Mid Cheshire Hospitals NHS Foundation Trust

AGENDA

Board of Directors
A meeting will be held in Public at
09.30am on Tuesday, 7 May 2019
in the Boardroom, Leighton Hospital

Action Key	
A	Approval
I	Information
D	Discussion

Item No	Title of Item	Action	Led By	Page No.
1.	**Welcome and Apologies** To welcome members of the public and attendees and to receive apologies for absence from Board Members. *(to note)*	I	Chairman **09.30**	-
2.	**Patient or Staff Story** *(verbal)*	I/D	Director of Nursing & Quality **09.32**	-
3.	**Board Member's Interests** *(to note)* To **consider** any • Changes to Directors' interests since the last meeting • Conflicts of interest deriving from this agenda	I	Chairman **09.50**	-
4.	**Minutes of the Last Meeting** To **approve** the minutes of the Board of Directors meeting held in Public on Monday 1 April 2019	A	Chairman **09.52**	**4**
5.	**Matters Arising and Action Log** *(attached) (to approve)*	A	Chairman **09.55**	**19**
6.	**Annual Work Programme 2019/20** *(attached)* *(to approve)*	I/A	Chairman **09.57**	**20**
7.	**Chairman's Announcements** (*to note a verbal report*)	I	Chairman **10.00**	-
	7.1 Chief Executive Office Appointment			
	7.2 Interim Director of Finance and Strategic Planning			
	7.3 Non-Executive Director Appraisals			
	7.4 CCICP Showcase Event			
	7.5 Meetings with East Cheshire NHS Trust			
	7.6 Board Away Day – 15 April 2019			
8.	**Governor's Items** (*to note a verbal report*)			-
	8.1 Extra Ordinary Council of Governors Meeting – 3 April 2019	I	Chairman **10.15**	
	8.2 Council of Governors Meeting – 25 April 2019			

Item No		Title of Item	Action	Led By	Page No.
9.	**Interim Chief Executive's Report** *(to note a verbal report)*				
	9.1	**System Update**	I	Interim Chief Executive **10.25**	-
	9.2	**Exec to Exec Meeting with East Cheshire Trust**			
	9.3	**CQC Engagement Meeting**			
	9.4	**NHSI Quarterly Review Meeting**			
10.	**CARING**				
	10.1	**Quality, Safety & Experience Report** *(attached) (for discussion)*	I/D	Director of Nursing & Quality **10.40**	**21**
11.	**SAFE**				
	11.1	**Draft Quality Governance Committee notes from the meeting held on 8 April 2019** *(attached) (to note)*	I	Committee Chair **10.50**	**68**
	11.2	**Serious Untoward Incidents and RIDDOR Events** *(verbal)* (*to note*)	I/D	Interim Medical Director **10.55**	-
12.	**RESPONSIVE**				
	12.1	**Performance Report** *(to follow) (to note)*	I/D	Director of Finance **11.00**	**at end of pack**
	12.2	**Draft Performance & Finance Committee notes from the meeting held on 26 April 2019** *(to follow) (to note)*	I	Committee Chair **11.10**	-
	12.3	**Legal Advice** *(verbal)* (*to note*)	I	Interim Chief Executive **11.15**	-
	12.4	**Freedom to Speak up Guardian Q4 Report 2018/19** *(attached) (to note)*	I/D	Director of Nursing **11.20**	**82**
	12.5	**Budget Update** *(presentation) (to note)*	I/D	Director of Finance **11.25**	**85**
13.	**WELL-LED**				
	13.1	**Visits of Accreditation, Inspection or Investigation** *(verbal)* (*to note*)	I	Interim Chief Executive **11.35**	-

Item No	Title of Item	Action	Led By	Page No.
13.2	**Quality Account** *(attached) (to note)*	I/D	Director of Nursing and Quality **11.40**	**146**
13.3	**Report on the Use of the Trust Seal** *(attached) (to note)*	I	Interim Chief Executive **11.45**	**237**
13.4	**Providers Licence Self-Certification 2018** *(attached) (to approve)*	A/D	Interim Chief Executive **11.50**	**239**
14.	**EFFECTIVE**			
14.1	**Workforce Report** *(attached) (to note)*	I/D	Director of Workforce and OD **11.55**	**247**
14.2	**Transformation and People Committee notes from the meeting held on 4 April 2019** *(attached) (to note)*	I	Committee Chair **12.05**	**250**
14.3	**Consultant Appointments** *(verbal) (to note)*	I	Interim Medical Director **12.10**	**-**
15.	**Any Other Business** *(verbal)*	A/I/D	Chairman	**-**
16.	**Time, Date and Place of Next Meeting** To confirm that the next meeting of the Board of Directors will take place in public, in the Autumn Suite, Hunters Lodge Crewe at 9.30am on **Monday 3 June 2019.**	I	Chairman	

Board of Director Meeting held in Public (Action Log)

Action No	Date of Meeting	Action	Lead	Deadline Date	Comments	Date of Board meeting to be reviewed	Status
19/03/10/1/10	04-Mar-19	Outcome of the complaints investigation in Urology to be reported to QGC	J Tunney	08-Apr-19		07-May-19	

Board of Directors Workplan 2019/20

Version: 2

Item	Board of Directors Meeting												Board Away Day				
	April	*May*	*June*	*July*	*August*	*Sept*	*Oct*	*Nov*	*Dec*	*Jan*	*Feb*	*March*	*Apr*	*Jun*	*Oct*	*Dec*	*Feb*
Patient/Staff Story	x	x	x	x	x	x	x	x	x	x	x	x					
Minutes of the Last Meeting	x	x	x	x	x	x	x	x	x	x	x	x					
Board Actions	x	x	x	x	x	x	x	x	x	x	x	x					
Annual Work Programme	x	x	x	x	x	x	x	x	x	x	x	x					
Chairman's Report	x	x	x	x	x	x	x	x	x	x	x	x					
Governor Items	x	x	x	x	x	x	x	x	x	x	x	x					
Chief Executive's Report	x	x	x	x	x	x	x	x	x	x	x	x					
Caring																	
Nursing and midwifery staffing comprehensive report							x										
Patient Survey Results (National)			x														
Patient Quality Safety and Experience Report	x	x	x	x	x		x	x	x	x	x	x					
Staff Survey		x															
Safe																	
Health & Safety Update to Board														x			
SUI & RIDDOR	x	x	x	x	x	x	x	x	x	x	x	x					
Quality Governance Committee	x	x	x	x	x	x	x	x	x	x	x	x					
Guardian of Safe Working Hours Report	x			x			x			x							
Responsive																	
Annual Budget/Planning/ Budget Pack	x											x					x
Quality Account		x															
Legal Advice	x	x	x	x	x	x	x	x	x	x	x	x					
Performance & Finance Committee	x	x	x	x	x	x	x	x	x	x	x	x					
Performance Report	x	x	x	x	x	x	x	x	x	x	x	x					
Report on Use of Trust Seal		x			x			x			x						
Corporate Trustee													x		x		x
Freedom to Speak up Guardian		x			x			x			x						
Well-Led																	
Annual Budget/Contract Discussions	x											x					
Annual Plan	x	x										x					
Annual Report & Accounts (Extra Ordinary Board)		x															
Audit Committee		x	x				x		x		x						
Board Assurance Framework	x			x		x			x			x					
Quarterly Organisational Risk Register	x			x			x			x							
Learning from Deaths Quarterly Report			x			x			x			x					
Trust Strategy				x				x							x		x
Visits of Accreditation, Inspection or Investigation	x	x	x	x	x	x	x	x	x	x	x	x					
Well-Led Governance Framework Self Assessment																	x
Corporate Goverance Handbook										x							
Board Sub-Committee Annual Review			x														
Emergency Preparedness, Resilience& Response (EPPR)							x										
Doctors Revalidation Report						x											
Effective																	
Workforce Report	x	x	x	x	x	x	x	x	x	x	x	x					
Equality Delivery System					x												
Workforce Race Equality Scheme						x											
Gender Pay Gap Report																	
Transformation and People Committee	x	x	x	x	x	x	x	x	x	x	x	x					
Consultant Appointments	x	x	x	x	x	x	x	x	x	x	x	x					
Medical Staffing Update (Part II)	x	x	x	x	x	x	x	x	x	x	x	x					

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

We Care Because You Matter

Quality, Safety and Experience Report

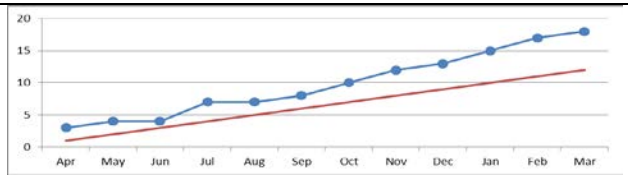
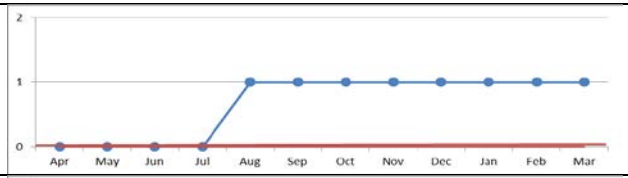
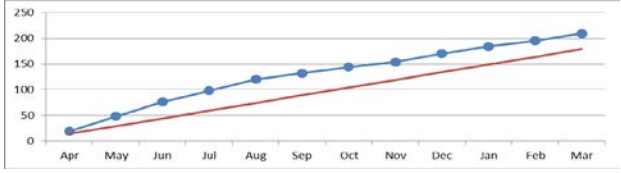
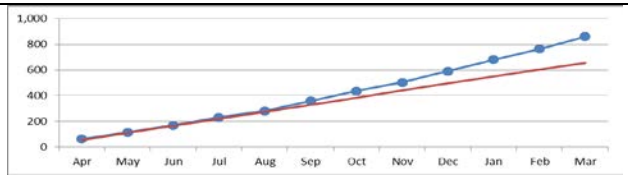
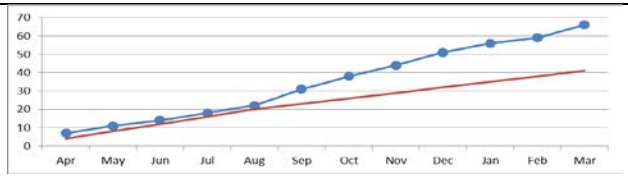
May 2019

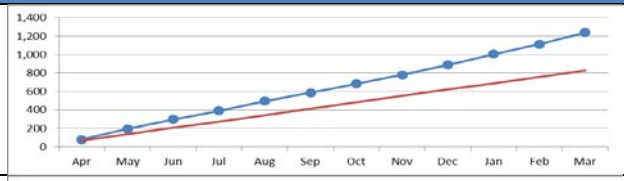
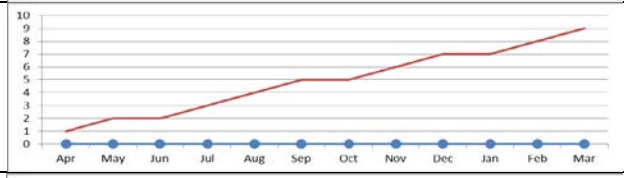
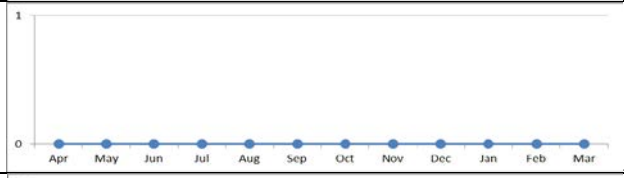
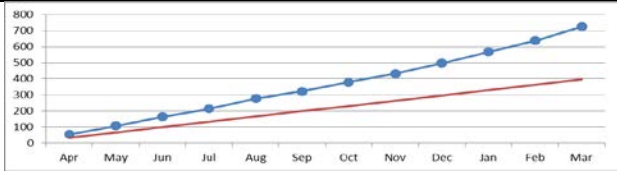
(March 2019 data)

Contents

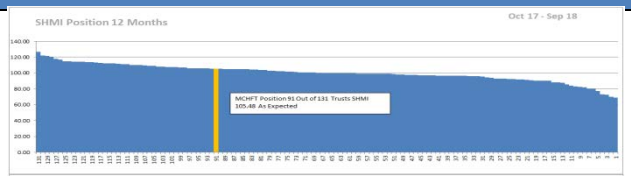
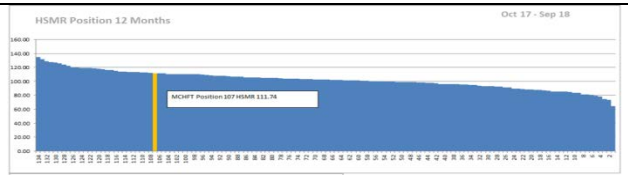
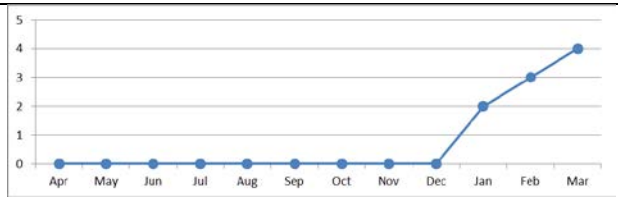
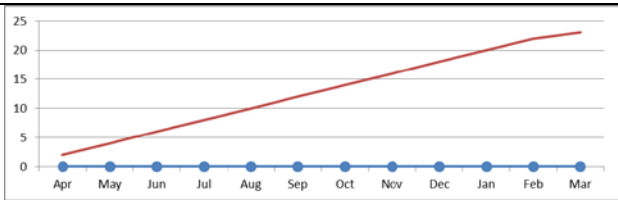
Contents (continued):

Board Papers – Quality, Safety & Experience Section: May 2019

Indicators	Target	Trajectory 2018/19
Acute Trust		
Patient Safety Harm Incidents The target is to reduce patient safety harm incidents by 5% when compared to the previous financial year by the end of March 2019.	**Less than 2161 at end of March 2019**	
Serious Incidents The target is to reduce patient safety serious incidents by 10% when compared to the previous financial year by the end of March 2019.	**Less than 12 at end of March 2019**	
Never Events Zero tolerance of Never Events.	**Zero**	
Pressure Ulcers – Hospital Acquired The target is to reduce hospital acquired pressure ulcers by 10% when compared to the previous financial year by the end of March 2019.	**Less than 150 at end of March 2019**	
Inpatient Falls The target is to reduce inpatient falls by 10% when compared to the previous financial year by the end of March 2019.	**Less than 656 at end of March 2019**	
Medication Harm Incidents The target is to reduce medication incidents resulting in harm by 10% when compared to the previous financial year by the end of March 2019.	**Less than 41 at end of March 2019**	

Indicators	Target	Trajectory 2018/19
CCICP		
CCICP Patient Safety Harm Incidents The target is to reduce CCICP patient safety harm incidents by 5% when compared to the previous financial year by the end of March 2019.	**Less than 828 at end of March 2019**	
CCICP Serious Incidents The target is to reduce CCICP patient safety serious incidents by 10% when compared to the previous financial year by the end of March 2019.	**Less than 9 at end of March 2019**	
CCICP Never Events Zero tolerance of CCICP Never Events.	**Zero**	
CCICP Pressure Ulcers – Community Acquired The target is to reduce community acquired pressure ulcers by 10% when compared to the previous financial year by the end of March 2019.	**Less than 398 at end of March 2019**	

Board Papers – Quality, Safety & Experience Section: May 2019

Indicators	Target	Trajectory 2018/19
SHMI The Trust's target is to be at least within the "as expected" bracket. This has been achieved for the latest reporting period.	**As expected**	
HSMR The Trust's target is to be at least within the "as expected" bracket. This has been achieved for the latest reporting period.	**As expected**	
MRSA Zero tolerance of MRSA cases.	**Zero**	
C-Diff Avoidable The target is less than 23 avoidable cases of Clostridium Difficile in 2018/19.	**Less than 23 at end of March 2019**	
Safety Thermometer The Trust target is that >95% of patients receive harm free care as monitored by the Safety Thermometer.	**>95%**	

Quality & Safety Section:

Description **Aggregate Position** **Trend**

Patient Safety Harm Incidents

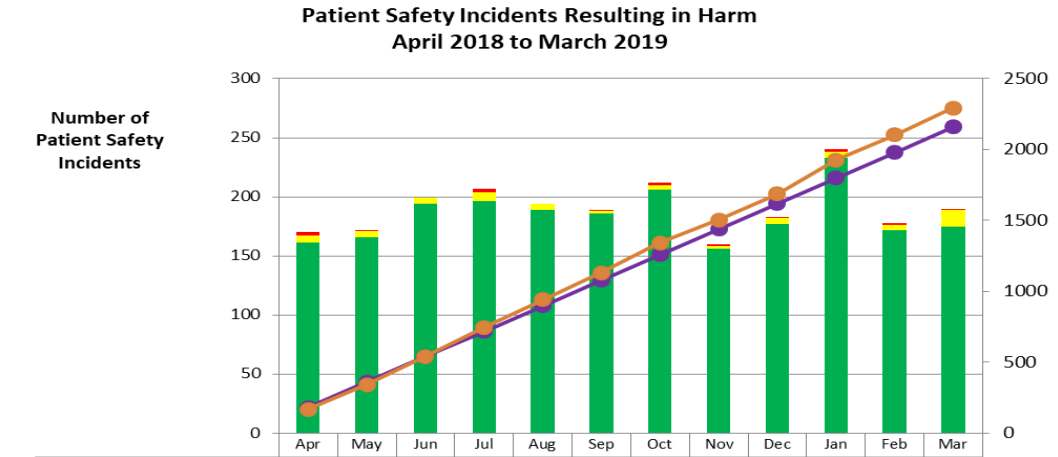
The target is to reduce patient safety harm incidents by 5% when compared to the previous financial year by the end of March 2019.

This chart demonstrates the total number of reported patient safety harm incidents.

For March 2019, there were a total of 190 patient safety harm incidents:
92.1% (175 incidents) have resulted in low harm
7.4% (14 incidents) have resulted in moderate harm
0.5% (1 incidents) resulted in serious harm

To reduce the number of patient safety harm incidents, a number of initiatives are being undertaken.
These include:

- Twice monthly Patient Safety Summit Meetings with Executive & Senior Teams
- Twice monthly Patient Safety Matters newsletter that is delivered Trust wide
- NEWS2 was launched to all inpatient areas on the 5 November 2018.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Serious Incident	3	1	0	3	0	1	2	2	1	2	2	1
Moderate Harm	6	5	5	8	5	2	4	2	5	5	4	14
Low Harm	161	166	194	196	189	186	206	156	177	233	172	175
Target	180	360	540	720	900	1080	1260	1440	1620	1800	1980	2161
Cumulative Total 2018/19	170	342	541	748	942	1131	1343	1503	1686	1926	2104	2294

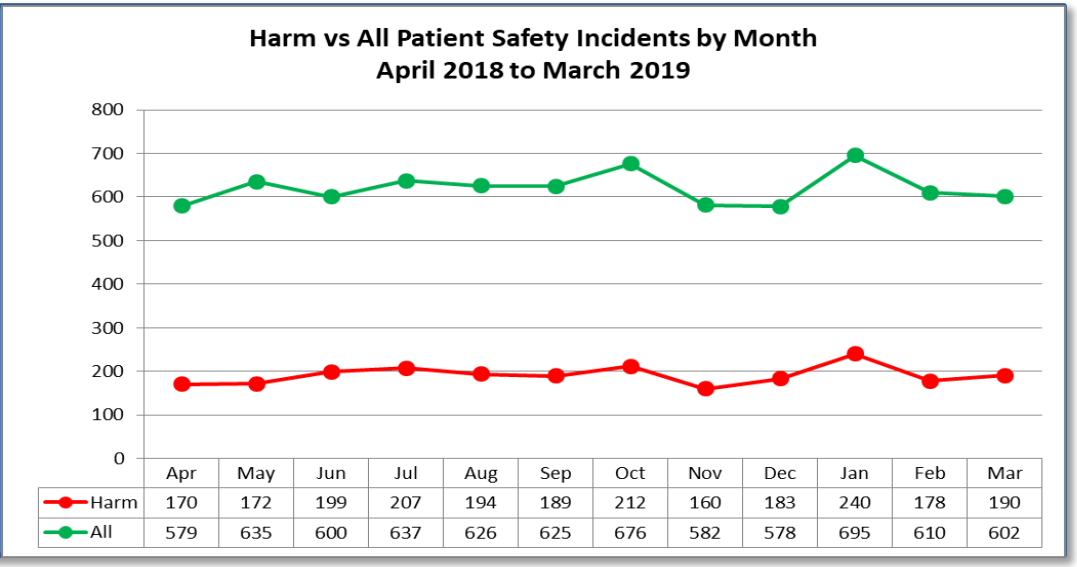
Harm vs All Patient Safety Incidents

The aim is to maintain / widen the gap between harm and all patient safety incidents reported

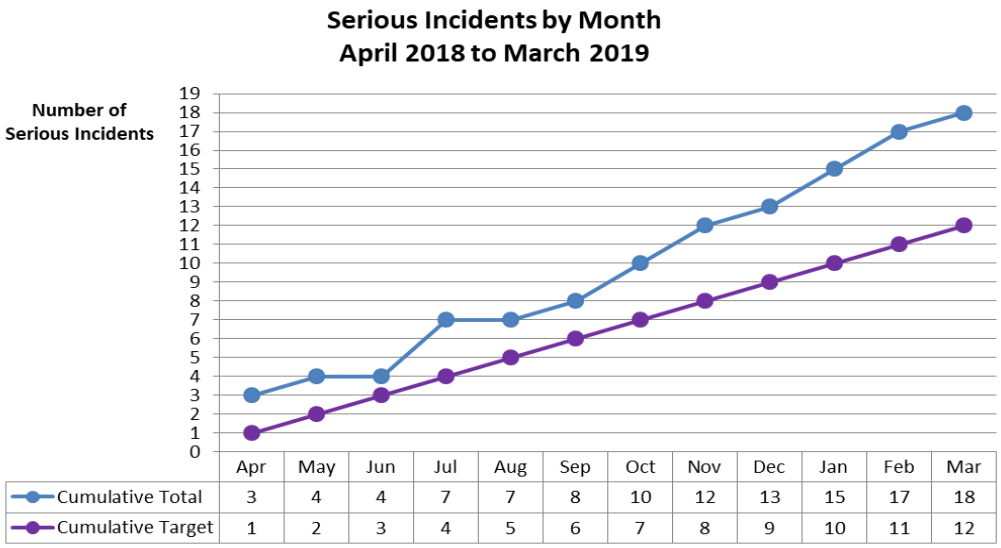
This chart demonstrates the number of incidents that have resulted in harm vs all patient safety incidents.

In March 2019, the gap between harm and all patient safety incidents was 412. The aim over the twelve month period is to see this gap widening.

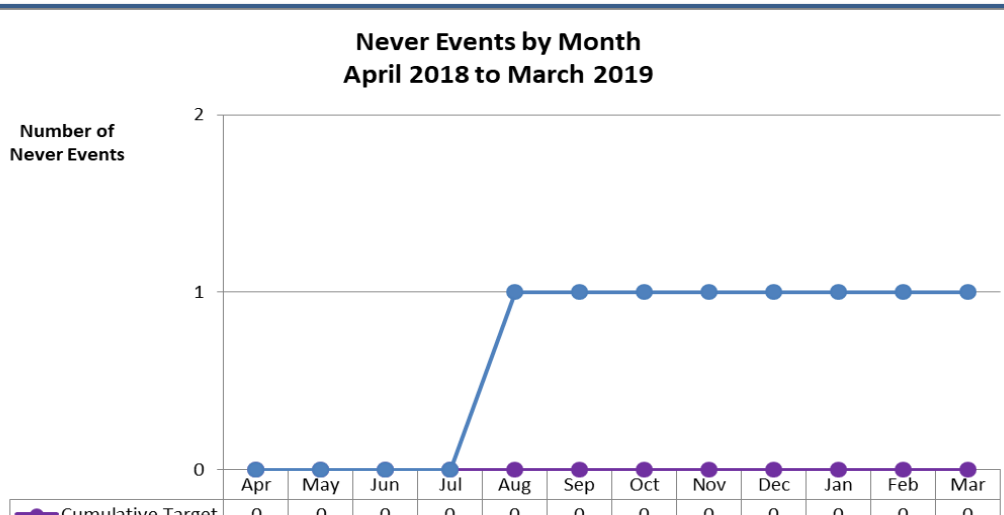
Within healthcare, a safety culture is defined as a "culture where staff has a constant and active awareness of the potential for things to go wrong. It is also a culture that is open and fair and encourages people to speak up about mistakes." An important benefit in a safety culture in the NHS is "A potential reduction in the recurrence and in the severity of patient safety incidents through increased reporting and organisational learning" *Source: 7 steps to patient safety, NPSA, 2004.*



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Harm	170	172	199	207	194	189	212	160	183	240	178	190
All	579	635	600	637	626	625	676	582	578	695	610	602

Description	Aggregate Position	Trend
Serious Incidents *The target is to reduce patient safety serious incidents by 10% when compared to the previous financial year by the end of March 2019.*	This chart demonstrates the number of incidents that have resulted in serious harm. For March 2019, there was one serious incident reported. • Patient Fall resulting in fractured neck of femur on Ward 14.	

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative Total	3	4	4	7	7	8	10	12	13	15	17	18
Cumulative Target	1	2	3	4	5	6	7	8	9	10	11	12

Description	Aggregate Position	Trend
Never Events *The target is to have zero Never Events*	This chart demonstrates the number of Never Events that have been reported. For March 2019 no Never Events were reported.	

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative Target	0	0	0	0	0	0	0	0	0	0	0	0
Cumulative Total	0	0	0	0	1	1	1	1	1	1	1	1

Description	Aggregate Position	Trend

Pressure Ulcers (PU) – Hospital Acquired

The target is to reduce hospital acquired pressure ulcers by 10% when compared to the previous financial year by the end of March 2019.

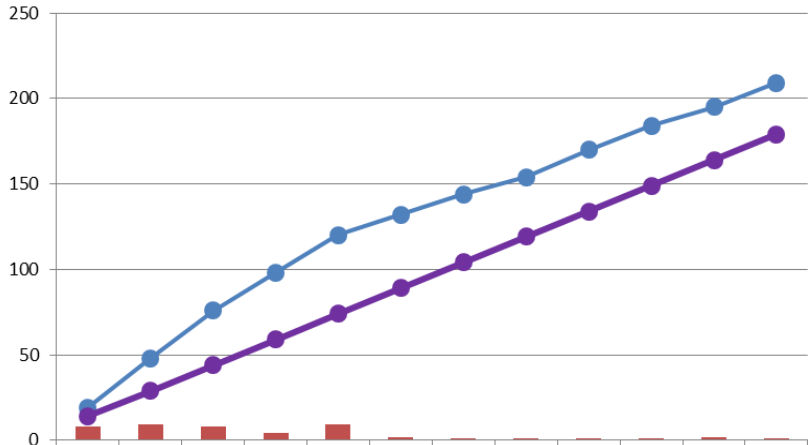
For March 2019, there were a total of 14 hospital acquired pressure ulcer incidents:

- 7.1% (1 PU) has resulted in lapses of care identified. This was a category 2 pressure ulcer. All lapses in care identified for pressure ulcers are reviewed at the monthly pressure ulcer panel.
- 42.9% (6 PU's) have been classed as no lapses of care identified following investigation. Four were category 2 pressure ulcers, and two were unstageable pressure ulcers.
- 50% (7 PU) are awaiting confirmation.

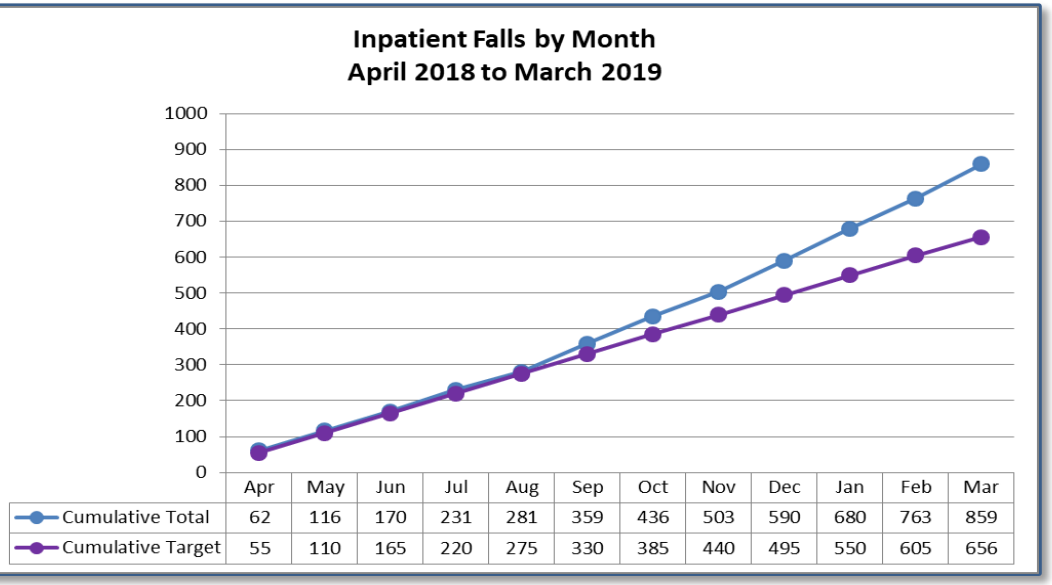
Improvement actions include

- Daily verification of all reported pressure ulcers by the Tissue Viability Specialist Nurse
- Photographing of all pressure ulcers to ensure accurate documentation within the Trust is becoming embedded into everyday clinical practice.
- A number of pressure relieving equipment trials are being undertaken within the Trust, including heel off-loading devices and ED trolley toppers
- Ward staff competency workbooks for Pressure Ulcer Prevention and categorisation has been reviewed and updated.
- React 2 Red has been re-launched within the Surgery and Cancer division and is led by a divisional Matron.

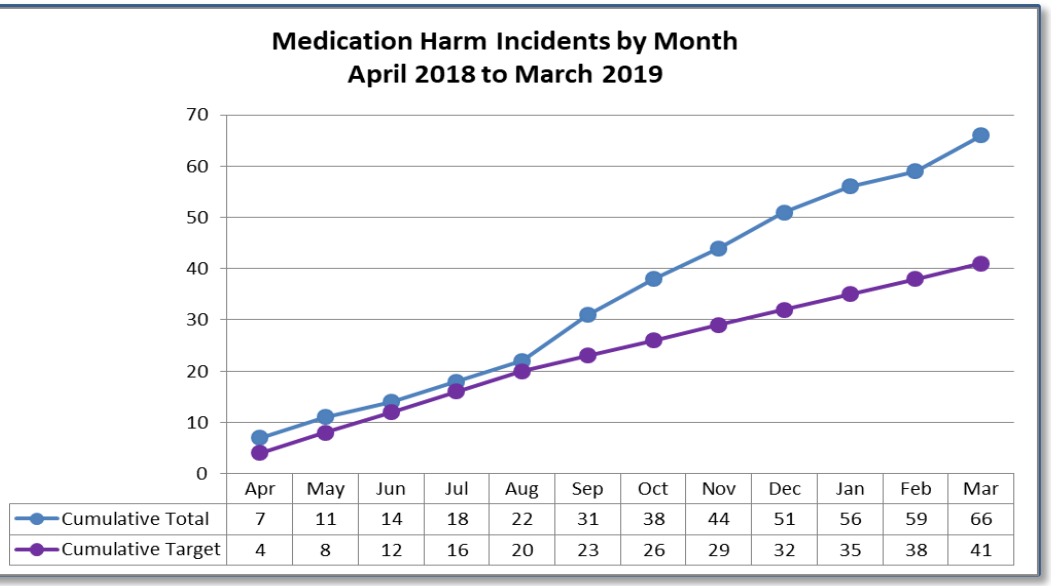
Hospital Acquired Pressure Ulcers by Month
April 2018 to March 2019



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Avoidable	8	9	8	4	9	2	1	1	1	1	2	1
Cumulative Total	19	48	76	98	120	132	144	154	170	184	195	209
Cumulative Target	14	29	44	59	74	89	104	119	134	149	164	179
% Avoidable PU	42.1%	31.0%	28.6%	18.2%	40.9%	16.7%	8.3%	10.0%	6.3%	7.1%	18.2%	7.1%

Description	Aggregate Position	Trend
Inpatient Falls. *The target is to reduce inpatient falls by 10% when compared to the previous financial year by March 2019*	For March 2019, there were a total of 96 inpatient falls • 72.9% (70 falls) have resulted in no harm • 23.9% (23 falls) have resulted in low harm • 2.1% (2 fall) has resulted in moderate harm • 1.1% (1 fall) has resulted in serious harm Improvement actions include: • A Fall Prevention guide has been created in order to support staff with appropriate interventions • Falls Focus Programme - bespoke education, training and support is delivered by the Falls Specialist Nurse in individual areas • Development of Falls Teams in all areas which include nursing staff and health care assistants	

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative Total	62	116	170	231	281	359	436	503	590	680	763	859
Cumulative Target	55	110	165	220	275	330	385	440	495	550	605	656

Medication Harm Incidents	For March 2019, there were a total of 7 medication incidents resulting in harm reported: • 85.7% (6 medication incidents) have resulted in low harm • 14.3% (1 medication incident) has resulted in moderate harm • 0% (0 medication incidents) have resulted in serious harm Improvement actions include: • Junior medical staff training • E-learning package in place • Zero tolerance to prescription anomalies at ward level • Monthly lessons learned shared from the Safer Medicines Practice Group	

The target is to reduce medication incidents resulting in harm by 10% when compared to the previous financial year by the end of March 2019.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative Total	7	11	14	18	22	31	38	44	51	56	59	66
Cumulative Target	4	8	12	16	20	23	26	29	32	35	38	41

Central Cheshire Integrated Care Partnership (CCICP)

Description **Aggregate Position** **Trend**

CCICP Patient Safety Harm Incidents

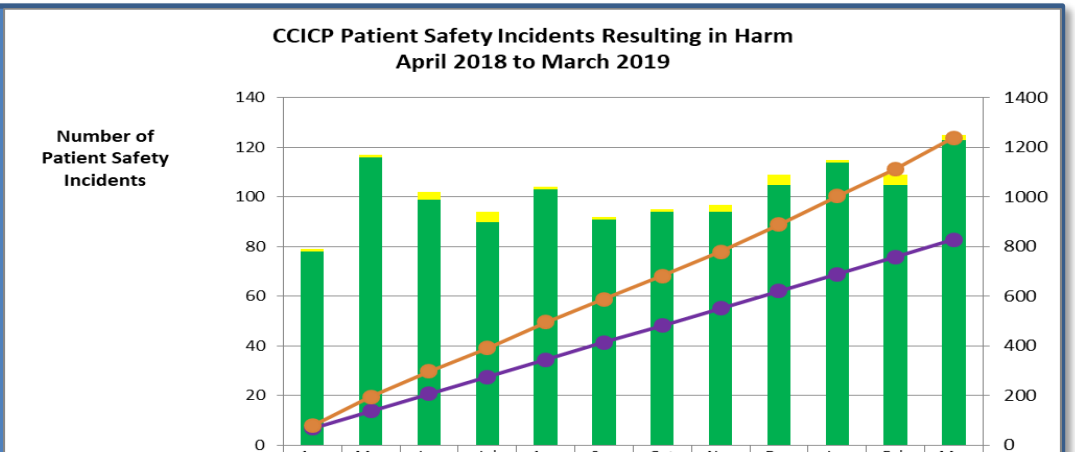
The target is to reduce CCICP patient safety harm incidents by 5% when compared to the previous financial year by the end of March 2019.

For March 2019, there were a total of 125 patient safety harm incidents:

- 98.4% (123 incidents) have resulted in low harm
- 1.6% (2 incidents) have resulted in moderate harm
- 0% (0 incidents) have resulted in serious harm

To reduce the number of patient safety harm incidents, a number of initiatives are being undertaken.
These include:

- Twice monthly Patient Safety Summit Meetings with Executive & Senior Teams
- Twice monthly Patient Safety Matters newsletter that is delivered Trust wide
- Local quality champions introduced



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Serious Incident	0	0	0	0	0	0	0	0	0	0	0	0
Moderate Harm	1	1	3	4	1	1	1	3	4	1	4	2
Low Harm	78	116	99	90	103	91	94	94	105	114	105	123
Target	69	138	207	276	345	414	483	552	621	690	759	828
Cumulative Total 2018/19	79	196	298	392	496	588	683	780	889	1004	1113	1238

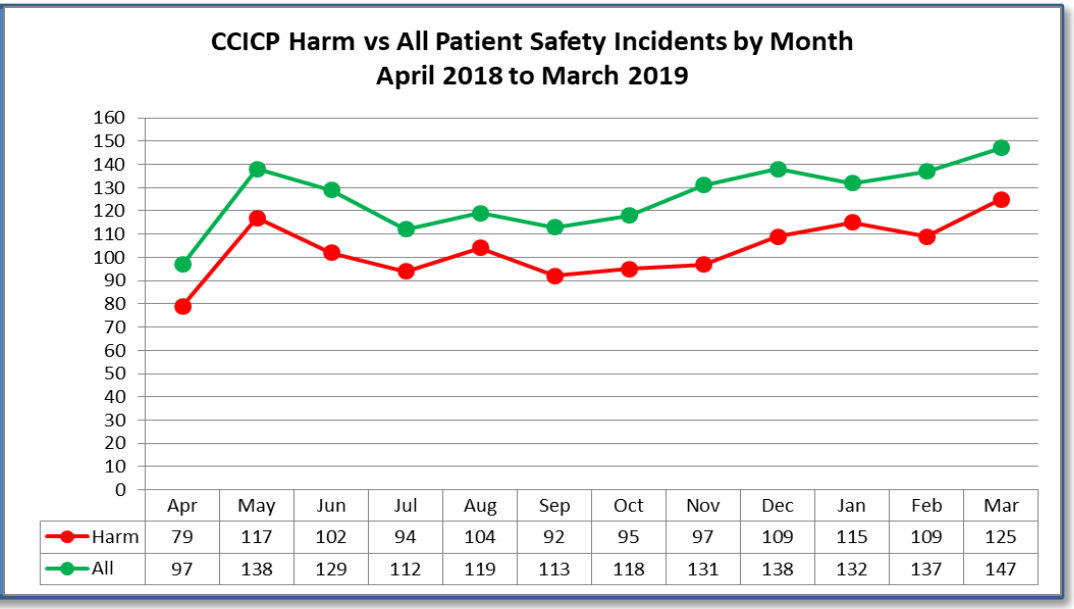
CCICP Harm vs All Patient Safety Incidents

The aim is to increase no harm reporting and eventually widen the gap between harm and all incidents.

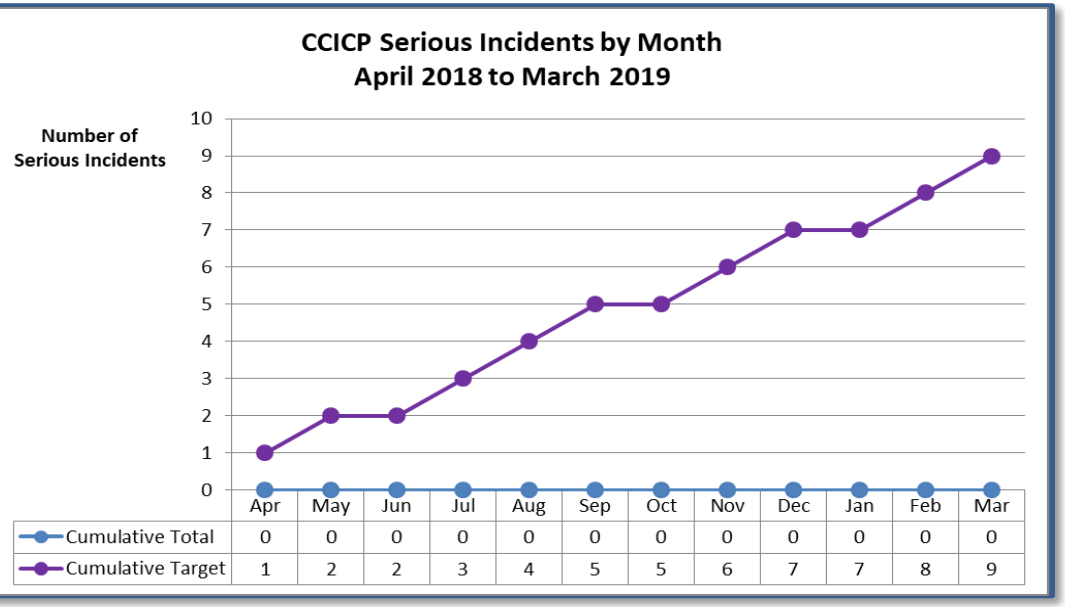
This chart demonstrates the number of incidents that have resulted in harm vs all patient safety incidents.

In March 2019, the gap between harm and all patient safety incidents was 22.

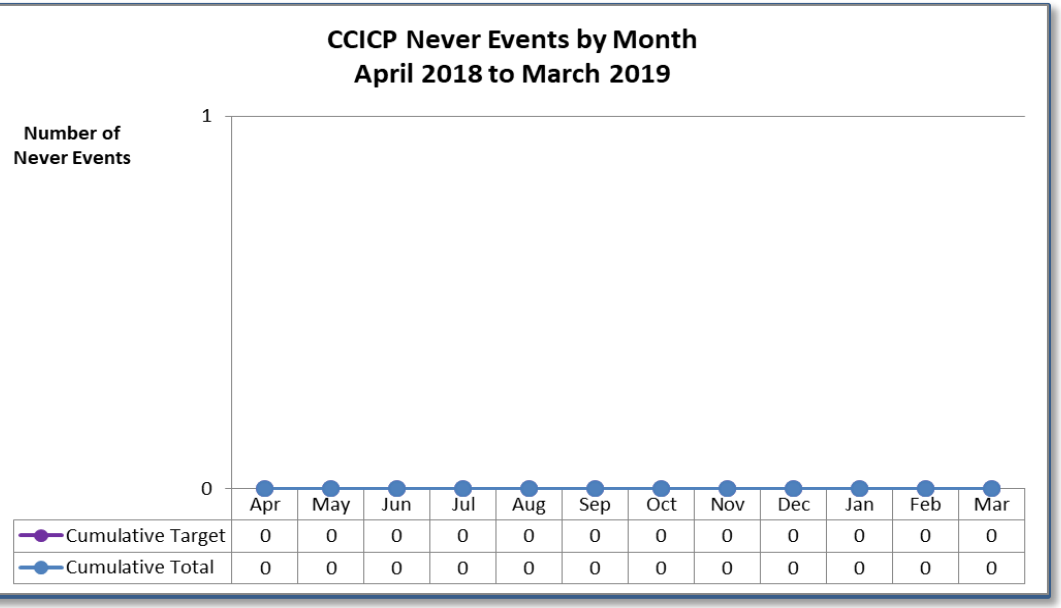
Within healthcare, a safety culture is defined as a "culture where staff have a constant and active awareness of the potential for things to go wrong. It is also a culture that is open and fair and encourages people to speak up about mistakes." An important benefit in a safety culture in the NHS is "A potential reduction in the recurrence and in the severity of patient safety incidents through increased reporting and organisational learning" *Source: 7 steps to patient safety, NPSA, 2004.*



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Harm	79	117	102	94	104	92	95	97	109	115	109	125
All	97	138	129	112	119	113	118	131	138	132	137	147

Description	Aggregate Position	Trend
CCICP Serious Incidents *The target is to reduce patient safety serious incidents by 10% when compared to the previous financial year by the end of March 2019.*	This chart demonstrates the number of incidents that have resulted in serious harm. For March 2019, there were no serious incidents reported.	

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative Total	0	0	0	0	0	0	0	0	0	0	0	0
Cumulative Target	1	2	2	3	4	5	5	6	7	7	8	9

Description	Aggregate Position	Trend
CCICP Never Events *The target is to have zero Never Events*	This chart demonstrates the number of Never Events that have been reported. For March 2019 no Never Events were reported. No Never Events have been reported for CCICP since the merger of the Trust in October 2016.	

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative Target	0	0	0	0	0	0	0	0	0	0	0	0
Cumulative Total	0	0	0	0	0	0	0	0	0	0	0	0

Description	Aggregate Position	Trend

Pressure Ulcers – Community Acquired

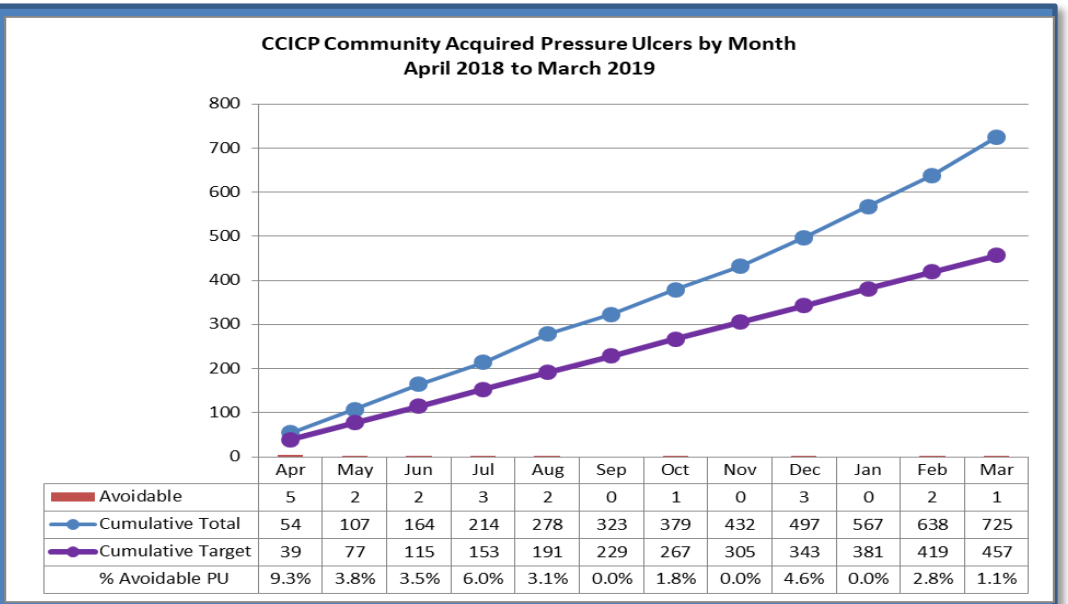
The target is to reduce community acquired pressure ulcers by 10% when compared to the previous financial year by the end of March 2019.

For March 2019, there were a total of 87 community acquired pressure ulcer incidents:

- 1.2% (1 PU's) has resulted in lapses in care.
- 42.5% (37 PU's) have been classed as no lapses in care
- 56.3% (49 PU's) are currently undergoing investigation prior to confirmation as to whether the PU was avoidable or unavoidable.

Improvement actions include:

- A competency workbook for Pressure Ulcer Prevention is being rolled out to all staff within CCICP during May, June and July.
- Training is being undertaken across care communities around supporting patients whom are making unwise, to ensure staff consider undertaking timely capacity assessments and promoting the involvement of the safeguarding team.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Avoidable	5	2	2	3	2	0	1	0	3	0	2	1
Cumulative Total	54	107	164	214	278	323	379	432	497	567	638	725
Cumulative Target	39	77	115	153	191	229	267	305	343	381	419	457
% Avoidable PU	9.3%	3.8%	3.5%	6.0%	3.1%	0.0%	1.8%	0.0%	4.6%	0.0%	2.8%	1.1%

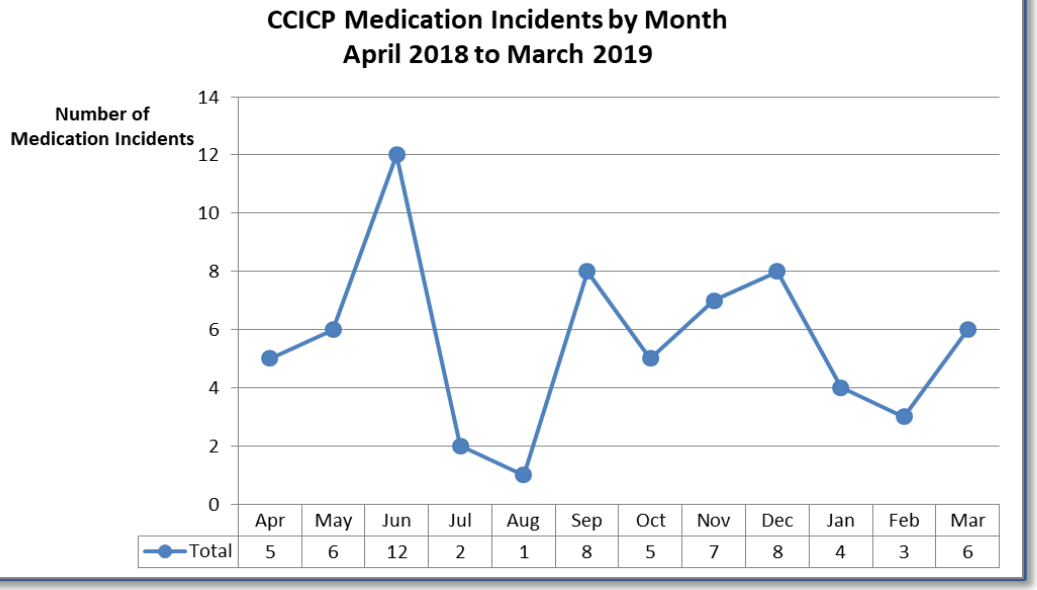
CCICP Medication Incidents.

The aim is to increase no harm reporting of Medication Incidents.

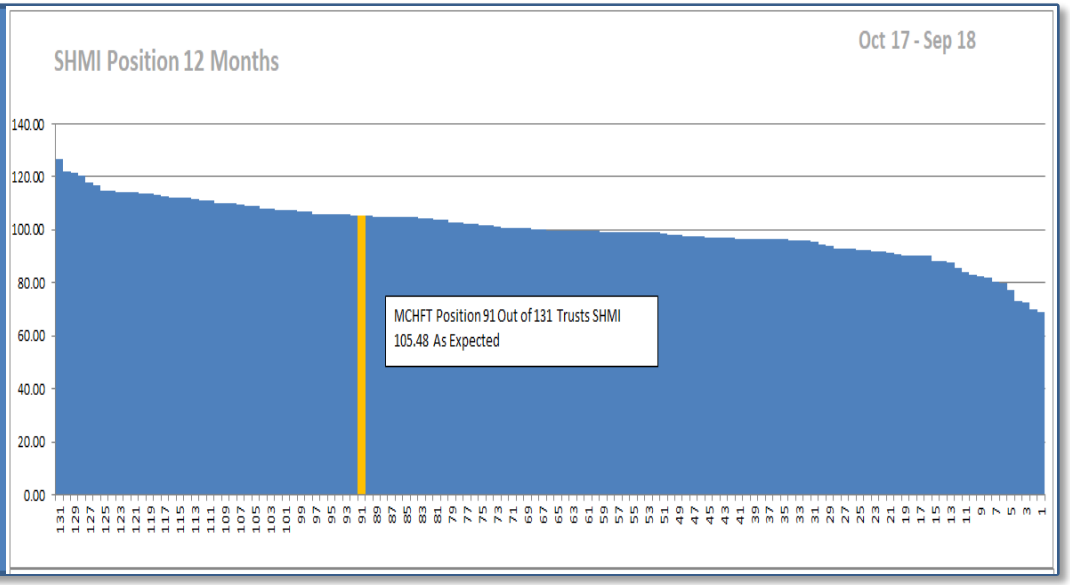
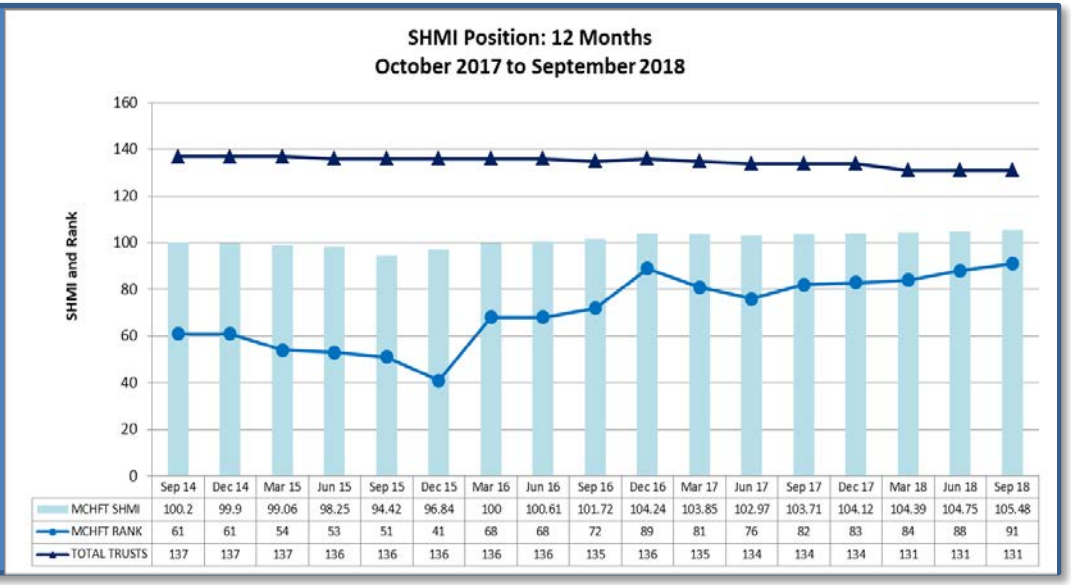
For March 2019, there was a total of 6 medication incidents reported:

- 83.3% (5 medication incident) resulted in no harm
- 16.7% (1 medication incident) resulted in low harm
- 0% (0 medication incidents) have resulted in moderate harm
- 0% (0 medication incidents) have resulted in serious harm

CCICP has a dedicated pharmacy lead who is actively encouraging the reporting of all grades of incidents across all services.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total	5	6	12	2	1	8	5	7	8	4	3	6

Description	Aggregate Position	Trend
SHMI *The Trust's target is to be at least within the "as expected" bracket.*	The chart benchmarks the Trust's latest SHMI against all NHS Trusts. MCHFT is shown as the yellow bar. The Trust's SHMI is 105.48 for the time period October 2017 to September 2018 and places the Trust 91 out of 131 Trusts and is "as expected".	
MCHFT *12 month rolling position Summary Hospital-Level Mortality Indicator (SHMI) by Trust.*	The chart shows the SHMI and rank of MCHFT for each of the 12 month rolling position submissions for the period October 2017 to September 2018 and is "as expected".	

