Mid Cheshire Hospitals NHS Foundation Trust

Board of Directors

Monday 7 December 2020
9.30am
Virtual – via Microsoft Teams

AGENDA

No	BAF Risk	Item
PRELIMINARY BUSINESS		
1 9:30		**Apologies (v)** Chair
2 9:32		**Declarations of Interest (v)** Chair To receive declarations of interest in agenda items and / or any changes to the register of directors' declarations of interest pursuant to Section 8 of Standing Orders
3 9:35		**Draft Minutes of the Last Meeting - 2 November 2020 (d)** Chair To approve the draft minutes of the last meeting of the Board of Directors, discuss any matters arising and review the action log
4 9:40		**Chair's Opening Remarks (v)** • Governor Items
CONTEXT / OVERVIEW		
5 9:50		**Chief Executive's Report (d)** To note • **5.1 Annex Hospital Redevelopment Governance Arrangements (d)** To approve
6 10:00	**BAF19**	**Integrated Performance Report (Month 7 - October 2020) (d)** Chief Executive To note
QUALITY - Patient Safety, Clinical Effectiveness & Patient Experience		
7 10:05		**Quality & Safety Committee (QSC) Update - 18 November 2020 (v)** Medical Director/ Director of Nursing & Quality

No	BAF Risk	Item
10:10		• **7.1 Quality Account 2019/20 (d)** Director of Nursing and Quality To approve
8 10:15	**BAF 9**	**Serious Incidents (v)** Medical Director To note
PERFORMANCE		
9 10:20		**Performance & Finance Committee (PAF) Update - 19 November 2020 (v)** Deputy Chief Executive & Director of Finance/ Chief Operating Officer To note
WELL LED		
10 10:30		**Workforce & Digital Transformation (WDT) Committee Update – 16 November 2020 (v)** Director of Workforce and OD / Chief Operating Officer / Chief Information Officer To note
GOVERNANCE		
11 10:35		**Audit Committee - 9 November 2020 Chair's Report (d)** Committee Chair To note
10:40		• **11.1 Assurance & Escalation Framework (d)** Company Secretary To approve
12 10:45	**BAF19**	**Fit and Proper Persons Annual Review 2020 (d)** Company Secretary To note
CONCLUDING BUSINESS		
13 10:50		**Any Other Business** Chair To consider any other matters of business

No	BAF Risk	Item
14 11:00		**Items for the Risk Register/Changes to the Board Assurance Framework (BAF) (v)** Chair To identify any additional items for the Risk Register or changes to the BAF arising from discussions at this meeting
15 11:05		**Key Messages from the Board (v)** Chair To agree

Time, Date and Place of Next Meeting

Thursday 28 January 2021, 9.30am via Microsoft Teams

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

Action Log – Board of Directors 7 December 2020

Agenda item		Assigned to	Deadline	Status
Board of Directors 02/11/2020 5 Chief Executive's Report (d)				
247.	Copy of Chief Nurse's report to Simon Stevens and letter from the North West Chief Nurse to be circulated to the Board	Sumner, James	07/12/2020	Pending Completed
	Explanation action item Report following the visit of Ruth May to MHCFT to Simon Stevens to be circulated along with the letter praising the work of MCHFT from the NW Chief Nurse.			
Board of Directors 02/11/2020 8.1 Performance and Finance Committee (PAF) (22 October 2020) - Chair's Report (d)				
248.	Update from the EU Exit meeting to be circulated to Board Members	Bennett, Oliver	07/12/2020	Pending Completed
	Explanation action item Key messages of the meeting on EU Exit with Keith Willetts to be circulated to Board.			
Board of Directors 02/11/2020 5 Chief Executive's Report (d) *replaces Action 210 05/10/2020 (Part II) - Proposal for Board oversight on the development of the Strategic Outline Business case for hospital redevelopment - now moved to Action 272 below*				
272.	Hospital Redevelopment Governance Structure	Keating, Caroline	25/11/2020	Pending Agenda item 5.1
	Explanation action item Paper to be brought to the next Board Meeting			
	Explanation Keating, Caroline Paper submitted to December Board as annex to CEO Report			

BOARD OF DIRECTORS

Agenda Item	**5**	Date of Meeting: 07/12/2020
Report Title	**Chief Executive's Report November 2020**	
Executive Lead	James Sumner, Chief Executive	
Lead Officer	Caroline Keating, Company Secretary	
Action Required	To note	

☐ **Acceptable assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of controls

Key Messages of this Report *(2/3 headlines only)*

- Update on key issues including the Covid-19 vaccination programme, finance and performance
- Hospital redevelopment governance arrangements included for approval by the Board

Next Steps (*actions to be taken following agreement of recommendation/s by Board/Committee)*

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Strategic Objective(s) *(indication of which objective/s the report aligns to)*

• Manage Covid response and recovery	☐	• Provide safe and sustainable services	☐
• Provide outstanding care/patient experience	☐	• Provide strong system leadership by working together	☐
• Deliver most effective care to achieve best possible outcomes	☐	• Be well governed and clinically led	✓
• Be the best place to work	☐		

Impact *(is there an impact arising from the report on the following?)*

• Quality	✓	• Compliance	✓
• Finance	✓	• Legal	☐
• Workforce	✓	• Risk/BAF Click here to select relevant risk	
• Equality	☐		

Equality Impact Assessment (*must accompany the following submissions)*

Strategy	☐	Policy	☐	Service Change	☐

REPORT DEVELOPMENT

Committee/ Group Name	Date	Report Title	Lead	Brief summary of key issues raised and actions agreed

Chief Executive's Report
Board Meeting – 7 December 2020

Key Highlights

1. Although we remain focussed on the restoration and recovery of non-Covid services and ensuring we treat as many patients as possible, Trust performance against the Phase 3 milestones has been impacted by increased hospital admissions due to Covid-19 with fewer elective operations than planned in November.

2. In response to communications from the Chief Nursing Officer for England in September 2020[1], the Trust, in conjunction with the acute providers within the Cheshire Collaboration[2], put forward a bid to NHSI/E for non-recurrent financial support to recruit registered nurses from overseas between November 2020 and October 2021. Approval of this bid was received on 27 November. The £400k funding will support an increase of 178 international nurses, thereby further closing the nurse vacancy gap (BAF 3) and helping to reduce nurse bank and agency spend.

3. Following consultation with key stakeholders, we took the decision to stand down a number of key meetings, including all Board Committees, Executive Groups and non-essential meetings, for a 4 week period from end November into December. This was due to the increase in admissions (both Covid- and usual winter-related) and the need to enable staff to focus on the increased operational pressures faced by the Trust. This decision and the implications for business continuity arising from it are recorded and maintained within Corporate Governance in line with best practice.

4. We are moving forward at pace to achieve our aim of redeveloping the hospital site at Leighton. A series of clinical services workshops took place in November which enabled an indicative Schedule of Accommodation (SOA) to be drafted. The SOA enables further work to be undertaken on construction costs and option development. Other key areas of work include the development of detailed service specification briefs and service level Clinical Quality and Performance Statements and on-going stakeholder engagement sessions to review service delivery options. These will feed into the development of the Strategic Outline Case due to be submitted to the Board in March 2022.

5. We have also developed governance arrangements for the overall hospital development programme with a structure which includes a Hospital Redevelopment Programme Board and Steering Group with key stakeholders represented. These arrangements are identified in the paper included in the Annex to this report.

[1] Nursing and midwifery workforce response to COVID-19 – third phase (10 September 2020); International Recruitment Financial Support Offer (25 September 2020)

[2] Mid Cheshire Hospitals NHS FT, East Cheshire NHS Trust, Warrington & Halton Hospitals NHS Trust, Countess of Chester NHS FT

Covid-19

6. At 27 November 2020, there were 57 confirmed positive Covid-19 patients in the hospital, including 12 in critical care - a significant increase from last month. The infection rate in Cheshire East increased significantly at the beginning of November but is now falling, resulting in a slow reduction in the number of Covid-19 patients in our hospital. However, there were c. 90 fewer elective operations per week than planned due to the staffing support required for the Critical Care Unit and some Covid wards where acuity is high.

7. The curtailment of the elective programme remains under constant review; however, the majority of non-covid elective services (e.g. outpatients, diagnostics, endoscopy and screening programmes) remains uninterrupted.

8. **Infection Prevention & Control (IPC)**: to prevent nosocomial infections, some patients remain longer on the acute medical unit (AMU) to enable Covid swab results to be obtained. Although this impacts patient flow, mainly from AMU to other specialty wards, and patient admissions from ED, this is considered the optimal approach, and we are working to establish more rapid testing capacity, with one-hour turnaround, on the Leighton Hospital site.

9. **Staff Self-Screening**: the distribution of Lateral Flow Device (LFD) self-testing kits to staff is underway, using a system developed by the Digital Technology & Information Services Department, with some 1300 staff now registered to receive them. These kits provide results in around 30 minutes and have been well received by staff. The plan is to distribute 200 testing kits per day until 11 December across six distribution hubs at Leighton Hospital, Victoria Infirmary Northwich and our community sites. Based on learning from pilot sites, it is expected that some 150 staff at any one time may test positive and will need to self-isolate until the results are validated by a PCR swab test. Digital Technology & Information Services (DTIS) has developed a new staff risk assessment for Covid-19 which is being implemented.

10. **Covid-19 Vaccination:** plans are underway to deliver a full vaccination programme on the Leighton site for all staff and associates (staff who work in MCHFT but employed by others), as well as social care assessors, mental health teams, Red Cross, volunteers etc (some 6081 individuals in total). Although there are some logistical issues with the transport and delivery of the vaccine itself, a vaccination site, which meets national specifications, is in place as is the workforce plan to vaccinate 975 people every five days.

11. From an ICP perspective, the Trust is also supporting the primary care networks in preparing to vaccinate all phase one of the population. This is likely to begin later in December and fixed vaccination sites have been agreed with the national team, with national guidance on these just received[3]. Further work with primary care to support care home and housebound patient vaccinations will be part of the rollout through the district nursing team and others from CCICP professional groups.

12. The NHS has also issued guidance on the Board's responsibility in relation to IPC and testing (Appendix I). The IPC Board Assurance Framework referred to was approved by the Board in August 2020 and is submitted to the Quality & Safety Committee for review

[3] Covid-19 Vaccine Deployment_Pod Definition Document 27 November 2020

every 6 months. However, given the current challenges with Covid-19, it is considered that a substantive report on IPC should be submitted to the Board monthly.

Restoration of Clinical Services

13. The Trust continued to make progress in October in the restoration of non-Covid services, delivering against many of the milestones set out in the Phase 3 plan. However, increased admissions from Covid-19 impacted Trust performance. The key messages for October are:

- Ordinary electives have over-performed by 13.5% against our recovery plan; however, Daycase activity is 17% behind
- MRI and CT over-performed against recovery plan but under-performed on other diagnostics, including endoscopy.
- New outpatient activity is behind recovery plan but follow-up outpatient activity is ahead of plan
- Cancer referrals are above plan by 5%, which is nearly 10% more than the same period last year
- The number of cancer treatments was 4% (3 patients) below plan, which represents 87% of the activity levels delivered in the same period last year
- The number of cancer patients waiting >62 days continued to make progress and is 31% better than plan (56 patients in the backlog against a plan of 81)
- The RTT waiting list has grown by 9% more than planned due to the issues above; however, the number of patients waiting >52 weeks is 9% better than plan.

The Chief Operating Officer will update further at the Board meeting on these challenges

Trust 'Business as Usual'

Finance – Month 7 (October) 2020/21

14. The Trust has entered a different financial regime for the second half of the financial year, based on financial allocations and a Cheshire & Merseyside Health Care Partnership (HCP) control total. As a result, the Trust has submitted an expected £10.2m deficit for the second half of the financial year, approved by the Board in November.

15. For October, the Trust was £17k better than the submitted plan (in-month deficit of £0.94m), with expected increases in expenditure in relation to the Phase 3 recovery plan, Winter planning and ongoing support for Covid-19 within the hospital. Months 1-5 top-up payments have all been received with only September (£2.4m) outstanding.

16. The Emergency Department capital bid (£15.4m) has now been signed off by the Treasury.

Workforce

17. **Health and Wellbeing -** a review of all health and wellbeing interventions delivered over the Covid period has been undertaken, with a second phase of implementation planned over the next three to six months. This phase will focus on further improvements to the psychological wellbeing support for staff, including access to a region-wide resilience hub; additional improvement to and availability of areas for staff to rest, relax and recuperate; improved

access to hot food out of hours; financial wellbeing through the introduction of a new salary sacrifice scheme which also provides additional staff discounts, as well as financial and debt management advice; promotion of agile/flexible working to support staff in balancing home and work life; and a commitment to deliver on our corporate social responsibility at both an individual and Trust level. We are also working with our Physiotherapy and Occupational Therapy teams to create a 'one stop' staff health and wellbeing hub.

18. **Flu Vaccine -** as at 20 November 2020, the Trust has vaccinated almost 70% of frontline staff against the NHSE/IE requirement of 90% uptake by end November so that we can be prepared to deliver the Covid vaccination programme when the vaccines become available. Whilst this will be challenging, it is considered achievable.

Digital Clinical System (Electronic Patient Record)

19. The procurement for the Trust's Digital Clinical System is underway with two suppliers moving through the process. To support the Trust's digital journey, we have been awarded £250k by NHSX for the development of the Full Business Case and are working with a specialist organisation, Apira Ltd, in this regard.

Author: James Sumner, Chief Executive
Date: December 2020

17 November 2020

Key actions: infection prevention and control and testing

Organisations

It is the board's responsibility to ensure that:

1. Staff consistently practice good hand hygiene and all high touch surfaces and items are decontaminated multiple times every day – once or twice a day is insufficient.

2. Staff maintain social distancing in the workplace, when travelling to work (including avoiding car sharing) and to remind staff to follow public health guidance outside of the workplace.

3. Staff wear the right level of PPE when in clinical settings, including use of face masks in non-clinical settings.

4. Patients are not moved until at least two negative test results are obtained, unless clinically justified.

5. Daily data submissions have been signed off by the Chief Executive, the Medical Director or the Chief Nurse, and the Board Assurance Framework is reviewed and evidence of reviews is available.

6. Where bays with high numbers of beds are in use, these must be risk assessed, and where 2m can't be achieved, physical segregation of patients is considered, and wards are effectively ventilated.

7 Staff testing:

a. Twice weekly lateral flow antigen testing for NHS patient facing staff is implemented. Whilst lateral flow technology is the main mechanism for staff testing, this can continue to be used alongside PCR and LAMP testing.

b. If your trust has a high nosocomial rate you should undertake additional targeted testing of all NHS staff, as recommended by your local and regional infection prevention and control team. Such cases must be appropriately recorded, managed and reported back.

8 Patient testing:

a. All patients must be tested at emergency admission, whether or not they have symptoms.

b. Those with symptoms of COVID-19 must be retested at the point symptoms arise after admission.

c. Those who test negative upon admission must have a second test 3 days after admission, and a third test 5-7 days post admission.

d. All patients must be tested 48 hours prior to discharge directly to a care home and must only be discharged when their test result is available. Care home patients testing positive can only be discharged to CQC-designated facilities. Care homes must not accept discharged patients unless they have that person's test result and can safely care for them.

e. Elective patient testing must happen within 3 days before admission and patients must be asked to self-isolate from the day of the test until the day of admission.

Systems

Local systems must:

9 Assure themselves, with commissioners, that a trust's infection prevention and control interventions (IPC) are optimal, the Board Assurance Framework is complete, and agreed action plans are being delivered.

10 Review system performance and data; offer peer support and take steps to intervene as required.

BOARD OF DIRECTORS

Agenda Item	**5 Annex A**	Date of Meeting: 07/12/2020
Report Title	**Hospital Redevelopment Programme Governance Arrangements**	
Executive Lead	James Sumner, Chief Executive	
Lead Officer	Caroline Keating, Company Secretary	
Action Required	To approve	

☐ **Acceptable assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of controls

Key Messages of this Report *(2/3 headlines only)*

- Robust governance structure to provide necessary oversight and management of the project
- Sufficiently agile structure to facilitate its development as the Trust moves through the approvals process
- Structure facilitates effective and timely reporting to the Board

Next Steps (*actions to be taken following agreement of recommendation/s by Board/Committee)*

- Governance structure to be put in place with the Programme Board and Steering Group operational from December 2020
- Formal reporting to the Board from January 2021

Strategic Objective(s) *(indication of which objective/s the report aligns to)*

• Manage Covid response and recovery	☐	• Provide safe and sustainable services	✓
• Provide outstanding care/patient experience	☐	• Provide strong system leadership by working together	☐
• Deliver most effective care to achieve best possible outcomes	☐	• Be well governed and clinically led	☐
• Be the best place to work	☐		

Impact *(is there an impact arising from the report on the following?)*

• Quality	☐	• Compliance	☐
• Finance	☐	• Legal	☐
• Workforce	☐	• Risk/BAF **BAF13 Estate, infrastructure and equipment**	
• Equality	☐		

Equality Impact Assessment (*must accompany the following submissions)*

Strategy ☐ Policy ☐ Service Change ☐

REPORT DEVELOPMENT

Committee/ Group Name	Date	Report Title	Lead	Brief summary of key issues raised and actions agreed
Hospital Redevelopment Group	191120	Hospital Redevelopment Governance Arrangements	JS	Agreed with minor amends

Hospital Redevelopment Programme
Governance Arrangements

Introduction

1. The Trust has embarked on an ambitious strategy to secure national approval to the redesign of the hospital and obtain capital funding from the Health Infrastructure Plan (HIP) which aims to ensure the NHS' hospital estate supports the provision of world-class healthcare services. The Trust's intention is to build a new hospital on the Leighton site which will take into consideration the overall Integrated Care System requirements for system-wide health and social care improvement.

2. This is a significant undertaking which requires a robust governance structure through which the programme will be overseen and managed, enabling the Board to be provided with acceptable assurance on the controls in place and the progress in delivery.

Executive Summary

3. The Trust has appointed external consultants, Archus Ltd. to provide expert support to the overall programme.

4. A Programme Team has been established to plan, monitor and manage the systems and processes required to deliver the programme's aims, aligned to a clear timetable, in the first instance to develop a Strategic Outline Case to help the Trust and NHS England/ Improvement (NHSE/I) get the scheme onto the national HIP framework. It is envisaged that this phase will be completed for Board approval by March 2021. If this is successful, the Full Business Case will be developed for Board and regulatory approval in 2021/21 (exact timetable contingent on regulatory approval).

5. The governance structure outlined in this paper is designed to be as agile as possible, linking with the current Trust structure but able to evolve as the programme becomes more intensive as the Trust moves through the regulatory approvals process. It facilitates timely and efficient reporting to the Board through regular updates as well as reports from the Board Assurance Framework (BAF).

Background and Analysis

6. The governance structure (Appendix I) identifies the main decision-making bodies for the programme – the Hospital Redevelopment Programme Board (HRPB) supported by the Hospital Redevelopment Steering Group (HRSG). The main purpose of the HRPB, chaired by the Chief Executive as the Senior Responsible Officer, is to ensure that the hospital redevelopment programme is completed successfully; specifically, that the primary objectives are delivered safely, to time and on budget.

7. HRPB members include the Deputy CEO/DoF as the Programme Lead, the Medical Director (to reinforce the programme as clinically led) and the Director of Estates. Those in attendance include the Head of Transformation and Company Secretary with representatives from Archus Ltd and NHSE/I. The terms of reference for the HRPB are at Appendix II.

8. The HRPB will report to the Board of Directors which will be provided with regular updates at its formal meeting (the programme will be included on the Board agenda as a substantive item). In addition, the Board will be provided with information on the key risks to the programme via BAF reporting, as the Hospital Redevelopment Programme is one of the key mitigations to reducing BAF Risk 13[1].

9. The HRSG, chaired by the Deputy CEO/DoF as Programme Director, with administrative support provided by Archus, will be responsible for co-ordinating the work required to deliver the key areas of the project. Initially, it has been decided not to set up separate workstreams to address those key areas (i.e. new ways of working; technological solutions, workforce, finance, space utilisation and estates) but to link the work required to existing Executive Groups, with two Task & Finish (T&F) groups established for Space Utilisation and Finance. The latter may, in due course, evolve into a Programme Management Office with a wider brief as the Trust moves through from developing the SOC to the Full Business Case and beyond.

10. Members of the HRSG Group include all Executive Directors with other key individuals, including the Head of Communications, in attendance. The Terms of Reference for the HRSG are at Appendix III.

11. The risk register for the programme will be overseen by the HRSG. Archus will be given access to the Trust's new 4Risk system but will only be able to see risk records in relation to the Hospital Redevelopment programme, as they will be responsible for maintaining the programme risk register. This risk register will feed through to the HRPB as the body responsible for managing the overall risk of the hospital redesign. In addition, notable risks will be brought to the Board's attention as part of the regular BAF reporting process[2], thereby enabling the Board to receive assurance about actions taken to manage the risks.

12. Any issues that might arise through the process that require additional scrutiny and assurance will be referred back to the Trust's established governance structure, including the Executive Risk & Assurance Group.

Conclusion

13. The proposed governance structure:

- is sufficiently robust to provide the scrutiny and assurance necessary for successful delivery of the overall hospital redevelopment programme from SOC to FBC completion
- has the required Executive focus to ensure successful oversight and management of the programme
- is supported by expert external consultants
- can evolve as necessary as the programme progresses
- links the management of the programme risks to the Trust's risk management framework, including reporting to the Board via the BAF
- facilitates timely reporting to the Board.

[1] **IF** the Trust fails to provide modern, efficient, sustainable estate, infrastructure and equipment **THEN** this could lead to high cost business continuity issues in future

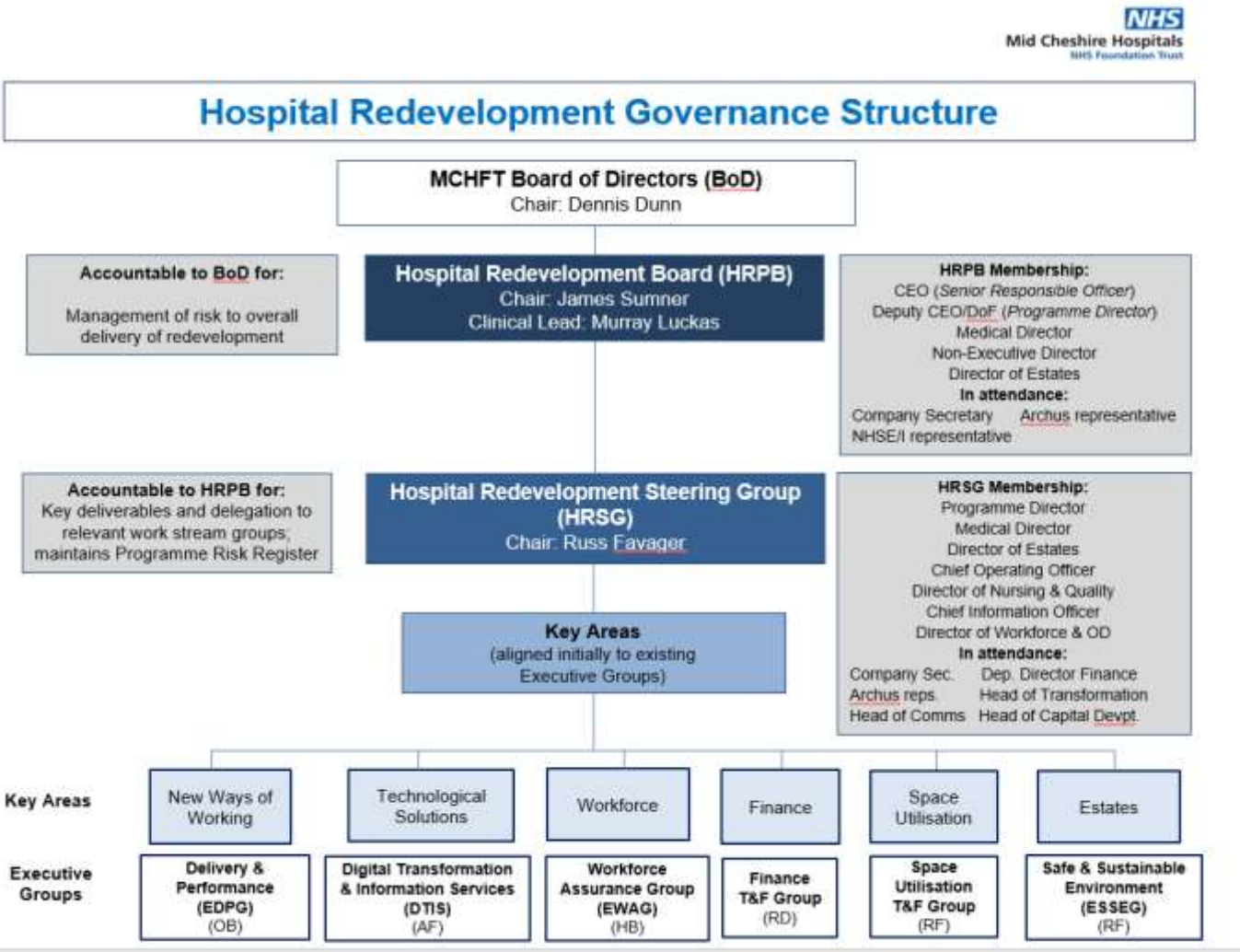
[2] Reporting to Part II of the Board together with other significant risks that, for clear and acceptable reasons, cannot be made public

Recommendation

14. To approve

Author: **Caroline Keating, Company Secretary**
Date: **14 November 2020**

Appendix I


NHS
Mid Cheshire Hospitals
NHS Foundation Trust
Hospital Redevelopment Governance Structure
MCHFT Board of Directors (BoD)
Chair: Dennis Dunn
Accountable to BoD for:
Management of risk to overall delivery of redevelopment
Hospital Redevelopment Board (HRPB)
Chair: James Sumner
Clinical Lead: Murray Luckas
HRPB Membership:
CEO (Senior Responsible Officer)
Deputy CEO/DoF (Programme Director)
Medical Director
Non-Executive Director
Director of Estates
In attendance:
Company Secretary
Archus representative
NHSE/I representative
Accountable to HRPB for:
Key deliverables and delegation to relevant work stream groups, maintains Programme Risk Register
Hospital Redevelopment Steering Group (HRSG)
Chair: Russ Favager
HRSG Membership:
Programme Director
Medical Director
Director of Estates
Chief Operating Officer
Director of Nursing & Quality
Chief Information Officer
Director of Workforce & OD
In attendance:
Company Sec.
Dep. Director Finance
Archus reps
Head of Transformation
Head of Comms
Head of Capital Devpt
Key Areas
(aligned initially to existing Executive Groups)
Key Areas
New Ways of Working
Technological Solutions
Workforce
Finance
Space Utilisation
Estates
Executive Groups
Delivery & Performance (EDPG) (OB)
Digital Transformation & Information Services (DTIS) (AF)
Workforce Assurance Group (EWAG) (HB)
Finance T&F Group (RD)
Space Utilisation T&F Group (RF)
Safe & Sustainable Environment (ESSEG) (RF)

Appendix II

Hospital Redevelopment Programme Board
Terms of Reference

Authority/Constitution

1. The Hospital Redevelopment Programme Board (HRPB) is authorised by the Board of Directors to act within its terms of reference as a senior decision-making body of Mid Cheshire Hospitals NHS FT (MCHFT).

2. The HRPB has no executive powers other than those specifically delegated in these Terms of Reference.

3. The HRPB has the authority to oversee and take decisions relating to the organisation's activities which also support the achievement of the organisation's objectives.

4. The HRPB is authorised to request specific reports from individual functions within the organisation and to seek any information it requires from any member of staff in order to perform its duties.

5. The HRPB is authorised to create operational sub-groups, advisory or working groups as are necessary to fulfil its responsibilities within its terms of reference. The Group may not delegate executive powers and remains accountable for the work of any such group. Any of these groups will report directly to the HRPB who will oversee their work.

Purpose

6. The aim of the HRPB is to ensure that the hospital redevelopment programme is completed successfully; specifically, that the primary objectives are delivered safely, to time and on budget.

7. The HRPB has a key role in supporting the Senior Responsible Owner (SRO) in making decisions and providing both challenge and approval on issues affecting the progress of the programme.

8. The SRO has executive responsibility for providing approvals and taking decisions affecting programme process and delivery throughout the programme. To fulfil these responsibilities, the HRPB will set the direction for the programme, support the SRO in decision-making and oversee the overall progress of the programme.

Membership

9. The HRPB shall be comprised of the following members:

- Chief Executive/Senior Responsible Owner (*Chair*)
- Deputy CEO/Director of Finance (*Deputy Chair/Project Director*)
- Non-Executive Director
- Medical Director
- Director of Estates (*Deputy Project Director*)

10. The following are required to attend in a non-voting capacity:

- Company Secretary
- NHSE/I representative
- Archus representative

11. The HRPB will be deemed quorate when the Chair or Deputy Chair plus two additional members including the Medical Director and the Non-Executive Director are present. Members may only nominate a deputy to attend on their behalf if they have sufficient understanding of the area they are representing to be able to contribute effectively to the Board's business; however, this should only be in exceptional circumstances and should be agreed with the Chair. Deputies will count towards the quorum.

12. Other staff or external advisers may be co-opted or requested to attend for specific agenda items as necessary.

Requirements of Membership

13. Members must attend at least 75% of all meetings each financial year but should aim to attend all scheduled meetings. Attendance will be recorded and monitored.

14. Conflicts of Interest – the Companies Act 2006 defines a conflict of interest as arising when the interests of directors or 'connected persons' are incompatible or in competition with the interests of the organisation. HRPB members are required to exercise judgement and to declare such interests as there is a risk of implied improper conduct. The relevant interest, once declared, will be recorded in a register of interests, maintained by the Company Secretary.

Duties

15. In order to fulfil its role and obtain the necessary assurance, the HRPB will:

- oversee the management of the delivery of the Strategic Outline Case (SOC) on the development of plans to replace buildings on the Leighton Hospital site
- confirm the scope of the project and sign off the Project Initiation Document
- approve a robust Project Plan

- ensure the requirements for business case approval are met, including ensuring appropriate business case approvals
- monitor progress from workstreams associated with the development of the new hospital
- ensure that Delivery Plans, including objectives, key milestones, resource plans, process, performance monitoring arrangements and all major deliverables associated with the programme aim are in place
- ensure that governance and assurance systems operate effectively and underpin programme delivery
- resolve any issues escalated to the HRPB in addition to identifying and monitoring any corrective actions where identified
- refer any decision required to be made that does not fall within the authority of the HRPB to the relevant Committee of the Trust and/or the Board of Directors
- ensure that there is effective identification and management of the risks associated with the aims of the Programme Board by ensuring that relevant assurances are sought with respect to the effectiveness of risk controls and that future actions are focused on managing risks to an acceptable level
- prioritise work associated with the aim of the Programme Board, identifying and agreeing those areas which will not be progressed until later dates in the project including after the new hospital has been built
- provide leadership, advice and decision-making support to the Hospital Redevelopment Steering Group
- ensure that the Project Team is sufficiently resourced to deliver successfully within the agreed scope time, cost and quality parameters
- ensure that each workstream has accountable representation and that they deliver in line with the Project Plan
- act as an approving body for decisions and recommendations presented by the Project Team
- ensure there is an integrated, comprehensive and effective Communications Plan in place to ensure all stakeholders (internal and external) are informed and involved throughout the process
- identify whether any fundraising opportunities are available for this project and action accordingly
- ensure all project evaluation and lessons learned reports are prepared in accordance with the agreed Post Project Evaluation Strategy.

16. The HRPB is committed to protecting and respecting data privacy. The HRPB will have regard to the EU General Data Protection Regulation (Regulation (EU) 2016/679) (GDPR) and demonstrate, where applicable, compliance with data protection legislation, in particular the Data Protection Act 1998 (DPA).

Equality, Diversity & Inclusion

17. In conducting its business, the HRPB will at all times seek to promote its commitment to equality and diversity by the creation of an environment that is inclusive for both our workforce, patients and service users, including those who have protected characteristics and vulnerable members of our community.

Reporting

18. The HRPB will be accountable to the Board of Directors. The Board will be informed of HRPB's work through an assurance report from the Chair submitted following each meeting.

19. Regular assurance reports will be received from the Hospital Redevelopment Steering Group (Appendix I) with other reports on key areas as required.

Administration of Meetings

20. Meetings shall be held monthly with additional meetings held on an exception basis at the request of the Chair or any three members of the HRPB.

21. The Company Secretary will make arrangements to ensure that the HRPB is supported administratively. Duties in this respect will include development and monitoring of a Workplan, agenda setting, taking minutes of the meeting and providing appropriate support to the Chair and HRPB members.

22. Agendas and papers will be circulated at least 4 working days in advance of the meeting.

23. A record of the meeting will be circulated to members for comment as soon as is reasonably practicable.

Review

24. The Terms of Reference shall be reviewed at each stage of the programme (next review date March 2021).

Appendix III

Hospital Redevelopment Steering Group
Terms of Reference

Authority/Constitution

1. The Hospital Redevelopment Steering Group (HRSG) is authorised by the Hospital Redevelopment Programme Board (HRPB) to act within its terms of reference as a decision-making body of Mid Cheshire Hospitals NHS FT (MCHFT).

2. The HRSG has no executive powers other than those specifically delegated in these Terms of Reference.

3. The HRSG has the authority to oversee and take decisions relating to the organisation's activities which also support the achievement of the organisation's objectives.

4. The HRSG is authorised to request specific reports from individual functions within the organisation and to seek any information it requires from any member of staff in order to perform its duties.

Purpose

5. The aim of the HRSG is to ensure that the hospital redevelopment programme is completed successfully; specifically, that the primary objectives are delivered safely, to time and on budget.

6. The HRSG has a key role in supporting the HRPB in making decisions and providing both challenge and approval on issues affecting the progress of the programme.

Membership

7. The HRSG shall be comprised of the following members:

- Deputy CEO/Director of Finance *(Chair/Project Director*)
- Chief Operating Officer *(Deputy Chair*)
- Director of Estates *(Deputy Project Director*)
- Medical Director
- Director of Nursing & Quality
- Chief Information Officer
- Director of Workforce & OD

8. The following are required to attend in a non-voting capacity:

- Company Secretary
- Deputy Director of Finance
- Head of Capital Development
- Head of Transformation
- Head of Communications
- Archus representatives

9. The HRSG will be deemed quorate when the Chair or Deputy Chair plus three additional members from MCHT are present. Members may only nominate a deputy to attend on their behalf if they have sufficient understanding of the area they are representing to be able to contribute effectively to the Group's business; however, this should only be in exceptional circumstances and should be agreed with the Chair. Deputies will count towards the quorum.

10. Other staff or external advisers (e.g. Archus supply chain representatives including cost consultant, architect, engineers) may be co-opted or requested to attend for specific agenda items as necessary.

Requirements of Membership

11. Members must attend at least 75% of all meetings each financial year but should aim to attend all scheduled meetings. Attendance will be recorded and monitored.

12. Conflicts of Interest – the Companies Act 2006 defines a conflict of interest as arising when the interests of directors or 'connected persons' are incompatible or in competition with the interests of the organisation. HRSG members are required to exercise judgement and to declare such interests as there is a risk of implied improper conduct. The relevant interest, once declared, will be recorded in a register of interests, maintained by the Company Secretary.

Duties

13. In order to fulfil its role and obtain the necessary assurance, the HRSG will:

- manage the delivery of the Strategic Outline Case (SOC) on the development of plans to replace buildings on the Leighton Hospital site
- deliver and update the Project Initiation Document seeking approval from the HRPB as required
- deliver and update the Project Plan with approval by the HRPB as required
- ensure the business case is developed in accordance with the Government 5 case model
- monitor progress from key areas associated with the development of the new hospital
- ensure that Delivery Plans, including objectives, key milestones, resource plans, process, performance monitoring arrangements and all major deliverables associated with the programme aim are delivered
- ensure that there is effective identification and management of the risks associated with the aims of the Steering Group by seeking relevant assurances with respect to the effectiveness of risk controls and that future actions are focused on managing risks to an acceptable level

- prioritise work associated with the aim of the Steering Group, identifying and agreeing those areas which will not be progressed until later dates in the project including after the new hospital has been built
- ensure that the Project Team delivers its objectives successfully within the agreed scope time, cost and quality parameters
- ensure that each key area has accountable representation and that they deliver in line with the Project Plan
- develop and implement an integrated, comprehensive and effective Communications Plan to ensure all stakeholders (internal and external) are informed and involved throughout the process
- develop an effective Post Project Evaluation Strategy.

15. The HRSG is committed to protecting and respecting data privacy. The HRSG will have regard to the EU General Data Protection Regulation (Regulation (EU) 2016/679) (GDPR) and demonstrate, where applicable, compliance with data protection legislation, in particular the Data Protection Act 1998 (DPA).

Equality, Diversity & Inclusion

16. In conducting its business, the HRSG will at all times seek to promote its commitment to equality and diversity by the creation of an environment that is inclusive for both our workforce, patients and service users, including those who have protected characteristics and vulnerable members of our community.

Reporting

17. The HRSG will be accountable to the Hospital Redevelopment Programme Board. The HRPB will be informed of HRSG's work through a report from the Chair submitted following each meeting.

18. Reports may be received from the key areas (Appendix I) as required.

Administration of Meetings

19. Meetings shall be held monthly with additional meetings held on an exception basis at the request of the Chair or any three members of the HRSG.

20. Archus Ltd will administer and minute the HRSG meeting on behalf of MCHFT. Duties in this respect will include development and monitoring of a workplan, agenda setting, taking minutes of the meeting and providing appropriate support to the Chair and HRSG members.

21. Agendas and papers will be circulated at least 4 working days in advance of the meeting.

22. A record of the meeting will be circulated to members for comment as soon as is reasonably practicable.

Review

23. The Terms of Reference shall be reviewed at each stage of the programme (next review date March 2021).

Mid Cheshire Hospitals
NHS Foundation Trust

Board of Directors
Integrated Performance Report

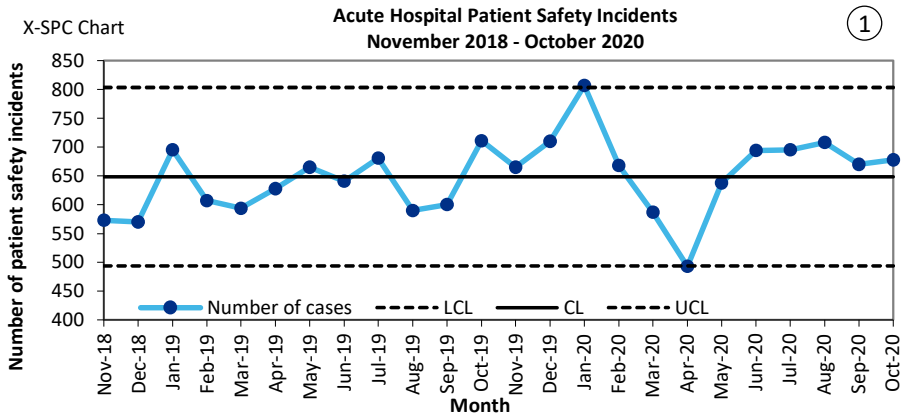
October 2020

"To Deliver Excellence in Healthcare through Innovation & Collaboration"

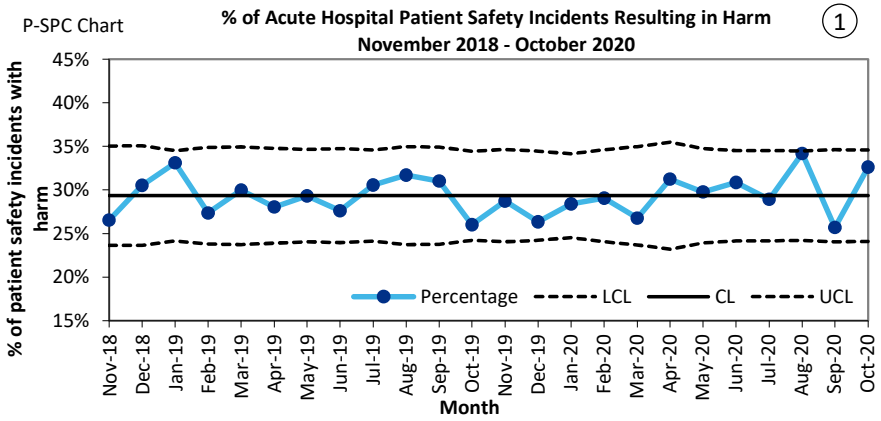
Board Papers - Quality, Safety & Experience

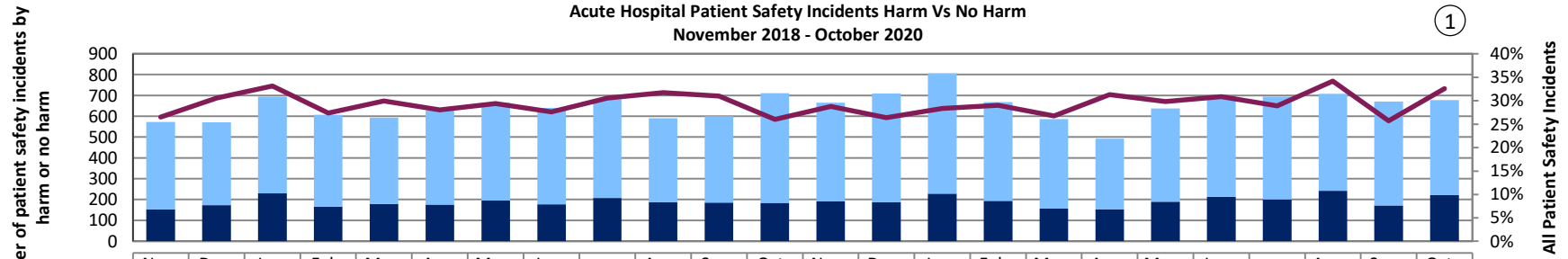
Acute Hospital Patient Safety Incidents (Excludes CCICP)

X-SPC Chart



P-SPC Chart





	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
No Harm	421	396	465	441	416	452	470	464	473	403	414	526	474	523	578	474	430	339	448	480	494	466	498	457
Harm	152	174	230	166	178	176	195	177	208	187	186	185	191	187	229	194	157	154	190	214	201	242	172	221
% Harm	27%	31%	33%	27%	30%	28%	29%	28%	31%	32%	31%	26%	29%	26%	28%	29%	27%	31%	30%	31%	29%	34%	26%	33%

Accountable: Medical Director
Data Owner: Quality Governance
To note: P-SPC charts adjust the control limits to take into account each month's denominator.

Key Narrative: 678 incidents were reported in October 2020 of which 33% resulted in harm. The total number of acute hospital patient safety incidents has remained close to the 24-month average for the last 6 months reported.

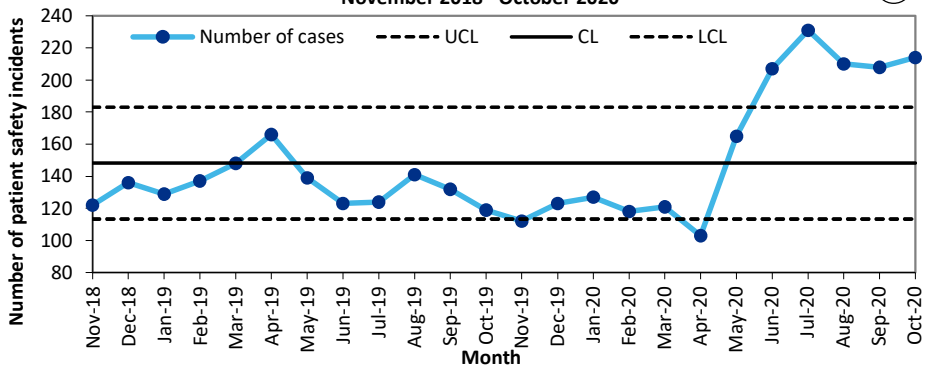
Low Harm 214, Moderate Harm 5, Serious Incident 2

Data Rating: ①captured locally, ②system captured, ③published/benchmarked

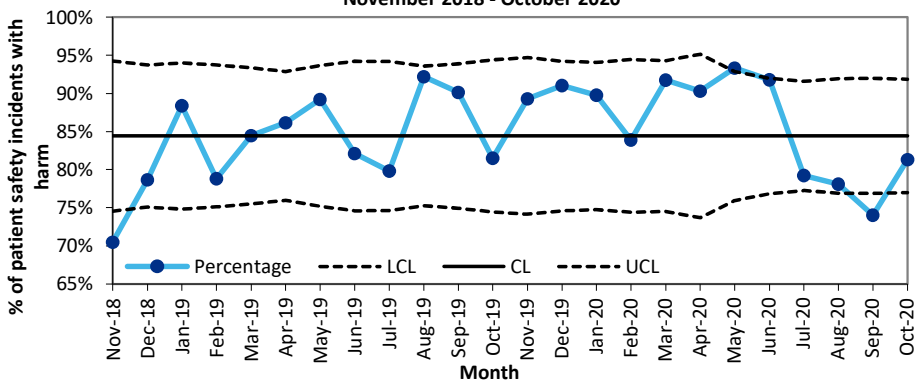
Board Papers - Quality, Safety & Experience

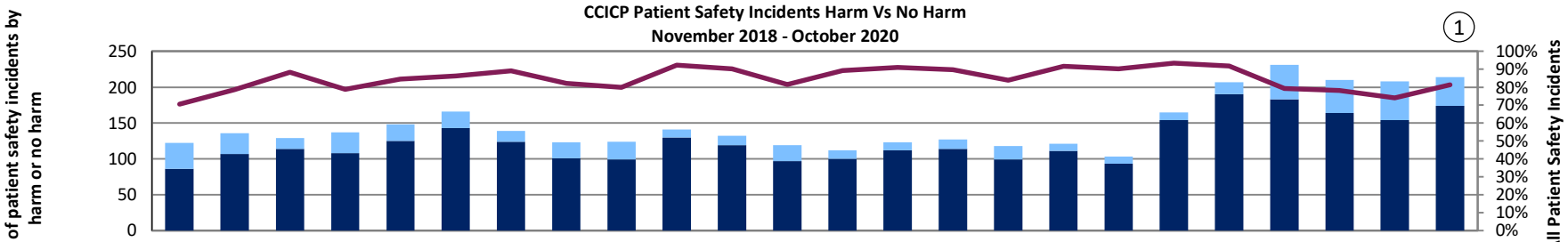
Central Cheshire Integrated Care Partnership (CCICP) Patient Safety Incidents

X-SPC Chart



P-SPC Chart





	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
No Harm	36	29	15	29	23	23	15	22	25	11	13	22	12	11	13	19	10	10	11	17	48	46	54	40
Harm	86	107	114	108	125	143	124	101	99	130	119	97	100	112	114	99	111	93	154	190	183	164	154	174
% Harm	70%	79%	88%	79%	84%	86%	89%	82%	80%	92%	90%	82%	89%	91%	90%	84%	92%	90%	93%	92%	79%	78%	74%	81%

Accountable: Medical Director
Data Owner: Quality Governance
To note: P-SPC charts adjust the control limits to take into account each month's denominator.

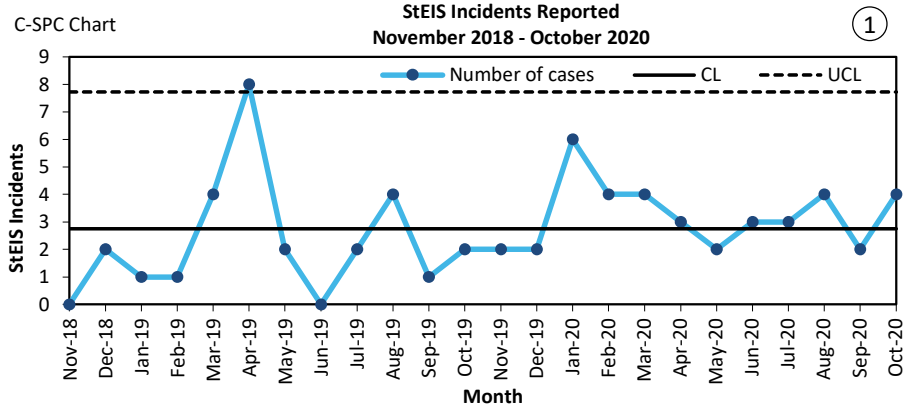
Key Narrative: 214 CCICP patient safety incidents were reported in October 2020, of which 81% resulted in harm. The average number of incidents reported per month over the last 5 months is 214, a 59% increase on the November 2018 to May 2020 monthly average.

Low Harm 170, Moderate Harm 4, Serious Incident 0

Data Rating: ①captured locally, ②system captured, ③published/benchmarked

Board Papers - Quality, Safety & Experience

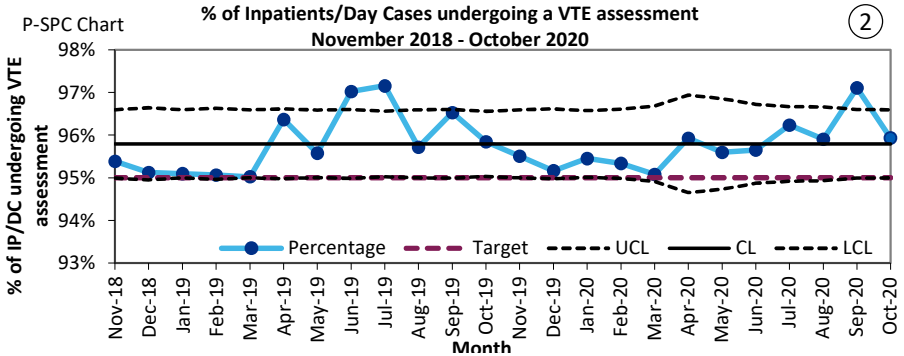
StEIS Incidents - Trust Total



Accountable: Medical Director **Data Owner:** Quality Governance

Key Narrative: There were 4 serious incidents reported to StEIS in October 2020. The SPC chart shows April 2019 breaching the upper control limit with the remaining data points falling within the expected range.

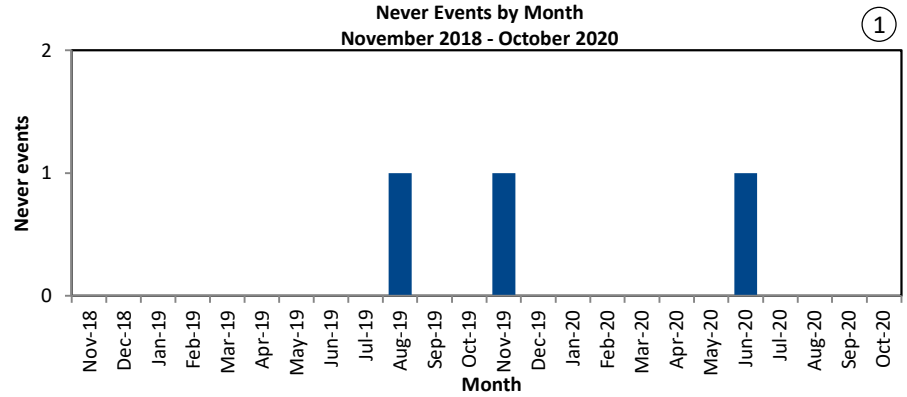
VTE



Accountable: Medical Director **Data Owner:** Information Services

Key Narrative: The percentage of VTE assessments completed remains above target, achieving 95.9% in October 2020. The P-SPC charts adjust the control limits to take into account each month's denominator.

Never Events - Trust Total



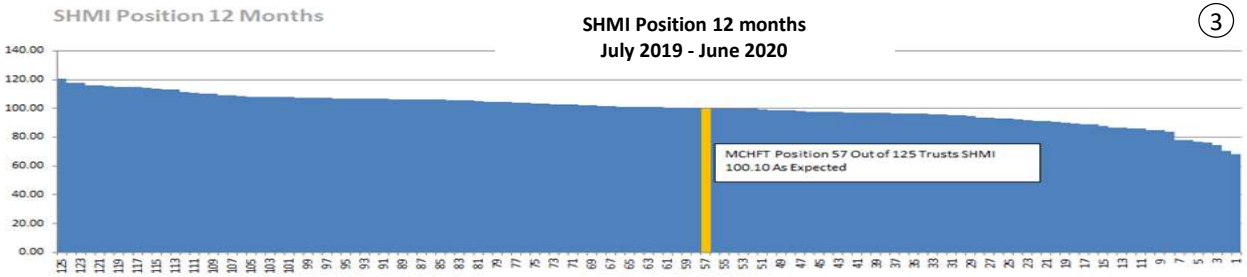
Accountable: Medical Director **Data Owner:** Quality Governance

Key Narrative: There were no never events reported in September 2020.

