Quality Account 2014/15

Quality and Safety at Heart

Mid Cheshire Hospitals NHS Foundation Trust
Quality Account 2014/15

“Mid Cheshire Hospitals
NHS Foundation Trust
prides itself on the quality
and safety of care it
delivers to patients
and carers”

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Part 1
Statement on quality from the Chief Executive

I am delighted to introduce the Quality Account for Mid Cheshire Hospitals NHS Foundation Trust for the period of April 2014 to March 2015.

Mid Cheshire Hospitals NHS Foundation Trust (MCHFT) is the organisation that runs Leighton Hospital in Crewe, Victoria Infirmary in Northwich and Elmhurst Intermediate Care Centre in Winsford.

In terms of achieving our quality objectives, 2014/15 is a year that we are all particularly proud of due to a significant number of great achievements in Quality, Safety and Experience.

The journey began with the launch of our new Quality and Safety Improvement Strategy. This strategy is particularly important as it was developed by the public, patients and our staff, and places real focus on the areas they felt were most important. You will see that achievements have been made in all areas of the Strategy which are described within the Quality Account.

There have been many other significant achievements during the year. These include:

- Rated as "GOOD" by the Care Quality Commission;
- Our mortality rate has reduced significantly, so we are now rated well within the "as expected" range;
- Achieving a significant number of national awards such as the Royal College of Midwives' Midwifery Service of the Year Award, the CHKS Top 40 Hospital Award and a Health Service Journal Award for medical handover (*pictured opposite, top to bottom respectively*);
- The introduction of a dementia care bundle which includes open visiting and carer support, alongside individualised care for patients with dementia;
- A significant reduction in hospital acquired

pressure ulcers;
- Being in the top 20% of Trusts for staff saying that quality and safety is a top priority, as well as being in the top 20% for staff saying they would recommend working in or having treatment at the Trust.

We are immensely proud of our staff and the care they deliver. This was reflected by the Care Quality Commission during their comprehensive inspection in October 2014. They consistently found staff to be caring and compassionate. The outcome of their inspection was a rating of “GOOD”. We are very proud to be one of only a small number of acute Trusts to have achieved this rating.

We continued our focus on quality as a key priority throughout the year with 60 frontline clinicians undertaking Quality Improvement training (*some of whom are pictured below*). This has equipped them with the skills and knowledge to take forward improvements within the clinical areas where they work. Many of these projects have had huge improvements for patients and some have received recognition nationally.

Finally, I want to take this opportunity to thank our staff. They do a tough job, sometimes in difficult circumstances, but always keep patient care as a top priority. 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.

There are a number of inherent limitations in the preparation of Quality Accounts which may impact the reliability or accuracy of the data reported. These include:

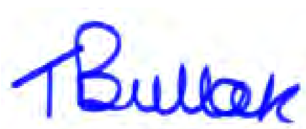
- Data is derived from a large number of different systems and processes. Only some of these are subject to external assurance, or included in internal audits programme of work each year.
- Data is collected by a large number of teams across the trust alongside their main responsibilities, which may lead to differences in how policies are applied or interpreted. In many cases, data reported reflects clinical judgement about individual cases, where another clinician might have reasonably have classified a case differently.
- National data definitions do not necessarily cover all circumstances, and local interpretations may differ.
- Data collection practices and data definitions are evolving, which may lead to differences over time, both within and between years. The volume of data means that, where changes are made, it is usually not practical to reanalyse historic data.

The Board of Directors have sought to take all reasonable steps and exercise appropriate due diligence to ensure the accuracy of the data reported, but recognises that it is nonetheless subject to the inherent limitations noted above. Following these steps, to my knowledge, the information in the document is accurate, with the exception of the matters identified in respect of the 18 week referral to treatment incomplete pathway indicator as described on page 39.

This report also demonstrates that the Trust has a number of assurance mechanisms in place which demonstrate how we scrutinise the quality of the care that we deliver. Examples of these include our extensive audit programme and the nursing acuity tool that is used to ensure the correct staffing is in place.

I hope you enjoy reading this Quality Account and find it of value. We are continually striving

to improve our care and would therefore welcome any feedback you may have.



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

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

Priorities for improvement in 2015/16

During 2013/14, the Trust conducted an extensive engagement programme based on the key themes from the Francis Inquiry into the failings at Mid Staffordshire NHS Foundation Trust. This consultation exercise informed our Quality and Safety Improvement Strategy which describes our key priorities for quality and safety from 2014 to 2016 inclusively.

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

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

The Trust will be a provider that:

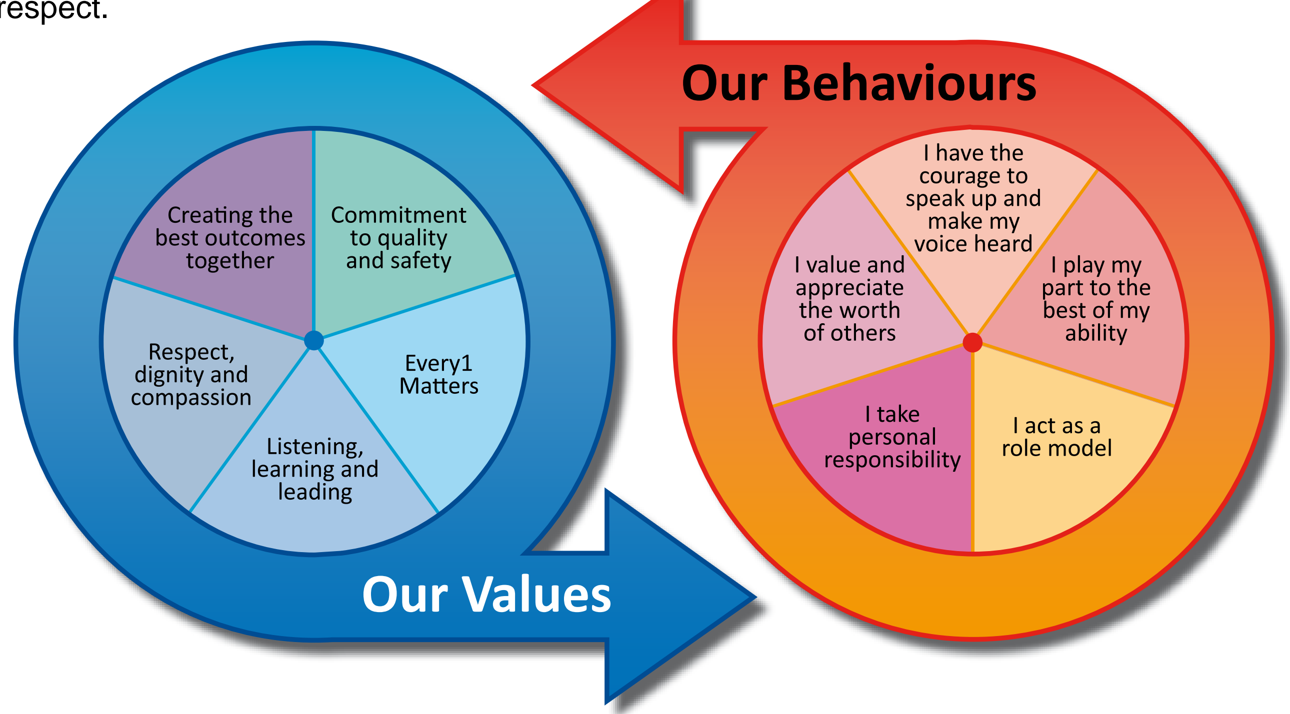
- Delivers high quality, safe, cost-effective and sustainable healthcare services;
- Provides a working environment that is underpinned by values and behaviours;
- Is committed to patient-centred care;
- Treats patients and staff with dignity and respect.

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

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

The values and behaviours developed with Trust staff underpin the delivery and success of the Strategy. The Trust recruits and nurtures its staff based on the values and behaviours (*pictured below*) so that they are observed across all areas of the organisation.

The subsequent development of the Quality and Safety Improvement Strategy has allowed the Trust to focus its key areas of improvement



under the three domains of quality as determined by the Health and Social Care Act 2012. The Strategy is ambitious but achievable.

Experience

- Improving nutrition and hydration for patients
  "The Trust will continue to provide an environment that promotes healthy nutrition and is tailored to individual patient need."

- Supporting patients with dementia and their carers
  "The Trust will support patients who have concerns about their memory and will work with patients who have dementia and their carers to promote a positive experience whilst in hospital."

- Improving communication
  "The Trust will ensure that staff improve their understanding of patients and their care needs. The Trust will use this knowledge to communicate effectively with patients and involve them in their care."

Effectiveness

- Improving documentation and reducing duplication
  "The Trust will review and improve its paper documentation so that it is relevant, adds value to care and avoids duplication."

- Reducing cancellations
  "The Trust will reduce the number of hospital initiated outpatient clinic cancellations by 20% by 2016."

- Appropriate nurse staffing levels
  "The Trust will ensure it has appropriate levels of nurse staffing and skill mix that meet the needs of its patients."

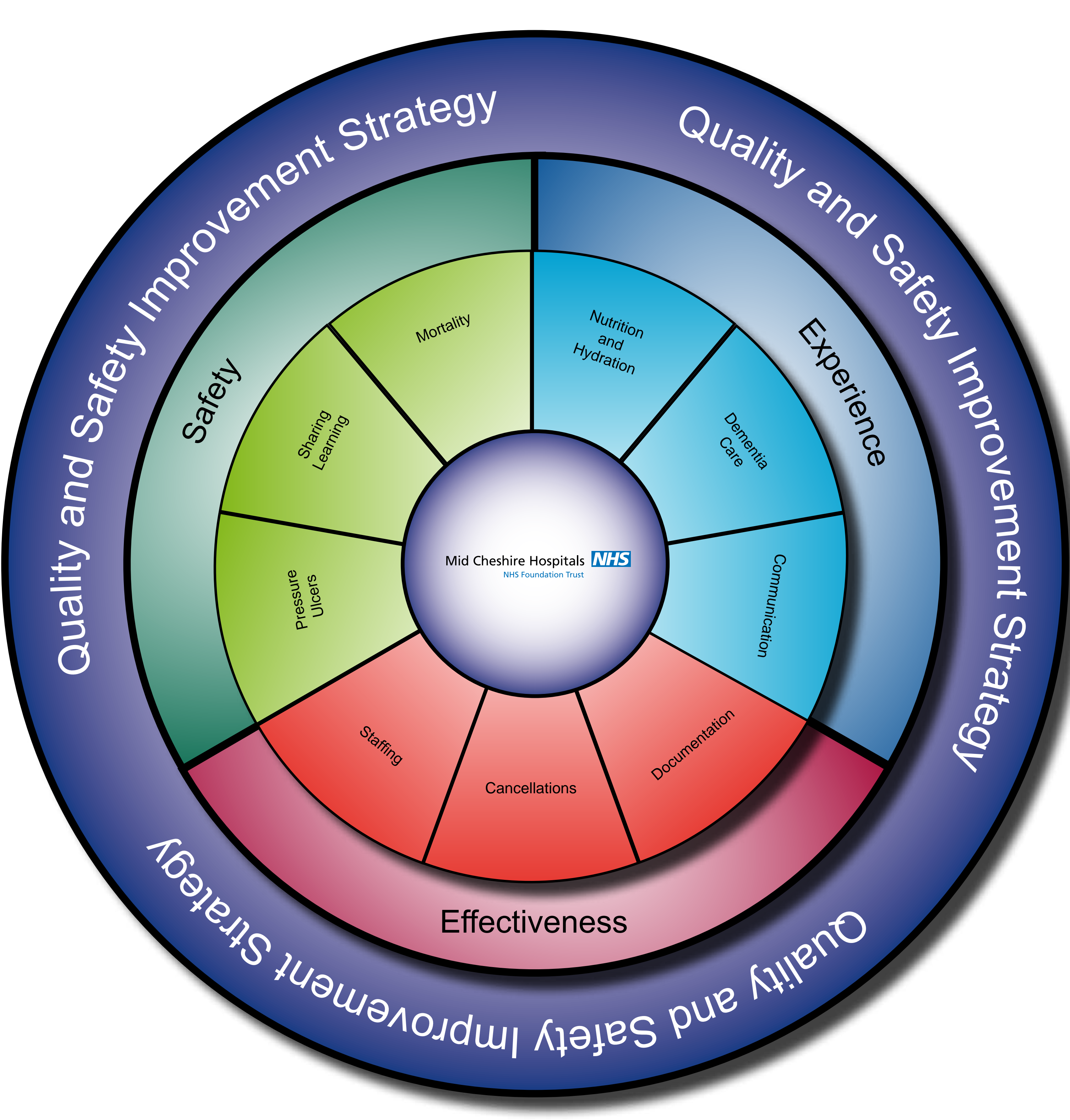
Safety

- Reducing pressure ulcers
  "The Trust will eliminate avoidable hospital acquired pressure ulcers by 2016."

- Sharing learning from feedback and incidents
  "All clinical staff will work together to respond to feedback from patients and carers and to learn from incidents that occur. The Trust will then ensure it responds to such learning and embeds this into practice."

- Reducing mortality rates
  "The Trust will reduce its mortality rates each quarter so that they reach expected levels as measured by the Summary Hospital-Level Mortality Indicator (SHMI)."

The logo for the Trust's Quality and Safety Improvement Strategy is shown overleaf. This has been used to promote awareness of the Strategy around the Trust and at public engagement events. An easy-read poster has been created and circulated to all wards and departments, whilst the logo has also been included on all the Trust's Quality and Safety boards *(pictured below with ward staff)*.


Quality and Safety Improvement Strategy
Quality and Safety Improvement Strategy
Quality and Safety Improvement Strategy
Safety
Experience
Effectiveness
Mortality
Sharing Learning
Pressure Ulcers
Nutrition and Hydration
Dementia Care
Communication
Staffing
Cancellations
Documentation
Mid Cheshire Hospitals NHS
NHS Foundation Trust

Monitoring and reporting of the Quality and Safety Improvement Strategy

Each element of the Strategy has a responsible lead who reports progress each quarter to the Quality and Safety Improvement Strategy Committee, which is chaired by the Director of Nursing and Quality. This Committee reports directly to the Quality, Effectiveness and Safety Committee (QuESt).

QuESt is responsible for providing information and assurances to the Board of Directors that the Trust is safely managing the quality of patient care, the effectiveness of quality interventions and patient safety. All elements of the Strategy have objectives that require both qualitative and quantitative evidence of achievement.

QuESt reviews the key areas of improvement in relation to the Quality and Safety Improvement Strategy to ensure progress is being made in relation to the aims and keys areas identified.

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

Statements of assurance from the Board

Review of services

During 2014/15, the Trust provided and/or sub-contracted 39 relevant health services.

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

The income generated by the relevant health services reviewed in 2014/15 represents 100% of the total income generated from the provision of NHS services by the Trust for 2014/15.

Feedback from patients

National patient surveys

To improve the quality of services that the NHS delivers, it is important to understand what patients think about their care and treatment. The Care Quality Commission (CQC) uses national surveys to find out about the experience of patients when receiving care and treatment from healthcare organisations.

Accident and Emergency national survey

During 2014, a questionnaire was sent to 850 people who had attended the accident and emergency department (A&E) at Leighton Hospital during January, February or March 2014.

Responses were received from 344 patients which equates to a response rate of 41.5% of completed eligible returns.

In comparison to the most recent nationally published data, the Trust is **about the same** (middle 60% of all Trusts) on all questions in the survey which relate to the following categories:

- Arrival at Accident and Emergency;
- Waiting times;
- Doctors and nurses;
- Tests;
- Hospital environment and facilities;
- Leaving Accident and Emergency;
- Overall patient experience.

The Trust's overall score has improved by 0.2% since the last survey undertaken in 2012. The individual results have shown improvements in 14 questions as shown in the chart above.

What has changed?

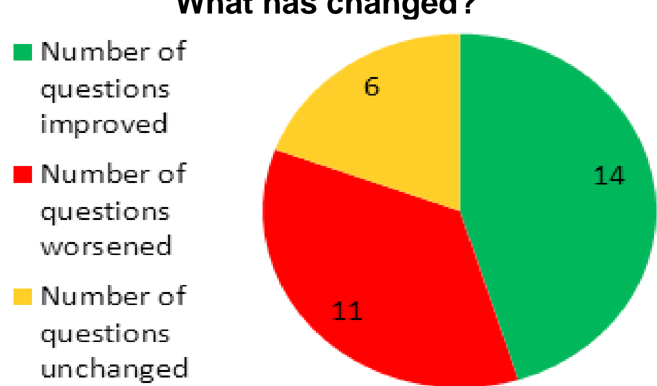


Chart 1: Changes in responses from 2014 survey (when compared with the results from the 2012 survey)

There has been a **statistically significant** improvement on the following question:

- Staff explaining test results to patients in an understandable way.

There was a 5%, or greater, improvement in relation to:

- Staff doing all they could to help control pain;
- Staff advising patients when they could resume normal activities.

Areas identified for improvement:

- **Waiting times** - Patients were not always told how long they would have to wait to be treated;
- **Medication** - Staff did not always tell patients about the medication side effects to watch for.

Actions to be progressed:

- Install an LED display to inform patients about waiting times upon on arrival to the department;
- Review processes to improve the explanations of medication side effects.

During the survey, many patients also commented on what was particularly good about their care. Their feedback included the following:

> *"I was treated very well, everyone was kind and respectful of my disability. I was treated as an intelligent being, informed about procedures, purpose of tests etc. My husband was included in all conversations and found staff very helpful."*

> *"Being elderly and suffering from dementia, sometimes people tend to speak to the person with the patient as they don't think it is worth addressing the patient because they cannot understand what is happening. The doctor and nurses who attended to my mother explained everything to her and me."*

> *"The service I received was absolutely fantastic and I cannot make faults with any of the staff or treatment."*

National Cancer Survey

The survey included all adult patients (aged 16 and over) who had a primary diagnosis of cancer who had been admitted to hospital as an inpatient or as a day case and had been discharged between 1st September and 30th November 2013.

383 eligible patients were sent a survey and 236 questionnaires were returned completed across nine tumour groups. This equates to a 66% response rate against the national response rate of 64%.

There were improvements in 15 questions when compared to the last time the survey was undertaken in 2012, and the most improved results related to:

- Staff giving a complete explanation of purpose of test (diagnostic);
- Staff explaining completely what would be done during the test;
- Doctors not talking in front of patients as if they were not there.

The scores for 42 questions remained the same whilst the score fell in 12 questions. As a result of the survey, the following actions have been agreed:

- Specialist nurses are to undertake bespoke training for the ward-based staff in relation to breast cancer and colorectal cancer to increase knowledge of these conditions;
- Posters will be developed to promote the Macmillan Information and Support Manager's contact details for ward patients to help them access information about help at home and financial support;
- Information about clinical trials will be included in individual patient prescriptions to trigger discussions as required;
- Information leaflets will be updated to ensure that patients know that they can bring a friend with them to their appointments.

During the survey, many patients described what was particularly good about their care. Their feedback included the following:

> *"The treatment and care I received from start to finish has been excellent. Everybody made me feel as though I was the only one in my situation and not a number."*

> *"The NHS staff who helped me are God's angels. I cannot thank them enough. This has been the toughest time of my life, especially going through chemotherapy. I will never forget the expertise and support I have received, but most of all I appreciate the compassion and kindness. Thank you."*

> *"All the staff are to be commended for their wonderful approach to a very difficult treatment. The whole experience was made so comfortable and relaxed. Overall, I am very proud of the way the NHS has treated me. The doctors and nurses are all a credit to their respective professions."*

National children and young people inpatient and day case survey

During 2014, 329 children / young people who were either an inpatient or day case patient and discharged in August 2014 were sent a questionnaire to find out about their experiences. 93 responses were received which equates to an overall response rate of 27% of completed eligible returns.

Response rates have been further broken down to the following age groups:

- 0-7 years 20.1%
- 8-11 years 31.1%
- 12 -15 years 27.7%

Questions in the survey covered the following:

- Going to hospital;
- The hospital ward;
- Food and facilities;
- Hospital staff;
- Pain Management and Operations;
- Medicines and leaving hospital;
- Overall perspective on care.

The Trust scored well in relation to questions which asked about:

- The provision of understandable information about treatment;
- Explaining what would be done during an operation;
- Parents feeling that their child was safe on the ward;
- Parents feeling that staff knew how to care for their child's individual or special needs;
- Treating parents and children with dignity and respect.

The following areas have been identified for improvement:

- **Parent facilities** - Parents felt facilities could be improved for overnight accommodation;
- **Medication** - Medication was not always given on time;
- **Communication** - Provision of written information to take home.

During the survey, many patients also commented on what was particularly good about their care. Their feedback included the following:

"The cleanliness of the children's ward is excellent. We visited many years ago and found our more recent experiences much improved."

"We were allocated one particular nurse for the pre-op and to look after us for the operation. This was really good for my child's confidence and reassurance. She was exceptionally helpful and kind."

"I appreciated that there were breast feeding facilities in the waiting area where I could feed my two-month old baby in privacy. I was grateful that, whilst I was there, the staff alerted me to when it was our turn to see the doctor on our day visit to the hospital."

"I was very impressed with the doctor that saw my son. He was friendly and made me feel at ease and able to ask any questions I wanted. He also explained the next steps to my son's care well and I feel very confident he will be treated to a very high standard."

"I was seen very quickly and everyone was brilliant. I was very well looked after. The beds were awesome. Thank you."

