy, dementia, and respiratory diseases.

Equality healthcare is a basic right, and we should all have equal access to treatment. On average, people with a LD die 16 years earlier than the general population, with approximately 1,200 people with a LD dying avoidably every year.

Nationally, Cheshire East has a greater prevalence of people with learning disabilities, therefore The Trust needs to ensure that staff have the skills, knowledge, and experience to care for those people effectively.

Here at the Trust, we continue to work hard to ensure that the care and support we provide to people with a learning disability is of high quality, is person-centred, enables good clinical outcomes and leads to an enhanced patient and carer experience.

People with a LD often find admission to hospital very frightening, and we are working with carers, LD community teams and patients to improve the services we offer.

To help people with a LD access hospital service and therefore improve their overall health, we have introduced several initiatives. These include:

- The LD Phlebotomy Clinic continues to be held every quarter. Demand for this clinic is high, as patients have their bloods taken in a calm, friendly and quiet environment.

Carers and relatives are extremely grateful for the service that is offered, particularly as obtaining blood samples can mean critical medications are monitored and reviewed and further investigations can take place, such as CT (Computed Tomography) scans.

If we are unsuccessful in obtaining the blood samples at the clinic, we look to attempt the investigations at the patient's home. This involves collaborative working with GPs (General Practitioner) and the LD Community teams, as well as best interest decision making with patients and carers.

- We continue to produce easy read information leaflets.

- The Trust continues to promote and raise the awareness of the importance of making reasonable adjustments for people with learning disabilities. These may include:
- Double appointments at a time to suit patients and carers.
- Hospital tours to familiarise patients with the environment.
- Meeting with the Community LD teams to plan pathways for complex LD patients needing admission to hospital.
- Contacting primary care to ensure when a person with LD is coming into hospital for treatment under general anaesthetic, we make the most of this opportunity and check whether the patient needs any specific blood tests performing, chiropody or dental treatment at the same time.
- Patients coming in for planned operations can take home items such as hospital gowns and oxygen masks, to familiarise themselves with the equipment pre-operatively.
- Use of hospital passports and individualised care plans.

The Adult Safeguarding Lead (ASL) is the Liaison Nurse for people with learning disabilities and their carers. Part of the role includes co-ordinating care and engaging with patients, carers, social care, and the LD community teams to ensure that the hospital experience is a positive one.

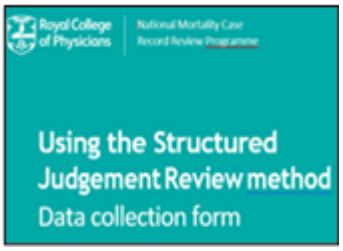
- Education and training of staff is pivotal when supporting people with LD in hospital. Staff are now able to access an e-learning package in relation to caring for people with a LD. The training forms part of the mandatory Level 3 Adult Safeguarding requirements.
- The Trust has an educational video in relation to mental capacity assessments and best interest decision making. Staff now have the opportunity to view practical application of the Mental Capacity Act in hospital-based scenarios.
- The Trust has recently taken part in Round 4 of the NHS England (NHSE) and NHS Improvement (NHSI) Learning Disabilities Improvement Standards Collection National Audit. This involved an organisational checklist, feedback from patients and carers plus a staff questionnaire.

Results from previous rounds have demonstrated that the Trust is above the national average in the following areas:

- Service users felt safe when they received care from the Trust.
- Patients had things explained to them in a way they could understand.
- Staff believe that people with a LD receive the same quality of care as any other person.

And needs to concentrate on the following areas of improvement:

- Raising awareness of the electronic LD flag.
- Recognise if someone on a waiting list has a LD.
- Audit restrictive practices.



- We continue to review all LD deaths within the Trust using the Structured Judgement Review process, and fully support the national Learning Disability Mortality Review (LeDeR) Programme. Any areas for improvement are highlighted and shared across all Divisions, as well as good practice. This may extend to primary care if there are wider lessons to share.

There have been some excellent examples of good practice shared over the past 12 months such as communication with carers, application of the Mental Capacity Act and prompt involvement of the hospital palliative care team.

Areas highlighted for improvement include:

- Ensure abbreviations are not used.
- Importance of prompt recognition of the dying patient.

- Throughout the pandemic, the Adult Safeguarding Lead has provided in-house training to the Vaccination team to ensure that COVID-19 vaccines can be delivered to patients with a LD whilst in hospital. Associated mental capacity assessments and best interest decision making principles are applied to ensure that those at risk receive the appropriate protection.

Dementia

Dementia describes a group of symptoms associated with a progressive decline of brain functions such as memory, understanding, judgement, language and thinking. The most common form of dementia is Alzheimer's disease. People with dementia are at an increased

risk of physical health problems and become increasingly dependent on health and social care services and on other people.
In Cheshire East there are estimated to be 5730 people over the age of 65 living with dementia

- 65% are likely to be women
- One in five people over 90 has a form of dementia
- One in 20 people over 65 has a form of dementia

18% of Cheshire East's population is over the age of 65. We have the highest percentage in England compared to 16% nationally. The impact of dementia on the individual and their family can be substantial and distressing.

The Alzheimer's Society's statement is one that is supported by the Trust, "Our diagnosis should not define us, nor should we be ashamed of it."

People living with dementia have the right to an early and accurate diagnosis and to receive evidence-based, appropriate, and compassionate care and treatment. There are many ways that the Trust is demonstrating its commitment to Dementia care, and these include:

- The Dementia Care Group meets regularly to review, monitor, and challenge the commitment to our patients with dementia and their carers. Our carer representative ensures that the people with dementia in hospitals are treated appropriately and hold us to account for the delivery of that care.

- The Trust has a 3-year Dementia Strategy 2020-23, that regularly audits care delivery and patient / carer feedback. These audits help to shape service delivery and provide a valuable insight in to where we are doing well and where we need to improve.

- Our Dementia Specialist Nurse works closely with the Psychiatric Liaison Team to plan care and treatment. Their weekly multi-disciplinary meetings review patients currently in hospital and demonstrate how a joint approach can improve both clinical outcomes and patient carer experience.

- Working closely with our District Nursing colleagues, we often attend home visits to support people with dementia and clinical decision making.
- The Trust continues to support our patients with dementia through the Charity Appeal. Monies have secured bespoke training opportunities, interactive televisions, radios, and privacy screens. We also have plans for a

sensory garden and activities co-ordinator which will be commenced in the next few months.

- The Trust worked in collaboration with the End-of-Life Partnership to deliver a Leadership in Dementia training programme. The course covered areas such as managing complex behaviour, leadership development and making positive changes for patients with dementia and was extremely well evaluated.

Comments from those who attended included, “I am learning so much around dementia and I am seeing my patients differently. “I am really enjoying this course. It has opened my eyes and I really hope it can be rolled out to more staff” –*Sister Ward 2 / AMU (Acute Medical Unit)*.

The course concluded with each graduate presenting an area of improvement that they would be taking back to their own wards and departments.
Improvements included a more dementia-friendly menu, easy-read discharge leaflets and community training packages and each student will be updating the Dementia Care Group on their progress in 6-months’ time.

Infection Prevention and Control

The last twelve months have proved extremely challenging in relation to Infection Prevention and Control (IPC) in light of the COVID-19 pandemic which was declared globally by the World Health Organisation on March 11th, 2020.

Taking into account the generic IPC measures required for COVID-19 management, this means that other organisms continued to be effectively managed and despite the pandemic challenges, the over-arching safety of patients and staff was not compromised by the pandemic diversion in terms of infections.

Key achievements for 2020-21 represent the following:

- Management of two waves of COVID-19 (in addition to managing other organisms/infections)

- IPC advisory group meeting three times per week to provide Silver command with multi-disciplinary decision-making, prevention strategies and processes related to COVID-19

- Clear updated guidance and campaigns relating to PPE (Personal Protective Equipment) guidance BeEquiPPEd1, 2 and 3

- Significant sharing of initiatives and processes with local and national IPC colleagues

- External visits from NHSI/E (late 2020) highlighting many areas of good practice (some of which were integrated into national IPC documents)

- A commitment to training hours and supporting staff during the COVID-19 pandemic
- Achievement of the C. difficile trajectory (24/27 cases)
- No MRSA (Methicillin Resistant Staphylococcus Aurea) bacteraemia isolates (blood stream infections) for two years
- A reduction in episodes of MRSA colonisation (93 cases compared to 137)
- A reduction in hospital associated MSSA bacteraemia cases (9 compared to 15)
- A small reduction in both hospital and community associated E. coli bacteraemia
- A reduction in hospital associated Pseudomonas bacteraemia cases (2 compared to 6)
- An absence of influenza outbreaks and Norovirus outbreaks
- Maintenance of the environmental audits to review environmental hygiene.

Response to COVID-19

During COVID-19 the Trust established command and control response to provide a structure of co-ordination and decision making across the organisation.
Several workstreams pulled together subject matter experts and key individuals to support and facilitate the challenges faced by the pandemic.

- PPE & Supplies
- Infection Control
- Vaccination
- Workforce
- Wellbeing & Support
- Staff Testing
- Operational Flow
- Estates

During COVID-19 tactical silver has remained the key conduit for change and communication. A series of action cards based on a Driver approach formed a basis of change, reporting into Silver to provide clear consistent actions and forward progression.
Where needed strategic interface through Gold executive level meetings formed part of the approval structure.

An adaptive approach to change in action was also added into the change process again using Silver with a strong reliance on effective communication; this facilitated the volume and

complexity of guidance, standards and change from NHS England & NHS Improvement and Emergency planning northwest.

This form of adaptive continuous improvement resulted in a number of successful initiatives and qualitive outcomes examples of these include:
COVID-19 Quality Metrics: Staff PPE availability, staff & patient screening protocols, COVID-19 clinical pathways, face mask compliance.

New Roles and ways of working: Infection Control Champions, Head of Nursing Emergency Preparedness, enhanced care skills- enabling high oxygen device use outside of Critical Care on the respiratory ward.

Technical & clinical collaboration: Improvement & Innovation; Site enhancement of piped oxygen, safe system of work with the use of Oxygen menus for wards - providing safe allocation of oxygen devices to the available oxygen flow empowering clinical team insight and promoting patient safety.

Be Safe Be EquiPPEd campaign: a clear consistent approach to engaging, training & educating all staff in the correct use of PPE. This included, roadshow engagement events, practical demonstrations using mannequins, posters and display stands with pertinent information. This was also supported by video animations that were circulated via the regular Coronavirus bulletin.

Wellbeing provision and support: A series of wellbeing events, packages, support toolkits and serenity & wellbeing rooms have been part of the resources for assisting staff wellbeing. Mental Health first aiders and the recruitment of a Pastoral Nurses support team continue to support staff. Access to a range of practical support including financial, legal, counselling, and on-line support has supplemented the provision for staff. Partnerships and collaboration, for example with Cheshire & Mersey Resilience Hub, other partners and MCHFT Charity have further sustained the support avenues for staff.

Vaccine and COVID-19 Testing: The role out of vaccination, provided a great challenge providing vaccination for public, Trust, social care staff in high volume. The regulation, safety and proficient provision provided a highly effective showcase of the professional, evidence-based response to the requirement of the national vaccination programme.

The COVID-19 Testing Hub & process has provided a service to staff and the public, giving assurance and direction in such uncertainty. These dedicated teams have promoted patient and staff safety in the workplace and across a variety of environments.

Through COVID-19 the response across the whole organisation, has generated a collective response of collaborative working. The contribution from the many individuals, departments and services are too many to include within the examples given.

This synopsis of workstreams provides insight into the many elements of the COVID-19 response, providing a positive qualitive impact at this most challenging of times.

Freedom to Speak Up

The Mid Staffordshire inquiry and subsequent Freedom to Speak Up (FTSU) review by Sir Robert Francis led to a requirement for all NHS Trusts to appoint Freedom to Speak up Guardians. The Guardians provide staff with someone to go to if they have a concern about a patient safety risk, wrong-doing or malpractice.

Trusts are required to report the number of concerns raised and themes identified in relation to speaking up cases to the National Guardians Office on a quarterly basis. In addition, there is a requirement to report any actions that are being taken to further embed the Guardian role and any local activities to promote the speaking up agenda.

They are also required to report to the Board on all speaking up matters (including whistleblowing) and support the organisation in developing an open and transparent culture.

At Mid Cheshire Hospitals NHS Foundation Trust, the FTSU Guardian responsibilities are delegated to the Head of Nursing Emergency Preparedness.

The FTSU Guardian offers a confidential service to staff, volunteers, students, sub-contractors, agency workers and any other persons undertaking duties within Mid Cheshire Hospitals NHS Foundation Trust. The role of the FTSU Guardian is to:

- Undertake a review where it is highlighted by any intelligence, that there has been evidence of staff not being able to raise concerns for whatever reason, or where concerns raised have not been acted upon
- Work alongside key stakeholders in promoting an open and honest “no blame” culture, where staff are able to raise concerns safely without fear of reprisal
- Support and signpost individuals in raising concerns
- Ensure investigations following the raising of concerns are undertaken in a timely manner and outcomes fed back to the individual/individuals who raised them
- Ensure all concerns are stored and recorded in a confidential manner
- Provide a quarterly report to the Board of Directors highlighting concerns raised and lessons learned
- Work with the Director of Workforce & OD and other key stakeholders to ensure a continuous process of improvement on speaking up
- Be visible and accessible to all within MCHFT
- Contribute to a culture where speaking up becomes “the norm” and raising concerns is seen as business as usual.

A number of reporting mechanisms are in place across the Trust to support staff to raise concerns. These currently include:

- Directly to the Freedom to Speak up Guardian
- FTSU boxes in various locations across Trust sites

- Incident report form
- Exit Interviews/Exit Survey
- Manager
- Employee Support Advisors (ESA)
- Dedicated speak up email address
- Staff Support Voicemail
- External sources e.g. CQC, National Whistleblowing Helpline and Counter fraud.

Several drop-in sessions have been held at Leighton Hospital and in a variety of community settings including Eagle Bridge Medical Centre, Victoria Infirmary Northwich and where these sessions have not resulted in concerns being raised, they allowed the FTSU Guardian to meet and talk to staff about the role and promote the FTSU service.

Promotion of the Freedom to Speak up Champion's role continued with attendance at the BAME network meeting in August 2021 and from this meeting a BAME network representative supported the FTSU 'open door' event at Leighton site during September.

During the FTSU month (October 2021) the FTSU Guardian held a number of FTSU walkabouts took place which were also supported by BAME network volunteers.

During the year, the appointment of a new Non-Executive Director aligned to support and promote the FTSU role provides links into the Trust Board.

Freedom to Speak Up training via E- learning is now available to all colleagues. Two packages available are 'Speak – Up' Core training for all workers and 'Listen - Up' Training for all Managers.

A total of 33 concerns have been reported to the National Guardian Office during 2021/22. 17 during 2019/20 and 12 during 2018/19. Concerns have been raised through a variety of mechanisms. It is positive to note the increase in cases reported throughout the period compared to the previous years which evidences that staff feel empowered to raise concerns.

Staff Group	Count
Additional Clinical Services	1
Administrative and Clerical	6

Allied Health Professional	4
Estates and Ancillary	5
Nursing and Midwifery	16
Students	1
Unknown	0
Grand Total	**33**

Nursing & Midwifery and Allied Health Professional colleagues have raised the most concerns over the 12-month period.

Themes of concerns have centred around workload, intimidation, and impact of wellbeing.

Workload with its possible safety impact was raised by the FTSU Guardian at the Patient Safety Summit. The specific concerns continue to be addressed by the Divisions involved, however this also links into the organisational active recruitment and retention strategies and development of new roles and ways of working. The FTSU Guardian actively participates in these groups. Themes from FSTU helping to represent a form of feedback, for e.g. workload impact on wellbeing.

To continually monitor and review the service, an electronic questionnaire has been developed and is being piloted. Each member of staff using the FTSU service will be sent an electronic survey to complete which will provide user feedback. A QR code and paper version will also be available. This will provide data to feed back to the Guardians office and other qualitive information on the service.

Safe Staffing

Nursing and Midwifery

The COVID-19 pandemic has continued to create workforce challenges across health and social care. The surge of the Omnicom variant at the end of 2021 brought additional workforce supply challenges. The need to be responsive to the different phases of the pandemic throughout 2021 has required and continues to require rapid staff deployment and redeployment.

Measures introduced early in the pandemic across the Trust to manage the response to COVID-19 have continued. This has required health care professionals to be flexible in what they do, working in different clinical areas within their scope of practice. There has been a continued need to be responsive in terms of acuity and dependency to the different phases of the COVID-19 pandemic throughout 2021. The bed reconfiguration and expansion are a dynamic activity to meet expected capacity requirements. Changes to the ward bed base and

patient pathways have affected the staffing requirements, to ensure we meet the nationally recommended safe staffing ratios and patient safety.

The senior nursing team continue to carry out 6 weekly COVID-19 acuity reviews, using professional judgement and the monthly safe staffing report is reviewed at the Trust Board meeting to ensure that there is line of sight. This approach has enabled a tactical response to the COVID-19 pandemic demand, flexing staffing levels to meet the changing requirements while maintaining high-quality patient care. It is expected that staff movement and deployment will continue to be necessary as we move through the different phases of the pandemic. However, every effort has been made to minimise staff movements where possible, staff have worked tirelessly throughout to provide the best care for patients.

The nursing and midwifery workforce is reviewed twice a year in line with NHS Improvement (2018) Developing Workforce Safeguards guidance. Where available a recognised evidenced-based tool, such as the Safer Nursing Care Tool or Birthrate Plus is used to gather acuity and dependency data that in turn informs the nursing and midwifery establishment. The annual strategic staffing review was completed in October 2021 in line with agreed acuity methodology, supported by two validated data sets. This evidence recommended investment in 4 adult inpatient wards which has now agreed by the Trust Board. This will improve quality of patient care by matching staffing to patient care needs.

The Safe Staffing Group has continued to support a culture of safe staffing levels across all clinical workforce groups. The group have monitored several workforce metrics including the Unify safe staffing data which is submitted to NHS England, bank and agency fill rates, acuity and dependency data and electronic rostering key performance indicators. This has enabled learning by the development of senior nursing knowledge and skills in understanding workforce data and identifying demand, supply, and practice issues. The group were able to predict nursing workforce issues within Health Care Support Worker Group and identify a course of action early to mitigate the risk, providing information and assurances to the Trust Quality Group.

During 2021/22 the Trust continued to implement electronic rostering across the Nursing, Midwifery and Allied Health Care Professional's workforce now achieving level 2 compliance with NHSE/I eRostering levels of Attainment. 2500 staff are now electronically rostered. The project focus is now on the remaining Allied Health Professionals staff groups and nonclinical staff later this year.

Implementation of the Allocate SafeCare Acuity module has been delayed due to the COVID-19 pandemic and is now planned for June 2022. This will provide a resource allocation decision support tool for senior nursing staff to aid deployment of staff. The software will support senior nurses align staffing numbers to patient acuity from SafeCare alongside clinical judgement to redeploy staff across the organisation to maximise patient safety.

Medical staffing

Medical staffing continues to remain an area of challenge for the Trust with ongoing projects in the area. The successful Physician Associate recruitment programme has continued with this group providing support to medical rotas in both inpatient and outpatient areas and expanding the skills that they can offer. The Trust has seen a growth in the number of health professionals working at the level of advanced practice and supporting medical roles in many areas. Specific leadership development in this area has been supported which will further drive the development of advanced practice at the Trust. To support Consultant recruitment, a bespoke programme has been designed to support senior non- Consultant Doctors to attain Consultant status whilst working at MCHFT in the specialties of Acute Medicine and Anesthesia. For Junior Doctors, work continues to develop educational and pastoral support for our increasing pool of international medical graduates working at MCHFT.

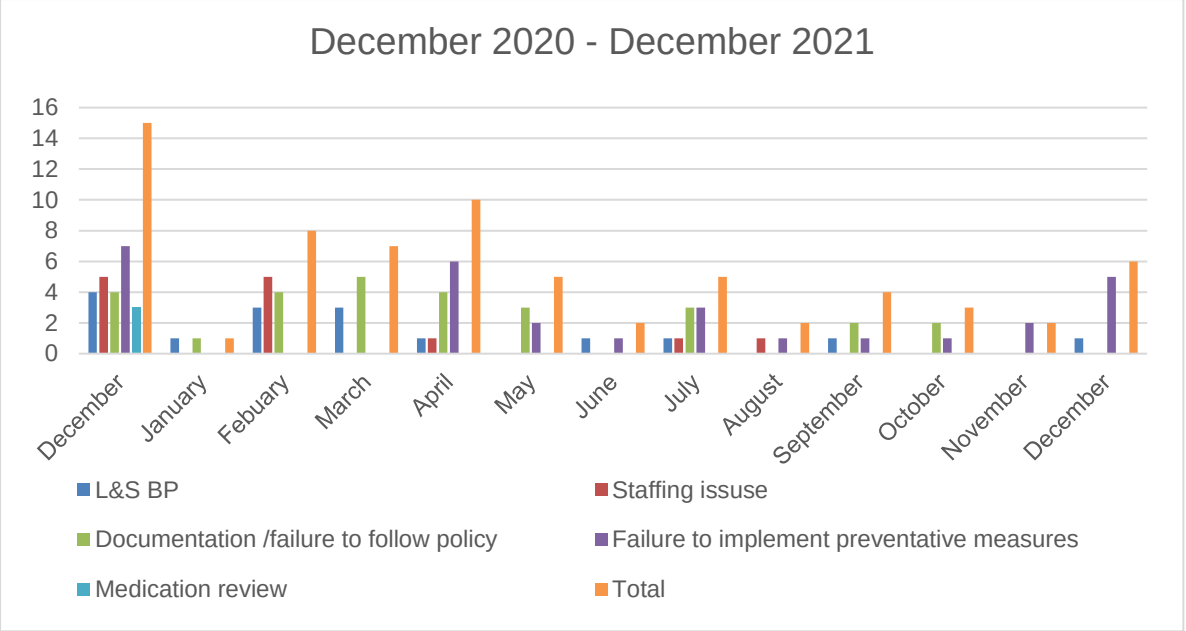
Reducing Inpatient Falls

During 2021/22 the Trust has implemented a number of changes to support with the reduction of falls across the organisation. The Trust Falls bundle, in line with national guidance is audited Quarterly offering assurance of compliance. Additional falls training is conducted within the Quality Care Programme, Induction Programme and Harm Free Care study days incorporating any identified themes from lapses in care. Trust Falls Link Nurses have been supported to develop Falls Awareness and ward resources. To support a Multidisciplinary team approach, falls prevention training and use of the bundle has been extended to Therapy Services.

The Falls Group meet monthly to monitor all Falls through the Trust Governance Dashboard, identifying themes and areas for improvement.

All falls of low harm and above are reviewed at a falls panel to establish any lapses in care. From this, ward and departments are asked to develop an improvement plan which is shared across the Trust through the Harm Free Care Group to ensure shared Learning. In addition, all improvements are shared on a ‘Quality Improvement forum’ page which provides a platform for shared learning and discussion across the Divisions. Due to COVID-19 pressures, the completion of ward action plans has been put on hold.

The Quality Team monitor all lapses in care, identifying themes and producing initiatives to reduce Falls across all Divisions. The below graph shows completed data months with details lapses in care:



Medication Review

Medication reviews have been a focus within the Harm Free Care training, this has been extended to the pharmacy team who have conducted training within the Pharmacy department. Plans to commence medical staff training are aimed to increase awareness of the importance of medication reviews with examples of lessons learnt.

Preventative measures

The Trust Quality Team have completed a trial of new Falls Sensor equipment and availability within the Trust. Collaborative working between Harm Free Care, Tissue Viability services and product manufacturers allowed a holistic approach to training sessions ensuring Device Related Pressure Ulcer Prevention was provided alongside the falls training.

A Keep me Safe prevention meeting is held weekly whereby managers can join the Harm Free Care Team in developing an individual patient Falls prevention plan. The meeting allows managers to identify patients at risk of falls with no current history and discuss preventative measures. A Falls prevention plan is documented and entered into the patient's notes, preventative measures are shared with the nursing Team and the patient.

Developing a proactive approach to falls prevention, the Trust offers a weekly frequent fallers report which is disseminated to the Ward managers highlighting patients that have a previous falls history. In addition, the Harm Free Care Team conduct a review of frequent fallers to ensure preventative measures are in place.

In September 2021 the Trust celebrated Falls Awareness Week, a crossroad event was conducted engaging staff and raising awareness of patients at risk of falls and how to take appropriate preventative measures.

Documentation

Falls Bundle completion is audited quarterly to monitor compliance. Results are collated by the Harm Free Care Team and shared at the Falls Group to identify areas for improvement.

Ongoing initiatives to reduce lapses in care are:

- Harm Free Care practitioner aims to review 5 patients per day (Mon- Fri) that may be at risk of a Falls located in admission areas to capture patients at the start of their hospital journey
- Link nurse, Identification and Training ensuring dissemination of information and localised training
- In line with the National Audit of inpatient falls the Harm Free Care Team have commenced a Falls Safe audit which measures the gap between reported and none reported Falls, results are collated and shared at the Falls Group identifying any areas for improvement.

To ensure continuous improvement, the Quality Team will continue to monitor inpatient fall incidents and address any future areas for improvement through Falls review panels. Lapses identified will be escalated to the Harm Free Care Group and Trust Quality Group appropriately.

Alongside the Falls panel reviews, monitoring is achieved through Trust quality metrics data collection. Oversight of the Quality Metrics dashboards are reviewed monthly at the Quality Metrics & Ward Accreditation Group, to provide assurance against practice and local actions taken in response to ward/department areas that report a Red RAG status. Escalations through the relevant committees will provide assurance from Ward to Board.

Reducing Pressure Ulcers

Pressure ulcers remain a key indicator of the quality and experience of patient care, they have a profound impact on the overall wellbeing of patients affecting both their physical and psychosocial wellbeing, with the potential to be both painful and debilitating. It is recognised that some pressure ulcers are preventable, consequently the necessity to avoid their occurrence is a universal goal for all health professionals.

Several potential themes have emerged in relation to COVID-19 correlating with an increase in the number of reported pressure ulcers. These include: physiological challenges related to COVID-19, the increased use of medical devices to support treatment, poor nutrition due to the patient's condition and decreased mobility.

Central Cheshire integrated care partnership (CCICP)

The population of South Cheshire and Vale Royal currently stands at around 295,000. CCICP provides its services from the following five Care Communities: -

- SMASH (Sandbach, Middlewich, Alsager, Scholar Green and Haslington)
- Winsford
- Nantwich & rural
- Northwich
- Crewe

The health and care needs of the population are growing with significant challenges to the health and social care system which has been further challenged by the global COVID-19 pandemic.

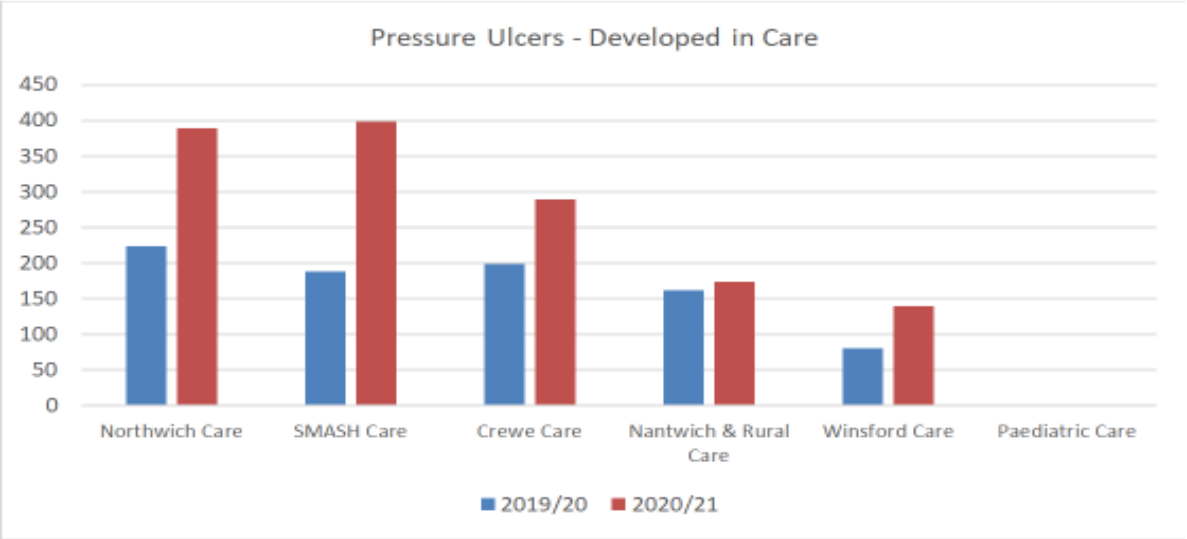
In addition, we experienced many patients being reluctant to seek help for skin problems or attend face-to-face consultations for fear of contracting the virus.

CCICP saw an increase in activity during 2020-2021 which can be attributed to the provision of ambulatory wound care from April 2020 but also due to an increase in provision of care to patients within their own homes. CCICP also experienced a significant increase in patients with multiple complex health concerns.

A cluster review of our 12 category four pressure ulcers that developed in our care between June 2020 and June 2021 identified that 100% of these patients had complex conditions. All 12 of these incidents had a full investigation and a Route cause analysis (RCA) undertaken. The review identified that in 83% of the RCA's there were no lapses in care that contributed to the development of the pressure damage with 75% of the cases having no lapses in care identified. Only one of the RCA's identified that documentation standard improvements were required. The cluster review also identified that a significant proportion of those patients who obtained category 4 pressure damage often made informed decisions around not following professional advice or accepting the prescribed equipment to optimise pressure relief. Over 40% of these pressure ulcers had COVID-19 identified as a contributing factor to the development of pressure damage.

A cluster review of the 18 reported category three pressure ulcers between the same period identified that 70% of these patients were over the age of 70 with 47% being between the age of 80 and 100 years old.

In 61% of the RCA's no lapses in care were identified and for those where lapses in care were found, comprehensive improvement plans have been developed and implemented. Again, the cluster review also identified that a significant proportion of those patients who obtained category 3 pressure damage often made informed decisions around not following professional advice or accepting the prescribed equipment to optimise pressure relief.



The above demonstrates the occurrence of pressure ulcers per care community. Our specialist Tissue Viability Team (TVN) have undertaken training video's which have been cascaded across CCICP. Where there has been a higher incidence of pressure damage occurrence in specific care communities our TVN's have dedicated their time to working with the teams and shadowing individual clinicians to promote knowledge, skills and confidence in pressure area prevention and optimal wound care provision. A comprehensive improvement plan has been developed and implemented within Sandbach and Crewe care community to promote standards around quality care and documentation.

CCICP are also developing of a new induction programme to enable new staff to the community setting and CCICP to have education and training in advance of commencing in post.

CCICP Pressure Ulcer Prevention

CCICP have introduced and implemented several preventative strategies across our services to promote quality patient care and enhance harm free care provision.

Safety Huddles

Safety huddles are held amongst District Nurses, Allied Health Professionals, Specialist Nurses and the wider Multi-Disciplinary Team (MDT), designed to focus on patients whom are at risk of sustaining harm, highlight new patients on the caseload and discuss effective care.

CCICP have adopted the supportive MDT approach, by hosting a virtual 'safety huddle' each Friday to improve the management of pressure damage. Each Care Community meets weekly to discuss all unstageable, category three and category four pressure ulcers as well as any complex patients the District Nursing Team are concerned regarding. It also provides an opportunity to discuss any problems the team are facing which may impact on safe care provision. These huddles ensure that complex patients have everything in place to ensure that deterioration is avoided where possible.

CCICP Equipment

Pressure ulcers occur when tissue is compressed between the bony prominence and an external surface, therefore it is paramount that any surface a patient is lying or sitting on, are appropriately assessed to best support pressure ulcer prevention or healing.

There are two main types of support surfaces: an active or dynamic pressure-relieving surface, which alternates where there is pressure in contact with the patient's body, pressure is relieved by inflating and deflating cells using an electrical pump. Secondly, a reactive (or static) pressure-redistributing surface, which enables pressure to be distributed over a large surface area by immersing or supporting the patient's body in the contours of the surface, for example a high-specification foam mattress or cushion, memory foam mattress or gel surface (Young, 2021). NICE (2015) guidance recommends that, as a minimum, patients should be cared for on a high-specification pressure-redistributing foam mattress and/or cushion.

Our assessment process promotes the review of equipment and positional change. In addition to the assessment and supply of equipment CCICP have also undertaken the below actions to promote a preventative pressure damage approach to care.

High Spec Foam Cushions: CCICP have purchased and supplied over 1000 cushions over the past 18 months. This has ensured patients had access to appropriate equipment in a timely manner. Now that CCICP have moved to Ross Care these cushions will be supplied directly to patients from the supplier.

Repose Contour Overlay: For those patients at risk of pressure damage who make an informed decision to sleep in a rise recliner chair CCICP purchased a small supply of repose contour overlay cushions designed to provide offloading support to patients on a rise recliner chair.