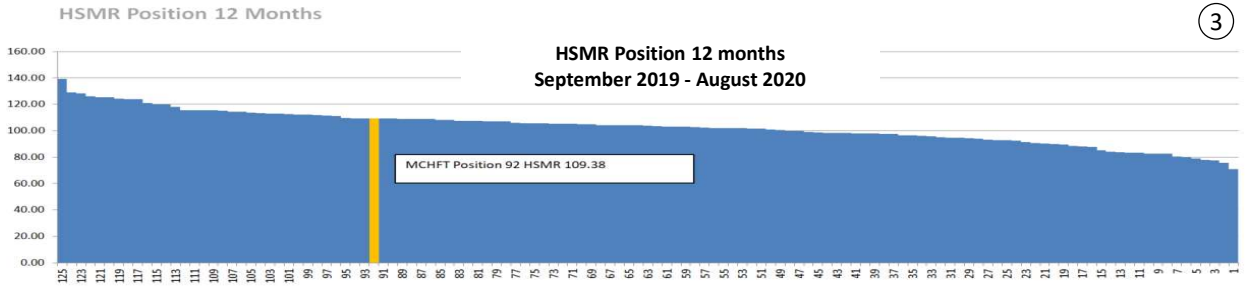
Data Rating: ①captured locally, ②system captured, ③published/benchmarked

Board Papers - Quality, Safety & Experience

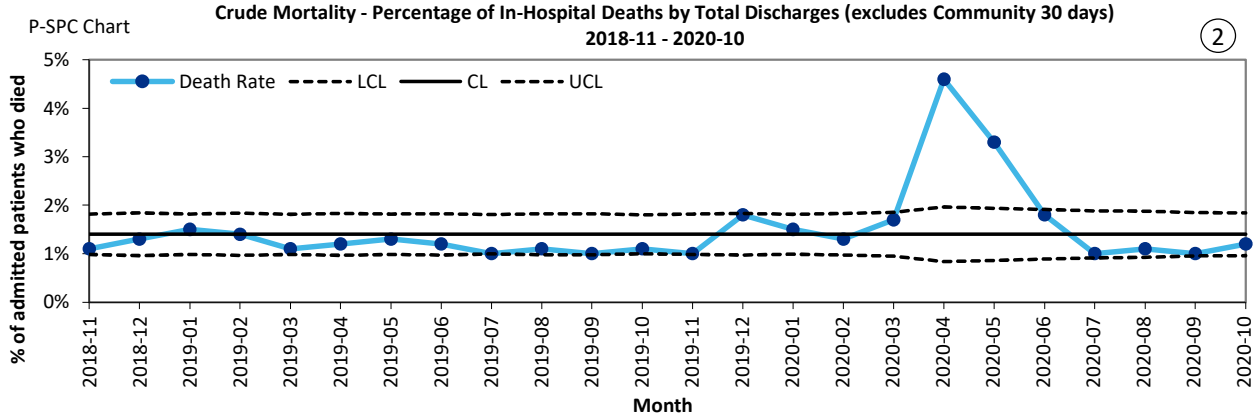
Mortality



③



③



②

Key Narrative: The latest release of SHMI is 99.22 (rank 51) against the previous value of 100.10 (rank 57). This is still in the 'as expected' range. Please note that the number of submitting Trusts has dropped from 129 to 125 due to Trust mergers that is now reflected in the data

Key Narrative: The latest HSMR release is 109.38. Recent releases had shown a deterioration in HSMR which is likely to be the result of low rates of palliative coding compared to other Trusts. This release shows a slight improvement. Please note that the Trust mergers in SHMI are reflected in this data.

Key Narrative: Crude mortality has remained largely consistent over the time period; exceptions are December 2019 & March-June 2020 where the rate increased and shows special cause variation on the chart. The latter period represents the beginning of the Coronavirus pandemic, resulting in a reduced number of inpatients within the Trust overall but an increase in the severity of illness and resultant mortality amongst the inpatient cohort.
The most recent rate for October 2020 is slightly higher (but fewer deaths) than October 2019.

Accountable: Medical Director
Data Owner: Quality Governance
To note: P-SPC charts adjust the control limits to take into account each month's denominator.

Data Rating: ①captured locally, ②system captured, ③published/benchmarked

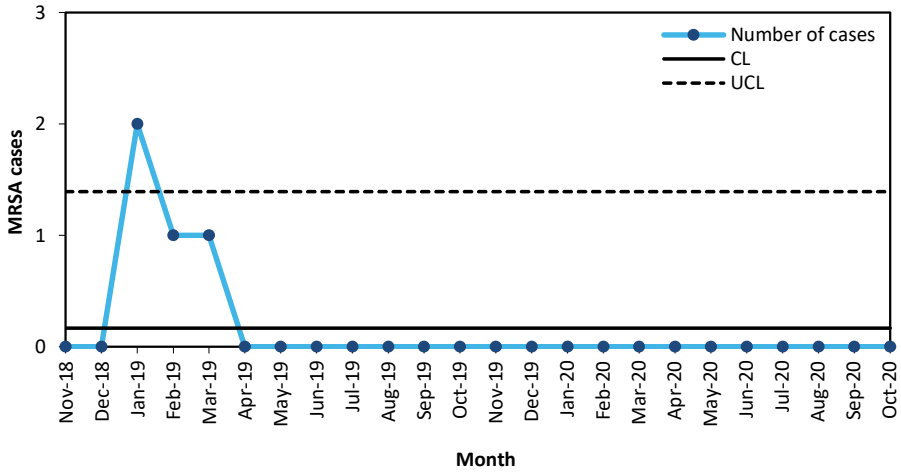
Board Papers - Quality, Safety & Experience - Infection Control

MRSA

C-SPC Chart

MRSA Bacteraemia Cases Reported Within the Trust
November 2018 - October 2020

①



Accountable: Director of Nursing and Quality
Data Owner: Infection Prevention Control Team

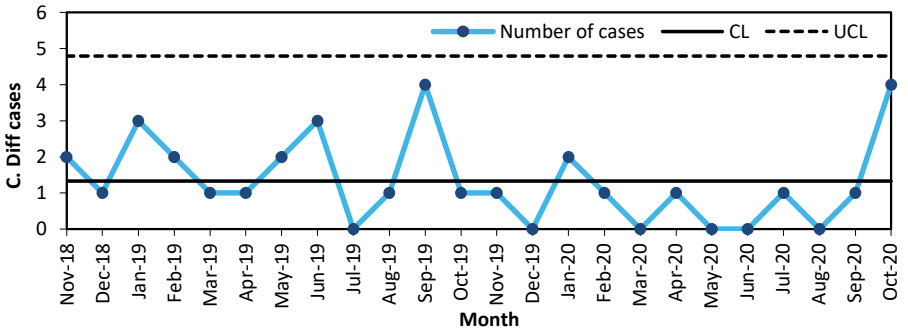
Key Narrative: There have been no MRSA bacteraemia cases reported since March 2019.

C. Diff Positive Cases

C-SPC Chart

Hospital Onset Healthcare Acquired C. Diff Cases
November 2018 - October 2020

①



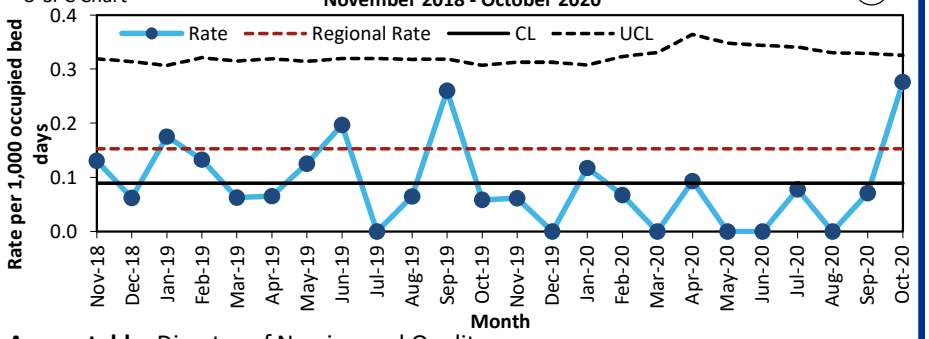
	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
Avoidable	0	0	0	0	0	0	0	0	1	0	0	0
Unavoidable	1	0	2	1	0	1	0	0	0	0	1	0
Awaiting Confirmation	0	0	0	0	0	0	0	0	0	0	0	4

Hospital Onset Healthcare Acquired C.Diff Rate per 1,000 Occupied Bed Days

U-SPC Chart

November 2018 - October 2020

①



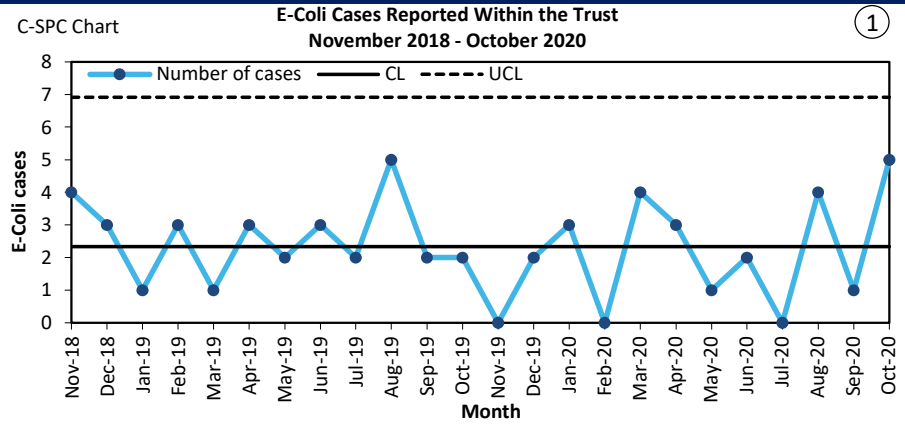
Accountable: Director of Nursing and Quality
Data Owner: Infection Prevention Control Team
Key Narrative: There were 4 hospital onset healthcare acquired C.Diff cases recorded in October 2020 with a rate of 0.28 cases per 1,000 occupied bed days, above the current regional rate. The P-SPC charts adjust the control limits to take into account each month's denominator.

Data Rating: ①captured locally, ②system captured, ③published/benchmarked

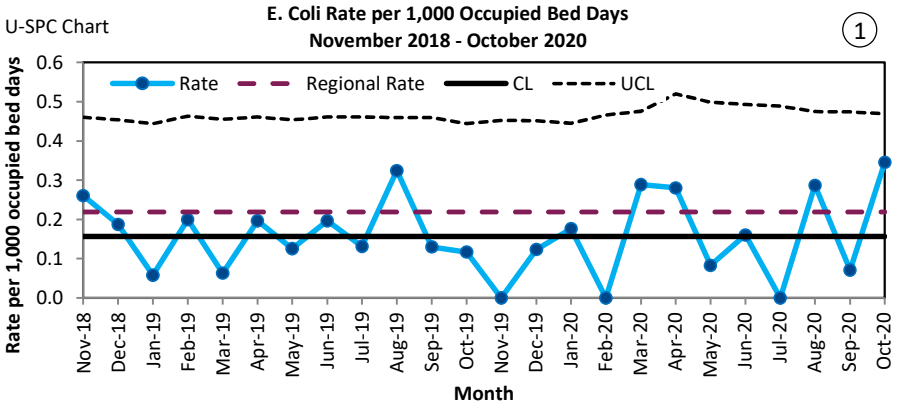
Board Papers - Quality, Safety & Experience - Infection Control

E-Coli Cases

C-SPC Chart



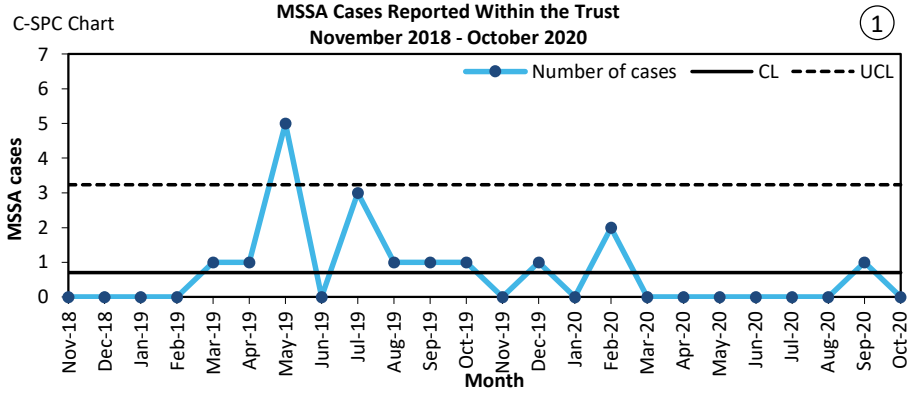
U-SPC Chart



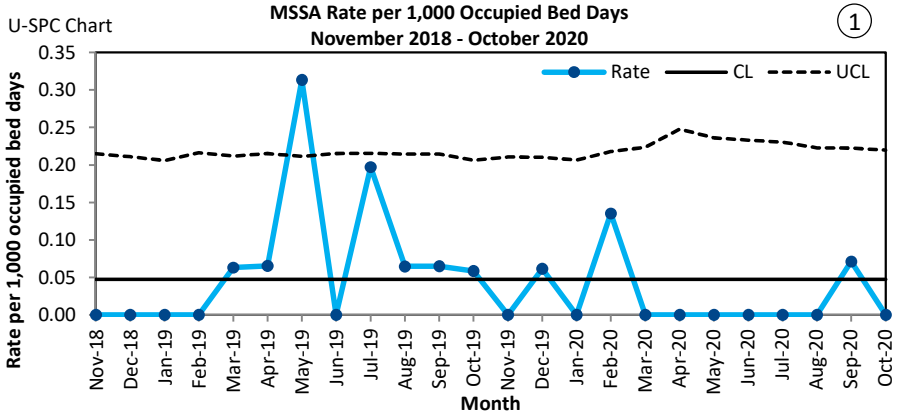
Accountable: Director of Nursing and Quality
Data Owner: Infection Prevention Control Team
Key Narrative: There were 5 E-Coli cases recorded in October 2020 with a rate of 0.35 cases per 1,000 occupied bed days, above the current regional rate. The U-SPC chart adjusts the control limits to take into account each month's denominator.

MSSA

C-SPC Chart



U-SPC Chart



Accountable: Director of Nursing and Quality
Data Owner: Infection Prevention Control Team
Key Narrative: There were no MSSA case reported in September 2020. The U-SPC chart adjusts the control limits to take into account each month's denominator.

Data Rating: ①captured locally, ②system captured, ③published/benchmarked

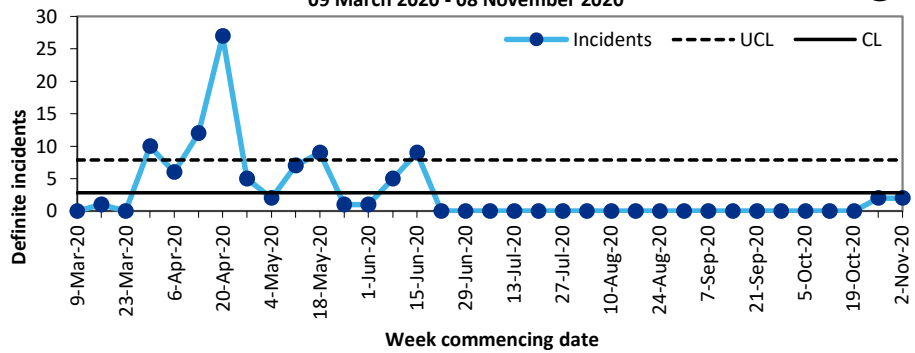
Board Papers - Quality, Safety & Experience

COVID-19 Healthcare Acquired Infections

C-SPC Chart

MCHFT Definite COVID-19 Incidents by Result Week
09 March 2020 - 08 November 2020

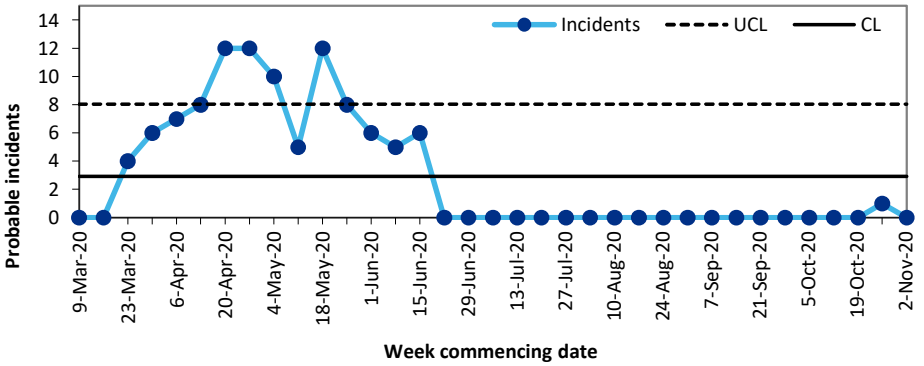
①



C-SPC Chart

MCHFT Probable COVID-19 Incidents by Result Week
09 March 2020 - 08 November 2020

①

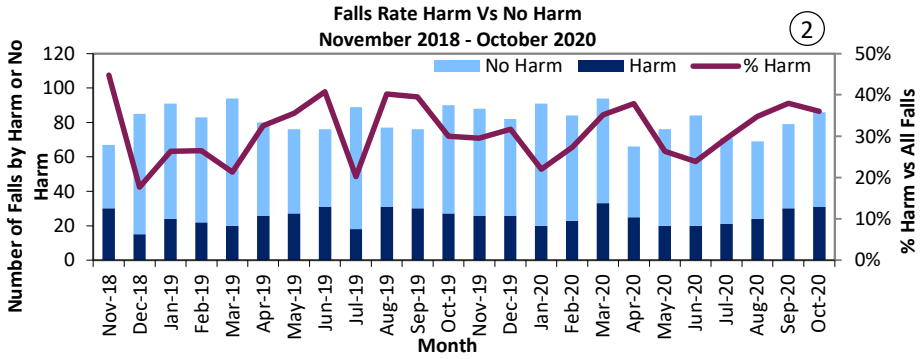


Accountable: Director of Nursing and Quality
Data Owner: Information Services
Key Narrative: There were 2 definite incidents recorded in both weeks commencing 26th October and 2nd November. There was 1 probable incident reported the week commencing 26th October 2020. These are the first incidents reported since the end of the first peak of the coronavirus pandemic.

Falls

Falls Rate Harm Vs No Harm
November 2018 - October 2020

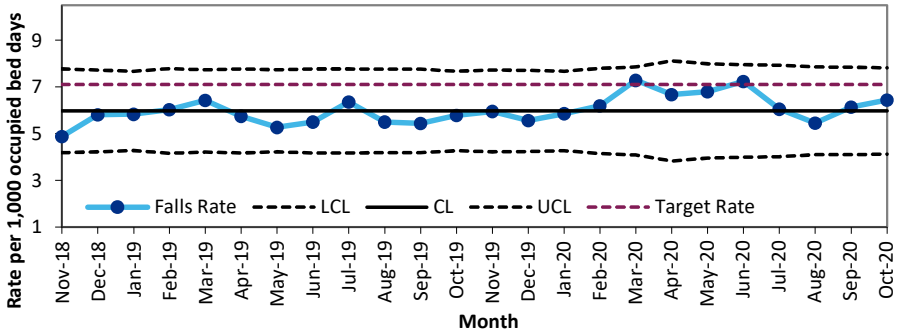
②



U-SPC Chart

Falls Rate per 1,000 Occupied Bed Days
November 2018 - October 2020

②



Accountable: Director of Nursing and Quality
Data Owner: Nursing Quality Team
Key Narrative: 86 falls were reported in October 2020 with a rate of 5.94 per 1,000 occupied bed days, below the target rate of 6.6.
31 falls resulted in harm (36%).
The U-SPC chart adjusts the control limits to take into account each month's denominator.

Data Rating: ①captured locally, ②system captured, ③published/benchmarked

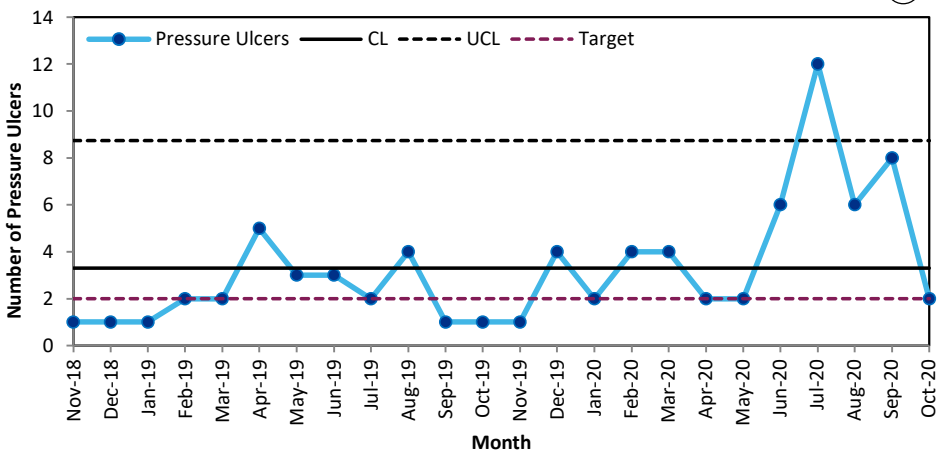
Board Papers - Quality, Safety & Experience

Acute Hospital Pressure Ulcers

C-SPC Chart

Acute Hospital Pressure Ulcers - Lapses in Care Identified
November 2018 - October 2020

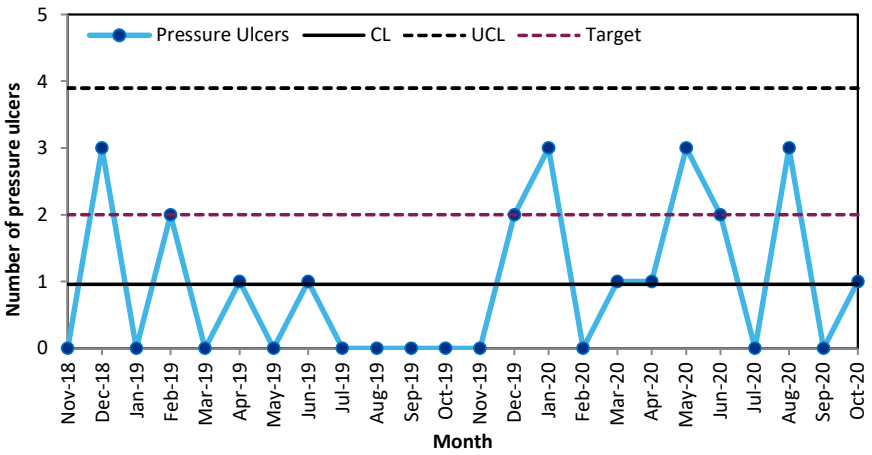
①



C-SPC Chart

Community Pressure Ulcers - Lapses in Care Identified
November 2018 - October 2020

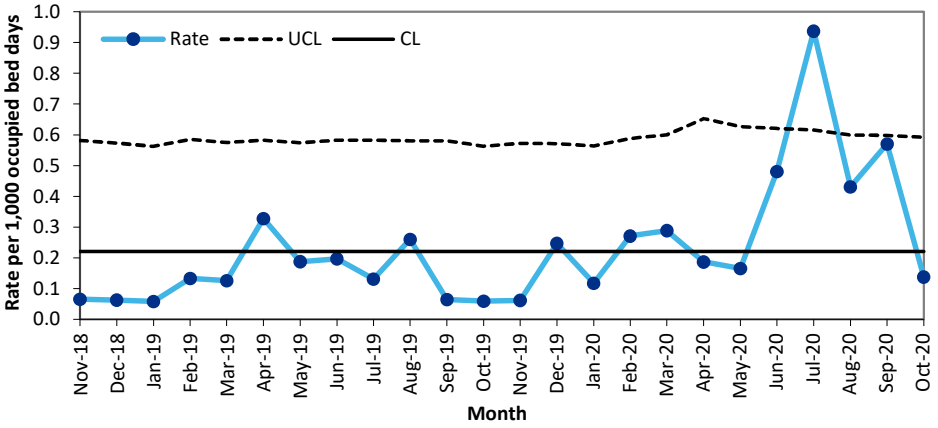
①



U-SPC Chart

Acute Hospital Pressure Ulcers - Lapses in Care Rate per 1,000 Occupied Bed Days
November 2018 - October 2020

①



To note: U-SPC charts adjust the control limits to take into account each month's denominator.

Accountable: Director of Nursing and Quality
Data Owner: Nursing Quality Team

Key Narrative:

Acute: There were 2 acute hospital lapses in care identified in October 2020, matching the monthly target. The rate of cases per 1,000 occupied bed days was 0.14. There have been 38 acute lapses of care reported in the current financial year against a target of 14.

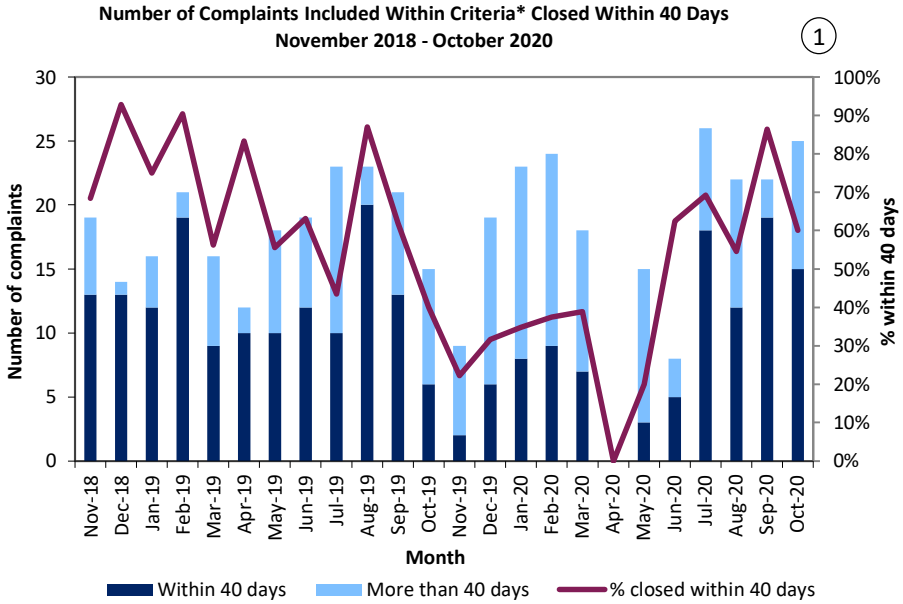
Community: There was 1 community lapses of care identified in the in October 2020. There have been 10 community lapses of care reported in the current financial year against a target of 14.

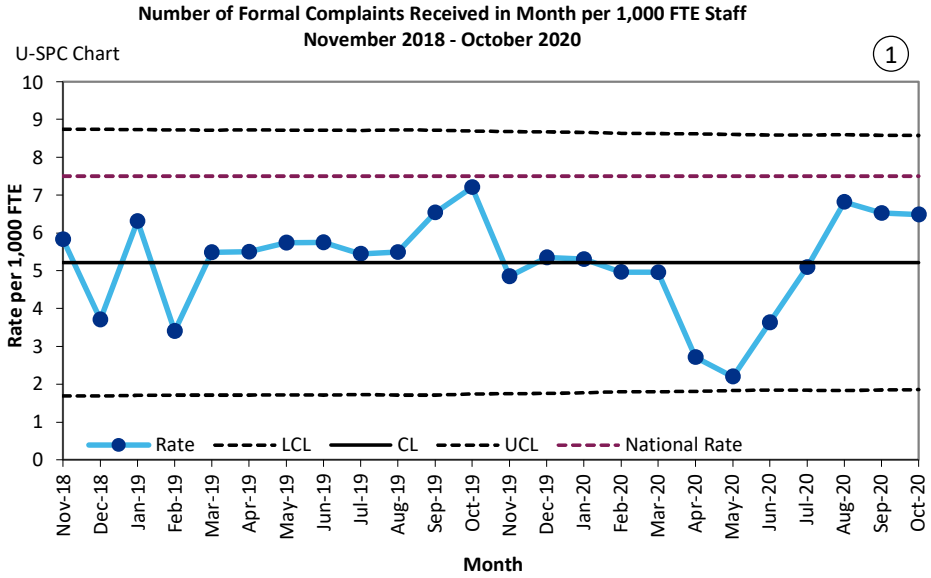
Current financial year reported cases subject to validation.

Data Rating: ①captured locally, ②system captured, ③published/benchmarked

Board Papers - Quality, Safety & Experience

Formal Complaints





Accountable: Director of Nursing and Quality
Data Owner: Customer Care Team

Key Narrative: 25 complaints were closed in October 2020, of which 15 (60%) were closed within 40 days. The rate of formal complaints received in October 2020 was 6.49 per 1,000 FTE staff, remaining below the national rate.

**exclusion criteria includes, for example: complaints linked to an investigation, multi-agency and cross-divisional and complaints, withdrawn complaints, complaints put on hold during the COVID-19 period.*

Data Rating: ①captured locally, ②system captured, ③published/benchmarked

Board Papers - Quality, Safety & Experience

Safer Staffing Divisional Analysis

①

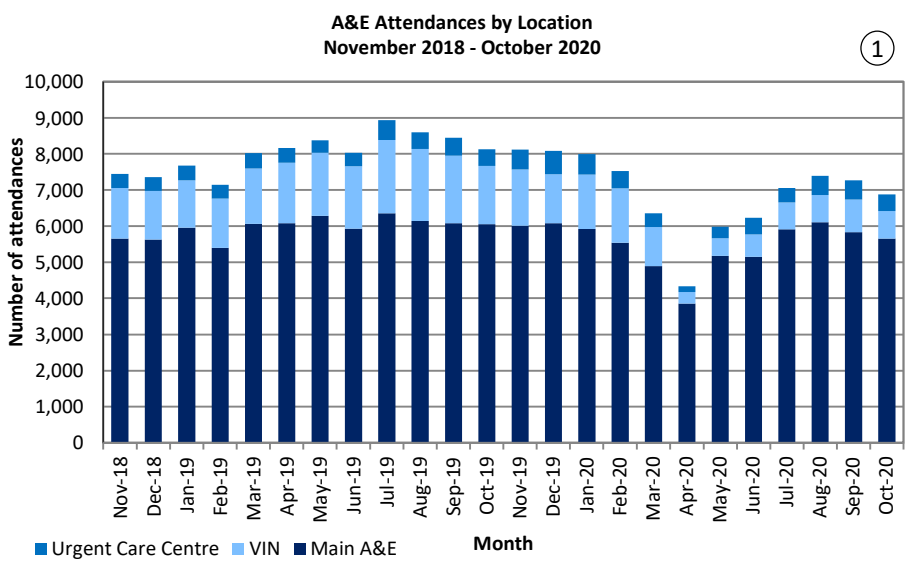
Ward Name	Day				Night				Day		Night	
	Qualified		Unqualified		Qualified		Unqualified		Qualified	Unqualified	Qualified	Unqualified
	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Fill Rate	Fill Rate	Fill Rate	Fill Rate
MCHFT	41589.7	37125.9	33455.0	27528.9	31288.5	28641.6	23095.5	19717.9	89%	90%	92%	81%
Ward 11 Surgical/Gynae	2090.5	2046.5	2116.5	1892.8	1164.0	1116.0	1788.0	1536.0	98%	89%	96%	86%
Ward 12 SAU	1329.0	1263.0	1026.5	1025.5	804.0	715.0	792.0	732.0	95%	100%	89%	92%
Ward 12 Surgical Speciality	1318.5	1294.5	951.5	839.0	780.0	744.0	576.0	492.0	98%	88%	95%	85%
Ward 10 Ortho Trauma	2234.8	2074.8	3093.5	2596.5	1140.0	1128.0	2292.0	2000.3	93%	84%	99%	87%
Ward 9 Orthopaedic Elective	1092.0	831.0	840.0	682.0	744.0	720.0	708.0	384.0	76%	81%	97%	54%
Ward 13 Elective	1221.5	1080.5	1272.0	689.3	804.0	792.0	792.0	396.0	88%	54%	99%	50%
Ward 26 Labour	3268.2	3135.0	560.7	518.7	2601.9	2536.4	384.0	372.7	96%	93%	97%	97%
Maternity Unit (Ward 23)	1374.2	1380.6	1068.3	956.6	744.0	735.3	756.0	708.7	100%	90%	99%	94%
Child & Adolescent Unit	3590.8	2606.7	1624.5	1133.5	2339.0	2174.3	731.5	659.0	73%	70%	93%	90%
NICU Ward 22	1710.9	1610.5	745.1	275.9	1322.3	1209.0	344.0	290.3	94%	37%	91%	84%
Midwifery Led Unit	864.9	844.4	0.0	0.0	766.0	768.3	0.0	0.0	98%		100%	
Critical Care Unit (RED)	4185.3	3810.5	550.5	472.5	4099.3	3719.3	432.0	158.3	91%	86%	91%	37%
Acute Medical Unit	1603.0	1589.0	2017.0	2047.8	1932.0	1868.5	1452.0	1524.0	99%	102%	97%	105%
Ward 1 Coronary Care	2065.5	2038.5	1144.5	1064.0	1500.0	1464.0	972.0	912.0	99%	93%	98%	94%
Ward 4 Elderly	1256.0	1071.5	1833.0	1286.0	1056.0	695.1	1416.0	1080.0	85%	70%	66%	76%
Ward 3 Short Stay Medical	2265.8	2028.3	2147.0	1868.5	1752.0	1668.0	1776.0	1476.0	90%	87%	95%	83%
Ward 14 Gastroenterology	1535.0	1333.5	1596.0	1526.0	1140.0	1080.5	1380.0	1344.0	87%	96%	95%	97%
Ward 5 Covid (RED)	1994.5	1226.5	1551.0	927.5	1452.0	1080.0	888.0	697.5	61%	60%	74%	79%
Ward 6 Rehab	1805.5	1639.0	2262.5	1959.5	1560.0	1416.0	1320.0	1223.5	91%	87%	91%	93%
Ward 7 Surveillance (AMBER)	1502.5	1364.0	2046.0	1404.0	1116.0	948.0	1248.0	1082.5	91%	69%	85%	87%
Winter Ward 19	1453.5	1369.0	1919.5	1757.5	1236.0	1104.0	1452.0	1401.5	94%	92%	89%	97%
Winter Ward 18	604.0	292.0	822.5	412.0	456.0	204.0	672.0	372.0	48%	50%	45%	55%
Ward 21b Rehabilitation	1224.0	1196.8	2267.0	2194.0	780.0	756.0	924.0	875.8	98%	97%	97%	95%
Elmhurst	768.0	768.0	2525.5	2462.5	744.0	746.5	1908.0	1824.0	100%	98%	100%	96%
South Cheshire Surveillance (AMBER)	1882.0	1825.0	2417.0	2059.5	1855.0	1783.0	2256.0	1980.0	97%	85%	96%	88%

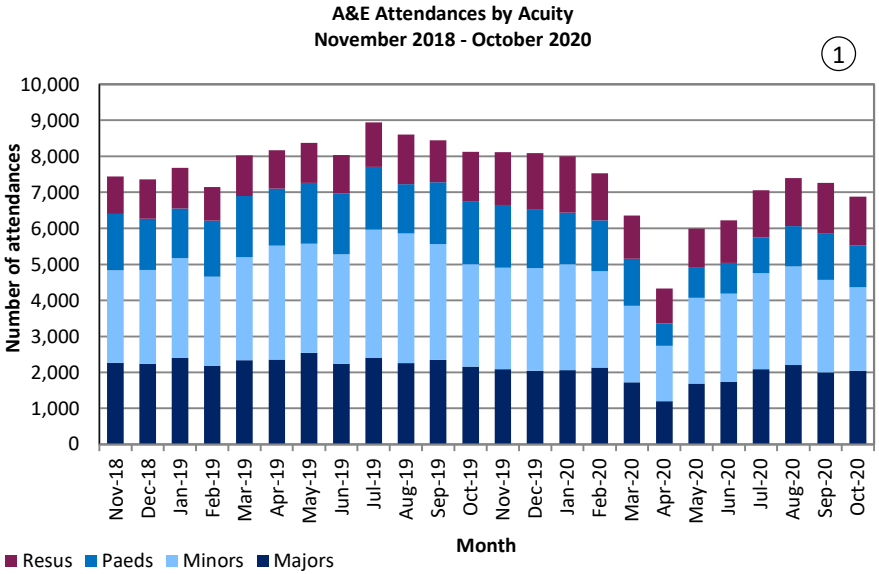
Accountable: Director of Nursing and Quality
Data Owner: Information Services
Key Narrative: The highlighted cells reflect wards where the qualified staffing rate is below 85% of planned levels.

Data Rating: ①captured locally, ②system captured, ③published/benchmarked

Board Papers - Performance

A&E Activity





Accountable: Chief Operating Officer
Data Owner: Information Services

Key Narrative: October 2020 shows a decrease in the total number of A&E attendances compared to the previous 2 months with 6,882 attendances reported across all locations. The latest months activity is equivalent to 85% of the 6-month pre-covid average for September 2019 to February 2020.

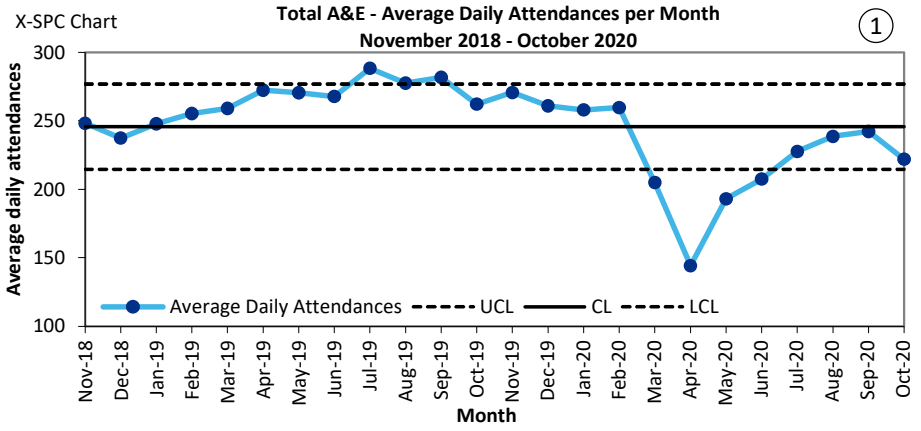
There were 5,655 attendances reported in October 2020 for the main A&E department at Leighton Hospital (type 1), 3.1% lower than the previous reported month but still comparable to the same period last year (93%) and compared to the 6-month pre-covid average (95%).

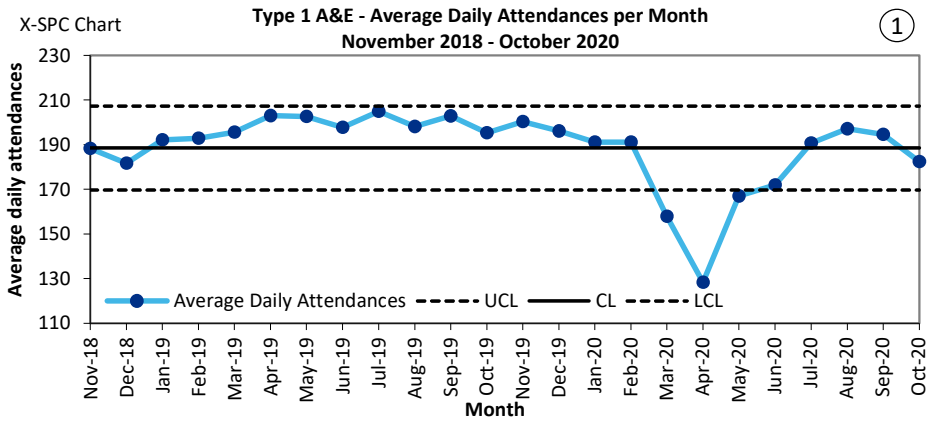
The main drivers for the decrease in activity between September 2020 and October 2020 were minors (-248) and paeds (-146) with a small increase in majors (45).

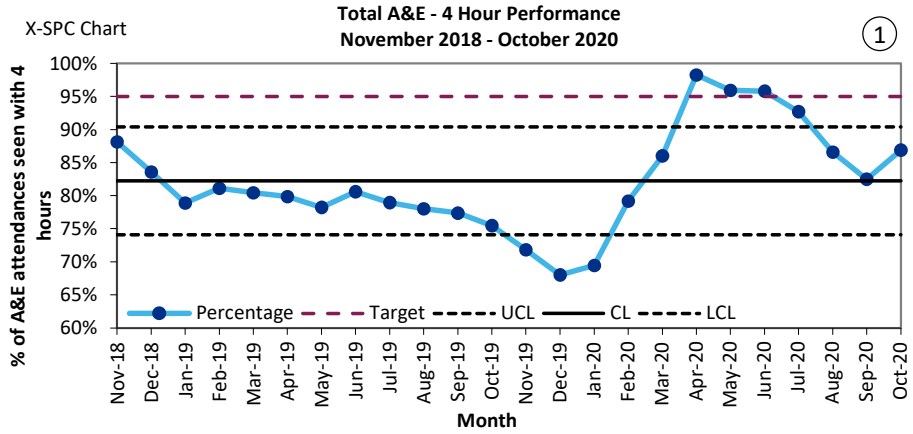
Data Rating: ①captured locally, ②system captured, ③published/benchmarked

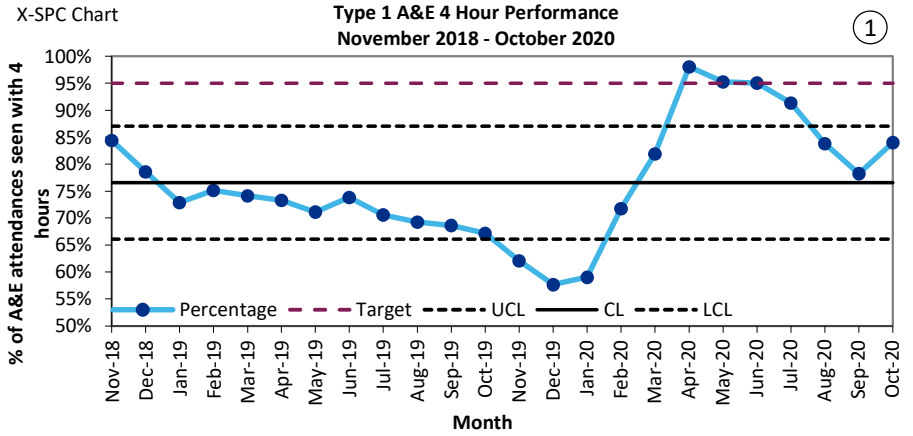
Board Papers - Performance

A&E Performance









Accountable: Chief Operating Officer

Data Owner: Information Services

Key Narrative: The average total daily A&E attendances for October 2020 was 222, 8% lower than the prior month and 15% lower than the same period in the previous year. As noted above Type 1 and Total A&E performance has improved in October compared to September. Across the 24 months shown above, performance significantly improved when attendances decreased across the months of April, May and June 2020.

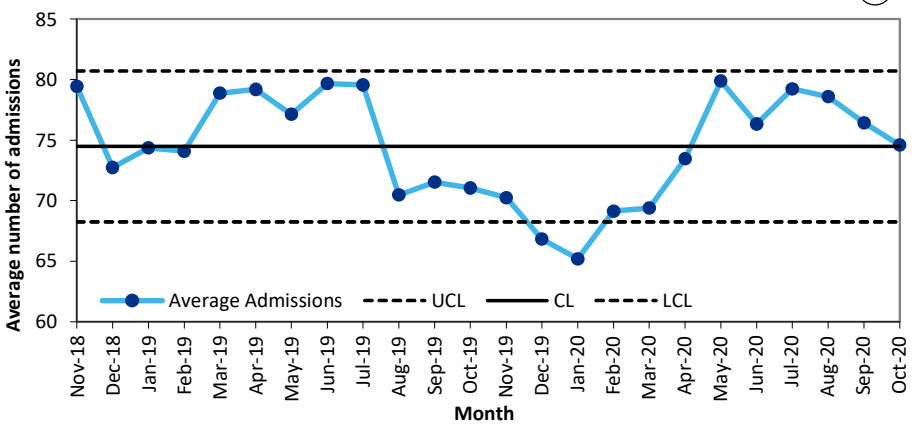
Data Rating: ①captured locally, ②system captured, ③published/benchmarked

Board Papers - Performance

Unplanned Admissions

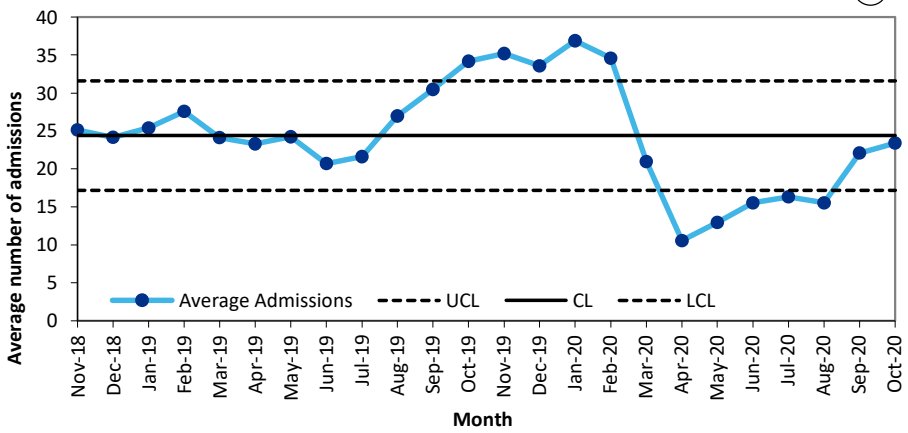
X-SPC Chart

Average Daily Admissions from A&E
November 2018 - October 2020



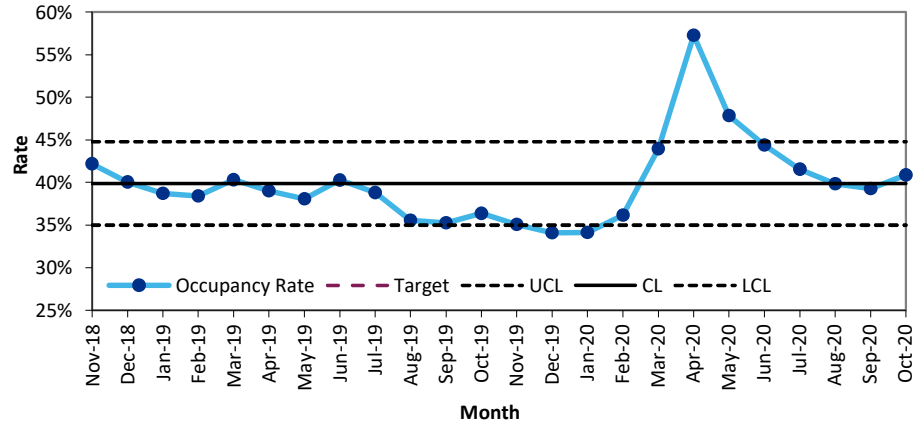
X-SPC Chart

Average Daily Admissions per Month - GP Referred
November 2018 - October 2020



X-SPC Chart

Type 1 Attendance to Admissions Conversion Rate - Overall
November 2018 - October 2020



Accountable: Chief Operating Officer **Data Owner:** Information Services

Key Narrative: There was a change in recording of activity between admissions from A&E and via GP from August 2019 driving some of the variation seen in the average daily admission charts from August 2019 until the onset of the covid pandemic. Activity from March 2020 to date includes admissions to RAU reflecting a new pathway designed to support the covid pandemic averaging 214 admissions per month.

The average daily admissions via A&E for October 2020 was 74.6 matching the 24-month average and 5% higher than October 2019.

Average daily admissions via GP have continued to increase over the last 6 months since the lowest rate in April 2020. The rate remains below the pre-covid levels with October 2020 reaching 69% of the 6-month pre-covid average.

Type 1 attendance to admission conversion ratio for October 2020 was 40.9%, close to the 24-month average.

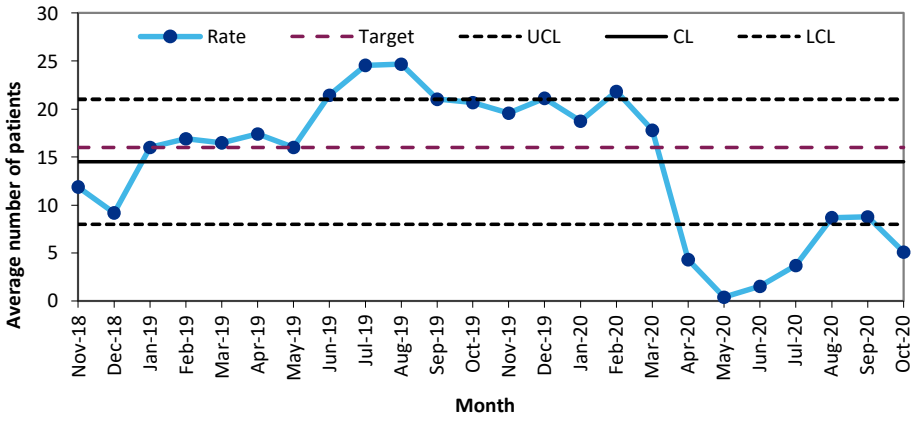
Data Rating: ①captured locally, ②system captured, ③published/benchmarked

Board Papers - Performance

Inpatient Metrics

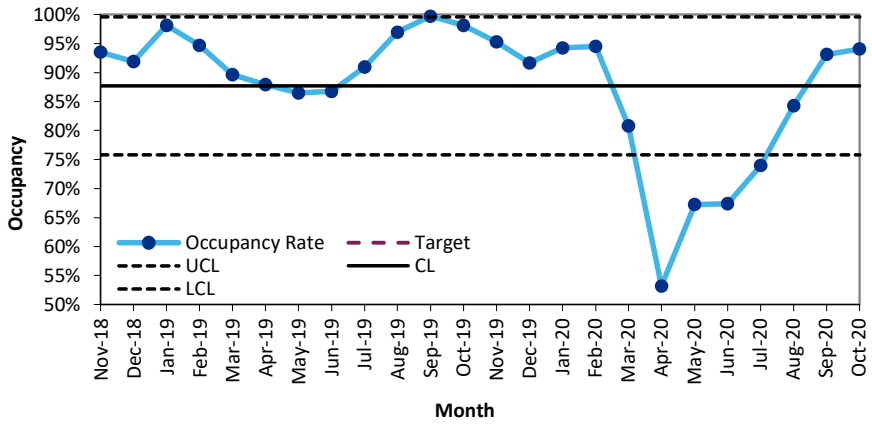
X-SPC Chart

Average Number of People Delayed per Day
November 2018 - October 2020



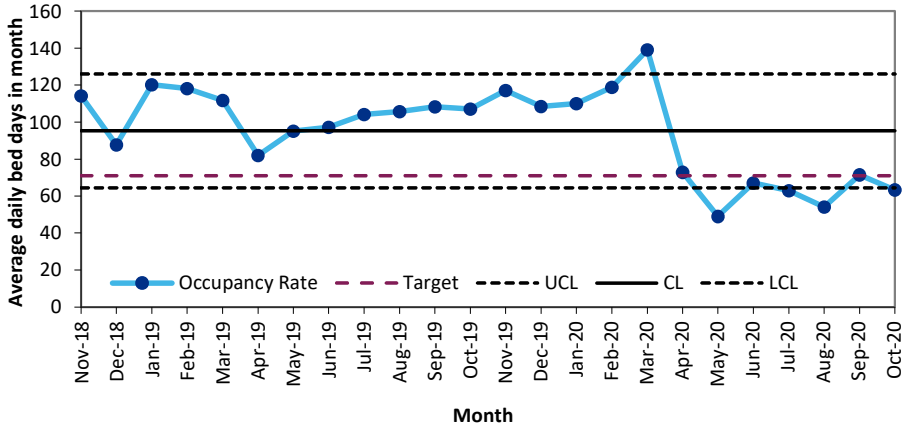
X-SPC Chart

Bed Occupancy
November 2018 - October 2020



X-SPC Chart

Super Stranded Patients
November 2018 - October 2020



Accountable: Chief Operating Officer **Data Owner:** Information Services

Key Narrative: The average number of people delayed per day during October 2020 was 5.1, similar to the recent months activity and has remained below target since the onset of the covid pandemic.

