Quality Report

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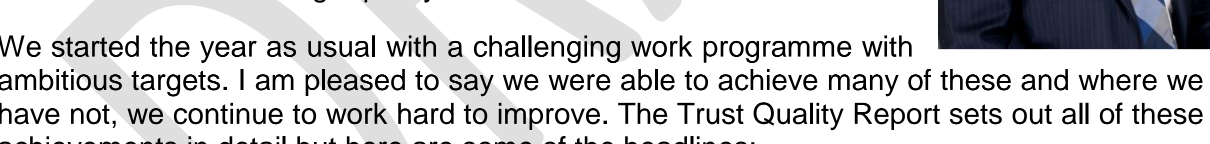
Part 1. Welcome and Overview

Statement on Quality from Sir Mike Deegan, Chief Executive

Statement from the Medical Director

My aim as Medical Director is to ensure that Clinical Quality and Patient Safety remains absolutely central to what we do here in Central Manchester University Hospitals NHS Foundation Trust (CMFT).

2015 – 2016 has been one of continuing challenge for the NHS as a whole and Central Manchester University Hospitals NHS FT has not been an exception to that. As last year, challenging financial targets coupled with increased pressures on services such as our Accident and Emergency Departments have meant our staff have had to work even harder to deliver high quality care.



We started the year as usual with a challenging work programme with ambitious targets. I am pleased to say we were able to achieve many of these and where we have not, we continue to work hard to improve. The Trust Quality Report sets out all of these achievements in detail but here are some of the headlines:

Quality Improvement

You may remember that last year I reported that a large number of Trust staff of all disciplines took part in a programme of Quality Reviews by undertaking follow up visits. This was an excellent way to engage both staff and patients in a review of the quality of our services. This year we undertook the whole process again. However, in June 2015 we were notified that the CQC were going to undertake their routine comprehensive inspection of our services in November so we scaled this back just slightly undertaking one day reviews with smaller teams of staff. As ever the findings were shared with teams and improvements are being made.

The CQC visited us in November and …………

Mortality – as one of a number of key measures on quality of care mortality measures are one that I keep in continued focus.

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I am pleased again to report that the position to date is that for SHMI the Trust is below 100 and for HSMR 101. This, triangulated with other information, assures me that the mortality rate for the organisation is again slightly below expected.

In the section on mortality you will be able to see some of the progress we have made on mortality review and the development of a new Trust Strategy.

Sepsis – has continued to be a major focus for 2015/16. ADD HERE WHEN SEPSIS REPORT IN

We have decided after a review of progress and discussion with our Governors that this will continue to be a focus going forward to 2016/17.

Dementia - ADD HERE WHEN DEMENTIA REPORT IN

Patient Safety and Harm Free Care – Last year I reported that we had signed up to a regional campaign called Making Safety Visible. The programme used a measuring and monitoring of safety framework to develop a surveillance system. There were two key outcomes planned:

- Improved understanding and capability for measuring and monitoring safety within the Board team, and;
- Improved measuring and monitoring of safety within the organisation with measurable benefits

I am pleased to report that we achieved both of those outcomes and that the organisation has made significant progress on the development of safety indicators and their review at all levels. All our staff from the Board to individual clinical staff at the front line delivering care have access to a range of online safety metrics to enable them to assess quality and make improvements. This includes the development of a consultant portal which allows doctors immediate access to real time information on the safety of their patients and the effectiveness of their care.

This year I am committed to working with clinical teams to reduce to zero the number of 'never events' reported. I am disappointed to report that despite a comprehensive programme of work the Trust still reported 6 of these events in 2015/16. This year my teams will be working again with individual clinicians on how to prevent never events. I have also been clear with all staff that individuals who fail to follow safety procedures will be held to account accordingly.

Medical Education – As part of our continued commitment to improve the experience of junior doctors, following a successful trial in February 2015, a web based induction system was introduced across the Trust in June 2015. The system ensures pre-employment contact and that information required by the new starters is in a single place. This has successfully reduced the time spent by junior doctors on induction.

The first Developing Excellence in Medical Education conference was held last year in Manchester. I am pleased to say that the Trust's Medical Education team received four awards for their posters at the conference demonstrating their ingenuity and commitment in the development and training of doctors.

Our Trust library service was assessed and received a Library Quality Assurance Framework score of 90% compliance against national standards. This was a significant improvement on the previous year's results and is a reflection of the dedication and hard work of the team.

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I am also pleased to say that the pass rates of our year 5 medical students remain high. 99% was achieved which is a credit to the students but also to the various staff who have been involved in supporting them during their training.

Research and Innovation - We are dedicated to driving continuous improvement in the care our patients receive through clinical research. We support some 300 investigators, who undertake research across a diverse range of clinical areas to deliver improved diagnostics, treatments and devices for patients in Manchester and beyond.

In 2015/16 we dramatically improved our performance in initiating clinical studies. This means we are able to provide patients with quicker access to clinical studies as part of their clinical pathway.

Leadership and Safe Supervision – You will remember that I reported last year that I have established a number of leadership development programmes to ensure that the clinicians of today are our effective leaders of tomorrow.

I am really pleased to report here briefly on some of the outputs of that work and of direct benefit to patients.

- Dr Ben Parker, Consultant Rheumatologist won an Outstanding Best Practice award from the British Society for Rheumatology for our departmental virtual biologics clinic (VBC). The VBC streamlines pre biologic screening, makes sure we are following the correct NICE guidance, and has greatly increased our research study recruitment as well as saving significant amounts of money. Dr Parker designed the service and continues to run it. He will be receiving his award at the BSR conference this April and the VBC will be promoted nationally by the BSR as an example of best practice.
- The work done by Dr Leonard Ebah and his team on Acute Kidney Injury. Acute kidney injury (AKI) is sudden damage to the kidneys that causes them to stop working properly. It can range from minor loss of kidney function to complete kidney failure and is often associated with other acute illness. The teams work has resulted in amongst other things a 12% reduction in AKI incidence in our hospitals and a reduction in length of AKI related hospital stay of 22%. They have achieved this by making improvements to both identification and treatment of early stage AKI.
- Two consultants Dr Sarah Vause, Consultant in Fetal and Maternal Medicine and Dr Ashish Sukthankar, Consultant in Genitourinary Medicine are leading the Trust work on ensuring that all services review the need and arrangements for the provision of urgent care over seven days. They have undertaken a detailed piece of work looking at standards of care across all days of the week and the changes needed to ensure consistent high quality care across all seven days.

Each of these programmes of work have demonstrated to me the enormous talent and contribution of the future leaders of our organisation and most importantly have, and will continue to have, direct impact on the quality of care received by each of our patients.

I would like to take this opportunity to thank all of our staff and our partner's involved in the delivery of care for their hard work and very much look forward to another successful year ahead.

Professor R C Pearson
Executive Medical Director

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Care Quality Commission and External Regulations

Care Quality Commission

Central Manchester University Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is fully registered with no conditions. Central Manchester University Hospitals NHS Foundation Trust has had no conditions on registration.

The Care Quality Commission has not taken enforcement action against Central Manchester University Hospitals NHS Foundation Trust during 2015/16.

Central Manchester University Hospitals NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

Central Manchester Foundation Trust is required to register with the Care Quality Commission and its current registration status is held with no conditions.

The Care Quality Commission (CQC) carried out a scheduled comprehensive inspection of our hospitals and community services in November 2015.The inspection was welcomed by the organisation and has been a key external assurance mechanism for the assessment of quality of care.
The Trust worked closely with the CQC in the run up to the onsite inspection, sharing many documents and data sets to give them a full understanding of the services provided.

The CQC assess core services against five key lines of enquiry:

- Are services safe?
- Are services caring?
- Are services responsive?
- Are services effective?
- Are services well led?

In order to fully engage all staff in the assessment and to continue our programme of improvement the preparation project was entitled Shine. The Shine project was made up of staff from right across the organisation representing their respective Divisions and specialty areas. Every single member of staff was invited to get involved and the assessors commented that during the inspection they were welcomed by pleasant, professional and knowledgeable teams.

Circa 115 inspectors visited the Trust over the 2 weeks of the inspection; most of these were allocated to the hospital inspections, a smaller team of 15 visiting our community services. The Dental and Learning disability services were not included in the inspection and we expect this to be scheduled sometime in the future. CQC advised they will like to collaborate with the Dental hospital in the future to produce inspection standards to be used for future Dental hospital inspections.

As a large acute and community services trust our services include many of the core areas that the CQC inspect. Those services and the findings against each of the key lines of enquiry are set out below. The findings were made on the basis of observation through visits to the areas, discussions with staff and patients at interview and focus groups and review of documentary and statistical information.

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Acute Core Services

	Safe	Effective	Caring	Responsive	Well-led
Urgent and emergency services					
Surgery					
Medical care (including older people's care)					
Critical care					
Maternity and gynaecology					
Services for children and young people					
End of life care					
Outpatients and diagnostic imaging					
Transition services					
Neonatal Care					

Community Core Services

	Safe	Effective	Caring	Responsive	Well-led
Community health services for adults					
Community health services for children, young people and families					
Community inpatient services					
End of life care					

Section on response to findings here

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CMFT Quality Reviews

The Trust Quality Reviews – Assessing the Quality of Care

Central Manchester University Hospitals NHS Foundation Trust aims to continually improve the quality of the services it provides and seeks to provide the best care possible to the people who use our services. One of the ways in which we do this is to gather information generated by a number of different methods which provides us with a comprehensive view of the quality of our services and helps us to identify where improvements need to be made.

In support of our approach to continuous improvement the Trust tracks a number of clinical measures, undertakes a comprehensive programme of ward accreditation as well as regular senior leadership walk rounds. Other examples of how we collect information on the quality of our services are information and data review, drawing on clinical outcomes and patient feedback and by talking to staff and patients about their experiences. Finally and probably most importantly getting out and about and making sure we can see how all of this comes together across our hospitals and community services. Together all of this enables us to form a view on quality. We are also working closely with external partners and regulatory bodies such as the Commissioners and CQC in order that we gain an independent view of our services too.

There are two key groups of people in the hospitals and services who can tell us about quality of care;

- patients (including their families and carers)
- and staff (of all disciplines and levels)

The Trust works hard to seek and act upon the views of patients and has made significant changes to practice and service delivery models on the basis of that information.

The Quality Review

The purpose of the Quality Review was to ensure that the organisation could be assured of the quality of care being delivered and that we could quickly identify and respond when we recognise that improvement is required. The aim of the reviews is to use the findings and resulting response to uphold public trust and confidence for patients and families in the services we provide and for them to be assured that they will receive the best possible experience and the best care at the right time.

This year the Trust was notified in the summer that the CQC would be undertaking their comprehensive review of our services in November 2015. For this reason it was decided that whilst the internal Quality Review should still go ahead, the exercise would be scaled down in order that the organisation was not going through two full assessments in one year. The teams were smaller and the reviews undertaken over a shorter timescale.

Staff and patient representatives were invited to take part in the annual Quality Reviews in 2015. Approximately 100 members of staff expressed an interest in taking part. The teams were selected from the applicants ensuring staff were allocated to areas other than their own and were representative of all staff groups and all levels of experience.

Each team has been led by a Director in the organisation. No team member was involved in a review of their own Division. This provided a mix of expertise and experience as well as an independence from the Division being reviewed.

The visits were all completed by October 2015. The teams used a number of methodologies including interviews, meeting attendance, observation in clinical areas and patient conversations. All teams received training and preparation to undertake the reviews.

We would like to thank all of the patients, staff, students and governors that contributed to the 2015 quality review.

Review Outcomes

The headline findings for the organisation were:

Celebrating success

- Positive and professional attitude of staff throughout the organisation and pride in what they do
- Commitment to learning and making improvements
- High levels of incident reporting and 'being open'
- Good awareness of Safeguarding requirements
- Improvements in some Community facilities and premises
- Patient safety seen as a priority in all areas
- Improvements in checks prior to surgery and interventional procedures
- Awareness of Equality Diversity & Inclusion requirements
- Good use of Audit and Clinical Effectiveness (ACE) Days to improve outcomes
- Evidence of good infection control practice
- Training of a good standard
- Excellence in Child and Adolescent Mental Health Services
- Good evidence of use of Clinical Audit

Improvements required

- Information Technology infrastructure requires improvement – in Community Services in particular
- Environmental improvements required – Radiology, Adult Emergency Department in MRI and Community premises
- Timeliness of reporting on radiological tests
- Noise at night on wards
- Patient records – storage and protection of confidential data
- Staffing numbers and the ability to release staff for training
- Medical devices – checking, maintenance and training
- Communication and feedback
- Variability of cleanliness and tidiness
- Never events
- Timeliness of preparation and delivery of take home medications

PART 2. Statements of Assurance from the Board and Priorities for Improvement from the Board of Directors

Overview of Priorities

In 2015 - 2016 we sought to improve performance across many areas of care. In the following section we present those areas of work with performance data.

We have set these out in the following table and the detail is contained over the following pages. The Board of Directors of Central Manchester University Hospitals NHS Foundation Trust is assured that the priorities for quality improvement agreed by the Board are closely monitored through robust reporting mechanisms in place in each Division.

During 2015/16 the Central Manchester University Hospitals NHS Foundation Trust provided and/or sub-contracted all services as set out as Mandatory Services under the Terms of Authorisation relevant health services.

The Central Manchester University Hospitals NHS Foundation 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 health services reviewed in 2015 - 2016 represents 100 per cent of the total income generated from the provision of relevant health services by the Trust for 2015 -2016.

The Trust utilises indicators extensively to inform and monitor the quality agenda. The Trust formally uses this data to triangulate quality, workforce and financial indicators on a monthly basis at a number of different forums, including the Operational Managers Meeting chaired by the Chief Operating Officer and at every Board of Directors meeting.

The Board of Directors intends to use this information to inform all decision making processes including priority setting throughout 2016/17. The organisation will utilise the information to understand performance against the strategic aim Improving the safety and clinical quality of our services. This understanding will then inform prioritisation and quality improvement plans.

Triangulation of this information and comprehensive understanding of cause and effect enables a focus on work streams that will improve both quality and productivity.

Whilst all Executive Directors have responsibility for the delivery of quality improvement, the named Executive leads for quality are the Medical Director and the Chief Nurse.

The Medical Director and Chief Nurse have set five clinical quality objectives for 2016/17 and these are:

- Mortality
- Sepsis
- End of Life Care
- Dementia
- Out-patient Care

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The broad commitments set out in the Quality Strategy remain relevant and, along with the ambitions set out in the Trust Transformation Strategy will underpin Divisional and corporate work programs for 2016.The following areas will be a focus for delivery in 2016/17:

- Leadership
- Evidence based care
- Research and innovation
- Communication
- Listening and responding
- Openness and transparency
- Accountability
- Celebrating success

Delivery of the Quality Strategy commitments will be underpinned by the development and delivery of a new Patient Experience Framework during 2016/17.

The Trust Risk Management Committee oversees the management of all high level risks to the delivery of the organisational strategic aims and key priorities and these are mapped on the Board Assurance Framework.

A thematic review of current risks on the Trust's risk register highlights the following three overarching risks to clinical quality:

- **Demand** - maintaining and improving the quality of clinical services with an increasing demand on services
- **Staffing** - maintaining and improving the quality of clinical services whilst reducing the nursing vacancy rate
- **Finance** – maintaining and improving the quality of clinical services within the current financial constraints

See more detail under 'Clinical Risks' on **page 26**

All risks are monitored, those presenting a more significant threat to the Trust objectives, scored 15 and above, are monitored bi-monthly at the Trust Risk Management Committee. Detailed plans are in place to reduce all of these risks to an acceptable level.

To deliver high quality services and continuous improvement the organisation will maintain a continued focus on leadership. The organisation invested significantly in the development of all of its leaders in 2013/14 and 2015/16 and this is expected to continue to deliver quality improvements into 2016/17.

The Board of Directors maintains a focus on performance against the Trust's quality metrics through the organisational governance processes and through regular review of a comprehensive suite of quality metrics from which Board members drill down into the organisation to interrogate performance.

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NHS Outcomes Framework

In this report you will see performance figures and, where possible, comparative information so that you can see how well we are doing alongside our other NHS colleagues. There are some indicators which are measured as part of the NHS Outcomes Framework and we are presenting those here. This is so that all organisations are clear about performance in these areas and that comparisons can be made.

The Outcomes Framework is a set of indicators designed to improve standards of care in five key areas:

1. Preventing people from dying prematurely

2. Enhancing quality of life for people with long-term conditions

3. Helping people to recover from episodes of ill-health or following injury

4. Ensuring that people have a positive experience of care

5. Treating and caring for people in a safe environment and protecting them from avoidable harm

The indicators presented here all directly inform the five key areas of the NHS Outcomes framework above.

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Summary Hospital - Level Mortality Indicator (SHMI)

The Central Manchester University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons.

The Summary Hospital-level Mortality Indicator (SHMI), introduced during 2011, is a method to measure hospital mortality. It is based on all patient deaths including those which happen up to 30 days following discharge from hospital. It relies heavily on accurate record keeping and coding. The patient case note is examined by clinical coding staff who reflect what doctors have written in relation to any existing conditions the patient has, such as diabetes, as well as their diagnosis for their current hospitalisation episode and any procedures undertaken. The patient's risk of dying is calculated using these measures. The baseline is 100, so a score below 100 means that mortality rates in an organisation are low (better) than expected.

We have continued our extensive program of work and have this year seen an improvement in our SHMI figures.

Indicator	Outcome/s	CMFT 2014/15	CMFT 2015/16	National Average 2015/16	Highest Performing Trust 2015/16	Lowest Performing Trust 2015/16
SHMI	To be confident that our mortality rate accurately reflects clinical practice, coding and data quality	99	97	100	66.1	120.9

Patient Reported Outcome Measures

The Central Manchester University Hospitals NHS Foundation Trust considers that this data is as described for the following reason; all patients undergoing these procedures have the opportunity to complete quality of life assessment questionnaires before and after surgery, the figures represent the percentage of patients reporting improvements in their health outcomes.

The Trust has supported fully the process for gathering patient feedback prior to surgical procedures as part of the pre-operative process. This is collected by surveys which are then returned to our survey providers, the questionnaires which are sent to patients following their surgery are co-ordinated by an independent survey organisation. By sharing patient level detail with clinicians we will ensure learning and development. We need to continue promoting the completion of the surveys and continue to work with our survey providers to achieve high quality data which allows comprehensive review.

Indicator	Outcome/s	CMFT 2014/15	CMFT 2015/16	National Average 2015/16	Highest Performing Trust 2015/65	Lowest Performing Trust 2015/16
Groin hernia surgery	To improve health outcomes following each of the 4 procedures	Not available at time of reporting. Too few responses to report				
Varicose vein surgery		Not available at time of reporting. Too few responses to report				
Hip replacement surgery		Not available at time of reporting. Too few responses to report				
Knee replacement surgery		Not available at time of reporting. Too few responses to report				

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The percentage of patients readmitted to a hospital within 28 days

The Central Manchester University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons; as it is nationally standardised data which allows us to draw comparisons against the NHS as a whole.

Indicator	Outcome/s	Relative Risk 2014/15	Relative Risk 2015/16	Actual 2015/16	Expected 2015/16	Super Spells 2015/16	Rate 2015/16
Aged 0-15	To reduce readmissions and improve health outcomes	94.87	94.9	1556	1639.63	21,064	7.39%
Aged 16 or over		99.38	93.49	3490	3733.15	53,214	6.46%

Trust responsiveness to the personal needs of its patients

The Central Manchester University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons; the data is a direct extract from data provided by the Care Quality Commission based on scores from patients who participated in the national patient experience survey having spent at least one night in our organisation in July 2014.

The Trust has achieved an improved overall score this year for the five questions compared to 2013/14.

Improvements particularly relate to three of the questions:

> ‘Did you find someone on the hospital staff to talk to about your worries and fears?’
>
> ‘Were you given enough privacy when discussing your condition or treatment?’
>
> ‘Were you involved as much as you wanted to be in decisions about your care and treatment?’

Monthly internal monitoring of patient feedback, using an electronic survey tool shows a sustained improvement in all five questions since the month of the National Inpatient Survey.

Indicator	Outcome/s	CMFT 2014/15	CMFT 2015/16	National Average 2015/16	Highest Performing Trust 2015/16	Lowest Performing Trust 2015/16
Amalgamated and adjusted scores from the 5 key questions in the national adult in-patient survey	To demonstrate continuous improvement in our responsiveness to the personal needs of our patients	67.2%	67.2%	Not available	88%	56%

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The percentage of staff employed who would recommend the Trust as a provider of care to their family or friends

The Central Manchester University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: The data below is taken from the 2014 NHS Staff Survey. Questions 12a, Q12c and Q12d feed into Key Finding 24: “Staff recommendation of the Trust as a place to work or receive treatment”. This is weighted by the number of respondents who “agree” or “strongly agree” with each statement and are then given a score of between1-5, 1 being the lowest and 5 being the highest.

NHS England introduced the Staff Friends and Family Test (SFFT) in all NHS trusts that provide acute, community, ambulance and mental health services in England from April 2014. Their vision is that all staff should have the opportunity to feedback their views on their organisation at least once per year.

The Trust surveyed different groups of staff every 3 months throughout the year and compared the results with those received as part of the staff survey which was very slightly below the national average, 3.65 compared to 3.67.

Regular surveys will allow us to identify any working areas or staff groups that might require a particular focus in order to ensure that staff view the Trust favorably as a place to work and receive care.

Data not ready until end of March/early April

Indicator	**Outcome**	**CMFT 2014/15**	**CMFT 2015/16**	**National Average Acute Trust 2015/16**	**Highest Performing Acute Trust 2015/16**	**Lowest Performing Acute Trust 2015/16**
Staff Survey Key Finding 24 – staff recommending the Trust as a place to work or receive treatment - an indicator of the Friends and Family Test	Staff report that they are treated with the appropriate values and behaviours by colleagues and by the organisation and that they would recommend the Trust.	3.65				

The percentage of patients who were risk assessed for venous thromboembolism (VTE)

The Central Manchester University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons. Patients are assessed, unless part of the agreed group of exclusions. This is documented and then checked by the coding team. All patients who have a correctly completed VTE assessment are coded accordingly and this is the figure presented.

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The table below demonstrates that the Trust has continued to maintain its performance of assessing at least 95% of appropriate patients for VTE year on year. The aim is to maintain a minimum of 95% compliance throughout the year.

Indicator	Outcome/s	CMFT 2014/15	CMFT 2015/16	National Average 2015/16	Highest Performing Trust 2015/16	Lowest Performing Trust 2015/16
VTE assessment	To risk assess 95% of appropriate patients (in previous years this has been a 90% target)	96%	96%	96%	100%	75%

The rate, per 100,000 bed days of cases of clostridium difficile infection in patients aged 2 or over

The Central Manchester University Hospitals NHS Foundation Trust considers that this data is as described for the following reason; as it is nationally standardised data which allows us to draw comparisons against the NHS as a whole.