Elbow Lifts: The Tissue Viability Service identified an increase in the number of pressure ulcers occurring to elbows, CCICP purchase a small supply of elbow lifts for those patients unable to self-fund the equipment. CCICP have found the elbow lifts extremely effective in reducing occurrence of pressure damage to elbows.

CCICP Training

Tissue Viability Team have cascaded training virtually (Training Videos have been developed and shared) and face to face sessions have been provided across our nursing and therapy workforce, promoting knowledge and skill around pressure area prevention.

The focus of the training has been utilising the aSSKINg Acronym (Assess risk, Surface, Skin Inspection, Surface, Keep moving, Incontinence and moisture, Nutrition and hydration). This exhibits CCICPs proactive approach in preventative care and the early identification of pressure damage, ensuring a robust plan is implemented to prevent further deterioration and support timely healing.

The training has a clear focus on preventative pressure damage care. It is recognised that one type of learning is not suitable or sufficient for all learners.

Therefore, in addition to the three recorded teaching presentations, the Tissue Viability Service (TVS) also attend CCICP bases to work in very small groups with staff directly about pressure ulcer prevention.

Patient information

A preventative approach to care is paramount to supporting harm free care. Our development of patient information leaflets will support our ongoing work in promoting independence and raising awareness to our patient's families and carers around strategies patients can undertake to reduce the risk of developing pressure damage. These leaflets have been developed in partnership with the MCHFT patient participation group.

· CCICP Wound Self-Care patient information leaflet

· CCICP Helping to prevent pressure ulcers – Information for patients and carers

· CCICP information on Emollients and their application

Quality Metrics

CCICP are currently working in partnership with Elliott Blanchard LTD to develop a Community Quality Metrics and Accreditation tool. The quality metrics element enables teams to self-assess their care and services monthly against a set of standards. This enables Teams and services to identify early any concerns within their services facilitating them to implement timely improvements. An example of the areas that would be reviewed are documentation standards, patient assessments, Infection prevention and control practices and equipment assessments. The self-assessments process will then be reviewed by the Quality Team annually using a community accreditation process.

CCICP have identified an increase in pressure damage developing in care there is clear evidence that this increase can be corelated to the national picture, increased CCICP Community Nursing activity, COVID-19, and an Increase in the number of complex patients being cared for on the community caseload.

There is clearly a significant amount of work that has been undertaken and in place to promote quality standards and preventative care across CCICP.

The cluster reviews of category 3 and 4 pressure ulcers have demonstrated that CCICP have provided high levels of care to a cohort of complex patients within the community setting. Where improvements have been identified within specific investigations, robust improvement plans have been developed, implemented, and cascaded to ensure learning is shared across the organisation.

Trust TVN service

The Trust Tissue Viability Specialist Nurse (TVSN) as part of the Quality Team provides a review of developed in care Pressure Ulcers and Moisture Associated Skin Damage (MASD). The TVSN has been supported by a Skin Care Specialist Nurse (SCSN) as a permanent position since October 2021 to verify skin damage and provide prevention and management

plans. Both the TVSN and SCSN provide Trust wide training on pressure ulcer prevention and management and moisture associate skin damage prevention and management.

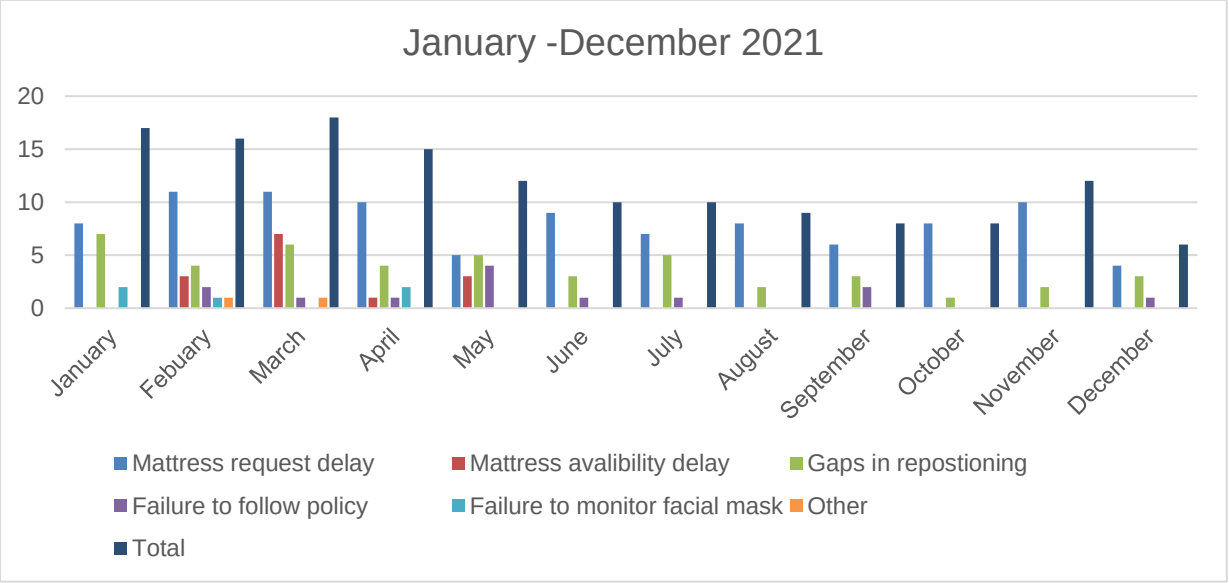
The development of a Standard Operating Procedure ensures all developed in care pressure ulcers, category two and above are reviewed at pressure ulcer panel to establish any lapses in care. From this ward and departments are asked to develop an improvement plan which is shared across the Trust through the Harm Free Care Group. In addition, all improvements are shared on a 'Quality Improvement Forum' page which provides a platform for shared learning and discussion across the Divisions.

The Skin Care Group meet monthly to monitor all pressure ulcer incidents through the Trust Governance Dashboard, identifying themes and areas for improvement.

To ensure continuous improvement, the Quality Team will continue to monitor Pressure Ulcer incidents and address any future areas for improvement through Pressure Ulcer review panels. Lapses identified will be escalated to the Harm Free Care Group and Trust Quality Group appropriately.

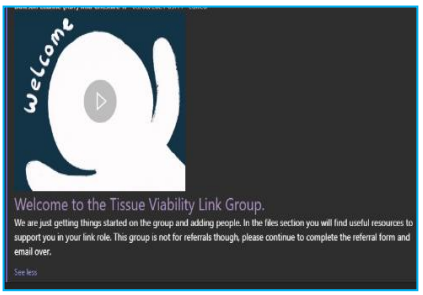
Alongside the pressure ulcer reviews, monitoring is achieved through Trust quality metrics data collection. Oversight of the Quality Metrics dashboards are reviewed monthly at the Quality Metrics & Ward Accreditation Group, to provide assurance against practice and local actions taken in response to ward/department areas that report a Red RAG status. Escalations through the relevant committees will provide assurance from Ward to Board.

The Trust has undertaken several initiatives to reduce harm as a result of pressure ulcer care. The below chart shows the number of lapses in care and common themes:



Trust Pressure ulcer training and documentation

Training is completed on the Quality Care Programme for Registered Nurses and this has been expanded to include days for International Nurses Quality Care Programme day. HCA training is provided on induction for new starters and link work with the HCA Clinical Support Workers to provide input into the Skills Sessions that they provide. Additional training is planned for existing HCA by the TVSN and SCSN to support refresher training. As part of the overall Quality Team the TVSN and SCSN also provide training on Preceptorship training days. 'Bite Size' training are delivered at ward level tailored to individual staff members.



To facilitate Link Nurse/HCA training sessions within COVID-19 restrictions, a Teams Group has been set up to share information and training materials so that the staff have access to up-to-date materials when they require them. Lessons Learned documents are also communicated via this page. A collaborative Link Nurse Day was held for both hospital and community staff to facilitate shared learning and training. Additional sessions are planned for the coming year where CCICP Teams will provide training along with the Quality Team TVSN/SCSN to support both Hospital and Community staff education and teamwork. As a result of the COVID-19 pandemic, there have been an increased number of patients nursed in the prone position whereby the patient lies flat on their stomach to aid oxygenation, the TVSN has offered support to the Critical Care Team around pressure ulcer reduction in proned patients.

Device related pressure ulcer prevention guidance has been disseminated to the wards to improve awareness of the risk of this form of pressure damage. Collaborative working between Harm Free Care, Tissue Viability Services and product manufacturers allowed a holistic approach to Falls Sensor training sessions ensuring device related pressure ulcer prevention was provided alongside the falls training. The theme of device related pressure ulcer prevention continued with training tailored to the fracture clinic staff which incorporated sharing awareness to the ward's referral processes and advice for patients that may be considered to have a high-risk plaster cast to prevent wounds occurring.

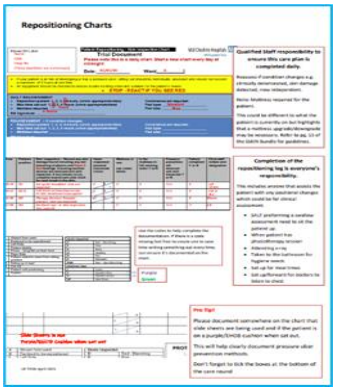
Training has been extended to Student Nurses, Trainee Advance Practitioners and Medical staff to increase pressure ulcer prevention awareness.

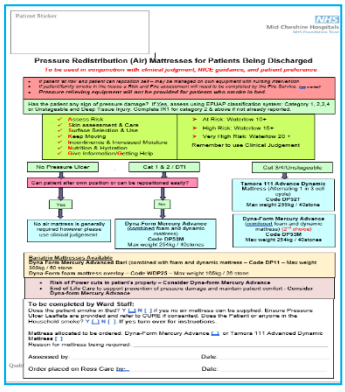
The TVSN has worked with the Neonatal Link Nurse to support the development of a Neonatal Skin Care Safe Operating Procedure. Support was also provided with the update to the Paediatric Skin Care Bundle. Additionally, the Adult Skin Bundle has been updated to reflect

the aSSKINg model (Assess risk, Surface, Skin Inspection, Surface, Keep moving, Incontinence and moisture, Nutrition and hydration) and is now implemented on the wards.

Following a cluster review of pressure ulcer incidents in 2021, highlighted themes include lack of Trust availability of support surfaces and delay in transfer onto an air mattress. An improvement plan was actioned by the Quality Team to assess the need for air mattresses within the Trust. An audit collated data from nine wards within the Trust to review the patient clinical need for air mattresses. 291 patients were reviewed and 163 of these were deemed to need an air mattress as a support surface for pressure ulcer prevention. 103 of the patients were already on the appropriate mattress. During the audit, all patients allocated an air mattress were assess as requiring one. Working in collaboration, the Quality Team and Estates and Facilities Team now utilise a live database to ensure clinical need of air mattress allocation is met whilst maintaining stock levels. This allows daily monitoring and assessment of stock levels to support clinical demand as bed capacity increases across the Trust by way of escalation beds. Since this implementation lapses in care as a result of lack of mattress availability has been eliminated since July 2021. Clarification of the process for requesting an air mattress has been disseminated across the Divisions, Teams are advised to contact the Quality Team for further support ensuring clinical need requirements.

Gaps in the completion of repositioning charts remains an area for improvement within the Trust. The TVSN and SCSN have been working with staff to support correct completion of the Daily Skin Inspection and Repositioning charts. This has included a ‘How to Guide’ and is incorporated into training sessions. Action Plans are completed by the wards following lapses in care that are identified and these are presented at the Harm Free Care Group, all improvements are then shared on a ‘Quality Improvement Forum’ page which provided a platform for shared learning and discussions across the Divisions. Due to COVID-19 pressures, the completion of ward action plans has been put on hold.





To aid continued pressure ulcer prevention on discharge, wards are supported in the request process for home air mattresses. CCICP TVN and the Quality Team have been working to support both the Community Teams and in hospital staff providing a clinical guidance flow chart, supporting clinical judgement when arranging for an air mattress in the patient’s home. In addition, CCICP Teams can assess and request pressure redistribution cushions for patients in their own homes to further pressure ulcer prevention.

Ward Accreditation & Quality Metrics

Patients who are admitted to hospital believe that they are entering a place of safety, where they, and their families and carers, have a right to believe that they will receive the best possible care (NICE 2007).

At Mid Cheshire Hospitals NHS Foundation Trust, we are committed to improving and sustaining the standards of care for all our patients to ensure they are treated and cared for in a timely manner, to support improved health outcomes and overall experience.

In 2019 the Trust launched the Ward Accreditation Programme 'Going for Gold'. Going for Gold is a product from Elliot Blanchard Ltd and was developed to ensure high quality, safe and compassionate care services across the organisation. The programme reflects the values and behaviours of the Trust and triangulates information in line with the CQC key lines of inquiry.

Going for Gold sets clear expectations in relation to the achievement of specific safety and quality standards, setting ambitious but realistic goals to take wards on a quality improvement journey. The framework provides a process of assurance from 'Front door to Board' and includes an award status based on the level of success achieved.

The Ward Accreditation Programme:

- Strengthens leadership at ward level
- Supports improvement in the quality of care our patients receive
- Reduces avoidable harm
- Improves the patient experience.

Background

Following implementation of the accreditation programme an initial 16 inpatient wards received an accreditation during 2019/20. In 2020/21 planned ward accreditation visits were postponed due to the national COVID-19 pandemic.

In 2021/22 there is now a total of 21 wards / 22 departments that require an annual accreditation following roll out implementation of quality metrics to the Trusts outpatient departments.

Ward accreditation assessments are designed to be unannounced. Each measure (within a standard) has a criterion of measurement. Throughout the accreditation a range of assessment techniques are used including;

- Observation of practice
- Talking to/using information from patients and carers
- Talking to/using information from staff
- Quantitative/qualitative data provided as part of the data pack
- Review of nursing and medical records.

In 2021 a review of the accreditation team was undertaken to have a permanent accreditation team consisting of Corporate Nursing. The team includes; Head of Nursing Engagement & Wellbeing, Clinical Quality Outcomes Matron, Head of Nursing Emergency Preparedness, Harm Free Care Practitioner and Pastoral Support Nurse. To ensure executive oversight the Director of Nursing & Quality and the Deputy Director of Nursing & Quality will shadow approximately 2 accreditations per year.

Award Status and Definition

Following an assessment, the accreditation team discusses observations and agrees an initial impression of the ward status. Three areas of success and three areas of improvement are provided as immediate feedback, along with any immediate actions. Any immediate actions will be reviewed within 7-10 days by a member of the accreditation team. Upon completion the outcome of the accreditation is presented at an accreditation panel, led by the Director of Nursing and Quality. The aim of the validation process is to ensure consistency and identify common themes as part of a Trust wide improvement process.

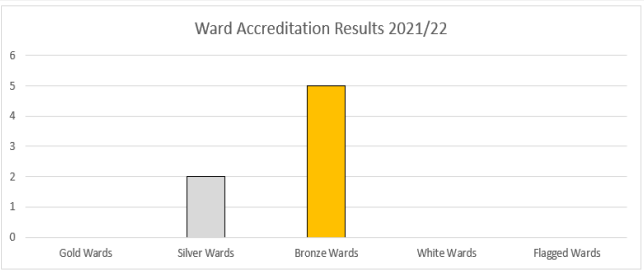
The Ward status will be agreed using the following;

Awarded Status	Definition
GOLD	Achieved excellent standards and have clear evidence of sustaining this success in data over at least 6 months
SILVER	Achieved very good standards and have some data over time to evidence this
BRONZE	Achieved good standards as expected by the Trust but have no evidence of sustaining this over time or have fallen below expected standards but are completing appropriate actions to address this
WHITE	Have not achieved the Trust minimum standards in at least one area and are not completing appropriate actions to address this issue – some additional support is required
FLAGGED	Serious concerns have been identified in relation to safety or quality that require weekly monitoring and significant support

Results 2021

During September – December 2021 7 accreditations have been undertaken. (4 within the Division of Medicine, 2 within Surgery & Cancer and 1 with Diagnostics and Clinical Services). The below graph demonstrates the overall Ward Accreditation Results for September – December 2021;

TOTAL RESULTS FOR 2021/22	n	%
Gold Wards	0	0%
Silver Wards	2	29%
Bronze Wards	5	71%
White Wards	0	0%
Flagged Wards	0	0%
TOTAL WARDS COMPLETED	7	33%
TOTAL WARDS TO COMPLETE	21	



Outcomes:

Outcomes from each accreditation are broken down in to; Well Led, Communication with MDT, Patient Communication, Healing Environment, Nursing Care and Processes and Record Keeping.

The below graph highlights individual ward performance against each area of the accreditation;

	Surgery and Cancer						Diagnostics		Medicine and Emergency Care								Womens and Children's			
Type results as G=3,S=2,B=1,W=0,F=5	Ward 9	Ward 10	Ward 13	Ward 15	Ward 18 SSW	Ward 12	Ward 21B	Elmhurst	Ward 1	Ward 2	Ward 4	Ward 5	Ward 6	Ward 7	Ward 14	Ward 19	AMU	Ward 26 MLU	Children's Ward	Ward 23 Maternity	Neonatal Ward
Month Accreditation took place (MMM):		Oct		Sept		Nov	Nov		Oct		July				Oct						
WELL LED TEAMS																					
COMMUNICATION WITH MDT																					
PATIENT COMMUNICATION																					
HEALING ENVIRONMENTS																					
NURSING CARE AND PROCESSES																					
RECORD KEEPING																					
OVERALL RESULT																					

Immediate Actions

There are a number of immediate actions that were identified during each accreditation. Assurance has been gained following each accreditation that actions have been addressed and signed off by a visiting member of the accreditation team within 7 – 10 days. Examples of immediate actions identified and addressed across different areas include;

- Medication is stored as per policy and medication cupboards are locked when not in use.
- Review of stock storage off Ward floors.
- COSHH cupboard is locked when not in use.
- Compliance with daily checks such as resuscitation trolley checks and CD checks.
- Door codes are not written on door frames.
- Ensure documentation is stored to maintain patient confidentiality.
- Improve compliance with IPC standards and ANTT.
- Review ward activity during the night to reduce noise and light.
- Compliance with medication policy when delivering patient medication.

Long term improvement feedback

In addition to immediate actions identified, wards were also given initial feedback on long term improvement ideas that will support their journey towards achieving gold standard. Examples of improvement ideas include;

- Quality Improvement projects are shared with the wider team to ensure engagement.
- De-clutter of ward environments.
- Review ward estates to support improvement in ward dayroom.
- Improve compliance with the use of the Dementia Care bundle.
- Improve compliance with use of staff ID stamps
- Review use of 1:1 security model – consider other options for 1:1 care of patients.

- Review process for communication sharing across MDT.

Celebrating Success

Following assessment 3 areas of success are shared with the Ward Manager to highlight practice that the wards should be proud of, these include;

- Excellent patient feedback relating to the care they have received.
- Excellent communication between staff / patients and staff/staff.
- Calm ward environments – staff working well together and are 'in tune' with the patient's needs.
- Excellent Ward Manager leadership
- Proactive discharge planning – preparing TTO's for weekend discharges.
- Implementation of safety crosses to improve compliance with resuscitation trolley checks and CD checks, as per policy.

Quality Metrics

Quality metrics provide a systematic approach to continually improve the quality of services and safeguard high standards of care, forming part of strong governance structures within the organisation and are the foundation data to the ward accreditation process. In addition to the inpatient ward areas, as part of the phase 2 roll out, quality metrics were implemented into outpatient areas during 2020/21 with the plan to expand ward accreditations to all areas that undertake quality metrics.

Due to the global pandemic of COVID-19 the monthly quality metrics were postponed during the months of March 2020 and April 2020 and the commencement of the accreditations was delayed, as without an overview of at least 6 months data from the quality metrics, the ward accreditation team could not fully assess a ward as part of the accreditation process.

In May 2020 data collection of the quality metrics was recommenced. However, to ensure compliance and support ward managers during this time it was agreed that the focus would be on three areas of data collection;

- Patient safety
- Infection Prevention & control, including COVID-19 specific questions.
- Needs Specific Care: End of Life COVID-19 specific questions.

The full suite of data collection recommenced in August 2020.

Due to the second wave of the COVID-19 pandemic and the work pressures of the wards / staff it was agreed that the wards would reduce full data collection of quality metrics for January 2021 and February 2021 back to the three areas;

- Patient safety
- Infection Prevention & control, including COVID-19 specific questions.
- Needs Specific Care: End of Life COVID-19 specific questions.

The below graph highlights an overview of the quality metrics at Trust level;

CQC Theme	Audit Topic	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022
Safe	Patient Safety	95	96	95	93	95	95	96	94	93	96	92
Safe	Harm Free Care	92	93	92	94	93	93	93	92	95	95	93
Safe	Medication Safety	95	96	95	95	95	95	96	97	95	98	94
Safe	Infection Prevention & Control	96	97	97	96	97	96	97	95	95	96	93
Well Led	Record Keeping	94	95	96	93	96	95	95	95	94	95	94
Well Led	Well Led Team	91	93	95	91	95	94	95	94	93	95	92
Caring	Nutrition and Hydration	94	94	95	94	94	94	95	94	96	95	95
Caring	Toileting and Hygiene	94	95	96	94	94	96	97	94	97	96	95
Caring	Patient Experience	90	91	91	92	92	91	93	93	92	94	92
Responsive	Needs Specific Care - CYP	91	88	100	97	89	83	89	85	91	85	0
Responsive	Needs Specific Care - DEMENTIA	91	90	88	90	88	91	90	90	90	92	90
Responsive	Needs Specific Care - EOL	96	95	93	92	93	94	97	95	96	96	94
Responsive	Needs Specific Care - LD	95	93	94	94	96	95	96	96	91	93	91
Responsive	Needs Specific Care - MATERNITY	98	100	95	72	0	0	96	93	-	0	0
Responsive	Needs Specific Care - NEONATAL	86	90	66	85	88	91	92	86	100	100	0
Responsive	Pain Management	86	87	88	89	89	90	89	93	92	92	91
Responsive	Communication	92	94	93	92	96	95	95	95	95	96	92
Effective	Cleanliness	92	93	93	92	95	93	94	94	93	95	93
Effective	Discharge and Patient Flow	89	87	89	88	88	86	89	88	90	90	90
Overall	Overall Quality	92	93	92	91	93	93	94	93	94	94	93

Quality Improvement

To support with local quality improvement, based on metrics outcomes, a quarterly quality metrics review with each ward area was implemented in October 2021. This process allowed identification of areas for improvement at a local level, whereby 3 areas of quality improvement on each ward / department was agreed based on the quality metrics outcomes.

The below highlights the 3 areas of improvement for the 7 wards that have received a ward accreditation to date;

Oct-21	Concern 1		Concern 2		Concern 3	
Ward 10	MO7	Drug fridge temperature are checked and recorded daily	PE09	Patients are asked about religious and spiritual needs on admission	DPF 02 & 04	All patients have an estimated date of discharge set. Estimated dates of discharge are recorded and known by patients.
Ward 15	IPC 14	Hand hygiene audit has been completed this month	NSC DEM 01	Dementia / delirium assessments have been completed	NH 05	Patients are given help and assistance with meals
Ward 12	PS21	Fluid Balance Charts completed accurately	HFC19	Staff have completed relevant moving and handling training	C10	Commodes are clean and labelled
Ward 1	IPC 07	Staff can explain process for managing patient with MRSA/CDI/CPE	NH01	MUST Screening tool completed within 6 hours of admission	DPF02	All patients have an estimated date of discharge set
Ward 4	DPF-08	TTOs are on ward for all patients needing them today	HFC02 & IPC17	Falls risk assessments completed within 6 hours of admission & Peripheral cannula sites are checked regularly and documentation completed	PS21	Fluid balance charts completed accurately
Ward 14	P11	Pain Link Nurse identified and updates provided for all staff	COM 10	Patient Records show evidence of patient / carer involvement in care	DPF 02	All patients have an estimated date of discharge set
21b	PS-21	Fluid balance charts completed accurately	HFC-07	Pressure Ulcer Tissue Viability care plan completed if required	C-10 & C-13	Commodes are clean & labelled. Additional patient areas are clean and tidy

Theme	Audit Topic
Safe	Patient Safety
Safe	Harm Free Care
Safe	Medication Safety
Safe	Infection Prevention & Control
Well Led	Record Keeping
Well Led	Well Led Team
Caring	Nutrition and Hydration
Caring	Toileting and Hygiene
Caring	Patient Experience
Responsive	Needs Specific Care - DEMENTIA
Responsive	Needs Specific Care - EOL
Responsive	Needs Specific Care - LD
Responsive	Pain Management
Responsive	Communication
Effective	Cleanliness
Effective	Discharge and Patient Flow
Overall	Overall Quality

Summary of Benefits

The teams have been engaged and participating in the ward accreditation program since 2019. The Trust has endured the pressures associated with COVID-19 and also the annual winter acuity pressures which has put a strain on overall staffing levels as well as many patient and ward moves. Despite this the Trust has remained engaged in the quality metrics and ward accreditation process. This has demonstrated a culture of strong frontline leadership, positive engagement and staff support.

Statements of assurance from the Board

Review of services

During 2021/22 the Trust provided and/or sub-contracted 42 relevant health services. The Trust has reviewed all the data available to them on the quality of care in all these relevant health services. The income generated by the relevant health services reviewed in 2021/22 represents 91% of the total income generated from the provision of relevant health services by the Trust for 2019/20.

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, incorporating national, regional, and local projects, which is informed and monitored using priority levels.

National Clinical Audit

During 2021/22, 45 national clinical audits and 3 national confidential enquiry (Clinical Outcome Review Programmes) covered NHS services that MCHFT provides.

During that period, MCHFT participated in 98% 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 enquires that the Trust participated in during 2021/22 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 2021/22, 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 2021/22

Name of audit	MCHFT participation	Stage / % of cases submitted
Case Mix Programme	Yes	Data collection ongoing
Child Health Clinical Outcome Review Programme:		
Transition from child to adult health services	Yes	Data collection ongoing
Elective Surgery (National PROMs Programme)	Yes	See PROMs section of this report
Emergency Medicine QIPs:		
Pain in Children	Yes	Data collection ongoing
Infection Prevention & Control	Yes	Data collection ongoing
Falls and Fragility Fractures Audit programme (FFFAP):		
National Audit of Inpatient Falls	Yes	Data collection ongoing
National Hip Fracture Database	Yes	Data collection ongoing
Inflammatory Bowel Disease Audit	Yes	Data collection ongoing
Learning Disabilities Mortality Review Programme	Yes	Data collection ongoing
Maternal and Newborn Infant Clinical Outcome Review Programme:		
Perinatal Mortality Surveillance	Yes	Data collection ongoing
Perinatal Morbidity and Mortality Confidential Enquiries	Yes	Data collection ongoing
Medical & Surgical Clinical Outcome Review Programme:		
Epilepsy	Yes	Data collection ongoing
Crohn's disease	Yes	Data collection ongoing
National Adult Diabetes Audit:		
National Diabetes Core Audit	Yes	Data collection ongoing
National Pregnancy in Diabetes Audit	Yes	Data collection ongoing
National Diabetes Footcare Audit	Yes	Data collection ongoing
National Inpatient Diabetes Audit, including National Diabetes in-patient Audit – Harms	Yes	Data collection ongoing
National Asthma & Chronic Obstructive Pulmonary Disease Audit Programme:		
Paediatric Asthma Secondary Care	Yes	Data collection ongoing
Adult Asthma Secondary Care	Yes	Data collection ongoing

Chronic Obstructive Pulmonary Disease Secondary Care	Yes	Data collection ongoing
Pulmonary Rehabilitation	Yes	Data collection ongoing
National Audit of Breast Cancer in Older Patients	Yes	Data collection ongoing
National Audit of Care at the End of Life	Yes	Data collection ongoing
National Audit of Dementia	-	Due to the coronavirus pandemic, audit timelines amended
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	No	Unable to participate due to insufficient resources
National Cardiac Arrest Audit	Yes	Data collection ongoing
National Cardiac Audit Programme:		
Myocardial Ischaemia National Audit Project	Yes	Data collection ongoing
National Heart Failure Audit	Yes	Data collection ongoing
National Comparative Audit of Blood Transfusion:		
2021 Audit of Patient Blood Management and NICE Guidelines	Yes	Data collection ongoing
2021 Audit of the perioperative management of anaemia in children undergoing elective surgery	-	Postponed until 2022
National Early Inflammatory Arthritis Audit	Yes	Data collection ongoing
National Emergency Laparotomy Audit	Yes	Data collection ongoing
National Gastrointestinal Cancer Programme:		
Oesophago-gastric Cancer	Yes	Data collection ongoing
National Bowel Cancer Audit	Yes	Data collection ongoing
National Joint Registry	Yes	Data collection ongoing
National Lung Cancer Audit	Yes	Data collection ongoing
National Maternity and Perinatal Audit	Yes	Data collection ongoing
National Neonatal Audit Programme - Neonatal Intensive and Special Care	Yes	Data collection ongoing
National Paediatric Diabetes Audit	Yes	Data collection ongoing
National Perinatal Mortality Review Tool	Yes	Data collection ongoing

National Prostate Cancer Audit	Yes	Data collection ongoing
Respiratory audits (British Thoracic Society):		
National Outpatient Management of Pulmonary Embolism	Yes	Data collection ongoing
National Smoking Cessation 2021 Audit	Yes	Data collection complete
Sentinel Stroke National Audit programme (SSNAP) (Acute / Community)	Yes	Data collection complete
Serious Hazards of Transfusion	Yes	Data collection ongoing
Society for Acute Medicine's Benchmarking Audit	Yes	Data collection ongoing
Transurethral RESection and Single instillation mitomycin C evaluation in bladder Cancer Treatment	Yes	Data collection ongoing
The Trauma Audit & Research Network	Yes	Data collection ongoing

Mid Cheshire Hospitals NHS Foundation Trust is committed to improving the quality of the healthcare we provide. To help with this, an improvement plan should be completed for all local and national clinical audits undertaken to measure our compliance against standards and to identify any actions that could lead to improvements. The status of all national and local clinical audits is included in the divisional audit programmes which are sent for inclusion in the sub-specialty governance meeting agendas. The statuses of the national clinical audit improvement plans are also reported monthly to the Trust Improvement Group.

The Trust holds Quality Improvement Sessions throughout the year, specialties will either discuss local and national audits at their individual meetings or hold a joint session with other specialties to share learning and foster improvement. We have a further session set aside as a Trust-wide Quality Improvement Session whereby topics are discussed that are applicable to all. The Trust-wide quality improvement session for 2021/22 was used to discuss safety culture, civility, and human factors.

The reports of 38 national clinical audits were/are being reviewed by the provider in 2021/22 and the Trust intends to take the following actions to improve the quality of healthcare provided: National Clinical Audit Participation 2021/22 – Actions

National Clinical Audit and Clinical Outcome Review Programme	Actions taken / to be taken
Case Mix Programme (CMP)	Review and improvement plan in progress.
Falls and Fragility Fractures Audit programme (FFFAP):	
National Hip Fracture Database	Review and improvement plan in progress.
National Audit of Inpatient Falls	Since the launch of the falls bundle in Oct 2020, bay tagging has been used more widely across the Trust as a preventative measure as evidenced in the post falls questionnaires, this is also encouraged via all platforms of falls training within the Trust. Latest report received and improvement plan in progress.
Inflammatory Bowel Disease (IBD Registry), Biological Therapies	Review and improvement plan in progress.
Major Trauma Audit	Review and improvement plan in progress.
Maternal, Newborn and Infant Clinical Outcome Review Programme:	
Perinatal Mortality	MBRRACE Perinatal Mortality report to be presented at combined perinatal quality improvement session. Pre-conceptual advice given to women with type 1 and type 2 diabetes, Consultant debriefs provide information for future pregnancies and summary letter to patients in accordance with the recommendation.
National Perinatal Mortality Review Tool	Perinatal Mortality Review Tool (PMRT) engagement letters sent to all parents and feedback incorporated back into reports. PMRT quarterly report to highlight areas of quality improvement and outcomes of audit of impact
Saving Lives, Improving Mothers Care	Referral pathways to specialist Perinatal Mental Health Team with specific referral criteria. Perinatal mental health midwife in post. Specialist perinatal team develop plans for birth and postnatal period which is communicated with the GP and wider Multi-Disciplinary Team if necessary. Distribute RCP acute care toolkit 15: Managing acute medical problems in pregnancy to Clinical Leads for acute medicine and Emergency Department.

