NHS
Mid Cheshire Hospitals
NHS Foundation Trust

Quality Account 2020/21

Quality and Safety at Heart
Mid Cheshire Hospitals NHS Foundation Trust

Quality Account 2020/21


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

Statement on Quality from the Chief Executive

Welcome to the Quality Account Report for Mid Cheshire Hospitals NHS Foundation Trust for 2020/21.

As I reflect on another challenging but productive year at Mid Cheshire Hospitals NHS Foundation Trust, I am delighted to share some of our work through the Quality Account for the period of April 2020 to March 2021.

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

Patient safety and quality are at the heart of everything that we do, as Chief Executive I have a great sense of pride in how we have responded to the Covid-19 global pandemic and the resilience that our organisation has shown. As a Trust we have committed to deliver further year-on-year improvements and ensured our patients and our staff remained safe and supported during this time.

One of the key challenges we have faced during 2020/21 is our response to the Coronavirus Pandemic (Covid-19). The Trust has implemented many changes to the core function of the organisation in accordance with the requirements set down by Public Health England and NHS England/Improvement. In response to Covid-19 the Trust has worked within the principles of both the National Outbreak Policy and Emergency Preparedness Pandemic Policy to implement changes to support patients and staff either suspected or confirmed as Covid-19 positive. Some of these changes have included increasing Critical Care Capacity, redefining ward areas to ensure strict infection prevention and control and continually providing staff with the correct level of Personal Protective Equipment and training.

During the pandemic I have been humbled by the acts of kindness staff have shown to each other and the support we have received from the local community. There is not a single person in Mid Cheshire Hospitals NHS Foundation Trust who has not had a part to play. We recognise how the impact of the last year may have affected the health and wellbeing of our staff. In response the Health & Wellbeing Group have worked tirelessly to ensure that staff health and wellbeing was made an absolute priority, such as the implementation of permanent wellbeing rooms / spaces for staff and enhancing psychological support for staff at all levels through the Mental Health First Aid Service, Employee Assistance Programme and Listening Ear Service.

As a result of the coronavirus pandemic a number of monitoring elements have remained suspended under the quality and safety priorities. Despite the suspension of monitoring requirements we have continued to make good progress on our quality and safety improvements and in response to the Covid-19 pandemic the Trust has undertaken a number of initiatives to ensure the highest standards of Infection Prevention and Control measures are in place.

We recognise that providing health care is not without risk and that sometimes patients can be unintentionally harmed in the care of hospitals. You will read throughout this Quality Account of the Trust's ambitious aims to continue to reduce harm across our organisation. Our Quality and Safety Improvement Strategy, aligned with the third strategic aim of the National Patient Safety Strategy: Improvement, is the vehicle by which we have steered the direction of travel for quality and safety focusing on the 4 indicators below;

- Preventing deterioration and sepsis
- Medicines safety
- Maternal and neonatal safety
- End of life care

For the year 2020/21 the Trust continued to deliver a high quality, timely service to our patients. Prior to the suspension of non-urgent clinical activity due to Covid-19, the Trust's waiting times in elective and cancer care were one of the highest performing in the country. We are now working hard to restore these services fully whilst operating in this new world challenged by the threat of Covid-19 infection.

Key achievements for the Trust in 2020/21 include;

- In response to the Pandemic, the Trust launched a Be safe Be EquiPPEd Campaign aimed to make our workplace as safe as possible for staff and patients during the Coronavirus pandemic through appropriate and correct use of PPE. The Trust was shortlisted for a Nursing Times award for this Campaign.
- The Ward Accreditation Programme ensures high quality, safe and compassionate care services across the organisation. The Quality Metrics tool that drives the accreditation process have been reviewed and adapted during 2020/21. This has supported a culture of continuous improvement of quality of services and safeguarding high standards of care during the Covid-19 pandemic.
- In June 2020, the Trust appointed a Head of Nursing for Safe Staffing and Workforce Utilisation. This post aims to build on providing assurance and enhancing best practice that the Trust plans safe nursing, midwifery, and care staffing levels across all in-patient ward areas and that there are appropriate systems in place to manage the demand for nursing, midwifery, and care staffing.
- The Trust maintained their CQC rating of "Good" for the Use of Resources assessment following the latest inspection.
- The Trust pledged to the Nursing Times Covid-19: Are You OK campaign? Which aims to raise awareness of the potential long-term impact of working during a pandemic on nurses' mental health and wellbeing.

With regards to our mortality rates, the latest publication for our mortality data for the reporting period April 2019 to March 2020 demonstrates a Summary Hospital Level Mortality Indicator (SHMI) of 99.47 and the Trust remains in the 'as expected' range. This currently places the Trust 54 out of 125 Trusts. We are continuing to drive improvements in mortality and patient safety through our Learning from Deaths programme and with the appointment of a new Associate Medical Director for Patient Safety in 2020.

I hope this Quality Account provides you with a clear picture of how important quality improvement, safety and patient experience are to us at MCHT. 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 can confirm that the Board of Directors have reviewed the 2020/21 Quality Account and I am pleased to share that they agree that this is a true and fair reflection of our performance.

Finally, I want to take this opportunity to thank our staff who are highly skilled, dedicated and committed. They work hard to deliver safe and compassionate care to our patients' day in and day out, and in particular during the global pandemic period. I would also like to extend my appreciation to our Governors, Volunteers, Members, Patient Representatives and other Stakeholders who have helped shape our quality programme by taking time out to support and advise us.

James Sumner
Chief Executive

Date: 26 May 2021

Part 2

Priorities for improvement and statements of assurance from the Board

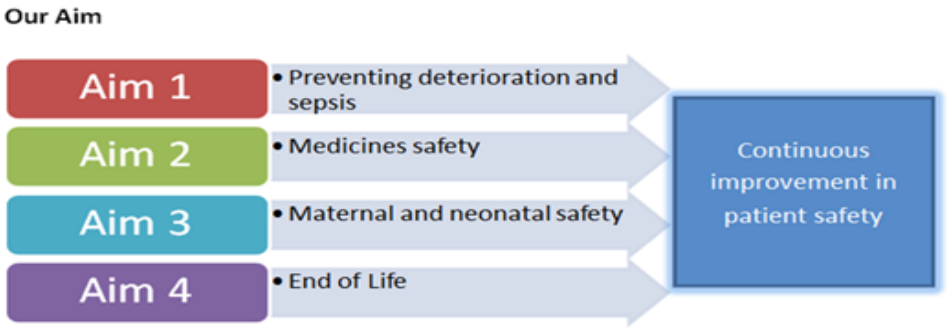
At Mid Cheshire Hospitals NHS Foundation Trust (MCHFT), we want to be sure that everyone in our local community who may use our services has absolute confidence that our care and treatment is completely patient centred. As a Trust, we are committed to the delivery of our Quality and Safety Improvement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

The vision for Mid Cheshire Hospitals NHS Foundation Trust is ***'To Deliver Excellence in Healthcare through Innovation and Collaboration'*** and to be a provider that;

- ***Delivers Outstanding Clinical Quality, Safety & Experience***
- ***Being A leading Partner in a Progressive Health Economy***
- ***Striving for Outstanding Organisational Effectiveness***
- ***Aspiring to Excellence in Practice through our Workforce***
- ***Creating a 21st Century Infrastructure for Transformative Health and Social Care***

The purpose of the Quality & Safety Improvement Strategy is to support the delivery of the organisation's vision and mission. The values and behaviours developed with our staff underpin delivery and success of the Trust's strategy. We recruit and nurture our staff so that we see these values and behaviours at all times from all staff.

Following the completion of the first year of the 2020/21 Quality Strategy and the impact of Covid-19, the Trust has agreed to continue the 2020/21 strategy for a second year through 2021/22 whilst aligned to The National Patient Safety Strategy 2019.



The NHS Patient Safety Strategy, published jointly by NHS England and NHS Improvement in July 2019, describes how a focus on 3 strategic aims (**Insight, Involvement, and Improvement**) will support delivery of the NHS safety vision of **continuously improving patient safety**.

Mid Cheshire Hospitals Foundation Trust Quality Safety and Improvement strategy equally sets out the local vision for continuously improving quality and patient safety. We have aligned our priorities with the ambition of the third national strategic aim: **Improvement**.

The first 3 programme aims of work are aligned to those areas already identified nationally as the areas of care delivery where most harm is seen. End of life care is a Trust priority, and so warrants its own priority programme for our 2021/22 Strategy.

Alongside these priorities the Trust continues to be committed to working with its partners on the other national priority areas: safety for older people, safety of people with learning disabilities, and delivery of safer working practices to meet the challenges of antimicrobial resistance, and where relevant these will be reflected in our 4 priority programmes.

It is envisaged that delivery of the priority programmes will be supported by information and learning derived from the Trust's internal patient safety systems, and that of the local healthcare system; intelligent use of clinical incident data, complaints themes and learning from our collective experience will inform the decisions we make to identify positive change, with an aim to drive continuous improvement in patient safety.

This Quality and Safety Improvement Strategy is a key tool in MCHFT demonstrating delivery and alliance with the nationally set vision for patient safety. At the same time, it is fully aligned with those quality and safety priorities that have been identified locally and will be delivered in ways that will build upon our existing patient safety culture and strengthen our existing patient safety systems.

The Quality & Safety Improvement Strategy 2021/22 will be monitored through the Quality & Safety Improvement Strategy Steering group on a monthly basis. Each work stream of the strategy will deliver a detailed update of progress to the committee for approval and monitoring. Progress will be escalated to the Trust's Quality Group (TQG) and then escalated to the Trust's Executive Quality Governance Group (EQGG).

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

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

In addition, progress against the quality goals will also be reported in the annual Quality Account. This report will be made available to the public on the Trust's website, NHS choices and will also be included in the Trust's Annual Report.

Priorities for improvement in 2020/21

Seven Day Hospital Services

The Trust was planning to use the learning from the Seven Day Hospital audits to continue its risk-based approach to investment in the multi-disciplinary team ready for 2020/21 in order to make progress towards complying with the four priority clinical standards with the seven-day services programme. A Board Assurance Framework for Seven Day Hospital Services was presented to the Trust's Quality Governance Committee in November 2019 but due to the impact of managing the Covid-19 pressures further requirements for Board Assurance Frameworks were stood down for 2020-21 from a national level. The Trust maintains a firm commitment to the principles and standards of Seven Day Hospital Services and will restart this work at the earliest opportunity.

Patient Feedback

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

Friends and Family Test

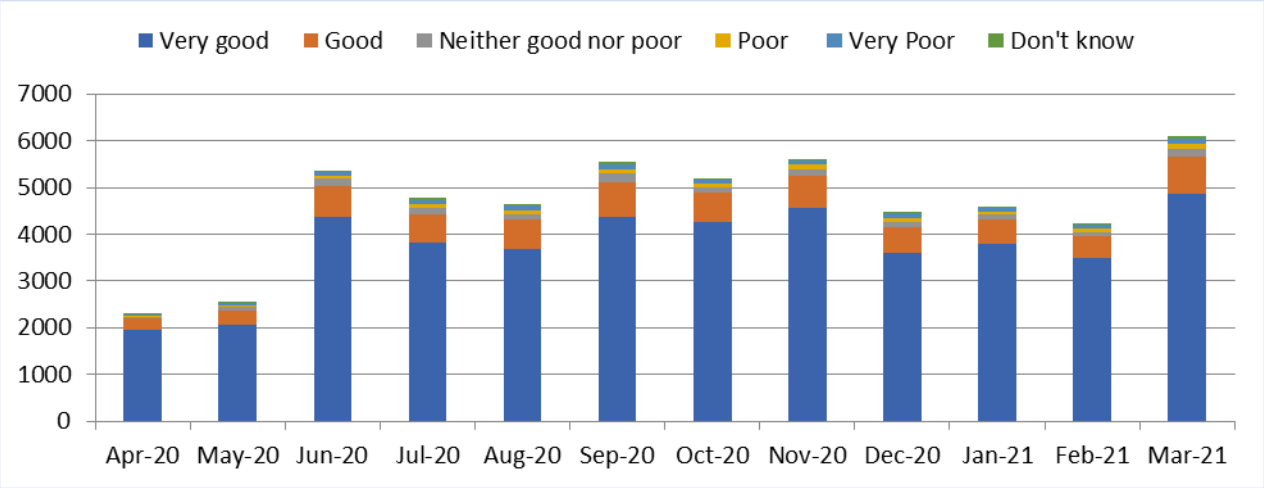
In April 2020, the Friends and Family Test (FFT) was revised nationally, with revised question and responses aimed at making responses simple, easy and accessible to all. In addition to the revised question, free text comments in responses are actively encouraged. Nationally, the FFT was put on hold from March 2020 due to the covid-19 pandemic and data collection and submission centrally was reestablished in December 2020.

Throughout this period the Trust has continued, where possible, to collect FFT data in the revised format with an average response rate of 12%. The response rate increased in November and December 2020 to 16% and 17% respectively. Trust services have continued to receive FFT reports and FFT staff champions have been introduced to promote FFT and monitor and respond to feedback for services.

A QR code has been developed for each of the Trust FFT reporting locations and updated posters, leaflets and pull up banners are currently being procured for display in patient areas. Trust community services staff will also have QR codes that patients can use to

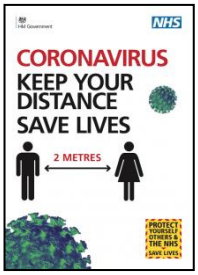
access feedback platforms easily from home. Cards are still available for completion by patients, where technology may be problematic.

During 2020/21 the Trust received 55,398 responses with 93% of responses being very good or good.



Examples of patient's comments from the FFT include:

Ear Nose and Throat (ENT) Outpatients



You said '*too many people around the reception area waiting to book in. I had to move twice from my seat to try and keep a sensible distance away, there was no signage showing where to queue and no reminders to stay 2 metres apart. People were aimlessly walking between the seating area and as my appointment wasn't on time, I felt extremely vulnerable'*.

We have displayed social distances posters in the ENT waiting area.

Emergency Department

You said '*some patients unclear what do not sit on these chairs meant. I was worried about entering a hospital with the current pandemic, but I felt safe once inside'*.

We have ensured chairs that are not to be used are clearly marked and adhere to social distance guidelines.

You said '*my one concern was people using the vending machine which I thought was not good practice during the times we are in at the moment'*.

We have fitted a hand sanitiser on the wall next to the vending machine.

National Surveys

The Trust is eligible for participation in four national patient surveys. All four surveys for 2020/21 are currently in their fieldwork period (pre-survey scoping) as per the schedule below:

2020/21 National Survey Schedule:

	When will patients receive care?	When will trusts draw samples?	Fieldwork period
The Urgent and Emergency Care Survey - **Type 1 (Major)** - **Type 3 (UCC, Minors, Minor Injury Unit VIN)**	September 2020 August and September 2020	October 2020	October 2020 – March 2021
The Adult Inpatient Survey	November 2020	December 2020	January 2021 – May 2021
The Children and Young People's Patient Experience Survey	November and December 2020 Also included January 2021	February 2021	March 2021 – June 2021
Maternity Survey	January and February 2021	March 2021	April 2021 – August 2021

National Inpatient Survey 2019

The results of the National Inpatient Survey 2019/20 were received in July 2020. The Trust's overall average score for the 2019/20 survey was 72.5%, a slight decrease from the previous survey score of 74.7%. There were no areas of concern in the survey results from the Trust regulators and improvement was noted in length of discharge delays and single sex accommodation for patients.

To address areas where there was a less positive score the Trust formed a working group consisting of clinical staff, patient experience staff and patient representatives to identify key priorities and develop improvement methodologies. There has been some delay with the projects due to the covid-19 pandemic, but the work is ongoing on the three key areas:

Increase awareness of nurse in charge

- Magnetic staff names have been produced to place on the patient board.
- Trialling of this initiative has commenced on Acute Medical Unit (AMU), Ward 11 and 14.

Improving discharge awareness

- Developed an Integrated Discharge Team survey around all aspect of discharge care
- Patient and Public Involvement Team support with distribution of the survey,

Reducing noise at night

- The *Shh Campaign* has been developed
- Patient and staff guidance posters have been produced and disseminated across ward areas
- Charity funding request was successful to purchase Shh campaign pens for ward staff.

