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 Tuesday, 2 May 2017
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 09.42	-
4.	**Minutes of the Last Meeting** To **approve** the minutes of the Board of Directors meeting held in Public on Monday, 3 April 2017 *(attached) (to approve)*	A	Chairman 09.43	-
5.	**Matters Arising and Action Log** *(attached) (to approve)*	A	Chairman 09.45	-
6.	**Annual Work Programme** **2017/18 Work Programme** *(attached) (to approve)*	I/A	Chairman 09.47	-
7.	**Chairman's Announcements** (*to note a verbal report*) **7.1 Board Away Day – 10 April 2017**	I	Chairman 09.50	-
8.	**Governors' Items** (*to note a verbal report*) **8.1 Governor Induction – 7 April 2017** **8.2 New Governors MMU/ Staff Medical Practitioner**	I	Chairman 10.00	-
9.	**Chief Executive's Report** (*to note a verbal report*) **9.1 System Wide Support** **9.2 Cheshire & Merseyside 5 Year Forward Plan** **9.3 NHS Improvement Progress Review Meeting** **9.4 Cheshire West & Chester Health & Wellbeing Board** **9.5 Cheshire East Health & Wellbeing Board**	I	Chief Executive 10.10	-

Item No	Title of Item	Action	Led by	Page No
10.	**CARING**			
	10.1 **Quality, Safety & Experience Report** *(attached)* (*to note*)	I/D	Director of Nursing & Quality **10.30**	-
	10.2 **National Staff Survey** *(attached) (presentation)* Mrs Rachael Hooker, Learning and Development Manager	I/D	Director of Workforce and OD **10:40**	-
11.	**SAFE**			
	11.1 **Draft Quality Governance Committee notes from** **11.1.1** meeting held on **13 March 2017** *(attached)* **11.1.2** meeting held on **11 April 2017** *(to follow)* (*to note*)	I	Committee Chair **10.55**	-
	11.2 **Serious Untoward Incidents and RIDDOR Events** *(verbal)* (*to note/discussion*)	I/D	Deputy Chief Executive/ Medical Director **11.00**	-
	11.3 **Use of the Trust Seal November 2016 – April 2017** *(attached) (to note)*		Chief Executive **11:05**	-
12.	**RESPONSIVE**			
	12.1 **Performance Report** *(attached)* (*to note*)	I/D	Chief Operating Officer **11.10**	-
	12.2 **Draft Performance & Finance Committee notes from the meeting held on 20 April 2017** *(to follow)* (*to note*)	I	Committee Chair **11.20**	-
	12.3 **Legal Advice** *(verbal)* (*to note*)	I	Chief Executive **11:25**	-
	12.4 **Annual Plan 2017-18** *(verbal) (for discussion)*	D/I	Director of Finance **11.30**	-
	12.5 **Access and Flow 2017/18** *(attached)* *(for discussion)*	D/A	Chief Operating Officer **11.40**	-
	12.6 **Business Case for Emis versus Adastra in the GPOOH Service and Primary Care Streaming Function** (to follow) (for discussion and approval)	D/A	Medical Director **11:50**	-

Item No	Title of Item	Action	Led by	Page No
13.	**WELL-LED**			
	13.1 **Draft Quality Account 2016/17** *(attached) (to note)*	I/D	Director of Nursing & Quality 11.50	-
	13.2 **Cheshire Integrated Care Partnership (CCICP) Progress Report and 6 month Corporate Governance Statement - October 2016–April 2017** *(attached) (to note)*	I/D	Chief Operating Officer 11.55	-
	13.3 **Draft Transformation and People Committee notes from the meeting held on 6 April 2017** *(attached) (to note)*	I	Committee Chair 12.05	-
	13.4 **Visits of Accreditation, Inspection or Investigation** - RoSPA Gold Award for Health and Safety *(verbal)* (*to note*)	I D/I	Chief Executive 12.10 Deputy Chief Executive/ Medical Director 12.15	- -
	13.5 **Board Assurance Framework Q4** *(attached)(to note)*	D/I	Chief Executive 12.20	-
	13.6 **Top 5 Strategic Risks Q4** *(attached)(to note)*	I	Chief Operating Officer 12:25	-
	13.7 **CCICP Board Minutes – 16 February 2017** *(attached) (to note)*			
14.	**EFFECTIVE**		Deputy Chief Executive/ Medical Director 12.40	-
	14.1 **Consultant Appointments** *(verbal)* (*to note*)	I		
	14.3 **Board Effectiveness Survey** *(attached) (to note)*	D/I	Chief Executive 12:45	
15.	**Any Other Business (verbal)**	I/A/D	Chairman 12:50	-
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 June 2017**	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
17/01/12.1.6	09/01/2017	Review of the acquisition of CCICP and any remaining risks.	D Frodsham		Following end of year	May	Open
17/04/9.6.2	03/04/2017	NHS Providers summary of the 5YFV for England to be circulated	T Bullock	10/04/2017		May	Completed
17/04/11.1.2	03/04/2017	QGC Action notes from March to be included in the May Board Papers	K Dowson	02/05/2017		May	Completed

Board of Directors Workplan 2017 /18

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							
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					
Staff Survey												x					
CQC Comprehensive Inspection Action Plan				x							x						
Safe																	
Health & Safety Update to Board													x				
SUI & RIDDOR	x	x	x	x	x	x	x	x	x	x	x	x					
Quality Governance Committee	x	x	x	x	x	x	x	x	x	x	x	x					
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															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						
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					
Board Sub-Committee Annual Review			x														
Workforce Race Equality Scheme							x										
Board Actions	x	x	x	x	x	x	x	x	x	x	x	x					

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Board Report May 2017

Quality: Safety and Experience

(March 2017 data)

This report provides an overview of performance relating to safety and experience in February 2017.

Key messages for March are:

- There was one serious incident reported in month.
- The Trust's HSMR is 111.61.
- The Trust SHMI is currently 101.72 for the period October 2015 – September 2016.
- One MRSA Bacteraemia case has been reported in month.
- No avoidable Clostridium Difficile cases have been reported in month.
- 24 complaints were received in month.
- The Trust's NHS Choices Star rating is currently 5 stars for Victoria Infirmary, and 4.5 stars for Leighton Hospital.

Board Papers – Quality, Safety & Experience Section: May 2017

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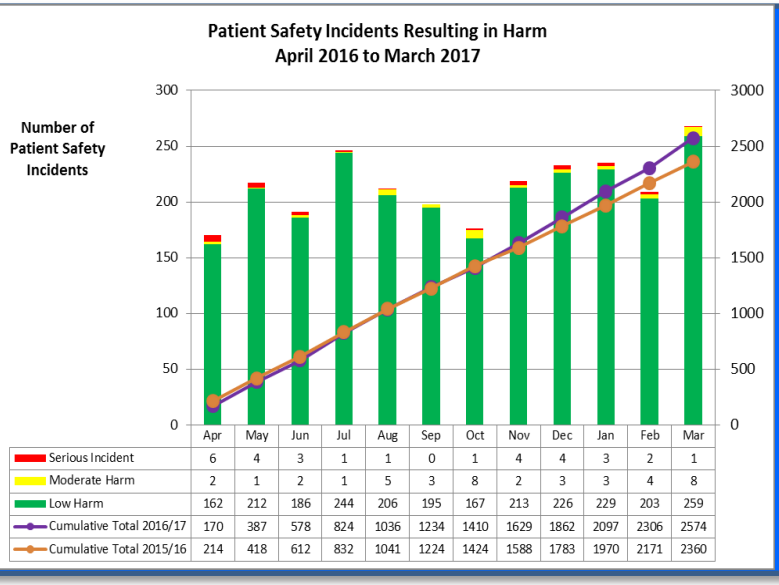
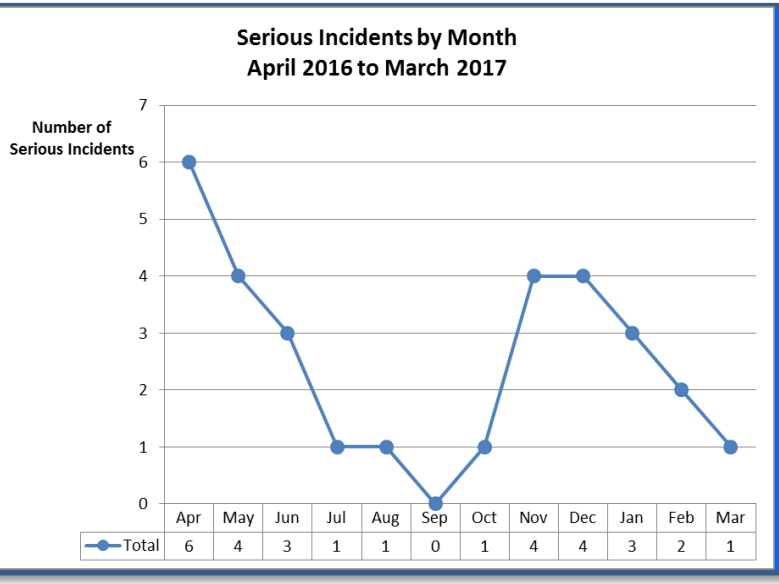
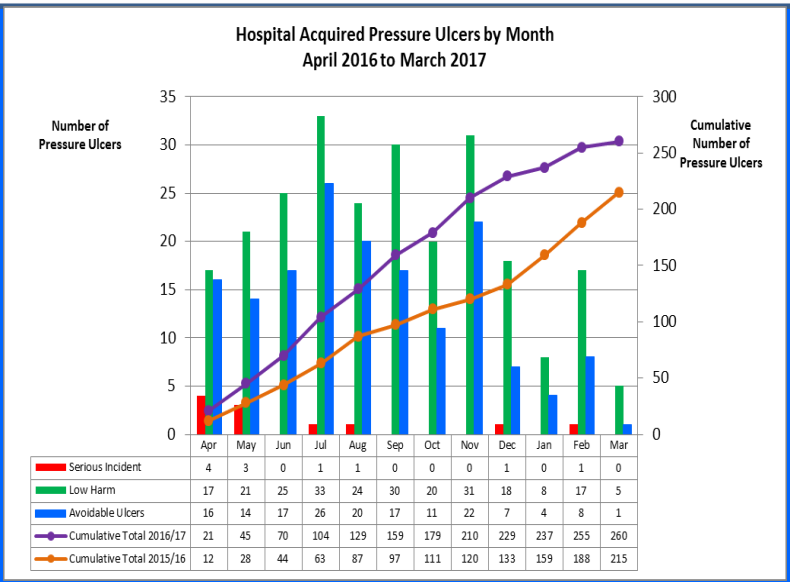
Quality & Safety Section:

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: 97.2% (2502 incidents) have resulted in low harm 1.6% (42 incidents) have resulted in moderate harm 1.2% (30 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. Degrees of Harm
Serious Incidents.	This chart demonstrates the number of incidents that have resulted in serious harm. Two serious harm incidents were reported in March 2017. 30 serious incidents have been reported for this financial year to date.		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. Serious Incidents

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Serious Incident	6	4	3	1	1	0	1	4	4	3	2	1
Moderate Harm	2	1	2	1	5	3	8	2	3	3	4	8
Low Harm	162	212	186	244	206	195	167	213	226	229	203	259
Cumulative Total 2016/17	170	387	578	824	1036	1234	1410	1629	1862	2097	2306	2574
Cumulative Total 2015/16	214	418	612	832	1041	1224	1424	1588	1783	1970	2171	2360

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total	6	4	3	1	1	0	1	4	4	3	2	1

Board Papers – Quality, Safety & Experience Section: May 2017

Description	Aggregate Position	Trend	Variation
Pressure Ulcer (PU) Incidents including avoidable pressure ulcers.	For this financial year to date: • 95.8% (249 PU's) have resulted in low harm (defined as a patient that has developed a stage 2 or unstageable PU) • 4.2% (11 PU's) have resulted in serious harm (defined as a patient that has developed a stage 3 or 4 PU) In March 2017, 1 avoidable PU was reported, as shown by the blue bar on the chart. Improvement actions include: • Successful elements of the React to Red Collaborative have been rolled out across the Trust. This has included: ○ Implementation of the pressure ulcer safety cross ○ Implementation of positional charts in bays and bed spaces		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.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Serious Incident	4	3	0	1	1	0	0	0	1	0	1	0
Low Harm	17	21	25	33	24	30	20	31	18	8	17	5
Avoidable Ulcers	16	14	17	26	20	17	11	22	7	4	8	1
Cumulative Total 2016/17	21	45	70	104	129	159	179	210	229	237	255	260
Cumulative Total 2015/16	12	28	44	63	87	97	111	120	133	159	188	215

Pressure Ulcers

Board Papers – Quality, Safety & Experience Section: May 2017

Description	Aggregate Position	Trend	Variation

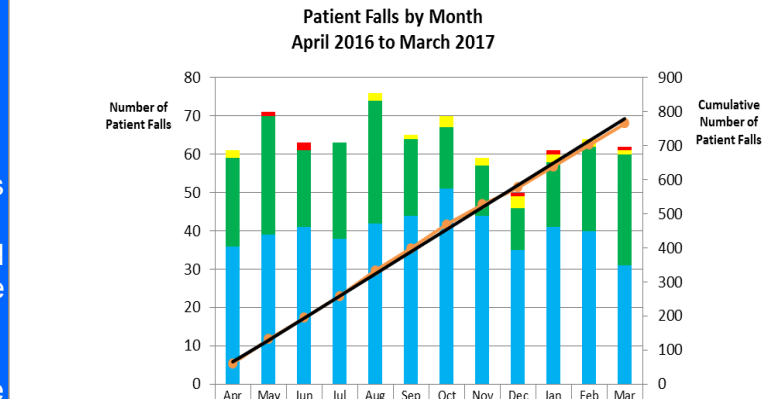
Patient Falls Incidents.

For this financial year to date:

- 63% (482 falls) have resulted in no harm
- 33.9% (259 falls) have resulted in low harm
- 2.4% (18 falls) have resulted in moderate harm
- 0.7% (6 falls) have resulted in serious harm

All patient falls are reviewed by the Patient Falls Prevention Group on a monthly basis.

- Successful initiatives from the One Step Ahead collaborative commenced roll out across the organisation in October 2016 including:
  - Toilet/commode tagging
  - Cohort of higher risk patients to increase supervision
  - Staff placement in bays to increase supervision
  - Safety crosses in all ward areas



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Serious Incident	0	1	2	0	0	0	0	0	1	1	0	1
Moderate Harm	2	0	0	0	2	1	3	2	3	2	2	1
Low Harm	23	31	20	25	32	20	16	13	11	17	22	29
No Harm	36	39	41	38	42	44	51	44	35	41	40	31
Cumulative Total 2016-17	61	132	195	258	334	399	469	528	578	639	703	765
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 achieved in month.

Patient Falls

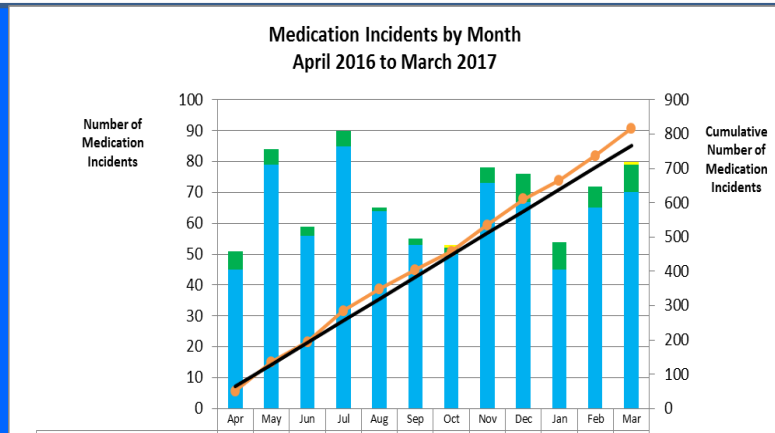
Medication Incidents.

For this financial year to date:

- 92% (752 medication incidents) have resulted in no harm
- 7.8% (63 medication incidents) have resulted in low harm
- 0.2% (2 medication incidents) have resulted in moderate harm
- 0% (0 medication incidents) have resulted in serious harm

Improvement actions include:

- Development of an action plan to improve prescribing errors across the Organisation. This will be monitored by the Safety Medicines Practice Group and Executive Quality Governance Group.



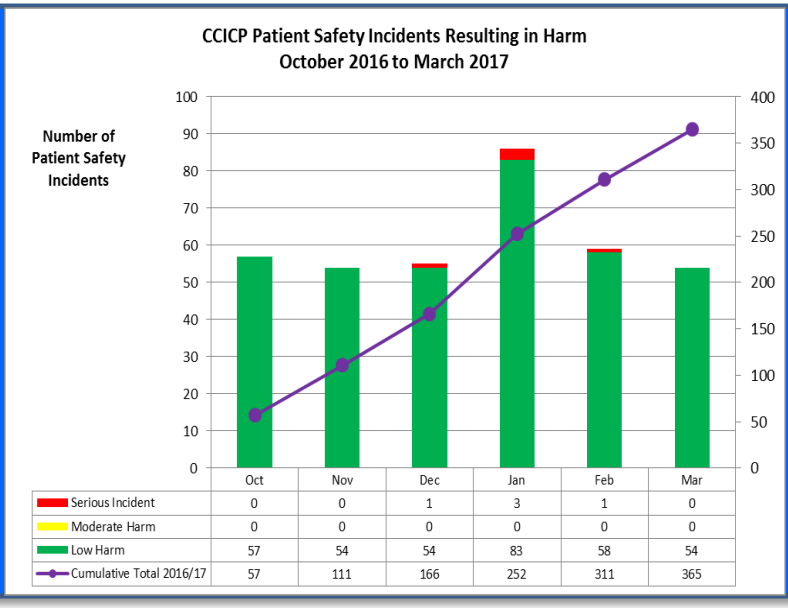
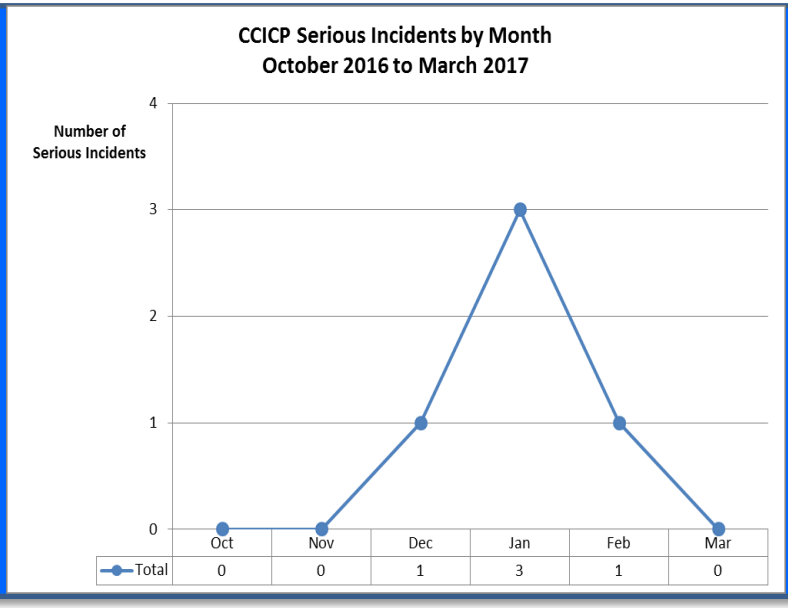
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Serious Incident	0	0	0	0	0	0	0	0	0	0	0	0
Moderate Harm	0	0	0	0	0	0	1	0	0	0	0	1
Low Harm	6	5	3	5	1	2	2	5	9	9	7	9
No Harm	45	79	56	85	64	53	50	73	67	45	65	70
Cumulative Incidents 2016-17	51	135	194	284	349	404	457	535	611	665	737	817
Trust Target	64	128	192	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.

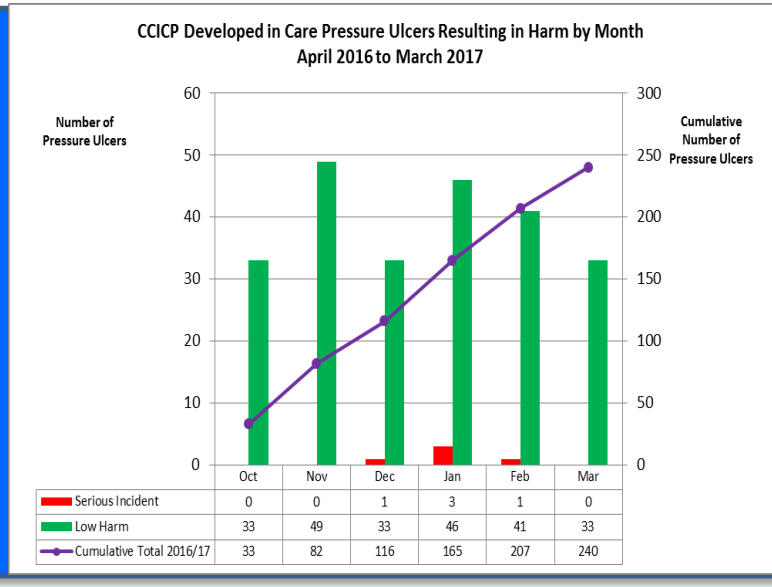
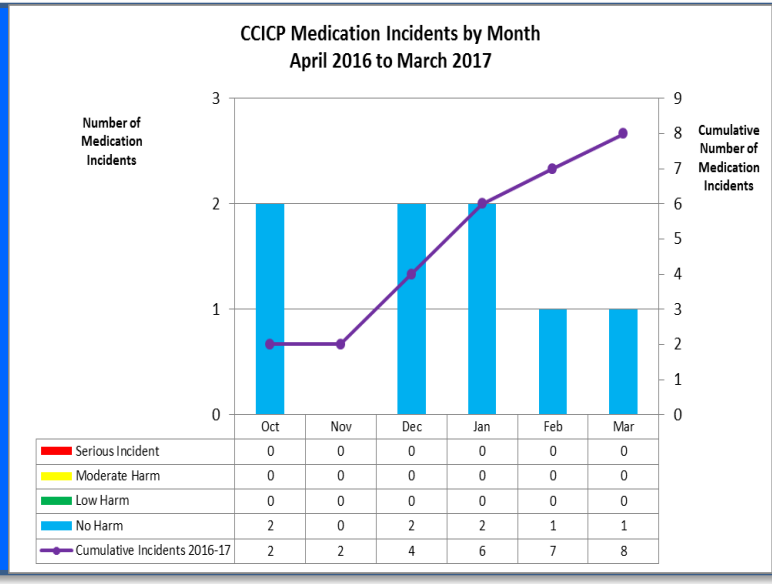
The aim was not achieved in month.

Medication Incidents

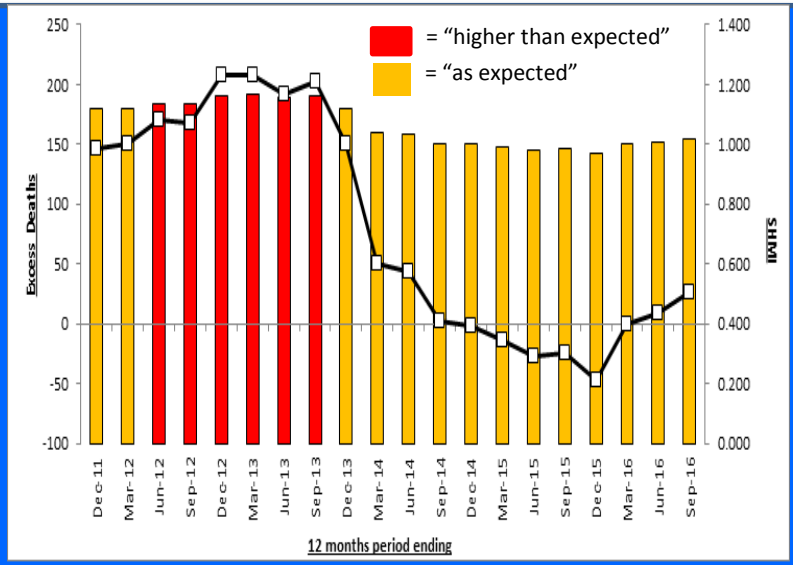
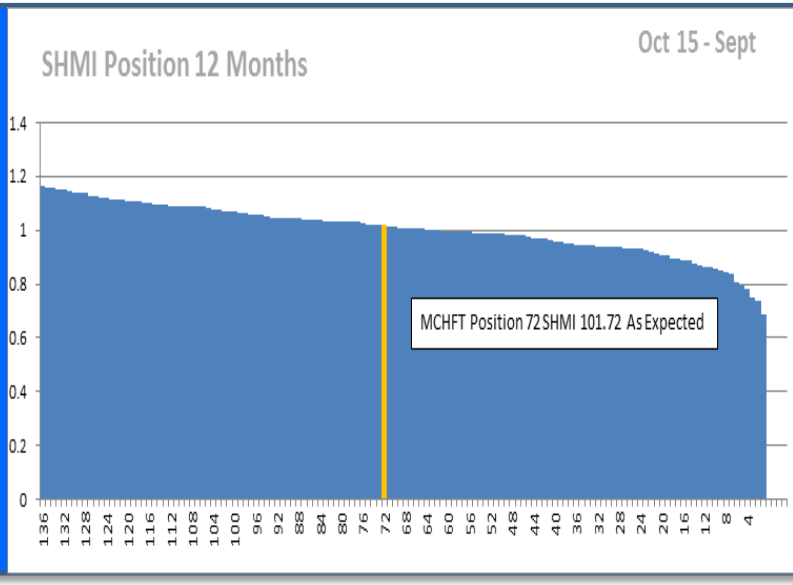
Board Papers – Quality, Safety & Experience Section: May 2017

Description	Aggregate Position	Trend	Variation
CCICP Patient Safety Incidents resulting in harm.	This chart demonstrates the total number of reported patient safety incidents which resulted in harm. From October 2016 when the partnership commenced: • 98.6% (360 incidents) have resulted in low harm • 0% (0 incidents) have resulted in moderate harm • 1.4% (5 incidents) have resulted in serious harm		CCICP aims agreed for 2017/2018. CCICP Degrees of Harm
CCICP Serious Incidents.	This chart demonstrates the number of incidents that have resulted in serious harm. Five serious incidents have been reported since October 2016 when the partnership commenced.		CCICP aims agreed for 2017/2018 CCICP Serious Incidents

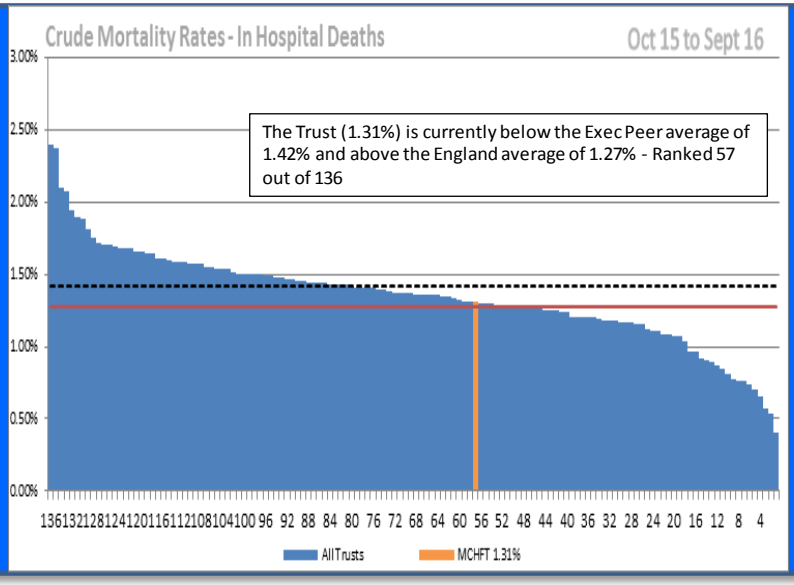
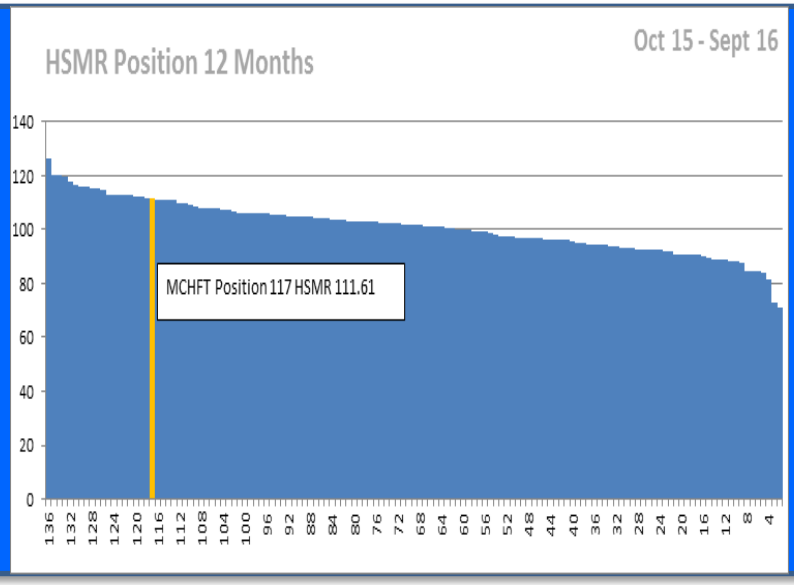
Board Papers – Quality, Safety & Experience Section: May 2017

Description	Aggregate Position	Trend	Variation
CCICP Pressure Ulcer (PU) Incidents including avoidable pressure ulcers.	Since October 2016 when the partnership commenced: • 97.9% (235 PU's) have resulted in low harm (defined as a patient that has developed a stage 2 or unstageable PU) • 2.1% (5 PU's) stage three or stage four PU's have been reported	 Oct Nov Dec Jan Feb Mar Serious Incident 0 0 1 3 1 0 Low Harm 33 49 33 46 41 33 Cumulative Total 2016/17 33 82 116 165 207 240	CCICP aims agreed for 2017/2018. CCICP Developed in Care Pressure
CCICP Medication Incidents.	From October 2016 when the partnership commenced: • 100% (8 medication incidents) have resulted in no harm • 0% (0 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	 Oct Nov Dec Jan Feb Mar Serious Incident 0 0 0 0 0 0 Moderate Harm 0 0 0 0 0 0 Low Harm 0 0 0 0 0 0 No Harm 2 0 2 2 1 1 Cumulative Incidents 2016-17 2 2 4 6 7 8	CCICP aims agreed for 2017/2018. CCICP Medication Incidents

Board Papers – Quality, Safety & Experience Section: May 2017

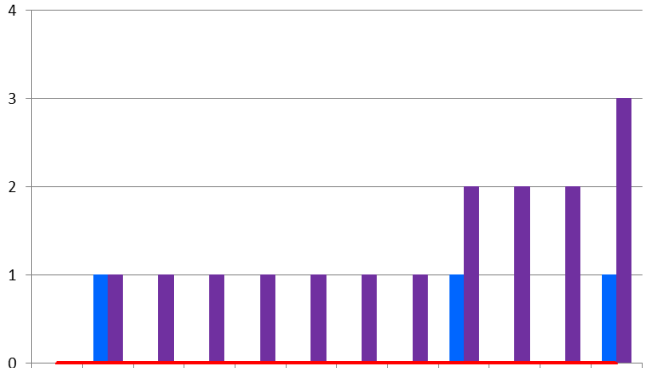
Description	Aggregate Position	Trend	Variation
Summary Hospital-Level Mortality Indicator (SHMI).	The chart demonstrates the Trust's Summary Hospital-Level Mortality Indicator (SHMI) and calculated "excess deaths". For the period October 2015 to September 2016, the Trust's SHMI is 101.72 and "as expected		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 not being achieved. SHMI
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 101.72 for the time period October 2015 to September 2016 and places the Trust 72 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 not being achieved SHMI by Trust

Board Papers – Quality, Safety & Experience Section: May 2017

Description	Aggregate Position	Trend	Variation
Crude Mortality.	The chart benchmarks the Trust's crude mortality rate for the period October 2015 to September 2016 against an executive peer and England average. The Trust (1.31%) is currently below the executive peer average of 1.42% but not the England average of 1.27% and places the Trust 57 out of 136 Trusts.		The Trust's aim is to continually reduce its crude mortality rate. **Crude Mortality**
HSMR by Trust.	The chart benchmarks the Trust's HSMR against all NHS Trusts. MCHFT is shown by the amber bar. The Trust's HSMR is 111.61 (October 2015 to September 2016) and places the Trust 117 out of 136 Trusts.		The Trust's aim is to have an HSMR <100. **HSMR by Trust**

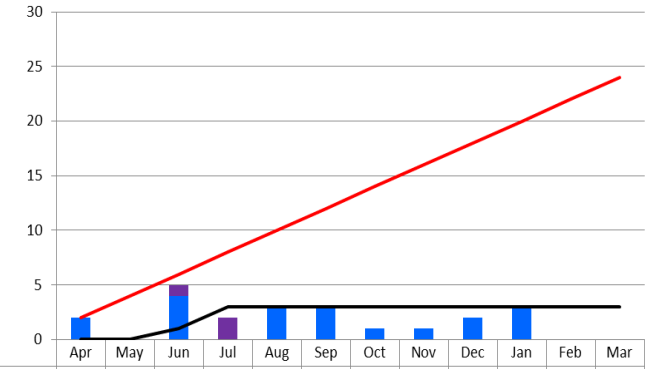
Board Papers – Quality, Safety & Experience Section: May 2017

Description	Aggregate Position	Trend	Variation
MRSA Bacteraemia Cases.	In this financial year there have been three confirmed MRSA bacteraemia cases reported. A root cause analysis has been undertaken for all confirmed MRSA bacteraemia cases and lapses in care have been addressed.	**MRSA Bacteraemia cases reported within the Trust April 2016 to March 2017**	The target for MRSA Bacteraemia is zero in 2016/17. The target has not been achieved.

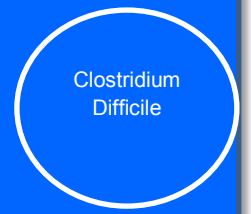


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Monthly	0	1	0	0	0	0	0	0	1	0	0	1
Cumulative	0	1	1	1	1	1	1	1	2	2	2	3
Target	0	0	0	0	0	0	0	0	0	0	0	0

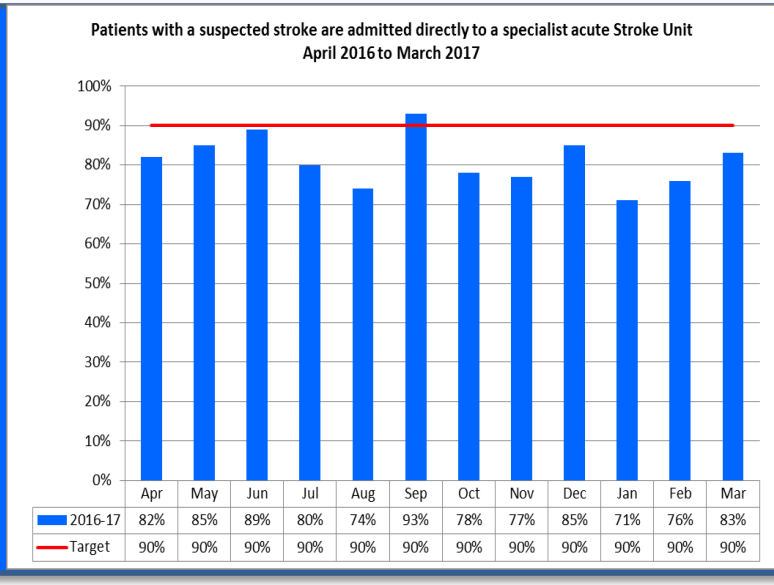
Description	Aggregate Position	Trend	Variation
Clostridium Difficile toxin positive cases.	In March 2017, no avoidable cases were reported. Actions arising from review of the Clostridium Difficile cases include: • Ward Managers to reinforce the importance of accurate stool chart documentation • Implementation of immediate bed-side reviews • Bi-weekly harm free care meetings with clinical teams and Director of Infection Prevention and Control (Director of Nursing)	**Clostridium Difficile toxin positive cases reported within the Trust April 2016 to March 2017**	The target is less than 24 avoidable cases of Clostridium Difficile in 2016/17. The target has been achieved.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Avoidable	0	0	1	2	0	0	0	0	0	0	0	0
Unavoidable	2	0	4	0	3	3	1	1	2	3	0	0
Avoidable Total	0	0	1	3	3	3	3	3	3	3	3	3
Avoidable Target	2	4	6	8	10	12	14	16	18	20	22	24



Board Papers – Quality, Safety & Experience Section: May 2017

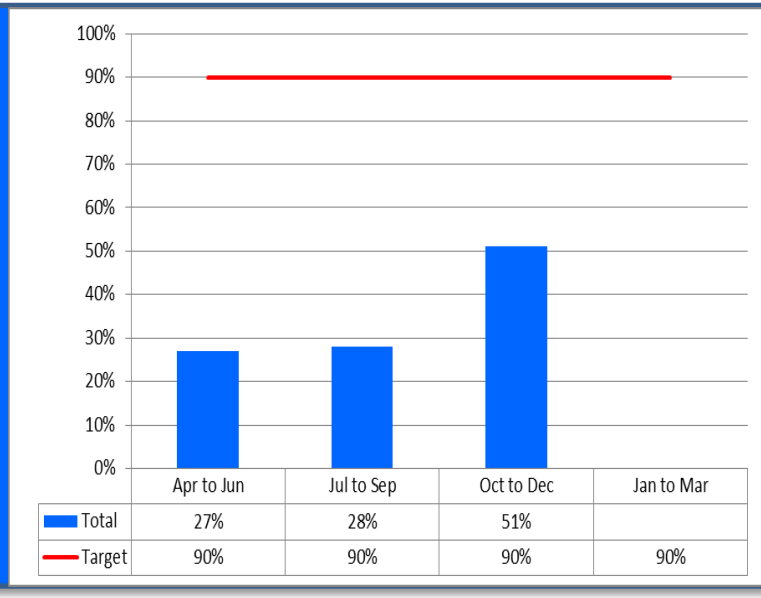
Description	Aggregate Position	Trend	Variation
Patients with a suspected stroke admitted directly to a specialist acute stroke unit	In March 2017, 24 out of 28 patients (83%) were admitted directly to the stroke unit.		As part of the Sentinal Stroke National Audit Plan (SSNAP) the Trust aim for 2016/2017 is 90% of suspected stroke patients to be admitted directly to the stroke unit. The target was not achieved in month.

Stroke

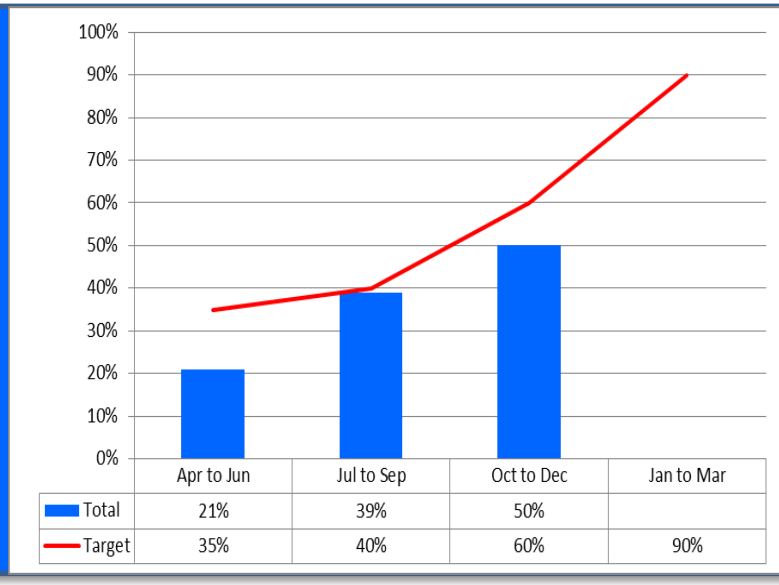
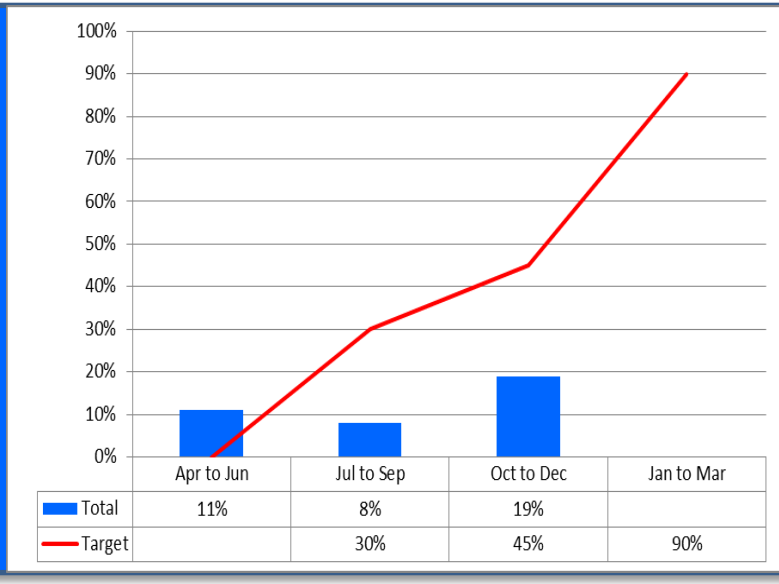
Board Papers – Quality, Safety & Experience Section: May 2017

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.	For quarter 3, the specific actions on the plan were delivered and RAG rated green. 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: • Launch of creative screen saver messages to support the themes of 'time to move' and 'think before you e-mail'. • Relaunch of the green walking route. • Promotion of the Cardinus stress risk assessment tool.	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	For quarter 3, progress against the action plan is required, although there is no funding allocated to quarter 3. 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

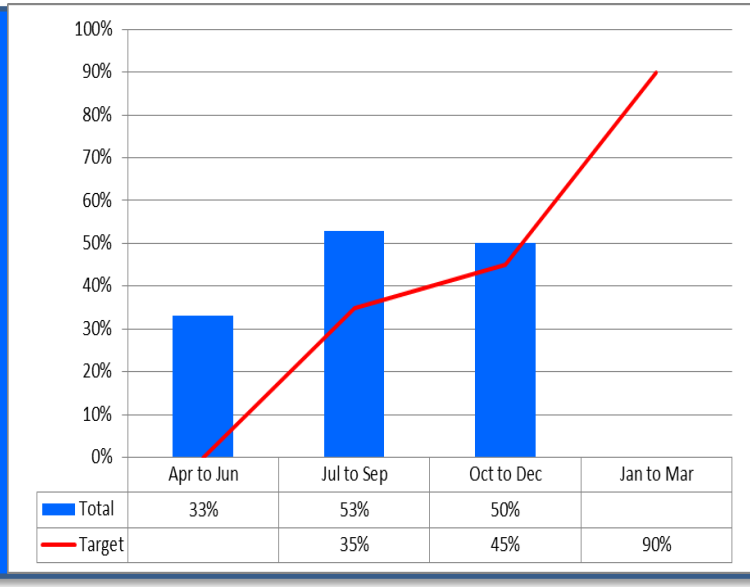
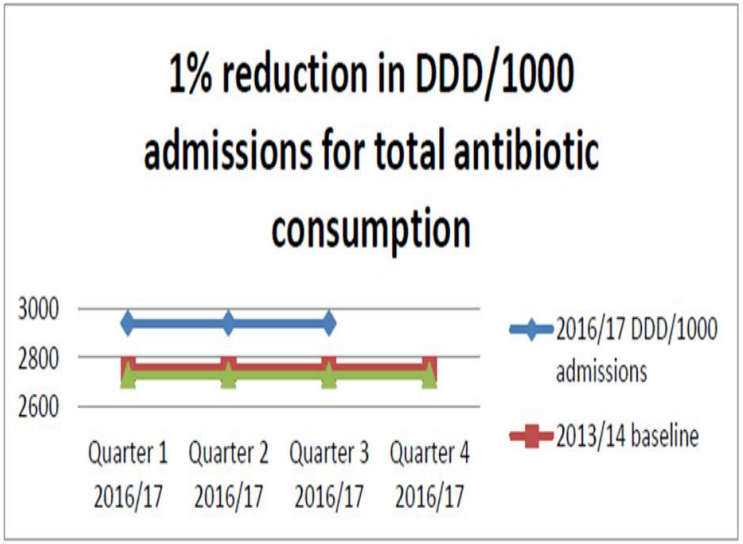
Board Papers – Quality, Safety & Experience Section: May 2017

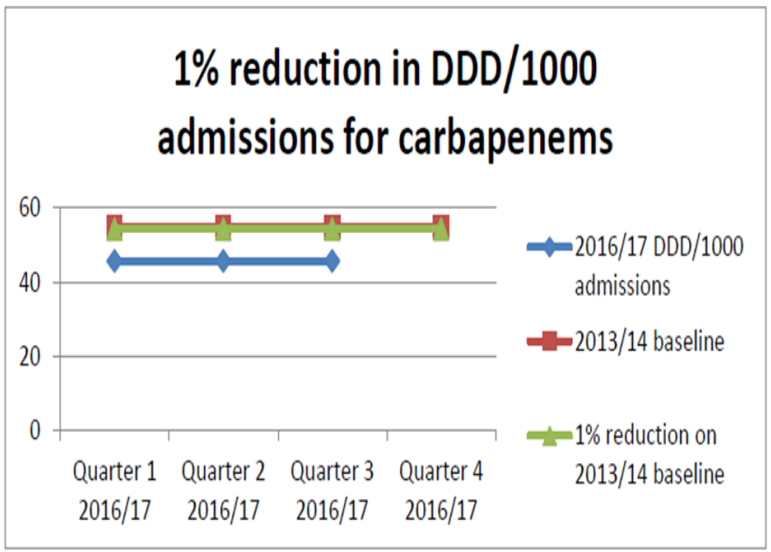
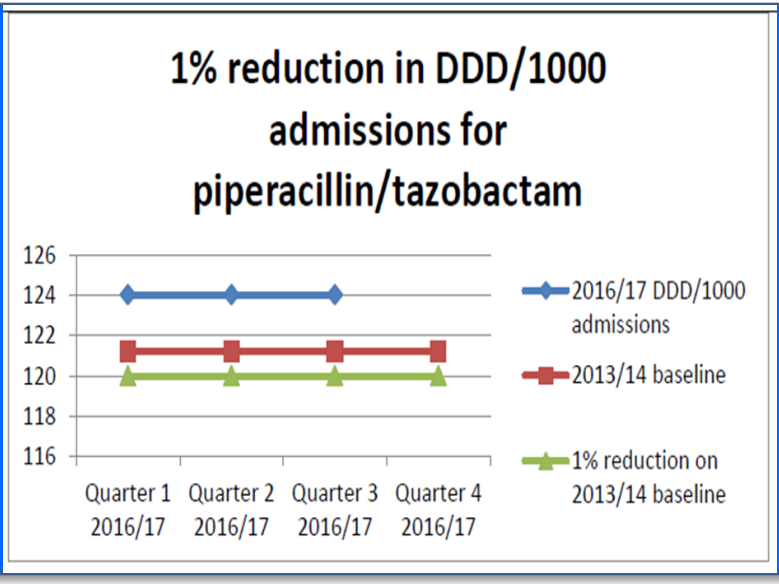
Description	Aggregate Position	Trend	Variation
National CQUIN – Health & Wellbeing Part 1c The financial value for this CQUIN is £396,107.	To achieve the CQUIN target for Health & Wellbeing Part 1c the Trust must improve the uptake of flu vaccinations for front line clinical staff by December 2016.	MCHFT achieved 75.6% uptake amongst front line healthcare workers by 31st December 2016 and therefore met the CQUIN target.	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. **National CQUIN – Health & Wellbeing Part 1c**
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.	 Apr to Jun / Jul to Sep / Oct to Dec / Jan to Mar Total: 27% / 28% / 51% / 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 quarter. **National CQUIN – Sepsis Emergency Departments 2a Part 1**

Board Papers – Quality, Safety & Experience Section: May 2017

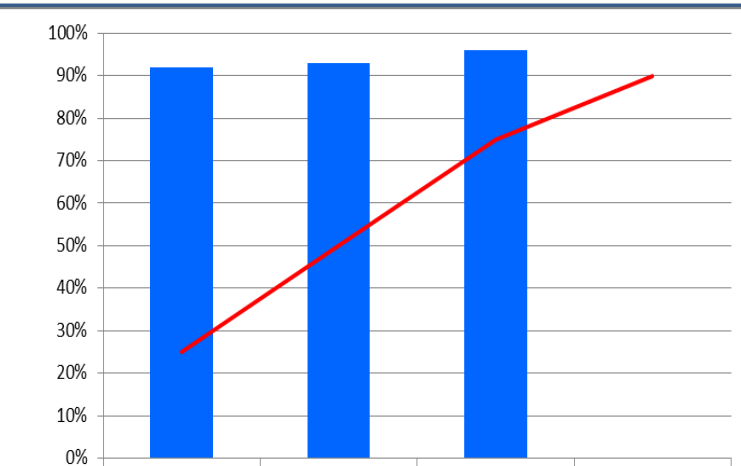
Description	Aggregate Position	Trend	Variation
National CQUIN – Sepsis Emergency Departments 2a Part 2: Antibiotic Administration The financial value for this CQUIN is £118,832.	To achieve the CQUIN target for Sepsis Antibiotic Administration 2a Part 2, a random sample of 30 sets of notes, where clinical 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.	 Apr to Jun / Jul to Sep / Oct to Dec / Jan to Mar Total: 21% / 39% / 50% Target: 35% / 40% / 60% / 90%	The CQUIN target for Sepsis 2a Part 2 is for 90% by the end of quarter 4. The target was not achieved in quarter. 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.	 Apr to Jun / Jul to Sep / Oct to Dec / Jan to Mar Total: 11% / 8% / 19% Target: / 30% / 45% / 90%	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 not achieved in quarter. National CQUIN – Sepsis Inpatients 2b Part 1

Board Papers – Quality, Safety & Experience Section: May 2017

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.		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 quarter. 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.		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 not 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.		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.		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 not achieved in month. **National CQUIN – piperacillin-tazabactam consumption Part 3a 3**

Board Papers – Quality, Safety & Experience Section: May 2017

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 3. An empiric review was documented in the medical notes within 72 hours of commencing treatment for 96% of audited prescriptions for antibiotics in quarter 3.	 Apr to Jun / Jul to Sep / Oct to Dec / Jan to Mar Total: 92% / 93% / 96% 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: May 2017

Description	Aggregate Position	Trend	Variation

Safety Thermometer - Harm Free Care.