Indicator	Outcome/s	CMFT 2014/15	CMFT 2015/16	National Average 2015/16	Highest Performing Trust 2015/16	Lowest Performing Trust 2015/16
Clostridium Difficile infection per 100,000 bed days	To reduce C Difficile infection	18.6	Not Available	18	14.5	37.5

The rate of patient safety incidents reported and the number and percentage of such incidents which led to severe harm or death

The Central Manchester University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons; increased reporting at low level of incidents, improved data quality checks.

The Trust continues to take the following actions to improve incident reporting via the National Reporting and Learning System (NRLS), and so the quality of our service:

- Data quality management
- Awareness raising of need to report near misses
- Patient Safety Training which includes Human Factors
- Patient Safety Initiatives
- Harm Free Care initiative

Indicator	Outcome/s	CMFT April 14-Sept 14	CMFT 2015/16	Comparator Group Average 2015/16	Highest Performing Trust 2015/16	Lowest Performing Trust 2015/16
Rate of incidents per 100 admissions	5a Patient Safety incident reporting	60.63				
Percentage of severe harm or death	5b Severity of harm	0.2%				

This is based on the Acute Teaching Organisation cluster under the National Reporting and Learning system.

*NRLS now produce the data differently by 1000 bed days rather than by 100 admissions therefore there isn't a comparator for the previous year

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Priority	Page	2013/14	2014/15	2015/16
Patient Safety				
Patient Safety Events • Learning from Incidents • Medication Safety Harm Free care • Falls • Pressure Ulcers • Catheter acquired infection		✓ ✓ ✓ ✓	✓ ✓ ✓ ✓	✓ ✓ ✓
Clinical Risks				
• Communication of Tests Results • Never Events • Care for People with Physical and Mental health Problems		N/A	N/A	
Clinical Effectiveness				
Infection prevention		–	–	
Hospital Mortality		✓	✓	✓
Clinical Audit		✓	✓	✓
Commissioning for Quality Improvement Scheme (CQUINS) • Local • national		✓ ✓	✓ ✓	N/A
Advancing Quality • Acute myocardial infarction (heart attack) • Coronary artery bypass graft (CABG) • Heart failure • Hip and Knee replacement • Pneumonia • Stroke		✓ ✗ ✓ ✓ ✓ ✓	✗ ✓ ✓ ✗ ✓ ✓	N/A (Not undertaken this year- CCG pulled out of AQ programme)
Patient Experience				
Real time patient feedback - Friend and Family Test		✓	✓	
End of life care		–	✓	✓

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Patient Safety

(Note Items in Yellow will change before final version)

The information detailed below is the position as of the end of April 2016. As in previous reports this information may change and as such will be updated in future reports.

Safety Improvement Strategy

The Trust was one of the first to commit to the national **'Sign up to Safety'** campaign which aims to reduce avoidable harm by 50% over three years.

Harm can be defined in many ways, but is usually referred to as any unintended physical or emotional injury resulting from, or contributed to by clinical care.

Safety programmes are being implemented to reduce risk and improve patient experience. These include improvements in safety culture, safety in theatres, improving communication of test results and obstetric care.

We are proud to have received funding for the programme to improve patient safety in obstetrics from the NHS Litigation Authority. This supports our work implementing safety strategies to reduce risk in obstetric care (detailed below) which has resulted in a decrease in fetal death in utero.

Detection of fetal compromise: expansion of the intrapartum electronic documentation system and extended ultrasound services for women who are of high risk of fetal compromise or stillbirth.

Proud to Care

Safety Improvement Strategy

2014-2017

Antenatal screening: development of a pregnancy application.

Reduction in maternal and neonatal morbidity associated with caesarean section: reduce operative complications performed in second stage of labour by the introduction of "fetal pillow" device.

Reduction of obstetric and anal sphincter injuries: introduction of "Episcissors".

Development of an electronic system for patients who either phone or attend Triage: an electronic system to respond and track triage phone calls

*Our full **Safety Improvement Strategy** can be found on our website: **www.cmft.nhs.uk***

Learning from Incidents

Organisations that report more incidents usually have a better and more effective safety culture demonstrated by high numbers of no harm or near miss incidents. It is vital that staff feel comfortable to report when errors occur so that learning can be shared, improvements made and reoccurrence prevented.

This year the level of Patient Safety Incident reporting is 62.5 incidents per 1000 bed days. This is a slight decrease in volume from last year following improvements in services such as the implementation of the electronic diagnostic system ICE which has seen a decrease in reporting relating to diagnostic test incidents. Of all incidents reported, 91.4% were no harm or near miss compared to a national average of 74.3%.

As the numbers of near miss incidents that our staff report increases, the level of serious harm incidents has reduced. This is because we can learn from these near misses and put things in place to prevent a more serious error from occurring. In this way we can view our near misses as good catches!

After every incident we review what happened and where possible make changes to prevent the same thing happening again, examples of some of the actions following incidents are given below.

- Pilot of electronic VTE risk assessments
- Development of specific training packages
- Implementation of extended visiting within one division to reduce falls

Serious Harm Incidents

Whilst our aim is to increase incident reporting it is also to reduce the levels of serious harm. Incident grading ranges from 1–5 with serious harm incidents being classed as actual harm level 4 & 5. The table below demonstrates these. It can be seen that there has been an ? in these from the previous year although this is still a decrease from 2012-13 level. There are key safety programmes in place to reduce these over the next year as detailed in our Safety Improvement Strategy.

Year	Level 4 /5 Actual Harm	Per 1000 bed days
2012-13	59	0.11
2013-14	47	0.09
2014-15	55	0.10
2015-16	34	0.08
2015-16*	45	0.10

(***includes unconfirmed which are still under investigation**)

Types of incident that resulted in serious harm:

- Falls account for around half of our serious harm incidents (23)
- Maternity (still birth / early neonatal death) (5)

Lessons Learned: Communication & Feedback

To communicate learning and feedback from incidents we produce a twice yearly electronic publication accessible to all staff entitled **Lessons Learned.** This contains information around learning from various types of incidents, patient safety issues and initiatives, improvements and general risk and governance updates.

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This year, we implemented a new monthly patient safety bulletin called **Safety One Liners** which shares information, initiatives and good practice. We have also utilised social media (TWITTER) to facilitate wider learning join us **@CmftPtSafety.**

Safety One Liners Jan 2016

Message from Medical Director and Chief Nurse

Welcome to Safety One Liners. Technology helps us care safely for our patients every day. The key message in this bulletin is that we must work *with* the technology – take extra care when inputting information, make sure equipment is checked and correctly calibrated and most importantly respond when the equipment is telling you something.

Point Of Care Testing Glucose Meters: Always enter the patient's District Number (or EPMI number at TGH) so the result is available electronically for patient review.

Did you know? over 50% of our serious harm incidents are **Falls.**

Check TAB Alarms regularly to make sure they are in-situ and working

Medication Secure Storage: Make sure all medication is stored in locked cupboards and within expiry date.

Patient Triggering on EWS = ABG

If a patient is triggering on the Early Warning Score for

five hours - low risk,

second hour - medium risk

first hour - high risk or

Just **Concerned?**

Do an ABG to ensure quick diagnostic results and responsive treatment

During the year we have also implemented a system for learning from successes called Excellence Reporting, so far we have had 45 of these reported and we will be developing systems to support structured learning from these further next year.

Training is available for staff to help improve and engage in a culture of safety including, Human Factors - Patient Safety and Root Cause Analysis. This training and feedback help staff to understand how errors can occur and what we can do to help prevent this.

Being Open & the Duty of Candour

The Trust is committed to promoting a culture of openness and transparency across all areas of its activities and as such communicating honestly and sympathetically with patients and their families/carers when things go wrong.

In line with the findings of the Francis report (2013), we believe that patients, their families /carers should receive a meaningful and sincere apology of regret for any harm that has occurred. This process involves being open, honest and transparent.

In November 2014 The Statutory Duty of Candour came into force. This supports the requirement for clinicians to be open and candid with patients about avoidable harm and for safety concerns to be raised.

Our policy is that following any incident resulting in harm, information must be given to the patient and or their relatives as soon as possible after the event. This can range from informing the patient of the error as it occurs to sharing our investigation findings and actions planned to prevent reoccurrence.

For our actual harm incidents 3 to 5, we monitor that this is being undertaken within the Trust timeframes. Currently 97% have been completed within the Trust timeframe.

We provide Being Open & Duty of Candour training for staff, which has been well attended since its development and have also updated electronic processes for staff to follow when completing the process.

We also want our staff to be supported within these processes and as such advocate the Speak out Safely campaign which encourages staff to raise concerns freely.

Never Events

A Never Event is described by NHS England as a serious largely preventable Patient Safety Incident that should not occur if the available preventative measures have been implemented. There are 14 Never Events which include wrong site surgery, retained

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instrument and wrong route administration of chemotherapy. Practice for these is set nationally and we have risk assessments and measures in place to prevent them.

We set out to have zero events at the start of the year however despite this we had 6. All of these were related to completion of procedures and occurred in a range of settings including theatres, maternity and endoscopy.

Following these events full investigations were undertaken and actions generated and completed.

The Trust established a Never Events Working Group over 12 months ago. This group developed an action plan which is being implemented with a number of actions completed during the year including;-

- ✓ Update of the Safer Surgery Checklist Policy and Procedure
- ✓ Update of counting procedures
- ✓ Identification of all invasive procedures undertaken in non-theatre environments and the completion of risk assessments on each of these and where required implementation of local procedures for safety checks.
- ✓ Development of training materials – videos.

The new National Safety Standards for Invasive Procedures were published in September 2015, supported by a Patient Safety Alert with actions to be completed by all trusts over the coming 12 months. These include a number of actions that we have already completed earlier this year including the identification of procedures undertaken across all care settings with a risk assessment against each of these to identify whether local safety procedures are in place or required and the implementation of local Safety Standards in a number of non-theatre environments.

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Type of Incidents Reported

Narrative on the changes will appear here when we have full year data.

Incident Type	2014-15	2015-16	Change
Treatment / Clinical Care	4054	4183	▲
Clinical Assessment Inc. Scree	3818	3095	▼
Communication / Documentation	2547	2348	▼
Access, Admission, Transfer, D	2171	2320	▲
Personal Accident/ Incident	2429	2164	▼
Medication Errors	1970	1997	▲
Infrastructure / Facilities /	1404	1968	▲
Pressure Ulcers	1220	911	▼
Medical Device	662	663	▲

Safeguarding Adult / Children	166	169	▲
Security, Theft, Violence And	91	63	▼
Pathway Deviation	59	57	▼
ED Capacity	13	46	▲
Information Governance	51	27	▼
Total	20654	20011	▼

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Comparison with other Trusts

We report all our Patient Safety Incidents to NHS England (NHSE) and we are monitored alongside all other acute hospital Trusts. Data is made available from NHSE in 6 month groupings. The information on the table below provides details of the latest published data.

The Trust reported a total of 12,784 incidents (62.5 incidents per 1000 bed days) during the period of October 2014 - March 2015. This makes us the top reporter in terms of the numbers of incidents that are reported nationally.

Area	CMFT	Best Trust	Worst Trust	Average
Number of Incidents	12,784	12,784	443	N/A
Rate of incidents reported per 1000 bed days	62.5	82.2	3.5	35.9
Number Resulting in Severe harm or death	24	2	128	N/A
Percentage Resulting in Severe harm or death	0.3%	0%	5.2%	0.5%

Medication Safety (report being rewritten)

Clinical Risks

Through the year the Trust records risks on the Trust Risk Register. The risk register is used to ensure that staff are aware of risks and that actions are being taken to mitigate those risks. A small number of those risks are deemed serious enough to require a regular report to the Trust Risk Management Committee. This committee is attended by Executive and Non-Executive Directors and progress reports are made on progress to reduce the risk.

The risk register is by its nature a changing document and the Trust sets out to mitigate and reduce all risks to patient safety as quickly as possible.

This year we have reviewed the process to further refine our reporting on the journey of risk and assurance that where possible all risks are being reduced.

Examples of high level clinical risks this year include:

Communication of Test Results

Last year we reported that this was a risk and that whilst every year the vast majority of tests results are communicated to clinicians and acted upon in a timely way in a small number of cases we had identified harm occurring as a result of the results not being communicated or acted upon quickly enough.

This year we have focused on an upgrade to the current electronic communication system for test results. Clinical Work Station (the old system) was replaced in all departments on 24 June 2015 by a new system called Sunquest ICE. This was a huge logistical operation which was supported by a dedicated team of technical staff to ensure it was managed as safely as possible. We are delighted to report that this change took place safely and on the planned day.

The benefits seen to date are:

- User friendly
- Easier to use so tests can be requested more quickly
- Mobile
- Wider access to results – it doesn't matter if the tests were requested within primary (community) or secondary (in hospital) care
- Opportunities for sharing results between different hospitals and specialties
- Improved patient safety i.e. reduced sampling and labelling errors

Following a review of all reported incidents pre and post implementation of the new system we are pleased to report that we have improved safety and reduced harm for those tests managed on that system.

The Trust is now concentrating on results that are communicated differently, we have seen evidence that harm still occurs for example, when a radiological result is not communicated in a timely way and we are reviewing our processes to ensure this is improved.

Never Events

As reported in the Patient Safety section the Trust had in 2015/16 * against an aim of 0. These events have not resulted in serious harm this year but because of their potential to do so we maintained the high risk score across the year; we are aiming for a period of six

months without any events before we can be assured that the work undertaken has addressed the risk.

We have a number of local teams now working on this to assess the level of risk in every single part of the Trust and make sure that everything possible that can be done to avoid never events in the future is done. (more detail can be seen on **page 22**)

Care of Patients with both Physical and Mental Health Problems

The Trust identified earlier in the year that patients presenting with both mental and physical health problems may not always get the right support for their mental health.

In 2015/16 we appointed an independent consultant to advise us on what we needed to do differently to ensure every patient had all their healthcare needs met to the best of our ability. We are pleased to report that this work has now concluded and a detailed plan is in place for improvement. Once assurance can be gained that the plan has been implemented and that quality of care is satisfactory then this risk can be downgraded.

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Clinical Effectiveness

Infection Prevention and Control

Infection prevention and control is a fundamental aspect of safe patient care. Protecting our patients against hospital acquired infections is a key priority for our organisation and one which we consider to be the responsibility of all staff.

Our aim is to eliminate all avoidable hospital associated infections, caused by MRSA and *Clostridium difficile* (CDI). This year we have continued to make good progress by reducing the number of patients who developed infections whilst in our care.

It is a mandatory requirement for all trusts to report all Methicillin Resistant *Staphylococcus aureus* (MRSA) bacteraemia and *Clostridium difficile* infections (CDI).

Methicillin Resistant *Staphylococcus aureus* (MRSA) bactereamia

What To reduce the number of cases of MRSA bacteraemia (bloodstream infections) within the Trust

How Much Zero avoidable infections

By When March 2016

Outcome NEED to finalise figures at end of financial year

Progress

The total number of reportable MRSA bacteraemia attributable to the Trust is five (but TBC end of year). This compares to seven incidents for the last year which represents a TBC reduction. All five of these cases were reviewed and deemed to be avoidable infections. Of the five cases two patients acquired MRSA during their hospital stay; two patients had a delay of treatments and one was a contaminant. (A contaminant is when the sample has become contaminated during the taking of the blood and is not a true infection).

Once final figures insert updated graph here

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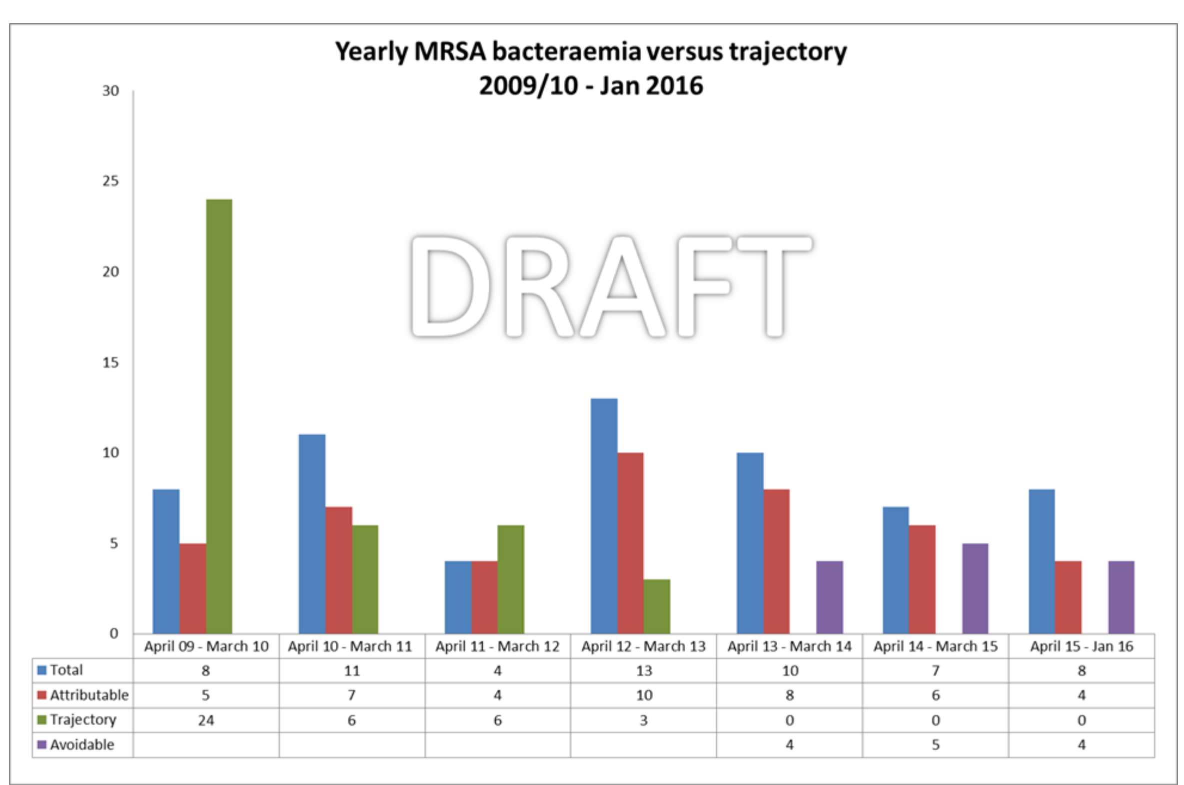

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Clostridium difficile Infection (CDI)

Clostridium difficile is a cause of healthcare associated diarrhoea which has the potential to cause serious illness. It is a common bacterium that exists harmlessly in the bowel of 3% of healthy adults and up to 30% of older people. *Clostridium difficile* can multiply and produce toxins that cause diarrhoea and illness, usually as a consequence of treatment with antibiotics.

A trajectory of no more than 66 hospital attributable cases was set by NHS England for 2015-16.

What To reduce the number of cases of CDI within the Trust

How much No more than 66 lapses in care

By when 31 March 2016

Outcome Need to collate figures at end financial year (NB to date four lapses in care).

The number of attributable incidents of CDI reported to Public Health England (PHE) for 2015/206 was TBC. Of these TBC were deemed to demonstrate a lapse in care.

Progress

We review all cases of CDI at a multi-disciplinary meeting to determine whether the case was linked with a lapse in the quality of care provided to the patient. A lapse in care is denoted as an avoidable infection. Furthermore each CDI case is also reviewed externally by our local Clinical Commissioning Group (CCG) who have upheld all our decisions.

Although we have reported TBC cases of *Clostridium difficile* infection, we have TBC lapses in care; compared to the 10 in the previous year. This is a reduction of TBC%. Moreover of these TBC cases were all agreed as unavoidable.

In addition we have reviewed our antibiotic treatments for high risk patient groups, such as those who are immunocompromised or previously known to have had *Clostridium difficile* infection.

TBC - Once final figures insert updated graph

Cumulative CMFT Attributable CDI cases 2014/15 - 2015/16

Number of reported CMFT-attributable cases

	April	May	June	July	August	September	October	November	December	January	February	March
2014/2015	6	14	18	25	38	44	46	50	55	61	69	75
2015/2016	2	4	11	22	25	30	37	47	54	58		

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Carbapenemase Producing *Enterobacteriaeae* (CPE)

Carbapenamase-producing *Enterobacteriaceae* (CPE) is the name given to gut bacteria which have developed resistance to a group of antibiotics called carbapenems. Infections caused by CPE bacteria can usually still be treated with antibiotics. However, treatment is more difficult and may require combinations of drugs to be effective.

Though a number of Trusts have experienced problems with CPE, we have the greatest number of cases in any Trust to date.

In recognition of this, CMFT has invested considerable resource in the identification and control of CPE, coupled with a detailed research programme to inform current and future strategy. In particular a considerable amount of work is being undertaken with Public Health England to help generate the evidence base for national and international guidelines for controlling CPE and other antibiotic resistant organisms.

What To reduce the number of cases of CPE within the Trust

By when 31 March 2016

Outcome Need to collate figures at end financial year

Progress

We investigate all our CPE bacteraemias with all staff involved in the patients care; root causes identified and issues addressed. Five incidence of CPE bacteraemia were reported this year compared to 17 in the previous year.

The IPCT have worked closely with the divisions on a variety of control strategies including an enhanced screening policy and continued review and management of cohort wards. This approach has been successful in reducing our acquisition rate. The average number of new acquisitions for the first three quarters of 2015 was 55 per month. This decreased to TBC for the final quarter.

TBC - Once final figures insert x2 updated graph/bar chart (1 graph showing CPE BSIs and 1 graph showing reduction in acquisitions)

Key Priorities/Next Steps for 2016/17

- Continue to implement actions to further reduce the incidence of CPE and contribute to national strategy.
- Introduce a managed service for the use of hydrogen peroxide vapour to enhance decontamination of the environment.
- We are currently exploring ways to utilise the electronic patient management system (PatientTrack) to monitor the usage of intravenous devices.
- To build on the work already undertaken and extend our programme of surveillance for Surgical Site Infections (SSI's).

Focus on Practice

Hand Hygiene

International Hand Hygiene Day May 2015 and International Infection Control week (October 2015)

The trust participated in national initiatives including in May, the World Health Organisation (WHO) Save Lives: Clean your hands campaign and in October International Infection Control week. The Infection Prevention and Control/Tissue Viability team (IPC/TV) had display stands in each atrium for both the public and staff. This year we focused on hand hygiene and the events generated a good response with positive feedback.

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Replacement of Hand Gel Dispensers

The latest initiative in our on-going hand hygiene campaign which we launched in July 2013 is the replacement and upgrade of alcohol hand gel dispensers across the Trust. All old dispensers have been replaced with new and additional ones have been sited where required, including new signage and posters.

The purpose of this is that immediate access to alcohol hand gel at the point of care is considered the strongest predictor in the undertaking of hand hygiene. Having alcohol hand gel in more accessible places will continue to improve compliance in the undertaking of this activity whilst managing patient care across the trust.