Cancer Patient Experience Survey

The survey results for the Trust were received in July 2020/21. **A target of 99% for having good CNS support was highlighted, with the Trust being the top scoring in the UK in this question**. All scores in the survey were above or within the national average, with no specific issues highlighted. The Cancer Services Team, however, are currently working on analysing the results in terms of specific tumour groups and developing an improvement plan to support work around:

Education

- Information ward rounds and navigators for patients
- Information points on ward
- Inpatient staff education

Information

- Development of Trust cancer information book/leaflet
- Cancer page on Trust website
- Review of the care planning process

Partners

- Work with CCG and GP leads to relaunch Oncology Steering Group
- Work with research partners to increase the portfolio and raise awareness of studies

Local Survey

The Trust has an annual programme of local surveys related to national survey results and divisional and specialty priorities. Local surveys are an important means of providing local patient engagement for local services and informing potential areas of improvement. The programme is overseen by a combination of clinical and patient experience staff, service champions and patient representatives, that collectively form the Action Group for Patient Experience. Surveys are reviewed and approved by the Group prior to circulation and results are reviewed to ensure improvement actions are in place where required. Co-production of surveys and improvements between staff and patients enables better quality and targeted surveys and improvements in Trust services.

In the financial year 2020/21, a total of 14 surveys were undertaken, which is a smaller number than usual due to demands on services during the pandemic. These surveys were completed by patients in various settings including inpatient care, outpatient clinics and in community settings.

Examples of local surveys that have taken place in 2020/21 are:

COVID-19 Satisfaction Survey

Key findings	Actions
42 surveys completed • **Average rating of the care patients/service users received during this time was 4/5 stars** • **Change in services such as virtual appointments have been well received on the whole** • **Communication regarding care is the key area for improvement** • **19 patients that took part in the survey were admitted and tested positive for Covid-19** • **16 of the 19 patients did not feel the next steps of their care was made clear after they had been confirmed Covid positive** • **78% felt there was sufficient communication in relation to the precautions that were in place regarding social distancing** • **Majority of patients felt that staff were wearing the appropriate PPE** • **Visiting Restrictions - 58% found it easy to communicate with relatives/carers whilst in hospital and 25% responded with "sometimes". Remaining 17% did not find it easy**	➢ Look at publicising alternative methods of communication in a better way. ➢ Alternatives such as face timing relatives could be carried forward post Covid-19 ➢ Survey to be carried out again, including more questions to address the actions raised

Wound Care Survey

Key findings	Actions
• **Overall, feedback on the wound care clinics is very positive. The service they provide across the Care Communities is rated as 4.75 out of 5. Patients report that the wound care clinics are good and easily accessible and 93% would recommend.** • **28% of our patients received advice leaflet** • **88% of patients said they felt they were involved in their care/treatment plan**	➢ Ensure all patients receive an advice leaflet ➢ Increase the number of people who feel involved in their care/treatment plan

Special Schools Health Service– Central Cheshire Integrated Partnership (CCICP)

Key findings	Actions
A paper-based survey was completed by 135 patients using Physiotherapy, Occupational Therapy, Special Needs Nursing and Speech and Language Therapy at three special schools (Hebden Green, Springfield and Russet School). • 88% said the team were easy to contact • 95% reported the team were friendly and approachable • 98% said they were treated with dignity and respect • 89% reported they felt supported by the teams • 86% said the teams communicated and shared information with them about their child effectively	➢ Patient /parent communication – specifically in OT and SALT, and sharing of information – also specifically in OT and SALT ➢ Services to consider consistency of staff for service users, although identification not always practical ➢ Potential to consider electronic form in the future ➢ Consider option for positive comments box for each question as well. Negative comments only received due to wording of question

A routine monthly Trust patient survey, specific to Trust priorities for patient experience, alternates between medical and surgical services. This has been postponed during 2020-21 due to the pandemic but recommenced in November 2020 with a trial involving mixed survey methods (paper and electronic surveys) to increase accessibility. The survey has also been revised in 2020/21 to reflect the Trust key priorities from the National Inpatient Survey 2019 and enable ongoing monitoring of improvement.

NHS Choices

The NHS choices website provides an external opportunity for patients to provide comments about their recent experience in the Trust. The Trust responds to all posts, thanking patients for their feedback and providing information around how comments can be shared with teams or acted on to improve services.

There was a total of 33 new postings on the NHS choices website during 2020/21, 28 of which were positive postings and 5 negative. Examples of comments posted on NHS choices include:

Courteous and professional throughout
★★★★★ out of 5

Posted on 19 January 2021
Having had cause to visit Leighton hospital a couple of times recently on behalf of a neighbour who is shielding, please would you pass on my thanks to all the staff, but especially security staff at the main entrance, the pharmacy staff, and the x-ray reception all of whom were professional and courteous throughout at a time when all NHS staff are working under tremendous pressure it is often easy to fail to pass on thanks when people do a great job under challenging circumstances.

Endoscopy Unit
★★★★★ out of 5

Posted on 23 January 2021
What a lovely warm welcome I received when I arrived at the reception and it continued all the way through. What a fantastic Doctor, and lovely nurses that comforted me throughout the process. The after care of tea and toast was also much appreciated. Anyone worrying about this procedure need not do so, as you will be extremely well looked after. Please forward my thanks onto all the staff involved including the ladies who talked me through the pre-op paperwork and advice such as pre-op medicines etc. Many thanks.

Estates and Facilities
★★★ out of 5

Posted on 17 January 2021

Why can you not provide a location and parking map of the various departments? you do for everything else. It would be very helpful for impaired walkers bothering your very busy personnel and save motionally impaired customers from long walks...maybe. Apart from that your hospital staff are very efficient.

Trust replied - The Trust is currently looking into alternative options for printing and sending patient letters and information to patients which should allow a greater opportunity for additional information to be provided for patients prior to attending the hospital.

Social Media – Twitter and Facebook

Patient feedback and engagement is actively encouraged by the Trust through our social media platforms as well as through the Trust website and is used in a number of ways. Examples of this are:

Examples of patient feedback through Twitter and the Trust #FeedbackFriday campaign is always invaluable for staff but particularly so in times such as the national pandemic.

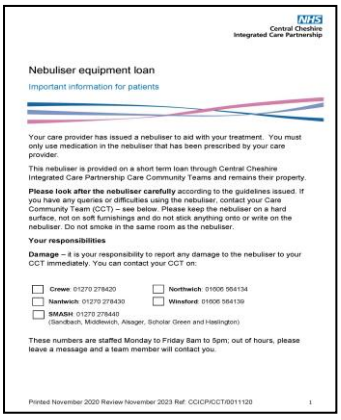
During the pandemic social media has been used to ensure that patients are kept up to date with national and Trust guidance. Keeping patients and families up to date with visiting guidance is just one of the areas where this has been utilised, with notices and videos from staff to delivery key messages.

Patient Information

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

To support this, the Trust has an active Reader's Panel with 76 members who review patient information on a monthly basis. The role of the Readers' Panel is to ensure:

- Patients and the public provide a user perspective in relation to the content and production of patient literature by being involved in the development of the written information.
- Patient information is accessible to patients, their carers' and visitors.
- The language used in leaflets is user-friendly, simple and easy to understand.
- There is a consistent approach to patient information across the Trust ensuring a high standard of production.



The Readers' Panel have reviewed 16 leaflets such as:

- Discharge advice for parents and carers of children who have sustained a minor burn or a scald – The Emergency Department
- Nebuliser equipment loan – Community Nurses
- Dry Eye Disease – Eye Care Centre

In 2020/21, the group developed and/or reviewed 41 leaflets, with examples including:


Cardiac Rehabilitation

Mid Cheshire Hospitals NHS Foundation Trust

Home Exercise Programme – Amber Level

Information for patients

The following programme should only be completed following advice from your Cardiac Rehabilitation Practitioner.

Who is this for?
A suitable standing exercise regime for patients following an acute cardiac event or procedure and/or those with long term cardiac conditions. You should find the red level comfortable before attempting this level.

Equipment needed: chair, step, weights (food tins/water bottles) for resistance.

Timings/Reps: **See circuit for timings. Total 20 minutes in the order listed, with 10 seconds gentle marching in between each exercise.**

Additional information

- Ensure you have read the corresponding Cardiac Rehabilitation Warm Up and Safety Guide. (15 minute warm up first)
- Always monitor your level of exertion, refer to the RPE scale as explained in the Monitoring Intensity Guide.
- Remember it's okay to feel a bit out of breath as long as you can still hold a conversation.
- When performing strengthening exercises, **do not** hold your breath or grip weights excessively as this can increase your blood pressure.

Toe taps to side with single arm raise 2 minutes	Stand feet hip width apart. Extend with your heel, tapping your toes out to one side. At the same time raise the same arm parallel to the floor. Return to start position and repeat with the opposite arm and leg.	
Bicep curls with weights, feet marching 1 minute	Hold weights in both hands. Keep your back straight and palms facing forwards. Curl both arms up near your shoulder from your elbow. Lower arms back slowly to start position. Keep your feet marching throughout.	

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- Trans perineal Prostate Biopsy – Urology Department
- Heart Failure - Heart Failure Nurse Specialist Team
- Various home exercise programmes leaflets – Cardiac Rehabilitation Team

Patient/Staff Stories

The Trust actively encourages patient and staff stories from Board Level. Listening to patients and staff stories of their experiences and journeys through our system enables redesign and improvements in care according to patients' needs, allowing every step in the patient journey to be examined and improved.

Stories are also used to promote the achievements of service improvement activity using tangible evidence from the stories provided by the patients' themselves. Sharing the lessons learned and the processes for successful implementation of improvements is a valuable way of spreading the learning throughout the organisation.

Collaborative working between the Patient and Public Involvement Team, Customer Care Team and clinical staff has increased participation in patient and staff stories, with stories pertinent to care during the Covid-19 pandemic at the forefront during 2020/21.

Patient Experience Network National Awards

The Trust submitted two applications for the Patient Experience Network National Awards with the voluntary services project shortlisted under the Strengthening the Foundation category:

PEN Patient Experience Network

- Innovation around Volunteering, led by Voluntary Services Manager (Strengthening the Foundation category)
- Identifying the Unwell Child in the Community Settings – CCICP (Using Insight to improve integrated Care category)

The awards were held virtually in 2020/21 and although we were not successful in gaining first place, the Trust is very proud of the work that the nominees implemented around the

relationship and co-working between The Trust and volunteers and improvements made in the provision of care for unwell children in the community setting.

Ecards

The Trust has a website facility for family and friends to send ecards to patients, which was part of a quality improvement project. Patients can receive a message from their family or friends in the form of a card produced from the website post and delivered to the ward. 2020/21 has seen an increase in ecards, with family and friends keen to send messages of support to their loved ones during difficult times. A total of 760 messages have been received and delivered by patient experience staff.

Customer Care Team

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

The Customer Care Team aims to respond to concerns and issues in a timely and effective manner, irrespective of whether this involves an informal concern, advice or a formal complaint. Most concerns can usually be resolved directly by staff that are caring for patients, however, sometimes patient or family members/carers prefer to talk to someone who is not directly involved in their care and the Customer Care Team are able to help. The Team can be contacted by telephone, email, in writing and in normal circumstances face to face, however, the latter has not been available in 2020/21 due to social distancing guidance.

Complaints Process

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

In 2020/21 leadership for the Trust Patient Experience Team, including Customer Care was transferred to the Quality Governance Team to reinforce triangulation of learning from complaints, patient safety incidents and claims. This has helped to promote improved scrutiny and investigation around concerns and issues involving patient care and more cohesive lessons learned and actions and enabled more opportunities for the team to work

together. To support this process a weekly Triangulation Group is in place to review all new complaints, patient safety incidents and claims and highlight potential themes.

A two-stage quality assurance process prior to executive scrutiny of formal complaint responses was implemented in 2020/21, to ensure complainants receive an open and thorough response to their concerns. A standard operating procedure has also been developed to support electronic review and of all complaints at executive level, which has speeded up the response process and incorporates review by relevant executive officers (eg Medical Director reviewing medical issues) prior to sign off. Formal complaint responses are also reviewed at the Trust Complaints Review Group which includes patient representation to promote transparency.

Timely processing of formal complaints is monitored through key performance indicators for acknowledging formal complaints within three working days and complaint responses being completed within forty working days.

A recovery plan was implemented in July 2020, following the re-instatement of NHS complaints at a national level to deal with the backlog of formal complaints at this point and ensure that complainants responses were dealt with as quickly as possible. Performance targets increased from this point but were affected by the impact of the Covid-19 pandemic on clinical services from November onwards. Complaints were put on hold again at a local level in November 2020 and will be reinstated again from the 1st April 2021, with the recovery plan remaining in place.

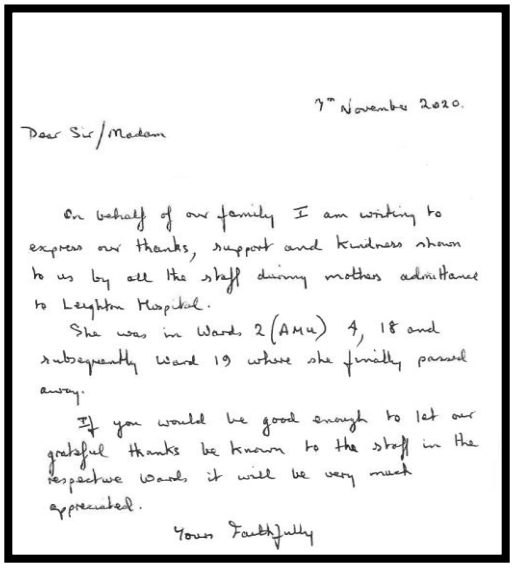
The Trust received 251 formal complaints in 2020/21 and dealt with 1049 informal concerns and enquiries for advice that were logged on Trust systems. Both formal complaints and informal concerns increased considerably as the year progressed due the impact of the pandemic on Trust services and arrangements for patients and their families. Improvement actions taken as a result of issues raised through formal complaints and informal concerns include:

Issue	Improvement Action(s)
Access to Phlebotomy Services / Appointments	Due to patients being unable to attend GP practices during the pandemic, the number of patients using the phlebotomy service within the Trust significantly increased, putting pressure on the service and leading to patients not being able to get through. A call centre was implemented to ensure that patients can contact the Trust in a timely manner for appointments and to provide further support for the Phlebotomy service.
Communication with Relatives	Restrictions placed on patient visiting and admission protocols have had a significant impact on communication between healthcare staff and relatives/carers/friends during the pandemic. Ward based communication sheets/books have been implemented, with password access, to ensure information is shared with next of kin shared around the care of their loved one. Electronic devices have

	also been made available on ward areas to enable patient's and relatives to communicate directly on screen and Ward Assistants have been employed to support electronic communication.
Management of Patient Property	The restrictions in place around visiting and admission have also had an impact on the management of patient property during hospital admissions. The Customer Care Team have managed to locate and return property as much as possible during this difficult period. A report was commissioned to assess property issues in detail, including complaints, concerns, incidents and claims, the results of which have been shared with wards. A working group has been established to review the current policy and process for managing property based on the report findings and take further actions forward.
Community Services at Victoria Infirmary, Northwich (VIN)	A rise in concerns received around the level of services offered at VIN has contributed to the implementation of an enhanced GP out of hours service with an additional nurse practitioner post. The Minor Injuries Unit is now open 7 days a week and can also provide a weekend x-ray service.
Discharge Medication	Several concerns have been raised from patients awaiting medication on discharge from their hospital stay. Workstations have been provided at ward level to allow patients to be discharged directly from the ward without pharmacy input if discharge medications are not required. Funding for additional staff has been secured to increase the levels of prescribing pharmacists to support the discharge process.

Compliments

The Trust received 223 compliments through the Customer Care Team in 2020/21 that were logged on Trust systems. Compliments are shared with relevant staff across the Trust to ensure that their dedication and hard work is recognised, something which has been of particular importance this year for the Trust as a whole. Compliments have been recorded for numerous staff groups the Trust, not limited to but including:



7th November 2020.

Dear Sir/Madam

On behalf of our family I am writing to express our thanks, support and kindness shown to us by all the staff during mothers admittance to Leighton Hospital.

She was in Wards 2 (AMU) 4, 18 and subsequently Ward 19 where she finally passed away.

If you would be good enough to let our grateful thanks be known to the staff in the respective Wards it will be very much appreciated.

