

AGENDA

Board of Directors
A meeting will be held in Public at
09.30am on Monday, 1 July 2019
in the Boardroom, Leighton Hospital, Crewe

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 <ul style="list-style-type: none"> 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 meetings held in Public on Monday 3 June (attached) (for approval)	A	Chairman 09.52	4
5.	Matters Arising and Action Log (verbal) (to approve)	A	Chairman 09.55	-
6.	Annual Work Programme 2019/20 (attached) (to approve)	I/A	Chairman 09.57	18
7.	Chairman's Announcements (to note a verbal report) <div> <div>7.1</div> <div>Senior Leaders – 3 June 2019</div> </div> <div> <div>7.2</div> <div>Volunteers Evening – 4 June 2019</div> </div> <div> <div>7.3</div> <div>Board Away Day – 24 June 2019</div> </div> <div> <div>7.4</div> <div>Celebration of Achievement – 27 June 2019</div> </div>	I	Chairman 10.00	-
8.	Governor's Items (to note a verbal report) <div> <div>8.1</div> <div>NEDs/Governors Meeting – 20 June 2019</div> </div>	I	Chairman 10.10	-

Item No	Title of Item	Action	Led By	Page No.
9.	Chief Executive's Report <i>(to note a verbal report)</i>			
9.1	System Update	I	Interim Chief Executive 10.15	-
9.2	Joint Exec to Exec with ECT			
10.	CARING			
10.1	Quality, Safety & Experience Report <i>(attached) (for discussion)</i>	I/D	Director of Nursing & Quality 10.30	18
10.2	National Inpatient Survey 2019 <i>(presentation) (for discussion)</i>	I/D	Director of Nursing & Quality 10.40	-
11.	SAFE			
11.1	Draft Quality Governance Committee notes from the meeting held on 10 June 2019 <i>(attached) (to note)</i>	I	Committee Chair 11.00	64
11.2	Serious Untoward Incidents and RIDDOR Events <i>(verbal) (to note)</i>	I/D	Interim Medical Director 11.05	-
12.	RESPONSIVE			
12.1	Performance Report <i>(attached) (to note)</i>	I/D	Chief Operating Officer 11.05	83
12.2	Draft Performance & Finance Committee notes from the meeting held on 20 June 2019 <i>(to follow) (to note)</i>	I	Committee Chair 11.15	-
12.3	Legal Advice <i>(verbal) (to note)</i>	I	Interim Chief Executive 11.20	-
12.4	ED Workforce Business Case <i>(attached) (for approval)</i>	A/D	Chief Operating Officer 11.25	109
13.	WELL-LED			
13.1	Visits of Accreditation, Inspection or Investigation <i>(verbal) (to note)</i>	I	Interim Chief Executive 11.45	-
13.2	Trust Strategy Update <i>(verbal) (to note)</i>	A/D	Chief Operating Officer 11.50	145

Item No	Title of Item	Action	Led By	Page No.
13.3	CNST <i>(attached) (to approve)</i>	A/D	Director of Nursing & Quality 11.55	150
13.4	Well Led Internal Improvement Plan <i>(attached) (for information)</i>	I/D	Interim Chief Executive 12.00	168
14.	EFFECTIVE			
14.1	Workforce Report <i>(attached) (to note)</i>	I/D	Director of Workforce and OD 12.05	174
14.2	Transformation and People Committee notes from the meeting held on 6 June 2019 <i>(attached) (to note)</i>	I	Committee Chair 12.15	177
14.3	Consultant Appointments <i>(verbal) (to note)</i>	I	Interim Medical Director 12.20	-
15.	Any Other Business <i>(verbal)</i>	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 Boardroom, Leighton Hospital at 9.30am on Monday, 5 August 2019	I	Chairman	

Version: 3[illegible]



Quality, Safety and Experience Report

July 2019

(May 2019 data)



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

Contents

Metric	Page Number
Quality & Safety Section:	
Safety Indicators	4
Patient Safety Harm Incidents	8
Harm vs No Harm	8
Serious Incidents	9
Never Events	9
Hospital Acquired Pressure Ulcers	10
Medication Incidents	10
Inpatient Falls - Harm	11
Inpatient Falls – Rate Per 1,000 Bed Days	11
Inpatient Falls – Fractured NOF	11
CCICP Patient Safety Harm Incidents	12
CCICP Harm vs No Harm	12
CCICP Serious Incidents	13
CCICP Never Events	13
CCICP Community Acquired Pressure Ulcers	14
CCICP Medication Incidents	14
SHMI	15
HSMR	16
MRSA	17
C-Diff	17
MSSA	18
E-Coli	18
Information Governance ICO Reportable Incidents	19
CQUIN 2017/18 Targets	20
Registered Nurses day shift	25
Registered Nurses night shift	25
Support Worker day shift	25
Support Worker night shift	25
Safer Staffing	26

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

Contents (continued):

Metric	Page Number
Experience Section:	
Experience Indicators	27
Monthly Complaints & Formal thank you letters	28
Formal Complaints by Division	28
Ombudsman	29
Complaint Trends	29
Closed Complaints	30
Closed Complaints by Division	30
Closed Complaints Details	31
Number of Informal Concerns	41
Informal Concern Trends	41
New claims received	42
Claims closed with/without damages	42
Value of Claims by month	43
Top five Claims by Specialty	43
Inquests concluded by Month	44
NHS Choices Star Ratings	44
NHS Choices Postings	45
Friends & Family responses	45
Number of responses received for IP, Day Case, ED, maternity compared to eligible patients	46
Compliments	46

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

Indicators	Target	Trajectory 2019/20
Acute Trust		
Patient Safety Harm Incidents The target is to reduce the total number of patient safety harm incidents when compared to the previous financial year by the end of March 2020.	Less than 2294 at end of March 2020	
Serious Incidents The target is to reduce patient safety serious incidents when compared to the previous financial year by the end of March 2020.	Less than 18 at end of March 2020	
Never Events Zero tolerance of Never Events.	Zero	
Pressure Ulcers – Hospital Acquired The target is to have no more than two lapses in care (avoidable) pressure ulcers per month.	Less than 24 lapses in care at end of March 2020	
Medication Harm Incidents The target is to reduce the total number of medication incidents resulting in harm when compared to the previous financial year by the end of March 2020.	Less than 66 at end of March 2020	

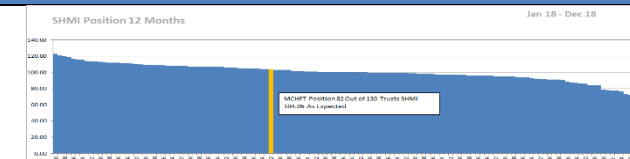
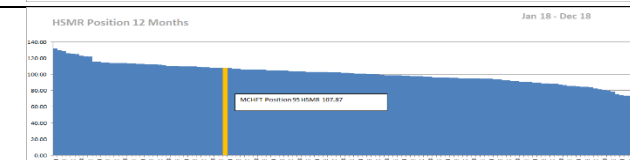
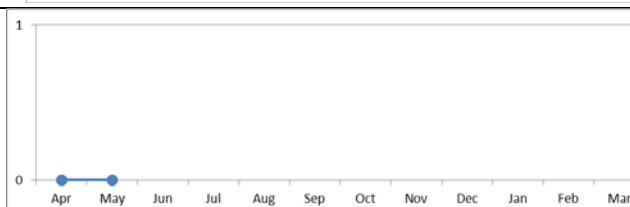
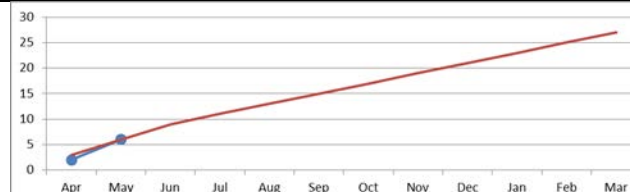

Board Papers – Quality, Safety & Experience Section: July 2019

Indicators	Target	Trajectory 2019/20																										
Acute Trust																												
Inpatient Falls - Harm The target is to have a reduction in harm from patient falls when compared to the previous financial year.	Less than 268 at end of March 2020	<table><thead><tr><th>Month</th><th>Falls</th></tr></thead><tbody><tr><td>Apr</td><td>20</td></tr><tr><td>May</td><td>50</td></tr><tr><td>Jun</td><td>70</td></tr><tr><td>Jul</td><td>90</td></tr><tr><td>Aug</td><td>110</td></tr><tr><td>Sep</td><td>130</td></tr><tr><td>Oct</td><td>150</td></tr><tr><td>Nov</td><td>170</td></tr><tr><td>Dec</td><td>190</td></tr><tr><td>Jan</td><td>210</td></tr><tr><td>Feb</td><td>230</td></tr><tr><td>Mar</td><td>268</td></tr></tbody></table>	Month	Falls	Apr	20	May	50	Jun	70	Jul	90	Aug	110	Sep	130	Oct	150	Nov	170	Dec	190	Jan	210	Feb	230	Mar	268
Month	Falls																											
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Jan	210																											
Feb	230																											
Mar	268																											
Inpatient Falls – Rate Per 1,000 Bed Days A reduction in the number of falls per 1,000 bed days when compared to the RCP National Audit 2015 (average number of patient falls per 1,000 bed days).	Ratio less than 6.6	<table><thead><tr><th>Month</th><th>Ratio</th></tr></thead><tbody><tr><td>Apr</td><td>5.5</td></tr><tr><td>May</td><td>4.5</td></tr><tr><td>Jun</td><td>5.0</td></tr><tr><td>Jul</td><td>5.2</td></tr><tr><td>Aug</td><td>5.4</td></tr><tr><td>Sep</td><td>5.6</td></tr><tr><td>Oct</td><td>5.8</td></tr><tr><td>Nov</td><td>6.0</td></tr><tr><td>Dec</td><td>6.2</td></tr><tr><td>Jan</td><td>6.4</td></tr><tr><td>Feb</td><td>6.5</td></tr><tr><td>Mar</td><td>6.6</td></tr></tbody></table>	Month	Ratio	Apr	5.5	May	4.5	Jun	5.0	Jul	5.2	Aug	5.4	Sep	5.6	Oct	5.8	Nov	6.0	Dec	6.2	Jan	6.4	Feb	6.5	Mar	6.6
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Mar	6.6																											
Inpatient Falls – Fractured NOF A reduction in the number of fractured NOF resulting from patient falls when compared to the previous financial year.	Less than 10 at end of March 2020	<table><thead><tr><th>Month</th><th>Fractured NOF</th></tr></thead><tbody><tr><td>Apr</td><td>1</td></tr><tr><td>May</td><td>2</td></tr><tr><td>Jun</td><td>3</td></tr><tr><td>Jul</td><td>4</td></tr><tr><td>Aug</td><td>5</td></tr><tr><td>Sep</td><td>6</td></tr><tr><td>Oct</td><td>7</td></tr><tr><td>Nov</td><td>7</td></tr><tr><td>Dec</td><td>7</td></tr><tr><td>Jan</td><td>8</td></tr><tr><td>Feb</td><td>9</td></tr><tr><td>Mar</td><td>10</td></tr></tbody></table>	Month	Fractured NOF	Apr	1	May	2	Jun	3	Jul	4	Aug	5	Sep	6	Oct	7	Nov	7	Dec	7	Jan	8	Feb	9	Mar	10
Month	Fractured NOF																											
Apr	1																											
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Nov	7																											
Dec	7																											
Jan	8																											
Feb	9																											
Mar	10																											

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

Indicators	Target	Trajectory 2018/19
CCICP		
CCICP Patient Safety Harm Incidents The target is to reduce the total number of CCICP patient safety harm incidents when compared to the previous financial year by the end of March 2020.	Less than 1238 at end of March 2020	
CCICP Serious Incidents The target is to continue the trend of having zero CCICP patient safety serious incidents by the end of March 2020.	Zero	
CCICP Never Events Zero tolerance of CCICP Never Events.	Zero	
CCICP Pressure Ulcers – Community Acquired The target is to have no more than two lapses in care (avoidable) pressure ulcers per month.	Less than 24 lapses in care at end of March 2020	
CCICP Medication Incidents The target is to reduce the total number of medication incidents when compared to the previous financial year by the end of March 2020.	Less than 67 at end of March 2020	

Board Papers – Quality, Safety & Experience Section: July 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 The target is less than 27 cases of Clostridium Difficile in 2019/20. The target includes cases who have been identified in the community but had a hospital admission in the previous 28 days.	Less than 27 at end of March 2020	
Safety Thermometer The Trust target is that >95% of patients receive harm free care as monitored by the Safety Thermometer.	>95%	

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

Quality & Safety Section:

Description

Aggregate Position

Trend

Patient Safety Harm Incidents

The target is to reduce the total number of patient safety harm incidents when compared to the previous financial year by the end of March 2020.

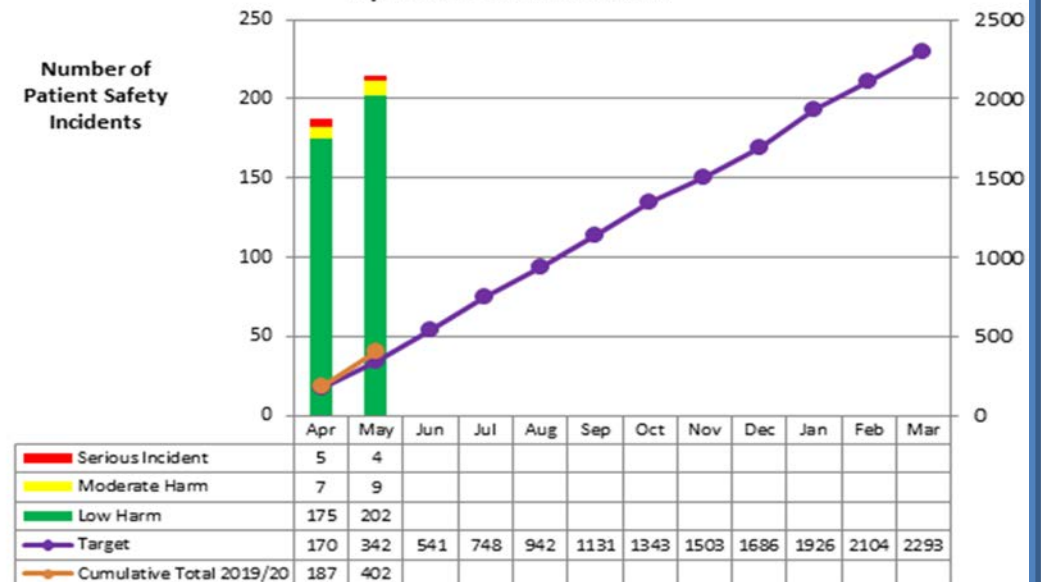
This chart demonstrates the total number of reported patient safety harm incidents. For May 2019, there were a total of 215 patient safety harm incidents:

95.3% (202 incidents) have resulted in low harm
4.2% (9 incidents) have resulted in moderate harm
2.0% (4 incidents) resulted in serious harm

Improvement actions include;

- The Trust continues with twice monthly Patient Safety Summit meetings. 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.
- Direct feedback to all staff on the outcome incidents they have reported to demonstrate the changes in practice that have been made as a result of the incident.

**Patient Safety Incidents Resulting in Harm
April 2019 to March 2020**



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.

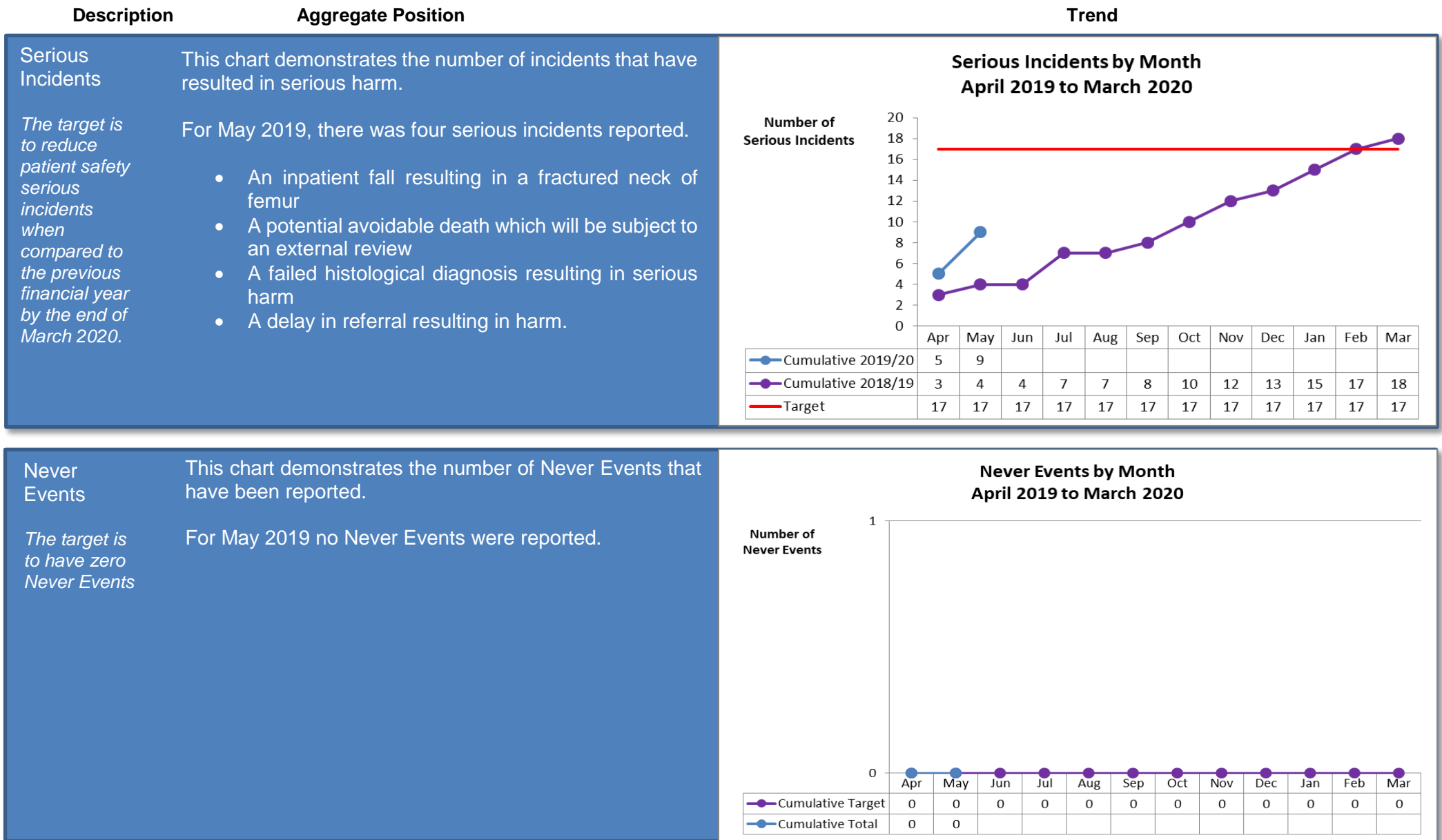
In May 2019, the gap between harm and all patient safety incidents was 449. The aim over the twelve month period is to see this gap widening.

A safety culture survey was undertaken in the Trust in December 2018 to January 2019. The results were shared at the EQGG in April 2019 and divisional improvement plans developed to take into account the feedback received during the survey.

**Harm vs All Patient Safety Incidents by Month
April 2019 to March 2020**



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



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

Description

Aggregate Position

Trend

Pressure Ulcers (PU) – Hospital Acquired
The target is to have no more than 24 pressure ulcers resulting from lapses in care by the end of March 2020.

For May 2019, there were a total of 17 hospital acquired pressure ulcer incidents:

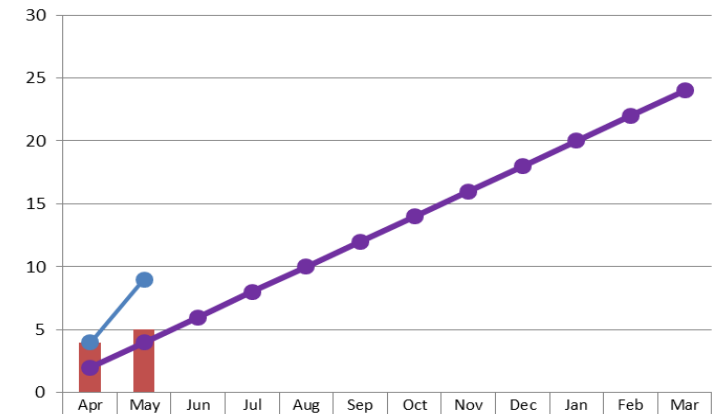
- 29% (5 PUs) occurred with lapses in care that did contribute to the PU.
- 6% (1 PU) occurred with lapses in care that did not contribute to the PU.
- 41% (7 PUs) are awaiting confirmation from PUP.
- 24% (4 PUs) occurred with no lapses in care identified.

Improvement actions include;

The following guides have been ratified and shared with staff to support pressure ulcer prevention:

- Relaunch of weekly audits by Matrons which will review mattresses, skin assessments and repositioning
- Divisional improvement plans to be completed on identification of common themes across ward areas. E.g., Lack of skin assessment.

**Hospital Acquired Pressure Ulcers by Month
April 2019 to March 2020**



Lapses in Care Identified	4	5										
Cumulative Lapses in Care	4	9										
Lapses in Care Cumulative Target	2	4	6	8	10	12	14	16	18	20	22	24
% Lapses in Care PU	26.7%	29.4%										

Medication Harm Incidents
The target is to reduce the total number of medication incidents resulting in harm when compared to the previous financial year by the end of March 2020.

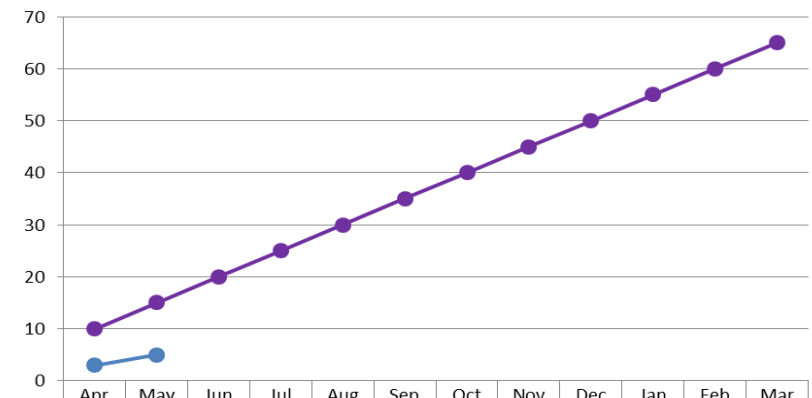
For May 2019, there were a total of 2 medication incidents resulting in harm reported:

- 100% (2 medication incidents) have resulted in low harm
- 0% (0 medication incidents) have resulted in moderate harm
- 0% (0 medication incidents) have resulted in serious harm

Improvement actions include:

- Junior medical staff training and E-learning package in place
- Medicines management training for nurses has been updated
- Monthly lessons learned shared from the Safe Medicines Practice Group
- Pharmacy enablement policy approved which enables pharmacists to amend prescriptions which are unsafe or unclear.

**Medication Harm Incidents by Month
April 2019 to March 2020**



Cumulative Total	3	5										
Cumulative Target	10	15	20	25	30	35	40	45	50	55	60	65

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

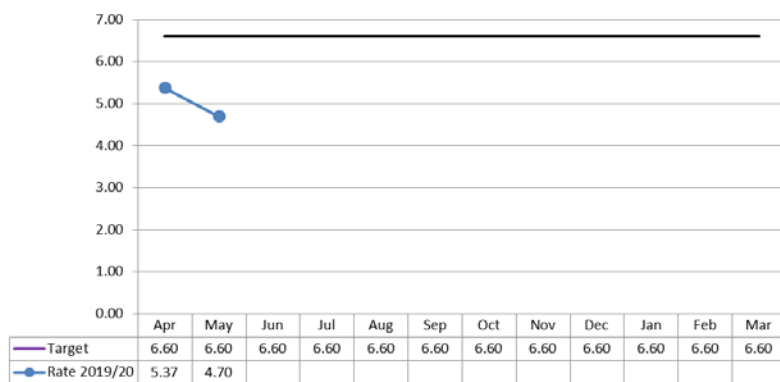
Description

Inpatient Falls.

A reduction in the number of falls per 1,000 bed days when compared to the previous financial year (less than 6.6)

Aggregate Position

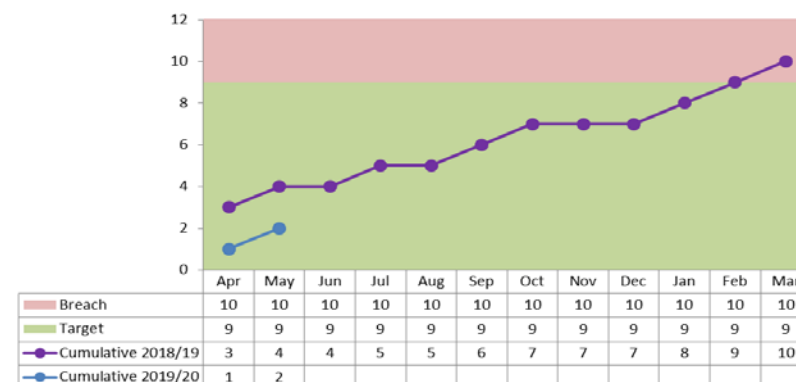
Inpatient Falls Rate Per 1,000 Bed Days & Month
April 2019 to March 2020



For May 2019, the falls rate per 1,000 bed days was 4.70.

Trend

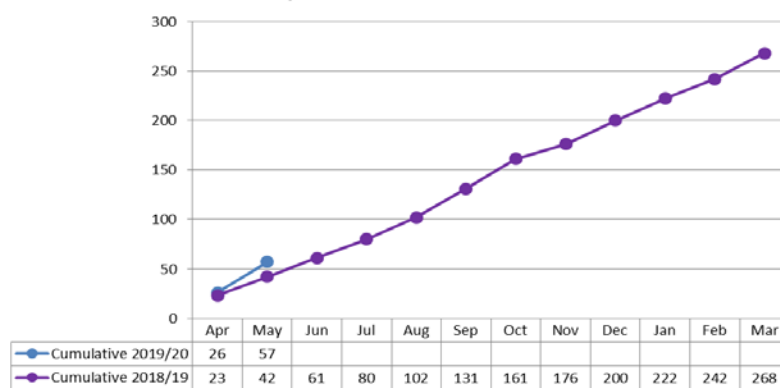
Inpatient Falls Resulting in Fractured Neck of Femur by Month
April 2019 to March 2020



In May 2019, there was a total of one fractured neck of femur at Elmhurst.

A reduction in the total number of falls with harm compared to previous year (less than 268)

Inpatient Falls Resulting In Harm by Month
April 2019 to March 2020



In May 2019, there were a total of 31 falls with harm.

- 93.5% (29) resulting in low harm
- 3.25% (1) resulting in moderate harm
- 3.25% (1) resulting in major harm

Improvement actions include:

- Royal College of Physicians pocket cards for lying and standing blood pressure monitoring circulated to all clinical areas
- Concise or Comprehensive investigations undertaken where all moderate or severe harm has occurred. Outcomes shared with staff at ward level and discussed at Falls Group

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

Central Cheshire Integrated Care Partnership (CCICP)

Description

Aggregate Position

Trend

CCICP Patient Safety Harm Incidents

The target is to reduce the total number of CCICP patient safety harm incidents when compared to the previous financial year by the end of March 2020.

For May 2019, there were a total of 122 patient safety harm incidents:

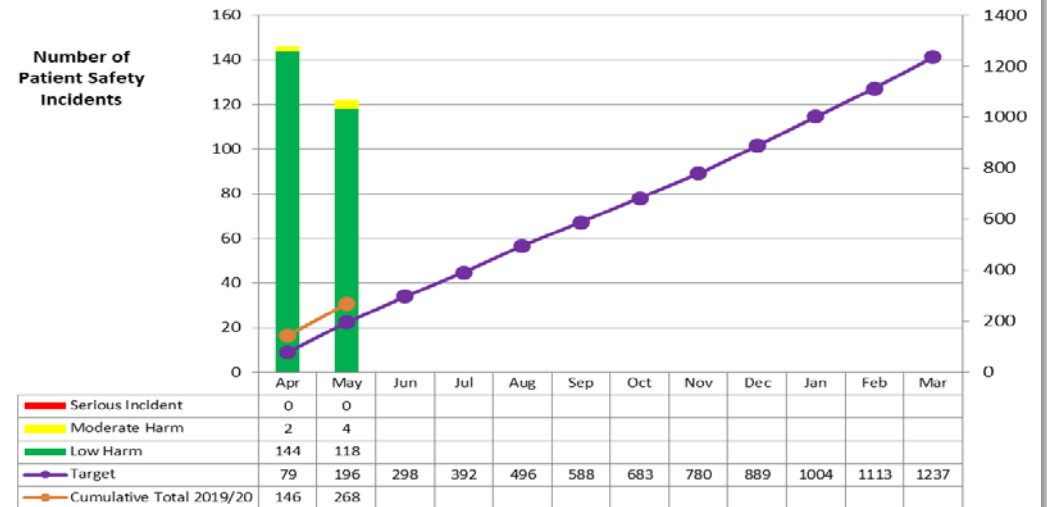
- 96.7% (118 incidents) have resulted in low harm
- 3.3% (4 incidents) have resulted in moderate harm
- 0% (0 incidents) have resulted in serious harm

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

These include:

- Sharing of learning from reported incidents through safety alerts, lessons learned episodes of care, individual patient stories and Safety Matters.
- Incident report training for all new staff to the Trust. This training ensures that all staff in the Trust know how to report a patient safety incident and they also understand the importance of incident reporting.

CCICP Patient Safety Incidents Resulting in Harm
April 2019 to March 2020



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 May 2019, the gap between harm and all patient safety incidents was 19.

