Mid Cheshire Hospitals NHS
NHS Foundation Trust

A G E N D A

Board of Directors
A meeting will be held in Public at
9.30am on Monday, 7 November 2016
In the Board Room, Leighton Hospital

Action Key	
A	Approval
I	Information
D	Discussion

Item No	Title of Item	Action	Led by	Page No
1.	**Welcome and Apologies** To welcome members of the public and attendees and to receive apologies for absence from Board Members. *(to note)*	I	Chairman 09.30	-
2.	**Patient or Staff Story** *(to note)*	I	Director of Nursing & Quality 09.32	-
3.	**Board Members' Interests** *(to note)* To **consider** any • Changes to Directors' interests since the last meeting • Conflicts of interest deriving from this agenda	I	Chairman 09.40	-
4.	**Minutes of the Last Meeting** To **approve** the minutes of the Board of Directors meeting held in Public on Monday, 3 October 2016 *(attached) (to approve)*	A	Chairman 09.42	-
5.	**Matters Arising and Action Log** *(attached) (to approve)*	A	Chairman 09.45	4
6.	**Annual Work Programme** **6.1 2016/17 Work Programme** *(attached) (to approve)*	I/A	Chairman 09.47	5
7.	**Chairman's Announcements** (*to note a verbal report*) **7.1 NHS Providers regional meeting** **7.2 C&W STP meeting** **7.3 BOARD development (AQUA)** **7.4 Corporate Trustee Meeting** **7.5 Council of Governors meeting** **(i) Constitutional change**	I	Chairman 09.50	-
8.	**Governors' Items** (*to note a verbal report*) **8.1 Council of Governors Meeting – 27 October 2016** **8.2 New Governor Induction**	I	Chairman 09.55	-

Item No	Title of Item	Action	Led by	Page No
9.	**Chief Executive's Report** (*to note a verbal report*)			
	9.1 **Cheshire & Merseyside STP**	I	Chief Executive 10.00	-
	9.2 **Cheshire & Wirral Local Transformation Plan**			
	9.3 **Local Delivery Plan (Connecting Care)**			
	9.4 **Community Services**			
10.	**CARING**			
	10.1 **Quality, Safety & Experience Report** *(attached)* (*to note)*	I/D	Director of Nursing & Quality 10.20	6
	10.2 **Nursing and Midwifery Staffing Annual Comprehensive Report** *(to follow) (to note)*	I/D	Director of Nursing & Quality 10.30	-
	10.3 **Cheshire & Merseyside Pressure Ulcer Project** *(verbal) (to note)*	I/D	Director of Nursing & Quality 10.35	-
11.	**SAFE**			
	11.1 **Draft Quality Governance Committee notes from the meeting held on 10 October 2016** *(attached)* (*to note*)	I	Committee Chair 10.40	-
	11.2 **Serious Untoward Incidents and RIDDOR Events** *(verbal)* (*to note/discussion*)	I/D	Deputy Chief Executive/ Medical Director 10.45	-
12.	**RESPONSIVE**			
	12.1 **Performance Report** *(to follow)* (*to note*)	I/D	Chief Operating Officer 10.50	-
	12.2 **Draft Performance & Finance Committee notes from the meeting held on 27 October 2016** *(to follow)* (*to note*)	I	Committee Chair 11.00	-
	12.3 **Legal Advice** *(verbal)* (*to note*)	I	Chief Executive 11:05	-
	12.4 **NHS Improvement & Action to Reduce Agency Spend** *(attached) (to note/discussion)*	I/D	Director of Nursing and Quality 11:15	38
	12.5 **Exceptional Use of the Trust Seal and Quarterly Report** *(attached) (to note)*	I/A	Chief Executive 11:25	47

Item No	Title of Item	Action	Led by	Page No
13.	**WELL-LED**			
	13.1 **Board Assurance Framework Quarter 2** *(attached) (to note)*	I/D	Deputy Chief Executive/ Medical Director 11.30	49
	13.2 **POAC Capital Authorisation** *(attached) (for approval)*	D/A	Chief Operating Officer 11.40	-
	13.3 **Draft Transformation and People Committee notes from the meeting held on 6 October 2016** *(attached) (to note)*	I/D	Committee Chair 11.50	-
	13.4 **Visits of Accreditation, Inspection or Investigation** (*verbal)* (*to note*)	I	Chief Executive 11.55	-
	13.5 **Draft Audit Committee notes from the meeting held on 10 October 2016** *(attached) (to note)*		Committee Chair 12.00	-
14.	**EFFECTIVE**			
	14.1 **Consultant Appointments** *(verbal)* (*to note*)	I	Deputy Chief Executive/ Medical Director 12.05	-
	14.2 **Annual Plan** *(verbal) (for discussion)*	I/D	Director of Finance 12.10	-
15.	**Any Other Business (verbal)**	I/A/D	Chairman 12.25	-
16.	**Time, Date and Place of Next Meeting**			
	To confirm that the next meeting of the Board of Directors will take place in public, in the Board Room at Leighton Hospital, at 9.30am on Monday, 5 December 2016	I	Chairman	

Resolution: To exclude the press and public from the meeting at this point on the grounds that publicity of the matters being reviewed would be prejudicial to public interest, by reason of the confidential nature of business. The press and public are requested to leave at this point.

Board of Director Meeting held in Public (Action Log)

Action No	Date of Meeting	Action	Lead	Deadline Date	Comments	Date of Board meeting to be reviewed	Status
BoD16/10/9.8.3	03-Oct-16	NHS Providers Briefing on the Planning Guidance to be circulated to the Board	T Bullock	07-Nov-16		Nov-16	Open
BoD16/10/11.1	03-Oct-16	Focus of Patient Safety Walkaround to be reviewed with Integrated Governance	A Lynch	07-Nov-16		Nov-16	Open
BoD16/10/12.3	03-Oct-16	Final legal costs for Community Services to be reported to the Board	T Bullock	07-Nov-16		Nov-16	Open

Board of Directors Workplan 2016 /17

Item	Board of Director Meeting												Board Away Day				
	April	*May*	*June*	*July*	*August*	*Sept*	*Oct*	*Nov*	*Dec*	*Jan*	*Feb*	*March*	*Apr*	*June*	*Oct*	*Dec*	*Feb*
Patient/Staff Story	x	x	x	x	x	x	x	x	x	x	x	x					
Chief Executive Report	x	x	x	x	x	x	x	x	x	x	x	x					
Chairman's Report	x	x	x	x	x	x	x	x	x	x	x	x					
Governor Report	x	x	x	x	x	x	x	x	x	x	x	x					
Caring																	
CQC Registration biannual Report				x				~~x~~	~~x~~	x							
Nursing and midwifery staffing comprehensive report								x									
Patient Survey Results (National)						x											
Patient Quality Safety and Experience Report	x	x	x	x	x	x	x	x	x	x	x	x					
~~*Report on Nursing & Midwifery Staffing*~~	~~x~~	~~x~~	~~x~~	~~x~~	~~x~~	~~x~~	~~x~~	~~x~~	~~x~~	~~x~~	~~x~~	~~x~~					
Staff Survey												x					
CQC Comprehensive Inspection Action Plan				x							x						
Safe																	
Health & Safety Update to Board													x			~~x~~	
SUI & RIDDOR	x	x	x	x	x	x	x	x	x	x	x	x					
Quality Governance Committee	x	x	x	x	x	x	x	x	x	x	x	x					
Effective																	
Consultant Appointments	x	x	x	x	x	x	x	x	x	x	x	x					
Medical Staffing Update (Part II)	x	x	x	x	x	x	x	x	x	x	x	x					
Responsive																	
Annual Budget/Planning / Budget Pack	x											x					x
Quality Account	x																
Legal Advice	x	x	x	x	x	x	x	x	x	x	x	x					
Performance & Finance Committee	x	x	x	x	x	x	x	x	x	x	x	x					
Performance Report	x	x	x	x	x	x	x	x	x	x	x	x					
Report on Use of Trust Seal	x			x			x			x							
Corporate Trustee Minutes	x								x						x		x
~~*Diabetes Partnership Review (tbc)*~~																	
~~*Stronger Together (part 11)*~~	~~x~~	~~x~~	~~x~~														
Well-Led																	
Annual Budget/Contract Discussions	x											x					
Annual Plan (Extraordinary BoD Meetings)	x	x										x					
Annual Report & Accounts		x	x														
Audit Committee		x	x			x		x		x		x					
Board Assurance Framework		x			x			x			x						
Top 5 Risks		x			x			x			x						
~~*Capital Programme*~~		~~x~~		-				~~x~~		-				~~x~~		~~x~~	
~~*Quality Governance Framework*~~																x	
Trust Strategy	x																x
Trust Strategy Update	x			x			x			x							
Visits of Accreditation, Inspection or Investigation	x	x	x	x	x	x	x	x	x	x	x	x					
Well-Led Governance Framework Self Assessment													x				
Corporate Goverance Handbook		x															
Transformation and People Committee	x	x	x	x	x	x	x	x	x	x	x	x					
Terms of Reference of Board Committees									x								
Board Actions	x	x	x	x	x	x	x	x	x	x	x	x					

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Board Report November 2016

Quality: Safety and Experience

(September 2016 data)

This report provides an overview of performance relating to safety and experience in September 2016.
Key messages for September are:

- No Serious incidents were reported in month
- The Trust's HSMR is 107.28 and places the Trust 102 out of 135 Trusts
- The Trust is achieving its aim to have a SHMI at or below 1.0 from April 2015
- Patients with a suspected stroke and admitted to a specialist stroke unit has increased to 93% from 74% last month
- No MRSA Bacteraemia cases have been reported in month
- One avoidable Clostridium Difficile case has been reported in month. The target continues to be achieved.
- 25 complaints were received, which is an increase from the previous month
- The Trust's NHS Choices Star rating is 5 stars for Victoria Infirmary, and 4 stars for Leighton Hospital

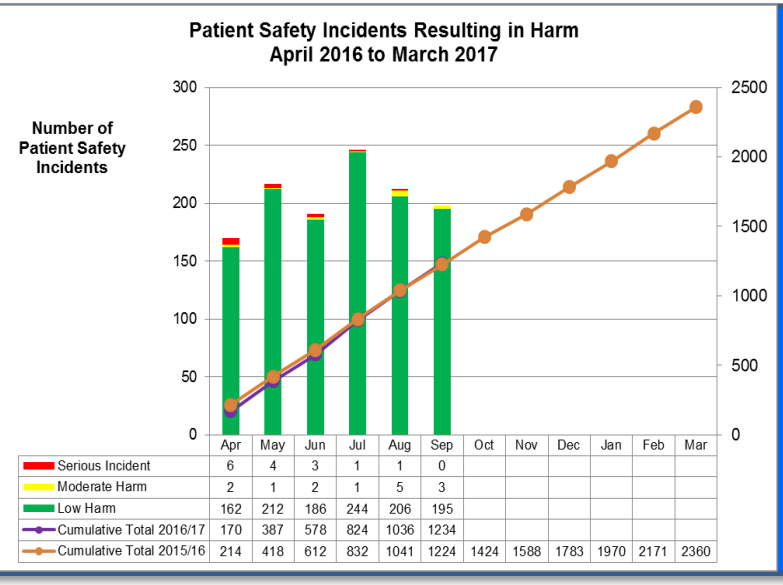
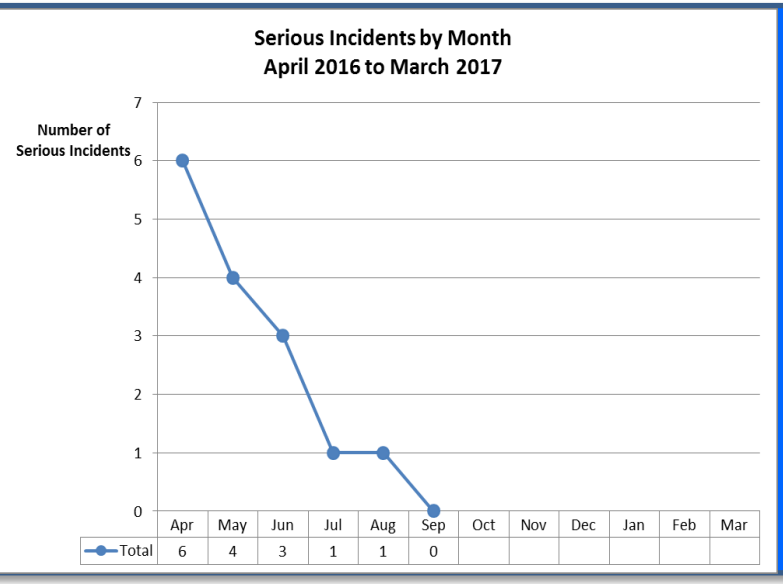
Please note that the incident data for the CCICP will be included in the December 2016 report following the partnership commencing on the 1 October 2016.

Board Papers – Quality, Safety & Experience Section: November 2016

Contents

Contents (continued):

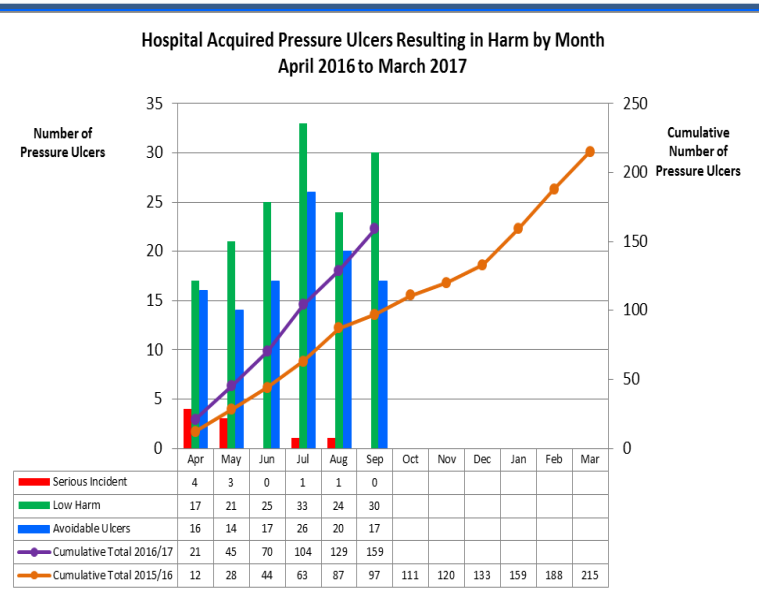
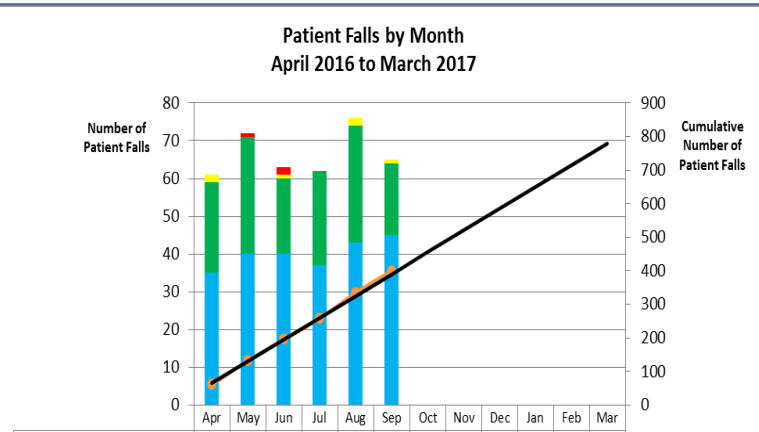
Quality & Safety Section:

Description	Aggregate Position	Trend	Variation
Patient Safety Incidents resulting in harm.	This chart demonstrates the total number of reported patient safety incidents which resulted in harm. For this financial year to date: 97.6% (1205 incidents) have resulted in low harm 1.1% (14 incidents) have resulted in moderate harm 1.2% (15 incidents) have resulted in serious harm		The Trust's aim is to reduce the number of harm incidents by the end of January 2018 in comparison to the previous financial year. The aim was not achieved in month.
Serious Incidents.	This chart demonstrates the number of incidents that have resulted in serious harm. No serious harm incidents were reported in September 2016. 15 serious incidents have been reported for this financial year to date. • 7 x Stage 3 pressure ulcers • 3 x Patient falls resulting in fractured neck of femur • 2 x Stage 4 pressure ulcer • 1 x Delay in follow up appointment • 1 x Never Event wrong size implant inserted • 1 x Treatment regime		The Trust's Sign Up To Safety aim is to have no serious incidents and a zero tolerance on Never Events by the end of January 2018. The aim is not currently being achieved.