Hand Hygiene Monitoring Project

Hand hygiene is considered a key element of infection prevention and control and is monitored and audited regularly in all clinical areas through direct observation of practice. The trust has participated in an innovative project, in collaboration with a Lancashire based company Veraz Limited, who have developed a system to objectively measure hand hygiene compliance in clinical areas on an on-going basis. The VeraMedico system automatically tracks and records each episode of hand hygiene compliance via monitoring equipment, wireless networks and electronic badges. When staff are compliant with hand hygiene the badge lights up green.

The project consists of the three phases, with the pilot on four wards as the initial. Preliminary results indicate improved hand hygiene compliance and a poster presentation summarising the first stage of the trial have been showcased at the national Infection Prevention Society Conference held in September 2015.

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Other

Internal Audit Review of Processes for *Clostridium difficile* Infection

The Monitor Risk Assessment Framework 2014/15 set out a range of performance indicators upon which the Trust is assessed on a quarterly basis. One of the indicators relate to *Clostridium difficile* infection. The aim of the audit was to provide assurance that there are robust processes in place to support the overall decision of whether a case was unavoidable or avoidable.

The review confirmed we have appropriate processes in place to consider all *Clostridium difficile* infection cases attributed to the Trust leading to the decision as to whether the infection was avoidable or unavoidable. Whilst the audit review agreed and reported all

cases were suitably assessed, the panel recommended that the record keeping of the processes be strengthened, which has been actioned.

Harm Free Care

Catheter Associated Urinary Tract Infection (CAUTI)

This is defined as a urinary tract infection acquired whilst a patient has a urinary catheter in situ.

What To establish robust surveillance of the incidence of catheter associated urinary tract infections.

By when March 2016

Outcome Achieved ✓

Progress

Catheter associated urinary tract infection is one of the most common types of hospital acquired infections. During patients stay in hospital, 10%-12% of patients will require a urinary catheter which will make them more susceptible to a urinary tract infection.

A trust-wide Urinary Catheter Audit was undertaken in November 2015. This audit measured compliance with the new integrated care pathway (ICP) for catheterisation and catheter care, which was implemented across all adult divisions within the Trust from December 2014.

The results of the audit will be used to inform the CAUTI action plan for 2016 and will enable us to focus our resources.

A prevalence survey of the incidence of CAUTI was included in the data collection from the audit. It identified that 19.2% of our patients had a urinary catheter and that of these patients 9.6% had a CAUTI.

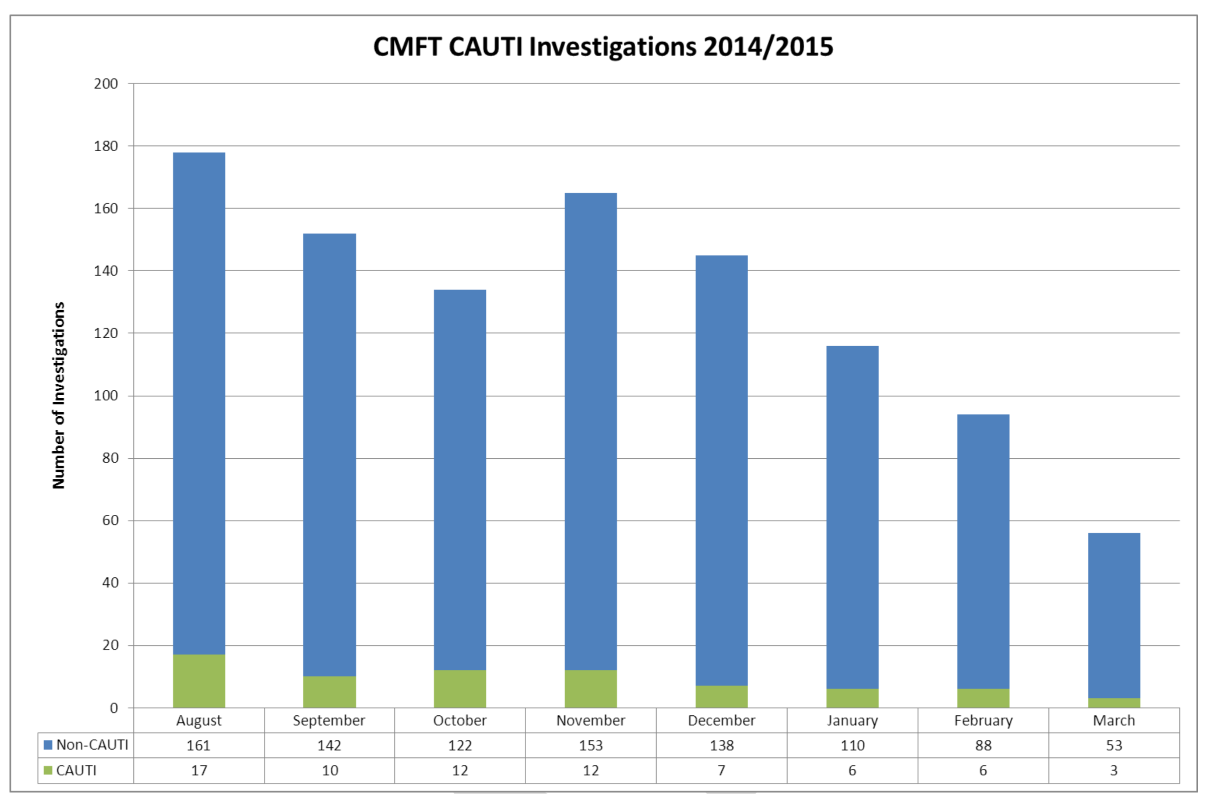
(Need to put in here end of year figures for incidence).

The following table and chart represent the number of positive urine samples investigated and the number identified CAUTIs detailed by month. ***TO BE UPDATED APRIL 2016***

Table 1 - Outcome of positive CSU/MSU investigations (August 2014 – March 2015) ***TO BE UPDATED APRIL 2016***

Investigation Outcome	Number
Not a CAUTI	967 (93%)
CAUTI	73 (7%)
Total	**1040**

Chart 1 – Outcome of positive CSU/MSU investigations by month (August 2014 – March 2015)) ***TO BE UPDATED APRIL 2016***



	August	September	October	November	December	January	February	March
Non-CAUTI	161	142	122	153	138	110	88	53
CAUTI	17	10	12	12	7	6	6	3

Next Steps
We are currently exploring ways to utilise the electronic patient management system (Bedman) to facilitate data collection.

Reduction in Harm from pressure ulceration

What To reduce harms caused to patients from pressure ulceration

How Much To reduce the number of acquired pressure ulcers on 2015/2016

By When March 2016

Outcome A further reduction in avoidable pressure ulceration

Progress ✓

The Trust has continued to reduce the incidents of pressure ulceration across both community and acute services. The main focus has been to reduce the number of avoidable pressure ulcers. Building on from the progress of 2014/2015 the Trust has continued to significantly reduce the number of pressure ulcers patients have developed whilst in our care.

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	Grade 1	Grade 2	Grade 3	Grade 4
2014/2015 (actual)	244	447	31	8
2015/2016 to end Feb 16	123	324	8	3
% reduction of avoidable pressure ulcers on previous year	49%	28%	87%	62.5%

Education

The Infection Prevention and Control /Tissue Viability (TV) Team have been supporting staff in the clinical areas with identification and reporting of tissue damage. By being highly visible in the clinical area, the team have been able to undertake one to one training sessions on pressure ulcer prevention & management. It has also given the opportunity for clinical staff to stop and ask the specialist team about patient management.

Bespoke training has also been undertaken with the divisions regarding issues raised following investigation of avoidable pressure ulceration for example, prevention of medical device (probes, naso – gastric tubes, oxygen masks, and cannulas) related pressure damage. Training for new starters on trust induction and international nurses has been delivered.

Within the critical care areas, weekly wards rounds are undertaken with the aim of preventing tissue damage in patients at very high risk of pressure damage. This is to ensure that all appropriate care and prevention plans are in place.

The Infection Prevention and Control /Tissue Viability Team took part in an International event "Stop the Pressure" day in November 2015, the team visited patient and visitor areas within the organisation to increase public awareness on how to reduce the risk of pressure ulceration and give skin care advice.

Patient information

Patient information leaflets have been developed for all adult acute and community areas. The leaflet gives patients and carers advice on how they can help reduce their risk of tissue damage. It also gives them information on how to contact the IPC/TV team if they have a problem with their skin.

Improvements in documentation

Following pressure ulcer investigation into each incident, it was identified that there was a need to improve the documentation specifically in the community setting thus improving communication between carers and district nurses. The community integrated care pathway

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has been developed which has improved communication and ensure the same standard of care is provided for all patients.

A new wound assessment chart has been developed within the Acute hospitals which will improve the monitoring of healing wounds.

Equipment
The current contract for the provision of dynamic mattresses across acute and community service is due for renewal August 2016. Currently the team are reviewing and developing a service contract to meet the needs of patients within our care.

Next steps/ further improvements

- We are currently evaluating a portable camera to improve monitoring of patients wound within the community. The device will allow district nurses to liaise with the Infection Prevention and Control /Tissue Viability Team. This technology has the potential to enable district nurses to consult with the team whilst with the patient and receive immediate advice on management of the pressure ulcer/ wound.
- Undertaking an evaluation of a new technology with critical care that can detect damage before it is visibly seen on the skin. This is intended to instigate earlier prevention strategies and therefore prevent deeper tissue damage.

Mortality

The process of a continual endeavour to understand the factors affecting mortality and to decrease avoidable in-hospital deaths is overseen within the organisation by the CMFT Mortality Surveillance Group, chaired by an Associate Medical Director. The group has supported the development and use of a single mortality review tool for adult use, and consistent use of neonatal and paediatric tools, and in the review of stillbirth.

There are a number of key mortality measures which are reported publicly. Two of the main indicators are Summary Hospital–level Mortality Indicator (SHMI) and Hospital Standardised Mortality Indicator Ratio (HSMR). Both of these indicators compare acute Trusts in England, and have an average of 100.
The key differences between HSMR and SHMI are:

- SHMI includes all deaths, while HSMR includes only a compilation of 56 diagnoses (which account for around 80% of deaths)
- SHMI includes post-discharge deaths while HSMR relates only to in-hospital deaths
- HSMR is adjusted for more factors than SMHI such as palliative care and case mix.

The amount of coding for palliative care is particularly significant in overall HSMR scores, as in some Trusts over a quarter of cases are so coded

Information and data sources reviewed regularly in the Trust include:

External:

- National datasets such as the Standardised Hospital Mortality Indicator (SHMI) and the Hospital Standardised Mortality Ratio (HSMR). These methodologies are used and published by the NHS Information Centre and Dr Foster respectively.
- Disease of condition specific mortality alerts from Dr Foster

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Regional data published by the Advancing Quality Alliance (AQuA). AQuA is a NHS health and care quality improvement organisation with whom the Trust works to improve quality of care. AQuA publications compare hospitals across the Northwest, for overall mortality rates and HSMR and SHMI, as well as other indicators of coding indices and quality.

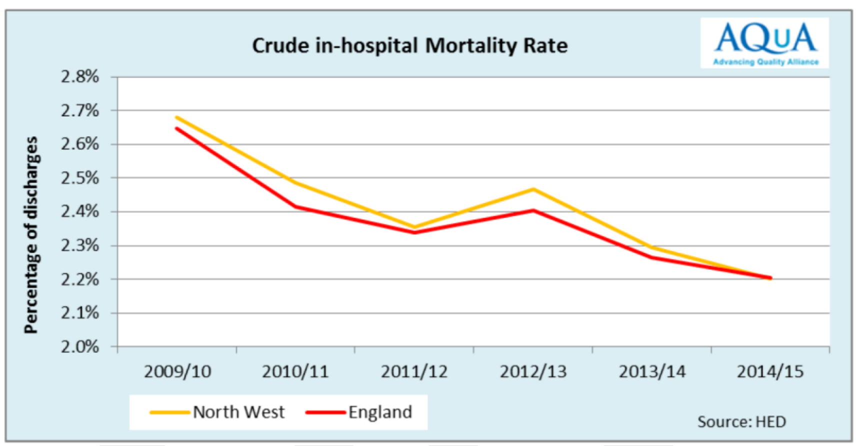
Internal:

- Mortality Dashboard/Indicators which includes internal information about the number of deaths in the organisation
- A six monthly narrative report from each Division based on mortality review
- Information from the Emergency Bleep meeting where we review emergency calls made

Performance

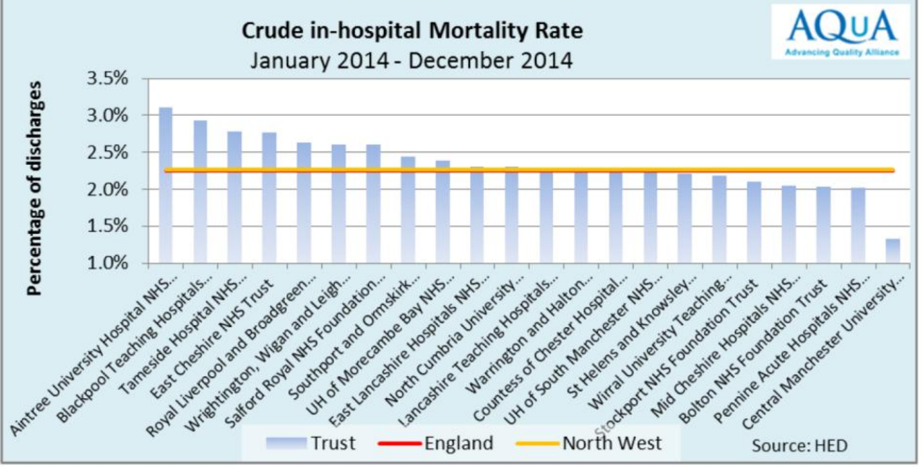
SHMI 98 HSMR 101

For the organisation overall, crude death rates (actual number of deaths presented as a percentage of hospital discharges) are decreasing, in line with those in England and the North West as shown below (AQuA analytics quarterly report September 2015)



Across the North West, the Central Manchester University Hospitals NHS Foundation Trust crude mortality rate is the lowest by some margin; (AQuA analytics September 2015).

Part of this we believe is due to the low mortality rates but some of it is also due to the fact that we have a large number of admissions and discharges in our children's and *maternity services which decrease the* percentage rate.



Local processes

In 2015/16 the Trust set out its mortality review processes in a comprehensive Strategy document. This strategy sets out the Trust approach to mortality and learning from mortality review over the coming years and is designed to support the objective of providing safe high quality patient care.

The aim of the strategy is to ensure that this Trust is a leader in quality of care, that this is evidenced to all and most importantly reflected in outcome measures such as crude mortality, HSMR and SHMI.

The Trust has defined clinical effectiveness as:

The provision of the highest standards of care based on sound evidence based practice, given in an environment which is safe, free from unacceptable risk and operating a constant dynamic of improvement

This can only be delivered where outcomes are transparent, accountability is clear and the commitment to clinical effectiveness is shared by all.

Our mortality strategy integrates with a number of other key strategies and work streams including the Quality strategy to ensure a cohesive and embedded approach to mortality reduction at all levels.

All deaths reviewed are graded to enable us to identify where specific improvements are required. The grades are as follows:

- Grade 0 – no suboptimal care
- Grade 1 – suboptimal care but different management would not have prevented the death
- Grade 2 – suboptimal care, different care might have made a difference (possibly avoidable death)*
- Grade 3 – suboptimal care, different care would reasonably have been expected to make a different (probably avoidable death)**

* *Grade 2 reviews will be fed back to the clinical team, actions undertaken and lessons shared*

** *Grade 3 reviews will be as above and reported to the Clinical Head of Division for further investigation and management*

The organisation has defined a number of types of deaths that must be reviewed formally, these are:

- 10% random sample to a maximum of 50 deaths in each Division
- All deaths where the patient is aged under 18
- All maternal deaths
- All neonatal deaths
- Any unexpected death
- Any death as a result of Venous Thromboembolism
- All deaths following elective surgery
- All deaths where the patient has MRSA
- Any death where the circumstances are subject to patient safety incident investigation
- Any death of a patient resulting from a ‘never event’

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- Any death graded at a 3 (see classification score above) following an Emergency Bleep Meeting
- Any death where a serious complaint has been received
- Any death of a patient who has a recognised learning disability

Themes
A review of themes from the divisional mortality reports shows slight variability across different clinical areas.

Themes include issues around specific aspects of care; poor documentation, failure to respond to early warning scores, documentation of fluid balance, preoperative assessment, delay in weekend assessment and treatment, delayed recognition of Acute Kidney Injury and non-communicating children. These areas all have on-going work programs to improve performance, with demonstrable improvement in several areas.

Internal analysis of week-end death rates has demonstrated small increases in over the last 3 years. However, within CMFT, patients admitted at the weekends, compared with weekdays; do not have an increased risk of death. Divisional mortality groups include consideration of this in their discussions.

Summary
The overall mortality figures for CMFT are stable although the aspiration of the organisation is for these to decrease and reflect an ever improving high standard of care. There remain issues of coding to address. A systematic approach to themes analysis, with sharing of this across the organisation, has led to interventions that will improve patient safety. This is facilitated by a standard reporting format and framework.

Learning from Clinical Audit to Improve Care

National Audit

National clinical audit is designed to improve patient outcomes across a wide range of conditions. Its purpose is to engage all healthcare professionals across England and Wales in systematic evaluation of their clinical practice against standard, to support and encourage improvement and deliver better outcomes in the quality of treatment and care. During 2015/16 Central Manchester University Hospitals NHS Foundation Trust participated in a number of the national clinical audits identified by the Healthcare Quality Improvement Partnership (HQIP).

National audit is divided into two main categories: snapshot audits [patient data collected over a short, pre-determined period) and those audits where data on every patient with a particular condition or undergoing specific treatment is included, for example patients who have had a stroke and patients who have treatment for certain types of cancer.

A total of 54 audits are listed on the HQIP database for inclusion in the Quality Accounts. There are 4 which we do not participate in as the service is not provided by the Trust which means that there were 50 national clinical audits and 2 national confidential enquiries covered by relevant health services during 2015/16. During that period the Trust participated in xxxx of national clinical audits and 100 % of national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Central Manchester University Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2015/2016 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

Title	Eligible ✓Yes ×No	Participating Site	% of Cases Submitted
Acute			
Adult Critical Care Case Mix Programme – ICNARC CMP)	✓	**CMFT**	**2267 (100%)**
Chronic Kidney Disease in Primary Care	×		
British Thoracic Society Emergency Use of Oxygen	✓	**MRI Trafford**	**31 (100) 9 (100%)**
National Emergency Laparotomy Audit	✓	**CMFT**	**192 (100%) Year 2**
National Joint Registry (NRJ)	✓	**CMFT** (April 14 – Feb 15)	
College of Emergency Medicine VTE Risk in Lower Limb Immobilisation (care in emergency departments)	✓	**CMFT**	**50/50 (100%)**
College of Emergency Medicine Procedural Sedation in Adults (care in emergency departments)	✓	**CMFT**	**100/100 (100%)**
Trauma Audit & Research Network (TARN)	✓	**MRI RMCH**	**Awaiting figure**
National Complicated Diverticulitis Audit (CAD)	×		**Rang 07952 552 615 Awaiting reply**
Blood Transfusion			
2015 Audit of Patient Blood Management in Scheduled Surgery	✓	**CMFT**	**46 (100%)**
2015 Audit of the Use of Blood in Lower GI Bleeding	✓	**CMFT**	**Email sent to Dr I Gall requesting figures**
2016 Audit of the Use of Blood in Haematology	✓		**Completion 18/03/16**

DRAFT

Title	Eligible ✓Yes ×No	Participating Site	% of Cases Submitted
	Cancer		
Bowel Cancer (National Bowel Cancer Audit Programme)	✓	**CMFT**	**191 (100%)**
Head & Neck Cancer (DAHNO)	✓	**CMFT**	
Lung Cancer (National Lung Cancer Audit)	✓	**MRI** **Trafford**	**143 (100%)** **68 (100%)**
Oesophago-gastric Cancer (National)	✓	**CMFT**	**177 (100%)**
National Prostate Cancer Audit	✓	**CMFT**	**588 (100%)**
	Heart		
Acute Myocardial Infarction (MINAP)	✓	**CMFT**	**776 (100%)** **January - September** Laura Seville –h hoping to have the Oct-Dec MINAP data completed mid-March
Adult Cardiac Surgery Audit (ACS)	✓	**CMFT**	**664 (100%)**
Cardiac Arrhythmia (Cardiac Rhythm Management Audit)	✓	**MRI** **Trafford**	**Awaiting information O Miskimin & Amir Zaidi**
Congenital Heart Disease (Paediatric Cardiac Surgery)	✓	**CMFT**	**Awaiting email Laura Seville**
Coronary Angioplasty (NICOR Adult Cardiac Interventions Audit)	✓	**CMFT**	**1522 (100%)**
National Heart Failure(HF)	✓	**MRI** **Trafford**	**271 (100%)** **January - September** **29/41 (70%)** **TGH Awaiting figure** Laura Seville -I am not sure about Heart Failure Oct - Dec, we have just appointed a new member of staff and she needs to get used to it first. The data needs to be completed around June 16 so it will be done by then.
National Cardiac Arrest Audit (NCCA)	✓	**MRI** **Trafford** **RMCH**	**Figure available after the 26th Feb.**
National Vascular Registry The repair of Abdominal aortic aneurysm (AAA).	✓	**CMFT**	**Submission 26.3.16**
National Vascular Registry Carotid	✓	**CMFT**	**Submission 26.3.16**

DRAFT

Title	Eligible ✓Yes ×No	Participating Site	% of Cases Submitted
endarterectomy.			
National Vascular Registry Lower limb angioplasty/stenting	✓	**CMFT**	On-going
National Vascular Registry Lower limb bypass	✓	**CMFT**	On-going
National Vascular Registry Lower limb amputation	✓	**CMFT**	On-going
Pulmonary Hypertension Audit	×		
Long Term Conditions			
National Adult Diabetes Audit	✓	**CMFT**	**3922 (100%) 2013/14 3967 (100%) 2014/15**
National Diabetes Foot care Audit	✓	**MRI Trafford**	
National Pregnancy in Diabetes Audit	✓	**CMFT**	**83/87 (95%) 4 patient's refused**
National Diabetes Inpatient Audit	✓	**MRI Trafford**	**171 (100%) 28 (100%)**
National Paediatric Diabetes Audit	✓	**RMCH Trafford**	**286 (100%) 79 (100%)**
The National Chronic Obstructive Pulmonary Disease (COPD) Rehabilitation Audit	✓	**CMFT**	**12 (100%)**
Renal Replacement Therapy (Registry)	✓	**CMFT**	
Rheumatoid and Early Inflammatory Arthritis	✓	**MRI Trafford**	**49 (unknown %) Awaiting Trafford figure**
Inflammatory Bowel Disease (IBD) Programme Biologics Audit	✓	**MRI Trafford RMCH**	**Data Submission 29/02/16**
Mental Health			
Prescribing Observatory for Mental Health (POMH)	×		
Older People			
Sentinel Stroke National Audit Programme	✓	**MRI Trafford**	
Fall and Fragility Fractures Audit	✓	**CMFT**	

DRAFT

Title	Eligible ✓Yes ×No	Participating Site	% of Cases Submitted
Programme (FFFAP). Hip Fracture			
Fall and Fragility Fractures Audit Programme (FFFAP). Inpatient Falls	✓	**CMFT**	
UK Parkinson's Audit (previously known as the National Parkinson's Audit	✓	**MRI** **Trafford**	**20 (100%)** **21 (100%)**
Women's & Child Health			
College of Emergency Medicine Vital Signs in Children (care in emergency departments)	✓	**RMCH**	**100/100 (100%)**
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE UK) • Maternal deaths eligible for notification are: **All deaths of pregnant women and women up to one year** following the end of the pregnancy (regardless of the place and circumstances of the death). • Perinatal and Infant Death	✓ ✓	**St Marys**	
Neonatal Intensive and Special Care (NNAP	✓	**St Mary's**	
Paediatric Intensive Care Audit Network (PICANet)	✓	**RMCH**	
British Thoracic Society Paediatric Asthma	✓	**RMCH**	Audit closes 28/02/16
UK Cystic Fibrosis Registry	✓	**RMCH**	? Data collection not started yet
Other			
Elective Surgery (National PROMS Programme)	✓	**MRI** **Trafford**	
National Audit of Intermediate Care	✓	**CMFT**	Awaiting figure Jan Barnes
National Ophthalmology Audit	✓	**MREH**	**Data collection not yet commenced**

DRAFT

Local Clinical Audit

Local clinical audits are carried out by doctors, nurses and other hospital staff. Audits can be done as part of training, for example by junior doctors, but they also take place to look at areas where patient safety is important.
Clinical audit is a way of ensuring what should be done **is** being done. Where the results of an audit are not satisfactory, the Trust requires that an action plan is put in place to make changes to services to improve patient care. When these changes have been made the audit is repeated to make sure that there has been an improvement.

