NHS
Mid Cheshire Hospitals
NHS Foundation Trust

Quality Account

2022-23

Because you Matter

Part 1: Statement on Quality from the Chief Executive Officer

Welcome to the Quality Account Report for Mid Cheshire Hospitals NHS Foundation Trust for 2022/23.

The National Health Service has endured a uniquely challenging period since the spring of 2020 and there is no doubt the impact of COVID-19 will be long-lasting. I have had the pleasure of joining Mid Cheshire Hospitals NHS Foundation Trust (MCHFT) in September 2022 as the Chief Executive Officer, I am delighted to share some of our work through the Quality Account for the period of April 2022 to March 2023.

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

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

Whilst the Coronavirus Pandemic (Covid-19) may no longer constitutes a public health emergency of international concern during 2022/23 it remained one of the key challenges we faced during 2022/23 . During the year we have, at pace, implemented many changes to the core function of the organisation in accordance with the requirements set down by Public Health England and NHS England/Improvement. In response to COVID-19 the Trust has worked within the principles of both the National Outbreak Policy and Emergency Preparedness Pandemic Policy to implement changes to support patients and staff either suspected or confirmed as COVID-19 positive. Throughout the COVID-19 pandemic, our Trust has evolved our response to support the very best possible care for those impacted. Some of these changes have included increasing Critical Care Capacity, redefining ward areas to ensure strict infection prevention and control and continually providing staff with the correct level of Personal Protective Equipment and training.

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

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

We recognise that providing health care is not without risk and that sometimes patients can be unintentionally harmed in the care of hospitals. You will read throughout this Quality Account of the Trust's ambitious aims to continue to reduce harm across our organisation. Our Quality and Safety Improvement Strategy, aligned with the third strategic aim of the National Patient Safety Strategy: Improvement, is the vehicle by which we have steered the direction of travel for quality and safety focusing on the four indicators below:

- Improving Patient Nutrition
- Enhance Staff Wellbeing
- Improve Patient Communication to reduce the risk of increased complaints from patients and relatives
- Harm Free Care – Antimicrobial Prescribing

For the year 2022/23, the Trust continued to deliver a high quality, timely service to our patients. Key achievements for the Trust in 2022/23 include:

- Central Cheshire integrated care partnership (CCICP) have introduced Urgent Crisis Response into the community. This has enabled patients to have access to care from Therapists and Advanced Clinical Practitioners 8am to 8pm 7 days per week which went live on 1 April 2022 in line with the below national drivers.

- The Trust has continued to collect Friends and Family Test (FFT) responses throughout 2022/23 and successfully completed monthly submissions to the national system. During 2022/23 the Trust received 68,864 responses with 92% noting good or very good care.

- In 2022-23, the Trust launched its single approach to improvement called Improvement Matters. Improvement Matters provides a structured approach to problem-solving and a clear and consistent framework for all improvement activity. During 2022-3, the Trust engaged with over 600 staff and patients to develop a Vision for Quality and Improvement Aims, as set out in the MCHFT Operating Model.

In relation to our mortality rates, the latest publication of our mortality data for the reporting period October 2021 to September 2022 demonstrates a Summary Hospital Level Mortality Indicator (SHMI) and the Trust remains positively in the 'as expected' range. We know that our ongoing focus to drive improvements through our Learning from Deaths Programme and being aligned with the health care needs of our patients, has contributed to this achievement.

I hope this Quality Account provides you with a clear picture of how important quality improvement, safety and patient experience are to us at MCHFT. We strive to deliver high quality, safe, cost-effective, and sustainable healthcare services that meet the high standards that our patients deserve. We want MCHFT to continue to be the health care provider that patients trust to provide those highest standards of care and the organisation that staff have pride in and are willing to always give of their best.

I can confirm that the Board of Directors have reviewed the 2022/23 Quality Account and I am pleased to share they agree that this is a true and fair reflection of our performance. Finally, I want to take this opportunity to thank our staff who are highly skilled, dedicated and committed. They work hard to deliver safe and compassionate care to our patients' day in and day out, and in particular during the global pandemic. I would also like to extend my appreciation to our Governors, Volunteers, Members, Patient Representatives, and other Stakeholders who have helped shape our quality programme by taking time out to support and advise us.

Ian Moston
Chief Executive Officer

Date 10 May 2023

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

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

Trust Mission & Values

Our Vision for Quality, where quality is our organising principle at the heart of everything we do, underpins the overarching Trust Mission; ***To inspire hope and provide unparalleled care for the people and communities of Cheshire, helping them to enjoy life to fullest***.

At Mid Cheshire Hospitals NHS Foundation Trust (MCHFT), we want to be sure that everyone in our local community who may use our services has absolute confidence that our care and treatment is completely patient centred. As a Trust, we are committed to the delivery of our Trust Strategy 2021-26.

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

We put you first

involving you in decisions which affect you and making time to learn from what you tell us to get it right for patients and staff every time.

We strive for more

setting ourselves high standards, encouraging innovation and sharing best practice to be the best we can be and deliver great quality, safe care.

We respect you

embracing diversity and treating everyone with understanding, dignity and compassion to support and care for the people we work with and for.

We work together

with colleagues and partners to go beyond traditional boundaries and deliver care which truly benefits our patients and meets their individual needs and wants.

...Because you Matter

Mid Cheshire Hospitals NHS Foundation Trust (MCHFT) provides good quality, safe and effective healthcare to the people of Cheshire and beyond and is therefore committed to co-producing a shared Vision for Quality. This is underpinned by the agreed Trust values, a robust improvement approach using a new continuous improvement methodology and the identification of improvement aims based on robust data analysis and through deep engagement with staff and patients.

The Trust Quality & Safety Improvement Plan 2022-2023 supports the delivery of the organisation's values and mission and continue to learn from experience to ensure reliable, continuous improvement in the quality and safety of our patients. In this iteration of the Quality & Safety Improvement Plan we will continue to learn from experience to ensure reliable, continuous improvement in the quality and safety of our patients. To achieve this, we will underpin the Quality & Safety Improvement Plan with our continuous improvement measurement framework – Quality Matters, a model of continuous improvement based around 6 clear steps, known as the 6 D's.

Quality & Safety Improvement Plan Aims 2022-23

Aim 1 → **Improving Patient Nutrition**

- The aim of the Collaborative was to reduce the incidents of patients receiving the incorrect consistency of diet and fluids

Aim 2 → **Enhance Staff Wellbeing**

- The aim of the Collaborative was to enhance the wellbeing of staff across MCHT & CCICP

Aim 3 → **Improve patient communication to reduce the risk of increased complaints from patients and relatives**

- The aim of the Communication with Relatives work was to reduce the number of issues relating to communication with relatives within complaints on Wards 4 and 12 by 50% by May 2023.

Aim 4 → **Harm Free Care - Antimicrobial Prescribing**

- The aim of the Collaborative was to increase the appropriate use of antibiotics on 4 wards (wards 3, 6, 11, 12) to more than 90% by April 2023.

The Quality & Safety Improvement Plan 2022/23 progress is monitored through the Quality & Safety Harm Free Care Steering group monthly. Each work stream of the strategy delivers a detailed update of progress to the committee for approval and monitoring. Progress is escalated to the Trust's Quality Group (TQG) and then escalated to the Trust's Executive Quality Governance Group (EQGG).

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

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

The Trust is making good progress in the development of our Quality and Safety Improvement Strategy for 2023-2024 which will replace the Quality & Safety Improvement Plan 2022-2023. Our absolute obligation to engagement is paramount. Targeted stakeholder events have ensured full involvement from Staff across all sites in the focus for improvement for 2023-24. The Quality Strategy 23-24 will be based on the four care models within the overarching Trust Strategy: Help me when things go wrong, Help me find out what's going on, Help me stay independent and End of life.

Priorities for improvement 2022/23

Seven-Day Services

Central Cheshire integrated care partnership (CCICP) have introduced Urgent Crisis Response into the community. This has enabled patients to have access to care from Therapists and Advanced Clinical Practitioners 8am to 8pm 7 days per week which went live on 1 April 2022 in line with the below national drivers.

The NHS Long term plan set out standards for each system to be achieved by April 2022; This included an Urgent Community Crisis 2hour Response from any referral source (including people and professionals) 8am – 8pm 7 days per week. This standard will be monitored through the legally mandated Community Services Data Set (CSDS) for both health and social care providers.

The Urgent Community Response (UCR) standards were a first for community service and aimed to increase capacity, responsiveness and improve outcomes for patients with targeted funding identified to support delivery through the Ageing Well (AW) Service Development Funding (SDF) received by each system.

National guidance set out the minimum requirements for 2-Hour's response for Integrated Care systems:

- Provide services at scale: ensuring full geographical coverage of two-hour UCR care
- Provide services from 8am to 8pm, seven days a week, at a minimum
- Accept referrals into two-hour UCR services from all appropriate sources

- Submit complete data returns to the Community Services Data Set (CSDS) to demonstrate the achievement of the two-hour standard.

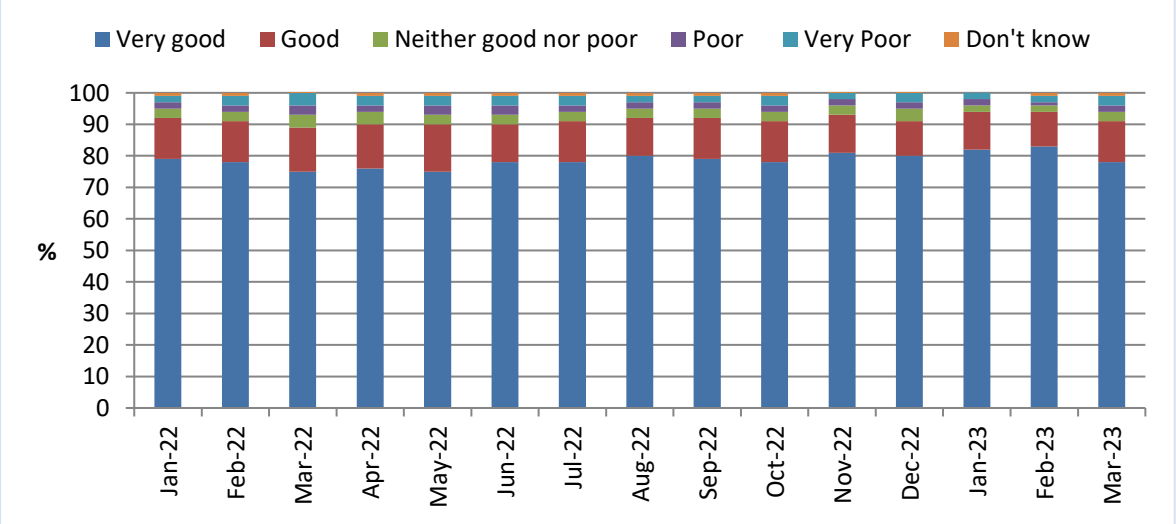
Patient Experience

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

Friends and Family Test

The Trust has continued to collect Friends and Family Test (FFT) responses throughout 2022/23 and successfully completed monthly submissions to the national system. Submission rates have remained consistent through the year, with ongoing work to ensure the capture of appropriate samples. The Trust has developed QR codes (machine readable optical labels containing information about an attached item) to support an increase in responses, particularly in community health. Manual completion of cards is also still available where technology may be problematic.

During 2022/23 the Trust received 68,864 responses with 92% noting good or very good care.



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

"I was admitted on Wednesday and have been looked after so well until Friday night when we could come home. There have been midwives and other staff members checking on me and baby non-stop. There is nothing you could do to improve the service for me. We can't thank you enough."

Ward 23 (Postnatal Ward)

"My experience was absolutely brilliant. Efficient and the staff that I saw were so kind and everything was so timely. I cannot thank the NHS enough."

Dermatology Outpatients, July 2022

"Staff were cheery and amazing, and nothing was too much trouble ward 11 nurse team are wonderful. A&E team couldn't have been treated any better in the situation and pain I was in I could say thank you enough and I'm quite happy for this not to be private as they should all know what an absolutely amazing job they are doing."

Emergency Department and Ward 11

"Very informative, empathetic and professional gave me plenty of time to discuss my issues and didn't feel rushed at any point which was great. Came up with some good solutions which I will be trying. Referred to other services very quickly and I already have other appointments made. Very impressed."

Community Chronic Pain Service

Urology Outpatients Department

You said: "Once in the right place everything was fine on any adjoining letter it would help to put the entrance number i.e. entrance 3 Urology or entrance 3 main entrance etc each time I have had to ring up prior to my visit to check which entrance"

We did: We have amended our patient letters to state we are located closest to Entrance 3.

Emergency Department, Leighton

You said: "No communication referring to waiting times. Systems very confusing" and "Unclear systems of communication, no indication of wait times. Massive room for improvement to treat people with dignity and provide clear communication channels instead of confusion".

We did: We have devised a leaflet to give to patients that are attending Emergency Department as a GP accepted patient and a leaflet entitled 'Emergency Department Corridor Care' which will be given to patients who are being cared for whilst waiting in the corridors of the department.

TV screens have been installed in the department's old waiting room, above streaming and in the new department waiting room that will display information and waiting times.

An explanatory journey sign is being reviewed for the new reception build in early 2023.

Eye Care Centre

You said: **"**Eye examinations were made in a professional manner and in no way do I have any concerns. As a person who has worked successfully in a technical role in manufacturing on product and process development, I would be interested in more detail of the instrumentation and how it does the process of finding problems. I have taken leaflets and looked at the posters displayed but would like better understanding of what is happening. Could the TV screens in the waiting room perhaps give more video instruction on processes? This I think would before useful."

We did: A short video is currently in the process of being put together to discuss tests within clinic. Posters are now displayed within the department detailing the tests being undertaken within the Eye Care Centre.

National Surveys

NHS England produces and uses a range of different surveys as a valuable source of feedback directly from patients and service users about the care that they receive. The Trust participated in four of these national patient surveys in 2022/23.

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

Two national surveys the Trust is mandated to participate in published results in 2022/23, and one is in fieldwork stage and due to close March 2023.

Survey	Detail
National Adult Inpatient Survey 2021 **(results published in September 2022)**	The Trust response rate for the survey was 39%. Benchmark results showed the Trust to be better than most Trusts in 1 of 47 questions and about the same in the remaining 46 questions, with the overall patient experience being 8.1 out of 10. There were no regulator concerns raised. Areas identified for improvement work were around waiting for beds on arrival, discussions around equipment and adaptations at home, support after leaving hospital, and disturbance from hospital lighting. Several projects are ongoing to address the areas/questions highlighted including, but not limited to: • FFT QR codes, new digital platform and Trust internet • Urgent and emergency care project reviewing flow and capacity to support timely admission • Continuous recruitment programmes, both national and international • Development of ongoing patient feedback methodologies through the Integrated Placement of Care Hub

National Maternity Survey 2022 (results published in January 2023)	The survey is split into three sections that ask questions about: Antenatal care, labour and birth and postnatal care. The Trust response rate for the survey was 47%. Out of the 50 questions, the benchmark results showed the Trust to be somewhat better/better/much better than expected in 16 questions, about the same in 35 questions and no questions worse than comparable Trusts. No areas of concern from a regulator perspective. Areas identified for improvement work were centred around antenatal care including medical history awareness, choice and information around place of birth, and time to ask questions at check-ups. Partners supporting throughout admission was also highlighted. Work is ongoing to review and improve maternity care through improvement action plans.
Urgent and Emergency Care 2022	Fieldwork on the 2022 iteration of the survey closes in March 2023, with results expected around June 2023.

Local Surveys

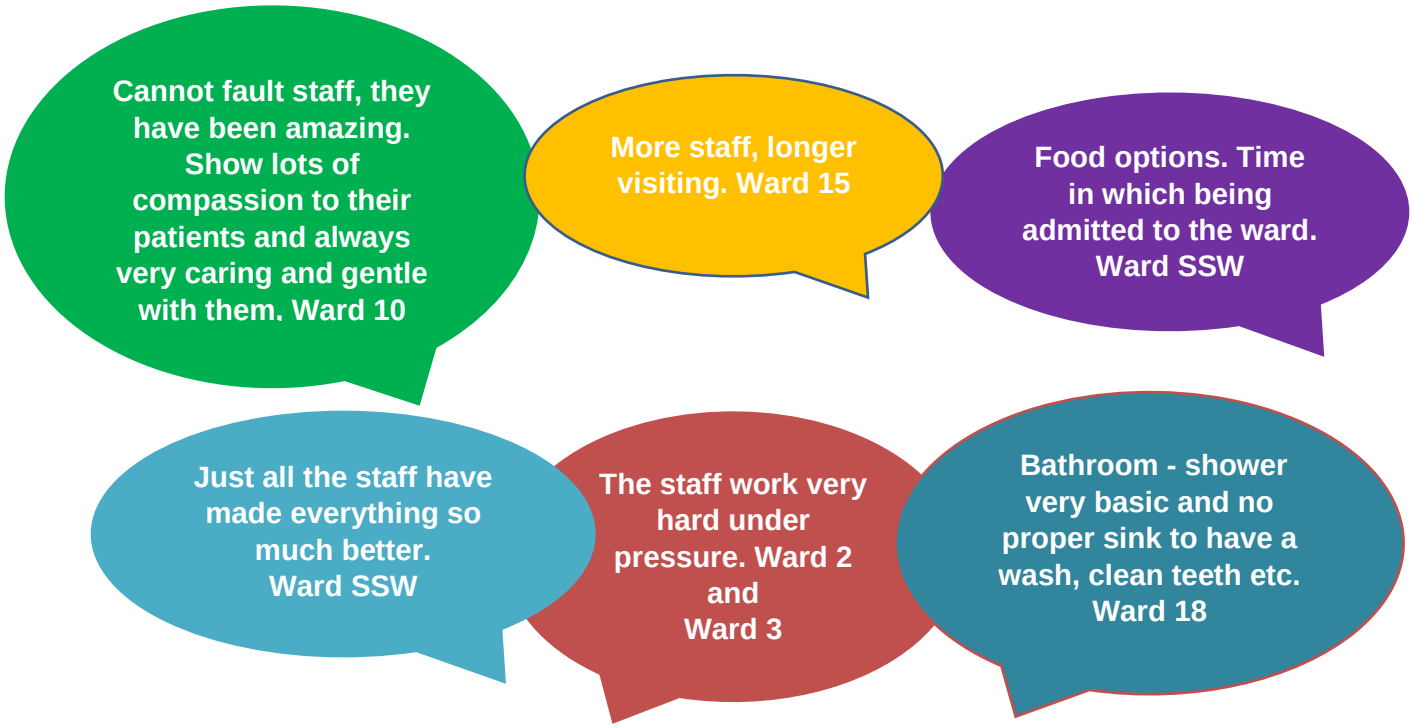
The Action Group for Patient Experience supports review and co-production of local surveys prior to dissemination and data collation and analysis is supported through the Patient and Public Involvement Team. Most surveys now use a mixed methodology of electronic and manual data collection to support improved responses.

Examples of local surveys that have taken place include:

Survey	Detail
Specialist Community Stroke Survey	The survey had a good response rate of 52% and showed a 100% positive response for the experience of care with the service. Improvement actions highlighted from the survey included review of current patient information provision and potential standardisation across the team; review staffing to pilot group therapy interventions in different geographical areas; assess current weekend therapy provisions; review timescales and methods for first patient contact across the caseload.
Endoscopy Unit Survey	Overall, this survey showed a positive response with 100% of patients saying they would have the procedure again. The questionnaire was paper based only, with a response rate of 23%. Areas highlighted were waiting times from arrival and explanations around withdrawing consent if necessary. Improvement actions highlighted included communication around delays to patients; review of consent in patient information, assessing current weekend therapy provision; review of timescales and method for first patient contact across the caseload; exploring survey dissemination in other languages.

Tele-dermatology Service Survey	The survey trialled a text message methodology with a 14% response rate. 83% of patients said they had a positive experience and 92% said they would be happy to use the service for future appointments. Improvement actions included developing an information sheet for GPs to give to patients explaining the service and details of how to access the outcome of the referral; shorten the questionnaire in the next iteration to support the response rate.
Local Inpatient Survey 2021	The local inpatient survey is undertaken monthly to assess patient views of elements of their care and experience on discharge from hospital. Results across 2022/23 showed a positive increase in the overall patient experience and positive decrease in patients being disturbed by noise at night from lighting and other patients.

Examples of local survey positive and negative comments include:



NHS Choices

NHS Choices feedback collates information in relation to compliments, comments or complaints regarding the services provided by the Trust. This information is shared with the Divisions to help improve the services at the Trust and ensure that positive comments are fed back to the staff. During 2022/23, 57 postings were made in relation to care and services at the Trust, with 82% positive comments and 18% negative. All comments are responded to.

Ward 18
During my stay in Ward 18 (5th-7th) for my hernia operation, I received the best care and attention from all the staff. Likewise from the doctors and nurses in the Treatment Centre. Thank you.

MCHFT Response
On behalf of Ward 18, Treatment Centre and Medical Staff thank you for taking the time to provide us with such positive feedback for the care that you received during your stay. It is lovely to hear that you received the attention that you needed before during and following your surgery. Your kind comments will be passed on to all involved and we hope that you have had a speedy recovery.

Emergency Department

Arrived in an ambulance with my 18 months old, with symptoms of secondary drowning. It's been 7 hours, and still not seen a doctor. And they act like this is normal, how is a 7/8 hour wait with a child normal!? The worst hospital in the country. Avoid at all costs.

MCHFT Response
The department has seen significant increase in attendance over the last few months and unfortunately this has a huge impact on our waiting to be seen times. This was further exacerbated by the number of acute emergency that attended this weekend. I am sorry that you and your child waited for such a long time, this is not the experience that we want for our patients.

Patient Information

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

In 2022/23, the group developed and/or reviewed 32 leaflets, with examples including:

- CCICP- Patient Passport Paediatrics (original version and symbols version)
- Rheumatology- Interstitial Lung Disease associated with connective tissue
- Colorectal Patient Workshop handbook
- Diabetes Frailty Leaflet - Specialist Diabetes Team

To support this, the Trust has an active Reader's Panel with 73 members who review patient information on a monthly basis and provide a user perspective in relation to the content and production of patient literature by being involved in the development of the written information

During 2022/23 the Trust has begun work on generating QR codes for leaflets displayed across the Trust, which will direct patients to an electronic version of the leaflet and support enhanced accessibility.

Patient/Staff Stories

The Trust actively encourages patient and staff stories at Board Level and within other Trust Groups. Listening to patients and staff experiences and journeys enables redesign and improvements in care according to patients' needs, allowing every step in the patient journey to be examined and improved. Stories are also used to promote achievements and service improvement activity, using tangible evidence from stories provided through the patient voice. Sharing lessons learned and processes used in successful implementation of improvements is a valuable way of spreading the learning throughout the organisation. All stories are shared with the specific areas of care concerned or involved and through Trust groups and committees to support wider learning and cross service development. Examples of digital stories that have been created in-conjunction with patients/relatives during 2022/23 include:

Emergency Department - The story was told by the patient's daughter, as the patient was still upset from their experience to share their story. The daughter explained the traumatic experience her mum had encountered regarding DNACPR discussion. This story is now included in the Resuscitation E-learning Programme for staff.

Community Occupational Therapy - The story was told by the patient's husband, who praised the care, treatment and advice provided by the Occupational Therapy service and was grateful for the adaptions that were put in place to allow his wife to live a more fulfilled life at home.

Ecards

The Trust has a website facility for family and friends to send ecards to patients, which was part of a previous quality improvement project for junior medical staff. Patients can receive a message from their family or friends in the form of a card produced from the website post and delivered to the ward. 2022/23 has seen a total of 68 messages received and delivered by patient experience staff. Numbers have decreased significantly with the reintroduction of visiting following the pandemic.

Interpreting and Translation

The Trust is committed to ensuring that fair and equitable healthcare provision is available and supported for the local population and service users.

In 2022/23 the Trust continued to provide telephone, face-to-face, video and written translation services for staff to access to support patient care. Video interpreting is still in the early stages of development at the Trust and work is underway to increase this method of provision. National challenges are recognised with the increasing diversity and breadth of language provision needed, and the Trust is working closely with the primary service provider to meet local population needs.

Patient Advice and Complaints Team

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

The Patient Advice and Complaints Team aims to respond to concerns and issues in a timely and effective manner, irrespective of whether this involves an informal concern, advice or a formal complaint. Most concerns can usually be resolved directly by staff that are caring for patients, however, sometimes patient or family members/carers prefer to talk to someone who is not directly involved in their care and the Patient Advice and Complaints Team are able to help. The Team can be contacted by telephone, email, in writing and face to face.

Complaints Process

Trust Policy and process for handling complaints reflects the Local Authority Social Services and National Health Service Complaints Regulations (England 2009) and follows the Principles of Good Complaint Handling outlined by the Parliamentary and Health Service Ombudsman (PHSO). The Trust is committed to providing an accessible, fair and efficient service for patients and service users who express concerns or make a complaint about the care, treatment or services they have experienced with independent support signposted through the Healthwatch Advocacy Service and the PHSO.

In 2022/23 the Trust continued to strengthen triangulation and learning from complaints and patient safety incidents, with improved scrutiny and investigation around concerns and issues involving patient care and more cohesive lessons learned and improvement actions. To support this process a weekly Triangulation Group reviews all new complaints, patient safety incidents and claims, and highlights and investigates potential themes.

A robust process for formal complaints is in place, with a two-stage quality assurance process following initial investigation and response completion, prior to executive sign-off. This process provides appropriate scrutinisation and assurance in relation to the quality of response.

Timely processing of formal complaints is monitored through key performance indicators for acknowledging formal complaints within three working days and completion of complaint responses within forty working days. This has remained a challenging target throughout the 2022/23 due to service demands on clinical services and staff, however, acknowledgement of formal complaints has remained at 100% compliance throughout the year.

Complainants have been updated in relation to any delays around complaint responses and a risk assessment remains in place around the backlog and related staffing increases remain in place to provide continued support.

The Trust received 265 formal complaints in 2022/23 and dealt with 3009 informal concerns and enquiries for advice and signposting that were logged on Trust systems. Both formal complaints and informal concerns remain considerably

higher than pre pandemic numbers, with the PALS service in particular seeing a significant increase in contacts (152%). Improvement actions taken as a result of issues raised through formal complaints and informal concerns include, but are not limited to:

- The Emergency Department Practice Educator has completed further triage training with a key focus on analgesia administration; arranged further training for staff to ensure nursing competency in performing male catheterisation; provided training sessions in relation to discharge planning to the newly qualified nurses in the Emergency Department
- The Emergency Department has devised a leaflet which is given at triage and explains the process for patients arriving for assessment by a speciality
- More comfortable high back chairs have been placed in the Emergency Department along with a television to display waiting times
- Additional staff have been funded to provide corridor care in the Emergency Department
- Additional staff in the Emergency Department (ED) have received training in using ultrasound to assist in finding a vein when using cannulas or intravenous equipment
- Paediatric trained nurses have been recruited to work in the children's area of the ED and Emergency Department nurses have undertaken additional paediatric training

- Maternity take home medication is now prescribed prior to ladies leaving theatre, in preparation for discharge, and a daily pharmacist processes prescriptions in readiness patient discharge
- Gas and air cylinders are now permanently kept in the induction area on the labour ward
- Training, with a focus on end-of-life care, is being facilitated on an ongoing basis by the Macmillan team and bereavement training has been undertaken with ward staff in Medicine and Emergency Care
- Nursing staff have completed further training in NEWS2; Acute Illness Management; cannulas; falls documentation

- A handover book has been introduced to support information handover between wards and a full understanding of patient needs for discharge
- Further education has been provided by the Deputy Associate Medical Director for Medicine and Emergency Care around setting up TIVA pumps
- A patient group directive has been introduced which enables preoperative nurses to dispense ready labelled antibiotics to a specific group of patients
- The standard operating procedure for wound care has been updated to support improved checks and documentation around the number of dressings removed and inserted into the wound during reviews
- A relative's digital story on behalf of a patient relating to discussions around DNACPR has been incorporated into resuscitation training
- A lived experience patient has provided training in vulnerable adult sessions following submission of a complaint which staff felt was valuable in raising awareness

Complaints Review Group

The Complaints Review Group meets bi-monthly and is responsible for providing information and assurances to the Trust Patient Experience Group that it is effectively managing all issues relating to the Trust complaints framework and national complaints agenda. Group membership includes multidisciplinary staff and patient and Healthwatch representatives. During 2022/23 the Group continued to scrutinise, review and share learning from complaints.

