Mid Cheshire Hospitals NHS Foundation Trust

AGENDA

Board of Directors
A meeting will be held in Public at
09.30am on Tuesday, 3 April 2018
in the Boardroom, Leighton Hospital

Action Key	
A	Approval
I	Information
D	Discussion

Item No	Title of Item	Action	Led By
1.	**Welcome and Apologies** To welcome members of the public and attendees and to receive apologies for absence from Board Members. *(to note)*	I	Chairman **09.30**
2.	**Patient or Staff Story** *(verbal)*	I/D	Director of Nursing & Quality **09.32**
3.	**Board Member's Interests** *(to note)* To **consider** any • Changes to Directors' interests since the last meeting • Conflicts of interest deriving from this agenda	I	Chairman **09.50**
4.	**Minutes of the Last Meeting** To **approve** the minutes of the Board of Directors meeting held in Public on Monday, 5 March 2018 *(attached)* *(to approve)*	A	Chairman **09.52**
5.	**Matters Arising and Action Log** *(verbal) (to approve)*	A	Chairman **09.55**
6.	**Annual Work Programme 2018/19** *(attached)* *(to approve)*	I/A	Chairman **09.57**
7.	**Chairman's Announcements** (*to note a verbal report*) **7.1 Remuneration Committee – 12 March** **7.2 Meeting with Antoinette Sandbach MP** **7.3 Cheshire & Merseyside Health & Care Partnership Meeting – 14 March** **7.4 Meeting with University of Chester Vice Chancellor** **7.5 UHNM Chair Appointment**	I	Chairman **10.00**
8.	**Governor's Items** (*to note a verbal report*) **8.1 Governor/NED Meeting – 12 March** **8.2 Governor Agenda Setting Meeting – 16 March**	I	Chairman **10.10**

Item No	Title of Item	Action	Led By
9.	**Chief Executive's Report** *(to note a verbal report)*	I	Chief Executive **10.15**
9.1	**System Update**		
9.2	**Executive Away Day**		
9.3	**Director of Workforce Recruitment**		
9.4	**Use of Resources Assessment**		
9.5	**CQC Unannounced Inspection**		
9.6	**Sexual Health Tender**		
10.	**CARING**		
10.1	**Quality, Safety & Experience Report** *(attached) (for discussion)*	I/D	Director of Nursing & Quality **10.35**
11.	**SAFE**		
11.1	**Draft Quality Governance Committee notes from the meeting held on 20 March 2018** *(attached) (to note)*	I	Committee Chair **10.45**
11.2	**Serious Untoward Incidents and RIDDOR Events** *(verbal)* (*to note*)	I/D	Deputy Chief Executive/ Medical Director **10.50**
11.3	**Guardian of Safe Working Hours Report** *(attached) (to note)*	I/D	Director of Workforce and OD **10.55**
12.	**RESPONSIVE**		
12.1	**Performance Report** *(attached) (to note)*	I/D	Director of Finance **11.00**
12.2	**Draft Performance & Finance Committee notes from the meeting held on 22 March 2018** *(to follow) (to note)*	I	Committee Chair **11.10**
12.3	**Legal Advice** *(verbal)* (*to note*)	I	Chief Executive **11.15**
12.4	**Annual Planning and Budget** *(verbal) (to note)*	A/D	Director of Finance **11:20**
13.	**WELL-LED**		
13.1	**Visits of Accreditation, Inspection or Investigation** *(verbal)* (*to note*)	I	Chief Executive **11.25**
13.2	**Trust Strategy Update** *(attached) (to approve)*	I	Director of Strategic Partnerships **11:30**

Item No	Title of Item	Action	Led By
13.3	**CCICP Partnership Board notes from the meeting held on 15 February** *(attached) (to note)*	I	Director of Strategic Partnerships **11.35**
13.4	**Board Effectiveness Survey (Governors)** *(attached) (to note)*	I/D	Chief Executive **11:40**
13.5	**Gender Pay Gap Paper** *(attached) (to note)*	I	Director of Workforce and OD **11.50**
13.6	**Corporate Governance Handbook update** *(attached) (to approve)*	A/D	Chief Executive **11.55**
13.7	**Annual Review of Board Committees** *(attached) (to approve)*	I/D	Chief Executive **12.00**
14.	**EFFECTIVE**		
14.1	**Workforce Report** *(attached) (to note)*	I	Director of Workforce and OD **12.05**
14.2	**Transformation and People Committee notes from the meeting held on 8 March 2018** *(attached) (to note)*	I	Committee Chair **12.15**
14.3	**Consultant Appointments** *(verbal) (to note)*	I	Deputy Chief Executive/ Medical Director **12.20**
14.4	**Q3 Board Assurance Framework** *(attached) (to note)*	I/D	Deputy Chief Executive/ Medical Director **12:25**
14.5	**Q3 Organisational Risk Register** *(attached) (to note)*	I/D	Deputy Chief Executive/ Medical Director **12.30**
15.	**Any Other Business** *(verbal)*	I/A/D	Chairman **12.35**
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 **Tuesday, 8 May 2018**	I	Chairman

Board of Directors Workplan 2018 /19 Version: 1

Item	Board of Directors Meeting												Board Away Day			
	April	*May*	*June*	*July*	*August*	*Sept*	*Oct*	*Nov*	*Dec*	*Jan*	*Feb*	*March*	*Apr*	*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																
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														
Safe																
Health & Safety Update to Board													x			
SUI & RIDDOR	x	x	x	x	x	x	x	x	x	x	x	x				
Quality Governance Committee	x	x	x	x	x	x	x	x	x	x	x	x				
Guardian of Safe Working Hours Report			x				x		x			x				
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		x
Whistleblowing Report						x										
Well-Led																
Annual Budget/Contract Discussions	x											x				
Annual Plan	x	x										x				
Annual Report & Accounts (Extra Ordinary Board)		x														
Audit Committee		x	x				x		x		x					
Board Assurance Framework	x		x	x					x			x				
Quarterly Organisational Risk Register	x			x			x			x						
Learning from Deaths Quarterly Report			x			x			x			x				
Trust Strategy	x							x						x		x
Visits of Accreditation, Inspection or Investigation	x	x	x	x	x	x	x	x	x	x	x	x				
Well-Led Governance Framework Self Assessment																x
Corporate Goverance Handbook										x						
Transformation and People Committee	x	x	x	x	x	x	x	x	x	x	x	x				
Board Sub-Committee Annual Review			x													
Doctors Revalidation Report						x										
Board Actions	x	x	x	x	x	x	x	x	x	x	x	x				

We Care Because You Matter

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

Board of Directors

Quality, Safety and Experience Report

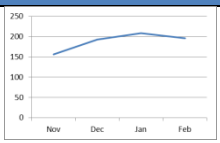
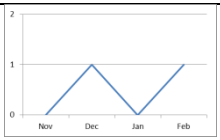
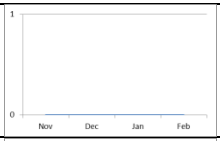
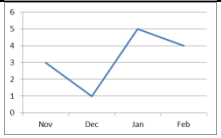
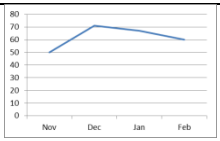
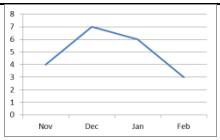
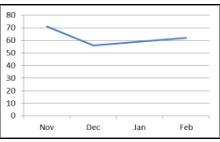
April 2018

(February 2018 data)

Contents

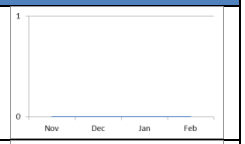
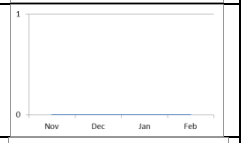
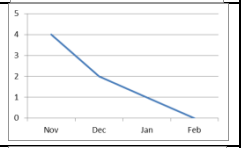
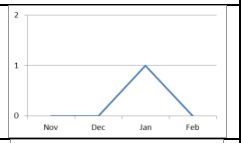
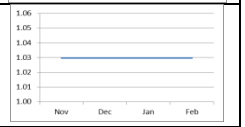
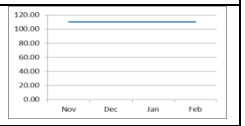
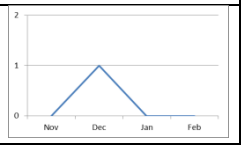
Contents (continued):

Board Papers – Quality, Safety & Experience Section: April 2018

Indicators	Position compared to previous month	Target	Last four months				Trajectory
			Nov-17	Dec-17	Jan-18	Feb-18	
Patient Safety Harm Incidents The aim is to reduce the number of harm incidents by the end of March 2018, measured by comparison to the previous financial year. In 2016/2017 2574 patient safety harm incidents were reported.	⬇	**<2574 at end of March 2018**	**156**	**193**	**208**	**196**	
Serious Incidents The aim is to have no serious incidents by the end of March 2018	⬆	**Zero at end of March 2018**	**0**	**1**	**0**	**1**	
Never Events Zero tolerance of Never Events	⇔	**Zero**	**0**	**0**	**0**	**0**	
Pressure Ulcers - Avoidable The aim is to reduce hospital acquired avoidable pressure ulcers by 5% quarter on quarter in 2017/2018	⬇	**5 at end of quarter 4**	**3**	**1**	**5**	**4**	
Inpatient Falls The aim is to reduce inpatient falls by 10% by January 2018	⬇	**733 at end of March 2018**	**50**	**71**	**67**	**59**	
Medication Incidents The aim is to reduce medication incidents resulting in harm by 10% in comparison to the previous financial year	⬇	**59 at end of 2017/2018**	**4**	**7**	**6**	**3**	
CCICP Patient Safety Harm Incidents The aim is to reduce the number of harm incidents.	⬆		**71**	**56**	**59**	**62**	

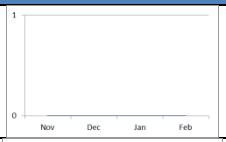
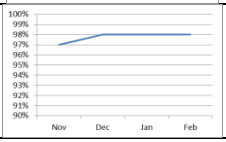
Key							
⬆⬇	**Position Declined since last month**	⬆⬇	**Position Improved since last month**	⇔	**No change to previous month remains on target**	⇔	**No change to previous month not on target**

Board Papers – Quality, Safety & Experience Section: April 2018

Indicators	Position compared to previous month	Target	Last four months				Trajectory
			Nov-17	Dec-17	Jan-18	Feb-18	
CCICP Serious Incidents The aim is to have no serious incidents by the end of March 2018	⇔	**Zero at end of March 2018**	**0**	**0**	**0**	**0**	
CCICP Never Events Zero tolerance of Never Events by the end of March 2018	⇔	**Zero at end of March 2018**	**0**	**0**	**0**	**0**	
CCICP Pressure Ulcers - Avoidable The aim in quarter 1 is to develop a process to enable pressure ulcers to be classified as avoidable or unavoidable. A baseline for a 5% improvement will be agreed, which will then be measured quarterly.	⇓		**4**	**2**	**1**	**0**	
CCICP Medication The aim is to reduce harm medication incidents. A target will be set in quarter 3 once a full year's data is available.	⇑		**0**	**0**	**1**	**0**	
SHMI The Trust's aim within the Sign Up To Safety Campaign is to have a SHMI at or below 1.0 from April 2016	**1.02** ⇔	**Below 1.0**	**1.02**				
HSMR The Trust's aim is to have an HSMR <100	**110.02** ⇔	**<100**	**110.02**				
MRSA The target for MRSA Bacteraemia is zero in 2017/18	⇔	**Zero at end of 2017/2018**	**0**	**1**	**0**	**0**	

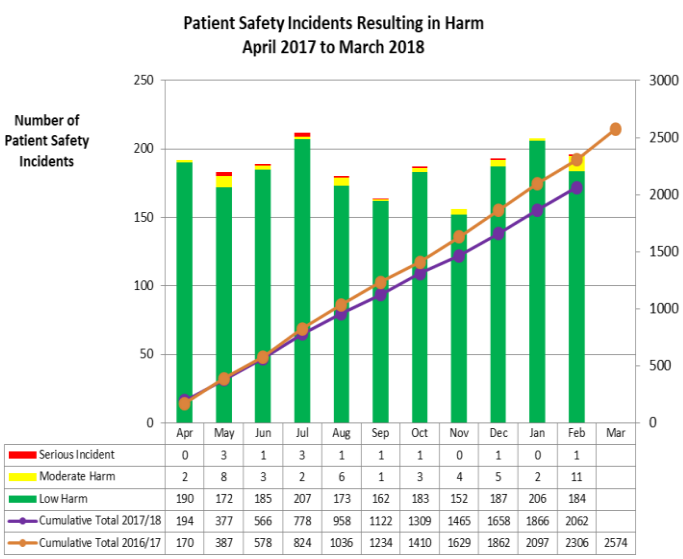
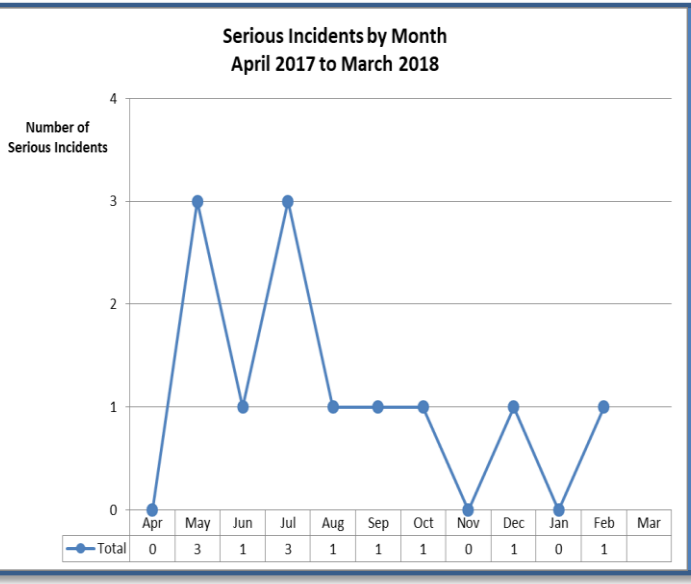
Key							
⇑ ⇓	**Position Declined since last month**	⇑ ⇓	**Position Improved since last month**	⇔	**No change to previous month remains on target**	⇔	**No change to previous month not on target**

Board Papers – Quality, Safety & Experience Section: April 2018

Indicators	Position compared to previous month	Target	Last four months				Trajectory
			Nov-17	Dec-17	Jan-18	Feb-18	
C-Diff Avoidable The target is less than 24 avoidable cases of Clostridium Difficile in 2017/18	⇔	**<24 at end of 2017/2018**	**0**	**0**	**0**	**0**	
Safety Thermometer The Trust aim is that >95% of patients receive harm free care as monitored by the Safety Thermometer.	⇔	**>95%**	**97%**	**98%**	**98%**	**98%**	

Key							
⇑⇓	**Position Declined since last month**	⇑⇓	**Position Improved since last month**	⇔	**No change to previous month remains on target**	⇔	**No change to previous month not on target**

Quality & Safety Section:

Description	Aggregate Position	Trend	Performance against previous month
Patient Safety Incidents resulting in harm.	This chart demonstrates the total number of reported patient safety incidents which resulted in harm. For February 2018, there were a total of 196 patient safety incidents: 93.9% (184 incidents) have resulted in low harm 5.6% (11 incidents) have resulted in moderate harm 0.5% (1 incidents) have resulted in serious harm		To reduce the number of patient safety harm incidents, a number of initiatives are being undertaken. These include: • Twice monthly Patient Safety Summit Meetings with Executive & Senior Teams • Twice monthly Patient Safety Matters newsletter that is delivered Trust wide
Serious Incidents.	This chart demonstrates the number of incidents that have resulted in serious harm. For February 2018, there was one serious incident reported: • Unexpected death There have been no never events reported since November 2016.		To reduce the number of serious incidents a number of initiatives are being undertaken. These include: • Twice monthly Patient Safety Summit Meetings with Executive & Senior Teams • Twice monthly Patient Safety Matters newsletter that is delivered Trust wide

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Serious Incident	0	3	1	3	1	1	1	0	1	0	1	
Moderate Harm	2	8	3	2	6	1	3	4	5	2	11	
Low Harm	190	172	185	207	173	162	183	152	187	206	184	
Cumulative Total 2017/18	194	377	566	778	958	1122	1309	1465	1658	1866	2062	
Cumulative Total 2016/17	170	387	578	824	1036	1234	1410	1629	1862	2097	2306	2574

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

Board Papers – Quality, Safety & Experience Section: April 2018

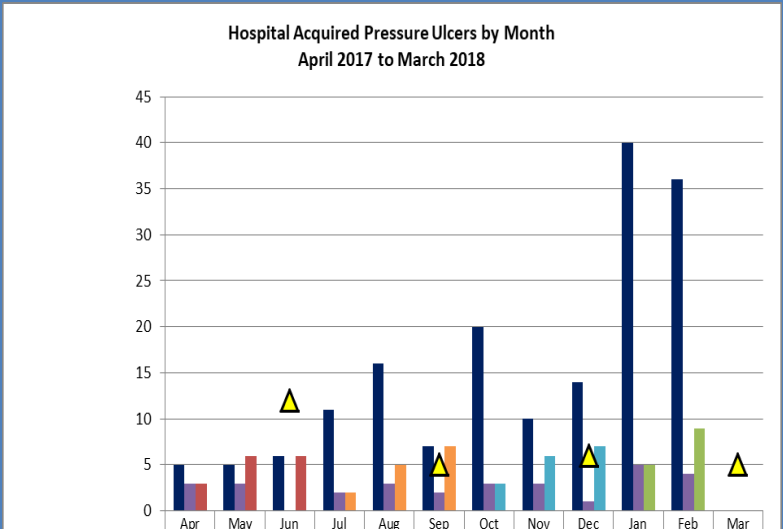
Description	Aggregate Position	Trend	Performance against previous month

Pressure Ulcer (PU) Incidents including both avoidable and unavoidable pressure ulcers based on EPUA Guidance

For February 2018, there were a total of 36 hospital acquired pressure ulcer incidents:

- 11.1% (4 PU's) have resulted in avoidable harm
- 6 pressure ulcers occurred on Ward 10 (Orthopaedic Trauma), these were all unavoidable
- 5 pressure ulcers occurred on Ward 4, one of these was avoidable
- 4 pressure ulcers occurred on Ward 5, one of these was avoidable

The 5% reduction target (Quarter on quarter in 2017/18) to achieve by the end of quarter 4, is to have no more than 5 avoidable pressure ulcers reported. There have been 9 avoidable pressure ulcers reported to date in quarter 4.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Monthly	5	5	6	11	16	7	20	10	14	40	36	
Avoidable	3	3	0	2	3	2	3	3	1	5	4	
Cumulative Avoidable	3	6	6	2	5	7	3	6	7	5	9	
5% ¼ Reduction Target			12			5			6			5

Improvement actions include:

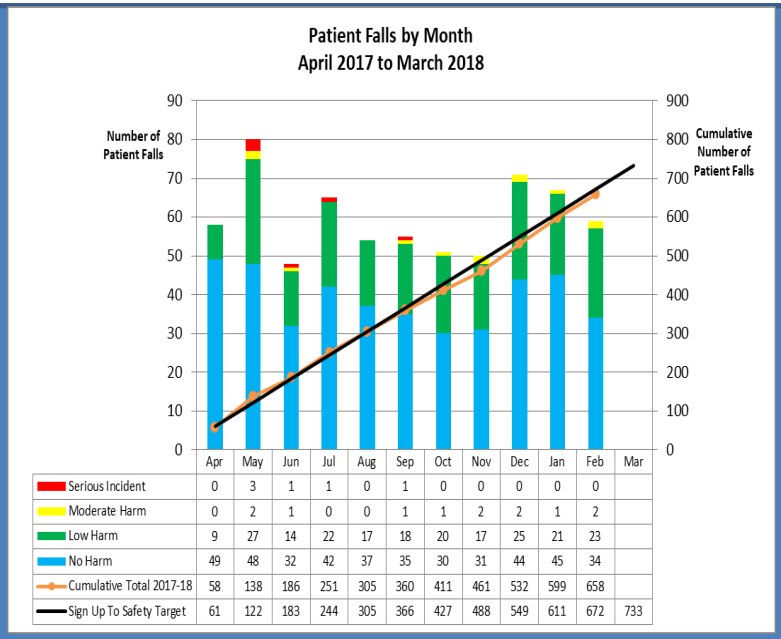
- As part of the Trustwide evaluation of pressure relieving mattresses, trials of new mattresses commenced in January 2018
- The SKIN bundle and repositioning chart were reviewed and updated in February 2018
- Photographing pressure ulcers prior to discharge has been implemented along with the photography on admission
- There is an ongoing education programme led by the Pressure Ulcer Prevention team

Board Papers – Quality, Safety & Experience Section: April 2018

Description	Aggregate Position	Trend	Performance against previous month

Patient Falls Incidents.

- For February 2018, there were a total of 59 patient falls
- 57.6% (34 falls) have resulted in no harm
- 39% (23 falls) have resulted in low harm
- 3.4% (2 fall) has resulted in moderate harm
- 0% (0 falls) have resulted in serious harm



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Serious Incident	0	3	1	1	0	1	0	0	0	0	0	
Moderate Harm	0	2	1	0	0	1	1	2	2	1	2	
Low Harm	9	27	14	22	17	18	20	17	25	21	23	
No Harm	49	48	32	42	37	35	30	31	44	45	34	
Cumulative Total 2017-18	58	138	186	251	305	360	411	461	532	599	658	
Sign Up To Safety Target	61	122	183	244	305	366	427	488	549	611	672	733

Improvement actions include:

- Bespoke training where an increase in falls has been identified
- Continued review of practice during senior nurse walkabout
- Focus work through the cares programme
- Development and approval of a post-falls chart

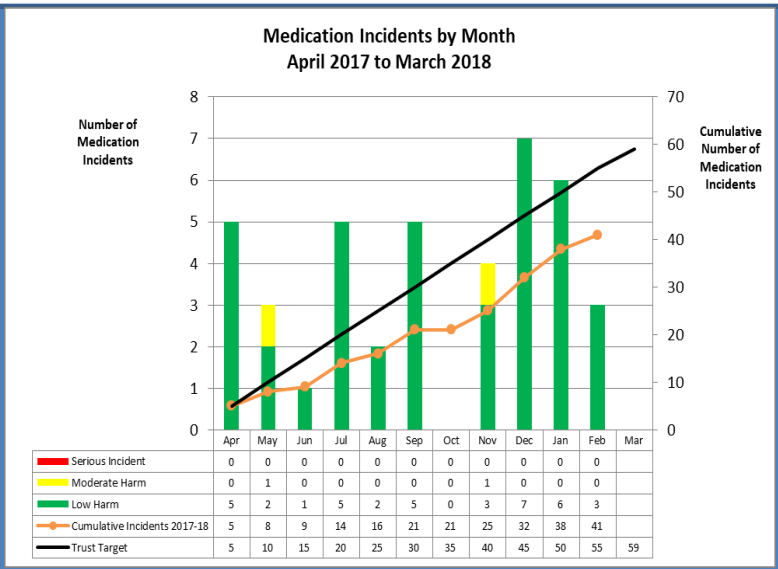
Board Papers – Quality, Safety & Experience Section: April 2018

Description	Aggregate Position	Trend	Performance against previous month

Medication Incidents.