National inpatient survey

Between October 2014 and January 2015, a questionnaire was sent to 850 adult inpatients who had been admitted to Leighton Hospital.

Responses were received from 400 patients which equates to a response rate of 47.8% of completed eligible returns.

Questions in the survey cover the following areas:

- The Emergency Department;
- Waiting to get a bed on the ward;
- The hospital and the ward;
- Doctors;
- Nurses;
- Care and treatment;
- Leaving hospital;
- Overall views and experiences.
-

The individual results have shown improvements in 20 questions, stayed the same for 9 questions and worsened scores in 28 questions as shown in the chart below.

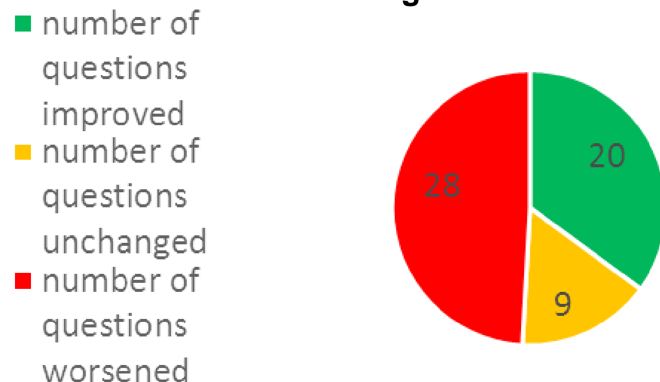


Chart 2: Comparison of responses from 2014 national inpatient survey (when compared with results from the 2013 survey)

There has been a **statistically significant** improvement in relation to respondents who felt that there were enough nursing staff on duty.

In addition, there was a 5%, or greater, improvement for:

- Patients being given information about their condition or treatment in Accident and Emergency;
- Confidence in treatment provided by doctors;
- Assistance given to patients at meal times when needed;
- Staff advising patients who to contact if they are worried about their condition after they have been discharged;
- Patients asked during their stay for their views on quality of care.

Areas identified for improvement:

- **Noise at night** - A 'quiet protocol' was introduced in 2014 with the aim of reducing unnecessary noise at night. A good night's sleep is important for every patient's recovery. The 'quiet protocol' is active from 11.00pm to 6.00am every night where staff work hard to keep noise levels to a minimum. *Pictured below: Ward Managers supporting the initiative.*

Patients also commented on what was particularly good about their care:

> *"The doctor who admitted me was "on the ball" and knew what was happening straight away. He was polite and careful. The nurses worked through the night to get me comfortable and to reduce my temperature."*

> *"The nurses were very compassionate, communicated really well when I asked anything. The medical teams were very warm, friendly and courteous. They were tremendous in their psychological support as well as their medical help. They seemed to be a happy team."*

> *"The staff in Accident and Emergency were excellent, they saved my life. Critical Care was perfect, absolutely first class care from all the doctors and nurses."*

"The Health Care Assistants were very caring and nothing was too much trouble. They were very helpful. The ward was spotlessly clean and beds were changed every day."

"The surgeon was pleasant, informative and spoke to me as an equal. I knew she was very busy but she didn't rush me at all."

Local patient surveys

The Trust has an annual Patient and Public Involvement Programme which includes a variety of methods for patient involvement, such as local patient surveys.

In 2014/15, 48 local surveys were undertaken. Local surveys are completed in wards and departments and patients are encouraged to provide feedback in a number of ways, including touch screen kiosks, paper-based surveys and one-to-one interviews with staff, volunteers and Governors.

The results collated from these surveys are shared with the relevant teams. Good practice is highlighted and action plans are developed to address any issues which have been identified from the results. The action plans are monitored by the action group for patient experience which meets each month.

A sample of results from randomly selected surveys are highlighted below:

Communication

55 responses were received from a sample size of 100.

The results showed that:
- 98% of patient said they were made to feel welcome;
- 98% of patients felt they were treated with dignity and respect;
- 94% of patients said that information was shared with them in a way that they could understand.

Key issues included:
- 22% of patients reported that they were not offered a private room to discuss sensitive or confidential issues;
- 51% of patients had not noticed the poster advertising the Lead Nurse, Matron and Ward Manager details.

Changes implemented following the survey:
- Posters advertising details of the Lead Nurse, Matron and Ward Managers updated on the wards;
- Staff reminded to prioritise the use of a private room for patients when discussing sensitive matters.

Endoscopy Unit Survey

137 responses were received out of a sample of 270.

The results showed that:
- 90% of patients felt that the instructions in the letter were clear;
- 74% of patients were given their results in an appropriate area;
- 99% of patients would recommend the Endoscopy service.

Key issues included:
- 12% of patients were not offered sedation / Entonox for their procedure;
- 33% of those patients who were delayed received no explanation for this.

Changes implemented following the survey:
- All delays are communicated appropriately to patients and their carers;
- Staff ensure that, where appropriate, patients have the opportunity to discuss sedation / Entonox.

Child and Adolescent Unit

101 responses were received out of 400.

The results showed that:
- 90% of respondents said staff were available when they needed them;
- 92% of respondents said they had trust in the doctors treating them;
- 97% of respondents said nurses and doctors washed their hands between touching patients;
- 97% of respondents said they were given

enough privacy when discussing their condition or treatment;
- 95% of respondents said hospital staff did everything they could to control pain.

Key issues included:
- 25% of respondents felt that there were times when a member of staff said one thing and another said something quite different.

Changes implemented following the survey:
- Staff have been reminded to check parents' / patients' understanding of what they have been told prior to discussing additional management plans.

Friends and Family Test: Patient element

The NHS Friends and Family Test (FFT) is a nationwide initiative to gain feedback from patients about the care and treatment they receive in hospital. Patients are asked whether they would recommend NHS services to their friends and family if they needed similar care or treatment. This is an important indicator of the quality of care they have received.

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

The Friends and Family Test is completed on the adult wards as well as within the Emergency Department, assessment areas and maternity services. Every patient that receives treatment in those areas can give feedback about the quality of care they have received. The Test has been extended to new areas during 2015 including outpatients, day case units and children's services.

Responses are anonymous and patients are asked to complete a survey card which can be handed to a member of staff or posted into a confidential post box. Patients attending the Emergency Department or maternity ward can choose to complete the survey on a touch screen kiosk which has a multi-language option.

How are the results calculated?

In September 2014, NHS England changed the FFT measure from a Net Promoter Score to a percentage for the proportion of positive responses. The responses from all patients are used to calculate the percentage of patients that would recommend the service ("extreme likely" and "likely"). Patients are also invited to comment on the reason for the answer they give.

Posters are displayed in the Emergency Department, assessment areas, the wards and maternity unit to promote the score achieved and to highlight patient comments. Examples of comments have included:

> *"Good care and support from nursing staff and physiotherapists were very good with their help towards my recovery during my rehabilitation. I was in good comfortable surroundings and there was an excellent choice of food at all meal times. Personal care and sensitivity to personal needs was very good. There was a choice of two day rooms, one with a TV and a quieter room."*

> *"Care was excellent for all patients in my bay. Professional, friendly, reassuring and obviously enjoy their job. They are extremely caring in their approach."*

> *"I cannot put into words how the staff are so helpful, kind and understanding. If you feel down they would come in and have a good chat and it made me feel a lot better. To end this I would like to wish them all the best, good luck and many thanks."*

"Having arrived at A&E with ankle and leg fractures I was in considerable pain, apart from the three-hour wait. My treatment has been exceptional, from all the medical staff. I must single out the nursing staff who were both very friendly and efficient."

"I am the daughter of a patient, my father was here for nine weeks and my views on all the staff are very high standards of care were given all the time."

"From the moment I arrived at hospital until I left with my new baby, I was cared for extremely well. All staff were amazing and I cannot fault anything. Your staff are very caring and nothing was too much trouble for any of them."

"I had absolutely wonderful midwives, both of them really made me feel as comfortable as possible and were great to me, felt like they were long-time friends! The doctor who helped with the delivery was amazing, so laid back, friendly and such a calming influence. I was over the moon with all the staff that treated me."

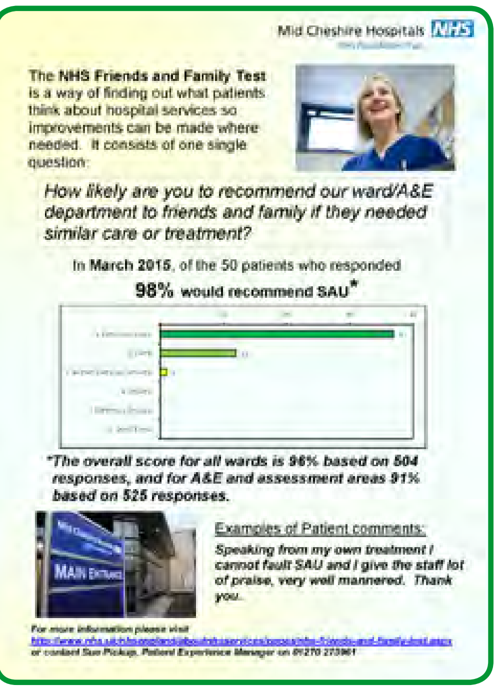
"The doctor I see in outpatients is compassionate, thorough and immensely knowledgeable. He is approachable and will patiently answer any question. I cannot express fully how exceptional he is."

Trust results

The response rates for the assessment areas and the Emergency Department averaged 20%, with 90% of patients saying that they would recommend these areas to their friends and family. This result is better than the results of Trusts both in the local area and nationally.

The response rates from the inpatient wards ranged from 34% to 50% across the year, with 97% of patients recommending the Trust. This is consistently higher than the results of local Trusts and the national average.

Posters are displayed across the organisation on wards and in the Emergency Department to promote the scores achieved and to highlight patient comments (*example pictured*).



More than 15,000 responses have been received to the Friends and Family Test, with 94% of patients overall indicating they are likely to recommend services or treatment to their family or friends.

What could be improved?

Examples of actions taken so far include increased options on the menus to cater for special diets and improvements to sign posting. However, the main themes from feedback tend to focus on positive comments relating to staff in all areas.

The Friends and Family Test results are published on the NHS Choices website:

- www.nhs.uk/Services/hospitals/Overview/DefaultView.aspx?id=505
- www.nhs.uk/Services/hospitals/Services/Service/DefaultView.aspx?id=208744.

94%

of patients say that they are likely to recommend the Trust for treatment (Friends and Family Test)

NHS Choices

Patients can comment about their experience on the NHS Choices website (www.nhs.uk). There were a total of 140 new postings on the website in 2014/15 relating to MCHFT. Leighton Hospital is currently achieving a star rating of 4 stars out of a maximum rating of 5 stars and the Victoria Infirmary in Northwich is achieving 5 stars.

Leighton Hospital

Victoria Infirmary

The Trust displays examples of postings on notice boards and takes action following any suggestions for improvement.

Examples of comments posted on NHS Choices include:

> *"I was very impressed with the new main entrance and particularly the clear colour coded signposting (pictured below). To attend for an x-ray I simply needed to follow the yellow sign posts which were very clear. When I went in for my x-ray the staff were very kind and helpful."*

> *"I visited here on advice from my occupational health doctor at work and I was seen by the triage nurse within ten minutes of being there. I was seen by a doctor and examined and left within an hour and a half. The doctor put me at ease and explained everything brilliantly. The lady on reception helped me with questions and I didn't feel like we were mithering. It is the first time I have used this hospital as I have recently moved to the area and I was very impressed."*

> *"I was seen within 15 minutes of arriving at the Minor Injuries Unit at Northwich Victoria Infirmary and I received first class service from a Sister and Student Nurse. I was out within 45 minutes of being seen. I cannot praise the service too highly."*

Other patient and public involvement programme activities

Patient Register Group meetings

These meetings are held at local libraries. The group consists of volunteers and members of the public who assist the Trust with various methods of involvement and is an opportunity for the Trust to share news of developments and seek views from members. In 2014/15, the meetings covered many topics including presentations about End of Life care, the Orthopaedic Trauma Specialist role, Dementia services, the Student Quality Ambassador role, Foundation Trust membership and the 'Stronger Together' programme which is a joint initiative with University Hospitals of North Midlands NHS Trust.

Readers' Panel

The panel has increased its membership to 79 members. The panel has reviewed a total of 13 leaflets including information about Critical Care, Febrile Convulsion and various leaflets for Ear, Nose and Throat services.

The panel has submitted many suggestions including grammatical changes and diagram or picture alterations. Some members of the panel have also been involved in projects in reviewing information for new services.

Patient Information Committee

In 2014/15, the Committee reviewed and approved 23 local patient information leaflets. Over the last 12 months, the Trust has increased the number of leaflets available in easy-read version, including A&E Minors and Majors easy-read leaflets, and large print versions of Endoscopy and Sigmoidoscopy information.

A range of leaflets have also been translated into other languages based on local community needs including post-operative instructions following a minor oral surgery procedure and details on services provided to children having Paediatric Oncology shared care.

Patient stories

The Board of Directors' meetings commence with a patient story which is presented as a video clip, audio account or letter. The stories are a combination of positive and negative experiences which ensure that the Trust's agenda is grounded in the value of listening to and learning from the experience of patients and carers.

One story shared with the Board was first heard at a "Learning Through Collaboration" event held for staff with a focus on improving awareness of long term conditions. A patient representative and volunteer for the Alzheimer's Society talked about his role as a carer of his wife who has Dementia. One of his requests in his story was for staff to ensure they listen to and involve carers and use their knowledge to learn about the patient's needs.

The Board also observed a series of photographs taken by volunteers to capture examples of good practice and areas for improvements across the hospital site which included sign posting and cleanliness.

During 2014/15, the Trust has taken part in a project led by AQuA (the Advancing Quality Alliance) to support the Trust in developing the use of patient stories further to influence improvements - www.patientstories.org.

The patient's story is always shared with the relevant team, ward or department and examples are included in Customer Care training.

Planning the delivery of services

Whether through direct consultation or through the provision of information, the Trust continues to directly involve service users (or their representatives) in planning both the provision of new services and changes to existing ones. A focus group (*pictured below*) was held to seek the views of patients, Foundation Trust Members and the public in plans for the new Surgical Admissions Lounge due to open June 2015.

Partnership Working

The Trust held a stand, with support from Governors, at the Crewe and Nantwich Senior Forum's Health and Wellbeing Fair, which was attended by 75 agencies. The stand included information about the Customer Care Team and opportunities to provide feedback on the care and services provided by the Trust.

Community Groups

Talks by the Patient Experience Manager have taken place at community groups to raise awareness about the Customer Care Team.

Learning Through Collaboration

An event was held to raise awareness with staff of long term conditions. The event was supported by organisations including Diabetes UK, Parkinson's UK, Alzheimer's Society and Multiple Sclerosis Society. The event was attended by nearly 100 staff and will be repeated in 2015. Staff felt the most valuable aspect of the event was hearing "the patient voice".

Healthwatch

The Trust works closely with Cheshire East and Cheshire West Healthwatch groups to explore opportunities of engaging with hard-to-reach groups. The Patient and Public Involvement Manager has attended health promotion events aimed at the travelling community. A joint initiative during the year has included mystery shopper visits by Healthwatch volunteers to assess communication skills for the reception of visitors to the Trust.

Customer Care Team

The role of the Customer Care Team is to provide on-the-spot advice, information and support for patients and relatives if they wish to raise concerns. The team can also support patients when dealing with issues about NHS care and provide advice and information about local health services. The Customer Care Team aims to respond to patients' concerns and issues effeciently and effectively, irrespective of whether they have been raised as an informal concern or a formal complaint. The majority of concerns can usually be resolved swiftly by staff who care for patients. However, sometimes patients or a family member may want to talk to someone who is not involved in their care and the Customer Care Team are then able to help.

A new poster has been developed and displayed across the Trust which is called 'Tell us what you think'. It provides information on how to contact the team and reinforces that the Trust welcomes feedback in relation to concerns, complaints, advice, information, suggestions and compliments.

Compliments

1,960 formal compliments were received by the Trust during 2014/15 which expressed thanks from patients and families about the care received. All compliments are shared with the relevant teams who are mentioned.

1,960

compliments received by the Trust during 2014-2015

Review of complaints

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

The Trust is committed to providing an accessible, fair and efficient service for patients and service users who wish to express their concerns or make a complaint with regard to the care, treatment or services provided by the Trust. The Trust promotes the Healthwatch advocacy service to anyone making a complaint to highlight independent support available.

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

The Complaints Policy was revised and updated in light of national guidance and clarifies that the Chief Executive is the 'responsible person' with overall accountability for the complaints process and will ensure compliance with the regulations and ensure action is taken in the light of the outcome of the investigation.

The Complaints Review panel is chaired by a Non-Executive Director and has membership which includes the Director of Nursing and Quality, a Governor and a patient representative. The panel reviews individual cases of closed complaints and follows best practice as recommended by the Patients Association in monitoring progress against action plans and undertaking detailed reviews.

All complaint meetings are recorded and a copy of the CD is given to the complainant at the end of the meeting. Feedback about this activity has been very positive and one family has even shared their copy of the CD with a member of the family who lived abroad and was unable to attend the meeting.

A survey of complainants was undertaken in 2014 to seek views on how well they felt their concerns were handled and whether they felt satisfied with the action taken. The survey highlighted that patients had not always been offered updates on the changes made as a result of the complaint.

A poster has been developed to illustrate improvements that have been made as a result of feedback from patients or their carers which has been shared with staff.

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

Table 1: Overview of complaints received by the Trust

	2012/13	2013/14	2014/15
Number of complaints received	199	228	260
Number of requests for review by Ombudsman	5	3	6
Number accepted for review by Ombudsman	4	1	4
Number upheld/partially upheld by Ombudsman	2	2	1

Learning disability access

Healthcare for All (DH 2008) identifies six criteria for meeting the needs of people with a learning disability which should be met by all NHS Foundation Trusts. The Trust is pleased to declare that it meets all six criteria as described below.

Does the NHS Foundation Trust have a mechanism in place to identify and flag patients with learning disabilities and protocols that ensure pathways of care are reasonably adjusted to meet the health needs of these patients?

The Trust has an established flagging system in place for people coming into the Trust with a learning disability. However, the system has recently been refined and an email is now generated when a patient with a learning disability is admitted. This informs the Dignity Matron, other Matrons within the organisation and the Clinical Site Managers that the patient has been admitted and to which ward. This has enhanced the patient experience considerably.

For example, a patient with a learning disability who had palliative care needs was admitted. The Dignity Matron was alerted by email and went to the ward straight away. She then contacted the Macmillan Nurse involved in the patient's care who also attended the ward. An appropriate plan of care was implemented and the Macmillan Nurse liaised with other members of the multi-disciplinary team. The Dignity Matron also informed that patient's Learning Disability Community Nurse of this admission. Reasonable adjustments were put in place and the plan of care was appropriate and patient-centred.

The Trust is currently working on a similar flagging system for introduction in Paediatrics. This will be an "opt-out" system and is presently awaiting approval from the Paediatric Governance Committee.

Does the NHS Foundation Trust provide readily available and comprehensible information to patients with learning disabilities about the following criteria: Treatment options, complaints procedures and appointments?

Work continues with the development of easy-read literature for patients with a learning disability. The picture pathways for the Emergency Department, minors and majors, are now completed and photo symbols continue to be used as new leaflets are developed / updated.

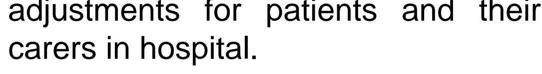
The Dignity Matron and Patient Information Co-ordinator are currently working on a hospital communication resource.

Does the NHS Foundation Trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities?

The Dignity Matron is the main contact for parents and carers when patients are admitted to hospital with a learning disability. Support can take many forms including practical, emotional and financial guidance. New carer guidelines have recently been introduced to help staff across the organisation support and involve parents and carers. A new **Carers' Charter** (*pictured overleaf*) has also been implemented which again highlights to staff the importance of involving carers as equal care partners. The Dignity Matron continues to visit patients and their carers at home to discuss the best way in which to facilitate their admission. Home visits provide a very effective way of highlighting the reasonable adjustments that are required, as well as meeting patients in the environment where they are most relaxed.

Does the NHS Foundation Trust have protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff?

Awareness training continues to be delivered as part of the three-day Healthcare Assistant Development



Carers' Charter

At Mid Cheshire Hospitals NHS Foundation Trust, we recognise the value and expertise of carers. This Charter details how we aim to work in partnership with you and provide you with help and support.

We will:
- Treat you with dignity, respect and compassion
- Recognise you as equal partners
- Listen and learn from you Involve you throughout the care process; from admission to discharge
- Offer practical support to enable you to continue your caring role whilst the person you care for is in hospital, should you wish
- This will include flexible visiting hours, meals and information
- Respect and take into account your ethnicity and culture, religion, gender, sexual orientation, age and other characteristics, without making assumptions
- Help to overcome any visual, auditory or language problems you may experience, so that your views can be clearly understood
- Give information that is clear and accurate and is easy to understand
- Ensure that staff are trained to understand the distress and anxiety that caring can cause so that they can signpost you to appropriate support
- Inform you whom to contact in an emergency or crisis, even if the person you care for is unwilling to let you be involved
- Give you an opportunity to contribute to wider policy and service related decisions
- Ensure that our staff adhere to the values and behaviours expected from them, and that they support and advocate for you as carer, as well as the person you are caring for.

