

Quality Account 2015/16



Quality and Safety at Heart
Mid Cheshire Hospitals NHS Foundation Trust
Quality Account 2015/16



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

Contents

Part 1.	
Statement on quality from the Chief Executive	4
Part 2.	
Priorities for improvement and statements of assurance from the Board	
Priorities for improvement in 2016/17	7
Review of services	10
Feedback from patients	11
Implementing the duty of candour	32
Progress towards the sign up to safety campaign	32
Feedback from staff	38
Participation in clinical audits and research	39
Commissioning for Quality & Innovation framework (CQUIN)	48
Feedback from the Care Quality Commission (CQC)	52
Data quality assurance	56
Performance against quality indicators and targets	59
Part 3.	
Review of quality performance	71
Priority 1: Nutrition and hydration	74
Priority 2: Dementia care	76
Priority 3: Communication	79
Priority 4: Documentation	84
Priority 5: Cancellations	86
Priority 6: Nurse staffing	89
Priority 7: Pressure ulcers	93
Priority 8: Sharing learning	96
Priority 9: Mortality	101
Reducing falls: Governors' choice of indicator	104
Statements from external agencies	107
Statement of Directors' responsibilities in respect of the quality report	115
Appendices.	
Appendix 1 - Glossary & abbreviations	118
Appendix 2 - Feedback form	124
Appendix 3 – 2015/16 limited assurance report on the content of the Quality Report and mandated performance indicators	125

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 2015 to March 2016.

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.

Patient safety and quality are at the heart of everything that we do. As Chief Executive I am incredibly proud of what we, at MCHFT, have achieved so far and with the Board, I have committed myself to deliver further year-on-year improvements. We hope that you find this Quality Account describes our achievements to date and our plans for the future

Throughout 2014/2015, we have made good progress; progress which has largely been achieved collaboratively as a result of the hard work, commitment and dedication of every single member of staff. We have continued to see and treat an increasing number of patients with more complex needs on both an elective and non-elective basis. We have continued to build on the successes of our Care Quality Commission rating of 'Good' following the report published in January 2015; and we are proud to continue the excellent work within our maternity services as we were named 'Midwifery Service of the Year' in March 2015.

We officially opened our state of the art treatment centre in July 2015 signifying the completion of a £23million project that also included the creation of 14 critical care bays and eight operating theatres which opened in Spring 2014. The redevelopment of the Treatment Centre has led to a vastly improved environment, including the creation of a surgical admissions lounge, new consulting and examination rooms and more single sex waiting areas. There are also a number of specially-chosen finishing touches such as distinct colour schemes for male and female areas and 'sky ceiling' photo panels in waiting areas. We are immensely proud of the new facilities that MCHFT has been able to provide in the Treatment Centre; they will enable us to further improve both the quality of care and overall hospital experience that our patients receive in state-of-the-art facilities for the benefit of both our patients and our staff.

We recognise that providing health care is not without risk and that sometimes patients can be unintentionally harmed in the care of hospitals. You will read throughout this Quality Account of our ambitious aims to further radically reduce harm across our organisation. Our Quality and Safety Improvement Strategy is the vehicle by which we have steered the direction of travel for quality and safety. The strategy has been refreshed following a period of extensive engagement with our key partners and stakeholders including patients and staff.

We have agreed that we will focus on:

- Appropriate nurse staffing levels
- Supporting patients with dementia and their carers
- Medication
- Zero tolerance to never events
- Sepsis
- Acute Kidney Injury
- Reducing pressure ulcers
- Reducing inpatient falls
- Reducing mortality figures

2015-2016 has been a challenging year for the Trust and we have worked hard to ensure that the patients we support get the right care, when they need it, at the right time and on the most suitable site.

We believe that staff who enjoy their work and have pride in it, will provide patients with better care. We are delighted that this year we have a significantly positive improvement in a number of areas in both patient and staff satisfaction scores: importantly we have seen an improvement in staff saying they would recommend us to their family and friends. Our patients agree, with 95% of patients stating that they would recommend the Trust as recorded by the Family and Friends Test.

Patients want to know that they will be provided with the best treatment and care available, based on up-to-date evidence and by well trained staff. 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.

We are proud that our *C-difficile* infection rates have fallen to 8 unavoidable cases this year compared to last year's rates. This is a considerable achievement and reflects the actions undertaken to help reduce healthcare associated infections.

Our work on mortality rates continues to show benefits. We have consistently reported that the Trust has achieved a continued reduction in its mortality rates to remain at expected levels as measured by the Summary Hospital-Level Mortality Indicator (SHMI). The latest publication for the period to June 2015 demonstrates a further reduction in the SHMI to 0.98 and the Trust remains in the 'as expected' range. There has also been a further reduction, against a performance that was already better than peer, in the number of calculated excess deaths for the period.

I hope you will enjoy reading about the many examples of the improvement work that teams across the organisation are pursuing. We strive to deliver high quality, safe, cost-effective and sustainable healthcare services that meet the high standards that our patients deserve. We want MCHFT to continue to be the health care provider that patients trust to provide those highest standards of care - and the organisation that staff have pride in and are willing always to give of their best.

I am pleased to advise that the Board of Directors has reviewed the 2015/16 Quality Account and confirm that it is a true and fair reflection of our performance. I also confirm that, to the best of my knowledge, the information in the Quality Account is accurate.

We hope that this Quality Account provides you with a clear picture of how important quality improvement and patient safety are to us at MCHFT.

Finally, I want to take this opportunity to thank our staff. They do a tough job, sometimes in difficult circumstances, but always keep patients' 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.



A handwritten signature in black ink that reads "Tracy Bullock". The signature is written in a cursive, flowing style.

Tracy Bullock
Chief Executive
Mid Cheshire Hospitals NHS Foundation Trust
tracy.bullock@mcht.nhs.uk

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 2016/17

During 2015/16, the Trust conducted an extensive engagement programme to inform its Quality and Safety Improvement Strategy which describes the key priorities for quality and safety from 2016 to 2018 inclusively.

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

“To deliver excellence in healthcare through innovations and collaboration”

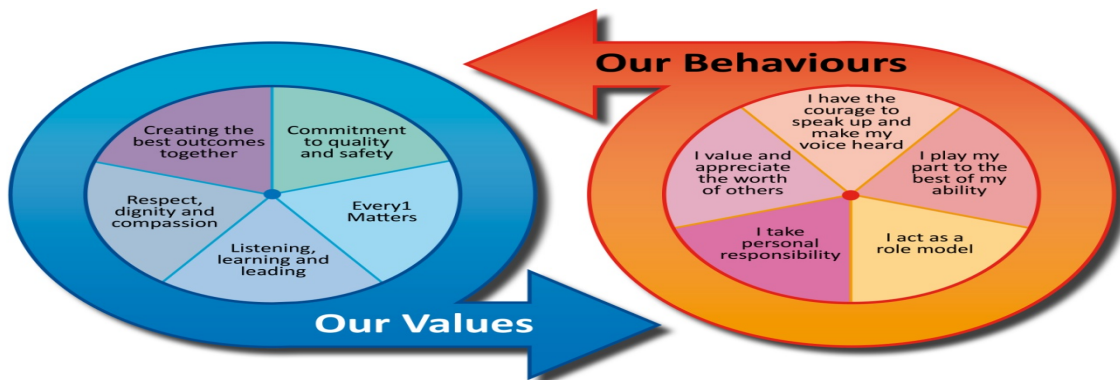
The Trust will be a provider that:

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

The strategy links closely with other key strategies such as the Clinical Services Strategy and the 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 so that these values and behaviours are observed by all staff.



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

Experience

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.

Supporting patients with dementia and their carers

The Trust will continue to 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.

Medication

The Trust will ensure the use of safe and effective medication across the organisation.

Effectiveness

Zero tolerance to never events

The Trust will have zero tolerance of Never Events.

Sepsis

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

Acute Kidney Injury

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

Safety

Reducing pressure ulcers

The Trust aims to eliminate avoidable pressure ulcers by January 2018.

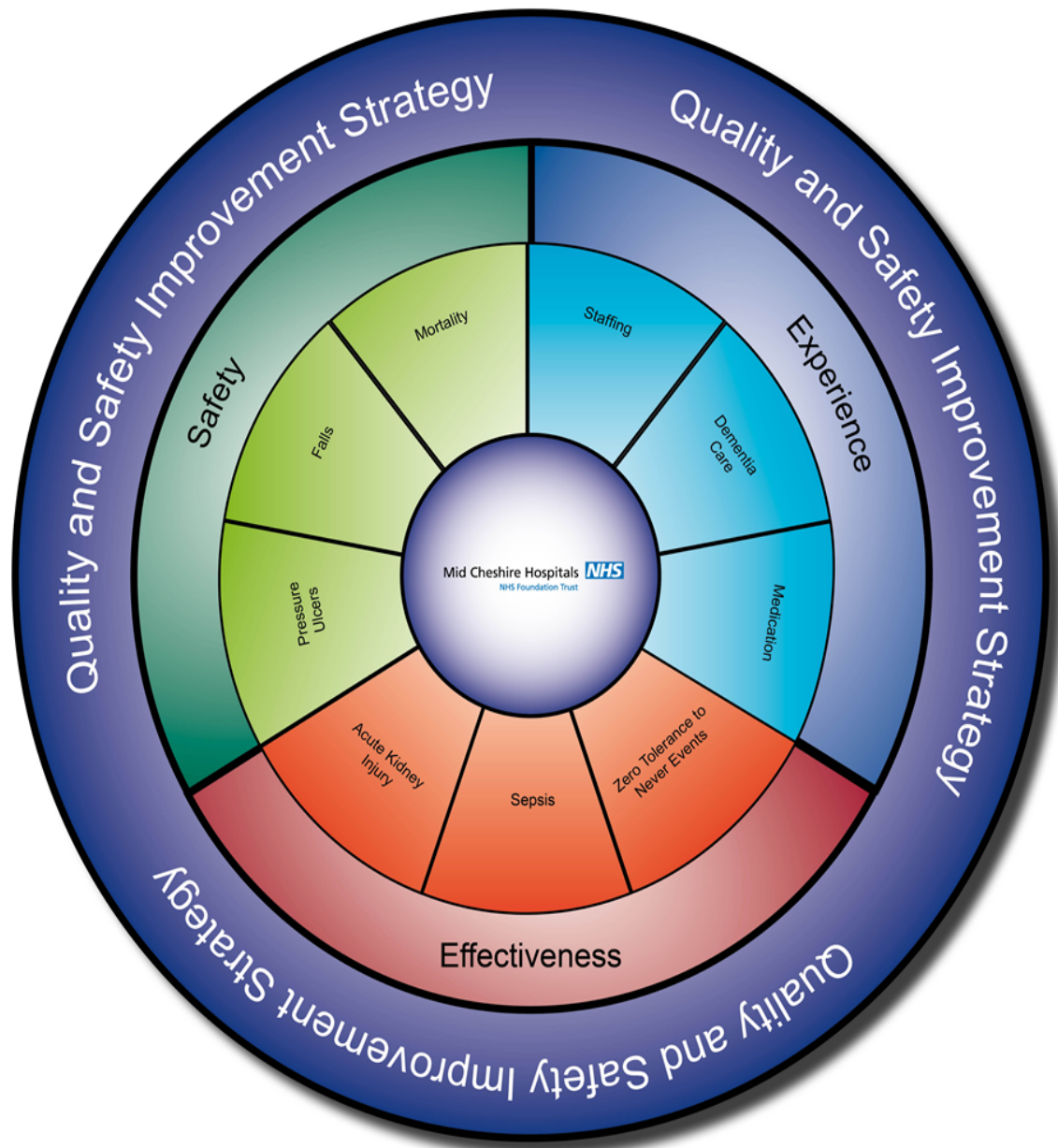
Reducing inpatient falls

The Trust aims to reduce in-patient fall incidents by 10% by January 2018.

Reducing mortality figures

The Trust's Summary Hospital-Level Mortality Indicator (SHMI) will remain at or below 100 from April 2015.

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



Monitoring and reporting of the Quality and Safety Improvement Strategy.

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

The Executive Quality Governance Group is responsible for providing information and 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.

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

Review of services

During 2015/16, 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 2015/16 represents 100% of the total income generated from the provision of NHS services by the Trust for 2015/16.

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.

The Trust reviews all results from national surveys and develops action plans to address any areas of improvement required. The results are shared with staff, including comments made by patients about what has been particularly good about their experience and what could be improved.

National inpatient survey

Between October 2015 and January 2016, a questionnaire was sent to 1,250 adult inpatients who had been admitted to Leighton Hospital. Responses were received from 680 patients which equates to a response rate of 56.8% 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

What has changed since the last inpatient survey?

There has been a statistically significant improvement in the results for 18 questions, which included:

- Improving pain control
- Patients being involved in decisions about their care and treatment
- Doctors answering questions in an understandable way
- Patients being given enough information about their condition/treatment
- Patients feeling they were well looked after by staff

There were no questions that had a significantly worse response.

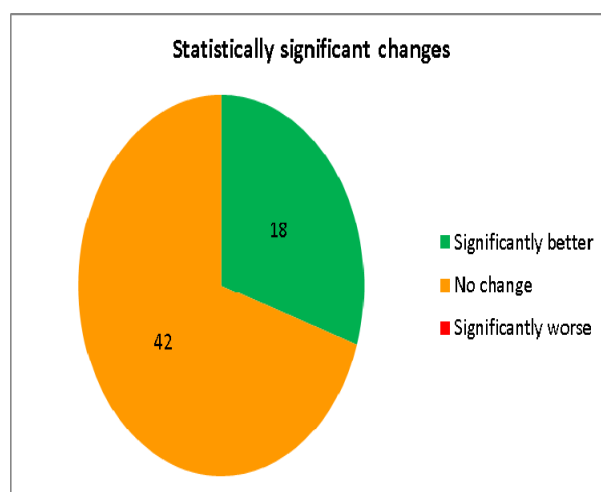
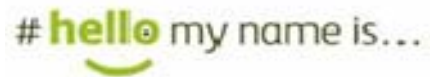


Chart 1: statistically different changes in results since last inpatient survey

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

- Talking to staff about worries or fears

Patients being able to talk to staff about any worries or fears has seen a **5% improvement** compared to 2014. This has been attributed to awareness raising during customer care training with staff and promotion of the #hellomynameis initiative.



- Reducing noise at night

The 'quiet protocol' was relaunched in 2015 with the aim of reducing unnecessary noise at night on the wards. There has been a **5% improvement** and ward staff have worked hard to improve the night time environment for patients, including offering ear plugs and night masks to patients.

Examples of **comments made by patients** from the national inpatient survey have been shared with staff and visitors to the Trust:

Inpatient Survey 2015 Mid Cheshire Hospitals NHS Foundation Trust

General Feedback

Patients were asked what was particularly good about the service they received and these were some of their comments:

- The ward was run very competently. Most of the staff were great and nothing was too much trouble for almost everyone. I met some lovely patients and staff.*
- Very smooth process from first arrival to discharge.*
- Staff were very reassuring in a very frightening time. The nurses supported junior doctors very well i.e. if junior doctor wasn't quite sure on how to do something the nurses guided them. This did not alarm me as it is a teaching hospital and I felt safe in their care.*
- Some of the nurses took time to make me a cup of tea at night when I was unsettled and they came and asked if I was OK and if I needed anything.*
- The staff were all happy and appeared to work well together as a team. This was reflected in the way they treated patients. The patients I was with appeared to respond to this atmosphere too which again bounced back to the staff.*
- I have never had an emergency admission to hospital and was very scared. I had an overall good experience and related this to the patient experience manager as a compliment.*
- I received help to overcome a fear of blood tests and since leaving hospital have had no problem with them.*
- Considering I did not know I was going to be admitted to hospital and hadn't come prepared, the treatment I got was superb, night gown, toothpaste, brush, etc. Staff, doctors, etc. were very helpful and understanding, meals were also good.*
- The speed with which I was dealt with on admission; The prompt and comprehensive assessment of my injuries; The follow up to that assessment was all positive. Pleasant and helpful staff at all levels*

National maternity survey

The survey questionnaire was sent to mothers giving birth in January and February 2015. Responses were received from 137 patients which equates to a response rate of 46.9% of completed eligible returns. The national maternity survey had previously been carried out in 2013.

Questions in the survey cover the following:

- Ante natal care
- Labour
- Birth
- Care in hospital after the birth

What has changed since the last survey?

There has been a statistically significant improvement on 4 questions which included:

- Being treated with kindness
- Cleanliness of room
- Cleanliness of toilets and bathrooms
- Active support and encouragement about baby feeding

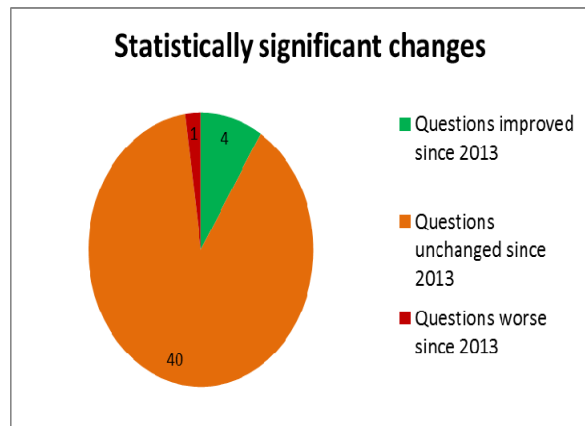


Chart 2: statistically different changes in results since last maternity survey

Areas the Trust agreed to focus on to improve based on the results from 2013:

- Partners to accompany women overnight, for example at induction and on the maternity ward

Partners are now able to stay and women are advised of this option at their ante-natal appointments. Additional comfortable recliners have been purchased and the maternity ward code of conduct is shared with partners who are staying.

Examples of **comments made by patients** from the national maternity survey have been shared with staff and visitors to the Trust. These are shown overleaf:

General Feedback

Women were asked what was particularly good about the service they received and these were some of the comments:

The midwives and all healthcare professionals that have been involved from pre-natal to postnatal care have been brilliant and have made the whole pregnancy/baby experience enjoyable.

Excellent one-to-one care with midwife during labour and immediately afterwards with skin to skin.

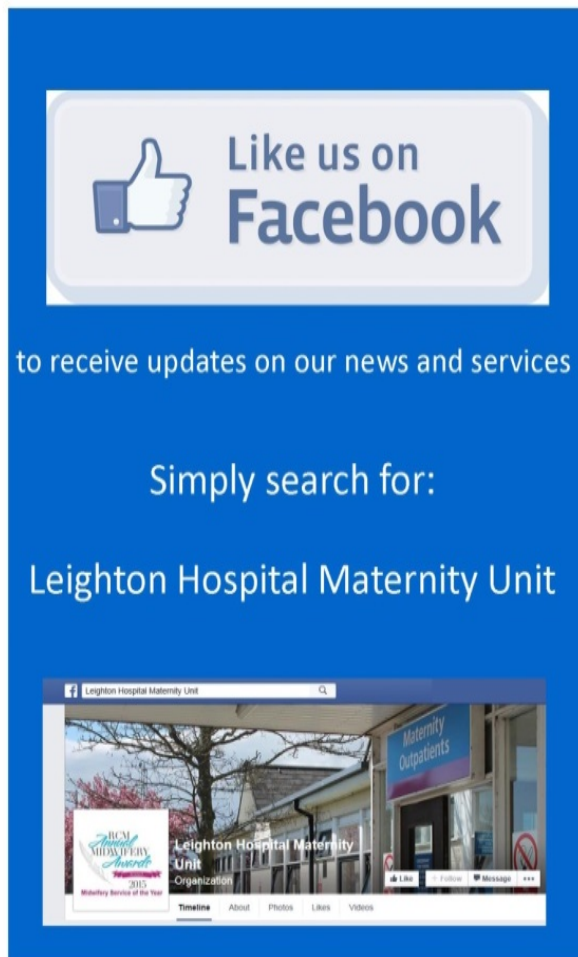
Very helpful midwives, always there to help you. Hospital staff were very supportive and helpful. Highly recommended. I was a bit nervous in hospital, but the staff were very helpful.



All elements of care provided by the antenatal team before birth, and the midwives and staff on the maternity ward and labour ward at Leighton Hospital Crewe were absolutely fantastic. Before, during and after pregnancy and birth they were all brilliant and looked after me really well. Always happy to help with any questions. The care provided was excellent.

I had the utmost care without being induced right through to giving birth. The midwives and all healthcare professional that have been involved from pre-natal to post-natal care have been brilliant and have made the whole pregnancy/baby experience enjoyable.

The day I went into hospital I could not fault the midwives, they were all very nice and always there with me. I visited triage on 2 occasions due to reduced movement, they saw me straight away and linked me up to a monitor. The midwives that day were brilliant. Many thanks for making my experience that much more pleasant. Very happy patient. Brilliant midwives!



The Maternity Facebook page went live on 22nd April 2015 with the aim of promoting Leighton Hospital Maternity Services and making information accessible via social media.

The Facebook page enables marketing of the Maternity Services, raising the profile of the services offered and provides current evidence based information to women and their families.

Public health related posts include the promotion of the flu vaccine over the winter months, up to date guidance relating to the Zika Virus, Safe Sleep Week, No Smoking Day and NHS England Saving Babies Lives Campaign.

The page is also used to post messages of thanks from mothers. Feedback has shown that mothers find the page an easy way of thanking staff during this busy time in their life. All staff mentioned are then put forward for Maternity Employee of the Month and a winner is chosen at random and receives a certificate for their portfolio. All messages are also forwarded to the staff members for them to keep.

The site's first postings during May 2015 reached between 1,100 and 1,900 people (as per Facebook statistics based on the people that like the post and the number of 'Facebook friends' they have). The accredited baby friendly unit post reached 3,500 people, with Cathy Warwick CBE, Chief Executive of the Royal College of Midwives visit to the unit reaching 16,400 people.

The post announcing that partners are welcome to stay overnight on Ward 23 and in the induction bay reached an impressive 27,700 people with 1,100 likes, comments and shares.

A total of 1,954 people have 'liked' the page meaning that the information on the page reaches a wide audience.

Although the page is accessed mainly by local people, it has been viewed by people from all over the country and rest of the world including Ireland, United Arab Emirates, USA, Canada and Australia.

No complaints or negative feedback have been posted to the site.

Local patient surveys

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

In 2015/16, 31 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:

Pharmacy Survey

56 responses were received out of a sample of 85.

The results showed that:

- 98% of patients felt that the pharmacy department was easy to find
- 100% of patients said the pharmacy staff were approachable
- 100% of patients said they were provided with information about the purpose of their medication.

Key issues included:

- Contact details for pharmacy if patients had questions when they arrived home
- Waiting time / delays in the pharmacy department.

