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# Scrutiny Committee

# Agenda

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| **Date:** | **Thursday, 1st September, 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 top of each report.

It should be noted that Part 1 items of Cheshire East Council decision making 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 3 - 12)

   To approve as a correct record the minutes of the previous meeting held on 14 June 2022.

4. **Public Speaking/Open Session**

For requests for further information
**Contact**: Helen Davies
**Tel:** 01270 68685705
**E-Mail:** helen.davies@cheshireeast.gov.uk

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: Mid Cheshire Hospitals NHS Foundation Trust** (Pages 13 - 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.

6. **Update from the Police and Crime Commissioner**

To receive an update on the work of the Police and Crime Commissioner.

7. **Safer Cheshire East Partnership (SCEP) Update**

To receive a presentation by the Director of Adult Social Care on the current priority areas for SCEP.

8. **Appointments to the Cheshire and Merseyside Integrated Care System Joint Health Scrutiny Committee** (Pages 129 - 142)

To appoint one Labour Group member and one Independent Group member to the Cheshire and Merseyside Integrated Care System Joint Health Scrutiny Committee.

9. **Work Programme** (Pages 143 - 146)

To consider the Work Programme and determine any required amendments.

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

# CHESHIRE EAST COUNCIL

Minutes of a meeting of the **Scrutiny Committee**
held on Tuesday, 14th June, 2022 in the Committee Suite 1,2 & 3, Westfields, Middlewich Road, Sandbach CW11 1HZ

## PRESENT

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

Councillors L Anderson, R Bailey, L Crane, M Simon, C Bulman, P Redstone and D Edwardes

## OFFICERS IN ATTENDANCE

Helen Charlesworth-May- Executive Director of Adults, Health Health and Integration
Helen Davies- Democratic Services
Brian Reed- Statutory Scrutiny Officer
Dr. Susan Roberts- Consultant in Public Health
Nichola Thompson- Director of Commissioning
Deborah Upton- Senior Lawyer

## ALSO PRESENT

Dr. Anushta Sivanathan, Medical Director and Consultant Psychiatrist at Cheshire & Wirral Partnership (CWP)
Paul Devlin, the Deputy Director of Nursing at East Cheshire Trust
Katherine Sheerin, Director of Transformation and Partnerships at East Cheshire NHS Trust

## 33 APOLOGIES FOR ABSENCE

Apologies of absence were received from Councillor David Brown, Councillor Stephen Carter (Councillor Carol Bulman substituted), Councillor David Marren (Councillor David Edwardes substituted), Councillor Brendan Murphy, Councillor Lloyd Roberts, and Councillor Lesley Smetham (Councillor Patrick Redstone substituted).

## 34 DECLARATIONS OF INTEREST

In the interests of openness Councillor Liz Wardlaw declared that in respect of agenda item five, Feedback on Quality Accounts: Cheshire & Wirral Partnership NHS Foundation Trust, as she occasionally worked for Cheshire and Wirral Partnership NHS Foundation Trust.

In the interests of openness Councillor Denis Murphy declared that in respect of agenda item seven, Feedback on Quality Accounts: East Cheshire NHS Trust, as

he was Chair of the Trustees of the League of Friends at Macclesfield District General Hospital.

35 **MINUTES OF PREVIOUS MEETING**

RESOLVED: That the minutes be received as a correct and accurate record.

36 **PUBLIC SPEAKING/OPEN SESSION**

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

37 **FEEDBACK ON QUALITY ACCOUNTS: CHESHIRE & WIRRAL PARTNERSHIP NHS FOUNDATION TRUST**

Dr. Anushta Sivanathan, Medical Director and Consultant Psychiatrist at Cheshire & Wirral Partnership (CWP) attended the meeting via Microsoft Teams and presented the CWP Quality Account to the Committee.

The Committee was advised that CWP was regulated by the Care Quality Commission (CQC) and at present there was no concerns. CWP complete a book of best practice each year to improve performance.

There were three priorities for 2021-22, these had been met but some achievement had stalled due to pandemic challenges. There had been improvement in clinical effectiveness, patient experience and patient safety.

The outreach vaccination service had successfully vaccinated 30,000, specifically those hard-to-reach who wouldn't have been reached by traditional GP services.

The impact of the pandemic and lockdown had affected the mental health of young people.

There had been investment in 24/7 acute psychiatric services and two crisis cafes in Crewe and Macclesfield.

Services for children and young people had seen a significant impact from the pandemic from 1 in 9 to 1 in 6.

A Well-Being Hub with access to specialist mental health had been developed, this had been piloted in South Cheshire and rolled out to East Cheshire.

1,793 compliments had been received all of which were communicated back to staff.

The Committee were given the opportunity to ask questions or make comments, there was an acknowledgement of the challenges faced by the pandemic but awareness that the pandemic has created future issues for children and young people including, learning and self-esteem.

Whilst engagement and focus was with the community the Committee noted that schools are on front-line, and prevention measures needed to manage emerging issues and to recover from the pandemic.

The Medical Director and Consultant Psychiatrist noted that Cheshire East Council had been instrumental in ensuring support was provided to schools and

teachers to support others. Not all schools were covered but CWP in partnership with the council was working towards that as part of a long-term plan.

There was some discussion about the Crisis Cafes, and future plans for expansion, the Medical Director and Consultant Psychiatrist noted that both cafes were recently opened in areas where the greatest need was. The next phase would be to assess how CWP can work in partnership with the council to ensure crisis cafes can support communities across Cheshire East.

The Committee noted the quality of services was high but spreading people across services could impact those services and/or become a staffing issue. The Committee was advised that staffing was a serious challenge, and together with the impact of the pandemic, plus cover/cross cover, CWP was looking at the workforce, new roles, and types of roles, skill mix and moving away from the traditional approach of doctors, nurses and therapists. CWP had a comprehensive work force offer through workforce development however in terms of recruitment to retention it was acknowledged there was a national shortage of nurses trained in learning disabilities.

RESOLVED: That:

a) the Medical Director and Consultant Psychiatrist be thanked for attending the meeting and presenting to the Committee;
b) the 2021/22 Cheshire and Wirral Partnership Quality Account be received and noted; and
c) That the committee's feedback and response to the 2019/20 Quality Account for sent in the form of a letter.

## 38 FEEDBACK ON QUALITY ACCOUNTS: EAST CHESHIRE NHS TRUST

Paul Devlin, the Deputy Director of Nursing at East Cheshire Trust attended the meeting via Microsoft Teams and updated the Committee on the progress through the Quality Account.

The Committee were advised that all services had seen pressures that related to the pandemic, however there had been a number of achievements such as:

the trust became a Disability Confident Employer;

the opening of The Christie at the Macclesfield site;

the opening of same day emergency care unit; and

ongoing support from community for staff.

Staff had continued to respond to the development of care models, and progression of recovery plans. The focus for teams was now on improved care and this work had carried into current year through an improvement plan.

A designated panel now investigated when falls had occurred and staff were supported in prevention work.

In terms of Infection and prevention control, the focus continued, and other infection rates remained within trajectory.

Wait times at East Cheshire had increased and this was a focus for teams.

Intrapartum services had been paused at Macclesfield General Hospital but it was planned to re-establish the service this year, the Trust had been working closely with patients to support this.

Priorities for 2022/23 were outlined within quality strategy and mirrored the key lines of enquiry that Care Quality Commission (CQC) used when inspecting.

The Committee were invited to ask questions and make comment, there was some discussion about:

Bad patient feedback, the Committee were advised that in terms of response rates to feedback, the Emergency Department tended to be low, comments that related to length of wait were reflective of operational challenges.

The Committee noted that despite intrapartum care being paused, planned home births still went ahead.

There had been Improvements in diagnostic waiting times, scanning and radiology and in terms of number of patients who had waited over 52 weeks for treatment. Those who waited over 104 weeks had been supported with surveillance, however the Deputy Director of Nursing acknowledged that 52 and 104 week waits were unacceptable, a Harm Review was undertaken to assess if harm had occurred during wait times and that was reported to the Trust assurance committee.

The Committee acknowledged the challenges with waiting times, and asked for a more detailed report to be brought back to a future meeting with comparative data to other Trusts.