For February 2018, there were a total of 3 medication incidents resulting in harm reported:

- 100% (3 medication incidents) have resulted in low harm
- 0% (0 medication incident) have resulted in moderate harm
- 0% (0 medication incidents) have resulted in serious harm

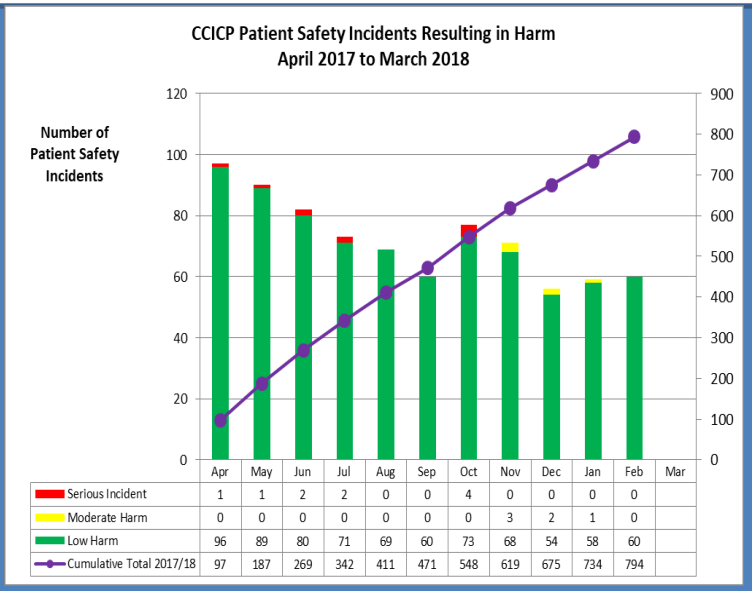
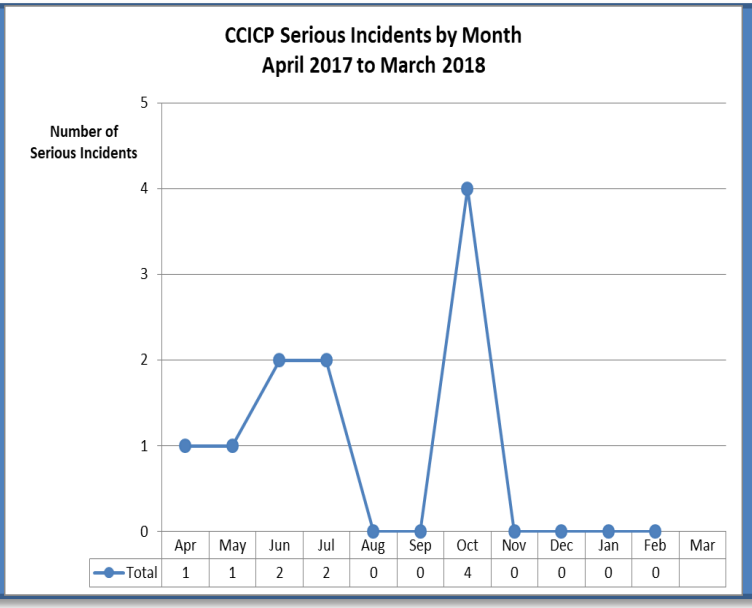


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Serious Incident	0	0	0	0	0	0	0	0	0	0	0	
Moderate Harm	0	1	0	0	0	0	0	1	0	0	0	
Low Harm	5	2	1	5	2	5	0	3	7	6	3	
Cumulative Incidents 2017-18	5	8	9	14	16	21	21	25	32	38	41	
Trust Target	5	10	15	20	25	30	35	40	45	50	55	59

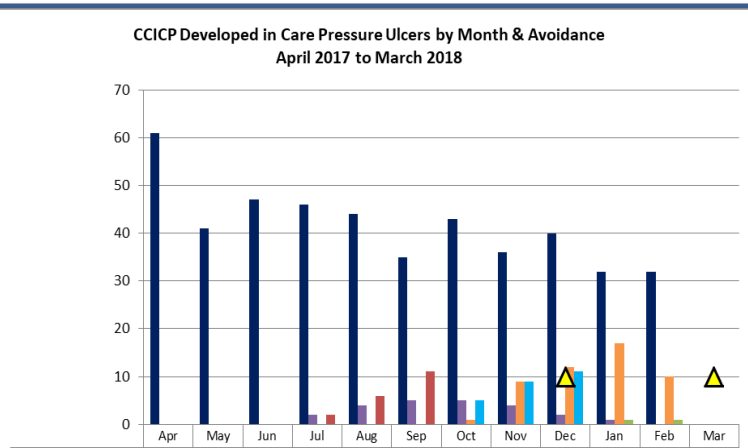
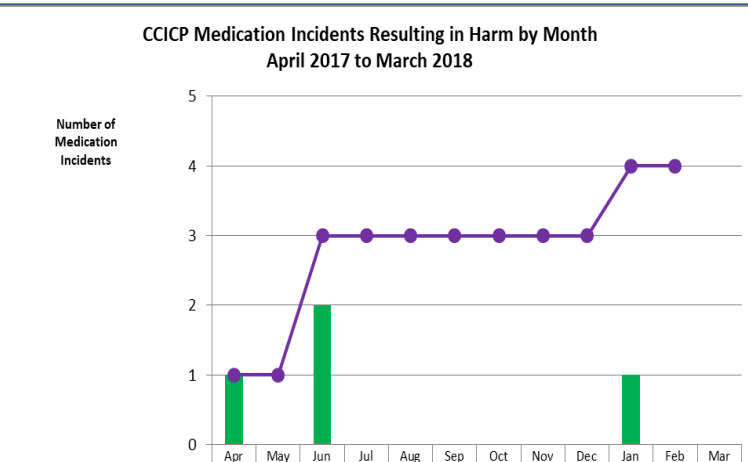
Improvement actions include:

- Junior medical staff training
- E-learning package in place
- Zero tolerance to prescription anomalies at ward level

Board Papers – Quality, Safety & Experience Section: April 2018

Description	Aggregate Position	Trend	Performance against previous month
CCICP Patient Safety Incidents resulting in harm.	For February 2018, there were a total of 60 patient safety incidents: • 100% (60 incidents) have resulted in low harm • 0% (0 incidents) have resulted in moderate harm • 0% (0 incidents) have resulted in serious harm		To reduce the number of patient safety harm incidents, a number of initiatives are being undertaken. These include: • Focused training and education to staff via team leader meetings • Development of a Quality role to support the Quality improvements in CCICP in March 2018
CCICP Serious Incidents.	For February 2018, no serious incidents were reported in CCICP.		To reduce the number of serious incidents a number of initiatives are being undertaken. These include: • Twice monthly Patient Safety Summit Meetings with Executive & Senior Teams • Twice monthly Patient Safety Matters newsletter that is delivered Trust wide

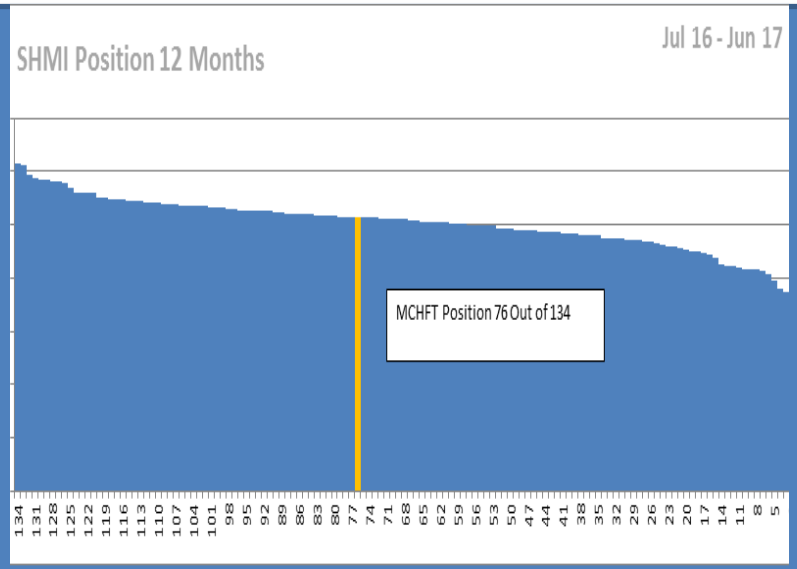
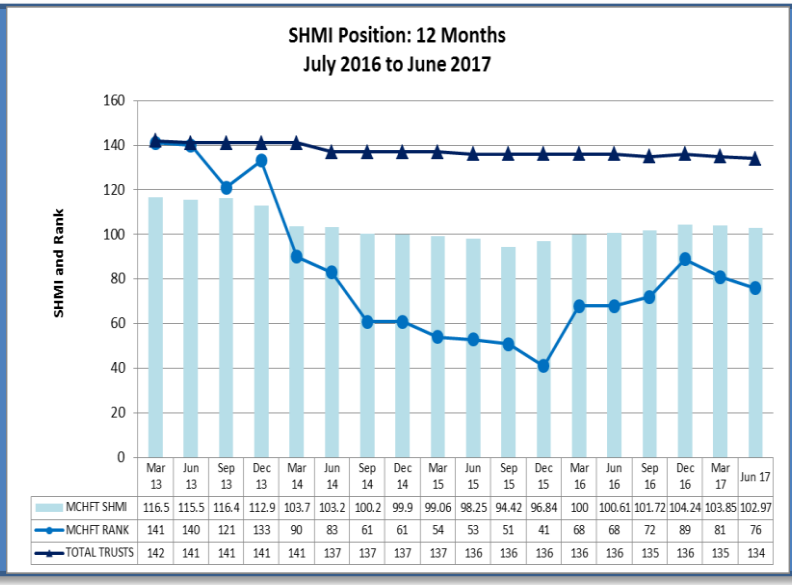
Board Papers – Quality, Safety & Experience Section: April 2018

Description	Aggregate Position	Trend	Performance against previous month
CCICP Pressure Ulcer (PU) Incidents by Avoidance	For February 2018, there were a total of 32 developed in care pressure ulcers: • 0% (0 PU's) resulted in avoidable harm. 10 of these incidents are currently unconfirmed.		• Membership at the Trust Skin Care Group has been expanded to include representatives from CCICP • Design of an audit tool to assess if pressure ulcer is avoidable or unavoidable • Identification of a cohort of patients with established chronic wounds
CCICP Medication Incidents.	For February 2018, no medication incidents resulted in harm.		Membership at the Trust Safer Medicines Practice Group has been expanded to include representatives from CCICP. This is to ensure that learning is shared across both Organisations

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Monthly	61	41	47	46	44	35	43	36	40	32	32	
Avoidable				2	4	5	5	4	2	1	0	
Unconfirmed				0	0	0	1	9	12	17	10	
Cumulative Avoidable				2	6	11	5	9	11	1	1	
5% ¼ Reduction Target									10			10

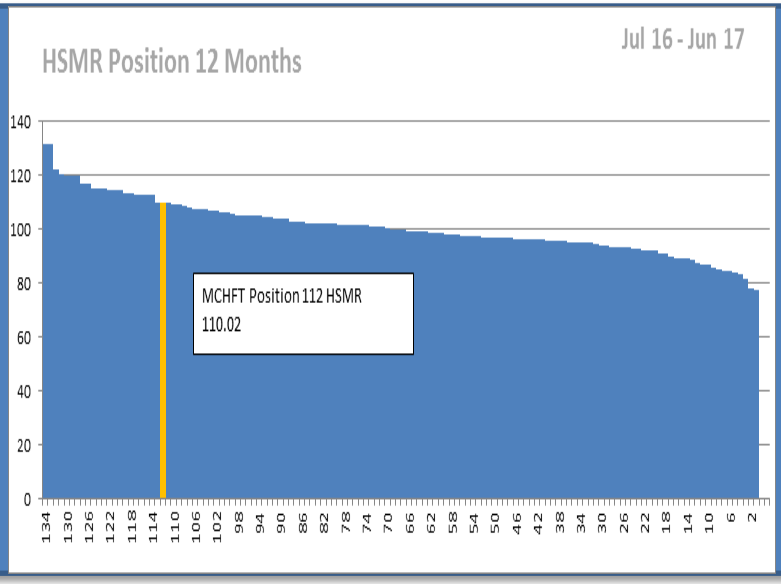
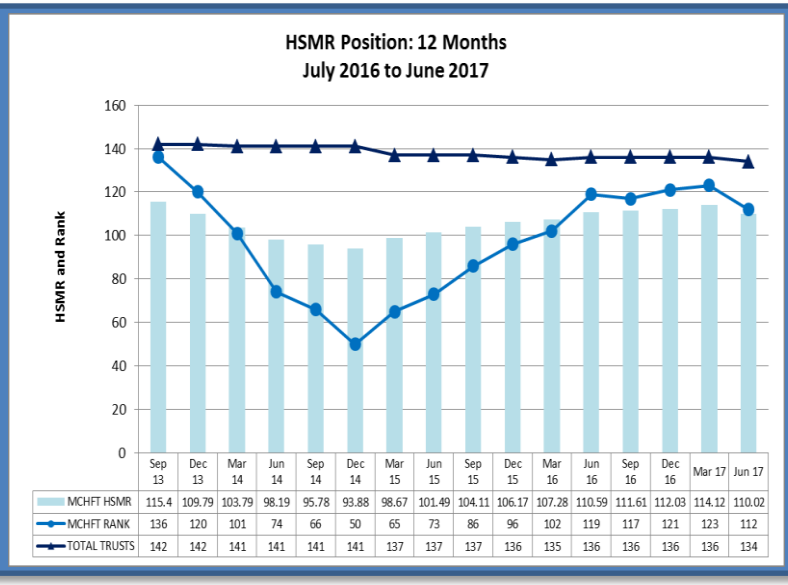
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Serious Incident	0	0	0	0	0	0	0	0	0	0	0	
Moderate Harm	0	0	0	0	0	0	0	0	0	0	0	
Low Harm	1	0	2	0	0	0	0	0	0	1	0	
Cumulative Incidents 2017-18	1	1	3	3	3	3	3	3	3	4	4	

Board Papers – Quality, Safety & Experience Section: April 2018

Description	Aggregate Position	Trend	Performance against previous quarter
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 102.97 for the time period July 2016 to June 2017 and places the Trust 76 out of 134 Trusts.		The Trust's aim is to have a SHMI at or below 1.0 from April 2016
MCHFT 12 Month Rolling Position Summary Hospital-Level Mortality Indicator (SHMI) by Trust.	The chart shows the SHMI and rank of MCHFT for each of the 12 month rolling position submissions for the period July 2016 to June 2017.		The Trust's aim is to have a SHMI at or below 1.0 from April 2016

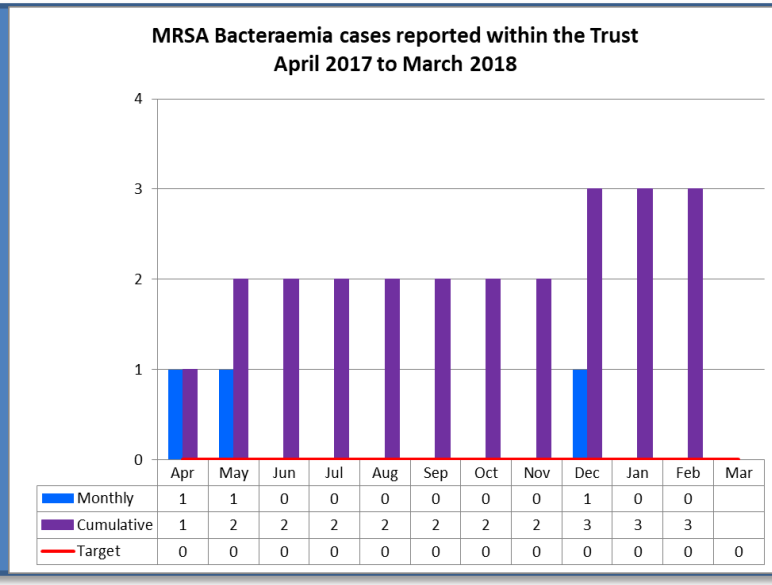
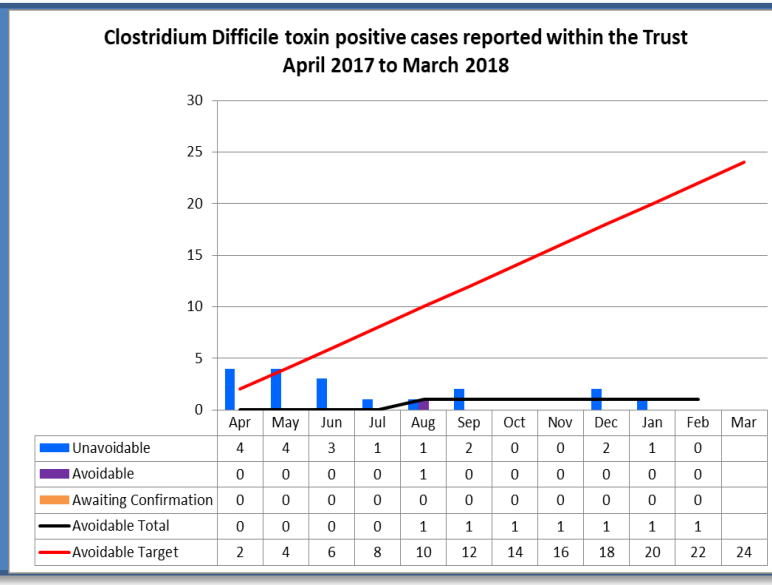
	Mar 13	Jun 13	Sep 13	Dec 13	Mar 14	Jun 14	Sep 14	Dec 14	Mar 15	Jun 15	Sep 15	Dec 15	Mar 16	Jun 16	Sep 16	Dec 16	Mar 17	Jun 17
MCHFT SHMI	116.5	115.5	116.4	112.9	103.7	103.2	100.2	99.9	99.06	98.25	94.42	96.84	100	100.61	101.72	104.24	103.85	102.97
MCHFT RANK	141	140	121	133	90	83	61	61	54	53	51	41	68	68	72	89	81	76
TOTAL TRUSTS	142	141	141	141	141	137	137	137	137	136	136	136	136	136	135	136	135	134

Board Papers – Quality, Safety & Experience Section: April 2018

Description	Aggregate Position	Trend	Performance against previous quarter
Hospital Standardised Mortality Rate (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 110.02 (July 2016 to June 2017) and places the Trust 112 out of 134 Trusts.		The Trust's aim is to have an HSMR <100
MCHFT 12 Month Rolling Position HSMR Position	The data in the chart shows the HSMR and rank of MCHFT for each of the 12 month rolling position submissions for the period July 2016 to June 2017.		The Trust's aim is to have an HSMR <100

	Sep 13	Dec 13	Mar 14	Jun 14	Sep 14	Dec 14	Mar 15	Jun 15	Sep 15	Dec 15	Mar 16	Jun 16	Sep 16	Dec 16	Mar 17	Jun 17
MCHFT HSMR	115.4	109.79	103.79	98.19	95.78	93.88	98.67	101.49	104.11	106.17	107.28	110.59	111.61	112.03	114.12	110.02
MCHFT RANK	136	120	101	74	66	50	65	73	86	96	102	119	117	121	123	112
TOTAL TRUSTS	142	142	141	141	141	141	137	137	137	136	135	136	136	136	136	134

Board Papers – Quality, Safety & Experience Section: April 2018

Description	Aggregate Position	Trend	Performance against previous month
MRSA Bacteraemia Cases.	In February 2018, no MRSA bacteraemia cases were reported in the Trust. In this financial year there has been three confirmed MRSA bacteraemia cases reported.		A recovery plan has been developed and is monitored through the Executive Infection Prevention Control Group
Clostridium Difficile toxin positive cases.	In February 2018, no avoidable cases were reported. The total avoidable cases year to date is 1.		Improvement actions include: • Bed side reviews are in place on the identification of infection • Consultant level engagement in C-difficile root cause analysis

Board Papers – Quality, Safety & Experience Section: April 2018

CQUIN Indicator	Indicator Name	Milestone Achieved								
		Q1	Financial Incentive Achieved	Q2	Financial Incentive Achieved	Q3	Financial Incentive Achieved	Q4	Financial Incentive Achieved	Maximum Value
1a	**Health & Wellbeing** 5% point improvement in two of the three questions on H&W, MSK & Stress.	✓	No Payment in Q1	✓	No Payment in Q2	✓	No Payment in Q3			£144,109
1b	**Health & Wellbeing** Maintain the four changes for improving healthy food for NHS staff, visitors and patients. Introduce three new changes to food and drink provision.	✓	No Payment in Q1	✓	No Payment in Q2	✓	No Payment in Q3			£144,109
1c	**Health & Wellbeing** Achieve an uptake of flu vaccinations of front line clinical staff of 70% by end of February 2018.	NOT REQUIRED	No Payment in Q1	NOT REQUIRED	No Payment in Q2	NOT REQUIRED	No Payment in Q3			£144,109
2a	**Sepsis: Identification** Greater than 90% of eligible patients to have a timely identification of sepsis by the end of quarter four 2017/18.	✓ Partially	£13,510	✓ Partially	£13,510	✓ Partially	£13,510			£108,082
2b	**Sepsis: Treatment** Greater than 90% of eligible patients to have a timely treatment of sepsis by the end of quarter four 2017/18.	✗	Payment not achieved	✓ Partially	£13,510	✓ Partially	£13,510			£108,082
2c	**Sepsis: Antibiotic Review** An empiric review for at least 90% cases in the sample should be performed by the end of quarter four 2017/18.	✓	£27,020	✓	£27,020	✓	£27,020			£108,082
2d Part 1	**Reduction in antibiotic consumption** Achieve a reduction of x% or more in total antibiotic consumption per 1,000 admissions.	NOT REQUIRED	No Payment in Q1	NOT REQUIRED	No Payment in Q2	NOT REQUIRED	No Payment in Q3			£36,027
2d Part 2	**Reduction in carbapenem consumption** Achieve a reduction of x% or more in total carbapenem consumption per 1,000 admissions.	✓	No Payment in Q1	✓	No Payment in Q2	NOT REQUIRED	No Payment in Q3			£36,027
2d Part 3	**Reduction in piperacillin tazabactam consumption** Achieve a reduction of x% or more in total piperacillin tazabactam consumption per 1,000 admissions.	✓	No Payment in Q1	✓	No Payment in Q2	NOT REQUIRED	No Payment in Q3			£36,027
4	**Mental Health in Emergency Department** Achieve a 20% reduction in attendances to the Emergency Department for people with Mental Health needs.	✓	£43,233	✓	£172,931	✓	£43,233			£432,328

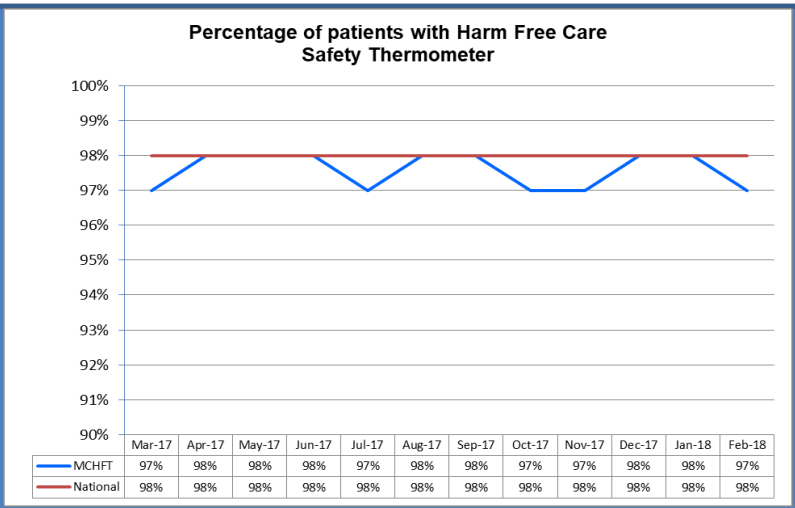
Board Papers – Quality, Safety & Experience Section: April 2018

CQUIN Indicator	Indicator Name	Milestone Achieved								
		Q1	Financial Incentive Achieved	Q2	Financial Incentive Achieved	Q3	Financial Incentive Achieved	Q4	Financial Incentive Achieved	Maximum Value
6	**Offering advice and guidance** Providers to set up and operate advice and guidance services for non-urgent GP referrals, allowing GPs to access consultant advice prior to referring patients into secondary care.	✓	£108,082	✓	£108,082	✓	£108,082			**£432,328**
7	**NHS e-Referrals** Availability of services and appointments for e-Referral service.	✓	£108,082	✓ Partially	£64,849	✓	£108,082			**£432,328**
8a	**Supporting proactive and safe discharge** Acute providers.	✓	£64,849	✓	£172,931	✓	£21,616			**£432,328**
8b	**Supporting Proactive and Safe Discharge –** Community Providers	NOT REQUIRED	No Payment in Q1	✓	£83,415	NOT REQUIRED	No Payment in Q3			**£139,025**
9	CQUIN 9 does not apply until year 2									
10	**Improving the assessment of wounds (Community Only)** The indicator aims to increase the number of wounds which have failed to heal after 4 weeks that receive a full wound assessment	NOT REQUIRED	No Payment in Q1	✓	£69,512	NOT REQUIRED	No Payment in Q3			**£139,025**
11	**Personalised Care and Support Planning (Community Only)** This CQUIN is to be delivered over two years with an aim of embedding personalised care and support planning for people with long -term conditions.	NOT REQUIRED	No Payment in Q1	✓	£34,756	✓	£20,854			**£139,025**
Public Health England CQUIN										
PH1	**Breast Screening Programme Clerical Staff Development (Health Promotion role)** Update and improve the clerical teams knowledge of health promotion to support clients who access The Breast Screening Unit and key partners involved in the Breast Screening Programme	✓	£3,401.50	✓	£3,401.50	✓	£3,401.50			**£13,606**

Board Papers – Quality, Safety & Experience Section: April 2018

CQUIN Indicator	Indicator Name	Milestone Achieved								
		Q1	Financial Incentive Achieved	Q2	Financial Incentive Achieved	Q3	Financial Incentive Achieved	Q4	Financial Incentive Achieved	Maximum Value
PH2	**Cancer Screening Programme – reducing professional stress and building resilience** Holistic mapping review of health & wellbeing services and support available to staff within the bowel and breast screening programmes for the management of professional stress and building resilience	✓	£5,837.25	✓	£5,837.25	✓	£5,837.25			**£23,349**
Specialist Commissioning										
SC1	**Nationally Standardised Dose Banding for Adult Intravenous Systemic Anticancer Therapy (SACT) 38** A tool kit has been developed to support CQUIN. Targets will be set for each of the SACT drugs.	✓	£3,828.30	✓	£3,828.30	✓	£22,969.80			**£38,283**
SC2	**Hospital Pharmacy Transformation and Medicines Optimisation**	✓		✓		✓				**£57,424**