Yours Faithfully

'Unfortunately over the last 4 months I have had many an appointment at Leighton with the radiography department. What I think needs noting is their excellent service. I've had xrays, CT scans, MRI, colonoscopy and endoscopy. My first thanks is to all the people who organise the appointments, and who send out information and reminders. These people are often forgotten and never seen but they have been amazing. I expected to be waiting months and months in our current pandemic situation but was seen as quickly as they could see me. From a charity forum other hospitals are really struggling to see people for investigations but Leighton has out shone themselves. My next thanks is to the radiographers, HCAs, cleaners and reception staff in the department. All polite, efficient, easy to talk too and professional. I've met so many now and all had an amazing happy disposition and standards of care. I know they are working extra long and hard during these times and they need to be thanked for every minute'.

'I came in this morning to the minor injuries unit around 9:30 because I injured my knee last night. All of the staff I interacted with were really caring and the nurse was exceptional; excellent knowledge and explained everything that he was checking and how it meant that aspect of my knee was fine. Keep up the brilliant work! 😁*'*

Overall Patient Experience Scores

Publication of the Overall Patient Experience Scores for the 2019 Adult Inpatient Survey update was suspended due to Covid-19 work pressures.

Source: https://www.england.nhs.uk/statistics/statistical-work-areas/pat-exp/ (29.04.2021)

However, overall scores for the Trust based on the CQC Benchmark Report are about the same as other Trusts in all sections.

Benchmark report from the CQC 2019

The Trust has scored About The Same as other trusts in all sections

Question sections	Lowest trust score in England	MCHFT Score 2018	MCHFT Score 2019	Highest trust score in England
Emergency Department	7.5	8.4	8.2	9.0
Waiting List	7.4	8.6	8.4	9.6
Waiting to get a bed	5.7	7.0	6.5	9.2
The hospital and ward	7.2	8.0	7.7	8.9
Doctors	8.1	8.9	8.6	9.5
Nurses	7.2	7.9	7.7	9.0
Care and treatment	7.3	8.1	7.8	9.0
Operations and procedures	7.6	8.3	8.3	9.2
Leaving hospital	6.2	6.9	6.7	8.4
Respect and Dignity	8.3	9.0	8.8	9.7
Overall Experience	7.4	8.2	8.0	9.2

A score of 10 represents the best possible response. The higher the score for each question, the better the trust is performing

Trust Health & Wellbeing

During the first wave of the pandemic, the Trust's Health & Wellbeing Group worked tirelessly to ensure that staff health and wellbeing was made an absolute priority.

As a result of the work achieved by this group during the initial stages of the pandemic, it was agreed that a Health & Wellbeing Project Board would be established, chaired by the Director of Workforce & OD, Heather Barnett, to embed the work already progressed by the group and identify additional work streams which would support our staff moving forward.

The Health and Welling Project Board has been focusing on delivery of phase 1 and 2 of their strategic action plan which is now nearing completion. Some examples of the work streams which the project board have progressed include:

- enhancing psychological support for staff at all levels through the Mental Health First Aid Service, Employee Assistance Programme and Listening Ear Service
- permanent wellbeing rooms/spaces for staff
- progressing the installation of plumbed in filtered water stations
- the creation of honesty larders
- on-site fresh food stalls
- improving and establishing outdoor wellbeing areas
- developing a first-class lounge for staff courtesy of Project Wingman
- re-launching the MCHFT Walking Route
- developing a staff discounts book for staff
- exploring enhanced salary sacrifice options
- delivering virtual Mindfulness and Resilience sessions
- delivering Virtual Schwarz rounds
- launch of the BAME staff network
- sign up to the Clinical Leaders Network "Enhancing Mental Health Resilience Programme" to enhance psychological wellbeing

The work of the Health & Wellbeing Project Board continues with a specific focus on our People Recovery Plan to ensure our staff are well supported and have time to recover following the third wave.

The Trust's Covid-19 vaccination programme is now well established with 89% of staff having now received their first Covid-19 vaccination. Second vaccinations have now commenced, with 76% of front-line staff having received their second dose, please note this is subject to change.

We are confident that through the Health & Wellbeing Project Board which provides assurance to EWAG, the health and wellbeing of our staff will remain a key priority.

The COVID-19: Are You OK? Pledge

In 2020 Mid Cheshire Hospitals Foundation Trust took a number of steps to safeguard staff mental health and wellbeing including pledging to the Nursing Times Covid-19: Are You OK campaign? The Are You Ok Campaign? aims to raise awareness of the potential long-term impact of working during a pandemic on nurses' mental health and wellbeing.

The Trust recognised the often-distressing nature of caring for patients with Covid-19, particularly when patient numbers are high, and resources are stretched. The Trust recognised the potential negative impact on the mental health and wellbeing of nurses and other staff of working through the coronavirus pandemic and are committed to providing support to those who are affected. The Trust also recognised that the effects of this work may be delayed and/or enduring and will ensure support remains available after the crisis has passed.

In supporting the campaign, the Trust has pledged to:

- Provide easily accessible formal mental health and wellbeing support to staff for as long as it is needed;
- Foster a culture of mutual support, in which staff are alert to the possibility that colleagues may be experiencing problems as a result of their work during the pandemic, and ready to offer informal support such as listening and signposting to internal or external sources of formal support;
- Ensure that staff who are experiencing problems know that they will receive a positive, supportive response if they disclose problems, and understand that being asked ‘Are you OK?’ is a gesture of support and care, not an accusation of weakness.

Infection Prevention & Control

In response to the Covid-19 pandemic the Trust has undertaken a number of initiatives to ensure the highest standards of Infection Prevention and Control measures are in place;

Be Safe Be EquiPPEd

The Be Safe, Be EquiPPEd campaign aimed to make our workplace as safe as possible for staff and patients during the Coronavirus pandemic through appropriate and correct use of PPE. The comprehensive, multi layered campaign ensured a clear and consistent approach to engaging, training and educating all staff providing patient care, to effectively select and use PPE appropriate for the clinical situation.

The Trust noted good levels of compliance with donning and doffing, correct use of PPE and FIT checking across its wards as a result of the campaign. Our priority has always been to protect the health of our patients and our staff. To achieve this during the

Coronavirus pandemic, PPE was of critical importance and the need for education and training of staff essential. Through the Be Safe, Be EquiPPEd campaign the Trust endeavoured to make the guidance as consistent and as accessible as possible by engaging with and supporting staff in a number of different ways.

By using this comprehensive approach Trust staff were supported to become 'experts' in infection prevention and control through daily briefings, training in use of PPE, simulation, on-the-ground support and other activity.

The campaign included a variety of elements;

- A series of staff 'roadshow' engagement events were held to launch the campaign, including practical demonstrations (using mannequins) of the PPE equipment required in the hospitals Red, Amber, and Green wards.
- A full range of clear and simple branded campaign materials such as posters and display stands supported the campaign and were displayed across the Trust.
- Short video animation clips were also developed to reflect the same information and were circulated Trust wide via the regular Coronavirus staff bulletin.
- A Matron rota supported PPE training during the campaign launch which also covered late shifts.
- Senior Managers and Executive Directors took part in daily walkabouts across inpatient ward areas to address any staff concerns and issues with PPE usage.
- The Trust Implemented floor walkers to promote the campaign which involved initial visits to inpatient wards followed by a focus on non-clinical areas across the Trust. These were well received and instrumental in sharing communication Trust wide and offering pastoral support to staff concerns.
- Each division and community were assigned PPE champions to cascade PPE training and communication. The Trust held regular short forum meetings for the champions to feed into with updates on stock, any education items, fielding of questions and links in with the infection prevention and control team.

Main achievements of the campaign;

- Ensuring staff had the PPE they need and were capable and confident to use it appropriately was an incredibly important during Covid-19 to maintain a safe, caring and effective environment for staff and patients.

- The campaign has not only protected the safety of staff and patients but also supported the mental wellbeing of staff.

- Comprehensive support and ongoing opportunities to raise concerns and have them quickly responded to, has given staff confidence and reassurance which reduced anxiety levels during a challenging time.

- The Be Safe, Be EquiPPEd campaign has been effective as it brought together various staff from all levels across the Trust who have worked together to quickly identify and address a range of issues and concerns relating to PPE and provide comprehensive, accessible and practical solutions for staff to engage with.

- Delivering clear simple, information supporting this with robust and comprehensive engagement with staff on the ground ensured large numbers of staff within the Trust became proficient and felt confident in using the right PPE in the right environment.

- Being able to capture large amounts of staff in this way created an informal peer support network as staff felt able and empowered to support each other with donning and doffing etc.

Coronavirus Pandemic Trust Wide Action cards

A number of action cards were developed, and a senior lead was allocated to facilitate each workstream. The leads were tasked with delivery of the agreed actions within the action cards and held responsibility for daily progress updates through Silver Command. The Action cards included the implementation of the Ward Based IPC Champions. This role involved over 30 members of staff who were redeployed into an IPC champions role to support the wards to prevent nosocomial infections. This allowed a supernumerary member of staff, identified as the champion, to base themselves on the ward assisting with Infection Prevention Control (IPC) measures. This included ensuring all patients wore face masks, the prevention of patients moving around the wards unnecessarily including contacting visitors, ensuring good ventilation on the wards and supporting the wards with regular touch point cleaning. A daily feedback session allowed the IPC champions to escalate any issues raised to their rota manager for appropriate escalation to Trust managers.

Safe Staffing

The Covid-19 pandemic created a workforce resourcing challenge across health and social care. Measures were introduced across the Trust to free up as much capacity as possible to manage the response to Covid-19. This has required health care professionals to be flexible in what they do, working in different clinical areas within their scope of practice. New models of care delivery have been utilised in the short and medium term to ensure workforce sustainability and maintain high-quality patient care.

Ward configurations and staffing levels have been subject to constant review as the Trust has created Covid-19 positive and surveillance wards. During this year, whilst dealing with the pandemic, the Trust introduced 6 weekly staffing and acuity reviews, using the professional judgement of its senior nursing team to ensure safe staffing throughout the period, recorded through a safe staffing tracker. The Trust board has continued to review the monthly safe staffing report for assurance though out the Covid-19 pandemic.

In June 2020, the Trust appointed a Head of Nursing for Safe Staffing and Workforce Utilisation. This post aims to provide assurance that the Trust plans safe nursing, midwifery, and care staffing levels across all in-patient ward areas and that there are appropriate systems in place to manage the demand for nursing, midwifery, and care staffing. In February 2021, the post holder successfully completed the Chief Nursing Officer Safer Staffing Fellowship programme, which features a strong focus on the workforce and safer staffing evidence-based decision support tools. This has enabled learning in a workforce context and developed senior nursing knowledge and skills to lead safe staffing reviews.

In November 2020, a Safe Staffing Group was established. The group is responsible for providing information and assurances to the Trust Quality Group, that the Trust is supporting a culture of safe staffing levels across all clinical workforce groups. Overseeing best practice in effective staff deployment and utilisation, including evidence-based tools, professional judgement, and workforce data, ensuring the right staff with the right skills are in the right place based on patient needs, acuity, dependency, and risk.

The nursing and midwifery workforce is reviewed twice a year in line with NHS Improvement (2018) Developing Workforce Safeguards guidance. Where available a recognised evidenced-based tool, such as the Safer Nursing Care Tool or BirthRate + is used to gather acuity and dependency data that in turn informs the nursing and midwifery establishment. To provide further validity and reliability of the Safer Nursing Care Tool data, refresher training has been provided for 70 senior nurses across inpatient wards, in addition a new validation process for each data collection has been introduced.

During 2019/20 the Trust continued to implement electronic rostering across the nursing and midwifery workforce with all inpatient areas completed in March 2021. 1850 staff are now electronically rostered. The project focus is now nurse specialist and outpatient teams, moving to allied health professionals later this year.

Implementation of the Allocate SafeCare Acuity module has been delayed due to the Covid -19 pandemic and is now planned for June 2021. This will provide a resource allocation decision support tool for senior nursing staff to aid deployment of staff. The software will support senior nurses align staffing numbers to patient acuity from SafeCare alongside clinical judgement to redeploy staff across the organisation to maximise patient safety.

Freedom to Speak UP

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

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

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

At Mid Cheshire Hospitals NHS Foundation Trust, the FTSU Guardian responsibilities had been delegated to the Director of Nursing & Quality role since 2016; however, the Head of Nursing Emergency Preparedness commenced in this role on 1st September 2020.

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

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

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

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

October 2020 was the Freedom to Speak up Month and promotional work was undertaken. A Freedom to Speak Up Team Talk was held on 29th October 2020 to introduce the FTSU Guardian and the FTSU Non-executive Director, with responsibility and oversight for raising concerns. The talk reminded staff what the Guardian’s role entails, what concerns can be raised and the methods available to staff when raising concerns.

The Freedom to Speak Up Guardian and the Anti-Fraud Specialist are committed to working together to encourage staff to raise genuine concerns in a responsible way and to have the issue(s) satisfactorily resolved within the Trust. A Joint Working Protocol has been developed and uploaded to the intranet.

There are plans to arrange drop-in clinics in Leighton Hospital and in community locations once it is appropriate for face to face meetings to take place in a safe environment. The Guardian attends CCICP Governance meetings to ensure the role is integrated within community settings in the meantime.
A total of 21 concerns were raised during 2020/21, this compares to 17 during 2019/20 and 12 during 2018/19. Concerns have been raised through a variety of mechanisms. It is positive to note the increase in cases reported throughout the period compared to the previous years which evidences that staff feel empowered to raise concerns.

Estates & Ancillary and Nursing & Midwifery colleagues have raised the most concerns over the 12-month period. Quarter 1 and Quarter 2 themes were predominately related to Covid-19 and infection control. In addition, historically most concerns originated from Nursing and

Midwifery colleagues and it is encouraging that other staff groups are becoming increasingly confident to raise concerns.

7 concerns were raised anonymously. Where concerns are reported this way, it restricts the ability for individual feedback to be provided. Information in these cases is cascaded to the Patient Safety Summit meeting or to an appropriate person e.g. the Divisional Matron/Head of Nursing to share general feedback at team meetings. The Trust uses staff survey results to benchmark itself against peer organisations on indicators relevant to raising concerns.

Falls

During 2020/21 the Trust has implemented a number of changes to support with the reduction of falls across the organisation. December 2020 saw the introduction of the new falls bundle. To support this a number of training sessions were held in all areas and is now in line with national guidance. Quarterly audits have commenced to offer reassurance of compliance. Additional falls training is conducted within the Quality care programme, induction programme and Harm Free Care study days. The Quality team completed a deep dive in to six months of data for all falls reported with moderate harm and above. The results were shared providing reassurance that the new falls bundle would provide improvements with documentation and assessment.

Developing a proactive approach to falls prevention, the Trust offers a weekly frequent fallers report which is disseminated to the ward managers highlighting patients that have a previous falls history. A prevention meeting is held weekly where managers can join the harm free care team in developing an individual prevention plan. The meeting allows managers to identify patients at risk of falls with no current history and discuss preventative measures.

The Trust has developed a new Standard Operating Procedure which ensures all falls of low harm and above are reviewed at a falls panel to establish any lapses in care. From this, ward and departments are asked to develop an improvement plan which is shared across the Trust through the Harm free care group to ensure shared Learning. In addition, all improvements are shared on a ‘Quality Improvement forum’ page which provides a platform for shared learning and discussion across the divisions.

Pressure Ulcers

A new Trust Tissue Viability Specialist Nurse (TVSN) commenced in post in November 2020, continuing to review any developed in care pressure and moisture associated skin damage. In February 2021 the Trust expanded its service and recruited a band 6 Skin Care Specialist Nurse to support the TVSN in the verification of damage, management of wounds and to provide Trust wide training.

Training is carried out within the Quality Care programme, induction programme and Harm Free Care study days. In addition to this, ‘bite size’ training sessions are provided, tailored to individual staff members. This facilitates advice and training where full sessions are not possible with the current COVID-19 restrictions.

The Trust has reviewed and made changes to its review panel process. The development of a new Standard Operating Procedure ensures all developed in care pressure ulcers,

category two and above are reviewed at pressure ulcer panel to establish any lapses in care. From this ward and departments are asked to develop an improvement plan which is shared across the Trust through the Harm Free Care Group. In addition, all improvements are shared on a 'Quality Improvement Forum' page which provides a platform for shared learning and discussion across the divisions.

