Mid Cheshire Hospitals NHS
NHS Foundation Trust

Quality Account 2016/17

Quality and Safety at Heart
Mid Cheshire Hospitals NHS Foundation Trust
Quality Account 2016/17


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

Contents -To be updated pg no's at the end

Part 1

Statement on quality from the Chief Executive

Add signature

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Throughout the document, there may be terminology that is not very familiar to readers. Where possible, the Trust has tried to write clearly in a user friendly way. However, some elements in the Quality Account are prescribed by the Department of Health or Monitor. To help readers, there is a glossary of terms at the back of the document in Appendix 1.

Part 2

Priorities for improvement and statements of assurance from the Board

Priorities for improvement in 2017/18

During 2016/17, the Trust conducted an extensive engagement programme to inform of its Quality and Safety Improvement Strategy which describes the key priorities for quality and safety from 2016 to 2018 inclusively.

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

''To deliver excellence in healthcare through innovations and collaboration''

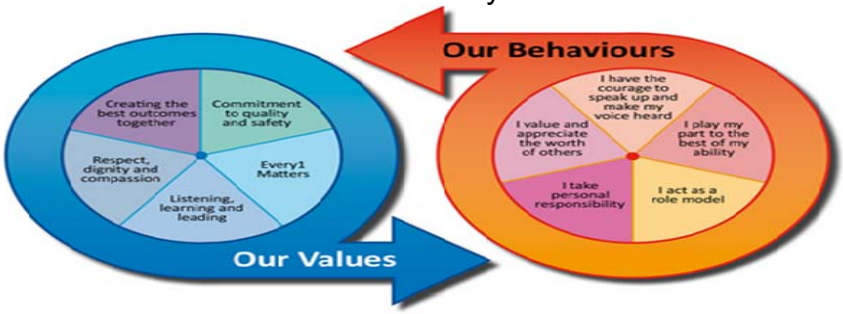
The Trust will be a provider that:

- Delivers high quality, safe, cost-effective and sustainable healthcare services
- Provides a working environment that is underpinned by values and behaviours
- Is committed to patient-centred care
- Treats patients and staff with dignity and respect.

The strategy links closely with other key strategies such as the Clinical Services Strategy and the People and Organisational Development Strategy 2016 – 2018. It is when these work hand in hand that collectively the Trust can deliver the vision and mission of the organisation.

The strategy is based on what people from Vale Royal, South Cheshire and the surrounding areas told the Trust they wanted from their hospitals. In addition, staff, governors and other stakeholders also contributed to the development of the strategy through workshops held to discuss and collate opinions.

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



The subsequent development of the Quality and Safety Improvement Strategy has allowed the Trust to focus its key areas of improvement under the three domains of quality as determined by the Health and Social Care Act 2012.

Experience

Staffing

We will ensure we have appropriate levels of nurse staffing and skill mix that meet the needs of our patients.

Dementia Care

We will continue to support patients who have concerns about their memory and we will work with patients who have dementia and their carers to promote a positive experience whilst in hospital.

Medication

Following a review of our strategy in March 2017, our aim is to reduce medication errors resulting in harm by X% and ensure the use of safe and effective medication across the organisation.

Effectiveness

Never Events

We will have zero tolerance of Never Events in the organisation.

Sepsis

We will ensure the prompt recognition and treatment of sepsis, ensuring that 90% of patients are receiving appropriate care as per the sepsis pathway by January 2018.

Acute Kidney Injury

We will ensure the prompt recognition and treatment of Acute Kidney Injury (AKI) ensuring that 90% of patients are receiving appropriate care as per the AKI pathway by January 2018.

Safety

Pressure Ulcers

Following a review of our strategy in March 2017, Our aim, in both the acute Trust and Central Cheshire Integrated Care Partnership (CCICP) is to reduce stage 2 avoidable pressure ulcers by 5% per quarter, based on the previous quarter's results and have zero tolerance to avoidable stage 3 and 4 pressure ulcers.

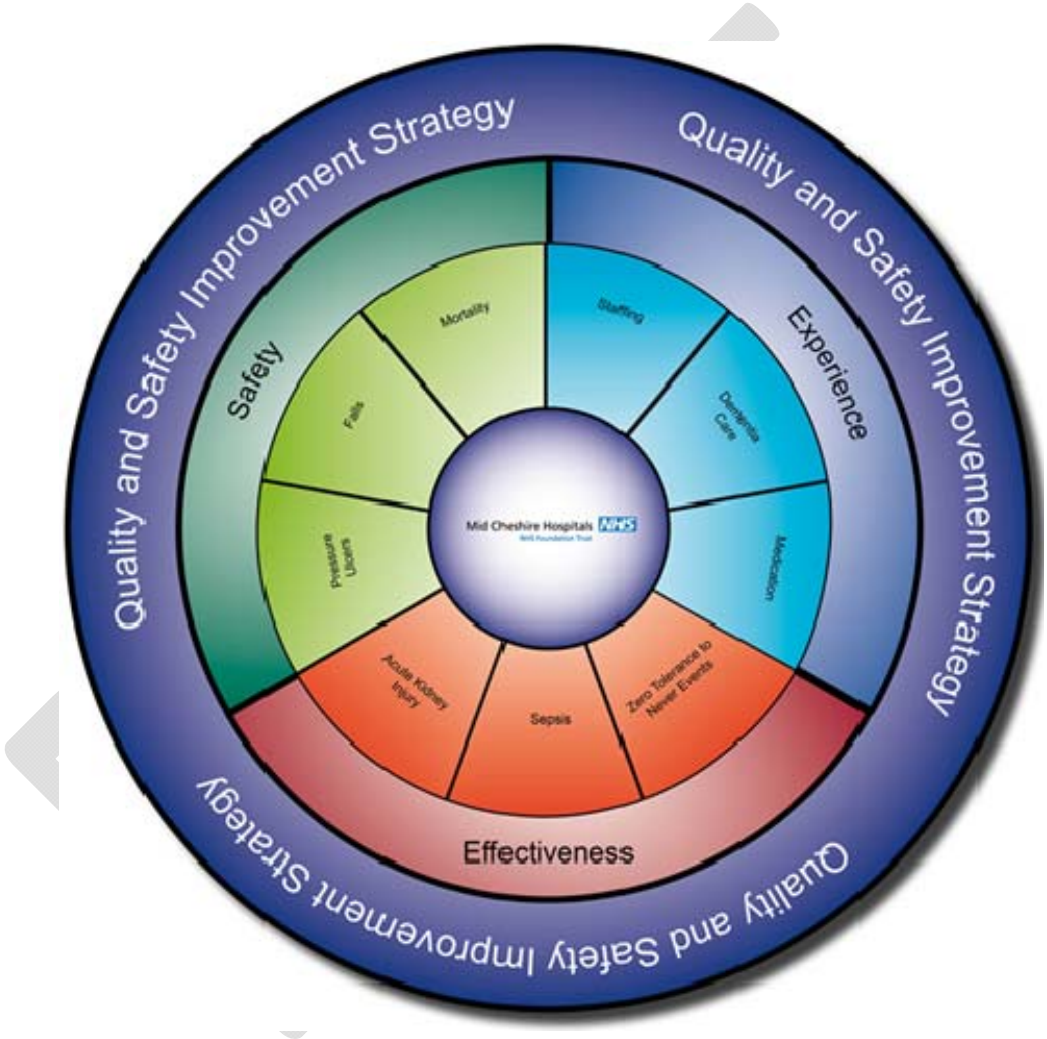
Falls

We will reduce in-patient fall incidents by 10% by January 2018.

Mortality

Our Summary Hospital-Level Mortality Indicator (SHMI) will remain at or below 100 from April 2015.

The logo for the Trust's Quality and Safety Improvement Strategy is shown below. This has been used to promote awareness of the strategy around the Trust and at public engagement events. The logo has been included on all the Trust's Quality and Safety boards.



Monitoring and reporting of the Quality and Safety Improvement Strategy.

Each element of the strategy has a responsible lead who reports progress each quarter to the Quality and safety Improvement Strategy Group, which is chaired by the Director of Nursing and Quality. This group reports directly to the Executive Quality Governance Group.

The Executive Quality Governance Group 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. All elements of the strategy have objectives that require both qualitative and quantitative evidence of achievement.

The Executive Quality Governance Group reviews the key areas of improvement in relation to the Quality and Safety Improvement Strategy to ensure progress is being made in relation to the aims and key areas identified.

In addition, progress against the key areas of improvement is also included in the annual Quality Account. This report is made available to the public on the Trust's website, on NHS choices and is also included in the Trust's Annual Report and Accounts.

Since the Trust entered the Central Cheshire Integrated Care Partnership in October 2016 care is provided throughout community settings via a number of services. This provided the opportunity to refresh the Quality & Safety Improvement Strategy for 2017/18 and include key focus areas for our community teams.

Feedback from patients

National patient surveys

The Trust values and encourages feedback on how all services perform and uses a wide variety of methods including patient satisfaction surveys. The Trust also actively seeks the views and involvement of patients, their carers, our Foundation Trust members and the wider community in the design and delivery of all services. Their views play a central role in monitoring and driving improvements in the quality, safety and efficiency of our services.

The Trust participates in a national annual programme of patient satisfaction surveys. The Care Quality Commission uses the results from the surveys in the regulation, monitoring and inspection of Trusts in England. Results are shared with the relevant teams and good practice is highlighted and action plans developed to address issues identified from the results

National Inpatient Survey

Between August 2016 and January 2017, a questionnaire was sent to 1250 adult inpatients discharged in the July 2015. Responses were received from 681 patients, a 57% response rate. The results include patients' perceptions of:

- the quality of communication between medical professionals (doctors and nurses) and patients
- the standards of hospital cleanliness
- the availability of help to eat when needed
- being involved in decisions about their care and treatment.

What has changed since the last inpatient survey?

There has been an improvement in the results for following questions

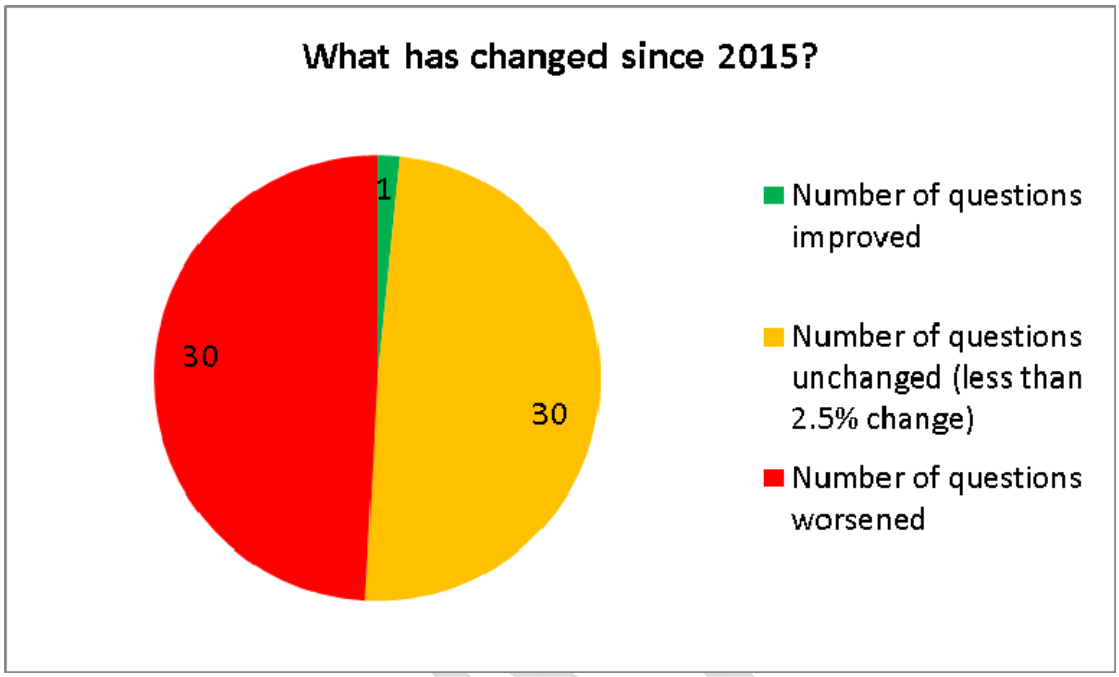
- Patients having enough help from staff to eat their meals
- The number of patients in single sex accommodation on admission had increased
- Communication style of doctors and nurses
- Respect and dignity

It is unfortunate that a number of patient satisfaction indicators had declined since the previous survey so a working group was held in March with a multi disciplinary group of staff. The working group, including ward managers and matrons with staff from pharmacy and the integrated discharge team will lead on developing actions to address areas requiring improvement.

Presentations of the results and action plan are delivered to the Trust board, governors, and patient register group during the year. Progress against

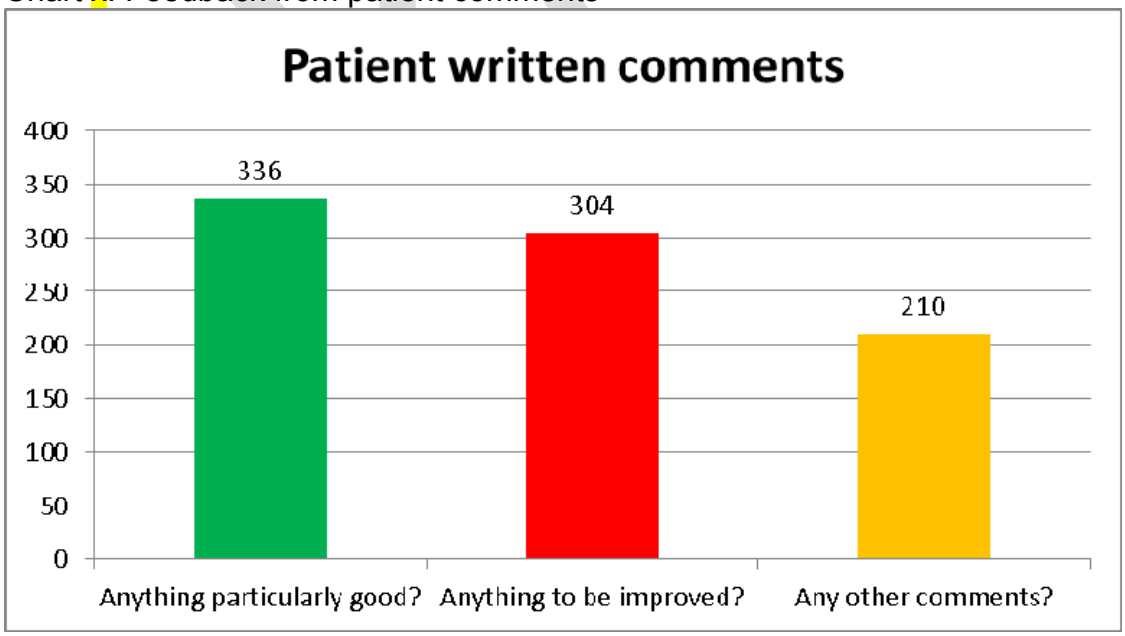
actions will be monitored by local surveys and reported to the Executive Patient Experience Group.

Chart x: Changes in results since 2015



There were 14 questions with statistically significant worse scores and 0 questions with statistically significant better scores.

Chart x: Feedback from patient comments



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

- Improving patient information for patients on the ward and at the bedside
- Reducing delays on discharge

Action taken

All adult inpatients now have a bedside folder which includes information to help during their admission.

A poster which explains what happens in preparing patients for a safe discharge is also now displayed at the bedside. A new information leaflet is being developed to enable patients to record their estimated date of discharge and provides useful details about preparing for leaving Leighton Hospital.

Examples of comments made by patients from the national inpatient survey when asked what was particularly good about their care:

Attitude of all the nursing staff and auxiliaries. The ENT team very efficient, very thorough and very informative. Once they were involved in my case they arranged for the necessary scans to be done very quickly and the rapid transfer to the Royal Stoke University Hospital for surgery and post-op treatment. They provided continuity of care throughout my stay in hospital.

I have been in hospital on three separate occasions recently. I was admitted as an emergency and was put at ease and pain relief given. I had prompt attention, was reassured and was told fully and made aware of my complications. On the second occasion I was treated again with great respect and reassured. Finally on the third occasion my operation went well as a day patient. All the staff from attendance to leaving were great and I was fully aware of what was to be done. I had marvellous treatment.

The nurses were very efficient, caring and interested in how I felt and what I may need. I could find no fault in either nursing staff or doctors. Compassion and helpfulness was there in abundance.

I have never had a serious operation before and was apprehensive about the whole thing. In the event everything was carefully and fully explained beforehand so I knew what was to happen at each stage and what to expect during my stay in the hospital. Overall I thought the hospital care was excellent.

I feel that the hospital is very well run. There is a high feeling of pride across all levels of staff from consultants to cleaners. They all maintain a constant level of service from ward to ward and morning to night. The food also deserves praise. The menu was varied, the choice system efficient and the presentation looked 'home cooked' and appetising.

National Cancer Survey

The National Cancer Patient Experience Survey 2015 was the fifth repeat of the survey first undertaken in 2010. It is been designed to monitor national progress on cancer care; to provide information and to drive local quality improvements.

The sample included all adult (aged 16 and over) NHS patients with a confirmed primary diagnosis of cancer and included patients discharged after an inpatient episode or day case attendance for cancer related treatment between April and June 2015

Patients were asked to rate their care on a scale of zero (very poor) to 10 (very good); we were very pleased that our patients gave an average rating of 8.6.

Patient experience at the Trust was better than the national average in 16 questions;

- The same for 6 questions;
- Less than 5% below national average in 22 questions;
- More than 10% below national average in 5 questions.

The results demonstrated improved scores relating to patient experience for 6 out of the 7 issues actioned in 2015.

Question	2014 (average score)	2015 (national average)
Patient told they could bring a family member or friend when first told they have cancer	69% (71%)	74% (79%)
Patient had confidence and trust in all ward nurses	64% (66%)	78% (72%)
Always / nearly always enough nurses on duty	51% (56%)	56% (66%)
Patient was able to discuss worries or fears with staff during admission	56% combined (60%)	51% inpatient (52%) 69% day case (70%) /outpatient
Hospital staff gave family or someone close all the information needed to help with care at home	54% (56%)	54% (58%)
Taking part in cancer research was discussed with patient	20% (21%)	18% (28%)
Patient given a care plan	24% (27%)	33% (33%)

The following questions are included in phase 1 of the Cancer Dashboard developed by Public Health England and NHS England:

National Cancer Dashboard	MCHFT Score	National Average Score
Patient definitely involved in decisions about care and treatment	76%	78%
Patient given the name of the CNS who would support them through their treatment	96%	90%
Patient found it easy to contact their CNS	89%	87%
Always treated with respect and dignity by hospital staff	91%	87%
Staff told patient who to contact if worried post discharge	93%	94%
Practice staff definitely did everything they could to support patient	64%	63%

Local patient surveys

The Trust agrees on an annual patient and public involvement programme, which includes a variety of local patient experience surveys undertaken across areas within the Trust.

In 2016/17 a total of 30 local surveys were undertaken. Local surveys are completed by patients in wards and departments. Patients are encouraged to provide feedback for surveys in numerous ways including via touch screen kiosks, paper based surveys and patient interviews.

Three of these local surveys included within the 2016/17 programme are profiled below:

Phlebotomy Patient Satisfaction Survey

The phlebotomy service covers both Leighton Hospital and Victoria Infirmary, Northwich providing a service to patients 12 years and older. For patients under the age of 12, a specialised service is provided at the Krishnan Chandran Children's Centre.

At Leighton Hospital site the service covers inpatient wards under the management of the relevant division, where patients are bled on the ward. Outpatient clinics are also available where patients are bled in the phlebotomy rooms based in the outpatient clinic area. The outpatient service is open each day Monday – Friday from 08:30 and covers until 17:00, with the exception of Mondays where the service is available until 17:45 and Thursdays until 18:45.

At Victoria Infirmary, Northwich, the phlebotomy service is accessible Monday – Friday 08:30 to 16:30.

The phlebotomy service is also provided at some GP practices via a contract through the CCG, and GP's are encouraged to utilise this service rather than referring patients to the Phlebotomy service at the hospital sites.

The Trust sent out 73 Surveys to the target population. 50 were returned giving us a response rate of 69%

We were delighted with the results which indicated that:

- 100% of patients said that the department was easily accessible
- 92% of patients were satisfied with the opening times available
- 96% of patients were satisfied with the cleanliness of the cubicles
- 100% of patients rated staff as being courteous and of a professional manner
- 88% of patients are aware that their GP services operate a phlebotomy service

Key Issues and Actions Taken

- Concerns were raised by patients about operating hours not being convenient to accommodate people who work office hours so we changed our opening times to include two evenings.
- Concerns were raised that our waiting room was too hot and a television would be of benefit to patients waiting as waiting times can sometimes be lengthy when clinics are overrunning. We had a television installed in our waiting room.
- Concerns were raised around our waiting times and staffing levels. To address this the department lead is training staff in venepuncture to address shortfalls in staffing levels and continue to make service improvements to ensure our patients overall experience of phlebotomy is of the highest standard.

Endoscopy Unit Patient Postal Survey 2016

The Trust sent out 300 Surveys to our target population during the month of August/September 2016. 106 surveys were returned giving us a response rate of 35%.