In March 2017, 97% of patients received harm free care as measured by the Safety Thermometer.

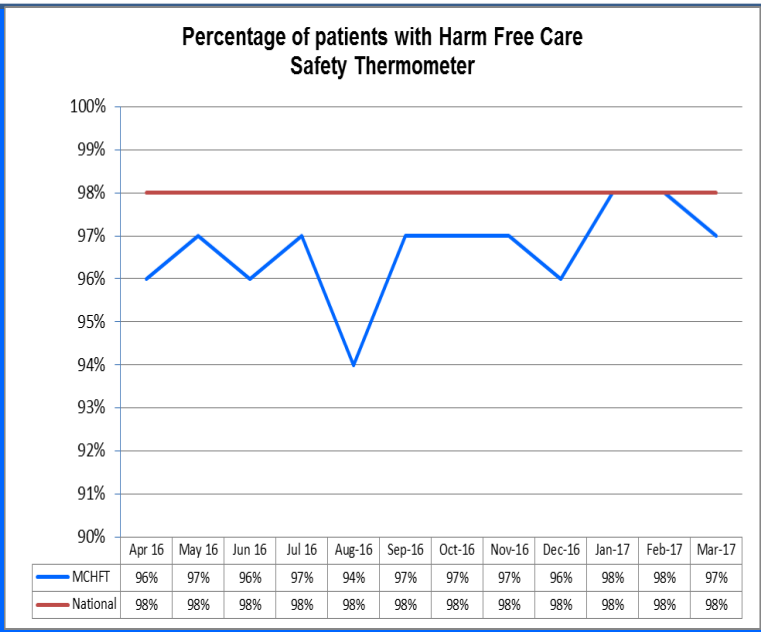
The Safety Thermometer data is collected during the morning of the first Wednesday of each month and is collected by the nursing staff on duty on the ward assisted by the Divisional Senior Nursing Teams.

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



	Apr 16	May 16	Jun 16	Jul 16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
MCHFT	96%	97%	96%	97%	94%	97%	97%	97%	96%	98%	98%	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: May 2017

Description	Aggregate Position	Trend	Variation
Registered Nurses monthly expected hours by shift versus actual monthly hours per shift. Day time shifts only	93.9% of expected Registered Nurse hours were achieved for day shifts. Any registered nurse numbers that fall below 85% are required to have a divisional review and an update of actions provided to the Director of Nursing & Quality and the Deputy Director of Nursing & Quality.	Trend **March 2017 93.9%** February 2017 94% January 2017 92.8%	The lowest staffing levels during the day were on Ward 9 at 81.2%. **Registered Staff Day Time**
Registered Nurses monthly expected hours by shift versus actual monthly hours per shift. Night time shifts only	101.1% of expected Registered Nurse hours were achieved for night shifts.	Trend **March 2017 101.1%** February 2017 99.8% January 2017 97.7%	The lowest staffing levels during the night were on Ward 12 at 91.4% **Registered Staff Night Time**

Board Papers – Quality, Safety & Experience Section: May 2017

Description	Aggregate Position	Trend	Variation
Healthcare Assistant monthly expected hours by shift versus actual monthly hours per shift. Day time shifts only	100.9% of expected HCA hours were achieved for day shifts.	Trend **March 2017 100.9%** February 2017 100.2% January 2017 99.5%	The lowest staffing levels during the day were on NICU at 43.3% **Support Worker Day Time**
Healthcare Assistant monthly expected hours by shift versus actual monthly hours per shift. Night time shifts only	111.3% of expected HCA hours were achieved for night shifts. For areas with over 100% staffing levels for HCA's this is reviewed and is predominately due to wards requiring 1 to 1 specials for patients following a risk assessment or to increase staffing numbers when there are registered nursing gaps that are not filled.	Trend **March 2017 111.3%** February 2017 107.7% January 2017 106.8%	The lowest staffing levels during the night were on NICU at 80.6% **Support Worker Night Time**

Board Papers – Quality, Safety & Experience Section: May 2017

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		44200.1	41490	31860.5	32143.1	25283.8	25559.4	17131.4	19074.9	93.9%	100.9%	101.1%	111.3%	14775	4.5	3.5	8.0
AMU	Gen. Medicine	2011.3	1950.3	1519	1476.3	1898.8	1874.3	1519	1531.3	97.0%	97.2%	98.7%	100.8%	688	5.6	4.4	9.9
CAU	Paeds	2873	2873	894	894	1656	1656	356.5	356.5	100.0%	100.0%	100.0%	100.0%	514	8.8	2.4	11.2
Critical Care	Gen. Medicine	4193.5	4193.5	418.5	418.5	2584	2584	0	0	100.0%	100.0%	100.0%	-	218	31.1	1.9	33.0
Elmhurst	Rehab	871.5	871.5	2232	2202	775	775	1550	1800	100.0%	98.7%	100.0%	116.1%	907	1.8	4.4	6.2
Ward 1	Gen. Medicine	2193.8	2068.8	1162.5	1281.3	1519	1519	759.5	808.5	94.3%	110.2%	100.0%	106.5%	783	4.6	2.7	7.3
Ward 11	Gen. Surg	1500	1620	930	1177.5	580.7	702.5	290.4	459	108.0%	126.6%	121.0%	158.1%	337	6.9	4.9	11.7
Ward 10	Gen. Surg & Urology	1717	1549	992	992	635.5	635.5	317.8	307.5	90.2%	100.0%	100.0%	96.8%	278	7.9	4.7	12.5
Ward 12	Gen. Surg & Gynae	2243	1987	1984	1944	953.3	871.3	635.5	686.8	88.6%	98.0%	91.4%	108.1%	891	3.2	3.0	6.2
Ward 13	Gen. Surg	2288	1952	1984	1992	953.3	902	635.5	656	85.3%	100.4%	94.6%	103.2%	951	3.0	2.8	5.8
Ward 14	Gen. Medicine	1716	1530	1488	1446	744	732	1116	1212	89.2%	97.2%	98.4%	108.6%	915	2.5	2.9	5.4
Ward 15	Trauma & Ortho	2250.5	1938.5	2728	2656	953.3	902	953.3	963.5	86.1%	97.4%	94.6%	101.1%	947	3.0	3.8	6.8
Ward 18	Gen. Medicine	1403.8	1285	1550	1781.3	759.5	759.5	759.5	980	91.5%	114.9%	100.0%	129.0%	657	3.1	4.2	7.3
Ward 2	Gen. Medicine	1806.3	1681.3	1550	1612.5	759.5	1139.3	1139.3	1127	93.1%	104.0%	150.0%	98.9%	907	3.1	3.0	6.1
Ward 21B	Rehab	1310.5	1213	1813.5	1800.5	775	775	775	1062.5	92.6%	99.3%	100.0%	137.1%	731	2.7	3.9	6.6
Ward 23	Obstetrics	1238	1238	785.3	772.7	764.7	764.7	764.7	764.7	100.0%	98.4%	100.0%	100.0%	675	3.0	2.3	5.2
Ward 26	Obstetrics	3236.3	3236.3	627	627	2725.7	2725.7	382.3	382.3	100.0%	100.0%	100.0%	100.0%	167	35.7	6.0	41.7
Ward 4	Gen. Medicine	1716	1584	1860	1908	744	768	1488	1656	92.3%	102.6%	103.2%	111.3%	960	2.5	3.7	6.2
Ward 5	Gen. Medicine	2452.5	2227.5	1550	1612.5	1519	1482.3	759.5	759.5	90.8%	104.0%	97.6%	100.0%	937	4.0	2.5	6.5
Ward 6	Gen. Medicine	2042.5	1992.5	1937.5	2050	1519	1470	759.5	1078	97.6%	105.8%	96.8%	141.9%	864	4.0	3.6	7.6
Ward 7	Gen. Medicine	1758.8	1615	1550	1768.8	759.5	747.3	1139.3	1457.8	91.8%	114.1%	98.4%	128.0%	954	2.5	3.4	5.9
Ward 9	Trauma & Ortho	1702	1382	1488	1376	635.5	635.5	317.8	451	81.2%	92.5%	100.0%	141.9%	459	4.4	4.0	8.4
NICU	Paeds	1675.8	1501.8	817.2	354.2	1069.5	1138.5	713	575	89.6%	43.3%	106.5%	80.6%	35	75.4	26.5	102.0

Board Papers – Quality, Safety & Experience Section: May 2017

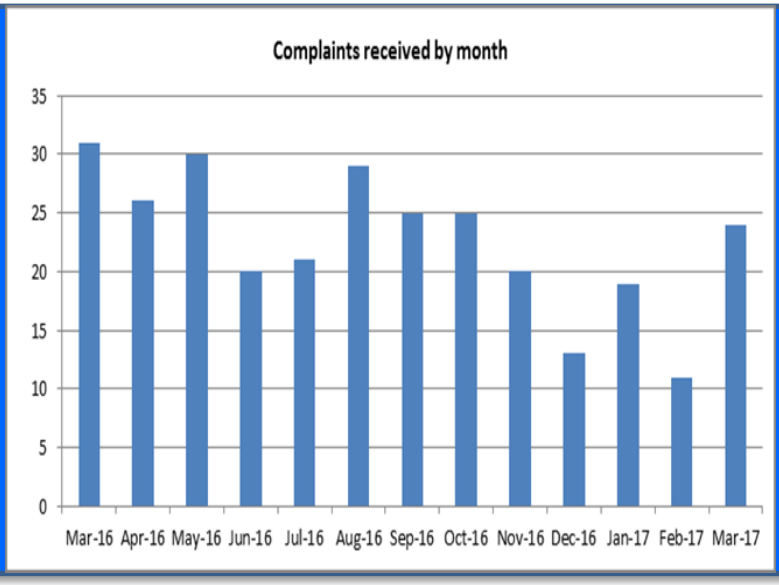
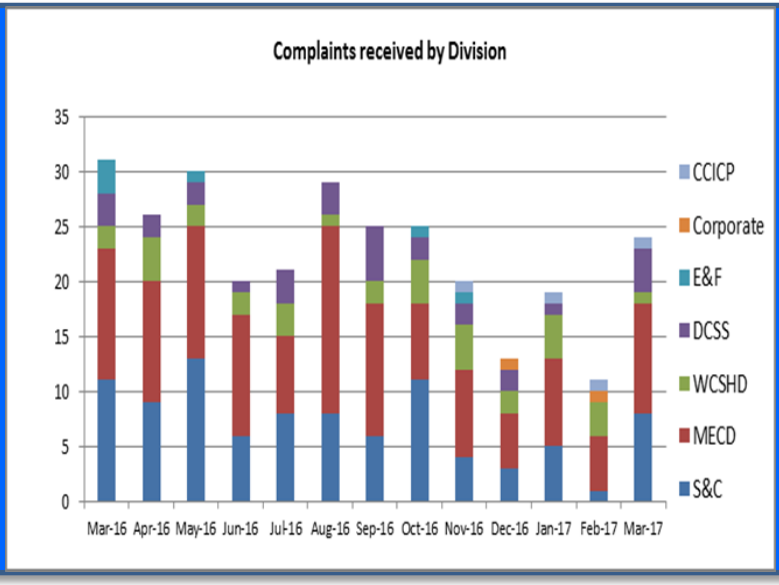
Ward Name	Main Specialties	Safety Thermometer Results			
		Hospital Acquired Pressure Ulcers	Patient Falls resulting in harm	CAUTI	New VTE
MCHFT		2.33% (22)	0.32% (3)	0.11% (1)	0.11% (1)
AMU	Gen. Medicine	0% (0)	0% (0)	0% (0)	0% (0)
CAU	Paeds	0% (0)	0% (0)	0% (0)	0% (0)
Critical Care	Gen. Medicine	9.09% (1)	0% (0)	0% (0)	9.09% (1)
Elmhurst	Rehab	3.57% (1)	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)	0% (0)
Ward 14	Gen. Medicine	3.12% (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)	0% (0)	0% (0)	0% (0)
Ward 2	Gen. Medicine	0% (0)	0% (0)	0% (0)	0% (0)
Ward 21B	Rehab	0% (0)	0% (0)	0% (0)	0% (0)
Ward 23	Obstetrics	0% (0)	0% (0)	0% (0)	0% (0)
Ward 26	Obstetrics	0% (0)	0% (0)	0% (0)	0% (0)
Ward 4	Gen. Medicine	0% (0)	0% (0)	0% (0)	0% (0)
Ward 5	Gen. Medicine	3.45% (1)	0% (0)	0% (0)	0% (0)
Ward 6	Gen. Medicine	0% (0)	0% (0)	0% (0)	0% (0)
Ward 7	Gen. Medicine	3.12% (1)	0% (0)	0% (0)	0% (0)
Ward 9	Trauma & Ortho	5.26% (1)	0% (0)	0% (0)	0% (0)
NICU	Paeds	0% (0)	0% (0)	0% (0)	0% (0)
DN – Alsager	District Nursing	13.33% (6)	0% (0)	0% (0)	0% (0)
DN – Church View	District Nursing	3.45% (1)	0% (0)	0% (0)	0% (0)
DN – Danebridge	District Nursing	0% (0)	5.56% (1)	0% (0)	0% (0)
DN – Eaglebridge	District Nursing	4.41% (3)	0% (0)	0% (0)	0% (0)
DN – Firdale	District Nursing	0% (0)	0% (0)	0% (0)	0% (0)
DN – Grosvenor / Hungerford	District Nursing	0% (0)	0% (0)	0% (0)	0% (0)
DN – Middlewich	District Nursing	4% (1)	4% (1)	0% (0)	0% (0)
DN – Rope Green	District Nursing	8.7% (2)	0% (0)	0% (0)	0% (0)
DN – Sandbach	District Nursing	2.99% (2)	0% (0)	1.49% (1)	0% (0)
DN – Winsford	District Nursing	2.17% (1)	2.17% (1)	0% (0)	0% (0)

Experience Section:

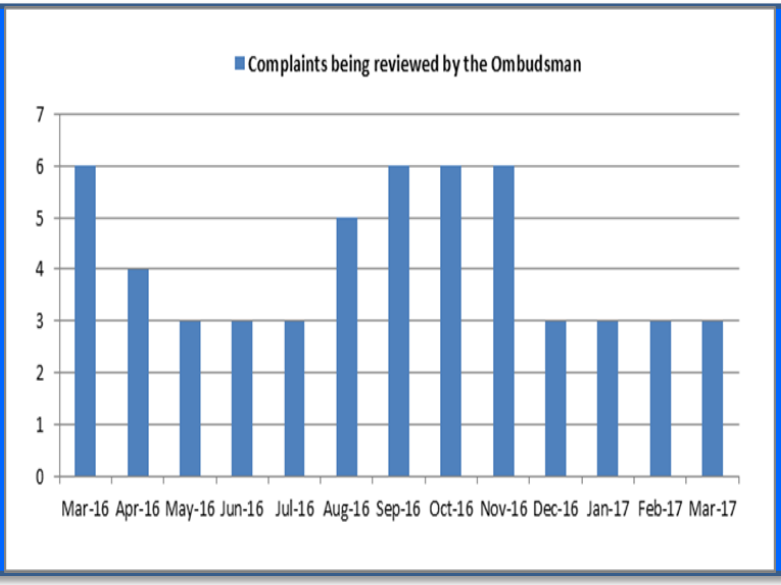
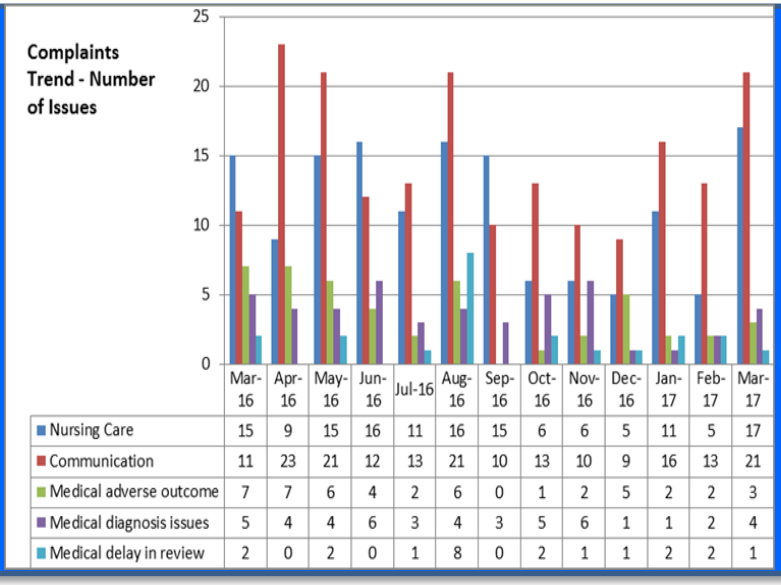
Indicators	YTD 16/17	Last four months			
		Dec-16	Jan-17	Feb-17	Mar-17
Complaints received by month	262	13	19	10	24
Complaints being reviewed by the Ombudsman		3	3	3	3
Closed complaints by month	285	23	11	13	16
Contacts raising informal concerns	1019	68	102	94	91
Compliments received in month	1872	374	172	151	190
Number of new claims received in month	40	6	3	3	2
Number of claims closed	29	0	4	4	4
Number of inquests concluded	14	2	5	0	0
NHS Choices - Star Ratings (Leighton)		4	4.5	4.5	4.5
NHS Choices - Star Ratings (VIN)		4.5	5	5	5
NHS Choices - Number of new postings	116	9	9	12	14
F&FT Response Rate ED, MIU, UCC and Assessment Areas*		4%	4%	4%	5%
Proportion of positive responses ED, MIU, UCC and Assessment Areas		96%	96%	97%	97%
F&FT Response Rate Inpatients and Daycases		29%	22%	28%	25%
Proportion of positive responses Inpatients and Daycases		98%	98%	99%	99%
F&FT Response Rate Outpatients		5%	5%	5%	4%
Proportion of positive responses Outpatients		95%	97%	96%	97%
F&FT Response Rate Maternity - Birth		15%	14%	16%	12%
Proportion of positive responses Maternity - Birth		97%	100%	92%	96%
F&FT Response Rate Community (CCICP)		18%	21%	20%	21%
Proportion of positive responses Community (CCICP)		88%	90%	88%	91%

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

Board Papers – Quality, Safety & Experience Section: May 2017

Description	Aggregate Position/Description	Trend	
Monthly Trust complaints received by the Trust	24 complaints were received in March 2017 which covered categories. The highest categories were: • Communication • Nursing Care • Attitude of Staff Highest 3 areas receiving complaints/issues were: • ED: 6 complaints/ 12 issues • Ward 15: 2 complaints/ 11 issues • Ward 12: 2 complaints/ 10 issues		Formal Complaints
Number of formal complaints by Division	This graph shows the breakdown of complaints by month for each division. S&C: 8, DCSS: 4, W&CD: 1, MECD: 10, CCICP: 1, E&F: 0, Corporate Services: 0 Examples of complaints for March 2017 S&C – Cancellation x 3 of surgery DCSS – Poor communication regarding MRI appointment W&CD – lack of understanding from ante natal clinic regarding bariatric patients MECD – Privacy & dignity concerns in ED CCICP – Gauze left in situ when dressing a post-surgical wound causing a haematoma insulin pump CCICP – pressure ulcer care by district nurse		Formal Complaints by Division

Board Papers – Quality, Safety & Experience Section: May 2017

Description	Aggregate Position/Description	Trend	
Complaints being reviewed by the Public Health Service Ombudsman (PHSO)	In March 2017 3 complaints were active with the PHSO		Ombudsman
Complaint Trends and number of issues	The main trends in March 2017 were: • Communication: 13 complaints/ 21 issues • Nursing: 10 complaints/ 17 issues • Attitude of staff: 7 complaints/ 7 issues		Complaint Trends

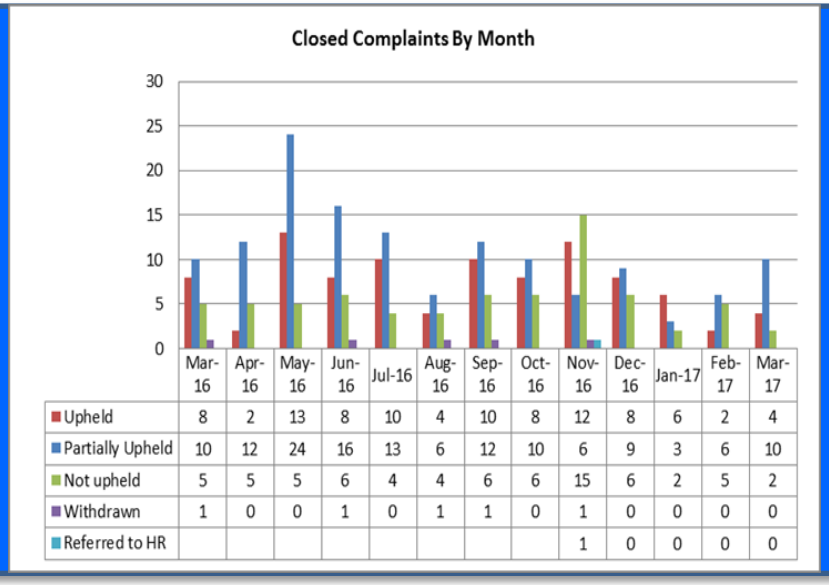
	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Nursing Care	15	9	15	16	11	16	15	6	6	5	11	5	17
Communication	11	23	21	12	13	21	10	13	10	9	16	13	21
Medical adverse outcome	7	7	6	4	2	6	0	1	2	5	2	2	3
Medical diagnosis issues	5	4	4	6	3	4	3	5	6	1	1	2	4
Medical delay in review	2	0	2	0	1	8	0	2	1	1	2	2	1

Board Papers – Quality, Safety & Experience Section: May 2017

Description	Aggregate Position/Description	Trend

Closed Complaints

16 complaints were closed in March 2017.



	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Upheld	8	2	13	8	10	4	10	8	12	8	6	2	4
Partially Upheld	10	12	24	16	13	6	12	10	6	9	3	6	10
Not upheld	5	5	5	6	4	4	6	6	15	6	2	5	2
Withdrawn	1	0	0	1	0	1	1	0	1	0	0	0	0
Referred to HR									1	0	0	0	0

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	Ref HR	Sub-Total
Medicine and Emergency Care	2	4	1	0	0	7
Surgery and Cancer	0	3	0	0	0	3
Diagnostics & Clinical Support Services	0	1	0	0	0	1
Women's and Children's	2	2	0	0	0	4
Estates & Facilities	0	0	0	0	0	0
CCICP	0	0	1	0	0	1
		Total closed				**16**

Complaints closed by Division

Table Removed Under Section 40 of the Freedom of Information Act

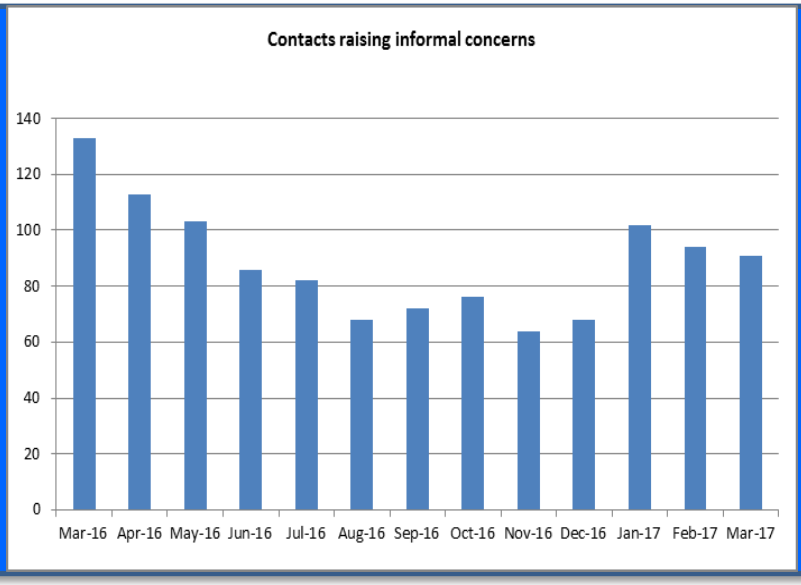
Board Papers – Quality, Safety & Experience Section: May 2017

Description	Aggregate Position/Description	Trend

Informal Concerns Numbers

The number of contacts raising informal concerns for March 2017 was 91, a decrease of 3 on the previous month.

The Division of Medicine and Emergency Care has received the largest number of individual concerns raised at 44. Nine of these issues belong to Respiratory.



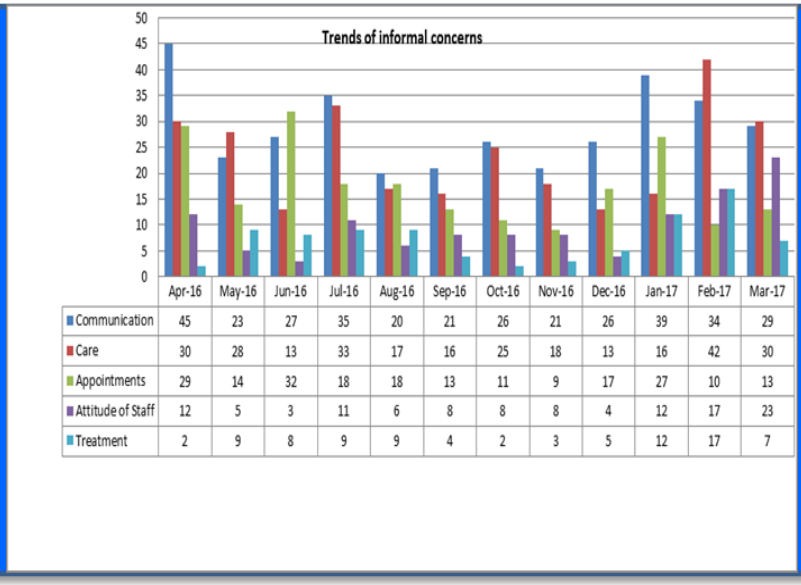
Informal Concerns Feedback

Informal Concerns Trends

Care was the highest trend for informal concerns in March 2017, with 13 of the 30 issues raised belonging to the Division of Medicine and Emergency Care. Four of these 13 issues belong to the Emergency Department and relate to medical care.

Of the 29 issues relating to communication, 10 belong to the Division of Medicine and Emergency Care, with 3 of the 10 issues relating to Respiratory.

Of the 23 issues relating to attitude of staff, 7 belong to the Division of Medicine and Emergency Care, with 3 of the 7 issues belonging to the Emergency Department.



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Communication	45	23	27	35	20	21	26	21	26	39	34	29
Care	30	28	13	33	17	16	25	18	13	16	42	30
Appointments	29	14	32	18	18	13	11	9	17	27	10	13
Attitude of Staff	12	5	3	11	6	8	8	8	4	12	17	23
Treatment	2	9	8	9	9	4	2	3	5	12	17	7

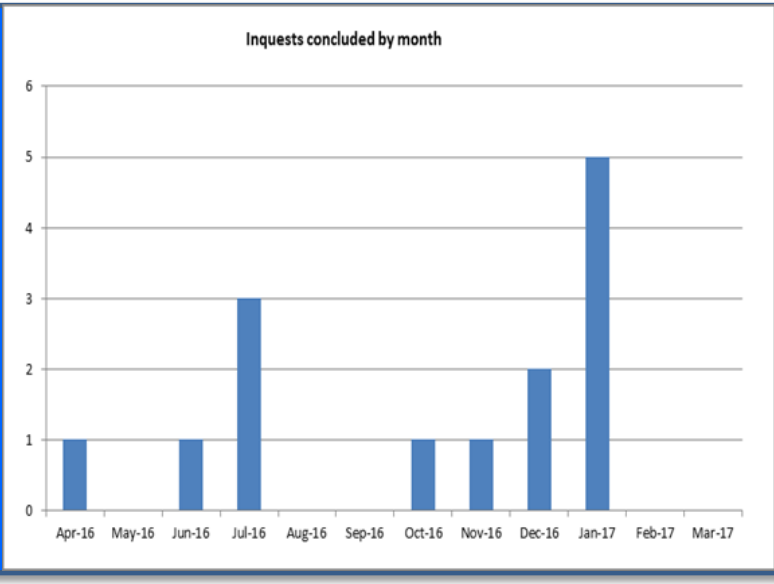
Informal Concerns Trends

Board Papers – Quality, Safety & Experience Section: May 2017

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

Description	Aggregate Position/Description	Trend
Value of claims closed by month	**Information removed under Section 43 of the Freedom of Information Act**	
Top five claims by Specialty	**Information removed under Section 43 of the Freedom of Information Act**	

Board Papers – Quality, Safety & Experience Section: May 2017

Description	Aggregate Position /Description	Trend	
Number of Inquests concluded by month	No inquests were concluded in March 2017.		Inquests
NHS Choices Star Ratings	Leighton Hospital is rated at 4.5 stars. Victoria Infirmary, Northwich is rated at 5 stars. The ratings are based on 264 postings received to date.		NHS Choices – Star Ratings

Board Papers – Quality, Safety & Experience Section: May 2017

Description	Aggregate Position /description	Trend

NHS Choices postings

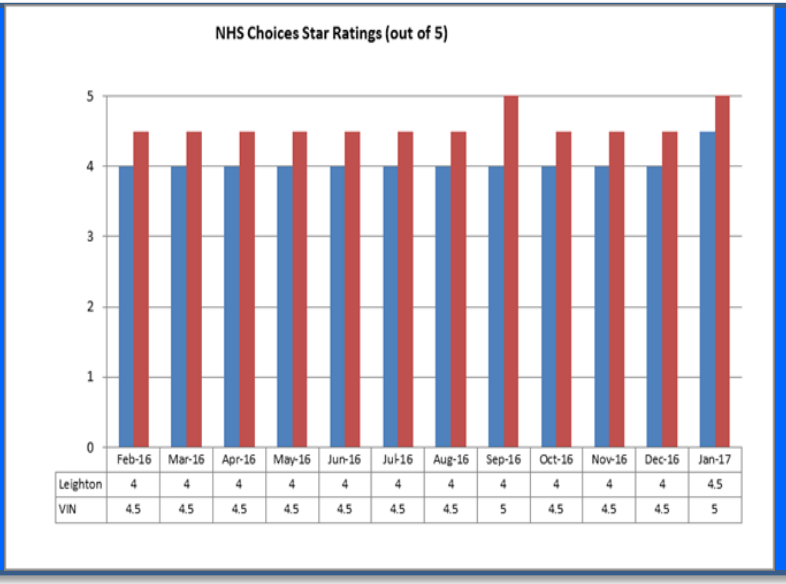
There were 14 postings on NHS Choices in March 2017. Examples of feedback included:

"all the staff involved very considerate and professional. Having had an operation previously in a London hospital the standard of care is very high at the treatment centre here" (Cytoscopy)

"my wife …suffers with anxiety and this midwife helped her through her thoughts. I couldn't have a asked or wished for a better midwife to deliver my children" (labour ward)

I cannot praise the lovely staff highly enough. I was treated as an individual and not just "another patient." (treatment centre, colonoscopy)

"Whilst I appreciate that it is a very busy department feeding both inpatients and outpatients, I do feel that the wait of 45 minutes was far too excessive." (pharmacy)



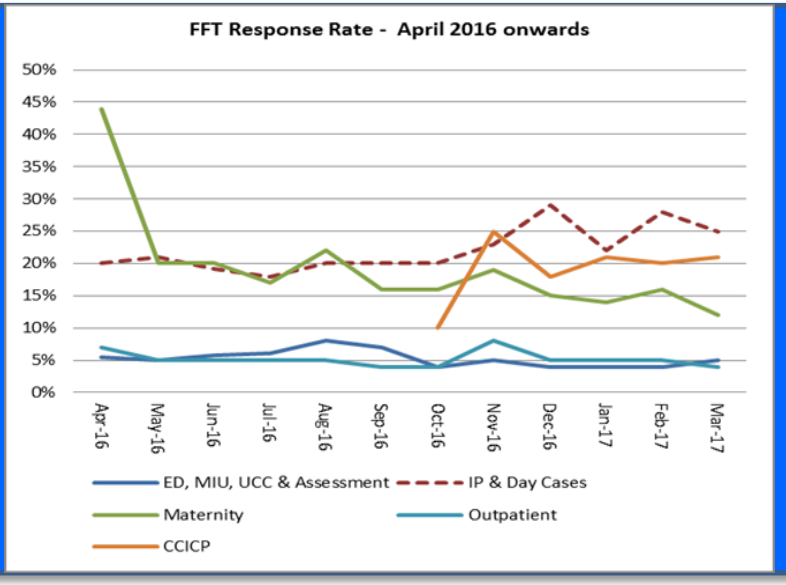
NHS Choices - Postings

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

In March 2017 the Trust has scored the following positive response scores :

Inpatients and day cases	99%
Emergency care /Assessment areas	97%
Outpatients	97%
Maternity	96%
CCICP	91%

2686 responses were received and 97% of those patients would recommend our hospital services.



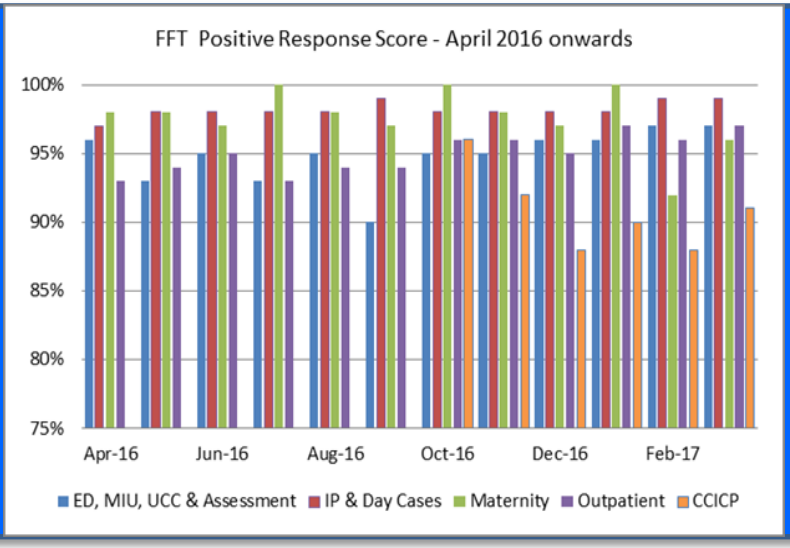
Family & Friends Test

Board Papers – Quality, Safety & Experience Section: May 2017

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

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

March 2017 Ward/Dept	% Response	Total Responses received	How many would recommend
A&E , UCC & MIU	5%	271	263
Inpatients & Daycases	25%	1123	1107
Maternity	12%	28	27
Outpatients	4%	768	738
CCICP	21%	433	395

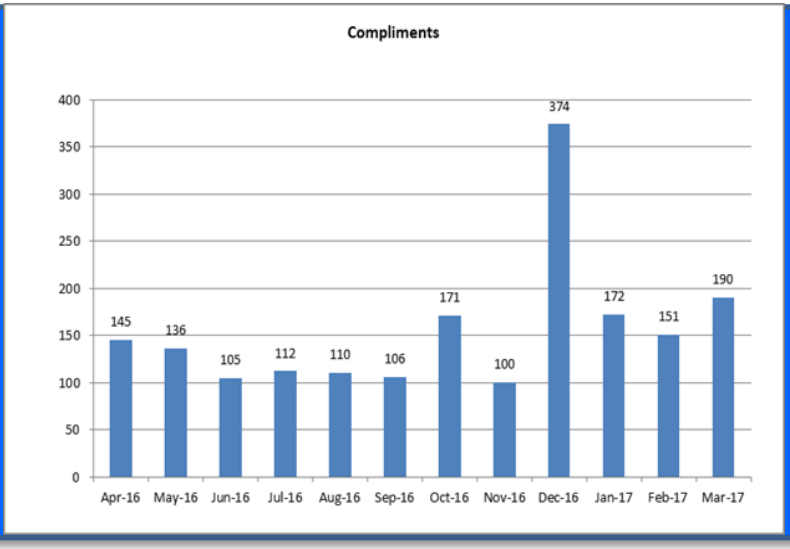


Family & Friends Test

Compliments received

There were 190 compliments/thank-you's received for March 2017.

'Just to say a huge thank-you to Victoria Infirmary for being there for me and my family over the years. It is such a fantastic hospital so a deep thank-you to all.'
'We would like to register a commendation for the professional care our daughter received from your Paediatric Continence Service. Her treatment has been completely successful and we are all delighted with the kindness, respect and patience that staff showed to us all. A big thank you!'



Compliments

Mid Cheshire Hospitals NHS
NHS Foundation Trust

2016 NHS Staff Survey

EVERY 1 MATTERS
PATIENTS RESULTS FINANCE PARTNERS STAFF

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Content

- MCHFT response rates
- How does 2016 compare to 2015
  - Our top and bottom ranking scores
  - FFT and Engagement Scores
- Improvements
- Changes to Questions
- Benchmarking and National Performance
- Proposed areas for action & next Steps

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Mid Cheshire Hospitals NHS
NHS Foundation Trust

- Response Rates

2015	2016		Trust Performance
Trust	Trust	Acute Trust Average	
60%	58%	44%	↓
503	715	42%	↑

! Increase in Sample Size

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PATIENTS RESULTS FINANCE PARTNERS STAFF

Mid Cheshire Hospitals NHS
NHS Foundation Trust

- Year on Year Comparison

Top 5 Ranking Scores	2015	2016		Trust Performance	
	Trust	Trust	Acute Trust Average		
Percentage of Staff/ Colleagues reporting most recent experiences of violence *(higher reporting is good)*	70%	77%	67%	**Improvement – Top performing Trust**	↑
Percentage of Staff agreeing that their role makes a difference to patients/ services users	89%	93%	90%	Improvement – Best 20% of Acute Trusts	↑
Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month *(lower score is better)*	26%	25%	31%	Improvement – Best 20% of Acute Trusts	↓
Fairness and effectiveness of procedures for reporting errors, near misses and incidents *(higher score is better)*	3.83	3.86	3.72	Improvement – Best 20% of Acute Trusts	↑
Percentage of staff feeling unwell due to work related stress in the last 12 months *(lower score is better)*	32%	31%	35%	Improvement – Best 20% of Acute Trusts	↓

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Mid Cheshire Hospitals NHS
NHS Foundation Trust

- Year on Year Comparison

Bottom 5 Ranking Scores	2015	2016		Trust Performance	
	Trust	Trust	Acute Trust Average		
Quality of Appraisal *(higher score is better)*	2.99	3.02	3.11	Improvement – Worse than average	↑
Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months *(lower score the better)*	25%	25%	25%	Equal result in 2015 – Average	=
Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months *(lower score the better)*	16%	15%	15%	Improvement – Average	↓
Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves *(lower score is better)*	57%	56%	56%	Improvement – Average	↓
Quality of non-Mandatory training, learning or development *(higher the better)*	4.05	4.06	4.05	Improvement - Average	↑

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Mid Cheshire Hospitals NHS
NHS Foundation Trust

- Where are our 2015 Bottom 5 Ranking Scores in 2016?