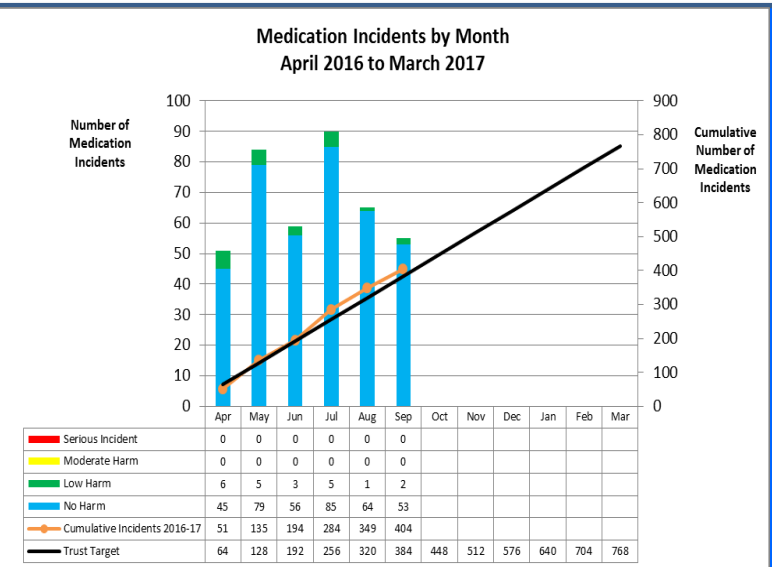
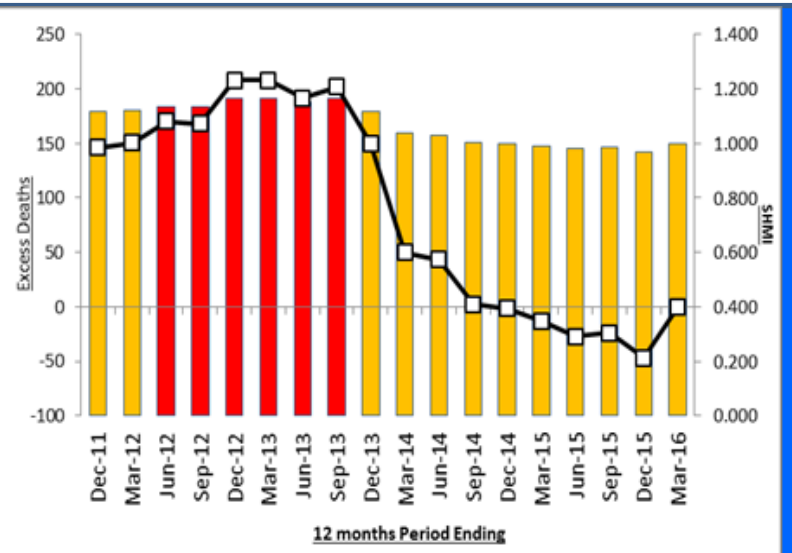
Degrees of Harm

Serious Incidents

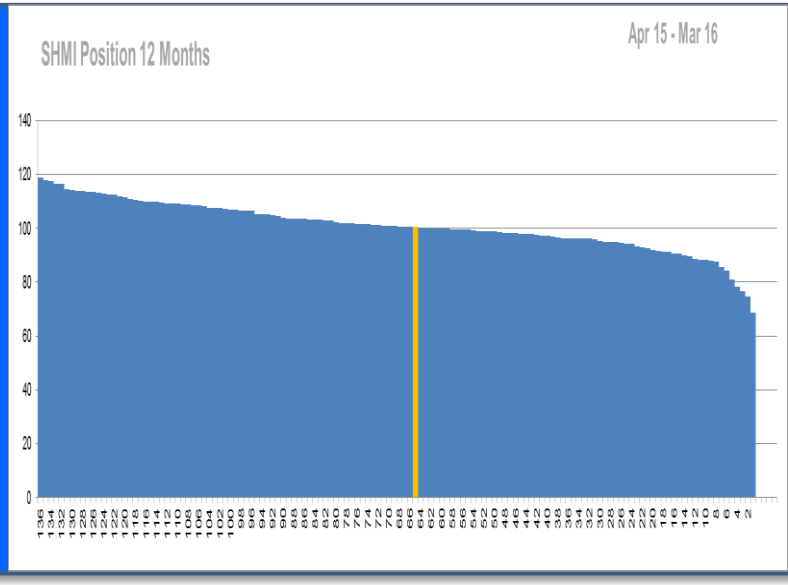
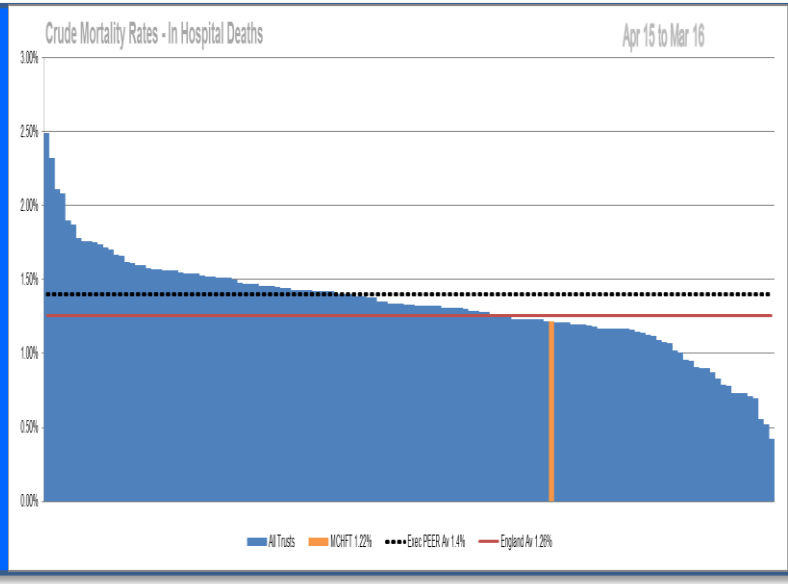
Board Papers – Quality, Safety & Experience Section: November 2016

Description	Aggregate Position	Trend	Variation
Pressure Ulcer (PU) Incidents including avoidable pressure ulcers.	For this financial year to date: • 94.3% (150 PU's) have resulted in low harm (defined as a patient that has developed a stage 2 or unstageable PU) • 5.7% (9 PU's) have resulted in serious harm (defined as a patient that has developed a stage 3 or 4 PU) In September 2016, 17 avoidable PU's were reported, as shown by the blue bar on the chart. Improvement actions include: • Launch of the 'React to Red' safety collaborative in May 2016. A number of projects are underway as part of the collaborative on a cohort of wards	 Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Serious Incident 4 3 0 1 1 0 Low Harm 17 21 25 33 24 30 Avoidable Ulcers 16 14 17 26 20 17 Cumulative Total 2016/17 21 45 70 104 129 159 Cumulative Total 2015/16 12 28 44 63 87 97 111 120 133 159 188 215	The aim in the Trust's Quality & Safety Improvement Strategy and Sign Up To Safety Campaign is to have no avoidable hospital acquired PU's by the end of January 2018. The aim has not yet been achieved. **Pressure Ulcers**
Patient Falls Incidents.	For this financial year to date: • 60.2% (240 falls) have resulted in no harm • 37.6% (150 falls) have resulted in low harm • 1.5% (6 falls) have resulted in moderate harm • 0.8% (3 falls) have resulted in serious harm All patient falls are reviewed by the Patient Falls Prevention Group on a monthly basis. Improvement actions include: • The Falls Safety Collaborative was launched on 1st April 2016 • A number of projects are being trialled as part of the collaborative on a cohort of wards Over the past 3 years we have reduced falls by 29.4%.	 Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Serious Incident 0 1 2 0 0 0 Moderate Harm 2 0 1 0 2 1 Low Harm 24 31 20 25 31 19 No Harm 35 40 40 37 43 45 Cumulative Total 2016-17 61 133 196 258 334 399 Sign Up To Safety Target 65 130 195 260 325 390 455 520 585 650 715 780	The Trust's aim within the Sign Up To Safety Campaign is to reduce inpatient falls by 10% by January 2018. The Sign up to Safety aim was not achieved in month. **Patient Falls**

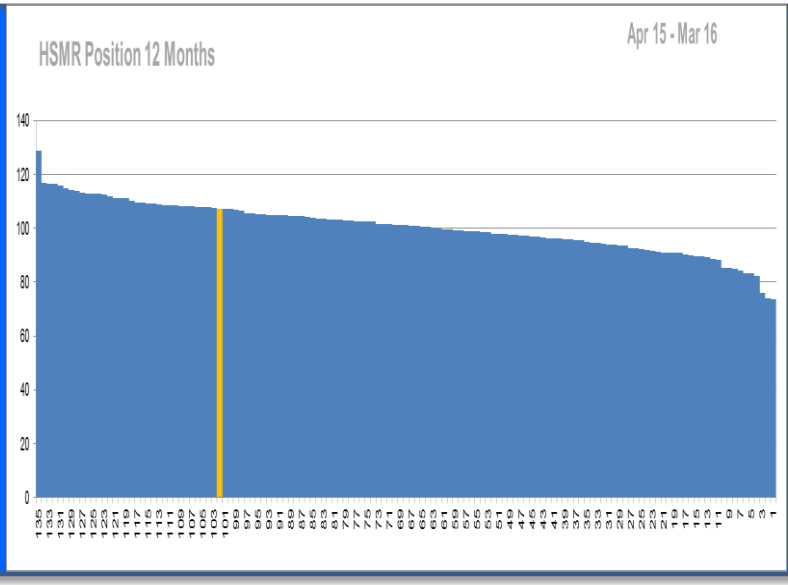
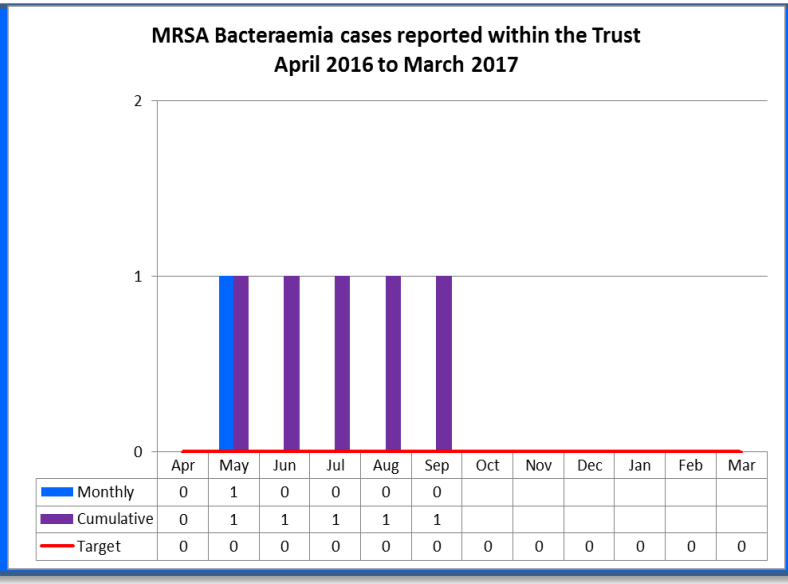
Board Papers – Quality, Safety & Experience Section: November 2016

Description	Aggregate Position	Trend	Variation
Medication Incidents.	For this financial year to date: • 94.6% (382 medication incidents) have resulted in no harm • 5.4% (22 medication incidents) have resulted in low harm • 0% (0 medication incidents) have resulted in moderate harm • 0% (0 medication incidents) have resulted in serious harm Improvement actions include: • Introduction of ward based medicines safety audit monthly monitoring	 Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Serious Incident 0 0 0 0 0 0 Moderate Harm 0 0 0 0 0 0 Low Harm 6 5 3 5 1 2 No Harm 45 79 56 85 64 53 Cumulative Incidents 2016-17 51 135 194 284 349 404 Trust Target 64 128 192 256 320 384 448 512 576 640 704 768	The Trust's aim is to reduce medication incidents by 5% by the end of January 2018 in comparison to the previous financial year. The aim was not achieved in month. Medication Incidents
Summary Hospital-Level Mortality Indicator (SHMI).	The chart demonstrates the Trust's Summary Hospital-Level Mortality Indicator (SHMI) and calculated "excess deaths". For the period April 2015 to March 2016, the Trust's SHMI is 1.0 and "as expected"		The Trust's aim within the Sign Up To Safety Campaign is to have a SHMI at or below 1.0 from April 2015. The aim is currently being achieved. SHMI

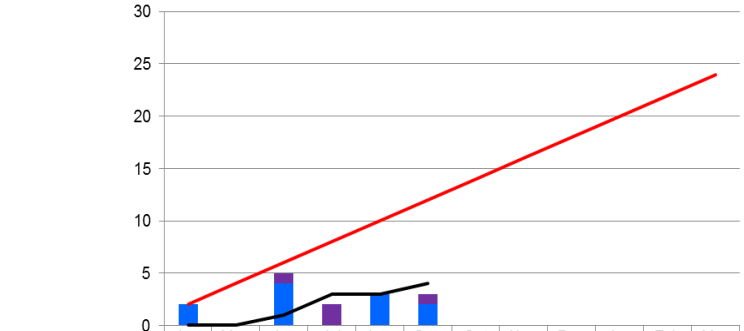
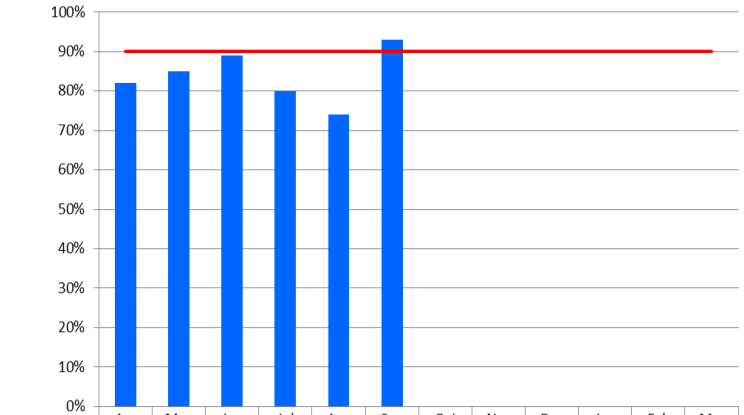
Board Papers – Quality, Safety & Experience Section: November 2016

Description	Aggregate Position	Trend	Variation
Summary Hospital-Level Mortality Indicator (SHMI) by Trust.	The chart benchmarks the Trust's latest SHMI against all NHS Trusts. MCHFT is shown as the yellow bar. The Trust's SHMI is 1.0 for the time period April 2015 to March 2016 and places the Trust 68 out of 136 Trusts.		The Trust's aim within the Sign Up To Safety Campaign is to have a SHMI at or below 1.0 from April 2016. The aim is currently being achieved. **SHMI by Trust**
Crude Mortality	The chart benchmarks the Trust's crude mortality rate for the period April 2015 to March 2016 against an executive peer and England average. The Trust (1.22%) is currently below the executive peer average of 1.4% and the England average of 1.26% and places the Trust 42 out of 136 Trusts.		The Trust's aim is to continually reduce its crude mortality rate. **Crude Mortality**

Board Papers – Quality, Safety & Experience Section: November 2016

Description	Aggregate Position	Trend	Variation
HSMR by Trust.	The chart benchmarks the Trust's HSMR against all NHS Trusts. MCHFT is shown by the green bar. The Trust's HSMR is 107.28 (April 2015 to March 2016) and places the Trust 102 out of 135 Trusts.		The Trust's aim is to have an HSMR <100. HSMR by Trust
MRSA Bacteraemia Cases.	In this financial year there has been one confirmed MRSA bacteraemia case reported. This was a contaminant case and lapses in care have been addressed via the root cause analysis process.	 Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Monthly 0 1 0 0 0 0 Cumulative 0 1 1 1 1 1 Target 0 0 0 0 0 0 0 0 0 0 0 0	The target for MRSA Bacteraemia is zero in 2016/17. The target has not been achieved. MRSA

Board Papers – Quality, Safety & Experience Section: November 2016

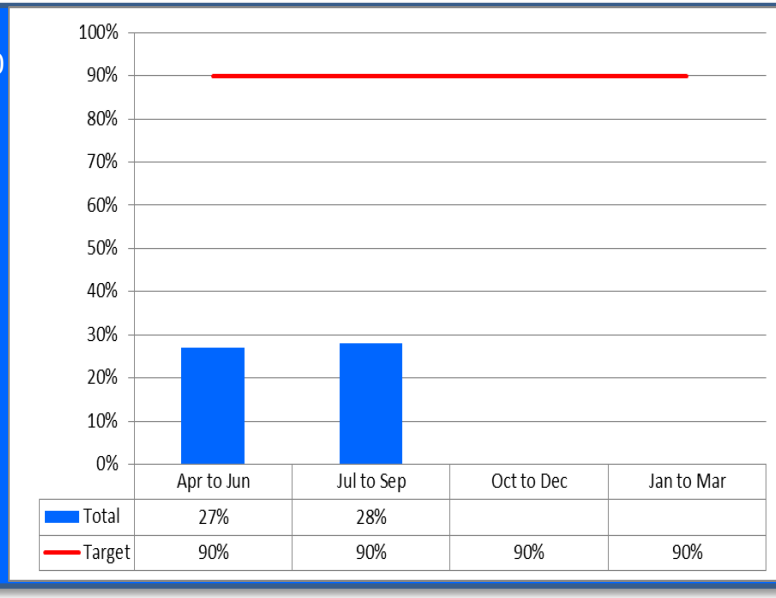
Description	Aggregate Position	Trend	Variation
Clostridium Difficile toxin positive cases.	In September 2016, one avoidable case was reported. Actions arising from review of the Clostridium Difficile cases include: • Ward Managers to reinforce the importance of accurate stool chart documentation • Ward staff to attend the weekly Clostridium Difficile Infection meetings to support ownership at a ward level • Matrons to lead on formal RCA process for all avoidable and unavoidable cases of Clostridium Difficile	**Clostridium Difficile toxin positive cases reported within the Trust April 2016 to March 2017**  Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Avoidable 0 0 1 2 0 1 Unavoidable 2 0 4 0 3 2 Avoidable Total 0 0 1 3 3 4 Avoidable Target 2 4 6 8 10 12 14 16 18 20 22 24	The target is less than 24 avoidable cases of Clostridium Difficile in 2016/17. The target has been achieved. Clostridium Difficile
Patients with a suspected stroke admitted directly to a specialist acute stroke unit	In September 2016 28 out of 30 patients (93%) were admitted directly to the stroke unit. Improvements in practice aimed at delivering the target have included: • An agreed pathway with UHNM was implemented on the 4 July 2016 • Bi-weekly teleconferences are being held between UHNM and MCHFT to discuss operational and clinical issues • Clinical Meeting to be held to discuss the new pathway and any actions and or amendments required • An individual patient review is held for each patient where the pathway was not fully adhered	**Patients with a suspected stroke are admitted directly to a specialist acute Stroke Unit April 2016 to March 2017**  Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar 2016-17 82% 85% 89% 80% 74% 93% Target 90% 90% 90% 90% 90% 90% 90% 90% 90% 90% 90% 90%	As part of the Sentinal Stroke National Audit Plan (SSNAP) the Trust aim for 2016/2017 is 90% of suspected stroke patients to be admitted directly to the stroke unit. The target was achieved in month. Stroke

Description	Aggregate Position	Trend	Variation	
National CQUIN – Health & Wellbeing Part 1a The financial value for this CQUIN is £396,107.	To achieve the CQUIN target for Health & Wellbeing Part 1a the Trust must introduce a Health & Wellbeing initiative from two options provided. The Trust has chosen option 2. • Introduce a range of physical activity schemes for staff. Include an emphasis on promoting active travel, building physical activity into working hours and reducing sedentary behaviour • Improving access to physiotherapy services for staff. A fast track service for staff suffering from musculoskeletal issues to ensure staff are reviewed in a timely manner • Introduce a range of mental health initiatives for staff. Offer support to staff such as stress management courses, line management training, mindfulness courses and counselling services	For quarter 2, progress against the action plan is required, although there is no funding allocated to quarter 2. The Health & Wellbeing steering group monitors progress against the action plan and the group agrees the frequency of meetings to monthly. Actions taken to date include: • Relaunch of the green walking route. • Completion of the Race to Rio virtual walking challenge. • Participation in the Cheshire & Warrington Team Games.	The CQUIN target for Health & Wellbeing Part 1a is to have implemented the initiatives as agreed in the plan and actively promoted these initiatives to staff. The target was achieved in month.	National CQUIN – Health & Wellbeing Part 1a
National CQUIN – Health & Wellbeing Part 1b The financial value for this CQUIN is £396,107.	To achieve the CQUIN target for Health & Wellbeing Part 1b the Trust must provide healthy food for NHS staff, patients and visitors • Banning price promotions on sugary drinks and foods high in fat, sugar and salt (HFSS) • Banning advertisement on NHS premises of sugary drinks and foods high in HFSS • Banning sugary drinks and foods high in HFSS from checkouts • Ensuring that healthy options are available at any point including those for staff working night shifts	For quarter 2, progress against the action plan is required, although there is no funding allocated to quarter 2. The Health & Wellbeing steering group monitors progress against the healthy eating plan. Actions taken to date include: • Agreement that no foods HFSF will be promoted within the Trust by in-house catering, the RVS or League of Friends. • Only healthy options have been promoted since 1st June 2016. • All confectionary has been moved away from till points. • National data collection return was completed and returned within the required timescales.	The CQUIN target for Health & Wellbeing Part 1b is to have implemented all four outcomes as outlined in the CQUIN. The target was achieved in month.	National CQUIN – Health & Wellbeing Part 1b