The results indicated that:

- 91% of patients responded that they had been offered the choice of sedation/Entonox for their procedure
- 94% of patients responded that they were treated politely and with respect in the Endoscopy Unit
- 75% of patients responded that they did not think the service in the endoscopy unit could be improved
- 52% of patients responded that, 'how to withdraw consent,' had been explained to them

Key Issues and Actions Taken

- 25% of patients responded that it had not been explained to them how they could withdraw their consent. The team have put numerous measures in place to ensure that patients have this information

Figure 1
An upper GI endoscopy

Are there any alternatives to an upper GI endoscopy?

A barium meal is an x-ray test of your upper digestive system.
A urea breath test can be used to detect a germ (helicobacter pylori) that can
ulcers.

What does the procedure

Patient information is also available via the website

before undergoing the procedure. There is a flow chart displayed in all procedure rooms to guide the nursing staff. Patient information leaflets have been updated to make it more explicit about how to withdraw consent. http://www.mcht.nhs.uk/information-for-patients/patient-leaflets/eido-lite/

- Delays - 30% of patients' who responded said that they did not receive explanations for delays. The team are working hard to ensure that all patients whose treatment is delayed receive a suitable and appropriate explanation. Feedback has been given to staff in endoscopy and the Treatment Centre regarding the communication of delays to patients.

Acute oncology Team (AOT) Survey 2016

The Trust sent out 45 surveys to our target population during 2016 and 26 patients responded giving a response rate of 58%.

The results indicated that:

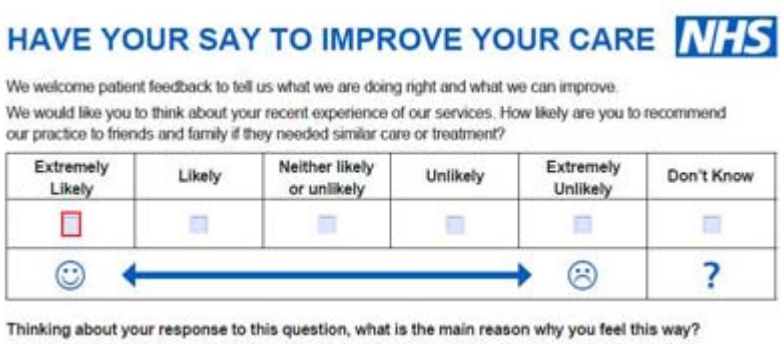
- 92% of service users felt they had been informed of any problems they may develop as a consequence of their treatment.
- 88% of service users felt they were prepared about potential side effects and who to contact should this develop.
- 92% of service users felt the AOT spent enough time with them.
- 92% of service users had trust and confidence in the AOT.
- 82% of service users received an acute oncology patient leaflet.

Key Issues and Actions Taken:

- The Acute Oncology Team were reminded to consistently introduce themselves and explain their role to patients.
- The Acute Oncology Team will ensure all patients reviewed will receive an information leaflet informing them about the service.
- The Acute Oncology team will review the patient survey for 2017 to reflect the community aspects of the service and get feedback from patients receiving care and support from the team within a community setting.

Friends and Family Test:

The NHS Friends and Family Test (FFT) was created to help service providers understand whether patients are happy with the service provided, or where improvements are needed. It is a quick and anonymous way to give patient views after receiving care or treatment across the NHS.



HAVE YOUR SAY TO IMPROVE YOUR CARE NHS

We welcome patient feedback to tell us what we are doing right and what we can improve.

We would like you to think about your recent experience of our services. How likely are you to recommend our practice to friends and family if they needed similar care or treatment?

Extremely Likely	Likely	Neither likely or unlikely	Unlikely	Extremely Unlikely	Don't Know
☐	☐	☐	☐	☐	☐
☺ ⟷				☹	?

Thinking about your response to this question, what is the main reason why you feel this way?

One of the key benefits of the FFT is that patients can give their feedback in near real time and the results are available to staff more quickly than traditional feedback methods. This enables staff to take swift and appropriate action should any areas of poor experience be identified. The results of the FFT are published on www.nhs.uk so that patients and members of the public can see how their local services are viewed by those who have used them. The results can provide a broad measure of patient experience that can be used alongside other data to inform patient choice.

The Friends and Family Test is completed on the adult wards, the emergency department, assessment areas, maternity services, community services, outpatients, day case units and children's services. Every patient that receives treatment in those areas can give feedback about the quality of care they have received.

Responses are anonymous and patients are asked to complete a survey card which can be handed to a member of staff or posted into a confidential post box. Patients attending the emergency department and in some outpatient areas can choose to complete the survey on a touch screen kiosk which has a multi-language option.

How are the results calculated?

The responses from all patients are used to calculate the percentage of patients that would recommend the service ("extreme likely" and "likely"). Patients are also invited to comment on the reason for the answer they give.

Trust results

Over 32,000 patients have responded to the Friends and Family Test, with 94% of patients indicating that they are likely to recommend services or treatment to their friends or family.

The majority of written comments provided by patients are positive and include the following examples:

Paediatric Day Cases

'Staff are very good. Settled my autistic son very well. Nothing was too much trouble'.

'The information given to my child was excellent and well suited to his age. Communication on the day was excellent, we felt fully informed throughout the day. Lots of distraction on the ward and in theatre to stop him worrying'.

'Pre-op explanation using flash cards. Approach of staff was fantastic and reassuring to us at all times'.

Ward 12 – '*Everything was checked thoroughly and I felt confident I was in safe hands. Medications were found to address pain and sickness issues quickly. Cleanliness standards were high and food choices fine. I observed a lot of kindness to elderly patients'.*

Elmhurst – '*The staff are caring and very efficient, very friendly, fantastic. All my needs were met in spades, fabulous food, I wanted for nothing. I have been very happy here, very sorry to leave, very, very happy here'*.

Ambulatory Care Unit – '*I was impressed with all the care and attention, very professional. Food was good but lots of room for improvement for example more choice'.*

Cardiology – '*Very caring, staff answered all questions promptly'*.

Ward 13 – '*All members of staff, especially all nurses, have gone about their work in a most friendly, caring and professional way, as sometimes they encountered some very difficult situations'*.

Ward 9 – '*Very impressed by the efficient process from start to finish, above all that and reassuring words from doctors and staff*'.

Examples of action taken as a result of feedback from the Friends and Family Test include the purchase of new chairs in the Eye Care Centre and signposting for visitors to overflow car parking spaces at peak time

NHS Choices

The NHS choices website provides an opportunity for patients to provide comments about their recent experience in hospital. There were a total of 116 new postings on the NHS choices website in 2016/2017.

There have been 85 positive postings and 31 negative.

Leighton Hospital is currently achieving a star rating of 4 stars out of a maximum of 5 stars and the Victoria infirmary, Northwich is achieving 4.5 stars out of 5.

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

Examples of comments posted on NHS choices include:

Medical Imaging – I attended for a very intimate procedure and naturally concerned and embarrassed but I was treated with the greatest kindness and respect.

Macmillan Cancer Centre - The whole process was speedy and efficient in a caring environment, a first class service!

Children's Ward - I don't think this ward at Leighton is operating within acceptable levels and as such the care and attention is not where it needs to be for service users to feel confident in their treatment and care.

Victoria Infirmary - I was very impressed efficient friendly treatment I received in a clean airy environment.

Treatment Centre - Staff were friendly, caring and knowledgeable

Orthopaedics – Everything went like clockwork, from the decision to have the procedure through to discharge

A&E - We got told we have to wait 2 hours to be seen, which we did not mind as it was the middle of the night. 8 hours later we were seen to, 8 hours. I am sorry but this is absolutely horrific, he was in agony and he was just left to wait.

ENT - I was very pleasantly surprised by the level of customer service provided to me by both the medical and reception staff.

Ophthalmology – I wait months for a referral for my little boy to then get a text less than a day for his appointment with no letter beforehand which I couldn't make due to work commitments. I then call to rearrange to only get the answer machine every time and nobody bothers to call you back!

ECG - I attended today to have a stress echo and was so well looked after. Just wanted to say thank you again for all the team being so reassuring and helpful

Urology - All nursing staff were polite, explained everything and despite being very busy, were always there when you needed them. The food was much better than I had experienced in the past.

Order Comms (Pathology) Main Outpatients Department (OPD) Project

ICE Order Comms (Pathology) was successfully implemented in all areas throughout the Trust in 2011 with the exception of Main Outpatients Department (OPD). This was due to infrastructure issues that restricted the installation of cabling to support the printing required for the project.

In 2016 a solution was identified and agreed in consultation with the OPD and Phlebotomy Managers to change the process in how requests are made which would result in all requests being centrally managed and printed in Phlebotomy. Following the successful pilot of ICE Order Comms (Pathology) Requesting in the Diabetes Centre, the system has now been implemented in the Main OPD.

The successful implementation of ICE Order Comms (Pathology) in the OPD is seen as a key part of the Trust's stepwise introduction of electronic systems. The implementation of this system in Main OPD will be completed by 31 Jan 17. The paper request forms will no longer be available for routine use in the Main OPD after this date. The implementation of ICE Order Comms within Main OPD has proven to be extremely beneficial to the Trust especially from a quality and safety perspective. The adaption and positive approach to the new process by the Phlebotomy department has been fundamental to the success of the project. There are many benefits to implementing Order Comms Requesting in the OPD, including improvements in patient safety and experience, as well as saving time and money due to the reduction in human error and illegibility. The whole patient flow journey process is vastly improved from the clinic room to Phlebotomy and onwards to Pathology**.**

Other patient and public involvement programme activities:

Experience of Care Week

Staff and volunteers celebrated Experience of Care Week by having a display and inviting patients, visitors and staff to see examples of patient feedback

as part of a national initiative. Examples included recent patient survey results and action taken following concerns raised.

Patient Information

Readers' Panel

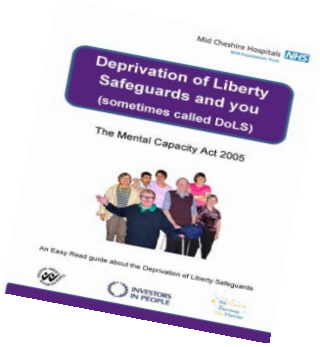
The Trust continues to have an active panel with over 70 members and they have reviewed 22 leaflets. Members receive information leaflets in draft by post or email to review and comment on. Staff find the process helpful in developing information which they feel confident will meet the needs of patients. Leaflets reviewed by the panel include – Pulmonary Embolism, Knee Meniscal Repair and Trabeculectomy Surgery.

Patient Information Group

The group meets on a monthly basis and membership includes patients' representatives and multi-disciplinary group of staff. In 2016/2017, the committee reviewed 20 leaflets and 1 poster. There have been requests from staff and patients for information to be translated or provided in other formats.

The Women and Children's patient information and documentation group have ratified six new comprehensive patient information leaflets including menopause, merional injection instructions, Intrahepatic Cholestasis of Pregnancy Support and Autistic Spectrum Disorder and Sensory Issues.

Leaflets produced in other formats:



Easy Read

- Going for a blood test
- Deprivation of Liberty Safeguards (DoLs) and You

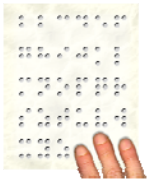
Large print

- Pregnancy booklet – Maternity Services
- Treatment and condition specific leaflets including Orthopaedic pre-operative assessment.

Other languages

- Information for carers of a child with a gastrostomy button translated from English into Slovakian
- Colorectal letter translated from English into Slovakian
- Breast Feeding information from English into Polish

Accessible Information



The Accessible Information Standard directs and defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents, where those needs relate to a disability, impairment or sensory loss.

It is of particular relevance to individuals who are blind, deaf, deafblind and / or who have a learning disability, although it will support anyone with information or communication needs relating to a disability, impairment or sensory loss, for example people who have aphasia, autism or a mental health condition which affects their ability to communicate.

By implementing the standard the Trust aims to ensure that individuals with information and communication support needs are able to understand and therefore follow advice or instructions regarding their health. This will result in improvements in patient safety and clinical outcomes due to increasing the ability of patients, service users, carers and parents to recognise the signs and symptoms of diseases and conditions, and therefore take appropriate action, for example skin cancer or stroke; comply with pre- and post-operative advice, and take prescription medication appropriately.

As part of the Trust's launch of the standard an event was held with partnership organisations with advice and information and displays from IRIS – Vision Resource Centre in Crewe, a registered volunteer from Guide Dogs, staff from the Deafness Support Network, Northwich and Trust staff from the JET library and the Patient Information Co-ordinator.

The event was attended by over 40 staff and a guide has been developed for staff to ensure the Trust is achieving the standard.

Patient Register Group Meetings

In 2016/2017 the Trust held patient register group meetings in the community. The group consists of volunteers and members of the public. Topics covered have included confidentiality of patient information and Acute Kidney Injury (AKI), Patient Led Assessment of Care Environment (PLACE) and updates on services provided in the Eye Care Centre.

The topics are well received and are a combination of sharing information and also seeking views on services.

Partnership Working

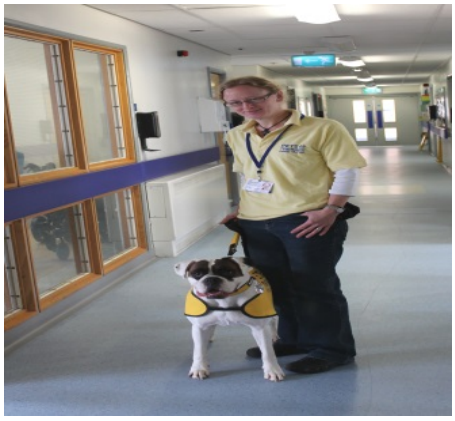
The Trust is very grateful to several companies who have helped with garden projects. Barclays Bank helped to create the Critical Care Garden, Bentley Rotary Club helped in the MacMillan garden and Wesleyan Financial Services tidied up and planted ward 21b garden area. In addition we had volunteers from Petty Pool College and a Nantwich Scout Troop come in and help tidy up Coronary Care and Michael Heal unit gardens.

Wesleyan Financial Services Urology garden

38th S.W.C scout troup working in the

Barclays Team – Ward 21B garden

Bentley Rotary



Pets as Therapy have become regular weekly visitors to the Trust. Visits are made to a wide variety of wards and patients enjoy chatting with the volunteers and stroking the dogs. Staff are equally delighted to have the dogs visit.

Dance Therapy 'In This Moment'

In THIS Moment has been created in partnership with Cheshire East Council (Cultural Services), Leighton Hospital and Mid Cheshire Hospitals Charity and is supported by additional investment from Cheshire East Council Participatory Budgets scheme (Public Health).

The aim of the project is to deliver weekly dance and person-centred creative practice to:

- Enhance the healing environment in the hospital
- Contribute to the prevention of the early onset of Dementia
- Offer people a way to live well with dementia within dementia friendly communities
- Challenge perceptions around dance and who can dance
- Undertake a qualitative enquiry, collecting observations about the project from all stakeholders

Practical dance activity started on ward 21b in November 2016. There have been 10 weeks of sessions since November 2016 over which the Trust has engaged with 110 people including 100 patients in attendance of the sessions.

The lead dance Artist works on Ward 21b every Thursday. Upon arrival she checks in with the ward manager and members of the physiotherapy team. Usually staff have gathered people who are interested in participating in the day room or dining space. Importantly the dance session is responsive to its environment which means that some weeks the lead dance artist has to wait for the washing and dressing to finish or for people to be assisted along the corridor from their bays.

A Physiotherapy assistant has also joined in all sessions. This has been invaluable to the service as he knows the participants well and is an enthusiastic advocate for the session. He also holds important information about each individual and their physical condition and will inform the dance artist of any difficulties or issues that may affect the patient's ability to participate in the dance session.

U3A – University of the Third Age Alsager and District

A talk was given by staff from the Integrated Discharge Team as part of an event organised by the U3A which covered the role of the team and the discharge process. Members of the U3A were able to ask questions and gain a greater understanding of plans made for patients when they leave hospital.

St Matthew, Haslington and St Michael All Angels, Crewe Green Branch

Members of the branch have been providing emergency toiletry bags to the Trust for our patients for the last 12 years and delivered the latest donations. The bags are distributed to patients by housekeepers in wards and departments, mainly to patients admitted as emergencies who do not have these items or patients who do not have family members or carers to provide these. The bags are always well received by patients and we appreciate the support from the branch.

Book Club

A book club has been set up for patients on Ward 21b (Rehabilitation). Members of the Crewe and Nantwich book club come in pairs and attend the ward after the evening meal and meet with patients and the senior librarian from the JET library and with the voluntary services manger. Volunteers take it in turn to read sections of the story and then they have a discussion about the content.

Healthwatch – Cheshire East and Cheshire West and Chester

The Trust has worked closely with both Healthwatch groups during the year. Healthwatch Cheshire East have conducted several Enter and View visits, including to the Frenulotomy Service (tongue-tied). The service is able to perform frenotomies on babies experiencing posterial and anterior ties. Submucosal ties procedures are carried out by ENT (ear nose and throat) clinicians with a 2-4 week waiting time. The frenulotomy service at MCHFT has strong links with external community organisations, such as CHERUBS (a breast feeding support team in Cheshire) and the Infant Feeding Team who are the main referrers into the service. The frenulotomy service is offered on a weekly basis (Fridays) with a current waiting time of 7 days. Each family is offered a 45 minute appointment in which a pre-consultation is provided, the procedure, and support with breast feeding post procedure. During the visit Healthwatch had the opportunity to observe a family and their new born baby boy (4 days old) who had been referred to the clinic by the infant feeding team with a suspected tongue tie. The family were very complimentary of the infant feeding team and noted their daily phone calls had been invaluable. Before the procedure took place, information was provided to the family and images shown to describe what a tongue tie is and advice was given as to what the procedure would entail.

Healthwatch Cheshire East are having regular displays to promote their role and to seek the views of patients.

Royal Voluntary Service befriending programme

The Royal Voluntary Service (RVS) provides a dementia befriending service on wards 4, 7 and 15. Volunteers come in and work one on one with a patient. The volunteers engage in activities to keep the patient engaged and stimulated. This could be simply chatting to the patient, reading the Daily Sparkle together, colouring pictures, completing puzzles or playing board games. The RVS volunteer can also assist with meal times and helping the patient to eat as long as they have completed the patient feeding course. This could be providing encouragement to eat, helping with unwrapping cutlery or actually feeding the patient if they no longer are steady with their own cutlery. There are currently 40 RVS volunteers providing this assistance each coming in for a couple of hours each week.

Customer Care Team

The role of the Customer Care Team is to provide on-the-spot advice, information and support for patients and relatives if they wish to raise concerns. The team can also support patients when dealing with issues about NHS care and provide advice and information about local health services. The Customer Care team aims to respond to patients concerns and issues in a

timely and effective manner, irrespective of whether they have been raised as an informal concern or a formal complaint. The majority of concerns can usually be resolved swiftly by those staff who are caring for patients. However, sometimes patients or a family may want to talk to someone who is not involved in their care and the Customer Care Team are then able to help.

The Customer Care Team also receives Ecards from relatives who chose to send messages in this way. This year, 7 Ecards were delivered to patients in the Trust between April and December 2016

Compliments

1,872 formal compliments were received by the Trust during 2016/17 which expressed thanks from patients and families about the care received. This is a slight decrease compared with previous years. All compliments are shared with the relevant teams who are mentioned.

	2013/14	2014/15	2015/16	2016/17
Number of compliments received	2,112	1,960	1,727	1,872

Table 1: Overview of compliments received by the Trust

Review of complaints

The Trust adheres to the Local Authority Social Services and National Health Service Complaints Regulations (England) 2009 and follows the Principles of Good Complaint Handling outlined by the Parliamentary and Health Service Ombudsman.

The Trust is committed to providing an accessible, fair and efficient service for patients and service users who wish to express their concerns or make a complaint with regard to the care, treatment or services provided by the Trust. The Trust promotes the Healthwatch advocacy service to anyone making a complaint to highlight independent support available. The Trust promotes the Healthwatch advocacy service to anyone making a complaint to highlight the independent support available. To help raise awareness of this service, the Trust has, this year, developed a new poster to promote support on making a complaint, entitled 'Supporting your Voice in the NHS'.

The Trust recognises the importance of having a robust and flexible process for the management of complaints to ensure complainants receive a timely and person-centred response to the issues they have raised.

The complaints policy clarifies that the Chief Executive is the 'responsible person' with overall accountability for the complaints process. She ensures compliance with the regulations, that complaints are fully responded to and actions are implemented in the light of the outcome of the complaint review.

The complaints review group is chaired by the Director of Nursing and Quality and has a Governor and patient representative amongst its members. The panel reviews individual cases of closed complaints and follows best practice as recommended by the Patient's Association in monitoring progress against action plans and undertaking detailed reviews.

All complaint meetings are recorded and a copy of the CD is given to the complainant at the end of the meeting. The Trust is also able, with the consent of the complainant, to provide copies of the disc to external bodies such as the Coroner's Office and The Parliamentary Health Service Ombudsman to assist them in their information gathering.

The Customer Care Team is active in seeking the views of their service users and send out surveys to complainants in order to gain feedback. Responses from the surveys last year did highlight that clarification was needed regarding the purpose of the survey. With this in mind, the Customer Care Team developed a new questionnaire to alleviate this problem and to gain further insight into the service they provide.