Parliamentary Health Service Ombudsman (PHSO)

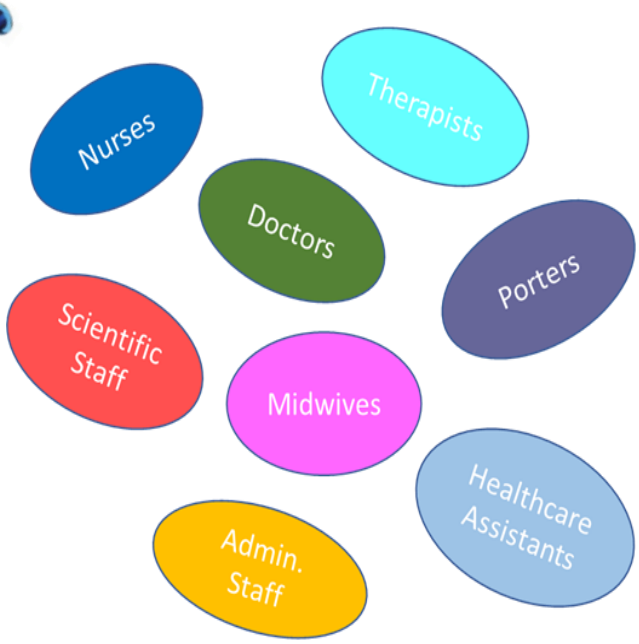
The Trust has received two potential investigations for assessment from the PHSO in 2022/23 and two requests for information only, no investigations have been confirmed. The PHSO have provided the Trust with two formal complaints investigations, with one being not upheld and one partially upheld. In response to the partially upheld investigation the Trust was fully compliant with the action required to provide an apology to the patient's relative within appropriate timescales.

Compliments

The Trust received 364 compliments through the Patient Advice and Complaints Team in 2022/23 that were logged on Trust systems (29% increase). Compliments are shared with relevant staff across the Trust to ensure that their dedication and hard work is recognised, something which has been of particular importance this year for the Trust as a whole. Compliments have been recorded for numerous staff groups within the Trust, including but not limited to:

"Please convey our thanks to the team following a recent outpatient appointment at the Eye Care centre. My personal opinion, shared by my Wife, is that the Eye care centre clinicians collectively present the reference standard for skill, care and compassion. Other hospitals could learn a great deal from them"

"I wish to compliment your staff for the attitude and expertise attended to my wife during her visit to your Emergency Department. She is profoundly deaf and at all times during her five-hour assessment/treatment she was provided with excellent service by each administrator, nurse and doctor we contacted. They are a credit to your organisation".



I would like to make a compliment about the maternity service, the antenatal team in we're always kind understanding and very caring and the consultant was fantastic. I was admitted for early induction. The midwives explained everything and were extremely kind and could not do enough. I went into labour and was taken care of by what can only be described as an angel! She and the student midwife were amazing, I felt like I had family with me not staff. The midwife was prompt in spotting that my baby was breech and was there the entire time whilst I held on to her scared. She was so reassuring and just incredible. My partner was also treated with kindness and compassion throughout especially by the anaesthetist and theatre staff!! I will be forever grateful. I was sent home after a night's stay on ward 23 where all the staff were amazing and helpful throughout my stay a massive thank you thank you!!!!!!

Learning Disabilities and Dementia

Learning Disabilities Access

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

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

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

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

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

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

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

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

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

We have also extended this service to other complex patients who find it difficult to access the hospital for blood tests; for example people with a significant mental health issue.

We continue to produce easy read information leaflets. The Trust continues to promote and raise the awareness of the importance of making reasonable adjustments for people with learning disabilities. These may include:

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

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

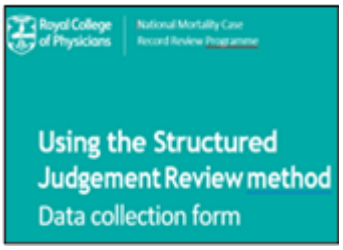
- Education and training of staff is pivotal when supporting people with LD in hospital. Staff are now able to access an e-learning package in relation to caring for people with a LD. The training forms part of the mandatory Level 3 Adult Safeguarding requirements.
- The Trust has now implemented the national mandatory Oliver McGowan Learning Disability and Autism training. We have also re-introduced face to face training through our Adults at Risk study days. The last training day included a person with LD and their carer plus a person who has Autism. Their first-hand experiences of hospital care were invaluable and the feedback from attendees was extremely positive.
- The Trust has an educational video in relation to mental capacity assessments and best interest decision making. Staff now have the opportunity to view practical application of the Mental Capacity Act in hospital-based scenarios.
- The Trust has recently taken part in Round 5 of the NHS England (NHSE) and NHS Improvement (NHSI) Learning Disabilities Improvement Standards Collection National Audit. This involved an organisational checklist, feedback from patients and carers plus a staff questionnaire.

Results from previous rounds 1-4 have demonstrated that the Trust is above the national average in the following areas:

- 100% of people felt they were treated with respect
- 78% of service users felt appointments and meetings were arranged to suit them
- 88% of staff felt that we treated children, young people and adults with a LD/Autism with dignity and respect.

Round 4 highlighted areas for improvement and in response to this we have:

- Awareness of the “LD” flag raised during training sessions
- The Head of Nursing (HON) for Adult Safeguarding now receives a list every 2 weeks of adults with a LD who are on a waiting list. Community LD teams and /or carers can also contact the HON who can expediate appointments where patients in the community are having difficulties
- The HON for Adult Safeguarding now undertakes a quarterly audit of restrictive practice, which is shared with our safeguarding colleagues from the Integrated Care Board (ICB). The audit is carried out by reviewing incident reports alongside seeing the actual incident in real time; looking at the body camera footage worn by the Security Team.
- We continue to review all LD deaths within the Trust using the Structured Judgement Review process, and fully support the national Learning Disability Mortality Review (LeDeR) Programme. Any areas for improvement are highlighted and shared across all Divisions, as well as good practice. This may extend to primary care if there are wider lessons to share.



- The HON for Adult Safeguarding also attends the Cheshire and Merseyside ICB LeDeR Review Group.

There have been some excellent examples of good practice shared over the past 12 months such as:

- Communication with families, timely prescription of anticipatory end of life medications and evidence of multi-agency working including referrals to Chaplaincy.

Areas highlighted for improvement include:

- Where patients are unable to tolerate oral medications, alternatives could have been sought earlier
- Timely decisions regarding commencement of an End-of-Life Care Plan
- Where patients are fed vi8a PEG (Percutaneous Endoscopic Gastrostomy), we need to ensure we discuss how we manage this when patients are at end of life.

Dementia

Dementia describes a group of symptoms associated with a progressive decline of brain functions such as memory, understanding, judgement, language and thinking. The most common form of dementia is Alzheimer's disease. People with dementia are at an increased risk of physical health problems and become increasingly dependent on health and social care services and on other people.

In Cheshire East there are estimated to be 5730 people over the age of 65 living with dementia

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

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

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

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

- The Dementia Care Group meets regularly to review, monitor, and challenge the commitment to our patients with dementia and their carers. Our carer representative ensures that the people with dementia in hospitals are treated appropriately and hold us to account for the delivery of that care.
- The Trust's 3-year Dementia Strategy 2020-23 is due to be renewed this year. The current Strategy has led to improvements demonstrated through regular audits of issues such as number of ward moves, prompt referrals to Occupational Therapy and the use of supporting documentation such as the Dementia Care Bundle.

- Our Dementia Specialist Nurse works closely with the Psychiatric Liaison Team to plan care and treatment. Their weekly multi-disciplinary meetings review patients currently in hospital and demonstrate how a joint approach can improve both clinical outcomes and patient carer experience. Our Dementia Specialist Nurse also provided training for staff in relation to the management of agitated patients with dementia. This was done in collaboration with Liaison Psychiatry.
- Working closely with our District Nursing colleagues, we often attend home visits to support people with dementia and clinical decision making.

- A particularly valuable addition to the team has been our Activity Co-ordinator. The post has been funded for 12 months by the Charity Appeal. The Activity Co-ordinator does group work as well as 1:1 sessions with particular patients. The feedback has been extremely positive from both patients and their families:

    - *"On another note, please thank the activities lady on the Ward. What a fantastic idea, she certainly kept my mum and the others occupied with games, quizzes and general conversations. I do hope that this continues for other patients as it certainly helped my mum."*
    - "*The activities really helps keep your brain functioning and your mind off your problems. The young lady is extremely caring with a lovely personality*"
- Dementia Link Nurse sessions have been re-commenced and they involve staff from both MCHFT and CCICP. Sessions involves outside speakers who can enhance the care we provide for our patients with dementia and their carers and involved signposting for community support and simulation to improve our communication.
- The Dementia Specialist Nurse has been working closely with the Integrated Discharge Team to devise behavioural management plans to support patients moving from hospital care to care out in the community.

Infection Prevention and Control

The last twelve months have continued to be challenging in relation to Infection Prevention and Control (IPC) in light of ongoing COVID-19 infections, along with other seasonal infections, such as Influenza and Norovirus.

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

Key achievements for 2021-22 represent the following:

- Management of COVID-19 infections, in addition to other organisms/infections.
- IPC advisory group meeting weekly to provide multi-disciplinary decision-making, prevention strategies and processes related to all aspects of IPC
- Clear updated guidance and campaigns relating to PPE (Personal Protective Equipment) guidance following on from BeEquiPPEd1, 2 and 3 during COVID to a Stay Safe campaign
- Significant sharing of initiatives and processes with local and national IPC colleagues
- A commitment to training hours and supporting staff following the COVID-19 pandemic
- Maintenance of the environmental audits to review environmental hygiene, including the production of improvement plans which are monitored.
- IPC Involvement in new build and refurbishment programmes

Pastoral Support Service

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

Although this service does not cover all staff groups, the Pastoral Team have endeavoured to provide pastoral support/signpost to alternative services for any member of staff that may approach the team.

Background

The Pastoral service was implemented into the organisation as a proof of concept in June 2021 to support the health and wellbeing of staff. The service offers a unique resource that has previously not existed or has been delivered informally and inconsistently by colleagues / managers to staff.

The Pastoral Support Team acts in a supportive role as a coach / mentor / supportive listener. They are required to work closely with staff where appropriate to provide a robust model of pastoral support, offering pastoral advice and guidance as well as clinical support. They signpost other agencies and services within the Trust and across the wider system and community as appropriate.

Staff engagement

During 2022-23, the Pastoral Team have engaged with staff through a number of avenues;

- Weekly ward visits across the hospital site to wards and departments
- Acceptance of self-referrals
- Acceptance of referrals and working in collaboration with others eg. Line Managers, Freedom to Speak Up Guardian, Quality Governance, Pastoral Midwife, Practice Educator Facilitator's, HCA Clinical Skills, Legal services, Safeguarding, Occupational Health
- 6 weekly diarised drop-in sessions at Victoria Infirmary Northwich, Elmhurst, Infinity House and across all care communities at various bases
- Monthly drop-in sessions at the hospital site
- Meeting all new starters to the organisation in contributing to the induction programmes of Nurses and HCAs as well as contributing to the Preceptorship

programme for Nurses and facilitating introductory meetings and trainings specifically tailored for our overseas Nurses

- Responsive to the requests to offer time to whole teams; introduction of the Pastoral Team and 'taster sessions' and providing information and signposting to the wide range of health and wellbeing support and resources available
- Action concerns raised within Patient Safety Summit; establish contact and provide support to individuals/teams as appropriate
- Continuing to offer support to those individuals/teams that have experienced traumatic clinical incidents
- Support to those experiencing the process of inquest, fitness to practice investigations and action plans/clinical competencies.

Since the implementation of the Pastoral Support Service the total number of individual staff members offered support is approaching 500 which equates to 10% of the workforce. Referrals are associated with both home and work life stressors.

There are over 50% of staff who have received continuing regular/semi-regular sessions with the Pastoral Team.

In addition, the Pastoral Team have visited several Wards, Departments and Teams across the organisation to facilitate conversations, to offer support and intervention and share information of the health and wellbeing support that is available.

Collaborative Working

To enhance staff experience it is important to take a collaborative approach, with multidisciplinary working to enhance staff health and wellbeing, therefore the Pastoral Team continued to work with a number of groups across the organisation;

- Health and Wellbeing Project Board
- Stress Steering Group
- Menopause Working Group
- Arts Steering Group
- Staff Retention Subgroup
- Patient Safety Summit
- Civility and Psychological Safety Group
- Equality, Inclusion and Diversity Group
- BAME Network
- CIRC Overseas Nurses Recruitment
- Quality Safety Improvement Plan Group
- Participation in ward accreditations

Celebrations of achievement

Since the introduction of the Pastoral Support Service, the team have received recognition for a number of achievements;

- NHS England and NHS Improvements Beneficial Changes Network published a narrative from the Pastoral Team 'Programme to enhance staff health and wellbeing'
- Runner-up for the 'Staff Wellbeing Award' from Cheshire and Merseyside Professional Pride Awards
- A successful first 'Cultural celebration event' that was held at the Trust on the 5th July 2022
- Recognition of the Trusts Pastoral Support Service from the University of Chester, with shared organisational learning on the development and the service.
- Recognition of the Pastoral Team from the Chief Nurse of North West Integrated Care Board
- Indra Kunder celebrated scooping the RCN North West Award for outstanding contribution to Equality, Diversity and Inclusion in October 2022.

Examples of feedback;

I felt listened to and felt that the pastoral team took on board my concerns and upset and helped to formulate a plan to meet the needs I had and allowed a good outcome to be found

I have had ongoing support from your services which have enabled me to remain in work and helped me build a better way of coping with daily stresses

I felt fully supported & listened to & that I had someone who was "on my side" cheering me on.

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

Freedom to Speak Up

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

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

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

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

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

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

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

- Directly to the Freedom to Speak up Guardian
- FTSU boxes in various locations across Trust sites
- Incident / Speaking Up report form
- Exit Interviews/Exit Survey
- Manager
- Employee Support Advisors (ESA)
- Dedicated speak up email address
- Staff Support Voicemail
- External sources e.g., CQC, National Whistleblowing Helpline and Counter fraud.

Walkabouts across the organisation, Leighton site, Victoria Infirmary, and a variety of community settings within Central Cheshire Integrated Care Partnership continue, these sessions allow the FTSU Guardian to meet and talk to staff about the role and promote the FTSU service.

Promotion of the Freedom to Speak up Champion’s role has occurred through FTSU month. Further promotion of the Champions role is planned. The Guardian attends the Trust partnership / Network meetings, for example; Cultural Diversity group and Disabled and Carers Group.

During the FTSU month (October 2022) the FTSU Guardian held a number of FTSU walkabouts, a Staff quiz was promoted on the Trusts FTSU service with prizes for the winner.

The Non-Executive Director aligned to support and promote the FTSU role provides links into the Trust Board. The FTSU Guardian facilitated a Board well led event regarding FTSU. The policy for speaking Up has been updated and follows the outline for the National Speak Up Policy. This is designed to be inclusive and support resolution by managers wherever possible, it provides a standard for local freedom to speak up across the NHS.

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

A total of 41 concerns have been reported to the National Guardian Office during 2022/23. This has showed an improvement from previous years. Concerns have been raised through a variety of mechanisms. It is positive to note the increase in cases reported throughout the period compared to the previous years which evidences that staff feel empowered to raise concerns.

Staff Group	**Count**
Allied Health Professionals	4
Medical & Dental	1
Ambulance	
Registered Nurses & Midwives	10
Administrative & Clerical	1
Additional professional scientific & Technical	1
Additional Clinical Services	3
Estates & Ancillary	15
Healthcare Scientists	0
Students	0
Not Known / Other	6
Grand Total	41

Estates and ancillary workers have raised the most concerns over the past 12-month period. This sees a change from the previous year whereby Nursing & Midwifery saw the largest group raising concerns.

Themes of concerns have centred around civility, safety, intimidation, and cases also show an element of detriment and inappropriate attitudes or behaviours.

The impact of safety is raised by the FTSU Guardian at the Patient Safety Summit. The specific concerns continue to be addressed by the Divisions involved, however, there has also been thematic reviews undertaken by the Guardian to provide further insight, for example in Estates and facilities. This insight helps to shape further enquiry and actions to address issues raised by staff. The Guardian also feeds into the organisations Network forums, actively participating in these groups. Feedback on themes from the FSTU help to represent insight and aid triangulation of issues, for example, the impact on wellbeing from incivility, fed into the Civility and Psychological safety Group.

To monitor and review the service, an electronic questionnaire has been developed. Each member of staff using the FTSU service will be sent an electronic survey to complete which

will provide user feedback. This will be used to improve the service and provide Guardian feedback. Plans are in place to enhance the Trust Intranet page for Freedom to Speak up.

Safe Staffing

The Trust is committed to ensuring that levels of nursing staff, which include registered nurses, midwives, and unregistered health care assistants (HCA's), match the acuity and dependency needs of patients within clinical ward areas. The Trust undertakes a bi-annual review of nurse staffing in line with national guidance and agreed acuity methodology. Based on this review, recommendations are made around investment, skill mix and recruitment in specific areas of the Trust.

The senior nursing team carry out monthly reviews in ward areas, using workforce, quality data and professional judgement. This includes an appropriate level and skill mix of nursing staff to provide safe and effective care. Staffing levels are viewed along with reported outcome measures, 'registered nurse to patient ratios and the number of staff per shift required to provide safe and effective patient care.

Safe staffing levels are managed daily. At the daily staffing meetings, the matrons and ward managers, supported by the heads of nursing discuss the overall view of their wards for the next three shifts by registered and unregistered workforce numbers and ratios. Consideration is given to acuity and dependency on the wards, as well as bed capacity and operational activity within the trust which may impact on safe staffing.

In the event of shortfalls of staff or unexpected increases in patient acuity and dependency requirements, the agreed staffing levels are reviewed with escalation actions specified when required.

The monthly safe staffing report is reviewed at the Trust Board meeting and is also available on the Trust website.

Medical staffing

Medical workforce continues to remain an area of challenge for the Trust with ongoing projects in this area. During 22/23, the Trust has continued with recruitment to its CESR (certificate of Eligibility for Specialist Registration) programme within the specialties of Acute Medicine and Anaesthesia. This is a programme to support senior non -Consultant Doctors to attain Consultant status. The Trust has appointed two senior Consultants as Medical Workforce leads to develop a more detailed medical workforce strategy which supports recruitment and retention of medical staff.

The focus for medical workforce development during 22/23 has been around the Junior Doctor workforce. The Trust has developed a formal programme of international recruitment for Doctors at this level, with a coordinated and centralised recruitment process which offers

robust induction, supervision and mentorship during the programme. In addition, novel posts have been created at Junior Doctor level which combine clinical work with the emerging need and opportunities within digital health and patient safety. The Trust continues to work with the various Junior Doctor forums to support health and wellbeing in this staff group and has this year made progress with the availability of hot food during evening and night shifts, and with the inclusion of protected structured development time in all rotas for Foundation Doctors. The focus for 23/24 will be supporting the development of a Chief Registrar programme, which forms part of our recruitment pipeline for Consultant medical staff as well as continuously improving our health and wellbeing offer.

Reducing Inpatient Falls

The Trust saw an increase in patient falls with 1044 in 2020-2021 to 1199 in 2021-2022.

Year	Total Inpatient MCHFT only	No Harm	Low Harm	Moderate	Major	Catastrophic	Lapses that Contributed	Lapses that did not contribute	No Lapses
2020-21	1044	710	321	4	7	2	4	6	128
2021-22	1199	906	273	9	11	0	16	16	248

During 2022/23 the Trust has implemented a number of changes to support with the reduction of falls across the organisation. The Trust Falls Care Bundle, in line with national guidance is audited Quarterly offering assurance of compliance and identifying areas for improvement. Additional falls training is conducted within the Quality Care Programme, Induction Programme, International Nurses Induction and Harm Free Care Study Days incorporating any identified themes from lapses in care. Trust Falls Link Nurses have been supported to develop Falls Awareness and ward resources. To support a multidisciplinary team approach, falls prevention training and use of the falls bundle has been extended to Therapy Services.

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

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

The Harm Free Care Team monitor all lapses in care, identifying themes and producing initiatives to reduce Falls across all Divisions

Medication Review

Medication reviews have been a focus within the Harm Free Care training, to increase staff understanding of medications that may contribute to a fall. Training is completed by the

Pharmacy Team and reference documentation is available for all staff to access via the trust intranet.

Preventative measures

- Developing a proactive approach to falls prevention, the Harm Free Care Team receive a daily report of patients admitted to the Trust following a fall. These patients are then highlighted to clinical staff by the Harm Free Care Team and signposted to complete the Falls Care Bundle and commence fall preventatives measures promptly at a local level
- The Harm Free Care Team produce a Weekly Frequent Fallers Report which is disseminated to the Ward Managers, Matrons and Heads of Nursing highlighting patients that have a previous falls history and who are currently undergoing inpatient care within their divisions. This report also highlights patients who have been subject to an increased number of ward moves, which may increase the risk of further falls. In addition, the Harm Free Care Team conduct a review of all frequently falling patients to ensure preventative measures are in place alongside a Falls Prevention Plan
- In September 2022 the Trust celebrated Falls Awareness Week, a crossroad event was conducted engaging staff and raising awareness of patients at risk of falls and how to take appropriate preventative measures
- In November 2022 the Trust purchased a 100 falls sensor alarm monitors with accompanying bed and chair sensor mats. Falls sensor training, has been rolled out across all divisions with identified Link Nurses/Super users and is included monthly on the Harm Free Care Study Days. In November 2022 the Harm Free Care Team along with the support of the manufactures completed superuser falls alarm/sensor training sessions over several days. The aim of this was to enable cascade training to all clinical staff via the superuser model. Superusers where then required to ensure training was provided to clinical staff at a local level. Additional training sessions were provided at a ward level by the Harm Free Care Team and practical sessions were incorporated in all nursing inductions for new starters to the Trust. Falls sensors are now available across all Divisions stored in a central store, clinical staff are able to request a falls sensor via the Harm Free Care Team or via the portering system. Elmhurst Intermediate Care Centre hold their own supply of Sensors to reduce delays in transfer across sites
- Identifying themes from incident reviews, the role of staff allocated to provide 1-1 care required clarification. As a result, the Harm Free Care Team launched a 1- 1 action card and the use of a yellow arm band. The Action Card acts as a reference for staff supervising patients who require 1 to 1 supervision, providing them with a guide to their responsibilities and ensuring the patient is not left unattended. Staff providing 1-1 care are identified by wearing a yellow armband. Training has been disseminated across all Divisions.

Documentation

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

Ongoing initiatives to reduce lapses in care are:

- Continuous Falls Care Bundle Training
- Incident Reporting Training
- 1:1 Action Cards Training
- In line with the National Audit of Inpatient Falls - Falls Safe Audit completion, measuring the gap between reported and none reported falls. Results are collated and shared at the Falls Group identifying any areas for improvement
- In line with the National Audit of Inpatient Fall - audit completion which identifies the time of a medical review post fall and the provision of analgesia to patients who have sustained an inpatient frailty fracture. Results are collated and shared at the Falls Group identifying any areas for improvement
- Engagement with the Manual Handling Team to ensure effective manual handling of patients who fall
- Link nurse, identification and training ensuring dissemination of information and localised training.

Falls Assurance

To ensure continuous improvement, the Trust will continue to monitor inpatient falls incidents and address any future areas for improvement. Lapses identified will be escalated to the Quality, Safety and Harm Free Care Group and Trust Quality Group appropriately.

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

Reducing Pressure Ulcers

Central Cheshire integrated care partnership (CCICP)

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

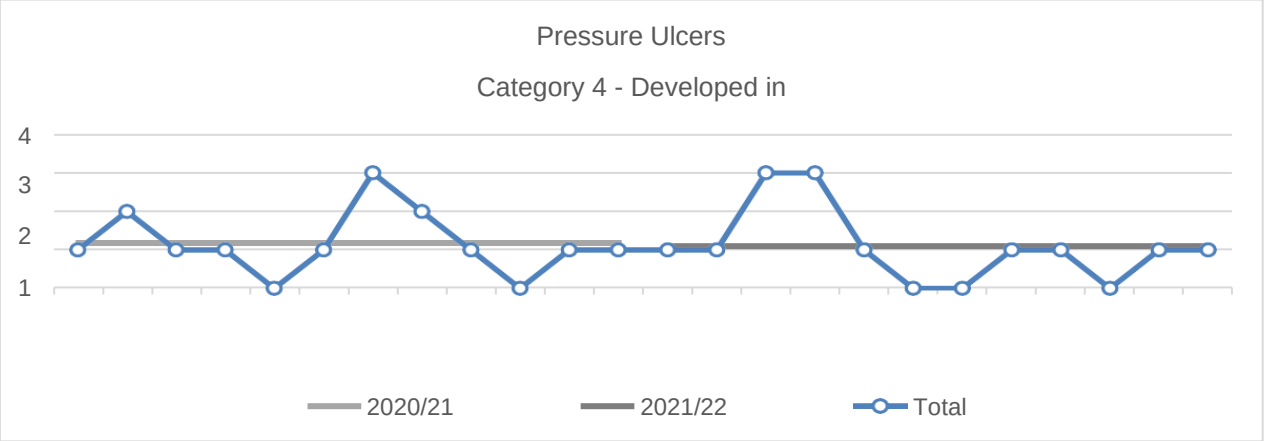
- SMASH (Sandbach, Middlewich, Alsager, Scholar Green and Haslington)
- Winsford
- Nantwich & rural
- Northwich
- Crewe

CCICP have seen a 15% reduction in the number of category 3 and 4 pressure ulcers develop in care in 2021-22 compared to 2020-2021, in view of the increased patient activity and the number of new services aligned to CCICP this demonstrates that CCICP's preventative strategies are supportive of harm free care. A cluster review of 26 category 3 and category 4 pressure ulcers developing in CCICP's care was undertaken for the period of March 2021 and April 2022. This cluster review investigated any themes and areas where improvement and learning could be identified. Of the 13 category 4 pressure ulcers developed in care. 30%

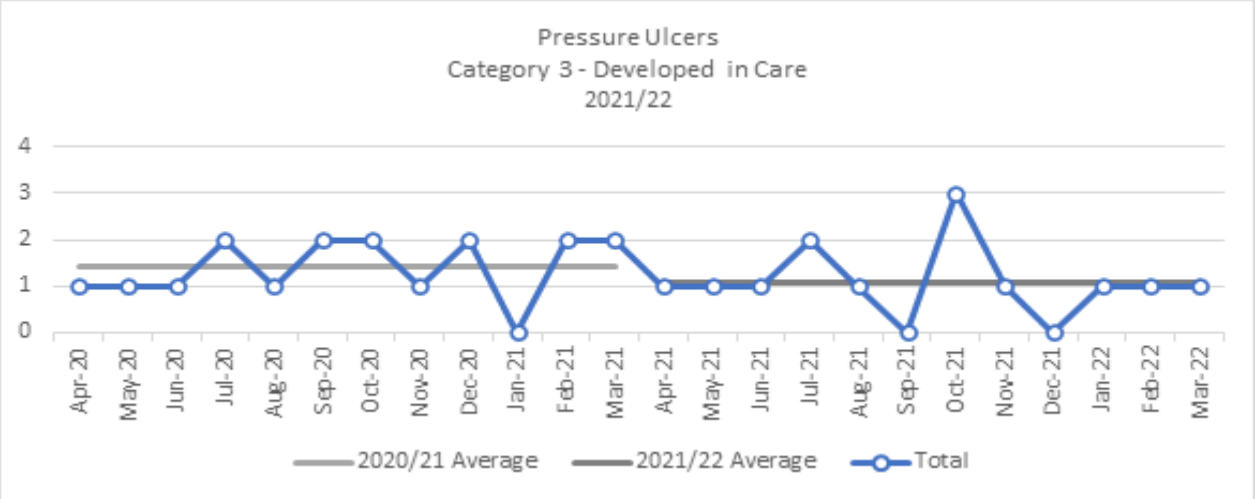
developed in the SMASH Care community. Of the 4 pressure ulcers which developed in SMASH, 75% developed on the Sandbach caseload.

23% of the pressure ulcers developed in the Northwich care Community, 15% developed in the Nantwich care Community, 15% developed in the Crewe care Community and 15% developed in the Winsford care Community.

92% of all category 4 pressure ulcers which developed in care had no lapses in care. Of the 4 patients who developed a category 4 pressure ulcer in care in the SMASH Care Community, 75% had no lapses in care.



There were 13 category 3 pressure ulcers that developed in care during the period of March 2021 and April 2022. 85% of the category 3 pressure ulcers did not have lapses in care that contributed to the development of pressure damage.



Care Community	SMASH	Northwich	Crewe	Nantwich	Winsford
No Lapses	4	6	4	3	5
Lapses that contributed	2		1		
Lapses that did not contribute		1			

CCICP have introduced and continued a number of preventative strategies across our services to reduce the incidence of pressure damage occurring.

Safety Huddles

CCICP have continued the supportive MDT approach, by hosting a virtual 'safety huddle' each Friday to improve the management of pressure damage and quality documentation standards. Each Care Community meets weekly to discuss all unstageable, category 3 and category 4 pressure ulcers as well as any complex patients the District Nursing Team require support and advice with. It also provides an opportunity to discuss any problems the team are facing which may impact on safe care provision. These huddles ensure that complex patients have everything in place to ensure that deterioration is avoided where possible.

Training

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

- Commenced the role out of pressure ulcer prevention to the Care Community Therapy teams.
- Restarted joint CCICP/MCHFT Link Nurse education sessions
- Supported new Wound Care Clinic (WCC) staff and caseload holders by shadowing the service to support pressure ulcer prevention within the WCC setting.
- Continued to offer Pressure Ulcer Prevention support through our community nurse settings
- Participated in the National Stop the Pressure Campaign by creating a video around the "aSSKINg" acronym to raise awareness within the Care Communities involving therapies and specialist services and community nurses.
- PUP training with DN (District Nursing) Out of Hours team
- Rolling program: wound assessment, dressing selection remote education sessions.