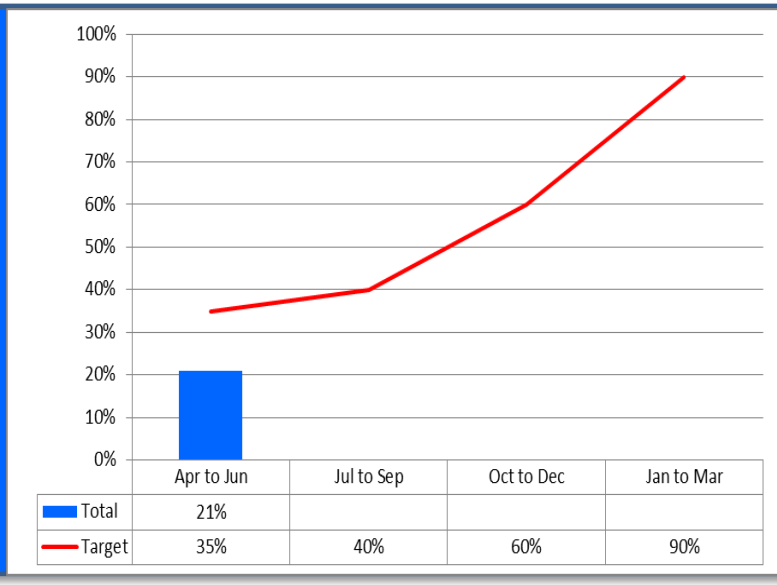
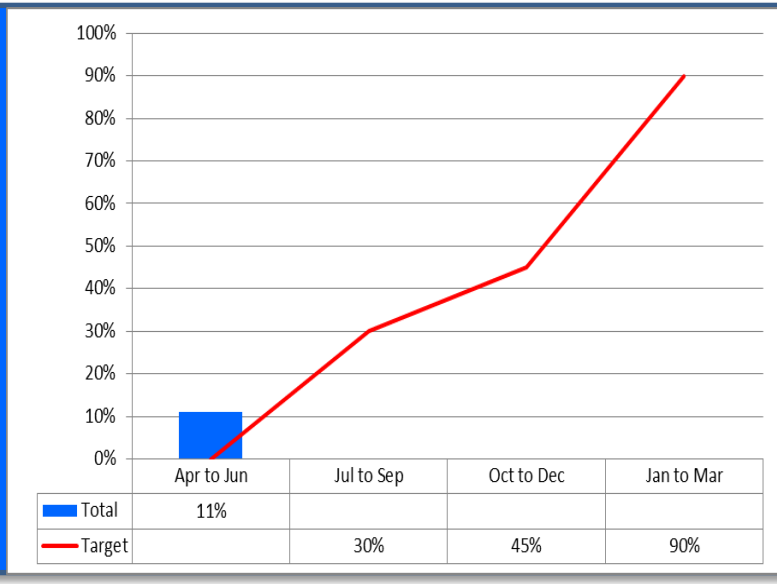
Board Papers – Quality, Safety & Experience Section: November 2016

Description	Aggregate Position	Trend	Variation
National CQUIN – Health & Wellbeing Part 1c The financial value for this CQUIN is £396,107.	To achieve the CQUIN target for Health & Wellbeing Part 1c the Trust must improve the uptake of flu vaccinations for front line clinical staff by December 2016. Providers will be expected to submit cumulative data monthly over four months on the ImmForm website.	The flu group meets monthly to plan delivery of the annual flu campaign. Led by the Deputy Director of Nursing & Quality, the group comprises of Matrons from across the Trust who act as flu leads for their respective areas. The Trust has organised 100 peer to peer vaccinators to help ensure MCHFT reaches the 75% uptake level by the 31st December 2016. The campaign commenced on Monday 3rd October 2016.	The CQUIN target for Health & Wellbeing Part 1c is to achieve an uptake of flu vaccinations by front line clinical staff of 75% by 31st December 2016. The target was achieved in month.

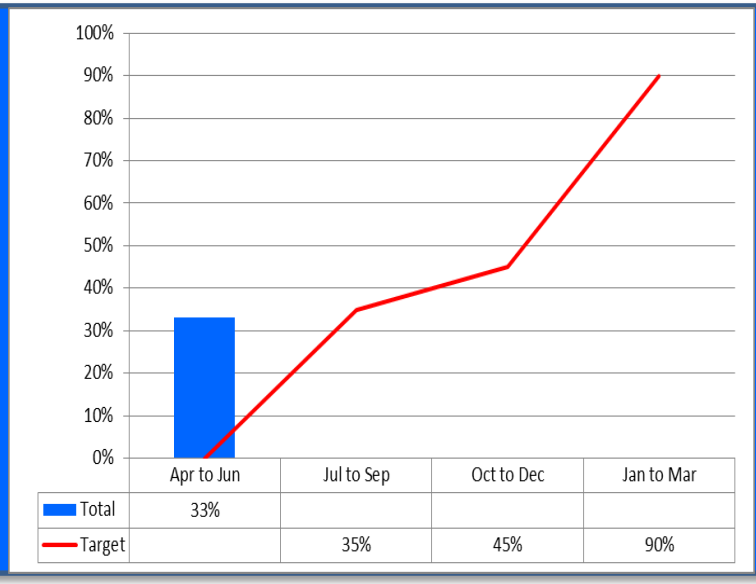
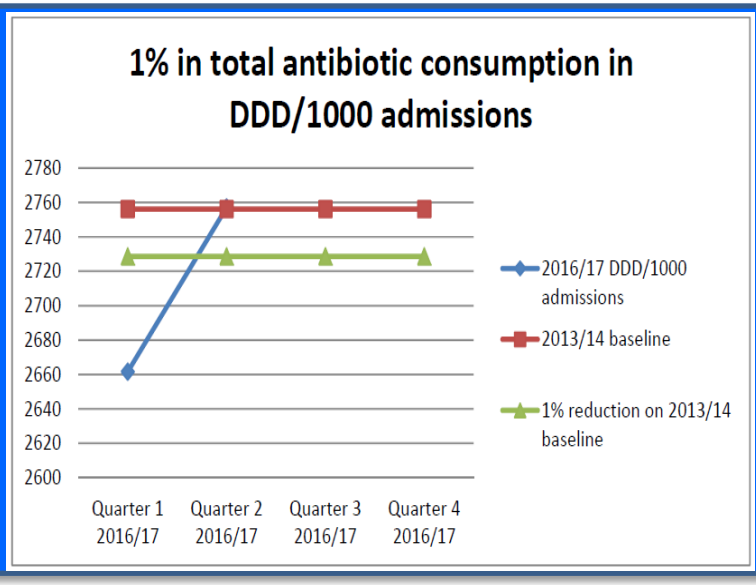
National CQUIN – Health & Wellbeing Part 1c

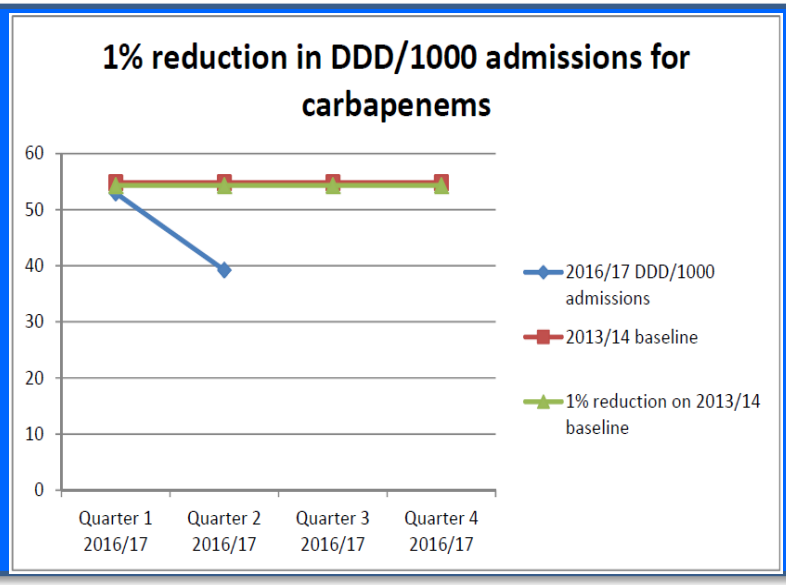
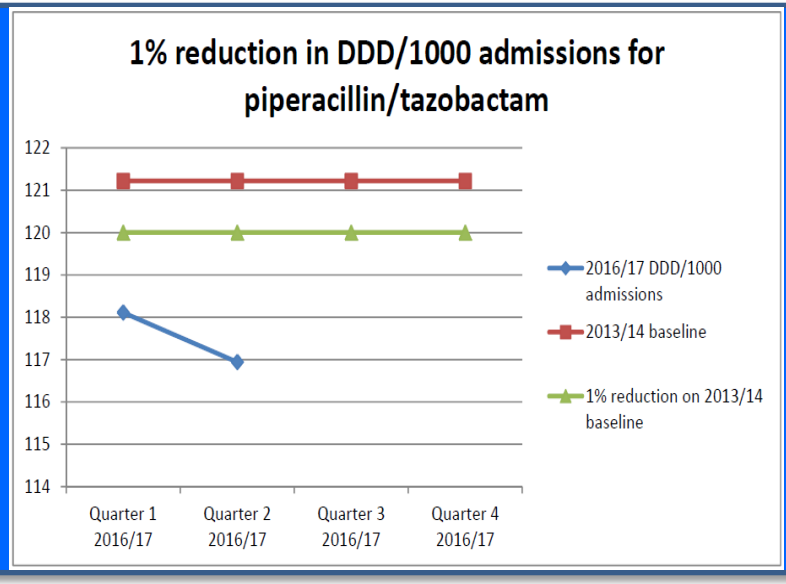
Description	Aggregate Position	Trend	Variation
National CQUIN – Sepsis Emergency Departments 2a Part 1: Screening The financial value for this CQUIN is £79,221.	To achieve the CQUIN target for Sepsis Screening 2a Part 1, a random sample of 50 sets of notes are reviewed each month to ensure all patients presenting in emergency departments are screened for sepsis as part of the admission process, where this is appropriate. Actions for improvement include: • A full time permanent sepsis specialist nurse has been appointed to the Trust • The revised sepsis pathway in line with NICE guidance has now been launched across the Trust. • Each area has nominated sepsis programme and an education programme has commenced	 Apr to Jun / Jul to Sep / Oct to Dec / Jan to Mar Total: 27% / 28% / / Target: 90% / 90% / 90% / 90%	The CQUIN target for Sepsis Part 2a Part 1 is for >90% of eligible patients to be screened for sepsis by the end of quarter four of 2016/17. The target was not achieved in month.

National CQUIN – Sepsis Emergency Departments 2a Part 1

Description	Aggregate Position	Trend	Variation
National CQUIN – Sepsis Emergency Departments 2a Part 2: Antibiotic Administration The financial value for this CQUIN is £118,832.	To achieve the CQUIN target for Sepsis Antibiotic Administration 2a Part 2, a random sample of 30 sets of notes, where clinical codes indicate sepsis, are reviewed each month to ensure patients receive antibiotics within 60 minutes of arrival at hospital and an empiric review within 3 days of the prescribing of antibiotics. Actions for improvement include: • A full time permanent sepsis specialist nurse has been appointed to the Trust • A sepsis trolley has been provided to the ED team to support timely administration of antibiotics		The CQUIN target for Sepsis 2a Part 2 is to be locally agreed. The target was not achieved in month. The results for Q2 are still pending. National CQUIN – Sepsis Emergency Departments 2a Part 2
National CQUIN – Sepsis Inpatients 2b Part 1: Screening The financial value for this CQUIN is £79,221.	To achieve the CQUIN target for Sepsis Screening 2b Part 1, a random sample of 50 sets of notes are reviewed each month to ensure all inpatients are screened for sepsis, where this is appropriate. Actions for improvement include: • A full time permanent sepsis specialist nurse has been appointed to the Trust • The revised sepsis pathway in line with NICE guidance has now been launched across the Trust. • Each area has nominated sepsis programme and an education programme has commenced		The CQUIN target for Sepsis Part 2b Part 1 is for >90% of eligible patients to be screened for sepsis by the end of quarter four of 2016/17. The target was achieved in month. The results for Q2 are still pending. National CQUIN – Sepsis Inpatients 2b Part 1

Board Papers – Quality, Safety & Experience Section: November 2016

Description	Aggregate Position	Trend	Variation
National CQUIN – Sepsis Inpatients 2b Part 2: Antibiotic Administration The financial value for this CQUIN is £118,832.	To achieve the CQUIN target for Sepsis Antibiotic Administration 2b Part 2, a random sample of 30 sets of notes, where clinical codes indicate sepsis, are reviewed each month to ensure patients receive antibiotics within 60 minutes of identification of sepsis and an empiric review within 3 days of the prescribing of antibiotics. Actions for improvement include: • The revised sepsis pathway in line with NICE guidance has now been launched across the Trust. • Each area has nominated sepsis programme and an education programme has commenced		The CQUIN target for Sepsis Inpatients 2b Part 2 is for >90% of eligible patients to receive antibiotics within 60 minutes of identification of sepsis and empiric review within 3 days by the end of quarter four of 2016/17. The target was achieved in month. The results for Q2 are still pending. National CQUIN – Sepsis Inpatients 2b Part
National CQUIN – Reduction in antibiotic consumption Part 3a1 The financial value for this CQUIN is £79,221.	To achieve the CQUIN target for antibiotic consumption Part 3a1, the Trust must have a reduction of 1% or more of total antibiotic consumption per 1,000 admissions. Quarter 2 data suggests an increase in the total antibiotic consumption to a similar level to the baseline 2013/14 data. However quarter 1 and 2 demonstrate cumulatively a > than 1% reduction in total oral antibiotic consumption, in line with the CQUIN requirements. This picture is similar to that of other Trusts in the North West region.		The CQUIN target for antibiotic consumption Part 3a1 is for a reduction of 1% or more in total antibiotic consumption per 1,000 admissions. The target was achieved in month. National CQUIN – Antibiotic consumption Part 3a 1

Description	Aggregate Position	Trend	Variation
National CQUIN – Reduction in carbapenem consumption Part 3a 2 The financial value for this CQUIN is £79,221.	To achieve the CQUIN target for antibiotic consumption Part 3a 2, the Trust must have a reduction of 1% or more of carbapenem consumption per 1,000 admissions. Quarter 1 data has now been reported on the National database and mirrors the quarter 1 data provided in the previous reports which used local data. Using local data as a comparison for quarter 2 this in on target with 54.82 being the baseline and 39.23 being the DDD/1000 admissions for quarter 2 2016/17		The CQUIN target for antibiotic consumption Part 3a 2 is for a reduction of 1% or more in carbapenem consumption per 1,000 admissions. The target was achieved in month. **National CQUIN – carbapenem consumption Part 3a 2**
National CQUIN – Reduction in piperacillin-tazabactam consumption Part 3a 3 The financial value for this CQUIN is £79,221.	To achieve the CQUIN target for antibiotic consumption Part 3a 3, the Trust must have a reduction of 1% or more of piperacillin-tazabactam consumption per 1,000 admissions. Quarter 1 data has now been reported on the National database and mirrors the quarter 1 data provided in the previous reports which used local data. Although quarter 2 National data is not yet available, early indication suggests that the target is met.		The CQUIN target for antibiotic consumption Part 3a 3 is for a reduction of 1% or more in piperacillin-tazabactam consumption per 1,000 admissions. The target was achieved **National CQUIN – piperacillin-tazabactam consumption Part 3a 3**

Board Papers – Quality, Safety & Experience Section: November 2016

Description	Aggregate Position	Trend	Variation

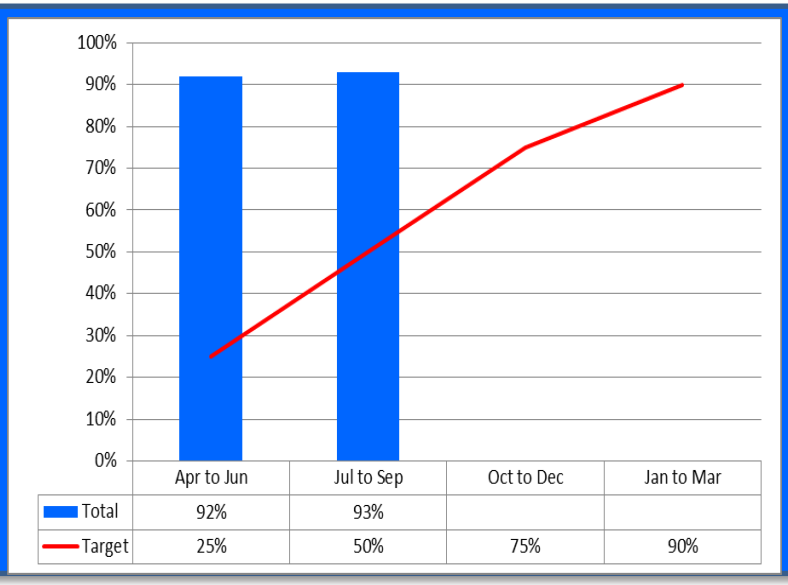
National CQUIN – Empiric review of antibiotic prescriptions Part 3b

The financial value for this CQUIN is £79,221.

To achieve the CQUIN target for empiric review of antibiotic prescriptions Part 3b, a local audit of a minimum of 50 antibiotic prescriptions must be undertaken from a representative sample across all sites and wards.

150 prescriptions were audited across all wards at MCHFT in quarter 2.

An empiric review was documented in the medical notes within 72 hours of commencing treatment for 93% of audited prescriptions for antibiotics in quarter 2.



	Apr to Jun	Jul to Sep	Oct to Dec	Jan to Mar
Total	92%	93%		
Target	25%	50%	75%	90%

The CQUIN target for empiric review of antibiotic prescriptions Part 3b is for an empiric review to be performed for at least 90% of cases in the sample.

The target was achieved in month.

National CQUIN – Empiric review Part 3b

Board Papers – Quality, Safety & Experience Section: November 2016

Description	Aggregate Position	Trend	Variation

Safety Thermometer - Harm Free Care.

In September 2016 97% of patients received harm free care as measured by the Safety Thermometer.

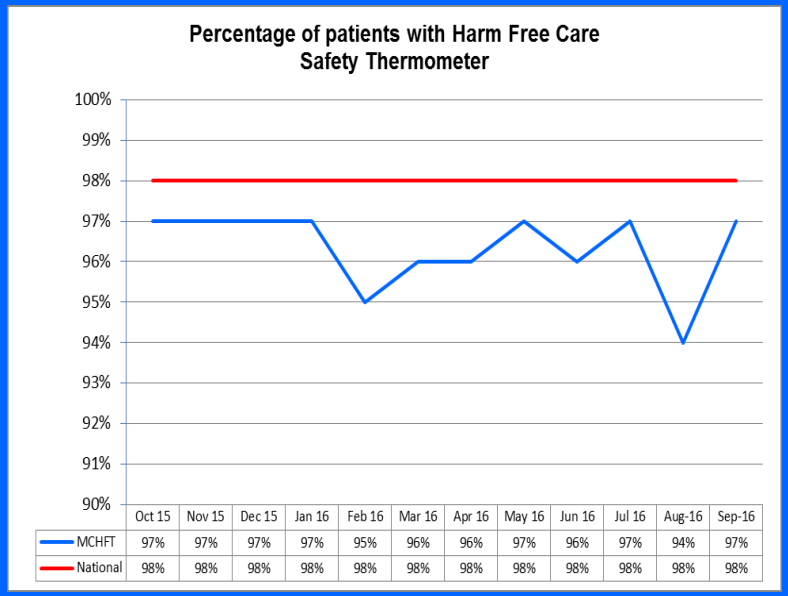
The Safety Thermometer data is collected during the morning of the first Wednesday of each month and is collected by the nursing staff on duty on the ward assisted by the Divisional Senior Nursing Teams.