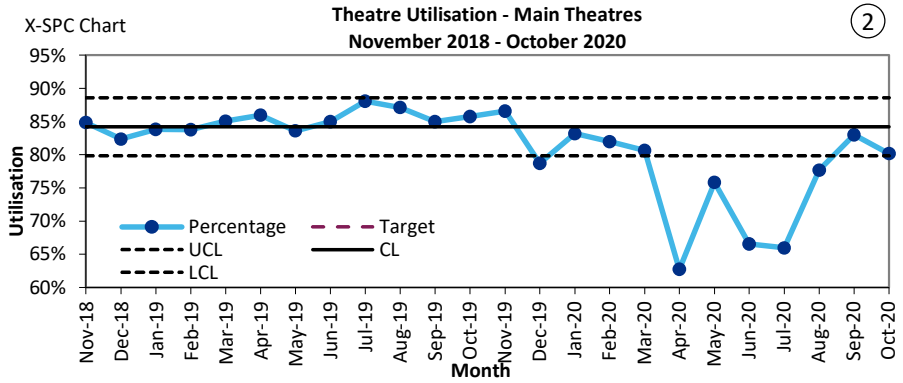
The average number of bed days in month for super-stranded patients was 64.5 in October 2020, below the target of 71.

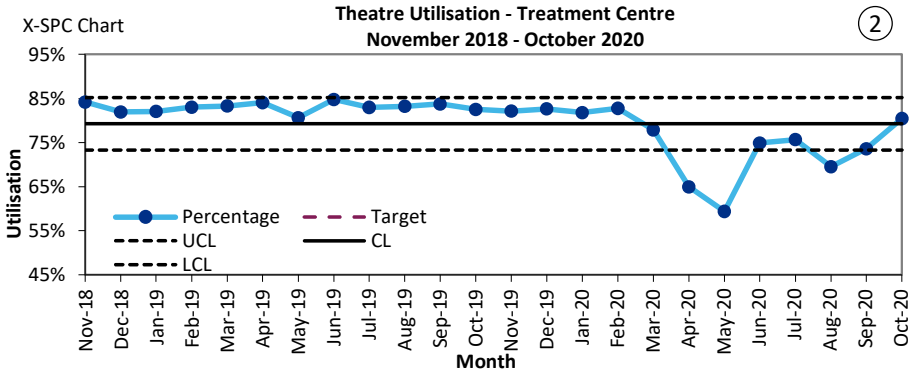
The percentage bed occupancy shows an increasing trend in the last 6 months since the lowest occupancy rate recorded in April 2020. The rate reported in October 2020 was 94.1%, remaining above the 24-month average. The bed occupancy figure reported with the IPR does not exclude lost beds that are not suitable for patient admissions for infection prevention and control (IPC) reasons.

Data Rating: ①captured locally, ②system captured, ③ published/benchmarked

Board Papers - Performance

Theatre Utilisation

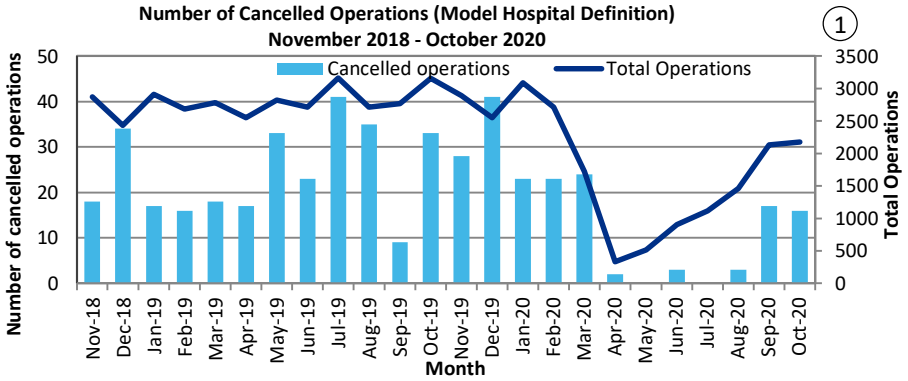


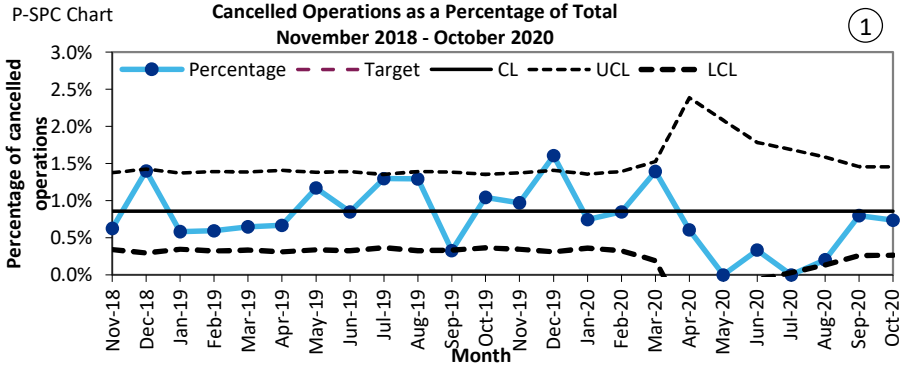


Accountable: Chief Operating Officer **Data Owner:** Information Services

Key Narrative: Theatre utilisation for main theatres in October 2020 was 80.2%. Theatre utilisation in the treatment centre was 80.4%, the first month above the 24-month average since February 2020.

Cancelled Operations





Accountable: Chief Operating Officer **Data Owner:** Information Services

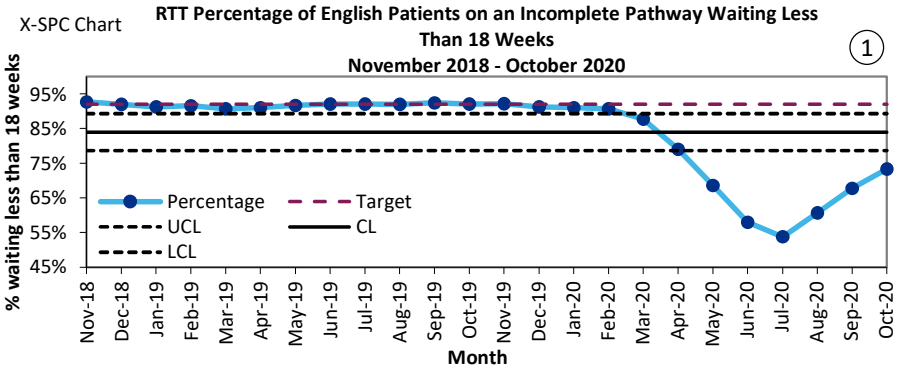
Key Narrative: The total number of operations in October 2020 has increased to 2,174, 76% of the pre-covid 6-month average. 16 operations were cancelled on the day of, or after, admission by the hospital for non-clinical reasons in October 2020 (0.7%).

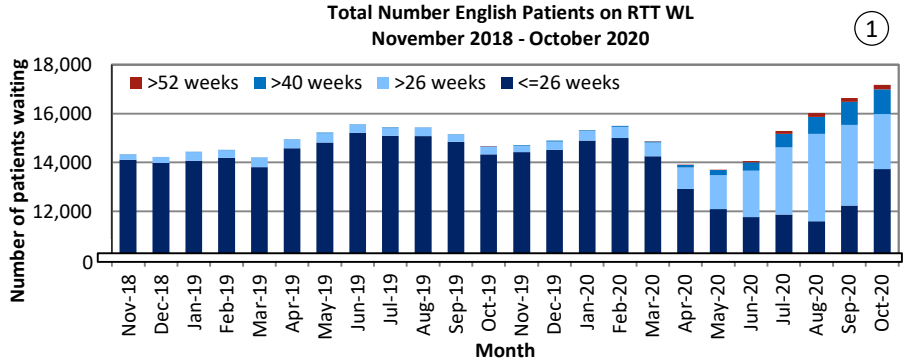
The P-SPC chart adjusts the control limits to take into account each month's denominator.

Data Rating: ①captured locally, ②system captured, ③ published/benchmarked

Board Papers - Performance

Referral to Treatment Waiting Times (RTT)





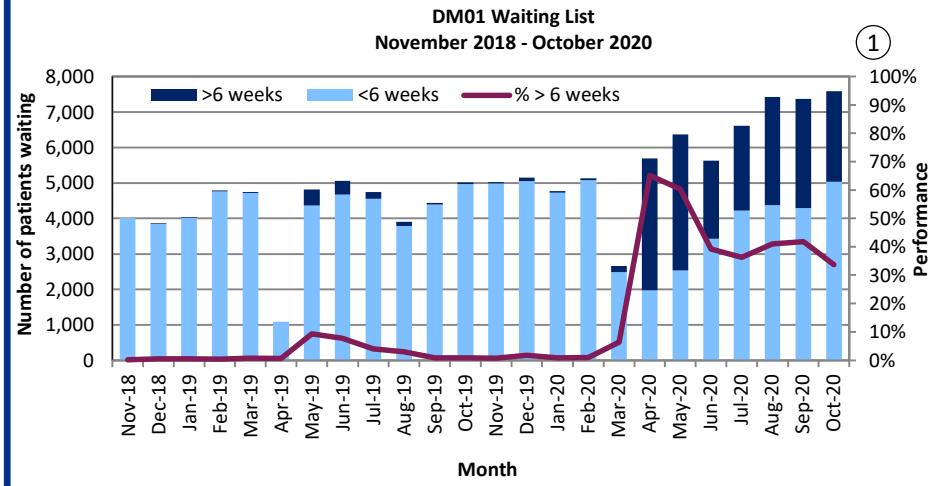
Accountable: Chief Operating Officer **Data Owner:** Information Services

Key Narrative: The total number of patients on the RTT WL continues to grow with 17,179 patients waiting at the end of October 2020, of which 180 patients were waiting for more than 52 weeks, 19 more than reported in September 2020.

Performance has been improving over the last 3 months reaching 73.4% in October 2020 compared to the lowest performance of 53.8% seen in July 2020. Performance remains below the national 92% standard which was last achieved in November 2019.

Latest month's data provisional.

Diagnostic Waiting Times



Accountable: Chief Operating Officer **Data Owner:** Information Services

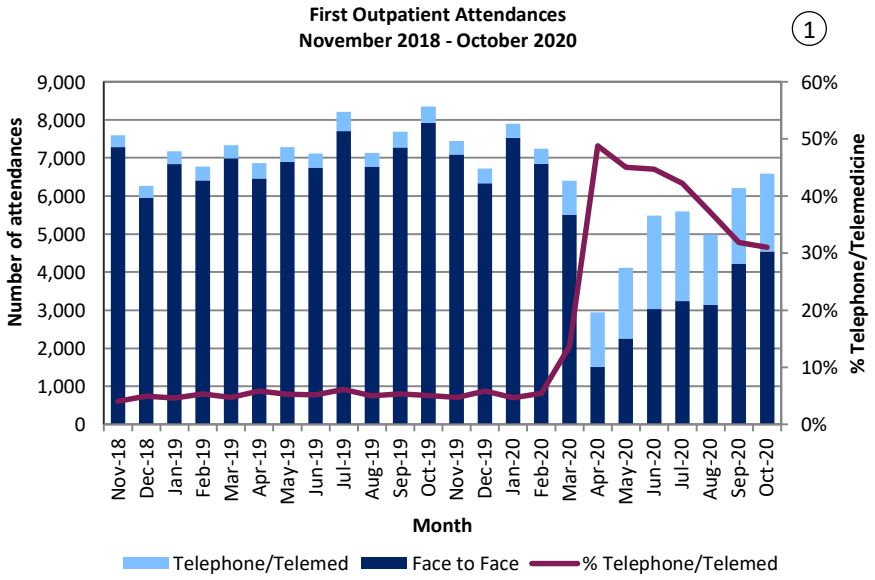
Key Narrative: The total number of patients on the DM01 waiting list continues to grow, with 7,590 patients waiting for a diagnostic test at the end of October 2020, an increase of 224 from the previous month.

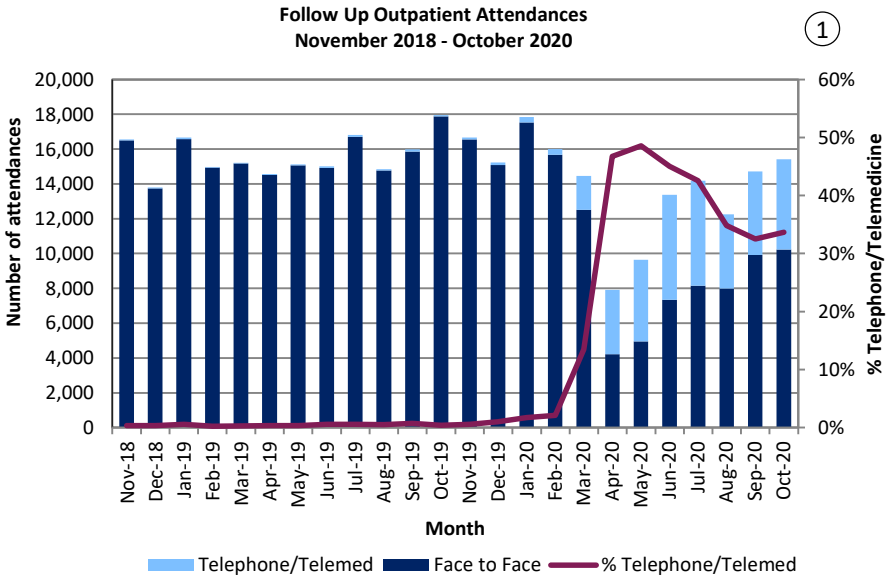
The number of patients waiting more than 6 weeks has reduced from 3,078 in September 2020, to 2,563 in the latest months report.

Data Rating: ①captured locally, ②system captured, ③ published/benchmarked

Board Papers - Performance

Outpatient Activity





Accountable: Chief Operating Officer **Data Owner:** Information Services

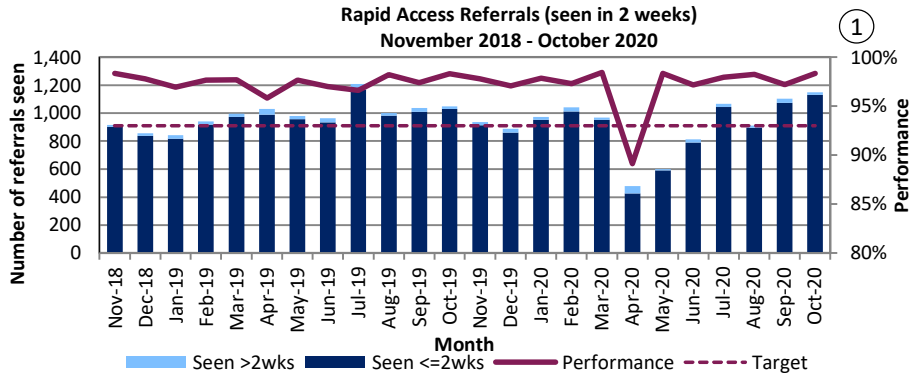
Key Narrative: October 2020 shows the highest reported activity since the onset of the covid pandemic with 6,583 first outpatient and 15,413 follow up outpatient attendances reported. This is an increase of 6.1% and 4.8% on the prior month and 87% and 93% of the 6-month pre-covid average for first and follow up appointments respectively. The proportion of activity delivered via telephone and telemedicine appointments remains at around 1/3 of total outpatient activity for October 2020.

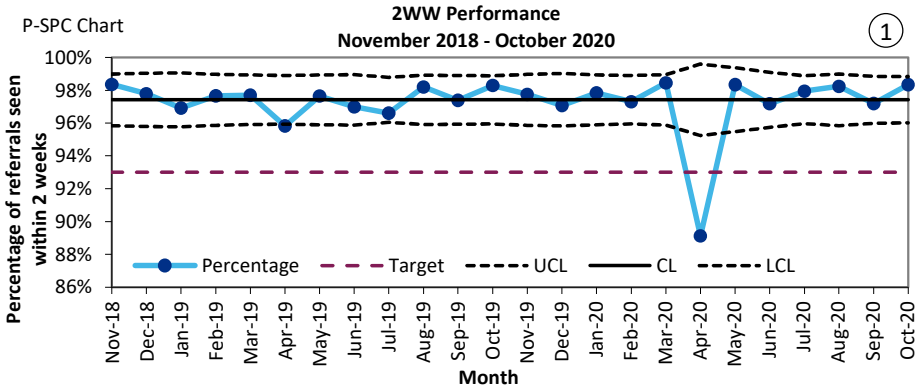
Data includes contracted specialties.

Data Rating: ①captured locally, ②system captured, ③published/benchmarked

Board Papers - Performance

Rapid Access Referrals





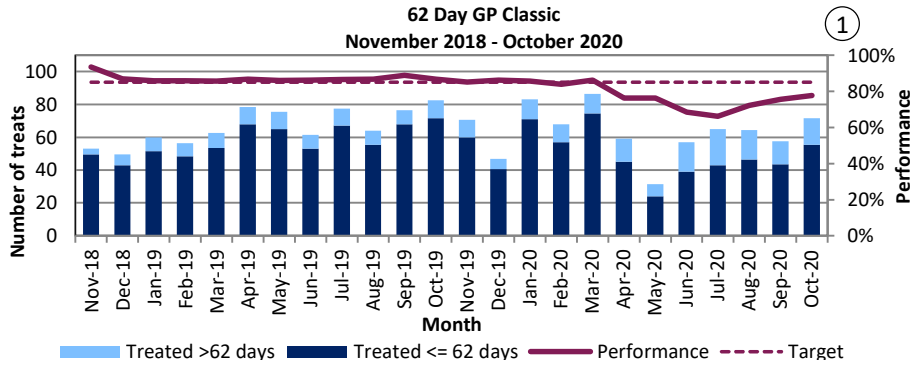
Accountable: Chief Operating Officer **Data Owner:** Cancer Performance

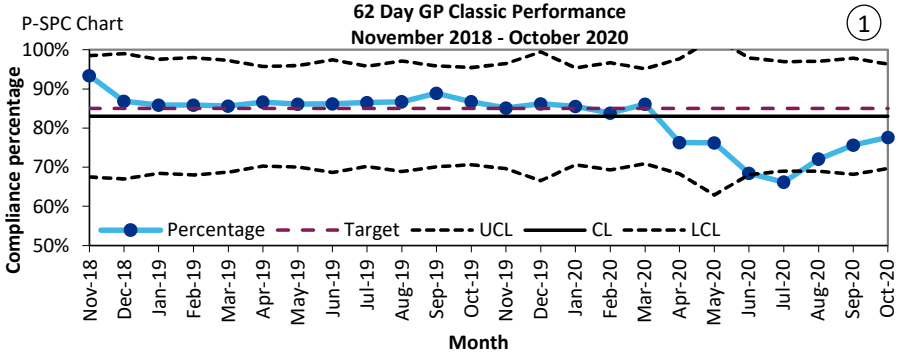
Key Narrative: 1149 rapid access referrals were seen in October 2020, the second highest month across the 24-month period reported.

The 2 week wait performance has consistently delivered above the 93% standard with the exception of April 2020. The P-SPC chart adjusts the control limits to take into account the denominator.

Latest month's data provisional.

62 Day





	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
104+day Confirmed Cancer	2	3	3	0	3	2	1	8	20	7	2	3

Accountable: Chief Operating Officer **Data Owner:** Cancer Performance

Key Narrative: Delivery against the 62-day standard remains a challenge, performing below the standard for the last 7 months. The performance in October 2020 was 77.6% with performance increasing over the last 3 months.

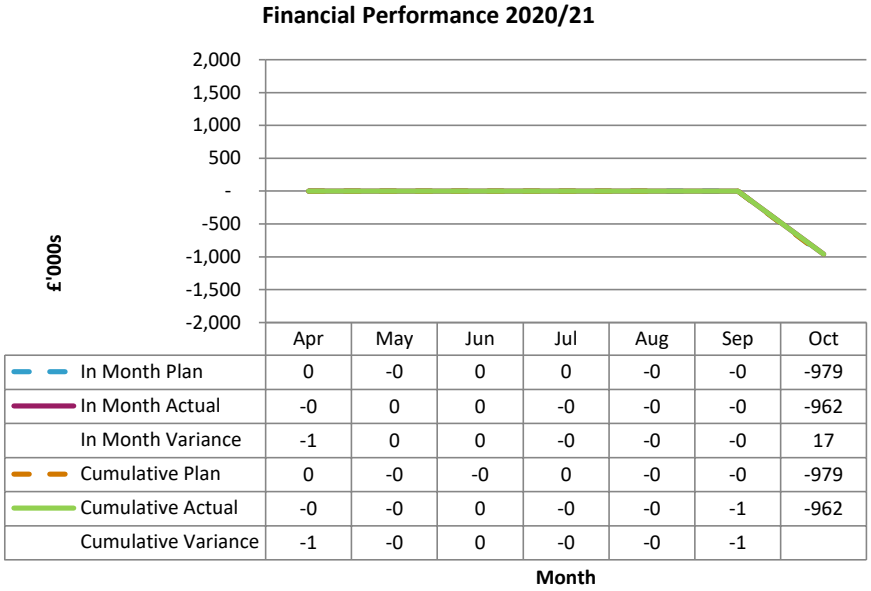
The P-SPC chart adjusts the control limits to take into account the denominator.

Latest month's data provisional.

Data Rating: ①captured locally, ②system captured, ③ published/benchmarked

Board Papers - Finance

Financial Performance



	Apr	May	Jun	Jul	Aug	Sep	Oct
In Month Plan	0	-0	0	0	-0	-0	-979
In Month Actual	-0	0	0	-0	-0	-0	-962
In Month Variance	-1	0	0	-0	-0	-0	17
Cumulative Plan	0	-0	-0	0	-0	-0	-979
Cumulative Actual	-0	-0	0	-0	-0	-1	-962
Cumulative Variance	-1	-0	0	-0	-0	-1	

	YTD Rating		YE Rating	
Indicator	**Plan**	**Actual**	**Forecast**	**Status**
Finance				
Use of Resource Rating				
Capital Service Capacity				
Liquidity				
I&E Margin				
Distance from Financial Plan				
Agency Spend				

Accountable: Director of Finance **Data Owner:** Finance Department

Current view

The first half of the financial year saw the Trust having a break-even position, in line with national guidance. For the second half of the year, the Trust is forecasting to make a £10.2m deficit and for October it was in line with those expectations, being £17k better than this plan.

The Trust has had months 1-5 Top up funding paid from the previous financial regime, with month 6 currently being validated by regulators.

The overall expenditure has remained at a similar level in month to October, as the restoration activity has continued and Winter planning has been enacted, offset by some of the covid-19 expenditure that was in the early months run rate.

Forward view

Regulators are completing final reviews of the financial forecasts that Trusts have submitted, and therefore it is possible that the £10.2m deficit forecast could still change. It is expected that for the month 8 accounts that the position will be finalised.

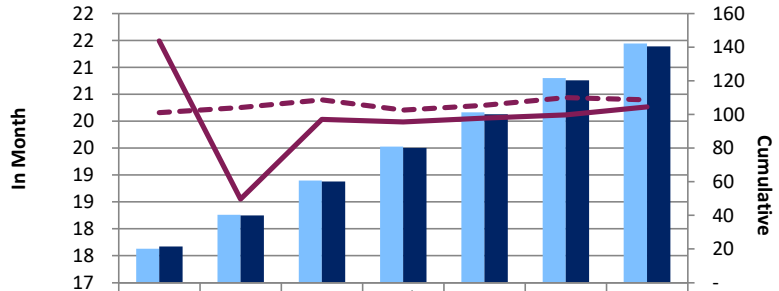
The forecast contains Winter planning, Phase 3 restoration forecast and continuing the support for covid affected areas of the hospital.

Data Rating: ①captured locally, ②system captured, ③published/benchmarked

Board Papers - Finance

Income

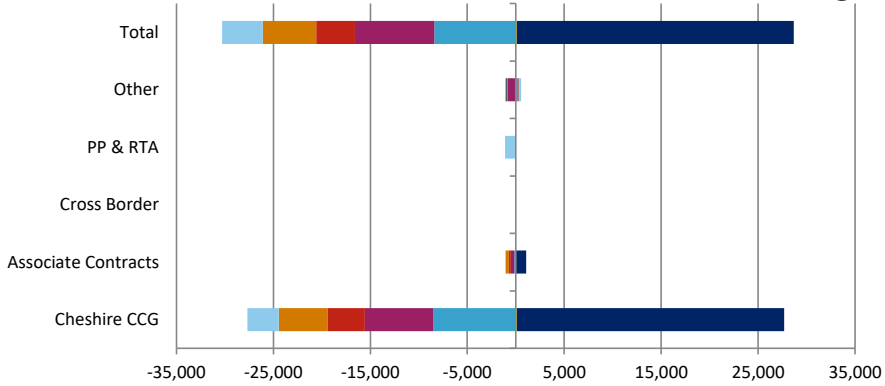
Contract Income Performance 2020/21 £'m ②



	Apr	May	Jun	Jul	Aug	Sep	Oct
Cumulative budget	20	40	61	81	101	122	142
Cumulative actual	21	40	60	80	100	120	141
In month budget	20	20	20	20	20	20	20
In month actual	21	19	20	20	20	20	20

Month

Cumulative Variance to Patient Care Income Plan £'000s ②



	Cheshire CCG	Associate Contracts	Cross Border	PP & RTA	Other	Total
Unplanned Care	-8,512	-151	-27	-	290	-8,399
Day case	-7,053	-343	-2	-	-789	-8,187
Elective	-3,869	-212	-1	-	74	-4,009
Outpatients	-5,002	-342	-2	-	-144	-5,490
High cost drugs	127	10	2	-	-16	122
COVID	27,554	1,069	0	-	-82	28,542
Other Contracts	-3,245	-31	3	-1,117	178	-4,212
Total	1	0	-27	-1,117	-489	-1,632

Accountable: Director of Finance **Data Owner:** Finance department

Current View:

Income from Patient Care activity covers both contract income, Private Patient funding and Injury Cost Recovery Scheme (ICRS) income. This income is £1.6m below plan. Contract (allocation) income is £0.5m below plan which relates to non-contract/cross border flow activity, not currently being billed as part of the covid-19 guidelines. Private patient and the ICRS income is under plan by £1.1m year to date, as a result of the reduced activity within the hospital and social distancing measures in place.

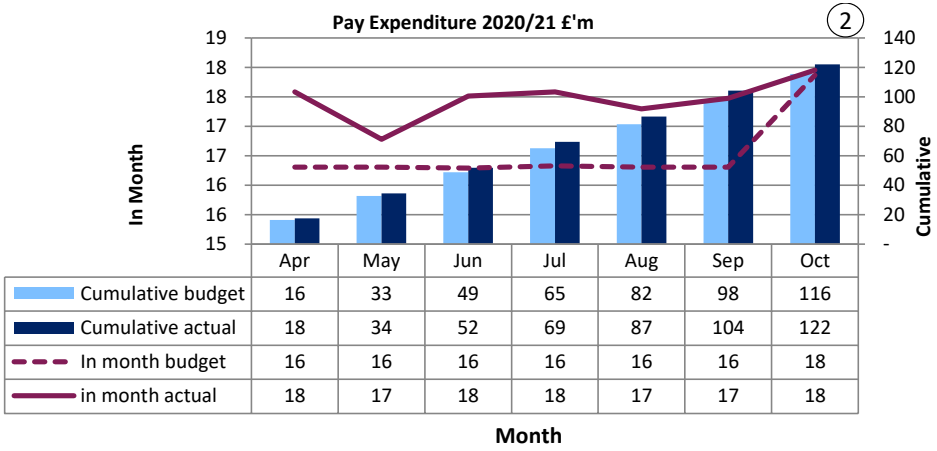
Forward View:

From October onwards block contract income values have been revised, with an expectation organisations manage to a system control total for October to March. The elective incentive scheme has not been factored in to the position, and the Trust is awaiting guidance on how this will be allocated.

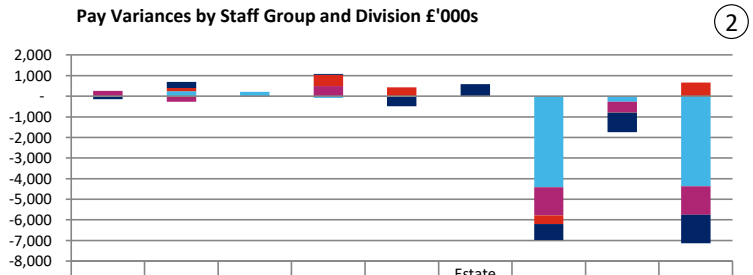
Data Rating: ①captured locally, ②system captured, ③published/benchmarked

Board Papers - Finance

Pay



	Apr	May	Jun	Jul	Aug	Sep	Oct
Cumulative budget	16	33	49	65	82	98	116
Cumulative actual	18	34	52	69	87	104	122
In month budget	16	16	16	16	16	16	18
in month actual	18	17	18	18	17	17	18



	DMEC	S&C	W&C	CSSD	CCICP	Estates	COVID	Other	Total
Total	117	434	166	1,005	-57	579	-6,974	-1,738	-6,468
Infrastructure Support Staff	-115	296	-31	58	-455	579	-764	-944	-1,375
Non Clinical Staff	-14	155	-4	543	435	-	-430	-19	665
Medical Staff	263	-262	-8	487	0	-	-1,367	-503	-1,390
Nursing Staff	-17	245	210	-82	-37	-	-4,413	-272	-4,367

Accountable: Director of Finance **Data Owner:** Finance Department

Current View:

Whilst the cumulatively Pay was worse than the NHSI expectation by £6.4m, for the first 6 months of the year – for October, it is £85k worse that the forecast. This reflects the revised forecast for the second half of the year.

The direct costs associated with covid-19 are £7m and are broken down into areas such as the bank incentive (£1.3m), additional medical costs (£1.6m), increase acuity for rotas and infection control measures (£2.1m) and the impact of increase sickness & quarantine for staff (£2m).

Forward View:

There is significant pressure on the pay budgets as a result of measures put in place to support the Trust with the pandemic, which will continue into Q3 of 2020/21.

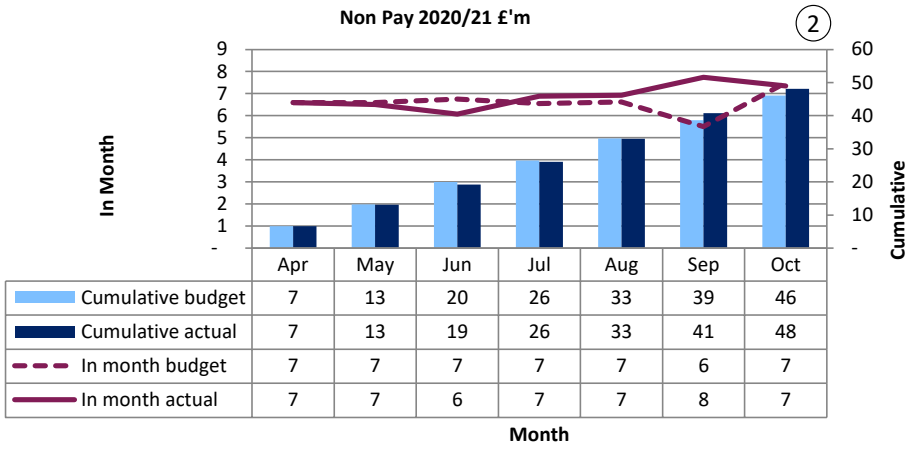
The forecast has also taken into account the additional pressure expected over the winter period, which will increase the pay expenditure.

Within the forecast for the second half of the year, there has been a level of premium cost built in to support an increase in outsourcing and others ways of increasing capacity to achieve the phase 3 restoration of services, however as all Trusts are pressured with delivering an increase in performance – this will be depended on availability of workforce.

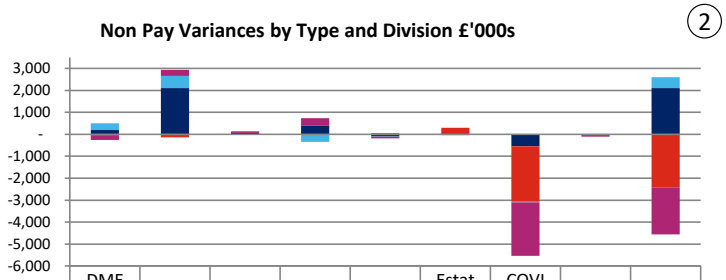
Data Rating: ①captured locally, ②system captured, ③ published/benchmarked

Board Papers - Finance

Non-Pay



	Apr	May	Jun	Jul	Aug	Sep	Oct
Cumulative budget	7	13	20	26	33	39	46
Cumulative actual	7	13	19	26	33	41	48
In month budget	7	7	7	7	7	6	7
In month actual	7	7	6	7	7	8	7



	DMEC	S&C	W&C	CSSD	CCICP	Estates	COVID	Other	Total
Total	245	2,797	137	389	-139	256	-5,535	-109	-1,958
Other Non Pay	-225	270	71	327	-77	-35	-2,434	-27	-2,131
Drugs	306	562	7	-339	-2	-0	-25	-14	496
Non Clinical Supplies	-36	-141	-3	0	43	239	-2,527	1	-2,423
Clinical Supplies	200	2,106	63	401	-103	52	-549	-69	2,100

Accountable: Director of Finance **Data Owner:** Finance Department

Current View:

Non Pay was £2m worse than the expectations set out by NHSI regulators, for the first half of the financial year – however October is better than budgeted by £139k, which reflects the first month's forecast for the second half of the year.

The in month position reflects a reduction in run rate spend of covid-19 related non pay costs, and to date the Trust has spent £5.5m on costs associated with covid-19.

The in month reduction, has been offset by a continued increase in expenditure for clinical supplies and outsourcing as the phase 3 restoration plans, and there has been an increase of £0.5m in these areas as the plans for restoration have been enacted.

Forward View:

There are considerable challenges associated with securing the supply of PPE, which presents a challenge when looking to forecast for the remainder of the year – particularly as the Trust looks to support the restoration of services.

At the end of the first quarter the Trust was underspending in key planned care areas by £1m a month. This has decreased in the second quarter, and it is forecast that non pay will increase by circa £5m in the second half of the year in order to support restoration of services.

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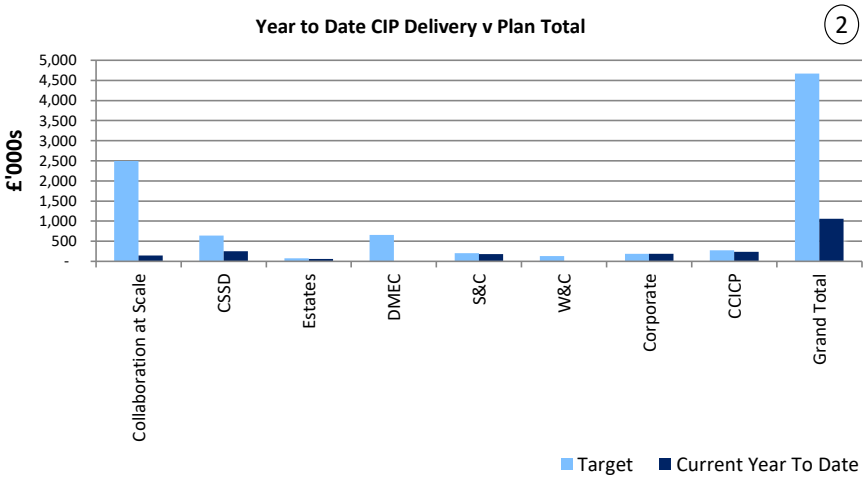
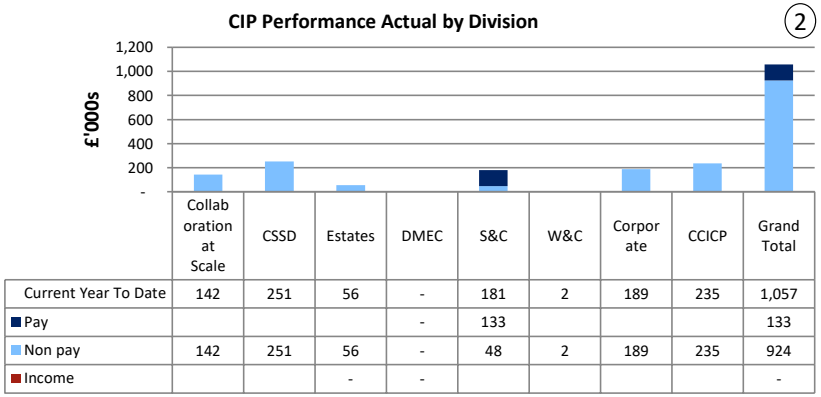
Board Papers - Finance

Cost Improvement Programmes (CIP)





	Collaboration at Scale	CSSD	Estates	DMEC	S&C	W&C	Corporate	CCICP	Grand Total
Current Year To Date	142	251	56	-	181	2	189	235	1,057
Pay				-	133				133
Non pay	142	251	56	-	48	2	189	235	924
Income			-	-					-

Accountable: Director of Finance **Data Owner:** Finance Department

Current View:

The Trust is not currently being managed by regulators in terms of a cost improvement programme. The targets shown within the graph opposite illustrate the indicative cost savings expected in accordance with the draft plan.

However, the Trust is continuing to look to support either existing schemes or new schemes that can progress in areas of the hospital that have capacity to support focus around this, which is being managed via the monthly finance meetings, with a particular focus on collaboration at scale schemes that can be progressed.

Saving schemes that will be progress this year, at present are focussed on having no or low patient impact.

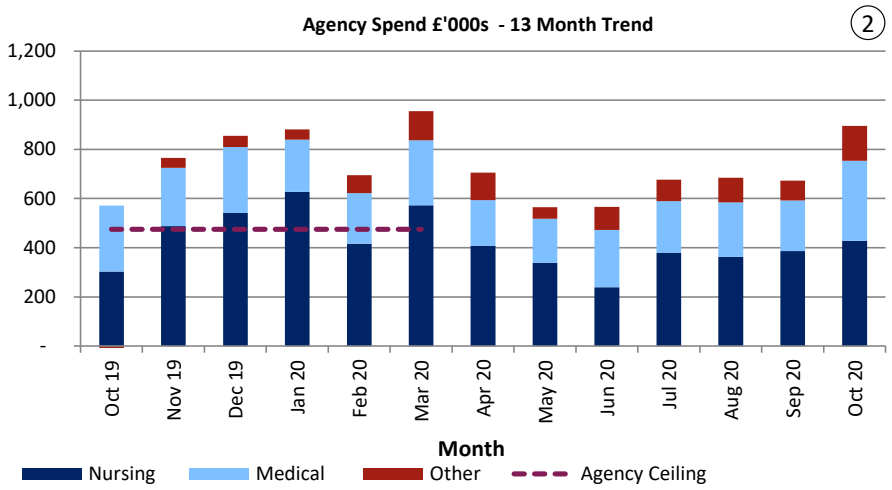
Forward View:

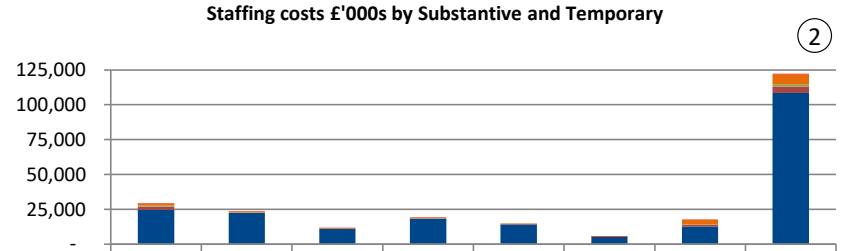
Work that the collaboration at scale work stream has previously put forward for system wide opportunities will be reviewed both in terms of time frames in light of the impact of Covid-19 - but also their direct impact on the Trust.

Data Rating: ①captured locally, ②system captured, ③ published/benchmarked

Board Papers - Finance

Bank and Agency





	DMEC	S&C	W&C	CSSD	CCICP	Estates	Other	Total
Total	29,380	23,569	11,546	19,267	15,015	5,745	17,676	122,198
Waiting List	129	113	15	49	-	0	174	481
Bank	1,704	528	510	528	280	275	3,359	7,185
Locum	509	208	18	225	223	-	166	1,349
Agency	2,361	424	70	259	297	0	1,355	4,765
Substantive	24,677	22,295	10,932	18,207	14,215	5,469	12,622	108,417

Accountable: Director of Finance **Data Owner:** Finanace Department

Current View:

Agency expenditure increased in the month from September to £0.895m. Within registered nursing, the challenge with agency use lies within the Emergency Department, and other key specialised areas such as the Child & Adolescent unit – which has seen an increase as the Winter planning has been implemented.

In other areas, there has been an increase in the medical agency spend as part of the Winter planning preparation and there has also be agency spend in relation to supporting the informatics team in managing a period of significant vacancy.

Forward View:

Cohort 4 of the international nurse recruitment scheme are with the Trust, and are undergoing an intensive programme aimed to try and shorten the period they require to registered nurses within the UK. The Trust has also been pro-active in offering nurses who undertook final year paid placements contracts in advance anticipating a required increase ahead of Winter. This is positive for the Trust, in supporting the plan to close the nurse vacancy gaps, however it cannot be underestimated the level of challenge that the coming Winter is expected to bring.

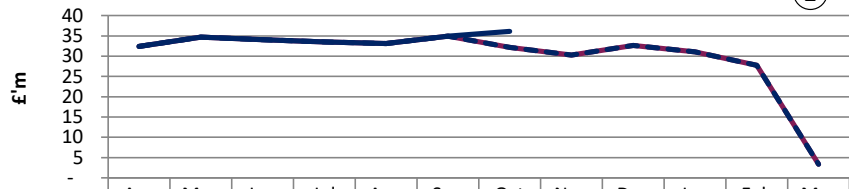
There are challenges within the specialist areas within nursing, which is now where some of the focus needs to be with workforce planning, particularly within the Emergency Department, along with the other specialisms such as medical workforce that will need to be reviewed.

Data Rating: ①captured locally, ②system captured, ③ published/benchmarked

Board Papers - Finance

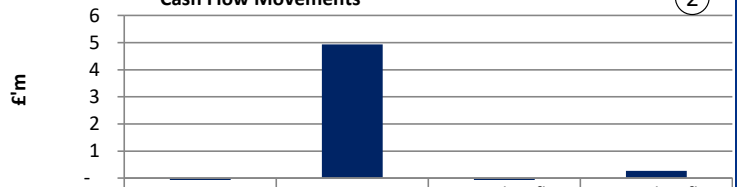
Cash

Cash Position ②



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Plan	32	35	34	34	33	35	32	30	33	31	28	3
Actual	32	35	34	34	33	35	36					
Forecast	32	35	34	34	33	35	32	30	33	31	28	3

Cash Flow Movements ②



	Operating Surplus / (Deficit)	Increase / (Decrease) in Working Capital	Net Cash Inflow / (Outflow) from Capital Expenditure	Net Cash Inflow / (Outflow) from Borrowings
Variance to Opening Balance	-0	5	-1	0

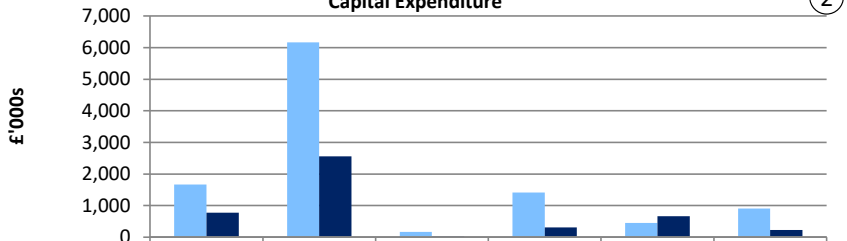
Accountable: Director of Finance **Data Owner:** Financial Services

Current View: Based on the revised plan for 20/21, Cash is better than anticipated by £4m. This is mainly due to an increase in Trade Payables of £2.5m, and £1.5m income received in advance for COVID Top-up.

Forward View: The cash position includes £20m of contract income paid in advance to support cash flow during the COVID-19 pandemic, this is expected to be repaid in March 2021.

Capital

Capital Expenditure ②



	Rolling Estates	Strategic Estates	Rolling IT	Strategic IT	Other	Leases
Plan	1,665	6,163	164	1,413	445	906
Actual	778	2,559	26	304	659	225

②

		Year to Date £'000s			Year End £'000s		
		Plan	Actual	Variance	Plan	Forecast	Variance
Estates	Rolling	1,665	778	-887	4,292	4,879	587
Estates	Strategic	6,163	2,559	-3,604	8,223	7,370	-853
IT	Rolling	164	26	-138	353	305	-48
IT	Strategic	1,413	304	-1,109	5,655	1,686	-3,969
Other		445	659	214	11,152	10,697	-455
Leases		906	225	-681	3,679	2,500	-1,179
		10,756	**4,552**	**-6,204**	**33,354**	**27,437**	**-5,917**

Accountable: Director of Finance **Data Owner:** Financial Services

Current View: The underspends on capital schemes are due to slippage on six major schemes, notably Maintenance & Refurbishment of £1.6m and Car Park Expansion £1.1m.

Forward View: The EPR and EPMA schemes are expected to slip into 21/22 to the value of £3m. New schemes added to the plan and forecast for ED £9.4m and Endoscopy £0.8m.

Data Rating: ①captured locally, ②system captured, ③ published/benchmarked

Board Papers - Finance

Statement of Financial Position October 2020

(2)

		Plan Apr to October (£'000)	Actual Apr to October (£'000)	Variance (£'000)
Assets	Assets, Non-Current	104,878	105,360	482
	Assets, Current	48,675	51,703	3,028
ASSETS, TOTAL		**153,553**	**157,063**	**3,510**
Liabilities	Liabilities, Current	-43,789	-47,269	-3,480
	Liabilities, Non Current	-8,788	-8,801	-13
TOTAL ASSETS EMPLOYED		**100,976**	**100,993**	**17**
Taxpayers' and Others' Equity				
	Taxpayers Equity	100,976	100,993	17
TOTAL FUNDS EMPLOYED		**100,976**	**100,993**	**17**

Accountable: Director of Finance **Data Owner:** Financial Services

Current View:
The main Balance Sheet movement is an increase in Trade Payables of £2.5m, due to the relaxation of COVID payment policies. In addition, £1.5m of COVID Top-up funding has been received in advance.

Deferred Income includes £20m of additional contract payments to support COVID-19 cash flows, which is anticipated to be repaid in March 2021.

Forward View:
Over the coming months the only significant changes anticipated to the Balance Sheet is the receipt of funding for the new ED build, and additional funding Endoscopy.

COVID Capital Schemes October 2020

Bid Month	Scheme Description	Scheme Rationale	Scheme Type	Bid Value	Year to Date £'000s		
				£'000s	Plan	Actual	Variance
Apr-19	Voice over IP	Enables Switchboard virtual operator	IT	91	91	91	0
May-19	Upgrade of Oxygen Supply	To enable the use of CPAP and Ventilators	Infrastructure	56	56	56	0
May-19	Blood Gas GEM 5000	Additional required	Clinical Equipment	39	39	39	0
May-19	IMPRIVATA: ONESIGN SINGLE	Single Sign on enablement	IT	109	109	109	0
May-19	Armstrong FD140 Vents	For CPAP	Clinical Equipment	90	90	90	0
May-19	Trilogy Ventilator	For CPAP	Clinical Equipment	31	31	31	0
May-19	Benevision N17 touch Elan	Patient Monitoring	Clinical Equipment	73	73	73	0
				489	**489**	**489**	**0**

(2)

Accountable: Director of Finance
Data Owner: Financial Services

Current View:
These capital schemes are now all spent, however to date the agreed funding has not yet been received.

Forward View:
Funding to be followed up with NHSI.

Data Rating: ①captured locally, ②system captured, ③published/benchmarked

Board Papers - Finance

Income and Expenditure

Budget 2020/21 £'000		Month: Plan Oct (£'000)	Month: Actual Oct (£'000)	Month: Variance Oct (£'000)	Year to Date: Plan April to Oct (£'000)	Year to Date: Actual April to Oct (£'000)	Year to Date: Variance April to Oct (£'000)	Forecast: 2020/21 (£'000)
	Operating							
	Operating Income							
	Commissioning Income							
222,328	Inter System Block	18,682	18,677	-5	128,918	128,919	1	222,328
19,555	Intra System Block	1,597	1,472	-125	11,571	11,130	-441	19,555
180	Non Block	12	18	6	122	47	-74	180
242,063	**Total Commissioning Revenue**	**20,290**	**20,167**	**-123**	**140,611**	**140,096**	**-515**	**242,063**
12,616	*Other Operating Income*	1,743	1,816	73	13,733	12,342	-1,391	12,616
0	*Inter-Trust Income*	0	0	0	0	0	0	0
254,679	**TOTAL OPERATING INCOME**	**22,033**	**21,983**	**-50**	**154,344**	**152,438**	**-1,906**	**254,679**
	Operating Expenses							
-205,373	Employee Benefits Expenses (Pay)	-17,872	-17,957	-85	-115,730	-122,198	-6,468	-205,373
-17,803	Drugs	-1,481	-1,505	-23	-10,396	-9,900	496	-17,803
-19,388	Clinical Supplies	-1,649	-1,555	93	-11,301	-9,201	2,100	-19,388
-3,725	Non Clinical Supplies	-317	-390	-73	-2,160	-4,583	-2,423	-3,725
-46,634	Other operating expenses	-4,040	-3,898	142	-22,248	-24,378	-2,131	-46,634
-292,924	**TOTAL OPERATING EXPENSES**	**-25,359**	**-25,305**	**54**	**-161,834**	**-170,260**	**-8,426**	**-292,924**
-38,245	**EBITDA**	**-3,326**	**-3,322**	**4**	**-7,490**	**-17,822**	**-10,331**	**-38,245**
	Non Operating							
	Non Operating Income							
-379	Interest	-21	-19	1	-270	-100	169	-379
0	Asset disposal	0	0	0	0	0	0	0
	Non-Operating Expenses							
-6,432	Depreciation & Finance Leases	-534	-505	30	-3,760	-3,425	335	-6,432
-2,248	PDC Dividend Expense	-187	-180	7	-1,311	-1,260	51	-2,248
-47,304	**Adjusted Financial Performance surplus/(deficit)**	**-4,068**	**-4,026**	**42**	**-12,831**	**-22,606**	**-9,776**	**-47,304**
8,762	Baseline M1 - 6	0	0	0	8,762	8,762	0	8,762
9,818	COVID Top Up M1 - 6	0	0	0	0	9,818	9,818	9,818
9,798	Baseline M7-12	1,633	1,633	0	1,633	1,633	0	9,798
8,736	COVID Top Up M7 - 12	1,456	1,456	0	1,456	1,456	0	8,736
-10,190	**Net Surplus/(deficit) before Exceptional Items**	**-979**	**-937**	**42**	**-979**	**-937**	**42**	**-10,190**
0	Donations for purchase of assets	0	0	0	0	0	0	0
0	Depreciation on Donated Assets	0	-25	-25	0	-176	-176	0
0	Prior Period Adjustments	0	0	0	0	0	0	0
-10,190	**Net Surplus/(Deficit) after Exceptional Items**	**-979**	**-961**	**18**	**-979**	**-1,112**	**-133**	**-10,190**

Data Rating: ①captured locally, ②system captured, ③published/benchmarked

Board Papers - Finance

Balance Sheet

Current Position:

Assets Non-Current
The capital programme expenditure is £6.2m less than the anticipated plan, mainly due to slippage on the Maintenance & Refurbishment of £1.6m and Car Park Expansion £1.1m.

Assets Current
Trade receivables lower by £1.0m mainly due to prompt payments by NHS organisations. Cash is better than plan by £4m, and also includes £20m of contract income being paid in advance to support cash flow during the COVID pandemic.

Current Liabilities
Trade Payables has increased by £2.5m due to the relaxation of COVID payment terms. Deferred Income includes an additional £20m contract payments to support COVID cash flows. Loans of £13.2m coverted to PDC.

Taxpayers Equity
Working Capital Loans and the Interim Capital Loans to the value of £13.2m have been converted to PDC in September.