Board Papers – Quality, Safety & Experience Section: April 2018

Description	Aggregate Position	Trend	Performance against previous month
Safety Thermometer - Harm Free Care.	In February 2018, 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.		The target is for >95% of patients to receive harm free care as monitored by the Safety Thermometer

	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
MCHFT	97%	98%	98%	98%	97%	98%	98%	97%	97%	98%	98%	97%
National	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%

Description	Aggregate Position	Trend	Performance against previous month
Registered Nurses monthly expected hours by shift versus actual monthly hours per shift. Day time shifts only	89.33% 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 **February 2018 89.33%** January 2018 90.7% December 2017 91.3%	The lowest staffing levels during the day were on Ward 9 at 54.6%
Registered Nurses monthly expected hours by shift versus actual monthly hours per shift. Night time shifts only	95.97% of expected Registered Nurse hours were achieved for night shifts.	Trend **February 2018 95.97%** January 2018 97.4% December 2017 95.1%	The lowest staffing levels during the night were on Ward 5 at 74.1%
Healthcare Assistant monthly expected hours by shift versus actual monthly hours per shift. Day time shifts only	97.14% of expected HCA hours were achieved for day shifts.	Trend **February 2018 97.14%** January 2018 102.7% December 2017 101.7%	The lowest staffing levels during the day were on Ward 9 at 33.3%
Healthcare Assistant monthly expected hours by shift versus actual monthly hours per shift. Night time shifts only	105.45% 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 **February 2018 105.45%** January 2018 112.6% December 2017 116.8%	The lowest staffing levels during the night were on Ward 9 at 46.4%

Board Papers – Quality, Safety & Experience Section: April 2018

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				
MCHFT		38501.1	34576.9	27603.5	26859.4	23398.2	22179.9	14704.8	16701.3	89.33%	97.14%	95.97%	105.45%	14048	135.7	65.8	201.7
AMU	GEN MEDICINE	1827.5	1711.3	1372	1268.3	1715	1519	1372	1335.3	93.6%	92.4%	88.6%	97.3%	805	4.0	3.2	7.2
CAU	PAEDIATRICS	2452	2452	1019	1019	1932	1932	540.5	540.5	100%	100%	100%	100%	466	9.4	3.3	12.8
Critical Care	GEN MEDICINE	3692	3692	690.5	690.5	2261	2261	0	0	100%	100%	100%	-	255	23.3	2.7	26.1
Elmhurst	REHABILITATION	799.5	799.5	2016	1968	700	700	1400	1400	100%	97.6%	100%	100%	821	1.8	4.1	5.9
Ward 1	GEN MEDICINE	1987.5	1893.8	1050	1018.8	1372	1359.8	686	686	95.3%	97%	99.1%	100%	862	3.8	2.0	5.8
Ward 12	GEN SURGERY	2027	1643	1792	1696	861	656	574	584.3	81.1%	94.6%	76.2%	101.8%	856	2.7	2.7	5.3
Ward 13	GEN SURGERY	2072	1600	1792	1680	861	656	574	635.5	77.2%	93.8%	76.2%	110.7%	866	2.6	2.7	5.3
Ward 14	GEN MEDICINE	1554	1266	1344	1506	672	672	1008	1128	81.5%	112.1%	100%	111.9%	853	2.3	3.1	5.4
Ward 2	GEN MEDICINE	1637.5	1606.3	1400	1318.8	686	820.8	1029	1151.5	98.1%	94.2%	119.7%	111.9%	871	2.8	2.8	5.6
Ward 21b	GEN MEDICINE	1219.5	972.5	1638	2171	700	700	700	1312.5	79.7%	132.5%	110%	187.5%	647	2.6	5.4	8.0
Ward 23	OBSTETRICS	1124	1092.3	709.3	671.3	690.7	703	690.7	690.7	97.2%	94.6%	101.8%	100%	555	3.2	2.5	5.7
Ward 26	OBSTETRICS	3007.3	3007.3	589	589	2590	2590	345.3	345.3	100%	100%	100%	100%	144	38.9	6.5	45.4
Ward 4	GEN MEDICINE	1554	1254	1680	1512	672	672	1344	1344	80.7%	90%	100%	100%	890	2.2	3.2	5.4
Ward 5	GEN MEDICINE	2100	1762.5	1400	1300	1372	1016.8	686	1016.8	83.9%	92.9%	74.1%	148.2%	884	3.1	2.6	5.8
Ward 6	GEN MEDICINE	1750	1593.8	1750	1962.5	1372	1176	686	1090.3	91.1%	112.1%	85.7%	158.9%	767	3.6	4.0	7.6
Ward 7	GEN MEDICINE	1590	1440	1400	1525	686	686	1029	1274	90.6%	108.9%	100%	123.8%	886	2.4	3.2	5.6
Ward 9	TRAUMA & ORTHOPAEDICS	1534	838	1344	448	574	481.8	287	133.3	54.6%	33.3%	83.9%	46.4%	209	6.3	2.8	9.1
NICU	PAEDIATRICS	1738.3	1637.3	165.7	147.9	1610	1449	0	0	94.2%	89.3%	90%	-	279	11.1	0.5	11.6
Ward 11 SAU	GEN SURGERY	1260	1305	840	937.5	524.5	571.4	262.3	505.8	103.6%	111.6%	108.9%	192.8%	459	4.1	3.1	7.2
Ward 18 SSW	GEN MEDICINE	1175	1106.3	700	693.8	686	686	343	441	94.2%	99.1%	100%	128.6%	617	2.9	1.8	4.7
Ward 10 Ortho	GEN SURGERY	2400	1904	2912	2736	861	871.3	1148	1086.5	79.3%	94%	101.2%	94.6%	1056	2.6	3.6	6.2

Board Papers – Quality, Safety & Experience Section: April 2018

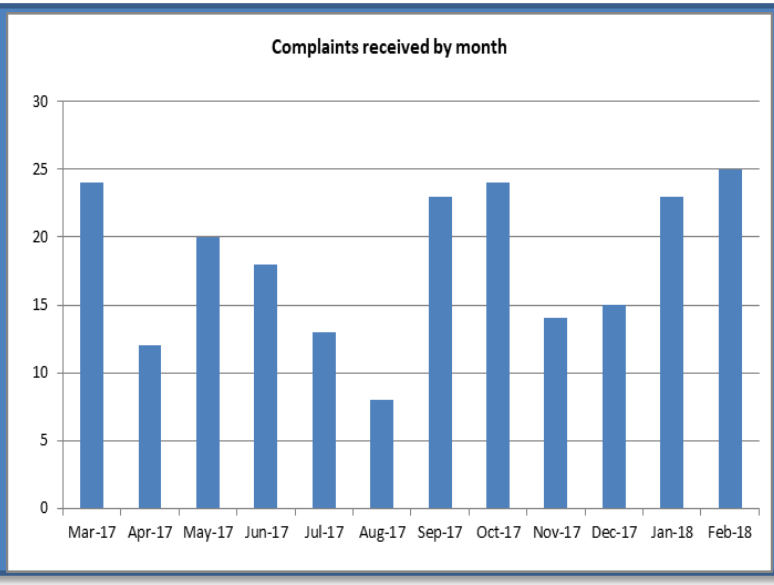
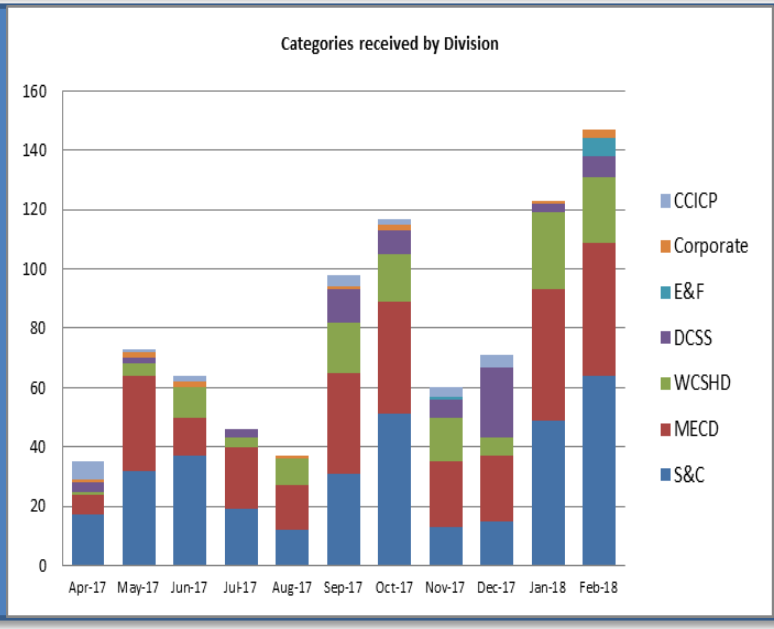
Ward Name	Main Specialties	Safety Thermometer Results			
		Acquired Pressure Ulcers	Patient Falls resulting in harm	CAUTI	New VTE
MCHFT		**1.05% (9)**	**0.82% (7)**	**0.23% (2)**	**0.82% (7)**
AMU	Gen. Medicine	0% (0)	12.5% (4)	0% (0)	0% (0)
CAU	Paediatrics	0% (0)	0% (0)	0% (0)	0% (0)
Critical Care	Gen. Medicine	0% (0)	0% (0)	0% (0)	0% (0)
Elmhurst	Rehab	0% (0)	0% (0)	0% (0)	0% (0)
Ward 1	Gen. Medicine	0% (0)	3.12% (1)	0% (0)	0% (0)
SAU	Gen. Surgery	0% (0)	0% (0)	0% (0)	0% (0)
Ward 10 SSW	Gen. Surgery & Urology	0% (0)	0% (0)	0% (0)	0% (0)
Ward 12	Gen. Surgery & Gynae	0% (0)	0% (0)	0% (0)	0% (0)
Ward 13	Gen. Surgery	0% (0)	0% (0)	0% (0)	0% (0)
Ward 14	Gen. Medicine	0% (0)	3.12% (1)	0% (0)	6.25% (2)
Ward 15	Trauma & Ortho	2.56% (1)	0% (0)	0% (0)	0% (0)
Ward 2	Gen. Medicine	6.45% (2)	0% (0)	3.23% (1)	9.68% (3)
Ward 21B	Rehab	4.35% (1)	0% (0)	0% (0)	0% (0)
Ward 23	Obstetrics	0% (0)	0% (0)	0% (0)	0% (0)
Ward 26	Obstetrics	0% (0)	0% (0)	0% (0)	0% (0)
Ward 4	Gen. Medicine	0% (0)	0% (0)	0% (0)	0% (0)
Ward 5	Gen. Medicine	0% (0)	0% (0)	0% (0)	0% (0)
Ward 6	Gen. Medicine	4.17% (1)	0% (0)	0% (0)	4.17% (1)
Ward 7	Gen. Medicine	3.12% (1)	0% (0)	3.12% (1)	3.12% (1)
Ward 9	Trauma & Ortho	0% (0)	0% (0)	0% (0)	0% (0)
NICU	Paediatrics	0% (0)	0% (0)	0% (0)	0% (0)
DN – Alsager	District Nursing	9.09% (2)	0% (0)	0% (0)	0% (0)
DN – Ashfields and Haslington	District Nursing	0% (0)	0% (0)	0% (0)	0% (0)
DN – Dane bridge	District Nursing	0% (0)	0% (0)	0% (0)	0% (0)
DN – Eagle bridge	District Nursing	0% (0)	0% (0)	0% (0)	0% (0)
DN – Firdale	District Nursing	1.92% (1)	0% (0)	0% (0)	0% (0)
DN – Grosvenor & Hungerford & Rope Green	District Nursing	0% (0)	0% (0)	0% (0)	0% (0)
DN – Middlewich	District Nursing	0% (0)	0% (0)	0% (0)	0% (0)
DN - Church View	District Nursing	0% (0)	0% (0)	0% (0)	0% (0)
DN – Winsford	District Nursing	2.44% (1)	0% (0)	0% (0)	0% (0)
Intermediate care	Intermediate Care	0% (0)	0% (0)	0% (0)	0% (0)

Experience Section:

Indicators	Last four months			
	Nov-17	Dec-17	Jan-18	Feb-18
Complaints received by month	14	15	23	25
Complaints being reviewed by the Ombudsman	1	1	1	2
Closed complaints by month	22	8	23	17
Contacts raising informal concerns	95	63	102	90
Compliments received in month	186	253	138	155
Number of new claims received in month	6	3	5	6
Number of claims closed	3	0	1	3
Number of inquests concluded	0	1	1	0
NHS Choices - Star Ratings (Leighton)	4.5	4.5	4.5	4.5
NHS Choices - Star Ratings (VIN)	5	5	5	5
NHS Choices - Number of new postings	9	12	15	18
F&FT Response Rate ED, MIU, UCC and Assessment Areas*	4%	3%	3%	22%
Proportion of positive responses ED, MIU, UCC and Assessment Areas	91%	91%	84%	81%
F&FT Response Rate Inpatients and Daycases	22%	16%	14%	23%
Proportion of positive responses Inpatients and Daycases	98%	99%	97%	98%
F&FT Response Rate Outpatients	7%	4%	5%	4%
Proportion of positive responses Outpatients	96%	95%	97%	96%
F&FT Response Rate Maternity - Birth	14%	11%	16%	5%
Proportion of positive responses Maternity - Birth	97%	100%	100%	90%
F&FT Response Rate Community (CCICP)	16%	7%	23%	17%
Proportion of positive responses Community (CCICP)	88%	95%	92%	91%

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

Board Papers – Quality, Safety & Experience Section: April 2018

Description	Aggregate Position/Description	Trend
Monthly Trust complaints received by the Trust	25 complaints were received in February 2018 which covered 145 concerns. Of the categories, the highest categories were: • Communication - With patients face to face • Nursing - Medication Delay • Medical - Adverse Outcome • Attitude of Staff - Nursing Highest 3 areas receiving complaints/issues were: • Ward 18, received 2 complaints / 15 issues • Ward 2, received 2 complaints / 14 issues • Ward 23, received 3 complaints / 12 issues	 Formal Complaints
Number of formal complaints by Division	This graph shows the breakdown of issues by month for each division. S&C: 64 DCSS: 7 W&CD: 22 DMEC: 45 CCICP: 0 E&F: 6 Corporate Services: 3	 Formal Complaints by Division

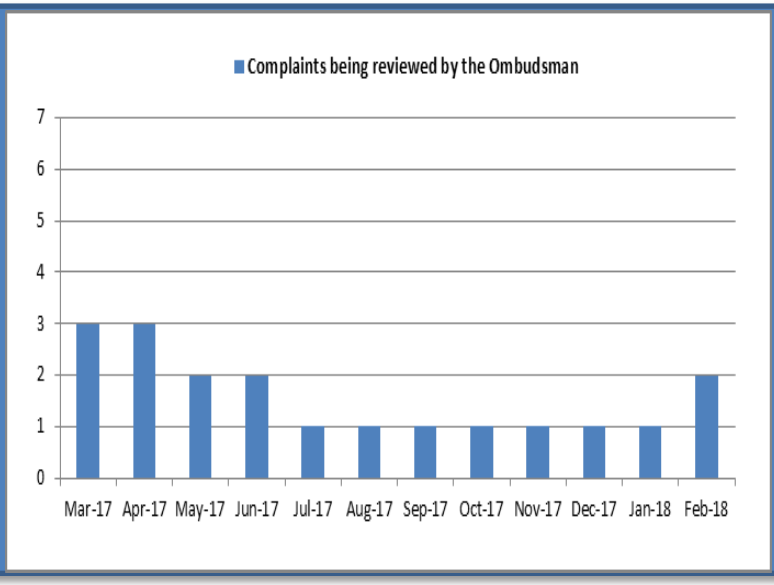
Board Papers – Quality, Safety & Experience Section: April 2018

Description	Aggregate Position/Description	Trend

Complaints being reviewed by the Public Health Service Ombudsman (PHSO)

In February 2018, 2 complaints were active with the PHSO.

- 1 has been active for a long period of time and is undergoing a review external to the PHSO
- 1 new case agreed for investigation in February. All information has been shared with the PHSO. The concern was with regard to care leading up to the patient's death



Ombudsman

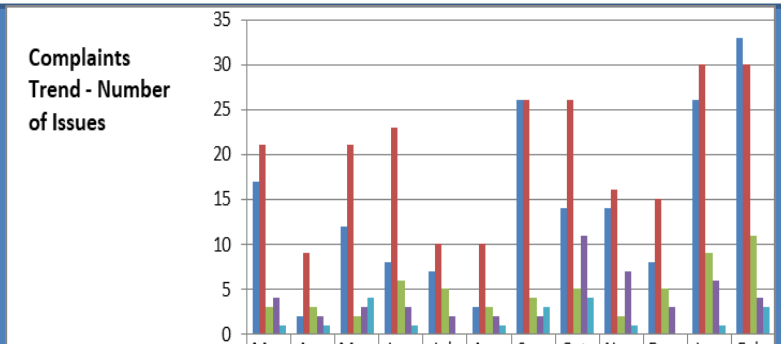
Complaint Trends and number of issues

The main trends in February 2018 were:

Nursing Care with 12 complaints raising 33 issues

Communication with 16 complaints raising 30 issues

Medical Adverse Outcome with 11 complaints raising 11 issues



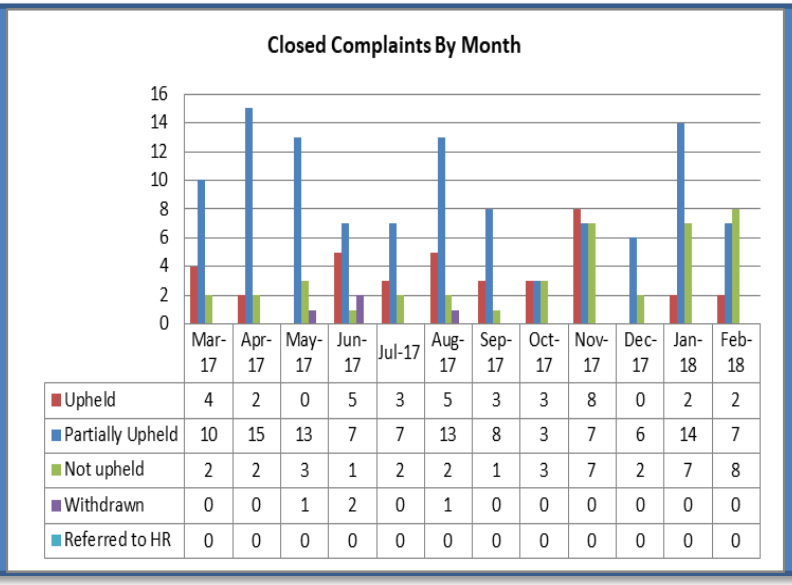
	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
Nursing Care	17	2	12	8	7	3	26	14	14	8	26	33
Communication	21	9	21	23	10	10	26	26	16	15	30	30
Medical adverse outcome	3	3	2	6	5	3	4	5	2	5	9	11
Medical diagnosis issues	4	2	3	3	2	2	2	11	7	3	6	4
Medical delay in review	1	1	4	1	0	1	3	4	1	0	1	3

Complaint Trends

Description	Aggregate Position/Description	Trend

Closed Complaints

17 complaints were closed in February 2018.



	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
Upheld	4	2	0	5	3	5	3	3	8	0	2	2
Partially Upheld	10	15	13	7	7	13	8	3	7	6	14	7
Not upheld	2	2	3	1	2	2	1	3	7	2	7	8
Withdrawn	0	0	1	2	0	1	0	0	0	0	0	0
Referred to HR	0	0	0	0	0	0	0	0	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	1	3	1	0	0	5
Surgery and Cancer	0	3	2	0	0	5
Diagnostics & Clinical Support Services	1	1	2	0	0	4
Women's and Children's	0	0	1	0	0	1
Corporate Services	0	0	1	0	0	1
CCICP	0	0	1	0	0	1
		Total closed				**17**

Complaints closed by Division

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

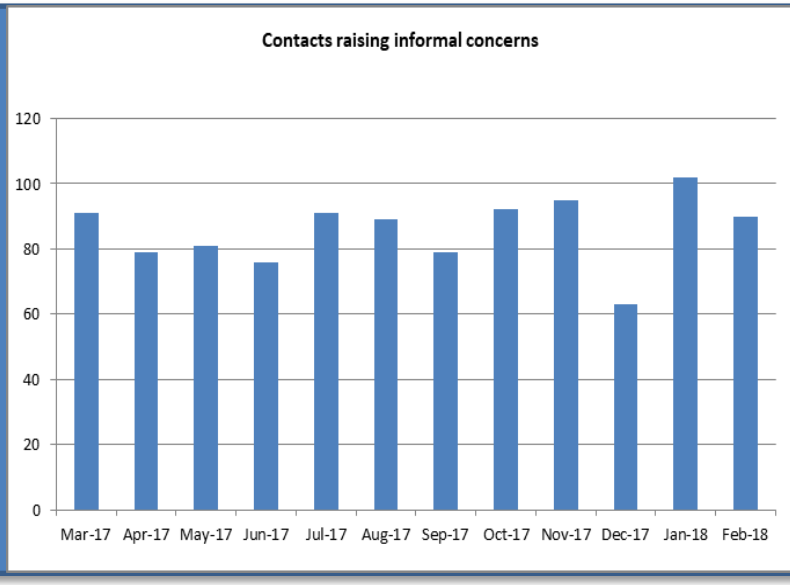
Board Papers – Quality, Safety & Experience Section: April 2018

Description	Aggregate Position/Description	Trend

Informal Concerns Numbers

The number of contacts raising informal concerns for February 2018 was 90 which is 12 less than the previous month.

The Division of Surgery and Cancer has received the largest number of individual concerns raised at 40, with 12 of the individual concerns raised belonging to Ophthalmology.

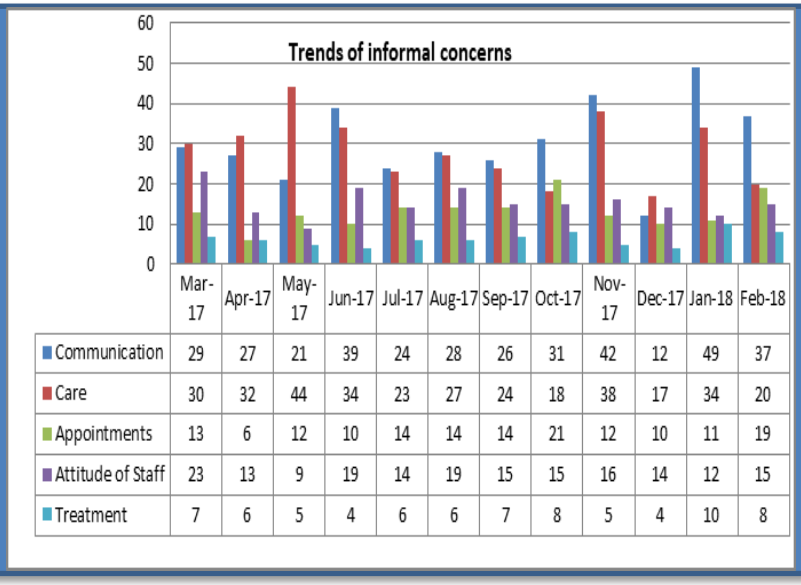


Informal Concerns Feedback

Informal Concerns Trends

Communication was the highest trend for informal concerns in February 2018, with 13 of the 37 issues raised belonging to the Division of Surgery and Cancer. 4 of the 13 issues belong to the Eye Care Centre.

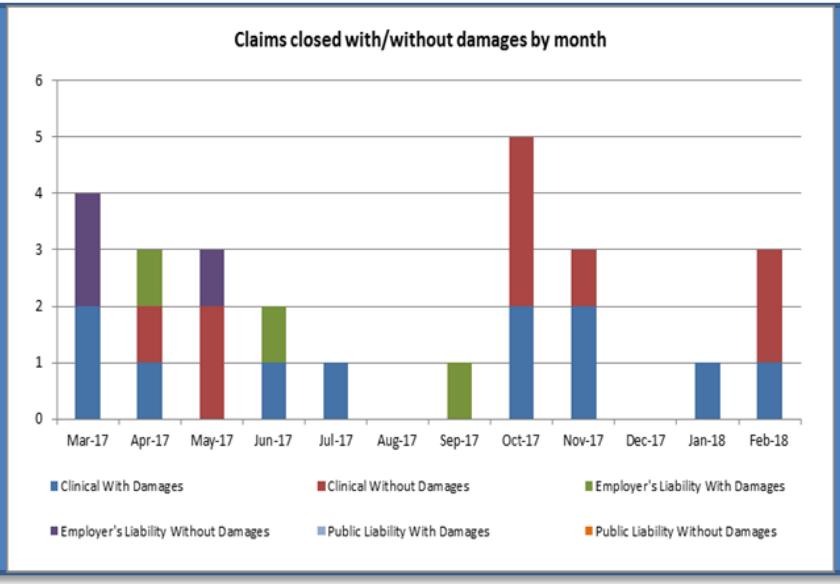
Of the 20 issues raised regarding care, 8 belong to the Division of Medicine and Emergency Care with 7 of the 8 issues relating to the Emergency Department.