Data is collected on the following each month:

- Hospital Acquired Pressure Ulcers
- Community Acquired Pressure Ulcers
- Patient Falls (Including in and out of hospital falls)
- Urinary Tract Infections
- Catheters
- Venous Thromboembolism (VTE) Risk Assessment
- VTE Prophylaxis
- Hospital Acquired VTE
- Community Acquired VTE

Actions taken include:

- Review of data at appropriate Trust Groups
- Production of ward level Safety Thermometers to aid local improvements



	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug-16	Sep-16
MCHFT	97%	97%	97%	97%	95%	96%	96%	97%	96%	97%	94%	97%
National	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%

>95% of patients to receive harm free care as monitored by the Safety Thermometer.

Harm Free Care

Board Papers – Quality, Safety & Experience Section: November 2016

Description	Aggregate Position	Trend	Variation
Registered Nurses monthly expected hours by shift versus actual monthly hours per shift. Day time shifts only	95.6% of expected Registered Nurse hours were achieved for day shifts.	Trend **September 2016 95.6%** August 2016 95.8% July 2016 95.4%	The lowest staffing levels during the day were on NICU at 83.1%. **Registered Staff Day Time**
Registered Nurses monthly expected hours by shift versus actual monthly hours per shift. Night time shifts only	97.5% of expected Registered Nurse hours were achieved for night shifts.	Trend **September 2016 97.5%** August 2016 98.8% July 2016 100.4%	The lowest staffing levels during the night were on Ward 12 at 86.7% **Registered Staff Night Time**

Board Papers – Quality, Safety & Experience Section: November 2016

Description	Aggregate Position	Trend	Variation
Healthcare Assistant monthly expected hours by shift versus actual monthly hours per shift. Day time shifts only	99.8% of expected HCA hours were achieved for day shifts.	Trend **September 2016 99.8%** August 2016 101.2% July 2016 99.7%	The lowest staffing levels during the day were on NICU at 43.8% **Support Worker Day Time**
Healthcare Assistant monthly expected hours by shift versus actual monthly hours per shift. Night time shifts only	106.7% of expected HCA hours were achieved for night shifts.	Trend **September 2016 106.7%** August 2016 105.1% July 2016 103.4%	The lowest staffing levels during the night were on NICU at 58.3% **Support Worker Night Time**

Board Papers – Quality, Safety & Experience Section: November 2016

Ward Name	Main Specialties	Day				Night				Day		Night		Care Hours Per Patient Day			
		Qualified		Unqualified		Qualified		Unqualified		Qualified	Unqualified	Qualified	Unqualified	Cumulative count over month of pts at 23:59 each day	Qualified	Unqualified	Overall
		Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Fill Rate	Fill Rate	Fill Rate	Fill Rate				
MCHT		42098.5	40140.2	30405	30414.8	24178.3	23801.2	16006.5	17098.1	95.3%	100.0%	98.4%	106.8%	14914	4.1	3.0	7.1
AMU	Gen. Medicine	1950	1809	1470	1421.3	1837.5	1751.8	1470	1457.8	1950	1809	1470	1421.3	755	4.7	3.8	8.5
CAU	Paeds	2317.5	2317.5	1032	1032	1380	1380	80.5	80.5	2317.5	2317.5	1032	1032	439	8.4	2.5	11.0
Critical Care	Gen. Medicine	3899	3899	496	496	2432	2432	0	0	3899	3899	496	496	229	27.6	2.2	29.8
Elmhurst	Rehab	847.5	847.5	2160	2190	750	750	1500	1537.5	847.5	847.5	2160	2190	830	1.9	4.5	6.4
Ward 1	Gen. Medicine	2125	2031.3	1125	1187.5	1470	1359.8	735	869.8	2125	2031.3	1125	1187.5	741	4.6	2.8	7.4
Ward 10 SAU	Gen. Surg	1455	1432.5	900	900	562	552.6	281	384	1455	1432.5	900	900	318	6.2	4.0	10.3
Ward 10 SSW	Gen. Surg & Urology	1661	1549	960	960	615	604.8	307.5	307.5	1661	1549	960	960	632	3.4	2.0	5.4
Ward 12	Gen. Surg & Gynae	2171	2035	1920	1984	922.5	799.5	615	717.5	2171	2035	1920	1984	886	3.2	3.0	6.2
Ward 13	Gen. Surg	2216	2048	1920	1880	922.5	891.8	615	615	2216	2048	1920	1880	909	3.2	2.7	6.0
Ward 14	Gen. Medicine	1662	1632	1440	1608	720	720	1080	1332	1662	1632	1440	1608	947	2.5	3.1	5.6
Ward 15	Trauma & Ortho	2178.5	1986.5	1920	1904	922.5	830.3	615	625.3	2178.5	1986.5	1920	1904	943	3.0	2.7	5.7
Ward 18	Gen. Medicine	1360	1310	1500	1625	735	735	735	771.8	1360	1310	1500	1625	730	2.8	3.3	6.1
Ward 2	Gen. Medicine	1750	1562.5	1500	1556.3	735	955.5	1102.5	1200.5	1750	1562.5	1500	1556.3	896	2.8	3.1	5.9
Ward 21B	Rehab	1271.5	1219.5	1755	1716	750	750	750	750	1271.5	1219.5	1755	1716	711	2.8	3.5	6.2
Ward 23	Obstetrics	1200	1200	760	747.3	740	740	740	740	1200	1200	760	747.3	652	3.0	2.3	5.3
Ward 26	Obstetrics	3046.3	3046.3	639.7	639.7	2639.3	2639.3	370	370	3046.3	3046.3	639.7	639.7	161	35.3	6.3	41.6
Ward 4	Gen. Medicine	1662	1638	1800	1770	720	720	1440	1560	1662	1638	1800	1770	951	2.5	3.5	6.0
Ward 5	Gen. Medicine	2377.5	2215	1500	1468.8	1470	1396.5	735	722.8	2377.5	2215	1500	1468.8	935	3.9	2.3	6.2
Ward 6	Gen. Medicine	1980	1905	1875	1868.8	1470	1384.3	735	869.8	1980	1905	1875	1868.8	798	4.1	3.4	7.6
Ward 7	Gen. Medicine	1702.5	1696.3	1500	1825	735	735	1102.5	1445.5	1702.5	1696.3	1500	1825	951	2.6	3.4	6.0
Ward 9	Trauma & Ortho	1646	1414	1440	1288	615	615	307.5	338.3	1646	1414	1440	1288	477	4.3	3.4	7.7
NICU	Paeds	1620.2	1346.3	792.3	347.1	1035	1058	690	402.5	1620.2	1346.3	792.3	347.1	23	104.5	32.6	137.1

Board Papers – Quality, Safety & Experience Section: November 2016

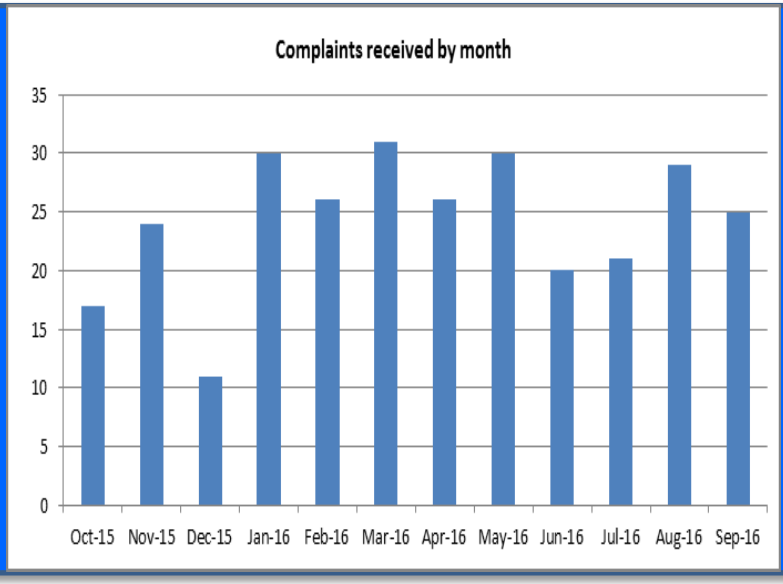
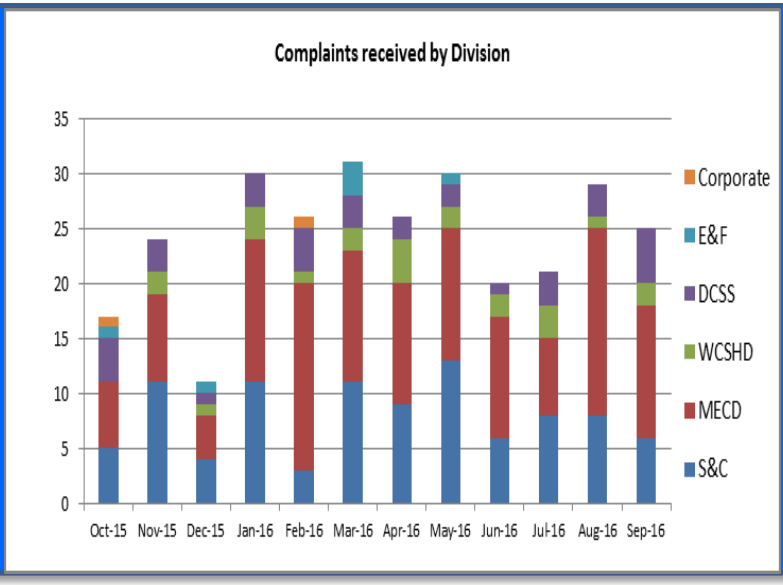
Ward Name	Main Specialties	Safety Thermometer Results			
		Hospital Acquired Pressure Ulcers	Patient Falls resulting in harm	CAUTI	New VTE
MCHFT		0.75% (4)	1.7% (9)	0% (0)	0.94% (5)
AMU	Gen. Medicine	0% (0)	0% (0)	0% (0)	0% (0)
CAU	Paeds	0% (0)	0% (0)	0% (0)	0% (0)
Critical Care	Gen. Medicine	0% (0)	0% (0)	0% (0)	0% (0)
Elmhurst	Rehab	0% (0)	0% (0)	0% (0)	0% (0)
Ward 1	Gen. Medicine	0% (0)	0% (0)	0% (0)	0% (0)
Ward 10 SAU	Gen. Surg	0% (0)	0% (0)	0% (0)	0% (0)
Ward 10 SSW	Gen. Surg & Urology	0% (0)	0% (0)	0% (0)	0% (0)
Ward 12	Gen. Surg & Gynae	0% (0)	0% (0)	0% (0)	0% (0)
Ward 13	Gen. Surg	0% (0)	0% (0)	0% (0)	3.12% (1)
Ward 14	Gen. Medicine	3.33% (1)	0% (0)	0% (0)	0% (0)
Ward 15	Trauma & Ortho	0% (0)	0% (0)	0% (0)	0% (0)
Ward 18	Gen. Medicine	0% (0)	4% (1)	0% (0)	0% (0)
Ward 2	Gen. Medicine	0% (0)	0% (0)	0% (0)	3.12% (1)
Ward 21B	Rehab	4.17% (1)	25% (6)	0% (0)	0% (0)
Ward 23	Obstetrics	0% (0)	0% (0)	0% (0)	0% (0)
Ward 26	Obstetrics	0% (0)	0% (0)	0% (0)	0% (0)
Ward 4	Gen. Medicine	3.12% (1)	6.25% (2)	0% (0)	3.12% (1)
Ward 5	Gen. Medicine	0% (0)	0% (0)	0% (0)	6.45% (2)
Ward 6	Gen. Medicine	3.7% (1)	0% (0)	0% (0)	0% (0)
Ward 7	Gen. Medicine	0% (0)	0% (0)	0% (0)	0% (0)
Ward 9	Trauma & Ortho	0% (0)	0% (0)	0% (0)	0% (0)
NICU	Paeds	0% (0)	0% (0)	0% (0)	0% (0)

Experience Section:

Indicators	YTD 16/17	Last four months			
		Jun-16	Jul-16	Aug-16	Sep-16
Complaints received by month	151	20	21	29	25
Complaints being reviewed by the Ombudsman		3	3	5	6
Closed complaints by month	163	31	27	15	29
Contacts raising informal concerns	452	86	82	68	72
Compliments received in month	608	105	112	110	106
Number of new claims received in month	22	1	7	0	1
Number of claims closed	17	8	3	4	1
Number of inquests concluded	5	1	3	0	0
NHS Choices - Star Ratings (Leighton)		4	4	4	4
NHS Choices - Star Ratings (VIN)		4.5	4.5	4.5	5
NHS Choices - Number of new postings	49	11	10	14	7
F&FT Response Rate ED, MIU, UCC and Assessment Areas*		6%	6%	8%	7%
Proportion of positive responses ED, MIU, UCC and Assessment Areas		95%	93%	95%	90%
F&FT Response Rate Inpatients and Day cases		19%	18%	20%	20%
Proportion of positive responses Inpatients and Day cases		98%	98%	98%	99%
F&FT Response Rate Outpatients		5%	5%	5%	4%
Proportion of positive responses Outpatients		95%	93%	94%	94%
F&FT Response Rate Maternity - Birth		20%	17%	22%	16%
Proportion of positive responses Maternity - Birth		97%	100%	98%	97%

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

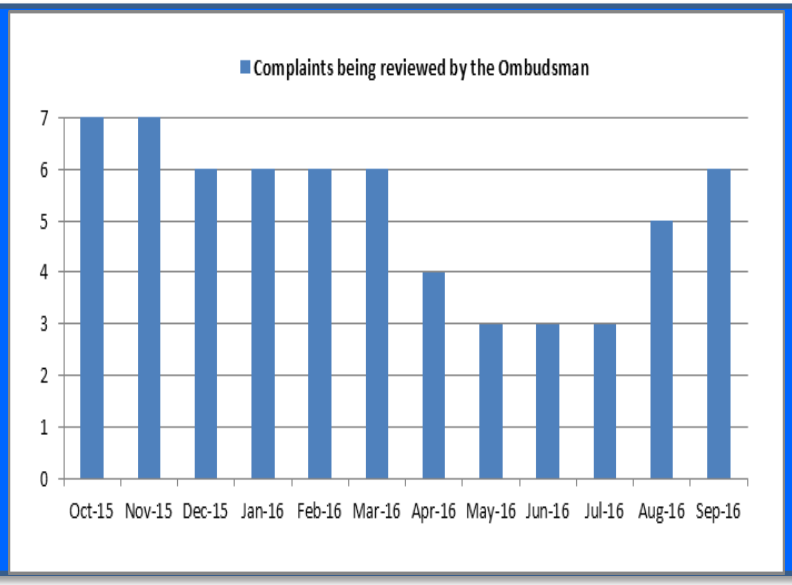
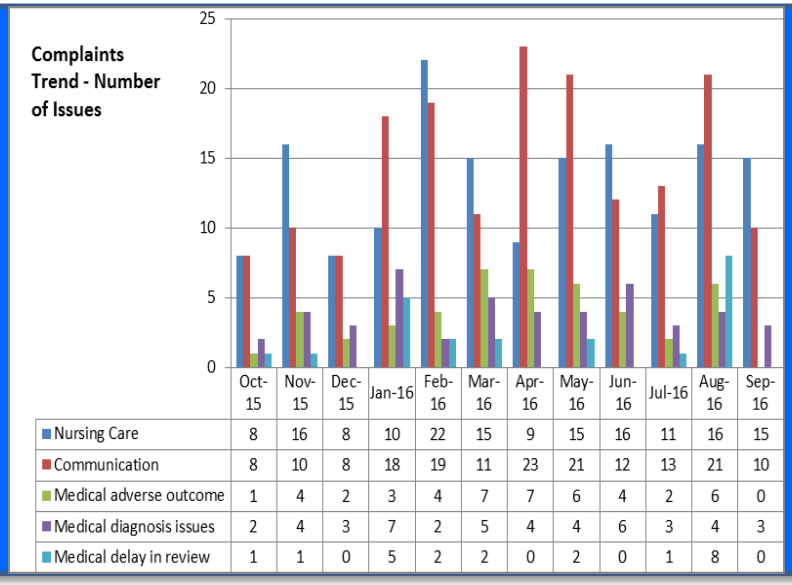
Board Papers – Quality, Safety & Experience Section: November 2016

Description	Aggregate Position/Description	Trend
Monthly Trust complaints received by the Trust	25 complaints were received in September 2016 which covered 63 categories. The highest categories were: • Communication • Medical - other • Nursing - other Highest 3 areas receiving complaints/issues were: • Emergency Department: 7 complaints/ 13 categories • Ward 13: 3 complaints / 8 categories • Elmhurst: 2 complaints / 5 categories	
Number of formal complaints by Division	This graph shows the breakdown of complaints by month for each division. S&C: 6 DCSS: 5 W&CD: 2 MECD: 12 Examples of complaints for September 2016: S&C – Excess dose of analgesia given DCSS – Unprofessional behaviour of staff W&CD – Communication regarding Gynae surgery MECD – Patient felt clinically unsafe when receiving treatment for neutropenia	

Formal Complaints

Formal Complaints by Division

Board Papers – Quality, Safety & Experience Section: November 2016

Description	Aggregate Position/Description	Trend
Complaints being reviewed by the Public Health Service Ombudsman	In September 2016 6 complaints were active with the Public Health Service Ombudsman.	
Complaint Trends and number of issues	The main trends in September 2016 were: • Nursing Care • Communication • Staff attitude	

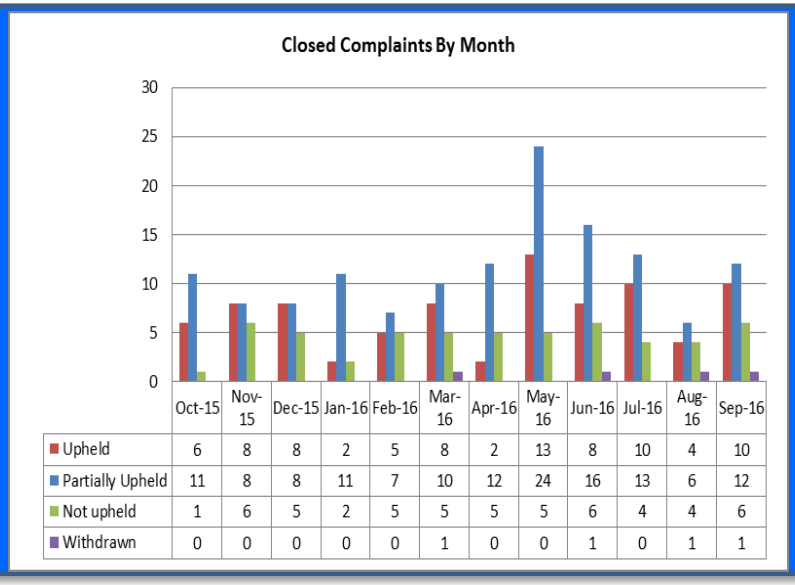
Ombudsman

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Nursing Care	8	16	8	10	22	15	9	15	16	11	16	15
Communication	8	10	8	18	19	11	23	21	12	13	21	10
Medical adverse outcome	1	4	2	3	4	7	7	6	4	2	6	0
Medical diagnosis issues	2	4	3	7	2	5	4	4	6	3	4	3
Medical delay in review	1	1	0	5	2	2	0	2	0	1	8	0

Complaint Trends

Board Papers – Quality, Safety & Experience Section: November 2016

Description	Aggregate Position/Description	Trend
Closed Complaints	29 complaints were closed in September 2016	



Closed Complaints by Division

The Table provides a breakdown of closed complaints by division, demonstrating those complaints which were upheld, not upheld or partially upheld.