The Committee noted that both local hospitals had participated in the Ward Accreditation Scheme, and queried the burden on staff to achieve the accreditation. The Deputy Director of Nursing gave reassurances to the Committee that the monthly audit process sampled three patients in significant detail and conducted a detailed review of patient safety and feedback. Audit compliance was good but if patients had negative experiences this was a cause for concern to the Trust. In terms of workload, this was not considered an unmanageable burden for ward managers.

RESOLVED: That:

- Paul Devlin be thanked for his attendance and presentation to the Committee;
- the East Cheshire NHS Trust Quality Account be received and noted; and
- comments from the meeting be fed back to the Trust for inclusion within the Quality Account 2021/22.

39 **UPDATE FROM EAST CHESHIRE NHS TRUST**

Katherine Sheerin, Director of Transformation and Partnerships at East Cheshire NHS Trust attended the meeting and addressed the Committee since last updating at the previous meeting on the 21 March. During that meeting the Committee were advised that a statement of intent had been circulated 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.

This update followed the six-week engagement exercise, with the results available for review.

The Committee were advised there had been 273 responses, this was expected for this kind of exercise. Unique web-page views were in the thousands. Of the 273 responses, these were reflective of patients, employees, carers, and other public sector bodies, 83% were female, however the respondents were skewed towards affluent areas.

Critical care was given positive ratings, however given the low number of responders it was acknowledged that it was difficult to determine a service-users view.

Waiting times, communications with patients and difficulties with parking had negative ratings.

Maternity services and bringing back of Intrapartum care was also mentioned within the responses.

The Committee were advised the results will be in public domain from the 30 June, NHS assurance had been given and the case for change had been approved, and would be published in full alongside a summary version.

The next steps would be to submit a pre-consultation business case to NHS England.

The Committee were invited to ask questions or make comments, it noted that there had been very low responses from voluntary groups and this cohort supported many NHS functions. The Director of Transformation and Partnerships noted that communication had taken place with existing networks but this was an area to address with Phase 2.

The Committee highlighted the importance of dynamic consultations to help restore confidence with patients and those negatively affected through reduction of services during the pandemic.

The Committee questioned mitigation towards long waiting lists, and were advised that the Trust was working across Cheshire and Merseyside to determine a collective approach rather than trying to impact as individual organisations.

Some success had been achieved using international nursing; using clinical support workers in innovative ways; the induction of more medical students into the Trust, for longer periods of time; and rotations within the Trust and into primary care.

RESOLVED:

That the Director of Transformation and Partnerships be thanked for their attendance and presentation to the Committee; and that the presentation be received and noted.

40 **PHARMACEUTICAL NEEDS ASSESSMENT (PNA)**

Doctor Susan Roberts, a Consultant in Public Health attended the Committee and presented the report.

The Committee were advised that the Pharmaceutical Needs Assessment (PNA) needed to be published by the 1 October 2022, and that Dr. Matt Tyer, the Director of Public Health had responsibility to do this.

Between 1 April 2021- 10 June 2022 there had been 105 consultations responses with 354 partial responses. The Draft PNA provisional findings were deemed adequate (this was the target for the public health team) and the conclusions needed to be tested.

The Committee had some concerns regarding:

- automated medication from robots in hospital pharmacies;
- the expansion of the Basford area of the borough and the impacts on medical centres;
- there were no reviews of accessibility within the consultation (this was to be reviewed for future consultations);
- The Pharmaceutical offer and challenges to Cheshire East villages (the challenges were acknowledged and articulated within the PSA response); and
- that despite advertising the consultation within pharmacies, no paper copies were available.

The public health team would take these comments to inform future learning and gave reassurances to the Committee that all comments during the consultation period would be analysed to feed into the consultation results.

RESOLVED:

That the production of the PNA and the consultation findings be received and that it be noted that the consultation findings may result in an amendment to the draft PNA once evaluated.

## 41 PLACE PARTNERSHIP BOARD UPDATE

Helen Charlesworth-May, Executive Director of Adults, Health and Integration introduced the report to the Committee, the report was considered by the Adults and Health Service Committee on 30 May, who had been asked to make decisions, detail of which was contained within the report that was for review by the Scrutiny Committee.

The report outlined progress with design and implementation and the proposed scrutiny arrangements for Cheshire East when the Integrated Care System (ICS) would be implemented across the Cheshire and Merseyside (C&M) footprint on the 1 July.

The key considerations for the report included the joint scrutiny arrangements and the political balance arrangement across the nine authorities, the Committee

was advised that these did not impact on any existing stand-alone arrangements the local authority had in place for Health Scrutiny.

Deborah Upton, Senior Lawyer advised the Committee that as an example, if the Integrated Care Board (ICB) wished to implement any new policies across the C&M area, the joint committee would consider the referral. Political balance has to be calculated across all nine authorities, and would be reviewed post-elections and on an annual basis to ensure that any changes were taken into account.

The Chair noted there had been a point raised by members of the Adults and Health Committee, as to the proportionality of the joint committee, as Cheshire East had a larger population than some others and Members felt that this should have been taken into account when considering the proportionality. The Senior Lawyer advised that, the calculation of political balance had been adhered to across C&M as a collective and this did not take population numbers into consideration.

The Committee were invited to ask questions and make comments.

There were comments of concern that related to the proportionality of the joint committee.

The Senior Lawyer advised the Committee that there had been a request to write to the Secretary of State (SoS) by Members of the Adult and Health Committee. The Monitoring Officer had advised that any appeal to the SoS would require a change to legislation and therefore was unlikely to be successful.

The Committee were pleased to note that rural proofing had been retained within the report, however there was some discussion about coterminous boundaries. The Committee had a strong desire to retain co-terminosity across Cheshire. The Executive Director of Adults, Health and Integration advised that patient choice was recognised, and there are options for those requiring care into Greater Manchester, Derbyshire, or Staffordshire, however Cheshire East would be part of the wider C&M footprint and even if Cheshire East had local arrangements with Cheshire West, there were no guarantees that funding would flow from C&M equally.

The Chair asked that the specific and unique requirements of the rural borough be acknowledged, and additionally she requested further information for the Committee regarding the 2 seats allocated to Cheshire East for the Joint Scrutiny committee who was responsible for choosing/nominating Cheshire East representatives, and on what premise was the political proportionality of the Cheshire East representation to the Joint Scrutiny Committee based?

The recommendations within the report were considered, there was agreement to split the two parts of the second recommendation as the Committee were unable to reach an accord on the third recommendation.

RESOLVED: That:

1) the progress to date on the Place Partnership Board (working title) be noted;

2) the establishment of a Cheshire and Merseyside Integrated Care System Joint Health Scrutiny Committee be recommended to Council; and

3) a meeting date be sought for this Committee in July to discuss in more detail the 'Protocol for the establishment of Joint Health Scrutiny Arrangements in Cheshire and Merseyside'.

## 42 FEEDBACK ON QUALITY ACCOUNTS: MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST

The Chair noted that representatives from Mid Cheshire Hospitals NHS Foundation Trust had been unable to attend the meeting due to executive interviews being held at the same time. The Committee had a number of questions that related to the Quality Account and agreed to defer the item until the next available meeting.

RESOLVED:

That representatives from Mid Cheshire Hospitals NHS Foundation Trust be invited to present this item at the next available meeting.

## 43 WORK PROGRAMME

The Committee considered the Work Programme, it was noted that the current items had been completed during the meeting. Helen Davies, Democratic Services Officer advised that there had been conversations with lead Directors for forthcoming work streams within the terms of reference for the Committee. The Work Programme would be updated with these and suggestions by the Committee and reviewed by the Chair and Vice Chair within the month.

The Committee requested consideration be given to adding an item that engaged with the Safer Cheshire East Partnership (SCEP), road traffic collisions and impacts on residents particularly in relation to winter gritting.

It was noted there had been some actions arising from this meeting that would be added to the Work Programme for forthcoming meetings.

The Chair noted discussions had been started with agencies such as the Police and Crime Commissioner and North West Ambulance Service.

The Committee noted that flooding was within its terms of reference, and requested an update on the Task and Finish Group report of the former Environment and Regeneration Overview and Scrutiny Committee.

Brian Reed, Statutory Scrutiny Officer advised that since the sign-off point by that Group, there had been concerns raised by officers within the Place Directorate and officers were working to address these concerns ahead of the onward journey to Corporate Leadership Team.