The Trust reported 395 Hospital acquired Pressure Ulcers compared to 164 reported in 2019/20. In response, the Trust has undertaken a deep dive review of Quarter 4 incidents.

The report looked at the data of 35 incidents reviewed at panel between January -March 2021. The incidents consist of 24 category 2 Pressure Ulcers, 1 category 3, 1 category 4 and 9 unstageable ulcers from 15 departments within the Trust. The report excludes CCICP data. Themes in lapses in care were recognised, and evidence of actions provided to ensure continuous improvements. Where new areas for improvement are found, action plans were produced.

In response to the lapses in care identified, the Quality Team have been working with the divisions to address the areas identified as a lapse in care and have implemented actions based on the following themes identified:

- Requesting of mattresses through the Quality Team and referral to TVN
- Trust availability of air mattresses
- Adherence to policy training
- Delays in repositioning
- Surgical face mask monitoring in patients.

Improvements are underway to address the areas identified as lapses in care as recorded within a Quality Team Gap analysis, the progress will be shared with the Trust Skin Care Group and escalated to the Harm Free Care Group.

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

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

CCICP have implemented a virtual weekly safety huddle across all care communities where reviews are undertaken of all patients who have unstageable, category 3 and 4 pressure ulcers together with those patients whom are identified as deteriorating in health. This has enabled CCICP to ensure that all specialist services, assessments, care and equipment are in place to optimise patient's wellbeing. The safety huddles have been supported by District Nurses, Tissue Viability Specialists and clinicians such as Bladder and Bowel, wheelchair and Podiatry specialists.

CCICP have for the second year running purchased and supplied to patients across South Cheshire and Vale Royal high spec pressure relieving cushions to patients whom are identified as being at risk of developing pressure damage.

Statements of assurance from the Board

Review of services

During 2020/21 the Trust provided and/or sub-contracted 40 relevant health services.

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

The income generated by the relevant health services reviewed in 2020/21 represents 87% of the total income generated from the provision of relevant health services by the Trust for 2020/21.

Participation in Clinical Audits and Research

Clinical audit evaluates the quality of care provided against evidence-based standards and is a key component of clinical governance and quality improvement. Mid Cheshire Hospitals NHS Foundation Trust (MCHFT) produces an annual programme for clinical audit, incorporating national, regional and local projects, which is informed and monitored using priority levels.

National Clinical Audit

During 2020/21, 45 national clinical audits and 1 national confidential enquiry (Clinical Outcome Review Programmes) covered NHS services that MCHFT provides.

During that period, MCHFT participated in 98% of national clinical audits and 100% of national confidential enquiries (Clinical Outcome Review Programmes) of the national clinical audits and national confidential enquires (Clinical Outcome Review Programmes) which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Trust was eligible to participate in during 2020/21 are shown in the table below.

The national clinical audits and national confidential enquires that the Trust participated in during 2020/21 are shown in the table below.

The national clinical audits and national confidential enquires that the Trust participated in, and for which data collection was completed during 2020/21, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Clinical Audit Participation 2020/21

Name of audit	MCHFT participation	Stage / % of cases submitted
BAUS Urology Audits: Female stress urinary incontinence	Yes	Data collection ongoing
BAUS Urology Audits: Percutaneous Nephrolithotomy	Yes	Data collection ongoing
Case Mix Programme (CMP)	Yes	Data collection ongoing
Elective Surgery (National PROMs Programme)	Yes	See PROMs section of this report
Falls and Fragility Fractures Audit programme (FFFAP):		
National Inpatient Falls	Yes	Data collection ongoing
National Hip Fracture Database	Yes	Data collection ongoing
Fracture Neck of Femur (RCEM)	Yes	Data collection ongoing
Infection Control (RCEM)	Yes	Data collection ongoing
Inflammatory Bowel Disease (IBD) Audit	Yes	Data collection ongoing
Learning Disabilities Mortality Review Programme (LeDeR)	Yes	Data collection ongoing
Mandatory Surveillance of HCAI	Yes	Data collection ongoing
Maternal and Newborn Infant Clinical Outcome Review Programme:		
Perinatal Mortality Surveillance	Yes	Data collection ongoing
Perinatal Morbidity and Mortality Confidential Enquiries	Yes	Data collection ongoing
Medical & Surgical Clinical Outcome Review Programme (NCEPOD):		
In-hospital Care of Out of Hospital Cardiac Arrests	Yes	Data collection complete
National Asthma & Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP):		
Adult Asthma Secondary Care	Yes	Data collection ongoing
Chronic Obstructive Pulmonary Disease (COPD) Secondary Care	Yes	Data collection ongoing
Pulmonary Rehabilitation (Community)	Yes	Data collection ongoing
National Audit of Breast Cancer in Older Patients (NABCOP)	Yes	Data collection ongoing
National Audit of Cardiac Rehabilitation	Yes	Data collection ongoing

National Audit of Care at the End of Life (NACEL)	Yes	Data collection ongoing
National Audit of Dementia (care in general hospitals)	Yes	Data collection ongoing
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	No	Due to insufficient resources unable to participate
National Cardiac Arrest Audit (NCAA)	Yes	Data collection ongoing
National Cardiac Audit Programme (NCAP):		
Myocardial Ischaemia National Audit Project (MINAP)	Yes	Data collection ongoing
National Heart Failure Audit	Yes	Data collection ongoing
National Comparative Audit of Blood Transfusion programme - 2020 Audit of the management of perioperative paediatric anaemia	Yes	Suspended due to COVID
National Diabetes Audit – Adults	Yes	Data collection ongoing
National Audit of Rheumatoid and Early Inflammatory Arthritis (NEIAA)	Yes	Data collection ongoing
National Emergency Laparotomy Audit (NELA)	Yes	Data collection ongoing
National Gastrointestinal Cancer Programme:		
Oesophago-gastric Cancer (NAOGC)	Yes	Data collection ongoing
National Bowel Cancer Audit (NBOCA)	Yes	Data collection ongoing
National Joint Registry (NJR)	Yes	Data collection ongoing
National Lung Cancer Audit (NLCA)	Yes	Data collection ongoing
National Maternity and Perinatal Audit	Yes	Data collection ongoing
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Yes	Data collection ongoing
National Ophthalmology Database Audit	Yes	Data collection ongoing
National Paediatric Diabetes Audit (NPDA)	Yes	Data collection ongoing
National Prostate Cancer Audit (NPCA)	Yes	Data collection ongoing
Pain in Children (RCEM)	Yes	Data collection ongoing
Perioperative Quality Improvement Programme (PQIP)	Yes	Data collection ongoing
Sentinel Stroke National Audit programme (SSNAP) (Acute / Community)	Yes	Data collection ongoing
Serious Hazards of Transfusion Scheme (SHOT)	Yes	Data collection ongoing

Society for Acute Medicine's Benchmarking Audit (SAMBA)	Yes	Data collection ongoing
Surgical Site Infection Surveillance	Yes	Data collection ongoing
The Trauma Audit & Research Network (TARN)	Yes	Data collection ongoing
UK Registry of Endocrine and Thyroid Surgery	Yes	Data collection ongoing

Mid Cheshire Hospitals NHS Foundation Trust is committed to improving the quality of the healthcare we provide. To help with this, an improvement plan should be completed for all local and national audits undertaken to measure our compliance against standards and to identify any actions that could lead to improvements.

The Trust holds a minimum of 10 Quality Improvement Sessions per year, two of which are dedicated to discussing the results of the Trauma Audit & Research Network (TARN). We have a further session set aside as a Trust-wide Quality Improvement Session whereby topics are discussed that are applicable to all. Specialties will either discuss local and national audits at their individual meetings or hold a joint session with other specialties to share learning and foster improvement.

During the National pandemic, the Trust-wide quality improvement session was used to review any learning from our mortality cases where the cause of death was Covid-19. The session also included presentations from our Infection Prevention Control team and the RECOVERY research trial.

Despite the global pandemic, 53 audit projects were recorded as completed during the period 1st April 2020-31st March 2021.

The reports of 32 national clinical audits were/are being reviewed by the provider in 2020/21 and the Trust intends to take the following actions to improve the quality of healthcare provided:

Table 6: National Clinical Audit Participation 2020/21 – Actions

National Clinical Audit and Clinical Outcome Review Programme	Actions taken / to be taken
Case Mix Programme (CMP)	Quarterly reviews of all ICNARC/Critical Care activity at the multidisciplinary team meeting and all individual cases discussed with any issues being taken forward by the clinical lead as part of the governance strategy.
Elective Surgery (National PROMs Programme)	See Patient Reported Outcome Measures Scores section of this report.
Falls and Fragility Fractures Audit programme (FFFAP):	
National Hip Fracture Database	Review and improvement plan in progress
National Audit of Inpatient Falls	Falls risk assessment updated as part of Falls Care Bundle to help improve provision of walking aids and multifactorial assessment.

Inflammatory Bowel Disease (IBD Registry), Biological Therapies	Review and improvement plan in progress
Major Trauma Audit	Results to be presented at Quality Improvement Session to discuss the results and agree improvements. Local audit registered to review the time taken to access CT scans.
Maternal, Newborn and Infant Clinical Outcome Review Programme:	
Perinatal Mortality	Review and improvement plan in progress
Saving Lives, Improving Mothers Care	Review and improvement plan in progress
Stillbirths and neonatal deaths in twin pregnancies (sprint report)	Review and improvement plan in progress
Medical & Surgical Clinical Outcome Review Programme:	
NCEPOD In Hospital Care of Out of Hospital Cardiac Arrests	Review and improvement plan in progress
National Asthma and COPD Audit Programme (NACAP):	
National Chronic Obstructive Pulmonary Disease	COPD Discharge Bundle produced and development ongoing with the Integrated Respiratory Team. Escalation plan produced to meet the 120-minute target for patients requiring ventilation.
National Adult Asthma	Local audit being undertaken in relation to the national recommendations to understand the reasons behind compliance with a view to improvement.
National Audit of Breast Cancer in Older Patients (NABCOP)	Local audits from national findings to be undertaken to further understand barriers to compliance with a view to making improvements.
National Audit of Care at the End of Life (NACEL)	Education sessions with emphasis on prognosis, communication, documentation and hydration/nutritional needs.
National Cardiac Arrest Audit (NCAA)	Quarterly reports reviewed and included in improvement plan which is reviewed by the Resuscitation Group.
National Cardiac Audit Programme:	
Myocardial Ischaemia National Audit Project (MINAP)	Review and improvement plan in progress
National Heart Failure Audit	Review and improvement plan in progress
National Diabetes Audit – Adults	Review and improvement plan in progress
National Early Inflammatory Arthritis Audit (NEIAA)	Review and improvement plan in progress
National Emergency Laparotomy Audit (NELA)	Review and improvement plan in progress
National Gastrointestinal Cancer Programme:	
Oesophago-gastric Cancer (NAOGC)	Review and improvement plan in progress
National Bowel Cancer Audit (NBOCA)	Review and improvement plan in progress
National Joint Registry	Review and improvement plan in progress
National Maternity and Perinatal Audit	Review and improvement plan in progress
National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)	Review and improvement plan in progress
National Ophthalmology Audit	Review and improvement plan in progress
National Paediatric Diabetes Audit	Review and improvement plan in progress
National Prostate Cancer Audit	A faster diagnosis pathway has been introduced

	to improve access to MRI. Trans perineal prostate biopsy commenced in January 2021 to maximise diagnostic accuracy.
Sentinel Stroke National Audit Programme (SSNAP) (Acute / Community)	Some discrepancy around the reported results for the Trust as the pathway is across two hospital sites – work is underway with the project providers to correct this.
RCEM Mental Health (self-harm)	Report published in March 2021 for review and production of improvement plan
RCEM Assessing for Cognitive Impairment in Older People	Report published in February 2021 for review and production of improvement plan
RCEM Care of Children in ED	Report published in January 2021 for review and production of improvement plan

NB Some annual reports were delayed in 2020/21 due to the Covid-19 pandemic

Local Clinical Audits

The reports of 45 local clinical audits were reviewed by the provider in 2020/21 and the Trust intends to take/has taken the following actions to improve the quality of healthcare provided in the sample of projects below:

Local Clinical Audit	Actions Taken / To Be Taken
Re-audit of quality of care given to children and young people presenting with self-harm	Overall, significant improvements have been seen in achieving the majority of standards as audited during the 1st cycle. Update existing MCHT Paediatric Self Harm Proforma.
CTG Monitoring in labour	Introduce new Intrapartum CTG sticker with section for buddy analysis. Introduce new Intrapartum CTG sticker with section to sign and print review. A slide on the need to document the delay in review of CTG to be added to the mandatory training.
Referral to Cardiology from the Pre-operative assessment clinic for optimisation prior to surgery	Establish an electronic log of activity in the 'Cardiology-Anaesthetic Multidisciplinary Team (MDT) Virtual Clinic'.
Inter-Hospital Transfer of Emergency Department Patients	Medical review and discussion with the receiving team is done well but there is room for improvement in risk assessment, NEWS 2 documentation prior to transfer and use of the transfer checklist. Presentation of above results in departmental meetings. Encourage staff in refresher sessions about said safety assessment prior to transfer. Process review of transfer against Standard Operating Procedure. Aim for a Plan Do Study Act (PDSA) cycle initiation plotting current processing.
Quality Assessment of GP referrals & clinical evaluation of patients in Rapid Access Chest Pain Clinic (RPACP)	Educational event delivered Poster designed and displayed RACPC proforma updated Adherence to NICE guidance directed focus on prescription of antianginal medications and investigations
Prescribing Audit	Criteria to be reviewed prior to re-audit, specifically criteria 12 as it is currently unfair to prescribers

3 Monthly Controlled Drugs Audit	Return all drugs from Victoria Infirmary (VIN) as these are not in use. Create and distribute a Lessons Learned Poster detailing common errors. Data required to be added to the report for completeness. Send out results to ward managers via email for awareness. Contact Endoscopy Lead to discuss removal of controlled drugs from VIN.

Participation in clinical research

Research and Development

'The world faces an unprecedented challenge in our efforts to tackle the spread of Covid-19 and it is vital we harness our research capabilities to the fullest extent to limit the outbreak and protect life'.

-Professor Chris Whitty, Chief Medical Officer and NIHR Co-Lead

Recruitment to much of our usual research portfolio was suspended during 2020/21 due to the global pandemic. To support the fight against Covid-19, the National Institute for Health Research (NIHR) called for all Trusts with NIHR funded research departments to prioritise support for urgent Covid-19 research. The research team at MCHFT moved with unprecedented speed and flexibility to open new Urgent Public Health (UPH) research studies.

This comprehensive re-prioritisation of research activity could only be undertaken safely by risk assessing all studies within the existing research portfolios, in preparation for them to be stood down in favour of the Covid-19 UPH studies. All studies were closed to recruitment. Most study activity was halted, apart from those studies where it was determined there may be an element of patient safety risk, should all follow up activity be ceased.

Research Team Leads from the 3 research portfolios joined to develop and implement a combined team plan, that enabled the Trust to meet the national obligation to deliver an Urgent Public Health portfolio, while ensuring that participants on existing studies were safe and supported.

This combined effort meant that during 20/21 MCHFT opened or re-activated 6 UPH studies; two treatment trials, three observational trials and one staff study.

Urgent Public Health portfolio at MCHFT 20/21:

RECOVERY. NIHR priority level 1a

This national clinical trial aims to identify treatments that may be beneficial for people hospitalised with suspected or confirmed Covid-19

ISARIC CCP-UK. NIHR priority level 1a.

Europe's largest analysis of hospitalised UK patients with Covid-19

SIREN. NIHR priority level 1a.

SARS-COV2 immunity and reinfection evaluation; The impact of detectable anti SARS-COV2 antibody on the incidence of Covid-19 in healthcare workers

RECOVERY RS. NIHR priority level 1b.

The largest global non-invasive respiratory support trial for Covid-19, compares the effectiveness of three ventilation methods

UKOSS. NIHR priority level 1b.
To determine the incidence of hospitalisation with pandemic Covid-19 infection in pregnancy and assess the outcomes of pandemic Covid-19 in pregnancy for mother and infant.

PANCOVID. NIHR priority level 1b.
A global registry of women with suspected Covid-19 or confirmed SARS-CoV-2 infection in pregnancy and their neonates; understanding natural history to guide treatment and prevention.

The number of patients receiving NHS services provided or sub-contracted by Mid Cheshire Hospitals NHS Foundation Trust that were recruited between 01/04/20 and 28/02/21 to participate in research approved by a research ethics committee was 653.