	Sep 14	Dec 14	Mar 15	Jun 15	Sep 15	Dec 15	Mar 16	Jun 16	Sep 16	Dec 16	Mar 17	Jun 17	Sep 17	Dec 17	Mar 18	Jun 18	Sep 18
MCHFT SHMI	100.2	99.9	99.06	98.25	94.42	96.84	100	100.61	101.72	104.24	103.85	102.97	103.71	104.12	104.39	104.75	105.48
MCHFT RANK	61	61	54	53	51	41	68	68	72	89	81	76	82	83	84	88	91
TOTAL TRUSTS	137	137	137	136	136	136	136	136	135	136	135	134	134	134	131	131	131

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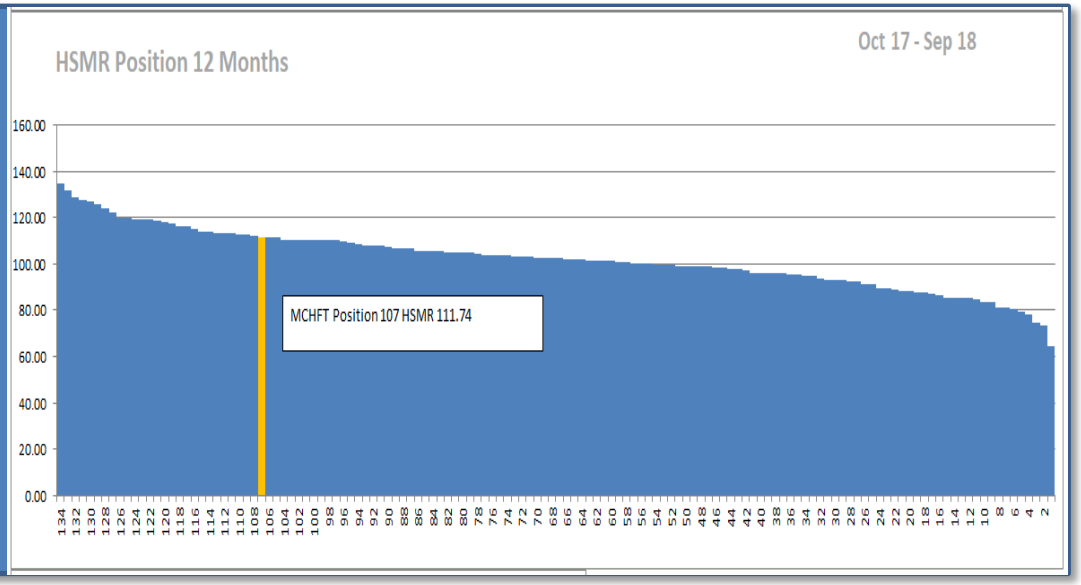
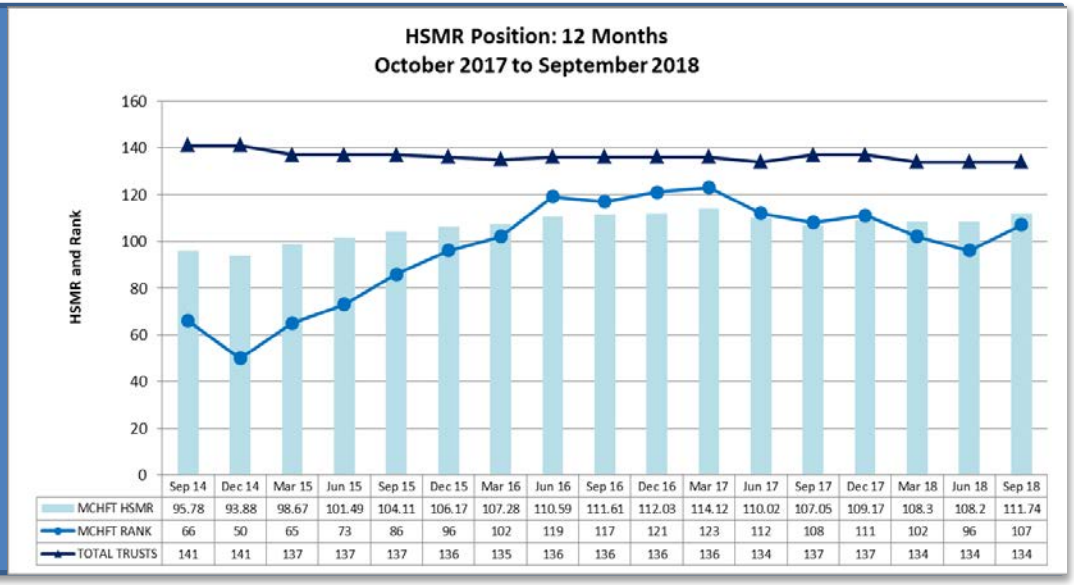
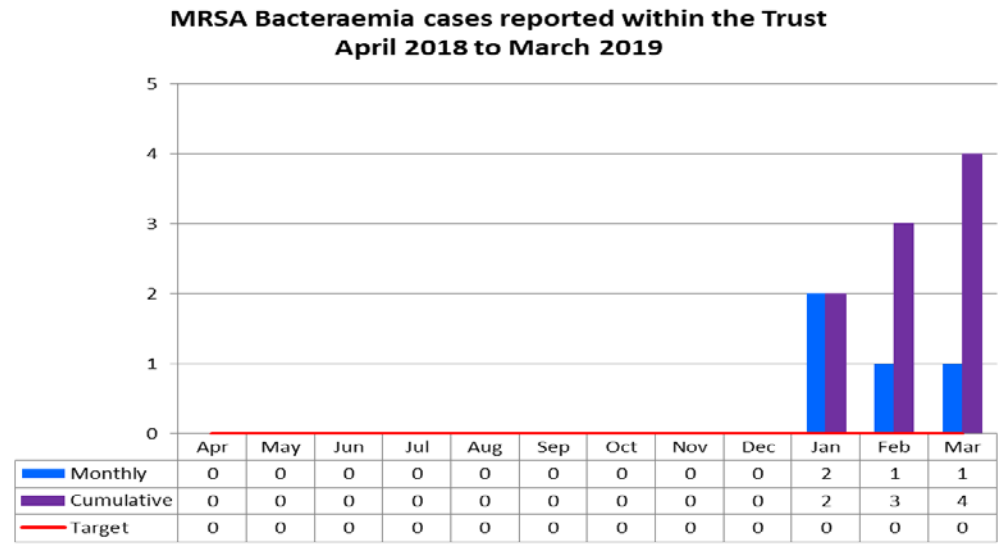
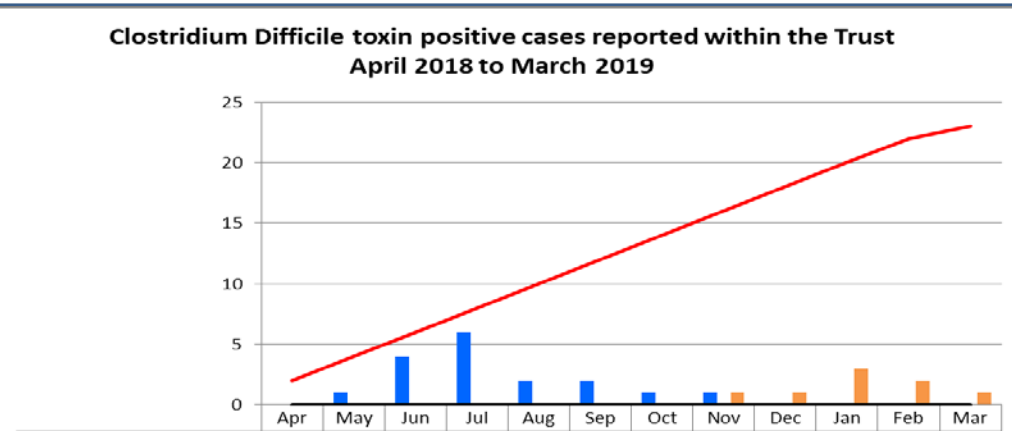
Description	Aggregate Position	Trend
Hospital Standardised Mortality Rate (HSMR) by Trust. *The Trust's target is to be at least within the "as expected" bracket.*	The chart benchmarks the Trust's HSMR against all NHS Trusts. MCHFT is shown by the amber bar. The Trust's HSMR is 111.74 (October 2017 to September 2018) and places the Trust 107 out of 134 Trusts and is "as expected".	
MCHFT *12 month rolling position for HSMR*	The data in the chart shows the HSMR and rank of MCHFT for each of the 12 month rolling position submissions for the period October 2017 to September 2018 and is "as expected".	

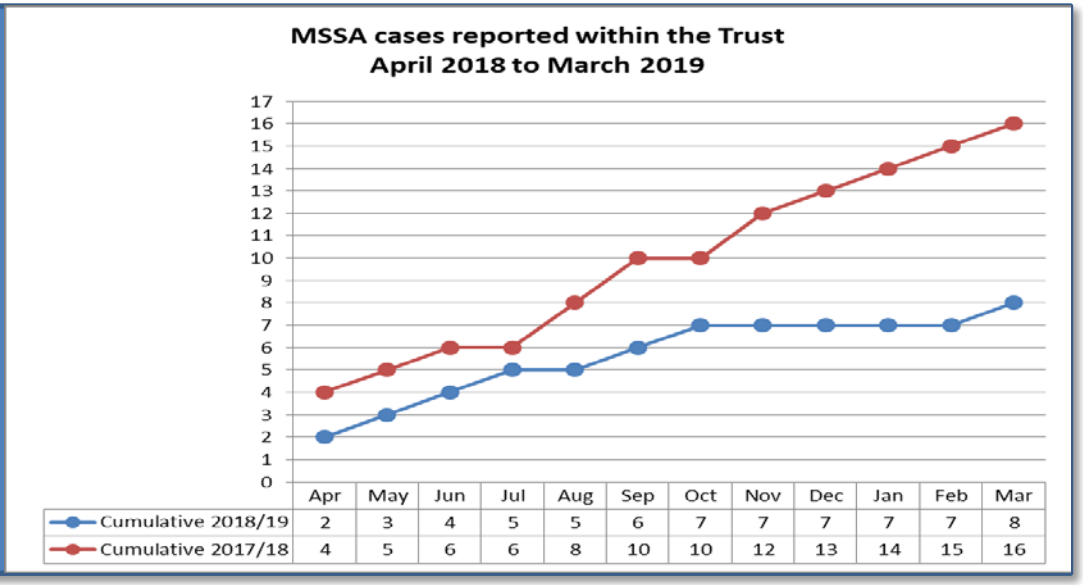
	Sep 14	Dec 14	Mar 15	Jun 15	Sep 15	Dec 15	Mar 16	Jun 16	Sep 16	Dec 16	Mar 17	Jun 17	Sep 17	Dec 17	Mar 18	Jun 18	Sep 18
MCHFT HSMR	95.78	93.88	98.67	101.49	104.11	106.17	107.28	110.59	111.61	112.03	114.12	110.02	107.05	109.17	108.3	108.2	111.74
MCHFT RANK	66	50	65	73	86	96	102	119	117	121	123	112	108	111	102	96	107
TOTAL TRUSTS	141	141	137	137	137	136	135	136	136	136	136	134	137	137	134	134	134

Description	Aggregate Position	Trend
MRSA Bacteraemia Cases. *Zero tolerance of MRSA cases.*	In March 2019, one MRSA bacteraemia case was reported in the Trust. The case occurred on Ward 13. In this financial year there have been four confirmed MRSA bacteraemia cases to date. In March there was one case that was attributed toward 13. The Post Infection Review identified that this case was avoidable. The primary site for Ward 13 was an invasive device with other contributory factors. A Trust wide report and improvement plan is in place along with suggested improvements from an external review that took place in April 2019. All actions are monitored at the Executive Infection Prevention and Control Group.	

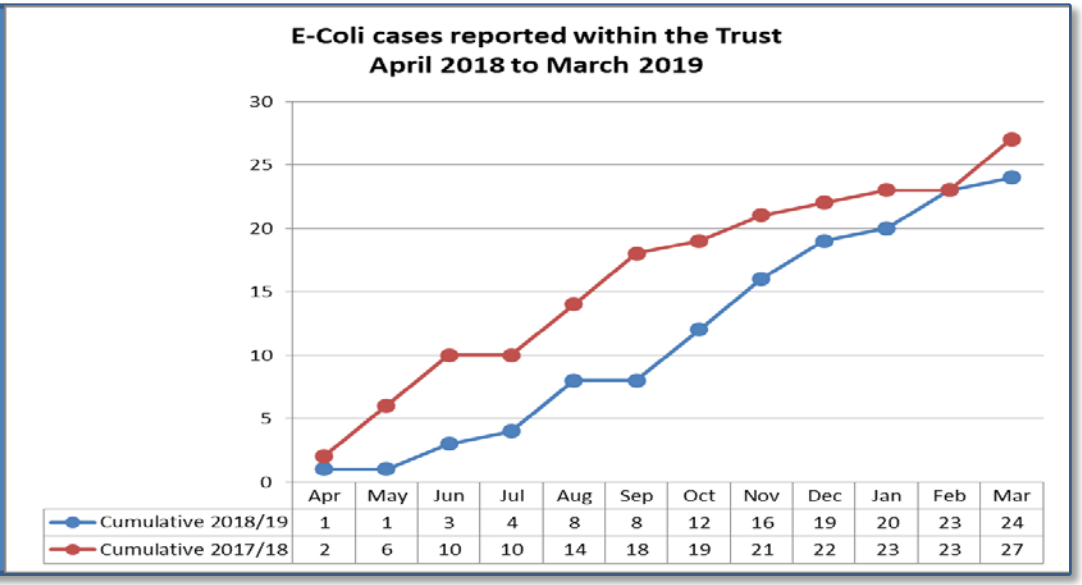
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Monthly	0	0	0	0	0	0	0	0	0	2	1	1
Cumulative	0	0	0	0	0	0	0	0	0	2	3	4
Target	0	0	0	0	0	0	0	0	0	0	0	0

Description	Aggregate Position	Trend
Clostridium Difficile toxin positive cases. *The target is less than 23 avoidable cases of Clostridium Difficile in 2018/19*	In March 2019, no avoidable cases were reported. The total avoidable cases year to date is zero. The total unavoidable is seventeen. Improvement actions include: • Bed side reviews are in place on the identification of infection • Consultant level engagement in C-difficile root cause analysis and lessons learnt	

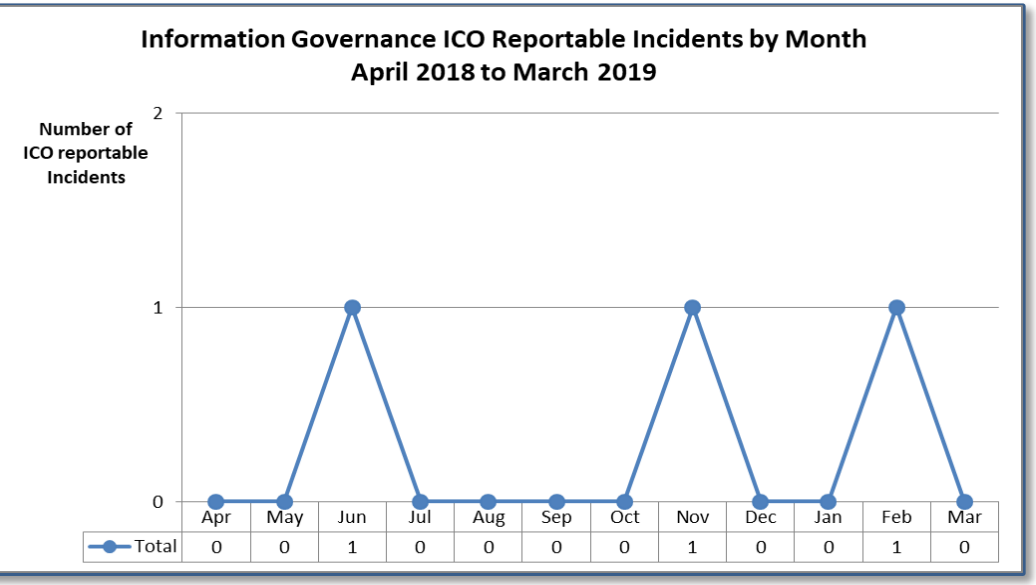
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Unavoidable	0	1	4	6	2	2	1	1	0	0	0	0
Avoidable	0	0	0	0	0	0	0	0	0	0	0	0
Awaiting Confirmation	0	0	0	0	0	0	0	1	1	3	2	1
Avoidable Total	0	0	0	0	0	0	0	0	0	0	0	0
Avoidable Target	2	4	6	8	10	12	14	16	18	20	22	23

Description	Aggregate Position	Trend
MSSA Cases. *The aim is to have a reduction in MSSA cases when compared to the previous financial year, to demonstrate an incremental improvement*	In March 2019, one MSSA case was reported in the Trust. The case occurred on Ward 14. In this financial year there has been eight confirmed MSSA cases reported.	

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative 2018/19	2	3	4	5	5	6	7	7	7	7	7	8
Cumulative 2017/18	4	5	6	6	8	10	10	12	13	14	15	16

Description	Aggregate Position	Trend
E-Coli Cases. *The aim is to have a reduction in E-Coli cases when compared to the previous financial year, to demonstrate an incremental improvement*	In March 2019, one E-Coli case was reported. The case occurred on Ward 21B. In this financial year there have been twenty four- confirmed E-Coli cases reported.	

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative 2018/19	1	1	3	4	8	8	12	16	19	20	23	24
Cumulative 2017/18	2	6	10	10	14	18	19	21	22	23	23	27

Description	Aggregate Position	Trend
Information Governance Information Commissioners Office (ICO) reportable incidents.	In March 2019, no information governance ICO reportable incidents were reported in the Trust. The Trust has detailed plans in place to address the requirements of the General Data Protection Regulations (GDPR) which is overseen by the Information Governance Group.	

CQUIN 2018-19 Performance

CQUIN Indicator	Indicator Name	Milestone Achieved								
		Q1	Financial Incentive Achieved	Q2	Financial Incentive Achieved	Q3	Financial Incentive Achieved	Q4	Financial Incentive Achieved	Maximum Value
1a	**Health & Wellbeing** 5% point improvement in two of the three questions on H&W, MSK & Stress	NO PAYMENTS	No payment	ON TRACK	No payment	ON TRACK	No payment		£137,574	**£137,574**
1b	**Health & Wellbeing** Maintain the four changes for improving healthy food for NHS staff, visitors and patients. Introduce three new changes to food and drink provision.	NO PAYMENTS	No payment	ON TRACK	No payment	ON TRACK	No payment		£137,574	**£137,574**
1c	**Health & Wellbeing** Achieve an uptake of flu vaccinations of front line clinical staff of 75% by end of February 2019.	NO PAYMENTS	No payment	ON TRACK	No payment	ON TRACK	No payment		£137,574 £137,180	**£137,574** **CCICP £137,180**
2a	**Sepsis: Identification** The percentage of patients who met the criteria for sepsis screening and were screened for sepsis.	✓ **Partially**	£25,795 (£10,318 partial payment)	✓ **Partially**	£25,795 (£10,318 partial payment)	✓ **Partially**	£25,795		£25,795	**£103,181**
2b	**Sepsis: Treatment** The percentage of patients who were found to have sepsis and received IV antibiotics within1 hour.	✓ **Partially**	£25,795 (£10,318 partial payment)	✓ **Partially**	£25,795 (£10,318 partial payment)	✓ **Partially**	£25,795		£25,795	**£103,181**
2c	**Sepsis: Antibiotic Review** Percentage of antibiotic prescriptions documented and reviewed by a competent clinician within 72 hours	✓	£25,795	✓	£25,795	✗	£25,795		£25,795	**£103,181**
2d Part 1	**Reduction in antibiotic consumption** Achieve a reduction of x% or more in total antibiotic consumption per 1,000 admissions.	✓	No payment	NO PAYMENTS	No payment	NO PAYMENTS	No payment		£34,393	**£34,393**
2d Part 2	**Reduction in carbapenem consumption** Achieve a reduction of x% or more in total carbapenem consumption per 1,000 admissions.	✓	No payment	NO PAYMENTS	No payment	NO PAYMENTS	No payment		£34,393	**£34,393**

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CQUIN Indicator	Indicator Name	Milestone Achieved								
		Q1	Financial Incentive Achieved	Q2	Financial Incentive Achieved	Q3	Financial Incentive Achieved	Q4	Financial Incentive Achieved	Maximum Value
2d Part 3	**Reduction in piperacillin tazabactam consumption** Achieve a reduction of x% or more in total piperacillin tazabactam consumption per 1,000 admissions.	✓	No payment	NO PAYMENTS	No payment	NO PAYMENTS	No payment		£34,393	**£34,393**
4	**Mental Health in Emergency Department** Maintain 20% reduction in attendances to the Emergency Department for people with Mental Health needs.	✓	No Payment	✗	£82,545	NO PAYMENTS			£330,178	**£412,723**
6	**Offering advice and guidance** Providers to set up and operate advice and guidance services for non-urgent GP referrals, allowing GPs to access consultant advice prior to referring patients into secondary care.	✓	£65,908	✓	£65,908	✓	£65,908		£226,998	**£412,723**
9a	**Tobacco screening** Percentage of unique adult patients who are screened for smoking status AND whose results are recorded..	✓	£5,159	✓	£5,159	✗	£5,159		£5,159	**£20,636**
9b	**Tobacco brief advice** Percentage of unique patients who smoke AND are given very brief advice	✓	£20,636	✓	£20,636	✗	£20,636		£20,636	**£82,545**
9c	**Tobacco referral and medication offer** Percentage of unique patients who are smokers AND are offered referral to stop smoking services AND offered stop smoking medication.	✓	£25,795	✓	£25,795	✗	£25,795		£25,795	**£103,181**
9d	**Alcohol brief advice or referral** Percentage of unique adult patients who are screened for drinking risk levels AND whose results are recorded in local data systems	✓	£25,795	✓	£25,795	✗	£25,795		£25,795	**£103,181**
9e	**Alcohol brief advice or referral** Percentage of unique patients who drink alcohol above lower-risk levels AND are given brief advice OR offered a specialist referral if the patient is potentially alcohol dependent	✓	£25,795	✓	£25,795	✗	£25,795		£25,795	**£103,181**

Board Papers – Quality, Safety & Experience Section: May 2019

CQUIN Indicator	Indicator Name	Milestone Achieved								
		Q1	Financial Incentive Achieved	Q2	Financial Incentive Achieved	Q3	Financial Incentive Achieved	Q4	Financial Incentive Achieved	Maximum Value
10	**Improving the assessment of wounds** **(Community Only)** The indicator aims to increase the number of wounds which have failed to heal after 4 weeks that receive a full wound assessment.	✓	No payment	✓	£68,590	NOT REQUIRED	No payment		£68,590	**£137,180**
11	**Personalised Care and Support Planning** **(Community Only)** This CQUIN is to be delivered over two years with an aim of embedding personalised care and support planning for people with long-term conditions	✓	No payment	✓	No payment	NOT REQUIRED	No payment		£137,180	**£137,180**
PHE1	**Breast Screening Programme Clerical Staff Development (Health Promotion role)** Update and improve the clerical teams knowledge of health promotion to support clients who access The Breast Screening Unit and key partners involved in the Breast Screening Programme	✓	£3,742.50	✓	£3,742.50	✓	£3,742.50		£3,742.50	**£14,969**
PHE2	**Cancer Screening Programme – reducing professional stress and building resilience** Holistic mapping review of health & wellbeing services and support available to staff within the bowel and breast screening programmes for the management of professional stress and building resilience	✓	£5,822	✓	£5,822	✓	£5,822		£5,822	**£23,288**
SP 1	**Nationally Standardised Dose Banding for Adult Intravenous Systemic Anticancer Therapy (SACT) 38** A tool kit has been developed to support CQUIN. Targets will be set for each of the SACT drugs.	✓	£10,292	✓	£10,292	✓	£10,292		£10,292	**£41,167**
SP 2	**Hospital Pharmacy Transformation and Medicines Optimisation**	✓	£15,437	✓	£15,437	✓	£15,437		£15,437	**£61,749**

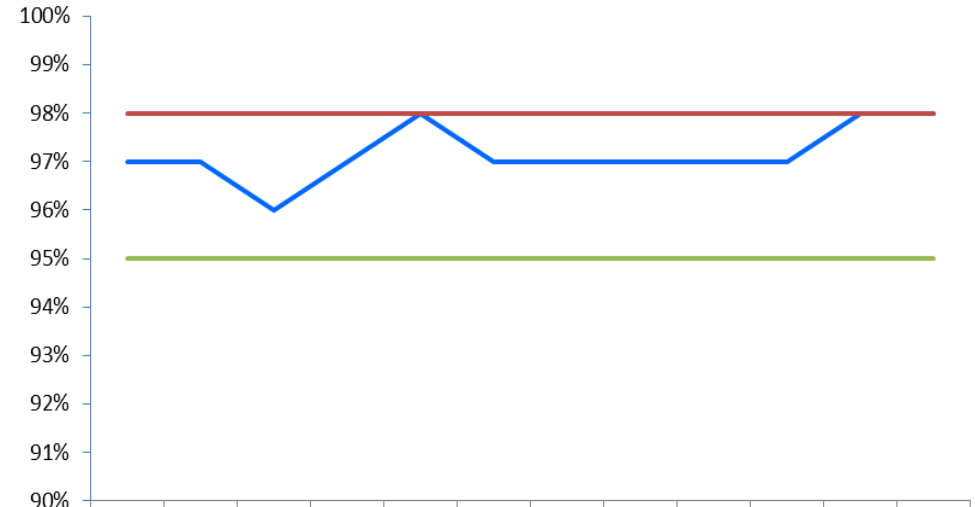
Description	Aggregate Position	Trend

Safety Thermometer - Harm Free Care.

In March 2019, 98% of patients received harm free care as measured by the point prevalence Safety Thermometer.

The Safety Thermometer data is collected during the morning of the first Wednesday of each month and is collected by the nursing staff on duty on the ward/DN caseload assisted by the Senior Nursing Teams. This is applicable to inpatient areas and district nursing caseloads only.

The target is for >95% of patients to receive harm free care as monitored by the Safety Thermometer. The Patient Safety Thermometer process is currently under review nationally.



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
MCHFT	97%	97%	96%	97%	98%	97%	97%	97%	97%	97%	98%	98%
National	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

Ward Name	Main Specialties	Safety Thermometer Results March 2019			
		Acquired Pressure Ulcers	Patient Falls resulting in harm	CAUTI	New VTE
MCHFT		**0.80% (7)**	**0.57% (5)**	**0.34% (3)**	**0.11% (1)**
AMU	Gen. Medicine	0% (0)	0% (0)	0% (0)	0% (0)
CAU	Paediatrics	0% (0)	0% (0)	0% (0)	0% (0)
Critical Care	Gen. Medicine	0% (0)	0% (0)	0% (0)	0% (0)
Elmhurst	Rehab	0% (0)	0% (0)	0% (0)	0% (0)
Ward 1	Gen. Medicine	3.33% (1)	3.33% (1)	0% (0)	0% (0)
SAU	Gen. Surgery	0% (0)	0% (0)	0% (0)	0% (0)
SSW	Gen. Surgery & Urology	0% (0)	5% (1)	5% (1)	0% (0)
Ward 15	Gen. Surgery & Gynae	0% (0)	0% (0)	0% (0)	0% (0)
Ward 13	Gen. Surgery	0% (0)	0% (0)	0% (0)	0% (0)
Ward 14	Gen. Medicine	0% (0)	0% (0)	0% (0)	0% (0)
Ward 10	Trauma & Ortho	0% (0)	2.56% (1)	0% (0)	0% (0)
Ward 2	Gen. Medicine	0% (0)	0% (0)	0% (0)	0% (0)
Ward 21B	Rehab	4.17% (1)	0% (0)	0% (0)	0% (0)
Ward 23	Obstetrics	0% (0)	0% (0)	0% (0)	0% (0)
Ward 26	Obstetrics	0% (0)	0% (0)	0% (0)	0% (0)
Ward 4	Gen. Medicine	0% (0)	3.12% (1)	0% (0)	0% (0)
Ward 5	Gen. Medicine	3.12% (1)	0% (0)	0% (0)	0% (0)
Ward 6	Gen. Medicine	0% (0)	0% (0)	4% (1)	0% (0)
Ward 7	Gen. Medicine	0% (0)	0% (0)	0% (0)	0% (0)
Ward 9	Trauma & Ortho	0% (0)	0% (0)	0% (0)	0% (0)
Ward 19	Winter Ward	3.7% (1)	0% (0)	3.7% (1)	0% (0)
NICU	Paediatrics	0% (0)	0% (0)	0% (0)	5.56% (1)
DN – Alsager	District Nursing	0% (0)	0% (0)	0% (0)	0% (0)
DN – Ashfields and Haslington	District Nursing	2.7% (1)	0% (0)	0% (0)	0% (0)
DN - Danebridge	District Nursing	0% (0)	0% (0)	0% (0)	0% (0)
DN – Eagle Bridge	District Nursing	2% (1)	2% (1)	0% (0)	0% (0)
DN – Firdale	District Nursing	0% (0)	0% (0)	0% (0)	0% (0)
DN – Grosvenor, Hungerford & Rope Green	District Nursing	0% (0)	0% (0)	0% (0)	0% (0)
DN - Church View	District Nursing	2% (1)	0% (0)	0% (0)	0% (0)

Board Papers – Quality, Safety & Experience Section: May 2019

Description	Aggregate Position		Trend
Registered Nurses monthly expected hours by shift versus actual monthly hours per shift. Day time shifts only	90.3% of expected Registered Nurse hours were achieved for day shifts. Any registered nurse numbers that fall below 85% are required to have a divisional review and an update of actions provided to the Director of Nursing & Quality and the Deputy Director of Nursing & Quality.	Trend **March 2019 90.3%** February 2019 92.7% January 2019 95.1%	The lowest staffing levels during the day were on Ward 9 at 75.5%
Registered Nurses monthly expected hours by shift versus actual monthly hours per shift. Night time shifts only	93.2% of expected Registered Nurse hours were achieved for night shifts.	Trend **March 2019 93.2%** February 2019 98.6% January 2019 100.9%	The lowest staffing levels during the night were on Ward 6 at 67.7%
Healthcare Assistant monthly expected hours by shift versus actual monthly hours per shift. Day time shifts only	101.6% of expected HCA hours were achieved for day shifts.	Trend **March 2019 101.6%** February 2019 96.2% January 2019 100.5%	The lowest staffing levels during the day were on Ward 9 at 72.6%
Healthcare Assistant monthly expected hours by shift versus actual monthly hours per shift. Night time shifts only	110.9% of expected HCA hours were achieved for night shifts. For areas with over 100% staffing levels for HCA's this is reviewed and is predominately due to wards requiring 1 to 1 specials for patients following a risk assessment or to increase staffing numbers when there are registered nursing gaps that are not filled.	Trend **March 2019 110.9%** February 2019 97.4% January 2019 97.1%	The lowest staffing levels during the night were on Ward 9 at 50%
Total number of wards that are lower than 85% RN fill days and nights is 8.	Ward 14 (night) 79.6%, Ward 15 (day) 81.7% and (night) 78.5%, Ward 4 (day) 80.6%, Ward 5 (day) 84.5% and (night) 71%, Ward 6 (night) 67.7%, Ward 7 (day) 84.8%, Ward 9 (day) 75.5%, Ward 10 (day) 84.1%.	• Actions taken: Staffing reviewed on daily basis by Matrons/HoN following Escalation process • Risk assessments taken place to review bed occupancy and patient acuity before transferring staff	

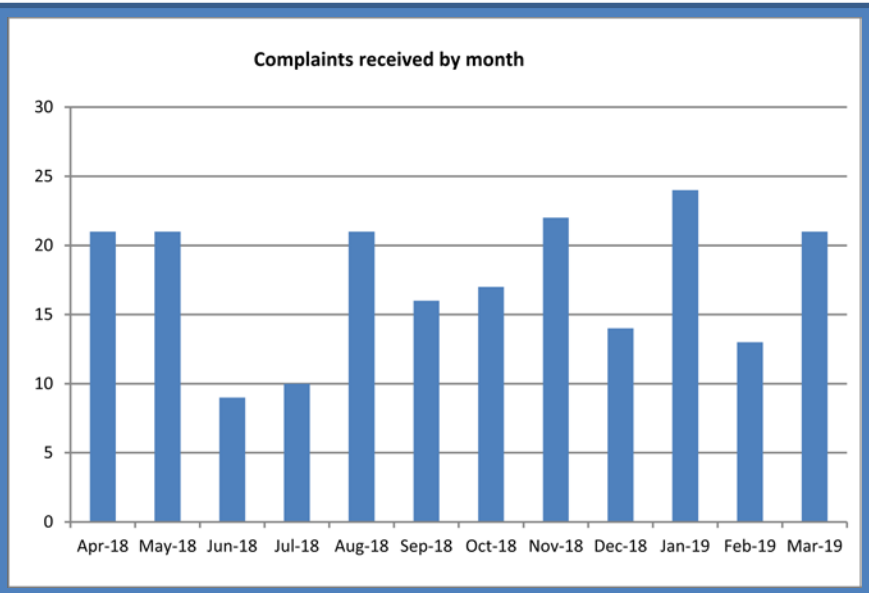
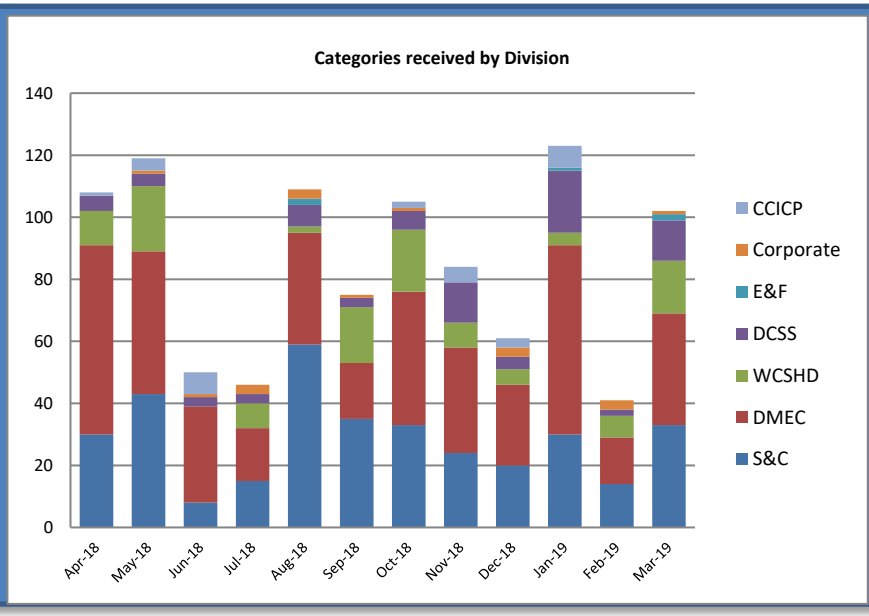
Board Papers – Quality, Safety & Experience Section: May 2019

Ward Name	Day				Night				Day		Night		Care Hours Per Patient Day			
	Qualified		Unqualified		Qualified		Unqualified		Qualified	Unqualified	Qualified	Unqualified	Cumulative count over month of pts at 23:59 each day	Qualified	Unqualified	Overall
	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Fill Rate	Fill Rate	Fill Rate	Fill Rate				
MCHFT	41263.9	37264.9	30521.2	31019.6	25999.8	24235.7	17541.4	19450.4	90.3%	101.6%	93.2%	110.9%	14779	172.5878	74.59985	247.1877
AMU	2011.3	1803.5	1519	1451.8	1898.8	1788.5	1519	1506.8	89.7%	95.6%	94.2%	99.2%	752	4.8	3.9	8.7
CAU (Winter)	1682.5	1682.5	712	712	1656	1656	379.5	379.5	100.0%	100.0%	100.0%	100.0%	509	6.6	2.1	8.7
Critical Care	3993.5	3993.5	547	547	2517.5	2517.5	0	0	100.0%	100.0%	100.0%	-	236	27.6	2.3	29.9
Elmhurst	871.5	871.5	2232	2262	775	775	1550	1675	100.0%	101.3%	100.0%	108.1%	919	1.8	4.3	6.1
Ward 1	2181.3	1943.8	1162.5	1237.5	1519	1408.8	759.5	918.8	89.1%	106.5%	92.7%	121.0%	907	3.7	2.4	6.1
Ward 13	2440	2088	1984	2016	953.3	922.5	953.3	1096.8	85.6%	101.6%	96.8%	115.1%	888	3.4	3.5	6.9
Ward 14	1332	1350	1488	1620	1116	888	1116	1260	101.4%	108.9%	79.6%	112.9%	942	2.4	3.1	5.4
Ward 15	2320	1896	1984	1960	953.3	748.3	953.3	912.3	81.7%	98.8%	78.5%	95.7%	835	3.2	3.4	6.6
Ward 2	1793.8	1662.5	1550	1525	759.5	1016.8	1139.3	1139.3	92.7%	98.4%	133.9%	100.0%	942	2.8	2.8	5.7
Ward 21b	1200	1109	1950	1878.5	775	775	775	812.5	92.4%	96.3%	100.0%	104.8%	743	2.5	3.6	6.2
Ward 23	1238	1238	785.3	785.3	764.7	764.7	764.7	764.7	100.0%	100.0%	100.0%	100.0%	655	3.1	2.4	5.4
Ward 4	1704	1374	1860	1854	744	732	1488	1488	80.6%	99.7%	98.4%	100.0%	985	2.1	3.4	5.5
Ward 5	2452.5	2071.3	1550	1543.8	1519	1078	759.5	1261.8	84.5%	99.6%	71.0%	166.1%	958	3.3	2.9	6.2
Ward 6	1806.3	1612.5	1937.5	1950	1519	1029	759.5	1163.8	89.3%	100.6%	67.7%	153.2%	808	3.3	3.9	7.1
Ward 7	1681.3	1425	1550	2168.8	759.5	722.8	1139.3	1727.3	84.8%	139.9%	95.2%	151.6%	959	2.2	4.1	6.3
Ward 9	1438	1086	992	720	635.5	615	492	246	75.5%	72.6%	96.8%	50.0%	263	6.5	3.7	10.1
NICU	1924.6	1547.3	183.4	240.1	1782.5	1483.5	0	0	80.4%	130.9%	83.2%	-	193	15.7	1.2	16.9
Ward 11 SAU	1500	1402.5	930	915	580.7	590.1	580.7	562	93.5%	98.4%	101.6%	96.8%	367	5.4	4.0	9.5
Ward 18 SSW	1470	1326.3	1162.5	1187.5	759.5	759.5	759.5	808.5	90.2%	102.2%	100.0%	106.5%	590	3.5	3.4	6.9
Ward 10 Ortho	2816	2368	3720	3736	953.3	943	1271	1271	84.1%	100.4%	98.9%	100.0%	1072	3.1	4.7	7.8
Ward 26 MLU	785.3	779	0	101.3	764.7	740	0	74	99.2%	-	96.8%	-	35	43.4	5.0	48.4
Ward 26 Labour	2622	2634.7	722	608	2294	2281.7	382.3	382.3	100.5%	84.2%	99.5%	100.0%	221	22.2	4.5	26.7

Experience Section:

Indicators	YTD 18/19	Last four months			
		Dec-18	Jan-19	Feb-19	Mar-19
Complaints received by month	209	14	24	13	21
Complaints being reviewed by the Ombudsman	3	0	1	1	0
Closed complaints by month	226	15	16	23	18
Contacts raising informal concerns	1145	65	96	105	97
Compliments received in month	4779	507	675	409	406
Number of new claims received in month	52	4	6	5	6
Number of claims closed	36	2	3	4	1
Number of inquests concluded	3	0	0	1	0
NHS Choices - Star Ratings (Leighton)		4.5	4.5	4.5	4.5
NHS Choices - Star Ratings (VIN)		5	5	5	5
NHS Choices - Number of new postings	87	5	9	13	4
F&FT Response Rate ED, MIU, UCC and Assessment Areas*		23%	19%	14%	18%
Proportion of positive responses ED, MIU, UCC and Assessment Areas		87%	84%	84%	87%
F&FT Response Rate Inpatients and Day cases		32%	32%	34%	36%
Proportion of positive responses Inpatients and Day cases		95%	95%	94%	95%
F&FT Response Rate Outpatients		3%	4%	4%	3%
Proportion of positive responses Outpatients		96%	94%	95%	94%
F&FT Response Rate Maternity - Birth		13%	13%	13%	10%
Proportion of positive responses Maternity - Birth		100%	100%	100%	100%
F&FT Response Rate Community (CCICP)		0%	0%	91%	10%
Proportion of positive responses Community (CCICP)		0%	0%	n/a	94%

*ED = Emergency Department; MIU = Minor Injuries Unit; UCC = Urgent Care Centre

Description	Aggregate Position/Description	Trend
Monthly complaints received by the Trust.	21 complaints were received in March 2019 which covered 102 concerns. The highest categories were: • Communication • Nursing - Other • Medical – Adverse Outcome • Medical – Medication Error/Delay • Attitude – Nursing Staff Highest 3 areas receiving complaints/issues were: • Emergency Department - 8 complaints with 20 issues • Haematology - 2 complaints with 7 issues • General Surgery – 2 complaints with 7 issues	 Formal Complaints
Number of formal complaint issues by division.	This graph shows the breakdown of issues by month for each division. S&C: 33 DCSS: 13 W&CD: 17 DMEC: 36 CCICP: E&F: 2 Corporate Services: 1	 Formal Complaint issues by division

Description	Aggregate Position/Description	Trend

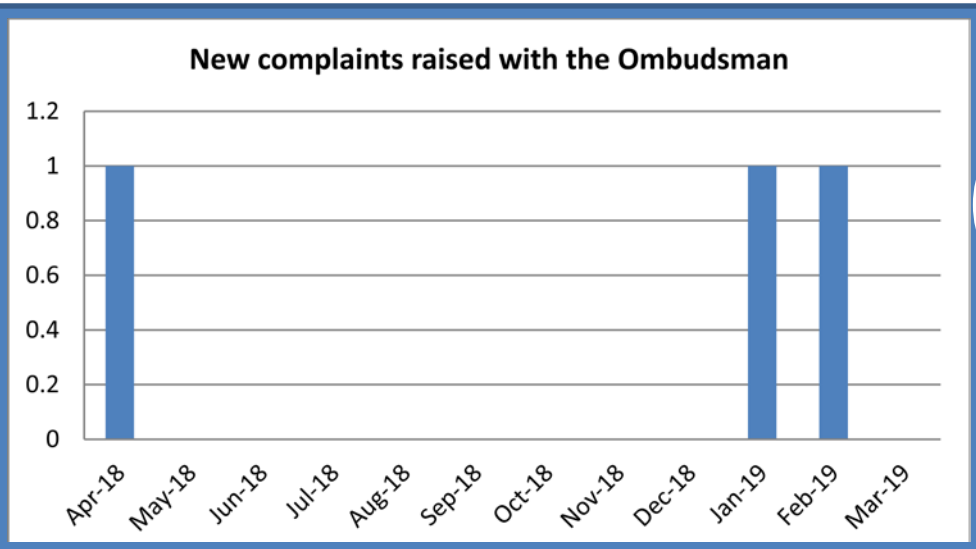
New complaints raised with the Public Health Service Ombudsman

In March 2019, there were no new complaints opened with the PHSO.

There was 1 existing case which is at the investigation stage.

In addition there was 1 case that remains at the assessment stage.

In the last rolling 12 months we have had 3 cases with the PHSO of which none to date have been upheld.



Ombudsman

Complaint trends and number of issues.

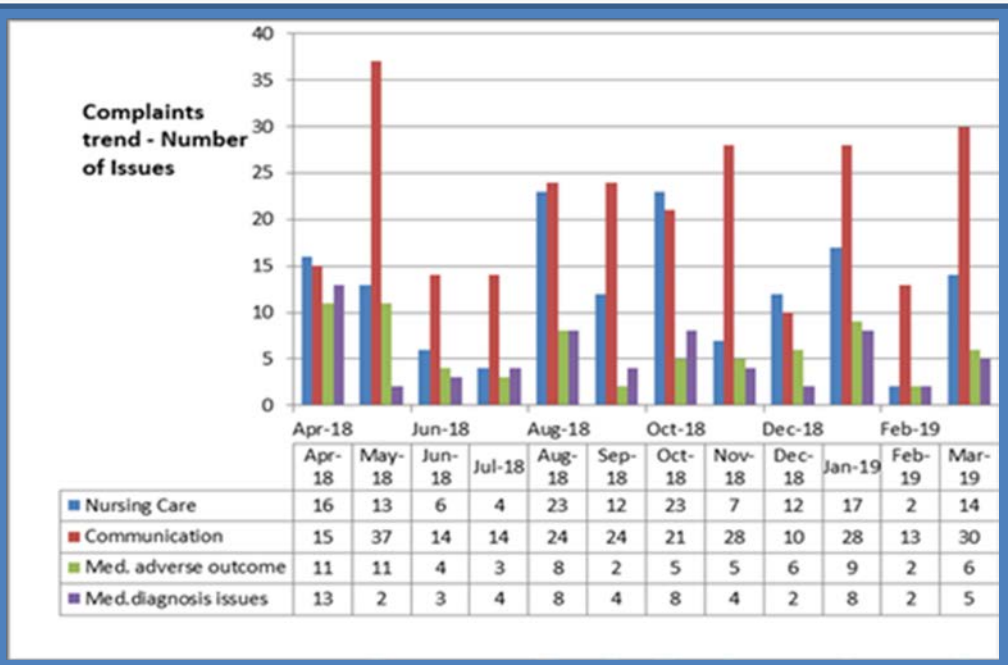
The main trends in March were:-

Nursing care - 10 complaints raising 14 issues.

Communication - 12 complaints raising 30 issues.

Medical Adverse Outcome – 6 complaints raising 6 issues.

Medical diagnosis – 5 Complaints raising 5 issues.



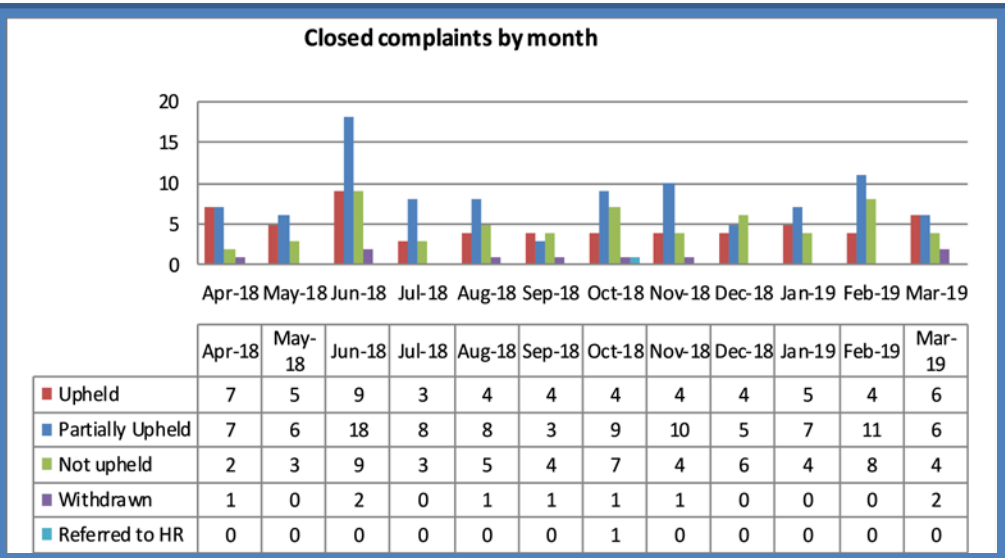
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Nursing Care	16	13	6	4	23	12	23	7	12	17	2	14
Communication	15	37	14	14	24	24	21	28	10	28	13	30
Med. adverse outcome	11	11	4	3	8	2	5	5	6	9	2	6
Med.diagnosis issues	13	2	3	4	8	4	8	4	2	8	2	5

Complaint Trends

Description	Aggregate Position/Description	Trend

Closed Complaints

In March 2019 18 complaints were closed.



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Upheld	7	5	9	3	4	4	4	4	4	5	4	6
Partially Upheld	7	6	18	8	8	3	9	10	5	7	11	6
Not upheld	2	3	9	3	5	4	7	4	6	4	8	4
Withdrawn	1	0	2	0	1	1	1	1	0	0	0	2
Referred to HR	0	0	0	0	0	0	1	0	0	0	0	0

Closed Complaints

Closed complaints by Division

The table provides a breakdown of closed complaints for March 2019 by division, demonstrating those complaints which were upheld, not upheld, partially upheld or referred to Human Resources (HR)

Division	Upheld	Partially Upheld	Not Upheld	Withdrawn	Ref HR	Sub-Total
DMEC	4	2	1	2	0	9
Corporate	0	0	0	0	0	0
Surgery & Cancer	0	4	2	0	0	6
Women & Children's	1	0	1	0	0	2
DCSS	1	0	0	0	0	1
CCICP	0	0	0	0	0	0

Total closed = 18

Board Papers – Quality, Safety & Experience Section: May 2019

Closed Complaints March 2019

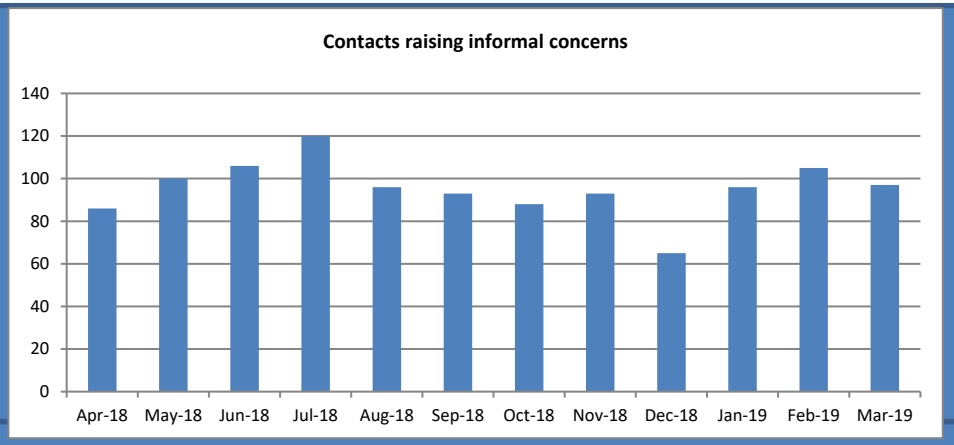
Tables removed under Section 40 of the Freedom of Information Act.

Description	Aggregate Position/Description	Trend

Informal concerns numbers.

The number of contacts raising informal concerns for March 2019 was 97 raising 175 individual concerns.

The Division of Medicine and Emergency Care has received the largest number of individual concerns raised at 77, with 18 of these individual concerns relating to Gastroenterology and 13 to the Emergency Department.



Informal Concerns Feedback

Informal concerns trends.

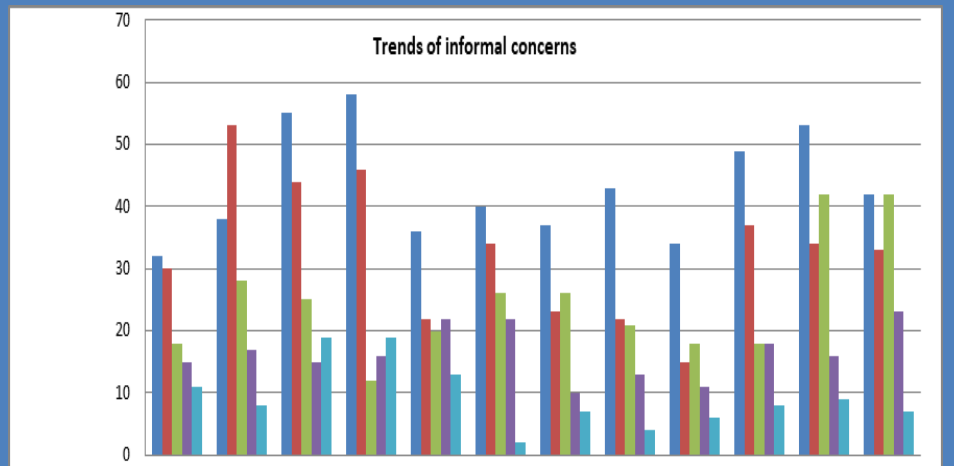
Communication and Appointments were the highest trends for informal concerns in March 2019.

<u>42 communication issues raised:</u>
13 relate to communication with patients face to face
18 relate to the Division of Medicine and Emergency Care.

<u>42 appointment issues raised:</u>
6 relate to Gastroenterology
5 relate to Ophthalmology, Respiratory and Dermatology respectively

<u>33 care issues raised</u>
24 relate to medical care

14 medical care issues relate to the Division of Medicine and Emergency Care with 7 for the Emergency Department.
6 nursing care issues, 3 relate to the Division of Medicine and Emergency Care and 1 to Surgery and Cancer.

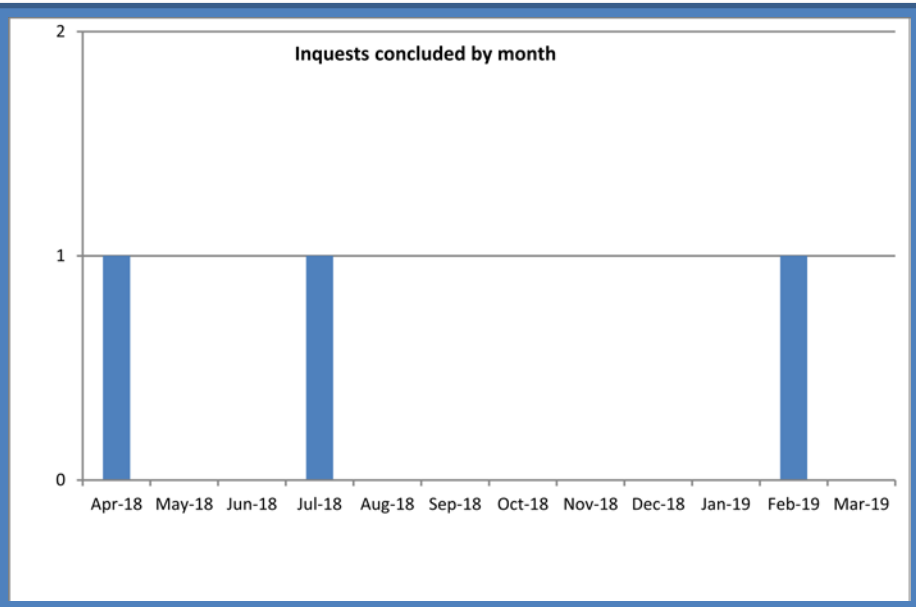


	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Communication	32	38	55	58	36	40	37	43	34	49	53	42
Care	30	53	44	46	22	34	23	22	15	37	34	33
Appointments	18	28	25	12	20	26	26	21	18	18	42	42
Attitude of Staff	15	17	15	16	22	22	10	13	11	18	16	23
Treatment	11	8	19	19	13	2	7	4	6	8	9	7

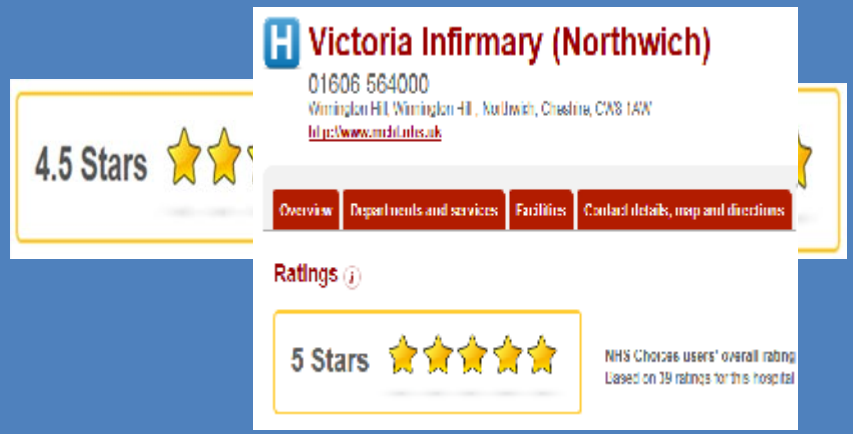
Informal Concerns Trends

Description	Aggregate Position/Description	Trend
New claims received.	Narrative and Graph removed under Section 43 of the Freedom of Information Act.	Claims
Claims closed with/without damages.	Narrative and Graph removed under Section 43 of the Freedom of Information Act.	Closed Claims

Description	Aggregate Position/Description	Trend
Value of claims closed by month	Narrative and Graph removed under Section 43 of the Freedom of Information Act.	Value of Claims
Top five claims by Specialty	Narrative and Graph removed under Section 43 of the Freedom of Information Act.	Top 5 Claims by Specialty

Description	Aggregate Position /Description	Trend
Number of Inquests concluded by month	No inquests were concluded in March 2019.	

Inquests

NHS Choices Star Ratings	In March 2019 Leighton Hospital is rated at 4.5 stars. Victoria Infirmary, Northwich is rated at 5 stars. The above ratings are based on 189 postings received to date.	