A safety culture survey was undertaken in the Trust in December 2018 to January 2019. The results were shared at the EQGG in April 2019 and divisional improvement plans developed to take into account the feedback received during the survey

CCICP Harm vs All Patient Safety Incidents by Month
April 2019 to March 2020



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

Description

Aggregate Position

Trend

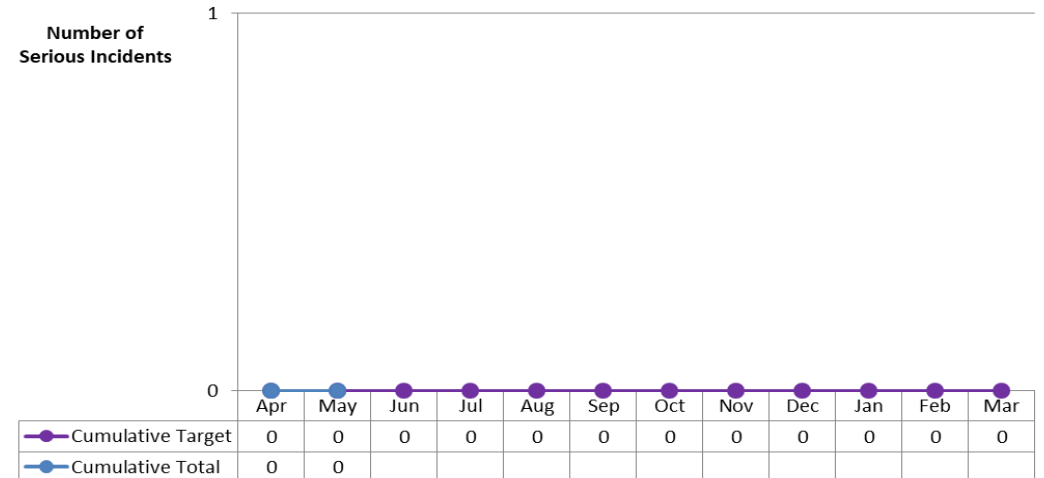
CCICP Serious Incidents

This chart demonstrates the number of incidents that have resulted in serious harm.

For May 2019, there were no serious incidents reported.

The target is to continue the trend of having zero CCICP patient safety serious by the end of March 2020.

CCICP Serious Incidents by Month
April 2019 to March 2020



CCICP Never Events

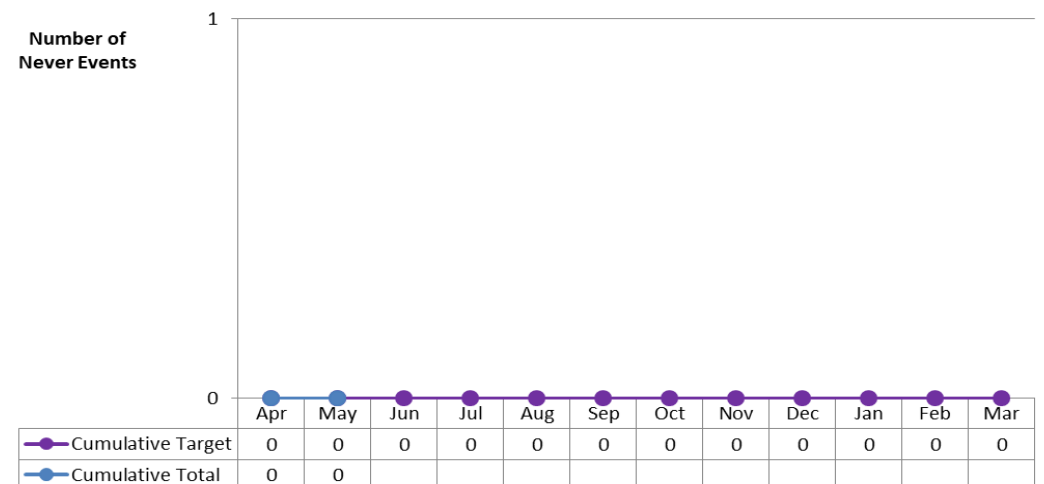
This chart demonstrates the number of Never Events that have been reported.

For May 2019 no Never Events were reported.

The target is to have zero Never Events

No Never Events have been reported for CCICP since the merger of the Trust in October 2016.

CCICP Never Events by Month
April 2019 to March 2020



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

Description	Aggregate Position	Trend																																																																	
<p>Pressure Ulcers – Community Acquired</p> <p><i>The target is to have no more than 24 pressure ulcers resulting from lapses in care by the end of March 2020.</i></p>	<p>For May 2019, there were a total of 77 community acquired pressure ulcer incidents:</p> <ul style="list-style-type: none">• 0% (0 PU's) have resulted in lapses in care.• 63.6% (49 PU's) have been classed as no lapses in care• 36.4% (28 PU's) are currently undergoing investigation prior to confirmation as to whether the PU had any lapses in care. <p>Improvement actions include:</p> <ul style="list-style-type: none">• Promote attendance of residential care home colleagues and care agencies to the CCICP Pressure Ulcer Panel, to share learning and develop quality patient care standards within the care home setting.• Approval of the purchase of 250 pressure relieving cushions for a 12 month trial, to supply pressure relieving cushions to at risk patients whom previously would have been expected to purchase themselves.	<p>CCICP Community Acquired Pressure Ulcers by Month April 2019 to March 2020</p> <table><tr><th></th><th>Apr</th><th>May</th><th>Jun</th><th>Jul</th><th>Aug</th><th>Sep</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th><th>Mar</th></tr><tr><td>Lapses in Care Identified</td><td>3</td><td>0</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>Cumulative Total</td><td>3</td><td>3</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>Lapses in Care Cumulative Target</td><td>2</td><td>4</td><td>6</td><td>8</td><td>10</td><td>12</td><td>14</td><td>16</td><td>18</td><td>20</td><td>22</td><td>24</td></tr><tr><td>% Avoidable PU</td><td>3.6%</td><td>0.0%</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Lapses in Care Identified	3	0											Cumulative Total	3	3											Lapses in Care Cumulative Target	2	4	6	8	10	12	14	16	18	20	22	24	% Avoidable PU	3.6%	0.0%										
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Lapses in Care Cumulative Target	2	4	6	8	10	12	14	16	18	20	22	24																																																							
% Avoidable PU	3.6%	0.0%																																																																	
<p>CCICP Medication Incidents.</p> <p><i>The target is to reduce the total number of medication incidents when compared to the previous financial year by the end of March 2020</i></p>	<p>For May 2019, there were a total of 3 medication incidents reported:</p> <ul style="list-style-type: none">• 100% (3 medication incidents) resulted in no harm• 0% (0 medication incidents) resulted in low harm• 0% (0 medication incidents) have resulted in moderate harm• 0% (0 medication incidents) have resulted in serious harm <p>Improvement actions include;</p> <ul style="list-style-type: none">• New Medication competency rolled out across CCICP, to date 92% of community nursing staff have undertaken it.• Head of nursing meets with all clinicians involved in an insulin incident to support and promote learning.	<p>CCICP Medication Incidents by Month April 2019 to March 2020</p> <table><tr><th></th><th>Apr</th><th>May</th><th>Jun</th><th>Jul</th><th>Aug</th><th>Sep</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th><th>Mar</th></tr><tr><td>Total</td><td>12</td><td>15</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>Cumulative Target</td><td>5</td><td>10</td><td>15</td><td>20</td><td>25</td><td>30</td><td>35</td><td>40</td><td>45</td><td>50</td><td>55</td><td>60</td></tr></table>		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	12	15											Cumulative Target	5	10	15	20	25	30	35	40	45	50	55	60																										
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar																																																							
Total	12	15																																																																	
Cumulative Target	5	10	15	20	25	30	35	40	45	50	55	60																																																							

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

Description

Aggregate Position

Trend

SHMI

The Trust's target is to be at least within the "as expected" bracket.

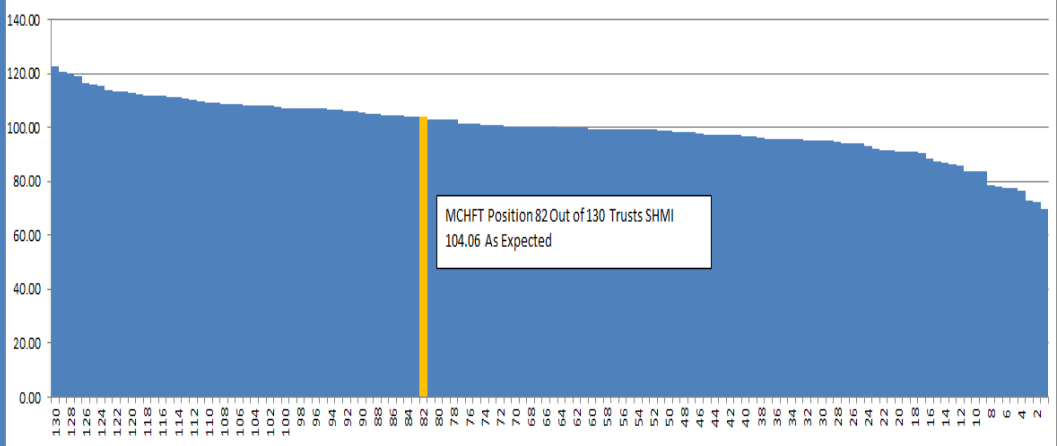
The chart benchmarks the Trust's latest SHMI against all NHS Trusts.

MCHFT is shown as the yellow bar.

The Trust's SHMI is 104.06 for the time period January 2018 to December 2018 and places the Trust 82 out of 130 Trusts and is "as expected".

SHMI Position 12 Months

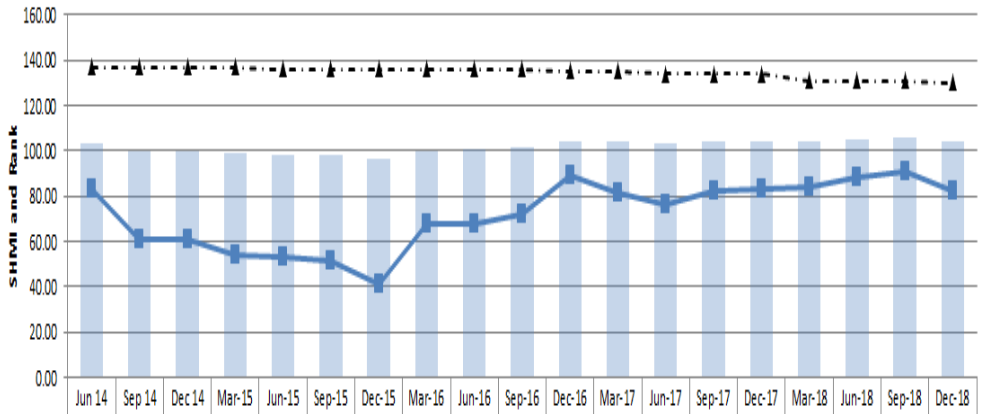
Jan 18 - Dec 18



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 January 2018 to December 2018 and is "as expected".



MCHFT SHMI	103.15	100.20	99.90	99.06	98.25	98.42	96.84	100.00	100.61	101.72	104.24	103.85	102.97	103.71	104.12	104.39	104.75	105.48	104.06
MCHFT RANK	83	61	61	54	53	51	41	68	68	72	89	81	76	82	83	84	88	91	82
TOTAL TRUSTS	137	137	137	137	136	136	136	136	136	136	135	135	134	134	134	131	131	131	130

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

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.

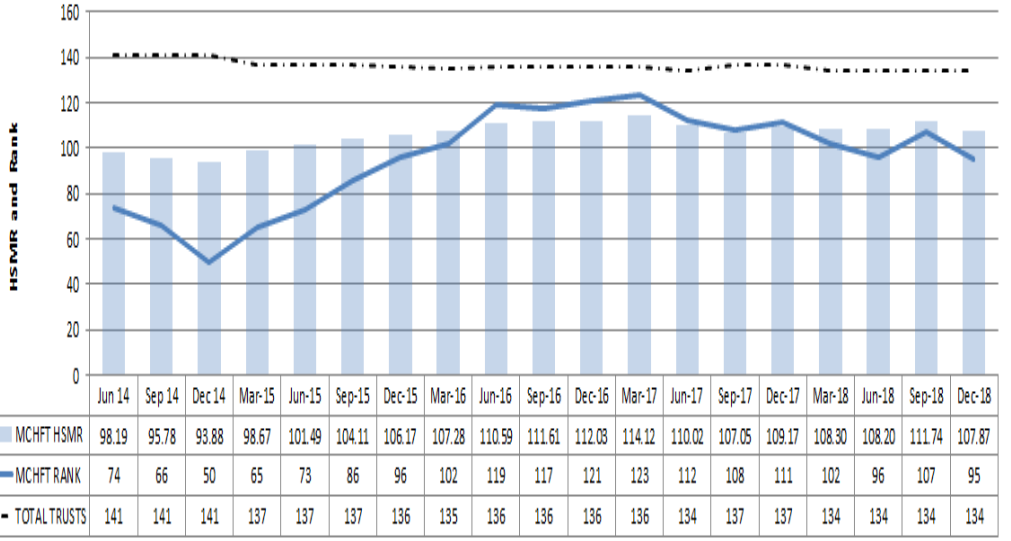
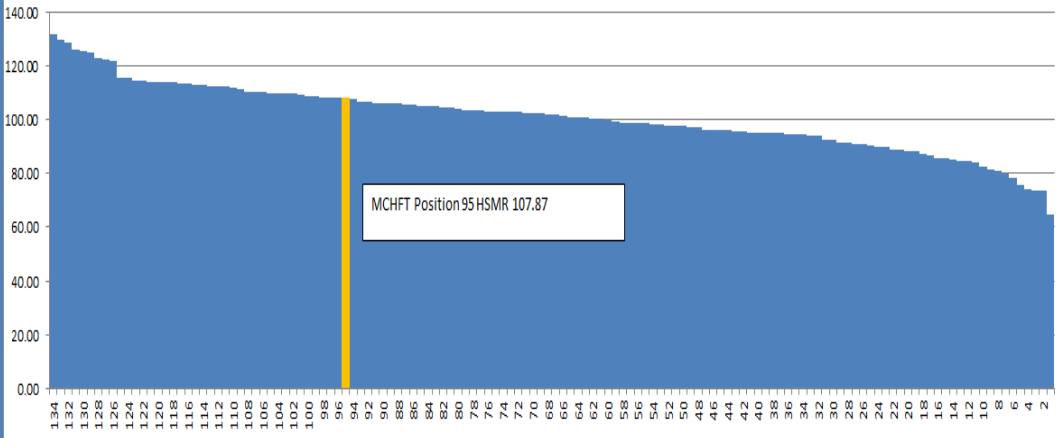
The chart benchmarks the Trust's HSMR against all NHS Trusts.

MCHFT is shown by the amber bar.

The Trust's HSMR is 107.87 (January 2018 to December 2018) and places the Trust 95 out of 134 Trusts and is "as expected".

HSMR Position 12 Months

Jan 18 - Dec 18



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 January 2018 to December 2018 and is "as expected".

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

Description

Aggregate Position

Trend

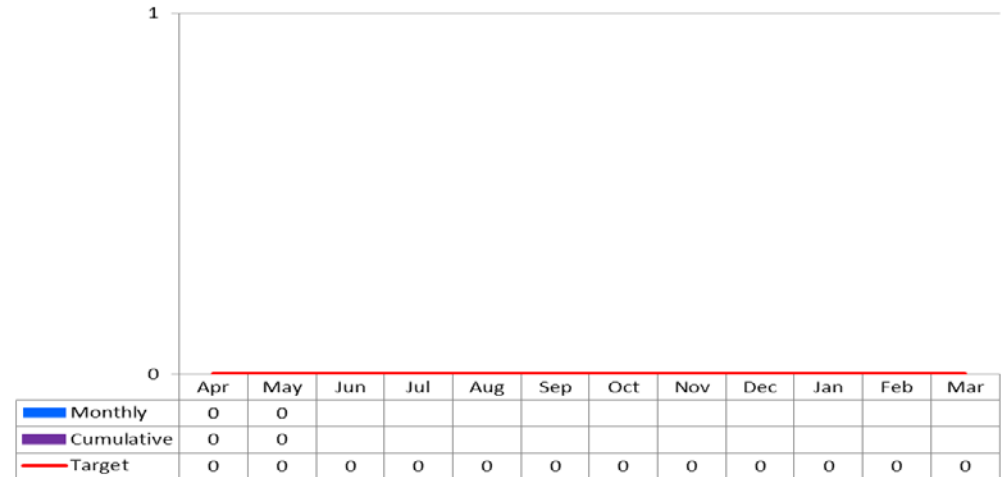
MRSA Bacteraemia Cases.

Zero tolerance of MRSA cases.

In May 2019, no MRSA bacteraemia cases were reported in the Trust.

In this financial year there have been no confirmed MRSA bacteraemia cases to date.

MRSA Bacteraemia cases reported within the Trust
April 2019 to March 2020



Clostridium Difficile toxin positive cases.

The target is less than 27 cases of Clostridium Difficile in 2018/19

In May 2019, no avoidable cases were reported.

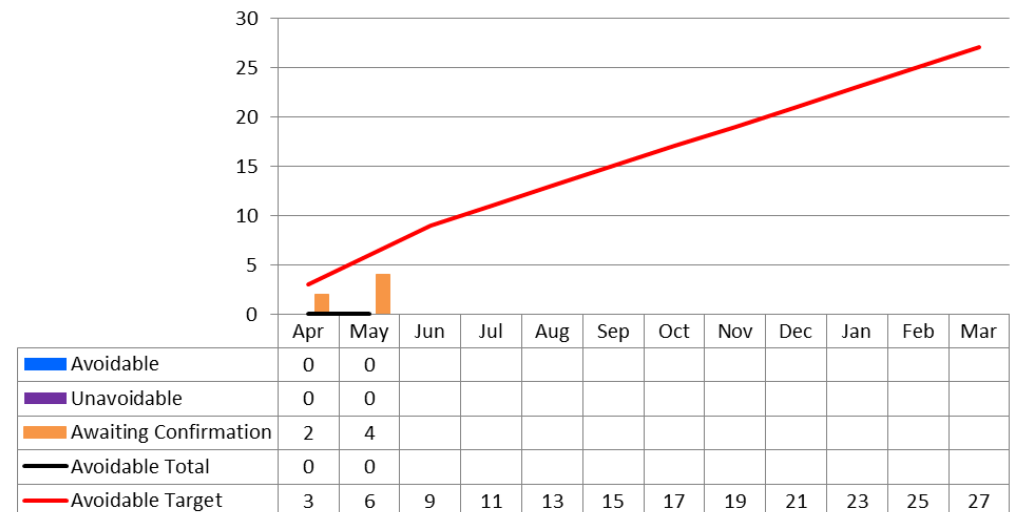
The target is less than 27 cases of Clostridium Difficile in 2019/20. The target includes cases that have been identified in the community but had a hospital admission in the previous 28 days.

For May there are 4 cases waiting confirmation from the PIR, of these 2 are Hospital Onset Healthcare Associated Clostridium Difficile and 2 Community Onset Healthcare Associated Clostridium Difficile.

Improvement actions include:

- Continuing focus on inappropriate anti-microbial prescribing
- All cases are subject to post infection reviews in accordance with NHS England requirements. Any lapses in care are addressed through this process
- Share lapses in care with individual clinicians involved in patient pathway to ensure lessons learnt.

Clostridium Difficile Toxin Positive Cases Report Within the Trust
April 2019 to March 2020



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

Description

Aggregate Position

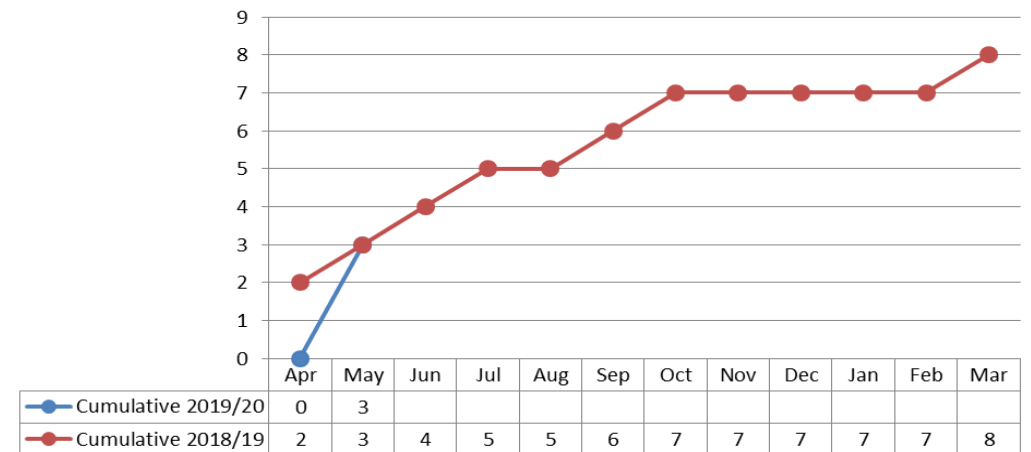
Trend

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 May 2019, 3 MSSA cases were reported in the Trust.
2 of these occurred in Critical Care and 1 occurred on Ward 15
In this financial year there has been 3 confirmed MSSA cases reported.

**MSSA cases reported within the Trust
April 2019 to March 2020**

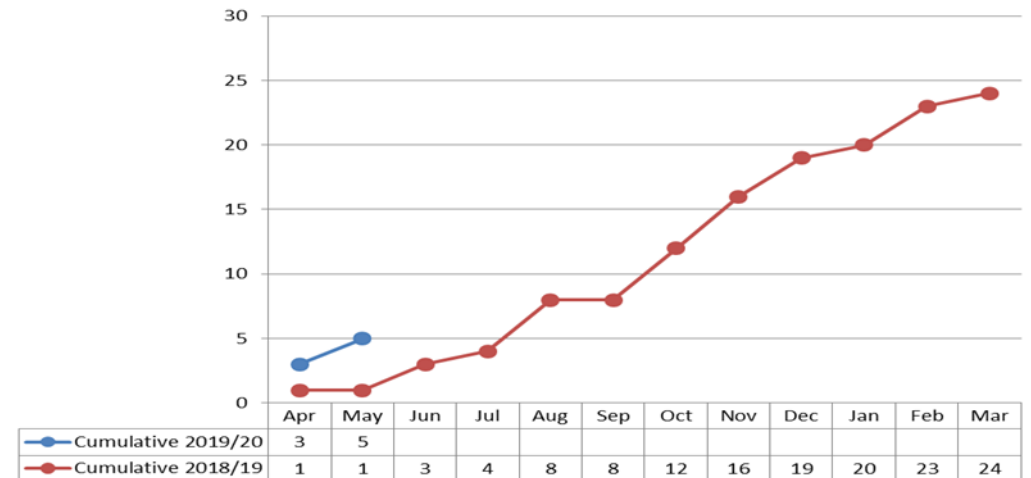


E-Coli Cases. In May 2019, two E-Coli cases were reported.

The aim is to have a reduction in E-Coli cases when compared to the previous financial year, to demonstrate an incremental improvement

These occurred on Ward 3 (AMU) and Emergency Department.
In this financial year there have been three confirmed E-Coli cases reported.

**E-Coli cases reported within the Trust
April 2019 to March 2020**



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

Description

Aggregate Position

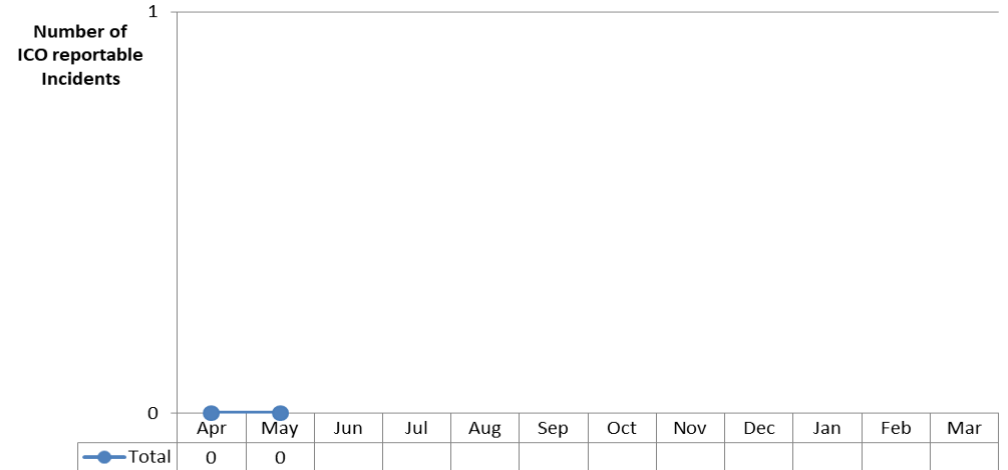
Trend

Information Governance Information Commissioners Office (ICO) reportable incidents.

In May 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.

**Information Governance ICO Reportable Incidents by Month
April 2019 to March 2020**



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



















CQUIN 2018-19 Performance

CQUIN Indicator	Indicator Name	Milestone Achieved								Maximum Value	Comments
		Q1	Financial Incentive Achieved	Q2	Financial Incentive Achieved	Q3	Financial Incentive Achieved	Q4	Financial Incentive Achieved		
1a	Health & Wellbeing 5% point improvement in two of the three questions on H&W, MSK & Stress		No payment		No payment		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 payment		No payment		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 payment		No payment		No payment		£137,574 £137,180	£137,180 CCICP	
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 (£10,318 partial payment)	 Partially	£25,795 (£10,318 partial payment)	£103,181	
2b	Sepsis: Treatment The percentage of patients who were found to have sepsis and received IV antibiotics within 1 hour.	 Partially	£25,795 (£10,318 partial payment)	 Partially	£25,795 (£10,318 partial payment)	 Partially	£25,795 (£10,318 partial payment)	 Partially	£25,795 (£10,318 partial payment)	£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	Continuation of antimicrobial stewardship and promotion of IV switch to oral
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 payment		No payment		£34,393	£34,393	











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

CQUIN Indicator	Indicator Name	Milestone Achieved								Maximum Value	Comments
		Q1	Financial Incentive Achieved	Q2	Financial Incentive Achieved	Q3	Financial Incentive Achieved	Q4	Financial Incentive Achieved		
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 payment		No payment		£34,393	£34,393	
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 payment		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 payment		£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	A continued CQUIN in 19/20 with revised milestones. Meetings with divisional reps and leads relaunched to ensure focus. Audit C tool updated and relaunched as part of "love your liver week". Training sessions being delivered in Assessment areas
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	

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

CQUIN Indicator	Indicator Name	Milestone Achieved								Maximum Value	Comments
		Q1	Financial Incentive Achieved	Q2	Financial Incentive Achieved	Q3	Financial Incentive Achieved	Q4	Financial Incentive Achieved		
9d	Alcohol screening 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	
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		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		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	

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

CQUIN Indicator	Indicator Name	Milestone Achieved								Maximum Value	Comments
		Q1	Financial Incentive Achieved	Q2	Financial Incentive Achieved	Q3	Financial Incentive Achieved	Q4	Financial Incentive Achieved		
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	

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

Description

Aggregate Position

Trend

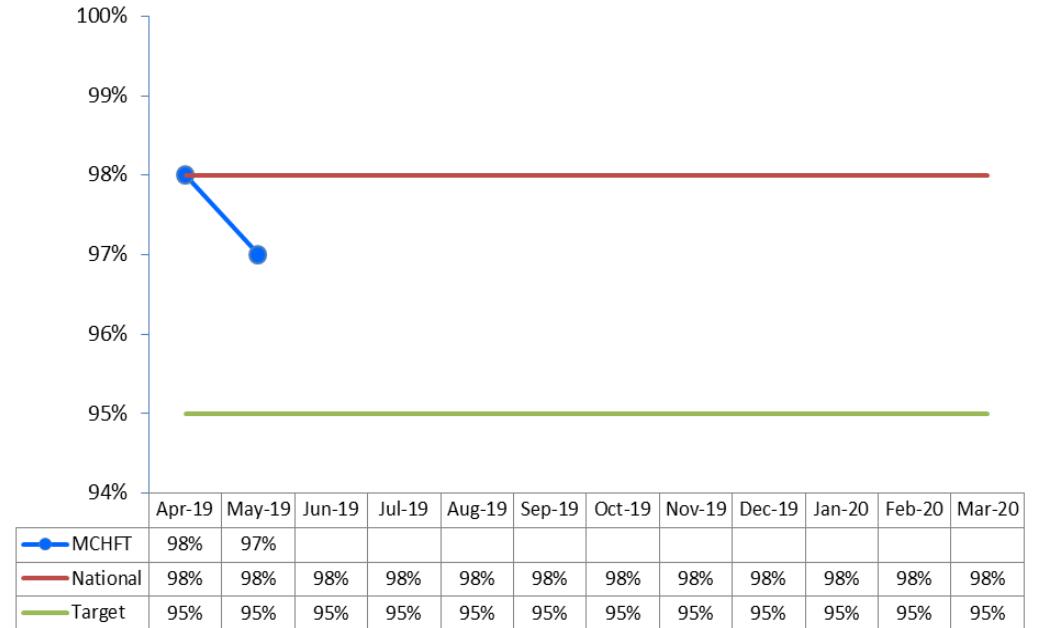
Safety
Thermometer
- Harm Free
Care.

In May 2019, 97% 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.