Commissioning for Quality and Innovation (CQUIN)

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

As a result of the Coronavirus Pandemic a number of monitoring elements, such as CQUINs and Quality Schedule have been suspended during 2020-2021. Despite the suspension of monitoring requirements, we have continued to make good progress on our quality and safety improvements and in response to the Covid-19 pandemic the Trust has undertaken a number of initiatives to ensure the highest standards of Infection Prevention and Control measures are in place.

Feedback from Care Quality Commission (CQC)

The Trust is required to register with the Care Quality Commission (CQC) under section 10 of the Health and Social Care Act 2008 and its current registration status is registered without conditions. The Trust's registration includes the services provided at Leighton Hospital, Victoria Infirmary in Northwich, Elmhurst Intermediate Care Centre in Winsford and the community services within the Central Cheshire Integrated Care Partnership (CCICP). The Care Quality Commission has not taken enforcement action against the Trust during the period April 2020 to March 2021.

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

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

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

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

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

Our latest ratings can be seen here:

The Trust developed an improvement plan in response to the 2019 CQC inspection findings. Divided in to "must do" and "should do" actions, the CQC improvement plan responded to each of the findings, and by October 2020, all of the "must do" actions had

been addressed. At time of writing the “should do” action plan is very near completion and closure.

The development and delivery of quality Improvement plans relating to regulatory compliance, are overseen by the Quality Summit. Quality Summit met fortnightly during 2020/21 with representation from all Divisions. The meeting is Chaired by Director of Nursing & Quality, and members include Deputy Medical Director, Heads of Nursing, Assistant Medical Directors, and Divisional General Managers. Quality Summit reports into Executive Quality Governance Group, with onward reporting to the Quality & Safety Committee. Quality & Safety Committee is a sub-committee of the Board and has delegated authority to oversee matters relating to quality of care and the maintenance of unconditional registration with the CQC. Divisions have been required to provide updates to the Quality Summit on their progress with implementation of CQC improvement plan actions, including assurances on how changes are being monitored and improvements embedded into practice.

As part of the Trust’s quality and safety assurance framework, an annual programme of unannounced inspection visits was planned for 2020/21, to seek assurance of care and services delivered being safe, effective, responsive, caring and well led. Due to pressures experienced Trust-wide during the response to the Covid-19 pandemic, fewer inspections were held than originally planned. Where unannounced inspections have been undertaken, they have focused on assessing areas and services identified by the CQC as requiring improvement and have aimed to evidence that where changes have been implemented these have resulted in sustained improvement. Victoria Infirmary in Northwich was prioritised in this programme of work and both the Minor Injuries Unit and Outpatient Department delivered from there, took part in an unannounced visit during October 2020. Changes had been implemented in response to CQC findings, and staff reported that these had resulted in them feeling more supported, that practice was safer, senior leaders were more visible and seeking advice when needed was much easier. Patients reported feeling safe whilst in the building, appreciated the accessibility of the services, and commended the staff for their positive attitude and hard work during difficult times. Where actions have resulted from these visits, improvement plans have been developed and delivery is monitored at the appropriate Divisional Board meeting.

The Trust has maintained contact with its designated CQC Relationship Manager within year. Regular engagement meetings have been held over Microsoft Teams, with attendance from Trust Executives and senior leaders.

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

The Trust has received 9 enquiries from the CQC during 2020/21. All responses were returned within the given timeframes.

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

Data Quality Assurance

NHS and General Practitioner registration code validity (April 20 – December 20) From NHS Digital SUS dashboard)

The Trust submitted records during 2020/21 to the secondary uses service for inclusion in the Hospital Episodes Statistics which are included in the latest published data.

The percentage of records in the published data which included the patient's valid NHS number was:

- 99.8% for admitted patient care
- 100% for outpatient care
- 99.4% for accident and emergency care

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

- 100% for admitted patient care
- 97.3% for outpatient care
- 100% for accident and emergency care

Information Governance toolkit attainment

The Trust is required to make an annual submission to NHS Digital in order to provide an assurance that adequate measures are in place to protect the data it holds. This is done in the form of a self-assessment called the Data Security and Protection Toolkit (DSPT) which is supplemented by an external audit. The 2019/20 DSPT submission was submitted with all 160 mandatory standards being met. The external audit was fulfilled reporting the Trust as having 'substantial assurance' in this area. The Trusts 2020/21 DSPT submission is not due until the 31/06/2021.

The 2019/20 DSPT submission was submitted with all 160 mandatory standards being met. The external audit was fulfilled reporting the Trust as having 'substantial assurance' in this area.

Data Security and Protection Toolkit (DSPT) status

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

The DSPT is measured by an online submission and an external audit both of which ordinarily require completion by the 31st March.

However due to the impact of Covid-19 the deadline for the 2020/21 submission has been extended to the 30th June 2021. Due to this extension the Trust is not in a position to publish its 2020/21 DSPT status as part of this Quality Account.

However, the Trust is currently in a strong position regarding its DSPT progress and is expected to meet the 2020/21 standard as it did in 2019/20. Please note that the outcome of the Trust's DSPT submissions is available on the NHS Digital website.

Clinical coding error rate

The Trust was not subject to the Payment by Results clinical coding audit during 2020/21 by the Audit Commission.
The Clinical Coding department were subject to a Data Security Protection Toolkit (DSPT) audit, the results of this audit are tabled below.

CODING FIELD	PERCENTAGE CORRECT	Mandatory	Advisory
Primary Diagnosis	91.00%	90.00%	95.00%
Secondary Diagnosis	93.91%	80.00%	90.00%
Primary Procedure	91.04%	90.00%	95.00%
Secondary Procedure	96.15%	80.00%	90.00%

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

- Deliver a robust annual coding audit programme to ensure that staff maintain and enhance their skills in line with the National Clinical Coding Standards.
- Action any recommendations from the Clinical Coding Audits, escalating to the Data Quality Group where appropriate.
- Continue to support and deliver an internal training programme for the Novice Clinical Coders, through the mentorship programme delivered by the Clinical Coding Team Leaders.
- Continue to deliver required training to all Clinical Coders and support them in their professional development.
- The Clinical Coding Management team will continue to develop the clinician engagement programme to promote the importance of accurate clinical data.
- Continually review coding resources and performance.

Patient Safety Alerts Compliance 2020/21

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

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

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

A monthly safety alert group monitors progress of the alerts to ensure they are fully implemented within the specified timeframes.

During 2020/21, the Trust received 7 patient safety alerts; none breached the timeframes allocated.

Reference no.	Title	Date alert issued	Date due to be completed	Status
Natpsa/2020/002	Interruption of high flow nasal oxygen during transfer	01/04/2020	08/04/2020	Closed – Actions completed
Natpsa/2020/003	Blood control safety cannula & needle thoracostomy for tension pneumothorax	02/04/2020	09/04/2020	Closed – Actions completed
Natpsa/2020/004	Risk of death from unintended administration of sodium nitrite	06/08/2020	06/11/2020	Closed – Actions completed
Natpsa/2020/005	Steroid emergency card to support early recognition and treatment of adrenal crisis in adults	13/08/2020	13/05/2021	Actions remain ongoing
Natpsa/2020/006	Foreign body aspiration during intubation, advanced airway management or ventilation	01/09/2020	01/06/2021	Actions remain ongoing
Natpsa/2020/007	Philips respironics v60 ventilator	23/09/2020	23/12/2020	Closed – Action was not required
Natpsa/2020/008	Natpsa/2020/008/nhsps deterioration due to rapid offload of pleural effusion from chest drains	01/12/2020	01/06/2020	Actions remain ongoing

Never Events 2020/21

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

In 2020/21, 2 incidents occurred which met the definition of a Never Event at Mid Cheshire Hospitals NHS Foundation Trust. A comprehensive root cause analysis was undertaken and an improvement plan developed to prevent reoccurrence.

The table below provides a description of the incident and outlines the root cause and the recommendations. The patient's were informed immediately of the incident and the learning has been shared.

Summary of Never Events 2020/21			
Type of Never Event	**Description of incident**	**Root Cause**	**Recommendations**
Wrong Site Surgery	A 60 year old lady attended the One Stop Breast Care Clinic following a referral by her GP for a palpable breast lump. An ultrasound scan (USS) was performed which identified the palpable lump and also a non palpable lump. USS guided core biopsy of both lesions were taken. The Consultant Radiologist inserted a Magseed Tumour Marker into the palpable breast lump. The patient was discussed at the Multi-disciplinary Team meeting; the biopsy results confirmed both lesions as malignant. The medical plan was for a further Magseed Tumour Marker to be inserted into the non-palpable breast lump prior to the patient undergoing surgery. The patient re attended the Breast Care Unit where a second Magseed Tumour Marker was inserted into the palpable breast lump by mistake. The error was identified by the Superintendent Radiographer when they were 'cashing up' the clinic at the end of the clinic and noticed there was no imaging report for the patient. The images were reviewed, and the error was identified. The patient re attended the Breast Care Unit where a Magseed Tumour Marker was inserted correctly into the non-palpable breast lump. The patient	The investigation found that there was confusion regarding the insertion of the second Magseed tumour marker and a lack of effective communication between the members of the multidisciplinary team. There was a failure in process to identify this confusion and to encourage the staff to seek clarity regarding the request. The form requesting the insertion of the second marker was unclear and the WHO checklist was not completed appropriately.	Revision of the WHO checklist to ensure that it is specific enough to safely support the procedures for which it is being used. Verbalisation of the WHO checklist when completed with all members of staff present.

Summary of Never Events 2020/21			
Type of Never Event	**Description of incident**	**Root Cause**	**Recommendations**
	underwent surgery as planned. The patient's treatment has not been delayed as a result of the error.		
Wrong Site Procedure	A 64 year old lady attended the Eye Care Centre at Mid Cheshire Hospitals NHS Foundation Trust for a pan retinal photocoagulation procedure to the right eye. The case notes used by the team undertaking the procedure were the incorrect case notes. The notes were for a patient with the exact same name who had been listed for a left panretinal laser photocoagulation. The case notes that were used for the patient's procedure, had an addressograph label for the patient who was in front of the doctor on the history sheet page, for the doctor to record the clinical episode of this visit. The surgeon proceeded to do a left pan retinal photocoagulation as stated in the records, unaware that the notes were for the wrong patient. Both patients with the same name had been in clinic on the same day and both patients required pan retinal photocoagulation.	The investigation is currently ongoing	The investigation is currently ongoing however immediate actions were taken which included: • A white board to be placed in laser room and used as in theatres and details to be checked against patients notes and confirmed with patient. Details to be recorded are: Name of patient Date of Birth Hospital Number Procedure Site of procedure/operation • LocSSIP for laser procedures performed in the Eye Care Centre to be reviewed to ensure it is fit for purpose and in line with national guidance • Review of all surgical procedures undertaken in an outpatient setting to confirm that the WHO safety checklist, LocSSIPs and consent process are being adhered too in line with national and Trust policy • Audit of 'consent at listing' process / Confirmation of Consent section on Consent Forms to establish if Trust Consent Policy is followed • All clinic staff to be

Summary of Never Events 2020/21			
Type of Never Event	**Description of incident**	**Root Cause**	**Recommendations**
			aware of new 'Fresh Set of Eyes' initiative which allows staff to raise a concern and state that they are not happy to proceed with a procedure until a registered professional has reviewed the concerns raised • Observational review to be undertaken to observe how patients are identified within the eye care centre, called into the clinic rooms and have their identification and planned procedure checked prior to the procedure commencing

Learning from Deaths

During 2020/21 the Learning from Deaths programme was suspended due to the Covid-19 pandemic. The Trust however continued to review deaths where the patient had a learning disability or serious mental health illness, deaths where families, carers or staff raised concerns and deaths where concerns were raised at the weekly Patient Safety Summit via clinical incident reports.

The Trust also undertook a deep dive into all Covid-19 deaths from the first wave in quarter 1 2020/21. 143 deaths were reviewed, and there were no deaths judged to be more likely than not to have been due to problems in care provided to the patient. A similar review is underway for all Covid-19 deaths from the second wave in quarters three and four 2020/21.

During quarters one to four 1222 patients were part of the Learning from Deaths process within Mid Cheshire Hospitals NHS Foundation Trust.

Number of deaths included in the Learning from Deaths process 2020/21	
Quarter	**Number of deaths**
April 2020 to March 2021	1222
Quarter 1 2020/21	400
Quarter 2 2020/21	168
Quarter 3 2020/21	305
Quarter 4 2020/21	349

By the end of March 2021, 182 case record reviews were carried out in relation to 1222 deaths. In 7 cases an investigation was undertaken and in 2 cases both a case record review and an investigation was completed.

Number of case record reviews/investigations during 2020/21	
Quarter	**Deaths reviewed or investigated (as of end of April 2021)**
April 2020 to March 2021	189
Quarter 1 2020/21	145 (144 case reviews & 1 investigation)
Quarter 2 2020/21	5 (4 case reviews & 1 investigation)
Quarter 3 2020/21	14 (10 case reviews & 4 investigation)
Quarter 4 2020/21	24(24 case reviews & 1 investigation)

7 (0.57%) deaths reviewed or investigated (as at the end of April 2021) were judged more likely than not to have been due to problems in care provided to the patient. The 7 cases all underwent a comprehensive investigation and were reported as a serious incident in line with the national Serious Incident Framework.

Number of deaths reviewed which were judged more likely than not to have been due to problems in care provided to the patient	
Quarter	**Deaths reviewed which were judged more likely than not to have been due to problems in care provided to the patient. (% of all deaths in that period)**
April 2020 to March 2021	7
Quarter 1 2020/21	1
Quarter 2 2020/21	1
Quarter 3 2020/21	5
Quarter 4 2020/21	0

These numbers have been estimated using the Structured Judgement Review (SJR) and comprehensive investigations processes.

The Trust learns from inpatient deaths by undertaking mortality reviews using the Royal College of Physicians SJR Process. SJRs are undertaken by a cohort of senior medical and nursing staff trained in the SJR process. The Trust's Learning from Deaths Policy outlines the existing embedded process for reviewing all in-hospital deaths.

SJR blends traditional, clinical-judgement based review methods with a standard format. The approach requires reviewers to make safety and quality judgements over phases of care and to make explicit written comments about care for each phase. The result is a relatively short, but rich, set of information about each case in a form that can also be aggregated to produce knowledge about clinical services and systems of care.

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

The SJR produces two types of data:

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

The phases of care which are reviewed are:

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

The overall quality of care is assessed during the SJR process. Care scores are recorded after the judgement comments have been written. One score is given to each phase of care. The reviewers then judge their overall decision on the overall quality of care

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

- Deaths where families, carers or staff raise concerns
- Deaths where concerns are raised by the Coroner
- Deaths where concerns are raised at the Patient Safety Summit via clinical incident reports
- All learning disability deaths
- All deaths of patients who have a diagnosed serious mental health illness
- Outlier data deaths (This is reviewed annually by the Hospital Mortality Reduction Group (HMRG)
- Medical Examiner concerns (all in-patient deaths are scrutinised by a Medical Examiner)
- Divisional Review Concerns

Where an SJR identifies a potentially avoidable death and or poor care, a report is obtained from both the consultant responsible for the case and their clinical lead or Associate Medical Director addressing the issues raised by the SJR and any lessons learned. In addition, a peer review SJR is undertaken. In the event of a discrepancy between the initial SJR and the peer review SJR, a final judgement is made at the Hospital Mortality Reduction Group.

Learning from the reviews is shared through several other forums including at Grand Rounds, Divisional Quality Improvement Sessions and Medical Training Sessions.

The Trust has a well-established HMRG led by the Associate Medical Director for Patient Safety. This group leads the Trust's mortality reduction programme and, on a bi-monthly basis, meets with the Divisional Mortality Reduction Groups to ensure a unified approach to mortality reduction across the Trust and to share learning opportunities.

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

Summary of Learning

Although the Learning from Deaths programme was suspended in 2020/21 due to the Covid-19 pandemic, the Trust undertook a Covid-19 mortality review. The review looked at all deaths due to Covid-19 from the first wave and the reviews were carried out by a Physician and an Intensivist.

The learning from these reviews were shared across the organisation at the Trust Quality Improvement Session and thought the Trust Governance Structure to the Quality and Safety Committee.