This was discussed at the complaints review group which led to further discussions with the Picker Institute's national group to update the survey questionnaire to enable the Trust to meet national standards and recommendations for future surveys.

The newly updated questionnaire is now part of a new initiative where, rather than carrying out an annual survey, complainants are sent a copy of the survey approximately 60 days following closure of their complaint. This allows current feedback to be utilised by the team to initiate immediate changes where a sudden trend is being identified, and also long term improvements to the efficacy of the process.

The initiative was introduced in October 2016 and early analysis is that this is a positive move to receiving feedback on current concerns.

Some of the key themes of complaints received in 2016/17 were on nursing care, delays and communication. Examples of these are summarised in the table below together with actions taken to address the concerns raised.

Themes	Actions Taken
Emergency Department: **When the ED is busy, patients are left on trolleys in the corridor with nobody looking after them or taking responsibility while waiting for medical review or transfer to a ward.**	There is now an extra nurse on each shift in the emergency department to provide additional support to patients.
Eye Care Centre: **Patients attending for cataract day**	There are now staggered appointment times for patients to

surgery in the treatment centre were experiencing long delays as all patients for the session arrived at once.	arrive for their day surgery. This reduces the overall time spent in the hospital for the procedure.
Women & Children's: Communication concerns when contacting the triage team following severe post-partum bleeding. Documentation was incorrect and messages not linked from several calls.	There are now 2 separate log books for antenatal and postnatal calls to ensure continuity when several contacts made. Staff have been informed of the appropriate questions to ask when severe post-partum bleeding is reported.

Table 2: Examples of complaints and actions taken

The following table shows the number of complaints received by the Trust and referrals to the Ombudsman over the past 3 years.

	2013/14	2014/15	2015/16	2016/17
Number of complaints received	228	254	283	263
Number of requests for review by Ombudsman	3	6	7	6
Number accepted for review by Ombudsman	1	4	5	6
Number upheld/partially upheld by Ombudsman	2	1	7*	0**

*The complaints upheld / partially upheld by the Ombudsman include those complaints that had been referred to them in previous years.
**3 cases have not yet been closed within 2016/17.

Table 3: Overview of complaints received by the Trust

A poster has been developed to illustrate improvements that have been made as a result of feedback from patients or their carers. This poster, entitled “you Said, We Did” is shared with staff in all areas across the Trust.

Learning disability access.

The Trust has had another successful year in ensuring that people with a learning disability (LD) have equitable access to care and services. The Trust continues to make reasonable adjustments (required by law as laid down in the Equality Act 2010) for our most vulnerable patients, which enhance the hospital experience for both patient and carer.

This year we have implemented a phlebotomy clinic specifically for patients with a learning disability.

The clinic is run by specialist staff who have a sound understanding of this unique client group, and has been extremely successful. The clinic runs in the evening so the department is empty, and the time slots available are flexible and appropriate for each individual patient.

Patients attend the clinic with their family and/or carers and bloods are obtained in a very person-centred way. The clinic downloads games and pictures onto an IPad to help relax the patients when the blood is being taken, and refreshments are provided throughout. The Trust works alongside families and carers to find out about the person first, so we can adopt our approach and the environment to suit.

The clinic has been set up with a generous donation from the Prostate Support Group, which enabled the team to buy items such as a television, a CD player and pictures for the walls.

Referrals are taken from families, carers, GP's and members of the LD community services. Feedback so far has been very encouraging, particularly in respect of the flexibility of appointments and the environment itself.

The Trust continues to make reasonable adjustments for LD patients on an individual basis, and the following case study demonstrates our commitment and dedication to getting it right. The case study is presented in line with the six safeguarding principles (Department of Health, 2011).

Case study

This patient story involves patient **A** with a severe learning disability. **A** was undergoing two procedures at the same time.

The procedures were booked, both specialties organised to attend theatre and the mental capacity assessment and best interest checklist completed with the patient. **A's** carers were present at the meeting plus an advocate as there were safeguarding concerns raised in relation to **A's** family. We also involved LD Health Facilitation at this point.

Background
On the day of the operation, **A** failed to attend. **A's** carers were contacted and we were told that they did not know **A** was due to be admitted. Attempts had been made to confirm the date with the carers and messages left for them with all the details. Communication had broken down and the carefully laid plans had failed to come to fruition.

Plan
Despite the obvious difficulties, everyone involved with **A** knew that we needed to get these procedures completed in **A's** best interests. We discussed the requirements again, and a pre-operative assessment (POAC) date was given to **A's** carers, plus a date for the procedures themselves. On the day of the pre-op, **A's** Care Manager telephoned to say that **A** couldn't attend as it would be too much for **A** to come to POAC during the same week as the procedures themselves! This issue had not been raised with us before and left us with the dilemma of having to arrange POAC requirements such as a blood pressure recording, MRSA swab and **A's** weight and height.

Empowerment
A lacks capacity to consent and as such a best interest meeting was held to discuss the planned procedures. Liaison took place with **A's** advocate and **A's** GP.

It was agreed that blood tests would be taken once **A** was asleep as this was notoriously difficult to do under normal circumstances.

Two necessary procedures were to be undertaken under the one general anaesthetic.

Protection
As stated in this safeguarding principle we have a "positive obligation to take additional measures for patients who may be less able to protect themselves".

Reasonable adjustments made for this patient included:

- Being first on a morning theatre list
- Patient's own carer to be present right until **A** asleep, and then straight away once **A** awake in recovery
- **A** not to wear a hospital gown or bracelet as this would distress **A**
- Pre-med on arrival
- Emlar cream prior to cannula insertion
- Treat post-operatively
- All procedures to be undertaken under the one general anaesthetic
- The LD Health Facilitator visited **A** at home prior to the procedure to obtain a BP recording, take the MRSA swab and record **A's** height and weight.
- Give flu job once asleep

Prevention
A was supported whilst **A** waited for **A's** pre-med to work. **A** brought in items from home to keep calm and entertained.

A's care staff knew **A** very well and could easily pick up the signs when **A's** levels of anxiety were increasing.

A also had the support of the LD Health Facilitator on the day of the procedure. The facilitator had completed a care plan for **A**, which had been shared with hospital staff prior to **A's** admission. This enabled us to understand **A** in greater depth and be aware of **A's** likes, dislikes and how to minimize **A's** distress.

Proportionality
A was a day case and first on the morning list. This meant that **A** could go home as soon as possible after the procedure. The fact that we were able to undertake two procedures plus obtain baseline bloods and give a flu job under the same anaesthetic, demonstrated our commitment to being least restrictive to **A's** rights.

Partnership
There was effective liaison between hospital staff, **A's** GP, the care staff, advocacy and LD Health Facilitation.

We all worked together to ensure that **A's** procedures were carried out, despite initial setbacks.

The care plan completed by the LD Health Facilitator was particularly helpful

Accountability
Advocacy were involved with **A** because there were safeguarding concerns raised in relation to **A's** family support.

We are accountable to our patients, and as such, aware of the need for an Independent Mental Capacity Advocate to support **A** throughout this admission.

We also were aware that we needed to work with our partner agencies in an open and transparent way to ensure **A** received the treatment **A** required.

Outcome
A's treatment was carried out, as planned, and **A** went home with their carers fairly soon after waking up from the anaesthetic.

Communication links with **A's** carers have improved following the initial failings, and I am confident that future interventions will go smoothly.

Implementing the Duty of Candour

The Trust has a contractual duty to be open and honest; the Statutory Duty of Candour ensures that all healthcare providers must 'notify anyone who has been subject to an incident which has resulted in moderate harm, serious harm or death (Department of Health, 2013). The Trust is committed to being transparent, open and honest when things go wrong with patients and or their relatives or carers. This is reflected in the Trust's *Being Open* (including Duty of candour) policy.

When an incident is identified as having resulted in moderate harm, serious harm or death the Trust informs the patient or their relatives or carers as early as possible following the incident. The patient and or their relatives or carers are provided with an apology and explanation of the incident and any investigations which will be conducted. The patient and or their relatives or carers are provided with contact details of a senior member of the Trust to contact if they have any queries. They are also informed that the investigation report (root cause analysis) and resulting action plans and lessons learned will be shared following the review.

Where appropriate the patient and or their relatives or carers are involved in the investigation to ensure all lessons are learned. An example of this is when a patient falls in hospital; the fall is discussed with the patient to establish what they believe to be the cause of the fall and if anything could have been done to prevent the fall.

Once the investigation has been completed the report, action plan and lessons learned are shared with the patient and or their relatives or carers to

ensure that they are satisfied that any lessons learned will help to prevent future incidents.

In 2016/2017, the Duty of Candour was undertaken for all incidents which resulted in moderate harm, serious harm or death.

Progress towards the 'Sign up to Safety' campaign

The Trust is committed to consistently delivering safe care and taking action to reduce harm to patients in its care.

The Trust is supportive of the NHS England national 'Sign up to Safety' campaign which has the goal to reduce avoidable harm by 50% and save 6,000 lives.

The trust has officially signed up to the campaign and has committed to taking action in the following five pledges:

1) Put Safety First

We will....

- ensure the Summary Hospital-Level Mortality Indicator (SHMI) will remain at or below 100 from April 2015
- reduce avoidable pressure ulcers by X% across the hospital wards and by X% in the community by January 2018.
- reduce inpatient fall incidents by 10% by January 2018
- ensure the prompt recognition and treatment of Acute Kidney Injury (AKI), ensuring that 90% of patients are receiving appropriate care as per the AKI pathway by January 2018
- ensure the prompt recognition and treatment of sepsis, ensuring that 90% of patients are receiving appropriate care as per the sepsis pathway by January 2018
- have zero tolerance of Never Events within the organisation.

2) Continually Learn

We will....

- determine the organisation's safety culture, identify areas for improvement and action accordingly to time and target, working in partnership with staff and stakeholders
- continue to develop information systems to support clinical dashboards, improving access to clinical outcome data and acting on these to improve
- use available data to create a dynamic risk profile which will provide an early warning system, reduce risks and support continual improvement
- review and improve action planning processes, accountabilities and responsibilities. Prioritise action plans that are high impact and develop organisation systems for shared learning. Ensure there is a link to learning from safety culture assessment.

3) Honesty

We will....

- always tell our patients and their families / carers if there has been an error or omission resulting in harm
- publish patient safety information on our website
- continue to raise awareness of being open with our staff and ensure that this is included in all our patient safety training.

4) Collaborate

We will....

- continue to work with the Advancing Quality Alliance (AQuA) to develop a cohort of staff with quality improvement skills and share benchmarking information to improve quality and safety
- work with partners to share best practice and improve clinical pathways for patients. These partners include NHS South Cheshire and Vale Royal Clinical Commissioning Group and University Hospitals of North Midlands NHS Trust
- share outcomes from national clinical audits and our participation in research programmes to ensure improvements are implemented across the organisation
- continue to work with AQuA in developing a cohort of patient safety champions within our organisation.

5) Support

We will....

- continue the Trust programme of quality improvement training in collaboration with AQuA
- continue to develop our medical staff through the Clinical Leadership Programme
- further develop our programme of patient safety training, educating staff in human factors and why things go wrong
- continue to develop our newly-appointed Consultants through the Consultant Foundation Programme which includes education and support on safety, change and managing behaviours
- work together to respond to feedback from patients and carers and to learn from incidents that occur. We will then ensure we respond to such learning and embed this into practice.

The Trust identified six areas for improvement to enable the Trust to support the Sign up to Safety campaign.

The six areas chosen by the Trust were:-

- Mortality
- Pressure Ulcers
- Falls
- Acute Kidney Injury
- Sepsis
- Never Events

A driver diagram was developed for each of the six chosen areas.

The six aims have been incorporated into the organisation's Quality and Safety Improvement Strategy, 2016-2018. The Strategy is monitored by the Quality and Safety Improvement Strategy Group with escalation to the Executive Quality Governance Group. Progress against the six aims can be found in section 3 of the quality accounts.

The progress of the Sign up to Safety Campaign is monitored quarterly by the Executive Quality Governance Group.

Feedback from staff

The NHS staff survey is undertaken by all NHS Trusts on an annual basis. The Quality Account Reporting Arrangements require the Trust to report on the responses for the following questions for the Workforce Race Equality Standard:

- The percentage of staff who report that they have experienced harassment, bullying or abuse from staff in the last 12 months.

The Trust score in 2016 was 25% which is no change from the 2014 result. This result is consistent with other acute NHS Trust's and falls within the 'average' bracket. The scores for White and Black and Minority Ethnic (BME) staff as required for the Workforce Race Equality Standard are as follows:

Key Finding		2015	2016
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White	23%	24%
	Black and Minority Ethnic	33%	19%

The results from 2016 show that there has been a significant reduction of 14% in BME staff who had experienced harassment, bullying or abuse from other staff members. In comparison there was a slight increase of 1% compared to 2015 in White staff who reported experiencing harassment, bullying or abuse.

- The percentage of staff who believe the Trust provides equal opportunities for career progression or promotion

90% of staff who completed the 2016 staff survey believe that the Trust provides equal opportunities for career progression and promotion. This is a slight increase of 1% from the previous year. The national average was 87%. This result put the Trust in the best 20% of all acute trusts in 2016.
The scores for White and BME staff as required for the Workforce Race Equality Standard can be found in the table below:

Key Finding		2015	2016
Percentage of staff believing the organisation provides equal opportunities for career progression and promotion	White	92%	91%
	Black and Minority Ethnic	79%	86%

86% of BME staff reported in 2016 that they feel the Trust provides equal opportunities for career progression and promotion, an increase of 7% compared to 2015. 2016 saw a slight decrease of 1% compared to the previous year for White staff.

Progress Report on Equality and Diversity

Equality and Diversity at Mid Cheshire Hospitals NHS Foundation Trust is led and monitored by the Equality and Diversity Group which meets quarterly. The terms of reference of the group have been revised in 2016 with membership widened to look to include a greater representation across the Trust.

New equality objectives have been identified and agreed for 2016-2020 which are as follows:

- To make our information and services accessible to the people we serve.
- To increase support for LGBT staff.
- To encourage the recruitment conversion and progression rates of black, Asian and minority ethnic (BME) staff.
- To work with partners to identify and implement methods of raising awareness of modern exploitation issues (e.g. forced marriage, female genital mutilation (FGM), human trafficking, modern slavery and child sex exploitation).

Progress has already been made against the objectives and work is currently underway in forging links with community groups in the local area.

In February 2017 the Trust celebrated LGBT History Month (Lesbian, Gay, Bisexual and Transgender) by flying the rainbow flag outside the main entrance at Leighton Hospital. Body Positive Crewe and North Wales also attended an event in February to provide information and raise awareness of issues faced by LGBT people.

The final draft of the Equality and Diversity Annual Report for 2016 is currently being finalised. The report reviews the objectives set for the period 2012-2016. This will be reported to several committees in February/March 2017 for approval and published on the Trust website.

The Annual NHS Staff Survey asks NHS employees a broad range of questions seeking their views on and experience of staff satisfaction, training, line management, appraisals and making a difference to patients. Our 2016 Staff Survey identified that satisfaction levels across all staff has improved year on year and the gap between satisfaction levels between staff with a disability and without is closing with satisfaction levels of staff with a disability improving by 4.6%.

The Trust continues to see a disproportionate conversion within the gender and ethnic diversity strands of the recruitment monitoring information but this has improved in both cases over the course of the past year. There has been a change to the Trust's recruitment policy in that all persons undertaking recruitment activity must now go through Trust recruitment and selection training, and the training itself has an increased focus on diversity and bias. It appears that this is now having a positive impact on our outcomes in these areas.

We are continually looking to improve the equality information that we hold about our patients and staff and this is an ongoing priority. There has been an improvement in the equality data that is recorded for staff, with more staff choosing to disclose equality data compared to previous years.

The Trust Equality Delivery System report for 2016 has now been published and was presented to the Healthwatch Board. This is a tool to help us to understand how equality can drive improvements and strengthen the accountability of services to patients and the public. The Trust continues to be 100% compliant with the specific duties outlined in the public sector equality duty as outlined in the Equality Act 2010

The Trust continues to ensure the completion of an Equality Impact Assessment (EIA) for each new service and policy. A complete set of EIAs was completed in 2014 as part of the 3 yearly update requirements for all existing services and policies and therefore will be fully reviewed in 2017.

Statements of assurance from the board

Review of services

During 2016/17 the Trust provided and/or sub-contracted 40 relevant health services.

The Trust has reviewed all the data available to them on the quality of care in all of these relevant health services.

The incomes generated by the relevant health services reviewed in 2016/17 represents 100% of the total income generated from the provision of relevant health services by the Trust for 2016/17.

Participation in Clinical Audits

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 2016/17, 32 national clinical audits and 3 national confidential enquiries (Clinical Outcome Review Programmes) covered NHS services that MCHFT provides.

During that period, MCHFT participated in 97% national clinical audits and 100% national confidential enquiries (Clinical Outcome Review Programmes) of the national clinical audits and national confidential enquires (Clinical Outcome Review Programmes) which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Trust was eligible to participate in during 2016/17 are shown in table X

The national clinical audits and national confidential enquires that the Trust participated in during 2016/17 are shown in table X

The national clinical audits and national confidential enquires that the Trust participated in, and for which data collection was completed during 2016/17, 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.

Table X: National Clinical Audit Participation 2016/17

National Clinical Audit and Clinical Outcome Review Programme	Participation	Data submission
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	100%
Adult Asthma	Yes	16 cases
Asthma (paediatric and adult) care in emergency departments	Yes	100%
Bowel Cancer (NBOCAP)	Yes	75%*
Case Mix Programme (CMP)	Yes	100%
Child Health Clinical Outcome Review Programme	Yes	100%
Diabetes (Paediatric) (NPDA)	Yes	100%
Elective Surgery (National PROMs Programme)	Yes	81%
Endocrine and Thyroid National Audit	Yes	26 cases*
Falls and Fragility Fractures Audit programme (FFFAP)	Yes	83%*
Head and Neck Cancer Audit	Yes	100%
Inflammatory Bowel Disease (IBD) programme	Yes	17 cases*
Learning Disability Mortality Review Programme (LeDeR Programme)	Yes	NA
Major Trauma Audit	Yes	93.2 - 100+%*
Maternal, Newborn and Infant Clinical Outcome Review Programme	Yes	100%
Medical & Surgical Clinical Outcome Review Programme	Yes	100%
National Audit of Dementia	Yes	100%
National Cardiac Arrest Audit (NCAA)	Yes	NA
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme	Yes	NA
National Diabetes Audit - Adults	Yes	100%
National Emergency Laparotomy Audit (NELA)	Yes	102 cases*
National Heart Failure Audit	Yes	42%*

National Joint Registry (NJR)	Yes	100%
National Lung Cancer Audit (NLCA)	Yes	100%
National Ophthalmology Audit	Yes	100%
National Prostate Cancer Audit	Yes	42%**
Neonatal Intensive and Special Care (NNAP)	Yes	100%
Oesophago-gastric Cancer (NAOGC)	Yes	81-90%
Paediatric Pneumonia	Yes	NA
Percutaneous Nephrolithotomy (PCNL)	Yes	19 cases*
Rheumatoid and Early Inflammatory Arthritis	Yes	27 cases*
Sentinel Stroke National Audit programme (SSNAP)	Yes	100%
Severe Sepsis and Septic Shock – care in emergency departments	Yes	100%
Stress Urinary Incontinence Audit	Yes	14 cases*

* Based on most recent report or online data
** Minimal aspects of care then
NA Data submission in progress or due to commence

Table X: National Clinical Audit Non-Participation 2016/17

National Comparative Audit of Blood Transfusion - Audit of Patient Blood Management in Scheduled Surgery	No	Resource implications

The reports of 23 national clinical audits were reviewed by the provider in 2016/17 and the Trust intends to take the following actions to improve the quality of healthcare provided:

Table X: National Clinical Audit Participation 2016/17 – Actions

National Clinical Audit	Actions Taken / To Be Taken
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Report awaited. Work undertaken to improve data collection through local audit pro-forma highlighting mandatory fields which has significantly improved the dataset

Bowel Cancer (NBOCAP)	Work underway to improve the enhanced recovery program through identification of a nurse link on colorectal ward, engaging Health Care Assistants with ERAS and stoma care, increased Colorectal Nurse Specialist hours to drive ERAS and improving data capture and completeness.
Case Mix Programme (CMP)	Review of delayed discharges and bed availability in progress. Case outliers discussed through MDT process highlighting any actions required through Trust Critical Care Delivery Group. Data submission and rates of infection remain good.
Diabetes (Paediatric) (NPDA)	Delivery of key care processes remains very good and above national achievement. MCHFT continues to not routinely screen for cholesterol, in keeping with recent NICE guidance and communication with the National Clinical Director the NPDA has confirmed that discussion is underway to remove this from the list of key care processes for future national audits.
Elective Surgery (National PROMs Programme)	The objective is to ensure that at least 85% of patients receive a pre-operative PROMS questionnaire if they are undergoing surgery for: i. Groin hernia ii. Varicose Vein Surgery iii. Hip replacement Surgery iv. Knee replacement Surgery Work has been undertaken to ensure patients receive a pre-operative questionnaire and ensure compliance with the 85% target.
Inflammatory Bowel Disease (IBD) programme	Improved the care for patients receiving Biologic therapy in line with NICE guidelines with the assistance of the Blueteq database. Further improvements under discussion include a second IBD nurse and a set-up session for patient review on the Planned Intervention Unit when receiving medication.
Major Trauma Audit	Identified as one of the highest performing Trauma units in the Country, the 5th highest nationally for data submission. Work continuing to progress where transexamic acid is required within 3 hours of injury.
Maternal, Newborn and Infant Clinical Outcome Review Programme	793B - Standard process pathway to be developed for all late fetal losses, stillbirths and neonatal deaths. Fetal Loss Pack to be updated for babies born between 22+0 and 23+6 week gestation to ensure an electronic adverse incident form is completed and case review is carried out and reported to MBRRACE –UK.
Medical & Surgical Clinical Outcome Review Programme	1815 - Work is in progress to formalise partnership working with UHNM and potentially provide three ERCP lists and an extra hot gallbladder list. A routine nutrition assessment tool is being implemented and changes in practice for alcohol services review of patients admitted with alcohol related pancreatitis.