Each year the Trust carefully plans which audits it wants to carry out. Important topics for audit are those areas in which we can improve patient safety and the quality of patient care. The plan also makes sure that we repeat audits where we did not meet our expected standard of care to see what improvements have been made. The Trust registered 409 clinical audits in 2015/16, which took place across all our divisions.

Most audits are carried out by collecting information from a patient's health record or by observing hospital staff perform their duties. For example, an audit of the Procedure Safety Checklist was undertaken by members of staff, observing their colleagues taking part in the safety processes.

Learning and Improving from Clinical Audit

This year we have implemented a new Clinical Audit Module, which enables us to track and monitor the completion of actions following clinical audit. Review of actions to date demonstrates the following levels of completion

	*Total Actions	% Current Actions Overdue
Clinical & Scientific Services	414	14%
Corporate	57	42%
Dental Hospital	106	1%
Manchester Royal Eye Hospital	84	8%
Medicine and Community	301	32%
R&I	6	100%
Royal Manchester Children's	259	14%
Specialist Medical Services	198	13%
St Mary's Hospital	213	14%
Surgery	114	11%
Trafford Hospitals	150	6%
Total	**1902**	18%

Here is some more detail about several of the individual audits which took place in 2015-16:

The Dental Hospital recognised a problem with who was responding to the emergency pager. They undertook an audit to find out what exactly was wrong and as a result of their findings they changed the way they organised their response. They repeated the audit later and their results were much better, showing that the changes implemented had been successful. This was a good example of identifying a potential problem by using a clinical audit and demonstrating change. The staff involved will share the lessons they learned

through an article in a Trust newsletter and as a poster at an exhibition of audits later in the year.

The Emergency Department repeated an audit on Sepsis. This was important because Sepsis is a potentially life-threatening condition and it is key to take the right steps to tackle the infection quickly. After the last audit the department made changes to improve the way they recognised and responded to patients with severe sepsis by introducing a training program and a new method of communication. They wanted to repeat the audit to see if these changes had worked.

The staff leading the audit collected information on all the patients who had been treated for Sepsis in the month of September. From the results of the audit they could show that the changes were having an impact. A third more patients were being treated in the time necessary and their work meant that the department had reduced the mortality of patients with sepsis and the length of time they stayed in hospital. There was still more work to be done in this area and the staff involved intend to conduct a third project later in the year.

More case studies to add…

National Confidential Enquiries (NCE)

During 2015/16 national confidential enquiries covered relevant health services that Central Manchester Foundation Trust (CMFT) provides.

During that period CMFT participated in 100% national confidential enquiries which it was eligible to participate in. The national confidential enquiries that CMFT was eligible to participate in during 2015/16 were:

- Mental Health study
- Non Invasive ventilation

The national confidential enquiries that CMFT participated in during 2015/16 were:

- Mental Health study
- Non Invasive ventilation

The national confidential enquiries that CMFT participated in, and for which data collection was completed during 2015/16 are listed below alongside the number of cases submitted to the enquiry as a percentage of the number of registered cases required by the terms of the enquiry.

NCE Study	Eligible	Participated	% Submission	Status
Mental Health study	Yes	Yes		On-going
Non Invasive ventilation	Yes	Yes		On-going

DRAFT

Outcomes
The reports of two studies were received and have both been reviewed by the Trust. These were the reports of Gastrointestinal bleed and the Sepsis study, published July 2015 and November 2015 respectively. The trust has undertaken a gap analysis on the recommendations from both reports and where applicable, actions are being taken to address any gaps identified. Some examples of these are

Research

We are dedicated to continuously improving the way we conduct our research whilst providing all patients with better access to clinical studies.

We undertake research in a diverse range of clinical areas across our eight hospitals, regularly recruiting the first global patient into a study.

In 2015/16 we carried out a programme of work to ensure that research is accessible to all patients. We developed a recruitment strategy for all staff, which provides the tools to develop robust and successful approaches for recruiting patients to studies. This was complimented by a workshop delivered to research staff which focused on improving recruitment and retention of Black, Asian and Minority Ethnic patients to clinical studies, ensuring research is accessible to all.

We have also worked to streamline our research processes to enable improved set up of clinical studies, whilst maintaining robust governance procedures. This means we can provide patients with better access to clinical studies as part of their clinical pathway.

We're proud to share the positive impact research has for our patients. In 2015 we launched our patient stories campaign, which saw patients from across different ages and backgrounds share their stories of how being involved in research has helped transform their care.

Manchester is leading the way for research and innovation

An analysis published by the National Institute for Health Research (NIHR), placed CMFT in the top 10 research active hospitals in the UK, which confirms our position as a national leader in research and innovation. This is in tandem with Manchester's growing presence in the national healthcare agenda through Devolution Manchester and increased partnership, working across NHS Trusts through networks such as the Manchester Academic Health Science Centre (MAHSC).

You can learn more about the impact of our research, including inspirational stories from our patients in our Annual Report [Pls insert page no]; www.cmft.nhs.uk; or follow us on Twitter (@CMFT_Research).

As host of the NIHR Clinical Research Network: Greater Manchester, and through our representation on the strategic and management boards of the Greater Manchester Academic Health Science Network (GM AHSN), we are also helping bridge the gap between regional NHS organisations, industry and academia to support the UK's health and wealth agenda.

Medical Education and Library Services - Undergraduate Medical Education

CMFT, in partnership with Manchester Medical School, train over 400 undergraduate degree students each year on site. The medical degree is a 5 year course at the University of Manchester. During the past academic year, the Undergraduate Medical Education Team organised clinical placements and a range of other teaching sessions.

We recently received recognition of our clinical skills teaching and resources by the General Medical Council (GMC). During a regional visit to CMFT they noted the Trust's commitment to developing students' clinical skills and published a case study through their main Sharing good practice webpage http://www.gmc-uk.org/education/27707.asp

Formal teaching sessions supplement the direct patient contact time for our medical students, and provide depth and breadth to learning. During the last academic year, over 3,500 separate teaching sessions were delivered by a range of staff across the Trust. 94% of all planned sessions were successfully delivered. This academic year, 99.21% (125) of our 5th year medical students passed their final year exams to successfully complete their degree course.

Caption: Medical students at their graduation. Caption: 94% of planned undergraduate teaching sessions where delivered as planned.

Postgraduate Medical Education

After completing a medical degree, our doctors undertake a 2 year Foundation Doctor training placement. This is followed by a number of years working as a Specialty Trainee either in our hospitals or in linked General Practices.

The annual General Medical Council National Training Survey told us that we were in the top 10 nationally for trainee satisfaction in the following specialties:

- *Genitourinary Medicine*
- *Child and Adolescent Mental Health*
- *Respiratory Medicine*

We also had some areas to improve on such as:

- *Diabetes and Endocrinology*
- *GP training in Obstetrics & Gynaecology*
- *Acute Internal Medicine*

We have been working closely with our external stakeholders (Health Education North West) and our staff in those departments to improve the experience of our junior doctors. The Postgraduate Medical Education Team will continue to work collaboratively with its trainees and trainers to promote and improve its practice and deliver a high quality training programme for doctors at all levels. The team remains committed to delivering educational outcomes that will enhance the future of its trainee doctors and, through them, improve the quality of patient care.

The Trust's Medical Education Team walked away from the first Developing Excellence in Medical Education Conference (DEMEC) in Manchester with four awards for their posters, voted for by more than 700 conference delegates.

demec
Developing Excellence in
Medical Education Conference

Allison Booth of the Undergraduate Medical Education Team and Karen Stuart, of the Postgraduate Medical Team, shared top honours in the e-learning category with their respective posters: 'A pilot study of the use of video-conferencing technology in Medical student welfare' and 'Smart solutions using web-based induction for trainees'. In the continuing professional development category, Dr Margaret Kingston took the prize with, 'Developing effective role modelling skills in doctors' and Professor Simon Carley, won the global perspectives category with colleagues from the UK, Australia and Sweden with, 'Are there too few women presenting at emergency medicine conferences?'

Professor Robert Pearson, Medical Director commented: "there were 268 poster entries and for our Medical Education Team to be awarded 'Peoples' Choice' in 3 out of 7 categories is hugely impressive. This showcases the knowledge, expertise, skill, ingenuity and hard work of our Medical Education Team in the development and training of doctors.

Library Services

The CMFT Library Services provides a service to all staff and students on clinical placement. In 2015/16 the library service achieved an accreditation score of 90% against national standards. This was an increase of 16% from 2014/15. The library service underpins education and training by providing access to the latest knowledge, information, and evidence published in the disciplines of medicine, nursing, and allied health.

This year the library team successfully bid to Health Education North West to improve the quality of the textbooks to support examination revision for undergraduate finals and professional examinations for medical trainees.

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This year the library has developed a Clinical Outreach services sourcing the latest evidence and guidelines for our CMFT Clinicians, this has resulted in over 400 searches of the medical literature. The library team also supported a number of research studies including the Stillbirth Priority Setting Partnership working with St Mary's Hospital and the Maternal and Fetal Health Research Centre, University of Manchester. This work resulted in a presentation at the 2015 International Clinical Librarians Conference in Edinburgh.

Medical Appraisal

What 90% of doctors to have had a completed annual appraisal

When March 2016

Outcome Met standard/did not meet standard for full year

Progress

Medical revalidation was introduced by the General Medical Council (GMC) to provide assurance to patients, the public, and employers that doctors are up-to-date and fit to practice and to contribute to the on-going improvement in the quality of medical care delivered to patients. Medical appraisal is at the heart of revalidation; it is where a doctor's performance is reviewed against four areas that are set out by the GMC. These are:

- knowledge, skills and performance
- safety and quality
- communication, partnership and teamwork
- maintaining trust

All licensed doctors at CMFT, along with all other doctors in the UK, are required to have an annual appraisal with supporting information collected about their work, including feedback from patients, doctors, nurses and other colleagues. In 2015/16, we had a big drive on appraisal with good success and have developed a robust system of appraisal and clinical governance that supports our doctors in preparation for revalidation. CMFT's doctors use the Trust's electronic appraisal system to store their appraisal documents. This system tracks every doctor's appraisal, making it easier for them to store information that will help to demonstrate they meet the required standards.

To further support the monitoring and management of appraisal at CMFT, the Trust also sends quarterly and annual appraisal and revalidation reports to NHS England, using the Framework for Quality Assurance (FQA) and Annual Organisational Audit (AOA) respectively. A paper is also presented annually to the Trust Board, highlighting the results of the AOA and any actions that are required to improve the appraisal and revalidation process.

Patient Experience

Patient experience feedback provides a rich source of data to support continuous improvement of the Trust's services. Patient feedback is sought and received through a range of formats.

Examples of patient involvement in 2015/16 include:

Trafford asked to write 100-200 words detailing the aim of the projects and outcomes for 2015/16

Open Visiting

MREH

'We're Listening… We're Improving' @ Manchester Royal Eye Hospital

Manchester Royal Eye Hospital has always been at the forefront of patient engagement. This year we have taken another step forward and taken a more collaborative, blended approach to both patient engagement and service transformation. For us it has always been important to ensure that patient feedback directly drives improvements to our service.

New and dedicated roles in the hospital, including a business manager and an experience & quality lead, are combining forces and developing relationships with corporate teams to spur innovation and public participation. Patient and staff experience research from an array of sources has been completely blended into a single, coherent and ambitious vision. The evidence comes from our numerous patient listening events, assessments against outpatient and elective standards, filmed interviews and an experience-based co-design event. We've actively engaged with hundreds of patients this year.

The ethos of the Manchester Royal Eye Hospital's ***We're Listening… We're Improving*** campaign extends to patients, their carers and our staff. The significant weight of blended evidence is now driving a long-term programme to overhaul the processes by which our outpatient department functions.

Pushing Manchester Royal Eye Hospital right to the top of the *Ladder of Participation*, we are inviting patients to join forces becoming co-producers of our services. In this way patients make a regular commitment to working groups implementing positive change.

St Mary's currently writing 100-200 words detailing the aim of the projects and outcomes for 2015/16

Their example will be related to:

The maternity team have used the IQP methodology and the EBD questionnaire approach to improve the patient experience around the maternity visiting policy. This was triggered by a series of complaints both formal and informal and challenges on the wards where different midwives would 'manage' situations differently. An initial patient consultation was undertaken and a pilot scheme introduced to 'test' the water, some changes in IOL Bay were immediately introduced. A second Consultation has just been undertaken to test patient and visitor satisfaction with the revised policy, and taking into account concerns raised by staff and a final readjustment of the policy will be completed and the Maternity Visiting policy will be ratified at the Obstetric Clinical Effectiveness Meeting.

DRAFT

CSS will need rewording

Patient & Carer Forum:

The Adult Critical Care Service at CMFT has led on a Network initiative and established a Patient & Carer Forum which is chaired by an ex patient. As part of this initiative a Network helpline based at CMFT has been set up. As well as improving patient/carer information through filmed patient stories and leaflet information, a few afternoon tea events have also taken place at a café in Didsbury.

Surgery School: If one example I think this is the best?

This is a patient focused education forum aimed at preparing patients for surgery and teaching them the techniques to reduce postoperative pulmonary complications including use of incentive spirometry, coughing and deep breathing exercises, oral hygiene and patient information. Patients scheduled for major elective surgery are invited to attend a 1 hour educational session which is delivered by a multidisciplinary team. The session also includes a visit to the critical care units which provides an excellent opportunity to see the environment in which they will be cared for, meet staff and ask questions and share their worries and concerns.

Since the start of the project the incidence of post-operative pneumonia has reduced by around 48%.

Surgery School Clinics A3.pdf

R & I asked to write 100-200 words detailing the aim of the projects and outcomes for 2015/16

EBD project in the CRF to gain patient views on their experience of taking part in research

Division of Medicine and Community

Improving the healthcare experience for patients who have a learning disability and or autism Title agreed and asked to write 100-200 words detailing the aim of the projects and outcomes for 2015/16

Divisions not yet responded

Division of Surgery

Division of Specialist Medical Services

RMCH

UDHM

Patient Experience for Patients and Families affected by Cancer

During the year cancer teams have continued to engage with patients and carers who are living with or affected by cancer.

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Cancer –Supporting people living with or affected by cancer.

Cancer – Involving patients in the co - design of services for patients living with or affected by cancer following treatment.

Next Steps

To build on the success of already established improvements that have been made and to provide a structure to engage with all staff to continue to develop excellent patient experience, a new and innovative, value-based **Patient Experience Framework** is being developed.

The new **Patient Experience Framework** will align key strategies and will recognise the interconnection of patient and staff experience. Effective leadership and good communication structures will be fundamental to successful delivery, and frontline leaders will be placed at the heart of driving patient experience, supported and coached by senior leaders.

The Trust's 2014 Staff Survey has shown that staff motivation is above average when compared to other organisations. Research commissioned by the Association of UK University Hospitals' HR Forum has demonstrated a causal relationship between staff motivation and patient satisfaction. Need to check we can quote this The Trust is therefore well placed to harness this high level of staff motivation to support improvements in Patient Experience.

The Patient Experience Framework will be underpinned by the following key principles:

- Patient and staff experience are intrinsically linked;
- Frontline leaders are champions for Patient Experience;
- Patient Experience is the responsibility of every member of staff;
- Multi-professional engagement in development and delivery of the Framework is essential;
- Individual needs, values and preferences must be respected;
- Patients are active partners in care;
- Environments of care must be conducive to supporting delivery of dignified, healing, compassionate and age appropriate care;
- Effective information, communication and education underpins patient and staff experience;
- Emotional and spiritual support and involvement of friends and family enhance patient experience;
- Patient and staff experience feedback must be sought through a variety of mechanisms most suited to individual preferences.

Through extensive engagement and consultation with patients and with all staff groups, **the Patient Experience Framework** will define the elements that make a **patient's experience excellent** and the factors that **motivate staff to drive improvement.**

Leadership, at every level, will form a thread through the **Patient Experience Framework,** from strategic alignment and support by the Board of Directors to front line leaders championing patient experience in their area.

Skills training will be developed and delivered to all staff to ensure that everyone in the organisation is equipped and empowered to drive improvements in patient experience and measures will be established to monitor our success.

The findings from patient experience feedback, such as National Patient Surveys, the Friends and Family Test and Patient Experience Tracker surveys will be drawn together along with the introduction of additional methods to monitor progress, and a communication framework has been developed to ensure that frontline staff know what patients say about their experience of the Trust's services, have clear routes to share their ideas for improvement and have authority to drive change locally.

Personal accountability will be core to the delivery of the **Patient Experience Framework** and will be reflected within the appraisal process and in personal development plans.

Ward Accreditations

The annual Ward Accreditation process was launched in 2011, as part of the Trust's assurance mechanisms for ensuring high quality care and the best patient experience. The process, which is underpinned by the Trust's values and behaviours framework and the Nursing and Midwifery Strategy, includes inpatient wards, day case areas, critical care areas, dialysis units and for the first time in 2015/16 Emergency Departments.

Annual unannounced Accreditations are conducted by teams comprised of a Director or Deputy Director of Nursing, a Head of Nursing and a member of the Quality Improvement Team. The accreditation team undertake a half day observation visit to the clinical area, informed by analysis of a range of data relating to the area, including audit data, the quality dashboard, complaints, incidents, compliments and student feedback. Discussions with patients and staff are also key element of the process.

The Ward Accreditation process aims to provide a level of assurance for the Board of Directors, that areas are consistently delivering high quality care across four main categories. The categories have remained constant since 2011, but the standards required within each category are reviewed annually to ensure that they remain current and relevant. An example of a recent change in 2015 is the inclusion of a section on safer staffing.

The categories are as follows:

- **Culture of Continuous Improvement:** including leadership, team culture and use of evidence based practice and safer staffing.
- **Environment of Care:** including infection control, accessibility and safety standards.
- **Communication About and With Patients:** including team communication, documentation and patient perceptions.
- **Nursing Processes:** including medication management and the meals service.

Each category is scored using standard criteria as White, Bronze, Silver or Gold, with the collated scores providing the overall Ward Accreditation result for the area. This result is validated by the Directors and Deputy Directors of Nursing to ensure consistency in approach.

The criteria for each of the scores are as follows:

- **Gold:** Excellent, achieving highest standards with evidence in data that success sustained for at least six months.

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- **Silver:** Very good, achieving minimum standards or above with evidence of improvement in relevant data.
- **Bronze:** Good, achieving minimum standards or below but with evidence of active improvement work.
- **White:** Not achieving minimum standards and no evidence of active improvement work.

All areas are supported to continuously improve and when wards/departments achieve gold, this success is formally recognised by the Chief Executive, Chief Nurse and senior divisional staff who attend the area to present the certificate. In addition, a small team is invited to the annual We're Proud of You Gala dinner where a wall plaque is presented to the team by the Chairman.

Insert Ward Accreditation Results Insert final results for 2015 – 2016

Table: Ward Accreditation Results 2015 /2106

	2015	
	Number	%
Gold		
Silver		
Bronze		
White		

Add photos of awards being presented at the N+M conference

Patient Experience Improvement Initiative

At the beginning of 2015/2016 in order to support and spur innovation, prizes of £10k and £5k to fund patient experience improvements were introduced in recognition of areas that demonstrated the most improvement in the quality of patient experience. The aim of the initiative was to engage clinical teams to demonstrate and sustain success.

The winning teams for 2015/2016 were:

- **Ward 62 (St Mary's Hospital)**
- **Central Manchester District Nursing Service and Intermediate Care Nurses**
- **Infant Feeding Team**

Need to add what they have spent the prize money on?

DRAFT

Developments for 2016/2017

The Accreditation process is a well embedded assurance mechanism in inpatient areas that has been demonstrated to drive continuous improvement across the Trust's services as well as recognising and valuing excellence.

This year Accreditation processes were introduced into the Trust's Emergency Departments and processes have now been developed for, Outpatient areas, Clinical Research Units, and Theatres and will be undertaken in 2016/17.

CMFT provides a wide range of services both in the acute and community settings, engagement with community-based staff to develop plans for the creation of an appropriate accreditation process for community services will also take place in 2016/17.

In order to further embed sustained and continuous improvement and to enable teams to collate their achievements an ***Accreditation Portfolio*** has been developed and will be introduced in 2016/17.

Teams will collect and display evidence in the ***Accreditation Portfolio*** throughout the year, in line with each of the Accreditation Categories, demonstrating their improvement journey. The electronic database of evidence will be reviewed by the accreditation team at a number of points over the course of the year in addition to an annual Ward Accreditation observation visit. This approach will add a further tier of assurance into the process and provide a database of best practice, which can be shared and spread across the organisation.

Friends & Family Test (FFT)

The Friends and Family Test (FFT) is a single survey question which asks patients:

'How likely are you to recommend our service to friends and family if they needed similar care or treatment?'