	Plan Apr to October (£'000)	Actual Apr to October (£'000)	Variance (£'000)
Assets			
Assets, Non-Current	**104,878**	**105,360**	**482**
Assets, Current			
Trade and other Receivables	10,034	8,986	-1,047
Other Assets (including Inventories & Prepayments)	6,455	6,600	146
Cash and Cash Equivalents	32,187	36,116	3,929
Total Assets, Current	**48,675**	**51,703**	**3,028**
ASSETS, TOTAL	**153,553**	**157,063**	**3,510**
Liabilities			
Liabilities, Current			
Finance Lease, Current	-589	-548	41
Loans Commercial Current	-203	-192	11
Trade and Other Payables, Current	-10,895	-13,588	-2,692
Provisions, Current	-242	-277	-35
Other Financial Liabilities	-31,860	-32,665	-805
Total Liabilities, Current	**-43,789**	**-47,269**	**-3,480**
Net Current Assets/(Liabilities)	**4,886**	**4,434**	**-452**
Liabilities, Non Current			
Finance Lease, Non Current	-3,189	-3,202	-13
Loans Commercial Non-Current	-3,651	-3,651	0
Provisions, Non-Current	-1,948	-1,948	0
Trade and Other Payables, Non-Current	0	0	0
Total Liabilities Non-Current	**-8,788**	**-8,801**	**-13**
TOTAL ASSETS EMPLOYED	**100,976**	**100,993**	**17**
Taxpayers' and Others' Equity			
Taxpayers Equity			
Public dividend capital	96,336	96,336	0
Retained Earnings	-12,645	-12,628	17
Donated asset reserve	0	0	0
Revaluation Reserve	17,285	17,285	0
TOTAL TAXPAYERS EQUITY	**100,976**	**100,993**	**17**
TOTAL FUNDS EMPLOYED	**100,976**	**100,993**	**17**

Forward View:

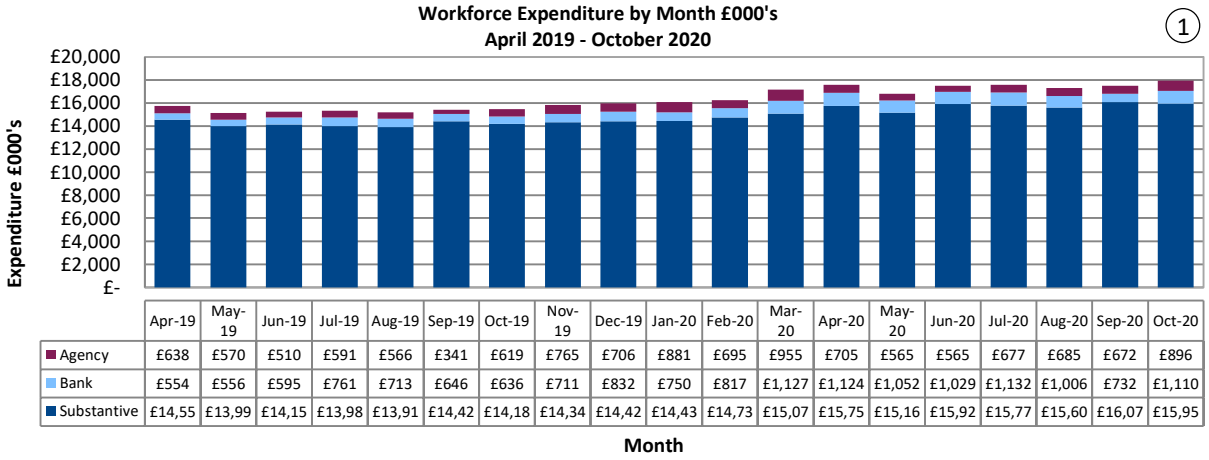
The forecast has been updated to include additional PDC funding and capital spend in relation to the ED build £9.4m and Endoscopy £0.8m.

Cash flows are expected to remain consistent with regular cash coming in, and with regular payments being made to suppliers.

Data Rating: ①captured locally, ②system captured,③published/benchmarked

Board Papers - Workforce

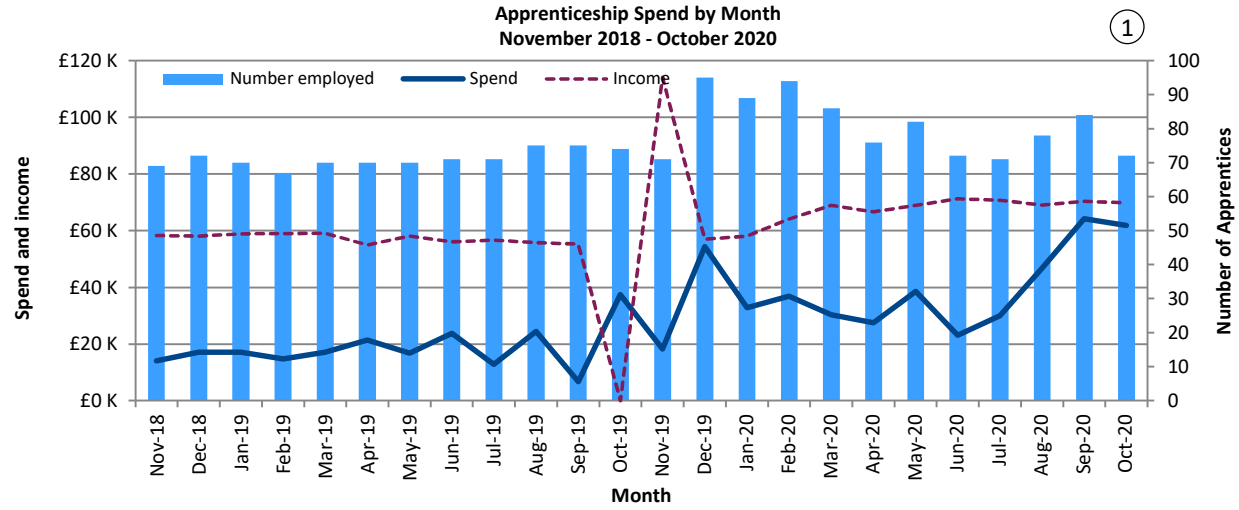
Finance and Costings



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
Agency	£638	£570	£510	£591	£566	£341	£619	£765	£706	£881	£695	£955	£705	£565	£565	£677	£685	£672	£896
Bank	£554	£556	£595	£761	£713	£646	£636	£711	£832	£750	£817	£1,127	£1,124	£1,052	£1,029	£1,132	£1,006	£732	£1,110
Substantive	£14,55	£13,99	£14,15	£13,98	£13,91	£14,42	£14,18	£14,34	£14,42	£14,43	£14,73	£15,07	£15,75	£15,16	£15,92	£15,77	£15,60	£16,07	£15,95

Accountable: Director of Workforce & Organisational Development
Data Owner: Workforce Directorate

Key Narrative: Total workforce expenditure for October 2020 is £17,957k, an increase of £481k (2.8%) from the previous month and 16.3% higher than October 2019. The year to date expenditure is £6,466k above budget (5.6%).



Accountable: Director of Workforce & Organisational Development
Data Owner: Workforce Directorate

Key Narrative: The number of Apprentices employed in October 2020 was 72, similar to the number employed in October 2019.

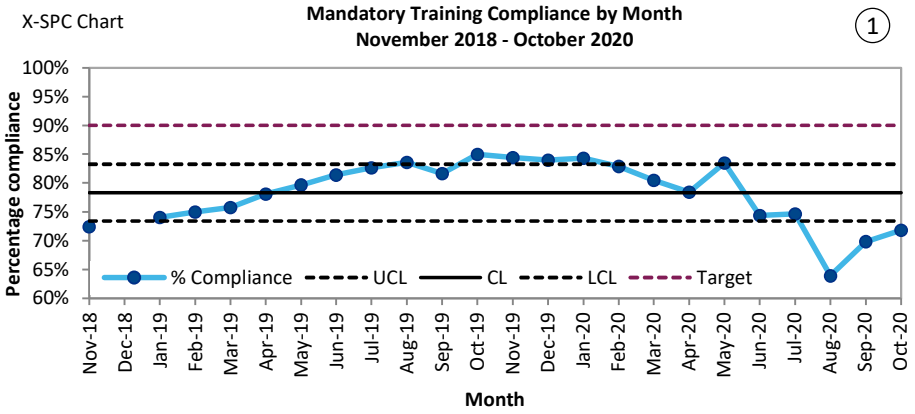
Apprenticeship spend has increased in recent months and has been running close to income levels for the last 2 months.

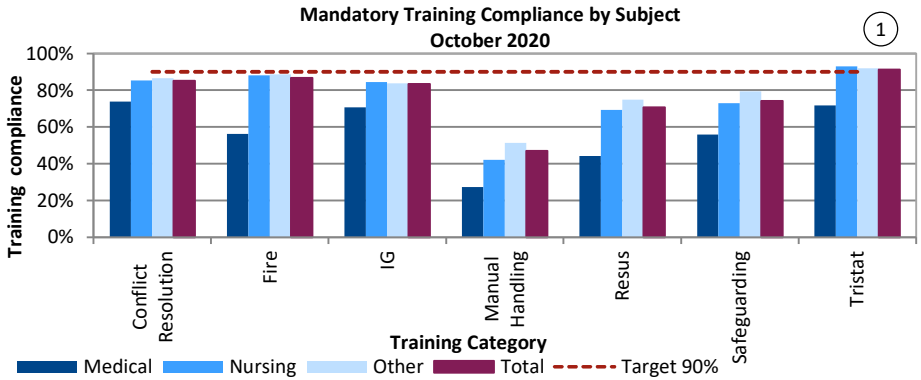
Data Rating: ①captured locally, ②system captured, ③ published/benchmarked

Board Papers - Workforce

Training

X-SPC Chart

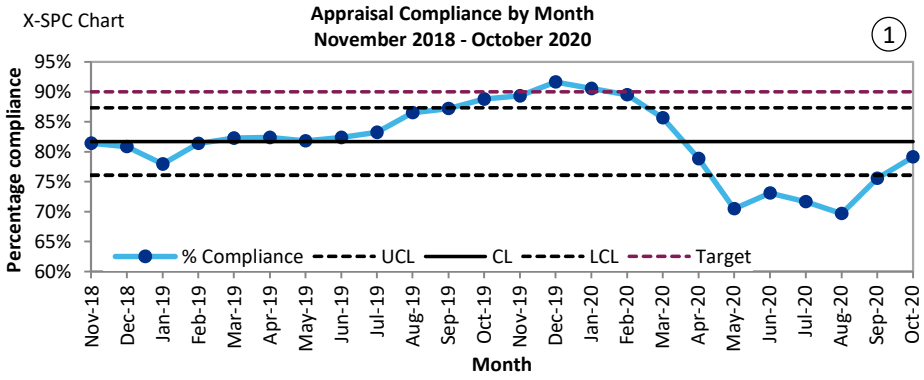


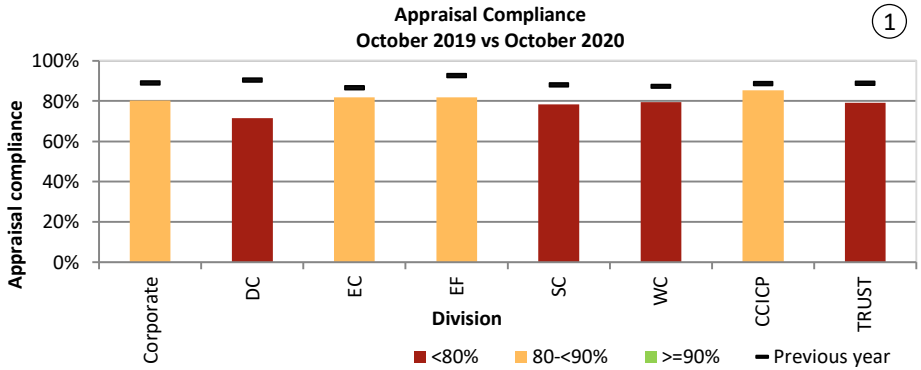


Accountable: Director of Workforce & Organisational Development
Data Owner: Workforce Directorate
Key Narrative: The SPC chart shows an increasing trend from October 2018 to August 2019 but remaining below the 90% target. There has been a decline in compliance in recent months with August 2020 having the lowest compliance, with improvements seen in the last 2 months.

Appraisals

X-SPC Chart





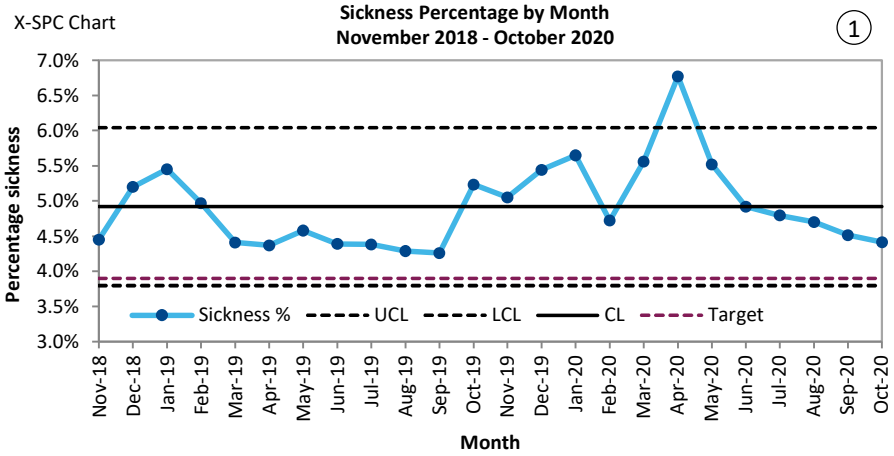
Accountable: Director of Workforce & Organisational Development
Data Owner: Workforce Directorate
Key Narrative: The SPC chart shows an increasing trend of compliance from June 2019 which peaked in December 2019, 1 of only 2 months to meet the 90% target over the 24 month period. Compliance has fallen below the lower control limit for the last 5 reported months with compliance increasing in the last 2 months.

Data Rating: ①captured locally, ②system captured, ③ published/benchmarked

Board Papers - Workforce

Sickness

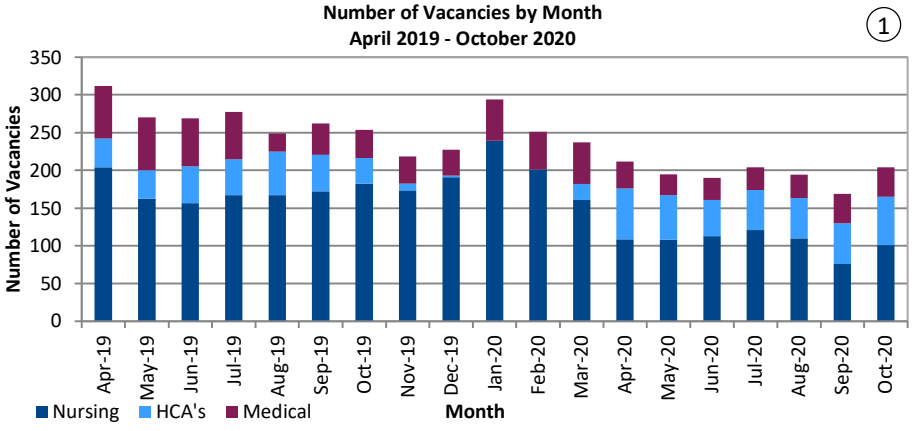
X-SPC Chart



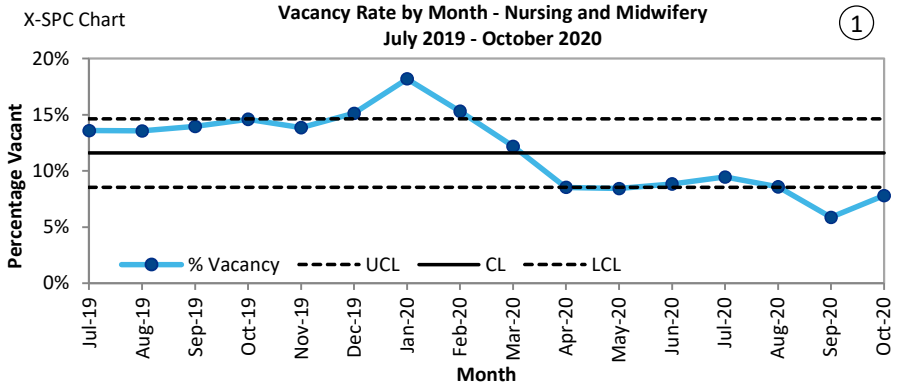
Accountable: Director of Workforce & Organisational Development
Data Owner: Workforce Directorate

Key Narrative: There has been a steady reduction in sickness levels in the last few months with October 2020 sickness rates reported as 4.4%. The target has not been met over the 24-month period reported.

Vacancies



X-SPC Chart

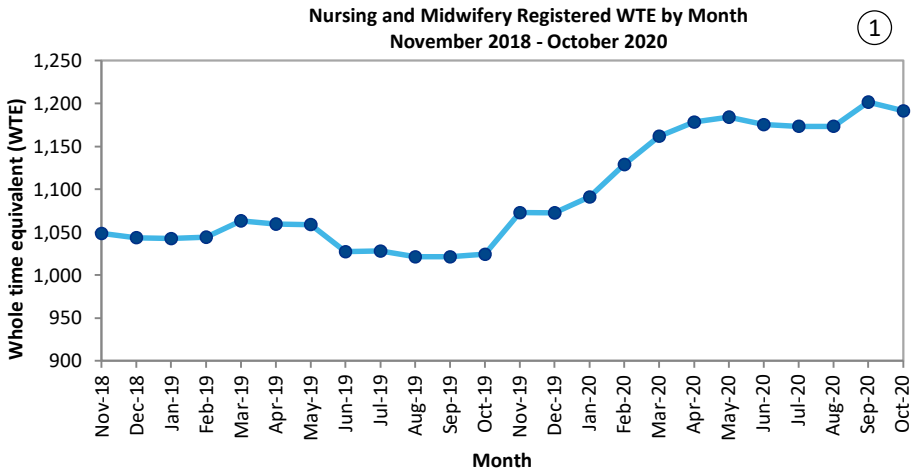


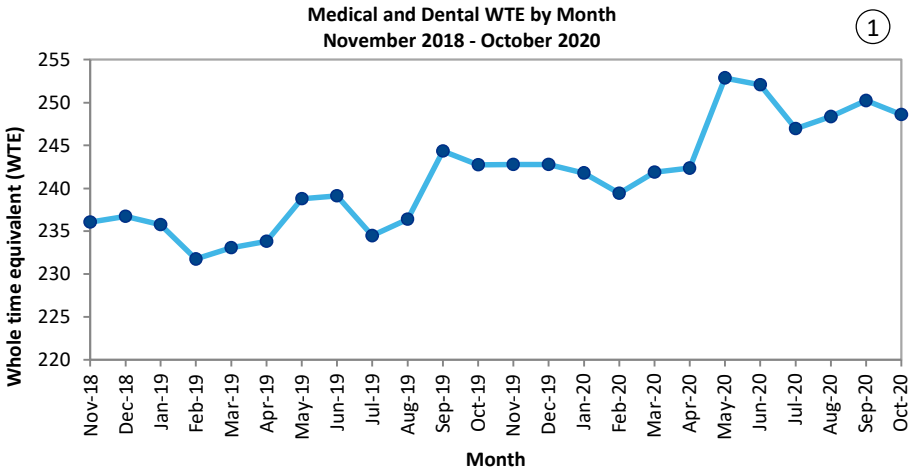
Accountable: Director of Workforce & Organisational Development
Data Owner: Workforce Directorate
Key Narrative: The vacancy figures for the current financial year have been restated to exclude International Recruitment, Nurse Apprentices and COVID. There has been a marked improvement in the number and percentage of vacancies in the current financial year.

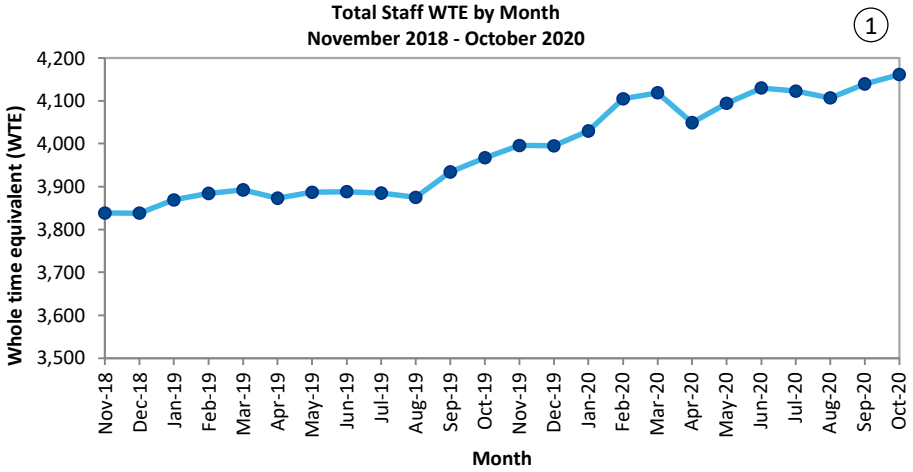
Data Rating: ①captured locally, ②system captured, ③ published/benchmarked

Board Papers - Workforce

Total Staff Whole Time Equivalent (WTE)







Accountable: Director of Workforce & Organisational Development
Data Owner: Workforce Directorate

Key Narrative: The chart shows an increasing trend of total staff WTE over the 24 month period increasing by more than 200 between November 2018 and October 2020.

Data from ESR report: Monthly staff in post (WTE)

Data Rating: ①captured locally, ②system captured, ③ published/benchmarked

BOARD OF DIRECTORS

Agenda Item	**7.1**	Date of Meeting: 07/12/2020
Report Title	**Quality Account 2019-20**	
Executive Lead	Julie Tunney, Director of Nursing & Quality	
Lead Officer	Laura Egerton, Head of Nursing Engagement and Wellbeing	
Action Required	To approve	

X **Acceptable assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of controls

Key Messages of this Report *(2/3 headlines only)*

- Priorities for improvement 19/20 and statements of assurance
- Review of quality performance
- Priorities for improvement 20/21

Next Steps (*actions to be taken following agreement of recommendation/s by Board/Committee)*

- Report submission on the 15th December 2020.

Strategic Objective(s) *(indication of which objective/s the report aligns to)*

• Manage Covid response and recovery	☐	• Provide safe and sustainable services	✓
• Provide outstanding care/patient experience	✓	• Provide strong system leadership by working together	✓
• Deliver most effective care to achieve best possible outcomes	✓	• Be well governed and clinically led	✓
• Be the best place to work	✓		

Impact *(is there an impact arising from the report on the following?)*

• Quality	✓	• Compliance	☐
• Finance	☐	• Legal	☐
• Workforce	☐	• Risk/BAF BAF9 Activity and patient outcome data	
• Equality	☐		

Equality Impact Assessment (*must accompany the following submissions)*

Strategy ☐ Policy ☐ Service Change ☐

REPORT DEVELOPMENT

Committee/ Group Name	Date	Report Title	Lead	Brief summary of key issues raised and actions agreed
N/A				

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

Quality Account 2019/20

Quality and Safety at Heart
Mid Cheshire Hospitals NHS Foundation Trust

Quality Account 2019/20


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

Part 1

Statement on Quality from the Chief Executive

It has been a very challenging but productive year at Mid Cheshire Hospitals NHS Foundation Trust, and I am delighted to share some of our work through the Quality Account for the period of April 2019 to March 2020.

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

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

One of the key challenges we have faced during 2020 is our response to the Coronavirus Pandemic (COVID-19). The Trust has implemented many changes to the core function of the organisation in accordance with the requirements set down by Public Health England and NHS England. In response to Covid19 the Trust has worked within the Outbreak Policy and Emergency Preparedness Pandemic Policy to implement changes across the organisation to support patients and staff either suspected or confirmed as COVID 19 positive, including increasing Critical Care Capacity, redefining ward areas to ensure strict infection prevention and control and providing staff with the correct Personal Protective Equipment and training.

As a result of the Coronavirus Pandemic a number of monitoring elements have been suspended under the quality and safety priorities. Despite the suspension of monitoring requirements, we have continued to make good progress on our Quality and Safety Improvement Strategy; progress which has largely been achieved collaboratively as a result of the hard work, commitment and dedication of all of our staff.

We recognise that providing health care is not without risk and that sometimes patients can be unintentionally harmed in the care of hospitals. You will read throughout this Quality Account of the Trusts ambitious aims to continue to reduce harm across our organisation. Our Quality and Safety Improvement Strategy is the vehicle by which we have steered the direction of travel for quality and safety focusing on the 9 indicators below;

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

For the year 2019/20 the Trust continued to deliver a high quality, timely service to our patients. Prior to the suspension of non-urgent clinical activity due to Covid 19, the Trust's waiting times elective and cancer care were one of the highest performing in the country. We are now working hard to restore these services fully whilst operating in this new world challenged by the threat of Covid 19 infection.

Key achievements for the Trust in 2019/20 include;

- The Trust received a CQC rating of Good in November 2019.
- The Trust is pleased to report 0 MRSA blood stream infections attributable to the Trust reported during 2019/20. This has been due to the sustained focus on strategies to reduce the risk of avoidable cases including embedding Aseptic Non Touch Technique (ANTT) in practice across the organisation.
- The Trust launched the ward accreditation programme 'Going for Gold'. The ward accreditation programme ensures high quality, safe and compassionate care services across the organisation. During 2019/20 16 wards received an accreditation; of these wards the Trust awarded 1 gold ward, 7 silver wards, 5 bronze wards and 3 white wards.
- The Trust has successfully implemented E-Rostering across 27 wards/units.
- The Trust submitted two applications for the Patient Experience Network National Awards (PENNA) with the voluntary services project shortlisted under the Strengthening the Foundation category. The awards were due to be held in March 2020 but were postponed due to the coronavirus pandemic. PENNA are revising plans for the awards and the announcement of winners is currently awaited.
- Winsford District Nursing team achieved 1000 days without a category 3 or 4 pressure ulcer developing in the teams care. This is an outstanding achievement and dedication to the quality care provided by the nurses within the team.

Patients want to know that they will be provided with the best treatment and care available, based on up-to-date evidence and by well trained staff. This report also demonstrates that the Trust has a number of assurance mechanisms in place which demonstrate how we scrutinise the quality of care we deliver. Examples of these include our extensive audit program and the Commissioning for Quality and Innovation (CQUIN).

Prior to Covid 19 the Trust's Emergency Department waiting times were particularly challenged due to increasing demand. The team at Mid Cheshire implemented an expansion of the Emergency Department and significantly increased the workforce during the year to meet this demand and further plans are underway to continue to expand this service. The Trust has also implemented a safety checklist within the department to ensure patients waiting are safe and being cared for.

With regards to our mortality rates; the latest publication for our mortality data for the reporting period April 2019 to March 2020 demonstrates a SHMI of 99.47 and the Trust remains in the 'as expected' range. This currently places the Trust 54 out of 125 Trusts.

I hope you will enjoy reading about the many examples of the improvement work that teams across the organisation are pursuing. We strive to deliver high quality, safe, cost-effective and sustainable healthcare services that meet the high standards that our patients deserve.

We want MCHFT to continue to be the health care provider that patients trust to provide those highest standards of care - and the organisation that staff have pride in and are willing always to give of their best.

I am pleased to confirm that the Board of Directors has reviewed the 2019/20 Quality Account and agree that it is a true and fair reflection of our performance. We hope that this Quality Account provides you with a clear picture of how important quality improvement and patient safety are to us at MCHFT.

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

James Sumner
Chief Executive
Date: 25 August 2020

Priorities for improvement and statements of assurance from the Board

At Mid Cheshire Hospitals NHS Foundation Trust (MCHFT), we want to be sure that everyone in our local community who may use our services has absolute confidence that our care and treatment is completely patient centred. As a Trust, we are committed to the delivery of our Quality and Safety Improvement Strategy 2020/21.

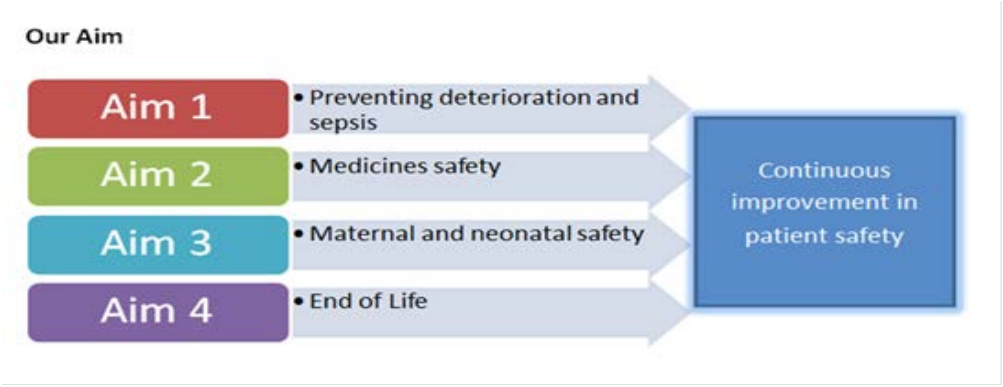
Following the successful completion of the 2019/20 Quality Strategy, the Trust held a limited programme of engagement sessions due to the Covid-19 pandemic, to consult with our stakeholders. The engagement sessions gave us the opportunity to share our achievements and obtain ideas of what we should focus on in the 2020/21 strategy.

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

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

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

In the 2020/21, using the Quality & Safety Improvement Strategy we will continue to learn from experience to ensure reliable, continuous improvement in the quality and safety of our patients. To achieve this we will underpin the Quality & Safety Improvement Strategy with The NHS Patient Safety Strategy 2019 to support safety improvement programmes that prioritise the most important safety issue.



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

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

The first 3 programme aims of work are aligned to those areas already identified nationally as the areas of care delivery where most harm is seen. End of life care is a Trust priority, and so warrants its own priority programme for our 2020/21 Strategy.

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

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

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

The Quality & Safety Improvement Strategy 2020/21 will be monitored through the Quality & Safety Improvement Strategy Steering group on a monthly basis. Each work stream of the strategy will deliver a detailed update of progress to the committee for approval and monitoring. Progress will be escalated to the Trusts Quality Group (TQG) and then escalated to the Trusts Executive Quality Governance Group (EQGG).

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

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

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

Priorities for Improvement in 2019/20: Feedback from patients

Local patient surveys

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

In the financial year 2019/20, 36 surveys were undertaken. These surveys were completed by patients in various settings including whilst they are receiving treatment on the wards, in outpatient clinics, accessing diagnostic testing and in the community.

Three of the local surveys that have taken place in 2019/20 are detailed below:

CT Colonoscopy Survey

Patient satisfaction surveys were given to 75 patients, of which 73 responded, a response rate of 97%.

Key findings:

- 99% of respondents stated that the information leaflet explaining the examination was clear and easy to understand.
- 100% of patients reported that their privacy and dignity was maintained during the examination.
- 89% of patients reported that their appointment has been carried out on time.
- Excellent examples of good practice supported through the patient satisfaction survey results including good appointment timekeeping, high quality patient information and high levels of patient experience reported.

Actions:

- Very positive outcome across the board. The results reiterated the importance of effective staff training in this area and ensuring adequate time is allocated for CT colon appointments.
- To capture more patients through a bigger sample.

Pain Survey

Feedback from 50 patients was captured regarding their experiences whilst receiving care from the acute pain team. The results were collected by one of the patient experience team volunteers through patient interviews.

Key findings:

- 80% of the patient surveys underwent planned surgery and 20% underwent emergency surgery.
- 98% of respondents received pain relief information.
- Results indicated that pain relief information was received in various locations including outpatient clinic, within the hospital ward, at preoperative assessment and at orthopaedic joint school.
- 100% of patients reported they had been asked regularly about their pain throughout the day.
- 96% of patients reported being able to rate their pain using a verbal rating scale e.g. none, mild, moderate, severe.

Actions:

- Pre-printed prescriptions and NMP for availability of prescription
- Review feasibility for 7 day service.

Lindsay's Leg Ulcer Group Survey

The Lindsay Leg Club (LLG) is a leg ulcer clinic run by volunteers offering a social environment to support the clinical side of the service, which is a concept aimed at improving the isolation and social contact for patients in the community.

The club is a national concept but is new to CCICP and the survey considers how patients feel about the 'club' environment, seeks insight into the clinical aspect and whether the LLG offers enough privacy and dignity to individuals.

To explore patient feedback around LLG the team gave out 20 surveys of which 17 were returned, a response rate of 85%.

Key Findings:

- 94% of patients felt there was time to ask questions and felt comfortable asking.
- 94% of patients felt welcomed and relaxed.
- 30% of patients said there was a lack of privacy.
- 94% of patients were happy with the information provided about treatment.
- 88% of patients felt the venue was accessible.

Actions:

- Privacy and venue: Screens to protect patients' privacy where required.

New Local Inpatient Survey

The new local Inpatient Survey was launched in April 2019 and over 1000 patients have responded. The survey was brought in to replace core quarterly surveys and the monthly open and honest survey, with the aim of providing evidence against the national inpatient survey measures in between annual collection dates and enabling a benchmark of levels of generic patient satisfaction with their inpatient care. Increasing survey returns gives more inpatients the opportunity to provide feedback and highlight areas of good practice and areas for improvement. Feedback is also being used to inform the ward accreditation programme.

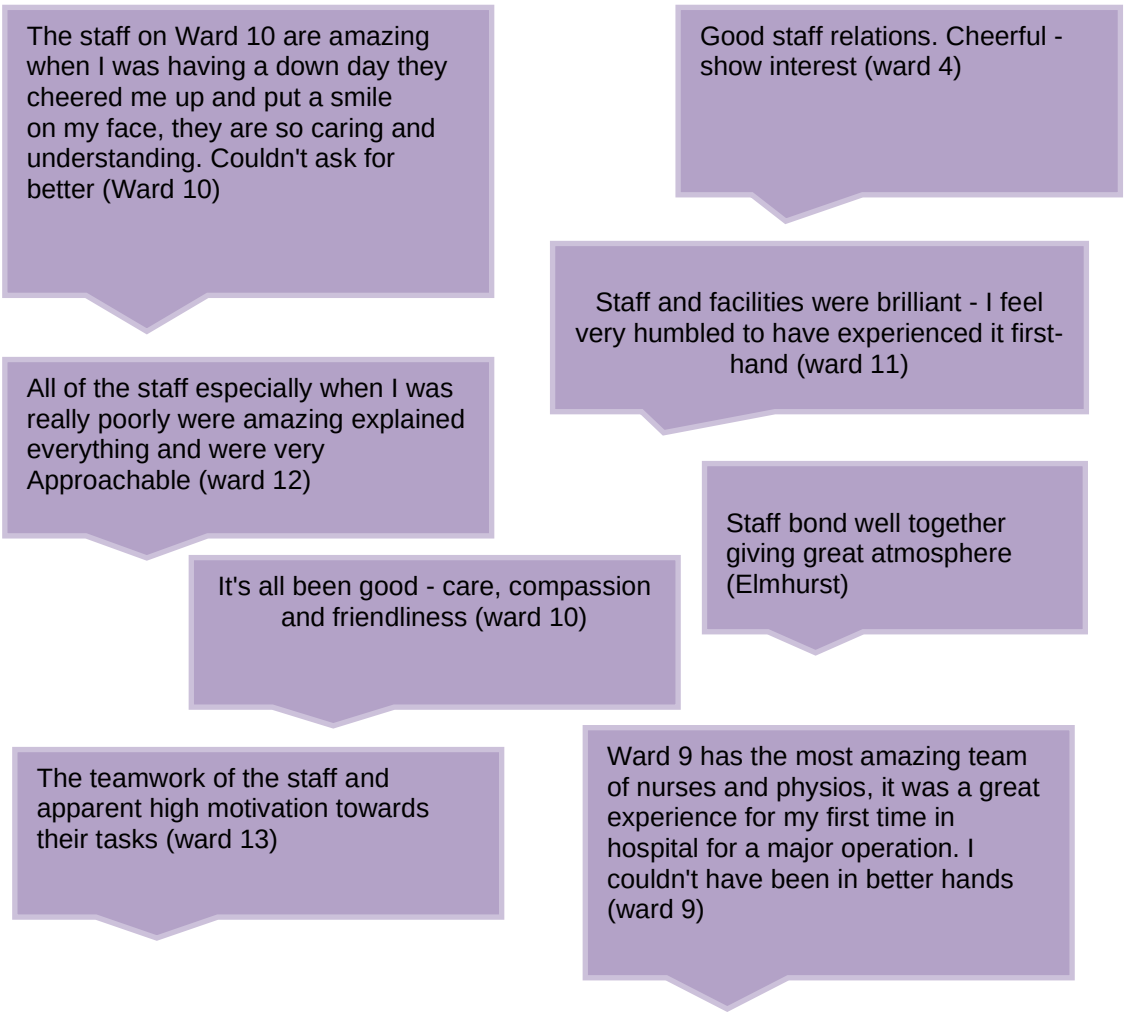
Key findings:

- Ward level reports and comments have been sent to ward managers for information and action, and key areas and themes highlighted.
- Areas scored highly include respect and dignity, staff working well together, privacy when being examined or discussing patient care.

Actions:

- A pilot scheme has been introduced in one ward area to ensure patients spiritual and cultural needs are being met, with the chaplaincy team supporting staff to support patients. This has been well received and plans are to roll out to other wards.

Examples of patient comments received:



National Surveys

National Inpatient Survey

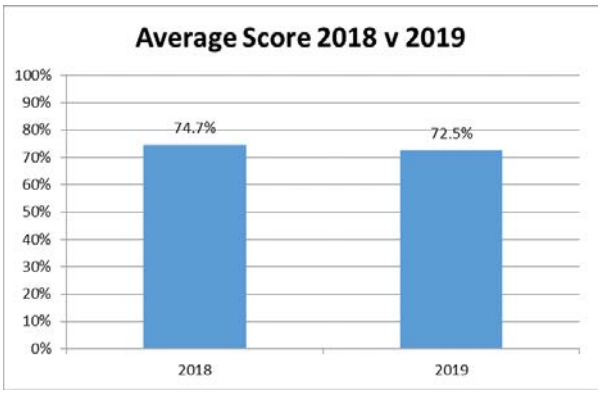
The survey was distributed to patients admitted in July and August 2019 and the Trust received 570 survey responses, a response rate of 48.1%. A national comparison has not yet been published.

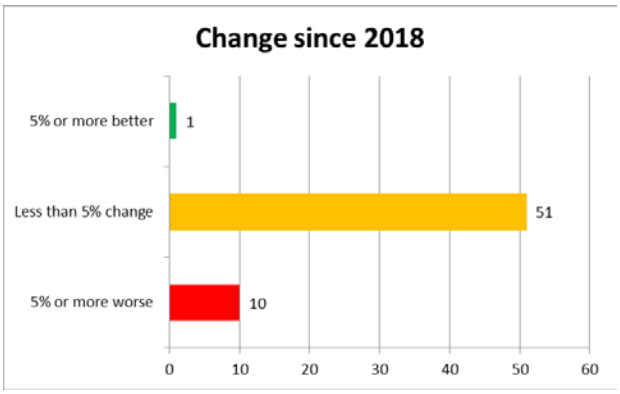
The results include patients' perceptions of their hospital stay including:

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

The Trust scored an average score of 72.5% which is slightly lower than in 2018. Compared with the 2018 survey, the Trust showed a 5% or greater improvement on 1 question score and a 5% or greater reduction in score on 10 questions.

What has changed since the last survey?





As part of this survey, a large amount of qualitative data is collected and over 800 free text comments were analysed and themed. More than 50% of the comments received were positive.

What has changed since the last inpatient survey?

The trust has significantly improved on the score for patients being delayed on discharge by 8%.

In the CQC Benchmark 2018 report the trust scored better than other trusts on 1 question – patients having enough help to eat at meal times, and scored worse on two questions for delay delays on discharge.

The CQC Benchmark report for the 2019 results will be published in June 2020.

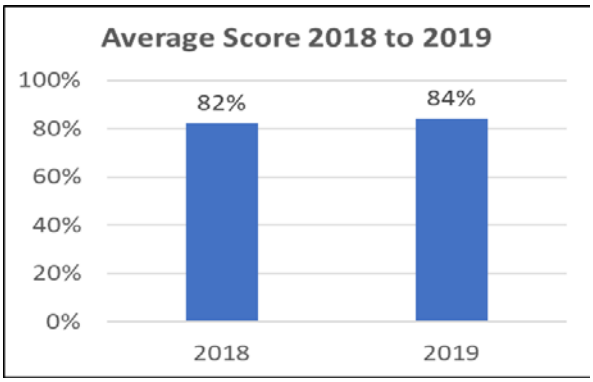
Action planning:

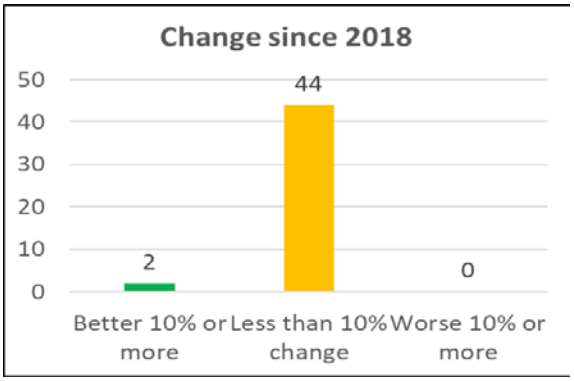
The results for the 2019 inpatient survey were received in January 2020. A workshop including all members of the multi disciplinary working group was established to review the outcome and to identify themes and developed an action plan to ensure continuous improvement. Results are shared widely across the organisation and at public meetings. The group are focusing on continuing to reduce delays on discharge, and communication/information provision.

National Maternity Survey

The 2019 national survey looks at women's experiences of maternity care. It asked women about their experiences during labour and birth and the quality of antenatal and postnatal support. The survey for Mid Cheshire includes responses from 119 women who gave birth in February 2019.

300 surveys were posted and there was a 40% response rate. The average Mean Rating Score, across all questions, was 84% which is higher than in 2018.





What has changed since the last survey?

In the CQC Benchmark report the trust scores better than other trusts on 10 questions and no questions scored worse.

Areas showing at least a 5% improvement from 2017:

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

Action Plan:

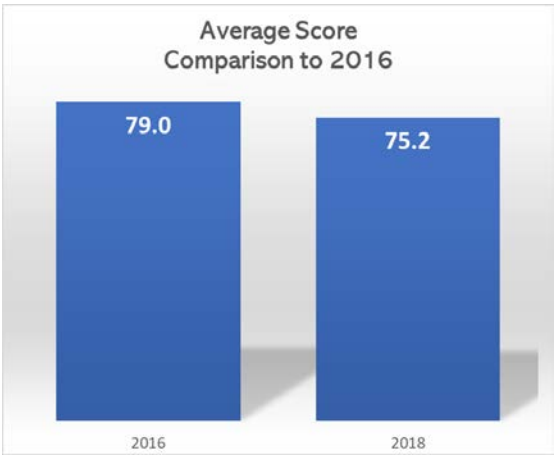
A working group is progressing actions on the following themes including:

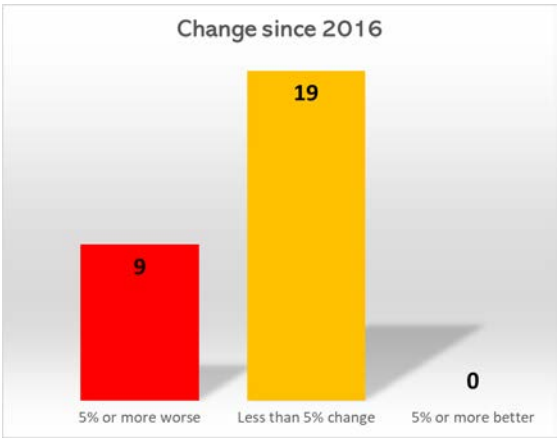
- Discharge Delays – the work that was done last year will not have been captured in the results of this survey so we are anticipating an improvement in next year's survey results.
- Homebirth – promoting home birth choice. An audit will also be undertaken to ensure homebirth option is offered to women.
- Post-natal care and information which will include a review of current information with women to identify any areas for improvement.

National Urgent and Emergency Care Survey

This survey looked at the experiences of people who attended type 1 A&E department or type 3 Urgent & Emergency Care (UEC) services. Questionnaires were sent to patients between October 2018 and March 2019.

Responses were received from 286 people at Mid Cheshire Hospitals NHS Foundation Trust giving a 32% response compared to 30% nationally. The average score compared to 2016 was reduced from 79% to 75.2%.





What has changed since the last survey?

In the CQC Benchmark report the trust scores below other trusts information for one question about medication side effects for those prescribed new medications and being told about possible medication side effects to watch out for. Staff are ensuring patients receive the patient information leaflet and offer explanations of possible side effects if applicable.

The trust scored highly on the following question:

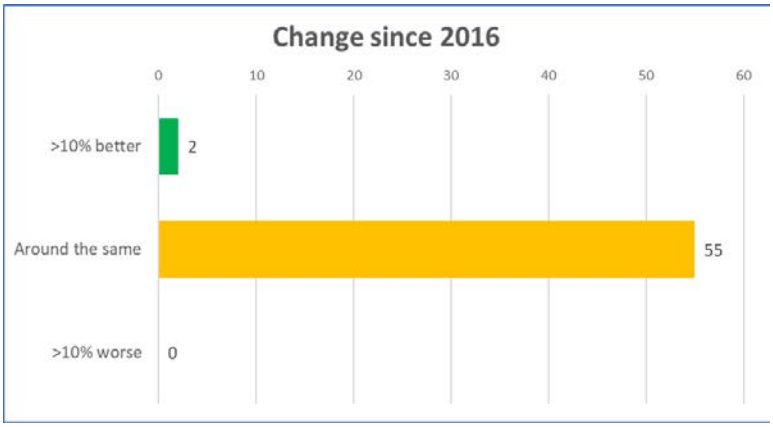
- While you were in A&E did you feel threatened by other patients or visitors (we scored 9.8 – highest trust scored 9.9).

Action Plan

- Refurbished Emergency Department waiting room opened spring 2019.
- Television units display current waiting times.
- A patient safety checklist for patients waiting in the corridor is audited monthly.
- More and bigger vending machines installed.

National Children's and Young People's Survey 2018

The Children and Young People's survey looks at the experiences of children, young people and their parents and carers attending hospital as an inpatient or day case and discharged October/November 2018. Overall 824 questionnaires were mailed, with 194 responding, a response rate of 27% compared to 25% nationally.



What has changed since the last survey?

The results have remained largely the same as in the 2016 survey, although 2 questions showed a 10% or more improvement in score: choice of admission dates and parents having the opportunity to prepare food in the hospital.

The Trust scored in the top 20% of Trusts on questions around food; advice to parents when leaving hospital, staff distracting the child during an operation or procedure, and cleanliness. No questions scored worse than other trusts.

Scores which have significantly improved since 2016 included:

- Did the ward where your child stayed have appropriate equipment or adaptations for your child's physical or medical needs?
- Were members of staff available when your child needed attention?

Action plan

- To reduce delays to discharge due to waiting for medication.
- Review where patients noted inappropriate wards for their age (i.e. teenagers with babies).
- Communication and sharing of information.

National Cancer Survey

The survey is designed to monitor national progress on cancer care and provides information to drive local quality improvements. This was the 8th year published September 2019. 51 of the 52 questions relating directly to patient experience have been summarised as a percentage score for the patients who reported a positive experience only.

https://www.ncpes.co.uk/reports/2018-reports/national-reports-2018/4539-cpes-2018-national-report/file

Patients were sent the postal questionnaire (with 2 reminders) and had the option to complete the survey online. The sample included all adult (aged 16 and over) NHS patients with a confirmed primary diagnosis of cancer (ICD10 codes). The sample included patients discharged from an NHS Trust after an inpatient episode or day case attendance for cancer related treatment between April and June 2019.

The Trust had a 67% response rate (England national average 64%).

What has changed since the last survey?

- Respondents gave an average rating of 8.9 for the Trust where the scale was zero (very poor) to 10 (very good). The national average was 8.8.
- Patient experience at MCHFT was better than national average in 33 questions including the overall rating.
- Patient experience at MCHFT scored lower than the national average in 15 questions.

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

National Cancer Dashboard	MCHFT Score 2017	National Average Score 2018	MCHFT Score 2017	National Average Score 2018
Patient definitely involved in decisions about care and treatment (Q16)	81%	↑84%	79%	79%
Patient given the name of the CNS who would support them through their treatment (Q17)	93%	↔93%	91%	91%
Patient found it easy to contact their CNS (Q18)	87%	↑89%	86%	85%
Always treated with respect and dignity by hospital staff (Q37)	92%	↓88%	89%	89%
Staff told patient who to contact if worried post discharge (Q39)	96%	↓93%	94%	94%
Practice staff definitely did everything they could to support patient (Q53)	70%	↓57%	60%	59%

Actions Taken

- Pathway Navigators / Support Workers (as first point of contact) for Breast, Colorectal and Prostate pathways to attend Cancer Alliance agreed Training Programme.
- Implementation of Holistic Needs Assessment (HNA) at diagnosis / pre-treatment for Breast, Colorectal and Prostate pathways.
- Implementation of End of Treatment Summary for Breast, Colorectal and Prostate pathways.

Patient Experience Network National Awards

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

- Innovation around Volunteering led by Jo Newbrook, Voluntary Services Manager (Strengthening the Foundation category)

- Identifying the Unwell Child in the Community Settings – CCICP (Using Insight to improve integrated Care category)

The awards were due to be held in March 2020 but were postponed due to the coronavirus pandemic. PENNA are revising plans for the awards and the announcement of winners is currently awaited.

NHS Choices

The NHS choices website provides an opportunity for patients to provide comments about their recent experience in hospital.
https://www.nhs.uk/Services/hospitals/ReviewsAndRatings/DefaultView.aspx?id=505

There were a total of 70 new postings on the NHS choices website of which 62 were positive postings and 8 negative.

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

Examples of comments posted on NHS choices include:

Friends and Family Test

The NHS Friends and Family Test (FFT) helps the Trust understand whether patients are happy with the service provided and where improvements may be needed. It is a simple, quick and anonymous way to ensure patients have an opportunity to feedback on care received across all Trust services. Responses are mainly collected through text messaging or automated voice messages and postcards.

Trust results

59,821 patients responded to the Friends and Family Test, which is 14,786 patients more than last year, with an improved score by 1% to 92% of patients indicating that they are likely to recommend services or treatment to their friends or family.

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

Examples of You Said We did:

You Said	We Did
Some negative comments from patients at the ENT Outpatients clinic relating to 'appointment cancellation issues', 'waiting time and delays to see consultant'.	Feedback has been reviewed at the teams quality improvement session for the consultants to be made aware of and discuss the issues relating to them.
Issues raised regarding – pull cord in treatment centre toilets "Please could you change this button to have a long pull, cord, because if I had fallen on the floor I could not have been able to reach the button. "	Patient toilets have been checked and each patient toilet has a call bell on one side of the room near to the door and a long red pull cord on the side near to the toilet. In response to the feedback signs have been put on the door of the toilet informing patients of the location of the two emergency contact points.

Feedback from patients is being shared through a number of methods including a social media initiative, **#feedbackfriday**, highlighting positive experiences of care for our patients and their families and communicated via Twitter.

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

Maternity Facebook comments

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

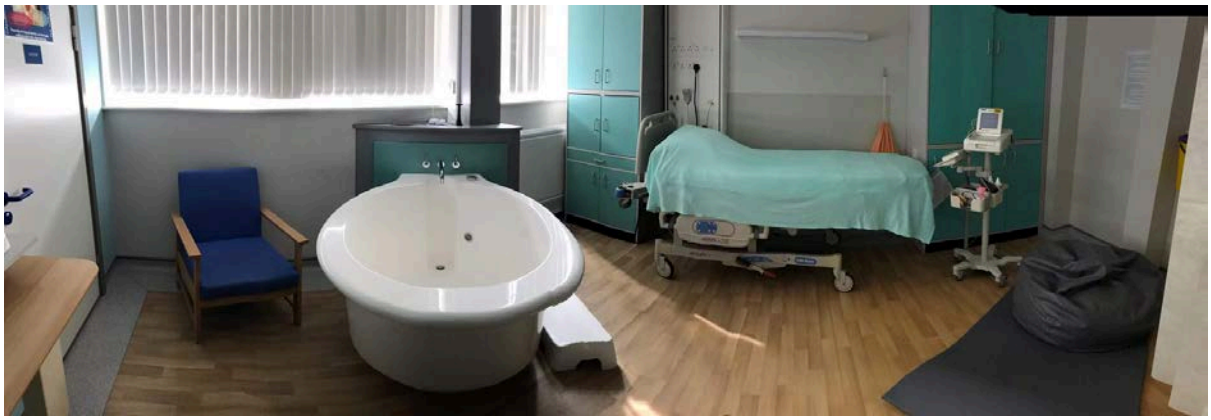
The Facebook page raises the profile of the services offered and provides current evidence based information to women and their families.