The Committee noted concern about delays and requested it be kept informed on progress, it was acknowledged that the service committees had a role to self-scrutinise but this Committee had the statutory function and had a strong view that any statutory scrutiny should be reviewed by this Committee before it went to the service committee.

The Chair noted that any statutory work regarding flooding should wait until the report was available.

A request was made for an update by Super Intendent Peter Crowcroft following his last overview at this Committee to update on any pilot work to note extensions or work ceasing.

RESOLVED:

That the Work Programme be received and noted.

The meeting commenced at 10.30 am and concluded at 1.15 pm

Councillor L Wardlaw (Chair)

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Mid Cheshire Hospitals
NHS Foundation Trust

# MCHFT QUALITY ACCOUNT 2021/22

## 1.0 Why is this item before the Scrutiny Committee?

MCHFT's Quality Account is an annual report to the people we serve about the quality of services we provide. We would like to present an 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?

Thank you for the received Commentary on our Quality Account which is 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. The presentation gives an overview of the overall Quality Account 2021-22.

## 3.0 RECOMMENDATIONS

The aim in reviewing and publishing information about quality is so that MCHFT can demonstrate public accountability by listening to and involving the public, partner agencies and, most importantly, acting on feedback we receive. The Quality Account is Published on the Trust website.

## 4.0 SUMMARY OF MAIN ISSUES

For the year 2020/21 the Trust continued to deliver a high quality, timely service to our patients. Prior to the suspension of non-urgent clinical activity due to Covid-19, the Trust's waiting times in elective and cancer care were one of the highest performing in the country. 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 2020/21 include;

- In response to the Pandemic, the Trust launched a Be safe Be EquiPPEd Campaign aimed to make our workplace as safe as possible. The Trust was shortlisted for a Nursing Times award for this Campaign.
- The Quality Metrics tool that drives the Ward Accreditation process has been reviewed and adapted during 2020-21 supporting continuous improvement of quality of services and safeguarding high standards of care during the Covid-19 pandemic.
- In June 2020, the Trust appointed a Head of Nursing for Safe Staffing and Workforce Utilisation providing assurance that the Trust plans safe staffing levels across all in- patient ward areas.
- The Trust maintained their CQC rating of "Good" for the Use of Resources assessment following the latest inspection.
- The Trust pledged to the Nursing Times Covid-19: Are You OK campaign? Which aims to raise awareness of the potential long-term impact of working during a pandemic on nurses' mental health and wellbeing.

## 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?

MCHFTs Quality Account and ambitions fully support the Council's priority to enable residents to benefit from good health and wellbeing. Many of our Quality Improvement projects reflect the aims of the National Patient Safety Strategy and the NHS Long Term Plan. Patient safety is central to all that we do at MCHFT.

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 4,000$m^2$ 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.

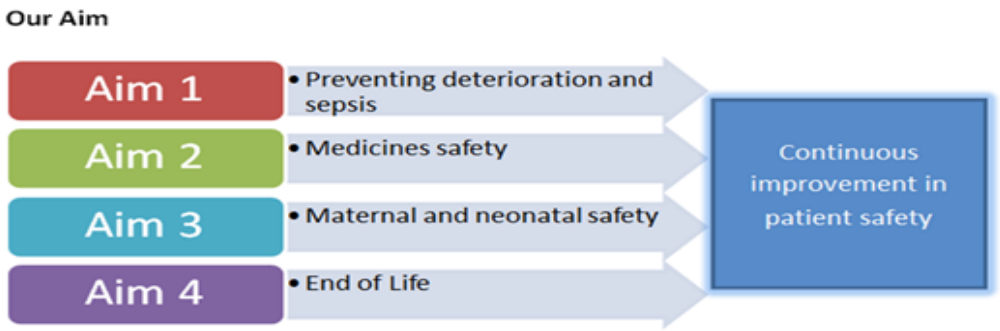
The purpose of the Trust Strategy 2021-26 is to support the delivery of the organisation's mission. The values and behaviours developed with our staff underpin delivery and success of the Trust's strategy. We recruit and nurture our staff so that we always see these values and behaviours.


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.

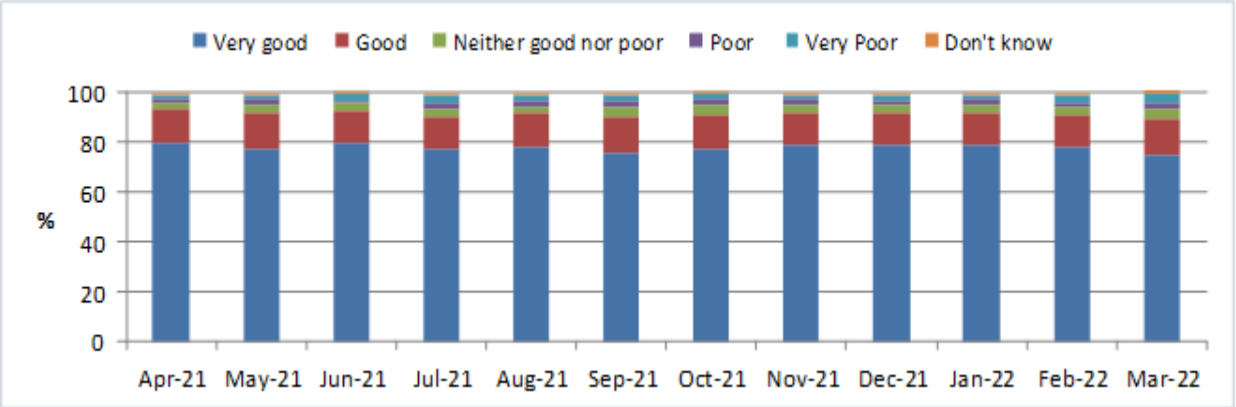
# Patient feedback

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.



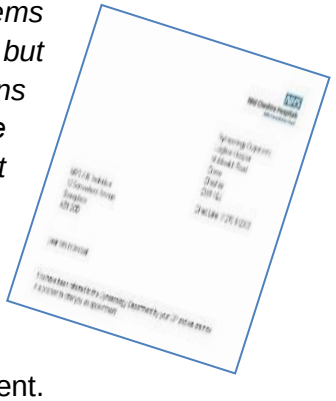
Examples of positive and negative comments received through the FFT include:

*"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**<br><br>**(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.<br><br>Improvement actions that have been taken within Urgent and Emergency care include:<br><br>• Audient speaker system installed to support communication<br>• Civility and psychological safety work underway<br>• ED newsletter developed<br>• Coded safe installed for storage of patient property<br>• The Trust was an early implementer site for 111 First<br>• A Clinical Assessment Service (CAS) has been implemented |
| **National Children & Young People Survey 2020**<br><br>**(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.<br><br>Areas identified for improvement, which have been affected by the ongoing impact of the COVID-19 pandemic, include:<br><br>• Activities and things to do whilst in hospital<br>• 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**<br><br>**(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.<br><br>Areas identified for improvement work were:<br>• patient feedback<br>• lighting in ward areas<br>• provision of discharge information<br><br>Several projects are ongoing to address the areas identified including:<br>• FFT QR codes, new digital platform, and Trust internet<br>• Quality Improvement (QI) project as part of a learning cohort with the Trust QI partners, the Advancing Quality Alliance (AQuA) around learning from feedback<br>• Business case for Patient Safety Partners as part of the Patient Safety Strategy<br>• Continuation of the June 2021 Trust Shhhhh Campaign to support patients during admission<br>• 7 days no delays project to support improvements and initiatives in relation to capacity and patient flow<br>• 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.<br><br>Areas identified for improvement work were:<br>• Mothers being given enough support for their mental health during pregnancy<br>• Midwives or the doctor appearing to be aware of mothers' medical history during antenatal check-ups<br>• Mothers being given a choice about where their postnatal care would take place<br>• Midwives listening to mothers during antenatal check ups<br>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.<br><br>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.<br><br>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.<br><br>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:<br><br>• Patients not being bothered by noise/staff noise at night (following the Shhhh Campaign)<br>• Patients being treated with respect and dignity |