	2015		2016	
	Trust	Benchmark against other Acute Trusts	Trust	Benchmark against other Acute Trusts
KF3: Percentage of staff agreeing that their role makes a difference to patients/service users	89%	Below (worse than) average	93%	Best 20% of Acute Trusts
KF22: Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months	16%	Above (worse than) average	15%	Average
KF12: Quality of Appraisals	2.99	Below (worse than) average	3.02	Below (worse than) average
KF15: Percentage of staff satisfied with the opportunities for flexible working patterns	48%	Below (worse than) average	52%	Better than average
KF9: Effective team working	3.71	Average	3.82	Best 20% of Acute Trusts

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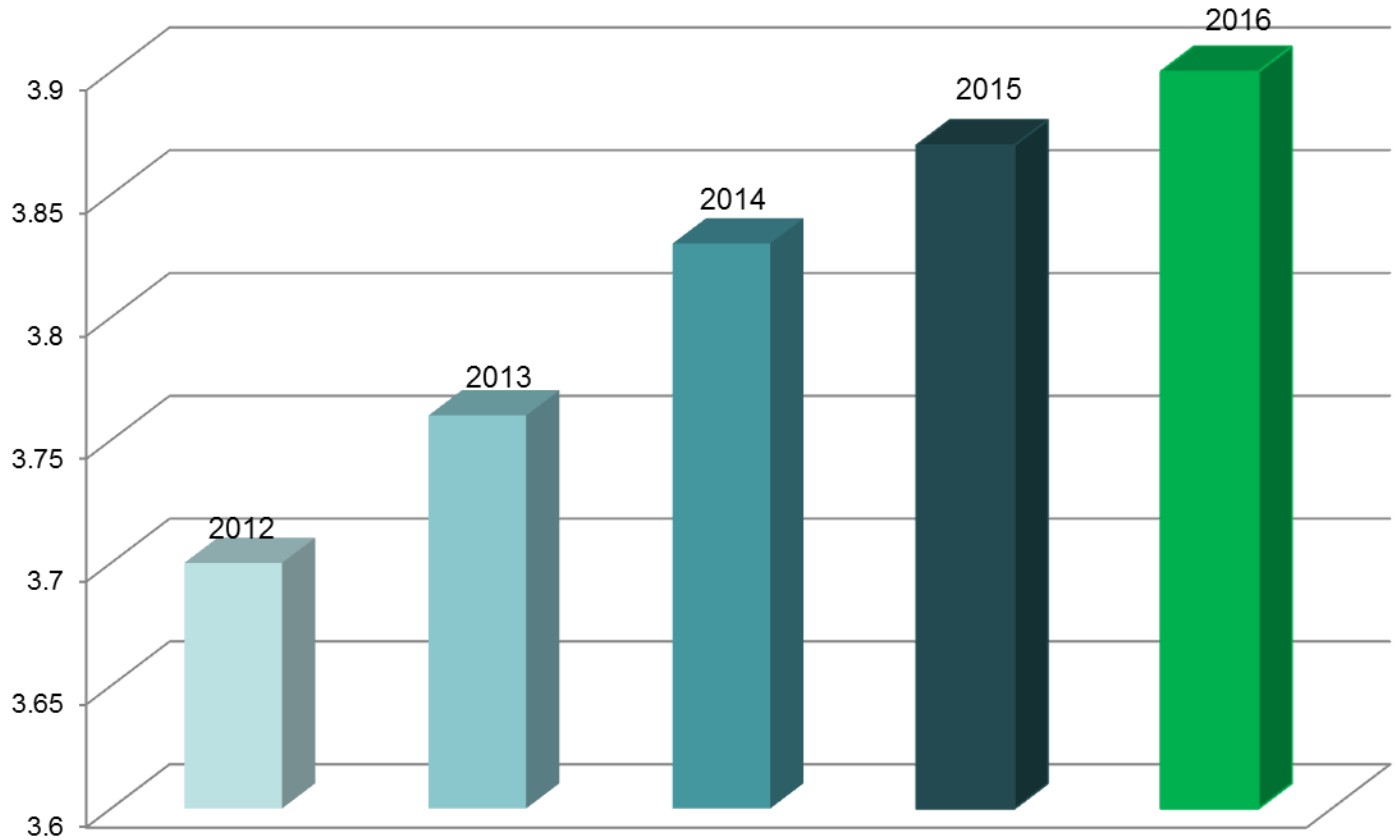
NHS Foundation Trust

- Our Staff Engagement Story



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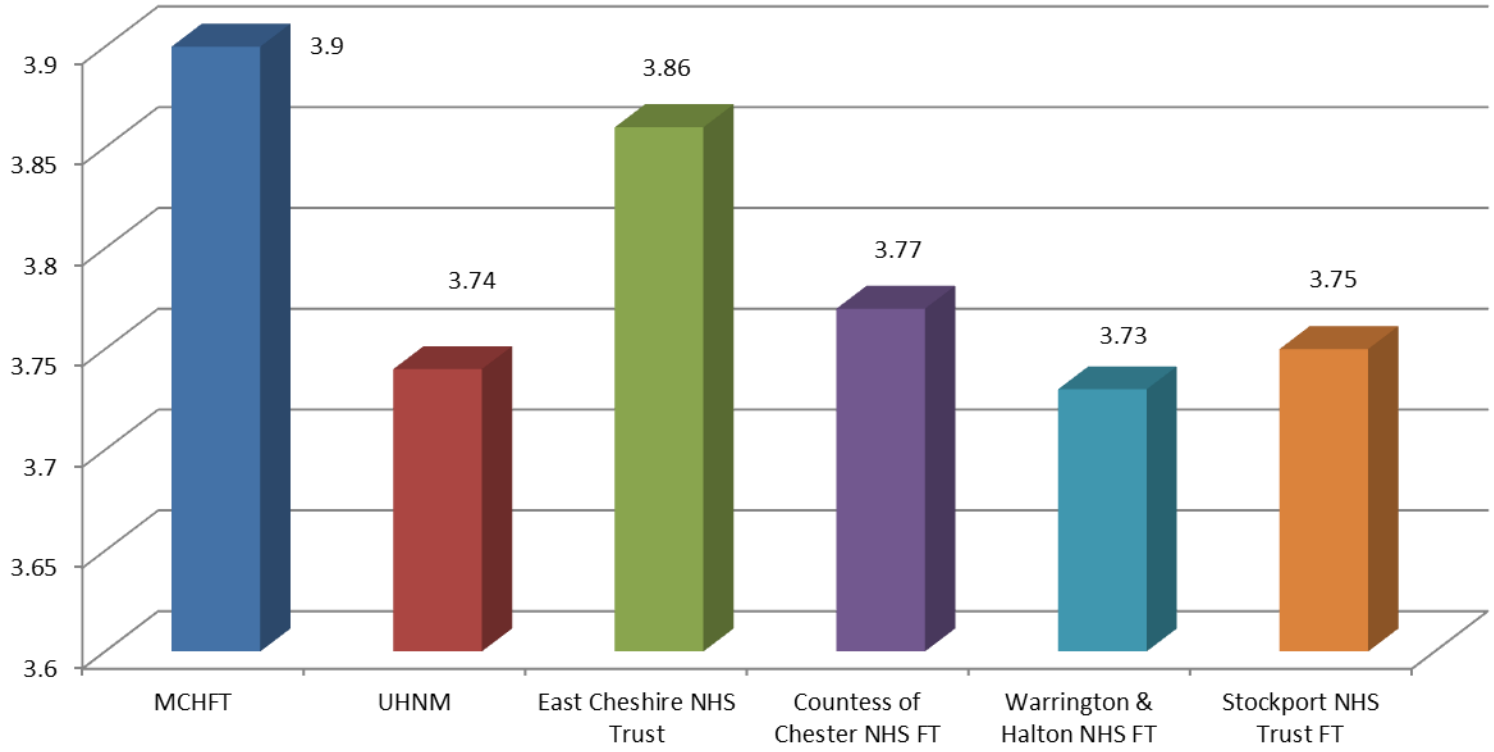
Staff Engagement Score Comparison



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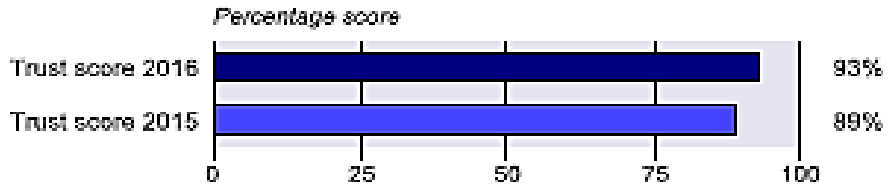
Mid Cheshire Hospitals NHS
NHS Foundation Trust

- Most Improved Responses

Where Staff Experience has Improved

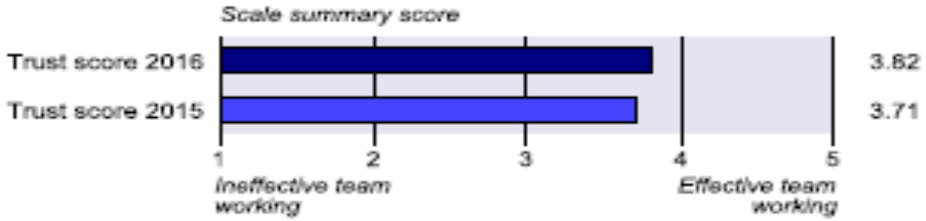
Percentage of staff Agreeing that their role makes a difference to patients/ service users

(the higher the score the better)



Effective Team Working

(the higher the score the better)



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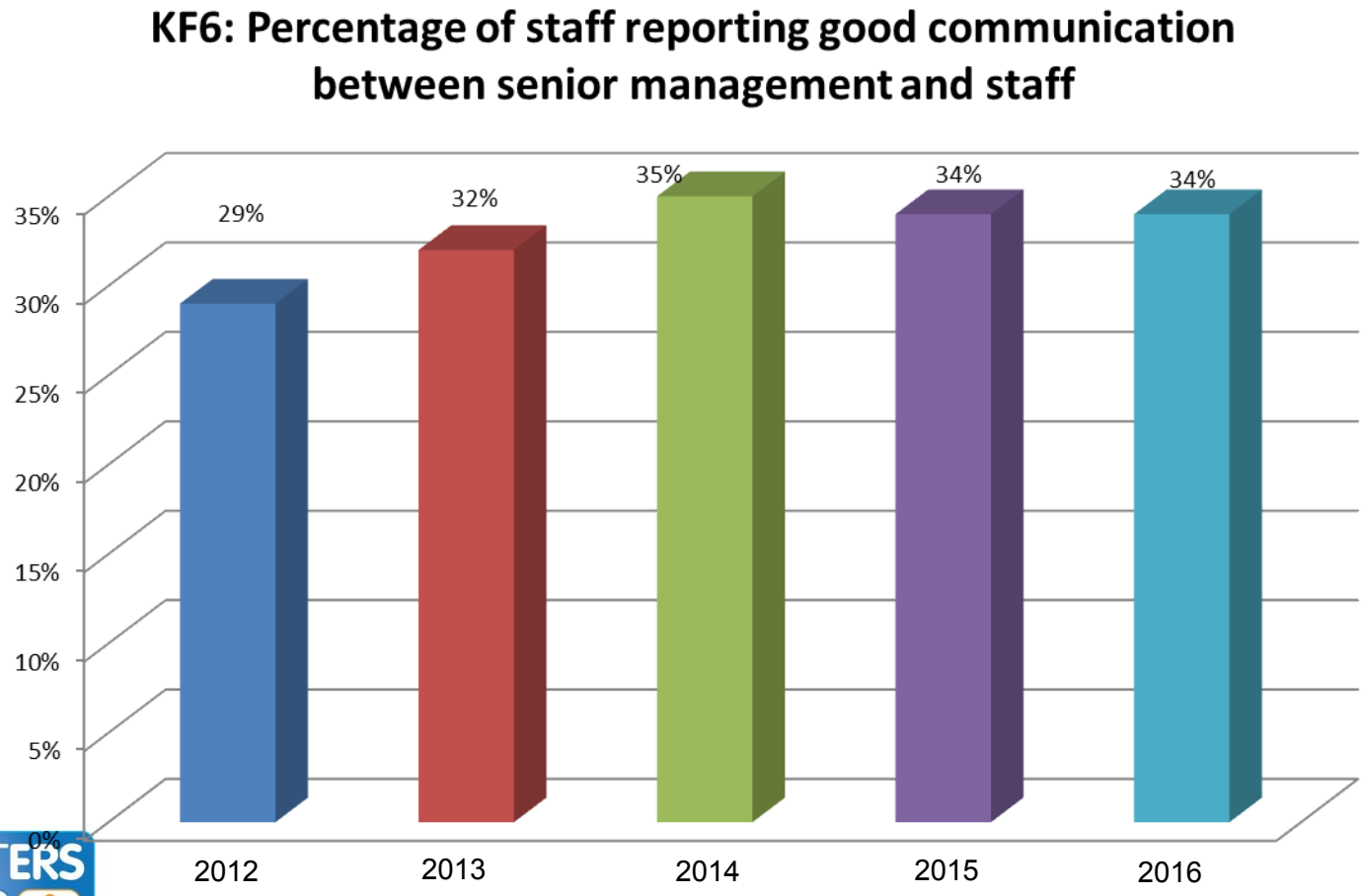
Mid Cheshire Hospitals NHS
NHS Foundation Trust

- Area where the Trust is scoring consistently worse



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Mid Cheshire Hospitals NHS
NHS Foundation Trust

- Benchmarking all 32 Indicators against Acutes Trusts shows we are …

◎ In the best 20% of acute Trusts in 16 areas

◎ Better than average in 11 areas

◎ Average in 4

◎ Below Average in 1 area

◎ 0 areas in the worst 20%

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PATIENTS RESULTS FINANCE PARTNERS STAFF

Listening into Action

Optimise

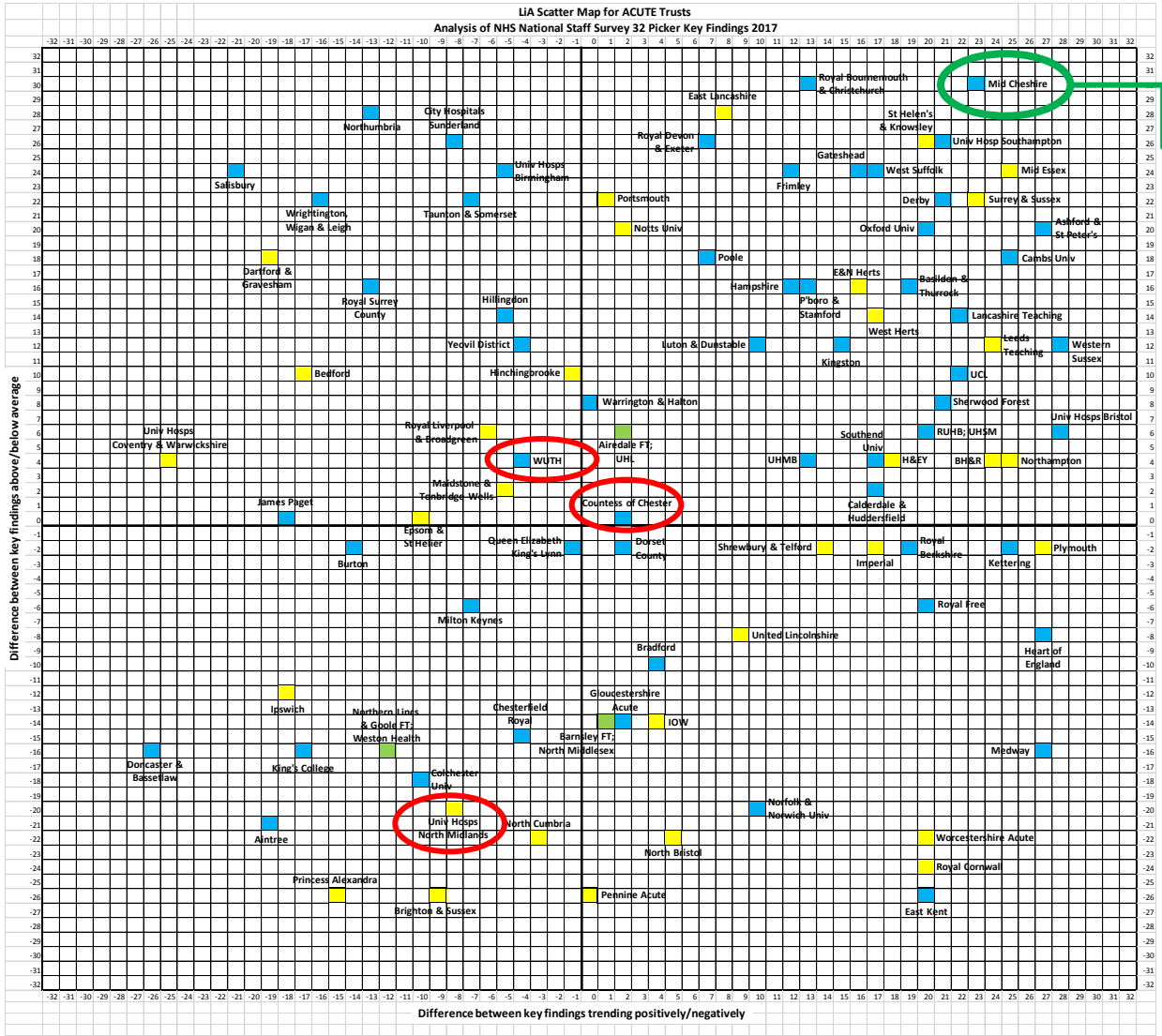
2017 LiA League Table - ACUTE Trusts

2016-17 Comparative Ranking	Trend	Trust
1	5	Mid Cheshire Hospitals FT
2	17	The Royal Bournemouth & Christchurch Hospitals FT
3	-	East Lancashire Trust
4	3	Northumbria Healthcare FT
5	4	University Hospital Southampton FT
6	12	St Helens & Knowsley Teaching Hospitals Trust
7	9	Royal Devon & Exeter FT
8	6	City Hospitals Sunderland FT
9	76	Mid Essex Hospital Services Trust
10	30	West Suffolk FT
11	1	Gateshead Health FT
12	n/a	Frimley Health FT (formed in 2015)
13	2	University Hospitals of Birmingham FT
14	12	Salisbury FT
15	16	Surrey & Sussex Healthcare Trust
16	12	Derby FT
17	5	Portsmouth Hospitals Trust
18	14	Taunton & Somerset FT
19	15	Wrightington Wigan & Leigh FT
20	66	Ashford & St Peter's FT
21	46	Oxford University Hospitals FT
22	8	Nottingham University Hospitals Trust
23	13	Cambridge University Hospitals FT
24	16	Poole Hospital FT
25	9	Dartford & Gravesham Trust
26	20	Basildon & Thurrock University FT
27	14	East & North Hertfordshire Trust
28	5	Peterborough & Stamford Hospitals FT
29	3	Hampshire Hospitals FT
30	1	Royal Surrey County Hospital FT
31	19	Lancashire Teaching Hospitals FT
32	11	West Hertfordshire Hospitals Trust
33	12	The Hillingdon Hospitals FT
34	33	Western Sussex Hospitals FT
35	25	Leeds Teaching Hospitals Trust
36	6	Kingston Hospital Trust
37	19	Luton & Dunstable Hospital FT
38	15	Yeovil District FT
39	12	University College London Hospitals FT
40	3	Hinchingbrooke Healthcare Trust
41	14	Bedford Hospital Trust
42	34	Sherwood Forest FT
43	15	Warrington & Halton FT
44	17	University Hospitals Bristol FT
45=	n/a	Royal United Hospitals Bath FT (not in 2015 results)
45=	48	University Hospital of South Manchester FT
47=	14	Airedale FT
47=	17	University Hospitals of Leicester Trust
49	26	Royal Liverpool & Broadgreen University Hospitals
50	41	Northampton General Hospital Trust
51	17	Barking Havering & Redbridge University Trust
52	23	Hull & East Yorkshire Trust
53	8	Southend University Hospital FT
54	11	University Hospitals of Morecambe Bay FT
55	20	Wirral University Teaching Hospital FT
56	49	University Hospitals Coventry & Warwickshire Trust
57	9	Calderdale & Huddersfield FT
58	20	Maidstone & Tunbridge Wells Trust
59	4	Countess of Chester Hospital FT
60	49	Epsom & St Helier University Hospitals Trust
61	48	James Paget University Hospitals FT
62	8	Plymouth Hospitals Trust
63	31	Kettering General Hospital FT
64	15	Royal Berkshire FT
65	7	Imperial College Healthcare Trust
66	15	Shrewsbury & Telford Hospital Trust
67	28	Dorset County Hospital FT
68	6	The Queen Elizabeth Hospital King's Lynn FT
69	49	Burton Hospitals FT
70	n/a	Royal Free London FT
71	23	Milton Keynes Hospital FT
72	15	Heart of England FT
73	-	United Lincolnshire Hospitals Trust
74	8	Bradford Teaching FT
75	53	The Ipswich Hospital Trust
76	4	Isle of Wight Acute Sector Trust
77	18	Gloucestershire Hospitals FT
78=	34	Barnsley FT
78=	-	North Middlesex University Hospitals Trust
80	11	Chesterfield Royal Hospital FT
81	15	Medway FT
82=	11	Northern Lincolnshire & Goole Hospitals FT
82=	19	Weston Area Health Trust
84	27	King's College Hospital FT
85	31	Doncaster & Bassetlaw Hospitals FT
86	12	Colchester Hospital University FT
87	8	Norfolk & Norwich University Hospitals FT
88	n/a	University Hospitals of North Midlands Trust (new 2016)
89	42	Aintree University Hospital FT
90	2	Worcestershire Acute Hospitals Trust
91	n/a	North Bristol Trust
92	10	North Cumbria University Hospitals Trust
93	4	Royal Cornwall Hospitals Trust
94	6	East Kent Hospitals University FT
95	13	Pennine Acute Hospitals Trust
96	6	Brighton & Sussex University Hospitals Trust
97	45	The Princess Alexandra Hospital Trust

Listening into Action

Optimise

2017 LiA Scatter Map of NSS 32 Picker Key Findings - ACUTE Trusts



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NHS Foundation Trust

Next Steps and Actions

- Appraisal techniques and training
- Address behaviours that fall below our expectations and do not fit with our values
- Reduce bullying and harassment in the workplace
- Encourage our staff to report and tackle bullying and harassment with confidence;
- Expand our range of health and wellbeing services
- Review of non-Mandatory training and development

EVERY 1 MATTERS
PATIENTS RESULTS FINANCE PARTNERS STAFF

Mid Cheshire Hospitals NHS
NHS Foundation Trust

EVERY 1 MATTERS
PATIENTS RESULTS FINANCE PARTNERS STAFF

Mid Cheshire Hospitals NHS
NHS Foundation Trust

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:	2 May 2017

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Recommendation

The Board of Directors are asked to note that no sealings have taken place since the last Board report in November 2017.

Report of Sealings for the period 31 October 2016 to 30 April 2017

Seal Number	***Description***	***Date of Board Approval***	***Date of Sealing***
91	Deed of Indemnity for the transfer of staff to MCHFT from East Cheshire Trust (revised version)	Chairman's Action Reported to Board of Directors 5 December 2016	5 December 2016

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Board of Directors Performance Report

March 2017

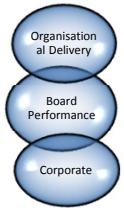
"To Deliver Excellence in Healthcare through Innovation & Collaboration"

Introduction

Performance Report

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

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



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

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

Tracy Bullock
Chief Executive

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Headline Measures

Organisational Delivery			
Indicator	**Standard**	**YTD**	**Mar-17**
Cancer			
Urgent referrals seen in 2 wks (%)	93.00%	98.12%	98.10%
No of Patients Seen		*8,659*	*842*
No of Breaches		*163*	*16*
62 day from urgent GP (%)	85.00%	92.86%	95.92%
No of Patients Seen		*666*	*49*
No of Breaches		*48*	*2*
62-day wait for first treatment from NHS Cancer Screening Service referra	90.00%	95.39%	94.74%
No of Patients Seen		*109*	*10*
No of Breaches		*5*	*0.5*
Unplanned Activity			
A&E <4hrs Standard (%)	95.00%	90.24%	97.21%
A&E Attendances LH & MIU (% to plan)		100.49%	98.53%
A&E Attendances LH & MIU (Vol)		*86,127*	*7,357*
Planned Activity			
Incomp Pathways <18wk (%)	92.00%	94.37%	95.73%
>6wk Diagnostic Waits (%)	1.00%	0.34%	0.09%
Total Patients Waiting for a First Outpatient Appointment			7,057

Indicator	**Standard**	**YTD**
Workforce		
Sickness absence Rolling 12 Month		3.95%
Turnover Rolling 12 Month		10.91%

Corporate					
	YTD Rating		YE Rating	YE Metric	
Indicator	**Plan**	**Actual**	**Forecast**	**Plan**	**Forecast**
Finance					
Use of Resource Rating		3	3		
Capital Service Capacity	4	2	3	0.80	1.49
Liquidity	4	4	4	-23	-20
I&E Margin	4	2	3	-0.32%	-0.49%
Distance from Financial Plan	0	1	2	0.00%	-0.17%
Agency Spend	1	2	3	0.00%	30.30%

	YTD Target	**YTD Actual**	**YTD Variance**	**FY Target**	**FY Forecast**	**FY Variance**
Cost Improvement Scheme Total (£000's)	3,315	3,327	12	3,315	3,327	12
Revenue Generation Scheme total (£000's)	3,694	2,324	-1,370	3,694	2,324	-1,370
Commission Contact Income SC & VR (£000's)	152,596	154,000	1,403			
Contract Income (£'000) Net of Drugs	195,579	191,524	-4,054			
Pay to Budget (£000's)	-155,962	-152,843	3,119			
Non Pay to Budget (£000's) Net of Drugs	-56,055	-56,402	-348			
Agency Trajectory (£000's)	-6,203	-7,195	-992			

Exec Summary

In March, the Trust delivered all five NHS Improvement Single Oversight Framework performance indicators. For the first time in 2017/18, this includes the 4-hour A&E standard for the first time since December 2015, with over 97% of patients admitted, transferred or discharged from A&E within the 4 hour standard.

The Trust continues to achieve the 92% standard for RTT 18 week incomplete pathways, with performance in March being 95.7%. The month also saw the Trust achieve the Non-Admitted RTT element for the second consecutive month, but did not achieve the target for Admitted patients.

Diagnostics waiting times continued to perform well, with just 0.09% of patients waiting longer than 6 weeks for their diagnostic test against a threshold of 1%.

Cancer services continue to perform strongly across all key performance indicators, with all standards being achieved in March 2017.

The volume of GP referrals continues to be below target, however the number of referrals received has increased considerably against the February position and that of March 2016. Elective activity remains low, with March continuing to see both inpatient and day case spells 12% below planned levels.

The UoRR metric is 3, primarily a result of the override resulting from the Liquidity rating of 4. The liquidity rating is a result of working capital equivalent to -18 days of operating expenditure, prior to the support of the working capital facility provided by NHSI.

The Trust's I&E position is a deficit of £0.6M against a planned deficit of £0.6M The main areas resulting in this worse than planned position, excluding drugs offsets are Contract Income (£4.1M), Other Income £0.7M, Pay £3.1M, Non-Pay £0.4M and Depreciation £0.5M. The movement in month is related to the recently agreed settlement on the contract with South Cheshire & Vale Royal of £154.0M which is £3.0M less than the forecast value.

The Trust is meeting its CIP target but has not delivered the Revenue Generation due to gaps in the clinical workforce.

The Trust is currently £1.0M behind its Agency spend trajectory which for the full year is £6.2M being £3.5M less than 2015/16.

Single Oversight Framework

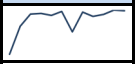
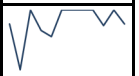
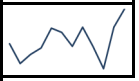
Triggers

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

The Trust operational trigger rating continues as RED as a result of failure of a primary target during the year (A&E 95% 4-hour waiting time),despite this being achieved during the month of March 2017 itself.

The Trust has a Use of Resource rating of 3 cumulative and is forecasting a rating of 3 for the full year. This results in a 'trigger' on the Finance & Resource theme. This is primarily driven by the liquidity rating as a result of our underlying low cash balance for which the Trust is receiving targeted support in the form of a working capital facility. The Trust is worse than plan for its I&E margin ytd but is expected to meet its control total plan by year end. The Agency trajectory target is currently not being met with a worsening position since October.

Operational Performance

	Current YTD													Monthly Trend
	Target	Actual	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	
Maximum 6 week wait for Diagnostic procedures	1%	0.34%	1.22%	0.49%	0.18%	0.16%	0.21%	0.11%	0.63%	0.13%	0.24%	0.18%	0.07%	0.09%	
All Cancers: 62-day wait for first treatment from urgent GP referral (%)	85%	92.86%	91.49%	96.55%	89.47%	92.81%	89.76%	95.24%	95.37%	92.74%	93.67%	91.40%	89.90%	95.92%	
All Cancers: 62-day wait for first treatment from NHS Cancer Screening Service referral (%)	90%	95.39%	94.74%	77.78%	100.00%	92.31%	90.00%	100.00%	100.00%	100.00%	100.00%	94.12%	100.00%	94.74%	
18 weeks from point of referral to treatment - patients on an incomplete pathway (%)	92%	94.37%	94.65%	94.80%	93.95%	93.99%	93.52%	93.50%	93.49%	94.47%	94.26%	95.32%	95.49%	95.73%	
A&E - maximum waiting time of 4 hours from arrival to admission/transfer/discharge (%)	95%	90.24%	89.78%	85.57%	87.46%	88.86%	93.12%	92.18%	89.21%	93.33%	89.25%	84.47%	93.33%	97.21%	
A&E STF Trajectory			88.0%	89.0%	92.0%	95.0%	95.0%	95.0%	92.0%	92.0%	92.0%	93.5%	92.0%	92.8%	

Financial & Resource

		Unit	YE Plan	YE Forecast	YE Rating	YTD Plan	YTD Actual	YTD Rating
Financial Sustainability	Capital Service Capacity	0.0x	0.80	1.49	3	0.60	1.91	2
	Liquidity	days	-23	-20	4	-23	-18	4
Financial Efficiency	I&E Margin	%	-0.32%	-0.49%	3	-1.43%	0.24%	2
Financial Controls	Distance from Financial Plan	%	0.00%	-0.17%	2	0.00%	1.67%	1
	Agency Spend	%	0.00%	30.30%	3	0.00%	23.96%	2
Overall UOR Rating					3			3

Operational Delivery: *Cancer Pathway*

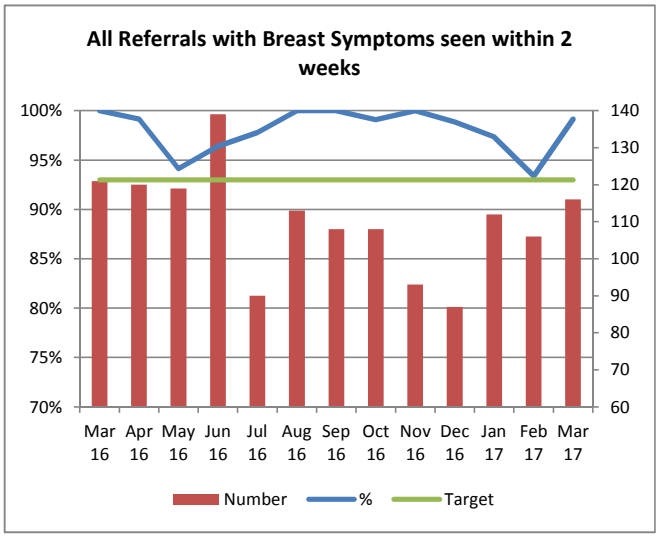
Headline Measures

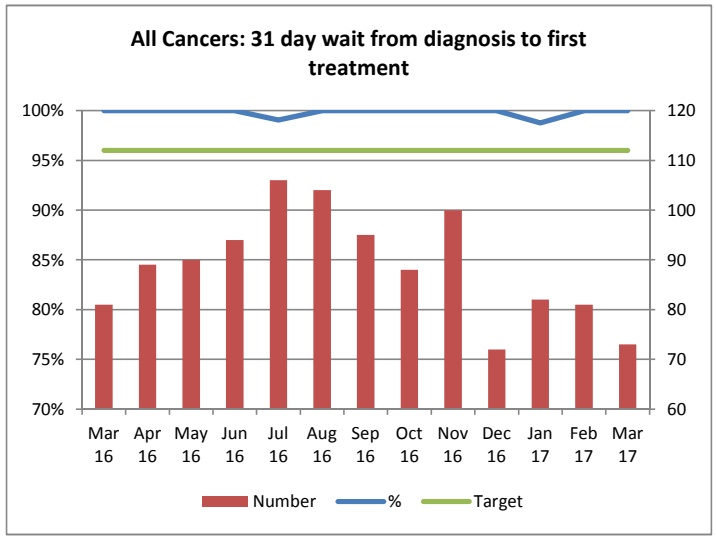
	Current YTD		Rolling 13 months											
	Target	Actual	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Monthly Trend
Urgent GP referrals seen within 2 weeks (% to Target)	93%	98.12%	96.61%	97.09%	97.55%	96.86%	98.20%	98.55%	98.25%	98.60%	98.79%	98.93%	97.66%	99.15%	98.10%	
Number of Referrals		*8659*	*708*	*755*	*774*	*795*	*666*	*685*	*687*	*713*	*743*	*652*	*641*	*706*	*842*	
Number of Breaches		*163*	*24*	*22*	*19*	*25*	*12*	*10*	*12*	*10*	*9*	*7*	*15*	*6*	*16*	
% seen within 7 days		*56.9%*							*58.7%*	*64.5%*	*62.0%*	*51.1%*	*69.1%*	*54.3%*	*63.1%*	
62 day wait for 1st treatment from urgent GP referral for suspected cancer (% to Target)	85%	92.86%	93.41%	91.49%	96.55%	89.47%	92.81%	89.76%	95.24%	95.37%	92.74%	93.67%	91.40%	89.90%	95.92%	

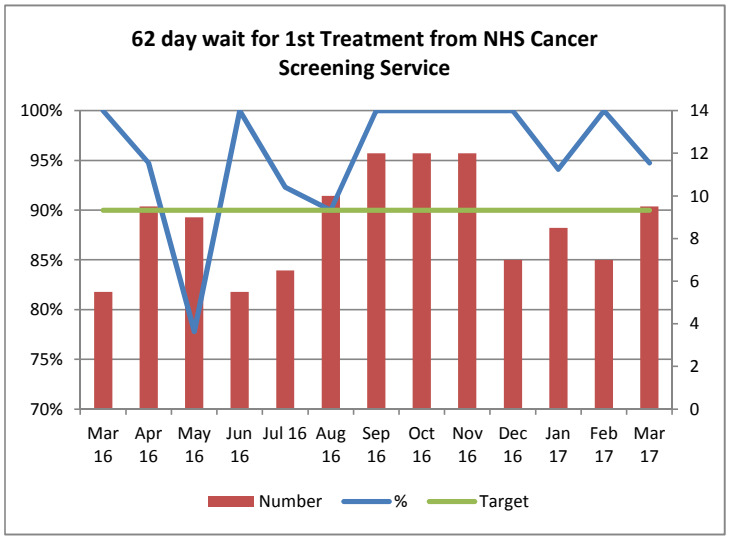
Commentary

The Trust has achieved all cancer standards during the month of March 2017 and has met the headline measuresfor cancer access in every month of the 2017/17 financial year.

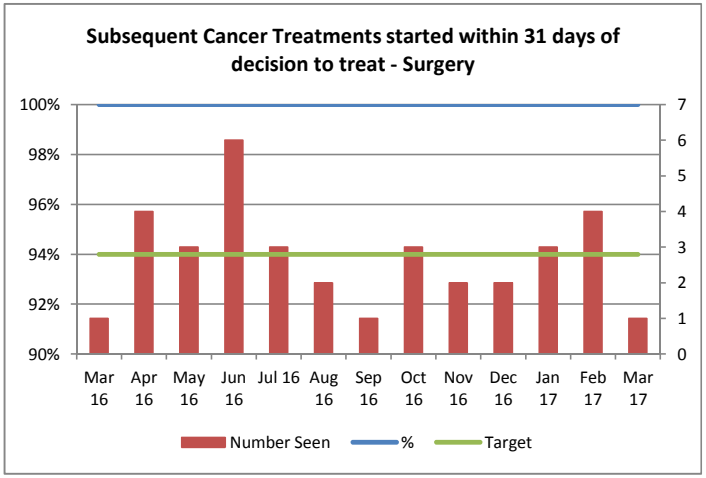
Primary Measures

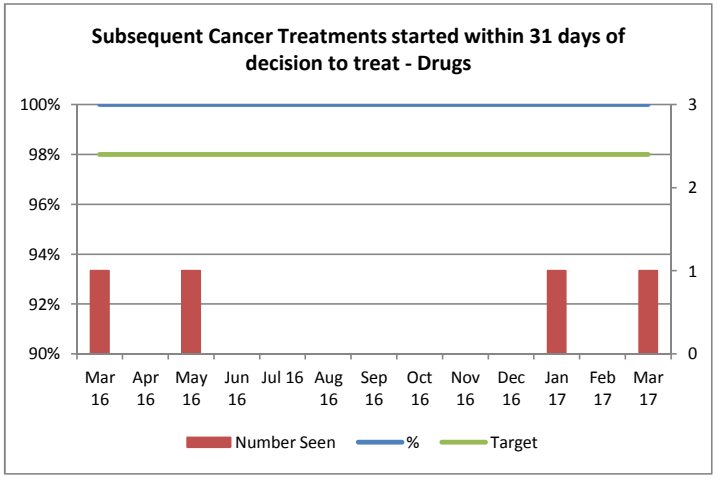


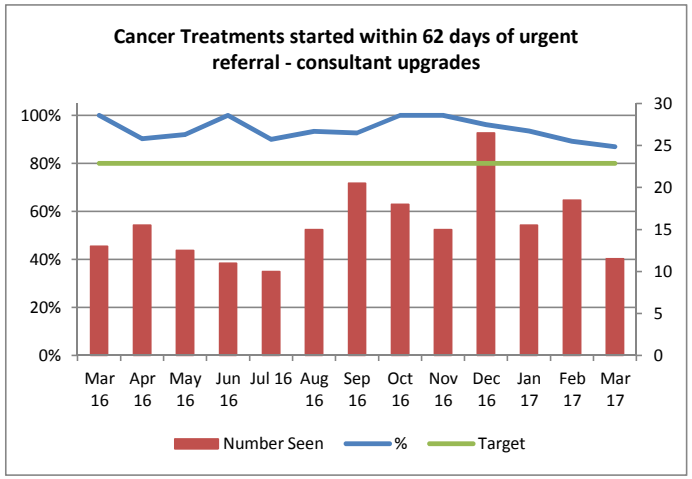




Operational Delivery: *Cancer Pathway*







Operational Delivery: *Unplanned Activity - A&E*

Headline Measures

	Current YTD		Rolling 13 months												
	Target	Actual	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Monthly Trend
A&E - >4 hr wait time from arrival to admission/ transfer/ discharge (% to Target)	95%	90.24%	84.52%	89.78%	85.57%	87.46%	88.86%	93.12%	92.18%	89.21%	93.33%	89.25%	84.47%	93.33%	97.21%	
No. of 4hr breaches		*8,405*	*1,215*	*709*	*1,128*	*934*	*854*	*503*	*570*	*813*	*443*	*753*	*1,082*	*411*	*205*	

	Plan	Actual	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Monthly Trend
A&E Attendances Leighton & MIU (% to Plan)		*100.49%*	*102.2%*	*98.0%*	*104.2%*	*101.1%*	*99.3%*	*100.1%*	*103.6%*	*104.1%*	*97.2%*	*100.5%*	*103.7%*	*95.1%*	*98.5%*	
A&E Attendances Leighton & MIU (No.)	*79,842*	*86,127*	*7,215*	*6,937*	*7,816*	*7,447*	*7,663*	*7,307*	*7,288*	*7,533*	*6,643*	*7,005*	*6,965*	*6,166*	*7,357*	

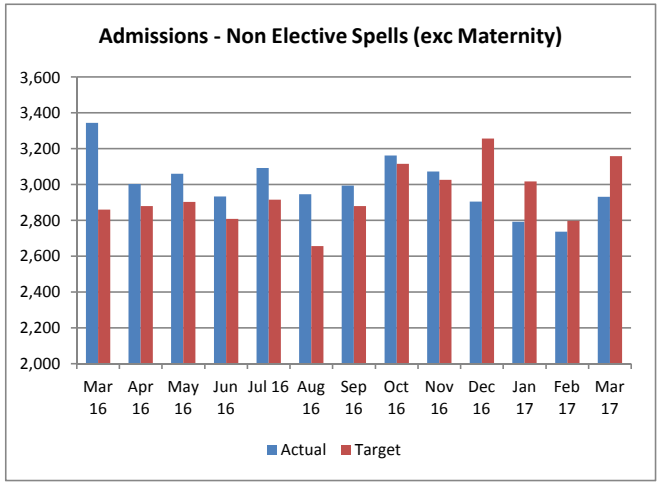
A&E Attendance Case Mix (Leighton)	*Major*		*57.70%*	*58.3%*	*59.6%*	*54.8%*	*56.6%*	*58.0%*	*59.6%*	*57.6%*	*59.0%*	*60.4%*	*59.3%*	*56.2%*	*56.1%*	*55.8%*	
	Minor		*34.94%*	*34.3%*	*34.9%*	*38.1%*	*37.9%*	*36.6%*	*35.6%*	*37.7%*	*35.0%*	*33.8%*	*32.7%*	*32.1%*	*32.4%*	*32.0%*	
	Resus		*3.27%*	*4.8%*	*3.5%*	*4.6%*	*3.5%*	*3.4%*	*2.5%*	*2.3%*	*3.1%*	*2.8%*	*4.2%*	*4.1%*	*2.9%*	*2.3%*	
	Unknown/UCC		*4.09%*	*2.7%*	*2.0%*	*2.5%*	*2.0%*	*2.0%*	*2.3%*	*2.3%*	*2.9%*	*3.1%*	*3.8%*	*7.6%*	*8.6%*	*9.9%*	

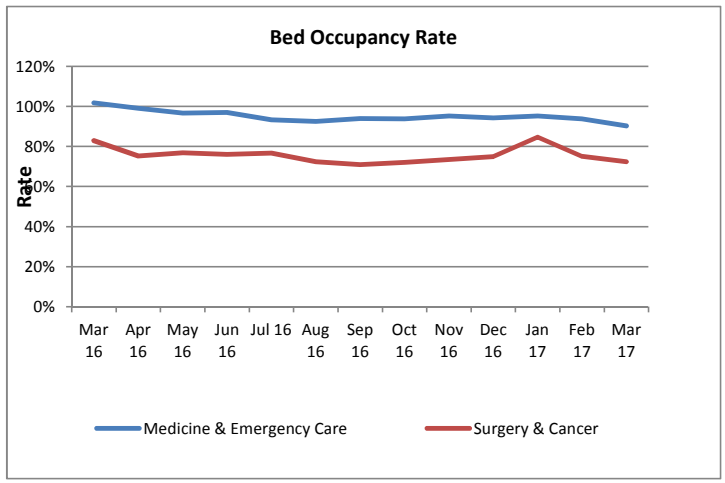
Commentary

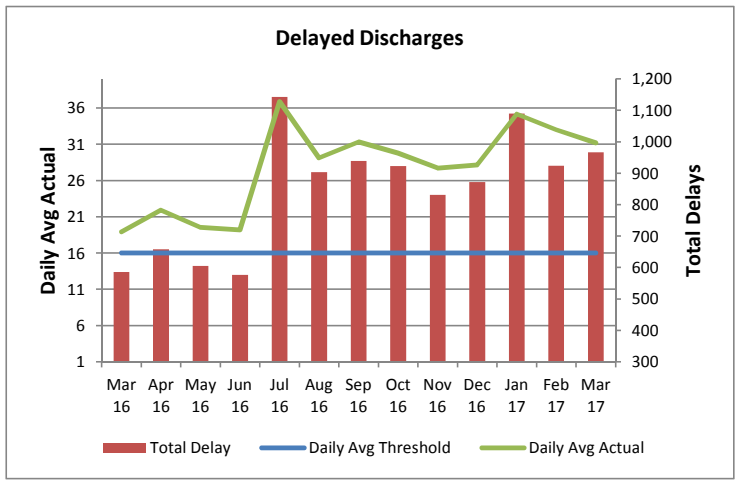
ED attendances in March 2017 increased considerably compared to February 2017 and were also higher than March 2016. The Trust achieved 97.2% against the 95% 4 hour access standard., an improvement form 93.3% for February 2017, which itself was comparatively strong performance both against peer and against the same period in 2016. The improvements experienced can be attributed to the combined affect of service changes implementedthrough the Access& Flow programme, lower than expected bed occupancy levels and implementation of the Rapid Assessment & Treatment cubicles within ED. In recent months, performance agains this measure in Mid Cheshire has consistently been in the top quartile nationally.