	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
Communication	29	27	21	39	24	28	26	31	42	12	49	37
Care	30	32	44	34	23	27	24	18	38	17	34	20
Appointments	13	6	12	10	14	14	14	21	12	10	11	19
Attitude of Staff	23	13	9	19	14	19	15	15	16	14	12	15
Treatment	7	6	5	4	6	6	7	8	5	4	10	8

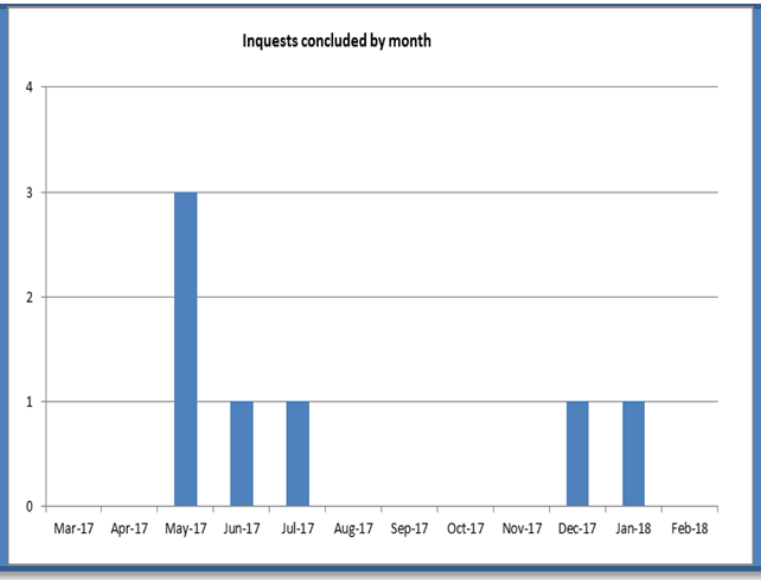
Informal Concerns Trends

Description	Aggregate Position/Description	Trend
New claims received.	Table and narrative removed under Section 40 of the Freedom of Information Act.	Claims
Claims closed with/without damages.	Table and narrative removed under Section 40 of the Freedom of Information Act.	Closed Claims

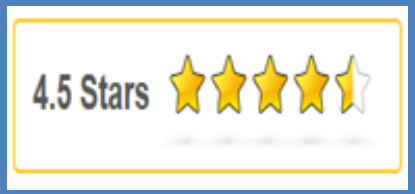
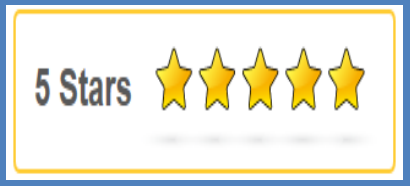


Description	Aggregate Position/Description	Trend
Value of claims closed by month	Table and narrative removed under Section 40 of the Freedom of Information Act.	Value of Claims
Top five claims by Specialty	Table and narrative removed under Section 40 of the Freedom of Information Act.	Top 5 Claims by Specialty

Board Papers – Quality, Safety & Experience Section: April 2018

Description	Aggregate Position/Description	Trend
Number of Inquests concluded by month	No inquests were concluded in February 2018	

Inquests

NHS Choices Star Ratings	The ratings are based on 240 postings received to date. Leighton Hospital is rated at 4.5 stars. Victoria Infirmary, Northwich is rated at 5 stars.	 

NHS Choices – Star Ratings

Board Papers – Quality, Safety & Experience Section: April 2018

Description	Aggregate Position /description	Trend

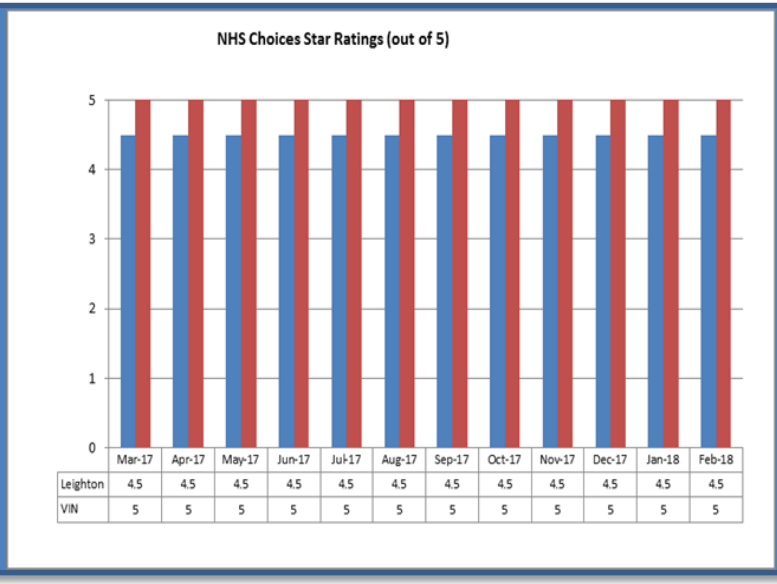
NHS Choices postings

Of the postings on NHS Choices in February 2018 1 was negative and 17 were positive. Examples of feedback included:

"My 23year old son had a nasty viral infection which caused his heart rate and blood pressure to fluctuate quite badly. The care and attention we received was absolutely amazing. All staff involved were really caring and professional. The best treatment he could have wished for. Considering the department was so hectic, they all deserve a medal" (A&E)

"All staff we dealt with were polite, helpful and informative. We felt our little girl was looked after thoroughly and we were involved at all stages. We ended up having to stay over and the nurses were able to find us food at 1:30 am after having not eaten for most of the day" (A&E and CAU)

"I felt like a pain and there was no concern or compassion at all the staff need to realise people are frightened and scared, and for the staff to crack a smile or be a little more friendly would go a long way, when get taken for assessment there was not one word it's almost like your next in line, be aware staff people are scared and anxious!!!" (A&E)



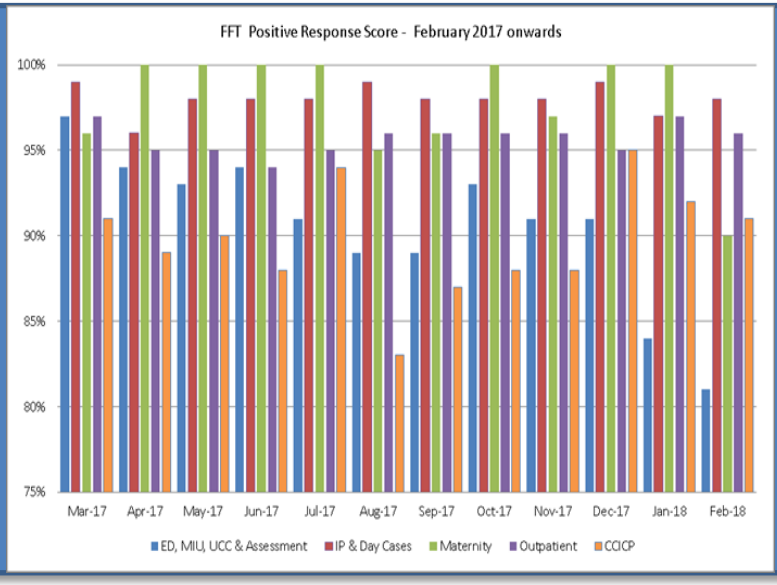
NHS Choices - Postings

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 February 2018 the Trust has scored the following positive response scores:

Inpatients and day cases	98%
Emergency care /Assessment areas	81%
Outpatients	96%
Maternity	90%
CCICP	91%

3283 responses were received, an increase of nearly 1,000 with the introduction of text messaging in A & E and Assessment areas and 91% of those patients would recommend our hospital services.



Family & Friends Test

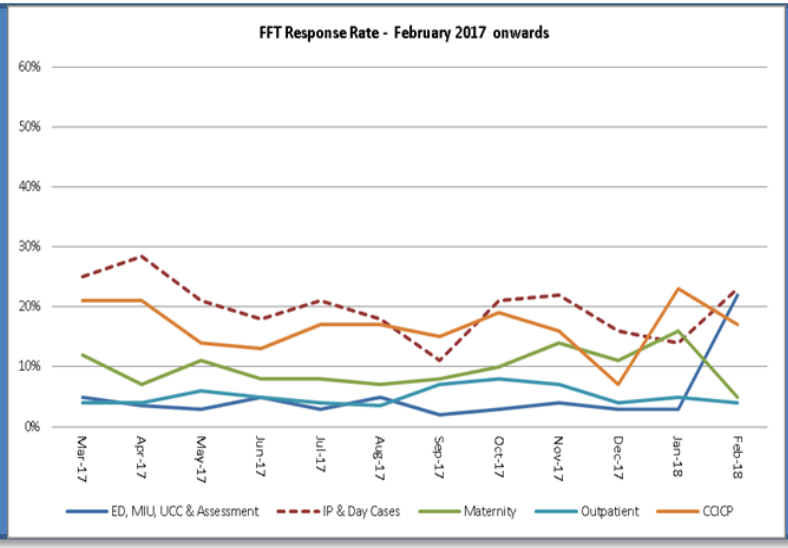
Board Papers – Quality, Safety & Experience Section: April 2018

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

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

January 2018 / Ward/Dept	% Response	Total Responses received	How many would recommend
A&E , UCC & MIU	22%	1205	982
Inpatients & Daycases	23%	829	815
Maternity	5%	10	9
Outpatients	4%	747	717
CCICP	17%	381	348

Text messaging commenced in A & E and for Day Cases in February 2018.



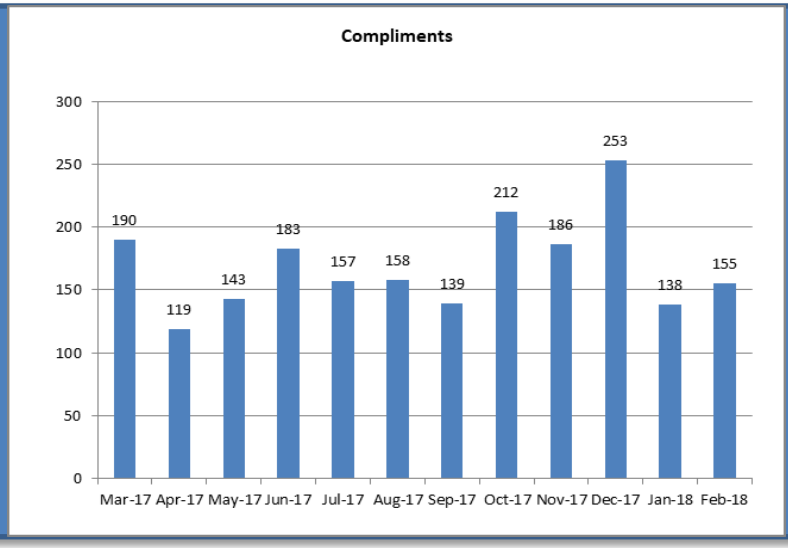
Family & Friends Test

Compliments received

There were 155 compliments/thank-you's received for February.

"I want to say how impressed I was with the service and care I received following the birth of my son. Each member of staff was so kind and caring and nothing was too much trouble. I cannot fault the care and compassion we received while we were there".

"My husband went to A&E in January, everyone was efficient and friendly and he received excellent treatment in resolving the problem. A big thank you to everyone. First class".



Compliments

Mid Cheshire Hospitals
NHS Foundation Trust

Title of Paper :	Guardian of Safe Working Hours Report (Q3)	
Author:	Derek Pegg, Guardian of Safe Working Hours	
Executive Lead:	Estelle Carmichael, Director of Workforce and OD	
Type of Report:	Concept Paper	
	Strategic Options Paper	
	Business Case	
	Information	✓
	Review/Benefits/Audit	

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

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

Positive Benefit:	Assurance that our Junior Doctors are working in accordance with the agreed Contract
Risk:	Common themes associated with exception reports

To be published on Trust Website –complete version	***Yes***
If no, to be published on Trust Website – redacted	***n/a***
If not to be published complete or redacted, please detail the reason why	**n/a**
Presented at Board Meeting of:	**3 April 2018**

Mid Cheshire Hospitals
NHS Foundation Trust

REPORT FROM THE

GUARDIAN OF SAFE WORKING HOURS

1st October 2017 – 31st December 2017

1. INTRODUCTION

To report progress with the 2016 junior doctors contract and the work of the Guardian of Safe Working Hours (GoSWH) to the Board.

The GoSWH is required to provide to the Board, a quarterly report which will include details of the including exceptions, fines and rota gaps.

2. CURRENT POSITION

Since the new Junior Doctor's Contract went live in October 2016, the Trust has assimilated Doctors in Training on to the Contract in accordance with the schedules set out in the final contract agreement. This means that we currently employ doctors in training on both the old and the new contract.

During the December rotation, the most significant change in terms of number of doctors in training leaving and joining the Trust, the following rotas were not fully staffed:

ROTA NAME	WTE OF DOCTORS REQUIRED FOR THE ROTA	WTE DOCTORS IN POST ON THE ROTA	WTE VACANCIES	ACTION TAKEN/ TO BE TAKEN TO FILL THE ROTA
STH Emergency Medicine	6.0	5.0	1.0	None taken
STL Emergency Medicine	8.0	7.0	1.0	Rota reduced from 1:9 to 1:8
FY1 General Surgery	6.0	5.0	1.0	Shifts covered by agency locum as LAS recruitment not successful
STL T&O/ENT	9.0	7.6	1.4	LAS Recruitment Query only LE slots
STL Surgery/Urology	7.0	7.0	0	Rota reduced from 1:9 to 1:7
STH Obs & Gynae	7.0	5.6	1.4	0.4 wte vacancy is a trust funded post. 1.0 wte vacancy covered by Consultant
STL Obs & Gynae	6.0	4.2	1.8	2.0 slots filled. 1.0 wte Nurse Practitioner & 1.0 wte filled by MTI candidate
STH Histopathology	2.0	0.0	2.0	LAS recruitment

The above table provides a summary of the action being taken to ensure that gaps in rotas are filled in an efficient and productive manner, whilst also ensuring the safety of our patients.

3. EXCEPTION REPORTING

The GoSWH is required to provide a Board report on a quarterly basis summarising exception reports being completed and ensuring that the Trust take appropriate action to address any significant issues identified in these report. The Board has been presented with three previous GoSWH reports covering the period 7th December 2016 to 31st March 2017; 1st April to 30th June 2017 and 1st July to 30th September 2017.

Exception reporting is the method for reviewing Junior Doctors working hours to ensure appropriate breaks and that they are able to start and finish on time. This mechanism also enables junior doctors to report any unsafe working practices.

During the period 1st October – 31st December 2017 a total of 9exception reports were received from trainee Doctors and the following table is a summary of those exceptions:

SPECIALTY	ROTA	NO. EXCEPTION REPORTS	EXCEPTION TYPE
General Medicine	FY1	1	Late Finish
General Medicine	Flexi	2	Hours and Rest
Medicine	FY2	1	Hours and Rest
ENT	ST Combined	1	Hours and Rest
Urology	STL Surgery/Urology	4	Hours and Rest

Each of the exception reports is reviewed by the doctor's educational supervisor and the following is a summary of the responses: Exceptions highlighted are still currently open and have not been responded to by the educational supervisor for the doctor therefore this is marked TBC.

REFERENCE	SUMMARY OF EXCEPTION	HOURS TO BE PAID	PAY COST (X1.5)	FINE COST (X2.5)
01 – 31 OCTOBER 2017				
21169	Late Finish	1 hour TOIL[1]		
21254	Late Finish	1		
22563	Late Finish & Unable to take Breaks	TBC		
01 – 30 NOVEMBER 2017				
26192	Late Finish (night shift)	1.5		22.16

[1] TOIL – Time off in Lieu

01 – 31 DECEMBER 2017				
28590	Change to work pattern (Acting down)	TBC		
28153	Unable to take breaks	TBC		
29752	Breaks	TBC		
29747	Breaks	TBC		
29749	Breaks and Late Finish	TBC		
Total Cost to the Trust for the Reporting Period				£22.16

	Fine Costs
Running Total Fines to Date	£450.65

The fines are held by the GoSWH and will be used to improve the working lives of Doctors in Training. The Trust is not permitted to access the fines for any other reason.

4. CONCLUSION

This is now the fourth report by the GoSWH and it is concluded that the Trust continues to take appropriate steps to implement the new national contract for the relevant junior doctors.

The Trust has seen a reduction in the number of exception reports since the last period 1st July 2017 to 30th September 2017 ,however the reason for the current exception reports is due to:-

a. A significant increase in the number of Doctors in Training who have assimilated to or been employed on the new 2016 Junior Doctor Contract and
b. The level of gaps on a number of rotas.
c. Winter pressures.

The action being taken to address the gaps on our rotas are set out in the table in section 2.

Derek Pegg
20 February 2018

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Board of Directors Performance Report

February 2018

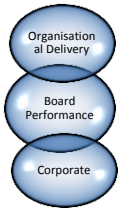
"To Deliver Excellence in Healthcare through Innovation & Collaboration"

Introduction

Performance Report

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

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



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

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

Tracy Bullock
Chief Executive

Contents

Headline Measures

Organisational Delivery				
Indicator	**Standard**	**YTD**	**Feb-18**	
Cancer				
Rapid Access Referrals (%) *(seen in 2 wks)*	93.00%	96.67%	93.05%	
Total Patients Seen		*8,104*	*806*	
Patients seen >14 days		*270*	*56*	
62 day GP Classic (%)	85.00%	93.63%	91.38%	*
Accountable Patients Treated		*651*	*58*	
No. of Breached Pathways (adjusted)		*42*	*5*	
62 day Screening (%)	90.00%	96.77%	100.00%	*
Accountable Patients Treated		*124*	*12*	
No. of Breached Pathways (adjusted)		*4*	*0*	
Unplanned Activity				
A&E <4hrs Standard (%)	95.00%	87.99%	77.92%	
A&E Attendances (LH/MIU/UUC) (% to plan)		96.57%	94.38%	
A&E Attendances LH & MIU (Vol)		*80,151*	*6,650*	
Planned Activity				
Incomp Pathways <18wk (%)	92.00%	96.26%	94.17%	
>6wk Diagnostic Waits (%)	1.00%	0.31%	0.08%	
Total Patients Waiting for a First Outpatient Appointment			8,501	

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

Indicator	Standard	YTD
Workforce		
Sickness absence Rolling 12 Month		4.28%
Turnover Rolling 12 Month		10.66%

Corporate					
	YTD Rating		YE Rating	YE Metric	
Indicator	**Plan**	**Actual**	**Forecast**	**Plan**	**Forecast**
Finance					
Use of Resource Rating		3	3		
Capital Service Capacity	4	4	4	0.76	0.67
Liquidity	4	2	2	-23	-3
I&E Margin	2	2	2	0.38%	0.98%
Distance from Financial Plan	0	1	1	0.00%	0.60%
Agency Spend	1	1	1	-10.22%	-29.26%

	YTD Target	YTD Actual	YTD Variance	FY Target	FY Forecast	FY Variance
Cost Improvement Schemes Total (£000's)	4,548	3,884	-681	4,922	4,144	-778
Capped Expenditure Process Schemes (£'000)	4,818	4,311	-507	7,062	6,652	-410
Commission Contact Income SC & VR (£000's)	171,211	171,211	0			
Contract Income (£'000)	203,086	204,316	1,230			
Pay to Budget (£000's)	-151,503	-152,463	-960			
Non Pay to Budget (£000's)	-63,366	-64,284	-918			
Agency Trajectory (£000's)	-5,142	-3,898	1,244			

Exec Summary

In February 2018, the Trust delivered four of the five NHS Improvement Single Oversight Framework performance indicators. The indicator not achieved was The 4 hour A&E waiting time target.

The 4-hour A&E standard in February achieved 77.92% against the 95% performance standard. This is a deterioration in performance compared to the same month in 2017 (93.33%).

The Trust has achieved all three headline cancer access standards for February. Rapid access referrals and 62 day treatment pathways have continuously achieved above target for over 12 months. Cancer 62 day Screening achieved 100% with no breach recorded in February.

The Trust continues to achieve the 92% standard for RTT 18 week incomplete pathways, with performance in February 2018 at 94.17%. The Trust is continuing to monitor this standard, with specific reference to managing the level of 'over performance' being delivered against 92%.

Diagnostics waiting times continue to perform well, with just 0.08% of patients waiting longer than 6 weeks for their diagnostic test against a regulatory threshold of 1%.

The UoRR metric is 3, primarily a consequence of the override resulting from the impact of the Trust's ability to service DH loans from revenues and depreciation. The forecast position is to over-achieve the control total of £5.3M deficit and deliver a £3.9M deficit target prior to STF, this being the result of IT and Community services non-recurrent savings and in addition the £0.6M Tranche 1 winter funding.

The Trust's I&E position is a surplus of £2.0M which is in line with plan as at Month 11.

The SC & VR commissioning contracts represent the revised contract value in line with the agreed Capped Expenditure Process (CEP).

CIP schemes are behind plan by £0.7M due to the no longer proceeding e-rostering scheme and infusion pump consumable savings not materialising. Income generation schemes have been removed in light of the CEP leading to fixed income for the Trust. In addition, CEP schemes are £0.5M worse than plan due to scheme slippage However, to date combined savings of £8.2M have been achieved.

The Trust is currently £1.2M better than its Agency spend trajectory which for the full year is £6.2M.

Single Oversight Framework

Triggers

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

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

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 capital serive capacity metric which will improve when short term loans required to support liquidity are repaid. The Trust is meeting plan for its I&E margin ytd and is expected to exceed its control total plan by year end. The Agency trajectory target is currently better than plan.