Saving Lives, Improving Mothers Care Rapid report – learning from SARS-Cov-2 related and associated maternal deaths in the UK	MCHT Management and Timing of Delivery for Women with COVID-19 SOP V2 in place. NICE COVID-19 Guidelines distributed to all clinical staff to be followed as necessary. All women with COVID-19 overseen by Consultant Obstetrician who will refer to most up to date RCOG guidance to plan clinical care.
Stillbirths and neonatal deaths in twin pregnancies (sprint report)	Update Preterm Labour Including Cervical Cerclage, Tocolysis, Antenatal Corticosteroids and Magnesium Sulphate guideline to include recommendations on delaying birth and offering of antenatal steroids.
Medical & Surgical Clinical Outcome Review Programme:	
NCEPOD Dysphagia in Parkinson's	Review and improvement plan in progress.
NCEPOD In Hospital Care of Out of Hospital Cardiac Arrests	Local audit being undertaken against the NCEPOD recommendations to check compliance.
National Asthma and COPD Audit Programme (NACAP):	
National Chronic Obstructive Pulmonary Disease	Presentation of progress at the Trust Improvement Group in March 2022.MCHT is also working with the innovation agency as part of a regional project to improve performance.
National Adult Asthma	Updating the asthma pathway to improve compliance. Presentation of progress at the Trust Improvement Group in March 2022. MCHFT is also working with the innovation agency as part of a regional project to improve performance.
National Audit of Breast Cancer in Older Patients (NABCOP)	Good outcomes in terms of morbidity and re-operation rates. Liaison with data Manager to investigate data recommendations.
National Audit of Care at the End of Life (NACEL)	Review and improvement plan in progress.
National Cardiac Arrest Audit (NCAA)	Quarterly reports reviewed and included in improvement plan which is reviewed by the Resuscitation Group.
National Cardiac Audit Programme:	

Myocardial Ischaemia National Audit Project (MINAP)	As a result of the national findings a local audit and re-audit was undertaken around the prescription of secondary prevention medications after myocardial infarction. The re-audit showed an improvement in our figures which should be represented in the national results going forward.
National Heart Failure Audit	Completed actions include having an identified heart failure lead, ensuring that patients receive the disease modifying drugs they should be on (pathway in place) and reviewing cardiac rehabilitation provision as a priority.
National Diabetes Audit – Adults	Review and improvement plan in progress
National Early Inflammatory Arthritis Audit (NEIAA)	Early arthritis pathway in place through referral pathways. Targeted therapy and AHP rheumatology standard operating procedures in place.
National Emergency Laparotomy Audit (NELA)	Review and improvement plan in progress.
National Gastrointestinal Cancer Programme:	
Oesophago-gastric Cancer (NAOGC)	Local audits to be undertaken in line with the recommendations and service level agreement in place for referral of high-grade dysplagia cases at specialist multi-disciplinary team.
National Bowel Cancer Audit (NBOCA)	Review and improvement plan in progress
National Joint Registry	Concentrate resources and focus on reducing and minimising the need for revision rate (knee arthroplasty surgery at 5 years) and the cost for the patient/wider health economy.
National Maternity and Perinatal Audit Sprint report - Ethnic and Socio-economic Inequalities in NHS Maternity and Perinatal Care for Women and their Babies	Antenatal booking and antenatal appointments include full risk assessment of health and social wellbeing. Individualised information and care given based on this assessment. A scoping exercise has been undertaken to pinpoint areas of ethnic diversity and socio-economic deprivation. A continuity of carer action plan focuses on the areas in the lowest decile.

National Maternity and Perinatal Audit Sprint report – Maternity care for women with BMI 30+	Currently women with a BMI of 30+ are given 'Eating Healthily and Weight Management in Pregnancy' leaflet. Public Health Support Workers to give targeted advice to women with a BMI over 30 at dating scan appointment. Preconception advice given by GP or Practice Nurses unless women access diabetes preconception clinic. Review all readmissions of women with BMI over 30 from Jan-Jun 2021 to identify common causes of readmission.
National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)	Rates of parental consultation was 100% for MCFHT, patient led ward rounds to commence (quality improvement project). MCHFT scored 100% for on-time screening for retinopathy of prematurity (ROP).
National Paediatric Diabetes Spotlight Audit	The paediatric diabetes team participates in Cheshire network meetings and northwest regional network meetings to maintain our multidisciplinary expertise. Review of service to ensure it follows NICE guidance.
National Prostate Cancer Audit	Review and improvement plan in progress
Sentinel Stroke National Audit Programme (SSNAP) **(Acute / Community)**	Review and improvement plan in progress, SSNAP presentation at specialty quality improvement session 15/2/22.
RCEM Mental Health (self-harm)	Review and improvement plan in progress
RCEM Assessing for Cognitive Impairment in Older People	There will be a re-launch of the cognitive impairment tool and the patient safety checklist has been revised to include a prompt for the use of dementia care bundles.
RCEM Care of Children in ED	Local documentation includes a section mandating senior review for under 1-year olds. A consultant reviews all documentation for children leaving the department without a clinical review. We have a system in place to identify children and young people who frequently attend and we have a locally developed psychosocial assessment tool which forms part of the safeguarding documentation.

BAUS spotlight renal colic audit	Actions in place to ensure nonsteroidal anti-inflammatory drugs as first line management, serum calcium check and a CT KUB scan performed within 24 hours.
National Lung Cancer Audit	According to Getting It Right First Time (GIRFT) data we are in the highest quartile of Trusts with proportion of patients seen by a specialist nurse. Conduct a surgical resection audit in accordance with the recommendations.
National Paediatric Asthma Audit	Review and improvement plan in progress.
Society for Acute Medicine's Benchmarking Audit	Review and improvement plan in progress.
Each Baby Counts	Key messages reviewed, no recommendations.

NB Some annual reports were delayed in 2021-22 due to the COVID-19 pandemic

Local Clinical Audits

The reports of 97 local clinical audits were reviewed by the provider in 2021/22 and the Trust intends to take/have 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
Adherence to Antibiotic Prophylaxis during elective laparoscopic cholecystectomy	To consider a research project studying the effect of antibiotic prophylaxis in high-risk groups as few articles also reported that bile spillage does not increase the risk of Surgical Site Infection.
Urinary Catheterisation Practice and Documentation in Surgical Inpatients **(re-audit)**	Clinicians verbally reminded about the significance of adequate documentation of urinary catheterisation of surgical inpatients via presentations and discussions at nursing handovers.
Re-audit of post-operative pain management in paediatric patients at MCHFT	To explore the possibility of incorporating the pain leaflet as a part of e-discharge letter and as part of the admission pack to help prevent unnecessary re-attendance/re-admission.

Audit of the administration prophylactic antibiotics for orthopaedic and trauma surgery with implants and the compliance with the Trust antibiotic policy	Ideal body weight estimation tool placed in Microguide and in Theatres as laminated hard copy. Findings presented to the Trauma and Orthopaedics team.
Audit of tele-dermatology service	Re-educate GPs with regards to required images and image quality; Less referrals will be rejected due to absence of relevant images Less patients will be brought up for clinic appointments because accurate opinion cannot be provided remotely Better quality of opinion offered by secondary care
Prescription of secondary prevention medications after Myocardial Infarction audit & re-audit	As a result of the National audit findings (MINAP) an audit was undertaken to look at the rate of prescription of secondary prevention medications after Myocardial Infarction. Following the first cycle, a quality improvement project was conducted as the action and the re-audit demonstrated an improvement in compliance and met the target as set out by the national audit.
Treatment of Acute Hyperkalaemia in Adult Patients	Flow charts produced and shared with Divisional Matrons for cascading.
Discharge notification process	All NHSCSP notifications must be compliant with recommended follow up as stated in NHSCSP Publication 20/Local Colposcopy Guidelines – 2 local audits in progress to check compliance.
Audit of Local Standard Safety Checklist for Invasive Procedures (LocSSIPs) in Paediatric Department	Induction to cover the use of LocSSIPs as mandatory for every invasive procedure (including failed attempts) and highlight the quality of documentation. Posters of the importance of LocSSIPs and audit findings to be displayed at procedure sites/staff rooms/doctors' room. Housekeepers to make sure adequate forms are present and checked every week. Education for staff on the process for electronic documentation when performing an invasive procedure. Addition of space for documenting failed attempt on to the LocSSIP form. Change the debrief section on the LocSSIP form to debrief/reflection.

	Addition of the adjustment and removal documentation to the central Line LocSSIP. New LocSSIP for Surfactant administration. As part of a wider Trust initiative, a training video was produced by the Associate Director for Patient Safety around the correct use of the LocSSIP documents.

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, incorporating national, regional, and local projects, which is informed and monitored using priority levels.

Participation in clinical research

Research is...

Good for patients:

Patients value the opportunity to participate in research studies and evidence shows that those who receive care in research-active institutions have better health outcomes.

Good for staff:

Best patient care is based on the best clinical evidence and many healthcare professionals say they find the experience of being involved in research studies positive and rewarding as well as helping their career.

Good for the organisation:

Research supports the Trust, for example in Care Quality Commission assessments of use clinical research to improve patient care.

Highlighted in **bold** are a few of the studies to which MCHFT has contributed this year, with examples of the benefits of the research.

Informing Public Health policy

ISARIC is the largest study of COVID-19 cases anywhere in the world, enabling the production of the most accurate risk prediction models for the UK population. **ISARIC** feeds data dynamically to Public Health Scotland, Public Health England, SPI-M, NERVTAG and SAGE and hence informs national policy decision.

Service planning

During the SARS-CoV-2 pandemic, the circulation of Respiratory Syncytial Virus (RSV) was dramatically reduced. Data suggests that as social distancing restrictions for SARS-CoV-2 are relaxed, RSV infection returns, causing delayed or even summer epidemics, with different age distributions. The ability to track, anticipate and respond to a surge in RSV cases is critical for planning acute care delivery. The **BRONCHSTART** study aims to understand the onset of RSV spread at the earliest opportunity. This will influence service planning, to inform clinicians whether the population at risk is a wider age range than normal, and whether there are changes in disease severity. This information is also needed to inform decision making on the timing of passive immunisation of children at higher risk of hospitalisation, intensive care admission or death with RSV infection, which is a public health priority.

Changing practice

Using data from 57, 824 hospital admissions, **ISARIC** developed and validated an easy-to-use risk stratification score based on commonly available parameters at hospital presentation. The 4C Mortality Score outperformed existing scores, showed utility to directly inform clinical decision making, and can be used to stratify patients admitted to hospital with COVID-19 into different management groups.

Vulnerable populations

It is not known what impact SARS-CoV-2 will have on pregnant women and their babies. Single case reports of COVID-19 infection in pregnant women, with vertical transmission of infection to infants, are emerging, and given known adverse pregnancy outcomes of both SARS-CoV and MERS-CoV, a rapid study on COVID-19 infection in pregnancy is important to inform prevention and treatment. The **UK Obstetric Surveillance System (UKOSS)** is being used to determine the incidence of hospitalisation with COVID-19 infection in pregnancy and assess the outcomes of COVID-19 in pregnancy for mother and infant.

Targeting Treatments, reducing harms

Recent research indicates that people with some types of breast cancer may not benefit from chemotherapy and would do just as well with hormone treatment alone. Current methods are not as good as we would like, which means that some patients may be given chemotherapy unnecessarily. Tests have been developed to try to predict which people could avoid chemotherapy but research is needed into how best to use all of these tests.

The **OPTIMA** study is investigating whether a personalised decision about chemotherapy using these new tests can be made safely and effectively. We hope to learn how to target treatment towards those that need it and save other patients from having unnecessary chemotherapy.

New Treatments

Having launched as an emergency response in just nine days in March 2020, **RECOVERY** has found three effective treatments for COVID-19, discoveries that have vastly improved the care of patients hospitalised by coronavirus worldwide. These are: the inexpensive steroid dexamethasone, the arthritis treatment tocilizumab, and Ronapreve, a synthetic monoclonal antibody treatment that protects the immunocompromised. The study has also proved six other treatments to be ineffective against COVID-19 (including hydroxychloroquine and convalescent plasma), helping healthcare services to prioritise resources.

The **RECOVERY** Trial is currently testing the following treatments: high-dose vs standard corticosteroids, empagliflozin (a drug for diabetes and heart and kidney disease) , sotrovimab (a monoclonal antibody treatment against the spike protein) and molnupiravir (an antiviral treatment).

The number of patients receiving NHS services provided or sub-contracted by Mid Cheshire Hospitals NHS Foundation Trust that were recruited between 01/04/21 and 02/03/2022 to participate in research approved by a research ethics committee was 969.

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.

As a result of the Coronavirus Pandemic a number of monitoring elements, such as CQUINs and Quality Schedule have been suspended during 2020-2022. Despite the suspension of monitoring requirements, we have continued to make good progress on our quality and safety improvements and in response to the COVID-19 pandemic the Trust has undertaken a number of initiatives to ensure the highest standards of Infection Prevention and Control measures are in place. Plans to achieve CQUIN goals for 2022-2023 are underway.

Feedback from Care Quality Commission (CQC)

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 registered without conditions. 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). The Care Quality Commission has not taken enforcement action against the Trust during the period April 2020 to March 2021.

As detailed within our Statement of Purpose the Trust is registered to provide the following core services:

- Urgent and emergency services
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity

- Services for children & young people
- End of life care
- Outpatients
- Gynaecology and Termination of Pregnancy
- Diagnostic Imaging service
- Community health services for adults
- Community health services for children, young people and families
- Community health inpatient services
- Community end of life care

The Trust was inspected by Care Quality Commission during November and December 2019. During their visit they undertook unannounced inspections of 3 Core Services:

- Urgent and emergency services
- Medical care (including older people's care)
- Community health services for children, young people and families

During these inspections the CQC investigated key lines of enquiry using the pre-inspection information the Trust had provided within their Provider Information Return, and information CQC gathered during inspection activity from patients, their families and carers, and Trust staff. The Trust maintained their overall rating of "Good" following this round of inspections.

As the Trust has not been inspected by the CQC during 2021/22 the previous CQC ratings remain in place. The reports from this 2019/20 inspection have been published and are available on the CQC's website along with their ratings of the care. Our latest ratings can be seen here:

The Trust developed an improvement plan in response to the 2019 CQC inspection findings. Divided in to “must do” and “should do” actions, the CQC improvement plan responded to each of the findings, and by October 2020, all the “must do” actions had been addressed, and shortly following this all the Should do actions were closed. A new group has formed in the Trust to look at the new CQC inspection process regarding Direct Monitoring and to prepare for inspection.

The meeting is Chaired by Director of Nursing & Quality, and members include Deputy Medical Director, Heads of Nursing, Assistant Medical Directors, and Divisional General Managers.

As part of the Trust’s quality and safety assurance framework, an annual programme of unannounced inspection visits was planned for 2021/22, to seek assurance of care and services delivered being safe, effective, responsive, caring and well led. Due to pressures experienced trust-wide during the response to the COVID-19 pandemic, fewer inspections were held than originally planned. Where unannounced inspections have been undertaken, they have focused on assessing areas and services identified by the CQC as requiring improvement and have aimed to evidence that where changes have been implemented these have resulted in sustained improvement. Ward 13 was prioritised in this programme of work and an improvement plan was put in place in response to the findings.

The Trust has maintained contact with its designated CQC Relationship Manager within year. Regular engagement meetings have been held over Microsoft Teams, with attendance from Trust Executives and senior leaders.

The Trust maintained their rating of “Good” for the Use of Resources assessment following the latest inspection. The Use of Resources assessments are designed to improve understanding of how effectively and efficiently trusts are utilising their financial and human resources.

The Trust has received 22 enquiries from the CQC during 2021/22. All responses were returned within the given timeframes.

The Trust has contributed to the SEND CQC inspection within Cheshire and Wirral Partnership Trust and will be implementing an improvement plan within the Community Paediatric service.

Data Quality Assurance

NHS and General Practitioner registration code validity (April 21 – January 21) From NHS Digital SUS dashboard)

The Trust submitted records during 2021/22 to the secondary uses service for inclusion in the Hospital Episodes Statistics which are included in the latest published data.

- 99.9% for admitted patient care;
- 100% for outpatient care;
- 96.2% for accident and emergency care.

The percentage of records in the published data which included the patient's valid General Medical Practice code was:

- 99.6% for admitted patient care;
- 97.3% for outpatient care;
- 98.5% for accident and emergency care.

Information Governance, Data Security and Protection Toolkit (DSPT) status

Mid Cheshire Hospitals NHS Foundation Trust, like all NHS organisations, is required to meet the standards of the DSPT. The DSPT is a key performance indicator for the Trust on all areas of information governance and IT security.

The DSPT is measured by an online submission and an external audit both of which ordinarily require completion by the 31st March.

However due to the impact of COVID-19 the deadline for the 2021/22 submission has been extended to the 30th June 2022. Due to this extension the Trust is not in a position to publish its 2021/22 DSPT status as part of this Quality Account.

However, the Trust is currently in a strong position regarding its DSPT progress and is expected to meet the 2021/22 standard as it did in 2020/21. Please note that the outcome of the Trust's DSPT submissions is available on the NHS Digital website once finalised.

Clinical coding error rate

The Trust was not subject to the Payment by Results clinical coding audit during 2021/22 by the Audit Commission.

The Clinical Coding department were subject to a Data Security Protection Toolkit (DSPT) audit, the results of this audit are tabled below.

CODING FIELD	MCHT PERCENTAGE CORRECT	MANDATORY STANDARD	ADVISORY STANDARD
Primary Diagnosis	90:00%	90.00%	95:00%
Secondary Diagnosis	94:00%	80:00 %	90.00%
Primary Procedure	98:00%	90:00 %	95:00%
Secondary Procedure	92:00%	80:00%	90:00%

The Trust will continue to take the following actions to improve data quality:

- Deliver a robust annual clinical 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 and Clinical Coding Operational Group where appropriate.
- Continue to support and delver an internal training programme for Novice Clinical Coders, through the mentorship programme delivered by the Clinical Coding Team Leaders.
- Continue to invest in the training to all Clinical Coders, to support their professional development and enhance their skill set.
- Continue to support and encourage Novice Clinical Coders to gain their Accredited Clinical Coding (ACC) exam to obtain clinical coding qualified status.
- 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.

Patient Safety Alerts Compliance 2020/21

Mid Cheshire Hospitals NHS Foundation Trust is a recipient of patient safety alerts issued via the Central Alerting System (CAS). The Trust has a robust governance structure for the management of patient safety alerts.

The Trust's Compliance and Regulation Manager acts as the Central Alerting System Liaison Officer (CASLO). The CASLO is responsible for the retrieval of alerts from the MHRA website, their subsequent management within the Trust and updating the MHRA website on closure of designated alerts. The Trust utilises its risk management system, Ulysses Safeguard, to manage patient safety alerts and this includes the distribution of alerts within the Trust and managing evidence of compliance with each alert.

Patient Safety Alerts are overseen by the Executive team and each patient alert will have a nominated Executive Lead. The Compliance and Regulation Manager will action each patient safety alert with the relevant senior management clinical team.

During 2021/22, the Trust received nine patient safety alerts; none breached the timeframes allocated.

Reference	Title	Date Alert Issued	Deadline	Status
NatPSA/2022/002/MHRA	Philips Health Systems V60, V60 Plus and V680 ventilators - potential unexpected shutdown	29-Mar-22	31-May-22	Closed - Action Was Not Required
NatPSA/2022/001/UKHSA	Potential contamination of Alimentum and Elecare infant formula food products	04-Mar-22	11-Mar-22	Closed - Actions Completed
NatPSA/2021/010/UKHSA	The safe use of ultrasound gel to reduce infection risk	11-Nov-21	31-Jan-22	Closed - Actions Completed
NatPSA/2021/009/NHSPS	Infection risk when using FFP3 respirators with valves or Powered Air Purifying Respirators (PAPRs) ...	25-Aug-21	25-Nov-21	Closed - Actions Completed
NatPSA/2021/008/NHSPS	Elimination of bottles of liquefied phenol 80%	25-Aug-21	25-Feb-22	Closed - Actions Completed
NatPSA/2021/007/PHE	Potent synthetic opioids implicated in increase in drug overdoses	18-Aug-21	20-Aug-21	Closed - Actions Completed
NatPSA/2021/006/NHSPS	Inappropriate anticoagulation of patients with a mechanical heart valve	14-Jul-21	28-Jul-21	Closed - Actions Completed
NatPSA/2021/005/MHRA	Philips ventilator, CPAP and BiPAP devices: Potential for patient harm due to inhalation of particle ...	23-Jun-21	21-Feb-22	Closed - Actions Completed
NatPSA/2021/004/MHRA	Recall of Co-codamol 30/500 Effervescent Tablets, Batch 1K10121, Zentiva Pharma UK Ltd due to precau ...	16-Jun-21	21-Jun-21	Closed - Action Was Not Required
NatPSA/2021/003/NHSPS	Eliminating the risk of inadvertent connection	16-Jun-21	16-Nov-21	Closed - Actions Completed

	to medical air via a flowmeter			
NatPSA/2021/002/NHSPS	Urgent assessment/treatment following ingestion of 'super strong' magnets	19-May-21	19-Aug-21	Closed - Actions Completed

Never Events 2021/22

Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventable measures have been implemented.

In 2021/22, three incidents occurred which met the definition of a Never Event at Mid Cheshire Hospitals NHS Foundation Trust. A comprehensive root cause analysis was undertaken, and an improvement plan developed to prevent reoccurrence.

The table below provides a description of the incident and outlines the root cause and the recommendations. The patient was informed immediately of the incident and the learning has been shared.

Summary of Never Events 2021/22			
Type of Never Event	**Description of incident**	**Root Cause**	**Recommendations**
Wrong Implant June 2021	A patient consented to and was listed for a right total knee replacement. Despite routine checks being undertaken, during the procedure an incorrect component was implanted. This was discovered on the third set of checks, before the cement had cured, the component was removed, and the correct	A formal stop was not carried out before the insertion of the implants	The Standard Operating Procedure and checklist for the checking of implants have been updated utilising the LocSSIP. Incoming calls to theatres are now diverted to prevent distraction in theatre, but to allow emergency calls out to be made

Summary of Never Events 2021/22			
Type of Never Event	**Description of incident**	**Root Cause**	**Recommendations**
	component implanted. **No Harm**		
Wrong Site Surgery October 2021	A patient was admitted following consent for repair of a laparoscopic inguinal hernia on the left side. However, the approach for a right sided laparoscopic hernia repair was initially undertaken. **Low Harm**	The surgery is high risk for incorrect side surgery to occur, due to the laparoscopic nature, where if the operating Surgeon has a momentary lapse of concentration, it is difficult for nursing staff to be aware if the correct side has been identified	The outcomes from this are that effective barriers are required to mitigate against recurrence and therefore the local standard for invasive procedures (LocSSIP) has been amended to reflect the "stop" moment for the team to focus on the correct procedure being undertaken. A clinical audit of this will be completed, from which the outcomes will provide assurance of the efficacy of this action.The Theatre team will also participate in the Advancing Quality Alliance (AQuA) Safety Culture sessions to enhance their working relationships in the theatre environment.
Wrong Site Surgery December 2021	A patient undergoing a scar removal following a previous biopsy had the incorrect scar excised. The patient had multiple scars from previous excisions and a large tattoo covered the area. The patient was relisted and had	The investigation is currently ongoing	The investigation is currently ongoing however immediate actions were taken which included: • The process from decision to excise to surgical removal has been reviewed by the Associate Medical Director for Patient Safety and the Quality Governance Manager, incorporating

Summary of Never Events 2021/22			
Type of Never Event	**Description of incident**	**Root Cause**	**Recommendations**
	the correct surgery completed within 48hours. An observational review of the procedure is to be undertaken to identify any gaps in barriers.		environmental visits and staff debrief • Medical photographs are made available to the operating surgeon at the time of the procedure.

Learning from the Maternity Healthcare Safety Investigation Branch (HSIB) 2021 / 2022

Between 2021/22 the Trust referred a total of 10 maternity cases to the HSIB and 9 of those cases were progressed.

In 2021/22 the HSIB returned 5 final reports and the Trust received a total of 18 safety recommendations. A total of 31 improvement actions has either been completed or are in progress, in response to the safety recommendations.

HSIB have published 5 national learning reports, the Trust is currently collating the learning and will demonstrate assurance regarding the safety recommendations or develop actions where there are assurance gaps as appropriate.

Implementation of the National Patient Safety Strategy

The Trust is currently in the process of implementing the National Patient Safety Strategy which was launched in 2019. As part of the implementation of the Strategy four Patient Safety Specialists have been nominated in the Trust, led by the Associate Medical Director for Patient Safety.

The Trust has developed a policy based on the national recommendations for the introduction of Patient Safety Partners. In June 2021 the *Framework for Involving Patients and Patient Safety,* was announced as a priority in the NHS Patient Safety Strategy. Presented in two parts, the Framework describes how organisations should:

- Part 1 support patients, their families, and carers to be directly involved in their own or their loved one's safety
- Part 2 support and embed the new Patient Safety Partner (PSP) role in becoming involved in wider governance and leadership of safety activities within health care organisations.

The policy was agreed at the Trust Patient Safety Group and the recruitment process to embed part 2 of the framework is underway in the Trust.

The Trust investigation process has been strengthened to ensure that all patients and or their family members are involved in the investigation process of all serious incidents. A liaison officer is nominated for all serious incident investigations. The liaison officer will ensure that the patient and or family member is given the opportunity to be,

- asked if they have anything, they wish the investigation to consider
- asked to provide their account of events
-

The Patient Safety Specialists will continue to implement the recommendations made in the National Patient Safety Strategy in 2022/23

Learning from Deaths 2021/22

During quarters one to four 1299 patients were part of the Learning from Deaths process within Mid Cheshire Hospitals NHS Foundation Trust.

Number of deaths included in the Learning from Deaths process 2021/22	
Quarter	**Number of deaths**
April 2021 to March 2022	1299
Quarter 1 2021/22	400
Quarter 2 2021/22	279
Quarter 3 2021/22	303
Quarter 4 2021/22	317

By the end of March 2022, 88 case record reviews were carried out in relation to 1299 deaths. In 3 cases an investigation was undertaken and in 3 both a case record review and an investigation was completed.

Number of case record reviews/investigations during 2020/21	
Quarter	**Deaths reviewed or investigated (as of end of April 2021)**
April 2021 to March 2022	88
Quarter 1 2021/22	14
Quarter 2 2021/22	29
Quarter 3 2021/22	20
Quarter 4 2021/22	25

1 (0.07**%** of 1299 of total deaths) deaths reviewed or investigated (as at the end of April 2021) and were judged more likely than not to have been due to problems in care provided to the patient. The ***number*** all underwent a comprehensive investigation and were reported as a serious incident in line with the National Serious Incident Framework.

Number of deaths reviewed which were judged more likely than not to have been due to problems in care provided to the patient	
Quarter	**Deaths reviewed which were judged more likely than not to have been due to problems in care provided to the patient.**
April 2021 to March 2022	1
Quarter 1 2021/22	1
Quarter 2 2021/22	0
Quarter 3 2021/22	0
Quarter 4 2021/22	0

These numbers have been estimated using the Structured Judgement Review (SJR) and comprehensive investigations processes.

The Trust learns from inpatient deaths by undertaking mortality reviews using the Royal College of Physicians SJR Process. SJRs are undertaken by a cohort of senior medical and nursing staff trained in the SJR process.

SJR blends traditional, clinical judgement-based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score 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 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 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.

SJRs are undertaken on all deaths which meet the criteria below:

- Deaths where families, carers or staff raise concerns
- Deaths where concerns are raised by the Coroner
- Deaths where concerns are raised at the Patient Safety Summit via clinical incident reports
- All learning disability deaths
- All deaths of patients who have a diagnosed serious mental health illness
- Outlier data deaths (Liver disease and CCF Non hypertensive) – suspended
- Medical Examiner concerns (all in-patient deaths will be scrutinised by a Medical Examiner)
- Divisional Review Concerns

Where an SJR identifies a potentially avoidable death and or poor care, a report is obtained from both the consultant responsible for the case and their clinical lead or Associate Medical Director addressing the issues raised by the SJR and any lessons learned. In addition, a peer review SJR is undertaken. In the event of a discrepancy between the initial SJR and the peer review SJR, a final judgement is made at Hospital Mortality Reduction Group.

Subsequent organisation learning from the Divisional Reviews, RCA's and the SJR process must be dynamic, with immediate actions and improvements undertaken in a timely manner to prevent reoccurrence. The Trust's Incident Reporting, Management, Learning and Improvement policy describes the approach to organisational learning.

The Trust holds a six-monthly meeting for all SJR reviewers. The purpose of the meeting is to share the learning from the SJR process and provide additional support for the SJR reviewers.

The Trust has a well-established mortality reduction group led by the Associate Medical Director for Patient Safety. This group leads the Trust's mortality reduction programme.

The Trust also undertakes a review of all Learning Disability Deaths. These reviews are led by the Privacy and Dignity Matron who is Learning Disabilities Mortality Review (LeDeR) trained. Learning is reported through the Trust Mortality Groups.

Total Deaths Reviewed by LIKERT Score (Completed SJRs)

	Definitely not preventable	Slight evidence for preventability	Possibly preventable but not very likely, less than 50-50	Probably preventable, more than 50-50	Strong evidence for preventability	Definitely preventable
This Year (21/22) N=88	73	11	3	1	0	0

(Source: SJR database, 2022)

Total Deaths Reviewed by Overall Care Score (Completed SJRs)

	Excellent Care	Good Care	Adequate Care	Poor Care	Very Poor Care
This Year (21/22) N=88	18	42	24	4	0

(Source: SJR database, 2022)

Learning from the Structured Judgement Reviews is shared through several forums including at Grand Rounds, Divisional Quality Improvement Sessions and Medical Training Sessions. Learning is also shared as a patient story within the Divisional Teams.

Performance against quality indicators and targets

National quality targets

	2017-18	2018-19	2019-20	2020-21	2021-22	Target	Achieved
Clostridium Difficile infections	2 avoidable cases	2 avoidable cases	2 avoidable cases	3 avoidable cases	10 avoidable cases to date	0	✖
Percentage of patient who wait	87.12%	83.63%	76.78%	85.08%	64.95%	95%	✖

4 hours or less in A&E							
The percentage of patients waiting 6 weeks or more for a diagnostic test	0.31%	0.41%	3.27%	42.31%	35.09%	1%	✖
Summary Hospital-level Mortality Indicator	-	100.95	99.47	94.30	97.20	-	-
Venous thromboembolism (VTE) risk assessment	95.50%	95.24%	95.91%	96.01%	94.11%	95%	✖
Percentage of patients receiving first definite treatment for cancer within 62 days of an urgent GP referral for suspected cancer	93.70%	88.98%	86.22%	75.87%	82.01%	85%	✖
Percentage of patients receiving first definite treatment for cancer within 62 days of referral from an NHS Cancer Screening Service	97.09%	94.44%	89.29%	84.97%	73.11%	90%	✖
The percentage of Referral to Treatment (RTT) pathways within 18 weeks for incomplete pathways	95.90%	92.38%	91.37%	69.02%	60.50%	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.

Indicator	Measure Description			
SHMI	A) The value and banding of the summary hospital-level mortality indicator ('SHMI') for the Trust for the reporting: and			
December 19 - November 20	95.45	100	113.28	88.27
January 20 - December 20	95.01	100	113.01	88.49
February 20 - January 21	94.93	100	112.50	88.89
March 20 - February 21	93.11	100	112.63	88.79
April 20 - March 21	94.30	100	112.80	88.51
May 20 - April 21	93.96	100	112.64	88.78
June 20 - May 21	93.74	100	112.35	89.01
July 20 - June 21	95.26	100	111.99	89.29
August 20 - July 21	95.80	100	112.06	89.24
September 20 - August 21	96.75	100	111.89	89.37
October 20 - September 21	97.20	100	111.75	89.48

The value and banding of the summary hospital-level mortality indicator ('SHMI')

The Trust considers that this data is as described for the following reasons:

- For the reporting period October 2020 to September 2021 the Trust SHMI was 97.20.
- 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:

- Having a well-established Mortality Reduction Group (MRG) led by the Associate Medical Director for Patient Safety. This group monitors the mortality reduction improvement plans across 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.			
December 19 - November 20	1.36%	1.51%	-	-
January 20 - December 20	1.37%	1.47%	-	-
February 20 - January 21	1.46%	1.50%	-	-
March 20 - February 21	1.63%	1.59%	-	-
April 20 - March 21	1.69%	1.59%	-	-
May 20 - April 21	1.57%	1.52%	-	-
June 20 - May 21	1.50%	1.48%	-	-
July 20 - June 21	1.46%	1.44%	-	-
August 20 - July 21	1.45%	1.44%	-	-
September 20 - August 21	1.44%	1.44%	-	-
October 20 - September 21	1.45%	1.42%	-	-

The value and banding of the summary hospital-level mortality indicator ('SHMI')

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.

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**
April 2019 - June 2019	96.31%	No data available	No data available	No data available
July 2019 - September 2019	96.48%	No data available	No data available	No data available
October 2019 - December 2019	95.63%	No data available	No data available	No data available
January 2020 - March 2020	95.36%	No data available	No data available	No data available
April 2020 - June 2020	95.71%	No data available	No data available	No data available
July 2020 - September 2020	96.45%	No data available	No data available	No data available
October 2020 - December 2020	99.10%	No data available	No data available	No data available
January 2021 - March 2021	95.38%	No data available	No data available	No data available
April 2021 - June 2021	94.18%	No data available	No data available	No data available
July 2021 - September 2021	93.80%	No data available	No data available	No data available
October 2021 - December 2021	94.21%	No data available	No data available	No data available
January 2022 - February 2022	94.40%	No data available	No data available	No data available

The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE).

The Trust considers that this data is as described for the following reasons:

- There has been a decrease in the compliance rate with VTE risk assessment in the last year during the Covid-19 pandemic.