The following changes have been implemented following the survey:

- Pharmacy patient helpline cards are inserted in all outpatient medication bags.
- A Performance board and posters have been designed and displayed in the pharmacy outpatient waiting area. These explain the current average waiting time and give information about the reasons for any delay.



Mid Cheshire Hospitals **NHS**
NHS Foundation Trust

Any further questions?

We will try to give you all the important information about your medication when we give out your prescription.

If you have any further questions after leaving the hospital we operate a Medicines Helpline. This service is available to answer any questions you may have about the medication we have dispensed.

We can answer questions such as:

- How and when should I take my medicines?
- Will my medicine cause side effects?
- Can I take other medicine?

**The Medicines Helpline is open
Monday to Friday 10am to 3pm
01270 273221**

Please be aware, we can only answer questions about medicines given to you by the hospital.
For questions about your illness or medicines prescribed by your GP.
• Please phone your doctor's surgery

Diabetes Transition Survey

50 responses were received which included 20 completed by the parent/carer and 30 from young people

The results showed that:

- 92% of young people felt the transition process was started and finished at the correct age
- 93% of young people said the transition process was explained clearly to them and they felt involved

Key issues included:

- The need to improve engagement with adult services and
- Implementation of a transition plan

The following changes have been implemented following the survey:

- The 'Ready Steady Go' transition plan is being trialled with 6 diabetes patients aged 13-19 years
- A keyworker has been identified in adult services
- Formal handover sessions between paediatric and adult services have been developed and implemented
- Regular meetings are now held between the paediatric diabetes team and the adult diabetes teams

Pain Survey

100 responses were received out of a sample of 100.

The results showed that:

- 72% of patients received breakthrough analgesia within 30 minutes
- 100% of patients received information regarding pain relief
- 95% of patients were satisfied with the way their pain was assessed.
- 96% of patients felt listened to.

Key issues included:

- The need to standardise pain management and pain scoring.
- A lack of patient information regarding post-operative pain relief.

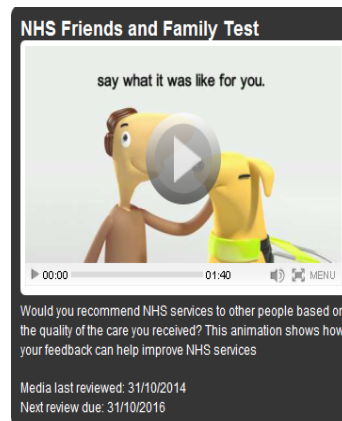
The following changes have been implemented following the survey:

- Staff have undergone further training in relation to Patient Controlled Analgesia (PCA), Epidural analgesia and the pain scoring system.
- Treatment and condition specific leaflets are now given to patients following surgery and staff record that the leaflets that have been given to the patients.

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 the service they have experienced 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, the emergency department, assessment areas, maternity services, outpatients, day case units and children's services. Every patient that receives treatment in these areas can give feedback about the quality of care they have received.



A child friendly post box has been introduced to encourage feedback from children. The FFT test card for children encourages them to write their own response and draw a picture if they wish.

My bed was comfortable. I liked the nurses and the TV and my Daddy could stay.

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?

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

Trust results

Nearly 26,000 patients have responded to the Friends and Family Test, with 95% of patients indicating that they are likely to recommend services or treatment to their family or friends.



Most of the written feedback focuses on positive comments from patients about their experiences of the staff who care for them:

‘The sheer joy of experiencing the excellent care and attention of all the very professional staff who treated me like royalty and showed me every respect. Thank you so much’.

‘Excellent care has been provided to me, both in terms of attending to my condition promptly and treating it, and also the high standard of care given by the nursing team. My stay in hospital could not have been much better’.

‘Comfortable and caring atmosphere. Very friendly. Attentive and skilled staff always on hand for care and help. Nothing is too much trouble’.

The Friends and Family results are published on the NHS Choices website which also includes flip clips explaining about FFT. The Trust also displays film clips in waiting areas on plasma screens to encourage patients to take part. The results can be accessed via the following links:

<http://www.nhs.uk/Services/hospitals/Overview/DefaultView.aspx?id=505>

<http://www.nhs.uk/Services/hospitals/Services/Service/DefaultView.aspx?id=208744>

NHS Choices

Patients can comment about their experience on the NHS Choices website. There were a total of 121 new postings on the NHS Choices website in 2015/16. 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 4.5 stars out of 5.



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:

Eye Care Centre – ‘If you have an eye issue, I would recommend Leighton’.

A&E – ‘The treatment she received was thorough and staff were courteous’.

SAU – ‘I’ve been in for surgery and the staff made my stay very welcoming and made me much more relaxed’.

Ward 6 – ‘My experience in ward 6 was extremely good, the staff at all levels were magnificent, I can’t praise them enough’.

Macmillan Centre – ‘The nurses and chemotherapy team are all amazing. Doing such a difficult job on a daily basis, but again showing compassion and care at all times’.

Sexual Health Centre – ‘Very pleased with the service and would certainly recommend’.

Treatment Centre – ‘I came away from this appointment feeling far better than when I entered the hospital. The consultant and senior sister on duty were exceptionally patient and considerate’.

Ward 10 – ‘Wow - absolutely fantastic and I cannot thank you enough for your help, support and class A service in such horrible circumstances’.

Fracture Clinic – ‘I cannot fault the speed with which I was seen nor the kind attention of the doctor and team. I want to place on record the wonderful service’.

Michael Heal Unit – ‘All the staff without exception were friendly and helpful’.

Other patient and public involvement programme activities

Patient Register Group Meetings

In 2015/16, the Trust held patient register group meetings at local libraries and churches. The group consists of volunteers and members of the public who assist the Trust with various methods of patient and public involvement. The meetings provide an opportunity for the Trust to share news of developments and seek views from members. Areas of interest covered included presentations about the new surgical admissions lounge, the care of the emergency patient and an update on the outpatient department transformation work.

Readers' Panel

The Trust has an active readers' panel of over 70 members. The panel receives draft patient information leaflets by post to check and review and offer comments. The panel reviewed a total of 29 leaflets during 2015/16. Information included domestic abuse, the role of the Eye Care Liaison Officer and use of Efudix cream.

The panel has submitted many suggestions including grammatical changes and diagram or picture changes which are reviewed by the leaflet authors. The panel receives an annual summary which outlines the changes made as a result of their contributions and acknowledges their contribution during the year.

Patient Information Committee

In 2015/16, the Committee reviewed and approved 23 local patient information leaflets and reviewed the patient information policy. The Committee also completed an audit of completed consent forms in 50 sets of patient's notes. The audit is carried out to review the documentation of consent by healthcare professionals and to monitor that information patients are given prior to a procedure or surgery.

Over the last 12 months, the Trust has produced the following leaflets in easy read version:

- Making Choices about my health
- Getting ready for my visit to hospital
- Getting ready to have my operation
- Getting ready to go home from hospital
- My stay in hospital



There have also been requests for patient information to be translated into other languages and formats. This has included mobile lithotripsy which was transferred onto a CD; induction of labour and hiatus hernia leaflets were translated into Polish and a heart failure leaflet translated into Portuguese.

Partnership Working

Staff and students from Petty Pool Vocational College kindly donated their time and energy to tidy up the garden area for the Coronary Care Unit. The garden is enjoyed by patients and their relatives who benefit from them the opportunity to enjoy some fresh air and to have a brief respite from the ward environment.



Learning Through Collaboration

An event was held to raise awareness for staff of long term conditions. The event was supported by the Stroke Association, Parkinson's UK and the Alzheimer's Society.



The event was attended by nearly 100 staff and consisted of a series of presentations from the Paediatric Specialist Nurse for Diabetes; patients and carers talking about dementia and the Hospital Alcohol Liaison Service. There was also the opportunity for staff to talk to expert patients about living with a long term condition.

Healthwatch

The Trust works closely with Cheshire East and Cheshire West Healthwatch groups to explore opportunities for engaging with 'hard-to-reach' groups. Since April 2015, Healthwatch have carried out a number of enter and view audits. These have included visits to the Emergency Department, Ward 12 and Maternity Services. Healthwatch also supported the Trust with the national Patient Led Assessment of Care Environment (PLACE) audit.

In July 2015, Healthwatch interviewed 91 inpatients on a number of wards for feedback about meals during their stay.

The survey highlighted that patients were not always given the opportunity to wash their hands before meal times. Ward staff have been reminded to offer hand wipes if patients are unable to use a washhand basin.

healthwatch
Cheshire East

Patient Meals Survey

Ward

Question	Response Scale
1. Do you enjoy your meals?	Always/Sometimes/Never
2. Do you feel the meals are well presented?	Always/Sometimes/Never
3. Are your meals hot enough?	Always/Sometimes/Never
4. Do you feel that meals are served promptly?	Always/Sometimes/Never
5. Do you feel that meals are served in a courteous manner?	Always/Sometimes/Never
6. Are you made comfortable before your meal?	Always/Sometimes/Never

Customer Care Team

The role of the Customer Care Team is to provide on-the-spot advice, information and support for patients and relatives if they wish to raise concerns. The team can also support patients when dealing with issues about NHS care and provide advice and information about local health services. The Customer Care Team aims to respond to patients' concerns and issues in a timely and effective manner, irrespective of whether they have been raised as an informal concern or a formal complaint. The majority of concerns can usually be resolved swiftly by those staff who are caring for patients. However, sometimes patients or a family 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 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.

The Customer Care Team also receive Ecards from relatives who chose to send messages in this way. This year, 56 Ecards were delivered to patients in the Trust.

Compliments

1,727 formal compliments were received by the Trust during 2015/16 which expressed thanks from patients and families about the care received. This is a slight decrease compared with previous years. All compliments are shared with the relevant teams who are mentioned.

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

Table 1: Overview of compliments received by the Trust

Review of complaints

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

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

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

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

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

All complaint meetings are recorded and a copy of the CD is given to the complainant at the end of the meeting. Feedback about this activity has been very positive.

A survey of complainants was undertaken in 2015 to seek the views on how well they felt their concerns had been handled and whether they felt satisfied with the actions taken. The survey showed that complainants felt their complaints were being resolved in a more timely manner with only 32% saying the process took too long (compared to 51% in 2014).

The survey responses did highlight that clarification was required regarding the purpose of the survey, as many responses raised issues with the outcome of their complaint rather than the complaint process itself. This was discussed at the complaints review group which led to further discussions with the Picker Institute's national group to update the survey questionnaire to enable the Trust to meet national standards and recommendations for future surveys.

Some of the key themes of complaints received in 2015/16 focussed on nursing care, medical care and communication. Examples of these are summarised in the table below together with actions taken to address the concerns raised.

Themes	Actions Taken
<i>Treatment Centre –issues have been raised regarding requests for sedation which were not communicated to the appropriate staff prior to an endoscopy.</i>	The team have updated the pre endoscopy checklist to ensure all communication regarding sedation is discussed, recorded and acted upon.
<i>Urology - issues regarding information requirements for patients and carers on discharge with regard to catheter care and equipment were highlighted</i>	A catheter passport has been developed which includes information for carers, district nurses and relatives. This also includes what equipment the patient requires and contact numbers for support and advice. This passport is held by the patient and can be utilised for any further admissions or appointments with health care professionals.
<i>Pharmacy – issues were identified regarding delays in providing regular medication for some groups of patients.</i>	Work has been carried out to increase the stock levels of medications prescribed by outpatient clinics for patients requiring 8 weeks or more of prescribed drugs which cannot be provided by their GP practice.

Table 2: Examples of complaints and actions taken

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

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

*The complaints upheld / partially upheld by the Ombudsman include those complaints that had been referred to them in previous years.

Table 3: Overview of complaints received by the Trust

Staff and visitors being shown around the new treatment centre before it opened in July 2015.



Staff taking part in equipment training to care safely for patients.



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

You Said

➔

We Did...

Customer Care Feedback and Action Taken

Here are some examples to show how we have responded to feedback from patients ...

<div style="background-color: #ffcc00; border-radius: 15px; padding: 10px; font-weight: bold; font-size: 24px;">You Said</div> <div style="font-size: 48px; color: purple; font-weight: bold;">➔</div>	<p>“The waiting times on display in Pharmacy were out of date. In addition, it was difficult to obtain medication for an 8 week supply of medication.”</p> <p>A real-time position for the display/waiting time has now been implemented. Pharmacy are increasing their stock levels to provide eight week prescription supplies.</p>	
<div style="background-color: #ffcc00; border-radius: 15px; padding: 10px; font-weight: bold; font-size: 24px;">You Said</div> <div style="font-size: 48px; color: purple; font-weight: bold;">➔</div>	<p>“On discharge of a patient, a document was not sent home with the patient when it should have been.”</p> <p>It is now documented in the daily handover book to make sure that patients have all paperwork upon discharge or transfer. This has also been covered in monthly staff training and reminder correspondence has been sent on to the Modern Matrons and Ward Managers.</p>	
<div style="background-color: #ffcc00; border-radius: 15px; padding: 10px; font-weight: bold; font-size: 24px;">You Said</div> <div style="font-size: 48px; color: purple; font-weight: bold;">➔</div>	<p>“Despite no smoking signage being in place around the hospital, patients, visitors and staff continue to smoke in the hospital grounds.”</p> <p>A meeting was held within the Trust to discuss the issue of smoking on Trust premises. E-cigarettes were also discussed. The smoking policy is to be reviewed.</p>	
<div style="background-color: #ffcc00; border-radius: 15px; padding: 10px; font-weight: bold; font-size: 24px;">You Said</div> <div style="font-size: 48px; color: purple; font-weight: bold;">➔</div>	<p>“There is sometimes a wait for patients to be discharged from the hospital once they have been told they can go home.”</p> <p>A discharge coordinator has now been appointed. The purpose of this role is to plan patients discharge arrangement whilst working with all staff to ensure a safe and timely discharge.</p>	

You Said, We Did Flyer February 2016

Mid Cheshire Hospitals



NHS Foundation Trust

Learning disability access.

The Trust has had yet another successful year in relation to enhancing both the patient and carer experience for those with a learning disability (LD) and those caring for them.

An area where staff have helped a considerable number of patients is through the use of reasonable adjustments. Reasonable adjustments are required by law to ensure that disabled people receive the same service, as far as possible, as people who are not disabled. This is laid down in the Equality Act 2010 and it is the Trust's duty to respond.

The following case study demonstrate some of the adjustments staff made to ensure that one particularly vulnerable patient was able to access the clinical care he needed. The case study shows the commitment staff have to meeting the needs of patients with a LD plus their recognition of how valuable carers are and how their involvement only enhances the overall experience. The case study is presented in line with the six safeguarding principles (Department of Health, 2011).

Case Study

A was referred to the Dignity Matron by one of the Urology Consultants, for support with **A** coming in for an elective procedure. **A** needed to come into hospital for a flexible cystoscopy and to have his toe nails clipped. Both needed to be done under a general anaesthetic.

Empowerment: **A's** mental capacity was assessed and **A** was found to lack capacity in relation to the planned procedures. **A** was unable to weigh in balance both the cystoscopy and the general anaesthetic. A best interest decision was therefore made. **A** was very much included in the best interest meeting. Terminology was kept clear and simple, with use of pictures and diagrams. **A** was supported by care staff who knew him really well. As **A** had no-one to act on his behalf other than paid carers, an Independent Mental Capacity Advocate (IMCA) was present at the meeting. **A** was given a step by step guide to the day, in easy read, so he could look at the plan at his leisure.

Protection: Staff completed a hospital passport with **A** and brought it into hospital. An all-female team were assigned to **A**, including a female anaesthetist. **A** is needle phobic, therefore the anaesthetist was informed of the need for a gas induction.

Prevention: The carers were with **A** throughout the procedure, especially in the anaesthetic room and recovery. **A** brought in his box of photographs to show to staff. This was an excellent vehicle for conversation and helped minimise the distress for **A**. The visit was led and shaped by information from **A** and his carers. The staff gave clear post-operative instructions so that when there was some post –operative haematuria, carers were expecting it and knew how to manage it.

Proportionality: **A** underwent his procedure first thing on the morning. This meant he was nil by mouth for the least amount of time and could go home as early as possible. Social care supported the procedure by booking a night carer for the night after the operation to enable **A** to go home the same day.

Partnerships: The best interest meeting included **A's** IMCA, Social Worker, Care Staff, LD Community Nurse and the Dignity Matron from the Trust. The meeting was very person-centred and took a focussed multi-disciplinary approach. **A** wanted to have his toe nails clipped, therefore podiatry attended the theatre once he was asleep to oblige. Liaison took place with the Urology Consultant, Anaesthetist, Treatment Centre staff and Theatre staff.

Accountability: Ongoing collaboration with disciplines involved; ongoing communication with **A** and his carers; treats were provided for **A** post operatively: strawberries and ice cream! The Dignity Matron emailed carers for an update and to check **A** was settled and comfortable back at home.

Outcome - The thank you email says it all!

"Everyone who A and indeed Claire and I met yesterday were brilliant!!
I feel A had a great experience throughout and it was very well orchestrated! Thank you so much for the obviously hard work that had gone into A's visit...
I know A is keen to be supported to send a card to you all... as a thank you...
You missed out on your hug.... as he hugged nearly everyone else before we had left the discharge lounge...
He did call out a few times "Thank you girl" and "girl, I like you"... We enjoyed our lunch as well... Thank you and you shouldn't have!
Personally I have not seen A so relaxed during a health appointment...a credit to you and your team...
He was a little distressed upon returning home seeing blood in his urine, but we were given enough information and guidance to expect this and to push fluids, to flush him through....
This was the case and his urine was flushing through clear during the evening....
I left him late afternoon as he was tucking into some strawberries and ice cream, which he was excited about getting from you!
He retired to bed about 11pm last night and slept right through until 8am this morning and he has seemed in good humour and not needed pain relief so far today....
Thank you ever so much to everyone including the toenail cutting services..."*

**Name changed*

Other examples of adjustments made by staff have included:

- Home visits by Consultants where coming into hospital could be very distressing for the patient
- Appointment times to suit patient and/or carer
- Carers able to accompany the patient into the anaesthetic room and recovery
- CT scans performed under general anaesthetic
- Bloods / ECG's undertaken on home visits due to patient's anxiety levels
- Patient's able to wear their own clothes into operating theatres.

Another important area that the Trust is working hard to improve is the transition of children with a LD into adult services. A transition pathway is in the process of being developed however, in the meantime, the collaboration between paediatrics and adult services is working well. Children with a complex learning disability are flagged to the Dignity Matron around the age of 14. The Dignity Matron will meet the child and their carers and attend meetings and appointments as appropriate. This enables the child and their family to develop an early relationship with someone from adult services and to set up pathways at the earliest opportunity. The Dignity Matron will also refer the child to adult LD community services. This again helps with transition and gives families access to support and guidance at home from adult services.

The Trust has also been instrumental in the development of accessible information. There is now a comprehensive range of leaflets, including a hospital passport (shown below), which are available on wards and in departments as well as on our Trust internet site. The easy read patient information leaflets can be sent out with appointment letters if staff know the patient has a LD or can be used in best interest meetings to enhance a patient's understanding of the proposed treatment plan.

Information about ME to help YOU

**For People with Learning Disabilities coming into
Mid Cheshire NHS Hospitals**

Name:




This information belongs to me.
Please share my information with other health professionals involved in my care.
Please return it to me when I am discharged.

**Nursing and medical staff, please look at my
information before any interventions take place.**

Things you need to know about me

Things which are important to me

My likes and dislikes

Hospital passport

Getting ready for my visit to hospital



An Easy Read guide to planning for your hospital appointment



The hospital staff

Lots of different staff work in the hospital.

The nurses are the people you will see the most.



The Trust has a Dignity Matron.

They can give you extra help. They help hospital staff understand your needs.



The nurses on your ward will help you. They will check you are okay.

They will bring your medication and help you wash.



There will be a call bell next to your bed.

Press this if you need to ask the nurse for pain relief or help with something.

Sample from the easy read guide for hospital appointments

Implementing the Duty of Candour

The Statutory Duty of Candour ensures that all healthcare providers must 'notify anyone who has been subject to an incident which results in moderate harm, serious harm or death' (Department of Health, 2013).

The Trust is committed to being transparent, open and honest when things go wrong with patients and / or their relatives or carers. This is reflected in the Trust's *Being Open* policy.

When an incident is identified as having resulted in moderate harm, serious harm or death, the Trust informs the patient or their relatives or carers as early as possible following the incident.

The patient and / or their relatives or carers are provided with an apology and explanation of the incident and any investigations which will be conducted. The patient and / or their relatives or carers are provided with contact details of a senior member of the Trust to contact if they have any queries. They are also informed that the investigation report (root cause analysis) and resulting action plans and lessons learned will be shared following the review.

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

Once the investigation has been completed, the report, action plan and lessons learned are shared with the patient and / or their relatives or carers to ensure that they are satisfied that any lessons learned will help to prevent future incidents.

Progress towards the 'Sign up to Safety' campaign

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

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

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

1) Put Safety First

The Trust will....

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

2) Continually Learn

The Trust will....

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

3) Honesty

The Trust will....

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

4) Collaborate

The Trust will....

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

5) Support

The Trust will....

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

The pledges were developed using intelligence of the Trust's performance against qualitative and quantitative indicators together with feedback from staff and patients. The Trust's safety improvement plan is aimed at improving outcomes and effectiveness which means saving lives, improving the quality of life of our patients, speeding up their recovery and reducing readmissions.