Insert Picture of Nurse providing electronic tablet to patient to complete FFT

The FFT survey question was launched in 2013 and initially feedback was asked of adult patients who attended Accident and Emergency Departments, received inpatient care and all women using Maternity Services.

In 2015, the inclusion criteria were expanded to include patients using the community, outpatients, and mental health services. Separate processes to capture feedback from children and young people and their parents were also included and the requirement to capture 'narrative comments'.

The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.

FFT is a quick and simple survey used to collect feedback from patients. One of the advantages of FFT over other patient feedback tools is that patients are able to provide feedback in near real time making results available to staff quickly. This allows timely action to address poor experiences and celebrate and promote good practice. A variety of methods are used to display results and any action taken based on the feedback is displayed in a number of formats that include 'You said….We Did' posters and 'Tops and Pant' displays in children's services.

Insert photo of 'You said….We Did' posters, "Tops and Pants" displays

Ensuring collection methods are available and suitable for those areas new to FFT collection, has required a whole system review of the different needs of each patient group, types of collection methods available and required and how reports are generated and accessed. This work, completed in 2015/16, will provide a platform to increase response rates and capture 'narrative comments' that can be used to make further service improvements to improve patient experience.

Add year end data

Table: FFT Response and Results

Area	Response Rate	Percentage of patients who were' likely' and' extremely likely 'to recommend our services
Inpatients*		
Emergency Departments*		
Outpatients	**N/A**	
Community	**N/A**	
Maternity	**N/A**	
Children and Young People	**N/A**	

*Target Response Rates have not been set in 2015-16. In 2016/17 the target response rate has been set at 40% for inpatients and 20% for all other areas.

Add narrative to provide analysis of the year end data

DRAFT

Food and Hydration

Complaints, Concerns, Compliments & the Complaint Handling Service

The Patient Services team continues to build upon the comprehensive review of the Trust Patient Advice and Liaison Service (PALS) that commenced in 2014/15. During this financial year, efforts have continued to improve complaint acknowledgement and response times and to work towards on-going improvements in quality across the Trust's services.

Formal Complaints, PALS Concerns and Compliments

The availability and quality of complaints data and reporting has improved during the year, allowing the Corporate team and the Divisions to gain further insights into the common causes of complaints and how we can use this data to drive improvements, both in the services we provide and in our complaints handling processes.

The Trust publishes in-depth quarterly complaints reports and an annual complaints report. The reports include a wide variety of information regarding Formal Complaints, PALS Concerns, and Compliments and how we use the learning from these to make improvements and celebrate achievements. Table 1 provides a comparison of the number of Formal Complaints, PALS concerns and Compliments received by the Trust for the past 4 years. Table 2 presents this data for Formal Complaints in the context of the clinical activity undertaken within the Trust and Diagram 1 presents the top 12 themes for Formal Complaints during 2015/16.

Table 1 Formal Complaints, PALS concerns and Compliments

	2012-13	2013-14	2014-15	2015-16
Formal Complaints	1044	1112	1023	
PALS Concerns	2777	2768	3573	
Compliments				

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Table 2 Formal Complaints received in context of Clinical Activity

		2014-15	2015-16
Inpatients	Formal Complaints received(FC)		
	Finished Consultant Episodes (FCE)		
	Rate of FCs per 1000 FCEs		
Out-patients	Formal Complaints received (FC)		
	Number of appointments		
	Rate of FCs per 1000 appointments		
A&E	Formal Complaints received (FC)		
	Number of attendances		
	Number of FCs per 1000 attendances		

Brief narrative relating to the content of Table 2 will be added once we have the data.

Diagram 1 Diagram 1 will be updated at the end of the year.

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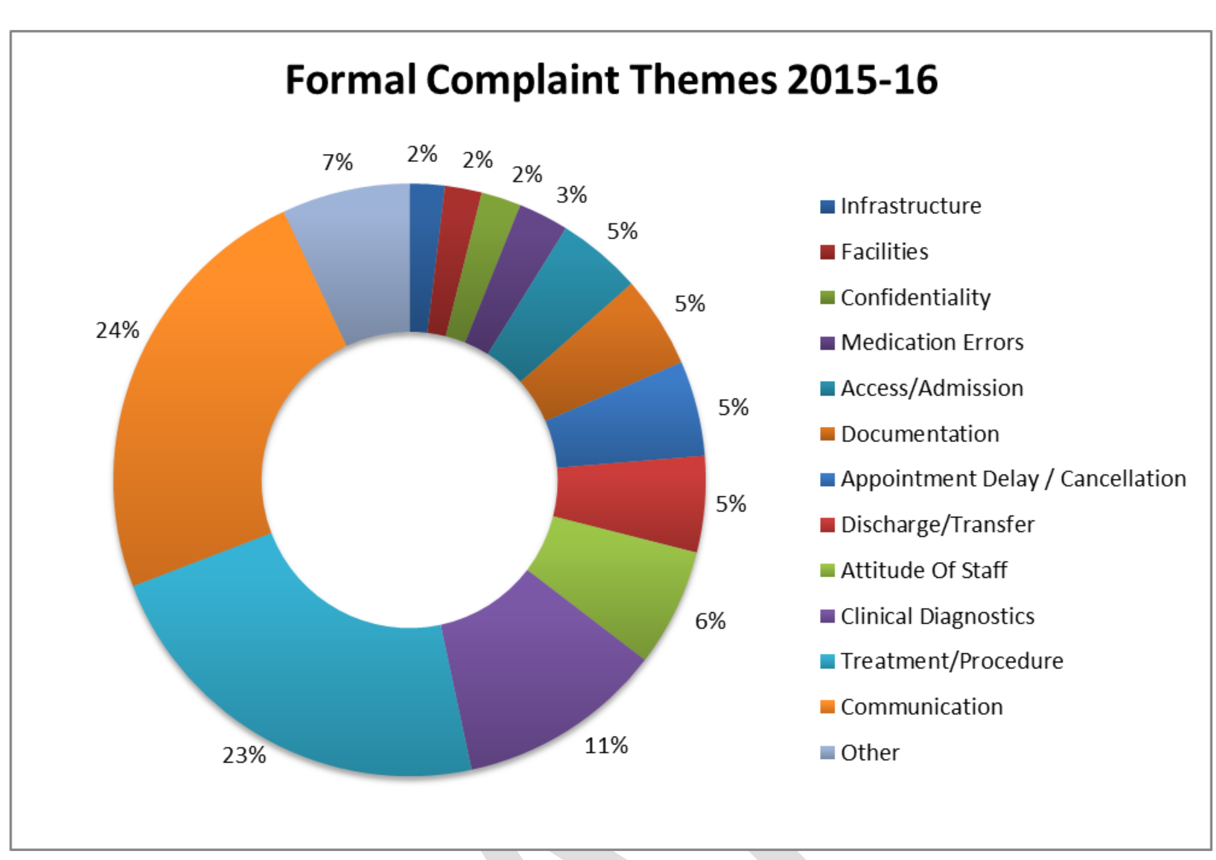

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Parliamentary and Health Service Ombudsman (PHSO)

Following completion of the local resolution process for a complaint (i.e. an appropriate level of investigation and response by the Trust), if complainants remain dissatisfied, they can ask the PHSO to investigate their complaint and its handling by the Trust. Table 3 shows the number of Trust complaint cases closed 2015/16 or under on-going investigation by the PHSO at the end of 2015/16.

Table 3 Closed and current PHSO cases

	Current cases under investigation at end of 2015/16	Closed cases	Number fully-upheld	Number partly-upheld	Number not-upheld
2015-16					

During 2015/16, the PHSO published numerical data on all the complaint cases it reviews, investigates and either up-holds, partially-upholds or does not uphold. Table 4 shows the numbers of cases in these categories from CMFT compared to other Shelford Group NHS Trusts. The final two columns set this data against the clinical activity of the trusts.

Table 4

2014-15	Enquiries received	Enquiries PHSO accepted for investigation	Investigations fully or partly upheld	Investigations not upheld	Enquiries per 10,000 clinical episodes	Enquiries accepted per 100,000 clinical episodes
Cambridge University Hospitals NHS Foundation Trust	73	15	10	10	2.64	5.43
Oxford University Hospitals NHS Trust	78	11	5	6	1.92	2.71
University Hospitals Birmingham NHS Foundation Trust	99	24	10	9	4.34	10.52
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	101	37	14	20	2.04	7.47
Guy's and St Thomas' NHS Foundation Trust	101	16	9	6	2.72	4.31
Central Manchester University Hospitals NHS Foundation Trust	**129**	**24**	**5**	**8**	**3.24**	**6.04**
University College London Hospitals NHS Foundation Trust	131	19	3	11	3.41	4.95
Sheffield Teaching Hospitals NHS Foundation Trust	135	29	3	20	2.75	5.91
Imperial College	150	26	14	8	3.95	6.84

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Healthcare NHS Trust						
King's College Hospital NHS Foundation Trust	183	24	11	6	3.85	5.04

Patient feedback via Patient Opinion, NHS Choices and Healthwatch

During 2015/16 the Trust increased its responsiveness to patient feedback that is posted on three patient feedback websites. When a patient or member of the public posts either positive or negative feedback on patientopinion.org.uk, NHS Choices or healthwatch.co.uk these posts are sent to the respective clinical division for investigation (if appropriate) and to provide feedback. The learning from this feedback can then be fed into local teams and any identified improvements to service can be made. As part of this work, the Trust increased its subscription level with Patient Opinion which allows multiple users to post feedback directly within the site and therefore provides a much more responsive service.

Tell Us Today

The 'Tell Us Today' service provides in-patients with a central telephone number by which they can access a senior member of staff, within the hospital, within an hour. This enables swift, local resolution of any concerns which can be dealt with prior to them escalating into more formal complaints. The service to date has been rolled out in all in-patient areas and of the calls received, only a very small percentage have been escalated into formal complaints. The types of call are logged and monitored to ascertain any emerging common themes that demonstrate an area for improvement.

PALS and Complaints developments ***Picture of pals leaflet to be added***

During 2015/16 there have been a number of developments within the PALS and Complaints Service. A new Trust Complaints, Concerns and Compliments Policy has been published along with two new PALS leaflets, one of which is an easy-read version. In addition to this, the external PALS and Complaints website has been updated and is now located via a link from the Trust homepage (one click away). As part of this work, a selection of 'lessons learned' from complaints have been published on the website and a new quarterly newsletter entitled, **'Patient Experience Matters'** has also been published within the Trust to share learning from complaints.

In November 2014, the PHSO, Healthwatch and the Local Government Ombudsman jointly published **'My Expectation for Raising Concerns and Complaints'**. This document provides trusts with a framework for a user-led vision for raising concerns and complains and is based upon the five steps of the complaints process. The five steps are:

- Considering a Complaint;
- Making a Complaint;
- Staying Informed;
- Receiving Outcomes and;

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- Reflecting upon the Experience

The framework is based upon the experiences of users of complaints services and explicitly states how a quality service should operate.

Further to this, NHS England published 'Assurance of Good Complaints Handling for Acute and Community Care – a toolkit for commissioners', in November 2015. This document outlines how Clinical Commissioning Groups might assure the quality of the complaints procedures in the Trusts from which they commission services.

The Patient Services team has therefore used both these publications to undertake a review of the PALS and Complaints processes within the Trust. This work, carried out in conjunction with managers, staff and users of the service, will inform the PALS and Complaints development and improvement programme for 2016/17.

PALS office move

During 2016, work started on the design phase to relocate the PALS office from a corridor at the rear of the Manchester Royal Infirmary to a new, central, more visible location at the New MRI Entrance. The area identified for the move, which was previously a shop, is being re-fitted to house a new PALS office and the adjacent reception desk will also be re-fitted and staffed as part of this relocation. Building work is due to be completed by June 2016.

Education Programme

A programme of education for PALS Case Managers, Divisional Complaints Coordinators and other key staff directly involved in responding to complaints was developed and delivered in 2015/16. The programme included sharing and learning from complaints across divisions, a master-class on writing letters and summarising meetings with complainants and a session developing bespoke reports within the Safeguard complaints management system. A further programme is currently under development for 2016/17 and provisionally includes mediation skills development, further sessions on writing high quality complaints responses and an educational session from the PHSO.

Next Steps

The Patient Service Team will continue to develop and improve our complaints handling process in line the **Patient Experience Matters** branding to ensure that a user-led service is truly provided to complainants.

John's Campaign

Learning Disability

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Other News

Manchester Acute Kidney Injury Strategy (MAKIS)

A Quality Improvement Programme to reduce the incidence and impact of AKI in CMFT.

Acute kidney injury (AKI) is a rapid reduction in kidney function resulting in difficulties in clearing excess water, electrolytes and toxins. It is very common amongst patients admitted in hospital. AKI occurs in 1 in 5 patients in most UK hospitals including ours. Whilst two thirds of these patients come to hospital with AKI (community acquired), a significant proportion is still developed during their inpatient stay (hospital acquired AKI).

AKI has significant consequences including **prolonged hospital stay**, increased risk of long term **kidney damage (chronic kidney disease)** and significantly **increased risk of death**. A local audit at our hospital in 2013-14 exposed significant deficiencies in the identification, management and follow up of AKI cases. In recognition of this, the Trust setup an AKI team **(Manchester Acute Kidney Injury Team- MAKIT)** tasked with addressing this important clinical issue.

MAKIT aimed to achieve the following key objectives by end of 2015:

- **Improvement in AKI detection:** 100% recognition of all AKI cases within 24 hours
- **Improvement in fluid and drug management in AKI:** 95% appropriate management
- **Reduction in new cases (incidence) of AKI:** 10% reduction in total number of cases of AKI
- **Reduction in length of stay (LOS):** 10% reduction LOS of patients with AKI
- **Shortening time to recovery:** 20% reduction in "AKI days" (the total number of days spent in AKI)

To achieve these, a multifaceted AKI quality improvement programme was implemented. Key aspects of this include

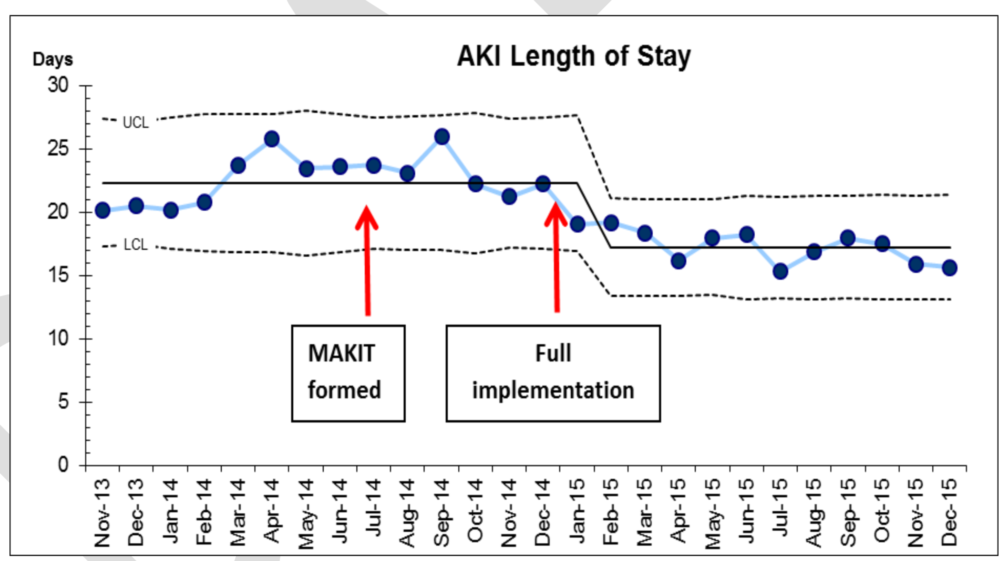
- The development and implementation of a bespoke **electronic alerts system for AKI**. This system outperforms other such alerts developed elsewhere by detecting 100% of cases of AKI
- The development and implementation of a 10 point simple **Priority Care Checklist (PCC)** to improve reliability and consistency of AKI care.
- A multipronged **awareness and education programme** using various media and methods
- The use of two AKI **clinical nurse specialists** to assist ward teams
- Setting up of **a network of pharmacists** to assist with AKI notifications and medication reviews

The monitoring of AKI management and patient outcome data over the past two years shows significant improvements in all the above key metrics as shown in the table. **These improvements have resulted in 60 fewer AKI cases and 6 fewer deaths per month.** MAKIT has won several local and national awards for its achievements.

Key metrics, targets and current attainment

Metric	Targets by 31/12/15	Attainment/ Reduction
AKI Detection	95%	100%
Fluid Assessment	95%	100%
Drug Review	95%	99%
AKI incidence	10% Reduction	18%
AKI LOS	10% Reduction	22%
AKI Days	20% Reduction	28%
AKI Deaths	10% Reduction	13%

The LoS graph show convincing reduction from 22.3 days previously to 17.2 days since hospital wide implementation in Feb 15 (23% reduction).



In 2016, MAKIT plans to consolidate and sustain these interventions and improvements across all areas of CMFT including Trafford but also to assist other hospitals across greater Manchester in implementing similar AKI improvement programmes.

MAKIT members receiving their Improvement Science Certificates from Professor Peter Trainer of Manchester Academic Health Sciences Centre (MAHSC)
From left: Robert Henney, Susan Heatley, Marc Vincent, Rachael Challiner, Leonard Ebah, Peter Trainer , Prasanna Hanumapura and Deryn Waring.

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End of Life Care

'We will ensure that all patients under the care of CMFT, and their families and carers, receiving palliative and end of life care are listened to and cared for compassionately by staff with the right skills. We will adhere to best practice guidance where available, and deliver holistic patient centred care that recognises individual circumstances and addresses diverse needs. '

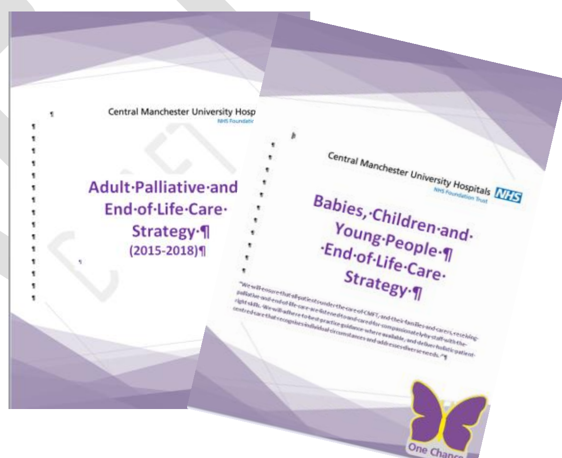
Trust End of Life Care Strategy (2015)

Progress 2015-16

There has been a significant amount of work undertaken by Trust staff during 2015-16 to improve end of life care for our patients during the last year of life and following death. This includes:

- Publication of the Trust End of Life Care Strategy 2015-18. This sets out our aims and plans for end of life care over the next 3 years.

- The Trust steering group was revised to establish a separate Children/Young people and adult palliative and end of life groups with revised terms of reference. The work of these groups is underpinned by a comprehensive work plan, aligned to national and evidence based requirements, in order to deliver improvements in the patient and carer experience.



- Implementation of the Adult Priorities for Care for the Dying Person individualised care plan and communication record across acute wards and community settings. This has been supported by a rolling programme of training for staff in all areas of the Trust and is included as part of the annual clinical mandatory training requirements.

- The Trust Spiritual Care Team has extended its service to our patients living in our local community.

- The Trust has invested to provide a substantial increase in the number of syringe drivers available across acute and community settings in order to improve symptom management for patients.

- The Trust is working with central Manchester CCG to deliver the EPaCCS (Electronic Palliative Care Co-ordination System) to improve the communication between health care professionals and support patients' wishes at end of life. Work will continue during 2016-17.

- On-going development of clinical pathways to optimise quality of life for patients at end of life through the provision of intravenous/subcutaneous treatments at home.

- 79% of adult patients known to the community Macmillan specialist palliative care team were supported to die in their place of choice.

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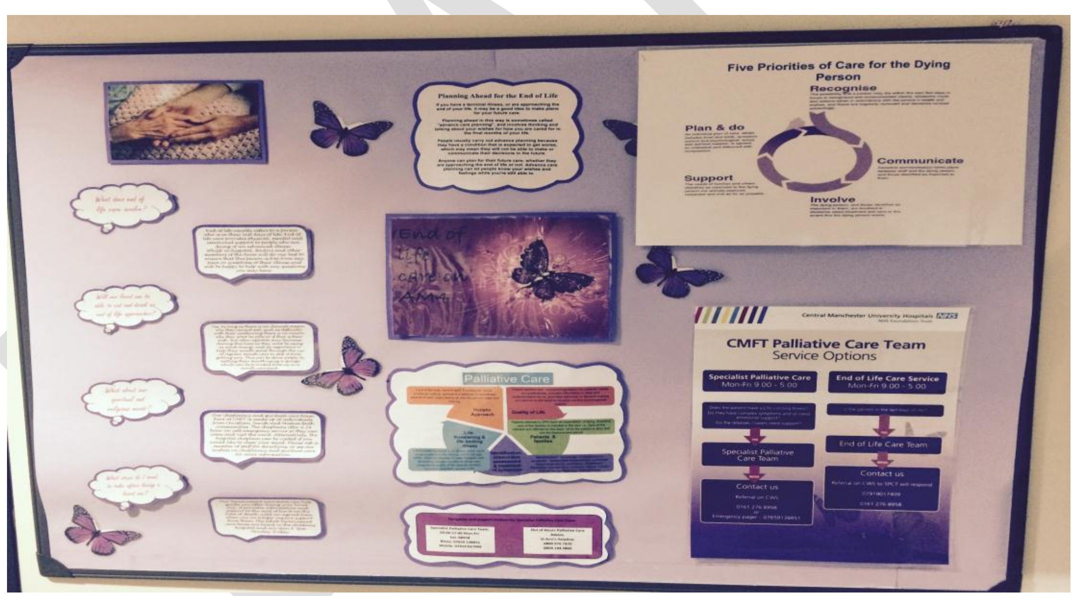
- Improvements in collaborative working between our community and acute based specialist palliative care teams to support quality care.

Education and Training

- Palliative and End of Life Care teaching sessions for our junior doctors and medical students are in place
- Communication skills and T34 syringe driver training for all staff who deliver end of life care.
- Development of the palliative care champion programme across all sites
- Development of a postgraduate community palliative care module for health professionals in collaboration with Manchester Metropolitan University.
- Brilliant Basics topic this year as part of our overall improving quality programme for all nursing staff. The main focus was communicating effectively at end of life with different scenarios acted out to increase understanding and challenge thinking.

EOLC Display boards on wards

- Wards across the Trust have developed EOLC display boards containing information for patients, families and carers and are an education source for staff



Audit

End of Life Care Audit: Review of expected adult inpatient death and compliance to the Five Priorities for Care of the Dying Person:

Audit being completed Feb/March 2016

Bereavement Care

- A questionnaire has been developed asking carers and relatives their experience in the EOLC plan, management and care delivered to their loved one. Relatives consent to this at the point they collect the death certificate and the questionnaire sent to them 2 weeks following the death.