The Trust has taken the following actions to improve this result, and therefore the quality of its service, by:

- Developing a daily report which is sent to each ward and highlights any patients that have not yet had a completed VTE risk assessment entered onto the patient records. The Ward Manager/ Coordinator will then highlight the cases that require a risk assessment to the medical team to ensure it is completed. The patient record is then updated accordingly

- Monthly monitoring of the percentage of patient's risk assessed for VTE by the clinical Divisions and Trust Patient Safety Group

- 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.

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	**MCHFT Performance**	**National Average**	**Upper Limit**	**Lower Limit**
1st Oct 2016 to 31st Mar 2017	3,353	5,122	14,506	1,301
1st Apr 2017 to 30th Sep 2017	3,485	5,226	15,228	1,133
1st Oct 2017 to 31st Mar 2018	3,462	5,449	19,897	1,311
1st Apr 2018 to 30th Sep 2018	3,663	5,583	23,692	566
1st Oct 2018 to 31st Mar 2019	3,711	5,841	22,048	1,278
1st Apr 2019 to 30th Sep 2019	3,808	6,276	21,685	1,392
1st Oct 2019 to 31st Mar 2020	4,084	6,502	22,340	1,758

1st April 2020 to 31st March 2021	7, 398	12, 502	37,572	3,169

Please note from April 2020 the data is reported annually rather than 6 monthly.

Mid Cheshire Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- All patient safety incidents are captured on the Trusts incident reporting system. These are then uploaded to the National Reporting & Learning System (NRLS)

- The level of reporting of incidents in the Trust demonstrates a risk aware culture and highlights that the Trust has a positive safety culture where staff feel able to report patient safety incidents. The data above demonstrates that staff have continued to report incidents throughout the pandemic. An education programme has also been undertaken in the Trusts community services to improve reporting in this area,

- The Trust consistently reports more no harm/near miss incidents than harm incidents, which again demonstrates a positive risk aware culture within the Trust. 63% (4635) of the incidents reported resulted in no harm compared to 37% (2763) which resulted in a level of harm (low to severe),

- Themes and trends from incidents are reported to the appropriate Trust Committees and Groups monthly for discussion, analysis and for learning to be identified and acted upon. Examples of these committees includes the Skin Care Group, the Patient Falls Prevention Group, the Medical Devices Group and the Nutritional Advisory Group.

The Trust has taken the following actions to improve the reporting of patient safety incidents and therefore the quality of its service:

- A daily huddle chaired by the Associate Director of Quality Governance is held. The huddle is attended by the Quality Governance Managers, Patient Safety Team and Quality Governance Senior Team. Incidents from the previous 24 hours are discussed to ensure they have the appropriate level of harm assigned and level of investigation required is agreed

- Patient Safety Summit is a weekly meeting led by clinical teams. The Summit provides an opportunity for cross-divisional learning and sharing of immediate learning following incidents. All moderate and above patient safety incidents are discussed at the Summit along with all cardiac arrests, delays in referral to critical care outreach and child

deaths. Clinical teams are encouraged to attend to promote learning and improvement. The Patient Safety Summit is chaired by the Medical Director

- Following 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 staff is provided this ensures that staff know how to report a patient safety incident and they also understand the importance of incident reporting. This training is provided face to face and via an eLearning module

- Direct feedback is provided 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

- A telephone line has been set up in the organisation which allows staff to report an incident over the phone if they are unable to access a PC to report the incident online. The incident is then input on to the incident reporting system by the Patient Safety Team

- A weekly triangulation meeting is held, attended by the patient safety, patient experience and legal teams. All new, incidents graded as potentially moderate and above, complaints, claims and inquests are reported at the meeting to ensure that learning is captured and triangulated.

Indicator	**Measure Description**			
Patient Safety Incidents	The number and percentage of such patient safety incidents that resulted in severe harm or death.			
Period	**MCHFT Performance**	**National Average**	**Upper Limit**	**Lower Limit**
1st Oct 2016 to 31st Mar 2017	4	6	31	0
1st Apr 2017 to 30th Sep 2017	1	5	29	0
1st Oct 2017 to 31st Mar 2018	3	5	24	0
1st Apr 2018 to 30th Sep 2018	4	5	22	0

1st Oct 2018 to 31st Mar 2019	5	5	23	0
1st Apr 2019 to 30th Sep 2019	1	5	24	0
1st Oct 2019 to 31st Mar 2020	6	5	22	0
1st April 2020 to 31st March 2021	18	55	261	4

Mid Cheshire Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust has seen an increase in the reporting of serious incidents in the period April 2020 to March 2021. The Trust has a positive reporting culture. Incidents where there is the potential for learning are reported as serious incidents to ensure openness and transparency.

The Trust has taken the following actions to improve the reporting of patient safety incidents and therefore the quality of its service:

- The Trust has invested in external root cause analysis training for all staff that undertake serious incident investigations. This training is also attended by members of the executive team and senior members of the divisional teams.

- Quality Governance Managers are attending the HSIB investigation training in preparation for the PSIRF introduction in 2022-23.

- All serious incidents are discussed at the Quality Governance daily huddle and at the weekly Patient Safety Summit.

- All serious incidents are reported to the Executive Team on a weekly basis by the Medical Director. All serious incidents are reported to board level through a serious incident report. The report also highlights themes in incident reporting identified in month and learning from Patient Safety Summit. This ensures openness and transparency within the Trust.

- The Trust has implemented *Being Open* and Duty of Candour which ensures that, if an incident occurs which results in moderate harm, severe harm or death, the patient and or their family are informed of the incident, involved in the investigation and the development of the final report. The report, lessons learned, and improvement plans from any investigation are shared with the patient and or their family.
  Compliance with Duty of Candour is monitored through the daily Quality Governance Huddles. This is to ensure that Duty of Candour is applied to all incidents where it is required. Compliance is further monitored through the monthly Trust Patient Safety Group.

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**	**Upper 95% control limit**	**Lower 95% control limit**
Hip Replacement					
April 18-March 19	EQ5D	0.43	0.46	0.57	0.33
April 18-March 19	VAS	15.18	14.05	20.17	5.27
April 18-March 19	OXFORD HIP	21.87	22.30	26.166	18.52
April 19-March 20	EQ5D	0.446	0.460	0.504	0.417
April 19-March 20	VAS	11.917	14.1	17.251	10.898
April 19-March 20	OXFORD HIP	22.966	22.4	23.971	20.927
April 20-March 21	EQ5D	0.439	0.467	0.523	0.411
April 20-March 21	VAS	15.499	14.7	18.746	10.620
April 20-March 21	OXFORD HIP	21.857	22.6	24.530	20.628
Knee Replacement					
April 18-March 19	EQ5D	0.31	0.34	0.40	0.25
April 18-March 19	VAS	5.51	7.42	12.70	0.15
April 18-March 19	OXFORD KNEE	16.83	17.19	20.09	13.52
April 19-March 20	EQ5D	0.308	0.341	0.380	0.303
April 19-March 20	VAS	6.160	7.9	10.774	5.059

April 19-March 20	OXFORD KNEE	17.563	17.3	18.753	15.926
April 20-March 21	EQ5D	0.364	0.317	0.376	0.259
April 20-March 21	VAS	7.021	7.5	11.651	3.316
April 20-March 21	OXFORD KNEE	18.309	16.7	18.735	14.627

The Trust's patient reported outcome measure scores for hip replacement surgery and knee replacement surgery during the reporting period.

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 remains inline with National expected average range of improvement. In 2019 -20 performance increase with our Oxford Hip and Knee PROM's scores higher than the national average.

The Trust intends to take / have 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.
- Undertake an annual review including individual surgeon PROMS scores in conjunction with NJR figures.

- Using the Model Hospital Framework, benchmark our Trust against surrounding Trust

Indicator	Measure Description	
Readmission Rates	The percentage of patients aged 0 to 15 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 2016 – Dec 2016	12.14%	10.44%
Jan 2017 - Dec 2017	12.41%	10.69%
Jan 2018 - Dec 2018	13.58%	11.38%
Jan 2019 - Dec 2019	12.61%	11.96%
Jan 2020 - Oct 2020	12.39%	11.46%
Period	**Trust per CHKS**	**Peer Group av CHKS**
Jan 2021 - Dec 2021 *	13.96%	12.19%

The percentage of patients aged 0 to 15 readmitted to a hospital which forms part of the Trust within 28 days of being discharged.

The Trust considers that these results are as described for the following reasons:

The Trust saw an upward trend in readmission rates between January 2021 and December 2021. Readmissions during this time frame were varied as activity has continued to be atypical since the beginning of the national pandemic. The increase in readmissions for new-borns experiencing weight loss and jaundice following discharge from inpatient maternity services seen in 2020 continued to fluctuate during 2021 due to availability of community services during a challenging period (due to sickness absence).

There has been a slight increase in the number of readmissions with respiratory viral infections, which is attributed to the predicted surge in children under age 2 presenting with bronchiolitis. This cohort of children have not been exposed to the usual viral illnesses due to the national COVID-19 measures i.e., social distancing.

The Trust intends to take / have taken for the following actions to improve this result, and therefore the quality of its service, by monitor readmissions and expects to see a reduction in readmissions as services adjust to the new normal and service delivery within the community affected by high rates of COVID-19 sickness absence return to business as usual.

Indicator	Measure Description	
Readmission Rates	The percentage of patients aged 16 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 2016 – Dec 2016	8.23%	7.73%
Jan 2017 - Dec 2017	9.04%	8.16%
Jan 2018 - Dec 2018	8.52%	7.63%
Jan 2019 - Dec 2019	8.99%	8.50%
Jan 2020 - Oct 2020	10.54%	9.27%
Period	**Trust per CHKS**	**Peer Group av CHKS**
Jan 2021 - Dec 2021 *	9.57%	8.73%

The percentage of patients aged 16 and over readmitted to a hospital which forms part of the Trust within 28 days of being discharged

The Trust considers that this data is as described for the following reasons:

Analysis of the data shows that almost 27.43% were from admissions that were discharged from Clinical Decisions Unit (CDU). When CDU admissions are removed the readmission % with 28 days falls below the peer average at 7.13%. There has been an improvement in the % of readmissions compared to 2020, which was impacted by raised admission rates at the start of the COVID-19 pandemic.

There was an increase in total admissions in 2021 with 51.24% being admitted into CAU and AMU. Overall, 82.27% of readmissions had an emergency admission originally. A greater proportion are therefore related to the AE specialty, which are more likely to have a readmission.

The Trust will take the following actions to improve this result, and so the quality of its service, by:

- Post the COVID-19 pandemic to identify any complex patients and frequent attenders being readmitted and design services to prevent this
- Continue to provide monthly information to clinical teams, through the Divisional Governance structure, to enable speciality led reviews where re-admission rates are high. *provisional data – Please note a change in the benchmarking company from HED to CHKS, *latest figures taken from CHKS on 21/03/2022.*

Indicator	Measure Description			
Clostridium difficile	The rate per 100,000 bed days of cases of Clostridium 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**
2017-2018	11.1	13.65	90.3	0
2018-2019	13.5	11.5	81.6	0
2019-2020	9.92	13.62	51.1	0
2020-2021	15.2	15.4	92.6	0

The rate per 100,000 bed days of cases of Clostridium difficile (Cdiff) infection reported within the Trust amongst patients aged 2 or over

The Trust considers that this data is as described for the following reasons:

Prior Healthcare Exposure

From April 2017, reporting Trusts were asked to provide information on whether patients with CDI had been admitted to the reporting trust within the three months prior to the onset of the current case. This allows a greater granulation of the healthcare association of cases.

* Hospital-onset healthcare-associated (HOHA) - Date of onset is ≥ 2 days after admission (where day of admission is day 1)

* Community-onset healthcare-associated (COHA) - Date of onset is < 2 days after admission and the patient was admitted to the trust in the 4 weeks prior to the current episode

* Community-onset indeterminate association - Date of onset is < 2 days after admission and the patient was admitted in the previous 12 weeks, but not the previous 4 weeks prior to the current episode

* Community-onset community-associated - Date of onset is < 2 days after admission and the patient had not been admitted to the trust in the previous 12 weeks prior to the current episode.

Since 2018 HOHA and COHA categories are attributed to the reporting Trust.

CDI objectives were set for the Trust for 2021/22 at 27 cases. The Trust reported 33 cases of Cdiff in the HOHA category, 10 cases have been identified as avoidable, 18 cases were classified as unavoidable, 5 are awaiting PIR classification. 5 cases were reported in the COHA category awaiting classification PIR

• 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:

- Monitoring national and regional data sets to ensure data sets are consistently reporting accurate data.
- Aligned improvement work with regional colleagues to learn and share experiences.
- Closely monitor antimicrobial stewardship 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.
- Robust environmental visit programme with enhanced focus on cleaning, nursing and estates.

Part 3: Review of quality performance

Medicines Safety

The pharmacy has recently implemented a new automated dispensing robot and dispensing system. This will improve medication safety as the medications are scanned into the robot using the bar code reducing the risk of inadvertently selecting the wrong medication. The pharmacy has also undergone a large reconfiguration project which will promote workflow and efficiency therefore improving safety and turnaround times.

The pharmacy has also implemented automated medication cabinets in pharmacy and in the newly built Emergency Department. These use fingerprint recognition (so are secure, have a full audit trail and remove the need for keys) and helps staff find their requested medication quickly by illuminating the shelf where the medication is stored. The automated cabinets can monitor the stock and automatically order more from pharmacy when they are running low. This will reduce the number of times that medications are not available and release time to care as staff are not manually counting and ordering stock.

In February 22 the on-line medicines management training for nursing staff went live. This has been a huge piece for work for the specialist pharmacists and pharmacy technicians involved and includes adult and women and children's medicine management training. This now means that staff do not need to wait for the face-to-face training and can access the training at a time convenient to them.

The Trust continues to monitor medication related incidents at the Trust Safe Medicines Practice Group. The Group has approved numerous standard medication administration charts to promote standardised and safe prescribing of high-risk medications.

The pharmacy department currently has a number of vacancies which is impacting on service provision to wards and the dispensary function. Active recruitment is underway as is a staffing review to ensure appropriate and safe staffing levels. Over establishment (a 'bench') of pharmacy staffing has been approved to help the continuity of services. A plan to move to more FP10 (Community prescriptions) is being developed to release pharmacy time to focus on key hospital services.

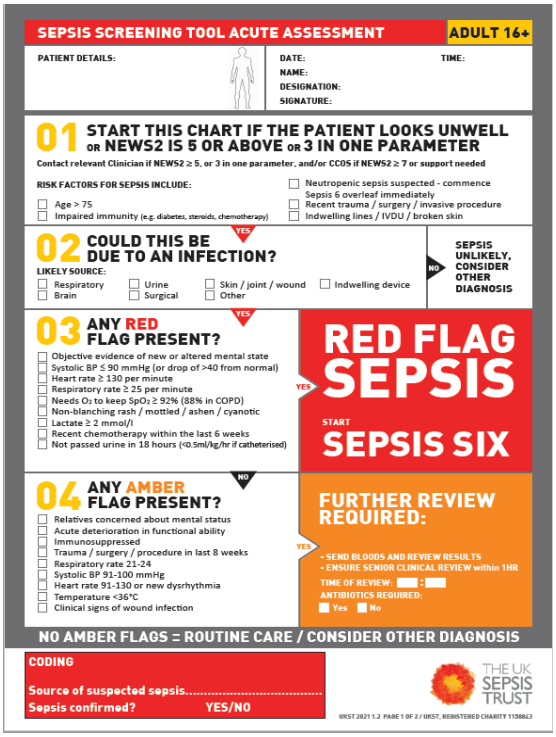
Preventing Deterioration and Sepsis

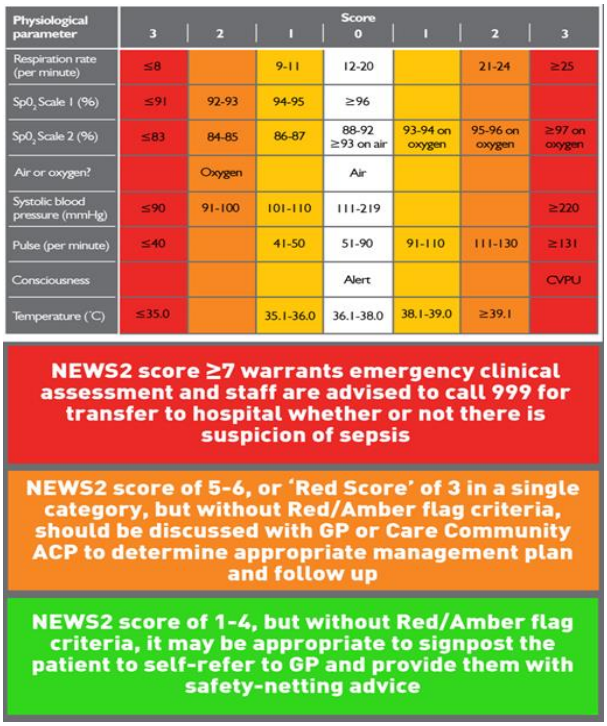
Mid Cheshire have continued to progress to improve early recognition and treatment of sepsis throughout 2021/22 despite the pressures and the unpredicted circumstance of the COVID-19 pandemic. The sepsis steering group continues to meet monthly when possible, bringing together disciplines from each division to review result of audits and identify improvement opportunities. Consisting of five workstreams: Community, Emergency Department hospital acquired, coding and education, there are plans to develop robust strategies for each lead of the five workstreams in the strategy to reduce sepsis.

Training has continued to be a priority for the Sepsis Steering Group with an emphasis on training of the sepsis PGD now in use for A&E staff including neutropenic sepsis, this enables patients to receive their lifesaving intravenous antibiotics promptly on arrival to the department. Education continues through the various avenues available to our staff including Quality Care Program, Sepsis E-learning, ward-based training, Harm Free Study Day, Acute Illness Management Course and Nurse and HCA Induction.

External Advancing Quality data related to sepsis performance indicates no significant shifts in performance over the past months but maintains the Trust in the GREEN and competitively well placed in the region. We are achieving the overall CPS target (70.4% against a target of 70.4%) for 2021/22. This encompasses aspects of early identification of sepsis, appropriate initial diagnostics and sepsis management. Looking at a total of 7 measures, composite process score (CPS) is calculated based on the pass rate of these measures for each patient included in the audit process. Senior review and the use of the Sepsis pathway continue to be the areas in most need of improvement.

All Sepsis pathways have been updated, standardised, approved and launched on the 15.03.2022. All five workstreams are working towards a plan to continue pathway education following the launch of the Sepsis pathway on the 15th March 2022 and improve Senior review delays.





Physiological parameter	Score 3	2	1	0	1	2	3
Respiration rate (per minute)	≤8		9-11	12-20		21-24	≥25
SpO_2 Scale 1 (%)	≤91	92-93	94-95	≥96			
SpO_2 Scale 2 (%)	≤83	84-85	86-87	88-92 ≥93 on air	93-94 on oxygen	95-96 on oxygen	≥97 on oxygen
Air or oxygen?		Oxygen		Air			
Systolic blood pressure (mmHg)	≤90	91-100	101-110	111-219			≥220
Pulse (per minute)	≤40		41-50	51-90	91-110	111-130	≥131
Consciousness				Alert			CVPU
Temperature (°C)	≤35.0		35.1-36.0	36.1-38.0	38.1-39.0	≥39.1	

Central Cheshire integrated care partnership - Sepsis

Within the past year, a community quality improvement project has been undertaken by Advanced Community Practitioners (ACP) to implement the use of the National Early Warning Score 2(NEWS2) tool to enable early identification of sepsis within community nursing teams.

Following this project, the following improvement have been made:

- Sepsis/NEWS2 e-learning is now mandatory and to be completed 2 yearly for NEWS2 & once for sepsis
- Community Sepsis Pathway and NEWS2 scoring charts have been developed and distributed to appropriate staff. These will go to every staff member completing observations as an A5 guide to be used within the patients' home or clinic setting
- Sepsis/NEWS2 information has been updated throughout the care communities from patient notes, patient safety netting advice and office notice boards
- Changes to the community EMIS template have been made to merge the NEWS2 template in with the community template observations section. This automatically calculates NEWS2 scores and advises on the likely appropriate outcomes if indicative of sepsis. The A5 tool can also be used in conjunction with this to help guide clinical decisions
- Bespoke training has also been offered/undertaken based on the training needs of each care community. Further training for new starters or refresher updates will be given when required for each care community
- Ongoing data collection will be undertaken to monitor the effectiveness of these changes and reviewed monthly. This includes figures on NEWS2/Sepsis e-learning completion, number of NEWS2 recordings within each care community and if an

appropriate escalation was recorded. This will give information on which areas may be struggling to use the new system/complete training, where appropriate further support will be offered by the ACP's on an individual care community basis.

Further to this work we have continued to train all the community therapists in NEWS2 and sepsis awareness as well as upskill them to taking basic observations (Temp, BP, Sp02, Pulse, RR, AVPU). Due to the number of community therapists this work is still ongoing and being delivered, alongside this there is also a rolling programme in place for new starters.

Maternal and Neonatal Safety

MCHFT Maternity Unit has been involved in the Maternity and Neonatal Safety Improvement Programme (MatNeoSIP) since its launch in 2016, the programme aims to:

- Improve the safety and outcomes of maternal and neonatal care by reducing unwarranted variation and provide a high-quality healthcare experience for all women, babies and families across maternity and neonatal care settings in England
- Contribute to the national ambition, set out in Better Births of reducing the rates of maternal and neonatal deaths, stillbirths, and brain injuries that occur during or soon after birth by 50% by 2025.

The Women and Children's Division is committed to a number of quality improvement projects following locally, regional and national strategy to improve the safety of services in both Maternity and Neonatology.

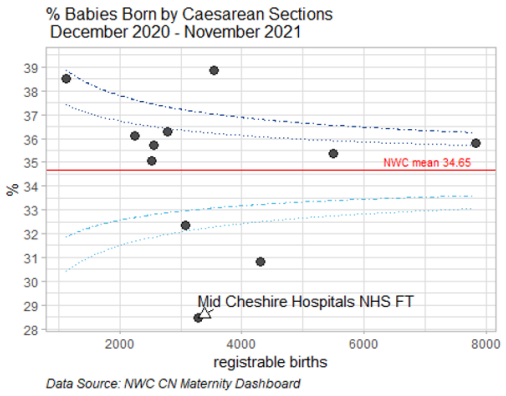
Measurements:

- Achievement of CNST Maternity Incentive Scheme Year 3.
- Delivery of the Baby Friendly Initiative, Saving Babies Lives Care Bundle and Neonatal FiCare.
- Training in Post-Partum Haemorrhage with improving guidance compliance.
- Term admissions to the Neonatal Unit reviewed with actions identified.
- Personalised Care Plans with improving Continuity of Care.

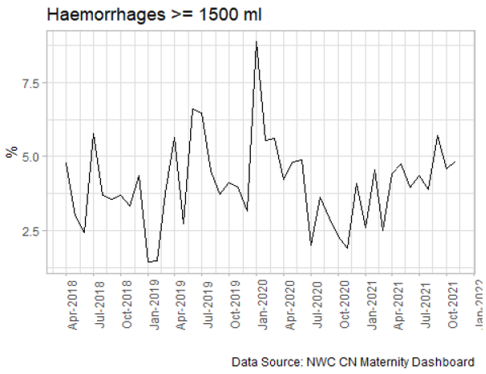
As part of the Trust's Quality and Safety Improvement Strategy 2020/21 the Women and Children's Division decided that the focus would be on training in identification and management of postpartum haemorrhage with the aim to improve the care and experience for women suffering a postpartum haemorrhage. This work continued into 2021/22. The Trust had been identified as an outlier in the Northwest region for Postpartum Haemorrhage above 1500mls during 2019/20, however by April 2021 MCHFT were no longer an outlier and this trend continues up to the latest comparison released in December 2021.

Percentage of Haemorrhages ≥1500 ml Caesarean Sections

Total Caesarean Sections



Run Chart for Percentage of Haemorrhages ≥1500 ml



Although the dashboard comparison showed rates were high, this does not show enough detail about the relationship between blood loss and maternal wellbeing following a large blood loss or effective management of the loss. This was looked at in more detail by looking at individual cases and carrying out a comparison of estimated blood loss, maternal wellbeing and the need for any additional treatment (fluids or blood transfusion).

A Postpartum Haemorrhage Risk Assessment & Management Checklist was introduced in October 2020 to be used for all women giving birth. The purpose is to identify women most at risk and to ensure measures are put in place to help prevent or manage the situation more efficiently if a haemorrhage occurs. An audit of the use of the proforma and management was undertaken using notes from February to November 2021, this showed that the proforma was fully completed in only 69% of cases reviewed. However, it was identified that the management was appropriate even in cases where the proformas was not used. An action plan has been developed to improve compliance in the areas identified during the audit.

The improved use of the form has been evident during recent case reviews. The use of the form will be audited in the ongoing documentation audit, it will be also included in the standard labour notes to make it easier to remember to complete for staff.

Initially the Royal College of Obstetricians and Gynaecologists (RCOG) Heaving Blood Loss Following Birth was given to women, however it was adapted in March 2021 to include a section advising women how to arrange a debrief appointment and also to include information relating to breastfeeding following a PPH following feedback from staff and women.

The accurate weighing of blood loss is now consistent with staff working on the labour ward and midwifery led unit using the chart for dry weights, it has been identified as being a valuable aide memoir for existing and new staff.

Multidisciplinary mandatory training sessions for 2021/22 resumed to face to face from September 2020. A copy of the Postpartum Haemorrhage Risk Assessment & Management Checklist is used during the scenario to familiarise staff with the contents and the benefits of using it real time are highlighted.

To obtain feedback from women experiencing PPH, a survey of women suffering PPH >1500mls is still being carefully considered, this will focus on their experiences of care as an inpatient as well as the support they received when they returned home. However, this will need to be carried out in a sensitive manner and appointments will need to be available in a timely manner to support those who are prompted to request an appointment by being sent the survey. Currently there is a backlog of debrief appointments due to Consultants having other clinical commitments during COVID-19 and it may be traumatic to women to send a survey and prompt anxiety but be unable to offer support in a timely way.

End of Life

Nearly half of all deaths in England occur in hospitals. For this reason, it is a core responsibility of hospitals to deliver high quality care for patients in their final days and appropriate support to their carer's.

There is only one opportunity to get it right and to then create a positive lasting memory for relatives and carers. At MCHFT we aim to provide the best possible care for patients at the end of life, whatever their disease/illness. 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 on the needs of the patient and their family and provides documentation and evidence that we are doing so.

Progress

We aim 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 on the needs of the patient and their family and provides documentation and evidence that we are doing so.

Education and training

Education is delivered in collaboration with The End of Life Partnership and online teaching is established for core study days (Syringe pump training, Blue booklet education, Symptom at the end of life, Priorities for End of Life Care & Verification of expected death). These study days have been delivered during 2021/22 in a combination of face-to-face training and online sessions. 230 staff have attended these End of Life Study Days during 2021/22.

In addition to this core programme additional £3000 has been provided by MCHFT during 2021/22 for additional End of Life / Symptom Control training. This is in direct response to requests from Heads of Nursing following the COVID-19 Pandemic, in response to complaints and mortality reviews.

CCICP have funded Statutory and Mandatary End of Life Care sessions – a two day programme each month and bespoke events for community areas.

End of Life Care Education is established within junior doctor's medical education, the nursing preceptorship, student nurse, international nurse and 'Return to Practice' programmes. During 2021/22 End of Life Care sessions have been re-established on the Health Care Assistant educational programme.

Additional sessions for Foundation Year 1 and Foundation Year 2 junior doctors have been requested, delivered and well evaluated.

Bespoke support is provided for clinical areas. In response to COVID-19, the end of life challenges that brings and the relocation of staff, these bespoke sessions have been very important for clinical areas.

The palliative and end of life care link nurse study day was completed with an on-site socially distanced study day during May & November 2021.

Reliable Care - Audit

We have completed the National Audit of Care at the End of Life (NACEL) Round 3. The third round of the audit is comprised of the following elements:

- an Organisational Level Audit covering two questionnaires specific to the Trust/Health Board and hospital/submission level questions.
- a Case Note Review reviewing deaths over a set time period.
- a Quality Survey completed online, or by telephone, by the bereaved person.
- a Staff Reported Measure completed online, by members of staff who are most likely to come into contact with dying patients and those important to them.

The results of this audit have just been received. They will be escalated to the Trust Executive Team and an action plan developed. We are registering for NACEL Round 4 during 2022.

In response to this we have been involved in the COVID-19 Mortality review group to ensure that end of life care is reviewed. We also take part in the Structured Review Judgement mortality reviews.

Planning for patients with uncertain recovery –

Ongoing Quality Improvement work around Communication, DNACPR and Advanced Care Planning continues. This includes collaborative working around patient's who lack capacity and joint education with The End of Life Partnership / Medical consultants / Privacy & Dignity Matron.

As a result of the bespoke support provided to clinical areas quality improvement work was carried out for the group of patients who received ward based respiratory support as their ceiling of treatment from October 2020 onwards. This work involved daily clinical review of patients on the respiratory support unit (in receipt of CPAP or HFNO), support for their families,

development of symptom control guidelines and support for nursing, medical and physiotherapist teams. As we continue to see patient's with COVID-19 – this work is ongoing.

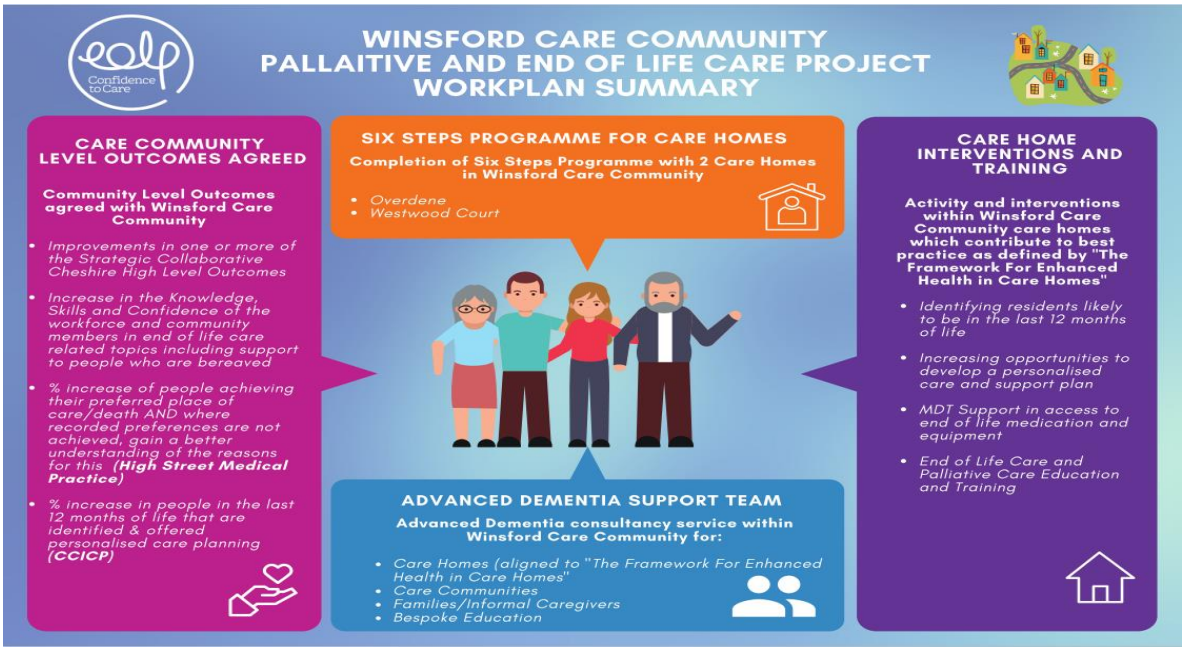
Improving communication between primary and secondary care continues and we have shared palliative care records between hospital, hospice and community settings via EPaCCS (Electronic Palliative Care Coordination System) improving timely and appropriate communication and an established integrated multidisciplinary team meeting for specialist palliative care.