Non-elective admissions remain below target levels, with March seeing emergency admission rates below plan for the fourth consecutive month. Formally reportable delayed discharges (DTOCs) remain high,

Primary Drivers

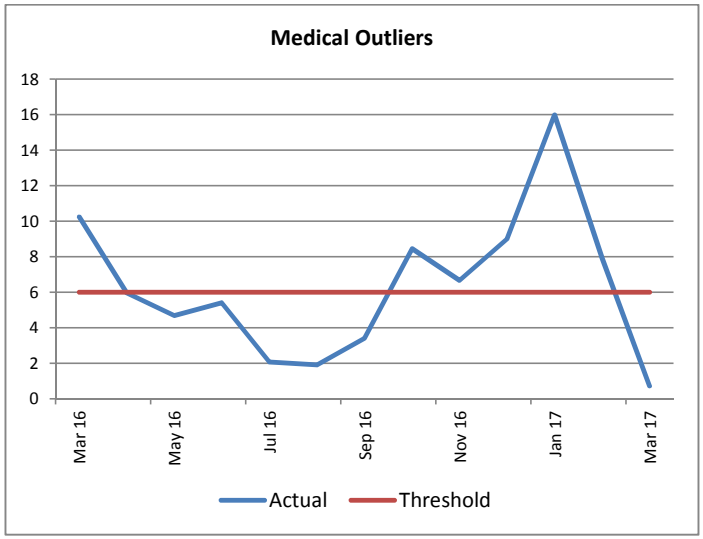


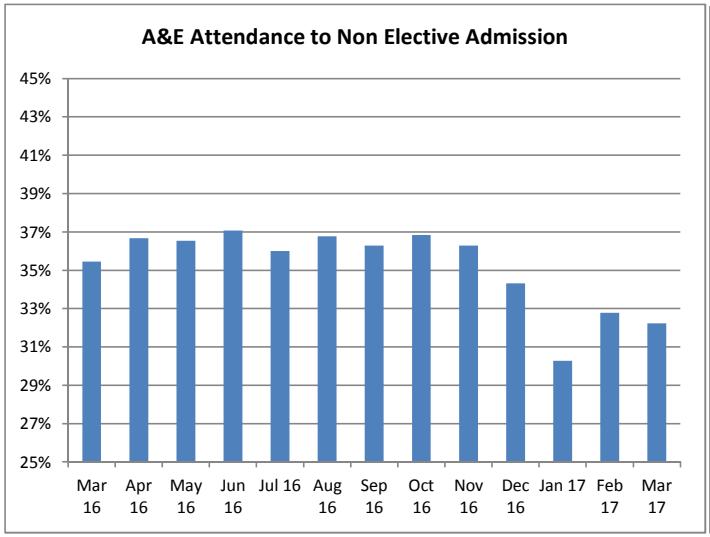


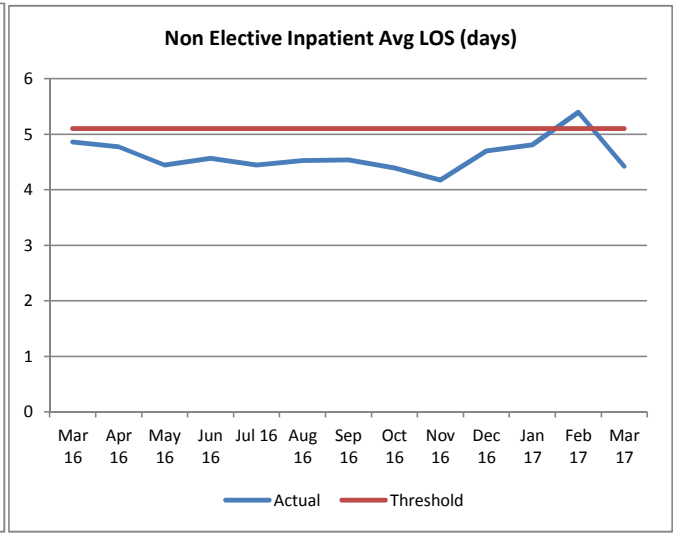


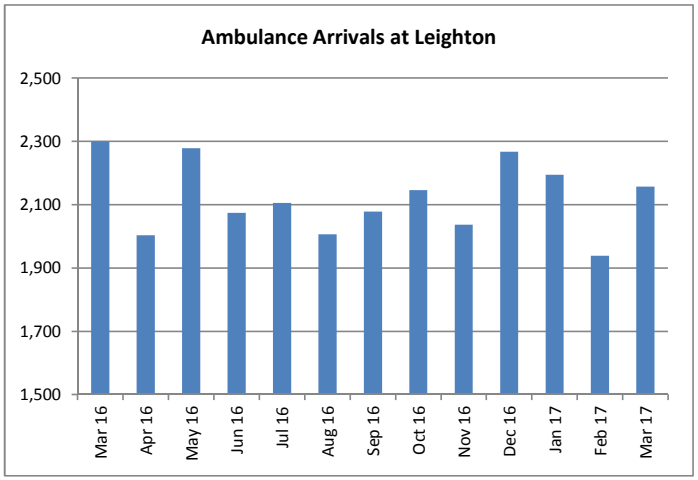
Operational Delivery: *Unplanned Activity A&E*

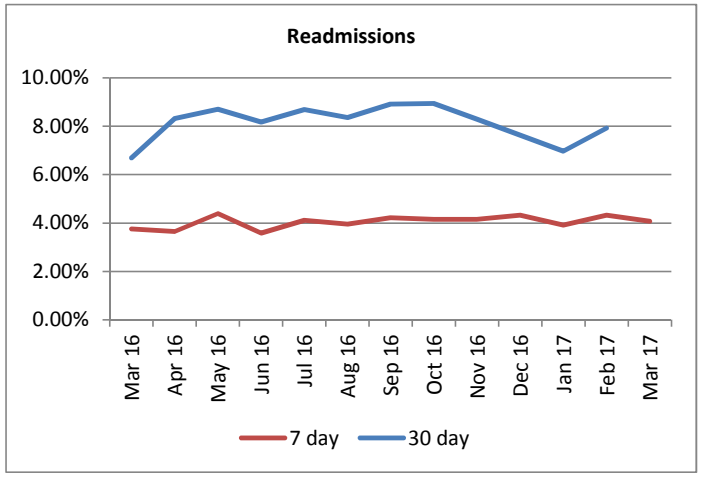
Secondary Drivers

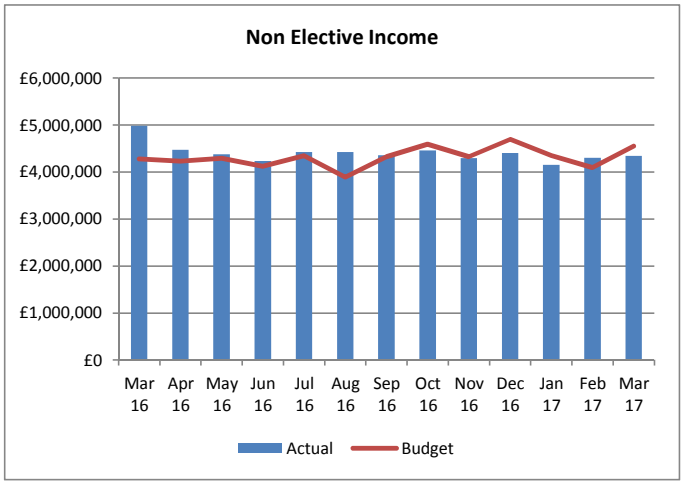












Operational Delivery: *Planned Activity*

Headline Measures

	Current YTD		Rolling 13 months											
	Target	Actual	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Monthly Trend
18 weeks from Referral to Treatment in Aggregate - Incomplete	92%	94.37%	94.56%	94.65%	94.80%	93.95%	93.99%	93.52%	93.50%	93.49%	94.47%	94.26%	95.32%	95.49%	95.73%	
Total 18 Weeks		*182,225*	*15,435*	*17,025*	*16,956*	*17,358*	*17,158*	*16,688*	*15,923*	*14,876*	*14,191*	*13,780*	*12,696*	*12,570*	*13,004*	
No. > 18 Weeks		*10,251*	*839*	*910*	*882*	*1,050*	*1,032*	*1,081*	*1,035*	*969*	*785*	*791*	*594*	*567*	*555*	
Diagnostic Waiting Time	1%	0.34%	0.98%	1.22%	0.49%	0.18%	0.16%	0.21%	0.11%	0.63%	0.13%	0.24%	0.18%	0.07%	0.09%	
Total Number of Waiters		*54,046*	*3,678*	*5,588*	*7,121*	*6,149*	*4,358*	*3,806*	*3,767*	*3,630*	*3,149*	*3,826*	*3,786*	*4,305*	*4,561*	
Waiters of 6 Weeks +		*183*	*36*	*68*	*35*	*11*	*7*	*8*	*4*	*23*	*4*	*9*	*7*	*3*	*4*	
Total Patients Waiting for a First Outpatient Appointment			9,905	10,673	10,720	10,937	10,967	10,746	10,155	9,544	8,359	7,842	7,205	7,812	7,057	
Longest Wait Time (weeks) - under development																

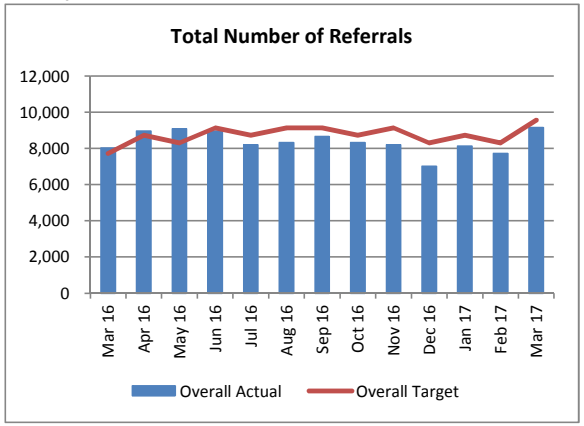
Commentary

The Trust reported 95.7% against the 92% incomplete pathways standard for RTT,. This puts the Trust at a year-end position of 94.37% against the 92% standard. he improvement in performance has largely been driven by the reduction in long waiters in the specialty of Gastroenterology and the performance in this specialty has now fully recovered.

Referral s from GPs in March 2017 increased compared to February 2017 and also compared to March 2017. There were over 9,100 total referrals into the Trust , which is the highest number of referrals received in a single month for over 2 years.

The Trust has delivered the diagnostic wait time consistently since May 2016. In March 2017, 0.09% of patients waited longer than 6 weeks for their diagnostic tests, providing a year-end performance of 0.34% against the 1% standard.

Primary Drivers

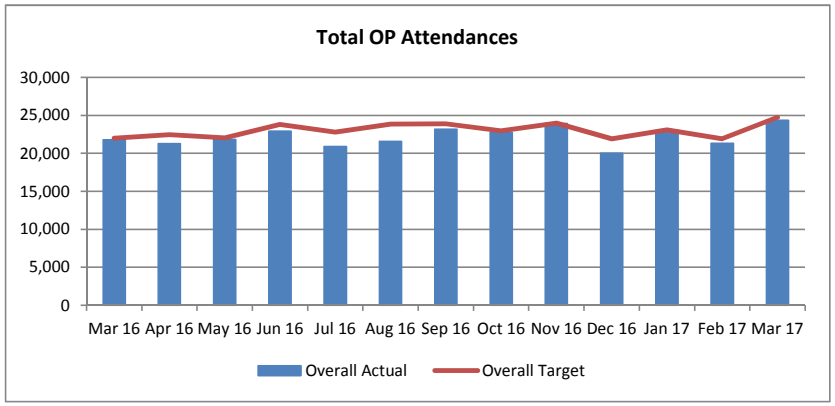


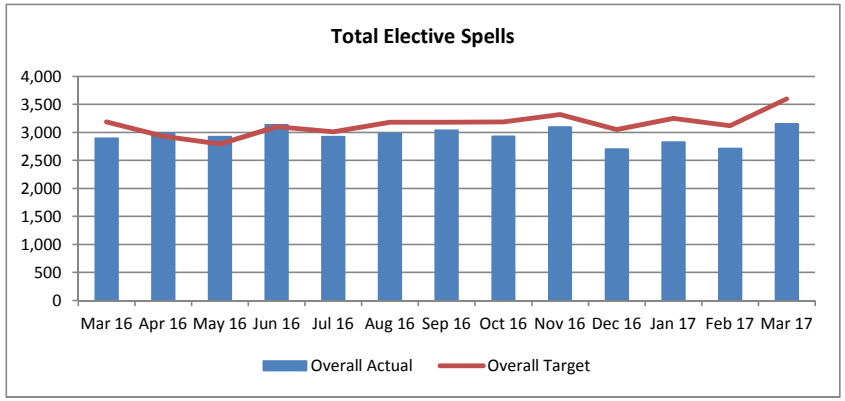
Referral Breakdown

	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Monthly Trend
GP Actual	5,048	5,762	5,622	5,586	5,055	5,035	5,383	5,063	5,061	4,192	4,930	4,592	5,534	
GP Target	5,072	5,505	5,243	5,767	5,505	5,767	5,767	5,505	5,767	5,243	5,505	5,243	6,029	
% to Target	99.5%	104.7%	107.2%	96.9%	91.8%	87.3%	93.3%	92.0%	87.8%	80.0%	89.6%	87.6%	91.8%	
Other Actual	2,980	3,196	3,465	3,370	3,151	3,298	3,277	3,263	3,135	2,821	3,200	3,126	3,621	
Other Target	2,656	3,222	3,069	3,376	3,222	3,376	3,376	3,222	3,376	3,069	3,222	3,069	3,529	
% to Target	112.2%	99.2%	112.9%	99.8%	97.8%	97.7%	97.1%	101.3%	92.9%	91.9%	99.3%	101.9%	102.6%	
Total Actual	8,028	8,958	9,087	8,956	8,206	8,333	8,660	8,326	8,196	7,013	8,130	7,718	9,155	
Total Target	7,728	8,728	8,312	9,143	8,728	9,143	9,143	8,728	9,143	8,312	8,728	8,312	9,559	
% to Target	103.9%	102.6%	109.3%	98.0%	94.0%	91.1%	94.7%	95.4%	89.6%	84.4%	93.2%	92.9%	95.8%	
GP % of Total	62.9%	64.3%	61.9%	62.4%	61.6%	60.4%	62.2%	60.8%	61.7%	59.8%	60.6%	59.5%	60.4%	

Operational Delivery: *Planned Activity*

Primary Drivers



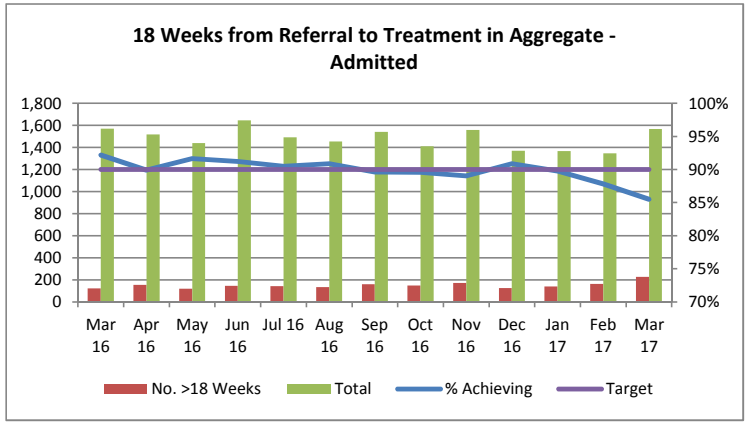


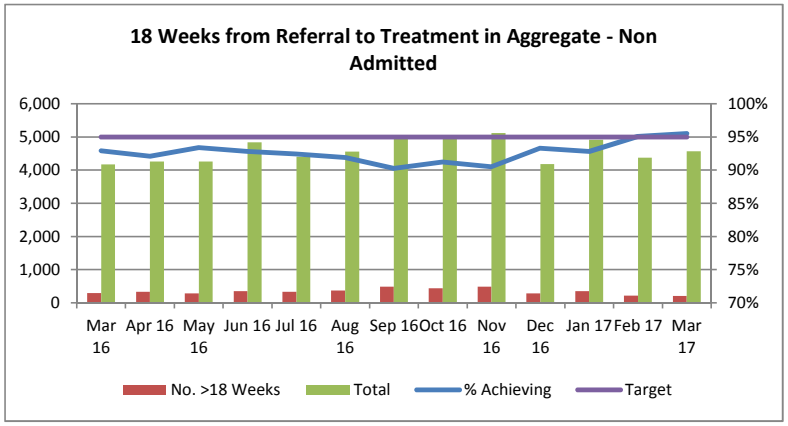
OP Attendance Breakdown	YTD	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Monthly Trend
New Actual	90,887	6,890	7,218	7,208	7,533	6,530	6,851	7,565	7,421	7,305	6,202	6,811	6,243	7,110	
New Target	92,301	6,710	6,970	6,693	7,329	7,002	7,333	7,337	7,081	7,408	6,747	7,138	6,791	7,764	
% to Target	98.5%	102.7%	103.6%	107.7%	102.8%	93.3%	93.4%	103.1%	104.8%	98.6%	91.9%	95.4%	91.9%	91.6%	
F U Actual	197,897	14,877	14,053	14,610	15,363	14,368	14,715	15,599	15,346	16,631	13,820	16,223	15,063	17,229	
F U Target	207,066	15,293	15,478	15,342	16,457	15,807	16,498	16,540	15,894	16,549	15,170	15,958	15,098	16,983	
% to Target	95.6%	97.3%	90.8%	95.2%	93.4%	90.9%	89.2%	94.3%	96.6%	100.5%	91.1%	101.7%	99.8%	101.4%	
Total Actual	288,784	21,767	21,271	21,818	22,896	20,898	21,566	23,164	22,767	23,936	20,022	23,034	21,306	24,339	
Total Target	299,368	22,002	22,447	22,035	23,786	22,809	23,831	23,876	22,975	23,957	21,917	23,096	21,889	24,747	
% to Target	96.5%	98.9%	94.8%	99.0%	96.3%	91.6%	90.5%	97.0%	99.1%	99.9%	91.4%	99.7%	97.3%	98.4%	
New % of Total	31.5%	31.7%	33.9%	33.0%	32.9%	31.2%	31.8%	32.7%	32.6%	30.5%	31.0%	29.6%	29.3%	29.2%	

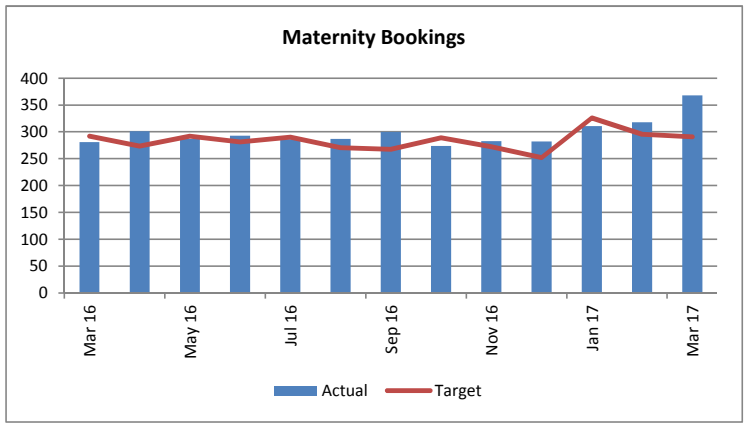
Elective Spells Breakdown	YTD	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Monthly Trend
I P Actual	3,920	274	356	313	313	294	298	302	332	324	258	210	304	342	
I P Target	4,667	394	348	332	365	348	365	365	352	369	335	359	342	393	
% to Target	84.0%	69.6%	102.2%	94.4%	85.7%	84.4%	81.6%	82.7%	94.4%	87.9%	77.0%	58.5%	88.8%	87.1%	
Daycase Actual	34,398	2,625	2,630	2,614	2,825	2,630	2,684	2,739	2,598	2,773	2,442	2,618	2,411	2,809	
Daycase Target	36,247	2,793	2,580	2,462	2,738	2,660	2,818	2,818	2,834	2,952	2,717	2,892	2,775	3,208	
% to Target	94.9%	94.0%	101.9%	106.2%	103.2%	98.9%	95.3%	97.2%	91.7%	93.9%	89.9%	90.5%	86.9%	87.6%	
Total Actual	38,318	2,899	2,986	2,927	3,138	2,924	2,982	3,041	2,930	3,097	2,700	2,828	2,715	3,151	
Total Target	40,914	3,187	2,928	2,794	3,103	3,008	3,183	3,183	3,186	3,321	3,052	3,252	3,117	3,601	
% to Target	93.7%	91.0%	102.0%	104.8%	101.1%	97.2%	93.7%	95.5%	92.0%	93.3%	88.5%	87.0%	87.1%	87.5%	
I P % of Total	10.2%	9.5%	11.9%	10.7%	10.0%	10.1%	10.0%	9.9%	11.3%	10.5%	9.6%	7.4%	11.2%	10.9%	

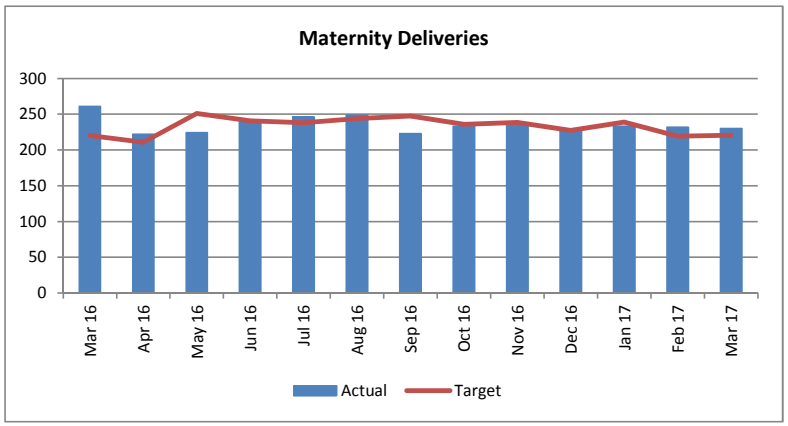
Operational Delivery: *Planned Activity*

Primary Drivers





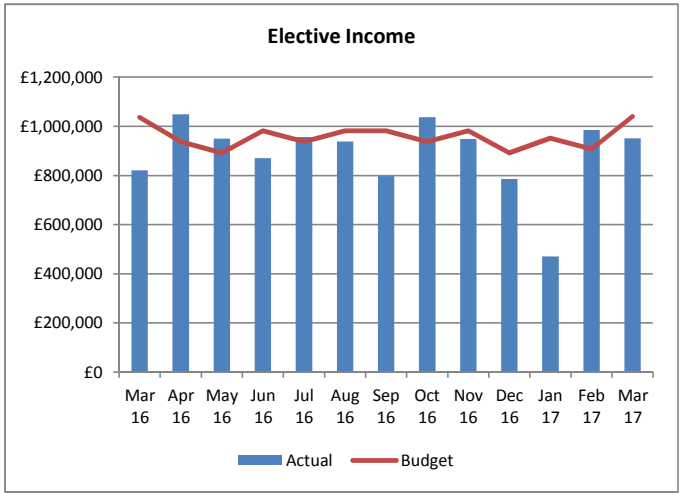


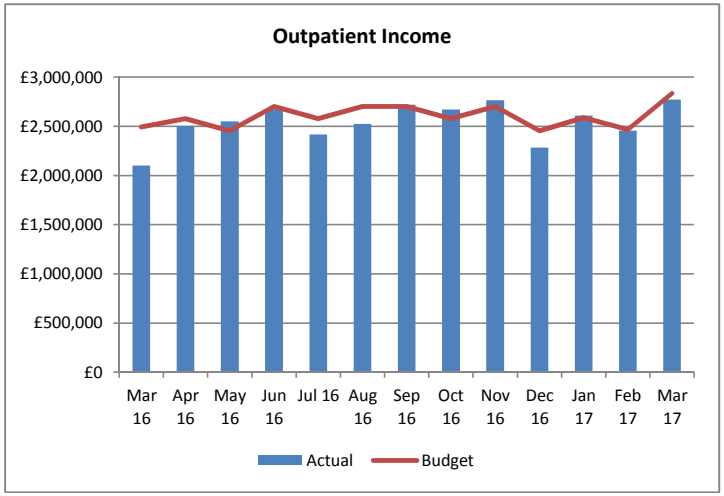


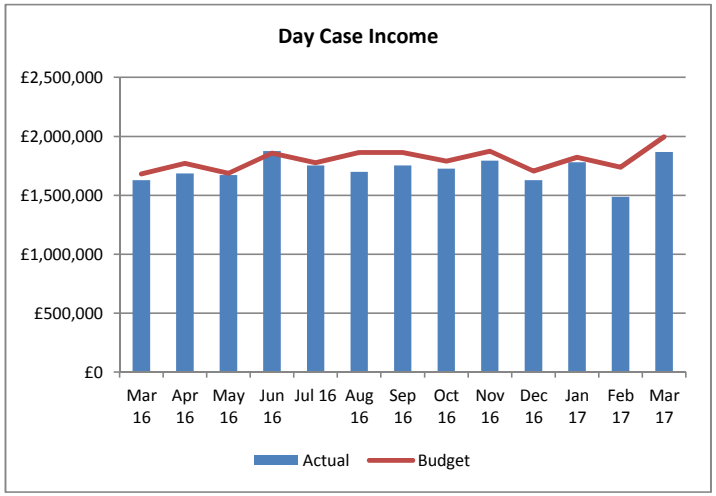
Operational Delivery: *Planned Activity*

Secondary Drivers

			Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Monthly Trend
Bed Occupancy Rate	Medicine & Emergency Care		101.7%	99.0%	96.6%	97.0%	93.2%	92.5%	94.0%	93.7%	95.2%	94.2%	95.2%	93.8%	90.3%	
	Surgery & Cancer		82.8%	75.2%	76.9%	76.0%	76.7%	72.4%	71.0%	72.0%	73.4%	74.9%	84.6%	75.1%	72.3%	
Elective Inpatient Avg LOS (Days)			3.7	2.5	3.1	2.6	3.2	3.2	2.7	3.3	2.3	3.3	2.1	2.8	2.4	
Delayed Transfers of Care (MFFD)		16.00	19	22	20	19	37	29	31	30	28	28	35	33	31	
Medical Outliers			10	6	5	5	2	2	3	8	7	9	16	8	1	
Readmission (Emergency Re-admissions after Planned Surgery)																
** reported from 16/17. One month delay*	30 Day Rate		0.00%	2.94%	2.97%	3.24%	2.77%	2.91%	3.15%	3.29%	3.14%	3.46%	3.27%	2.95%	0.00%	
	7 Day Rate		0.00%	1.15%	1.21%	1.33%	1.65%	1.01%	1.16%	1.29%	1.37%	1.24%	1.75%	1.67%	1.40%	
Cancelled Operations - Non Clinical - Cancellation Rate			2.07%	0.84%	1.57%	1.09%	1.40%	0.98%	1.48%	1.16%	0.61%	2.12%	0.85%	1.25%	1.07%	
Theatre Efficiency																
	Main Theatres		72.2%	74.0%	71.7%	77.3%	74.9%	79.6%	76.6%	77.6%	75.7%	75.5%	71.4%	76.3%	76.2%	
	TC Theatres		71.7%	70.0%	73.0%	71.7%	72.3%	74.4%	74.6%	77.2%	73.9%	72.6%	72.1%	76.0%	75.3%	
DNA (OP Efficiency)			6.16%	6.24%	6.11%	6.39%	6.34%	6.47%	6.72%	5.92%	6.15%	6.28%	6.13%	5.44%	5.35%	
Hospital Cancellation Rate (OP Efficiency)			5.48%	5.93%	4.75%	4.87%	5.19%	5.99%	5.01%	5.36%	5.34%	5.56%	5.40%	5.73%	6.03%	







Financial Performance: Income & Expenditure Position - Aggregated

	Month			Year to Date			Forecast	Base Budget 2016/17 £'000
	Plan March (£'000)	Actual March (£'000)	Variance March (£'000)	Plan April to March (£'000)	Actual April to March (£'000)	Variance April to March (£'000)	2016/17 (£'000)	
Operating								
Operating Income								
NHS Acute Activity Income								
Elective	1,044	984	-59	11,423	10,788	-635	10,618	11,460
Non-Elective	4,555	4,524	-31	51,840	52,648	808	52,733	53,215
Maternity	953	1,113	160	12,141	12,359	218	12,099	12,138
Day cases	2,058	1,854	-203	21,748	20,703	-1,045	20,789	21,748
Outpatients	2,845	2,772	-72	31,340	30,965	-375	30,949	31,340
A&E	689	752	63	7,887	8,271	383	8,373	7,887
Other NHS	7,213	4,031	-3,182	72,557	65,548	-7,009	62,586	58,989
Total NHS Clinical Revenue	**19,357**	**16,031**	**-3,326**	**208,937**	**201,282**	**-7,655**	**198,146**	**196,777**
Other Operating Income	1,989	1,846	-143	23,081	23,387	306	23,482	22,302
TOTAL OPERATING INCOME	**21,346**	**17,877**	**-3,469**	**232,018**	**224,669**	**-7,349**	**221,628**	**219,079**
Operating Expenses								
Employee Benefits Expenses (Pay)	-14,177	-13,926	251	-155,962	-152,843	3,119	-153,702	-146,239
Drugs	-1,589	-1,376	213	-18,737	-15,908	2,829	-15,973	-18,709
Clinical Supplies	-1,744	-1,649	95	-18,669	-17,908	761	-17,918	-18,415
Non Clinical Supplies	-315	-188	127	-3,193	-3,084	109	-3,131	-2,610
Other operating expenses	-2,468	-2,423	45	-28,813	-30,310	-1,497	-29,289	-26,422
TOTAL OPERATING EXPENSES	**-20,293**	**-19,562**	**731**	**-225,374**	**-220,053**	**5,321**	**-220,013**	**-212,395**
EBITDA	**1,053**	**-1,685**	**-2,738**	**6,644**	**4,616**	**-2,028**	**1,615**	**6,684**
Non Operating								
Non Operating Income								
Interest & Asset disposal	4	-2	-6	48	21	-27	20	47
Non-Operating Expenses								
Depreciation & Finance Leases	-444	-457	-13	-5,425	-4,913	512	-4,910	-5,651
PDC Dividend Expense	-158	-49	109	-1,896	-1,787	109	-1,678	-1,900
Net Surplus/(deficit) before Exceptional Items	**455**	**-2,193**	**-2,648**	**-629**	**-2,063**	**-1,434**	**-4,952**	**-820**
Provision against Contract dispute	0	0	0	0	0	0	0	0
Reversal of 15/16 unused bad debt prov	0	0	0	0	1,050	1,050	1,050	
Charitable Income	0	55	55	43	398	355	398	0
Net Surplus/(deficit) after Exceptional Items	**455**	**-2,138**	**-2,593**	**-586**	**-615**	**-29**	**-3,504**	**-820**

The Trust delivered a £0.6M deficit cumulative against a planned deficit of £0.6M.

The transfer of Community Services (CS) on the 1st October is consolidated into the reported position . The impact of community services is improving the position by £1.2M

Contract income is £7.7M worse than plan cumulative. Key variances include planned income and drugs.

Other is £0.3M better than plan cumulative as a result of training and nhs recharge variances.

Pay is £3.1M better than plan cumulative as a result of underspends in medical pay from unfilled vacancies and community services.

Non-Pay is £2.2M better than plan cumulative as a result of high cost drugs (income offset) and Other (outsourcing).

The forecast position shows the non-adjusted position, however the year end position iincludes an adjustment of £3.4M to PbR income on the Other income line as a result of the recent agreement with South Cheshire & Vale Royal CCGs in respect of the contract settlement for 1617. This is without prejudice to the current contract dispute in repsect of zero day admissions.

Financial Performance: Income & Expenditure Position - MCHFT

	Month			Year to Date			Base Budget 2016/17 £'000
	Plan March (£'000)	Actual March (£'000)	Variance March (£'000)	Plan April to March (£'000)	Actual April to March (£'000)	Variance April to March (£'000)	
Operating							
Operating Income							
NHS Acute Activity Income							
Elective	1,044	984	-59	11,423	10,788	-635	11,460
Non-Elective	4,555	4,524	-31	51,840	52,648	808	53,215
Maternity	953	1,113	160	12,141	12,359	218	12,138
Day cases	2,058	1,854	-203	21,748	20,703	-1,045	21,748
Outpatients	2,845	2,772	-72	31,340	30,965	-375	31,340
A&E	689	752	63	7,887	8,271	383	7,887
Other NHS	4,986	1,448	-3,538	59,197	51,832	-7,365	58,989
Total NHS Clinical Revenue	**17,130**	**13,448**	**-3,682**	**195,577**	**187,566**	**-8,011**	**196,777**
Other Operating Income	1,819	2,029	210	22,060	22,665	605	22,302
Inter-Trust Income	48	48	0	286	286	0	
TOTAL OPERATING INCOME	**18,997**	**15,525**	**-3,472**	**217,923**	**210,517**	**-7,406**	**219,079**
Operating Expenses							
Employee Benefits Expenses (Pay)	-12,384	-12,331	54	-145,205	-143,267	1,939	-146,239
Drugs	-1,588	-1,376	212	-18,726	-15,905	2,821	-18,709
Clinical Supplies	-1,677	-1,311	366	-18,269	-17,360	909	-18,415
Non Clinical Supplies	-186	-209	-23	-2,418	-2,693	-275	-2,610
Other operating expenses	-2,025	-2,159	-134	-26,155	-27,452	-1,297	-26,422
Inter-Trust Charges	-82	-82	0	-491	-491	0	
TOTAL OPERATING EXPENSES	**-17,942**	**-17,468**	**475**	**-211,264**	**-207,168**	**4,097**	**-212,395**
EBITDA	**1,054**	**-1,943**	**-2,997**	**6,658**	**3,349**	**-3,309**	**6,684**
Non Operating							
Non Operating Income							
Interest & Asset disposal	4	-2	-6	48	21	-27	47
Non-Operating Expenses							
Depreciation & Finance Leases	-444	-457	-13	-5,425	-4,913	512	-5,651
PDC Dividend Expense	-158	-11	147	-1,896	-1,749	147	-1,900
Net Surplus/(deficit) before Exceptional Items	**456**	**-2,413**	**-2,869**	**-615**	**-3,292**	**-2,677**	**-820**

The Trust excluding Community Services, delivered a £3.3M deficit cumulative before exceptional items against a planned deficit of £0.6M.

Contract income is £8.0M worse than plan cumulative. Key variances include planned income and drugs.

Other is £0.6M better than plan cumulative as a result of training and nhs recharge variances.

Pay is £1.9M better than plan cumulative as a result of underspends in medical pay from unfilled vacancies .

Non-Pay is £2.2M better than plan cumulative as a result of high cost drugs (income offset) and Other (outsourcing).

The year end position iincludes an adjustment of £3.4M to PbR income on the Other income line as a result of the recent agreement with South Cheshire & Vale Royal CCGs in respect of the contract settlement for 1617. This is without prejudice to the current contract dispute in repsect of zero day admissions.

Financial Performance: Income & Expenditure Position - CCICP

	Month			Year to Date			
	Plan March (£'000)	Actual March (£'000)	Variance March (£'000)	Plan April to March (£'000)	Actual April to March (£'000)	Variance April to March (£'000)	Base Budget 2016/17 £'000
Operating							
Operating Income							
NHS Acute Activity Income							
Elective	0	0	0	0	0	0	
Non-Elective	0	0	0	0	0	0	
Maternity	0	0	0	0	0	0	
Day cases	0	0	0	0	0	0	
Outpatients	0	0	0	0	0	0	
A&E	0	0	0	0	0	0	
Other NHS	2,227	2,555	328	13,360	13,688	328	26,968
Total NHS Clinical Revenue	**2,227**	**2,555**	**328**	**13,360**	**13,688**	**328**	**26,968**
Other Operating Income	170	-183	-353	1,021	722	-299	2,043
Inter-Trust Income	82	82	0	491	491	0	979
TOTAL OPERATING INCOME	**2,479**	**2,454**	**-25**	**14,872**	**14,901**	**29**	**29,990**
Operating Expenses							
Employee Benefits Expenses (Pay)	-1,793	-1,595	197	-10,757	-9,576	1,180	-21,731
Drugs	-1	0	1	-11	-3	8	
Clinical Supplies	-67	-338	-271	-400	-548	-148	
Non Clinical Supplies	-129	21	150	-775	-391	384	
Other operating expenses	-443	-264	179	-2,658	-2,858	-200	-7,687
Inter-Trust Charges	-48	-48	0	-286	-286	0	-571
TOTAL OPERATING EXPENSES	**-2,481**	**-2,224**	**256**	**-14,887**	**-13,662**	**1,224**	**-29,989**
EBITDA	**-2**	**230**	**231**	**-15**	**1,239**	**1,253**	**0**
Non Operating							
Non Operating Income							
Interest & Asset disposal	0	0	0	0	0	0	
Non-Operating Expenses							
Depreciation & Finance Leases	0	0	0	0	0	0	
PDC Dividend Expense	0	0	0	0	0	0	
Net Surplus/(deficit) before Exceptional Items	**-2**	**230**	**231**	**-15**	**1,239**	**1,253**	**0**

ommunity Services delivered a £1.2M surpluscumulative against a planned break event budger.

Contract income is £0.3M better than plan cumulative as a result of contract variations agreed in year in respect of property services costs.

Other is £0.3M worse than plan cumulative as a result of expected Integrated Community Teams income being phased in the early part of 2017/18.

Pay is £1.2M better than plan cumulative as a result of unfilled vacancies partly clinical and partly corporate. The vacancy rate has been improving month on month since transfer.

Non-Pay is on plan cumulative with some samll variances being seen as a result of refining the puchase ledger and budget.

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Financial Performance: Income & Expenditure Position

		Income			Expenditure				NET TOTAL	
		Contract	Variable	Better/ (Worse) than Budget	Pay	Better/ (Worse) than Budget	Non-Pay	Better/ (Worse) than Budget	Total	Better/ (Worse) than Budget
Surgical & Cancer Div Mgt	Divisional Management S&C	0	0	(126)	(816)	(408)	(66)	(37)	(882)	(572)
Endoscopy	Endoscopy	6,256	1	(414)	(2,712)	(94)	(1,230)	378	2,314	(130)
General Surgery Directorate	General Surgery	16,643	110	(1,385)	(8,069)	618	(1,764)	126	6,920	(641)
Head & Neck Directorate	Head & Neck	5,404	407	(156)	(2,417)	273	(841)	(54)	2,553	62
Macmillan Cancer Centre	Macmillan Cancer Centre	523	1,582	127	(802)	2	(1,254)	(136)	48	(6)
Ophthalmology	Ophthalmology	12,654	73	(72)	(3,951)	334	(3,722)	(12)	5,054	250
Orthopaedic Directorate	Orthopaedics	20,116	303	(641)	(6,121)	105	(3,748)	(318)	10,550	(854)
Theatres & TC	Theatres & TC	0	363	17	(7,288)	(184)	(2,662)	(89)	(9,588)	(256)
Urology Directorate	Urology	6,213	126	670	(2,743)	17	(406)	(40)	3,190	647
Surgical and Cancer Division	**Surgery & Cancer**	**67,808**	**2,963**	**(1,979)**	**(34,918)**	**663**	**(15,694)**	**(183)**	**20,159**	**(1,499)**

The Surgical Division is £1,499k worse than budget as at Month 12. The key variances are General Surgery and Orthopaedic income worse than plan as a result of consultant vacancies in General Surgery and lower elective activity in Orthopaedics as a result of winter pressures. Pay is better than plan as a result of medical vacancies and non-pay is worse than plan as a result of drugs costs in MacMillan, which is offset by income and surgical supplies costs in Orthopaedics and Theatres.

		Income			Expenditure				NET TOTAL	
		Contract	Variable	Better/ (Worse) than Budget	Pay	Better/ (Worse) than Budget	Non-Pay	Better/ (Worse) than Budget	Total	Better/ (Worse) than Budget
Emergency Care Divisional Mgmn	Divisional Mangement M&EC	0	57	57	(2,081)	181	(109)	(58)	(2,133)	180
Accident & Emergency Dir	Emergency Department	12,788	799	756	(5,877)	235	(1,172)	(109)	6,538	883
Anaesthetics & Critical Care	Anaesthetics & Critical Care	6,449	44	166	(7,808)	(33)	(1,312)	(341)	(2,627)	(208)
Medical Directorate	General Medicine	39,682	296	(549)	(22,713)	464	(4,747)	161	12,517	76
Urgent Care Centre	Urgent Care Centre	811	0	(228)	(418)	31	0	1	393	(197)
Emergency Services Division	**Medicine & Emergency Care**	**59,729**	**1,195**	**203**	**(38,897)**	**878**	**(7,340)**	**(346)**	**14,688**	**735**

The Medicine & Emergency Care Division is £735k better than budget as at Month 12. The main variances are better than plan on income in A&E as a result of higher non-elective admissions than plan. Lower non-elective admissions are being seen in recent months in General Medicine. Pay is better than plan as a result of medical vacancies and non-pay is worse than budget as a result of MASE and drug costs which are part offset by income.

		Income			Expenditure				NET TOTAL	
		Contract	Variable	Better/ (Worse) than Budget	Pay	Better/ (Worse) than Budget	Non-Pay	Better/ (Worse) than Budget	Total	Better/ (Worse) than Budget
Wom Chil & sexl hlth Div Magmn	Divisional Mangement W&C	0	27	27	(1,317)	3	(100)	90	(1,390)	119
Gum clinic	GUM clinic	0	0	(6)	0	0	(37)	(37)	(37)	(43)
Obstetric & Gynaecology Dir	Obstetrics & Gynaecology	16,951	87	(445)	(8,625)	(27)	(1,502)	210	6,911	(262)
Paediatric Directorate	Paediatrics	11,637	116	775	(7,531)	(15)	(1,128)	(139)	3,094	622
Women and Childrens Division	**Women and Children**	**28,588**	**230**	**351**	**(17,473)**	**(39)**	**(2,767)**	**124**	**8,579**	**436**

The Womens and Childrens Division is £436k better than budget as at Month 12. The key variances are better than plan on income as a result of non-elective admissions in Paediatrics being higher than expected, offset by IVF income in Gynaecology being worse than plan. There are no significant variances on the Pay and Non-pay lines.

Financial Performance: Income & Expenditure Position

		Income			Expenditure				NET TOTAL	
		Contract	Variable	Better/ (Worse) than Budget	Pay	Better/ (Worse) than Budget	Non-Pay	Better/ (Worse) than Budget	Total	Better/ (Worse) than Budget
Diag & Clinc Spt Sv Div Mgmnt	Divisional Management D&S	0	0	0	(309)	6	(22)	9	(331)	15
Dermatology	Dermatology	2,138	26	9	(1,268)	85	(364)	(24)	532	70
ECG department	ECG	400	47	(5)	(988)	94	(78)	(1)	(619)	88
Elmhurst	Elmhurst	1,993	151	(23)	(1,529)	(63)	(338)	27	278	(59)
Integrated Discharge	Integrated Discharge	0	7	7	(394)	(11)	(3)	1	(390)	(2)
Medical Records Department	Medical Records Department	0	0	0	(1,634)	(86)	(207)	(28)	(1,841)	(114)
Outpatients	Outpatients	0	198	31	(529)	1	(61)	(7)	(392)	25
Pathology Directorate	Pathology	11,991	4,230	(250)	(9,592)	396	(9,135)	480	(2,506)	626
Pharmacy Departments	Pharmacy	2,686	230	(1,008)	(3,049)	79	(2,860)	846	(2,993)	(84)
Radiology Directorate	Radiology	3,692	743	293	(5,930)	(78)	(2,487)	461	(3,982)	676
Therapeutic Departments	Therapies	0	175	8	(2,010)	(45)	(460)	(47)	(2,295)	(84)
Victoria Infirmary Northwich	Victoria Infirmary Northwich	2,084	38	(74)	(1,681)	(51)	(293)	8	147	(118)
Diagnostics and Support Divisi	**Diagnostics and Support**	**24,985**	**5,846**	**(1,013)**	**(28,913)**	**328**	**(16,309)**	**1,725**	**(14,391)**	**1,040**

The Diagnostics Division is £1,040k better than plan as at Month 12. The key variances include worse than plan on income as a result of Pharmacy drugs pass through costs lower than expected (offsetting cost underspend). Pay is worse than plan in Radiology as a result of locum costs for vacancies and agency costs for radiographer vacancies being offset by underspends in Pathology, Dermatology and Pharmacy from vacancies. Non-Pay is better than plan as a result of drugs costs being lower than anticipated in Pharmacy and Pathology.

		Income			Expenditure				NET TOTAL	
		Contract	Variable	Better/ (Worse) than Budget	Pay	Better/ (Worse) than Budget	Non-Pay	Better/ (Worse) than Budget	Total	Better/ (Worse) than Budget
Estates & Facilities Div Mgnt	Divisional Management E&F	0	0	0	(477)	5	(214)	(54)	(690)	(50)
Catering Directorate	Catering	0	1,389	102	(1,446)	(112)	(1,350)	(54)	(1,407)	(65)
Estates Departments	Estates Departments	0	462	(32)	(1,597)	(90)	(6,162)	271	(7,296)	149
Hotel Services	Domestics	0	2	(1)	(1,368)	(63)	(15)	(9)	(1,382)	(74)
Laundry Services Departments	Laundry	0	1,246	36	(1,105)	(99)	(763)	1	(622)	(63)
Security	Security	0	1,672	79	(716)	31	(603)	(65)	353	45
Site Services	Porters	0	4	(3)	(2,696)	70	(90)	(12)	(2,783)	55
Estates & Facilities Division	**Estates & Facilities Division**	**0**	**4,775**	**180**	**(9,405)**	**(257)**	**(9,197)**	**76**	**(13,827)**	**(1)**

The Estates and Facilities Division is £1k worse than plan as at Month 12. The main variances include worse than plan on pay as a result of agency costs in Laundry, Estates and Catering.

		Income			Expenditure				NET TOTAL	
		Contract	Variable	Better/ (Worse) than Budget	Pay	Better/ (Worse) than Budget	Non-Pay	Better/ (Worse) than Budget	Total	Better/ (Worse) than Budget
Executive Management	Executive Management	0	0	0	(1,337)	27	(216)	2	(1,553)	29
Computer Services	Computer Services	0	78	36	(1,303)	36	(1,708)	(141)	(2,933)	(69)
Finance & Information	Finance & Information	0	51	20	(2,796)	(5)	(693)	(45)	(3,438)	(30)
Human Resources	Human Resources	0	528	49	(2,069)	104	(452)	166	(1,992)	320
Risk Manangement & R&D	Risk Management & R&D	0	464	(76)	(1,504)	45	(20)	73	(1,060)	42
Quality Assurance Departments	Nurse Management	0	505	442	(2,838)	(398)	(7,131)	(33)	(9,464)	11
Trust Central Expenditure	Trust Central Expenditure	6,454	6,136	(5,166)	(1,473)	551	(156)	1,907	10,961	(2,708)
Other Departments	Other Departments	0	297	(12)	(342)	153	(684)	(354)	(730)	(213)
	Corporate	**8,011**	**7,316**	**(2,288)**	**(12,539)**	**379**	**(10,297)**	**1,434**	**(7,509)**	**(474)**

The Corporate Division is £474k worse than plan as at Month 12. The key variances are income on Trust Central as a result of the STF and CQUIN schemes non-achievement against plan and the provision against the contract dispute. Pay and Non-Pay are better than plan as a result of vacancies and investment slippage.

Community Services		**13,688**	**719**	**27**	**(9,575)**	**1,179**	**(3,800)**	**43**	**1,032**	**1,249**
EBITDA		**201,253**	**23,786**	**(6,939)**	**(152,843)**	**3,266**	**(66,165)**	**3,014**	**6,031**	**(660)**

Financial Performance: Commissioner Income Analysis

Commissioner	FY Target (£'000)	YTD Target (£'000)	Final Actual (£'000)	Final Variance (£'000)
NHS South Cheshire CCG	99,862	99,862	100,576	714
NHS Vale Royal CCG	52,734	52,734	53,424	690
NHS Eastern Cheshire CCG	7,439	7,439	7,680	242
NHS West Cheshire CCG	2,872	2,872	3,005	133
NHS North Staffordshire CCG	2,037	2,037	1,966	-71
Specialist Commissioning Group	7,578	7,578	8,050	473
NHS Commissioning Board	1,510	1,510	1,525	15
OTHER CCGs	2,236	2,236	2,402	165
Overseas Visitors Chargeable	0	0	0	0
NON-CONTRACT ACTIVITY	1,916	1,916	1,888	-28
NON CCG SPECIFIC TARGETS	30,750	30,750	20,764	-9,986
TOTAL	**208,936**	**208,936**	**201,282**	**-7,654**

The South Cheshire and Vale Royal contracts are in line with the year end agreement of £154M which is £3.4M less than PbR rules. This is the result of the negotiated settlement of all disputed areas in the 2016/17 contract and without prejudice to disputed items in 2017/18. This impact together with differences in drugs expectationa and QIPP is shown in the Non-CCG specific target line.

Other commissioners are not showing any significant variances, other than Specialist Commissioning which is a result of high cost drugs.

Other Contract Income	FY Target (£'000)	YTD Target (£'000)	YTD Actual (£'000)	Final Variance (£'000)
Bed Based Services	5,960	5,960	5,948	-12
Adult & Neonatal Critical Care	8,040	8,040	8,059	19
Urgent Care Centre	1,007	1,007	787	-220
Community Paediatrics	1,298	1,298	1,301	2
Direct Access Services	9,418	9,418	9,870	452
Unbundled Radiology	3,982	3,982	3,808	-174
High Cost Drugs	13,357	13,357	9,758	-3,600
Screening Programmes	1,473	1,473	1,473	0
Audiology	909	909	1,123	214
IVF	945	945	288	-657
CQUIN	3,914	3,914	2,910	-1,005
STF	6,500	6,500	6,365	-135
Community Services	13,359	13,359	13,688	330
Other	2,392	2,392	171	-2,221
TOTAL	**72,556**	**72,556**	**65,548**	**-7,008**

Other contract income is showing £7.0M worse than plan.

An analysis of the key service lines identifies that this is primarily the result of High Cost Drugs where expenditure (and therefore recovery) predictions were not realised in relation to new drugs and changes in use in 2016/17. In addition, the impact of the year end settlement recognised in other.

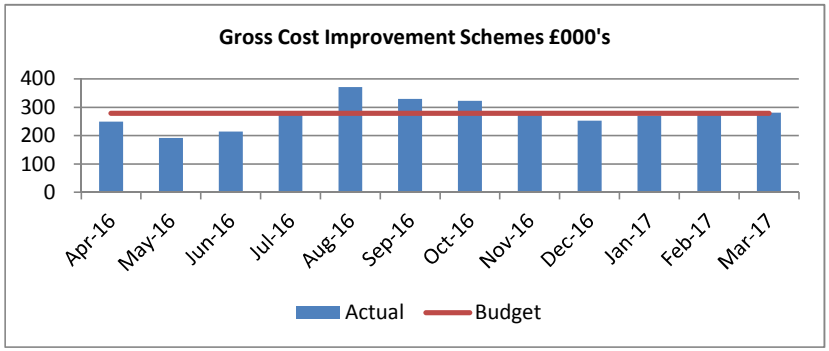
Direct Access is better than plan whilst IVF is worse than plan. CQUIN is worse than plan due to the contract agreement and the failure of the Sepsis CQUIN.