The page is also used to post messages of thanks from mothers. Feedback has shown that mothers find the page an easy way of thanking staff during this busy time in their life. All staff mentioned are then put forward for Maternity

Employee of the Month and a winner is chosen at random and receives a certificate for their portfolio. All messages are also forwarded to the staff members for them to keep.

The unit held an open day and received positive messages both promoting the event and thanking staff afterwards with feedback;

'*Really good event, thank you for the tour. Even though I've been onto LW and MLU in a work capacity it was great to see it from the perspective of me using it! Really helped my husband to understand how it works too. Also very excited to collect the hamper I won'*.



Some examples of messages posted are below:

'*I wish to pass on my thanks to all staff for the safe arrival of our baby boy. I came into the hospital for an induction and it resulted in an unplanned caesarean section the next day. After theatre and recovering I was moved to Ward 23 until Wednesday when I was discharged. Throughout my stay I was made to feel welcome and supported by all staff. My experience was completely positive and I will look back with fondness at my time spent at Leighton'*.

'I just want to say a massive thank you to my midwife Sam on the MLU for all the help and support she gave me when delivering my little girl and keeping so calm and collected when she noticed she was facial presentation and getting the help me and my daughter needed for a safe delivery. My baby is perfect ❤thanks again to an amazing team!'

Other patient and public involvement programme activities programme activities:

Patient Register Group

Meetings were held of the Patient Register Group attended by patient representatives, volunteers and governors. Topics covered included an introduction from the Voluntary Service Manager on the roles performed by volunteers at the Trust. Attendees were shown a short video that highlighted the rewarding work carried out by some of the hospital's 300 volunteers. Roles range from hand-holding to phone answering and chaplaincy. Volunteers enhance patient experience, provide vital assistance to ward staff, as well as allowing the volunteers to gain experience of and give back to the NHS.

Other topics included the new Pre-Operative Assessment Clinic (POAC) project. The Lead POAC Nurse presented a departmental trial of telephone appointments rather than face-to-face appointments for some of their patients. This resulted in more patients passing POAC on the day, reduced the need for unnecessary investigations, increased capacity and improved patient experience. The group noted some of the positive comments the service had received from patients.

An added benefit from the project highlighted the cost saving to the hospital. By reducing the number of unnecessary investigations being carried out on some of these patients (for example, MRSA swabbing), nearly £14,000 was being saved each month! Feedback from the group was positive and they were reassured to hear that at the end of their telephone POAC, patients were asked if they still felt a face-to-face appointment would be helpful for them.

Finally, a group discussion took place around how the Trust communicates with its patients and public, and how they in turn can feedback to the Trust. Most attendees were also Trust Members and received feedback through meetings and newsletters. However, there was some debate around the role of technology in communications from the Trust. Some welcome email, text messages and social media as forms of communications, whilst others were keen to receive letters and hard copies. It was concluded that, whilst the use of technology was helpful to many, efforts would be made to make hard copies of the Trust's Newsletter available around the hospital and to local GP practices, libraries and other public buildings.

Patient Information Group

The group meets on a monthly basis with a membership of eighteen, including three patient representatives and a multi-disciplinary group of staff. In 2019/20, the group reviewed 33 leaflets, such as the Bereavement booklet, Planning Your Discharge from Leighton Hospital, Alcohol and Dementia.

The Royal National Institute of Blind People (RNIB) supported the Accessible Information Event held in October 2019 at Leighton Hospital. The stand was visited by many staff and public.

Readers Panel

The Trust continues to have an active reader's panel with 76 members to review patient information on a monthly basis. The aim of the Readers' Panel is to ensure:

- Patients and the public provide a user perspective in relation to the content and production of patient literature by being involved in the development of the written information.
- Patient information is accessible to patients, their carers' and visitors.

- The language used in leaflets is user-friendly, simple and easy to understand.
- There is a consistent approach to patient information across the Trust ensuring a high standard of production.

22 leaflets have been reviewed by the Readers' Panel including; Cartiva Implant Surgery, Bronchoscopy, Swallowing advice x 4 by the Speech and Language Therapy Team.

Leaflets produced in other formats:

There are a number of initiatives in place to ensure standards are met for accessible information. The aim of the accessible information standard is to make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need.

A standard operating procedure and flow chart, has been produced to assist staff to identify and record information and communication needs for patient's service users, carers and parents, where those needs relate to a disability, impairment or sensory loss.

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

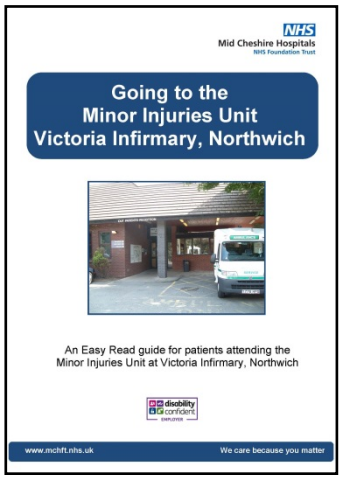
Information produced this year includes Cardiac Rehabilitation Service leaflet in large print, and the following leaflets in Polish:

- Information for patients discharged in a lower limb plaster cast or a rigid boot.
- Planning your discharge from Leighton Hospital.
- Crohn's and Colitis.

Easy Read

Two new easy read leaflets have been produced:

- Pre-operative Assessment – explains what the patient can expect at this appointment and what to bring with them.
- Minor Injury Unit, Victoria Infirmary Northwich – a step by step guide of the patient's journey, from booking in at reception to being discharged from the Unit.



Bereavement Service

The Bereavement Service is available to patients, their relatives and carers or friends using Health Services provided by the Trust and is also available to staff. Provision of a centralised, Trust wide culturally sensitive service, ensures that comprehensive information, guidance and support is available for bereaved relatives and friends during working hours.

Access to Bereavement Service

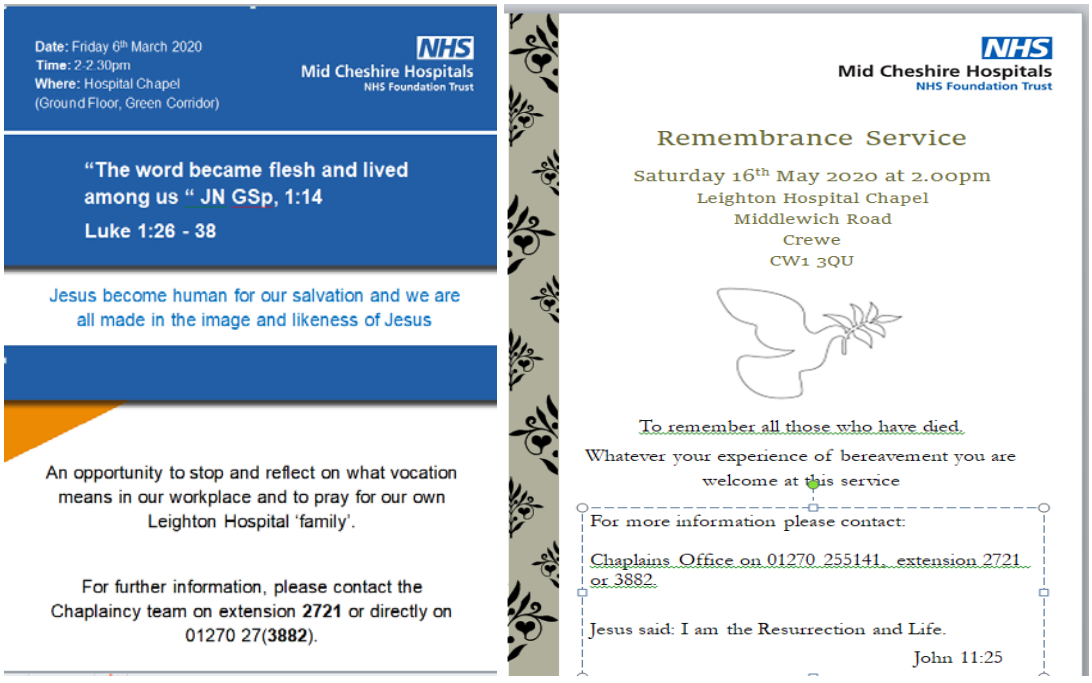
The service is available Monday to Friday between 8:30am and 4:30pm (excluding bank holidays) although there is flexibility to accommodate those who cannot access or make contact during these hours. Any patient, relative, carer, friend or member of staff wishing to access this service outside of normal office hours can do so by prior arrangement.

An answering machine is available 24 hours a day to take messages. Messages are retrieved and acted upon on a daily basis Monday to Friday. In the absence of the Bereavement Manager, General Office staff are accessible.

Bereavement Information for to support relatives

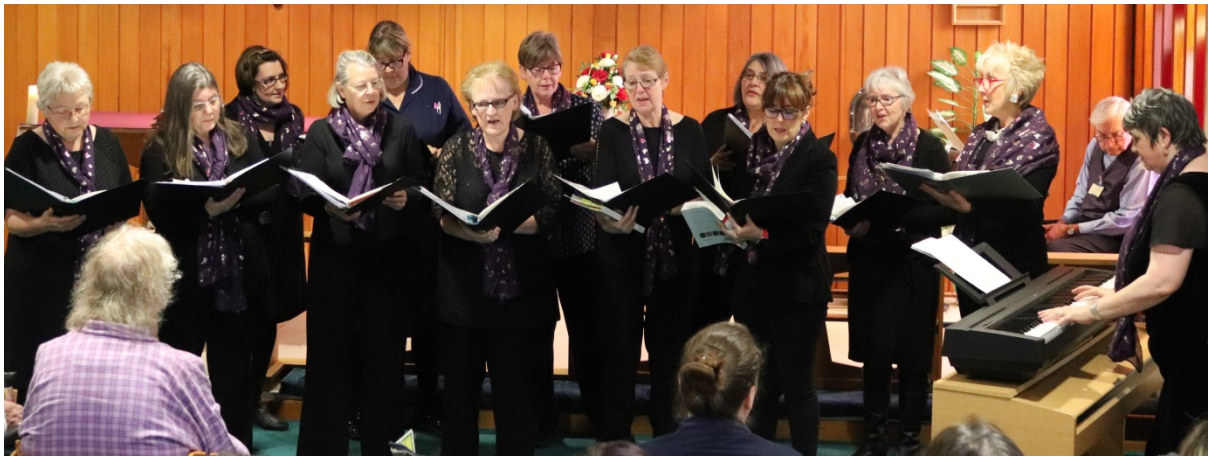
Ward staff inform relatives of the Trust's Bereavement Service and provide them with the Bereavement Pack. The bereavement pack has recently been updated following the 'Learning from deaths' guidance https://www.england.nhs.uk/ourwork/part-rel/nqb/national-guidance-for-nhstrusts-engaging-with-bereaved-families/.

Spiritual Support Events



Annual Christmas Carol Service

The Annual Christmas Carol service takes place in December every year. This year the Hospital Choir came along to perform. The service was well attended by staff and patients.



Customer Care Team

The role of the Customer Care Team is to provide prompt advice / information and support for patients and relatives if they wish to raise concerns regarding care and services provided by the Trust. The team can also support patients when dealing with issues about NHS care and provide advice and information about local health services.

The Customer Care Team aims to respond to patient's concerns and issues in a timely and effective manner, irrespective of whether they have been raised as an informal concern or a formal complaint. The majority of concerns can usually be resolved quickly by staff that are caring for patients. However, it is also recognised that on occasions a patient or family member/carer may want to talk to someone who is not involved in directly their care and the Customer Care Team are then able to help. The Customer Care team offer support by means of telephone or email enquiries and are available to provide face to face discussion and support if preferred.

In January 2019 a new Customer Care Team office was opened in the main entrance at Leighton Hospital. This was to promote and support the services offered by the Customer Care Team by means of a 'drop-in' service available without appointment.

Overview of the activity by means of 'drop-in' visits to the Customer Care Team Office**;**

Month	Customer Care Team drop-in
January 2019	2
February 2019	27
March 2019	23
April 2019	18
May 2019	15
June 2019	11
July 2019	26
August 2019	13
September 2019	16
October 2019	21
November 20019	26

December 2019	23
January 2020	39
February 2020	19
March 2020	10 prior to closure due to COVID19
Total	279

Common concern trends that are raised by the 'drop-in' visits are:

- Cancelled/rescheduled appointments
- Care on the Wards for inpatients (raised by patients or relatives)
- Car parking issues
- Lost property
- Attitude of staff
- Unsafe/inappropriate discharge
- General advice or signposting e.g. what is our complaints process/how to complain.

The Customer Care Team also receives Ecards from relatives who wish to send messages in this way. This year, 10 Ecards were delivered to patients in the Trust between April 2019 and March 2020.

Compliments

5105 formal compliments were received by the Trust during 2019/20 which expressed thanks from patients and families about the care received. The Trust values the feedback given by patients and their family in relation to care they have received at the Trust and have taken further action to ensure every compliment is noted and shared with the appropriate staff/teams. Compliments now include all thank you letters, emails and compliments inclusive of feedback from various modes of social media.

Overview of compliments received by the Trust

	2016/17	2017/18	2018/19	2019/20
Number of compliments received	1,872	1913	4779	5105

'I was admitted to Leighton Hospital and my broken ankle was operated on. A few days later I was admitted to Elmhurst Care facility in Winsford. I just want to say throughout I received outstanding care. All staff I encountered in both facilities were totally professional and caring. I received the best care possible and I would like to thank all of you for the provision of such excellent service.'

'I gratefully accepted help from a lady in your Physiotherapy Department; she got a porter for me who was most pleasant as he wheeled me down to reception. I am extremely thankful for the kind help'

261 formal complaints were received by the Trust during 2019/20.

Overview of complaints received by the Trust

	2016/17	2017/18	2018/19	2019/20
Number of complaints received	283	215	209	261

Review of complaints

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

The Trust is committed to providing an accessible, fair and efficient service for patients and service users who wish to express their concerns or make a complaint with regard to the care, treatment or services provided by the Trust. The Trust shares with all complainants the services also offered by the Healthwatch advocacy service to highlight that independent support is available in addition to the support offered by the Customer Care Team. The Healthwatch service is also promoted by means of community Healthwatch stands within the Trust premises to support engagement with the public in regarding the support and advice the Heathwatch service provides.

The Trust recognises the importance of having a robust and flexible process for the management of complaints to ensure complainants receive a timely and person-centred response to the issues they have raised. In October 2018 Key Performance Indicators (KPI's) for the management of complaints were agreed with all divisions within the Trust to ensure that concerns raised are responded to in a timely manner. With the introduction of the KPI's the customer care team have been working closely with the divisions to promote a service which responds to all formal complaints within 40 working days. The response KPI was 65% in Quarter 1 of 2019/20 but decreased in Quarters 3 and 4 due to staffing levels and the pandemic. A recovery plan to support the team has been approved to increase this metric in the next financial year.

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

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

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

The Customer Care Team continues to seek the views of their service users and send out surveys to complainants in order to gain feedback to support an improvement in the way that the service is delivered. However as the Trust had identified that response rates had previously been relatively low the Trust has completed a review of surveys used by other Trusts and has designed and ratified a new survey.

The new survey has been redesigned in a booklet format with clearer more tailored questions, in an easy to read format. This was launched in April 2019 and we have seen an increase in response rates since this time. Since the launch in April 2019 we have received 26 completed surveys which on the whole rated the experience positively. Analysis of this feedback enable us to identify any in which the service was working well and areas where the service could be improved.

Overview of customer care survey results

Question	Response	Action required
How did you find out about the Customer Care Team?	• Leaflet or poster within the Trust sites (31.6%) • Trust website (36.3%) • Other (31.6%)	Ensure that posters advertising the service are displayed in all clinical areas.
Who was your first contact in relation to raising your complaint?	• Member of the Trust team directly involved in the care (5.3%) • A member of the Trust administration staff (10.5%) • The Customer Care Team within the Trust (84.2%)	The results are shared with the divisions to encourage staff working in clinical areas to resolve patient's concerns during the in-patient stay.
Was the Trust complaint response in a format that you could understand?	• Yes definitely (84.2%) • Yes to a certain extent (10.5%)	All complaint responses are reviewed through the quality process before final sign off by the Chief Executive.
Did you feel you were kept updated with the progress of your complaint?	• Yes (84.2%) • No (16%)	To review the progress of complaints on a weekly basis and ensure complainants are kept informed of progress or delays.

Key themes of complaints 2019/20

Some of the key themes of complaints received in 2019/20 were in regard to nursing medication delays and concerns regarding nutrition, communication face to face with patients and relatives, medical adverse outcomes and medical diagnosis. Examples of these are summarised in the table below together with actions taken to address the concerns raised.

Theme	Actions	Outcome
Medical adverse outcome problems / medical diagnosis	• Action plans are agreed divisionally to address issues raised following incident reporting, root cause analysis and patient safety summit. • Feedback from patients and relatives. Concerns raised within complaints are shared with relevant staff. • Clinical incidents, complaints, legal claims and concerns raised from the Coroner are discussed at weekly Triangulation Review Group meetings and actions required to address concerns escalated to divisions as appropriate • Themes relating to clinical care are identified by means of review at the Triangulation Review Group Meetings and these are escalated to the divisions for further review, Complaint Review Group and Executive Patient Experience Group.	Actions plans are monitored through the divisional boards to ensure compliance Staff develop a greater understanding of the impact on patients and their relatives when care delivery has not met the patient's needs Divisions are contacted following the meetings and are aware of patient concerns raised through the Triangulation Review Group which required immediate action. This supports the provision of responsive action to ensure safe and appropriate care delivery
Nursing medication delays	• Implementation of label printers and bedside authorisation of discharge to be further rolled out • On line tracking facility now available for staff which identifies when the medications ordered are available from pharmacy	Views on discharge audit completed to monitor patient experience. These views are shared with staff to ensure that medications are ordered and available in a timely manner
Nursing nutritional concerns	• New nutritional screening tool has been implemented to improve the identification of patients who are at risk of poor nutrition and who require additional support	Monitoring of nursing compliance for nutritional screening and support in progress and is included in the Ward Accreditation Metrics Nutritional patient survey completed yearly to obtain patient views on how the Trust is meeting the needs of patients with regards to nutrition
Communication face to face	• Customer care education	Shadowing experiences have

	programme to be developed to support staff to recognise the importance of good communication and the impact on patients and families when patient experience is negative • Communication workshops in place and to be delivered on a quarterly basis to provide education for staff as to the importance of communicating effectively • Improve divisional working in relation to complaint handling by means of review of representation at the Complaint Review Group to extend to Matron staff	been offered to members of staff to work alongside the Customer Care Team in order that they have an increased awareness of the concerns which are raised by patients or their relatives and how the Customer Care Team support the patient or relative to resolve their concerns A program of communication workshops has been developed in conjunction with the Customer Care Team and Learning and Development. Staff who have attended the workshops have given positive feedback and comment that the workshops help them to develop a greater understanding of the elements of good communication
Communication with relatives and patients when concerns are raised with regards to care delivery	• Key performance indicators agreed with the divisions to support appropriate handling of patient concerns and appropriate investigation and actions by the division to improve the standard of care delivered at the Trust. • To provide monitoring and reporting of divisional adherence to complaint action plans • To trial new complaint satisfaction survey to gain feedback from patient and relatives who raise concerns and audit the results	Divisions aware of all complaints raised and the timescales in which the complaint resolution is agreed and actions plans progressed. Complaints are investigated by senior managers within the divisions and this includes discussions with staff and review of the patient's documentation. The complaint response is approved by the Head of Nursing for each division reviews and signed by the Chief Executive or Director of Nursing and Quality Increase in survey responses

Learning disabilities access

There are 1.5 million people with a learning disability (LD) in the UK.

The health inequalities experienced by people with a LD are partly caused by poor quality healthcare. In addition, there are a number of health conditions that people with a learning disability are more likely to experience, including epilepsy, dementia and respiratory diseases.

Equality healthcare is a basic right, and we should all have equal access to treatment. On average, people with a LD die 16 years earlier than the general population, with approximately 1,200 people with a LD dying avoidably every year.

Here at Mid Cheshire Hospitals NHS Foundation Trust (MCHFT) we continue to work hard to ensure that the care and support we provide to people with a learning disability is of high quality, is person-centred, enables good clinical outcomes and leads to an enhanced patient and carer experience.

People with a LD often find admission to hospital very frightening, and we are working with carers, LD community teams and patients to improve the services we offer.

To help people with a LD access hospital services and therefore improve their overall health, we have introduced a number of initiatives. These include:

- The LD Phlebotomy Clinic continues to be held every quarter. Demand for this clinic is high, as patients have their bloods taken in a calm, friendly and quiet environment.

  Carers and relatives are incredibly grateful for the service that is offered, particularly as obtaining blood samples can mean critical medications are monitored and reviewed and further investigations can take place such as CT scans.

- We continue to produce easy read information leaflets, the latest being for the Minor Injuries Unit at the Victoria Infirmary, Northwich.

  One of our patient's Ben and his Mum Jane kindly agreed to be the "models" for our leaflet. They have subsequently been asked to speak at a conference being held in March, entitled "Treat Me Right". They will be discussing their lived experience of having a LD and caring for someone with one.

- The Trust continues to promote and raise the awareness of the importance of making reasonable adjustments for people with learning disabilities. These may include:

  - Double appointments at a time to suit patients and carers.
  - Hospital tours to familiarise patients with the environment.
  - Meeting with the Community LD teams to plan pathways for complex LD patients needing admission to hospital.
  - Contacting primary care to ensure when a person with LD is coming into hospital for treatment under general anaesthetic. We make the most of this

opportunity and check whether the patient needs any specific blood tests performing, chiropody or dental treatment at the same time.

- Patients coming in for planned operations can take home items such as hospital gowns and oxygen masks, to familiarise themselves with the equipment pre-operatively.
- Use of hospital passports and individualised care plans.

The Adult Safeguarding Lead (ASL) is the Liaison Nurse for people with learning disabilities and their carers. Part of the role includes co-ordinating care and engaging with patients, carers, social care and the LD community teams to ensure that the hospital experience is a positive one.

- LD patients requiring orthopaedic surgery can find it difficult to follow post-operative advice. The ASL works with patients and carers plus the therapists who will be involved in the after care, to ensure that the person will attain the best clinical outcome. This is often done with home visits, which enables to the therapists to assess the person in their own environment and plan interventions early on in the patient journey.
- Education and training of staff is pivotal when supporting people with LD in hospital. Staff are now able to access an e-learning package in relation to caring for people with a LD. Evaluations have been excellent and the e-learning will be rolled out across the Trust over the coming months.
- The Trust has also launched an educational video in relation to mental capacity assessments and best interest decision making. Staff now have the opportunity to view practical application of the Mental Capacity Act in hospital based scenarios.
- MCHFT has recently taken part in the NHS England (NHSE) and NHS Improvement (NHSI) Learning Disabilities Improvement Standards Collection National Audit. This involved an organisational checklist, feedback from patients and carers plus a staff questionnaire. Results are awaited but a gap analysis will follow to address any areas of improvement that are highlighted. The audit will also be an excellent opportunity to share best practice nationally.
- We continue to review all LD deaths within the Trust, and fully support the national Learning Disability Mortality Review (LeDeR) Programme. Any areas for improvement are highlighted and shared across all divisions, as well as good practice. This may extend to primary care, if there are wider lessons to share. There have been some excellent examples of good practice shared over the past 12 months such as communication with carers, application of the Mental Capacity Act and prompt involvement of the hospital palliative care team.

Ward Accreditation

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

The Ward accreditation programme;

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

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

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

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

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

During 2019/20 16 wards received an accreditation; of these wards the Trust awarded 1 Gold ward, 7 Silver wards, 5 Bronze wards and 3 White wards. In response to the white wards, the wards were provided with a support coaching programme. The programme

consisted of 6 sessions whereby learning objectives were set to support the ward managers during this process.

E Roster

E-Rostering has been introduced across the NHS as an operational efficiency programme of work. Mid Cheshire Hospital Foundation Trust (MCHFT) has been implementing eRostering as a wide scale Nursing and Midwifery workforce change since November 2018.

E-rostering ensures staff are appropriately allocated to provide high quality and efficient health services. Effective e-rostering considers factors such as patient needs, staff needs, organisational needs, the workforce and skills required to deliver services, and workforce availability. Trusts are responsible for striking the right balance between patient safety, cost and efficiency: used in the right way, e-rostering can help achieve this.

Open, transparent and fair eRostering processes help to drive greater employee engagement, employee satisfaction and wellbeing, as well as acting as a key driver for retention. The Trust requires consistent and effective roster management to support the assurance of safe staffing, fair shift allocation, and methods for dealing with capacity gaps and live organisation information and reporting throughout the organisation.

The initial project plan was a roll out across 5 core inpatient wards, with a full roll out to all 17 core inpatient wards in Surgery & Cancer, Medicine & Emergency Care and Diagnostics & Clinical Support completed by May 2019. The next phase of implementation has consisted of Critical Care, Critical Care Outreach, Ward 19, Accident & Emergency and Women's & Children's. eRostering is now live across 27 inpatient units.

As of 01st June 2020 the following data forms the current Project Status:

	Number	Comments
Wards/Units Implemented	27	
Nurses & Midwives Rostered	1402/1818	77% N&M Workforce
Electronic Pay	27	2 month QA process
HealthRoster Trained	144	Includes Finance & HR
SafeCare Trained	393	Includes Site & SMOC
ME App downloads	1407	Additional staff on EOL

To date eRostering has seen the following Quantifiable benefits;

- Improved rostering practices with rosters 6 weeks in advance across all 28 Units.
- Rosters 6 weeks in advance has improved the opportunity to secure Bank and Agency workers to fill gaps and negotiate better Agency rates.
- Compliance with working time directive as substantive and bank hours are now combined.
- Proactive management of annual leave to ensure that every shift has an experienced substantive staff member who can take charge.
- Increased use of substantive staff contracted hours leading to better productivity, as contracted hours are used before bank staff requests are made.
- Incentivising staff to use the system by moving the booking of requests, such as annual leave and shift preferences onto the system using a mobile App.
- Increased visibility of staffing issues and movement across wards.
- eRostering system is linked to the Bank system so Bank shifts match the demand template to prevent overbooking.
- Roster Creators were trained to use the auto-roster option in the software to reduce administration time.
- Through education, Roster Creators/Managers have improved knowledge and understanding of headroom, demand, care hours per patient day and key performance indicators.
- Simplified payroll processes – A reduction in paper timesheets has saved on administration time for both Ward Managers and Payroll.
- Improved payroll accuracy as enhancements are paid directly from the roster with direct ESR interface.

Next steps

The eRostering Business Case was approved at April Trust Board which supports the expansion of the eRostering Project to enable the Trust to have an electronic rostering system across all non-clinical workforce groups as well as rolling out to all remaining clinical staff (except medics).

The project will have a larger permanent eRostering and Safer Staffing team established to ensure that a robust service is delivered to clinical teams, providing on-going roster configuration, maintenance support and training.

Continuous roll out of the eRostering project will enable the safety of our patients to be proactively managed by ensuring resources are deployed appropriately, taking into account the demands of our patients. Additionally, it will allow us to deliver a live acuity driven daily

staffing status supporting our senior nurses to make informed professional judgement staffing decisions.

Seven Day Hospital Services

The Trust uses the learning from the Seven Day Hospital audit to continue its risk based approach to investment in the multi-disciplinary teams ready for 2020/21 in order to make progress towards complying with the four priority clinical standards with the seven-day services programme.

Significant work has taken place which includes a focus on the infrastructure, medical staffing, nursing and therapy support to deliver services across seven-days. With this aim, business cases in Therapies, the Acute Care Team and the Emergency Department were presented to the Board in 2019/20 which contain investment proposals to help improve our services over the week and 'out of hours'.

During 2019/20 the monitoring of the Seven Day Services standards was devolved from a national level to a local level. A Board Assurance Framework for Seven Day Hospital Services was presented to the Trust's Quality Governance Committee in June and November 2019. These Assurance Frameworks showed that the consistent delivery of the 'First Consultant Review within 14 hours of an Emergency Admission' (Standard 2) remains a challenge. The Trust achieves the standards relating to 'access to diagnostic tests' (Standard 5), 8 out of 9 'Consultant led interventions' (Standard 6) and the twice daily 'ongoing consultant-directed reviews' (Standard 8).

Freedom to Speak UP

In 2015 Sir Robert Francis produced his Freedom to Speak Up Review which, amongst a range of recommendations and principles, called for all NHS organisations to appoint a Freedom to Speak Up Guardian to improve the way each organisation deals with concerns raised by NHS staff as part of the process of fostering "a culture of safety and learning in which all staff feel safe to raise concerns".

The Guardian is someone whose role it is to act as an independent and impartial source of advice to staff, with access to anyone in the organisation, including the CEO, or if necessary outside the organisation, where concerns are identified which affect patient care. The Guardian ensures that the primary focus is on the safety issue; that the case is handled appropriately, investigated promptly and issues addressed; and that there are no repercussions for the person who raised it.

Mid Cheshire Hospitals NHS Trust is committed to supporting and encouraging all those who raise honestly held concerns about safety and creating a shared culture of openness and honesty in which the raising of concerns is welcomed with a focus on learning rather than blame.

The Director of Nursing and Quality is currently the Trust's Freedom to Speak Up Guardian, supported by a Non-Executive Director Freedom to Speak Up Guardian, who both act as independent and impartial source of advice to staff at any stage of raising a concern. Whilst

the Guardian does not investigate the concerns raised, they help to facilitate the raising concerns process where needed, ensuring Trust policies are followed correctly.

The Trust has a 'Freedom to Speak Up/Raising Concerns (Whistleblowing)' policy which has been adopted in line with recommendations of Sir Robert Francis' review.

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

A number of options are available to staff to ensure that concerns can easily be raised:

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

- Staff are able to leave a confidential message raising any concerns using the Staff Voicemail Service or email a dedicated 'speaking up' email address, both of which are managed by the Human Resources Department.

- Freedom to Speak Up boxes were launched during 2019/20 to provide staff with an additional way to raise concerns. Following a successful pilot, additional boxes were placed across a number of locations, including the community based sites. Staff are able to anonymously submit concerns via the boxes.

- Staff are able to raise concerns via the Trust's incident reporting system. The concerns raised via this approach are sent directly to the Freedom to Speak Up Guardian.

Feedback is an important part of the process. Where concerns raised are not done so anonymously, face to face feedback is provided by an appropriate manager or the Guardian. Where concerns are raised anonymously, feedback on improvements or process changes, as a result of the concern raised, is communicated across the relevant division using a 'you said, we did' approach or at team meetings.

A total of 17 concerns were raised during the 2019/20 period. This compares to 12 concerns raised during the previous year. The lowest number of concerns were reported during quarter two with the remaining quarters having an equal number of concerns raised. The most popular methods of reporting concerns were directly to the Guardian and via the Freedom to Speak Up boxes.

Staff are able to report multiple concerns and in some cases concerns have been raised across a number of areas, however are only counted once in the reporting figures. 13 concerns raised related to patient safety issues and 4 issues related to staff safety concerns. Concerns were also raised throughout the year relating to fraud, a perceived bullying culture and governance issues.

No particular themes have been identified during the period, with the exception that the majority of concerns were raised by nursing staff, a trend seen in previous years. The data from the 2019/20 period has shown that concerns raised during the period were split across all divisional and community areas. During the first quarter of 2019/20, the majority of concerns were raised in ward based areas; however the remaining quarters saw a mix in the divisions where concerns originated from.

A total of 5 concerns were raised anonymously. Where concerns are reported this way, it restricts the ability for individual feedback to be provided. Information in these cases is cascaded to the Patient Safety Summit meeting or to an appropriate person e.g. the Divisional Matron/Head of Nursing to share general feedback at team meetings.

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

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

- My organisation treats staff who are involved in an error, near miss or incident fairly.
- When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again.
- We are given feedback about changes made in response to reported errors, near misses and incidents.
- I would feel secure raising concerns about unsafe clinical practice.
- I am confident that my organisation would address my concern.
- My organisation acts on concerns raised by patients / service users.

Central Cheshire Integrated Care Partnership

Special Schools Hebden Green and Springfield

CCICP have seen significant developments in the Special Needs Nursing Team over the past year to increase child safety within the school environments. A pharmacy technician has been employed and enhanced our medicines management processes. Medication administration records have been implemented in both special schools, a robust audit process is in place to ensure the continuation of good practice. Both schools have maintained 100% standards in audits for transcribing and storage. In addition, both schools now have emergency equipment within the schools to better manage emergency situations, and all staff attend annual Paediatric Intermediate Life Support training. Several standard operating procedures have also been rewritten to further increase our quality and governance processes.

Additionally CCICP have worked in partnership with the local authority to enable redevelopment of clinical spaces at Hebden Green School working in collaboration with the school to refurbish the nurses, physio and Speech and Language clinical areas.

CCICP Pressure Ulcer promotion

CCICP undertook a pressure cushion review following the purchase of 250 pressure relieving cushions. The review evidenced the effectiveness of the provision of pressure relieving cushions to patients at risk of developing pressure damage. 95% of patients identified at risk of developing pressure damage did not go on to develop pressure damage after the supply of the cushions and in 78% of patients with existing pressure damage at the time of supply of the cushions the pressure damage either fully healed or improved.

Feedback from Community Nursing teams concluded that providing cushions enables clinicians to be proactive in the prevention of future pressure damage development. It also enabled the provision of timely treatment and care to patients without the discomfort of conversations around the cost of patients purchasing cushions. Following receipt of this paper CCICP's Operational Management Board approved the purchase of a further 500 cushions.

Additionally Winsford District Nursing team achieved 1000 days without a category 3 or 4 pressure ulcer developing in the teams care. This is an outstanding achievement and dedication to the quality care provided by the nurses within the team. The Nantwich District Nursing team also achieved 365 days without a category 3 or 4 pressure ulcer demonstrating that the implementation of caseload management has had a positive impact on quality patient care.

Stoma

The Specialist Nursing, Assessment and Prescription Service (SNAPS) was launched in July 2019 and provides stoma patients with direct access to specialist support and a prescribing hub for stoma products.

Patients no longer have to go through their GP's and can access SNAPS to get prescriptions, support and expert advice from the Stoma Care Specialist team.

SNAPS also deliver care across primary, community and hospital settings, providing ongoing support for stoma education and management. This includes pre-op counselling and education, review following hospital discharge, home visits to patients who may need them, annual reviews and support either in a clinic setting or at home for patients who require intervention due to issues with their stoma i.e. skin integrity, rather than accessing their GP.

The team also train other professionals and are in the process of developing an online education resource for both patients and staff.

Community Diabetes team

Diabetes is a challenging and complex condition to manage. There are many different types of diabetes and the numbers of people with diabetes continue to rise. CCICP Community Diabetes Specialist Nursing service receives approximately 1500 referrals each year. People with insulin treated diabetes or complex needs are offered a plan of support. Through individualised patient centred care the Diabetes Specialist Nurses work with the person with diabetes or carer / family to develop the necessary skills and knowledge to promote diabetes self- management.

For some people the service may offer support with using technology to manage their diabetes. Recently the service introduced an app based system for women with diabetes in pregnancy. This provides many benefits including viewing of blood glucose readings in real time and gives direct access to a Diabetes Specialist Nurse for advice.

The team were delighted by the nominations from patients and their families in the Public Choice category of the Trust Celebration of Achievement Awards in 2019. The award was won for the team's excellent knowledge of diabetes and care provided to equip Community Health Care Professionals, deliver diabetes care and offer the most appropriate diabetes treatment the service offers a range of education programmes. More recently the learning opportunities have been adapted to incorporate remote learning opportunities.

Community IV Service launch

The “IV at Home” service allows patients to receive medication through intravenous injections in their own homes rather than having to remain in hospital. The service launched in May 2020 and has been well received by patients.

The service is made up of highly skilled nurses who provide a 9am to 5pm service, seven days a week to people in the South Cheshire and Vale Royal areas.

The IV at Home service work with nurses and consultants at Leighton Hospital to identify patients most suitable for the therapy, a multidisciplinary approach is then provided to the patient consisting of consultants, pharmacists, microbiology and nurses to ensure quality and safe care.

Providing IV medications to patients in their own home will allow them to resume or continue with their life quicker whilst maintaining the high quality of care they would have received in hospital. In doing so, this also frees up hospital beds to support acute admissions, which we are already seeing as a positive result.

Bladder and Bowel service

Over the past 12 months the Community Bladder and Bowel Service (CCBS) have increased their team of Specialist Nurses to meet the demand of Adult and Children in the CCICP area.

The service has progressed and within each initial level 2 assessment "every contact counts" and the SPN's assess all aspects of Bladder and Bowel Health ruling out red flags in line with best practice guidelines. The service is also working alongside other Multi-Disciplinary Teams to reduce falls, cognitive impairment and pressure area development.

The service has looked at different ways of working to reduce waiting time so patients can be seen in a timely manner and care pathways commenced to reduced symptoms and improve quality of life.

Within children's and young adult service we now have an Advanced Practitioner in post to focus on play therapy, complex toilet training, and health promotion in special school, main stream schools and support children with complex needs related to bladder and bowel dysfunction.

The Community Bladder and Bowel Service has also increased training for CCICP health professionals and other services, the purchase of a demonstration model has enabled practical demonstrations of male/female and supra pubic catheterisation to be undertaken during training.

Statements of assurance from the Board

Review of services

During 2019/20 the Trust provided and/or sub-contracted 40 relevant health services.

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

The income generated by the relevant health services reviewed in 2019/20 represents 100% of the total income generated from the provision of relevant health services by the Trust for 2018/19.

Participation in Clinical Audits and Research

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

National Clinical Audit

During 2019/20, 45 national clinical audits and 3 national confidential enquiries (Clinical Outcome Review Programmes) covered NHS services that MCHFT provides.

During that period, MCHFT participated in 93% of national clinical audits and 100% of national confidential enquiries (Clinical Outcome Review Programmes) of the national clinical audits and national confidential enquires (Clinical Outcome Review Programmes) which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Trust was eligible to participate in during 2019/20 are shown in the table below.

The national clinical audits and national confidential enquires that the Trust participated in during 2019/20 are shown in the table below.

The national clinical audits and national confidential enquires that the Trust participated in, and for which data collection was completed during 2019/20, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Clinical Audit Participation 2019/20

National Clinical Audit and Clinical Outcome Review Programme	Participation	Data submission*
Assessing Cognitive Impairment in Older People	Yes	100 cases

/ Care in Emergency Departments (RCEM)		
BAUS Urology Audits: Female stress urinary incontinence	Yes	25 cases
BAUS Urology Audits: Percutaneous Nephrolithotomy	Yes	12 cases
Care of Children in Emergency Departments (RCEM)	Yes	126 cases
Case Mix Programme (CMP)	Yes	100%
Child Health Clinical Outcome Review Programme (NCEPOD)	Yes	100%
Elective Surgery (National PROMs Programme)	Yes	See PROMs section of this report
Endocrine and Thyroid National Audit	Yes	12 cases
Falls and Fragility Fractures Audit programme (FFFAP):		
National Inpatient Falls	Yes	100%
National Hip Fracture Database	Yes	100%
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit	Yes	69 cases
Major Trauma Audit	Yes	100%
Mandatory Surveillance of bloodstream infections and clostridium difficile infection	Yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme:		
Perinatal Mortality Surveillance	Yes	100%
Perinatal Morbidity and Mortality Confidential Enquiries	Yes	100%
Maternal Mortality Surveillance and Mortality Confidential Enquiries	Yes	100%
Medical & Surgical Clinical Outcome Review Programme:		
Pulmonary Embolism	Yes	100%
Acute Bowel Obstruction	Yes	100%
Mental Health – Care in Emergency Departments (RCEM)	Yes	93 cases
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP):		
Adult Asthma Secondary Care	Yes	66 cases
Chronic Obstructive Pulmonary Disease (COPD) Secondary Care	Yes	197 cases
Pulmonary Rehabilitation (Community)	Yes	86 cases
National Audit of Breast Cancer in Older Patients (NABCOP)	Yes	100%
National Audit of Cardiac Rehabilitation	Yes	100%

National Audit of Care at the End of Life (NACEL)	Yes	100%
National Audit of Dementia (care in general hospitals)	Yes	100%
National Cardiac Arrest Audit (NCAA)	Yes	100%
National Cardiac Audit Programme:		
Myocardial Ischaemia National Audit Project (MINAP)	Yes	100%
National Heart Failure Audit	Yes	40%
National Diabetes Audit – Adults	Yes	100%
National Audit of Rheumatoid and Early Inflammatory Arthritis (NEIAA)	Yes	57 cases
National Emergency Laparotomy Audit (NELA)	Yes	91%
National Gastrointestinal Cancer Programme:		
Oesophago-gastric Cancer (NAOGC)	Yes	85-100%
National Bowel Cancer Audit (NBOCA)	Yes	93%
National Joint Registry (NJR)	Yes	98%
National Lung Cancer Audit (NLCA)	Yes	100%
National Maternity and Perinatal Audit	Yes	100%
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Yes	100%
National Ophthalmology Audit	Yes	100%
National Paediatric Diabetes Audit (NPDA)	Yes	107 cases
National Prostate Cancer	Yes	154 cases
Perioperative Quality Improvement Programme	Yes	
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis):		
Antiobiotic Consumption	Yes	100%
Antibiotic Stewardship	Yes	30 cases per quarter
Sentinel Stroke National Audit programme (SSNAP) (Acute / Community)	Yes	90%+ / 165 cases
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Yes	100%
Society for Acute Medicine's Benchmarking Audit (SAMBA)	Yes	100%
Surgical Site Infection Surveillance Service	Yes	100%
UK Parkinsons Audit	Yes	42 cases

*All rates/figures are based on latest available data/reports

Non-Participation

National Clinical Audit and Clinical Outcome Review Programme	Reason for Non-Participation
National Audit of Seizure Management in Hospitals (NASH3)	Lack of clinical resource / project quality
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	Lack of clinical resource
National Smoking Cessation Audit	Lack of clinical resource

The reports of 32 national clinical audits were reviewed by the provider in 2019/20 and the Trust intends to take the following actions to improve the quality of healthcare provided:

National Clinical Audit Participation 2019/20 – Actions

National Clinical Audit and Clinical Outcome Review Programme	Actions taken / to be taken
Case Mix Programme (CMP)	Quarterly reviews of all ICNARC/Critical Care activity at the multidisciplinary team meeting and all individual cases discussed with any issues being taken forward by the clinical lead as part of the governance strategy.
Elective Surgery (National PROMs Programme)	See Patient Reported Outcome Measures Scores section of this report.
Falls and Fragility Fractures Audit programme (FFFAP): National Hip Fracture Database	Review and improvement plan in progress.
Inflammatory Bowel Disease (IBD Registry), Biological Therapies	Review and improvement plan in progress.
Major Trauma Audit	Outcomes in major trauma are in line with expected level and consultant led trauma teams within 30 minutes was 100% compliant for the last financial year. Work is still ongoing to improve times to CT for NICE head injured patients.
Maternal, Newborn and Infant Clinical Outcome Review Programme:	
Perinatal Mortality	Review and improvement plan in progress.
Saving Lives, Improving Mothers Care	Review and improvement plan in progress.
Medical & Surgical Clinical Outcome Review Programme:	
NCEPOD Mental Health in Young People	Review and improvement plan in progress.
NCEPOD Pulmonary Embolism	Review and improvement plan in progress.
NCEPOD Acute Bowel Obstruction	Review and improvement plan in progress.
National Asthma and COPD Audit Programme (NACAP):	
National Chronic Obstructive Pulmonary	Joint development of a COPD Discharge Bundle

Disease	for acute care and the Integrated Respiratory Team. Quality Improvement project underway around ventilation requirements on presentation for acutely unwell patients.
National Adult Asthma	Review and improvement plan in progress.
National Audit of Breast Cancer in Older Patients (NABCOP)	Positive results around short time to treatment, short hospital stay, surgical treatment and tests offered. Work is ongoing to increase capacity for one stop clinics.
National Audit of Care at the End of Life (NACEL)	Education sessions with emphasis on prognosis, communication, documentation and hydration/nutritional needs. Acute palliative care nurse role to review patients in admitted to acute areas.
National Cardiac Arrest Audit (NCAA)	Rate of cardiac arrest is lower than national figures and data submission remains good. A review of pre-arrest factors relating to 'Do Not Actively Resuscitate' order and escalation of deteriorating patients is underway.
National Cardiac Audit Programme:	
Myocardial Ischaemia National Audit Project (MINAP)	Review and improvement plan in progress.
National Heart Failure Audit	Review and improvement plan in progress.
National Diabetes Audit – Adults	Review and improvement plan in progress.
National Early Inflammatory Arthritis Audit (NEIAA)	Review and improvement plan in progress.
National Emergency Laparotomy Audit (NELA)	Review and improvement plan in progress.
National Gastrointestinal Cancer Programme:	
Oesophago-gastric Cancer (NAOGC)	Review and improvement plan in progress.
National Bowel Cancer Audit (NBOCA)	Review and improvement plan in progress.
National Maternity and Perinatal Audit	Working in-conjunction with local authorities on healthy lifestyle programmes and information leaflets for pregnant women and families. Use of the Maternity Voices Partnership to discuss/address barriers to women's birth choices. Audits underway around obstetric haemorrhage and tears in instrumental delivery.
National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)	Audits of NICE Guidance for antenatal steroids and the use of magnesium are underway. Development of multidisciplinary care bundle for admission normothermia of very preterm babies. Incident reporting implemented for very preterm babies admission temperature is below 36^{o}C. Working with local parent representative to improve parental attendance on ward rounds.

National Ophthalmology Audit	Trust results favourable against national standards. Work is ongoing to improve mechanisms for obtaining and reviewing post-operative outcomes data and patient reported outcome measures (PROMs).
National Paediatric Diabetes Audit	Review and improvement plan in progress.
National Prostate Cancer Audit	Review and improvement plan in progress.
Sentinel Stroke National Audit Programme (SSNAP) **(Acute / Community)**	Some discrepancy around the reported results for the Trust as the pathway is across two hospital sites – work is underway with the project providers to correct this. The team are working towards reducing door to needle time and investigating the use of a portable phone to enable attendance in the Emergency Department on patient arrival. / Changes to Stroke Team pathways and a focus on rehabilitation.
Feverish Child (RCEM)	Electronic calculation of PEWS at triage. Sepsis screening tool and visual cues/checklist redesigned into paediatric casualty card. NICE traffic light system and feverish illness/sepsis incorporated into departmental teaching programme and simulation sessions. Advice leaflets developed for provision on patient discharge.
Vital Signs in Adults (RCEM)	Introduction of electronic observations record and incorporation of patient safety checklist for repeat observations.
VTE Risk in Lower Limb Immobilisation (RCEM)	Pathway revised to include patients immobilised in boots as well as casts and pathway re-launched. Specific information provided for patients presenting at satellite unit. Advice sheet produced and available in Polish.
UK Parkinsons Audit (Community)	Review and improvement plan in progress.

NB A number of annual reports were delayed in 2019-20 due to purdah

Local Clinical Audits

The reports of 77 local clinical audits were reviewed by the provider in 2019/20 and the Trust intends to take/has taken the following actions to improve the quality of healthcare provided in the sample of projects below:

Local Clinical Audit	Actions Taken / To Be Taken
Follow-up in Laryngo Pharyngeal Reflux	Development and implementation of a pathway for patients presenting with Laryngo Pharyngeal Reflux and improved patient information leaflet to include follow-up options. Investigation of potential for

	telephone follow-up and development of business case for transnasal oesophagoscopy.
Anaesthetic Audit of Day Case Tonsillectomies	Development and implementation of new post-operative nausea and vomiting guidelines based on national guidance. Development and implementation of new fasting guidelines for children and related patient information leaflet to decrease post-operative nausea and vomiting. Continuous data collection on unplanned overnight admissions for elective paediatric surgery to identify and recurring causes.
Mole Mapping Referral Criteria	Improvements in the specificity of the mole mapping system seen from previous results and fewer mildly atypical and benign lesions removed. Inclusion of increase in size and development of reticular streaks in excision criteria and editing of mole mapping pro forma to include list of criteria to aid documentation and future audit. Upgrade of all patients with suspicious melanoma to the 2 week wait pathway.
Routine Enquiry for Domestic Abuse	Specific room/venue in antenatal clinic for individual review of booking patients. Patients notified on allocation of booking appointment that the first five minutes will be alone with a midwife. Routine screening provided during observations at booking appointments.
Quality of Care Given to Children and Young People Presenting with Self Harm	Development and implementation of new self-harm pro-forma including prompts for safeguarding checklist with reminders and CAMHS tick list. Inclusion of risk assessment and equipment removal forms in new self-harm pro-forma and promotion of out of hours CAMHS service for further availability of CAMHS weekend service.
Monitoring of Vital Signs for Patients who are Acutely Unwell or at Risk of Clinical Deterioration	Further education provided for nursing teams and medical teams around accurate NEWS2 recording and identification of patients requiring SPO2 respectively. Update NEWS2 Policy around documentation on vital signs charts. Updates to prescription charts and fluid balance charts to improve oxygen prescribing and fluid balance monitoring.

Participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by MCHFT in 2019/20 that were recruited during the period to participate in research approved by a research ethics committee was 585.

Commissioning for Quality and Innovation (CQUIN)

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

A proportion of the Trust's income in 2019/20 was conditional on achieving quality improvement and innovation goals agreed between MCHFT and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2019/20 and for the following 12 month period are available electronically at:

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

The overall financial value of CQUIN schemes is currently 2.5% of the provider's contract value.
The overall financial value of CQUIN schemes is currently 1.25% of the provider's contract value.

The financial value of the 2019/20 CQUIN scheme for the acute Trust was £2,314,858. The total amount the Trust received in payment for the CQUIN scheme was £1,026,271

The financial value of the 2018/19 CQUIN scheme for the Trust was £4,254,800.

The financial value of the 2019/20 CQUIN scheme for CCICP was £368,637. The total amount the Trust received in payment for the CQUIN scheme was £368,637

For 2019/20 there are **seven** National goals of which **four** apply to MCHFT, **two** apply to CCICP and **one** applies to both.

The North of England Specialised Commissioners has negotiated **one** goal in relation to hospital pharmacy transformation and medicines optimisation.

Key CQUIN results for 2019/20:

Achieved 

Partially Achieved 

Not achieved 

Milestones not set for this quarter 

**Due to the Covid19 pandemic outbreak Quarter 4 CQUIN was suspended.

Goal	Goal name	RAG Status Q1	RAG Status Q2	RAG Status Q3	Financial Value of the goal (£)
1a.	Antimicrobial resistance – Lower Urinary Tract Infections in Older People				£223,517
1b.	Antimicrobial Resistance Antibiotic Prophylaxis in				£223,517

	Colorectal Surgery Antimicrobial				
2.	Flu Vaccinations (Acute & CCICP)				£631,353
3a.	Alcohol and Tobacco – Screening				£149,011
3b.	Alcohol and Tobacco – Tobacco brief advice				£149,011
3c.	Alcohol and Tobacco – Alcohol brief advice				£149,011
7.	Three high impact actions to prevent Hospital Falls				£447.034
9.	Six month reviews for stroke survivors				£184,319
11a.	Same Day Emergency Care – Pulmonary Embolism				£149,011
11b.	Same Day Emergency Care – Tachycardia with AF				£149,011
11c.	Same Day Emergency Care – Community Acquired Pneumonia				£149,011

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

Feedback from Care Quality Commission (CQC)

The Trust is required to register with the Care Quality Commission (CQC) under section 10 of the Health and Social Care Act 2008 and its current registration status is registered without conditions. The Trust's registration includes the services provided at Leighton Hospital, Victoria Infirmary in Northwich, Elmhurst Intermediate Care Centre in Winsford and the community services within the Central Cheshire Integrated Care Partnership (CCICP). The Care Quality Commission has not taken enforcement action against the Trust during the period April 2019 to March 2020.