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

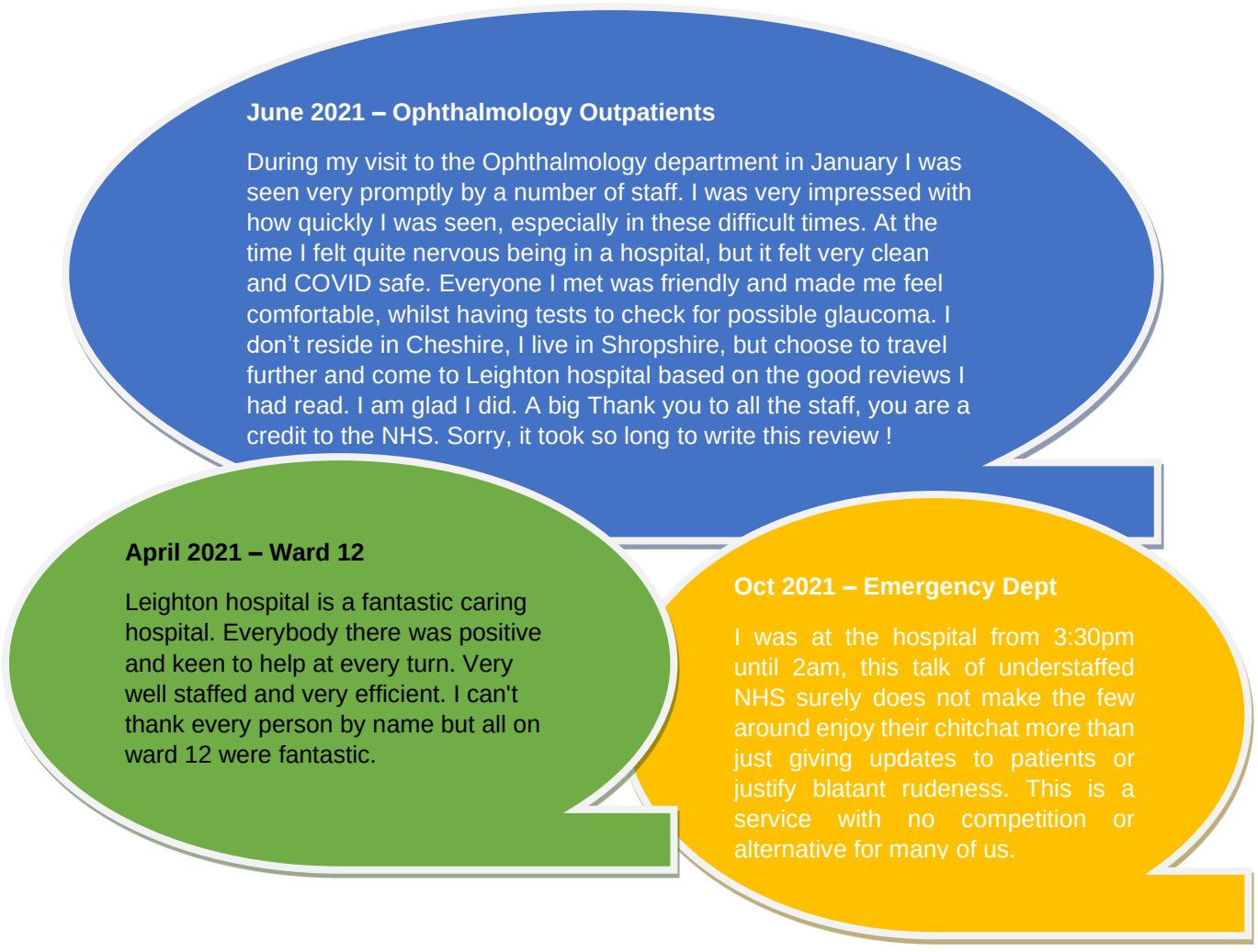
Areas that decreased in results, which have been addressed in ward areas, include:

- Staff introducing themselves
- Discussion around discharge

## NHS Choices

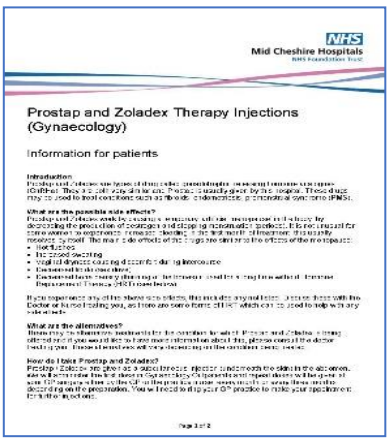
NHS Choices feedback collates information in relation to compliments, comments or complaints regarding the services provided by the Trust. This information is shared with the Divisions to help improve the services at the Trust and ensure that positive comments are fed back to the staff.

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:

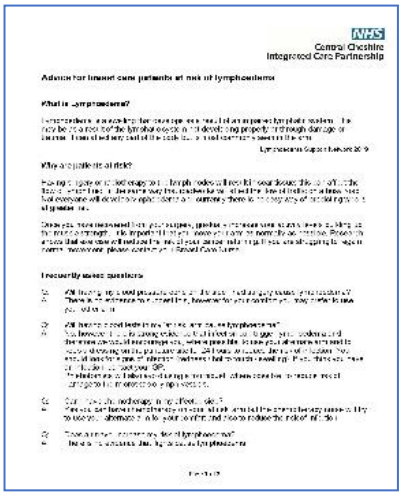
- Female Trial without Catheter (TWOC): frequently-asked questions – Urology Department
- Prostap and Zoladex Therapy Injections – Gynaecology Department
- Post COVID-19 Recovery Service – Post COVID-19 Recovery Service

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.

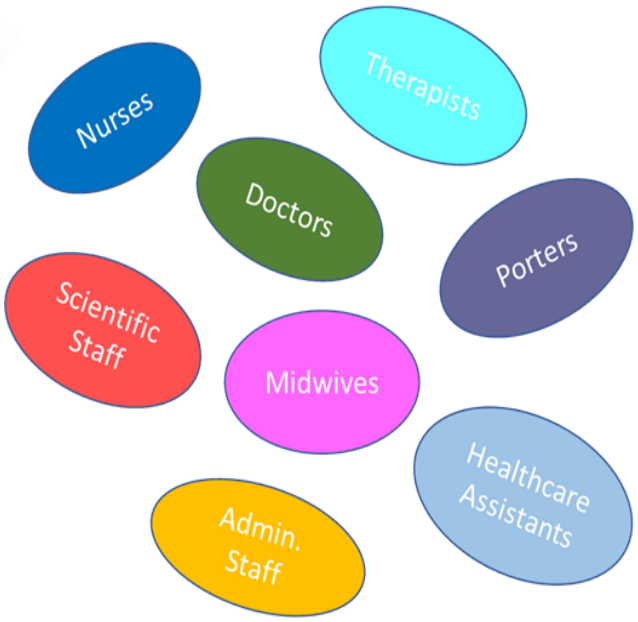
## Compliments

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.

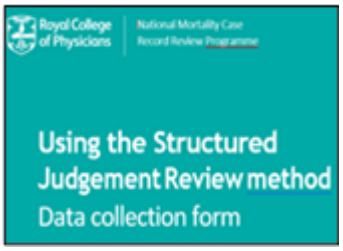
- Education and training of staff is pivotal when supporting people with LD in hospital. Staff are now able to access an e-learning package in relation to caring for people with a LD. The training forms part of the mandatory Level 3 Adult Safeguarding requirements.
- The Trust has an educational video 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.