Programme and this aspect of the training has been opened up to qualified staff as well. Adult Safeguarding training is mandatory and includes case studies, covers the five principles of the Mental Capacity Act (MCA) and best interest decision making. Ad-hoc learning disability training takes place on a regular basis. There are also electronic prompts and guidelines on the Trust's Intranet advising staff on how to best support patients in hospital with a learning disability.

The Learning Disability Specialist Health Facilitator and the Dignity Matron are progressing an e-learning package which concentrates on learning disability awareness and making reasonable adjustments for patients and their carers in hospital.

Does the NHS Foundation Trust have protocols in place to encourage representation of people with learning disabilities and their family carers?
The Learning Disability Development Group has a new carer representative who is due to attend her first meeting in April.

The Changing Places facility is now fully operational and the feedback from patients and carers has been excellent.

There is also a CQUIN which focusses on the experience of patients with a learning disability which aims to gather feedback from patients and carers who have attended the hospital. The Dignity Matron has attended carer groups as part of this CQUIN to gain valuable face to face feedback.

Does the NHS Foundation Trust have protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public boards?
A second audit took place in December 2014 which looked at elective admissions for surgery for people with a learning disability. Results demonstrated a considerable improvement in the number of quality of assessments made in relation to mental capacity and reasonable adjustments. The audit results have been shared as part of the learning disability self-assessment framework and the Learning Disability Development Group.

The Dignity Matron is also working as part of a collaborative stakeholder project group which is looking at the experiences of patients who have died. Data will be collected from primary and secondary care, themes will be identified and recommendations will be made.

Participation in clinical audits and research

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

National clinical audits

During 2014/15, 29 national clinical audits and three national confidential enquiries covered NHS services that the Trust provides.

During the same period, the Trust participated in 93% of the national clinical audits and 67% of the national confidential enquiries in which it was eligible to participate.

The national clinical audits and national confidential enquiries that the Trust was eligible to participate in and actually participated in during 2014/15 can be seen in Tables 3 and 4. These tables also show the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Table 2: National clinical audit participation 2014/15

National Clinical Audit / Programme	Participation	% Data Submission
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Yes	91.4%
Adult Community Acquired Pneumonia	Yes	Data collection in progress
Adult critical care (Case Mix Programme – ICNARC CMP)	Yes	100%
Bowel cancer (NBOCAP)	Yes	86%
Diabetes (Paediatric) (NPDA)	Yes	100%
Elective surgery (National PROMs Programme)	Yes	100%
Epilepsy 12 audit (Childhood Epilepsy)	Yes	100%
Falls and Fragility Fractures Audit Programme: National Hip Fracture Database	Yes	100%
Fitting Child (Care in Emergency Departments)	Yes	100%
Head and neck oncology (DAHNO)	Yes	>=80%
Inflammatory bowel disease (IBD)	Yes	100%
Lung cancer (NLCA)	Yes	>=75%
Major trauma (The Trauma Audit & Research Network, TARN)	Yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK): Saving Lives, Improving Mothers Care	Yes	100%
Medical and Surgical Clinical Outcome Review Programme NCEPOD: Sepsis Study	Yes	100%
Mental Health (Care in Emergency Departments)	Yes	100%
National Audit of Dementia	Yes	Data collection in progress

National Clinical Audit / Programme	Participation	% Data Submission
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	Yes	Data collection in progress
National Comparative Audit of Blood Transfusion programme: Patient Information and Consent	Yes	100%
National Emergency Laparotomy Audit (NELA)	Yes	100%
National Heart Failure (HF)	Yes	Data collection in progress
National Joint Registry (NJR)	Yes	95%
National Prostate Cancer Audit	Yes	Data collection in 2015/16
Neonatal intensive and special care (NNAP)	Yes	100%
Oesophago-gastric cancer (NAOGC)	Yes	>90%
Older People (Care in Emergency Department)	Yes	100%
Pleural Procedures	Yes	100%
Rheumatoid and early inflammatory arthritis	Yes	Data collection in progress
Sentinel Stroke National Audit Programme (SSNAP)	Yes	Data collection in progress

Table 3: National clinical audit non-participation 2014/15

National Clinical Audit / Programme	Participation	Reason
National Cardiac Arrest Audit (NCAA)	No	Resource implications
Diabetes (Adult) ND(A)	No	Resource implications
Medical and Surgical Clinical Outcome Review Programme NCEPOD: Gastrointestinal Haemorrhage	No	Resource implications

The reports of 26 national clinical audits were reviewed by the Trust in 2014/15. Table 6 highlights the actions taken / to be taken to improve the quality of healthcare provided as a result of national clinical audits.

Table 4: National clinical audit participation 2014/15 – actions taken

National Clinical Audit / Programme	Actions taken / to be taken by the Trust
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Data validation exercises undertaken to ensure accuracy and weekly reviews in place to maintain data validation. Work in progress to review medication management in repatriated patients.
Adult critical care (Case Mix Programme – ICNARC CMP)	Formal review of unexpected deaths in the first six months of the year highlighted good practice.

National Clinical Audit / Programme	Actions taken / to be taken by the Trust
Asthma in Children (Care in Emergency Departments)	Further education within the Emergency Department around early assessment of children with suspected/known asthma, timely administration of beta agonists and recording observations following treatment.
Bowel cancer (NBOCAP)	A significantly higher proportion of bowel surgery is undertaken via a laparoscope (key hole) than other Trusts. The Cheshire and Merseyside network is not an outlier for any of the criteria published.
National Diabetes Inpatient Audit (NADIA)	Improved access to consultant, dietician and podiatrist recognised and significant reduction in hypoglycaemic episodes. Increased numbers of risk assessments undertaken of diabetic feet, incorporating inspection, sensation, pulses and education.
Diabetes (Paediatric) (NPDA)	Insulin pump service commenced in April 2014 and a high HbA1c policy implemented. Monthly multidisciplinary team meetings include discussion of children and young people with HbA1c >75 mmol/ml.
Elective surgery (National PROMs Programme)	Feedback from patients remains very positive in relation to outcomes.
Epilepsy 12 audit (Childhood Epilepsy)	Good practice noted around paediatric assessment and early diagnosis. Detailed annual review forms and information packs for all newly diagnosed patients developed and introduced. RCPCH drug information sheets available in all paediatric clinic rooms.
Falls and Fragility Fracture Audit Programme: National Hip Fracture Database	Work underway to examine the potential for a full time Ortho-Geriatrician appointment to further improve outcomes as demonstrated nationally.
Head and neck oncology (DAHNO)	Recording of staging data has improved. There has been further improvement on the number of patients reported to have undergone dental assessments, speech and swallowing assessments and dietary assessments prior to treatment.
Inflammatory Bowel Disease (IBD) Programme	Business case and pathway under development to adopt faecal calprotectin to aid assessment of disease activity.
Major trauma (Trauma Audit & Research Network, TARN)	Good data completion highlighting extra survivors against expectation, but slightly higher length of stay. Work undertaken around initial assessment on day one in preparation for physical rehabilitation requirements, which forms the initial part of the major trauma rehab prescription.
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK): Saving Lives, Improving Mothers Care	The Trust is compliant with the majority of standards identified. Areas of non-compliance have been addressed in the national clinical audit gap analysis.

National Clinical Audit / Programme	Actions taken / to be taken by the Trust
Medical and Surgical Clinical Outcome Review Programme NCEPOD: Tracheostomy	Building on current first responder training with mandatory training for some ward nurses and further training for respiratory medical staff, in accordance with clinical guidelines. Tracheostomy pathway and passport under development.
Medical and Surgical Clinical Outcome Review Programme NCEPOD: Lower Limb	This service is no longer provided within the Trust. The service is now provided at the Royal Stoke University Hospital.
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	Report due out in late Spring 2015.
National Comparative Audit of Blood Transfusion Programme: Patient Information and Consent	Policy for patient information and consent for transfusion in place in line with the SaBTO recommendations. New documentation for 'consent and transfusion' currently under development.
National Emergency Laparotomy Audit (NELA)	Interim arrangements with UHNM surgical peers in place whilst consulting on joint working arrangements for 24 hour access to interventional radiology.
National Heart Failure (HF)	Report due out in May 2015
National Joint Registry (NJR)	The results show that the Trust is one of the best 5–10% of hospitals in the country.
National Prostate Cancer Audit (NPCA)	Multiparametric MRI scanning is now widely available to decrease the likelihood of unnecessary repeat biopsies, to improve staging data and assist treatment decision making for patients.
Neonatal intensive and special care (NNAP)	Local audit instigated in relation to hypothermia demonstrated use of suitable heating and regular thermostat checks to ensure appropriate temperature in delivery room, operating theatre and postnatal wards and use of air curtains in incubators.
Oesophago-gastric cancer (NAOGC)	Case ascertainment for curative surgery is excellent and the Trust's capture is rated as green at over 90% in the national audit.
Pleural Procedures	Case load submitted was small (four cases) which accurately reflected the activity during the audit submission period. It highlighted areas of good performance in chest drain insertion and management. The respiratory team has since developed a standard documentation proforma for all pleural procedures.
Rheumatoid and Early Inflammatory Arthritis	A significant number of patients have a composite RAID score of zero which would imply that their arthritis is having no impact whatsoever on any of the seven RAID domains.

National Clinical Audit / Programme	Actions taken / to be taken by the Trust
Sentinel Stroke National Audit Programme (SSNAP)	Actions are in place to review the pathway for patients who have a stroke and review the provision of a seven-day stroke service to include stroke physicians and therapists. Arrangements are in place with the Royal Stoke University Hospital to provide a seven-day service for high risk TIA patients. The Trust is working closely with Commissioners to improve access to specialised support for patients on discharge from hospital.
Paracetamol Overdose: Care in Emergency Departments (ED)	66% of patients with paracetamol overdose were treated according to MHRA guidelines. Since the audit, Emergency Department teaching sessions on poisoning have been altered to incorporate the new MRHA guidance.
Severe Sepsis and Septic Shock (Care in Emergency Departments)	Performance has improved and, to further enhance performance, the sepsis pathway is to be updated to reflect revised guidelines and to make it more user friendly.

Local clinical audits

The reports of 148 local clinical audits and four regional audits were reviewed by the Trust in 2014/15. 36% of these audits were re-audits.

Table 5 highlights some examples of the actions taken by the Trust as a result of local clinical audits to improve the quality of healthcare provided.

Table 5: Examples of actions taken following local clinical audits

Local Audit	Actions taken / to be taken by the Trust
Re-admissions to gynaecology ward	More than half of re-admissions involved hyperemesis which led to the development and implementation of an outpatient hyperemesis service. This also led to new and improved patient information relating to post-operative care and medical management of miscarriage and the introduction of a patient passport which includes all contact details.
Compliance with paediatric inter-hospital transfer guidance	All critical and ward level transfers were carried out by appropriate teams and with recommended timescales. A review of transfer documentation resulted in the development of ‘packs’ for each level of transfer, containing all guidance and relevant paperwork. Training and local governance documents have been updated in line with changes.
Adherence to the NICE Quality Standards for glaucoma in adults	A comparison between new and follow-up patients highlighted overall good compliance for new patients following the introduction of NICE Guidance. To improve communication with patients, a copy of their discharge letter is now sent to them as routine practice. Education and information has also been provided about treatment based on age and new educational documentation has been provided as part of the trainee pack to aid and improve consultation and discussion with patients.

Local Audit	Actions taken / to be taken by the Trust
Time from Referral to Scan for VTE Patients	Work is underway to train and develop staff skills to offer a seven-day service
Readmissions due to Infective and Non-infective Exacerbations of Asthma and/or COPD in Patients that have had Inhaler Technique Counselling During a Previous Admission	Audit results showed a 7% readmission rate with 100% of patients who required a new device or additional aids receiving them and receiving counselling regarding new techniques if required. In addition, all patients requiring further follow-up were appropriately referred to the integrated respiratory team and all had appropriately documented information about inhaler technique, counselling and any referrals to the integrated respiratory team documented in the discharge letter.
Bowel Preparation and its Effects on the Completion Rate of Colonoscopy	Project showed a 9% failed colonoscopy rate of which 20% was due to poor/inadequate bowel preparation, potentially leading to increased length of inpatient stay. The online referral form for colonoscopy has been modified to clarify bowel preparation and a pre-procedure patient information leaflet has been produced.

Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by the Trust between April 2014 and December 2014 that were recruited to participate in research approved by a research ethics committee was 399.

There were ten clinical research staff participating in research approved by a Research Ethics Committee during the reporting period. Participation in clinical research demonstrates the Trust's commitment to improving the quality of care offered and contributing to wider health improvements. Clinical staff keep up-to-date with the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

During 2014/15, the Research Midwives were commended by the Comprehensive Research Network: North West Coast for achieving the highest recruitment to maternity interventional trials in the whole region.

The Trust was involved in conducting 134 active clinical research studies during the reporting period including, but not limited to, the following areas:

- Cancer;
- Cardiovascular;
- Congenital Disorders;
- Diabetes ;
- Eyes;
- Ears;
- Generic Health Relevance and Cross Cutting Themes;
- Infection;
- Inflammatory and Immune System;
- Injuries and Accidents;
- Medicines for Children;
- Musculoskeletal;
- Oral and Gastrointestinal;
- Primary Care;
- Renal and Urogenital;
- Reproductive Health and Childbirth;
- Respiratory;
- Skin;
- Stroke.

Commissioning for Quality & Innovation framework (CQUIN)

A proportion (2.5%) of the Trust's income in 2014/15 was conditional upon achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Further details of the agreed goals for 2014/15 and for the following 12-month period are available online at: www.mcht.nhs.uk/information-for-patients/why-choose-us/quality.

The financial value of the 2014/15 CQUIN scheme for the Trust was £3,855,822.

For 2014/15, there were three national CQUIN goals which focussed on the Friends and Family Test, NHS Safety Thermometer and Dementia Care.

The Trust and the Clinical Commissioning Groups (CCGs) for Vale Royal and South Cheshire agreed a further nineteen goals. The North West Specialised Commissioning Group (SCG) negotiated two goals in relation to screening services for vulnerable and deprived groups. Goals for the neonatal services provided at the Trust were agreed with the Local Area Team.

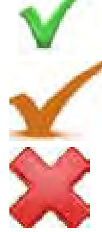
Table 6 briefly describes the goals included in this year's CQUIN and the Trust's performance against each of the CQUIN goals.

It can be seen that, of the 27 CQUIN goals, the Trust has achieved, or has plans to achieve, the vast majority of them. There are some challenges for the implementation of elements of the Advancing Quality (AQ) care pathways for acute myocardial infarction, chronic obstructive pulmonary disease, diabetes and sepsis.

Actions are in place to improve the Trust's position against these elements of the CQUIN. For the Advancing Quality goals (4–14), the Trust has anticipated the final results. The reporting period for the Advancing Quality programme does not close until August 2015.

Unfortunately, the Trust did not meet the data entry requirements for pneumonia (goal 7) and the data completeness for stroke (goal 8). In addition, it achieved 19% for the Friends and Family Test response rate for the Emergency Department and assessment areas (goal 1 part two) - this was 1% below the requirement. Actions are in place to address these issues.

Key for Table 6: *CQUIN results for 2014/15* (overleaf)



Achieved

Partially Achieved

Not achieved

Off track but recoverable (applies only to Advancing Quality CQUIN where data is delayed by four months)

Table 6: CQUIN results for 2014/15

Goal	Goal Name	Description of Goal	Status
1	Friends & Family Test (FFT)		
	Part 1: Further Implementation of the FFT	Implement the staff F&F Test	✓
		Implement the F&F Test in outpatient and day case departments by 1 October 2014.	✓
	Part 2: Increase response rates	Increase response rates in acute inpatient services:	
		Quarter 1 – at least 25%	✓
		Quarter 4 – at least 30%.	✓
		Increase response rates in A&E:	
		Quarter 1 – at least 15%	✓
		Quarter 4 – at least 20%	✓
	Part 3: Further increase response rates within inpatient services	Further increase response rates within inpatient services to achieve a response rate of 40% or more for the month of March 2015.	✓
2	NHS Safety Thermometer	Reduce pressure ulcer prevalence as measured by the Safety Thermometer to 3.7%.	✓
3	Dementia: Part 1: Assess and Refer	The proportion of patients aged 75 and over to whom the case finding question is applied following emergency admission; the proportion of those identified as potentially having dementia who are appropriately assessed and the number referred to on GP services.	✓
	Part 2: Training	Named lead clinician for dementia and appropriate training for staff.	✓
	Part 3: Supporting carers	Ensuring carers feel supported.	✓
4	Advancing Quality (AQ): Acute Myocardial Infarction	Implement the AQ care pathway for Acute Myocardial Infarction.	☺
5	Advancing Quality (AQ): Heart Failure	Implement the AQ care pathway for Heart Failure.	☺
6	Advancing Quality (AQ): Hip and Knee Replacement	Implement the AQ care pathway for Hip and Knee Replacement.	✓

Goal	Goal Name	Description of Goal	Status
7	Advancing Quality (AQ): Pneumonia	Implement the AQ care pathway for Pneumonia.	✗
8	Advancing Quality (AQ): Stroke	Implement the AQ care pathway for Stroke.	✗
9	Advancing Quality (AQ): Chronic Obstructive Pulmonary Disease (COPD)	Implement the AQ care pathway for COPD.	☺
10	Advancing Quality (AQ): Hip Fracture	Implement the AQ care pathway for Hip Fracture.	☺
11	Advancing Quality (AQ): Sepsis	Implement the AQ care pathway for Sepsis.	☺
12	Advancing Quality (AQ): Acute Kidney Injury	Implement the AQ care pathway for Acute Kidney Injury.	✓
13	Advancing Quality (AQ): Diabetes	Implement the AQ care pathway for Diabetes.	☺
14	Advancing Quality (AQ): Alcoholic Liver Disease	Implement the AQ care pathway for Alcoholic Liver Disease.	✓
15	Prevention of inappropriate emergency admissions	To review each emergency admission over the age of 85 who is living in a nursing or residential home to determine if the admission could have been prevented. This will be progressed in partnership with local care homes.	✓
16	Promoting the elderly voice and carer involvement	To use patient passports for elderly patients who do not have capacity, on the elderly care ward in the first instance.	✓
		To improve communication with care home facilities at the earliest point of intervention to ensure passports are comprehensive and accurate.	✓
		To involve carers/relatives in the care of the elderly patient as much as they wish. This will be progressed through the process of open visiting.	✓
		To involve the RVS volunteer scheme as part of the care team on the care of the elderly ward and the trauma orthopaedic ward to ensure socialisation and normalisation of daily activities.	✓

Goal	Goal Name	Description of Goal	Status
17	Promoting self management in patients with long term conditions at Elmhurst	To implement self administration of medicines at Elmhurst Intermediate Care Centre to promote independence, participation in self care and improve understanding of medication regimes.	✓
18	Promoting self management in patients with long term conditions (Diabetes or Parkinson's)	To develop self care pathways for patients who have Diabetes or Parkinsons to manage their medicines	✓
19	Improving outpatient experiences Part 1: adult general outpatients	To review the current use of adult general outpatients facilities and work closely with patient focus groups to prioritise and improve patient experience.	✓
	Part 2: urology patients	To progress nurse led services for urology patients to reduce waiting times, improve outcomes and improve patient experience.	✓
	Part 3: triage service for pregnant women	To review the effective use of the triage service for pregnant women to improve patient experience.	✓
	Part 4: paediatric outpatient facilities	To review the current use of paediatric outpatient facilities and work closely with patient/parent focus groups to prioritise and improve patient experience.	✓
20	Liaison between acute care and primary care for patients who self discharge	To review communication with primary care in relation to admissions who self discharge from assessment areas; gastroenterology wards and the female surgical ward.	✓
21	Management of people with complex learning disabilities	To improve the experience of patients with learning disabilities who access hospital services as an emergency.	✓
22	Implementing Medicine Homecare Services	To develop robust policies and processes to manage the provision of medicines via the Homecare route.	✓
23	Bowel screening service for vulnerable and deprived groups	Ensure that a health inequalities action plan is in place to provide a bowel screening service for vulnerable and deprived groups.	✓
24	Breast screening service for vulnerable and deprived groups	Ensure that a health inequalities action plan is in place to provide a breast screening service for vulnerable and deprived groups.	✓
25	Neonatal specialised commissioning: Medical genetics	To increase the availability of array CGH as a first line test to replace karyotyping on prenatal samples to provide a rapid and detailed screen for chromosome imbalance in pregnancies at increased risk of a genetic abnormality.	✓

Goal	Goal Name	Description of Goal	Status
26	Neonatal specialised commissioning: Retinopathy of prematurity (ROP) screening	To achieve an increase in screening to a target of 95% of babies with a birth weight of <1501g or a gestation of <32+0 weeks who undergo 1st Retinopathy of Prematurity (ROP) screening whilst still an in-patient and screened 'on time'.	✓
27	Neonatal specialised commissioning foetal medicine dashboard	To measure parental involvement in decision making and the foetal loss rate after invasive diagnostic procedures.	✓

The Care Quality Commission has officially rated your local hospital as

Feedback from Care Quality Commission (CQC)

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

The Care Quality Commission has not taken enforcement action against the Trust during the period April 2014 to March 2015.