Operational Performance

	Current YTD		Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Monthly Trend
	Target	Actual														
Maximum 6 week wait for Diagnostic procedures	1%	0.31%	0.07%	0.09%	0.04%	0.17%	0.44%	0.76%	0.34%	0.21%	0.24%	0.25%	0.39%	0.53%	0.08%	
All Cancers: 62 day GP Classic (%) *	85%	93.63%	86.41%	96.46%	96.83%	92.81%	94.00%	93.04%	95.08%	91.67%	95.74%	94.50%	96.77%	87.30%	91.38%	
All Cancers: 62 day Screening (%) *	90%	96.77%	100.00%	100.00%	100.00%	100.00%	100.00%	85.71%	100.00%	91.67%	83.33%	94.12%	100.00%	100.00%	100.00%	
18 weeks from point of referral to treatment - patients on an incomplete pathway (%)	92%	96.26%	96.07%	96.48%	96.69%	96.98%	97.57%	97.37%	96.78%	97.10%	96.79%	96.36%	95.15%	94.46%	94.17%	
A&E - maximum waiting time of 4 hours from arrival to admission/transfer/discharge (%)	95%	87.99%	93.33%	97.21%	93.37%	90.66%	94.24%	92.63%	95.26%	93.99%	88.28%	88.05%	74.22%	78.38%	77.92%	
A&E STF Trajectory			0.00%	0.00%	91.72%	91.72%	91.72%	91.34%	91.34%	91.34%	90.52%	90.52%	90.52%	90.52%	90.52%	

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

Financial & Resource

		Unit	YE Plan	YE Forecast	YE Rating	YTD Plan	YTD Actual	YTD Rating
Financial Sustainability	Capital Service Capacity	0.0x	0.76	0.67	4	0.68	0.62	4
	Liquidity	days	-23	-3	2	-20	-5	2
Financial Efficiency	I&E Margin	%	0.38%	0.98%	2	0.15%	0.89%	2
Financial Controls	Distance from Financial Plan	%	0.00%	0.60%	1	0.00%	0.74%	1
	Agency Spend	%	-10.22%	-29.26%	1	-9.79%	-31.56%	1
Overall UOR Rating					3			3

Operational Delivery: *Cancer Pathway*

Headline Measures

	Current YTD		Rolling 13 months											
	Target	Actual	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Monthly Trend
Rapid Access Referrals (%) (seen in 2 wks)	93%	96.67%	99.15%	98.10%	97.14%	97.84%	97.20%	97.51%	97.35%	96.82%	97.60%	98.23%	95.85%	94.83%	93.05%	
Total Patients Seen		*8104*	*706*	*842*	*665*	*742*	*785*	*763*	*793*	*723*	*750*	*736*	*626*	*715*	*806*	
Patients seen >14 days		*270*	*6*	*16*	*19*	*16*	*22*	*19*	*21*	*23*	*18*	*13*	*26*	*37*	*56*	
% seen within 7 days		*52.6%*	*54.3%*	*63.1%*	*55.6%*	*53.5%*	*48.7%*	*44.2%*	*46.2%*	*64.7%*	*54.8%*	*51.4%*	*52.9%*	*54.6%*	*53.1%*	
62 day GP Classic (%) *	85%	93.63%	86.41%	96.46%	96.83%	92.81%	94.00%	93.04%	95.08%	91.67%	95.74%	94.50%	96.77%	87.30%	91.38%	

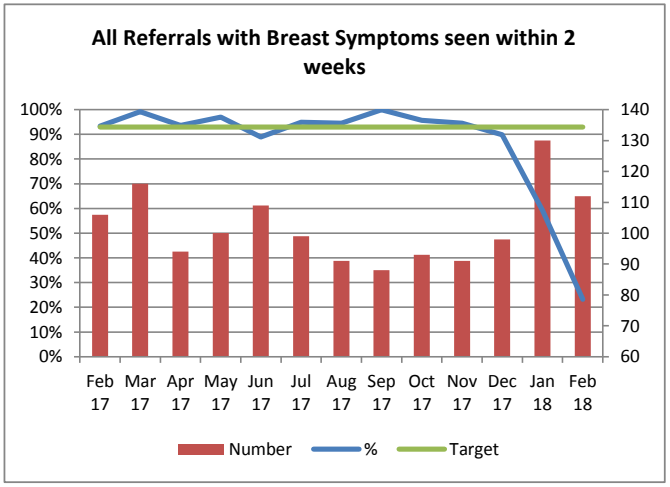
** Provisional figures subject to change depending*

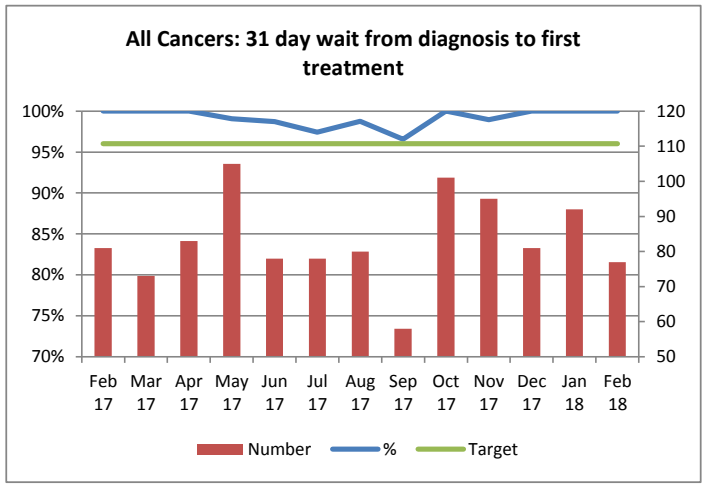
Commentary

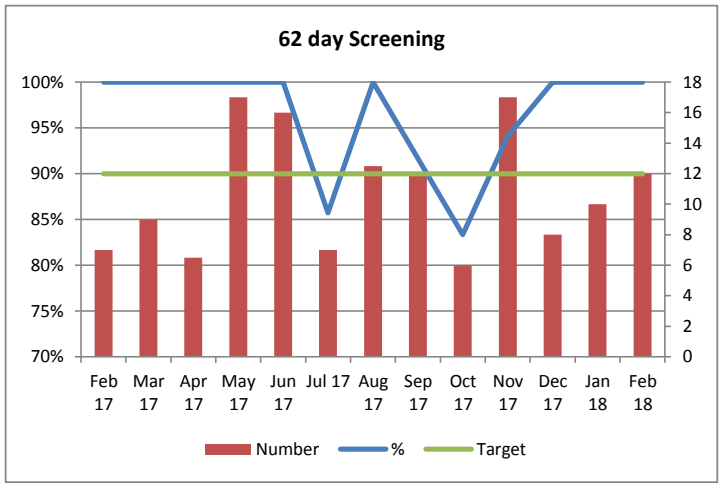
The Trust has achieved all three headline cancer standards during the month of February 2018. The figures presented in this paper reflect the Trust's regulatory performance measures (adjusted figures that take into account breach reallocation between providers).
The Trust has continued it's positive performance against the Rapid Access referrals standard, again achieving above the 93% target . January and February have, however seen an increase in patients seen over the 14 day standard mainly driven by breast. The number of patients seen compared to February 2017 is 14% higher this month.
The 2 week Breast Symptomatic standard has fallen to 23% in February 2018. The deterioration in performance relates to a sho rtfall in capacity in radiology. This is down to difficulty in recruitment of consultant radiologists. In terms of recovery, PHE have agreed extra funding and progress is being made with recruitment and cover.

The screening 62 day standard was met in February with no breach recorded for three months. The standard continues to be met on a year to date basis.

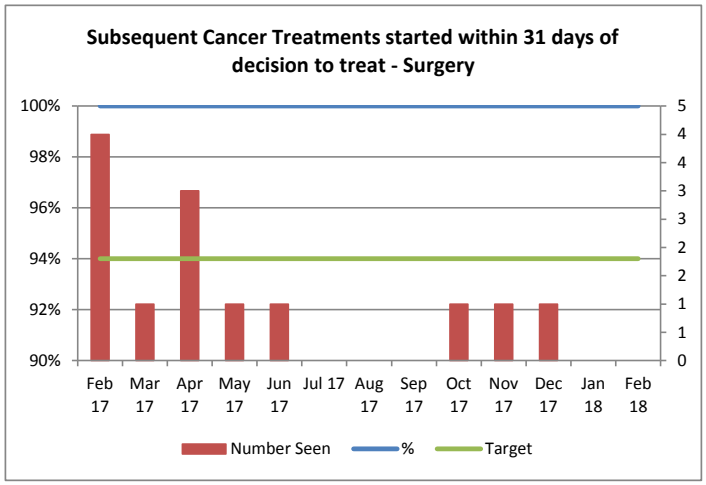
Primary Measures

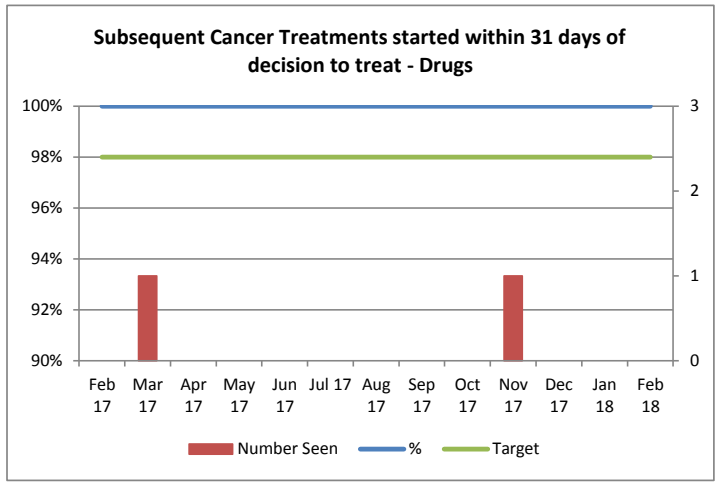


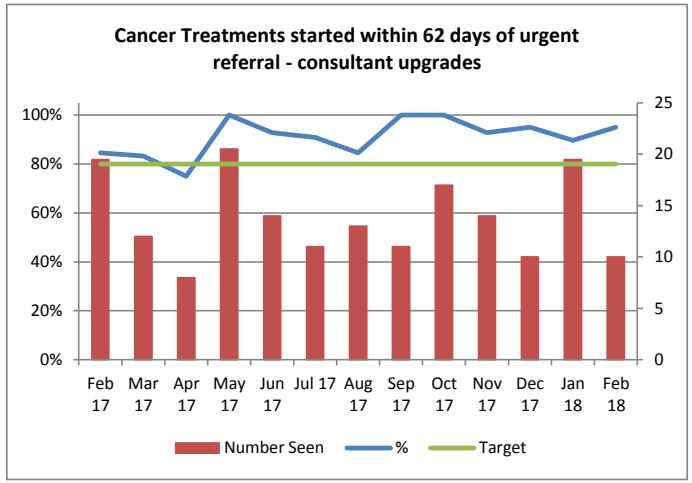




Operational Delivery: *Cancer Pathway*







Operational Delivery: *Unplanned Activity - A&E*

Headline Measures

	Current YTD		Rolling 13 months												
	Target	Actual	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Monthly Trend
A&E - >4 hr wait time from arrival to admission/ transfer/ discharge (% to Target)	95%	87.99%	93.33%	97.21%	93.37%	90.66%	94.24%	92.63%	95.26%	93.99%	88.28%	88.05%	74.22%	78.38%	77.92%	
No. of 4hr breaches		*9,623*	*411*	*205*	*474*	*737*	*437*	*567*	*332*	*422*	*872*	*851*	*1,920*	*1,543*	*1,468*	

	Plan	Actual	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Monthly Trend
A&E Attendances (LH/MIU/UUC) (% to Plan)		*96.57%*	*95.1%*	*98.5%*	*98.2%*	*101.8%*	*99.9%*	*96.3%*	*93.1%*	*97.1%*	*99.8%*	*92.9%*	*99.3%*	*97.1%*	*94.4%*	
A&E Attendances (LH/MIU/UUC) (No.)	*80,496*	*80,151*	6,166	7,357	7,144	7,890	7,593	7,697	7,011	7,023	7,439	7,119	7,447	7,138	6,650	

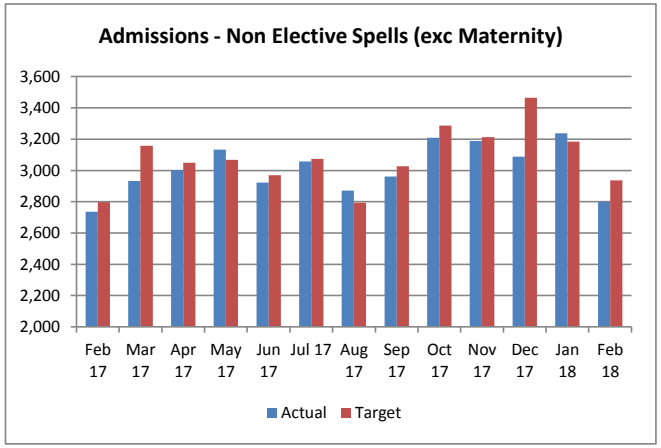
A&E Attendance Case Mix (based on acuity score on arrival)	*Major*		*19,707*	*1,405*	*1,579*	*1,652*	*1,740*	*1,727*	*1,743*	*1,769*	*1,724*	*1,688*	*1,599*	*1,773*	*2,148*	*2,144*	
	Minor		*34,445*	*2,678*	*3,167*	*3,141*	*3,442*	*3,421*	*3,345*	*3,152*	*2,939*	*3,198*	*2,942*	*3,375*	*2,988*	*2,502*	
	Paediatrics		*16,036*	*1,183*	*1,631*	*1,433*	*1,674*	*1,568*	*1,626*	*1,182*	*1,416*	*1,588*	*1,557*	*1,383*	*1,304*	*1,305*	
	Resus		*9,974*	*900*	*980*	*918*	*1,034*	*877*	*983*	*908*	*944*	*965*	*1,022*	*928*	*698*	*697*	

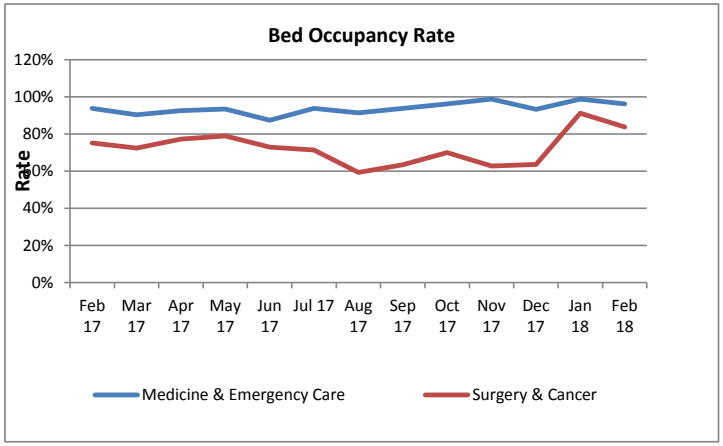
Commentary

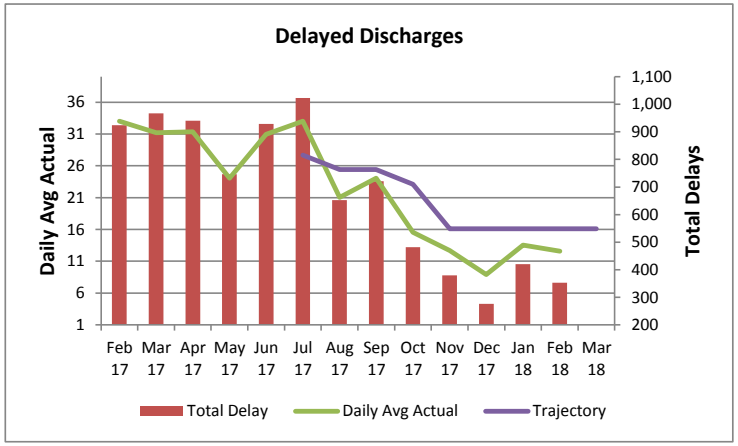
ED attendances in February saw a rise of 7.2% on the same period last year. The Trust achieved 77.92% against the 4-hour access standard in February. Poor performance has been driven by the increase in demand and the higher acuity of patients arriving. Comparatively ,February 2017 saw 1,405 patients with an acuity score of "major" versus February 2018 which saw 2,148 (an increase of 743). Up to 44 escalation beds were open over a period in February.

Non elective admissions in February were 7.3% higher than for the same period last year, which is in line with the increase in attendances. The Type 1 conversion rate from A&E was 36.91% in February. The number of medical patients on non medical wards decreased from 27 in January to 25 in February. Delayed transfers of care continues to be below the target set averaging 13 against a trajectory of 16.

Primary Drivers

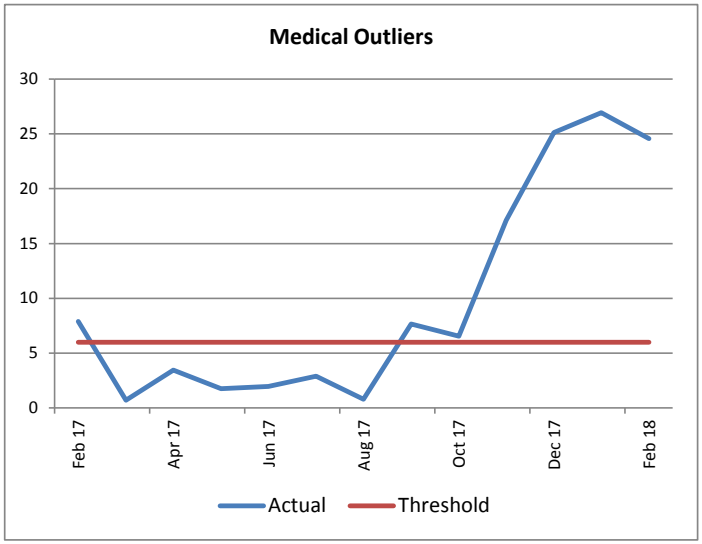


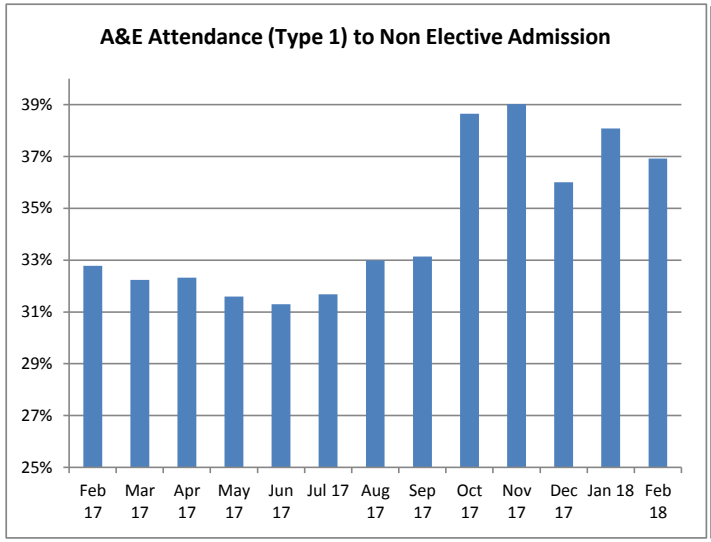


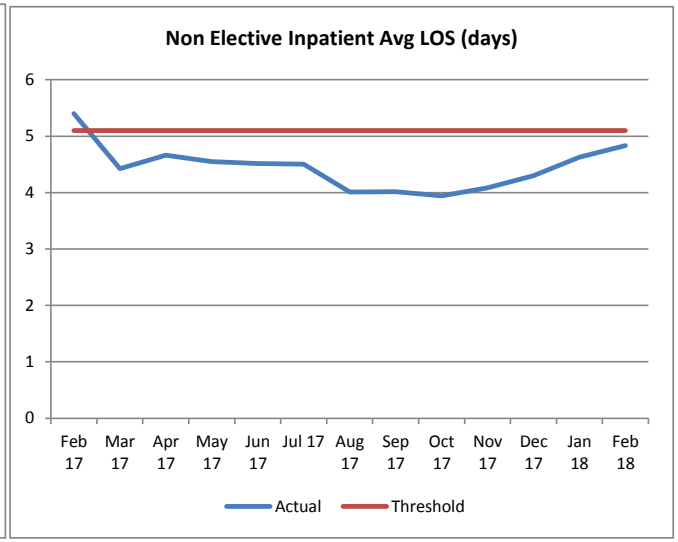


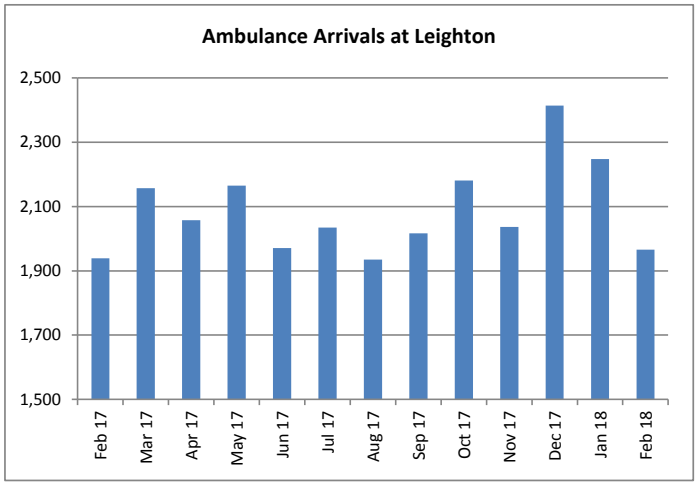
Operational Delivery: *Unplanned Activity A&E*

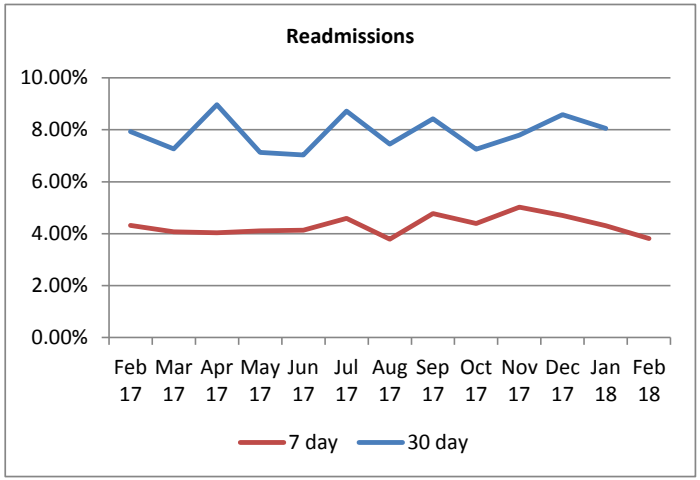
Secondary Drivers

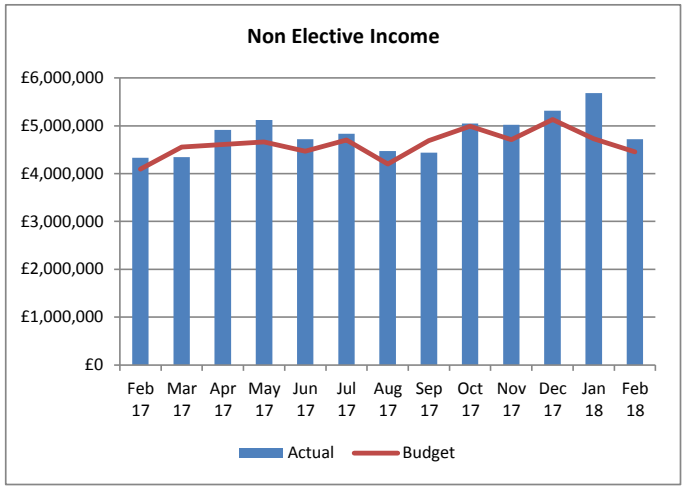












Operational Delivery: *Planned Activity*

Headline Measures

	Current YTD		Rolling 13 months											
	Target	Actual	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Monthly Trend
18 weeks from Referral to Treatment in Aggregate - Incomplete	92%	96.26%	96.07%	96.48%	96.69%	96.98%	97.57%	97.37%	96.78%	97.10%	96.79%	96.36%	95.15%	94.46%	94.17%	
Total 18 Weeks		*132,589*	*11,234*	*11,526*	*11,564*	*10,990*	*11,165*	*11,576*	*12,431*	*12,297*	*12,054*	*12,258*	*12,158*	*12,845*	*13,251*	
No. > 18 Weeks		*4,954*	*442*	*406*	*383*	*332*	*271*	*305*	*400*	*356*	*387*	*446*	*590*	*711*	*773*	
Diagnostic Waiting Time	1%	0.31%	0.07%	0.09%	0.04%	0.17%	0.44%	0.76%	0.34%	0.21%	0.24%	0.25%	0.39%	0.53%	0.08%	
Total Number of Waiters		*40,239*	*4,305*	*4,561*	*4,582*	*4,192*	*4,090*	*3,560*	*3,189*	*3,380*	*3,306*	*3,191*	*3,614*	*3,587*	*3,548*	
Waiters of 6 Weeks +		*124*	*3*	*4*	*2*	*7*	*18*	*27*	*11*	*7*	*8*	*8*	*14*	*19*	*3*	
Total Patients Waiting for a First Outpatient Appointment			7,812	7,057	7,223	7,172	7,352	7,643	8,029	7,809	7,731	7,916	8,085	8,342	8,501	
Longest Wait Time (weeks)											*42*	*37*	*42*	*40*	*41*	

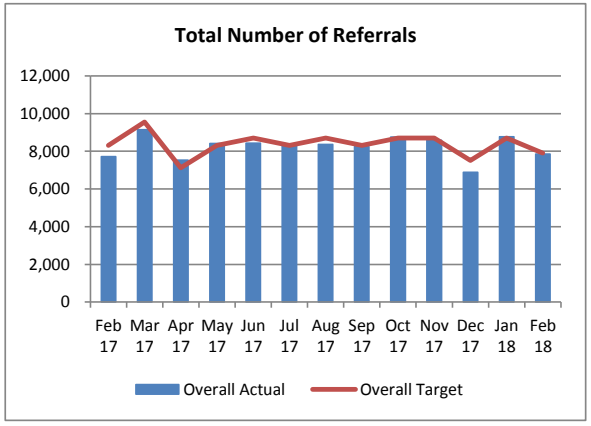
Commentary

The Trust reported 94.17% against the 92% incomplete pathways standard for RTT. Four specialties have failed to meet the 92% at specialty level. These are General Surgery, Cardiology, Respiratory Medicine and Community Paediatrics. The Divisions have recovery plans in place which are monitored through PMG. The Trust is now actively managing the level of over performance against this standard in light of the Capped Expenditure Programme with the aim of the over performance reducing over the coming months.
Both admitted and non admitted internal targets were not met in February these targets have been heavily impacted by the cancellation of elective work over January.

The Trust has delivered the diagnostic wait time consistently since July 2016. In February 2018, 0.08% of patients waited longer than 6 weeks for their diagnostic tests. All modalities delivered the standard, however significant outsourcing continued in medical imaging to support this position.

After a period of increased GP referrals (September - November) December saw a drop against plan this drop has not been maintained in January or February where GP referrals were higher than previous years. A year on year comparison shows a 7.3% increase in GP referrals from February 2017 to February 2018.