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

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

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

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

During these inspections the CQC investigated key lines of enquiry using the pre-inspection information the Trust had provided within their Provider Information Return, and also information CQC gathered during inspection activity from patients, their families and carers, and Trust staff.

As part of the Trust's preparation and assurance gathering for future CQC inspection activity, the Director of Nursing & Quality commissioned a programme of work during 2019/20 to seek assurance on behalf of the Board, of care and services delivered by the Trust being safe, effective, responsive, caring and well led. A mock CQC inspection was delivered Trust wide, which focussed on the CQC KLOEs. The inspection was designed to provide opportunity for staff to prepare themselves for future CQC inspection activity, and to showcase the excellent work across the Trust.

An improvement plan was created as a result of the mock inspection. Delivery of this plan is overseen by Quality Summit. Quality Summit meets fortnightly and membership includes Heads of Nursing, Assistant Medical Directors, and Divisional General Managers. It is chaired by the Director of Nursing & Quality, and regularly reports into the Executive Quality Governance Group. The improvement plan evidences the completion and ongoing monitoring, where required, of actions taken to improve and maintain service quality and patient safety within the Trust. Delivery of the plan is managed by the Quality Summit group with oversight by the Executive Quality Governance Group, and assurances provided to Quality Governance Committee. Quality Governance Committee is a Board sub-committee with delegated authority from the Board of Directors to oversee matters relating to quality of care and the maintenance of unconditional registration with the CQC. Each Division provides a progress update to the Quality Summit fortnightly on the improvement actions for

their areas, including assurances on how changes are being monitored and improvements embedded into practice.

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

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

The Trust has received 12 enquiries from the CQC during 2019/20. All responses were returned within the given timeframes.
The Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

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

Overall trust quality rating	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good
Are resources used productively?	Good

Data Quality Assurance

NHS and General Practitioner registration code validity (April 19 – November 19 From NHS Digital SUS dashboard)

The Trust submitted records during 2019/20 to the secondary uses service for inclusion in the Hospital Episodes Statistics which are included in the latest published data.

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

- 99.9% for admitted patient care;
- 100% for outpatient care;
- 99.3% for accident and emergency care.

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

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

Information Governance toolkit attainment

The Trust is required to make an annual submission to NHS Digital in order to provide an assurance that adequate measures are in place to protect the data it holds. This is done in the form of a self-assessment called the Data Security and Protection Toolkit (DSPT) which is supplemented by an external audit.

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

Clinical coding error rate

The Trust was not subject to the Payment by Results clinical coding audit during 2019/20 by the Audit Commission.
Clinical Coding department were subject to a Data Security Protection (DSP) Toolkit audit, the results of this audit are listed in the table below.

CODING FIELD	PERCENTAGE CORRECT	Mandatory	Advisory
Primary Diagnosis	90.00%	90.00%	95.00%
Secondary Diagnosis	92.03%	80.00%	90.00%
Primary Procedure	94.70%	90.00%	95.00%
Secondary Procedure	86.99%	80.00%	90.00%

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

- Deliver a robust annual coding audit programme to ensure that staff maintain and enhance their skills in line with the National Clinical Coding Standards.

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

Learning from Deaths

During 2019/20 1033 of Mid Cheshire Hospitals NHS Foundation Trust patients died. This comprised of the following number of deaths which occurred in each quarter of that reporting period:

- 249 in the first quarter
- 219 in the second quarter
- 269 in the third quarter
- 296 in the fourth quarter.

By 31 March 2020, 750 case record reviews and 9 investigations have been carried out in relation to 1033 of the deaths included above.

In 9 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 216 in the first quarter
- 262 in the second quarter
- 175 in the third quarter
- 106 in the fourth quarter

9 representing 0.87% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.
In relation to each quarter, this consisted of: 1 representing 0.4% of deaths for the first quarter; 1 representing 0.5% for the second quarter; 4 representing 1.5% for the third quarter; 3 representing 1% for the fourth quarter. These numbers have been estimated using the Structured Judgement Review Process and or root cause analysis process.

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

care goes well and to identify points where there may be gaps, problems or difficulty in the care process.

The SJR produces two types of data:

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

The phases of care which are reviewed are:

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

The overall quality of care is assessed during the SJR process. Care scores are recorded after the judgement comments have been written. One score is given to each phase of care. The reviewers then judge their overall decision on the overall quality of care. The Trust's Learning from Deaths Policy built upon the Mortality Case Note Review Standard Operating Procedure, which outlined the existing embedded process for reviewing all in-hospital deaths.

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

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

- All deaths where families, carers or staff raise concerns
- Deaths where concerns are raised by the Coroner
- Deaths where concerns are raised at the Patient Safety Summit
- Deaths due to alcohol related liver disease
- Relevant elective deaths
- Deaths due to septicaemia (at the weekend)
- Deaths due to congestive heart failure – non-hypertensive (at the weekend)
- Deaths due to an acute myocardial infarction
- Deaths from admissions on a Monday

The learning from these reviews is reported in the Trust quarterly Learning From Deaths Report and is collated and shared in a quarterly newsletter, 'Learning from our Mortality Reviews' as well as at the Trust Mortality Reduction Groups. The Trust has a well-established HMRG led by the Medical Director. This group leads the Trust's mortality

reduction programme and, on a quarterly basis, meets with the Divisional Mortality Reduction Groups to ensure a unified approach to mortality reduction across the Trust and to share learning opportunities.

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

Summary of Learning

Below are a number of the positive comments made during the reviews;

- Excellent Advance Nurse Practitioner Reviews
- Good evidence of use of the LOCSIPPS
- Excellent Macmillan support
- There were a number of examples of excellent communication with patients and their families
- Evidence of excellent multi-disciplinary team approach to patient care
- Evidence of good planning and preparation for end of life care with regular family input
- Excellent continuity with medical care and escalation of care needs as appropriate

The SJRs undertaken in Q1, 2 & 3 have identified the following learning themes;

- Delays in commencement of end of life care plans
- End of life care plans not fully completed
- Ceilings of care not documented
- Evidence of the Emergency Department checklist not being fully completed
- Sepsis pathways not completed
- Antibiotics not given in timely manner when sepsis suspected

Actions and Assessment of Impact

Improvement work is ongoing in relation to the identified themes and these are monitored through the Quality & Safety Improvement Strategy and the Deteriorating Patient Steering Group. End of Life Care and Sepsis are both work streams in the Quality and Safety Improvement Strategy 2019/20. The improvement work is monitored and reported through the Quality and Safety Improvement Strategy Group.

A care pathway group chaired by the Executive team monitors the compliance with care pathways. Clinical leads have been identified for each of the pathways and monitoring is undertaken by the Care Pathway Group, reporting to the Quality and Safety Improvement Strategy Group with escalation to the Executive Quality Governance Group and assurances to the Quality Governance Committee.

There have been no deaths during the previous reporting period which were not included in the Quality Account for the previous reporting period.

Performance against quality indicators and targets

National quality targets

	2015-16	2016-17	2017-18	2018-19	2019-20	Target	Achieved
Clostridium Difficile Infections	10 avoidable cases	3 avoidable cases	2 avoidable cases	1 avoidable cases	0	0	✓
Percentage of patients who wait 4 hours or less in A&E	93.40%	90.25	87.12%	83.63%	76.78%	95%	✗
The percentage of patients waiting 6 weeks or more for a diagnostic test	0.55%	0.34%	0.31%	0.41%	3.16%	1%	✗
Summary Hospital-level Mortality Indicator				105.48	98.85		
Venous thromboembolism (VTE) risk assessment	96.11%	96.09%	95.50%	95.24%	95.91%	95%	✓
Percentage of patients receiving first definite treatment for cancer within 62 days of an urgent GP referral for suspected cancer	91.22%	90.98%	93.70%	88.98%	86.22%	85%	✓
Percentage of patients receiving first definite treatment for cancer within 62 days of referral from an NHS Cancer Screening Service	97.94%	93.67%	97.09%	94.44%	89.29%	90%	✗
The percentage of Referral to Treatment (RTT) pathways within 18 weeks for incomplete pathways	95.02%	94.82%	95.90%	92.38%	91.37%	92%	✗

The Trust continues to deliver a high quality, timely service to our patients. The waiting times for the elective programme is one of the highest performing in the country. The organisation continues to deliver the national cancer waiting times for our patients.

Nationally these standards have become more challenging to deliver due to increasing demand and workforce challenges.

The waiting times with the Emergency Department remain particular challenged, this is mirrored nationally however the increasing demand the Mid Cheshire Emergency Department have experienced is higher than the national increase. The team at Mid Cheshire have agreed the physical expansion of the Emergency Department and significantly increased the workforce across 2019/20 to meet this demand. We have also implemented a safety checklist within the department to ensure patients waiting are safe and being cared for.

National quality indicators

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

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

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

Indicator	Measure Description			
SHMI	A) The value and banding of the summary hospital-level mortality indicator (SHMI) for the Trust for the reporting period.			
Period	**Trust Performance**	**National Average**	**95% Upper Limit**	**95% Lower Limit**
January 17-December 17	104.12	100	112.47	88.91
April 17 – March 18	104.39	100	112.57	88.84
July 17 – June 18	104.75	100	112.51	88.88
October 17 – September 18	105.48	-	112.72	88.72
January 18 – December 18	104.06	100	112.44	88.93
April 18 – March 19	100.95	-	113.07	88.44
July 18 – June 19	102.10	100	113.31	88.26
October 18 – September 19	101.31	100	113.57	88.05
November 18 – October 19	101.97	100	113.71	87.94
December 18 – November 19	100.84	100	113.56	88.06
January 19 – December 19	100.38	100	113.99	87.73
February 19 – January 20	99.54	100	113.78	87.89
March 19 – February 20	98.85	100	113.58	88.04

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

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

- For the reporting period March 2019 to February 2020, the SHMI is currently 98.85 and is in the 'as expected' range.

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

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

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

- Having a reducing hospital mortality rates driver diagram, which is reviewed 6 monthly and approved by HMRG. There are five primary drivers:

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

Indicator	Measure Description			
SHMI	B)The percentage of patient deaths with palliative care coded at either diagnosis or specilaity level for the Trust for the reporting period.			
Period	**Trust Performance**	**National Average**	**95% Upper Limit**	**95% Lower Limit**
July 17 – June 18	0.91%	1.14%	2.89%	0.44%
October 17 – September 18	0.88%	1.15%	2.83%	0.48%
January 18 – December 18	0.90%	1.12%		
April 18 – March 19	0.97%	1.14%		
July 18 – June 19	1.02%	1.17%		
October 18 – September 19	1.09%	1.16%		
November 18 – October 19	1.13%	1.19%		
December 18 – November 19	1.12%	1.17%		
January 19 – December 19	1.12%	1.18%		
February 19 – January 20	1.07%	1.22%		
March 19 – February 20	1.06%	1.20%		

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

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

Indicator	Measure Description				
PROM	The Trust's patient reported outcome measure scores for groin hernia surgery, varicose vein surgery, hip replacement surgery and knee replacement surgery during the reporting period.				
Date	**Measure**	**Trust performance**	**National Average**	**Highest Result**	**Lowest Result**
Hip Replacement					
2016-2017	EQ5D	0.415	0.437	0.53	0.328
2017-2018	EQ5D	0.448	0.458	0.55	0.357
2016-2017	VAS	12.768	13.112	20.183	7.893
2017-2018	VAS	11.567	13.877	18.514	7.991
2016-2017	OXFORD HIP	20.441	21.379	25.044	15.968
2017-2018	OXFORD HIP	21.682	22.21	25.045	18
April 18 - March 19	EQ5D	0.43	0.46	0.57	0.33
April 18 - March 19	VAS	15.18	14.05	20.17	5.27
April 18 - March 19	OXFORD HIP	21.87	22.30	26.166	18.52
Knee Replacement					
2016-2017	EQ5D	0.308	0.322	0.398	0.237
2017-2018	EQ5D	0.328	0.334	0.406	0.254
2016-2017	VAS	6.098	6.85	14.443	0.465
2017-2018	VAS	7.169	8.153	13.985	1.752
2016-2017	OXFORD KNEE	15.858	16.393	19.686	12.231
2017-2018	OXFORD KNEE	17.83	17.102	20.394	12.899
April 18 - March 19	EQ5D	0.31	0.34	0.40	0.25
April 18 - March 19	VAS	5.51	7.42	12.70	0.15
April 18 - March 19	OXFORD KNEE	16.83	17.19	20.09	13.52

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

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

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

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

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

Indicator	Measure Description	
Readmission Rates	The percentage of patients aged 0 to 14 readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.	
Period	**Trust per HED**	**Peer Group av HED**
January 15 – December 15	11.40%	10.40%
January 16 – December 16	12.14%	10.44%
January 17 – December 17	12.41%	10.69%
January 18 – December 18	13.58%	11.38%
January 19 – December 19	12.61%	11.96%

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

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

The complexity of some of the young patients relies on a multidisciplinary approach and support in the home, for example there has been an increase in children suffering from mental health issues are readmitted due to support services including other agencies requiring a more robust approach.

The percentage increase is in keeping with peers however as a Trust steps are being taken to reduce the readmission rate. All children and parents being discharged receive safety netting advice written information where appropriate including advising Children/parents/ guardians what to observe for and how to manage any clinical issues. This includes if necessary open access back to the ward and a 24 hr telephone support service in place. At the point of discharge the GP letters are created to ensure the GP are aware as soon as possible to facilitate support from primary care. Children who meet the criteria will also be followed up the Children's Home Care Team.

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

An audit is in the process of being designed to explore delayed and failed discharges to identify issues that may be addressed using quality improvement methodology and the findings will be shared with the appropriate governance committee.

Indicator	Measure Description	
Readmission Rates	The percentage of patients aged 15 and over readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.	
Period	**Trust per HED**	**Peer Group av HED**
January 15 – December 15	7.90%	7.10%
January 16 – December 16	8.23%	7.73%
January 17 – December 17	9.04%	8.16%
January 18 – December 18	8.52%	7.63%
January 19 – December 19	8.99%	8.50%

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

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

- Analysis of the Trusts data shows that Emergency Medicine and Assessment Unit (AMU) are the main outliers causing the above peer position. A Deep dive into Emergency Medicines data shows that patients admitted in to the Clinical Decisions Unit are the main contributor of the high percentage, no clinical concerns or discrepancies were found. AMU patient data shows certain medical presentations are more likely to be readmitted alongside a group of more vulnerable patients which has highlighted an opportunity to develop service changes to support this cohort differently.

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

- Development of a new electronic dashboard to provide clinical teams patient level data at a ward level on a monthly basis
- Continue to monitor this through the sub-divisional governance groups and Divisional Board
- Identification of opportunity to change clinical pathways to support the prevention of re-admissions in a complex group of patients

Indicator	Measure Description			
	Trust Performance		England	
Responsiveness to patient needs	2017/18	2019/20	2017/18	2019/20
Access and Waiting	79.3	79.5	83.5	82.3
Safe, high quality, coordinated care	67.3	68.7	66.8	65.8
Better information, more choice	66.3	67.7	68.6	67.3
Building closer relationships	87.5	88.0	85.8	85.0
Clean, comfortable, friendly place to be	78.7	78.4	81.4	80.4
Inpatient overall patient experience score	75.8	76.4	77.2	80.8
Overall Score	66.9	69.0	68.6	67.2

The Trust's responsiveness to the personal needs

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

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

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

Access and Waiting

This domain captures information about how frequently admission dates are changed, how long patients wait for treatment (higher scores for shorter waits) and how long patients wait after arriving to be allocated a bed. For this domain, two out of the three questions scores have improved slightly. The overall domain score has improved slightly from 79.3 to 79.5.

Safe, high quality, co-ordinated care

This domain includes questions about whether patients were given consistent messages by different members of staff and whether there were delays in discharge from hospital. Of the two questions in this domain, one score has decreased and one score has improved with fewer patients reporting experience of delayed discharges (score increasing from 67.3 to 68.7).

Better information, more choice

This domain captures feedback on whether patients were involved as much as they wanted to be in decisions about their care and treatment and whether staff clearly explained the purpose and side effects of medicines. All three questions that form this domain have shown improved scores and the overall domain score has improved from 66.3 to 67.7.

- More patients were satisfied with their involvement in decisions about their care and treatment (score increasing from 74 to 75)
- More patients reported being told about medication side effects to watch for at home (score increasing from 44 to 46)
- More patients received an explanation of the purpose of the medications they were to take at home (score improves from 81 to 82).

Building closer relationships

This domain includes four survey questions, and the overall domain score has improved from 87.5 to 88. The domain assesses whether doctors or nurses provided information to patients in a way they could understand and whether doctors or nurses spoke about patients as if they weren't there. Two of the four questions included in this domain have improved scores and two remain the same.

- Fewer health professionals spoke in front of patients as if they weren't there (for doctors the score increased again from 89 to 90 and for nurses the score improves from 90 to 91)
- More health professionals gave information to patients in a way they could understand (for doctors the score remains same at 86 and for nurses the score remains same at 85).

Clean, comfortable, friendly place to be

For the seven survey questions the domain score reduced slightly from 78.7 to 78.4. This domain captures feedback on whether patients were disturbed by noise at night, asking patients what they thought about the cleanliness of their hospital room or ward and how patients felt they were treated by staff, including how much privacy they were given, whether they were helped to manage their pain and if they felt that they were treated with dignity and respect. There has been an improvement in two of the seven question scores. Two scores are reduced – noise and cleanliness.

- Patients' opinions of cleanliness of the room or ward stayed the same (score reduced from 87 to 84)
- Patients' reporting of whether they were treated with respect and dignity stayed the same (score remaining at 90)
- The score rating for hospital food remains the same at 60.

The overall patient experience score has improved from 75.8 to 76.4.

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

- Improve ward cleanliness
- To reduce delays for patients when they are medically fit to leave hospital to continue the improvements made in in 2019

Scores have been included from Survey Contractor as the CQC Benchmark report is not available until June 2020.

Indicator	Measure Description			
Friends & Family	Staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.			
Period	**Trust Performance**	**National Average**	**Upper Limit**	**Lower Limit**
2017 staff survey	75%	70.2%	89.3%	48%
2018 staff survey	77.5%	69.9%	90.3%	49.2%
2019 staff survey	76%	71%	90.5%	48.8%

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

The Staff Friends and Family Test is carried out in all NHS Trusts providing acute and community health services in England with the aim of giving all staff the opportunity to feed back their views on their organisation at least once a year.

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

The 2019 results place the Trust in the reporting category of combined acute and community trusts, instead of solely acute trust for the third year and whilst there has been a slight decline in the overall position in 2019, the results are broadly reflective of the previous two years.

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

- Progressing the actions within the NHS People Plan to ensure national and local strategic objectives are achieved
- Prioritising the wellbeing of all staff by delivering a range of health and wellbeing initiatives with a focus on psychological and physical health
- Progressing a number of organisational development workstreams which focus on quality improvement, organisational culture and civility
- Involving staff in decision-making and keeping them informed of changes and developments across the organisation
- Taking an open and honest approach in ensuring staff are informed about the Trust's performance and key decisions being made, as well as giving staff the opportunity to put forward any views or suggestions about how we can improve the experience of our patients, services users and staff
- Working with our Staff Governors who make a valuable contribution to the governance and development of the organisation.
- Using a range of well-established forums for consulting with and engaging staff and their representatives as well as developing new and innovative ways of communicating with staff including virtual team briefs, interactive team talk sessions and video briefings.

Indicator	Measure Description			
VTE	The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.			
Period	**Trust Performance**	**National Average**	**95% Upper Limit**	**95% Lower Limit**
January 17 – March 17	95.61%	96.00%	99.87%	63.02%
April 17 – June 17	95.58%	96.00%	99.97%	51.38%
July 17 – October 17	95.55%	No data available	No data available	No data available
October 17 – December 17	95.31%	No data available	No data available	No data available
January 18 – March 18	94.59%	No data available	No data available	No data available
April 18 – June 18	95.07%	No data available	No data available	No data available
July 19 – September 18	95.57%	No data available	No data available	No data available
October 18 – December 19	95.24%	No data available	No data available	No data available
January 19 – March 19	95.06%	No data available	No data available	No data available
April 19 – June 19	96.31%	No data available	No data available	No data available
July 19 – October 19	96.48%	No data available	No data available	No data available
October 19 – December 19	95.63%	No data available	No data available	No data available
January 20 – March 20	95.36%	No data available	No data available	No data available

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

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

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

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

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

Indicator	Measure Description			
C.Difficile	The rate per 100,000 bed days of cases of C.difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period.			
Period	**Trust Performance**	**National Average**	**95% Upper Limit**	**95% Lower Limit**
2015-2016	22.2	15.1	67.2	0
2016-2017	12.2	14.92	82.6	0
2017-2018	11.1	13.65	90.3	0
2018-2019	13.5	11.5	81.6	0
2019-2020	16	Not yet published	Not yet published	Not yet published

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

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

Prior Healthcare Exposure

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

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

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

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

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

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

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

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

- The Trust objective for 2019/20 was 23 cases. The Trust reported 16 cases of C.difficile in the HOHA category of which 15 were classified as unavoidable and 1 has been identified as an avoidable case and 12 cases in the COHA category all of which were classified as unavoidable
- Antimicrobial stewardship is closely monitored in line with Trust policy ensuring a focus on antimicrobial prescribing and feedback to medical staff
- Multi-disciplinary bedside reviews of all CDI positive patients throughout their stay.

Indicator	Measure Description			
Patient Safety Incidents	The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period.			
Period	**Trust Performance**	**National Average**	**95% Upper Limit**	**95% Lower Limit**
April 2016 – September 2016	3,348	4,955	13,485	1,485
October 2016 – March 2017	3,353	5,122	14,506	1,301
April 2017 – September 2017	3,485	5,226	15,228	1133
October 2017- March 2018	3,462	5,449	19,897	1,311
April 2018 – September 2018	3,633	5,583	23,692	566
October 2018 - March 2019	3,711	5,841	22,048	1,278
April 2019 – September 2019	Not available	Not available	Not available	Not available

The number of patient safety incidents reported within the Trust.

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

- Nationally, it is viewed that being a high reporter of incidents is a positive position as it demonstrates a risk aware culture within the Trust and highlights that staff are not afraid to report patient safety incidents

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

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

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

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

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

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

Indicator	Measure Description			
Patient Safety Incidents	The number and percentage of such patient safety incidents that resulted in severe harm or death.			
Period	**Trust Performance**	**National Average**	**Highest Result**	**Lowest Result**
April 2016 – September 2016	18	18	111	0
October 2016 – March 2017	19	20	98	0
April 2017 – September 2017	19	19	121	0
October 2017- March 2018	18	19	99	0
April 2018 – September 2018	11	19	96	0
October 2018- March 2019	13	19	85	0
April 2019 – September 2019	Not available	Not available	Not available	Not available

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

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

- The Trust has a positive reporting culture and is a high reporter of incidents. Nationally this is seen as positive. The Trust has undertaken a number of actions as described below to reduce the level of harm caused to patients and to learn from our incidents.

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

- Undertaking a comprehensive investigation for all incidents, which result in severe harm or death in line with the national serious incident framework. An Executive led review meeting is held following the incident investigation to ensure that lessons are learned and improvement plans are implemented to prevent a reoccurrence
- Reporting all incidents which result in severe harm or death to the Board of Directors to ensure openness within the Trust
- Implementing the Trust's *Being Open* (including Duty of candour) policy which ensures that, if an incident occurs which results in moderate harm, severe harm or death, the patient and / or their family are informed, involved in the investigation and the final report, lessons learned and improvement plans from the comprehensive investigation are shared with them.

Part 3

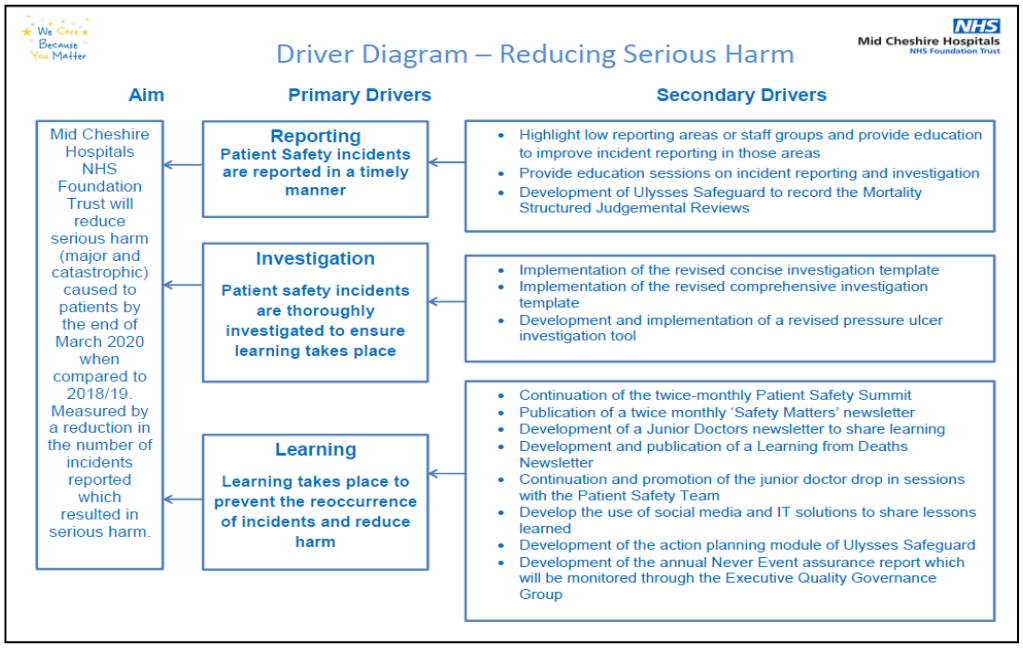
Review of quality performance

Reducing Serious Harm

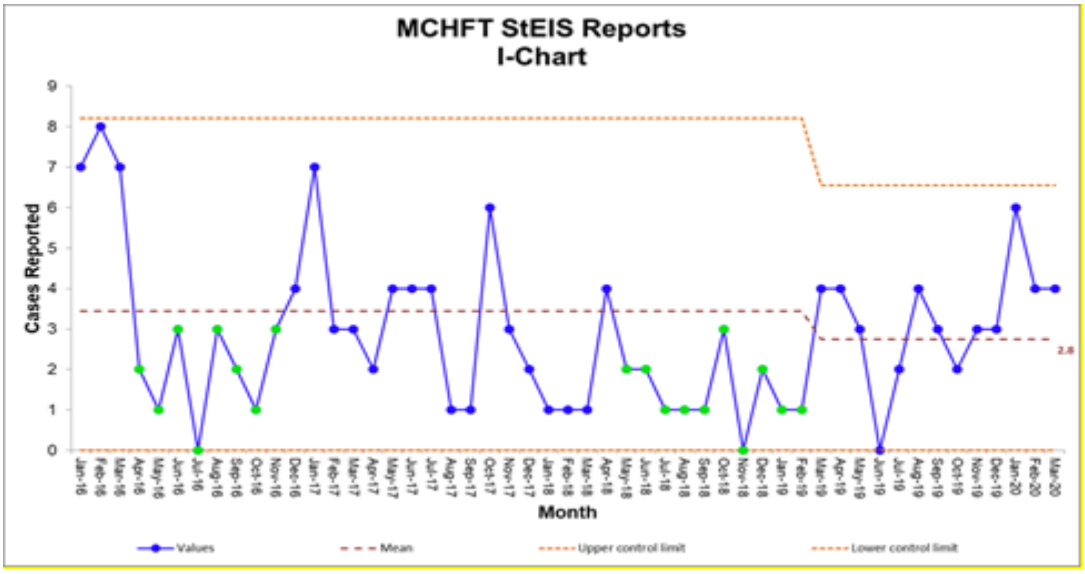
Our aim is to reduce serious harm (major and catastrophic) caused to patients by the end of March 2020 when compared to 2018/19.

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

Reduction in serious harm driver diagram Driver Diagram;



Serious incidents

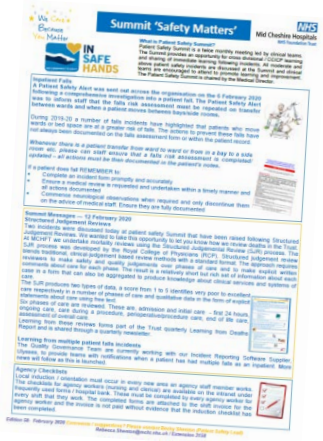


The Trust has reported 37 serious incidents in the period April 2019 to March 2020. The target of 19 serious incidents or less has not been achieved for the financial year.

In August 2019 a Never Event occurred in the organisation. Following the insertion of a double lumen peripherally inserted central catheter (PICC) line, the stylet was left insitu in error following the procedure.

A Never Event was reported in November 2019. An incorrect Intramedullary (IM) nail was inserted into a patient. The patient was undergoing a right sided IM nailing however a left IM nail was inserted.
Comprehensive investigations were undertaken following both incidents to ensure lessons have been learned and improvements undertaken to prevent a reoccurrence.

A comprehensive investigation was undertaken for all the incidents resulting in serious harm or potential serious harm in line with the Trust Incident Reporting, Investigation, Learning and Improvement Policy and national guidance. An Executive Led Review Meeting was held during each investigation and an improvement plan developed and implemented.


Summit 'Safety Matters'

A review of the 48 hour rapid response process was undertaken to ensure immediate learning takes place following the reporting of a suspected serious incident.

A revised lesson learned template has been developed to share learning from the investigations. The lessons learned which are shared following each comprehensive investigation highlights the root cause of the incident, good practice which was identified, areas for improvement and the learning points that the review panel wish to share.
Learning from all investigations is also shared at the two-weekly Patient Safety Summit. Patient Safety Summit is a two weekly meeting led by clinical teams. The Summit provides an opportunity for cross divisional / CCICP learning and sharing of immediate learning following incidents. All moderate and above patient safety incidents are discussed at the Summit and clinical teams are encouraged to attend to promote learning and improvement. The Patient Safety Summit is chaired by the Medical Director.

Following Patient Safety Summit, the Safety Matters Newsletter is shared across the organisation to further share the learning from incident investigation and mortality reviews. Both paper and hard copies of the newsletter are distributed.
The serious incident look back report was shared at Executive Quality Governance Group. The report demonstrated the aggregation of the serious incidents in 2018/19. The look back will be repeated to review the serious incidents for 2019/20.
Structured Judgement Reviews were completed to ensure learning from mortality case reviews.

The quarterly Learning from Deaths Report was shared which highlighted the learning from the Structured Judgement Reviews.

There was the development and distribution of a quarterly 'Learning from Deaths Newsletter'. Hard copies of the report are distributed to the clinical areas.

The Trust has introduced 6 monthly SJR reviewer meetings to share learning.

There has been continued teaching with the Junior Medical Teams to promote incident reporting and learning from serious incidents.

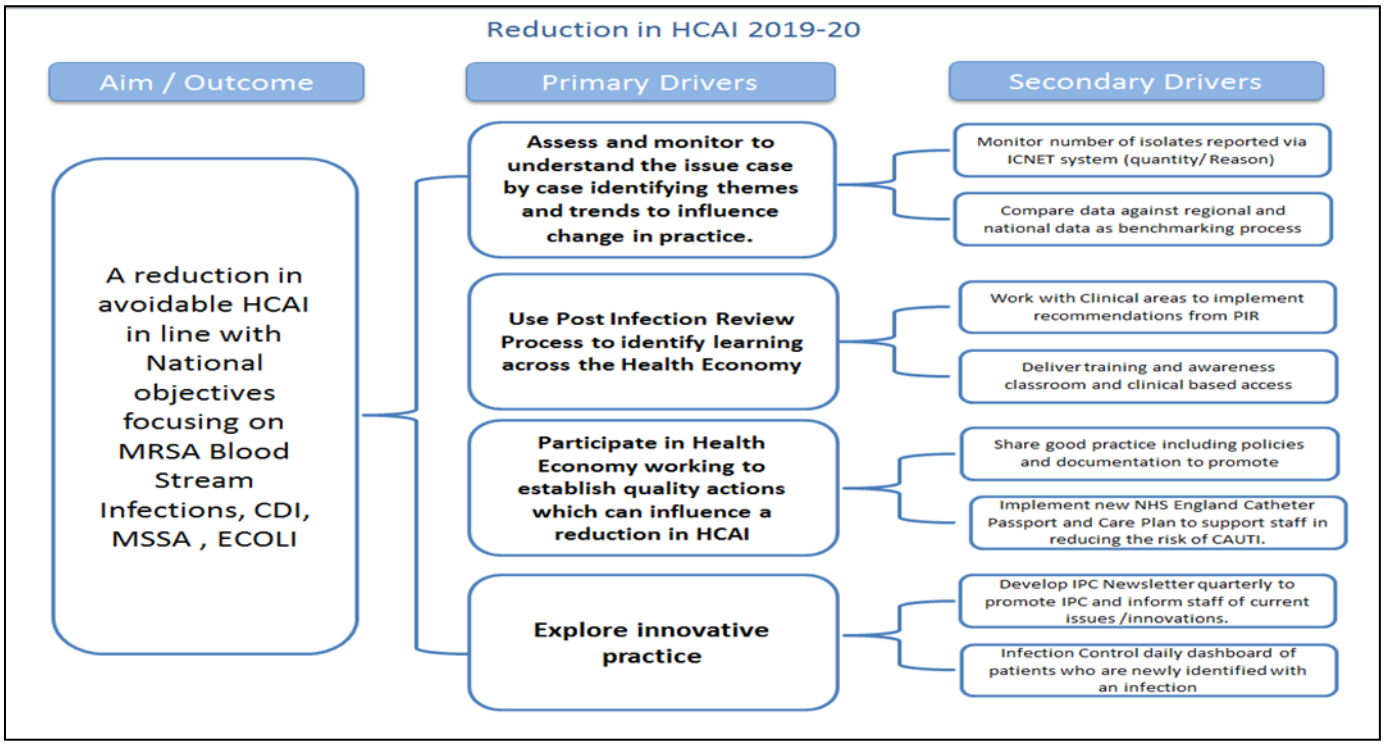
An incident reporting telephone line has been set up to promote no harm incident reporting. Staff are able to phone the Quality Governance team on a dedicated phone line Monday to Friday, 09:00-16:00 to report incidents when they are unable to access the electronic incident reporting form. It is hoped this will save staff time and increase no harm reporting which will encourage further learning.

A gap analysis has been developed to ensure the Trust fully implements the NHS England and NHS Improvement 'NHS Patient Safety Strategy'. As part of the strategy we will ensure that the investigation teams are equipped to learn from what goes well as well as to respond appropriately to things going wrong.

RCA training took place in February 2020 for the Executive, Divisional Senior Management and Quality Governance Teams. Following the training an After Action Review took place to review the training, what worked well with the current review process and what could be improved. The RCA template and Incident Reporting, Investigation, Learning and Improvement Policy are to be reviewed following the feedback.

Reducing Hospital acquired infections

Why is it important?
Reducing the risk of Health Care Associated Infection remains a priority as part of delivering safe quality care to our health population.
This year the Trust have continued to focus on reducing Clostridium Difficile Infections, preventing the occurrence of MRSA blood stream infections and participating in a health economy approach to reducing gram negative bacteraemia in particular ECOLI.
Learning from cases is important to establish any "Lapse in Care'' which either directly or indirectly contributed to a case, identifying any measures which can be implemented to prevent CDI in other patients.



The Trusts aim is to have a reduction in avoidable HCAI in line with National objectives focusing on MRSA Blood Stream Infections, CDI, MSSA , ECOLI

Progress to Date

- There have been no MRSA Blood Stream Infections Year to date.

- There have been 16 Hospital attributable CDI cases all of which have had or are in the process of having a Post Infection Review (PIR), initial findings continue to show the same themes as previous years, age, co morbidities and antibiotics required as part of the care pathway. One case was identified as avoidable due to antimicrobial prescribing.

- There have been 12 cases of Community onset, hospital attributable CDI. The PIR's are being undertaken as planned with the CCG and the Public Health Infection Prevention and control team, this supports the community in the reduction of antimicrobials strategy.

- We are continuing to undertake the mandatory PIR for Public Health on ECOLI, MSSA, and remain part of the health economy working group focusing on Health Care Associated Infections. We are undertaking additional reviews on the MSSA cases and have started to highlight cases which are line related; these will have a more formal PIR led by the Consultant Microbiologist. The reviews undertaken to date have shown that documentation of lines remains an issue, the draft care plan trial has now completed and rolled out across the trust in January and February 2020.

- As part of the 90 day improvement project on Aseptic Non-Touch Technique (ANTT), it was agreed that the ward Managers would keep records of staff who have been updated in ANTT. The new IV project nurse will use this information to support clinical areas in improving compliance.

- The role out of the urinary catheter passport completed its final 90 days, this includes launching the national urinary care passport and care plans based on the HOUDINI principles across the Health economy. The project lead would be happy to present this work to QSIS at a future meeting.

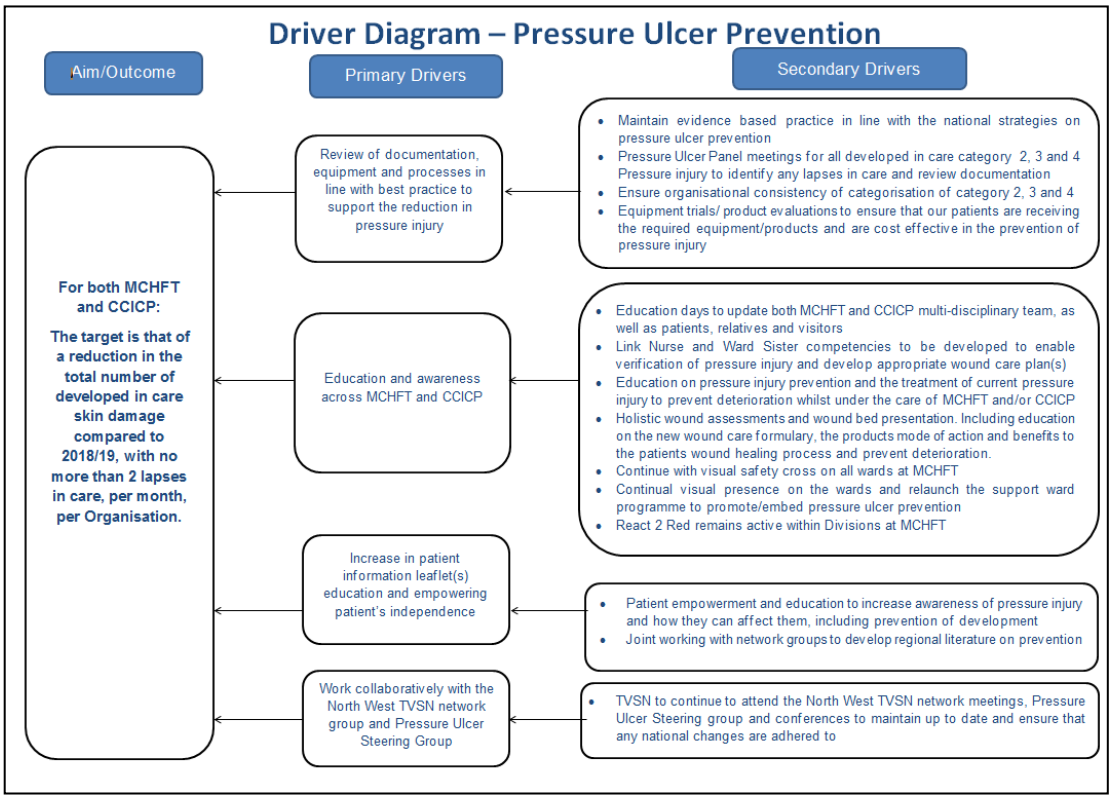
- Development of a Newsletter in draft format which is awaiting feedback from the operational group and final confirmation of the title.

- IPC dashboard for new organisms in progress.

Reducing Pressure Ulcers

A pressure ulcer is an injury to the skin or underlying tissue caused by pressure, friction or moisture. They can be extremely uncomfortable and, in severe cases, can result in severe harm to patients. All patients are potentially at risk of developing a pressure ulcer. However, they are more likely to occur in people who are seriously ill, have a neurological condition, impaired mobility, impaired nutrition or poor posture or a deformity (NICE, 2014). The vast majority of pressure ulcers are avoidable with the right interventions for prevention and treatment (NHS England, 2014).

The Trust aims is a reduction in the total number of developed in care skin damage compared to 2018/19, with no more than 2 lapses in care, per month, per organisation.



Progress to date

	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20
No lapses in care	9	5	4	5	2	2	4	3	6	5	3	13
Lapses in care that did not contribute	0	5	3	6	4	2	2	0	1	1	2	4
Lapses in care that did contribute	4	3	3	2	3	1	1	1	2	1	4	0
Awaiting confirmation by PUP	1	1	5	3	14	10	2	1	4	2	0	1
Total	14	14	15	16	23	15	9	5	13	9	9	18

Action taken during 2019/2020;

- The Pressure ulcer panel continues to meet monthly chaired by the Deputy Director of Nursing. All developed in care skin damage are reviewed including no lapses in care to identify themes, trends and lessons learnt.

- There has been five category 4 pressure ulcer and six category 3 pressure ulcer developed in care since April 2019 (11 in total).

- A Pressure Ulcer Summit was held in October 2019. The summit included sharing of patient stories and lessons learnt from the root cause analysis investigations. There were speakers presenting on NMC responsibilities, legalities of documentation, nutrition, continence, safeguarding, capacity and mechanical devices/casts. The summit was very well attended by both CCICP and MCHFT staff. The feedback from the summit was extremely positive. There will now be a twice yearly pressure ulcer summit which will be open to all staff with a focus on Health care assistants.

- The Tissue Viability Nurse specialist has commenced in post and is working closely with the CCICP TVNs and MCHT staff.

- The Trust's Skin Care group continues to meet monthly and is chaired by the Clinical Quality and Outcomes Matron. The group has multidisciplinary and cross divisional representation. The group have reviewed monthly skin care governance reports which have been used to inform Quality Improvement work. There has been an increase in pressure ulcers both in the Trust and nationally. Therefore a bespoke bi weekly teaching programme was started to address the themes identified from pressure ulcer panel. This is ward based teaching and covers the topics of documentation and skin assessment.

- There was a Stop the pressure day on the 21st November 2019. This is an international event to raise awareness of the impact of pressure ulcers. There were boards at the cross roads and the team visited every ward to ask the staff how they would like to be supported with pressure ulcer teaching. From the feedback it was unanimous that staff preferred study days, as it is time away from the clinical area where they can focus and engage with teaching. As a result, a harm free care day will be starting in March 2020 to facilitate this teaching. These days will be twice monthly, all day. They will include pressure ulcer prevention training as well as falls and sepsis training. The aim of the sessions is to highlight the lessons learnt from the root causes analysis conducted, and use these experiences and lessons learnt as an interactive quiz for staff to participate in, and to see if they could have prevented these pressure ulcers from developing. This will be a really useful learning opportunity as well as giving staff real case scenarios.

- Representatives from MCHFT and CCICP TVN teams have attended the Cheshire and Merseyside Pressure ulcer prevention steering group meetings held quarterly. The steering groups are a great opportunity to discuss national guidance and the potential implications this may have from across the regions. At the previous meeting,

the new best practice statements and guidelines from European Pressure Ulcer Advisory Panel (EPUAP) were discussed along with the national wound care strategy. There is a focus on standardising documentation, reporting of incidents and making evidence informed recommendation in terms of products/equipment. From this group there is a North West pressure ulcer policy which will be rolled out across MCHFT and CCICP.

- There is currently a business case being developed for the Dynamic mattress contract. Currently MCHT own their dynamic mattresses, but some of the parts are becoming obsolete and difficult to replace. Therefore a rental agreement contact is being considered by the Trust. As most Trusts across the region are on a rental agreement for the dynamic mattresses, this has been much discussion with other Trusts.

- There was a mattress audit conducted in October 2019. The audit highlighted how many dynamic mattresses were in operation on patients. This proved invaluable as the Trust is now able to add rental units to be used on an ad hoc basis when escalation areas have been opened. On the day, 80 static mattresses which were removed and replaced with new mattresses. They will be monitored by the house keepers and any of the new mattresses can be condemned and replaced under the company's warranty.

- The process for ordering dynamic mattress has changed, and the mattresses are now all being allocated on a risk assessment basis. This allows the Quality Team to audit the daily usage of the systems, it ensures that the most high risk patient receive a mattress, and has drastically reduced the waiting times for the mattresses. It has also highlighted the lack of dynamic mattresses in the system at times of extreme pressure on bed capacity. During these times, additional rental units have been sourced to ensure all patients receive the correct mattress.

- The root cause analysis tool for category 2 and unstageable pressure ulcers has been revised and is awaiting to be added to Ulysses. This will form a new process for all RCA tools to be attached onto the Ulysses system.

- The North West pressure ulcer policy has now been approved and is in place across MCHFT and CCICP. The policy will underpin a new 'ASSKING' skin bundle and associated care bundle to assess and manage pressure ulcers. The SSKIN documentation has been reviewed and is in the process of being amended and updated to reflect new guidelines from NHSI and EPUAP and incorporate medical devices including the new 'ASSKING' assessment tool and updated body maps for documenting any skin changes.

- Ward 21b have started to use single patient inflatable heel off-loading devices. The initial feedback from staff and patients is positive and patients have remarked they are comfortable to wear whilst in bed. All wards can now order the off-loading devices.

- Moisture management and nappy care guidelines have been agreed on the neonatal unit. The feedback from staff is that the use of silicone based barrier films is reducing the incidence of moisture associated skin damage.

- CCICP has received investment in to the Community Tissue Viability Service, increasing its service by 2.2 WTE Band 6 specialist nurses and 0.5WTE additional admin support to meet the increasing referral demand and enhance the support and training into CCICP. The investment has enabled the service to develop new wound care pathways, patient information leaflets and advise with the setting up of the wound care clinics in CCICP. Additionally, the enhanced team has supported the roll out of staff training through development of online training across the South and Vale Royal locality.

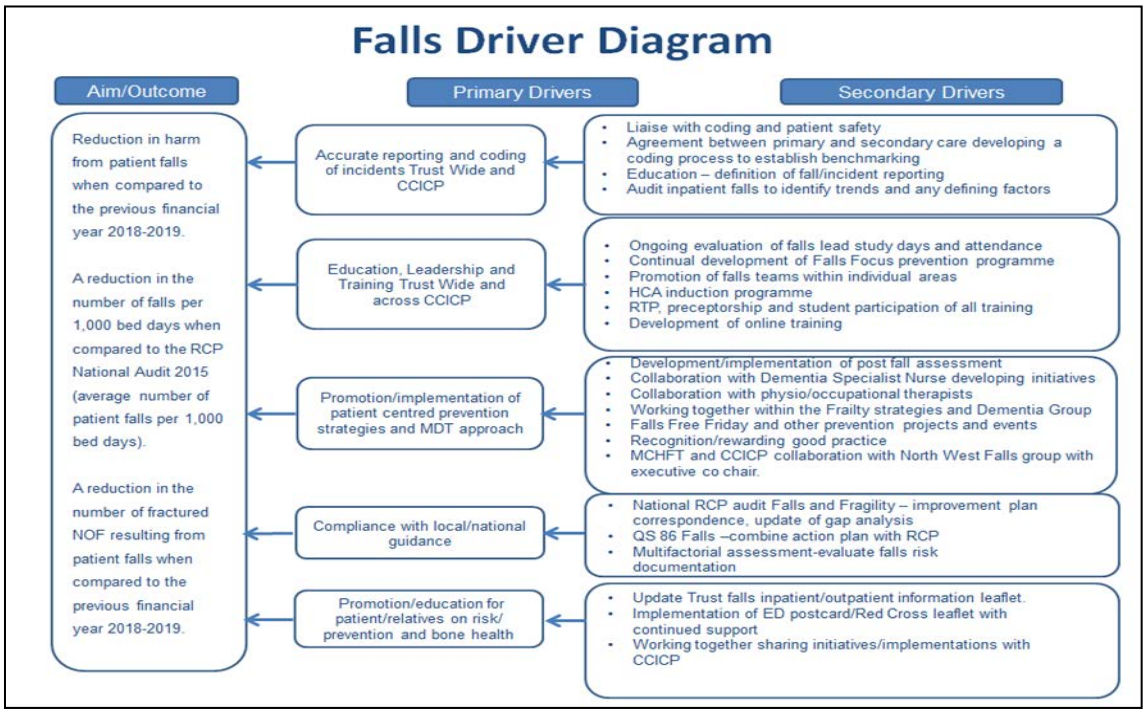
- CCICP team are pivotal to the newly introduced weekly safety huddles which are further enhancing care of patients from the Community Nursing Teams.

- CCICP tissue viability team have purchased a pressure ulcer model which is utilised to support staff and patient's knowledge of pressure ulcers. The model provides a visual aid to support understanding the appearance of pressure ulcers to ensure that they are correctly reported and categorised. The enhanced service has enabled a greater visibility of the specialist tissue viability clinicians across care communities and within the hospital setting promoting a reduction in pressure damage and optimal wound healing going forward.

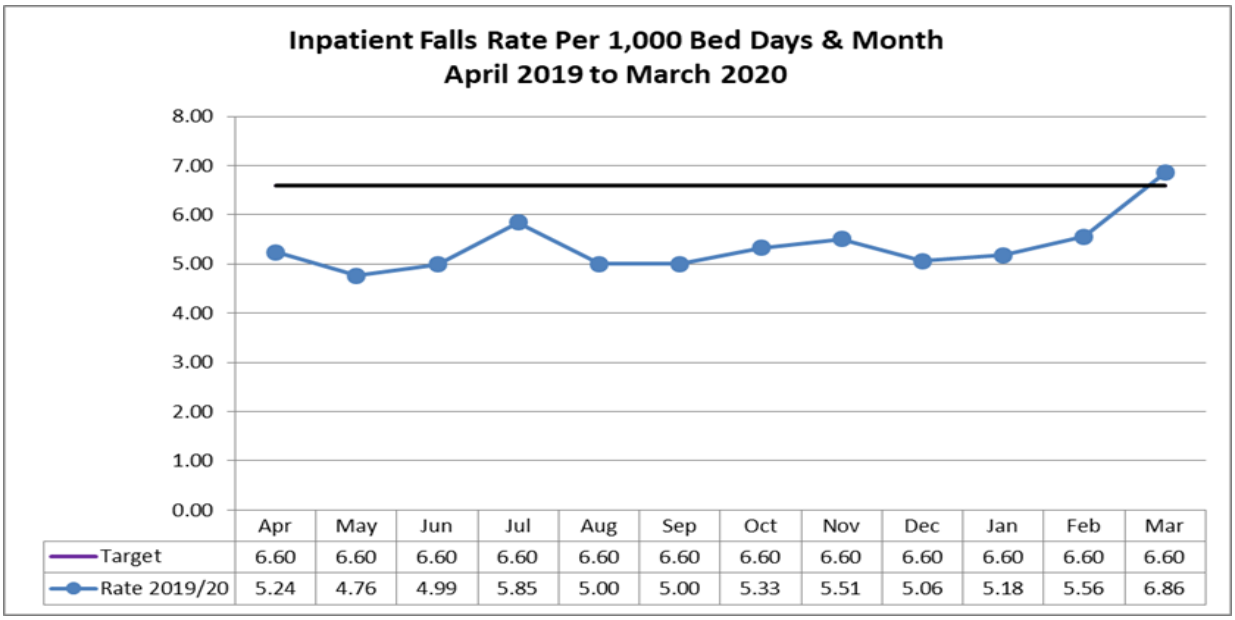
Reducing Inpatient falls

The Trusts aims to reduce inpatient falls when compared to the previous financial year is;

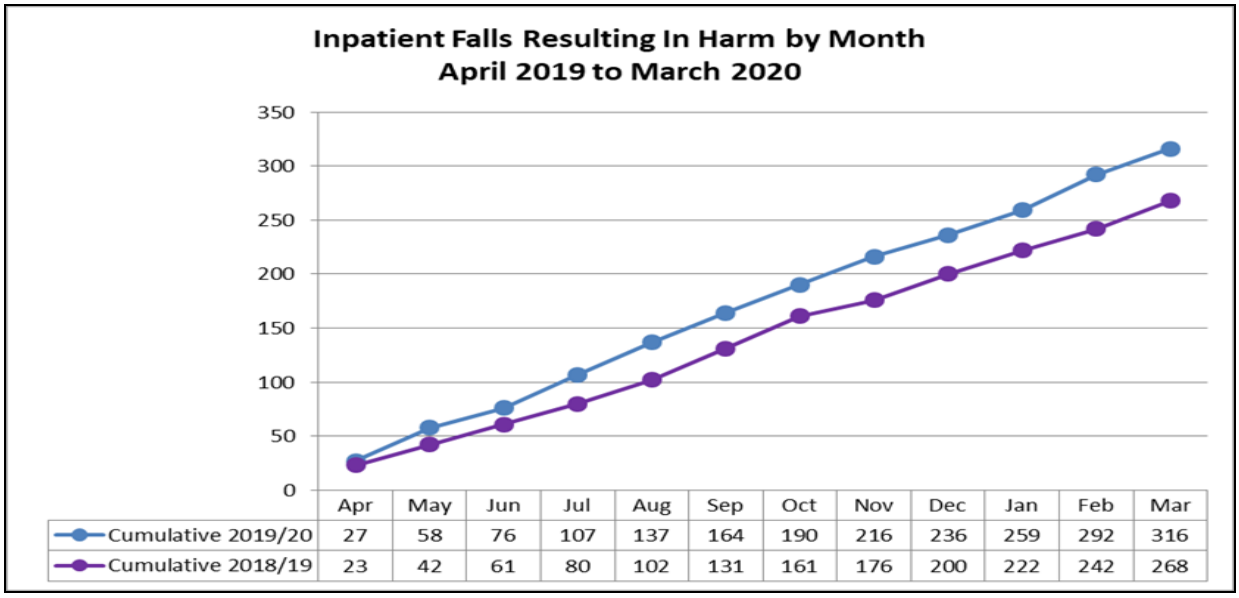
- To reduce the number of patient harms from falls when compared to the previous year (2018/19)
- To reduce the number of falls per 1,000 bed days when compared to the Royal Collage of Physicians National Audit 2015 (average number of patient falls per 1,000 bed days).
- To reduce the number of fractured neck of femurs (NOF) resulting from patient falls when compared to the previous financial year 2018-2019.