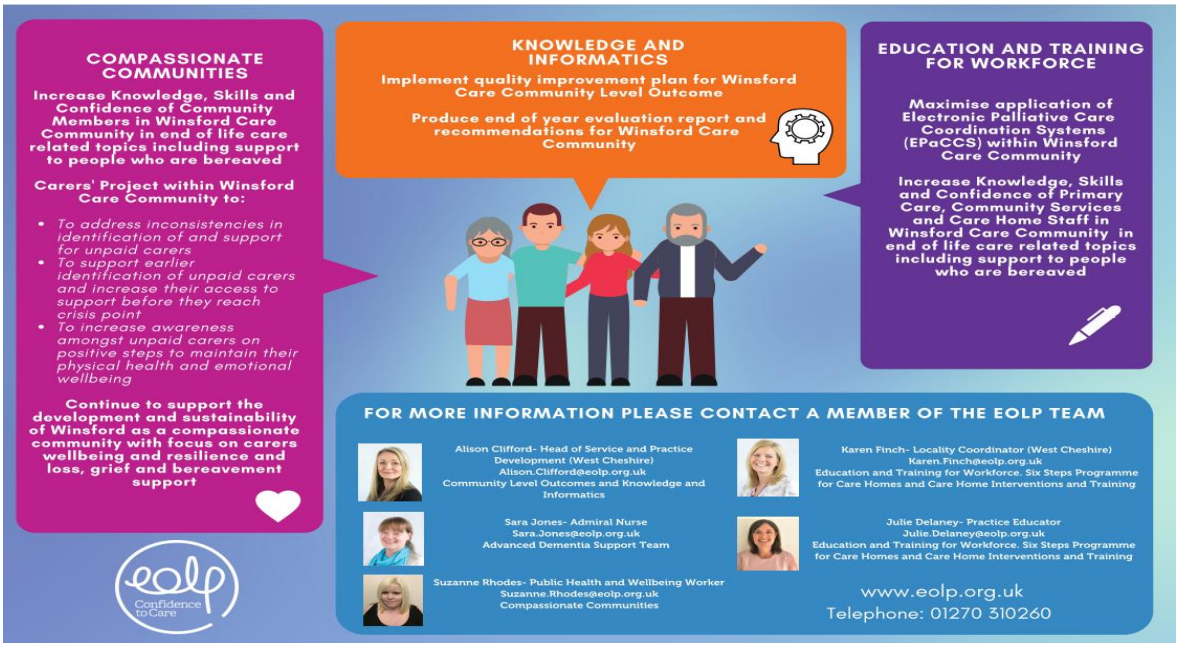
Central Cheshire integrated care partnership

Just over a year ago, The End of Life Partnership (EOLP) began piloting a different way of supporting end of life care that involved closer working with four Care Communities across Cheshire. The aims of the pilot were to;

- Maximise the use of EOLP's finite resources and expertise
- Focus EOLP's activities around areas that have the most impact
- Compliment current changes within the health and social care system around the development of care communities
- Remain responsive and flexible to both strategic and locally identified priorities
- Support increased sustainability of quality improvements that are introduced within the system

The below information details the Workplan Summary of initial aims and a Progress Report covering October to December 2021.




COMPASSIONATE COMMUNITIES
Increase Knowledge, Skills and Confidence of Community Members in Winsford Care Community in end of life care related topics including support to people who are bereaved
Carers' Project within Winsford Care Community to:
To address inconsistencies in identification of and support for unpaid carers
To support earlier identification of unpaid carers and increase their access to support before they reach crisis point
To increase awareness amongst unpaid carers on positive steps to maintain their physical health and emotional wellbeing
Continue to support the development and sustainability of Winsford as a compassionate community with focus on carers wellbeing and resilience and loss, grief and bereavement support
KNOWLEDGE AND INFORMATICS
Implement quality improvement plan for Winsford Care Community Level Outcome
Produce end of year evaluation report and recommendations for Winsford Care Community
EDUCATION AND TRAINING FOR WORKFORCE
Maximise application of Electronic Palliative Care Coordination Systems (EPaCCS) within Winsford Care Community
Increase Knowledge, Skills and Confidence of Primary Care, Community Services and Care Home Staff in Winsford Care Community in end of life care related topics including support to people who are bereaved
FOR MORE INFORMATION PLEASE CONTACT A MEMBER OF THE EOLP TEAM
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Compassionate Communities
Karen Finch- Locality Coordinator (West Cheshire)
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Education and Training for Workforce. Six Steps Programme for Care Homes and Care Home Interventions and Training
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eolp
Confidence to Care

WINSFORD CARE COMMUNITY PALLIATIVE AND END OF LIFE CARE PROJECT

Progress Summary - October 2021-December 2021

CARE COMMUNITY LEVEL OUTCOME AGREED

Central Cheshire Integrated Care Partnership (CCICP) have agreed the care community level outcome they wish to work towards over the next 12-months, which is: "% increase in people in the last 12 months of life that are identified & offered personalised care planning"

High Street Medical Practice would like to work toward the following outcome: "% increase of people achieving their preferred place of care/death AND where recorded preferences are not achieved, gain a better understanding of the reasons for this "

Data obtained for Winsford GP Practices for the period Q3-4 2019-20 showed that 30% (48 of 181 deceased patients) had both a code relating to Preferred Place of Care/Death AND an actual Place of Death recorded. Of these 48 patients, 43 (90%) had achieved their preferences.

SIX STEPS PROGRAMME FOR CARE HOMES

Overdene have now completed the Six Steps Programme. Each step was delivered via Microsoft Teams successfully. This programme helped to improve knowledge and confidence around Palliative and End of Life Care within the home to better support residents and families.

Westwood Court completed Step Three of the programme. Step Four of the programme will commence during Quarter 4.

The Six Steps programme has been updated to reflect new North West model for life limiting conditions. Further information is available at cheshire-epaige.nhs.uk

CARE HOME INTERVENTIONS AND TRAINING

4 members of staff working in Care Homes within Winsford Care Community have attended an EoLP core education session between October 2021-December 2021. Training which staff have accessed includes:

- Syringe Pump Training
- Verification of Expected Death Training

Discussions and ongoing contact continues to take place with Westwood Court, Overdene, The Laurels and Winsford Grange regarding the results of the Training Needs Analysis (TNA) and the education needs of the workforce. Training is being delivered in response.

5 bespoke training sessions to care home staff have been delivered between October 2021-December 2021. Training sessions have included:

- 1 x Advance Care Planning Training - 4 delegates
- 1 x Syringe Pump Training - 3 delegates
- 3 x Introduction to Palliative and End of Life Care Training sessions- 13 delegates

Further training sessions to care home staff are scheduled to begin in Quarter 4. These include:

- Introduction to Palliative and End of Life Care
- Syringe Pump Training

A meeting has taken place with the Advanced Clinical Practitioner and it has been agreed that EoLP will attend a future ward round at the Laurels Care Home.

A meeting has been organised with Overdene for January 2022 for EoLP to provide support to the home in relation to their Palliative Care Register.

There have been 6 care home interventions during Quarter 3. These have been aligned to "The framework for enhanced health in care homes" as follows:

- 5 x Education and Training Interventions
- 1 x Identifying Resident in the Last 12-Months of Life Intervention

Met with Senior Project Manager for Cheshire West ICP regarding Care Home Engagement Events to see how EoLP can support.

ADVANCED DEMENTIA SUPPORT TEAM

The Advanced Dementia Support Team (ADST) have supported 46 dementia clinical consultancies in Winsford between October 2021-December 2021.

Dementia Support Drop In Clinics have taken place in a number of Care Homes within Winsford.

Attendance by ADST at monthly GP/ Care Home meetings. Updates from ADST provided as part of monthly meetings which also includes discussions on consultancies as part of wider MDT.

Working with St Luke's Hospice to deliver Dementia Training to trained staff in order to support the hospice in the potential setting up of a Carers Wellbeing Programme.

EDUCATION AND TRAINING FOR WORKFORCE

A programme of education against the results of the TNA with Community Team staff (CCICP) has been agreed. Communication Skills and Symptom Management training sessions to Community Health Care Assistants and Rehab Assistants was due be delivered in Quarter 3 however due to the pressures on clinical staff resulting from COVID-19, these sessions were cancelled and will be rescheduled to take place during Quarter 4.

Dicussion are in place regarding the delivery of an EPaCCS training session for GP's and District Nurses within Winsford.

A TNA has been circulated to GP's for completion. The results of the TNA will be collated and a programme of education will be agreed.

EoLP have been contacted by Changing Lives to deliver x 2 Introduction to Loss, Grief and Bereavement sessions during Quarter 4.

COMPASSIONATE COMMUNITIES

Delivery of Advanced Care Planning training to Carers from Making Spaces is planned to take place during Quarter 4.

EoLP attended the Redeeming our Communities event in Winsford in October 2021.

Meetings have taken place between EoLP and the Public Health Team at Cheshire West and Chester Council in relation to our work with Carers.

An update on the Carers Project was provided at the Winsford Care Community meeting.

Dates for the Carers Wellbeing Programme have now been set with the course due to commence in January 2022.

Funding has been secured to deliver a Crafting Memories event as part of Wellbeing Winsford.

KNOWLEDGE AND INFORMATICS

Baseline data has been obtained from High Street Medical Practice using the EARLY tool which will help to support the development of a Palliative Care Register which is reflective of all patient conditions in the last 12-months of life. The next steps will be to review the data with clinicians within the Care Community.

Bespoke Winsford Care Community Dashboards have been developed which are refreshed on a six-monthly basis (April and October).

MEMBERSHIP AND NETWORKS

EoLP now has representation on the following groups:

- Winsford Care Community Meeting
- Area Partnership Meeting
- Winsford Wellbeing Meeting
- Care Community Steering Group
- Winsford GP Meeting

We put you first | We strive for more | We respect you | We work together

Governors' choice of indicator

Pastoral Care

The Trust recognises the need to enhance staff health and well-being and reduce unwanted variation in retention rates through a proven model of pastoral support. The commitment of the team is to support, encourage, influence and facilitate all Nurses and Midwives; Newly Qualified, New-in-post, International Nursing recruits and Healthcare Assistants (HCA) within the clinical environment to develop practice that is of the highest standard, patient centred and evidence based.

At the beginning of July 2021, the Pastoral Team were recruited to MCHFT. The team consists of two Registered General Nurses and one Registered Mental Health Nurse. The team have recently expanded to include a Health Care Assistant who will be joining in April 2022.

The role of the Pastoral Team is to offer confidential, supportive, and reflective time and space, dedicated for Nurses, Midwives, Health Care Assistants and students across MCHFT and CCICP.

The Team are supportive of staff with an understanding that we all have a limited capacity and that stresses at home make it harder to manage at work and vice versa. It is recognised also that health and wellbeing is not only necessary to living a full life but is vital to the staff to ensure a well-functioning health care system.

To ensure all aspects of the role are covered the team members have identified priorities:

- International Nurses
- New starters/third year students at MCHT and retention
- Health & wellbeing and staff needing support with their mental health
- HCA's

The Team offer a timely response and are supporting staff with any concerns they may have, whether with home or work life difficulties, be that offering of time and space, information and guidance, signposting or more intensive support.

The two RGNs also assist the Practice Educator Facilitators by supporting staff with clinical skills as needed, the same is also an expectation from the HCA once commenced in the role. The Pastoral HCA will be working closely with Clinical Support Team to support HCAs in their clinical skills development. Information and formats are shared amongst the team to allow cross cover as needed.

Initially, the priority of the team was to create awareness of the new service. Communications were emailed out to Ward Managers, Matrons, and Heads of Nursing/Midwifery in MCHFT and CCICP. This was also included by the Communications Team on the e-bulletins. Leaflets were created with contact details and distributed throughout the Trust and CCICP. In addition, the Pastoral Team have secured training sessions within the Quality Day, HCA day and

Preceptorship Day for new starters, international nurses and HCAs so the service could be introduced to those staff commencing work in the Trust.

The team offer culturally sensitive care and attention to the international nurses, mentoring and guiding them both in their clinical and non-clinical areas, signposting them to ensure their spiritual and cultural needs are met. The team not only support their health and wellbeing but also aim to support and encourage professional and career growth.

The team hold regular monthly drop-in sessions across the organisation, which is open to all staff. The team have an open-door policy and has been well utilised and is receiving consistent positive feedback. Strong professional relationships are being developed, for example working closely with the Practise Educator Facilitators, Independent Domestic Violence Advisor, Alcohol Liaison Service, CURE Team, Freedom to Speak up Guardian, Professional Nurse Advocates, and the Midwifery Pastoral Nurse. The Team utilise local health and wellbeing charities and other non-statutory services alongside Occupational Health and other NHS services.

Some of the services the team work jointly with includes (not limited to) Occupational Health, Practice Educator Facilitators, Clinical Skills Support Team, Safeguarding, Independent Domestic violence Advisor, Legal Services, Freedom to Speak Up, Equality and Diversity Lead, BAME network and the International Nurse Project Team. The Pastoral Nurses play a vital role in the Health & Wellbeing Group, Civility and Psychological Safety Group, Retention Group and the Patient Safety Summit. This is to ensure maximum use of resources available for staff support by encouraging a collaborative multidisciplinary working thereby promoting a practice that is of the highest standard, patient centered, and evidence based.

The Pastoral team work closely with legal services which involves supporting staff who may need to attend inquests. Details are shared with the team at an early stage to ensure and establish paramount support is offered to staff members involved. The team also support staff by attending Court hearings to help guide them through the proceedings. As an enhancement to the Inquest support, a “second victim” support package is currently under development by the RMN in the Team, as is discussion with the Service Manager for Emergency Planning and Site Operations in regard to embedding a process of support to staff following significant and untoward events.

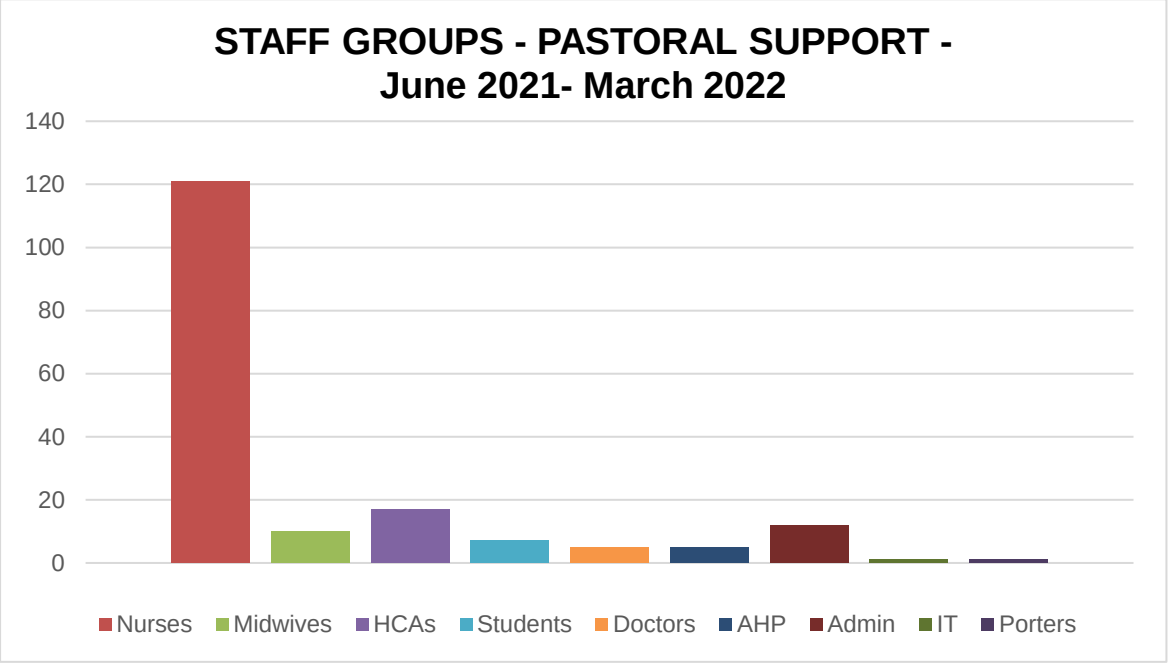
The team liaise with Professional Nurse Advocates to share learning and support. Regular drop-in sessions are organised, and the team regularly visit community sites to ensure staff are included to allow ease of access to the team.

The Pastoral Nurses attend the weekly Patient Safety Summit meetings. This means that the team have early knowledge to any incident in which staff members may be involved and adversely affected; thereby enabling the team to respond swiftly to support the staff as needed by arranging debrief/support session.

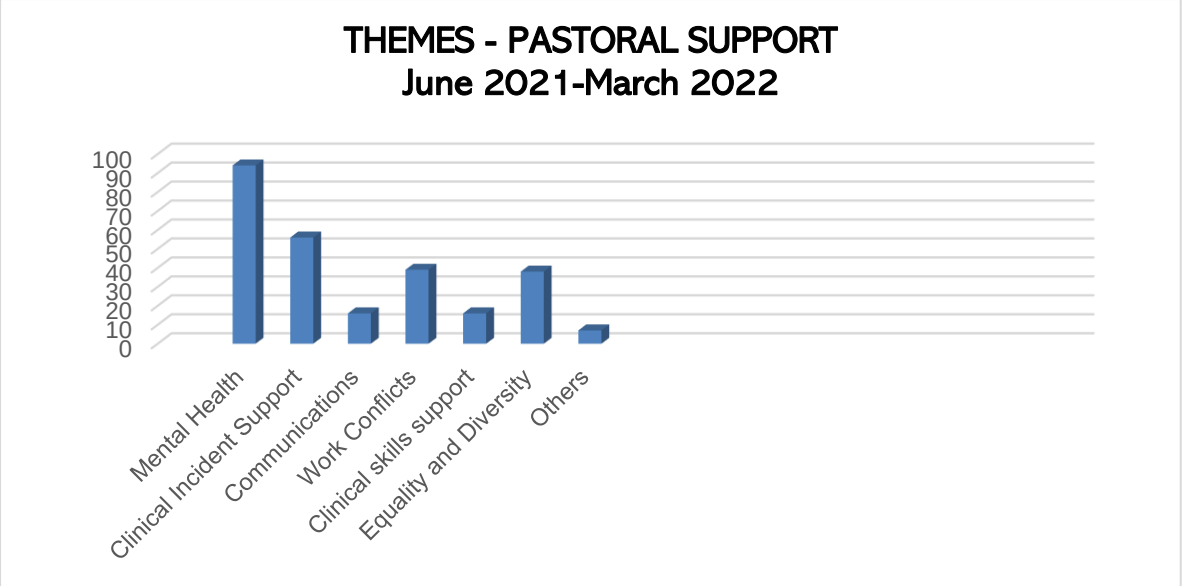
In addition to the above it is believed that the Pastoral Team can:

- Raise the profile of the importance of the prevalence of mental illness and the drive towards parity with physical health
- Embrace the fluidity of the roles of RGN and RMN so to strengthen the support to our staff in a holistic manner.
- Improve retention rates and improve recruitment rates also with the Trust having an attractive dedicated wrap round service to support our staff
- Promote wellbeing and motivation at work, to minimise any associated stress
- Support staff with the core needs of autonomy, belonging and contribution to encourage staff flourishing and thriving at work
- Influence nursing practice by sharing knowledge and experience
- Help with continuity of care, with less Nurses leaving and greater stability on staffing in clinical areas, this results in better care being provided.

Although initially commissioned for the Nurses, midwives, students and HCAs the team are being approached by different staff groups and prompt pastoral support is provided as needed. The graph below shows the different staff groups that receive/received support from the team:



The graph below outlines the some of the common Themes for staff support:



Early outcomes for the team are positive as a snapshot of feedback examples demonstrate:

I have had ongoing support from the Pastoral Team which has enabled me to remain in work and help me build a better way of coping with daily stresses

The Team were there for me in a timely manner when I really needed them and helped me through a difficult time

If it wasn't for this service I would have walked away from my career without a doubt. They saved me

Very friendly and supportive team members who gave me the opportunity to talk, they were empathetic and made me feel better

Seen at short notice when reached crisis point. Helped to have someone objective to speak to and there be no judgement. Seem as regularly as needed and books lent to me to support understanding my issues and what might help me. Link to the Resilience Hub and other websites given and regular contact offered ongoing gentle support. Definitely prevented me from going into an anxiety based depressive spiral and kept me able to work rather than withdraw.

Annex 1 - Statements from commissioners, local Healthwatch organisations and overview and scrutiny committees.

NHS Cheshire CCG Response 2021/22 Quality Account
Mid Cheshire Hospitals NHS Foundation Trust

NHS Cheshire CCG Response to Quality Account Report (April 2021 to March 2022) for Mid Cheshire Hospitals NHS Foundation Trust.

NHS Cheshire CCG remains committed to commissioning high quality services from our providers and we make it clear as part of the contracting process the standards that are expected to be delivered. Oversight and scrutiny of performance against the contract is normally managed through regular quality and performance meetings with the Trust, alongside progress reports that demonstrate levels of compliance or areas of concern. As part of the national response to the continued demands and pressure through COVID-19 these assurance processes were scaled back throughout the year, to reduce the burden and support the capacity of staff to respond to the pandemic. However regular quality leads meetings were maintained, and we are therefore able to verify the accuracy of this quality account.

The on-going challenges associated with the pandemic have continued and the Trust has worked hard to respond to these challenges and to implement positive changes to support both patients and staff. The Trust has also recognised the impact that the pandemic has had on its staff and has taken positive steps to support staff resilience and well-being. We would like to take this opportunity to commend the work of the Trust's dedicated teams who have been working in extremely challenging circumstances, implementing new ways of working and managing the unprecedented demands of the pandemic.

Despite the COVID-19 pressures the Trust continues to make good progress in the development of the quality and safety improvement plan for the new year. There has been positive performance across an array of national surveys, audit, research and improved information across multiple media platforms and more local improvements such the early recognition and treatment of sepsis through a specific focus on training both in the hospital and community settings. During the year, the Trust has also implemented and audited several changes in line with national guidance to support a reduction in falls across the organisation and the Trust remains committed to prevention, learning and continued reduction in falls.

The Trust has also continued to improve and sustain good standards of care through its ward accreditation programme that has strengthened ward-based leadership, supported quality improvements, reduced avoidable harm, improved patient experience, and strengthened the Trusts discharge processes. We look forward to seeing further improvements throughout 2022/23.

There has been sustained focus on the quality of maternity services during the year with an existing programme of work to improve services. Following the publication of the final report of the Ockenden review we would highlight the positive assurance to date on the progress of immediate and essential actions and the Trust's continued commitment to improving the safety of services within Women's and Children's services.

Cheshire CCG note the impact that the pandemic has had on incident reporting patterns and the type of incident reported and acknowledge this general trend is shared by all acute providers as a direct consequence of the increased operational pressures. However, Never Events are serious, preventable patient safety incidents that should not occur if the available preventable measures are implemented, and it is noted that during 2021/22 that the Trust reported three Never Event incidents. As part of the serious incident process the Trust and Cheshire CCG will ensure that root causes and learning is fully captured and changes to system, process and practice is implemented and sustained, and we welcome the continued focus on reducing Never Events and the number of harm incidents overall.

The partnership approach between the CCG and Trust to quality assurance and improvement alongside the formal contract meeting structure has enabled better two-way information sharing and enhanced working relationships. We welcome a continuation of this process into the new year and the benefits it brings to improved patient experience and outcomes.

In closing we would like to congratulate the Trust on facilitating a successful COVID-19 vaccination programme, implementing the changes to its newly completed emergency department and for developing its plans to implement a community diagnostic centre based at Northwich Infirmary. We wish the Trust every success in the continued implementation of the strategy and through the CCG's successor organisation welcome continued work and partnership to assure the quality of services commissioned in 2022/23.

Healthwatch Cheshire East Response to Mid Cheshire Hospitals NHS Foundation Trust Quality Account 2021/22

Response to Quality Account 2021/22- Mid Cheshire Hospitals NHS Foundation Trust.
Statement for inclusion in the report:

Healthwatch Cheshire East would like to commend the Trust for the outstanding work it has carried out in these unprecedented times.
Healthwatch Cheshire East has worked in partnership with the Trust over the period covered by this report forming close working relationships with staff at the hospital through a number of opportunities:

- A&E Watch undertaken in July 2021
- Representation at Patient Quality and Experience meetings
- Engagement with the hospital on a regular basis at different levels.

Healthwatch Cheshire East feels this quality account, broadly reflects the work undertaken at the Trust over the period and particularly would like to praise the organization for its work during the Covid epidemic. In addition, Healthwatch Cheshire East would like to highlight the Trust's work in the following areas:

- Victoria Infirmary in Northwich received £1.7 million to become one of 40 new Community Diagnostic Centres in England
- A continued commitment to Seven-Day Hospital Services
- The results of national and local customer satisfaction surveys are encouraging to see
- Staff wellbeing initiatives and support.

Healthwatch Cheshire East felt that overall, this was an informative report and contained lots of interesting and relevant information.

Cheshire East Council, Democratic Services Review of Mid Cheshire Hospitals NHS Foundation Trust Quality Account 2021/22

Mr. James Sumner,
Mid Cheshire Hospitals NHS Foundation Trust
Leighton Hospital
Middlewich Road
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Cheshire
CW1 4QJ

Democratic Services

Westfields, Middlewich Road

Sandbach, Cheshire

CW11 1HZ

Tel: 01270 685705

email:
helen.davies@cheshireeast.gov.uk

DATE: 26 May 2022

Dear Mr. Sumner,

The Cheshire East Scrutiny Committee welcomes the opportunity to comment on the Quality Account (QA) and congratulates the Trust on a successful year particularly given the immense pressures felt by the NHS during the last two years and for the context of this QA, navigating the easing of lockdown restrictions from the Covid-19 Pandemic and the inevitable backlog of work the pandemic created.

These are the official comments and queries from the Cheshire East Council Scrutiny Committee, on the Quality Accounts for 2021/22 of Mid Cheshire NHS Foundation Trust.

- The Committee was pleased to note the Trust performance keeps up with and is sometimes higher than the national average for reported outcome measure scores for hip replacement surgery and knee replacement surgery.

- The overview given in Part 3 was useful for the Committee to appreciate each service provided by the Trust.

- The complaints system was paused at times through the pandemic, which will have had an adverse effect on response times. The Committee note the timely response and actions taken for most complaints but would query has the back log, (if any) been addressed.

- The compliments were noted and are obviously heart felt.

- The Committee was pleased to note the attention being given to staff well-being.

- Attention to patients with learning difficulties is noted. The efforts to ensure they feel safe and understood is commendable.

- There were concerns regarding insufficient resources in relation to Children and Young People and Seizures and Epilepsy.

- The Committee noted that the following unannounced inspections during November and December 2019 by the Care Quality Commission, the three core services were found to require improvements. The Committee would be interested to understand, in due course, what the Trust has done to address safety measures since these inspections.

- The Committee noted the high percentages of patients admitted to the hospital for patient care, outpatient care and accident and emergency care.

- The Committee noted the data on page 77-78 in relation to the percentage of patient safety incidents that resulted in severe harm or death significantly rose during certain periods. However it was encouraged to see the reporting culture within the Trust is positive which in turn had resulted in an increase in reporting. The Committee would endorse the message from the Trust to encourage reporting of serious incidents to ensure openness and transparency.

- The training of staff in Dementia Care is noted but noted it would be helpful to see an analysis of the journey of the patient and their family.

- Freedom to Speak Out initiative is clearly a welcome and important initiative and the fact that staff numbers taking the opportunity to speak up has increased must be seen as a positive outcome.

- Safe staffing levels are an imperative and strategy to ensure this is evidenced. It would be good to know reliance on agency staff is low and that bank staff are not overstretched in relation to their day jobs.

- Falls prevention work is extensive.

- Pressure sore prevention and the positive impact of the air mattress management/availability noted.

- Ward accreditation scheme; Going For Gold reads as an excellent initiative.

- The opening of the new Emergency Department is noted.

- Also the good use of the Victoria Infirmary Northwich for out-patient diagnostics.

- The national survey information highlights the pressures on the system and comparative performance of Mid Cheshire Hospital. It is very positive that the information is used to develop the forward strategy.

The Committee hope that the Trust find these comments and queries useful, and would request that this Quality Account be discussed at the forthcoming meeting of the Scrutiny Committee on the 14th June 10.30am at Westfields, Sandbach. If the Trust could make contact with Helen Davies in Democratic Services at the address provided to make the necessary arrangements we look forward to seeing you in due course.

Yours Sincerely

Councillor Liz Wardlaw
Chair of the Cheshire East Council Scrutiny Committee

Council of Governors Review of Mid Cheshire Hospitals NHS Foundation Trust Quality Account 2021/22

The Council of Governors (CoG) at Mid Cheshire Hospitals NHS Foundation Trust provides an important link between the organisation and its members. The CoG is comprised of elected and appointed governors who represent the interests of patients, staff, local stakeholder organisations and the wider public. As such, we welcome the opportunity to comment on the Quality Account for 2021/22 as it is an important tool in ensuring that the care provided by the Trust is reviewed objectively and as a means of illustrating to patients, carers and partners the performance of the trust in relation to priorities.

Overall, we felt that the report gives a fair reflection of the services provided by the Trust. As Governors we are provided with a lot of information during the year about the services that are provided, about patient and families experiences of care, about clinical outcomes and the wider aspects which impact on the planning and delivery of care and the detail within the Quality Account reflects this. Given that the Quality Account is more than 100 pages in length, we will be liaising with the Executive Team over the coming months to look at how this is presented to the wider public. We noted with interest the work of the Reader's Panel and would advocate for the principles that have been adopted for patient information to be considered for major Trust publications also. We would also welcome further information about the different formats that will be produced to cater for those with specific accessibility needs/requirements.

It is clear, both from the Quality Account and from the information we have been provided with during our regular meetings, that 2021/22 has been a challenging year and the Trust has had to adapt its ways of working as a result of the Covid-19 pandemic. Some of these changes have included increasing the number of beds available in Critical Care, redefining ward areas to ensure strict infection prevention and control and putting in place enhanced support for staff. The CoG has been particularly concerned about the impact of the pandemic on staff (as reflected by our choice of quality indicator) and the significant work undertaken by the Health and Wellbeing Group, Senior Leaders and Managers at all levels is appreciated. Many different aspects of health and well-being have been considered as part of this – with enhanced support being provided through the Mental Health First Aid Service, Wellbeing Rooms, Employee Assistance Programme, the Freedom to Speak Up Guardian, Professional Nurses Advocates and the introduction of Pastoral Nurses. Staffing and staff well-being will remain a key focus for us during 2022/23, as will the steps the Trust is taking to address waiting lists, waiting times, access to services as well as wider improvements to care.

The Quality Account provides information on the steps the Trust has taken to improve quality, including the actions arising from local and national audits and the focus on safety (including safe staffing levels); patient experience and outcome as well as on the 4 specific safety and quality indicators (sepsis, medicines safety, maternal and neonatal safety and end of life care). The CoG noted with interest the appointment of four patient safety specialists as part of the implementation of the national patient safety strategy and we look forward to hearing more about their work and impact during 2022/23.

We were made aware during the year that both formal complaints and informal concerns have remained considerably higher than pre COVID-19 pandemic due to the impact on Trust services and staffing levels and restrictions remaining in place affecting staff, patients, and

families. The Quality Account details many of the improvement actions taken because of issues raised through formal complaints and informal concerns and patients' experiences of care will continue to be central to our discussions during 2022/23.

It is becoming more and more apparent that the impact of COVID will be felt for a long time and in many ways – such as patient wait times, delayed diagnoses, hospital activity, deterioration in people's mental health, changes to employment and the long-term impact for those directly affected. It is more important than ever, therefore, that those involved in commissioning, planning and delivering care work collaboratively to address the challenges facing health and care today and in the future. The investment in services both at Leighton and particularly at Victoria Infirmary Northwich is welcomed and it is hoped that wider investment and the development of new ways of working will benefit our local communities and those who use MCHFT services.

The Council of Governors would like to thank MCHFT for the opportunity to review and provide a response to the 2021/22 Quality Account. The Trust is explicit that providing high quality and safe care is their number one priority and this has been evident throughout the past year, notwithstanding the difficulties and challenges experienced.

Dr Katherine Birch
Lead Governor on behalf of MCHFT CoG

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 2021/22 and supporting guidance detailed requirements for quality reports 2021/22

- 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 2021 to 31 March 2022
    - papers relating to the quality reported to the board over the period 1 April 2021 to 31 March 2022
    - feedback from commissioners dated 10 May 2022
    - feedback from governors dated 20 May 2022
    - feedback from local Healthwatch organisations dated 18 May 2022
    - feedback from Overview and Scrutiny Committee dated 23 May 2022
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, May 2022
    - the (latest) national patient survey October 2021
    - the (latest) national staff survey 4 October to 26 November 2022
    - CQC inspection report dated 14 April 2020

- 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

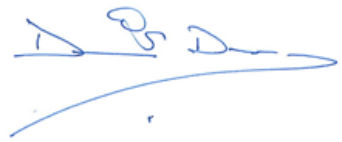
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality report.

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

Dennis Dunn

Chairman



Date 26 May 2022

Russ Favager

Interim Chief Executive

Date 26 May 2022

Appendices

Appendix 1 - Glossary and abbreviations

Terms	Abbreviation	Description
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.

Terms	Abbreviation	Description
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.
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.
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
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

Terms	Abbreviation	Description
		operations and to monitor the performance of joint replacement implants and effectiveness of different types of surgery.
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.
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.
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).

Terms	Abbreviation	Description
Sepsis		A life threatening condition that arises when the body's response to an infection injuries its own tissue and organs.
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.
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).

NHS
East Cheshire
NHS Trust

Quality Account 2021/22

www.eastcheshire.nhs.uk

Listening and responding to deliver high quality person-centred care

Spotlight on 2021/22

Achievements - year at a glance

The trust celebrated some great achievements during 2021/22, these have included:

April

East Cheshire NHS Trust was proud to receive re-accreditation as a Disability Confident Leader.

May

The High Sheriff of Cheshire paid tribute to staff and volunteers at Cheshire's Alderley Park COVID-19 vaccination centre.

June

A commemorative mural was generously donated to East Cheshire NHS Trust by local artist, James O'Meara, to reflect the courage, hard work and commitment of staff and volunteers during the pandemic.

July

Local Macclesfield retiree, John Jones raises a total sum of over £100,000 for East Cheshire NHS Trust charitable funds over 30 years of fundraising for the trust.