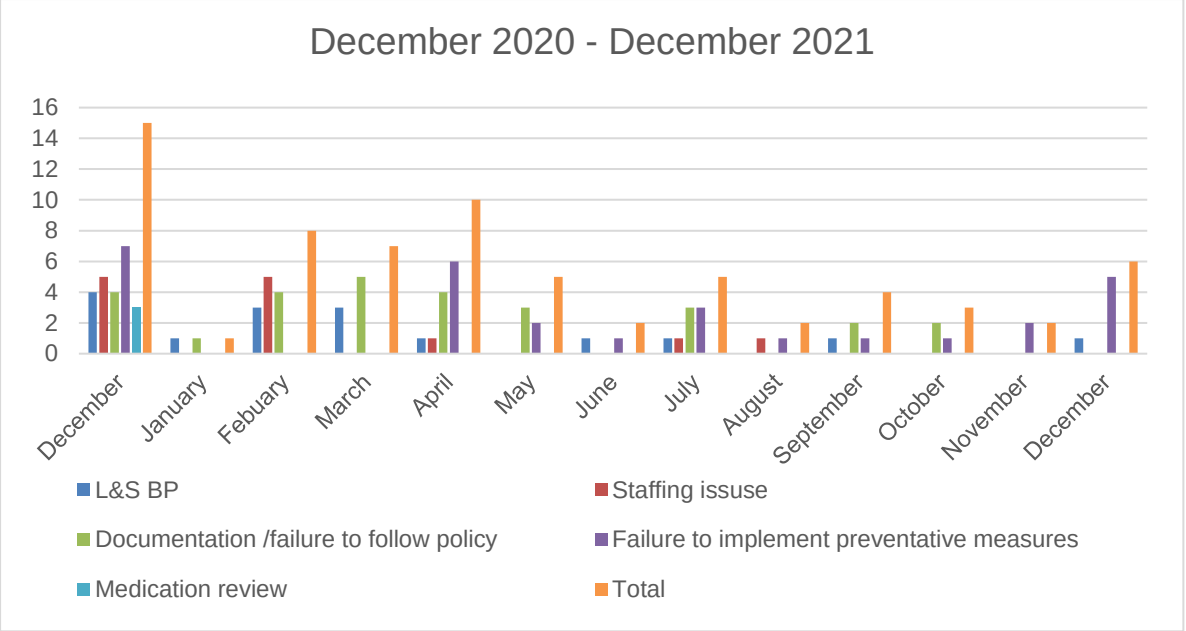
## Reducing Inpatient Falls

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.

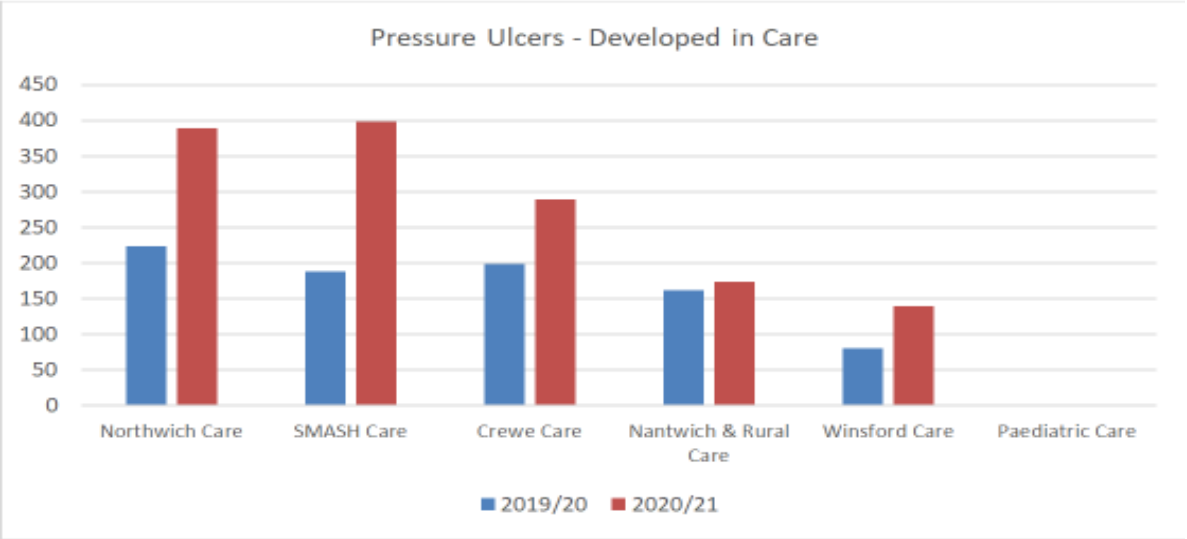
In addition, we experienced many patients being reluctant to seek help for skin problems or attend face-to-face consultations for fear of contracting the virus.

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.

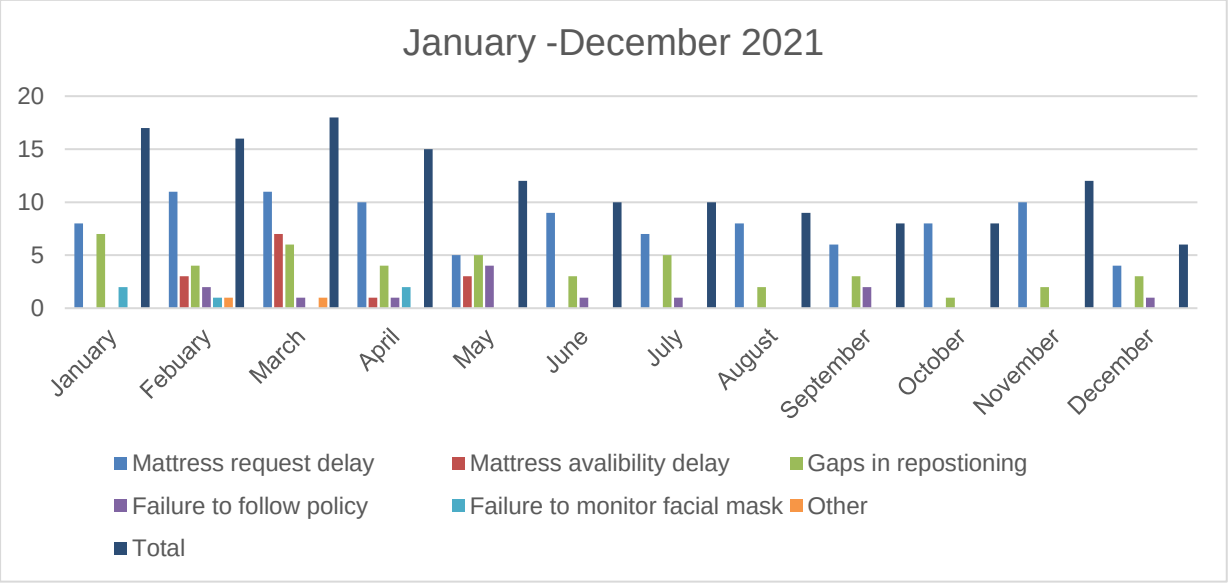
The development of a Standard Operating Procedure ensures all developed in care pressure ulcers, category two and above are reviewed at pressure ulcer panel to establish any lapses in care. From this ward and departments are asked to develop an improvement plan which is shared across the Trust through 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.

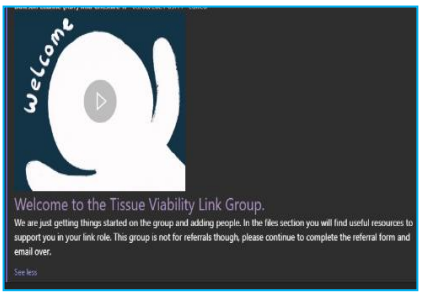
Alongside the pressure ulcer reviews, monitoring is achieved through Trust quality metrics data collection. Oversight of the Quality Metrics dashboards are reviewed monthly at the Quality Metrics & Ward Accreditation Group, to provide assurance against practice and local actions taken in response to 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.

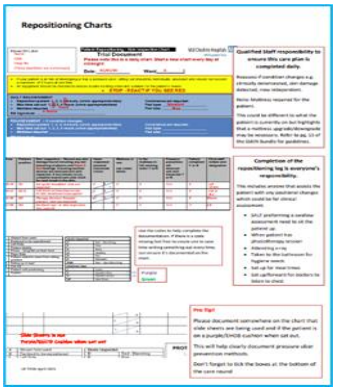
Training has been extended to Student Nurses, Trainee Advance Practitioners and Medical staff to increase pressure ulcer prevention awareness.

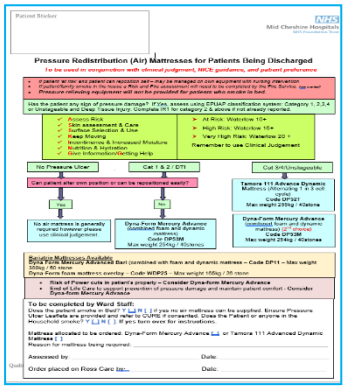
The TVSN has worked with the Neonatal Link Nurse to support the development of a Neonatal Skin Care Safe Operating Procedure. Support was also provided with the update to the Paediatric Skin Care Bundle. Additionally, the Adult Skin Bundle has been updated to reflect

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.