Progress to date



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target	6.60	6.60	6.60	6.60	6.60	6.60	6.60	6.60	6.60	6.60	6.60	6.60
Rate 2019/20	5.24	4.76	4.99	5.85	5.00	5.00	5.33	5.51	5.06	5.18	5.56	6.86



The table below shows the number of falls resulting in a fractured neck of femur in 2019/20 compared to 2018/19;

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19 Falls Resulting in #NOF	**3**	**1**	**0**	**1**	**0**	**1**	**1**	**0**	**0**	**1**	**1**	**1**
2019/20 Falls Resulting in #NOF	**1**	**1**	**0**	**1**	**1**	**1**	**0**	**0**	**1**	**1**	**3**	**1**

Unfortunately in 2019/20 the Trust did not achieve its aim to reduce harm from patient falls when compared to 2018/19 and reported a total of 11 falls resulting in fractured neck of femurs in 2019/20. When compared to 2018/19 the Trust had an 18% increase in patient falls resulting in harm during 2019/20. However, the Trust has remained below the national rate of 6.60 when compared with per 1,000 bed days.

In addition to falls data collected for the Trusts Quality & Safety Improvement Strategy, the Trust also submitted data for CQUIN 2019/20: Three high impact interventions to prevent Hospital Falls.

During quarters 1, 2 and 3 of 2019/20, 303 admitted patients aged 65 years or over with a length of stay at least 48 hours were audited and results are detailed below. (Please note Q4 data not available due to suspension of CQUIN);

		Q1 19-20	Q2 19-20	Q3 19-20
	Total Sample	100	102	101
Three Falls Prevention Actions Met and Recorded				
1) Lying and standing blood pressure recorded at least once during admission **2) No hypnotics or anxiolytics to be given during stay OR rationale for giving hypnotics or antipsychotics or anxiolytics documented** **3) Mobility assessment documented within 24 hours of admission to inpatient unit stating walking aid not required OR walking aid provided within 24 hours of admission to inpatient unit**	Numerator	32	40	38
	Denominator	93	102	101
	Compliance	34.4%	39.2%	37.6%
1) Lying and standing blood pressure recorded at least once during admission	Numerator	49	64	54
	Denominator	93	102	101
	Compliance	52.7%	62.7%	53.5%
2) No hypnotics or anxiolytics to be given during stay OR rationale for giving hypnotics or antipsychotics or anxiolytics documented	Numerator	88	100	100
	Denominator	93	102	101
	Compliance	94.6%	98.0%	99.0%
3) Mobility assessment documented within 24 hours of admission to inpatient unit stating walking aid not required OR walking aid provided within 24 hours of admission to inpatient unit	Numerator	57	72	66
	Denominator	93	102	101
	Compliance	61.3%	70.6%	65.3%

In order to achieve a reduction in falls and achieve the three high impact interventions there have been a number of actions undertaken or in development;

- The Trust's Falls group meet monthly and is chaired by the Clinical Quality and Outcomes Matron. The group has multidisciplinary and cross divisional representation inclusive of CCICP Falls lead. The group have reviewed monthly falls governance reports which have been used to inform Quality Improvement work.

- Data identifies that 70% of falls within the Division of Medicine and Emergency Care over a three month period were found to be unwitnessed. A deep dive into data has indicated that Ward 1 has the highest prevalence of unwitnessed falls within the bay. A Quality Improvement Bay Tagging project has been registered. The trial will

commence on 13th January 2020. Consultation with members of the wider multi-disciplinary team (MDT) including Pharmacy, Consultant body, Dietetics and Physiotherapy have taken place and support given from the disciplines for engagement with the bay tagging initiative from an MDT perspective.

- During 2019 the Trust implemented a footsteps project on Wards 7 and 21B to support the falls reduction agenda. A review of the project was undertaken in October 2019 and focused on no and low harm falls between March 2019 and August 2019, with a review of the trend of falls over the last 15 months to understand any impact from the footsteps project. The review focussed on the location and time of a fall, the mechanism of the fall and outcome of the incident review.

- The Trust took part in a national Falls Awareness campaign in September 2019. Engagement sessions were held at the crossroads daily. The Quality Matron and Divisional Matrons visited all wards and provided resources to support ward staff, patients and visitors. External Health advisors supported the event and shared information about signposting to relevant organisations.

- The Falls Risk Assessment tool has been reviewed and is being updated following consultation with members of the Multi-Disciplinary Team.

- Staff education continues to remain a priority. Educational sessions continue as part of the Quality Care Delivery Programme and additional training has been delivered including;
    - Face to face engagement sessions delivered as part of falls awareness week in October 2019
    - Education delivered to two cohorts of International Nurses
    - The Royal College of Physicians (RCP) guidance on “how to measure lying and standing BP as part of a falls assessment” is include in all training days within the Trust including Induction, HCA induction and the Quality Matters programme
    - RCP pocket lanyards are available in all clinical areas.

- The Cheshire and Mersey Falls Collaborative Group continues with new meetings planned to include continence care representation.

- A substantive Harm Free Care Practitioner was successfully appointed into post during Quarter 3. Patients who have fallen more than once during their admission are being reviewed by the Harm Free Care Practitioner.

CCICP have made significant improvements to achieve a reduction in falls by aiming to support a 10% reduction of unnecessary North West Ambulance Service hospital admissions by the end of March 2020. In order to achieve this a number of actions have been taken;

- A Falls clinical lead has been identified and attends the Falls prevention meetings at the Trust

- A Falls pathway has been drafted

- A Hospital data analysis has been completed to understand baseline admission data for falls. In addition, the Business Intelligence Unit is aiming to develop a system to highlight to the Care Community Teams patients admitted to the Trust following a fall and with a completed frailty assessment
- Home Hazard assessment template for therapists has been drafted

- Engagement completed across South and Vale Royal with community groups commissioned to support falls prevention – Health box, Age UK, Brio, Telecare, and One You. Routes of referral to and from these services has been established and confirmed.

- Multifactorial assessments – benchmarking has been completed.

- Falls prevention leaflets have been developed and are distributed as a standard part of assessments to support initial falls prevention advice.

Recognising and Responding to Deteriorating Patients

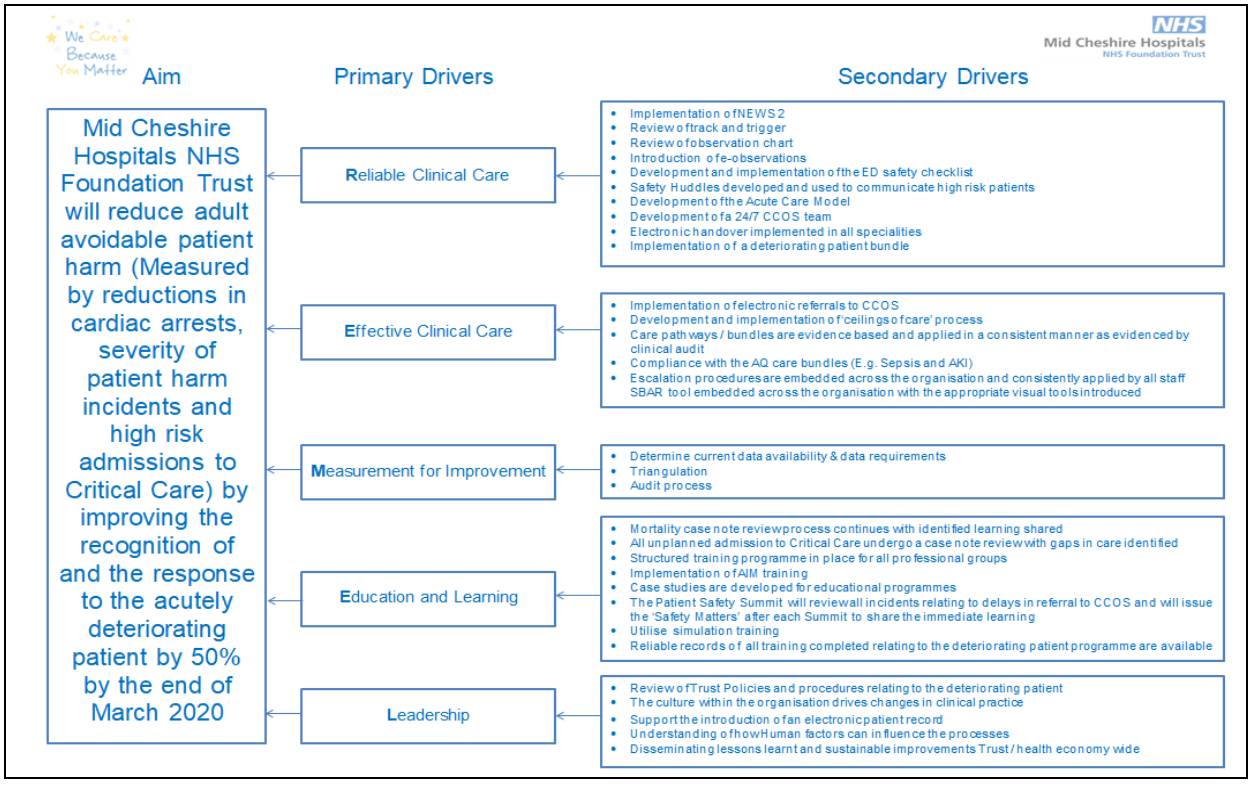
Our aim is for Mid Cheshire Hospitals NHS Foundation Trust to reduce adult avoidable patient harm (measured by reductions in cardiac arrests, severity of patient harm incidents and high risk admissions to Critical Care) by improving the recognition of and the response to the acutely deteriorating patient by 50% by the end of March 2020.

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

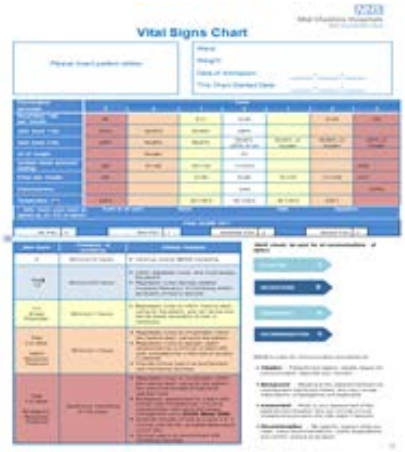
Progress
The Executive Led Deteriorating Patient Steering Group has cross-divisional representation, is chaired by the Medical Director and reports to the Trust Mortality Reduction Group and up through the committee structure to Board as appropriate. The group meets quarterly.

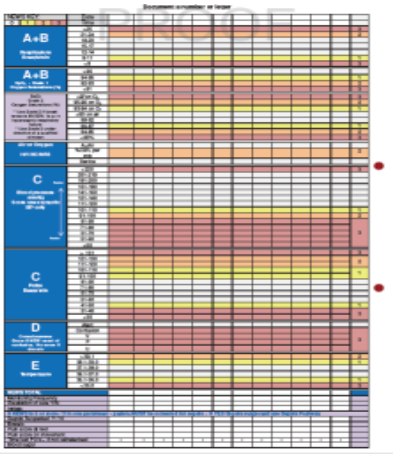
The group has six work streams with a nominated lead for each:

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



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





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

A training implementation plan was developed and approved by the Deteriorating Patient Steering Group. The training programme is being led by the Critical Care Outreach Service Lead Nurse. AIM training is now run monthly led by the Critical Care Outreach Lead Nurse. The AIM course is being well attended with courses being fully booked.
An AIM course for support workers is being developed to be delivered in house by Critical Care Outreach Service Lead Nurse with roll out from May 2020. Pocket cards with escalation prompts are now available for staff.

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

The business case for the Acute Care Team has been approved and is currently being implemented including the development of the team. The senior team has been recruited. March 2020 will be the launch date for the new team with a week-long crossroads event planned to allow staff to meet the team.

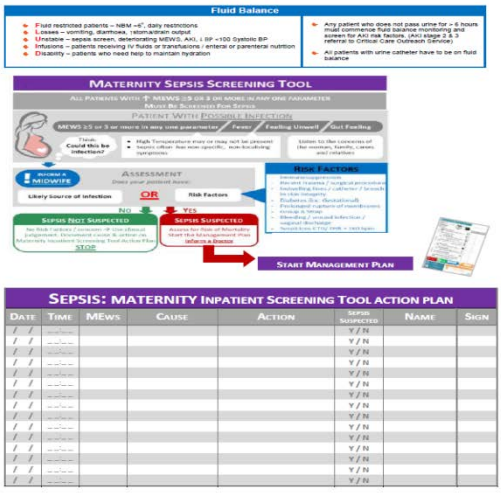
The Deputy Medical Director is leading the work on lines and this is being taken forward as a work stream group. A vascular access improvement plan has been developed. The Vascular Access Steering Group has been meeting regularly. A benefit can be seen in the emergency list. The number of cancellations has been reduced by 40% and theatre time is more effectively used. The new Patient Passport for mid and PICC lines will pull together documentation for insertion and aftercare. The business case for a Vascular Access nurse is continuing.Consideration is being given to using one type of PICC line and one type of

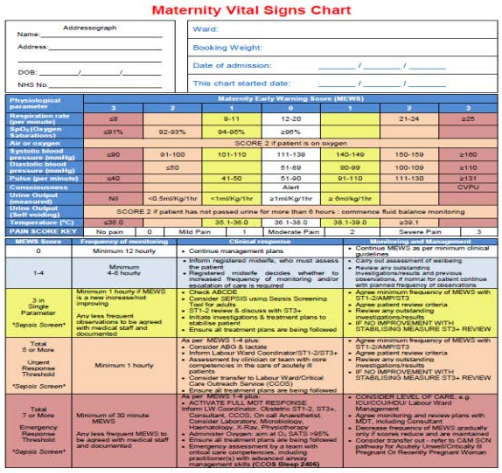
mid line which will help with staff familiarisation. This project is ongoing and will include ensuring the lines are CT contrast compatible

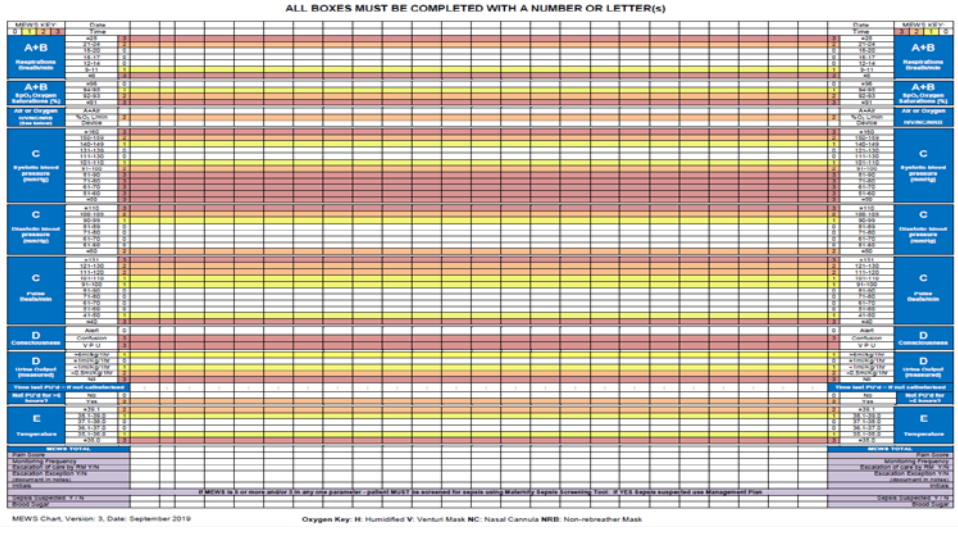
The out of hour's handover first meeting has been held to establish issues and concerns. It is planned that at the next meeting a handover will be mapped out.

A Maternity EWS has been developed by the Critical Care Outreach Lead Nurse and Maternity Team. This was launched in the Trust in October 2019 following regional approval. The Maternity EWS is being presented regionally on the 6 March 2020 for approval prior to being rolled out across Cheshire, Merseyside and East Lancashire with possibly Greater Manchester.

The Maternity EWS Chart







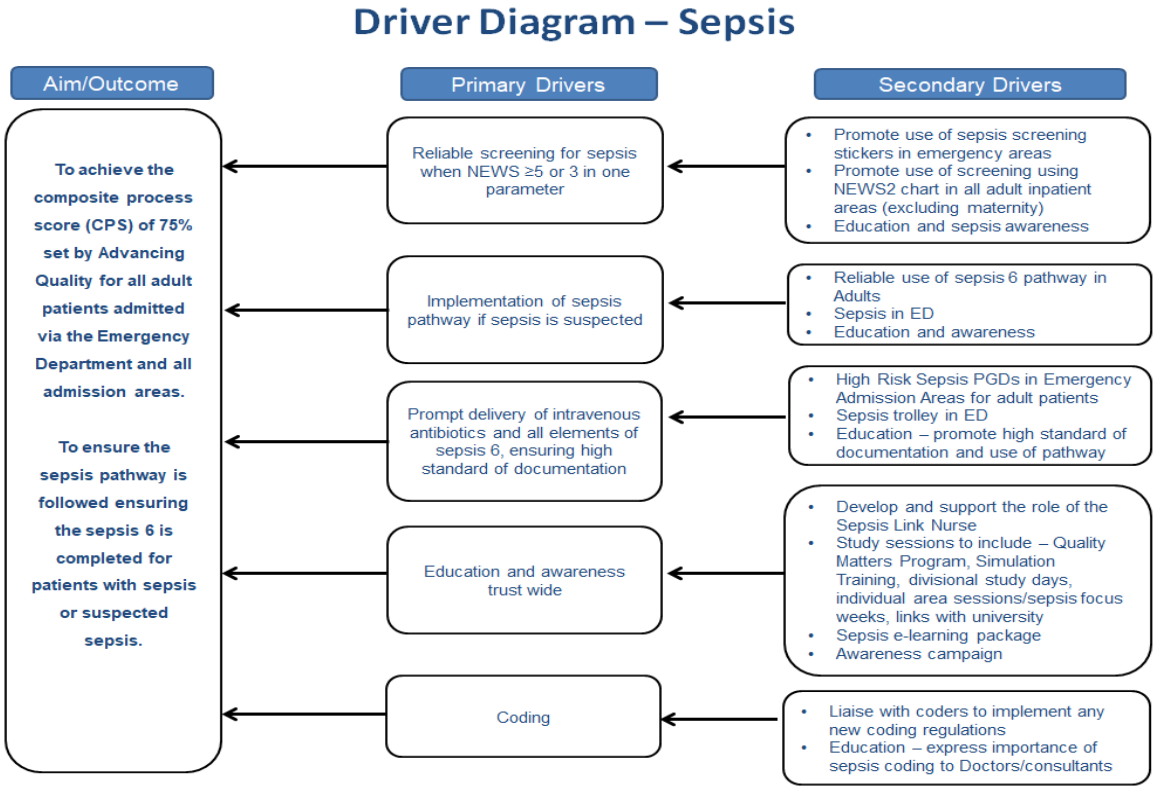
Recognising & Treating Sepsis

Following the completion of the Sepsis CQUIN in 2018/19 the Trusts aim is ensure compliance with the sepsis pathway for patients with sepsis or suspected sepsis remained active during 2019/20 and has been monitored and driven via the Advancing Quality (AQ) programme.

The AQ programme provides a systemic, structured and evidence-based approach to monitoring the Trusts compliance with the sepsis pathway and to achieve a Composite Process Score (CPS) of 75%. The CPS score calculates the percentage of measures received by a patient of all the eligible measures for the sepsis pathway, which are;

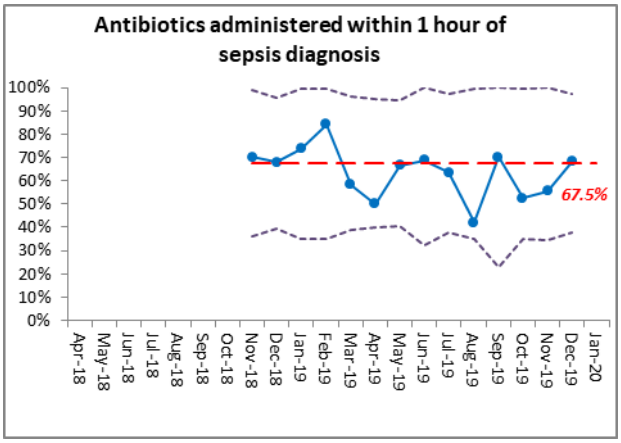
- Did the patient have a National Early Warning Score (NEWs) recorded within 1 hour of hospital arrival
- Were blood cultures taken within 1 hour of sepsis diagnosis
- Were antibiotics administered within 1 hour of sepsis diagnosis
- Was a serum lactate taken within 1 hour of sepsis diagnosis
- Were IV fluids commenced within 1 hour of sepsis diagnosis
- Did the patient have a senior review within 2 hours of sepsis diagnosis
- Was a sepsis care pathway commenced following sepsis diagnosis

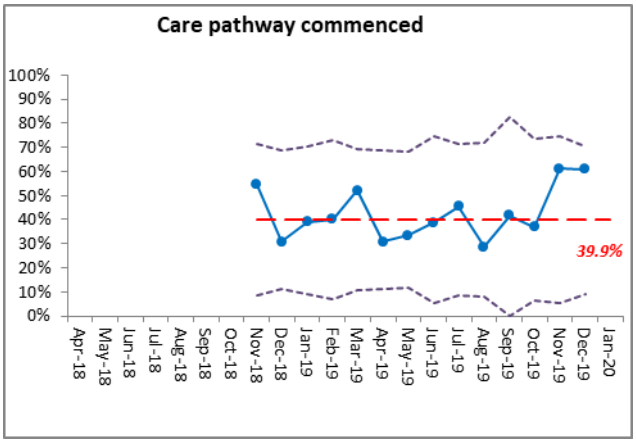
Assurance and monitoring of the sepsis Advancing Quality (AQ) outcomes is monitored via the Care Pathway meeting, an executive led meeting chaired by the Trusts Medical Director. In addition, a Sepsis Steering Committee actively promotes the sepsis pathway and looks to continual improvement methods to further advance patient outcomes. Progress from the Sepsis Steering Committee is monitored through the Quality and Safety Improvement Strategy Group.



Unfortunately during 2019/20 the Trust did not achieve its CPS of 75%, achieving an end of year cumulative CPS of 64%.

Although the Trust did not achieve its end of year Cumulative CPS score, overall data does show an improvement month on month for many of the measures including the administration of antibiotics within 1 hour of sepsis diagnosis and the commencement of the sepsis pathway;





The table below highlights the individual measures that have improved performance during October – December 2019.

AQ Measures	October 2019	November 2019	December 2019	Nov – Dec
Antibiotics - 60 mins from diagnosis	52.6%	55.6%	68.2%	**+12.6%**
Serum Lactate – 60 mins from diagnosis	73.7%	61.1%	63.6%	**+2.5%**
IVI – 60 mins sepsis diagnosis	83.3%	40%	42.9%	**+2.9%**
Senior Review – 2 hrs from diagnosis	36.8%	50%	56.5%	**+6.5%**
Care Pathway utilised	36.8%	61.1%	60 .9%	**+0.2%**
Composite Process Score	59.8%	64.7%	66.9%	**+2.2%**
Appropriate Care Score	19%	15%	28%	**+13%**

Education and awareness of sepsis screening, recognition and treatment of sepsis with all staff remains key. Training with link nurses and ward staff remains on going, with training provided at a monthly Quality Care Delivery Programme - a mandated study day for all new staff to attend as part of their induction. A number of training programmes consist of sepsis training including preceptorship training and the FY 1 Doctor Induction programme. In addition link nurse training is provided by the Trust's Harm Free Care Practitioner and an E-Learning package is now available for staff on the Trusts learning zone.

In 2019/20 the Sepsis Steering Committee has seen changes to its membership, including a Consultant Medical Microbiologist and Infection Prevention Doctor as Chair and a new Consultant Lead for the Emergency Department. There remains continued multidisciplinary divisional representation at the Sepsis Steering Committee to drive forward improvements in sepsis care across the Trust and the Advancing Quality Programme Manager has been invited to the Sepsis Steering Committee in an advisory capacity to support with progress.

The Patient Group Directives (PGD) remains in use within the Emergency Department and the Ambulatory Care Unit. Updates have been made to the PGD and additional training sessions are being rolled out in the Emergency Department to capture new starters and refresh those that need an update in using the revised PGD.

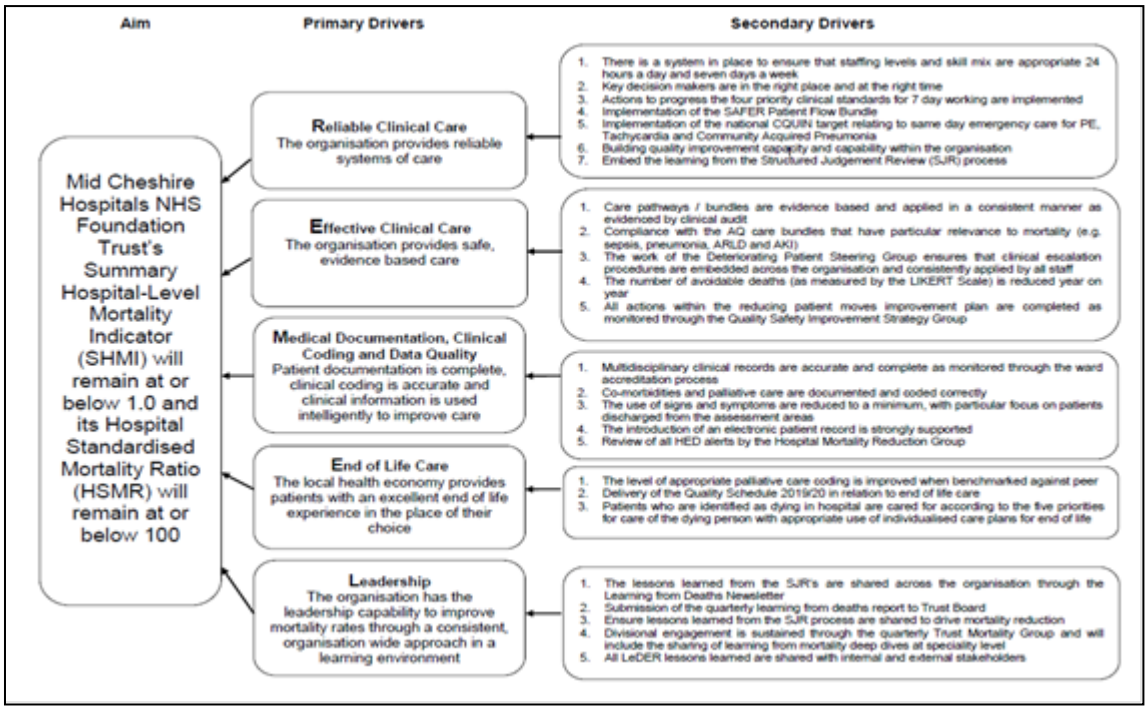
Within CCICP a Standard Operating Procedure (SOP) has been developed and approved for recognising the deteriorating child and a pathway has been established in line with the Sepsis Trusts identification guidelines for children under 18. Identification of the unwell child boxes have been implemented within clinics and all paediatric staff have been trained in the use of thermometers and an understanding of the parameters, which may indicate a deteriorating child. Training has been provided to all paediatric staff in identifying signs and symptoms of the unwell child.

Each Care Community within CCICP has designated Sepsis Link Nurses who have a responsibility in ensuring that each team is compliant and understands the NEWS2 CCICP Sepsis Pathway. There is on-going education across CCICP on how to use NEWS2 – using face to face training and the online Royal College of Physicians training. The Electronic Medical Information Service (EMIS) has been updated to recognise NEWS2 when observations are inputted which will create information for audit.

As part of the secondary driver for CCICP a pilot project has been established working with the Clinical Commissioning Group (CCG) in selected nursing homes, training staff to use the CCICP NEWS2 pathway. The long term aim is to roll out the CCICP sepsis pathway and NEWS2 to all Nursing Homes within the each Care Community. In addition, work continues with the CCG implementing the adult sepsis pathway into Nursing Homes within the CCICP footprint.

Mortality

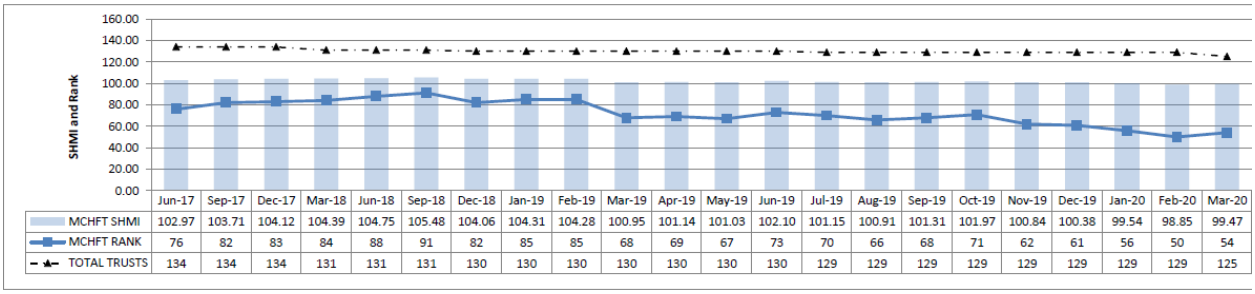
SHMI and HSMR are indicators which report on mortality at Trust level across the NHS in England. These measures are important because high mortality rates may be an indication of problems with the quality and safety in a hospital.



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

Progress

Summary Hospital-level Mortality Indicator (SHMI) April 2019 to March 2020

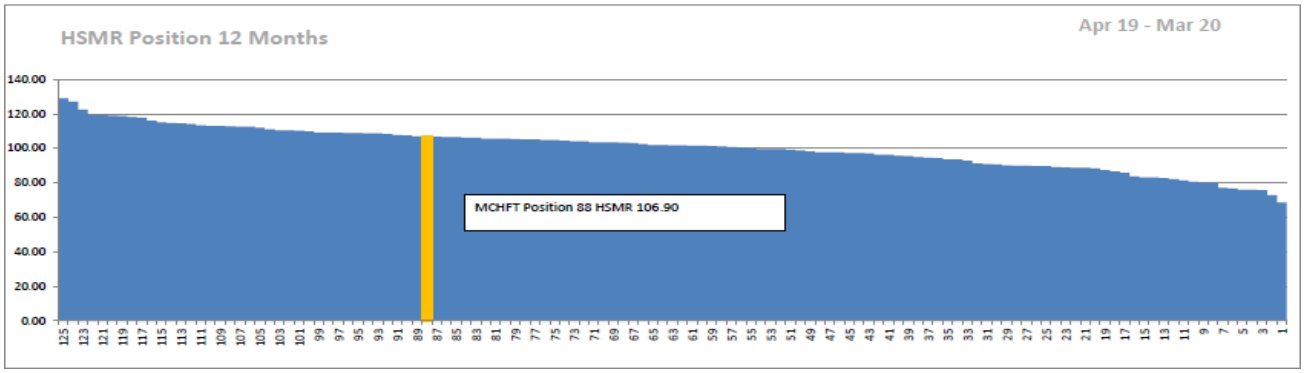


	Jun-17	Sep-17	Dec-17	Mar-18	Jun-18	Sep-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
MCHFT SHMI	102.97	103.71	104.12	104.39	104.75	105.48	104.06	104.31	104.28	100.95	101.14	101.03	102.10	101.15	100.91	101.31	101.97	100.84	100.38	99.54	98.85	99.47
MCHFT RANK	76	82	83	84	88	91	82	85	85	68	69	67	73	70	66	68	71	62	61	56	50	54
TOTAL TRUSTS	134	134	134	131	131	131	130	130	130	130	130	130	130	129	129	129	129	129	129	129	129	125

(Source NHS Digital, 2020)

The above chart demonstrates the SHMI position for the reporting period April 2019 to March 2020. The SHMI is currently 99.47 and is as 'expected'. This currently places the Trust 54 out of 125 Trusts.

Hospital Standardised Mortality Rate (HSMR) April 2019 to March 2020;



(Source HED, 2020)

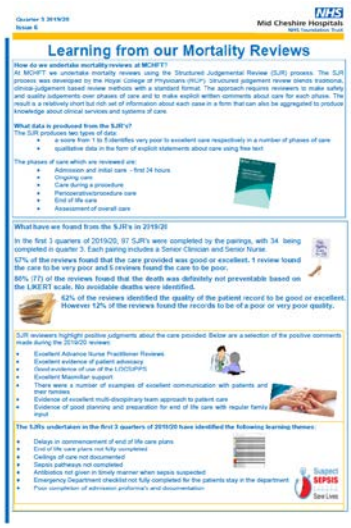
The above chart demonstrates the HSMR position for the reporting period April 2019 to March 2020. The HSMR is currently 106.90, this places the Trust 88 out of 129 Trusts.

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

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

In addition to the escalations from the weekly reviews, in line with national guidance, the Hospital Mortality Reduction Group has agreed a number of other clinical conditions / criteria that will result in an in-patient death undergoing a SJR. These are reviewed on an annual basis and in 2019/20 included:

- All deaths where families, carers or staff raise concerns
- Deaths where concerns are raised by the Coroner
- Deaths where concerns are raised at the Patient Safety Summit
- Deaths due to alcohol related liver disease
- Relevant elective deaths
- Deaths due to septicaemia (at the weekend)
- Deaths due to congestive heart failure – non-hypertensive (at the weekend)
- Deaths due to an acute myocardial infarction
- Deaths from admissions on a Monday



At the Trust we undertake mortality reviews using the Structured Judgemental Review (SJR) process. The SJR process was developed by the Royal College of Physicians (RCP). Structured judgement review blends traditional, clinical-judgement based review methods with a standard format.

The approach requires reviewers to make safety and quality judgements over phases of care and to make explicit written comments about care for each phase. The result is a relatively short but rich set of

information about each case in a form that can also be aggregated to produce knowledge about clinical services and systems of care.

The SJR produces two types of data:

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

Six phases of care are reviewed:

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

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

Lessons learned are produced and shared across the organisation in the form of a quarterly learning from deaths newsletter. The learning is also shared at the Trust Mortality Reduction Group and the Divisional Boards through the quarterly Learning from Deaths Report.

The SJR reviewers meet on a 6 monthly basis with the Medical Director to share their learning from the process, review the data gathered and to discuss how the SJR process and learning can be further developed.

Learning from the reviews

During the SJR process the reviewers will also highlight positive judgments about the care provided. Below are a number of the positive comments made during the reporting period;

- There were a number of examples of excellent communication with patients and their families
- Evidence of excellent multi-disciplinary team approach to patient care
- Evidence of good planning and preparation for end of life care with regular family input
- Excellent continuity with medical care and escalation of care needs as appropriate
- Excellent practice and documentation
- Anticipatory recognition and management of end of life care exemplary
- Excellent multidisciplinary communication and referral occurred
- Meticulous care from stroke & therapy teams
- Good involvement of family in end of life discussions
- Excellent care delivered to patient during high activity in the Emergency Department
- Team working for patient best interest and plans appropriate really good
- Great communication and compassion

The SJRs undertaken in Q1, 2 & 3 have identified learning themes relating to documentation and end of life care.

Improvement work is ongoing in relation to the identified themes and these are monitored through the Quality & Safety Improvement Strategy and the Deteriorating Patient Steering Group.

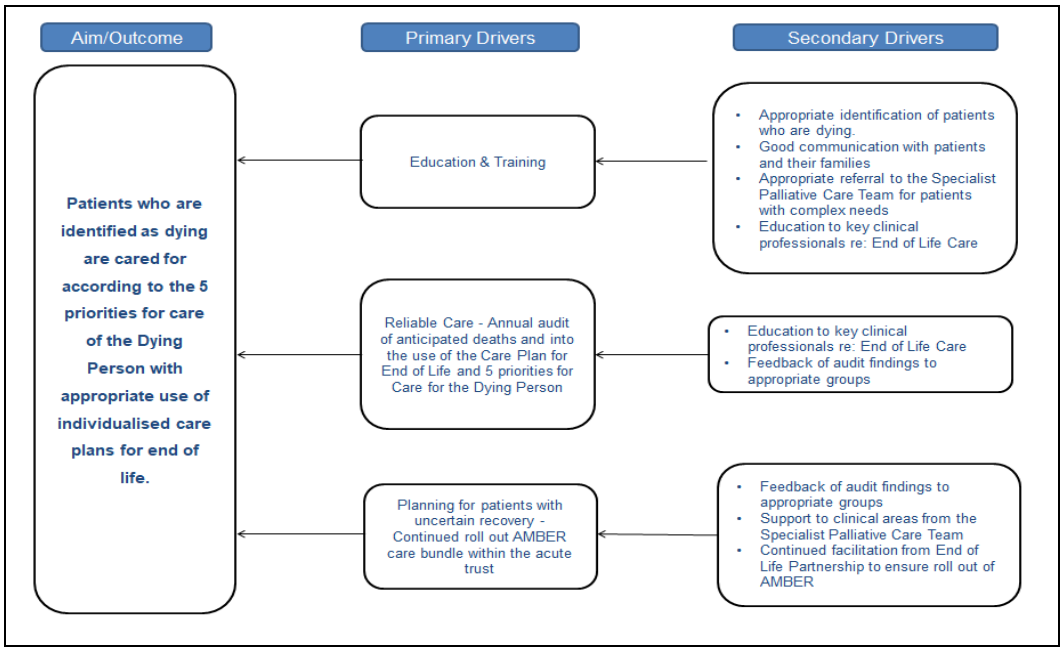
The RCP within their guidance recommend word cloud analysis to review the results. The above word cloud demonstrates a selection of the positive comments made in the reviews in 2018/19.

The Trust has a well-established Hospital Mortality Reduction Group led by the Medical Director. This group leads the Trust's mortality reduction programme and, on a quarterly basis, meets with the Divisional Mortality Reduction Groups to ensure a unified approach to mortality reduction across the Trust and to share learning opportunities.
The Trust's mortality reduction programme is succinctly described in a driver diagram that was most recently updated in March 2019. The five primary drivers to reducing the Trust's mortality rates are:

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

End of Life Care

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



Education and training

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

Bespoke support is provided for clinical areas and individual staff members. There are Macmillan Education study days available throughout the year - funded places are available for all healthcare professions working locally within both primary and secondary care.

A joint integrated palliative care link nurse meeting was held on 27th Nov 2019 – this will now become a biannual event for hospital and community staff leading to improved collaboration.

The possibility of including End of Life Care in mandatory training is being considered as part of the Improvement Plan following National Audit of Care at the End of Life (NACEL) 2018/19. Meeting with the Learning and Development Lead has taken place.

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

End of Life Care and Bereavement Group now has community representation with both District Nursing and Specialist Palliative Care attending.
Referrals to Specialist Palliative Care Team have increased over the 12 month period by approximately 30%.

Audit
During 2019 the national NHS Benchmarking audit 'National Audit of Care at the End of Life' (NACEL) (Round 2) has been undertaken. This consisted of an Organisational Audit / Clinical Case note Review / Hospital site Audit and Quality Bereavement Survey. The clinical case note review looked at deaths in hospital during April and May 2019.

The results of this audit are produced nationally and national publication is awaited. The Trust's draft dashboard of results has been received. The audit looks at appropriate identification of patients who are dying and records of communication with patients and their families. Results of the audit when published will be presented to Executive Patient Experience Group (EPEG) and an Improvement Plan developed.

NACEL Round 1 output was presented to EPEG at the beginning of the year. The results were also presented to the Quality Improvement Education Programme for clinicians. Actions related to NACEL (Round 1) Improvement Plan are ongoing including work around 7 day services for Specialist Palliative Care.

Planning for patients with uncertain recovery
Continued roll out of the AMBER Care Bundle is ongoing. Amber Care Bundle went live on wards 2 and 3 at MCHFT in April 2019. Baseline audit completed. Working with medical consultants who are championing its use within clinical areas. Education resources / folders created for each clinical area.

A GP and Consultant collaborative 'DNACPR' evening was held in July 2019.
Education for Consultant groups around 'Having the Conversation' and 'uDNACPR' has been undertaken as part of the quality improvement sessions in September 2019. Additional sessions were held for junior doctors from F1 – SPR too. Work with specific disease groups such as Integrated Respiratory Team, Heart Failure Team and the Advanced Nurse Practitioners about the patient with uncertain recovery is currently being undertaken. An abstract has been produced around this work and will be presented.

Ongoing Quality Improvement work around Communication, DNACPR and Advanced Care Planning continues. This includes collaborative working around patient's who lack capacity and joint presentation to medical doctors with Privacy & Dignity Matron.

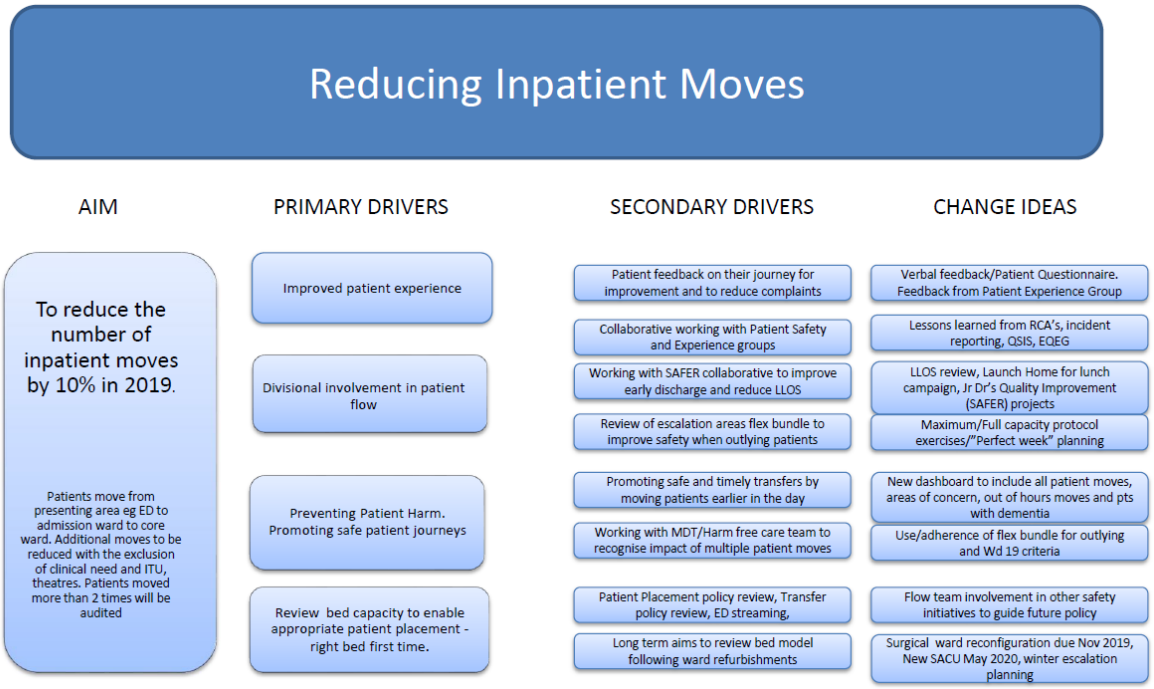
Improving communication between primary and secondary care continues and progress has been made for the Specialist Palliative Care Team to have read / write access to EPaCCS (Electronic Palliative Care Coordination System) thus sharing access to palliative care records for many patients.

Reducing Inpatient Moves

The Trust has received feedback from staff and patients regarding patient moves in the organisation. Faced with continued pressures, bed and site management teams are often resorting to placing patients on wards that are not specifically designed or designated for the type of care patients require. This is commonly known as “medical outliers” and within the Trust this is known as “boarding”. When patients are moved or “boarded” the staff face challenges supporting patients on wards where specific expertise may not be regularly available. When these patient moves happen out of hours and without the patient being informed of the reasons this is potentially unpleasant and stressful.

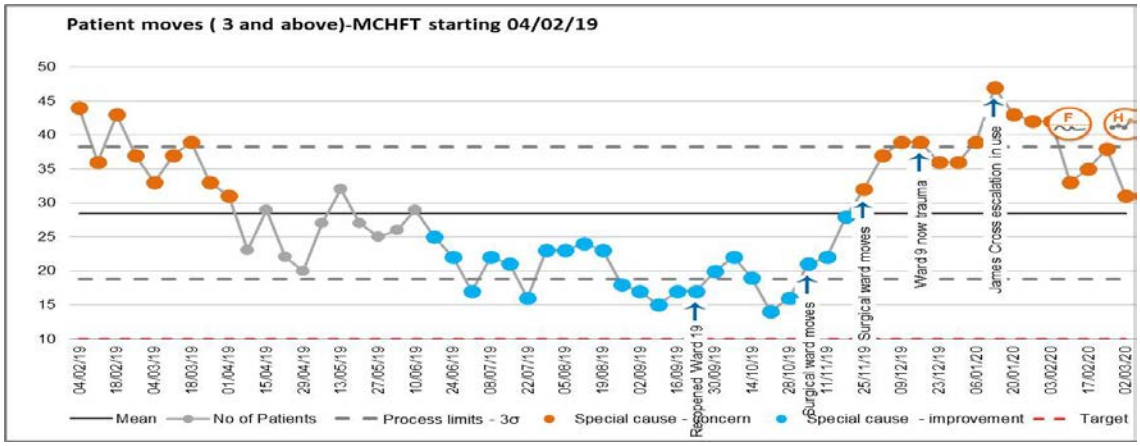
Aim

The Trust aims to reduce the number of inpatient moves by 10% in 2019/20.



Progress to date

The Trust has developed a patient dashboard to monitor and prevent further patient moves;



In addition, there have been a number of on-going work streams related to reducing patient moves and ensuring our patients are cared for in their most appropriate clinical setting;

SAFER

Work is continuing to review our processes and strategy around reviewing patients' long length of stay. During 2019/20 all patients with a length of stay over 21 days were reviewed via a ward weekly visit and patients discussed with the multi-disciplinary team including the Nurse in Charge, Matron, Physio and Integrated Discharge Team (IDT).

Further work is ongoing with plans to include the medical team and Quality Improvement (QI) projects involving improving time of discharge, and criteria led discharge planning

Policy Review

Work is ongoing in relation to Policy review. Current policies under review include the Patient Placement Policy, Trust Escalation Policy and Full Capacity Protocol which are due to be amended by end March 2020.

Bed Management

In January 2020 the Trust undertook a 'Perfect Week'. This saw the Bed Management team collecting data regarding bed turnaround in the trust. Data collected identified a variation of 45 minutes to a few hours with many reasons for this. The Trust aims to undertake further auditing to fully understand how to improve general turnaround and provide timely bed management. In addition the Trust aims to review the bed management processes and is working with IT to implement a "live" bed management system.

Governors' choice of indicator

Maximising waiting times of 62 days from urgent GP referral to first treatment for all cancers

As a Trust maintaining and reducing our waiting times has always been a top priority. This is particularly important within cancer services, the national standard for patients that have been referred via rapid access pathway (previously known as a Two Week Wait referral), is to ensure that 85% of our patients are diagnosed and treated within a maximum of 62 days. As an organisation we strive to achieve this for all our patients. However, we recognise that treatment times increase for patients with complex diagnostic pathways or through patient's choice.

Throughout 2019/20 we introduced a number of initiatives to further improve our waiting times for our cancer patients and to support the new national 28-day faster diagnosis standard: -

- We successfully piloted and implemented a straight to test pathway for patients presenting with symptoms of prostate cancer where patients underwent a multi-parametric MRI prostate scan before their first consultation. This has resulted in the reduction of men undergoing invasive biopsies where cancer is unlikely.
- We launched a colorectal 90-day transformation programme to improve waiting times and access to straight-to-test for endoscopy.
- We implemented a new pathway for patients presenting with non-specific symptoms suggestive of cancer (previously known as vague symptoms) to ensure early clinical triage and rapid diagnosis.

The table below highlights the Trust performance over the last 12 months. The organisation has embedded nationally agreed optimal pathways to achieve faster diagnosis.

Headline Measures

	Current YTD		Rolling 13 months												
	Target	Actual	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	Monthly Trend
Rapid Access Referrals (%) (seen in 2 wks)	93%	88.98%	95.83%	97.65%	96.99%	96.60%	98.20%	97.39%	98.28%	97.76%	97.07%	97.84%	97.31%	98.45%	88.98%	
Total Patients Seen		*481*	*1030*	*980*	*963*	*1207*	*1000*	*1036*	*1048*	*936*	*888*	*974*	*1040*	*967*	*481*	
Patients seen >14 days		*53*	*43*	*23*	*29*	*41*	*18*	*27*	*18*	*21*	*26*	*21*	*28*	*15*	*53*	
% seen within 7 days		*0.0%*	*30.3%*	*39.4%*	*37.6%*	*38.2%*	*43.3%*	*54.7%*	*59.3%*	*46.3%*	*44.0%*	*56.5%*	*38.7%*	*36.1%*	*56.1%*	
62 day GP Classic (%) *	85%	75.93%	86.62%	86.09%	86.18%	86.45%	86.72%	88.89%	86.67%	85.11%	86.17%	85.54%	83.82%	86.13%	75.93%	

** Provisional figures subject to change depending*

During the last quarter of 2019/20 we began to see the impact of the national coronavirus pandemic. Despite the challenges across the organisation we maintained the oncology services within the Macmillan Cancer Unit and our chemotherapy provision. We successfully outsourced breast cancer surgery to a local independent sector hospital where our breast surgeons where rostered to operate and we rapidly implemented a multi-disciplinary group to prioritise surgical patients requiring surgery. In addition, The Christie NHS Foundation Trust were designated as the region's cold site for protected cancer surgery. Whilst cancer services were maintained as much as possible there has been

significant impact for diagnostic pathways and waiting times. The national cancer screening programmes were suspended during the pandemic response and Rapid Access referrals decreased during the peak of the pandemic.

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

NHS
Cheshire
Clinical Commissioning Group

Mid Cheshire NHS Foundation Trust Quality Account 2019-2020

NHS Cheshire Clinical Commissioning Group Commentary

We are committed to commissioning high quality services from our providers and we make it clear in our contract the standards we expect them to deliver. We manage their performance through regular progress reports that demonstrate levels of compliance or areas of concern. It is through these arrangements that the accuracy of this quality account has been validated.

Mid Cheshire Hospitals NHS Foundation Trust has continued to demonstrate high levels of commitment to improving patient and staff experience, this is evidenced throughout 2019/20 in the achievement of response rates that are consistently above national average to national surveys. The Trust has an established governance mechanism for reviewing survey results and where required has developed an improvement plan.