The CQC conducted a Comprehensive Inspection of the Trust in October 2014 and published its report in January 2015. The Trust was given an overall rating of “Good”, which has only been awarded to a small number of acute hospitals in the country and puts the Trust amongst the highest rated in the country. The inspectors identified that improvements were required to ensure that services were responsive to people’s needs but noted some areas of outstanding practice and innovation. During this inspection, the CQC were assured by the evidence witnessed and noted that the Trust had completed the recommendations following the Dementia Care inspection in February 2014 and closed the action plan from this inspection.

The inspection was conducted by a team of 38 inspectors which consisted of a variety of healthcare workers, including Consultants and Student Nurses, as well as members of the public. Throughout the inspection, the CQC spoke to patients, staff and visitors about their experiences of the Trust and received very positive feedback. Additionally, they also spoke to other NHS organisations and partners including the Clinical Commissioning Groups, NHS England, the General Medical Council, the Nursing and Midwifery Council, the Royal Colleges and Healthwatch teams.

The focus of the inspection was on five questions for every service they examined:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people’s needs?
- Is it well-led?

The five questions provided a rating of either “Outstanding”, “Good”, “Requires Improvement” or “Inadequate” and related to the nine key areas inspected:

- Accident and Emergency;
- Medical Care;
- Critical Care;
- Surgical Care;
- Outpatients;
- End of Life Care;
- Maternity and Family Planning;
- Children and Young People;
- Elmhurst Intermediate Care Centre.

The inspection found areas of good practice were identified as follows:

- There are good systems in place for reporting and managing incidents and that there is a risk-aware culture within the Trust with a willingness to learn from incidents;
- Staffing levels were sufficient to meet patients’ needs and processes are in place to ensure resource and capacity risks are managed and mitigated;
- Multidisciplinary team work is well established and used effectively to manage

patient's individual care and treatment needs;
- Staff provide patients and their relatives with emotional support and treat all patients with dignity, compassion and respect;
- Staff had a good knowledge and understanding of the need to ensure that vulnerable people are safeguarded;
- Staff understand and follow best practice for infection control guidance.

Identified areas for improvement were:
- Ensure adequate and appropriate medical staffing at all times to provide timely reviews of patients at outpatient clinics and out of hours;
- Improve patient flow throughout the hospital;
- Implement an effective system for managing patient discharge letters;
- Consider improving arrangements for clinical supervision to enable staff to be supported and effectively carry out their responsibilities to an appropriate level;
- Ensure timely access to treatment for upper gastrointestinal bleeds and stroke thrombolysis, including out of hours;
- Reduce the number of elective surgery patients being readmitted to hospital following discharge.

The Trust's internal review processes had previously identified areas for improvement and these areas were identified as "Requires Improvement" in the CQC report. Work has already begun to address these issues.

External comments:
Simon Whitehouse, Chief Executive of NHS South Cheshire CCG and NHS Vale Royal CCG, said:

> *"We would like to extend our congratulations to MCHFT for the positive CQC report and the achievement of a 'Good' rating. This is great news for the local health and social care economy and all of MCHFT's current and future patients."*

Salli Jeynes, Chief Executive of The End of Life Partnership, said:

> *"Well done to everyone at MCHFT for all your hard work and commitment to your patients which has resulted in such a good CQC report. Your 'good' rating across all aspects of End of Life care is a real achievement and so important for patients and their families. We are proud to be working with you and your staff in support of excellent and compassionate care."*

Outstanding practice:
There were areas of outstanding practice observed from the inspection:
- The End of Life care services has direct access to electronic information in community services, which ensures that hospital staff have up-to-date information about their patients;
- The Rapid Discharge Pathway enables patients to be discharged home in the last hours / days of their life;
- The introduction of the electronic handover tool for medical staff, for which the Trust received a Health Journal Award;
- The new Critical Care unit is designed in accordance with best practice and aims to reduce delirium and problems associated with sensory deprivation.

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

In line with the new inspection approach by the CQC, the quality and risk profiles have been replaced with a new model: the Intelligent Monitoring report. This report is based on a number of statistical tests which are used to determine the thresholds of "risk" and "elevated risk" for each indicator. All Trusts have been categorised into one of six summary bands, with Band 1 representing highest risk and Band 6 the lowest risk. However, in light of the recent CQC inspection, the Trust was unbanded when the most recent report was released in December 2014.

Data quality assurance

NHS and General Practitioner registration code validity

The Trust submitted records during 2014/15 to the secondary uses service for inclusion in the hospital episodes statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was:

- 99.8% for admitted patient care;
- 99.9% for outpatient care;
- 99.4% for accident and emergency care.

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

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

Information Governance toolkit attainment

The attainment levels assessed provide an overall measure of the quality of data systems, standards and processes within an organisation. The Trust's Information Governance assessment was submitted at the end of March 2015 and had an overall score increase for 2014/15 from 78% to 80%.

There are 45 requirements in total within the toolkit. In order to be graded 'satisfactory', each requirement must be at level two or above. The Trust submission in 2013/14 showed 42 requirements were satisfactory and this remains the same for 2014/15. Unfortunately, the Trust remains graded as "not satisfactory" (status: red).

Carrying on from the Trust-wide information asset and sharing review in 2014, an annual review was launched of all assets to ensure an up-to-date information asset register is available for the Trust. Linking into this review, work is also being conducted to improve and embed the information asset owner network. Information Governance is continuing to conduct a project to renew all sharing agreements in place with third parties and ensure privacy impact assessments are in place for all relevant projects within the Trust.

At final submission of the Information Governance Toolkit, the Information Governance team had supported the training of 4175 (98%) staff, students and volunteers over the course of 2014/15. The Trust met its target for the second year running to achieve the toolkit requirement of at least 95% of individuals being trained in information governance.

There have also been new policies and procedures developed within Information Governance during 2014/15, including the Information Risk Policy.

The Trust has a progressive Information Governance Committee which meets quarterly and has an agenda which covers areas of work around the six sections of the toolkit. The outstanding requirements are highlighted at each committee and toolkit leads are required to provide feedback on the progress of requirements.

Clinical coding error rate

In 2014/15, the Trust remained in the top 20 percent of Trusts in the Payment by Results clinical coding audit.

The error rates reported for diagnoses and treatment coding (clinical coding) were:

- Primary diagnoses incorrect: 10%
- Secondary diagnosis incorrect: 9.6%
- Primary procedures incorrect: 6.7%
- Secondary procedures incorrect: 12.3%

The Trust remains pleased with these results. Please note that the results shown should not be extrapolated further than the actual sample audited. A cross section of services was reviewed within this sample.

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

- Deliver the recommendations of the clinical coding audit;
- Continue to deliver required training for all accredited coders;
- Continually review coding resources and performance.

Performance against quality indicators and targets

National quality targets

Table 7: National quality and performance standards

Key: Achieved ✓ Not Achieved ✗

	2012-13	2013-14	2014-15	Target	Achieved
MRSA bacteraemias	1	4	1	0	✗
Clostridium Difficile infections	23	26	10 avoidable cases	23	✓
Percentage of patient who wait 4 hours or less in A&E	95.04%	95.38%	92.3%	95%	✗
The percentage of Referral to Treatment (RTT) pathways within 18 weeks for completed admitted pathways	92.94%	91.39%	93.07%	90%	✓
The percentage of Referral to Treatment (RTT) pathways within 18 weeks for completed non-admitted pathways	96.96%	95.89%	93.90%	95%	✗
The percentage of Referral to Treatment (RTT) pathways within 18 weeks for incomplete pathways	95.6%	95.08%	94.41%	92%	✓
The percentage of patients waiting 6 weeks or more for a diagnostic test	0.87%	0.49%	0.37%	<1%	✓
Percentage of patients seen within two weeks of an urgent GP referral for suspected cancer	95.08%	95.56%	95.96%	93%	✓
Percentage of patients seen within two weeks of an urgent referral for breast symptoms where cancer was not initially suspected	94.78%	95.39%	95.47%	93%	✓
Percentage of patients receiving first definite treatment for cancer within one month (31 days) of a cancer diagnosis	99.25%	99.59%	99.55%	96%	✓
Percentage of patients receiving subsequent treatment for cancer within 31 days where that treatment is surgery or anti-cancer drugs	100%	99.3%	99.2%	94% surgery	✓
	100%	100%	100%	98% drugs	✓
Percentage of patients receiving first definite treatment for cancer within 62 days of an urgent GP referral for suspected cancer	89.71%	90.82%	89.34%	85%	✓
Percentage of patients receiving first definite treatment for cancer within 62 days of referral from an NHS Cancer Screening Service	94.68%	94.84%	95.94%	90%	✓

** The adjusted performance takes into account those patients who were referred to a treating trust outside of the agreed Network reallocation policy. Where patients are referred after the agreed day in the 62-day pathway the full breach reallocation is assigned to the referring Trust. This accounts for the difference between unadjusted and adjusted performance (after reallocation).*

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 the Health and Social Care Information Centre (HSCIC).

For each indicator, the number / percentage / value / score / rate (as applicable) for at least the last two reporting periods should be presented in a table. In addition, where the data is made available by the HSCIC, a comparison should be made of the numbers / percentages / values / scores / rates of the Trust's indicators with:

a) the national average; and,
b) those Trusts with the highest and lowest figures.

Table 8: The value and banding of the Summary Hospital-level Mortality Indicator (SHMI)

Date	Trust Performance	National Average	95% Upper Limit	95% Lower Limit
July 2012 - June 2013	1.15 Higher than expected	1.00	1.13	0.89
October 2012 - September 2013	1.16 Higher than expected	1.00	1.12	0.89
January 2013 - December 2013	1.12 Higher than expected	1.00	1.12	0.89
April 2013 - March 2014	1.04 As expected	1.00	1.12	0.89
July 2013 - June 2014	1.03 As expected	1.00	1.12	0.89
October 2013 - September 2014	1.00 As expected	1.00	1.12	0.90

The Trust is delighted to report that it has reduced its mortality levels to the 'as expected' range.

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

- A series of inter-related projects to reduce the Trust's mortality rates which are in progress under the primary drivers of:
  - **R**eliable clinical care;
  - **E**ffective clinical care;
  - **M**edical documentation, clinical coding and data consistency;
  - **E**nd of Life care;
  - **L**eadership.
- Completing an action plan which was developed following a review of the Trust's mortality rates by the Advancing Quality Alliance (AQuA) in January 2014;
- A weekly mortality case note review group, which is led by the Lead Consultant for Patient Safety, which has been established to review themes and areas for further work in conjunction with the Hospital Mortality Reduction Group.

Table 9: The percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust

Date	Trust Performance	National Average	95% Upper Limit	95% Lower Limit
July 2012 - June 2013	1.49%	2.07%	4.41%	0%
October 2012 - September 2013	1.30%	1.20%	3.10%	0%
January 2013 - December 2013	1.50%	1.20%	3.20%	0%
April 2013 - March 2014	1.30%	1.30%	3.10%	0%
July 2013 - June 2014	1.40%	1.30%	3.10%	0%

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 deaths that are coded with palliative care either in diagnosis or treatment specialty. The Trust compares closely with the national average for palliative care coded deaths which is a positive position to be in and reflects accurate coding practice.

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

- Reviewing medical documentation, clinical coding and data consistency as part of a series of inter-related projects to continue to reduce the Trust's mortality rates.

Table 10: The Trust's patient reported outcome measures scores (PROMS)

Date	Trust Performance	National Average	Highest Result	Lowest Result	Position Nationally
Groin Hernia Repair					
2012-2013	9.2	9.1	31.03	0.14	Top 60%
2013-2014	7.5	8.5	23.8	-14.4	Top 65%
2014-2015	8.88	8.74	12.5	0.9	Top 60%
Varicose Vein Surgery					
2012-2013	8.2	9.3	27.2	0	Top 50%
2013-2014	NA	10	31.1	-4.33	NA
2014-2015	No Data Available	No Data Available	No Data Available	No Data Available	No Data Available
Hip Replacement Surgery					
2012-2013	49.9	43.7	69	0	Top 30%
2013-2014	46.8	43.8	72.4	20.4	Top 35%
2014-2015	No Data Available	No Data Available	No Data Available	No Data Available	No Data Available
Knee Replacement Surgery					
2012-2013	52.7	31.2	52.7	0	Top performing Trust in country
2013-2014	41	34	61.4	14.4	Top 20%
2014-2015	No Data Available	No Data Available	No Data Available	No Data Available	No Data Available

The Trust considers that these results are as described because the numbers of patients undergoing varicose vein surgery at the Trust are minimal.

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

- Continuing to work closely with patients undergoing surgery within the clinical focus groups to encourage their full participation in the completion of the PROMS questionnaires before surgery and six months following surgery;
- 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 or knee replacement surgery.

Table 11: The percentage of patients aged 0 to 15 readmitted to hospital within 28 days of being discharged

Date	Trust Performance	Peer Group Average
January 2012 - December 2012	8.4%	10.3%
January 2013 - December 2013	8.8%	10.6%
January 2014 – December 2014	10.8%	10.8%

The Trust is consistent with peer and considers this is because of the following reasons:

- There is an open access process in place which allows the Paediatricians to discharge children and offer 'open' access for a limited time dependent on the child's diagnosis and where they are on the clinical pathway;
- The Child & Young Persons Home Care Team (speciality focused) work in conjunction with the Child and Adolescent Unit and take referrals for children who are discharged and may require follow up at home. This service may prevent the need for children to be readmitted;
- Consultant Paediatricians carry out daily ward rounds seven days a week. They are able to review all patients, make prompt clinical decisions and plan and co-ordinate their follow-up care with the multidisciplinary team.

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

- The Trust continues to look at the feasibility of introducing a nurse-led 'hospital at home' service which would also support admission avoidance and reduce the need for readmissions (acute focused);
- The Trust introduced rapid access slots in Consultant clinics in July 2014. The aim is to provide an alternative pathway for suitably identified children who would normally be seen as assessments or ward attenders. A process of ongoing audit is in place and a qualitative review with reflection on the difference the service has made is planned for 2015;
- In January 2014, a dedicated Advice and Guidance Service for GPs to request advice on the management of Paediatric patients started. The aim of this service is to support GP colleagues and offer an alternative to acute admission or outpatient referral for specialist advice. An update was presented to the GP Forum in Autumn 2014, with a re-audit of the service in January 2015. A review of the benefits and longer term aims for this service in conjunction with the commissioners will take place in Spring 2015.

Table 12: The percentage of patients aged 16 or over readmitted to hospital within 28 days of being discharged

Date	Trust Performance	Peer Group Average
January 2012 - December 2012	6.3%	6.3%
January 2013 - December 2013	5.9%	6.7%
January 2014 – December 2014	6.9%	7.7%

The Trust is pleased to report that its readmission results continue to remain below peer and considers that this is for the following reasons:

- There has been focussed work undertaken by the clinical divisions. They have continued to review readmissions for patients who have respiratory conditions, cardiac conditions, urology conditions or who have undergone breast surgery. Dedicated Matrons have supported this work and implemented specific action plans to identify any issues identified.

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

- Continuing to progress collaborative working with community services;
- Extending the work with nursing homes to support them care for their patients;
- Embedding the use of patient passports for those patients with long term conditions.

Table 13: The Trust's responsiveness to the personal needs of its patients

Date	Trust Performance	National Average	Highest Result	Lowest Result
2012	73.5	75.6	87.8	67.4
2013	75.9	76.9	84.4	57.4
2014	76.1	Not available	Not available	Not available

The Trust is pleased to note that the responsiveness score to the personal needs of its patients continues to increase.

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

- Formally reviewing the staffing levels and skill mix on all inpatient wards every six months;
- Reviewing patient needs for staff requirements every day and making adjustments as required;
- Pursuing an active recruitment strategy to ensure the required nursing staff are available on the wards;
- Continuing to invest in nursing staff to undertake extended roles;
- Increasing the numbers of staff who are seconded from the Trust to undertake their nurse training.

Table 14: Staff employed by the Trust who would recommend the Trust as a provider of care to their family or friends (scores out of 5)

Date	Trust Performance	National Average	Highest Result	Lowest Result
2011 staff survey	3.52	3.50	4.05	2.84
2012 staff survey	3.59	3.57	4.08	2.90
2013 staff survey	3.79	3.68	4.25	3.05
2014 staff survey	3.86	3.67	4.20	2.99

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

- Over the last year there has been a lot of focus and communication to staff about how important all staff are in improving the quality of care and services we provide;
- The Trust's appraisal system includes values and behaviours;
- Received positive feedback about staff engagement from the CQC inspectors;
- Engagement sessions with the Trust's Chief Executive and other members of the Executive Team have taken place which have had quality and patient experience at the heart of those discussions;
- The Chief Executive delivers weekly briefings which focus on the patient safety and quality agenda;
- Patient stories are told at Board meetings each month to ensure that patients are at the heart of all decisions being made by the Board;
- All internal leadership programmes include a focus on patients and have had patients come and deliver presentations to participants about their experiences at the Trust;
- Patients are on the Trust's judging panels for the Celebration of Achievement evening. Their perspective on what matters has been valued and there is also a Patient Choice Award category for nominations;
- Staff focus groups run twice a year to ascertain their views and they are asked if they would they recommend the Trust as a place to receive treatment and any negative responses are discussed;
- Patients are sometimes included in the selection process for new staff.

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

- Reducing violence, bullying and harassment towards staff;
- Reducing discrimination against staff;
- Improving team working;
- Improving the health and wellbeing of staff;
- Improving the quality of appraisals and number of staff completing health & safety training.

Table 15: The percentage of patients who were admitted to hospital who were risk assessed for venous thromboembolism (VTE)

Date	Trust Performance	National Average	Highest Result	Lowest Result
October 2013 - December 2013	96.8%	95.8%	100%	77.7%
July 2014 - September 2014	99.2%	96.1%	100%	86.4%
April 2014 - June 2014	99.2%	96%	100%	87.2%
July 2014 - September 2014	99%	96%	100%	86%
October 2014 - December 2014	99%	96%	100%	86%

The Trust has consistently remained above the national average for the previous five reporting periods in relation to the percentage of admitted patients who were risk assessed for VTE.

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

- Monthly monitoring of the percentage of patients risk assessed for VTE by the clinical divisions;
- Implemented the national guidance issued by the National Institute for Health and Clinical Excellence (NICE) relating to VTE risk assessment to ensure that all relevant patients are assessed on admission for their risk of developing a VTE. The VTE risk assessment has been included in the Trust's admission proformas to ensure this happens.

Table 16: The rate per 100,000 bed days of cases of Clostridium difficile infection reported within the Trust amongst patients aged 2 or over

Date	Trust Performance	National Average	Highest Result	Lowest Result
2011-2012	16.83	21.82	50.89	4.08
2012-2013	12.9	17.3	30.8	0
2013-2014	14.6	14.7	31.7	0
2014-2015	5	Not published	Not published	Not published

The Trust is pleased to report a reduction in the number of avoidable cases of Clostridium difficile. Ten cases were reported this year which represents a considerable achievement and reflects the efforts undertaken to reduce healthcare associated infections.

In order to maintain this achievement the Trust will continue to:

- Maintain environmental hygiene standards and ensure monitoring is increased at ward level;
- Monitor antibiotic prescribing compliance and raise awareness within divisions following antibiotic audits performed by Consultant Microbiologists and antimicrobial pharmacists;
- Maintain case management of Clostridium difficile patients by the Infection Prevention and Control Service and on-going review of all side rooms used for isolation purposes to ensure effective isolation practice and appropriate clinical management;
- Complete a root case analysis on all Clostridium difficile infection cases, to highlight all lapses in care and share learning with our community colleagues;
- Maintain weekly Clostridium difficile infection clinical review group meeting ensuring all aspects of patient management are assessed / actioned by wards with Clostridium difficile patients;
- Review of performance against regional and national data to identify any learning from similar Trusts.

Table 17: The number of patient safety incidents reported within the Trust

Date	Trust Performance	National Average	Highest Result	Lowest Result
April 2012 - September 2012	2,695	1,812	4,545	815
October 2012 – March 2013	3,015	1,964	4,517	924
October 2013 - March 2014	3,016	2,185	3,790	301
April 2014 - September 2014	2,814	2,052	4,301	908

The above data demonstrates that the Trust reports more patient safety incidents than the national average and this has been consistent for all reporting periods.

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

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

- Training about incident reporting for all staff throughout the Trust. This training ensures that all staff in the Trust know how to report a patient safety incident and they also understand the importance of incident reporting;
- Sharing learning from reported incidents via lessons learned flyers and individual patent stories.

Table 18: The number and percentage of patient safety incidents reported within the Trust that resulted in severe harm or death

Date	Trust Performance	National Average	Highest Result	Lowest Result
April 2012 - September 2012	6	16	69	2
October 2012 – March 2013	3	16	56	1
October 2013 - March 2014	4	15	60	0
April 2014 - September 2014	3	15	51	0

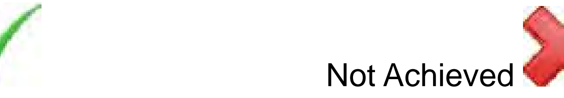
The above data demonstrates that, whilst the Trust is a high reporter of patient safety incidents, the Trust is consistently below the national average when its data for patient safety incidents which result in severe harm or death is compared with other organisations. This is a very positive position for the Trust.