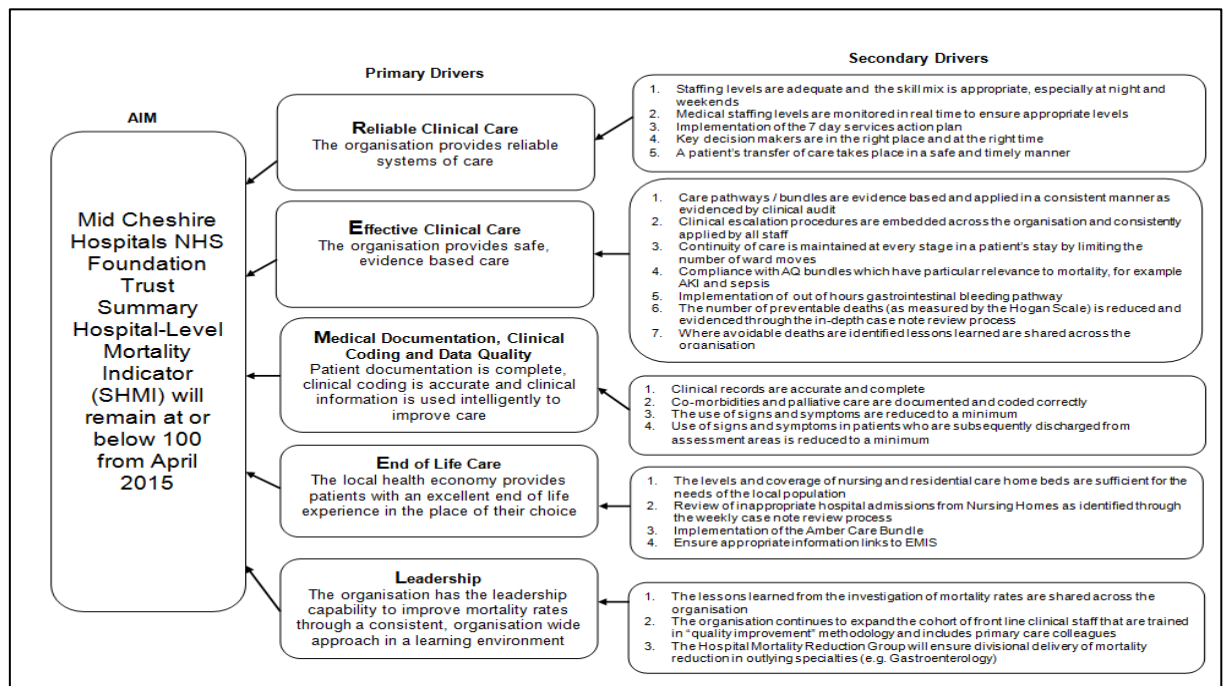
The commitment of the Trust to the Sign up to Safety' campaign has led to the development of **six** key projects being included in the Trust's quality and safety improvement strategy for the next two years. The six projects will be progressed through the actions described within the following driver diagrams for each project:

Safety Improvement Project One – Mortality

Aim: The Trust's Summary Hospital-Level Mortality Indicator (SHMI) will remain at or below 100 from April 2015

Lead Committee / Group: Hospital Mortality Reduction Group

Project Lead: Medical Director

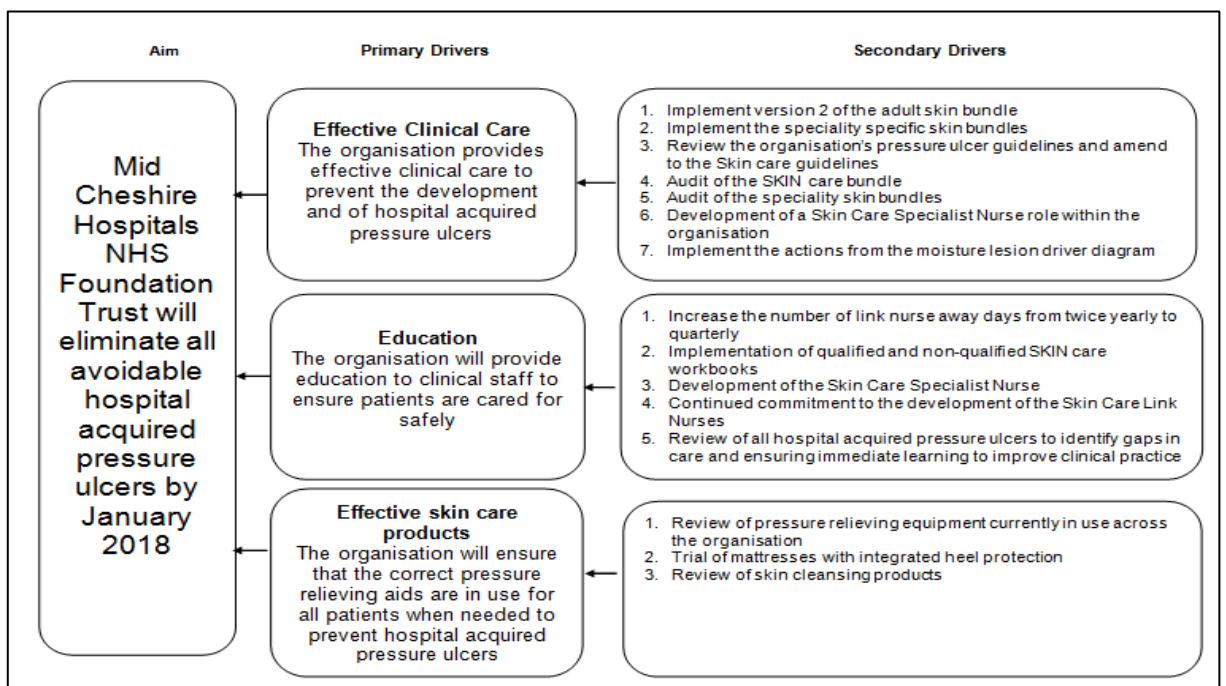


Safety Improvement Project Two – Pressure Ulcers

Aim: The Trust will eliminate all avoidable hospital acquired pressure ulcers by January 2018

Lead Committee / Group: Skin Care Group

Project Lead: Deputy Director of Nursing and Quality

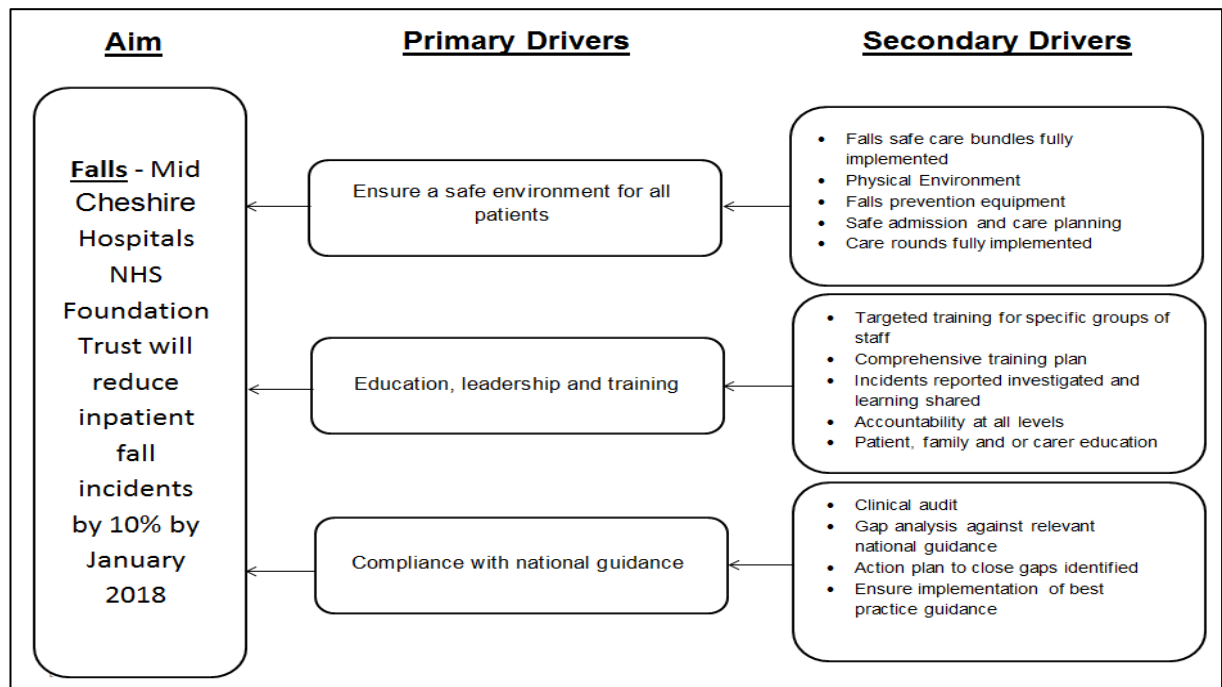


Safety Improvement Project Three – Falls

Aim: The Trust will reduce inpatient fall incidents by 10% by January 2018

Lead Committee / Group: Patient Falls Prevention Group

Project Lead: Professional Lead, Diagnostic & Clinical Support Services Division

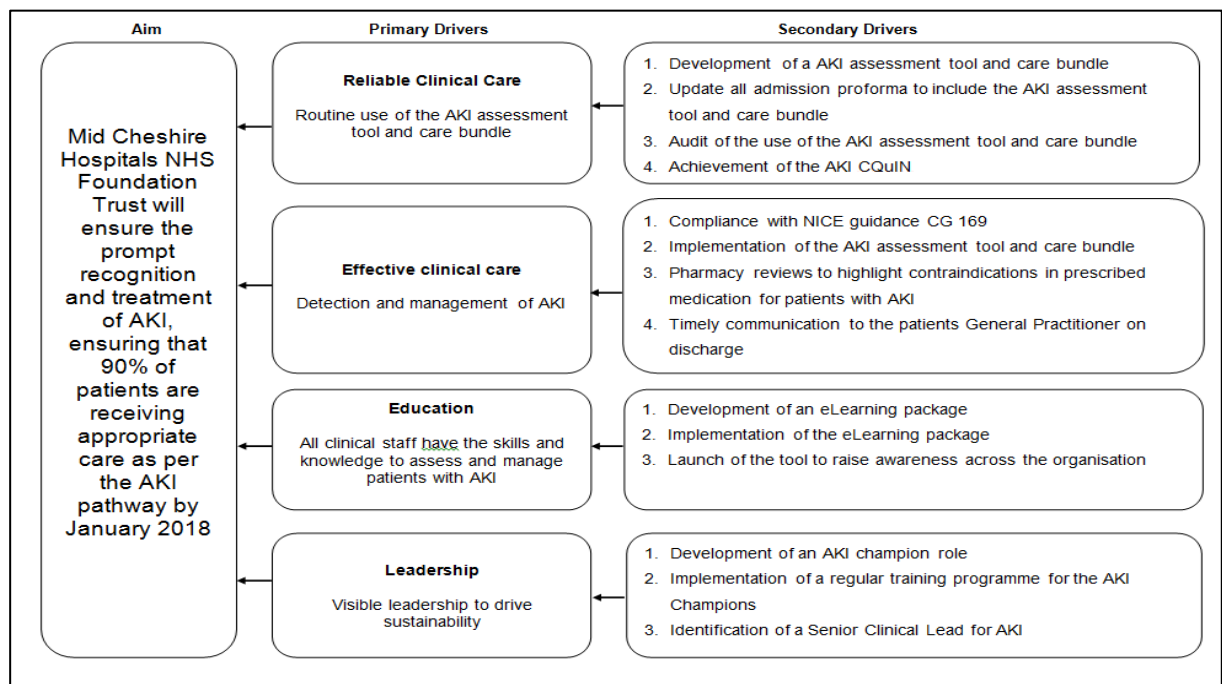


Safety Improvement Project Four – Acute Kidney Injury

Aim: The Trust will ensure the prompt recognition and treatment of AKI, ensuring that 90% of patients are receiving appropriate care as per the AKI pathway by January 2018.

Lead Committee / Group: AKI Steering Group

Project Lead: Consultant Nurse, Critical Care Outreach Services

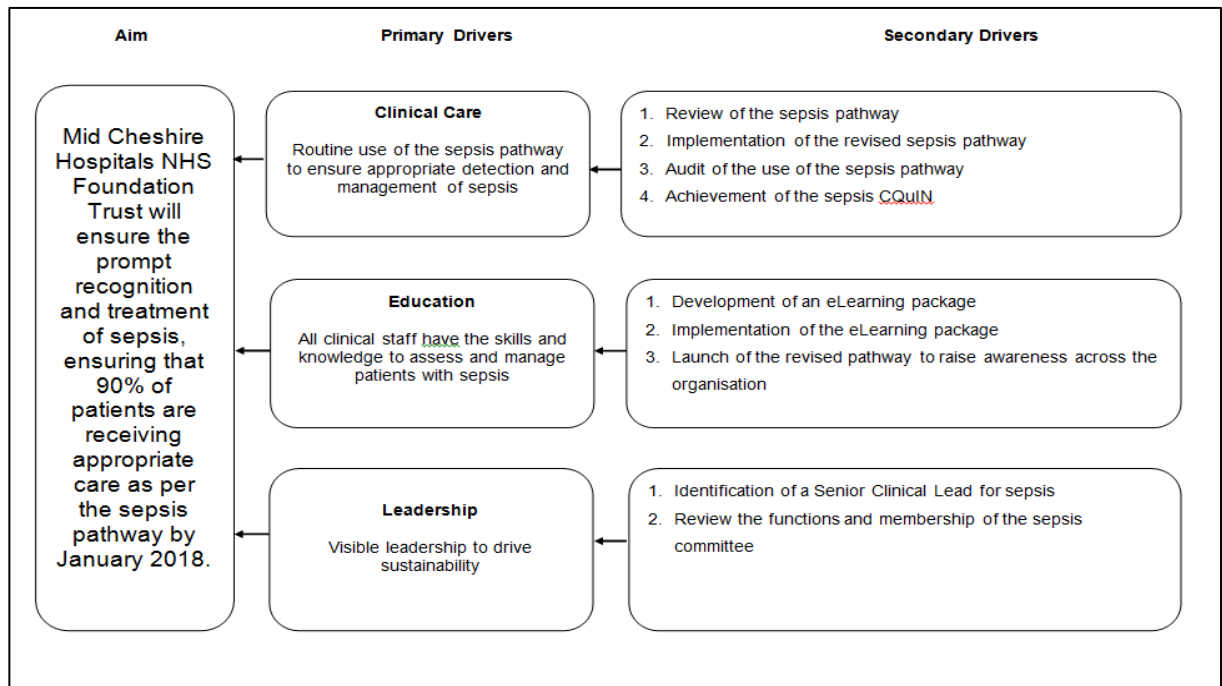


Safety Improvement Project Five – Sepsis

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

Lead Committee / Group: Sepsis Group

Project Lead: Consultant Acute Physician

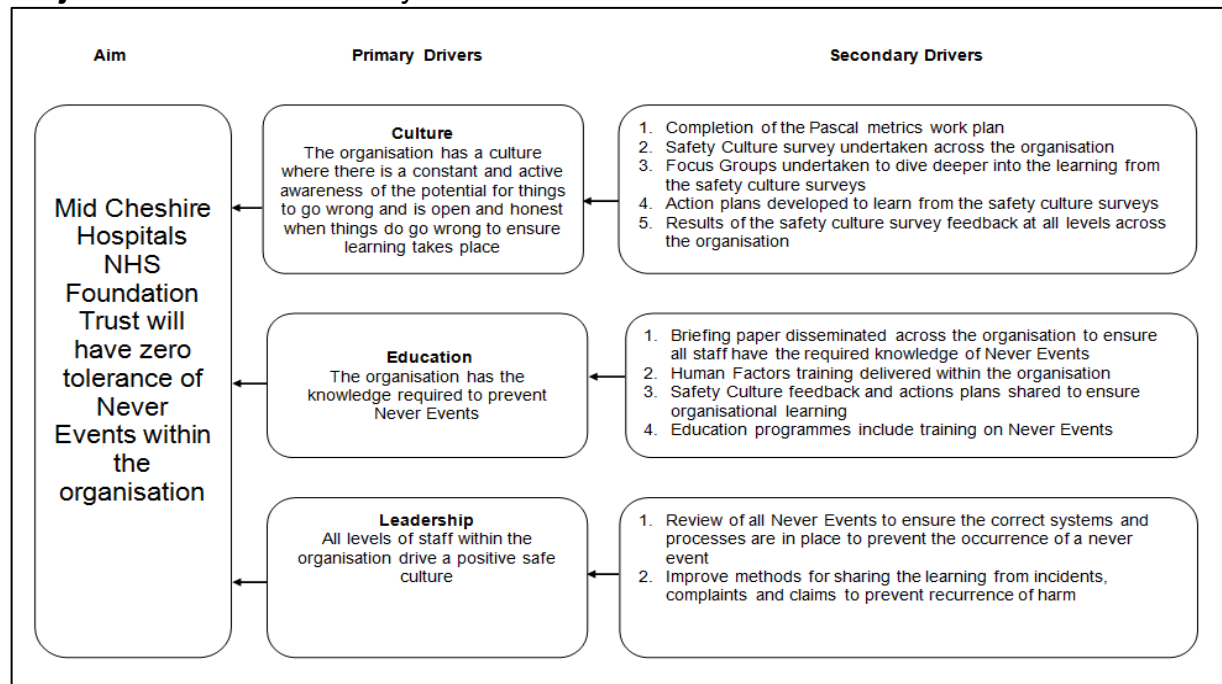


Safety Improvement Project Six – Never Events

Aim: The Trust will have zero tolerance of never events in the organisation

Lead Committee / Group: Executive Quality Governance Group

Project Lead: Patient Safety Lead



Feedback from staff

The NHS staff survey is undertaken each year and the Quality Account Reporting Arrangements (NHS England, 2016) require the Trust to report the most recent results for the following questions for the Workforce Race Equality Standard:

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

The Trust scored 25% in 2015 compared to 24% in 2014. This result was in the 'better than average' bracket when compared to all acute Trusts. The scores for White and Black and Minority Ethnic (BME) staff as required for the Workforce Race Equality Standard are as follows:

Key Finding		2015	2014
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White	23%	23%
	BME	33%	24%

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

90% of staff who completed the staff survey in 2015 believed that the Trust provides equal opportunities for career progression and promotion which maintained the score it obtained in the 2014 staff survey. The national average was 87%. This score put the Trust in the 'better than average' group when ranked against all acute Trusts.

The scores for White and Black and Minority Ethnic (BME) staff as required for the Workforce Race Equality Standard can be found in the table below:

Key Finding		2015	2014
Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	White	92%	91%
	BME	79%	63%

Participation in clinical audits and research

Clinical audit evaluates the quality of care provided against evidence based standards and is a key component of governance and quality improvement. The Trust produces an annual programme for clinical audit, incorporating national, regional and local projects, which is informed and monitored using priority levels.

National clinical audits

During 2015/16, 29 national clinical audits and 5 national confidential enquiries covered NHS services that the Trust provides.

During the same period, the Trust participated in 91% of the national clinical audits and 100% 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 2015/16 can be seen in Tables 4 and 5. 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.

National Clinical Audit / Programme	Participation	% Data Submission
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Yes	100%
Adult critical care (Case Mix Programme – ICNARC CMP)	Yes	100%
Bowel cancer (NBOCAP)	Yes	100%
Diabetes (Paediatric) (NPDA)	Yes	100%
Elective surgery (National PROMs Programme)	Yes	100%
Falls and Fragility Fractures Audit Programme: National Hip Fracture Database	Yes	85%
Falls and Fragility Fractures Audit Programme: National Audit of Inpatient Falls	Yes	100%
Head and neck oncology (DAHNO)	Yes	100%
Inflammatory bowel disease (IBD)	Yes	100%
Lung cancer (NLCA)	Yes	100%
Major trauma (The Trauma Audit & Research Network, TARN)	Yes	100%

National Clinical Audit / Programme	Participation	% Data Submission
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Yes	100%
Medical and Surgical Clinical Outcome Review Programme NCEPOD: Acute Pancreatitis Study	Yes	100%
Medical and Surgical Clinical Outcome Review Programme NCEPOD: Study of the Care of Patients with Mental Health Problems in Acute General Hospitals	Yes	100%
Child Health Clinical Outcome Review Programme: Chronic Neurodisability	Yes	Data collection in progress
Child Health Clinical Outcome Review Programme: Young People's Mental Health	Yes	Data collection in progress
National Complicated Diverticulitis Audit (CAD)	Yes	100%
National Emergency Laparotomy Audit (NELA)	Yes	≥50%***
National Heart Failure (HF)	Yes	77%***
National Joint Registry (NJR)	Yes	>90%
National Prostate Cancer Audit	Yes	34%*
Neonatal intensive and special care (NNAP)	Yes	100%
Oesophago-gastric cancer (NAOGC)	Yes	>90%
Rheumatoid and early inflammatory arthritis	Yes	12 data submissions**
Sentinel Stroke National Audit Programme (SSNAP)	Yes	100%
National Diabetes Inpatient Audit (NADIA)	Yes	100%
National Pregnancy in Diabetes Audit	Yes	100%
BTS Emergency Oxygen	Yes	100%
National End of Life Care	Yes	100%
National Comparative Audit of Blood Transfusion programme: Audit of Patient Blood Management in Scheduled Surgery	Yes	100%

National Clinical Audit / Programme	Participation	% Data Submission
National Comparative Audit of Blood Transfusion programme: Audit of Red Cell & Platelet transfusion in adult haematology patients	Yes	100%
Royal College of Emergency Medicine: VTE Risk in Lower Limb Immobilisation	Yes	100%
Royal College of Emergency Medicine: Procedural Sedation in the Emergency Department	Yes	100%
Royal College of Emergency Medicine: Vital Signs in Children	Yes	100%

- * The Trust is only eligible for minimal aspects of this dataset, care is then transferred elsewhere.
- ** One Rheumatology Consultant participated from the Trust
- *** Based on the 2015 annual report and an over predicted number of cases for the size of the Trust

Table 4: National clinical audit participation 2015/16

National Clinical Audit / Programme	Participation	Reason
National Cardiac Arrest Audit (NCAA)	No	Nurse specialist resource implications
Diabetes (Adult) ND(A)	No	Consultant, specialist nurse and data collection resource implications
National Comparative Audit of Blood Transfusion programme: Lower Intestinal Bleeding and Use of Blood in Haematology	No	Consultant, specialist nurse and data collection resource implications

Table 5: National clinical audit non-participation 2015/16

The reports of 28 national clinical audits were reviewed by the Trust in 2015/16. Table 6 details the actions taken / to be taken to improve the quality of healthcare provided as a result of national clinical audits.

National Clinical Audit / Programme	Actions taken / to be taken by the Trust
Adult Community Acquired Pneumonia (CAP)	Work is in progress to increase the numbers of medical and nursing specialists in line with an increased respiratory bed base and moving towards 7 day working. Local results compare favourably to national with a CAP pathway in place that is regularly reviewed.
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Latest report currently under review. Data validation exercises undertaken to ensure accuracy and weekly reviews in place to maintain data validation.
Adult critical care (Case Mix Programme – ICNARC CMP)	Critical Care ward discharge process developed, approved and implemented following an increase in delayed discharges highlighted in ICNARC and local incident reporting.
Bowel cancer (NBOCAP)	Latest report currently under review. Local audit confirms that only 7% of patients have not undergone reversal of a defunctioning ileostomy within 18 months of resection without a clinical reason. Quarterly review of data by individual surgeons introduced to improve accuracy of data.
Elective surgery (National PROMS Programme)	The objective is to ensure that at least 85% of patients receive a pre-operative PROMS questionnaire if they are undergoing surgery for: <ul style="list-style-type: none"> i. Groin Hernia ii. Varicose Vein Surgery iii. Hip Replacement Surgery iv. Knee Replacement Surgery The target was achieved with 95% - 100% of patients receiving a questionnaire.
Falls and Fragility Fracture Audit Programme: National Hip Fracture Database	Sunday morning trauma lists have commenced. Re-audit is currently underway around next day mobilisation by physiotherapy and weekend cover. The bone health assessment tool is incorporated in neck of femur pathway.
Falls and Fragility Fractures Audit Programme: National Audit of Inpatient Falls	Following joint review of national results and local Fallsafe audit, various initiatives are currently being trialled across the Trust, including bay tagging; night placement; patient cohorts; bespoke ward round for patients aged 80 years plus; continence rounds; bay based desk for nursing staff.