Primary Drivers

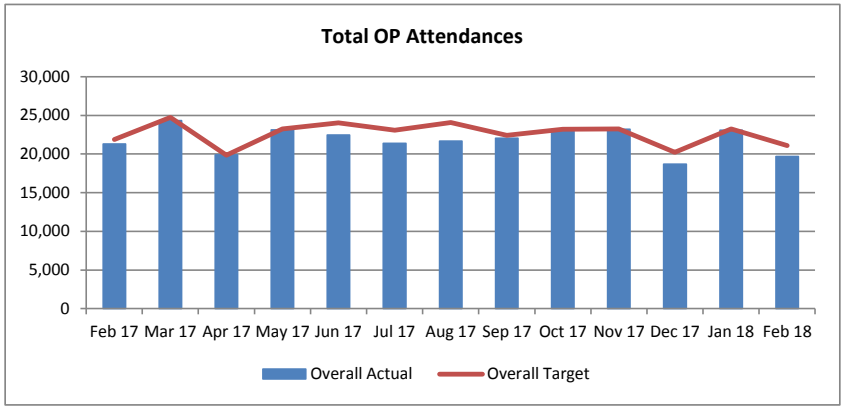


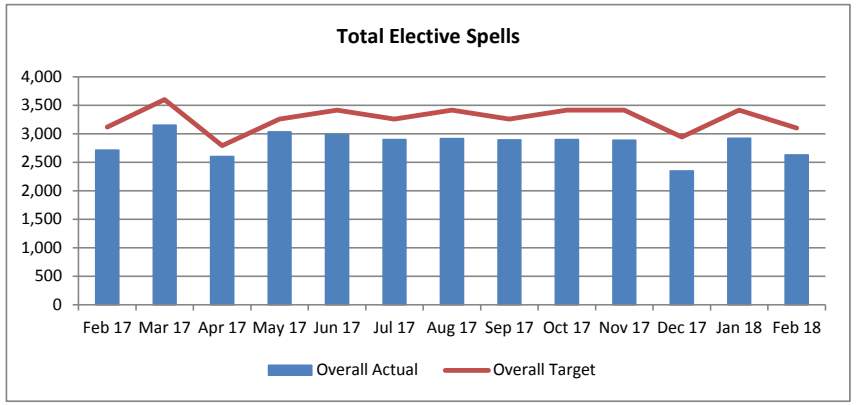
Referral Breakdown

	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Monthly Trend
GP Actual	4,592	5,534	4,427	4,779	5,248	5,115	5,211	5,277	5,506	5,424	4,157	5,573	4,927	
GP Target	5,243	6,029	4,507	5,259	5,509	5,259	5,509	5,259	5,509	5,509	4,758	5,509	5,008	
% to Target	87.6%	91.8%	98.2%	90.9%	95.3%	97.3%	94.6%	100.3%	99.9%	98.5%	87.4%	101.2%	98.4%	
Other Actual	3,126	3,621	3,101	3,632	3,179	3,191	3,156	2,969	3,252	3,166	2,731	3,205	2,931	
Other Target	3,069	3,529	2,614	3,050	3,195	3,050	3,195	3,050	3,195	3,195	2,759	3,195	2,904	
% to Target	101.9%	102.6%	118.6%	119.1%	99.5%	104.6%	98.8%	97.3%	101.8%	99.1%	99.0%	100.3%	100.9%	
Total Actual	7,718	9,155	7,528	8,411	8,427	8,306	8,367	8,246	8,758	8,590	6,888	8,778	7,858	
Total Target	8,312	9,558	7,121	8,309	8,704	8,309	8,704	8,309	8,704	8,704	7,517	8,704	7,912	
% to Target	92.9%	95.8%	105.7%	101.2%	96.8%	100.0%	96.1%	99.2%	100.6%	98.7%	91.6%	100.9%	99.3%	
GP % of Total	59.5%	60.4%	58.8%	56.8%	62.3%	61.6%	62.3%	64.0%	62.9%	63.1%	60.4%	63.5%	62.7%	

Operational Delivery: *Planned Activity*

Primary Drivers



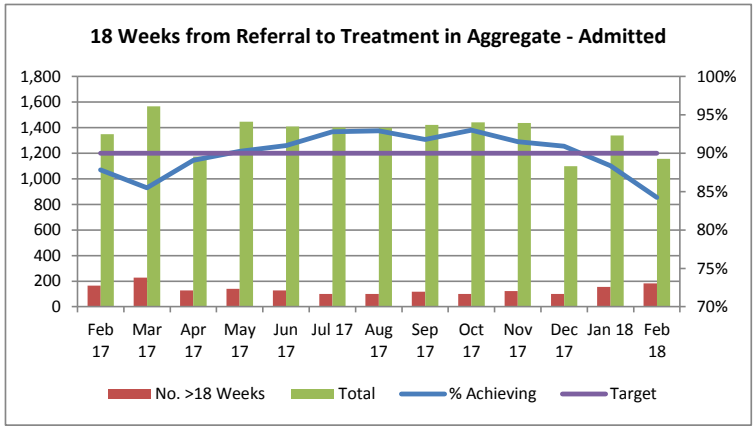


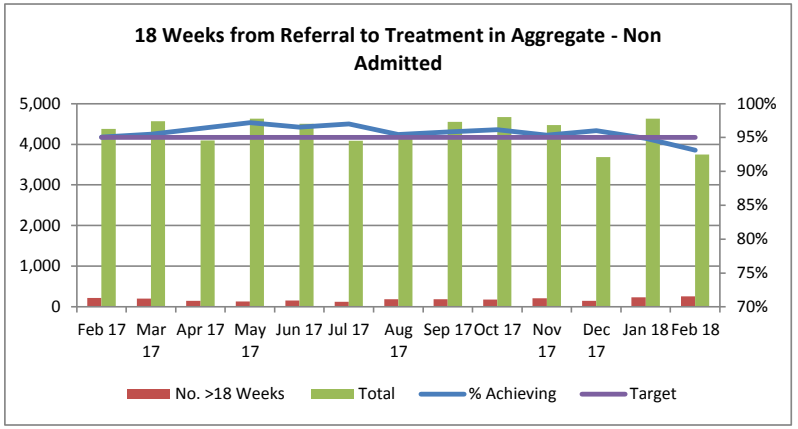
OP Attendance Breakdown	YTD	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Monthly Trend
New Actual	84,810	6,243	7,110	5,727	6,787	6,746	6,192	6,421	6,821	6,988	6,910	5,805	6,862	6,198	
New Target	91,268	6,791	7,764	6,098	7,113	7,423	7,098	7,427	6,941	7,250	7,253	6,272	7,253	6,585	
% to Target	92.9%	91.9%	91.6%	93.9%	95.4%	90.9%	87.2%	86.5%	98.3%	96.4%	95.3%	92.6%	94.6%	94.1%	
F U Actual	199,227	15,063	17,229	14,147	16,325	15,723	15,181	15,236	15,240	16,178	16,308	12,893	16,216	13,488	
F U Target	203,087	15,098	16,983	13,765	16,118	16,623	15,967	16,663	15,462	15,955	15,987	13,971	15,991	14,504	
% to Target	98.1%	99.8%	101.4%	102.8%	101.3%	94.6%	95.1%	91.4%	98.6%	101.4%	102.0%	92.3%	101.4%	93.0%	
Total Actual	284,037	21,306	24,339	19,874	23,112	22,469	21,373	21,657	22,061	23,166	23,218	18,698	23,078	19,686	
Total Target	294,355	21,889	24,747	19,863	23,231	24,046	23,065	24,090	22,403	23,205	23,240	20,243	23,244	21,089	
% to Target	96.5%	97.3%	98.4%	100.1%	99.5%	93.4%	92.7%	89.9%	98.5%	99.8%	99.9%	92.4%	99.3%	93.3%	
New % of Total	29.9%	29.3%	29.2%	28.8%	29.4%	30.0%	29.0%	29.6%	30.9%	30.2%	29.8%	31.0%	29.7%	31.5%	

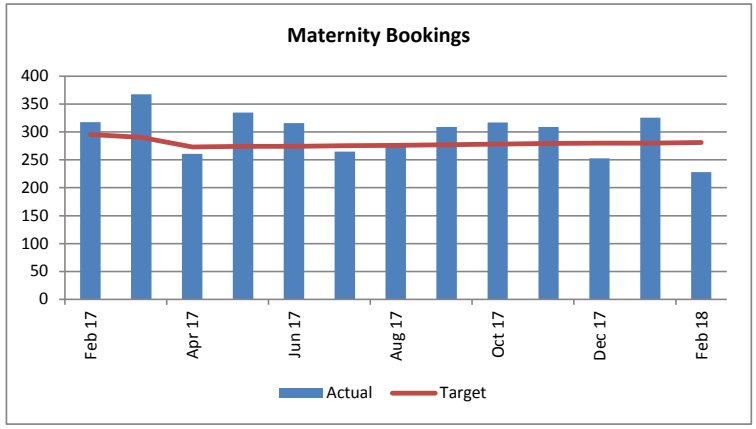
Elective Spells Breakdown	YTD	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Monthly Trend
I P Actual	3,595	304	342	260	307	294	266	298	279	299	308	234	164	240	
I P Target	4,348	342	393	281	330	346	330	346	330	346	346	298	346	314	
% to Target	82.7%	88.9%	87.0%	92.5%	93.0%	85.0%	80.6%	86.1%	84.5%	86.4%	89.0%	78.5%	47.4%	76.4%	
Daycase Actual	33,291	2,411	2,809	2,342	2,728	2,689	2,636	2,619	2,616	2,603	2,578	2,115	2,756	2,389	
Daycase Target	38,080	2,775	3,208	2,509	2,931	3,071	2,931	3,071	2,931	3,071	3,071	2,650	3,071	2,790	
% to Target	87.4%	86.9%	87.6%	93.3%	93.1%	87.6%	89.9%	85.3%	89.3%	84.8%	83.9%	79.8%	89.7%	85.6%	
Total Actual	36,886	2,715	3,151	2,602	3,035	2,983	2,902	2,917	2,895	2,902	2,886	2,349	2,920	2,629	
Total Target	42,428	3,117	3,601	2,790	3,261	3,417	3,261	3,417	3,261	3,417	3,417	2,948	3,417	3,104	
% to Target	86.9%	87.1%	87.5%	93.3%	93.1%	87.3%	89.0%	85.4%	88.8%	84.9%	84.5%	79.7%	85.5%	84.7%	
I P % of Total	9.7%	11.2%	10.9%	10.0%	10.1%	9.9%	9.2%	10.2%	9.6%	10.3%	10.7%	10.0%	5.6%	9.1%	

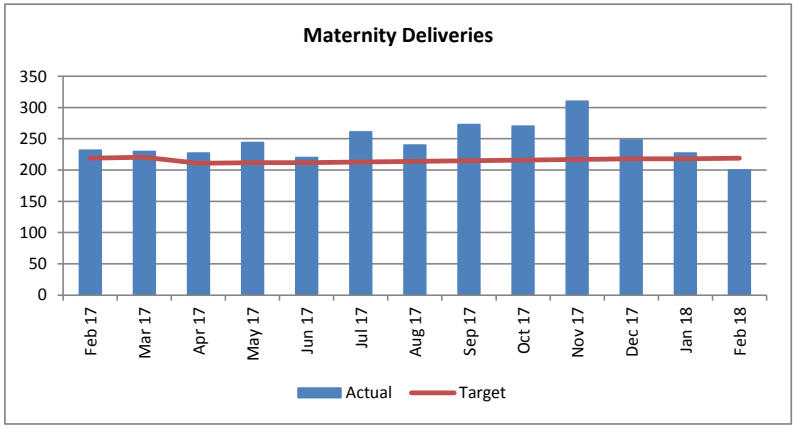
Operational Delivery: *Planned Activity*

Primary Drivers





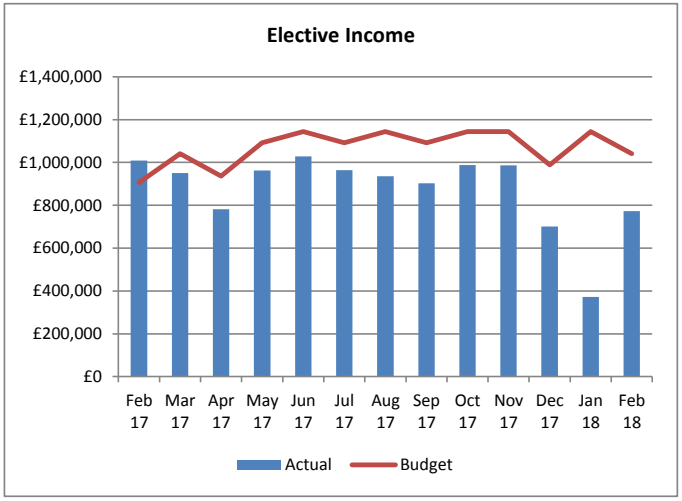


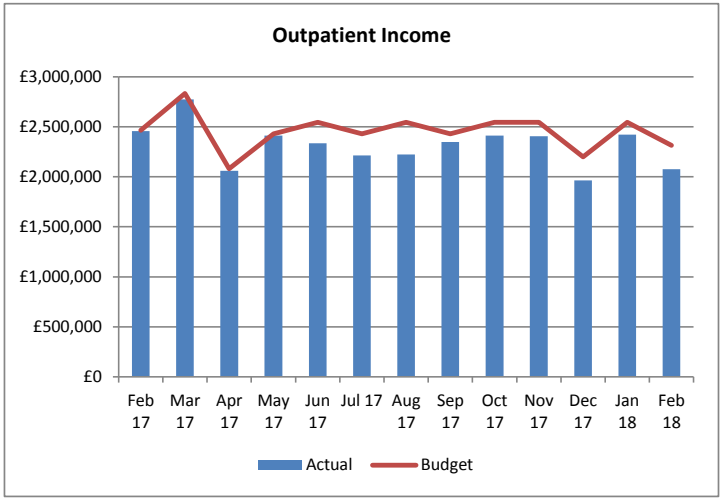


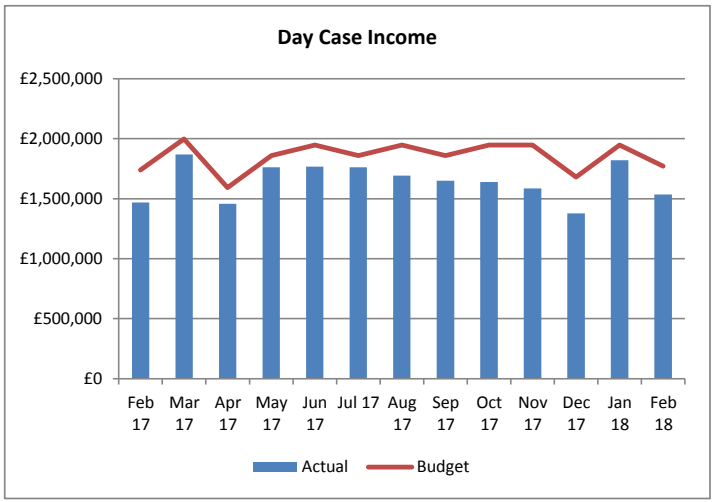
Operational Delivery: *Planned Activity*

Secondary Drivers

			Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Monthly Trend
Bed Occupancy Rate	Medicine & Emergency Care		93.8%	90.3%	92.6%	93.3%	87.4%	93.7%	91.4%	93.8%	96.1%	98.8%	93.3%	98.7%	96.1%	
	Surgery & Cancer		75.1%	72.3%	77.3%	78.9%	72.9%	71.3%	59.3%	63.5%	70.1%	62.7%	63.7%	91.1%	83.7%	
Elective Inpatient Avg LOS (Days)			2.9	2.4	3.4	2.9	3.1	3.7	2.6	2.3	2.4	2.7	2.4	2.3	2.4	
Delayed Transfers of Care (MFFD)		16.00	33	31	31	24	31	33	21	24	16	13	9	14	13	
Delayed Transfers of Care (% of Acute Beds)			6.6%	6.3%	6.4%	4.9%	6.6%	7.1%	4.6%	5.2%	3.4%	2.7%	1.9%	2.6%	2.5%	
Medical Outliers			8	1	3	2	2	3	1	8	7	17	25	27	25	
Readmission (Emergency Re-admissions after Planned Surgery)																
** reported from 16/17. One month delay*	30 Day Rate		2.95%	0.27%	4.00%	3.05%	3.06%	2.76%	2.92%	3.12%	2.77%	2.63%	3.00%	3.01%		
	7 Day Rate		1.67%	1.40%	1.73%	1.56%	1.49%	1.05%	1.11%	1.44%	1.64%	1.23%	1.04%	1.19%	0.89%	
Cancelled Operations - Non Clinical - Cancellation Rate			1.25%	1.07%	1.30%	1.06%	0.80%	0.86%	0.40%	0.57%	1.27%	0.75%	2.24%	1.01%	1.08%	
Theatre Efficiency																
	Main Theatres		76.3%	76.2%	77.6%	79.5%	78.4%	77.9%	78.6%	80.5%	78.9%	77.0%	74.4%	74.9%	74.2%	
	TC Theatres		76.0%	75.3%	75.7%	79.6%	72.7%	75.0%	76.0%	71.5%	78.1%	75.5%	77.5%	74.5%	71.5%	
DNA (OP Efficiency)			5.44%	5.35%	5.86%	5.94%	6.63%	5.82%	5.82%	5.94%	5.62%	5.39%	6.22%	5.50%	5.22%	
Hospital Cancellation Rate (OP Efficiency)			5.73%	6.03%	6.57%	7.63%	7.51%	7.94%	7.58%	6.11%	6.27%	6.19%	7.18%	7.34%	6.88%	







Financial Performance: Income & Expenditure Position - Aggregated

	Month			Year to Date			Forecast	
	Plan February (£'000)	Actual February (£'000)	Variance February (£'000)	Plan April to February (£'000)	Actual April to February (£'000)	Variance April to February (£'000)	2017/18 (£'000)	Budget 2017/18 £'000
Operating								
Operating Income								
NHS Acute Activity Income								
Elective	957	798	-159	11,023	9,393	-1,630	9,856	12,496
Non-Elective	4,350	4,778	428	50,287	54,278	3,991	59,212	57,367
Maternity	1,029	995	-34	12,171	12,676	504	13,828	13,208
Day cases	1,745	1,532	-213	20,079	18,045	-2,034	19,685	22,066
Outpatients	2,242	2,109	-133	26,207	24,872	-1,335	27,134	29,033
A&E	695	709	14	8,455	8,948	492	9,761	9,309
Other NHS	6,318	6,806	488	69,568	71,771	2,203	77,514	70,720
Total NHS Clinical Revenue	**17,336**	**17,727**	**391**	**197,791**	**199,983**	**2,192**	**216,991**	**214,199**
Other Operating Income	1,894	1,972	78	20,869	20,632	-237	22,495	22,840
TOTAL OPERATING INCOME	**19,230**	**19,699**	**469**	**218,660**	**220,615**	**1,955**	**239,486**	**237,039**
Operating Expenses								
Employee Benefits Expenses (Pay)	-13,817	-14,016	-199	-151,503	-152,463	-960	-166,593	-165,061
Drugs	-1,376	-1,367	9	-15,147	-15,073	74	-16,493	-16,526
Clinical Supplies	-1,561	-1,510	51	-17,960	-16,591	1,369	-18,096	-19,518
Non Clinical Supplies	-275	-287	-12	-3,100	-3,611	-511	-3,930	-3,338
Other operating expenses	-1,801	-1,855	-54	-27,159	-29,009	-1,850	-31,328	-30,178
TOTAL OPERATING EXPENSES	**-18,830**	**-19,035**	**-205**	**-214,869**	**-216,747**	**-1,878**	**-236,440**	**-234,621**
EBITDA	**400**	**664**	**264**	**3,791**	**3,868**	**77**	**3,046**	**2,418**
Non Operating								
Non Operating Income								
Interest & Asset disposal	3	5	2	33	43	10	36	36
Non-Operating Expenses								
Depreciation & Finance Leases	-488	-434	54	-5,349	-4,488	861	-5,039	-5,850
PDC Dividend Expense	-159	-159	0	-1,745	-1,745	0	-1,900	-1,900
Net Surplus/(deficit) before STF/Exceptional Items	**-244**	**76**	**320**	**-3,270**	**-2,322**	**948**	**-3,857**	**-5,296**
STF	699	489	-210	5,294	4,335	-959	6,261	5,994
Net Surplus/(deficit) before Exceptional Items	**455**	**565**	**110**	**2,024**	**2,013**	**-11**	**2,404**	**698**
Prior Period Adjustment	0	-210	0	0	0	0	0	0
Charitable Income/Depreciation	0	0	0	0	-35	-35	-59	258
Net Surplus/(deficit) after Exceptional Items	**455**	**355**	**110**	**2,024**	**1,978**	**-46**	**2,345**	**956**

The Trust delivered a £2.0M surplus (before charitable donations) cumulative against a planned surplus of £2.0M.

Contract income is £2.2M better than plan cumulative. Key variances include planned income under-performance due to capacity constraints, non-elective due to casemix including sepis coding. In other NHS, drugs, winter and the impact of the CEP are the main variances. Cumulative £1.2M of winter monies has been recognised.

Other income is 0.2M worse cumulative as a result of Training income, RTA income and nhs recharge variances.

Pay is £1.0M worse than plan cumulative. The key impacts are a higher spend on nursing than plan , medical pay is better than plan and there remain underspends in community services from unfilled vacancies. Winter plans account for £0.2M of the in month variance.

Non-Pay is £0.9M worse than plan cumulative. The key impacts are reduced spend on clinical supplies related to activity reduction and non-clinical supplies is worse in community related to higher costs than planned. In addition, other operating expenses is worse than plan and includes costs of outsourcing to cover medical gaps. Winter plans account for £0.2m of the in month variance.

The forecast is to acheive better than the agreed control total prior to STF and deliver the cost savings under the CEP, recognising the reduced income flows from South Cheshire & Vale Royal CCGs. The forecast has improved as a result of the £0.6M Tranche 1 winter monies, non-recurrent slippage in Community services £0.5M and net STF gain (incentive vs performance) of £0.3M.

* EBITDA Total excludes Charitable Income

Financial Performance: Income & Expenditure Position - MCHFT

	Month			Year to Date			Forecast	
	Plan February (£'000)	Actual February (£'000)	Variance February (£'000)	Plan April to February (£'000)	Actual April to February (£'000)	Variance April to February (£'000)	2017/18 (£'000)	Budget 2017/18 £'000
Operating								
Operating Income								
NHS Acute Activity Income								
Elective	957	798	-159	11,023	9,393	-1,630	9,856	12,496
Non-Elective	4,350	4,778	428	50,287	54,278	3,991	59,212	57,367
Maternity	1,029	995	-34	12,171	12,676	504	13,828	13,208
Day cases	1,745	1,532	-213	20,079	18,045	-2,034	19,685	22,066
Outpatients	2,242	2,109	-133	26,207	24,872	-1,335	27,134	29,033
A&E	695	709	14	8,455	8,948	492	9,761	9,309
Other NHS	4,125	4,838	713	45,600	47,642	2,042	51,183	44,645
Total NHS Clinical Revenue	**15,143**	**15,759**	**616**	**173,823**	**175,854**	**2,031**	**190,660**	**188,124**
Other Operating Income	1,813	1,888	75	20,010	19,708	-303	21,481	21,941
Inter-Trust Income	48	82	34	476	741	265	737	571
TOTAL OPERATING INCOME	**17,004**	**17,729**	**725**	**194,310**	**196,302**	**1,993**	**212,878**	**210,636**
Operating Expenses								
Employee Benefits Expenses (Pay)	-12,019	-12,317	-298	-132,217	-134,225	-2,008	-146,646	-144,096
Drugs	-1,374	-1,366	8	-15,121	-15,052	69	-16,469	-16,497
Clinical Supplies	-1,472	-1,418	54	-16,983	-15,574	1,409	-16,986	-18,455
Non Clinical Supplies	-207	-206	1	-2,351	-2,593	-241	-2,818	-2,520
Other operating expenses	-1,423	-1,758	-335	-23,012	-24,838	-1,826	-26,790	-25,672
Inter-Trust Charges	-82	-82	0	-897	-897	0	-979	-979
TOTAL OPERATING EXPENSES	**-16,576**	**-17,147**	**-570**	**-190,583**	**-193,179**	**-2,596**	**-210,688**	**-208,219**
EBITDA	**427**	**582**	**155**	**3,727**	**3,123**	**-603**	**2,190**	**2,417**
Non Operating								
Non Operating Income								
Interest & Asset disposal	3	5	2	33	43	10	36	36
Non-Operating Expenses								
Depreciation & Finance Leases	-488	-434	54	-5,349	-4,488	861	-5,039	-5,850
PDC Dividend Expense	-159	-159	0	-1,745	-1,745	0	-1,900	-1,900
Net Surplus/(deficit) before STF/Exceptional Items	**-217**	**-6**	**211**	**-3,334**	**-3,067**	**268**	**-4,713**	**-5,296**
STF	699	489	-210	5,294	4,335	-959	6,261	**5,994**
Net Surplus/(deficit) before Exceptional Items	**482**	**483**	**1**	**1,960**	**1,268**	**-691**	**1,548**	**698**
Prior Period Adjustment	0	-210	-210	0	0	0	0	0
Charitable income	0	0	0	0	-35	-35	218	
Net Surplus/(deficit) after Exceptional Items	**482**	**273**	**-209**	**1,960**	**1,233**	**-726**	**1,766**	**698**

The Trust excluding Community Services, delivered a £1.3M surplus position cumulative against a planned £2.0M surplus. (prior to charitable income)

Contract income is £2.0M better than plan cumulative. Key variances include planned income as a result of capacity constraints and non-elective as a result of casemix including Sepsis coding. £146M of the £176M actual value is fixed in line with the CEP. The variance relates to services commissioned by NHSE, Public Health England and out of area commissioners. In month, an additional £0.4M of NHSE funding for winter has been recognised .