Patient information

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

- CCICP Wound Self-Care patient information leaflet
- CCICP Helping to prevent pressure ulcers – Information for patients and carers on emollients and their application.
- Completed moisture associated skin damage (MASD) leaflet to assist staff/carers/patients in the management of MASD.
- Completion of CCICP Wound management guidance.

Bladder and Bowel Service.

The District Nurses (DN) have received training on first line assessment and the Bladder and Bowel Service continues to offer double up visits and face to face education for the DN's.

CCICP Equipment

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

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

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

High Spec Foam Cushions: CCICP have again purchased and supplied over 1000 cushions over the past 12 months. This has ensured patients had access to appropriate equipment in a timely manner. CCICP have moved to Ross Care so these cushions will be supplied directly to patients from the supplier.

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

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

Inpatient TVN Service

In line with the National picture, the Trust saw an increase in developed in care pressure ulcers with 394 in 2020-2021 to 508 in 2021-2022.

Year	Total developed in care Pressure Ulcers (MCHT)	CAT 2	CAT 3	CAT 4	Unstageable	Lapses that Contributed	Lapses that did not contribute	No Lapses
2020-21	394	307	11	5	71	114	17	136
2021-22	508	389	12	4	103	121	16	250

As part of the Quality Team, the inpatient Tissue Viability Specialist Nurse (TVSN) and Skin Care Specialist Nurse (SCSN) monitor developed in care pressure ulcers and Moisture Associated Skin Damage (MASD). Advice and holistic reviews are provided for patients with unstageable, category three and category four pressure ulcers. Category two pressure Ulcers, MASD and deep tissue injuries are managed at ward level with appropriate training. Wards are encouraged to contact the TVSN/SCSN for advice where required.

In line with the Trust Standard Operating Procedure for pressure damage prevention, all category two and unstageable pressure ulcers are reviewed at a pressure ulcer panel to establish any lapses in care. For developed in care category three and four pressure ulcers a full root cause analysis (RCA) document is completed. The Trust has recently revised its RCA documentation of pressure ulcers in line with the Regional Pressure Ulcer Steering Group. Where lapses in care/ areas for learning are identified, action plans are developed and lessons learnt are shared across all Divisions.

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

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

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

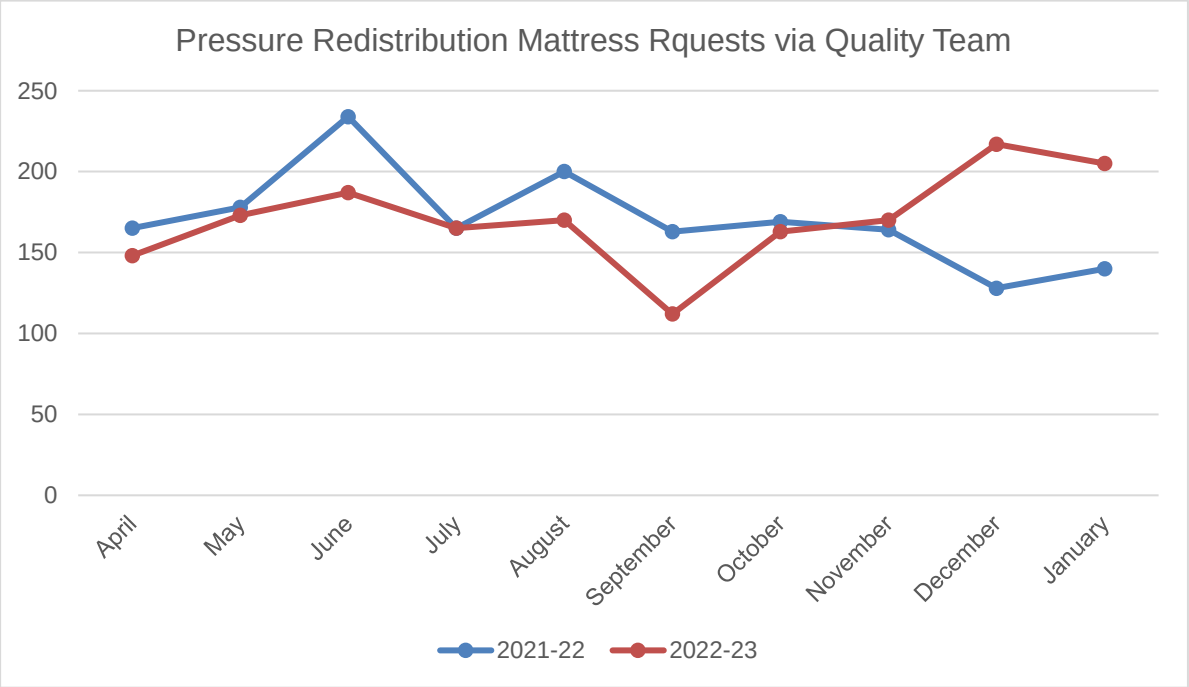
actions taken in response to ward/department areas that report a Red RAG status. Escalations through the relevant committees will provide assurance from Ward to Board.

The Trust has undertaken several initiatives to reduce harm as a result of pressure ulcer care adapting to support the Trusts increased bed base with the opening of escalation beds.

Themes highlighted includes support service provision, which has been reviewed as part of the continuous improvement for reduction of lapses in care contributing to pressure ulcer development.

Equipment:

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



Clarification of the process for requesting a pressure redistribution mattress has been disseminated across the Divisions, Teams are advised to contact the Quality Team for further support ensuring clinical need requirements.

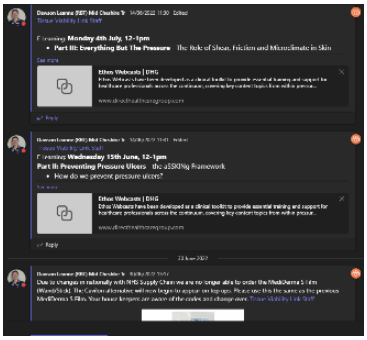
In September 2022 the TVSN/SCSN completed an audit on the use of pressure redistribution mattresses across the Trust. This concluded that all patients on these mattresses had a clinical need/ pressure ulcer risk factor to require such a mattress. In line with the pressure ulcers panel themes, it was noted that some patients needed to be upgraded from high specification foam mattress to a pressure redistribution mattress. To support this 'Mattress Champions' were introduced across the wards as a role to ensure patients were reviewed each shift for mattress requirements and requests were placed for them in a timely manner. The Mattress Champion role also supports with ensuring the correct decontamination process is followed after patient use. Training has been provided across all Divisions to support the launch out of the Mattress Champion role.

Teaching and Training:

The TVSN and SCSN provide regular teaching sessions on Pressure Ulcer and MASD prevention and management.

- HCA (Health Care Assistant) Induction
- Preceptorship
- International Nurse Induction
- HCA Skills Sessions
- Harm Free Care Study Day (also including Dressing Selection)
- Quality Care Programme
- Collaborative TVN Link Staff sessions with CCICP & MCHFT Staff

Designed by NHS England and mapped to the National Wound Care Strategy, staff are able to complete a wound care module available on the Trust eLearning page.



The Trust Link Nurse Pressure Ulcer page acts as a platform for sharing of information and ideas. Policies, guidance, lessons learned, display board photography and webinar links are shared on this platform.

Additional Training has also been provided to reduce harm:

- Correct categorisation of pressure ulcers education
- 'How to sheets' circulated to support completion of incident forms including photography and MASD reporting in line with current national guidelines.
- Educational posters provided guidance on the identification of DTIs & Unstageable pressure ulcers
- TVN Link Staff and Face-to-Face Teaching sessions provided
- Support for MASD awareness, training posters provided on the four branches of MASD. The TVSN represented the Trust at a Reginal Roadshow presenting on the current best practice principles of MASD
- Training sessions completed on Negative Pressure Wound Care Therapy and vacuum pump use across CCICP and MCHFT
- Online training sessions disseminated to Multidisciplinary Teams (MDT) staff highlighting a shared responsibility with the aim of Pressure Ulcer Prevention
- Training on the completion of incident investigation tools.

Pressure Ulcer Prevention Day

The TVSN and SCSN helped to raise awards of Pressure Ulcers across the Trust facilitating a crossroads event outlining the importance of Pressure Ulcer Prevention. The Keep Moving (section of the aSSKINg model) was also included to support the Trusts Re-conditioning the Nation initiative.

The Stop the pressure Day also incorporated a focus on MDT work as ''Pressure Ulcers are everyone's business.'' Recognition of the Estates and Facilities Teams role in the management and delivering of support surfaces was noted.

Discharge Lounge

The Trust Discharge Lounge opened in August 2022. Its function is to support Urgent Emergency Care (UEC), patient safety, quality and flow, by providing a suitable and safe facility for adult inpatients who meet the criteria and are being discharged that day. The facility provides a comfortable area to await 'take home' medications and/or transport, promoting a quality discharge experience for patients. The release of core beds to the discharge lounge allows appropriate clinical placement for UEC patients to be expeditated, supporting safe and timely transfers out of the emergency department. It provides 9 reclining chairs and three beds which can accommodate a range of patients.

The discharge lounge has its own doctor who completes patient discharge and take-home medication summaries reducing the delays on core wards. Departmental pharmacists work alongside the Doctor to streamline the prescriptions of take-home medications.

In the six operational months of opening, the Discharge Lounge has welcomed over 2000 patients, which has released 8508 hours of core beds and 354 bed days. In addition to this, the Discharge Lounge patients have priority access to take-home medication and transport, meaning that on average the patients discharge was completed in around 2 hours and 20 minutes in March 2023, a reduction from 3 hours 45 minutes in August 2022. This ensures a better patient experience and enables those more vulnerable and elderly to return home within daylight hours, leading to better outcomes of discharge success.

Interim targets of 100 patients per week have been succeeded and the Discharge Lounge is working towards its new target of 150 patients per weeks, maximising utilisation throughout the 12 hours of opening, a 10% increase in discharge from core wards through the discharge lounge has been recorded over the 6 months. Future aims are to achieve 10 patients by 10 am in the lounge, supported by the admission of the first five patients who will have been identified the previous night as the first patients to be accessing the lounge at 8 am.

The nursing team in the discharge lounge, provide regular contact with care providers, patients, relatives and transport providers. As a result of this communication, failed discharges due to not achieving cut off times for patients to be 'home' in time for local services to be delivered have been reduced. The feedback from patients and relatives and service users has been extremely positive, with Friends and Family feedback obtaining 100%.

Reconditioning Games

Between November 2022 – March 2023 the Trust took part in the national reconditioning games – a campaign aimed at raising awareness of deconditioning.

The campaign aimed to prevent deconditioning by encouraging all sectors in the health and social care arena to come up with innovative and fun ways to promote physical activity, and functional and emotional well-being. The aim was to reduce deconditioning and associated harms; improving hospital discharges and improving patient outcomes.

What it is:

As an in-patient in hospital, a person will be much less active than normal, and this inactivity leads to 'deconditioning', which causes people to lose fitness or muscle tone, especially through lack of exercise.

Deconditioning is the loss of physical, psychological, and functional capacity due to inactivity" (Public Health England 2021) and is associated with the loss of muscle mass, increased risk of falls and reduced independence.

This in turn leads to delayed discharges, increased risks of hospital acquired complications and leaves patients in a state of excessive dependency, unable to return home in time.

Who took part?

A number of teams across the Trust took part in the reconditioning games, examples of activity include;

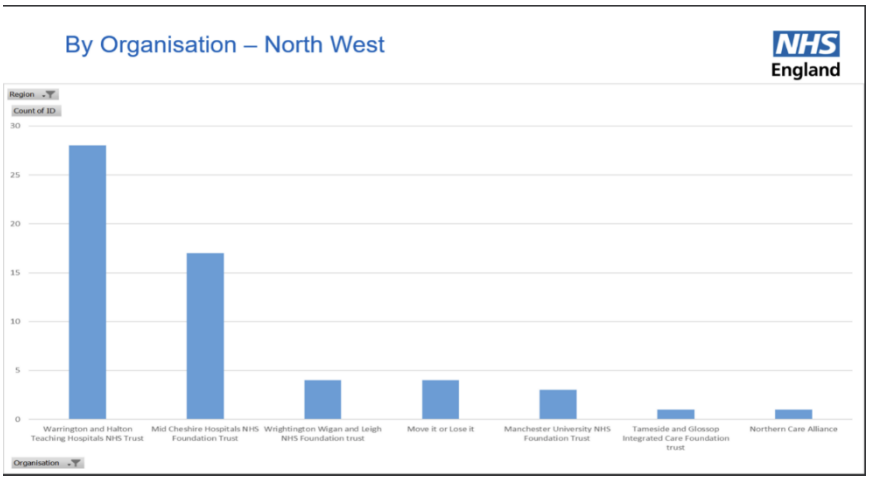
Ward 3 – Boredom Busters; A series of games/ activities such as Cards and Jenga are offered to patients, supported by the volunteers. The Trust librarian produced a scrap book for the patients to read through. Ward staff supported with craft activities and encouraging patient participation – for example making Christmas cards in December. Radios were ordered for each bay.

Ward 19 – Breakfast Club; Patients are invited / encouraged to the ward day room daily for breakfast. The dayroom provides facilities for a social breakfast, including table clothes, menus, teapots and breakfast served from a trolley. The ward have liaised with the hospital shop and have a daily delivery of left over newspapers from the previous day – to be provided with breakfast.

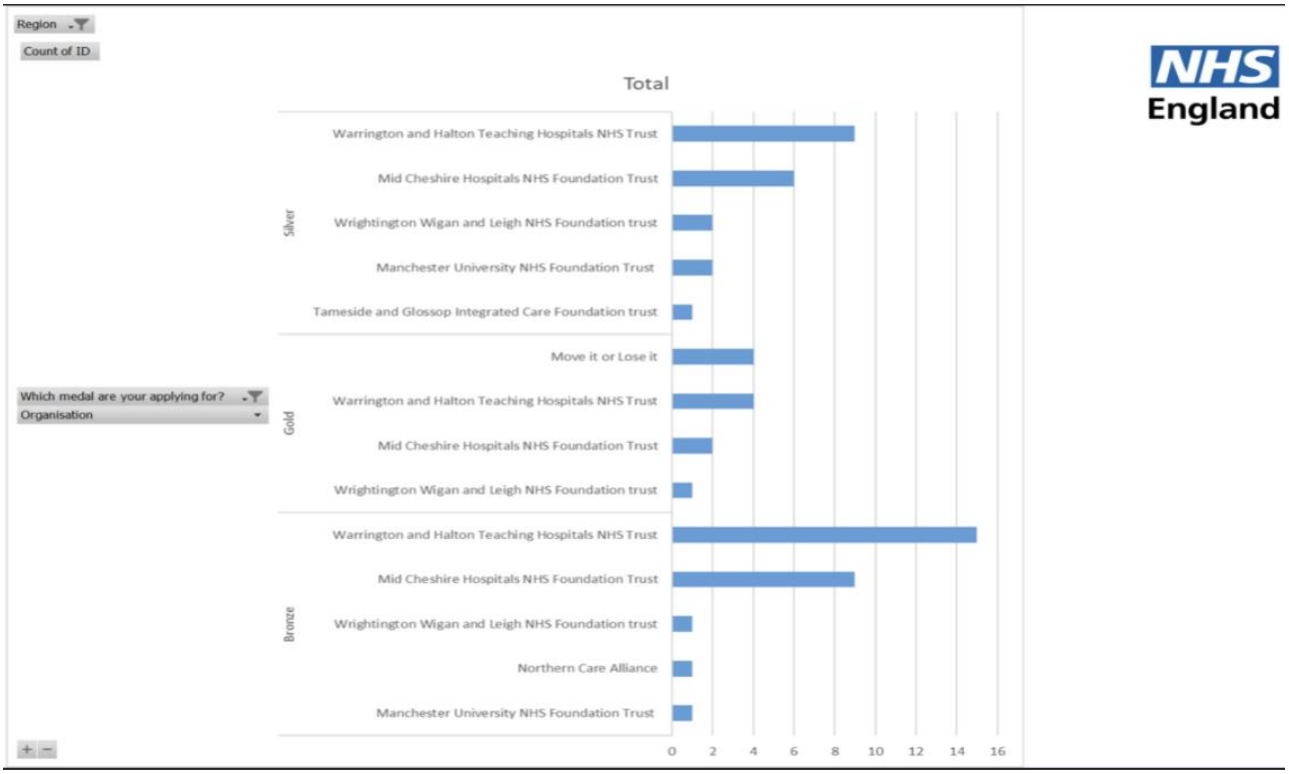
Ward 15 – Games & Activities; Daily activities between 2-3pm, supported by the therapy teams. In addition to the introduction of giant 'garden games' for patients to participate in.

Outcomes

Recognition of Trust reconditioning activities was rewarded throughout the campaign with Bronze, Silver & Gold Medals as a great way to celebrate activities and progress. The following graphs highlight the Trust medal position across the North west and medal allocation split by organisation;



Medal split by organisation



End of life care

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

There is only one opportunity to get it right and to then create a positive lasting memory for relatives and carers. At MCHFT we aim to provide the best possible care for patients at the end of life, whatever their disease/illness. We strongly believe that high quality care consists

of the five priorities for end of life care being embedded in everybody's clinical practice. The use of individualised care plans helps to focus care on the needs of the patient and their family and provides documentation and evidence that we are doing so.

Progress

We aim to provide the best possible care for patients at the end of life, whatever their disease. We strongly believe that high quality care consists of the five priorities for end of life care being embedded in everybody's clinical practice. The use of individualised care plans helps to focus care on the needs of the patient and their family and provides documentation and evidence that we are doing so.

Education and training

Education is delivered in collaboration with The End of Life Partnership and online teaching is established for core study days (Syringe pump training, Blue booklet education, Symptom at the end of life, Priorities for End of Life Care & Verification of expected death). These study days have been delivered during 2022/23 in a combination of face-to-face training and online sessions.

End of Life Care Education is established within junior doctor's medical education, the nursing preceptorship, student nurse, international nurse and on the Health Care Assistant educational programme.

Sessions for Foundation Year 1 and Foundation Year 2 junior doctors have been requested, delivered and well evaluated as part of their core foundation educational programme.

Bespoke support is provided for clinical areas.

The palliative and end of life care link nurse study day was completed with a face to face study day during May & November 2022

Reliable Care - Audit

We have completed the National Audit of Care at the End of Life (NACEL) Round 4. The fourth round of the audit is comprised of the following elements:

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

The results of this audit have just been received. Key findings can be seen in the following infographic. They have been escalated to the Trust Executive Team and an action plan developed. We are registering for NACEL Round 5 during 2024.

National Audit of Care at the End of Life 2022/23
Key findings at a glance

NC088 - Mid Cheshire Hospitals NHS Foundation Trust

*UK refers to the findings for England and Wales

(CNR – Cat 1)

94%

UK 87%

Case notes recorded that the patient might die within hours or days

(CNR– Cat 1)

97%

UK 95%

Case notes, with an individualised plan of care, recorded a discussion (or reason why not) with the patient regarding the plan of care

(CNR – Cat 1)

98%

UK 98%

Case notes recorded a discussion (or reason why not) with families/carers regarding the possibility the patient may die

(CNR – Cat 1)

91%

UK 87%

Case notes recorded extent patient wished to be involved in care decisions, or a reason why not

(CNR – Cat 1)

80%

UK 76%

Case notes recorded an individualised plan of care

(CNR – Cat 1)

87%

UK 79%

Case notes recorded patient's hydration status assessed daily once dying phase recognised

(QS)

62%

UK 54%

Families/carers were asked about their needs

(QS)

71%

UK 71%

Families/carers felt the quality of care provided to the patient was good, excellent or outstanding

(H/S)

No

UK 60%

Hospitals have face-to-face specialist palliative care service available 8 hours a day, 7 days a week

(SRM)

100%

UK 85%

Staff feel confident they can recognise when a patient might be dying imminently

61%

UK 82%

Staff feel supported by their specialist palliative care team

78%

UK 83%

Staff feel they work in a culture that prioritises care, compassion, respect and dignity

National Audit of Care at the End of Life 2022/23

Summary scores at a glance

214 Hospital/site overviews (H/S)

7,620 Case Note Reviews (CNR)

3,600 Quality Surveys (QS)

11,143 Staff Reported Measures (SRM)

NC088

50 Case Note Reviews (CNR)

18 Staff Reported Measures (SRM)

46 Quality Surveys (QS)

*UK refers to the findings for England and Wales

Communication with the dying person (CNR)

8.9 | UK 8.0

Communication with the families and others (CNR)

8.1 | UK 7.1

Involvement in decision making (CNR)

9.7 | UK 9.2

Individualised plan of care (CNR)

7.9 | UK 7.6

Needs of families and others (QS)

6.0 | UK 5.5

Families' and others' experience of care (QS)

6.7 | UK 6.3

Workforce/Specialist Palliative Care (H/S)

7.5 | UK 8.1

Staff confidence (SRM)

8.2 | UK 7.5

Staff support (SRM)

6.5 | UK 7.1

Care and culture (SRM)

7.4 | UK 7.6

Quality Improvement

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

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

We have met as a group to look at improving support for families and carers at the end of life as families or carers don't always feel supported at the time that their loved one is dying.
We know this through data from the National Audit of Care at the End of Life (NACEL)
This is important because how people die remains in the memory of those who live on.
This problem links with the trust's strategic improvement aim - Person Centered Care. We are starting to look at small changes that might make a big difference to how people feel.

Ward Accreditation & Quality Metrics

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

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

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

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

The Ward accreditation programme;

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

Background

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

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

The assessment is undertaken by a permanent accreditation team consisting of Corporate nursing.

Award Status and Definition

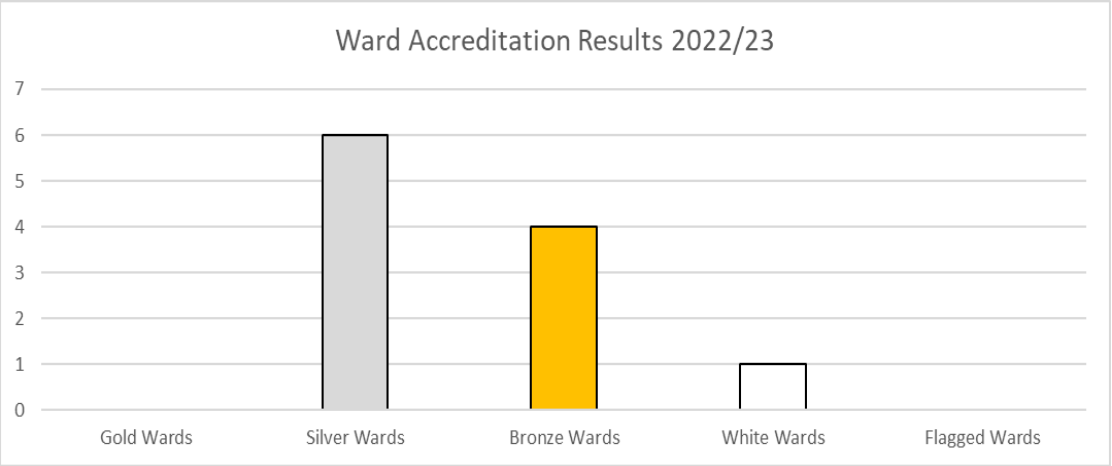
Following an assessment the accreditation team discusses observations and agree an initial impression of the ward status. Three areas of success and three areas of improvement are provided as immediate feedback, along with any immediate actions. Any immediate actions will be reviewed within 7-10 days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

The Ward status will be agreed using the following;

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

Results

The below graph demonstrates the overall Ward Accreditation Results to date;



Outcomes

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

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

	Surgery and Cancer						Diagnostics		Medicine and Emergency Care								Womens and Children's			
Type results as G=3,S=2,B=1,W=0,F=5	Ward 11						Ward 19		Ward 6	AMU	Ward 4	Ward 3	Ward 5	Ward 7	Ward 15	SCPH		Ward 16/17	Ward 23		
Month Accreditation took place (MMM):	Sept						Sept		May	July	Aug	Sept	Nov	Nov	Nov	Jan-23		July	Feb-23		
WELL LED TEAMS																			Pending		
COMMUNICATION WITH MDT																			Pending		
PATIENT COMMUNICATION																			Pending		
HEALING ENVIRONMENTS																			Pending		
NURSING CARE AND PROCESSES																			Pending		
RECORD KEEPING																			Pending		
OVERALL RESULT																			Pending		

**White Wards will receive white in all sections, if 1 area of white is recorded*.

Celebrating Success

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

- Good evidence of MDT huddles including medical staff, therapies and discharge coordinator input
- Excellent patient feedback received – excellent care provided, staff caring and compassionate
- Excellent organisation, management of staff Teams, staff training and appraisals
- Excellent communication witnessed between staff and Patients
- Evidence of continuous improvement aims shared across the ward through notice boards and the quality board
- Property forms completed to a high standard.

Continuous Improvement

A visual operating model for continuous improvement at MCHFT has been developed, incorporating the Trust's Mission, the Vision for Quality and Strategic Improvement Aims, all underpinned by the Trust values and Improvement Matters as the single improvement approach at MCHFT. The Continuous Improvement model supports quality metrics improvements and training has been offered to all Ward Managers and Matrons on the new methodology. Individual continuous improvement projects have been commenced across the wards, to action areas of improvement and are registered on the Improvement Matters 'Improvement Tracker.'

Summary of Benefits

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

CCICP ACCREDITATION

The primary purpose of the Quality Visits is to measure service performance against the Care Quality Commission's five key lines of inquiry: Safe, Effective, Caring, Responsive and Well-led. The intention is through a supportive process to foster a culture of continuous improvement, empowering local teams to take ownership and make changes where required and celebrate and share good practice across CCICP.

The Quality Visits endeavour to identify areas of excellence and good practice whilst also identifying areas where quality improvements may be required; and then supporting the services and teams to implement these improvements. The Quality Visits also provide an opportunity for our senior leaders to be visible across CCICP and give staff the opportunity to discuss any areas of concern whilst also sharing great practice and celebrating success.

Our Quality Visits also give our senior leaders and managers an opportunity to meet our patients and discuss how it feels for patients to receive care from CCICP.

Finally, allowing other leaders to shadow and support our quality visits enables good practice and learning to be cascaded across the organisation.

Due to CCICP providing a wide variety of services our assessment paperwork is for guidance only and should be adapted to accord with the nature of the service being visited. The Community Accreditation tool is also used to support and inform the Quality Visits process and as this is more widely disseminated across CCICP it has a greater influence over our assessment processes.

Quality Visits are undertaken with limited notice to managers and staff. This enables us to observe the service provided by our staff and experienced by our patients as it is on a routine day.

In advance of the visit the following information will be obtained relating to the service being visited:

1. Complaints and compliments related to the service
2. Incidents relating to the service
3. Sickness levels
4. Staff turnover
5. Mandatory training compliance

Quality Visits are based on the following outcome rating:

Blue – The quality visit has demonstrated practice which has been evidenced

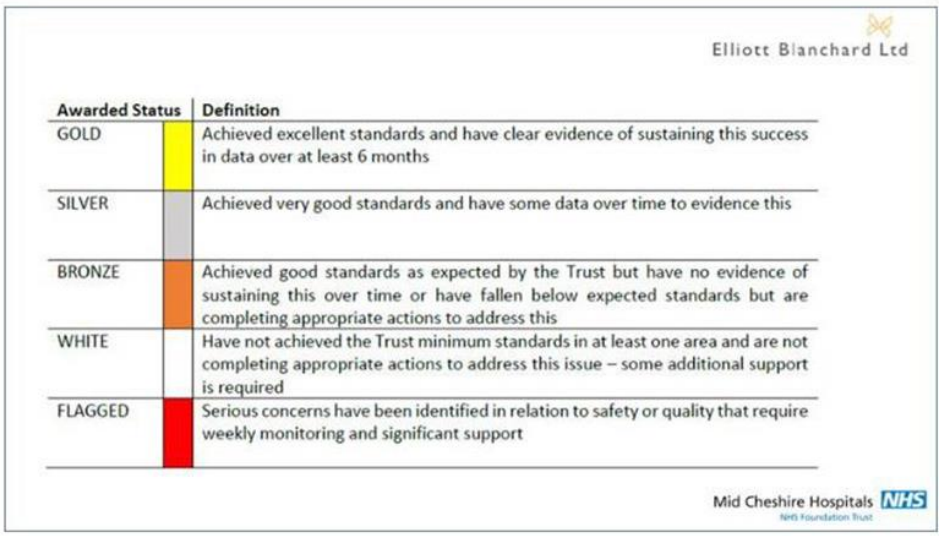
Green – The quality visit has demonstrated that the service provides a good level of practice which has been evidenced

Amber – The quality visit has demonstrated that there are areas where quality improvements can be made to the service.

Red – The quality visit has identified that the service need support to evidence a quality and safe service is being provided.

In 2021 CCICP worked in partnership with Elliott Blanchard to develop a Community Accreditation Program for Community Nursing services. This accreditation tool was to work alongside the QSUS metrics that Community Nursing services were undertaking for self-assessment.

The Community Accreditation process is focused on a standardised set of pre-determined quality metrics which are reviewed by an assessment team and then validated, the teams are provided with an overarching quality outcome. This outcome is based around what is found during the visit.