Percentage of patients with Harm Free Care
Safety Thermometer



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

Description	Aggregate Position	Trend	Trend
Registered Nurses monthly expected hours by shift versus actual monthly hours per shift. Day time shifts only	90.6% 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 May 2019 90.6% April 2019 90.5% March 2019 90.3%	The lowest staffing levels during the day were on Ward 9 at 65.9%
Registered Nurses monthly expected hours by shift versus actual monthly hours per shift. Night time shifts only	95% of expected Registered Nurse hours were achieved for night shifts.	Trend May 2019 95% April 2019 92.9% March 2019 93.2%	The lowest staffing levels during the night were on Ward 6 at 70.2%
Healthcare Assistant monthly expected hours by shift versus actual monthly hours per shift. Day time shifts only	95.1% of expected HCA hours were achieved for day shifts.	Trend May 2019 95.1% April 2019 95.3% March 2019 101.6%	The lowest staffing levels during the day were on Ward 9 at 79%
Healthcare Assistant monthly expected hours by shift versus actual monthly hours per shift. Night time shifts only	94.8% 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 May 2019 94.8% April 2019 94.1% March 2019 110.9%	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 3 (AMU) (day) 83% and (night) 84.5%, Ward 5 (day) 81.7% and (night) 71%, Ward 6 (night) 70.2%, Ward 7 (day) 82.9%, Ward 9 (day) 65.9%, Ward 13 (day) 82.5%, Ward 14 (night) 80.6% and Ward 15 (day) 83% and (night) 81.7%	<ul style="list-style-type: none"> • 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: July 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	42678.0	38361.3	32269.9	32424.9	26967.6	25275.5	18632.2	20568.9	90.6%	95.1%	95%	94.8%	15450	172.4	81.4	253.8
AMU	2011.3	1668.5	1519	1488.8	1898.8	1604.8	1519	1482.3	83.0%	98.0%	84.5%	97.6%	809	4.0	3.7	7.7
CAU (Winter)	1707.5	1707.5	831.5	831.5	1598.5	1598.5	310.5	310.5	100.0%	100.0%	100.0%	100.0%	491	6.7	2.3	9.1
Critical Care	3890.5	3890.5	600.5	600.5	2403.5	2403.5	0	0	100.0%	100.0%	100.0%	-	214	29.4	2.8	32.2
Elmhurst	871.5	877.5	2232	2238	775	775	1550	1650	100.7%	100.3%	100.0%	106.5%	890	1.9	4.4	6.2
Ward 1	2193.8	1912.5	1162.5	1143.8	1519	1433.3	759.5	771.8	87.2%	98.4%	94.4%	101.6%	933	3.6	2.1	5.6
Ward 13	2472	2040	1984	1928	953.3	902	953.3	994.3	82.5%	97.2%	94.6%	104.3%	908	3.2	3.2	6.5
Ward 14	1344	1332	1488	1560	1116	900	1116	1236	99.1%	104.8%	80.6%	110.8%	931	2.4	3.0	5.4
Ward 15	2352	1952	1984	1976	953.3	779	953.3	922.5	83.0%	99.6%	81.7%	96.8%	919	3.0	3.2	6.1
Ward 19	1356.3	1200	1550	1550	759.5	796.3	1139.3	1470	88.5%	100.0%	104.8%	129.0%	925	2.2	3.3	5.4
Ward 2	1806.3	1562.5	1550	1412.5	1139.3	1065.8	1139.3	1151.5	86.5%	91.1%	93.5%	101.1%	930	2.8	2.8	5.6
Ward 21b	1187	1148	1963	2067	775	787.5	775	1137.5	96.7%	105.3%	101.6%	146.8%	742	2.6	4.3	6.9
Ward 23	1238	1225.3	785.3	785.3	764.7	764.7	764.7	764.7	99.0%	100.0%	100.0%	100.0%	563	3.5	2.8	6.3
Ward 4	1716	1572	1860	1800	744	768	1488	1488	91.6%	96.8%	103.2%	100.0%	535	4.4	6.1	10.5
Ward 5	2325	1900	1550	1525	1519	1078	759.5	1078	81.7%	98.4%	71.0%	141.9%	915	3.3	2.8	6.1
Ward 6	1793.8	1531.3	1937.5	1912.5	1519	1065.8	759.5	1053.5	85.4%	98.7%	70.2%	138.7%	848	3.1	3.5	6.6
Ward 7	1758.8	1458.8	1550	1975	759.5	747.3	1139.3	1580.3	82.9%	127.4%	98.4%	138.7%	960	2.3	3.7	6.0
Ward 9	1454	958	992	784	635.5	584.3	512.5	256.3	65.9%	79.0%	91.9%	50.0%	226	6.8	4.6	11.4
NICU	1924.6	1725.9	183.4	162.7	1782.5	1874.5	0	46	89.7%	88.7%	105.2%	-	277	13.0	0.8	13.8
Ward 11 SAU	1500	1650	930	1027.5	580.7	674.4	580.7	627.6	110.0%	110.5%	116.1%	108.1%	463	5.0	3.6	8.6
Ward 18 SSW	1495	1320	1162.5	1218.8	759.5	759.5	759.5	820.8	88.3%	104.8%	100.0%	108.1%	640	3.2	3.2	6.4
Ward 10 Ortho	2848	2480	3720	3640	953.3	953.3	1271	1271	87.1%	97.8%	100.0%	100.0%	1120	3.1	4.4	7.5
Ward 26 MLU	785.3	798	0	133	764.7	740	0	74	101.6%	-	96.8%	-	44	35.0	4.7	39.7

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

Experience Section:

Indicators	Last four months			
	Feb-19	Mar-19	Apr-19	May-19
Complaints received by month	13	21	21	22
Complaints being reviewed by the Ombudsman	1	0	0	0
Closed complaints by month	23	18	15	20
Contacts raising informal concerns	105	97	86	103
Compliments received in month	409	406	290	269
Number of new claims received in month	5	6	3	7
Number of claims closed	4	1	2	3
Number of inquests concluded	1	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	13	4	4	1
F&FT Response Rate ED, MIU, UCC and Assessment Areas*	14%	18%	17%	16%
Proportion of positive responses ED, MIU, UCC and Assessment Areas	84%	87%	84%	85%
F&FT Response Rate Inpatients and Daycases	34%	36%	36%	38%
Proportion of positive responses Inpatients and Daycases	95%	95%	94%	94%
F&FT Response Rate Outpatients	4%	3%	3%	2%
Proportion of positive responses Outpatients	95%	94%	96%	97%
F&FT Response Rate Maternity - Birth	13%	10%	14%	18%
Proportion of positive responses Maternity - Birth	96%	100%	100%	97%
F&FT Response Rate Community (CCICP)	0%	10%	10%	7%
Proportion of positive responses Community (CCICP)	n/a	94%	91%	89%

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

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

Description

Monthly complaints received by the Trust.

Aggregate Position/Description

22 complaints were received in May 2019 which covered 77 concerns. In addition there were 3 re-opened complaints.

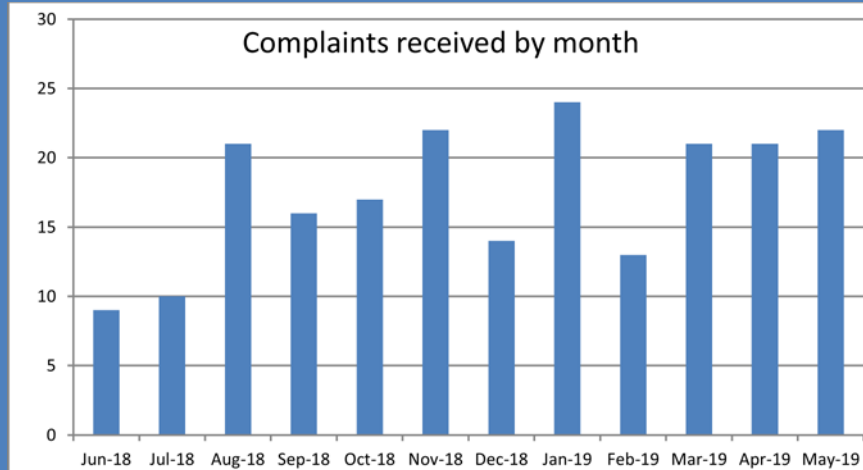
The highest categories were:

- Communication
- Medical – Adverse Outcome
- Nursing - Other

Highest 3 areas receiving complaints/issues were:

- Emergency Department – 6 complaints with 14 issues
- Cardiology - 4 complaints with 6 issues
- Orthopaedic – 3 complaints with 13 issues

Trend



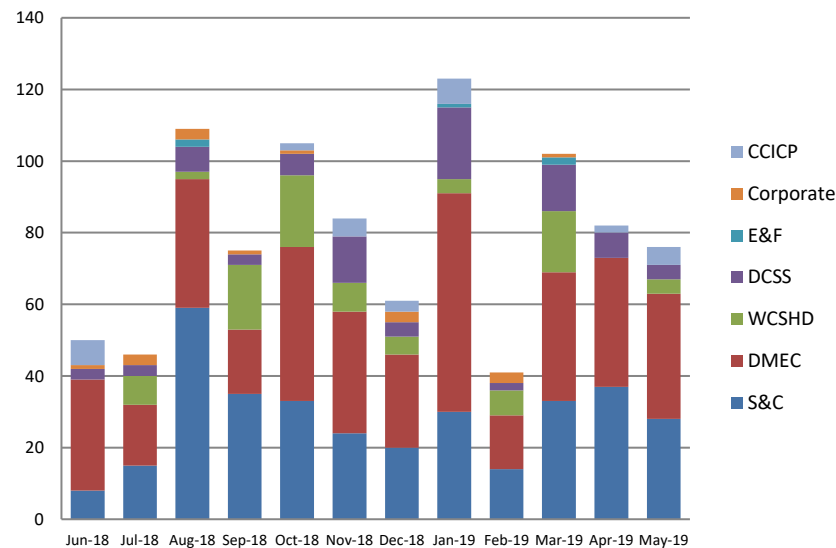
Formal Complaints

Number of formal complaint issues by division.

This graph shows the breakdown of issues by month for each division.

S&C: 28
DCSS: 4
W&CD: 4
DMEC: 35
CCICP: 5
E&F: 1
Corporate Services: 0

Categories received by Division



Formal Complaint issues by division

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

Description

Aggregate Position/Description

Trend

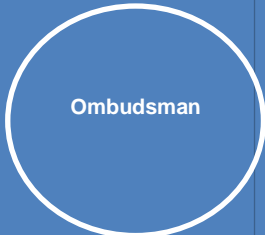
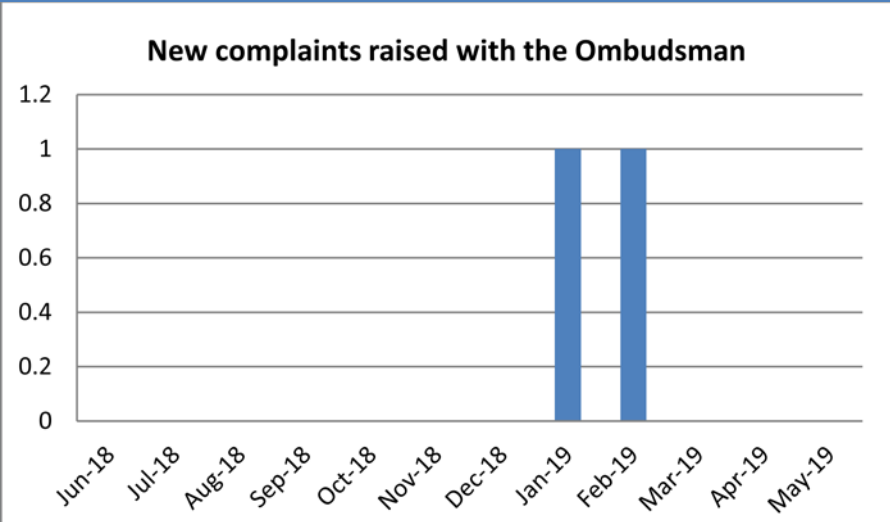
New complaints raised with the Public Health Service Ombudsman

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

There was 1 existing case which was opened in Jan 2019 which has now been closed by the PHSO with no action required.

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

In the last rolling 12 months we have had 2 cases with the PHSO of which none to date have been upheld.



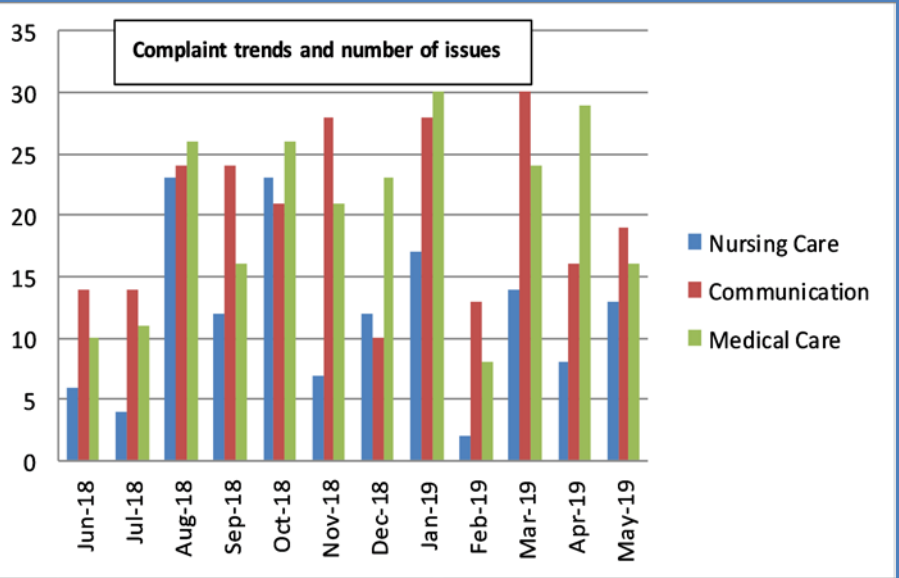
Complaint trends and number of issues.

The main trends in May 2019 were:-

Nursing care - 9 complaints raising 13 issues. 7 of these were categorised as 'other.'

Communication - 12 complaints raising 19 issues. 10 of these issues related to communication with patients.

Medical care - 12 complaints raising 16 issues. 7 of these concerns related to medical adverse outcome



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

Description

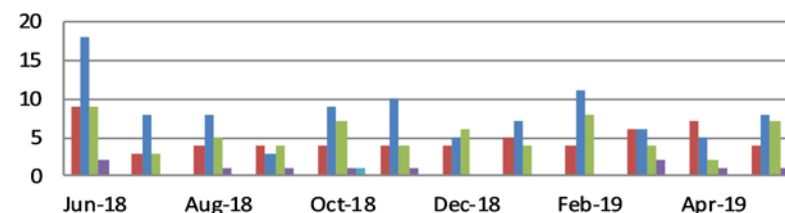
Aggregate Position/Description

Trend

Closed
Complaints

In May 2019, 20 complaints were closed. One of these was a re-opened complaint.

Closed complaints by month



Closed
Complaints

Closed
complaints
by Division

The table provides a breakdown of closed complaints for May 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	1	3	3	0	0	7
Corporate	1	0	0	0	0	1
Surgery & Cancer	0	3	2	1	0	6
Women & Children's	0	0	1	0	0	1
DCSS	2	2	0	0	0	4
CCICP	0	0	1	0	0	1

Total closed = 20

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

Closed Complaints May 2019 - Tables removed under Section 40 of the Freedom of Information Act

Description

Aggregate Position/Description

Trend

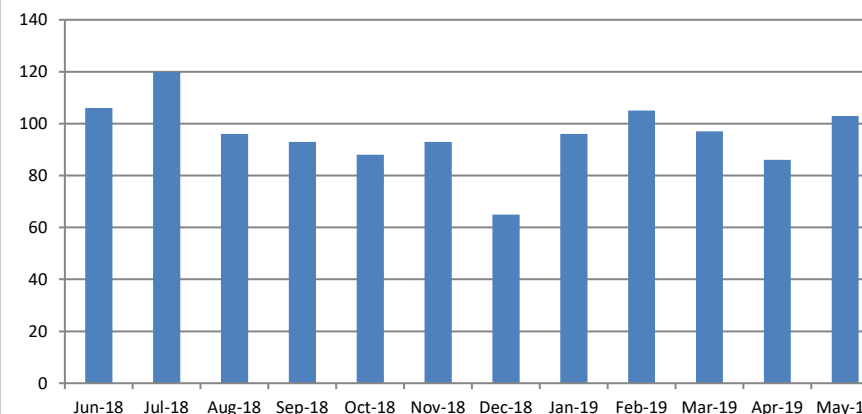
Informal concerns numbers.

The number of contacts raising informal concerns for May 2019 was 103 raising 208 individual concerns.

The Division of Medicine and Emergency Care received the highest number of overall concerns at 97 with the Surgery and Cancer Division receiving 52.

The Emergency Department received the largest number of individual concerns raised at 44. Orthopaedic received 17 concerns and General Medicine received 14.

Contacts raising informal concerns



Informal concerns numbers

Informal concerns trends.

Communication and care were the highest trends for informal concerns in May 2019.

55 communication issues raised:

37 relate to communication with patients

23 relate to the Division of Medicine and Emergency Care

38 care issues raised:

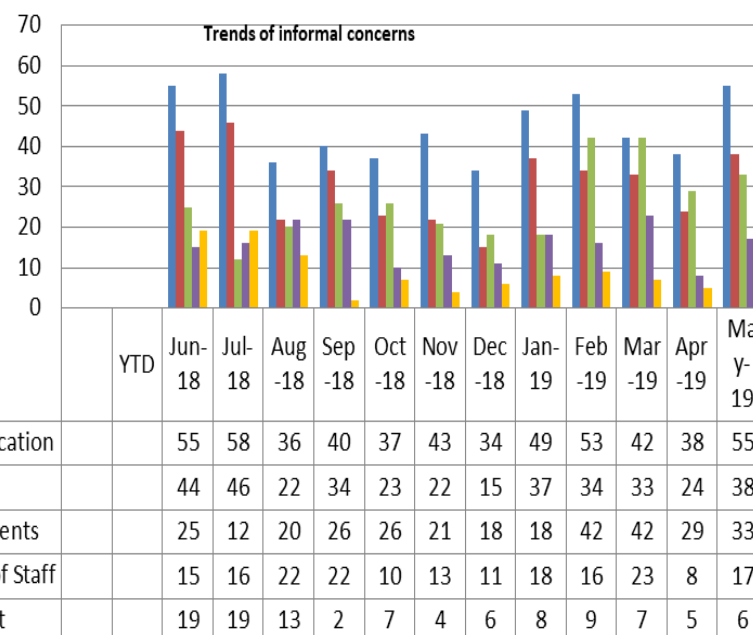
17 relate to medical care, of which 6 relate to the Emergency Department and 2 to General Medicine

19 relate to nursing care, 8 of which relate to the Emergency Department and 3 to Ward 1

33 appointment issues raised (including delays and cancellations):

6 relate to Gastroenterology and 5 to Ophthalmology and Orthopaedics respectively.

Trends of informal concerns



Informal concerns trends

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

Description

Aggregate Position/Description

Trend

New claims received.

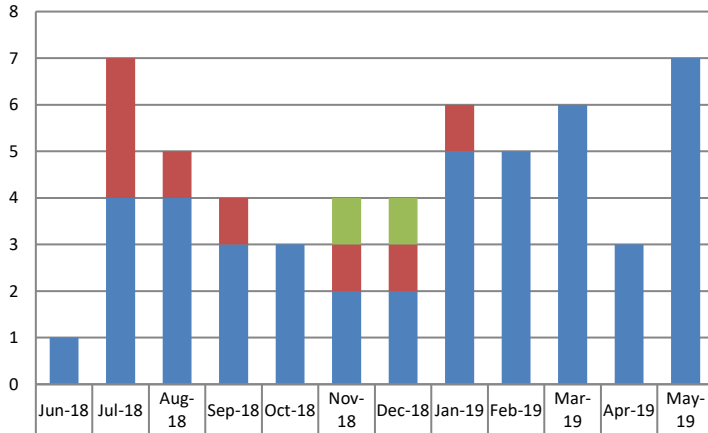
In May 2019, 7 new clinical negligence claims were received. These related to:

- Emergency Care - General Medicine (2)
- Emergency Care - Gastroenterology (1)
- Surgery and Cancer - Urology (1)
- Women's and Children's – Obstetrics (1)
- Surgery and Cancer - Orthopaedics & Diagnostics and Clinical Support – Radiology (1)
- Surgery and Cancer - Breast Surgery & Diagnostics and Clinical Support – Radiology (1)

No new employer's liability claims were received.

No new public liability claims were received.

New claims by month



Public Liability	0	0	0	0	0	1	1	0	0	0	0
Employer's Liability	0	3	1	1	0	1	1	1	0	0	0
Clinical	1	4	4	3	3	2	2	5	5	6	7

Claims

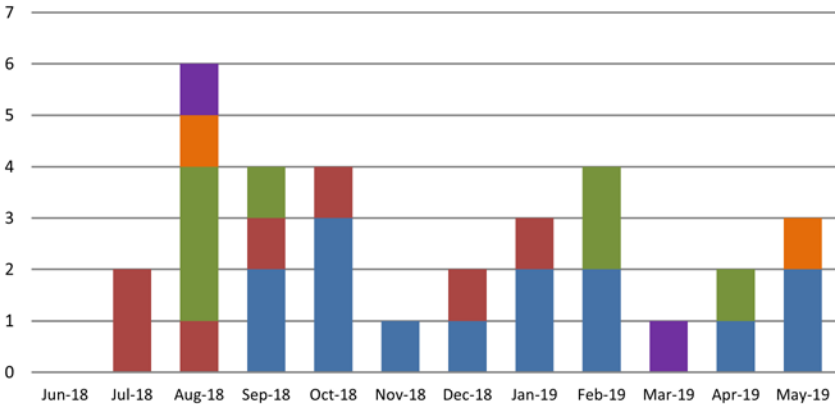
Claims closed with/without damages.

In May 2019 the following claims were closed with/without damages:-

2 clinical negligence claims were closed and both were upheld.

1 public liability claim was closed and this was not upheld.

Claims closed with/without damages by month



Clinical with damages Clinical without damages Employer's liability with damages
Public liability without damages Series3

Closed Claims

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

Description

Aggregate Position/Description

Trend

Value of claims closed by month

In May 2019 damages of £46,250 were paid out on 2 clinical negligence claims.

Emergency Department (ED) and Women's & Children's
Narrative removed under Section 40 of the Freedom of Information Act.

Lessons Learnt:

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

Outcome:

Claim upheld and settled with £3000 damages paid.

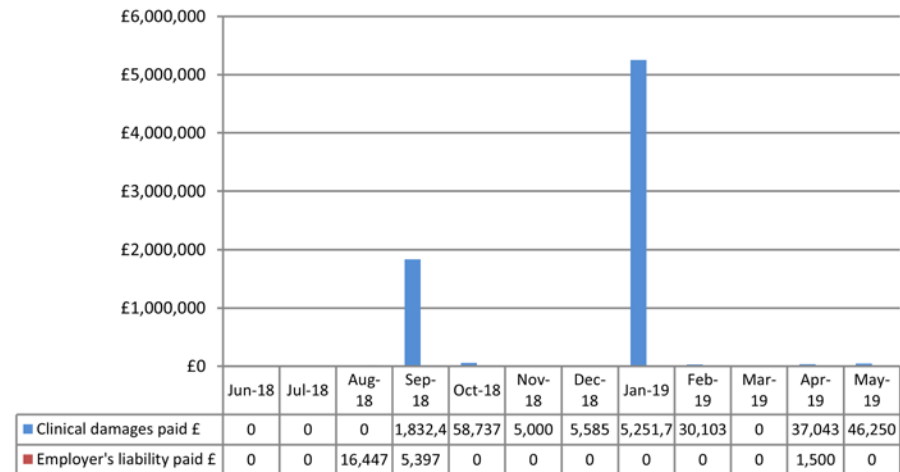
Women's and Children's, Obstetrics

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

Outcome:

Claim upheld and settled with £43,250 damages paid.

Value of claims by month



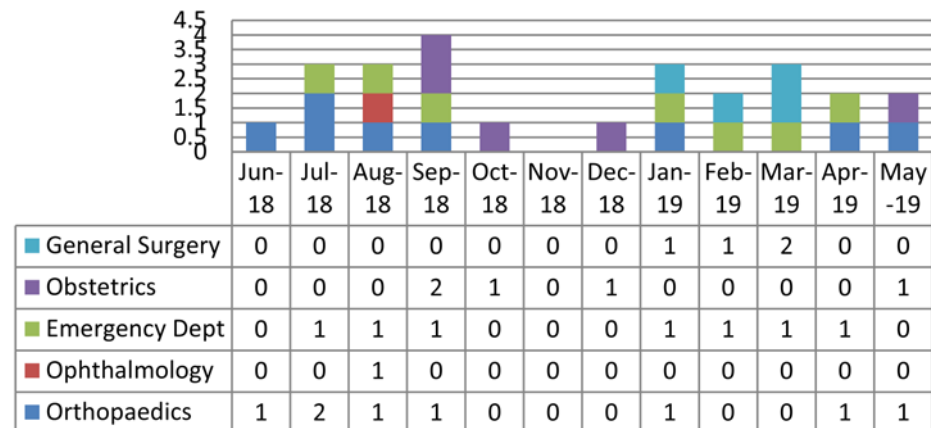
Value of claims

Top five claims by Specialty

In May 2019, 2 new claims were received which relate to the Trust's top five specialties for claims:

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

Top five claims by speciality



Top 5 claims by specialty

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

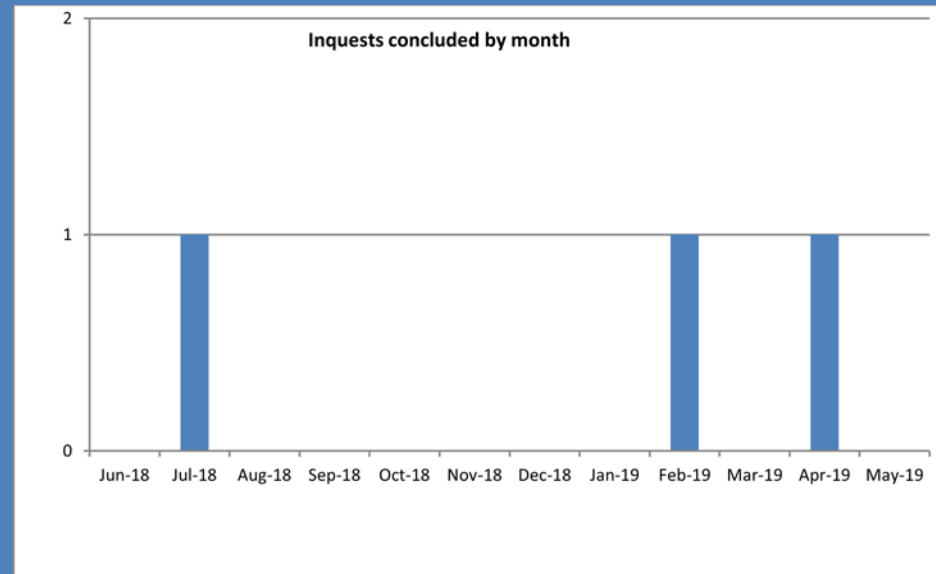
Description

Aggregate Position /Description

Trend

Number of Inquests concluded by month

No inquests were concluded in May 2019.



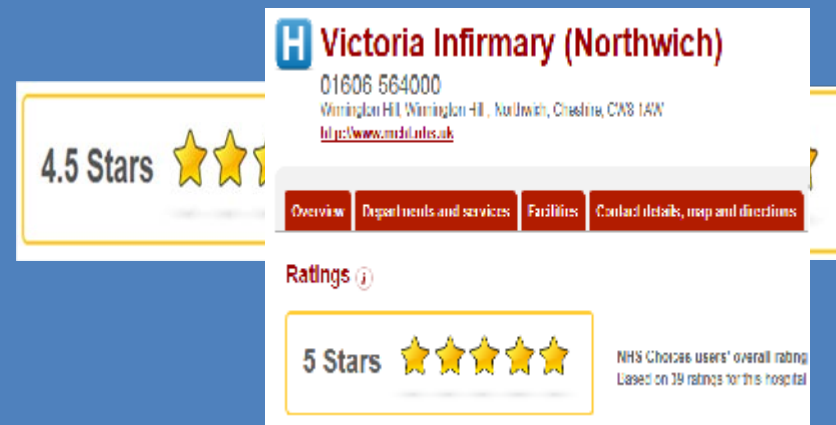
Inquests

NHS Choices Star Ratings

In May 2019 Leighton Hospital is rated at 4.5 stars.

Victoria Infirmary, Northwich is rated at 5 stars.

The above ratings are based on 78 postings received within the previous 12 months.



NHS Choices – Star Ratings

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

Description

Aggregate Position /description

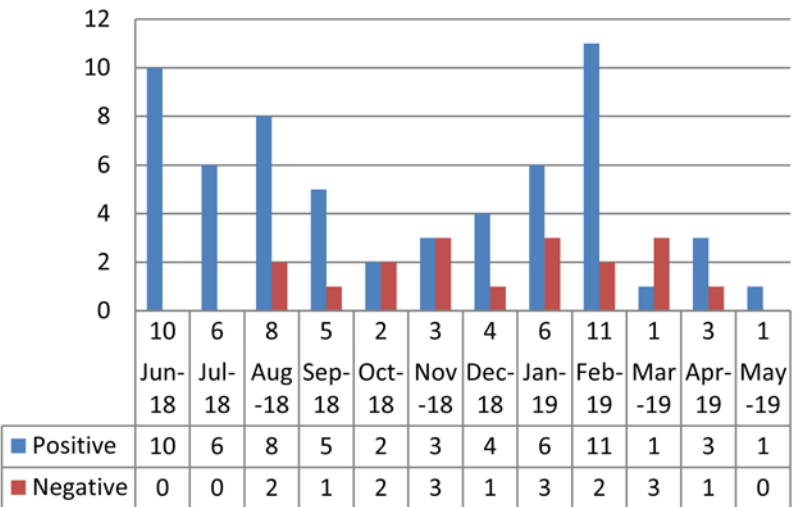
Trend

NHS
Choices
postings

There was 1 posting on NHS Choices in May 2019 of which was positive. The comment is detailed below:

“Cannot speak highly enough of the care given to my mother-in-law during her final days on this ward. Her views were respected and every dignity given to her allowing her to pass in the manner she wished. Wonderful staff many thanks.”
(Ward 5)

NHS Choices - New postings



NHS
Choices
–
Postings

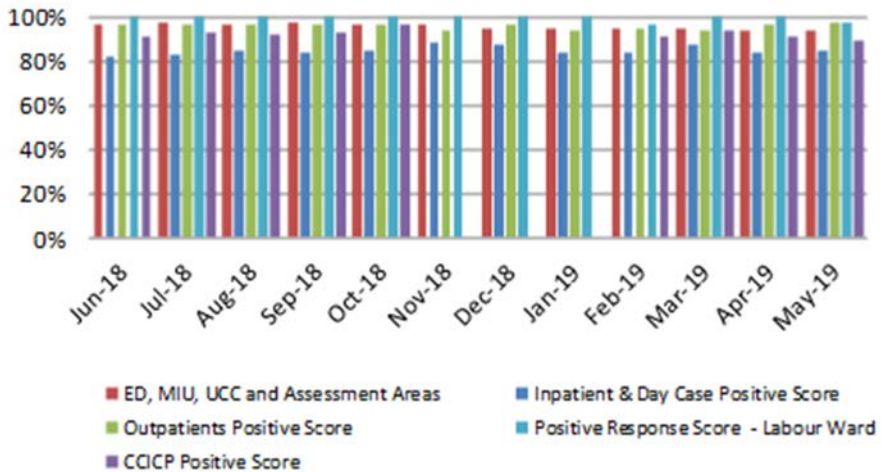
The
Family
and
Friends
Test.