National Diabetes Audit - Adults	Report under review. Work undertaken to enable participation in National project and submission of secondary care data.
National Emergency Laparotomy Audit (NELA)	The main clinical outcome of thirty day mortality (crude & risk adjusted) is favourable, as is the percentage of patients requiring a return to theatre. Improved communication of risk and ownership of data is being facilitated between surgeons, anaesthetists and critical care as a focus for improving emergency surgery.
National Heart Failure Audit	Work in progress to address data discrepancies in heart failure cases where patients are not seen on the Cardiology Ward, which impacts on Trust data capture and completeness.
National Lung Cancer Audit (NLCA)	Work underway to improve data collection and completeness with reference to Performance Status and CNS contact. Re-audit NOS histological confirmation rates. Establish support worker role to enhance patient experience and facilitate Cancer pathway.
National Prostate Cancer Audit	Report limited to case ascertainment and data completeness due to issues with data extraction by the project host. Work continued locally to improve quality and submission of data.
Neonatal Intensive and Special Care (NNAP)	Education in progress for all clinical staff around reporting every neonatal admission with temperature < 36 C. System for reported incidents to be reviewed and actioned through existing risk governance structure. Local audit of temperature regulation care bundle planned.
Oesophago-gastric Cancer (NAOGC)	To complete audit on temperature monitoring / temperature regulation care bundle
Percutaneous Nephrolithotomy (PCNL)	Work underway to further decrease post-operative stay through comprehensive nephrostomy care and early patient education, suitable post-operative pain management and nephrostomy removal as an outpatient/attendance instead of re-admission.
Rheumatoid and Early Inflammatory Arthritis	Actions in progress include modification of referral pathway to include early inflammatory arthritis in the choose and book, education for GP's around referral pathways and development of a business case agreed with CCG for Best Practice Tariff Clinic.
Sentinel Stroke National Audit programme (SSNAP)	Work ongoing towards provision of a seven day specialist ward round rota following development of a seven day working business case. Training in place for thrombolysis training in line with stroke guidelines. Review of inter-disciplinary therapy standards to evidence requirement for therapy input as part of wide Community Service project.
VTE Risk in Lower Limb Immobilisation in Plaster	Guideline for the use of low molecular weight heparin in patients with lower limb injuries, based on College of

Cast (CEM 2015-16)	Emergency Medicine guidance, developed, approved and implemented.
Procedural Sedation in the Emergency Department (CEM 2015-16)	Work ongoing around trainee education in the use of the reviewed sedation pro-forma and relevant documentation. The possibility of using a sticker for sedation is under discussion.
Vital Signs in Children (CEM 2015-16)	Good practice demonstrated with patients being assessed by more experienced ED staff and abnormal vital signs were noted and acted upon. Education in progress around neurological assessment for triage nurses and repeat observations within 60 minutes for abnormalities.
National Smoking Cessation Audit (BTS)	The Trust was fully compliant with all measures

Local Clinical Audits

The reports of 88 local clinical audits were reviewed by the provider in 2016/17 and the Trust intends to take the following actions to improve the quality of healthcare provided:

Local Clinical Audit	Actions Taken / To Be Taken
Exclusion of Lens During routine CT Head exam at MCHFT	Causes of non-compliance of lens of eye not being exposed during head CT were due to suboptimal positioning of head, inadequate equipment and improper planning of the scan. Actions taken included an update to the local protocol and raised awareness of this for all Radiographers and Medical Imaging Assistants; replacement head sponge ordered; the importance of positioning was re-enforced with reminder posters placed in the CT control room; positioning recorded on Soliton radiology system.
Are Central Lines Being Assessed Correctly for their Position on Chest X-ray?	Variability in the position of right internal jugular central line tips, the majority of which were judged to be too high and low compliance with new recommendations suggested in AAGBI guidance. Actions in progress include agreed Critical Care department guidelines on vascular access to include optimum tip position; development of an aide-memoire for trainees on critical care; review of equipment availability with regard to vascular access devices, with particular consideration of the availability of a range of line lengths to enable correct tip position from a range of access sites.
Delay for Hip Fracture Surgery due to Warfarin	22% of the patients sampled had their surgery delayed due to persistently elevated INR results requiring further treatment, which has an impact on patient safety and care. Actions taken included updating the current guideline to recommend giving 2mg Vitamin K immediately to patients on Warfarin irrespective of the INR on admission; bloods sent

	on admission as normal and further actions recommended per protocol
Delay in Elective Caesarean Section	Delays in lists commencing were predominantly due to emergency cases and midwifery workload. An issue was highlighted in communicating delays to patients. Actions underway include improved documentation of reasons for delay and the potential for electronic collection of data (using Medway); investigate the potential for a 3 day week for elective CS and review of staffing to address delays related to emergency cases taking priority; high risk cases listed on Tuesday and Wednesday only.
Trustwide Falls Audit (Fall Safe Care Bundle)	The results showed that the FallSafe criteria was not all being adhered to and that a re-launch was required across the trust, which formed part of the Falls Safety Collaborative initiative being implemented piloting new ways of working. Actions taken included Best Practice Action Plans being issued for Ward Managers and Matrons to complete outlining the strategies for improvement specific to their Wards; a FallSafe Awareness Day to re-emphasize the topic of falls; continue to increase knowledge of falls and procedures and actions that should be undertaken to help prevent falls from occurring

Participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2016-17 that were recruited during that period to participate in research approved by a research ethics committee was 162.

There were 8 clinical research staff participating in research approved by a Research Ethics Committee during the reporting period. Participation in clinical research demonstrates the Trust's commitment to improving the quality of care offered and contributing to wider health improvements. Clinical staff keep up to date with the latest treatment possibilities and active participation in research leads to successful patient outcomes. The Trust was involved in conducting 154 active clinical research studies during the reporting period including, but not limited to, the following areas:

- Cancer
- Cardiovascular
- Critical Care
- Diabetes
- Eyes
- Generic Health Relevance and Cross Cutting Themes
- Infection
- Inflammatory and Immune System
- Injuries and Accidents

- Paediatrics
- Musculoskeletal
- Oral and Gastrointestinal
- Primary Care
- Reproductive Health and Childbirth
- Respiratory
- Skin
- Stroke

Commissioning for Quality & Innovation framework (CQUIN)

The CQUIN framework was introduced in April 2009 as a national framework for locally agreed quality improvement schemes. These schemes require the development of clear plans and goals through agreement between providers and commissioners.

A proportion of the Trust's income in 2016/17 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2016/17 and for the following 12 month period are available electronically at:

http://www.mcht.nhs.uk/information-for-patients/why-choose-us/quality/

The overall financial value of CQUIN schemes is currently 2.5% of the provider's contract value.

The financial value of the 2016/17 CQUIN scheme for the Trust was £3,510,106. The total amount the Trust received in payment for the CQUIN scheme was £……..

The financial value of the 2015/16 CQUIN scheme for the Trust was £3,798,574.

For 2016/17, there are **three** national goals which focus on NHS staff health and wellbeing (goal one), Sepsis (goal two) and Antimicrobial resistance and stewardship (goal three).

MCHFT and the Clinical Commissioning Groups (CCGs) for Vale Royal and South Cheshire have agreed a further **nine** goals (goals four to twelve).

Public Health England has agreed **two** goals which relate to the breast and bowel screening programmes (goals thirteen and fourteen).

The North of England Specialised Commissioners has negotiated **three** goals in relation to neonatal services and chemotherapy banding (goals fifteen to seventeen).

Table X briefly describes the goals included in this year's CQUIN and the Trust's performance against each of the CQUIN goals.

Key for Table X (CQUIN results for 2016/17):

Achieved 

Partially Achieved 

Not achieved 

Goal No.	Goal name	Description of Goal	Financial Value of goal (£)	Status
1.	Introduction of health and wellbeing initiatives- **Option B**	Implementation plan covering physical activity, mental health and improving access to physiotherapy for people with MSK issues.	396,107.00	
	Healthy food for NHS staff, visitors and patients	The responses to the 11 questions below will form part of a national data collection. Providers will submit the responses by July 2016 via UNIFY following locally agreed sign off process by the commissioner.	396,107.00	
	Improving the uptake of flu vaccinations for frontline clinical staff	Achieving an uptake of flu vaccinations by **frontline clinical staff** of 75% by Q3	396,107.00	
2.	ED Sepsis Screening The percentage of patients who met the criteria for sepsis screening and were screened for sepsis **Payment based**	Focussed on incentivising the screening of a specified group of adult and child patients in emergency departments and other units that directly admit emergencies. The ED screening element of the CQUIN requires an established local protocol that defines which emergency patients require sepsis screening. Local adaptation will be needed to reflect the types of Early Warning Score in local	79,221.00	

	on 90 % of eligible patients screened for each quarter	use for children and adults.		
	ED Sepsis Antibiotic Administration % of patients presenting with severe sepsis, Red Flag Sepsis or septic shock and had an empiric review within three days of the prescribing of antibiotics.	To rapidly initiate intravenous antibiotics, within 1 hour of presentation, for those patients who have suspected severe sepsis, Red Flag Sepsis or septic shock. An empiric antibiotics review is carried out by a competent decision maker by day 3 of them being prescribed	118,832.00	✖
	Acute inpatients Sepsis Screening The percentage of patients who met the criteria for sepsis screening and were screened for sepsis	Total number of patients sampled for case note review who were admitted to the provider's acute inpatient services that met the criteria of the local protocol and were screened for sepsis. The inpatient screening element of the CQUIN requires an established local protocol that defines which inpatients require sepsis screening. Local adaptation will be needed to reflect the types of scoring systems in local use for children and for adults.	79,221.00	✖
	Acute inpatients Sepsis Antibiotic Administration % of patients presenting with severe sepsis, Red Flag Sepsis or septic shock and had an empiric review within three days of the prescribing of antibiotics.	To rapidly initiate intravenous antibiotics, within 1 hour of presentation, for those patients who have suspected severe sepsis, Red Flag Sepsis or septic shock. An empiric antibiotics review is carried out by a competent decision maker by day 3 of them being prescribed	118,832.00	✔
3.	Antimicrobial Resistance and Stewardship Reduction in antibiotic consumption per	Reduction of 1% or more of total antibiotic consumption per 1,000 admissions. Reduction of 1% or more of carbapenem per 1,000 admissions	79,221.00 79,221.00	✖ ✔

	1,000 admissions	Reduction of 1% or more of piperacillin-tazabactam per 1.000 admissions Submission of consumption data to PHE for years: 2014/15 to 2016/17	79,221.00 79,221.00	✗ ✓
	Antimicrobial Resistance and Stewardship Empiric review of antibiotic prescriptions	Percentage of antibiotic prescriptions reviewed within 72 hours from agreed sample of 50 antibiotic prescriptions.	79,221.00	✓
Local CQUINs				
4.	Clinical Utilisation Review	Implement CUR initiative	282,749.00	Suspended
5.	Avoidable Admissions	Using available data from identified projects developed on the AQuA quality improvement programme, a progress report will provide an update of the projects the individual work-streams are undertaking that contribute to a reduction in avoidable hospital admissions Participants to present progress to Commissioners and Trust staff	79,221.00	✓
6.	VTE Exemplar Site	MCHFT to work towards 100% compliance of VTE Exemplar Centre Criteria	79,221.00	✓
7.	Breast Cancer Survivorship End of Treatment Summary and Care Plan for Primary Breast Cancer and Communication with GPs End of Treatment Summary and Care Plan for Primary Breast Cancer and Communication with GPs	All primary breast cancer patients risk stratified as low risk (supported self-management) and women who are vulnerable i.e. with a diagnosis of long term depression, serious mental illness, dementia or learning disability to ensure there are sufficiently timed clinic slots to ensure all identified women in the cohort receive an extended appointment.	174,287.00	✓

8.	End of Life Care Evaluation & presentation of audit data Education / training plans to use EPaCCS in place	Improve the care of patients who are likely to be in the last year of their life by enhancing communication between primary and secondary care through EPaCCS	158,443.00	✓
9.	Consultant Advice and Guidance Paediatrics, Orthopaedics and Haematology Dr Alan Adams / Michael Dearden Three prioritised specialties (Paediatrics, Orthopaedics & Haematology) to go live by 1 September 2016	MCHFT will support the roll-out of a Consultant Advice & Guidance solution (selected by the Commissioner) to go live ASAP after 1 April 2016. This will be accessible to all GPs working within NHS South Cheshire CCG and NHS Vale Royal CCG. MCHFT will work with the system supplier to offer Consultant input into at least three prioritised specialties (Paediatrics, Orthopaedics & Haematology) to go live by 1 September 2016	158,443.00	✓
10.	SAFER Flow Bundle Qtr. 3- Plan and Implement strategies to improve compliance with the SAFER bundle based on data recorded during quarters 1 and 2.	Implement the SAFER Patient Flow Bundle to improve patient flow and prevent unnecessary waiting for patients to be reviewed.	158,443.00	✓
11.	Cheshire Care Record (CCR)	To assist in the provision of a Cheshire Care Record (CCR) across the Pioneer footprint of Cheshire, it will provide a view of summary patient data that is read only and cannot be amended or added to by the users. The CCR will be used by Health and Social care professionals to support direct patient care only and incorporates data from the below organisations, linking to the existing West Cheshire Care Record under the IDCR Programme	158,443.00	✓

12.	Care Bundles Sepsis Acute Kidney Injury Pneumonia Alcohol Related Liver Disease	Report percentage of all eligible patients to receive all clinical interventions for each clinical condition Complete action plans to identify gaps and actions to achieve compliance for all measures in each care bundle Present update at Clinical Quality and Patient Safety Review meeting.	158,443.00	✓
Specialist Commissioning CQUINs				
13.	Bowel Cancer Screening Programme Review	To undertake a comprehensive review of communications / information available to stakeholders (patients, referrers) at all stages of the NHS screening pathway to identify the full range of resources available, their purpose, content, format and accessibility (languages).	21,982.00	✓
14.	Neonatal Critical Care – Two year follow up for preterm babies	It is recommended that all preterm babies born more than 10 weeks early (<30 weeks of gestation) should have a follow up evaluation 2 years after their due date (corrected age), to ensure that they are developing normally. Structured assessment at two years of corrected age is important to ensure that any effects of prematurity, e.g. visual impairment and intellectual development, are identified in a timely way to enable the appropriate management has been put in place to optimise outcomes.	25,970.00	✓
15.	Pre-term babies hypothermia prevention	The aim of this scheme is the prevention of hypothermia in preterm babies (<34 weeks) by routine monitoring within 1 hour of admission, and by taking corrective action. The ambition is for all units to be achieving 95% or more babies with a temperature of greater than or equal to (> =) 36^{o}C in 1 year.	25,970.00	✓
16.	Nationalised Standardised Dose banding Adult IV Systemic Anticancer Therapy (SACT).	A toolkit has been developed to support CQUIN. Realistic percentage targets will need to set for each of the 19 SACT drugs (9 are applicable to MCHT) determined by number of doses dispensed (numerator) by number of doses dispensed that match the dose banding (denominator).	25,970.00	✓

17.	Communication Breast Screening A review of specific resources should take place. This should include a review of the format, target group, content, language and method of delivery	To undertake a comprehensive review of communications / information available to stakeholders (patients, referrers) at all stages of the NHS screening pathway to identify the full range of resources available, their purpose, content, format and accessibility (languages).	21,982.00	

Feedback from Care Quality Commission (CQC)

The Trust is required to register with the Care Quality Commission (CQC) and its current registration status is **unconditional** which means there are no conditions attached to the registration.

The Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Following the CQC Comprehensive Inspection in October 2014 the Trust was an overall rating of “Good”. The inspectors identified that improvements were required to ensure that services were responsive to people’s needs but noted some areas of outstanding practice and innovation.

The Trust has updated its registration to include the services provided at Victoria Infirmary in Northwich and Elmhurst Intermediate Care Centre in Winsford. From 1st October 2016 the Trust entered into a partnership (non-legal entity) with Cheshire and Wirral Partnership NHS Foundation Trust and South Cheshire and Vale Royal GP Alliances to acquire Community Services for Cheshire East, commissioned by NHS South Cheshire CCG and NHS Vale Royal CCG. The Community Services Central Cheshire Integrated Care Partnership (CCICP) has been established. Services are managed and maintained by Mid Cheshire Hospital Foundation Trust (MCHFT) as the main provider. The application for Community services was submitted to the CQC on the 15th December 2016 and the Statement of Purpose was updated accordingly.

Last rated
15 January 2015

Mid Cheshire Hospitals NHS Foundation Trust

Overall rating	Inadequate	Requires improvement	Good	Outstanding

Are services

Safe?	Good
Effective?	Good
Caring?	Good
Responsive?	Requires improvement
Well led?	Good

Specific ratings were published for the sites inspected as per the tables below:

Last rated
15 January 2015

Mid Cheshire Hospitals NHS Foundation Trust

Victoria Infirmary

Overall rating	Inadequate	Requires improvement	Good	Outstanding

	Safe	Effective	Caring	Responsive	Well led	Overall
Urgent and emergency services (A&E)	Good	Good	Good	Requires improvement	Good	Good
Medical care (including older people's care)	Good	Requires improvement	Good	Requires improvement	Good	Requires improvement
Surgery	Good	Good	Good	Good	Good	Good
Intensive/critical care	Requires improvement	Good	Good	Good	Good	Good
Maternity and gynaecology	Good	Good	Good	Requires improvement	Good	Good
Services for children & young people	Good	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients	Good	Not rated	Good	Requires improvement	Good	Good

Last rated
15 January 2015

Mid Cheshire Hospitals NHS Foundation Trust

Leighton Hospital

Overall rating	Inadequate	Requires improvement	Good	Outstanding

	Safe	Effective	Caring	Responsive	Well led	Overall
Urgent and emergency services (A&E)	Good	Good	Good	Requires improvement	Good	Good
Medical care (including older people's care)	Good	Requires improvement	Good	Requires improvement	Good	Requires improvement
Surgery	Good	Good	Good	Good	Good	Good
Intensive/critical care	Requires improvement	Good	Good	Good	Good	Good
Maternity and gynaecology	Good	Good	Good	Requires improvement	Good	Good
Services for children & young people	Good	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients	Good	Not rated	Good	Requires improvement	Good	Good

Following the comprehensive inspection an action plan was developed around the key findings and has been submitted to the CQC. The action plan is monitored through the Executive Quality Governance Group and is progressing within the allocated timescales with a completion date of the end of April 2017.

The actions the CQC highlighted that the Trust MUST take to improve include:

- Ensuring that medical staffing is appropriate and sufficient at all times to provide appropriate and timely treatment of patients, including out of hours. In response to this the Trust developed a Business plan to increase the level of medical cover and began to appoint and train alternative staff to support activities from shortfalls in junior medical staff. This paper was approved in July 2015 and will progress towards 7 day services, recognising the limitations of this investment against the required resources to fully implement a 7 day service. With regards to the equitable provision of junior doctors, in November 2015 the Medical Director has taken on responsibility for arranging the Medical Directors Forum meetings for Cheshire and Merseyside. This topic will be included as an agenda item at the meetings. To assist with marketing the Trust and enabling it to actively pursue international recruitment a microsite was developed in March 2015. Additionally the Trust is working with other providers through a local health economy Provider Board to redesign existing service provision and develop new services to better manage patients outside hospital and reduce emergency admissions. The University Hospital of North Midlands (UNHM) is considered a key partner and this view is supported by the Board of Directors of both Trusts. Both Trusts' strategies are mutually supportive in that UHNM wish to increase specialist services and can only do this through reducing traditional district general hospital activity, whilst MCHFT have a strategy to increase traditional district general hospital activity; and in return, will support UHNM in further increasing its specialist activity.

- To improve patient flow and reduce the number of bed moves within the Trust the Patient Placement Policy has been reviewed, Clinical Site Manager cover has been increased and the Access and Flow Transformation Work Stream has been developed, which will monitor bed productivity and patient flow.

- The backlog of discharge letters has been cleared and monitoring continues to ensure that the improvements made are sustainable.

- Ensuring that escalation areas are appropriate environments for the care of patients and provide them with ready access to bathing and toilet facilities, the Trust has relocated the Primary Assessment Area (PAA) to a ward area with full patient facilities and reviewed its Patient Placement Policy and PAA procedure. The Royal Voluntary Service and Red Cross provide support for the internal volunteering service and discharge team.