National Clinical Audit / Programme	Actions taken / to be taken by the Trust
Head and neck oncology (DAHNO)	A data collection template and process for sign off at patient tracking meetings has been developed to improve the accuracy of Somerset data and upload to the new national audit. A dental assessment pro-forma and pathway for patients with new diagnosis of head and neck cancer has also been developed.
Inflammatory Bowel Disease (IBD) Programme: Biologics	Latest report is currently under review.
Lung cancer (NLCA)	A proactive collaboration between the Trust, South Cheshire Clinical Commissioning Group and Cheshire East Council's public health team was presented with Macmillan's Team Excellence Award. The MacMillan Lung Cancer Project Team worked together to redesign the lung cancer pathway. Educating General Practitioners (GP) and practice nurses has increased referrals and reduced the volume of cancers diagnosed through emergency admission. In addition, access to a Lung Cancer Clinical Nurse Specialist at diagnosis has increased.
Major trauma (Trauma Audit & Research Network, TARN)	Work has been undertaken around the use of tranexamic acid in trauma as part of the Trust's major trauma guidelines for adults and children to reduce blood loss in patients with both normal and exaggerated fibrinolytic responses to surgery. Continued partnership working with the Royal Stoke University Hospital in relation to spinal referrals.
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK): Perinatal Confidential Enquiry	Expansion on current practice to review to all term stillbirths using a standardised pro-forma. All members of staff potentially interacting with bereaved parents will have access to basic bereavement skills as part of the divisional training programme through either additional sessions or e-learning.
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.
MBRRACE-UK: Perinatal Mortality Surveillance	Recommendations relating to lessons learned, governance and reporting have already been implemented within the Trust. Adaptations to the maternity Medway system around smoking history, age and education to ensure complete and accurate information in care is reflected by MDRRACE-UK nationwide.

National Clinical Audit / Programme	Actions taken / to be taken by the Trust
MBRRACE-UK: Saving Lives Improving Mothers Care	Report published December 2015 and an action plan is in development.
Medical and Surgical Clinical Outcome Review Programme NCEPOD: Sepsis Study	Latest report currently under review in conjunction with the Trust's sepsis group, Advancing Quality and National CQUIN data. Sepsis champions and pathway in place but currently under further development.
Medical and Surgical Clinical Outcome Review Programme NCEPOD: Gastrointestinal (GI) Haemorrhage Study	Partnership working with the University Hospital North Midlands (UHNM) agreed and pathways (including GI bleeding pathway) in place. Resourcing issues around substantive clinical posts in gastroenterology currently being addressed, which will enable further advancements and compliance with national guidance.
National Emergency Laparotomy Audit (NELA)	A local audit has been instigated to further progress work around antibiotic therapy, time from operation decision to theatre for emergency surgical patients and critical care admission post emergency laparotomy. A business case is under development for a surgical geriatrician role in-conjunction with Division of Medicine and Emergency Care.
National Joint Registry (NJR)	Work has been undertaken to support specific staff for data inputting to support new digital annual reporting, interactive clinical activity reports and the new NJR Quality Data Provider certification.
National Prostate Cancer Audit (NPCA)	Clinical Nurse Specialist (CNS) training has taken place in relation to complete psychological support and development of the service. Feasibility work is underway to explore the establishment of a joint Surgeon, Oncologist and CNS service for patients to access. Improved quality of data collection and data submission has been evidenced through adherence to data specification.
Neonatal intensive and special care (NNAP)	Work has been undertaken to promote breastfeeding, with the Trust achieving Baby Friendly Initiative programme status in 2015.
Oesophago-gastric cancer (NAOGC)	Ongoing work is taking place in relation to specialist MDT review at UHNM and technology for the Trust to link in as patient advocate to address variations in patient management and appropriate access to early endoscopy to enable early cancer detection.

National Clinical Audit / Programme	Actions taken / to be taken by the Trust
Rheumatoid and Early Inflammatory Arthritis	Work is planned to modify the referral pathway to include early inflammatory arthritis in choose and book and to educate GPs around referral pathways. A business case is to be developed and agreed with commissioners for a best practice tariff clinic.
Sentinel Stroke National Audit Programme (SSNAP)	Work is ongoing towards provision of a seven day specialist ward round rota following development of a seven day working business case. Acute stroke protocols for best practice have been amended in line with service plans. The Trust is working with the commissioners to develop referral guidelines for access to psychological care. A review of inter-disciplinary therapy standards is in progress to evidence the requirement for therapy input as part of the service plans.
National Pregnancy in Diabetes Audit (Nov15)	The Trust is performing better than the country as a whole. Progress has been made in working with GP's to enhance the preparation of women with diabetes for pregnancy and as part of the diabetes multidisciplinary team to further improve glycaemic control.
Fitting Child (Care in Emergency Departments) 14-15	Further education is being provided in relation to thorough and complete history taking. A patient safety leaflet has been developed as information for parents.
Mental Health (Care in Emergency Departments)	Clinical pathway have been developed and implemented for the assessment and management of patients presenting to the Emergency Department (ED) with mental health related conditions, including relevant supporting information to guide clinical assessment and management.
Older People (Care in Emergency Department)	Work is in progress to review appropriate tools for assessing cognitive impairment, which will be incorporated into ED documentation with relevant training for ED staff.
BTS Emergency Oxygen	Report awaited
National End of Life Care	Report awaited
National Heart Failure (HF)	Report awaited
National Complicated Diverticulitis Audit (CAD)	Report awaited

Table 6: National clinical audit participation 2015/16 – actions taken

Local clinical audits

The reports of 142 local clinical audits and 0 regional audits were reviewed by the Trust in 2015/16. 38% of these audits were re-audits.

Table 7 highlights some examples of the actions taken by the Trust as a result of local clinical audits to improve the quality of healthcare provided.

Local Project	Actions taken / to be taken by the Trust
Monitoring of Shoulder Dystocia	Overall, there was excellent care provided for women who delivered following a shoulder dystocia, with good outcomes for mothers and babies. Previously, it had been difficult to ascertain how long each manoeuvre had been performed for; but following an update in the shoulder dystocia proforma to include this as mandatory data, both data collection and practice have improved
Adherence to NICE Clinical Guidance on the Diagnosis and Management of Colorectal Cancer	The audit demonstrated that both NICE and local cancer guidelines are being followed appropriately and that the introduction of a colorectal pathway has helped to reduce waiting times. Patients listed directly have a reduced time to diagnosis in comparison to those seen initially in clinic. Identifying patients that can be scoped directly at first contact decreases time to treatment (potentially by up to 15 days) thus improving patient care. Electronic referral forms with clear criteria which are fully completed by GPs are essential for direct listing.
Self-administration of Medicines at Elmhurst Intermediate Care Centre	Historically, all patients at Elmhurst had medicines administered during drugs rounds in the same manner as patients in hospital. The project has evidenced that, since this initiative was established two years ago, all patients are routinely assessed for the ability to self-administer medicines during their stay in the rehabilitation setting. This is advantageous in re-gaining their confidence and independence before discharge home and aims to reduce the number of re-admissions.

Local Project	Actions taken / to be taken by the Trust
Re-audit of the Diagnosis, Prevention and Management of Delirium	The audit demonstrated the need for a more extensive education programme for trainee doctors and senior clinicians which has been taken forward through trainee doctor induction, education sessions, consultant meetings and dementia champions. The medical pro-forma has been updated to combine the delirium risk factor assessment to the abbreviated mental test assessment. Work is on-going with dementia specialist nurse and matrons to ensure effective use of the dementia tools.

Table 7: Examples of actions taken following local clinical audits

Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by the Trust between April 2015 and February 2016 that were recruited to participate in research approved by a research ethics committee was 330.

Recruitment figures are uploaded centrally usually in the month following the date of recruitment and are then verified by the Clinical Research Network North West Coast before being distributed to Trusts. There has been a transition in the national and regional platforms used to collect this data which has caused a delay in receiving the figures for March 2016.

The following chart shows the numbers of patients recruited to clinical trials over the past eleven months. There were, on average, 30 patients recruited each month.

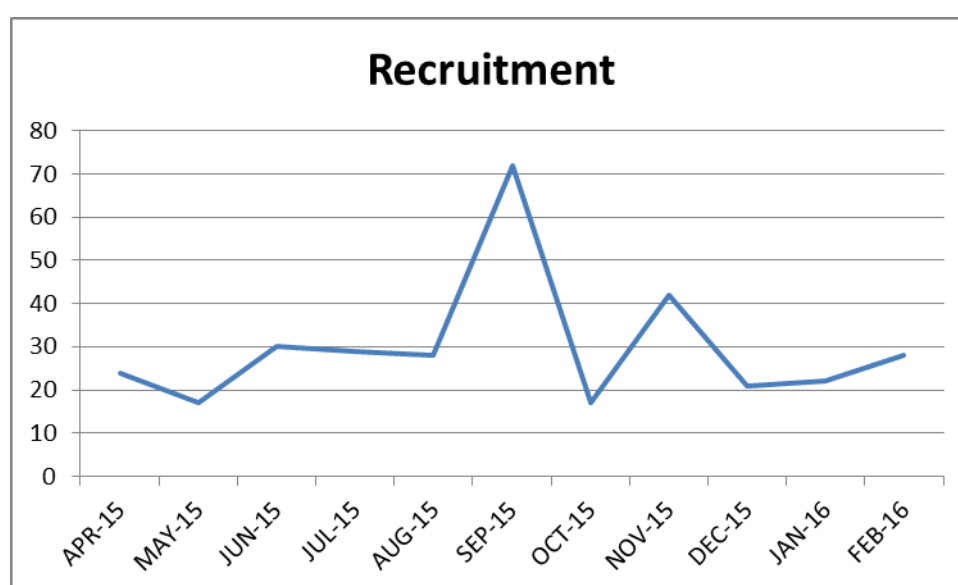


Chart 3: Numbers of patients recruited to clinical trials

There were nine 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.

The Trust was involved in conducting 152 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 2015/16 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 2015/16 and for the following 12 month period are available online at:

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

The financial value of the 2015/16 CQUIN scheme for the Trust was £3,798,574. The total amount the Trust received in payment for the CQUIN scheme was £3,392,013.

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

For 2015/16, there were four national CQUIN goals which focussed on Acute Kidney Injury, Sepsis, Dementia Care and Urgent & Emergency Care.

The Trust and the Clinical Commissioning Groups (CCGs) for Vale Royal and South Cheshire agreed a further sixteen goals. The North West Specialised Commissioning Group (SCG) negotiated two goals in relation to neonatal services provided at the Trust.

Table 8 briefly describes the goals included in this year's CQUIN and the Trust's performance against each of the CQUIN goals.

Key for Table 8 (CQUIN results for 2015/16):

Achieved



Partially Achieved



Off track but recoverable



(applies only to advancing quality CQUIN where data is delayed by 4 months)

Not achieved



Goal No.	Goal Name	Description of Goal	Financial Value of goal (£)	Status
1.	Acute Kidney Injury (AKI)	Diagnose AKI and provide follow up information to GP's on discharge	370,333.17	
2.	Sepsis: Part 1: Screening	Ensure appropriate sepsis screening tool in place and utilised	185,166.59	
	Part 2: Antibiotic administration	Initiation of intravenous antibiotics within one hour of presentation for those patients with suspected severe sepsis or septic shock	185,166.59	
3	Dementia: Part 1: Find, assess, investigate, refer and inform (FAIRI)	The proportion of patients aged 75 and over to whom the case finding question is applied following an emergency admission; the proportion of those identified as potentially having dementia who are appropriately assessed; the number referred onto GP services and those who have a written plan of care on discharge which is shared with the patient's GP	222,199.90	

Goal No.	Goal Name	Description of Goal	Financial Value of goal (£)	Status
	Part 2: Staff training	Appropriate training is available to staff	37,033.32	✓
	Part 3: Supporting carers	Ensure carers feel supported	111,099.95	✓
4	Urgent and Emergency Care	Improving the recording of diagnoses in the emergency department of patients with mental health needs	370,333.17	✓
5	Advancing Quality (AQ): Acute Myocardial Infarction	Implement the AQ care pathway for Acute Myocardial Infarction	15,000	😊
6	Advancing Quality (AQ): Heart Failure	Implement the AQ care pathway for Heart Failure	15,000	✓
7	Advancing Quality (AQ): Hip and Knee Replacement	Implement the AQ care pathway for Hip and Knee Replacement	15,000	✓
8	Advancing Quality (AQ): Pneumonia	Implement the AQ care pathway for Pneumonia	15,000	😊
9	Advancing Quality (AQ): Chronic Obstructive Pulmonary Disease (COPD)	Implement the AQ care pathway for COPD	15,000	✗
10	Advancing Quality (AQ): Hip Fracture	Implement the AQ care pathway for Hip Fracture	15,000	😊
11	Advancing Quality (AQ): Sepsis	Implement the AQ care pathway for Sepsis	15,000	😊
12	Advancing Quality (AQ): Acute Kidney Injury	Implement the AQ care pathway for Acute Kidney Injury	15,000	😊
13	Advancing Quality (AQ): Diabetes	Implement the AQ care pathway for Diabetes.	15,000	😊
14	Advancing Quality (AQ): Alcoholic Liver Disease	Implement the AQ care pathway for Alcoholic Liver Disease	15,000	✗

Goal No.	Goal Name	Description of Goal	Financial Value of goal (£)	Status
15	Advancing Quality (AQ): Patient Experience	Engage with patients to elicit their views about their experiences to inform the development of the service:		
	Part 1: Hip and Knee Replacement	Patients on the elective hip or knee pathway	188,364	✓
	Part 2: Heart Failure	Patients on the heart failure pathway	188,364	✓
	Part 3: Sepsis	Patients following the sepsis pathway	188,364	✓
16	Transition for young people with Diabetes	Review the transition pathway to improve patient experience and ensure the delivery of effective quality care for young people and their families	188,364	✓
17	Person centred care for patients who have a diagnosis of cancer of unknown primary (CUP)	Develop self-care pathways and the provision of information to support self-care / self-management for patients to manage their care	188,364	✓
18	Cancer survivorship risk stratification	Patients ending acute treatment for cancer are to be stratified into the following categories: Supported self-management Shared care Complex case management	188,364	✓
19	Discharge:			
	Part 1: Patient Experience	Understand patients' / carers' views of the discharge process	188,364	✓
	Part 2: Discharge Documentation	Review and develop existing documentation used in discharge planning	188,364	✓
	Part 3: E-discharge Correspondence	Improve the quality of correspondence between GPs and Acute Physicians	188,364	✓
	Part 4: Complex Discharge	Review the process of discharge of patients with complex care needs through the use of patient stories	188,364	✓
20	Integrated care record	Implementation of the integrated digital care record	188,364	✓

Goal No.	Goal Name	Description of Goal	Financial Value of goal (£)	Status
21	Neonatal Specialised Commissioning: Neonatal Admissions	Improve learning from avoidable term admissions (≥ 37 week gestation) into neonatal units	47,621	✓
22	Neonatal Specialised Commissioning: Neonatal Critical Care	Reduce clinical variation and identify service improvements by ensuring data completeness in the audit questions identified	47,621	✓

Table 8: CQUIN results for 2015/16

It can be seen that, of the 22 goals, the Trust has achieved, or has plans to achieve, the majority of CQUIN goals. There are some challenges with the implementation of elements of the Advancing Quality (AQ) care pathways for chronic obstructive pulmonary disease, pneumonia, acute kidney injury, diabetes, alcoholic liver disease and sepsis.

Actions are in place to improve the Trust's position against these elements of the CQUIN. For the Advancing Quality goals (5–14), the Trust has anticipated the final results. The reporting period for the Advancing Quality programme does not close until August 2016.

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 2015 to March 2016.

In addition, the Trust has not been involved in any special reviews / investigations by the Care Quality Commission during the period April 2015 to March 2016.

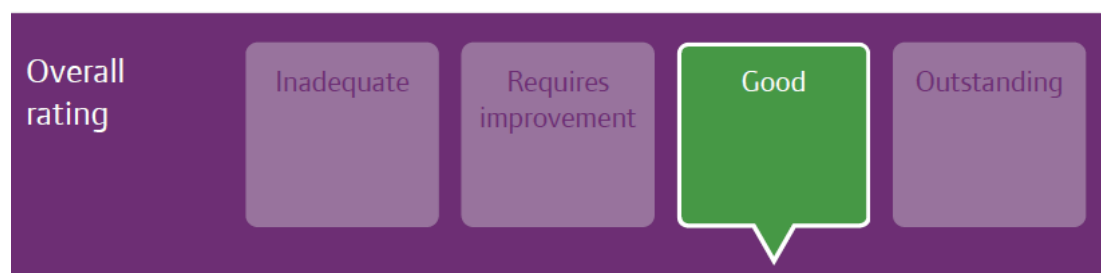
The CQC report following the Comprehensive Inspection of the Trust in October 2014 was published in January 2015 and awarded the Trust an overall rating of “Good”. This rating has only been awarded to a small number of acute hospitals in the country and puts the Trust as amongst the highest rated in 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.



Last rated
15 January 2015

Mid Cheshire Hospitals NHS Foundation Trust



Are services

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

Table 9: Care Quality Commission’s rating for the Trust

Specific ratings were published for Leighton hospital as per the table below:



Last rated
15 January 2015

Mid Cheshire Hospitals NHS Foundation Trust

Leighton Hospital



Table 10: Care Quality Commission's rating for Leighton hospital

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

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

The actions the CQC highlighted that the Trust must take include:

- Ensuring that medical staffing is appropriate and sufficient at all times to provide appropriate and timely treatment of patients, including out of hours. In response to this, the Trust has developed a business plan, primarily as a quality investment, to increase the level of medical cover and to begin to appoint and train alternative staff to support activities arising from current shortfalls in junior medical staff and in readiness for future further reductions expected from 2016. This business plan was approved in July 2015 and will progress towards 7 day services, recognising the limitations of this investment against the required resources to fully implement a 7 day service.

With regards to the equitable provision of junior doctors, in November 2015, the Medical Director took responsibility for arranging the Medical Directors' Forum meetings for Cheshire and Merseyside. This topic will be included as an agenda item at the meetings. To assist with marketing the Trust and enabling it to actively pursue international recruitment, a microsite has been developed. Additionally, the Trust is working with other providers through a local health economy Provider Board to redesign existing service provision and develop new services to better manage patients outside of the hospital and reduce emergency admissions. The University Hospital of North Midlands (UNHM) is considered a key partner and this view is supported by the Board of Directors of both Trusts.

- Improving patient flow and reducing the number of bed moves within the Trust. To progress this action, the patient placement policy has been reviewed, Clinical Site Manager cover has been increased and the access and flow transformation work stream has been developed, which will monitor bed productivity and patient flow.
- Clearing a backlog of discharge letters. This action has been completed and monitoring continues to ensure that the improvements made are sustainable.
- Ensuring that escalation areas are appropriate environments for the care of patients to provide them with ready access to bathing and toilet facilities. The Trust has subsequently relocated the Primary Assessment Area (PAA) to a ward area with full patient facilities and reviewed its policy for admitting patients to this area.

Additional actions which have been taken throughout the Trust to improve care include:

- producing guidance for staff about the availability of clinical supervision and support
- the provision of training and documents to ensure that staff are acting in accordance with patient's best interests when they are deemed not to have capacity
- the use of e-learning modules for mandatory training

- the development of partnership agreements with UHNM for upper gastrointestinal bleeds and stroke thrombolysis
- implementation of an updated sudden death checklist for paediatrics
- review of readmissions and improvement of theatre utilisation within the surgical division
- commencement of the Advancing Quality diabetes pathway and the recruitment of a Diabetic Specialist Nurse
- approval of a business case for the additional Consultant anaesthetic sessions required
- review of level 3 safeguarding training

The Trust was also randomly selected to participate in a national review of Information Security within the NHS. This report was requested by the Minister for Health and commissioned by the CQC. The review was conducted by the Health and Social Care Information Centre supported by a colleague from an independent auditing / research company. The aim of the review was to conduct informal discussions with a selection of identified staff members, including the Caldicott Guardian and Senior Information Risk Owner, to ascertain the impression of staff about information security within the Trust. The findings of this review were not attributable to individual staff or the Trust but contributed to a general report on information security in the NHS.

Data Quality Assurance

NHS and General Practitioner registration code validity

The Trust submitted records during 2015/16 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:

- 99.82% for admitted patient care;
- 99.96% for outpatient care;
- 99.30% 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;
- 99.98% for accident and emergency care.

Clinical coding error rate

In 2014/15, the Trust was in the top 20 percentile of Trusts in the payment by results clinical coding audit. This meant that an audit was not required in 2015/16. However, the Trust commissioned an audit to support the Information Governance Toolkit return by the Merseyside Internal Audit Agency (MIAA) Clinical Coding Academy which measures the same indicators as the Payment by Results audit.

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

- Primary diagnoses incorrect: 9%
- Secondary diagnosis incorrect: 9%
- Primary procedures incorrect: 4%
- Secondary procedures incorrect: 9%

The Trust remains pleased with these results and notes a further improvement on the previous year.

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

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 2016 and had an overall score increase for 2015/16 from 80% to 90%.

There are 45 requirements in total within the toolkit. In order to be graded 'satisfactory', each requirement must be at level 2 or above. The Trust submission in 2014/15 showed 42 requirements were satisfactory and this has increased to 43 for 2015/16. Unfortunately, the Trust remains graded as "not satisfactory" (status: red) due to these unsatisfactory requirements.

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

At final submission of the Information Governance Toolkit, the Information Governance team had supported the training of 3,715 (98%) staff, students and volunteers over the course of 2015/16. The Trust met its target for the third year running to achieve the toolkit requirement of at least 95% of individuals being trained in information governance.