We commend the progress in improving access to services for people with learning disabilities, to ensure care is patient centred and is delivered in a meaningful way. This is evident by ensuring information is user friendly and furthermore, treatment is accessible and co-ordinated to reduce multiple hospital visits.

We note that there has been an increase in the reporting of falls with harm across the Trust when compared to 2018/19. The Trust has delivered training on incident reporting and reviewed policy and practice in this area too. This will have had a positive impact on the learning culture in the Trust and should be recognised as a means of improving safety. However it is also recognised that the Trust has remained below the national rate of 6.60 per 1000 bed day for falls with harm when compared with peers. It is pleasing to see that the Trust has developed an improvement plan to reduce falls overall and we look forward to observing a reduction of falls in the forthcoming year.

We are pleased to note that the Trust has launched a ward accreditation programme *Going for Gold* which focuses on high quality, safe compassionate care. We look forward to seeing this progress and the sustainability in the forthcoming year.
We welcome the reduction of lapses in care related to the development of pressure ulcers with moderate harms reported from October 2019 to March 2020 and that the improvement programme is on-going. We would also like to congratulate the Winsford based community nursing team who have managed to go 1000 days without a moderate harm pressure ulcer and look forward to seeing the learning shared across the community to reduce the overall harm related to pressure ulcers.
We acknowledge the Trusts positive work around Methicillin-Resistant Staphylococcus Aureus (MRSA) infections and avoidable Escherichia Coli (E.Coli) infections and the improvement plan going forward to reduce overall rates of Health Care Associated Infections and Sepsis. We expect to see improvements sustained in the forthcoming year.

It is positive to note that learning from completing Structured Judgment Reviews in relation to End of Life Care has been acted on by the Trust and informed an action plan for improvements.

In the national survey there is evidence that the Trust has made improvements related to the delayed discharge process which has led to an 8% increase in achieving a timely discharge from 2018/19, recognising that the ambition remains to do more to reduce the overall length of hospital stays.

We would like to congratulate the Trust in delivering performance levels that exceeded the national target for 85% of patients receiving definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer. We also note that the Trust narrowly missed achieving its target of a maximum 62-day wait from referral from an NHS cancer screening service to the first definitive treatment for cancer. The target was set at 90% and the Trust achieved 89.29%.

In closing we are of the opinion that this account provides a balanced picture of the Trusts performance during 2019/20. We support the priorities that the Trust has identified for the forthcoming year and value working in partnership with you to assure the quality of services commissioned in 2020-21.

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

01270 686468
email: joel.hammond-gant@cheshireeast.gov.uk

12 November 2020
Dear Ms Mann and Mr Bennett,

Health and Adult Social Care and Communitites Overview and Scrutiny Committee Review of Mid Cheshire Hospitals NHS Foundation Trust Quality Account 2019/20

As Chairman of the committee I am writing to submit its statement in response to the consideration of the Mid Cheshire Hospitals NHS Foundation Trust's Quality Account 2019/20 following its meeting on 5 November 2020. Please include the information below in the committee's section of the Quality Account.

The Health and Adult Social Care and Communities Overview and Scrutiny Committee reviewed the draft Quality Account at its meeting on 5 November 2020. Overall the committee was pleased with the content of the Quality Account and believes it provides a good picture of the performance of the Trust.

Of particular interest to the committee was how the Trust had adapted to the Covid-19 pandemic, how staff had coped with the new ways of working and stricter PPE requirements, and what the Trust's staffing levels and vacancy rates had been since the beginning of the pandemic outbreak.

Members were pleased to hear of the success of the Trust's workforce development strategy, which had involved a significant international recruitment drive that was onto its sixth cohort of nurses, each of which had recruited around 20-40 nurses to the Trust.

The committee also asked about what steps the Trust's A&E department had taken to manage the arrival of confused (delirium/dementia) patients who, under the new Covid-19 secure protocols, would have to travel alone to hospital, and may be confused, worried and requiring a lot of support.

Members enquired as to how effectively the Trust's maternity services had integrated with those of East Cheshire NHS Trust, following the decision by the latter to continue to deliver its maternity services from neighbouring hospitals. The committee was pleased to hear that this had been a smooth transition and that services had not been adversely impacted due to heightened demand on services and space.

Thank you again for your attendance at our meeting on 5 November 2020, and I hope the comments above are well received by the Trust. If you have any comments or questions about the committee's submission please contact Joel Hammond-Gant on the address provided.

Yours Sincerely,
Councillor Liz Wardlaw
Chairman of the Health and Adult Social Care Overview and Scrutiny Committee

Response to Quality Account 2019/20– Mid Cheshire Hospitals NHS Foundation Trust.
Statement for inclusion in the report:

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

- Representation at Patient Quality and Experience meetings
- Engagement with the hospital on a regular basis at different levels
- 2 A&E Watch visits and reports

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

- We felt the themed patients surveys worked well
- The use of, “You said, We did” - Always a simple and effective way of identifying issues and a response
- The use easy read versions of information leaflets
- The report shows a clear pathway for treatment of sepsis, whilst acknowledging that the Trust has not performed as well as it had hoped. However there appear to be clear plans to improve on this with roles such as Designated Sepsis Link Nurses in each care community and working with certain care homes to provide training.

Healthwatch Cheshire East felt that overall this was a good report and contained lots of interesting information and relevant information.

Statement from MCNHSFT Council of Governors (CoG)

2020 has been a period of exceptional challenge for the NHS and for the country as a whole. We have all faced an unprecedented situation as a result of Covid-19 and it would be wholly remiss of us to provide this statement without paying tribute to those working in the care sector, who have continued to provide the highest levels of care possible. It has been humbling to witness the dedication of staff and on behalf of the Council of Governors and the constituencies we represent I want to thank all staff working for MCHNHSFT and those supporting our wider communities for their ongoing commitment during the pandemic.

As a Council we have seen first-hand how the trust, and its partners, have responded to the pandemic, and it is hoped that many of the innovative and creative solutions introduced at speed to ensure continuity of care will continue, in particular in the use of digital services for residents. We have already seen the widespread use of virtual appointments during the early stages of the Covid-19 pandemic and the ways in which services have adapted and embraced new ways of working provides real opportunities going forwards. We are obviously concerned about the demand on health services once the immediate crisis begins to end and we are acutely aware the Trust is already planning for the future.

Looking back over the last year, the CoG would like to commend the Trust for their work to tackle some long standing issues (such as Emergency Department waiting times) and the focus on patient safety and quality - at Ward level through the expansion of the ward accreditation programme 'Going for Gold', through the introduction of Patient Safety Summits and through local initiatives in the Community. We are particularly pleased to note that the Summary Hospital-Level Mortality Indicator (SHMI) remains in the 'as expected' range and that the CoG priority for 19/20 (62 day maximum wait from urgent GP referral to first treatment for all cancers) was achieved in line with the 85% threshold in 11 out of the 12 months covered by this report.

The CoG congratulates the Trust on receiving an overall 'Good' rating from the CQC inspection that took place during the year. It was disappointing to see that safety was flagged as 'requiring improvement' and the CoG has been included in discussions regarding the action plans that have been put in place. Progress against these is an area we will scrutinise moving forward.

Patient feedback is a key element of any quality framework and it is clear that many different approaches are used across the Trust to elicit patient's views. Feedback from the National Inpatient Survey was provided to the CoG (along with other stakeholders) and an action plan is in place to address specific priority areas. It will be interesting to see the impact of these further actions as many areas in the survey showed little movement from previous years. The CoG also welcomes the positive feedback provided by respondents in the National Maternity Survey, National Urgent and Emergency Care Survey, Children's and Young People's Survey, National Cancer Survey and the actions taken to address specific areas identified in the surveys. We were also pleased to see the inclusion of local patient surveys in the Quality Account, together with detail about how the findings have been used to improve services - although it would be useful to understand why these three local surveys were selected out of the 36 available and we note that the numbers of patients responding to the surveys are small.

We were particularly pleased to see the work being undertaken to ensure that those with a Learning Disability are provided with care which meets their needs and is developed with them. The CoG saw first-hand the difference that this makes when we heard from a family using the phlebotomy clinic during one of our quarterly Council meetings and we would be keen for the results of the National Audit to be fed back to Council.

It is clear that there has been a major programme of work undertaken across the organisation to look at the different themes arising from complaints and we welcome the introduction of the new Customer Care Team Office at the Leighton site which extends the support available to patients and their families should they have a concern or complaint. Communication continues to be a recurring theme arising in complaints, and we would encourage the Trust to review the effectiveness of previous actions in this area and to consider how all staff are engaged with this.

The CoG welcomes the focus on clinical audit within the Quality Account as audits are an excellent way of reviewing the care provided against specific standards and taking steps to make improvements thereafter. The CoG will be discussing with the relevant leads / Non-Executive Directors any recurring areas of non-compliance once the action plans are implemented and re-audits undertaken. Of particular interest will be the effectiveness of the steps taken to improve compliance with the sepsis pathway given the relatively low compliance rates reported in the 19/20 quality account.

The Council also notes the work undertaken by the Trust in respect of their independent scrutiny of all hospital deaths, through their Learning from Deaths programme. This involves clinical peer reviews using a nationally recognised approach. The CoG has received several reports and presentations on mortality over the last few years and we are pleased to see the focus on learning and improvement arising from this. Given that delays in the commencement of end of life care have been identified as one of the themes coming out of the Learning from Deaths reviews, the CoG welcomes the focus in the 20/21 quality strategy on End of Life Care (Aim 4), alongside sepsis, medications safety and maternal and neonatal safety. Enabling the right support to be provided when it is needed, and ensuring advance care planning is undertaken are critical to meeting the holistic needs of patients and their families.

A particular area that the CoG would like to see improvement is on the number of serious incidents recorded. Whilst all incidents have the potential to cause harm, serious incidents may have a long term impact on the health and well-being of patients and their families. It is an area the CoG routinely focuses on and will be an area of further discussion in Executive and Non-Executive meetings during the year.

The Council would like to thank MCHNHSFT for the opportunity to review and provide a response to the 2019/2020 Quality Account. The Trust is clear that providing high quality and safe care is their number one priority and this is evident through the progress with the quality priorities for 2019/2020 and the focus for the year 2020/21.

Dr Katherine Birch
Lead Governor

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

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

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

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

- the content of the Quality Report meets the requirements set out in the NHS foundation Trust annual reporting manual 2019/20 and supporting guidance detailed requirements for quality reports 2019/20

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

    - board minutes and papers reported to the board over the period 1 April 2019 to 31 March 2020
    - papers relating to the quality reported to the board over the period 1 April 2019 to 31 March 2020
    - feedback from commissioners dated 25.11.20
    - feedback from governors dated 18.11.20
    - feedback from local Healthwatch organisations dated 13.11.20
    - feedback from Overview and Scrutiny Committee dated 12.11.20
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 16.07.20
    - the (latest) national patient survey 01.07.20
    - the (latest) national staff survey 28.02.20
    - CQC inspection report dated 14.04.20

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

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

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

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

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

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

By order of the board

……..Date…….Chairman

……..Date…….Chief Executive

Appendix 1 - Glossary and abbreviations

Terms	Abbreviation	Description
Acute Kidney Injury	AKI	A sudden episode of kidney failure or kidney damage that happens within a few hours or a few days. AKI causes a build-up of waste products in the blood, making it hard for the kidneys to keep the right balance of fluid in the body.
Advancing Quality	AQ	A programme which rewards hospitals which improve care in a number of key areas – heart attacks, pneumonia, hip and knee replacements, heart failure and heart bypass surgery – when compared to research which identifies what best care constitutes.
Advancing Quality Alliance	AQuA	A north west NHS health and care quality improvement organisation.
Amber Care Bundle		The AMBER care bundle aims to improve the quality of care for patients whose recovery is uncertain and who may be approaching the end of their lives despite treatment. It gives staff a greater opportunity to involve patients and their families in discussions about treatment and future care.
Antimicrobial resistance & stewardship		A coordinated program that promotes the appropriate use of antimicrobials, improves patient outcomes, reduces microbial resistance and decreases the spread of infections caused by multidrug-resistant organisms.
Aseptic Non Touch Technique	ANTT	A international set of principles aimed to standardise practice. It defines the infection prevention and control methods and precautions necessary during invasive clinical procedures to prevent the transfer of microorganisms to sterile body sites from healthcare professionals, procedure equipment or the immediate environment to the patient.
ASSKING framework	ASSKING	A skin care bundle that defines and ties together best practice for pressure ulcer prevention; **A**ssess risk **S**kin assessment and skin care **S**urface **K**eep moving **I**ncontinence **N**utrition **G**iving Information
Board (of Trust)		The role of Trust's board is to take corporate responsibility for the organisation's strategies and actions. The chair and non-executive directors are lay people drawn from the local community and are accountable to the Secretary of State. The chief

Terms	Abbreviation	Description
		executive is responsible for ensuring that the board is empowered to govern the organisation and to deliver its objectives.
Care Quality Commission	CQC	The independent regulator of health and social care in England. Its aim is to make sure better care is provided for everyone, whether in hospital, in care homes, in people's own homes, or elsewhere.
Central Cheshire Integrated Care Partnership	CCICP	A collaboration between Mid Cheshire Hospital Foundation NHS Trust and the South Cheshire and Vale Royal GP Alliance.
Clinical Commissioning Group	CCG	This is the GP led commissioning body who buy services from providers of care such as the hospital.
Clostridium Difficile	C-diff	A naturally occurring bacterium that does not cause any problems in healthy people. However, some antibiotics that are used to treat other health conditions can interfere with the balance of 'good' bacteria in the gut. When this happens, C-diff bacteria can multiply and cause symptoms such as diarrhoea and fever.
Commissioner		A person or body who buy services.
Commissioning for Quality and Innovations	CQUIN	CQUIN is a payment framework developed to ensure that a proportion of a providers' income is determined by their work towards quality and innovation.
Deprivation of Liberty Safeguards	DOLs	The Mental Capacity Act allows restraint and restrictions to be used but only in a person's best interest. Extra safeguards are needed if the restrictions and restraints used will deprive a person of their liberty. These are called the Deprivation of Liberty Safeguards.
Duty of Candour		A legal duty to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. It aims to help patients receive accurate truthful information from health providers.
Endoscopy		A nonsurgical procedure used to examine a person's digestive tract using an endoscope – a flexible tube with a light and camera attached to it.
Health Service Ombudsman		The role of the Health Service Ombudsman is to provide a service to the public by undertaking independent investigations into complaints where the NHS in England have not acted properly or fairly or have provided a poor service.
Hospital Evaluation	HED	This is an on-line solution delivering information

Terms	Abbreviation	Description
Data		which enables healthcare organisations to drive clinical performance in order to improve patient care and deliver financial savings
National Joint Registry		Set up by the Department of Health and Welsh Government in 2002 to collect information on all hip, knee, ankle, elbow and shoulder replacement operations and to monitor the performance of joint replacement implants and effectiveness of different types of surgery.
National Patient Surveys		Co-ordinated by the CQC, they gather feedback from patients on different aspects of their experience of care they have recently received, across a variety of services/settings: Inpatients, Outpatients, Emergency care, Maternity care, Mental Health services, Primary Care services and Ambulance services.
National Safety Standards for Invasive Procedures	NatSSIPs	A set of national safety standards to support NHS hospitals to provide safer surgical care.
Never Event		Serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented.
Oncology		The study of cancer. An oncologist manages a person's care and treatment once he/she is diagnosed with cancer.
Patient Reported Outcome Measures	PROMs	A programme in which patients complete a questionnaire on their health before and after their operation. The results of the two questionnaires can be compared to see if the operation has improved the health of the patient. Any improvement is measured from the patient's perspective as opposed to the clinicians.
Quality Account		This is a statutory annual report of quality which provides assurance to external bodies that the Trust Board has assessed quality across the totality of services and is driving continuous improvement.
Re-admission Rates		A measure to compare hospitals which looks at the rate at which patients need to be readmitted to hospital after being discharged (leaving hospital).
Sepsis		A life threatening condition that arises when the body's response to an infection injuries its own tissue and organs.
Summary Hospital level	SHMI	SHMI is a hospital level indicator which measures

Terms	Abbreviation	Description
Mortality Indicator		whether mortality associated with hospitalisation was in line with expectations. The SHMI value is the ratio of observed deaths in a Trust over a period of time divided by the expected number given the characteristics of patients treated by that Trust Depending on the SHMI value, Trusts are banded between 1 and 3 to indicate whether their SHMI is low (3), average (2) or high (1) compared to other Trusts. SHMI is not an absolute measure of quality. However, it is a useful indicator for supporting organisations to ensure they properly understand their mortality rates across each and every service line they provide.
Venous Thrombo-Embolism	VTE	This is a blood clot which can develop when a person may not be as mobile as they are usually or following surgery. The blood clot itself is not usually life threatening, but if it comes loose it can be carried in the blood to another part of the body where it can cause problems – this is called a Venous Thromboembolism (VTE).
Workforce Race Equality Standards		Standards to ensure the Trust addresses race equality issues.

Appendix 2 - Feedback form

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

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

How useful did you find this report?

Very useful □
Quite useful □
Not very useful □

Did you find the contents?

Too simplistic □
About right □
Too complicated □

Is the presentation of data clearly labelled?

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

If no, what would have helped?

_____
_____

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

_____
_____
_____

Audit Committee
Chair's Assurance Report
November 2020

Report to	Board of Directors
Date	9 November 2020
Report from	Les Philpott, Non-Executive Director
Report prepared by	Katharine Dowson, Head of Corporate Governance
Executive Lead	Russell Favager, Deputy Chief Executive and Director of Finance
Committee meeting quoracy	Yes ☒ No ☐

KEY AREAS OF ASSURANCE

Risk Management and Assurance Framework: Acceptable Assurance –

- Good consultation with AC Members/ Executives/ Quality Governance throughout development of documents
- Risk Management Process (RMP) guidance and Revised Risk Assurance Framework approved
- Training against process to start in December
- Internal Audit (IA) annual Q4 review to incorporate new risk processes and Audit Committee (AC) to review against implementation in Autumn 2021.

Laundry Case Study: Acceptable Assurance –

- Lessons arising from case study incorporated into new risk management and assurance framework
- AC assured new risk processes are sufficiently robust to pick up these risks now and ensure clear oversight
- Aspects of case study to be used to inform risk training
- Study has highlighted need to standardise corporate record keeping.

Report of Board Committees: Acceptable Assurance –

- Board Committees agendas/ discussions are appropriate
- Report does not describe actions and next steps where not discussed at Committee – this requires triangulation at Board.BAF will (when finalised) provide this evidence i.e. risk controls/ action plans. Audit Committee expectation that Board Committee Chairs help close the loop by ensuring clarity on next steps for risks and action at Committee and through Chair's assurance reports.

Conformance report: Acceptable Assurance – Good progress on the 'no Purchase Order, no Pay' campaign following challenge at the last Audit Committee

Medical Devices Internal Audit Action Plans Acceptable Assurance –

- Good progress / grip on action plan to address recommendations of Internal Audit reports

- Key challenge is tracking medical devices, IT tracking system proposed would require significant investment
- Medical devices risks all reviewed/ updated on organisational risk register - TW0010 tracking of medical devices/ EF0604 maintenance of medical devices
- Further update on actions requested to next meeting.

External Audit: Acceptable Assurance – technical update received including update on widened scope (National Audit Office) to reach value for money opinion at year end. Greater scrutiny of governance on risk and input required starting in December.

KEY CONCERNS/RISKS

- Requirement for additional investment to create the recommended automated Medical Devices asset tracking system (software/ IT infrastructure)
- Increased Trust input/ information requirement to establish Value for Money opinion for end of year Accounts

Priority Areas: DECISIONS MADE

Approved the Risk Management and Assurance Framework incorporating new Risk Management Process.

RECOMMENDATION

To note

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**11.1**	Date of Meeting: 07/12/2020
Report Title	**Assurance and Escalation Framework**	
Executive Lead	James Sumner, Chief Executive	
Lead Officer	Caroline Keating, Company Secretary	
Action Required	To approve	

☐ **Acceptable assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of controls

Key Messages of this Report *(2/3 headlines only)*

- Final version following version 1 approval by the Audit Committee in July 2020
- Latest inputs reflect changes made to the Trust's governance and risk management arrangements

Next Steps (*actions to be taken following agreement of recommendation/s by Board/Committee)*

- Framework to be submitted to the Board of Directors for approval, following consideration by Audit Committee.
- Provisional date for review January 2022

Strategic Objective(s) *(indication of which objective/s the report aligns to)*

• Manage Covid response and recovery	☐	• Provide safe and sustainable services	☐
• Provide outstanding care/patient experience	☐	• Provide strong system leadership by working together	☐
• Deliver most effective care to achieve best possible outcomes	☐	• Be well governed and clinically led	✓
• Be the best place to work	☐		

Impact *(is there an impact arising from the report on the following?)*

• Quality	☐	• Compliance	☐
• Finance	☐	• Legal	☐
• Workforce	☐	• Risk/BAF **BAF19 Governance systems and risk assurance**	
• Equality	☐		

Equality Impact Assessment (*must accompany the following submissions)*

Strategy ☐ Policy ☐ Service Change ☐

REPORT DEVELOPMENT

Committee/ Group Name	Date	Report Title	Lead	Brief summary of key issues raised and actions agreed
Audit Committee	13 July 2020	Assurance & Escalation Framework	C Keating	Agreed with minor amends to 1st and 2nd lines of assurance
Audit Committee	9 November 2020	Risk Management & Assurance Framework	C Keating	Agreed

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

Assurance and Escalation Framework

Author:	Company Secretary
Date Agreed: (Audit Committee)	9 November 2020
Date Approved: (Board of Directors)	7 December 2020
Review Date:	January 2022

CONTENTS

Appendix

Introduction

1. Mid Cheshire Hospitals NHS Foundation Trust ("the Trust") has developed a range of policies, systems and processes, which, when drawn together, comprise a robust framework for the assurance of quality and escalation of risk within the Trust.

2. This document describes the risk escalation and assurance framework and demonstrates how the Trust's risk systems and learning from events is monitored by an effective committee structure. It also illustrates how this process links to NHS Improvement's quality governance requirements.

3. A robust governance framework is essential as it provides assurance to the Chief Executive, the Chairman, the Board of Directors, the Council of Governors, senior managers and clinicians that the essential standards of quality and safety are being met by the organisation. It also provides assurance that the processes for governance are embedded throughout the organisation. The Board determines the appropriate mechanisms for its annual evaluation of its performance and effectiveness taking account of the various frameworks for Governance issued by NHS Improvement (e.g. The NHS Foundation Trust Code of Governance and the NHS Improvement (Monitor) Quality Governance Framework).

Purpose

4. This framework describes the responsibility and accountability for the Trust's governance structure and systems through which the Board receives assurance or escalated concerns/ risks related to quality of services, performance targets, service delivery and achievement of strategic objectives. It also addresses performance and ensures that potential performance problems are identified early and rectified.

Definition of Quality

5. The Trust has adopted the following definition of quality as used by the Care Quality Commission in its inspection framework:

   - **Care that is safe** – working with patients and their families to reduce avoidable harm and improve outcomes
   - **Care that is clinically effective** – not just in the eyes of clinicians but in the eyes of patients and their families
   - **Care that provides a positive experience for patients and their families**

Culture

6. The Trust has an open, honest and learning culture, which is described in its "Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy. The Trust encourages the reporting of all adverse incidents by its staff and the reporting of complaints and concerns by patients, their carers and relatives. The Trust also has an appointed Freedom to Speak Up Guardian with all employees made aware of the Guardian's role and availability.

Staff Involvement

7. The Trust has a number of policies and mechanisms which encourage staff at all levels to be involved in performance monitoring and to raise concerns about any risk issues. These include:

- Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy and Procedure
- Being Open Policy including the Duty of Candour Policy
- Risk Management and Assurance Framework including the Risk Management Strategy and Assurance & Escalation Framework
- Learning from Deaths Policy
- Incident Reporting and Management Policy
- Data Security and Protection Incident Reporting Policy
- Information Governance Policy and Management Framework
- Staff Code of Conduct
- Confidentiality and Data Protection Policy
- Anti-Fraud, Bribery and Corruption Policy
- Health & Safety Policy
- Incident Investigation, Learning, Reporting and Improving Policy
- Complaints and Concerns Handling Policy
- Freedom to Speak Up Guardian
- Safeguarding policies and procedures
- Lead Governor/Chairman meetings
- National staff surveys
- Internal staff surveys
- Board Effectiveness Survey
- Staff Partnership Forum
- Monthly meetings with staff side organisations
- Various staff communications including Trust Bulletins
- Appraisals Process
- Mandatory Training
- Monthly meetings of operational Executive Groups
- Safety Matters Bulletin

Patients/Relatives/Carers/Public Involvement

8. The Trust encourages patients, their carers and the public to make comments and/or raise concerns both formally and informally via a number of groups, individuals or mechanisms, such as:

- Friends & Family Test
- MCHFT Health & Wellbeing Board
- Compliments
- Customer Care
- Patient experience surveys
- Patient Stories
- Healthwatch
- Governors

- Local Authorities – Health & Wellbeing Boards
- Specialty specific patient focus groups
- Patient Led Assessments of the Care Environment (PLACE)
- Ward Nursing Staff
- Patient Safety Walk Rounds
- Trust Membership Office
- Patient Reference Group

Commissioners & Regulators

9. In addition to the internal routes for raising concerns and escalating risk, there are formal mechanisms which can be used by key stakeholders e.g. commissioners and regulators to raise concerns:

    - Contract and performance review meetings with the Cheshire Clinical Commissioning Group (CCG)
    - Board to Board meetings with other NHS providers/CCG
    - CQC Relationship Manager meetings

Trust's Internal Quality and Performance Monitoring

10. The Trust has a number of fora where performance is discussed. The key performance meetings (held monthly) are the operational Executive Groups and the Board Committees (i.e. Performance & Finance (PAF), Quality & Safety (Q&S) and Workforce & Digital Transformation (WDT)).

11. Each of the Board Committees receive the Trust's Integrated Performance Report (IPR) on a monthly basis prior to submission to the Board. The IPR details a range of indicators with the most recent month's performance against target on a RAG-rated basis. The content of the report covers those areas of performance that have been reported through the escalation process and/or are subject to scrutiny by commissioners.

12. Performance is managed at a local level through the Executive-led Delivery & Performance Group (EDPG) and each Division has a monthly meeting led by the Divisional General Managers. Each Division considers its performance against key performance targets and reviews the performance of individual teams within the division against these indicators. Where performance issues are highlighted, outlying teams are identified and actions plans developed and implemented to address the issues.

13. The EDPG meetings provide the opportunity to feed into the PAF Committee, supported by rigorous reporting mechanisms to inform discussion. Reporting of key issues adversely affecting performance is done on an exception basis and any key risks requiring escalation are raised at the monthly Executive Risk & Assurance Group and, if necessary, the weekly Executive Team meetings to be managed accordingly.

14. The Quality & Safety Committee receives performance information and intelligence relating to all aspects of quality, safety and patient experience via the IPR or substantive reports. Reporting is on an exception basis and any significant risks or issues in these areas are

reported through to the Board of Directors either via the monthly Committee Chair's Assurance Report or the quarterly Board Assurance Framework. Other Committees also receive information on significant risks relating to their remit with the same escalation process to the Board.

15. Any areas of adverse performance will be identified in the Integrated Performance Report and the Finance Report, submitted to the PAF Committee for monitoring and providing assurance to the Board on remedial action being taken.

16. A ward dashboard is in operation which provides specific information on key areas (e.g. infections, sickness absence, pressure ulcers, falls etc) on a ward by ward basis. This dashboard is overseen by the Director of Nursing & Quality. The Trust also has a ward assessment programme with a set of standards and involving patient feedback.

17. Areas of significant concern relating to safety and risk are discussed at the Divisional Boards and Executive Groups and are escalated, as appropriate, to the ERAG and relevant Board Committee (cf Governance Structure at Appendix I).

18. The Trust is also represented on the A&E Delivery Board which is attended by system-wide Partners.

Cost Improvement Plans (CIPs)

19. Progress on in-year CIPs are reported monthly to the Performance & Finance Committee with future schemes discussed quarterly. Divisional finance meetings scrutinise the CIPs with exception reporting through the Executive Delivery & Performance Group.

Financial Plan

20. The Trust has an annual Financial Plan that is approved by the Board, following scrutiny at the PAF Committee. The Plan is submitted to commissioners and regulators for final sign off.

Quality & Safety Improvement Strategy and Quality Report

21. The Trust has in place a Quality and Safety Improvement Strategy, the implementation of which is supported by a Quality Implementation Plan. The delivery of the continuous quality improvement described by the strategy and plan is monitored by the Executive Quality Governance Group and scrutinised by both the WDT and the Q&S Committees.

22. The Trust's annual Quality Account provides a report to the public about the quality of the services the Trust provides and the progress against its strategic and annual quality objectives. It provides an opportunity for scrutiny on how the Trust performs in relation to quality and sets out the focussed areas for quality improvement for the forthcoming year. Assurance is obtained on the Trust's Quality Account from the commissioners and the Trust's external auditors, KPMG.

Compliance with Regulators

Care Quality Commission

23. The Trust has systems in place to ensure adherence to CQC registration. Overall compliance to registration requirements is monitored through the governance process.

24. The Quality & Safety Committee receives reports on any areas of non-compliance or with compliance concerns. The exception reporting also provides assurance against the steps being taken to ensure compliance is achieved. Performance against the CQC Improvement Plan is overseen by the Quality Summit and the Executive Quality Governance Group.

25. A regular engagement meeting takes place with the CQC Relationship Manager with senior staff from the Trust.

NHS Improvement

26. The Board confirms compliance with NHS Improvement regarding the conditions of the Provider Licence in relation to all targets and national core standards.

27. The Performance & Finance Committee receives reports on key performance targets and national core standards. Exception reporting also provides assurance against the steps being taken to ensure compliance is achieved.

Risk Assurance and Escalation

28. Risks are reported routinely to the various groups identified on the Trust's governance structure for the purpose of monitoring and oversight:

Forum	Risk oversight / monitoring responsibilities	Regular risk reporting
Divisional Boards (or equivalent for Corporate functions)	Responsible for monitoring their risk registers across their specialties, assisting risk owners with decision-making as required, and ensuring that controls are effective in managing risk.	Monthly oversight of high priority risks (those scored as 15 or more) and quarterly oversight of medium priority risks.
Executive Groups	Executive-led Groups have specific remits and are responsible for monitoring key risks and controls relating to their remit, receiving updates from divisions and corporate functions.	Monthly monitoring of high priority operational risks. Review of medium priority risks every quarter.
Executive Risk and Assurance Group (ERAG)	Oversees the management of risks relating to the Trust's strategic objectives. Responsibility for considering the potential impact of operational risk on the Trust's strategic objectives.	Monthly report of key changes to the principal risks and high priority operational risks.
Risk Sub-Group	This Sub-Group supports the ERAG and has a 'check and challenge' remit to	Monthly report of principal risks and high priority operational risks with deep

Forum	Risk oversight / monitoring responsibilities	Regular risk reporting
	review the quality and effectiveness of risk management across the Trust.	dives to review quality of risk registers.
Board Committees	Each Committee has a specific remit and is responsible for monitoring the sections of the BAF relating to their remit as well as the relevant high priority operational risks.	Quarterly reports providing overview of relevant sections of the BAF, incorporating high priority operational risks and assurances relating to principal risks.
Trust Board	Oversight of the BAF as a means of monitoring the risks relating to the achievement of strategic objectives and associated assurances about key controls.	Quarterly BAF report providing overview of high priority operational risks and assurances relating to the Trust's principal risks.

29. Risk escalation involves the transfer of accountability to a higher level and is distinct from risk reporting and monitoring where the ownership and accountability is retained at the original level. The risk owner should be 'a person with authority and accountability to make the decision to treat, or not to treat a risk'[1]. Risks may be escalated when specific decisions need to be taken, e.g.:

- additional resource required to manage the risk
- approval to accept risks at a certain level
- change in responsibility for managing the risk when it is beyond the scope of the originating department

30. Risks are prioritised using a risk assessment methodology that is detailed in the Risk Management Process Guide. The table overleaf shows the responsibilities relating to different priorities of risk:

[1] ISO Guide 73 definition

Priority level Risk rating	Risk approval	Monitoring & reporting	Action
High Overall score 15-25	• Divisional manager or equivalent + • Executive Director	• Action plan monitored at Divisional Board (or equivalent) monthly. • Risk reported to relevant Executive-Led Group(s) monthly. • Changes in risk score (included downgrades) to be brought to the attention of the relevant Executive-Led Group(s). • All risks at this level will be reported to the ERAG (monthly) and Trust Board (quarterly) and to Board Committees where relevant to their remit.	• Risk response to be agreed as a priority (in consultation with Divisional management and Executive Director). • Requests for resources outside of authorised budget should follow the Trust's established processes.
Medium Overall score 8-12 + rare events with major or catastrophic impact	• Local manager + • Divisional manager or equivalent for corporate functions	• Action plan monitored at Divisional Board (or equivalent for corporate functions) at least quarterly. • Risk reported to relevant Executive-Led Group(s) quarterly. • Risks at this level with a major or catastrophic impact will be reported annually to the ERAG.	• Risk response to be agreed as soon as practicable. • Requests for resources outside of authorised budget should follow the Trust's established processes.
Low Overall score 1-6 but excluding rare events with major or catastrophic impact	• Local management (e.g. of ward, speciality, corporate team)	• Monitoring arrangements to be agreed locally.	• Risk response to be agreed locally. • Requests for resources outside of authorised budget should follow the Trust's established processes.

31. Details relating to the risk registers and risk management processes can be found in the Risk Management Strategy and the associated Process Guide, both of which are held on the Trust's intranet.

Board Assurance Framework (BAF)

32. The Board Assurance Framework underpins the delivery of the Trust's strategic objectives and incorporates the highest risks faced by the organisation. It, therefore, aligns the Trust's principal risks with key controls and assurances for each of the Trust's strategic objectives. Where gaps in assurance are identified, mitigating actions are developed to reduce the risk of non-delivery of these key objectives.

33. The BAF provides a vehicle for the Board of Directors to be assured that the systems, policies and people in place are operating in a way that is effective and focussed on the key risks which might prevent the Trust's objectives being achieved. Principal risks are identified by

the Board and reviewed quarterly on receipt of the BAF and annually against the Trust's strategic objectives.

34. Principal risks are owned by Executive Directors who are responsible for ensuring the risk assessment, controls, actions and assurance information are kept up to date to reflect the current status of the risks.

35. At the operational level, the Executive Risk and Assurance Group maintains oversight of the BAF taking into account relevant operational risks that have a bearing on the Trust's principal risks. The Board Committees scrutinise their delegated BAF risks prior to the Board of Directors, focussing on any significant changes to the BAF and high scoring operational risks within their remits.

Internal and External Sources of Assessment and Assurance

36. The sources listed below provide evidence of assessment and assurance for the Trust:

Internal (1st Line)

- Reports from Divisions
- Project Updates
- Update reports on action plans

Internal (2nd Line)

- Integrated Performance Report
- Finance Report
- Staff Survey Results
- Serious Incident (SI) Investigations Outcome Reports
- Data Security & Protection Toolkit
- Annual Governance Statement
- Incident reporting and management
- Complaints & Concerns Report
- Clinical Audit Reports
- Quality Impact Assessments
- Exception Reporting (on specific areas of performance)

External (3rd Line)

- Internal Audit Reports & Head of Internal Audit Opinion
- Local Counter Fraud Report
- External Audit reports
- CQC Inspections
- Well Led Governance Review
- External visits/inspection reports
- National Audits reports
- Independent/External Reviews (e.g. Ombudsman Reports)
- Quality Account

- National Staff Surveys
- National Inpatient Surveys
- National Patient Satisfaction Surveys (e.g. Friends & Family Test)
- PLACE Inspection reports
- Healthwatch reports

37. The Trust also commissions additional external reviews of activities, services and events where a need for independent assessment and assurance has been identified.

38. Evidence of how the sources of assurance are reviewed through the governance structure can be tracked in minutes of meetings, and reports from Executive Group Chairs and Board Committee Chairs.

Escalation of Issues to the Board

39. In addition to the above mechanisms, any issue identified through the course of the organisation's daily business that pose a significant threat to the Trust and its ability to deliver services is considered by the Chief Executive and Chairman of the Trust. The Chief Executive, or nominated Director, will ensure the Company Secretary informs all Directors and Non-Executive Directors immediately of the issue and the risks posed to the Trust.

Assuring Board Effectiveness

40. There are a number of ways in which the Board of Directors assures itself that it is fulfilling its duties effectively. These include:

- Self-assessments (as required by The NHS Foundation Trust Code of Governance and NHSI/Monitor's Quality Governance Framework etc)
- Annual Board Effectiveness Survey
- External effectiveness reviews (including Well Led Governance Review)
- Annual assessment against Board Governance Assurance (annual governance statement and corporate governance statement)
- Board Away Days / Board Development Sessions
- Scrutiny of Trust Board minutes
- Robust monitoring and follow up of the Board's workplan
- Board Director induction and appraisal
- Monitoring of relevant action plans and sharing of lessons learnt.

Learning Lessons

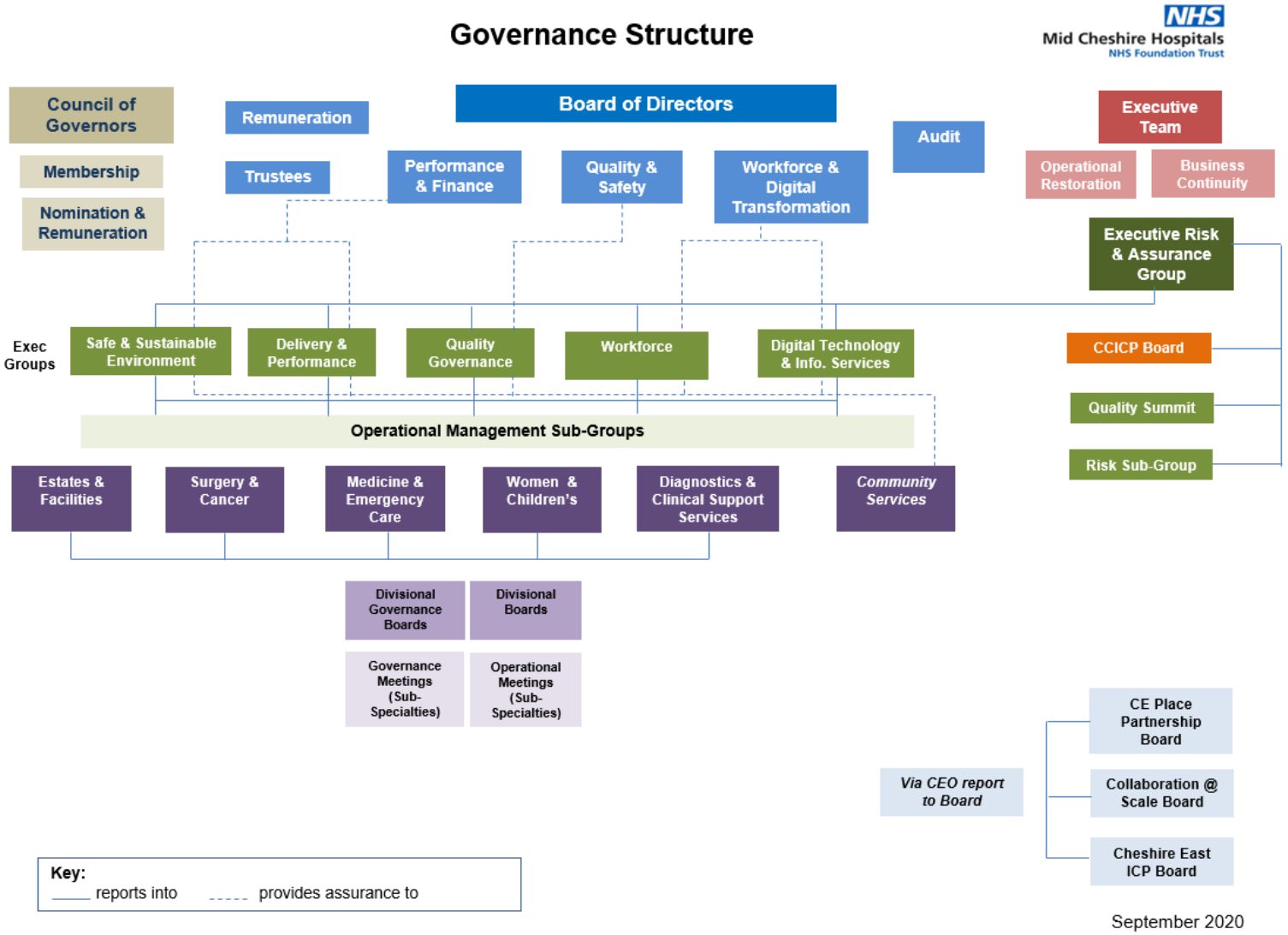
41. The Trust is committed to learning lessons in an open and transparent way. It does this through the examination of complaints, incidents, serious incidents, staff feedback, patient feedback, internal reports, external reviews, assessments and inspections and the review of national reports and reviews. This is achieved in a number of ways, for example:

- Divisional Governance Groups
- Trust Board and Board Committees performance and effectiveness reviews
- Board engagement programme e.g. Trust walkrounds
- Medical Staff Committee

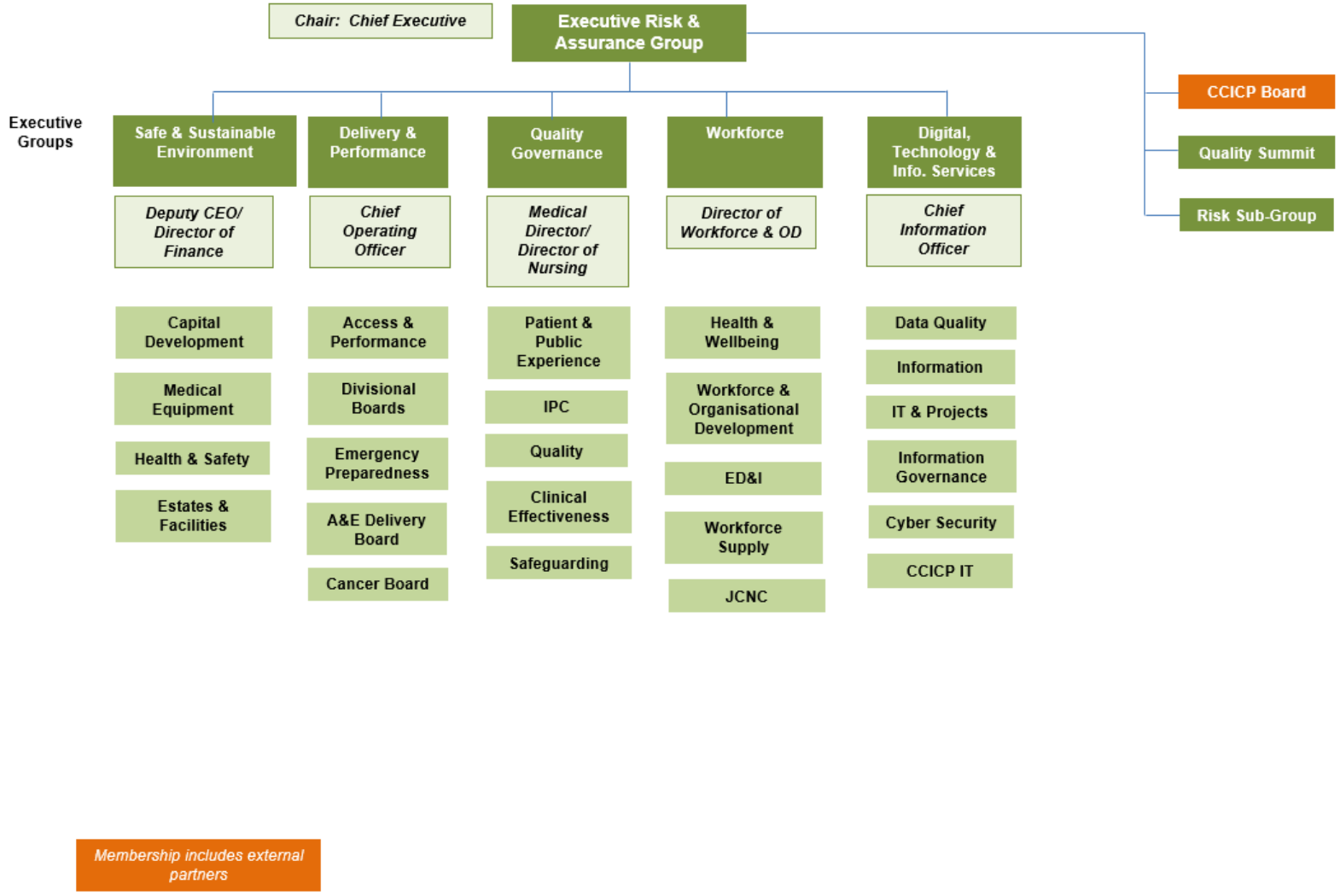
- Analysis of complaints, incidents and Serious Incident (SI) reports to consider themes and trends
- ERAG & Executive Group Meetings
- ERAG and Executive Group evaluation and review of performance
- Executive Team weekly meetings
- External Visits reporting
- Review of SI reports by Directors and Commissioners
- SI report feedback by Directors to other Directors and clinical leads
- Senior Leadership meetings (including ERAG)
- Targeted training and development
- Professional teachings and fora
- Meetings of Harm (Corporate & Divisional)
- Trust Communications (e.g. CEO Briefing; E-bulletin)

Conclusion

42. The Assurance and Escalation Framework will be reviewed on an annual basis by the Audit Committee and submitted to the Board of Directors for approval. To ensure it is effectively utilised, the Board Committees will retain oversight of its implementation through their workplans, review of issues escalated to them and, specifically, through their review of their allocated risks on the Board Assurance Framework. The Audit Committee will also ensure the framework remains fit for purpose by reviewing, as appropriate, the systems and processes contained within it.


Governance Structure
NHS
Mid Cheshire Hospitals
NHS Foundation Trust
Council of Governors
Membership
Nomination & Remuneration
Remuneration
Trustees
Board of Directors
Performance & Finance
Quality & Safety
Workforce & Digital Transformation
Audit
Executive Team
Operational Restoration
Business Continuity
Executive Risk & Assurance Group
Exec Groups
Safe & Sustainable Environment
Delivery & Performance
Quality Governance
Workforce
Digital Technology & Info. Services
CCICP Board
Quality Summit
Risk Sub-Group
Operational Management Sub-Groups
Estates & Facilities
Surgery & Cancer
Medicine & Emergency Care
Women & Children's
Diagnostics & Clinical Support Services
Community Services
Divisional Governance Boards
Divisional Boards
Governance Meetings (Sub-Specialties)
Operational Meetings (Sub-Specialties)
Via CEO report to Board
CE Place Partnership Board
Collaboration @ Scale Board
Cheshire East ICP Board
Key:
reports into
provides assurance to
September 2020

Governance Structure – Executive Risk & Assurance Group



Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**12**	Date of Meeting: 07/12/2020
Report Title	**Fit and Proper Persons Annual Report**	
Executive Lead	Caroline Keating, Company Secretary	
Lead Officer	Katharine Dowson, Head of Corporate Governance	
Action Required	To note	

X **Acceptable assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of controls

Key Messages of this Report *(2/3 headlines only)*

- No concerns were raised during the annual Fit and Proper Persons checks

Next Steps (*actions to be taken following agreement of recommendation/s by Board/Committee)*

- Checks will be noted on Directors' files and filed centrally
- Checks to be rolled out to Cheshire East Integrated Care Partnership Board

Strategic Objective(s) *(indication of which objective/s the report aligns to)*

• Manage Covid response and recovery	☐	• Provide safe and sustainable services	☐
• Provide outstanding care/patient experience	☐	• Provide strong system leadership by working together	☐
• Deliver most effective care to achieve best possible outcomes	☐	• Be well governed and clinically led	✓
• Be the best place to work	☐		

Impact *(is there an impact arising from the report on the following?)*

• Quality	☐	• Compliance	☐
• Finance	☐	• Legal	☐
• Workforce	☐	• Risk/BAF BAF19 Governance systems and risk assurance	
• Equality	☐		

Equality Impact Assessment (*must accompany the following submissions)*

Strategy ☐ Policy ☐ Service Change ☐

REPORT DEVELOPMENT

Committee/ Group Name	Date	Report Title	Lead	Brief summary of key issues raised and actions agreed
NA				

Fit and Proper Persons Requirements

Introduction

1. Regulatory standards for the Fit and Proper Persons requirements for directors (Appendix I) came into force for all NHS provider organisations from 27 November 2014. This was a direct response to the Francis Inquiry into Mid-Staffordshire NHS Foundation Trust and reflected growing requirements, both within the NHS and in the corporate sector about the standards of conduct required for Board Directors.

Fit and Proper Persons Requirements (FPPR) Checks

2. The annual checks included a review of national registers for insolvency, bankruptcy and disqualified directors, with no findings of concern.

3. All Directors completed a self-declaration stating that they continue to comply with the FPPR.

4. A checklist has been completed and signed by the Chairman for each MCHFT Director which ensures all required FPPR checks are documented and available for Care Quality Commission Well Led inspections.

Partnership Boards

5. In February 2018 the Kirkup report, which focused on the failings in leadership at Liverpool Community Health NHS Trust was published. The Trust reviewed the recommendations and found the Trust's processes to be compliant; however, through the gap analysis it was agreed that the same levels of scrutiny should apply to all Trust directors including the Central Cheshire Integrated Care Partnership (CCICP) Board. Since 2018, all GP Alliance representatives have completed an annual declaration and were subject to a check against the national registers.

6. As a Foundation Trust, Cheshire and Wirral Partnership NHS Foundation Trust is subject to the same Fit and Proper Requirements as the Trust and has provided the Trust with a statement of assurance that all those directors on the CCICP Partnership Board have completed checks.

7. The same provisions are recommended for the Cheshire East Integrated Care Partnership Board. Assurances have already been received from East Cheshire Hospitals NHS Trust that their members have been checked in the past year. The next step is to widen this to the remaining Board members.

Future Developments

8. In response to the Kirkup review, the Government set up the Kark review which reported in February 2019 and made a number of recommendations on the effectiveness and application of the current FPPR. The first of these two recommendations (Appendix II) were accepted by the Government, but no further guidance on what this may mean has yet been released.

Recommendations

9. To note that the Board of Directors and CCICP Partnership Board remain compliant with the FPPR and have completed their annual checks.

10. To agree that FPPR checks for GP and Cheshire East Council representatives on the Cheshire East Integrated Care Partnership should be completed.

Author: **Katharine Dowson, Head of Corporate Governance**
Date: **23 November 2020**

Appendix I

FPPR Requirements

The requirements are defined in Schedule 4 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

A Trust must not appoint a person to a Director level post unless:

- they are of good character;
- they have the necessary qualifications, competence, skills and experience;
- they are able by reason of their health, after reasonable adjustments are made, properly to perform their work;
- they have not been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement in the course of carrying on a regulated activity; and
- none of the grounds of unfitness specified in Part 1 of Schedule 4 of the 2014 Regulations apply to them.

In assessing good character, consideration must be given to:

- whether the person has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence; and
- whether the person has been erased, removed or struck off a register of professionals maintained by a regulator of health care or social work professionals.

The grounds of unfitness specified in Part 1 of Schedule 4 of the 2014 Regulations are:

- The person is an undischarged bankrupt or a person whose estate has had a sequestration awarded in respect of it and who has not been discharged;
- The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland;
- The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986;
- The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it;
- The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006,
  or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland;
- The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.

Appendix II

Recommendations of the Kark Review 2018

None of the recommendations made below should remove from the Trust Board the overarching responsibility for good corporate governance and the overall responsibility of the Boards of Trusts to protect those working in the hospitals and to protect their patients.

1. **All directors (executive, non-executive and interim) should meet specified standards of competence to sit on the board of any health providing organisation. Where necessary, training should be available.**

2. **That a central database of directors should be created holding relevant information about qualifications and history**

3. The creation of a mandatory reference requirement for each Director

4. The FPPT should be extended to all Commissioners and other appropriate Arms-Length Bodies (including NHSI and NHSE)

5. The power to disbar directors for serious misconduct (through a new regulatory organisation, potentially hosted by NHSI)

6. We recommend that, in relation to Regulation 5 (3) (d) of the Regulations, the words “been privy to” are removed.