Family/Carer Support

- Family and carer support is essential particularly when their loved one is in hospital. Families and carers often stay at the hospital for long periods throughout the day or night. Our Butterfly bags contain refreshments and toiletries specifically for them as an acknowledgement of their difficult situation.

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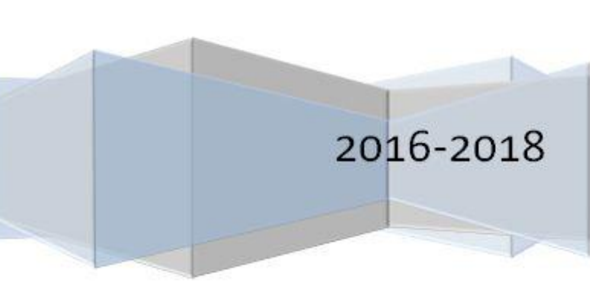
Transition of Care for Young People

Transition of care refers to the coordination and continuity of health care when moving from one healthcare setting to either another or home. For example, older adults who suffer from a variety of health conditions often need health care services in different settings to meet their many needs. For young people, the focus is on moving successfully from child to adult health services.

Central Manchester University Hospitals NHS
NHS Foundation Trust

Transition of Care for
Young People Strategy



The Trust identified earlier in the year that although on the whole our practice in transition service is good, it lacked consistency across all services. This was also the view expressed by the CQC at their last inspection of our Trust in November 2015. The CQC was of the view that we could improve our transition service, by standardising the quality of transition services across the organisation to the same high level provided in some areas.

What we have done so far

Two groups have been established to oversee and lead on the improvement plans; a Strategic group led by an Executive Director-Professor Bob Pearson, Medical Director and an Operational Group led by Sue Lunt, Hospital Director at RMCH. We have developed a transition strategy in line with the recently published NICE guidelines on transition (Transition from Children's to adults' services for young people using health or social care services)..

The Strategy has been written to bring together key areas of work and in doing so aims:

- To provide safe and effective transition and transfer from children's services to adult services for all young people with complex and/ or long term conditions
- To ensure young people are prepared for transition to adult services
- To care for young people and their families in adult services without any loss in the quality of services provided and a good patient experience

The strategy is currently out for consultation across the various Divisions in the Trust after which, it will be implemented across relevant services.

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Urgent and Emergency Care

The Trust seeks to provide safe, effective and responsive care to all urgent and elective patients. To do this we ensure effective inter-agency working on Urgent and Emergency Care in Central Manchester. This issue has the most senior level of commitment, focus and oversight across Central Manchester including independent advice and assurance

2015/16 has been a challenging year for us with the non-elective workload and pressures facing the Trust, and in particular the MRI, being significant and above that being experienced by other Trusts locally in terms of number of attendances, acuity and admissions.

We have therefore undertaken a programme of actions, including shorter-term tactical responses and longer-term transformation schemes. Robust governance arrangements are in place to ensure that all risks are identified and managed rapidly and effectively as possible.

In order that our patients are seen as quickly as possible by the most experienced and skilled clinician the Trust streams care for emergency patients through the specialist hospitals, where they are required. Urgent care pathways are now well developed in the Royal Manchester Children's Hospital, the Royal Eye Hospital, Saint Mary's Hospital and our Cardiac Services within Manchester Royal Infirmary (MRI). Trafford Urgent Care Centre supports our patients who access Trafford Hospital.

The **Emergency Department at the MRI** is our largest emergency access area and sees around 400 patients each day. Work has continued to strengthen our staffing within Emergency Services and look into innovative ways of responding to the needs of our patients. The Trust has a number of transformation plans in place that will deliver greater access to healthcare on a day care basis, enabling those fit to return home to do so and avoid overnight admission. The transformation plans are themed across the MRI and are aligned to our Trust Vision and Values. The diagram below sets outs those values alongside the strategic priorities for the MRI.

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CMFT VISION

"To be recognised internationally as leading healthcare; excelling in quality, safety, patient experience, research, innovation and teaching; dedicated to improving health and well-being for our diverse population."

CMFT VALUES

Pride, Respect, Empathy, Dignity, Compassion and Consideration

MRI Strategic Priorities

Integrated Care

Excellence in integrated care supporting secondary and tertiary care across acute and community settings through providing seamless and timely pathway

Care Models

Develop defined models of care / care pathways and provide out of hospital capacity appropriate for patient needs supporting patients to only stay in hospital as long as clinically necessary

Rehabilitation & Complex Healthcare

Develop a centre of excellence for complex healthcare and rehabilitation

Internal Efficiencies/Flow

Maximise efficiency whilst delivering excellence in education and research opportunities ensuring patients are in right place, right time, reducing exposure to risk of hospital acquired infections

Support Primary Care/UCFR/Ambulatory

Support Primary Care in their response to patients and implement pre and post rapid access to senior decision makers

Workforce

Explore innovative and flexible workforce models to support the delivery of the strategic aims, being seen as the employer of choice and excellence in education, innovation and research

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The **Emergency Gynaecology Unit** within Saint Mary's Hospital is a 24 hour walk in service led by Nurses who have expertise in early pregnancy problems from abdominal pain and or vaginal bleeding. The nursing team will arrange scans and follow up appointments and provide practical and emotional support throughout this often distressing time. The unit sees 12,624 new attendances and 11,955 follow up appointments per year.

One partner of a patient wrote to us and said:

"Attending the emergency gynaecology unit is a potentially terrifying experience for anyone, my wife had cause to attend when she had some bleeding in the early stages of pregnancy and we were seen promptly and professionally. The reassurance, management and follow up were all excellent and you should be proud of the staff on the unit and the sonography staff who did my wife's scans".

In 2015/16 we have seen an increase in demand on the **Paediatric Emergency Department** service and this has impacted on our ability to meet the emergency department target but we are continuously working on ways to ensure that all patients are seen as quickly as possible.

We are really proud of Paediatric Emergency team, and our consistent high quality of care. We have implemented a new House Keeper role in the department following children and family feedback, we continue to look for innovative ideas to improve the quality of the service we provide and are currently working up plans to increase the physical capacity of the department.

Trafford Urgent Care Centre provides access to medically led services both injuries and illness. The service is enhanced for the population by direct access to acute medical unit via GP and community services.

The current model was implemented following the Trafford New Health Deal. The attendances have been in line with the projections within the model. The model was enhanced during the process both in staffing and opening hours. Though it has been difficult to attract and retain suitable medical staff we have provided a high standard of care and service. This has been evidenced by the high patient satisfaction levels of users of the service. There are clear pathways of care for people who attend and need a higher level of care than can be provided.

In line with the original consultation the model is now being reviewed with the CCG. This is to ensure the modelling of numbers and acuity are accurate. This will lead to an evaluation of model 3 that was included in the original consultation.

The **Emergency Eye Department** treats 25,000 patients each year, and these patients travel from all over the North West of England to benefit from our expertise. In 2015/16, 99.91% of these patients have been seen and treated within 4-hours, only 21 have waited longer, and 97% would recommend us as a place for treatment to their family and friends.

The service at Manchester Royal Eye Hospital is internationally renowned and we receive visits each year from professionals around the world looking to learn from what we do. The team is closely knit from medical staff, nurse practitioners, acute optometrists and administrative support, ably supported by a state of the art ophthalmic imaging service. The service goes from strength to strength and major successes this year include Mr John Uddin completing his Advanced Nurse Practitioner training, appointment of Miss Reshma Thampy as a second Consultant with a special interest in this area, the introduction of an award-winning patient pager service, allowing patients to leave the department while waiting without fear of losing their place, and launch of an out-reach service at Altrincham General Hospital.

Further improvements are planned for 2016/17, including new staff rotas, enhanced triage, improvements for doctors in training and better links with community optometrists and eye services at other Trusts.

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The Transformation Team

The Transformation Team are dedicated to ensuring the best possible care for the diverse and changing population of Greater Manchester by working with staff, patients and families to recognise where we need to grow and change to ensure the highest level of quality.

The team was formed in April 2014. It is a small team, led by the Director of Transformation with some members having worked at the Trust in various roles prior to joining the team, bringing first-hand experience of working across our Hospitals.

The role of the Transformation team is to build on the good work within our hospitals, co-ordinating wide scale projects to promote best practice; both from elsewhere in the Trust and further afield, ensuring care is not just good but great.

The team started by establishing a clear aim, to be in the top 10% of similar sized Trusts for quality. This means patients could be confident that outcomes of their care, safety and experience, as well as the experience of staff and efficiency would be at the highest level. If we achieve this we could save 230 extra lives and 26,000 more inpatients would state they had a good experience whilst in our hospitals.

To do this, we work with services to meet what we call the ‘CMFT standard’: setting a standard of care that should be expected for all patients which ever hospital or service they are using, a level of service that we would hope to receive if we were patients. Setting this standard has helped clinical teams to assess the care they give, demonstrating when they have best practise examples to share, or where they might need support for improvement.

Any changes that are led by the Transformation team have an executive sponsor, a clinical lead and involve staff from all different levels to engage as many people as possible through all our change processes. One person alone cannot transform, it is only by working together, bringing all our combined experience and knowledge that we can really affect change and drive forward transformation. This means we work with both clinical and non-clinical staff to think outside the box, using innovative ideas, technology and their expertise to find improved ways of working.

- Over 100 staff have participated in Transformation workshops and events
- 350 clinicians, nurses and senior managers have taken part in formal leadership programmes resulting in 150 change projects

We work closely with our Organisation Development and Training team to offer a number of training and development programmes that help staff turn their ideas into real change. Training programmes such as the Newly Appointed Consultant Programme has enabled new clinical leaders to drive wide scale clinical improvement programmes to transform care across our hospitals.

Examples of achievements and improvement include:

- Developed the concept of running a ‘Perfect Week’, providing additional focus and resources to do things differently and make positive changes that improve the experience of patients
- Launched an Ambulatory Care Service
- Supported a 7 day services event with clinicians
- Held an Experience Based Design approach with the Royal Eye Hospital Outpatients, bringing staff and patients together to co-design an improved service, based around what matters most to patients
- Hosted the 3rd Hospital Transformation Network with over 70 participants from 30 organisations to share learning across the NHS.

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Informatics Update

Adoption of pioneering applications

CMFT is an NHS pioneer in adopting Patientrack, an electronic track and trigger system with automated alerts. The system presents to front line staff a patient's observations and identifies patients whose condition is deteriorating, alerting medical staff via a range of electronic devices. The system is operational 24 hours a day, 7 days a week and improves monitoring of conditions and early intervention.

We're already seeing the benefits; with 80% of observations (e.g. blood pressure, heart rate) completed on time, the Trust can see which patients have had their observations carried out, the completeness and timeliness of those observations and the responses to those observations.

Analysis has also demonstrated an overall fall in risk of death over the study period and cardiac arrests fell from approximately 300 per year to approximately 60.

"Recognising when a patient's health deteriorates and responding in a timely fashion has been one of our national priorities in acute in-hospital care for the past 18 months. Patientrack has proved invaluable to clinical staff in our transformation of this pathway and I personally I'm delighted to see the patient benefits mirror those in the trial."

Jane Eddleston, Clinical Lead for Critical Care at CMFT, and Department of Health Adviser for Critical Care.

Building the Future

We've started our journey towards having an Electronic Patient Record (Chameleon). With all our internal developments we're aiming to make working lives easier and bring benefits to patients, staff and the Trust as a whole. To make sure we're doing this we're not developing any of this in isolation. We're working in partnership with a lot of people from a variety of clinical and non-clinical roles across the Trust. This approach worked very well in the development of Chameleon View which went live across the Trust last year.

'I am a consultant Urologist at MRI and have been using Chameleon for the past couple of weeks. I spend a significant amount of time dealing with patient investigation results and having these results available on the same platform as clinic letters, discharge summaries and operation notes is already making this task significantly easier. I am very grateful to the team that developed Chameleon.'

Mr Iain McIntyre, Consultant Urological Surgeon, Manchester Royal Infirmary

'Having access to Chameleon View is great. This morning it helped me solve a problem that would've taken me much longer and would've meant opening up two systems. And, best of all, it meant that we stopped a child having an unnecessary blood test '.

Steve Bellfield, Healthcare Support Worker on Ward 76

Chameleon View:

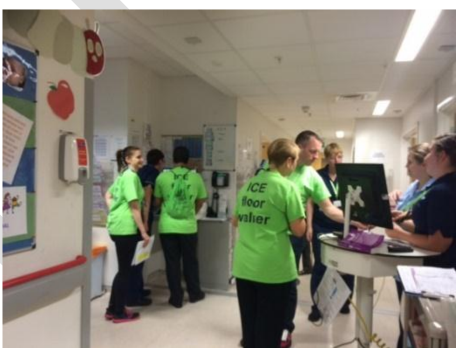
- Brings together key clinical information from existing systems into a single view – eliminating the need for clincal staff to open multiple systems
- Provides robust security access allowing only those with legitimate access to view patient records
- Reduces reliance on the paper case note
- Provides opportunities for some to move to paper-lite or even paperless practice

Transformation

One of the biggest successes for the Trust and Informatics was the implementation of a new system (Sunquest Integrated Clinical Environment (ICE)) used by staff to order tests e.g. X-rays, and to refer patients to services such as Community Midwifery, Continence Advisor, and District Nursing.

With near 9,000 registered users, we now see on average 7,757 orders a day placed for tests and requests (pathology, radiology and service referral).

The new system offers many benefits:



- It's easy to use and find information
- Requesting tests and service referrals is quicker
- Results can be shared across primary care (e.g. GPs) and secondary care (e.g. hospitals and clinics).
- Continued improvement to patient safety with labels for tests being printed at the patient's side.
- Reducing the amount of paper used.
- Integration with the Trust EPR: Chameleon View enabling the presentation of results in both tabular and graphical formats.

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How we did it: We switched from our old system to the new system overnight. It was the most technically and logistically challenging implementation we've ever faced. It was true team work between Informatics, clinical and front-line colleagues which made it such an overwhelming success. On the day of implementation over 60 Floorwalkers offered help and support 24/7 during 335 shifts to make sure frontline staff were fully supported.

'I just wanted to feedback regarding the ICE floorwalkers this week who have, without exception, been very helpful and supportive and quick to respond at all times. Please thank them for their support and good humour during the transition'.

Peter-Marc Fortune, Consultant Paediatric Intensivist

Integrating Care

We have supported the development of an integrated care record for 'at risk' patients. This brings together key information from health and social care provider systems into a single care record which can be accessed by relevant care professionals. After a successful pilot, GP practices in the area can now use these records to develop care plans for patients who are identified as being at risk of unscheduled or unplanned care. Care plans can be shared and accessed by other professionals, including community nurses, social workers and

community mental health workers. So far around 6,000 care plans have been created by GPs in the city and there are around 900 registered users of the system.

Safeguarding

This joint project between Saint Mary's and Informatics involved colleagues from across the Trust and was supported through the Trust's Adult and Children's Safeguarding Groups. Informatics staff reviewed the national reporting requirements and then worked with Faye Macrory (FGM lead) to agree how we could collect the information and how the information would be used to help safeguard these vulnerable patients. We then developed an on-line data collection tool and in the first six months (September 2014 to March 2015) identified 191 eligible FGM patients.

Winning First Prize at the British Journal of Midwifery Practice Awards 2015.

From left to right Peggy Mulongo, FGM Mental Health Practitioner; Faye Macrory, Consultant Midwife; Dr David Foster, DH Deputy Director of Nursing

Going Digital

An overarching priority is for Informatics to play an integral role in breaking down traditional IT, information and communication boundaries between healthcare professionals, patients, service providers and all organisations involved in the care of the patient.

We will enable this service transformation and integrated working through:

1. Providing a single clinical view of the patient through the Chameleon Electronic Patient Record and integrating best of breed systems and technologies.
2. Providing business intelligence, predictive analysis, and big data solutions.

We will ensure that ***Going Digital* our Annual Plan** is deliverable and sustainable by:

1. Providing a contemporary and integrated technical framework with technical resilience, performance and infrastructure.
2. Innovating, developing and managing programmes such that the transformation of processes is safe, sustainable and always aiming to be thinking ten steps ahead.
3. Having the best structures and business approach to position Informatics for future challenges:
   - Finance
   - Governance, Risk and Control
   - Our People
   - Communications and Engagement
   - Sustainability

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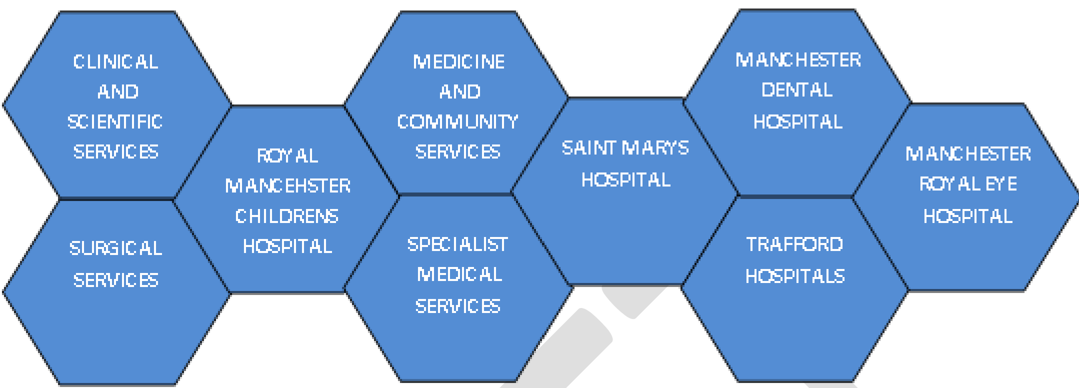
Divisional Reports

CMFT has nine clinical divisions as demonstrated in the diagram below. Each of the divisions has a unique identity and provides a specialists service but all share one aim: to be the best at what they do.



Here is a summary of some of the on-going work within the nine divisions.

Medicine and Community Services

Outcomes of last year's 3 top priorities 15/16

1. Focus on recruitment and retention of staff, alongside the development of new models of nursing care - the Division has continued to progress the recruitment of nursing staff, including overseas recruitment. Recruitment and retention remains a challenge and the Division will continue to consider innovative ways in which to attract staff across nursing and provide opportunities for development to support retention
2. Reduce the number of beds within the Division as part of the transformation project in order to improve staffing levels across the permanent medical wards - although this year we have made significant improvements in safely reducing capacity, 16 beds from Ward 27 and a forecast net saving of 3 beds from Ward 30, we have had to manage different challenges in terms of demand management with CPE cohorted areas currently utilising much needed bed and workforce capacity and this remains a challenge for the Division.

3. Improvements in infection control practice across the Division and a reduction in hospital acquired infections - CPE remains a challenge across the Division with an increase in acquisitions. The Division continues to undertake audits to monitor compliance with hand hygiene and PPE practices to support improvements to be made. The Clinical Head of Division is the interim medical lead for Infection Control and ensures that clinical leadership and support is provided for this area of work.

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3 main Outcomes from the Divisional Quality Review

Acute Services Review

1. Generally, staffing shortfalls were cited as an issue that prevented progress towards making improvements in the Division. Reduced staffing levels led to some delays in providing elements of care and ability to attend training sessions.
2. Medication Storage across wards and services including medications delivered by pharmacy were left unattended, medication cupboards were unlocked and there were issues with staff unable to access keys in a timely manner in order to unlock medication fridges
3. Administrative /clerical staff in the Emergency Department stated they felt morale was low and there was a lack of leadership being demonstrated

Community Services Review

1. IT remains a concern and issues for community staff including on-going problems with connectivity to the Trust computer network, compatibility with other electronic systems and the time taken to address these problems due to services being off site
2. Support for staff regarding change management in relation to the Integrated Team establishment and Health & Social Care integration in 2016.
3. Issues with the community estates including overcrowding, poor building fabric and inadequacy of availability of space.

Responses to address the outcomes

Acute Services

1. On-going recruitment initiatives to continue across acute services for nursing and medical staff. Medical recruitment undertaken in India and is now moving through the recruitment process. Overseas recruited nurses are now being placed within ward areas and are undergoing any training required. Continuation of daily review of staffing across all areas, escalation process for the use of temporary staff and scrutiny of e-rostering system.
2. Divisional Medicines Management action plans in place to address issues alongside matron reviews of medication storage including fridge temperature checks. Audit also in place regarding storage of medication once delivered by Pharmacy.
3. The Emergency Department have undertaken a review of the management structure for administration and nursing staff to provide support to all staff and completed bespoke management sessions with admin staff including taking into consideration the recent Aston Programme (team building, leadership and management structure programme) and stress survey results.

Community Services

1. Divisional Informatics Group continues to monitor progress with improved corporate IT support and understanding of the issues. The directorates have an escalation process in place for any support required with IT issues.
2. As the Integrated Teams become established, staff have been encouraged to raise any concerns via the monthly 'ask the management' sessions, through their line manager or at their individual team meetings in order to address any concerns about premises and roles moving forward into the new model. Regular Estates planning meetings and site visits are held in partnership with Manchester City Council and NHS Property Services.
3. Community services continue to escalate issues and ensure the Estate priorities have a high profile. An estates specific action plan is in place and leads have been identified for each of the community estates and properties to ensure that any issues can be addressed.

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Improvements from Clinical audit, incidents, complaints and claims

1. A support process has been implemented for discharging patients who have CPE to nursing homes due to families and patients experiencing long delays in discharge planning process
2. Senior review process within Emergency Department implemented for the review of x-ray results in order to reduce the risk of any missed diagnoses and subsequent delays in treatment.
3. Due to an acknowledged gap in staff awareness regarding the DNR policy, discussions took place across the whole multi-disciplinary ward team about this (was this only on one ward?). New DNR booklets were ordered and are available on every ward. 2222 posters have been updated and provided to ensure staff had access to the correct emergency information.

Top 3 risks

1. Patient safety is at risk when demand within the Emergency Department outweighs the capacity available. This continues to be a risk for the Division and has been acknowledged as an MRI-wide risk due to issues with bed capacity and flow of patients.
2. The Estates risk within community services has been updated to accurately reflect the concerns identified. Some aspects of the estates are acknowledged as not fit for purpose and work continues between the Trust and NHS Property Services to ensure actions are put in place to improve both safety and cleanliness of the estates as well as support staff to deliver safe patient care in these settings.
3. Infection control continues to be a risk for the Division due to the number of CPE acquisitions across the acute services. This is actively managed with the involvement of senior medical and nursing staff alongside the Corporate Infection Control team.

Division's top 3 priorities for next year 2016/17

1. The recovery of the financial sustainability and position for the Division, including the closing of trading gap and turnaround initiatives.
2. Responding to changing commissioner requirements for community and urgent care services with a significant shift in sub-acute provision into a community provision, as well as the requirements for acute services, including Healthier Together and single hospital service
3. To continue to recruit and retain a competent, capable workforce that will support our provision of our core service contracts as well as delivery of radical reform in the future.