In total 143 deaths were reviewed. The case review looked at patient demographics, treatment escalation plans critical care referral process, UDNACPR decision making, end of life care, nosocomial infections, quality of care and preventability. No deaths reviewed were judged to be more likely than not to have been due to problems in care provided to the patient.

Multiple positive comments were made during the reviews, the themes were;

- Communication and documentation
- Palliative Care referral/review
- Good end of life care
- Prompt decision making
- Early referral to critical care

Lessons learned from the reviews included:

- Improved IPC and cohorting practices
- Improved communication between teams
- Expanded Critical Care multidisciplinary team meetings with respiratory input
- Clearer pathway for escalation and mutual aid across the ICU Network

This learning was implemented in the organisation before the second wave of the Covid-19 pandemic in quarter three of 2020/21.

Performance against quality indicators and targets

National quality targets

	2016-17	2017-18	2018-19	2019-20	2020-21	Target	Achieved
Clostridium Difficile infections	3 avoidable cases	2 avoidable cases	2 avoidable cases	1 avoidable case	1 Avoidable case To date	0	✓
Percentage of patient who wait 4 hours or less in A&E	90.25%	87.12%	83.63%	76.78%	85.08%	95%	✗
The percentage of patients waiting 6 weeks or more for a diagnostic test	0.34%	0.31%	0.41%	3.27%	42.31%	1%	✗
Summary Hospital-level Mortality Indicator	103.85	104.39	100.95	99.47	95.45	As expected	✓
Venous thromboembolism (VTE) risk assessment	96.09%	95.50%	95.24%	95.91%	96.01%	95%	✓
Percentage of patients receiving first definite treatment for cancer within 62 days of an urgent GP referral for suspected cancer	90.98%	93.70%	88.98%	86.22%	75.87%	85%	✗
Percentage of patients receiving first definite treatment for cancer within 62 days of referral from an NHS Cancer Screening Service	93.67%	97.09%	94.44%	89.29%	84.97%	90%	✗
The percentage of Referral to Treatment (RTT) pathways within 18 weeks for incomplete pathways	94.82%	95.90%	92.39%	91.37%	68.77%	92%	✗

National quality indicators

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

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

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

Indicator	Measure Description			
SHMI	A) The value and banding of the summary hospital-level mortality indicator (SHMI) for the Trust for the reporting period.			
Period	**Trust Performance**	**National Average**	**95% Upper Limit**	**95% Lower Limit**
March 19 - February 20	98.85	100	113.58	88.04
April 19 - March 20	99.47	100	104.50	94.60
May 19 - April 20	100.60	100	105.80	95.60
June 19 - May 20	100.10	100	105.30	95.10
July 19 - June 20	99.22	100	104.50	94.20
August 19 - July 20	98.39	100	103.60	93.30
September 19 - August 20	96.45	100	101.70	91.40
October 19 - September 20	94.96	100	100.10	90.00
November 19 - October 20	94.45	100	113.18	88.36
December 19 - November 20	95.45	100	113.28	88.27

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

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

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

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

- Having a well-established Hospital Mortality Reduction Group (HMRG) led by the Associate Medical Director for Patient Safety. This group monitors the mortality reduction improvement plans across the Trust. On a bi-monthly basis the HMRG meets with the divisional mortality reduction groups to ensure a unified approach to mortality reduction across the Trust and to share learning opportunities.

Indicator	Measure Description			
SHMI	B) The percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust for the reporting period.			
Period	**Trust Performance**	**National Average**	**95% Upper Limit**	**95% Lower Limit**
March 19 - February 20	1.06%	1.20%	-	-
April 19 - March 20	1.07%	1.24%	-	-
May 19 - April 20	1.17%	1.30%	-	-
June 19 -May 20	1.27%	1.34%	-	-
July 19 - June 20	1.27%	1.36%	-	-
August 19 - July 20	1.26%	1.36%	-	-
September 19 - August 20	1.26%	1.37%	-	-
October 19 - September 20	1.30%	1.41%	-	-
November 19 - October 20	1.30%	1.45%	-	-
December 19 - November 20	1.36%	1.51%	-	-

This is an indicator designed to accompany the Summary Hospital-level Mortality Indicator (SHMI) and represents the percentage of deaths reported in the SHMI indicator where the patient received palliative care.
The SHMI makes no adjustments for palliative care. This indicator presents the crude percentage rates of death that are coded with palliative care either in diagnosis or treatment speciality.

Indicator	Measure Description				
PROM	The Trust's patient reported outcome measure scores for groin hernia surgery, varicose vein surgery, hip replacement surgery and knee replacement surgery during the reporting period.				
Date	**Measure**	**Trust performance**	**National Average**	**Upper 95% control limit**	**Lower 95% control limit**
Hip Replacement					
April 17-March 18	EQ5D	0.448	0.458	0.55	0.357
April 17-March 18	VAS	11.567	13.877	18.514	7.991
April 17-March 18	OXFORD HIP	21.682	22.21	25.045	18
April 18-March 19	EQ5D	0.43	0.46	0.57	0.33
April 18-March 19	VAS	15.18	14.05	20.17	5.27
April 18-March 19	OXFORD HIP	21.87	22.30	26.166	18.52
April 19-March 20	EQ5D	0.446	0.460	0.504	0.417
April 19-March 20	VAS	11.917	14.1	17.251	10.898
April 19-March 20	OXFORD HIP	22.966	22.4	23.971	20.927
Knee Replacement					
April 17-March 18	EQ5D	0.328	0.334	0.406	0.254

April 17-March 18	VAS	7.169	8.153	13.985	1.752
April 17-March 18	OXFORD KNEE	17.83	17.102	20.394	12.899
April 18-March 19	EQ5D	0.31	0.34	0.40	0.25
April 18-March 19	VAS	5.51	7.42	12.70	0.15
April 18-March 19	OXFORD KNEE	16.83	17.19	20.09	13.52
April 19-March 20	EQ5D	0.308	0.341	0.380	0.303
April 19-March 20	VAS	6.160	7.9	10.774	5.059
April 19-March 20	OXFORD HIP	17.563	17.3	18.753	15.926

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

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

- Trust performance data represents the adjusted average health gains which have been calculated using statistical models which account for the fact that each provider organisation deals with patients with different case-mixes
- Data allows for fair comparisons between providers and England as a whole. Random variation in patients mean that small differences in averages, even when case-mix adjusted, may not be statistically significant
- Case mix adjusted figures are calculated only where there are at least 30 modelled records.

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

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

Indicator	Measure Description	
Readmission Rates	The percentage of patients aged 0 to 14 readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.	
Period	**Trust per HED**	**Peer Group av HED**
Jan 2016 – Dec 2016	12.14%	10.44%
Jan 2017 - Dec 2017	12.41%	10.69%
Jan 2018 - Dec 2018	13.58%	11.38%
Jan 2019 - Dec 2019	12.61%	11.96%
Jan 2020 - Oct 2020	12.39%	11.46%

The percentage of patients aged 0 to 14 readmitted to a hospital which forms part of the Trust within 28 days of being discharged.

The Trust considers that these results are as described for the following reasons: The trust is continuing to see a downward trend in readmissions as demonstrated during Jan 2020 - Oct 2020. Readmissions during this time frame were varied as activity was not typical due to the pandemic. A small increase was noted of readmissions of new-borns experiencing weight loss and Jaundice following discharge from maternity inpatient services, this may have been due to the change in community postnatal vising from midwifery and health vising services at the start of the pandemic however steps were quickly put in place for mothers to receive additional support and the numbers reduced.

The Trust intends to take / have taken for the following actions to improve this result, and therefore the quality of its service, by reviewing and ensuring effective safety net advice for children and parents/ carers. Work is ongoing to develop robust dashboards to highlight areas of potential increased admissions and respond accordingly.

Indicator	Measure Description	
Readmission Rates	The percentage of patients aged 15 and over readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.	
Period	**Trust per HED**	**Peer Group av HED**
Jan 2016 – Dec 2016	**8.23%**	**7.73%**
Jan 2017 - Dec 2017	**9.04%**	**8.16%**
Jan 2018 - Dec 2018	**8.52%**	**7.63%**
Jan 2019 - Dec 2019	**8.99%**	**8.50%**
Jan 2020 - Oct 2020	**10.54%**	**9.27%**

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

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

Analysis of the data shows that almost 26% were from admissions that were discharged from Clinical Decisions Unit (CDU) When CDU admissions are removed the readmission % with 28 days moves closer in line with the peer average at 9.5%. The number of emergency readmissions also increased at the start of the COVID pandemic with raised admission rates particularly high for April and May 2020 following admissions to AMU and RAU.
The overall number of readmissions has reduced over the full 2020 calendar year compared to 2019. This is related to the reduced number of elective admissions. A greater proportion are therefore related to the AE specialty, which are more likely to have a readmission.

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

- Monitoring through the sub-divisional governance groups and Divisional Board
- To review data post pandemic to identify any areas of opportunity to support readmission for complex patients and frequent attenders
- Embed use of electronic dashboard to provide more detailed information on a monthly basis to clinical teams

Indicator	Measure Description			
VTE	The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.			
Period	**Trust Performance**	**National Average**	**95% Upper Limit**	**95% Lower Limit**
April 2018 - June 2018	95.07%	No data available	No data available	No data available
July 2018 - September 2018	95.57%	No data available	No data available	No data available
October 2018 - December 2018	95.24%	No data available	No data available	No data available
January 2019 - March 2019	95.06%	No data available	No data available	No data available
April 2019 - June 2019	96.31%	No data available	No data available	No data available
July 2019 - September 2019	96.48%	No data available	No data available	No data available
October 2019 - December 2019	95.63%	No data available	No data available	No data available
January 2020 - March 2020	95.36%	No data available	No data available	No data available
April 2020 - June 2020	95.71%	No data available	No data available	No data available
July 2020 - September 2020	96.45%	No data available	No data available	No data available
October 2020 - December 2020	99.10%	No data available	No data available	No data available
January 2021 - March 2021	95.38%	No data available	No data available	No data available

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

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

- The Trust continues to achieve the 95% target for the completion of VTE risk assessment by implementing a number of actions as described below.

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

- Developing a daily report which is sent to each ward and highlights any patients that have not yet had a completed VTE risk assessment entered onto the patient records. The Ward Manager/ Coordinator will then highlight the cases that require a risk assessment to the medical team to ensure it is completed. The patient record is then updated accordingly

- Monthly monitoring of the percentage of patient's risk assessed for VTE by the clinical divisions

- Regular review of the VTE risk assessment tool to ensure it continues to be compliant with National Institute for Health and Clinical Excellence (NICE) guidance. The tool is included within the Trust admission proforma to ensure it is completed in a timely manner at admission and the appropriate VTE prevention interventions are implemented

- Continued education for medical staff on induction on the importance of VTE assessment.

Indicator	Measure Description			
C.Difficile	The rate per 100,000 bed days of cases of C.difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period.			
Period	Trust Performance	National Average	95% Upper Limit	95% Lower Limit
2016-2017	12.2	14.92	82.6	0
2017-2018	11.1	13.65	90.3	0
2018-2019	13.5	11.5	81.6	0
2019-2020	9.92	13.62	51.1	0
2020-2021	8.5 (up to Dec 2020)	Not yet published	Not yet published	Not yet published

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

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

Prior Healthcare Exposure

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

* Hospital-onset healthcare-associated (HOHA)- Date of onset is ≥ 2 days after admission (where day of admission is day 1)

* Community-onset healthcare-associated (COHA) - Date of onset is < 2 days after admission and the patient was admitted to the trust in the 4 weeks prior to the current episode

* Community-onset indeterminate association - Date of onset is < 2 days after admission and the patient was admitted in the previous 12 weeks, but not the previous 4 weeks prior to the current episode

* Community-onset community-associated - Date of onset is < 2 days after admission and the patient had not been admitted to the trust in the previous 12 weeks prior to the current episode.

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

- The Trust continues to have a robust Post Infection Review (PIR) process in place for all cases of Clostridium difficile (CDI) including a secondary review with our Commissioners, this facilitates the opportunity to review the case and establish if any "lapse of care" has occurred either contributing or not contributing to the development of CDI. This is a learning opportunity aimed at implementing/strengthening procedures to reduce the risk of CDI developing in other patients.

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

- No new CDI objectives were set for the Trust for 2020/21 so remained at 23 cases. The Trust reported 15 cases of C.difficile in the HOHA category, 1 case has been identified as avoidable, 5 were classified as unavoidable, 8 are awaiting PIR classification. 9 cases were reported in the COHA category awaiting classification PIR's
- Antimicrobial stewardship is closely monitored in line with Trust policy ensuring a focus on antimicrobial prescribing and feedback to medical staff
- Multi-disciplinary bedside reviews of all CDI positive patients continue throughout their stay.

Indicator	**Measure Description**			
Patient Safety Incidents	The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period.			
Period	**MCHFT Performance**	**National Average**	**95% Upper Limit**	**95% Lower Limit**
1st Oct 2016 to 31st Mar 2017	3,353	5,122	14,506	1,301
1st Apr 2017 to 30th Sep 2017	3,485	5,226	15,228	1,133
1st Oct 2017 to 31st Mar 2018	3,462	5,449	19,897	1,311

1st Apr 2018 to 30th Sep 2018	3,663	5,583	23,692	566
1st Oct 2018 to 31st Mar 2019	3,711	5,841	22,048	1,278
1st Apr 2019 to 30th Sep 2019	3,808	6,276	21,685	1,392
1st Oct 2019 to 31st Mar 2020	4,084	6,502	22,340	1,758

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

- All patient safety incidents are captured on the Trusts incident reporting system. These are then uploaded to the national Reporting & Learning System (NRLS).

- The level of reporting of incidents in the Trust demonstrates a risk aware culture and highlights that the Trust has a positive safety culture where staff feel able to report patient safety incidents. As demonstrated above the total number of incidents reported continues to increase with each data release.

- The Trust consistently reports more no harm/near miss incidents than harm incidents, which again demonstrates a positive risk aware culture within the Trust.

- Themes and trends from incidents are reported to the appropriate Trust Committees and Groups on a monthly basis for discussion, analysis and for learning to be identified and acted upon. Examples of these committees includes the Skin Care Group, the Patient Falls Prevention Group and the Nutritional Advisory Group.

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

- Patient Safety Summit is a weekly meeting led by clinical teams. The Summit provides an opportunity for cross-divisional learning and sharing of immediate learning following incidents. All moderate and above patient safety incidents are discussed at the Summit and clinical teams are encouraged to attend to promote learning and improvement. The Patient Safety Summit is chaired by the Medical Director.

- Following Patient Safety Summit a ‘Safety Matters’ newsletter is developed and distributed across the organisation. The newsletter contains learning from incidents, mortality case note reviews, local or national updates and Summit messages of the week.

- A daily Patient Safety Huddle is held with the Senior Quality Governance Team, Patient Safety Team and Quality Governance Managers. All moderate and above incidents from the previous working day are discussed. The daily huddle ensures any applicable incidents are reported within the timeframes set out in the Serious Incident Framework and that immediate learning is actioned and shared. The daily huddle will also ensure that Duty of Candour is completed in line with national timeframes.

- Incident report training for staff is provided this ensures that staff know how to report a patient safety incident and they also understand the importance of incident reporting.

- Direct feedback is provided to all staff on the outcome of the incidents they have reported to demonstrate the changes in practice that have been made as a result of the incident.

- A telephone line has been set up in the organisation which allows staff to report an incident over the phone if they are unable to access a PC to report the incident online. The incident is then input on to the incident reporting system by the Patient Safety Team.

- A weekly triangulation meeting is held attended by the patient safety, patient experience and legal teams. All new, incidents graded as potentially moderate and above, complaints, claims and inquests are reported at the meeting to ensure that learning is captured and triangulated.

- All serious incidents are reported to Board through the Trust governance structure on a monthly basis.

Indicator	Measure Description			
Patient Safety Incidents	The number and percentage of such patient safety incidents that resulted in severe harm or death.			
Period	**MCHFT Performance**	**National Average**	**95% Upper Limit**	**95% Lower Limit**
1st Oct 2016 to 31st Mar 2017	4	6	31	0
1st Apr 2017 to 30th Sep 2017	1	5	29	0
1st Oct 2017 to 31st Mar 2018	3	5	24	0
1st Apr 2018 to 30th Sep 2018	4	5	22	0
1st Oct 2018 to 31st Mar 2019	5	5	23	0
1st Apr 2019 to 30th Sep 2019	1	5	24	0
1st Oct 2019 to 31st Mar 2020	6	5	22	0

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

- The Trust is in line with the national average for the reporting of serious incidents. The Trust has a positive reporting culture in the organisation.