STF is less than plan due to the failure of the A&E improvement trajectory in Q3.

Other includes the contract agreement impact and variations in year, including Q1/Q2 on Integrated Teams (£0.5M) and Community

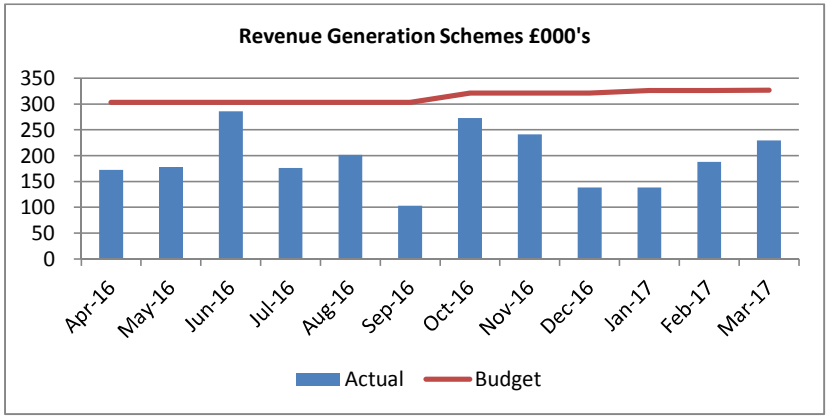
Financial Performance: Cost Improvement Programme

Cost Improvement Schemes						
Scheme Category	**YTD Target**	**YTD Actual**	**YTD**	**FY Target**	**FY Forecast**	**FY Variance**
Access & Flow	1,100	1,100	0	1,100	1,100	0
Drugs	300	259	-41	300	259	-41
Non-Pay Efficiency	234	293	60	234	293	60
Nursing Agency	1,047	1,047	0	1,047	1,047	0
Pathology Efficiency	282	282	0	282	282	0
Pay Savings	23	22	-2	23	22	-2
Procurement	330	325	-5	330	325	-5
TOTAL (£'000)	**3,315**	**3,327**	**12**	**3,315**	**3,327**	**12**



The Cost Improvement Programme has acheived the full year target.

Revenue Generation Schemes						
Scheme Category	**YTD Target**	**YTD Actual**	**YTD**	**FY Target**	**FY Forecast**	**FY Variance**
Best Practice Tariff	420	234	-186	420	234	-186
Bowelscope QIPP	856	250	-606	856	250	-606
ENT QIPP	106	0	-106	106	0	-106
General Surgery QIPP	123	49	-74	123	49	-74
Income Generation	484	753	269	484	753	269
Ophthalmology QIPP	59	42	-17	59	42	-17
Orthopaedics QIPP	676	390	-286	676	390	-286
Other Income	221	140	-81	221	140	-81
Other QIPP	149	59	-90	149	59	-90
Outpatients QIPP	300	162	-138	300	162	-138
Theatres QIPP	300	245	-55	300	245	-55
TOTAL (£'000)	**3,694**	**2,324**	**-1,370**	**3,694**	**2,324**	**-1,370**



Revenue Generation schemes are £1.4M worse than plan cumulative as a result of not achieving the Orthopaedic QIPP and in addition, delays in accreditation are affecting the role out of Bowelscope at partner sites.

Financial Performance: Capital Report

WHOLE PROJECT PROPOSED PLAN	APPROVED	SCHEME	BROUGHT FORWARD	2016/17 MONITOR ANNUAL PLAN	2016/17 CUMULATIVE ACTUAL	2016/17 BETTER/WORSE THAN BUDGET	2016/17 FORECAST	2017/18 FORECAST	2018 + FORECAST	TOTAL FORECAST
ROLLOVER SCHEMES FROM 15/16 CAPITAL PROGRAMME										
60	60	CAR PARK BARRIERS	0	60	0	60	0	60		60
2404	2404	MRI SCANNER	1836	126	382	-256	382			2218
310	310	OPHTHALMOLOGY OUTPATIENTS	24	286	286	0	286			310
		OTHER ROLLOVERS 15/16		0	-35	35	-35			-35
NEW WORKS										
50	50	BISTRO & 2 OFFICES		50	0	50	0	50		50
35	25	BLOCK ME CONVERT TO OFFICES		35	60	-25	60			60
25	35	BLOCK MF CONVERT TO OFFICES		25	0	25	0			0
		DR'S MESS INTO RMO'S		42	0	42	0	42		42
11		MATERNITY		11	11	0	11			11
COMPLIANCE ISSUES										
6673	6673	ASBESTOS REMOVAL	5397	122	122	0	122	100	300	5919
7500	2544	WARD REFURBISHMENTS & FIRE COMPARTMENTATION	0	2544	2345	199	2345	3043	8952	14340
CLINICAL DEVELOPMENT										
850		3RD CT ENABLING		850	0	850	0	850		850
70		CENTRALISED POAC		70	0	70	0	70		70
50	50	ED RAPID ACCESS BAYS		50	65	-15	65			65
1500	1500	MRI SCANNER 3RD BUILD		1500	109	1391	109	1500		1609
335	335	OPHTHALMOLOGY OUTPATIENTS - PHASE 2		335	86	249	86	303		389
98	98	SEXUAL HEALTH CLINIC		98	98	0	98			98
ENABLING										
1500	250	DESIGN TEAM & PAINTERS	833	250	314	-64	314	250	750	2147
IM&T ROLLOVER SCHEMES FROM 15/16 CAPITAL PROGRAMME										
26		ASCRIBE HANDOVER	10	13	13	0	13			23
42	42	DAWN	27	15	0	15	0			27
1223	693	INFRASTRUCTURE	605	22	24	-2	24			629
31	31	INTERSITE CONNECTIVITY	6	25	19	6	19			25
458	329	RADIOLOGY INFORMATION SYSTEM	230	228	96	132	96			326
72	72	STORAGE DATA ARCHIVING	21	51	24	27	24		300	345
1170	420	VOICE OVER IP	42	420	171	249	171	77		290
336	336	OTHER ROLLOVER IT SCHEMES 15/16	312	0	3	-3	3			315
IM&T NEW SCHEMES										
600		CLINICAL PORTAL		600	0	600	0	1200		1200
1000		EDMS		1000	0	1000	0	1956		1956
244		E-HANDOVER		244	0	244	0	256		256
65		INTERFACING		65	20	45	20	40	80	140
75		IT APPLICATIONS		75	110	-35	110	75	150	335
25		NET CALL / CALL CENTRE		25	12	13	12			12
30		PCTI / DOCMAN		30	18	12	18			18
350		ROSTERING SYSTEM		350	0	350	0			0
150		UPS		150	0	150	0	150		150
30		WIRELESS UPGRADE		30	6	24	6			6
ADDITIONAL										
80	80	DISHWASHER		80	62	18	62			62
7	7	ECG SLEEP SYSTEM		7	6	1	6			6
		PATHOLOGY TEMPERATURE MONITORING SYSTEM		0	30	-30	30			
		MEC SOFTWARE FOR CARDIAC MONITORS			**16**	**-16**	**16**			**16**
LEASING ARRANGEMENTS										
3000	500	MEC EQUIPMENT		500	352	148	352	150		502
		3RD CT SCANNER		600	0	600	0	600		600
		3RD MRI SCANNER		800	0	800	0	800		800
		ACCESS CONTROL		100	0	100	0	100		100
		LAUNDRY FINISHING	70	70	0	70	0	70		140
		OPHTHALMOLOGY EQUIPMENT	150	150	0	150	0			150
		REPLACEMENT CT SCANNERS		600	0	600	0	600		600
DONATED										
		BUILDIINGS								
		EQUIPMENT		0	58	-58	58			58
BACKLOG MAINTENANCE										
1075	422	MAINTENANCE	334	396	397	-1	397	175	525	1431
6833	1054	GENERAL PROVISION	1711	1054	732	322	732	2250	4500	9193
38393	**18320**	**TOTAL PROGRAMME**	**11608**	**14154**	**6012**	**8142**	**6012**	**14767**	**15557**	**47914**

The capital programme is less than anticipated by £8142K lower compared to plan. The following schemes are underspent; General Provision £321K, Ward Refurbishment £199K, Third CT Scanner enabling £850K, Third MRI Scanner £1391K, Ophthalmology Outpatients phase 2 £249K, Voice Over IP £249K, Clinical Portal £600K, Rostering System £350K, EDMS £1,000K, E Handover £244K.

In addition Finance leases of circa £2,300K where the lease has now been assed as an operating lease and not a finance lease or they have not started yet. This includes the replacement MRI Scanner £650K, 3rd MRI Scanner £650K, Medical imaging equipment £652K, Ophthalmology Equipment £120K, Washer disinfectors £186K.

Accruals have been made for Theatres £72K, Ward 11 refurbishment £165K , ME & MF Alterations £116K and Ward 16 £304K, other minor schemes £40K.

Financial Performance: Statement of Financial Position

	Plan Apr to March (£'000)	Actual Apr to March (£'000)	Variance (£'000)	Forecast 2016/17 (£'000)
Assets				
Assets, Non-Current	**90,488**	**81,664**	**-8,824**	**79,960**
Assets, Current				
Trade and other Receivables	8,147	8,251	104	10,149
Other Assets (including Inventories & Prepayments)	5,264	5,083	-181	4,933
Cash and Cash Equivalents	437	5,648	5,211	2,000
Total Assets, Current	**13,848**	**18,982**	**5,134**	**17,082**
ASSETS, TOTAL	**104,336**	**100,553**	**-3,783**	**97,042**
Liabilities				
Liabilities, Current				
Finance Lease, Current	-1,617	-1,700	-83	-885
Loans Commercial Current	-857	-401	456	-4,997
Trade and Other Payables, Current	-15,011	-13,305	1,706	-12,951
Provisions, Current	-231	-169	62	-231
Other Financial Liabilities	-6,657	-7,326	-669	-7,343
Total Liabilities, Current	**-24,373**	**-22,902**	**1,471**	**-26,407**
Net Current Assets/(Liabilities)	**-10,525**	**-3,920**	**6,605**	**-9,325**
Liabilities, Non Current				
Finance Lease, Non Current	-6,789	-4,169	2,620	-3,038
Loans Commercial Non-Current	-9,587	-12,897	-3,310	-8,301
Provisions, Non-Current	-1,685	-1,651	34	-1,675
Trade and Other Payables, Non-Current	0	0	0	**0**
Total Liabilities Non-Current	**-18,061**	**-18,717**	**-656**	**-13,014**
TOTAL ASSETS EMPLOYED	**61,902**	**58,934**	**-2,968**	**57,621**
Taxpayers' and Others' Equity				
Taxpayers Equity				
Public dividend capital	75,157	75,157	0	75,157
Retained Earnings	-22,965	-26,386	-3,421	-27,756
Donated asset reserve	0	0	0	0
Revaluation Reserve	9,709	10,162	453	10,220
TOTAL TAXPAYERS EQUITY	**61,901**	**58,933**	**-2,968**	**57,621**
TOTAL FUNDS EMPLOYED	**61,901**	**58,933**	**-2,968**	**57,621**

Non Current assets is mainly due to the capital programme being less than anticipated by £8142K lower compared to plan. The following schemes are underspent; General Provision £321K, Ward Refurbishment £199K, Third CT Scanner enabling £850K, Third MRI Scanner £1391K, Ophthalmology Outpatients phase 2 £249K, Voice Over IP £249K, Clinical Portal £600K, Rostering System £350K, EDMS £1,000K, E Handover £244K.

In addition the plan was produced before the final position for 2015/16 was established which meant the opening balance was £1,614K in the plan more than the actual position which is mainly due to the revaluation completed at the end of 2015/16. The remainder relates to Finance leases of circa £2,300K where the lease has now been assed as an operating lease and not a finance lease or they have not started yet. This includes the replacement MRI Scanner £650K, 3rd MRI Scanner £650K, Medical imaging equipment £652K, Ophthalmology Equipment £120K, Washer disinfectors £186K.

Trade Receivables are slightly higher than anticipated. There was a significant movment in month when South Cheshire CCG and Vale Royal CCG agreed a settlement figure and the majority of their outstanding debts were either cancelled or paid.

Other Assets is less mainly due to delays in new operating leases , IT Maintenance and Radiology Maintenance and EBME Maintenance contracts, an assumption that maintenance contracts would increase due to the 3rd MRI Scanner and other pieces of equipment.

Trade and Other Payables - Trade Creditors are less than anticipated due the increase in the number of creditors being paid.

Other Financial Liabilities is mainly due to the impact of the income tax and National Insurance for the new community staff not included in the plan. In addition deferred income increased due to an increase in the Maternity Pathway prepayment.

Current Loans are lower than anticipated due to the Trusts delay in the capital programme and the utilisation of loans.

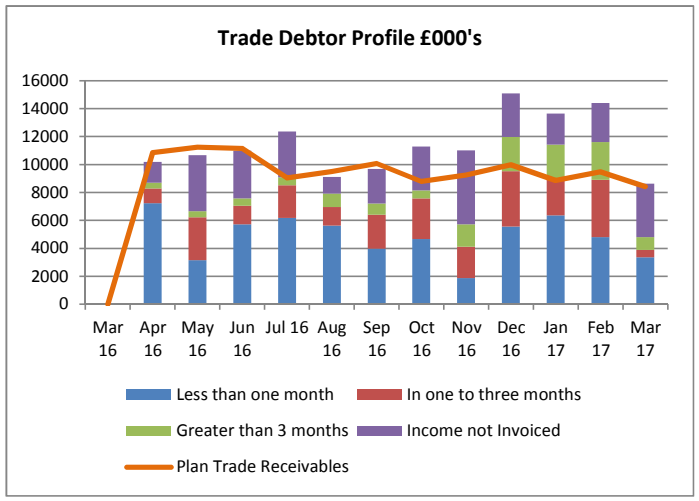
Non Current Liabilities are due to Finance being classified as operating leases or delay in expected Finance leasesas per abover, Loans are due to loans for the second ward, CT enabling, Clinical Portal and the Third MRI scanner not drawn down. However this is offset by £8,098K additional working capital loans.

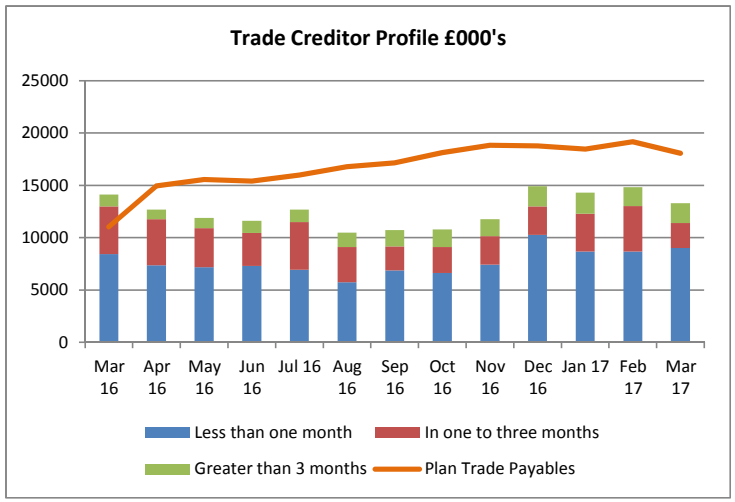
Financial Performance: Cash Position and Working Capital

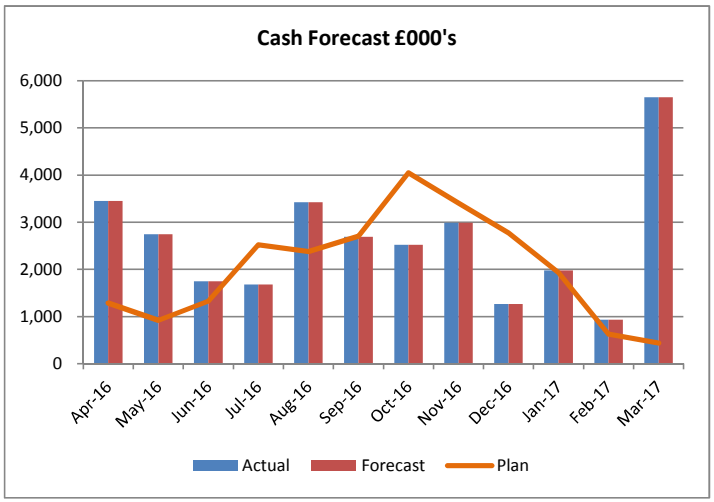
	Plan Apr to March (£'000)	Actual Apr to March (£'000)	Variance
Surplus/(deficit) after tax	**-820**	**-605**	**215**
Non-cash flows in operating Surplus/(deficit) total	5,636	4,878	-758
Operating cash flows before movements in working capital	**4,816**	**4,273**	**-543**
Increase/(Decrease) in working capital Total	1,947	-1,100	-3,047
Net cash inflow/(outflow) from operating activities	**6,763**	**3,173**	**-3,590**
Net cash inflow/(outflow) from investing activities total	-11,098	-5,254	5,844
Net Cash inflow/(outflow) before financing	**-4,335**	**-2,081**	**2,254**
Net cash inflow/(outflow) from financing activities Total	4,010	6,965	2,955
Net increase/(decrease) in cash and cash equivalents	**-325**	**4,884**	**5,209**
Opening cash balance	**764**	**764**	**0**
Closing cash balance	**439**	**5,648**	**5,209**

Cash is £5,209K better than anticipated. This is due to the better than anticipated financial position offset by a lower than anticipated depreciation . In addition the cash position has reduced due to the decrease in the working capital by around £3,047K, mainly due to the decrease in creditors.

The delay in the capital programme improves the cash position by £5,844K. However some of these schemes were to be funded via loans which have not been approved which reduce the improvement by £9,644K. However the Trust has received two working capital facilities the first £4,997K and the second in March £3,101K. The later was to help cover the non-payment of STF Q3 and Q4. Subsequently the Q3 payment was made in March.







Finance: *Staff Costs*

Headline Measures

	YTD £000's	Rolling 13 months £000's												
		Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Monthly Trend
Pay Budget	132,974	11,980	11,964	11,866	12,055	11,964	12,056	12,024	12,019	12,166	12,131	12,385	12,345	12,385	
Pay Actual	130,937	12,214	11,755	11,794	11,934	11,783	11,689	11,925	11,892	12,241	11,825	12,102	11,997	12,331	
Variance	2,037	-235	208	72	121	181	367	99	127	-75	306	283	348	55	
% to Budget	*98.5%*	*102.0%*	*98.3%*	*99.4%*	*99.0%*	*98.5%*	*97.0%*	*99.2%*	*98.9%*	*100.6%*	*97.5%*	*97.7%*	*97.2%*	*99.6%*	
Nursing Staff % to Budget	99.7%	107.1%	99.9%	104.9%	99.6%	99.2%	98.1%	98.9%	98.6%	101.6%	98.4%	97.0%	100.5%	98.7%	
Medical Staff % to Budget	93.5%	100.8%	92.4%	87.6%	94.4%	94.3%	90.1%	98.4%	100.6%	94.9%	90.7%	94.4%	90.4%	99.5%	
Other Staff % to Budget	101.5%	98.2%	105.0%	102.8%	102.0%	101.1%	101.2%	100.2%	98.0%	104.2%	101.9%	101.2%	98.7%	109.3%	

Commentary

figures exclude Community Services

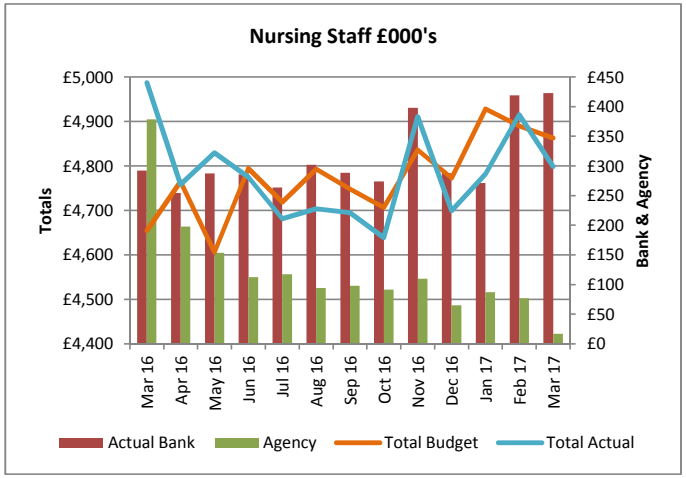
Pay is better than budget by £1.9M as at Mth 12. There are significant underspends on Medical pay, Nursing pay is £0.2M better than plan due to slippage on winter plans and other pay is over by £1.0M due to the vacancy target not being allocated to individual staff groups and pressures in agency for AHPs.

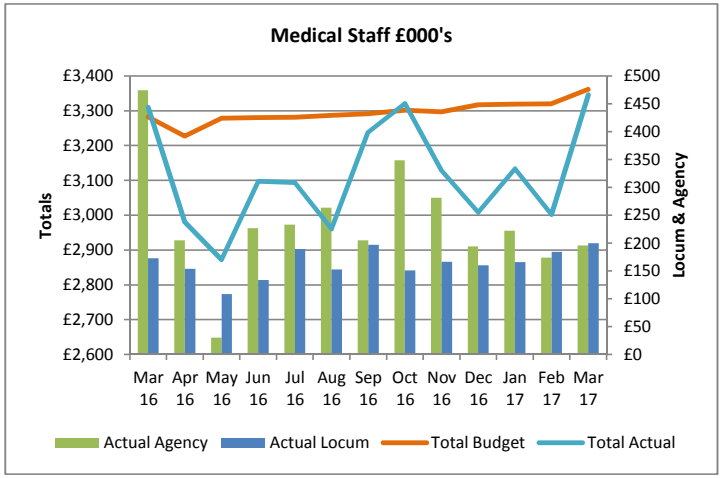
Nursing vacancies have continued to be high all year. Nursing Agency spend has had a sustained reduction since April, however, bank use over establishment for HCAs continues to support one to one patient supervision.

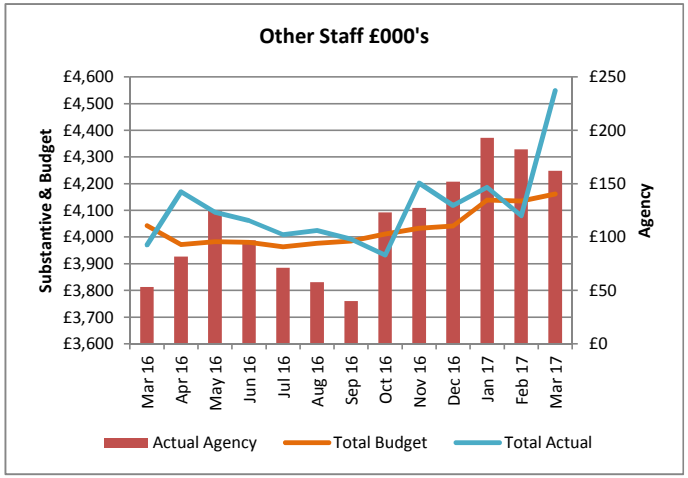
Medical pay is underspent against budget (£2.4M) as a result of consultant and junior doctor vacancies being unable to be filled with substantive or acceptable locum arrangements .

The Agency trajectory is failing in month by £0.1M and cumulatively by £1.0M. Earlier lower medical agency costs are offset by increased spend in Gastroenterology and Endoscopy and new pressures Radiography and Therapy Services.

Primary Drivers

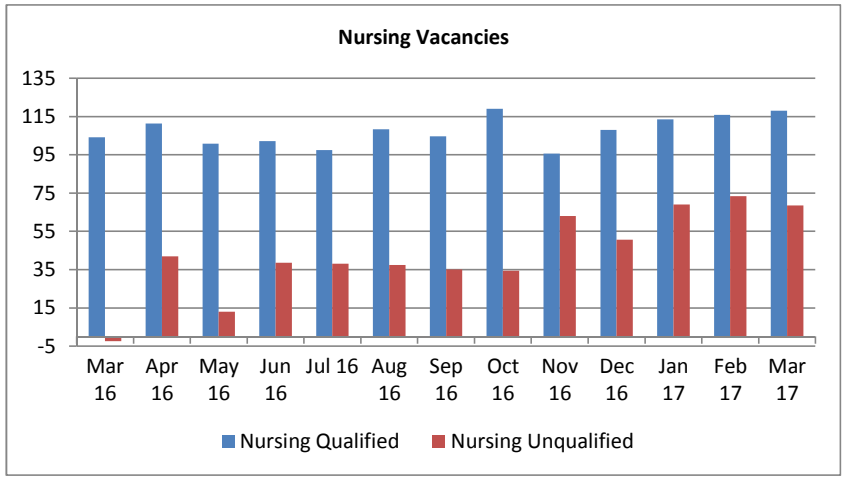


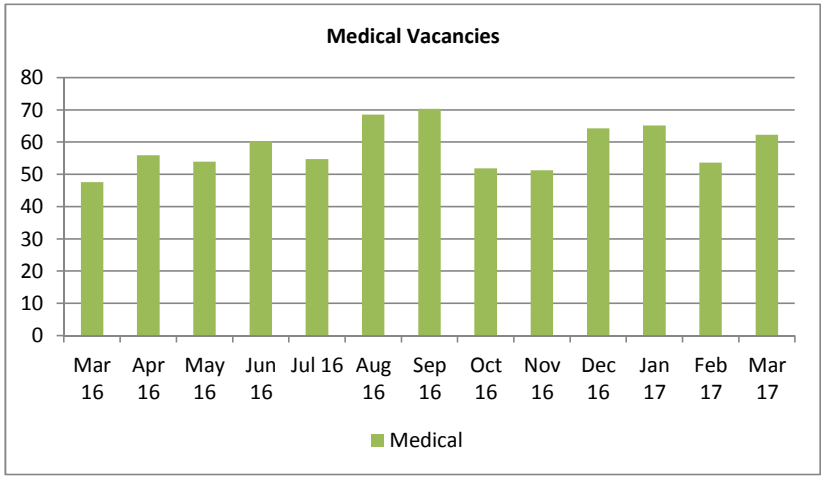




Finance: *Staff Costs*

Secondary Drivers





Agency Trajectory

	YTD	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Monthly Trend
Plan (exc CCICP)	-6,203	-593	-539	-572	-561	-515	-563	-525	-495	-477	-506	-495	-470	-484	
Actual (exc CCICP)	-7,195	-1,079	-638	-416	-570	-611	-568	-540	-699	-721	-572	-668	-618	-574	
Variance (exc CCICP)	-992	-486	-99	156	-9	-96	-5	-15	-204	-244	-66	-173	-148	-90	
CCICP Actual	-1	0	0	0	0	0	0	0	-0	-0	-0	-0	0	0	

	Rolling 13 Months													
	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Monthly Trend
Sickness Rate (Rolling 12 mths)	3.99%	3.99%	3.97%	3.95%	3.92%	3.85%	3.78%	3.80%	3.81%	3.87%	3.95%	3.96%	3.95%	
Total Leavers	31	28	24	41	36	31	39	35	37	36	44	27	42	
Turnover (Rolling 12 mths)	11.93%	11.87%	11.52%	11.63%	11.60%	11.19%	10.76%	10.56%	10.71%	10.87%	10.78%	10.66%	10.91%	

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Title of Paper :	Access and Flow 2017/18	
Author:	Liz Huntbach, Senior Project Manager - Access & Flow Jonathan O'Brien - Director of Operations	
Executive Lead:	Denise Frodsham – Chief Operating Officer	
Type of Report:	Concept Paper	X
	Strategic Options Paper	
	Business Case	
	Information	X
	Review/Benefits/Audit	

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

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

Positive Benefit:	The paper provides an overview of the key work stream enablers, KPIs and quality impact assessment of the Access and Flow Programme for 2017/18.
Risk:	There is a risk that the Trust is unable to manage non-elective activity within the resources available, resulting in failure of regulatory standards relating to patient access.

To be published on Trust Website –complete version	***Y***
If no, to be published on Trust Website – redacted	***N***
If not to be published complete or redacted, please detail the reason why	N/A
Presented at Board Meeting of:	2nd May 2017

Mid Cheshire Hospitals NHS
NHS Foundation Trust

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Author:	Liz Huntbach, Senior Project Manager - Access & Flow Jonathan O'Brien - Director of Operations	
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Type of Report:	Concept Paper	✓
	Strategic Options Paper	
	Business Case	
	Information	✓
	Review / Benefits / Audit	
Link to Strategic Objectives:	Quality, Safety & Experience	✓
	Strong Progressive FT	✓
	Organisational Delivery	✓
	Workforce Development & Effectiveness	✓
	Fit for Purpose Infrastructure	✓
	Emergency Preparedness	
Link to Board Responsibility:	Performance	✓
	Accountability	
	Strategy	
	Implementation	✓
Action Required:	Decide	
	Approve	✓
	Note	
	Recommend	
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To be published on Trust website – complete version	Y	
To be published on Trust website – redacted version	N	
If not to be published complete or redacted, detail the reason why	N/A	

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1. Executive Summary

The Access & Flow Transformation Programme is entering its second full year of delivery, having achieved the majority of objectives agreed during the 2016/17 financial year. Whilst not achieving the four hour standard, it is recognised that non-elective flow and the four-hour standard performance at Mid Cheshire Hospitals NHS Foundation Trust is improving, comparing favourably to both peer and on a national basis.

The paper provides an overview of the work which will be undertaken in the 2017/18 financial year, with a specific focus on realigning the bed base in the Medicine & Emergency Care Division to more accurately align with the demand profile expected throughout the financial year. Along with process changes which will support improvements to non-elective flow and reduce reliance on beds as capacity in the system, a number of enablers are proposed which will facilitate non-elective flow and are aimed at reducing inappropriate extended lengths of stay and the number of medically optimised patients in the acute hospital setting.

Winter resilience planning is taken into account, with early identification of the schemes to be implemented from December 2017 to March 2018 inclusive, with the expected financial impact of such schemes identified.

The net financial impact of the proposal is to achieve a £765K cost improvement (part-year effect) during 2017/18 and a recurrent cost improvement of approximately £950K. Full financial tables and a breakdown of how this is achieved is included in the paper and appendices. A risk assessment and quality impact assessment of the proposed changes are also included in the paper.

The paper was approved at the Executive Management Board (EMB) on 6th April 2017 and the recommendation contained within the paper is for the Trust Board of Directors to approve the proposed programme for 2017/18 for implementation.

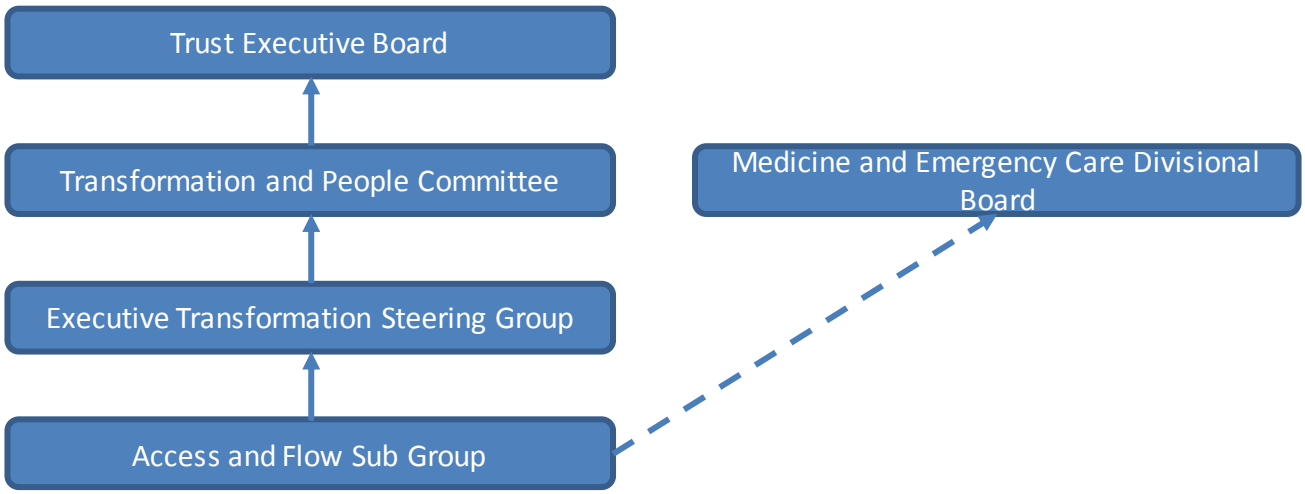
2. Introduction

The Access & Flow Transformation Programme at Mid Cheshire Hospital NHS Foundation Trust (MCHFT) has successfully delivered the majority of objectives set for 2016/17. Non-elective flow in the hospital has been improved through the accumulation of many small improvements across the Emergency Department, assessment units, core ward processes, and diagnostics and discharge arrangements. Whilst not consistently yet delivering the four hour standard, the Trust's performance against non-elective access standards is currently situated firmly in the top quartile of acute trusts nationally, which has largely been achieved through less of a focus and reliance on beds as capacity and a greater focus on system and process improvement to drive the quality and efficiency of patient pathways.

The aim of the Access & Flow programme for 2017/18 will be to deliver higher quality care in the right setting within a flexible medical bed base. This will be achieved by implementing a number of key enablers that will sit under five key work streams. This is a very challenging aim in the current operational and regulatory environment and is not without risk. The programme will therefore work to manage risks effectively throughout the financial year.

Governance Structure

The governance structure will follow existing arrangements for Access & Flow.



The Access & Flow programme will be overseen and chaired by Jonathan O'Brien, Director of Operations and will continue to have a full time Senior Project Manager. Clinical Leadership will be provided within the work streams with overall supervision from Dr Doug Robertson, Associate Medical Director for Medicine & Emergency Care.

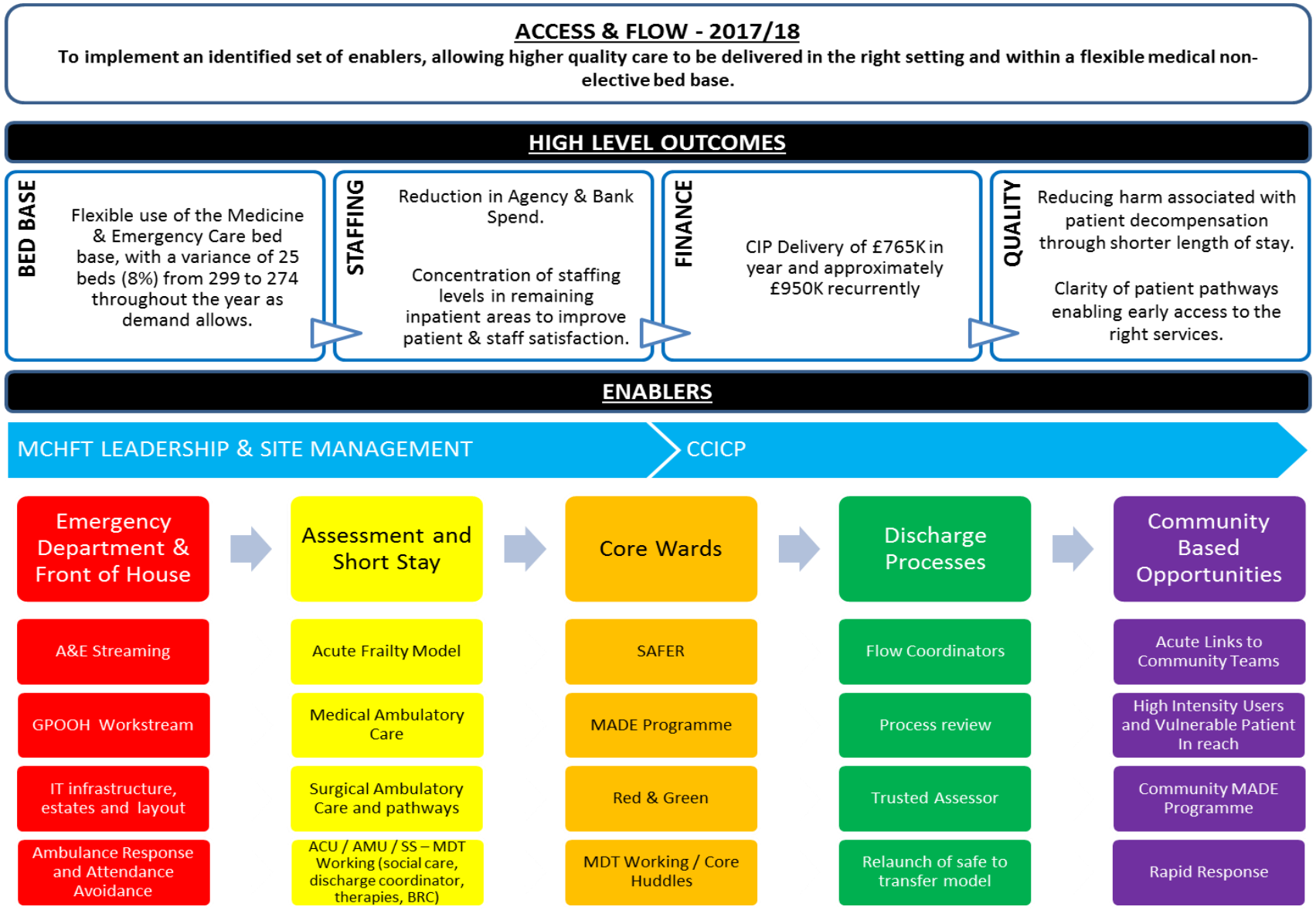
3. Access & Flow Workstreams

There will be five work streams in Access & Flow in 2017/18. Each will have an identified lead, working on a number of enablers. The high level structure of the programme is shown in Chart 1 on page 4. The work streams are:

- ✓ Emergency Department and Front of House
- ✓ Assessment and Short Stay
- ✓ Core wards
- ✓ Discharge processes
- ✓ Community Based Opportunities

Supporting the work streams will be the overarching changes made to the operational management of the site and wider health economy through CCICP.

Chart 1: Access & Flow 2017/18 Overview



i. Emergency Department and Front of House

Work stream Leads: Names removed under Section 40 of the Freedom of Information Act

Aim

To deliver a 24/7 ED with extended primary care streaming (8am – 11 pm), 365 days within a shared front door service, directing people to the right care in the right area so that they receive the care that they need be it Emergency Care, Urgent Care, GP or Primary Care services. This will have an impact on the ED by directing flows more consistently to a minor illness primary care led service and support performance against the 4 hour access target.

NHS England guidance for primary care streaming have outlined the standards for best practice at the front door. For this there should be:

- Streaming
- An onsite GP (8am to 11pm, 365 days per year)
- Shared and robust governance between Urgent, Emergency and Primary Care services.

The Royal College of Emergency Medicine recommends that Emergency Departments use simple streaming as part of their initial assessment processes. Processes should be resourced to meet variation in demand, and be delivered by trained clinical staff.

There are three main objectives of good quality initial streaming /assessment:

1. Improving safety
2. Identifying acuity to ensure that the most time-critical patients are treated by the right service within appropriate time frames and that appropriate prioritisation occurs for the remainder.
3. Improving efficiency in the system to ensure that patients do not wait unnecessarily for investigations or diagnostic decision making.

A multiagency steering group has been set up to deliver the vision and transformation of the front of house working processes. The new model will facilitate early streaming and navigation of patients ensuring the right patients access ED and the co-located GP service. The group will also work on community strategies to reduce ED attendance and admission avoidance. The group will ensure the service offered is complaint with NHS Improvement mandatory standards by September 2017. Capital funding is available to support the development and the Trust is bidding for approximately £750,000 to support some minor estates modifications and IT infrastructure in the Emergency Department and urgent primary care services.

Key Enablers

- **Creating a vision for the service** - **Shared Front Door Vision:** 'Patients presenting to the 'Front of House' will consistently be directed to a clinician or service with the skill set to provide their care first time within a robust, resilient and timely service.'

- **Workforce modelling** - review of the current workforce identifying the skills and competency required for the vision, providing training and development programmes.

- **Clinical streaming** - complementing self-streaming and ensuring that the patient is directed to the appropriate area and skill set to deliver their care, making use of the available capacity of all areas.

- **IT infrastructure, Estates and layout** – as part of the vision the physical area will be reviewed to identify opportunities for improved access, flow and efficiency.

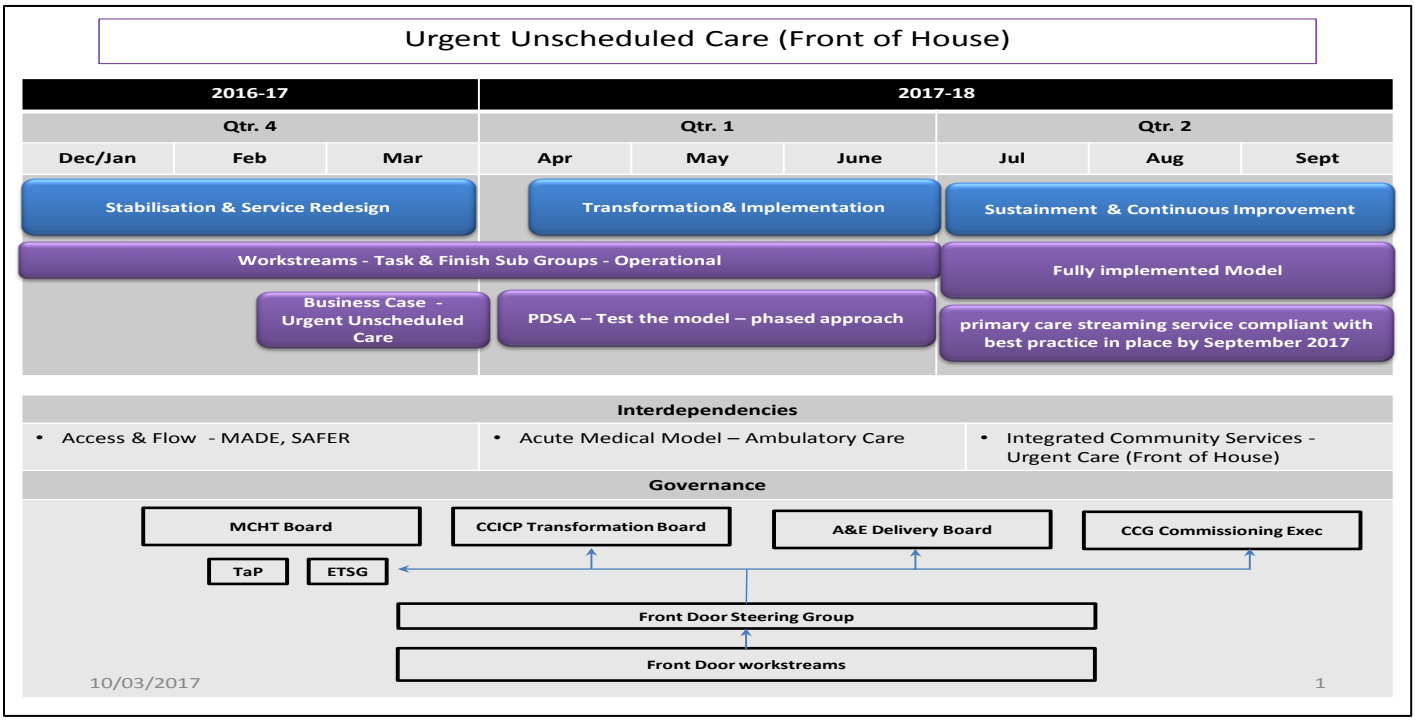
- **Attendance avoidance** - as part of the shared front door initiatives that support admission and attendance avoidance will be developed with the CCICP. This will include the best use of community services, Primary Care services, Ambulance & Paramedic services and third sector organisations.

Key Performance Indicators

The following KPIs will be monitored throughout the year:

95% 4 hour Access Target	Minors / Majors 4 hour Access Target compliance
Time to triage	Total Time in ED
% of patients directed to each flow stream	4 &12 hour trolley waits
Emergency department re-attendance within 72 hours	Patient feedback
Access to each flow stream & ambulatory care	Conversion rate

Key Milestones



ii. Assessment and Short Stay

Medicine & Emergency Care Leads: Names removed under Section 40 of the Freedom of Information Act

Surgery & Cancer Leads: Names removed under Section 40 of the Freedom of Information Act

Aim

To provide direct access to specialised medical and surgical clinicians and increase the number of patients who can be managed on an ambulatory pathway. To design and develop a comprehensive frailty service.

Key Enablers

- Frailty pathway

It is widely recognised that hospitals are not the safest place for frail elderly patients, who are particularly at risk of inpatient deconditioning and associated comorbidities. Pathways will be designed for frail elderly patients, with an aim of reducing overall length of stay. Frail elderly patients will be identified and rapidly assessed by experts. This pathway is in the early stages of development by a multi professional group supported by the acute models of care programme. Once the strategic view and operational processes are mapped out the team will be looking to promote the service amongst hospital and community partners.

- Rapid access to clinics and diagnostics

Work will take place with the diagnostic division to ensure that patients who present via the GP non elective route have the same level of access to emergency and urgent diagnostics as ED patients, decreasing the length of stay in the ambulatory care units and assessment wards.

- MDT working in assessment and short stay areas

Following their successful pilot on Ward 2, regular MDT board rounds will be rolled out in AMU and short stay to ensure pace continuity and clarity of the patient journey. This will link to the frailty work but also the work with the SAFER bundle, ensuring that patient journeys are planned clearly and communicated to patients and carers.

- Surgical Pathways

The surgical ACU was opened in September 2016. Currently, the unit is open from 1200 and 2000 Monday to Friday and treats general surgical patients. The Division of Surgery & Cancer have been allocated Ward 11 to enable the development of a fit-for-purpose and flexible assessment area, working for the wider Division. On 28th March 2017, the Division commenced a 12 month national programme led by NHS Elect, with 11 other sites, being in the first cohort of Trusts to develop robust surgical ambulatory care services.

Work is planned to identify the main causes of emergency admissions to surgery so that fast track pathways can be developed reducing patient LOS and improving patient experience.

Key Performance Indicators

Targets and final measures to be confirmed but the following figures are monitored on the ACU dashboard:

Proportion of ambulatory patients transferred to a core ward	Proportion of GP admissions that attend the ambulatory care directly for Medicine and Surgery
Readmission rates	Number of hours GP patients wait in the ED
Reduction in time from admission to patient assessment by frailty Consultant (eligible patients)	Reduction of length of stay in patients identified with frailty conditions on medial wards
Reduced length of time to initial therapy assessment	

iii. Medical Core Wards
Leads: Names removed under Section 40 of the Freedom of Information Act

Aim

To embed the SAFER patient flow bundle and implement systems and processes that keep length of stay to a minimum for all patients ensuring the patient is aware of each step of their journey.