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

Emergency care /assessment areas 85%;
Inpatients and day cases 94%;
Outpatients 97%;
Maternity (Labour ward) 97%;
CCICP 89%.

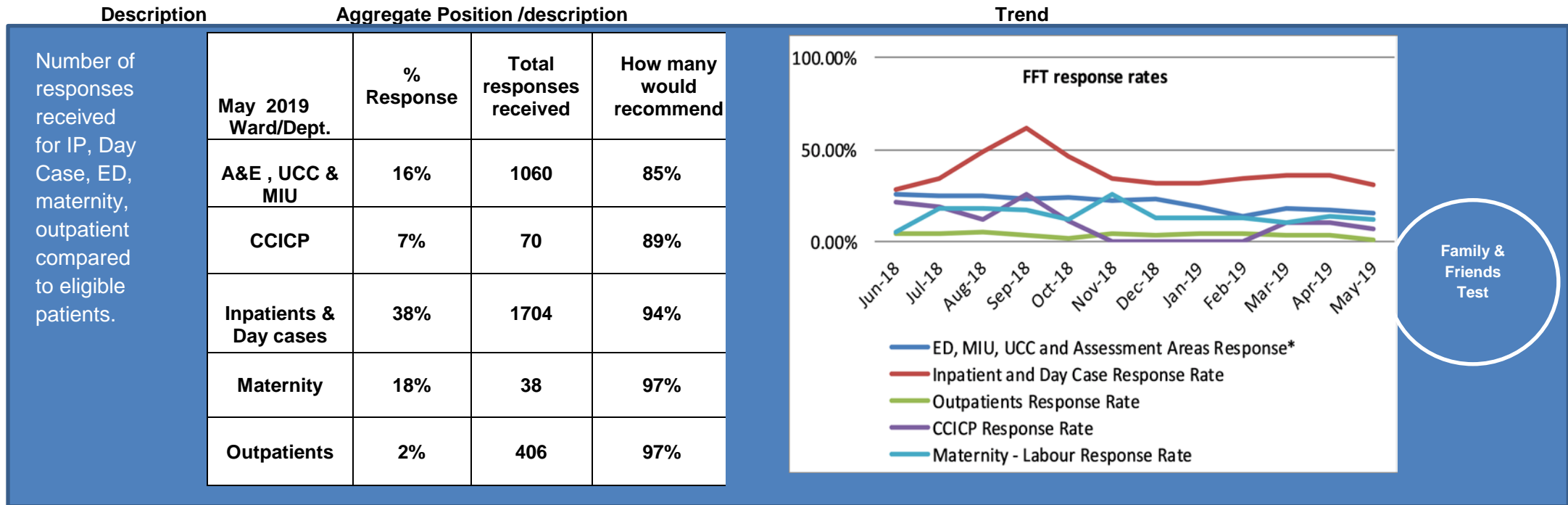
Text messaging will be in place in all areas by July 2019.

Friends and Family Positive Scores



Family &
Friends
Test

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



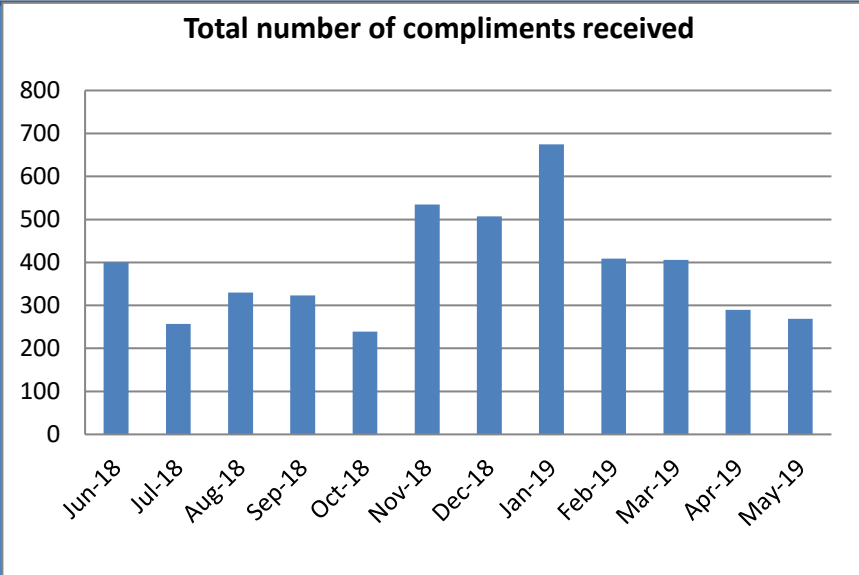
Family & Friends Test

Compliments received

There were 269 compliments received in May 2019. 45 of these were logged by the Customer Care Team and 224 received across the Trust.

'Thanks to the staff at Northwich Infirmary for their kind treatment of my 2 year old daughter. She is now putting weight on her heel again and recovered quickly. She loves her teddy bear. Thanks again.'

I would like to thank every member of staff I came into contact with for my surgery. They were all amazing. I saw my surgeon several times whilst in hospital, very reassuring. Every nurse and doctor and support staff were excellent and made a challenging couple of days as positive as possible. Thanks so much for your help pre-op and to all the amazing staff at Leighton.'



Compliments

Board of Directors Performance Report

May 2019

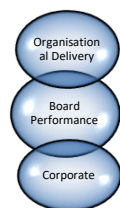
**"To Deliver Excellence in Healthcare through Innovation &
Collaboration"**

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.

Dr Paul Dodds
Interim Chief Executive

Contents

	<i>Page No</i>
Headline Measures	1
Single Oversight Framework	2
Organisation al Delivery	3
Cancer Pathway	3
Unplanned Activity	5
Length of Stay	7
Planned Activity	8
Corporate	
Income and Expenditure Position	12
Commissioner Income Analysis	17
Cost Improvement Programme	18
Capital Summary	19
State of Financial Position	21
Cash position and Working Capital	22
Staff Costs	23

Headline Measures

Organisational Delivery			
Indicator	Standard	YTD	May-19
Cancer			
Rapid Access Referrals (%) (seen in 2 wks)	93.00%	96.72%	97.66%
Total Patients Seen		2,013	982
Patients seen >14 days		66	23
62 day GP Classic (%)	85.00%	85.52%	85.50%
Accountable Patients Treated		132	59
No. of Breached Pathways (adjusted)		21	10
62 day Screening (%)	90.00%	93.33%	88.23%
Accountable Patients Treated		15	8
No. of Breached Pathways (adjusted)		2	1

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

Unplanned Activity			
4 Hour Access Standard (%)	95.00%	79.08%	78.27%
A&E Attendances (LH/MIU/UUC) (% to plan)		97.65%	95.17%
A&E Attendances LH & MIU (Vol)		16,551	8,382

Planned Activity			
Incomp Pathways <18wk (%)	92.00%	91.20%	91.69%
>6wk Diagnostic Waits (%)	1.00%	7.73%	9.34%
Total Patients Waiting for a First Outpatient Appointment			9,981

Indicator	Standard	YTD
Workforce		
Sickness absence Rolling 12 Month		4.42%
Turnover Rolling 12 Month		9.60%

Corporate					
Indicator	YTD Rating		YE Rating	YE Metric	
	Plan	Actual	Forecast	Plan	Forecast
Finance					
Use of Resource Rating	3	3	3		
Capital Service Capacity	4	4	4	0.15	-0.04
Liquidity	3	3	3	-9	-9
I&E Margin	3	4	4	-2.90%	-2.90%
Distance from Financial Plan	1	1	1	0.00%	0.00%
Agency Spend	1	3	3	-14.00%	28.00%

	YTD Target	YTD Actual	YTD Variance	FY Target	FY Forecast	FY Variance
Cost Improvement Schemes Total (£000's)	758	503	-254	5,342	5,342	0
Commission Contact Income SC & VR (£000's)	32,370	32,468	98			
Contract Income (£'000)	38,980	39,042	44			
Pay to Budget (£000's)	-31,073	-30,866	207			
Non Pay to Budget (£000's)	-12,115	-12,441	-326			
Agency Trajectory (£000's)	-806	-1,209	-403			

Exec Summary

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

The RTT Incomplete Pathway standard in May achieved 91.69%, against the 92% performance standard. Performance over the last 3 months has seen an improving trend, as per planned trajectory.

The 4 hour Access Standard in May achieved 78.27% against the 95% performance standard. This performance is a deterioration on the same period last year, however is set against over 400 more attendances in month arriving at the department. The first two months have seen 1,500 more attendances than the previous year.

The Trust has achieved two out of the three headline cancer access standards for May, with 62 Day Screening standard achieving 88.23% against a 90% target.

Diagnostics waiting times for May is 9.34% against a 1.00% threshold. The failure against the Diagnostic Waiting Time standard is expected as per the failure seen within the Imaging server upgrade.

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 deficit of £1.26M which is in line with the plan year to date.

This position includes the Provider Sustainability Fund (PSF) earned to date, which is depended on meeting the financial control total and also the Marginal Rate Emergency Threshold (MRET).

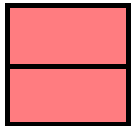
There is a variation in the CIP scheme, with challenges around delivering improvements to sickness rates within nursing and delays to other programmes of work.

The rate of agency use remains above the ceiling rate set by NHS, which increases the likelihood of this Use of Resource Rating deteriorating.

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 maintain at this level throughout 2019/20.

Operational Performance	Current YTD		May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Monthly Trend
	Target	Actual														
Maximum 6 week wait for Diagnostic procedures	1%	7.73%	0.17%	0.32%	0.56%	0.31%	0.44%	0.48%	0.17%	0.54%	0.47%	0.42%	0.76%	0.64%	9.34%	
All Cancers: 62 day GP Classic (%) *	85%	85.52%	92.91%	92.00%	91.40%	91.78%	86.11%	86.50%	93.40%	86.90%	85.83%	85.84%	85.22%	85.52%	85.50%	
All Cancers: 62 day Screening (%) *	90%	93.33%	89.47%	91.67%	100.00%	91.84%	100.00%	100.00%	100.00%	81.80%	87.50%	100.00%	95.00%	93.33%	88.23%	
18 weeks from point of referral to treatment - patients on an incomplete pathway (%)	92%	91.20%	93.27%	93.14%	92.97%	93.05%	92.43%	92.82%	92.28%	92.01%	91.30%	91.63%	90.67%	90.68%	91.69%	
A&E - maximum waiting time of 4 hours from arrival to admission/transfer/discharge (%)	95%	79.08%	85.15%	81.78%	84.59%	87.14%	84.61%	85.51%	88.13%	83.57%	78.89%	81.12%	80.41%	79.90%	78.27%	
STF Trajectory			92.72%	92.72%	93.92%	93.92%	93.92%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%			
Provider Submitted Trajectory														83.60%	86.10%	

* 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	0.15	-0.04	4	0.15	-0.04	4
	Liquidity	days	-9	-9	3	-9	-9	3
Financial Efficiency	I&E Margin	%	-2.90%	-2.90%	4	-2.90%	-2.90%	4
Financial Controls	Distance from Financial Plan	%	0.00%	0.00%	1	0.00%	0.00%	1
	Agency Spend	%	-14.00%	28.00%	3	-14.00%	28.00%	3
Overall UOR Rating					3			3

Operational Delivery: Cancer Pathway

Headline Measures

	Current YTD		Rolling 13 months													
	Target	Actual	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Monthly Trend
Rapid Access Referrals (%) (seen in 2 wks)	93%	96.72%	96.76%	97.54%	96.37%	96.73%	96.50%	96.87%	98.36%	97.78%	96.91%	97.66%	97.69%	95.83%	97.66%	
Total Patients Seen		2013	956	855	855	887	771	989	917	855	842	940	996	1031	982	
Patients seen >14 days		66	31	21	31	29	27	31	15	19	26	22	23	43	23	
% seen within 7 days		30.3%	39.6%	43.7%	44.4%	35.2%	51.4%	41.5%	34.0%	35.4%	38.6%	38.1%	30.5%	30.3%	39.3%	
62 day GP Classic (%) *	85%	85.52%	92.91%	92.00%	91.40%	91.78%	86.11%	86.50%	93.40%	86.90%	85.83%	85.84%	85.22%	85.52%	85.50%	

* Provisional figures subject to change depending

104+ day waits - (Cancer patients treated)

1	0	1	0	4	0	0	3	0	1	3	2	5
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Commentary

The Trust has achieved two of the three headline cancer standards during the month of May 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.

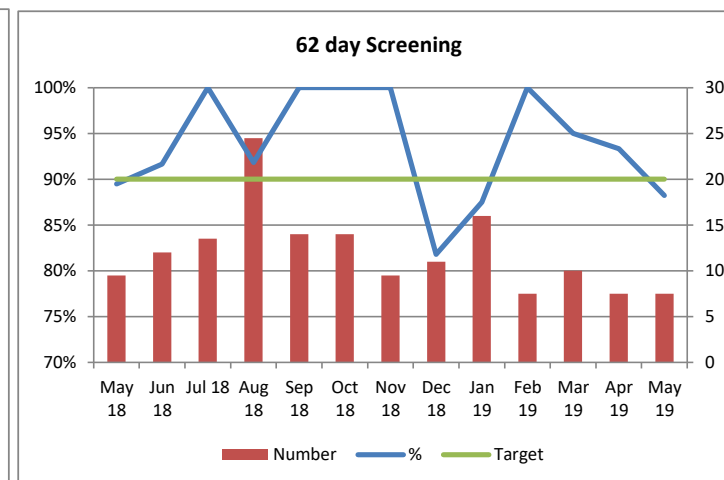
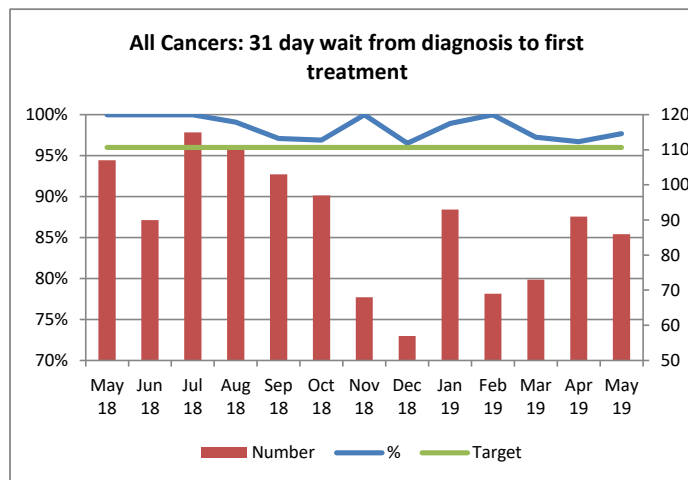
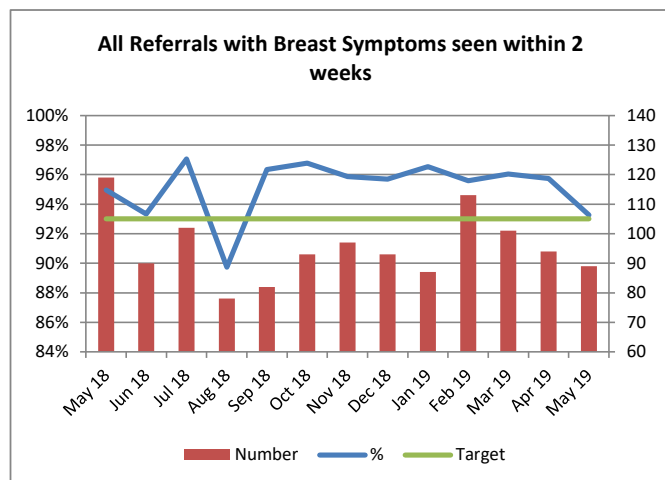
The Trust has continued it's strong performance against the Rapid Access referrals standard, achieving 97.66% for May, despite a 3% increase in referrals compared to the same month last year.

The 62 Day GP Classic standard has achieved 85.50% against an 85% target.

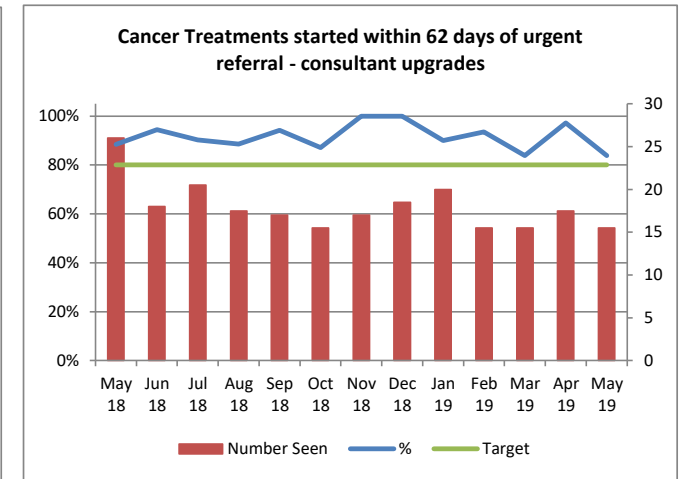
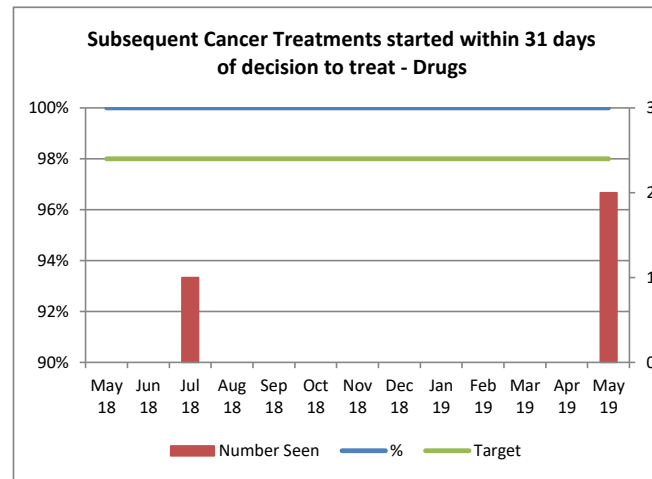
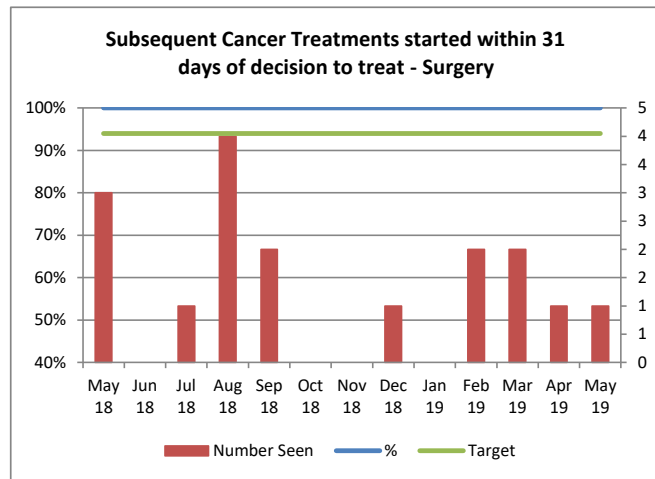
There were five recorded long wait (104 days and over) for patients on a 62 day cancer pathway in May.

The 62 day screening standard was failed in May and will be in June due to an administrative error in the booking of first outpatient appointments. A full review has been undertaken. Due to the small number of patients the metric can only manage one breach before falling below the 90% threshold.

Primary Measures



Operational Delivery: *Cancer Pathway*



Operational Delivery: *Unplanned Activity - A&E*



Headline Measures

	Current YTD	
	Target	Actual
A&E - >4 hr wait time from arrival to admission/ transfer/ discharge (% to Target)	95%	79.08%
No. of 4hr breaches		3,463

	Plan	Actual
A&E Attendances (LH/MIU/UUC) (% to Plan)		97.65%
A&E Attendances (LH/MIU/UUC) (No.)	16,177	16,551

A&E Attendance Case Mix (based on acuity score)	Major	4,891
	Minor	6,206
	Paediatrics	3,267
	Resus	2,184

A&E Attendance Location (based on Discharge)	Major	6,650
	Minor	6,234
	Paediatrics	3,267
	Resus	397

Rolling 13 months													
May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Monthly Trend
85.15%	81.78%	84.59%	87.14%	84.61%	85.51%	88.13%	83.57%	78.89%	81.12%	80.41%	79.90%	78.27%	
1,179	1,472	1,286	967	1,158	1,167	884	1,209	1,621	1,349	1,574	1,642	1,821	

May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Monthly Trend
95.3%	98.9%	99.6%	97.7%	94.9%	100.0%	98.4%	95.8%	99.3%	97.0%	95.4%	100.4%	95.2%	
7,937	8,081	8,344	7,517	7,524	8,056	7,445	7,358	7,679	7,147	8,034	8,169	8,382	

2,460	2,386	2,168	2,380	2,228	2,455	2,269	2,235	2,392	2,170	2,341	2,351	2,540	
2,992	3,325	3,643	2,990	2,810	2,768	2,560	2,605	2,782	2,489	2,855	3,166	3,040	
1,676	1,648	1,691	1,181	1,516	1,709	1,562	1,422	1,372	1,556	1,702	1,587	1,680	
805	722	835	966	969	1,120	1,048	1,095	1,128	928	1,126	1,063	1,121	

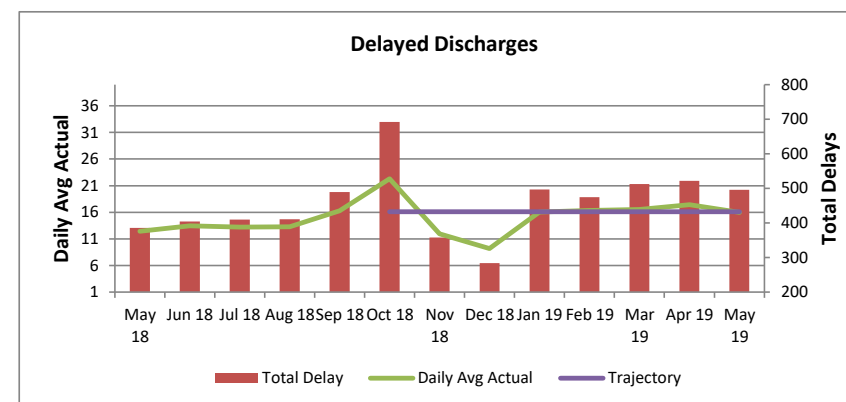
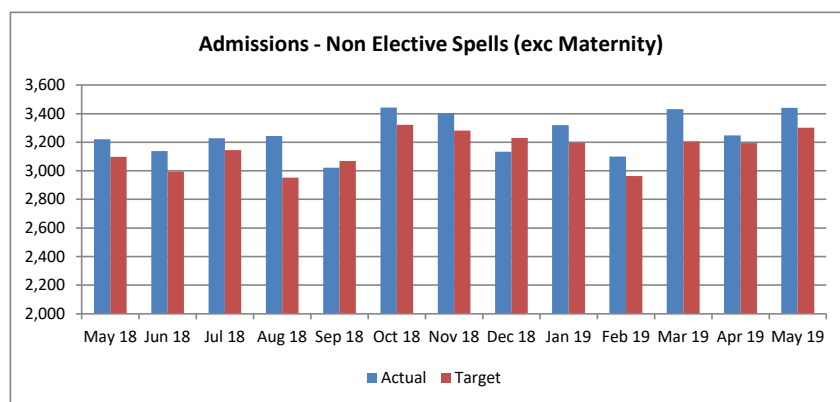
3,170	3,136	3,121	3,225	3,090	3,413	3,187	3,176	3,354	2,983	3,317	3,245	3,405	
2,948	3,157	3,364	2,977	2,775	2,791	2,560	2,573	2,738	2,454	2,801	3,123	3,111	
1,676	1,648	1,691	1,181	1,516	1,709	1,562	1,422	1,372	1,556	1,702	1,587	1,680	
139	140	161	134	142	139	130	186	210	150	204	212	185	

Commentary

The Trust has achieved 78.27% against the 4-hour access standard in May 2019, with a 6% increase in attendances compared to the same period last year. The number of higher acuity patients (Resus and Majors) arriving in A&E continues to rise with 12% more than the same period last year. As a result of the increase in higher acuity attendances, emergency admissions are higher than expected for May, at 104% of target although conversion rates for April and May are marginally down on the same months last year.

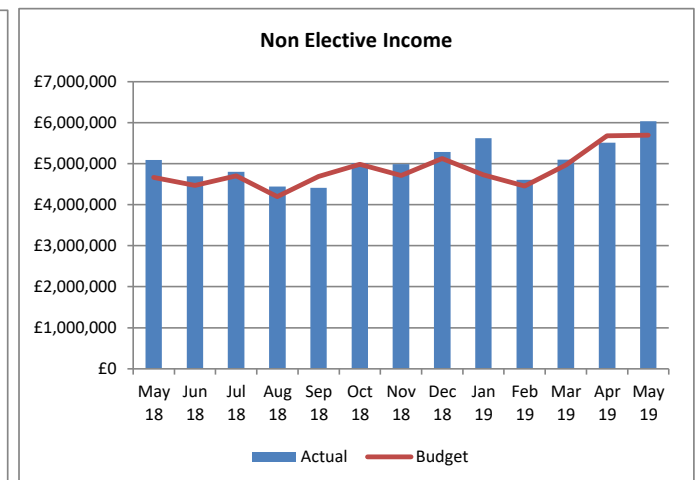
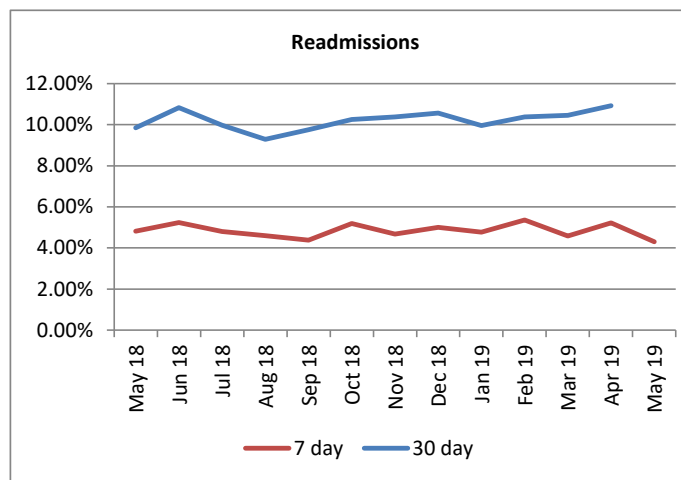
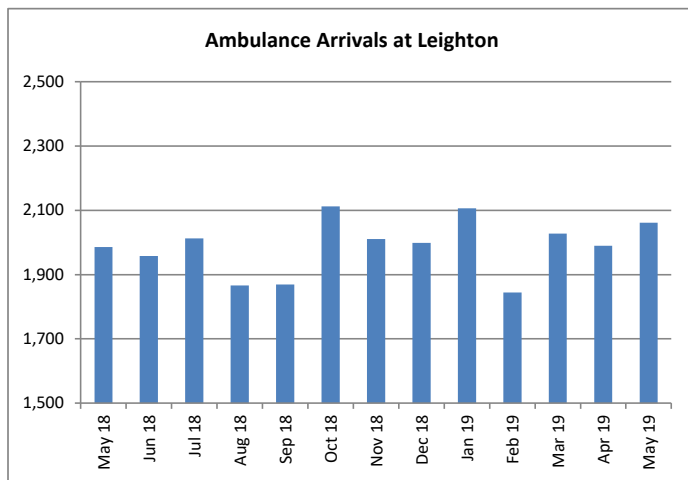
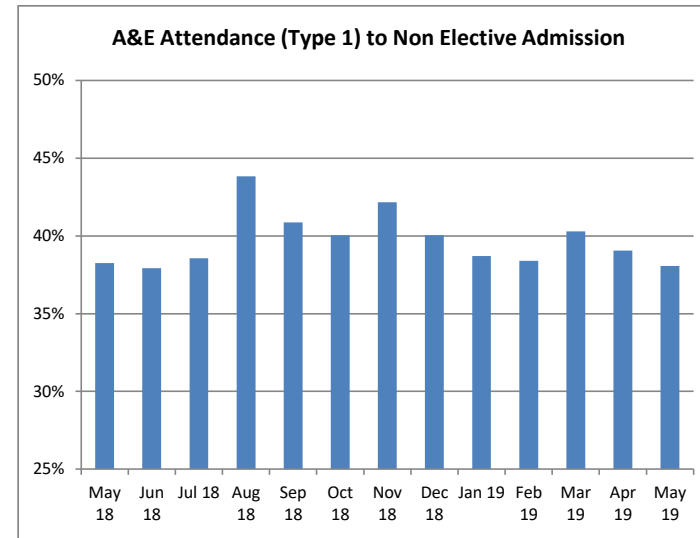
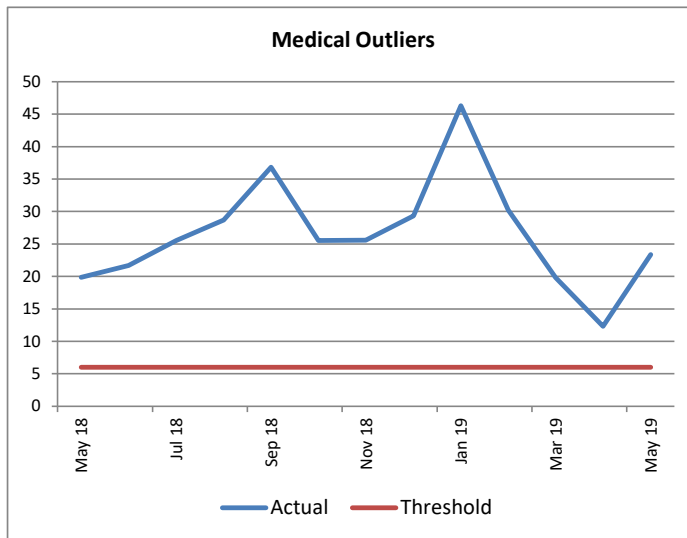
Patients medically optimised for discharge in May is within the threshold of 16.