NHS Choices – Star Ratings

Description	Aggregate Position /description	Trend

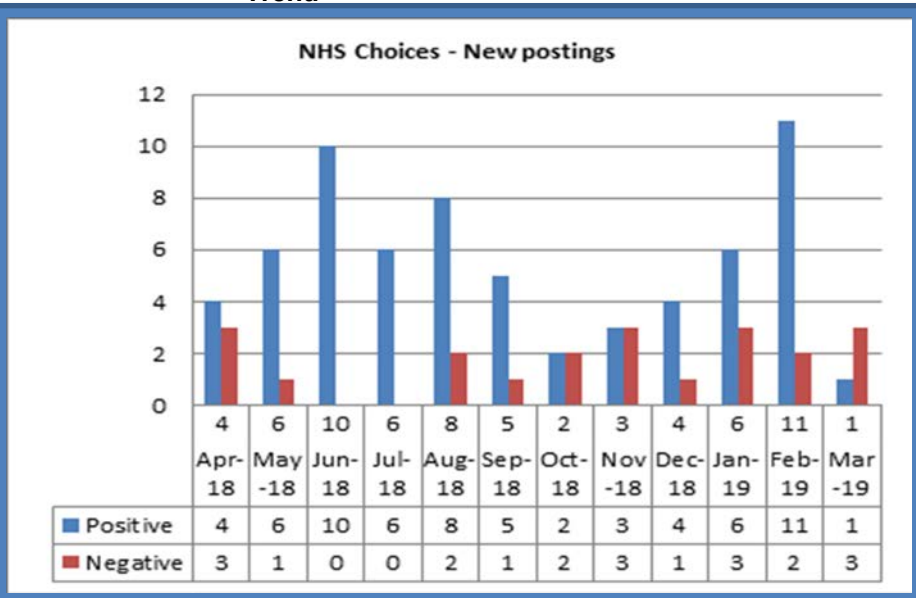
NHS Choices postings

There were 4 postings on NHS Choices in March 2019 of which 1 was positive and 3 were negative. Examples of feedback included:

During my stay at Leighton labour ward all the staff were very friendly, down to earth approachable and accommodating! It's easy to see why this hospital has won awards for its service in the maternity department" (Maternity)

We were desperately trying to get out of the unit and get my mother home (or at least off the trolley) ...which would have left you a bed for someone else. (Emergency Department)

I miscarried at 13 weeks last year…. I am now happily pregnant again, but when I went for my booking in appointment, my previous pregnancy hadn't been closed down on the system. It took quite a while to sort out and was a bit upsetting seeing all the details of my lost pregnancy on the screen" (Antenatal clinic)



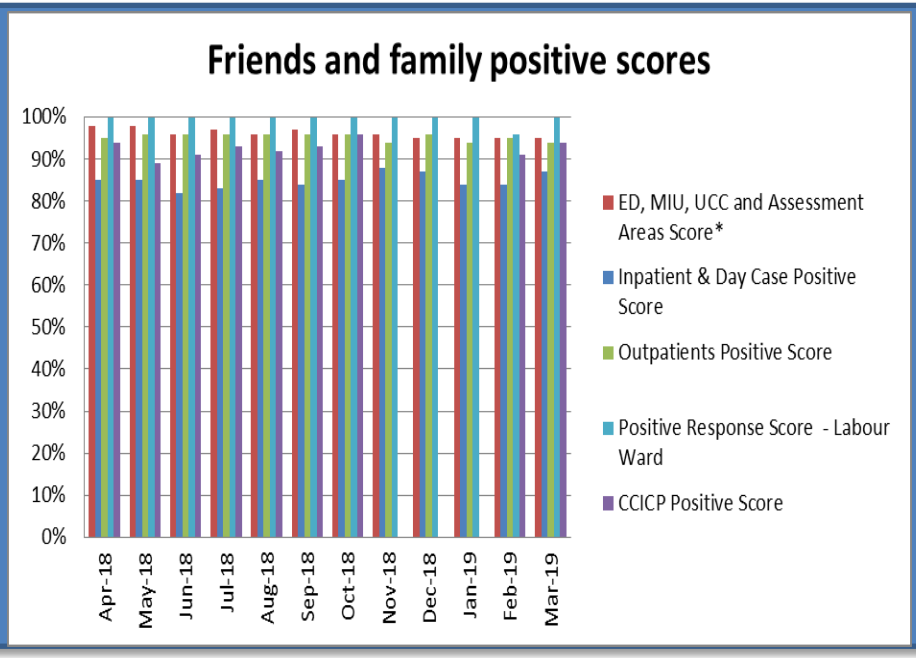
NHS Choices – Postings

The Family and Friends Test asks patients if this would recommend our hospital services to a friend or relative based on their treatment and experience

In March 2019 the Trust has scored the following positive response scores:

Emergency care /assessment areas 87%; Inpatients and day cases 95%; Outpatients 94%; Maternity (Labour ward) 100%; CCICP 96%.

Text messaging will be in place in all areas by May 2019.

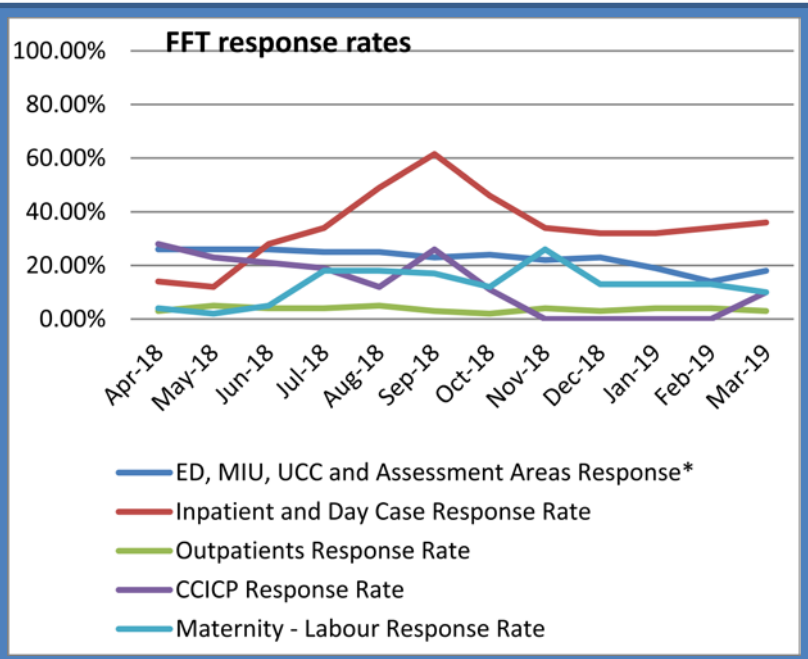


Family & Friends Test

Description | **Aggregate Position /description** | **Trend**

Number of responses received for IP, Day Case, ED, maternity, outpatient compared to eligible patients.

February 2019 Ward/Dept.	% Response	Total responses received	How many would recommend
A&E , UCC & MIU	18%	1189	87%
CCICP	10%	102	94%
Inpatients & Day cases	36%	1616	95%
Maternity	10%	60	100%
Outpatients	3%	545	94%



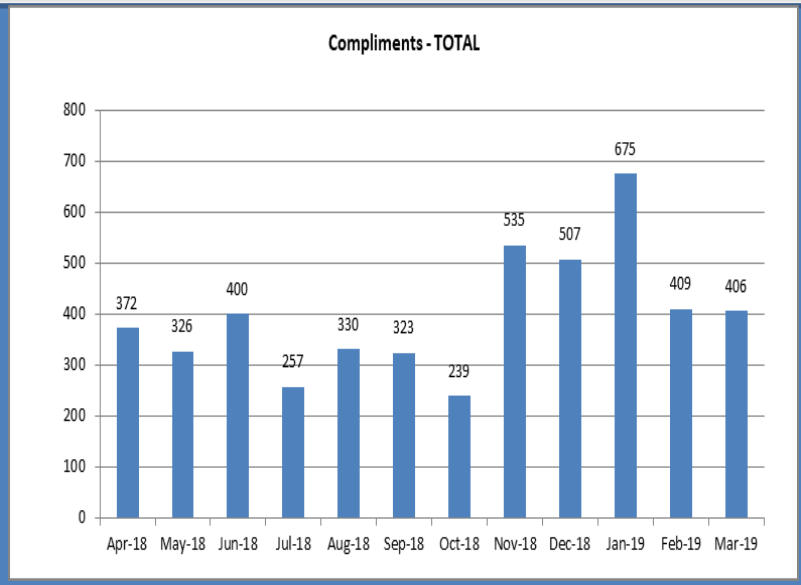
Family & Friends Test

Compliments received

There were 406 compliments received in March 2019. 98 of these were logged by the Customer Care Team and 308 received across the Trust.

'On behalf of our family, I wanted to write to say what fantastic treatment and care my mother-in-law received when an inpatient on wards 4, 11, 17, 18 and 19. The care from ALL staff, - care assistants, nursing, doctors, - could not have been better. The cleanliness of the wards and the food was also excellent. A five star experience.'

'A huge thank-you for the care on ward 25. The staff member was positive, patient and understanding. She put my needs first and was so caring and empathic'.



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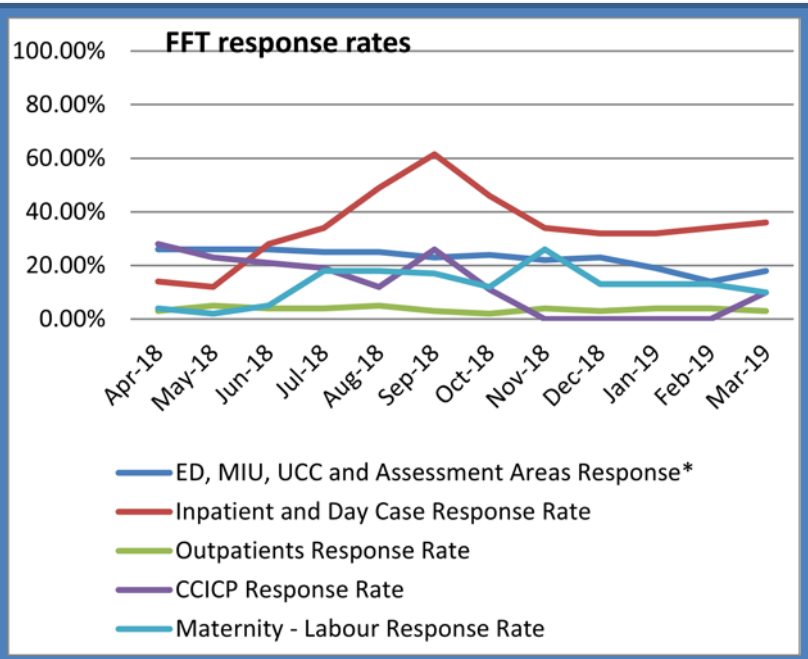

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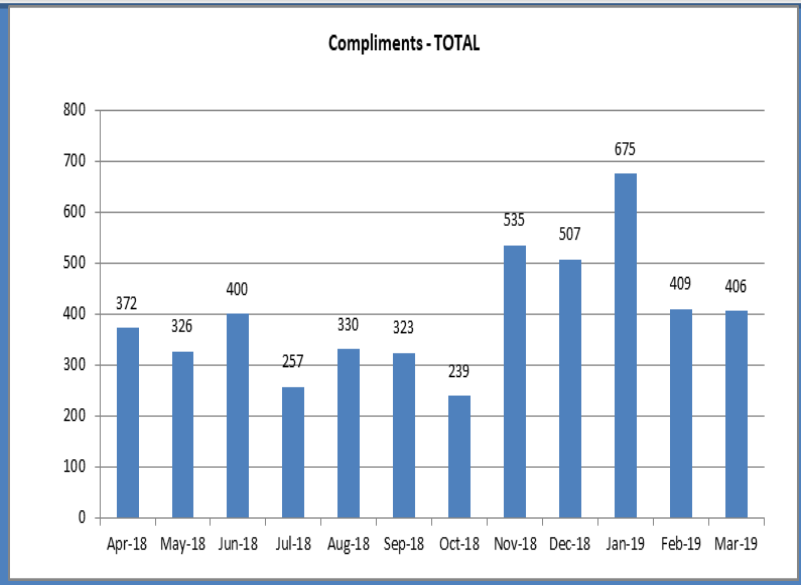


Compliments

Title of Paper:	Freedom to Speak Up Report: Q4 2018/19	
Author:	Julie Tunney: Director of Nursing & Quality	
Executive Lead:	Julie Tunney, Director of Nursing & Quality and Freedom to Speak Up Guardian	
Type of Report:	Concept Paper	
	Strategic Options Paper	
	Business Case	
	Information	x
	Review/Benefits/Audit	

Link to Strategic Domains:		***Link to Domain:***	
Delivering Outstanding Clinical Quality, Safety & Experience	✓	Safe	✓
Being a Leading partner in a Progressive Health Economy		Effective	✓
Striving for Outstanding Organisational Effectiveness		Caring	✓
Aspiring to Excellence in Practice Through Our Workforce	✓	Responsive	✓
Creating a 21st Century Infrastructure for Transformative Health and Social Care	✓	Well-Led	✓

Link to Board Responsibility:	Performance	
	Accountability	✓
	Strategy	✓
	Implementation	✓
Action Required:	Decide	
	Approve	✓
	Note	✓
	Recommend	
	Delegate	

Positive Benefit:	A workforce that feels safe to report concerns is essential to the continuing improvement and development of the patient and staff experience.
Risk:	Concerns go unreported and this leads to failure to provide good quality and safe individual care for our patients

To be published on Trust Website –complete version	**Y**
If no, to be published on Trust Website – redacted	
If not to be published complete or redacted, please detail the reason why	
Presented at Board Meeting of:	7 May 2019

FREEDOM TO SPEAK UP GUARDIAN QUARTERLY REPORT
January – March 2019 (Quarter 4)

Introduction & Background

The Mid Staffordshire inquiry and subsequent Freedom to Speak Up (FTSU) review by Sir Robert Francis highlighted serious concerns about the way NHS organisations deal with concerns raised by staff and the treatment of those who have spoken up and were victimised for doing so.

All NHS trusts are required to appoint Freedom to Speak up Guardians. The Guardians provide staff with someone to go to if they have a concern about a patient safety risk, a wrong-doing or malpractice. They are also required to report to the Board on all speaking up matters (including whistleblowing) and support the organisation in developing an open and transparent culture. The Guardian role at the Trust is undertaken by the Director of Nursing and Quality.

This report provides an update about the current position in relation to speaking up and raising concerns and sets out the additional activities to further embed these important roles and activities further.

Freedom to Speak Up Activity during Quarter 4

The Freedom to Speak up Guardian continues, with the support of the Employee Support Advisers (ESA), to remind staff of the important of raising concerns within the Trust. The ESA's continue to meet on a quarterly basis to update of the Freedom to Speak Up agenda, generate ideas and share best practice.

The Whistleblowing (Raising Concerns) Trust policy is under review to incorporate Freedom to Speak Up and work is currently underway to revise the current policy to ensure best practice is being applied. The policy lead is attending a development session provided by the Healthcare People Management Associate (HPMA) in association with Browne Jacobson entitled 'Handling Whistleblowing concerns and preventing problem' in May 2019. The session will review the many lessons to be learned from handling whistleblowing cases and attendance at this session will inform the revised Trust policy.

Freedom to Speak Up boxes are being launched over the coming months which will be placed outside of the Boardroom, in the Emergency Department and in Maternity Services initially before potentially being expanded to cover other areas. This follows the recent successful trial in the Patient Safety Summit meeting where this approach was used. This will allow staff to raise concerns anonymously should they so wish to do and is in addition to the other established mechanisms in place across the Trust. Efforts will continue to encourage and empower staff to raise concerns using these other mechanisms with further promotion of these mechanisms planned throughout the year.

In addition, work is underway to develop a section on the incident reporting system whereby staff can anonymously report any concerns. This is in addition to the Freedom to Speak Up incident reporting option that was added to the system some months ago. The alerts will be managed by one person as and when they arise and a report will be prepared on a quarterly basis to manage concerns and monitor any trends. Where a

serious anonymous patient safety concern is raised an investigation will take place to ascertain the facts.

The development of a newsletter is being explored to enable some level of feedback to be given to staff where concerns are raised anonymously. Whilst the newsletter would not be able to provide exact detail, an overview of themes and general actions would be given to provide assurance to staff that concerns raised are dealt with effectively.

Quarterly Reporting Q4

During the period 1st January 2019 to 31st March 2019 **no** Freedom to Speak Up concerns were raised. This is the first reporting period during the financial year where no concerns have been reported. It is recognised that further communication is required to promote the Freedom to Speak Up agenda.

Crossroad events are planned for the summer months with similar corresponding events in community settings to promote the role and raise awareness.

National Guardian Reporting

The data included in this report will be shared with the National Guardians Office to ensure compliance and national learning.

Title of Paper:	Draft Quality Report	
Author:	Becky Consterdine, Interim Quality and Outcomes Matron	
Executive Lead:	Julie Tunney, Director of Nursing	
Type of Report:	Concept Paper	
	Strategic Options Paper	
	Business Case	
	Information	x
	Review/Benefits/Audit	

Link to Strategic Domains:		***Link to Domain:***	
Delivering Outstanding Clinical Quality, Safety & Experience	x	Safe	x
Being a Leading partner in a Progressive Health Economy	x	Effective	x
Striving for Outstanding Organisational Effectiveness	x	Caring	x
Aspiring to Excellence in Practice Through Our Workforce	x	Responsive	x
Creating a 21st Century Infrastructure for Transformative Health and Social Care		Well-Led	x

Link to Board Responsibility:	Performance	
	Accountability	x
	Strategy	
	Implementation	
Action Required:	Decide	
	Approve	
	Note	x
	Recommend	
	Delegate	

Positive Benefit:	Statutory Requirement
Risk:	Non-compliance

To be published on Trust Website –complete version	**N**
If no, to be published on Trust Website – redacted	**N**
If not to be published complete or redacted, please detail the reason why	**It will be published, following laying of full Annual Report & Accounts before Parliament**
Presented at Board Meeting of:	**7 May 2019**

Mid Cheshire Hospitals
NHS Foundation Trust

Quality Account 2018/19

Quality and Safety at Heart
Mid Cheshire Hospitals NHS Foundation Trust

Quality Account 2018/19


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

Statement on Quality from the Chief Executive

It has been a very eventful year at Mid Cheshire Hospitals NHS Foundation Trust, and I am delighted to share some of our work through our Quality Account for the period of April 2018 to March 2019.

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

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

Throughout 2018/2019 we have continued to make good progress on our Quality and Safety Improvement Strategy; progress which has largely been achieved collaboratively as a result of the hard work, commitment and dedication of all our staff. We have continued to see and treat an increasing number of patients with more complex needs on both an elective and non-elective basis.

For the year 2018/19 the Trust delivered four of the five of the NHS Improvement Standard Oversight Framework performance indicators. The standard not achieved was the four hour access standard, (nationally known as the A&E Target) which delivered 83.63% in 2018/19. A full programme of improvement work is underway during 2019/20 to improve this performance

Following the successful integration of community services we are proud that the programme of continuous improvement and transformation for these services has continued. The development of 5 care communities sets the future direction of patient centred care across geographical footprints and supports closer working relationships between partner organisations and enhances holistic patient pathways.

MCHFT was named nationally within the top five combined acute and community Trusts for the annual staff survey results in 2018/19. This is a continued achievement that every one of our staff can be proud of.

Key achievements in 2018/19 include:

- The Surgical Ambulatory Care Unit winners of the Integration and Continuity of Care category for the Patient Experience Network Awards (PENNA) 2018. The Surgical Ambulatory Unit focusses around the teams launch and delivery of this new service which has been successful in reducing unnecessary hospital admissions and has consistently received positive patient feedback
- The Virtual Fracture Clinic were also winners at PENNA 2018.The team won the Innovative Use for Technology and Social Media Category for streamlining the process for the fracture clinic patients and avoiding unnecessary hospital attendances
- The Trust were successful winners of the National Wounds UK Award 2018 for the most innovative abstract in work to reduce moisture associated skin damage
- The bespoke phlebotomy clinic for adults with learning disabilities continues to support patients and obtain samples in a non-threatening environment. The clinic was recently shortlisted for a Nursing Times Award 2018
- A continued reduction of the number of patients having E-coli infections and the improvement of Patient Screening and treatment for Sepsis

We recognise that providing health care is not without risk and that sometimes patients can be unintentionally harmed in the care of hospitals. You will read throughout this Quality Account of the Trusts ambitious aims to continue to reduce harm across our organisation. Our Quality and

Safety Improvement Strategy is the vehicle by which we have steered the direction of travel for quality and safety focusing on the 9 indicators below;

- Reducing serious harm
- Reducing hospital or community acquired avoidable pressure ulcers
- Reducing inpatient falls
- Reducing mortality figures
- Reducing hospital acquired infections
- Reducing inappropriate inpatient moves
- Recognising and responding to the deteriorating patient
- Recognising and treating sepsis
- Improving end of life care

Patients want to know that they will be provided with the best treatment and care available, based on up-to-date evidence and by well trained staff. This report also demonstrates that the Trust has a number of assurance mechanisms in place which demonstrate how we scrutinise the quality of the care that we deliver. Examples of these include our extensive audit program and the nursing acuity tool that is used to ensure the planned required levels of staffing is in place.

We are proud that our C-difficile infection rates have fallen from 3 avoidable cases to 2 avoidable cases in 2018/19. Overall we had 24 C-difficile infections against an objective of 23. Importantly, of those, 19 were deemed to have been unavoidable following in-depth analysis with our commissioners. The remaining 4 have not yet been assigned and are awaiting review. Although we did not achieve the objective of no MRSA blood stream infections this year having identified 4 patients, we have implemented a robust focused approach to reduce the risk of occurrence in other patients to ensure the risk of Health Care Associated Infections is minimised.

With regard to our mortality rates; the latest publication for our mortality data for the period to June 2018 demonstrates a SHMI of 104.75 and the Trust remains in the ‘as expected’ range.

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

I am pleased to confirm that the Board of Directors has reviewed the 2018/19 Quality Account and agree that it is a true and fair reflection of our performance. We hope that this Quality Account provides you with a clear picture of how important quality improvement and patient safety are to us at MCHFT.

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

Dr Paul Dodds
Interim Chief Executive
Date: 23 April 2019

Priorities for improvement and statements of assurance from the Board

Following the successful completion of the 2017/18 Quality Strategy, the Trust conducted an extensive engagement programme to inform the development of the 2018/19 Quality and Safety Improvement strategy. Nine Key priorities have been identified.

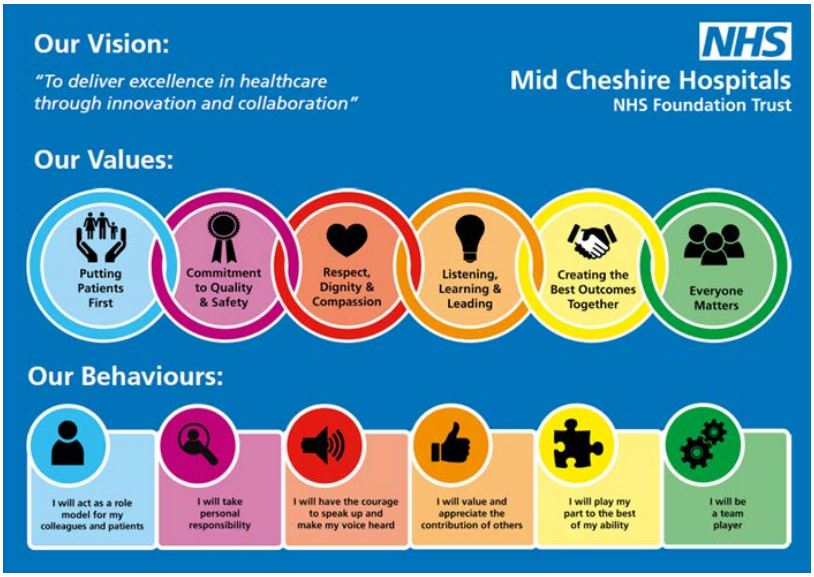
The overall purpose of the new strategy is to support the delivery of the organisation's vision and mission:

"***To deliver excellence in healthcare through innovations and collaboration"***

The Trust will be a provider that:

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

The strategy links closely with other key strategies such as the Trust Strategy and Our Workforce Matters Strategy 2018-21; it is when these work hand in hand that collectively the Trust can deliver the vision and mission of the organisation.



The strategy is based on views from people from Vale Royal, South Cheshire and the surrounding areas who told the Trust what they wanted from their hospital. In addition, staff, governors and other stakeholders also contributed to the development of the strategy.

The values and behaviours developed with Trust staff underpin the delivery and success of the strategy. The Trust recruits, supports and develops its staff so that these values and behaviours are observed by all staff.

The Quality and Safety Improvement Strategy for 2018/19 includes the three key elements of quality; experience, effectiveness and safety however also has focus on the quality domains set by the Care Quality Commission (CQC);

Safe

Reducing Serious Harm – To reduce patient safety serious incidents by 10% in the acute Trust when compared to the previous financial year by the end of March 2019 and reduce patient safety serious incidents by 10% in CCICP when compared to the previous financial year by the end of March 2019.

Reducing Hospital Acquired Infections – Reduction in avoidable HCAI in line with National Objectives with specific focus on MRSA Blood Stream Infections, Avoidable Cases of CDI, E.Coli and MSSA

Pressure Ulcers – For both the acute Trust and CCICP the target is to reduce hospital acquired pressure ulcers by 20% when compared to the previous financial year by the end of March 2019.

Falls – The target is to reduce inpatient falls by 10% when compared to the previous financial year by the end of March 2019.

Responsive

Reducing Inpatient Moves – The number of ward moves is 2 or less for all patients. Data will be analysed for those patients moved more than twice. Moves beyond this will be analysed for clinical necessity for example a move to critical care would be excluded.

Effective

Deteriorating Patient - Mid Cheshire Hospitals NHS Foundation Trust will reduce adult avoidable patient harm (measured by reductions in cardiac arrests, severity of patient harm incidents and high risk admissions to critical care) by improving the recognition of the response to the acutely deteriorating patient by 50% by the end of March 2019.

Sepsis –Mid Cheshire Hospitals NHS Foundation Trust aims to screen 90% of patients for sepsis who have signs of infection in ED, admission areas and inpatient areas and we will deliver intravenous antibiotics to 90% of patients who develop high risk (red flag) sepsis signs in ED, admission areas and inpatient areas.

Mortality – Mid Cheshire Hospitals NHS Foundation Trust's Summary Hospital-Level Mortality Indicator (SHMI) is to be within the ''as expected'' bracket and the Hospital Standardised Mortality Ratio (HSMR) is to be within the ''as expected'' bracket

Caring

End of Life – Mid Cheshire Hospitals NHS Foundation Trust will ensure patients who are identified as dying in the hospital are cared for according to the 5 priorities for care of the dying person, with appropriate use of individualised care plans for end of life.

Priorities for improvement in 2018/19: Feedback from patients

Local patient surveys

Annual patient and public involvement programmes are compiled at divisional level and agreed at Trust level. These divisional programmes comprise of a list of patient and public involvement surveys, identified as key areas of interest.

In the financial year 2018/2019, 42 surveys were undertaken. These surveys were completed by patients in various settings including whilst they are receiving treatment on the wards, in outpatient clinics and in the community.

Additionally, 4 core surveys are collected each quarter in inpatient areas, and an open and honest monthly patient survey which is collected by face to face interviews with inpatients. These core surveys collect patient feedback on key focus areas including communication, privacy and dignity, infection control and nutrition and hydration.

Three of the local surveys that have taken place in 2018/2019 are detailed below:

Orthopaedic Patient Satisfaction Survey

The second round of this annual survey was conducted in July-September 2018.
Paper questionnaires were distributed to inpatients seen by the orthopaedic physio team. 100 questionnaires were available for distribution. 59 completed questionnaires were returned giving a response rate of 59%.

Responses were very positive including 100% of patients who answered were treated with kindness, compassion, dignity and respect, honesty and understanding and 98% of patients who answered said they felt the therapist listened to their views about their treatment. The results for this survey were fed back to staff at team meeting. A patient leaflet has been designed in conjunction with the patient experience team, which will explain the patient's right to a second opinion

Macmillan Patient Satisfaction Survey

The Macmillan team conducted a generic patient satisfaction survey enquiring about patient experiences of the care and treatment they received whilst attending the Macmillan Unit. In total 83 responses were received out of a possible 100 surveys that were distributed, giving a response rate of 83%. Reponses were overwhelmingly positive with 100% of patients rating the level of care they received from the staff in the unit as good / very good or excellent.

Antenatal Screening Survey

A survey was conducted to obtain feedback on women's experiences attending the antenatal clinic for ultrasound scans. 84 questionnaires were completed by women who attended the Antenatal Clinic.
Overall the responses received were positive including 99% of respondents indicated that they felt they had enough verbal and/or written information to help them decide whether or not to have a scan / screening test and 99% of respondents indicated that they felt they had enough time to ask questions.
Results of this survey were shared with all Obstetric Medical Staff and staff within the Antenatal Clinic.
A Maternity Voices Partnership has been set up to enable women to provide further feedback on their experiences of maternity care, including antenatal screening and to seek views on the improvements being considered.

National Surveys

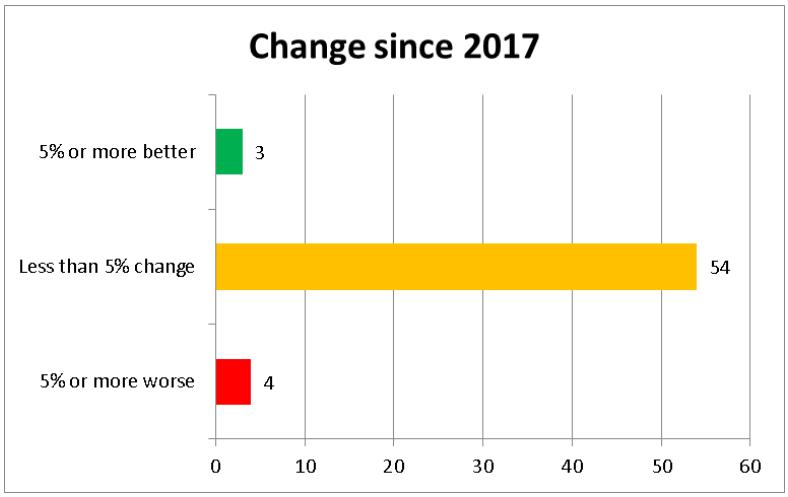
National Inpatient Survey

The survey was distributed to patients admitted in July 2018. With 691 surveys returned completed, the Trust had a response rate of 59% an increase of 6%.
The results include patients' perceptions of their hospital stay including:

- Admission to hospital,
- The quality of communications between medical professionals (doctors and nurses) and patients and care from non-clinical staff,
- Choice of food and rating and help provided, if needed, at meal times,
- Being involved in decisions about their care and treatment and
- Information provided.

The Trust scored an average score of 74.7% which is slightly higher than in 2017.
Compared with the 2017 survey, the Trust showed a 5% or greater improvement on 3 question scores and a 5% or greater reduction in score on 4 questions.

What has changed since the 2017 Inpatient Survey?



As part of this survey, a large amount of qualitative data is collected. Over 700 free text comments were analysed and themed. 61% of the comments received were positive

What has changed since the last inpatent survey?

The trust has significantly improved on the following questions :

- Staff helping patients to eat meals (12% improvement on 2017)
- Doctors: not talking in front of patients as if they weren't there; giving understandable answers to important questions

A workshop including all members of the multi disciplinary working group was established to review the outcome and to identify themes to develop an action plan to ensure continuous improvement. Results are shared widely across the organisation and at public meetings. A poster was distributed to wards and departments with examples of comments made by patients from the survey when asked what was particularly good about their care.

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

Delays at Discharge and Medications Side effects

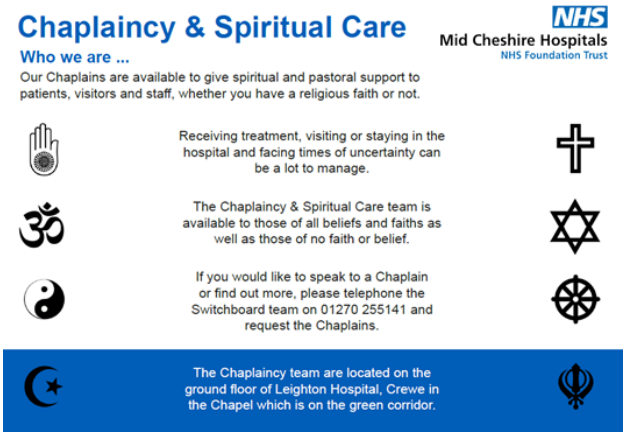
TTO labelling machines are now in place on three wards to enable ward prescribing and reduce delays associated with waiting for take home medications. This is being rolled out to other wards. Early Discharge Facilitators have been appointed on core wards. A prescription tracker system is being introduced within the pharmacy department.

Emotional Support

The working group linked in with the chaplaincy team for assistance with emotional support for patients. There is a large team of chaplains both paid and volunteer chaplaincy visitors, who can provide emotional support to patients. A trust spiritual strategy was launched in October 2018 with two launch events at the crossroads talking to staff and patients. A poster has been developed to promote the chaplaincy team.

Support at meal times

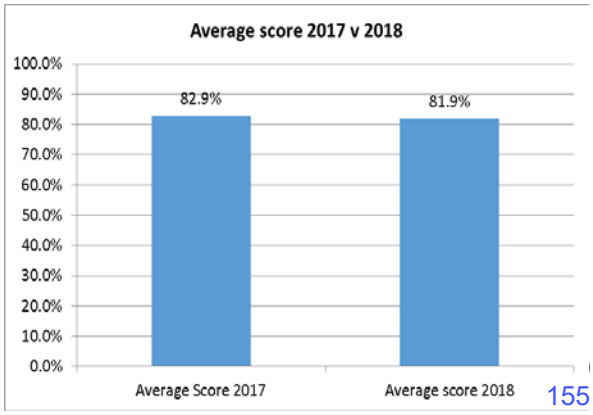
Volunteers were appointed and trained in 2018 to assist with helping patients to eat meals. Currently we have 20 trained volunteers to liaise with the dieticians to ensure they are reaching the wards and areas where the demand for assistance at mealtimes is at its highest. A dining companion role has been compiled and is now advertised on our Trust internet volunteer page.

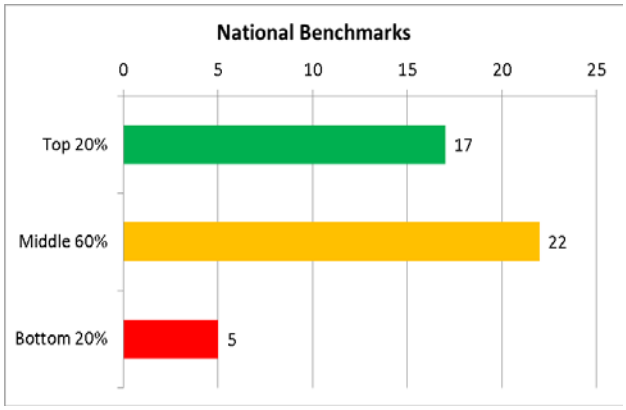


National Maternity Survey

The 2018 national survey looks at women's experiences of maternity care. It asked women about their experiences during labour and birth and the quality of antenatal and postnatal support. The survey for Mid Cheshire includes responses from 112 women who gave birth in February 2018.

300 surveys were posted and there was a 37% response rate. The average Mean Rating Score, across all questions, was 81.9% which is slightly lower than in 2017.





Patient satisfaction scores from women included:

- 97% reported that they had skin to skin contact with their baby shortly after birth
- 100% reported that a midwife or health visitor ask them how they were feeling emotionally
- 90% reported that in the six weeks after birth that they received help and advice from health professionals about their baby's health and progress

Areas showing at least a 5% improvement from 2017:

- Were you offered a choice of hospital
- Were you offered a choice of giving birth in a midwife led unit or birth centre?
- Were you offered a choice of giving birth in a consultant led unit?
- If you raised a concern during labour and birth, did you feel that it was taken seriously?

Areas where we have performed better than other trusts:

The survey looked at how the Trust performed against the national average for each question and across eight different areas. The trust performed better than the national average for two sections 'Feeding' and 'Care after Birth' and individual questions the Trust performed better than the national average for:

- Skin to skin contact with baby shortly after birth
- Midwives and other health professionals gave you consistent advice about feeding you baby
- Midwives that saw you appear to be aware of the medical history of you and your baby
- Midwives take your personal circumstances into account when giving you advice
- In the first 6 weeks after birth did you receive help and advice from a midwife or a health visitor about feeding your baby
- In the 6 weeks after birth did you receive help and advice from health professionals about your baby's health and progress

Action Planning

A working group is progressing actions on the following themes:

- Discharge Delays – the work that was done last year will not have been captured in the results of this survey so we are anticipating an improvement in next year's survey results.
- Homebirth – promoting home birth choice

- Postnatal care and information which will include a review of current information with women to identify any areas for improvement

National Cancer Survey

The survey is designed to monitor national progress on cancer care and provides information to drive local quality improvements. This was the 7th year and 49 of the 50 questions relating directly to patient experience have been summarised as a percentage score for the patients who reported a positive experience only.

http://www.ncpes.co.uk/reports/2017-reports/national-reports-2/3579-cpes-2017-national-report/file

Patients were sent the postal questionnaire (with 2 reminders) and had the option to complete the survey online. The sample included all adult (aged 16 and over) NHS patients with a confirmed primary diagnosis of cancer (ICD10 codes). The sample included patients discharged from an NHS Trust after an inpatient episode or day case attendance for cancer related treatment between April and June 2018. A Freephone helpline was available for respondents to ask questions, receive support and for translation / interpreting facility where first language was not English.

Patients affected or distressed by the survey were given a Freephone number to the Trust Survey Contractor, who contacted the Trust Survey Lead (Cancer Services Manager) with queries / concerns.

The Trust had a 63% response rate (England national average 63%).

What has changed since the last inpatient survey?

- Respondents gave an average rating of **8.9** for the Trust where the scale was zero (very poor) to 10 (very good). The national average was **8.8**
- Patient experience at the Trust was better than national average in 39 questions including the overall rating (26 in 2016)
- The same for 4 questions (7 in 2016)
- Patient experience at the Trust scored lower than the national average in 9 questions (19 in 2016)
- **95%** Received all the information needed about the test
- **91%** Hospital staff gave information about support groups (83% in 2016)
- **77%** Possible side effects explained in an understandable way (73% in 2016)
- **64%** Hospital staff gave information on getting financial help (54% in 2016)
- **88%** Patient had confidence and trust in all doctors treating them (81% in 2016)
- **79%** Hospital staff definitely did everything to help control pain (85% in 2016)
- **86%** Beforehand patient had all information needed about chemotherapy treatment though **only 68%** given information about whether chemotherapy was working (76% in 2016)

- Only **40%** Colorectal patient felt always / nearly always enough nurses on duty
- **65%** Always / nearly always enough nurses on duty (60% in 2016).

Six questions from Phase 1 of the Cancer Dashboard developed by Public Health England and NHS England

National Cancer Dashboard	MCHFT Score 2016	National Average Score 2016	MCHFT Score 2017	National Average Score 2017
Patient definitely involved in decisions about care and treatment	83%	78%	↓81%	79%
Patient given the name of the CNS who would support them through their treatment	93%	90%	↔93%	91%
Patient found it easy to contact their CNS	88%	86%	↓87%	86%
Always treated with respect and dignity by hospital staff	87%	88%	↑92%	89%
Staff told patient who to contact if worried post discharge	97%	94%	↓96%	94%
Practice staff definitely did everything they could to support patient	70%	62%	↓69%	60%

Actions Taken

- Analyse the tumour specific differences
- Interpret narrative feedback comments when published
- Develop action plan in collaboration with respective Divisions
- Monitor progress through Cancer Governance Group.

PEN Awards

The Trust had three applications shortlisted for the national Patient Experience

The Virtual Fracture Clinic application led by consultant orthopaedic surgeon Mr Nicholas Boyce-Cam, was shortlisted under the 'Innovative Use of Technology/social digital media' Category. This entry documented how this new system was introduced to streamline the process for fracture clinic patients and avoid unnecessary hospital attendances.

CCICP were shortlisted for their application from the advanced community matrons, documenting how they have transformed services to better meet the challenges and needs of the population they serve.

The Surgical Ambulatory Unit were shortlisted under two categories – strengthening the foundation and integration and continuity of care. This application was led by Matron Helen Williamson and focussed around the teams launch and delivery of this new service which has been successful in reducing unnecessary hospital admissions and has consistently received positive patient feedback.

The Trust is pleased to announce that the Surgical Ambulatory Care Unit and the Virtual Fracture Clinic both successfully won the awards in their category for the Patient Experience Network Awards (PENNA) 2018.

NHS Choices

The NHS choices website provides an opportunity for patients to provide comments about their recent experience in hospital.

There were a total of 87 new postings on the NHS choices website in 2018/2019.
There have been 66 positive postings and 21 negative.

Leighton Hospital is currently achieving a star rating of 4.5 stars out of a maximum of 5 stars and the Victoria infirmary, Northwich is achieving 5 stars out of 5.

The Trust, wherever possible, can respond to the posting thanking patients for feedback and providing information on how their comments can be shared with teams or acted on to improve services.

Examples of comments posted on NHS choices include:

Specialty	Patient Posting	Trust Response from department lead.
Women's & Children Maternity – Early Pregnancy Assessment	**EPAU review - dignity respect and outstanding care.** My partner and I were seen several times at EPAU for early pregnancy scans and then management of our miscarriage. We must say the care, dignity and respect we were shown was truly first rate and made all the difference. Everything was explained to us very clearly,	In response to the posting via NHS choices, Firstly I would like to thank you for taking the time to make this post. It's so nice

Unit (EPAU)	prompt actions were taken and the team did everything they could to be extremely thorough and careful with such a delicate situation. We were mainly treated by one particular member of staff and she was so caring and great at her job. She made us feel very involved, well cared for and in very safe experienced hands. We can't thank this member of staff and the EPAU team enough for the difference this made to our experience.	to hear the kind words you have for the staff working in the Early Pregnancy Assessment Unit (EPAU) and that your care and treatment at this sensitive time was dealt with respect and dignity. I will ensure the team are aware of your positive experience and the great work they are doing. Many thanks.
Diagnostics and Clinical Services – Medical Imaging	I had an MRI scan for a knee injury. My appointment was at 5:45 on a Wednesday and having been to Leighton before, I was anxious about finding a parking space. It was very easy at that time of day. The nurse/ admin person in the department read out various questions relating to my health for me to answer. As I was a nervous patient I asked the person to slow down as they rattled through the questions too fast! The person operating the scanner was very reassuring, gave me a buzzer in case of problems and played "you tube" music for me, at my request. However the scanner was so noisy I couldn't really hear the music through the headphones, but it was a nice touch. During the scan, the person checked that I was okay.	Thanks you for leaving your feedback on NHS Choices .I will feedback your comments to the Medical Imaging staff.
Surgery and Cancer - Gynaecology	I visited the Treatment Centre yesterday 23/11/18 for a Hysteroscopy, polypectomy and to have some biopsies taken. I was extremely anxious after a worrying few weeks leading up to this. I would like to thank the amazing team on duty yesterday for making me feel at ease from start to finish. From arrival to going home, I was treated with care, compassion, respect and dignity and I felt extremely looked after, even though it was clear, whilst I was in the recovery department, that they were short staffed and under pressure. Please can you pass on my heartfelt thanks to the amazing team who looked after me so well. We are so lucky to have access to such amazing healthcare on our doorstep.	Thank you very much for taking the time to positively comment on the care and treatment you recently received whilst attending the Treatment Centre. I will pass on your comments to the staff involved. Thank you again.
Medicine and Emergency Care	I attended the Out of Hours Unit which referred me to A&E on the evening of 11 August. The GP in the Out of Hours Unit gave me a very thorough examination before referring me to A&E after asking that I be seen by a Doctor from the Orthopaedics Department. I was seen by a Doctor and a Registrar from Orthopaedics who again gave me a very thorough looking over and were very reassuring in that I thought I had had a DVT when I had not. All concerned explained fully what they were doing and the conclusions they reached. I could not have asked for better treatment.	Thank you so much for your kind comments regarding your recent visit to the GP Out of Hours Service. I will ensure your comments are shared with my team and the orthopaedic team and we hope you have made a full recovery
CCICP	I attended the Out of Hours Unit which referred me to A&E on the evening of 11 August. The GP in the Out of Hours Unit gave me a very thorough examination before referring me to A&E after asking that I be seen by a	Thank you so much for your kind comments regarding your recent visit to the GP Out of

	Doctor from the Orthopaedics Department. I was seen by a Doctor and a Registrar from Orthopaedics who again gave me a very thorough looking over and were very reassuring in that I thought I had had a DVT when I had not. All concerned explained fully what they were doing and the conclusions they reached. I could not have asked for better treatment.	Hours Service. I will ensure your comments are shared with my team and the orthopaedic team and we hope you have made a full recovery

Friends and Family Test

The NHS Friends and Family Test (FFT) helps the Trust understand whether patients are happy with the service provided, or where improvements are needed. It is a quick and anonymous way to give patient views after receiving care or treatment. This simple survey is run in areas across the Trust ensuring patients have an opportunity to provide feedback on the care received. Responses are mainly collected through text messaging or automated voice messages and postcards.

Trust results

Over 48,000 patients have responded to the Friends and Family Test, which is 10,000 patients more than last year with 91% of patients indicating that they are likely to recommend services or treatment to their friends or family.

One of the key benefits of the Friends and Family Test is that results are quickly available to staff, enabling them to take swift action where poor experiences have been identified.

Areas/wards are being encouraged to display up to date FFT information and patient feedback on their quality and safety boards.

Examples of actions taken as a result of feedback from the Friends and Family Test include:

- ❖ Provision of juice and biscuits in the Children's Outpatient department and toys are constantly checked and renewed
- ❖ Improved monitoring of hand sanitizers to ensure they are full and in working order in outpatients
- ❖ Fault highlighted with baby changing area in the emergency department and promptly actioned
- ❖ Letters for patients attending the Treatment Centre have been reviewed in response to feedback

Maternity Facebook comments

The Maternity Facebook page aids in promoting Leighton Hospital Maternity Services and making information accessible via social media. The number of followers of the Facebook page has risen to 3694 followers.

The Facebook page raises the profile of the services offered and provides current evidence based information to women and their families. Recent posts by the Maternity Unit include

- Promoting parent education sessions which include topics of labour and birth, infant feeding, safe sleeping, early days with a newborn and a great chance to meet other parents.
- Pregnancy Advice - Making sure your body is ready for pregnancy is vitally important for the long term health of you and your baby. Take this quick quiz to see if you are 'pregnancy ready'. https://www.tommys.org/planning-for-pregnancy-tool
- Friends of Freya - Staff on our Neonatal Unit Leighton Hospital Ward 22 Neonatal Unit were extremely grateful for the donation of filled wash bags from Friends of Freya. This will make the stay for parents who are not prepared for their baby being admitted to the unit a little easier.

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

Some examples of the messages left are below:

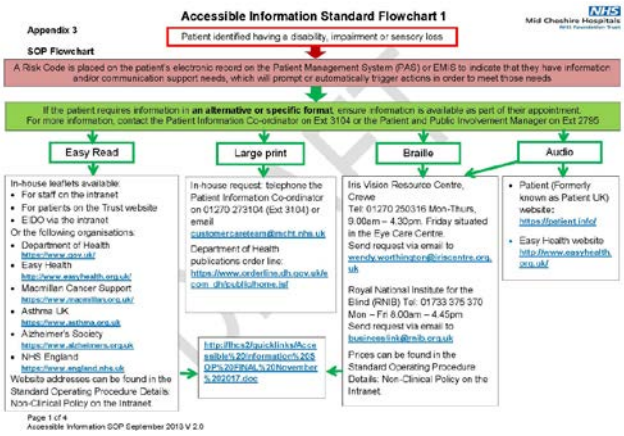
- ❖ Just a quick message to say thank you to the lovely Alana who delivered our third baby at Leighton. Our Armistice baby was delivered a few minutes past 11am on the 11th November. Alana was everything a midwife should be and the care we received from her and all the members of the Maternity team was exceptional. Thank you again, Sarah & Steve Porter xx.
- ❖ I just want to say a big thank you to Heather who delivered my baby. My husband and I only arrived at the hospital at 3.10am, and my daughter (Rosie) decided she didn't want to hang about, and was delivered in the triage room! A little bit of a shock being quicker than we expected, but thank you for bringing her into the world safe and well. She's now just over one and is running around everywhere, full of life. Thank you again! X

Other patient and public involvement programme activities

Patient Information Group

The group meets on a monthly basis with a membership of 11 including two patient representatives and a multi-disciplinary group of staff. In 2018/19, the group reviewed 26 leaflets reviewed, including Personal Wheelchair Budgets; know your numbers, Vague Symptoms

A flow chart has been developed to support the work being undertaken to meet the Accessible Information Standard. This aims to ensure staff are proactive in the approach to meeting the information needs of patients and are supported in being able to provide alternative types of information.



Readers Panel

The Trust continues to have an active reader's panel with 78 members to review patient information on a monthly basis. The aim of the Readers' Panel is to ensure:

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

Leaflets reviewed by the Patient Information Group included: Personal Wheelchair budgets, Musculoskeletal Single Point of Access Service and general patient advice leaflets on self-help including tennis elbow and carpal tunnel.

Leaflets produced in other formats:

The Trust has a number of initiatives in place to ensure it meets the standard for Accessible Information. The aim of the accessible information standard is to make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need.

The Trust has produced guidance to assist staff to identify and record information and communication needs for patient's service users, carers and parents, where those needs relate to a disability, impairment or sensory loss.

Staff follow a booking in procedure which asks patients if they have any disabilities or communication methods other than normal practice e.g. Braille, signing for hard of hearing, interpreters due to language barrier.

Information produced this year includes large print maps, a stroke leaflet and patient leaflets for condition and specific treatments.

Easy Read

Information produced in an easy read format includes a review of the leaflet for patients attending the Minors Unit in the Emergency Department which is aimed at making the visit less stressful for the patient.

You will then have to book in at the reception desk.

The person on the front desk will ask your name, address and what is wrong with you.

Patient Register Group

The register group met twice in 2018 at local venues in the community. The meetings were attended by governors, volunteers, patient representatives and with an open invitation to members of the public. The group aims to provide information about new developments in the Trust and also an opportunity to seek patient and public views.

Topics covered have included an overview of the new Virtual Fracture Clinic system, presented by Mr Nic Boyce-Cam, Consultant Orthopaedic Surgeon, and the Surgical Transformation Project, documenting the launch of the Surgical Ambulatory Care Unit and the benefits this has brought to patients. The physiotherapy team manager Michelle Kaey also came to talk to the group about the trust wide led work around EndPJparalysis, a simple concept that encourages patient to get up, dressed and moving while in hospital, which can prevent the complications of being immobile, including chest infections, muscle degeneration, clotting; as well as shifting patient's perceptions 'I'm sick' to 'I'm getting better'

Voluntary Services

Annual Volunteers' Celebration Evening

The Nightingale Choir

A major highlight during National Volunteers' week (first week of June) is our Annual Volunteers' Celebration Evening. Held again this year at Nantwich Football club, the evening was very well attended, with volunteers representing all areas of the Trust and covering a multitude of volunteer roles. The evening is a chance for the Trust to thank our family of volunteers who make such a valuable contribution to the hospital. It also gives volunteers a chance to meet one another, perhaps catching up with old friends, or making new. The musical entertainment on the night was provided by the Nightingale choir. The Volunteers' evening is an ideal opportunity to congratulate and present long service awards, to those reaching particularly momentous anniversaries. The awards were presented by Trust Chairman, Dennis Dunn MBE and Chief Executive Tracy Bullock. This year we proudly recognised 12 volunteers reaching milestone anniversaries, between 10 and 46 years.

Partnership Working - Hospital Garden Space

There has once again seen a great deal of activity in the hospital gardens. The official opening of the beautiful Urology Outpatient garden was held. This event was a fitting celebration after all the dedication, hard work and fundraising efforts. There has been a programme of ongoing maintenance throughout the year here and across other garden areas around the hospital, including the Therapy Garden and Ward 1 courtyard. Such projects continue to be coordinated by Trust volunteers and supported by volunteers from Barclays Bank (Gadbrook Park). Barclays Bank have adopted the Urology garden and will therefore continue to maintain this for us. Discussions have begun already regarding 2019/20 garden projects with Barclays Bank, who have confirmed the excellent news that they will double their involvement, allocating two department teams of volunteers to the hospital.

The MacMillan garden has continued to be maintained by volunteers from Bentleys. Their group of volunteers now called 'Give back gardeners', support the local community and have confirmed their commitment to the MacMillan unit for the year ahead.

Neo Natal Unit - Peer Support volunteers

The first three volunteers were recruited this year into the new role of Volunteer Peer Supporters, for the Neonatal Unit. These volunteers have first-hand experience of having a premature baby cared for on the unit and felt they could provide support to other parents going through this difficult journey.

Dining Companions

This year Voluntary services in conjunction with the RVS, have promoted Patient Feeding training to volunteers. This has led to an increase in the number of volunteers that are trained and can now assist patients at meal times. This help is proven to make a significant difference to patients' wellbeing and recovery.

50 Years of Hospital Radio

Leighton Hospital Radio celebrated their 50th Anniversary on 14th November. The station, which is volunteer led, started life at Coppenhall Hospital in 1968. It later moved to the Memorial and Barony hospitals, before making Leighton hospital its base in 1987. The 50th birthday was marked

with a display in the Outpatients department, presenting photos and memorabilia from over the five decades, which Chairman Bob Squirrel and many of the radio volunteers helped to bring together. Chief Executive Tracy Bullock, presented the broadcasters with a certificate to commemorate half a century in broadcasting in South Cheshire and two special radio programmes presented by Stewart Green and Angela McCully-Jackson were also aired.

Chief Executive Tracy Bullock, celebrating 50 years with Hospital Radio volunteers, Stewart Green, Bob Squirrel (chair) and Anthea Taylor.

Christmas Community Activities

Bags of Joy – As in previous years, hundreds of Christmas 'Bags of Joy' were delivered to the hospital. These had been kindly made and donated by volunteers from Elim Church and contained such items as toiletries, chocolates and socks, along with a small message. They also donated many "mermaid blankets" to the Children's ward. The bags were added to the gifts already generously donated by staff and distributed by ward staff to patients over Christmas.

Carol singers – Volunteer Carol singers from the churches of Audlem Baptist, Wheelock Heath Baptist and St Andrews, Aston provided Christmas cheer to the wards in December, enjoyed by patients and staff. Many patients requested their favourite carols and joined in with the singing.

Pets As Therapy (PAT)

We are fortunate to now have regular visits from three PAT dogs, visiting a wide variety of wards, across the hospital. These visits allow patients the chance to chat with the volunteers and stroke the dogs. Staff enjoy the visits as much as the patients and it is wonderful to see how patients engage with our canine friends. One of our PAT dogs Brann, wearing his Christmas antlers with pride, visited the Children's ward over the festive season. This brought smiles to many faces.

Royal Voluntary Service (RVS) Befriending Service

The RVS Befriending service currently has 11 active volunteers based at Leighton hospital, with a further 9 in the recruitment process. The service spans the week and is currently across 5 wards (4, 6, 7, 10, and 19). Most recently they have introduced volunteers to the Clinical Decision Unit. The RVS support staff by engaging patients in activities including; reading, discussing news

headlines and completing puzzles. More recently some Volunteers have undertaken additional training to assist with supporting patients at meal times. They are also being trained to use a digital therapy system RITA for older patients with cognitive impairment, such as dementia.

Compliments / Complaints

Customer Care Team

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

In January 2019 a new Customer Care Team office was opened in the main entrance to promote the support the Customer Care Team can offer and improve access for patients and their families if they need support.

The Customer Care Team also receives Ecards from relatives who chose to send messages in this way. This year, 10 Ecards were delivered to patients in the Trust between April 2018 and March 2019.

Compliments

4779 (figure to date) formal compliments were received by the Trust during 2018/19 which expressed thanks from patients and families about the care received. This is a significant increase compared with previous years. All compliments are shared with the relevant teams who are identified.

	2015/16	2016/17	2017/18	2018/19
Number of compliments received	1727	1,872	1913	4779

Overview of compliments received by the Trust

Complaints

209 formal complaints were received by the Trust during 2018/2019 which is a 3% reduction compared to 2017/2018.

	2015/16	2016/17	2017/18	2018/19
Number of complaints received	264	283	215	209

Overview of complaints received by the Trust

Review of complaints

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

The Trust is committed to providing an accessible, fair and efficient service for patients and service users who wish to express their concerns or make a complaint with regard to the care, treatment or services provided by the Trust. The Trust promotes the Healthwatch advocacy service to anyone making a complaint to highlight the independent support available. The Trust also promotes the Healthwatch service by supporting the use of community Healthwatch stands within the Trust premises to encourage engagement with the public in regarding the support and advice the Heathwatch service provides.

The Trust recognises the importance of having a robust and flexible process for the management of complaints to ensure complainants receive a timely and person-centred response to the issues they have raised. In October 2018 key performance indicators for the management of complaints were agreed with all divisions within the Trust to ensure that concerns raised are responded to in a timely manner.