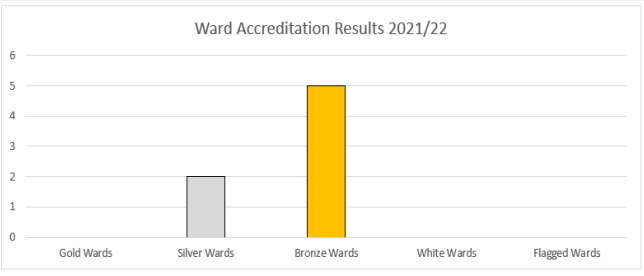
The Ward status will be agreed using the following;

| 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.<br><br>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.<br><br>NICE COVID-19 Guidelines distributed to all clinical staff to be followed as necessary.<br><br>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:** | |

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| **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. |

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| **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.<br><br>Preconception advice given by GP or Practice Nurses unless women access diabetes preconception clinic.<br><br>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)**<br><br>**(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. |

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| **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.<br>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**<br>**(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.<br>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<br>Less patients will be brought up for clinic appointments because accurate opinion cannot be provided remotely<br>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.<br>Posters of the importance of LocSSIPs and audit findings to be displayed at procedure sites/staff rooms/doctors' room.<br>Housekeepers to make sure adequate forms are present and checked every week.<br>Education for staff on the process for electronic documentation when performing an invasive procedure.<br>Addition of space for documenting failed attempt on to the LocSSIP form.<br>Change the debrief section on the LocSSIP form to debrief/reflection. |

| | |
|---|---|
| | Addition of the adjustment and removal documentation to the central Line LocSSIP.<br><br>New LocSSIP for Surfactant administration.<br><br>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<br><br>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.<br><br>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.<br><br>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.<br><br>**No Harm** | | |
| Wrong Site Surgery<br><br>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.<br><br>**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<br><br>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:<br>• 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<br>• 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.

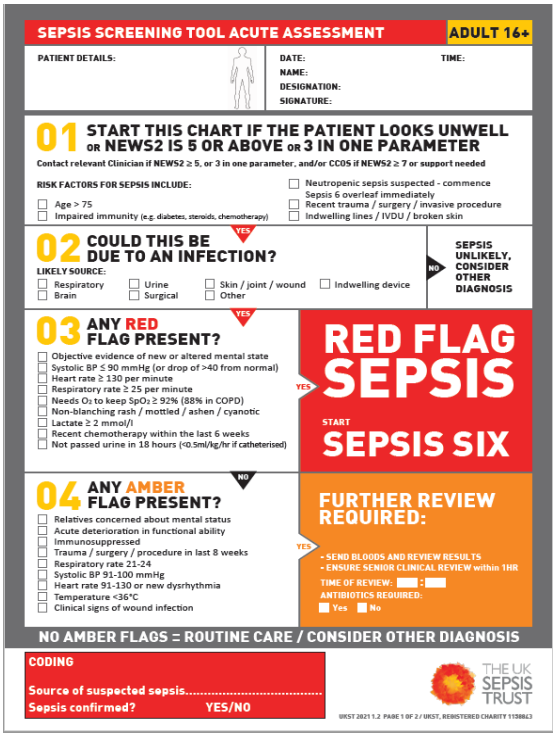
## Preventing Deterioration and Sepsis

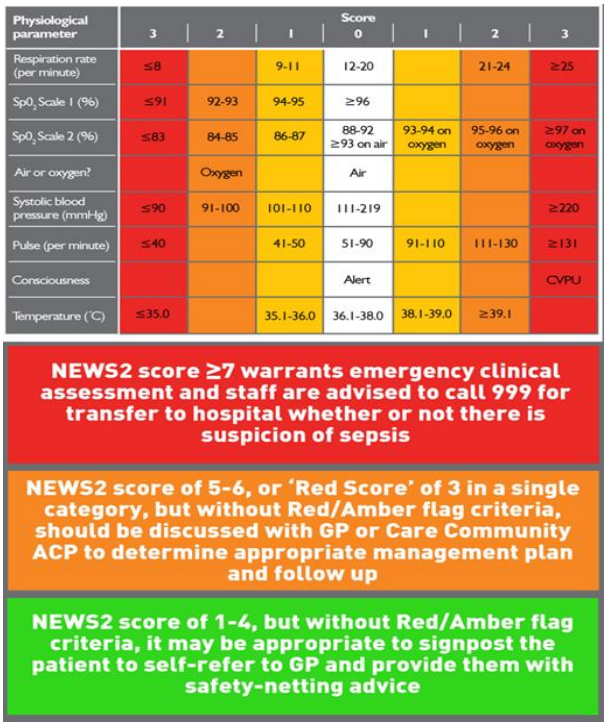
Mid Cheshire have continued to progress to improve early recognition and treatment of sepsis throughout 2021/22 despite the pressures and the unpredicted circumstance of the COVID-19 pandemic. The sepsis steering group continues to meet monthly when possible, bringing together disciplines from each division 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.

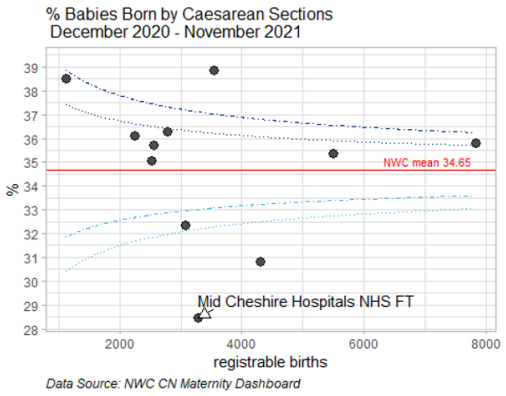
Measurements:

- 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.

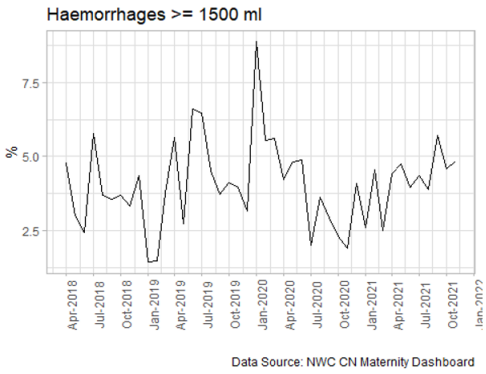
As part of the Trust's Quality and Safety Improvement Strategy 2020/21 the Women and Children's Division decided that the focus would be on training in identification and management of postpartum haemorrhage with the aim to improve the care and experience for women suffering a postpartum haemorrhage. 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.

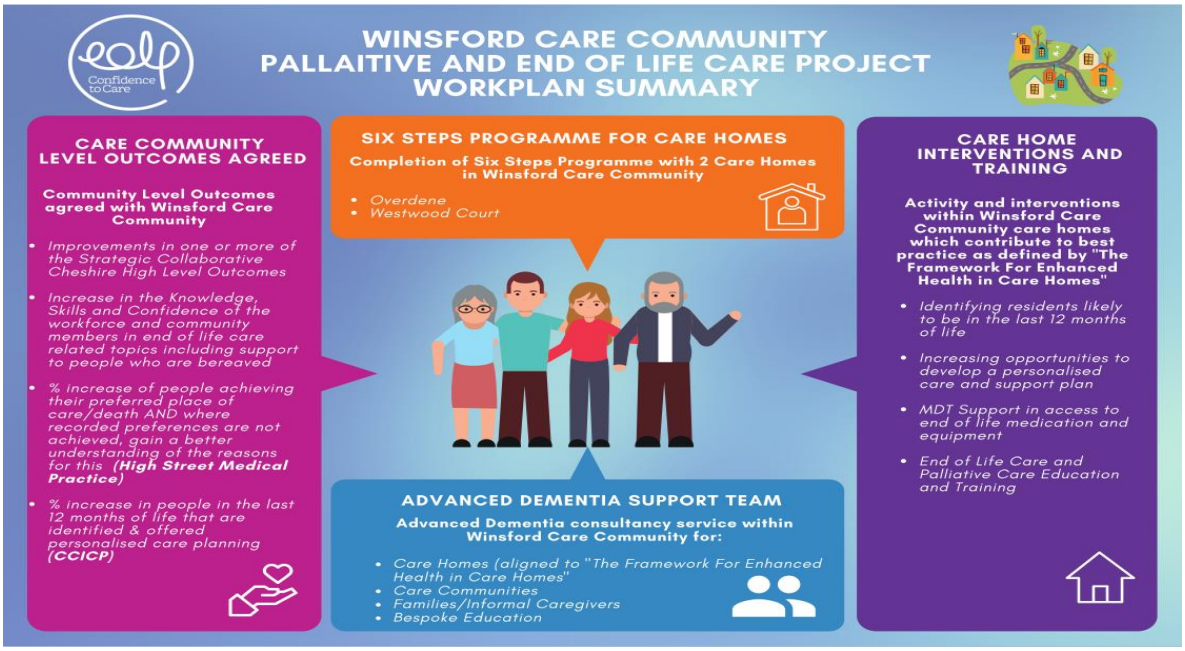
Improving communication between primary and secondary care continues and we have shared palliative care records between hospital, hospice and community settings via EPaCCS (Electronic Palliative Care Coordination System) improving timely and appropriate communication and an established integrated multidisciplinary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