Additional actions which have been taken throughout the Trust to improve care include producing guidance to staff on clinical supervision; provision of training and documents to ensure that staff are acting in accordance with patient's best interests when they are deemed not to have capacity; use of e-learning modules for mandatory training; implementation of an updated sudden death checklist for peadiatrics; development of partnership agreements with UHNM for upper GI Bleeds and Stroke thrombolysis; review of readmissions and improvement of the theatre utilisation within the Surgery & Cancer unit; commencement of the Advancing Quality diabetes pathway and the recruitment of a Diabetic Specialist Nurse; recruitment of a Sepsis Nurse and review of level 3 safeguarding training and implementation of documents and lessons learned from incidents.

The inspection process was extremely thorough and staff and patients alike can be assured that the services and treatments provided at MCHFT are fit for purpose and delivered by highly skilled, caring and committed staff.

Data Quality Assurance

NHS and General Practitioner registration code validity (April 16 – February 17 From NHS Digital SUS dashboard)

The Trust submitted records during 2016/17 to the secondary uses service for inclusion in the hospital episodes statistics which are included in the latest published data.
The percentage of records in the published data which included the patient's valid NHS number was:

- 99.8% for admitted patient care;
- 99.9% for outpatient care;
- 99.1% for accident and emergency care.

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

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

Clinical coding error rate

In 2016/17, the results from the IG toolkit audit are as follows:-

CODING FIELD	PERCENTAGE CORRECT	IG REQ 505 LEVEL 2
Primary Diagnosis	92.38%	90.00%
Secondary Diagnosis	96.34%	80.00%
Primary Procedure	95.55%	90.00%
Secondary Procedure	92.34%	80.00%

Please note that the results shown should not be extrapolated further than the

actual sample audited. A cross section of services was reviewed within this sample.

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

- Deliver the recommendations of the clinical coding audit
- Continue to deliver required training/individual audits for all clinical coders
- Continually review coding resources and performance

Information Governance toolkit attainment

The attainment levels assessed provide an overall measure of the quality of data systems, standards and processes within an organisation.

The Trust's Information Governance Assessment Report overall score was 94% and was graded green. There are 45 requirements in total within the toolkit. In order to be graded 'satisfactory', each requirement must be at level 2 or above. The Trust submission in 2015/16 showed 43 requirements were satisfactory and this has increased to 45 for 2016/17. The Trust is graded as "satisfactory" (status: green) for the first time.

Information Governance is continuing to renew all sharing agreements in place with third parties and to work with all departments to ensure that privacy impact assessments are in completed for all relevant projects within the Trust.

At final submission of the Information Governance Toolkit, the Information Governance team had supported the training of 4314 (97%) staff, students and volunteers over the course of 2016/17. The Trust met its target for the fourth year running to achieve the toolkit requirement of at least 95% of individuals being trained in information governance.

The Trust has a progressive Information Governance Group which meets quarterly and has an agenda which covers areas of work around the six sections of the toolkit. The outstanding requirements are highlighted at each group meeting and the toolkit leads are required to provide feedback on the progress of requirements. Additionally an Information Toolkit Action Group was established to support with the collection of evidence throughout the year

Performance against quality indicators and targets

National quality targets

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 number, percentage, value, score or rate (as applicable) for at least two reporting periods should be presented in a table. In

addition, where the required data is made available by NHS Digital, 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.

Period	Trust Performance	National Average	95% Upper Limit	95% Lower Limit
October 14 - September 15	98.42	1.00	not avail	not avail
January 15 - December 15	96.84	1.00	1.116	0.896
April 15 – March 16	100	1.00	1.116	0.896
July 15 – June 16	100.61	1.00	1.123	0.891
October 15 - September 16	101.72	1.00	1.127	0.888

Table X: 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:

- The trust has remained in the 'as expected' range for the reporting period July 2015 to June 2016. The Trust SHMI is currently 1.01.

The Trust intends to take / has taken the following actions to further improve this result, and so the quality of its service, by:

- Participation in the national *Sign up to Safety* campaign. A series of inter-related projects to achieve this are in progress under the primary drivers of:
  Reliable clinical care
  Effective clinical care
  Medical documentation, clinical coding and data consistency
  End of life care
  Leadership

- Continuation of the weekly mortality case note review group, which is led by the Lead Consultant for Patient Safety. The group was established to review themes and areas for further work in conjunction with the Hospital Mortality Reduction Group.

- The formation of a Trust Mortality Reduction Group. The group consists of members of the Hospital Mortality Reduction Group and Divisional Mortality Groups. The aim of the Trust Mortality Reduction Group is to re-invigorate the Trust's drive to reduce its mortality rates and ensure a uniformed approach to mortality reduction across the Trust.

- Implementation of the actions from a gap analysis on the recommendations from the Care Quality Commission Learning, Candour and Accountability report.

Date	Trust Performance	National Average	Highest Result	Lowest Result
October 14 - September 15	0.63%	0.89%	14.11%	0.00%
January 15 - December 15	0.55%	0.92%	14.90%	0.00%
April 15 - March 16	0.54%	0.94%	14.80%	0.00%
July 15 - June 16	0.57%	0.98%	22.40%	0.00%
October 15 - September 16	0.57%	0.99%	21.80%	0.00%

Table X: The percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust

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.

Date	Measure	Trust performance	National Average	Highest Result	Lowest Result
Groin Hernia					
2014-2015	EQ5D	0.073	0.084	0.154	-0.005
2015-2016	EQ5D	0.088	0.088	0.158	0.022
2014-2015	VAS	0.073	0.084	4.550	-6.351
2015-2016	VAS	0.088	0.088	5.587	-5.867
Hip Replacement					
2014-2015	EQ5D	0.437	0.436	0.524	0.331
2015-2016	EQ5D	0.419	0.439	0.541	0.323
2014-2015	VAS	11.111	11.973	17.310	6.441
2015-2016	VAS	10.832	12.358	19.327	5.160
2014-2015	OXFORD HIP	20.637	21.443	24.652	16.291
2015-2016	OXFORD HIP	20.356	21.637	24.835	17.220
Knee Replacement					
2014-2015	EQ5D	0.283	0.315	0.418	0.183

2015-2016	EQ5D	0.332	0.321	0.396	0.180
2014-2015	VAS	4.168	5.761	15.406	1.133
2015-2016	VAS	4.919	6.191	13.057	0.794
2014-2015	OXFORD KNEE	14.892	16.116	19.581	11.286
2015-2016	OXFORD KNEE	16.316	16.389	19.812	11.890
Varicose Vein					
2014-2015	EQ5D	No Data	0.094	0.154	-0.009
2015-2016	EQ5D	No Data	0.094	0.143	-0.005
2014-2015	VAS	No Data	-0.503	3.938	-5.792
2015-2016	VAS	No Data	-0.451	6.320	-7.861
2014-2015	ABERDEEN	No Data	-8.237	5.700	-16.534
2015-2016	ABERDEEN	No Data	-8.543	3.080	-18.545

Table X: The Trust's patient reported outcome measures scores (PROMS)

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

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

- Comparing the PROMS results with those from then Joint Registry when all results have been published
- 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.

0-15 28 days readmission		
Date	Trust per HED	Peer Group av HED
Jan 2013 – Dec 2013	10.7%	10.7%
Jan 2014 – Dec 2014	11.4%	10.9%
Jan 2015 – Dec 2015	11.4%	10.4%
Jan 2016 – Sep 2016	12.02%	10.21%

Table X: The percentage of patients aged 0-15 readmitted to hospital within 28 days of being discharged.

The Trust considers that this data is as described for the following reasons…….Update…….

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

16 and over 28 day readmission		
Date	Trust per HED	Peer Group av HED
Jan 2013 – Dec 2013	8.1%	7.6%
Jan 2014 – Dec 2014	8.6%	7.7%
Jan 2015 – Dec 2015	7.9%	7.1%
Jan 2016 – Sep 2016	8.18%	7.64%

Table X: The percentage of patients aged 16 and over readmitted to hospital within 28 days of being discharged.

The Trust recognises that its readmission rates for patients aged 16 and over is higher than peer and has increased for the period of January 2016 to September 2016. The Trust considers that this data is as described for the following reasons:

- For patients over the age of 16 readmission rates have remained static over the past 4 years but above peer, a higher proportion of elderly patients is potentially accountable for this variance from peer data and an increased frail population would be expected to require increased hospital admissions

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

- A review has been undertaken of readmission rates by specialty and by consultant to identify underlying themes and practices that result in readmission
- The Trust is developing action plans to address issues from identified trends in readmission rates
- The Trust continues to review readmissions for patients who have respiratory conditions, cardiac conditions, urology conditions or who have undergone breast surgery. Dedicated matrons are supporting this work and are implementing specific action plans to identify any issues identified

- The Trust has Implemented a flagging system for patients with specific conditions that notifies clinicians when a patient is admitted
- Continuing to progress collaborative working with community services to prevent readmission

Date	Trust Performance	National Average	Highest Result	Lowest Result
2013	75.9	76.9	84.4	57.4
2014	76.1	Not available	Not available	Not available
2015	78.3	Not available	Not available	Not available
2016	75.6	Not available	Not available	Not available

Table X: The Trust's responsiveness to the personal needs of its patients

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

- Overall our average score for questions for the National Inpatient Survey have reduced by 2.8%

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

- Reviewing individual patient care needs every day and making staffing adjustments as required
- Ensuring that Trust induction, training and the appraisal process reinforce the importance of the Trust's values and behaviours
- Focusing key safety improvement initiatives on the implementation of patient care pathways
- Improving the discharge process to ensure a safe and timely discharge.

Date	Trust Performance	National Average	Highest Result	Lowest Result
2013 staff survey	3.79	3.68	4.25	3.05
2014 staff survey	3.86	3.67	4.20	2.99
2015 staff survey	3.89	3.76	4.10	3.30
2016 staff survey	3.91	3.76	4.10	3.34

Table X: Staff employed by the Trust who would recommend the Trust as a provider of care to their family or friends (scores out of 5)

The Trust is delighted to report these results, and considers that these results are as described for the following reasons:

- Over the last year there has been continued focus and communication to staff about how important all staff are in improving the quality of care and services we provide.
- The Trust's appraisal system also includes the Trust's values and behaviours which are discussed during appraisal
- The Employee of the Month and Team of the Month scheme which provides staff with recognition for going above and beyond what is expected, as well as for displaying the Trust's key values and behaviours
- Engagement sessions with the Trust's Chief Executive and other members of the Executive Team have taken place which have had quality and patient experience at the heart of those discussions
- The Chief Executive delivers weekly briefs which focus on the patient safety and quality agenda
- Patient stories are told at Board meetings each month – to ensure that patients are at the heart of all decisions being made by the Board
- Patients are on the Trust's judging panels for the Celebration of Achievement evening. Their perspective on what matters has been valued and there is also a Public Choice category for nominations
- Staff focus groups run twice a year to ascertain their views and they are asked if they would they recommend the Trust as a place to receive treatment and any negative responses are discussed.

NB: The below actions are subject to change dependent on the outcome of May's Board Meeting where the National Staff Survey Results will be presented and actions for the coming year will be agreed. The suggested actions below are based on the initial analysis of the results by the OD Team.

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

- Improving the quality of appraisals
- Reducing violence, bullying and harassment towards staff in particular looking at behaviours that fall below our expectations
- Improving local management communication and visibility

Date	Trust Performance	National Average	Highest Result	Lowest Result
Jan 2015 - Mar 2015	96.02%	99.00%	100.00%	79.23%
Apr 2015 - Jun 2015	96.78%	98.90%	100.00%	86.10%
Jul 2015 - Sept 2015	97.19%	99.00%	100.00%	75.00%
Oct 2015 - Dec 2015	95.22%	96.00%	100.00%	78.52%

Jan 2016 - Mar 2016	95.44%	96.00%	100.00%	78.06%
Apr 2016 - Jun 2016	95.56%	96.00%	100.00%	80.61%
Jul 2016 - Oct 2016	96.52%	96.00%	100.00%	72.14%
Oct 2016 - Dec 2016	96.17%	96.00%	100.00%	76.48%

Table X: The percentage of patients who were admitted to hospital who were risk assessed for venous thromboembolism (VTE)

The Trust is pleased to note that it has met the 95% national target for venous thromboembolism (VTE) risk assessment for the previous 3 years and continues to do so.

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

- Monthly monitoring of the percentage of patients risk assessed for VTE by the clinical divisions.
- Bi-monthly monitoring of the percentage of patients risk assessed for VTE by the Trust VTE Group, to ensure the continued compliance with the national target.
- The development and implementation of a gap analysis and action plan to enable the organisation to become an Exemplar VTE Centre.
- 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.
- Education for medical staff on induction on the importance of VTE assessment.
- Monthly audits of compliance with the completion of VTE assessment and VTE prophylaxis administration. The results are presented to the VTE Group and actions implemented to improve results where required. An example of this is the introduction of a tear off information leaflet for patients which is being included with the VTE risk assessment tool in the admission proforma.

Date	Trust Performance	National Average	Highest Result	Lowest Result
2013-2014	14.6	14.7	31.7	0
2014-2015	13.8	15.1	62.2	0
2015-2016	22.2	Not published	Not published	Not published
2016-2017	12.2	Not published	Not published	Not published

Table X: The rate per 100,000 bed days of cases of Clostridium difficile infection reported within the Trust amongst patients aged 2 or over

The Trust is pleased to report a significant reduction in cases of *Clostridium difficile* infection; from 40 cases to 22 this reporting year, which gives the Trust the lowest rate per 1000,000 bed days for the last four years.

The Trust has, therefore, met its target for this organism for 2016/17; which was 24 cases (22 reported) and a bed day rate of 13.1 (12.2 achieved).

In addition, the number of avoidable cases of *Clostridium difficile* infection has reduced from eight to three this reporting year, which reflects the efforts taken to reduce healthcare associated infections.

The Trust intends to take the following actions to further improve *Clostridium difficile* infection rates and focus on the prevention of avoidable cases by:

- Maintaining environmental hygiene standards and good hand hygiene at ward level
- Ensuring robust action planning follows each monthly completion of the revised infection prevention & control audit tool for wards and clinical areas
- Maintaining antibiotic stewardship by continued monitoring of compliance with antibiotic prescribing guidelines (audits performed by Consultant Microbiologists and Antimicrobial Pharmacist)
- Bedside review of all new *Clostridium difficile* infection cases with the clinical team and Consultant Microbiologist
- Maintaining timely review of all *Clostridium difficile* infection cases with the Consultant and the multi-disciplinary team to perform a root cause analysis and identify learning from each case
- Developing the collaborative review process with the CCG to further identify learning relating to cases of *Clostridium difficile* infection across the whole health economy and not just hospital associated cases

Date	Trust Performance	National Average	Highest Result	Lowest Result
Oct 2013 - Mar 2014	3016	2185	3790	301
Apr 2014 - Sept 2014	2814	2052	4301	908
Oct 2014 - Mar 2015	2767	4539	12784	443
Apr 2015 - Sept 2015	3159	2680	3948	1773
Oct 2015 - Mar 2016	3116	2800	4068	1723

Table X: The number of patient safety incidents reported within the Trust

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

- Nationally, it is viewed that being a high reporter of incidents is a positive position as it demonstrates a risk aware culture within the Trust and highlights that staff are not afraid to report patient safety incidents. The majority of the incidents reported resulted in no harm to the patient, which again demonstrates a positive risk aware culture within the Trust.

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

- The introduction of a bi-weekly Patient Safety Summit in October 2016 which is chaired by the Director of Nursing and Quality and is attended by the Medical Director, Deputy Medical Director, Deputy Director of Nursing and Quality, patient safety team and senior member of the divisional senior management teams. The aim of the Patient Safety Summit is to provide an opportunity for cross divisional learning for all incidents and sharing of immediate learning following all incidents graded moderate and above.
- Incident report training for all new staff to the Trust. This training ensures that all staff in the Trust knows how to report a patient safety incident and they also understand the importance of incident reporting.
- Feedback to all staff on the outcome of the incidents they have reported to demonstrate the changes in practice that have been made as a result of the incident.
- Sharing learning from reported incidents through Director of Nursing and Quality safety alerts, lessons learned episodes of care and individual patient stories.

Date	Trust Performance	National Average	Highest Result	Lowest Result
Oct 2012 - Mar 2013	3	16	56	1
Oct 2013 - Mar 2014	4	15	60	0
Apr 2014 - Sept 2014	3	15	51	0
Oct 2014 - Mar 2015	6	23	128	2
Apr 2015 - Sept 2015	6	14	87	2

Oct 2015 - Mar 2016	18	10	33	1

Table X: The number and % of such patient safety incidents that resulted in severe harm or death.

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

- The Trust has been under the national average for incidents that resulted in sever harm or death until the period October 2015 – March 2016. In November 2015 the Trust implemented the new National Reporting and Learning System guidance which altered the way in which incidents were graded. This has resulted in an increase in the number of moderate and above incidents being reported by the Trust.

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

- The introduction of a bi-weekly Patient Safety Summit where the sharing of immediate learning following all incidents that resulted in severe harm or death are discussed to prevent reoccurrence.
- Undertaking a full root cause analysis for all incidents which result in severe harm or death. A review meeting is held following the incident investigation which is always chaired by an executive lead to ensure that lessons are learned and actions are implemented to prevent a reoccurrence
- Reporting all incidents which result in severe harm or death to the Board of Directors to ensure openness within the Trust
- Implementing the Trust's *Being Open* (including Duty of candour) policy which ensures that, if an incident occurs which results in severe harm or death, the patient and / or their family are informed and the lessons learned and actions from the root cause analysis are shared with them.

Central Cheshire Integrated Care Partnership (CCICP)

In September 2016 a new local health partnership was awarded a multimillion pound contract to provide a range of community health services for people across South Cheshire and Vale Royal.

Central Cheshire Integrated Care Partnership (CCICP) is a new and innovative collaboration between Mid Cheshire Hospitals NHS Foundation Trust (MCHFT), Cheshire and Wirral Partnership NHS Foundation Trust (CWP), and the South Cheshire and Vale Royal GP Alliance, which covers all 30 local GP practices.

By working together, the three organisations aim to transform, develop and deliver health care services in the community that are focussed on delivering high quality, safe care in the right place at the right time.

From the 1st October Community services transferred to Mid Cheshire under the new partnership. The transition has gone well and services have continued to be delivered as expected with no issues raised by stakeholders

The principles of CCICP are to ensure

- Integrated care
- Person centred care
- Developing services to be centred around Care Communities

We have started the transformation work which are initially prioritised around three areas

- Care Community Teams
    - Winsford
    - Northwich
    - Crewe
    - SMASH
    - Nantwich and Rural
- MSK Physiotherapy- Focusing on improving routes into and pathways across the service
- Work on Front of House

These three clinical work streams are facilitated by further enabling groups that focus on estates, workforce, IT, quality and finance

Staff have reported feeling engaged in all processes and being able to influence change. This is positive as the work continues as it is essential to harness their experience and good ideas

Examples of quality practice in CCICP

A pilot trial at Keele University has investigated the feasibility of giving patients direct access to physiotherapy services, with initial findings indicating that it could offer benefits to patients, GP practices and physiotherapists.
This successful pilot trial highlights the excellent partnership that exists between the academic team at Keele University and the NHS physiotherapy service in Central Cheshire Integrated Care Partnership. It has shown that a full trial is feasible.
The study, Stepping up the Evidence for Musculoskeletal Services (STEMS), is the first randomised clinical trial to be conducted into direct patient access to physiotherapy, and was funded by the Chartered Society of Physiotherapy Charitable Trust.

Community Nurse Wins National Award

A Crewe-based nurse has been presented with a national award for her outstanding contribution to patient care in the local area. A Paediatric Community Matron at Eagle Bridge Health and Wellbeing Centre, has been named as the 'Nursing in Practice' Nurse of the Year in the latest GP Practice Awards. The awards are designed to recognise, highlight and reward the hard work and innovation that gets carried out every day in surgeries across the country. She has been praised for delivering a successful paediatric community matron service, which is designed to help families cope better with their child's health needs and reduce the number of emergency hospital and GP visits. The role involves working closely with families so that they can self-manage their child's condition and are able to recognise and respond to any problems. As part of the service, she also keeps those who are involved in a child's care updated and connected. The role was set up in 2007 to reduce emergency hospital admissions, as well as the number of emergency GP appointments that take place. The service provides a 'one stop shop'. Previously, parents may have felt that there was a lack of integration regarding their child's care, but now they feel more confident knowing that someone's an advocate for them and who is talking and guiding them through everything." It is believed that, thanks to all the hard work, more than 70 GP appointments and a number of hospital admissions were avoided over the last year.