Division	Upheld	Partially Upheld	Not Upheld	Withdrawn	Sub-Total
Medicine and Emergency Care	5	5	4	0	14
Surgery and Cancer	2	4	1	1	8
Diagnostics & Clinical Support Services	2	2	1	0	5
Women's and Children's	1	1	0	0	2
Estates & Facilities	0	0	0	0	0
			Total closed		**29**

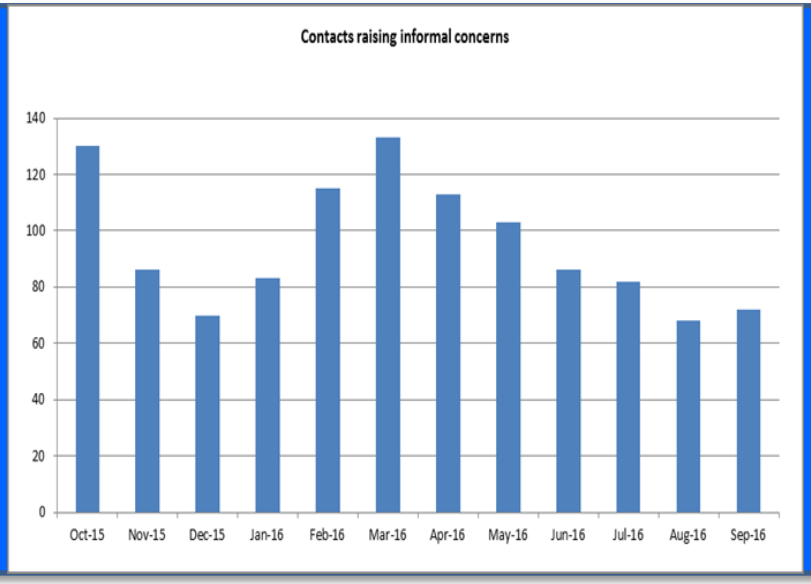
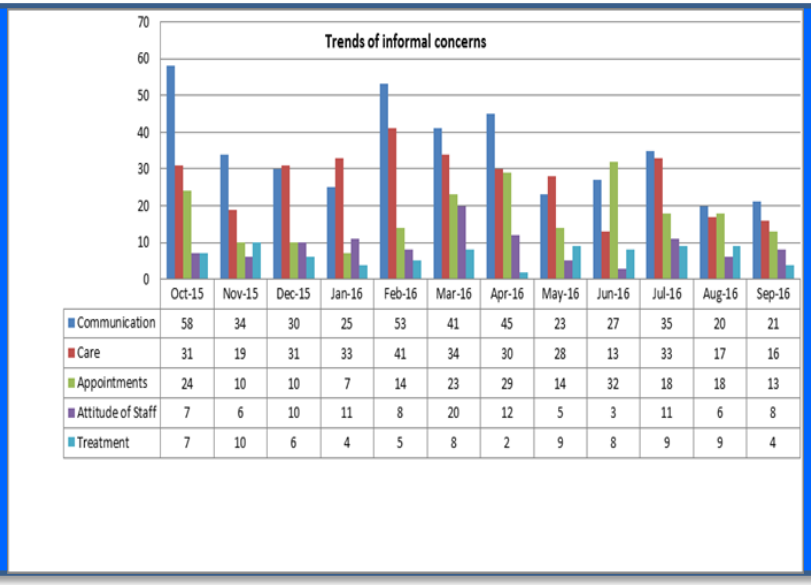
Complaints closed by division

Division	Specialty	Department	Details Of Complaint	Outcome Details	Lessons Learned	Incident Link ?

Table deleted under S40 of the Freedom of Information Act

Estates and Facilities Division						
None for this period.						

Board Papers – Quality, Safety & Experience Section: November 2016

Description	Aggregate Position/Description	Trend
Informal Concerns Numbers	The number of contacts raising informal concerns for September 2016 was 72, 4 more than the previous month. The Division of Surgery and Cancer has received the largest number of issues with 27 contacts raising concerns.	
Informal Concerns Trends	Communication was the highest trend for informal concerns in September 2016, with 9 of the issues raised belonging to the Division of Surgery and Cancer.	

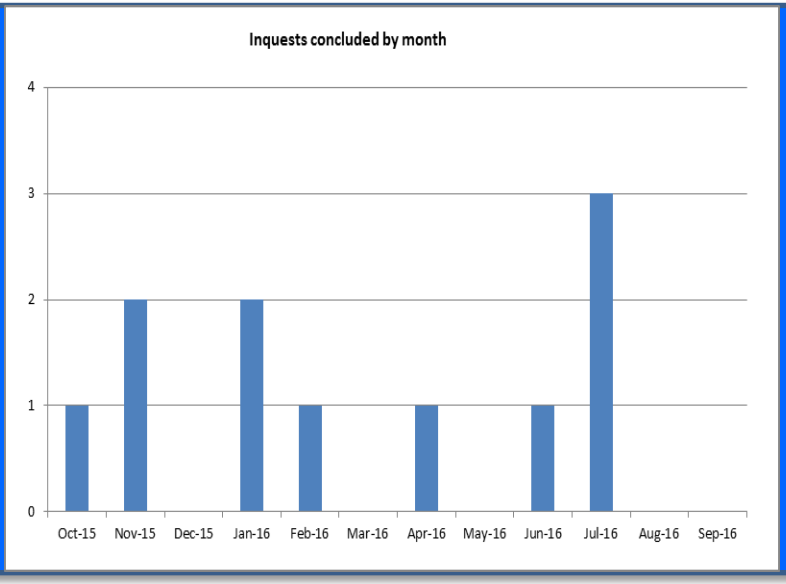
	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Communication	58	34	30	25	53	41	45	23	27	35	20	21
Care	31	19	31	33	41	34	30	28	13	33	17	16
Appointments	24	10	10	7	14	23	29	14	32	18	18	13
Attitude of Staff	7	6	10	11	8	20	12	5	3	11	6	8
Treatment	7	10	6	4	5	8	2	9	8	9	9	4

Description	Aggregate Position/Description	Trend
New claims received	1 claim was received in September 2016	Graph removed under Section 43 of the Freedom of Information Act.
Claims closed with/without damages	1 clinical negligence claim was closed in September 2016. This related to Paediatrics and the claim was not upheld.	Graph removed under Section 43 of the Freedom of Information Act.

Board Papers – Quality, Safety & Experience Section: November 2016

Description	Aggregate Position/Description	Trend
Value of claims closed by month	The total value of damages paid out on clinical negligence claims in September 2016 was nil.	Graph removed under Section 43 of the Freedom of Information Act.
Top five claims by Specialty	Section removed under Section 43 of the Freedom of Information Act	Graph removed under Section 43 of the Freedom of Information Act .

Board Papers – Quality, Safety & Experience Section: November 2016

Description	Aggregate Position /Description	Trend	
Number of Inquests concluded by month	No inquests were concluded in September 2016.		Inquests
NHS Choices Star Ratings	Leighton Hospital is rated at 4 stars. Victoria Infirmary, Northwich is rated at 5 stars. The above ratings are based on 170 postings received to date. There were 7 postings in September for Leighton Hospital and 0 postings for Victoria Infirmary.		NHS Choices – Star Ratings

Board Papers – Quality, Safety & Experience Section: November 2016

Description	Aggregate Position /description	Trend

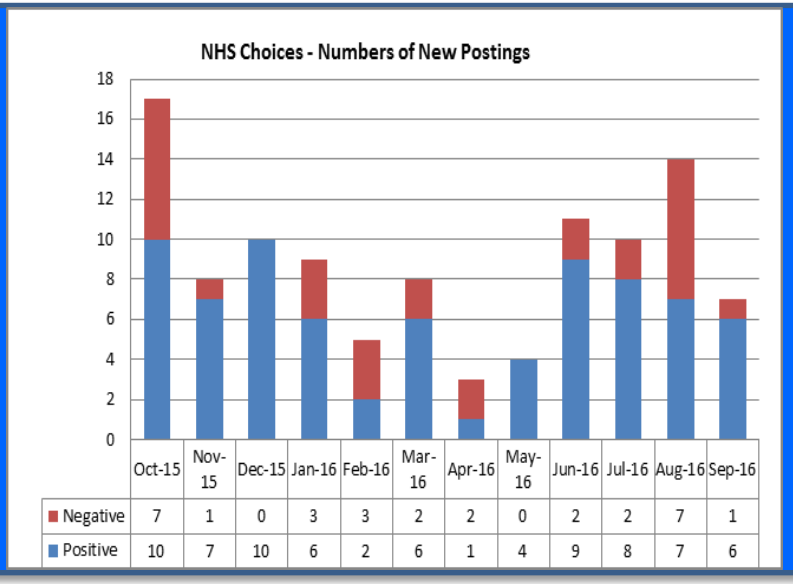
NHS Choices postings

There were 7 postings on NHS Choices in September Examples of feedback included:

Orthopaedic - Everything went like clockwork, from the decision to have the procedure through to discharge.

Treatment Centre - They were friendly, caring and knowledgeable.

Area not stated - The care I have received has been of the highest standard



	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Negative	7	1	0	3	3	2	2	0	2	2	7	1
Positive	10	7	10	6	2	6	1	4	9	8	7	6

NHS Choices - Postings

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

In September 2016 the Trust has scored the following positive response scores :

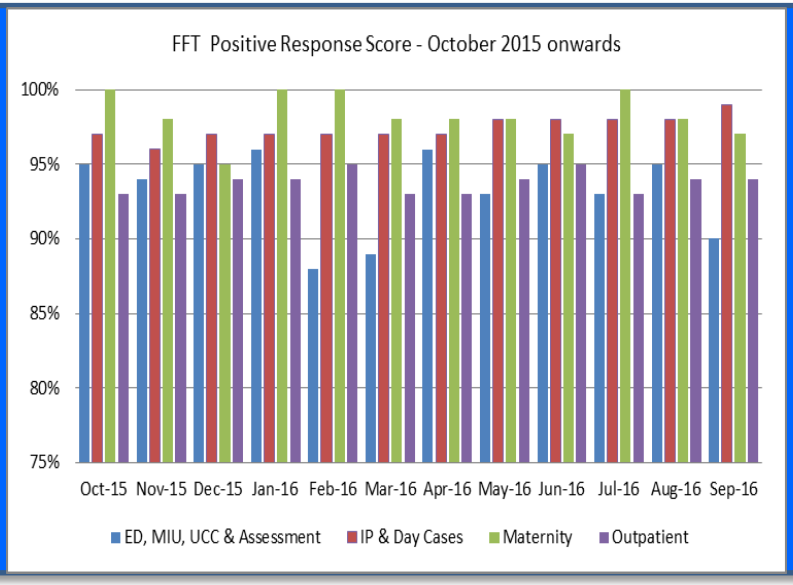
Inpatients and day cases –20%

Emergency Care /Assessment areas –7%

Outpatients - 4%

Maternity – 16%

In total 1986 responses were received and 95% of patients would recommend our hospital services.



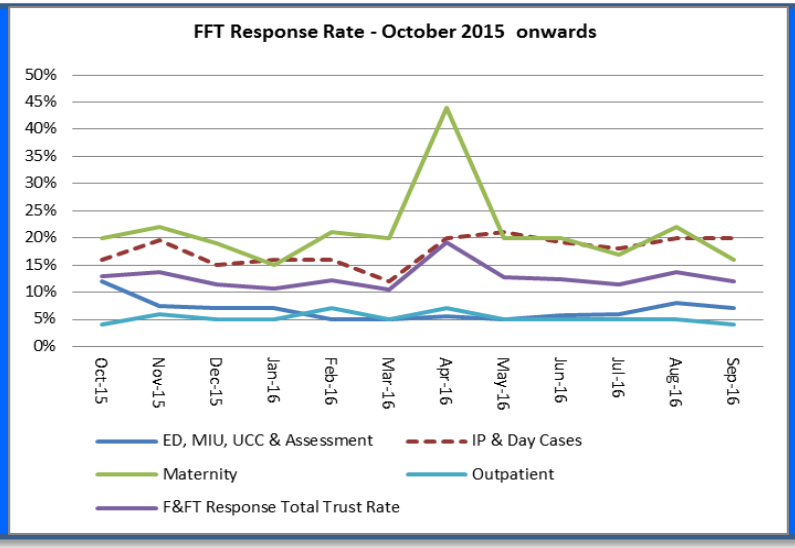
Family & Friends Test

Board Papers – Quality, Safety & Experience Section: November 2016

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

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

September-16 Ward/Dept	% Response	Total Responses received	How many would recommend
A&E , UCC & MIU	7%	328	295
Inpatients & Daycases	20%	871	858
Maternity	16%	36	35
Outpatients	4%	751	706

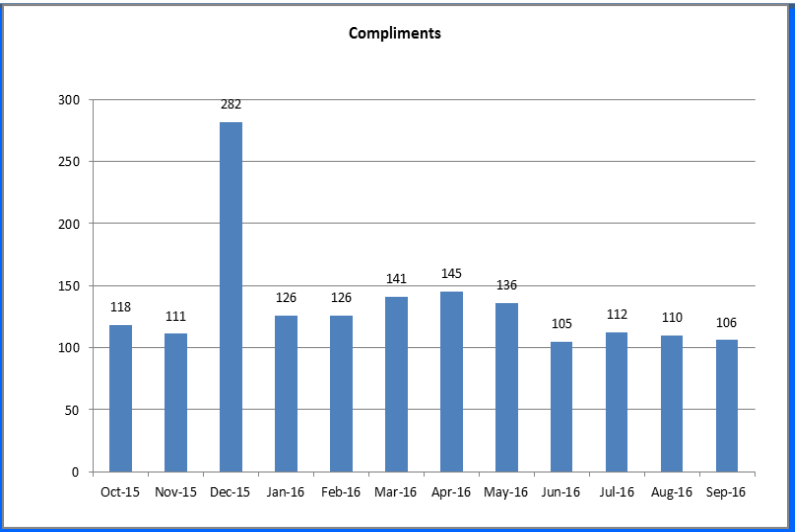


Family & Friends Test

Compliments received

There were 106 compliments/thank-you's received for September 2016.

I would just like to say a big thank you to all the staff who have looked after my Dad when he had his fall last week. Nathan in A & E went above any beyond his responsibilities in cleaning up my Dad's stoma, went out of his way to make my Dad feel comfortable, and noticed straight away that there was a problem with his kidneys. Dad is now in critical care, and I am amazed at the whole department. Everyone has been wonderful, keeping us updated at all hours, on his progress.



Compliments

Title of Paper :	Briefing Note – NHS Improvement: Taking further action to reduce agency spending	
Author:	Alison Lynch, Director of Nursing and Quality	
Executive Lead:	Alison Lynch, Director of Nursing and Quality	
Type of Report:	Concept Paper	
	Strategic Options Paper	
	Business Case	
	Information	✓
	Review/Benefits/Audit	

Link to Strategic Objectives:		***Link to Domain:***	
Quality, Safety & Experience	✓	Safe	✓
Strong Progressive FT	✓	Effective	
Organisational Delivery	✓	Caring	
Workforce Development & Effectiveness		Responsive	
Fit for Purpose Infrastructure		Well-Led	✓
Emergency Preparedness			

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

Positive Benefit:	To review the self – certification checklist in relation to Trust commitment to reducing agency spend.
Risk:	No newly emerging risk identified

To be published on Trust Website –complete version	***N***
If no, to be published on Trust Website – redacted	***Y***
If not to be published complete or redacted, please detail the reason why	
Presented at Board Meeting of:	7th November 2016

Briefing paper to Board of Directors

7 November 2016

NHS Improvement: Taking further action to reduce agency spending.

On 7 October 2016 and 17 October 2016 the Trust received correspondence from NHS Improvement in relation to agency spend. MCHFT has exceeded its agency ceiling in the first five months of 2016/17 by £0.1 million.

It has been one year since NHS Improvement introduced the agency rules and the sector has delivered reductions in agency spending of over £600 million. Spending on agency staffing across England is 20% lower than in the same period last year. MCHFT has overcome some real workforce challenges and used the rules as a springboard to improve governance and processes, negotiate lower rates and reduce demand across every staff group and this has been recognised as an excellent and important achievement.

The North region is already £15 million (5%) above the aggregate agency spending ceiling this financial year. Therefore NHS Improvement have requested assurance that every Trust Board has implemented all appropriate controls to meet their ceilings.

Jim Mackey's letter on 7 October highlighted further actions to reduce agency spending, which include promoting transparency, better data, stronger accountability to boards and additional reporting of high-cost overrides. Further details on these expectations are descibed below.

Promoting transparency and collaboration

From November 2016 NHS Improvement will be sharing data on agency expenditure (in relation to ceilings and total workforce costs) for all Trusts in the region.

From November 2016 further regional workshops will be held to ensure that agency spending forms a key component of STP discussions.

From Quarter 2, NHS Improvement will pubilish in their quarterly finance report Trusts level data on agency expendituture. This is likely to include the best and worst perfoming Trusts against ceiling and relative to workfoce costs.

Data on MCHFT agency spending at Quarter 2

- Monthly agency spending broken down by cost centre/service line. This must be submitted to NHS Improvement by 12pm on 24 October 2016.

- A list of MCHFT 20 highest-earning agency staff (anonymised). This must be submitted to NHS Improvement by 12pm on 31 October 2016.
- Chief Executives must personally sign off on, prior to submission (or no later than one week if completed retrospectively):
    - All shifts by individuals costing more than £120 per hour
    - All framework overrides above price cap (already being returned weekly)

      The existing weekly override reporting returns will include shift data on those shifts costing more than £120 per hour from 23 November 2016

Stronger accountability to Trust Boards

Following Trust Board discussion, an agency self-certification checklist must be completed and submitted to NHS Improvement by 30 November 2016. This is included at Appendix 1 for discussion at Board of Directors meeting on 7 November 2016.