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Outcomes of last year's 3 top priorities 15/16

1. **IPC –**improvement measures include a trial of Surficide technology (using ultra violet light to decontaminate areas), a range of interventions to reduce Central Line Acquired Blood Stream Infections (CLABSI) within Critical Care with a plan for roll out across RMCH (also part of the Making it Safer Together paediatric patient safety collaborative), and nursing investment to support the IPC agenda
2. **Food and Drink –** participation in the 2015 CMFT Nutrition and Hydration Week (including food tastings and senior staff involvement in food service process to get 'first hand' experience and feedback from patients and families), new menus introduced in RMCH (November 2015) and a plan for evaluation, and re-convening of the RMCH Patient Dining Group to support collaborative working between staff involved in the food service process.
3. **Workforce –** nursing workforce programme in place to support recruitment and retention including: majority of wards have a Band 6 educator role in place to support newly qualified staff, offer of alternative shift pattern for inpatient areas which provides additional cover within existing establishments and accelerated programme for conversion of RGN to RSCN. Successful recruitment within a challenging national context to Consultant posts in Respiratory Medicine and Cardiology.

3 Main Outcomes from the Divisional Quality Review

1. Cleanliness and tidiness
2. Secure storage of case notes on Ward 76
3. Recording of drug fridge temperatures

Responses to address the outcomes

1. Cleanliness and tidiness: cleanliness issues shared with Sodexo, on-going monitoring programme and participation in CMFT wide SHINE programme (focus on working jointly with Sodexo to drive improvements) and escalation as required. Tidiness: focus on de-cluttering ('Dump the Junk')
2. Ward 76 casenote storage : Interim measures (frosting of glass for area where notes were stored within cages) and long term solutions implemented or in progress (alternative storage in secure office area by main reception desk on short stay area, Day Case discharge notes are locked away and lockable cupboards ordered)
3. Drug Fridge Temperature: all drug fridges within RMCH were reviewed, signage provided to support appropriate recording of temperature and CMFT Temperature Record Book implemented. Audit planned.

Improvements from Clinical audit, incidents, complaints and claims

1. Audit: change to practice as a result of audit of ultrasound screening for liver disease in paediatric cystic fibrosis with reduced costs for the service, and reduction in unnecessary scans

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2. Incidents: ammonia testing procedures reviewed, and learning (ammonia testing should be undertaken as a matter of urgency in any child with an unexplained depressed level of consciousness) shared at a Grand Round and more widely by the North West and North Wales Paediatric Transfer Service (NWTS)
3. Complaints: additional equipment ordered for Ward 75 (reclining chairs), environmental improvements at the Winnicott Centre

Top 3 risks

1. Staffing (having the right staff in the right place at the right time, to deliver the right care). Vacancies / gaps in staffing impact adversely on patient care and experience, achievement of hospital activity targets, and the ability to release staff to undertake training). National shortages in paediatric services for nursing and medical staff makes recruitment and retention more challenging.
2. Limited capacity for inpatient admissions, particularly during the winter months when demand is higher. This impacts adversely on:
    - Patient care and outcomes (such as delays in admission for surgery or diagnostic tests; or patients being admitted to a ward not usually associated with the specialty looking after them)
    - Patient experience (making it more difficult to allocate each patient a bed space which is appropriate for their age, developmental needs and gender)
    - Achieving activity targets.
3. Delivery of a balanced budget

Division's top 3 priorities for next year 2016/17

1. IPC
2. Environment (making RMCH more friendly for children and young people, including launch of storybook to obtain feedback from pre-school patients)
3. Workforce

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Manchester Royal Eye Hospital

Outcomes of last year's 3 top priorities 14/15

1. **Continue to develop the Listening and Learning Programme, both staff and patient focussed; inclusive of the launch of the MREH Twitter account and introduction of the patient pagers.**
   Since the launch of @ManchesterREH our followers have increased month on month. During November 2015 our Tweets accumulated 33,500 impressions with an average engagement rate of 2.6%. We were mentioned 74 times by other people, gained a further 35 followers and our profile was visited 1,986 times.
   Patient pagers are now in all clinic modules within the MREH and Peter Mount House. This allows patients who are attending for multiple appointment slots to move freely from the clinics without fear of missing their appointment. The pagers have received two Trust awards, 'Transform Together' hosted by the Transformation Team and the Sodexo Dignity Award at the Nursing and Midwifery Conference. It has been highly Commended by the national Vision 20:20 Conference and have been nominated for a national Patient Experience Network Award.
   Bimonthly staff focus groups continue to be held by the Divisional Director to ensure that staff are aware of Trust and wider NHS developments.
   MREH had the highest return rate for the Trust patient satisfaction survey, demonstrating an exceptional level of staff engagement.
2. **Continue to develop the workforce to ensure this is fit for purpose for the future NHS; developing roles and responsibilities.**
   2015 saw the graduation of two Advanced Nurse Practitioners (ANP) within the MREH. Job plans are now in place to ensure that their skills are fully utilised in nurse led clinics and minor operation theatre lists. One ANP will be undertaking clinics in our satellite centre at Altrincham General Hospital which has been opened to help ease the capacity pressures within the MREH. In addition we have increased the number of nurse led injectors to support the ever increasing Macular Treatment

Centre Clinics. This service has recently been extended to Trafford General Hospital, providing care closer to patient's homes.

3. **Continue to learn from feedback/develop new methods of obtaining feedback and show improvements in patient and staff experience; supported by the Trust Values and Behaviours and the Nursing and Midwifery Strategies.**
   The MREH continues to actively utilise all communication strategies, such as the formal, Trust complaints and PALS service, Friends and Family Test and NHS Choices, and informal routes such as Twitter. In addition, MREH has worked with Healthwatch to host a patient feedback week during October. The information received during this week and responses from the MREH and other Trust departments will be published by Healthwatch. During February 2016, we also held an event in conjunction with the Transformation Team to gather the opinions of both staff and patients to develop future services.

3 Main Outcomes from the Divisional Quality Review

1. Security of medical records
2. Patient experience in the out-patient areas
3. Infection control

Responses to address the outcomes

1. **Security of medical records**
   Lockable cupboards and trolleys have been installed in the out-patient areas. Medical records are also stored behind reception desks or in locked rooms if not required that day. This process is audited regularly to ensure standards are maintained.
2. **Patient experience in the out-patient areas**
   There has been considerable expansion of services to off-site areas to help reduce the overcrowding and long waits in out-patient areas. Staff in the out-patient areas have instigated a 'rounding' schedule whereby they inform patients at check-in and on an hourly basis of any delays to appointment times. An electronic Patient Experience Tracker has now been purchased for the children's area in Clinic H. This has questions that are more appropriate for children to answer and results are displayed for staff and patients to see. New toys have been purchased and there is an on-going replacement programme. The implementation of 'virtual' clinics for patients with certain conditions has reduced the number of hospital visits for some patients whilst maintaining safety.
3. **Infection Control**
   A review of cleaning methods for reusable lenses has been undertaken and amendments to this process implemented. A full appraisal of the options available for cleaning vs. single use items is currently being undertaken. During International Infection Control Week the Division reiterated the 'bare below the elbows' directive, empowering staff to challenge colleagues to ensure compliance.

Improvements from Clinical audit, incidents, complaints and claims

1. **Safe Site Surgical Checklist:** As a result of a 'never event' last year the MREH has developed a new checklist for the insertion of implants and correct site of surgery. This ensures that when decisions are made to change a procedure mid-point additional time out is taken to ensure that everything is present and correct.

2. **Pain Control:** Pain control in both in-patient and out-patient areas continue to feature in complaints. A Divisional Pain Sub Group has now been instigated as part of the

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Trust Brilliant Basics Programme and a number of initiatives in all areas have been introduced. Results via the patient experience tracker data are encouraging.

Top 3 risks

Patient safety continues to be the top objective for MREH. Incidents, complaints and claims are continuously monitored and managed by the Divisional Clinical Effectiveness Board and themes and learning shared widely amongst teams.

1. **Capacity and space in the out-patient clinics** can result in delayed follow up appointments and subsequent treatment. Recent high level incidents have identified that patients 'lost to follow up' have increased.
2. **Lack of a clear standard operating procedure for the management of patients who do not attend (DNA) appointments** has also resulted in delays to treatment.
3. **Unavailability of medical records both paper and electronic** continues to present clinicians with difficulties when treating patients.

Division's top 3 priorities for next year 2016/17

1. **Outpatient Improvement Programme**
   Utilising information from the Patient Experience Trackers, complaints and incidents and a coordinated approach by the MREH and Transformation teams, a large project focussing on the patient journey through the out-patient service is being developed. A process of experience based design, patient and staff stories and mystery shoppers have helped formulate a detailed plan for work over the next 12 months, focussing on health records, patient access, patient management, specialist customer care and clinic H redesign.

2. **Theatre Improvement Programme**
   Commenced last year, the theatre improvement plan will continue during 2016/17. 2015/16 saw the introduction of a Surgical Admissions Lounge on Ward 55 which ensures a seamless admission process for patients and staff. Further developments will increase theatre activity and productivity by reducing turnaround times and preventing cancellations by improving the pre-operative assessment process.

3. **Expansion of the Trust Accreditation Programme to Theatres and Out Patient areas.**
   As part of the Trust's overall Improving Quality Programme the out-patient and theatre areas will now be included within the accreditation process. Departments will be assessed on their ability to respond to patient and staff feedback and improvements made from the experiences of both. Whilst both areas continually strive to provide the best care, this process of assessment is new and staff are keen to be involved in the process.

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University Dental Hospital of Manchester (UDHM)

Outcomes of last year's 3 top priorities 14/15

1. **Continue to develop the Listening and Learning Programme, staff and patient focussed.** The Twitter account is now in use allowing patients and carers to see information regarding upcoming events and leave feedback regarding treatment. Bimonthly staff focus groups continue to be held by the Divisional Director to ensure that staff are aware of Trust and wider NHS developments. The Patient Listening Event is now an annual occurrence. The UDHM Quality Forum focusses on both staff and patient satisfaction with regular reviews of the Staff Pulsecheck data and 'You Said, We Did' initiative.

2. **Continue to develop the workforce to ensure this is fit for purpose, developing new roles and responsibilities.** 2015 saw the first Registered Dental Nurses attend the Trust Preceptorship Programme, a programme that has recently been expanded to support newly qualified practitioners from a variety of disciplines. A newly appointed consultant in the Emergency Dental Clinic is leading work on a new trauma network and we have appointed the first Consultant in Special Care Dentistry in the city. A designated Specialist Dental Nurse has been employed at Peter Mount House which has improved both staff and patient experience within the Maxillo Facial Department. Dental Nurses have continued to develop extended skills in intravenous cannulation and radiology.

3. **Continue to learn from feedback/develop new methods of feedback and show improvements in patient and staff experience.** Improvements to internal and external signage have been made and further plans to engage with Manchester Council are in progress. CMFTVs are now installed in all clinics providing a platform for staff to provide health education information to patients. Additional patient experience trackers have now been purchased to improve the amount of feedback acquired that is also clinic specific. The Endodontic clinic continues to use bespoke feedback that demonstrates high levels of patient satisfaction. Improvements to the

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telephone system for patients wishing to change appointments/contact the hospital have been made.

3 main Outcomes from the Divisional Quality Review

1. **Security and storage of medical records.**
2. **High numbers of cancelled appointments and high DNA rates.**
3. **Storage of medication**

Responses to address the outcomes

1. **Security and storage of medical records.** Lockable cupboards have been installed in the clinic areas. Medical records are also stored behind reception desks or in locked rooms if not required that day. This process is audited regularly to ensure standards are maintained. Electronic patient records are now in use in many areas with further roll out planned during 2016/17.

2. **High numbers of cancelled appointments and high DNA rates.** A review of the patient reminder service has been completed and this resulted in the division changing the frequency of reminders and the wording of the text messages that are sent to encourage patients to attend their appointments. Paediatric patients booked for elective procedures are also being called 2-3 days prior to their appointments to reduce the DNA rate which allows us enough time to fill all slots.

3. **Storage of medication.** A full review of the storage of medication has been undertaken in collaboration with the Pharmacist. New drug fridges have been purchased and robust processes in place to monitor their usage and safety.

Improvements from Clinical audit, incidents, complaints and claims

1. **Correct site surgical checklist** UDHM is considered as the lead in patient safety in the UK. It has developed and presented a Safer Site Surgical Checklist to ensure enhanced patient safety that is now widely adopted across the UK.
   Review of weight limits for all dental chairs. Robust processes introduced to ensure that weight limits are not exceeded and all staff are fully aware of restrictions, following the collapse of a dental chair whilst a patient was receiving treatment.

Top 3 risks

Patient safety continues to be the top objective for UDHM. Incidents, complaints and claims are continuously monitored and managed by the Divisional Clinical Effectiveness Board and themes and learning shared widely amongst teams.

1. **Access to General Anaesthetic lists, particularly paediatric patients** is causing long waiting times for patients. Work is on-going with the Anaesthetic Department to resolve this issue on a long term basis, whilst short term measures to manage this are undertaken. In addition, a shortage of trained nurses in the main MRI Theatres and a cap on nursing agency costs has also led to cancelled theatre lists.
2. **Activity and subsequent income** has been lower than forecast during 2015/16 leading to long waiting lists in some specialities. Recruitment of key personnel has now been achieved and waiting times expected to reduce. Additional activity is also being undertaken at Trafford General Hospital where possible and a number of 'mega-weeks' are planned.

3. **Age of the building and issues with asbestos management** mean that any renovations are difficult and time consuming but work on the 2nd floor clinics has now commenced.

Division's top 3 priorities for next year 2016/17

1. **Purchase of equipment.** Plans are in place to purchase £10k worth of equipment per month on an on-going basis to ensure that sufficient stock and replacement of worn out equipment is maintained.
2. **Recruitment of clinical staff.** Active recruitment of staff to manage the demands of the service will continue. Ensuring that UDHM is a safe and attractive place to work will encourage applications from current trainees.
3. **Agreement of local tariffs for treatment.** To ensure adequate income for specialist procedures within the UDHM, tariffs will need to be reviewed and agreed. As a part of this work a process of Service Line Reporting has commenced to identify treatments and services that improve patient experience and remain profitable.

Trafford Hospitals

Outcomes of last year's 3 top priorities 14/15

1. **Productivity and Efficiency in Manchester Orthopaedic Centre.** A 13 week Engagement Programme with Four Eye commenced in August 2015 with a detailed project plan in place. A scheduling tool was implemented to maximise scheduling opportunities based on individual consultants operating times. This resulted in an increase in cases scheduled each week. Weekly activity targets ('Magic Numbers') were communicated and monitored against through the weekly scheduling meeting.

   A new role was developed within pre-operative assessment services to oversee the pre-operative pathway for major cases e.g. joint replacement and hip arthroscopy. An extra nurse started on the ward between 7-9am to support ward nurses admitting patients in a timely manner. An escort role was also introduced to reduce delays in transferring patients to and from theatre. These changes resulted in improvements in productivity and efficiency in our orthopaedic theatres.

2. **Addressing the financial deficit and resolving outstanding clinical model issues.** Robust plans were developed and these will continue to address the financial deficit in 2016/17, including Outpatient transformation, implementation of Urgent Care Centre Model 3 (Nurse led) and delivery of orthopaedic elective plans. Plans also include the development of a resilient team through recruitment and retention to deliver the financial plans.

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3. **Progressing the development of becoming a Centre of Excellence for elderly care and rehabilitation.** Trafford Hospital is committed to becoming an Age Friendly Hospital and centre of excellence for frail elderly and rehabilitation care. Approval has been gained to appoint to a Nurse Consultant post for Older People and Frailty, the first in the Hospital. It is anticipated the post holder will drive the older age agenda forwards.

   Wards 2, Complex Discharge and Ward 4, General Medicine successfully attained Gold Accreditations during 2015/16 and will be applying for the Quality Mark Elder Friendly Wards, a nationally approved quality improvement programme.

   The hospital committed to supporting John's Campaign and welcomes carers to stay with patients suffering from dementia, including an overnight stay.

   In recognition of the impact of hospital admission on patients, and possible social isolation of relatives/carers, the hospital undertook an open visiting pilot project on Ward 1, Stroke Unit. Outcomes included a reduction in falls, formal complaints and improved communication with families. As a result of the successful pilot, open visiting will be rolled out across all inpatient areas during 2016/17.

3 main Outcomes from the Divisional Quality Review

The Quality Review Team reported that they generally had a very positive visit to Trafford Hospital. They noted that the welcome and the responsiveness of all groups of staff was impressive. Most of the teams remarked that for most of the areas, they would recommend the services at Trafford Hospitals to family and friends. Main concerns raised were as follows:

1. The WHO checklist was not being used in Endoscopy.
2. Staffing levels were noted to be low in some areas due to vacancies and sickness absence.
3. Privacy in Outpatient areas was recognised as a concern. Consultations can be overheard as the doors are of poor quality.

Responses to address the outcomes

1. The WHO checklist was implemented in Endoscopy with support from the Division of Specialist Medicine in October 2015. Compliance with the checklist is audited monthly and the results monitored by the Clinical Effectiveness Committee. Discussions are in progress to adapt the checklist to better suit the patient pathway in Trafford Endoscopy suite.

2. Nursing recruitment and retention action plans are in place and overseas recruitment is underway.

3. Staff are aware of the issues and take care to maintain confidentiality as much as possible. Music is also played in the outpatient areas to help to mask conversations. There are longer term plans in the Estates Strategy to refurbish the Outpatient area.

Improvements from Clinical audit, incidents, complaints and claims

1. A number of complaints were received in relation to the phlebotomy service. A Phlebotomy Service Action Plan was developed as a result which included a full

service review, reconfiguration of teams, customer service training, improvements to signage and provision of better information for patients and GPs. Further work is in progress to address accessibility of the service for people of working age.

2. Following an incident, a clear pathway was produced for the management and transfer of patients with possible cervical spine injury following an inpatient fall. This pathway includes guidance on cervical spine immobilisation, log rolling and use of the scoop stretcher. The guidance also includes when to suspect a cervical spine injury and the key signs to aid recognition of a cervical spine injury.

Top 3 risks
Trafford Division has identified three key risks as follows:

1. **Sustainability of the Urgent Care Centre:** If the Division is unable to provide adequate numbers of junior and middle grade doctors the viability of the Urgent Care Centre is at significant risk. Active recruitment into the vacant roles is in progress and the Division of Medicine and Community is trying to assist where there are gaps in the rota.
2. **Electronic sign off of test results:** The process for the electronic sign off of test results is currently being reviewed through a Task and Finish Group led by the Clinical Head of Division and overseen by the Divisional Clinical Effectiveness Committee.
3. **Compliance with correct site surgery procedures:** A Task & Finish Group has been established to undertake the development of local safety procedures for invasive procedures across the division over the next 6 months. This involves clinicians and frontline staff who undertake the invasive procedures.

Division's top 3 priorities for next year 2015/16

1. Integration of services – improvement in the delivery of services and reduction of waste.
2. Financial viability – to meet financial targets and be a financially viable Division.
3. Further development towards becoming a Centre of Excellence for elderly care and rehabilitation

Clinical and Scientific Services

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Outcomes of last year's 3 top priorities 2015/16

1. **Patient Experience Data** All outpatient areas are now collecting patient experience data using various/multiple methods. There has been extensive work carried out by the teams to ensure data collection against the outpatient standards and this is becoming embedded within departments. All inpatients are being offered the opportunity to answer the friends and family test which has received excellent results. In line with the Trust patient experience communication framework, directorates are beginning to display this information for patients and visitors using the trust branded formats which has been well received. There is on-going work to update CMFT – TV's within the Division to ensure up to date and relevant information is displayed.

2. **Response to Cancer Survey** The Divisional Cancer Survey Action plan has been a standing agenda item on the Divisional Quality Board with directorates providing regular updates on progress. As a result of this work, we have seen big improvements to patient information provided in advance of tests/ procedures. The radiology team have filmed a patient undergoing a CT, MR, Ultrasound and X-ray so that patients can view these before coming for their scans. The move to the new CRIS facility has had a big impact on patient experience and with pathways currently being developed; this facility will be able to provide further services in the coming year. Procedures that previously required an inpatient stay are being carried out as day cases including some liver biopsies. Patient satisfaction with this service is very high. The majority of the action plan is complete with the exception of the purchase of the additional MR scanner which is on-going.

3. **Improve patient information** Neurophysiology has produced a photographic walk through of the department for patients (in particular children and those with learning disabilities). Better signage and maps have been produced for a number of departments to better aid patients find their way around the hospital. The radiology team have launched their internal website with details of all tests carried out in the department, links to leaflets which can be printed for patients as well as waiting times and information on referring for tests. Sections of this website will be available on the Internet for public access in the near future. In collaboration with the Patient & Carer Forum, Critical Care have developed information leaflets for patients and relatives regarding delirium.

3 main Outcomes from the Divisional Quality Review

Overall the team found the majority of staff to be very helpful and welcoming and morale seemed to be very good. Staff acknowledged improvements that had been made since the last quality visit and were very positive about these. The team found good evidence of multi-disciplinary working and a culture of continuous improvement. Minor areas for improvement include:

1. Radiology waiting area, dark and dingy – not a great patient environment.
2. Poor communication, training and support around end of life in Critical Care.
3. Pharmacy Outpatients struggling to meet 20 min Turnaround time

Responses to address the outcomes

1. Radiology waiting area received new flooring and new chair covers. The corridor leading to Radiology is currently being refurbished and the possibility of a staff photography / art competition is being discussed within the team.
2. The issues relating to comments from relatives regarding communication have been fed back to nursing and medical staff via a number of forums. Additional training has been provided particularly in relation to care after death. The daily core huddle has been updated to ensure that each patient receiving end of life care and their families

are spoken to by the nurse in charge and consultant for the day to ensure their needs are being addressed.

3. Pharmacy team working closely with the Lloyds team to review fluctuating clinic loads to ensure staff can be allocated to more busy periods. The use of the tracking screen for patients prescriptions has been welcomed by patients and reduced the number of enquiries / complaints regarding this.

Improvements from Clinical audit, incidents, complaints and claims

Keepsafe Boxes in Critical Care
As a result of a number of complaints / instances where patients personal items have gone missing, the department have introduced 'keepsafe' boxes. These are at each bedside and are locked boxes which can house small items such as patients glasses, watches, dentures etc.

Updated prescription standards on Critical care and Monthly Audits
Following a complaint regarding a prescription error, the critical care team reviewed the prescribing standards for the units and updated them. These have since been reissued to staff and a zero Tolerance approach introduced. The Unit Pharmacists is also carrying out monthly retrospective audits against the prescription standards and feeding back to staff regarding any issues.