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

- A comprehensive investigation is undertaken for all incidents, which result in severe harm or death in line with the national serious incident framework. An Executive led review meeting is held following the incident investigation to ensure that lessons are learned, and improvement plans are implemented to prevent a reoccurrence.

- The Trust has invested in external root cause analysis training for all staff that undertake serious incident investigations. This training is also attended by members of the executive team and senior members of the divisional teams.

- All incidents which result in severe harm or death are reported through the governance structure to the Board of Directors to ensure openness and transparency within the Trust.

- The Trust has implemented *Being Open* and Duty of Candour which ensures that, if an incident occurs which results in moderate harm, severe harm or death, the patient and or their family are informed of the incident, involved in the investigation and the development of the final report. The report, lessons learned, and improvement plans from the comprehensive investigation are shared with the patient and or their family.

Part 3

Review of quality performance

Medicines Safety

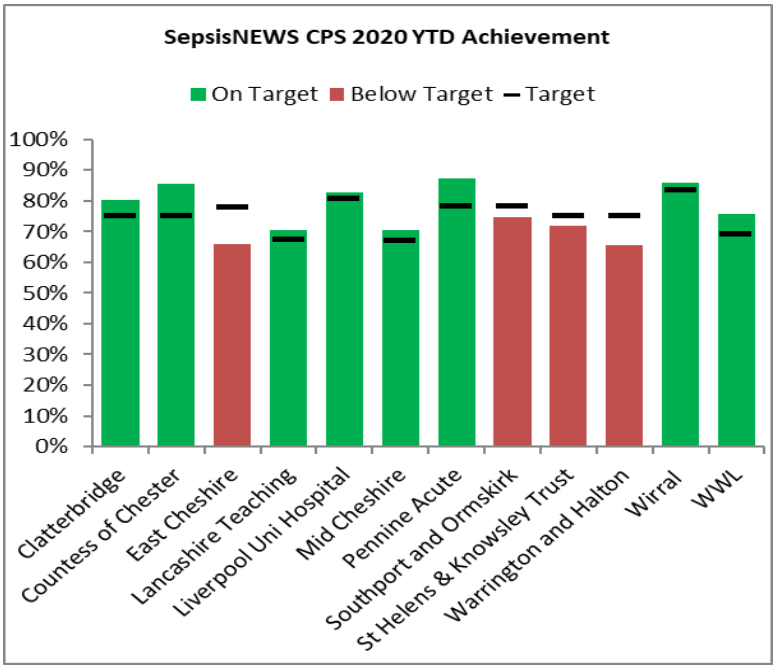
The Trust has appointed a Pharmacy Technician who is based within the Emergency Department (ED), providing additional localised support. Following Medical team prescribing, the Pharmacy Technician completes medication histories as well and reconciling medicines. On average they complete 7 per day. As a result, the accuracy of inpatient prescriptions has increased, and fewer omitted doses have been reported. The Pharmacy Technician also checks the controlled drugs, orders urgent medications, reviews and ensures stock lists and levels are fit for purpose and correct. The Pharmacy Technician assists in the monitoring of medication security and supports ED staff in all aspects of medicines management.

Preventing Deterioration and Sepsis

Progress continues to be made with improving the management of patients with sepsis despite the challenges of the last 12 months. The Sepsis Steering Group continues to meet monthly when possible, bringing together disciplines from each division to review result of audits and identify improvement opportunities. Priorities from the latter part of 2020 have included quality improvement training, ten staff from Mid-Cheshire have undergone quality improvement training provided by Advancing Quality Alliance (AQuA). Staff have been supported to work on sepsis related projects including identification of sepsis in the community setting and the timely management of hospital acquired sepsis. Training has continued to be a priority for the Sepsis Steering Group with an emphasis on training of the sepsis PGD for A&E staff including neutropenic sepsis, this enables patients to receive their lifesaving intravenous antibiotics promptly on arrival to the department. Education continues through the various avenues available to staff including Quality Care Program, Sepsis E-learning, ward-based training, Harm Free Study day, Acute Illness Management Course and staff induction. Similarly, work on education has been a priority in the community, teams have received bespoke training in identifying sepsis, this has included nursing staff and therapy staff who have received training to complete a full observations using newly supplied equipment and carrying out the sepsis screening process using their tools and pathway.

External Advancing Quality data related to sepsis performance shows that the Trust has exceeded its target measurement scores on the sepsis pathway for 2020/21. This encompasses aspects of early identification of sepsis, appropriate initial diagnostics and sepsis management. Looking at a total of 7 measures composite process score (CPS) is calculated based on the pass rate of these measures for each patient included in the audit process. Data was paused from February 2020 to May 2020 due to the pandemic; therefore, the CPS is calculated from May 2020 onwards. The CPS target for 2020 was 61.7%, this was exceeded in 2020 with the end of year CPS reaching 70.4%.

The graph below shows how we at Mid Cheshire compare to other Trusts who participate in the program.



Maternal and Neonatal Safety

Mid Cheshire Hospitals NHS Foundation Trust Maternity Unit has been involved in the Maternity and Neonatal Safety Improvement Programme since its launch in 2016, the programme aims to:

- improve the safety and outcomes of maternal and neonatal care by reducing unwarranted variation and provide a high-quality healthcare experience for all women, babies and families across maternity and neonatal care settings in England
- contribute to the national ambition, set out in Better Births of reducing the rates of maternal and neonatal deaths, stillbirths, and brain injuries that occur during or soon after birth by 50% by 2025

The Women's and Children's Division is committed to a number of quality improvements projects following locally, regional and national strategy to improve the safety of services in both Maternity and Neonatology which include:

1. Achievement of CNST Maternity Incentive Scheme Year 3.
2. Delivery of the Baby Friendly Initiative, Saving Babies Lives Care Bundle and Neonatal Family Integrated Care.
3. Training in Postpartum Haemorrhage recognition, management and care.
4. Reducing Term admissions to the Neonatal Unit to keep mothers and babies together.
5. Personalised Care Plans and improving Continuity of Care.

As part of the Trust's Quality and Safety Improvement Strategy 2020/21 the Women and Children's Division decided that the focus would be on training in identification and management of postpartum haemorrhage with the aim to improve the care and experience for women suffering a postpartum haemorrhage. This was deemed important as the Trust had been identified as an outlier in the Northwest region for Postpartum Haemorrhage

above 1500mls. Although the dashboard comparison showed rates were high, this does not show enough detail about the relationship between blood loss and maternal wellbeing following a large blood loss or effective management of the loss. A deep dive audit was carried out to identify themes in these cases and an action plan was devised to improve identification, management and care of women during the early postpartum period.

The Divisional Quality Lead for Women and Children's Division embarked on the Advancing Quality project which provides support, advice and resources for quality improvement projects. Knowledge gained has enabled the team to identify areas for improvement and put plans in place to address these areas. A Postpartum Haemorrhage Risk Assessment & Management Checklist has been introduced to aid staff in documenting their management of blood loss and to ensure that women receive care that is consistent. A leaflet providing information and offering a debrief appointment is now given to all women suffering a postpartum haemorrhage as a gap in postnatal support was identified.

In order to implement this change a core member of Labour Ward Staff led on cascade training for staff in the use of the proforma and related requirements.

Further areas of improvement have been delayed due to Covid 19 and the cessation of face to face training. It was planned that the use of the proforma would be included in the mandatory training sessions for obstetric emergencies, however these sessions are continuing remotely. Therefore, in situ training sessions will be planned for small groups in relation to the use of the proforma, as well as the accurate weighing of blood loss.

There is also a plan to obtain feedback from women experiencing PPH through focus groups and or surveys to ensure that their needs are being met.

PPH was featured as a topic of the month with information boards in clinical areas and an MDT MS Teams discussion to round the month off. Two cases were presented, one where the proforma was used and one where it was not. This highlighted that the management was timelier and more effective with the use of the proforma.

All healthcare assistants on the labour ward have been observed weighing blood loss to ensure consistency of weighing and the chart used for dry weights of inco's, sheets etc have been checked and updated. Only slight discrepancies in some items were found. Scales are now available in all delivery rooms/theatres to ensure that no items are removed or discarded prior to weighing.

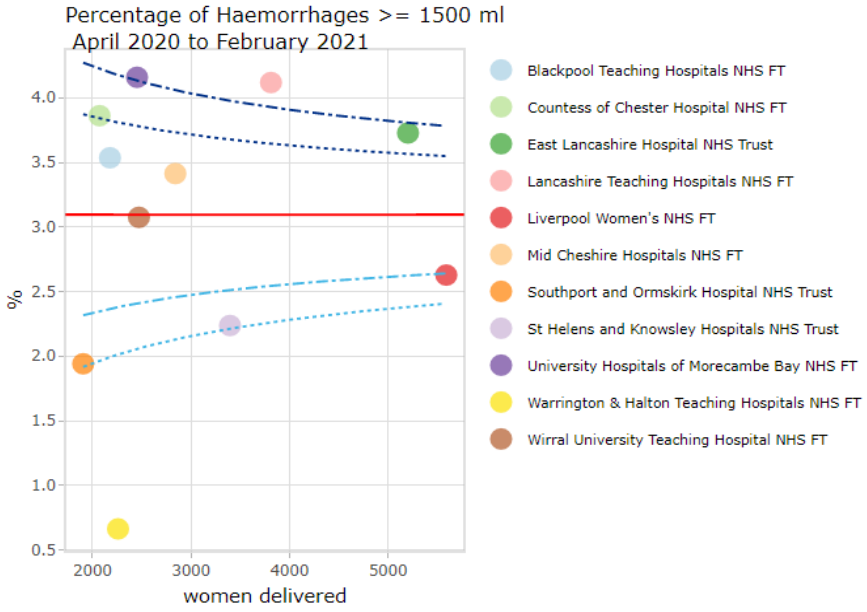
The multidisciplinary mandatory training sessions for 2021/21 have commenced using MS Teams due to social distancing measures in place. The scenario for PPH highlights the importance of using the Postpartum Haemorrhage Risk Assessment & Management Checklist.

There is also a plan to obtain feedback from women experiencing PPH through focus groups and or surveys to ensure that their needs are being met.

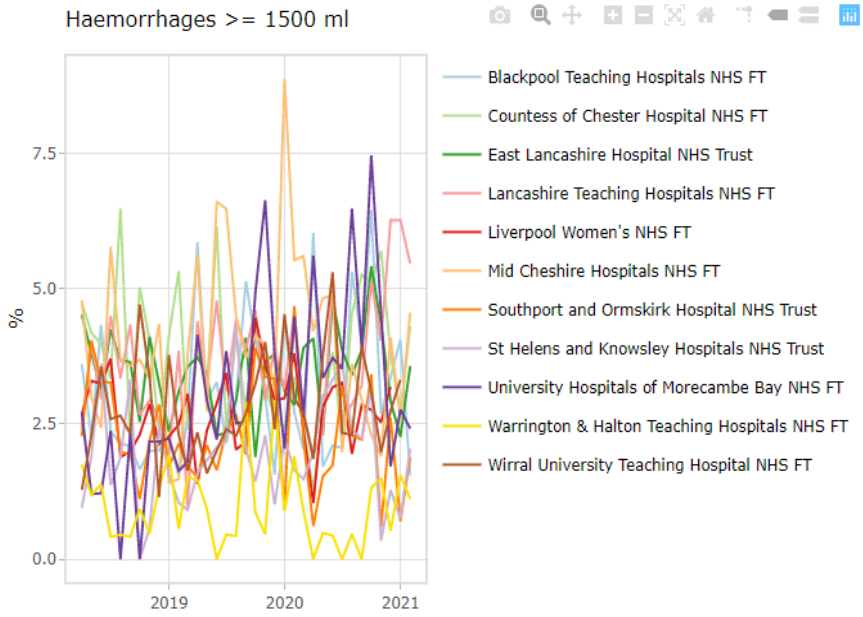
An audit is currently being undertaken to ensure that the proforma is being completed accurately, results of which will be fed back to the Obstetric Quality Improvement session along with actions to further improve compliance with guidelines, documentation and care of women suffering a PPH. Initial feedback from the audit is that the checklist is well used.

On the latest edition of the Northwest Coast Strategic Clinical Network highlight report MCHFT are no longer an outlier for PPH > 1500mls. Anecdotally this is because other trusts have implemented or improved upon weighing blood loss.

2.2 Percentage of Haemorrhages ≥1500 ml



Run Chart for Percentage of Haemorrhages ≥1500 ml



End of Life

End of Life Care:
It is a core responsibility of health care providers to deliver high quality care for patients in their final days and provide appropriate support to their carers. There is only one opportunity to get it right and to then create a positive lasting memory for relatives and carers. We aim to provide the best possible care for patients at the end of life, whatever their disease. We strongly believe that high quality care consists of the five priorities for end of life care being embedded in everybody's clinical practice. The use of individualised care plans helps to focus care around the needs of the patient and their family and provides documentation and evidence that we are doing so.

CCICP has successfully undertaken a project for supporting patients whose Preferred Place of Care and Preferred Place of Death is within their own home and who require an urgent package of care to enable this to happen. In partnership with the End of Life Partnership and Saint Luke's Hospice CCICP have supported timely transfer of patients care to within their own homes.

Education and training – End of Life Care Education is established within junior doctor's medical education, the nursing preceptorship, student nurse and 'Return to Practice' programmes.

Bespoke support is provided for clinical areas. In response to Covid, the end of life challenges that brings and the relocation of staff, these bespoke sessions have been very important for clinical areas. Sessions have been provided for International nurses with specific training needs around end of life care. Reflection and future planning sessions have taken place for nurses, medical staff and Allied Health Professionals. These sessions have led to ongoing quality improvement in specific clinical areas.
Link nurse study day with a focus on End of Life Care during Covid-19 pandemic, support and resilience was completed with an on-site socially distanced study day.

Education is delivered in collaboration with The End of Life Partnership and online teaching is established for core study days (Syringe pump training, Blue booklet education, Symptom at the end of life & Verification of expected death) Communication skills and Advance Care Planning training have also been transferred to remote learning.

Advance Care Planning training is being delivered in small bitesize sessions for an hour a week to Winsford Care Care Community Nursing staff. This is to support the pilot scheme being undertaken between both Winsford and Nantwich & Rural Care Communities and The End of Life Partnership looking at improving outcomes for palliative patients within the community setting. The End of Life Partnership and each Care Community are measuring impact of these pilot schemes.

Reliable Care - Audit - The national NHS Benchmarking audit 'National Audit of Care at the End of Life' NACEL (Round 2) was completed in 2019. This consisted of an Organisational Audit / Clinical Case note Review / Hospital site Audit and Quality Bereavement Survey. The clinical case note review looked at deaths in hospital during April & May 2019. The results of this audit are produced nationally. MCHFT's dashboard of results has been received and an improvement plan developed. The audit looks at appropriate identification of patients who are dying and records of communication with patients and their families. Results of the audit will be presented to End of Life & Bereavement Group, QSIS and the Quality Safety Committee.

The national annual audit was not completed (due to Covid-19) during 2020. In response to this we have been involved in the Covid Mortality review group to ensure that end of life care is reviewed.

The Trust is registered for the National Audit of Care at the End of Life Round 3 to begin April 2021.

Planning for patients with uncertain recovery – Ongoing Quality Improvement work around Communication, DNACPR and Advanced Care Planning continues. This includes collaborative working around patient's who lack capacity and joint education with Medical consultants / Privacy & Dignity matron.

As a result of the bespoke support provided to clinical areas quality improvement work was carried out for the group of patients who received ward based respiratory support as their ceiling of treatment from October 2020 onwards. This work involved daily clinical review of patients on the respiratory support unit (in receipt of CPAP or HFNO), support for their families, development of symptom control guidelines and support for nursing, medical and physiotherapist teams.

Improving communication between primary and secondary care continues and progress has been made for the Specialist Palliative Care Team to have full access to EPaCCS (Electronic Palliative Care Coordination System) thus sharing access to palliative care records for many patients.