August

Patients who are referred for same day treatment to Macclesfield Hospital can now experience an improved care pathway at the beginning of their journey thanks to a brand-new £2.2 million Same Day Emergency Care unit (SDEC).

September

In honour of organ donors, their recipients and those waiting for a lifesaving transplant, during Organ Donation Week (20th to 26th September 2021) staff came together to participate in the North West Organ Donation 'Race for Recipients' to raise awareness of this year's national 'Leave them Certain' campaign.

October

The trust was pleased to take delivery of a new, custom-built, bespoke patient minibus now on site at Macclesfield Hospital following a successful fundraising campaign to replace the existing rented patient transport vehicle.

November

This month saw the opening of The Christie at Macclesfield. All existing East Cheshire patients are now able to access a comprehensive cancer service which will encompass oncology, chemotherapy, radiotherapy haematology and ongoing support.

December

As part of a plan to reduce carbon emissions at East Cheshire NHS Trust, four electric car charging points have been installed in the patients and visitors car park which is located by the main entrance of Macclesfield Hospital.

January

As part of the Greater Manchester response to the national Level 4 COVID-19 incident, the trust benefited from the support of 11 military personnel from the 1st Battalion Scots Guards who provided assistance to staff delivering front line services.

February

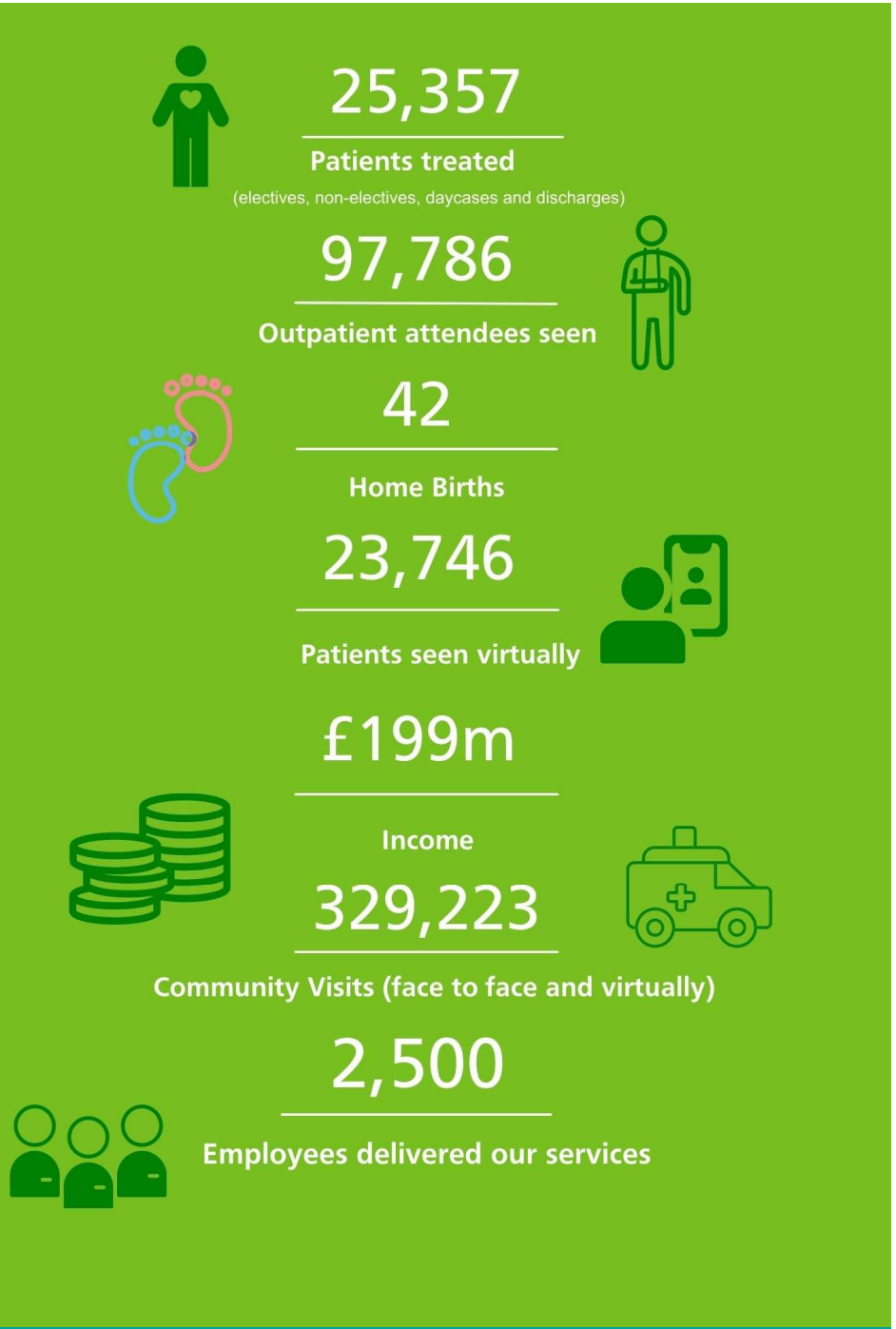
As a special surprise on Valentine's Day, the Trust Board said thank you to all, to let them know how valued they are and that they 'love' what they all do for our patients. Each team received Valentine's chocolates and a card.

March

A commemorative tree was planted in the grounds of Macclesfield Hospital as a special gift from Macclesfield Town Council to say thank you for the trust's hard work in response to the COVID-19 pandemic.

Trust Wide Achievements

- Integration of services progress at pace, with outstanding agility and teamwork
- Made care accessible by deploying technology and digital solutions to enable virtual clinics, consultations and virtual wards at home, supported by health and care partners
- The trust has completed the improvements to the Intensive Care Unit at Macclesfield for a much improved quality patient experience
- Awarded five exceptional compassion awards, a positive challenge with so many demonstrating outstanding care
- Opening of The Christie Cancer Centre service on the Macclesfield site, bringing cancer solutions to local communities
- Continue to implement our clinically led recovery plans



Focus on Quality of Patient Care

•Pressure Ulcer initiatives to identify early signs and stop pressure ulcers where possible

•Identified the need for improved boots, mattresses and cushions across hospital and community locations to help mange pressure ulcers

•Focused on skill mixes and nurse ratios as part of the safer staffing models

•Introduced a falls panel

•Embedded the Saving babies lives bundle into the care we provide despite the services ongoing suspension

•Worked successfully with partnering trusts to continue to delivery high standards of maternity care

•Focused on IPC both for COVID-19 and outside of this to ensure a retained focus on CDiff and MRSA rates

Focus on Quality of Patient Care

•Started to reduce waiting lists as we learn to live with COVID -19

•Raised research awareness across the trust

•Increase dour use of IT across the trust releasing time to care

•Continue to work towards a full autism friendly hospital through the National Autistic Society

•Improved award communication for our LD and Autistic patients

•Increased our trained patient safety specialists

•Continued to ensure patients die in their preferred place

•Further developed the Care Communities models and

•Improved our dementia care through a number of improvement initiates

Patient Engagement

- Healthwatch – continue to be an independent voice for the people of East Cheshire and work with the trust to improve health and care services.
- Maternity Voices Partnership - supported the trust to remain connected to women as Intrapartum services have been suspended at Macclesfield.
- Local patient surveys – monthly across the trust to highlight areas if good practice and opportunities for improvement.
- Patient experience panel – New panel inclusive for patients, carers, volunteers to engagement in developments,, patient improvement initiatives and strategic engagement for the future.
- Learning Disability (LD) benchmarking – trust performing well in many areas of the LD survey for provision of reasonable adjustments training in LD and Autism awareness, waiting times for LD patients and involving patients in access and decisions.

Patient Comments

From arriving until leaving I was treated with incredible care and attention – **Patient Experience**

Friendly and informative staff. Very caring and compassionate throughout. Felt COVID-19 safe at all times – **Patient, ETU**

Staff very patient and explanations given to my questions answered clearly and concisely – **Patient, Cardio**

We feel our concerns have been treated professionally and quickly. Staff have been kind and helpful on interaction. Our concerns have been treated with the upper most respect and compassion **– Patient, Paediatric therapies**

Always friendly, knowledgeable, informative, respectful, never judged, very compassionate. We love this team so much. They're easy to talk to and never impatient or off hand **– Patient, Paediatric diabetes**

The nurse technician was very respectful and explained what the procedure entailed – **Patient, Cardio**

The staff were very lovely. They really supported me and gave me confidence. Were very supportive and helped me with my son's autism – **Family member, Autism pathway**

The incredible nurses and care staff that work under enormous strain and pressure and never falter in their kindness, patience and professionalism – **Patient, Ward 5**

The friendliness, professionalism and empathy of staff during a difficult time. Thank you to ALL staff – **Patient, Ward 9**

2022/23 Priorities

Well led

Our goal: Our leadership, governance and culture are used to drive and improve the delivery of high-quality person-centred care. To enable this we aim to transform our quality management and improvement systems with the following initiatives.

Insight: Priorities for leadership, development and cultural change are informed by the views of patients, staff and our partners.

Involvement: Inclusive leadership will underpin and support us to work in partnership for patients.

Improvement: Promoting a continuous improvement approach and sharing our successes.

Caring

Our goal: People are respected and valued as individuals and are empowered as partners in their care, practically and emotionally. Our ambition is to deliver and improve care by being people centred through the following initiatives:

Insight: Making experience and insight data count to drive improvement and learning by using patient experience QI methodologies.

Involvement: Embedding an organisation wide approach to using insight from patient feedback to shape our services and improve patient outcomes.

Improvement: Setting clear priorities for patient experience quality improvement that are aligned and where the need for improvement is greatest.

2022/23 Priorities

Safe

Our goal: People are protected by a strong comprehensive safety system and a focus on openness, transparency and learning when things go wrong. This will be delivered using the following initiatives:

Insight: Improving understanding of safety by drawing intelligence from multiple sources of patient safety information.

Involvement: Equipping patients, colleagues and partners with the skills and opportunities to improve patient safety throughout the whole system.

Improvement: Designing and supporting programmes that deliver effective and sustainable change inn the most important areas.

Effective

Our goal: Outcomes for people who use services are consistently better than expected when compared with other similar services. This will be delivered using the following initiatives:

Insight: Colleagues routinely draw on internal and external evidence from a variety of sources to achieve best clinical outcomes promoting quality of care.

Involvement: Clinical effectiveness data is regularly reviewed by colleagues and patients inclusively and used to drive improvement where the need is greatest.

Improvement: Quality improvement methodology is used in a timely manner to implement evidence based practice from audit, research, patient feedback in innovative and efficient ways.

2022/23 Priorities

Responsive

Our goal: Services are tailored to meet the needs of individual people and are delivered in a way to ensure flexibility, choice and continuity of care. This will be delivered using the following initiatives:

Insight: Through listening to our patients' experiences of their care and to the views of our work colleagues we will generate and share actionable insight to help deliver improvement work more effectively.

Involvement: We'll work together across our organisation to share insight and research, making sure that our services are aligned wherever possible – putting the patient at the centre of it all and offering patient choice to ensure timely interventions.

Improvement: People can access services and appointments in a timely way and in line with NHS Constitution pledges with services that are designed and improved to meet the needs of patients.

NHS East Cheshire NHS Trust

NHS Stockport NHS Foundation Trust

Public Engagement Summary Highlights

Sustainable Hospital Services for the People of East Cheshire & Stockport

May 2022

This confidential document is for discussion purposes only and is not for onward distribution

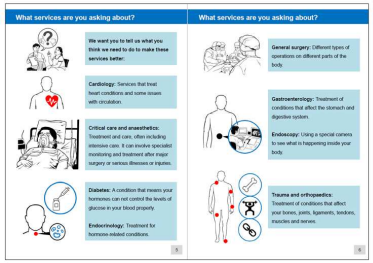
Engagement: Report of Findings

The listening exercise ran for 6 weeks from 21 February 2022 to 2 April 2022

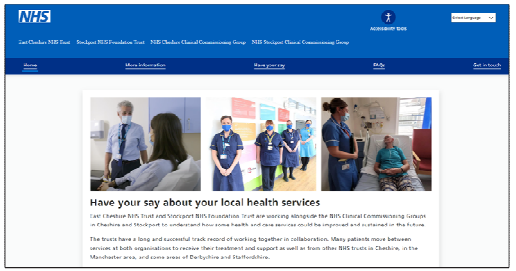
273 responses received

Methodology

- Stakeholder briefings
- Press and media releases
- Engagement documents including easy read
- Dedicated engagement microsite
- Social media
- Dedicated telephone line
- Postal and online survey
- Internal staff communications channels
- 17 pieces of correspondence were received



Two posts per week over the six week exercise highlighted different calls to action and encouraged involvement



2,163 unique page views and 1,403 new visitors to the site

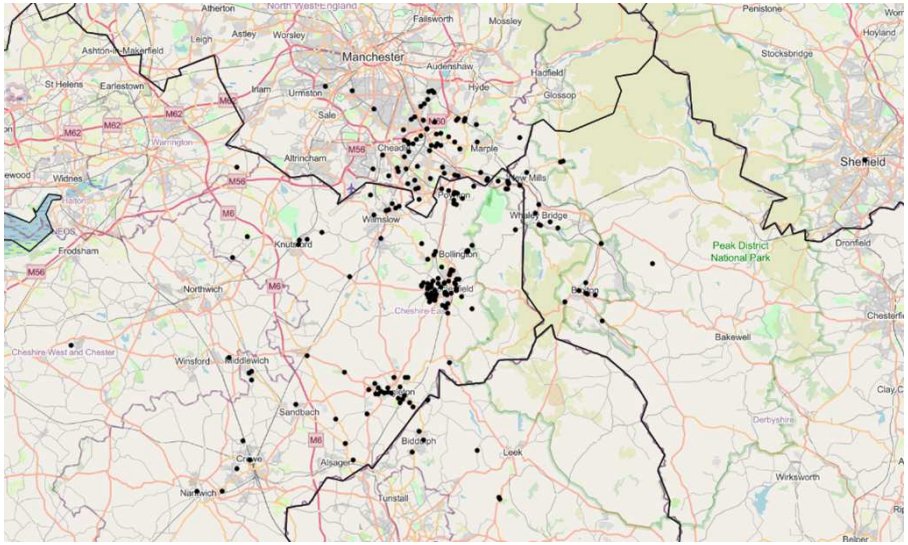
Respondents Profiles

	No.	%
Patient	97	36%
NHS employee	93	34%
Member of the public	41	15%
Carer	24	9%
From another public sector organisation	7	3%
Other (please specify below)	7	3%
From a health-related group, charity or organisation	1	0.4%
From a non-health voluntary group, charity or organisation	-	-
Base	*270*	

Demographics

- 9% non-white British
- 4% non heterosexual
- 9% currently pregnant
- Broad range of ages (low response from under 25s)
- 10% have a disability (5% mental health condition)
- 42% carers
- 2% armed forces veterans
- 14% male
- 83% female (2 trans or other)

Geo-mapping of responses: Higher responses in East Cheshire



Index of Multiple Deprivation (IMD)

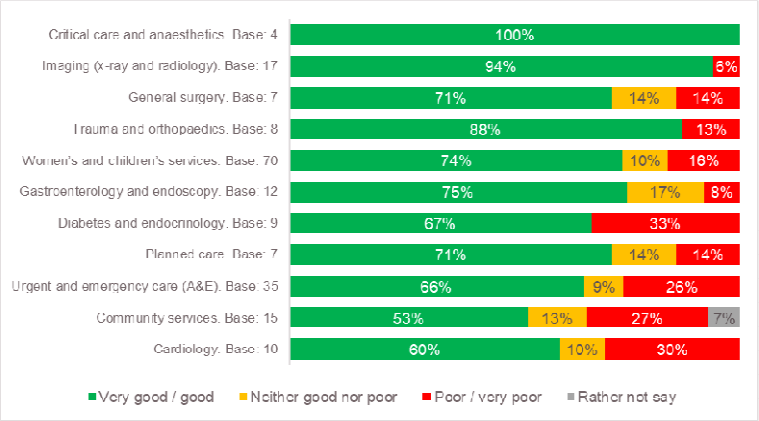
The IMD is the official measure of relative deprivation for small areas in England, with the most deprived 10% of small areas categorised as '1' while the least deprived 10% of small areas are described as '10'.

IMD decile	No.	%
1	3	1%
2	8	3%
3	23	8%
4	17	6%
5	13	5%
6	10	4%
7	30	11%
8	19	7%
9	38	14%
10	60	22%
No postcode provided	32	12%
Postcode unable to be profiled	20	7%
Base	*273*	

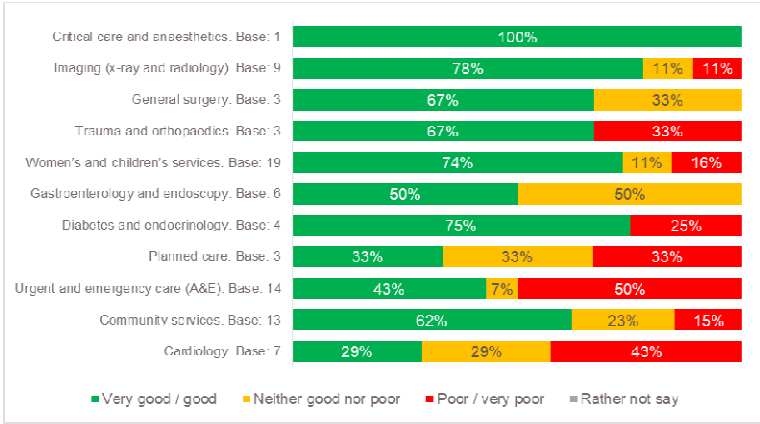
Service Ratings

How would you rate your experience of accessing and using the following services?

Service rating – respondents from the East Cheshire area



Service rating – respondents from the Stockport area



- Generally, services tended to be rated positively.
- Critical care and anaesthetics and imaging were rated most positively in both areas.
- Diabetes & endocrinology and cardiology were rated least positively in East Cheshire
- A&E and Cardiology were rated least positively in Stockport
- The highest levels of responses were for women's and children's services in both areas

Please note that the number of respondents (base) are low for many services.

Themes by Service

	Cardiology	Critical care and anaesthetics	Community Services	Diabetes and endocrinology	Gastroenterology and endoscopy	General surgery	Imaging (X-ray and radiology)	Planned care	Trauma and orthopaedics	Urgent and emergency care (A&E)	Women's & children's services
No of Respondents	**38**	**28**	**72**	**30**	**39**	**34**	**49**	**41**	**38**	**88**	**141**
Red = Negative	Access – Waiting time for services is too long (9 / 28%)	Staff were professional and friendly (5 / 25%)	Consider the need for adequate staffing (11 / 21%)	Ensure appropriate staffing (e.g. specialist expertise) (6 / 26%)	Services provided are good (16 /49%)	Services provided are good (9 / 36%)	Staff were professional and friendly (14 / 37%)	Concern over waiting lists to access care e.g. backlog (7 / 28%)	Services provided are good (6 / 20%)	Services provided are good (19 / 26%)	Quality of care was good e.g. antenatal, postnatal care (34 / 29%)
Amber = An observation	Staff were professional and friendly (7 / 22%)	Services provided are good (5 / 25%)	Communication with patients requires improvement (10 / 19%)	Services provided were poor (5 / 22%)	Staff are professional and helpful (11 /33%)	Ensure appropriate staffing (4 / 16%)	Services provided are good e.g. efficient (14 / 37%)	Communication with patients requires improvement (6 / 24%)	Waiting time for services is long (6 / 20%)	Concern over long waiting time to be seen (14 / 19%)	Staff were professional and helpful (33 / 27%)
Green = Positive	Services provided are good (5 / 16%).	Consider greater support for staff (e.g. recognition) (3 / 15%).	Staff were helpful and friendly (8 / 15% Observation Increased provision of services is required (8 / 15%)	Concern over lack of specialists e.g. endocrine consultant, adult diabetologist (5 / 22%).	Ensure adequate staffing e.g. more staff, share specialists knowledge (5 / 15%).	Ensure greater integration between healthcare providers (4 / 16%).	Concern over long waiting time for services e.g. availability of appointments (9 / 24%).	Services provided are good (5 / 20%).	Ensure provision of trauma and orthopaedic services locally (5 / 17%) Ensure sufficient resources and capacity to meet demand (5 / 17%).	Concern over inadequate staffing (e.g. lack of staff) (10 / 14%) Staff were professional and helpful (10 / 14%).	Consider the need to re-open maternity unit at Macclesfield Hospital (23 / 19%)

Positive Feedback

Across the different services, the recurring positive themes were that staff were professional and helpful and that the services were good.

Macclesfield District General Hospital provides excellent service to the local community and services should remain so!

Felt I was given true informed choice. Excellent communication using non medical language.

I had a surgical procedure as a day patient. All of the staff I encountered were very friendly & professional. They looked after me really well and put me at ease.

The experience and expertise of the trauma and orthopaedic services within the Trust are high. Communication between A&E trauma and the orthopaedic department could be improved.

Really clear, practical advice and support

I have personally accessed diagnostic services in the cardio respiratory team and strongly feel services like this should be provided locally.

Macclesfield District General Hospital provides excellent service to the local community and services should remain so!

I think planned care works to the best that it can, whilst dealing with a huge and ever increasing backlog

Used [A&E] lots of times personally and with my children. Fantastic resource and vital for the growing population of Congleton and Macclesfield. Again to travel over 20 mins would be unacceptable. This service is essential and should be local

So good to be able to access all the test I require in one trust. Not travelling to different trust to see different people. Telephone and face to face appointments with caring consultant.

Excellent service, quick to diagnose skin cancer and refer to specialist.

Areas for Improvement

Key recurring negative themes were:

- Communication with patients requires improvement
- Long waiting times to access services
- The need for adequate staffing was also highlighted

Travel and transport

The main travel method was by car (236 / 87%), and the average travel time to an NHS site was 26 minutes. Key issues identified were around difficulties parking at hospitals and lack of adequate public transport options.

Maternity at Macclesfield

Concern was also raised over the lack of maternity services provision, with respondents highlighting the need to re-open the maternity unit at Macclesfield District General Hospital.

SHH Wards very busy, which meant that I was left for long periods on my own with no communication about what was happening

Too long waiting times

I have witnessed what happens when aftercare is not followed up in a timely manner. It means we have little faith in the service offered at our local hospital

There is hardly any public transport, car parking is horrendous

Cardiology should be provided in a specialist centre such as Manchester

Lack of staff often covering multiple areas which not only impacts on patient safety but also the well being of our staff and clinicians.

I am very happy with the service I have received from all the staff at Knutsford and Macclesfield.

However, I think it's appalling that the maternity unit is not open so I will not be able to give birth in my local hospital. I will have to travel to a hospital that I have never visited before and will be cared for by staff I have never met. Also the antenatal classes are not running locally at the moment for no good reason. I feel let down.

Next Steps

- The Case for Change will go through internal and external governance processes and will be in the public domain from 30th June 2022
- Clinicians will consider the engagement responses and public views at workshops to be held during the summer
- There will be an options appraisal process, which will include engagement with staff, patients and carers to develop proposed solutions into viable options
- NHS Regulators and Health Overview & Scrutiny Committees will consider the process and the proposals for change which may result in formal consultation

Cheshire East Council

Working for a brighter future together

Scrutiny Committee

Date of Meeting:	14 June 2022
Report Title:	Briefing note on the draft Pharmaceutical Needs Assessment- Update
Report of:	Dr Matt Tyrer, Director of Public Health
Report Reference No:	To be provided by Democratic Services
Ward(s) Affected:	All

1. Purpose of Report

1.1. The purpose of this report is to update members on the progress of the Pharmaceutical Needs Assessments (PNA) production.

1.2. The production of the PNA supports three Outcomes from the Health and Wellbeing Strategy 2018-21: Create a place that supports health and wellbeing for everyone living in Cheshire East; improving the mental health and wellbeing of people living and working in Cheshire East; and enable more people to live well for longer.

2. Executive Summary

2.1 Cheshire East Health and Wellbeing Board has a statutory responsibility to publish an up-to-date statement of pharmaceutical needs every 3 years.

2.2 PNAs are used by the NHS to make decisions on which NHS funded services need to be provided by local community pharmacies. These services are part of local health care and public health and affect NHS budgets.

2.3 Within the draft PNA, provisional findings indicate that current pharmaceutical provision in the towns and villages of Cheshire East borough is assessed as adequate in terms of location, opening hours and pharmaceutical services offered to the population (See appendix for Executive Summary).

2.4 The draft PNA has been published for a formal period of consultation ran from 1 April 2022 to 10 June 2022. Scrutiny Committee members were invited to consult at the start of the consultation period.

2.5 As at the 31 May 2022, 90 complete responses and 331 partial responses have been received. A comprehensive analysis of these responses will be undertaken and amendments to the PNA made accordingly. Findings will also be summarised in a specific consultation report. The PNA will be submitted for final approval by the Health and Wellbeing Board in September prior to publication on 1 October 2022.

3. Recommendations

The Scrutiny Committee is to note the progress in the production of the PNA and that the consultation findings may result in an amendment to the draft PNA once they have been evaluated.

4. Reasons for Recommendations

4.1. Every Health and Wellbeing Board (HWB) in England has had a statutory responsibility to publish and keep up to date a statement of the needs for pharmaceutical services of the population in its area and the production of the PNA is in line with this duty

4.2. The PNA process links to ensuring that Cheshire East Council: works together with residents and partners to support people and communities to be strong and resilient; and reduces health inequalities across the borough.

5. Other Options Considered

5.1. As the production of the PNA is a statutory requirement, the Cheshire East Health and Wellbeing Board must publish a finalised PNA by 1 October 2022. There is no other option.

6. Background

6.1. Cheshire East Health and Wellbeing Board has a statutory responsibility to publish an up-to-date statement of pharmaceutical needs every 3 years.

6.2. PNAs are used by the NHS to make decisions on which NHS funded services need to be provided by local community pharmacies. These services are part of local health care and public health and affect NHS budgets.

6.3. PNAs are also relevant when deciding if new pharmacies are needed, in response to applications by businesses, including independent owners and large pharmacy companies. Applications are keenly contested by applicants

and existing NHS contractors and can be open to legal challenge if not handled properly.

6.4. The PNA covers community pharmacy opening times, services delivered from community pharmacies, and accessibility in relation to disability, language needs, ethnicity, sexuality, and rurality. The production of the PNA has involved:

- Analysis of data relating to pharmaceutical need and demand from wide and varied sources
- Regular consultation with members of the Cheshire East PNA Steering Group, which brings together representatives from key organisations across Cheshire East
- A public survey, and incorporation of 2 questions regarding pharmacies as part of broader Healthwatch conversations
- A dispensing doctors survey
- A community pharmacy contractors survey

6.5. A revised PNA must be published on the 1 October 2022. This represents an extended deadline due to the COVID-19 pandemic. The day-to-day responsibility for the development was delegated to the Director of Public Health (on 23 November 2021 at minute number 31). The Health and Wellbeing Board will be presented with the final draft in September 2022 for sign-off. A contingency arrangement of a virtual sign-off has been agreed in case the September meeting is cancelled, or timing is not sufficient to meet publishing deadline of the 1 October 2022.

6.6. Within the draft PNA, provisional findings indicate that current pharmaceutical provision in the towns and villages of Cheshire East borough is assessed as adequate in terms of location, opening hours and pharmaceutical services offered to the population.
NB Appendix A provides more detail on the findings related to the above.

6.7. Through examination of the available information, the draft PNA has not identified current or anticipated future need for new NHS pharmaceutical service providers in Cheshire East.

7. Consultation and Engagement

7.1. Formal consultation on the draft PNA ran for the statutory period from 1 April 2022 to 10 June 2022. Key stakeholders as identified in the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations were consulted and invited to share their thoughts and comments on the draft PNA. Stakeholders were invited to consider whether the purpose of the PNA is clearly stated, whether it reflects the current provision of services within their area, whether it reflects the needs of the local population, and have they

identified any information gaps which could affect the statutory statements or conclusions in the document.

7.2. By the 31 May 2022 90 complete responses and 331 partial responses had been received.

7.3. A comprehensive analysis of these responses will be undertaken and amendments to the PNA made accordingly. Findings will also be summarised in a specific consultation report. The PNA will be submitted for final approval by the Health and Wellbeing Board in September prior to publication on 1 October 2022.

8. Implications

8.1. Legal

Every Health and Wellbeing Board (HWB) in England has had a statutory responsibility (Section 128A of NHS Act 2006, as amended by Health Act 2009 and Health and Social Care Act 2012) to publish and keep up to date a statement of the needs for pharmaceutical services of the population in its area, referred to as a pharmaceutical needs assessment (PNA).

8.2. Finance

This report is undertaken by the Public Health team within Cheshire East Council on behalf of the Health and Wellbeing Board. There are no financial implications to the Council aside from the time and resources it has taken to produce the report and conduct the consultation. These resources form part of the existing Public Health ring-fenced budget and therefore no changes are required to the Council's existing Medium Term Financial Strategy (MTFS).

8.3. Policy

None identified. This is a statutory report to be published to inform NHS England of the local picture. NHS England is the decision-making body about the commissioning of new pharmacy premises.

8.4. Equality

An Equality Impact Assessment was completed. It highlighted the need to proactively promote the PNA with certain population groups more, due to the low number of responses to the public survey. This has been addressed as part of the formal consultation process. Its recommendations/decisions here (Appendix B).

8.5. Human Resources

None identified

8.6. Risk Management

None identified. This is a statutory report to be published to inform NHS England of the local picture. NHS England is the decision-making body about the commissioning of new pharmacy premises.

8.7. Rural Communities

Both rural and town areas of the Council's footprint are considered as part in this report.

8.8. Children and Young People/Cared for Children

There are no direct implications for children and young people.

8.9. Public Health

This work and its recommendations aim to guide improvement of public health in relation to pharmaceutical services through intelligence-informed approaches.

8.10. Climate Change

The PNA includes consideration of ways in which local pharmacies promote wellbeing and healthy lifestyles and illness prevention.

Access to Information	
Contact Officer:	Dr Susan Roberts, Consultant in Public Health Susan.Roberts@cheshireeast.gov.uk <work telephone number>
Appendices:	Appendix A Executive Summary draft PNA Appendix B Equality Impact Assessment
Background Papers:	

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Appendix A

Cheshire East Draft Pharmaceutical Needs Assessment 2022-25
Executive Summary
(with reference to the full PNA draft)

Pharmaceutical Needs Assessments (PNAs) are carried out to assess the current and future needs for pharmaceutical services in the local population. They ensure that community pharmacy services are provided in the right place and meet the needs of the communities they serve.

Every Health and Wellbeing Board (HWB) has a statutory responsibility to conduct a PNA at least every three years. This PNA follows the 2018 version of the PNA. NHS England is required to use the finalised PNA to consider applications to open a new pharmacy, move an existing pharmacy or to commission additional services from a pharmacy. The national deadline for its production was extended due to the COVID-19 pandemic.

The PNA covers opening times *(Chapter 12)*, services delivered *(Chapter 7)*, and accessibility in relation to disability, language needs, ethnicity, sexuality, and rurality *(Chapter 16)*. The production of the PNA has involved:

- Analysis of data relating to pharmaceutical need and demand from wide and varied sources.
- Regular consultation with members of the Cheshire East Pharmaceutical Needs Assessment Steering Group, which brings together representatives from key organisations across Cheshire East.
- A public survey and incorporation of 2 questions regarding pharmacies as part of broader Healthwatch conversations. *(Appendix A and Appendix E)*
- A dispensing doctors survey. *(Chapter 10 and Appendix F)*
- A community pharmacy contractors survey. *(Appendix B)*

Conclusion

Based on this PNA, currently pharmaceutical provision in the towns and villages of Cheshire East borough is assessed as **adequate** in terms of location, opening hours and pharmaceutical services offered to the population.

Through examination of the available information, the PNA has not identified current or anticipated future need for new NHS pharmaceutical service providers in Cheshire East.