Further support on medical agency staffing

A medical locum guide is in place to support reduction in reliance on premium medical agency spending, this will be further reviewed and webinar's attended where the guide will be discussed.

Senior Managers

From 31 October 2016 Trusts will be required to secure approval from NHS Improvement in advance of:

- Signing new contracts with agency senior managers where the daily rate exceeds £750, including on-costs
- Extending or varying existing contracts where the daily rate exceeds £750, including on-costs or incurring additional expenditure to which they are not already committed

Trusts will need to demonstrate that they first tried to fill the role internally, within their STP footprint or with in the NHS. Guidance on this new process will be published on NHS Improvement's website and Provider Bulletin at the end of October.

Summary

This briefing paper provides contextual information to the Trust Board in completing the self-certification checklist to NHS Improvement on 30 November 2016.

	Self-certification checklist Please discuss this in your board meeting	Yes - please specify steps taken	No. We will put this in place - please list actions
	Governance and accountability		
1	Our trust chief executive has a strong grip on agency spending and the support of the agency executive lead, the nursing director, medical director, finance director and HR director in reducing agency spending.	The CEO is assured of the processes in place to reduce reliance on temporary staffing and the controls to reduce agency spend. Approval processes include agency spend against capped rates, wage cap and overall agency cap through already established frameworks.	
2	Reducing nursing agency spending is formally included as an objective for the nursing director and reducing medical agency spending is formally included as an objective for the medical director.	Agency spend reduction is a formal objective for the Director of Nursing.	This will be included as an objective for the Medical Director
3	The agency executive lead, the medical director and nursing director meet at least monthly to discuss harmonising workforce management and agency procurement processes to reduce agency spending.	The Director of Finance is the Executive agency lead with procurement being a key aspect of their portfolio. The DoN, the MD and the Executive Board members meet weekly and agency spend is a regular item for discussion.	From 24 October the weekly agency returns will be discussed and challenged at the Executive Director meetings.
4	We are not engaging in any workarounds to the agency rules.	The processes in place do not allow for workarounds; these processes include the management response if an individual should act outside the agreements.	
	High quality timely data		
5	We know what our biggest challenges are and receive regular (eg monthly) data on: - which divisions/service lines spend most on agency staff or engage with the most agency staff - who our highest cost and longest serving agency individuals are - what the biggest causes of agency spend are (eg vacancy, sickness) and how this differs across service lines.	A Board sub-committee (Transformation & People) receives bi-monthly reports on agency spend. A further Board sub-committee (Performance & Finance) receives information at service level and includes medical agency spending.	To further strengthen this the bi-monthly report will include monitoring of highest cost and longest serving agency staff and booking reasons.
	Clear process for approving agency use		
6	The trust has a centralised agency staff booking team for booking all agency staff. Individual service lines and administrators are not booking agency staff.	The Trust has a Staffing bank where all non-medical locum staff are booked, including agency. There is a process for response if individuals act outside agreements to use the temporary staffing bank. There is an agreed process in place via the Medical Staffing department for agency Medical staff.	

7	There is a standard agency staff request process that is well understood by all staff. This process requires requestors and approvers to certify that they have considered all alternatives to using agency staff.	The Trust has an approved Agency Booking policy. An agreed SBAR (Situation, Background, Assessment and Recommendation) process is in use where alternatives to booking agency are described and actions are recorded.	
8	There is a clearly defined approvals process with only senior staff approving agency staff requests. The nursing and medical directors personally approve the most expensive clinical shifts.	The Divisional Senior Managers have responsibility for approval within clearly defined rules that are escalated to Trust Executives. This includes during out of hours periods. The most expensive shifts are approved through an agreed proces via the Finance Director and Workforce Director. Where necessary, escalations to the CEO or weekly executive meeting are made	
Actions to reducing demand for agency staffing			
9	There are tough plans in place for tackling unacceptable spending; eg exceptional over-reliance on agency staffing services radiology, very high spending on on-call staff.	Plans are in place to robustly monitor agency usage within agreed processes.	
10	There is a functional staff bank for all clinical staff and endeavour to promote bank working and bank fill through weekly payment, auto-enrolment, simplifying bank shift alerts and request process.	There is a functional staff bank in place. There are trajectories in place to monitor bank vs agency usage.	We will develop a plan to include auto enrolement to bank at point of recruitment to posts.
11	All service lines do rostering at least 6 weeks in advance on a rolling basis for all staff. The majority of service lines and staff groups are supported by eRostering.	A Rostering Policy is in place and the KPI of 6 weeks for roster production is in place.	An e-rostering business case is due to be presented at Trust Board in January 2017 which will be reliant on borrowing if it is to be implemented.

12	There is a clear process for filling vacancies with a time to recruit (from when post is needed to when it is filled) of less than 21 days.	The Trust currently measures 'time to recruit' at 51 working days (10weeks) from the point of advertising to employee start date. This compares well to peer organisations and the Trust is also participating in the NW Streamlining programme to support delivery of further improvements in the efficiency of the 'time to hire' process. The Trust has a staff "bench" to support early recruitment in areas where recruitment has been challenging. An internal recruitment audit is also being carried out to review the effectiveness and efficiency of the recruitment process from the point of resignation to the replacement start date.	
13	The board and executives adequately support staff members in designing innovative solutions to workforce challenges, including redesigning roles to better sustain services and recruiting differently.	There is a Board and sub Board level approval for innovative methods of addressing workforce challenges. These have included: - Pharmacy Technician's administering medications, - Open days for one stop recruitment - Joint appointments with neighbouring Trusts - Return to Practice Programme's - Supporting package to newly appointed Band 5 RN's, - Assistant Practitioner, Advanced Biomedical Scientists and Advanced Nurse Practitioners are well established.	
14	The board takes an active involvement in workforce planning and is confident that planning is clinically led, conducted in teams and based on solid data on demand and commissioning intentions.	The Board are assured of the workforce planning process that is linked to clinical service strategy development and business plans which the Board approves.	
Working with your local health economy			
15	The board and executives have a good understanding of which service lines are fragile and currently being sustained by agency staffing.	The Board are aware of which service lines are fragile / unsustainable in relation to workfore or finance. For example, gastroenterology is such a service and this is reviewed weekly at the Executive Director meeting with escalations to theTransformation and People / Board as appropriate.	

16	The trust has regular (eg monthly) executive-level conversations with neighbouring trusts to tackle agency spend together.	The Trust has developed relationships with the neighbouring Tertiary Trust's through our 'Stronger Together programme' which meets bimonthly and over the years this has included joint appointments to ensure clinical sustainability of services e.g. Cardiology, Vascular and subsequently Gastroenterology. Discussions with other Trusts within the North West have taken place where issues have arisen e.g. Gatroenterology with limited success due to capacity constraints within those Trusts. A key work stream of the STP is workforce which will contiunue to review workforce issues and solutions within the STP.	

Signed by [Date]

Trust Chair: [Signature]

Trust Chief Executive: [Signature]

Please submit signed and completed checklist to the agency inbox (NHSI.agencyrules@nhs.net) by 30 November 2016

7 October 2016

Wellington House
133-155 Waterloo Road
London, SE1 8UG

T: 0203 747 000
E: nhsi.enquiries@nhs.net
W: improvement.nhs.uk

Provider Chief Executives
Copied to Provider Finance Directors

Dear colleague

Strengthening financial performance & accountability in 2016/17: next steps

On the 21 July 2016, NHS Improvement and NHS England published the document 'Strengthening Financial Performance and Accountability in the NHS', which sets out the pressing need to stabilise finances in the NHS and kick-start an expenditure reduction programme in 2016/17. Many providers have risen to this challenge and the sector achieved its aggregate financial plan at Quarter 1.

I am now writing to you ahead of Quarter 2 regarding a series of next steps and follow up actions.

High pay bill growth

NHS Improvement regional teams have been engaging with those Trusts that experienced high pay bill growth in 15/16 and 16/17 to better understand the business decisions and Board governance arrangements that supported this level of investment and led to Boards making a decision to invest in pay bill that their Trust could not afford.

NHS Improvement regional teams will be in touch this month to discuss the outcome of this work. In advance of these discussions please would you and your Board take the opportunity to fully review the investments in pay that the Trust has made over the past two years to ensure that this investment remains appropriate. Where investments have been undertaken without Board approval please could you ensure that your Board is content with any delegated decisions. NHS Improvement regional teams will be requesting Board assurance updates as part of the review meetings held in October 2016.

Agency staffing

I appreciate your hard work and the progress over the last year in reducing spending on agency staff. However, across the sector we are falling short of what is needed and must do more to reduce over-reliance on agencies. Regional directors will be writing to you shortly to set out further actions in relation to agency spending – some universal and some reserved for Trusts that are missing their agency expenditure ceiling. These will include:

- Greater transparency, including national publication and sharing of Trust-level agency expenditure across regions.

- Measures to ensure boards have sight of prices paid and spending at cost centre level and are actively holding executives to account on reducing agency expenditure across all parts of the Trust.

- Requiring Chief Executive oversight and further reporting to NHS Improvement across areas of high concern, including off-framework use, high-price overrides and on-call rates.

- Action in respect of high on-call rates, grade inflation, high bank rates and payments for hours not worked; these are often reported to us and we will work with trusts to understand where this is occurring and intervene.

- A closing down of the use of senior interims through a national approvals process and more effective use of internal NHS senior leadership capacity.

- An initiative to drive close local collaboration and mutual support on agency.

As an immediate step, to help your Trust and your relationship team develop a better understanding of your agency spending and where the biggest challenges are, we ask all NHS Trusts and Foundation Trusts to provide the following information at Quarter 2:

a) Monthly agency spending broken down by cost centre/service line (request already sent to trusts on 3 October 2016).

b) A list of your 20 highest-earning agency staff (anonymised, in the template provided in Appendix 1).

c) A list of agency staff that have been employed for more than 6 consecutive months (also anonymised, in the template provided in Appendix 1).

A thorough understanding of service line data should also help you when identifying where services are being delivered by agency staff in an unaffordable and sub-optimal way. Work is ongoing to review services which are unsustainable for financial, quality or other reasons and it is expected that the plans being developed to provide many of these services in other ways will be reflected in the Operational Plan and STP process but where there are benefits to be realised in 2016/17 I would expect these plans to be pursued. Rotas supported by high cost agency usage in areas such as radiology may provide a particular opportunity.

Protocol for revising financial forecasts

The' Reset' emphasises the responsibility of NHS Trust and Foundation Trust Boards to ensure the delivery of financial balance, whilst maintaining the quality of healthcare provision. It is however recognised that in exceptional circumstances it may be necessary for an NHS Trust or Foundation Trust Board to consider revising its financial forecast during the year. If these circumstances occur it is expected that the Trust Board's primary focus is the delivery of a recovery plan demonstrating the actions and mitigations that they will put in place to ensure that any deterioration in financial position is managed and recovered at the earliest possible time.

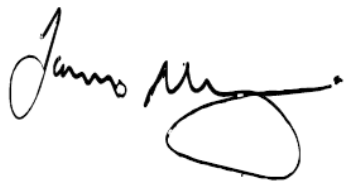
In order that NHS Trust and Foundation Trust Boards are able to demonstrate the highest standards of governance, and for the purposes of consistency and transparency, we are introducing a protocol for any adverse change to a financial forecast that we expect all Trust Boards to adhere to. A copy of the protocol and assurance statement is attached as Appendix 2a and 2b.

Publishing information

Finally, I would like to make you aware that from Quarter 2 NHS Improvement will be publishing Trust level financial and performance information in our quarterly report. An example of the type of information that will be published is contained within the attached Appendix 3 for your information. We also require all Trusts to clearly post their quarterly finance and performance reports on their Trust website in a transparent and timely manner.

I hope that this update is helpful. NHS Improvement will be working closely with you over the forthcoming months to support the delivery, and where possible improvement, in the Trust's forecast financial outturn for 2016/17 and beyond.

Yours sincerely



Jim Mackey
Chief Executive

Enclosures
Appendix 1 – Template for Trusts with Highest Agency Usage
Appendix 2a – NHSI Protocol for Changes to an In-Year Financial Forecast
Appendix 2b – Template Assurance Statement
Appendix 3 – Publishing Quarterly Finance and Performance Information

Title of Paper :	Report on the use of the Trust Seal	
Author:	Katharine Dowson	
Executive Lead:	Tracy Bullock, Chief Executive	
Type of Report:	Concept Paper	
	Strategic Options Paper	
	Business Case	
	Information	x
	Review/Benefits/Audit	

Link to Strategic Objectives:		***Link to Domain:***	
Quality, Safety & Experience		Safe	
Strong Progressive FT	x	Effective	x
Organisational Delivery		Caring	
Workforce Development & Effectiveness		Responsive	
Fit for Purpose Infrastructure		Well-Led	x
Emergency Preparedness			

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

Positive Benefit:	Compliance with the Trust's Constitution
Risk:	Non-compliance.

To be published on Trust Website –complete version	***Y***
If no, to be published on Trust Website – redacted	***n/a***
If not to be published complete or redacted, please detail the reason why	
Presented at Board Meeting of:	7 November 2016

Exceptional Authorisation of the Trust Seal

The Board are asked to note that the Trust Seal was used with exceptional authorisation from the Chairman and Trust Board Secretary on 20 October 2016. This was due to the urgency with which sealing was required for the Deed of Indemnity from East Cheshire Trust in regard to the transfer of Community Services staff. Authorisation in exceptional circumstances is permitted within the Constitution but must be reported to the Board at the next available opportunity.

Recommendation

The Board of Directors are asked to note the report below of sealings made since the last Board report in July 2016.

Report of Sealings for the period 1 July to 31 October 2016

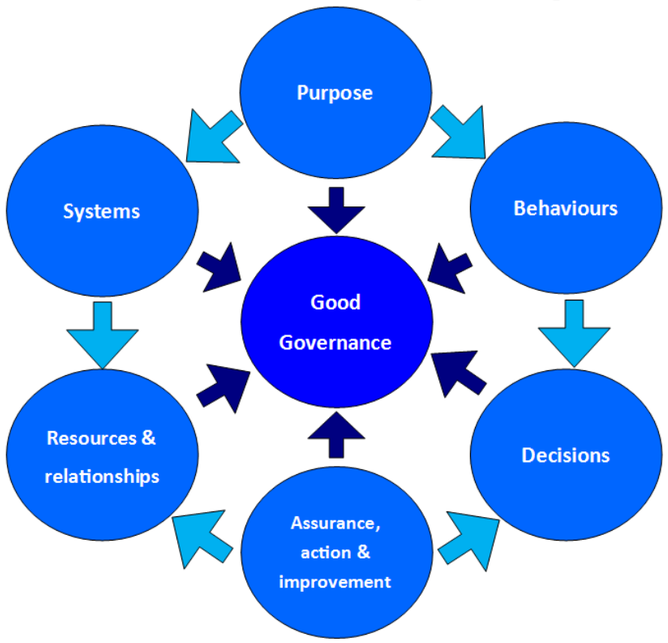
Seal Number	***Description***	***Date of Board Approval***	***Date of Sealing***
89	Property Lease between Mid Cheshire Hospitals NHS Foundation trust and Cheshire East Council	3 October 2016	13 October 2016
90	Deed of Indemnity with East Cheshire Trust, South Cheshire CCG and Vale Royal CCG	Approved by Chairman and Trust Board Secretary	20 October 2016

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Board Assurance Framework

Quarter 2 Report

2016/2017



Strategic Domain: Quality, Safety & Experience

Q1: Deliver the central requirements of quality; Patient Experience, Clinical Effectiveness and Patient Safety through the Quality and Safety Improvement Strategy.

Principal Risk

1. There is a risk that patients will suffer harm, have a poor experience and poor outcomes due to:
   - poor professional practice
   - inappropriate behaviours
   - poor systems or processes
   - failure to learn from mistakes
   - lack of clear requirements/standards

resulting in compromised quality of care, poor patient experience, regulatory intervention and reputational damage

Initial Rating			Current Rating			Target Rating		
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating
5	4	20	5	2	10	5	1	5

Initial Date	Date of Update	Target Date / Review Date	Link To CQC Outcomes	Accountable Executive	Responsible Manager	Board Committee	Delegated Committee
01/07/2010	27/03/2016	Review Date: December 2016	CQC – 1, 4, 10, 11, 12, 13, 14	Director of Nursing & Quality	Quality & Clinical Outcomes Matron and Patient Safety Lead	Quality Governance Committee	Quality and Safety, Improvement Strategy Group

Key Controls / Assurances Established	Gaps In Controls	Potential Assurances On Controls (I) = Internal (E) = External & Include Due Date	Positive Assurances On Controls (I) = Internal (E) = External & Include Due Date	Gaps In Assurances On Controls	Risk Appetite (Treat Or Accept) & Action Plan (If Required)
1. Divisional Board Meetings 2. Quality & Clinical Outcomes Matron and Patient Safety Team 3. Quality & Safety Improvement Strategy 4. Advancing Quality (AQ) clinical pathways 5. National, regional and local clinical audits 6. CQC inspection process 7. DPR process 8. Leadership programmes 9. Nursing revalidation & appraisal linked to values and behaviours 10. Medical Appraisal 11. Royal Marsden Manual available as well as policies and procedures 12. Central Alerts System 13. NICE Guidance and Quality Standards process 14. Incident reporting & investigation procedure 15. Gap analysis of national guidelines and high level enquiries to enable learning locally 16. Executive Quality Governance Group 17. Horizon scanning, agility and ability to respond 18. Annual Quality Report 19. Quality and Safety Improvement Strategy Group 20. Hospital Mortality Reduction Group 21. Executive Patient Experience Group 22. Sign up to Safety Implementation Plan 23. Executive Safeguarding Group 24. Executive Infection Prevention and Control Group 25. Risk Management Strategy and Policy & Risk Assessment procedures	None.	1. Quality and Safety Improvement Strategy Group action points & reports bi-monthly(I) 2. Integrated Governance monthly reports(I) 3. Executive Quality Governance Group action points & reports monthly (I) 4. Internal clinical audit programme linked to RCAs, incident trends & national guidance (I) 5. Quality and Safety Improvement Strategy 2016-2018 approved April 2016 (I). 6. Quality Improvement Training for 30 frontline staff provided by AQuA 2015 - 16 (I/E) 7. Strategy progress report - twice yearly to Executive Quality Governance Group (I) 8. Quality Improvement Training for multidisciplinary group of local healthcare professionals provided by AQuA Q1 2016 - 17 (I/E) 9. Revised TOR for Quality and Safety Improvement Strategy Group to include senior divisional representation – September 2015 (I) 10. AQuA Improvement Practitioner Training (Level 2) for 6 candidates July 2016 (I/E)	1. Feedback from AQUA (E) - 2. Quality Account 2015/16 (E) 3. Positive external agency feedback on Quality Accounts 2014/15 (E) 4. CQC unconditional registration (E) - Apr 2015 5. Internal audit programme (E) – 2015/2016 6. National Clinical Audit Programme (E) 7. CQC Comprehensive Inspection - Good Rating October 2014 (E) 8. Quality Improvement Training for 60 members of frontline staff 2014 – 2015, provided by AQuA. (I/E) 9. Integrated Governance Monthly & Quarterly reports 10. Annual Governance Statement Data quality assurance through scrutiny at Quality Governance Committee 11. Internal Audit reports provide assurance in relation to staffing management 12. Launch of 4 priority clinical care pathways	Risks identified to patient safety & experience agenda being addressed within Divisions	

Risk Register Links (all listed below)		
Link to Significant Risks	Link to Corporate Risks	Link to other BAF Objectives
• CS0275 • CS0311 • DC0765	• DC0797	• Q2 • W1

Q2:	Maintain unconditional registration with the Care Quality Commission.