Part 3

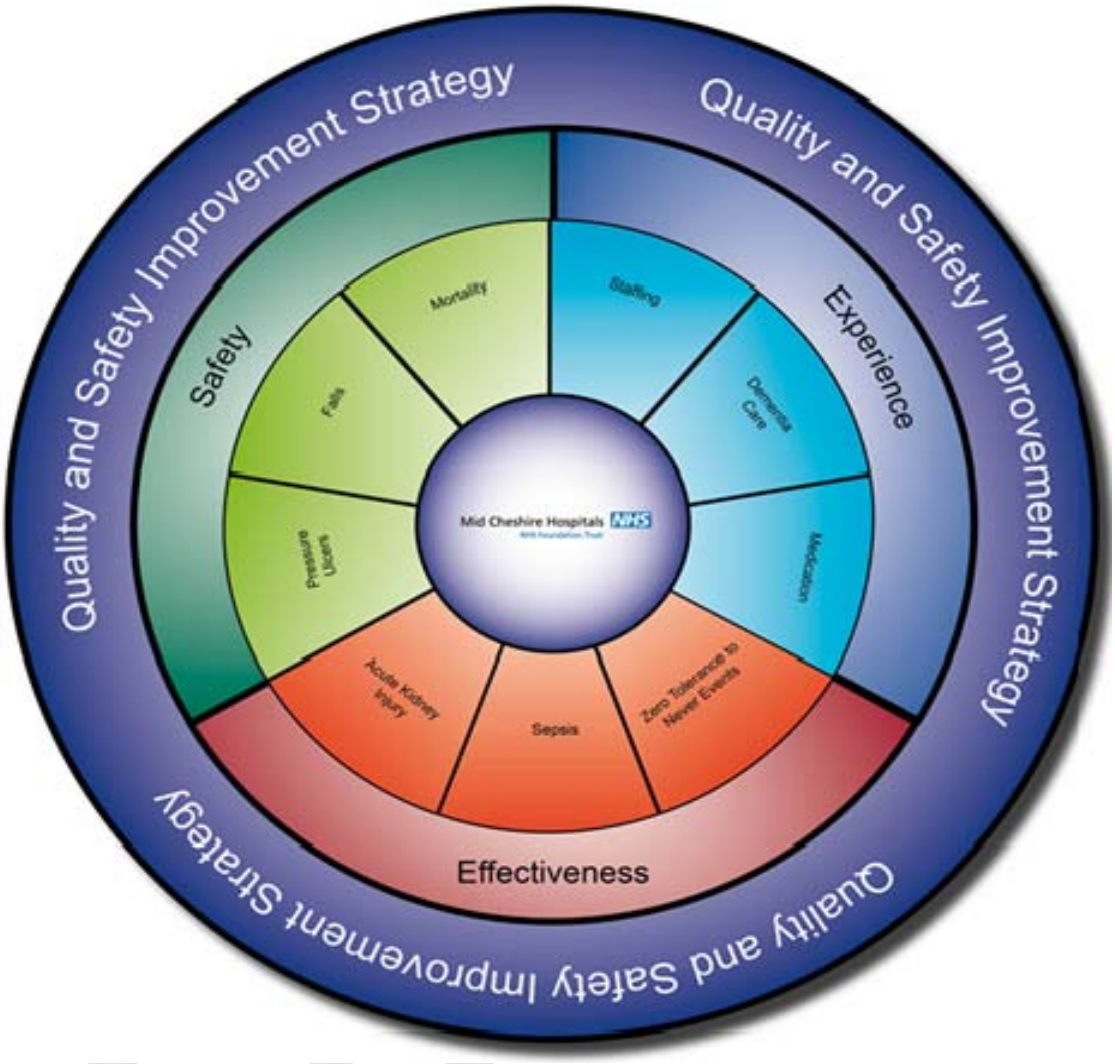
Review of quality performance

This section of the Quality Account details progress against the first year of the Trust's two year Quality and Safety Improvement strategy.

This review of quality performance has been described under the following domains of:

- Experience

- Effectiveness
- Safety



Experience:
Appropriate nurse staffing levels

What do we want to achieve?

We will ensure we have appropriate levels of nurse staffing and skill mix that meet the needs of our patients. During this element of the strategy, all reference to nurses also applies to midwives.

Why is it important?

We have a duty to ensure staffing levels are adequate. Therefore having the right people, with the right skills, in the right place at the right time is essential to ensure patients receive safe, appropriate, timely and responsive care (National Quality Board, 2013).

What progress was made in 2016/17?

- Staffing boards remain in place in a visible location for staff, patients and visitors. This provides assurance around current and actual staffing levels on a daily basis, identifies the nurse in charge and highlights the uniforms for each professional working in the clinical area.

- Nursing acuity assessment is undertaken on a daily basis utilising the Safe Nursing Care Tool (SNCT) which measures the individual dependency of patients and uses generic multipliers to calculate the staffing required.

- Every six months formal establishment reviews are undertaken with each division. These meetings are chaired by the Director of Nursing utilising the real time nursing acuity data. The meetings have full input from the Deputy Director of Nursing and Quality, Heads of Nursing, Head of Midwifery and Matrons. Whilst focusing on the acuity and dependency results they also take into consideration a wider suite of quality indicators that need to be considered factoring in best practice and expertise to allow more informed decisions around future investment.

- Staffing levels are recorded on a database by each ward on a daily basis and results are reported each month to the public board meetings and published on the hospital website.

- Day time Registered Nurses monthly expected hours by shift versus actual monthly hours per shift. The results over the year show an average fill rate of 95%.

- Night time Registered Nurses monthly expected hours by shift versus actual monthly hours per shift. The results over the year show an average fill rate of 99.7%.

- Day time Healthcare Assistant monthly expected hours by shift versus actual monthly hours per shift. The results over the year show an average fill rate of 98.2%.

- Night time Healthcare Assistant monthly expected hours by shift versus actual monthly hours per shift. The results over the year show an average fill rate of 103%.

- The staffing database also includes the use of Care Hours Per Patient Day data as a measure over time which the Trust has been using since June 2016. This supports the recently published 'Safe Sustainable and productive Staffing (SSPS) paper published in July 2016 by the National Quality Board which aims to support NHS providers to deliver the right staff, with the right skills in the right place at the right time. This data is used in conjunction with the safe staffing acuity tools and the professional judgement of senior staff to support decision making around staffing.

- Staffing is reviewed on a daily basis and there is a robust escalation plan in place to address any staffing levels that fall below plan. This includes completing an SBAR (Situation, Background, Assessment and Recommendation) form for requesting temporary staff that is authorised through the Heads of Nursing and Deputy Director of Nursing to ensure all options have been considered to safely cover the clinical areas.

- The Trust has successfully introduced weekly pay for our bank staff. This commenced in May 2016. We have also eliminated our agency spend for unregistered nursing except for in an emergency and have reduced our use of agency staff and off framework agencies.

- Staff are encouraged to report any incidences where staffing levels fall below agreed levels and the level of impact this has potentially had on patients. All incidences are reviewed at the fortnightly 'Patient Safety Summit' chaired by the Director of Nursing, with attendance from Medical Director, Deputy Director of Nursing, Heads of Nursing and divisional governance leads.

- The Trust is continuing with its recruitment plans and has focused on:

    - Inspirational and ward specific adverts using social media, newspapers etc.
    - Planned recruitment drives specific to the divisions
    - Close working with the University of Chester and student nurses to improve MCHFT ownership and relationships
    - Flexible working arrangements where possible

- Overseas recruitment
- Return to practice programme with experienced nurses in post. Currently into its 3rd cohort and very positively received.
- Trust attendance at job fairs and school fairs
- Offering alternative career pathways to registered staff to encourage retention i.e. ANP and specialist nurse roles

- The Trust has provided monthly re-validation sessions for all staff, led by the Divisional Head of Nurses, Director of Nursing & Quality and Deputy Director of Nursing & Quality. This process has supported staff in preparing for revalidation; understanding the requirements and sharing ideas on how best to approach their own revalidation.

- The results from the Staff Survey show that the Trust have the best results of all Trusts in the country and is in the top 20% for over 50% of the questions answered. We are delighted to report that the Trust was not in the bottom 20% for any of the answers and the overall position shows that staff engagement has continued to improve.

Experience:
Supporting patients with dementia and their carers

What do we want to achieve?

We will continue to support patients who have concerns about their memory and we will work with patients who have dementia and their carers to promote a positive experience whilst in hospital.

Why is this important?

There are over 700,000 people with dementia in England and this figure is expected to increase to around 850,000 by 2021 (Prince & Knapp et al, 2014). However, only 51% of people with dementia have a formal diagnosis. This is despite the fact that timely diagnosis can greatly improve the quality of life of the person with dementia and enable support to be provided to carers.

The Department of Health (2015) estimated that 25% of hospital beds are occupied by people with dementia. However, informal reports suggest this is a gross underestimate, with some hospitals stating that 40-50% of their patients have dementia (Alzheimer's Society, 2016). It is recognised that admission to hospital for patients with dementia can have a significant negative impact on the person's physical and mental health and have an emotional impact on carers (Kasterisdis et al, 2015). Therefore, it is important that we ensure patients in hospital receive appropriate care and provide support to carers.

What progress was made in 2016/17?

We have aimed to involve carers from the point of admission and have signed up to John's Campaign, offering open visiting for carers of people with dementia. This fits well with work that is being planned going forward to implement a "Partnership in Care" approach.

Feedback from carers has been integral to enhancing the care we deliver. Open visiting has been well evaluated and comments received from the monthly carer survey and recent National Audit of Dementia have been used to progress plans to improve dementia care within the Trust.

The Trust continues to work closely with external partners:

- The Alzheimer's Society attend our Dementia Care group, provide support for our staff carers every two months and liaise closely with the dementia team around individual patient/carer issues.
- The Royal Voluntary Service provide a successful and expanding ward based befriending service supporting people with dementia and have donated items to improve the patient experience.
- Partnership working with Dementia UK has culminated in a new Admiral Nursing service within the Trust which will commence in 2017.

- Cheshire Dance is currently piloting “In This Moment” – a project exploring the benefits of music, movement and sensory stimulation, particularly for older people with cognitive impairment.
- The Dementia End of Life Practice Development team collaborate with the dementia team to deliver training to link staff

Each ward and department has information boards and dementia link staff, as a resource for further information and support. Dementia link sessions continue quarterly and remain popular.

Recognition of the need to enhance our healing environment has led to exciting discussions and planning around necessary dementia friendly improvements. These have been detailed within a business proposal and funding application and the outcome is awaited.

Dementia training is mandatory for all patient- facing staff. Additionally, all staff at band 6 and above are required to complete mental capacity training. We have identified gaps in both areas of training which we are working on with the Learning and Development team. We are confident that improvements in this area will be made soon.

We continue to work with pharmacy to monitor the safe use of antipsychotic medication. Staff are educated in relation to the use of antipsychotics as a last resort and the importance of de-escalation as the first line intervention. There are policies and protocols in place to ensure safe practice and Liaison Psychiatry are available for advice and support 24 hours a day.

Plans are in progress to enhance our assessment and provision of 1:1 care within an Enhanced Care Protocol. This aims to identify those who may need enhanced care and aim to ensure their safety via robust assessment and appropriate resource allocation.

The dementia team, ward staff and bed managers work closely to avoid unnecessary ward moves for people with dementia. There have been no recent formal complaints relating to inappropriate discharges (Between 23:00-06:00) of people with dementia. Mechanisms are in place to review any future complaints and share learning as appropriate.

Work is in progress with the clinical audit team to audit readmission rates (within 30 days). This will be used to identify trends , themes and any gaps in service provision that need to be addressed and will help to inform effective discharge planning

The Trust has consistently achieved the 90% target for screening emergency admissions over the age of 75 for memory problems and referring them to their GP for further investigation.

Experience:
Medication

What do we want to achieve?

In 2016/17 the aim of our strategy was to ensure safe and effective medication prescribing and administration across the organisation. Following a review of our strategy in March 2017, our aim is to reduce medication errors resulting in harm by X% and ensure the use of safe and effective medication across the organisation.

Why is this important?

Medicines prevent, treat and manage many illnesses or conditions and are the most common intervention in healthcare (NICE, 2016). However, medication errors have the potential to cause harm to patients and can cause an increased length of stay in an acute care setting (NICE, 2007). Therefore, medicine optimisation will ensure a patient-centred approach to safe and effective medicine use, ensuring patients obtain the best possible outcomes from their medicines whilst minimising patient harm.

What progress was made in 2016/17?

- Wards are undertaking a monthly medication audit, the results of which are monitored through the Trust Operational Safety and Effectiveness Group. These audits include omitted medicines, medication security, prescribing and adherence to the MCHFT Controlled Drug Policy. Results demonstrate 98.7% of medicines are administered when they are due (omitted doses rate is 1.3%).
- Lessons learnt are disseminated through the Safe Medicines Management Group.
- The Trust has successfully piloted a pharmacy technician administering medicines on ward 21b. Due to the success of the pilot, ward 2 has recruited a pharmacy technician to support the medication administration round.
- Medicines reconciliation target met in 2016:

Criterion 1				**Exceptions**	
Adult patients admitted to Leighton Hospital to have a medication history taken by Pharmacy within 48 hours of admission (Target ≥ 75%)				A – Patients who were discharged within the 48 hour sample time.	
Audit Cycle	**Patients (n =)**	**Exceptions (n =)**	**Frequency**	**Compliance (%)**	**Status**
2014-15 (July 16)	**44**	**0**	**42/44**	**95%**	
2015-16	94	40	50/54	**93%**	

(Jan 16)					
2016-17 (Jul 16)	89	55	34/34	**100%**	↑

Criterion 2				**Exceptions**	
100% of adult patients taking critical medicines to have a medication history performed within 48 hours of admission (Target 100%)					
Audit Cycle	**Patients (n =)**	**Exceptions (n =)**	**Frequency**	**Compliance (%)**	**Status**
2015-16 (Jan 16)	24	0	24/24	**100%**	
2016-17 (July 16)	34	21	13/13	**100%**	↔

- All NICE approved medicines are added to the formulary within 90 days of publication.
- A Self-medication policy is fully implemented at Elmhurst Intermediate Care Centre.
- The Trust has introduced a prescribing pharmacist to work on ward 5. This is proving to support with safe and timely discharging of patients. A surgical admission prescribing pharmacist has also been appointed to support the surgical admissions process.
- Pharmacy is taking part in a trial of a new software system to send a patient's discharge prescription to their nominated community pharmacy (with the patient's consent). This will allow the patient to be supported by their community pharmacist once discharged from hospital.
- The self-administration of IV antibiotics in the community has commenced. Patients with infections requiring long-term IV antibiotics have been trained on the ward to be able to self-administer their antibiotics. The patient is then issued with the antibiotic in a specially made elastomeric device so it can be safely administered at home without the need of an infusion pump.

Effectiveness:
Zero tolerance to Never Events

What do we want to achieve?

We will have zero tolerance of Never Events in the organisation.

Why is this important?

Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. They have the potential to cause serious patient harm or death, however this outcome is not required for the incident to be categorised as a 'Never Event' (NHS England, 2015).

Never Events can lead to very serious adverse outcomes and they can damage our patients' confidence and trust in our organisation. We therefore have zero tolerance to Never Events and, by implementing best practice, can reassure our patients that we are doing all that we can to prevent them.

What progress was made in 2016/17?

Over the last three years five Never Events have been reported by the Trust. The details are shown below in table X:

Financial Year	Type of Never Event
2014-15	Wrong Route Administration Of Chemotherapy
	Retained Foreign Object Post-Operation
2015-16	Wrong Implant/Prosthesis (Incorrect intraocular lens)
2016-17	Wrong Implant/Prosthesis (Incorrect size hip implant)
	Wrong Site Anaesthetic Block

During 2016/17 two Never Events were reported by the Trust. A comprehensive investigation was undertaken following both cases and action plans developed to prevent reoccurrences.

- A Never Event was reported in April 2016, this related to a wrong size implant being inserted during surgery

- A Never Event was reported in November 2016, this related to a wrong side block prior to surgery

A briefing paper was disseminated across the organisation to ensure all staff have the required knowledge of Never Events.

A Local Safety Standards for Invasive Procedures Standard Operating Procedure has been developed and approved to ensure the Trust is compliant

with the national alert for National Safety Standards for Invasive Procedures (NatSSIPs).
NatSSIPs address many of the underlying causes of Never Events by ensuring that evidence based best practice is implemented. A Task and finish group has been formed to implement NatSSIPs. Local Safety Standards for Invasive Procedures are currently in development.

The location of the marking for all orthopaedic surgical procedures has been standardised.

A standard operating procedure is being developed to ensure there is an agreed process for ‘stop before you block’. A 'stop before you block' check is being incorporated into the anaesthetic section of the theatre documentation.
The 'stop before you block' process is being included in the local induction programme for all staff groups within the theatre department.

To improve the checking of the size of implants prior to surgery a whiteboard has been located in all theatres where the size of implants can be documented prior to opening.

A standard operating procedure has been developed giving guidance on the standardised procedure for the checking of the implant sizes prior to implantation. The standard operating procedure supports the checking process of the implant size. An additional implant "time out" has been introduced in theatres so that the implant size can be clarified with the theatre team prior to it being implanted.

Effectiveness:
Sepsis

What do we want to achieve?

We will ensure the prompt recognition and treatment of sepsis, ensuring that 90% of patients are receiving appropriate care as per the sepsis pathway.

Why is this important?

Sepsis is a common and potentially life threatening condition caused by a whole body inflammatory response to an infection which can result in injury to the body's tissues and organs. Sepsis, if not recognised and treated early, can lead to shock, multiple organ failure and death (UK Sepsis Trust, 2015).

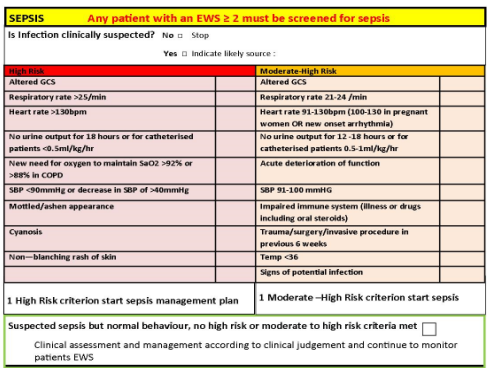
Each year it is estimated that, in the United Kingdom, more than 100,000 people are admitted to hospital with sepsis and approximately 37,000 of those will die as a result of the condition. Therefore, timely initiation of evidence-based pathways should improve outcomes for patients with sepsis (NHS Choices, 2014).

What progress was made in 2016/17?

- In August 2016 the Trust employed a full time sepsis specialist nurse to support the delivery of care for patients at risk or diagnosed with sepsis.

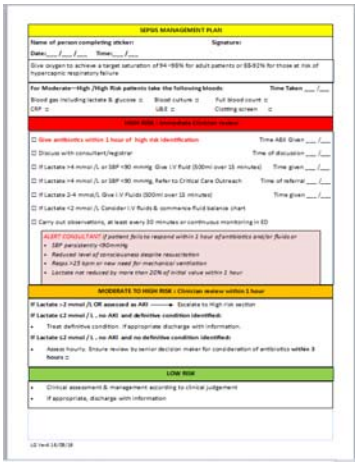
- The role of the sepsis nurse has a specific focus on education of screening patients for sepsis and the timely delivery of antibiotics for those patients diagnosed with sepsis as part of the national CQUIN. The sepsis specialist nurse predominately spent time in the Emergency Department and acute assessment area's when first in post. As a result of this, the number of patients screened for sepsis has increased along with the administration of antibiotics to patients with high risk sepsis features. Plans have now been set to roll out the education of screening and antibiotic administration across the whole Trust.

- A sepsis pathway had been reviewed and designed in line with new NICE Guidance; this pathway was then trialled in the Trust but staff felt it did not support the clinical pathway. With this feedback on board, staff from all divisions met at a task and finish group and a new pathway was designed. This pathway was trialled in the Emergency Department and acute assessment area's and is now being rolled out Trust wide.

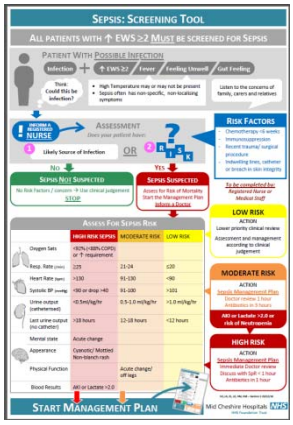


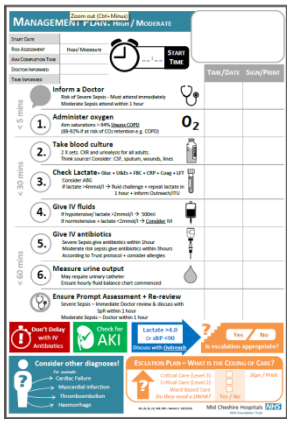
SEPSIS	Any patient with an EWS ≥ 2 must be screened for sepsis		
Is Infection clinically suspected? No ☐ Stop Yes ☐ Indicate likely source :			
High Risk		**Moderate-High Risk**	
Altered GCS		Altered GCS	
Respiratory rate >25/min		Respiratory rate 21-24 /min	
Heart rate >130bpm		Heart rate 91-130bpm (100-130 in pregnant women OR new onset arrhythmia)	
No urine output for 18 hours or for catheterised patients <0.5ml/kg/hr		No urine output for 12 -18 hours or for catheterised patients 0.5-1ml/kg/hr	
New need for oxygen to maintain SaO2 >92% or >88% in COPD		Acute deterioration of function	
SBP <90mmHg or decrease in SBP of >40mmHg		SBP 91-100 mmHG	
Mottled/ashen appearance		Impaired immune system (illness or drugs including oral steroids)	
Cyanosis		Trauma/surgery/invasive procedure in previous 6 weeks	
Non—blanching rash of skin		Temp <36	
		Signs of potential infection	
1 High Risk criterion start sepsis management plan		1 Moderate –High Risk criterion start sepsis	
Suspected sepsis but normal behaviour, no high risk or moderate to high risk criteria met ☐ Clinical assessment and management according to clinical judgement and continue to monitor patients EWS			

Sepsis pathway before task and finish group which is currently in use



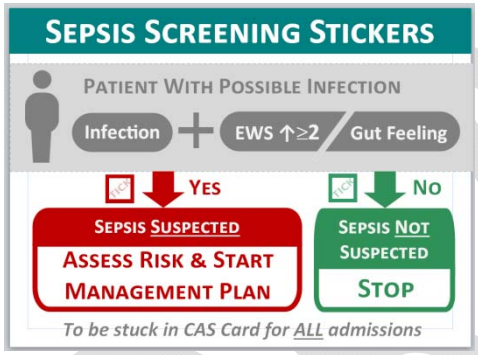
on all medical and surgical wards.