Improved Core Huddles on Critical Care – End of life care/ communication
Following a number of complaints regarding communication during end of life care the critical care team have updated their core huddle agenda to include a prompt for the Nurse in Charge and the Consultant of the day to ensure they have introduced themselves personally to family members. The Nurse in charge and Consultant will also ask the family if they have any questions or concerns.

Changes to Ultrasound scan
Within the ultrasound room usual practice was for the screen to be switched on and in full view of the patient whilst the sonographer is checking for any problems. Unfortunately this particular patient was suffering a miscarriage and patient said they knew straight away that something was wrong from looking at the screen and this was very distressing. Sonographers are now leaving the screen switched off until they have checked whether everything is ok and only after that they are asking the patient if they wish to see the screen.

Update to Home Visit Policy for AHP's
Following an incident involving a patient who fell in their home, the Policy has been updated to state that patients should not be left unattended when there are two members of staff visiting a patient. One member of staff should always stay with the patient.

Top 3 risks

1. Radiology reporting timescales and MR capacity.
2. MEAM medical device maintenance schedule
3. Resuscitation Service (Resuscitation Trolley Audits, defibrillators, Trustwide DNAR Audit)

Division's top 3 priorities for next year 2016/17

1. **Improvements to Staff Recognition processes**- We currently receive compliments for staff via a number of channels and plan to streamline the process in which we recognise staff in order to improve staff satisfaction and

morale. We aim to provide real-time feedback where possible and formally recognise outstanding practice.

2. **Patient Experience Communication framework** – In light of the Trustwide framework which has recently been established, the Division will be developing various work streams to ensure adherence to the framework. These include continued patient involvement events, improvements to staff forums and core huddle briefings, use of corporately branded information for patients such as the 'you said, we did' posters and better use of the CMFT-TV's.
3. **Continue to develop CRIS day case services to enhance the patient experience-** Work is currently underway to develop the clinical pathways for patients requiring lung biopsy and renal angiography to support patient admission to CRIS as a daycase rather than an inpatient.

Saint Mary's Hospital

Outcomes of last year's 3 top priorities 15/16

1. Embedding the Equality, Diversity and Inclusion Objectives in conjunction with the Quality Strategy and the Nursing and Midwifery strategy
   - Use of quality bus to deliver key messages to staff using the values and behaviours framework is embedded. During equality, diversity and Inclusion week the focus was on dress code and perceptions of discrimination.
   - The division has 14 equality advocates who have attended initial training
   - EDS evidence for the year demonstrates we are achieving all the standards

2. Reducing short term sickness, maintaining good levels of staff retention and motivation through staff engagement and embedding the Values and behaviours framework.
   - Recruiting to turnover

- Managing sickness in line with policy, support for managers provided on managing sickness and absenteeism
- Student summer evaluation forum held
- Nursing and midwifery staffing being supported to undergo revalidation
- Values and behaviours framework incorporated into all work streams and disseminated at every opportunity
- Staff supported to attend frontline leadership course

3. Service development: Improving quality the quality of services provided led by the quality Improvement and Directorate management teams, engaging with staff to streamline pathways
   The Division has:
   - Rolled out an appointment reminder service to help patients remember when their appointments are and to improve clinic usage.
   - Worked with colleagues from radiology to align clinic appointments with ultrasound appointments where possible in both Obstetrics and Gynaecology to reduce the time patients have to spend in outpatients.
   - Rolled out IPads to our community midwifery teams to enable them to access vital patient information whilst working in the community helping them to provide more informed care.

3 Main Outcomes from the Divisional Quality Review

1. Demand and staffing
2. Safeguarding
3. NICE guidance and audit

Responses to address the outcomes

1. Demand and staffing
   - A workforce plan has been developed for gynaecology nursing
   - An obstetric and neonatal strategy to manage capacity and demand has been endorsed by the executive team.
2. Safeguarding
   - Compliance for level 3 safeguarding has continued to improve and is monitored monthly. Divisional safeguarding work plan is in place
3. NICE guidance and audit
   - Improved engagement of clinical teams and good performance against Divisional audit forward plan

Improvements from Clinical audit, incidents, complaints and claims

1. Improvements in VTE management in Gynaecology- education package for all ward based staff on the use of anti-embolism stockings undertaken. Patient track system is now being used to record VTE assessments to promote completion of accurate and timely VTE assessments and sharing of information between clinicians. It is anticipated this will lower the risks to patient safety associated with preventable VTE.

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2. Reduction in stillbirths in Obstetrics- All cases are reviewed as part of the risk management process; research clinics and excellent bereavement service are in place. Education for staff is on-going to Increase detection of small gestational age (SGA) babies/Saving Babies Lives in the North Of England (SaBINE)
3. Launch of wound care standards in Obstetrics and Gynaecology to reduce the risks of surgical site infections
4. Audit, subsequent actions and re audit of pain management and provision of analgesia in post-operative neonates has demonstrated a marked improvement of pain management in NICU.
5. Improvements in compliance with Safe Surgical Check List (SSCL) both in and out of theatre settings.

Top 3 risks

1. Midwifery and medical staffing and Obstetric capacity. There has been an increase in the numbers of women booking at Saint Mary's Hospital from 5000 to 9000 in the last 6 years. A further increase in 2015/16 along with an increase in the induction of labour rate, combined also with a delay in the ability to recruit midwives and medical staff.
2. Patient results in Gynaecology are not managed in a timely manner and this has led to some patients incurring delays in their treatment or missed opportunity for treatment.
3. The lack of availability of junior medical staff on NICU and the post natal wards to meet increasing demand as a result of increasing birth rate and complexity of patients.

Division's top 3 priorities for next year 2016/17

1. To complete and implement Local safety standards for interventional procedures(LocSSIPs) across the division and look at developing and implementing a model for improvement and engagement using human factors to help support prevention of never events
2. Service development- continue to improve the quality of our services and effectively encourage stakeholder participation
3. Commit to driving safe and effective efficiencies throughout the Division

Division of Specialist Medicine

Outcomes of last year's 3 top priorities 14/15

The Division has developed plans to address the shortfall of bed and workforce capacity across medical specialty services, in particular for Clinical Haematology and Cardiology patients, where the clinical team have developed a Business case, which has been approved by the Trust Board in November, to support the redesign and reconfiguration of the Bone Marrow

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Transplant Unit and Clinical Haematology Day Unit.

Temporary PODs have been installed in the Haematology Unit to provide single room facilities for our patients in the interim to the main reconfiguration being commissioned over the next 12 months.

For the Manchester Heart Centre, the redesign of Wards 3&4 to assist in managing access and capacity issues, have also been the focus for the approach through the Division to mitigate risks.

All areas engaged in the 'Shine' project - Health Records improvement plan, identifying key touch points causing friction for frontline staff, resolving, improving access and content of notes. The development and implementation of the ICE electronic ordering system has improved the requesting process for diagnostic tests for our patients.

Work continues with all specialty teams across the MRI to deliver care to '*The Right Patient at the Right Time in the Right Bed'*, through The Perfect Week exercise and also by closer working with acute medicine to improve safe management outlying medical patients within/out of the Division. Clinical teams have engaged in reviewing pathways of care that cross Division boundaries.

3 main Outcomes from the Divisional Quality Review

1. The Division had very positive feedback from patients as part of the Quality Review, in particular commending staff for their flexibility and kindness to patients, sometimes in difficult circumstances such as short staffing and lack of bed capacity, and the impact of CPE outbreaks. Main areas for improvement related to addressing some concerns surrounding Safe Surgery Checklist with Cardiac Catheter Laboratory and Endoscopy. The consultants have led the actions here to address and improve these procedures to ensure that interventional procedures are safer.
2. The capacity risks relating to beds and workforce and some infrastructure were recognised and as described above the Division has developed improvement plans and have approved investment to improve these areas significantly over 2016/17.
3. Some further improvement is required surrounding medication and health records storage and these are being addressed, led by Ward Managers and supported by the multi-disciplinary ward teams

Responses to address the outcomes

1. Safe Surgery Checklist fully implemented across the Division and assurance provided by monthly audit of compliance in Cardiac Surgery, Catheter Labs, Dermatology and Endoscopy, led by specialty matrons and respective consultant clinical leads.
2. A specialty cohort area has been developed on AM3 for managing haematology patients, to improve capacity and access to service, whilst the above improvements are being commissioned.
3. Focused improvement work regarding medication and health records storage implemented within the Division.

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Improvements from Clinical audit, incidents, complaints and claims

1. The overall themes emerging from complaints and incidents are highlighting that the main areas of risks are bed capacity, access and waiting times for patients, and workforce shortages in particular nursing staff. Improving information for patients related to specific services, including treatment effects and any potential adverse risks re medication are to be given to patients.
2. The implementation of the ICE system has also highlighted the need for a focus on review of wrong blood in tube incidents, which identified the need to increase monitoring by Ward Managers and Matrons.
3. Significant improvements have been enabled to reduce patient falls and pressure ulcer prevention through two nurse led campaigns called respectively ' *Catch me if you can'* and '*Move and Groove.*'

Top 3 risks

1. The risks presented by CPE have been significant and have remained a key of our improvement work to reduce risks of transmission between patients, and CPE acquisitions, particularly in at risk patient groups e.g. Bone Marrow Transplant patients
2. The impact of lack of bed capacity, nursing workforce shortfalls increase the Division's risk of failing to achieve financial and productivity target due to a lack of capacity in terms of beds and medical workforce in key speciality areas.
3. A third and connected key risk to the above relates to lack of access services, leading to increased waiting time, potential impact on reputation of Trust/Division/Directorate/Speciality.

Division's top 3 priorities for next year 2015/16

1. Delivering Inpatient services across all our medical specialty services at local and tertiary level, safely and through the right sized bed and workforce levels.
2. Delivering Outpatients Transformation improvement projects within the Division.
3. Improving patient access to services and reducing waiting times.

Division of Surgery (awaiting report)

Data Assurance Processes and Information Governance

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Our People

Our people are the driving force behind what we deliver as a Trust for one another, our patients and our community.

By supporting our people in becoming the best at what they do they will deliver the highest quality care and experience for our patients.

The CMFT People Strategy is being developed with people across the organisation: staff, patients, students and trainees, and wider partners.

The 3 year strategy outlines how we are working together to create the right values culture so that all of our staff can succeed in delivering our vision and priorities.

It sets out our commitment to and our priorities for leading and enabling our staff to succeed now and in the future.

What follows is an overview of these priorities and some key highlights from 2015-16

1. ***Anticipating and understanding how our workforce needs to change so that we have the skills and flexibility to continuously provide the highest quality of care.***

   We have and will continue to work with partner organisations across the city to better understand how our workforce will change and develop in light of the changes to the way that health and social care will be delivered across the region from April. This means looking at new more flexible roles and identifying the skills, knowledge and experience they will need to deliver new models of care.

   What have we done so far?

2. ***Making sure that we have the best people in the right roles and with the right skills***

   Having the right staffing and skills levels, optimises the contribution staff are able to make. We have developed workforce plans for all areas that are aligned to our hospital business plans and we have invested in an electronic rostering system that has been used by our nursing team to ensure that we have the right levels across all our wards. Our Electronic Rostering team won a prestigious annual award this year for putting patients at the heart of workforce planning.

3. ***Attracting and recruiting new high calibre people whilst at the same time supporting the career development of our existing staff.***

   Can we add something here around pre=-employment and the WP work.

   We have introduced creative and modern ways to attract and recruit staff including developing our 'Proud to Care' campaign which has been very successful in recruiting ? (how many) Band 5 nurses both domestically as well as from Europe and India.

   We have started to introduce assessment and selection processes that embed our values and all new staff receive a copy of our values on their first day at work. This ensures any new recruits know what is expected of them and are able to contribute to shaping a compassionate caring culture.

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We have recruited 13 new graduates onto our own graduate development programme following the success of our first cohort. We also support regional and national graduate development schemes.

Central Manchester is a recognised apprenticeship training provider offering accredited level 2 and 3 programmes within health and social care, pharmacy and business administration. This year 190 apprentices are on programmes. Increasing access to apprentice positions across the Trust will be a priority over the next 12 months.

We know that we already have some of the best people working in our hospitals and so it is essential we ensure they have the support to develop and grow their careers. Retaining our talented workforce through? has been a key focus this year.

4. ***Further developing a workplace that encourages creativity, innovation and supports the health and wellbeing of our staff so we are better able to meet the needs of our patients.***

Further developing a high performing inclusive and values based culture has been a top priority for us this year.

Almost 1000 staff have in the last 12 months received training in Living our Values ensuring we further embed a strong patient and customer focus and our CQC inspection has encouraged all of us to look at where we are clearly demonstrating our values and where we can make improvements that make a difference to patient and staff experience.

We have strengthened our appraisal process so all staff are able to demonstrate how they live our values on a day to day basis and are supported by their managers to set clear goals and objectives aligned to the Trusts strategic priorities. This year in our staff survey 93% of staff said that they had received an appraisal in the last 12 months which is above the national average.

We continue to invest in developing strong leadership and effective people management. Almost 500 staff have now completed a leadership and management programme and 250 of these are medical staff who are critical to leading our hospitals and shaping the future of care. This year we introduced the Foundation and Intermediate Leadership Programmes designed and delivered by CMFT staff to support frontline and new managers.

We have supported our staff to develop their skills in leading change and implementing quality improvements so that more people can work with our patients to improve outcomes.

We have engaged in different ways with our staff to identify ways to support them and maintain their health and well-being. For example
Identified how we can support the needs of our staff who also act as carers.
How many staff ? We ran a very successful influenza vaccine campaign in order to protect patients and staff.

5. ***Encouraging and developing our people to be more involved in making decisions that affect them and our patients and recognising and rewarding achievement that drives excellent patients experience and outcomes.***

Seeking the views of our staff is critical to understanding what challenges they face and how we can improve. As well as the annual national staff survey this year we introduced a quarterly electronic staff pulse check. This asks staff a range of questions particularly focussed on their view of CMFT as a place to receive care and to work. The pulse check has helped us gather the thoughts and ideas of staff more frequently and enabled us to respond more quickly.

2015 staff survey to be added

Finally every year we recognise the great achievements of our staff who every day go that extra mile to deliver excellent patient care. Last year over 250 staff attended a sponsored 'We're Proud of You' gala event where their success was acknowledged.

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Glossary of Definitions

Term	Definition
AKI	Acute Kidney Injury is a rapid reduction in kidney function resulting in difficulties in clearing excess water, electrolytes and toxins. It is very common amongst patients admitted in hospital.
Bacteraemia	The presence of bacteria in the blood.
Care provider	An organisation that cares for patients. Some examples of which are hospital, doctors, surgery or care home
Catheter Associated Urinary Tract Infection (CaUTI)	An infection believed to have been caused by a urinary catheter
Clinical	Relating to the care environment
Clostridium difficile	A type of infection. Symptoms of *C. difficile* infection range from mild to severe diarrhoea
Condition	An illness or disease which a patient suffers from
COPD	Chronic obstructive pulmonary disease. The name for a collection of lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease.
Core Values	A group of ideals which the Trust believes all staff should exhibit
CQUIN	Commissioning for Quality and Innovation. This is a system introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specialised areas of care.
Dementia	Is a syndrome (a group of related symptoms) that is associated with an on-going decline of the brain and its abilities
Emergency readmissions	Unplanned readmissions that occur within 28 days after discharge from hospital. They may not be linked to the original reason for admission
Falls	Unintentionally coming to rest on the ground, floor/lower level, includes fainting, epileptic fits and collapse or slip
Harm	An unwanted outcome of care intended to treat a patient
Improving quality programme (IQP)	An approach taken to bring about quality improvement in our clinical areas using specific improvement tools
HSMR	Hospital Standardised Mortality Ratio. A system which compares

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	expected mortality of patients to actual
Length of stay (LOS)	The amount of days that a patient spends in hospital
Monitor	Monitor was established in 2004 and authorises and regulates NHS Foundation Trusts. Monitor works to ensure that Foundation Trusts comply with the conditions they have signed up to and that they are well led and financially robust.
Mortality	Mortality relates to death. In health care mortality rates means death rate.
MRSA	Methicillin-resistant *Staphylococcus aureus*- is a bacterium that is found on the skin and in the nostrils of many healthy people without causing problems. However, for some people it can cause infection that is resistant to a number of widely used antibiotics
NCEPOD	National Confidential Enquiry into Patient Outcome and Death. Reviews the management of patients, by undertaking confidential surveys and research.
Never Events	These are largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented
NHS Professionals (NHSP)	Specialist organisation within the NHS recruiting and supplying temporary doctors, nurses, and corporate staff
Patient safety incidents	Is any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care
Pressure ulcer	sometimes known as bedsores or pressure sores, are a type of injury that affect areas of the skin and underlying tissue, caused when the affected area of skin is placed under too much pressure. They can range in severity: Grade One – Discolouration of intact skin not affected by light finger pressure Grade Two – Partial thickness skin loss or damage Grade Three –Full thickness skin loss involving damage of subcutaneous tissue Grade Four – Full thickness skin loss with extensive destruction and necrosis (dead tissue
Patient reported outcome measures (PROMs)	Tools which help us measure and understand the quality of the service we provide for specific surgical procedures. They involve patients completing two questionnaires at two different time points, to see if the procedure has made a difference to their health.
R Codes	R Codes are clinical codes used to record a patients signs & symptoms i.e. **Chest Pain**, **Abdominal Pain** etc.
Root Cause Analysis	A systematic method of doing an investigation that looks beyond the

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(RCA)	people concerned to try and understand the underlying causes and environmental context in which the incident happened.
Safety thermometer	A point of care survey which is used to record the occurrence of four types of harm (pressure ulcers, falls, catheter associated urinary tract infection and venous thromboembolism
SHMI	Standardised hospital mortality index. A system which compares expected mortality of patients to actual mortality (similar to HSMR).
Sunquest Integrated Clinical Environment (ICE)	A system to request and report radiology and pathology investigations and to order a wide range of service referrals.
The Trust	Central Manchester NHS Foundation Trust. A Foundation Trust is part of the National Health Service in England and has to meet national targets and standards. NHS Foundation Trust status also gives the organisation greater freedom from central Government control and financial flexibility.
Urinary Catheter	A device which is placed into a patient's bladder for the purpose of draining urine
Venous thromboembolism (VTE)	A blood clot formed within a vein
Vein	A blood vessel that carries blood towards the heart

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PART 3. Other Information

Performance of the Trust against Selected Metrics

The following information sets out the Trust's performance against 10 important indicators which have been selected in conjunction with the Governors, other key stakeholders and the Board of Directors. You will see that the information is presented to show results over three years and where possible we have provided results from other Trusts so that a comparison against performance is possible.

Overall the results demonstrate year on year improvement and we will continue to focus our efforts to ensure even better results. We value the feedback from our patients which we continuously use to improve care and treatment. The results featured below in the areas of nutrition and hydration has seen a slight deterioration this year and therefore will be a feature of targeted improvement efforts.

		Data Source	2013/14	2014/15	2015/16	Latest Available Benchmark	Indicator Comments
Patient Safety Measures	Improvement in VTE risk assessments carried out	Trust Data	96%	96%	96%	95%	DOH Data
	Reduction in hospital acquired grade 3 or 4 pressure ulcers	Trust Data	63	39		89	-
	Reduction in serious patient safety incidents resulting in actual harm (those graded at Level 4 or 5)	National Patient Safety Authority Data	42	APC			
Clinical Effectiveness	Reduce hospital standardised mortality ratio (HSMR)	Dr Foster	91.6	93.81	103.22	100	Target is national
	Reduce Summary Hospital Mortality Indicator (SHMI)	Dr Foster	103.9	99	97	100	Target is national
	Reduce the number of potentially avoidable cardiac arrests outside of critical care area (Trust Data)	Trust Data via Resuscitation Summary Report	174	198			? to remove this. Check with SC
	Improve stroke care audit composite score	National Audit Data	Q4 43.7 (Grade D)	Q4 (Calendar year Oct-Dec)-51.9 (Grade D)	Q3 (Calendar year July-Sept) 62.1 (grade c)		

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Patient Experience Measures	Increase overall satisfaction expressed with pain management	Locally collected data via electronic tracker devices	89.18%	90.20%	90.50%	85% (local target)	
	Increase overall satisfaction expressed with fluids and nutrition provided		78.11%	93.40%	93%	85% (local target)	
	Increase overall satisfaction with the cleanliness of the ward or department		90.51%	94.36%	95.10%	-	

*This number differs from that reported in the account 2012/13 because it now represents a full year's figure.

**This number differs from that reported in the account 2012/13 because the criteria used for this has been amended in this year's report to include, fracture neck of femur (broken hip), incidents from Trafford hospital and those incidents identified after year end.

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Achievements against key national priorities and National Core Standards

		Data Source	2013/14	2014/15	2015/16	Latest Available Benchmark	Indicator Comments
Infection Control	Reduction of the number of Clostridium Difficile cases (Intelligent Board)	Trust Data	54	75	54	55	-
	Clostridium Difficile Infection per 100,000 bed days in patients aged 2 or over		12.7	18.6		-	-
	Reduction of the number of MRSA cases (Intelligent Board)	Trust Data	8	5	6	0	
Cancer Waiting Times	Maximum waiting time of two weeks from urgent GP referral to first out-patient appointment for all urgent suspected cancer referrals	Open Exeter Cancer Waiting Times system	96%	95%	95.1%	93%	
	Maximum 31 days from decision to treat to start of treatment extended to cover all cancer treatments	Open Exeter Cancer Waiting Times system	98%	98%	97.5%	96%	
	Maximum 31 days from decision to treat to start of subsequent treatment Surgery	Open Exeter Cancer Waiting Times system	98%	97%	96%	94%	
	Maximum 31 days from decision to treat to start of subsequent treatment Chemotherapy	Open Exeter Cancer Waiting Times system	98.8%	100%	100%	98%	
	Maximum waiting time of 62 days from urgent referral to treatment for all cancers	Open Exeter Cancer Waiting Times system	87%	82.3%	83.6%	85%	-
	Maximum waiting time of 62 days from cancer screening programme	Open Exeter Cancer Waiting Times system	85.1%	71.4%	90.9%	90%	-
Referral To Treatment	18 weeks maximum wait from point of referral to treatment (non admitted patients)	UNIFY2	96%	94.9%*	93.8%	95%	
	18 weeks maximum wait from point of referral to treatment (admitted patients)	UNIFY2	92%	89.1%	86%	90%	
	18 weeks maximum wait from patients not yet treated	UNIFY2	93%	92.4%	92.1%	92%	

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Urgent Care	Maximum waiting time of 4 hours in A&E from arrival to admission, transfer or discharge	Sitrep	95%	94%	94%	95%	

Feedback from Governors

Commissioner's Statement

Feedback from the Health and Wellbeing Scrutiny Committee

Statement of Directors' responsibilities in respect of the Quality Report

Annex 1: Statements from commissioners, local Healthwatch organisations and Overview and Scrutiny Committees

Annex 2: Statement of Directors' Responsibilities in Respect of the quality Report 2015/16