Primary Drivers



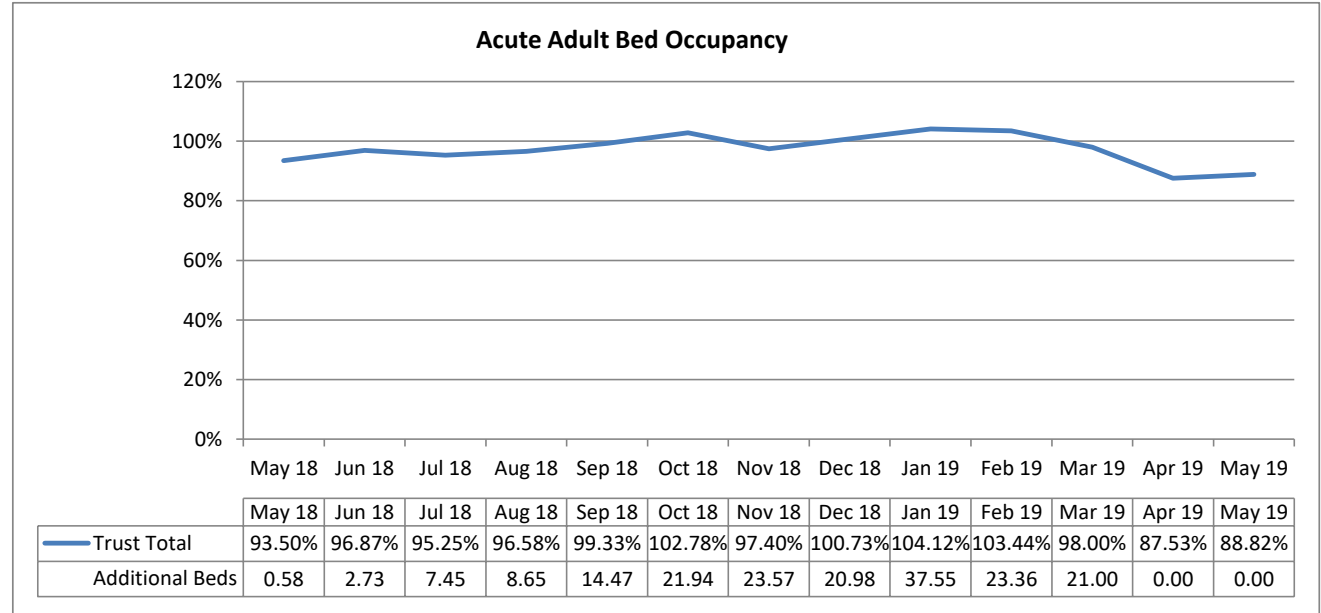
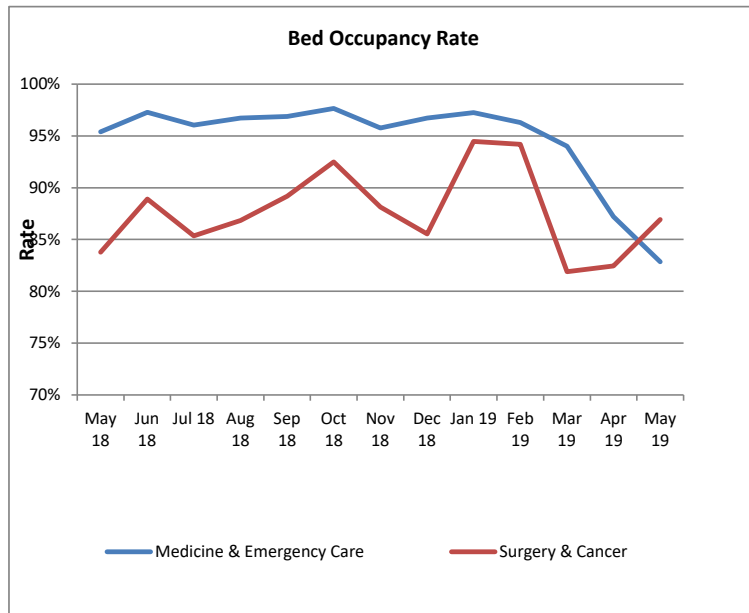
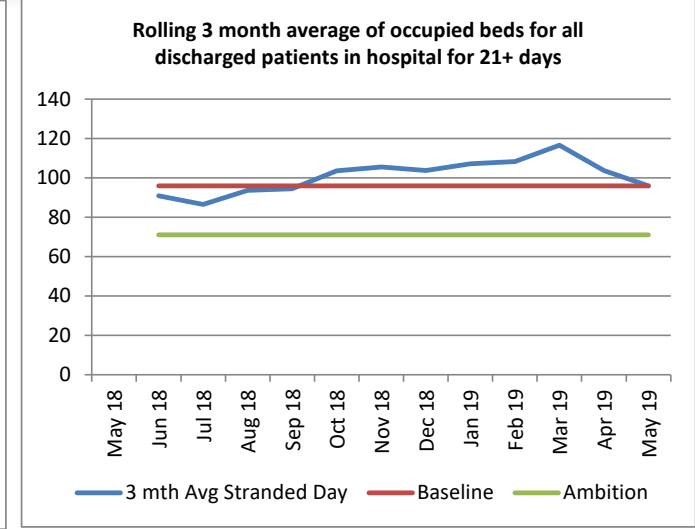
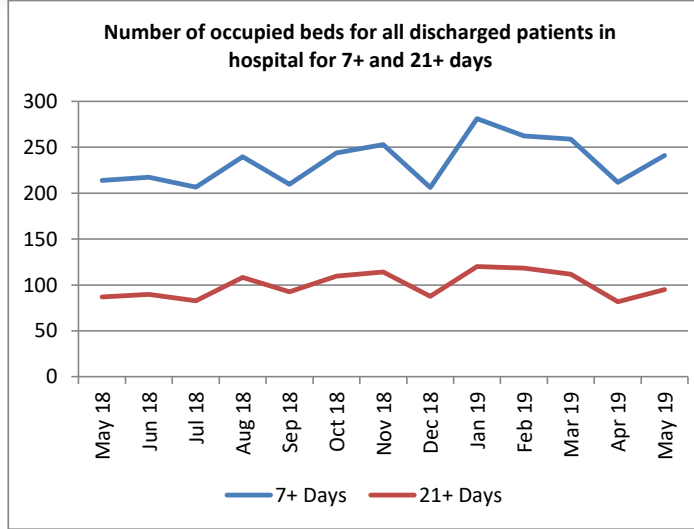
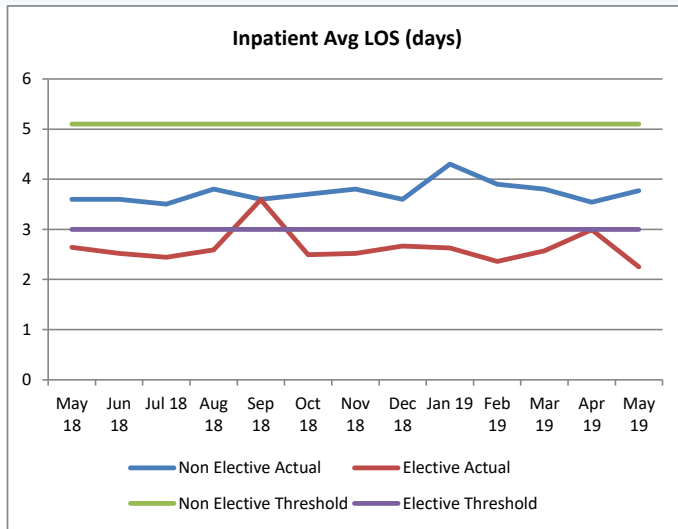
Operational Delivery: *Unplanned Activity A&E*

Secondary Drivers



* Readmissions brought in line with national definition

Operational Delivery: *Length of Stay*



Operational Delivery: *Planned Activity*

Headline Measures

	Current YTD		Rolling 13 months													
	Target	Actual	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Monthly Trend
18 weeks from Referral to Treatment in Aggregate - Incomplete	92%	91.20%	93.27%	93.14%	92.97%	93.05%	92.43%	92.82%	92.28%	92.01%	91.30%	91.63%	90.67%	90.68%	91.69%	
Total 18 Weeks		29,629	14,405	14,713	14,630	15,373	14,988	14,284	14,331	14,232	14,427	14,505	14,197	14,355	15,274	
No. > 18 Weeks		2,606	969	1,010	1,029	1,069	1,135	1,025	1,106	1,137	1,255	1,214	1,324	1,338	1,268	
Open Pathways >39 Weeks Waiting											11	5	10	10	15	
Diagnostic Waiting Time	1%	7.73%	0.17%	0.32%	0.56%	0.31%	0.44%	0.48%	0.17%	0.54%	0.47%	0.42%	0.76%	0.64%	9.34%	
Total Number of Waiters		5,900	4,127	4,619	4,257	3,814	4,105	4,168	4,017	3,870	4,029	4,785	4,749	1,091	4,809	
Waiters of 6 Weeks +		456	7	15	24	12	18	20	7	21	19	20	36	7	449	
Total Patients Waiting for a First Outpatient Appointment			9,579	9,354	9,496	9,851	9,654	9,496	9,430	8,948	9,428	9,823	9,682	9,800	9,981	
Longest Wait Time (weeks)											47	47	46	48	44	

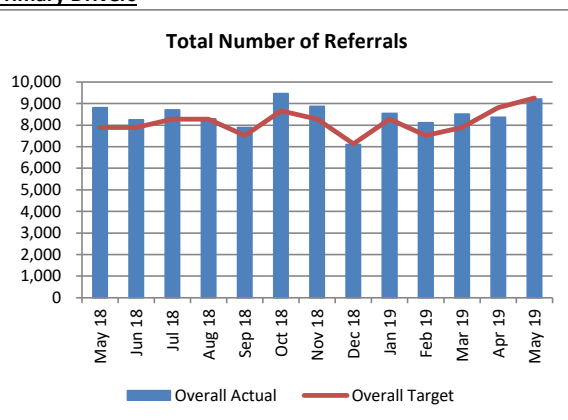
Commentary

The Trust's current RTT Incomplete Pathway position is 91.69% for May. Seven specialties have failed to meet the 92% target in May, these are General Surgery, Urology, Gastroenterology, Cardiology, Thoracic Medicine, Gynaecology and Trauma and Orthopaedics. Detailed improvement plans and trajectories are in place and reviewed weekly by the Chief Operating Officer and Director of Operations. The Trust performance of 91.69% is ahead of the planned trajectory of 91.50% and full compliance will be in place for June 2019.

Mid Cheshire do not currently have any 52 week breaches for May, however there are 15 patients waiting over 39 weeks; (4 in General Surgery, 1 in Gastro, 2 in Cardiology, 6 in Urology, 2 in Ophthalmology). All long wait patients are monitored and reviewed weekly at director led performance meetings.

In May 2019, 9.34% of patients waited longer than 6 weeks for their diagnostic tests. The failure of the Diagnostic six week standard is expected as a result of the failed Soliton server upgrade. Full compliance against this standard will be delivered in July 2019.

Primary Drivers

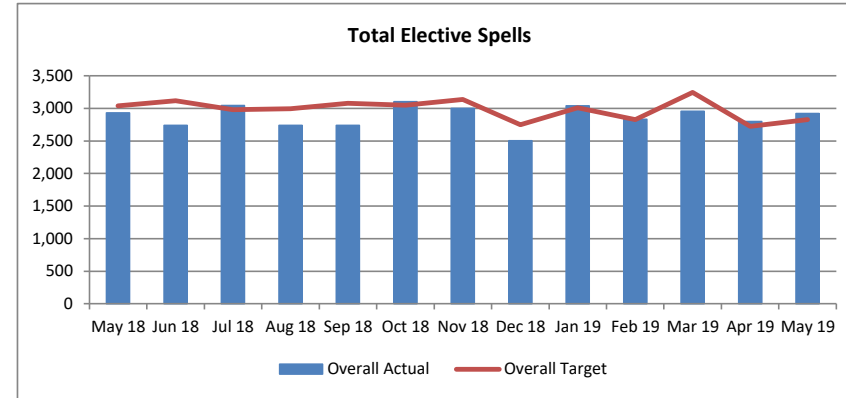
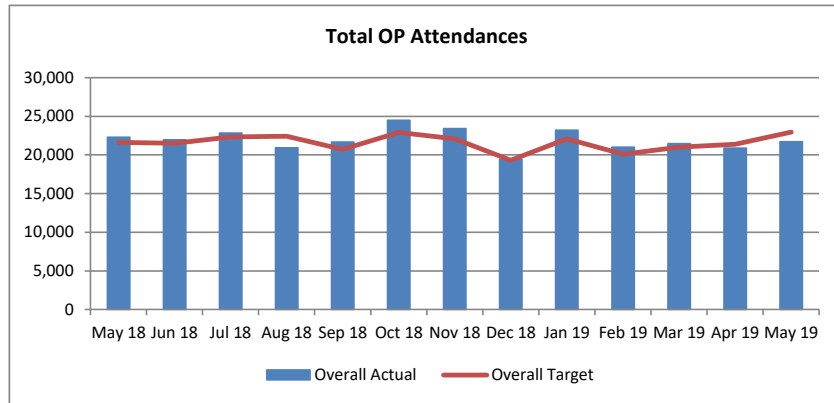


Referral Breakdown

	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Monthly Trend
GP Actual	5,400	5,065	5,355	5,184	4,925	5,755	5,684	4,412	5,424	4,915	5,270	5,136	5,797	
GP Target	4,920	4,920	5,157	5,157	4,683	5,394	5,157	4,446	5,157	4,683	4,920	4,829	5,071	
% to Target	109.8%	103.0%	103.8%	100.5%	105.2%	106.7%	110.2%	99.2%	105.2%	105.0%	107.1%	106.4%	114.3%	
Other Actual	3,408	3,186	3,352	3,107	2,968	3,714	3,189	2,696	3,118	3,204	3,250	3,234	3,422	
Other Target	2,976	2,976	3,120	3,120	2,833	3,263	3,120	2,689	3,120	2,833	2,976	3,988	4,187	
% to Target	114.5%	107.1%	107.5%	99.6%	104.8%	113.8%	102.2%	100.3%	100.0%	113.1%	109.2%	81.1%	81.7%	
Total Actual	8,808	8,251	8,707	8,291	7,893	9,469	8,873	7,108	8,542	8,119	8,520	8,370	9,219	
Total Target	7,896	7,896	8,276	8,276	7,515	8,657	8,276	7,135	8,276	7,515	7,896	8,817	9,258	
% to Target	111.6%	104.5%	105.2%	100.2%	105.0%	109.4%	107.2%	99.6%	103.2%	108.0%	107.9%	94.9%	99.6%	
GP % of Total	61.3%	61.4%	61.5%	62.5%	62.4%	60.8%	64.1%	62.1%	63.5%	60.5%	61.9%	61.4%	62.9%	

Operational Delivery: *Planned Activity*

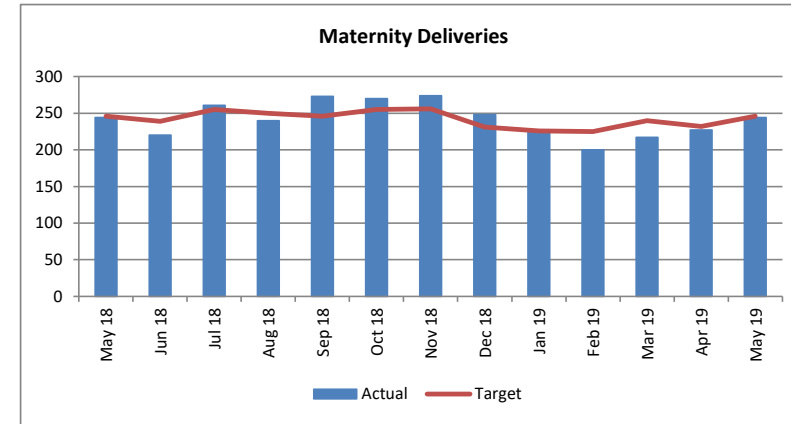
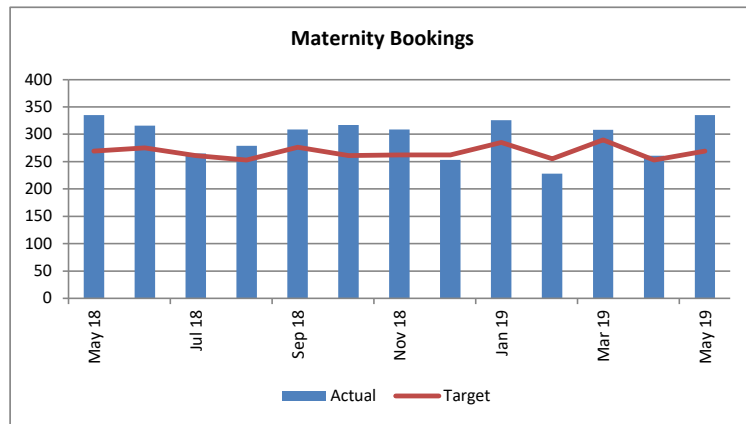
Primary Drivers



OP Attendance Breakdown		YTD 18 19	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Monthly Trend
New Actual		81,335	7,138	6,868	7,001	6,211	6,648	7,713	7,203	5,946	6,861	6,397	6,877	6,583	6,929	
New Target		74,744	6,224	6,212	6,495	6,502	5,934	6,778	6,496	5,625	6,496	5,901	6,189	6,416	6,848	
% to Target		108.8%	114.7%	110.6%	107.8%	95.5%	112.0%	113.8%	110.9%	105.7%	105.6%	108.4%	111.1%	102.6%	101.2%	
F U Actual		182,101	15,170	15,089	15,835	14,737	15,014	16,778	16,207	13,493	16,352	14,629	14,583	14,310	14,800	
F U Target		181,624	15,407	15,283	15,844	15,912	14,774	16,157	15,600	13,701	15,604	14,194	14,803	14,988	16,096	
% to Target		100.3%	98.5%	98.7%	99.9%	92.6%	101.6%	103.8%	103.9%	98.5%	104.8%	103.1%	98.5%	95.5%	91.9%	
Total Actual		263,436	22,308	21,957	22,836	20,948	21,662	24,491	23,410	19,439	23,213	21,026	21,460	20,893	21,729	
Total Target		256,368	21,631	21,495	22,339	22,414	20,708	22,935	22,095	19,326	22,100	20,095	20,992	21,403	22,944	
% to Target		102.8%	103.1%	102.1%	102.2%	93.5%	104.6%	106.8%	105.9%	100.6%	105.0%	104.6%	102.2%	97.6%	94.7%	
New % of Total		30.9%	32.0%	31.3%	30.7%	29.6%	30.7%	31.5%	30.8%	30.6%	29.6%	30.4%	32.0%	31.5%	31.9%	
Elective Spells Breakdown		YTD 18 19	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Monthly Trend
I P Actual		3,055	293	263	276	226	259	284	280	241	157	288	272	225	230	
I P Target		3,341	301	294	271	288	281	308	308	241	181	264	304	263	277	
% to Target		91.4%	97.4%	89.4%	101.9%	78.6%	92.2%	92.3%	91.0%	100.1%	86.9%	109.0%	89.4%	85.6%	83.0%	
Daycase Actual		31,155	2,637	2,476	2,766	2,513	2,479	2,817	2,717	2,262	2,882	2,543	2,685	2,572	2,688	
Daycase Target		32,775	2,738	2,825	2,709	2,709	2,795	2,740	2,827	2,507	2,826	2,565	2,942	2,462	2,548	
% to Target		95.1%	96.3%	87.7%	102.1%	92.8%	88.7%	102.8%	96.1%	90.2%	102.0%	99.1%	91.3%	104.5%	105.5%	
Total Actual		34,210	2,930	2,739	3,042	2,739	2,738	3,101	2,997	2,503	3,039	2,831	2,957	2,797	2,918	
Total Target		36,116	3,039	3,119	2,980	2,996	3,076	3,048	3,135	2,748	3,007	2,829	3,247	2,724	2,825	
% to Target		94.7%	96.4%	87.8%	102.1%	91.4%	89.0%	101.8%	95.6%	91.1%	101.1%	100.1%	91.1%	102.7%	103.3%	
I P % of Total		8.9%	10.0%	9.6%	9.1%	8.3%	9.5%	9.2%	9.3%	9.6%	5.2%	10.2%	9.2%	8.0%	7.9%	

Operational Delivery: *Planned Activity*

Primary Drivers

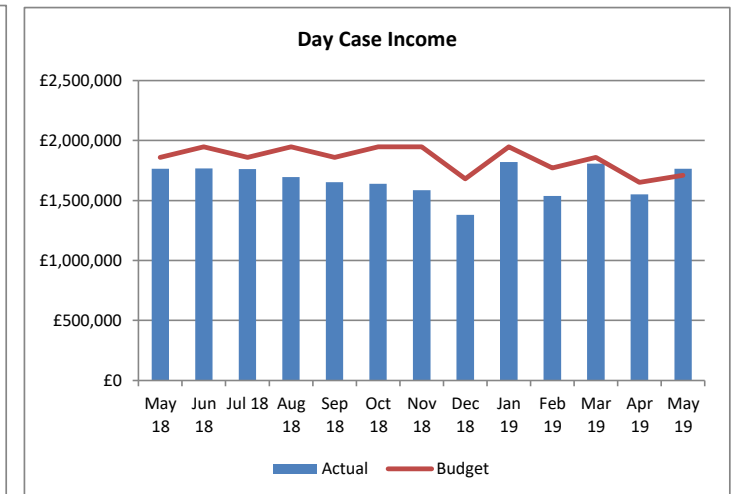
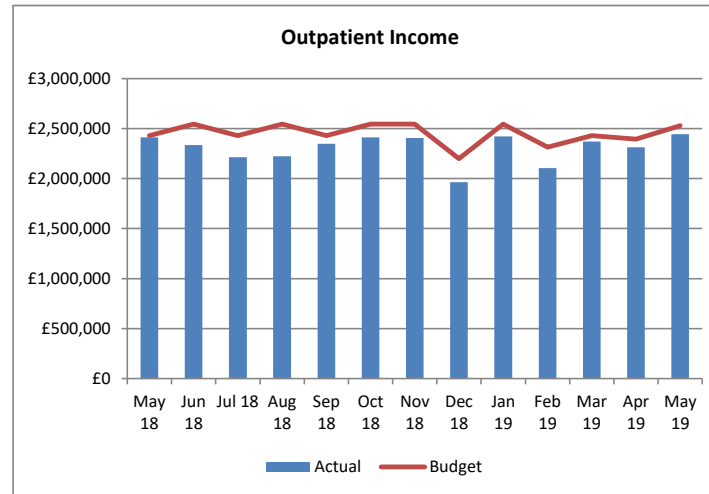
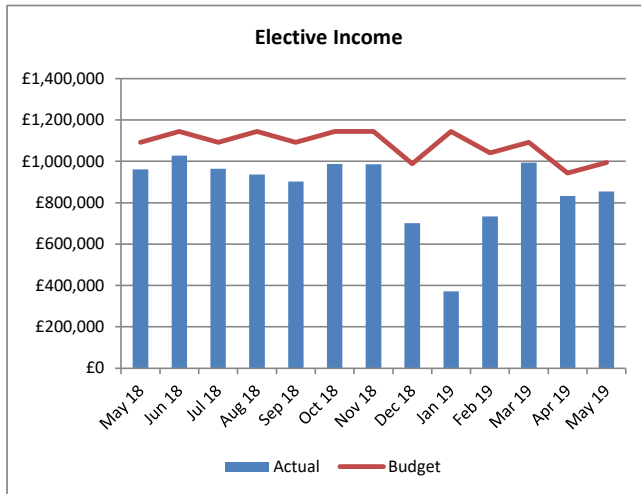


Operational Delivery: *Planned Activity*

Secondary Drivers

		May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Monthly Trend
Bed Occupancy Rate	Medicine & Emergency Care	95.4%	97.3%	96.1%	96.7%	96.9%	97.7%	95.8%	96.7%	97.3%	96.3%	94.0%	87.2%	82.9%	
	Surgery & Cancer	83.8%	88.9%	85.4%	86.9%	89.2%	92.5%	88.1%	85.5%	94.5%	94.2%	81.9%	82.5%	86.9%	
Elective Inpatient Avg LOS (Days)		2.6	2.5	2.4	2.6	3.6	2.5	2.5	2.7	2.6	2.4	2.6	3.0	2.3	
Delayed Transfers of Care (MFFD)		16.00	12	13	13	16	22	12	9	16	17	17	17	16	
Delayed Transfers of Care (% of Acute Beds)			2.7%	2.9%	2.8%	2.8%	3.3%	4.5%	2.4%	1.8%	3.1%	3.3%	3.3%	3.5%	
Medical Outliers		20	22	26	29	37	26	26	29	46	31	20	12	23	
Readmission (Emergency Re-admissions after Planned Surgery)															
	30 Day Rate	3.35%	2.99%	3.12%	2.73%	3.01%	3.28%	2.96%	2.87%	2.66%	3.86%	3.29%	3.36%		
	7 Day Rate	1.27%	1.03%	1.42%	1.27%	1.28%	1.16%	1.15%	1.09%	1.06%	1.45%	1.05%	1.40%	1.44%	
Cancelled Operations - Non Clinical - Cancellation Rate		1.07%	0.95%	0.95%	0.95%	0.73%	1.86%	0.63%	1.40%	0.58%	0.60%	0.65%	0.67%	1.18%	
Theatre Efficiency															
	Main Theatres	78.9%	78.9%	76.7%	78.4%	78.4%	77.9%	77.2%	73.9%	74.5%	76.2%	78.5%	76.7%	75.0%	
	TC Theatres	74.2%	72.6%	75.6%	73.2%	73.4%	76.6%	73.5%	72.0%	69.4%	73.0%	73.5%	72.4%	68.2%	
DNA (OP Efficiency)		5.92%	5.83%	6.09%	5.74%	5.55%	5.72%	5.62%	5.95%	5.75%	5.42%	5.41%	5.93%	5.98%	
Hospital Cancellation Rate (OP Efficiency)		6.79%	6.80%	7.03%	7.27%	7.57%	7.65%	7.63%	8.27%	7.65%	7.83%	8.12%	7.92%	7.47%	

* Readmissions, DNA Rate and LOS metrics brought in line with national definitions



Financial Performance: Income & Expenditure Position - Aggregated

	Month			Year to Date			Forecast	Budget 2019/20 £'000
	Plan May (£'000)	Actual May (£'000)	Variance May (£'000)	Plan April to May (£'000)	Actual April to May (£'000)	Variance April to May (£'000)	2019/20 (£'000)	
Operating								
Operating Income								
<i>NHS Acute Activity Income</i>								
Elective	994	861	-133	1,937	1,687	-250	11,526	11,526
Non-Elective	5,699	6,000	301	11,379	11,552	173	68,654	68,654
Maternity	1,140	1,037	-103	2,174	2,071	-103	13,430	13,430
Day cases	1,710	1,673	-37	3,361	3,316	-45	20,777	20,777
Outpatients	2,528	2,438	-90	4,922	4,756	-166	30,611	30,611
A&E	1,080	991	-89	2,069	2,054	-15	12,196	12,196
Other NHS	6,381	6,653	272	12,172	12,636	464	74,802	74,802
Total NHS Clinical Revenue	19,532	19,653	121	38,014	38,072	58	231,996	231,996
<i>Other Operating Income</i>	1,960	2,038	78	3,899	3,992	94	25,533	25,533
<i>Inter-Trust Income</i>	0	0	0	0	0	0	0	0
TOTAL OPERATING INCOME	21,492	21,691	199	41,913	42,064	152	257,529	257,529
Operating Expenses								
Employee Benefits Expenses (Pay)	-15,254	-15,121	133	-31,073	-30,866	207	-186,378	-186,378
Drugs	-1,449	-1,443	6	-2,899	-2,855	44	-17,392	-17,392
Clinical Supplies	-1,552	-1,679	-127	-3,118	-3,153	-35	-18,951	-18,951
Non Clinical Supplies	-276	-345	-69	-575	-683	-102	-3,658	-3,658
Other operating expenses	-2,788	-2,948	-160	-5,523	-5,750	-227	-32,037	-32,037
TOTAL OPERATING EXPENSES	-21,320	-21,536	-216	-43,188	-43,307	-113	-258,415	-258,415
EBITDA	173	155	-18	-1,275	-1,243	32	-886	-886
Non Operating								
Non Operating Income								
Interest & Asset disposal	3	11	8	6	22	16	-541	-541
Non-Operating Expenses								
Depreciation & Finance Leases	-465	-445	21	-941	-880	61	-5,808	-5,808
PDC Dividend Expense	-166	-166	0	-332	-332	0	-1,989	-1,989
Adjusted Financial Performance surplus/(deficit)	-455	-444	12	-2,542	-2,433	109	-9,224	-9,224
Provider Sustainability Fund	484	484	0	968	968	0	7,535	7,535
Net Surplus/(deficit) before Exceptional Items	29	40	12	-1,574	-1,465	109	-1,689	-1,689
Donations for purchase of assets	38	17	-21	76	36	-40	216	216
Depreciation on Donated Assets	-33	-32	1	-56	-56	0	-276	-276
Prior period Adjustments	0	0	0	0	246	246	0	0
Difference between NHSI return and Trust	0	0	0	294	0	-294	0	0
Net Surplus/(deficit) after Exceptional Items	34	25	-9	-1,260	-1,239	21	-1,749	-1,749

The Trust has a deficit of £1.2m at the end of month 2 which was on plan cumulatively to the end of May. However with the position CCICP is £0.1m under plan and MCHT is off is off plan by £0.1m.