2021 - 2022 CCICP Quality Visit Progress: CCICP have now undertaken Quality Visits across all of its services.

A brief overview of the outcomes of our Quality Visits are provided below together with some highlights from our most recent service reviews.

CCICP Pain Service

During August 2021 the CCICP Community Pain Service had a quality visit undertaken. During the quality visit three members of the quality team observed three members of staff, one registered pain specialist and two Occupational Therapy Assistants. The quality team also spoke to the Chronic Pain Team Leader. As the visit was undertaken during Covid 19 the majority of consultations being undertaken were virtual resulting in the quality team not being able to speak directly to patients about their experience of the care provided.

Excellent practice was observed in terms of managing the patients' expectations and Patient preferences were also considered. There was clear evidence of holistic consultations and a holistic approach within the team. Appropriate pain management and clear de-prescribing of inappropriate medications whilst empowering patients to find other ways to manage their pain was of very high priority for the team.

The following recommendations were made to the service

- Consideration should be given to implementing a patient experience survey within the chronic pain team
- A review of the use of outcome measures to be used to demonstrate impact of relaxation sessions on patients.
- Promotion of Ulysses reporting by the team.
- Consideration should be given to whether there is scope to utilise prescribing within the team and whether this could improve the patient experience.
- Consideration should be given as to whether laptops are needed for the team and whether headsets would be useful.

The team achieved a green rating across all the five domains and developed and implemented an improvement plan to focus on the recommendations.

Therapy Booking Service

The Therapy Booking Service received a quality visit review in 2021. The therapy booking service is a telephone booking service which supports patients receiving appointments with Podiatry, MSK and the Paediatric Advanced Nurse Practitioner. The service receives around 800 calls weekly and has visible technology to identify calls received and timeframe patients are waiting for call to be answered. The service is proactive in identifying opportunities to support patients getting a positive experience when using the service. They have undertaken audits to identify capacity concerns in podiatry and have developed new systems and processes for both podiatry and MSK. These new ways of working have reduced the need for patients to contact the booking service and enabled patients to be seen in accordance with their waiting time rather than on a first come basis. This new system has also reduced the number of calls made to the booking service significantly. The team won the CCICP unsung hero Trust award which was for a team who may not necessarily be on the frontline of healthcare but have made a significant contribution to the Trust by either supporting colleagues, teams or relatives/loved ones over the last 12 months.

There were a small number of recommendations made to this service however the service was rated as blue across all five domains.

CCICP SALT Service

During December 2021 CCICP Quality team undertook a quality visit to the Community SALT service. Clinical visits were observed, clinicians and visitors were introduced to patients. The clinicians demonstrated a compassionate approach to care. The care was patient centred and patients were directly involved.

Those patients who were assessed in a care home, clear feedback was provided to the carers. A template was used to enable the feedback process to be efficient within care homes. Through the visit and the documentation audit it was evident that joined up working with the wider MDT could be enhanced. It was evident that some patients had numerous health professionals involved in care and a joint approach to care provision could have enabled more efficient care.

The triage process was based on the national SALT guidance however there did not appear to be a standardised approach to the process including dedicated time allocation for undertaking triage. The service had a large number of patients on the waiting list and there was a lack standardised processes and governance within the service. The service was rated as green for caring and amber for safe, well led, effective and responsive Following the review, the following recommendations were made;

- Review of leadership structure
- Therapy professional Lead to support team with developing and enacting improvements
- Split team structure to be reviewed
- Permanent admin funding to be identified
- Vacancies to be filled including new band 4
- Review of triage and allocation of visit process
- Review of discharge process and discharge letters
- SOP for service to be developed
- Contemporaneous documentation utilising EMIS
- Assessment and review slots to be identified in clinicians EMIS diary
- Standardise documentation process
- Outcome measure to be considered for service
- Discontinue recording on SharePoint
- Consider implementing Patient- initiated follow-up (PIFU) and community Speech and Language Therapy (SALT) clinics.

It should be noted that considerable progress and improvements have been made within the SALT service since the quality visit. The service now has a new management structure and robust processes are in place to reduce waiting lists.

CCICP IV at home service

In March 2022 the Quality Team visited the IV at home service. The IV at home service was a newly established service within CCICP. During the visit the staff identified they felt very well

supported, well informed and involved in processes such as the writing and implementation of service SOPs. It was commented that senior management are visible and accessible, as are other clinicians from other teams, which they valued highly. They identified they felt listened to and confident in raising concerns. Weekly MDTs take place, with medical, consultant, pharmacy and nursing present. The care that was observed demonstrated that patient's personalised care plans were in place for both self-administration and nurse-led IV infusion.

- As per Sepsis and NEWS2 policy, it is recommended that all staff complete the NEWS and input it on EMIS NEWS 2 templates.
- Review to be undertaken of the environment for where nMABs is delivered. An alternative venue was recommended.
- Ensure VIP score is documented at each clinical visit, in line with Trust policy and patient safety.
- Ensure all medication administered are documented including batch number & expiry dates as per Trusts medicines management policy.

The team were rated as blue in Caring and Well led and good in the other domains.

CCCIP Stroke Service

The stroke service received a quality visit in February 2022. During all patient visits clinicians demonstrated a kind compassionate approach to care that was both respectful and personalised. Patients were very clear of their goals and demonstrated a clear understanding of the input that was being provided by the team. Patients portrayed extremely complementary feedback about the service and the clinicians that were providing care. Patients were given the option of having a passport where appropriate and the quality team reviewed a passport that had been undertaken. The passport demonstrated a personalised individual approach to patient care. Patients were provided with information leaflets on accessing the service. Patients identified that they were always aware when clinicians would visit and informed of any changes of visits in advance. Patient involvement was observed as being actively promoted. Feedback from family was that the service had been outstanding. Patients portrayed that they felt more confident in their ability and independence and this was also reflected by the family.

The team were provided with some improvement opportunity's around;

- The quality team recommend that the Stroke team undertake a patient survey regarding patient experience as this would provide excellent feedback on this outstanding service
- The quality team would like the team to consider consistent use of an agreed outcome measure at the beginning and end of patient rehabilitation programme
- There is a low reporting of incidents within the team and the team may benefit from receiving training from the risk team if not already undertaken. The team received green for Safe and blue for the remaining four domains.

CCICP MSK Service

During May 2022 quality visit, Nantwich, Winsford, Alsager, and Crewe MSK services were reviewed. Visits were also undertaken at both VIN and Leighton MSK departments in the

subsequent week. All staff observed demonstrated a comprehensive, patient centred individualised approach to patients' assessments and care. Patients were informed about the assessment and clear information was provided to the patients around their ongoing treatment and care. Exercise programmes were provided and there was clear evidence that self-care and ongoing rehabilitation was promoted.

Patients felt that the service was easily accessible, and appointments were provided in a timely way, all patients felt they were treated with kindness and compassion by the clinicians providing their care. Patients were seen by the same clinician which enabled them to feel that they received continuity of care.

The team demonstrated a good use of PIFU to support patients ongoing care, this was clearly based around individual patient requirements through undertaking a comprehensive assessment, promoting self- care and providing PIFU. Contemporaneous record keeping was observed consistently by all clinicians using electronic devices. The therapy assistant explained that the computers on wheels were helpful in achieving contemporaneous records.

The service had some opportunities to identify some improvements particularly around safety.

The following actions were recommended;

- The service may consider repeating the dedicated patient feedback audit and consider patient stories
- The service needs to understand current DNA rate and review current appointment reminder process
- Ensure teams are compliant with statutory and mandatory training
- The team would benefit from using the Trust meeting template so that such areas (wider organisation challenges, risks, and quality improvements) could be discussed, and information shared
- Ensure that most recent CQC status posters are visible in all departments and waiting areas
- The service may consider inviting the FTSU guardian to team meetings to raise awareness, whilst ensuring FTSU team information is up to date in departments
- Ensure all electrical equipment being used is PAT tested and in date
- A reminder to staff to undertake hand washing pre and post clinical assessment
- The team should consider implementing robust lone working process for their service and staff across all sites
- Replace out of date safeguarding team details in staff rooms
- Ensure any broken equipment is clearly marked as out of use
- Storerooms to be decluttered and tidied, with out of date/no longer used paperwork (including patient advice information) removed
- The team would benefit from the CCICP risks being shared at their regular team meeting particularly those high scoring risks and those risks that may have an impact on the MSK service i.e. Pain Service Risk, Podiatry Risk, Defibrillator risk
- Service to be added to, and data populated weekly to the Therapy Escalation Tool
- The service would benefit from providing reports on patient outcomes to demonstrate the positive impact the service, team and staff have
- Please can the importance of IG safety be promoted across the teams
- A sign is required on the door of room 13 (patient toilet) in VIN to state for staff use only
- Please can staff be reminded of ensuring floor areas remain dry and free of

equipment such as exercise equipment to ensure slip and trip risk is minimised.

The service received green for Well Led and Effective, with blue for Caring and Responsive. The team were identified as requires improvement for Safe, but these areas could be easily rectified.

Elliott Blanchard Community Accreditation

Sandbach

The Sandbach visit was undertaken in August 2021, during the visit it was evident that significant lessons have been learnt and appropriate improvements have been actioned since the previous review, however there is evidence that some improvements are still outstanding.

There had been a reduction in category 3 pressure ulcers compared to 2020, medication incidents had increased slightly - no clear themes or trends seen (all low or no harm), staffing incidents had increased which is reflective of the increase in workload across community nursing.

The number of patient cancellations/DNAs were reviewed. There was no concern regarding the number of patients deferred. The RAG tool was utilised to support deferred visits. June 2021 identified that 53 priority 3 patients had been deferred during the month. The RAG tool was not always used fully so did not always reflect the situation within the team.

363 Patients on caseload - appropriate for team, acuity review shows average position. Band 6 Caseload Managers were appropriately aligned to caseloads. Caseload review time was allocated to the Caseload Managers. All staff could provide examples of how ongoing support was provided to them. Staff felt they were always able to attend learning and development opportunities. Mandatory training is on track for all staff and any outstanding staff have dates booked. Above 90% - well monitored. The community team always have a daily huddle to ensure smooth running of the day. This is led by the Team Leader or the Caseload Manager. There is always a 'person in charge' identified on each day and they coordinate communication between disciplines well. Due to not recording arrival and departure times in real time, Malinko was not up to date and accurate.

The team were given the following recommendations to work through following the visit:

- Ensure records are checked before each visit and completed in real time so information is contemporaneous for other members of the team
- Ensure visits are recorded accurately in Malinko - checking in and checking out of visits. Review of care time allocation based on patient individual care needs and checking schedule throughout the day
- Encourage more patient feedback using QSUS surveys, postcards, patient forums etc and use this for team Quality Improvement work

The overall outcome for this team was **Bronze**

Winsford Care Community

The visit was undertaken in November 2021 and identified that the community team leader uses an empowering style of leadership approach and is developing staff very well. Staff

morale was good in this community team. Staff said that positive feedback is often given by the community team leader. Staff were aware of and could describe the Trust values and these were demonstrated by staff during the visit. Staff spoken to all reported having up to date appraisals / personal development plans and felt supported in achieving these.

The community team always have a daily huddle to ensure smooth running of the day. This is led by the senior member of staff on duty. There is always a 'person in charge' identified on each day and they demonstrated coordination with communication between disciplines well.

The team have an excellent process to ensure accurate caseload management including effective caseload reviews and consideration of acuity and dependency. The team promote continuity of care wherever possible. If a home visit needs to be cancelled or delayed, staff always contact patients to let them know.

All staff described the process to escalate operational issues. Everyone was aware of the process and knew where to find the relevant contact numbers when problems cannot be resolved or if urgent /serious issues occur, including out of hours.

The team would benefit from consistently embedding the use of Malinko into everyday practice to enable accurate data to be obtained regarding care provided and capacity within the team.

The recommendations for Winsford were:

- Patient surveys to be completed in line with QSUS
- CCICP to consider TVN spending 1 session per month within the Winsford wound care clinic.
- Uniform policy to be embedded and the re-use of scissors to be discontinued

The overall outcome for this team was **Gold**

Crewe

Visits were undertaken to Crewe Care Community over two visits during May and June. The first visit was undertaken to the Eagle Bridge team and a follow up visit was undertaken to the Grosvenor, Rope and Hungerford team. The community team leader showed excellent leadership skills and team working was very strong. The Team leaders displays a kind compassionate calm approach to their leadership. The community team leaders used an empowering style of leadership approach and are developing staff very well. The Team feel that the team leaders were approachable, supportive, compassionate and responded to concerns. The team had experienced difficulty with sickness and vacancies. All recruitment was being undertaken. New funding for 2 WTE to support increased demand had been agreed for the team.

There were lots of processes in place to support the team, they had 1-1 meetings embedded, Motiv8 appraisals, Daily handover and the pastoral team involved to support staff wellbeing. Gifts provided during COVID 19, Cakes on International Nurses Day. Compassionate awards in the Trust. Freedom to Speak up Guardian visiting team. Nurse professional Lead and pharmacist visible in team. Professional Nurse Advocate within team and a Mental first aider in team.

The team always have a daily huddle to ensure smooth running of the service and there was a band 6 in charge for each shift this is displayed on the notice board and off duty. The 'person in charge' always used a clear process for visit allocation, based on an staff competencies.

Due to demands on the Crewe service not all patients are able to be seen on the same day and need to be planned for alternative days. An escalation tool is utilised to support patient and staff safety. However, the team are needing to defer lower priority patient visits on a daily basis. Wound clinics are now undertaken by the ambulatory wound care team. DN now only support Leg ulcer clinics and Catheter Clinics. Dedicated time is provided to the band 6 caseload managers to undertake caseload management. Caseload management is based on complexity of care and not just number of patients The most whole time equivalent (WTE) band 6 caseload managers caseload size is 87 patients which is in line with the Queens Nurse Institutes recommendations.

The team were given recommendations to work through following the visit. The actions identified for Crewe were.

- Improvement in undertaking contemptuous records
- Update trust value and behaviours (everyone one matters) boards
- Consider lockable prescription printer trays
- Upskill band 5 workforce - particularly training in PICC lines & syringe drivers
- Participation of team in Quality improvement projects to improve service delivery & harm free care.
- Clinic environment needs to adhere to IPC standards The overall outcome for Crewe was **Bronze** on both visits.

Quality visit progress table

Location	Service	Safe	Effective	Caring	Responsive	Well-Led	Date Improvement Plan Completed
Springfield's School	Paediatric Physio, OT,SALT & Special School Nursing						Complete
Hebden Green	Paediatric Physio, OT,SALT & Special School Nursing						Complete
Leighton Hospital	Dietetic						Complete
Leighton Hospital	SALT - Leighton Hospital						Complete
Leighton Hospital	Stoma						Complete
Leighton Hospital	MSK						In action
Leighton Hospital	OT						In action
Leighton Hospital	Pain Management						In action
Infinity	Therapy Booking Service						In action
Infinity	Paediatric SALT						Complete
Infinity	Paediatric Therapy						Complete
Infinity	Diabetes						Complete
Infinity	Tissue Viability Nursing						Complete
Infinity	Adult and Paediatrics Bladder and Bowel						Complete
Eagle bridge	Stroke						In action
St Luke's	Lymphoedema						Complete
Infinity	Wheelchair Service						Complete
Eagle Bridge	Integrated Respiratory						Not complete
Church View	Podiatry						In action
Elmhurst	Intermediate Care						Complete
Eagle bridge	MCATS						Complete
Leighton Hospital	POCH						Inaction
Leighton Hospital	OOH Nursing						Complete
Leighton Hospital	Paediatrics Continuing care						In action
Leighton Hospital	CURE						
Eagle Bridge	IV Service Crewe						In action

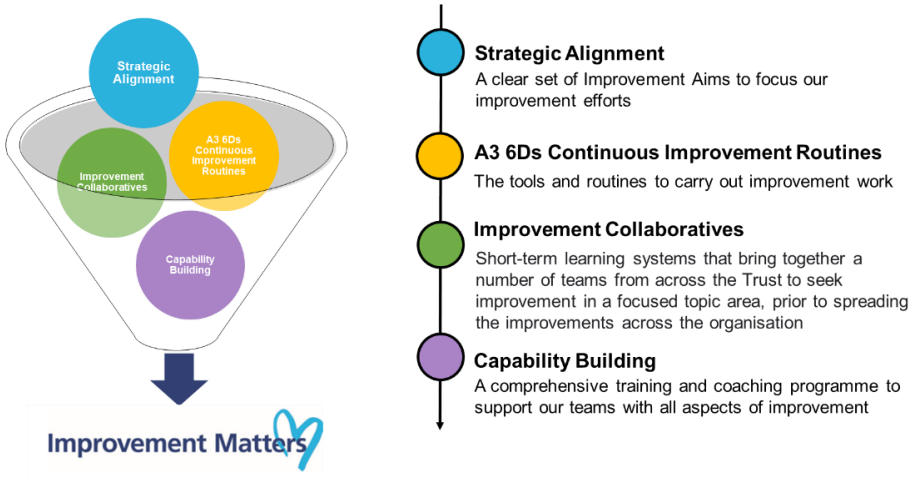
Ashfields	District Nursing						Complete
Alsager Clinic	Care Community						Complete
Winsford HC	District Nursing						Gold
Firdale	District Nursing						Complete
Danebridge	Northwich Care Community						Complete
Nantwich	Nantwich Care Community						Complete
Eaglebridge/ RGH	Crewe Care Community						In action
	White						
	Bronze						
	Silver						
	Gold						

Continuous Improvement

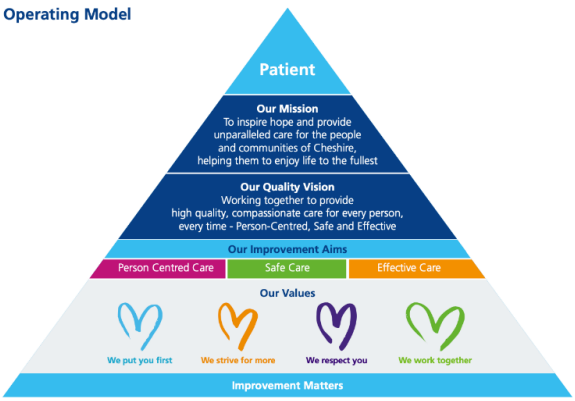
At MCHFT, we are committed to embedding a culture of continuous improvement in recognition of CI being the key enabler and support to staff in the delivery of our Trust Care Models and ambitions outlined in the Quality Strategy and enabling plans.

In 2022-23, the Trust launched its single approach to improvement called **Improvement Matters**. Improvement Matters provides a structured approach to problem-solving and a clear

and consistent framework for all improvement activity. Improvement Matters is made up of the following 4 key components:



During 2022-23, the Trust engaged with over 600 staff and patients to develop a Vision for Quality and Improvement Aims, as set out in the MCHFT Operating Model. These Improvement Aims allow all members of MCHFT staff to align their improvement work with the improvement priorities of the Trust, therefore all pulling in the same direction and improving care for our patients by focusing our improvement efforts on our biggest challenges.



To develop and embed a culture of continuous improvement at MCHFT, there is a commitment to ensure that our staff are equipped with the skills and confidence to address issues, overcome challenges, and make improvements. Over the last 12 months, the launch of Improvement Matters included the development of a robust capability building framework, offering improvement training, coaching and collaboratives to MCHFT staff.

All training is based around the Improvement Matters 6Ds and A3 to provide a structured framework for improvement that encourages problem-solving and scientific thinking, rather than jumping to a solution.

Between June and December 2022, 196 members of staff had been trained in improvement, via the Improvement Fundamentals course (introduction to improvement half day course), Improvement Champions course (intermediate level) and bespoke improvement training sessions for departments.

An Improvement Coaches course (advanced level) has been developed to support staff to deepen their improvement knowledge, skills, confidence, and capability in order to then coach, support and facilitate others in leading improvement. This will support capacity within the organisation to coach others in improvement and to embed a culture of CI, as there is consistent demand for improvement coaching and support.

Between June and December 2022, 43 members of staff had accessed Pocket QI (Quality Improvement) improvement coaching, with further staff and teams also supported via facilitation and bespoke improvement coaching sessions.

Continuous Improvement has been successfully embedded into all of the Leadership Programmes at the Trust (foundation, intermediate and senior), as well as Induction, the Preceptorship Programme and Foundation 2 Medical Education Programme.

Due to demand for increased support around measurement for improvement and to support the organisational ambition to become a learning organisation able to utilise data for improvement, a measurement for improvement masterclass was developed to provide additional support to staff around the use of data and charts for improvement.

Integration of Improvement Matters into Ward Accreditation Scheme has also taken place, with Bespoke Improvement Fundamentals training delivered to Ward Managers to support them in identifying areas for improvement from the QSUS metrics and using the A3 to improve. Further work is planned for the year ahead to provide refresher training for Ward Managers and improvement coaching to progress their A3's. Integration with the Community Accreditation Scheme is also in progress.

A Board Development Programme around CI was launched last year, with modules focusing on culture, strategy, measurement, and patient safety. Work is now taking place to finalise the Gemba Walks Framework and Training Package, as well as a schedule of Gemba Walks

aligned to Improvement Aims to commence in 2023 in order to increase visibility and executive involvement in improvement activity at the Trust.

An Improvement Hub (intranet site) was successfully launched to provide access to CI resources linked to the A3, improvement projects (via the new online Improvement Tracker), latest news, training and improvement support available at the Trust. Staff continue to access the Improvement Hub with a consistent increase in activity seen since its launch in June, with 1629 hits received by December 2022.

An Improvement Tracker was also developed in June 2022 to provide oversight of improvement work aligned to Improvement Aims, offer improvement support to staff leading projects and importantly, to share leaning and outcomes across the Trust. As of December 2022, there were 50 improvement projects logged and A3s commenced. Targeted improvement coaching is now taking place with project leads to progress and upload their completed A3s in order to celebrate improvements made. Some recent successful improvements A3s include the Discharge Lounge, Triage and Streaming Trial in ED (Emergency Department), Pain Management on Ward 3, Improving Communication with Relatives and Increasing Breastfeeding Rates Amongst Diabetic Patients.

The Trust runs Improvement Collaboratives around Trust wide improvement priorities where teams are brought together to explore their own root causes to the issue and to generate and test own change ideas using improvement boards and huddles. Collaborative Teams then report back progress so that we can learn from the changes and spread good practice and improvements across the Trust via the launch of an Improvement Change Package.

The first Trust wide Improvement Collaborative was launched in August 2022 around Antimicrobial Stewardship as part of the Safe Care Improvement Aim. The aim of the Collaborative was to increase appropriate use of antibiotics on 4 wards to more than 90% by April 2023. We are immensely proud of the ward teams involved who worked collaboratively to describe the problem, understand the root causes, and generate change ideas which they then tested on their wards using Plan, Do, Study Act (PDSA) cycles and Process Confirmation Boards and Huddles to track progress. The Collaborative continues to run until May 2023, with excellent progress already being made and data showing improvements in the percentage use of appropriate antibiotics to 93.7%.

Feedback from the Collaborative Ward Teams demonstrate their commitment, progress and outcomes achieved so far:

- “It has made us all aware of the use [of antibiotics] on the ward and brought to everyone's attention antibiotic use, engaging conversation and discussion to address, reduce and change to prevent the increase of Clostridium Difficile on the ward.” Ward 6
- “Increased awareness amongst medics and nursing staff of antibiotic usage and importance of review daily. Antibiotics are now discussed in the morning huddles.” Ward 3
- “Encourages and reminds staff to regularly review antibiotics and increase awareness amongst staff of antibiotics usage” Ward 12

- “Nurses and physicians are supportive and have a positive and encouraging attitude towards the implementation of the standard work.” Ward 11

As we move into 2023-24, the Continuous Improvement Team is expanding and aligning its scope by working collaboratively with the Transformation Team and delivering an integrated approach to continuous improvement, whilst also continuing to train frontline and corporate teams across the Trust.

Statements of assurance from the Board

Review of services

During 2022/23 the Trust provided and/or sub-contracted 42 relevant health services.

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

The income generated by the relevant health services reviewed in 2022/23 represents 91% of the total income generated from the provision of relevant health services by the Trust for 2020/21.

Participation in Clinical Audits and Research

Clinical audit evaluates the quality of care provided against evidence-based standards and is a key component of clinical governance and continuous 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 2022/2023, 51 national clinical audits and 4 national confidential enquiries covered NHS services that Mid Cheshire Hospital Foundation Trust provides.

During that period, Mid Cheshire Hospital Foundation Trust participated in 48 [94%] national clinical audits and 4 [100%] national confidential enquiries of the national clinical audits and national confidential enquires which it was eligible to participate in.

The table below shows:

The national clinical audits and national confidential enquires that Mid Cheshire Hospital Foundation Trust was eligible to participate in during 2022/2023.

The national clinical audits and national confidential enquires that Mid Cheshire Hospital Foundation Trust participated in during 2022/2023.

The national clinical audits and national confidential enquires that Mid Cheshire Hospital Foundation Trust participated in, and for which data collection was completed during 2022/2023, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry

National Clinical Audit, Clinical Outcome Review Programme or other national quality improvement programme	Applicable to MCHT	MCHT participation	MCHT Submission Rate^
Breast & Cosmetic Implant Registry	Yes	Yes	Continuous data collection
Intensive Care National Audit and Research Centre Case Mix Programme (ICNARC)	Yes	Yes	Continuous data collection
Child Health Clinical Outcome Review Programme	Yes	Yes	Continuous data collection
Cleft and Audit Network Database (RCS)	No	N/A	
Elective Surgery: National PROMS Programme (H&K replacement surgery)	Yes	Yes	Continuous data collection
Royal College of Emergency Medicine Infection Prevention & Control	Yes	Yes	In-progress
Royal College of Emergency Medicine Mental Health (self-harm)	Yes	Yes	In-progress
Epilepsy 12 – National Clinical Audit of Seizures and Epilepsies for Children and Young People	Yes	Yes	Continuous data collection (re-started submissions in December 2022)
Fracture liaison Service Database	No	N/A	
National Audit of Inpatient Falls	Yes	Yes	100%
National Hip Fracture Database	Yes	Yes	Continuous data collection
National Bowel Cancer Audit	Yes	Yes	Continuous data collection
National Oesophago-gastric Cancer	Yes	Yes	Continuous data collection
Inflammatory Bowel Disease Registry/Audit	Yes	No	Data submission re-started March 2023
LeDer – Learning from lives and deaths of people with a learning disability and autistic people	Yes	Yes	100%
Maternal and New-born Infant Clinical Outcome Review Programme (MBRRACE)	Yes	Yes	Continuous data collection
Mental Health Clinical Outcome Review Programme	No	N/A	
Muscle Invasive Bladder Cancer at Transurethral REsection of Bladder Audit	No	N/A	
National Diabetes Core Audit	Yes	Yes	Minimum dataset only
National Diabetes Foot Care Audit	Yes	Yes	Continuous data collection
National Diabetes Inpatient Safety Audit - NADIA Harms	Yes	Yes	100%
National Pregnancy in Diabetes Audit	Yes	Yes	100%
National Adult Asthma Secondary Care Audit	Yes	Yes	Continuous data collection
National Chronic Obstructive Pulmonary Disease Secondary Care Audit	Yes	Yes	Continuous data collection
National Paediatric Asthma Secondary Care Audit	Yes	Yes	Continuous data collection

National Pulmonary Rehabilitation Organisational and Clinical Audit	Yes	Yes	Continuous data collection
National Audit of Breast Cancer in Older patients	Yes	Yes	Continuous data collection
National Audit of Cardiac Rehabilitation	Yes	Yes	Continuous data collection
National Audit of Cardiovascular Disease Prevention (Primary Care)	No	N/A	
National Audit of End-of-Life Care	Yes	Yes	100%
National Audit of Dementia	Yes	Yes	On-going
National Audit of Pulmonary Hypertension	No	N/A	
National Bariatric Surgery Registry	No	N/A	
National Cardiac Arrest Audit	Yes	Yes	Continuous data collection
National Congenital Heart Disease Audit	No	N/A	
Myocardial Ischaemia National Audit Project	Yes	Yes	Continuous data collection
National Adult Cardiac Surgery Audit	No	N/A	
National Audit of Cardiac Rhythm Management	No	N/A	
National Audit of Percutaneous Coronary Interventions	No	N/A	
National Heart Failure Audit	Yes	Yes	Continuous data collection
National Child Mortality Database	Yes	Yes	Continuous data collection
National Clinical Audit of Psychosis	No	N/A	
National Early Inflammatory Arthritis Audit	Yes	Yes	Continuous data collection
National Emergency Laparotomy Audit	Yes	Yes	Continuous data collection
National Joint Registry	Yes	Yes	Continuous data collection
National Lung Cancer Audit	Yes	Yes	Continuous data collection
National Maternity and Perinatal Audit	Yes	Yes	Continuous data collection
National Neonatal Audit Programme (NNAP)	Yes	Yes	Continuous data collection
National Obesity Audit	Yes	Yes	Continuous data collection
National Ophthalmology Database Audit	Yes	Yes	100%
National Paediatric Diabetes Audit	Yes	Yes	Continuous data collection
National Perinatal Mortality Review Tool	Yes	Yes	Continuous data collection
National Prostate Cancer Audit	Yes	Yes	Continuous data collection
National Vascular Registry	No	N/A	
Neurosurgical National Audit Programme	No	N/A	
Out-of-hospital Cardiac Arrest Outcomes	No	N/A	
Paediatric Intensive Care Audit	No	N/A	

Perioperative Quality Improvement Programme (PQIP)	Yes	No	Data submission re-started in March 2023
Prescribing Observatory for Mental Health - Improving the quality of valproate prescribing in adult mental health services	No	N/A	
Prescribing Observatory for Mental Health - The use of melatonin	No	N/A	
Renal - National Acute Kidney Injury Audit	Yes	Yes	Continuous data collection
Renal - UK Renal Registry Chronic Kidney Disease Audit	Yes	Yes	Continuous data collection
British Thoracic Society - Adult Respiratory Support Audit	Yes	Yes	In-progress
Sentinel Stroke National Audit Programme	Yes	Yes	Continuous data collection
Serious Hazards of Transfusion UK National Haemovigilance Scheme	Yes	Yes	Continuous data collection
Society for Acute Medicine Benchmarking Audit	Yes	Yes	100%
Trauma Audit and Research Network	Yes	Yes	Continuous data collection
UK Cystic Fibrosis Registry	Yes	Yes	Continuous data collection
UK Parkinson's Audit	Yes	No	Plan in place to participate in next round

^Where data collection was completed during 2022/2023

Eligible NCEPOD Study	Participated	% Submitted
Transition from Child to Adult Health Services	Yes	100%
Crohn’s Disease	Yes	82%
Community Acquired Pneumonia	Yes	100%
Testicular Torsion	Yes	100%

National clinical audit: actions to improve quality

The reports of 34 national clinical audits were reviewed by the provider in 2022 and Mid Cheshire Hospital Foundation Trust intends to take/has taken the following actions to improve the quality of healthcare provided:

Audit Title	Outcome/Actions
National Lung Cancer Annual Report	The results of the audit have been reviewed by the Respiratory Team and a local improvement plan is in place. The improvement plan includes: • Review of nodule service, ensure dedicated timetabled sessions within consultant job plan and review of radiologist protected time for service development. • Develop business case for Lung Clinical Nurse Specialist (CNS) increased hours. • Dedicated time to be given to data lead to ensure that results are regularly reviewed and used to drive forward quality. • Joint surgical and oncology clinic is now running at Wythenshawe with criteria for referral, this will help to ensure that surgery is being offered to patients.
National Prostate Cancer Audit (NPCA) Annual report	The results of the audit were reviewed by the clinical team and a local gap analysis undertaken. Areas for improvement have been identified and local actions taken/planned include: • Identification of a clinician from within the multidisciplinary team (MDT) to support the input of data which will improve the completeness of key data fields. • NPCA indicators reviewed at Urology Quality Improvement Session and Cancer Board in order to raise awareness across the team. • Advanced Nurse Practitioner (ANP) trained to do transperineal prostate biopsies in order to improve access to the service. • Review of two week wait (2WW) referral proforma.
National Bowel Cancer Audit (NBoCA) Annual Report	The results of the audit have been reviewed by the clinical team and show that local performance for all colorectal cancer process & outcome Key Performance Indicators (KPIs) is meeting / surpassing national / peer benchmarks. A local action plan has been developed which identifies a number of areas for improvement including undertaking several local audits to look at completeness of multi-disciplinary team (MDT) reports to ensure all relevant details are being recorded.
British Thoracic Society (BTS) Smoking Cessation Audit	The results of the audit have been reviewed, along with the national recommendations, and the following local actions are in progress: • Referral pathways to allow MCHT to refer patients to community smoking cessation service e.g. East Cheshire “oneyou”, West Cheshire “chesirechangehub”. • Smokefree task and finish group implemented.