Principal Risk
1. There is a risk that we fail to comply with the requirements of regulators due to: • ineffective governance systems and processes • ineffective performance management • insufficient resources • inadequate pathways (capacity and effectiveness) in the local health economy • inappropriate internal models of care resulting in poor patient experience, poor quality of care, regulatory intervention and loss of income

Initial Rating			Current Rating			Target Rating		
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating
5	5	25	5	2	10	5	2	10

Initial Date	Date of Update	Target Date / Review Date	Link To CQC Outcomes	Accountable Executive	Responsible Manager	Board Committee	Delegated Committee
01/04/2013	27/03/2016	Review Date: December 2016	CQC – All	Director of Nursing & Quality	Governance Lead	Board of Directors	Executive Quality Governance Group (EQGG)

Key Controls / Assurances Established	Gaps In Controls	Potential Assurances On Controls (I) = Internal (E) = External & Include Due Date	Positive Assurances On Controls (I) = Internal (E) = External & Include Due Date	Gaps In Assurances On Controls	Risk Appetite (Treat Or Accept) & Action Plan (If Required)
1. Good Rating and Inspection Report published January 2015 2. Action plan developed and monitored bi-annually at Board of Directors meeting 3. Horizon scanning, agility and ability to respond 4. CQC re-inspection action plan 5. CQC action group 6. Quarterly meeting with CQC Inspection Manager	None.	1. Minutes from Board of Directors following bi-annual CQC report (I) 2. CQC Inspections (E)	1. Monthly CQC Action Group and Executive Quality Governance Group action points & reports (I) 2. Registration status with CQC (E) 3. Bi-Annual CQC Reports to Board of Directors (I) 4. Programme of Quality & Safety Visits within wards identifying any areas for improvement prior to formal inspections	None	Treat 1. Review preparation for re-inspection

Risk Register Links (all listed below)		
Link to Significant Risks	Link to Corporate Risks	Link to other BAF Objectives
• CS0275 CS0311 CS0328 • DC0765 DC0845 CS0329 • DC0887 DC0923 EC0265 • DC0929 EC0287 EC0346 • CS0325 CS0326 • EC0331 CS0327		• All

Strategic Domain: Strong Progressive FT

F1:	Continue to ensure there is strong transparent engagement with all our stakeholders by assuming that the Trust's 2020 vision is understood and the underpinning strategy is delivered throughout the organisation to all staff, governors, members and volunteers.

Principal Risk

1. There is a risk that we fail to embed a culture of excellence due to:
   - low levels of staff satisfaction and staff engagement in Trust priorities
   - low morale
   - non-compliance with systems and processes
   - in effective training and development

resulting in lack of engaged staff, demotivated staff, inability to deliver safe services

Initial Rating			Current Rating			Target Rating		
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating
5	4	20	5	2	10	5	2	10

Initial Date	Date of Update	Target Date / Review Date	Link To CQC Outcomes	Accountable Executive	Responsible Manager	Board Committee	Delegated Committee
01/04/2013	27/03/2016	Review Date December 2016	CQC – 1, 12, 13, 14	Chief Executive Officer	Divisional General Managers and Divisional Director of Estates & Facilities	Board of Directors	Executive Management Board

Key Controls / Assurances Established	Gaps In Controls	Potential Assurances On Controls (I) = Internal (E) = External & Include Due Date	Positive Assurances On Controls (I) = Internal (E) = External & Include Due Date	Gaps In Assurances On Controls	Risk Appetite (Treat Or Accept) & Action Plan (If Required)
1. Annual Governor planning event 2. Divisional Performance Reviews (DPR) 3. Development and Delivery of Trust and Clinical Service Strategies 4. Integrated Governance structure 5. KSF and appraisal processes 6. Public Board of Directors meeting (monthly) 7. Forward Thinking Event (annually) 8. Staff Focus Groups 9. Bespoke and regular CEO engagement sessions to reinforce vision 10. Feedback from Staff Survey (annually) 11. Annual Public Meeting 12. Connecting Care Board 13. Lead Governor attends Board of Directors meetings 14. Board Effectiveness Survey 15. Governor Handbook and Governor Induction Programme 16. Connecting Care Provider Board 17. Horizon scanning, agility and ability to respond 18. The Trust contributes to the Local delivery plans and the Sustainability & Transformation Plan (STP) 19. Health & Wellbeing strategy agenda 20. Stress Management surveys 21. Safety Culture surveys 22. CEO currently a member of the STP leadership group to ensure contribution and participation in the development	STP not currently developed to ensure alignment of Trust Strategy	1. DPR action points (I) 2. Internal audit programme (E) 3. Clinical Services Strategy updates 6 monthly and quarterly to Board of Directors (I) 4. BAF and Board of Directors agenda alignment (I) 5. Medical & Nursing Revalidation (I) 6. Recruitment process for Governors (I) 7. Communication plan agreed and in place (I) 8. Governor involvement in planning and approval of plans (I) 9. Internal Leadership programmes (I) 10. Regular NED/Governor informal meetings (I) 11. Council of Governors Papers (I) 12. Updates to CCG Governing Body on Trust Strategies (I/E)	1. National Staff Survey (E) 2. NHS Improvement's assessment of Annual Plan (E) 3. Exit Interviews (I) 4. MCHFT strapline "We Care Because You Matter" launched in September 2014 5. Joint session to CCG Boards by CEO on Strategy – July 2015 (E) 6. IIP reaccreditation achieved– July 2015 (E) 7. Annual Members meeting October 2015 (E) 8. CCG and Governors Clinical Services Strategy development day – November 2015 (E) 9. CEO Formal member of Cheshire East Health and Well Being Board (HWBB) and Cheshire West and Chester HWBB (E)	1. Assurance required regarding the effectiveness of Divisional Boards to communicate the vision 2. Regional STP not yet published	Treat 1. Continue supporting Divisions in aligning to the vision and strategy 2. Plan in place to deliver briefings to frontline staff 3. Bespoke engagement sessions to frontline staff at ward/departments by CEO 4. Continue monitoring of membership database to maintain minimum membership levels as required

Risk Register Links (all listed below)

Link to Significant Risks	Link to Corporate Risks	Link to other BAF Objectives
• CS0275		• Q1 • Q2 • W1

F2:	1. Ensure full compliance with NHS Improvement's Provider Licence. 2. Maintain compliance with Risk Assessment Framework, Continuity of Services. 3. Deliver the Commissioner Contractual requirements.

Principal Risk
1. NHS Improvement will intervene due to a failure to maintain financial stability as a result of not delivering the required surplus which may impact on the Trust's license

Initial Rating			Current Rating			Target Rating		
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating
4	5	20	4	2	8	4	2	8

Initial Date	Date of Update	Target Date / Review Date	Link To CQC Outcomes	Accountable Executive	Responsible Manager	Board Committee	Delegated Committee
01/04/2013	27/03/2016	Review Date December 2016	CQC – All	Director of Finance and Planning	Deputy Director of Finance & Head of Business Intelligence	Board of Directors	Performance & Finance Committee

Key Controls / Assurances Established	Gaps In Controls	Potential Assurances On Controls (I) = Internal € = External & Include Due Date	Positive Assurances On Controls (I) = Internal € = External & Include Due Date	Gaps In Assurances On Controls	Risk Appetite (Treat Or Accept) & Action Plan (If Required)
1. Annual plan and budget delegated to Divisions 2. Identified CIP schemes 3. Monthly meetings with Divisional accountants 4. Monthly finance and activity review meetings 5. Performance reporting system 6. DPR process 7. Job descriptions contain financial responsibilities 8. Training for budget managers 9. Monthly financial reports 10. Contracted Divisional targets monitored monthly 11. Weekly performance meetings 12. CCG Contract 13. CQuINS/Quality Schedule 14. Non-essential spend directive issued across Trust 15. Contract in place with Commissioners	1. High levels of medically fit for discharge affecting patient flow in the Emergency Department 2. Slippage on recruitment to deliver schemes (e.g. anaesthetics, general surgery, orthopaedics, bowel screening) 3. Failure to deliver efficiencies in theatres 4. Increased agency spend – medical and nursing 5. Sustainable ED performance solution 6. Loss of elective surgery activity due to emergency admissions and resulting medical outliers 7. Continued outsourcing of MR, CT and Gastroenterology activity 8. No winter resilience funding identified 9. Long term health economy plan 10. Lack of appropriate information to undergo due diligence in relation to the acquisition of Community Services in East Cheshire	1. Monthly Performance Reports (I) 2. Internal audit programme (E) 3. Annual plan (I) 4. Performance & Finance Committee action points and papers (monthly) 5. NHS Improvement approval of Community Services in East Cheshire acquisition	1. NHS Improvement - quarterly reports (E) 2. External audit of accounts (E) 3. Forward plan submitted to NHS Improvement (E) 4. Feedback from NHS Improvement investigation into Trust financial position (E) 5. Trust notified of efficiency requirement for 2016/17 being less than expected as a result of comprehensive spending review (I/E) 6. NHS Improvement will support working capital facility to support cash flow 6. Trust accepted financial controls in agreed plan 7. CCG Contract Meeting (E) 8. CQUIN Schemes agreed and in place 9. STF funding via annual plan agreed by NHS Improvement 10. RTT currently on track	1. Investment for winter planning 2016/2017 to be agreed 2. Month 1 RTT and 4 hourly performance behind trajectory 3. Sustainability Transformation Plan (STP) not currently finalised	Treat 1. Three major transformational projects: a. Access and Flow b. Surgical Transformation c. OPD utilisation remains ongoing. 2. Continued awareness of changing national priorities 3. Connecting care board to develop integrated community teams – October 2015. 4. Pilot with NHS Improvement to understand all agency spend – commenced September 2015 and ongoing 5. Continue to work towards the STP

Risk Register Links (all listed below)		
Link to Significant Risks	Link to Corporate Risks	Link to other BAF Objectives
• CS0311 • CS0236 • CS0327 • EC0265 • EC0346		• Q1 • Q2 • F3

F3:	Ensure that the leadership, management and governance of the Trust, assures delivery of high quality care, supports learning and innovation and promotes an open and fair culture in line with the Trusts vision and values.

Principal Risk

1. There is a risk that we do not provide effective leadership at every level due to:
   - lack of capacity
   - lack of capability
   - failure to recruit
   - lack of talent management and succession planning
   - inappropriate leadership style
   - lack of clarity over chain of responsibility and accountability regarding leadership expectations
   - competing priorities
   - inappropriate culture

resulting in inability to deliver strategic objectives, lack of credibility with staff, stakeholders and regulators, poor team working

3.

Initial Rating			Current Rating			Target Rating		
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating
4	4	16	4	2	8	4	1	4

Initial Date	Date of Update	Target Date / Review Date	Link To CQC Outcomes	Accountable Executive	Responsible Manager	Board Committee	Delegated Committee
01/07/2010	27/03/2016	Review Date December 2016	CQC – 3, 15	Director of Workforce and OD	Head of Organisational Development	Transformation and People Committee	Executive Workforce Assurance Group

Key Controls / Assurances Established	Gaps In Controls	Potential Assurances On Controls (I) = Internal (E) = External & Include Due Date	Positive Assurances On Controls (I) = Internal (E) = External & Include Due Date	Gaps In Assurances On Controls	Risk Appetite (Treat Or Accept) & Action Plan (If Required)
1. Coaching framework in place 2. Clinical Leaders Development Programme 3. Consultant Foundation Programme 4. Other levels of management programmes in place 5. KSF /appraisal system established and reviewed 6. Supervision and CPD framework is included as part of the coaching framework 7. Board development programme in place 8. Talent Management Strategy 9. Horizon scanning, agility and ability to respond 10. People and Organisational Development Strategy 2016-2018 11. Employment policies and procedures re leadership and capability 12. 3 yearly cycle of Disclosure & Barring Service checks being piloted	None	1. Quarterly Executive Workforce Assurance Group action points & papers (I) 2. Team coaching implemented (I) 3. Quality Improvement Training for 60 members of frontline staff 2014/2015 - provided by AQuA. (I/E) 4. EDS reviews completed October 2014(I) 5. Regional Streamlining project commenced across the North West	1. National Staff Survey 2015/2016 demonstrated improvements (E) 2. Staff accepted onto national leadership programmes (E) 3. CQC Comprehensive Inspection - Good Rating October 2014 (E) 4. IIP reaccreditation achieved – July 2015 5. Transformation & People Committee established in November 2015 6. 2nd Cohort of MCHFT coaches completed Foundation Certificate – October 2015 7. Development of People and OD Strategy approved by Board of Directors	None.	Treat 1. Supporting Divisions with service changes through OD, Coaching and Programme Management arrangements 2. Executive Workforce Assurance Group to support the key ambitions in line with the People and OD Strategy

Risk Register Links (all listed below)		
Link to Significant Risks	Link to Corporate Risks	Link to other BAF Objectives
		• Q1 • Q2 • F1 • F2 • W1

F4:	**Maximise the opportunities and advantages associated with horizontal integration, acknowledging and responding to:** • **National and regional agenda's** • **Favourable economies of scale** • **Increased market share** • **Reduction in costs** • **Sustainable clinical services** • **Align strategy to commissioner requirements**

Principal Risk

1. There is a risk that we do not develop effective external partnerships and alliances due to:
   - failure to engage effectively with potential partners
   - failure to influence and lead the development of the local health economy
   - inadequate pace and scale of change
   - insufficient capacity and capability

resulting in loss of market share, loss of staff, failure to improve the health of the local population and reduce the gap in health inequalities, failure to develop new care pathways, failure to achieve long term clinical and financial sustainability and viability

Initial Rating			Current Rating			Target Rating		
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating
5	5	25	2	5	10	2	5	10

Initial Date	Date of Update	Target Date / Review Date	Link To CQC Outcomes	Accountable Executive	Responsible Manager	Board Committee	Delegated Committee
01/05/2011	27/03/2016	Review Date December 2016	CQC - all	Chief Executive Officer	Chief Operating Officer	Board of Directors	MCHFT/UHNM Programme Management Board

Key Controls / Assurances Established	Gaps In Controls	Potential Assurances On Controls (I) = Internal (E) = External & Include Due Date	Positive Assurances On Controls (I) = Internal (E) = External & Include Due Date	Gaps In Assurances On Controls	Risk Appetite (Treat Or Accept) & Action Plan (If Required)
1. Delivery of transformational and change agendas 2. Trust and Clinical Services Strategies 3. Joint Virtual Programme Management Office 4. Successful partnerships/collaborations 5. MCHFT/UHNM Programme Management Board 6. MCHFT/UHNM Board to Board – 6 monthly 7. Shared elective work with UHNM 8. Stroke Pathway approved and implementation planned for 4th July 2016 9. Work ongoing with 4 District General Hospitals to review back and middle office support functions.	1. Time and resources to deliver 2. Pace – Commissioner and network engagement 3. Challenge from other provider organisations 4. Engagement with Overview and Scrutiny Committee 5. Local delivery plans and Sustainability & Transformation Plan (STP) not currently finalised 6. CEO vacancy at University Hospitals North Midlands NHS Trust	1. BIU to support delivery (I) 2. Dedicated senior management support in place (with backfill) (I) 3. Programme Management Board action points and papers (I) 4. MCHFT/UHNM Board to Board minutes and papers (I/E)	1 Ongoing rolling programme of Service Line Reviews (I) 2. Current operational and financial delivery (I) 3. Internal/external audit opinion (I/E) 4. Revised Programme Governance arrangements in place 2.3.15 (I/E) 5. 5 year plan approved by Board of Directors 2.3.15 (I/E) 5. Tender successfully approved for the Gynaecology Oncology Pathway to be moved to UHNM (I/E) 6. CEO Formal member of Cheshire East Health and Well Being Board (HWBB) and Cheshire West and Chester HWBB (E) 7. Increased focus on awareness training on Stronger Together programme e.g. CCG governing bodies (HWBB) (I/E) 8. Cheshire & Wirral Chief Executives weekly meeting	None	Treat 1. UHNM work programme – monitoring delivery 2. Continued awareness of changing national priorities

Risk Register Links (all listed below)		
Link to Significant Risks	**Link to Corporate Risks**	**Link to other BAF Objectives**
• CS0328 • CS0329		• Q1 • Q2 • F2 • F3 • W1

F5:	**Maximise opportunities to integrate services to provide optimised quality care in the most appropriate setting according to patient need taking into account:** • **National agenda's e.g. 5 Year Forward View and The Dalton Review** • **Changes to the political landscape** • **Explore new models of care**

Principal Risk

1. There is a risk that we do not develop effective external partnerships and alliances due to:
   - failure to engage effectively with potential partners
   - failure to influence the development of the local health economy
   - inadequate pace and scale of change
   - insufficient capacity and capability

resulting in loss of market share, loss of staff, failure to improve the health of the local population and reduce the gap in health inequalities, failure to develop new care pathways, failure to achieve long term stability and viability

Initial Rating			Current Rating			Target Rating		
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating
5	5	25	5	3	15	5	2	10

Initial Date	Date of Update	Target Date / Review Date	Link To CQC Outcomes	Accountable Executive	Responsible Manager	Board Committee	Delegated Committee
01/04/2015	27/03/2016	Review Date December 2016	CQC - 6	Chief Operating Officer	Chief Operating Officer	Board of Directors	Transformation and People Committee

Key Controls / Assurances Established	Gaps In Controls	Potential Assurances On Controls (I) = Internal (E) = External & Include Due Date	Positive Assurances On Controls (I) = Internal (E) = External & Include Due Date	Gaps In Assurances On Controls	Risk Appetite (Treat Or Accept) & Action Plan (If Required)
1. Regular formal meetings with partners (e.g. CCG Transformation & Priority Projects team) 2. Executives are closely aligned to the work of Connecting Care Board 3. Clinical Services Strategy 4. CEO has regular meetings with MPs and local Councillors 5. CEO attends Cavendish Group 6. GP engagement 7. Attendance by invite to local Healthwatch/OSC 8. Horizon scanning, agility and ability to respond 9. Understand and respond to the opportunities that may arise from the Five Year Forward View 2014. 10. Awarded in partnership with CWP & GP Alliance full contact for community services for South Cheshire & Vale Royal	1. A local health economy strategy needs to be developed with all partners	1. Fortnightly Executive Management Board (I) 2. Quarterly Clinical Services Strategy updates presented to the Board of Directors (I)	1. Connecting Care Steering Board (E) 2. NHS Improvement Risk Assessment Framework (E) 3. Connecting Care Provider Board (E) 4. Provider Board Steering Group (E) 5. Transformation and People Committee established - November 2015 with workplans reviewing controls and assurances(I)	1. Full cost benefit analysis of each of the potential partnerships 2. Clear business cases / risk assessments on services	Treat Internal: 1. Programme Management transformation agenda 2. Social Services undertaking a local health economy community bed model review