Contract income is on plan for the month with a share of the £500k additional block contract within the position and also charge for the FIT roll out commencing.

Other income is better than plan due to out of area training income. There is a risk associated with associate contracts, which are currently underperforming against contract values. Pay is better than budget but again underspends in CCICP and masking some pressures within MCHT, with nursing/HCAs continuing to show some challenges on the wards. This is offset by vacancies within medical pay, especially within diagnostics.

Drugs are underspent in relation to high cost drugs which are offset against contract income.

Other operating costs are overspent by £227K, within the month – there have been some higher than expected costs within radiology associated with the scanners for MRI/CT and also some additional reporting costs as a result of supporting the Solitan server upgrade.

The Provider Sustainability Fund, and the Marginal Rate Emergency Threshold have been included within the month. Within adjustments – there have been some one off accrual adjustments which impacted on month 1.

* EBITDA Total excludes Charitable Income

Financial Performance: Income & Expenditure Position - MCHFT

	Month			Year to Date			Forecast	Budget 2019/20 £'000
	Plan May (£'000)	Actual May (£'000)	Variance May (£'000)	Plan April to May (£'000)	Actual April to May (£'000)	Variance April to May (£'000)	2019/20 (£'000)	
Operating								
Operating Income								
<i>NHS Acute Activity Income</i>								
Elective	994	861	-133	1,937	1,687	-250	11,526	11,526
Non-Elective	5,699	6,000	301	11,379	11,552	173	68,654	68,654
Maternity	1,140	1,037	-103	2,174	2,071	-103	13,430	13,430
Day cases	1,710	1,673	-37	3,361	3,316	-45	20,777	20,777
Outpatients	2,528	2,438	-90	4,922	4,756	-166	30,611	30,611
A&E	1,080	991	-89	2,069	2,054	-15	12,196	12,196
Other NHS	3,974	4,186	212	7,253	7,703	450	44,664	44,664
Total NHS Clinical Revenue	17,125	17,186	61	33,095	33,139	44	201,858	201,858
<i>Other Operating Income</i>	1,842	1,913	71	3,662	3,755	93	24,165	24,165
<i>Inter-Trust Income</i>	0	0	0	0	0	0	0	0
TOTAL OPERATING INCOME	18,967	19,099	132	36,757	36,894	137	226,023	226,023
Operating Expenses								
Employee Benefits Expenses (Pay)	-13,313	-13,199	114	-26,990	-26,932	58	-162,157	-162,157
Drugs	-1,447	-1,440	6	-2,893	-2,854	39	-17,360	-17,360
Clinical Supplies	-1,463	-1,563	-100	-2,932	-2,940	-8	-17,791	-17,791
Non Clinical Supplies	-192	-276	-84	-410	-518	-108	-2,644	-2,644
Other operating expenses	-2,427	-2,546	-118	-4,800	-5,002	-202	-27,726	-27,726
Inter-Trust Charges	63	55	-8	126	111	-15	755	755
TOTAL OPERATING EXPENSES	-18,779	-18,969	-190	-37,899	-38,135	-236	-226,924	-226,924
EBITDA	188	130	-58	-1,142	-1,241	-99	-901	-901
Non Operating								
Non Operating Income								
Interest & Asset disposal	3	11	8	6	22	16	-541	-541
Non-Operating Expenses								
Depreciation & Finance Leases	-465	-443	21	-940	-879	61	-5,801	-5,801
PDC Dividend Expense	-166	-166	0	-332	-332	0	-1,989	-1,989
Net Surplus/(deficit) before PSF/Exceptional Items	-440	-468	-29	-2,408	-2,430	-22	-9,232	-9,232
Provider Sustainability Fund	484	484	0	968	968	0	7,535	7,535
Net Surplus/(deficit) before Exceptional Items	44	16	-29	-1,440	-1,462	-22	-1,697	-1,697
Donations for purchase of assets	38	18	-20	76	36	-40	216	216
Depreciation on Donated Assets	-33	-33	0	-56	-56	0	-276	-276
Prior period Adjustments	0	0	0	0	246	246	0	0
Difference between NHSI return and Trust	0	0	0	294	0	-294	0	0
Net Surplus/(deficit) after Exceptional Items	49	0	-49	-1,126	-1,236	-110	-1,757	-1,757

The Trust excluding Community Services, delivered a £1.2M deficit against a planned deficit of £1.1M - giving a £0.1M variance against plan cumulatively.

Contract income is on plan for the month with a share of the additional block contract within the position and also charge for the FIT roll out commencing. Other income is better than plan due to out of area training income.

Pay is better than budget, with pressures on the nursing/HCA pay offset by medical vacancies. Other Operating Expenses are £202K worse than budget as a result of additional costs associated with the 3rd MRI/CT scanners and also additional reporting costs in relation to the Solitan server upgrade.

Pathology costs are also showing a pressure, which is in line with the final quarter volumes from 1819 – which are offset against medical pay underspends.

The PSF and the MRET have been accrued into the position for May.

Financial Performance: Income & Expenditure Position - CCICP

	Month			Year to Date			Forecast	Budget 2019/20 £'000
	Plan May (£'000)	Actual May (£'000)	Variance May (£'000)	Plan April to May (£'000)	Actual April to May (£'000)	Variance April to May (£'000)	2019/20 (£'000)	
Operating								
Operating Income								
<i>NHS Acute Activity Income</i>								
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	2,407	2,467	60	4,919	4,933	14	30,138	30,138
Total NHS Clinical Revenue	2,407	2,467	60	4,919	4,933	14	30,138	30,138
<i>Other Operating Income</i>	118	125	7	237	237	0	1,368	1,368
<i>Inter-Trust Income</i>	0	0	0	0	0	0	0	0
TOTAL OPERATING INCOME	2,525	2,592	67	5,156	5,170	14	31,506	31,506
Operating Expenses								
Employee Benefits Expenses (Pay)	-1,941	-1,922	19	-4,082	-3,934	149	-24,221	-24,221
Drugs	-3	-3	0	-5	-6	0	-32	-32
Clinical Supplies	-89	-116	-27	-186	-213	-28	-1,159	-1,159
Non Clinical Supplies	-84	-69	15	-168	-162	6	-1,013	-1,013
Other operating expenses	-361	-402	-42	-722	-747	-25	-4,311	-4,311
Inter-Trust Charges	-63	-55	8	-126	-111	15	-755	-755
TOTAL OPERATING EXPENSES	-2,541	-2,567	-26	-5,290	-5,173	117	-31,492	-31,492
EBITDA	-15	25	40	-134	-2	132	14	14
Non Operating								
Non Operating Income								
Interest & Asset disposal	0	0	0	0	0	0	0	0
Non-Operating Expenses								
Depreciation & Finance Leases	-1	-1	0	-1	-1	0	-7	-7
PDC Dividend Expense	0	0	0	0	0	0	0	0
Adjusted Financial Performance surplus/(deficit)	-16	25	40	-135	-3	132	7	7
Provider Sustainability Fund	0	0	0	0	0	0	0	0
Net Surplus/(deficit) before Exceptional Items	-16	25	40	-135	-3	132	7	7
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
Difference between NHSI return and Trust	0	0	0	0	0	0	0	0
Net Surplus/(deficit) after Exceptional Items	-16	25	40	-135	-3	132	7	7

Community Services delivered a £0.13M surplus against the planned position.

Contract income is better than plan (£14K), due to an adjustment to the contract variation schedule.

Pay is £149K better than plan, as a result of underlying vacancies, with some levels of slippage not expected to continue throughout the year.

Inter-trust recharges reflect the 19/20 proposed charges agreed at the partnership board.

It is expected that there will be further investments starting during the year, which are currently awaiting CCG approval.

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	(3)	(170)	(140)	(11)	(3)	(182)	(147)
Endoscopy	Endoscopy	984	0	(71)	(326)	(1)	(132)	12	526	(60)
General Surgery Directorate	General Surgery	3,134	8	(105)	(1,583)	52	(352)	(36)	1,207	(88)
Head & Neck Directorate	Head & Neck	893	62	(37)	(437)	19	(116)	26	403	8
Macmillan Cancer Centre	Macmillan Cancer Centre	166	411	149	(183)	7	(356)	(23)	37	133
Ophthalmology	Ophthalmology	1,994	16	35	(734)	22	(650)	14	626	71
Orthopaedic Directorate	Orthopaedics	3,349	23	189	(1,195)	(33)	(599)	(41)	1,578	114
Theatres & TC	Theatres & TC	0	68	6	(1,289)	15	(373)	(77)	(1,593)	(55)
Urology Directorate	Urology	906	1	(126)	(518)	17	(121)	(6)	267	(115)
Bowel Cancer Screening Prog	Bowel Cancer Screening Prog	0	0	0	(114)	24	(68)	86	(182)	110
Surgical and Cancer Division	Surgery & Cancer	11,426	590	39	(6,551)	(18)	(2,779)	(49)	2,687	(28)

The division is £28K worse than plan cumulatively. Income is better than plan largely as a result of recharges on pass through drugs costs associated with The Christie contract. Pay is £18 worse than budget with a particular overspend associated with ward 10. Non pay is worse than budget, partly as a result of the offset against income for drugs recharges, but also an overspend associated with theatres. There are delays to the planned CIP scheme to undertake out of area Welsh work.

		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 Mgmt	Divisional Management M&EC	0	8	8	(407)	90	(21)	(10)	(420)	87
Accident & Emergency Dir	Emergency Department	3,178	119	(124)	(1,148)	(12)	(140)	(35)	2,009	(172)
Anaesthetics & Critical Care	Anaesthetics & Critical Care	1,186	2	72	(1,473)	(19)	(177)	1	(462)	55
Medical Directorate	General Medicine	7,976	21	(61)	(4,326)	(107)	(713)	(2)	2,959	(170)
Urgent Care Centre	Urgent Care Centre	113	0	0	(113)	8	0	12	0	19
Emergency Services Division	Medicine & Emergency Care	12,453	149	(105)	(7,466)	(40)	(1,050)	(34)	4,086	(180)

The Medicine and Emergency Care Division are £180K worse than plan. Contract income is below budget by £105K – with an over-performance within unplanned care offset by lower than budget levels of planned care within outpatients. The overspend is largely attributed to the unallocated CIP that the division has had allocated, which currently have a high risk of non delivery.

		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 Mgmt	Divisional Management W&C	0	3	3	(220)	1	(17)	8	(234)	12
Gum clinic	Gum clinic	0	0	0	0	0	0	0	0	0
Obstetric & Gynaecology Dir	Obstetrics & Gynaecology	2,745	11	(147)	(1,502)	42	(230)	(34)	1,024	(139)
Paediatric Directorate	Paediatrics	2,201	13	65	(1,400)	(26)	(160)	2	654	40
Women and Childrens Division	Women and Children	4,946	27	(79)	(3,121)	17	(407)	(25)	1,444	(87)

The Women's and Children's Division is £87K worse than plan. Contract income is below plan for Gynae (£30K), IVF services (£12K) and Maternity (£85K), which are offset by an over performance within Paediatrics (£27K). Pay is on plan, however the division is using agency locums within Paediatrics covering vacancies.

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 & Clinic Spt Sv Div Mgmnt	Divisional Management D&S	0	0	0	(54)	7	(2)	(36)	(56)	(29)
Dermatology	Dermatology	322	4	(15)	(176)	19	(59)	(3)	91	1
ECG department	ECG	75	3	(16)	(179)	18	(29)	(15)	(130)	(13)
Elmhurst	Elmhurst	345	32	3	(278)	(6)	(33)	(5)	66	(8)
Integrated Discharge	Integrated Discharge	0	0	0	(57)	(5)	0	0	(57)	(5)
Medical Records Department	Medical Records Department	0	0	0	(317)	17	(39)	(1)	(355)	15
Outpatients	Outpatients	0	24	(4)	(94)	1	(9)	0	(79)	(3)
Pathology Directorate	Pathology	2,294	664	273	(1,718)	108	(1,604)	(113)	(363)	268
Pharmacy Departments	Pharmacy	507	47	(80)	(625)	(18)	(499)	122	(570)	25
Radiology Directorate	Radiology	492	100	1	(1,173)	(7)	(580)	(87)	(1,161)	(92)
Therapeutic Departments	Therapies	0	0	0	(399)	(10)	(8)	5	(408)	(5)
Victoria Infirmary Northwich	Victoria Infirmary Northwich	344	1	(9)	(312)	(10)	(48)	(2)	(15)	(20)
Diagnostics and Support Divisi	Diagnostics and Support	4,379	876	153	(5,382)	116	(2,909)	(135)	(3,037)	134

The Division is currently £134K better than plan largely as a result of the release of an accrual associated with the ECT contract (£105K). Pay is underspent as a result of histopathology vacancies, which are offset against non-pay overspends for outsourced activity. Within non pay there are £56K of costs associated with the Solitan server upgrade, and to date £50K in relation to the delays in the 3rd CT/MRI scanners.

		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 Mgmt	Divisional Management E&F	0	9	9	(91)	(8)	(19)	17	(101)	18
Catering Directorate	Catering	0	257	36	(296)	(1)	(242)	(25)	(281)	10
Estates Departments	Estates Departments	0	80	1	(285)	34	(1,095)	1	(1,300)	35
Hotel Services	Domestics	0	0	0	(232)	9	(2)	0	(234)	9
Laundry Services Departments	Laundry	0	206	4	(203)	(7)	(183)	(47)	(179)	(50)
Security	Security	0	308	26	(131)	5	(108)	9	69	40
Site Services	Porters	0	0	0	(505)	12	(13)	(2)	(518)	10
Estates & Facilities Division	Estates & Facilities Division	0	861	76	(1,743)	44	(1,662)	(48)	(2,545)	73

The Estates and Facilities Division is £73K better than plan. Other income is better than plan as a result of increased takings within car parking. Within non pay there are additional costs associated with car park barrier repairs, increased cost of provisions within catering, and purchases of non-disposable bedding.

		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	4	4	(277)	(8)	(138)	(33)	(411)	(38)
Computer Services	Computer Services	0	8	1	(262)	11	(499)	40	(753)	52
Finance & Information	Finance & Information	0	8	3	(542)	15	(113)	6	(646)	24
Human Resources	Human Resources	0	150	70	(446)	35	(118)	(16)	(413)	89
Risk Management & R&D	Risk Management & R&D	0	62	(28)	(276)	6	(8)	7	(222)	(15)
Quality Assurance Departments	Nurse Management	0	7	(28)	(477)	(8)	(1,478)	4	(1,949)	(32)
Trust Central Expenditure	Trust Central Expenditure	901	1,054	22	(351)	(114)	35	147	1,639	55
Other Departments	Other Departments	4	100	73	(39)	4	(43)	1	21	78
Corporate	Corporate	904	1,394	118	(2,669)	(60)	(2,362)	156	(2,734)	213

The Corporate Division is £213K better than budget – with the only balancing CIP associated with the NHS Supply chain due to be allocated out.

Community Services	4,933	237	15	(3,934)	149	(1,128)	(46)	109	117
EBITDA	39,040	4,134	216	(30,866)	207	(12,299)	(181)	9	242

Financial Performance: Commissioner Income Analysis

Commissioner	FY Target (£'000)	YTD Target (£'000)	CEP Adjustmt	Final Actual (£'000)	Final Variance (£'000)
NHS Eastern Cheshire CCG	8,409	1,378	0	1,365	-13
NHS Eastern Cheshire CCG Community	423	70	0	70	0
NHS South Cheshire CCG Community	18,156	2,963	0	2,973	9
NHS South Cheshire CCG	107,294	17,608	0	17,666	58
NHS Vale Royal CCG	60,957	9,997	0	10,021	23
NHS Vale Royal CCG Community	11,065	1,802	0	1,808	5
NHS Warrington CCG	338	56	0	56	1
NHS West Cheshire CCG	3,803	628	0	509	-120
NHS West Cheshire CCG Community	215	36	0	36	0
NHS North Staffordshire CCG	2,763	453	0	320	-134
NHS Shropshire CCG	788	129	0	134	4
NHS Stoke on Trent CCG	1,805	296	0	213	-83
Public Health England	1,196	194	0	198	5
NHS Commissioning Board	2,125	354	0	282	-72
Specialist Commissioning Group	8,083	1,331	0	1,485	154
Non Contract Activity	2,202	365	0	481	116
Cross Border Flows (non Betsi)	117	19	0	5	-14
Betsi	294	48	0	13	-36
Non-Commissioner Specific	9,497	1,253	0	1,407	155
TOTAL	239,530	38,980	0	39,042	44

Contract income is on plan, with a share of the £0.5M accrued into the position as a result of the discussions around the contract block.

Other associate contracts are below plans, with Stoke/North Staffs/West Cheshire significantly down – which is a step change from the 1819 performance, and trend over the final quarter of last year. This follows a change in GP referral pattern beginning in February 2019.

Specialist Commissioning is over-performing as a result of the continued use of 3rd party suppliers for aseptic products.

Cross border flows includes Welsh commissioners where the Trust has a CIP of £0.25M to undertake planned activity – as the dispute over the rate to be paid for activity for Welsh health boards has now been concluded, the Trust has re-started the discussion over volumes that the Trust can complete here

Other Contract Income	FY Target (£'000)	YTD Target (£'000)	YTD Actual (£'000)	Final Variance (£'000)
Bed Based Services	6,048	1,008	1,022	14
Adult & Neonatal Critical Care	8,719	1,446	1,425	-21
Urgent Care Centre	0	0	0	0
Community Paediatrics	1,350	225	225	0
Direct Access Services	9,548	1,548	1,605	57
Unbundled Radiology	2,942	477	546	69
High Cost Drugs	10,589	1,765	2,009	244
Screening Programmes	1,593	266	266	0
Audiology	1,086	181	165	-16
IVF	199	33	21	-12
CQUIN	2,321	387	365	-22
Provider Sustainability Fund	4,320	432	432	0
Community Services	30,139	4,919	4,933	14
Capped Expenditure Programme	0	0	0	0
Winter funding	750	0	0	0
Marginal Rate Emergency Threshold	3,215	536	536	0
Other	3,749	625	760	135
TOTAL	86,568	13,848	14,310	462

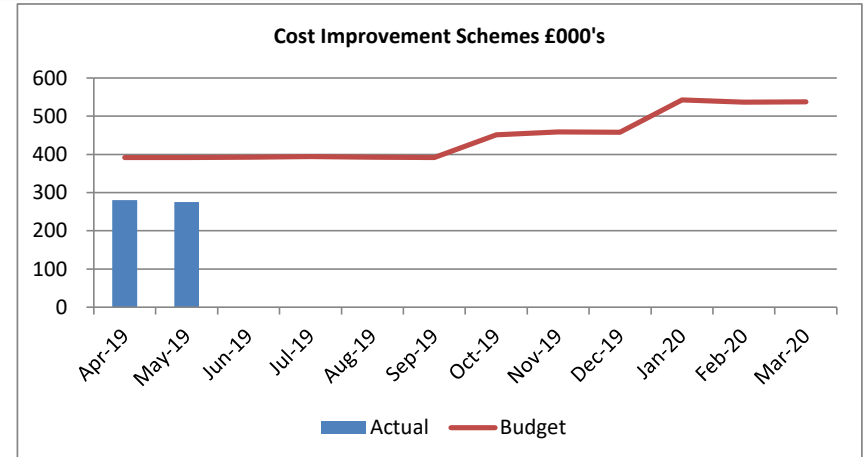
Other contract income is better than plan by £0.4M.

High cost drugs, as part of the specialised commissioning contract are over-performing as a result of the use of 3rd party suppliers to support the aseptic unit closure.

Diagnostics are showing an over-performance against the plan, which offset an underperformance of critical care and IVF, and other – which relates to the CCICP/FIT delayed programmes.

Financial Performance: Efficiencies

Cost Improvement Schemes (£'000's)						
Scheme Category	YTD Target	YTD Actual	YTD	FY Target	FY Forecast	FY Variance
Commercial	69	69	0	468	468	0
Drugs	50	50	0	300	300	0
Medical Workforce	0	0	0	146	146	0
Nursing Workforce	67	0	-67	800	800	0
Other Workforce	182	129	-53	1,089	1,089	0
Non Pay efficiencies	32	32	1	189	189	0
Procurement	312	223	-89	1,825	1,825	0
Theatres Efficiency	0	0	0	0	0	0
Service redesign	0	0	0	0	0	0
Market Share	46	0	-46	525	525	0
Total (£'000)	758	503	-254	5,342	5,342	0



The CIP Programme is behind plan, with the key schemes not achieving being the NHS Supply chain, savings and the out of work associated with Wales – which are expected to be delayed. Other CIP schemes which are at risk are nurse pay savings and the unallocated CIP, which has been allocated to divisions within month.

Financial Performance: Capital Report

SCHEME	BOARD APPROVED	FUNDING SOURCE	FUNDING APPROVED	EXPENDITURE BROUGHT FORWARD	2019/20 ANNUAL BUDGET	2019/20 CUMULATIVE BUDGET TO DATE	2019/20 CUMULATIVE ACTUAL	2019/20 BETTER/WORSE THAN BUDGET	2019/20 FORECAST	2019/20 + FORECAST	WHOLE PROJECT ACTUAL TO DATE	WHOLE PROJECT PROPOSED PLAN	TOTAL FORECAST
STRATEGIC INVESTMENTS (Requires individual signoff)													
ESTATES													
3RD CT ENABLING	Yes	Internal	Yes		1000	0	0	0	1000	0	0	1,000	1,000
A&E BUILD										13000	0	13,000	13,000
ACCESS CONTROL	Yes	Internal	Yes		170	0	-3	3	170	0	-3	170	170
CAR PARK LAND *	Yes	Loan	Yes	62	338	0	0	0	338	1500	62	1,900	1,900
CARDIO RESPIRATORY 3 CLINICAL ROOMS					100	0	0	0	100		0	100	100
CHLORINE DIOXIDE GENERATORS					12	0	0	0	12		0	12	12
DEMENTIA APPEAL	No	Donated	Not yet approved					0		1500	0	1,500	1,500
ENDOSCOPY WASHER BUILD *	No	Loan	Not yet approved					0		270	0	270	270
EPR PROJECT ACCOMODATION *	Yes	Internal	Not yet approved		350	0	0	0	350		0	350	350
ICU CONVERSION *					1200	0	0	0	1200		0	1,200	1,200
MRI SCANNER 3RD BUILD	Yes	Internal/Loan	Yes	182	933	156	349	-193	933		531	1,115	1,115
PATHOLOGY RISKS	Yes	Internal	Yes	83	17	17	22	-5	17		105	100	100
PHARMACY ROBOT ENABLING					200	0	0	0	200		0	200	200
SSD ENABLING *	Yes	Loan	Yes		668	0	4	-4	668		4	668	668
TURNKEY FOR REPLACEMENT CT SCANNERS	No	Internal	Yes	38	127	50	71	-21	127		109	165	165
TURNKEY OPTIMA SCANNER					135	0	0	0	135		0	135	135
UNDER / OVERS CAPITAL SCHEMES 18/19	Yes	Internal	Yes		0	0	7	-7	0		7	0	0
VIN JAG COMPLIANT					44	0	0	0	44		0	44	44
WARD REFURBISHMENT	Yes	Loan	Yes	343	1257	300	417	-117	1257	10250	760	11,850	11,850
WASTE COMPOUND AND SEGREGATION	Yes	Internal	Yes							350	0	350	350
TOTAL				708	6551	523	866	-343	6551	26870	1574	34129	34129
IT													
CORE INFRASTRUCTURE UPGRADE	yes	PDC	Yes		291	48	137	-89	291	180	137	471	471
CYBER SECURITY	Yes	PDC	Yes					0			0	0	0
HIGH IMPACT STAND ALONE IT SYSTEMS	Yes	Internal	Yes	35	77	50	0	50	77	400	35	512	512
NET CALL / CALL CENTRE	Yes	Internal	Yes							80	0	80	80
REPLACEMENT BUSINESS INTELLIGENCE SYSTEM	Yes	Internal	Yes	93	28	0	10	-10	28		103	121	121
SEQUEL / WINDOWS LICENCES	Yes	Internal	Yes		100	0	0	0	100	200	0	300	300
UNDER / OVERS CAPITAL SCHEMES 18/19	Yes	Internal	Yes		0	0	9	-9	0		9	0	0
UPS	Yes	Internal	Yes		250	0	0	0	250		0	250	250
VENDOR NEUTRAL ARCHIVE								0		350	0	350	350
VIRTUAL CLINICS	Yes	Internal	Yes		45	8	4	4	45		4	45	45
VIRTUAL DESKTOP	No	Internal	Yes					0		400	0	400	400
VOICE OVER IP	Yes	Internal	Yes		30	0	15	-15	30	395	15	425	425
VPN	Yes	PDC	Yes		70	70	48	22	70		48	70	70
SYSTEM REFRESH / REPLACEMENT													
BADGERNET	Yes	Internal	Yes							45	0	45	45
BLOOD TRACKING SYSTEM	No	Internal	Yes		140	0	0	0	140		0	140	140
CARDIO RESPIRATORY SYSTEM	No	Internal	Yes					0		350	0	350	350
CHEMOCARE	yes	Internal	Yes		85	0	0	0	85		0	85	85
DOCMAN	Yes	Internal	Yes		52	0	0	0	52		0	52	52
EPMA *					1500	0	0	0	1500		0	1,500	1,500
EPR					500	0	0	0	500	750	0	1,250	1,250
EPR IMPLEMENTATION COSTS										2333	0	2,333	2,333
LABCENTRE UPGRADE					800	0	0	0	800		0	1,600	1,600
PHARMACY ASCRIBE	No	Internal	Yes							200	0	200	200
SOLITON REPLACEMENT RIS										350	0	350	350
STAFF WIFI	No	Internal	Yes							100	0	100	100
TOTAL				128	3968	176	223	-47	3968	6933	351	10929	10929
TOTAL STRATEGIC INVESTMENTS				836	10519	699	1090	-391	10519	33803	1926	45,058	45,058

Strategic schemes are £0.4M overspent. mainly due to the Third MRI Scanner £0.2M and the Ward Refurbishment £0.1M which are ahead of the anticipated plan .