Key Enablers

- Ward by ward roll out of the SAFER bundle (including surgery)

Details of the bundle are contained in the box below. Compliance with the 5 parts of the bundle will improve the patient experience, decrease LOS and make overall journeys clearer.

- In and out of hospital MADE events

Specialised Multidisciplinary learning events designed to identify ways in which processes and communications can be improved to streamline the patient journey.

- MDT working

Scope and roll out improved MDT working processes on wards to enhance inter-professional communication and patient care, treatment and discharge planning

For this financial year the CCG have included the SAFER patient flow bundle as part of the SDIP programme. All wards will be expected to have rolled out SAFER by the end of Q3.

S - Senior Review- All patients will have a review before midday
A - All patients to have an expected date of discharge
F – Flow to commence by 10 am from assessment units
E – Early discharge 33% of patients should be discharged before midday
R – Review of all patients with LOS greater than 14 days

At the beginning of the Access & Flow programme in 2016, it was usual practice to have twice weekly consultant led ward rounds on most medical wards. This meant that patients on inpatient wards could sometimes wait a number of days before receiving a senior review delaying the vital decision making needed to progress patient care at an appropriate pace. During 2016/17 managers and clinicians worked together to alter job plans and plan new ways of working on the medical wards, enabling more frequent consultant ward rounds and a robust plan for senior registrar reviews to progress care.

In order to progress safely to discharge a patient should be able to answer four simple questions:

What is the matter with me?	**What is going to happen to me today?**
What is needed to get me home?	**When am I going home?**

Clear MDT working and communication will be key to answering these questions for our patients and for keeping pace in care delivery to minimise the risks of prolonged hospital stays. This focus will build on progress made regarding escalation of delayed investigations and consultations and the 7 day LoS reviews.

Finally, this year work will take place with Clinicians, discharge coordinators and nursing staff to embed SAFER as a whole bundle, building on progress that has been made with early discharges and length of stay through MDT working and LOS review meetings.

Key Performance Indicators

Discharges before 10 (one a day on each core ward)	Length of Stay
Discharges before midday (33% of overall discharges on all core wards)	Number of bed days consumed by patients in the hospital 7 days or more

iv. Discharge Processes

Leads: Names removed under Section 40 of the Freedom of Information Act

Aim

To ensure a safe and timely discharge for all patients with the correct level of support. It is recognised that delays in the safe transfer of patients from acute hospital beds to community care is constraining acute capacity.

Assessments of ongoing patient needs are taking place in the hospital setting and recent work has designed a model which supports early safe transfer out of hospital for these assessments.

Key Enablers

- Trusted Assessor

Currently patients are assessed for intermediate care, CHC funding and other community services within the hospital setting. This can result in skewed assessment and risk aversion, due to the clinical environment, delays and time wasted of community staff that have to come into the Trust to conduct assessments. Providing a system which enables ward staff or the integrated discharge team to identify patients who are community ready and safe to transfer without the need for separate agencies to will reduce delays in the patient journey.

- Process Reviews

As part of the development of the trusted assessor model, current practices and processes surrounding discharge planning will be mapped out and reviewed.

- Relaunch of Safe to transfer Model

Linked to the trusted assessor work this model will ensure that patients who no longer require acute care will be transferred out of the acute hospital setting as soon as it is safe for them to do so. This work was piloted in 2015/16 and resulted in significant bed day savings.

- Flow Coordinators

This is the reintroduction of a role on the medical wards, which is being developed to provide a single link for communication and continuity in discharge planning for patients. This has been introduced in mid-November and is currently being evaluated against LoS, patient feedback and impact on the nursing work load. Communication and discharge planning have been highlighted by initial results of the national inpatient survey as areas of potential improvement.

For this financial year there is a national CQUIN - Supporting Proactive and Safe Discharge. As part of this CQUIN, the proportion of non-elective patients discharged within 7 days to their usual place of residence must be increased. This carries a weighting of 40% of the CQUIN value.

Milestones will be agreed and managed through the Discharge meeting group which will report to the AEDB.

Key Performance Indicators

Reduction of patients in hospital >14 days	DTOC currently approx. 6.5% to move to 2.5% of beds or less (3.5% for 2017/18)
90% DST to take place in community	2.5% increase in patients discharge to usual residence
Number of medically optimised days	Patient experience feedback in patient survey
Excess bed day (eliminate the increase of £1m over 16/17)	

v. Community Based Opportunities

Leads: Names removed under Section 40 of the Freedom of Information Act

Aim

To link with community transformation partners to identify opportunities and make changes to improve pathways, ensuring seamless services for patients.

Key Enablers

Acute links to community teams	High intensity users and vulnerable patient care plans
Rapid Response	Community MADE Programme

- Acute links to community teams

IT solutions are being explored to enable notifications to be sent to Matron and district nursing teams when patients from their areas are admitted, providing opportunities for in reach and early discharge planning / transfer back for community management.

- Rapid Response

Starting in May a 90 day trial will provide GPs and assessment areas with access to community matrons to provide rapid assessment and intervention for people in their own environments potentially avoiding admissions to the GP medical non elective stream. This will potentially involve facilitating clinician to clinician phone calls between the acute assessment areas and community matron teams

- High intensity users and vulnerable patient care plans

Working alongside the community paramedic, community teams and the end of life care partnership develop care plans to avoid unnecessary conveyance to hospital for specific patient groups.

- Community MADE programme

The community MADE programme will address a broad range of themes such as community bed utilisation, working processes and practices and will feed into the work of the discharge processes section of the plan.

Key Performance Indicators

Admission avoidance numbers	Attendance avoidance numbers
Number of calls to rapid response	

4. Flexible Use of Bed Base

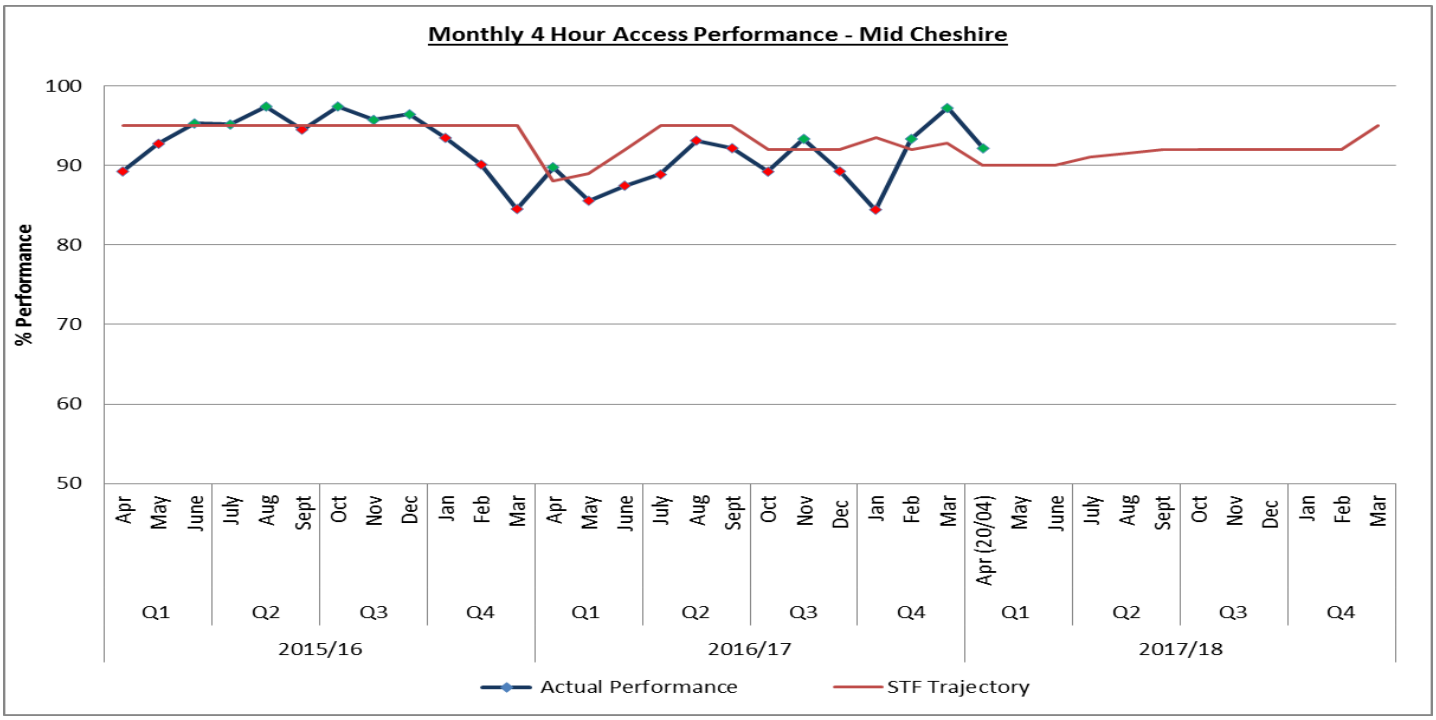
The Access & Flow programme in 2017/18 will focus on delivering medical non-elective flow and the A&E 95% standard within a flexible bed base, enabling a responsive service to winter pressures and infection control outbreak situations.

As background for this, the latest version of the Trust's STF trajectory is shown in red in the Table 2 and Chart 2. It should be noted that 30% of the Trust's STF income of £6m is dependent on achievement of this trajectory, with payment split into equal twelfths for achievement in each individual month.

Table 1: A&E STF Trajectory 2017/18

Profiled attendances for 2017-18													
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Avg attends	7,291	7,761	7,612	8,007	7,300	7,488	7,465	7,025	7,169	6,894	6,634	7,725	88,370
Perf Trajectory (%)	90.0%	90.0%	90.0%	91.0%	91.5%	92.0%	92.0%	92.0%	92.0%	92%	92%	95%	92%
Breaches (auto calc)	729	776	761	720	620	599	597	562	574	551	531	386	7,400
Qtrly Perf			90.0%			91.5%			92.0%			93.1%	

Chart 2: A&E STF Trajectory 2017/18



4.1 Medical Bed Capacity

Ward 18 has been identified as the flexible capacity within Medicine for a number of reasons:

1. This is the smallest medical ward with 25 beds, this therefore the least efficient medical ward
2. One of the two Consultants who care for patients on Ward 18 left on 31st March 2017.
3. Ward 18 has the least number of medical ward rounds per week and due to multiple factors has the longest length of stay
4. It affords the Trust the opportunity to care for in patients with diabetes differently.

Table 2 outlines the proposed profile of bed capacity for the Trust for the 2017/18 financial year.

Table 2: Bed Capacity Profiling 2017/18

Month / Division	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Medicine & Emergency Care	301	301	301	276	276	276	276	276	301	301	301	301
CCU	4	4	4	4	4	4	4	4	4	4	4	4
Ward 1	28	28	28	28	28	28	28	28	28	28	28	28
Ward 14	32	32	32	32	32	32	32	32	32	32	32	32
Ward 2	32	32	32	32	32	32	32	32	32	32	32	32
Ward 21B	24	24	24	24	24	24	24	24	24	24	24	24
Ward 4	32	32	32	32	32	32	32	32	32	32	32	32
Ward 5	32	32	32	32	32	32	32	32	32	32	32	32
Ward 6	28	28	28	28	28	28	28	28	28	28	28	28
Ward 7	32	32	32	32	32	32	32	32	32	32	32	32
AMU	32	32	32	32	32	32	32	32	32	32	32	32
Ward 18	25	25	25	Closed					25	25	25	25
Surgery and Cancer	134	134	134	134	134	134	134	134	140	140	140	140
SAU	15	15	15	15	15	15	15	15	21	21	21	21
Ward 10	23	23	23	23	23	23	23	23	23	23	23	23
Ward 12	32	32	32	32	32	32	32	32	32	32	32	32
Ward 13	32	32	32	32	32	32	32	32	32	32	32	32
Ward 15	32	32	32	32	32	32	32	32	32	32	32	32
Surgery and Cancer (ORTHO)	24	24	24	24	24	24	24	24	24	24	24	24
Ward 9	24	24	24	24	24	24	24	24	24	24	24	24
Vacant (Unfunded) Capacity	32	32	32	57	57	57	57	57	26	26	26	26
Ward 10	15	15	15	15	15	15	15	15	15	15	15	15
Ward 11 (SAU/SACU)	17	17	17	17	17	17	17	17	11	11	11	11
Ward 18	In Use			25	25	25	25	25	Winter			
Ward 19	Paediatrics Refurbish											

There are no plans for any additional ward refurbishment outside of the planned work on the paediatric wards. This will mean that the ward 18 space would still be functional and available at short notice should it be required.

4.2 Bed Modelling

The Business Intelligence Unit (BIU) have produced a bed model based on the profiled activity and expected Bed Day Index to provide an overview of the capacity required to achieve a 95% occupancy rate in Medicine & Emergency Care Division for each month during the 2017/18 financial year. This takes into account the flexible use of bed capacity as indicated previously and is shown in Table 3. This shows that a 95% occupancy level is a challenging proposition for the Division, however it should be noted that this is a much improved projected position if compared to both 2015/16 and 2016/17, when resource deficits to a 95% occupancy level were indicated to reach up to 45 beds over the winter months.

Table 3: Bed Modelling – Medicine & Emergency Care Division 2017/18

Available Beds												
Days In Month	30	31	30	31	31	30	31	30	31	31	28	31
Month	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Bed complement	301	301	301	276	276	276	276	276	301	301	301	301
Modelling Adjustment	0	0	0	0	0	0	0	0	0	0	0	0
Net Beds Available	301	301	301	276	276	276	276	276	301	301	301	301

Forecast												
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Total Spells	1927	1892	1788	1799	1771	1822	1949	1843	1935	1964	1826	1928
Occupied Bed Bays	8802	8768	8256	8116	8090	8281	8730	8493	8794	9403	8381	8920
Bed Day Index	4.57	4.63	4.62	4.51	4.57	4.55	4.48	4.61	4.54	4.79	4.59	4.63
Avg. Beds Required	293	283	275	262	261	276	282	283	284	303	299	288
Avg % Net Beds	97.47%	93.96%	91.43%	94.86%	94.55%	100.02%	102.03%	102.58%	94.25%	100.77%	99.44%	95.60%
Additional Beds Required To Achieve Target Occupancy Rate	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
95%	8	-3	-11	0	-1	15	20	22	-2	18	14	2

The overall Trust position taking into account both Medicine & Emergency Care and Surgery & Cancer Divisions, in relation to a 95% occupancy level is shown in the table below. As indicated, this shows that for any given month with current planned activity levels, the Trust does not breach a 95% occupancy level and in the majority of months the position is much better than this, approaching a 90% occupancy level.

Table 4: Bed Modelling – Total Trust Position 2017/18

Available Beds												
Days In Month	30	31	30	31	31	30	31	30	31	31	28	31
Month	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Bed complement	435	435	435	410	410	410	410	410	441	441	441	441
Modelling Adjustment	0	0	0	0	0	0	0	0	0	0	0	0
Net Beds Available	435	435	435	410	410	410	410	410	441	441	441	441

Forecast												
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Total Spells	2503	2473	2354	2411	2365	2427	2565	2420	2536	2541	2384	2544
Occupied Bed Bays	11872	11861	11236	11370	11419	11405	11976	11656	11990	12672	11442	12282
Bed Day Index	4.74	4.80	4.77	4.72	4.83	4.70	4.67	4.82	4.73	4.99	4.80	4.83
Avg. Beds Required	396	383	375	367	368	380	386	389	387	409	409	396
Avg % Net Beds	90.97%	87.96%	86.10%	89.45%	89.84%	92.72%	94.23%	94.77%	87.70%	92.69%	92.66%	89.84%
Additional Beds Required To Achieve Target Occupancy Rate	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
95%	-18	-32	-41	-24	-22	-10	-3	-1	-34	-11	-11	-24

5. Operational Enablers

A number of enablers have been identified through the Access & Flow programme which will support the implementation of the flexible capacity approach.

i. Specialist Nurse (Diabetes Quality Nurse)

Closing a clinical area specifically identified for the care of patients with diabetes and endocrine conditions risks the loss of specialist nursing and medical knowledge. Approximately 10-15% of inpatients have diabetes therefore the majority of these patients are not cared for in a specialist environment. The strategic development for improving the quality of diabetes care will require a step wise approach.

As an organisation we have signed up to the Advancing Quality agenda. A Trust wide strategy and analysis against national guidance such as NICE and JBDS needs to be developed to provide a clear clinical focus. Therefore as a first step a project management approach would drive this but it is envisaged that once there is a clear strategy and project plan a more clinical role such as a diabetic specialist nurse would be required.

Costs

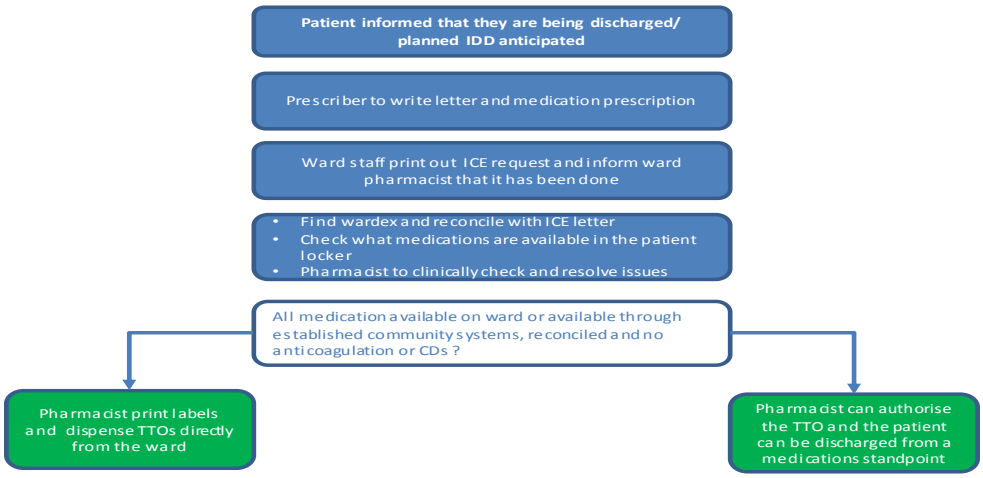
Quality Nurse Band 7	£45,317
Total	**£45, 317**

ii. Pharmacy – Improved TTO Processes

Reducing the time taken to dispense TTOs will:

- Increase patient satisfaction
- Decrease mistakes due to multiple hand offs
- Facilitate morning discharges
- Reduce stock wastage

A revised process has been discussed with Pharmacy to improve current processes. For the current process for dispensing TTOs please see Appendix 1. Providing a “roaming” pharmacist, a local medicine stock and a label printing machine will result in the following simplified process:



This change in process would result in a shorter turnaround time for patients awaiting take home medications and will enable discharge from hospital earlier in the day, supporting the work on the SAFER flow bundle.

Costs

Label Machine for Wards 1 & 2	**£580 (exc. VAT)**
Computer on wheels	**£3,000 (exc. VAT)**
B7 Pharmacist	**£48,000**
Recurrent Total	**£48,000**
Non Recurrent Total	**£3,580 (exc. VAT)**

iii. Enhanced Therapy: Frailty

Ward 7 is the base for the elderly care frailty consultants and is currently staffed to provide rehabilitation and assessment on arrival for the frail elderly patient. A full time physiotherapist, therapy assistant and OT are currently employed on a temporary basis on Ward 7, providing enhanced rehabilitation for frail elder and complex patients. As part of the national CQUIN the Trust is required to increase the number of patients >65 years discharged to their usual place of residence within seven days by 2.5%. Support to continue this scheme will have a direct impact on this measure and the SDIP for frailty.

Since starting the pilot on Ward 7, 100% of patients with an identified rehabilitation need have had a clinically significant increase in their functional capability as measured by the Canadian Model of Occupational Performance (COPM) score and patients improved an average of 5 points as measured by the Elderly Mobility Score (EMS). In a recent audit looking at cases from June to August collected on Ward 7, 105 patients were discharged to usual place of residence (41% of the patient group).

The proposal is to substantively fund the frailty therapy input onto Ward 7 as part of the development of the frailty model.

Cost

Physiotherapist - Band 6	£37,762
Occupational Therapist - Band 6	£37,762
Therapy Assistant - Band 3	£22,138
Total	**£97,662**

iv. Discharge Coordinators: Medicine

This role was introduced in November, funded by winter resilience finance, as a pilot on Wards 1, 4, 7, 14 and 18. The Discharge Coordinators are Band 3 members of staff, who provide daily support in relation to discharge coordination to the qualified nurse coordinator on each ward. This has had a dual impact on each Ward by introducing a dedicated member of staff to act as the point of coordination between various agencies (social care, CHC, ambulance services, IDT) and the ward on individual cases, whilst secondly freeing up the time of the qualified coordinator who would previously have done many of these duties. The pilot phase of this role has now enabled clear responsibilities to be defined and a detailed job description is being prepared.

Discharge coordinators are key to obtaining an early assessment of the home circumstances of individual patients, so that their discharge can be planned on arrival to the ward area as opposed to when declared medically optimised. Since being appointed, the timing of discharges each day has been brought forward. This role is also seen as key to the ward-by-ward implementation of the SAFER bundle in the 2017/18 financial year.

Costs

5.0 WTE Discharge Coordinators Band 3	5 x £22,400
Total	**£112,000**

v. Enhanced Therapy: REACT

This service based in ED, the assessment areas and short stay ward comprises Occupational Therapy, Physiotherapy and Speech and Language services. This has been funded as part of winter resilience monies in 2016/17.

Based on experience and feedback, REACT winter services had a positive effect on:

- Patient experience and outcomes
- Patient flow and 4 hour waits
- Increased numbers of home visits potentially shortening LOS
- Early expert assessment for patient potentially requiring a period of rehabilitation
- Signposting to relevant out of hospital enablement solution

Approximately 49% of patients referred to REACT were discharged from the emergency department. Most returned home with additional support. Patients who were admitted, had a rehabilitation plan if required or a plan for hydration and nutrition if swallowing difficulties were present. Based on the activity recorded over these periods approximately 3900 referrals would be expected per annum.

The proposal would be to enhance the existing substantively funded team, enabling home visits and greater community links which would support the frailty work and the safer discharge CQUIN.

Costs

Physiotherapist Band 6	£37,762
Occupational Therapist Band 6	£37,762
Therapy Assistant	£22,138
Total	**£97 662**

vi. British Red Cross Services

The British Red Cross (BRC) have been supporting the Trust for the past three years to provide transport home for frail and elderly patients form ED, assessment units and core ward areas. During the period December 2016 to March 2017, the BRC supported the discharge of over 600 patients from MCHFT. The service not only takes the patient home, but checks that there are no issues in relation to heating, food or settling the patient back to into their residence. There is a consistent telephone follow-up for each patient on the day following discharge, to ensure the patient has settled back into their home and further support as appropriate can be provided by the British Red Cross Support At Home team. This team is commissioned by the Local Authority and CCG to provide up to six weeks support at home for the vulnerable upon discharge. This seamless service has been invaluable to the Trust over the past six months, not only in supporting successful patient discharge, but ensuring from an operational perspective that this is timely, decongests departments quickly when patients are ready to go home and helps to prevent readmission.

Costs

British Red Cross Services	£135,000
Total	**£135,000**

vii. SACU Project Manager Support

Non-recurrent project management support to develop the Surgical Ambulatory Care Unit (SACU) will be required for the national programme.

Costs

Project Support	£41,000
Total	**£41,000**

6. Financial Analysis

The financial impact of the programme for 2017/18 is a net delivery of £765K CIP in 2017/18 and a recurrent CIP of approximately £950K, which results from a combination of costs removed from Ward 18, funding of identified enablers and savings from the winter resilience budget which has temporarily funded a number of the enablers in the past.

The financial tables in Appendix 3 provide the full financial breakdown of these changes and have been produced by the finance team for Medicine & Emergency Care. The remaining winter schemes for 2017/18 and their funding allocations are outlined from the outset of the financial year.

7. Human Resource Implications

The detailed pay budget for Ward 18 is outlined in table 5 below. In summary, the total cost of providing 25 inpatient beds on Ward 18 is £1.2M per annum.

Table 5: Ward 18 Staffing Structure & Budget

Pay		£1,067,172
Grade	Budgeted WTE	Staff in post
Admin & Clerical Band 2	1	1
Nursing Band 2	16.64	16.19
Nursing Band 5	12.51	8.51
Nursing Band 6	2.49	2.49
Nursing Band 7	1	1
Support Staff Band 3	0.5	0.5
Non-Pay		£103,267
Other		£18,382
TOTAL		**£1,188,821**

There are 29.69 WTE staff in post on Ward 18 and the reduction in substantive bed base will reduce the number of qualified nursing and HCA posts required within the medical division overall, by these numbers. A formal management of change process will be followed to ensure staff are supported into posts in other areas within the Division. There are sufficient vacancies within the Trust to ensure that suitable placements are available for all staff. Most staff affected will find equivalent posts covering vacancies in the M&EC division. The ward will be losing one substantive Consultant due to resignation and the remaining Consultant will continue to have an inpatient base for patients with endocrine or complex wound needs on Ward 7.

It is anticipated there will be a positive impact within the Division of a reduced number of registered nursing vacancies. This may have a subsequent positive impact on bank and agency spend and a positive clinical impact on the remaining medical floor through increased concentration of staff for whom the trust has a shortage of supply.

The reduction of the inpatient diabetes capacity will require early identification of patients within the medical bed base who may need additional support in relation to their diabetic care, or complex wounds related to diabetes. Ward 7 will be the inpatient area for any patients who may need expert input into the care and treatment of diabetes or complex wounds. Leadership will be provided by the Band 7 Quality nurse who in the first instance will ensure a smooth transition of nursing skills and competencies to ensure safe delivery of diabetes care associated with the move from ward 18 to ward 7.

8. Recommendation

It is recommended to the Board to support the plan for the Access & Flow programme for 2017/18, reallocation of funding to support the enablers requested and subsequent delivery of the CIP of £765K in 2017/18 and £950K recurrently.

- There are currently over 36 qualified nurse gaps across the medical division during winter when additional beds are required this figure increases. Reducing the number of wards will allow staff from ward 18 to be redeployed to improve staffing levels on other wards.

- Ward 18 is currently the diabetes and endocrinology ward, admission data suggests that the number of patents whose clinical condition means that they would benefit from admission to specific diabetes/endocrinology beds rarely exceed 10 patients at any time.

- The temporary loss of a Consultant Diabetologist means that a single-handed Consultant would not be able to safely cover 25 diabetes/endocrinology beds.

- A number of initiatives have been trialled over recent months to look at new ways of working; the success of these pilots has allowed the Trust to close winter bed capacity early and has delivered a significant improvement in patient flow as evidenced by the improvements in the 4 hour access standard.

- In order to implement these changes on a permanent basis a significant proportion of the funding required to keep ward 18 open will be reinvested in new posts that help to reduce length of stay.

A management of change paper is due to be presented to staff during the week commencing 17th April 2017.

Special considerations:
Divisional risk assessment for safe staffing levels.

Employees/Non-Employees at risk *(tick to indicate)*:			
Clinical staff (including HCA's, Students and AHP's)	✓	Other please indicate: Physiotherapist, Occupational therapists, Dietician, Social care team	✓
Contractors		Patients (including outpatients)	✓
Non clinical staff	✓	Visitors	✓

Assessor Details:		**Manager Details:**	
Name:	**Rachel Wilkinson**	**Name:**	**Linda Ormson**
Job Title:	**Modern Matron**	**Job Title:**	**Divisional Head of Nursing - MECD**
Date:	**13/04/17**	**Date:**	**13/04/17**

Hazard/Cause Identified	Potential Harm	Initial Risk Rating Consequence/Effect & Likelihood			Current Control Measures	Current Risk Rating Consequence/Effect & Likelihood			Accept Risk? (Yes or No)
		C	L	Risk Score CxL		C	L	Risk Score CxL	
Risk 1 There is a risk that not all staff will be placed into current vacancies.	Very low staff morale (50% – 75% of staff)	4	4	16	All staff will be supported through the management of change process as per Trust Policy. There has been a Trust wide vacancy freeze for Band 2 HCA's. There are sufficient RN vacancies within the Division. All staff will have access to Trust support mechanisms, with the opportunity to have 1:1 meetings with the relevant matron, Union Reps, HRM and the DHoN.	4	2	8	Yes
Risk 2 There is a risk to diabetic patients being placed on a ward that does not specialise in diabetes	Major injury / long term incapacity / disability e.g. loss of limb. An event affecting large numbers of persons. Any incident that appears to have resulted in permanent harm* as a direct result of the incident. Unsatisfactory management of patient care – local resolution (with potential to go to independent review) Increased length of hospital stay by 4 – 15 days Justified complaint (Stage 2) involving lack of appropriate care Late delivery of key objective / service due to lack of staff	4	5	20	All patients that are identified as requiring care specific to diabetes will be cohorted on Ward 7. Consultant cover will transfer from Ward 18 to Ward 7. Ward 7 currently accommodates patients with diabetes and complex wounds. In-reach support will be provided by Band 7 and Band 6 Specialist Nurses. Band 7 to develop specific diabetic care pathways. WTE Band 6 to transfer from Ward 18 to Ward 7 to provide senior support with diabetic patients and patients with complex wounds such as diabetic wounds and lava therapy.	4	3	12	Yes

Hazard/Cause Identified	Potential Harm	Initial Risk Rating Consequence/Effect & Likelihood			Current Control Measures	Current Risk Rating Consequence/Effect & Likelihood			Accept Risk? (Yes or No)
		C	L	Risk Score CxL		C	L	Risk Score CxL	
					Staff on Ward 7 to be a priority area in the training plan for the completion of the E-Learning Insulin Module.				
Risk 3 There is a risk of insufficient inpatient beds to accommodate all patients requiring specific diabetic care.	Major injury / long term incapacity / disability e.g. loss of limb. An event affecting large numbers of persons. Any incident that appears to have resulted in permanent harm* as a direct result of the incident. Unsatisfactory management of patient care – local resolution (with potential to go to independent review) Increased length of hospital stay by 4 – 15 days Justified complaint (Stage 2) involving lack of appropriate care Late delivery of key objective / service due to lack of staff	3	3	9	Flexibility of the number of patients under the care of the diabetic consultants.	3	2	6	Yes
Risk 4 There is a risk of insufficient inpatient medical beds to accommodate medical patients resulting in medical boarders.	Major injury / long term incapacity / disability e.g. loss of limb. An event affecting large numbers of persons. Any incident that appears to have resulted in permanent harm* as a direct result of the incident. Unsatisfactory management of patient care – local resolution (with potential to go to independent review) Increased length of hospital stay by 4 – 15 days Justified complaint (Stage 2) involving lack of appropriate care Late delivery of key objective / service due to lack of staff	4	4	16	Monitored and ward capacity will be made available for winter pressures or infection outbreak scenarios. Clear guidance and procedures are in place for senior medical review of medical boarders.	4	3	12	No
Risk 5 There is a risk of prolonged waits in ED due to constraints in bed provision.	Major injury / long term incapacity / disability e.g. loss of limb. An event affecting large numbers of persons. Any incident that appears to have resulted in permanent harm* as a direct result of the incident. Unsatisfactory management of patient care – local	4	4	16	This can be mitigated by the changes in working practices in the acute and community sector as in the A&F Plan.	4	3	12	No

Hazard/Cause Identified	Potential Harm	Initial Risk Rating Consequence/Effect & Likelihood			Current Control Measures	Current Risk Rating Consequence/Effect & Likelihood			Accept Risk? (Yes or No)
		C	L	Risk Score CxL		C	L	Risk Score CxL	
	resolution (with potential to go to independent review) Increased length of hospital stay by 4 – 15 days Justified complaint (Stage 2) involving lack of appropriate care Late delivery of key objective / service due to lack of staff								

If Risk not accepted by Division – List further actions required:	Target Risk Rating Consequence/Effect & Likelihood			Responsible person for actions	Date for completion	Date completed
	C	L	Risk Score CxL			
Risks 4-5 The flexible bed based described within the paper gives regular reviews of the position and trajectories. Should the the KPIs not be delivered for whatever reasons then the bed based assumptions will be reviewed and discussed for further actions at EMB and Divisional Board.	4	2	8	Divisional Head of Nursing / Divisional General Manager	May 2017	

FOR RISK & GOVERNANCE MANAGERS USE ONLY:

Approved by Risk & Governance Manager:		Date of approval:
Yes	☐	

External Sources		Internal Sources			
Care Quality Commission	☐	Trust Objectives	☐	Satisfaction Surveys	☐
National Health Service Litigation Authority	☐	Financial	☐	Human Resources	☐
Health & Safety Legislation	☐	RCA & Serious Untoward Incidents	☐	Health & Safety Audits	☐
HSE Inspection/Visit	☐	Strategic & Operational Planning	☐	Security Audits	☐
National Reports	☐	Capacity Planning	☐	Training Needs Analysis	☐
Coroner's Reports	☐	Incident & Near Miss Reporting	☐	Issues Raised From Trust Committees	☐
Media & Public Publications	☐	Complaints	☐	Risk Assessment	☐
Safety Alert Bulletins	☐	Claims	☐	Internal Audit	☐
National Patient Safety Alerts	☐	Patient Advice & Liaison Service	☐	Maintenance	☐
Ombudsman Reports	☐	Development	☐		
External Audit	☐				

Appendix A: Quality Impact Assessment

Quality and Safety Indicator	% chance of impact on indicator			Description of *Potential* Impact	If Negative – outline countermeasures
	+ve	Nil	-ve)		
Patient Safety – potential for increased incidents / harm	X		X	Reduction of patient LOS and inpatient waiting Reduction in harms associated with prolonged hospital stays Risk of increased readmission rate	If programme recommended discharge planning takes place readmission rate has the potential to decrease. In addition usual ward based practices to prevent hospital associated harms should continue The readmission rate will be used as a balancing measure to check for unintended consequences of changes to discharge and transfer processes. These will also be monitored by patient feedback.
Patient Safety – Mortality	x			Reduction of harms associated with hospital acquired deconditioning. Potential loss of diabetes and endocrine beds Risk of increased medical outliers Risk of prolonged waits in the ED delaying patient assessment and treatment due to constraints in bed provision	Clear plan for 16 beds on ward 7 to be used as diabetes and endocrine beds with appropriate consultant support. Diabetes in reach and a dedicated bed base on ward 7. This will be monitored and ward capacity will be made available for winter pressures/ outbreak scenarios. Clear guidance and procedures are in place to ensure daily senior medical review of outlying patients. Can be mitigated by the changes in working practices in the acute and community sector as advocated in the A&F plan.
Patient Safety – Infection Prevention	x			Increased flexibility of bed stock in times of outbreak and winter pressure. Reduced need to move cohorts of staff around the organisation to meet short term staff short falls Risk of patients queuing in ED with infection due to lack of capacity	Key changes in working practices at the front door and changes to ward practices will ease pressure and queuing in the ED
Patient Experience – patient satisfaction	x			Clearer pathways enabling earlier access to the right services	Wards will be encouraged to “pull” patients from admitting areas to ensure right time right bed.

				Risk of dissatisfaction due to being cared for in the wrong ward or location.	Development of clear diabetic pathways
Colleague Experience – colleague satisfaction	x			Decrease in the number of occasions that staff have to be relocated to different workplaces due to short term sickness and staffing gaps. Displacement of a functioning team to other areas.	No posts will be lost and the HR process of consultation will be followed.
Colleague Safety – potential for increase in lost-time incidents	x			Increase in the proportion of patients who are cared for in the right environment New staffing models to enable safest practice and staffing modelling built into all aspects of the plan.	
Mandatory Training – ability to complete and remain up to date	x			Flexibility of staffing may increase training capacity	
Reputation / Public Relations Impact	x			Improved performance against the patient access target Improved patient satisfaction survey results	
National Standards – A&E, Access, Cancelled Operations		x		Potential for increased outlying to surgery resulting in reduction of elective activity. Potential for improved reportable performance in diabetic care.	This will be mitigated by the actions in the plan and number of outlying patients will continue to be monitored.

Summary – Requires Full Risk Assessment

Appendix iii: Financial Tables

Financial Appraisal - Access & Flow and Winter 17/18					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
	2017/18 £'000	**2018/19 £'000**	**2019/20 £'000**	**2020/21 £'000**	**2021/22 £'000**
Recurrent Income	1,919	2,216	2,216	2,216	2,216
Non-recurrent Income	0	0	0	0	0
Total Income	**1,919**	**2,216**	**2,216**	**2,216**	**2,216**
Recurrent Expenditure	(1,229)	(1,307)	(1,323)	(1,339)	(1,355)
Recurrent Savings	75	100	100	100	100
Non recurrent expenditure	0	0	0	0	0
Non-Recurrent Savings	0	0	0	0	0
Total Expenditure/Saving	**(1,154)**	**(1,207)**	**(1,222)**	**(1,238)**	**(1,255)**
Recurrent EBITDA	765	1,009	994	978	961
Non-Recurrent EBITDA	0	0	0	0	0
EBITDA	**765**	**1,009**	**994**	**978**	**961**
Depreciation	0	0	0	0	0
Interest receivable/payable	0	0	0	0	0
I&E impact	**765**	**1,009**	**994**	**978**	**961**
Existing Budget	0	0	0	0	0
Servicing of Loans	0	0	0	0	0
Captial	0	0	0	0	0
Loan Income	0	0	0	0	0
Cash Flow Impact	**765**	**1,009**	**994**	**978**	**961**

Detailed Income & Expenditure Impact - Access & Flow and Winter 17/18

	Year 1 2017/18 £'000	Year 2 2018/19 £'000	Year 3 2019/20 £'000	Year 4 2020/21 £'000	Year 5 2021/22 £'000
Income					
Contract Income	1,919	2,216	2,216	2,216	2,216
	0	0	0	0	0
Recurrent Income	1,919	2,216	2,216	2,216	2,216
Income					
Contract Income	0	0	0	0	0
Non-Recurrent Income	0	0	0	0	0
Income From Activities	**1,919**	**2,216**	**2,216**	**2,216**	**2,216**
Recurrent Revenue Costs					
Pay - Access & Flow Reinvestment:					
B7 Specialist Nurse	(33)	(45)	(45)	(45)	(45)
B7 Pharmacist & Equipment	(36)	(48)	(48)	(48)	(48)
Enhanced therapy to support frailty	(73)	(97)	(97)	(97)	(97)
Discharge Co-Ordinators	(84)	(112)	(112)	(112)	(112)
REACT	(73)	(97)	(97)	(97)	(97)
Surgery Project Manager B8a	(41)	0	0	0	0
Red Cross 5 Day Service	(135)	(135)	(135)	(135)	(135)
Winter Planning:					
6 Surgical Beds	(136)	(140)	(140)	(140)	(140)
25 Medical Beds	(413)	(426)	(439)	(452)	(465)
Cleaning & Meals Medical Beds	(37)	(38)	(39)	(40)	(41)
Therapies / REACT 1 x B6, 1 x B7	(36)	(36)	(37)	(37)	(37)
Additional ED Nurse per shift 24/7	(57)	(57)	(58)	(58)	(59)
Additional ED HCA per shift 24/7	(36)	(37)	(37)	(37)	(38)
Additional SPR at weekends 2 x 10 hour shift	(17)	(17)	(17)	(17)	(17)
IDT Nurse on ACU, AMU, SS - Band 6 9-5 7 day	(22)	(23)	(23)	(23)	(23)
Non Pay					
(Included in winter ward costs above)	0	0	0	0	0
Total Recurrent Revenue Costs	**(1,229)**	**(1,307)**	**(1,323)**	**(1,339)**	**(1,355)**
Recurrent Savings					
Hotel Services & Meal costs	75	100	100	100	100
Non Recurrent Revenue Costs					
	0	0	0	0	0
Total Non Recurrent Revenue Costs	**0**	**0**	**0**	**0**	**0**
Non Recurrent Savings	0	0	0	0	0
Total Net Revenue Costs	**(1,154)**	**(1,207)**	**(1,222)**	**(1,238)**	**(1,255)**
Depreciation on Software	0	0	0	0	0
Interest on above	0	0	0	0	0
Total Capital Costs	**0**	**0**	**0**	**0**	**0**
Income & Expenditure Contribution	**765**	**1,009**	**994**	**978**	**961**
EDITDA Contribution	**765**	**1,009**	**994**	**978**	**961**
5 Year EDITDA Contribution	**4,707**				

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Title of Paper :	Progress Report -Community Services and 6 month Corporate Governance Statement	
Author:	Denise Frodsham (with all Executive Colleagues)	
Executive Lead:	Denise Frodsham	
Type of Report:	Concept Paper	
	Strategic Options Paper	
	Business Case	
	Information	
	Review/Benefits/Audit	x

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

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

Positive Benefit:	Receive assurance of the completion of the community services tender and successful implementation. Confirm that the Board is fully satisfied that it meets its statutory duties with assessment against Appendix F - Corporate Governance statement, 6 months from acquisition of the contract.
Risk:	Failure to provide assurance of safe, effective and compliant community services.

To be published on Trust Website –complete version	***Y*** *(delete as appropriate)*
If no, to be published on Trust Website – redacted	***N/A*** *(delete as appropriate)*
If not to be published complete or redacted, please detail the reason why	
Presented at Board Meeting of:	2nd May 2017

Delivering Community Services in Central Cheshire through the Central Cheshire Integrated Care Partnership

Progress Report and 6 months Corporate Governance Statement

Board of Directors, May 2017

1.0 Background

At its Extraordinary Board of Directors Meeting of Monday 22nd August 2016, MCHFT Board of Directors, formally agreed to accept the recommendations of the submitted business case, that the Trust should proceed to accept the transfer of Community Services to a consortium of providers (being MCHFT, Cheshire Wirral Partnership and South Cheshire / Vale Royal GP Alliance) with MCHFT being the prime provider.

A copy of the Executive summary and required Board certification documents are included for reference in Appendix 1.

A requirement of the Board Certification was to review Appendix F: Corporate governance statement, 6 months from the acquisition of the service.

This paper provides an update on the progress made to date and includes a completed Appendix F: corporate governance statement for approval and sign off, of the transaction.

2.0 Progress Summary

In line with the approved business case, the transfer of community services was successfully delivered on time and without any material issues on 1st October 2016. This followed completion of the partnership agreement and subsequently the sub contract agreements with the partner organisations as delegated to the Chief Executive.

A high level review of services within the first month, confirmed that all services were safe and able to continue to deliver following handover.

All Service Specifications (30 in total) have been reviewed and updated to reflect the current services provision and now include the workforce – roles, grades and WTE's and activity delivered. This will set the baseline against which the contract will be managed over the 5 year term. Service Specifications still require the allocation of finance resource allocations against the individual service lines to be completed but this is expected shortly.

Cost centres and budgets for all service lines have been completed.

A number of engagement events have been held both as the Partnership Board and by the leadership team and Trust Executives and Non Executives to community staff, who have responded positively to the engagement and constructively to future opportunities to transform services.

Corporate posts have been established and in the main now recruited too, supporting the ongoing monthly operational delivery of services.

During the transition a number of risks emerged which have been managed but still require longer term solutions. These are as follows:

EMIS – this IT solution is currently provided by East Cheshire Trust whilst a scoping of future state is completed. However the ability to develop, interrogate and enhance the development of services under the current arrangement is very limited and early assessment has already confirmed that an alternative solution is urgently required. An IT strategy and a number of business cases are in development and will be submitted for Board approval over the next few months.

Wheelchairs – it was agreed to leave the current service integrated but managed by CCICP. However ageing stock and poor control has resulted in this service being deemed unfit for

purpose. A management options paper confirmed the opportunity to assess outsourcing options and this is currently being scoped. Should a change in provision be deemed a solution then this will be subject to Board approval.

TUPE – the majority of staff did transfer successfully with a few errors and a minor number of individuals subject to dispute. This has all now been addressed and the TUPE consolidation list signed and closed down. There does however remain issues with some elements of information transfer using ESR, in particular appraisal and training history. This is having a negative impact on the performance data but will be resolved during the year. Further issues are arising due to a number of staff having several contracts aligned to various elements of roles being undertaken. Finally the introduction of IR35 from April 2017, has caused a particular risk with GPs who use this facility as part of the contracting arrangements with sessional activity within the GP OOHs services.

The business case specifically outlined a number of high risks to be mitigated during the transfer and these have been reviewed against the mitigations detailed in Appendix 1 and are responded to below.

Risk Category	Initial			Mitigated		
	Impact	Like-lihood	Total	Impact	Like-lihood	Total
Staffing, workforce and culture Vacancies have been identified and significant recruitment effort has been undertaken to stabilise the turnover and to increase to baseline staff in post. Engagement events have been positive with staff being willing and engaged in change and developing services	5	3	**15**	5	2	**10** **Remain**
Choice and competition No challenge has been put forward with regard to the tendering process and award of contract	5	2	**10**	5	1	**5** **Closed**
Legal (including litigations) Legal support from 'Gowling' received during the contract negotiations was sought. No challenge or future litigations are apparent.	5	4	**20**	5	3	**15** **Closed**
Assets and liabilities Equipment including wheelchair stock has been agreed. Estate costs are now known but indemnified by CCG at least for 2018	5	5	**25**	5	4	**20** **Remain but likelihood reduced to 15 (5x 3)**

/19. This element could remain a risk for 2019/20 and therefore remains under review.						
Infrastructure, capacity and skills Estate review is completed which shows some estate opportunity. Support infrastructure has been challenging but new roles are now recruited and this risk is being managed.	5	3	**15**	5	2	**10** **Remain**
Governance and leadership KPMG Governance review undertaken with some recommendations for improvement but overall the governance and leadership is progressing well through the Partnership Board to the MCHFT Board as the main contract holder	5	5	**25**	5	4	**20** **Remain but reduce to 16 (4 x 4) until KPMG actions are complete**
Service quality Rapid service reviews completed, service specifications updated to reflect current practice. There are significant opportunities for service improvement and redesign but currently services are delivering to the main KPIs	5	4	**20**	5	3	**15** **Remain but reduce to 12 (4x3)**
Clinical support Clinical support is provided by all three partner organisations as well as from the Director Nursing and Professional Head	5	3	**15**	5	2	**10** **Remain but reduce to 8 (4x2)**
Service delivery / interruption Services have continued throughout the transition without interruption. Only continued risk to service provision remains GP OOHs which is a priority service line review currently being undertaken	5	5	**25**	5	4	**20** **Remain but reduce to 15 (5x3)**
Finance Robust financial assessment has now been completed and with the exception of estates (listed above) the current contract is deemed to be sufficient to deliver the services	5	5	**25**	5	4	**20** **Remain but reduce to 9 (3 x 3)**
Statutory duties and inspections CQC readiness assessment is being	4	4	**16**	4	3	**12** **Remain**

undertaken against previous review and against baseline standards. Action plan in development to achieve by next assessment						
Publicity and reputation The operational handover has been completed without incident or negative publicity. Future transformation programmes will be scoped and implemented in line with best practice to ensure full awareness of any potential future adverse publicity or damage to the reputation of MCHFT or partner organisations	4	3	**12**	4	2	**8** Remain

3.0 Governance statement

The Executive Directors have each reviewed the relative elements of the Corporate Governance Statement and the assessment outcomes are detailed below.