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

- Undertaking a full root cause analysis for all incidents which result in severe harm or death. A review meeting is held following the incident investigation which is always chaired by an Executive lead to ensure that lessons are learned and actions are implemented to prevent a reoccurrence;
- Reporting all incidents which result in severe harm or death to the Board to ensure openness within the Trust;
- Implementing the Trust's Being Open policy which ensures that, if an incident occurs which results in severe harm or death, the patient and / or their family are informed and the lessons learned and actions from the root cause analysis are shared with them in line with the Duty of Candour;
- Implementing actions following a safety culture awareness survey which took place in conjunction with Pascal Metrics. The staff surveyed were those involved in the surgical patient pathway. 1,000 staff were sent the survey and the response rate was 70%. The feedback from Pascal Metrics was divided into work settings and was measured across each of the safety culture domains. There were positive results for most work settings. Each work setting will have its own action plan. Some are already complete, some are under construction and others will not be developed until the Trust starts work with them in prioritised order. The outcomes from this work are reported to the Pascal Metrics group, led by the Chief Executive and subsequently reported to the Quality, Effectiveness and Safety Committee.

Performance against local quality indicators

Table 19: Local quality indicators

Key: Achieved  Not Achieved

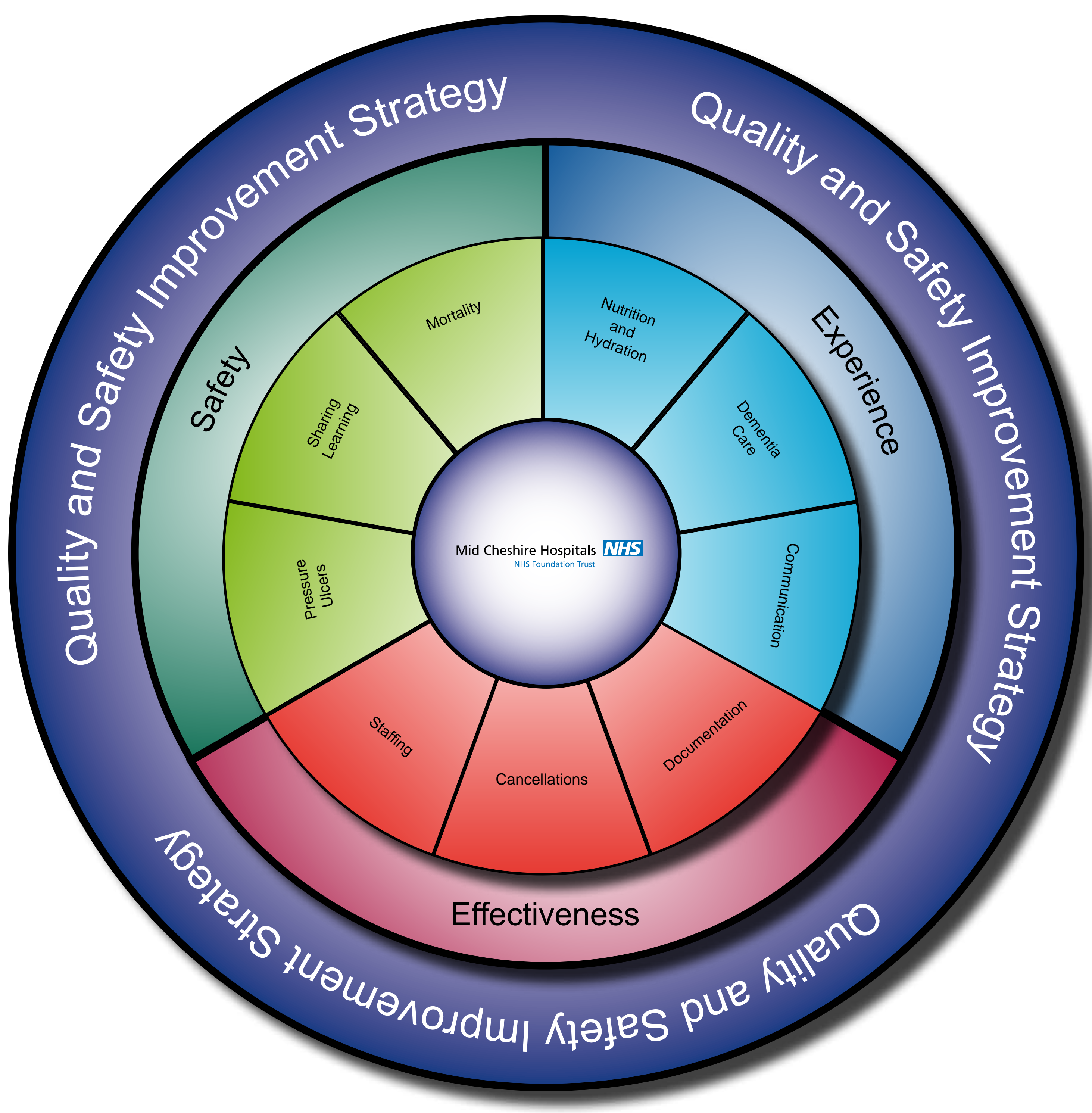
	2012-13	2013-14	2014-15	Target	Achieved?
Cancelled operations (%)	1.32%	0.83%	1.05%	1.09%	✓
Cancelled operations – % breaching 28 day guarantee	15.83%	16.06%	2.81%	5%	✓
Smoking during pregnancy	20.55%	17.34%	17.52%	< 15%	✗
Breastfeeding initiation rates	60.91%	66.96%	65.89%	65%	✓
Access to genito-urinary (GUM) clinics	100%	100%	100%	100%	✓
Falls risk assessments completed	96%	98%	100%	90%	✓
Pressure ulcer risk assessments completed	94%	99%	90%	90%	✓
Nutritional risk assessments completed	95%	90%	90%	90%	✓
% of patients who felt they were treated with dignity and respect	100%	100%	100%	100%	✓
% of patients who had not shared a sleeping area with the opposite sex	100%	100%	100%	100%	✓

Part 3
Review of quality performance

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

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

- Experience
- Effectiveness
- Safety



The new Quality and Safety Improvement strategy was launched in the Trust at the start of 2014. The logo appears on all the Trust's Quality boards.

The Trust also produced an easy read poster summarising the key aspects of the Strategy (*pictured below*).

Divisions have produced their own posters for the strategy, highlighting to their staff the role they can play in making it work.

In addition, the Student Quality Ambassadors produced a student version to show students the important role they play in providing a quality service to patients, *pictured opposite*.

Mid Cheshire Hospitals NHS

NHS Foundation Trust

Quality and Safety Improvement Strategy 2014/16

- Effectiveness -

Improving Documentation

We will make sure we record and share the right information about your care.

Reducing Cancellations

We will reduce the number of times we cancel your outpatient appointments.

The Right Nurse Staffing Levels

We will show you that we have the right number of staff working each day.

- Experience -

Nutrition and Hydration

We will make it easier for for you to eat and drink well while in hospital.

Dementia Care

We will help and support you and your carers with your memory difficulties.

Improving Communication

We will listen to you, your family and your carers.

"They talked me through everything so I knew exactly what was happening."

- Safety -

Reducing Pressure Ulcers

We will work with you to prevent you getting a pressure ulcer while you are in hospital.

Learning From Incidents

We will learn from and act on your comments and feedback.

You Said

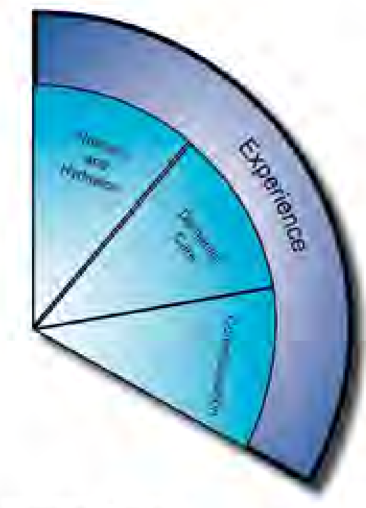
We Did...

Reducing Mortality

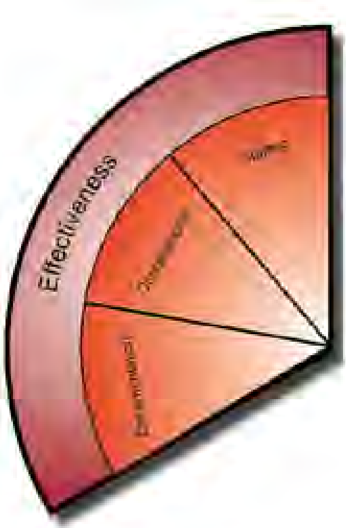
We will reduce the number of patients who die in our hospital when this is not expected.

Quality and Safety Improvement Strategy 2014-2016: Student involvement

Experience



- Nutrition - As student nurses working within the multi-disciplinary team, we can ensure patient nutritional needs are met. Take time to make sure fluid balances and nutritional intake charts are filled in
- Dementia - Students are currently taking part in dementia friends champion training and will inform fellow students through information sessions. The newly informed students will then be dementia friends. Attend a session if you get chance, there's a free badge!
- Communication - As students a large part of our course is focussed on communication and this will help improve students' evidence based practice



Effectiveness

- Documentation - As students we need to document clearly using a known model and have all documentation countersigned
- Cancellations - A student can influence patient experience to make it a positive one, which will help reduce future cancellations
- Staffing - While students hold supernumerary status, it is worth noting that when you are asked to involve yourself as part of the team, you should take this as being seen as a valued member of the team

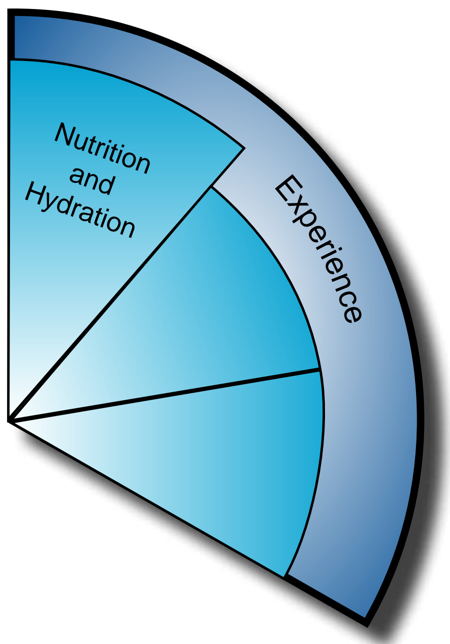
Safety

- Pressure ulcer prevention – Make yourself familiar with the skin bundle. Students are in the unique position to spend time honing their skills. Take time to attend to the personal care of your clients, and increase your background knowledge.
- Sharing learning – Incident reports are reviewed by some ward staff; see if you can do this with them
- Reducing mortality rates – Know your patients' Early Warning Score, report physiological changes to your mentor immediately, remember the 5 R's
- Be aware of the role of the student in the: EWS policy, Outreach policy, Sepsis pathway
- Work within your limits

PLEASE BECOME FAMILIAR WITH THE FULL QUALITY AND SAFETY IMPROVEMENT STRATEGY

FOR A FULL COPY CONTACT YOUR PAT, THE PEF TEAM, OR A STUDENT QUALITY AMBASSADOR

Experience: Improving nutrition and hydration for patients



Aim:

The Trust will continue to provide an environment that promotes healthy nutrition and is tailored to individual patient need.

This is important because:

In 2009, the British Association for Parenteral and Enteral Nutrition estimated that up to 40% of hospital patients are at risk of clinical malnutrition which can lead to poor patient outcomes, hospital acquired conditions and longer lengths of stay. Therefore, the provision of enjoyable and nutritious food and drinks is essential to help patients feel better, maintain their strength and energy and to promote a return to health following illness or surgery.

What progress was made in 2014/15?

- The Nutrition and Hydration Group was formed in May 2014 and is chaired by one of the Trust's Matrons. Membership of the group includes catering staff, representatives from all clinical divisions, Housekeepers, Dietitians, Matrons and the Voluntary Services Manager;
- The remit of the Nutrition and Hydration Group is to improve the quality of patient experience and three workstreams have been established to deliver this intention:
    - Food delivery;
    - Food choice;
    - Documentation and care planning.
- With these workstreams in mind, a comprehensive audit was carried out on the wards to review how food and drink was being served to patients, what choice was being offered and how often this was available;
- Based on the findings of the audit, the following improvements have been made:
    - Increased the options of beverages routinely available on the wards to seven. These are:
        - Tea;
        - Decaffeinated Tea;
        - Coffee;
        - Decaffeinated coffee;
        - Hot Chocolate;
        - Horlicks;
        - Bovril.
    - Increased the choice of snacks available during the day. These are made available to patients as they request them and routinely on drinks rounds. The snacks include:
        - Genoa cake;
        - Carrot and orange finger muffin;
        - Double chocolate wrapped muffin;
        - Twin pack of digestive biscuits;
        - Sweet assorted biscuits;
        - Gluten free biscuits and cakes.
    - Purchased and standardised the trolleys, flasks and cups available for patients on the wards so that a consistent and professional service is offered. This also means that fluid intake can be monitored more accurately.
- During National Nutrition and Hydration Week in March, the Trust used the opportunity to promote its menus and beverages to patients and the public;
- In addition to the stand (*pictured opposite*), a number of tea parties were held to celebrate Nutrition and Hydration Week with patients. This also provided the opportunity to promote the Trust's new menus amongst both staff and patients. In addition to the weekly menu, the Trust now offers long-

stay menus for those patients who will be staying for longer than 14 days, a healthy eating menu and other menus for specialist diets. A pureed or textured menu is also available for patients with specific chewing or swallowing needs;
- The Trust has a new catering service in the Medical Assessment Unit which ensures that a choice of hot food is available for patients who are admitted as an emergency;
- The Chefs and the Catering Manager regularly visit patients on the wards to discuss individual preferences and receive instant feedback on food choice and quality;
- Monthly ward audits are conducted to check that all patients are having their nutritional requirements assessed on admission. On average, this is undertaken within six hours in 94% of cases;
- The group has standardised protected meal times across the Trust to improve patient experience;
- The use of day rooms is being encouraged at meal times and this is particularly evident within rehabilitation areas. There are challenges within some areas that have no dayroom or the dayroom is used for a variety of purposes. The group is working with these areas to identify how this can be improved;
- Ward staff can contact volunteers for assistance if extra help is needed at meal times or on drink rounds.

What is planned for 2015/16?

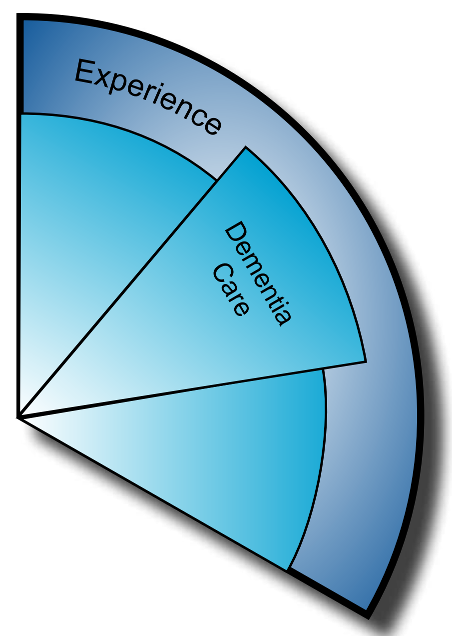
- An escalation process is being developed for wards to use should the number of patients requiring assistance with meals or drinks exceed the staffing allocation at that time;
- Current documentation is under review and will be revised to enable comprehensive care planning which will ensure patients get access to the extra help or special diet they may require. This will also include a specific care plan and a clearer beverage section will be included on our food intake charts;
- Work is taking place with the ward staff and catering department to continue ensuring the best possible choices of food are made available to patients;
- Awareness events are planned to make patients and staff more aware of menu options available;
- An audit is planned to monitor the frequency of drinks rounds on the wards.

Patient Feedback

"The food was very good with lots of lovely tea provided during the day. Many thanks."
Source: Inpatient Friends and Family Test

"There is always a good choice of food available. I've loved the fish and chips! Sorry to leave."
Source: Monthly Inpatient Survey

Experience: Supporting patients with dementia and their carers



Aim:

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

This is important because:

The Alzheimer's Society (2013) estimates that dementia affects over 670,000 people in England, yet only around 42% of people with dementia have a formal diagnosis. This is despite the fact that timely diagnosis can greatly improve the quality of life of the person with dementia and enable support to be provided to carers.

The Dementia Challenge was published by the Department of Health in 2012 and estimated that 25% of acute beds are occupied by people with dementia and that their length of stay is longer than people without dementia. Therefore, it is important that we ensure patients in hospital receive appropriate care and provide support to their carers.

What progress was made in 2014/15?

- The Trust consistently assessed more than 90% of patients aged 75 or over who were admitted as an emergency for memory problems;
- All patients who believe they have memory problems are referred to their GP for further assessment and possible review by a memory specialist and referred for an appropriate specialist clinical assessment;
- Every member of staff received a poster which identified the normal ageing process which enables them to recognise memory impairment as well as identify the key signs of delirium, depression and dementia;
- Staff have been trained in undertaking mental capacity assessments and best interest decisions on behalf of patients who lack capacity. This means that patients who lack capacity have equitable access to treatment and reasonable adjustments can be made to enhance the quality of care they receive;
- Flexible visiting hours have been introduced, with open visiting on some wards. Relatives and carers of patients with dementia all have the opportunity to access open visiting;
- The Trust is working with the Royal Voluntary Service to provide a befriending scheme for patients who are elderly and may have memory problems. The scheme encourages volunteers to befriend patients on the wards and engage in activities such as reading, playing card games and simply talking about the past;
- A Ward Worship initiative has also commenced which brings worship to patients who would otherwise not be able to access services. The patient and their families are invited to ward day rooms to receive prayer and sing hymns;
- A dementia care bundle, or pathway, has been introduced which includes a patient support plan and promotes a person-centred approach to patient care;
- The Dementia Specialist Nurse is visiting carer groups to gain valuable feedback from carers as to their experiences of hospital care from their perspective as well as that of the person they care for;
- Carer guidelines have been written and are available to staff on the Trust's Intranet. The

guidelines help ensure carers are included in decisions and are supported throughout the hospital journey. The Carers' Charter (*pictured previously on page 24*) is included within these guidelines;

- The Trust celebrated National Dignity Day by raising awareness of dementia care and end of life care. The day was supported by the Alzheimer's Society and the Dementia End of Life Practice Development Team from St Luke's Hospice. *Pictured above - staff visiting the Dignity Day information stand.*

What is planned for 2015/16?

- Audit the use of the dementia care bundle and its effect on improving outcomes for people with dementia;
- Attend focus groups where the Trust's approach to dementia care can be discussed with patients and carers;
- Continue staff education;
- Further develop the Royal Voluntary Service befriending scheme to include a 'home from hospital' component which will provide support when patients are discharged to their own home.

Patient Feedback

"This is our second time this year on Ward 15 and each time we have had positive support."

Source: Monthly Carer Survey

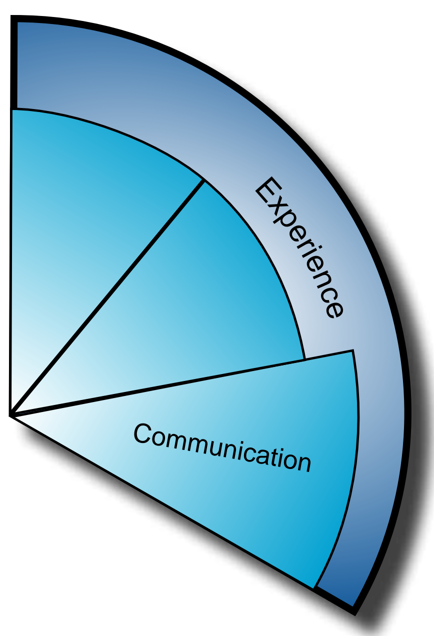
"Staff being helpful and giving information when I asked for it has made a massive difference to my experience."

Source: Monthly Carer Survey

"Staff were marvelous. My husband has improved so much during his stay: clean, well shaved, rosy cheeks etc. The care has knocked years off him!"

Source: Monthly Carer Survey

Experience: Improving Communication



Aim:

The Trust will ensure that staff improve their understanding of patients and their care needs. The Trust will use this knowledge to communicate effectively with patients and involve them in their care.

This is important because:

Inadequate communication is a frequent theme in feedback received from patients and families / carers. It is important that patients are included in discussions about care delivery, what this means and possible alternatives. This will reduce anxiety, ensure that patients feel involved in their care and help them to be better supported to manage their conditions.

The Patient Information Forum (2012) found that 80% of patients wanted to be more involved in decisions about their care and treatment. This aim will also support the principle of 'no decision about me, without me' as described by the Department of Health in 2012.

What progress was made in 2014/15?

The Trust has developed a communications working group which has representation from all areas. The work of the group has included the following:

- Introduction of new name badges for all staff (*example pictured below*);
- The roll out of the **#hellomynameis** campaign. This is a national campaign that was launched by Dr Kate Grainger who, following her experiences as a patient, highlighted that patients should expect **all** members of staff with whom they come into contact to introduce themselves by their name at the first contact. The Trust's progress with the campaign was shared at a national 'Always Events' conference in London in March 2015 where one of the Trust's Matrons was invited to speak;
- Ensuring patient bedside information folders are available to all patients which provides them and their visitors with useful information about the facilities available to them, such as information about food, drink, visiting arrangements and safety;
- Review of patient passports which provide specific information to staff about how to best care for individual patients with complex conditions;
- Review of patient information leaflets to ensure that they are up-to-date with the most useful information for patients, carers and relatives. Recently, a maternity bereavement booklet has been developed to help parents understand the grieving process and the practical considerations needed at such a difficult time;
- To improve the discharge experience for patients, a discharge communication checklist was rolled out across all ward areas to support patients', families' and carers' involvement leading up to discharge from hospital. Staff receive training in the discharge process as part of preceptorship and customer care training;
- Working with Ward Managers and ward staff to ensure that the name of the nurse and doctor responsible for each patient is clearly displayed on the patient board above the bed area so that patients and visitors know to whom they can direct any questions or concerns.