Financial Performance: Capital Report

SCHEME	BOARD APPROVED	FUNDING SOURCE	FUNDING APPROVED	EXPENDITURE BROUGHT FORWARD	2019/20 ANNUAL BUDGET	2019/20 CUMULATIVE BUDGET TO DATE	2019/20 CUMULATIVE ACTUAL	2019/20 BETTER/WORSE THAN BUDGET	2019/20 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		342	57	30	27	342	800	30	1,142	1,142
BACKLOG GENERAL PROVISION	Yes	Internal/Loan	Yes		1626	271	281	-10	1,626	8600	281	10,226	10,226
CT / VT - HEATING INFRASTRUCTURE	Yes	Internal	Yes		209	0	11	-11	209	1100	11	1,309	1,309
DESIGN TEAM	Yes	Internal	Yes		313	52	46	6	313	1252	46	1,565	1,565
TOTAL				0	2,490	380	369	11	2,490	11,752	369	14,242	14,242
IT													
INTERFACING	Yes	Internal	Yes		40	6	0	6	40	440	0	480	480
IT APPLICATIONS	Yes	Internal	Yes		50	8	0	8	50	500	0	550	550
TOTAL				0	90	14	0	14	90	940	0	1,030	1,030
TOTAL ROLLING ALLOCATIONS				0	2,580	394	369	25	2,580	12,692	369	15,272	15,272
ADDITIONAL													
EQUIPMENT	Yes	Internal	Yes		0	0	44	-44	44		44	0	44
ACQUISITION OF SCPH					1000	0	0	0	1000		0	1,000	1,000
COMMUNITY SERVICES	Yes	Internal	Yes		500	0	0	0	500		0	500	500
GP STREAMING IT FRONT OF HOUSE	Yes	PDC	Yes	108	142	24	0	24	142		108	250	250
ORDER COMMS					106	0	0	0	106				
SCPH ENABLING					400	0	0	0	400		0	400	400
LEASING INVESTMENTS													
3RD CT SCANNER	No	Internal	Yes		1159	0	0	0	1159		0	1,159	1,159
3RD MRI SCANNER	Yes	Internal	Yes		406	0	0	0	406		0	406	406
EQUIPMENT	Yes	Internal	Yes		600	100	0	100	600		0	600	600
LAUNDRY EQUIPMENT					566	0	0	0	566		0	566	566
MRI SCANNER DONATED										850	0	850	850
PORTABLE X-RAY MACHINE *3										360	0	360	360
REPLACEMENT CT SCANNER *2	No	Internal	Yes		916	0	0	0	916	406	0	1,322	1,322
ROOM 2 X-RAY	No	Internal	Not yet approved		500	0	0	0	500		0	500	500
SSD WASHERS	No	Internal	Yes		0	0	0	0	0		0	0	0
TOTAL LEASING INVESTMENTS				0	4147	100	0	100	4147	1616	0	5763	5763
TOTAL CAPITAL PROGRAMME (EXCLUDING LEASES)				944	15,247	1,117	1,503	-386	15,291	46,495	2,447	62,480	62,524
TOTAL CAPTIAL PROGRAMME				944	19,394	1,217	1,503	-286	19,438	48,111	2,447	68,243	68,287

The underspend on leased equipment is due o a delay in the procurment of these items

Financial Performance: Statement of Financial Position

	Plan Apr to May (£'000)	Actual Apr to May (£'000)	Variance (£'000)	Forecast 2019/20 (£'000)
Assets				
Assets, Non-Current	94,145	93,522	-623	105,433
Assets, Current				
Trade and other Receivables	9,742	10,986	1,244	9,255
Other Assets (including Inventories & Prepayments)	5,937	6,899	962	6,097
Cash and Cash Equivalents	10,493	10,537	44	4,760
Total Assets, Current	26,172	28,422	2,250	20,112
ASSETS, TOTAL	120,317	121,945	1,628	125,545
Liabilities				
Liabilities, Current				
Finance Lease, Current	-1,144	-1,413	-269	-2,348
Loans Commercial Current	-5,591	-5,559	32	-475
Trade and Other Payables, Current	-12,378	-13,318	-940	-13,590
Provisions, Current	-325	-335	-10	-325
Other Financial Liabilities	-9,314	-10,918	-1,605	-8,820
Total Liabilities, Current	-28,751	-31,543	-2,792	-25,558
Net Current Assets/(Liabilities)	-2,579	-3,121	-542	-5,446
Liabilities, Non Current				
Finance Lease, Non Current	-4,388	-3,193	1,195	-4,705
Loans Commercial Non-Current	-8,049	-8,049	0	-16,641
Provisions, Non-Current	-1,423	-1,423	0	-1,246
Trade and Other Payables, Non-Current	0	0	0	0
Total Liabilities Non-Current	-13,860	-12,665	1,195	-22,592
TOTAL ASSETS EMPLOYED	77,706	77,736	30	77,395
Taxpayers' and Others' Equity				
Taxpayers Equity				
Public dividend capital	77,508	77,508	0	77,668
Retained Earnings	-13,216	-13,195	21	-13,687
Donated asset reserve	0	0	0	0
Revaluation Reserve	13,414	13,422	8	13,414
TOTAL TAXPAYERS EQUITY	77,706	77,736	30	77,395
TOTAL FUNDS EMPLOYED	77,706	77,736	30	77,395

Assets Non Current

The main reason for the variance is the capital programme expenditure being £0.3M more than anticipated which is mainly due to the third MRI Scanner build £0.2M and the Ward Refurbishment £0.1M overspent due to the schemes being ahead of programme. This is offset by a delay in finance leases £0.9M mainly due to the Third CT Scanner.

Trade and other Receivables

NHS Trade Receivables is higher than anticipated which is mainly due to the outstanding debts with Christies £0.6M (£0.1M paid in June). In addition there is an outstanding payment of £0.3M from East Cheshire Council and Chester and West Cheshire Council.

Other Assets

In addition prepayments are higher than anticipated due to higher than anticipated lease payments for computers

Finance Lease Current

This mainly due to a delay in the payment in finance leases.

Trade and other Payables

This is higher than anticipated due to an outstanding payment to NHS Property Services due to issues with the last six months invoices. £0.7M has now been paid in June.

Other Financial Liabilities

This is mainly due to the two main CCG's phasing of contract payments compared to the Trust's plan £2.3M.

Finance Lease Non- Current

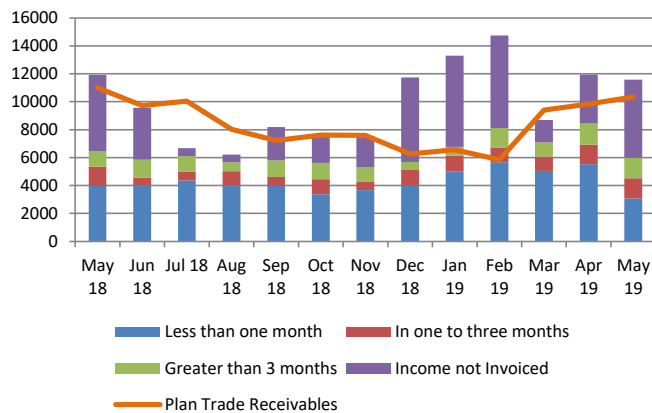
This due to the delay in the replacement of finance leases.

Financial Performance: Cash Position and Working Capital

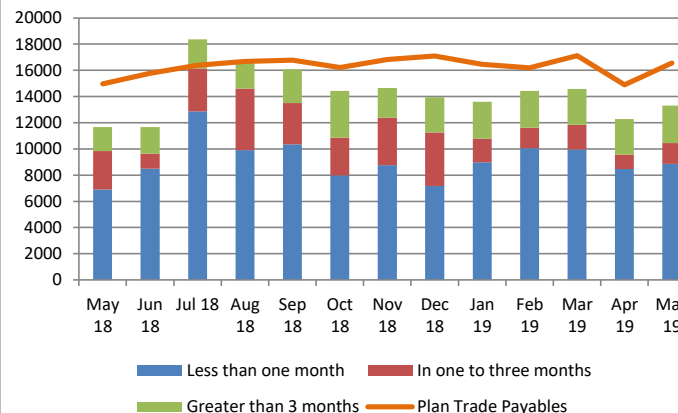
	Plan Apr to May (£'000)	Actual Apr to May (£'000)	Variance
Surplus/(deficit) after tax	-1,261	-1,235	26
Non-cash flows in operating Surplus/(deficit) total	1,095	917	-178
Operating cash flows before movements in working capital	-166	-318	-152
Increase/(Decrease) in working capital Total	943	1,063	120
Net cash inflow/(outflow) from operating activities	777	745	-32
Net cash inflow/(outflow) from investing activities total	-1,087	-1,230	-143
Net Cash inflow/(outflow) before financing	-310	-485	-175
Net cash inflow/(outflow) from financing activities Total	-447	-227	195
Net increase/(decrease) in cash and cash equivalents	-757	-712	20
Opening cash balance	11,249	11,249	0
Closing cash balance	10,492	10,537	45

Cash is better than plan, mainly due to Working capital and lower finance lease payments, offset by the overspend on the capital programme.

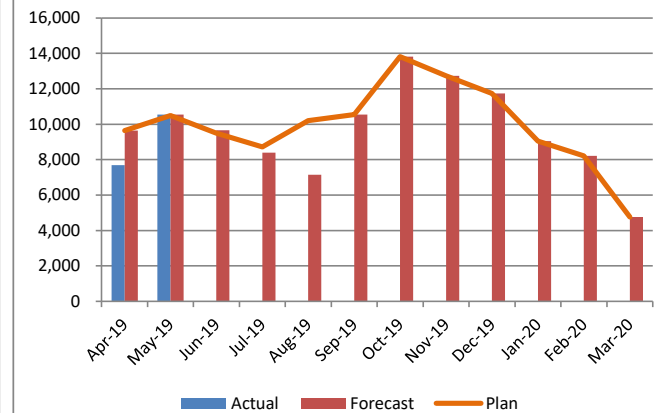
Trade Debtor Profile £000's



Trade Creditor Profile £000's










Cash Forecast £000's



Finance: Staff Costs

Headline Measures

		Rolling 13 months £000's													
	YTD £000's	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Monthly Trend
Pay Budget	31,169	14,112	14,008	14,158	14,900	14,225	14,325	14,219	14,361	14,616	14,424	14,642	15,818	15,351	
Pay Actual	30,864	14,152	14,237	14,183	14,960	14,639	14,820	14,682	15,094	14,902	14,875	14,859	15,744	15,120	
Variance	305	-40	-229	-25	-60	-414	-495	-463	-733	-286	-451	-217	74	231	
% to Budget	99.0%	100.3%	101.6%	100.2%	100.4%	102.9%	103.5%	103.3%	105.1%	102.0%	103.1%	101.5%	99.5%	98.5%	
Nursing Staff % to Budget	99.7%	99.9%	102.1%	100.5%	103.5%	103.1%	104.3%	107.0%	105.9%	100.9%	101.9%	97.7%	102.7%	96.7%	
Medical Staff % to Budget	95.7%	100.5%	99.2%	97.3%	92.0%	104.2%	107.2%	100.0%	108.7%	102.3%	105.6%	107.6%	95.3%	96.1%	
Other Staff % to Budget	100.4%	100.6%	102.7%	101.6%	102.0%	102.0%	100.3%	101.4%	102.0%	102.9%	103.0%	101.9%	98.8%	102.1%	

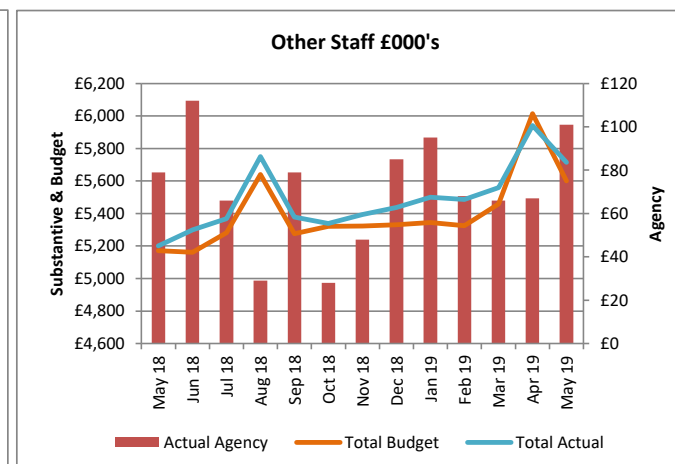
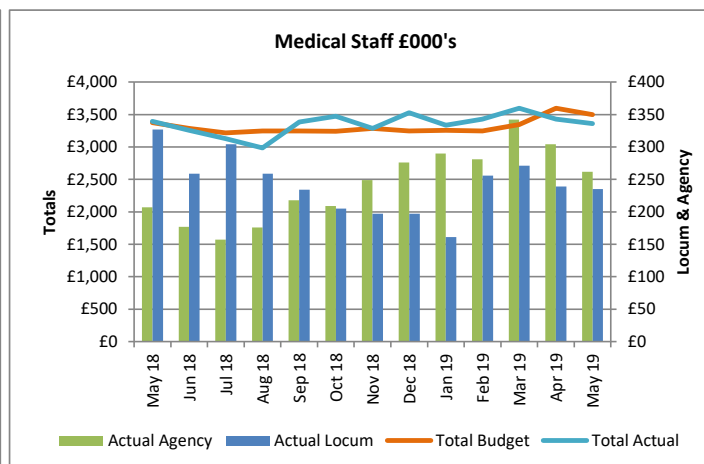
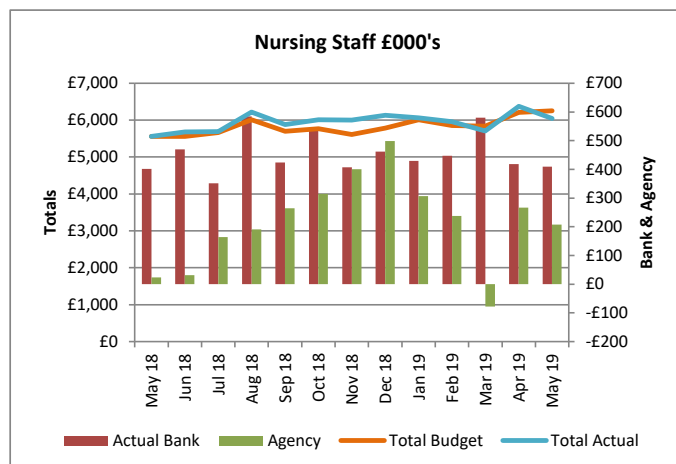
Commentary

Pay is better than budget by £0.2M year to date

Nursing costs are better than budget, largely as a result of CCICP underspends. Medical pay is underspent particularly within the diagnostics areas, which are offset against Medical and Surgical specialties.

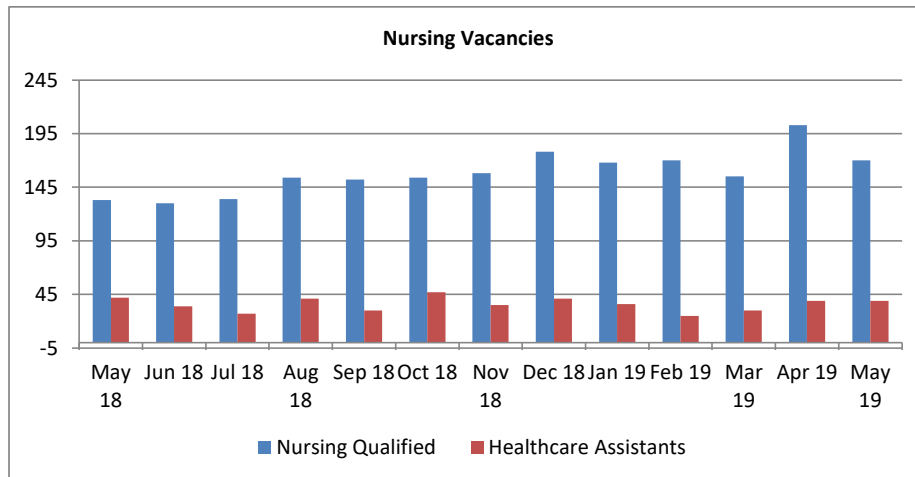
The NHSI agency ceiling has reduced to £5.7M for the Trust for 2019/20, down from £6.2M - which given the current run rate is likely to be exceeded, and impact one of the use of resources metrics.

Primary Drivers



Finance: Staff Costs

Secondary Drivers



Medical vacancies under review

Agency Trajectory

	YTD	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Monthly Trend
Plan	-806	-572	-561	-515	-563	-525	-495	-477	-506	-495	-470	-484	-403	-403	
Actual	-1,209	-416	-570	-611	-568	-540	-699	-721	-572	-668	-618	-574	-638	-571	
Variance	-403	156	-9	-96	-5	-15	-204	-244	-66	-173	-148	-90	-235	-168	
MCHFT Actual	-1,209	-416	-570	-611	-568	-540	-630	-644	-420	-458	-622	-497	-638	-571	
CCICP Actual	0	0	0	0	0	0	-69	-77	-152	-210	4	-77	0	0	
Planned Winter Escalations															

	Rolling 13 Months													
	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Monthly Trend
Sickness Rate (Rolling 12 mths)	4.37%	4.30%	4.29%	4.27%	4.27%	4.26%	4.24%	4.30%	4.27%	4.32%	4.33%	4.37%	4.42%	
Sickness FTE	143.13	137.51	150.24	157.85	161.00	163.87	170.79	197.97	209.20	192.17	171.32	169.20	177.64	
Total Leavers	41	38	38	63	48	34	34	23	25	21	37	35	29	
Turnover (Rolling 12 mths)	11.28%	11.33%	11.17%	11.67%	11.54%	11.25%	11.03%	10.89%	10.60%	10.03%	9.94%	9.90%	9.60%	

Title of Paper:	Trust Strategy Update – June 2019		
Author:	Chris Oliver		
Executive Lead:	Chris Oliver		
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	
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	X	Responsive	
Creating a 21st Century Infrastructure for Transformative Health and Social Care	X	Well-Led	X
Link to Board Responsibility:	Performance		
	Accountability		
	Strategy		X
	Implementation		
Action Required:	Decide		
	Approve		
	Note		X
	Recommend		
	Delegate		
Positive Benefit:	The Trust delivers the 2020/21 strategy which support the Trust's journey from Good to Outstanding		
Risk:	Competing demands detract the Trust from delivering against the strategy		
To be published on Trust Website –complete version		Yes	
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:	1 July 2019		

Trust Strategy Update – June 2019

Introduction

The Trust's current strategy takes the Trust forward to 2020/21 to support our journey from Good to Outstanding and deliver the Trust vision of delivering excellence in healthcare through innovation and collaboration.

This paper aims to provide an update against progress on the five strategic domains of the Trust strategy.

Strategic Domains

In order to successfully deliver the Trust's vision and continually progress on our journey from a 'Good' to 'Outstanding' CQC rating the Board of Directors has agreed the following five strategic domains as our focus, with underpinning strategic objectives which will be adopted locally by our clinical teams and inform our priorities and plans working collaboratively with the community and partners.



Key Highlights of Progress Made

The Trust has a proven track record in delivering high standards of safe care and treatment to our population and ensuring that their experience is the best it can be. Nevermore was this demonstrated in May 2018 when the Trust maintained its good rating with the CQC.

Below are some of the key achievements delivered against the five strategic domains.

D1 – Delivering Outstanding Clinical Quality, Safety and Experience

- The quality and safety strategy has been presented and approved at the Quality Governance Committee (QGC) which focuses on nine key indicators.
- The Trust continues to play an active role in the national GIRFT Programme with updates to QGC.
- The last staff survey again places the Trust in a strong position when compared to combined acute and community Trusts with eight of the ten indicators rated above average, one rated average and morale rated the best nationally. Also pleasing was an improvement against the 2017 inpatient survey.
- The Trust has scoped a draft Improving Quality Together programme, this has been discussed at QGC and will be a major topic at a forthcoming Board away day.
- The Trust has launched the Ward Accreditation programme, which focuses on a range of metrics with a coaching ethos of ward level continuous improvement.
- The Trust has played an active role with the community via our Governor workshops, to help shape our services.
- The Market Shaping programme has seen services change in delivery to attract more patients to choose Mid Cheshire Hospitals as their choice for healthcare.
- The Trust is an active participant in the national safety collaboration e.g. Care pathways, Cquins and Aqua.
- The Trust is moving forward with its risk-based approach to investment in seven day services, which has seen business cases for Therapies, General Surgery and Urology presented to the Board of Directors, with additional specialities programmed to be presented through 2019.
- The Trust has developed and approved a two-year research strategy.

D2- Being a Leading Partner in a Progressive Health Economy

- The executive team have scheduled meetings with East Cheshire Trust (ECT). Board to Board meetings have also taken place across the acute footprint with ECT as well as the Trusts two local CCG's.
- The Trust successfully delivered against the systemwide capped expenditure programme which has seen system benefits in terms of financial position but also relational improvement to create a strong foundation to take forward the changes required over the remainder of the 2020/21 strategy.
- The Trust has scoped services between itself and ECT. Now the substantive executive team are in place at the University Hospital North Midlands it is envisaged the Stronger Together programme will again gather pace, especially regarding the elective agenda
- The Trust is actively engaged with the pathology collaboration between MCHFT, ECT and UHNM, with significant efficiencies and quality improvements defined.

- The Trust continues to develop a flexible workforce with the sustainability of specialities strengthened with joint posts across a range of neighbouring Trusts.
- The Trust is also continuing with horizon scanning outside of the English NHS, looking to again enhance the positive relationship with Betsi Cadwaladr Health Board.
- The care communities within CCICP continue to strengthen and improve the quality of care delivered within the community, linking to the newly formed primary care networks as laid out in the Long-Term Plan.
- Development around conditions such as frailty will again strengthen the link between community and acute services.
- The Trust is continuing to play an active role in the development and progression of the East Cheshire Place.

D3 – Striving for Outstanding Organisational Effectiveness

- The Trust continues to perform strongly against the oversight framework with the exception of the four-hour standard. An in-depth review has been undertaken identifying attendance growth set against workforce and infrastructure constraints as leading issues. A robust business case to address the workforce will be presented to Trust Board in July, with the capital rebuild business case previously approved by Board and awaiting external funding.
- The Trust has been ranked third best nationally for cancer performance in 2018
- The Trust delivered a financial surplus in 2018/19. Significant investments have been made into frontline care in 2019/20 to ensure continued pursuit of excellence with the required capacity and capability.
- The Trust has undertaken a range of benchmarking data which in the main shows the Trust to be performing better than peers, with a programme of improvement to address areas where further gains can be made.
- The Trust has developed a new data warehouse enabling users to benefit from live data to deliver improvements.

D4 - Aspiring to Excellence in Practice through our Workforce

- The Trust is invested and reshaped the workforce directorate to ensure it is fit to deliver the needs of our workforce now and in the future.
- The workforce strategy published details how the Trust will recruit and retain individuals, developing new roles to ensure delivery of high quality care.
- Equality and inclusion are a key feature of the workforce strategy and the Trust has developed a range of initiatives to further promote the Trust as the employer of choice, with a series of branding to be released shortly.
- A key feature of the workforce strategy was to ensure the Trust continues to have a skilled workforce for the future demands of healthcare. The Trust is one of the first Trusts regionally to create a nursing apprentice programme aiming to recruit and retain a supply of future nurses.

D5 – Creating a 21st Century Infrastructure for Transformative Health and Social Care

- The Trust continues to deliver against the Ward Refurbishment programme with a dedicated ambulatory / planned care unit, taking place in 2019/20 to further support the Trust in delivering the standards in the Long Term Plan regarding same day emergency care.
- The Trust has, alongside East Cheshire Trust submitted a business case to regulators for the implementation of an electronic patient record.
- The newly created data warehouse has enabled real time data to be available to the teams to ensure visibility and improvement.
- The creation of a web-based portal for discharge across the whole health economy has supported the reduction in super stranded patients.
- The roll out of an electronic patient portal and scheduling tool for community teams has seen efficiencies in the delivery of care releasing capacity back to the frontline patient care.
- The roll out of virtual healthcare continues with skype sessions now in place across targeted care homes as well as the transfer from traditional outpatient clinics to virtual reviews in some specialities, with further roll outs expected.

Next Steps

As part of the 2020/21 strategy the Board will be aware of the creation of the Divisional plans on a page, these documents have been reviewed at the Acute Executive Management Board, with a refresher session having taken place in June 2019.

A full Divisional Strategy away day is planned for October 2019, with engagement from a range of external stakeholders, from this day the plans on a page will again be refocused to ensure all areas are aware of what they need to deliver in the last year of the strategy.

Conclusion and Recommendation

The Trust continues to make progress against a range of domains within the strategy, against a background of changing regulatory and commissioning structures as well as significant increased demand for our services.

The Trust Board is asked to note the progress made to date in anticipation of the full strategy event in October and formal board report in December.

Title of Paper :		Maternity Incentive Scheme – Year 2	
Author:		Sarah Wedgwood, Midwifery Matron	
Executive Lead:		Julie Tunney, Director of Nursing and Quality	
Type of Report:		Concept Paper	
		Strategic Options Paper	
		Business Case	
		Information	✓
		Review/Benefits/Audit	
Link to Strategic Domains:		Link to CQC 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:	Proven compliance with national indicators that contribute to safer maternity care. Full compliance leads to a 10% reduction in CNST premiums for MCHFT.		
Risk:	N/A		
To be published on Trust Website – complete version		Yes	
If no, to be published on Trust Website – redacted		N/A	
If not to be published complete or redacted, please detail the reason why		N/A	
Presented at Board Meeting of:		1 st July 2019	

Benchmark / Improvement Plan Template, Monitoring and Escalation

Maternity Incentive Scheme – Year 2 Published 12th December 2018



Our Values:

- Commitment to quality and safety
- Respect, dignity and compassion
- Listening, learning and leading
- Creating the best outcomes together
- Every 1 Matters

‘Delivering Excellence in Healthcare through Innovation and Collaboration’

Our Behaviours:

- I will act as a role model
- I will take personal responsibility
- I will have the courage to speak up and make my voice heard
- I will value and appreciate the worth of others
- I will play my part to the best of my ability

1. Purpose of this document

The purpose of this document is to outline the monitoring and escalation process for the 'Maternity Incentive Scheme – Year 2 published on 12th December 2018, benchmark / improvement plan review undertaken at Mid Cheshire Hospitals NHS Foundation Trust (MCHFT).

2. Process for monitoring and escalation of benchmark / improvement plan (see flowchart in Appendix 1)

The Trust standard template (see page 4) has been completed.

The **Initial “RAG” Rating** will be rated as follows:

Key:	Universal Compliance	Compliant	Partially Compliant	Non – Compliant
	Adherence 100%	Adherence 90% - 99%	Adherence 80% - 89%	Adherence < 79%

The overall **Current Position Rating** will be rated as follows:

Classification of progress		
Colour	Narrative	Description
B	Blue “Complete/BAU”	Completed: Improvement / action delivered
G	Green “On track”	Improvement on trajectory either: a) On track – not yet completed b) On track – not yet started
A	Amber “Problematic”	Delivery remains feasible issues / risks require additional intervention to deliver the required improvement e.g. Milestones breached.
R	Red “Delayed”	Off track / trajectory – milestone / timescales breached. Recovery plan required.

INTRODUCTION:

NHS Resolution is operating a second year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care.

The maternity incentive scheme applies to all acute trusts that deliver maternity services and are members of the CNST. As in year one, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund.











As in year one, the scheme incentivises ten maternity safety actions. Trusts that can demonstrate they have achieved **all** of the **ten** safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.






Trusts that **do not meet** the ten-out-of-ten threshold will **not** recover their contribution to the CNST maternity incentive fund, but may be eligible for a small discretionary payment from the scheme to help them to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund.











This document provides guidance on the safety actions for year two of the maternity incentive scheme.










In order to be eligible for payment under the scheme, trusts must submit their completed Board declaration form to NHS Resolution (MIS@resolution.nhs.uk) by 12 noon on Thursday 15 August 2019 and must comply with the following conditions:


- Trusts must achieve all ten maternity safety actions
- The Board declaration form must be signed and dated by the trust chief executive to confirm that:
 - The Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required standards as set out in the safety actions and technical guidance document.
 - The content of the Board declaration form has been discussed with the commissioner(s) of the trust's maternity services.
- The Board must give their permission to the chief executive to sign the Board declaration form prior to submission to NHS Resolution.