	Risks and mitigating actions	Evidence
The Board is satisfied that Mid Cheshire Hospitals NHS Foundation Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of healthcare services to the NHS. The Board has regard to such guidance on good corporate governance as may be issued by Monitor from time to time. The Board is satisfied that Mid Cheshire Hospitals NHS Foundation Trust implements:		
a) Effective board and committee structures;	Remaining limited risk of CCG / CCICP roles of Transformation board as identified in KPMG Report and accountability through Contract meeting – Terms of reference for the Transformation Board confirm this to not be a decision making body an therefore not an assurance risk. Conflicting interests between Partnership decisions and individual	• KPMG Governance Review • Partnership Agreement • Terms of Reference agreed Partnership Agreement in place with principals and behaviours documented

	Risks and mitigating actions	Evidence
	organisational allegiance – Mitigation Partnership Agreement in place with principals and behaviours documented	in detail
b) Clear responsibilities for its board, for committees reporting to the board and for staff reporting to the board and those committees;	None identified	Partnership Agreement, Committee Terms of reference for Operational Group, Clinical Governance and Workforce Groups. Monthly Divisional Finance and Activity Group established reporting to PAF Operational Groups minutes report through to Trusts main sub committees eg QGC, PAF and TAP.
c) Clear reporting lines and accountabilities throughout its organisation.	Accountability for Transformation currently resides within the Joint Transformation Board and the Partnership Board- Mitigation is the Terms of Reference for the Transformation Board which confirms that the Transformation Board is not a decision making body	Reporting lines all in place with clear line of accountability for escalations to the Trust Board
The Board is satisfied that Mid Cheshire Hospitals NHS Foundation Trust effectively implements systems and/or processes:		
a) To ensure compliance with the licence holder's duty to operate economically, efficiently and effectively;	Overarching budget not formally signed off for 2017/18. – Mitigation annual plan in place to define parameters	Board approved due diligence in place. Annual plan in place.

	Risks and mitigating actions	Evidence
b) For timely and effective scrutiny and oversight by the board of licence holder's operations;	Capped Expenditure Programme will impact on affordability of existing services.	Contract agreed and signed off. Segmental reporting in place for year end Departmental budgets agreed with Managers Performance report includes segmented position. CCICP Partnership Board minutes go to Trust Board of Directors
c) To ensure compliance with healthcare standards binding on the licence holder include, but not restricted to, standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of healthcare professions;	There are no significant risks in relation to this statement and the evidence is set out to support this	The Board maintains awareness of the regulatory, legal and standard requirements that are placed on Trusts and raises them at the Board as they become known and as they come into effect. The Trust's Care Quality Commission Statement of Purpose has been updated to reflect those services provided in the community.
d) For effective financial decision-making, management and control including, but not restricted to, appropriate systems and/or processes to ensure the licence holder's ability to continue as a going concern;	None	CCICP have adopted the MCHFT SFI's and financial codes of practice. Scheme of delegation for CCICP in place

	Risks and mitigating actions	Evidence
		Establishment control processes in place Additional capacity in Finance, procurement, HR and business intelligence in place to provide professional advice.
e) To obtain and disseminate accurate, comprehensive, timely and up-to-date information for board and committee decision-making;	Reliant on ECT for information provision at this stage – Mitigation is the development of case to bring in house. Current agreed SLA with ECT	Performance report Divisional Finance and Activity meetings in place.
f) To identify and manage (with, but not restricted to, forward plans) material risks to compliance with the conditions of its licence;	Capped Expenditure Programme yet to determine the risk.	Integrated into the Trusts annual planning process and submitted to NHSI.
g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate, external assurance on such plans and their delivery;		Annual Plan
h) To ensure compliance with all applicable legal requirements.		Partnership Agreement drawn up with appropriate legal support. Mandatory sub contracts using standard NHS contract documentation
The board is satisfied:		
a) There is sufficient capability at board level to provide effective organisational leadership on the quality of care provided;	There are no significant risks in relation to this statement and the evidence is set out to support this	There are Governance systems and processes in place through which MCHFT provides assurance to the Trust

	Risks and mitigating actions	Evidence
b) The board's planning and decision-making processes take timely and appropriate account of quality of care considerations; c) Accurate, comprehensive, timely and up-to-date information on quality of care is collected; d) It receives and takes into account the accurate, comprehensive, timely and up-to-date information on quality of care; e) Mid Cheshire Hospitals NHS Foundation Trust including its board actively engages on quality of care with patients, staff and other relevant stakeholders, and takes into account as appropriate views and information from these sources; f) There is clear accountability for quality of care throughout Mid Cheshire Hospitals NHS Foundation Trust including, but not restricted to, systems and/or processes for escalating and resolving quality issues, including escalating them to the board where appropriate.		Board on the quality of care provided. MCHFT has unconditional registration/licence with the following regulators: • Care Quality Commission • NHS Improvement An annual Quality Account is provided which reflects the quality of care provided across all regulated activities including Community Services since October 2016. Specifically relating to Community Services, a monthly Quality Report is provided to the CCICP Partnership Board that relates to quality of care and patient safety. The Head of Nursing/Professional Lead for Community Services and the Professional Leads for specific services are members of the following groups that directly report to a Board Sub-Committee: • Executive Patient Experience

	Risks and mitigating actions	Evidence
		Group • Executive Safeguarding Group • Executive Infection Prevention and Control Group Systems and processes are in place to seek staff and patient views through stakeholder events, the Quality Safety and Improvement Strategy has been refreshed to reflect improvement strategies within Community Services. Regular visits mirroring those of Executive Walkabouts are in place within Community Services, and the CEO holds regular engagement events in line with those already in place at the Hospital sites. Staff are encouraged to share ideas for development and have opportunity to help shape services through the Transformation Work-stream led by the Chief Operating Officer. The Trust Board Assurance Framework has been updated, reflecting the refreshed Trust Strategic Domains.
The board effectively implements systems to ensure it has	There are no significant risks in relation	MCHFT has in place a Board that is

	Risks and mitigating actions	Evidence
personnel on the board, reporting to the board and within the rest of the licence holder's organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of this licence.	to this statement and the evidence is set out to support this.	appropriately qualified and experienced in the management of NHS organisations. This is evidenced in the following ways: - The Trust has in place a robust recruitment process, supported by appropriate head hunters, that validates candidates qualifications, skills and experience against the essential requirements of the role; - Job description and person specifications in place for each Executive and Non-Executive Role, each of which is regularly reviewed to ensure they remain appropriate, current and up to date with the requirements of the organisation; - Nominations and Remuneration Committee ratify all Non-Executive Board appointments based on assurance provided that he appointable candidate has the skills, knowledge and behavioural sets required for the role. This is detailed in the minutes of these meetings; - In a similar vain the Appointments and Remuneration Committee ratifies the appointment to Executive Director roles based upon the person specification, job description and recruitment panel chairs recommendations. This can also be evidenced through the minutes of

	Risks and mitigating actions	Evidence
		this committees meetings; - All Directors are required to participate in an Annual appraisal and review of their performance in their roles (this includes Non-Executive and Executive Directors) and - We also complete a NED Skills Assessment and Gap Analysis to support recruitment to NED posts, ensuring that we have a broad range and diversity of skills, knowledge and experience to support the Board in discharging its legal and organisations duties. As the contract holder, the Trust operates in partnership with Cheshire & Wirral Partnership Trust and the South Cheshire & Vale Royal GP Alliance Ltd to ensure appropriate guidance, support and governance is in place for the effective operational management of the community services. To manage this relationship effectively between all partners and to ensure that community services form an integral feature within the Trust strategy, we recently appointed a Director of Strategic Partnerships. This post holder was formerly COO at the Trust and has significant and robust experience to

	Risks and mitigating actions	Evidence
		ensure that the needs of both the CCICP and MCHFT Boards are properly and appropriately considered. Having inherited a service with a significant number of vacancies, steps have been taken in the first 6 months of the contract to ensure staffing levels are in place across the key community services to deliver safe healthcare service to our community patients. This is evidenced through successful recruitment campaigns and improved staffing levels in key shortage roles. In addition, during April, we completed a first draft Workforce plan to review the service needs against the staff in post and patient needs and this is being linked in to the CCICP service planning process to enable effective recruitment and workforce management going forward. Further evidence of the Trust and our Board's capability and compliance in implementing systems to support the effective governance of CCICP are listed below: - The Trust is rated a 'Good' by the CQC, including being rated as good throughout the Well-Led section of the CQC assessment process and outcomes;

	Risks and mitigating actions	Evidence
		- We undertake an annual Board Effectiveness Survey to provide assurance that the Board is discharging its duties effectively and in line with the Trust's strategy; - An independent external Well Led Review was conducted in early 2017 and the report provides assurance that there are no leadership concerns of note; - Our Governors regularly hold our NEDs to account through joint Governor / NED meetings; - The Council of Governors hold the Board to account through regular invitation to CoG meetings; - A revised and refreshed Board Development programme is being implemented during 2017/18 to cover two financial years and to ensure that the Board continues to drive forward the Trust and CCICP is ways that support improvement and innovations to enable care to be delivered in the right and most appropriate setting for the patient; In order to ensure that our Board have an effective programme of continuing professional development at a personal level, the following opportunities are encouraged for all Board members: - Provider Trust Network Executive

	Risks and mitigating actions	Evidence
		Induction - Provider Trust NED Induction - NED induction process - Attendance at relevant conferences and development events (i.e. Executive Director Networks, NHS Confederation Conference); - Board members with clinical qualifications are subject to robust Revalidation processes and all Board members with professional registration have their membership checked annually; - Leadership and clinical/ management development programmes - Succession planning - Talent Management

4.0 Recommendation

The paper provides an overview of the completion and implementation of the community services contract. Overall, whist some risks remain, with close management and mitigating actions, the transaction and transfer has gone well, both according to plan and without any significant or serious complications.

From reviewing the Corporate Governance Statement, MCHFT Board of Directors are asked to confirm that MCHFT has complied with the principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of healthcare services to the NHS.

The Board are further asked to sign off the programme of acquisition, recognising that future business cases and progress reports will be received in line with usual Trust governance arrangements.

Denise Frodsham (May 2nd 2017)

Appendix 1 – Business Case Executive Summary

1.0 Executive Summary

1.1 Introduction, Background and Context

There is recognition nationally and locally that the way that health and social care is delivered has to undergo radical redesign in order to meet the needs of a population with an increasing prevalence of long term illness and within a context of significant financial pressure. Within this, it is increasingly important that acute hospitals, and partners, are able to provide high-quality care for people with multiple chronic conditions and complex needs. To respond effectively to these changing needs, health and social care services must be capable of providing ongoing support over time, anticipating and preventing deterioration and exacerbations of existing conditions, and supporting a person's multiple needs in a well-co-ordinated way.

In mid to late 2015, the CCGs of South Cheshire and Vale Royal began a process of reviewing and re-commissioning Community Services Health Care for Central Cheshire in response to the above challenges. In June 2016 the contract, which has a value of £27.43m, was awarded to the partnership of Mid Cheshire Hospitals NHS Foundation Trust, Cheshire and Wirral Partnership NHS Foundation Trust, the South Cheshire and Vale Royal GP Alliances. Together, these organisations are known as the Central Cheshire Integrated Care Partnership (CCICP).

This Business Case has been developed in support of the assessment of the suitability and viability of the CCICP in delivering Community Services in Vale Royal and South Cheshire from 1st October 2016 and for MCHFT to act as the Prime Provider. As it has been written for the Board of Directors of MCHFT, it focusses the impact on MCHFT specifically.

1.2 Initial Options Analysis

Included within this Case is an overview of the options available to MCHFT in relation to responding to the tender of Community Services in Central Cheshire. Whilst this constitutes a retrospective view, the likely impacts and risks associated with each option still hold the same relevance. By way of a summary, the potential options and considerations are summarised below:

Option		Recommendation
1	**MCHFT do not tender for the Community Services contract**	***Not to progress with this option*** Whilst it is arguable that this option poses the least immediate risk to MCHFT, the potential longer-term implications to the Trust and the overall financial sustainability of the Health and Social Care economy are considered too great.
2	**MCHFT tender for the Community Services contract as a single Provider**	***To discount this option*** Commissioners elected to carry out a Most Capable Provider (MCP) process within which only a partnership model would be considered
3	**MCHFT tender for the Community Services contract in partnership**	***To pursue this option*** It is considered that the magnitude of benefit and the ability to manage the risks associated with the transfer of the contact would be far more achievable by developing a new partnership model

1.3 The Central Cheshire Integrated Care Partnership

The Central Cheshire Integrated Care Partnership (CCICP), encompassing MCHFT, CWPFT, the South Cheshire GP Alliance and Vale Royal GP Alliance, recognises that health services need to change to deliver sustainable services that meet the demands of an ageing population. As a result, the Partnership intends to work with people, their families and carers to move away from a service supporting ill health to one of promoting health, wellbeing and empowerment. The intention is to enable the people of Central Cheshire to:

- Be more in control and more in charge of their own health
- Live in communities with facilities and functions that promote their health and wellbeing
- Feel that their family, friends and community are their 'first care team'
- Experience Person Centred Care; care that works towards their individual goals and ambitions, and care that looks at them as a whole person and not a disease or body part

1.4 Due Diligence

The transfer of Community Services requires a due diligence approach that relies heavily on the existing provider (East Cheshire Hospitals Trust) and Commissioners providing appropriate information to MCHFT in order to facilitate and fully understand the economic position of the transaction versus the contract value available.

However, as a result of delays in information being made available to MCHFT along with the timing of the notice given to the existing provider (new provider to be in place by 1st October 2016), there has been a limit on the level of due diligence which can be provided.

South Cheshire and Vale Royal CCGs commissioned Merseyside Internal Audit Advisory Services have also reviewed the procurement processes and the information provided for due diligence. Within this, the following conclusions are drawn:

- **TUPE** – There is a lack of clarity around the objective and legal methodology used to determine which staff will be transferring into the employment of MCHFT to deliver CCICP services.
- **Estates** – While the sites utilised to deliver services have been identified, there remains uncertainty over the rentals payable for a number of these and there are queries relating to asset ownership and transfer
- **ICT** – The CCGs are actively seeking to resolve a range of ICT issues with ECT in particular relating to EMIS licencing and access to patient data
- **Contracts** – A schedule of agreements incurring revenue income and expenditure covering services provided under SLA and contracts has been provided but is unsatisfactory as a prime source of relevant information
- **Financial Analysis** – It is not possible to determine, with certainty, that the cost base of the service would fit within the financial envelope as stated in the 2016/17 baseline

MCHFTs approach has been to follow the Monitor Guidance on Best Practice to Transactional Due Diligence and to identify the gaps and identify mitigation or secure indemnity as far as possible. This approach has considered finance, governance, quality, workforce and organisational development.

1.5 Assessing Benefits and Risks

In order to assess the suitability and viability of MCHFT, and the CCICP as a whole, to deliver the Community Services contract over a five year period from 1 October, 2016, the potential benefits and risks have been considered in detail within this Case.

Aligned to this Business Case, MCHFT have conducted a corporate risk assessment to support internal risk identification and management. This has been included as ***Appendix 1***. This Business Case has ensured that the MCHFT risk assessment has been taken account of and the same mechanism for scoring has been used.

Within this Case, both benefits and risks have been categorised and scored against scales for impact and likelihood, the summary of which is included below:

1.5.1 Benefit Summary

Benefit Category	Potential Impact	Likelihood	Total
Financial savings to support re-investment	3	4	**12**
Efficiency / effectiveness in non-clinical / back-office services	2	4	**8**
Quality of care and support	3	4	**12**
Performance & Inspections	2	3	**6**
Wider health and social care system	3	3	**9**
Strengthened & sustainable workforce	3	3	**9**

Total weighted potential benefit: **62/100 (HIGH)**

1.5.2 Risk Summary

The following table reflects the scores attributed to each risk category based on the assumption that mitigating activities will be undertaken. Whilst these are intended to provide a comprehensive analysis of the risks associated with the transfer and delivery of Community Services, it is also noted that unknown risks may exist.

Risk Category	Initial			Mitigated		
	Impact	Like-lihood	Total	Impact	Like-lihood	Total
Staffing, workforce and culture	5	3	**15**	5	2	**10**
Choice and competition	5	2	**10**	5	1	**5**
Legal (including litigations)	5	4	**20**	5	3	**15**
Assets and liabilities	5	5	**25**	5	4	**20**
Infrastructure, capacity and skills	5	3	**15**	5	2	**10**
Governance and leadership	5	5	**25**	5	4	**20**
Service quality	5	4	**20**	5	3	**15**
Clinical support	5	3	**15**	5	2	**10**
Service delivery / interruption	5	5	**25**	5	4	**20**
Finance	5	5	**25**	5	4	**20**
Statutory duties and inspections	4	4	**16**	4	3	**12**
Publicity and reputation	4	3	**12**	4	2	**8**

Total weighted *un-mitigated* risks: **25/25**
Total weighted *mitigated* risks: **20/25**

1.5.3 Major Risks and Mitigations

The following table provides a list of the major risks identified across all of the risk categories. For the purposes of this table, a major risk is defined as anything with a total risk score of 20 or more. A summary of the mitigating activities is included:

Risk	Initial			Mitigation
	Impact	Like-lihood	Total	
Legal L3 - Full range of current SLAs, contracts and sub-contracts are not fully understood leading to potential litigation challenges	5	4	**20**	• One potential litigation which is known and can be managed • Possible that a number of potential litigation challenges may arise but this is considered to be a limited risk based on available information • Lease, SLA and informal arrangements explored through due diligence and ongoing discussions
Assets & Liabilities A2 - Current lease agreement content and timescales prove prohibitive in including within any asset review or estate rationalisation exercise leading to a reduced potential to deliver efficiencies in the estate, related overheads and changes to support transformation of Services	5	5	**25**	• Initial scoping exercise has been undertaken which concludes that vast majority of existing facilities can continue to be utilised throughout mobilisation without significantly adversely impacting the delivery of Service and transfer of staff
Governance & Leadership G2 - Insufficient risk share arrangements leading to potentially significant financial implications for MCHFT and CCICP Providers and potential disputes throughout the lifetime of the Community Services contract	5	5	**25**	• CCICP Partnership Agreement in development • CCG Indemnity up to £582K included within the Contract
Quality Q1 - Lack of systems and processes in place for escalating and resolving quality issues leading to a lack of understanding, hindered processes of improvement and increase likelihood of the number and impact of safety issues	5	4	**20**	• New quality measures to be developed that ensure that a robust picture of how services are performing and delivering person centred care are captured • Structures of governance within the CCICP, with partners and Commissioners will built upon in order to support timely and effective reporting, escalating and decision-making arrangements

Service Delivery SD1 - Challenges associated with the transfer of Services to new provider partnership creates disruptions in service delivery and continuity of service	5	5	**25**	• Each of the organisations with the CCICP has experience of mobilising to deliver large-scale transfer of services and staff • CCICP governance structure and Partnership Agreement in place • Corporate Teams within the CCICP have been deployed to help ensure that required systems and infrastructure are in place from 1st October • Existing mechanisms of Business Continuity Management within MCHFT and CWPFT to be utilised • Timely and transparent escalation mechanisms in place, including a detailed risks and issues log and reporting through CCICP governance
Finance F1 - Contract value does not sufficiently cover the extent of the costs associated with the delivery of an safe, effective and high-quality Service	5	5	**25**	• CCG Indemnity up to £582K included within the Contract • Current vacancy levels are unlikely to be fully filled from Contract start therefore there is likely to be some slippage in year 1 to offset any pressures, initial TUPE list suggest the gaps (including new investment will be in the region of £3.3M) • Service Line Reviews, a series of service line reviews will be undertaken during the first year to identify any efficiencies in process and redesign of services • A full review of Procurement against existing prices will be undertaken as part of the mobilisation process. • Ability to give 12 months' notice should the contract be deemed undeliverable within the existing cost base
Finance F2 - Model does not deliver longer-term financial sustainability and risks are not adequately shared leaving MCHFT with financial shortfall	5	5	**25**	

1.6 Mobilisation

Resources are currently in place and are actively co-ordinating activities required in order to successfully transfer from 1st October and deliver all mobilisation activities during the first year of the contract. The planning associated with the entire mobilisation phase is split into three. This is to ensure that the CCICP is ready to deliver services at the 1st October commencement date, has plans in place for the initial period of mobilisation (3 months) and allows sufficient time to build a more comprehensive plan covering the entirety of the first twelve months of the contract. Within the Mobilisation Plan, activities regarded as 'critical' in ensuring the successful transfer of services from 1st October have been identified. Owners, timescales and tolerances have been agreed to ensure ownership, transparency and effective escalation. This is being managed by a cross-cutting Service Development workstream.

In addition, a comprehensive governance structure has been agreed for the CCICP including Board, Mobilisation Oversight Committee and cross-cutting workstreams. This is underpinned by the Partnership Agreement and will ensure that sufficiently senior staff and required capacity is attributed to all required activities throughout mobilisation. Within this, corporate resources including finance, HR, communications, IT, performance management and property services have been joined together, through the set-up of cross-cutting workstreams, to ensure that the total capacity to support mobilisation is maximised.

1.7 Conclusion

Acute hospitals will in future be fundamentally different from today, with a greater proportion of care delivered beyond the hospital walls, and an increased role in prevention and population health. These changes will be supported by the development of new care pathways, workforce arrangements and organisational models and this forms the basis of the formation of the CCICP.

The potential benefits and risks associated with this transaction have been explored in detail within this Business Case and a number of practical measures have been identified to support a decision to proceed with the CCICP model and the commencement of the contract. These include:

- Establishing effective internal governance systems that support integration across the partnership and with Commissioners and wider Partners
- Ensuring that the approach is underpinned by person-centred care and ensures clinical involvement in the design and delivery
- Understanding the financial consequences and seeking opportunities to share risk and liability
- Undertaking assessment of the transferring estate, infrastructure and systems in order to manage business continuity and identify opportunities for future transformation
- Engaging with staff during mobilisation and transfer and seeking new ways to empower and develop the workforce
- Creating opportunities for interaction and mutual learning between acute and community professionals

1.8 Recommendation

As identified within this Case, there are potentially severe and negative consequences to MCHFT, the local health and social care economy and the communities of Central Cheshire if the current provision of Community Services continues on the current trajectory. As such, a more transformational approach is required to improve the way that Primary, Community and

Acute Care is integrated and delivered in Central Cheshire. The re-commissioning of Community Services has provided an opportunity to do this.

The potential benefits of tendering for, and delivering, Community Services in partnership are explored in detail within this Case, as are the substantial risks associated with the transfer of the contract. During initial considerations, a number of these risks were reflected upon and a significant degree of time was spent speaking to NHS Trusts that had undertaken similar transfers. Further learning was also sought from recent failures (such as the Cambridge and Peterborough model) and successes (such as CWP's transfer of West Cheshire's Community Services in 2010 and more recently the transfer of Community Services in Tameside).

The conclusion of these initial considerations was that the magnitude of benefit and the ability to manage the risks associated with the transfer of the contact would be far more achievable by developing a new partnership model. As a result, and as part of more detailed and considered discussions, the Central Cheshire Integrated Care Partnership was formed.

Following the tender process and award of the contract to the CCICP, this Business Case has been developed and is supported by the completion of an MCHFT corporate risk assessment, due diligence and ongoing discussions with CCGs, partners and the current provider. This processes has included the advice of external legal experts and has utilised NHSI (formerly Monitor) guidance for undertaking a transaction of this nature.

As is noted, there are significant risks associated with the transfer of Services and information gaps exist in order to fully inform this decision which has limited some elements of due diligence. Nevertheless, it is considered that sufficient evidence has been reviewed across a range of information to provide a sufficient level of confidence of the ability to mitigate the risks that exist to a manageable position. When coupled with the potential benefits to MCHFT, the wider health and care economy and the communities of Central Cheshire, the recommendation of this Business Case is to proceed with the transfer of Community Services to the CCICP, with MCHFT being the Prime Provider.

Appendix 4 sets out the Monitor (now NHSI) risk assessment framework which requires that the Board is satisfied with a number of components of this transaction. Within this, the evidence that can be referenced for each component is included. Whilst this is intended to inform the decision, it should also be noted that the sign-off of this framework is not an NHSI requirement to support this transaction.

Appendix 4 – Board Certification, NHSI Requirements

NHSI certification	Comments / Source
Considered a detailed options appraisal before deciding that the transaction delivers benefits for patients and the trust in delivering its strategy	• Business Case • Trust Strategy • Evidence in Board minutes
Assured itself that a proposed transaction will meet the requirements of the choice and competition licence conditions	• Most Capable Provider Process • CCG legal advice • CCG public engagement • Business Case risk assessment
Conducted an appropriate level of financial, clinical and market due diligence relating to the proposed investment or divestment	• Business Case • The contract contains a 12 month break clause for the provider & commissioner • Due Diligence (within Business Case) • *NB:* Some information provided by the current provider was late, incomplete and inaccurate
Considered the implications of the proposed investment or divestment on the resulting entity's continuity of service risk rating, having taken full account of reasonable downside sensitivities	• Business Case • Corporate Risk Assessment
Conducted appropriate inquiry about the probity of any partners involved in the proposed investment or divestment, taking into account the nature of the services provided and likely reputational risk	• Partnership Agreement developed with legal support • Business Case
Conducted an appropriate assessment of the nature of services being undertaken as a result of the investment or divestment and any implications for reputational risk arising from these	• Due Diligence (within Business case) • Due to the poor quality of current service a 'lift & shift' to move the service from the current will be undertaken. Therefore, additional Due Diligence will be undertaken post transfer, in year 1, to develop & transform the service. This will include detailed service line reviews
Received appropriate external advice from independent professional advisers with relevant experience and qualifications	• Legal advice from Gowling WLG, which also included workforce advice
Taken into account the best practice advice in Monitor's transactions guidance or commented by exception where this is not the case	• Business Case, which has been developed to incorporate Monitor/NHSI guidance • Due Diligence (included within Business Case) • Risk assessment (included within Business Case)
Resolved any accounting issues relating to the investment or divestment and its proposed treatment	• Financial Due Diligence (included within Business Case)
Addressed any legal issues, including those associated with the transfer of staff (either via an acquisition, divestment or fixed term contract)	• Due Diligence (included within Business Case) • Legal advice from Gowling WLG
Complied with any consultation requirements	• South Cheshire CCG conducted a full public engagement event prior to commencing the re-procurement process

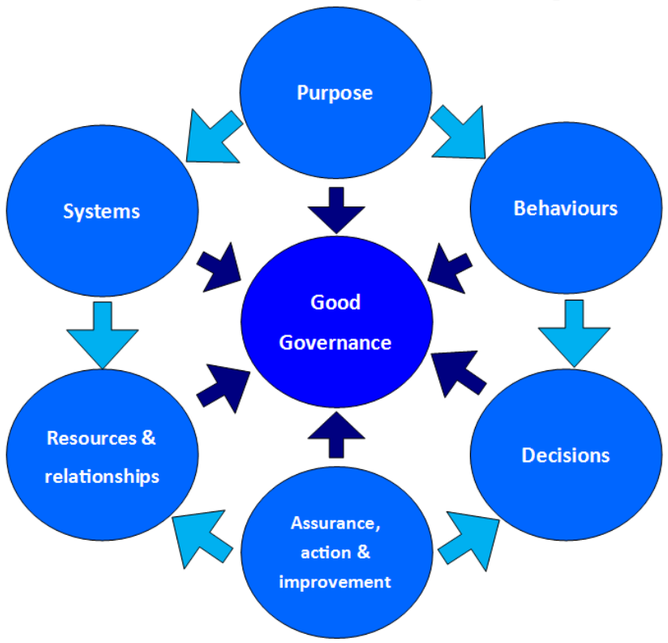
Established the organisational and management capacity and skills to deliver the planned benefits of the proposed investment or divestment	• Corporate services structure built to enable to development and transformation of a currently poorly performing service • Mobilisation planning • CCICP Governance within Partnership Agreement • The Partnership consortium consists of a Trust with experience of running Community Services
Involved senior clinicians at the appropriate level in the decision-making process and received confirmation from them that there are no material clinical concerns in proceeding with the investment or divestment, including consideration of the subsequent configuration of clinical services;	• Board of Directors • Executive Director Meetings • Attendance on the Community Services Operational Group • Risk Assessment re Community Services was approved through the Trusts Quality Governance Committee
In the case of a contract of a specified period, ensured appropriate legal protection in relation to staff, including on termination of the contract	• TUPE rights
Ensured relevant commercial risks are understood	• Limited to contracts with other providers and some estate provision • Legal advice from Gowling WLG
Made provision for the transfer of all relevant assets and liabilities	• Business Transfer Agreement
At the time of the acquisition, a corporate governance statement (see Appendix D of the 'Risk Assessment Framework') for the acquirer	• **Review in 6 months**
At the time of the acquisition, a Board statement that plans are in place to be able to make the corporate governance statement (see Appendix D of the Risk Assessment Framework) in the new organisation within six months, with the exception of the following statement concerning quality governance for which an appropriate timescale for compliance should be determined by the trust board and agreed with Monitor: **"The board is satisfied:** **(f) that there is clear accountability for quality of care throughout [insert name] foundation trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the board where appropriate."**	• **Review in 6 months**

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Board Assurance Framework

Quarter 4 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	06/12/2016	Review Date: April 2017	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 under review. Divisional quarterly quality reports developed and being piloted. 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, policy and procedures 26. Bi-weekly Patient Safety Summit	Embedding of quarterly quality reports into Divisions.	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 Corporate Risks (20+)	Link to other BAF Objectives
• CS0275 CS0311 CS0327 CS0328 DC0887 DC0923 EC0287 EC0331	• 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	06/12/2016	Review Date: April 2017	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 7. Regulated activity for Assessment or treatment of patients detained under the Mental Health Act 1983 approved 8. Registration of Community services via statement of purpose to be confirmed	None.	1. Minutes from Board of Directors following bi-annual CQC report (I) 2. CQC Inspections (E) 3. Application to the CQC for the registration of Community services submitted on 16/12/16 – Statement of Purpose updated (E) 4. Successful application to the CQC for the registration of the regulated activity for Assessment or treatment of patients detained under the Mental Health Act 1983 submitted on 1st December 2016 – Statement of Purpose updated (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 (I) 5. Formalised existing arrangements with CWP to provide evidence of compliance with M HA 1983 (E)	None	Treat 1. Review preparation for re-inspection

Risk Register Links (all listed below)								
Link to Significant Corporate Risks (20+)								Link to other BAF Objectives
• CS0275	CS0311	CS0328	DC0887	DC0923	EC0265	EC0287	EC0346	• All
• CS0325	CS0326	CS0347	EC0331	CS0327				

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	06/12/2016	Review Date April 2017	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. Horizon scanning, agility and ability to respond 17. The Trust contributes to the Local delivery plans and the Five Year Forward Vision Plan (FVP - previously referred to as the Sustainability & Transformation Plan (STP) 18. Health & Wellbeing strategy agenda 19. Stress Management surveys 20. Safety Culture surveys 21. CEO currently a member of the STP leadership group to ensure contribution and participation in the development	Review of Trust Strategy to align to FVP.	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) 10. Joint Board to Board meetings with CCG and UHNM	1. Assurance required regarding the effectiveness of Divisional Boards to communicate the vision	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 Corporate Risks (20+)	Link to other BAF Objectives
• CS0275 EC0287 EC0331 DC0923 DC0887 CS0328	• 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	07/12/2016	Review Date April 2017	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 16. Monthly Performance Report 17. NHS Improvement approval of Community Services in East Cheshire acquisition	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 - improving 4. Ongoing agency spend – medical and nursing 5. Sustainable ED performance solution - improving 6. Loss of elective surgery activity due to emergency admissions and resulting medical outliers - improving 7. Continued outsourcing of MR, CT and Gastroenterology activity - reducing 8. No winter resilience funding identified 9. Long term health economy plan	1. Monthly Performance Reports (I) 2. Internal audit programme (E) 3. Annual plan (I) 4. Performance & Finance Committee action points and papers (monthly)	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 5. Trust accepted financial controls in agreed plan 6. CQUIN Schemes agreed and in place 7. STF funding via annual plan agreed by NHS Improvement 8. RTT currently on track 9. Settlement agreed with CCG for 16-17	1. Month 10 RTT and 4 hourly performance on trajectory 2. In dispute with Commissioners over value of contract	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 Five Year Forward Vision Plan

Risk Register Links (all listed below)	
Link to Significant Corporate Risks (20+)	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	15/12/2016	Review Date April 2017	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	1. Links between talent management, succession planning and aspirant leaders. 2. Consistent approach to leadership development, linked to organisational priorities and values.	3. Quarterly Executive Workforce Assurance Group action points & papers (I) 4. Team coaching implemented (I) 5. Quality Improvement Training for 60 members of frontline staff 2014/2015 - provided by AQuA. (I/E) 6. EDS reviews completed October 2014(I) 7. 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 – November 2016 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 8. MCHFT is part of a regional streamlining programme (E) 9. Lead Partner on successful bid for Talent Management Funding for Cheshire and Wirral	1. Measurement of success against people & OD Strategy objectives	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 Corporate Risks (20+)	Link to other BAF Objectives
• CS0311 DC0887 DC0923 EC0287 EC0331 EC0346	• 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	06/12/2016	Review Date April 2017	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. 10. Local delivery plans	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	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	1. Discussions continue around Breast Screening and Symptomatic breast.	Treat 1. UHNM work programme – monitoring delivery 2. Continued awareness of changing national priorities

Risk Register Links (all listed below)	
Link to Significant Corporate Risks (20+)	**Link to other BAF Objectives**
• CS0328 CS0327	• 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	06/12/2016	Review Date April 2017	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. CCICP Task and Finish Groups(I) 4. 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 3. Contract disputes with Commissioners impacting on uncertainty of service continuity	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 Corporate Risks (20+)	**Link to other BAF Objectives**
• CS0328 CS0327	• Q1 Q2 F2 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	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
01/07/2010	06/12/2016	Review Date April 2017	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 16. Referrals on target at end of Month	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) 8. ED action plan delivered	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. Additional activity over and above non elective and Emergency Department plan	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 Corporate Risks(20+)	Link to other BAF Objectives
• CS0275 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	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
01/12/2010	06/12/2016	Review Date April 2017	CQC – All	Chief Operating Officer	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	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 Corporate Risks (20+)	**Link to other BAF Objectives**
• CS0275 CS0311 CS0327 CS0328 EC0287 EC0331	• 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	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
01/07/2010	15/12/2016	Review Date April 2017	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 3. Shortage occupations causing difficulties to Recruit. 4. National reduction in nursing students completing under graduate courses	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. Workforce planning undertaken and agreed as part of the People and OD Strategy and monitored by Executive Workforce Assurance Group (I) 11. People and OD Strategy (I) 12. Expansion of Bank and weekly pay (I) 13. Developing Apprenticeship working (I) 14. Successful Return to Nursing programme - to include two more programmes in 2017/2018 (I) 15. Leading the Cheshire Apprenticeship Strategy (I/E)	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 and Advanced Practitioners in conjunction with HEEN 3. Development of MCHFT People and OD Strategy 4. Temporary staffing project underway to reduce reliance on agency spending 5. Consideration of Internal Leadership Development e.g. Secondment

Risk Register Links (all listed below)	
Link to Significant Corporate Risks (20+)	Link to other BAF Objectives
CS0275 CS0311 C0887 C0287 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	06/12/2016	Review Date April 2017	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. Prime gap is the 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)	1. Asbestos management programme 2. Capital approvals to access loans is not yet secured	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 Corporate Risks (20+)	Link to other BAF Objectives
• CS0327	• 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	19/12/2016	Review Date April 2017	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 6. Cheshire and Mersey IT STP Group 7. Local Delivery Systems Group 8. Cheshire Digital Design Authority Group 9. Options paper around EDMS / Clinical Portal was presented to the ITSG in Oct 2016. Business case to ITSG in February 2017 E Rostering business case approved by ITSG and PAF in December 2016. Presented at BOD in January 2017	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) 7. Cerner trip to USA confirmed that Cerner Millennium would be a good clinical system choice should it be affordable. The solution may be made affordable if the Trust is accepted on to the GDE Fast Follower Programme and maximises on collaboration and opts for a shared solution. 8. Strong relationship with MCHFT IT Lead and CCG IT Lead 9. Email business case approved by ITSG and PAF in December 2016. Presented at BOD in January 2017	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 – 1st phase on plan 2. 5 high impact standalone IT solutions prioritised by Divisions / ITSG. Annual Planning Round commences for 2017/18 budget. 3. Money available within STP Digital Work stream. Head of ICT volunteered to be STP Lead for LDS 4. Business case for Cerner to amalgamate local capital plans into a single solution – going to ITSG in June 2017 5. Business case to participate in Cheshire & Merseyside PACS Collaborative as a fund saving initiative.

Risk Register Links (all listed below)	
Link to Significant Corporate Risks (20+)	Link to other BAF Objectives
• CS0326 CS0327	• Q1 Q2 F4 F5 D2 E1

Strategic Domain: Emergency Preparedness

E1: Ensure that the Trust has robust Emergency Preparedness and 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 / Business Continuity 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	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
01/07/2010	16/12/2016	Review Date March 2017	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 2016 (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	1. Lack of robust Emergency Preparedness and Business Continuity plans for Community Services 2. Lack of Emergency Preparedness training for Community Services staff	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 Corporate Risks (20+)	Link to other BAF Objectives
• CS0327	• Q2 F1

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Title of Paper :	Top Five Organisational Risks	
Author:	Associate Director of Governance	
Executive Lead:	Medical Director / Deputy Chief Executive	
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:	Outlines the top 5 organisational risks, their risk rating, link to the Board Assurance Framework and other risks on the Trust Corporate Risk Register
Risk:	Adequate monitoring of controls and mitigation risks

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	**N/A**
Presented at Board Meeting of:	April 2017

Top Five Organisational Risks

Mid Cheshire Hospitals NHS Foundation Trust's Annual Governance Statement 2016/2017 outlined the major risks to the organisation. The table below outlines the top five organisational risks, risk rating and their link to the Board Assurance Framework. The list was reviewed at the January meeting of the Executive Quality Governance Group with the "Acquisition of East Cheshire community Services" risk replaced by "Sustainability of vulnerable clinical services"

Table 1

The risk is:	Risk Rating	Link to Board Assurance Framework
The financial sustainability of MCHFT	25	• F2 • Q2
Not delivering high quality clinical care 7 days per week	20	• W1 • Q1 • Q2 • F1 • D1
The operational sustainability of MCHFT	20	• Q2 • D1
Non-delivery of the IT Strategy	20	• Q2 • I2
Sustainability of vulnerable clinical services	20	• Q2 • F4

Each risk assessment details the following:

- Controls in place to mitigate the risk
- Action plan to address the gaps in control with a target date for completion
- Where applicable links to other risks on the risk register

CCICP Partnership Board

Date/time: Thursday 16th February 2017 at 9:00am

Venue: Boardroom, Ashfields PCC, Sandbach

Chair: **Tim Welch, Director of Finance, CWP**

Action Notes: Caron Corbin, Business & Project Support Officer, CCICP

Quorate (Y/N): **Yes**

No.	Item			
1	**Present**	Mr T Welch ***Chair***	**(TW)**	Director of Finance, CWP
		Mrs D Frodsham	**(DF)**	Chief Operating Officer, MCHFT
		Mr M Oldham	**(MO)**	Director of Finance & Strategic Planning, MCHFT
		Dr P A Dodds	**(PAD)**	Medical Director & Deputy Chief Executive. MCHFT
		Dr J Price	**(JP)**	GP, Willow Wood surgery and Director SC/VR GP Alliance
		Dr N Paul	**(NP)**	GP, Ashfields Primary Care Centre and Director Howbeck Healthcare
		Mr A Styring	**(AS)**	Director of Operations, CWP
		Ms K Moore	**(KM)**	Operational Lead, CCICP
	In attendance	Mrs Caron Corbin (Notes)	**(CC)**	Business & Project Support Officer, CCICP
		Mrs Sue Hamman	**(SH)**	Head of Nursing, CCICP
		Mrs Esther Bolton	**(EB)**	Transformation Programme Manager
		Mr Andy Richards	**(AR)**	Deputy Chief Pharmacist, MCHFT
	Apologies	Dr Anushta Sivananthan	**(SV)**	Medical Director, CWP
		Mrs T Cookson	**(TC)**	Clinical Director (nurse) SC/VR GP Alliance

Circulation: Mrs D Frodsham - Chief Operating Officer, MCHFT; Mr M Oldham – Director of Finance & Strategic Planning, MCHFT; Dr P A Dodds – Medical Director & Deputy Chief Executive. MCHFT; Dr N Paul – GP Alliance; Dr J Price – GP Alliance; Mrs T Cookson – GP Alliance; Ms K Moore - Operational Lead, CCICP; Mr T Welch – Director of Finance, CWP; Mr A Styring - Director of Operations, CWP; Dr Anushta Sivananthan – Medical Director, CWP

No.	Item	Discussion	Decision made	Action	Responsible	Due date
2.	**Board Members Interests**	Board Members confirmed that there were no changes to interests previously recorded, nor any specific interests relating to items on the agenda.				
3.	**Minutes of previous meeting**	The minutes of the meeting of the 19th January were received and reviewed for accuracy.	Minutes of meeting of 19.01.17 agreed.			
4.	**Matters Arising**	Any matters arising from the previous minutes would be discussed under individual agenda items.				
5.	**Finance Report**	MO presented the high level budget figures to members. An underspend is forecast; however there are costs not yet finalised and therefore the risk that the underspend may be lower than currently forecast. The estates bill is significantly higher than expected. Amy Freeman has circulated an estimation of investment required to develop IT to support the Care Communities. Around £50k is required to replace obsolete IT equipment over 5 years old. MO and TW are attending the contract meeting Friday 17th February. Members discussed issues to highlight to the CCG at that	The Partnership Board agreed to share the updated budget statement forecast with CCG Investment in the new developments proposed is unaffordable at this time. Replacement of obsolete equipment should be treated as business as usual. .	Discuss underwriting of estates costs with CCG. At contract meeting highlight: • Investment required	MO MO/TW	17.02.17 17.02.17

No.	Item	Discussion	Decision made	Action	Responsible	Due date
		meeting.		for CQC Action Plan • Investment required to deliver change • Balance sheet risks Begin discussions on year end position		
6.	**Operational Lead's Report**					
6.1	**Operational Governance Structure**	The draft operational structure was presented to members for agreement. Members discussed the structure presented and the role of the Transformation Board in that structure.	It was agreed that CCICP Partnership Board is not accountable to Transformation Board and the governance structure should be amended to reflect that.	Amend governance structure as agreed.	KM	ASAP
6.2	**Therapy Booking**	The arrangement with East Cheshire has been extended for 2 months to allow issues re accommodation and recruitment to be resolved.				
		SH working with a cross organization group to look at safer staffing levels across District Nursing and developing tools to support that. JP pointed out that TC is also involved in a pilot for similar tools.		Contact TC to discuss pilot.	KM/SH	Next meeting
	Balanced Scorecard	The draft balanced scorecard had been circulated. KM highlighted that this is still a work in progress and some fields are not populated as the information is available. Also some terminology needs amending to reflect community. The Board				

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		discussed the document and agreed that the preferred format would be a one page summary with the detailed data sets to support. Several amendments were suggested.		Consider format and content of scorecard. Aim to present a report per care community going forward.	KM/DF	
	Quality Report	Risk – SH/KM have reviewed all high and medium level risks. All have been reduced. Training is being arranged for Clinical Service Managers to improve consistency in applying risk scores. Plans are in place to make the risk register web-based and Board members will be given access. Vacancies – currently at 11%. 17 in intermediate care however recruitment is underway. 10 vacancies are in community teams, 4 of these are related to the geriatrician service. Hebden Green – the issues previously identified are now being addressed.				
7.	**CQC Action Plan**	SH presented an overview of the outcomes of the East Cheshire Trust CQC inspection in 2014 which included community services and which concluded with an overall rating of inadequate. Some issues were addressed by ECHT immediately but longer term measures were not always in place to ensure issues did not recur. Any enforcement notices for inadequate				

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		rating were signed off at the time. Given the results, a re-inspection is due and could happen anytime. The action plan is in place, some items are closed and evidence is being collated to demonstrate that they are closed. A peer review and self-assessment exercise is planned.				
8.	**Pharmacy Support for Community Services**	AR presented the report circulated to members setting out the detailed options for the provision of pharmacy support for community services. The options presented were 1. Continue without dedicated pharmacy resource 2. Investment from MCHFT pharmacy 3. Split support provision between MCHFT and CWP 4. External tender The role would support audits and compliance, development of PGD, training and education and collaboration with practice and community pharmacists, supporting CCICP to meet CQC safe standards.	Agreed that the role is required subject to budget. Recruitment process can begin.	Start recruitment process.	KM/SH	ASAP
9.	**Transformation Programme Report**					
9.1	**Management Re-structure**	EB presented the paper outlining the options for a management structure. Option three is recommended as it supports the five care communities, providing both strong clinical leadership and management for each				