	• Implementation of Smokefree Site Policy – including VAPE Friendly Policy. • Implementation of a service for people visiting Outpatient Department via a “bleep” system/telephone review. • Standard Clerking Procedure will be standardised as part of the Electronic Patient Record implementation.
National Paediatrics Diabetes – Care Processes and Outcomes	The results of the audit have been reviewed by the clinical team and the local improvement plan has been updated. Actions implemented during 2022 include: • Dietitian time increased from October 2022. • Paediatric Diabetes Specialist Nurse from July 2022. • Additional paediatric diabetes consultant started in September 2022. • The team are also looking into ways to provide a clinical psychology service for children and young people with diabetes.
National Audit of Breast Cancer in Older Patient Annual Report	The audit results show that the breast service continues to perform well. Data shows high levels of one-stop clinics, surgery and adjuvant treatment for patients including those over 70. The team has identified a number of areas where improvements could be made linked to data submission and an improvement plan has been developed to address this. Actions include the introduction of a new patient clinic proforma which includes a section for performance score, mini mental test and comorbidities and there is an expectation that clinicians complete this for patients over 70. Use of the proforma will be locally audited to ensure compliance.
National Ophthalmology Database Audit	The results of the audit have been reviewed by the clinical team. Trust case ascertainment is reported as 100%. The team are committed to high quality care and good professional practice measured through continued participation in the audit. The provision of virtual reality cataract training equipment for trainee surgeons is known to reduce the complication rate and the team have put in a bid for provision of this equipment through the VIN hub project.
RCEM Infection Control	The results of the audit have been reviewed by the clinical team and the local improvement plan is in development. Existing processes/provisions include: • A fully dedicated 8 bed negative pressured Isolation area of the Emergency Department since moving to newbuild department. • 2 isolated cubicles in Resus, 4 in Majors. • Electronic processes to track patients with; Diarrhoea and Vomiting (D&V), Influenza, Covid, Methicillin-resistant Staphylococcus aureus (MRSA) on the graphical display.

	• Alert system to print markers on ED Cas card for: C.Difficile, Chemotherapy patients, Transplant patients, Tuberculosis (TB) Exposure. The team are looking to improve documentation of the screening process by incorporating it into the electronic triage script.
RCEM Pain in Children	The results of the audit were received by the Trust in May 2022. A review of the key recommendations highlighted the following area for action "Departments should have the staff, training, and equipment in place to deliver timely nerve blocks to children with femur fractures". – MCHT staff routinely provide nerve blocks to adults with femoral fractures, the audit lead will explore available paediatric training.
National Diabetes Foot Care Audit	The results of the audit show local 12-week outcomes as: • A higher percentage of patients alive and ulcer free at 12 weeks than the national average • Less lost to follow-up patients than the national average. The audit findings will be discussed at the clinical leads meeting, areas for improvement/action will be identified and a local improvement plan developed.
Children & Young People Asthma Organisational Audit Report	The results of the audit are with the clinical team for review and development of a local improvement plan.
Sentinel Stroke National Audit Programme Acute Clinical & Organisational Audit Report	In order to improve "time to scan" and increase the percentage of stroke patients given thrombolysis, the team are working towards ensuring early assessment of potential stroke patients presenting to ED by specialist stroke nurses. This will be supported by expanding the existing specialist stroke nurse rota to 24/7 coverage. Additional band 6 nursing hours have been identified and band 6 nurses on the Stroke Unit will receive appropriate training in order that they can support the existing rota.
Myocardial Ischaemia National Audit Project (MINAP)	The 2022 national report relates to audit data for the period 2020/2021. The Trust results showed that, the percentage of patients admitted to a cardiac ward, percentage of patients seen by a cardiologist and percentage of patients referred to cardiac rehab were high and better than the national average for these measures. The percentage of patients having an echo performed during admission fell significantly between 2019/2020 and 2020/2021 data periods and moved from above to below the national average. The demand for echo's was very high during this period and the Trust has since invested in echo services, including extra sessions on Saturdays and evenings. In addition, the Trust is looking to invest in the rehabilitation service during 2023/2024.

National Heart Failure Audit	The results of the audit are with the cardiology team for review and development of a local improvement plan.
National Adult Diabetes Audit	The results of the audit are with the Diabetes Specialist Team for review and development of a local improvement plan.
National Maternity and Perinatal Audit (NMPA)	The audit findings and national recommendations have been reviewed by the clinical team and benchmarked against current practice. Local actions include: • Local website developed to improve the availability and quality of information about possible interventions during labour and birth. • Virtual tour being filmed to include links to information and leaflets. • Induction of labour and apgars are monitored through North West Coast Strategic Clinical Network (NWCSCN) Maternity Dashboard with comparisons to other units and reviewed at local governance meetings. • An audit of postnatal maternal readmissions is planned for 2023/2024. • Information Governance Midwife working with Business Intelligence Team to ensure data completeness.
RCEM Fractured Neck of Femur (FNOF) Audit	The audit findings have been reviewed by the clinical team and benchmarked against current practice. Local actions include: • Existing FNOF pathway is being revised to incorporate reference to behavioural pain scoring tool. • New Abbey Pain Scale proforma created to aid use in cognitively impaired patients. • Patient Group Directions (PGDs) in place for simple analgesia and penthrox nurse-led administration. • Lead clinician for orthopaedics in place and looking to recruit nurse equivalent.
National End of Life Care (NACEL) Audit – Round 3	Round 3 results showed that the Trust performed better than the national average in 8 of the 11 key themes assessed by the audit. A local improvement plan has been developed to address any areas for improvement, actions include: • Undertaking quality improvement projects with focus on needs of families and others. • Development of a business case for 7-day service. • Ongoing education for all staff groups focused on end-of-life care.
National Audit of Seizures and Epilepsies (Epilepsy12)	The Trust was unable to submit data to Epilepsy 12 for the majority of 2022/2023 due to a lack of capacity within the clinical team. Increased staffing is now in place and the team have started to submit data to the audit.
Pulmonary Rehabilitation Audit	The audit results have been reviewed by the Pulmonary Rehabilitation Team and show that the service scores better

	than the national average in 3 of the 6 Key Performance Indicators (KPIs) and similar to the national average in 1 KPI. Results are lower than the national average in relation to KPI 2, which relates to patients undertaking practice exercise tests. The service are looking at the possibility of introducing practice walk tests in the future while considering the impact that this will have on the number of patients seen per assessment session.
National Paediatric Diabetes Audit – Parent & Patient Reported Experience Measures	Local results are above the national average for children and young people (CYP) and parents/carers reporting a positive relationship with the Trust diabetes team and accessibility of diabetes advice 24 hours a day. • The Trust provides face-to-face paediatric diabetes multi-disciplinary team (MDT) clinic appointments. • The paediatric diabetes team offers virtual appointments to patients and families when this is useful. • It is standard practice to equip school staff to help children and young people manage their diabetes whilst at school.
Perinatal Mortality Review Tool (PMRT) Annual report	The audit findings and recommendations have been reviewed by the clinical team and benchmarked against current practice. Results show that the Trust consistently meets >95% compliance with parental engagement. Locally: • All parents are given a letter prior to discharge and telephoned by the PMRT Lead Midwife. • Parental engagement materials e.g. the parent questionnaire and letters are used. • MCHT quarterly PMRT report is compiled and a rolling action plan in place. • There are currently no local improvement actions required against this report
National Hip Fracture Database (NHFD)	Following review of the audit findings a number of areas for improvement have been identified. Actions in progress include: • Topic to be covered in nursing study day by Advanced Clinical Practitioner (ACP) for Trauma & Orthopaedics. • ACP to attend junior doctor induction to cover the importance of undertaking 4AT post-surgery. • Timely feedback of compliance with NHFD standards to ward staff, to highlight area of good practice and areas requiring improvement. • Identification of ward champions to support achievement of best practice for Fractured Neck of Femur (NOF) patients. • Information leaflets downloaded from the NHFD to give to all hip fracture patients. The Team has also identified a number of other areas for focus and the new NHFD Audit Lead will be reviewing how these can be addressed moving forward.

National Early Inflammatory Arthritis Audit	Results show that the Trust is performing well in 4 of the 6 standards which contribute to the Best Practice Tariff but below the national average for patients being seen within 3 weeks of referral. A local improvement plan has been developed and actions planned/undertaken in order to increase the number of patients being seen within 3 weeks of referral, include: • Set up early inflammatory arthritis (EIA) clinic with dedicated slots for those patients identified from referrals. • Education for Musculoskeletal Clinical Assessment and Treatment Service (MCATS) team so that when a patient presents with relevant symptoms they can be identified early and sent to Rheumatology to allocate to an EIA clinic slots. • Consultants to review Electronic Referral System (ESR) rheumatology triage rota.
MBRRACE-UK Perinatal Mortality Surveillance Report	The report has been reviewed by the Clinical and Quality Leads and local practice has been benchmarked against the national recommendations. Of the 6 recommendations only 2 were relevant at Trust level and full compliance was assured. MCHFT unit level data will be presented at the Perinatal Audit Meeting.
Society of Acute Medicine Benchmarking Audit (SAMBA)	The results of the audit have been reviewed and a local improvement plan is in place, which includes the following actions: • Continue to provide immediate NEWS2 to support triage of admissions, in the context of increasing demand. • Same Day Emergency Care Service (SDEC) will now directly triage admissions streamed to Medicine. • Improve time to first assessment by decision maker, by expanding SDEC facilities..
BTS Outpatient Management of Pulmonary Embolism	Local results have been reviewed at the Acute Medicine Governance Meeting and an improvement plan is under development. Actions already in progress include: • Development of a patient leaflet, including medication, follow-up and contact details etc. • Acute Medicine Lead Pharmacist is now trained as a prescriber with a specialist interest in thromboembolism. • Improving patient information around the point of discharge.
National Joint Registry (NJR)	• The Trust is performing well and within the expected range for both Hip and Knee outlier analysis, which covers “90-day mortality”, “Revision rate since 2012” and “Revision rate since 2017”. • The Trust also scores highly for link ability, patient consent and compliance, resulting in the continued receipt of the ‘NJR data quality award’.

	• The team monitor and discuss all the NJR reports in the arthroplasty MDT and actions are taken if any issues are identified.
Maternal, Newborn and Infant Clinical Outcome Review Programme	• Local practice has been benchmarked against the national recommendations. • The MCHT Perinatal Mental Health Midwife runs joint clinics and has close links with the specialist Perinatal Mental Health Team. • Diabetic ketoacidosis (DKA) has been added to the Skills and Drills itinerary for 2023/2024. • Insomnia and sleep deprivation are included in mandatory training for all midwives and obstetricians. • MCHT Mental Health (Maternity) Guideline includes crisis management and indications for referral. • VTE Risk Assessment completion has good compliance, evidence shown on Quality Dashboard.
National Audit of Inpatient Falls Annual Report	MCHT has a rolling Falls Gap Analysis/Improvement Plan in place which is overseen by the Trust-wide Falls Group. Actions undertaken/in progress during 2022 include: • Falls Risk Assessment for Day Case areas introduced. • Bay tagging and 1-1 project relaunch – training disseminated across all divisions and to be included in all falls training days. • The Trust now utilises a 1-1 action card and identification armband to support the 1-1 role. • The Trust has purchased 100 falls sensors, which are now available to all wards and departments. Training has been disseminated across all Divisions. • Post Fall Medical Review Sticker amended to include analgesia administration following a fall. • Falls Bundle and Un-reported falls audits completed quarterly. • E-Learning and manual handling training provided across the Trust.
National Neonatal Audit Programme (NNAP)	The Trust received reports in March 2022 (2020 data) & November 2022 (2021 data). The audit findings and recommendations have been reviewed by the clinical team and a local improvement plan has been agreed. The Trust has a Neonatal Infant Feeding Lead, are Fi Care and BFI accredited and screening of Retinopathy of Prematurity Guideline (Oct 2022) has been updated in line with the RCPCH Guidance. There is a QI project in place to improve our temperature admission to the neonatal unit.
National NHS Learning Disabilities (LD) Benchmarking Standards (Year 4)	Trust level results are reviewed by the Trust Safeguarding Group. A local improvement plan is in place and includes the following actions:

	• Head of Adult Safeguarding now receives a list of all patients with a LD on a waiting list. The list is reviewed, and information shared with community LD teams where appropriate. • Adults with LD / autism and their carers are providing face-to-face training for staff across the organisation. • All LD / autism deaths are reviewed as part of the Structured Judgement Review (SJR) process. • All LD / autism deaths within the organisation are reported through to the LeDeR programme. • Restrictive practices audited every quarter. Results shared with Integrated Care Board via Trust Safeguarding Group.
UK Trauma Audit and Research Network (UKTARN)	TARN data is regularly reviewed by the clinical team. Results are discussed at the quarterly Trauma Committee and also presented at the Trust Quality & Safety Committee annually. A local improvement plan is in place which includes the following actions: • Business case to be developed for a cross-divisional, stand-alone TARN data input clerk. • Ongoing education for ED staff regarding urgency of CT scans. • Installation of new CT scanner in ED will improve time to CT scan. • In-house audit of times to CT in trauma patients to be undertaken. • On-going Trauma Team Training using SimMan. • Internal Trauma Study Day for nurses to continue.
Intensive Care National Audit and Research Centre Case Mix Programme (ICNARC	The ICNARC data is regularly discussed at the Critical Care Clinical Governance Meetings and the Trust Critical Care Delivery Group. Key local actions undertaken in response to the 2022 ICNARC reports include: • Introduction of a monthly morbidity and mortality meeting. This will identify any learning for sharing with the wider team and also identify any deaths that require a further in-depth Structured Judgement Review (SJR). • Critical care consultants will take responsibility for entering diagnostic data on the ICNARC database for patients admitted to the Intensive Care Unit (ICU). • A local review of selected patients will be undertaken whose predicted mortality was <20% according to the ICNARC report.

Local Clinical Audits

The reports of 72 local clinical audits were reviewed by the provider in 2022/2023. The table below includes examples of local audits reported in 2022/2023. The table also includes actions planned and undertaken in response to the audit findings.

Local Clinical Audit	Actions Taken / To Be Taken
NEWS2 Audit	• Data is collected locally, and any immediate issues are addressed at a ward level. • Trust level data is reviewed at the Deteriorating Patient Group for the identifications of themes. • The audit tool has been reviewed and updated for 2023/2024.
SKIN Bundle Audit	• Data is collected locally, and any immediate issues are addressed at a ward level. • Trust level data is reviewed at the Skin Care Group. • The audit results help to identify educational needs which are addressed through trust-wide training sessions. • The audit tool will be reviewed for 2023/2024.
Falls Bundle Audit	• Trust level data is reviewed at the Falls Group and issues are fed back to the relevant teams. • The Trust has a rolling Falls Improvement Plan which is overseen and monitored by the Falls Group. • Examples of on-going and planned actions are detailed in the table above under the National Audit of Inpatient Falls.
Resuscitation Trolley Audit	• Trust level data reviewed at the Resuscitation Group. • Audit findings shared with Heads of Nursing, Matrons, Ward/ Department Managers and Resuscitation Link Nurses. • Failed trolleys re-visited to ensure that they are now fit for purpose. • Resuscitation Link Nurses invited to attend Resuscitation Link Nurses Training to be held in March 2023. • On-going monthly monitoring/audit of Resuscitation Trolleys.
Infection Control Audit Programme including: • Hand Hygiene • Commodes • PPE • Environmental	• Any immediate issues are fed-back and addressed at area/ward level. • Where themes are identified the Infection Prevention & Control Team deliver targeted bespoke training to relevant wards/areas. • Audit results are reported/fed-back through Operational IPC group meetings, Trust Operational IPC Group, housekeeper meetings and discussed at Heads of Nursing meetings.
Post fall medical review and analgesia provision audit	• Slot on Medical Induction to provide training to medics regarding national guidance and Trust expectations. • Amendments made to Post Fall Medical Review “Yellow Sticker to include prompts to prescribe additional analgesia.
Surgical Proforma Documentation Audit & Re-audit	• Presentation and teaching to junior doctors. • Posters in doctor’s office. • Presence in handover and verbal reminders of importance of documentation (clinician awareness). • Re-audit.
WHO surgical checklist audit	• Immediate feedback provided to teams to address any observed non-compliance. • Education and support provided in theatre during the checklist audit. • Laminated WHO information displayed regarding completing effective and safe checklists.

	• Re-audit following further training and support.
Controlled drugs re-audit	• Ward technicians to be more actively involved in Controlled Drugs stock management on the wards.
Anticoagulation policy re-audit	• Explore if e-learning for prescribers can be made mandatory. • Pharmacists to complete anticoagulation forms if information is known. • A Direct-acting Oral Anticoagulant (DOAC) counselling form to be developed to improve counselling and documentation.
Bi-annual medication security audit	• Appropriate length cables to be ordered to attach medication bins to the wall in A&E.
Audit of ciclosporin prescribing	• To produce a sticker-based checklist for inclusion in the notes to improve compliance.
Gestational diabetes discharge (GDM) letter audit	• Pre-populated GDM follow-up drop down box added on Medway. • Discharge coordinators start on ward. • Posters displayed on ward, showing new GDM discharge letters.
Antenatal risk assessment and named consultant audit	• Session on Personalised Care and Support Plans has been added to mandatory training 2022/23. • Website updated to include easy to navigate information relating to place/mode of birth options. • Medway has been updated to include recording of discussions regarding mode/place of birth and of risks and benefits and information given.
Informed decision-making audit	• Training given to raise staff awareness of 'information given' section on Medway. All leaflets and web links are included in 'information given' section of Medway and recorded when given. • Induction of Labour leaflet has been updated in line with NICE Inducing Labour 2021 with all risks and information required to aid consistency.
Re-audit of investigation in CYP at initial presentation with newly diagnosed diabetes mellitus	• Update of local guideline for newly diagnosed diabetes patients including how to request investigation at the initial presentation.
Heavy menstrual bleeding audit	• Patient information leaflet on heavy menstrual bleeding has been created and is available on the Trust's website.
Smoking in pregnancy audit	• Ongoing work on promoting co testing at each face-to-face antenatal contact. • Data is analysed and checked monthly to ensure the smoking status is accurately documented and any discrepancies are corrected. • Public health support workers are performing an early intervention phone call to all patients identified as a smoker at referral to maternity services. This enables early very brief advice conversations and early referral to the stop smoking services.

Participation in clinical research

Research is...

Good for patients:

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

Good for staff:

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

Good for the organisation:

The Care Quality Commission (CQC) recognises that research activity is a key contributor to best patient care.

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

Children's public health research

The **GenOMICC** study looks at the genes (DNA) of people who become critically ill, or meet certain other criteria including outbreaks of public health interest such as unexplained hepatitis in children. It seeks to better understand why some people become sicker than others and, potentially, to discover new ways of treating patients. This year we were able to offer this opportunity to our paediatric patients and their families.

New Treatments

Fifteen percent of strokes are due to bleeding in or around the brain, called a haemorrhagic stroke. The most common of these is called an IntraCerebral Haemorrhage or ICH for which there is no current effective drug treatment. The **TICH-3** study is investigating whether rapid use of tranexamic acid (TXA) can reduce deaths and improve outcomes. It builds on the findings of the TICH-2 study and, if it confirms the improvements shown in the earlier trial it has the potential to change clinical practice globally.

Changing practice in pregnancy

Many babies come into contact with group B streptococcus (GBS) during labour or birth. This causes no problems for the vast majority, but a small number of babies may become seriously ill if they're infected. Pregnant women are not routinely screened for GBS in the UK but, because of our participation in the **GBS-3** study, this test will be widely offered to women delivering at MCHFT.

Personalised Medicine

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

Bringing research to the patient

Having successfully bid for funding to offer opportunities to participate in research beyond the hospital environment we opened and successfully recruited to the **Hypo-Resolve** study which aims to understand the impact hypoglycaemia has on people living with diabetes. This involved linking with the diabetes team in the community to involve patients we would not have reached in the hospital setting.

The number of patients receiving NHS services provided or sub-contracted by Mid Cheshire Hospitals NHS Foundation Trust that were recruited between 01/04/22 and 03/02/2023 to participate in research approved by a research ethics committee was 897.

Commissioning for Quality and Innovation (CQUIN)

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

The goals have a proportion of the Trusts contract income linked to them which is earned by the Trust upon achievement of the goals.

Further details of the agreed goals for 2022/23 are available electronically at:

https://www.england.nhs.uk/nhs-standard-contract/cquin/2022-23-cquin/

The overall financial value of CQUIN schemes is currently 1.25% of the provider's contract value however the Trust is not expecting to be penalised for CQUIN under performance this year due to the Cheshire and Mersey ICS adopting the aligned incentive contract in shadow form only.

For MCHFT, the financial value of the 2022/23 CQUIN scheme is £504K.

For CCICP, the financial value of the 2022/23 CQUIN scheme is £104.6k.

There are 15 indicators in the 2022/23 clinical commissioning group (CCG) / Integrated Care Board (ICB) CQUIN scheme.

All national indicators (capped at the five most important, where more than five apply) must be adopted where the relevant services are in scope for each contract.

CQUIN	CQUIN Description	Payment Threshold	RAG Status Q1	RAG Status Q2	RAG Status Q3	RAG Status Q4
Acute Trust Top 5 Indicators						
CCG 1 Flu Vaccination for Frontline healthcare workers **Acute & CCICP*	Achieving 90% uptake of flu vaccinations by frontline staff with patient contact.	70% - 90%			57%	TBC

CCG 2 Appropriate antibiotic prescribing for UTI in adults aged 16+	Achieving 60% of all antibiotic prescriptions for UTI in patients aged 16+ years that meet NICE guidance for diagnosis and treatment.	40% - 60%	51%	46%	50%	TBC
CCG 3 Recording of NEWS2 score, escalation time and response time for unplanned Critical Care admissions	Achieving 60% of all unplanned critical care unit admissions from non-critical care wards of patients aged 18+, having a NEWS2 score, time of escalation (T0) and time of clinical response (T1) recorded.	20% - 60%	80.95%	96%	79%	TBC
CCG 5 Treatment of community acquired pneumonia in line with BTS care bundle	Achieving 70% of patients with confirmed community acquired pneumonia to be managed in concordance with relevant steps of BTS CAP Care Bundle.	45% - 70%	31.63%	23%	31.25%	TBC
CCG 8 Supporting patients to drink, eat and mobilise after surgery	Ensuring that 70% of surgical inpatients are supported to drink, eat and mobilise within 24 hours of surgery ending	60% - 70%	100%	95%	87.87%	TBC
CCICP						
CCG 13 – Malnutrition screening in the community	Achieving 70% of community hospital inpatients and community nursing contacts having a nutritional screening that meets NICE Quality Standard QS24 (Quality statements 1 and 2), with evidence of	50% - 70%		7%	46%	TBC

	actions against identified risks					
CCG 14 – Assessment, diagnosis and treatment of lower leg wounds	Achieving 50% of patients with lower leg wounds receiving appropriate assessment diagnosis and treatment in line with NICE Guidelines	25% - 50%	4%	7%	7%	TBC
CCG 15 Assessment and documentation of pressure ulcer risk	Achieving 60% of community hospital inpatients aged 18+ having a pressure ulcer risk assessment that meets NICE guidance with evidence of actions against all identified risks.	40%-60%		40%	60%	TBC
Nationally Reported CQUIN						
CCG 4 Compliance with timed diagnostic pathways for cancer services	Achieving 65% of referrals for suspected prostate, colorectal, lung and oesophago-gastric cancer meeting timed pathway milestones as set out in the rapid cancer diagnostic and assessment pathways	55%-65%	28%	28%	40%	TBC
CCG 6 Anaemia screening and treatment for all patients undergoing major elective surgery	Ensuring that 60% of major elective blood loss surgery patients are treated in line with NICE guideline NG24.	45%-60%	99%	100%	99%	TBC
CCG 7 Timely communication of	Achieving 1.5% of acute trust inpatients having changes to medicines	0.5% - 1.5%	0%	0%	0%	TBC

changes to medicines to community pharmacists via the discharge medicines service	communicated with the patient's chosen community pharmacy within 48 hours following discharge, in line with NICE Guideline 5, via secure electronic message.					
CCG 9 Cirrhosis and fibrosis tests for alcohol dependent patients	Achieving 35% of all unique inpatients (with at least one-night stay) aged 16+ with a primary or secondary diagnosis of alcohol dependence who have an order or referral for a test to diagnose cirrhosis or advanced liver fibrosis.	20% - 35%	Agreement with CCG - Indicator not being reported on for 2022-23.			

Status:

Achieved in quarter	Partially achieved	Did not achieve quarter	Milestone not required for quarter

Feedback from Care Quality Commission (CQC)

The Trust is required to register with the Care Quality Commission (CQC) under section 10 of the Health and Social Care Act 2008 and its current registration status is registered without conditions. The Trust's registration includes the services provided at Leighton Hospital, Victoria Infirmary in Northwich, Elmhurst Intermediate Care Centre in Winsford and the community services within the Central Cheshire Integrated Care Partnership (CCICP). The Care Quality Commission has not taken enforcement action against the Trust during the period April 2022 to March 2023.

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

- Urgent and emergency services

- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity
- Services for children & young people
- End of life care
- Outpatients
- Gynaecology and Termination of Pregnancy
- Diagnostic Imaging service
- Community health services for adults
- Community health services for children, young people and families
- Community health inpatient services
- Community end of life care

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

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

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

As the Trust has not been inspected by the CQC during 2022/23 the previous CQC ratings remain in place. The reports from this 2019/20 inspection are available on the CQC's website along with their ratings of the care. Our latest ratings can be seen here:

The Trust developed an improvement plan in response to the 2019 CQC inspection findings. Divided in to “must do” and “should do” actions, the CQC improvement plan responded to each of the findings, and by October 2020, all of the “Must do” actions had been addressed, and shortly following this all the “Should do” actions were closed.