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

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

All complaint meetings are recorded and a copy of the CD is given to the complainant at the end of the meeting. The Trust is also able, with the consent of the complainant, to provide copies of the disc to external bodies such as the Coroner's Office and The Parliamentary Health Service Ombudsman to assist them in their information gathering.

The Customer Care Team continues to seek the views of their service users and send out surveys to complainants in order to gain feedback to support an improvement in the way that the service is delivered. However as the Trust has identified that current response rates to the survey are relatively low the Trust is completing a review of surveys used by other Trusts and in addition is reviewing the recommendations of the NHS England survey. It is planned to redesign and relaunch the survey offered to complainants in the 2018/2019.

Some of the key themes of complaints received in 2018/19 were in regards to nursing medication delays and concerns regarding nutrition, communication face to face with patients and relatives, medical adverse outcomes and medical diagnosis. Examples of these are summarised in the table below together with actions taken to address the concerns raised.

Themes	Actions Taken
Inpatient Wards: **Concerns were raised with regards to identifying patients who need support to maintain appropriate nutrition.**	The wards have implemented the new nutritional screening tool in October 2018 to support early recognition of patients who need support with maintaining good nutritional levels for recovery.
Trust Staff: **Concerns were raised with regard to the effectiveness of staff communication with patients and relatives**	A programme of communication workshops has been developed for all grades of staff which is now available bi-annually. Staff have been reminded of the importance of good communication with patients and their families and progress against this improvement is monitored by means of the divisional communication surveys and complaint analysis.
Trust medical and nursing staff: **Concerns were raised with regards to medical adverse outcomes and diagnosis problems.**	Action plans have been agreed divisionally to address issues raised by patients and families and the feedback received from the complaint investigations has been shared with relevant staff to ensure lessons were learnt from the incidents and actions were taken to improvements care. The Deteriorating Patient Group has been developed to improve recognition of the deteriorating patient for all staff, which has implemented the National Earning Warning Score to improve care of the deteriorating patient in the clinical areas. .

Learning disability access

People admitted to hospital with a learning disability (LD) need to be supported, assessed and treated by competent and compassionate staff, who have had access to appropriate education and training.

Mid Cheshire Hospitals NHS Foundation Trust (MCHFT) works exceptionally hard to ensure the care we provide to people with a LD is of a high quality, enabling good clinical outcomes and an enhanced patient and carer experience.

People with a learning disability are more likely to develop physical and mental health problems compared with the general population. Learning disability statistics demonstrate that:

- People with a LD have an increased risk of early death compared to the general population
- People with a LD are less likely to receive regular health checks
- People with learning disabilities are 2.5 times more likely to have health problems than other people
- The prevalence of dementia is much higher amongst older adults with LD compared to the general population
- Prevalence rates for schizophrenia in people with LD are approximately 3 times greater than for the general population

(Mental Health Foundation, 2018)

To address these issues and support our patients who have learning disabilities, we have introduced a number of initiatives at MCHFT. These are:

- Every quarter we hold a LD Phlebotomy Clinic. The clinic is held out of hours to minimise distress for patient's and provide a calm and non-threatening environment. The clinic is always fully booked, with double appointments so we can take our time and not rush our patients. The cakes and chocolates afterwards always go down particularly well! The service was recently shortlisted for a Nursing Times Award

- We have a large library of easy read information for our LD patients and carers to access. Recent additions include updated versions of our Emergency Department information leaflet, both from a minor and majors perspective

- The Trust's Dignity Matron continues to visit LD patients in their own home to plan elective admissions to hospital. This enables reasonable adjustments to be made such as:

  - Carers accompanying patient's into the anaesthetic room and recovery area after surgery
  - Double appointments
  - Tours prior to admission
  - Completion of Hospital Passports
  - Easy read information
  - Make the most of our opportunities i.e. when a patient is having a general anaesthetic, try to incorporate all health checks such as blood tests, podiatry, flu jabs.
  - Home visit(s) to take blood, perform ultra sounds if patients are reluctant to come into hospital.

The Dignity Matron also visits patients who have been admitted to the hospital via the emergency department. The Matron acts as a liaison between patients, carers, staff and community teams and helps to facilitate best interest and pre-discharge meetings.

- Every week the Dignity Matron works alongside the Pre-Operative Assessment (POAC) Nurses, to provide a clinic specifically for patients who lack capacity to consent to procedures themselves. These clinics enable the consent process to be completed and reasonable adjustments to be highlighted at an early stage. Areas of concern can be discussed with patients and their carers, to alleviate worries and fears and improve the overall patient/carer experience

- The Trust holds a LD development group, which has representation from Trust and community services. The group shares patient feedback, local and national best practice and reviews LD deaths

- All deaths of patients with a learning disability are reviewed from a clinical perspective as well as a LD perspective. Lessons learnt are shared across Divisions and potentially into primary care; if there are issues for the wider learning disabled community

- Patient stories from an LD and carer perspective have been shared at a senior level including the Trust Executive Board and the Local Safeguarding Adults Board

- We have recently taken part in an NHSI Learning Disabilities Standards project. The aim of the project is to gather data in relation to LD patients, carers and the organisation itself, with a view to highlighting improvement opportunities.

Seven Day Hospital Services

The Trust's has continued its risk based approach to investment in the multi-disciplinary teams ready for 2019/20 to make progress towards complying with the four priority clinical standards with the seven-day services programme.

Significant work has taken place which includes a focus on the infrastructure, medical staffing, nursing and therapy support to deliver services across seven-days. With this aim, business cases in General Surgery and Urology have been presented to the Trust's Board of Director in 2018/19 which contain investment proposals to help improve our services over the week and 'out of hours'. Further business cases are being developed to improve the level of services within Therapies and Acute Medicine.

In line with other Trusts, the consistent delivery of the 'First Consultant Review within 14 hours of an Emergency Admission' (Standard 2) remains a challenge, although there are plans in place, down to speciality level, as to how this could be achieved. The Trust will continue to develop networked arrangements with neighbouring Trusts to deliver Consultant-directed interventions, (e.g. interventional endoscopy, stroke thrombolysis) out of hours. The Trust achieves the seven-day services standards relating to 'access to diagnostic tests' (standard 5) and 'ongoing consultant-directed reviews'

Freedom to Speak Up

An outcome of the Freedom to Speak Up review, an independent review into creating an open and honest reporting culture in the NHS, led by Sir Robert Francis QC, was that NHS Trusts should appoint Freedom to Speak Up Guardians. The Guardian is someone whose role it is to act as an independent and impartial source of advice to staff, with access to anyone in the organisation, including the CEO, or if necessary outside the organisation, where concerns are identified which affect patient care. The Guardian ensures that the primary focus is on the safety issue; that the case is handled appropriately, investigated promptly and issues addressed; and that there are no repercussions for the person who raised it.

Speaking up should be something that everyone does and is encouraged to do. There is a shared belief across the Trust that raising concerns is a positive action and staff need to feel safe to raise concerns, confident that they will be listened to and the concerns raised will be acted upon. Mid Cheshire Hospitals NHS Trust is committed to supporting and encouraging all those who raise honestly held concerns about safety, with a focus on learning rather than blame.

The Director of Nursing and Quality is the Trust's Freedom to Speak Up Guardian and therefore is committed to providing confidential advice and support to staff in relation to concerns staff have about patient safety and/or the way their concern has been handled. Whilst the Guardian does not investigate the concerns raised, they help to facilitate the raising concerns process where needed, ensuring Trust policies are followed correctly.

The Trust have implemented a 'Raising Concerns' policy which has been adopted in line with recommendations of the review by Sir Robert Francis into whistleblowing in the NHS.

The Freedom to Speak Up Guardian regularly attends the National Guardian Freedom to Speak Up Conferences and update sessions which are an opportunity to share learning with peers from other organisations and to hear from the National Guardian's Office on best practice.

Additional ways staff can raise concerns

- Employee Support Advisers/Speak Up Champions – The Employee Support Advisors are trained staff volunteers who provide an opportunity for individuals to discuss any concerns in an informal forum and help to identify the range of options and support available. Quarterly information update sessions are held between the Guardian and the Employee Support Advisors and Champions to share knowledge and good practice

- Staff are able to leave a confidential message raising any concerns using the Staff Voicemail Service which is managed by the Human Resources Department

- A dedicated email address was set up in 2018 as another mechanism for staff to report any concerns

- A Freedom to Speak Up box has recently launched to provide staff with an additional way to raise concerns. The box was piloted during quarter three and quarter four at the Patient Safety Summit Meeting which is held fortnightly. Staff are able to anonymously submit concerns via the box which may affect patient safety. Any feedback on the issues raised is given at the following meeting. A review will be undertaken at the end of the financial year to assess the effectiveness and to explore whether the approach is to be rolled out across other areas

- Some concerns are raised locally and dealt with by local managers as part of their day-to-day work. These concerns would not be logged onto the whistleblowing log.

Staff are able to utilise any of these forums if they have concerns over quality of care, patient safety or bullying and harassment within the Trust.

Feedback is an important part of the process. Where concerns raised are not done so anonymously, face to face feedback is provided by an appropriate manager. Where concerns are raised anonymously, feedback on improvements or process changes, as a result of the concern raised, is communicated across the relevant division using a 'you said, we did' approach. The Trust are currently considering the promotion of positive outcome cases.

The Trust uses staff survey results to benchmark itself against peer organisations on indicators relevant to raising concerns. The Trust's overall staff engagement score was 7.2 out of 10 in 2018 compared to the national average of 7.0 as the national average for Acute and Community Trusts.

The Trust uses staff survey results as shown below to assess whether the arrangements in place for raising concerns are effective. The Trust score better than the national average when compared to other comparable trusts on the following key findings in the 2018 staff survey:

- My organisation treats staff who are involved in an error, near miss or incident fairly

- When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again

- We are given feedback about changes made in response to reported errors, near misses and incidents
- I would feel secure raising concerns about unsafe clinical practice
- I am confident that my organisation would address my concern
- My organisation acts on concerns raised by patients / service users.

Feedback from staff

The NHS staff survey is undertaken by all NHS Trusts on an annual basis and continues to be recognised as an important way of ensuring the views of staff working in the Trust inform local improvements and outcomes for both staff and patients. The results from all Trusts are made available and allow the Trust to be benchmarked. The survey is undertaken on behalf of the Trust by Quality Health (an independent contractor) using the nationally specified criteria.

The 2018 NHS Staff Survey saw changes introduced to the reporting of the results. In previous years trusts have been benchmarked against 32 Key Findings, however based on the outcome of a review by the National Staff Survey Co-ordination Centre these Key Findings have now been replaced by Ten Themes.

The following table provides an overview of the scores achieved by the Trust against the Ten Themes

Theme	2017 (Scores out of 10)	2018 (Scores out of 10)	Combined Acute and Community Trust Average	Trust Performance (when compared with all combined acute and community trusts in 2018)
Equality, Diversity and Inclusion	9.3	9.4	9.2	Above Average
Health and Wellbeing	6.4	6.1	5.9	Above Average
Immediate Managers	6.8	6.8	6.8	Average
Morale	No data	6.5	6.2	Best
Quality of Appraisals	5.3	5.6	5.4	Above Average
Quality of Care	7.7	7.6	7.4	Above Average
Safe Environment – Bullying and Harassment	8.2	8.3	8.1	Above Average
Safe Environment – Violence	9.4	9.6	9.5	Above Average
Safety Culture	6.9	6.9	6.7	Above Average
Staff Engagement	7.1	7.2	7.0	Above Average

* There is no comparative data prior to 2017 due to the significant organisational change that took place in 2016 with the inclusion of Central Cheshire Integrated Care Partnership (CCICP), which resulted in the organisation moving from an ‘Acute’ to a ‘Combined Acute and Community Trust’.

Staff Survey Data

Equality and Diversity	2017	2018	National 2018 average for combined acute and community Trusts	Best 2018 Score for combined acute and community Trusts
Q14 Percentage of staff believing the organisation provides equal opportunities for career progression and promotion *(% of staff electing 'Yes')*	92.3%	90.5%	85.5%	91.5%
Violence, harassment and bullying	**2017**	**2018**	**National 2018 average for combined acute and community Trusts**	**Best 2018 Score for combined acute and community Trusts**
Q13b. In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers? *(% of staff saying that they have experienced at least one incident)*	10.5%	9.3%	12.1%	8%
Q13c. In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from other colleagues? *(% of staff saying that they have experienced at least one incident)*	18.2%	16.1%	18.4%	14.4%

The Quality Account Reporting Arrangements require the Trust to report on the responses for the following questions for the Workforce Race Equality Standard:

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

The scores for White and Black and Minority Ethnic (BME) staff as required for the Workforce Race Equality Standard are as follows:

Key Finding		2017	2018
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White	21.5%	20.2%
	Black and Minority Ethnic	32.3%	32.1%

The national Trust average in the reporting category in 2018 was 23.6% for white staff and 29.9% for BME staff which puts the Trust in a slightly better than average position for white staff, however the results are slightly worse than the national Trust average for BME staff.

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

90.5% of staff who completed the 2018 staff survey believe that the Trust provides equal opportunities for career progression and promotion. The national average for combined acute and community Trusts in 2018 was 85.5% with the best score being 91.5%.

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

Key Finding		2017	2018
Percentage of staff believing the organisation provides equal opportunities for career progression and promotion	White	92.9%	91.2%
	Black and Minority Ethnic	84.2%	86.4%

The national Trust average in the reporting category in 2018 was 87.2% for white staff and for BME staff 74.2%, which puts the Trust in an above average position.

Action plans will be developed in 2019 to address any areas of concern highlighted in the staff survey.

Statements of assurance from the Board

Review of services

During 2018/19 the Trust provided and/or sub-contracted 40 relevant health services.

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

The income generated by the relevant health services reviewed in 2018/19 represents 100% of the total income generated from the provision of relevant health services by the Trust for 2018/19.

Participation in Clinical Audits and Research

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

National Clinical Audit

During 2018/19, 50 national clinical audits/other projects and 8 national confidential enquiries (Clinical Outcome Review Programmes) studies covered NHS services that MCHFT provides.

During that period, MCHFT participated in 96% of national clinical audits and 100% of national confidential enquiries (Clinical Outcome Review Programmes) of the national clinical audits and national confidential enquires (Clinical Outcome Review Programmes) which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Trust was eligible to participate in during 2018/19 are shown in the table below.

The national clinical audits and national confidential enquires that the Trust participated in during 2018/19 are shown in the table below.

The national clinical audits and national confidential enquires that the Trust participated in, and for which data collection was completed during 2018/19, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Clinical Audit Participation 2018/19

National Clinical Audit and Clinical Outcome Review Programme	Participation	Data submission
BAUS Urology Audits: Female stress urinary incontinence	Yes	27 cases*
BAUS Urology Audits: Percutaneous Nephrolithotomy	Yes	13 cases*
Case Mix Programme (CMP)	Yes	100%
Elective Surgery (National PROMs Programme)	Yes	See PROMs section of this report

Falls and Fragility Fractures Audit programme (FFFAP):		
National Inpatient Falls	Yes	NA
National Hip Fracture Database	Yes	100%*
Feverish Children (care in Emergency Departments)	Yes	100%
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit	Yes	43 cases*
Learning Disability Mortality Review Programme (LeDeR Programme)	Yes	100%
Major Trauma Audit	Yes	100%
Mandatory Surveillance of bloodstream infections and clostridium difficile infection	Yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme:		
Perinatal Mortality Surveillance	Yes	100%
Perinatal Morbidity and Mortality Confidential Enquiries	Yes	100%
Maternal Mortality Surveillance and Mortality Confidential Enquiries	Yes	100%
Maternal Morbidity Confidential Enquiries	Yes	100%
Medical & Surgical Clinical Outcome Review Programme:		
Pulmonary Embolism	Yes	100%
Acute Bowel Obstruction	Yes	100%
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP):		
Adult Asthma Secondary Care	Yes	NA
Chronic Obstructive Pulmonary Disease (COPD) Secondary Care	Yes	188 cases*
Pulmonary Rehabilitation - *Community*	Yes	NA
National Audit of Breast Cancer in Older Patients (NABCOP)	Yes	100%
National Audit of Cardiac Rehabilitation	Yes	Partial*
National Audit of Care at the End of Life (NACEL)	Yes	100%
National Audit of Dementia (care in general hospitals)	Yes	100%
National Audit of Intermediate Care (NAIC)	Yes	689 patients*
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	Yes	NA
National Cardiac Arrest Audit (NCAA)	Yes	100%
National Cardiac Audit Programme:		
Myocardial Ischaemia National Audit Project (MINAP)	Yes	100%
National Heart Failure Audit	Yes	75%*
National Comparative Audit of Blood Transfusion Programme:		
Use of Fresh Frozen Plasma and Cryoprecipitate in neonates and children	Yes	100%
Management of Massive Haemorrhage	Yes	100%
National Diabetes Audit – Adults:		
National Diabetes Foot Care Audit - *Community*	Yes	NA
National Diabetes Inpatient Audit (NaDIA)	Yes	100%
NaDIA Harms (reporting on diabetic harms)	Yes	100%
National Core Diabetes Audit	Yes	100%
National Diabetes in Pregnancy	Yes	100%
National Audit of Rheumatoid and Early Inflammatory	Yes	36 cases*

Arthritis		
National Emergency Laparotomy Audit (NELA)	Yes	100%
National Gastrointestinal Cancer Programme:		
Oesophago-gastric Cancer (NAOGC);	Yes	81-90%
National Bowel Cancer Audit (NBOCA)	Yes	100%
National Joint Registry (NJR)	Yes	100%
National Lung Cancer Audit (NLCA)	Yes	100%
National Maternity and Perinatal Audit	Yes	100%
National Mortality Case Record Review Programme	Yes	See Learning from Death section of this report
National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)	Yes	100%
National Ophthalmology Audit	Yes	99%*
National Paediatric Diabetes Audit (NPDA)	Yes	38 cases*
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis):		
Antibiotic Consumption	Yes	100%
Antibiotic Stewardship	Yes	30 cases per Quarter
Sentinel Stroke National Audit programme (SSNAP)	Yes	100%
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Yes	100%
Seven Day Hospital Services Self-Assessment Survey	Yes	100%
Surgical Site Infection Surveillance Service	Yes	100%
Vital Signs in Adults (care in Emergency Departments)	Yes	100%
VTE risk in lower limb immobilisation (care in Emergency Departments)	Yes	100%

* Based on most recent report or online data

NA Data submission in progress or due to commence

Non-Participation

National Clinical Audit and Clinical Outcome Review Programme	Reason for Non-Participation
National Adult Community Acquired Pneumonia (CAP) Audit	Lack of clinical resource
National Adult Non-Invasive Ventilation (NIV) Audit	Lack of clinical resource

The reports of 28 national clinical audits were reviewed by the provider in 2018/19 and the Trust intends to take the following actions to improve the quality of healthcare provided:

National Clinical Audit Participation 2018/19 – Actions

National Clinical Audit and Clinical Outcome Review Programme	Actions taken / to be taken
Case Mix Programme (CMP)	Quarterly reviews of all ICNARC/Critical Care activity at the multidisciplinary team meeting and all individual cases discussed with any issues being taken forward by the clinical lead as part of the governance strategy.
Elective Surgery (National PROMs Programme)	See Patient Reported Outcome Measures Scores section of this report.
Falls and Fragility Fractures Audit programme (FFFAP):	
National Hip Fracture Database	Trust results remain good and above national figures. Ongoing work is continuing around relevant assessments; therapy provision at weekends to support early mobilisation; nerve block training for advanced practitioners and anaesthetic supervision of trauma lists
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit	Review of report in progress
Major Trauma Audit	The trust compares favourably with Trauma Hospital in the Network. Work is in progress around transfer of patients for CT Scan in a timely manner; administration of transexamic acid within 3 hours; and trauma calls for consultant review.
Maternal, Newborn and Infant Clinical Outcome Review Programme:	
Perinatal Mortality	Compliance for standardised review and accurate data was good. Further work is underway in regard to a focus on 'quality of cause of death coding'; post mortem counselling and information for parents and placental histology for stillbirths
Saving Lives, Improving Mothers Care	Trust Guidelines around Induction of Labour, Obstetric Haemorrhage and Management of Venous Thromboembolism (VTE) in pregnancy have been updated to accommodate recommendations and an audit of VTE risk score is planned
Topical Study: Perinatal Mortality Surveillance Enquiry - Term, Singleton, Intrapartum Stillbirth and Intrapartum Related Neonatal Death	On review, the Trust was compliant with all recommendations, except documentation of discussion and the agreed management plan for labour and birth following previous caesarean section. A Vaginal Birth after Caesarean Section (VBAC) clinic is being set up with relevant guidance and pro-forma.

Medical & Surgical Clinical Outcome Review Programme:	
Acute Heart Failure	Existing pathway of care is being developed further to incorporate location, 24 hour review, initial investigations and bloods, access to echocardiograms and immediate treatments. All Heart Failure nurses are being trained as specialists in palliative care as part of the multidisciplinary team. A checklist is being developed to support escalation decision making with patients.
Cancer in Children, Teens and Young Adults	Review of report in progress
Perioperative Diabetes	Review of report in progress
National Audit of Breast Cancer in Older Patients (NABCOP)	Trust results are in line with national results. A crib sheet with performance score has been developed for clinics and the multidisciplinary team. The system for getting her2 results back for the multidisciplinary team has been improved and the cancer services department aim to get data for staging for all cancers.
National Audit of Cardiac Rehabilitation	Review of report in progress
National Audit of Care at the End of Life (NACEL)	Review of report in progress
National Audit of Dementia (care in general hospitals)	Issues with inconsistency of reported data were highlighted on review, thus no further action was taken with this report.
National Audit of Intermediate Care (NAIC) - *Community*	Intermediate Care Teams / Point of Care Hubs (PoCH) have been implemented and work is commencing around integration of health and social care teams to facilitate early discharge and prevention of unavoidable hospital admission.
National Cardiac Arrest Audit (NCAA)	Rate of cardiac arrest is lower than national figures and data submission remains good. A review of resuscitation stopped due to 'futility' in regard to pre-arrest factors relating to DNACPR is underway
National Cardiac Audit Programme:	
Myocardial Ischaemia National Audit Project (MINAP)	Work is ongoing to support direct admission to Cardiology or Coronary Care unit; checklist of medications depending on eligibility and pre-discharge angiography at partnership site.
National Heart Failure Audit	Work is underway to revise the acute heart failure pathway including location of care on a specialist unit; arrangements for heart failure review within 24 hours; initial investigations required to diagnose acute heart failure, including a standard protocol for the use of BNP/NT pro BNP and Echocardiography and immediate treatments
National Diabetes Audit – Adults:	
National Audit of Inpatient Diabetes (NADIA)	A diabetic alert system has been established along with an electronic system for identification of hypo/hyperglycaemia. Weekly multidisciplinary foot clinic implemented using a network diabetic foot pathway and twice weekly 'hot foot' clinic for direct access to medical/vascular care.
National Emergency Laparotomy Audit (NELA)	A pathway been developed for ortho-geriatrician support of elderly laparotomy patients, with review of patients as required. Review of surgical admission pro forma to collect pre and post-op p-possum (mortality risk).
National Gastrointestinal Cancer Programme:	
Oesophago-gastric Cancer (NAOGC);	Review of report in progress

National Bowel Cancer Audit (NBOCA)	Review of report in progress
National Joint Registry (NJR)	A review of revision of primary knee replacements was undertaken by the clinical lead and all planned cases for revision are now discussed at local multidisciplinary team prior to surgery. The Trust is involved in QIST, a national project aiming on optimising patients prior to surgery by identifying and treating anaemia.
National Maternity and Perinatal Audit	Infant feeding policy and skin to skin contact compliance through audit already achieved. Electronic maternity system, maternity dashboard, midwifery led unit guidelines, fit for birth programme and information on healthy eating in pregnancy all in place and business as usual in the Trust.
National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)	Patient information around pre-term labour a pro-forma for counselling pre-term parents introduced as part of the preterm pathway. Multidisciplinary developed care bundle in place for admission of pre-term babies. Work is in progress to work with local parent representatives to improve the attendance of parents on ward rounds and parental involvement in decision making.
National Ophthalmology Audit	Trust results favourable against national standards. Work is ongoing to improve mechanisms for obtaining post-operative refractions and to assess the use of post-operative Bromfenac to reduce complications.
Seven Day Hospital Services Self-Assessment Survey	See Seven Day Hospital Services section of this report.

Local Clinical Audits

The reports of 71 local clinical audits were reviewed by the provider in 2018/19 and the Trust intends to take/has taken the following actions to improve the quality of healthcare provided in the sample of projects below:

Local Clinical Audit	Actions Taken / To Be Taken
Monitoring of Vital Signs for Patients who are Acutely Unwell or at Risk of Clinical Deterioration	This audit was performed to highlight any issues in regards to accuracy of the use of our current track and trigger system. It was designed to highlight compliance with EWS documentation and the correct score being documented as this result will affect the appropriate clinical escalation. Our findings were the accuracy of EWS was poor due to the compliance of fluid balance monitoring where only 88% of patients had an accurate recording of their EWS. A comparison was done between EWS and NEWS2, this highlighted NEWS2 would have detected more patients to escalate early by its sensitivity, hence detecting acutely unwell patients early. NEWS2 was launched in the Trust in November 2018 and a further audit will be undertaken to assess accuracy in recording of the parameters.
An Audit to Assess the Implementation and Perceived Benefit of Group Therapy Sessions on Ward 6 (Stroke Rehab) to Establish a Local Standard	This audit was undertaken to review the pilot implementation of Group Therapy Sessions for stroke patients. Out of 17 possible groups, 15 sessions were actually held equating to 750 extra minutes of treatment and 60 extra treatments, 57 of which were in addition to patient individual sessions. All sessions ran for 45 minutes or longer therefore adhering to national guidelines. 12 of the sessions focused on upper limb exercises, 3 focused on bed exercises and all sessions included gait re-education and transfers (bed to chair, chair to chair). Following these results groups will be run 5 times a week, with assigned staff to ensure responsibility and consistency. Sessions will be pre-planned at set times daily and become ward routine with regular

	training sessions and assistant support for staff.
Compliance with NICE Guidance in the Diagnosis and Management of Atopic Eczema in the Under 12's	The audit was carried out to assess compliance with NICE Guidance, for which compliance was 100% around patient assessment and stepped care plan, assessment and documentation of severity and timely and appropriate referral. Areas for requiring improvement included provision of evidence based information, measurement of disease impact on Quality of Life / psychological impact, prescription of emollients. Standardised evidence based educational material/ supporting information has been developed as part of an atopic eczema pack, shared with paediatrics and will be given to all patients on all sites and the Dermatology internet site will be updated accordingly. Work on prescription of sufficient emollient, improved identification/ assessment of infection and standardising assessment processes to routinely capture all recommended criteria is currently in progress.
Audit of Nasal Trauma Referrals to ENT Emergency Clinics in MCHT	This audit highlighted a delay in seeing patients in clinic from trauma and issues with referral letters at clinic appointments. As a result of this the process for the administration team and medical staff to book and see patients is within 10 days of trauma and medical staff review all referrals and specify a timeframe for review based on the trauma date.
Management of Vaginal Birth after Caesarean	This audit was commenced to assess the management of Vaginal Birth After Caesarean (VBAC) using the existing Trust management pro-forma. Poor documentation highlighted a potential issue with discussion around risks and benefits and plan for labour. A midwife led VBAC clinic has now been set up and guidelines for management of women having VBAC in the latent phase of labour or with pre-labour spontaneous rupture of membranes has been developed. The VBAC management pro-forma has also been updated.

Participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by the Trust in between 01/04/18 and 28/02/2019 that were recruited during the period to participate in research approved by a research ethics committee was 611

Commissioning for Quality and Innovation (CQUIN)

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

A proportion of the Trust's income in 2018/19 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2018/19 and for the following 12 month period are available electronically at:

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

The overall financial value of CQUIN schemes is currently 2.5% of the provider's contract value.

The financial value of the 2018/19 CQUIN scheme for the acute Trust was £4,305,978. The total amount the Trust received in payment for the CQUIN scheme was £xxxxx

The financial value of the 2017/18 CQUIN scheme for the Trust was £4,274,560

The financial value of the 2017/18 CQUIN scheme for CCICP was £685,900 The total amount the Trust received in payment for the CQUIN scheme was £xxxxx

For 2018/19 there are **seven** National goals of which **four** apply to MCHFT, **two** apply to CCICP and **one** apply to both.

Public Health England has agreed **two** goals which relate to the breast and bowel screening programmes.

The North of England Specialised Commissioners has negotiated **two** goals in relation to chemotherapy banding and medicines optimisation.

Key CQUIN results for 2017/18:

Achieved

Partially Achieved

Not achieved

Insert Table

The table above briefly describes the goals included in this year's CQUIN and the Trust's performance against each of the CQUIN goals.

Feedback from Care Quality Commission (CQC)

CareQuality Commission

The Trust is required to register with the Care Quality Commission (CQC) under section 10 of the Health and Social Care Act 2008 and its current registration status is unconditional which means there are no conditions on its registration.

The Trust's registration includes the services provided at Leighton Hospital, Victoria Infirmary in Northwich, Elmhurst Intermediate Care Centre in Winsford and the community services within the Central Cheshire Integrated Care Partnership (CCICP), and the Statement of Purpose was updated accordingly.

The Care Quality Commission has not taken enforcement action against the Trust during the period April 2018 to March 2019.

Following the CQC Comprehensive Inspection in May 2018 the Trust received an overall rating of 'Good'. The inspectors identified, overall that the Trust was rated good for effective, caring, responsive and well led with safe rated as requires improvement.

Mid Cheshire Hospitals NHS Foundation Trust

Overall rating for this trust	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

In response to the inspection an improvement plan to address compliance actions was developed. The improvement plan evidences the completion and ongoing monitoring, where required, of the 'Must Do's' and 'Should Do' actions required to improve services and patient safety within the Trust. The Trusts CQC improvement plan is managed by the Quality Summit Group and monitored by the Executive Quality Governance Group. Escalation and assurances is provided to the Quality Governance Committee, a Board sub-committee with delegated authority from Trust Board to oversee matters relating to quality care and the maintenance of unconditional registration with the CQC. The improvement plan provides a progress update to the Quality Summit bi-monthly on the areas identified for improvement and provides identified monitoring and assurance routes to embed improvements into a business as usual approach.

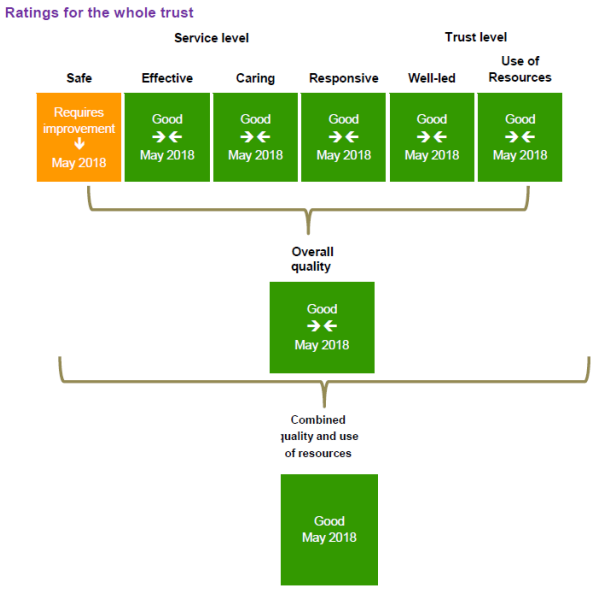
As part of the Trusts 'commitment to Quality' and journey from 'Good to Outstanding', the Executive Quality Governance Group oversees the strengthening of the Trust's local quality governance and assurance systems and processes, including the position in each division and Community Services (CCICP) against each of the CQC domains. Subsequent escalation and assurances will be via the committee structure to the Quality Governance Committee, and ultimately the Trust Board, maintaining a 'Ward to Board' approach.

The Trust has maintained its quarterly meetings with its designated CQC Relationship Manager. These quarterly Relationship meetings have a defined structure and format to ensure a consistent approach to relationship management. These meetings assist the Relationship Manager in developing an understanding of the organisation and, additionally, they will inform the CQC's regulatory planning.

The NHS Improvement Use of Resources assessment is an additional sixth key question which has been introduced in to the CQC inspection process and is combined with the Trusts overall quality rating for safe, effective, caring, responsive and well-led. The Use of Resources assessments are designed to improve understanding of how effectively and efficiently trusts are using their resources. Analysis is followed by a qualitative assessment by a team from NHS Improvement during a one-day site visit to the trust. Aspects such as finances, workforce, estates

and facilities, technology and procurement and the outcome of this assessment will be published alongside the Trusts CQC Inspection report.

In September 2018 the CQC Use of Resources assessment demonstrated an overall rating of 'Good' against Trust's Use of Resource, combined with the Trusts overall quality rating.



Data Quality Assurance

NHS and General Practitioner registration code validity (April 17 – November 17 From NHS Digital SUS dashboard)

The Trust submitted records during 2018/19 to the secondary uses service for inclusion in the Hospital Episodes Statistics which are included in the latest published data.

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

- 99.6% for admitted patient care;
- 99.9% for outpatient care;
- 98.5% for accident and emergency care.

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

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

Data Security and Protection Toolkit attainment

The Trust has completed its 2019/20 Data Security and Protection Toolkit submission, achieving 99 of 100 mandatory assertions, resulting in a 'Standards Not Met' overall assessment. An improvement plan will be developed and monitored to support the Trust in achieving the required training compliance by July 2019.

Clinical coding error rate

In 2018/19 the Clinical Coding department were subject to a Data Security Protection (DSP) Toolkit audit, this has replaced the Information Governance Toolkit audit. The results of the DSP audit are listed in the table below. The IG toolkit level requirements have also been included as a point of reference, for the standard attained by the Clinical Coding department, in this year's DSP audit.

The accuracy results give Mid Cheshire Hospital NHS Foundation Trust a performance Level 2,

CODING FIELD	PERCENTAGE CORRECT	IG LEVEL 2	IG LEVEL 3
Primary Diagnosis	94.00%	90.00%	95.00%
Secondary Diagnosis	94.03%	80.00%	90.00%
Primary Procedure	95.24%	90.00%	95.00%
Secondary Procedure	96.48%	80.00%	90.00%

The Trust was not subject to the Payment by Results clinical coding audit during 2018/19 by the Audit Commission.

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

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

Performance against quality indicators and targets

National quality targets

	2014-15	2015-16	2016-17	2017-18	2018-19	Target	Achieved
Clostridium Difficile infections	10 avoidable cases	10 avoidable cases	3 avoidable cases	2 avoidable cases	2 avoidable case	23	✖
Percentage of patient who wait 4 hours or less in A&E	92.30%	93.40%	90.25%	87.12%	84.20%	95%	✖
The percentage of patients waiting 6 weeks or more for a diagnostic test	0.37%	0.55%	0.34%	0.31%	0.37%	1%	✔

Summary Hospital-level Mortality Indicator		100	103.85	104.9	105.48		
Venous thromboembolism (VTE) risk assessment		96.11%	96.09%	95.50%	95.30%	95%	✓
Percentage of patients receiving first definite treatment for cancer within 62 days of an urgent GP referral for suspected cancer	89.34%	91.22%	90.98%	93.70%	89.62%	85%	✓
Percentage of patients receiving first definite treatment for cancer within 62 days of referral from an NHS Cancer Screening Service	95.94%	97.94%	93.67%	97.09%	94.03%	90%	✓
The percentage of Referral to Treatment (RTT) pathways within 18 weeks for incomplete pathways	94.41%	95.02%	94.82%	95.90%	92.63%	92%	✓

National quality indicators

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

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

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

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

Indicator	Measure Description			
SHMI	A) The value and banding of the summary hospital-level mortality indicator ('SHMI') for the Trust for the reporting: and			
Period	**Trust Performance**	**National Average**	**95% Upper Limit**	**95% Lower Limit**
January 2016 - December 2016	104.24	100	112.09	89.22
April 2016 – March 2017	103.85	100	112.31	89.04

July 2016 –June 2017	102.97	100	112.37	88.99
October 16 - September 17	103.71	100	112.05	89.25
January 17 - December 17	104.12	100	112.47	88.91
April 17 - March 18	104.39	100	112.57	88.84
July 17 - June 18	104.75	100	112.51	88.88
October 17 - September 18	105.48	100	112.72	88.72

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

- For the reporting period October 2017 to September 2018, the SHMI is currently 105.48 and is in the 'as expected' range. This currently places the Trust 88 out of 131.

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

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

- The HMRG developed a reducing hospital mortality rates driver diagram, which has been reviewed and approved by HMRG. There are five primary drivers:

    - **R**eliable Clinical Care
    - **E**ffective Clinical Care
    - **M**edical Documentation, Clinical Coding and Data Quality
    - **E**nd of life Care
    - **L**eadership

Percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust

Indicator	Measure Description			
SHMI	B) The percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust for the reporting period.			
Period	**Trust Performance**	**National Average**	**95% Upper Limit**	**95% Lower Limit**
July 16 - June 17	0.88%	1.06%	2.18%	0.41%
October 16 - September 17	0.91%	1.08%	2.27%	0.42%
January 17 - December 17	0.95%	1.11%	2.28%	0.46%
April 17 - March 18	0.96%	1.14%	2.19%	0.49%
July 17 - June 18	0.91%	1.14%	2.89%	0.44%

October 17 - September 18	0.88%	1.14%	2.83%	0.48%

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

Indicator	Measure Description				
PROM	The Trust's patient reported outcome measure scores for hip replacement surgery and knee replacement surgery during the reporting period.				
Date	**Measure**	**Trust performance**	**National Average**	**Highest Result**	**Lowest Result**
Hip Replacement					
2016-2017	EQ5D	0.415	0.437	0.533	0.328
2017-2018	EQ5D	0.448	0.458	0.550	0.357
2016-2017	VAS	12.768	13.112	20.183	7.893
2017-2018	VAS	11.567	13.877	18.514	7.991
2016-2017	OXFORD HIP	20.441	21.379	25.044	15.968
2017-2018	OXFORD HIP	21.682	22.210	25.045	18.000
Knee Replacement					
2016-2017	EQ5D	0.308	0.322	0.398	0.237
2017-2018	EQ5D	0.328	0.334	0.406	0.254
2016-2017	VAS	6.098	6.850	14.443	0.465
2017-2018	VAS	7.169	8.153	13.985	1.752
2016-2017	OXFORD KNEE	15.858	16.393	19.686	12.231
2017-2018	OXFORD KNEE	17.830	17.102	20.394	12.899

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

- Trust performance data represents the adjusted average health gains which have been calculated using statistical models which account for the fact that each provider organisation deals with patients with different case-mixes

- Data allows for fair comparisons between providers and England as a whole. Random variation in patients mean that small differences in averages, even when case-mix adjusted, may not be statistically significant
- Case mix adjusted figures are calculated only where there are at least 30 modelled records.

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

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

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

Indicator	Measure Description	
Readmission Rates	The percentage of patients aged 0 to 14 readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.	
Period	**Trust per HED**	**Peer Group av HED**
Jan 2014 – Dec 2014	11.40%	10.90%
Jan 2015 – Dec 2015	11.40%	10.40%
Jan 2016 – Dec 2016	12.14%	10.44%
Jan 2017 - Dec 2017	12.41%	10.69%
Jan 2018 - Sep 2018	13.74%	11.06%

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

- Readmission rates for patients aged 0 – 14 have been increasing both nationally and locally. Paediatric admissions generally have a high rate of readmission due to the offer extended to the child and family to return straight to ward should there be a worry once back home.

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

- Further work to understand other key influences of this increasing rate is ongoing and consideration will then be given as to how actions can be effectively implemented to improve the rate

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

Indicator	Measure Description	
Readmission Rates	The percentage of patients aged 15 and over readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.	
Period	**Trust per HED**	**Peer Group av HED**
Jan 2014 – Dec 2014	8.60%	7.70%
Jan 2015 – Dec 2015	7.90%	7.10%
Jan 2016 – Dec 2016	8.23%	7.73%
Jan 2017 - Dec 2017	9.04%	8.16%
Jan 2018 - Sep 2018	9.09%	8.40%

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

- There has been a significant increase in short stay emergency admissions which will have an impact on a Trust's readmission rate. In spite of this dramatic increase, the rate of readmissions has only increased 0.05% year to date at Mid Cheshire. This is set against an increase at peer Trusts of an average of 0.25% year to date.

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

- Focusing efforts to bring the readmissions down further this year through closer working with system partners such as CCICP (Central Cheshire Integrated Care Partnership). By working closer together with care in the community, deterioration/exasperations can be prevented, thus reducing the readmissions.
- The Trust has undertaken a review of all divisional and specialities readmission rates and no theme have been identified. To further support this work a further "deep dive" relating to readmissions was carried out at Elmhurst, the summary of the review highlighted that the readmission related to co-morbidities and a complex patient cohort. No earlier interventions or alternatives to admission were identified to support.

The Trust's responsiveness to the personal needs

Indicator	Measure Description			
Responsiveness to patient needs	**Trust Performance 2016/2017**	**2017/2018**	**National Average**	**2017-18 95% confidence interval**
Access and Waiting	83.3	79.3	83.5	0.19
Safe, high quality, coordinated care	65.7	67.3	72.6	0.23
Better information, more choice	63.6	66.3	68.6	0.27
Building closer relationships	85.0	87.5	85.8	0.15
Clean, comfortable, friendly place to be	78.7	78.7	81.4	013
Inpatient overall patient experience score	75.6	77.5	78.4	0.14

If patients reported all aspects of their care as 'good', we would expect a score of at least 60. If they reported all aspects as 'very good', we would expect a score of at least 80

Source: NHS Patient Survey Programme, Care Quality Commission
Further details of the methodology can be found in the methodology paper at: http://www.england.nhs.uk/statistics/statistical-work-areas/pat-exp/

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

Access and Waiting

Three survey questions, domain score reducing from 83.3 to 79.3. This domain captures information about how frequently admission dates are changed, how long patients wait for treatment (higher scores for shorter waits) and how long patients wait after arriving to be allocated a bed. For this domain, all three questions scores have reduced. The Trust has scored worse than the national average for this section.

Safe, high quality, co-ordinated care

This domain includes questions about whether patients were given consistent messages by different members of staff and whether there were delays in discharge from hospital. Of the two questions in this domain, one score has decreased and one score has improved with fewer patients reported experience of delayed discharges (score increasing from 65.7 to 67.3).

Better information, more choice

This domain captures feedback on whether patients were involved as much as they wanted to be in decisions about their care and treatment and whether staff clearly explained the purpose and side effects of medicines. Two questions that form this domain have shown improved scores and one remains the same.

- More patients were satisfied with their involvement in decisions about their care and treatment (score increasing from 69 to 74).
- More patients reported being told about medication side effects to watch for at home (score increasing from 41 to 44).
- More patients received an explanation of the purpose of the medications they were to take at home (score remains the same at 81).

Building closer relationships

Four survey questions, domain score increasing from 85 to 87.5
This domain assesses whether doctors or nurses provided information to patients in a way they could understand and whether doctors or nurses spoke about patients as if they weren't there. Three of the four questions included in this domain improved scores and one remains the same.

- Fewer health professionals spoke in front of patients as if they weren't there (for doctors the score increased from 85 to 89 and for nurses the score remains the same at 90.0).
- More health professionals gave information to patients in a way they could understand (for doctors the score increased from 82 to 86 and for nurses the score increased from 83 to 85).

Clean, comfortable, friendly place to be

Seven survey questions, domain score remains the same at 78.7. This domain captures feedback on whether patients were disturbed by noise at night, asking patients what they thought about the cleanliness of their hospital room or ward and how patients felt they were treated by staff, including how much privacy they were given, whether they were helped to manage their pain and if they felt that they were treated with dignity and respect. There has been an improvement in two of the seven question scores. Two scores are reduced – noise and cleanliness.

- Patients' opinions of cleanliness of the room or ward stayed the same (score reduced from 89 to 87).
- Patients' reporting of whether they were treated with respect and dignity stayed the same (score remaining at 90).
- The score rating for hospital food increased from 57 to 60.

The Overall Score has improved from 75.6 to 77.5

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

- To reduce unnecessary noise at night re-launch Quiet Protocol and to include "Invest to Rest" Campaign
- Improve ward cleanliness

- Continue to improve efficiency of patients being discharge from hospital by extending system of ward labelling of medication and support from ward based pharmacy staff and the ward discharge co-ordinators.

Scores have been included from Survey Contractor as the CQC Benchmark report is not available until June 2019.

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

Indicator	Measure Description			
Friends & Family	Staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.			
Period	**Trust Performance**	**National Average**	**Upper Limit**	**Lower Limit**
2017 staff survey	75%	70.2%	89.3%	48%
2018 staff survey	77.5%	69.9%	90.3%	49.2%

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

- The 2018 results place the Trust in the reporting category of combined acute and community trusts, instead of solely acute trust for the second year

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

- Creating action plans within divisions and Central Cheshire Integrated Care Partnership (CCICP) which focus on delivering sustainable improvement in the experience of our staff.
- Involving staff in decision-making and keeping them informed of changes and developments across the organisation.
- Taking an open and honest approach in ensuring staff are informed about the Trust's performance and key decisions being made, as well as giving staff the opportunity to put forward any views or suggestions about how we can improve the experience of our patients, services users and staff
- Working with seven staff Governors who make a valuable contribution to the governance and development of the organisation.
- Delivering a new Trust induction programme which is the first step in helping new staff to get to know more about the Trust and how we involve and engage them in our decision-making.
- Delivering 'Employee of the Month' and 'Team of the Month' schemes which provide staff with recognition for going above and beyond what is expected.
- Using a range of well-established forums for consulting with and engaging staff and their representatives, including:
    - Regular Executive and Non-executive ward safety visits;
    - Executive Director walkabouts
    - Regular formal and informal meetings with our Trade Union representatives, (Joint Local Negotiating Committee and Joint Consultation & Negotiation Committee)
    - Weekly CEO Brief
    - Regular Trust Briefings, (Trust Update and Payday Press)
    - CEO drop-in surgeries
    - CEO Engagement Events
    - Forward thinking events.
    - Staff Focus Groups

- Bright Ideas Scheme
- All Together Newsletter

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

Indicator	Measure Description			
VTE	The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.			
Period	**Trust Performance**	**National Average**	**95% Upper Limit**	**95% Lower Limit**
January 2016 - March 2016	95.44%	96.00%	100.00%	78.06%
April 2016 – June 2016	95.56%	96.00%	100.00%	80.61%
July 2016 – October 2016	96.52%	96.00%	100.00%	72.14%
October 2016 - December 2016	96.17%	96.00%	100.00%	76.48%
January 2017 - March 2017	95.61%	96.00%	99.87%	63.02%
April 2017 – June 2017	95.58%	96.00%	99.97%	51.38%
July 2017 - October 2017	95.55%	No data available	No data available	No data available
October 2017 - December 2017	95.31%	No data available	No data available	No data available
January 2018 - March 2018	94.59%	No data available	No data available	No data available
April 2018 - June 2018	95.07%	No data available	No data available	No data available
July 2018 - September 2018	95.57%	No data available	No data available	No data available
October 2018 - December 2018	95.24%	No data available	No data available	No data available

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

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

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

- Monthly monitoring of the percentage of patients risk assessed for VTE by the clinical divisions
- Quarterly monitoring of the percentage of patients risk assessed for VTE through the Executive led quarterly divisional quality assurance reviews
- Regular review of the VTE risk assessment tool to ensure it continues to be compliant with National Institute for Health and Clinical Excellence (NICE) guidance. The tool is included within the Trust admission proforma to ensure it is completed in a timely manner at admission and the appropriate VTE prevention interventions are implemented
- Continued education for medical staff on induction on the importance of VTE assessment.

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

Indicator	Measure Description			
C.Difficile	The rate per 100,000 bed days of cases of C.difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period.			
Period	**Trust Performance**	**National Average**	**95% Upper Limit**	**95% Lower Limit**
2014-2015	13.8	15.1	62.2	0
2015-2016	22.2	15.1	67.2	0
2016-2017	12.2	14.92	82.6	0
2017-2018	11.1	13.65	90.3	0
2018-2019	13.4 (to end of Jan) tbc	Not yet published	Not yet published	Not yet published

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

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

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

- The Trust objective for 2018/19 was 23 cases. The Trust reported 24 cases of C.Difficile for 2018/19, of which to-date 2 have been identified as avoidable cases, the remaining cases have been identified as unavoidable. Currently there are reviews outstanding on 3 cases.
- Antimicrobial stewardship is closely monitored in line with Trust policy ensuring a focus on antimicrobial prescribing and feedback to medical staff
- Multi-disciplinary bedside reviews of all CDI positive patients throughout their stay
- IPC team now has dedicated clinical areas assigned to them.
- Shared learning via the divisions quality forums.

The number of patient safety incidents reported within the Trust.

Indicator	Measure Description			
Patient Safety Incidents	The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period.			
Period	**Trust Performance**	**National Average**	**95% Upper Limit**	**95% Lower Limit**
April 2014 – September 2014	2,814	2,052	4,301	908
October 2014 –March 2015	2,767	4,539	12,784	443
April 2015 – September 2015	3,159	4,647	12,080	1,559
October 2015 – March 2016	3,116	4,818	11,998	1,499
April 2016 – September 2016	3,348	4,955	13,485	1,485
April 2017 – September 2017	3485	5226	15,228	1133

October 2017- March 2018	3462	5449	19,897	1,311

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

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

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

- Patient Safety Summit is a twice monthly meeting led by clinical teams. The Summit provides an opportunity for cross-divisional / CCICP learning and sharing of immediate learning following incidents. All moderate and above patient safety incidents are discussed at the Summit and clinical teams are encouraged to attend to promote learning and improvement. The Patient Safety Summit is chaired by the Medical Director.
- Following each Patient Safety Summit a 'Safety Matters' newsletter is developed and distributed across the organisation. The newsletter contains learning from incidents, mortality case note reviews, local or national updates and Summit messages of the week.
- Incident report training for all new staff to the Trust. This training ensures that all staff in the Trust knows how to report a patient safety incident and they also understand the importance of incident reporting.
- Direct feedback to all staff on the outcome of the incidents they have reported to demonstrate the changes in practice that have been made as a result of the incident.
- Sharing of learning from reported incidents through safety alerts, lessons learned episodes of care, individual patient stories and Safety Matters.

The number and percentage of such patient safety incidents that resulted in severe harm or death.

Indicator	Measure Description			
Patient Safety Incidents	The number and percentage of such patient safety incidents that resulted in severe harm or death.			
Period	**Trust Performance**	**National Average**	**Highest Result**	**Lowest Result**
April 2014 – September 2014	3	15	51	0
October 2014 –March 2015	6	23	128	2
April 2015 – September 2015	6	20	89	2
October 2015 – March 2016	18	19	94	0
April 2016 – September 2016	18	18	111	0
April 2017 – September 2017	19	19	121	0
October 2017- March 2018	18	19	99	0

The Trust considers that this data is as described for the following reasons:
The Trust has a positive reporting culture and is a high reporter of incidents. Nationally this is seen as positive. The Trust has undertaken a number of actions as described below to reduce the harm caused to patients and learn from our incidents.

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

- Undertaking a comprehensive investigation for all incidents, which result in severe harm or death. An Executive led review meeting is held following the incident investigation to

ensure that lessons are learned and improvement plans are implemented to prevent a reoccurrence

- Reporting all incidents which result in severe harm or death to the Board of Directors to ensure openness within the Trust
- Implementation of the Trust's *Being Open* (including Duty of candour) policy which ensures that, if an incident occurs which results in severe harm or death, the patient and / or their family are informed and the lessons learned and improvement plans from the comprehensive investigation are shared with them.

Learning from Deaths

During 2018/19 938 of Mid Cheshire Hospitals NHS Foundation Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:
213 in the first quarter;
225 in the second quarter;
223 in the third quarter;
277 in the fourth quarter

By 31/03/2019, 832 case record reviews (using the Trust Mortality Review Tool) and 94 investigations (using the Structured Judgement Review process) have been carried out in relation to 938 of the deaths included above.

In 94 cases a death was subjected to both a case record review and an investigation using the Structured Judgement Review process. The number of deaths in each quarter for which a case record review or an investigation was carried out was:
223 in the first quarter;
214 in the second quarter;
240 in the third quarter;
249 in the fourth quarter
0 representing 0% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient using either the Trust Mortality Review Tool or the Structured Judgement Review Process

In relation to each quarter, this consisted of:
0 representing 0% for the first quarter;
0 representing 0% for the second quarter;
0 representing 0% for the third quarter;
0 representing 0% for the fourth quarter.
These numbers have been estimated using the Trust Mortality Review Tool or the Structured Judgement Review process.

Six avoidable deaths in 2018 / 19 were identified and reported following comprehensive incident investigations. Action plans were developed following each of the Executive Led incident reviews.

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

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

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

The phases of care which are reviewed are:

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

The overall quality of care is assessed during the SJR process. Care scores are recorded after the judgement comments have been written. One score is given to each phase of care. The reviewers then judge their overall decision on the overall quality of care. The SJR process commenced at the Trust in April 2018.

The Trust's Learning from Deaths Policy has built upon the Mortality Case Note Review Standard Operating Procedure, which outlined the existing embedded process for reviewing all in-hospital deaths.

All in-patient deaths are reviewed on a weekly basis by a team of Consultants, led by the Lead Consultant for Patient Safety. A short mortality case note review form is completed and, if a death is identified where clinical care could potentially have been more appropriate, the case is referred for a Structured Judgement Review (SJR).

SJRs are undertaken by a cohort of senior medical and nursing staff trained in the SJR Process.

In addition to the escalations from the weekly reviews, in line with national guidance, the Hospital Mortality Reduction Group (HMRG) has agreed a number of other clinical conditions / criteria that result in an in-patient death undergoing a SJR. These are reviewed on an annual basis and currently include:

- Acute Cerebrovascular Accident (at the weekend)
- Pneumonia (at the weekend)
- Intestinal obstruction without hernia
- Alcohol related liver disease
- Infectious diseases (CQC Insight metric)
- Relevant elective deaths
- All deaths where families, carers or staff raise concerns
- Concerns raised by the Coroner
- Concerns raised at the Patient Safety Summit

Organisational learning from this process must be dynamic, with immediate actions and improvements undertaken in a timely manner to prevent reoccurrence. Short - medium term improvements, identified through organisational learning, are introduced through the Trust's governance structure. In the longer term organisational learning will take place through the triangulation and theming of data and information. The Trust's incident reporting, investigation and organisational learning processes describe our approach to organisational learning.

The learning from these reviews is collated and shared in a quarterly newsletter, 'Learning from our Mortality Reviews'
The Trust has a well-established HMRG led by the Medical Director. This group leads the Trust's mortality reduction programme and, on a quarterly basis, meets with the Divisional Mortality Reduction Groups to ensure a unified approach to mortality reduction across the Trust and to share learning opportunities.

The Trust's mortality reduction programme is succinctly described in a driver diagram that was most recently updated in March 2019. The five primary drivers to reducing the Trust's mortality rates are:

- **R**eliable Clinical Care
- **E**ffective Clinical Care
- **M**edical Documentation, Clinical Coding and Data Quality
- **E**nd of life Care
- **L**eadership

Below are a number of the positive comments made during the reviews.
- Excellent care provided
- Multi-specialty working
- Excellent prescribing of anticipatory medications
- Excellent communication with the family
- Risks of surgery well documented
- Excellent set of clinical records
- Good documentation and use of the fractured neck of femur pathway
- Good evidence of both nursing and medical reviews
- Medical review in Emergency Department well completed with a thorough history taken, medication and allergies recorded. Chest and abdominal examination recorded. VTE risk assessment completed
- Good documentation of discussions with relatives regarding end of life care and ceilings of care
- Good assessment of patient's capacity and requirement for a DoLs

The SJRs undertaken have identified the following learning themes:
- Poor completion of pathways including acute kidney injury, sepsis management and pneumonia
- Clinical observations not recorded in line with Trust guidance
- Failure to identify, and respond to, the deteriorating patient
- Delay in medical review
- Poor completion of fluid balance monitoring

Following a large scale training programme across the organisation, the National Early Warning Score 2 (NEWS2) was launched in the Emergency Department and in-patient ward areas on the 5 November 2018. NEWS2 has been launched in Theatres, Treatment Centre, Ambulatory Care Unit, Planned Interventions Unit, Outpatients Department and Elmhurst as part of the roll out programme in April 2019.
The revised vital signs chart includes the NEWS2 chart, neurological observation chart, sepsis and AKI guidance and SBAR information to ensure accurate handover in the clinical settings

A care pathway group chaired by the Executive team monitors the compliance with care pathways.