Other income is £0.3M worse cumulative as a result of training income, RTA income and nhs recharge variances.

Pay is £2.0M worse than plan cumulative as a result of higher spend on Nursing and corporate vacancy targets. In month, £0.2M is the result of winter plans.

Non-Pay is £0.6M worse than plan cumulative as a result of better than plan for clinical supplies (activity related). Other Operating Expenses is £1.8M worse as a result of continuing outsourcing pressures in diagnostics from staffing gaps. In month, £0.2M is the result of winter plans in Other operating expenses.

Financial Performance: Income & Expenditure Position - CCICP

	Month			Year to Date			Forecast	
	Plan February (£'000)	Actual February (£'000)	Variance February (£'000)	Plan April to February (£'000)	Actual April to February (£'000)	Variance April to February (£'000)	2017/18 (£'000)	Budget 2017/18 £'000
Operating								
Operating Income								
NHS Acute Activity Income								
Elective	0	0	0	0	0	0	0	
Non-Elective	0	0	0	0	0	0	0	
Maternity	0	0	0	0	0	0	0	
Day cases	0	0	0	0	0	0	0	
Outpatients	0	0	0	0	0	0	0	
A&E	0	0	0	0	0	0	0	
Other NHS	2,193	1,968	-225	23,968	24,129	161	26,331	26,075
Total NHS Clinical Revenue	**2,193**	**1,968**	**-225**	**23,968**	**24,129**	**161**	**26,331**	**26,075**
Other Operating Income	81	84	3	859	924	66	1,014	899
Inter-Trust Income	82	82	0	897	897	0	979	979
TOTAL OPERATING INCOME	**2,356**	**2,134**	**-222**	**25,724**	**25,950**	**227**	**28,324**	**27,953**
Operating Expenses								
Employee Benefits Expenses (Pay)	-1,798	-1,699	99	-19,286	-18,238	1,048	-19,947	-20,965
Drugs	-2	-1	1	-26	-21	5	-24	-29
Clinical Supplies	-89	-92	-3	-976	-1,017	-41	-1,110	-1,063
Non Clinical Supplies	-68	-81	-13	-749	-1,018	-270	-1,112	-818
Other operating expenses	-378	-97	281	-4,147	-4,171	-24	-4,538	-4,506
Inter-Trust Charges	-48	-82	-34	-476	-741	-265	-737	-571
TOTAL OPERATING EXPENSES	**-2,383**	**-2,052**	**331**	**-25,660**	**-25,206**	**454**	**-27,468**	**-27,952**
EBITDA	**-27**	**82**	**109**	**64**	**744**	**680**	**856**	**0**
Non Operating								
Non Operating Income								
Interest & Asset disposal	0	0	0	0	0	0	0	
Non-Operating Expenses								
Depreciation & Finance Leases	0	0	0	0	0	0	0	
PDC Dividend Expense	0	0	0	0	0	0	0	
Net Surplus/(deficit) before Exceptional Items	**-27**	**82**	**109**	**64**	**744**	**680**	**856**	**0**
STF	0	0	0	0	0	0	0	
Net Surplus/(deficit) before Exceptional Items	**-27**	**82**	**109**	**64**	**744**	**680**	**856**	**0**
Prior Period Adjustment	0	0	0	0	0	0	0	
Net Surplus/(deficit) after Exceptional Items	**-27**	**82**	**109**	**64**	**744**	**680**	**856**	**0**

Community Services delivered a £0.7M surplus cumulative against a planned break even position.

Contract income is £0.2M better than plan cumulative as a result of property income accrued to offset costs..

Pay is £1.0M better than plan cumulative as a result of unfilled vacancies partly clinical and partly corporate.

Non-Pay is £0.6M worse than plan cumulative due to property costs and incontinence products back invoices being received late from suppliers. (prior year and above expectations)

The forecast is now expected to achieve better than the Budget break even position . This is after current under-spends in pay particularly being utilised non-recurrently to fund the non-recurrent costs of implementing the approved IT System investment (EMIS) that will result in additional pay and non-pay spend in Q4.

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	(109)	(1,065)	(994)	(66)	(52)	(1,131)	(1,155)
Endoscopy	Endoscopy	5,585	1	(1,080)	(2,153)	91	(1,123)	168	2,310	(821)
General Surgery Directorate	General Surgery	15,389	59	(823)	(7,944)	259	(1,658)	24	5,845	(540)
Head & Neck Directorate	Head & Neck	5,017	375	(172)	(2,299)	153	(697)	77	2,396	57
Macmillan Cancer Centre	Macmillan Cancer Centre	583	1,529	400	(816)	(24)	(1,278)	(117)	17	258
Ophthalmology	Ophthalmology	10,646	59	(583)	(3,649)	289	(3,039)	490	4,017	195
Orthopaedic Directorate	Orthopaedics	16,999	240	(1,405)	(5,712)	255	(3,177)	(35)	8,350	(1,184)
Theatres & TC	Theatres & TC	0	321	(3)	(6,698)	36	(2,461)	(68)	(8,838)	(35)
Urology Directorate	Urology	5,103	74	(284)	(2,546)	(52)	(408)	(94)	2,224	(429)
Surgical and Cancer Division	**Surgery & Cancer**	**59,323**	**2,658**	**(4,059)**	**(32,883)**	**13**	**(13,907)**	**392**	**15,191**	**(3,654)**

The Surgical Division is £3.7M worse than plan cumulative. Net of income as the CEP impact is reflected in Corporate, the Division is £0.4M better than plan, although variable income from PHE is behind plan by £0.6M. The key variances in expenditure relate to medical staffing vacancies in Ophthalmology and Orthopaedics and Nursing vacancies in General Surgery. Non pay is better than plan in Ophthalmology as a result of lower than expected use of high cost drugs.

		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	119	119	(2,110)	(130)	(158)	(334)	(2,149)	(345)
Accident & Emergency Dir	Emergency Department	13,791	717	792	(5,333)	87	(698)	(133)	8,478	747
Anaesthetics & Critical Care	Anaesthetics & Critical Care	5,833	40	185	(7,262)	144	(1,063)	50	(2,452)	379
Medical Directorate	General Medicine	39,516	208	1,768	(20,464)	(759)	(4,665)	(501)	14,595	508
Urgent Care Centre	Urgent Care Centre	0	0	0	(599)	62	0	85	(599)	147
Emergency Services Division	**Medicine & Emergency Care**	**59,140**	**1,083**	**2,863**	**(35,768)**	**(596)**	**(6,583)**	**(832)**	**17,872**	**1,435**

The Medicine and Emergency Care Division are £1.4M better than plan. Net of income, the Division is £1.4M worse than plan. The key variances are Pay in the medical directorate as a result of higher nursing costs from use of bank HCA's over establishment for acuity pressures and escalation beds . Medical pay is lower than plan. Non-pay is worse than plan with non-deliverable infusion pump CIP in Divisional management and drug costs in the medical directorate.

		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	54	46	(1,221)	(133)	(149)	(26)	(1,315)	(113)
Obstetric & Gynaecology Dir	Obstetrics & Gynaecology	16,682	103	226	(7,938)	(16)	(1,318)	(183)	7,529	26
Paediatric Directorate	Paediatrics	10,750	93	32	(7,125)	(90)	(1,072)	(84)	2,646	(141)
Women and Childrens Division	**Women and Children**	**27,432**	**250**	**305**	**(16,284)**	**(239)**	**(2,539)**	**(293)**	**8,860**	**(228)**

The Womens and Childrens Division is £0.2M worse than plan cumulative. Net of income, the Division is £0.5M worse than plan. Pay pressures are a result of midwifery and medical over-establishment. Non-pay is £0.3M worse as a result of IVF recharges.

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	(266)	26	(27)	(99)	(293)	(73)
Dermatology	Dermatology	1,594	23	(141)	(796)	150	(287)	27	534	36
ECG department	ECG	332	23	(43)	(877)	121	(69)	2	(591)	80
Elmhurst	Elmhurst	1,829	167	7	(1,405)	(42)	(149)	25	442	(9)
Integrated Discharge	Integrated Discharge	0	0	0	(289)	(40)	(5)	(1)	(294)	(41)
Medical Records Department	Medical Records Department	0	0	(2)	(1,617)	32	(222)	(24)	(1,839)	6
Outpatients	Outpatients	0	141	(13)	(505)	(2)	(56)	(6)	(420)	(21)
Pathology Directorate	Pathology	11,047	3,564	161	(9,031)	33	(8,223)	(349)	(2,643)	(156)
Pharmacy Departments	Pharmacy	2,910	228	366	(2,901)	33	(2,939)	(513)	(2,701)	(114)
Radiology Directorate	Radiology	2,905	671	(508)	(5,674)	48	(1,971)	(193)	(4,070)	(654)
Therapeutic Departments	Therapies	0	5	5	(1,808)	124	(54)	37	(1,857)	166
Victoria Infirmary Northwich	Victoria Infirmary Northwich	1,846	7	(147)	(1,609)	(106)	(279)	(4)	(34)	(256)
Diagnostics and Support Divisi	**Diagnostics and Support**	**22,464**	**4,829**	**(315)**	**(26,777)**	**377**	**(14,282)**	**(1,098)**	**(13,766)**	**(1,036)**

The Diagnostics Division is £1.0M worse than plan cumulative. Net of income, the Division is £0.7M worse than plan. The key variances include better than plan on pay from staffing gaps in Imaging, ECG and Dermatology. Non-pay is worse on drugs and outsourcing imaging 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	(461)	13	(207)	(28)	(667)	(15)
Catering Directorate	Catering	0	1,278	86	(1,465)	(58)	(1,229)	(78)	(1,417)	(50)
Estates Departments	Estates Departments	0	422	(15)	(1,464)	(36)	(5,679)	317	(6,721)	266
Hotel Services	Domestics	0	0	0	(1,236)	(52)	(14)	(3)	(1,250)	(55)
Laundry Services Departments	Laundry	0	1,128	15	(1,044)	(128)	(778)	(69)	(694)	(182)
Security	Security	0	1,410	(88)	(636)	53	(642)	(105)	131	(140)
Site Services	Porters	0	0	0	(2,477)	56	(80)	(9)	(2,558)	47
Estates & Facilities Division	**Estates & Facilities Division**	**0**	**4,238**	**(2)**	**(8,784)**	**(152)**	**(8,630)**	**25**	**(13,176)**	**(129)**

The Estates and Facilities Division is £0.1M worse than plan cumulative. Pay costs are worse than plan in a number of areas as a result of sickness and operational pressures. Non pay is worse in Laundry as a reuslt of high linen costs , catering provision costs are higher than expected and security has costs of car park barrier repairs.

		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	(1,336)	9	(574)	15	(1,910)	24
Computer Services	Computer Services	0	81	68	(1,301)	78	(1,957)	(71)	(3,177)	76
Finance & Information	Finance & Information	0	41	12	(2,808)	(41)	(697)	24	(3,464)	(4)
Human Resources	Human Resources	0	464	25	(2,197)	25	(446)	125	(2,179)	175
Risk Manangement & R&D	Risk Management & R&D	0	363	(132)	(1,336)	99	(47)	38	(1,020)	4
Quality Assurance Departments	Nurse Management	0	351	221	(2,595)	(345)	(7,620)	88	(9,863)	(37)
Trust Central Expenditure	Trust Central Expenditure	12,229	5,419	2,374	(1,915)	(1,191)	(500)	1,002	15,232	2,184
Other Departments	Other Departments	19	146	39	(242)	(44)	(274)	(3)	(351)	(8)
	Corporate	**12,247**	**6,865**	**2,607**	**(13,730)**	**(1,410)**	**(12,114)**	**1,218**	**(6,732)**	**2,415**

The Corporate Division is £2.4M better cumulative. Net of income, there is a £0.2M adverse variance. Pay is worse as a result of maternity pressures and vacancy control targets and non-pay is better as a result of slippage on investments.

	Community Services	**24,129**	**927**	**229**	**(18,238)**	**1,048**	**(6,230)**	**(332)**	**588**	**945**
	EBITDA	**204,736**	**20,850**	**1,628**	**(152,463)**	**(960)**	**(64,285)**	**(919)**	**8,838**	**(252)**

Financial Performance: Commissioner Income Analysis

Commissioner	FY Target (£'000)	YTD Target (£'000)	CEP Adjustmt	Final Actual (£'000)	Final Variance (£'000)
NHS Eastern Cheshire CCG	8,202	7,501	0	7,242	-259
NHS Eastern Cheshire CCG Community	412	377	0	377	0
NHS South Cheshire CCG Community	16,982	15,559	0	15,559	-0
NHS South Cheshire CCG	100,862	94,998	1,420	94,494	-504
NHS Vale Royal CCG	55,138	51,217	1,315	51,721	504
NHS Vale Royal CCG Community	10,302	9,438	0	9,438	-0
NHS Warrington CCG	248	227	0	263	36
NHS West Cheshire CCG	3,342	3,055	0	3,245	191
NHS West Cheshire CCG Community	191	175	0	175	0
NHS North Staffordshire CCG	1,900	1,739	0	2,159	420
NHS Shropshire CCG	624	571	0	773	202
NHS Stoke on Trent CCG	1,407	1,288	0	1,422	135
Public Health England	1,635	1,498	0	925	-573
NHS Commissioning Board	1,511	1,383	0	1,383	0
Specialist Commissioning Group	8,449	7,743	0	8,185	442
Non Contract Activity	1,767	1,613	0	1,796	182
Cross Border Flows	165	150	0	610	459
Non-Commissioner Specific	7,123	4,556	-1,580	4,550	-6
TOTAL	**220,259**	**203,086**	**1,156**	**204,316**	**1,230**

The South Cheshire and Vale Royal contracts are in line with the agreed CEP value. Against PbR , the Trust is underperforming by £2.4M primarily a result of the profile of the plan being a significant surplus in month 12.

Non Commissioner Specific includes Public Health who commission the Bowel Scope programme and a target for Hep C very high cost drugs which will vary as associated with a small number of patients. (cost budget offset)

Other commissioners, except Eastern Cheshire CCG are showing positive variances related to elective activity in Ophthalmology and General Surgery.

Other Contract Income	FY Target (£'000)	YTD Target (£'000)	YTD Actual (£'000)	Final Variance (£'000)
Bed Based Services	5,951	5,455	5,422	-34
Adult & Neonatal Critical Care	7,884	7,239	7,336	96
Urgent Care Centre	0	0	0	0
Community Paediatrics	1,302	1,193	1,193	0
Direct Access Services	10,245	9,388	8,725	-663
Unbundled Radiology	3,613	3,312	3,195	-116
High Cost Drugs	9,953	9,124	9,152	29
Screening Programmes	1,474	1,351	1,351	0
Audiology	1,057	969	1,048	79
IVF	321	294	239	-56
CQUIN	4,453	3,898	3,362	-536
STF	5,993	5,294	4,335	-959
Community Services	27,805	25,488	25,649	162
CEP	-3,183	-960	1,156	2,116
WINTER FUNDING	0	0	1,212	1,213
Other	3,243	2,817	2,728	-88
TOTAL	**80,111**	**74,862**	**76,103**	**1,243**

Other contract income is showing £1.2M better than plan.

An analysis of the key service lines identifies that this is primarily the result of Direct Access related to medical imaging coding changes and CQUIN.

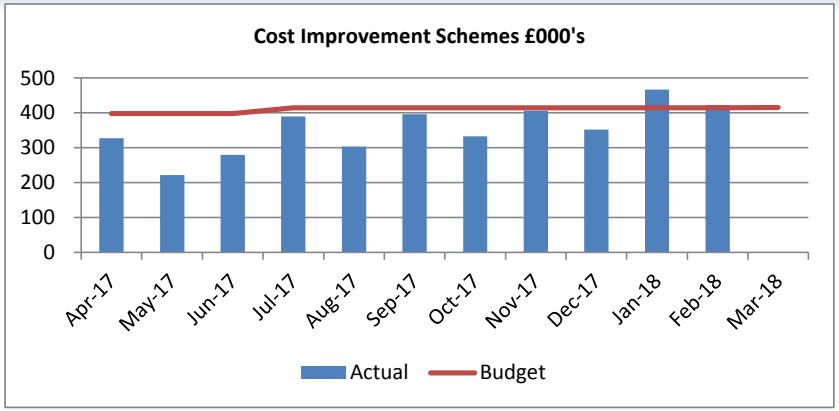
Non-perfromance of the A&E Q3 and Q4 STF trajectory has been recognised.

The impact of the CEP is £2.1M favourable but will unwind in Month 12.

Tranche 1 and 2 winter monies have been accrued. (£1.2M).

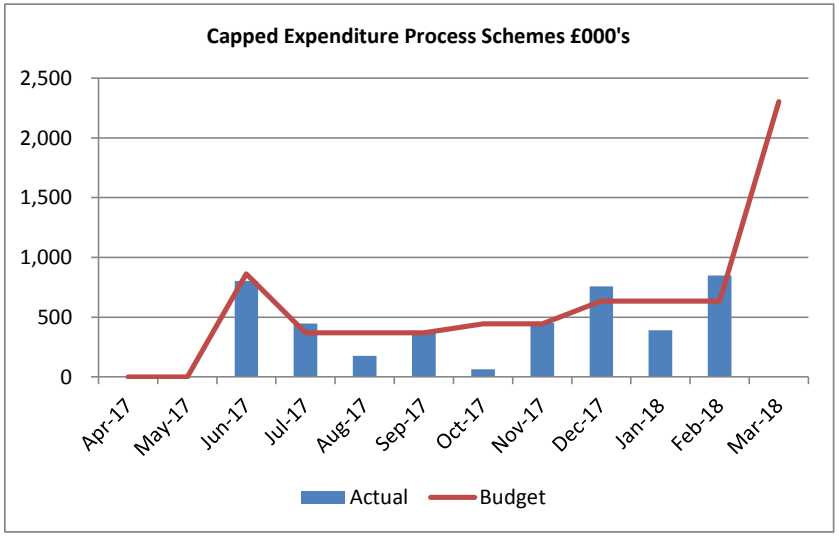
Financial Performance: Efficiencies

Cost Improvement Schemes (£'000's)						
Scheme Category	**YTD Target**	**YTD Actual**	**YTD**	**FY Target**	**FY Forecast**	**FY Variance**
Access & Flow	584	632	32	600	600	0
Back Office	179	136	-43	195	150	-45
Commercial	128	159	30	140	170	30
Drugs	380	335	-45	414	364	-50
Medical Workforce	1,635	1,596	-39	1,783	1,744	-39
Non-Pay Efficiency	312	30	-282	340	33	-307
Nursing Workforce	275	0	-275	300	0	-300
Procurement	688	688	0	750	750	0
Service redesign	367	308	-59	400	333	-67
Total (£'000)	**4,548**	**3,884**	**-681**	**4,922**	**4,144**	**-778**



The Cost Improvement Programme is underperforming on Nursing (use of temporary staffing and e-rostering) and Non-pay efficiency (infusion pump consumables). Mitigation for the e-rostering scheme has been made in the CEP budget re-statement.

Capped Expenditure Schemes (£'000's)						
Scheme Category	**YTD Target**	**YTD Actual**	**YTD**	**FY Target**	**FY Forecast**	**FY Variance**
Acute CEP Diagnostic	90	90	0	100	100	0
Acute CEP ECT Rota	90	0	-90	100	0	-100
Acute CEP Elective*	1,315	1,333	18	2,766	2,931	165
Acute CEP Diagnostic Capacity (	315	315	0	378	378	0
Acute CEP Diagnostic Capacity (	0	0	0	188	188	0
Acute CEP High Cost Drugs	550	367	-183	600	400	-200
Acute CEP Paeds	27	0	-27	30	0	-30
Acute CEP Pharmacy	45	0	-45	50	5	-45
Acute CEP PLCP	90	0	-90	100	0	-100
Acute CEP Tele-Derm	63	63	0	70	70	0
Acute CEP Winter	563	563	0	750	750	0
Acute CEP Interest	90	0	-90	100	100	0
Acute CEP Maternity	0	0	0	100	0	-100
Community CEP (Pay)	437	437	0	479	479	0
Community CEP (Non-Pay)	1,143	1,143	0	1,251	1,251	0
Grand Total	**4,818**	**4,311**	**-507**	**7,062**	**6,652**	**-410**



Capped Expenditure Process schemes are £0.5M worse than plan cumulative as a result of not achieving the full target on High cost drugs, schemes commencing later in the year than planned and some elements still in devleopment or showing slippage. In addition, PLCP will not impact in 2017/18 due to commitments to existing patients and the ECT partner schemes are still under discussion. Interest is set to deliver by the year end. The forecast is £0.4M worse than plan due to winter monies now being secured nationally.

Financial Performance: Capital Report

SCHEME	BOARD APPROVED	FUNDING SOURCE	FUNDING APPROVED	EXPENDITURE	2017/18	2017/18	2017/18 CUMULATIVE ACTUAL	2017/18 BETTER/WORSE THAN BUDGET	2017/18 FORECAST	2018/19 + FORECAST	WHOLE PROJECT ACTUAL TO DATE	WHOLE PROJECT PROPOSED PLAN	TOTAL FORECAST
STRATEGIC INVESTMENTS (Requires individual signoff)													
ESTATES													
DR'S MESS INTO RMO'S	Yes	Internal	Yes		42	42	43	-1	43	0	43	42	43
WARD 11 REFURBISHMENT	Yes	Internal	Yes	1500		0	-48	48	-48	0	1452	1,500	1,452
WARD 16 REFURBISHMENT	Yes	Internal	Yes	854	283	283	285	-2	283	0	1139	1,137	1,137
CAR PARK BARRIERS	Yes	Internal	Yes		60	60	12	48	60	0	12	60	60
CENTRALISED POAC	Yes	Internal	Yes		122	122	122	0	122	0	122	122	122
BISTRO & 2 OFFICES	Yes	Internal	Yes		178	178	25	153	128	58	25	236	186
OPHTHALMOLOGY OUTPATIENTS - PHASE 2	Yes	Internal	Yes	86	249	250	260	-10	260	0	346	335	346
UNDER / OVERS CAPITAL SCHEMES 16/17	Yes	Internal	Yes			0	11	-11	11	0	11	0	11
WARD REFURBISHMENT	Yes	Loan	Yes		4200	4000	207	3793	285	9915	207	14,115	10,200
MRI SCANNER 3RD BUILD	Yes	Internal/Loan	Yes	109	1540	1540	64	1476	69	1476	173	3,125	1,654
WASTE COMPOUND AND SEGREGATION	No	Internal	Not yet approved		250	250	0	250	0	250	0	500	250
BARIATRIC SIDE ROOM	No	Internal	Not yet approved		100	100	0	100	0	100	0	200	100
3RD CT SCANNER BUILD	No	Loan	Not yet approved		850	850	0	850	0	850	0	1,700	850
TOTAL				**2549**	**7874**	**7675**	**980**	**6695**	**1213**	**12649**	**3529**	**23072**	**16411**
IT													
VOICE OVER IP	Yes	Internal	Yes	171	295	295	344	-49	351	200	515	666	722
RADIOLOGY INFORMATION SYSTEM	Yes	Internal	Yes	96	132	132	-10	142	0	0	86	228	96
WIRELESS UPGRADE	Yes	Internal	Yes	6	24	24	26	-2	26	0	32	30	32
PCTI	Yes	Internal	Yes	18	12	12	6	6	12	0	24	30	30
E-HANDOVER	No	Internal	Not yet approved		244	244	0	244	0	244	0	488	244
UNDER / OVERS CAPITAL SCHEMES 16/17	Yes	Internal	Yes			0	5	-5	6	0	5	0	6
PATIENT ADMIN SYS / CORE ELECTRONIC PATIENT RECORDS	No	Loan	Not yet approved		1500	1500	0	1500	0	4500	0	6,000	4,500
EDMS & E NOTES	No	Loan	Not yet approved		1956	1956	0	1956	0	1000	0	2,956	1,000
UPS	Yes	Internal	Yes		150	150	0	150	0	150	0	300	150
CLINICAL PORTAL	No	Loan	Not yet approved		1260	1260	0	1260	0	660	0	1,920	660
Q PULSE	Yes	Internal	Yes		30	30	25	5	25	5	25	35	30
NET CALL / CALL CENTRE	Yes	Internal	Yes	12	13	13	4	9	13	0	16	25	25
HIGH IMPACT STAND ALONE IT SYSTEMS	Yes	Internal	Yes		100	100	77	23	100	400	77	500	500
PACS REPLACEMENT	Yes	Internal	Now Revenue		1590	1590	12	1578	0	0	12	1,590	0
E-PRESCRIBING	No	Loan	Not yet approved		900	900	0	900	0	1360	0	2,260	1,360
VENDOR NEUTRAL ARCHIVE	No	Loan	Not yet approved		605	605	0	605	0	605	0	1,210	605
CREDITS FOR CLEANING SOFTWARE	Yes	Internal	Yes		11	11	0	11	0	0	0	11	0
REPLACEMENT BUSINESS INTELLIGANCE SYSTEM	No	Internal	Not yet approved		80	80	0	80	25	55	0	135	80
SINGLE CLINICAL SYSTEM	No	Loan	Not yet approved							6569	0		6,569
TOTAL				**303**	**8902**	**8902**	**489**	**8413**	**558**	**15748**	792	**18384**	**16,609**
TOTAL STRATEGIC INVESTMENTS				**2852**	**16776**	**16577**	**1469**	**15108**	**1771**	**28397**	**4321**	**41456**	**33020**

The Estates strategic investments capital spend is £6,695K less than the plan. This is mainly due to the build for the third MRI Scanner, the build for the third CT Scanner Waste Compound , Bistro and Offices and Ward 17 refurbishment. Originally the MRI and Ward 17 refurbishment projects are delayed due to the delay in the approval of loans from the DoH. However the Ward 17 refurbishment has now started. The request for the loan application has be approved, and some will be drawn down in March. The business case for the third CT Scanner has still not been approved. The forecast has been amended due to the delay in the Ward 17, third MRI Scanner and the third CT Scanner, and Bariatric sideroom where some of the expenditure has been move to 2018/19.