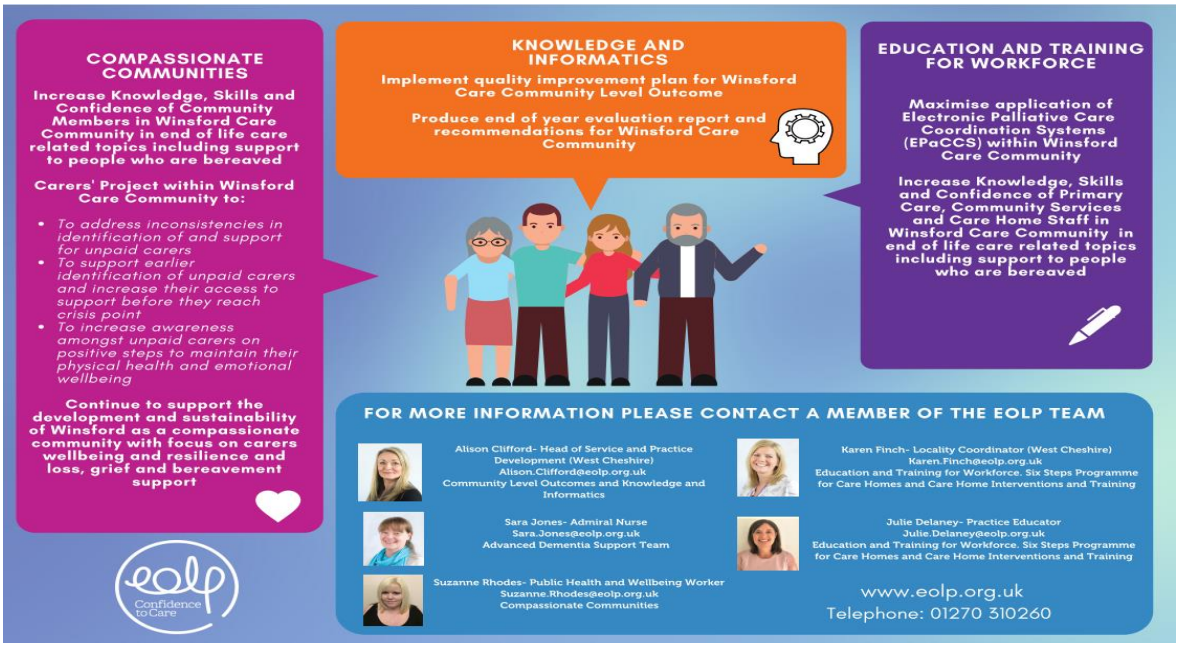
## Central Cheshire integrated care partnership

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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Sara Jones- Admiral Nurse
Sara.Jones@eolp.org.uk
Advanced Dementia Support Team
Suzanne Rhodes- Public Health and Wellbeing Worker
Suzanne.Rhodes@eolp.org.uk
Compassionate Communities
Karen Finch- Locality Coordinator (West Cheshire)
Karen.Finch@eolp.org.uk
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.

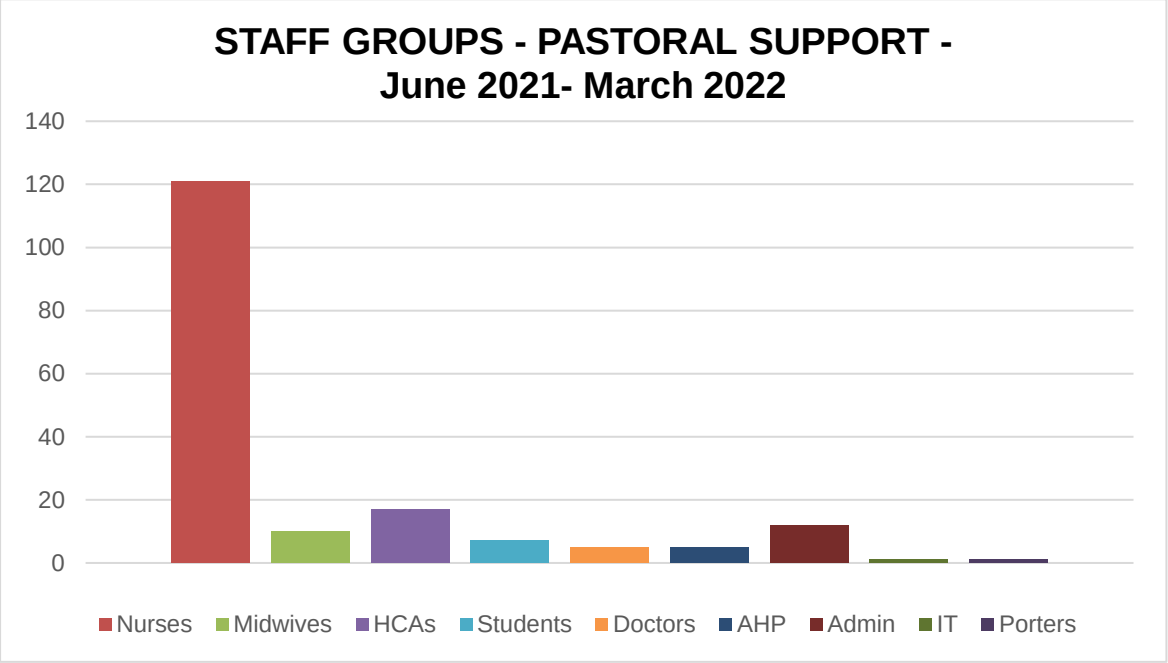
The team liaise with Professional Nurse Advocates to share learning and support. Regular drop-in sessions are organised, and the team regularly visit community sites to ensure staff are included to allow ease of access to the team.

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.

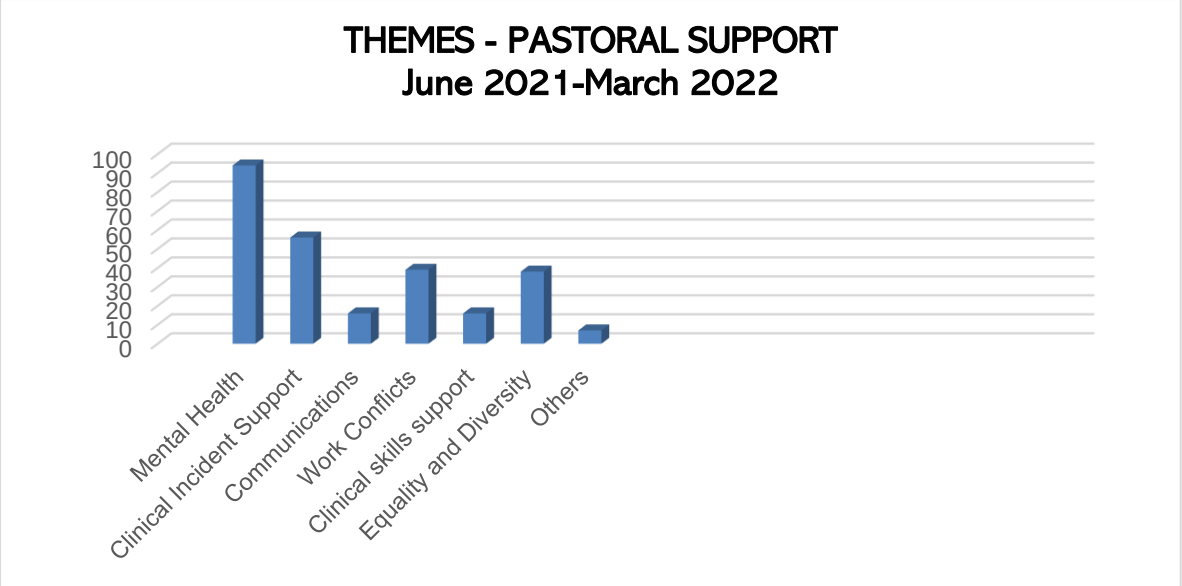
In addition to the above it is believed that the Pastoral Team can:

- 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
Crewe
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

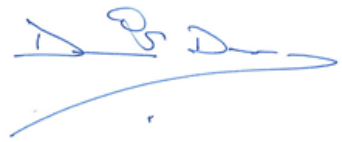
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality report.