1.1 Current need

- There is currently an adequate level of community pharmacy provision in every major town in the Borough. The maps show that this provision is mostly located either in the town centres or close to GP surgeries. There are bordering pharmacies accessible for

residents and the number of pharmacies in Cheshire East is near to the national average. *(Chapter 21)*

- The public survey shows that 77% of participants are satisfied with the pharmacy services received. The majority of participants were also satisfied with pharmacy opening hours (75% satisfied) and that it was very easy to get to their usual pharmacy (65%). Where residents left comments, common themes included: being unsatisfied with the prescription/dispensing service (7%); long waits (6%); being unsatisfied with opening hours (5%), being unhappy with service from staff (3%). *(Appendix A)*
- The current dispensing workload as demonstrated by the number of items dispensed per pharmacy is not significantly different to the England average. *(Chapter 11)*
- There are six practice premises in Cheshire East at which dispensing doctor services are available to eligible patients. Some of these practices cover very rural areas. Patients who receive dispensing doctor services are able to be supplied with medicines, but they may not be able to benefit from the wider range of essential and advanced services that community pharmacies are able to provide, or the Clinical Commissioning Group (CCG) and public health commissioned services. *(Chapter 10)*
- According to the Tartan rug, the town of Crewe experiences the greatest extent of deprivation in the Borough, and it also has the highest levels of premature mortality. There is a lower level of community pharmacy provision in the Crewe care community area and particularly in the north of the town, although the number of pharmacies per 100,000 population is still reasonable in terms of the national range *(Chapter 11)*. Consideration has been given within this and the previous PNA in relation to the planned housing developments in the area *(Chapter 15)*. However, we are assured that this area is adequately provided for by the pharmacies in central Crewe and the local independent provider in North East Crewe. The public survey respondents who reside in Crewe raised no concerns regarding access to pharmacies in terms of location.
- The pandemic has shown that community pharmacy has been resilient and adaptable. Being located in the heart of communities, many with high levels of deprivation, the pharmacies have been essential and valuable to residents, supporting them in their own communities. *(Chapter 19)*
- There is good coverage of pharmacy provision opening hours, with extended opening hours from 6.30am and throughout the day up to midnight. Care community areas with no evening or weekend provision are able to access the 100 hour pharmacies in neighbouring care communities and pharmacies outside of Cheshire East. *(Chapter 12)*

1.2 Future need

- The prescribing of medicines is predicted to grow by 7.7% by 2024 and a further 6.3% increase by 2029. This is a total increase in medicines use of 14.4% over the ten year period. Increases of this magnitude are likely in all areas of the country. Existing pharmacies may have to increase their capacity and review their working practices to meet this need. *(Chapter 15)*
- When using the Office of National Statistics population projections, pharmaceutical need is predicted to increase to a greater extent in the Knutsford care community and the Bollington, Disley and Poynton care community. The current dispensing workload is higher in the Bollington, Disley and Poynton care community (7,432) than the

England average (6,565) which is consistent with having fewer pharmacies per 100,000 population[1]. However, this high volume of dispensing may be attributed by cross-border activity as the Bollington, Disley and Poynton care community borders with neighbouring local authorities. There are pharmacies in neighbouring authorities available for residents to access pharmaceutical services from. This might involve a change in the skill mix and capacity within each pharmacy to cope with the predicted additional demand. *(Chapter 11)*

- Most of the increase in prescribing need will occur among older people. This PNA has highlighted several issues relevant to older people, including poor physical access to some community pharmacies, and insufficient accessibility aids in some pharmacies. *(Chapter 16)*
- We have taken consideration of the main strategic sites of planned housing developments in relation to current pharmaceutical provision, and Cheshire East is generally well provided for. One area of concern is the planned South Cheshire Growth Village at Basford, Crewe. Consideration of the proposed site suggests that the health needs of the population will be adequately met by Rope Green Medical Centre and the associated Well Pharmacy as well as pharmacies in central Crewe. However, this will need to be monitored as the development progresses. *(Chapter 15)*

1.3 Recommendations

- Patients who receive dispensing doctor services are able to be supplied with medicines, but they may not be able to benefit from the wider range of essential and advanced services that community pharmacies are able to provide, or the Clinical Commissioning Group and public health commissioned services. Existing pharmacies may have to increase their capacity and review their working practices to meet this need.
- Most of the increase in prescribing need will occur among older people. This PNA has highlighted several issues relevant to older people, including poor physical access to some community pharmacies, and insufficient accessibility aids in some pharmacies. It is recommended that NHS England, Cheshire East Council and NHS Cheshire Clinical Commissioning Group review accessibility of pharmacy sites, service quality and uptake, including consideration of cultural and equalities needs.
- When using the Office of National Statistics population projections, pharmaceutical need is predicted to increase to a greater extent in the Knutsford and Bollington, Disley and Poynton care communities. The current dispensing workload is higher in the Bollington, Disley and Poynton care community (7,432) than the England average (6,565) which is consistent with having fewer pharmacies per 100,000 population[2]. This might involve a change in the skill mix and capacity within each pharmacy to cope with the predicted additional demand.
- A potential future gap of pharmaceutical provision in Basford, Crewe was identified due to a large planned housing development. It is recommended that this is monitored

[1] NHSBSA General Pharmaceutical Services - England 2015/16-2020/21, Summary Tables, NHSBSA Copyright 2022. This information is licenced under the terms of the Open Government Licence.
[2] NHSBSA General Pharmaceutical Services - England 2015/16-2020/21, Summary Tables, NHSBSA Copyright 2022. This information is licenced under the terms of the Open Government Licence.

for pharmaceutical provision as the housing development progresses over the lifecycle of this PNA.

- Pharmacies have a continued important case-finding role in relation to high blood pressure.
- Pharmacies continue to have a role in support patients to recover quickly from minor ailments.

Appendix B

CHESHIRE EAST COUNCIL – EQUALITY IMPACT ASSESSMENT FORM

EQUALITY IMPACT ASSESSMENT

TITLE: Cheshire East Council Pharmaceutical Needs Assessment 2022

VERSION CONTROL

Date	Version	Author	Description of Changes
17/02/2022	**0.1**	**Sarah Trelfa**	**1st draft**
04/03/2022	**0.2**	**Sarah Trelfa**	**2nd draft**
16/03/2022	**0.3**	**Sarah Trelfa**	**Final draft**

CHESHIRE EAST COUNCIL –EQUALITY IMPACT ASSESSMENT

Stage 1 Description: Fact finding (about your policy / service /

Department	**Public Health**
Service	Public Health
Lead officer responsible for assessment	Sarah Trelfa
Other members of team undertaking assessment	Dr Susie Roberts, Healthwatch
Date	**16/03/2022**
Version	**0.3**
Type of document	**Project**
Is this a new/ existing/ revision of an existing document (please mark as appropriate)	**New**
Title and subject of the impact assessment (include a brief description of the aims, outcomes, operational issues as appropriate and how it fits in with the wider aims of the organisation)	Every Health and Wellbeing Board (HWB) in England has a statutory responsibility to publish and keep an up to date statement of the needs for pharmaceutical services of the population in its area, referred to as a Pharmaceutical Needs Assessment (PNA). The PNA is not a new policy, service or function but will be used in the decision-making process when identifying a need for new, or changes to, pharmaceutical services. It will be used by the local NHS England Area Team to assess applications for new, additional or relocated premises. It will also be used by NHS England to make decisions in the commissioning of NHS funded services that can be provided by local community pharmacies. Additionally, Local Authorities and Clinical Commissioning Groups may use the PNA when commissioning services to meet local health needs and priorities. This assessment therefore considers an assessment of the engagement of residents in Cheshire East who may influence the PNA, to ensure it meets the local health needs and priorities.

Please attach a copy of the strategy/ plan/ function/ policy/ procedure/ service	This is the fourth PNA for Cheshire East (previously published in 2011, 2015 and 2018) and this draft PNA is required to be approved by the Cheshire East Health and Wellbeing Board (HWB) by October 2022. According to section 128A of the 2006 Act, the PNA must relate to all the pharmaceutical services provided under arrangements made by the NHS Commissioning Board and should make an assessment of the following: • the demography of its area • whether there is sufficient choice to obtaining pharmaceutical services within its area • the different needs of different localities within the area • whether pharmaceutical services provided in the area of any neighbouring HWB would secure improvements, or better access to pharmaceutical services within its area • whether any other NHS services provided in or outside its area affect the need for pharmaceutical services in its area and would secure improvements or better access to pharmaceutical services within its area • Future needs relating to the number of people in its area who require pharmaceutical services, the demography of its area and the risks to the health or wellbeing of people in its area. Each HWB must also consult (for a minimum period of 60 days) with a number of professional bodies about the provision of pharmaceutical services within its area. Based on the action taken so far to complete the PNA, currently pharmaceutical provision in the towns and villages of Cheshire East borough is assessed as adequate in terms of location, opening hours and pharmaceutical services offered to the population. Through examination of the available information (as stated above and using data from NHS Business Services Authority, NHS England and CCG), the PNA has not identified current or anticipated future need for new NHS pharmaceutical service providers in Cheshire East. This brief impact assessment aims to consider the equality issues that may be present, and address them where possible, however it should be noted that the PNA is a high level document with multiple agencies involved in the provision of pharmaceutical services. As such, further work will need to be done, by all partners involved, to identify any equalities impacts as work progresses; for example as services are commissioned, procured, in the contract management of services and as operational decisions about service provision are made.
Who are the main stakeholders and have they been engaged with? (e.g. general public, employees,	Our main stakeholders are: • All Cheshire East residents • NHS England • Cheshire CCG • Local Pharmaceutical Committee (LPC) • Local Medical Committee (LMC)

Councillors, partners, specific audiences, residents)	• Any Local Healthwatch organisation, any other patient, consumer or community group with an interest in provision of pharmaceutical services it the area • Any persons in the pharmaceutical lists and any dispensing doctors • NHS trust or NHS foundation trust • NHS Commissioning Board • Any neighbouring Health and Wellbeing Boards As a part of the development of the PNA, to date, we have undertaken engagement with: • Regular consultation with members of the Cheshire East Pharmaceutical Needs Assessment Steering Group, which brings together representatives from the Cheshire Clinical Commissioning Group, NHS England, the Local Pharmaceutical Committee, the Local Medical Committee, and Healthwatch. • Community Pharmacies based in Cheshire East via a pharmacy contractors survey. This survey captured the advanced and essential services provided by pharmacies, accessibility, opening hours, public health services currently providing and willing or unable to provide, prescription collection and delivery offered. All 78 pharmacies within Cheshire East engaged with and responded to this survey. • Dispensing doctors in Cheshire East were consulted with via a dispensing doctors survey. This survey captured the advanced and essential services provided by dispensing doctors, accessibility, opening hours, public health services currently providing and willing or unable to provide, prescription collection and delivery. All 6 dispensing doctors submitted a response. • A public survey for all Cheshire East residents. This was conducted during November 2021-December 2022 to capture public views on pharmacy provision. The survey ran for a period of 30 days and was available both online on the Cheshire East Council website and in paper forms to complete in Cheshire East libraries. A total of 514 responses were received. In addition, a contact centre number was set up for respondents to participate in the survey, should they be unable to access the survey online. The public survey was widely promoted online via the internal staff newsletter, the council's social media platforms, through our steering group partners. The public survey was also promoted via a one-slide presentation on TV screens in the libraries and in leisure centres across Cheshire East.

	• Analysis of the public survey showed that fewer responses were received from younger age bands, 16-24, 25-34 and 35-44 and as such, are underrepresented within the survey. For the age band 45-54 the proportion is representative. The 55-64 and 65-75 age bands are over representative, whereas the oldest age band (75 and over) is representative. • The responses to sexuality show a majority of responses selected heterosexual (78%). 1% of respondents selected 'Gay or Lesbian'. There is no data available on sexuality at a Local Authority level, so it is unknown if this is representative of demography in Cheshire East. • There was also a skew in terms of gender, with more females (58%) providing a response to the survey than males (33%). • With regards to ethnicity, the majority of respondents identified as 'White – British' (52%) or 'White – English' (33%) (85% in total). This is representative of the ethnicity demography in Cheshire East. • Only a small number of respondents selected that they had a disability (71/466). Of those, 8% stated their disability was related to physical, long-term illness (6%), deaf or hard of hearing (3%), mental health (2%). • This PNA has used ONS population counts to provide population numbers by geographical areas within Cheshire East. This has been used to estimate the number of pharmacies available to residents within their local area and highlight potential differences in provision. Population characteristics of Cheshire East residents have been taken into account through use of Census 2011 data, looking at a number of socio-economic variables. This has allowed consideration of different services that may be required in different local areas of Cheshire East. • It is important to note that there was a small number of respondents to the Public Survey (514) and so we cannot be certain that this is representative of the Cheshire East population. • Analysis of the public survey showed no evidence to suggest an impact on the following protected characteristics: marriage & civil partnership, religion, gender reassignment, pregnancy and maternity. • However, analysis of both the public survey and the pharmacy contractors survey identified issues related to pharmacy accessibility and opening times. Therefore, in the consultation, we will seek to engage with groups with mobility

	issues/older age/disability via our network with Healthwatch. We will also seek to ask about opening hours in the consultation and raise this in the PNA as a recommendation for NHS England to consider when commissioning pharmacies. • There will also be the opportunity to feedback any other impacts relating to the PNA during the consultation process. We will do this by making the draft PNA available for consultation for a minimum of 60 days via the Cheshire East Council website. We will also engage with stakeholders and key contacts to further promote the formal consultation and improve engagement on the draft PNA (please see sections below for further detail). We will do this by compiling a list of key contacts (as identified by this EIA and by our steering group) and sending around an email with the link to the consultation on the Cheshire East Council website. We will publish the draft PNA in full. As well as this, we will provide a one page plain English summary, and a longer 3 page executive summary, which signposts to the relevant sections of the full draft PNA document. Hard copies of the draft PNA and the questionnaire will be made available to those who request it, as well as easyread copies. We will also set up a customer contact telephone line for residents and stakeholders to participate, should they be unable to access the paper copies and the online version. The customer services centre can also support with language interpretation.
Consultation/ involvement carried out.	**YES**
What consultation method(s) did you use?	• Public survey - available both online on the Cheshire East Council Website and in paper forms to complete in Cheshire East libraries. A total of 514 responses were received. In addition, a contact centre number was set up for respondents to participate in the survey, should they be unable to access the survey online. The public survey was widely promoted online via the internal staff newsletter, the council's social media platforms, through our steering group partners. The public survey was also promoted via a one-slide presentation on TV screens in the libraries and in leisure centres across Cheshire East. • Dispensing doctors in Cheshire East were consulted with via a dispensing doctors survey via email. • Community Pharmacies based in Cheshire East via a pharmacy contractors survey.

	• Regular consultation with members of the Cheshire East Pharmaceutical Needs Assessment Steering Group. Representatives from Healthwatch, NHS England, GPs and the Local Medical Committee, Local Pharmaceutical Committee and Cheshire Clinical Commissioning Group.

Stage 2 Initial Screening

Who is affected and what evidence have you considered to arrive at this analysis? **(This may or may not include the stakeholders listed above)**	The groups of people affected are all residents of Cheshire East.
Who is intended to benefit and how?	It is the intention that as many residents as possible will benefit from the review of pharmaceutical services. It will enable all stakeholders to shape the production of the PNA and comment on areas that have not been considered.
Could there be a different impact or outcome for some groups?	Yes - we are aware from the public survey that there is some variation in pharmaceutical provision, in particular access to some public health commissioned services, private consultation space, pharmacy accessibility, and language barriers. We want understand impact of this on the residents in Cheshire East in relation to pharmacy provision. Specifically, we will engage with the University of the 3rd Age, people with learning disabilities and autism, people with sensory disabilities, people with mental health conditions, gypsy & traveller community, people living in the 20% most deprived neighbourhoods in Cheshire East, asylum seekers, all care coordinators, faith groups, neighbouring health and wellbeing boards, and Cheshire & Warring Carers Trust to promote the consultation and seek feedback on their views regarding access to some public health commissioned services, private consultation space, pharmacy accessibility, and language barriers.

	Areas with higher levels of deprivation, such as Crewe and Macclesfield, are likely to be disproportionately affected by pharmaceutical changes and we want to understand the potential impact of this in the consultation. We will engage with Connected Community Development Officers and Local Area Coordinators to promote the consultation and seek feedback on their views to further inform the PNA. Rural communities are also likely to be impacted by changes in pharmaceutical provision and so we want to understand the potential impact of this in the consultation. Feedback will be used to further inform the PNA. We will make recommendations in the PNA to NHS England.
Does it include making decisions based on individual characteristics, needs or circumstances?	No
Are relations between different groups or communities likely to be affected? **(eg will it favour one particular group or deny opportunities for others?)**	The PNA finds that overall provision of pharmaceutical services in Cheshire East is adequate for the population. Future housing developments are included to highlight any potential gaps in pharmacy provision.
Is there any specific targeted action to promote equality? Is there a history of unequal outcomes (do you have enough evidence to prove otherwise)?	Protected characteristics such as age, gender and ethnicity are collected in relation to pharmaceutical services including sexual health (emergency hormonal contraception, chlamydia screening), substance misuse and stop smoking services. This data is used by commissioning leads to assess any gaps in access/uptake of services. (Data is not routinely collected for all services). Residents may also use customer feedback or complaints processes to inform pharmacies of specific barriers they experience.

	The PNA includes a recommendation for NHS England (and Cheshire East Council / Cheshire Clinical Commissioning Group) to review service quality and uptake, including consideration of cultural and equalities needs.

Is there an actual or potential negative impact on these specific characteristics?

Age	Y
Disability	Y
Gender reassignment	N
Marriage & civil partnership	N
Pregnancy & maternity	N
Race	Y
Religion & belief	N
Sex	Y
Sexual orientation	N

Stage 3 Evidence

	What evidence do you have to support your findings? (quantitative and qualitative) Please provide additional information that you wish to include as appendices to this document, i.e., graphs, tables, charts	Level of Risk (High, Medium or Low)
Age	There are a number of commissioned services that are targeted for specific age groups i.e. Chlamydia screening/emergency contraception services for under 25s and NHS Health Checks for 40-74 year olds which are both nationally mandated programmes. The public survey did not identify any negative impacts of the PNA on access or other service provision on the basis of age. In the pharmacy contractors survey, it was identified that not all sites are accessible to wheelchairs or have enough floor space to enable people in wheelchairs into the pharmacy. This may have a negative impact on those who are of an ageing population whose mobility needs change over time. This is also a concern with a growing ageing population in Cheshire East. However, no comments regarding this were identified in the public survey. We will seek to gain feedback from older adults, such as the University of the 3rd Age (U3A), and people with mobility issues through our contacts at Healthwatch. We will use this feedback to adapt the recommendations in the PNA and recommendations to NHS England.	**Low**
Marriage and Civil Partnership	There is no evidence to suggest an impact on this protected characteristic. There will be the opportunity to feedback any impacts relating to this during the consultation process.	**N/A**
Religion	There is no evidence to suggest an impact on this protected characteristic. There will be the opportunity to feedback any impacts relating to this during the consultation process.	**N/A**
Disability	In the pharmacy contractors survey, it was identified that not all sites are accessible to wheelchairs or have enough floor space to enable people in wheelchairs into the pharmacy. This may have a negative impact on those with a disability. However, no comments regarding this were identified in the public survey. We will seek to engage with Cheshire Advocacy, Pure Insight, Richmond Fellowship, and Disability Information Services, during the consultation to gather feedback on the PNA.	**Low**
Pregnancy and Maternity	There is no evidence to suggest an impact on this protected characteristic. There will be the opportunity to feedback any impacts relating to this during the consultation process.	**N/A**

Sex	Within the public survey responses, there was a skew towards number of females responding to the survey (58%). Therefore, we will seek to promote the PNA within male support groups, such as Mentell, to gather feedback on the PNA.	**N/A**
Gender Reassignment	There is no evidence to suggest an impact on this protected characteristic. There will be the opportunity to feedback any impacts relating to this during the consultation process.	**N/A**
Race	Questions were asked about languages spoken by pharmacy staff, which has been summarised in the PNA. There may be an impact on individuals accessing pharmaceutical services who speak their language. We will seek to engage with people whose first language is not English to ascertain their views on the PNA. We will also share the PNA consultation with Cheshire East Council Community Connector team to ask for their feedback regarding accessing pharmacy provision due to language barriers.	**N/A**
Sexual Orientation	In the public survey, the responses to sexuality show a majority of responses selected heterosexual (78%). 1% of respondents selected 'Gay or Lesbian'. There is no data available on sexuality at a Local Authority level, so it is unknown if this is representative of demography in Cheshire East. There is no evidence to suggest an impact on this protected characteristic. There will be the opportunity to feedback any impacts relating to this during the consultation process.	**N/A**

Stage 4 Mitigation

Protected characteristics	**Mitigating action** *Once you have assessed the impact of a policy/service, it is important to identify options and alternatives to reduce or eliminate any negative impact. Options considered could be adapting the policy or service, changing the way in which it is implemented or introducing balancing measures to reduce any negative impact. When considering each option you should think about how it will reduce any negative impact, how it might impact on other groups and how it might impact on relationships between groups and overall issues around community cohesion. You should clearly demonstrate how you have considered various options and the impact of these. You must have a detailed rationale behind decisions and a justification for those alternatives that have not been accepted.*	**How will this be monitored?**	**Officer responsible**	**Target date**

Age	The PNA includes a recommendation for NHS England (and Cheshire East Council and NHS Cheshire Clinical Commissioning Group) to review accessibility of pharmacy sites, service quality and uptake, including consideration of cultural and equalities needs.	An approach to monitoring will be further developed according to addressing relevant feedback as part of the consultation. Additionally, the Cheshire East PNA steering group will continue to meet annually and will review any changes to Pharmacy provision to determine if there is a requirement to reassess needs. Supplementary statements will be issued to reflect changes to the current PNA.	NHS England, Cheshire East Council and Cheshire CCG	Review by September 2025
Marriage and Civil Partnership	N/A			

Religion	N/A			
Disability	The PNA includes a recommendation for NHS England (and Cheshire East Council and NHS Cheshire Clinical Commissioning Group) to review accessibility of pharmacy sites, service quality and uptake, including consideration of cultural and equalities needs.	An approach to monitoring will be further developed according to addressing relevant feedback as part of the consultation. The Cheshire East PNA steering group will continue to meet annually and will review any changes to Pharmacy provision to determine if there is a requirement to reassess needs. Supplementary statements will be issued to reflect changes to the current PNA.	NHS England, Cheshire East Council and Cheshire CCG	Review by September 2025
Pregnancy and Maternity	N/A			

Sex	Pharmacies should ensure appropriate male/female staff are available to assist with gender specific services eg sexual health related services.	Pharmacies will be made aware of this EIA and encouraged to engage with this action.	Community pharmacies in Cheshire East	September 2025
Gender Reassignment	N/A			
Race	Pharmacies could review their service user feedback and complaints to see whether there are any reported access issues in this area to consider. Eg recruiting staff who speak a second language, use of interpretation services.	Pharmacies will be made aware of this EIA and encouraged to engage with this action.	Community pharmacies in Cheshire East	September 2025
Sexual Orientation	Pharmacies could review their policies and practises using evidence such as service user feedback and complaints to see whether there are any reported access issues in this area to consider. eg. relating to sexual health service	Pharmacies will be made aware of this EIA and encouraged to engage with this action.	Community pharmacies in Cheshire East	September 2025

5. Review and Conclusion

Specific actions to be taken to reduce, justify or remove any adverse impacts	How will this be monitored?	Officer responsible	Target date
Equality of access to pharmaceutical services for all Cheshire East residents.	The potential accessibility barriers and inequalities in access of pharmaceutical services in Cheshire East have been identified in the PNA through consideration of the demographics. The consultation will provide further opportunity to feedback concerns. Recommendations to improve equality of access are included in the PNA.	NHS England and Improvement	September 2022
Equality of access to pharmaceutical services for all Cheshire East residents.	Equality Impact Assessment to be reviewed before the next PNA in 2025 to assess whether additional survey work relating to facilities available at pharmacies for patients with protected characteristics is required.	Cheshire East Council – Public Health Team	September 2025

Please provide details and link to full action plan for actions	N/A
When will this assessment be reviewed?	September 2025
Are there any additional assessments that need to be undertaken in relation to this assessment?	No
Lead officer sign off	Sarah Trelfa
Date	16/03/2022

Head of service sign off	Dr Susie Roberts
Date	16/03/2022

Please publish this completed EIA form on the relevant section of the Cheshire East website

Working for a brighter future together

Scrutiny Committee

Date of Meeting:	14 June 2022
Report Title:	Place Partnership Board Update
Report of:	Helen Charlesworth-May Executive Director Adults, Health & Integration
Report Reference No:	SC/01/22-23
Ward(s) Affected:	All

1. Purpose of Report

1.1 The purpose of this report is for members to note the progress on the new governance arrangements for local Health and Care services, to consider and comment on the proposed joint scrutiny arrangements for Cheshire & Merseyside and approve the amended 'Protocol for the establishment of Joint Health Scrutiny Arrangements in Cheshire and Merseyside'.

2. Executive Summary

2.1 The government reforms of the NHS include introducing Integrated Care Systems (ICS) across the country. The geographical footprint of the local ICS covers 9 local authorities in Cheshire & Merseyside. Each of these 9 'places' will have a 'Place Partnership Board' or a similar governance forum, to allow for local decision making over health-related functions.

2.2 Discussions across Cheshire East are ongoing and have been very positive. There is a shared approach to tackling the wider determinants of health and to allocate resources at a 'place' level wherever possible. We need to put in place appropriate governance arrangements to facilitate local decision making and support greater integration of services for the benefit of our resident.

3. Recommendations

The Committee is asked to:

i. Note the progress to date on the Place Partnership Board (working title)
ii. Recommend to Council that the establishment of a Cheshire and Merseyside Integrated Care System Joint Health Scrutiny Committee (Appendix A); and 'Protocol for the establishment of Joint Health Scrutiny Arrangements in Cheshire and Merseyside' (Appendix B) be approved.

4. Reasons for Recommendations

4.1 The Health & Care Act 2022 abolishes NHS Clinical Commissioning Groups (CCGs) from 1 July 2022 and sees the creation of the Integrated Care Systems (ICS), with finances coming centrally to an Integrated Care Board (ICB) for each area. It is then for each ICB to agree how much funding it will delegate to the local level i.e., the 'Place'.

4.2 A governance forum at 'Place' is necessary if there is to be any funding delegation down to a Cheshire East ('Place') level, and this is envisaged in the statutory guidance. All partners are keen to have as much delegation down to Place level as possible, as local determination of services will provide the best results for our residents.

4.3 Actions are required to ensure that joint health scrutiny arrangements in Cheshire and Merseyside are fit to meet the challenge of the new statutory Integrated Care System (ICS) arrangements. This is the new ICS protocol.

4.4 Given the incoming changes and the establishment of Integrated Care Systems in England under the Health and Care Act 2022, the opportunity has been taken to review and update the existing Joint Health Scrutiny Protocol (agreed in 2014) to ensure that the framework for the operation of joint health scrutiny committees regarding substantial developments and variations of the health service across Cheshire and Merseyside was consistent with the arrangements for the new standing committee. This is the non-ICS elements. The proposed revised protocol is attached at Appendix B.

5. Other Options Considered

5.1 Other options have not been considered, as the proposed changes are necessary to meet the requirements of the Health & Care Act 2022.

6. Background and Decisions to Date

6.1 Integrating health and care services for the benefit of our residents is a clear priority within the Cheshire East Place Partnership Plan 2019-24. All partners signed up to the Plan, which sets out our aspirations to respond to the pressures facing health and care services and the opportunities provided by the establishment of integrated care systems.

6.2 Our plan sets out that we will work together to improve the health and wellbeing of local communities, enabling people to live longer and healthier lives. We will do this by creating and delivering safe, integrated, and sustainable services that meet people's needs through the best use of all the assets and resources we have available to us. The proposed legislative changes provide an opportunity to move this forward and support improved outcomes for the Cheshire East population.

6.3 This Committee at its meeting on 28 March agreed to enter into a S75 Agreement with the Clinical Commissioning Group (CCG) in respect of the Better Care Fund. This is an integral part of our joint approach to commissioning and integration for the future.

6.4 The Council at its meeting on 27 April agreed to set up a Section 75 Committee to share resources and decision making between the local authority and the NHS. The Section 75 Committee will comprise the Executive Director of Adults, Health & Integration and a representative from the NHS Cheshire CCG, who will formally oversee the S75 Agreement. This will then be taken over by the ICB from 1 July as part of the transfer of the CCG functions.

6.5 The Corporate Policy Committee at its meeting on 14 April noted the progress to date on governance arrangements at 'Place' and agreed that the terms of reference would come before this Committee to agree. It is of course necessary that all partners reach a consensus on the terms of reference, before putting them to their respective boards/committees.

7. Partnership Board Update

7.1 Cheshire East established a Place Executive Group, led by the Council's Chief Executive, with senior membership from the CCG, local NHS, Healthwatch and VCFSE sector. This Group is working together with the current Place Partnership Board to consider the proposed Terms of Reference for the future Place arrangements. It is anticipated that these will come to the next meeting of the Committee, on 18 July 2022.

7.2 The emerging scope and functions of the new Partnership Board are still to be determined, as we await further details from the ICB as to what functions they intend to delegate to Place, and how these will be discharged. The ICB has appointed a Place Director for each of the nine regions, and the Place Director for Cheshire East (Mark Wilkinson) will commence his role on 15 June. It is likely that the scope and functions will change over time, as the Partnership Board becomes more established, and when more delegated decision making over funding is provided by the ICB at 'Place' level.

8. Establishment of a Cheshire and Merseyside Integrated Care System Joint Health Scrutiny Committee

8.1 In response to the proposed establishment of Integrated Care Systems, the Chief Executives of the nine Merseyside and Cheshire local authorities agreed several actions to ensure that joint health scrutiny arrangements in Cheshire and Merseyside are fit to meet the challenge of the new statutory arrangements. It is considered appropriate to establish a standing joint health scrutiny committee which will have the opportunity to take on the Authorities' collective statutory responsibility to oversee and scrutinise the operation of the ICS at Cheshire and Merseyside level.

8.2 The overarching role of the Joint Committee is to scrutinise the work of the ICS in the discharge of its statutory responsibilities and functions at Cheshire and Merseyside level in order to support their effective exercise and, where appropriate, to make reports or recommendations to the ICS. Appendix A sets the proposed standing joint committee arrangements.

8.3 The main features of the document are as follows:

- Membership – each authority should nominate 2 representatives to serve on Committee.
- Political balance –membership has to reflect the aggregate political balance across the nine authorities, and this would be subject to annual calculation.
- Joint Committee remit – this would cover the ICS responsibilities exercised at Cheshire and Merseyside level, plus any proposals for changes in health services that not only impact all nine local authority areas but are also considered to be a substantial change by each of the nine.

8.4 The Scrutiny Committee has indicated that it is supportive of the proposal for joint scrutiny arrangements, and it is intended to take the protocol to the Scrutiny Committee at its meeting on 14 June for their comments, prior to presenting the proposal to full Council at its meeting on 20 July 2022.

9. Legal Implications

9.1 Many areas already have long established arrangements that enable decisions on key priorities to be made together in an agreed local collaborative forum. Decisions undertaken at these collaborative forums are possible due to the authority delegated to the relevant representative at that forum by their respective organisation and not by the forum itself. There are limited circumstances in which joint decision-making arrangements can be used, and this is recognised as a

weakness of the current system. The Health & Care Act 2022 provides that joint committees can be set up between the ICB and other partners for the future.

9.2 For the purposes of the proposed arrangements, the relevant joint committee powers are under Section 75 of the National Health Service Act 2006 and NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000. There is only power for a local authority to form a joint committee with the NHS where there is an agreement under Section 75 of the National Health Service Act 2006.

9.3 Post-July 2022 and the establishment of the ICS, local authorities will still have a statutory obligation to undertake health scrutiny at a "place" level. Individual local authority Health Scrutiny Committees will need to continue to meet to consider matters directly relating to their areas and to consider any potential substantial variations in health service provision that only impact on their respective local authority area. Each local authority will be responsible for determining these work plans and managing their relationships with NHS colleagues to ensure Health Scrutiny at this level (i.e. Place) meets its obligations and provides the necessary political oversight, transparency and challenge.

9.4 Joint committees must be politically balanced under the proportionality rules set out in the Local Government and Housing Act 1985. This means the joint scrutiny committee as a whole must be politically balanced across all nine local authorities.

10. Financial Implications

10.1 There are no direct financial implications as a result of the new Place Partnership Board and governance arrangements, although they will require administration and support. This is assumed to be provided by the ICB, although this is to be confirmed.

10.2 Temporary funding (£90k across all nine Local Authorities affected) has been requested to support the Joint Health Scrutiny Committee for an initial period of 18 months will be required. Each authority will be asked to contribute a total of £10,000 over the initial 18 months. This will be met from existing budgets.

11. Policy Implications

This report and its recommendations are within the Council's existing policy framework, and it supports the priorities set out in the Cheshire East Place Partnership Plan 2019-2024.

12. Equality

There are no direct equality implications as a result of this report.

13. Human Resources

There are no direct human resources implications as a result of this report. However, the change from the CCG to the ICB will have HR implications, albeit they will be indirect for the Council.

14. Risk Management

14.1 There is a risk that not all partners agree to the proposed terms of reference as set out in this report. However, this is considered very low risk as senior officers and members of the Place Partnership Board have been working together to collaboratively develop the integrated partnership arrangements. All relevant boards/committees within each partner organisation will be consulted in the same timeframe to ensure all organisations agree the current proposals.

14.2 It is assumed that partners can reach a consensus over decision making. However, in the event that a dispute arises between the partners over anything contained within the S75 Agreement, then the dispute mechanism in the S75 Agreement takes precedence. Similarly if any dispute arises over the allocation of ICB funding or priorities at Place, then this would be referred to the C&M ICB Chair for decision.

15. Rural Communities

There are no direct implications for rural communities as a result of this report, as the Place Partnership Board's will deliver to the agreed objectives in the Cheshire East Place Plan.

16. Children and Young People/Cared for Children.

There are no direct implications for Children and Young People/Cared for Children as a result of this report, as the Place Partnership Board's responsibility is to deliver the agreed objectives and priorities in the Cheshire East Place Plan, including those agreed for children and young people. The Director of Childrens Services is a member of the Partnership Board and this will ensure that appropriate emphasis is given to those services which affect children and young people.