Clinical leads have been identified for each of the pathways and monitoring is undertaken by the Care Pathway Group, reporting to the Quality and Safety Improvement Strategy Group with escalation to the Executive Quality Governance Group and assurances to the Quality Governance Committee

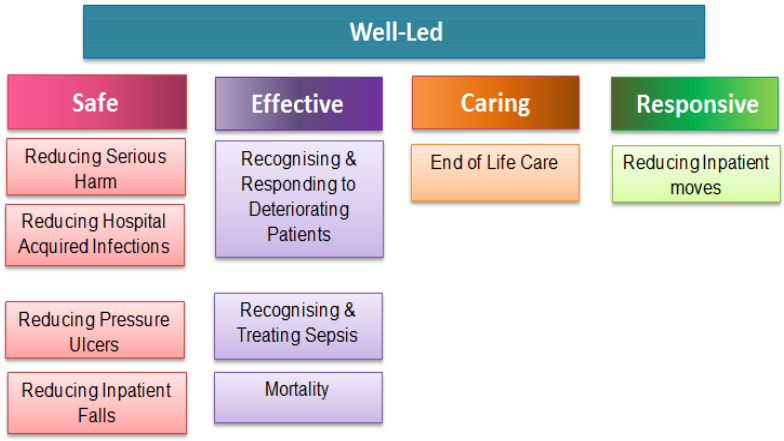
Priorities for 2018-19

The Trust wants to be sure that everyone in our local community who may use our services has absolute confidence that our care and treatment is completely patient centred. The Trust is committed to the delivery of our Quality and Safety Improvement Strategy 2018-19.

In 2018-19, the Trust aims to deliver the CQC domains as part of our Quality and Safety Improvement Strategy. These are key drivers in the elements of quality care.

The Trust held a programme of both staff and public engagement sessions to engage with the local community. The engagement sessions gave the opportunity to share achievements and obtain ideas of what the Trust should focus on in the 2018-19 strategy.

The common themes that emerged from the engagement sessions were:



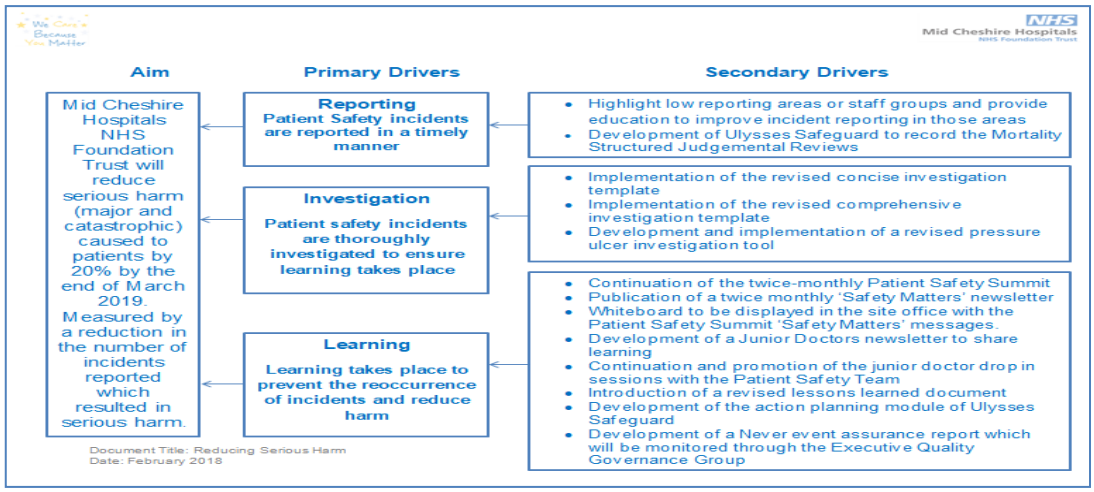
Reducing Serious Harm

Our aim is to reduce serious harm (major and catastrophic) caused to patients by 20% by the end of March 2019.

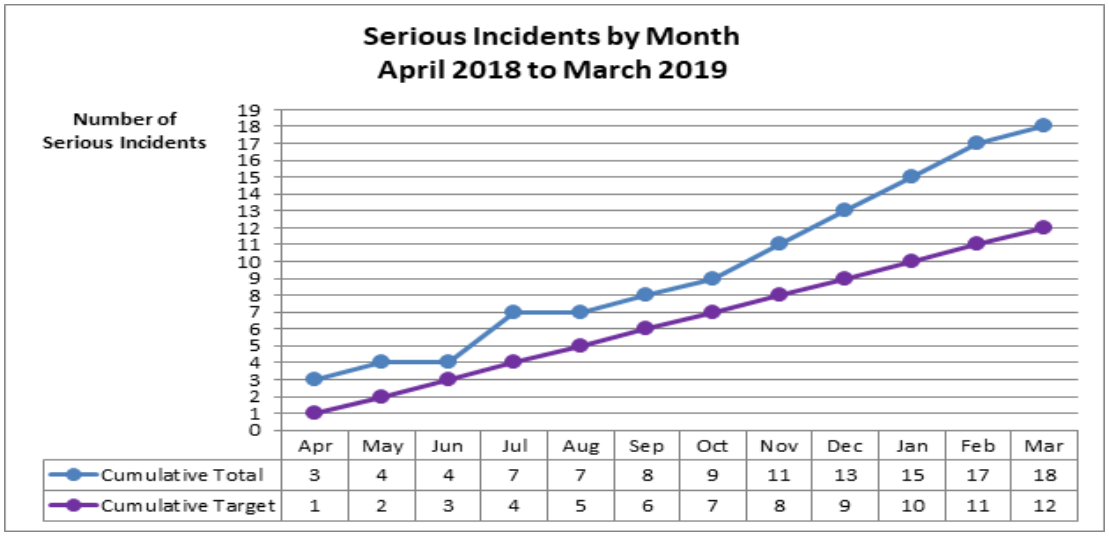
Why is it important?

Robust reporting, investigating and learning from our incidents will reduce the chance of the same incident reoccurring and causing serious harm to another patient.

Reduction in serious harm driver diagram



Serious incidents by month April 2018 to March 2019



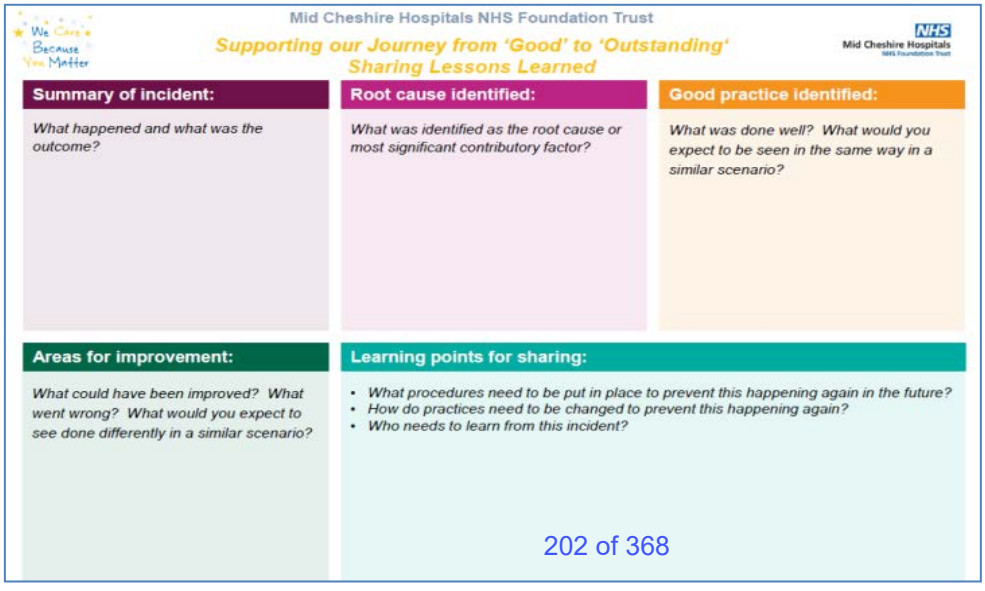
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Totals	Shift
Cumulative 2018/19	3	4	4	7	7	8	9	11	13	15	17	18	18	+38.5%
Cumulative 2017/18	0	3	4	7	8	9	10	10	11	11	12	13	13	

The Trust has reported 18 serious incidents in the period April 2018 to March 2019 against a target of 12.
The incidents reported in the period include:
Never Event – Retention of chest drain guidewire x 1
Patient fall resulting in fractured neck of femur x 10

There has been a 38.5% increase in the number of incidents reported which resulted in serious harm in 2018/19 compared to the previous financial year.

A comprehensive investigation was undertaken for all the incidents in line with the Trust Incident Reporting, Investigation, Learning and Improvement Policy and national guidance. A review meeting was held following each investigation and an improvement plan developed.

The concise and comprehensive investigation templates have been revised in line with national guidance to further develop the quality of the incident investigations conducted. Further specific tools have been developed for the investigation of hospital acquired pressure ulcers and venous thromboembolism.
A revised lesson learned template has been developed to share learning from the investigations.


Mid Cheshire Hospitals NHS Foundation Trust

Supporting our Journey from 'Good' to 'Outstanding'
Sharing Lessons Learned

Summary of incident:	Root cause identified:	Good practice identified:
What happened and what was the outcome?	*What was identified as the root cause or most significant contributory factor?*	*What was done well? What would you expect to be seen in the same way in a similar scenario?*

Areas for improvement:	Learning points for sharing:
What could have been improved? What went wrong? What would you expect to see done differently in a similar scenario?	• *What procedures need to be put in place to prevent this happening again in the future?* • *How do practices need to be changed to prevent this happening again?* • *Who needs to learn from this incident?*

The lessons learned which are shared following each comprehensive investigation highlight the root cause of the incident, good practice which was identified, areas for improvement and the learning points that the review panel wish to share.

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

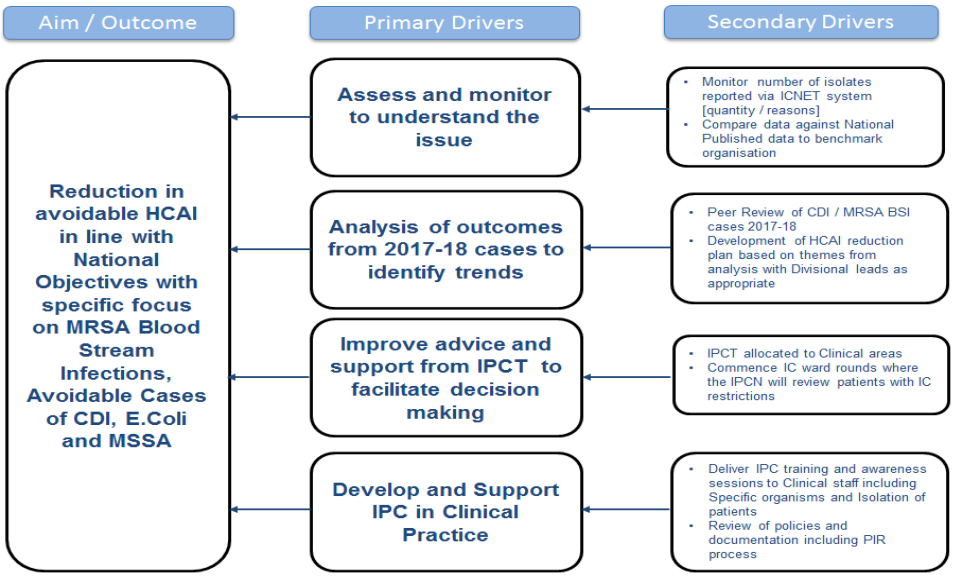

Summit 'Safety Matters'

Following Patient Safety Summit the Safety Matters Newsletter is shared across the organisation to further share the learning from incident investigation, complaint investigations and mortality reviews. Both paper and hard copies of the newsletter are distributed.

Reducing Hospital Acquired Infections

Reducing the risk of Health Care Associated Infection remains a priority as part of delivering safe quality care to our health population. This year the trust has continued to focus on reducing Clostridium difficile infections (CDI), preventing the occurrence of MRSA blood stream infections and participating in a health economy approach to reducing gram negative bacteraemia in particular ECOLI.

Reduction in Hospital Acquired Infections Driver Diagram



CDI -Despite a year on year reduction both locally and nationally, Clostridium difficile infection (CDI) is an unpleasant and potentially severe or fatal illness especially for our elderly and vulnerable population. It is acknowledged that this reduction has slowed over recent years and this may be due to factors outside of the organisations control for example antibiotics prescribed due to private medical treatment.
Learning from cases is important to establish any "Lapse in Care'' which either directly or indirectly contributed to a case, identifying any measures which can be implemented to prevent CDI in other patients.

Progress

NHS England sets all trusts an annual objective to support a year on year reduction in CDI the Trust have been set an objective of no more than 23 cases, this year the trust reported 24 cases. From the completed reviews only 2 of the cases were identified as avoidable with a contributing factor relating antimicrobial prescribing.

As part of a commitment to learning from incidents of infection each case of CDI is reviewed at a Post Infection Review, this is a multidisciplinary team approach to identify any factors which could have prevented the case of CDI occurring or used as a learning exercise to reduce the risk to other patient ensuring that robust systems and processes are in place to ensure rapid identification of any case.

What have we learnt?

All the patients reviewed had increased risk factors for the development of CDI including their age and other comorbidities this is in line with the regional and national picture.

Many of the patient's clinical pathways require multiple antibiotics which increases the risk of CDI. Two of the cases reviewed antibiotics could have been selected differently and therefore this contributed to the development of CDI

A new improved stool chart has been launched to support the staff in earlier identification of when the patient's bowel habit changes, this triggers a prompt to send samples sooner, this has also been supported by the launch of the new CDI policy.

MRSA BSI

Progress

The Trust continues to support the national objective of a zero tolerance approach to MRSA BSI. This year 4 cases have been identified from blood cultures taken within the organisation. A PIR was undertaken on all the cases with representation from clinical areas and the commissioners. As part of this process some clinical learning was identified which has resulted in a robust plan to implement system wide change.

What we have learnt

To provide more detailed information on where the patient was colonised with MRSA there has been a change to screening sites required the IPCT are supporting the clinical areas in implementing this change.

A 90 day improvement programme to review ANTT within the organisation against the latest national standards.

A new MRSA policy and Care plan reflective of local requirements and changes to national guidance.

ECOLI Reduction.

NHS England have set a target of a 50% reduction by 2020 (this is a CCG target). To ensure this is a collaborative across the health economy the Trust is a key stakeholder in a new HCAI reduction group. This group includes CCG's across South and Vale Royal and East Cheshire, representatives from Cheshire East council, East Cheshire NHS Trust, CWP and Midlands Partnership Trust.

Progress

Following an analysis of the data collected by the Trust the indication, is in line with the national profile and that although there are no clear themes to focus on individually adopting a multi-facetted approach will improve the outcomes for our patient population including the ongoing work on antimicrobial prescribing across the acute and community settings and improving the message on hydration for patient with multiple health needs not only during periods of warm weather but throughout the year.

Although there is no objective for acute organisations the trust has seen a reduction of acute attributable cases (although many of these cases are unavoidable due to clinical picture of the patient) with 27 cases reported in 2017/18 and 25 cases in 2018/1. In the community the number of cases reported has also seen a reduction with 180 cases in 2017/18 compared to 148 cases 2018/19.

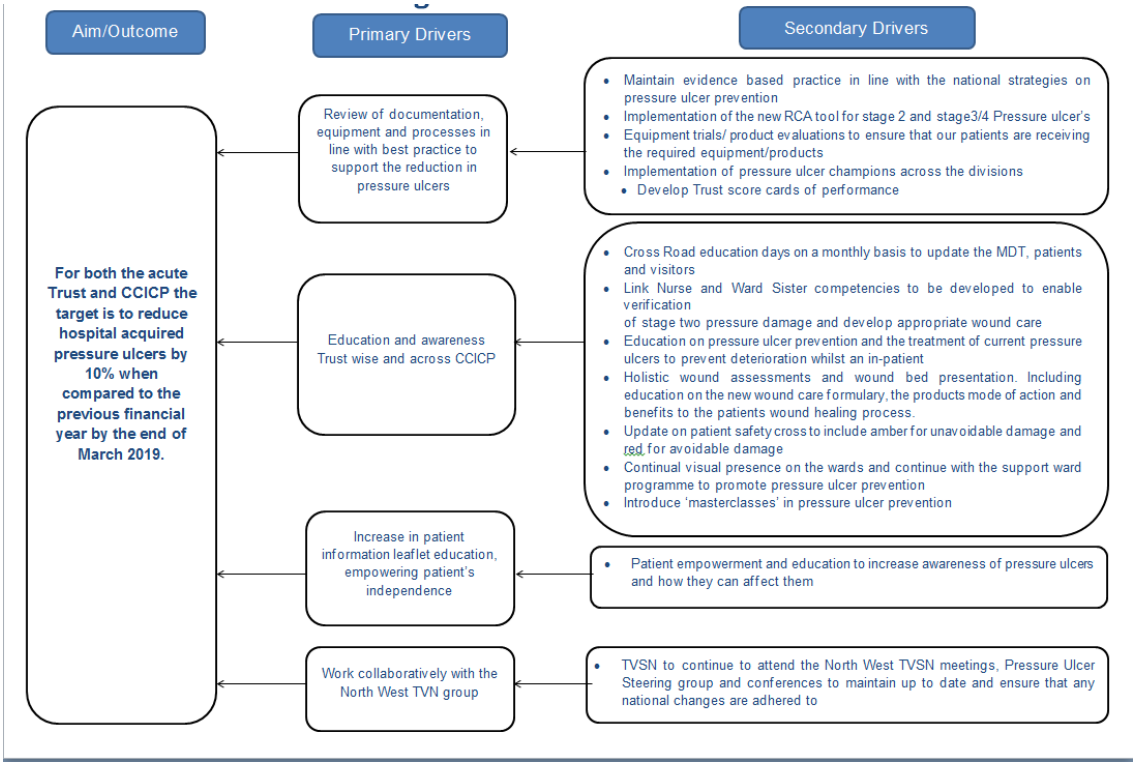
What are we doing to reduce Health Care Associated infections (HCAI)?

- IPCT supporting the clinical areas in managing patients with infections including but not limited to CDI, MRSA BSI, Gram negative BSI this includes correct isolation, hand washing, the use of PPE and accurate documentation.
- Multi-disciplinary Post infection reviews as appropriate
- A focus on antimicrobial stewardship supported by Consultant Microbiologist antimicrobial ward rounds and clinical advice.
- A review of documentation including care plans, stool charts to ensure they provide the relevant information for all staff.
- Continual review of data to extract key themes and ensure learning is implemented as appropriate.
- A commitment to ensure that all the new policies are user friendly and provide easily accessible information.
- Working a cross the Health Economy to improve patients hydration in their own home especially patients with UTI's
- Rolling out a Urinary Catheter Care Passport to ensure consistency in care for patients in any health care environment.

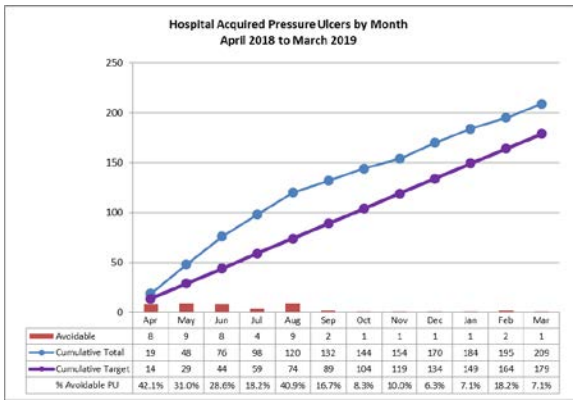
Reducing Pressure Ulcers

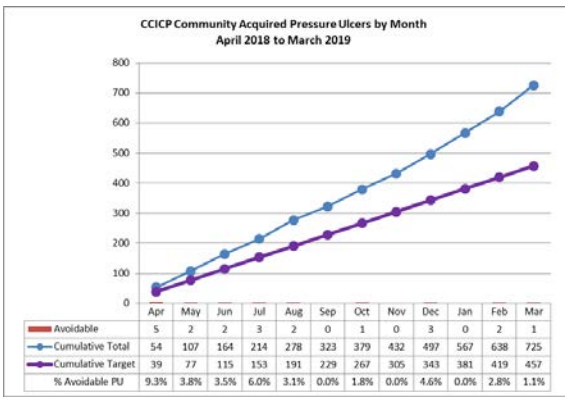
Following a review of the strategy in March 2018, the Trust's aim was to reduce pressure ulcers in both the acute Trust and CCICP. The target was to reduce hospital acquired pressure ulcers by 10% when compared to the previous financial year by the end of March 2019.

Pressure Ulcer Prevention Driver Diagram



Acquired Pressures Ulcers by month April 2018 to March 2019





Financial Year	Hospital acquired pressure ulcers (MCHFT)	Hospital acquired avoidable pressure ulcers (MCHFT)	Developed on caseload pressure ulcers (CCICP)	Developed on caseload avoidable pressure ulcers (CCICP)
2017/18	183	37	510	29
2018/19	209	47	725	21

Unfortunately the Trust did not achieve its aim to reduce hospital acquired avoidable pressure ulcers by 10% when compared to the previous financial year.

In response to the number of reported pressure ulcers the Trust continues to invest to reduce the number of hospital acquired avoidable pressure ulcers.

Within the Trust the investment is delivered by;

- The Tissue Viability Specialist Nurse reviews all reported hospital acquired pressure ulcers and Deep Tissue Injuries to ensure all appropriate interventions are in place and to determine the category of the pressure ulcer. In addition, a ward based investigation is undertaken for all hospital acquired category two and unstageable pressure damage, so that staff can understand what led to the development of the pressure ulcer and implement corrective action to eliminate gaps in care. Outcomes of the investigation are undertaken by the ward manager and matron for the area to ensure senior support and fed into the Pressure Ulcer Panel Meeting if confirmed avoidable damage

- The Clinical Quality and Outcomes Matron maintains senior leadership within the Trust to focus on the elimination of avoidable pressure ulcers

- The Trust's skin care group continues to meet monthly and is chaired by the Clinical Quality and Outcomes Matron. The group has a multidisciplinary, cross divisional review. The agenda has been updated to include updates from both MCHFT and CCICP on pressure ulcer prevention strategies and initiatives

- Staff education remains a priority within the Trust and CCICP to eliminate avoidable pressure ulcers. Tissue Viability Link Nurse Study days are held quarterly for MCHFT and CCICP staff. The number of link nurses within each ward/base remains that of a

'link team' which includes support from both Registered Nurses and Health Care Assistants

- Photographing of all pressure ulcers to ensure accurate documentation within the Trust is becoming embedded into everyday clinical practice. This supports the recognition of any deterioration or improvement in reported pressure ulcers, as well as accurate categorisation of pressure ulcers
- A number of pressure relieving equipment trials are being undertaken within the Trust to support the patient's care journey. This includes the trials of a Heel off-loading device, ED trolley toppers and friction prevention garments, which are currently in process
- The Trust is in the process of entering the procurement process in relation to the Hybrid mattress evaluation that has concluded
- The Trust has implemented the use of KerraPro silicone sheet to redistribute the pressure to patients at risk areas, such as Sacrum, elbows, heels, etc. This is embedded within everyday practice and the product is widely used within the Trust
- Tissue Viability Specialist representation from MCHFT and CCICP attend the quarterly Tissue Viability North West region meetings. This is a forum that meets and discusses best practice within the holistic patient care delivery and pressure ulcer prevention, as well as being up to date with both local and national initiatives
- The Tissue Viability Specialist Nurses attend the quarterly North West Pressure Ulcer Steering Group meetings. This is a forum that meets and discusses best practice within the holistic patient care delivery and pressure ulcer prevention, as well as being up to date with both local and national initiatives. The group is currently developing regional patient information leaflets and regional Policy in relation to Pressure Ulcer Prevention and Treatment in line with the National Health Service Improvement Pressure Ulcer changes
- Ward staff competency workbooks for Pressure Ulcer Prevention and categorisation has been reviewed and updated. This booklet is in the process of being added to an e-learning training package for health care assistance and registered nurses within the Trust
- The Tissue Viability Specialist Nurse continues to deliver the teaching education programme around Pressure ulcer prevention and delivers training to the Health Care Assistant induction students, Quality Matters sessions, preceptor students, pre-preceptor students, student nurses, pre- registration students, as well as adhoc ward based training as identified
- The Trust documentation has been reviewed by the Tissue Viability Specialist Nurse and has been updated in-line with the National NHS Improvement plan
- React 2 Red has been re-launched within the Surgery and Cancer division and is led by a division Matron
- The Tissue Viability Specialist Nurse is working within a Critical Care work stream with National Health Service Improvement to devise national guidance in relation to pressure ulcer prevention and treatment within the specific area
- The Trust has launched monthly multidisciplinary, cross divisional Pressure Ulcer Panel meetings to discuss all avoidable category 2 and unstageable pressure damage and

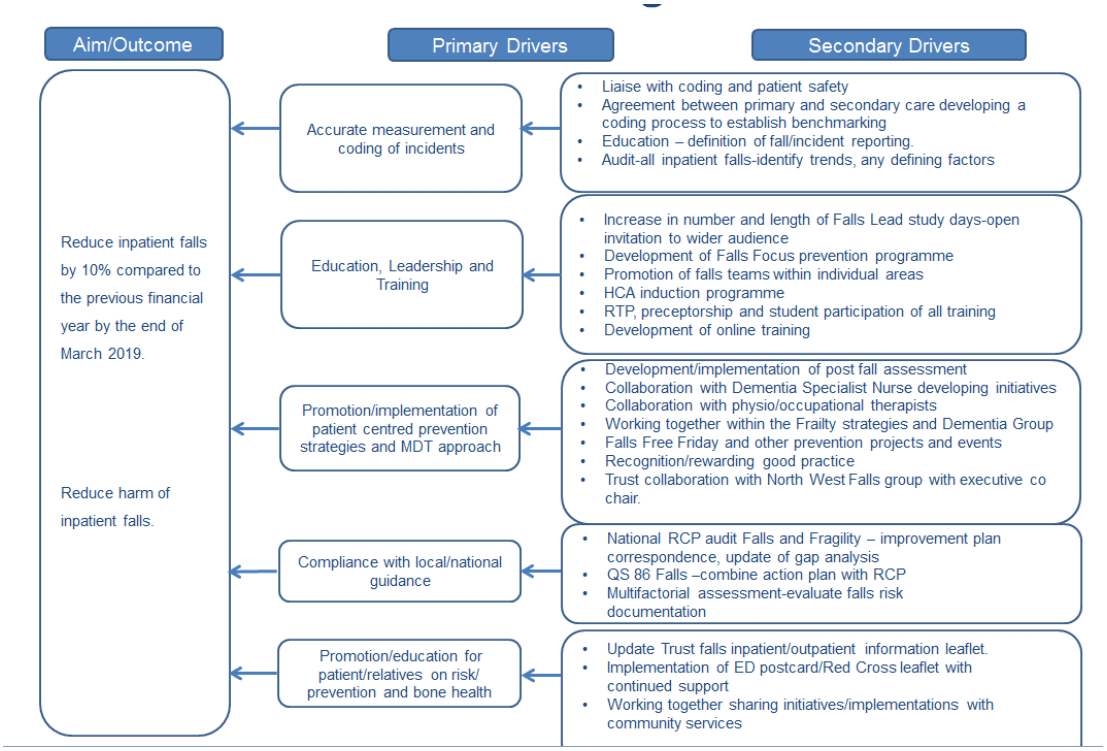
establish lessons learnt and develop action plans as required. This meeting also reviews all category 3 or 4 investigations tools to determine avoidability

- The Tissue Viability Specialist Nurse has reviewed the moisture associated skin damage products that the Trust had in place in relation to prevention and treatment and has made changes to the product selection following this review
- The Tissue Viability Specialist Nurse has reviewed both the care rounds and repositioning documentation and changes have been made to make the documents more user friendly and capturing the information that is required. These have been rolled out to all wards
- The Tissue Viability Specialist Nurse won an award at the National Wounds UK conference for the 'most innovative' abstract submitted for the work that has been done within the Trust in relation to the reduction of moisture associated skin damage.

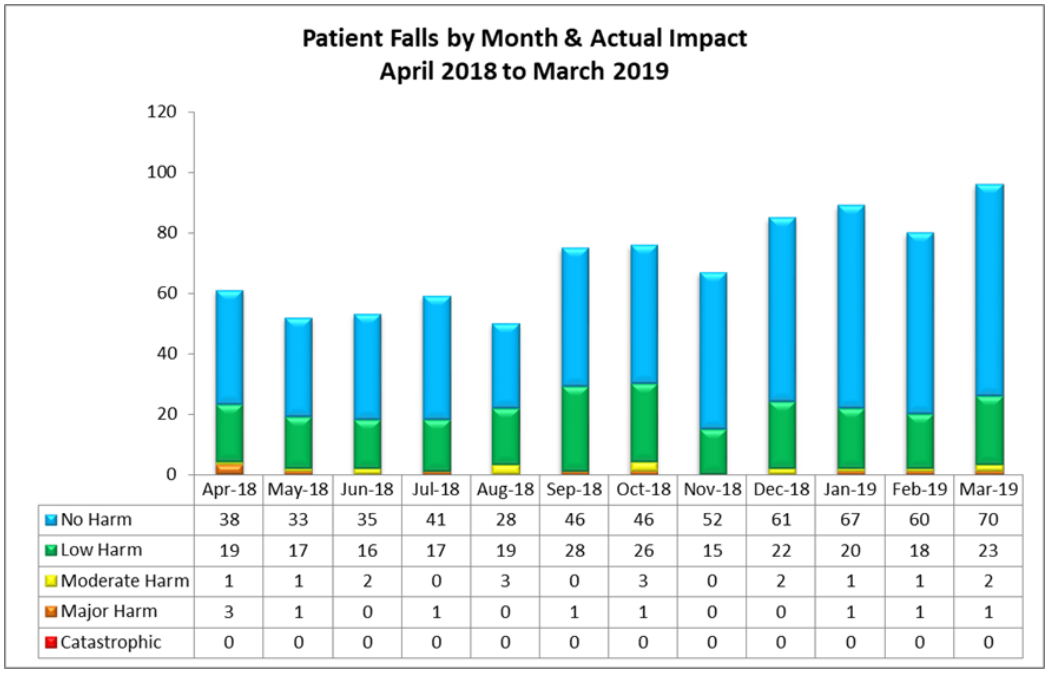
Reducing Inpatient falls

The Trust's aim is to reduce inpatient falls by 10% compared to the previous financial year by the end of March 2019

Falls Driver Diagram



Number of patient falls reported by month April 2018 to March 2019



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
No Harm	38	33	35	41	28	46	46	52	61	67	60	70
Low Harm	19	17	16	17	19	28	26	15	22	20	18	23
Moderate Harm	1	1	2	0	3	0	3	0	2	1	1	2
Major Harm	3	1	0	1	0	1	1	0	0	1	1	1
Catastrophic	0	0	0	0	0	0	0	0	0	0	0	0

Incident Type	2015/16	2016/17	2017/18	2018/19
Patient Falls	833	767	729	843

There has been a 16% increase in the number of reported inpatient falls in 2018/19 compared to the previous financial year

In order to achieve a reduction in falls there has been a number of actions undertaken or in development:

- Post fall assessments are completed by the Falls Specialist Nurse providing an individual prevention plan
- Falls Focus Programme - bespoke education, training and support is delivered by the Falls Specialist Nurse in individual areas
- Falls resulting in harm result in a Concise or Comprehensive review, with a focus to learn and implement improvements
- Falls prevention days increased in order to reach a wider audience
- Development of Falls Teams in all areas which include nursing staff and health care assistants
- A Fall Prevention guide has been created in order to support staff with appropriate interventions
- Community links established regarding falls prevention and support for patients
- Traffic light system commenced in rehabilitation areas which aids in safe mobilisation whilst rehabilitating
- Display boards in individual areas which are used as communication for staff, patients and relatives
- Signage in bays and toilets for patients as a reminder on how to call for assistance
- Promotional events held in the Trust and community to raise awareness.

The falls service has developed significant improvements since May 2018. Many patients now receive a complex, detailed assessment post fall by the Falls Specialist Nurse and an individualised prevention plan including assessment for frailty is then provided for the patient with a view to reducing the risk of further falls. We also encourage patients and their families to be involved in care planning whenever possible.

We continue to implement and promote the previous work for the 'One Step Ahead' collaborative which is across all ward areas. The specific elements of this collaborative are;

- Toilet/commode tagging
- Cohort higher risk patients
- Staff Placement/Changes to staff base
- Safety crosses

The Falls Specialist Nurse continues to evaluate and promote these initiatives within the ward areas with the inclusion of the Falls Teams. In addition educational sessions, workshops and promotional events are held within the Trust. Care rounds continue in all inpatient areas and trials of assessment notifications at bay entrances are taking place across the divisions highlighting at risk patients.

A Concise or Comprehensive investigation is undertaken where moderate or severe harm has occurred due to a fall. Outcomes of investigations are shared with staff at ward level and discussed at the Trust falls group. As a result of these investigations actions are taken in order to implement improvements.

All inpatients continue to be assessed for their risk of falls in hospital using the NICE guideline 161. Focus remains on individual risk factors such as falls history, lying/standing blood pressure, urinalysis and medications. Cognitive impairment is one of the largest risk factors which are supported by the Royal College of Physicians. We have established links with the Trust Dementia Nurse Specialist in order to support these patients in reducing falls risk. Part of this involves raising awareness of Delirium, treatments to consider and appropriate interventions to minimise the risk.

The Trust's Falls group continue to meet monthly and is chaired by the Clinical Quality and Outcomes Matron. The group has multidisciplinary and cross divisional representation inclusive of CCICP Falls lead.

Staff education continues to remain priority. Falls Education study days are held twice a year. This was open to the Falls Leads although invitation has recently extended to all staff members within the Trust. Falls Prevention training also forms part of the Quality Matters and Preceptorship programmes. The number of link nurses within each ward has increased to produce a 'falls prevention team' which includes support from both registered nurses and health care assistants. Links have also been developed with the community who now have representation on the Falls Group.

There is now a much improved provision of mobility aids utilised in the ward areas and improved communication system within the physiotherapy department which facilitates

prompt ordering of aids. In addition individualised areas are using a traffic light system in order to highlight the appropriate walking aid required and the support needed to mobilise.

The Trust participated in the second Royal College of Physicians National Falls audit in May 2017. Results were received in November and work is currently underway via a Gap analysis to identify areas for improvement. We have also since signed up to the new continual audit by the Royal College of Physicians which commenced in January 2019.

The Community Rehabilitation Team introduced a pilot in June 2017 providing a new seven days falls service. The therapist and paramedic offer an alternative response to emergency calls. As a partnership team, the therapist and paramedic are able to rapidly assess and respond to patients needs in their home. They can provide immediate advice, equipment and support to help prevent further falls.

There is an acknowledgement that we are not going to eliminate falls altogether, and we do have to balance the encouragement of independence with the management of risk. However, we know that there are many risk factors that can be mitigated. The Trust is working hard to reduce falls and any harm caused from falls.

Recognising & Responding to Deteriorating Patients

Our aim is for Mid Cheshire Hospitals NHS Foundation Trust to reduce adult avoidable patient harm (Measured by reductions in cardiac arrests, severity of patient harm incidents and high risk admissions to Critical Care) by improving the recognition of and the response to the acutely deteriorating patient by 50% by the end of March 2019

Why is it important?

Improving the recognition of, and the response to, the acutely deteriorating patient can reduce in-hospital cardiac arrests, serious harm to patients and high risk admissions to Critical Care.

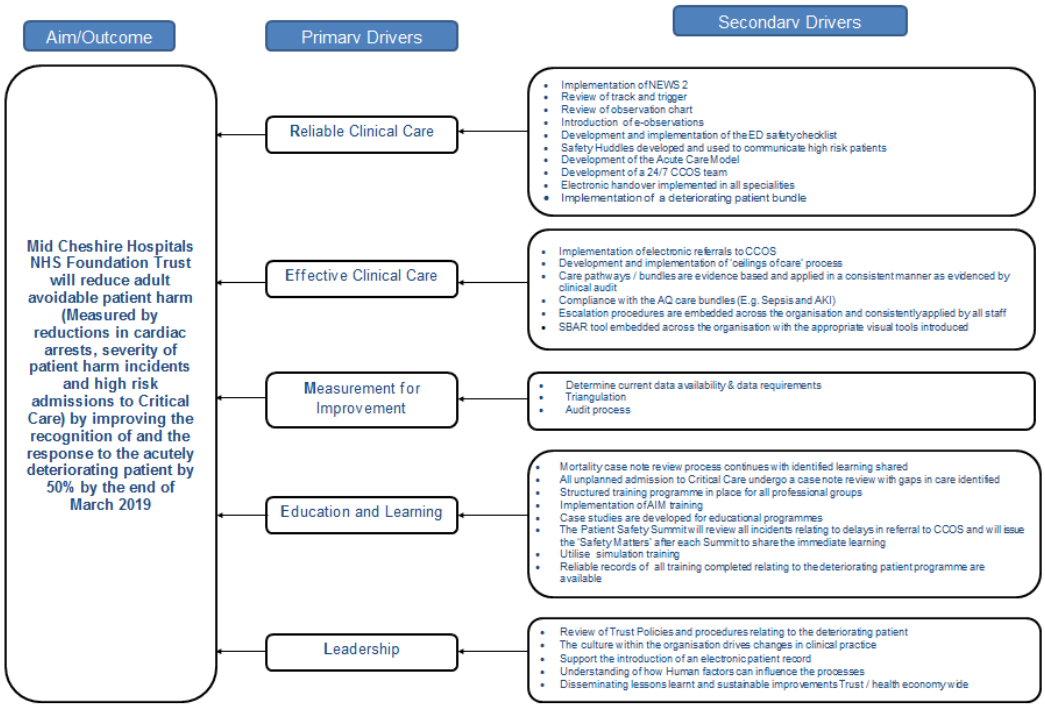
Progress

The Executive Led Deteriorating Patient Steering Group was formed in November 2017. The group has cross-divisional representation, is chaired by the Medical Director and reports to the Trust Mortality Reduction Group and up through the committee structure to Board as appropriate.

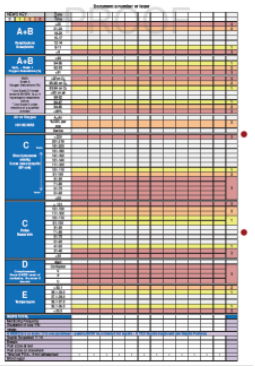
The group has six work streams with a nominated lead for each:

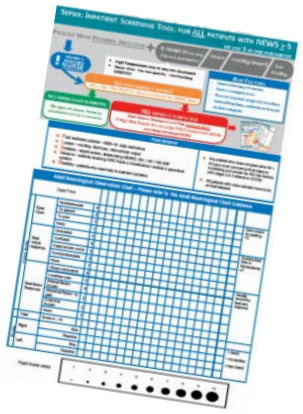
- Acute Care Model
- Unplanned Admissions to the Critical Care Unit
- Education and Training
- Quality Improvement Projects
- Policy
- Lines

Deteriorating Patients Driver Diagram



The National Early Warning Score (NEWS 2) was launched in the Trust on the 5 November 2018. The revised vital signs chart has been developed to incorporate NEWS2 and approved by the Deteriorating Patient Steering Group. The revised vital signs chart includes the NEWS2 chart, neurological observation chart, sepsis and AKI guidance and SBAR information to ensure accurate handover in the clinical settings.





The Trust vital signs policy has been rewritten to include the use of NEWS2. The divisional teams have updated their local admission proforma's and documents to again incorporate NEWS2.

The organisation has attended the AQuA Deteriorating Patient Collaborative which commenced on the 12 July 2018. The Trust also joined the NHS England NEWS2 Champion Network.

A training implementation plan was developed and approved by the Deteriorating Patient Steering Group. The training programme is being led by the Critical Care Outreach Service Lead Nurse.

The 2018 Mid Cheshire Hospitals NHS Foundation Trust Quality Improvement Session which was held on the 19 October focused on the care of the deteriorating patient and the launch of NEWS 2.

All unplanned admissions to Critical Care are reviewed by a clinical team using the Structured Judgement Review methodology. Learning from these reviews is taken forward through the Governance structure with lessons learned produced.

The Critical Care Matron has taken forward a piece of work relating to the insertion and management of lines. A competency passport for staff has been developed along with a patient passport. A decision tool to aid in selecting the correct line to use is being developed.

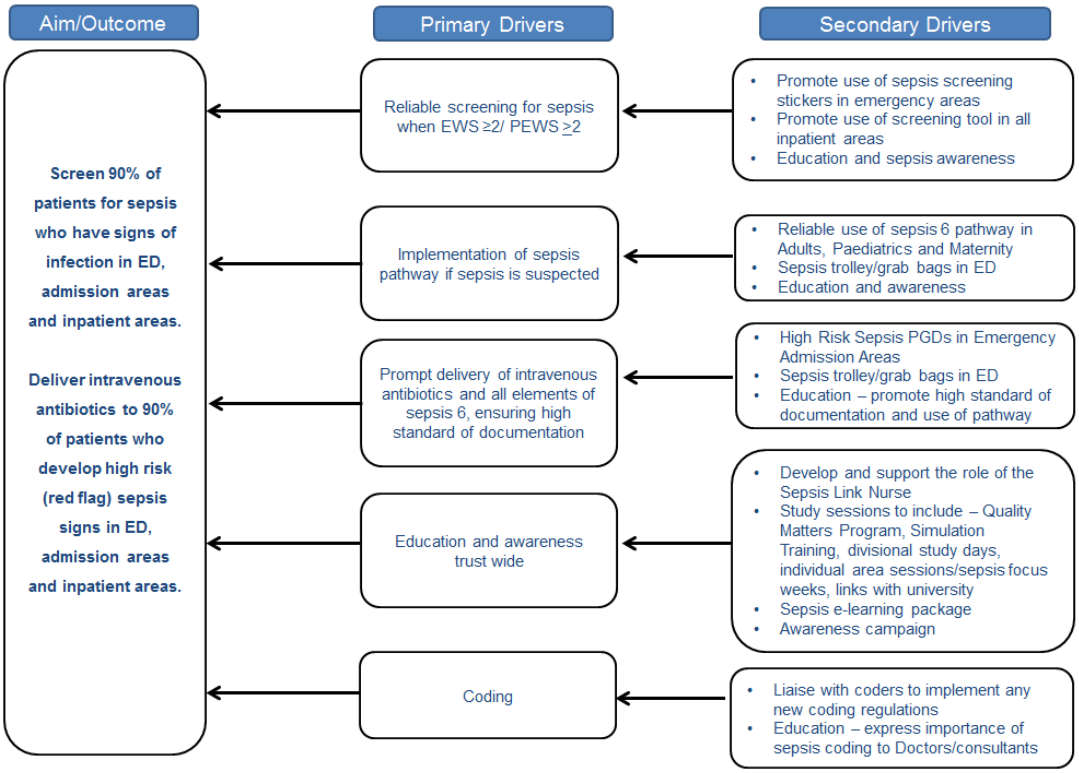
The Critical Care Outreach Service Lead Nurse has implemented an AIM training programme within the organisation.

Following the launch of NEWS2 in November 2018 data collection has been commenced to show the impact of NEWS2 on the measures within the driver diagram aim. This data is now being collated and will be presented at the Deteriorating Patient Steering Group in 2019/20.

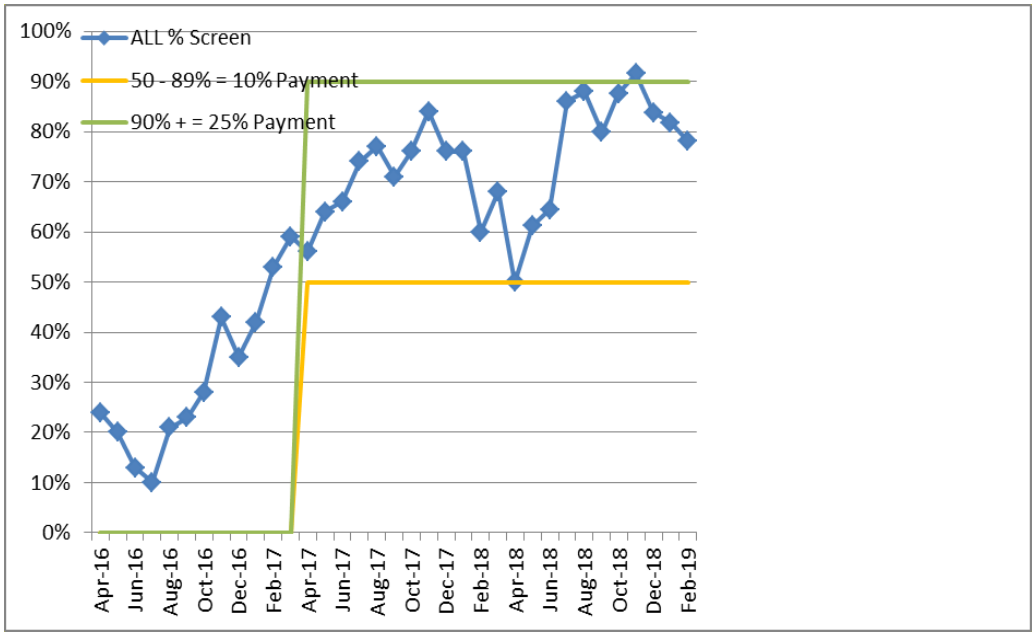
Recognising & Treating Sepsis

There are a number of strategies in place to improve performance as the sepsis team continue to work with the aim to achieve the National target of 90% for both part 2A (sepsis screening) and part 2B (antibiotic administration) of the CQUIN

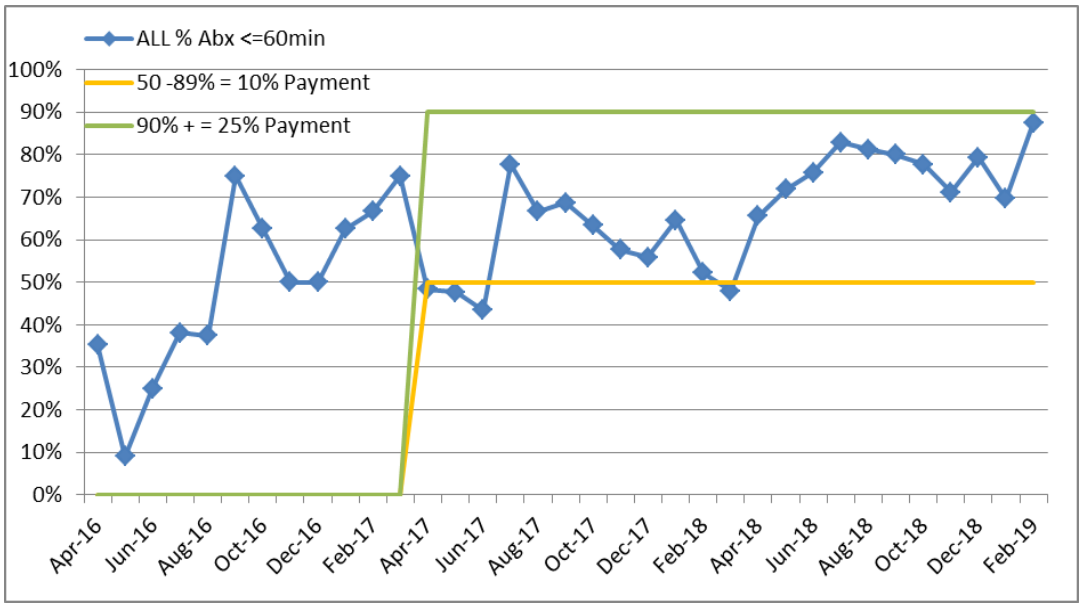
Sepsis Driver Diagram



The results below demonstrate progress to date for screening in the Emergency Department, inpatients and combined for 2018/2019; Pending end of year data.



The results below demonstrate progress to date for delivery of antibiotics in the Emergency Department inpatient's and combined for 2018/2019; NEED TO ADD FINAL FIGURES



The table below shows the end of quarter 4 results for each year:

	Year 16/17	Year 17/18	Year 18/19
Combined Screening	51%	67%	
Combined antibiotic delivery	69%	57%	

Education and awareness of sepsis screening, recognition and treatment of sepsis with all staff remains key. Training with link nurses and wards remains on-going, staff can contact the sepsis nurse at any time to have training needs updated or refreshed. All wards have sepsis link nurses;

the link nurses are educated on sepsis and aware of their roles and responsibilities which include teaching the staff in their area. Each ward is reminded each month to submit their monthly audit of sepsis screening, this highlights area's where improvement is needed.

Education continues via many avenues including the Quality Care Delivery Programme, preceptorship training, link nurse training, spontaneous visits to wards to check screening. Sessions are also booked in with the school of nursing for the return to practice nurses. Extra training for the launch of NEWS2 has also included education on the new way to screen patients for sepsis. The sepsis E-learning package remains in progress with several members of staff completing it. In December the quality team completed a quality week which promoted sepsis, awareness and recognition along with other quality domains. This was completed at the hospital cross roads and afterwards each ward and department was visited to ensure staff were happy with all aspects of sepsis care. Staff were also given edible goodies and drinks to thank them for their continuous sepsis care and recognition.

The launch of NEWS2 was rolled out in November, as a part of this all staff were trained on the new chart and how to identify sepsis and screening for sepsis. Results since the launch have improved sepsis screening for inpatients.

The Acute Medical Unit re-launched a triage area which has significantly increased screening results; this has continually remained a huge improvement on their sepsis screening. In November both inpatients and the Emergency Department met their target of 90% screening. This is the highest yet. Presence in ED and the inpatient areas has decreased over the last few months due to the sepsis team becoming 1 nurse; however this does not seem to have impacted on results to date. ED has had new staff starting, after discussing with senior staff in ED a roll out of training is to commence February/March to capture all staff that need updates and all new staff that need training on sepsis recognition and treatment.

During quarter 2 the sepsis team were in communication with computer services department about having a mandatory screening box on the triage screen in ED, unfortunately this is not possible so staff remain screening the patients using the sepsis screening stickers. The new Emergency Department cas card has now been launched. The screening sticker is incorporated into the cas card, next month's audit with prove if this is working or not and highlight if changes are needed.

During November the Trust held their a Celebration of Achievement Awards Ceremony; the sepsis team won the Outstanding Contribution to Quality and Safety award for improvement of sepsis care and recognition throughout the Trust.

The patient Group Direction (PGD) is in use in the Emergency Department now and the Ambulatory Care Unit. A new training programme is to be rolled out in the Emergency Department to capture new starters and refresh those that need an update in using the PGD. The staff also have access to the sepsis trolley which has all the equipment and medication on to be able to deliver the sepsis 6 to patients with sepsis and suspected sepsis, the PGD and high risk check list are available on the trolley so staff can administer antibiotics if needed without delay. The sepsis policy is readily available to staff to read and refer to, this is on the intranet for ease of access.

The sepsis nurse continues to audit the use of the pathway. This allows effectiveness of the pathway to be determined alongside the antibiotics delivery compliance. Education on the pathway use across all divisions including maternity and paediatrics continues, promoting the importance of the sepsis six. The pathway and all documents have now been update in line with the NEWS2 launch.

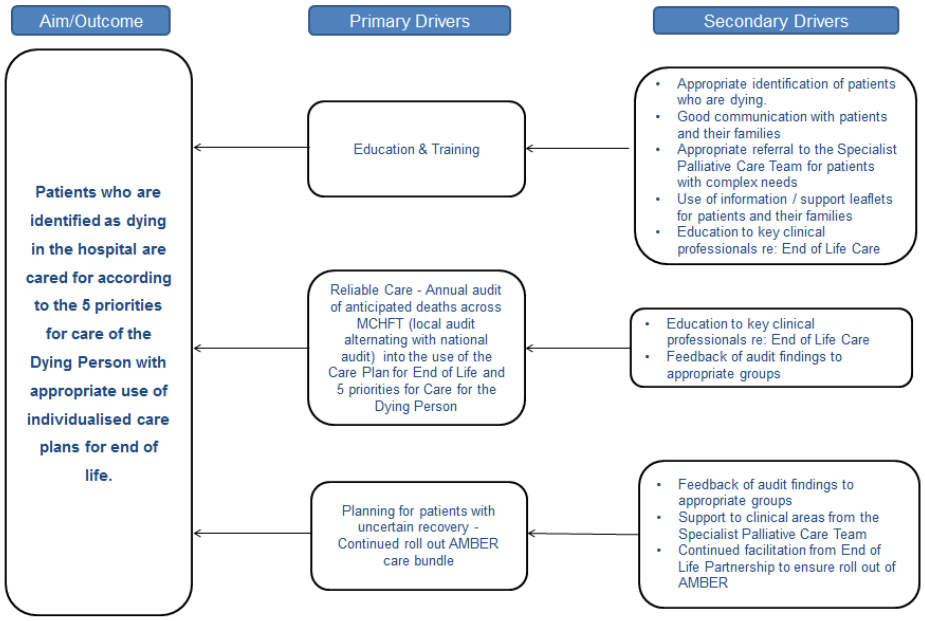
The collection of the AQ data continues. This helps to identify how the Trust is achieving compared to other Trusts. This looks at patients treated for moderate – high risk sepsis. The sepsis steering group continues to meet on a monthly basis. Representation from all divisions is requested to ensure sepsis care is delivered the same through the Trust.

Central Cheshire Integrated Care Partnership (CCICP) now has a developed sepsis pathway that ensures community nursing staff appropriately assess at risk patients. CCICP have worked in partnership with the acute Trust in order to design their robust pathway. Prior to the launch of the pathway all staff were trained in the use of the early warning scores for patients at risk of developing sepsis.

End of Life Care

Nearly half of all deaths in England occur in hospitals. For this reason, it is a core responsibility of hospitals is to deliver high quality care for patients in their final days and appropriate support to their careers. There is only one opportunity to get it right and to then create a positive lasting memory for relatives and carers. The Trust aims to provide the best possible care for patients at the end of life, whatever their disease. We strongly believe that high quality care consists of the five priorities for end of life care being embedded in everybody's clinical practice. The use of individualised care plans helps to focus care around the needs of the patient and their family and provides documentation and evidence that we are doing so.

End of Life Driver Diagram



Progress:

Education and training – The Trust now has a new Educator Facilitator in post for End of Life Care 2 days a week. End of Life Care Education is established within junior doctor's medical education programme, the nursing preceptorship and 'Return to Practice' programmes. Bespoke support is provided for clinical areas and individual staff members. There are 8 Macmillan Education study days available throughout the year funded places are available for all healthcare professions working locally within both primary and secondary care.

As part of the End of Life Care and Bereavement Group we now work collaboratively with the Customer Care Team to be able to monitor complaints and respond with education appropriately.

Audit - During 2018 The national NHS Benchmarking audit 'National Audit of Care at the End of Life' has been undertaken. This consisted of an Organisational Audit / Clinical Case note Review / Hospital site Audit and Quality Bereavement Survey. The clinical case note review looked at all deaths in hospital during April 2018. The data collection for this has been completed and submitted.

The results of this audit are produced nationally and will be available publically May 2019.

NHS Benchmarking have announced that this audit will be repeated during 2019.