The Trust is delighted to see improvements in the National Inpatient Survey in relation to involvement in discharge planning. This year, 88% of patients said they felt involved in discharge decisions compared to 80% last year.

As complaints are received, they are examined for themes in relation to:

- Face-to-face communication (from a patient's point of view);
- Face-to-face communication (from a relative's point of view);
- Telephone communication;
- Communication between healthcare professionals;
- Written communication (from a patient's point of view);
- Written communication (from a relative's point of view).

What is planned for 2015/16?

- Consider how a patient communication book might be used and identify areas of the Trust where this approach can be piloted;
- Review and audit the use of the patient discharge checklist;
- Review the National Inpatient Survey results for 2014 in relation to communication and patient involvement and progress any required actions;
- Continue to monitor the use of patient information leaflets across the Trust and increase their use where necessary;
- Include the #hellomynameis campaign and principles in observation audits and report compliance;
- Develop passports for those patients where there would be a benefit to their care and communication. Passports already in place will be shared more widely across the organisation as good practice.

Patient Feedback

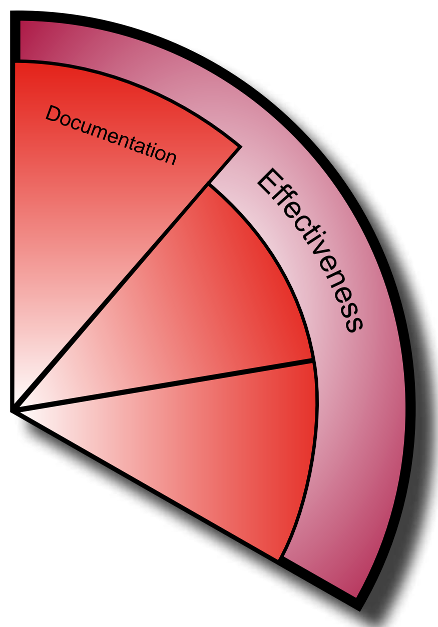
"From entering A&E, I had nothing but care and compassion from the stroke team. I was given all the information I required and my husband was kept up to date with my progress."

Source: National Inpatient Survey

"I was impressed with the vast amount of information and personal advice offered by Macmillan at Leighton Hospital".

Source: National Cancer Survey

Effectiveness: Improving documentation and reducing duplication



Aim:

The Trust will review and improve its paper documentation so that it is relevant, adds value to care and avoids duplication.

This is important because:

The NHS Institute for Innovation and Improvement (2012) published a report entitled 'Patients Not Paperwork' which included an online survey. 78% of nurses who responded stated that paperwork was difficult and time consuming to compete and 68% felt it added little value to patient care. The report concluded that the effective management of patient records can increase patient safety by reducing errors which generates a more efficient / accurate record.

Similarly, the Department of Health (2013) noted that a key to improving the working lives of staff is to reduce the volume of paperwork that they are required to complete so that they can focus the majority of their time with their patients.

What progress was made in 2014/15?

A group comprising of clinical and non-clinical members of staff has been developed and the following actions have been taken:

- A comprehensive review of the existing nursing and medical assessment proformas. This review involved the Clinical Audit Department to identify:
  - which parts contributed to knowing about patients to ensure they were cared for safely;
  - which sections were consistently completed well;
  - which elements showed duplication;
  - which parts of the documents reflected statutory requirements.

  The group used this work to decide which elements of the Trust's documentation required revision or removal;
- Documentation from other Trusts was studied to identify areas of good practice to discover the best way that patient information could be recorded;
- Identification of several key streams of work to review and develop a short stay nursing assessment booklet, a nursing care booklet for longer stay patients and a combined assessment document for medical and nursing staff.

The short stay nursing assessment booklet has been developed with the intention of reducing the amount of time spent recording assessments for low-risk patients and to quickly identify patients who are at risk of harm or deterioration while in hospital. Having identified the 'at risk' patients, a more detailed assessment can be conducted and appropriate preventative action taken.

A pilot version of the short stay nursing assessment booklet has been introduced in the Primary Assessment Area (*document pictured opposite*).

Audits of the new documentation will look at how much time the nursing staff are saving on completing documentation and the quality of the documentation. So far, nursing staff are reporting that they are able to spend more time with their patients as a result of the new booklet.

- An electronic nursing handover process has been standardised in the Division of Medicine and Emergency Care and is

being rolled out Trust-wide. This ensures staff pass on all the important information about patients in a standardised way. This makes it easier to highlight at risk patients;

- “Chemo Care” has been implemented. This is an electronic prescribing system specifically designed for chemotherapy. This will promote patient safety and efficient working, minimising delay for patients in the Macmillan Unit;
- Training for staff members in the clinical areas and medical records department has been progressed to promote the safe filing of patient records. This improves record keeping and retention of paper files which helps to promote the safety of patient care.

What is planned for 2015/16?

- The integrated medical and nursing assessment document will be completed and trialled for three months in the assessment areas. The purpose of this document will be to reduce the duplication of the patient assessment;
- Once the new documentation has been trialled and agreed a comprehensive staff training package will support roll out across the Trust;
- A specification for Trust-wide electronic prescribing will be completed. Once the specification has been agreed the tendering process for electronic prescribing will commence.

EPISODE DETAILS

Date of Arrival:	Time of Arrival:
Patient Location:	Source of Referral (GP/A&E/OPD/etc.):
On Call Consultant:	Acute Physician On Call:
Admitting Nurse (Print Name):	Nurse Signature:

PATIENT LABEL

Presenting Complaint

Allergies and adverse reactions

Details:

ICS System checked known infection? MRSA screen completed

Infection Status: Known MRSA YES NO; Known C Diff. YES NO

Preferred name:	Occupation (Current/Previous):
Age:	Religion:
Male / Female	Nationality:
Marital status:	First language:
Registered disabled: Yes / No	Specify disability:
Home tel. number:	Mobile tel. number:

UNIFIED DNACPR STATUS ON ADMISSION: YES / NO / UNKNOWN

IF DNACPR STATUS FORM IS PRESENT IS THIS WITH: PATIENT / IN CASE NOTES

NEXT OF KIN DETAILS (As discussed with admitting nurse)

Primary Contact	Secondary Contact
Name:	Name:
Relationship:	Relationship:
Address:	Address:
Tel. numbers: Home: Work: Mobile:	Tel. numbers: Home: Work: Mobile:
Aware of admission: Yes / No	Aware of admission: Yes / No
Can be contacted: Day / Night	Can be contacted: Day / Night

VITAL SIGNS ON ADMISSION - Time Completed (within 15 minutes of arrival)

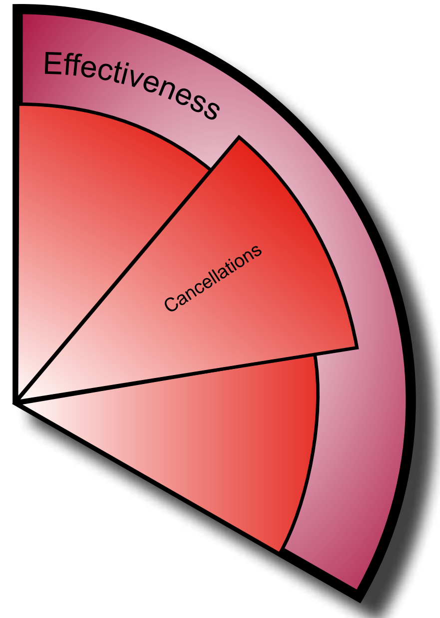
BP	Pulse	Temperature	Urinalysis Results
Respirations	Blood sugar	Height	
Oxygen Sats %	On room air / On O2	Weight	
Glasgow Coma /15	AVPU	BMI	Sample obtained Y/N

PREGNANCY STATUS:

Early Warning Score (EWS)		
	1-3	Action required as per EWS: YES / NO
	4-5	Medic informed of raised EWS / Bleep / Time
	6+	Outreach Nurse Informed of raised EWS / Bleep / Time

Pictured opposite: the short stay nursing assessment booklet that has been introduced in the Primary Assessment Area.

Effectiveness: Reducing cancellations



Aim:

The Trust will reduce the number of hospital-initiated outpatient clinic cancellations by 20% by 2016.

This is important because:

The National Outpatient Survey undertaken by the Care Quality Commission in 2011 highlighted that some of the Trust's patients are having their appointments cancelled and changed by the Trust. This is also reflected as one of the top five informal concerns raised by patients attending the Trust.

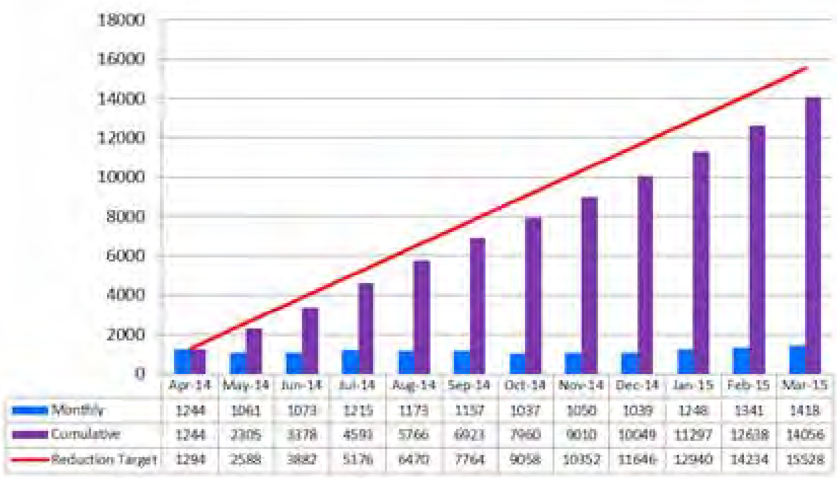
What progress was made in 2014/15?

Improvements have been made in the way that outpatient appointments are scheduled through the introduction of a partial booking system. This means that follow-up appointments are not booked more than six weeks in advance to reduce the risk of cancellations due to annual leave or study leave.

The Trust monitors the number of appointments each speciality cancels or re-books and challenges any specialities as required.

As a result of these interventions, hospital-initiated cancellations have reduced by 20% during 2014-15.

Chart 3 (*below*) shows the improvement that has been made over the year in reducing hospital-initiated cancellations.



	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Monthly	1244	1061	1073	1215	1173	1157	1037	1050	1039	1248	1341	1418
Cumulative	1244	2305	3378	4593	5766	6923	7960	9010	10049	11297	12638	14056
Reduction Target	1294	2588	3882	5176	6470	7764	9058	10352	11646	12940	14234	15528

Chart 3 - hospital-initiated outpatient cancellation rates

- Additional work has also been carried out to improve patient experience in the Outpatient Department. This has been renovated, the entrance doors have been replaced and the décor has a much lighter and brighter aspect;
- The timeslots allocated to patient appointments have been reviewed and adjusted to ensure they are of sufficient length to ensure that the consultation is effective. Providing the right time slot also helps to prevent excessive waits;
- Delays are sometimes impossible to avoid and, should they occur, outpatient staff have been instructed to keep patients fully informed of the nature of the delay and the expected wait times;
- Monitoring & information tools have been introduced which allow the clinical divisions to operationally manage their clinic utilisation, cancellation & did not attend (DNA) rates and take action to address any areas of concern. The number of patients who did not attend for their appointments has reduced over the past year. In addition, the Trust's figures demonstrate that its performance is even better than its peer (similar sized) organisations;
- The number of hospital-initiated cancellations and appointments that patients did not attend are displayed on the quality boards in the Outpatient Department.

What do we plan to do in 2015/16?

- Offer patients greater choice in the booking of their appointment and how they wish the Trust to communicate with them about that appointment;
- Introduce a facility to provide a text reminder service for patients with mobile phones;
- Develop an electronic room scheduling and booking-in system which will facilitate a reduction in waiting times caused by a lack of available clinic space. It will also make sure that the best use is made of the space that is available;
- Increase the number of bookings made via the Choose & Book service to give patients greater flexibility around their appointment times.

Patient Feedback

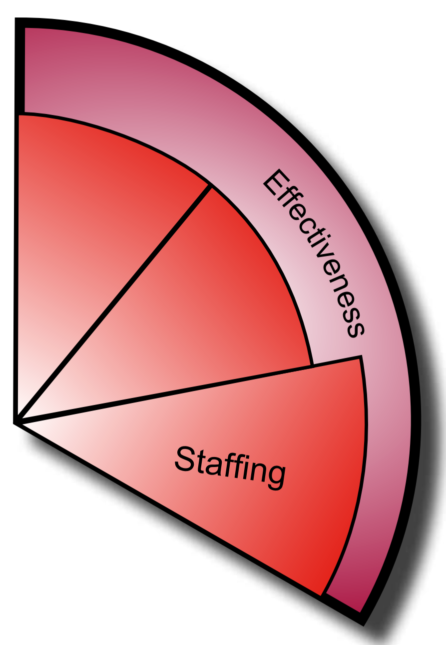
"Seen by GP and on the same day I got a call from the hospital with an appointment for the following day. Seen 15 minutes earlier than appointment time, saw the consultant and had the scan done by him in the clinic. Excellent service, friendly staff."

Source: NHS Choices

"I had to visit the cardiology department on six occasions in three weeks. Staff were great and made sure I wasn't kept waiting, they saw me early and grouped my appointments to save me time. Very helpful when I had to telephone to get advice and were always happy to help. Thanks for all your hard work, it really is appreciated".

Source: NHS Choices

Effectiveness: Appropriate nurse staffing levels



Aim:

The Trust will ensure it has appropriate levels of nurse staffing and skill mix that meet the needs of its patients.

This is important because:

Having the right people, with the right skills, in the right place at the right time is essential to ensure patients receive safe, appropriate, timely and responsive care (National Quality Board 2013).

What progress was made in 2014/15?

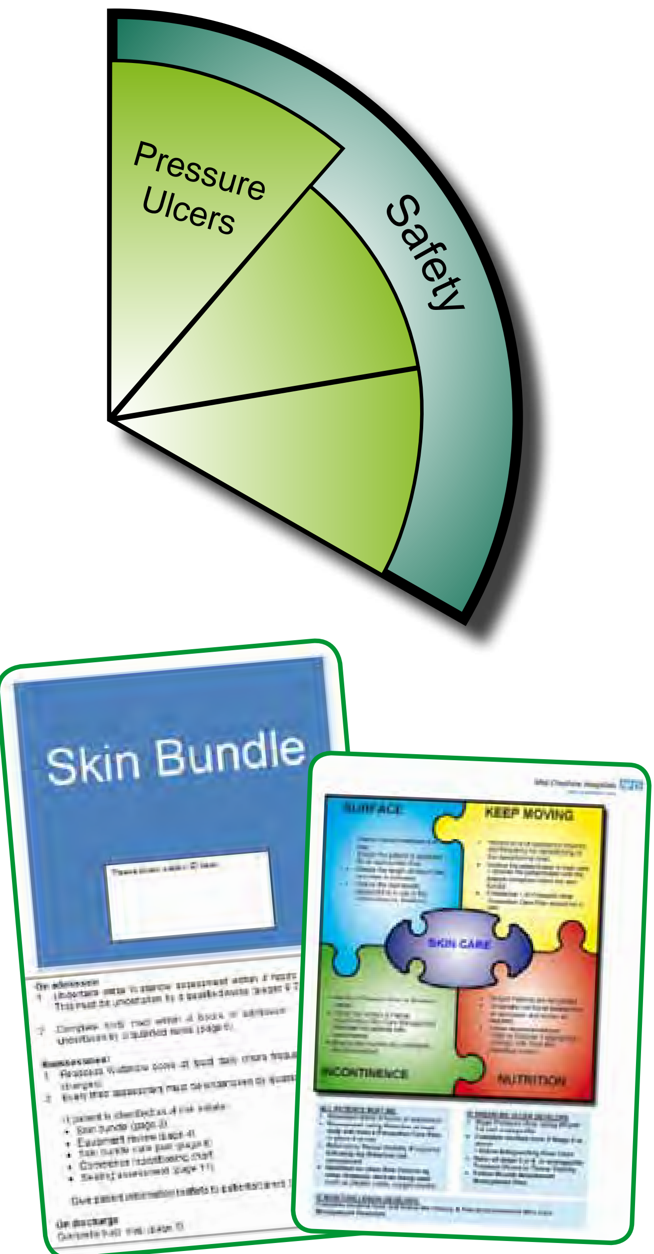
- Staffing boards were introduced on all inpatient wards (*Ward 12's board is pictured below*). These are updated on a daily basis. The boards are in a visible location for visitors to the ward. They have received positive feedback from both staff and patients and have also been complimented by other organisations. The boards were also viewed positively by the Care Quality Commission during their inspection of the hospital in October 2014;

- Nursing acuity assessment is undertaken across the hospital on a daily basis. This process assesses the needs of patients in a ward and determines how many staff are required. Every six months a formal review of the nurse staffing levels is undertaken by the Director of Nursing and Quality using the nursing acuity data and other quality data. Changes to staffing levels are agreed as a result of this review and a full report is discussed at the public Board meetings and published on the Trust's website;
- Staffing levels are reviewed daily and on a shift-by-shift basis. A clear escalation process is in place if staffing falls below plan or activity indicates increased levels of staffing are required;
- An active recruitment plan has focused on:
    - Review of current adverts;
    - Open evenings jointly held with the University of Chester;
    - Overseas recruitment;
    - Supporting local nurses to return to practice in acute care;
    - Review of shift patterns;
    - Funded secondment of Health Care Assistants to undertake nurse training.

What do we plan to do in 2015?

- Continue to review staffing levels on a daily basis
- Focus on recruitment: specifically return to practice and bespoke recruitment events
- Continue to report on nurse staffing to public Board meetings and publish the reports on the Trust's website.

Safety:
Reducing pressure ulcers



Aim:

The Trust will eliminate avoidable hospital-acquired pressure ulcers by 2016.

What is a pressure ulcer?

A pressure ulcer is "a localised injury to the skin and/or underlying tissue as a result of pressure, or pressure in combination with shear" (National Pressure Ulcer Advisory Panel 2009). There are five categories of pressure ulcer: stages 1, 2, 3, 4 and unstageable

This is important because:

In 2010, the Department of Health estimated the incidence of pressure ulcers in the UK equated to 29,800 acquired in hospital and 20,700 acquired in the community. Pressure ulcers are more likely to occur in patients who are malnourished, elderly, dehydrated, obese or have underlying medical conditions.

Pressure ulcers are challenging to treat and have a detrimental effect on a patient's health and wellbeing (McIntyre et al 2012).

What progress was made in 2014/15?