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

The Ward Manager and Specialist Nurse from the gastroenterology team welcoming patients to the Trust:



Performance against quality indicators and targets

National quality targets












	2013-2014	2014-2015	2015-2016	Target	Achieved ?
MRSA bacteraemias	4	1	0	0	
Clostridium Difficile infections	26	10 avoidable cases	8 avoidable cases	24	
Percentage of patient who wait 4 hours or less in A&E	95.38%	92.3%	93.4%	95%	
The percentage of patients waiting 6 weeks or more for a diagnostic test	0.49%	0.37%	0.55%	<1%	
Percentage of patients seen within two weeks of an urgent GP referral for suspected cancer	95.56%	95.96%	96.60%	93%	
Percentage of patients seen within two weeks of an urgent referral for breast symptoms where cancer was not initially suspected	95.39%	95.47%	95.53%	93%	
Percentage of patients receiving first definite treatment for cancer within one month (31 days) of a cancer diagnosis	99.59%	99.55%	99.48%	96%	
Percentage of patients receiving subsequent treatment for cancer within 31 days where that treatment is surgery or anti-cancer drugs	99.3% 100%	99.2% 100%	100% 100%	94% surgery 98% drugs	 
Percentage of patients receiving first definite treatment for cancer within 62 days of an urgent GP referral for suspected cancer	90.82%	89.34%	91.22%	85%	
Percentage of patients receiving first definite treatment for cancer within 62 days of referral from an NHS Cancer Screening Service	94.84%	95.94%	97.94%	90%	

Table 11: National quality and performance standards

Key: Achieved



Not achieved



Staff working within the MacMillan cancer centre



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 or 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 or rates of the Trust's indicators with

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

Date	Trust Performance	National Average	95% Upper Limit	95% Lower Limit
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
January 2014 – December 2014	1.00 As expected	1.00	1.12	0.90
April 2014 – March 2015	0.99 As expected	1.00	1.12	0.90
July 2014 – June 2015	0.98 As expected	1.00	1.12	0.90

Table 12: The value and banding of the Summary Hospital-level Mortality Indicator (SHMI)

The data shown in the above table demonstrates that the Trust SHMI for the period to June 2015 was 0.98 and the Trust remained within the 'as expected' range.

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

- Participating in the national *Sign up to Safety* campaign. As part of the campaign, the Trust's aim is for the SHMI to remain at or below 100 from April 2015. A series of inter-related projects to achieve this are in progress under the primary drivers of:
 - Reliable clinical care
 - Effective clinical care
 - Medical documentation, clinical coding and data consistency
 - End of life care
 - Leadership

- Including the reduction of the SHMI as an objective within the Trust's Quality and Safety Improvement Strategy 2016/18.
- Continuation of the weekly mortality case note review group, which is led by the Lead Consultant for Patient Safety. The group was established to review themes and identify areas for further work in conjunction with the Hospital Mortality Reduction Group.

Date	Trust Performance	National Average	Highest Result	Lowest Result
April 2013 to March 2014	1.30%	1.30%	3.10%	0%
July 2013 to June 2014	1.40%	1.30%	3.10%	0%
July 2014 to June 2015	0.9%	1.4%	3.3%	0.0%

Table 13: The percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust

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

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

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.

Date	Trust Performance	National Average	Highest Result	Lowest Result
Groin Hernia Repair				
2013-2014	7.5	8.5	23.8	-14.4
2014-2015	8.9	8.7	12.5	0.9
April 15 - Sept 15	7.6	8.8	13.5	0.0
Varicose Vein Surgery				
2013-2014	No data Available	10	31.1	-4.33
2014-2015	No data Available	9.5	15.4	0.2
April 15 - Sept 15	No data Available	10.4	13.0	0.37
Hip Replacement Surgery				
2013-2014	46.8	43.8	72.4	20.4
2014-2015	43.7	43.7	52.4	33.1
April 15 - Sept 15	No data Available	45.4	52.0	0.0
Knee Replacement Surgery				
2013-2014	41	34	61.4	14.4
2014-2015	28.3	31.5	41.8	20.4
April 15 - Sept 15	No data Available	33.4	41.2	0.0

Table 14: The Trust's patient reported outcome measures scores (PROMS)

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:

- Comparing the PROMS results with those from the Joint Registry when all results have been published
- Continuing to monitor feedback from patients at their follow up clinic appointments
- Reviewing the results on a case by case basis for those patients who feel they did not have a good outcome against the outcome recorded in the clinical records.
- Continuing to use information leaflets which describe the process and value of the information collected through the use of the PROMS questionnaire
- Undertaking phone calls to patients at home 48 hours following discharge from their hip or knee replacement surgery.

The Trust uses a benchmarking software provider to calculate the indicator below and provide peer comparisons relating to readmissions. The Trust changed its provider from CHKS to HED in 2015/16. As a consequence of there being differences in the calculation of the indicator between the two providers, and the peer group not being replicable due to the number of subscribers, the previous year's comparatives have been restated to HED for this indicator. The previous year's comparatives for these indicators has changed as detailed below:

Date	Trust Performance CHKS	Peer Group Average CHKS	Trust Performance HED	Peer Group Average HED
January 2013 – December 2013	10.9%	11.1%	10.7%	10.7%
January 2014 – December 2014	11.2%	11.6%	11.4%	10.9%
January 2015 – December 2015	12.2%	11.6%	11.4%	10.4%

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

The Trust recognises that its readmission rates for patients aged between 0 to 15 is higher than peer and intends to take / has taken the following actions to improve this result, and therefore the quality of its service, by:

- Promoting the open access arrangements that are in place which allow 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.
- Consultant Paediatricians undertaking 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 multi-disciplinary team
- Continuing to develop a Consultant delivered rapid review clinic to avoid re-admissions and to promote an email service for GPs to try and support care in the community.
- Taking an active part in a regional Vanguard project in terms of reviewing the provision of paediatric services including enhanced services in the community. The commitment to Vanguard hopes to deliver a prevention of admissions and re-admissions.

The Trust uses a benchmarking software provider to calculate the indicator below and provide peer comparisons relating to readmissions. The Trust changed its provider from CHKS to HED in 2015/16. As a consequence of there being differences in the calculation of the indicator between the two providers, and the peer group not being replicable due to the number of subscribers, the previous year's comparatives have been restated to HED for this indicator. The previous year's comparatives for these indicators has changed as detailed below:

Date	Trust Performance CHKS	Peer Group Average CHKS	Trust Performance HED	Peer Group Average HED
January 2013 – December 2013	7.7%	7.0%	8.1%	7.6%
January 2014 – December 2014	8.0%	7.2%	8.6%	7.7%
January 2015 – December 2015	7.9%	6.8%	7.9%	7.1%

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

The Trust is pleased to report that its readmission results have improved for the period January 2015 to December 2015 against the same period for the previous year. This improvement has slightly exceeded the improvement seen in the peer group average figure (0.7% reduction versus 0.6% reduction).

It is acknowledged that the percentages continue to exceed the peer group average and the Trust can confirm that there continues to be focussed work undertaken by the clinical divisions on this measure.

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

- Developing action plans to address issues from identified trends in readmission rates
- Continuing to review readmissions for patients who have respiratory conditions, cardiac conditions, urology conditions or who have undergone breast surgery. Dedicated matrons are supporting this work and are implementing specific action plans to identify any issues identified
- Continuing to progress collaborative working with community services to prevent readmission

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

Table 17: The Trust's responsiveness to the personal needs of its patients

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:

- Reviewing individual patient care needs every day and making staffing adjustments as required
- Increasing the numbers of staff who are seconded from the Trust to undertake nurse training
- Ensuring that Trust induction, training and the appraisal process reinforce the importance of the Trust's values and behaviours
- Focussing key safety improvement initiatives on the implementation of patient care pathways
- Increasing the provision of patient information leaflets

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

Table 18: Staff employed by the Trust who would recommend the Trust as a provider of care to their family or friends (scores out of 5)

The Trust is delighted to report 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 focus on communication to staff about their important role in improving the quality of care and services we provide.
- The Trust's appraisal system looks at values and behaviours

- The Trust 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 briefs which focus on the patient safety and quality agenda
- Patient stories are told at Board meetings each month – to ensure that patients are at the heart of all decisions being made by the Board
- All internal leadership programmes include a focus on patients – and have had patients 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 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.

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
- Improving the quality of appraisals
- Improving team working and communication

Date	Trust Performance	National Average	Highest Result	Lowest Result
January 2015 – March 2015	96.02%	99%	100%	79.23%
April 2015 – June 2015	96.78%	98.9%	100%	86.1%
July 2015 – September 2015	97.19%	99%	100%	75%

Table 19: The percentage of patients who were admitted to hospital who were risk assessed for venous thromboembolism (VTE)

The Trust has met the 95% national target for Venous thrombo-embolism (VTE) risk assessment for the previous 2 years and continues to do so.

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. This is undertaken by the Trust's VTE Group on a quarterly basis to ensure continued compliance with the national target.

- Implementation of 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.
- Education for all medical staff on the importance of VTE risk assessment.

Date	Trust Performance	National Average	Highest Result	Lowest Result
2013-2014	14.6	14.7	31.7	0
2014-2015	13.8	15.1	62.2	0
2015-2016	8.38	Not published	Not published	Not published

Table 20: The rate per 100,000 bed days of cases of Clostridium difficile infection reported within the Trust amongst patients aged 2 or over

The Trust is pleased to report a continued reduction in the number of Clostridium difficile infections per 100,000 bed days. In addition, the Trust is also able to report a reduction in the number of avoidable cases of Clostridium difficile. Eight cases were reported this year compared to ten last year; which represents a considerable achievement and reflects the efforts undertaken to reduce healthcare associated infections.

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

- Maintaining environmental hygiene standards and good hand hygiene at ward level
- Monitoring antibiotic prescribing compliance and share learning with divisions following antibiotic audits performed by Consultant Microbiologists and Antimicrobial Pharmacists
- Maintaining active management of Clostridium difficile cases through weekly multi-disciplinary meetings ensuring all aspects of patient care are reviewed and actioned where required
- Completing a root case analysis on all Clostridium difficile cases, to highlight any lapses in care and share learning with our community colleagues
- Reviewing the Trust's performance against regional and national data to identify any learning from similar Trusts.

Date	Trust Performance	National Average	Highest Result	Lowest Result
October 2013 to March 2014	3016	2185	3790	301
April 2014 to September 2014	2814	2052	4301	908
October 2014 to March 2015	2767	4539	12784	443

Table 21: The number of patient safety incidents reported within the Trust

The above table shows the total incidents reported for the period of 1 October 2014 to 31 March 2015 compared to the previous data from the NRLS.

The Trust's performance appears to have decreased when comparing to previous data. This is because the Trust is now grouped under the "Non Specialised - Acute Trust" category which is part of a pool of 140 other Trusts. In previous NRLS reports, the Trust was grouped under the "Small Acute" pool which contains 28 other Trusts.

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 all staff throughout the Trust about incident reporting. This training ensures that all staff know how to report a patient safety incident and they also understand the importance of incident reporting
- Feedback to all staff on the outcome of the incidents they have reported to demonstrate the changes in practice that have been made as a result of the incident.
- Sharing learning from reported incidents via lessons learned flyers and individual patient stories.

Date	Trust Performance	National Average	Highest Result	Lowest Result
October 2012 – March 2013	3	16	56	1
October 2013 to March 2014	4	15	60	0
April 2014 to September 2014	3	15	51	0
October 2014 to March 2015	6	23	128	2

Table 22: The number and percentage of patient safety incidents reported within the Trust that resulted in severe harm or death

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 held following an incident investigation is always chaired by an Executive lead to ensure that lessons are learned and actions are implemented to prevent a reoccurrence
- Reporting all incidents which result in severe harm or death to the Board of Directors to ensure openness within the Trust
- Implementing the Trust's *Being Open* 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.

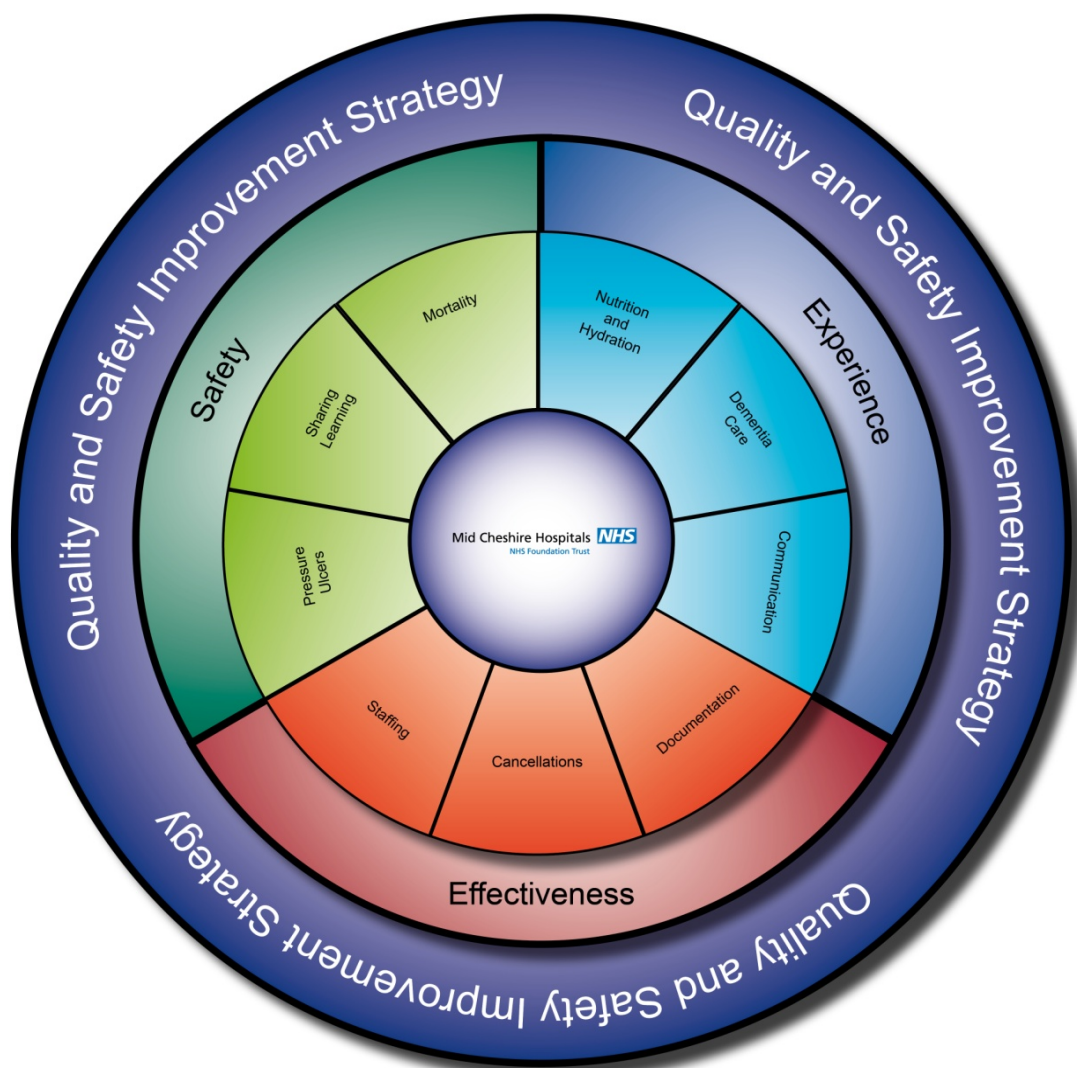
Part 3

Review of quality performance

This section of the Quality Account details progress against the second and final 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 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.

Mid Cheshire Hospitals 
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.

- Experience -

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

- Safety -

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

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

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

Learning From Incidents
We will learn from and act on your comments and feedback.

The Right Nurse Staffing Levels
We will show you that we have the right number of staff working each day.

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

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

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.

Quality and Safety Improvement Strategy 2014-2016:

Student involvement

Experience

- Nutrition & Hydration - As student nurses working within the multi-disciplinary team, we can ensure patient nutritional needs are met. Take time to make sure fluid balance and nutritional intake charts are filled in. Assist patients with meals and promote protected mealtimes
- Dementia care - 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. Encourage the use of the friends and family test.



Effectiveness

- Documentation - As students we need to document clearly using a known model and have all documentation countersigned. Share thoughts and ideas to reduce duplication in documentation
- Cancellations - A student can influence patient experience to make it a positive one, which will help reduce future cancellations made by patients
- Staffing - While students hold supernumary 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. Try and structure your learning opportunities early, allowing advanced notice of your absence from the ward.



Safety

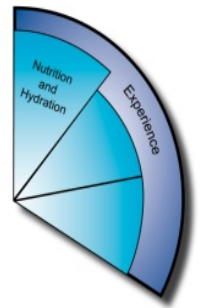
- Pressure ulcers – Make yourself familiar with the skin bundle. Students are in the unique position to spend time honing their skills. Take time to attend to the personal care of your clients, and increase your background knowledge of pressure ulcers. The PEFs run sessions too!
- Sharing learning – Incident reports are reviewed by some ward staff. See if you can do this with them and share ideas for learning in the trust
- Mortality – 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
- If you are unsure, seek advice.



PLEASE BECOME FAMILIAR WITH THE FULL QUALITY AND SAFETY IMPROVEMENT STRATEGY, FULL COPY IS AVAILABLE FROM:
<http://www.mch.nhs.uk/information-for-patients/why-choose-us/quality/quality-and-safety-improvement-strategy/?locale=en>

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 2015/16?

- The food nutrition and hydration policy for inpatients was updated and has been reviewed by the Nutritional Advisory Group. The policy has had a multidisciplinary review, including input from dietetics, language therapy and catering services to ensure the desired standards are met where food services are provided to patients.
- An escalation process has been developed and included in the revised food nutrition and hydration policy for inpatients. The escalation process should be used if the number of patients requiring assistance with meals or drinks exceeds the staffing allocation at that time. A flow chart will be promoted with the re-launch of the policy.
- Current documentation has been reviewed and a new nutritional assessment is being trialled in our assessment areas to enable comprehensive care planning which will ensure patients get access to the extra help or special diet they may require.
- Protected meal times continue to be promoted across the Trust to improve patient experience.
- The Chefs and the Catering Manager continue to visit patients on the wards to discuss individual patient preferences and receive instant feedback on food choices and quality.
- We continue to monitor patient satisfaction in relation to nutrition and hydration with a monthly inpatient survey. The survey focuses on the quality of meals delivered and the assistance given to patients at meal times. The results show that we consistently score between 90 – 100% of patients saying that they rate the hospital food as good or very good, that they were offered food that they enjoyed and that they always receive help from staff at mealtimes if this is required.

- The national inpatient survey also asks questions about food and mealtimes. The 2015 survey focussed on three questions which achieved the following results:
 - *How would you rate the hospital food?* The Trust received a 2% increase from 2014 with a mean rating score of 59%. This score placed the Trust in the 'about the same as other Trusts' category
 - *Were you offered a choice of food?* The Trust received a mean rating score of 87%, which was the same as 2014. This score placed the Trust in the 'about the same as other Trusts' category
 - *Did you get enough help from staff to eat your meals?* The Trust received a 3% increase from 2014 with a mean rating score of 75%. This score placed the Trust in the 'about the same as other Trusts' category
- A hostess service has been implemented on 4 wards across the Trust which has had a significant impact on reducing food waste across these areas. Positive feedback has been received regarding this service from both patient and staff and the service has demonstrated a quicker meal delivery.



Feedback from patients (taken from the national inpatient survey):

“1st class food - very tasty”

“Excellent food. Plenty of drinks”

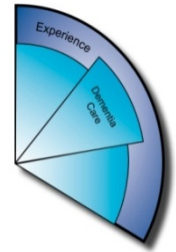
“Food is wonderful (I’m an ex chef!)”

“The hospital food was excellent. Fresh, hot, colourful, seasoned well and an appropriate sized portion”

“The food was the best of four hospital I’ve been in”

“Food was tasty, plentiful, hot and a varied diet”

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 2015 and estimated that between 25% and 40% 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 2015/16?

- The Trust continued to consistently assess more than 90% of patients aged 75 or over who were admitted as an emergency for memory problems
- All patients who believe they may have a memory problem are referred to their GP for further assessment and possible review by a memory specialist and referred for an appropriate specialist clinical assessment
- 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
- Dementia awareness training is mandatory for staff. The training highlights the importance of individualised care for patients whilst supporting their carers. This helps to support decision making and equity of access to treatments. It also helps to safeguard vulnerable adults.
- Open visiting is encouraged for carers of people living with dementia. This has been positively evaluated by all parties involved.

- The Trust has continued to work with the Royal Voluntary Service (RVS) to provide a befriending scheme for patients who are elderly and may have memory problems. The scheme encourages volunteers to befriend patients on three wards and engage in activities such as reading, playing card games and simply talking about the past. The project is having a wonderful effect upon the experience of patients and carers at the Trust.
- Building on the success of this project, the RVS have agreed to support the use of the 'Daily Sparkle' (a short magazine) as a reminiscence aid for use on the wards to optimize engagement.



- Nurses are working with the estates and facilities department to create a dementia friendly garden outside the older people's ward. The Trust is planning to involve the "Arts in Hospital" scheme with this initiative.
- A ward worship initiative has continued on a monthly basis, bringing 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.
- The dementia care bundle has been implemented and audited. This includes a personal support plan and promotes a person-centred approach to care. Feedback about this has been positive.

- The Trust encourages staff to promote the use of Twiddle-muffs for people with more severe dementia. Local community volunteers are working tirelessly to provide patients with their own individual Twiddle-muff and staff are reporting calming benefits with many patients.



- The dementia team has maintained their good working relationship with the Alzheimer's Society to gain valuable feedback from people living with dementia and their carers about their experiences of hospital care and to keep them abreast of developments in dementia care within the hospital.
- The Alzheimer's Society also attend the Dementia Care Pathway Group, which is an operational group driving forward standards in dementia care.
- The Trust has worked in partnership with the Alzheimer's Society to provide a support group for staff who are also caring for a person living with dementia at home.
- The Trust has listened to and acted upon the feedback provided by carers in the monthly carer survey.
- Carer guidelines have been written and are available to staff on the hospital intranet. The guidelines help ensure carers are included in decisions and are supported throughout the hospital journey. The carers' charter is included within these guidelines.

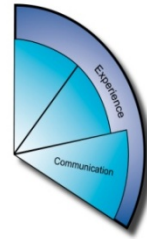
Feedback from patients / carers (taken from the monthly carer survey):

"I was impressed by the compassion shown by all staff and their determination to help me and my wife."

"It was great being able to stay with mum out of visiting times.....Staff worked really hard trying to find out about mum...I really appreciated being encouraged to bring photos in.."

"Staff knew dad had dementia -I didn't need to tell anyone – they just knew what to do"

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 2015/16?