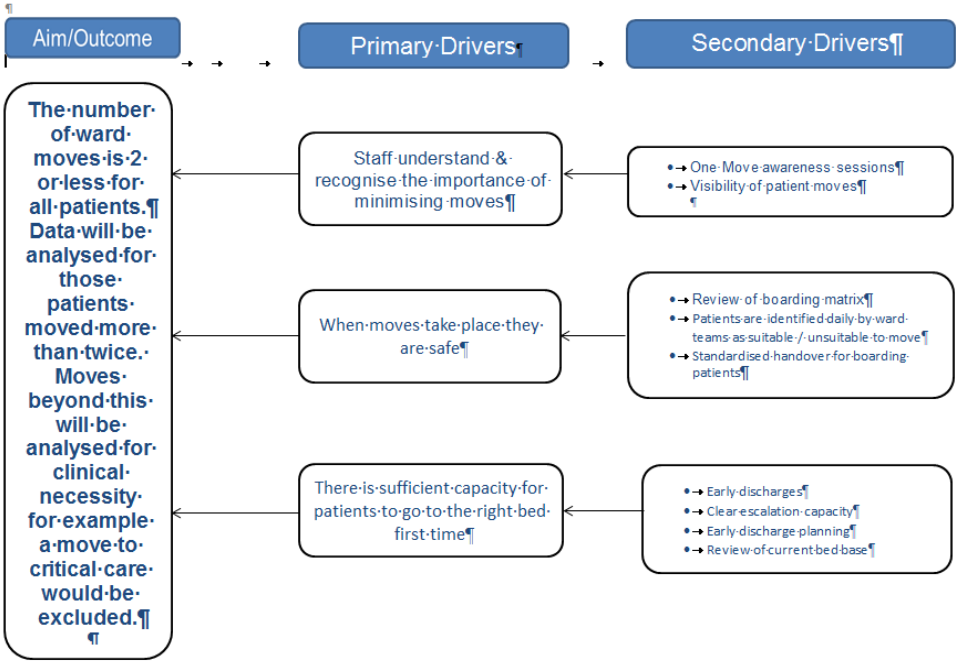
Planning for patients with uncertain recovery – Continued roll out of the AMBER Care Bundle is ongoing.

- Amber Care Bundle aiming to go live on wards 2 and 3 at the Trust in April 2019. A baseline audit being completed
- Working with medical consultants who are championing its use within clinical areas
- Amber Care training on wards 2 & 3 commenced on 31st Jan, weekly sessions for 6 weeks. Education resources / folders created for each clinical area.

Reducing Inpatient Moves

The Trust is committed to reducing inpatient moves throughout the organisation, especially when this occurs for non-clinical reasons. The national evidence suggests that patient moves are associated with extended length of stay and lack of continuity of care. As an organisation we have reviewed our current policies and procedures related to patient moves/ boarding to ensure that patient moves are kept to minimal level and clinically appropriate patients are moved to suitable areas. The introduction of the flex bundle has been a clinically led protocol designed to ensure a holistic assessment of the patients' needs are considered.

Reducing Inappropriate Inpatient Moves Driver Diagram



The following work streams are in place to support the reduction of patient moves and improve the quality and safety when patients are moved:

- Trust-wide bed modelling review to assess capacity & demand
- The National Emergency Intensive Support Team (ECIST) are providing assistance with the safe admission and discharge processes in the Trust.
- Implementation of the safe flex bundle which supports a holistic assessment criteria
- Live visibility around patient moves to support decision making

It is unlikely we can eliminate the practice of medical outliers / patient moves entirely however the Quality programme in 18/19 has developed safe procedures and identified long term plans to support the overall reduction of this metric. It is fair to say that there are further aspects of improvement work required for the success of this quality measure which will be carried into the Quality programme 19/20.

Governors' choice of indicator

Mortality

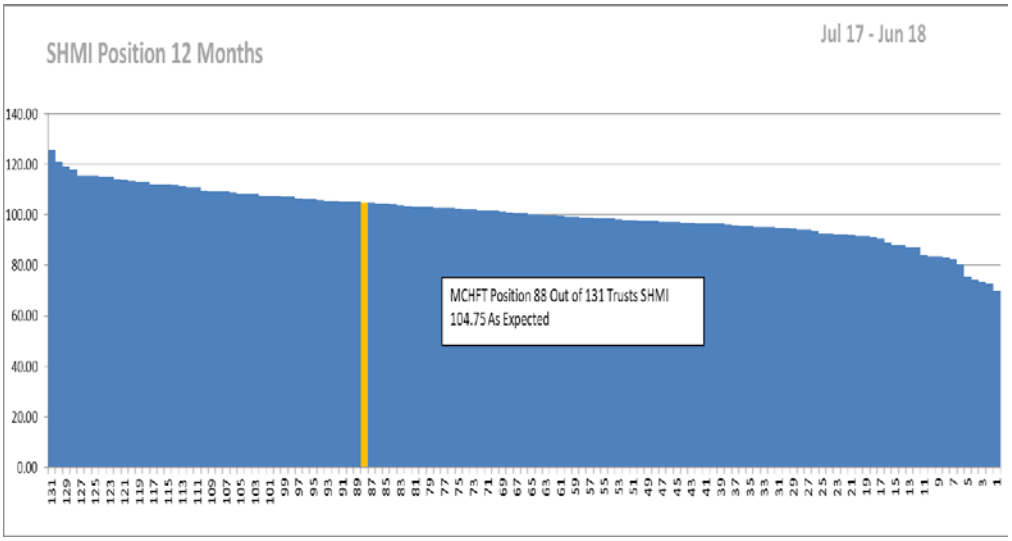
Our aim is for from April 2015, Mid Cheshire Hospitals NHS Foundation Trust's Summary Hospital-Level Mortality Indicator (SHMI) will remain at or below 1.0 and its Hospital Standardised Mortality Ratio (HSMR) will remain at or below 100

Why is it important?

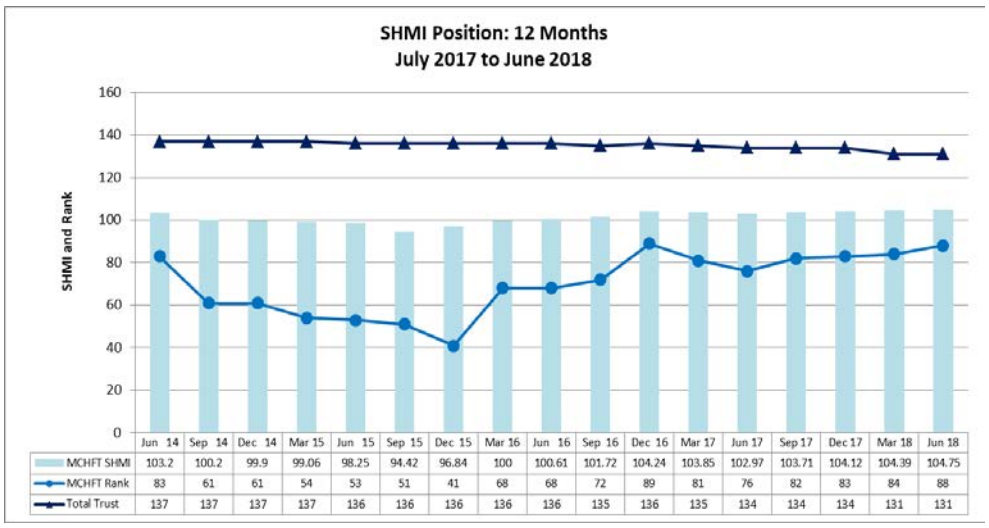
SHMI and HSMR are indicators which report on mortality at Trust level across the NHS in England. These measures are important because high mortality rates may be an indication of problems with the quality and safety in a hospital.

Progress

Summary Hospital-level Mortality Indicator (SHMI) July 2017 - June 2018



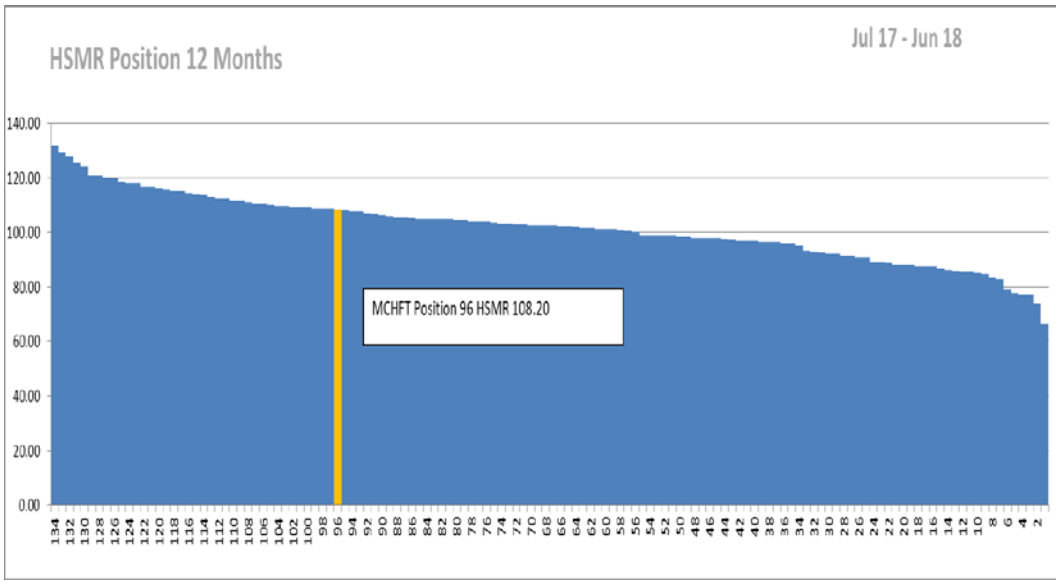
The above chart demonstrates the SHMI position for the reporting period July 2017 - June 2018. The SHMI is currently 104.75 and is in the 'as expected' range. This currently places the Trust 88 out of 131 Trusts.



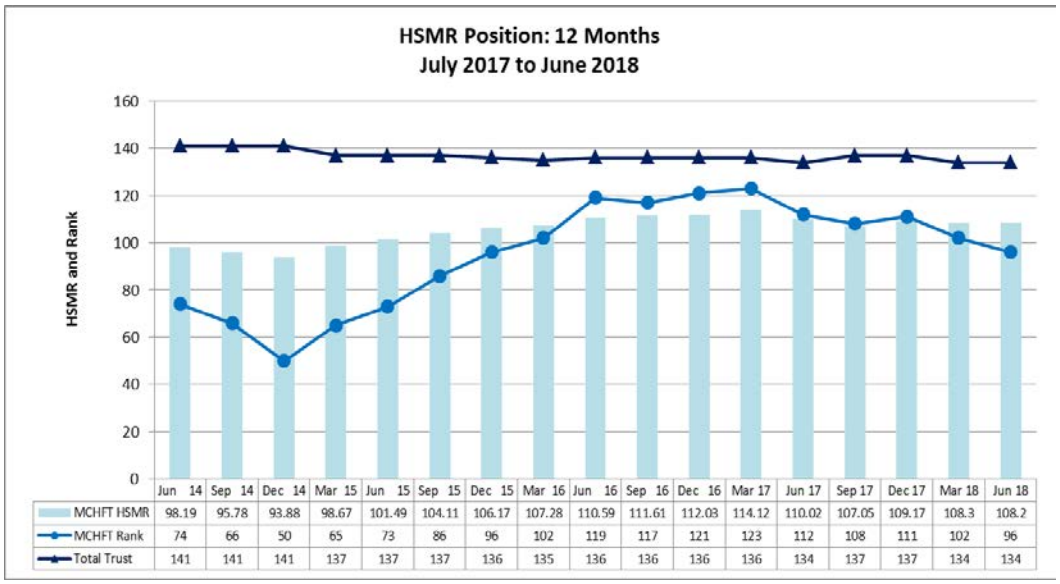
	Jun 14	Sep 14	Dec 14	Mar 15	Jun 15	Sep 15	Dec 15	Mar 16	Jun 16	Sep 16	Dec 16	Mar 17	Jun 17	Sep 17	Dec 17	Mar 18	Jun 18
MCHFT SHMI	103.2	100.2	99.9	99.06	98.25	94.42	96.84	100	100.61	101.72	104.24	103.85	102.97	103.71	104.12	104.39	104.75
MCHFT Rank	83	61	61	54	53	51	41	68	68	72	89	81	76	82	83	84	88
Total Trust	137	137	137	137	136	136	136	136	136	135	136	135	134	134	134	131	131

The above chart demonstrates the SHMI and rank of the Trust over time, up to latest reporting period.

Hospital Standardised Mortality Rate (HSMR) July 2017 - June 2018



The above chart demonstrates the HSMR position for the reporting period July 2017 - June 2018. The HSMR is currently 108.20 and places the Trust 96 out of 134 Trusts.



	Jun 14	Sep 14	Dec 14	Mar 15	Jun 15	Sep 15	Dec 15	Mar 16	Jun 16	Sep 16	Dec 16	Mar 17	Jun 17	Sep 17	Dec 17	Mar 18	Jun 18
MCHFT HSMR	98.19	95.78	93.88	98.67	101.49	104.11	106.17	107.28	110.59	111.61	112.03	114.12	110.02	107.05	109.17	108.3	108.2
MCHFT Rank	74	66	50	65	73	86	96	102	119	117	121	123	112	108	111	102	96
Total Trust	141	141	141	137	137	137	136	135	136	136	136	136	134	137	137	134	134

The above chart demonstrates the HSMR and rank of the Trust over time, up to the latest reporting period.

Learning from Deaths and Improvements

The Trust Learning from Deaths Policy built upon the Mortality Case Note Review Standard Operating Procedure, which outlined the existing embedded process for reviewing all in-hospital deaths.

All in-patient deaths are reviewed on a weekly basis by a team of consultants led by the Lead Consultant for Patient Safety. A short mortality case note review form is completed and if a death is identified where clinical care could potentially have been more appropriate, the case is referred for a Structured Judgement Review.

The Medical Director and Clinical Lead for Patient Safety undertook two sessions to educate a cohort of senior medical and nursing staff on how to undertake the Structured Judgement Review Process.
The clinical conditions that were included within the Structured Judgement Review Process for 2018/19 were agreed by the HMRG in line with national guidance. The clinical conditions selected included:

- Acute Cerebrovascular Accident (at the weekend)
- Pneumonia (at the weekend)
- Intestinal obstruction without hernia
- Alcohol related liver disease
- Infectious diseases (CQC Insight metric)
- All deaths where families, carers or staff raise concerns
- Concerns raised by the Coroner
- Concerns raised at the Patient Safety Summit
- Concerns raised during the Friday mortality screening process
- Relevant elective deaths

The Structured Judgement Review Process commenced in April 2018.

Organisational learning from this process must be dynamic, with immediate actions and improvements undertaken in a timely manner to prevent reoccurrence. Short - medium term improvements identified through organisational learning are introduced through the Trust's governance structure. In the longer term organisational learning will take place through the triangulation and theming of data and information

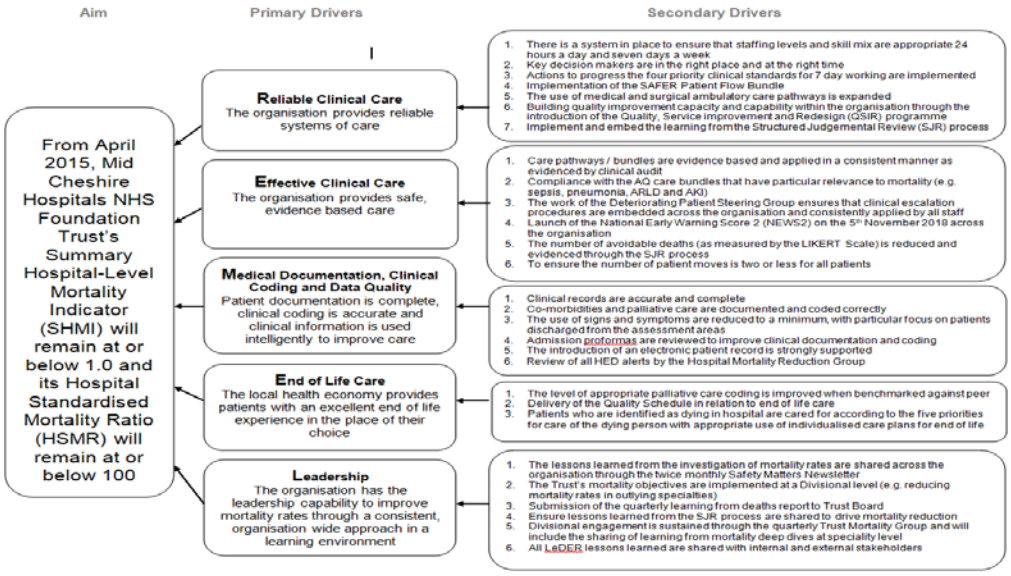
The Divisional Mortality Reduction Groups undertake mortality case note reviews in line with their terms of reference.
The Trust has a well-established Hospital Mortality Reduction Group (HMRG) led by the Medical Director. This group monitors the mortality reduction improvement plans across the Trust. On a quarterly basis the HMRG meets with the divisional mortality reduction groups to ensure a unified approach to mortality reduction across the Trust and to share learning opportunities.

Quarterly deep dives are undertaken to understand the mortality data further. To date deep dives have been completed on the following topics and the detail included in the quarterly Learning from Deaths Report.

- Gynaecology Mortality Rates
- Gastroenterology Mortality Rates
- Palliative Care Mortality Rates
- Paediatrics
- Cardiology

The HMRG developed a reducing hospital mortality rates driver diagram. There are five primary drivers are:

- Reliable Clinical Care
- Effective Clinical Care
- Medical Documentation, Clinical Coding and Data Quality
- End of life Care
- Leadership



The main areas of focus from the driver diagram currently are:

Actions to progress the four priority clinical standards for 7 day working included:

- Submitting data from the March / April 2018 survey centrally.
- Development of a business case for general surgery to support seven day working for presentation at Trust Board
- The NHS England team visited the paediatric department and discussed the process for the robust documentation of time to admission. They also discussed and provided clarity around the exclusion criteria in relation to the 7 day services data submission.
- NHS Improvement published a guidance document on the challenges and solutions for 7 day services. The divisional teams reviewed this to identify any learning to implement locally.

Actions to implement the Structured Judgement Review Process in line with national guidance:

- The Structured Judgement Review Process commenced in April 2018.
- The learning from these reviews has been collated and included in a quarterly newsletter
- A deep dive into the Structured Judgement Review Process has been completed and reported in the quarterly Trust Learning from Deaths Report

Actions to implement learning lessons

- The structure of the twice monthly Patient Safety Summit has been reviewed to include specific sections for each Division to feedback on learning from incident investigations and case note reviews.

Actions to progress the use of care pathways / bundles which are evidence based and applied in a consistent manner, as evidenced by clinical audit and include:

- The Trust re-joined the Advancing Quality (AQ) programme in April 2017 and has signed up for a further year in 2018/19. The four pathways chosen are:
- Sepsis
- Alcohol related liver disease (ARLD)
- Pneumonia
- Acute Kidney Injury (AKI)
- Clinical leads have been identified for each of the pathways and monitoring is undertaken by the Care Pathway Group, reporting to the Quality and Safety Improvement Strategy Group with escalation to the Executive Quality Governance Group and assurances to the Quality Governance Committee

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

Council of Governors

The Council of Governors (CoG) welcomes the opportunity to comment on the 2018/19 Quality Account for Mid Cheshire NHS Foundation Trust. The council of governors, collectively, is the body that binds a foundation trust to its patients, service users, staff and stakeholders and consists of elected members and appointed individuals who represent members and other stakeholder organisations. As Governors, we receive assurances about the quality and performance of the trust during the year and we are also involved in a range of other events, such as patient safety walkarounds, patient and carer surveys, public meetings, committee meetings and committee observations. All of these activities enable us to scrutinise the quality of care that is being provided and we hear first-hand from staff, patients and carers about the care they receive across all areas of the trust. We also hear through patient stories, staff feedback, reviews of incidents and complaints and reports to Council of the many ways that staff are working to improve quality – all of which reflect the Trust's ongoing commitment deliver the best possible care.

2018/19 was a challenging year for the Trust which, like other healthcare providers, has witnessed increased demand for its services as a result of an ageing population and evolving healthcare needs. In addition, wider social and economic pressures along with system reconfiguration have meant that maintaining high quality, safe care can at times be difficult for any provider of health and social care. Despite these challenges, feedback from patients about the standard of care they received is consistently high (as evidenced in both national and in local surveys) and the actions taken following previous surveys demonstrate that care has improved in some key areas. We were particularly pleased to see the significant improvements achieved in respect of staff helping patients to eat meals (12% improvement on 2017) and in the area of doctor:patient communication. Specific projects aimed at improving delays at discharge, emotional support and the suite of actions in place to enhance the care provided to maternity patients and patients with cancer should also lead to improvements in patient experience and the CoG will be interested to track the impact of these during 2019/20. We were also impressed with the work being done by the Patient Information Group to ensure that the trust meets the information needs of patients and that alternative types of information are provided and also by the Trust's approach to planning for the seven day service, the aim to reduce length of stay and the ways in which patients with a learning disability are supported should they require care/treatment.

The Trust's achievements are recognised not only by the CoG, by staff and by other stakeholders, but also at national level. The three national awards in the areas of surgical ambulatory care, fracture clinics and wound management, along with other projects shortlisted for national awards, reflect the innovative and creative ways in which services are being developed and it is hoped that the learning from these projects can be shared so as to support improvements across the sector. Participation in the national clinical audit programme also evidences the quality of care provided by the trust when compared to other trusts involved in these national programmes. Again the detailed action plans evidence a concern to learn and improve as do the actions taken by the Hospital Mortality Reduction Group to ensure a unified approach to mortality reduction across the Trust and to share learning opportunities. As these actions embed, the CoG would be keen to see the Trusts overall position (currently 88/131) improve - although it is recognised that the current position is in the 'as expected' range.

The pride that staff have in their services and their commitment to delivering high quality care is evident from our patient safety walkarounds, from discussions of patient stories at Board / Council

and in other CoG activities and this is testament both to the motivation of individual staff and also to the quality of leadership at all levels of the organisation. This is reflected in particular by the outcomes from the Friends and Family Test, in the staff survey and was recognised by the CQC in its review of the trust (May 2018) which we were delighted to see rated leadership of the trust as 'good'.

The CoG was delighted that the Trust achieved an *overall* rating of 'Good' following the comprehensive CQC inspection. It was disappointing therefore that the outcome for 'safe' was lowered to 'requires improvement' following the inspection. During their visit, the CQC observed failures to follow infection and control procedures within some clinical areas and they also had concerns regarding the ways in which compliance with infection control procedures were monitored. We recognise that the Trust has implemented an improvement plan in respect of this during 2018/19, progress of which is reported to the local CCGs on a quarterly basis.

The CoG also notes with concern the challenges experienced in year regarding achievement of some of the key indicators within the NHS Improvement Standard Oversight Framework and a decline in the standards relating to MRSA infections and pressure ulcers. Whilst 4/5 indicators within the NHS Improvement Standard Oversight Framework were consistently met, the standard not achieved was the four hour access standard, (nationally known as the A&E Target) which delivered 83.63% in 2018/19. Whilst many trusts across England failed to meet this target, the potential impact for patients and on staff is significant and as such this is an area that governors will continue to focus on during 2019/20. We are also keen to better understand the opportunities across the locality to reduce avoidable admissions and also to ensure staff wellbeing during periods of significant pressure. In addition to our focus on patient and staff experience within A&E, the CoG is keen to see progress on the 9 key priority areas within the Quality and Safety Improvement Strategy (which includes reductions in MRSA and pressure ulcers) and on the actions within the Workforce Matters Strategy. As a CoG we were pleased to see the commitments made within these strategies across Mid Cheshire NHS Foundation Trust and CCICP to supporting staff, reducing harm and on improving patient's experiences of care, and especially patient's experiences of end of life care given the impact of an ageing population both now and in the future.

Throughout the Quality Account key priorities are discussed, data on 2018/19 performance is presented clearly and actions / learning discussed. The commitment 'to deliver excellence in healthcare through innovations and collaboration' is clear and as a CoG we are confident that the 2018/19 Quality Account reflects a fair, representative and balanced overview of the quality of care across MCHFT and CCICP.

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Quality Accounts NHS South Cheshire and NHS Vale Royal CCG Statement – Mid Cheshire Hospitals NHS Foundation Trust

Note this response is written based on an incomplete draft

General Overview

NHS South Cheshire Clinical Commissioning Group (CCG) and NHS Vale Royal Clinical Commissioning Group (CCG) welcome the opportunity to comment on Mid Cheshire Hospitals Foundation Trust (MCHFT) Quality Account 2018/19.

We can confirm that we have reviewed the content of the Quality Account and this reflects a fair, representative and balanced overview of the quality of care in MCHFT and includes the mandatory elements required.

NHS South Cheshire CCG and NHS Vale Royal CCG endorse MCHFT's clear vision 'to deliver excellence in healthcare through innovations and collaboration' which is underpinned by agreed values and behaviours.

The priorities MCHFT identified in the Quality Account continue to build on a strong patient focus, supported by staff values and behaviours which underpin the quality agenda. In particular, we would like to highlight the on-going engagement with partners based on feedback from carers and patients.

Patient and Public Engagement

The CCGs note the continued collaborative approach which includes working with partners, local communities and working relationships relating to the quality of care delivered to patients at MCHFT, examples of which are the Readers Panel and the accessibility of information and leaflets to inform patient experience. We congratulate them on the continued achievements for a significant number of the quality indicators.

It was pleasing to see the involvement of voluntary services in a number of initiatives across the trust which is reflected in the national inpatient survey

Clinical Priorities

MCHFT continues to have a focus on a number of clinical areas to drive quality and safety forward and to improve outcomes for patients. Of particular note is the development of multidisciplinary teams in readiness for the seven day service which is hoped to improve quality outcomes, and the timely & effective delivery of services.

The aim to reduce inpatient moves will improve patient experience and support reduced length of stay. The CCG support the Trust's view that further work is required in 2019/20 to improve this quality measure.

The CCGs acknowledge that MCHFT work hard to ensure that care they provide to people with a Learning Disability is of a high quality and have introduced a number of initiatives to improve access.
The CCGs also recognise the work that the Trust has put into place to implement the 'Learning from Deaths' guidance and the commitment to learn from deaths and improve services.

The Trust has not achieved their targets that the Summary Hospital-Level Mortality Indicator (SHMI) will remain at or below 1.0 or that the Hospital Standardised Mortality Ratio (HSMR) will remain at or below 100. However, the Trust remains in the 'as expected' range for mortality.

Overall, the Trust's delivery of services to support people with cancer is making positive progress driving quality and safety forward – MCHFT remain above the National average in the Public Health England and NHS England Cancer Dashboard, although there has been a slight decrease but overall they remain above the national average.

CQC Inspection

The CCGs congratulate the Trust for the overall rating of 'Good' following the CQC Comprehensive Inspection in May 2018. The CQC is responsible for ensuring health and social care services meet essential standards of quality and safety.

It was therefore disappointing to see that the rating for 'safe' was downgraded to 'requires improvement'.

This is because the CQC observed failures to follow infection and control procedures across wards and areas within urgent and emergency care, maternity care and medicine services. The CQC also found a lack of adequate assurance that there was an effective process for overseeing and monitoring compliance with infection control procedures.

The CCGs recognise that the Trust implemented a comprehensive improvement plan, progress of which has been reported to the contract and quality meetings on a quarterly basis.

However, the CCGs are concerned that there has been an increase in infection control issues within the Trust despite the completion of the CQC improvement plan.

Quality and Safety

It is disappointing to note that there has been an increase in a number of areas relating to safety:

1. Following a long period without MRSA Bacteraemia infections, the Trust has reported four cases in the last quarter. In line with national guidance of acute trusts to have zero tolerance of MRSA bacteraemia, the CCGs have taken contractual action to support the Trust to learn from these outbreaks and to ensure safe care for patients.

   MCHFT has identified learning for all four cases and has developed comprehensive improvement plans for implementation across the Trust and workforce. The Trust has continued to take responsibility and be accountable for continuous quality improvement in relation to infection prevention and control, and this is reflected in the Quality Account.

2. The CCG acknowledge that the Trust has been working to reduce the incidence of serious harm. This has resulted in a target to reduce the numbers of Serious Incidents (SI). The CCGs have worked with the Trust to highlight that numbers of SIs alone should not be a performance target. This is to encourage the reporting of incidents and a robust learning culture.

3. Despite a target to reduce the numbers of pressure ulcers, the Trust has seen an increase in the number of hospital acquired and community acquired pressure ulcers.

   The CCGs recognise and acknowledge the positive work that has been undertaken to date which is described in the Quality Account.

   The CCGs have raised with the Trust that in line with the NHS Improvement Pressure Ulcer Guidance 2018, the new definitions of Pressure Ulcers should be used and the language of 'avoidable' and 'unavoidable' should not be used.

   MCHFT and the Central Cheshire Integrated Partnership (CCICP) have committed to work with the CCG and local partners and we look forward to working together in 2019/20 to improve the occurrence of pressure ulcers across the health economy.

The CCGs would like to recognise the following:

1. The Trust participation in a Health Economy approach to reduce Gram negative bacteraemia infections, specifically ECOLI. This group is led by the CCGs and MCHFT has contributed significantly to the analysis of data, this has enabled the multi-agency steering group to

identify an improvement plan which has resulted in a reduction of infections in this health economy.

2. The positive work to reduce the numbers of inpatient falls which has seen a slight reduction since 2015.

3. The work to recognise the deteriorating patient and improve screening and treatment for Sepsis, which the Trust has also acknowledged in their Celebration of Achievement Awards.

4. The CCGs note that there was one Never Event in 2018, however the Trust has demonstrated an open and honest approach and a robust learning culture in its management of the case.

As commissioners of the services, the CCGs support the work of MCHFT and the on-going commitment to continue to improve the quality and safety of all of their services. We look forward to working with the Trust as they work towards their priorities for 2019-20.

Healthwatch Cheshire CIC Response to Quality Account 2018/19

We recognise that there have been significant challenges for the Trust during 2018/2019 and value the relationship that Healthwatch Cheshire CIC and the Trust have, as noted in this document. We have noted and welcome the extensive use of patient surveys. The improvement in the National Inpatient Survey for 2018 compared to 2017 and the large increase in compliments received by the Trust is to be commended.

We look forward to continue working with the Trust during 2019-2020 to enable our community to have a powerful voice helping to shape and improve these services for the future".

Healthwatch Cheshire CIC
April 2019

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

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

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

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

- the content of the Quality Report meets the requirements set out in the NHS foundation Trust annual reporting manual 2018/19 and supporting guidance detailed requirements for quality reports 2018/19

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

    - board minutes and papers reported to the board over the period 1 April 2018 to 31 March 2019
    - papers relating to the quality reported to the board over the period 1 April 2018 to 31 March 2019
    - feedback from commissioners dated 09.04.18
    - feedback from governors dated 25.04.19
    - feedback from local Healthwatch organisations dated 11.04.19
    - feedback from Overview and Scrutiny Committee dated 14.05.2018
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 15.05.2017
    - the (latest) national patient survey 01.07.2018-31.07.8
    - the (latest) national staff survey 01.04.19
    - the Head of Internal Audit's annual opinion of the Trust's control environment dated 15.05.2018
    - CQC report relating to inspection dated 20.03.18 – 10.05.18

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

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

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

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

- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts

regulations) as well as the standards to support data quality for the preparation of the Quality report.

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

By order of the board

……Date……Chairman

……Date……Chief Executive

Appendix 1 - Glossary and abbreviations

Terms	Abbreviation	Description
Acute Kidney Injury	AKI	A sudden episode of kidney failure or kidney damage that happens within a few hours or a few days. AKI causes a build-up of waste products in the blood, making it hard for the kidneys to keep the right balance of fluid in the body.
Advancing Quality	AQ	A programme which rewards hospitals which improve care in a number of key areas – heart attacks, pneumonia, hip and knee replacements, heart failure and heart bypass surgery – when compared to research which identifies what best care constitutes.
Advancing Quality Alliance	AQuA	A north west NHS health and care quality improvement organisation.
Antimicrobial resistance & stewardship		A coordinated program that promotes the appropriate use of antimicrobials, improves patient outcomes, reduces microbial resistance and decreases the spread of infections caused by multidrug-resistant organisms.
Board (of Trust)		The role of Trust's board is to take corporate responsibility for the organisation's strategies and actions. The chair and non-executive directors are lay people drawn from the local community and are accountable to the Secretary of State. The chief executive is responsible for ensuring that the board is empowered to govern the organisation and to deliver its objectives.
Care Quality Commission	CQC	The independent regulator of health and social care in England. Its aim is to make sure better care is provided for everyone, whether in hospital, in care homes, in people's own homes, or elsewhere.
Central Cheshire Integrated Care Partnership	CCICP	A collaboration between Mid Cheshire Hospital Foundation NHS Trust and the South Cheshire and Vale Royal GP Alliance.
Clinical Commissioning Group	CCG	This is the GP led commissioning body who buy services from providers of care such as the hospital.
Clostridium Difficile	C-diff	A naturally occurring bacterium that does not cause any problems in healthy people. However, some antibiotics that are used to treat other health conditions can interfere with the balance of 'good' bacteria in the gut. When this happens, C-diff bacteria can multiply and cause symptoms such as diarrhoea and fever.
Commissioner		A person or body who buy services.

Terms	Abbreviation	Description
Commissioning for Quality and Innovations	CQUIN	CQUIN is a payment framework developed to ensure that a proportion of a providers' income is determined by their work towards quality and innovation.
Deprivation of Liberty Safeguards	DOLs	The Mental Capacity Act allows restraint and restrictions to be used but only in a person's best interest. Extra safeguards are needed if the restrictions and restraints used will deprive a person of their liberty. These are called the Deprivation of Liberty Safeguards.
Duty of Candour		A legal duty to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. It aims to help patients receive accurate truthful information from health providers.
Endoscopy		A nonsurgical procedure used to examine a person's digestive tract using an endoscope – a flexible tube with a light and camera attached to it.
Health Service Ombudsman		The role of the Health Service Ombudsman is to provide a service to the public by undertaking independent investigations into complaints where the NHS in England have not acted properly or fairly or have provided a poor service.
Hospital Evaluation Data	HED	This is an on-line solution delivering information which enables healthcare organisations to drive clinical performance in order to improve patient care and deliver financial savings
Intrahepatic Cholestasis		A condition that impairs the release of a digestive fluid called bile from liver cells. As a result, bile builds up in the liver, impairing liver function.
John's campaign		A campaign for extended visiting rights for family carers of patients with dementia in hospital.
Methicillin-Resistant Staphylococcus Aureus	MRSA	Staphylococcus aureus is a bacterium which is often found on the skin and in the nose of about 3 in 10 healthy people. An infection occurs when the bacterium enters the body through a break in the skin. A strain of this bacterium has become resistant to antibiotic treatment and this is often referred to as MRSA.
National Joint Registry		Set up by the Department of Health and Welsh Government in 2002 to collect information on all hip, knee, ankle, elbow and shoulder replacement operations and to monitor the performance of joint replacement implants and effectiveness of different types of surgery.

Terms	Abbreviation	Description
National Patient Surveys		Co-ordinated by the CQC, they gather feedback from patients on different aspects of their experience of care they have recently received, across a variety of services/settings: Inpatients, Outpatients, Emergency care, Maternity care, Mental Health services, Primary Care services and Ambulance services.
National Safety Standards for Invasive Procedures	NatSSIPs	A set of national safety standards to support NHS hospitals to provide safer surgical care.
Nephrotoxic		Damage to the kidneys
Never Event		Serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented.
Oncology		The study of cancer. An oncologist manages a person's care and treatment once he/she is diagnosed with cancer.
Patient Reported Outcome Measures	PROMs	A programme in which patients complete a questionnaire on their health before and after their operation. The results of the two questionnaires can be compared to see if the operation has improved the health of the patient. Any improvement is measured from the patient's perspective as opposed to the clinicians.
Percutaneous Nephrolithotomy		A minimally invasive procedure to remove stones from the kidney by a small puncture wound through the skin.
Preceptorship		A period transition for newly qualified nurses during which time they are supported by a mentor.
Quality Account		This is a statutory annual report of quality which provides assurance to external bodies that the Trust Board has assessed quality across the totality of services and is driving continuous improvement.
Re-admission Rates		A measure to compare hospitals which looks at the rate at which patients need to be readmitted to hospital after being discharged (leaving hospital).
Sepsis		A life threatening condition that arises when the body's response to an infection injuries its own tissue and organs.
Sign up to Safety		A national initiative to help NHS organisations and their staff achieve their patient safety aspirations and care for their patients in the safest possible way.

Terms	Abbreviation	Description
Sigmoidoscopy		A minimally invasive medical examination of the large intestine from the rectum using an instrument called a sigmoidoscope.
Submucosal tie		The posterior tongue-tie, hidden under the mucus lining of the tongue/mouth.
Summary Hospital level Mortality Indicator	SHMI	SHMI is a hospital level indicator which measures whether mortality associated with hospitalisation was in line with expectations. The SHMI value is the ratio of observed deaths in a Trust over a period of time divided by the expected number given the characteristics of patients treated by that Trust Depending on the SHMI value, Trusts are banded between 1 and 3 to indicate whether their SHMI is low (3), average (2) or high (1) compared to other Trusts. SHMI is not an absolute measure of quality. However, it is a useful indicator for supporting organisations to ensure they properly understand their mortality rates across each and every service line they provide.
To Take Out	TTO	Medication given to patient on discharge from hospital.
Venous Thrombo-Embolism	VTE	This is a blood clot which can develop when a person may not be as mobile as they are usually or following surgery. The blood clot itself is not usually life threatening, but if it comes loose it can be carried in the blood to another part of the body where it can cause problems – this is called a Venous Thromboembolism (VTE).
Workforce Race Equality Standards		Standards to ensure the Trust addresses race equality issues.

Appendix 2 - Feedback form

We hope you have found this Quality Account useful. To save costs, the report is available on our website and hard copies are available on request.

We would be grateful if you would take the time to complete this feedback form and return it to:
Clinical Quality and Outcomes Matron
Mid Cheshire Hospitals NHS Foundation Trust
Leighton Hospital
Middlewich Road
Crewe
Cheshire
CW1 4QJ
Email: quality.accounts@mcht.nhs.uk

How useful did you find this report?

Very useful □
Quite useful □
Not very useful □

Did you find the contents?

Too simplistic □
About right □
Too complicated □

Is the presentation of data clearly labelled?

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

If no, what would have helped?

_____
_____

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

_____
_____
_____

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

Title of Paper:	Report of Use of the Trust Seal	
Author:	Katharine Dowson	
Executive Lead:	Dr Paul Dodds	
Type of Report:	Concept Paper	
	Strategic Options Paper	
	Business Case	
	Information	X
	Review/Benefits/Audit	

Link to Strategic Domains:		***Link to Domain:***	
Delivering Outstanding Clinical Quality, Safety & Experience		Safe	
Being a Leading partner in a Progressive Health Economy		Effective	
Striving for Outstanding Organisational Effectiveness	X	Caring	
Aspiring to Excellence in Practice Through Our Workforce		Responsive	
Creating a 21st Century Infrastructure for Transformative Health and Social Care		Well-Led	X

Link to Board Responsibility:	Performance	
	Accountability	X
	Strategy	
	Implementation	
Action Required:	Decide	
	Approve	X
	Note	
	Recommend	
	Delegate	

Positive Benefit:	Board oversight of the use of the Trust Seal
Risk:	Non-compliance with Trust Constitution

To be published on Trust Website –complete version	***Y*** *(delete as appropriate)*
If no, to be published on Trust Website – redacted	***N*** *(delete as appropriate)*
If not to be published complete or redacted, please detail the reason why	
Presented at Board Meeting of:	7 May 2019

Recommendation

The Board of Directors are asked to note the sealings that have taken place since the last Board report. The Board received a verbal update in November 2018 that no sealings had taken place since the last report in May 2018. This report notes subsequent sealings up to 30 April 2019 as required by the Trust Constitution.

Quarterly Report of Sealings for the period 1 November 2018 to 30 April 2019

Seal Number	***Description***	***Date of Board Approval***	***Date of Sealing***
96	Agreement of lease between MCHFT and University Hospitals of North Midlands NHS Trust for rooms at Leighton Hospital.	4 February 2019	5 February 2019
97	Transfer of title deeds to Mid Cheshire Hospitals Charity as beneficiaries.	1 April 2019	1 April 2019
98	Lease renewal between Cheshire East Council and MCHFT for a room within the Chapel area.	1 April 2019	28 March 2019*
99	Tenancy at will with Virgin Care Services for premises at Victoria Infirmary, Northwich.	1 April 2019	28 March 2019*
100	Tenancy at will with the Stroke Association for premises at Leighton Hospital.	1 April 2019	28 March 2019*

Title of Paper:	NHSI Self-Certification 2019	
Author:	Katharine Dowson	
Executive Lead:	Paul Dodds	
Type of Report:	Concept Paper	
	Strategic Options Paper	
	Business Case	
	Information	*
	Review/Benefits/Audit	

Link to Strategic Domains:		***Link to Domain:***	
Delivering Outstanding Clinical Quality, Safety & Experience		Safe	
Being a Leading partner in a Progressive Health Economy	X	Effective	
Striving for Outstanding Organisational Effectiveness	X	Caring	
Aspiring to Excellence in Practice Through Our Workforce		Responsive	
Creating a 21st Century Infrastructure for Transformative Health and Social Care		Well-Led	X

Link to Board Responsibility:	Performance	X
	Accountability	X
	Strategy	X
	Implementation	X
Action Required:	Decide	X
	Approve	X
	Note	
	Recommend	
	Delegate	

Positive Benefit:	Positive Self-Certification
Risk:	Not complying with requirement for self-certification from NHSI

To be published on Trust Website –complete version	***Y***
If no, to be published on Trust Website – redacted	**N/A**
If not to be published complete or redacted, please detail the reason why	
Presented at Board Meeting of:	**7 May 2019**

Background:

Historically, NHS Foundation Trusts have been required to make the below declarations to NHSI on an annual basis based on a self-certification. However; no such submissions are now required and instead NHSI will select a number of Trusts and audit their processes for making such declarations. On that basis, the process for enabling the Board to make such a declaration has remained the same as in previous years.

NHS providers need to self-certify the following conditions after the financial year end:

1. Condition G6(3): The provider has taken all precautions to comply with the licence, NHS acts and NHS Constitution. (Appendix 2)

2. Condition G6(4): Publication of the above G6(3) self-certification.

3. Condition FT4 (8): The provider has complied with required governance arrangements – Corporate Governance Statement (Appendix 3)

4. Condition CoS7 (3): The provider has a reasonable expectation that required resources will be available to deliver the designated services for the 12 months from the date of the statement. This only applies to foundation trusts that are providers of Commissioner Requested Services (CRS). (Appendix 2)
5. Training of Governors: The provider has reviewed whether their Governors have received enough training and guidance to carry out their roles. (Appendix 4)

Introduction:

The Board of Directors are asked to review the guidance pertaining to the above declarations and respond to the statements in the worksheets and evidence shown at appendix 2, 3 & 4 as ‘Confirmed’ or ‘Not Confirmed’. Condition G6 and CoS7 are contained within the same declaration. In order to support the declaration being made further guidance to that given in the worksheets is provided at appendix 1.

In the event that the Board of Directors are unable to fully self-certify, it should NOT select 'Confirmed’. Under these circumstances a commentary explaining the reasons for the absence of a full self-certification and the action proposed to address the issues identified.

Recommendation:

The Chairman and Interim Chief Executive, on behalf of the Board of Directors, are recommended to sign the enclosed declarations as ‘Confirmed’

Appendix 1: Further guidance for the declarations

Declarations on Condition G6 – Systems for compliance with licence conditions and related obligations

1. The Licensee shall take all reasonable precautions against the risk of failure to comply with:

(a) the Conditions of this Licence,
(b) any requirements imposed on it under the NHS Acts, and
(c) the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.

2. Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include:

(a) the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and
(b) regular review of whether those processes and systems have been implemented and of their effectiveness.

3. Not later than two months from the end of each Financial Year, the Licensee shall prepare and submit to NHSI a certificate to the effect that, following a review for the purpose of paragraph 2(b) the Directors of the Licensee are or are not satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with this Condition.

4. The Licensee shall publish each certificate submitted for the purpose of this Condition within one month of its submission to NHSI in such manner as is likely to bring it to the attention of such persons who reasonably can be expected to have an interest in it.

Declarations on Condition FT4 (8), Corporate Governance

For declarations 1 - 6 the following guidance is taken from the NHS Provider Licence Conditions specific to Section 6 – Condition FT4 – NHS foundation trust governance arrangements:

1. This condition shall apply if the Licensee is an NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.

2. The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.

3. Without prejudice to the generality of paragraph 2 and to the generality of General Condition 5 (NHSI Guidance), the Licensee shall:

(a) have regard to such guidance on good corporate governance as may be issued by NHSI from time to time; and
(b) comply with the following paragraphs of this Condition.

4. The Licensee shall establish and implement:

(a) effective board and committee structures;
(b) clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and
(c) clear reporting lines and accountabilities throughout its organisation.

5. The Licensee shall establish and effectively implement systems and/or processes:

(a) to ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;

(b) for timely and effective scrutiny and oversight by the Board of the Licensee's operations;
(c) to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;
(d) for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);
(e) to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;
(f) to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;
(g) to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and
(h) to ensure compliance with all applicable legal requirements.

6. The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure:

(a) that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;
(b) that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;
(c) the collection of accurate, comprehensive, timely and up to date information on quality of care;
(d) that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;
(e) that the Licensee including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and
(f) that there is clear accountability for quality of care throughout the Licensee's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

7. The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licensee's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.

8. The Licensee shall submit to NHSI within three months of the end of each financial year:
(a) a corporate governance statement by and on behalf of its Board confirming compliance with this Condition as at the date of the statement and anticipated compliance with this Condition for the next financial year, specifying any risks to compliance with this Condition in the next financial year and any actions it proposes to take to manage such risks; and
(b) if required in writing by NHSI, a statement from its auditors either:
(i) confirming that, in their view, after making reasonable enquiries, the Licensee has taken all the actions set out in its corporate governance statement applicable to the past financial year, or
(ii) setting out the areas where, in their view, after making reasonable enquiries, the Licensee has failed to take the actions set out in its corporate governance statement applicable to the past financial year.

Katharine Dowson
Trust Board
Secretary
May 2019

Appendix 2 Worksheet "G6 & CoS7"

Financial Year to which self-certification relates **2018/19**

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed	OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	Confirmed	Please fill details in cell E22

OR

3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.		Please Respond

OR

3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.		Please Respond

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

[e.g. key risks to delivery of CRS, assets or subcontractors required to deliver CRS, etc.]

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Dr Paul Dodds	**Name**	Dennis Dunn
Capacity	Interim Chief Executive	**Capacity**	Chairman
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

Not Applicable.

Appendix 3 Worksheet "FT4 declaration" and Governors Training

Financial Year to which self-certification relates

2018/19

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	Independent External and Internal Auditors appointed to ensure appropriate internal controls and reporting CQC inspection (2018) rated as Good in Well Led NHS Counter Fraud Inspection in 2018 (passed with no major areas of concern)
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	Has completed an internal review against the revised Well Led Framework in the last 12 months including external review of areas where the Trust had identified areas for improvement. Conducted an external well led review in 2017. NHS England Conflicts of Interest guidance (2018) implemented in full
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	Corporate Governance Handbook outlines this process and is reviewed annually. External review of this in 2015 , recommendations implemented.
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	Use of Resources (2018) review rated as Good. CQC Well Led rated as Good (2018) External Audit opinion given annually Internal Audit programme and opinion annually Annual Report & Accounts issued annually detailing compliance incorporating the Annual Governance Statement on internal controls and the approach to risk.
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	Director of Nursing and Quality leads on Quality. Quality Account issued annually as part of the Annual Report & Accounts detailing the Trust approach to quality and the results achieved. Consultation completed on the Quality & Safety Improvement Plan in 2018 prior to relaunch in 2019.
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	Board recruitment and sucession planning is the remit of the Remuneration and Appointments Committee (for Executives) and Nominations & Remuneration Committee (for the Chair and Non-Executive Directors. All Board members are subject to a rigourous recruitment process and complete a Fit and Proper Persons Declaration which is reviewed annually.

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature _____

Name Dr Paul Dodds

Signature _____

Name Dennis Dunn

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A: Not Applicable

Worksheet "Training of governors"

Financial Year to which self-certification relates 2018/19 Please Respond

Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

Training of Governors

1	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Confirmed	OK

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Dr Paul Dodds	**Name**	Dennis Dunn
Capacity	Interim Chief Executive	**Capacity**	Chairman
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

A

Appendix 4 Governor Training 2018-19

All Governors were invited to meet with the Chairman on a 1to1 basis in autumn 2018 to discuss their role and any training and development needs to fulfil this role. There were no specific requests for training as a result of this, but a number of Governors expressed their interest in attending events provided locally and by Governwell (NHS Providers). The following events were attended by individual Governors in 2018/19.

- NHS Providers National Governor Forum, May 2018 – 1 Governor
- NW Governors Forum – 2 Governors

Following the annual self-assessment of Governors in July 2018, two training needs were identified, one was a general refresh of statutory skills and the role of the Governor which was incorporated into the October Council of Governors meeting. The other is Equality and Diversity which has been planned and will take place in 2019/20.

There were four new Governors in 2018/19 who all received an induction session alongside an assessment of their skills and knowledge.

To engage with Members and the public, Governors must feel confident in their knowledge of the Trust and the local health economy. To support this there has been ongoing learning through:

- Presentations at Council meetings by Executive Directors and invited speakers, for example Transformation, Annual Report & Accounts and the national in-patient and staff surveys
- Attendance at staff and members engagement events hosted by the Chief Executive
- Being the Governor representative on Trust Committees (Governors are invited to meet with the Chair of the Committee so they have a full understanding of the role of the Committee and their role and remit as part of the Committee membership)
- Monthly Ward/Department Walkrounds with members of the Board of Directors and Patient Safety Team
- Regular bi-monthly membership events on particular areas of the hospital including Winter Pressures, Paediatrics, Simulation Training and Diabetes

There has also been shared learning through distribution of items such as the NHS Providers Briefings on a range of topics.

Katharine Dowson
Trust Board Secretary
May 2019

We Care Because You Matter

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

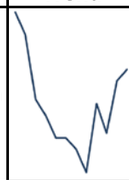
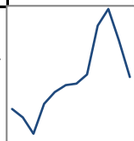
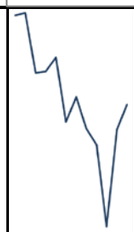
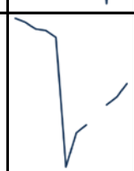
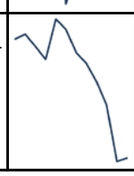
Board of Directors

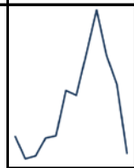
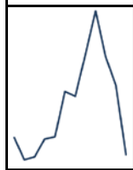
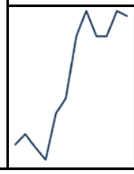
Workforce Report

May 2019

(March 2019 data)

Performance Report Workforce Chapter
Month: Mar-19

Measure	Target	Performance	Description	Narrative	Rolling Trend	Trend	C&W Average
Sickness Absence	3.40%	4.33%	Rolling 12m average Sickness Absence described as a Percentage	The rolling position declined slightly (+0.01%) from the previous month but remains Amber. DC, EF and CCICP all improved their rolling position. Corporate is currently Green and meeting the divisional target and DCSS, WC and CCICP are Amber. MEC, EF and SC are Red (5.31%, 4.83%, 4.70%)		↑	**4.92%**
In-Month Sickness Absence	N/A	4.41%	In-month 12m average Sickness Absence described as a Percentage	The in-month position improved from the previous month (-0.56%). All divisions experienced reduced sickness absence levels with the exception of WC (+0.01%)		↓	**4.88%**
Appraisal Rate	90.00%	82.25%	Percentage of Staff who have received an appraisal in the last 12 months. Excludes New Staff with less than 12m service and Bank Staff	Overall, there was a 0.88% improvement in the appraisal rates across the Trust. All divisions with the exception of Corporate and SC experienced an improvement in compliance, the most significant being EF (+5.04%). CCICP are now Green and the remaining divisions are Amber with the exception of Corporate and MEC who are Red (76.40% and 65.34%)		↑	**89.35%**
Mandatory Training	90.00%	76.21%	Mandatory Training Monthly Rate Excludes Bank Staff, Staff on long term sick & mat. leave.	Training compliance increased by1.22% in month. WC are Amber at 85.83%. Other divisions remain Red. MEC are the most challenged by this target (68.91%)		↑	**88.43%**
Staff Turnover	10.00%	9.94%	Number of Leavers expressed as a percentage of the workforce over a 12m rolling period. Exclude Junior Doctors, Temporary and Fixed term.	The rolling position for turnover declined slightly in month (-0.01%). Turnover reduced in Corporate, DC, EF, WC and CCICP . All divisions are Green against targe with the exception of MEC and CCICP (13.56% and 11.17%)		↑	**10.74%**

Measure	Target	Performance	Description	Narrative	Rolling Trend		
Agency Spend	(367)	(331)	In month and cumulative total spend for the Trust.	Agency spend reduced in month (£253k less than the previous month) and the agency spend target and NHSI ceiling target were both met. Nurse agency reducedsignificantly from last month (-£316k . All divisions reduced their agency spend with the exception of CCICP (+£9k) and WC (+10k).		↓	N/A
NHSI Ceiling	less than 100%	90.19%	Trust Agency Spend as a percentage of the Ceiling Set by NHS Improvement			↓	N/A
Over Cap Rates	N/A	65.99%	Number of Agency shifts filled by agency staff that are over the nationally determined capped rates				N/A

Key

Adverse Increase	↑
Positive Increase	↑
Adverse Reduction	↓
Positive Reduction	↓
Neutral Change/ No Change	↑↓=

Mid Cheshire Hospital
NHS Foundation Tru

Board of Directors Performance Report

March 2019

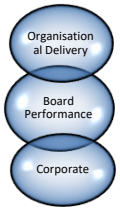
"To Deliver Excellence in Healthcare through Innovation & Collaboration"

Introduction

Performance Report

The MCHT Monthly Performance Report has been developed to integrate key domains of Quality and Safety, Performance and Corporate into one consistently presented report. It has been developed to provide an over arching view of performance against Trust priorities as set out in the NHS Improvement Compliance Framework, NHS Operating Framework, CCG CQuIN and Annual Plan.

The Monthly Performance Report will focus upon delivery of service improvements within 3 key domains:



The delivery of the service improvements within the 3 key domains are also reflected in the Board Assurance Framework which identifies where the organisation has insufficient assurance in delivering the strategic objectives of the organisation.
Within this Performance Report the indicators within each domain are presented on a summary page with the current month and year to date performance given. All indicators are measured against a NHS Improvement, national, peer or locally agreed target. A further analysis of all measures within each domain is then provided with supporting trend information and narrative. Performance against each indicator is rated as either red/green against the year to date or single month/quarter target as appropriate. Supporting narrative is provided on an exception basis.

This report is an evolving summary of overall Trust Performance, therefore measures, targets and reporting periods will be refined over time. A supporting and more detailed quality and safety report will be presented separately. This is also under further review.

Tracy Bullock
Chief Executive

Contents

Headline Measures

Organisational Delivery				
Indicator	**Standard**	**YTD**	**Mar-19**	
Cancer				
Rapid Access Referrals (%) *(seen in 2 wks)*	93.00%	97.13%	97.69%	
Total Patients Seen		*10,629*	*996*	
Patients seen >14 days		*305*	*23*	
62 day GP Classic (%)	85.00%	88.98%	85.22%	*
Accountable Patients Treated		*758*	*58*	
No. of Breached Pathways (adjusted)		*84*	*9*	
62 day Screening (%)	90.00%	94.44%	95.00%	*
Accountable Patients Treated		*153*	*10*	
No. of Breached Pathways (adjusted)		*9*	*0.5*	
Unplanned Activity				
4 Hour Access Standard (%)	95.00%	83.63%	80.41%	
A&E Attendances (LH/MIU/UUC) (% to plan)		97.12%	95.43%	
A&E Attendances LH & MIU (Vol)		*92,292*	*8,034*	
Planned Activity				
Incomp Pathways <18wk (%)	92.00%	92.38%	90.62%	
>6wk Diagnostic Waits (%)	1.00%	0.41%	0.76%	
Total Patients Waiting for a First Outpatient Appointment			9,682	

** Provisional figures subject to change depending on further validation or treatment outcome*

Indicator	**Standard**	**YTD**
Workforce		
Sickness absence Rolling 12 Month		4.33%
Turnover Rolling 12 Month		9.94%

Corporate					
	YTD Rating		YE Rating	YE Metric	
Indicator	**Plan**	**Actual**	**Forecast**	**Plan**	**Forecast**
Finance					
Use of Resource Rating		2	2		
Capital Service Capacity	2	2	2	2.39	1.77
Liquidity	2	3	3	-1	-7
I&E Margin	1	2	2	2.10%	0.40%
Distance from Financial Plan	0	3	3	0.00%	-1.70%
Agency Spend	1	2	2	-23.27%	6.44%

	YTD Target	**YTD Actual**	**YTD Variance**	**FY Target**	**FY Forecast**	**FY Variance**
Cost Improvement Schemes Total (£000's)	6,772	5,460	-1,102	6,772	5,610	-1,163
Commission Contact Income SC & VR (£000's)	189,707	189,942	235			
Contract Income (£'000)	228,702	229,011	307			
Pay to Budget (£000's)	-171,990	-175,495	-3,505			
Non Pay to Budget (£000's)	-68,615	-72,187	-3,572			
Agency Trajectory (£000's)	-4,382	-6,073	-1,691			

Exec Summary

In March 2019, the Trust delivered three of the five NHS Improvement Single Oversight Framework performance indicators (62 Day GP Classic, Rapid Access referrals and 62 Day Screening). The indicators not achieved were the 4 hour Access standard and the RTT Incomplete Pathway standard.