Standard / Process / Issue / Recommendation	Initial RAG Rating	Implementation / Action Required	Responsible Lead	Timescale (by end of)	Current Rating	Responsible Group	Closure Date & Evidence
Safety Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?							
a) A review of 95% of all deaths of babies suitable for review using the Perinatal Mortality Review Tool (PMRT) occurring from Wednesday 12 December 2018 have been started within four months of each death.	Ga	The Deputy Head of Midwifery to ensure that all deaths as per appendix 1 of this document are reported using the Perinatal Mortality Review Tool (PMRT)	Alison Walker	August 2019	B	W&C Divisional Board	Quarter 1  CNST PMRT report version 1.pdf Quarter 2  CNST PMRT report quarter 2. 2.pdf
b) At least 50% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018 will have been reviewed, by a multidisciplinary review team, with each review completed to the point that a draft report has been generated, within four months of each death.	Ga	The Deputy Head of Midwifery to ensure that all deaths as per appendix 1 have a multidisciplinary review team and a draft report generated within four months of the death.	Alison Walker	August 2019	B	Obstetric Governance Group	
c) In 95% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018, the parents were told that a review of their baby's death will take place and that their perspective and any concerns about their care and that of their baby have been sought.	B	<i>The Trust have a policy for 'Being Open Including the Duty of Candour'</i>	Medical Director & Deputy Chief Executive	Compliant	B	Operational Safety & Effectiveness Group	 Being Open July 2016 V5.pdf  SANDs letter 1.pdf  SANDs letter 2.pdf
d) Quarterly reports have been submitted to the trust Board that include details of all deaths reviewed and consequent action plans.	Gb	The Deputy Head of Midwifery to submit quarterly reports to the Obstetric Governance Group, Divisional Board and Trust Board	Alison Walker	August 2019	B	Obstetric Governance Group	 Divisional Board Minutes 22 March 2019  Action Points obs 08.03.19.pdf  Final Draft EQGG Action Notes - 17.04 Board/EQGG end of June Minutes.
Safety Action 2: Are you submitting data to the Maternity Services Data Set to the required standard?							
NHS Digital will issue a monthly scorecard to data submitters (trusts) that can be presented to the Board. The scorecard will be used by NHS Digital	Ga	All required information is submitted to NHS Digital using version 1 of the 'Maternity Services Data Set' (MSDS)	Kate Greenall Catherine Warner	August 2019	B	Obstetric Governance Group	 CNST Criteria v2 – October 2018 (1).pdf  CNST Criteria v2 - November 2018.pdf














Standard / Process / Issue / Recommendation	Initial RAG Rating	Implementation / Action Required	Responsible Lead	Timescale (by end of)	Current Rating	Responsible Group	Closure Date & Evidence
<p>to assess whether each MSDS data quality criteria has been met and whether the overall score is enough to pass the assessment. It is necessary to pass all three mandatory criteria and 14 of the 19 other criteria (see Appendix 2).</p> <p>The assessment will include data from the MSDS from January 2019. This data needs to be submitted to MSDS for the deadline of 31 March 2019.</p> <p>One MSDS criterion relates to data for six months, from October 2018 to March 2019, which needs to be submitted to MSDS for deadlines between 31 December 2018 and 31 May 2019.</p>							 CNST Criteria v2 - December 2018.pdf  CNST Criteria v2 - January 2019.pdf  Divisional Board Minutes 26 April 2019  screenshot MSDS submissions.pdf
One criterion relates to the submission of data for the first month of MSDSv2. This data relates to April 2019 and needs to be submitted to the deadline of 30 June 2019.	G	Version 2 of the 'Maternity Services Data Set' (MSDS) has not yet been published. Due to be published in March for implementation in April.	Kate Greenall Catherine Warner	August 2019	Ga	Obstetric Governance Group	Awaiting submission on 30.06.18
Safety Action 3: Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?							
a) Pathways of care for admission into and out of transitional care have been jointly approved by maternity and neonatal teams with neonatal involvement in decision making and planning care for all babies in transitional care.	B	<p>MCHFT have a local standard operating procedure for 'Transitional Care for Babies' which incorporates the recommendations: Local policy available which is based on principles of British Association of Perinatal Medicine (BAPM) transitional care where:</p> <ol style="list-style-type: none"> 1. There is evidence of neonatal involvement in care planning 2. Admission criteria meets a minimum of HRG XA04 but could extend beyond to BAPM transitional care framework for practice 	<p>Sarah Wedgwood</p> <p>Sara Nightingale</p> <p>Sarah Hand / Kathleen Fradley</p>	Compliant	B	<p>Obstetric Governance Group</p> <p>Paediatric Governance Group</p>	 Transitional Care for Babies on Ward 23 (F)















Standard / Process / Issue / Recommendation	Initial RAG Rating	Implementation / Action Required	Responsible Lead	Timescale (by end of)	Current Rating	Responsible Group	Closure Date & Evidence
		3. There is an explicit staffing model 4. The policy is signed by maternity/neonatal clinical leads					
b) A data recording process for transitional care is established, in order to produce commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2.	B	Data is available (electronic or paper based) on transitional care activity which has been recorded as per XA04 2016 NCCMDS.	Kate Greenall	03-02-19	B	Obstetric Governance Group Paediatric Governance Group	 CNST Evidence TC.pdf
c) An action plan has been agreed at Board level and with your Local Maternity Systems (LMS) and Operational Delivery Network (ODN) to address local findings from Avoiding Term Admissions Into Neonatal units (ATAIN) reviews.	Gb	An action plan from the monthly 'Term Admission Meetings to be written which includes 'An audit trail providing evidence and a rationale for developing the agreed action plan to address local findings from ATAIN reviews'.	Michael Grosdenier Jo Forkner Jackie Dunn	10-03-19	B	Obstetric Governance Group Paediatric Governance Group	 Divisional Board Minutes 22 March 2013 Version 1.1 (2).doc  CNST Safety Action LMS Minutes
d) Progress with the agreed action plans has been shared with your Board and your LMS & ODN	Gb	Action plan to be monitored and progress shared with Divisional Board, LMS and ODN.	Michael Grosdenier Jo Forkner Jackie Dunn	19-05-19	B	Obstetric Governance Group Paediatric Governance Group	LMS minutes  5) EQGG Outstanding Action Lr  neonatal stats.pdf  Divisional Board Minutes 24 May 2019
Safety Action 4: Can you demonstrate an effective system of medical workforce planning to the required standard?							
a) Formal record of the proportion of obstetrics and gynaecology trainees in the trust who 'disagreed/strongly disagreed' with the 2018 General Medical Council National Training Survey question: 'In my current post, educational/training opportunities are rarely lost due to gaps in the rota.' In addition, a plan produced by	Gb	Action plan to be written which addresses the 'Proportion of trainees with lost educational opportunities'.	Shanthi Pinto Karen McIntyre	August 2019	B	Obstetric Governance Group	 LOSS OF MEDICAL TRAINEES .pdf  GMC Survey 2017,18 response PG (1).pdf  Handover for LWS office poster.pdf  Educational Module final august 2018.pdf






Standard / Process / Issue / Recommendation	Initial RAG Rating	Implementation / Action Required	Responsible Lead	Timescale (by end of)	Current Rating	Responsible Group	Closure Date & Evidence
the trust to address lost educational opportunities due to rota gaps. 2018 GMC National Training Survey (covers the period 20 March to 9 May 2018)							 O+G.pdf
	Gb	The action plan which addresses the 'Proportion of trainees with lost educational opportunities to be formally recorded in Divisional Board minutes and signed off.	Shanthi Pinto Karen McIntyre	August 2019	B	Divisional Board	 Divisional Board Minutes 24 May 2019
	Gb	A copy of the action plan which addresses the 'Proportion of trainees with lost educational opportunities to be submitted to the Royal College of Obstetricians and Gynaecologists (RCOG) at workforce@rcog.org.uk.	Shanthi Pinto Karen McIntyre	August 2019	B	Obstetric Governance Group	 email RCOG.pdf  5) EQGG Outstanding Action L
b) An action plan is in place and agreed at Board level to meet Anaesthesia Clinical Services Accreditation (ACSA) standards 1.2.4.6, 2.6.5.1 and 2.6.5.6. Board minutes formally recording the proportion of ACSA standards 1.2.4.6, 2.6.5.1 and 2.6.5.6 that are met.	Gb	An action plan to be written which incorporates the standards described in appendix 3.	Selina Samuels	August 2019	B	Obstetric Governance Group Theatre Governance Group	 BIP Anaesthesia  BIP elective
Where trusts did not meet these standards, they must produce an action plan (ratified by the Board) stating how they are working to meet the standards.	Gb	The action plan to be presented at Divisional Board.	Selina Samuels Karen McIntyre	August 2019	B	Divisional Board	 Divisional Board Minutes 26 April 2019 Div Board Minutes June
Safety Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?							
a) A systematic, evidence-based process to calculate midwifery staffing establishment has been done.	Gb	A bi-annual report that includes evidence to support a-c being met. This should include:	Sarah Wedgwood	August 2019	B	Obstetric Governance Group	 Midwifery staffing paper 18-19 (3).pdf  Divisional Board Minutes 24 May 2019

Standard / Process / Issue / Recommendation	Initial RAG Rating	Implementation / Action Required	Responsible Lead	Timescale (by end of)	Current Rating	Responsible Group	Closure Date & Evidence
b) The obstetric unit midwifery labour ward coordinator has supernumerary status (defined as having no caseload of their own during that shift) to enable oversight of all birth activity in the service		•A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated. •Details of planned versus actual midwifery staffing levels. •An action plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken. Where deficits in staffing levels have been identified, maternity services should detail progress against the action plan to demonstrate an increase in staffing levels and any mitigation to cover any shortfalls. •The midwife: birth ratio. •The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 9% of the establishment which are not included in clinical numbers. This includes those in management positions and specialist midwives. •Evidence from an acuity tool (which may be locally developed) and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward status and the provision of one-to-one care in active labour and mitigation to cover any shortfalls	Alison Walker Jenny Butters				
c) Women receive one-to-one care in labour (this is the minimum standard that Birthrate+ is based on) d) A bi-annual report that covers staffing/safety issues is submitted to the Board.		Sarah Wedgwood Alison Walker Jenny Butters	August 2019	B	Obstetric Governance Group	 acuity quarterly report.pdf	
Safety Action 6: Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?							

Standard / Process / Issue / Recommendation	Initial RAG Rating	Implementation / Action Required	Responsible Lead	Timescale (by end of)	Current Rating	Responsible Group	Closure Date & Evidence
Board level consideration of the Saving Babies' Lives (SBL) care bundle (Version 1 published 21 March 2016) in a way that supports the delivery of safer maternity services.	B	'Saving Babies Lives' published March 2016 has had a gap analysis completed in May 2018	Catherine Warner		B	Obstetric Governance Group	 Saving Babies' Lives GAP Analysis V1 (Final)
Each element of the SBL care bundle implemented or an alternative intervention in place to deliver against element(s).	Gb	The 'Saving Babies Lives' published March 2016 gap analysis completed in May 2018 to be presented at Divisional Board	Jenny Butters Karen McIntyre	March 2019	B	Divisional Board	 Divisional Board Minutes 26 April 2019
Safety Action 7: Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?							
<p>User involvement has an impact on the development and/or improvement of maternity services.</p> <p>Evidence should include: Acting on feedback from, for example a Maternity Voices Partnership.</p> <p>User involvement in investigations, local and or Care Quality Commission (CQC) survey results.</p> <p>Minutes of regular Maternity Voices Partnership and/or other meetings demonstrating explicitly how a range of feedback is obtained, the action taken and the communications to report this back to women.</p>	Ga	<p>Show that MCHFT is acting on feedback from, Maternity Voices Partnership, via minutes of regular meetings demonstrating explicitly how a range of feedback is obtained, the action taken and the communications to report this back to women.</p> <p>User involvement in investigations, local and or Care Quality Commission (CQC) survey results.</p>	Sarah Wedgwood	August 2019	B	Obstetric Governance Group	 Minutes Maternity Voices Launch Event :  FB_IMG_1554316145307.jpg  Flyer mvp.pdf  Community-Midwives.pdf  Antenatal-Clinic.pdf  Ward-26.pdf  Ward-23 Feb 2019.pdf  Midwife-Led-Unit.pdf  Copy of February 2019 complaints close  Case Updates for Head of Midwifery W  MVP - Agenda - 06.06.19.pdf  TOR - MVP - Draft v1.0 - June 2019.pdf

Standard / Process / Issue / Recommendation	Initial RAG Rating	Implementation / Action Required	Responsible Lead	Timescale (by end of)	Current Rating	Responsible Group	Closure Date & Evidence
	G				B		 Maternity Voices 03.10.18 (1).pdf  MAT18_AN_RBT.pdf  MAT18_LB_RBT.pdf  MAT18_PN_RBT.pdf  Action Plan Template maternity survey 201  IDM 2019.pdf  Open day.pdf
Safety Action 8: Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?							
90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year.	B	W&C Divisional Mandatory Training Policy and Training Needs Analysis in place	Michelle McKay	August 2019	B	Obstetric Governance Group	 WC Mandatory Training Guideline V3.2019-20 Version 1 (Fi  W&C Divisional TNA
Training should include fetal monitoring in labour and integrated team-working with relevant simulated emergencies and/or hands-on workshops.	Ga	Ensure that at least 90% of MCHFT Maternity staff groups have attended in-house multi-professional training.	Michelle McKay	August 2019	B	Divisional Board	 2018 - 19 Skills and Drills compliance.pdf  Divisional Board Minutes 26 April 2019
Safety Action 9: Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?							
a) The Executive Sponsor for the Maternal and Neonatal Health Safety Collaborative (MNHSC) is actively engaging with supporting quality and safety improvement activity within the trust and the Local Learning System (LLS)	Ga	Evidence of executive sponsor engagement in quality improvement activities led by the trust nominated Improvement Leads for the MNHSC as well as other quality improvement activity for trusts in waves one and three	Julie Tunney	August 2019	B	Trust Board Obstetric Governance Group	 safety champions poster.pdf  E-mail from J Butters (2019.05.02).pdf

Standard / Process / Issue / Recommendation	Initial RAG Rating	Implementation / Action Required	Responsible Lead	Timescale (by end of)	Current Rating	Responsible Group	Closure Date & Evidence
	Ga	Evidence that the trust Board have been sighted on the local improvement plan, updated on progress, impact and outcomes with the quality improvement activities being undertaken locally.	Julie Tunney	August 2019	B	Obstetric Governance Group	 W&C - CQC Quality BIP Outcome of walk Report - Improvemenround Labour Ward 2   5) EQGG Outstanding Action Lr
	Ga	Evidence of attendance at one or more National Learning Set or the annual national learning event.	Karen McIntyre	Compliant	B	Obstetric Governance Group	 0 Maternity CEG Meeting Agenda 2015  3.0 Safety SIG ToR_Draft August 20
	Ga	Evidence of engagement with relevant networks and the collaborative LLS.	Karen McIntyre	August 2019	B	Obstetric Governance Group	 CM Safety SIG MINUTES 20190214  1.0 20190502 Stillbirth SIG C&M me  11.0 20190516  20190208 MAT CEG Safety SIG C&M Minu Minutes V2.0 201902  Mat Safety Champs Webex SF pregnancy
b) The Board level safety champions have implemented a monthly feedback session for maternity and neonatal staff to raise concerns relating to relevant safety issues	Ga	Evidence of a safety dashboard or equivalent, visible to staff which reflects action and progress made on identified concerns raised by staff	Paul Dodds Julie Tunney	August 2019	B	Obstetric Governance Group Trust Board	 Ward 23 Monthly Quality Report.PDF  Ward 26 Monthly Quality Report.PDF  Midwifery-Led Unit (MLU) Monthly Quality
	Ga	Demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified	Karen McIntyre	August 2019	B	Obstetric Governance Group	 LHRPS1_MFDWHL12 927_2111_001.pdf

Standard / Process / Issue / Recommendation	Initial RAG Rating	Implementation / Action Required	Responsible Lead	Timescale (by end of)	Current Rating	Responsible Group	Closure Date & Evidence
		issues?					
c) The Board level safety champions have taken steps to address named safety concerns and that progress with actioning these are visible to staff	Ga	Evidence that safety concerns raised by staff feedback sessions are reflected in the minutes of Board meetings and include updates on progress, impact and outcomes relating to the steps and actions taken to address these concerns.	Julie Tunney	August 2019	B	Trust Board	 W&C - CQC Quality Report - Improvement Framework V1 (Draft)  Maternity Inspection Report - Improvement Framework V1 (Draft)
Safety Action 10: Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?							
<p>Reporting of all qualifying incidents that occurred in the 2018/19 financial year to NHS Resolution under the Early Notification scheme reporting criteria.</p> <p>Qualifying incidents are term deliveries ($\geq 37+0$ completed weeks of gestation), following labour, that resulted in severe brain injury diagnosed in the first seven days of life. These are any babies that fall into the following categories:</p> <ul style="list-style-type: none"> • Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE) [OR] • Was therapeutically cooled (active cooling only) [OR] • Had decreased central tone AND was comatose AND had seizures of any kind. 	Ga	A report from 'Badger' was run for any of the qualifying cases for the time period 1 st April 2018 to 31 st December 2018 and there have been no cases that have resulted in severe brain injury being diagnosed	<p>Michael Grosdenier</p> <p>Jo Forkner</p>	August 2019	B	Obstetric Governance Group	 5) EQGG Outstanding Action Log  Patient Safety Summit - 10.04.2019.  maternity incentive scheme - year 2, safe

Appendix 1: Which perinatal deaths can we review using the PMRT?

- The PMRT has been designed to support the review of the following perinatal deaths:
 - Late fetal losses where the baby is born between 22⁺⁰ and 23⁺⁶ weeks of pregnancy showing no signs of life, irrespective of when the death occurred, or if the gestation is not known, where the baby is over 500g;
 - All stillbirths where the baby is born from 24+0 weeks gestation showing no signs of life;
 - All neonatal deaths where the baby is born alive from 22⁺⁰ but dies up to 28 days after birth;
 - Post-neonatal deaths where the baby is born alive from 22⁺⁰ but dies after 28 days following neonatal care; the baby may be receiving planned palliative care elsewhere (including at home) when they die.
- The PMRT is not designed to support the review of the following perinatal deaths:
 - Termination of pregnancy at any gestation;
 - Babies who die in the community 28 days after birth or later who have not received neonatal care;
 - Babies with brain injury who survive.

Appendix 2

Assessment to cover January 2019 data submitted for the deadlines of March 2019, one criteria relates to data between October 2018 and March 2019, submitted to deadlines December 2018 - May 2019, and one around MSDSv2 data for April 2019 being submitted to the deadline of June 2019

Mandatory categories 1-3 must be met to pass Safety action 2

- 1 January 2019 data contained at least 90% of HES births expectation, based on number of days in month (unless reason understood)
- 2 MSDSv2 readiness questionnaire completed and returned to NHS Digital within required timescales
- 3 Submit MSDSv2 data for April 2019 by the submission deadline of end of June 2019

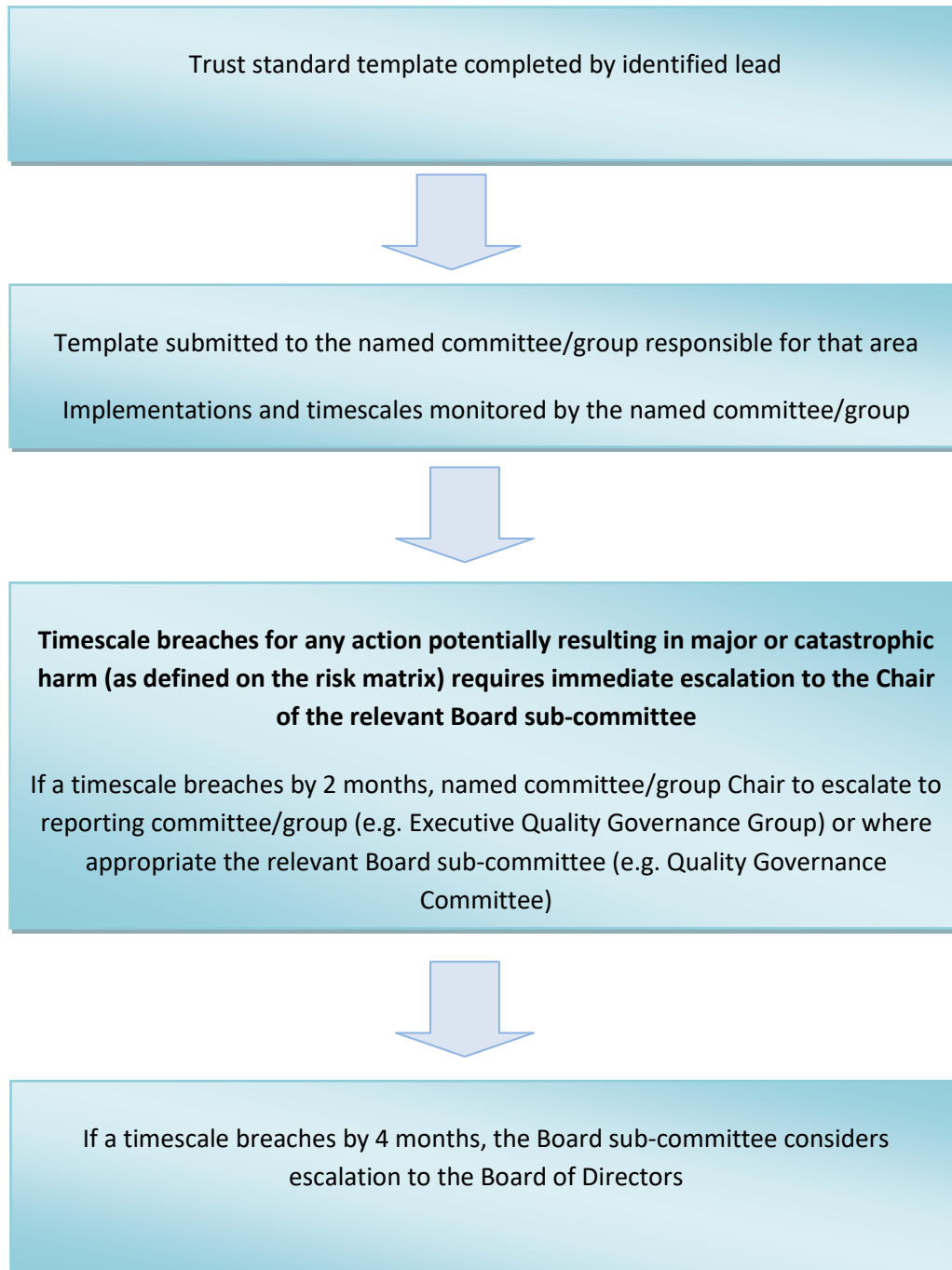
14 of the 19 optional categories 4-22 must be met to pass Safety action 2

- 4 Made a submission in each of the six months October 2018 - March 2019 data, submitted to deadlines December 2018 - May 2019
- 5 January 2019 data contained valid smoking at booking for at least 80% of bookings
- 6 January 2019 data contained valid smoking at delivery for at least 80% of births
- 7 January 2019 data contained all of the tables 501, 502, 404, 409, 401, 406, 408, 602 (unless justifiably blank)
- 8 January 2019 data contained all of the tables 101, 102, 103, 104, 112, 201, 205, 305, 307, 309, 511 (unless justifiably blank)
- 9 January 2019 data contained method of delivery for at least 80% of births
- 10 January 2019 data contained valid baby's first feed for at least 80% of births
- 11 January 2019 data contained valid in days gestational age for at least 80% of births
- 12 January 2019 data contained valid presentation at onset for at least 80% of births where onset of labour recorded
- 13 January 2019 data contained valid labour induction method (including code for no induction) for at least 80% of births where onset of labour recorded
- 14 January 2019 data contained valid place type actual delivery for at least 80% of births
- 15 January 2019 data contained valid site code for at least 80% of births
- 16 January 2019 data contained valid genital tract trauma code for at least 80% of vaginal births
- 17 January 2019 data contained valid Apgar score at five minutes for at least 80% of births
- 18 January 2019 data contained valid fetus outcome code for at least 80% of births
- 19 January 2019 data contained valid birth weight for at least 80% of births
- 20 January 2019 data contained valid figure for previous live births for at least 80% of bookings
- 21 MSDSv2 event or webinar attended in late 2018 / early 2019, or had 1:1 call with one of the NHS Digital team in lieu of attendance
- 22 January 2019 data contained valid (including "Not Stated") ethnic category (Mother) for at least 80% of bookings.

Anaesthesia Clinical Services Accreditation (ACSA) standards and action

- 1.2.4.6 Where there are elective caesarean section lists there are dedicated obstetric, anaesthesia, theatre and midwifery staff
- 2.6.5.1 A duty anaesthetist is available for the obstetric unit 24 hours a day, where there is a 24 hour epidural service the anaesthetist is resident
- 2.6.5.2 A separate anaesthetist is allocated for elective obstetric work
- 2.6.5.3 Where the duty anaesthetist has other responsibilities, an anaesthetist must be immediately available (within five minutes) to deal with obstetric emergencies
- 2.6.5.4 Medically-led obstetric units have, as a minimum, consultant anaesthetist cover the full daytime working week (equating to Monday to Friday, morning and afternoon sessions being staffed)
- 2.6.5.5 There is a named consultant anaesthetist or intensivist responsible for all level two maternal critical care patients (where this level of care is provided on the maternity unit)
- 2.6.5.6 The duty anaesthetist for obstetrics should participate in labour ward rounds

PROCESS FOR MONITORING AND ESCALATION OF BENCHMARK / IMPLEMENTATION PLAN



The identified lead is responsible for ensuring that all actions are completed within the timescales agreed in conjunction with the person responsible for the action

Section A : Maternity safety actions - Mid Cheshire Hospitals NHS Foundation Trust

Action No.	Maternity safety action	Action met? (Y/N)
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes
2	Are you submitting data to the Maternity Services Data Set to the required standard?	No
3	Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?	Yes
4	Can you demonstrate an effective system of medical workforce planning to the required standard?	Yes
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes
6	Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?	Yes
7	Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?	Yes
8	Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	Yes
9	Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?	Yes
10	Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?	Yes

Safety action 2: BIU data on target to be compliant. Unable to submit data to MSDS until 30.6.2019 and response will be the first week in July. Then we will be compliant.

Well Led – Deep Dive Report

Internal Improvement Plan



*‘Delivering Excellence in Healthcare through
Innovation and Collaboration’*



1. Purpose of this document

Following the Internal Development Review into Leadership and Governance that applied the NHSI Well-led Framework, the Trust identified 5 key priority areas for further analysis. MIAA and AQuA were commissioned by the Trust to undertake an external support review, with an aim to identify development opportunities and examples of best practice. This document tracks the implementation of the improvement actions that were identified based on their findings.

2. Process for monitoring and escalation of benchmark / gap analysis / improvement plan

The Initial “BRAG” Rating will be rated as follows – showing our position against the required standard / measure etc.

Key:	Universal Compliance	Compliant	Partially Compliant	Non – Compliant
	Adherence 100%	Adherence 90% - 99%	Adherence 80% - 89%	Adherence < 79%

The overall **Current Progress Rating** will be rated as follows, which shows our position against the improvement planned:

Current Progress Rating		
Colour	Narrative	Description
B	Blue “Complete/business as usual (BAU)”	Completed: Improvement / action delivered with sustainability assured.
G (a or b)	Green “On track”	Improvement on trajectory either: a) On track – not yet completed b) On track – not yet started
A	Amber “Problematic”	Delivery remains feasible, issues / risks require additional intervention to deliver the required improvement e.g. Milestones breached.
R	Red “Delayed”	Off track / trajectory – milestone / timescales breached. Recovery plan required.

Following the Internal Development Review into Leadership and Governance that applied the NHSI Well-led Framework, the Trust identified 5 key priority areas for further analysis. MIAA and AQuA were commissioned by the Trust to undertake an external support review, with an aim to identify development opportunities and examples of best practice. This document tracks the implementation of the improvement actions that were identified based on their findings.

Subject / KLOE	Action	Responsible Lead	Timescales (by end of)	Current Progress Rating	Responsible Committee/ Group	Evidence (What evidence will be provided to demonstrate sustainable improvement?)
KLOE 1 Talent Management and Succession Planning	Establish a Trust Talent Board	Director of Workforce & Organisational Development	April 2019		Executive Workforce Assurance Group	Trust Talent Board in place
	Develop a training programme for carrying out talent conversations	Director of Workforce & Organisational Development	April 2019		Executive Workforce Assurance Group	Managers trained and carrying out talent conversations.
	Develop Board of Directors and Divisional succession plans	Director of Workforce & Organisational Development	September 2019		Transformation and People Committee	Succession plans in place
KLOE 4 Governance between Organisations	Present the External Report at the CCICP Board	Director of Strategic Partnerships	June 2019		CCICP Board	Well Led Report circulated for review CCICP / CCG specification reviewed at

Subject / KLOE	Action	Responsible Lead	Timescales (by end of)	Current Progress Rating	Responsible Committee/ Group	Evidence (What evidence will be provided to demonstrate sustainable improvement?)
						CCICP Board in March 2019 Next steps and action plan outstanding
	Refresh the CCICP Board and define development needs	Director of Strategic Partnerships	June 2019		CCICP Board	Review of CCICP in line with development of an ICP ongoing with Options Paper to CEP Partnership Board in June 2019 Revised ToR and Strategy document to be presented at CCICP Board in June 2019
KLOE 6 Integrated Performance Reporting	Review detail required at each Board of Directors sub-committee	Chairs of Board of Directors Sub-Committees	April 2019		Quality Governance Committee / Performance and Finance Committee / Transformation	

Subject / KLOE	Action	Responsible Lead	Timescales (by end of)	Current Progress Rating	Responsible Committee/ Group	Evidence (What evidence will be provided to demonstrate sustainable improvement?)
					and People Committee	
	Review purpose and function of Acute Executive Management Group	Director of Workforce & Organisational Development	May 2019		Acute Executive Management Group	Revised Terms of Reference
	Consider the introduction of an Operational Board	Chief Executive	October 2019		Board of Directors	
	Consider the introduction of an Integrated Performance Report	Chief Executive	October 2019		Board of Directors	
KLOE 7 Inclusive Engagement	Review internal communication and engagement channels to improve staff engagement with Board of Directors and CEO	Director of Workforce & Organisational Development	October 2019		Executive Workforce Assurance Group	Communication and Engagement Strategy developed and agreed
	Build on relationships with GPs and between GPs and Consultants	Interim Medical Director	June 2019		Senior Medical Leadership Group	1. Schedule joint evening meetings 2. Regular telephone conversations with CCG Chairs 3. Attend CCG

Document owner: Director of Nursing & Quality

MCHFT Well Led Deep Dive Report - Internal Improvement Plan V2 May 2019

Subject / KLOE	Action	Responsible Lead	Timescales (by end of)	Current Progress Rating	Responsible Committee/ Group	Evidence (What evidence will be provided to demonstrate sustainable improvement?)
						Membership Meetings
KLOE 8 Quality Improvement	Scope and prioritise the QI work being undertaken across the organisation	Chief Operating Officer	April 2019		Acute Executive Management Group	
	Produce an Options Paper in relation to an "Improving Quality Together Programme" at MCHFT	Director of Operations	May 2019		Quality Governance Committee	




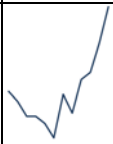

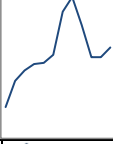
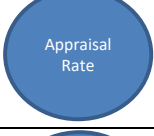
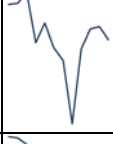

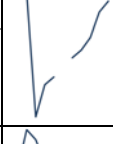


Board of Directors Workforce Report







July 2019

(May 2019 data)



Performance Report Workforce Chapter
Month: May-19

Measure	Target	Performance	Description	Narrative	Rolling Trend	Trend	C&W Average
	3.90%	4.42%	Rolling 12m average Sickness Absence described as a Percentage	Rolling sickness absence increased slightly in month (+0.05%) from the previous month and has moved into a Red position. S&C and WC 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 (5.43%, 5.15%, 4.72%)		↑	
	N/A	4.58%	In-month 12m average Sickness Absence described as a Percentage	In-month sickness absence increased from the previous month (+0.21%). Four divisions experienced reduced sickness absence levels: DCSS, EF, SC and WC		↑	
	90.00%	81.78%	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 0.57% decline in the appraisal rates across the Trust. Four divisions experienced a drop in compliance, the most significant being CCICP (-5.80%). DCSS and EF are Green and the remaining divisions are Amber with the exception of MEC who are Red (60.83%)		↓	
	90.00%	79.66%	Mandatory Training Monthly Rate Excludes Bank Staff, Staff on long term sick & mat. leave.	Training compliance increased by 1.06% in month and all divisions secured an improvement with the exception of WC (-0.56%). DCSS, SC and WC, and CCICP are Amber. Other divisions remain Red. MEC are the most challenged by this target (71.38%) but improved their position this month.		↑	
	10.00%	9.60%	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 improved slightly in month (-0.30%). Turnover reduced in all divisions with the exception of CCICP (-0.40%). All divisions are Green against target with the exception of MEC and CCICP (12.66% and 11.13%)		↓	

Measure	Target	Performance	Description	Narrative	Rolling Trend	Trend	C&W Average
	(403)	(570)	In month and cumulative total spend for the Trust.	Agency spend reduced in month (£68k less than the previous month) and the agency spend target was met. Medical and Dental agency spend reduced. All divisions saw reduced agency spend with the exceptions of DCSS and Corporate.		↓	N/A
	less than 100%	141.44%	Trust Agency Spend as a percentage of the Ceiling Set by NHS Improvement			↓	N/A
	N/A	48%	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	↑↓=