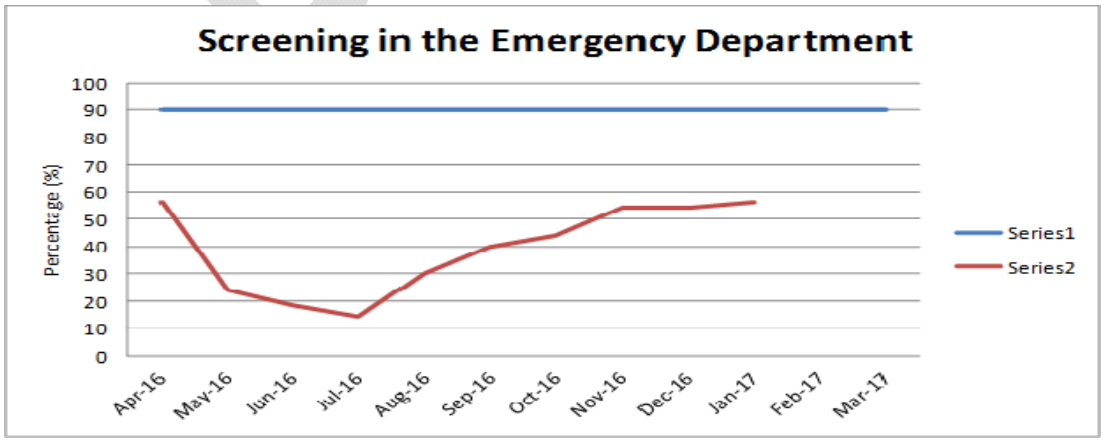
The new sepsis pathway based on Nice Guidance 2016.

- A new screening tool has also been rolled out in the assessment areas and the Emergency Department to help achieve our national target of 90% for screening for sepsis. The sticker has been designed to screen all new admissions and ticked according to their condition. If a patient is septic the sticker will direct staff to start the new sepsis pathway.



New screening sticker

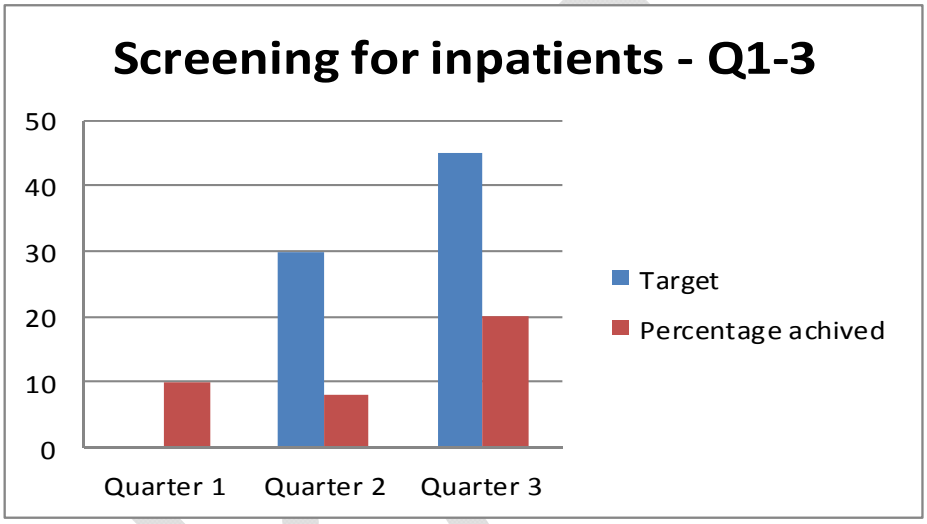
- The screening sticker was rolled out in the emergency department in mid-December 2016. Table X demonstrates an improvement since August 2016. Continual education about the sepsis sticker and screening will aim to improve screening overall aiming for our 90% target.



National CQUIN Data 2016-17

- Education continues on the screening of inpatients for sepsis. A sepsis champion link day was held at the end of January 2017 where all champions were invited to take part. The day consisted of education about sepsis, patient stories and scenario work. Champions were also asked to commence a 'train the trainer' programme with their staff on the wards/units, where they will educate staff on recognising sepsis and treating sepsis using the sepsis management plan and screening tool. The sepsis specialist nurse continues to meet with the link nurses to assess how well staff are achieving the training goals and any barriers they may have come across.

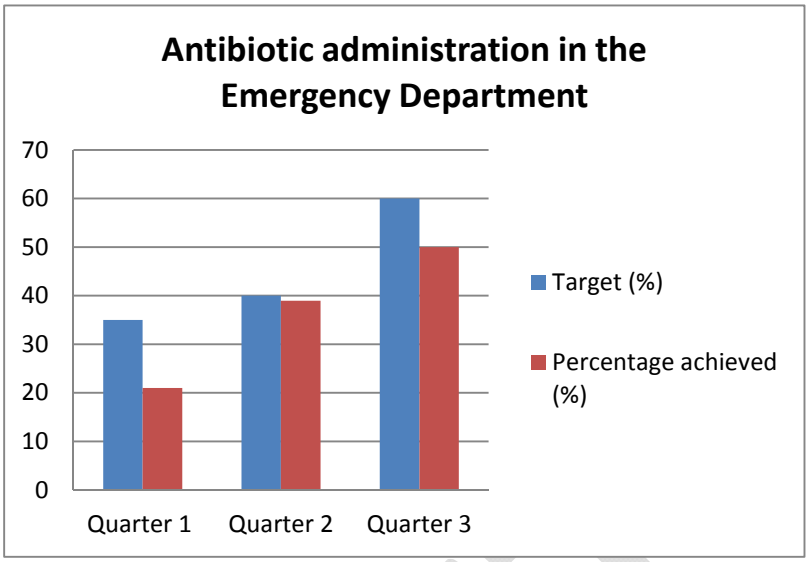
Table X demonstrates the results of the inpatient screening for quarters 1, 2 and 3.



National CQUIN data 2016-17

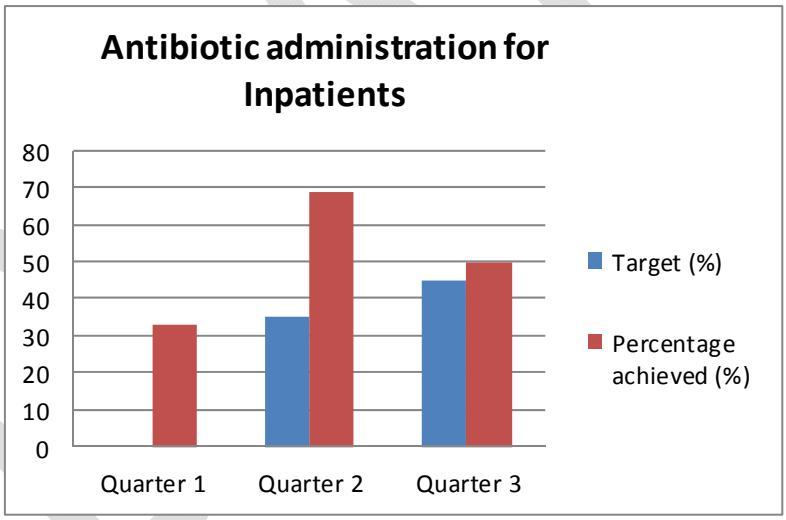
- The Trust continually audits the pathway monthly to ensure compliance, highlighting areas for improvement and share good practice with staff. The Trust continues to train staff on recognising the signs and symptoms of sepsis and the delivery of care, emphasising the golden hour to ensure patients get their intravenous antibiotics and recommended care within the hour. As part of her role, the sepsis specialist nurse supports the emergency department by educating staff about the golden hour and importance of administration of intravenous antibiotics.

Table X demonstrates the results of the antibiotic audits for the emergency department and for inpatients;



National CQUIN data 2016-17

Table X above demonstrates that the Trust has not reached its targets for antibiotic administration, however results are improving which indicates better quality of care for the patients and education for staff around the importance of antibiotic administration.



National CQUIN data 2016-17

Table X above demonstrates the Trust achieved all targets for antibiotic administration for inpatients, with quarter 1 set at baseline for achievement.

- The sepsis specialist nurse delivers education each month at a Quality Matters Programme which is designed for all new starters, newly qualified staff and staff that wish to refresh their skills and knowledge. The sepsis specialist nurse also delivers education to student nurses and newly qualified nurses as part of their preceptorship programme. Simulation training has also been introduced to staff with sepsis scenarios. Each scenario is different and includes live actor's to help

the training have a more realistic approach for staff. The sepsis nurse, clinical lead for sepsis, along with the simulation team will be attending different areas of the Trust with simulation scenario's to help spread awareness and education of sepsis care.

- Education for doctors is also delivered as part of core medical training programme, through simulation training and at the breakfast teaching meeting. One of the Trust's junior doctors joined the task and finish group and participated with the design of the new pathway.

- A monthly sepsis steering committee is held which highlights areas where sepsis care needs to be improved, the agreement of new ideas, signing off new documents and how the Trust is performing against national and local sepsis targets. The meeting includes representatives from each division where information is fed back to the appropriate people. The group also includes a patient representative who has personal experience of sepsis. His ideas and thoughts are greatly appreciated.

- A care pathway meeting is also held once a month to discuss the compliance with pathways and areas for improvement. Each area of the sepsis pathway is discussed and target plans are set with each lead to help highlight areas for improvement, share good practice with staff and check which areas are working well. The Clinical Quality and Outcomes Matron and sepsis specialist nurse both attend this meeting.

- The trust will continue to audit the use of the pathway; this will allow the Trust to identify specific elements of patient care such as timely bloods being taken, administration of oxygen therapy and compliance with fluid balance charts. The final years results will be available at the end of quarter 4.

Effectiveness:
Acute Kidney Injury (AKI)

What do we want to achieve?

We will ensure the prompt recognition and treatment of AKI, ensuring that 90% of patients are receiving appropriate care as per the AKI pathway.

Why is this important?

Acute kidney injury is sudden damage to the kidneys that causes them to stop working properly. It is normally a complication of another serious illness that, if not detected in time, can cause irreversible injury to the kidneys. This injury can also be fatal. In the United Kingdom alone, up to 10,000 deaths per year in hospital are associated with AKI (NHS Choices, 2014).

NHS England (2015) states that AKI is a harmful, yet common disease that represents a significant risk to patient safety. It is estimated that one in five emergency admissions to hospital are associated with AKI resulting in a major impact on health care services.

What progress was made in 2016/17?

The medical admission proforma and AKI management pathway were redesigned, with the admission proforma having a section for assessing patients for risk factors of AKI. If AKI is detected on the pathology system, then AKI management should be followed according to the AKI management plan / pathway sticker.
Despite redesign, compliance with the pathway remains sub-optimal. Therefore a multi professional working group are currently working to improve the compliance with the pathway and have enrolled on an AQuA programme to help address the challenges. The working group includes the following professionals:

- Critical Care Consultant (MCHFT Clinical Lead for AKI)
- Critical Care Outreach Lead
- Advanced Nurse Practitioner for Acute Admissions Unit (AMU)
- Pharmacist from AMU
- Senior Sister for Critical Care and Outreach
- Divisional Head of Nursing for Diagnostics and Clinical Support Services.

The working party is currently focusing on pharmacist reviews for AKI stage 3 patients on AMU. The pharmacist review is an important part of the pathway and NICE CG 169 guidance, not only to make sure that potential nephrotoxic medications are withheld, but also to make sure that medications that require dose adjustment in renal impairment are reviewed. It is envisaged that the focus on the pharmacist review will result in improvement in 3 areas of the clinical pathway:

- Increase in the percentage of patients who have a pharmacist review within 24 hours of their 1st AKI alert.
- Increase in the percentage of patients who should have their ACEi / ARBs discontinued within 24 hours of first AKI alert
- Increase in the percentage of patients who receive an AKI patient leaflet that includes self-management and sick day guidance advice.

To help achieve the referrals to the Pharmacist from ward staff, 2 new initiatives are being introduced:

1. A kidney shaped sticker will be placed on the prescription charts as a prompt to prescribers, nurses and pharmacists that a patient has AKI.

2. A poster for display in medication trolleys will prompt nurses to obtain a pharmacist review of their patients' prescriptions if a diagnosis of AKI has been made.

In addition to the pharmacist review work that is part of the AQuA programme, an audit is about to commence to try and identify why the percentage of patients requiring USS of the renal tract is not achieving 100%. NICE guidance and the AKI pathway state that USS renal tract is only required to be performed within 24 hours if the cause of the AKI is either unknown or if there is a suspicion of renal tract obstruction. The audit will explore the following:

- Timeliness of the request for USS renal tract

- Timing of the performance of the USS renal tract

- Where USS renal tract is reported as normal, whether the patient actually required the scan, for example if the patient's cause of AKI was thought to be pre-renal, such as sepsis or dehydration. This may identify capacity and demand management issues that are impacting the "right patent having the right scan at the right time".

Safety:
Reducing in-patient falls

What do we want to achieve?

We will reduce in-patient fall incidents by 10%.

Why is this important?

In-patient falls are the most commonly reported patient safety incident with over a quarter of a million falls reported in acute Trusts in England (NHS England, 2014).

All falls, even those that do not result in injury, can cause patients and their families to feel anxious and distressed. Therefore, it is important to ensure evidence based care plans relevant to each individual patient are implemented to reduce in-patient falls. Research has shown that multiple interventions tailored to the individual patient can reduce falls by 20-30% (National Audit of In-patient Falls Audit Report, 2015).

What progress was made in 2016/17?

Reducing patients falls is the aim within the Trusts Sign up to Safety Campaign and the Quality and Safety Improvement Strategy 2016-2018. The Trust aims to reduce patient falls by 10% by January 2018.

In the past three years the Trust has seen a reduction in the number of falls by **29.4%**

Year	Number of Falls
2013-14	976
2014-15	811
2016-17	

In order to achieve this there has been a number of actions:

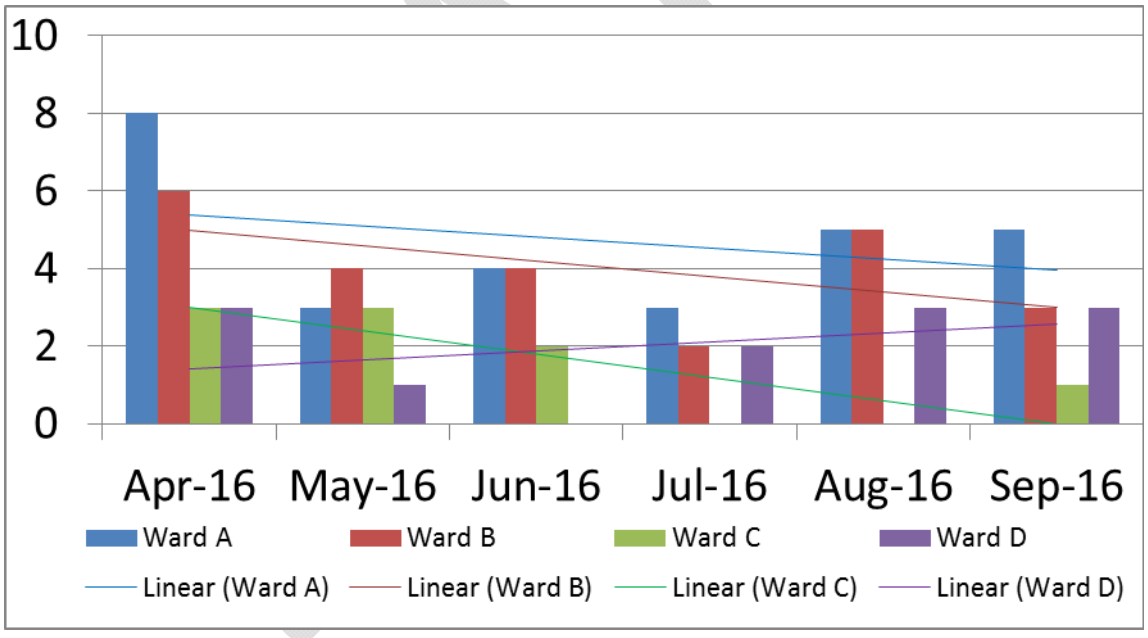
- Divisional staffing reviews and consequent investment
- Slipper socks introduced
- Fall sensors
- Falls lead and co-lead on each ward attend development days
- Falls Lead and co-lead provide local training and education at ward/department level
- Each fall has a post fall review undertaken by the Lead Nurse for Older People
- For each fall requiring an RCA an ‘Episode of Care document’ is produced that highlights local learning/ change required

- All toilet areas that are on wards that haven't been refurbished have signage that informs patients and staff on the appropriate area to use if the patient has mobility problems
- Care rounds
- Declutter Programme

The intention for MCHFT in 2016/17 is to focus on:

- Further reduction in the number of falls by 10%
- A reduction in harm to patients who have fallen

The falls safety collaborative called 'One Step Ahead' commenced in the Trust in April 2016. A cohort of four wards (Cycle1) received focus input and trialled a number of prevention initiatives. Across all the pilot wards we saw a shift in thinking and a greater focus on the potential for further falls prevention within MCHFT. The most successful wards benefited from clear leadership to deliver the message to all staff. The data shown in table X demonstrates a downward trend in all areas.



Following the success of Cycle 1, In November 2016 the Trust fully implemented the 'One Step Ahead' Falls Safety Collaborative across all inpatient wards (Cycle 2).

There were many positive ideas to help reduce falls from cycle1 and five specific proven changes have now be adopted by all ward areas within the Trust.

The changes are:

- Toilet/commode tagging
- Cohorting higher risk patients
- Staff Placement/Changes to staff base
- Safety crosses
- Safety Check trial

The collaborative has focused on senior nurse leadership for each ward falls team. The collaborative currently meet every two weeks to discuss the impact of the changes and any falls in their area.

Each ward has received a ward specific data pack which includes analysis of their falls data; this includes falls numbers, time of day, location.

The Lead Nurse for older people reviews all patients who have fallen and ensures appropriate interventions are in place. A Root Cause Analysis (RCA) investigation is undertaken where moderate or severe harm has occurred due to a fall. Outcomes of RCAs are shared with staff at ward level, at falls collaborative meetings and the Trust falls group.

All inpatients continue to be assessed for their risk of falls in hospital using the NICE guideline 161. This continues to be monitored via the care indicators. Focus has also been maintained on areas within the FallSafe care bundle that have the highest impact within the organisation these include falls history, lying/standing blood pressure and urinalysis.

Care rounds continue in all inpatient areas and trials of assessment notifications at bay entrances are taking place across the divisions highlighting at risk patients.

Four ward areas are also commencing trials of Safety check document to support handover. This is designed to structure and prioritise care following handover.

The Trust appointed the Divisional Matron for Surgery and Cancer as the Trust lead for falls prevention. This has ensured senior leadership within the organisation on the reduction and prevention of inpatient falls.

The Trust's Falls group continue to meet monthly and is chaired by the Lead Nurse for older people or Divisional Matron for Surgery and Cancer. The group has a multidisciplinary, cross divisional review and the terms of

reference have been reviewed to extend the group membership within the organisation.

Staff education continues as a priority. Workshops for the Falls Team continue on a twice yearly basis and Falls Prevention training also forms part of the Quality Matters, Preceptorship and HCA Induction programmes. The number of link nurses within each ward has increased to produce a 'falls prevention team' which includes support from both registered nurses and health care assistants. Links have also been developed with the community falls team who now have a representative attending the Falls Group.