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		of the five multi-disciplinary teams. Each of the options presented assume no redundancies or additional staffing costs. The Board discussed the options and agreed that option 3 was preferred at the Management level but that further work was required to design the teams beneath that level.	Agreed that Option 3 structure at management level should be taken forward. Multi-disciplinary team structure detail to be developed.			
9.2	**Alignment of Community Matrons to Care Communities**	EB presented the paper recommending moving one Community Matron and one Complex Care Practitioner from Crewe to Nantwich Care Community to support Audlem and Wrenbury where currently there is no provision. The Board discussed the proposal and whilst acknowledging the apparent gap, concluded that changes in provision should be based on an identified need evidenced by a clinical needs analysis.	The proposal was not supported at this time.	In one Care Community, complete a full clinical needs analysis and identify what provision may be required. Identify the functions of the Care Community Team based on the needs analysis.	EB	
9.3	**General - Transformation**	Several members of the Board attended the Clinical Commissioning Executive meeting with EB who gave a presentation setting out the CCICP plans. This was received very positively by the CCE. The Board discussed how they may support the development of care communities and improve visibility to	The Board expressed their thanks to EB for the presentation to CCE. Agreed that a Board Member will be linked to each Care Community in			

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		staff.	an Executive Sponsor role to raise visibility, act as critical friend and support development of care communities.			
10.	**Partnership Board Actions**	The Action Log was reviewed and updated with progress noted.				
11.	**Any other Business**					
11.1	**DVT Service**	DF had circulated to members the spec and estimated costs for the DVT service. The estimated cost of delivering the service is significantly above the cost envelope. The decision is not to proceed based upon, spec, cost and timeframe. Although the submission date changed to 16th March, the decision still remains not proceed on the bid.	Do not submit tender for the DVT service.	Send letter to CCG setting out the reason for not responding to the tender before the tender closing date.	DF	24.02.2017
11.2	**Keith Malone work with 111**	A document has been circulated to members from Keith Malone reviewing pathways through the OOHs service. The document requires sign off.	Responsibility delegated to Paul Dodds through MCHFT.			
12.	**Next Meeting:** **Date:** Thursday 16th March 2017 **Time:** 9am **Venue:** Board Room, Ashfields, Sandbach					

Mid Cheshire Hospitals NHS
NHS Foundation Trust

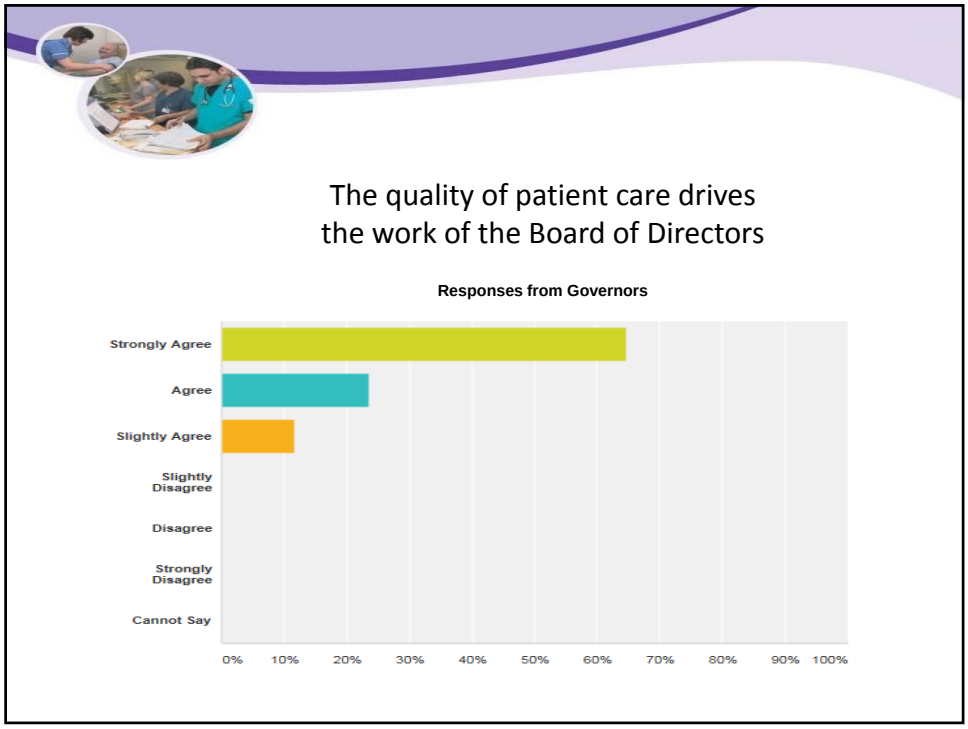
Board Effectiveness

Responses from Governors and Staff

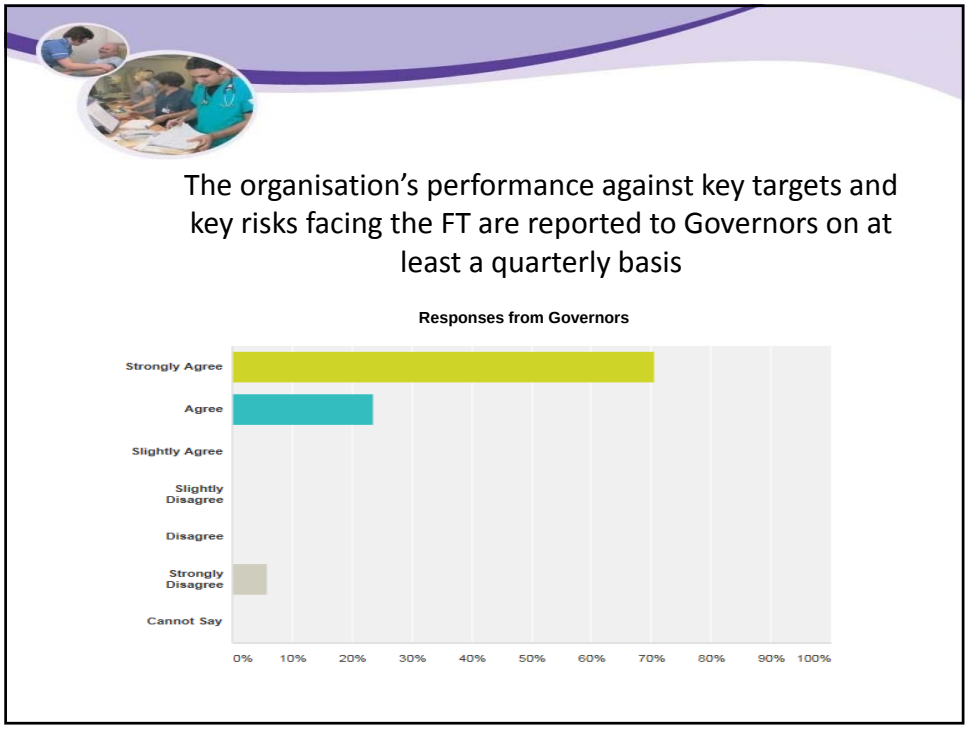
Spring 2017

Response Rates from Governors

- 17 Governors - March 2017

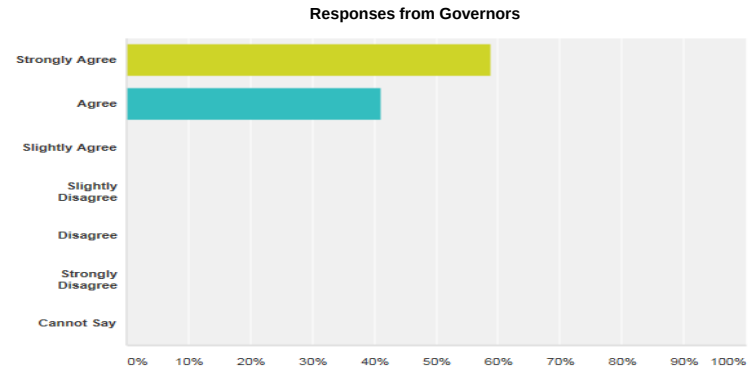


The quality of patient care drives the work of the Board of Directors

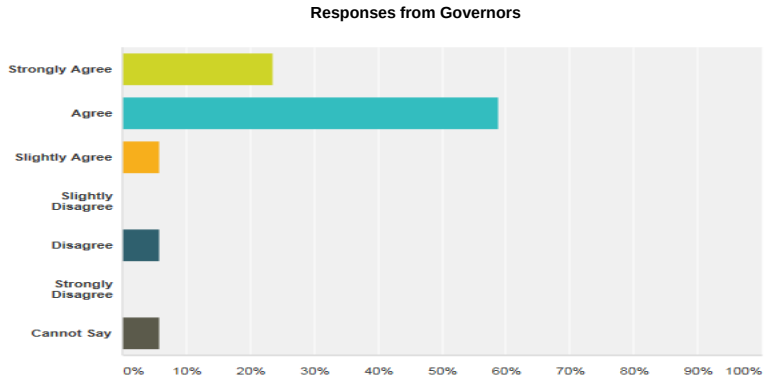


The organisation's performance against key targets and key risks facing the FT are reported to Governors on at least a quarterly basis

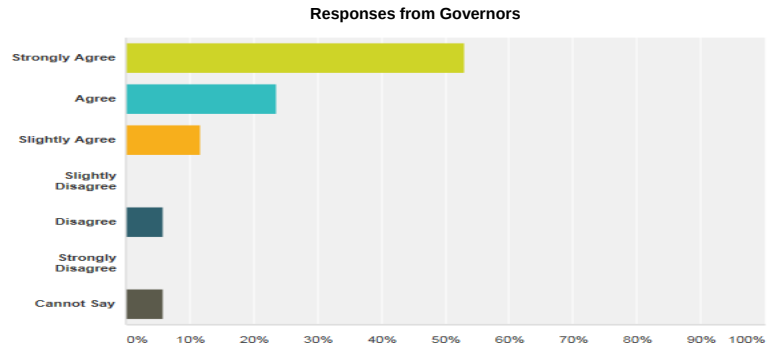
There is not a history of nasty surprises and only being told half the story by the Board of Directors – I am told the truth in a timely way



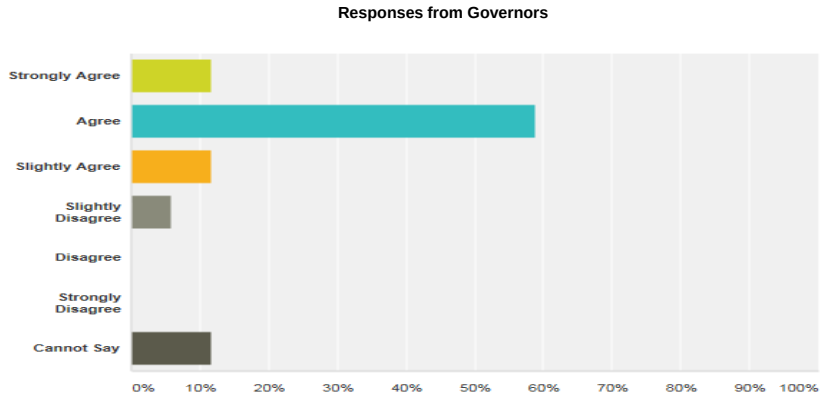
What I'm told by Directors matches what I'm told by staff and patient governors



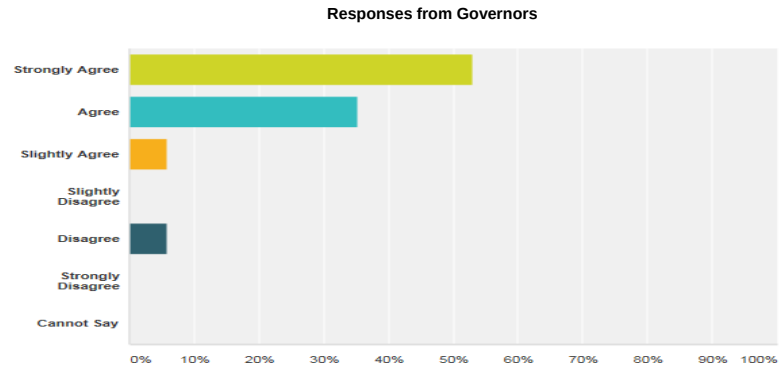
If performance slips, I understand the reasons why it has slipped and the key actions that being undertaken to rectify the situation



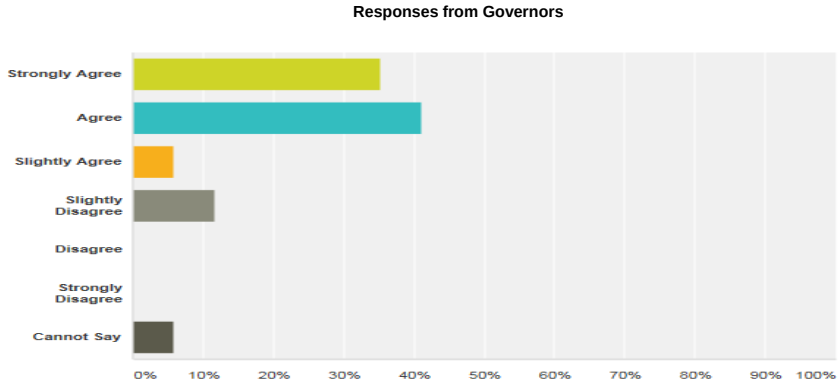
The Board of Directors has a history of quickly getting performance back on track



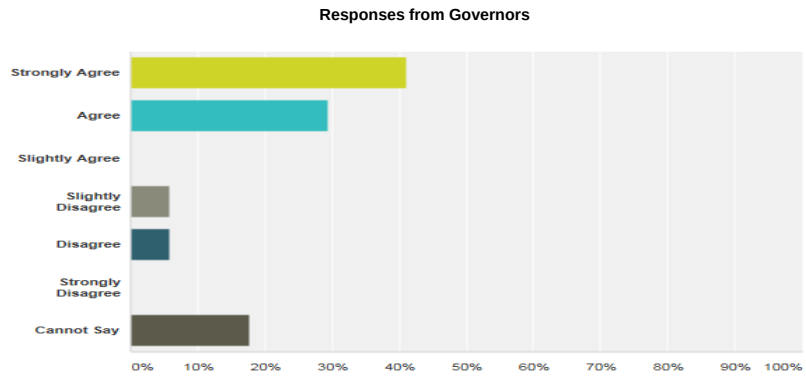
The Board of Directors take the Council seriously and treat Governors with respect – Directors genuinely listen to what we have to say and deliver on their promises



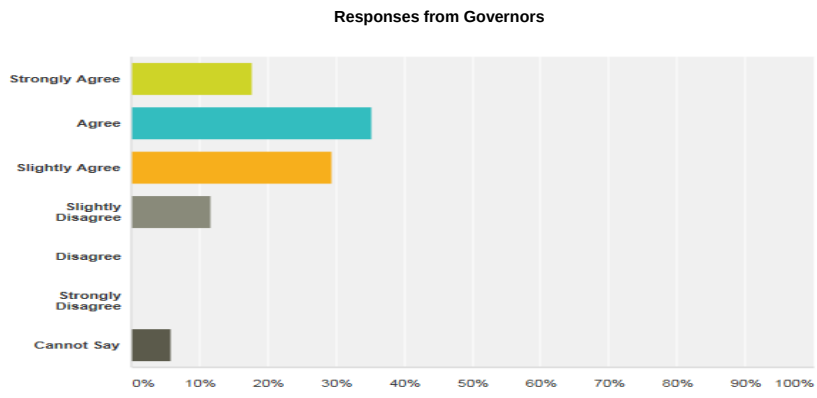
When the Board of Directors does not agree with the views of the Council, the reasons are effectively explained and communicated on a timely basis



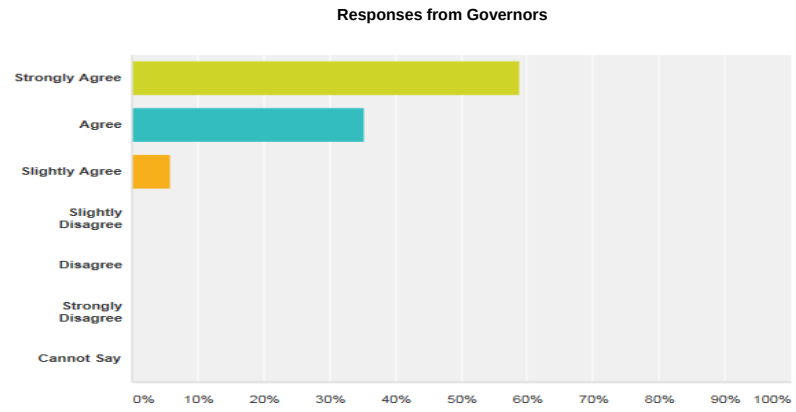
Issues I have raised with the Board of Directors have been dealt with promptly and to my satisfaction



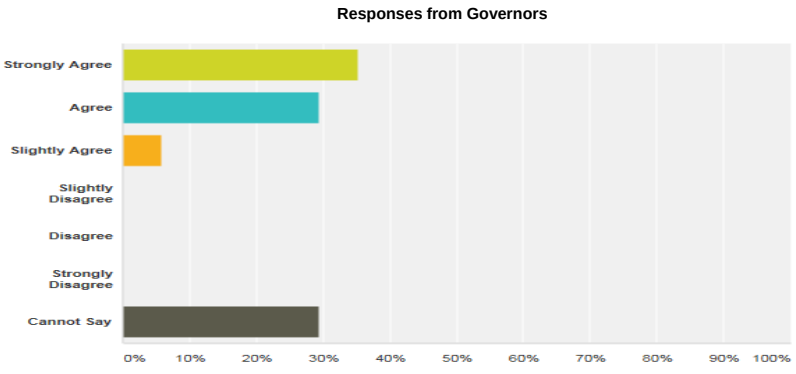
Governors and the wider membership have been able to shape the future direction of the organisation

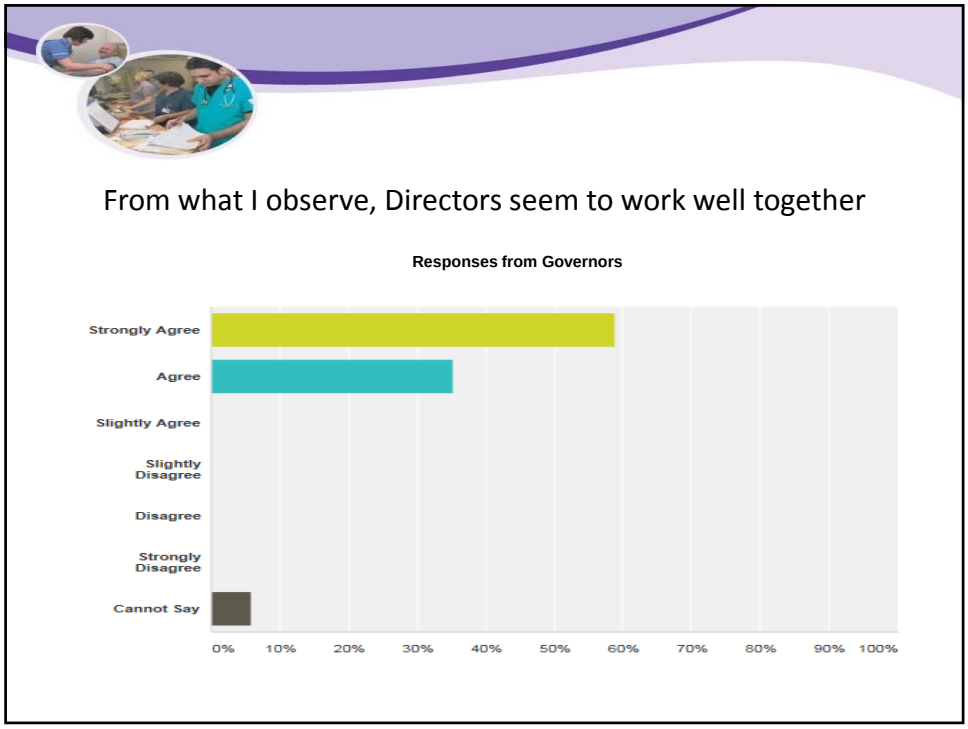


I am kept appropriately informed about progress towards delivering the organisational vision and strategic objectives

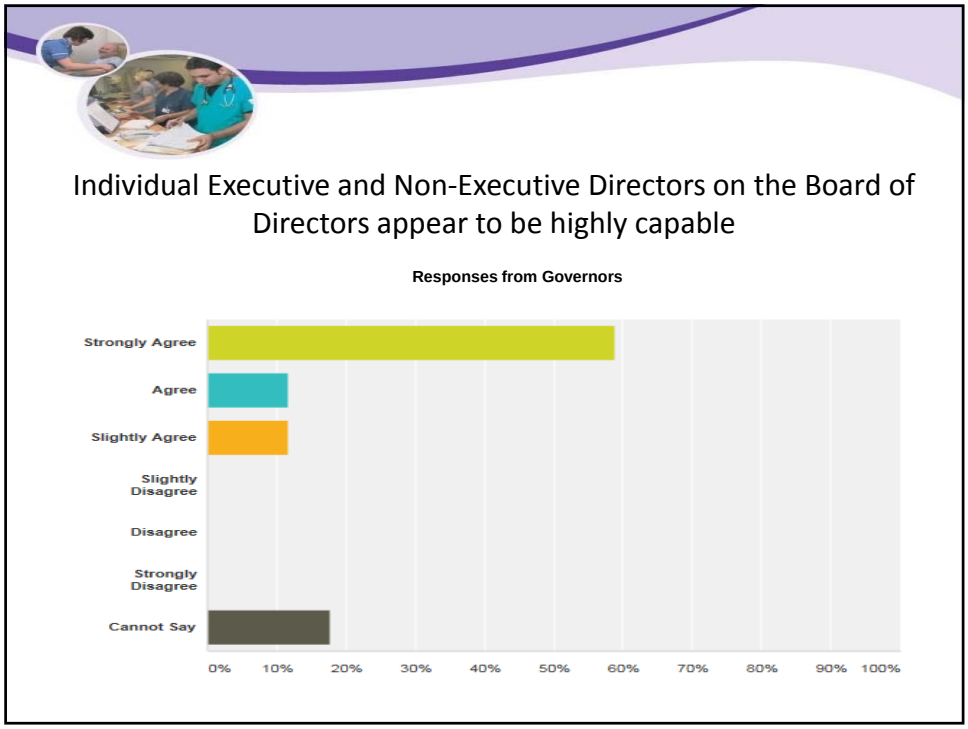


The Board of Directors has a Board appraisal process in place that is consistent with best practice and undertaken on at least an annual basis



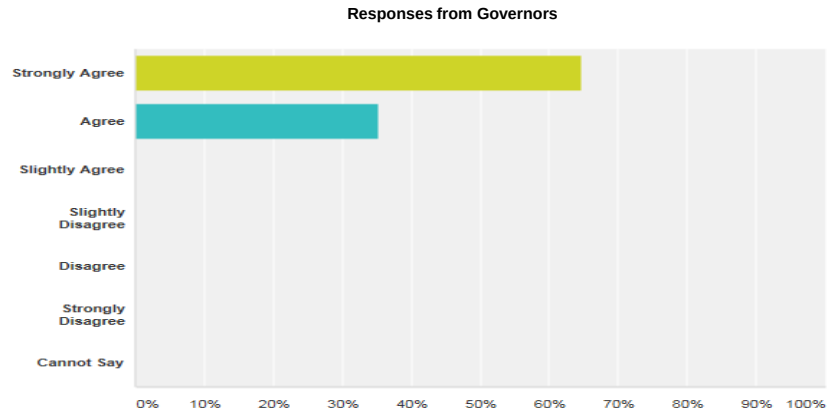


From what I observe, Directors seem to work well together



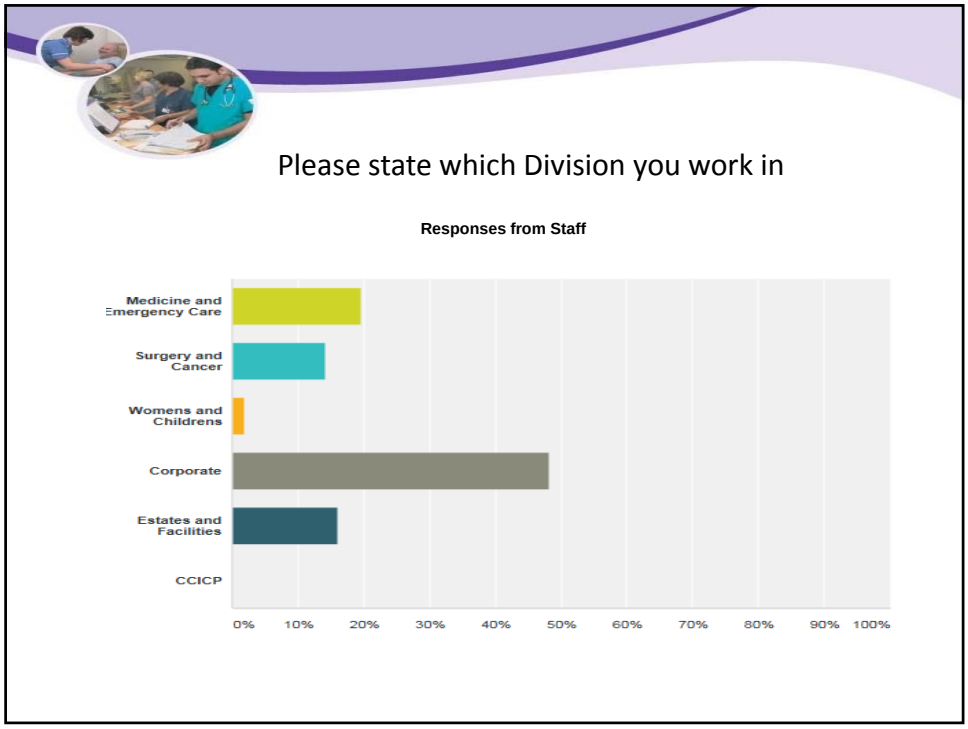
Individual Executive and Non-Executive Directors on the Board of Directors appear to be highly capable

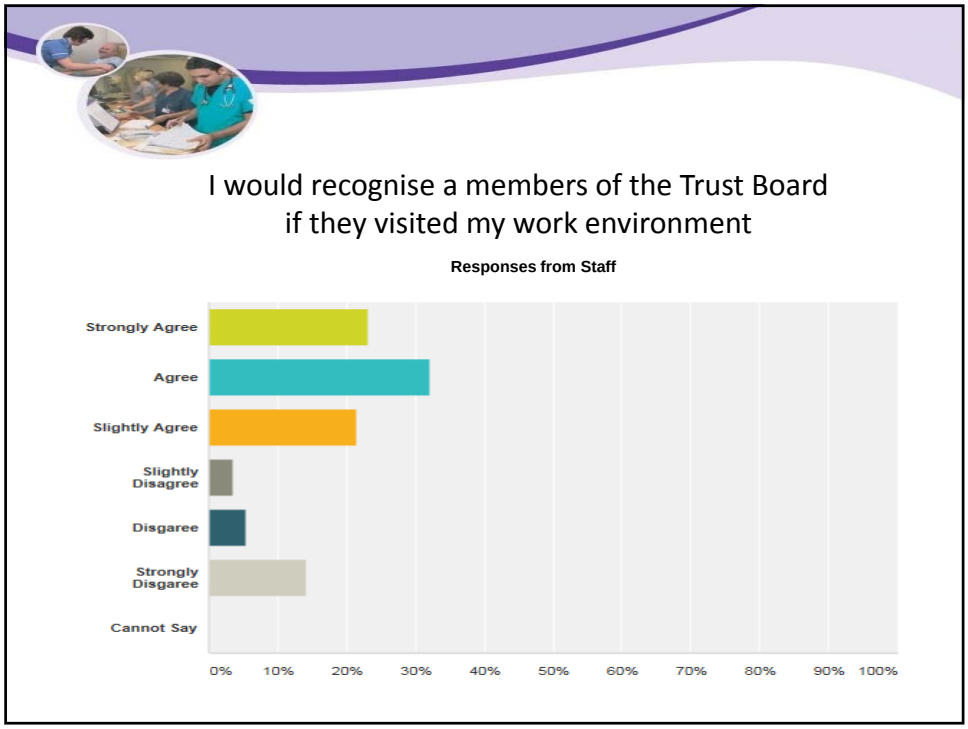
As governors, we are regularly briefed on major service developments and issues impacting on the FT



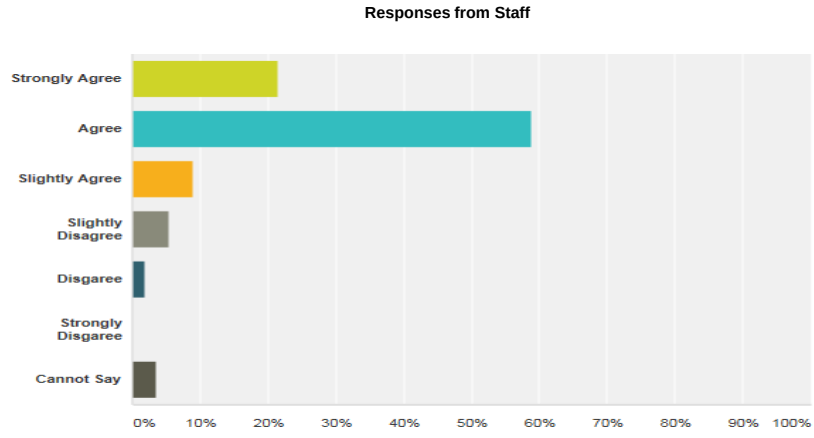
Response Rates from Staff Members

- 56 staff members - March 2017

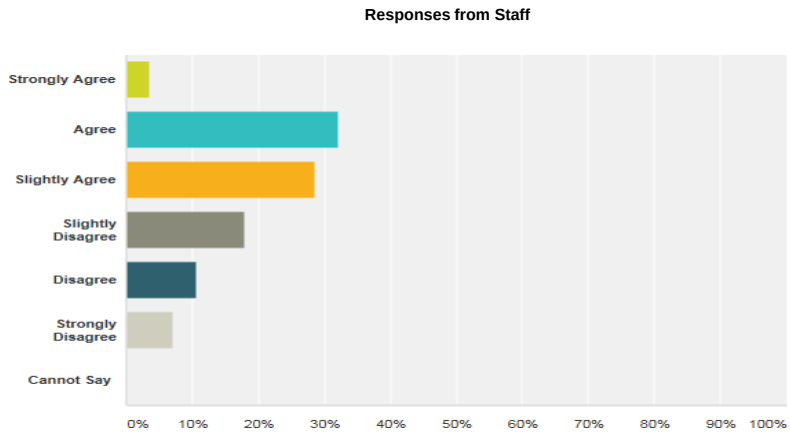

Please state which Division you work in
Responses from Staff
Medicine and Emergency Care
Surgery and Cancer
Womens and Childrens
Corporate
Estates and Facilities
CCICP
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%


I would recognise a members of the Trust Board if they visited my work environment
Responses from Staff
Strongly Agree
Agree
Slightly Agree
Slightly Disagree
Disgaree
Strongly Disgaree
Cannot Say
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%

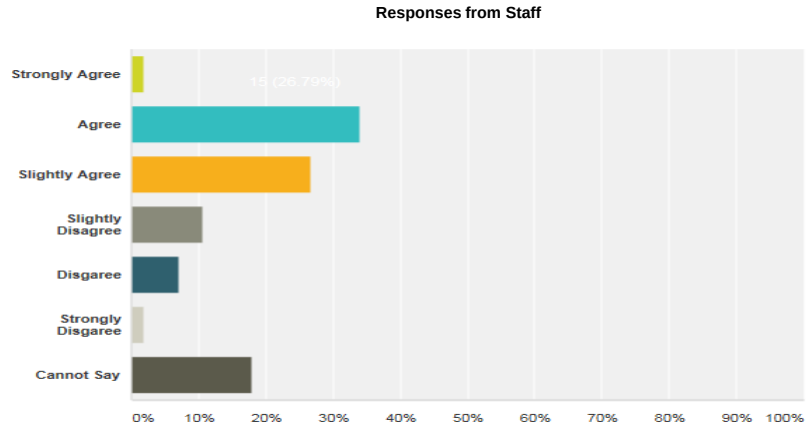
There is a widespread culture of safety within the organisation



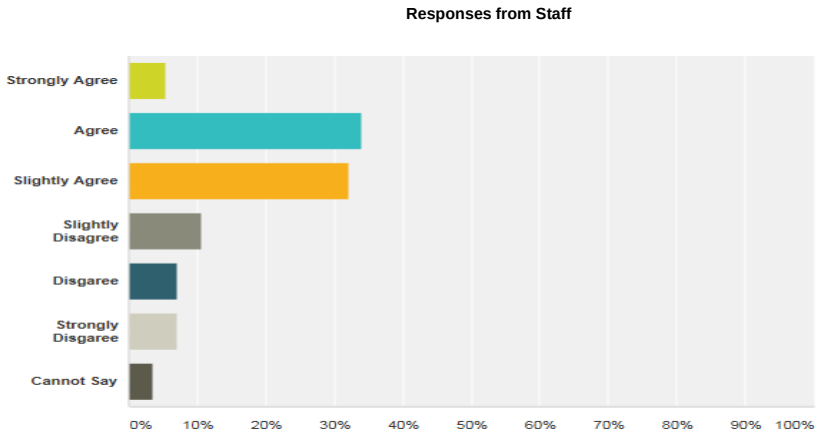
I have sufficient resources to perform optimally in my role



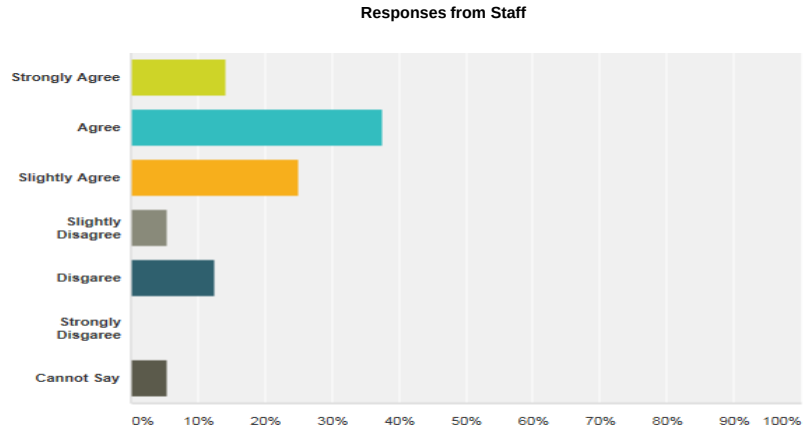
The Board of Directors has appropriately engaged staff in the development of the organisation's vision and strategic priorities



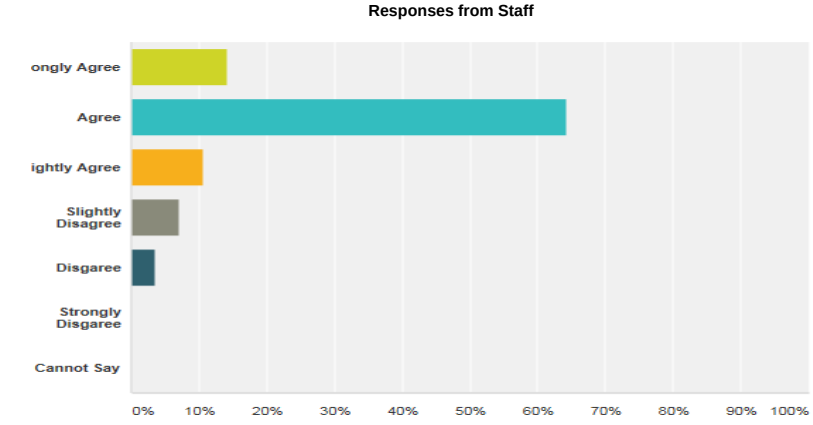
I understand the future direction of this organisation and my role in helping to deliver this vision



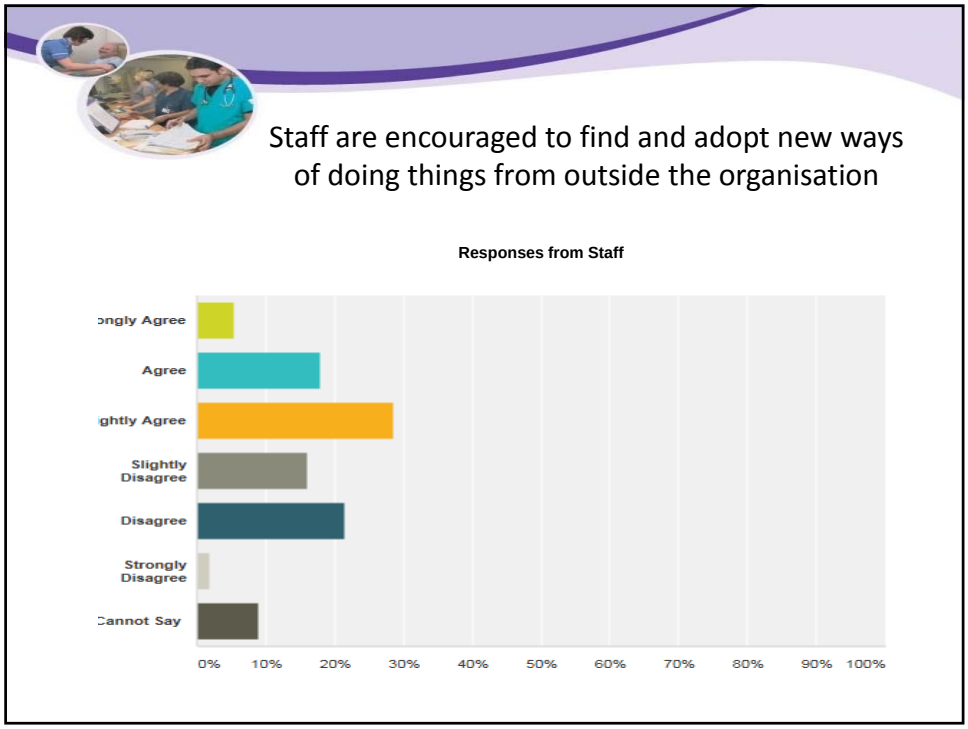
I am aware of the key risks faced by this organisation and my responsibilities in minimising these risks



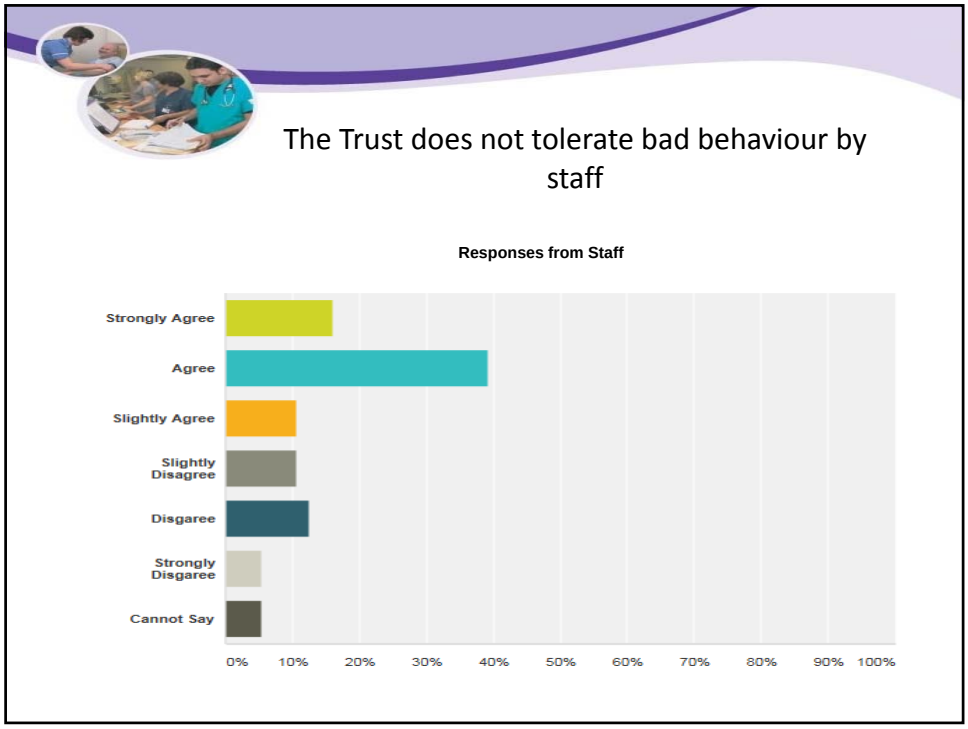
I could describe the values and behaviours expected of staff employed by this organisation



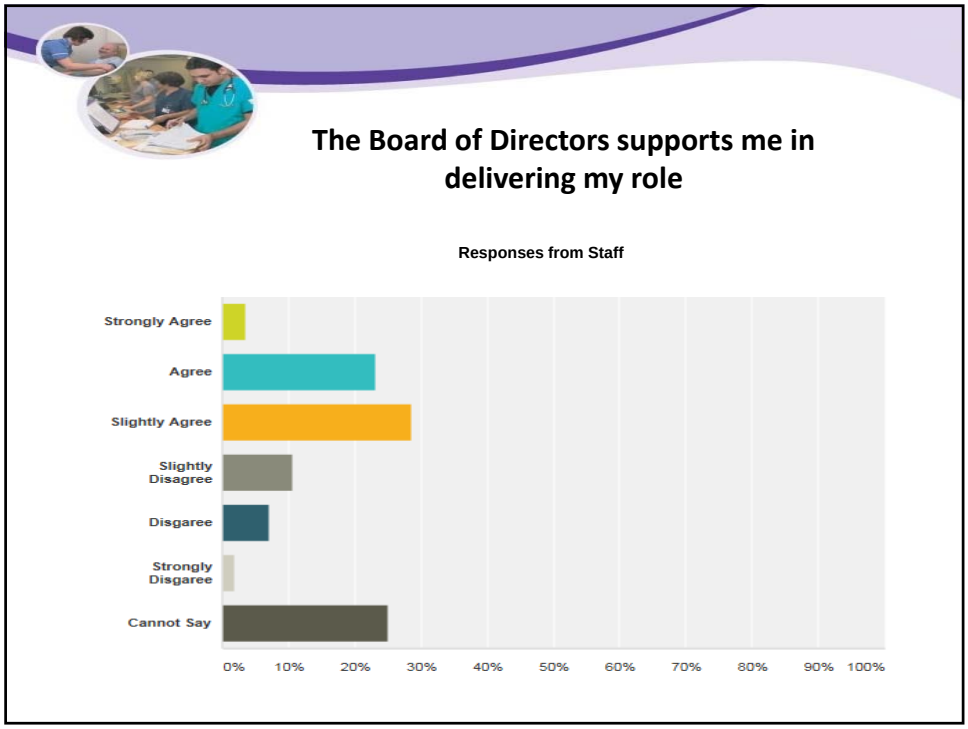
My line manager behaves in a way that gets the best out of me



Staff are encouraged to find and adopt new ways of doing things from outside the organisation

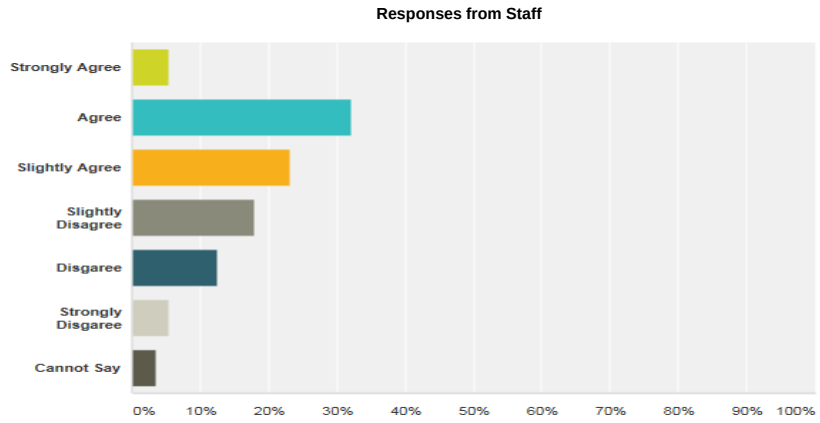


The Trust does not tolerate bad behaviour by staff

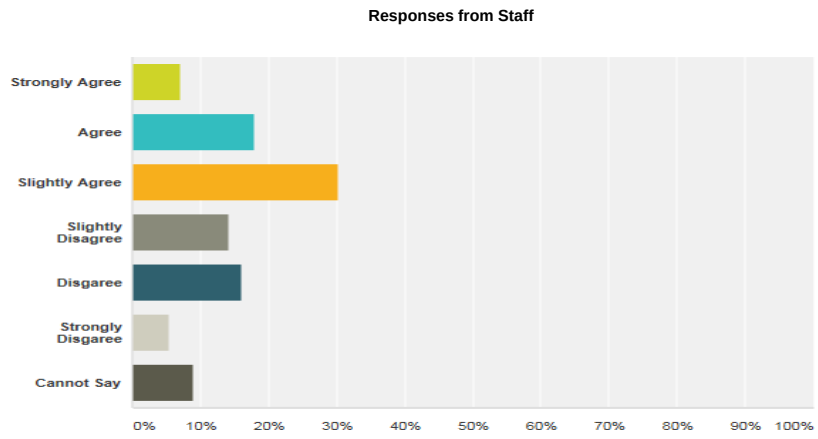


The Board of Directors supports me in delivering my role

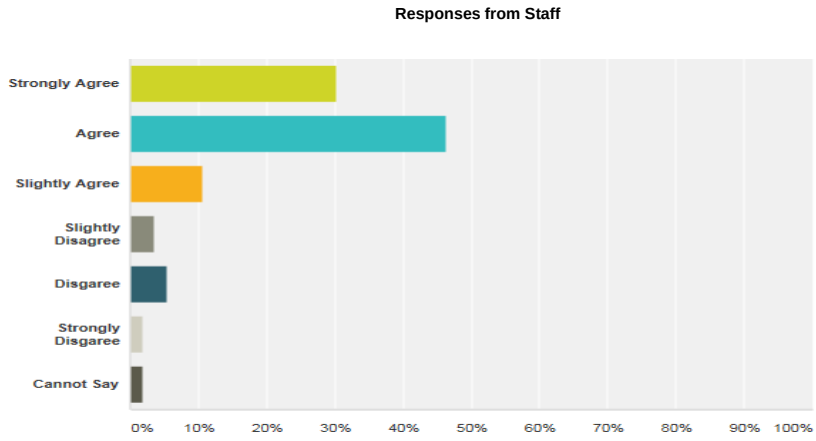
I am provided with meaningful information about how my part of the organisation is performing



The Board of Directors routinely seeks the views of staff and communicates what actions have been taken as a result of this feedback



I would be happy for my family to receive the care provided by this organisation



TO BE COMPLETED BY STAFF IN CLINICAL AREAS/WARDS ONLY - I would be happy for my family to receive the care provided on my ward/within my area