The communication group comprised of key staff who were able to influence and improve communication with patients. This was crucial to the success of the group and to ensure that there was optimum staff engagement at ward or department level. The communication group led the implementation of the **'# hello my name is'** campaign with personalised name badges across the organisation. This was combined with a communication campaign to raise the awareness of this simple yet effective concept. The strapline below was designed and shared with staff via the intranet:

***'Communication is the key; it's what we're all about
So read my badge, see my name, there really is no doubt
Let me introduce myself, its simple but its true
'# hello my name is....., a very warm welcome to you'***

The success of the campaign led to one of the Trust's matrons being asked to present at a national conference to discuss how the Trust implemented the principles of **'# hello my name is.....'**.

Small things make a **BIG** difference



#hello my name is...

Communication is the key, it's what we're all about
So read my badge, see my name, there really is no doubt
Let me introduce myself, it's simple but it's true
#hellomynameis ____, a very warm welcome to you



Find out more at: www.hellomynameis.org.uk

The communication group also ensured that all local patient surveys containing communication questions included a question about whether staff introduced themselves by their name.

During these surveys, over 90% of patients reported that staff **always** introduced themselves by name. The remaining patients reported that staff sometimes introduced themselves by name. No patients said that staff never introduced themselves.

Feedback from patients from the communications surveys:

Nice friendly team

Made patients feel at ease

Staff professional friendly, reassuring at a very frightening time.

Important to know who is looking after you

Fantastic staff, polite introduce to, good explanations, made a difference.

Very useful, nice to know who's who

Made a difference, made me feel welcome

Made you feel calmer

Lovely staff calm and reassuring

Nice to address by name, don't have to say excuse me

Felt great being able to use a person's name rather than their title

Staff were friendly. They were really supportive & introducing themselves was helpful as there are lots of staff.

Made the staff seem even more friendly than usual - brilliant!

Trust wide communications were also used to raise awareness of the patient information leaflets available on the intranet and encourage the use of EIDO leaflets. The ward managers continue to share this with their staff.

Staff encourage the use of patient boards above the beds to ensure they are up to date and contain the name of the nurse and doctor responsible for each patient. This helps patients and their visitors to know who they can approach to direct any queries. To help improve compliance, the trust has supported the redesign and purchase of new bespoke patient boards for all ward areas.

The value of the patient passports has been shared with staff and there are now an increasing number of patient passports in place and more are in development.



A Trust site survey reviewed the use and value of the discharge communication checklists which had been developed in 2014. The results showed that not all patients had been shown the checklist and it was recognised that the checklist was not consistently used on the wards. The ward managers have agreed to review the content of the checklist and ensure that the updated version is available in every patients' folder.

Results from the 2015 national inpatient survey showed that the Trust has made some encouraging improvements in relation to communication when compared to 2014.

- More patients felt that they were involved in decisions about their care and treatment – a high scoring question (in the top 20% of Trusts)
- More patients were told how their operation had gone in an understandable way – a high scoring question (in the top 20% of Trusts)
- More patients felt that, for important questions, doctors answered in an understandable way (a significant improvement since 2014)
- More patients felt involved in discharge decisions (a significant improvement since 2014)
- More patients felt happy about the amount of information they were given on their condition or treatment (a significant improvement since 2014).

Overall, the aim identified in the quality and safety improvement strategy was to reduce the number of complaints relating to communication by 10%.

The number of formal complaints relating to communication for 2014/15 was 145

The number of formal complaints relating to communication for 2015/16 was 110

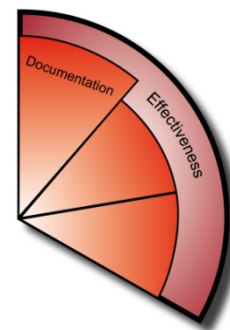
This shows a **reduction** of 35 formal complaints over the year which equates to a reduction of 26%.

The number of informal complaints relating to communication for 2014/15 was 576

The number of informal complaints relating to communication for 2015/16 was 490

This shows a **reduction** of 86 informal complaints over the year which equates to a reduction of 15%.

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 complete 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 they are required to complete so that they can focus the majority of their time with their patients.

What progress was made in 2015/16?

Following the successful pilot of the short stay nursing assessment booklet which was well received by the nursing staff on the Primary Assessment Area, further work has continued as part of the documentation review project.

The documentation review project had identified that there was a high volume of nursing and medical paperwork and that many of the questions we asked patients on admission were asked both by the nursing and medical staff.

A new nursing and medical integrated document has now been developed following this work by combining the short stay nursing assessment booklet with an improved medical proforma. The division of medicine and emergency care commenced a trial of this document which started in February 2016 for 3 months to evaluate the benefits.

The initial benefits identified in the development of this document are as follows:-

All members of the multidisciplinary team record their assessments and treatment plans in the same document to improve communication within the team. This action removes the need to record the medical plan in both nursing and medical documents and to ensure that the patients' journey is as seamless as possible.

The duplication of questions asked by nursing and medical staff have been removed which supports improved patient experience as patients do not have to repeat information for their assessments.

The document includes the new Infection control risk assessment to allow early identification of any infection risks for patients which ensures prompt advice is sought from the Infection Prevention and Control Team. In addition, the nursing staff can ensure appropriate screening and isolation is facilitated at the earliest opportunity.

A discharge check list is included which prompts staff to identify the intended date for discharge, share this information with the patient and family and ensure discharge arrangements are organised appropriately. In addition, a carbon copy is available to be given to the patient or carer to ensure they have involvement in the discharge plans and provides a written record of the discharge arrangements.

The nursing assessment for activities of daily living includes 10 domains (which has been extended from the short stay document) and signposts staff to care planning to best meet the patient's needs.

The medical section has been redesigned to provide a clear and easy to use template for the medical assessment of patients.

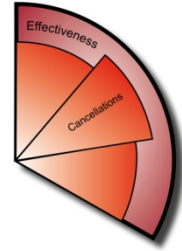
A staff feedback survey was circulated in March 2016 to ensure that staff are involved in this change process and are given the opportunity to comment on any improvements they can suggest to ensure that the document works well for all staff and improve integrated patient care.

NURSING ASSESSMENT DOCUMENTATION																																			
<p>Has the patient been admitted to any health care facility outside or inside the UK in the past 12 months? <input type="checkbox"/></p> <p>Does the patient have diarrhoea (type 5-7)? <input type="checkbox"/> Is the patient flagged for MRSA/ESBL/VRE/CPK or CPEC (CPE Contact)? <input type="checkbox"/> Is the patient CDIFFID positive? <input type="checkbox"/> Does the patient have an extensive rash that could be potentially infectious? <input type="checkbox"/> Does the patient have any respiratory symptoms that could be potentially infectious? <input type="checkbox"/> Does the patient have other risk factors eg Hickman/PICC/line, peg or urinary catheter, insitu? <input type="checkbox"/></p> <p>No infection issues identified <input type="checkbox"/></p>																																			
<p>Falls Screening (NICE 2013)</p> <p>Stage 1: Is the patient aged 65 years or above <input type="checkbox"/> Yes (falls assessment to be completed) <input type="checkbox"/> No (consider stage 2)</p> <p>Stage 2: Is the patient up to 50 to 65 years and judged to be a higher risk of falling due to an underlying condition over the last twelve months (as below)</p> <p>Sensory impairment <input type="checkbox"/> History of fall <input type="checkbox"/> Stroke <input type="checkbox"/> Delirium <input type="checkbox"/> Gait disturbances <input type="checkbox"/></p> <p>Other (any age) <input type="checkbox"/></p> <p>Yes to any stage 2 question <input type="checkbox"/> complete full fall assessment on admission</p> <p>No to any stage 2 question <input type="checkbox"/> Patient low risk & full fall assessment not required within the first 72 hours.</p> <p>Ensure patient has call bell to hand <input type="checkbox"/> Completed by: _____ Date: _____</p>																																			
<p>WATERLOW ASSESSMENT TO REDUCE THE RISK OF DEVELOPING PRESSURE ULCER</p> <p>Add total of scores (More than 1 score/category can be used) AND insert score into box below</p> <table border="1"> <thead> <tr> <th>BUILD WEIGHT FOR HEIGHT</th> <th>SKIN TYPE/TYPICAL RISK AREAS</th> <th>SEX</th> <th>REVIEW OF PRESSURE ULCER RISK ASSESSMENT (COMPLETE WITH 2 HOURS)</th> </tr> </thead> <tbody> <tr> <td>Average</td> <td>Healthy</td> <td>Male</td> <td rowspan="2">If Waterlow greater than 10, pressure ulcer or non-blanching erythema is present please commence skin bundle and complete TRI and wound care plan</td> </tr> <tr> <td>BMI = 20-24.9</td> <td>Tissue paper</td> <td>Female</td> </tr> <tr> <td>Above average</td> <td>Dry</td> <td>AGE</td> <td rowspan="2">W.L. score: _____ Date: _____ Signature: _____</td> </tr> <tr> <td>BMI = 25-29.9</td> <td></td> <td>18-49 1</td> </tr> <tr> <td>Obese BMI=30</td> <td>Oedematous</td> <td>50-64 2</td> <td rowspan="2">If Waterlow score is less than 10, skin is intact and no non-blanching erythema present please reassess daily</td> </tr> <tr> <td>Below average BMI <20</td> <td>Chapped, pyrexia, discoloured</td> <td>65-74 3</td> </tr> <tr> <td></td> <td></td> <td>75-85 4</td> <td rowspan="2">Score: _____ Date: _____ Signature: _____</td> </tr> <tr> <td></td> <td></td> <td>86+ 5</td> </tr> </tbody> </table>				BUILD WEIGHT FOR HEIGHT	SKIN TYPE/TYPICAL RISK AREAS	SEX	REVIEW OF PRESSURE ULCER RISK ASSESSMENT (COMPLETE WITH 2 HOURS)	Average	Healthy	Male	If Waterlow greater than 10, pressure ulcer or non-blanching erythema is present please commence skin bundle and complete TRI and wound care plan	BMI = 20-24.9	Tissue paper	Female	Above average	Dry	AGE	W.L. score: _____ Date: _____ Signature: _____	BMI = 25-29.9		18-49 1	Obese BMI=30	Oedematous	50-64 2	If Waterlow score is less than 10, skin is intact and no non-blanching erythema present please reassess daily	Below average BMI <20	Chapped, pyrexia, discoloured	65-74 3			75-85 4	Score: _____ Date: _____ Signature: _____			86+ 5
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Clinical Practitioner	ED or Medicine	Location
Date / Time Seen: DD / MM / YYYY	HH:MM	If ED: will need Medical notes
PRESENTING COMPLAINT(S)		
Reason for Admission & Presenting Complaint(s) (include Age)		
Source of History (patient, relative, interpreter etc):		
History of each Presenting Complaint including relevant risk factors		

Sample pages from the combined nursing and medical assessment proforma.

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 5 informal concerns raised by patients attending the Trust.

What progress was made in 2015/16?

Improvements in the management of outpatient clinic appointments have continued to affect a reduction in hospital initiated cancellations. Following the success of reducing cancellations by 20% in 2014/15, the Trust has seen a further reduction of 11.6% during 2015/16.

The graph below shows the improvements that have been made in reducing hospital initiated cancellations. Cancellations are measured as a percentage of the number of appointments. The graph shows this year's rates compared with the last two years. It can be seen that cancellation rates continue to fall.

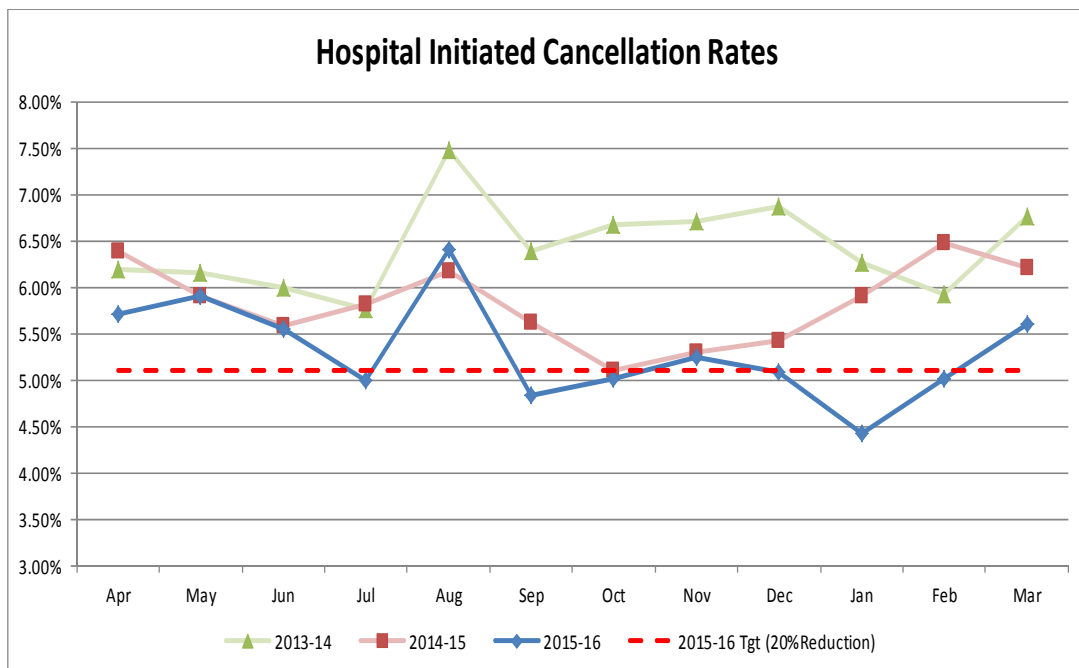


Chart 4: Hospital initiated outpatient cancellation rates

- Work has been undertaken with specialities to ensure adherence with the Trust's access management policy, improving the patient experience and ensuring that patients are given suitable notice of their appointment. Medical records continue to work with specialties to provide patients a minimum of 3 weeks' notice of their appointment.
- The Trust continues to monitor the number of appointments each specialty cancels or re-books and challenges any specialties as required.
- The introduction of a specialty booking team for surgery and a dedicated booking team for patients referred in with suspected cancer have enabled a focused approach to booking of clinics and an improved patient experience as they only have to speak to one team. A key element of this approach is to facilitate, where possible, the first outpatient appointment within 7 days for patients who have a suspected cancer. A local target has been set of 80% of patients to be seen within 7 days and this will be monitored weekly.
- For 2016/17, the Trust will monitor the start and finish times of clinics and a new governance structure will be put in place for the out patients rationalisation project group to enable a greater level of scrutiny at specialty level.
- The introduction of a text reminder system in February, which sends a text to a patient reminding them of their appointment both 7 days and 24 hours prior to their appointment, has already resulted in further improvements in the did not attend (DNA) rate.

The following graph shows a reduction in the number of patients who DNA their appointment over the past year. Significant improvements have been made for the most part of the year with the rate being lowest in February and March following the introduction of the text reminder system. In addition, the Trust's figures demonstrate that its performance is better than its peer (similar sized) organisations.

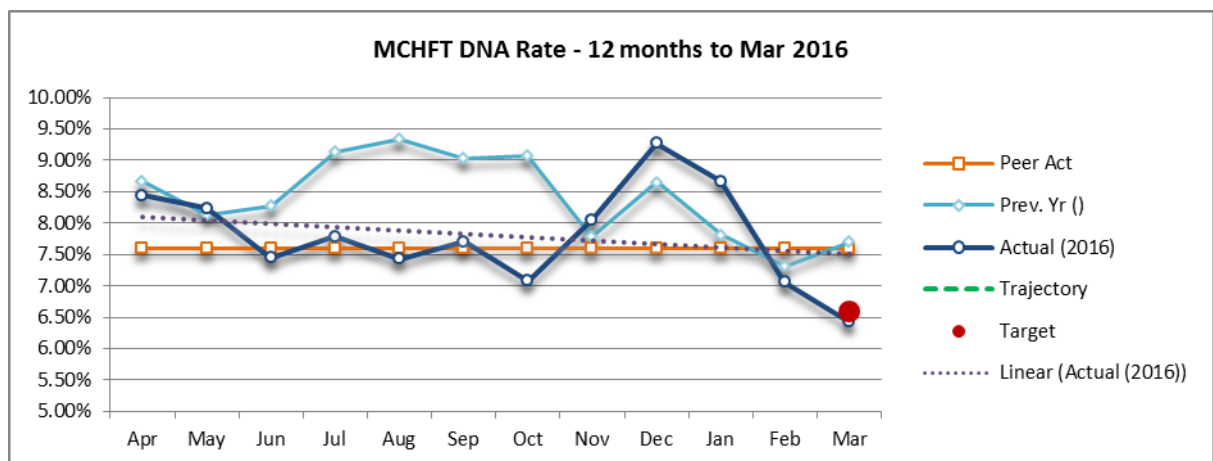


Chart 5: Did not attend (DNA) rates

Feedback from patients / carers (taken from the friends and family test):

'I was impressed with the speed at which my appointment was made and dealt with in hospital. Also, how helpful the staff were'.

'Staff very pleasant and efficient. Future appointment arranged with the utmost convenience to myself. Thank you'.

'Very efficient service. Hardly any waiting time. Appointment completed on time. Friendly, helpful staff'.

'You get first class attention, waiting time is good. Never had any troubles, very nice staff'.

'Received excellent care, very pleasant staff, only waited 30 minutes. First class'.

'Pleasant staff, short waiting time; treated with respect'.

'Super-efficient department, well organised. No waiting. Staff very helpful and reassuring, extremely pleasant'.

'I have been coming here now for over a year and each time the staff have been very polite, helpful, and efficient. Waiting times also very acceptable'.





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 2015/16?

- The staffing boards that were introduced on all inpatient wards from June 2014 continue to be updated on a daily basis. The boards are in a visible location for visitors to the ward and identify the planned and actual staffing numbers on duty that day by shift. The staffing boards also identify the nurse in charge of the shift and highlight the uniforms of the staff who are mostly likely to be working on the ward.
- 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 6 months a formal review of the nurse staffing levels is undertaken by the Director of Nursing using the nursing acuity 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 hospital website. This year, the reports have highlighted the need for additional investment in nursing staff working on the surgical wards and the paediatric unit. The Trust has agreed to invest in these requirements over the coming year.
- The staffing levels are recorded on a database by each ward on a daily basis and the results are reported each month to the public board meetings and published on the hospital website. The following data is reported:

Day time Registered Nurses monthly expected hours by shift versus actual monthly hours per shift. The results over the year show an average fill rate of 97% (ranging from 92.8% to 100.4%).

Night time Registered Nurses monthly expected hours by shift versus actual monthly hours per shift. The results over the year show an average fill rate of 99.6% (ranging from 98.5% to 101.3%).

Day time Healthcare Assistant monthly expected hours by shift versus actual monthly hours per shift. The results over the year show an average fill rate of 99.8% (ranging from 96.4% to 105.1%).

Night time Healthcare Assistant monthly expected hours by shift versus actual monthly hours per shift. The results over the year show an average fill rate of 103% (ranging from 98.1% to 106.4%).

- Staffing levels are reviewed on a shift by shift basis, or more frequently if required. A clear escalation process is in place if staffing levels fall below plan or activity indicates increased levels of staffing are required.
- The Trust's active recruitment plan has also continued its focus on:
 - Successful open days for the recruitment of health care assistants and qualified nursing staff. These resulted in the recruitment of seven qualified nurses and 71 healthcare assistants (most into permanent roles whilst the remainder joined the hospital bank team)
 - Open evenings jointly held with Chester University to encourage local students to undertake their nurse training in Crewe
 - Overseas recruitment of Spanish, Italian, Greek and Romanian qualified nurses
 - Review of shift patterns and updating of the roster policy.
- In August 2015, the Trust approved a plan to recruit 6 former nurses to a return-to-practice (RTP) programme with the aim of encouraging local people back into the workforce. The campaign was publicised using posters around the Trust using the strap line 'pick up your PIN' and in local supermarkets, libraries and other establishments. Press releases were published in local newspapers, and further publicity was gained from undertaking radio interviews with the two local radio stations. The six trainees commenced their university course on site at Leighton on 5th February 2016 and started their ward based placements three weeks later. The group are continuing with their academic study alongside specific skills training organised by the practice education team. Their qualification date is planned to be July 2016.

The RTP students at the start of their training:



- Following the success of recruiting two health care assistants (HCA's) to train for their nursing degree in March 2014 and recruiting eight members of staff in March 2015, the Trust further invested in training a further eleven HCAs who started their nurse training in March 2016. This means that, from March 2016, there are twenty one seconded students undertaking their nurse training, which is fantastic news for the Trust.

Comments from the March 2016 students before they started their nurse training included the following:

"I'm excited, can't wait for placements, ready for the challenge".

"I am feeling apprehensive about the three years ahead and the hard work it will entail but excited about all the new challenges I will experience, resulting in my long term goal of becoming a qualified nurse"

"I am thrilled to be starting my adult nurse training and looking forward to the challenges that lie ahead".

Some of the March 15 students meeting with the March 2016 students to share experiences: particularly about the first few weeks at university and how to complete assignments!



Feedback from patients / carers (taken from the friends and family test, NHS Choices and the national inpatient survey):

'From the moment I arrived in A&E in extreme pain, to after my emergency operation, I feel I had the best treatment and care'.

'If it was within my power I would pay the staff double. I have never seen people work so hard whilst maintaining professionalism, patience and compassion with a smile and great banter. Every person that I have come under the care of has been totally fantastic!'

'I was very happy with my treatment by the consultant. She took the time to explain to me what was happening with my condition and also was happy to speak to my children regarding my situation and care'.

'All the nurses, doctors, consultants were a credit to the hospital. Showing kindness and care throughout my 2 day stay. I felt no stress or concern under their professional care'.

'I had excellent nursing care for 10 days on my ward. They went beyond the call of duty, nothing was too much trouble. A special thank you to my surgeon'.

'I was tremendously impressed by the expertise and care given first by the Stoke Pathway Team, then by all in the Stroke unit at Leighton. Nothing was too much trouble. Even though everyone was busy they still act with kindness and treat us all as individuals'.

'All nursing care was outstanding, every single nurse showed a caring nature. All staff who dealt with my hospital stay made sure to show that they cared about my condition. Nearly all the nurses went out their way to make sure I was comfortable, informed and secure in my visit'.

'My whole experience was fantastic and I would not be scared to go back in hospital again'.

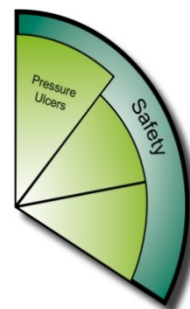
'There was a lot of love and kindness. Some staff really lovely, very caring'.

Pleasant, courteous and helpful nursing and care staff. The duty doctors were particularly caring and supportive, especially on this occasion'.