To note the RTT Incomplete Pathway performance is an interim figure as validation of pathways continue until the monthly statutory submission deadline.

The 4 hour Access Standard in March achieved 80.41% against the 95% performance standard.

The Trust has achieved all three headline cancer access standards for March.

Diagnostics waiting times continue to perform well, with just 0.76% of patients waiting longer than 6 weeks for their diagnostic test against a regulatory threshold of 1%.

The UoRR metric is 3, primarily a consequence of the override resulting from the impact of the Trust's ability to service DH loans from revenues and depreciation.

The Trusts' I&E position, before exceptional items is a surplus of £0.94M which is £4.3M worse than the planned surplus of £5.243M, with the position including £4.5M of the MOU with South/Vale Royal CCGs, which has now been settled and agreed.

This position includes the PSF earned to date for meeting the control total for the first three quarters (£3.835M), and also year end PSF shared out (£3.6M) which offsets the loss associated with missing the A&E target all year and the financial control total for the final quarter.

There is a variation in the CIP scheme, with challenges around delivering improvements to sickness rates within nursing and maintaining the medical vacancy factor.

The Trust has spent £6.1M on agency during 1819, which is £0.1M below the ceiling limit set by NHSI.

Single Oversight Framework

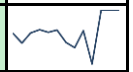
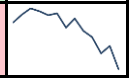
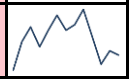
Triggers

Operational	For providers with Sustainability and Transformation Fund (STF) trajectories in any metric: failure to meet the trajectory for this metric for at least two consecutive months (quarterly for quarterly metrics), except where the provider is meeting the NHS Constitution standard.
Finance & Resource	Poor levels of overall financial performance (avg score of 3 or 4). Very poor performance (score of 4) in any individual metric. Potential value for money concerns.

The Trust's operational trigger rating continues as RED as a result of failure of a primary target during the year (A&E 95% 4 hour Access Standard).

The Trust has achieved a Use of Resource rating of 3, which is expected to improve during 2018/19, although, is at risk due to the deteriorating financial position. This results in a 'trigger' on the Finance & Resource theme. This is primarily driven by the capital service capacity metric which will improve when short term loans required to support liquidity are repaid in the year. Based on the settlement of the MOU, it is expected that whilst there will be a further deterioration of some of the metrics as indicated – the Trust should maintain its overall Use of Resources Rating of 3.

Operational Performance

	Current YTD													Monthly Trend
	Target	Actual	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	
Maximum 6 week wait for Diagnostic procedures	1%	0.41%	0.33%	0.26%	0.17%	0.32%	0.56%	0.31%	0.44%	0.48%	0.17%	0.54%	0.47%	0.42%	0.76%	
All Cancers: 62 day GP Classic (%) *	85%	88.98%	94.06%	87.13%	92.91%	92.00%	91.40%	91.78%	86.11%	86.50%	93.40%	86.90%	85.83%	85.84%	85.22%	
All Cancers: 62 day Screening (%) *	90%	94.44%	100.00%	100.00%	89.47%	91.67%	100.00%	91.84%	100.00%	100.00%	100.00%	81.80%	87.50%	100.00%	95.00%	
18 weeks from point of referral to treatment - patients on an incomplete pathway (%)	92%	92.38%	92.65%	93.00%	93.27%	93.14%	92.97%	93.05%	92.43%	92.82%	92.28%	92.01%	91.30%	91.63%	90.62%	
A&E - maximum waiting time of 4 hours from arrival to admission/transfer/discharge (%)	95%	83.63%	77.90%	82.65%	85.15%	81.78%	84.59%	87.14%	84.61%	85.51%	88.13%	83.57%	78.89%	81.12%	80.41%	
STF Trajectory			95.00%	92.72%	92.72%	92.72%	93.92%	93.92%	93.92%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	
Provider Submitted Trajectory														88.12%	95.00%	

** Provisional figures subject to change depending on further validation or treatment outcome*

Financial & Resource

		Unit	YE Plan	YE Forecast	YE Rating	YTD Plan	YTD Actual	YTD Rating
Financial Sustainability	Capital Service Capacity	0.0x	2.39	1.77	2	2.39	1.77	2
	Liquidity	days	-1	-7	3	-1	-7	3
Financial Efficiency	I&E Margin	%	2.10%	0.40%	2	2.10%	0.40%	2
Financial Controls	Distance from Financial Plan	%	0.00%	-1.70%	3	0.00%	-1.70%	3
	Agency Spend	%	-23.27%	6.44%	2	-23.27%	6.44%	2
Overall UOR Rating					2			2

Operational Delivery: *Cancer Pathway*

Headline Measures

	Current YTD		Rolling 13 months											
	Target	Actual	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Monthly Trend
Rapid Access Referrals (%) (seen in 2 wks)	93%	97.13%	98.64%	96.08%	96.76%	97.54%	96.37%	96.73%	96.50%	96.87%	98.36%	97.78%	96.91%	97.66%	97.69%	
Total Patients Seen		*10629*	*811*	*766*	*956*	*855*	*855*	*887*	*771*	*989*	*917*	*855*	*842*	*940*	*996*	
Patients seen >14 days		*305*	*11*	*30*	*31*	*21*	*31*	*29*	*27*	*31*	*15*	*19*	*26*	*22*	*23*	
% seen within 7 days		*39.5%*	*61.2%*	*45.2%*	*39.6%*	*43.7%*	*44.4%*	*35.2%*	*51.4%*	*41.5%*	*34.0%*	*35.4%*	*38.6%*	*38.1%*	*30.5%*	
62 day GP Classic (%) *	85%	88.98%	94.06%	87.13%	92.91%	92.00%	91.40%	91.78%	86.11%	86.50%	93.40%	86.90%	85.83%	85.84%	85.22%	

** Provisional figures subject to change depending*

104+ day waits - (Cancer patients treated)	3	1	1	0	1	0	4	0	0	3	0	1	3

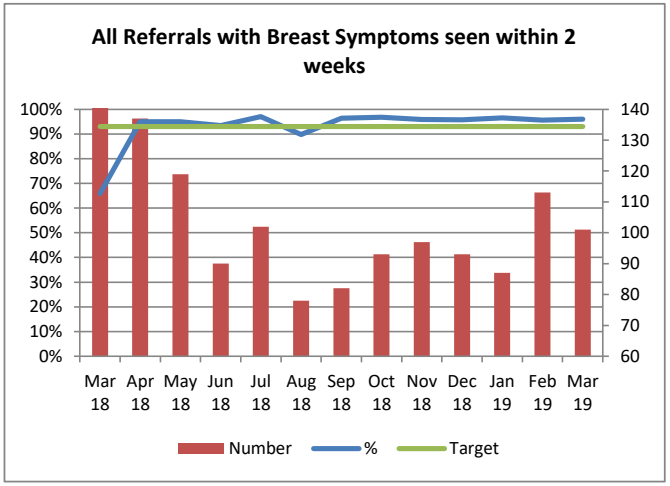
Commentary

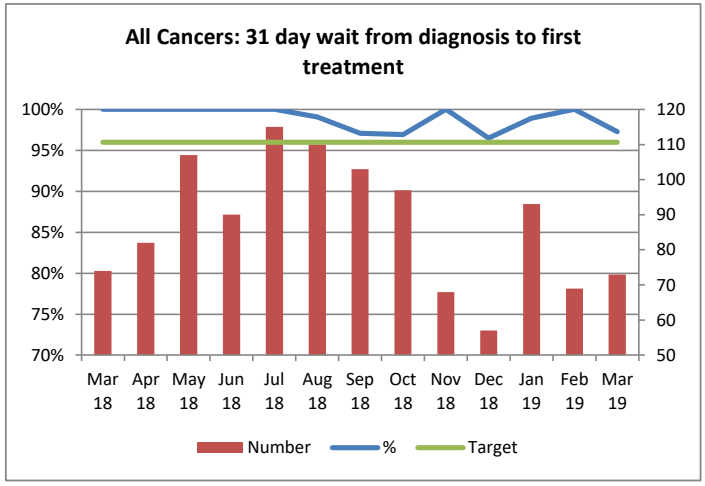
The Trust has achieved all three headline cancer standards during the month of March 2019. The figures presented in this paper reflect the Trust's regulatory performance measures adjusted figures that take into account breach reallocation between providers). From October 2018 the new cancer repatriation policy is in use.

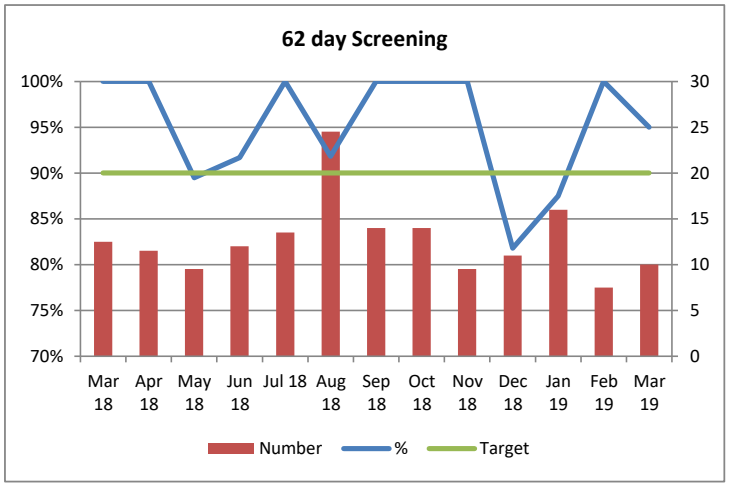
The Trust has continued it's strong performance against the Rapid Access referrals standard, achieving 97.69% for March, despite a 6% increase in referrals compared to the previous month. The 62 Day GP Classic standard has achieved 85.22% against an 85% target.

There were three recorded long wait (104 days and over) for patients on a 62 day cancer pathway in March.

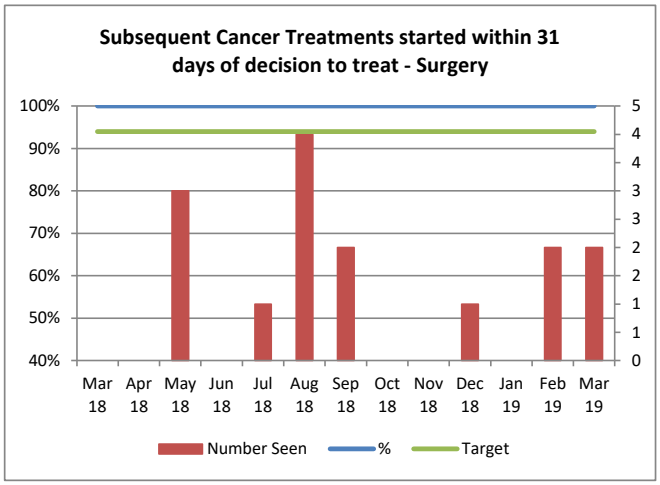
Primary Measures

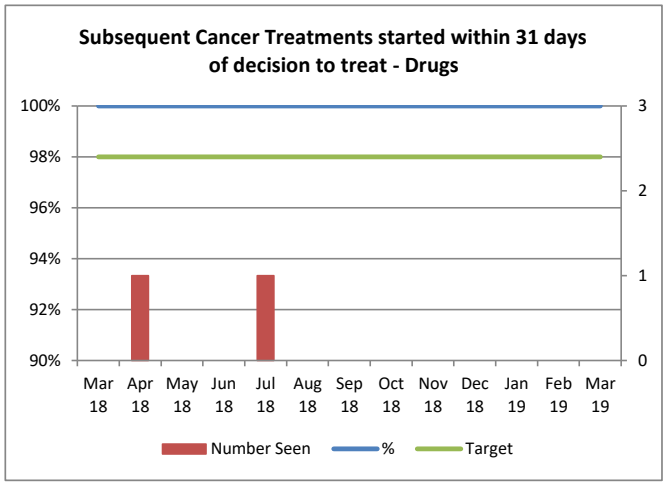


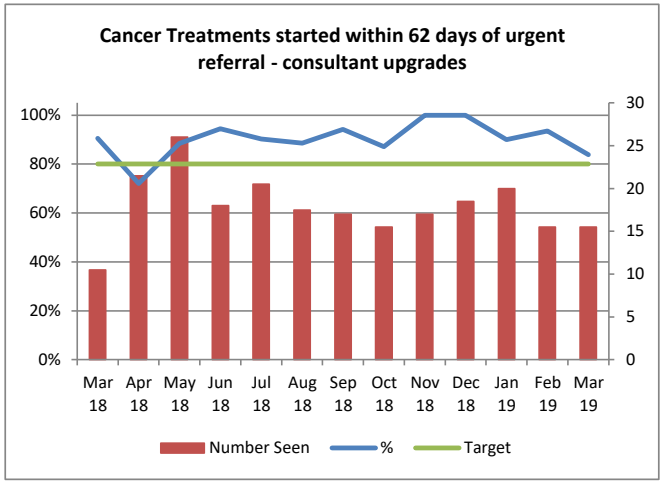




Operational Delivery: *Cancer Pathway*







Operational Delivery: *Unplanned Activity - A&E*

Headline Measures

	Current YTD		Rolling 13 months												
	Target	Actual	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Monthly Trend
A&E - >4 hr wait time from arrival to admission/ transfer/ discharge (% to Target)	95%	83.63%	77.90%	82.65%	85.15%	81.78%	84.59%	87.14%	84.61%	85.51%	88.13%	83.57%	78.89%	81.12%	80.41%	
No. of 4hr breaches		*15,110*	*1,679*	*1,244*	*1,179*	*1,472*	*1,286*	*967*	*1,158*	*1,167*	*884*	*1,209*	*1,621*	*1,349*	*1,574*	

	Plan	Actual	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Monthly Trend
A&E Attendances (LH/MIU/UUC) (% to Plan)		*97.12%*	93.6%	93.2%	95.3%	98.9%	99.6%	97.7%	94.9%	100.0%	98.4%	95.8%	99.3%	97.0%	95.4%	
A&E Attendances (LH/MIU/UUC) (No.)	*90,187*	*92,292*	7,598	7,170	7,937	8,081	8,344	7,517	7,524	8,056	7,445	7,358	7,679	7,147	8,034	

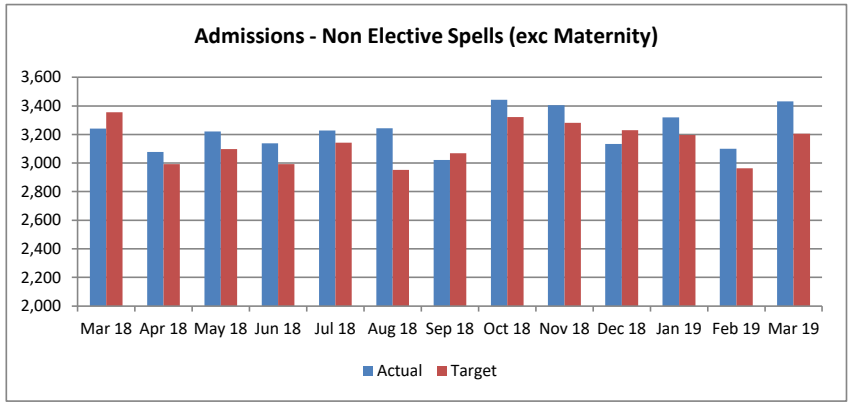
A&E Attendance Case Mix (based on acuity score)	*Major*		*27,772*	*2,422*	*2,288*	*2,460*	*2,386*	*2,168*	*2,380*	*2,228*	*2,455*	*2,269*	*2,235*	*2,392*	2,170	2,341	
	Minor		*34,618*	*2,886*	*2,799*	*2,992*	*3,325*	*3,643*	*2,990*	*2,810*	*2,768*	*2,560*	*2,605*	*2,782*	2,489	2,855	
	Paediatrics		*18,454*	*1,544*	*1,419*	*1,676*	*1,648*	*1,691*	*1,181*	*1,516*	*1,709*	*1,562*	*1,422*	*1,372*	1,556	1,702	
	Resus		*11,406*	*746*	*664*	*805*	*722*	*835*	*966*	*969*	*1,120*	*1,048*	*1,095*	*1,128*	928	1,126	
A&E Attendance Location (based on Discharge)	*Major*		*38,129*	*3,204*	*2,957*	*3,170*	*3,136*	*3,121*	*3,225*	*3,090*	*3,413*	*3,187*	*3,176*	*3,354*	*2,983*	*3,317*	
	Minor		*33,761*	*2,650*	*2,623*	*2,948*	*3,157*	*3,364*	*2,977*	*2,775*	*2,791*	*2,560*	*2,573*	*2,738*	*2,454*	*2,801*	
	Paediatrics		*18,454*	*1,544*	*1,419*	*1,676*	*1,648*	*1,691*	*1,181*	*1,516*	*1,709*	*1,562*	*1,422*	*1,372*	*1,556*	*1,702*	
	Resus		*1,906*	*200*	*171*	*139*	*140*	*161*	*134*	*142*	*139*	*130*	*186*	*210*	*150*	*204*	

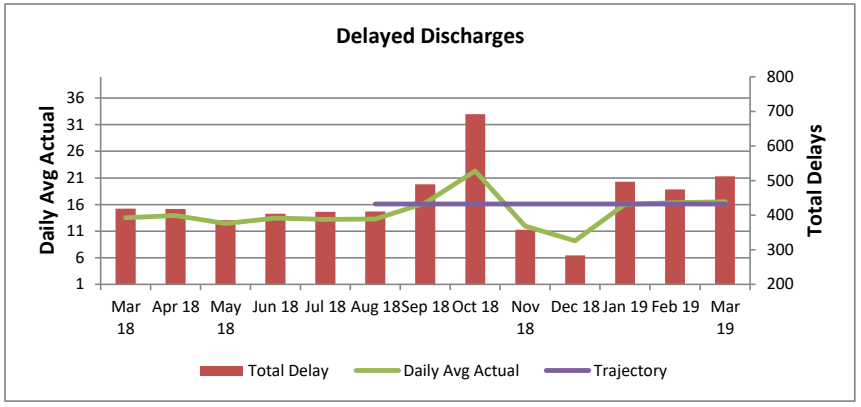
Commentary

The Trust has achieved 80.41% against the 4-hour access standard in March 2019, with a 17% increase in attendances compared to the previous month. The number of higher acuity patients (Resus and Majors) arriving in A&E continues to rise with 12% more than the previous month and 9% more than March 2018. As a result of the increase in higher acuity attendances, emergency admissions are higher than expected for March, at 107% of target.

Patients medically optimised for discharge remains within the DTOC threshold of 16.

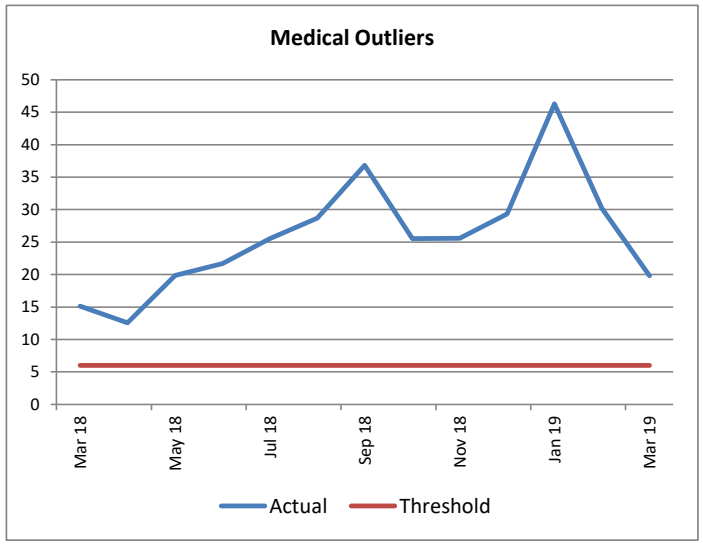
Primary Drivers

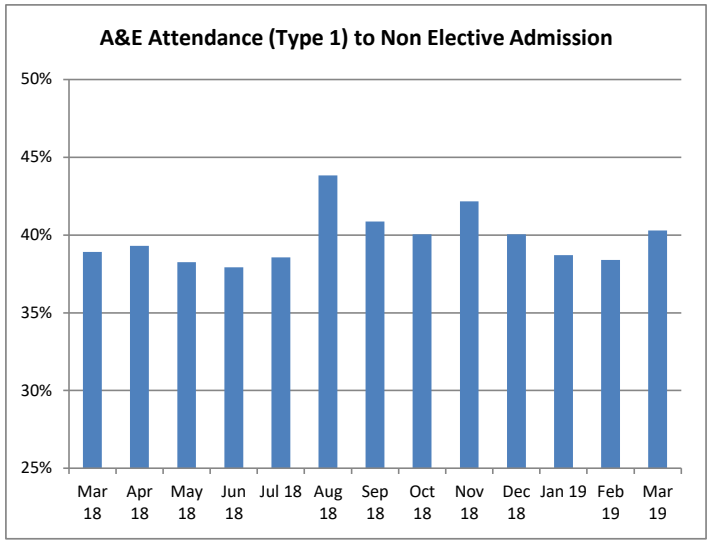


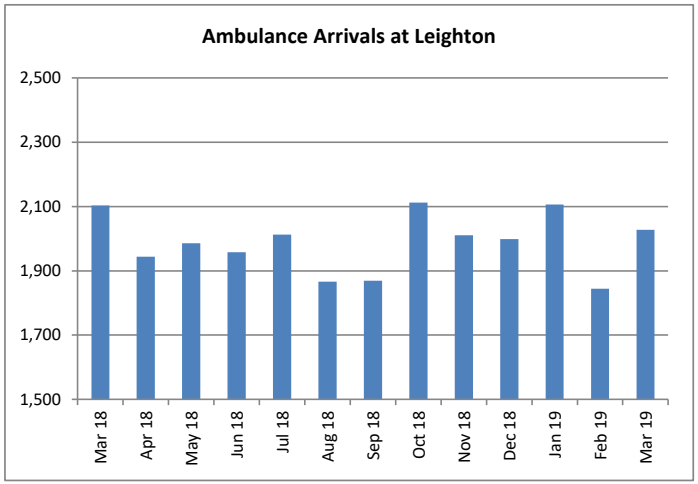


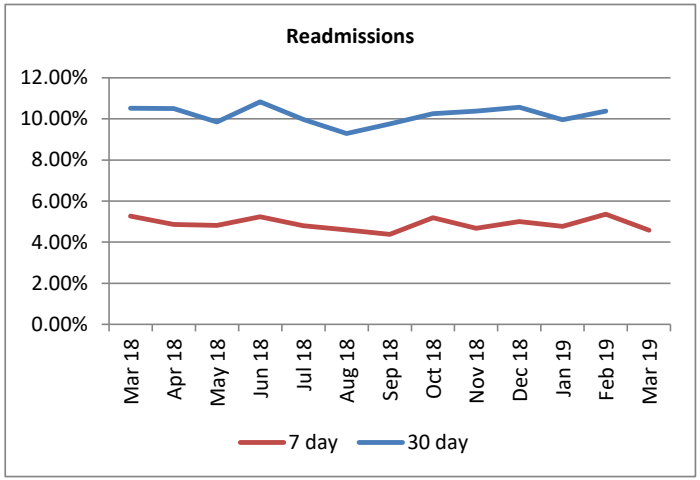
Operational Delivery: *Unplanned Activity A&E*

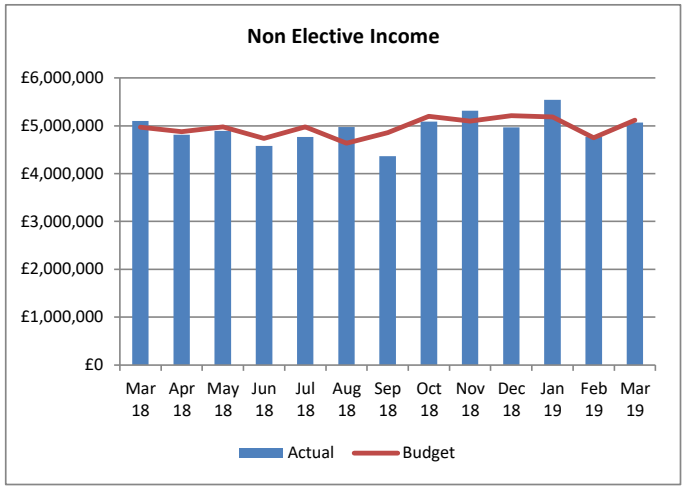
Secondary Drivers





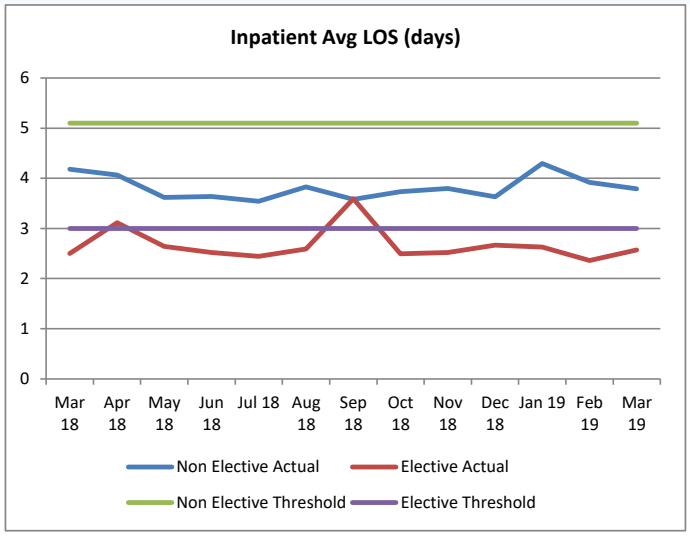


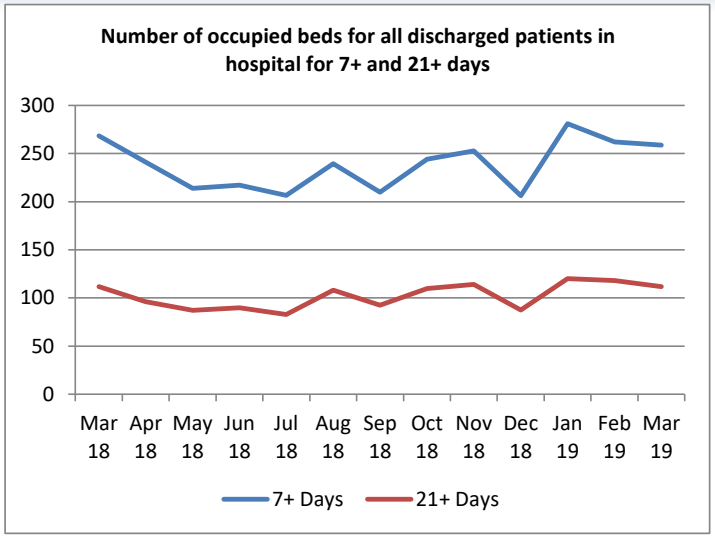


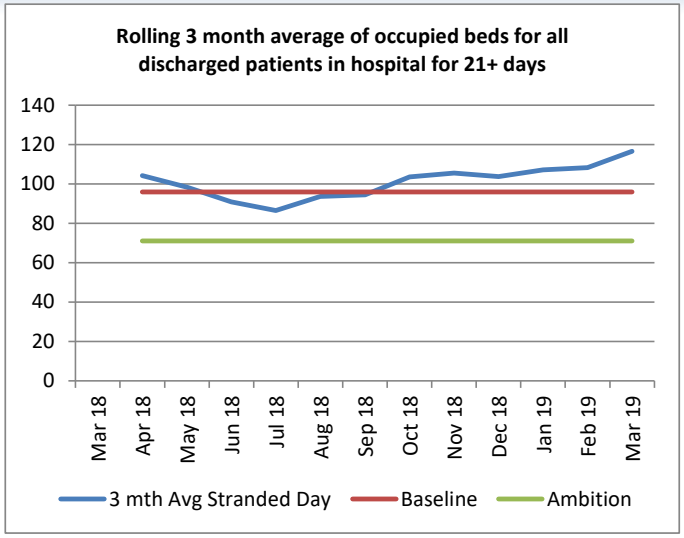


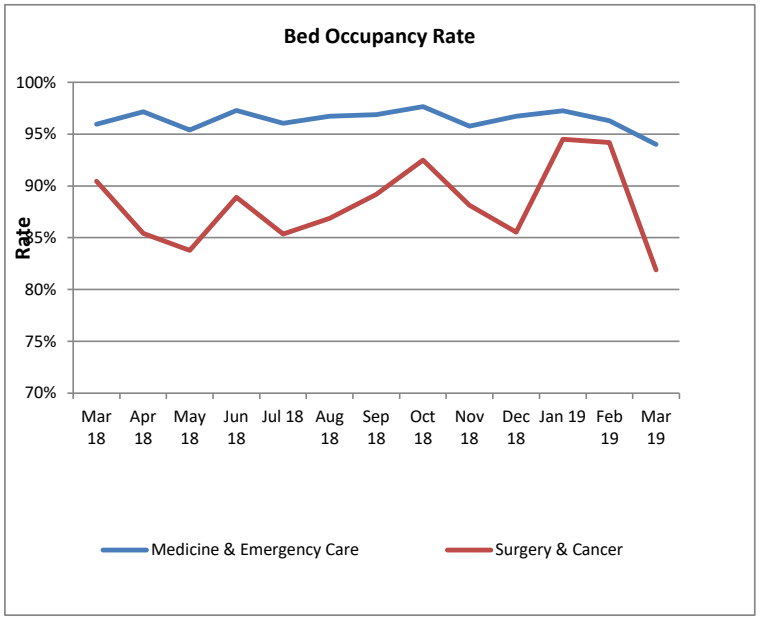
** Readmissions brought in line with national definition*

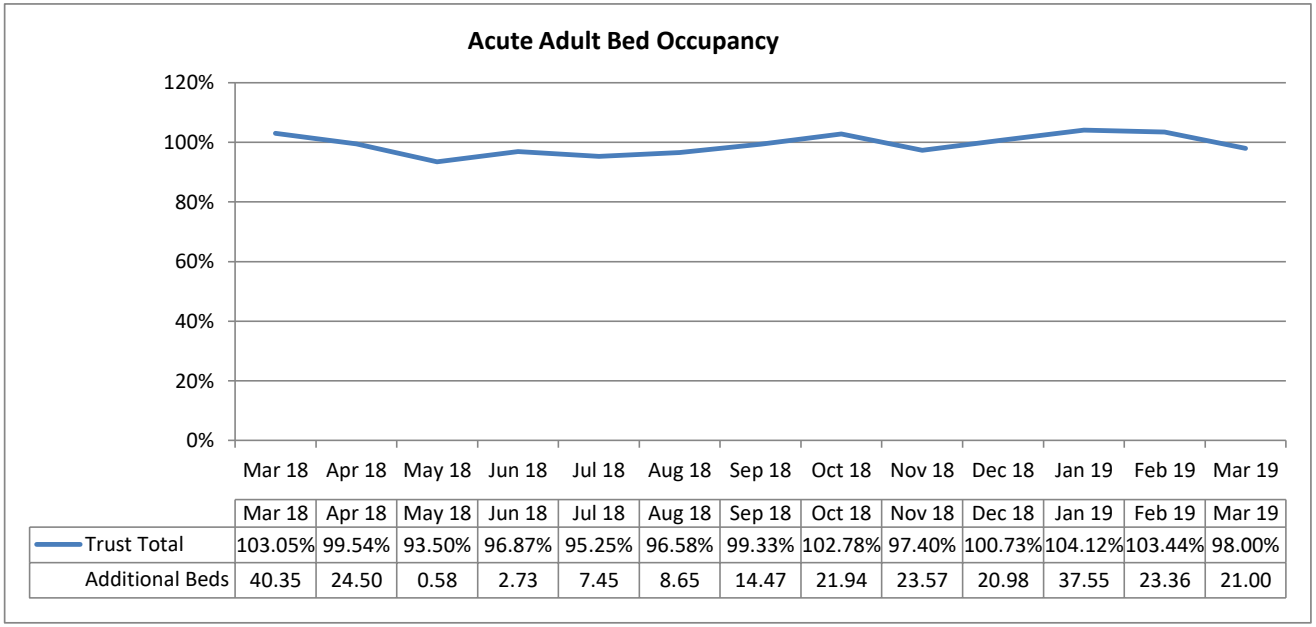
Operational Delivery: *Length of Stay*











	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19
Trust Total	103.05%	99.54%	93.50%	96.87%	95.25%	96.58%	99.33%	102.78%	97.40%	100.73%	104.12%	103.44%	98.00%
Additional Beds	40.35	24.50	0.58	2.73	7.45	8.65	14.47	21.94	23.57	20.98	37.55	23.36	21.00

Operational Delivery: *Planned Activity*

Headline Measures

	Current YTD		Rolling 13 months											
	Target	Actual	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Monthly Trend
18 weeks from Referral to Treatment in Aggregate - Incomplete	92%	92.38%	92.65%	93.00%	93.27%	93.14%	92.97%	93.05%	92.43%	92.82%	92.28%	92.01%	91.30%	91.63%	90.62%	
Total 18 Weeks		*174,491*	*13,990*	*14,253*	*14,405*	*14,713*	*14,630*	*15,373*	*14,988*	*14,284*	*14,331*	*14,232*	*14,427*	*14,505*	*14,350*	
No. > 18 Weeks		*13,293*	*1,028*	*998*	*969*	*1,010*	*1,029*	*1,069*	*1,135*	*1,025*	*1,106*	*1,137*	*1,255*	*1,214*	*1,346*	
Open Pathways >39 Weeks Waiting											*7*	*10*	*11*	*5*	*10*	
Diagnostic Waiting Time	1%	0.41%	0.33%	0.26%	0.17%	0.32%	0.56%	0.31%	0.44%	0.48%	0.17%	0.54%	0.47%	0.42%	0.76%	
Total Number of Waiters		*50,764*	*4,293*	*4,224*	*4,127*	*4,619*	*4,257*	*3,814*	*4,105*	*4,168*	*4,017*	*3,870*	*4,029*	*4,785*	*4,749*	
Waiters of 6 Weeks +		*210*	*14*	*11*	*7*	*15*	*24*	*12*	*18*	*20*	*7*	*21*	*19*	*20*	*36*	
Total Patients Waiting for a First Outpatient Appointment			8,866	9,243	9,579	9,354	9,496	9,851	9,654	9,496	9,430	8,948	9,428	9,823	9,682	
Longest Wait Time (weeks)											*44*	*46*	*47*	*47*	*46*	

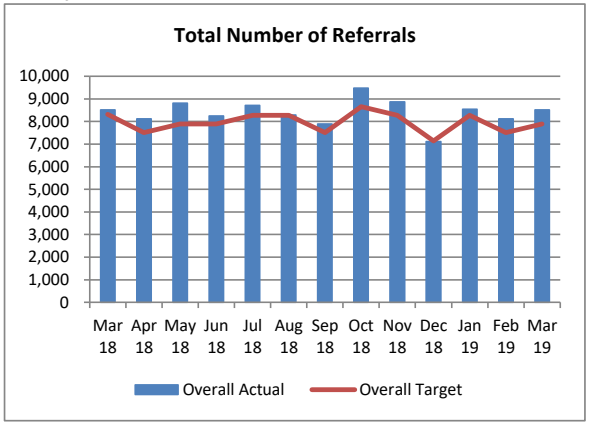
Commentary

The Trust's current RTT Incomplete Pathway position is 90.62% for March. This is an interim performance figure and pathways continue to be validated upto the statutory deadline. Currently eight specialties have failed to meet the 92% target in March, these are General Surgery, Urology, Gastroenterology, Cardiology, Dermatology, Thoracic Medicine, Gynaecology and Trauma and Orthopaedics.

Mid Cheshire do not currently have any 52 week breaches for March however there are 10 patients waiting over 39 weeks; (4 in General Surgery, 1 in Urology, 1 in ENT, 1 in Cardiology, 1 in Dermatology, 1 in Gynaecology and 1 in Trauma & Orthopaedics). All long wait patients are monitored and reviewed weekly at director led performance meetings.

The Trust has delivered the diagnostic wait time consistently since July 2016. In March 2019, 0.76% of patients waited longer than 6 weeks for their diagnostic tests, with all modalities delivering the standard.

Primary Drivers

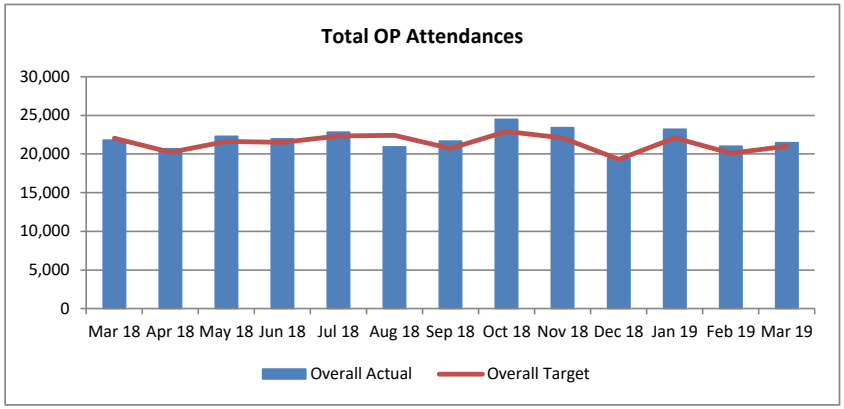


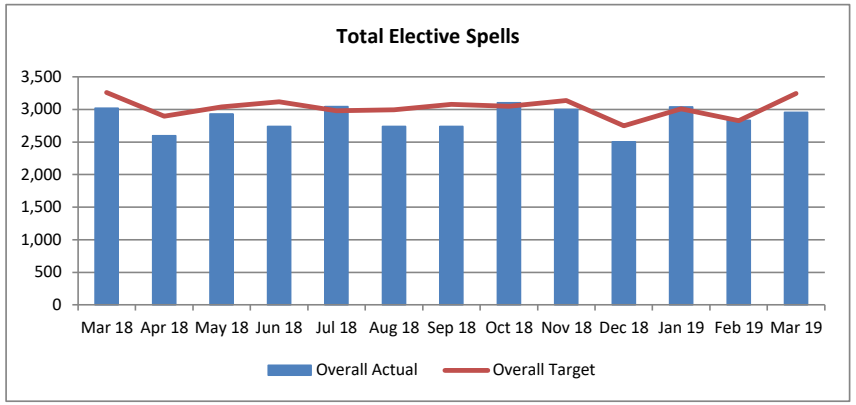
Referral Breakdown

	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Monthly Trend
GP Actual	5,388	4,858	5,400	5,065	5,355	5,184	4,925	5,755	5,684	4,412	5,424	4,915	5,270	
GP Target	5,259	4,683	4,920	4,920	5,157	5,157	4,683	5,394	5,157	4,446	5,157	4,683	4,920	
% to Target	102.5%	103.7%	109.8%	103.0%	103.8%	100.5%	105.2%	106.7%	110.2%	99.2%	105.2%	105.0%	107.1%	
Other Actual	3,119	3,256	3,408	3,186	3,352	3,107	2,968	3,714	3,189	2,696	3,118	3,204	3,250	
Other Target	3,050	2,833	2,976	2,976	3,120	3,120	2,833	3,263	3,120	2,689	3,120	2,833	2,976	
% to Target	102.3%	114.9%	114.5%	107.1%	107.5%	99.6%	104.8%	113.8%	102.2%	100.3%	100.0%	113.1%	109.2%	
Total Actual	8,507	8,114	8,808	8,251	8,707	8,291	7,893	9,469	8,873	7,108	8,542	8,119	8,520	
Total Target	8,308	7,515	7,896	7,896	8,276	8,276	7,515	8,657	8,276	7,135	8,276	7,515	7,896	
% to Target	102.4%	108.0%	111.6%	104.5%	105.2%	100.2%	105.0%	109.4%	107.2%	99.6%	103.2%	108.0%	107.9%	
GP % of Total	63.3%	59.9%	61.3%	61.4%	61.5%	62.5%	62.4%	60.8%	64.1%	62.1%	63.5%	60.5%	61.9%	

Operational Delivery: *Planned Activity*

Primary Drivers



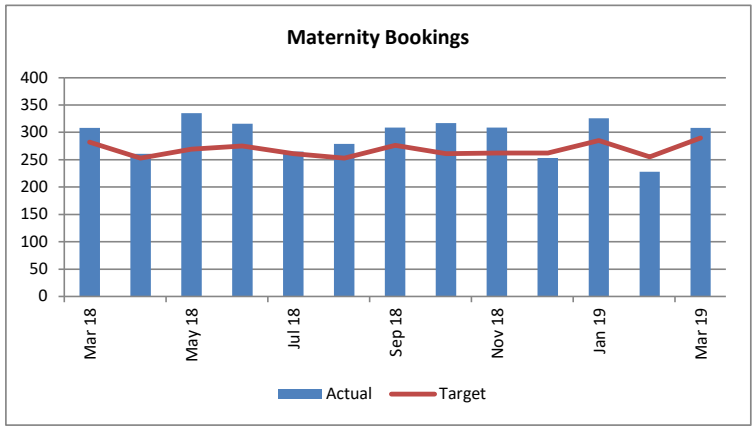


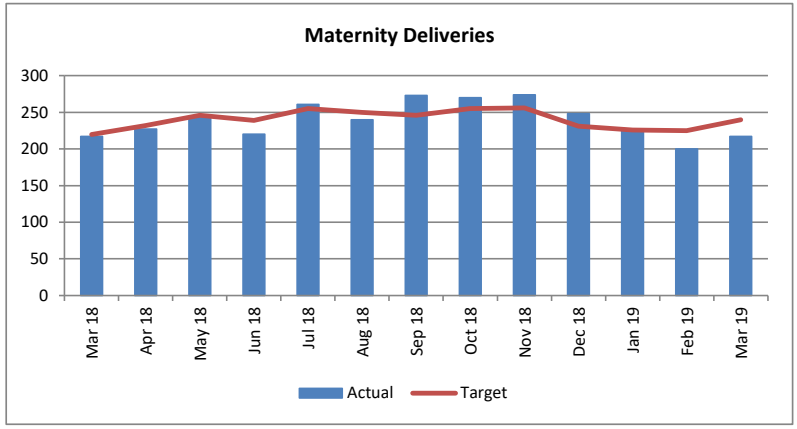
OP Attendance Breakdown	YTD 18 19	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Monthly Trend
New Actual	81,335	6,855	6,472	7,138	6,868	7,001	6,211	6,648	7,713	7,203	5,946	6,861	6,397	6,877	
New Target	74,744	6,909	5,892	6,224	6,212	6,495	6,502	5,934	6,778	6,496	5,625	6,496	5,901	6,189	
% to Target	108.8%	99.2%	109.9%	114.7%	110.6%	107.8%	95.5%	112.0%	113.8%	110.9%	105.7%	105.6%	108.4%	111.1%	
F U Actual	182,101	14,927	14,214	15,170	15,089	15,835	14,737	15,014	16,778	16,207	13,493	16,352	14,629	14,583	
F U Target	181,624	15,152	14,346	15,407	15,283	15,844	15,912	14,774	16,157	15,600	13,701	15,604	14,194	14,803	
% to Target	100.3%	98.5%	99.1%	98.5%	98.7%	99.9%	92.6%	101.6%	103.8%	103.9%	98.5%	104.8%	103.1%	98.5%	
Total Actual	263,436	21,782	20,686	22,308	21,957	22,836	20,948	21,662	24,491	23,410	19,439	23,213	21,026	21,460	
Total Target	256,368	22,061	20,237	21,631	21,495	22,339	22,414	20,708	22,935	22,095	19,326	22,100	20,095	20,992	
% to Target	102.8%	98.7%	102.2%	103.1%	102.1%	102.2%	93.5%	104.6%	106.8%	105.9%	100.6%	105.0%	104.6%	102.2%	
New % of Total	30.9%	31.5%	31.3%	32.0%	31.3%	30.7%	29.6%	30.7%	31.5%	30.8%	30.6%	29.6%	30.4%	32.0%	

Elective Spells Breakdown	YTD 18 19	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Monthly Trend
I P Actual	3,055	273	216	293	263	276	226	259	284	280	241	157	288	272	
I P Target	3,341	330	301	301	294	271	288	281	308	308	241	181	264	304	
% to Target	91.4%	82.8%	71.8%	97.4%	89.4%	101.9%	78.6%	92.2%	92.3%	91.0%	100.1%	86.9%	109.0%	89.4%	
Daycase Actual	31,155	2,745	2,378	2,637	2,476	2,766	2,513	2,479	2,817	2,717	2,262	2,882	2,543	2,685	
Daycase Target	32,775	2,931	2,593	2,738	2,825	2,709	2,709	2,795	2,740	2,827	2,507	2,826	2,565	2,942	
% to Target	95.1%	93.7%	91.7%	96.3%	87.7%	102.1%	92.8%	88.7%	102.8%	96.1%	90.2%	102.0%	99.1%	91.3%	
Total Actual	34,210	3,018	2,594	2,930	2,739	3,042	2,739	2,738	3,101	2,997	2,503	3,039	2,831	2,957	
Total Target	36,116	3,260	2,894	3,039	3,119	2,980	2,996	3,076	3,048	3,135	2,748	3,007	2,829	3,247	
% to Target	94.7%	92.6%	89.6%	96.4%	87.8%	102.1%	91.4%	89.0%	101.8%	95.6%	91.1%	101.1%	100.1%	91.1%	
I P % of Total	8.9%	9.0%	8.3%	10.0%	9.6%	9.1%	8.3%	9.5%	9.2%	9.3%	9.6%	5.2%	10.2%	9.2%	

Operational Delivery: *Planned Activity*

Primary Drivers



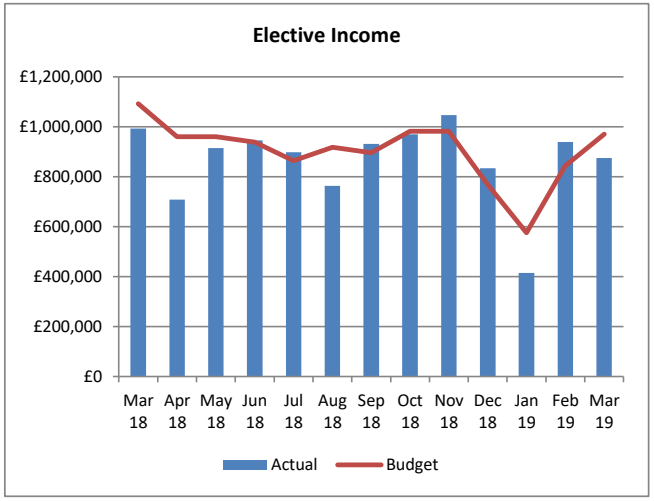


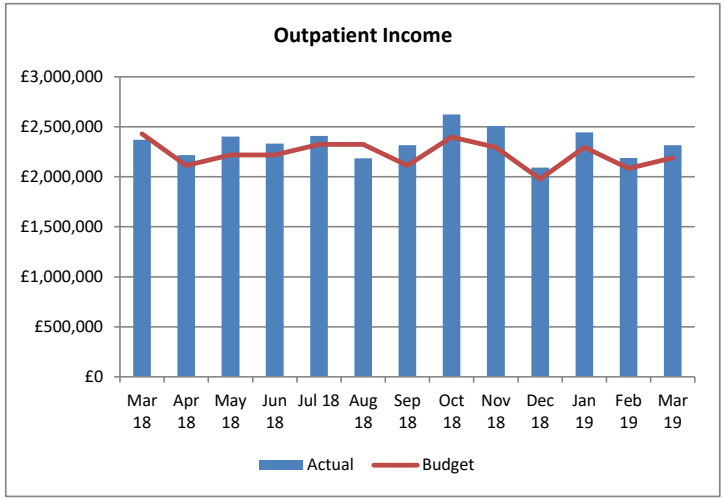
Operational Delivery: *Planned Activity*

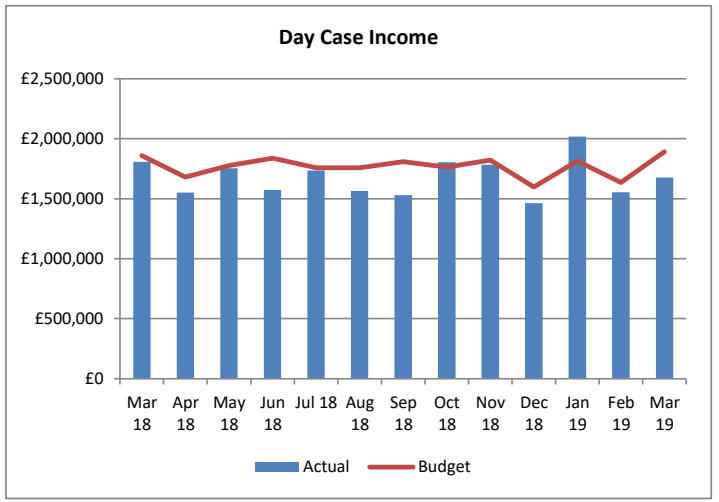
Secondary Drivers

			Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Monthly Trend
Bed Occupancy Rate	Medicine & Emergency Care		96.0%	97.1%	95.4%	97.3%	96.1%	96.7%	96.9%	97.7%	95.8%	96.7%	97.2%	96.3%	94.0%	
	Surgery & Cancer		90.4%	85.4%	83.8%	88.9%	85.4%	86.9%	89.2%	92.5%	88.1%	85.5%	94.5%	94.2%	81.9%	
Elective Inpatient Avg LOS (Days)			2.5	3.1	2.6	2.5	2.4	2.6	3.6	2.5	2.5	2.7	2.6	2.4	2.6	
Delayed Transfers of Care (MFFD)		16.00	14	14	12	13	13	13	16	22	12	9	16	17	17	
Delayed Transfers of Care (% of Acute Beds)			2.7%	2.8%	2.7%	2.9%	2.8%	2.8%	3.3%	4.5%	2.4%	1.8%	3.1%	3.3%	3.3%	
Medical Outliers			15	13	20	22	26	29	37	26	26	29	46	31	20	
Readmission (Emergency Re-admissions after Planned Surgery)																
	30 Day Rate		3.28%	3.36%	3.35%	2.99%	3.12%	2.73%	3.01%	3.28%	2.96%	2.87%	2.66%			
	7 Day Rate		1.41%	1.00%	1.27%	1.03%	1.42%	1.27%	1.28%	1.16%	1.15%	1.09%	1.06%	1.45%	0.00%	
Cancelled Operations - Non Clinical - Cancellation Rate			1.48%	1.40%	1.07%	0.95%	0.95%	0.95%	0.73%	1.86%	0.63%	1.40%	0.58%	0.60%	0.65%	
Theatre Efficiency																
	Main Theatres		76.8%	79.5%	78.9%	78.9%	76.7%	78.4%	78.4%	77.9%	77.2%	73.9%	74.5%	76.2%	78.5%	
	TC Theatres		71.8%	69.0%	74.2%	72.6%	75.6%	73.2%	73.4%	76.6%	73.5%	72.0%	69.4%	73.0%	73.5%	
DNA (OP Efficiency)			5.41%	5.29%	5.92%	5.83%	6.09%	5.74%	5.55%	5.72%	5.62%	5.95%	5.75%	5.42%	5.41%	
Hospital Cancellation Rate (OP Efficiency)			6.43%	6.72%	6.79%	6.80%	7.03%	7.27%	7.57%	7.65%	7.63%	8.27%	7.65%	7.83%	8.12%	

** Readmissions, DNA Rate and LOS metrics brought in line with national definitions*







Financial Performance: Income & Expenditure Position - Aggregated

	Month			Year to Date			Forecast	
	Plan Mar (£'000)	Actual Mar (£'000)	Variance Mar (£'000)	Plan April to Mar (£'000)	Actual April to Mar (£'000)	Variance April to Mar (£'000)	2018/19 (£'000)	Budget 2018/19 £'000
Operating								
Operating Income								
NHS Acute Activity Income								
Elective	971	890	-81	10,659	10,238	-421	10,238	10,659
Non-Elective	5,121	5,108	-13	59,627	59,150	-477	59,150	59,628
Maternity	1,128	1,158	30	13,986	13,558	-427	13,558	14,000
Day cases	1,892	1,675	-217	21,140	20,006	-1,134	20,006	21,139
Outpatients	2,188	2,316	128	26,546	28,031	1,485	28,031	26,672
A&E	896	927	31	10,139	10,513	374	10,513	10,139
Other NHS	10,272	6,759	-3,513	78,170	80,023	1,853	80,023	78,037
Total NHS Clinical Revenue	**22,468**	**18,833**	**-3,635**	**220,268**	**221,519**	**1,251**	**221,519**	**220,274**
Other Operating Income	2,128	2,457	329	25,605	26,932	1,327	26,932	22,502
Inter-Trust Income	0	0	0	0	0	0	0	0
TOTAL OPERATING INCOME	**24,596**	**21,290**	**-3,306**	**245,873**	**248,452**	**2,579**	**248,452**	**242,776**
Operating Expenses								
Employee Benefits Expenses (Pay)	-14,643	-14,859	-216	-171,990	-175,495	-3,505	-175,495	-168,313
Drugs	-1,289	-1,568	-279	-16,185	-17,329	-1,144	-17,329	-15,868
Clinical Supplies	-1,775	-1,622	153	-19,195	-18,484	711	-18,484	-18,370
Non Clinical Supplies	-306	-329	-23	-3,597	-3,930	-333	-3,930	-3,537
Other operating expenses	-2,323	-2,678	-355	-29,638	-32,444	-2,806	-32,444	-31,419
TOTAL OPERATING EXPENSES	**-20,336**	**-21,056**	**-720**	**-240,605**	**-247,681**	**-7,076**	**-247,681**	**-237,507**
EBITDA	**4,260**	**234**	**-4,026**	**5,268**	**770**	**-4,498**	**770**	**5,269**
Non Operating								
Non Operating Income								
Interest & Asset disposal	3	9	6	36	101	65	101	36
Non-Operating Expenses								
Depreciation & Finance Leases	-724	-483	241	-6,189	-5,421	768	-5,421	-6,190
PDC Dividend Expense	-192	155	347	-2,301	-1,953	348	-1,953	-2,300
Adjusted Financial Performance surplus/(deficit)	**3,347**	**-85**	**-3,432**	**-3,185**	**-6,503**	**-3,317**	**-6,503**	**-3,185**
Provider Sustainability Fund	987	3,608	2,621	8,428	7,443	-988	7,443	8,428
Net Surplus/(deficit) before Exceptional Items	**4,334**	**3,523**	**-811**	**5,243**	**939**	**-4,306**	**939**	**5,243**
Donations for purchase of assets	24	84	60	285	350	65	350	288
Depreciation on Donated Assets	-24	-23	1	-279	-279	0	-279	-278
Impairment Charge	0	0	0	0	-5,499	-5,499	-5,499	0
Prior Period Adjustments	0	0	0	0	0	0	0	0
Net Surplus/(deficit) after Exceptional Items	**4,334**	**3,584**	**-750**	**5,251**	**-4,489**	**-4,241**	**-4,489**	**5,253**

* EBITDA Total excludes Charitable Income

The Trust delivered a cumulative £0.9M surplus (before exceptional items) against a budget surplus of £5.2M, giving a variance of £4.3M. This contains the end of year PSF share which was £3.6M – in addition the position is an improvement on the previous forecast by £1M, and relates to reduction in pay of £0.35M, additional other income £0.2M, and non-pay £0.4M.

Commissioning/Other income are above plan by £2.8M, with contract income over-performing by £1.2M as a result of additional Winter funding (£0.6M) and the value of the MOU settlement being higher than the original budget (£0.6M).