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.<br><br>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). |

Working for a brighter future together

## Scrutiny Committee

| | |
|---|---|
| **Date of Meeting:** | 1 September 2022 |
| **Report Title:** | Appointments to the Cheshire and Merseyside Integrated Care System Joint Health Scrutiny Committee |
| **Report of:** | David Brown, Director of Governance and Compliance |
| **Report Reference No:** | |
| **Ward(s) Affected:** | No specific wards |

### 1. Purpose of Report

**1.1** This report seeks approval from the Scrutiny Committee to appoint members to the Cheshire and Merseyside Integrated Care System Joint Health Scrutiny Committee.

### 2. Executive Summary

**2.1** The Council, at its meeting on 20 June 2022, approved the establishment of a Cheshire and Merseyside Integrated Care System Joint Health Scrutiny Committee as set out in the Joint Committee Arrangements document at Appendix A.

**2.2** The Corporate Policy Committee, at its meeting on 4 November 2021 delegated the appointment of Members to external scrutiny functions to the Scrutiny Committee, which may invite any Member with the appropriate knowledge of health and social care, having regard to political proportionality.

**2.3** The Scrutiny Committee procedure rules at Chapter 3 part 1 section 2 page 23 of the constitution at paragraph 3.13 makes provision for the Chair of the Scrutiny Committee to make nominations.

## 3. Recommendation

**3.1** That the Committee appoints one Labour Group member and one Independent Group member with the appropriate knowledge of health and adult social care to the Cheshire and Merseyside Integrated Care System Joint Health Scrutiny Committee referred to in this report.

## 4. Reasons for Recommendations

**4.1** The Scrutiny Committee is responsible for the appointment of the Cheshire East Members to the Cheshire and Merseyside Integrated Care System Joint Health Scrutiny Committee.

**4.2** Appointment of members to the Cheshire and Merseyside Integrated Care System Joint Health Scrutiny Committee will ensure Cheshire East Council representation on that committee and Cheshire East Council influence upon the decisions made under the joint health scrutiny arrangements in Cheshire and Merseyside, in response to the challenge of the new statutory Integrated Care System (ICS).

## 5. Other Options Considered

**5.1** Whilst the Council could choose not to appoint Members to Cheshire and Merseyside Integrated Care System Joint Health Scrutiny Committee, this would result in Cheshire East Council not having influence upon joint health scrutiny arrangements and decisions at a regional level.

## 6. Background

**6.1** In response to the proposed establishment of Integrated Care Systems, several actions were agreed to ensure that joint health scrutiny arrangements in Cheshire and Merseyside are fit to meet the challenge of the new statutory arrangements.

**6.2** Full Council at its meeting held on 20 July 2022, agreed the establishment of 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.

**6.3** 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 out the proposed standing joint committee arrangements.

**6.4** The main features of the document are as follows:

- Membership – each authority should nominate 2 representatives to serve on Committee.
- Political balance –membership must 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.

**6.5** In line with Political Proportionality across the nine Authorities, the Committee is asked to appoint one Labour Group member and one Independent Group member with the appropriate knowledge of health and adult social care to the Cheshire and Merseyside Integrated Care System Joint Health Scrutiny Committee. The Committee will be informed at the meeting, of the nominees.

## 7.0 Implications

### 7.1 Legal

**7.1.1** 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.

**7.1.2** 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.

**7.1.3** 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.

**7.1.4** 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.

**7.2. Finance**

**7.2.1** 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. Each authority will be asked to contribute a total of £10,000 over the initial 18 months. This will be met from existing budgets.

**7.3. Policy**

**7.3.1** 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.

**7.4 Equality**

**7.4.1** There are no direct equality implications arising from the recommendations of this report, but the work of the joint committee will undoubtedly have such implications.

**7.5 Human Resources**

**7.5.1** There are no direct human resource implications for Cheshire East Council, since the proposal is for each authority to contribute towards the cost of shared support.

**7.6 Risk Management**

**7.6.1** Failure to appoint Cheshire East Council members to the Cheshire and Merseyside Integrated Care System Joint Health Scrutiny Committee would deprive the Council of having a voice in respect of joint health scrutiny matters at a regional level.

**7.7 Rural Communities**

**7.7.1** There are no direct implications for rural communities which arise from the recommendations of this report.

**7.8 Children and Young People/Cared for Children**

**7.8.1** There are no direct implications for children and young people/cared for children which arise from the recommendations of this report.

**7.9 Public Health**

**7.9.1** Whilst the work of the joint health scrutiny committee is directly focussed upon public health matters, there are no direct public health implications arising from the recommendations of this report.

**7.10 Climate Change**

**7.10.1** There are no direct climate change implications.

| **Access to Information** | |
|---|---|
| Contact Officer: | Brian Reed, Head of Democratic Services and Governance<br>brian.reed@cheshireeast.gov.uk |
| Appendices: | Appendix A: Terms of Reference for the Cheshire and Merseyside Integrated Care System Joint Health Scrutiny Committee |
| Background Papers: | The background papers relating to this report can be inspected by contacting the report writer. |

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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

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

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 | 1 | | | | 1 | 2 |
| Cheshire West and Chester | 1 | | 1 | | | 2 |
| Halton | 2 | | | | | 2 |
| Knowsley | 1 | | | 1 | | 2 |
| Liverpool | 1 | 1 | | | | 2 |
| St. Helens | 1 | | | | 1 | 2 |
| Sefton | 1 | 1 | | | | 2 |
| Warrington | 1 | | 1 | | | 2 |
| Wirral | 1 | | 1 | | | 2 |
| **Total** | **10** | **2** | **3** | **1** | **2** | **18** |

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.

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.

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 A**

# Work Programme – Scrutiny Committee – 2022/23

| 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/04/22-23 | 1 Sep 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 | Ensure that there is transparency in all aspects of council decision making | N/A |
| SC/06/22-23 | 1 Sep 2022 | Update from the Police and Crime Commissioner | To receive an update on the work of the Police and Crime Commissioner | Director of Adult Social Services | N/A | Work together with residents and partners to support people and communities to be strong and resilient | N/A |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| SC/09/22-23 | 1 Sep 2022 | Safer Cheshire East Partnership (SCEP) Update | To receive a presentation by the Director of Adult Social Care on the current priority areas for SCEP. | Director of Governance and Compliance (Monitoring Officer) | N/A | Ensure that there is transparency in all aspects of council decision making | N/A |
| SC/08/22-23 | 1 Sep 2022 | Appointments to the Cheshire and Merseyside Integrated Care System Joint Health Scrutiny Committee | To appoint members to the Cheshire and Merseyside Integrated Care System Joint Health Scrutiny Committee. | Director of Governance and Compliance (Monitoring Officer) | N/A | Ensure that there is transparency in all aspects of council decision making | N/A |
| SC/07/22-23 | 8 Dec 2022 | Waiting List update from East Cheshire NHS Trust | To consider detailed waiting list data including comparative data with other Trusts. | Director of Adult Social Services | N/A | Reduce health inequalities across the borough | N/A |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| SC/05/22-23 | Not before 1st Jun 2023 | Update on Cheshire and Merseyside Commissioned work | To receive an update by Cheshire and Wirral Partnership (CWP) NHS Foundation Trust, on the Cheshire and Merseyside commissioned group for patients specifically prone to suicidal tendencies. | Executive Director Adults, Health and Integration | N/A | Reduce health inequalities across the borough | N/A |

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