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

A newly formed CQC Assurance Group was established in 2022 to ensure ongoing monitoring of Key Lines of Enquiry and ensuring the Trust was up to date with the CQCs new Strategy. The meeting is Chaired by Director of Nursing & Quality, and members include Deputy Medical Director, Heads of Nursing, Associate Medical Directors, and Divisional Directors.

As part of the Trust’s quality and safety assurance framework, a programme of mock CQC inspections took place throughout the medical wards and individual recommendations were sent to each ward for action.

The Trust has maintained contact with its designated CQC Relationship Manager within year. Regular engagement meetings have been held over Microsoft Teams, with attendance from Trust Executives and senior leaders. A maternity focus group was held in December 2022 hosted by the CQC and a set of immediate actions were completed following the visit.

The CQC Relationship Manager has undertook two informal visits to Leighton Hospital and Victoria Infirmary with no concerns raised.

In July 2022, the Trust has contributed to the JTAI (Joint targeted area inspection of the multi agency response to the criminal exploitation of children) inspection of services for children in Cheshire East. Actions following the inspection have been reported through the Executive Quality Governance Group.

The Trust has received 53 enquiries from the CQC during 2022/23, with the addition of 7 StEIS related requests and 16 complaint responses. All responses were returned within the given timeframes.

Data Quality Assurance

NHS and General Practitioner registration code validity (April 22 to February 23) From NHS Digital SUS dashboard)

The Trust submitted records during 2022/23 to the secondary uses service for inclusion in the Hospital Episodes Statistics which are included in the latest published data.

- 99.9% for admitted patient care;
- 100% for outpatient care;

• 99.5% for accident and emergency care.

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

• 99.5% for admitted patient care;

• 97.8% for outpatient care;

• 100% for accident and emergency care.

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

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

The DSPT is measured by an online submission and an external audit which is conducted by MIAA. In 2021/22 the Trust received a rating of 'Substantial Assurance' as part of its DSPT submission. The 2022/23 submission will be made on the 30/06/2023.

Please note that the outcome of the Trust's DSPT submissions is available on the NHS Digital website once finalised.

Clinical coding error rate

The Trust was not subject to the Payment by Results clinical coding audit during 2022/23 by the Audit Commission.

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

- Deliver a robust annual clinical coding audit programme to ensure that staff maintain and enhance their skills in line with the National Clinical Coding Standards
- Action any recommendations from the clinical coding audits, escalating to the Data Quality and Clinical Coding Operational Group where appropriate
- Continue to support and delver an internal training programme for Novice Clinical Coders, through the mentorship programme delivered by the Clinical Coding Team Leaders

- Continue to invest in the training to all Clinical Coders, to support their professional development and enhance their skill set
- Continue to support and encourage Novice Clinical Coders to gain their Accredited Clinical Coding (ACC) exam to obtain clinical coding qualified status
- The Clinical Coding Management team will continue to develop the clinician engagement programme to promote the importance of accurate clinical data
- Continually review coding resources and performance.

Patient Safety Alerts Compliance 2022/23

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

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

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

During 2022/23, the Trust received nine patient safety alerts; all met the timeframe set.

Reference	Title	Date Alert Issued	Deadline	Status
SHOT/2022/001	Preventing transfusion delays in bleeding and critically anaemic patients	17/01/2022	15/07/2022	Closed within agreed timeframe - Actions Completed
NatPSA/2022/003/NHSPS	Inadvertent oral administration of potassium permanganate	05/04/2022	04/10/2022	Closed within agreed timeframe - Actions Completed

Reference	Title	Date Alert Issued	Deadline	Status
NatPSA/2022/004/MHRA	NovoRapid PumpCart in the Roche Accu-Chek Insight insulin pump: risk of insulin leakage causing hyperglycaemia and diabetic ketoacidosis	26/05/2022	26/11/2022	Closed within agreed timeframe - Actions Completed
NatPSA/2022/005/UKHSA	Contamination of hygiene products with Pseudomonas aeruginosa	24/06/2022	03/07/2022	Closed within agreed timeframe - Actions Completed
NatPSA/2022/007/MHRA	Recall of Mexiletine hydrochloride 50mg, 100mg and 200 mg Hard Capsules, Clinigen Healthcare Ltd due to a potential for underdosing and/or overdosing	04/08/2022	12/08/2022	Closed within agreed timeframe - Actions Completed
NatPSA/2022/008/MHRA	Recall of Targocid 200mg powder for solution for injection/infusion or oral solution, Aventis Pharma Limited t/a Sanofi, due to the presence of bacterial endotoxins	21/10/2022	26/10/2022	Closed within agreed timeframe - Actions Completed
NatPSA/2022/009/MHRA	Prenoxad 1mg/ml Solution for Injection in a pre-filled syringe, Macarthys Laboratories, (Aurum Pharmaceuticals Ltd), caution due to potential	10/11/2022	15/12/2022	Closed within agreed timeframe - Actions Completed

Reference	Title	Date Alert Issued	Deadline	Status
	missing needles in sealed kits			
Alert distributed by Office for Health Improvement and Disparities, Department of Health and Social Care	Urgent Safety Alert issued for baby self-feeding pillows	01/12/2022	02/12/2022	Closed within agreed timeframe - Actions Completed
NatPSA/2023/001/NHSPS	Use of oxygen cylinders where patients do not have access to medical gas pipeline system	10/01/2023	20/01/2023	Closed within agreed timeframe - Actions Completed

Never Events 2022/23

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

In 2022/23, one incident occurred which met the definition of a Never Event at Mid Cheshire Hospitals NHS Foundation Trust.

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

Type of Never Event	Description of incident	Recommendations
Wrong Site Surgery	The patient attended the Treatment Centre as an elective day case patient to undergo radiofrequency ablation of the sacroiliac joint on the right side. The patient was consented for the procedure to be performed on the right side and the right side was documented on the theatre list. The patient's right hand was marked to indicate that the right side was to be injected in theatre (it was practice for patients' hands to be marked	An observational walkaround in theatres was undertaken by the Clinical Governance Managers to assess the robustness of processes including checklists and marking. Processes and checks were found to be in place and robust during the walk round. An immediate change in practice was implemented with regards to marking patients for theatre.

Type of Never Event	Description of incident	Recommendations
	as they are seen pre-operatively whilst fully dressed). The procedure was performed on the left side in error. The Consultant performing the procedure realised that the block had been performed on the wrong side postoperatively and this was immediately discussed with the patient. The patient reported that she was happy with the outcome as she had been experiencing pain on the left side and had previously had a radiofrequency ablation on the left side. The patient subsequently also underwent radiofrequency ablation on the right side. The incident was graded as low harm.	Patients are now marked on the operative site in the treatment room so that the mark is easily visible during the procedure. A further recommendation is for the Clinical Governance Managers to review the surgical proformas from two radiofrequency ablation theatre lists to establish whether the operative site has been directly marked. This action is ongoing and due to be completed by March 2023.

Learning from Deaths 2022/23

During quarters one to four 1238 patients were part of the Learning from Deaths process within Mid Cheshire Hospitals NHS Foundation Trust.

Number of deaths included in the Learning from Deaths process 2022/23	
Quarter	Number of deaths
Quarter 1 (April 22 – June 22)	271
Quarter 2 (July 22 – September 22)	277
Quarter 3 – (October 22 – December 22)	350
Quarter 4 – (January 23 – March 23)	340
Total	1238

By the end of March 2023, 77 case record reviews were carried out in relation to 1238 deaths.

Number of case record reviews/investigations during 2022/23	
Quarter	Deaths reviewed or investigated (as of end of April 2022)
Quarter 1 (April 22 – June 22)	21
Quarter 2 (July 22 – September 22)	22
Quarter 3 – (October 22 – December 22)	22
Quarter 4 – (January 23 – March 23)	12
Total	77

0.16% (2 of 1238 total deaths) deaths were reviewed or investigated (as at the end of March 2023) and were judged more likely than not to have been due to problems in care provided to the patient. These were reported as a serious incident in line with the National Serious Incident Framework.

Number of deaths reviewed which were judged more likely than not to have been due to problems in care provided to the patient		
Quarter	Deaths reviewed which were judged more likely than not to have been due to problems in care provided to the patient.	Percentage of total deaths in quarter that were judged more likely than not to have been due to problems in care provided to the patient
Quarter 1 (April 22 – June 22)	0	0%
Quarter 2 (July 22 – September 22)	1	0.37%
Quarter 3 – (October 22 – December 22)	1	0.29%
Quarter 4 – (January 23 – March 23)	0	0%
Total	2	0.16%

These numbers have been estimated using the Royal College of Physicians Structured Judgement Review Process (SJR) Process. Potentially avoidable deaths are also identified through Patient Safety Investigations.

SJRs are undertaken by a cohort of senior medical and nursing staff trained in the SJR process. SJR blends traditional, clinical judgement-based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases

of care, to make explicit written comments about care for each phase, and to score care for each phase The result is a relatively short but rich set of information about each case in a form that can also be aggregated to produce knowledge about clinical services and systems of care.

The SJR produces two types of data:

1. A score from 1 to 5 identifies very poor - excellent care respectively in a number of phases of care
2. Qualitative data in the form of explicit statements about care using free text.

The phases of care which are reviewed are:

- Admission and initial care - first 24 hours
- Ongoing care
- Care during a procedure
- Perioperative/procedure care
- End of life care
- Assessment of overall care.

The objective of the review method is to look for strengths and weaknesses in the caring process, to provide information about what can be learnt about the hospital systems where care goes well and to identify points where they may be gaps, problems or difficulty in the care process.

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

- Deaths where families, carers or staff raise concerns
- Deaths where concerns are raised by the Coroner
- Deaths where concerns are raised at the Patient Safety Summit via clinical incident reports
- All learning disability deaths
- All deaths of patients who have a diagnosed serious mental health illness
- Outlier data deaths as identified by the Trust Mortality Group
- Medical Examiner concerns (all in-patient deaths will be scrutinised by a Medical Examiner)
- Divisional Review Concerns
- All deaths where Covid-19 was reported on part 1 or part 2 of the death certificate

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

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

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

Summary of what has been learnt from case record reviews and investigations conducted in relation to the deaths identified above and actions taken.

Outcome and learning	SJR/Patient Safety Outcome
An SJR found that there were omissions of critical medicines during a patient's admission due to the patient not eating and drinking. This was despite a plan from the Diabetic Specialist Nurses to reduce the patient's insulin regime to take this into account. **Learning** Safety huddles on the diabetes ward now include discussing any patients with uncontrolled diabetes, non-compliant patients or concerns around prescribing or no prescription of critical medication. Deep Dive into incidents relating to diabetes over the last 12 months undertaken and presented through the governance structure. Weekly training commenced, led by the Diabetic Specialist Team, which is available to all Nursing and Medical Staff	The SJR concluded that the death was probably preventable, more than 50-50 but close call (LIKET 4)
A patient safety investigation found that the unnecessary administration of chlordiazepoxide contributed to a patient's respiratory failure and rapid deterioration. There were missed opportunities to escalate the patient's care and provide appropriate treatment for type 2 respiratory failure, which may have resulted in a cardiac arrest. **Learning** Alcohol Liaison to provide training regarding Clinical Institute Withdrawal Assessment for Alcohol Score and adult detoxification regimes. Task and finish group to establish the Trust wide training requirements for the use of chlordiazepoxide.	The investigation concluded that lapses in care may have directly contributed to the patient's death.

Performance against quality indicators and targets

National quality targets

	2018-19	2019-20	2020-21	2021-22	2022-23	Target	Achieved
Clostridium Difficile infections	2 avoidable cases	2 avoidable cases	3 avoidable cases	10 avoidable cases to date	15 avoidable cases to date	0	✖
Percentage of patient who wait 4 hours or less in A&E	83.63%	76.78%	85.08%	64.95%	41.88%	95%	✖
The percentage of patients waiting 6 weeks or more for a diagnostic test	0.41%	3.27%	42.31%	35.09%	29%	1%	✖
Summary Hospital-level Mortality Indicator	100.95	99.47	94.30	97.20	95.12%	-	-
Venous thromboembolism (VTE) risk assessment	95.24%	95.91%	96.01%	94.11%	93.58%	95%	✖
Percentage of patients receiving first definite treatment for cancer within 62 days of an urgent GP referral for suspected cancer	88.98%	86.22%	75.87%	82.01%	73.0%	85%	✖
Percentage of patients receiving first definite treatment for cancer within 62 days of referral from an NHS Cancer Screening Service	94.44%	89.29%	84.97%	73.11%	74.5%	90%	✖

The percentage of Referral to Treatment (RTT) pathways within 18 weeks for incomplete pathways	92.38%	91.37%	69.02%	60.50%	58.32%	92%	✖

*Note that any cases awaiting confirmation of avoidable/unavoidable status will not be included

National quality indicators

Since 2012/13, all Trusts have been required to report performance against a core set of indicators using data made available to the Trust by NHS Digital.

For each indicator the numbers, percentages, values, scores or rates of each of the NHS foundation Trust's indicators should be compared with:

- the national average for the same and
- NHS Trusts and NHS foundation Trusts with the highest and lowest for the same.

Indicator	Measure Description			
SHMI	A) The value and banding of the summary hospital-level mortality indicator ('SHMI') for the Trust for the reporting: and			
Period	Trust Performance	National Average	95% Upper Limit	95% Lower limit
December 20 - November 21	96.15	100	108.51	91.97
January 21 - December 21	95.50	100	108.33	92.13
February 21 - January 22	95.52	100	108.27	92.18
March 21 - February 22	96.48	100	108.22	92.23
April 21 - March 22	95.26	100	108.28	92.18
May 21 - April 22	94.49	100	108.31	92.15
June 21 - May 22	95.15	100	108.31	92.15

July 21- June 22	94.31	100	108.38	92.09
August 21 - July 22	94.73	100	108.47	92.01
September 21 - August 22	94.43	100	108.54	91.94
October 21 - September 22	94.35	100	108.42	92.05
November 21- October 22	95.12	100	108.44	92.03

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

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

- For the reporting period November 2021 to October 2022 the Trust SHMI was 95.12.
- The month-on-month changes to the Trust SHMI and HSMR is caused by a number of different factors but mainly driven by natural variation in admissions resulting in death across the whole country. Using these models, the Trust has maintained a mortality rate that is 'within the expected range' for each month and quarterly release.

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

- Having a well-established Trust Mortality Group (TMG) led by Deputy Medical Director. This group monitors the mortality reduction improvement plans across the Trust.

Indicator	Measure Description			
SHMI	B) The percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust for the reporting period.			
Period	Trust Performance	National Average	95% Upper Limit	95% Lower Limit
December 20 - November 21	1.45%	1.47%	-	-
January 21 - December 21	1.42%	1.45%	-	-
February 21 - January 22	1.25%	1.45%	-	-

March 21 - February 22	1.36%	1.36%	-	-
April 21 - March 22	1.32%	1.42%	-	-
May 21 - April 22	1.31%	1.45%	-	-
June 21 - May 22	1.29%	1.46%	-	-
July 21- June 22	1.27%	1.47%	-	-
August 21 - July 22	1.25%	1.47%	-	-
September 21 - August 22	1.24%	1.47%	-	-
October 21 - September 22	1.24%	1.49%	-	-

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

This is an indicator designed to accompany the Summary Hospital-level Mortality Indicator (SHMI) and represents the percentage of deaths reported in the SHMI indicator where the patient received palliative care.

The SHMI makes no adjustments for palliative care. This indicator presents the crude percentage rates of death that are coded with palliative care either in diagnosis or treatment speciality.

Indicator	Measure Description			
VTE	The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.			
Period	**Trust Performance**	**National Average**	**95% Upper Limit**	**95% Lower Limit**
Jan-22	94.89%	No data available	No data available	No data available
Feb-22	94.87%	No data available	No data available	No data available
Mar-22	94.36%	No data available	No data available	No data available
Apr-22	91.9%	No data available	No data available	No data available
May-22	93.08%	No data available	No data available	No data available

Jun-22	92.48%	No data available	No data available	No data available
Jul-22	94.85%	No data available	No data available	No data available
Aug-22	93.92%	No data available	No data available	No data available
Sep-22	92.94%	No data available	No data available	No data available
Oct-22	94.47%	No data available	No data available	No data available
Nov-22	95.17%	No data available	No data available	No data available
Dec-22	93.89%	No data available	No data available	No data available
Jan-23	92.30%	No data available	No data available	No data available
Feb-23	94.21%	No data available	No data available	No data available

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

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

- The percentage of patient's risk assessed for VTE has been under 95% in 2022/23. However, there was an improvement in February 2023 to 94.21%.

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

- Developing a daily report which is sent to each ward and highlights any patients that have not yet had a completed VTE risk assessment entered onto the patient records. The Ward Manager/ Coordinator will then highlight the cases that require a risk assessment to the medical team to ensure it is completed. The patient record is then updated accordingly
- Monthly monitoring of the percentage of patient's risk assessed for VTE by the clinical Divisions and Trust Patient Safety Group
- Regular review of the VTE risk assessment tool to ensure it continues to be compliant with National Institute for Health and Clinical Excellence (NICE) guidance. The tool is included within the Trust admission proforma to ensure it is completed in a timely manner at admission and the appropriate VTE prevention interventions are implemented

- Continued education for medical staff on induction on the importance of VTE assessment.
- A project led by the Associate Medical Director for Patient Safety to improve VTE risk assessment compliance is underway.

Indicator	Measure Description			
Patient Safety Incidents	The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period.			
Period	**MCHFT Performance**	**National Average**	**Upper Limit**	**Lower Limit**
1st Apr 2018 to 30th Sep 2018	3,663	5,583	23,692	566
1st Oct 2018 to 31st Mar 2019	3,711	5,841	22,048	1,278
1st Apr 2019 to 30th Sep 2019	3,808	6,276	21,685	1,392
1st Oct 2019 to 31st Mar 2020	4,084	6,502	22,340	1,758
1st April 2020 to 31st March 2021	7, 398	12, 502	37,572	3,169
1st April 2021 to 31st March 2022	7,768	14,368	49,603	3,441

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

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

- All patient safety incidents are captured on the Trusts incident reporting system. These are then uploaded to the National Reporting & Learning System (NRLS)
- The level of reporting of incidents in the Trust demonstrates a risk aware culture and highlights that the Trust has a positive safety culture where staff feel able to report patient safety incidents. The data above demonstrates that staff have continued to report incidents throughout and following the pandemic. An education programme has also been undertaken in the Trusts community services to improve reporting in this area.
- The Trust consistently reports more no harm/near miss incidents than harm incidents, which demonstrates a positive risk aware culture within the Trust. 62% (4849) of the incidents reported resulted in no harm compared to 38% (2919) which resulted in a level of harm (low to death).
- Themes and trends from incidents are reported to the appropriate Trust Committees and Groups on a monthly basis for discussion, analysis and for learning to be identified and acted upon. Examples of these committees includes the Skin Care Group, the Patient Falls Prevention Group, the Medical Devices Group and the Nutritional Advisory Group.

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

- A daily huddle chaired by the Associate Director of Clinical Governance is held. The huddle is attended by the Clinical Governance Managers, Patient Safety Team and Clinical Governance Senior Team. Incidents from the previous 24 hours are discussed to ensure they have the appropriate level of harm assigned and level of investigation required is agreed
- Patient Safety Summit is a weekly meeting led by clinical teams. The Summit provides an opportunity for cross-divisional learning and sharing of immediate learning following incidents. All moderate and above patient safety incidents are discussed at the Summit along with all cardiac arrests, delays in referral to critical care outreach and child deaths. Clinical teams are encouraged to attend to promote learning and improvement. The Patient Safety Summit is chaired by the Executive Medical Director
- Following Patient Safety Summit a 'Safety Matters' newsletter is developed and distributed across the organisation. The newsletter contains learning from incidents, local or national updates and Summit messages of the week
- Incident report training for staff is provided and this ensures that staff know how to report a patient safety incident and they also understand the importance of incident reporting. This training is provided face to face and via an eLearning module
- Direct feedback is provided to all staff on the outcome of the incidents they have reported to demonstrate the changes in practice that have been made as a result of the incident
- A weekly triangulation meeting is held, attended by the patient safety, patient experience and legal teams. All new, incidents graded as potentially moderate and above, complaints, claims and inquests are reported at the meeting to ensure that learning is captured and triangulated.
- An internal Serious Incident Review Group has been established in 2022 to review and challenge the robustness of Investigation action plans before final sign off. The Group is led by the Executive Medical Director with the Associate Director of Clinical Governance and the Associate Director for Patient Safety.

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

1st Oct 2018 to 31st Mar 2019	5	5	23	0
1st Apr 2019 to 30th Sep 2019	1	5	24	0
1st Oct 2019 to 31st Mar 2020	6	5	22	0
1st April 2020 to 31st March 2021	18	55	261	4
1st April 2021 to 31st March 2022	13	58	216	3

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

- The Trust has seen a decrease in the reporting of serious incidents in the period April 2021 to March 2022. The Trust has a positive reporting culture. Incidents where there is the potential for learning are reported as serious incidents to ensure openness and transparency.

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

- Clinical Governance Managers and senior governance/patient safety leads are completing the HSIB investigation training in preparation for the PSIRF implementation.
- All serious incidents are discussed at the Clinical Governance daily huddle and at the weekly Patient Safety Summit.
- All serious incidents are reported to the Executive Team on a weekly basis by the Medical Director. All serious incidents are reported to board, all maternity serious incidents are included in the Quarterly Maternity Safety Report that is reported to Board.
- The Trust *Being Open* and Duty of Candour ensures that, if an incident occurs which results in moderate harm, severe harm or death, the patient and or their family are informed of the incident, involved in the investigation and the development of the final report. The report, lessons learned, and improvement plans from any investigation are shared with the patient and or their family.
  Compliance with Duty of Candour is monitored through the daily Clinical Governance Huddles. This is to ensure that Duty of Candour is applied to all incidents where it is required. Compliance is further monitored through the monthly Trust Patient Safety Group.

The Patient Safety Incident Response Framework (PSIRF)

A new approach to Patient safety incident investigations.

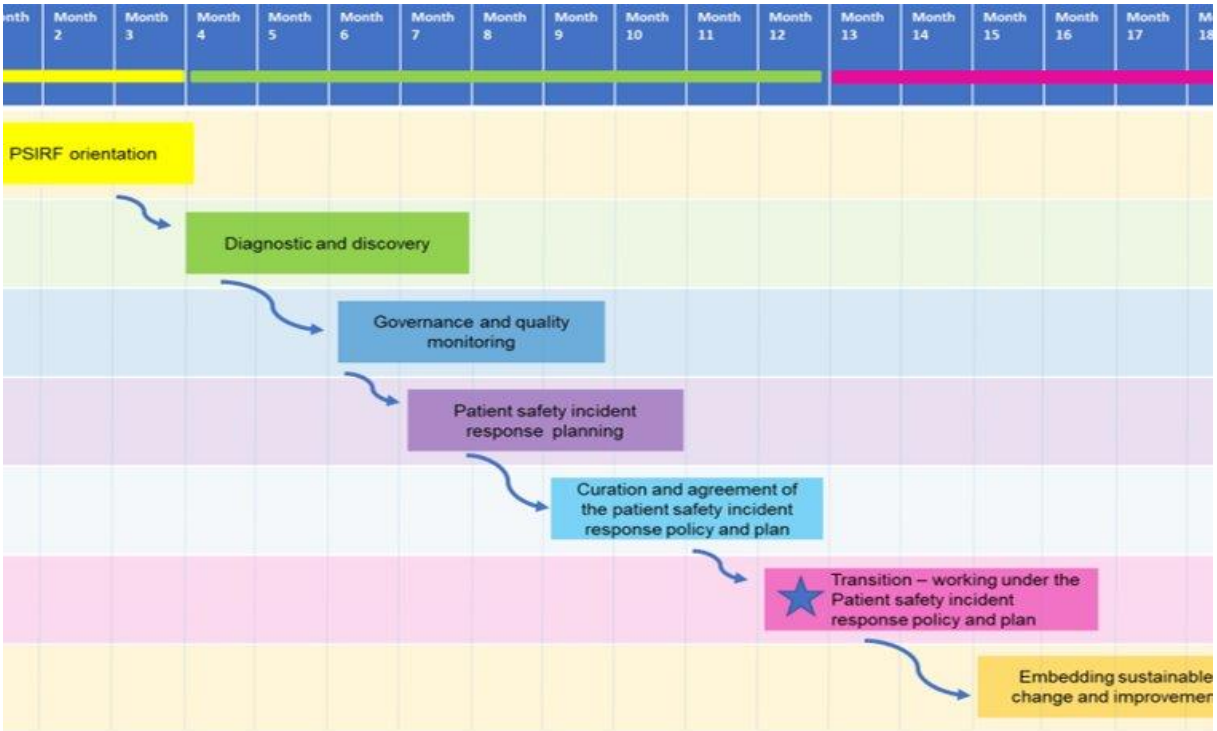
The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

The PSIRF replaces the Serious Incident Framework (SIF) (2015) and makes no distinction between ‘patient safety incidents’ and ‘Serious Incidents’.
A patient safety incident response planning exercise is used to inform what the organisation’s proportionate response to patient safety incidents should be.

The Patient Safety Incident Response Framework (PSIRF) is not an investigation framework: it does not mandate investigation as the only method for learning from patient safety incidents or prescribe what to investigate.
It is a framework that supports development and maintenance of an effective patient safety incident response system with four key aims:

1. compassionate engagement and involvement of those affected by patient safety incidents
2. application of a range of system-based approaches to learning from patient safety incidents
3. considered and proportionate responses to patient safety incidents
4. supportive oversight focused on strengthening response system functioning and improvement.

PSIRF supports organisations to respond to incidents in a way that maximises learning and improvement rather than basing responses on arbitrary and subjective definitions of harm. Organisations can explore patient safety incidents relevant to their context and the populations they serve rather than exploring only those that meet a certain nationally defined threshold.



Phase	Duration	Purpose
PSIRF orientation	Months 1–3	To help PSIRF leads at all levels of the system familiarise themselves with the revised framework and associated requirements. This phase establishes important foundations for PSIRF preparation and subsequent implementation.
Diagnostic and discovery	Months 4–7	To understand how developed systems and processes already are to respond to patient safety incidents for the purpose of learning and improvement. In this phase strengths and weaknesses are identified, and necessary improvements in areas that will support PSIRF requirements and transition are defined.
Governance and quality monitoring	Months 6–9	Organisations at all levels of the system (provider, ICB, region) begin to define the oversight structures and ways of working once they transition to PSIRF.
Patient safety incident response planning	Months 7–10	For organisations to understand their patient safety incident profile, improvement profile and available resources. This information is used to develop a patient safety incident response plan that forms part of a patient safety incident response policy.
Curation and agreement of the policy and plan	Months 9–12	To draft and agree a patient safety incident response policy and plan based on the findings from work undertaken in the preceding preparation phases.

The Trust have made good progress with the implementation, and are currently on track for implementation within the specified time frames.

A core PSIRF implementation group meets fortnightly to review progress and ensure a robust implementation plan. Currently, Phase 2 is underway, with good engagement. The planning phases have provided a foundation on which to build, and during the next phases more wider audiences will be engaged to ensure an informed transition.

There are numerous groups at a Regional and National level who meet regularly to share progress and build supportive collaborative networks. A future NHS platform also provides a digital forum on which documents and discussion forums are accessed.

Patient Safety Partners (PSPs) are a new role recommended with the NHS Patient Safety Strategy.

PSPs are patients, carers, family members or other lay people who are recruited to work in partnership with staff to influence and improve the governance and leadership of safety within an NHS organisation. As such, they perform a very different function from that of the traditional NHS volunteer and their roles may include:

- membership of safety and quality committees whose responsibilities include the review and analysis of safety data
- involvement in patient safety improvement projects
- working with organisation boards to consider how to improve safety
- involvement in staff patient safety training
- participation in investigation oversight groups

The Trust are in the process of recruitment and hope to have two PSP on board by March 2023.

Indicator	Measure Description				
Patient Reported Outcome Measure (PROM)	The Trust's patient reported outcome measure scores for, hip replacement surgery and knee replacement surgery during the reporting period.				
Date	**Measure**	**Trust performance**	**National Average**	**Upper 95% control limit**	**Lower 95% control limit**
Hip Replacement					
April 18-March 19	EQ5D	0.43	0.46	0.57	0.33
April 18-March 19	VAS	15.18	14.05	20.17	5.27
April 18-March 19	OXFORD HIP	21.87	22.30	26.166	18.52
April 19-March 20	EQ5D	0.446	0.460	0.504	0.417
April 19-March 20	VAS	11.917	14.1	17.251	10.898
April 19-March 20	OXFORD HIP	22.966	22.4	23.971	20.927
April 20-March 21	EQ5D	0.439	0.467	0.523	0.411
April 20-March 21	VAS	15.499	14.7	18.746	10.620
April 20-March 21	OXFORD HIP	21.857	22.6	24.530	20.628
April 21-March 22	No data available	No data available	No data available	No data available	No data available
April 21-March 22	No data available	No data available	No data available	No data available	No data available

April 21-March 22	No data available	No data available	No data available	No data available	No data available
Knee Replacement					
April 18-March 19	EQ5D	0.31	0.34	0.40	0.25
April 18-March 19	VAS	5.51	7.42	12.70	0.15
April 18-March 19	OXFORD KNEE	16.83	17.19	20.09	13.52
April 19-March 20	EQ5D	0.308	0.341	0.380	0.303
April 19-March 20	VAS	6.160	7.9	10.774	5.059
April 19-March 20	OXFORD KNEE	17.563	17.3	18.753	15.926
April 20-March 21	EQ5D	0.364	0.317	0.376	0.259
April 20-March 21	VAS	7.021	7.5	11.651	3.316
April 20-March 21	OXFORD KNEE	18.309	16.7	18.735	14.627
April 21-March 22	EQ5D	No data available	No data available	No data available	No data available
April 21-March 22	VAS	No data available	No data available	No data available	No data available
April 21-March 22	OXFORD KNEE	No data available	No data available	No data available	No data available

Please note a delay in 2021-2022 data reported by NHS digital.