Risk Register Links (all listed below)		
Link to Significant Risks	Link to Corporate Risks	Link to other BAF Objectives
		• Q1 • Q2 • F1 • F3 • W1

Strategic Domain: Organisational Delivery

D1: Maintain compliance with NHS Improvement's Risk Assessment Framework in the delivery of national targets and standards

Principal Risk

1. NHS Improvement will intervene due to a red governance as a result of a failure to deliver national targets and standards which may impact on the Trust's license

Initial Rating			Current Rating			Target Rating		
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating
4	5	20	4	4	16	4	2	8

Initial Date	Date of Update	Target Date / Review Date	Link To CQC Outcomes	Accountable Executive	Responsible Manager	Board Committee	Delegated Committee
01/07/2010	27/03/2016	Review Date December 2016	CQC - All	Chief Operating Officer	Deputy Chief Operating Officer	Board of Directors	Performance and Finance Committee

Key Controls / Assurances Established	Gaps In Controls	Potential Assurances On Controls (I) = Internal (E) = External & Include Due Date	Positive Assurances On Controls (I) = Internal (E) = External & Include Due Date	Gaps In Assurances On Controls	Risk Appetite (Treat Or Accept) & Action Plan (If Required)
1. Monthly monitoring though PAF committee, CCGs Contract meeting and Board Performance Report 2. DPR process 3. Monthly meeting with DGMs 4. Monthly finance and activity review meetings 5. Quarterly submissions to NHS Improvement 6. Daily monitoring and 3 x daily bed management meetings 7. Escalation Policy 8. Weekly performance review meeting 9. Breach analysis weekly 10. Access and Flow Transformation Programme 11. Review of all performance targets and standards. 12. Regular dialogue with NHS Improvement and the CCGs 13. Horizon scanning, agility and ability to respond 14. 18/52 Task and Finish group and action plan 15. Quarterly elective capacity and demand internal meetings	1. External influences on medically fit for discharge patients 2. Insufficient community capacity 3. Failure to deliver sustainable GP Out of Hours Service 4. Increased referrals (C 7%) above plan at end of Month	1. DPR process action points (I) 2. Monthly Performance & Finance Committee action points and reports (I) 3. Internal audit programme around data quality (E) 4. Issues escalated at CCGs Contract meeting (I) 5. Timely dashboard information (I) 6. Theatre KPI's agreed and action plan in place (I) 7. Access and Flow transformation Board KPI`s agreed (I)	1. Monthly Regional Cancer Board (E) 2. Annual CQC Registration (E) 3. Hospital pressure reports from NWAS (E) 4. Agreed Reallocation Policy across the Cancer Network (E) 5. Weekly Emergency Department national benchmarking (E)	1. ED action plan delivery unassured 2. Workforce gaps impact on opening winter beds 3. Additional activity over and above non elective and Emergency Department plan 4. No winter resilience funding identified	Treat 1. Regular monitoring of information and plans at Divisional level - ongoing 2. Partnership working - communication and agreeing action plans to support compliance - ongoing 3. Implementation of Escalation Plan at times of high NEL activity 4. Use of external providers, locums and waiting list initiatives as required

Risk Register Links (all listed below)		
Link to Significant Risks	Link to Corporate Risks	Link to other BAF Objectives
• CS0275 • DC0765 • DC0923 • EC0287 • EC0331 • CS0325		• Q1 • Q2 • F2 • W1

D2:	**Maximise operational delivery of all services and ensure the delivery of optimum efficiency and productivity from the transformation projects:** **a) Access and flow** **b) Surgical transformation** **c) OPD utilisation**

Principal Risk
1. There is a risk that we fail to respond to the challenges posed by the current and prospective environment within which we work due to: • lack of clear sense of strategic direction • inadequate pace and scale of change • insufficient capability and capacity resulting in failure to redesign services to meet service needs, failure to utilise resources effectively and reduce costs, failure to develop new care pathways, failure to achieve long term stability and viability

Initial Rating			Current Rating			Target Rating		
Consequence	**Likelihood**	**Risk Rating**	**Consequence**	**Likelihood**	**Risk Rating**	**Consequence**	**Likelihood**	**Risk Rating**
4	5	**20**	4	3	**12**	4	2	**8**

Initial Date	Date of Update	Target Date / Review Date	Link To CQC Outcomes	Accountable Executive	Responsible Manager	Board Committee	Delegated Committee
01/12/2010	27/03/2016	Review Date December 2016	CQC – All	Director of Workforce & OD	Project Leads	Transformation and People Committee	Executive Transformation Steering Group

Key Controls / Assurances Established	Gaps In Controls	Potential Assurances On Controls (I) = Internal € = External & Include Due Date	Positive Assurances On Controls (I) = Internal € = External & Include Due Date	Gaps In Assurances On Controls	Risk Appetite (Treat Or Accept) & Action Plan (If Required)
1. Project Board 2. Transformation and People Committee oversight of transformation programme 3. Horizon scanning, agility and ability to respond 4. Project managers in post 5. Capital programme for Theatres and SAL complete	1. Workforce gaps in key specialities 2. Understanding demographics for future non elective and elective demand 3. Limited capacity to flex sufficiently to respond in a timely manner 4. Robust workforce plan and recruitment strategy 5. Effective Primary Care demand management	1. Transformation & Performance Committee action points & papers (I) 2. Performance weekly meetings (I) 3. Project Board action points and papers (I)	1. Year 2 target achieved in OPD utilisation 2015/2016 (I) 2. Improvement trajectory agreed in theatre productivity (I) 3. Access and flow have performed well in terms of medical outliers and no opening of escalation beds 4. Monitoring of the overall impact of transformation projects (I) 5. Interdependences and risks for the programmes are understood at a strategic level (I) 6. Transformation and People Committee (TAP) with workplans reviewing controls and assurances(I) 7. Executive Transformation Steering Group reports to TAP	1. Additional activity over and above non elective and Emergency Department plan 2. Risk of Junior doctors strike on elective admissions	Treat 1. Ongoing service transformation projects a. Access and Flow b. Surgical transformation c. OPD Utilisation .

Risk Register Links (all listed below)		
Link to Significant Risks	**Link to Corporate Risks**	**Link to other BAF Objectives**
		• Q1 • Q2 • F1 • F3 • W1

Strategic Domain: Workforce Development & Effectiveness

W1:	**Ensure that the Trust has a fit for purpose workforce which is** **a) Appropriately qualified and trained through supported continuous professional development** **b) Through the correct skill mix and staffing levels** **c) Developed for the future through workforce remodelling**

Principal Risk

1. There is a risk that we will fail to embed a culture of excellence due to:
   - difficulty in recruiting high quality staff in some areas
   - difficulty in retaining high quality staff in some areas
   - low levels of staff satisfaction and engagement in Trust priorities
   - inappropriate behaviours
   - non-compliance with systems and processes
   - ineffective training and development

resulting in inadequate staffing levels, lack of engaged staff, high agency and locum costs, demotivated staff and an inability to deliver safe services

Initial Rating			Current Rating			Target Rating		
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating
5	5	25	5	4	20	5	2	10

Initial Date	Date of Update	Target Date / Review Date	Link To CQC Outcomes	Accountable Executive	Responsible Manager	Board Committee	Delegated Committee
01/07/2010	27/03/2016	Review Date December 2016	CQC – 12, 13, 14	Director of Workforce & OD	Head of Human Resources	Transformation and People Committee	Executive Workforce Assurance Group

Key Controls / Assurances Established	Gaps In Controls	Potential Assurances On Controls (I) = Internal (E) = External & Include Due Date	Positive Assurances On Controls (I) = Internal (E) = External & Include Due Date	Gaps In Assurances On Controls	Risk Appetite (Treat Or Accept) & Action Plan (If Required)
1. Annual Workforce planning process and Clinical Services Strategy 2. Executive Workforce Assurance Group 3. Divisional Workforce Groups 4. Sub regional workforce planning and development network 5. Training needs analysis in place 6. Education Governance Framework 7. Transformation and People Committee 8. Divisional Objectives 9. Staff Survey results and action planning 10. Horizon scanning, agility and ability to respond 11. Recruitment Policies 12. Statutory / mandatory training monitoring 13. DPR process 14. Professional registration checking and monitoring 15. 3 yearly cycle of Disclosure & Barring Service checks being piloted	1. Financial constraints 2. Health Education England (NW) allocation of junior medical staff resulting in gaps in rotas	1. DPR process action points (I) 2. Quarterly Executive Workforce Assurance Group action points and reports (I) 3. Feedback from networks (E) 4. Quarterly Learning and Development Forum action points and reports (I) 5. Education Governance Framework (I) 6. Quarterly Clinical Services Strategy feedback (I) 7. Nursing & Midwifery Workforce Development Group (I) 8. Nursing / patient acuity model (I) 9. Monthly corporate workforce performance group action points and papers (I) 10. Risk assessment developed related to potential changes to Foundation Doctor allocation September 2015 (I) 11. Annual workforce plan submitted to HEE – July 2015 (E) 12. HR Business Partner model embedded – September 2015 (I) 13. First Care Pilot 14. Regional Streamlining project commenced across the North West	1. Borders Agency visits (E) 2. Health Education England (NW) visits (E) 3. Chester College visits (E) 4. EWIN (AQUA) (E) 5. Internal audit mandatory report (I) 6. Completion of Annual Organisational Audit around revalidation (E) 7. National Staff Survey (E) 8. International recruitment events (I) 9. Transformation & People Committee with workplans reviewing controls and assurances (I) 10. Workplace planning undertaken as part of the People and OD Strategy and monitored by Executive Workforce Assurance Group 11. People and OD Strategy 12. Expansion of Bank and weekly pay	None	Treat 1. Due to the significant numbers of staff in the age profiles 40-50 years and 50-60 years, work has commenced to review the strategies for succession planning 2. Developing alternative roles i.e. Physicians Associates in conjunction with HEEN 3. Development of MCHFT People and OD Strategy 4. Temporary staffing project underway to reduce reliance on agency spending

Risk Register Links (all listed below)

Link to Significant Risks	Link to Corporate Risks	Link to other BAF Objectives
• CS0275 • CS0311 • DC0887 • EC0287 • EC0331 • EC0265 • EC0346		• Q1 • Q2 • F3 • F4 • F5 • D1 • I2

Strategic Domain: Fit for Purpose Infrastructure

I1:	Deliver the clinically prioritised Estate Strategy which is aligned to the Clinical Services Strategy.

Principal Risk

1. There is a risk that our physical infrastructure is not of sufficient standard due to:
   - difficulty in delivering backlog and capital programmes as identified on the estates action plan / risk assessments due to current financial circumstances

resulting in aged and deteriorating physical assets, poor patient experience, assets not being used effectively, high levels of hospital acquired infection, poor staff morale, sub-standard patient care and an inability to transform and modernise services

Initial Rating			Current Rating			Target Rating		
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating
5	5	25	5	4	20	5	2	10

Initial Date	Date of Update	Target Date / Review Date	Link To CQC Outcomes	Accountable Executive	Responsible Manager	Board Committee	Delegated Committee
01/07/2010	27/03/2016	Review Date December 2016	CQC – 10, 11	Chief Executive Officer	Divisional Director of Estates & Facilities	Performance & Finance Committee	Executive Infrastructure Development Group

Key Controls / Assurances Established	Gaps In Controls	Potential Assurances On Controls (I) = Internal (E) = External & Include Due Date	Positive Assurances On Controls (I) = Internal (E) = External & Include Due Date	Gaps In Assurances On Controls	Risk Appetite (Treat Or Accept) & Action Plan (If Required)
1. Performance & Finance Committee & Executive Infrastructure Development Group reviewing infrastructure 2. Estates Strategy reviewed by Estates Strategy Implementation Group 3. Ward refurbishment programme 4. Capital programme expenditure agreed annually 5. Backlog maintenance plans 6. Fire action plan developed and being managed following Cheshire Fire and Rescue Service enforcement notices 7. Monthly fire meetings 8. Timescales on fire action plans agreed 9. Investment priorities formulised 10. Horizon scanning, agility and ability to respond	1. Financial affordability (current annual programme funded) 2. National constraints on capital 3. Backlog maintenance programme 4. Asbestos management	1. Bi-monthly IDC action points and reports (I) 2. Estates Strategy Implementation Group action notes and reports (I) 3. Capital spend agreed by Board of Directors and monitored through the IDC (I) 4. Development Control Plan in place and refreshed as necessary (I) 5. Trust undertaking process of procurement for asbestos consultants (I)	1. New build certification (E) 2. Feedback from Cheshire Fire & Rescue Service (E) 3. Cheshire Fire and Rescue - Enforcement notice 740 closed December 2014 4. CF&R agreement to defer ward refurbishment for 2015/16 due to operational delivery risks 5. Work undertaken on the estate to date has significantly reduced the risk register in relation to fire (I/E)	Asbestos management programme	Treat 1. Reprioritised 5 year Capital Programme 2. Annual review as financial position changes 3. Asbestos management group managing issues relating to asbestos and creation of comprehensive register 4. Continuous monitoring of refurbishment programme

Risk Register Links (all listed below)		
Link to Significant Risks	Link to Corporate Risks	Link to other BAF Objectives
		• Q1 • Q2 • F4 • F5 • I2

I2: Deliver the clinically prioritised Information Technology (IT) Strategy

Principal Risk
1. The risk is the lack of capital funds to implement the Information Management and Technology Strategy will result in: • failure to improve the quality of care and patient safety • poor patient experience • inability to transform and modernise services • delays in completing horizontal and vertical integration • reputational risk

Initial Rating			Current Rating			Target Rating		
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating
4	5	20	4	5	20	4	2	8

Initial Date	Date of Update	Target Date / Review Date	Link To CQC Outcomes	Accountable Executive	Responsible Manager	Board Committee	Delegated Committee
01/07/2010	27/03/2016	Review Date December 2016	CQC – 6, 11	Medical Director	Head of ICT	Performance & Finance Committee	IT Strategy Group

Key Controls / Assurances Established	Gaps In Controls	Potential Assurances On Controls (I) = Internal € = External & Include Due Date	Positive Assurances On Controls (I) = Internal € = External & Include Due Date	Gaps In Assurances On Controls	Risk Appetite (Treat Or Accept) & Action Plan (If Required)
1. IT Strategy Group (ITSG) 2. Protection for main systems and edge equipment 3. Reports generated from managed security devices 4. Revenue and capital costs stringently monitored 5. Contracts with service providers 6. Information Governance Group oversees data security 7. IT roadmap to develop infrastructure in place 8. Information Governance Toolkit 9. Implementation of resilience back up servers (IT continuity) 10. NIMM (Network Infrastructure Maturity Model) 11. Regular milestones incorporated into the IT Strategy 12. SLAs in place with all Divisions	1. Financial affordability 2. The organisational culture to implement and embed the IT Strategy Trust wide and organisational capability to deliver and embed the EPR Solution 3. Capacity within IT Department to deliver the Strategy 4. Lack of local health and social care economy overarching strategy	1. Performance & Finance Committee action notes and reports (I) 2. IT Strategy Group action notes and reports (I) 3. MCHFT part of Cheshire Digital Care Record project (E) 4. MCHFT part of Graphnet Care Centric Clinical Access project with UHNM (E) 5. Refreshed clinical IT strategy approved by Board of Directors in Feb 2016	1. IG Toolkit (E) 2. National Infrastructure Maturity Model Level 3 (E) 3. EMIS (E) 4. Engagement with CCGs in developing local health economy digital roadmap by end of June 2016 5. Refreshed IT Strategy approved by Board of Directors Feb 2016 (I) 6. Desktop exercise conducted with PAA Consulting who confirmed IT infrastructure can support electronic patient record (EPR)	1. Independent review of the capability of the Trust's IT infrastructure to support a EPR	Treat 1. Voice over IP business case approved by Board of Directors with solution to be implemented by April 2017 2. Options paper around EDMS / Clinical Portal to be presented to the ITSG in Oct 2016 3. 5 high impact stand alone IT solutions prioritised by Divisions / ITSG

Risk Register Links (all listed below)		
Link to Significant Risks	Link to Corporate Risks	Link to other BAF Objectives
• CS0326		• Q1 • Q2 • F4 • F5 • D2 • E1

Strategic Domain: Emergency Preparedness

E1: Ensure that the Trust has robust Business Continuity Management Plans in place across all Divisions and services in line with NHS England EPRR requirements

Principal Risk

1. There is a risk that the Trust is not adequately prepared for a major incident due to:
   - Lack of robust Corporate and Divisional Business Continuity Plans for identified critical services
   - Gaps in staff training
   - Non-compliance with local and national requirements

resulting in service disruption, poor patient experience and patient safety, loss of income, reputational impact and regulatory intervention

Initial Rating			Current Rating			Target Rating		
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating
5	5	25	5	2	10	5	2	10

Initial Date	Date of Update	Target Date / Review Date	Link To CQC Outcomes	Accountable Executive	Responsible Manager	Board Committee	Delegated Committee
01/07/2010	27/03/2016	Review Date December 2016	CQC - 6	Medical Director	Governance Lead	Executive Quality Governance Group	Operational Safety and Effectiveness Group

Key Controls / Assurances Established	Gaps In Controls	Potential Assurances On Controls (I) = Internal (E) = External & Include Due Date	Positive Assurances On Controls (I) = Internal (E) = External & Include Due Date	Gaps In Assurances On Controls	Risk Appetite (Treat Or Accept) & Action Plan (If Required)
1. Business Continuity Plan & Major Incident Plan approved March 2016 2. Validation of Major Incident Plan through exercises 3. Additional corporate staff trained in emergency planning 4. Emergency Preparedness Group 5. Local Health Resilience Partnership (LHRP) representation at Executive and Practitioner level 6. Standard BCP template compliant with international standards 22301	None	1. Bi-monthly Emergency Preparedness Group action points and reports (I) 2. Quarterly LHRP action points and reports (E) 3. Feedback from validation exercises (I) 4. CBRN emergency response plan approved May 2015 (I)	1. NHS England EPRR Core Standards. Submitted fully compliant September 2016 (I) 2. Trust Evacuation Plan approved May 2015 (I/E) 3. Major Incident Live Exercise – multi agency feedback very positive (E) July 2015 4. Departmental/Service BCP's now in place (I) 5. Strategic Business Continuity Plan developed and in place (I) 6. External NWAS Decontamination training for ED staff completed. In house trainers will continue to train staff (I/E) 7. Mandated Pandemic Flu desktop exercise in March 2016 (I) 8. Review of EPRR processes to give assurance to NHS England following Paris attacks – March 2016	None.	Treat 1. Major Incident training – rolling programme 2. Business Continuity desktop exercises to be conducted through the year 3. Continue to roll out loggist training for major emergency process

Risk Register Links (all listed below)		
Link to Significant Risks	Link to Corporate Risks	Link to other BAF Objectives
		• Q2 • F1