'I was taken to ward 10 straight from a GP appointment. Upon arrival my bed was ready, staff were there on hand to take my details, give pain relief and examine me. The speed of this was exceptional. I was very scared being told I needed a general anaesthetic for my operation but, as the staff were aware this was my first operation and how scared I was, they were so reassuring and made me feel at ease. The staff on ward 10 - nurses, healthcare staff and other members were fantastic and I hope they really do get the credit they deserve. Wow, absolutely fantastic and I cannot thank you enough for your help, support and class A service in such horrible circumstances. Thanks again, it's very much appreciated!'

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?

- During 2015/16, the Trust invested additional funding on a permanent basis to recruit a skin care specialist nurse to work 18.75 hours / week. This nurse works closely with the wards to educate and support staff in the skin care they provide to their patients.
- The skin care specialist nurse reviews all reported hospital acquired pressure ulcers to ensure all appropriate interventions are in place and to determine the staging of the pressure ulcer. In addition, a ward based mini root cause analysis is undertaken so that staff can understand what led to the development of the pressure ulcer and implement corrective action to eliminate gaps in care.
- The Trust’s skin care group continues to meet monthly and is chaired by an experienced matron. The group co-opts members to join as required, for example this year has seen representation from the emergency department and the plaster room.
- There has been an increased level of education provided for staff via the skin care specialist nurse which has included awareness raising and education about the management and prevention of pressure ulcers and moisture lesions.
- In 2015/16, the Trust saw the development of 138 avoidable pressure ulcers out of the 212 hospital acquired pressure ulcers which equates to 65%. Unfortunately, this means there was an increase in hospital acquired pressure ulcers from 2014/15 of 62 pressure ulcers.

Upon review of these incidents, the most common root causes related to patient acuity and failure to document the implementation of planned interventions.

The graph below shows the number of hospital acquired pressure ulcers for 2015/16 compared to 2014/15.

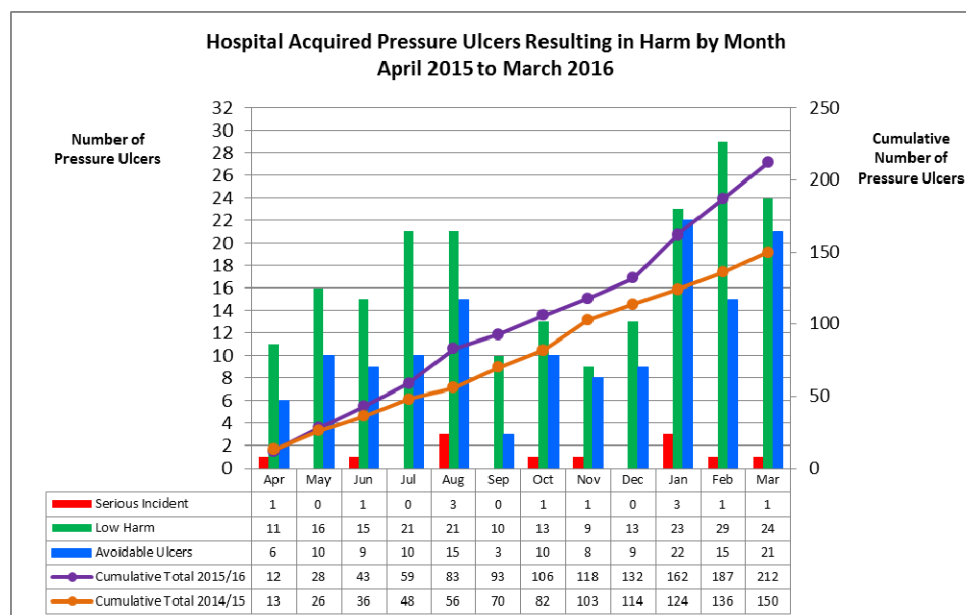


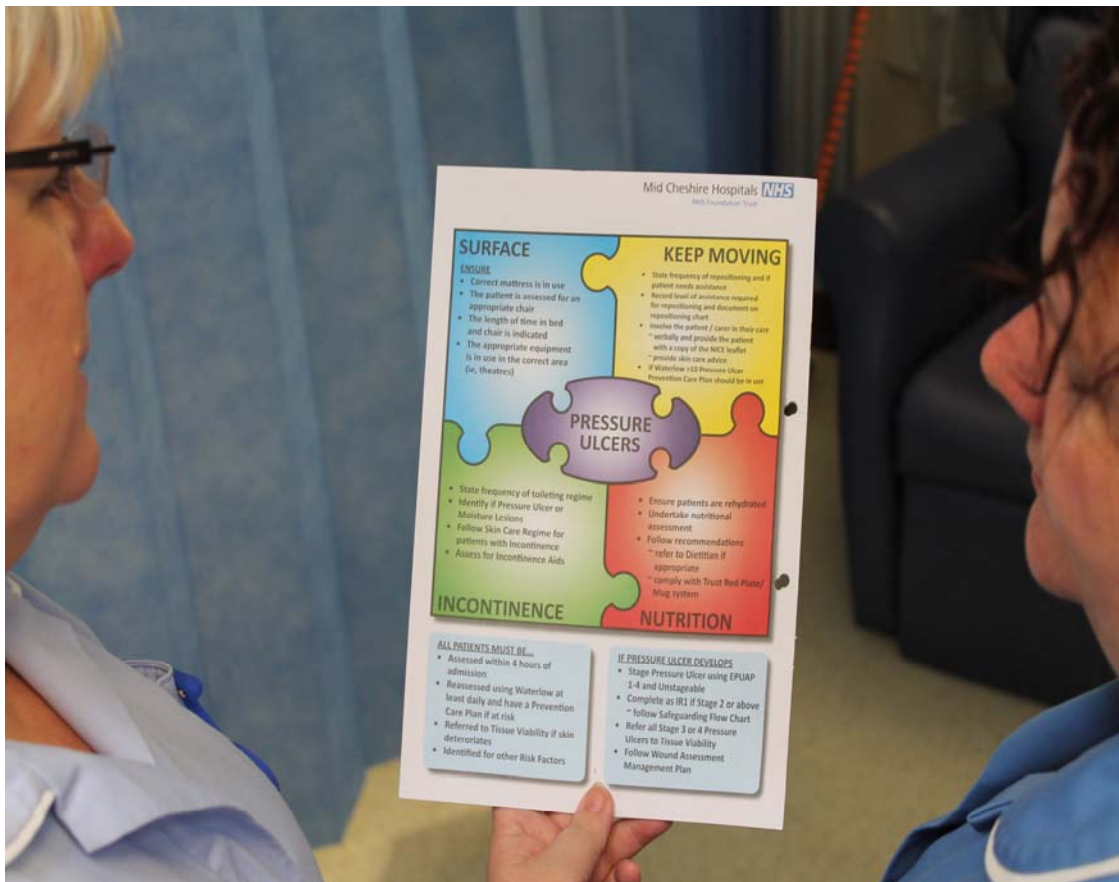
Chart 6: Numbers of hospital acquired pressure ulcers 2015/16
(Data Source: Ulysses, 2016)

The elimination of avoidable hospital acquired pressure ulcers remains a priority for the Trust and is part of the Quality and Safety Improvement Strategy for 2016/18.

In addition, the Trust will take forward the **React 2 Red** collaborative which is a national initiative aimed at reducing the development of pressure ulcers in hospitals and the community. This collaborative will be progressed in the Trust through 7 pilot areas which will:

- trial alternative pressure relieving mattresses
- trial new devices to relieve heel pressure
- work closely with continence experts to review training and product reviews. This will include a review of pads, pants and skin protection,
- undertake a daily proactive review of patients at risk of developing pressure ulcers
- utilise the patient and carer education provided by the **React 2 Red** collaborative
- participate in staff training using the literature and pocket guides provided as part of the **React 2 Red** collaborative
- work with the nutritional advisory group to enhance nutritional assessments
- implement an e-learning package for pressure ulcer prevention and management
- install new headboards with repositioning clocks to help patients, carers and staff work together to reposition vulnerable patients.

Staff undergoing training in the use of the SKIN bundle



Staff who attended skin care training - and won gift vouchers.



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 2015/16?

Following any patient safety incident, a retrospective review of the event is undertaken via a root cause analysis (RCA) 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.

A number of senior managers within the Trust have undertaken root cause analysis training to ensure incidents are being thoroughly investigated using the appropriate techniques.

Training on incident reporting and incident management is available to all staff. This includes training on using the online incident reporting system.

Lessons learned are shared across the organisation following all incidents that result in a root cause analysis investigation being undertaken or where trends in incidents are identified. The lessons learned template was 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.

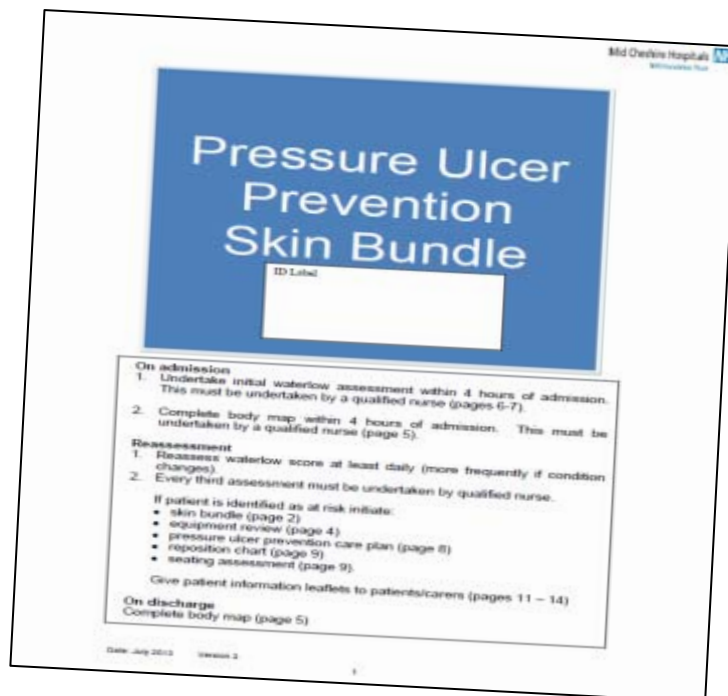
Learning From Our Incidents at MCHFT	
What Happened? <i>Write a brief description of the incident</i>	
Patient Background <i>Write a brief description including the patient's background and history</i>	
What we should have done	What we did not do
What was done well?	
On-going impact for the patient and their family <i>Write a brief outcome of how the incident affected the patient and their family</i>	
Impact for the Trust <i>Write a brief outcome of how this incident has impacted on the Trust in terms of quality, finance and reputation</i>	

Lessons Learned Poster Produced By

Date:

Document: Learning From Incidents template
Document Owner: Patient Safety Lead

An example of learning from an incident investigation was the development of the SKIN Bundle for all hospital admissions. The aim of the SKIN bundle is to prevent the development of hospital acquired pressure ulcers or the deterioration of existing pressure ulcers on admission.



The Trust has developed “You Said, We Did” posters which are circulated on a monthly basis showing items which have been raised from a formal complaint or informal concern where staff have been able to implement positive changes. The issues can cover a wide variety of subjects and provide information on what the Trust has done to improve services and environments for staff and public users. Examples of this are:

You Said “The waiting times on display in Pharmacy were out of date. In addition, it was difficult to obtain medication for an 8 week supply of medication.”

We Did “A real-time position for the display/waiting time has now been implemented. Pharmacy are increasing their stock levels to provide eight week prescription supplies.

You Said “There is sometimes a wait for patients to be discharged from the hospital once they have been told they can go home.”

We Did “A discharge coordinator has now been appointed. The purpose of this role is to plan patients discharge arrangement whilst working with all staff to ensure a safe and timely discharge”

The Trust has a 'Being Open' policy and feedback from incident investigations are shared with the patient or their relatives or carers following all incidents that result in moderate, serious or catastrophic harm.

When an incident is identified as having resulted in moderate harm, serious harm or death the Trust informs the patient or their relatives or carers as early as possible following the incident. The patient and / or their relatives or carers are provided with an apology and explanation of the incident and any investigations which will be conducted.

The patient and / or their relatives or carers are provided with contact details of a senior member of the Trust to contact if they have any queries. They are also informed that the investigation report (root cause analysis) and resulting action plans and lessons learned will be shared following the review.

Once the investigation has been completed the report, action plan and lessons learned are shared with the patient and / or their relatives or carers to ensure that they are satisfied that any lessons learned will help to prevent future incidents.

All staff receive 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.

Patient stories are undertaken on a regular basis and shared at board and ward level. Stories can be in the format of a video clip, voice recording or a letter of compliment. For example, a patient shared their experience of being admitted as an emergency following an accident at work and they praised staff for the teamwork observed and commended the hospital food. Another patient story was shared which featured support given to a patient from the Hospital Alcohol Liaison Service explaining that he now talks to other patients to give them support and understanding. He described the service as life changing for him.

In 2015, 18% of patients surveyed reported they had seen or were given information on how to complain compared to 20% in 2014. Details of how to complain are included in patient bedside folders. In addition, posters are displayed encouraging patients and relatives to provide feedback about their experiences. Leaflets explaining the role of the customer care team are displayed in public areas and ward information racks. Details are provided on how to raise concerns and make compliments or suggestions.

A survey of complainants was undertaken in 2015 to seek the views on how they feel their concerns had been handled and whether they felt satisfied with the actions taken. The survey showed that complainants felt we had made improvements in the time taken to address complaints with only 32% saying the process took too long compared to 51% in 2014 and 39% in 2013.

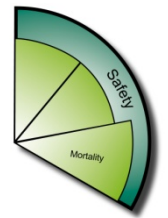
The Trust has undertaken a staff safety culture survey. The survey was based on the Manchester Patient Safety Framework and staff engagement surveys. The initial survey was conducted between September and November 2014. 675 responses were received, which is approximately 19.3% of staff.

Focus groups were then undertaken with the areas that had the lowest scores. Following the focus groups, action plans were developed based on the focus groups' suggestions on how the safety culture within the organisation could be further improved.

As part of the survey, staff were asked a number of questions including:

- The culture in the Trust makes it easy to learn from mistakes. 82% replied positively.
- Incidents are handled appropriately within the Trust. 91% replied positively.
- If an error occurs I am happy to report it without fear of blame. 80% replied positively.





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 the SHMI?

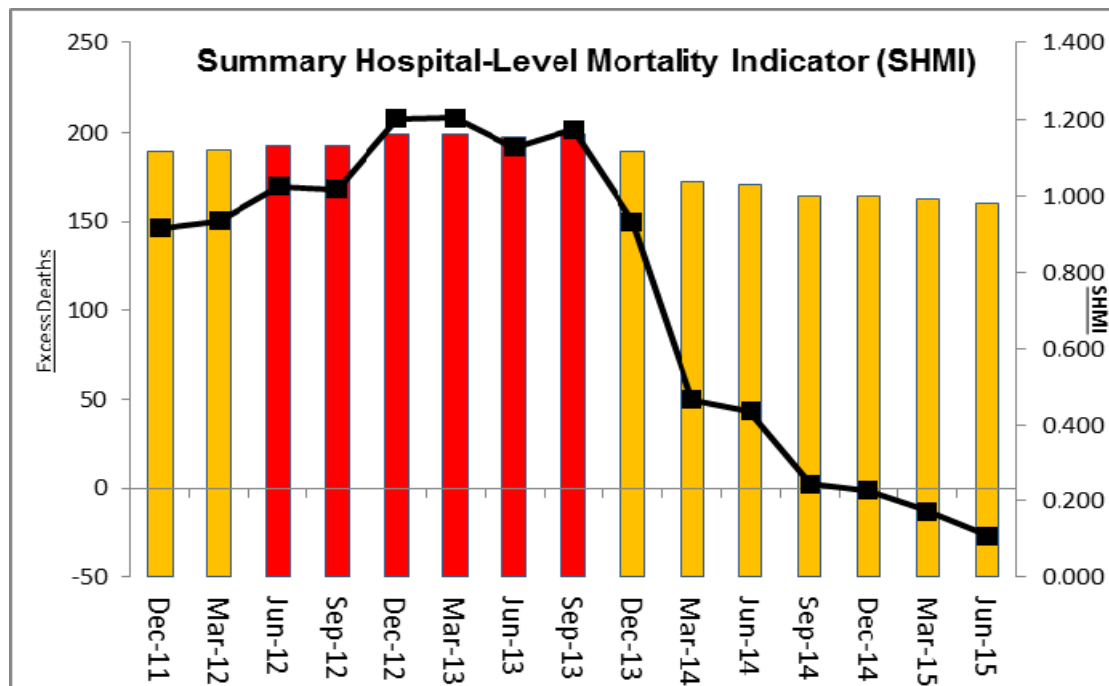
The SHMI is a ratio of the observed deaths to the expected number of deaths for a trust. The expected deaths are based on a number of factors which include age, gender and how a patient was admitted to a Trust.

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 2015/16?

The Trust has achieved a continued reduction in its mortality rates to remain at expected levels as measured by SHMI. The latest publication for the period to June 2015 demonstrates a further reduction in the SHMI to 0.98 and the Trust remains in the 'as expected' range. There has also been a further reduction in the number of calculated excess deaths for the period.



(Source: Information Services 2016)

Chart 7: Summary Hospital Level Mortality Indicator

Divisional strategies are being implemented to ensure 7 day working is in place across the organisation for all patients. 7 day working will ensure that patients have access to the appropriate investigations at the right time.

A Clinical Pathway Group has been formed and is chaired by the Deputy Medical Director. The group's responsibilities include reviewing high mortality groups, ensuring that care bundles/pathways are in place and identifying any gaps. The implementation of care bundles and pathways are audited as part of the clinical audit forward plans.

The use of the early warning system is monitored as part of the mortality case note review process. Where potential gaps are identified, learning is disseminated to the clinical teams.

An education programme on mortality, quality and patient outcomes was developed within the organisation. Workshops, which were scenario based, were held and training delivered to medical staff of all grades and senior nurses.

The Medical Director and the Clinical Lead for Patient Safety lead 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 hospital mortality reduction group (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's governance structure and report 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 are now used by clinical teams to drive forward improvement action plans at a speciality level. An example of the Trust's mortality dashboard is shown below:



The Trust also 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 action plan has now been closed by the Trust and Clinical Commissioning Groups following the completion of all the actions.

In 2015, the Trust joined the national 'Sign up to Safety' campaign. One of the six aims chosen by the Trust to progress is that 'Mid Cheshire Hospitals NHS Foundation Trust Summary Hospital-Level Mortality Indicator (SHMI) will remain at or below 100 from April 2015'.



Feedback from carers (taken from the bereavement survey):

'We were not sure what to expect over the 10 days my mother was in hospital. When my mother died I felt that if I could have scripted the care and treatment she received I could not have written anything better, and that staff made the worst experience of our family's lives a little less difficult.'

'All the nurses and their assistants, those fetching drinks and ward cleaners – all were caring and showed genuine warmth to mum and would often call in to see how she was when passing during their busy working day. I always found this comforting especially in the last final days.'

'I stayed with my husband in the last days of life. I received good care for him and myself... A bed was provided for me by my husband's bedside.'

'My feeling was that in the final days the nurses and doctors gave my wife every attention and did their best to save her... The staff were unfailingly kind and helpful... We were given every support as to the procedures to be followed after death which was a great help at this difficult time, especially in registering the death and other practical considerations.'

'The team were helpful and supportive. They were caring and sympathetic. I can't thank them enough for their care.'

'Myself and my family cannot praise the doctors on the ward highly enough for the care and commitment given to our mother during her last days. She was treated with dignity, respect, admiration and affection and we thank them all for their professional and caring attitude. After my mother died staff treated myself and the rest of my family with great sensitivity and understanding.'

'Mum was in hospital for the last 5 days and all the staff were helpful and supportive. They were all wonderful with mum.'

Reducing patient falls: Governors' choice of indicator

Inpatient falls are common and remain a great challenge for the NHS. Falls in hospital are the most commonly reported patient safety incidents, with more than 240,000 reported in acute hospitals and mental health trusts in England and Wales every year. (NPSA, 2010)

All falls, even those that do not result in injury, can cause older patients and their families to feel anxious and distressed. For those who are frail, minor injuries from a fall can affect their physical function, resulting in reduced mobility and undermining their confidence and independence. Some falls in hospital result in serious injuries, such as hip fracture and serious head injuries, and these injuries can result in death. (Royal College of Physicians, 2014)

Tackling the problem of inpatient falls is challenging. There are no single or easily defined interventions which, when implemented on their own, are shown to reduce falls. However, research has shown that multiple interventions performed by the multidisciplinary team and tailored to the individual patient can reduce falls by 20–30%. These interventions are particularly important for patients with dementia or delirium, who are at high risk of falls in hospitals (Royal College of Physicians, 2015).

Chart 8 shows the number of patient falls within the Trust over the 12 month period between April 2015 and March 2016.

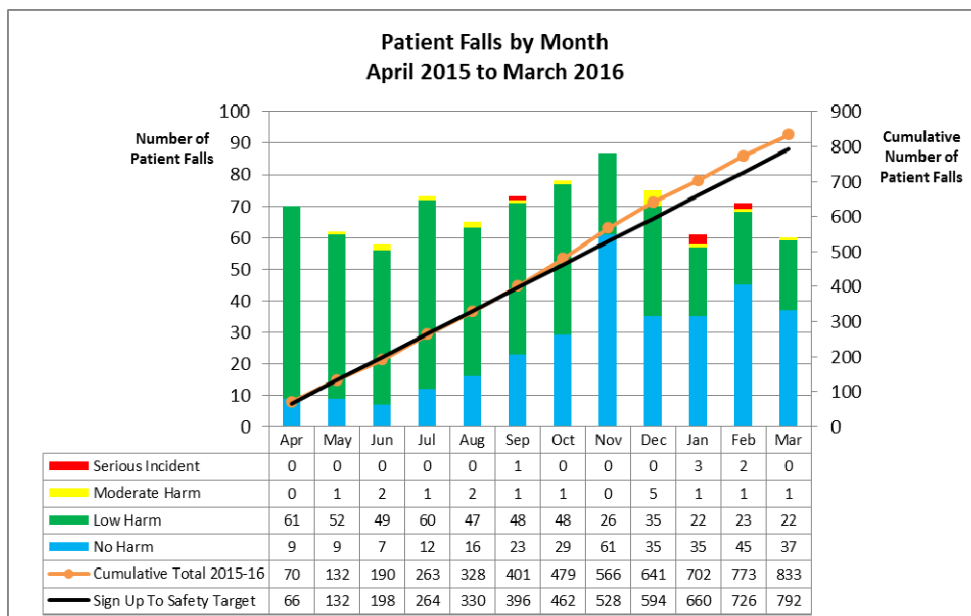


Chart 8: Patient falls by month

In November 2015, the grading of patient falls was reviewed in line with the Degree of Harm Briefing Paper issued by the National Reporting and Learning System (NRLS).