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

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

- Trust performance data represents the adjusted average health gains which have been calculated using statistical models which account for the fact that each provider organisation deals with patients with different case-mixes
- Data allows for fair comparisons between providers and England as a whole. Random variation in patients mean that small differences in averages, even when case-mix adjusted, may not be statistically significant

- Case mix adjusted figures are calculated only where there are at least 30 modelled records.
- The Trust remains inline with National expected average range of improvement. In 2019-2020 performance increase with our Oxford Hip and Knee PROM's scores higher than the national average.

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

- Continuing to monitor feedback from patients at their follow-up clinic appointments
- Reviewing the results on a case by case basis for those patients who feel they did not have a good outcome against the outcome recorded in the clinical records
- Continuing to use information leaflets which describe the process and value of the information collected through the use of the PROMS questionnaire
- Undertaking phone calls to patients at home 48 hours following discharge from their hip and knee replacement surgery.
- Undertake an annual review including individual surgeon PROMS scores in conjunction with NJR figures.
- Using the Model Hospital Framework, benchmark our Trust against surrounding Trust

Indicator	**Measure Description**	
Readmission Rates	The percentage of patients aged 0 to 15 readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.	
Period	**Trust per HED**	**Peer Group av HED**
Jan 2016 – Dec 2016	12.14%	10.44%
Jan 2017 – Dec 2017	12.41%	10.69%
Jan 2018 – Dec 2018	13.58%	11.38%
Jan 2019 – Dec 2019	12.61%	11.96%
Jan 2020 – Oct 2020	12.39%	11.46%
Period	**Trust per CHKS**	**Peer Group av CHKS**

Jan 2021 – Dec 2021	13.96%	12.19%
Jan 2022 – Dec 2022	14.76%	11.27%

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

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

The Trust saw an upward trend in readmission rates between January 2022 and December 2022. Some of this increase could be attributed to the department offering an 'open access' within 48 hours for worried parents who want to bring their child back for further review. There are also more children being discharged earlier with the caveat that the parent return with the child for an early review on the ward. These would be classed as 'Ward Attenders'. The increase in readmissions for new-borns experiencing weight loss and jaundice following discharge from inpatient maternity services seen in 2020 and 2021 continued to fluctuate during 2022 due to either clinical need or to establish feeding.

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

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

Indicator	**Measure Description**	
Readmission Rates	The percentage of patients aged 16 and over readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.	
Period	**Trust per HED**	**Peer Group av HED**
Jan 2016 – Dec 2016	8.23%	7.73%
Jan 2017 - Dec 2017	9.04%	8.16%
Jan 2018 - Dec 2018	8.52%	7.63%
Jan 2019 - Dec 2019	8.99%	8.50%
Jan 2020 - Oct 2020	10.54%	9.27%
Jan 2021 - Dec 2021	9.57%	8.73%
Jan 2022 – Dec 2022	8.55%	8.05%

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

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

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

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

The Trust will take the following actions to improve this result, and so the quality of its service, by: continuing to provide monthly information to clinical teams, through the Divisional Governance structure, to enable speciality led reviews where re-admission rates are high. Any clinical concerns about the readmission of an individual patient will be incident reported and reviewed, as necessary, through the Trust Quality & Safety Committee.

Indicator				
Clostridium difficile	The rate per 100,000 bed days of cases of Clostridium difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period.			
Period	**Trust Performance**	**National Average**	**95% Upper Limit**	**95% Lower Limit**
2018-2019	13.5	11.5	81.6	0
2019-2020	9.92	13.62	51.1	0
2020-2021	15.2	15.4	92.6	0
2021-2022	19.9	16.2	94.5	0

The rate per 100,000 bed days of cases of C.difficile infection reported within the Trust amongst patients aged 2 or over

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

Prior Healthcare Exposure

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

* Hospital-onset healthcare-associated (HOHA) - Date of onset is **≥ 3 day of admission** (where day of admission is day 1)

* Community-onset healthcare-associated (COHA) - Date of onset is ≤ day 2 of admission (where day of admission is day 1) and the patient was discharged to the trust in the 4 weeks prior to the current episode

* Community-onset indeterminate association - Date of onset is ≤ day 2 of admission (where day of admission is day 1) and the patient was discharged in the previous 12 weeks, but not the previous 4 weeks prior to the current episode

* Community-onset community-associated - Date of onset is ≤ day 2 of admission (where day of admission is day 1) and the patient had not been admitted to the trust in the previous 12 weeks prior to the current episode.

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

CDI objectives were set for the Trust for 2022/23 at 32 cases. The Trust reported 32 cases of Cdiff in the HOHA category, 15 cases have been identified as avoidable, 17 cases were classified as unavoidable. 6 cases were reported in the COHA category awaiting classification PIR.

The Trust continues to have a robust Post Infection Review (PIR) process in place for all cases of Clostridium difficile (CDI), this facilitates the opportunity to review the case and establish if any "lapse of care" has occurred either contributing or not contributing to the development of CDI. Completion of these reviews involve the patient's clinician, matron, ward manager, consultant microbiologist, antimicrobial pharmacist, and senior IPC practitioners.

Post Infection Reviews identify themes and trends and where necessary action plans developed to readdress omissions in practice.

This is a learning opportunity aimed at implementing/strengthening procedures to reduce the risk of CDI developing in other patients.

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

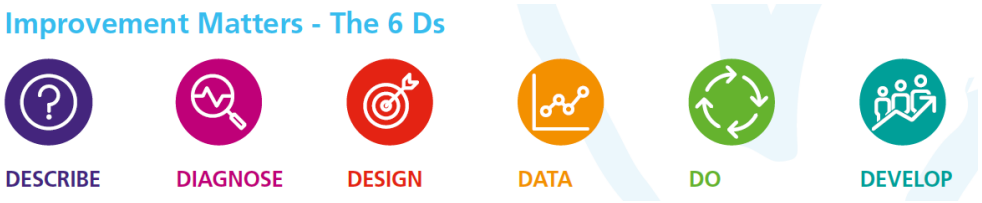
- Monitoring national and regional data sets to ensure data sets are consistently reporting accurate data.
- Aligned improvement work with regional colleagues to learn and share experiences.
- Multi-disciplinary bedside reviews of all CDI positive patients throughout their stay.
- Introduction of a Trust wide improvement collaborative focusing on improving antimicrobial stewardship
- CDI education focus for clinical teams including face to face , ward based sessions focusing an antimicrobial stewardship, timely isolation, and sampling
- Environmental visit programme with enhanced focus on cleaning, nursing and estates.

Part 3: Review of quality performance

Delivery of the Quality & Safety Improvement Plan through Continuous Improvement - Quality Matters

A visual operating model for continuous improvement at MCHFT has been developed, incorporating the Trust's Mission, the Vision for Quality and Strategic Improvement Aims, all underpinned by the Trust values and Improvement Matters as the single improvement approach at MCHFT.

A methodology using the 6 D's is utilised to monitor progress against the 4 aims.



In 2022-23 the Quality & Safety Improvement Plan aims were agreed based on Trust engagement and some of the top reported priorities. The following table highlights the 4 agreed aims for 2022-23.

Quality & Safety Improvement Plan Aims 2022-23

Aim 1	**Improving Patient Nutrition**

- The aim of the Collaborative was to reduce the incidents of patients receiving the incorrect consistency of diet and fluids

Aim 2	**Enhance Staff Wellbeing**

- The aim of the Collaborative was to enhance the wellbeing of staff across MCHT & CCICP

Aim 3	**Improve patient communication to reduce the risk of increased complaints from patients and relatives**

- The aim of the Communication with Relatives work was to reduce the number of issues relating to communication with relatives within complaints on Wards 4 and 12 by 50% by May 2023.

Aim 4	Harm Free Care - Antimicrobial Prescribing

- The aim of the Collaborative was to increase the appropriate use of antibiotics on 4 wards (wards 3, 6, 11, 12) to more than 90% by April 2023.

The purpose of the 6D A3 model is to ensure the Trust has a robust system in place to monitor performance and achievement against the 4 aims identified;

- Improving patient nutrition
- Enhance staff wellbeing
- Improve patient communication to reduce the risk of increased complaints from patients and relatives
- Antimicrobial prescribing.

The aim of the A3 model is to ensure a 'live' document of progress – reviewing and monitoring data to identify and track areas of improvement, in order to drive forward the initiative and monitor progress in relation to each aims problem statement.

All 4 aims are being progressed using the A3 model, keeping the document in 'real time'. Progress is monitored through the Quality & Safety Improvement Plan Group, now known as the Quality Safety and Harm Free Care Group (QSHFC) with regularly updated A3's.

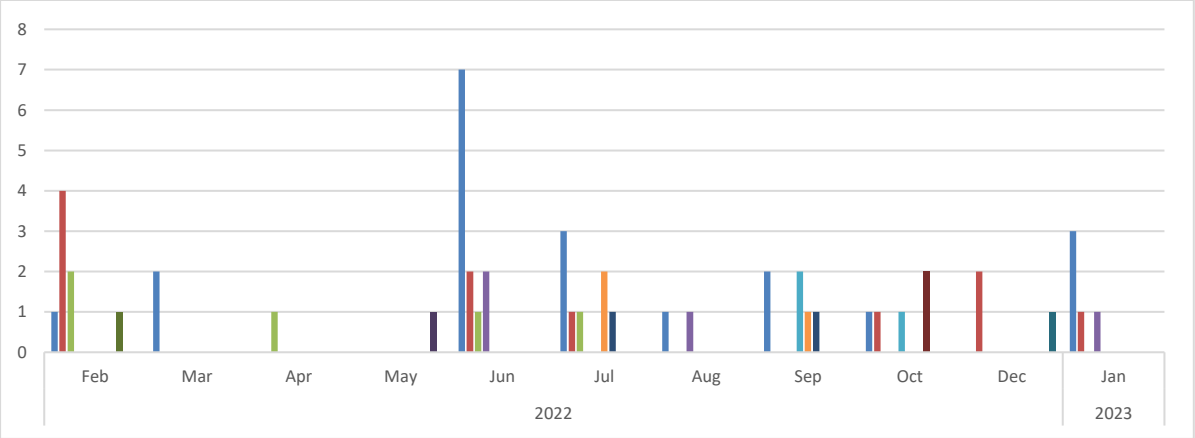
This report highlights the 'real time' progress for Quarter 1 & 2 against each of the 4 aims, utilising the A3 model. Each aim is at different progress stages therefore, the attached A3's reflect different stages of the 6D methodology.

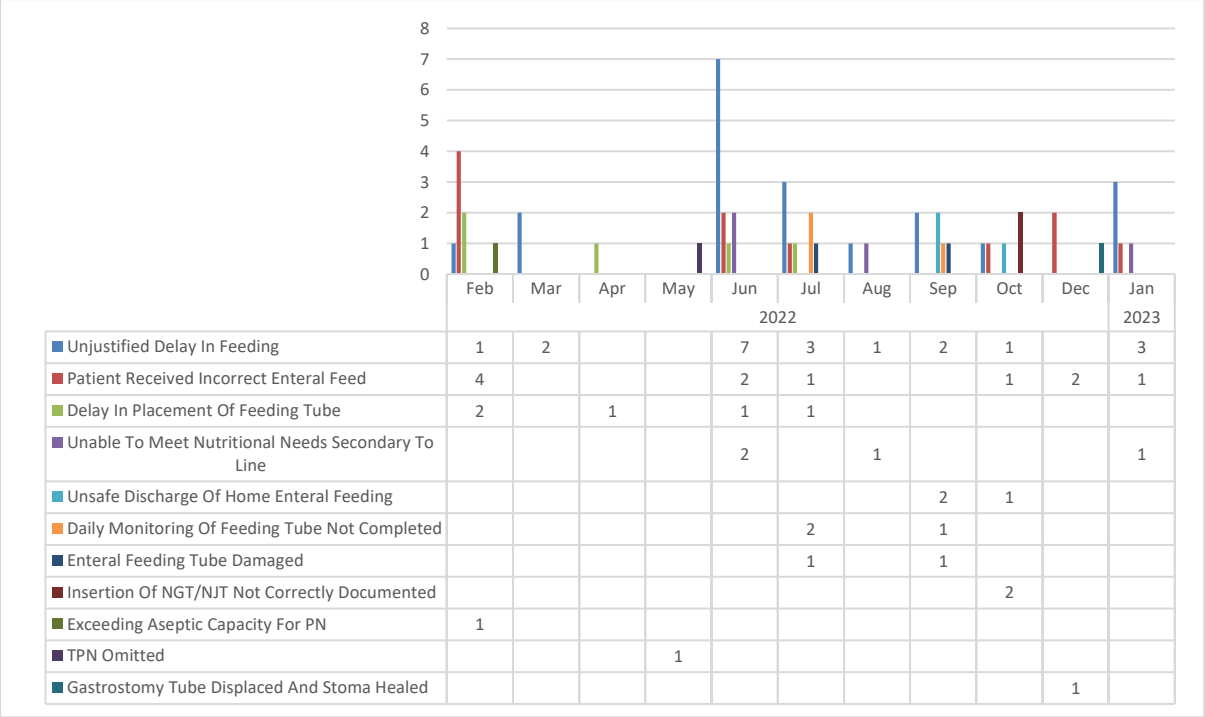
Improving Patient Nutrition

During 2022 and 2023 the Trusts Nutritional Advisory Group has continued to focus on developing Quality Improvement programmes to enhance the nutrition of patients who receive care within the hospital and within the community setting.

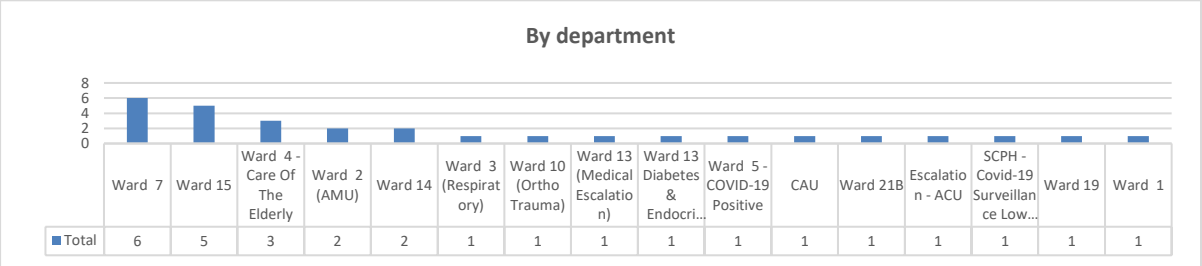
The Nutritional Advisory Group monitors risks, policies and incidents monthly to ensure that any themes are identified, and actions are in place to ensure learning is embedded. The group have seen the development and approval of a number of new policies, such policies will ensure that the Trust has robust processes in place to support the nutritional needs of patients in our care.

The below tables highlight the number of incidents reported relating to patient nutrition;





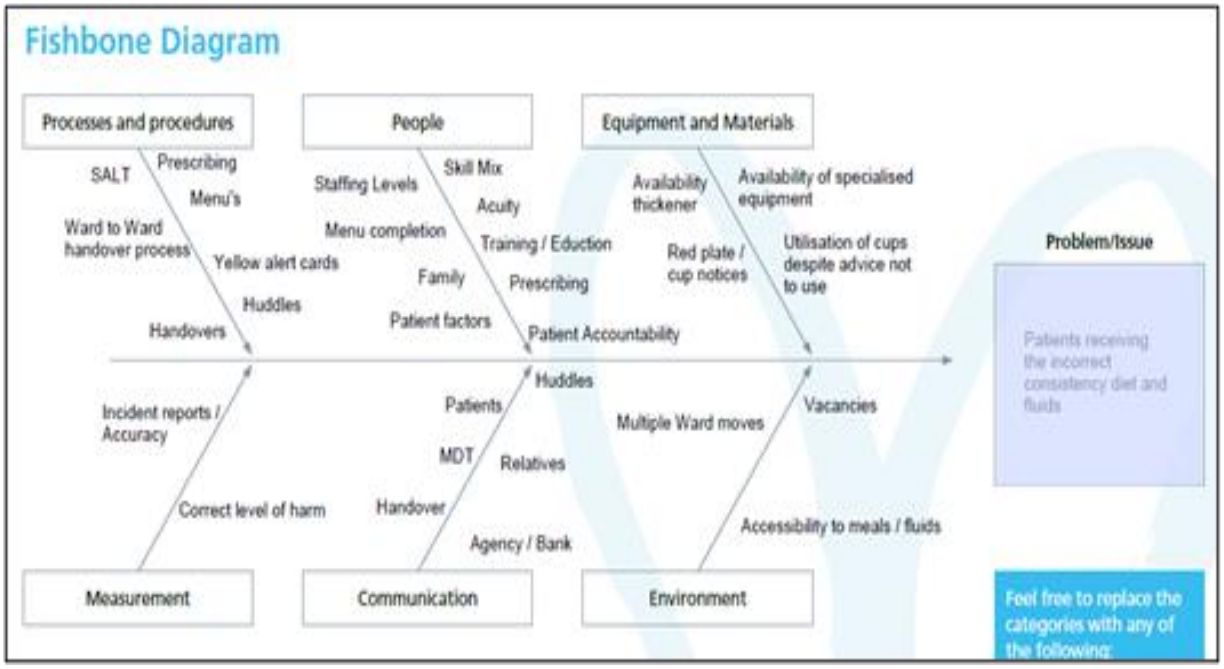
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Dec	Jan 2023
Unjustified Delay In Feeding	1	2			7	3	1	2	1		3
Patient Received Incorrect Enteral Feed	4				2	1			1	2	1
Delay In Placement Of Feeding Tube	2		1		1	1					
Unable To Meet Nutritional Needs Secondary To Line					2		1				1
Unsafe Discharge Of Home Enteral Feeding								2	1		
Daily Monitoring Of Feeding Tube Not Completed						2		1			
Enteral Feeding Tube Damaged						1		1			
Insertion Of NGT/NJT Not Correctly Documented									2		
Exceeding Aseptic Capacity For PN	1										
TPN Omitted				1							
Gastrostomy Tube Displaced And Stoma Healed										1	



	Ward 7	Ward 15	Ward 4 - Care Of The Elderly	Ward 2 (AMU)	Ward 14	Ward 3 (Respiratory)	Ward 10 (Ortho Trauma)	Ward 13 (Medical Escalation)	Ward 13 Diabetes & Endocri...	Ward 5 - COVID-19 Positive	CAU	Ward 21B	Escalation - ACU	SCPH - Covid-19 Surveillance Low...	Ward 19	Ward 1
Total	6	5	3	2	2	1	1	1	1	1	1	1	1	1	1	1

The Nutritional Advisory Group focused on quality improvements utilising the Trusts newly established Improvement Matters A3 problem solving and communication tool. This project has been identified through a review of our nutritional incidents and the monitoring of the Trust QSUS data. Our improvement project is based on;

- Reducing the incidents of patients receiving the incorrect consistency of diet and fluids



Some of the nutritional improvements undertaken through 2022-2023 are -

- The Community MUST (Malnutrition Universal Screening Tool) was updated to enable patients risk scoring to be self-generated from patients individualised nutritional information. This new tool also generates a nutritional care plan within the patient's electronic record which can be developed jointly with patients and families/carers. This new tool has enabled an enhanced focus on nutritional care within the community setting.
- The group have developed and implemented a new process for nutritionally compromised patients in the community who require a nasogastric (NG) tube to be in place to support feeding. These patients now have a patient passport and we have developed a Standing Operating Procedure (SOP) to ensure patients receive timely support in the event of complications with NG tubes.
- In addition, the group have seen the commencement of a Nutritional Multi-Disciplinary Team meeting. The development of an electronic speech and language referral process together with the implementation of nutritional patient passports for our high-risk patients.

Enhance Staff Wellbeing

The pressure on our colleagues throughout the past 12 months continued unabated since the last annual report. Colleagues not only faced the worries and concerns of the covid-19 pandemic and the direct impact this had on their working lives, but also had to contend with the cost-of-living crisis. These two events alone marked a significant impact on people's wellbeing and the Trust recognised the importance of supporting colleagues to remain resilient and well, both whilst at work and in their home lives.

Coming out of the pandemic and into the recovery phase in mid-2022, staff reported high levels of fatigue and burnout, combined with high levels of stress, anxiety, and depression. Colleagues also reported a desire to 're-connect' with other people in the Trust, having spent the best part of two years working virtually or remotely. Consequently, the Health & wellbeing Project Board planned and delivered the inaugural It's a Knockout Family Fun Day in May 2022. The event saw over one thousand colleagues and family members come together to enjoy a fun filled day, with teams competing in a series of obstacle courses and giant inflatables. Eighty five percent of attendees who completed an evaluation form following the event stated that the event had a positive effect on their wellbeing and feeling connected.

To help colleagues through the cost-of-living crisis, the Health & Wellbeing Project Board introduced several measures to support with financial wellbeing. This included a comprehensive leaflet that provided local, regional, and national signposting and resources, all in one easy to access document. In addition, the Trust implemented a scheme that enabled colleagues to have more control over their finances through the introduction of a wellbeing application where individuals can track earnings, save directly from their pay as well as having early access to a capped percentage of their earnings.

The Health & Wellbeing Project Board completed a self-assessment of the wellbeing offer using an organisational diagnostic framework tool provided by NHS (National Health Service) Employers. This identified areas where the Trust was performing well, such as relationships (where people feel listened to, teams work well together and treat each other with respect and civility) and fulfilment at work (where colleagues feel their roles are fulfilling and they relate to the purpose of the organisation). The Trust also performed well in several other areas including, personal health and wellbeing, environment, and professional wellbeing support. A key area for development and one that the Project Board will focus on in the year ahead relates to improved data insights.

The Trust has a confirmed Executive Lead for Wellbeing in post and last year confirmed a Non-Executive Director as the Wellbeing Guardian. The Wellbeing Guardian will work closely with the Health and Wellbeing Lead to focus on addressing gaps identified in the organisational diagnostic framework, as well as working with the Board to help influence and shape a wellbeing culture.

Our priority over the past year was to continue supporting our colleagues through the difficult cost of living crisis and recovery phase of the pandemic, however, it is also important to highlight some of the other interventions that took place throughout the year such as:

- Access to twenty-four-hour counselling and bereavement support for all staff – including legal and financial advice

- Menopause Cafes - providing peer support for women going through the menopause and promoting education to facilitate understanding and how to better support
- Mental Health Drop in Sessions
- Free complimentary massage therapy sessions
- Wellbeing Squads
- On-site Counselling
- Regular snacks and soft drinks for frontline staff
- Staff Wellbeing events (Leighton, VIN (Victoria Infirmary Northwich), Eagle Bridge, Infinity House.
- Pastoral Nurses support
- Stress awareness sessions (Leighton, Eagle Bridge, Victoria Infirmary, Infinity House.)
- Toolerstone vouchers (as part of reward and recognition programme)
- Regular Wellbeing events aligned with the national wellbeing dates (e.g., Mental Health Awareness)
- Free staff vaccinations – COVID-19 and Flu
- Arts Programme – 'Moments of Serenity'
- Mental Health First Aid training through St Johns Ambulance Service
- Smoking cessation support through CURE team
- Food donation collection points
- Dedicated Financial Advisor through Cheshire & Mersey Resilience Hub

In addition, the Trust's Flu & Covid Booster Campaign ran between September 2022 and February 2023. The Trust achieved a final position of 57.6% uptake amongst frontline healthcare workers for the flu vaccination placing Mid Cheshire Hospitals NHS Foundation Trust as the eighth best performing Trust in the Northwest. The Trust also had an uptake of 58.2% amongst frontline healthcare workers for the COVID booster vaccination programme which placed the Trust as the sixth best performing Trust in the Northwest.

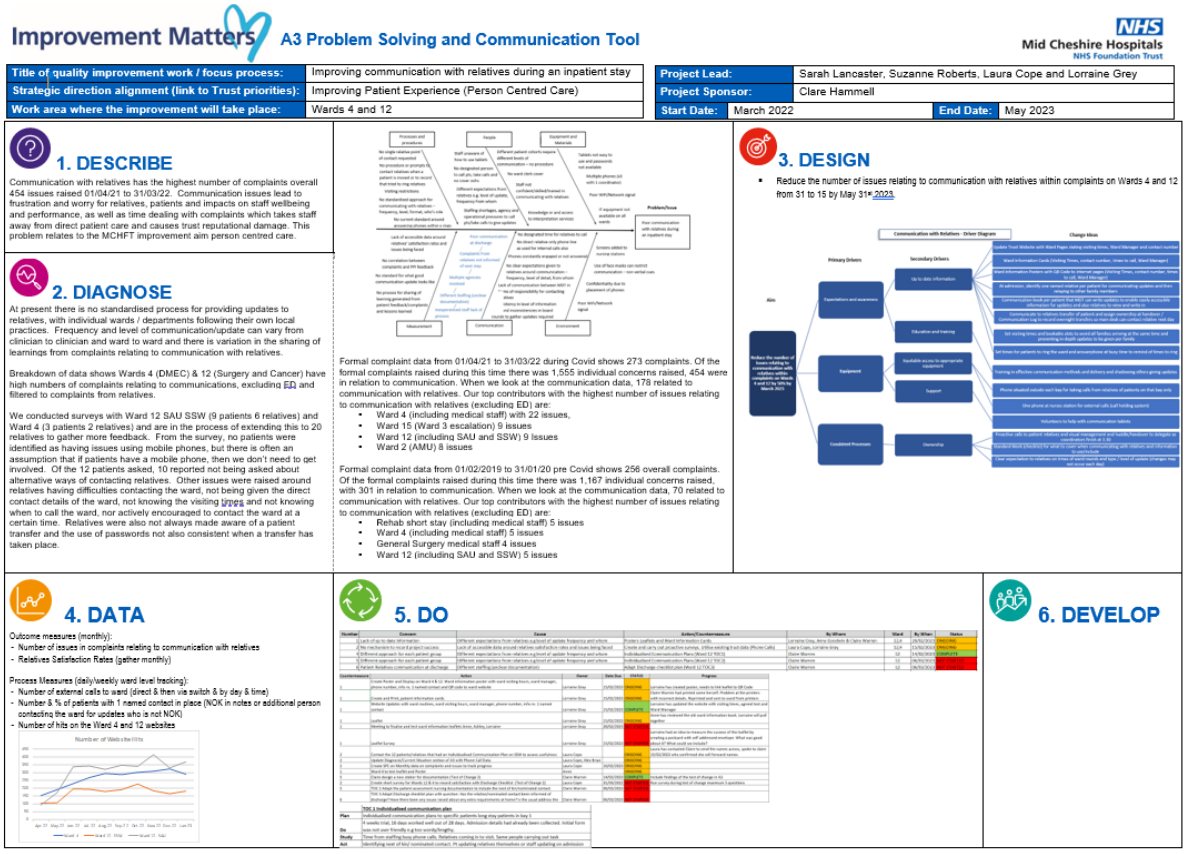
It remains important that both financial and psychological wellbeing of people remains a priority for the Trust. This will, therefore, continue to be a clear focus for the Health & Wellbeing Project Board in the coming twelve months.

Improve patient communication to reduce the risk of increased complaints from patients and relatives

Communication is a top theme of complaints received by the Trust and these issues can lead to frustration and worry for relatives and patients and impacts on staff wellbeing and performance, as well as time dealing with complaints which takes staff away from direct patient care and causes Trust reputational damage.

An improvement A3 linking to the improvement aim person centred care was produced. Progress is being made on the project focusing on sharing learning from complaints across

the Trust, with an overall aim to reduce the number of complaints received relating to communication, and more specifically communication with relatives, as this has been a theme of feedback and complaints exacerbated due to the restrictions on visiting during the pandemic.