Other operating income largely relates to over-performance on drugs recharges, however there has been additional income within CCICP in month 12 from formal agreement of SLAs within the local authorities.

Pay is £3.5M worse than plan. As part of reviewing the agency nurse costs, the level of accrual has been reduced due to bank system report that led to an over-inflation of agency rates.

Drugs are overspending as a result of increased charges related to the closure of the aseptic unit, which are offset within other operating income. Clinical Supplies are underspent as a result of the underperformance on the elective programme.

Other operating costs are overspent by £2.8M, of which £1.7M relate to outsourcing in pathology/radiology – and £0.7M relate to Estates costs (Utilities £0.3M, Provisions £70K, Carbon credits £160K, Waste £43K, other one off costs £43K).

The Provider Sustainability Fund reflects the first 3 quarters of the year for meeting the financial control target only (£3.8M), and also a share of the end of year PSF allocated by NHSI (£3.6M).

Financial Performance: Income & Expenditure Position - MCHFT

	Month			Year to Date			Forecast	
	Plan Mar (£'000)	Actual Mar (£'000)	Variance Mar (£'000)	Plan April to Mar (£'000)	Actual April to Mar (£'000)	Variance April to Mar (£'000)	2018/19 (£'000)	Budget 2018/19 £'000
Operating								
Operating Income								
NHS Acute Activity Income								
Elective	971	890	-81	10,659	10,238	-421	10,238	10,659
Non-Elective	5,121	5,108	-13	59,627	59,150	-477	59,150	59,628
Maternity	1,128	1,158	30	13,986	13,558	-427	13,558	14,000
Day cases	1,892	1,675	-217	21,140	20,006	-1,134	20,006	21,139
Outpatients	2,188	2,316	128	26,546	28,031	1,485	28,031	26,672
A&E	896	927	31	10,139	10,513	374	10,513	10,139
Other NHS	7,902	4,341	-3,561	49,730	51,267	1,537	51,267	49,574
Total NHS Clinical Revenue	**20,098**	**16,415**	**-3,683**	**191,828**	**192,764**	**936**	**192,764**	**191,811**
Other Operating Income	2,031	2,199	168	24,146	25,161	1,015	25,161	21,500
Inter-Trust Income	0	0	0	0	0	0	0	0
TOTAL OPERATING INCOME	**22,129**	**18,614**	**-3,515**	**215,974**	**217,925**	**1,951**	**217,925**	**213,311**
Operating Expenses								
Employee Benefits Expenses (Pay)	-12,845	-12,992	-147	-150,178	-153,891	-3,713	-153,891	-146,930
Drugs	-1,287	-1,565	-278	-16,161	-17,294	-1,133	-17,294	-15,844
Clinical Supplies	-1,690	-1,503	187	-18,172	-17,366	806	-17,366	-17,353
Non Clinical Supplies	-225	-253	-28	-2,628	-2,926	-298	-2,926	-2,568
Other operating expenses	-1,938	-2,232	-294	-24,877	-27,748	-2,871	-27,748	-26,706
Inter-Trust Charges	111	123	12	1,335	1,473	138	1,473	1,364
TOTAL OPERATING EXPENSES	**-17,874**	**-18,422**	**-548**	**-210,681**	**-217,753**	**-7,072**	**-217,753**	**-208,037**
EBITDA	**4,255**	**192**	**-4,063**	**5,293**	**172**	**-5,121**	**172**	**5,274**
Non Operating								
Non Operating Income								
Interest & Asset disposal	3	9	6	36	101	65	101	36
Non-Operating Expenses								
Depreciation & Finance Leases	-724	-483	241	-6,189	-5,421	768	-5,421	-6,190
PDC Dividend Expense	-192	155	347	-2,301	-1,953	348	-1,953	-2,300
Net Surplus/(deficit) before PSF/Exceptional Items	**3,342**	**-127**	**-3,469**	**-3,161**	**-7,102**	**-3,941**	**-7,102**	**-3,180**
Provider Sustainability Fund	987	3,608	2,621	8,431	7,443	-988	7,443	**8,428**
Net Surplus/(deficit) before Exceptional Items	**4,329**	**3,481**	**-848**	**5,270**	**341**	**-4,929**	**341**	**5,248**
Donations for purchase of assets	24	84	60	285	350	65	350	288
Depreciation on Donated Assets	-24	-23	1	-279	-279	0	-279	-278
Impairment Charge	0	0	0	0	-5,499	-5,499	-5,499	0
Prior Period Adjustments	0	0	0	0	0	0	0	0
Net Surplus/(deficit) after Exceptional Items	**4,329**	**3,542**	**-787**	**5,276**	**-5,087**	**-10,363**	**-5,087**	**5,258**

The Trust excluding Community Services, delivered a £7.1M deficit against a planned deficit of £3.2M - giving a £3.9M variance against plan cumulatively, excluding the impact of the provider sustainability fund (PSF).

The trust has reflected the MOU of £4.5M into the position, outside of this there are gains on other operating income associated with increased use of drugs from external contracts which are offset by drug costs.

Pay is £3.7M worse than plan cumulative as a result of higher spend on Nursing, due to un-funded escalation beds during the Summer months leading into Winter, being on top of the planned Winter ward and agency nursing being used to support a vacancy levels. Medical pay, is also under pressure as a result of gaps being filled with high cost agency staff. The underspend in clinical supplies of £0.8M is an offset of planned underperformance and the overspend on drugs is offset against increased other operating income.

Other Operating Expenses is £2.9M worse as a result of continuing outsourcing pressures in Diagnostics and Radiology (£1.7M) and pressures within Estates (£0.7M).

There is a cumulative reflection of the A&E performance provided for within the PSF, and it is has been assumed that the control total has been met for the first 3 quarters only, in terms of the original PSF – however the

Financial Performance: Income & Expenditure Position - CCICP

	Month			Year to Date			Forecast	
	Plan Mar (£'000)	Actual Mar (£'000)	Variance Mar (£'000)	Plan April to Mar (£'000)	Actual April to Mar (£'000)	Variance April to Mar (£'000)	2018/19 (£'000)	Budget 2018/19 £'000
Operating								
Operating Income								
NHS Acute Activity Income								
Elective	0	0	0	0	0	0	0	0
Non-Elective	0	0	0	0	0	0	0	0
Maternity	0	0	0	0	0	0	0	0
Day cases	0	0	0	0	0	0	0	0
Outpatients	0	0	0	0	0	0	0	0
A&E	0	0	0	0	0	0	0	0
Other NHS	2,370	2,418	48	28,440	28,756	316	28,756	28,440
Total NHS Clinical Revenue	**2,370**	**2,418**	**48**	**28,440**	**28,756**	**316**	**28,756**	**28,440**
Other Operating Income	97	258	161	1,459	1,771	312	1,771	1,459
Inter-Trust Income	0	0	0	0	0	0	0	0
TOTAL OPERATING INCOME	**2,467**	**2,676**	**209**	**29,899**	**30,527**	**628**	**30,527**	**29,899**
Operating Expenses								
Employee Benefits Expenses (Pay)	-1,798	-1,867	-69	-21,812	-21,604	208	-21,604	-21,812
Drugs	-2	-3	-1	-24	-35	-11	-35	-24
Clinical Supplies	-85	-119	-34	-1,023	-1,118	-95	-1,118	-1,023
Non Clinical Supplies	-81	-76	5	-969	-1,004	-35	-1,004	-969
Other operating expenses	-385	-446	-61	-4,761	-4,695	66	-4,695	-4,761
Inter-Trust Charges	-111	-123	-12	-1,335	-1,473	-138	-1,473	-1,335
TOTAL OPERATING EXPENSES	**-2,462**	**-2,634**	**-172**	**-29,924**	**-29,929**	**-4**	**-29,929**	**-29,924**
EBITDA	**5**	**42**	**37**	**-25**	**598**	**623**	**598**	**-25**
Non Operating								
Non Operating Income								
Interest & Asset disposal	0	0	0	0	0	0	0	0
Non-Operating Expenses								
Depreciation & Finance Leases	0	0	0	0	0	0	0	0
PDC Dividend Expense	0	0	0	0	0	0	0	0
Adjusted Financial Performance surplus/(deficit)	**5**	**42**	**37**	**-25**	**598**	**623**	**598**	**-25**
Provider Sustainability Fund	0	0	0	0	0	0	0	**0**
Net Surplus/(deficit) before Exceptional Items	**5**	**42**	**37**	**-25**	**598**	**623**	**598**	**-25**
Donations for purchase of assets	0	0	0	0	0	0	0	0
Depreciation on Donated Assets	0	0	0	0	0	0	0	0
Prior Period Adjustments	0	0	0	0	0	0	0	0
Net Surplus/(deficit) after Exceptional Items	**5**	**42**	**37**	**-25**	**598**	**623**	**598**	**-25**

Community Services delivered a £0.235M surplus cumulative against a planned balanced position.

Contract income is above plan (£0.3M), with variations for Stoma care, Pain and MCATS – and additional Winter funding, being the main reasons.

Other Operating income is better than budget as a result of an increase in charges within Estates, which is offset by an increase in cost in non-pay, some non-recurrent gains on 1718 income – and SLA income associated with the local authorities.

Pay is £208K better than plan cumulative as a result of unfilled vacancies partly clinical and partly corporate, continuing the trend from 2017/18 - however this in the main relates to slippage on the new variations and it is not expected that this is an underlying position.

Non pay is worse than budget, with an overspend on continence products within clinical supplies and rental costs offsetting the other operating income gains.

Inter-trust recharges reflect a review of vacancies which has been agreed with CCICP.

Financial Performance: Income & Expenditure Position

		Income			Expenditure				NET TOTAL	
		Contract	Variable	Better/ (Worse) than Budget	Pay	Better/ (Worse) than Budget	Non-Pay	Better/ (Worse) than Budget	Total	Better/ (Worse) than Budget
Surgical & Cancer Div Mgt	Divisional Management S&C	0	0	(50)	(988)	(971)	(91)	(92)	(1,079)	(1,112)
Endoscopy	Endoscopy	6,294	5	(686)	(1,768)	203	(819)	40	3,712	(442)
General Surgery Directorate	General Surgery	17,219	78	502	(9,541)	(315)	(1,857)	(105)	5,899	81
Head & Neck Directorate	Head & Neck	5,299	436	(330)	(2,513)	178	(682)	135	2,540	(17)
Macmillan Cancer Centre	Macmillan Cancer Centre	635	2,236	747	(1,026)	(95)	(1,871)	(427)	(26)	225
Ophthalmology	Ophthalmology	12,350	66	736	(4,393)	(67)	(3,699)	(324)	4,324	345
Orthopaedic Directorate	Orthopaedics	18,347	275	114	(6,661)	63	(3,372)	63	8,589	240
Theatres & TC	Theatres & TC	0	361	11	(7,420)	59	(2,892)	(331)	(9,951)	(261)
Urology Directorate	Urology	5,510	60	(63)	(2,953)	(161)	(578)	(101)	2,038	(326)
Bowel Cancer Screening Prog	Bowel Cancer Screening Prog	0	0	0	(605)	66	(442)	293	(1,047)	360
Surgical and Cancer Division	**Surgery & Cancer**	**65,655**	**3,516**	**982**	**(37,868)**	**(1,039)**	**(16,303)**	**(849)**	**15,000**	**(907)**

The Surgical Division is 0.9M worse than plan year to date. Pay is £1M worse than budget, with overspends on HCA bank and agency nursing costs high as a result of medical outliers which have resulted in a failure to close a surgical ward during the Summer months – despite the division requiring fewer beds. Overspends within the division also relate to acuity with Urology, and waiting lists within the General Surgery specialties and Ophthalmology, relating to supporting the opening of SACU, and out of area work – resulting into a medical pay overspend. Whilst non pay is overspent by £0.8M, £0.7M of this is offset by increased charges to the Christie as part of their SLA.

		Income			Expenditure				NET TOTAL	
		Contract	Variable	Better/ (Worse) than Budget	Pay	Better/ (Worse) than Budget	Non-Pay	Better/ (Worse) than Budget	Total	Better/ (Worse) than Budget
Emergency Care Divisional Mgmn	Divisional Mangement M&EC	0	7	7	(2,258)	(583)	(87)	(17)	(2,338)	(593)
Accident & Emergency Dir	Emergency Department	15,667	801	(170)	(6,778)	(456)	(815)	(143)	8,875	(769)
Anaesthetics & Critical Care	Anaesthetics & Critical Care	6,409	45	(46)	(8,088)	206	(1,197)	37	(2,831)	197
Medical Directorate	General Medicine	43,611	340	988	(24,415)	(1,796)	(4,390)	349	15,145	(459)
Urgent Care Centre	Urgent Care Centre	0	0	0	(740)	(21)	0	80	(740)	59
Emergency Services Division	**Medicine & Emergency Care**	**65,687**	**1,192**	**780**	**(42,280)**	**(2,650)**	**(6,489)**	**306**	**18,110**	**(1,565)**

The Medicine and Emergency Care Division are £1.6M worse than plan. The key issue for the division remains related to pay, with nursing pay and HCA spend continuing to reflect the cost of unfunded escalation beds, coupled with an increased need to use agency at above cap rates to cover an increasing number of vacancies. Medical pay costs continue to increase against the early part of the financial year due to the employment of a number of high cost agency doctors who are filling key gaps within the rotas for the division.

		Income			Expenditure				NET TOTAL	
		Contract	Variable	Better/ (Worse) than Budget	Pay	Better/ (Worse) than Budget	Non-Pay	Better/ (Worse) than Budget	Total	Better/ (Worse) than Budget
Wom Chil & sexl hlth Div Magmn	Divisional Mangement W&C	0	7	7	(1,305)	46	(128)	28	(1,426)	81
Gum clinic	Gum clinic	0	0	0	0	0	(1)	(1)	(1)	(1)
Obstetric & Gynaecology Dir	Obstetrics & Gynaecology	17,700	134	(767)	(8,709)	59	(1,418)	(70)	7,707	(777)
Paediatric Directorate	Paediatrics	11,666	121	(361)	(7,999)	(258)	(1,123)	(36)	2,664	(655)
Women and Childrens Division	**Women and Children**	**29,366**	**262**	**(1,121)**	**(18,013)**	**(153)**	**(2,670)**	**(79)**	**8,945**	**(1,352)**

The Women's and Children's Division is £1.1M worse than plan. Contract income continues to be significantly below plan for both Gynaecology and Obstetrics - both as a result of lower than planned activity, and reduced market share for Gynaecology. The pay pressure within paediatrics relates to ANPs and NICU, which have been accepted as pressures within the 1920 budgets.

Financial Performance: Income & Expenditure Position

		Income			Expenditure				NET TOTAL	
		Contract	Variable	Better/ (Worse) than Budget	Pay	Better/ (Worse) than Budget	Non-Pay	Better/ (Worse) than Budget	Total	Better/ (Worse) than Budget
Diag & Clinc Spt Sv Div Mgmnt	Divisional Management D&S	0	0	0	(295)	29	(41)	(125)	(336)	(95)
Dermatology	Dermatology	1,744	21	(54)	(994)	68	(326)	(2)	445	12
ECG department	ECG	400	20	(5)	(997)	128	(76)	4	(653)	128
Elmhurst	Elmhurst	1,997	172	(2)	(1,667)	(132)	(175)	6	327	(127)
Integrated Discharge	Integrated Discharge	0	23	23	(318)	(30)	(4)	(1)	(299)	(9)
Medical Records Department	Medical Records Department	0	0	(2)	(1,785)	(31)	(214)	9	(1,999)	(24)
Outpatients	Outpatients	0	152	(16)	(548)	27	(60)	(6)	(457)	4
Pathology Directorate	Pathology	12,109	4,006	915	(9,772)	414	(9,453)	(1,405)	(3,109)	(76)
Pharmacy Departments	Pharmacy	3,250	219	(68)	(3,483)	(147)	(3,703)	(565)	(3,717)	(780)
Radiology Directorate	Radiology	3,140	785	(11)	(6,450)	(1)	(2,604)	(686)	(5,128)	(699)
Therapeutic Departments	Therapies	0	0	0	(2,199)	(40)	(60)	37	(2,258)	(3)
Victoria Infirmary Northwich	Victoria Infirmary Northwich	2,032	2	(105)	(1,809)	(66)	(290)	5	(64)	(165)
Diagnostics and Support Divisi	**Diagnostics and Support**	**24,673**	**5,401**	**675**	**(30,316)**	**220**	**(17,008)**	**(2,729)**	**(17,250)**	**(1,834)**

The Diagnostics Division is £1.8M worse than plan year to date, with the key pressures continue to lie with the outsourced radiology and pathology tests £1.7M (net of medical vacancies). The over performance on income relates to increased charges to ECT and The Christie, and pass through drugs costs – largely as a result of the increased cost associated with aseptic unit remaining closed and subsequent outsourced costs. The general drugs CIP of £0.3M is held within pharmacy – with the performance being achieved within other divisions.

		Income			Expenditure				NET TOTAL	
		Contract	Variable	Better/ (Worse) than Budget	Pay	Better/ (Worse) than Budget	Non-Pay	Better/ (Worse) than Budget	Total	Better/ (Worse) than Budget
Estates & Facilities Div Mgnt	Divisional Management E&F	0	19	19	(529)	21	(195)	19	(705)	60
Catering Directorate	Catering	0	1,466	107	(1,736)	(105)	(1,439)	(115)	(1,710)	(113)
Estates Departments	Estates Departments	0	478	1	(1,589)	9	(7,222)	(503)	(8,332)	(493)
Hotel Services	Domestics	0	0	0	(1,371)	6	(16)	(4)	(1,387)	2
Laundry Services Departments	Laundry	0	1,162	(48)	(1,156)	(71)	(773)	15	(767)	(103)
Security	Security	0	1,735	42	(748)	19	(738)	(142)	249	(81)
Site Services	Porters	0	0	0	(2,902)	16	(86)	(6)	(2,988)	9
Estates & Facilities Division	**Estates & Facilities Division**	**0**	**4,861**	**122**	**(10,032)**	**(106)**	**(10,468)**	**(735)**	**(15,640)**	**(719)**

The Estates and Facilities Division is £0.7M worse than plan. Utility costs are £0.4M over budget for the year, and there are some 1718 costs (£0.2M), and one off costs (£70K). Within laundry, the loss of £40K for a SLA and bank usage to counter machine breakdowns have led the £103K adverse variance to budget. For Catering, the increase in wards have resulted in part of the overspend within non pay, along with one off costs associated with the refurbishment of the bistro.

		Income			Expenditure				NET TOTAL	
		Contract	Variable	Better/ (Worse) than Budget	Pay	Better/ (Worse) than Budget	Non-Pay	Better/ (Worse) than Budget	Total	Better/ (Worse) than Budget
Executive Management	Executive Management	0	17	17	(1,552)	(24)	(720)	(95)	(2,255)	(102)
Computer Services	Computer Services	0	108	98	(1,504)	47	(2,936)	(314)	(4,332)	(169)
Finance & Information	Finance & Information	0	41	9	(2,991)	153	(776)	(10)	(3,726)	152
Human Resources	Human Resources	0	611	132	(2,507)	41	(514)	91	(2,410)	263
Risk Manangement & R&D	Risk Management & R&D	0	492	(48)	(1,574)	32	(84)	16	(1,166)	0
Quality Assurance Departments	Nurse Management	0	226	118	(2,805)	(60)	(6,649)	116	(9,228)	174
Trust Central Expenditure	Trust Central Expenditure	14,796	8,937	(796)	(2,065)	(77)	(477)	798	21,191	(75)
Other Departments	Other Departments	20	167	50	(357)	(70)	(220)	51	(389)	31
	Corporate	**14,816**	**10,599**	**(420)**	**(15,355)**	**42**	**(12,375)**	**652**	**(2,315)**	**273**

The Corporate Division is £0.3M better than budget – which mainly relates to the additional PSF earned (£3.6M), offsetting the PSF not earned in the final quarter - or the A&E target for the whole year.

	Community Services	**28,756**	**1,451**	**627**	**(21,631)**	**181**	**(6,872)**	**(96)**	**1,704**	**712**
	EBITDA	**228,962**	**27,282**	**1,651**	**(175,495)**	**(3,505)**	**(72,186)**	**(3,529)**	**8,562**	**(5,384)**

Financial Performance: Commissioner Income Analysis

Commissioner	FY Target (£'000)	YTD Target (£'000)	CEP Adjustmt	Final Actual (£'000)	Final Variance (£'000)
NHS Eastern Cheshire CCG	8,096	8,096	0	8,129	32
NHS Eastern Cheshire CCG Community	412	412	0	412	0
NHS South Cheshire CCG Community	17,315	17,315	0	17,517	202
NHS South Cheshire CCG	104,968	104,968	-1,314	104,968	0
NHS Vale Royal CCG	56,821	56,821	-1,172	56,821	0
NHS Vale Royal CCG Community	10,603	10,603	0	10,636	33
NHS Warrington CCG	284	284	0	301	17
NHS West Cheshire CCG	3,537	3,537	0	3,485	-52
NHS West Cheshire CCG Community	191	191	0	191	0
NHS North Staffordshire CCG	2,307	2,307	0	2,474	167
NHS Shropshire CCG	892	892	0	781	-112
NHS Stoke on Trent CCG	1,609	1,609	0	1,624	15
Public Health England	1,540	1,540	0	1,308	-232
NHS Commissioning Board	1,604	1,604	0	1,604	0
Specialist Commissioning Group	8,645	8,645	0	7,949	-696
Non Contract Activity	2,007	2,007	0	2,073	66
Cross Border Flows (non Betsi)	149	149	0	99	-50
Betsi	229	229	0	654	425
Non-Commissioner Specific	7,493	7,493	0	7,985	492
TOTAL	**228,702**	**228,702**	**-2,486**	**229,011**	**307**

Other Contract Income	FY Target (£'000)	YTD Target (£'000)	YTD Actual (£'000)	Final Variance (£'000)
Bed Based Services	5,962	5,962	5,866	-96
Adult & Neonatal Critical Care	7,896	7,896	7,961	66
Urgent Care Centre	0	0	0	0
Community Paediatrics	1,303	1,303	1,303	0
Direct Access Services	9,509	9,509	9,729	219
Unbundled Radiology	3,505	3,505	3,468	-37
High Cost Drugs	9,762	9,762	9,991	229
Screening Programmes	1,530	1,530	1,567	37
Audiology	1,167	1,167	1,003	-164
IVF	258	258	210	-48
CQUIN	4,312	4,312	3,869	-443
PSF	8,428	8,428	7,443	-985
Community Services	28,149	28,149	28,321	171
CEP	-2,817	-2,817	-2,486	331
WINTER FUNDING	750	750	1,289	539
Memorandum of Understanding	4,500	4,500	4,500	0
Other	2,400	2,400	2,840	440
TOTAL	**86,614**	**86,614**	**86,874**	**259**

The MOU between the Trust and the CCG has been settled at £4.5M.

Other associate commissioners combined are showing a small over-performance. The underperformance on the Public Health England contract related to delays in relation to the bowel scope programme roll out at East Cheshire Trust.

Specialist Commissioning has a negative variance being the result of a high cost drug rebate of £0.5M in July, and a lower than expected volume of emergency patients who meet the criteria of specialised care, particularly within Paediatrics.

Cross border flows includes Welsh commissioners where the Trust has completed work with the North Welsh Health board, pre-dominantly in orthopaedic surgery, and ophthalmology. This activity ceased as a result of the required for the Trust to maintain waiting lists at March 2018 levels.

Other contract income is £0.3M better than plan.

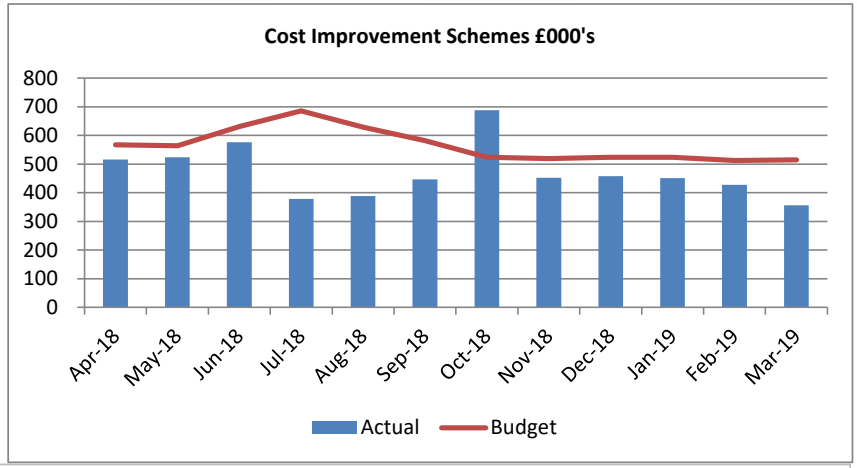
The PSF reflects the achievement of the financial target only, for the first 3 quarters of the year and a share of the PSF bonus paid in month 12 (£3.6M).

The remainder of the performance against plan is in large part due to expected increases in activity within the plan have not materialised – and where the trust was expecting to have a material CEP adjustment YTD of £2.8M the adjustment on the South and Vale Royal contracts has only been £2.5M.

Aside the CEP adjustment there were gains against the un-coded prior year spells valuation (£140k), additional Winter income (£539K), Direct Access Services with East Cheshire CCG (£219K), and Adult Critical Care (£66k) and High cost drugs (£204K) – with the rebate of £551K, passed directly onto Specialised Commissioning offsetting an over performance on home care drugs, AMD and aseptic drugs costs. These are offset by anticipated CQUIN income (£443K), Audiology (£164K).

Financial Performance: Efficiencies

Cost Improvement Schemes (£'000's)						
Scheme Category	**YTD Target**	**YTD Actual**	**YTD**	**FY Target**	**FY Forecast**	**FY Variance**
Access & Flow	524	439	-85	524	439	-85
Commercial	195	281	86	195	281	86
Drugs	657	657	0	657	657	0
Medical Workforce	1,550	965	-402	1,550	965	-586
Non-Pay Efficiency	1,228	1,362	134	1,228	1,512	284
Nursing Workforce	974	688	-265	974	688	-286
Procurement	684	285	-399	684	285	-399
Theatres Efficiency	100	100	0	100	100	0
Service redesign	540	463	-71	540	463	-77
Market Share	320	220	-100	320	220	-100
Total (£'000)	**6,772**	**5,460**	**-1,102**	**6,772**	**5,610**	**-1,163**



The CIP achievement for the full year is £1.1M worse than plan with the challenges in year to the following CIP schemes:- improvement of nurse/HCA sickness within Emergency Care (£0.2M), reduction in WLIs (£0.2M), and the Medical Vacancy factor in Surgery and Cancer (£0.3M).

There are a number of CCICP efficiencies that are over performing which offset the under-performances elsewhere.

Capped Expenditure Schemes (£'000's)						
Scheme Category	**YTD Target**	**YTD Actual**	**YTD**	**FY Target**	**FY Forecast**	**FY Variance**
TeleDerm	70	0	-70	70	0	-70
Non-Pay Efficiency	100	100	0	100	100	0
Drugs	50	50	0	50	50	0
Commercial	200	0	-200	200	0	-200
Procurement	100	0	-100	100	0	-100
Elective	1,116	452	-664	1,116	460	-656
Total (£'000)	**1,636**	**602**	**-1,034**	**1,636**	**610**	**-1,026**

The CEP schemes rolled over from 1718 have under achieved by £1M, with key issues around delivering planned cost savings in IVF, and work with East Cheshire in relation to births /out of hours contracts.

As a result of the regulatory direction to keep waiting list levels at March 2018 levels - the plan to deliver further income from out of area contracts in Wales has been stopped, which has led to a deterioration of the forecast for this legacy value.

Financial Performance: Capital Report

SCHEME	BOARD APPROVED	FUNDING SOURCE	FUNDING APPROVED	EXPENDITURE BROUGHT FORWARD	2018/19 ANNUAL BUDGET	2018/19 CUMULATIVE BUDGET TO DATE	2018/19 CUMULATIVE ACTUAL	2018/19 BETTER/WORSE THAN BUDGET	2018/19 FORECAST	2019/20 + FORECAST	WHOLE PROJECT ACTUAL TO DATE	WHOLE PROJECT PROPOSED PLAN	TOTAL FORECAST
STRATEGIC INVESTMENTS (Requires individual signoff)													
ESTATES													
CAR PARK BARRIERS	Yes	Internal	Yes	44	16	16	15	1	15		59	60	59
BISTRO & 2 OFFICES	Yes	Internal	Yes	120	58	58	58	0	58		178	178	178
UNDER / OVERS CAPITAL SCHEMES 17/18	Yes	Internal	Yes		0	0	1	-1	1		1	0	1
WARD REFURBISHMENT	Yes	Loan	Yes	224	1864	1864	2129	-265	2129	8600	2353	10,688	10,953
MRI SCANNER 3RD BUILD	Yes	Internal/Loan	Yes	174	1475	1475	182	1293	182	0	356	1,649	356
WASTE COMPOUND AND SEGREGATION	Yes	Internal	Yes		350	350	0	350	0	350	0	700	350
TURNKEY FOR REPLACEMENT CT SCANNERS	No	Internal	Yes		165	165	38	127	38	135	38	300	173
BARRIER ACCESS CONTROL	Yes	Internal	Yes		100	100	0	100	0	100	0	200	100
CAR PARK LAND *	Yes	Loan	Not yet approved		400	400	62	338	62	1860	62	2,260	1,922
EPR PROJECT ACCOMODATION *	Yes	Loan	Not yet approved		350	350	0	350	0		0	350	0
ENDOSCOPY WASHER BUILD *	No	Loan	Not yet approved		250	250	0	250	0	500	0	750	500
PATHOLOGY RISKS	Yes	Internal	Yes		100	100	83	17	83		83	100	83
SSD ENABLING *	Yes	Loan	Not yet approved		668	668	0	668	0	668	0	1,336	668
WARD REFURBUISHMENT *	No	Loan	Not yet approved		1600	1600	343	1257	343	900	343	2,500	1,243
DEMENTIA APPEAL	No	Donated	Not yet approved							1500		1,500	1,500
3RD CT ENABLING	No	Internal	Not yet approved							935		935	935
TOTAL				**562**	**7396**	**7396**	**2911**	**4485**	**2910**	**15548**	**3473**	**23506**	**19020.44**
IT													
UNDER / OVERS CAPITAL SCHEMES 17/18	Yes	Internal	Yes		0	0	-8	8	-8		-8	0	-8
UPS	Yes	Internal	Yes		250	250	0	250	0	250	0	500	250
Q PULSE	Yes	Internal	Yes	25	37	37	0	37	0	28	25	90	53
HIGH IMPACT STAND ALONE IT SYSTEMS	Yes	Internal	Yes	88	112	112	35	77	35	400	123	600	523
REPLACEMENT BUSINESS INTELLIGANCE SYSTEM	Yes	Internal	Yes		80	80	93	-13	93		93	80	93
CONFIGURATION MANAGEMENT SYSTEM	Yes	Internal	Yes		35	35	0	35	0		0	35	0
CORE INFRASTRUCTURE UPGRADE	yes	PDC	Yes		538	538	434	104	434	180	434	718	614
CYBER SECURITY	Yes	PDC	Yes	17	291	291	291	0	291		308	308	308
X-RAY MACHINE STORAGE	Yes	Internal	Yes		100	100	113	-13	113		113	100	113
SEQUEL / WINDOWS LICENCES	Yes	Internal	Yes		80	80	0	80	0	80	0	160	80
VIRTUAL DESKTOP	No	Internal	Yes		400	400	0	400	0	200	0	600	200
VIRTUAL CLINICS	No	Internal	Yes		50	50	5	45	5		5	50	5
VPN	Yes	PDC	Yes		70	70	35	35	35		35	70	35
VOICE OVER IP	Yes	Internal	Yes	466	100	100	1	99	1	100	467	666	567
SYSTEM REFRESH / REPLACEMENT													
LAB CENTRE PATHOLOGY	No	Internal	Yes		800	800	0	800	0	1600	0	2,400	1,600
CHEMOCARE	yes	Internal	Yes		85	85	0	85	0		0	85	0
DIGITAL DICTATION	Yes	Internal	Yes		60	60	0	60	0	73	0	133	73
DOCMAN	Yes	Internal	Yes		52	52	0	52	0		0	52	0
WIRELESS UPGRADE /N3 UPGRADE	Yes	Internal	Yes							65	0	65	65
PHARMACY ASCRIBE	No	Internal	Yes							200	0	200	200
STAFF WIFI	No	Internal	Yes							80	0	80	80
SOLITON MEDICAL IMAGING	No	Internal	Yes							250	0	250	250
BADGERNET	Yes	Internal	Yes							45	0	45	45
BLOOD TRACKING SYSTEM	No	Internal	Yes							200	0	200	200
CARDIO RESPIRATORY SYSTEM	No	Internal	Yes							350	0	350	350
TOTAL				**596**	**3140**	**3140**	**999**	**2141**	**999**	**4101**	1595	**7837**	**5,696**
TOTAL STRATEGIC INVESTMENTS				**1158**	**10536**	**10536**	**3910**	**6626**	**3909**	**19649**	**5068**	**31,343**	**24,716**

The Estates strategic investments capital spend is £4.5M underspent mainly due to a delay in the third MRI Scanner £1.3M. In addition the ward 12 refurbishment schemes is underspent, but has now started. Also there is a delay in the Turnkey works for the replacement CT scanner . The SSD Washers, EPR accommodation are due to start in 2019/20 , where as the waste compound and the Endoscopy washer build are due to start in 2020/21 The IT Strategic investments projects are £2.1M underspent which is mainly due to UPS Replacement (£0.25M), Core Infrastructure upgrade (£0.1M) and Virtual Desktop (£0.4M) and Lab Centre £0.80M which is now a revenue solution.

Financial Performance: Capital Report

SCHEME	BOARD APPROVED	FUNDING SOURCE	FUNDING APPROVED	EXPENDITURE BROUGHT FORWARD	2018/19 ANNUAL BUDGET	2018/19 CUMULATIVE BUDGET TO DATE	2018/19 CUMULATIVE ACTUAL	2018/19 BETTER/WORSE THAN BUDGET	2018/19 FORECAST	2019/20 + FORECAST	WHOLE PROJECT ACTUAL TO DATE	WHOLE PROJECT PROPOSED PLAN	TOTAL FORECAST
ROLLING ALLOCATIONS (Approved Delegated Budgets)													
ESTATES													
ASBESTOS REMOVAL	Yes	Internal	Yes		271	271	129	142	129	736	129	1,007	865
DESIGN TEAM	Yes	Internal	Yes		313	313	282	31	282	1252	282	1,565	1,534
CT / VT - HEATING INFRASTRUCTURE	Yes	Internal	Yes		459	459	38	421	38	1109	38	1,568	1,147
BACKLOG GENERAL PROVISION	Yes	Internal/Loan	Yes		2650	2650	1712	938	1,712	7873	1712	10,523	9,585
TOTAL				**0**	**3,693**	**3,693**	**2,162**	**1531**	**2,162**	**10,970**	**2162**	**14,663**	**13,132**
IT													
INTERSITE CONNECTIVITY	Yes	Internal	Yes		50	50	7	43	7		7	50	7
INTERFACING	Yes	Internal	Yes		151	151	111	40	111	390	111	541	501
IT APPLICATIONS	Yes	Internal	Yes		193	193	17	176	17	475	17	668	492
STORAGE & BACKUP	No	Internal	Yes							250		250	250
TOTAL				**0**	**394**	**394**	**135**	**259**	**135**	**1115**	**135**	**1,509**	**1,250**
TOTAL ROLLING ALLOCATIONS				**0**	**4,087**	**4,087**	**2,297**	**1,790**	**2,296**	**12,085**	**2,297**	**16,172**	**14,381**
ADDITIONAL													
EQUIPMENT	Yes	Internal	Yes		0	95	239	-144	239		239	0	239
MOBILE SCANNER CABIN						92	92	0	92				
PUBLIC WiFi					0	0	0	0	0		0	0	0
ACQUISITION OF SCPH					0	0	0	0	0	1000	0	1,000	1,000
PERSONAL CARE PORTAL					0	0	0	0	0		0	0	0
MEDICAL RECORDS RACKING	Yes	Internal	Yes		43	43	60	-17	60		60	43	60
CANCER MDT	Yes	PDC	Yes		30	30	0	30	0		0	30	0
GP STREAMING ESTATES	Yes	PDC	Yes	12	488	488	505	-17	505		517	500	517
GP STREAMING IT FRONT OF HOUSE	Yes	PDC	Yes	108	142	142	0	142	0		108	250	108
COMMUNITY SERVICES	Yes	Internal	Yes	105	630	630	464	166	464		569	735	569
LEASING INVESTMENTS													
EQUIPMENT	Yes	Internal	Yes		600	600	218	382	218	78	218	678	296
3RD CT SCANNER	No	Internal	Not yet approved		531	531	0	531	0		0	531	0
REPLACEMENT CT SCANNER	No	Internal	Not yet approved		532	0	0	0	0		0	532	0
3RD MRI SCANNER	Yes	Internal	Yes		600	0	0	0	0		0	600	0
ROOM 2 X-RAY	No	Internal	Not yet approved		250	250	0	250	0		0	250	0
SSD WASHERS	No	Internal	Not yet approved		320	320	0	320	0	320	0	640	320
TOTAL LEASING INVESTMENTS				**0**	**2833**	**1701**	**218**	**1483**	**218**	**398**	218	**3231**	**616**
TOTAL CAPITAL PROGRAMME (EXCLUDING LEASES)				**1,383**	**15,956**	**16,143**	**7,566**	**8,577**	**7,566**	**32,734**	**8,857**	**50,073**	**41,590**
TOTAL CAPTIAL PROGRAMME				**1,383**	**18,789**	**17,844**	**7,784**	**10,060**	**7,784**	**33,132**	**9,075**	**53,304**	**42,206**

The rolling allocation is £1.79M underspent due to the delay in some of the backlog maintenance and CTVT replacement, Asbesto s replacement and IT Applications.

The forecast spend has been reduced by the following: Asbestos £0.136M, Backlog Maintenance £1.08M , Ward Refurbishment £0.2 M , Endoscopy Washer Build £0.25M, EPR Project office £0.35M, Virtual Desktop £0.2M, Car Park Land purchase £0.3M, CCTV £0.15M, CTVT £0.15M, Replacement SSD washers build work £0.7M, UPs £0.25M, Virtual Clinics £0.1M, Lab Centre Upgrade £0.8M This cost have been moved to 2019/20. In respect of the Ward Refurbishment and the Endoscopy Build these are funded via loans and therefore the loans will be drawn down accordingly.

There have been three schemes added in year Personal Care Portal £70K and Public Wi-Fi £0.2M which are funded via external money. In addition the acquisition of South Cheshire Private Hospital £1Mwhere the expenditure is anticipated to now be in the next financial year.

Financial Performance: Statement of Financial Position

	Plan Apr to Mar (£'000)	Actual Apr to Mar (£'000)	Variance (£'000)	Forecast 2018/19 (£'000)
Assets				
Assets, Non-Current	**111,477**	**92,675**	**-18,802**	**92,675**
Assets, Current				
Trade and other Receivables	9,123	11,921	2,798	11,921
Other Assets (including Inventories & Prepayments)	6,600	6,047	-553	6,047
Cash and Cash Equivalents	11,930	11,249	-681	11,249
Total Assets, Current	**27,653**	**29,218**	**1,565**	**29,218**
ASSETS, TOTAL	**139,130**	**121,892**	**-17,238**	**121,892**
Liabilities				
Liabilities, Current				
Finance Lease, Current	-2,147	-1,243	904	-1,243
Loans Commercial Current	-696	-5,609	-4,913	-5,609
Trade and Other Payables, Current	-14,805	-14,567	238	-14,567
Provisions, Current	-225	-325	-100	-325
Other Financial Liabilities	-6,523	-8,206	-1,683	-8,206
Total Liabilities, Current	**-24,396**	**-29,950**	**-5,554**	**-29,950**
Net Current Assets/(Liabilities)	**3,257**	**-732**	**-3,989**	**-732**
Liabilities, Non Current				
Finance Lease, Non Current	-5,840	-3,502	2,338	-3,502
Loans Commercial Non-Current	-17,304	-8,049	9,255	-8,049
Provisions, Non-Current	-1,489	-1,423	66	-1,423
Trade and Other Payables, Non-Current	0	0	0	**0**
Total Liabilities Non-Current	**-24,633**	**-12,974**	**11,659**	**-12,974**
TOTAL ASSETS EMPLOYED	**90,101**	**78,968**	**-11,133**	**78,968**
Taxpayers' and Others' Equity				
Taxpayers Equity				
Public dividend capital	76,791	77,508	717	77,508
Retained Earnings	-2,283	-11,954	-9,671	-11,954
Donated asset reserve	0	0	0	0
Revaluation Reserve	15,592	13,415	-2,177	13,415
TOTAL TAXPAYERS EQUITY	**90,100**	**78,968**	**-11,132**	**78,968**
TOTAL FUNDS EMPLOYED	**90,100**	**78,968**	**-11,132**	**78,968**

Assets Non-Current
The main reason for the variance is that the plan is the capital programme expenditure being £11.8M less than anticipated which is mainly due to a delay in the third MRI Scanner build £1.29M, Backlog maintenance £1.09M, Waste Compound £0.35M, CTVT £0.28M, Ward Refurbishment £0.95M, Virtual Desktop £0.45M, SSD Washers £0.67M, Clinical Systems Accommodation £0.35M, Lab Centre Upgrade £0.80M (now a revenue solution), Car Park Land £0.34M other minor other minor IT schemes £1.24M. Some of the delays are due to a loan application which has not been approved by the Department of Health, approval of business cases The remainder is delay in the renewal of some finance leases in particular is the third MRI Scanner, the SSD Washers and the replacement CT scanner and an underspend on the depreciation charge. In addition the Trust has revalued its Land and buildings and this has resulted in a net impairment of £7.6M

Trade and other Receivables
NHS Trade Receivables are higher than anticipated which is mainly due to the Trust not anticipating its quarter 4 PSF which was £2.95M. However the Trust has accrued £3.60M of general distribution. In addition there are outstanding debts for Christies £0.8M

Other Assets
This is lower than anticipated due to lower prepayments due to delays in maintenance contracts for the new MRI Scanner and some operating leases, offset by an increase in stocks mainly due to drugs.

Finance Lease Current
This mainly due to a delay in the Third MRI Scanner, replacment CT scanner and the SSD Washers..

Loans Commercial Current
This is mainly due to the working capital loan of £5.0M moving to current borrowings which was not anticiapted in the plan

Other Financial Liabilities
This is mainly due to accruals being higher due to a large accrual for utilities and outstanding drug invoices. In addition defrred income is higher to to an early payment by East Cheshire Trust for April invoices.

Finance Lease Non- Current
This due to the delay in the replacement of finance leases.

Loans Commercial Non-Current
This is due to the delay in the drawing down of an approved loan for the ward refurbishments, Backlog Maintenance and the replacment SSD Washers. In addition the working capital loan has moved to loans current..

Taxpayers equity
there is an increase due to £0.72K of Public dividend capital offset by retained earnings due to a financial position worse than planned and a reduction in the value of lanad and builkdings of

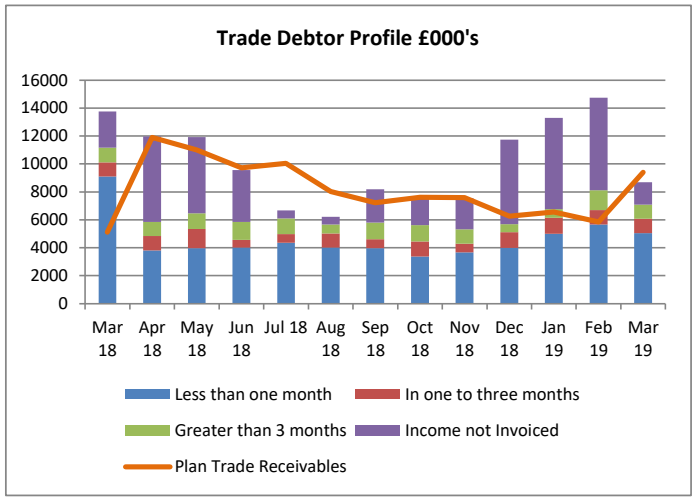
Financial Performance: Cash Position and Working Capital

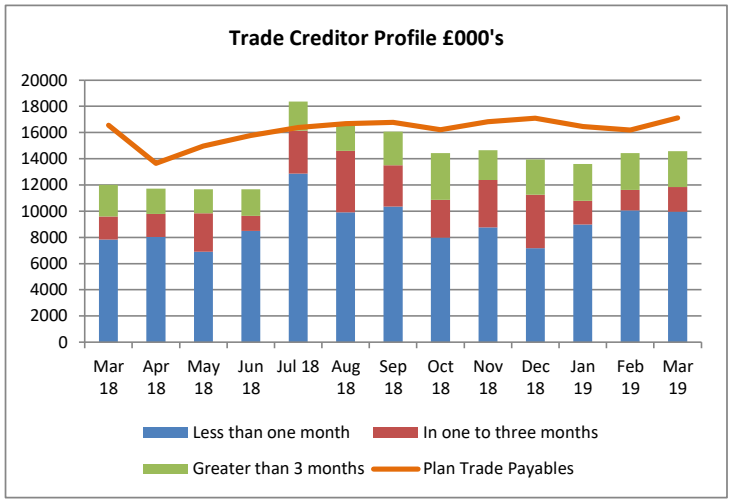
	Plan Apr to Mar (£'000)	Actual Apr to Mar (£'000)	Variance
Surplus/(deficit) after tax	**5,253**	**-4,489**	**-9,742**
Non-cash flows in operating Surplus/(deficit) total	6,395	11,098	4,703
Operating cash flows before movements in working capital	**11,648**	**6,609**	**-5,039**
Increase/(Decrease) in working capital Total	4,022	4,942	920
Net cash inflow/(outflow) from operating activities	**15,670**	**11,551**	**-4,119**
Net cash inflow/(outflow) from investing activities total	-14,133	-7,632	6,501
Net Cash inflow/(outflow) before financing	**1,537**	**3,919**	**2,382**
Net cash inflow/(outflow) from financing activities Total	2,631	-431	-3,062
Net increase/(decrease) in cash and cash equivalents	**4,168**	**3,488**	**-680**
Opening cash balance	**7,761**	**7,761**	**0**
Closing cash balance	**11,929**	**11,249**	**-680**

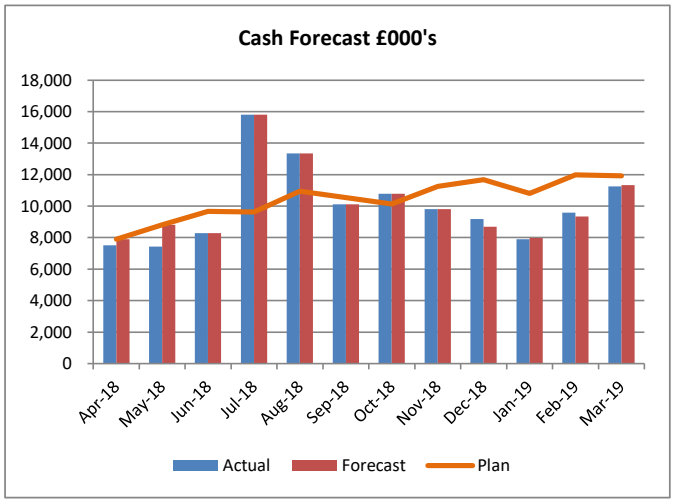
Cash is £0.68M less than anticipated; this is mainly due to the failure of the Q1, Q2, Q3 and Q4 A A&E target. In addition the Trust has missed its control total. This has meant that the Trust will not receive £4.6M of its planned PSF. However the Trust has been allocated £3,60M additional PSF as part of year end process. Non-cashflows variance is due to the impairment of the Land and buildings as part of the revaluation at year-end. This equates to £5.5M.

In addition the delay in the capital payment is improving the cash position but this is offset by £4.4M capital loan which has not been received for the ward refurbishment, Backlog maintenance and SSD Washers. The Trust is awaiting approval from the Department of Health. However the Trust has received £0.72M of Public capital dividend for IT projects which it wasn't anticipating.

Working capital has improved by £4.5M mainly due to a decrease in payables and an increase in Trade Creditors and deferred income.







Finance: *Staff Costs*

Headline Measures

	YTD £000's	Rolling 13 months £000's												
		Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Monthly Trend
Pay Budget	171,991	13,785	14,001	14,112	14,008	14,158	14,900	14,225	14,325	14,219	14,361	14,616	14,424	14,642	
Pay Actual	175,497	14,133	14,094	14,152	14,237	14,183	14,960	14,639	14,820	14,682	15,094	14,902	14,875	14,859	
Variance	-3,506	-348	-93	-40	-229	-25	-60	-414	-495	-463	-733	-286	-451	-217	
% to Budget	*102.0%*	*102.5%*	*100.7%*	*100.3%*	*101.6%*	*100.2%*	*100.4%*	*102.9%*	*103.5%*	*103.3%*	*105.1%*	*102.0%*	*103.1%*	*101.5%*	
Nursing Staff % to Budget	102.4%	105.0%	101.7%	99.9%	102.1%	100.5%	103.5%	103.1%	104.3%	107.0%	105.9%	100.9%	101.9%	97.7%	
Medical Staff % to Budget	101.7%	103.2%	95.4%	100.5%	99.2%	97.3%	92.0%	104.2%	107.2%	100.0%	108.7%	102.3%	105.6%	107.6%	
Other Staff % to Budget	101.9%	99.5%	102.9%	100.6%	102.7%	101.6%	102.0%	102.0%	100.3%	101.4%	102.0%	102.9%	103.0%	101.9%	

Commentary

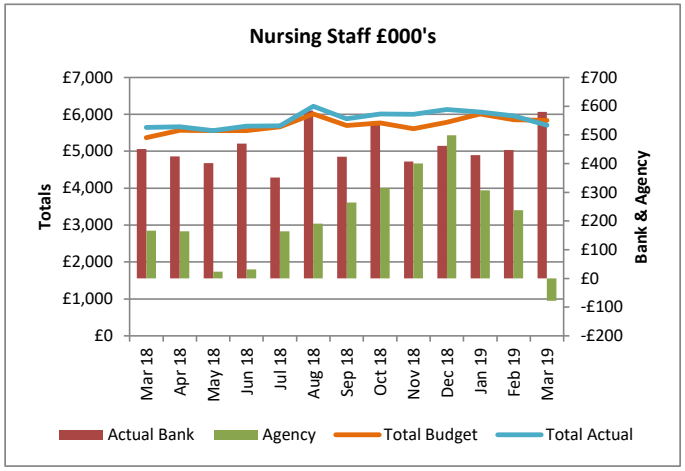
Pay is worse than budget by £3.5M year to date, with a £0.2M variance in month.

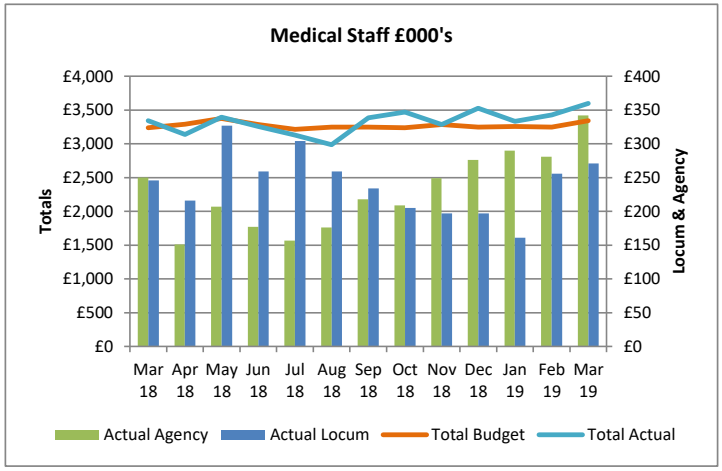
Nursing costs associated with keeping escalation beds/CAU assessment area open in April have been offset against agreed additional Winter money funding within contract income, however the further escalations over the Summer which have continued are unfunded. Whilst in November the planned Winter ward was opened, there have been escalation beds which have been opened on top of this – with the James Cross unit being opened for the majority of January, and part of February – which have further increased the financial pressure. The reduction in March in agency costs, relates to the review of the agency nurse accrual, which reveal a double count of VAT on agency rates paid.

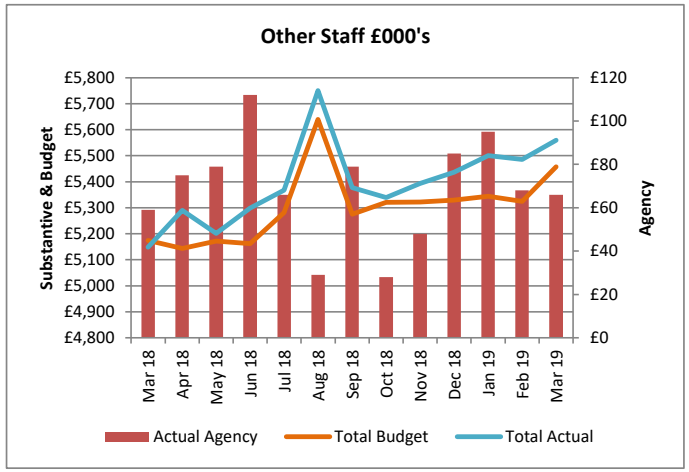
Medical pay is continuing to overspend, largely as a result of agency use of doctors to fill gaps in rotas, particularly within Medicine & Emergency Care.

Whilst the agency costs have exceeded the plan, the final position was under the NHSI ceiling.

Primary Drivers

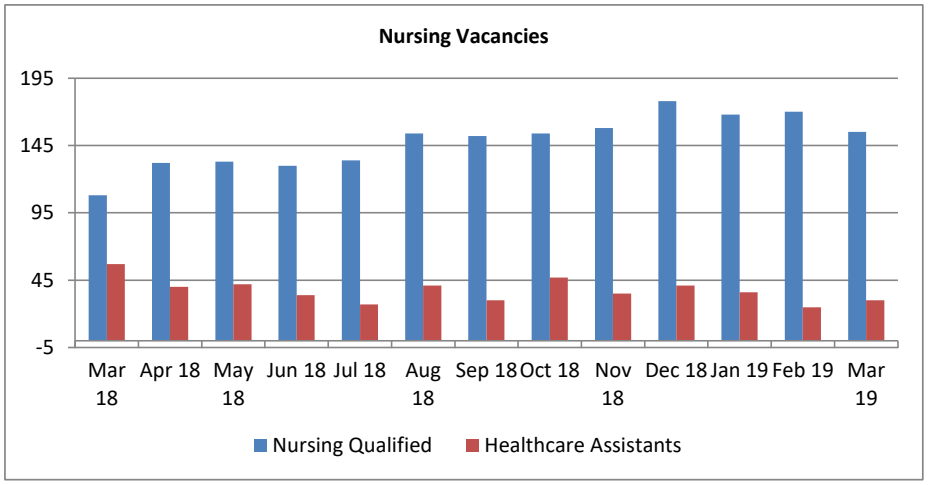






Finance: *Staff Costs*

Secondary Drivers



Medical vacancies under review

Agency Trajectory

	YTD	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Monthly Trend
Plan	-4,382	-484	-365	-365	-365	-365	-365	-365	-365	-365	-365	-365	-365	-367	
Actual	-6,073	-574	-389	-310	-320	-349	-348	-530	-490	-635	-792	-646	-682	-582	
Variance	-1,691	-90	-24	55	45	-22	-30	-198	-181	-332	-495	-327	-219	37	
MCHFT Actual	-4,534	-382	-190	-265	-251	-299	-300	-476	-445	-471	-583	-407	-478	-369	
CCICP Actual	-922	-77	-79	-45	-69	-50	-48	-54	-45	-87	-104	-134	-99	-108	
Planned Winter Escalations	-617	-115	-120	0	0	0	0	0	0	-77	-105	-105	-105	-105	

	Rolling 13 Months													
	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Monthly Trend
Sickness Rate (Rolling 12 mths)	4.38%	4.38%	4.37%	4.30%	4.29%	4.27%	4.27%	4.26%	4.24%	4.30%	4.27%	4.32%	4.33%	
Total Leavers	59	39	41	38	38	63	48	34	34	23	25	21	37	
Turnover (Rolling 12 mths)	11.18%	11.33%	11.28%	11.33%	11.17%	11.67%	11.54%	11.25%	11.03%	10.89%	10.60%	10.03%	9.94%	