Governors' choice of indicator

COVID-19 Quality Metrics

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

The Ward accreditation programme;

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

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

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

Ward assessments are designed to be unannounced, cover a review of records, observations of care given and discussion with patients, carers and staff members. Outcomes from each accreditation are broken down into; Well Led, Communication with Multi-disciplinary Teams, Patient Communication, Healing Environment, Nursing Care and Processes and Record Keeping.

During the accreditation if a ward is assessed as flagged, immediate and intensive support will be allocated, based on the findings, and monitored on a weekly basis. A ward assessed as white indicates there are elements of an assessment where set standards have not been fully met and it was not evident to the accreditation team that appropriate action was being taken to address the issue. It is important to note this does not indicate the ward as 'unsafe' but demonstrates that additional support is required. In response to a white ward an identified senior nurse will provide the ward with a support coaching programme. The programme consists of 6 sessions whereby learning objectives will be set to support the Ward Manager during this process.

The ward accreditation quality metrics tool has been reviewed and adapted during 2020/21. This has supported continually improving the quality of services and safeguard high standards of care during the Covid-19 pandemic.

During the Covid-19 pandemic a number of ward reconfigurations and Ward Manager moves has taken place making data collection of the full suite of quality metrics unachievable. Therefore, to provide assurance, whilst supporting Ward Managers during the pandemic it was agreed that the focus would be on 3 areas of data collection;

- Patient safety
- Infection Prevention & control, including Covid-19 specific questions.
- Needs Specific Care: End of Life Covid-19 specific questions.

In addition, a number of Covid-19 based Quality Metrics were implemented so that wards could monitor compliance against Covid-19 specific practice. The questions included;

- Check that all essential PPE is available for staff during general care of patients with 'suspected' Covid-19.
- Check that all essential PPE is available for staff when performing aerosol generating procedures (AGP) for patients with 'suspected' and 'confirmed' Covid-19
- Check that all essential PPE is available for staff during general care for patients with 'confirmed' Covid-19
- Check staff feel they are being given enough information about Covid-19
- Check staff feel they are being given adequate emotional support during the Covid-19 crisis
- Have patients been screened correctly, in line with Trust policy, for Covid-19?
- Can staff explain the process for managing a patient with suspected and confirmed Covid-19?
- If there are any current patients with Covid-19, has the correct pathway been followed?
- Are staff aware of what to do after someone dies from Covid-19?

The below dashboard demonstrates the Trusts response to the Covid-19 Quality Metrics;

Question Code	Question	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021
IPC-21c	Check that all essential PPE is available for staff during general care of patients with 'suspected' COVID-19	93	97	97	99	96	99	100	98	100	98	99	98
IPC-22c	Check that all essential PPE is available for staff when performing aerosol generating procedures (AGP) for patients with 'suspected' and 'confirmed' COVID-19	100	97	97	97	100	97	96	97	100	100	100	100
IPC-23c	Check that all essential PPE is available for staff during general care for patients with 'confirmed' COVID-19	96	96	100	100	99	100	93	100	98	99	99	98
IPC-24c	Check staff feel they are being given enough information about COVID-19	88	88	91	94	95	96	92	96	95	97	97	97
IPC-25c	Check staff feel they are being given adequate emotional support during the COVID-19 crisis	79	80	91	90	88	91	82	87	82	78	91	88
IPC-26c	Have patients been screened correctly, in line with Trust policy, for COVID-19?	100	90	95	98	100	98	100	97	98	98	98	99
IPC-27c	Can staff explain the process for managing a patient with suspected and confirmed COVID-19?	95	92	95	97	97	97	98	98	95	98	97	99
IPC-28c	If there are any current patients with COVID-19, has the correct pathway been followed?	100	100	80	100	100	87	88	100	100	98	97	100
IPC-29	Check that all essential PPE is available for staff when performing/supporting with aerosol generating proce	-	-	-	-	100	100	100	100	100		100	100
IPC-30	Check that all essential PPE is available for staff during general care for patients.	-	-	-	-	100	100	91	100	100	100	100	100
NSC-EOL-10c	Are staff aware of what to do after someone dies from COVID-19?	72	84	84	84	94	95	91	91	93	94	95	96

Oversight of the quality metrics dashboards are reviewed monthly at the Quality Metrics & Ward Accreditation Group, to provide assurance against practice and local actions taken in response to ward/department areas that report a Red RAG status. Escalations are reported to Trust Quality Group and provide assurance from Ward to Board.

The below dashboard demonstrates an increase in overall quality from April 2020 – March 2021 evidencing a continued improvement throughout the Covid-19 pandemic.

CQC Theme	Audit Topic	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021
Safe	Patient Safety	95	92	92	94	94	94	94	94	94	94	94	94
Safe	Harm Free Care	90	88	90	87	89	90	91	90	90	93	91	92
Safe	Medication Safety	97	98	97	93	94	96	96	97	95	97	96	97
Safe	Infection Prevention & Control	95	93	96	96	96	101	99	100	101	101	102	102
Well Led	Record Keeping	92	93	88	92	92	94	94	93	93	95	93	94
Well Led	Well Led Team	86	81	86	85	87	89	92	93	92	90	91	90
Caring	Nutrition and Hydration	89	86	85	95	93	93	94	92	93	94	94	92
Caring	Toileting and Hygiene	87	86	85	92	93	94	93	93	94	93	89	91
Caring	Patient Experience	84	82	82	90	89	90	89	89	88	89	91	88
Responsive	Needs Specific Care - CYP	0	0	100	97	85	92	95	95	100	80	92	91
Responsive	Needs Specific Care - DEMENTIA	89	82	71	80	84	88	90	84	87	88	91	88
Responsive	Needs Specific Care - EOL	87	86	84	89	94	95	94	93	89	95	96	92
Responsive	Needs Specific Care - LD	75	77	79	89	93	90	94	93	95	92	96	93
Responsive	Needs Specific Care - MATERNITY	0	91	93	91	0	0	100	100	0	0	-	97
Responsive	Needs Specific Care - NEONATAL	-	0	0	0	0	100	100	100	100	100	100	100
Responsive	Pain Management	82	85	79	83	88	88	88	88	89	90	84	86
Responsive	Communication	86	93	89	93	93	94	93	94	93	93	94	94
Effective	Cleanliness	90	92	85	91	91	93	91	91	91	92	90	91
Effective	Discharge and Patient Flow	76	73	73	86	90	90	86	88	88	84	88	87
Overall	Overall Quality	88	87	86	90	91	93	93	93	93	92	93	93

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

Cheshire CCG Response to Mid Cheshire Hospitals NHS Foundation Trust Quality Account 2020/21

We are committed to commissioning high quality services from our providers and we make it clear in our contracts the standards that we expect them to deliver. Oversight and scrutiny of performance against the contract is normally managed through regular Quality and Performance Contract meetings with the Trust, alongside progress reports that demonstrate levels of compliance or areas of concern. These assurance processes have been scaled back to reduce the burden and increase the capacity of staff to respond to the pandemic. It is through these modified arrangements that the accuracy of this Quality Account has been validated.

The pandemic has brought the most enduring challenges to the NHS that it has ever experienced and the Trust has worked tirelessly to ensure a timely response to protect patients, staff, and the wider community. We commend the Trust's Health and Wellbeing group which took a number of steps to safeguard staff mental health and wellbeing, including a pledge to the Nursing Times Covid-19: Are You OK campaign? The Trust will continue with this work during the forthcoming year.

It is clear to see that the Trust's workforce have been a fantastic asset, working in extremely challenging circumstances, whilst managing the unprecedented demands of the pandemic. As a direct result of the pandemic the agreed priorities for 2020/21 were not achieved and in recognition of this the Trust has included them within their 2021/22 priorities.

The CCG notes the Trust's continued commitment to improving the safety of services in both Maternity and Neonatology: and your participation in improvement projects locally, regionally and at a national level. This includes the Trust's aim to improve the care and experience for women suffering a postpartum haemorrhage and the CCG is pleased to note that this priority will continue in 2021/22.

We recognise the Trust's commitment with the Ward Accreditation programme 'Going for Gold', a product developed to ensure high quality, safe and compassionate care services across the organisation and we congratulate the Trust's innovative decision to incorporate a range of Covid19 quality metrics.

The Trust has seen an increase in pressure ulcers reported during the pandemic when compared to the previous year (2019/20) and have completed a thematic review, developed an action plan and made clear your intention to continue to demonstrate improvements in this area.

Despite the pandemic challenges the Trust has continued to focus on improving the management of sepsis, with training being a key priority. We look forward to seeing further improvements in this area for 2021/22.
We support the priorities that the Trust has identified for the forthcoming year and value working in partnership with you to assure the quality of services commissioned in 2021/22.

Healthwatch Cheshire East Response to Mid Cheshire Hospitals NHS Foundation Trust Quality Account 2020/21

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

- Representation at Patient Quality and Experience meetings
- Engagement with the hospital on a regular basis at different levels

Healthwatch Cheshire East feels this quality account, broadly reflects the work undertaken at the Trust over the period and particularly would like to praise the organization for its work in the following areas:

- Improving Discharge Awareness
- Wellbeing - Lots of positive initiatives
- Seven Day Hospital Services

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

Council of Governors Review of Mid Cheshire Hospitals NHS Foundation Trust Quality Account 2020/21

As Lead Governor I am writing to submit our response to Mid Cheshire Hospitals NHS Foundation Trust's Quality Account 2019/20.
Governors were provided with a copy of the final draft Quality Account and overall believe it provides a fair picture of the performance of the Trust during what has been a difficult year. In particular, the detail within the Quality Account captures the many changes to the planning and delivery of services brought about as a result of the coronavirus pandemic and describes how the trust has supported staff and patients during this challenging time. As governors, we have been provided with regular updates and copied into many internal staff briefings which have provided us with insight and assurance as to how patient/staff safety and staff wellbeing have been prioritised and it is heartening to see that this was recognised nationally by the Nursing Times. We hope that key new appointments (such as the Head of Nursing for Safe Staffing and Workforce Utilisation and the Associate Director for Patient Safety) together with the introduction of support tools build on these achievements.

Despite many quality initiatives and programmes being suspended / stood down during the year, the focus on collecting patient feedback and responding to comments / identifying areas to improve has been maintained. The ambition to continuously improve is recognised (as illustrated by the Cancer Services and Maternity teams) and we were particularly interested to see discharge awareness prioritised in response to the national inpatient survey. The CoG look forward to seeing how the actions taken by the working group improve arrangements for patients / families / partner organisations in this area. At both Trust Board and Council of Governor meetings we regularly hear from patients and staff about their experiences and, more recently, learning from complaints has also been included which is a welcome development. The quality account notes the increase in both formal complaints and informal concerns/enquiries during the year, which is attributed to the impact of the pandemic on trust services and arrangements for patients and their families. As a CoG, the rise in complaints is of interest to us and we would expect all complainants to be communicated with as quickly as possible (noting the recovery plan which is in place to address delays in this area as a result of the pressures arising from Covid). This will be an area that we will continue to prioritise during 2021/22 and will seek assurances that specific issues are resolved and, where applicable, actions taken/lessons learned.

Specific areas such as reducing falls, pressure ulcers and postpartum haemorrhage are key quality metrics and the impact of having a fall, developing tissue damage or experiencing a PPH can be significant. The steps taken to address areas identified as lapses in care / improve recognition and management are welcomed and we note the oversight of this through the Harm Free Group, the Quality Metrics and Ward Accreditation Group and Trust Quality Group which provides assurance as to the priority given to these and of the governance systems in place to support ward/service to board reporting. In addition, the work undertaken as part of the Trusts quality improvement plans relating to regulatory compliance evidences that the actions taken have brought about tangible benefits for staff and that patients also report positively on their experiences of care.
The CoG welcomes the focus on clinical audit within the Quality Account as audits are an excellent way of reviewing the care provided against specific standards and taking steps to make improvements thereafter. The examples given of actions to be taken following local

clinical audit illustrate how audits can be used to identify / support improvement, although we would be keen to know more about the outcomes of the other local audits completed in year in terms of compliance. The CoG were particularly interested in the findings from the NACEL given the priority given to end of life care and we would be keen to hear more about this and the actions taken / improvements achieved in 21/22.

The role and rapid response of the Trust in supporting new Urgent Public Health research is captured in the quality account and reflects the organisation's commitment to tackling the spread of Covid-19 across all areas of activity. This is also reflected in the work undertaken to support the national vaccination programme and more recently (and outside the scope of this report) through detailed Recovery and Restoration plans.
We noted also that Never Events have been captured in the quality account, with details provided both of the cases, root causes and recommendations and that the outcomes from Learning from Deaths reviews are detailed. Both of these approaches provide opportunities to further improve care and the detail in the quality account reflects the information provided to governors in year.

As a CoG, we have an opportunity to select a specific quality indicator each year. For 2020/21 this was the Going for Gold ward accreditation programme. This sets clear expectations in relation to the achievement of specific safety and quality standards, setting ambitious but realistic goals to take wards on a quality improvement journey. The framework provides a process of assurance from 'Front door to Board' and includes an award status based on the level of success achieved. During the Covid-19 pandemic a number of ward reconfigurations and Ward Manager moves took place making data collection of the full suite of quality metrics unachievable. Therefore, to provide assurance, whilst supporting Ward Managers during the pandemic it was agreed that the focus would be on 3 areas of data collection; patient safety; infection prevention & control, including covid-19 specific questions and needs specific care: end of life covid-19 specific questions. In addition, a number of Covid-19 based Quality Metrics were implemented so that wards could monitor compliance against Covid-19 specific practice. These were key priorities given the wider context and we would hope that the focus on the full Going for Gold programme can be re-established for 2021/22.

The Council would like to thank MCHNHSFT for the opportunity to review and provide a response to the 2020/21 Quality Account. The Trust is clear that providing high quality and safe care is their number one priority and this has been evident throughout the past year, notwithstanding the difficulties and challenges experienced.

Dr Katherine Birch
Lead Governor

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

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

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

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

- the content of the Quality Report meets the requirements set out in the NHS foundation Trust annual reporting manual 2020/21 and supporting guidance detailed requirements for quality reports 2020/21

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

    - board minutes and papers reported to the board over the period 1 April 2020 to 31 March 2021
    - papers relating to the quality reported to the board over the period 1 April 2020 to 31 March 2021
    - feedback from commissioners dated 18 June 2021
    - feedback from governors dated 11 June 2021
    - feedback from local Healthwatch organisations dated 9 June 2021
    - the Trust's complaints Annual report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 20 May 2021
    - the (latest) national patient survey July 2020
    - the (latest) national staff survey 6 October 2020 to 27 November 2020
    - CQC inspection report dated 14 April 2020

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

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

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

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

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

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

By order of the Board

Mr Dennis Dunn MBE JP DL, Chairman
Date: 26 May 2021

Mr James Sumner, Chief Executive
Date: 26 May 2021

Appendices

Appendix 1 - Glossary and abbreviations

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

Terms	Abbreviation	Description
Duty of Candour		A legal duty to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. It aims to help patients receive accurate truthful information from health providers.
Endoscopy		A nonsurgical procedure used to examine a person's digestive tract using an endoscope – a flexible tube with a light and camera attached to it.
Health Service Ombudsman		The role of the Health Service Ombudsman is to provide a service to the public by undertaking independent investigations into complaints where the NHS in England have not acted properly or fairly or have provided a poor service.
Hospital Evaluation Data	HED	This is an on-line solution delivering information which enables healthcare organisations to drive clinical performance in order to improve patient care and deliver financial savings
National Joint Registry		Set up by the Department of Health and Welsh Government in 2002 to collect information on all hip, knee, ankle, elbow and shoulder replacement operations and to monitor the performance of joint replacement implants and effectiveness of different types of surgery.
National Patient Surveys		Co-ordinated by the CQC, they gather feedback from patients on different aspects of their experience of care they have recently received, across a variety of services/settings: Inpatients, Outpatients, Emergency care, Maternity care, Mental Health services, Primary Care services and Ambulance services.
National Safety Standards for Invasive Procedures	NatSSIPs	A set of national safety standards to support NHS hospitals to provide safer surgical care.
Never Event		Serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented.
Oncology		The study of cancer. An oncologist manages a person's care and treatment once he/she is diagnosed with cancer.
Patient Reported Outcome Measures	PROMs	A programme in which patients complete a questionnaire on their health before and after their operation. The results of the two questionnaires can be compared to see if the operation has improved the health of the patient. Any improvement is measured from the patient's perspective as opposed to the

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