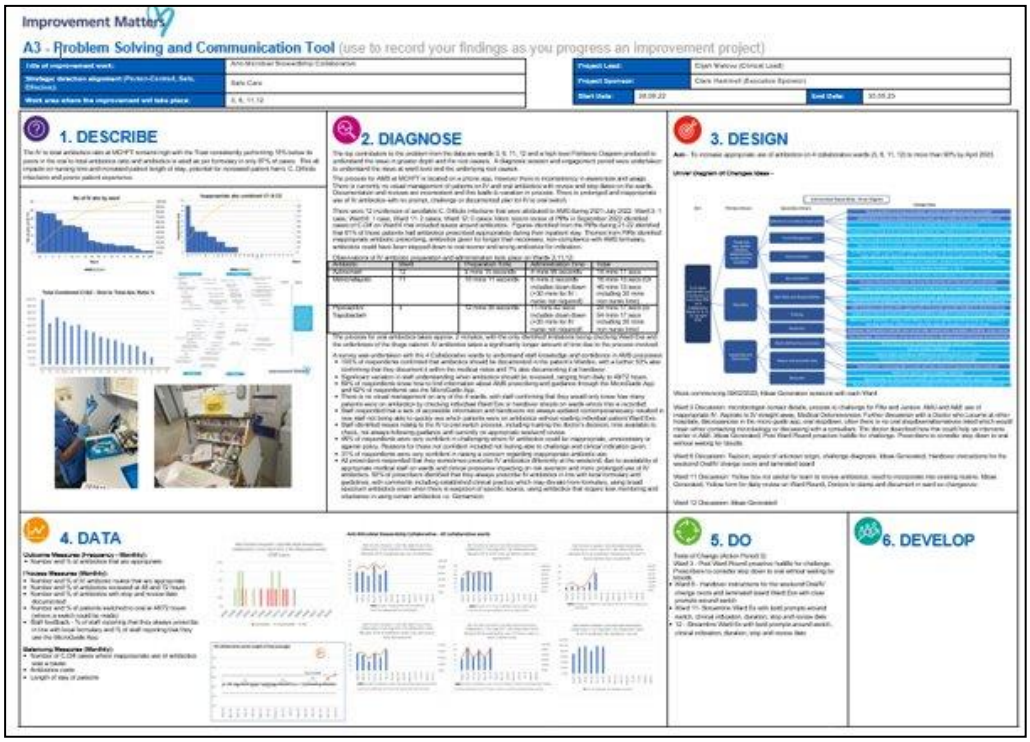


This work is initially set to look at improvements on Ward 4 and Ward 12 with a view to sharing successful actions taken across the wards and divisions. A Fishbone Diagram was completed following engagement with ward staff to understand the issue at ward level. A number of change ideas have been suggested and are being trialled by means of Plan Do Study Act cycles (PDSA) including introduction of ward business cards, enhancements to ward details on the website, setting up of communication plans with relatives, and production of a ward information leaflet to be given to relatives so that they can have an understanding of the ward routine, the layout and the staff on the ward, in order to help to alleviate any worries and support relatives to feel more reassured.

Harm Free Care - Antimicrobial Prescribing

Antimicrobial Stewardship was identified as an area for improvement last year due to the IV to total antibiotics ratio at MCHFT remaining high and the Trust consistently performing 15% below its peers in the oral to total antibiotics ratio, with antibiotics also used as per formulary in less than 90% of cases. This all impacts on nursing time and increased patient length of stay, potential for increased patient harm, C. Difficile infections and poorer patient experience.

An Improvement A3 was commenced and a Pareto Chart used to identify the top contributing wards, followed by a high-level Fishbone Diagram to understand the issue in greater depth. A ward-based diagnosis session and engagement period was then held to understand the issue at ward level and the underlying root causes around inappropriate antimicrobial stewardship.

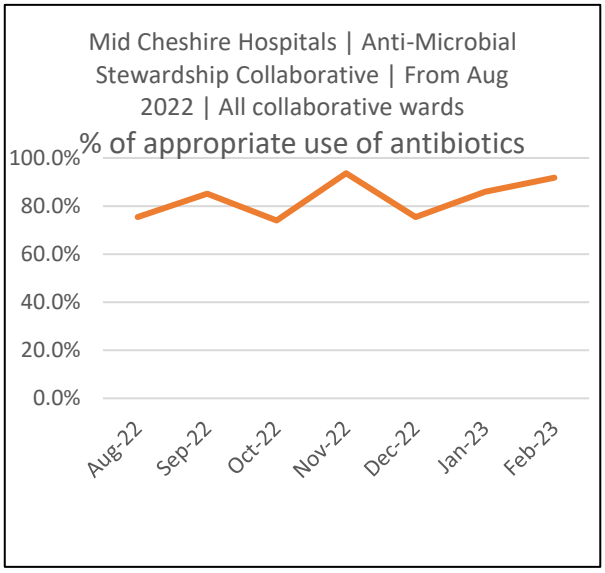


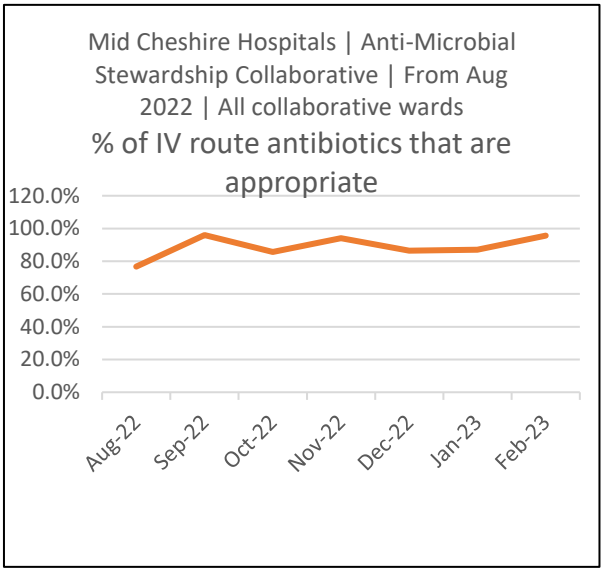
The Antimicrobial Stewardship Improvement Collaborative was launched in August 2022 as part of the Safe Care Improvement Aim. The aim of the Collaborative was to increase the appropriate use of antibiotics on 4 wards (wards 3, 6, 11, 12) to more than 90% by April 2023.

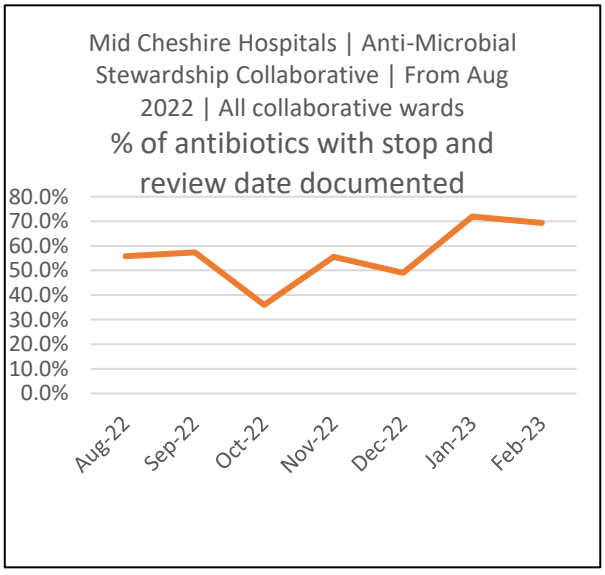
The 4 Ward Teams have developed their own A3s and generated a number of change ideas which they have been testing on their wards using Plan, Do, Study Act (PDSA) cycles, whilst using Process Confirmation Boards and Huddles to track progress. Some of the change ideas tested to date include:

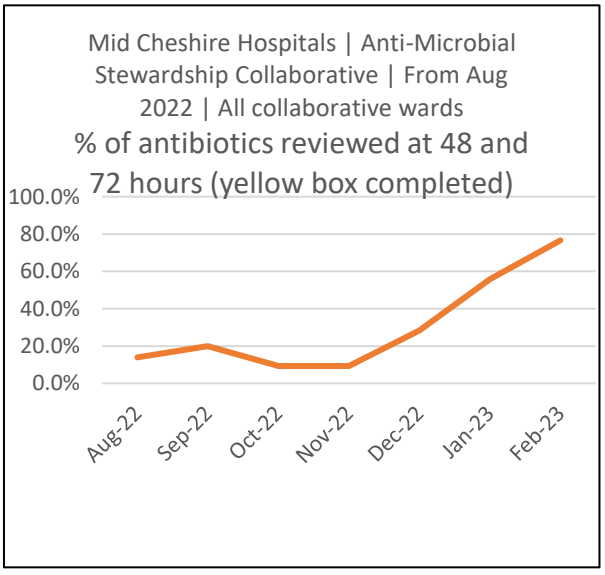
- Incorporating antibiotics discussions into daily huddles
- Patient antibiotics board to provide a visual display of patients on antibiotics
- Daily review of antibiotics and recording in Yellow Box
- New Yellow Box developed for Long Stay Wardexs
- Stamp to prompt and record the daily review of antibiotics
- Sticker in notes to prompt the daily review of antibiotics and completion of the Yellow Box in the Ward Ex
- Action Period 3 Change Ideas – Micro Guide printed and attached to trolleys, awareness raising of Micro Guide app, weekend antibiotics review board to improve weekend reviews of antibiotics.

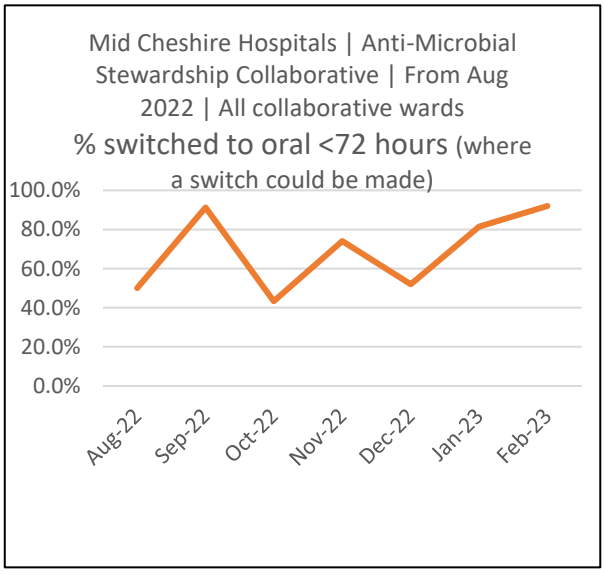
The Collaborative continues to run until May 2023, with excellent progress already being made and data showing improvements in the percentage use of appropriate antibiotics to 91.8%, appropriate IV routes to 95.7% and appropriate switch from IV to oral within 72 hours to 92%

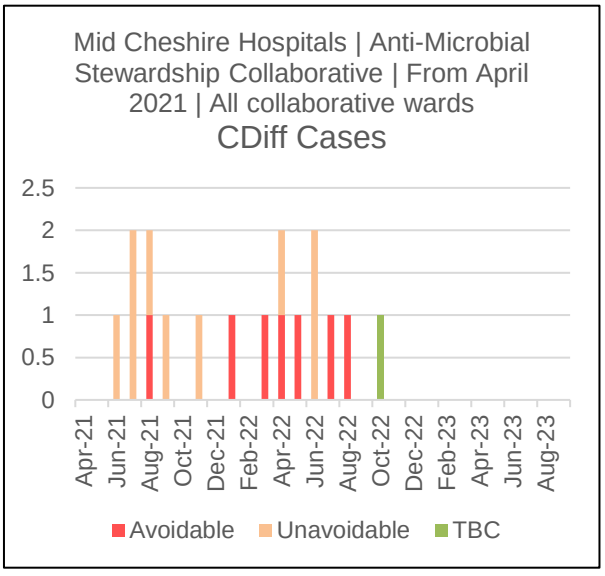

Mid Cheshire Hospitals | Anti-Microbial Stewardship Collaborative | From Aug 2022 | All collaborative wards
% of appropriate use of antibiotics
100.0%
80.0%
60.0%
40.0%
20.0%
0.0%
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23


Mid Cheshire Hospitals | Anti-Microbial Stewardship Collaborative | From Aug 2022 | All collaborative wards
% of IV route antibiotics that are appropriate
120.0%
100.0%
80.0%
60.0%
40.0%
20.0%
0.0%
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23


Mid Cheshire Hospitals | Anti-Microbial Stewardship Collaborative | From Aug 2022 | All collaborative wards
% of antibiotics with stop and review date documented
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23


Mid Cheshire Hospitals | Anti-Microbial Stewardship Collaborative | From Aug 2022 | All collaborative wards
% of antibiotics reviewed at 48 and 72 hours (yellow box completed)
100.0%
80.0%
60.0%
40.0%
20.0%
0.0%
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23


Mid Cheshire Hospitals | Anti-Microbial Stewardship Collaborative | From Aug 2022 | All collaborative wards
% switched to oral <72 hours (where a switch could be made)
100.0%
80.0%
60.0%
40.0%
20.0%
0.0%
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23


Mid Cheshire Hospitals | Anti-Microbial Stewardship Collaborative | From April 2021 | All collaborative wards
CDiff Cases
2.5
2
1.5
1
0.5
0
Apr-21
Jun-21
Aug-21
Oct-21
Dec-21
Feb-22
Apr-22
Jun-22
Aug-22
Oct-22
Dec-22
Feb-23
Apr-23
Jun-23
Aug-23
Avoidable
Unavoidable
TBC

Successful interventions will be packaged into an AMS Change Package that will be launched on May 23rd, 2023, at our AMS Launch Summit to celebrate the improvements made and to spread the learning across the Trust.

A further development in the AMS agenda is the joining of the East Cheshire Trust and Mid-Cheshire Trust Antimicrobial Stewardship Groups, this development will enable shared learning, a shared antimicrobial formulary and promote efficiencies to further support the AMS agenda at both Trusts.

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

NHS Cheshire & Merseyside Integrated Care Board (ICB) Response to Quality Account Report (April 2022 to March 2023) for Mid Cheshire Hospitals NHS Foundation Trust.

NHS Cheshire & Merseyside ICB expect high standards of care from the hospital and community services commissioned. Oversight and scrutiny of the contract with Mid Cheshire Hospitals Foundation Trust takes place by Cheshire East ICB at Place, through regular contract, quality and performance meetings as well as regular quality leads meetings. This enables verification of the accuracy of this quality account.

As the NHS continues to recover from the pandemic the Trust has set out their new quality and safety improvement plan 2022-23 and other strategies discussed in this report. The pressures on urgent care and patient flow have been managed by the initiatives undertaken by the Trust including quality improvement projects such as the Discharge Lounge and 7-day service across acute and community. Delivering services in a more inclusive way demonstrates that the Trust has listened to feedback from patients and visitors, specifically those with complex health needs.

The NHS is nothing without its workforce and the introduction of the award-winning pastoral support service has been effective in reducing sickness and improving retention as well as setting up the additional staff wellbeing initiatives to tackle stressors at home and at work and in particular the increased variety in mental health support offered is noted. This combined with the successful international recruitment of nurses and the planned international recruitment for junior doctors and the development programme for registrars will boost morale for the workforce.

It is clear that the Trust prioritises ensuring patients experience safe care during their hospital stay. We note the robust and varied support offered via the Falls Care Bundle and subsequent initiatives to reduce inpatient falls, which has been a common area for patient safety incidents often resulting in a prolonged length of stay in patients otherwise fit for discharge.

Similarly acknowledging the work undertaken by Central Cheshire Integrated Care Partnership (CCICP) to reduce pressure ulcers in the community has contributed to a 15% reduction to 2021-22 rates. We also praise the hospital for ensuring all inpatients have an appropriate mattress for their care through the collaborative work of the quality and estates teams; eliminating lapses in care for pressure ulcers relating to mattress provision.

The Trust's continuous improvement model (*Improvement Matters*) and ward accreditation programme are examples of positive innovation to raise standards of care across the Trust Divisions and we look forward to seeing the outcomes of these initiatives. As an example of this the new Discharge Lounge has released over 8,000 hours of core beds and 354 bed days in its first 6 months. As well as improving the discharge experience for patients and the pharmacy teams.

We were inspired by the re-conditioning games and the inventive ways to reduce boredom and inactivity for inpatients. We welcome quality improvement work underway for End-of-Life Care and communication in response to the National Audit of Care at the end of life.

Clinical audit is a key component in quality of care, and we were particularly interested to see the range and number of national audits completed in year. It is positive that the Trust is

meeting or is above the national average compliance rates for these audits, which is another great example of a culture for promoting good quality care standards across all Divisions.

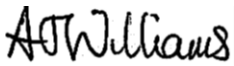
It is positive that the Trust is taking part in research projects which will effect change in service delivery and medical advancements for the nation as well as the local patients.

The robust patient safety culture is woven throughout the report, and we have seen first-hand the rigour that is put into the investigation progress for serious incidents and how learning has been embedded into practice. This dovetails well with the risk aware culture which has been present throughout the past few years. This is further evidenced by the progress against the introduction of the new patient safety incident response framework, and the trust-wide process being used to upskill and raise awareness across Divisions.

We note that the Trust has not met all the national quality targets for 2022-23 and can see the decline from 2018-19 achievements however we look forward to working with you in the coming year to support improvement and to facilitate meeting the quality targets.

In closing we acknowledge that the Trust has not received a CQC inspection since 2019 but the Trust's ongoing commitment to embedding the quality improvement work noted in this report will support with future inspections. We wish the Trust every success with the ongoing rollout of the Trust Strategy 2021-26 and look forward to continuing to work with you and see the development of the provider collaborative and system working.

Yours Sincerely



Amanda Williams

Associate Director of Quality and Safety Improvement (Cheshire East)

NHS Cheshire and Merseyside ICB

Response to Quality Account 2022/23– Mid Cheshire Hospitals NHS Foundation Trust.

Healthwatch Cheshire East has worked in partnership with the Trust over the period covered by this report forming close working relationships with staff at the hospital through a number of opportunities:

- A&E Watch undertaken in September 2022
- Production of 6 Ambulatory Wound Care Reports September to October 2022
- Representation at Patient Quality and Experience meetings
- Engagement with the hospital on a regular basis at different levels.

Healthwatch Cheshire East feels this quality account, broadly reflects the work undertaken at the Trust over the period.

Healthwatch were particularly impressed by the success of the Discharge Lounge. This appears to be a great success - most notably ensuring the vulnerable and elderly return home in day light hours where there is a greater opportunity for ongoing support to be accessed early.

End of Life Care. There appears a lot to be celebrated however the surveys both show that staff feel they need more support from specialist palliative care team. The figure shows the confidence is 19% lower than the national average. This we feel is cause for concern.

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

Cheshire East Council

Dear Ms Egerton

As Chair of the Cheshire East Council Scrutiny Committee, I am writing to submit its statement to be included in the Mid Cheshire Trust's Quality Account 2022/23. The draft Quality Account 22-23 has been shared with and reviewed by members of the Scrutiny Committee. Overall, the Committee is pleased with the content of the Quality Account and believes it provides a good picture of the performance of the Trust. I would also add the following comments:

The four improvement aims set out within the Trust Quality & Safety Improvement Plan 2022-23 are noted, and I am pleased to hear that good progress is being made in the development of the Quality and Safety Improvement Strategy for 2023-2024. The Committee looks forward to discussing this further at its meeting in June.

I am pleased to note that the Urgent Crisis Response (seven-day service) has been introduced into communities to enable patients to have access to care Therapists and Advanced Clinical Practitioners seven days a week. The Committee will be interested to understand what impact this initiative has had on staffing deployment and wellbeing, particularly as staffing shortages across the NHS continue to pose significant risk. A structure chart, highlighting the number of new positions/grades would be most helpful for Committee Members.

I am extremely pleased to see the excellent feedback on Maternity Services. At its meeting in December 2022, the Committee received an update on intrapartum maternity services at Macclesfield District General Hospital and the steps that are being taken in order to reintroduce these services at Macclesfield. An update of how the redeployment of staff from Macclesfield Maternity Unit to Leighton Maternity Unit has contributed to the care received by patients at Leighton, and what effect there will be to the service at Leighton when those redeployed staff return to Macclesfield, would be welcomed.

Communication is a key area referred to throughout the report and whilst I am pleased to see this has improved, there is further work needed. Quality & Safety Improvement Plan aim 3 seeks to reduce the number of issues relating to communication with relatives within complaints on Wards 4 and 12 by 50% by May 2023. It would be helpful to understand if this target has been achieved, and to also understand what barriers the Trust faces to achieving successful communication.

On behalf of the Committee, I would like to congratulate the Trust on the successful implementation of the Pastoral Support Service. The number of achievements received in recognition of this new service is excellent and something to be proud of. It is positive to see how this service is providing invaluable support to so many staff.

It is also encouraging to learn that the Freedom to Speak Up initiative is continuing and that this is well supported and promoted throughout the Trust.

The steps being taken by the Trust to ensure that levels of nursing staff match the acuity and dependency needs of patients within clinical ward areas and that safe staffing levels are managed daily are noted. It would be helpful for the Committee to understand how this information, which is gathered daily, helps with long-term planning and if there are patterns of local need which do not align to national minimum staffing levels. I note that there has been an increase in patient falls and query if this increase is linked to staffing levels.

The assessment process for pressure ulcers and the success by the Trust in achieving a 15% reduction in the number of category 3 and 4 pressure ulcers is noted. I am pleased to note the actions that have been undertaken to promote a preventative pressure damage approach to care.

I am pleased to note the opening of the Discharge Lounge in August 2022 and how this has contributed significantly to positive and quality discharge experience for patients as well as timely and safe transfers out of the emergency departments and the release of core beds.

I am pleased to learn of the Trusts participation in the National Reconditioning Games and how this campaign helps to prevent deconditioning. This provides an essential boost to the functional and emotional wellbeing of patients whose access to physical exercise is limited and their time spent in hospital is often isolating.

It is agreed that it is a core responsibility of hospitals to deliver high quality care for patients in their final days and ensure appropriate support to carers. The Committee will be interested to learn of the key findings of the National Audit of Care at the End of Life 2022-23 and the changes that need to be made to further improve this service and the experience of individuals (both the patient and carers).

The Ward Accreditation Programme ‘Going for Gold’ and the positive outcomes this has on patient experience and care is noted. Committee Members will be interested to understand if this accreditation programme is supported by staff on the Wards. It is noted that a number of Quality Visits have been undertaken to identify areas of excellence and also areas where quality improvements may be needed.

- Therapy Booking Service – on behalf of the Committee, I would like to congratulate the Service on winning the CCICP unsung hero Trust Award and the significant contribution they have made to improving patient experience.

- Salt Service – this team has an invaluable role to play in one of the primary aims of the hospital (improved patient nutrition). It is essential that the appropriate investment in staff and training is made in this area. It is noted that the Service was last reviewed in 2021 and a number of recommendations were made. It would be helpful for Committee Members to understand which recommendations have been acted upon to date.
- IV at Home Service – I am pleased to learn that following a visit in 2022, staff have reported that they feel well supported and that the service is rated as outstanding in Caring and Well led and good in all other domains.
- MSK Service – I note that following a visit in 2022, the Service received a bronze rating and that a number of recommendations were proposed for the team to work through. The Committee trusts that these issues are being addressed.

It is noted that the Trust has not been inspected by the CQC during 2022-23 and that the previous 2019 ratings remain in place. I am pleased to see that in response to the CQC 2019 visit, an improvement plan was developed, and all actions contained within this have now been responded to. It is clear that the Trust is continuing to ensure improvement and there are multiple initiatives in place to secure safe practice which is extremely positive.

I hope the comments above are well received by the Trust and that these matters can be further discussed at the Scrutiny Committee scheduled for 29 June 2023, 10am, Westfields - Sandbach. I understand that you will attend Committee to present the Quality Account 2022-23 report.

If you have any comments of questions about the Committee's submission, please contact Nikki Bishop, Democratic Services Officer (Nikki.bishop@cheshireeast.gov.uk).

Yours sincerely

Liz Wardlaw

Councillor Liz
Wardlaw Chair of
Scrutiny Committee
Cheshire East Council

Annex 2 - Statement of directors' responsibilities for the quality report

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

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

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

- the content of the Quality Report meets the requirements set out in the NHS foundation Trust annual reporting manual 2021/22 and supporting guidance detailed requirements for quality reports 2022/23

- the content of the Quality Report is not inconsistent with internal and external sources of information including:

    - board minutes and papers reported to the board over the period 1 April 2022 to 31 March 2023

    - papers relating to the quality reported to the board over the period 1 April 2022 to 31 March 2023

    - feedback from commissioners dated 10 May 2023

    - feedback from local Healthwatch organisations dated 12 May 2023

    - feedback from Overview and Scrutiny Committee dated 16 May 2023

    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, May 2023

    - the (latest) national patient survey October 2022

    - CQC inspection report dated 14 April 2020

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

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

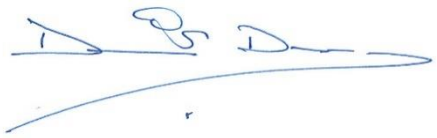
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice

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

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

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

By order of the Board



Dennis Dunn MBE JP DL
High Sheriff of Cheshire
Chairman

Date 2nd June 2023

Ian Moston
Chief Executive Officer

Date 2nd June 2023

Appendices

Appendix 1 - Glossary and abbreviations

Terms	Abbreviation	Description
Advancing Quality	AQ	A programme which rewards hospitals which improve care in a number of key areas – heart attacks, pneumonia, hip and knee replacements, heart failure and heart bypass surgery – when compared to research which identifies what best care constitutes.
Advancing Quality Alliance	AQuA	A north west NHS health and care quality improvement organisation.
Antimicrobial resistance & stewardship		A coordinated program that promotes the appropriate use of antimicrobials, improves patient outcomes, reduces microbial resistance and decreases the spread of infections caused by multidrug-resistant organisms.
Board (of Trust)		The role of Trust's board is to take corporate responsibility for the organisation's strategies and actions. The chair and non-executive directors are lay people drawn from the local community and are accountable to the Secretary of State. The chief executive is responsible for ensuring that the board is empowered to govern the organisation and to deliver its objectives.
Care Quality Commission	CQC	The independent regulator of health and social care in England. Its aim is to make sure better care is provided for everyone, whether in hospital, in care homes, in people's own homes, or elsewhere.
Central Cheshire Integrated Care Partnership	CCICP	A collaboration between Mid Cheshire Hospital Foundation NHS Trust and the South Cheshire and Vale Royal GP Alliance.
Clinical Commissioning Group	CCG	This is the GP led commissioning body who buy services from providers of care such as the hospital.

Terms	Abbreviation	Description
Clostridium Difficile	C-diff	A naturally occurring bacterium that does not cause any problems in healthy people. However, some antibiotics that are used to treat other health conditions can interfere with the balance of 'good' bacteria in the gut. When this happens, C-diff bacteria can multiply and cause symptoms such as diarrhoea and fever.
Commissioner		A person or body who buy services.
Commissioning for Quality and Innovations	CQUIN	CQUIN is a payment framework developed to ensure that a proportion of a providers' income is determined by their work towards quality and innovation.
Duty of Candour		A legal duty to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. It aims to help patients receive accurate truthful information from health providers.
Endoscopy		A nonsurgical procedure used to examine a person's digestive tract using an endoscope – a flexible tube with a light and camera attached to it.
Health Service Ombudsman		The role of the Health Service Ombudsman is to provide a service to the public by undertaking independent investigations into complaints where the NHS in England have not acted properly or fairly or have provided a poor service.

Terms	Abbreviation	Description
Hospital Evaluation Data	HED	This is an on-line solution delivering information which enables healthcare organisations to drive clinical performance in order to improve patient care and deliver financial savings
National Joint Registry		Set up by the Department of Health and Welsh Government in 2002 to collect information on all hip, knee, ankle, elbow and shoulder replacement operations and to monitor the performance of joint replacement implants and effectiveness of different types of surgery.
National Patient Surveys		Co-ordinated by the CQC, they gather feedback from patients on different aspects of their experience of care they have recently received, across a variety of services/settings: Inpatients, Outpatients, Emergency care, Maternity care, Mental Health services, Primary Care services and Ambulance services.
National Safety Standards for Invasive Procedures	NatSSIPs	A set of national safety standards to support NHS hospitals to provide safer surgical care.
Never Event		Serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented.
Oncology		The study of cancer. An oncologist manages a person's care and treatment once he/she is diagnosed with cancer.
Patient Reported Outcome Measures	PROMs	A programme in which patients complete a questionnaire on their health before and after their operation. The results of the two questionnaires can be compared to see if the operation has improved the health of the patient. Any improvement is measured from the patient's perspective as opposed to the clinicians.

Terms	Abbreviation	Description
Quality Account		This is a statutory annual report of quality which provides assurance to external bodies that the Trust Board has assessed quality across the totality of services and is driving continuous improvement.
Re-admission Rates		A measure to compare hospitals which looks at the rate at which patients need to be readmitted to hospital after being discharged (leaving hospital).
Sepsis		A life threatening condition that arises when the body's response to an infection injuries its own tissue and organs.
Summary Hospital level Mortality Indicator	SHMI	SHMI is a hospital level indicator which measures whether mortality associated with hospitalisation was in line with expectations. The SHMI value is the ratio of observed deaths in a Trust over a period of time divided by the expected number given the characteristics of patients treated by that Trust Depending on the SHMI value, Trusts are banded between 1 and 3 to indicate whether their SHMI is low (3), average (2) or high (1) compared to other Trusts. SHMI is not an absolute measure of quality. However, it is a useful indicator for supporting organisations to ensure they properly understand their mortality rates across each and every service line they provide.
Venous Thrombo-Embolism	VTE	This is a blood clot which can develop when a person may not be as mobile as they are usually or following surgery. The blood clot itself is not usually life threatening, but if it comes loose it can be carried in the blood to another part of the body where it can cause problems – this is called a Venous Thromboembolism (VTE).

Because you matter