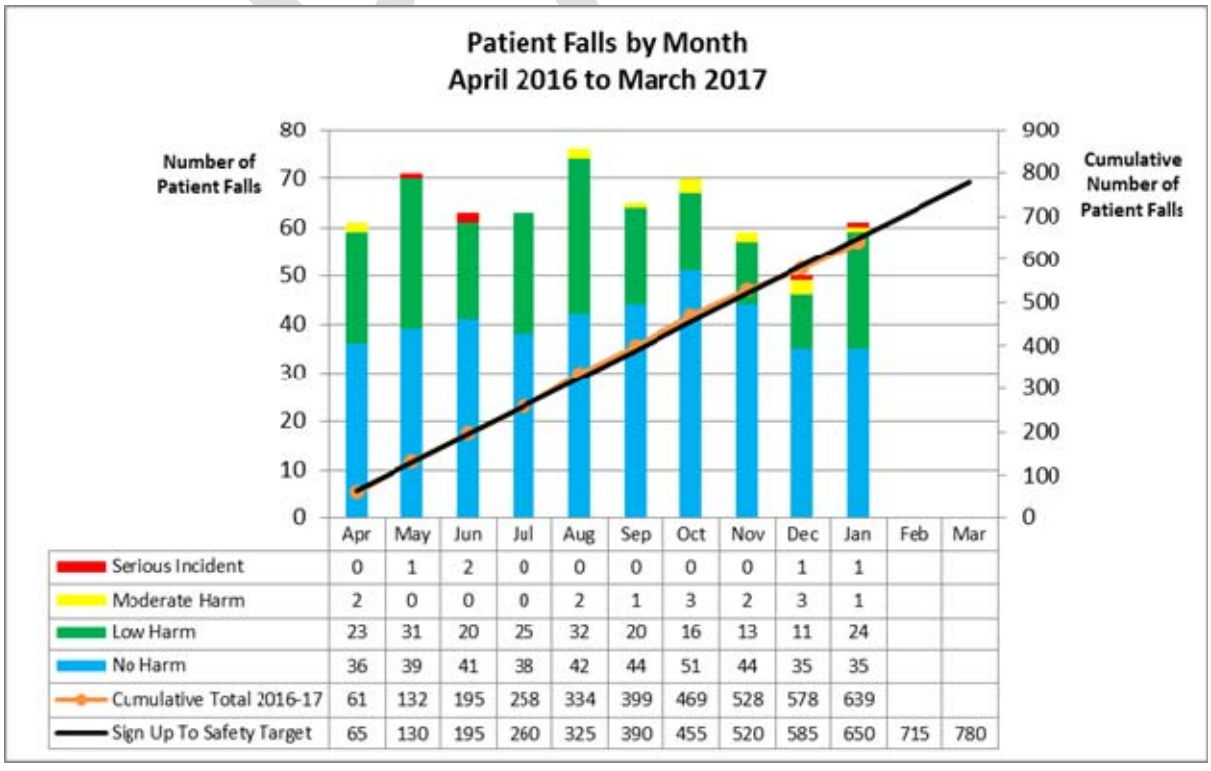
There is now a much improved provision of mobility aids in the ward areas. An improved communication system within the Physiotherapy Department allows for the prompt ordering of aids.

A number of sensor equipment trials are being undertaken within the Trust to support the patient's care journey.

The declutter programme continues on a quarterly basis and is led by Estates and Facilities, supporting wards to ensure ward environments are clutter free and tidy.

The Trust will be participating in the second National Falls audit in May 2017.

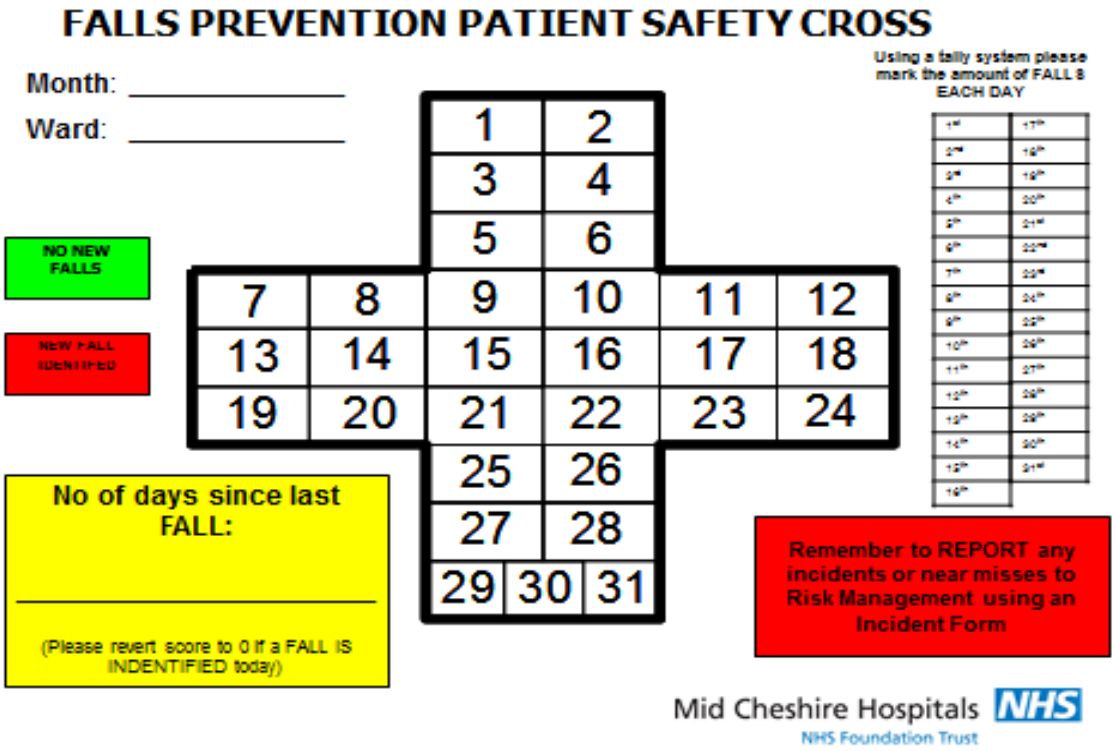
In December 2016, the Trust saw a further reduction in falls with the 10% Sign up to safety target being achieved 12 months ahead of target.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Serious Incident	0	1	2	0	0	0	0	0	1	1		
Moderate Harm	2	0	0	0	2	1	3	2	3	1		
Low Harm	23	31	20	25	32	20	16	13	11	24		
No Harm	36	39	41	38	42	44	51	44	35	35		
Cumulative Total 2016-17	61	132	195	258	334	399	469	528	578	639		
Sign Up To Safety Target	65	130	195	260	325	390	455	520	585	650	715	780

Table X shows the number of falls 2016/17 and a sustained reduction since the implementation in November 2016 of the 'One Step Ahead' Falls Safety Collaborative across all inpatient wards (Cycle 2).

There is an acknowledgement that we are not going to eliminate falls altogether, and we do have to balance the encouragement of independence with the management of risk. However, we know that there are many risk factors that can be mitigated. We are now working hard to sustain the success achieved and reduce the harm caused.



Mid Cheshire Hospitals NHS
NHS Foundation Trust

One Step Ahead

Safety:
Reducing mortality rates

What do we want to achieve?

We will ensure that our Summary Hospital-Level Mortality Indicator (SHMI) will remain at or below 100.

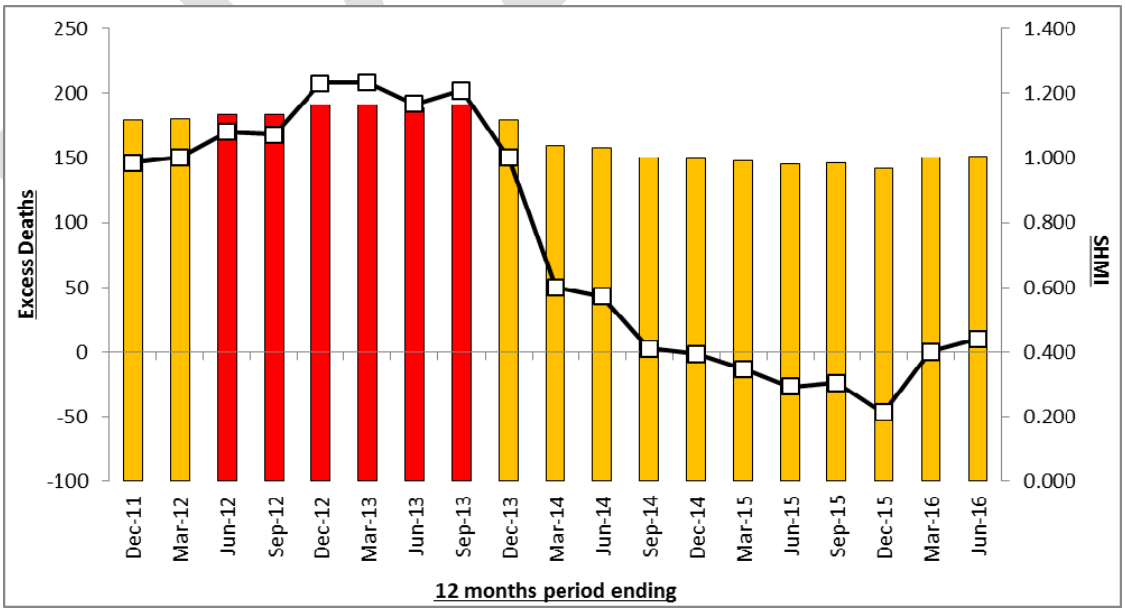
Why is this important?

SHMI is an indicator which reports on mortality at trust level across the NHS in England. It is a ratio of the observed number of deaths to the expected number of deaths for a provider on the basis of average England figures, given the characteristics of the patients treated (Health & Social Care Information Centre, 2011). The SHMI measures mortality both in hospital and within 30 days of a patient's discharge.

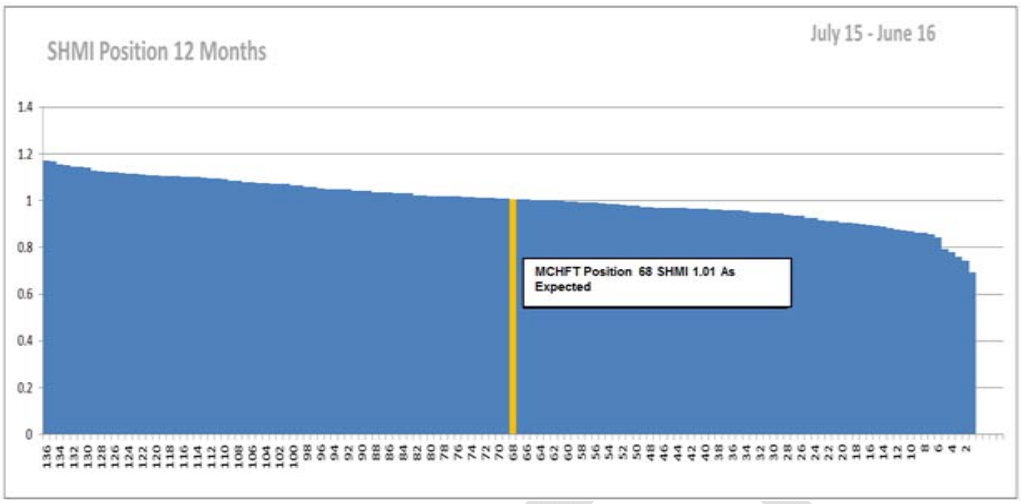
This measure is important because a high mortality rate may indicate problems with the quality and safety of care provided (Care Quality Commission: Intelligent Monitoring, 2013)

What progress was made in 2016/17?

The Trust has continued to remain in the 'as expected' range. For the period July 2015 to June 2016, the Trust's SHMI is 1.01 and "as expected.



The Trust's SHMI of 1.01 for the time period July 2015 to June 2016, places the Trust 68 out of 136 Trusts.



The Trust has a well-established Hospital Mortality Reduction Group (HMRG) led by the Medical Director. This group drives mortality reduction improvement plans within the Trust whilst supporting the clinical divisions to understand their mortality rates and implement their own mortality reduction action plans.
In 2016 a Trust Mortality Group (TMG) was developed to re-invigorate the Trust's drive to reduce its mortality rates and ensure a uniformed approach to mortality reduction across the Trust. The TMG will continue to meet quarterly in 2017/2018.

The Trust is participating in the national *Sign up to Safety* campaign and reducing mortality is one of the trust aims. A series of inter-related projects to achieve this are in progress under the primary drivers of:

Reliable clinical care
Effective clinical care
Medical documentation, clinical coding and data consistency
End of life care
Leadership

In 2016 a mortality case note review process standard operating procedure was developed which included the NHSE North (Cheshire and Merseyside) learning disability mortality review process. This was approved by the HMRG and describes the process for the weekly case note reviews and the in-depth case note review process.

All deaths are reviewed weekly, by a senior team of medical staff led by the Lead Consultant for Patient Safety and the Medical Director, to ensure that appropriate care was provided, any identified gaps investigated and learning shared with clinical teams. Where gaps in care are identified the case is referred for an in-depth mortality review. These reviews are undertaken by members of the senior medical team and a senior nurse. The findings of the

review are fed back to the HMRG and the patient's clinical teams to ensure learning.

A gap analysis was undertaken in response to the CQC report on learning, candour and accountability. Compliance with the recommendations made in the report will be monitored through the HMRG in 2017.

A mortality report based on the information received from HED has been developed to include speciality level data. The report ensures both corporate and divisional ownership of mortality data. Where trends are identified divisional mortality actions plans are developed using the **REMEL** acronym.

A care pathway group was formed in 2016, the group continue to lead the work to review and relaunch four priority clinical pathways. The four priority pathways which have been reviewed are:

- Sepsis
- Alcohol related liver disease
- Pneumonia
- Acute Kidney Injury

The pathways were relaunched on the 6 September 2016 and an education programme has commenced.

Reducing pressure ulcers – Governors' choice if indicator

What do we want to achieve?

Following a review of our strategy in March 2017, Our aim, in both the acute Trust and Central Cheshire Integrated Care Partnership (CCICP) is to reduce stage 2 avoidable pressure ulcers by 5% per quarter, based on the previous quarter's results and have zero tolerance to avoidable stage 3 and 4 pressure ulcers.

Why is this important?

A pressure ulcer is an injury to the skin or underlying tissue caused by pressure, friction or moisture. They can be extremely uncomfortable and, in severe cases, can result in severe harm to patients.

All patients are potentially at risk of developing a pressure ulcer. However, they are more likely to occur in people who are seriously ill, have a neurological condition, impaired mobility, impaired nutrition or poor posture or a deformity (NICE, 2014).

Approximately 186,000 patients develop a pressure ulcer in hospital each year. However, the vast majority of pressure ulcers are avoidable with the right interventions for prevention and treatment (NHS England, 2014).

What progress was made in 2016/17?

Over the last three years the Trust has seen an increase in the number of hospital acquired pressure ulcers, the details seen in table X.

Financial Year	Total number of hospital acquired pressure ulcers
2014-15	157
2015-16	211
2016-17	265

In response to the increase the Trust has made significant investment to eliminate the number of hospital acquired pressure ulcers:

- During 2016/17, the Trust has invested additional funding on a permanent basis to recruit a Tissue Viability Nurse to specifically focus on the elimination of avoidable pressure ulcers. This nurse works closely with the skin care specialist nurse to provide education and support to staff in the skin care they provide to their patients. The team also provides enhanced support with weekly focus on a target ward, this has raised the awareness of pressure ulcer prevention with the organisation.
- The Trust appointed Divisional Head of Nursing for Surgery and Cancer as the Trust lead for pressure ulcer prevention. This has ensured senior

leadership within the organisation to focus on the elimination of avoidable pressure ulcers.

- The skin care team review all reported hospital acquired pressure ulcers and moisture lesions to ensure all appropriate interventions are in place and to determine the staging of the pressure ulcer. In addition, a ward based mini root cause analysis is undertaken so that staff can understand what led to the development of the pressure ulcer and implement corrective action to eliminate gaps in care. Outcomes of the root cause analysis are undertaken by the ward manager and matron for the area to ensure senior support.
- The Trust's skin care group continues to meet monthly and is chaired by Divisional Head of Nursing for Surgery and Cancer. The group has a multidisciplinary, cross divisional review and the terms of reference have been reviewed to extend the group membership within the organisation.
- Staff education remains a priority within the Trust to eliminate avoidable pressure ulcers. Link Nurse study days have been increased to provide additional training, focusing specifically on the Emergency Department and ward assessment areas. The number of link nurses within each ward has increased to produce a 'link team' which includes support from both registered nurses and health care assistants.
- The skin care team have implemented the photographing of all pressure ulcers to ensure accurate documentation within the organisation. This supports the recognition of any deterioration or improvement in reported pressure ulcers.
- A number of pressure relieving equipment trials are being undertaken within the Trust to support the patient's care journey. This includes the trials of a hybrid mattress, pressure relieving boots, cushions and sole protectors for the end of beds.
- The Trust's Director of Nursing chairs the Cheshire and Merseyside Regional Pressure Ulcer prevention group which ensures communication of new initiatives from the regional group, including a new root cause analysis review tool and an e-learning training package for health care assistances. This also allows for networking with other experts in pressure ulcer prevention and shared knowledge and learning.

In 2016/17, the Trust saw the development of … avoidable pressure ulcers out of the … hospital acquired pressure ulcers reported which equates to …%.This means there was an increase in hospital acquired pressure ulcers from 2015/16 of…pressure ulcers. However, it is recognised that since the commencement of the role tissue viability nurse and skin care specialist nurse within the Trust, the Trust has seen as reduction of 63.6% in avoidable pressure ulcers since November 2016.

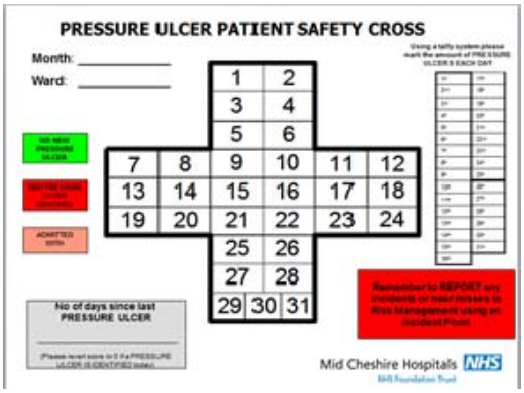
The graph below shows the number of hospital acquired pressure ulcers for 2016/17 compared to 2015/16.

Add chart.

The elimination of avoidable hospital acquired pressure ulcers remains a priority for the Trust as part of the Quality and Safety Improvement Strategy for 2016/18. In addition, The Trust has implemented the **React** 2 **Red** collaborative, a national initiative aimed at reducing the development of pressure ulcers in hospitals and the community. The collaborative has been developed within 6 ward areas within the Trust and then expanded to an additional 2 wards due its success. The Trust is pleased to report that Ward 13, who has participated in the React 2 Red collaborative, has gone 7 months without a hospital acquired pressure ulcer.

The collaborative was implemented to ensure **React** 2 **Red** initiatives were adopted within the **React** 2 **Red** wards. Due to the success of specific initiatives, they have been rolled out Trust wide to all inpatient ward areas, these include;

- Introduction of a safety cross, a visual aid to monitor the number of reported pressure ulcers per month.
- Implementation of repositioning boards at the end of each bay, highlighting to all members of the multidisciplinary time the frequency of patient repositioning.
- Separating repositioning charts onto clip boards at the end of each patient bed to support the documentation of repositioning



The Trusts Pressure Ulcer Prevention Team

Performance against quality indicators and targets

National quality targets

	2013-2014	2014-2015	2015-2016	2016-2017	Target	Achieved
MRSA bacteraemias	4	1	0	3 (to Jan)	0	✗
Clostridium Difficile infections	26	10 avoidable cases	8 avoidable cases	22 avoidable case (to Jan)	24	✓
Percentage of patients who wait 4 hours or less in A&E	95.38%	92.3%	93.4%	90.24%	95%	✗
The percentage of patients waiting 6 weeks or more for a diagnostic test	0.49%	0.37%	0.55%	0.34%	<1%	✓
Percentage of patients seen within two weeks of an urgent GP referral for suspected cancer	95.56%	95.96%	96.60%	98.12%	93%	✓
Percentage of patients seen within two weeks of an urgent referral for breast symptoms where cancer was not initially suspected	95.39%	95.47%	95.53%	97.86%	93%	✓
Percentage of patients receiving first definite treatment for cancer within one month (31 days) of a cancer diagnosis	99.59%	99.55%	99.48%	99.81%	96%	✓
Percentage of patients receiving subsequent treatment for	99.3% 100%	99.2% 100%	100% 100%	100% 100%	94% surgery 98% drugs	✓ ✓

cancer within 31 days where that treatment is surgery or anti-cancer drugs						
Percentage of patients receiving first definite treatment for cancer within 62 days of an urgent GP referral for suspected cancer	90.82%	89.34%	91.22%	92.86%	85%	✓
Percentage of patients receiving first definite treatment for cancer within 62 days of referral from an NHS Cancer Screening Service	94.84%	95.94%	97.94%	95.39%	90%	✓
The maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate-patients on an incomplete pathway				94.37%	92%	✓

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

Add

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 2016/17 and supporting guidance

- 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 April 2016 to (date of this statement)
    - papers relating to the quality reported to the board over the period April 2016 to (date of this statement)
    - feedback from commissioners dated XX/XX/20XX
    - feedback from governors dated XX/XX/20XX
    - feedback from local Healthwatch organisations dated XX/XX/20XX
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated XX/XX/20XX
    - the (latest) national patient survey XX/XX/20XX
    - the (latest) national staff survey XX/XX/20XX
    - the Head of Internal Audit's annual opinion of the Trust's control environment dated XX/XX/20XX
    - CQC inspection report dated XX/XX/20XX

- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered

- the performance information reported in the Quality Report is reliable and accurate

- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice

- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and

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

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the board

……Date……Chairman

……Date……Chief Executive

Appendices

Appendix 1 – Glossary and abbreviations
Appendix 2 – Feedback form
Appendix 3 – 2016/17 limited assurance report on the content of the Quality Report and mandated performance indicators.