The NRLS have advised that, if a patient has neurological observations undertaken as a precaution post fall which remain within normal limits, these incidents should not be graded as 'no harm' rather than 'low harm'. This is due to the observations being precautionary rather than observations for a treatment of harm. This has affected the grading of the Trust's patient falls and accounts for the increase in no harm incidents and reduction of low harm incidents from November 2015.

The Briefing Paper also advised that, when a patient fall results in a fractured neck of femur, this should be classed as a 'serious incident' and not a 'moderate incident'. Again, this accounts for the increase in incidents graded as serious from November 2015.

Work being undertaken to reduce the number of patient falls and harm caused

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

The Trust has a falls prevention group which meets monthly. The group's membership includes Nurses, Therapists and senior managers from within the organisation. The group monitors all patient falls on a monthly basis. A successful link nurse programme has been rolled out across the Trust to deliver education for staff on falls prevention.

A falls safety collaborative called "One Step Ahead" commenced in the Trust in April 2016. A cohort of wards is receiving focussed input and is trialling fall prevention interventions.

The interventions include:

- Cohorting high risk patients in ward bays
- Night placement of staff in the ward bay
- Ward bay tagging (so that there is always a member of staff in the bay)
- Safety Cross (to highlight to all staff on the ward the days when a fall has / has not occurred)
- Ditch the desk (to ensure staff members are based in the patient areas rather than the reception desk)

- Bay based desks. The picture below shows the ward layout on our most recently refurbished ward which has a nurses station based outside each bay rather than at the centre of the ward. This layout promotes the closer observation of patients and increases contact with patients at their bedside.



These interventions will be trialled and, if successful, will be implemented across the organisation.

National Patient Safety Agency, Slips trips and falls data update, London, NPSA, 2010

Royal College of Physicians, National Hip Fracture Database annual report 2014, London, RCP, 2014

Royal College of Physicians, National audit of inpatient falls Audit report 2015, London, RCP, 2015

Statements from external agencies

Healthwatch Cheshire East

Healthwatch Cheshire East welcomes the opportunity to comment on the Mid Cheshire Hospitals NHS Foundation Trust Quality Account 2015/16.

Healthwatch Cheshire East acts as the champion for the voice of the consumer and as such our comments and views on this report focus on how MCHFT have involved and listened to their consumers views (patients and carers).

We acknowledge the positive response from the Trust to recommendations from our enter and view reports and how things have now changed for the benefit of patient experience. We would also like to acknowledge the importance the Trust have with regard to PLACE visits and improving the patient experience; we are pleased to contribute to this aim as key partners and our recognition in your report highlights this relationship very well and demonstrates the positive working partnership we have.

Healthwatch Cheshire East has 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.

We welcome the recognition and importance the Trust has placed on patient involvement and utilising patient stories to improve service delivery. Within the Quality Priority for 2015/2016, **The Trust's, responsiveness to the personal needs of its patients**, we have seen a very positive response to patient requests for contact with regard to their negative experiences and the Trust have been very effective in resolving them. We are also pleased to attend regular Patient Experience Meetings to support an improved patient experience across the Trust. .

We are keen to work together with MCHFT, South Cheshire CCG and health and social care services to strive towards an holistic service and to support the navigation of integrated care in order to reduce delay, confusion and duplication for the patient and carer by working together to identify gaps in services.

We recognise that there have been significant challenges for the Trust during 2015/2016 and value the relationship that Healthwatch Cheshire East and the Trust have. We look forward to continue working with the Trust during 2016-2017 to enable our community to have a powerful voice helping to shape and improve these services for the future.

Veronica Kitton,
Manager

Healthwatch Cheshire West

Healthwatch Cheshire West values the opportunity to comment on these quality accounts.

MCHFT continues to be the main hospital trust supporting residents of Cheshire West and Chester who live in the Vale Royal Area, indeed some of the facilities owned and operated by MHCHFT lie within our geographical boundary.

In regard to the quality accounts document as produced Healthwatch Cheshire West is pleased to make the following comments:

- We note positive results from inpatient, maternity and pharmacy surveys.
- In relation to patient complaints, - responses seem appropriate, however, we have some concern about the upward path of data as presented '*Complaints Table 3*' that seems to indicate a significant increase in complaints year by year. This could be explained by a greater volume of patients using the service, however, no explanation for increase is included only a "*" comment explaining data additions.
- We feel that, where mentioned, all areas of concern should be highlighted.
- Suggest that information on performance should be presented across the three delivery areas, not as an amalgamation and that information on performance should be consistent in both years and presentation – this does not appear to be the case.
- We feel that not everyone reading the account will know what a '*never*' event is and that this requires further explanation. Indeed some other technical language used suggests an appendix should be added.
- In order to give balance we feel that sections involving service user comments should also include a selection of 'less than positive' or are these not received?
- Case studies seem to be a worthwhile addition to the document giving a 'lived' experience of the service that is easily understood by the reader.
- Healthwatch Cheshire West values the added sections on safety including the "*Clear Objectives for Actions Learning and Collaboration*" documentation.
- Regarding CQUIN targets:
 - HWCW notes the missed [(9) IAQCP for COPD and (14) IAQP for Alcoholic Liver Disorder]. We note comments in relation to the above missed targets but in relation to future goals feel that more information could be included here, to inform the reader of specific plans and actions to improve performance and additional information on what the 'challenges' as written are?

- We feel that the added quality and improvement strategy documents, add a positive value to service. We feel that this is a colourful, bright and clear section of the document that also demonstrates considerable work by committed staff across the hospital.
- Results from communications survey are pleasing.

Healthwatch Cheshire West feels that overall the document is positive, well produced and gives a good and fair account of service. However, in order to encourage more people to view its contents, we would like to see less technical language used in future documents; or if this cannot be avoided, due to subject matter; a simple summary at end or beginning of each section and an appendix of technical words and abbreviations used.

Neil Garbett
Community Engagement Worker

Governors

The 2015/16 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 are afforded access to relevant information to fulfil our function and are proactively engaged in the development of strategy to ensure the ongoing achievement.

2015/16 has seen a number of excellent achievements, not least amongst which are the CQC inspection the outcome of which saw the Trust receive a Good rating. This reflects very well the hard work and care offered at all levels of the organisation. National awards have once again been achieved by the Midwifery service. This later coming reflecting the continues success of the service following the facility enhancements of previous years. The ongoing success of the Midwifery Service is all the more notable because of the pressures on this area of work from other providers. It will be interesting to monitor whether similar improvements can be achieved in other areas to have benefitted from more recent estates redevelopment.

There have been positive improvements in patient and staff survey results collected through various means. These have been used by the Trust in feedback loops to patients and service users and featured in a variety of materials to engage the members of the Trust and users of the services. Where complaints are received they are handled fairly and effectively and lessons are learned and used to enhance provision

This year has seen a change in a number of the committee and sub-committee structures through which Governors are able to formally scrutinise quality. It is encouraging to note that despite these changes Governors retain clear sight of quality and are able to scrutinise and review performance statistics, patient and other users' perceptions as well as action plans to address these. The openness of the Trust remains clear as does the commitment to quality. Not all quality targets have been met over the reporting period and some areas where performance has been below that achieved in previous years, COPD, ALD and Pressure Ulcers as examples. However, Governors are assured that these areas are being actively addressed and issues reported transparently.

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

Jayne Hartley
Deputy Director of Nursing and Quality
Mid Cheshire Hospitals NHS Foundation
Trust

Overview and Scrutiny
Westfields, Middlewich Road
Sandbach, Cheshire
CW11 1HZ

Tel: 01270 686468
email: james.morley@cheshireeast.gov.uk

DATE: 26 May 2016

Dear Jayne,

RE: Health and Adult Social Care Overview and Scrutiny Committee Review of Mid Cheshire Hospitals NHS Foundation Trust Quality Account 2015/16

As Chairman of the Committee I am writing to submit its statement to be included in Mid Cheshire Trust's Quality Account 2015/16 following our meeting on 17 May 2016. Please include the information below in the Committee's section of the Quality Account.

The Health and Adult Social Care Overview and Scrutiny Committee reviewed the draft Quality Account at a meeting on 17 May 2016. Overall the Committee was pleased with the content of the Quality Account and believes it provides a good picture of the performance of the Trust.

The Committee was pleased to see that the Trust's financial deficits had been reduced and hopes that financial stability is sustainable in the long term. The Committee also noted the Trust's success in achieving zero MRSA and CDiff cases as well as no 'never events'. The 95% approval rating from the Friends and Family Test is also encouraging.

The Committee notes the Trust's performance on the ED waiting times but understands the pressures facing ED's which we mentioned in the Committee's recent Ambulance Services Report. The Committee noted similar levels of performance when it reviewed East Cheshire NHS Trust's Quality Account.

The Committee is concerned about the length of stays for patients and delayed discharges, which in turn affects ED waiting times and again notes that a similar situation is apparent in East Cheshire. The Committee is aware of some of the external

factors that can affect discharges and is considering a scrutiny review of delayed discharge during the 2016-17 municipal year.

The Committee also noted the relatively high rates of readmissions within 30 days and wants to ensure that patients are discharged at the right times and that effective recovery and care services are in place for them. The Committee also recognises a concern about an apparent need for additional intermediate care beds in the community to provide the additional care patients need to enable them to be discharged from hospital on time.

The Committee shares the Trust's disappointment with the increase in pressure ulcers cases and supports efforts to improve equipment and staff training to ensure pressure ulcers do not occur while patients are in hospital.

The Committee notes the nurse staffing levels of the Trust and supports efforts to train additional nurses locally in partnership with South Cheshire College and hopes more local young people looking to enter a career in nursing can be supporting into a role at their local Trust.

I hope the comments above are well received by the Trust and that some of the Committee's points above can be addressed. Thanks to you for your attendance at our meeting. If you have any comments or questions about the Committee's submission please contact James Morley on the address provided.

Yours Sincerely

Councillors Jos Saunders
Chairman of the Health and Adult Social Care Overview and Scrutiny Committee

Mid Cheshire Hospitals Foundation Trust (MCHFT) Quality Account 2015/16 commentary on behalf of NHS South Cheshire CCG and NHS Vale Royal CCG

NHS South Cheshire Clinical Commissioning Group (CCG) and NHS Vale Royal Clinical Commissioning Group (CCG) welcome the opportunity to comment on Mid Cheshire Hospitals Foundation Trust (MCHFT) Quality Account 2015/16.

We can confirm that we have reviewed the content of 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 is in the second year of their Quality and Safety Improvement Strategy. Therefore it is worth noting that a continued emphasis on the three domains of Experience, Effectiveness and Safety has built on the work undertaken in 2014/15. The priorities identified in the Quality Account have a strong patient focus which underpins the quality agenda and focuses on staff values and behaviours. In particular we would like to highlight the key role Student Quality Ambassadors have played in producing a student version of the Quality and Safety Improvement Strategy. This has emphasised to patients, staff and their peers the contribution student nurses make to delivering high quality care.

The Quality Account describes a number of initiatives around dementia which have been progressed in 2015/16 particularly linked to Department of Health dementia challenge. In particular the collaborative working with the Royal Voluntary Service who provide a befriending service to those patients who are elderly and may have memory problems should be commended. Support for staff who are caring for a person living with dementia at home has also been progressed in partnership with the Alzheimer's Society. The value of these initiatives to patients and carers is evidenced in the Quality Account by the comments from carers about the positive experiences they and their relatives have had.

It is noted that there has been a focus on improving communication which has resulted in a reduction of formal and informal complaints. It is pleasing to note that further work is ongoing to enhance communication for patients and staff with the implementation of the new nursing and medical integrated documentation being piloted across one ward in the Trust. This documentation can be used as a multidisciplinary team record and aids to improve communication across the teams.

MCHFT have continued to implement a number of initiatives to assist in the prevention of pressure ulcers. The investment of a skin care specialist nurse to focus on education and training with nursing staff will ensure that the focus on pressure ulcer prevention is maintained as a high priority throughout the Trust.

It is commendable to note the initiatives that MCHFT have undertaken to reduce their hospital mortality rates have been maintained in 2015/16. The expectation is that in 2016/17 these initiatives will continue with the Trust mortality rate remaining in the 'expected range'.





There has been much more focus on patient experiences and an increased use of modern media which has been reflected in the use of Facebook, which has highlighted awareness around National issues i.e. the update on the flu vaccinations and the Zika virus.

The 'You Said.... We Did' campaign is powerful tool to showcase to patients, carers and staff the improvements that have been made throughout the year and is commendable.

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. It is good to see that the Friends and Family Test has now been implemented as a child friendly initiative. MCHFT has a specific child friendly post box to encourage feedback, inspiring children to write their own response or draw a picture if they wish.

It is good to see collaborative working with Healthwatch Cheshire East and Healthwatch Cheshire West which has facilitated engagement with 'hard-to-reach' groups. It is pleasing to note that the audits that Healthwatch have undertaken and comments received from patient feedback have been used as evidence in order to drive change.

The results of the Staff survey 2015 showed an improvement in the number of staff who would recommend MCHFT as a place to work which indicates the ongoing work that senior managers are undertaking with the staff.

We look forward to maintaining a strong commissioning relationship with MCHFT in 2016/17. NHS South Cheshire CCG and NHS Vale Royal CCG 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.



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 2015/16 and supporting guidance;
- 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 2015 to May 2016
 - Papers relating to quality reported to the Board over the period April 2015 to May 2016
 - Feedback from the Commissioners dated 26 May 2016
 - Feedback from Healthwatch Cheshire East dated 16 May 2016
 - Feedback from Healthwatch Cheshire West dated 10 May 2016
 - Feedback from the Cheshire East Council Health and Adults Scrutiny Committee dated 26 May 2016
 - Feedback from Governors dated 26 May 2016
 - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 16 July 2015.
 - The 2015 national patient surveys
 - The 2015 national staff survey
 - The Head of Internal Audit's annual opinion over the Trust's control environment dated May 2016
 - Care Quality Commission (CQC) intelligent monitoring report dated May 2015.
- 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) as well as the standards to support data quality for the preparation of the quality report.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the Board, signed 24 May 2016

Dennis Dunn MBE
Chairman

Tracy Bullock
Chief Executive

Dr Paul Dodds
Medical Director and
Deputy Chief Executive

Alison Lynch
Director of Nursing
and Quality

Mark Oldham
Director of Finance

Denise Frodsham
Chief Operating Officer



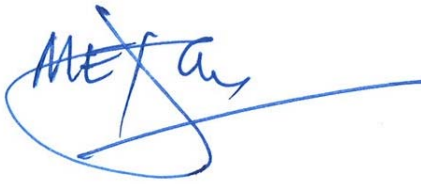
Dame Patricia Bacon
Non-Executive Director



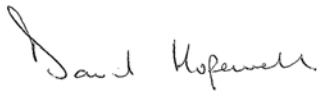
John Barnes
Non-Executive Director



John Church
Non-Executive
Director



Mike Davies
Non-Executive Director



David Hopewell
Non-Executive Director



Ruth McNeill
Non-Executive
Director

Appendices

Appendix 1 - Glossary and abbreviations

Terms	Abbreviation	Description
Acute Kidney Injury	AKI	AKI is a syndrome that results in a sudden decrease in kidney function or kidney damage within a few hours or few days. AKI causes a build-up of waste products in the blood and makes it hard for the kidneys to keep a balance of fluid in the body. This can also affect other organs such as the brain, heart, and lungs.
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 – heart attacks, pneumonia, hip and knee replacements, heart failure and heart bypass surgery – when compared to research which identifies what best care constitutes.
Board (of Trust)		The role of Trust’s board is to take corporate responsibility for the organisation’s strategies and actions. The chair and non-executive directors are lay people drawn from the local community and are accountable to the Secretary of State. The chief executive is responsible for ensuring that the board is empowered to govern the organisation and to deliver its objectives.
Care Quality Commission	CQC	The independent regulator of health and social care in England. Its aim is to make sure better care is provided for everyone, whether in hospital, in care homes, in people’s own homes, or elsewhere.
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.
Clinical Commissioning Group	CCG	This is the GP led commissioning body who buy services from providers of care such as the hospital.

Terms	Abbreviation	Description
Clostridium Difficile	C-diff	A naturally occurring bacterium that does not cause any problems in healthy people. However, some antibiotics that are used to treat other health conditions can interfere with the balance of 'good' bacteria in the gut. When this happens, C-diff bacteria can multiply and cause symptoms such as diarrhoea and fever.
Commissioner		A person or body who buy services.
Commissioning for Quality and Innovations	CQUIN	CQUIN is a payment framework developed to ensure that a proportion of a providers' income is determined by their work towards quality and innovation.
Dementia		Dementia describes a set of symptoms that may include memory loss and difficulties with thinking, problem-solving or language. Dementia is caused when the brain is damaged by diseases, such as Alzheimer's disease or a series of strokes.
Friends and Family Test	FFT	The NHS Friends and Family Test was created to help service providers and commissioners understand whether their patients are happy with the service provided, or where improvements are needed. It is a quick and anonymous way to give views after receiving care or treatment across the NHS.
Healthcare Associated Infections	HCAI	A generic name to cover infections like MRSA and C-diff.
Health Service Ombudsman		The role of the Health Service Ombudsman is to provide a service to the public by undertaking independent investigations into complaints where the NHS in England have not acted properly or fairly or have provided a poor service.
Hospital Evaluation Data	HED	This is an on-line solution delivering information which enables healthcare organisations to drive clinical performance in order to improve patient care and deliver financial savings

Terms	Abbreviation	Description
Hospital Episode Statistics	HES	This is the national statistical data warehouse for England for the care provided by NHS hospitals and for NHS hospital patients treated elsewhere. HES is the data source for a wide range of healthcare analysis for the NHS, government and many other organisations and individuals.
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	The ICNARC CMP is a high quality, clinical database holding over 18 years data relating to patient outcomes from adult, general critical care units in England, Wales and Northern Ireland.
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.
Monitor		This is the regulator of NHS Foundation Trusts. It is an independent body detached from central government and directly accountable to Parliament.
National Patient Surveys		Co-ordinated by the CQC, they gather feedback from patients on different aspects of their experience of care they have recently received, across a variety of services/settings: Inpatients, Outpatients, Emergency care, Maternity care, Mental Health services, Primary Care services and Ambulance services.
National 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

Terms	Abbreviation	Description
Never Events		Never Events are serious incidents that are preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a Never Event. Never Events include incidents such as: wrong site surgery, retained instrument post operation, wrong route administration of chemotherapy
NHS Choices		NHS Choices (www.nhs.uk) was launched in 2007 and is the official website of the National Health Service in England.
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.
Pressure ulcers		Pressure ulcers are an injury that breaks down the skin and underlying tissue. They are caused when an area of skin is placed under pressure. They are sometimes known as "bedsores" or "pressure sores". Pressure ulcers can range in severity from patches of discoloured skin to open wounds that expose the underlying bone or muscle.
Quality Account		This is a statutory annual report of quality which provides assurance to external bodies that the Trust Board has assessed quality across the totality of services and is driving continuous improvement.
Re-admission Rates		A measure to compare hospitals which looks at the rate at which patients need to be readmitted to hospital after being discharged (leaving hospital).

Terms	Abbreviation	Description
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.
Safer Nursing Care Tool	SNCT	The safer nursing care tool was launched in 2010 by the NHS Institute based on the work undertaken by the Association of UK University Hospitals (AUKUH). It is used to measure patient dependency/acuity to help determine nurse staffing levels on the wards.
Sepsis		Sepsis, also referred to as blood poisoning or septicaemia, is a potentially life-threatening condition, triggered by an infection or injury. In sepsis, the body's immune system goes into overdrive as it tries to fight an infection. This can reduce the blood supply to vital organs such as the brain, heart and kidneys. Without quick treatment, sepsis can lead to multiple organ failure and death
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. SHMI is not an absolute measure of quality. However, it is a useful indicator for supporting organisations to ensure they properly understand their mortality rates across each and every service line they provide.

Terms	Abbreviation	Description
Vanguard		In January 2015, the NHS invited individual organisations and partnerships to apply to become 'vanguard' sites for the new care models programme, one of the first steps towards delivering the Five Year Forward View and supporting improvement and integration of services. Each vanguard site will take a lead on the development of new care models which will act as the blueprints for the NHS moving forward and the inspiration to the rest of the health and care system
Venous Thrombo-Embolicism	VTE	This is a blood clot which can develop when a person may not be as mobile as they are usually or following surgery. The blood clot itself is not usually life threatening, but if it comes loose it can be carried in the blood to another part of the body where it can cause problems – this is called a Venous Thromboembolism (VTE).

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 are available 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

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?

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

Appendix 3 - 2015/16 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 2016 (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 2016, 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 2016 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period; and
- The percentage of patients waiting more than 4 hours in Accident & Emergency.

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 section 2.1 of the Monitor 2015/16 Detailed guidance for external assurance on quality reports; 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

- o board minutes for the period April 2015 to May 2016;
- o papers relating to quality reported to the board over the period April 2015 to May 2016;
- o feedback from Healthwatch Cheshire East dated 16 May 2016;
- o feedback from Healthwatch Cheshire West dated 10 May 2016;
- o the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 16 July 2015;
- o the national patient survey dated July 2015;
- o the national staff survey dated 12 December 2015;
- o Care Quality Commission Intelligent Monitoring Report dated May 2016; and
- o the Head of Internal Audit's annual opinion over the trust's control environment dated May 2016.

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 testing of indicators other than the two selected mandated indicators, or consideration of quality governance.

Basis for qualified conclusion

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. We have tested a sample of 25 pathways which were listed as incomplete at month end, selected on a random basis.

We identified the following errors:

- In 1 case the date of treatment recorded on the system was different to the date of treatment in the patient notes;
- In 3 cases the date of referral recorded on the system was different to the date of referral in the patient notes;
- In 1 case it was determined that the pathway was not a valid RTT pathway and should not have been opened and included in the data;
- In 4 cases we were unable to confirm the date of referral and/or the date of treatment to supporting documentation;
- In 2 cases the patient was reported as an open pathway one month too late based on the date of referral evidence in the patient notes; and

- In 5 cases the patient was reported as an open pathway for one month too long based on the date of treatment evidence in the patient notes.

Our procedures included testing a risk based sample of items, and so the error rates identified from that sample cannot directly be extrapolated to the population as a whole.

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 2016. 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 effects of the matters described in the "Basis for qualified conclusion" section above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016:

- 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 2.1 of the Monitor 2015/16 Detailed guidance for external assurance on quality reports; 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
26 May 2016