17. Public Health

A key purpose of the Integrated Care System is to ensure that all areas consider the wider determinants of health and health inequalities and tackling these is key part of the Health & Care Bill, which the Partnership Board will need to consider. The Director of Public Health is to be a member of the Partnership Board and this will ensure the appropriate emphasis is given to these areas.

18.Climate Change

There are no direct implications for climate change as a result of this report.

Access to Information	
Contact Officer:	Deborah Upton, Legal Services deborah.upton@cheshireeast.gov.uk
Appendices:	Appendix A Draft Cheshire and Merseyside Integrated Care System Joint Health Scrutiny Committee – Joint Committee Arrangements Document Appendix B Draft revised Protocol for the Establishment of Joint Health Scrutiny Arrangements in Cheshire and Merseyside
Background Papers:	Health & Care Bill 2020 Report to Adults & Health Committee on 28 March 2022 entitled '*Better Care Fund S75 Agreement'* Report to Corporate Policy Committee on 14 April 2022 entitled 'Governance Progress Report' Report to Council on 27 April 2022 entitled 'Recommendations from Corporate Policy Committee: Progress on Governance for the Integrated Care System'

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APPENDIX A

CHESHIRE AND MERSEYSIDE INTEGRATED CARE SYSTEM JOINT HEALTH SCRUTINY COMMITTEE

JOINT COMMITTEE ARRANGEMENTS DOCUMENT

Interpretation

In this document the following expressions shall have the following meanings:

- the following local authorities are referred to singularly as 'Authority' and together as 'the Authorities'

    a) Cheshire East Council;
    b) Cheshire West and Chester Council
    c) Halton Borough Council
    d) Knowsley Borough Council;
    e) Liverpool City Council;
    f) St. Helens Borough Council;
    g) Sefton Borough Council;
    h) Warrington Borough Council;
    i) Wirral Borough Council;

- the "Cheshire and Merseyside (ICS) Joint Health Scrutiny Committee" means the Joint Health Scrutiny Committee established by the Authorities to hold to account and scrutinise the work of the Integrated Care System at Cheshire and Merseyside level;

- the "Secretariat" means the financial, administrative, scrutiny and other officer support to the Joint Committee;

- the "Host Authority" means the council which hosts the Secretariat at the relevant time;

- the "Joint Committee Arrangements Document" means this document, as amended from time-to-time;

- the "Rules of Procedure" means the rules of procedure as agreed by the Joint Committee from time to time;

- "the Act" means the National Health Service Act 2006

- the "2013 Regulations" means the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

The conduct of the Joint Committee and the content of this document shall be subject to the relevant legislative provisions, in particular Sections 244 and 245 of the Act (as amended) as well as the 2013 regulations, and in the event of any conflict between

APPENDIX A

the relevant legislative provisions/ regulations and this Joint Committee Arrangements Document, the requirements of the legislation/ regulations will prevail.

1. Background

1.1 The Health and Care Act 2022 confirms new structural arrangements for health governance through the formal establishment of Integrated Care Systems (ICSs) for specific geographical areas. ICSs will comprise:

1.1.1 an Integrated Care Board (ICB) in which will be vested statutory responsibilities and duties related to arranging for the provision of relevant hospital and health services for its area; and

1.1.2 an Integrated Care Partnership (ICP) which is a joint committee established by the ICB and the Authorities within the ICS area. The ICP is primarily charged with setting the strategic framework (an Integrated Care Strategy) for its area within which the ICB, NHS England and the Authorities, will be expected to exercise their respective functions to meet the area's assessed needs.

1.2 In Cheshire and Merseyside:

1.2.1 The ICS is known collectively as NHS Cheshire and Merseyside ICS.

1.2.2 The ICB is known as NHS Cheshire and Merseyside ICB

1.2.3 The ICP is known as the Cheshire and Merseyside Health and Care Partnership.

1.3 Under Section 245 of the Act and Regulation 30 of the 2013 Regulations, two or more Authorities may form a joint health scrutiny committee and arrange for relevant health scrutiny functions to be exercised by that joint committee.

1.4 In 2014, all nine Cheshire and Merseyside Authorities gave their approval to a "Protocol for Establishment of Joint Health Scrutiny Arrangements for Cheshire and Merseyside". This protocol was developed in accordance with the Act and the 2013 Regulations. Substantively it provides a framework for the mandatory establishment of ad hoc joint committees where 2 or more of the authorities deem a service change proposal to be a substantial variation in those services. Nevertheless, the protocol, in accordance with legislation, provides for the establishment of discretionary joint health scrutiny arrangements, where deemed appropriate, with the scope to review and scrutinise any matter relating to the planning, provision and operation of the health service.

1.5 In the context of the establishment of the statutory ICS arrangements for Cheshire and Merseyside, it has been deemed appropriate to establish a standing joint health scrutiny committee which will have the opportunity to take

APPENDIX A

on the Authorities' collective statutory responsibility to oversee and scrutinise the operation of the ICS at Cheshire and Merseyside Level:

1.6 The Authorities by being parties to this Joint Committee Arrangements Document signify their agreement to its terms. Each Authority and each Member of the Joint Committee established under the terms of this document must therefore comply with its provisions.

1.7 The Joint Committee must have regard to the relevant legislation, including the Local Government Act 1972, regulations related to health scrutiny and to any statutory guidance issued in this respect.

2. Functions of the Joint Committee

2.1 The functions of the Joint Committee — to be known as the "Cheshire and Merseyside Integrated Care System Joint Health Scrutiny Committee"— are to be exercised with a view to supporting the effective planning, provision, and operation of health services at Cheshire and Merseyside level. This will include promoting transparency in how the ICS fulfils its responsibilities within Cheshire and Merseyside.

2.2 The overarching role of the Joint Committee is to scrutinise the work of the ICS in the discharge of its statutory responsibilities and functions at Cheshire and Merseyside level in order to support their effective exercise and, where appropriate to make reports or recommendations to the ICS.

2.3 In specific terms the Joint Committee's role will include the duties/ functions set out below:

- To be consulted and provide feedback on the development of an integrated care strategy for Cheshire and Merseyside;

- To review and scrutinise any matter relating to the planning, provision and operation of the health service at Cheshire and Merseyside level only;

- To be consulted by a relevant NHS body (e.g. NHS Cheshire and Merseyside Integrated Care Board) on any service change proposals that has previously been deemed by all nine authorities to constitute a substantial variation in services.

- To consider the merits of any service change proposals that have been deemed to be a substantial variation in services by all nine authorities and to exercise the collective statutory responsibilities of the authorities in relation to responding to such consultation by the proposer.

APPENDIX A

3. Operating Arrangements

3.1 Knowsley Borough Council shall act as the Host Authority and arrange for the necessary officer support in doing so. In this respect Knowsley Borough Council will be provide the Secretariat.

3.2 The Joint Committee initially shall be made up of 18 elected members in accordance with the provisions of the current Joint Health Scrutiny Protocol.

4. Council Membership

4.1 All elected members in the authorities will be entitled to serve on the joint committee other than executive members and those elected members appointed to serve on ICS bodies (e.g. on the Cheshire and Merseyside Health and Care Partnership)

4.2 Each of the authorities nominating representatives to serve on the Joint Committee will be expected to do so in accordance with the political balance that applies in their respective authorities, adjusted to take account of the overall political balance across the nine authorities.

4.3 The allocation of seats by both area and party for 2022/ 2023 based on two members per authority is therefore as follows in order to secure overall political balance within Cheshire and Merseyside:

Authority	Labour	Liberal Democrat	Conservative	Green	Ind	Total
Cheshire East						2
Cheshire West and Chester						2
Halton						2
Knowsley						2
Liverpool						2
St. Helens						2
Sefton						2
Warrington						2
Wirral						2
Total						**18**

Allocation of seats to be confirmed following further consultation between the 9 authorities.

APPENDIX A

4.4 The allocation of elected member places on the Joint Committee will be reviewed on an annual basis, ordinarily in the period following the date of the municipal elections. In years where municipal elections do not take place, the review will need to have taken place by 15 May in that year.

4.5 Taking into account the outcome of such a review, Elected Members will be appointed by their respective Authorities in accordance with the constitutional procedures applicable in those Authorities. In any event, each Authority will ordinarily be expected to appoint their representatives no later than 31 May in each year.

4.6 The term of office of each Authority representative appointed shall be a period of 1 year or until 31 May of the following year, whichever is the earlier. This term of office is however subject to the appointed Member remaining as an Elected Member during the term of office. In the event of a Joint Committee Member ceasing to be an elected member during the course of their term of office as a Joint Committee Member, their entitlement to serve on the Joint Committee will also cease at that point.

4.7 Each appointment may be renewable on an annual basis, subject to the decision of the respective Authority and the continuing entitlement of the appointee to serve on the Joint Committee.

5. Elected Members – Resignation or Removal from the Joint Committee

5.1 An Authority may decide, in accordance with its procedures, to remove one of its Members from the Joint Committee at any time prior to conclusion of that Member's term of office, and upon doing so shall give written notice to the Secretariat of the change in its Member.

5.2 An Elected Member representative may resign from the Joint Committee at any time by giving notice to his or her appointing council who will inform the Secretariat.

5.3 In the event that any Elected Member resigns from the Joint Committee, or is removed from the Joint Committee by his or her Authority, the Authority shall immediately take the appropriate constitutional steps to nominate and appoint an alternative Member to the Joint Committee, in accordance with the agreed Joint Committee arrangements.

5.4 Where an Elected Member fails to attend meetings of the Joint Committee over a six-month period or for 3 consecutive meetings then the Secretariat shall recommend to the relevant Authority that due consideration is given to removing the member from the appointment to the Joint Committee and the appointment of a replacement member from that Authority.

APPENDIX A

5.5 Where it becomes clear that an Elected Member has ceased to represent the political group for which they were nominated by their respective Authority, either through withdrawal of the whip, suspension, or expulsion from the relevant group, that Member shall be immediately removed from the Joint Committee's Membership. In these circumstances, the relevant Nominating Authority will be obliged to take the appropriate steps, including liaison with the relevant political group, to nominate, at the earliest opportunity an alternative Member to the Joint Committee, in accordance with the allocation of seats at paragraph 4.3 above, so as to ensure the Joint Committee appropriate political balance is maintained.

6. Financial Arrangements

6.1 The funding provided by the authorities collectively to support the work of the Joint Committee will be received by the Host Authority.

6.2 Each Authority will pay directly any expenses claimed by its own nominated representatives in the course of their duties on the Joint Committee.

6.3 The Host Authority will establish an independent remuneration panel to consider whether a Special Responsibility Allowance (SRA) should be paid to the Chairperson of the Joint Committee or any other Joint Committee Member, and if so, what the level of that SRA should be. If the Authorities subsequently decide, based on the recommendations of the independent remuneration panel that an SRA will be paid, the Authorities will be required to reach agreement on how the costs of the SRA will be apportioned between them.

6.4 The financial arrangements for the Joint Committee will be reviewed each year by the Authorities. If in subsequent years, the Joint Committee considers that the funding available to support its activities is insufficient to support it in carrying out its functions, it may make a request to the Authorities to approve additional funding. If additional funding is approved, the Authorities will decide how, the additional costs will be apportioned between them.

7. Promotion and Support of the Joint Committee

7.1 The Joint Committee shall be promoted and supported by the Host Authority and the Secretariat through:

(a) The inclusion of dedicated webpages on the work of the Joint Committee, with the publication of meeting agendas; minutes; and papers where those papers are public, in line with the rules of procedure and legal obligations under the Local Government Act 1972. All reports and recommendations made, with responses from the ICS will be published. Information on member attendance and other publications will be included, as required on the webpages;

(b) Other relevant administrative, financial, legal, communications and scrutiny officer support as appropriate.

7.2 The costs of any additional promotion work identified above will be identified as part of financial arrangements to be agreed by the Authorities as set out in section 6 above.

7.3 The Joint Committee shall be promoted and supported by each Authority including:

(a) Ensuring that briefings take place on the work of the Joint Committee for members and officers at Authority level to ensure they are fully informed about relevant matters.

(b) Information on each respective website about the work of the Joint Committee and links to the main webpages.

(c) Sharing of information on the work of their respective designated statutory Health Scrutiny Committee in order to ensure that the work programme of the Joint Committee complements local scrutiny work and vice-versa.

(d) Co-operating to ensure that the Joint Committee, where appropriate, is provided with additional officer support for research, training and development or other areas of expertise.

7.4 The elected members on the Joint Committee will provide a communication channel between the Joint Committee and their respective appointing Authorities. They will report back to their Authority on the work of the Joint Committee as appropriate and provide support and guidance to their member colleagues and officers of their Authority.

8. Validity of Proceedings

8.1 The validity of the proceedings of the Joint Committee shall not be affected by a vacancy in the membership of the Joint Committee or a defect in appointment.

8.2 All Joint Committee members (including co-opted members) must observe their own authority's Members Code of Conduct and any related Protocols as agreed by the Joint Committee.

9. Review and Amendment of Joint Committee Arrangements

9.1 This Joint Committee Arrangements Document will normally be reviewed on an annual basis by all Authorities jointly.

APPENDIX A

9.2 Proposed changes to the Joint Committee Arrangements Document can only be made with the collective approval of all the Authorities in the ICS area.

9.3 The Joint Committee may propose amendments to the Joint Committee Arrangements document and any such proposals will be referred to the Authorities and will only be implemented if they are approved by all the Authorities.

APPENDIX B

PROTOCOL FOR THE ESTABLISHMENT OF JOINT HEALTH SCRUTINY ARRANGEMENTS IN CHESHIRE AND MERSEYSIDE

1. INTRODUCTION

1.1 This protocol has been developed as a framework for the operation of joint health scrutiny arrangements across the local authorities of Cheshire and Merseyside. It allows for:

- scrutiny of substantial developments and variations of the health service; and,
- discretionary scrutiny of local health services.

1.2 The protocol provides a framework for health scrutiny arrangements which operate on a joint basis only. Each constituent local authority should have its own local arrangements in place for carrying out health scrutiny activity individually.

2. BACKGROUND

2.1 The relevant legislation regarding health scrutiny is:

- Health and Social Care Act 2012,
- The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013; and
- *The Health and Care Act 2022 (subject to parliamentary approval)*

2.2 In summary, the statutory framework authorises local authorities to:

- review and scrutinise any matter relating to the planning, provision and operation of the health service; and,
- consider consultations by a relevant NHS commissioning body or provider of NHS-funded services on any proposal for a substantial development or variation to the health service in the local authority's area.

2.3 Ultimately the regulations place a requirement on relevant scrutiny arrangements to reach a view on whether they are satisfied that any proposal that is deemed to be a substantial development or variation is in the interests of the health service in that area, or instead, that the proposal should be referred to the Secretary of State for Health and Social Care. In instances where a proposal impacts on the residents of one local authority area exclusively, this responsibility lays with that authority's health scrutiny arrangements alone.

2.4 Where such proposals impact on more than one local authority area, each authority's health scrutiny arrangements must consider whether the proposals constitute a substantial development or variation or not.

APPENDIX B

The regulations place a requirement on those local authorities that agree that a proposal is substantial to establish, in each instance, a joint overview and scrutiny committee for the purposes of considering it. This protocol deals with the proposed operation of such arrangements for the local authorities of Cheshire and Merseyside.

3. PURPOSE OF THE PROTOCOL

3.1 This protocol sets out the framework for the operation of joint scrutiny arrangements where:

a) an NHS commissioning body or health service provider consults with more than one local authority on any proposal it has under consideration, for a substantial development/variation of the health service;

b) joint scrutiny activity is being carried out on a discretionary basis into the planning, provision and operation of the health service.

3.2 The protocol covers the local authorities of Cheshire and Merseyside including:

- Cheshire East Council
- Cheshire West and Chester Council
- Halton Borough Council
- Knowsley Council
- Liverpool City Council
- St. Helens Metropolitan Borough Council
- Sefton Council
- Warrington Borough Council
- Wirral Borough Council

3.3 Whilst this protocol deals with arrangements within the boundaries of Cheshire and Merseyside, it is recognised that there may be occasions when consultations/discretionary activity may affect adjoining regions/ areas. Arrangements to deal with such circumstances would have to be determined and agreed separately, as and when appropriate.

4. PRINCIPLES FOR JOINT HEALTH SCRUTINY

4.1 The fundamental principle underpinning joint health scrutiny will be co-operation and partnership with a mutual understanding of the following aims:

- To improve the health of local people and to tackle health inequalities;

APPENDIX B

- To represent the views of local people and ensure that these views are identified and integrated into local health service plans, services and commissioning;

- To scrutinise whether all parts of the community are able to access health services and whether the outcomes of health services are equally good for all sections of the community; and,

- To work with NHS bodies and local health providers to ensure that their health services are planned and provided in the best interests of the communities they serve, taking into account any potential impact on health service staff.

5. SUBSTANTIAL DEVELOPMENT/VARIATION TO SERVICES

5.1 Requirements to consult

5.1.1 All relevant NHS bodies and providers of NHS-funded services[1] are required to consult local authorities when they have a proposal for a substantial development or substantial variation to the health service.

5.1.2 A substantial development or variation is not defined in legislation. Guidance has suggested that the key feature is that it should involve a major impact on the services experienced by patients and/or future patients.

5.1.3 Where a substantial development or variation impacts on the residents within one local authority area boundary, only the relevant local authority health scrutiny function shall be consulted on the proposal.

5.1.4 Where a proposal impacts on residents across more than one local authority boundary, the NHS body/health service provider is obliged to consult all those authorities whose residents are affected by the proposals in order to determine whether the proposal represents a substantial development or variation.

5.1.5 Those authorities that agree that any such proposal does constitute a substantial development or variation are obliged to form a joint health overview and scrutiny committee for the purpose of formal consultation by the proposer of the development or variation.

5.1.6 Whilst each local authority must decide individually whether a proposal represents a substantial development/variation, it is only the statutory joint health scrutiny committee which can formally comment on the

[1] This includes NHS E&I and any body commissioning services to the residents of Cheshire and Merseyside, plus providers such as NHS Trusts, NHS Foundation Trust and any other relevant provider of NHS funded services which provides health services to those residents, including public health.

proposals if more than one authority agrees that the proposed change is "substantial".

5.1.7 Determining that a proposal is not a substantial development/variation removes the ability of an individual local authority to comment formally on the proposal and exercise other powers, such as the power to refer to the Secretary of State. Once such decisions are made, the ongoing obligation on the proposer to consult formally on a proposal relates only to those authorities that have deemed the proposed change to be "substantial" and this must be done through the vehicle of the joint committee. Furthermore the proposer will not be obliged to provide updates or report back on proposals to individual authorities that have not deemed them to be "substantial".

5.1.8 For the avoidance of doubt, if only one authority amongst a number being consulted on a proposal deem it to be a substantial change, the ongoing process of consultation on the proposal between the proposer and the remaining authority falls outside the provisions of this protocol.

5.2 Process for considering proposals for a substantial development/variation

5.2.1 In consulting with the local authority in the first instance to determine whether the change is considered substantial, the relevant NHS commissioning body / provider of NHS-funded services is required to:

- Provide the proposed date by which it requires comments on the proposals
- Provide the proposed date by which it intends to make a final decision as to whether to implement the proposal
- Publish the dates specified above
- Inform the local authority if the dates change[2]

5.2.2 NHS commissioning bodies and local health service providers are not required to consult with local authorities where certain 'emergency' decisions have been taken. All exemptions to consult are set out within regulations.[3]

5.2.3 In considering whether a proposal is substantial, all local authorities are encouraged to consider the following criteria:

- *Changes in accessibility of services:* any proposal which involves the withdrawal or change of patient or diagnostic facilities for one or more speciality from the same location.

[2] Section 23 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013
[3] Section 24 *ibid*

APPENDIX B

- *Impact on the wider community and other services:* This could include economic impact, transport, regeneration issues.

- *Patients affected:* changes may affect the whole population, or a small group. If changes affect a small group, the proposal may still be regarded as substantial, particularly if patients need to continue accessing that service for many years.

- *Methods of service delivery:* altering the way a service is delivered may be a substantial change, for example moving a particular service into community settings rather than being entirely hospital based.

- *Potential level of public interest:* proposals that are likely to generate a significant level of public interest in view of their likely impact.

5.2.4 These criteria will assist in ensuring that there is a consistent approach applied by each authority in making their respective decisions on whether a proposal is “substantial” or not. In making the decision, each authority will focus on how the proposals impacts on its own area/ residents.

6. OPERATION OF A STATUTORY JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

6.1 General

6.1.1 A joint health overview and scrutiny committee will be made up of each of the constituent local authorities that deem a proposal to be a substantial development or variation. This joint committee will be formally consulted on the proposal and have the opportunity to comment. It will also be able to refer to the Secretary of State for Health and Social Care if any such proposal is not considered to be in the interests of the health service.

6.1.2 A decision as to whether the proposal is deemed substantial shall be taken within a reasonable timeframe and in accordance with any deadline set by the lead local authority (see section 6.6), following consultation with the other participating authorities.

6.2 Powers

6.2.1 In dealing with substantial development/variations, any statutory joint health overview and scrutiny committee that is established can:

- require relevant NHS bodies and health service providers to provide information to and attend before meetings of the committee to answer questions

APPENDIX B

- make comments on the subject proposal by a date provided by the NHS body/local health service provider
- make reports and recommendations to relevant NHS bodies/local health providers
- require relevant NHS bodies/local health service providers to respond within a fixed timescale to reports or recommendations
- carry out further negotiations with the relevant NHS body where it is proposing not to agree to a substantial variation proposal; and
- where agreement cannot be reached, to notify the NHS body of the date by which it intends to make the formal referral to the Secretary of State.

6.2.2 A joint health overview and scrutiny committee has the power to refer a proposal to the Secretary of State if:

- the committee is not satisfied that consultation with the relevant health scrutiny arrangements on any proposal has been adequate
- it is not satisfied that reasons for an 'emergency' decision that removes the need for formal consultation with health scrutiny are adequate
- it does not consider that the proposal would be in the interests of the health service in its area.

6.2.3 Where a committee has made a recommendation to a NHS commissioning body/local health service provider regarding a proposal and the NHS body/provider disagrees with the recommendation, the local health service provider/NHS body is required to inform the joint committee and attempt to enter into negotiation to try and reach an agreement. In this circumstance, a joint committee has the power to report to the Secretary of State if:

- relevant steps have been taken to try to reach agreement in relation to the subject of the recommendation, but agreement has not been reached within a reasonable period of time; or,
- there has been no attempt to reach agreement within a reasonable timeframe.

6.2.4 Where a committee disagrees with a substantial variation and has either made comments (without recommendations) or chosen not to provide any comments, it can report to the Secretary of State only if it has:

- Informed the NHS commissioning body/local health service provider of its decision to disagree with the substantial variation and report to the Secretary of State; or,
- Provided indication to the NHS commissioning body/local health service provider of the date by which it intends to make a referral.

6.2.5 In any circumstance where a committee disagrees with a proposal for a substantial variation, there will be an expectation that negotiations will

be entered into with the NHS commissioning body/local health service provider in order to attempt to reach agreement.

6.2.6 Where local authorities have agreed that the proposals represent substantial developments or variations to services and agreed to enter into joint arrangements, it is only the joint health overview and scrutiny committee which may exercise these powers.

6.2.7 A statutory joint health overview and scrutiny committee established under the terms of this protocol may only exercise the powers set out in 6.2.1 to 6.2.4 above in relation to the statutory consultation for which it was originally established. Its existence is time-limited to the course of the specified consultation and it may not otherwise carry out any other activity.

6.3 Membership

6.3.1 The participating local authorities must ensure that those Councillors nominated to a joint health overview and scrutiny committee produce a membership that reflects the overall political balance across the participating local authorities. However, political balance requirements for each joint committee established may be waived with the agreement of all participating local authorities, should time and respective approval processes permit.

6.3.2 A joint committee will be composed of Councillors from each of the participating authorities within Cheshire and Merseyside in the following ways:

- where 4 or more local authorities deem the proposed change to be substantial, each authority will nominate 2 elected members

- where 3 or less local authorities deem the proposed change to be substantial, then each participating authority will nominate 3 elected members.

  (Note: In making their nominations, each participating authority will be asked to ensure that their representatives have the experience and expertise to contribute effectively to a health scrutiny process)

Local authorities who consider change to be 'substantial'	**No' of elected members to be nominated from each authority**
4 or more	2 members
3 or less	3 members

6.3.3 Each local authority will be obliged to nominate elected members through their own relevant internal processes and provide notification of those members to the lead local administrative authority at the earliest opportunity.

6.3.4 To avoid inordinate delays in the establishment of a relevant joint committee, it is suggested that constituent authorities either arrange for delegated decision-making arrangements to be put in place to deal with such nominations at the earliest opportunity, or to nominate potential representatives annually as part of annual meeting processes to cover all potential seat allocations.

6.5 Quorum

6.5.1 The quorum of the meetings of a joint committee shall be one third of the full membership of any Joint Committee, subject to the quorum being, in each instance, no less than 3.

6.5.2 There will be an expectation for there to be representation from each authority at a meeting of any joint committee established. The lead local authority will attempt to ensure that this representation is achieved.

6.6 Identifying a lead local authority

6.6.1 A lead local authority should be identified from one of the participating authorities to take the lead in terms of administering and organising a joint committee in relation to a specific proposal.

6.6.2 Selection of a lead authority should, where possible, be chosen by mutual agreement by the participating authorities and take into account both capacity to service a joint health scrutiny committee and available resources. The application of the following criteria should also guide determination of the lead authority:

- The local authority within whose area the service being changed is based; or
- The local authority within whose area the lead commissioner or provider leading the consultation is based.

6.6.3 Lead local authority support should include a specific contact point for communication regarding the administration of the joint committee. There will be an obligation on the key lead authority officer to liaise appropriately with officers from each participating authority to ensure the smooth running of the joint committee.

6.6.4 Each participating local authority will have the discretion to provide whatever support it may deem appropriate to their own representative(s) to allow them to make a full contribution to the work of a joint committee.

6.7 Nomination of Chair/ Vice-Chair

APPENDIX B

The chair/ vice-chair of the joint health overview and scrutiny committee will be nominated and agreed at the committee's first meeting.

6.8 Meetings of a Joint Committee

6.8.1 At the first meeting of any joint committee established to consider a proposal for a substantial development or variation, the committee will also consider and agree:

- The joint committee's terms of reference;
- The procedural rules for the operation of the joint committee;
- The process/ timeline for dealing formally with the consultation, including:
    - the number of sessions required to consider the proposal; and,
    - the date by which the joint committee will make a decision as to whether to refer the proposal to the Secretary of State for Health and Social Care – which should be in advance of the proposed date by which the NHS commissioning body/service provider intends to make the decision.

6.8.2 All other meetings of the joint committee will be determined in line with the proposed approach for dealing with the consultation. Different approaches may be taken for each consultation and could include gathering evidence from:

- NHS commissioning bodies and local service providers;
- patients and the public;
- voluntary sector and community organisations; and
- NHS regulatory bodies.

6.9 Reports of a Joint Committee

6.9.1 A joint committee is entitled to produce a written report which may include recommendations. As a minimum, the report will include:

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

The lead authority will be responsible for the drafting of a report for consideration by the joint committee.

APPENDIX B

6.9.2 Reports shall be agreed by the majority of members of a joint committee and submitted to the relevant NHS commissioning body/health service provider or the Secretary of State as applicable.

6.9.3 Where a member of a joint health scrutiny committee does not agree with the content of the committee's report, they may produce a report setting out their findings and recommendations which will be attached as an appendix to the joint health scrutiny committee's main report.

7. DISCRETIONARY HEALTH SCRUTINY

7.1 More generally, the Health and Social Care Act 2012 and the 2013 Health Scrutiny Regulations provide for local authority health scrutiny arrangements to scrutinise the planning, provision and operation of health services.

7.2 In this respect, two or more local authorities may appoint a joint committee for the purposes of scrutinising the planning, provision and operation of health services which impact on a wider footprint than that of an individual authority's area.

7.3 Any such committee will have the power to:

- require relevant NHS commissioning bodies and health service providers to provide information to and attend before meetings of the committee to answer questions.
- make reports and recommendations to relevant NHS commissioning bodies/local health providers.
- require relevant NHS commissioning bodies/local health service providers to respond within a fixed timescale to reports or recommendations.

7.4 Ordinarily, a discretionary joint committee will not have the power to refer an issue to the Secretary of State for Health and Social Care. However, please note section 8.3 below.

7.5 In establishing a joint committee for the purposes of discretionary joint scrutiny activity, the constituent local authorities should determine the committee's role and remit. This should include consideration as to whether the committee operates as a standing arrangement for the purposes of considering all of the planning, provision and operation of health services within a particular area or whether it is being established for the purposes of considering the operation of one particular health service with a view to making recommendations for its improvement. In the case of the latter, the committee must disband once its specific scrutiny activity is complete.

APPENDIX B

7.6 In administering any such committee, the proposed approach identified in sections 6.3 – 6.9 (disregarding any power to refer to the Secretary of State) of this protocol should be followed, as appropriate.

APPENDIX B

8. SCRUTINY OF CHESHIRE AND MERSEYSIDE INTERGRATED CARE SYSTEM

8.1 Further to this protocol and in particular section 7 above, the nine local authorities have agreed to establish a discretionary standing joint health scrutiny committee in response to the establishment of the Cheshire and Merseyside Integrated Care System.

8.2 A separate Joint Scrutiny Committee Arrangements document has been produced in line with the provisions of this protocol to outline how the standing joint committee will operate.

8.3 In summary, the "Cheshire and Merseyside Integrated Care System Joint Health Scrutiny Committee" has the following responsibilities:

- To scrutinise the work of the Integrated Care System in relation to any matter regarding the planning, provision and operation of the health service at footprint level only; and
- To consider the merits of any service change proposals that have been deemed to be a substantial variation in services by all nine authorities.

9. CONCLUSION

9.1 The local authorities of Cheshire and Merseyside have adopted this protocol as a means of governing the operation of joint health scrutiny arrangements both mandatory and discretionary. The protocol is intended to support effective consultation with NHS commissioning bodies or local health service providers on any proposal for a substantial development of or variation in health services. The protocol also supports the establishment of a joint health overview and scrutiny committee where discretionary health scrutiny activity is deemed appropriate.

9.2 The protocol will be reviewed regularly, and at least on an annual basis to ensure that it complies with all current legislation and any guidance published by the Department of Health and Social Care.

Work Programme – Scrutiny Committee – 2021/22

Reference	Committee Date	Report title	Purpose of Report	Report Author /Senior Officer	Consultation and Engagement Process and Timeline	Corporate Plan Priority	Exempt Item and Paragraph Number
SC/05/22-23	14 Jun 2022	Feedback on Quality Accounts: Cheshire & Wirral Partnership NHS Foundation Trust	To review the 2021/22 Quality Accounts Cheshire & Wirral NHS Foundation Trust, and agree to any feedback and comments it wishes to provide.	Executive Director Adults, Health and Integration	Yes	An open and enabling organisation	N/A
SC/03/22-23	14 Jun 2022	Feedback on Quality Accounts: East Cheshire NHS Trust	For the Committee to provide commentary on the East Cheshire NHS Trust Quality Accounts which will be incorporated into the final document before it is published, as per NHS England and NHS Improvement recommendations to allow scrutiny and comment.	Executive Director Adults, Health and Integration	Yes	An open and enabling organisation	N/A

SC/04/22-23	14 Jun 2022	Feedback on Quality Accounts: Mid Cheshire Hospitals NHS Foundation Trust	For the Committee to provide commentary on the Mid Cheshire Hospitals NHS Foundation Trust Quality Accounts which will be incorporated into the final document before it is published, as per NHS England and NHS Improvement recommendations to allow scrutiny and comment.	Executive Director Adults, Health and Integration	Yes	An open and enabling organisation	N/A

SC/02/22-23	14 Jun 2022	Update from East Cheshire NHS Trust	To receive an update from representatives of East Cheshire NHS Trust following a six-week engagement period with the public on the subject of how clinical teams are being supported in working together to develop a joint clinical strategy that sets out new, single clinical pathways, and innovative solutions to best meet the growing care needs of local populations.	Executive Director Adults, Health and Integration	Yes	A council which empowers and cares about people	N/A
SC/12/21-22	14 Jun 2022	Pharmaceutical Needs Assessment (PNA)	To receive early consultation findings and options and next steps with the opportunity to feed the view of the Committee through to the Health and Wellbeing Board for its consideration.	Executive Director Adults, Health and Integration	N/A	A council which empowers and cares about people	N/A

SC/01/22-23	30 May 2022 14 Jun 2022	Place Partnership Board Update	For the Committee to note the progress on the new governance arrangements for local Health and Care services, to consider and comment on the proposed joint scrutiny arrangements for Cheshire & Merseyside and approve the amended 'Protocol for the establishment of Joint Health Scrutiny Arrangements in Cheshire and Merseyside'.	Executive Director Adults, Health and Integration Director of Governance and Compliance (Monitoring Officer)	N/A	An open and enabling organisation	N/A