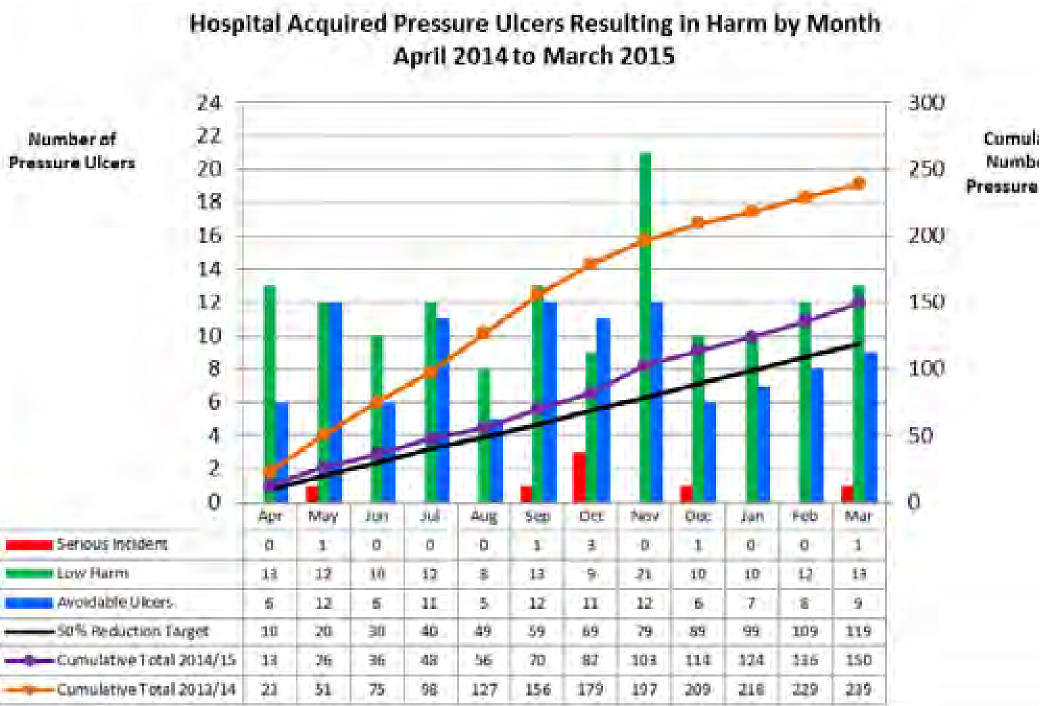
- A Skin Care Committee has been established with clinical representation from all divisions, which is chaired by an experienced Matron;
- During 2014/15, pressure ulcers were classed as avoidable or unavoidable. This was a new measurement for the Trust. To determine if the ulcer was avoidable or unavoidable, all cases of confirmed hospital-acquired pressure ulcers were reviewed by the Tissue Viability Nursing Service. A pressure ulcer is classed as unavoidable if all appropriate assessments and pressure-relieving interventions were in place for the duration of the patient's admission and there were no gaps within the healthcare documentation;
- In 2014/15, 105 of the 150 hospital acquired pressure ulcers were classed as avoidable which equates to 70%. The main reason for this relates to a lack of documentation in relation to patient repositioning. The Trust undertakes a Root Cause Analysis (RCA) for each stage 2 pressure ulcer. During 2014/15, the majority of these RCAs were undertaken within 45 days of the incident taking place. As part of this process the Ward Manager, ward staff and Tissue Viability Nurse review the patient and the documentation to look for any gaps in care. Once identified, these are actioned immediately;
- To improve documentation, an adult skin bundle (*pictured above*) has been implemented and reviewed following staff feedback;
- To ensure all patients receive timely assessment and interventions, a pressure ulcer assessment chart for the Emergency

Department and Planned Investigation Unit has been developed and implemented;

- A Tissue Viability Link Nurse programme has been developed to increase ward level teaching and sharing of best practice. Each Link Nurse attends four study days per year;
- A training programme has been developed for qualified and unqualified staff. This training is now delivered across the Trust by the Link Nurses. In 2014/15, 247 staff received pressure ulcer prevention training;
- Speciality specific skin bundles have been developed for the Critical Care department, neonatology and paediatrics;
- The Skin Care Committee has reviewed available pressure relieving aids and introduced pressure relieving gel pads;
- A 'Lessons Learned' poster, called an episode of care, is now completed by the ward staff for each confirmed hospital-acquired pressure ulcer. This is to ensure that all staff within the area learn from the incident. Lessons Learned posters are also shared across the organisation if a patient develops a pressure ulcer which is more severe than a stage 2;
- Patients and carers are provided with information leaflets that are included in the skin bundles and are given to the patient and / or their carer on admission;
- Chart 4 (*pictured opposite*) shows the number of hospital-acquired pressure ulcers for 2014/15 compared to 2013/14. There has been a 37% reduction in hospital acquired pressure ulcers this year. The staff are actively encouraged to report all potential pressure ulcers to ensure that all incidents are learned from to prevent recurrence.

What is planned for 2015/16?

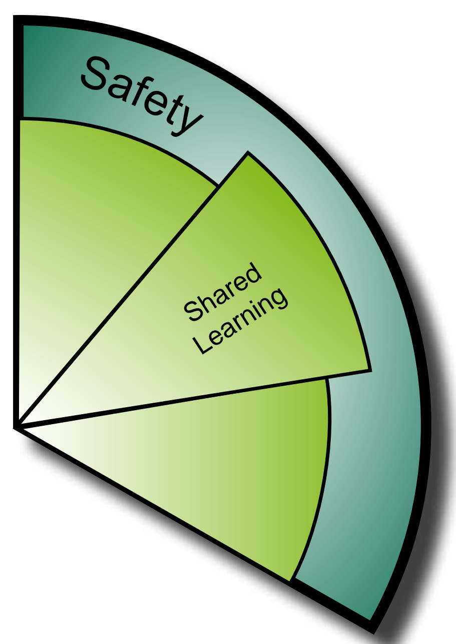
- Implementation of the revised adult skin bundle;
- Implementation of the speciality specific skin bundle;
- Audit the use of the skin bundles within the Trust;
- Continue education through the Tissue Viability Link Nurse programme;
- Recruit an additional part time Tissue Viability Nurse to work closely with ward-based staff to further reduce pressure ulcers.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Serious Incident	0	1	0	0	0	1	3	0	1	0	0	1
Low Harm	13	12	10	12	8	13	9	21	10	10	12	13
Avoidable Ulcers	6	12	6	11	5	12	11	12	6	7	8	9
50% Reduction Target	10	20	30	40	49	59	69	79	89	99	109	119
Cumulative Total 2014/15	13	26	36	48	56	70	82	103	114	124	136	150
Cumulative Total 2013/14	23	51	75	98	127	156	179	197	209	218	229	239

Chart 4 – hospital acquired pressure ulcers.

Safety: Sharing learning from feedback and incidents



Aim:

All clinical staff will work together to respond to feedback from patients and carers and to learn from incidents that occur. The Trust will then ensure it responds to such learning and embeds this into practice.

This is important because:

In 2011, the Health Service Ombudsman and Care Quality Commission (amongst other organisations) recognised the importance of feedback to help drive improvement in healthcare and strengthen the quality of services for patients and the public.

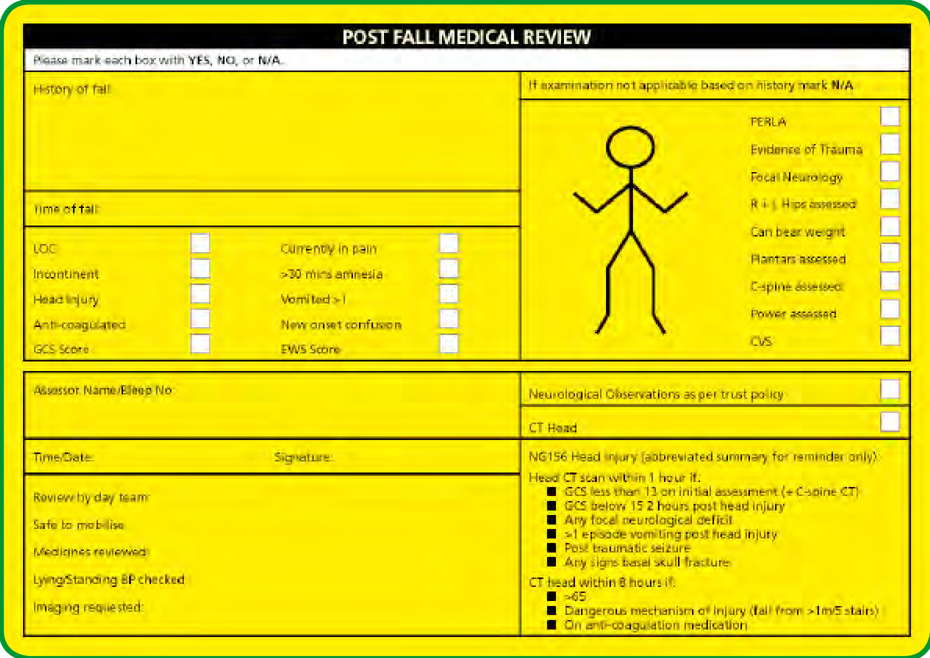
In the Francis Report (2013), it was reported that there was not enough priority given to learning and warning signals available from feedback which could lead to improved patient experiences.

What progress was made in 2014/15?

- The Trust's Complaints, Legal and Incidents Committee continued its work to look for trends between incidents, complaints, claims and inquests and instigated reviews when trends were identified. An example of this work was a review of missed fractures in Accident and Emergency that was commissioned in February. This report identified that the Trust was not an outlier in relation to missed fractures and that patients were always followed-up appropriately;
- Following a patient safety incident, a retrospective review of the event is undertaken via a Root Cause Analysis. The RCA is undertaken to identify how and why an incident occurred. The analysis is then used to identify areas for change, recommendations and sustainable solutions to minimise reoccurrence.

Following an RCA, action plans are developed and monitored locally by the Divisions and by the Integrated Governance Team to ensure that the required actions are fully implemented.

An example of an action from an RCA investigation was the development of a post fall sticker following an inpatient fall. This incident was investigated and an opportunity to improve post fall care was identified. The sticker (*pictured below*) is placed in the patient's healthcare record to ensure appropriate actions are taken for post fall care.



POST FALL MEDICAL REVIEW

Please mark each box with **YES, NO, or N/A.**

History of fall:

Time of fall:

LOC	☐	Currently in pain	☐
Incontinent	☐	>30 mins amnesia	☐
Head injury	☐	Vomited >1	☐
Anti-coagulated	☐	New onset confusion	☐
GCS Score	☐	EWS Score	☐

If examination not applicable based on history mark **N/A**

PERLA	☐
Evidence of Trauma	☐
Focal Neurology	☐
R + L Hips assessed	☐
Can bear weight	☐
Plantars assessed	☐
C-spine assessed	☐
Power assessed	☐
CVS	☐

Assessor Name/Bleep No:

Neurological Observations as per trust policy ☐

CT Head ☐

Time/Date: Signature:

Review by day team:

Safe to mobilise:

Medicines reviewed:

Lying/Standing BP checked:

Imaging requested:

NG156 Head injury (abbreviated summary for reminder only):

Head CT scan within 1 hour if:
- GCS less than 13 on initial assessment (+ C-spine CT)
- GCS below 15 2 hours post head injury
- Any focal neurological deficit
- >1 episode vomiting post head injury
- Post traumatic seizure
- Any signs basal skull fracture

CT head within 8 hours if:
- >65
- Dangerous mechanism of injury (fall from >1m/5 stairs)
- On anti-coagulation medication

- Lessons learned are shared across the organisation following all incidents that result in a root cause analysis being undertaken or where trends in incidents are identified. The lessons learned template has been reviewed in 2014 to include greater detail on how the incident has impacted on the patient and the organisation;
- A further document called an episode of care is produced locally by the department staff enabling new learning from the incident to be shared with the immediate team;
- The Trust has a 'Being Open' policy and feedback from incidents is shared with patients and / or their carers following all incidents that result in serious or catastrophic harm;
- All staff receive incident feedback from incidents that they report through the online incident reporting system 'Ulysses Safeguard'. This is a mandatory field within the incident reporting system that must be completed by the manager investigating the incident;
- Feedback from patients continues to be measured through a variety of methods, including local patient surveys, paper-based surveys, patient interviews and an electronic touch screen kiosk;
- Patient stories are undertaken on a regular basis and shared at Board and ward level. For example, the following story has been discussed with staff to reflect on how their communication about operational issues can be perceived by patients:

  "A patient attended for a day case procedure and praised the care of the medical staff and their team working. Whilst he appreciated there was a busy throughput of patients, he felt at times there was not the air of calm he would have preferred. On occasions the patient overheard conversations between staff about issues they were resolving, such as locating records or locating staff;"

- A survey of complainants was undertaken in 2014 to seek views on how well they feel their concerns have been handled and whether they feel satisfied with action taken. The survey highlighted that patients had not always been offered updates on the changes made as a result of the complaint. The Trust's Complaints Review Panel is progressing an action plan to address this;
- Staff are trained to investigate incidents and complaints to ensure that they are thoroughly investigated and appropriate actions are taken to prevent recurrence. Further training was provided in 2014 in relation to investigating serious incidents.

What is planned for 2015/16?

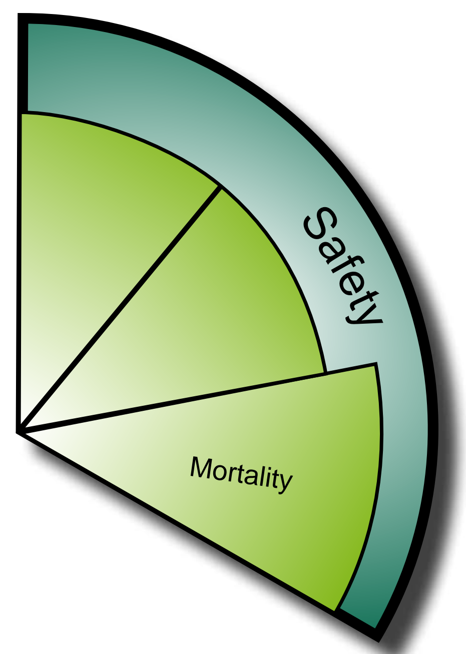
- The Trust has reviewed different ways to share lessons learned, including the production of podcasts, and these new ways will be used to share future lessons learned following incident investigations;
- The Trust is undertaking a safety culture survey to assess its safety culture. As part of this survey, staff will be asked if they feel the Trust learns from its incidents and how improvements can be made.

Patient Feedback

"I recently needed the help of the customer care team, but I wasn't sure how I would find their help. I found them 100% helpful. They were fantastic, I was so made up with them. Nothing was ever to much for them and they called when they said they would getting back to me super quick. Thanks girls."

Source: NHS Choices

Safety:
Reducing Mortality Rates



Aim:

The Trust will reduce its mortality rates each quarter so that they reach expected levels as measured by the Summary Hospital-Level Mortality Indicator (SHMI).

What is SHMI?

The SHMI is a ratio of the observed deaths to the expected number of deaths for a Trust. The expected deaths are based on a number of factors which include age, gender and how a patient was admitted to a Trust.

This is important because:

Measuring mortality rates is important because a high mortality rate may indicate problems with the quality and safety of care provided within an organisation (Care Quality Commission, Intelligent Monitoring, 2013).

What progress was made in 2014/15?

The Trust has achieved a quarterly reduction in its mortality rates to reach expected levels as measured by SHMI. The latest publication for the period April 2013 to March 2014 demonstrates that the Trust's SHMI has continued to reduce and remains within the 'as expected' range.

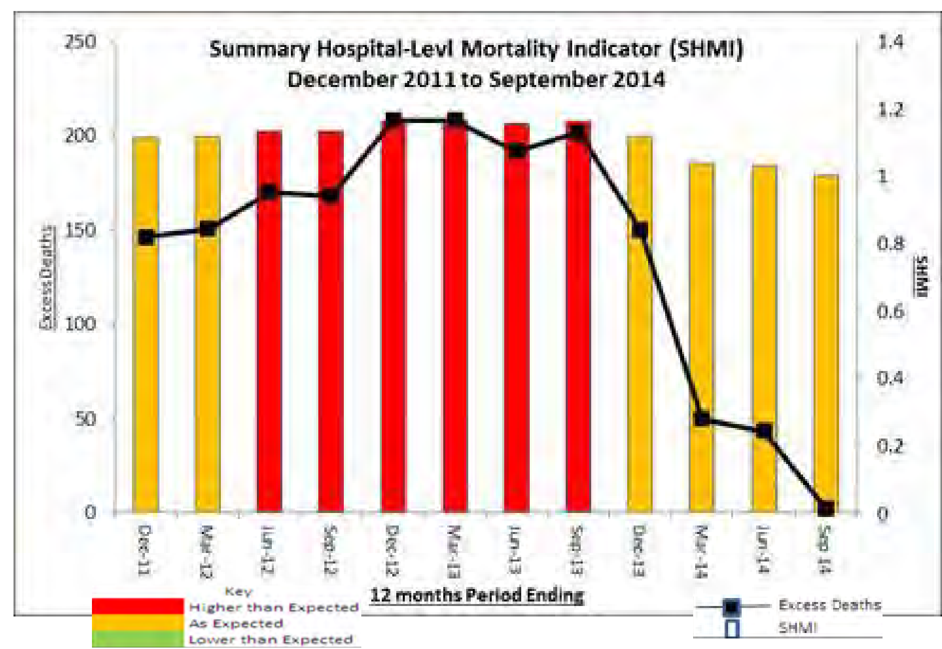


Chart 5 : The Trust's SHMI

- The Trust has a well-established Hospital Mortality Reduction Group (HMRG) led by the Medical Director. This group drives mortality reduction improvement plans within the Trust whilst supporting the clinical divisions to understand their mortality rates and implement their own mortality reduction action plans;
- The Trust developed a reducing in-hospital mortality driver diagram and action plan. The action plan incorporated the recommendations made by the Advancing Quality Alliance (AQuA), following their deep dive review into mortality rates across the local health care community;
- The Medical Director and the Clinical Lead for Patient Safety chair a weekly mortality case note review group where senior clinicians review deaths that have occurred across the Trust in the previous week. Cases where concerns have been highlighted are then referred for an in-depth mortality case note review. The results of the in-depth case note reviews are presented at the HMRG and learning is disseminated to the clinical teams;

- The clinical divisions have introduced divisional Reducing Mortality Groups that are part of the overall Trust governance structure and feed into the Divisional Boards and the HMRG. These local groups review their divisional mortality data and implement local action plans where trends are highlighted;
- Mortality dashboards have been developed and will be used by clinical teams to drive forward improvement action plans at a speciality level;
- A Clinical Pathway Action Group has been formed. Their responsibilities include reviewing high mortality groups and ensuring that care bundles/pathways are in place;
- An education programme on mortality, quality and patient outcomes has been developed within the organisation. Workshops, which are scenario-based, have been held and training delivered to medical staff of all grades. This training has been extended to include qualified nursing staff and will continue as a rolling programme to ensure all relevant staff have the opportunity to undertake this training;
- The care plan for End of Life care was launched across the organisation in June 2014. A training programme led by the Macmillan Care Nurses is being rolled out across the organisation. The care plan for End of Life care will ensure that patients have an individualised plan of care in place at the end of their life. End of Life care is reviewed as part of the mortality case note reviews and gaps in care highlighted to the clinical teams.

What is planned for 2015/16?

- Continue to implement the actions from the reducing in-hospital mortality action plan to sustain an on-going reduction in the mortality rates within the Trust.
- Implementation of divisional strategies to ensure seven-day working is in place across the organisation for all patients.
- Continue to disseminate the learning from the deep dive case note reviews.

Patient Feedback

"I would like to record my sincere thanks to the staff of the hospital, particularly on Ward 7, for their professionalism and kindness shown to both my wife and myself prior to her recent passing away, in particular in allowing me to attend her outside of normal visiting hours for the entire time she was in the ward. The nursing staff and doctors were exemplary throughout the sad period."

Source: NHS Choices

"On two occasions (Ward 5 in June 2014, Ward 7 in August 2014) our son was treated for aspiration pneumonia. During this time he was also diagnosed with secondary liver carcinoma of unknown primary. All his family would like to thank all the professional staff on both wards for the excellent care and treatments given to him during this difficult time. Although he could not be cured, the kindness of the nursing staff, particularly in easing his pain, was much appreciated."

Source: NHS Choices

Statements from external agencies

South Cheshire and Vale Royal Clinical Commissioning Groups

NHS South Cheshire CCG and NHS Vale Royal CCG welcome this opportunity to review and comment on Mid Cheshire Hospitals NHS Foundation Trust (MCHFT) Quality Account for 2014/15.
We confirm that we have reviewed the information contained within the Quality Account and this reflects a fair, representative and balanced overview of the quality of care in MCHFT and includes the mandatory elements required.

The Trust have adopted a Quality and Safety Improvement Strategy which has provided a new set of priorities for the year, focusing on patient care and safety, building on the work undertaken during 2013-14. The priorities identified in the Quality Account have a strong patient focus and have produced improvements in patient experience and outcomes.

The Quality Account includes evidence of achievements. These include a particular focus on Nutrition and Hydration. This initiative was implemented following patient feedback and includes standardising protected meal time, offering variety and choice of food/drinks on all wards.

The focus in supporting patients with dementia and their carers is demonstrated through ongoing reviews. The introduction of flexible visiting is among the wide range of initiatives.

MCHFT has embedded the rollout of the 'hello my name is….' campaign, across the Trust, which is commendable.

It is pleasing to see that the Trust has demonstrated significant improvements in the reduction of hospital acquired pressure ulcers. Work has been undertaken to improve documentation and implement an Adult Skin Bundle, which includes timely assessment and interventions.

We commend the Trust on the recent CQC inspection which received a rating of 'GOOD', this reflects the focus of whole Trust on quality and patient safety as a key priority. The Trust was specifically congratulated for the reduction in hospital mortality rates which has been a significant achievement.

While the Quality Account reflects the successes that MCHFT have achieved, there has been non achievement in some of the Advancing Quality Commissioning for Quality and Innovation (CQUIN) schemes and local quality indicators. It would have been beneficial to have information included that detailed the actions planned to improve performance in 2015/16.

Engagement with patients, carers and stakeholders is well represented in the Quality Account. Of particular note is the dedicated sections given to the Friends and Family Test, NHS Choices and Patient and Public Involvement. This section clearly shows how our local population can provide feedback to MCHFT about their experiences of care, which has led to quality improvement initiatives.

We support the priorities identified for improvement in 2015/16 and look forward to maintaining a strong commissioning relationship with MCHFT. We are committed to working in a collaborative manner to achieve positive experiences for our local population with a provider that has the continued high quality delivery of health care at its core.

Healthwatch Cheshire East and Healthwatch Cheshire West

Both Healthwatch Cheshire East and Healthwatch Cheshire West welcome the opportunity to comment on the Mid Cheshire Hospitals NHS Foundation Trust Quality Account 2014/2015.

Our respective organisations act as the champion for the voice of the consumer and as such our comments and views on this report focus on how the Trust have involved and listened to their consumers views (patients and their families).

Healthwatch have received many positive stories from the community praising the treatment and care received from the staff and volunteers at the Trust. We recognise that the Trust and the services it delivers are valued by the local community.

In particular we want to highlight comments we have had praising the role of volunteers on the wards supporting the clinical staff to provide additional care to patients.

"At Leighton Hospital they have started having male volunteers to help shave the older male patients. This works really well and the male patients are really happy about it."

The quality account clearly demonstrates a wide range of feedback from patients across a variety of services, with clear actions from the feedback indicating how the issues raised by the patients would be actioned and addressed. We welcome the steps highlighted by the Trust to ensure that they provide care that is responsive to the personal needs of the patients. When there was a lack of staff on wards or very busy staff, we have been told that the impact of this on patients and their families makes them feel worried, concerned and distressed.

We want to congratulate the Trust on the recent CQC inspection rating of 'Good' and the steps they have taken to reduce the mortality rates. We value the strong working relationship we have with the Trust and look forward to working with the Trust during 2015-2016 to enable our diverse communities to have a powerful voice helping to shape and improve these services for the future.

Cheshire East Council Health and Adult Social Care Overview and Scrutiny Committee

Thank you for contacting the Committee in relation to the Mid Cheshire Hospitals NHS Foundation Trust's Quality Account for 2014/15. The Council has had various health scrutiny arrangements over the years but each committee that has been in place has always valued the opportunity to consider the quality accounts of key local NHS service providers. However on this occasion the Health and Adult Social Care Overview and Scrutiny Committee will not be able to provide any formal comments on any Quality Accounts.

As you will be aware Cheshire East Council is holding elections on 7 May 2015 at the same time as the General Election, as are many other local authorities around the country. This means that it will not be possible to hold a meeting of the Committee, to consider any Quality Accounts and prepare any feedback

for inclusion in the final reports, in the required timeframes.

Following the elections a new committee membership will be agreed at the Annual Meeting of the Council on 27 May 2015. The Scrutiny Officer will supply this new membership with copies of key NHS Trust Quality Accounts for information. Any issues that Councillors identify from the Quality Accounts will be given consideration by the Committee in the summer. I am sure that in this case NHS Trusts will engage fully with the Committee.

Although the Health and Adult Social Care Overview and Scrutiny Committee will be unable to give consideration to the Quality Account in May I would like to note that some of our members recently took part in a Joint Health Overview and Scrutiny Committee with Cheshire West and Chester Council to consider the Trust's mortality data and other performance statistics, and the CQC's recent inspection. The Joint Committee was pleased that the CQC rated the Trust as Good and I hope that the Quality Account is able to reinforce this.

Yours Sincerely

Councillor Margaret Simon
Chairman of the Health and Adult Social Care Overview and Scrutiny Committee

Governors

Mid Cheshire Hospitals
NHS Foundation Trust

The 2014/15 Quality Account was shared with Governors for comment and, as Governor member of the Quality and Safety Improvement Strategy Committee, I am pleased to offer an account of Governor views and feedback.

As has been the case in previous years, the Quality Account offers a fair and balanced assessment of the performance of the Trust. The is rightly a focus upon the notable successes achieved in year and a positive account of the areas where improvements have been achieved, however, this is balanced with an honest accounting of those areas where improvement is still required or where targets have not been met. It is pleasing to note that the former substantially outweigh the latter. What's more, where challenges lie these are fully recognised and appropriate strategies are evidenced.

The contents of the Quality Account tally well with the regular monitoring of performance provided to, and discussed with, Governors both through the Council of Governors' meetings and the various committees and groups upon which we sit. Governors can also offer support to the analyses presented based upon their experiences and interactions with patients, carers and other constituencies. As Governors, we afforded access to relevant information to fulfil our function and are proactively engaged in the development of strategy to ensure the ongoing achievement.

2014/15 has seen a number of excellent achievements, not least amongst which are the CQC inspection outcome. This reflects very well the hard work and care offered at all levels of the organisation. National awards have also been achieved by the Midwifery service. This later coming after the recent investments in facility enhancement and demonstrates the joined up approach to enhancing both the physical estate of the Trust but also to service improvement within the new spaces. It will be interesting to monitor whether similar improvements can be achieved in other areas to have benefitted from more recent estates redevelopment.

At the time of last year's report the Trust was particularly challenged by a higher than expected mortality rate as measured by SHMI. This was addressed, in part, by some modifications to data coding to correct a skewing arising as an unintended consequence of a reporting convention. However, and in keeping with the Trust's attention to quality enhancement, recommendations provided by AQuA and the HMRG have been carried through and resulted in real improvements in mortality beyond those

arising from the reporting changes.

On behalf of the Council of Governors I am happy to endorse this Quality Account and to commend the Trust for their continuing attention to the delivery of the best quality care possible.

Professor Neil Fowler
Governor

Statement of Directors' responsibilities in respect of the quality report

The Directors are required under the Health Act 2009 and the National Health Service Quality Accounts Regulations to prepare quality accounts for each financial year.

Monitor has also 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 2014/15

- The content of the quality report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2014 to March 2015
    - Papers relating to quality reported to the Board over the period April 2014 to March 2015
    - Feedback from the Commissioners dated 15 May 2015
    - Feedback from Healthwatch Cheshire East dated 22 May 2015
    - Feedback from Healthwatch Cheshire West dated 2 June 2015 (received after sign-off from the Board of Directors, but included in this document as a joint statement with Healthwatch Cheshire East)
    - Feedback from the Cheshire East Council Health and Adult Social Care Overview and Scrutiny Committee dated 19 May 2015
    - Feedback from Governors dated 14 May 2015
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 12 June 2014
    - The 2014 national patient surveys
    - The 2014 national staff survey
    - The Head of Internal Audit's annual opinion over the Trust's control environment dated xx May 2015
    - Care Quality Commission (CQC) intelligent monitoring report dated December 2014.

- The quality report presents a balanced picture of the Trust's performance over this period;

- 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 and is subject to appropriate scrutiny and review; and

- The quality report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations published at www.monitor.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the quality report (available at www.monitor.gov.uk/annualreportingmanual).

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, signed 26 May 2015

Dennis Dunn MBE
Chairman

Tracy Bullock
Chief Executive

Dr Paul Dodds
Medical Director and
Deputy Chief Executive

Denise Frodsham
Chief Operating Officer

Julie Smith
Director of Nursing
and Quality

Mark Oldham
Director of Finance

Wendy Marston
Interim Director of Service
Transformation and Workforce

Dame Patricia Bacon
Non-Executive Director

John Barnes
Non-Executive Director

Mike Davis
Non-Executive Director

David Hopewell
Non-Executive Director

Ruth McNeil
Non-Executive Director

Appendices

Appendix 1 - Glossary and Abbreviations

Terms	Abbreviation	Description
Acute Myocardial Infarction	AMI	AMI is commonly known as a “heart attack” which results from the partial interruption of the blood supply to a part of the heart which can cause damage or death to the heart muscle.
Advancing Quality	AQ	A programme which rewards hospitals which improve care in a number of key areas such as heart attacks, pneumonia, hip and knee replacements and heart failure using research to determine the best care interventions.
Advancing Quality Alliance	AQUA	A membership body which aims to improve the quality of healthcare in the North West.
Alzheimer’s Society		A UK Alzheimer’s charity
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.
British Association for Parentaral and Enteral Nutrition.	BAPEN	A Charitable Association that raises awareness of malnutrition
C.A.S.P.E Healthcare Knowledge Systems	CHKS	An independent company which provides clinical data/ intelligence to allow NHS and independent sector organisations to benchmark their performance against each other.
Care Quality Commission	CQC	The independent regulator of health and social care in England.
Chronic Obstructive Pulmonary Disease	COPD	A description for lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease.
Clinical Commissioning Group	CCG	The GP led commissioning body who buy services from providers of care such as the hospital.
Clinical Nurse Specialist	CNS	Clinical specialist nurses work in a variety of acute and community settings, specialising in particular areas of practice.
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.

Terms	Abbreviation	Description
College of Emergency Medicine	CEM	A medical college to advance education and research in emergency medicine
Commissioner		A person or body who buys 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.
Comparative genomic hybridization	CGH	A method for comparing DNA samples
Cost Improvement Plan	CIP	A cost improvement plan aims to save money but also, through long-term plans to transform clinical and non-clinical services, improves patient care, satisfaction and safety.
Critical Care Unit		A specialised clinical area providing intensive care medicine.
Data for Head and Neck Oncology	DAHNO	The audit collects data from hospitals within England and Wales which diagnose and treat patients with cancer of the larynx and oral cavity.
Department of Health	DoH	A department of government that leads, shapes and funds health and care in England.
Diabetes UK		A UK Diabetes charity
Duty of Candour		Candour is defined in the Francis' report as: 'The volunteering of all relevant information to persons who have or may have been harmed by the provision of services, whether or not the information has been requested and whether or not a complaint or a report about that provision has been made.'
Enteral Nutrition	EN	The delivery of a nutritionally complete feed, containing protein, carbohydrate, fat, water, minerals and vitamins, directly into the stomach
Epilepsy 12		Epilepsy12 is a national clinical audit, established in 2009, with the aim of helping epilepsy services, and those who commission health services, to measure and improve the quality of care for children and young people with seizures and epilepsies
Falls and Fragility Fracture Audit Programme	FFFAP	A national clinical audit run by the Royal College of Physicians designed to audit the care that patients with fragility fractures and inpatient falls receive in hospital and to facilitate quality improvement initiatives.

Terms	Abbreviation	Description
Foundation Trust		An NHS Trust in England that has been created to devolve decision-making from central government control to local organisations and communities so they are more responsive to the needs and wishes of their local people. NHS Foundation Trusts have members drawn from patients, the public and staff and are governed by a board of governors comprising people elected from and by the membership base.
Francis Report 2013		This report followed a public inquiry that examined the causes of the failings in care at Mid Staffordshire NHS Foundation Trust between 2005-2009. The report makes 290 recommendations.
Friends and Family Test	FFT or F & F Test	Introduced in 2013 patients are asked whether they would recommend hospital wards, A&E departments and maternity services to their friends and family if they needed similar care or treatment.
Gastro Intestinal	GI	The whole digestive tract (gut).
Genito Urinary medicine	GUM	The area of medicine that deals with sexual health.
Health and Social Care Information Centre	HSCIC	The national provider of information, data and IT systems for health and social care
Health Protection Agency	HPA	The HPA provides advice and information to protect the public in England from threats to health from infectious diseases and environmental hazards. In April 2013, the HPA became part of Public Health England.
Healthcare Associated Infections	HCAI	A generic name to cover infections like MRSA and C-diff.
Heart Failure	HF	Heart failure is a condition caused by the heart failing to pump enough blood around the body at the right pressure
Hospital Mortality Reduction Group	HMRG	Group responsible for providing information and assurances to the Board of Directors of Mid Cheshire Hospitals NHS Foundation Trust that it is safely managing all issues relating to hospital mortality
Inflammatory bowel disease	IBD	Inflammatory bowel disease (IBD) encompasses ulcerative colitis and Crohn's disease. These are chronic diseases that involve inflammation of the gastrointestinal tract.
Integrated Care System	ICS	The system used by the Trust to record patient activity.
Intensive Care National Audit and Research Centre: Case Mix Programme	ICNARC CMP	A clinical database holding over 18 years data relating to patient outcomes from adult, general critical care units in England, Wales and Northern Ireland.

Terms	Abbreviation	Description
Left ventricular function	LV Function	The left ventricle (lower chamber) of the heart is the main pumping chamber of the heart.
Medicines and healthcare products regulatory Agency	MHRA	The branch of government that regulates medical devices and medicines.
Mental Capacity Act	MCH	A law to support and enhance the rights of people who may lack mental capacity
Methicillin-Resistant Staphylococcus Aureus	MRSA	Staphylococcus aureus is a bacterium which is often found on the skin and in the nose of about 3 in 10 healthy people. An infection occurs when the bacterium enters the body through a break in the skin. A strain of this bacterium has become resistant to antibiotic treatment and this is often referred to as MRSA.
Mid Cheshire Hospitals NHS Foundation Trust	MCHFT	The organisation which runs Leighton Hospital, Crewe, Victoria Infirmary, Northwich and Elmhurst Intermediate Care Facility, Winsford
Monitor		This is the regulator of NHS Foundation Trusts. It is an independent body detached from central government and directly accountable to Parliament.
Mothers and Babies: reducing Risk through Audits and Confidential Enquiries across the UK	MBRRACE-UK	An organisation which investigates maternal deaths, still births and infant deaths to support the delivery of safe, equitable, high quality, patient centred maternal, newborn and infant health services.
Multi Disciplinary Team	MDT	The team of professionals involved in a patient's care.
Multiple Sclerosis Society		A UK Multiple Sclerosis charity
Myocardial Ischaemia National Audit Project	MINAP	A national audit to enable hospitals measure their performance against targets and improve the care of patients following a heart attack.
N-acetylcysteine	NAC	A medication used to help treat paracetamol overdoses
National Bowel Cancer Audit Programme	NBOCAP	An audit to measure care and clinical outcomes, enabling comparisons between hospitals and bringing about improvements where necessary
National Cardiac Arrest Audit	NCAA	National clinical audit of in-hospital cardiac arrests with the aim of improving resuscitation care and patient outcomes.
National Confidential Enquiry into Patient Outcomes and Death	NCEPOD	A review of the management of patients through confidential surveys and research. The results are used to improve the quality of patient care.
National Diabetes Audit	NDA	A national audit looking into the care of people with diabetes in primary and secondary care
National Emergency Laparotomy Audit	NELA	An audit of the quality of care received by patients undergoing emergency laparotomy.

Terms	Abbreviation	Description
National Inpatient Diabetes Audit	NaDIA	An audit of diabetes inpatient care in England and Wales.
National Institute for Health and Care Excellence	NICE	NICE provide independent, authoritative and evidence-based guidance on the most effective ways to prevent, diagnose and treat disease and ill health, reducing inequalities and variation.
National Joint Registry	NJR	The NJR collects information on all hip, knee, ankle, elbow and shoulder replacement operations to monitor the performance of joint replacement implants.
National Lung Cancer Audit	NLCA	An audit of the care delivered during referral, diagnosis, treatment and outcomes for people diagnosed with lung cancer and mesothelioma.
National Neonatal Audit Programme	NNAP	An audit programme established to inform good clinical practice in aspects of neonatal care by auditing national standards.
National Oesophago-Gastric Cancer Audit	NAOGC	An audit of care and the outcomes of treatment for all oesophageal gastro cancer patients, both curative and palliative.
National Paediatric Diabetes Audit	NPDA	A national programme designed to improve care provided to children with diabetes and that of their families.
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 including: Inpatients, Outpatients, Emergency care and Maternity care.
National Pressure Ulcer Advisory Board	NPUAP	The voice for improved patient outcomes in pressure ulcer prevention and treatment through public policy, education and research
National Quality Board	NQB	The NQB brings together organisations with an interest in improving quality in the NHS.
National Reporting and Learning System	NRLS	National database that allows learning from reported incidents. All Trusts upload their incident reporting data to this database on a weekly basis.
NHS England		An NHS body to improve the health outcomes for people in England
NHS Institution of Improvement and Innovation	NHSiq	Now NHS Improving Quality this organisation is the driving force for improvement across the NHS in England
Non alcoholic steato-hepatitis	NASH	A common liver disease that occurs in people who drink little or no alcohol.
Non-Executive Director	NED	The non executive director holds the executive directors to account for the delivery of the trusts strategy ensuring that the Board acts in the best interests of its patients and the wider community.
Parenteral Nutrition	PN	Parenteral feeding is the administration of nutrients into the veins.

Terms	Abbreviation	Description
Parkinsons UK		A UK Parkinsons charity
Parliamentary and Health Service Ombudsman	PHSO	The PHSO provides 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.
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.
Payment by Results	PbR	The payment system in England under which commissioners pay healthcare providers for each patient seen or treated, taking into account the complexity of the patient's healthcare needs.
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.
Quality Effectiveness and Safety Committee	QuESt	A subcommittee of the board of directors that monitors Quality and Safety in the Organisation.
Referral to Treatment	RTT	The time from referral to a specialist consultant to first definitive treatment.
Retinopathy of Prematurity screening	ROP	A disorder of the developing retinal blood vessels in a preterm infant.
Rheumatoid Arthritis Impact of Disease	RAID	The Rheumatoid Arthritis Impact of Disease (RAID) is a patient-reported outcome measure evaluating the impact of rheumatoid arthritis (RA) on patient quality of life
Risk Adjusted Mortality Rates	RAMI	A measure to compare hospitals which looks at the actual number of deaths in a hospital compared to the expected number of deaths. The risk-adjustment is a method used to account for the impact of individual risk factors such as age, severity of illness (es) and other medical problems that can put some patients at greater risk of death than others.
Root Cause Analysis	RCA	A method for finding out the root cause of a problem
Royal College of paediatrics and Child Health	RCPCH	A member organisation that aims to transform child health through knowledge, innovation and expertise
Royal Voluntary Service	RVS	The Royal Voluntary Service is a volunteer organisation that can enrich the care of patients where needs are identified.

Terms	Abbreviation	Description
Safer Nursing Care Tool	SNCT	A tool used to judge the acuity and dependency of patients used to estimate what nursing establishment is required.
Scottish Intercollegiate Guidelines Network	SIGN	A network that develops evidence based clinical practice guidelines for the National Health Service (NHS) in Scotland
Sentinel Stroke National Audit Programme	SSNAP	SSNAP aims to improve the quality of stroke care by auditing stroke services against evidence based standards.
Speech and Language Therapy	SALT	A service designed to assess and treat speech, language and communication problems in people of all ages.
ST Elevation Myocardial infarction	STEMI	A type of heart attack determined by an electrocardiogram test
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
Systemic anti cancer therapy data set	SACT	The SACT collects clinical management information on patients undergoing chemotherapy in England.
The Advisory Committee on the Safety of Blood, Tissues and Organs	SABTO	Advises UK ministers and health departments on the most appropriate ways to ensure the safety of blood, cells, tissues and organs for transfusion/transplantation
Trauma Audit and Research Network	TARN	Provides accurate and relevant information to help Doctors, Nurses and Managers improve their services in trauma care.
Ulysses safeguard		The electronic system on which incidents are reported and investigations recorded.
Venous Thrombo-Embolism	VTE	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).

Appendix 2 - Feedback Form

We hope you have found this Quality Account useful.

To save costs, the report is available on our website and hard copies have been made available in waiting rooms or on request.

We would be grateful if you would take the time to complete this feedback form and return it to:

Clinical Quality and Outcomes Matron
Mid Cheshire Hospitals NHS Foundation Trust
Leighton Hospital
Middlewich Road
Crewe
Cheshire
CW1 4QJ

Email: quality.accounts@mcht.nhs.uk

How useful did you find this report?

- Very useful □
- Quite useful □
- Not very useful □
- Not useful at all □

Did you find the contents?

- Too simplistic □
- About right □
- Too complicated □

Is the presentation of data clearly labelled?

- Yes, completely □
- Yes, to some extent □
- No □

If no, what would have helped?

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Is there anything in this report you found particularly useful / not useful?

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Appendix 3 - 2014/15 limited assurance report on the content of the Quality Report and mandated performance indicators

Independent auditor's report to the council of governors of Mid Cheshire Hospitals NHS Foundation Trust on the quality report

We have been engaged by the council of governors of Mid Cheshire Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of Mid Cheshire Hospitals NHS Foundation Trust's quality report for the year ended 31 March 2015 (the 'Quality Report') and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the council of governors of Mid Cheshire Hospitals NHS Foundation Trust as a body, to assist the council of governors in reporting Mid Cheshire Hospitals NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2015, to enable the council of governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Mid Cheshire Hospitals NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2015 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway, prepared on the basis set out on page 17; and
- maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual' issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual';
- the quality report is not consistent in all material respects with the sources specified in here; and
- the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual' and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports'.

We read the quality report and consider whether it addresses the content requirements of the '*NHS foundation trust annual reporting manual,* and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the quality report and consider whether it is materially inconsistent with:

- board minutes for the period April 2014 to May 2015;
- papers relating to quality reported to the board over the period April 2014 to May 2015;
- feedback from Commissioners, dated 15/05/2015;
- feedback from governors, dated 08/05/2015;
- feedback from local Healthwatch organisation, dated 22/05/2015;
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 12th June 2014;

- the latest national patient survey, dated August 2014;
- the latest national staff survey, dated 2014;
- Care Quality Commission Intelligent Monitoring Report dated December 2014; and
- the Head of Internal Audit's annual opinion over the Trust's control environment dated April 2015.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the 'documents'). Our responsibilities do not extend to any other information.

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

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the 'NHS foundation trust annual reporting manual' to the categories reported in the quality report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual'.

The scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Mid Cheshire Hospitals NHS Foundation Trust.

Basis for qualified conclusion – 18 week Referral to Treatment indicator

The "maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway" indicator requires that the Trust accurately record the start and end dates of each patient's treatment pathway, in accordance with detailed requirements set out in national guidance.

Our testing identified that:

- we were unable to obtain evidence to support the start and/or end date of treatment for a sample of patient records' tested; and
- we were unable to obtain evidence to support whether a sample of patient records had been appropriately included/excluded from the calculations supporting the monthly RTT incomplete pathway metric.

As a result of the issues identified, we have concluded that there are errors in the calculation of the "maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway" indicator for the year ended 31 March 2015. We are unable to quantify the effect of these errors on the reported indicator.

Qualified Conclusion

Based on the results of our procedures, except for the matters set out in the basis for qualified conclusion paragraph above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2015:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual';
- the quality report is not consistent in all material respects with the sources specified in here and
- the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual'.

Deloitte LLP

Deloitte LLP

Chartered Accountants

Leeds

27th May 2015

Quality Account 2014/15

Mid Cheshire Hospitals NHS Foundation Trust
Leighton Hospital
Middlewich Road, Crewe
Cheshire CW1 4QJ