The IT Strategic investments projects are £8,413K less than plan. This is mainly due to the Vendor Neutral Archive scheme, E-Handover, EDMS, E Prescribing, Clinical Portaland the Patient Adminysystem . The funding for these schemes along with Patient Admin System and some of the IBM Software scheme is proposed to use as one funding stream for a single clinical system. The forecast spend for these has been amendedas itis likely these will be funded through revenue in the following years.. A business case for this proposal is being prepared. In respect of the PACS this has now been approved as revenue and the forecast has been amended accordingly.

Financial Performance: Capital Report

SCHEME	BOARD APPROVED	FUNDING SOURCE	FUNDING APPROVED	EXPENDITURE	2017/18	2017/18	2017/18 CUMULATIVE ACTUAL	2017/18 BETTER/WORSE THAN BUDGET	2017/18 FORECAST	2018/19 + FORECAST	WHOLE PROJECT ACTUAL TO DATE	WHOLE PROJECT PROPOSED PLAN	TOTAL FORECAST
ROLLING ALLOCATIONS (Approved Delegated Budgets)													
ESTATES													
ASBESTOS REMOVAL	Yes	Internal	Yes		150	138	27	110	40	710	27	860	750
DESIGN TEAM	Yes	Internal	Yes		280	257	245	12	280	1120	245	1,400	1,400
CT / VT - HEATING INFRASTRUCTURE	Yes	Internal	Yes		175	155	49	106	50	650	49	825	700
BACKLOG GENERAL PROVISION	Yes	Internal/Loan	Yes		1604	1527	343	1184	804	7550	343	9,154	8,354
TOTAL				**0**	**2,209**	**2,077**	**664**	**1412**	**1,174**	**10,030**	**664**	**12,239**	**11,204**
IT													
STORAGE - DATA ARCHIVING	Yes	Internal	Yes		27	27	56	-29	56		56	27	56
INTERSITE CONNECTIVITY	Yes	Internal	Yes		31	31	-3	34	31	25	-3	56	56
INTERFACING	Yes	Internal	Yes		85	80	13	67	40	155	13	240	195
IT APPLICATIONS	Yes	Internal	Yes		100	100	13	87	50	450	13	550	500
IBM HARDWARE	Yes	Internal	Yes		144	144	90	54	90	54	90	198	144
TOTAL				**0**	**387**	**382**	**169**	**213**	**267**	**684**	**169**	**1071**	**951**
TOTAL ROLLING ALLOCATIONS				**0**	**2,596**	**2,459**	**833**	**1,626**	**1,441**	**10,714**	**833**	**13,310**	**12,155**
ADDITIONAL													
EQUIPMENT	Yes	Internal	Yes		0	0	47	-47	47	0	47	0	47
GP STREAMING ESTATES	Yes	Internal	Yes		0	0	12	-12	12	491	12	491	503
GP STREAMING IT	Yes	Internal	Yes		0	0	55	-55	247	0	55	0	247
COMMUNITY SERVICES	Yes	Internal	Yes		0	0	0	0	200	800	0	800	1,000
LEASING INVESTMENTS													
EQUIPMENT	Yes	Internal	Yes		648	236	236	0	259	0	236	648	259
3RD CT SCANNER	No	Internal	Not yet approved		480	0	0	0	0	480	0	960	480
REPLACEMENT CT SCANNER	No	Internal	Not yet approved		480	0	0	0	0	480	0	960	480
3RD MRI SCANNER	No	Internal	Not yet approved		640	0	0	0	0	640	0	1,280	640
ACCESS CONTROL	No	Internal	Not yet approved		100	0	0	0	100	0	0	100	100
LAUNDRY FINISHING	No	Internal	Not yet approved		56	0	0	0	56	0	0	56	56
OPHTHALMOLOGY EQUIPMENT	No	Internal	Not yet approved		150	0	0	0	0	0	0	150	0
CCTV	No	Internal	Not yet approved		157	0	0	0	157	0	0	157	157
CATERING TROLLIES	Yes	Internal	Yes		180	180	137	43	137	0	137	180	137
TOTAL LEASING INVESTMENTS				**0**	**2891**	**416**	**373**	**43**	**709**	**1600**	373	**4491**	**2309**
TOTAL CAPITAL PROGRAMME (EXCLUDING LEASES)				**2,852**	**19,372**	**19,036**	**2,416**	**16,619**	**3,718**	**40,402**	**5,268**	**56,057**	**46,972**
TOTAL CAPTIAL PROGRAMME				**2,852**	**22,263**	**19,452**	**2,789**	**16,662**	**4,427**	**42,002**	**5,641**	**60,548**	**49,281**

In addition to the strategic capital schemes the rolling and additional schemes are £1,626K less than plan which is mainly due to Backlog Maintenace. The delay has been due to the delay in the approval of the capital loanand two project surveyors down for six months and in addition some long term sickness . The forecast has been amended accordingly. The variance in the the NHSI return is less than above. This is due to the actual carry forwards from 2016/17 being higher than those submitted in the NHSI plan.

The Finance lease forecast has been amended for the third MRI Scanner and the Third CT Scanner and the replacment scanner to reflect the delay in the capital forecast and moved to 2018/19.

Financial Performance: Statement of Financial Position

	Plan Apr to February (£'000)	Actual Apr to February (£'000)	Variance (£'000)	Forecast 2017/18 (£'000)
Assets				
Assets, Non-Current	**96,652**	**80,849**	**-15,802**	**81,935**
Assets, Current				
Trade and other Receivables	3,745	11,101	7,356	9,342
Other Assets (including Inventories & Prepayments)	5,344	5,025	-320	5,284
Cash and Cash Equivalents	5,454	6,166	712	7,877
Total Assets, Current	**14,543**	**22,291**	**7,748**	**22,503**
ASSETS, TOTAL	**111,195**	**103,140**	**-8,054**	**104,438**
Liabilities				
Liabilities, Current				
Finance Lease, Current	-184	-44	140	-1,156
Loans Commercial Current	-7	-401	-395	-460
Trade and Other Payables, Current	-14,805	-14,239	566	-13,910
Provisions, Current	-147	-105	42	-198
Other Financial Liabilities	-9,216	-7,686	1,530	-6,384
Total Liabilities, Current	**-24,359**	**-22,475**	**1,884**	**-22,108**
Net Current Assets/(Liabilities)	**-9,816**	**-183**	**9,632**	**395**
Liabilities, Non Current				
Finance Lease, Non Current	-5,746	-5,785	-39	-4,636
Loans Commercial Non-Current	-20,824	-9,395	11,429	-12,095
Provisions, Non-Current	-1,634	-1,668	-34	-1,582
Trade and Other Payables, Non-Current	0	0	0	**0**
Total Liabilities Non-Current	**-28,204**	**-16,848**	**11,356**	**-18,313**
TOTAL ASSETS EMPLOYED	**58,632**	**63,818**	**5,186**	**64,017**
Taxpayers' and Others' Equity				
Taxpayers Equity				
Public dividend capital	75,157	75,907	750	75,907
Retained Earnings	-26,745	-22,220	4,525	-22,020
Donated asset reserve	0	0	0	0
Revaluation Reserve	10,220	10,129	-91	10,129
TOTAL TAXPAYERS EQUITY	**58,632**	**63,816**	**5,184**	**64,016**
TOTAL FUNDS EMPLOYED	**58,632**	**63,816**	**5,184**	**64,016**

The main reason for the variance is that the plan is the capital programme expenditure being £16,662K less than anticipated which is mainly due to a delay in and the Third MRI Scanner build £1,476K, Third CT Scanner build £850K, Backlog Maintenance £1,185K and Ward Refurbishments £3,793K, . All of these are reliant on capital loan funding which has only been secured in February after the initial application in June 2017. Also in respect of Vendor Neutral Archive £605K, E-Prescribing £900K, EDMS £1,956K, PAS £1,500K and Clinical Portal £1260K these schemes are now part of a wider Clinical system replacement where are Business Case is going thorough an approval process. In addition there are delays in the UPS £150K, Waste Compound and Segregation £250K, E Handover £244k, however these are funded internally. The PAC's project has now been funded via revenue £1,590K. This is offset by an underspend on depreciation of £587K

NHS Trade Receivables are higher than anticipated as there are a number of other outstanding debts. These are Christies Hospital £669K which relates mainly to SLA which has just been signed and a payment has been promised. In addition University of North Midlands NHS Trust £223K, NHS England £546K, Eastern Cheshire CCG £1,441K (1,385K received early March) NHS Property Services £191K, Salford FT £153K, South Cheshire £1,431K and Vale Royal CCG £726K. In addition the Trust are outstanding £1,105K of Quarter 3 STF

Other Assets mainly relates to lower than anticipated prepayments and drug stocks.

Trade and Other Payables - This lower mainly due to lower capital creditors due to the delay in the capital programme and accruals being slightly lower than anticipated .

Provisions mainly relates to the actual opening balance being lower than the plan due to a lower than anticipated increase in provision at the end of 2016/17.

Loans are due to capital loans not been taken out £14,608K. In the plan it was anticipated that £3,574K was paid off on the Interim Revolving Working Capital Loan. However only £1,551K has been paid off and £1,550K remains on a support loan. The payment made on the Interim Revolving Working Capital loan should have been allocated against the support loan which would have been paid off.

Public Dividend Capital is due to the A&E funding not anticipated in the plan.

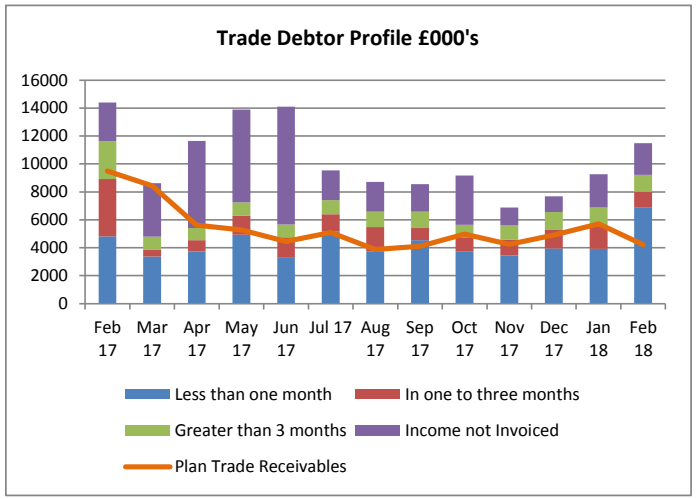
Retained Earnings is due to the late accrual for the Incentive and Bonus STF in 2016/17 of £2,257K and the trust better than anticipated financial position.

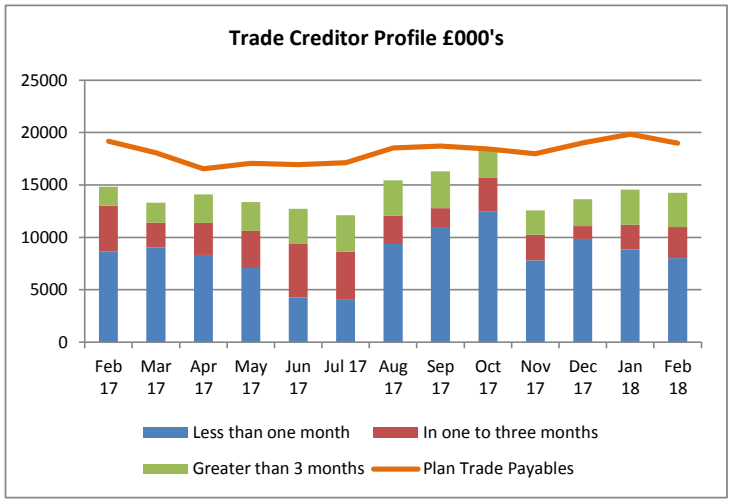
Financial Performance: Cash Position and Working Capital

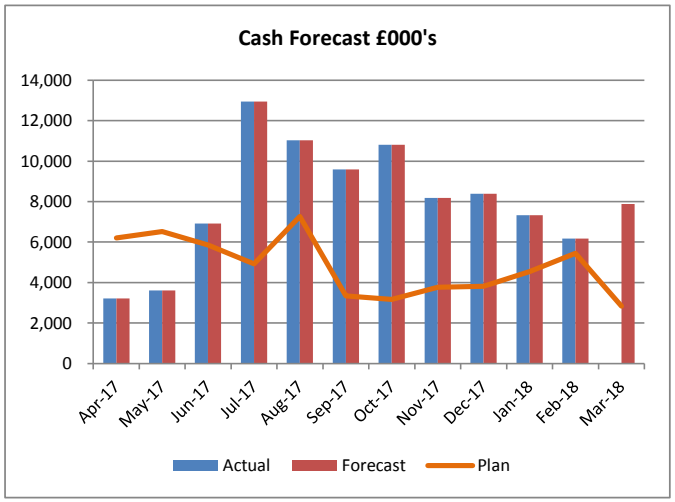
	Plan Apr to Feb (£'000)	Actual Apr to Feb (£'000)	Variance
Surplus/(deficit) after tax	**116**	**1,978**	**1,862**
Non-cash flows in operating Surplus/(deficit) total	5,316	4,708	-608
Operating cash flows before movements in working capital	**5,432**	**6,686**	**1,254**
Increase/(Decrease) in working capital Total	4,631	1,732	-2,899
Net cash inflow/(outflow) from operating activities	**10,063**	**8,417**	**-1,645**
Net cash inflow/(outflow) from investing activities total	-16,249	-3,545	12,704
Net Cash inflow/(outflow) before financing	**-6,186**	**4,873**	**11,059**
Net cash inflow/(outflow) from financing activities Total	5,789	-4,354	-10,143
Net increase/(decrease) in cash and cash equivalents	**-397**	**519**	**916**
Opening cash balance	**5,850**	**5,647**	**-203**
Closing cash balance	**5,453**	**6,166**	**713**

Cash is £713K better than anticipated. This is mainly due to the delay in repaying part of the Interim Revolving Working Capital loans and Support loans £3,573K. In addition the Operating Surplus is £1,862K better than planned but this is offset by depreciation being 587K less than plan. Also the movment in working capital is £2,899K less than anticipated due to the lower than expected increase in creditors and an increase in debtors which is expected to reverse in March.

The capital programme is £12,704K less than expected, this includes the movement in capital creditors. However this is offset by £14,603K capital loans not drawn down. A loan of £4,300K has been approved, with some being . In addition the Trust has received £750K PDC is wasn't expecting in the Plan fro the A&E Streaming project







Finance: *Staff Costs*

Headline Measures

	YTD £000's	Rolling 13 months £000's													
		Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Monthly Trend
Pay Budget	151,500	12,345	12,385	13,770	14,030	13,678	13,577	13,688	13,730	13,774	13,799	13,721	13,916	13,817	
Pay Actual	152,461	11,997	12,331	13,549	14,070	13,715	13,649	13,843	13,875	13,947	13,826	13,692	14,278	14,017	
Variance	-961	348	55	221	-40	-37	-72	-155	-145	-173	-27	29	-362	-200	
% to Budget	*100.6%*	*97.2%*	*99.6%*	*98.4%*	*100.3%*	*100.3%*	*100.5%*	*101.1%*	*101.1%*	*101.3%*	*100.2%*	*99.8%*	*102.6%*	*101.4%*	
Nursing Staff % to Budget	102.1%	100.5%	98.7%	101.8%	104.4%	99.8%	102.5%	97.5%	99.3%	101.6%	102.9%	102.4%	105.9%	104.7%	
Medical Staff % to Budget	99.2%	90.4%	99.5%	90.5%	101.9%	98.8%	98.0%	108.2%	103.5%	102.6%	97.4%	95.3%	98.5%	97.1%	
Other Staff % to Budget	100.0%	98.7%	109.3%	100.1%	95.1%	101.7%	100.1%	100.9%	101.4%	100.1%	99.1%	99.8%	101.6%	100.7%	

Commentary

Figures exclude Community Services for 2016/17

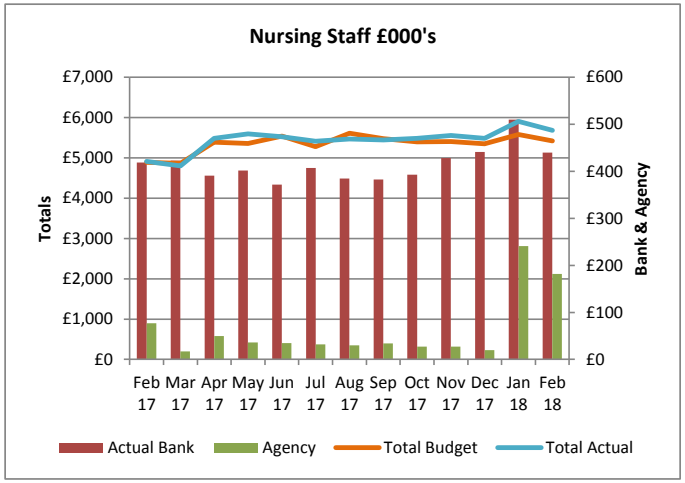
Pay is worse than budget by £1.0M as at Mth 11.

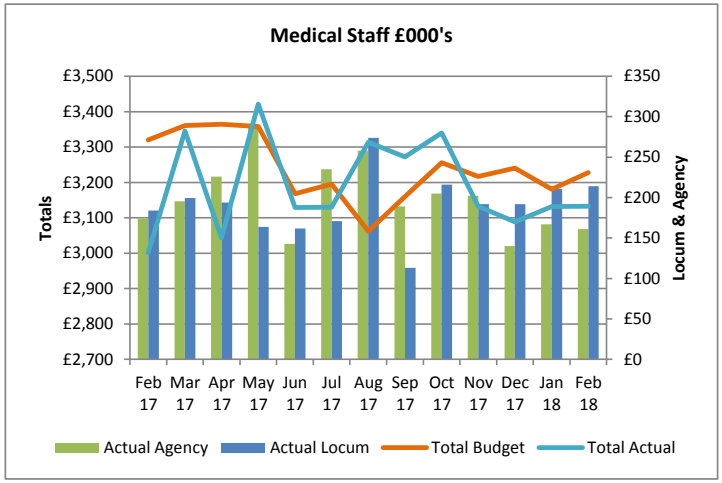
Nursing costs are higher than plan in Emergency Care as a result of Acuity and escalation capacity related to winter plans. Nursing vacancies have started to rise in recent months . Nursing Agency spend is higher than the run rate as a result of use of high cost agency to staff escalation capacity. Bank use over establishment for HCAs continues to support one to one patient supervision and is a financial pressure.

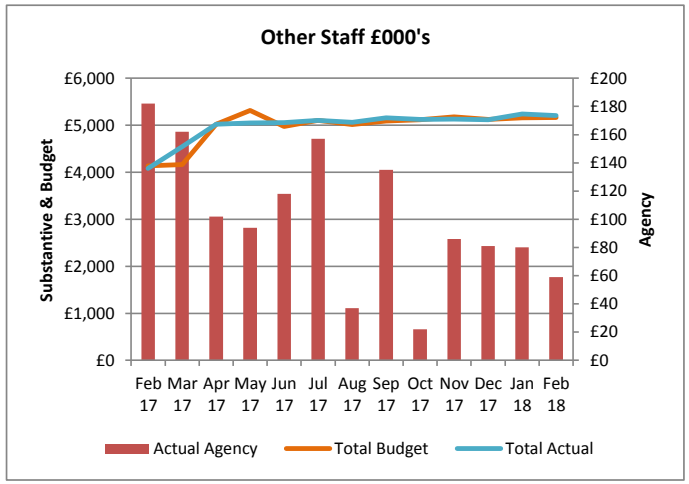
Medical pay is better than budget cumulative. However, better than previous allocations of junior doctors have been recieved. In month, an improved position is the result of less waiting list initiatives being run.

The Agency trajectory is back on plan in month despite high use of Nurse agency to staff escalation beds. Cumulative the Trust is better than the trajectory by £1.2M mainly as a result of the reclassification of locum costs in 2017/18 and reduced Nursing agency costs earlier in the year.

Primary Drivers

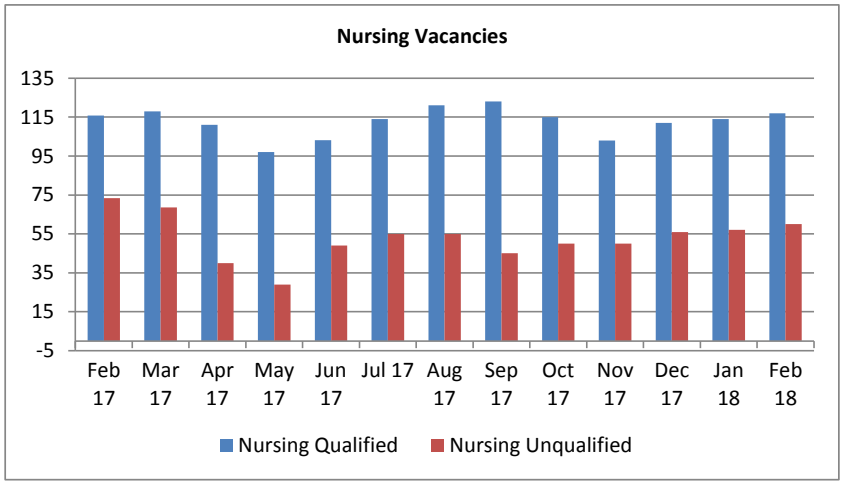


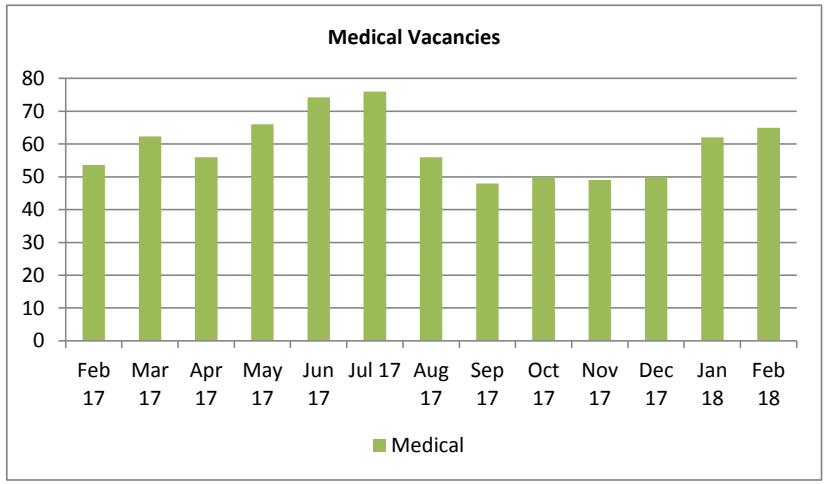




Finance: *Staff Costs*

Secondary Drivers





Agency Trajectory

	YTD	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Monthly Trend
Plan	-5,142	-470	-484	-482	-518	-472	-579	-510	-451	-433	-426	-423	-424	-424	
Actual	-3,898	-618	-574	-378	-419	-296	-424	-325	-358	-254	-315	-240	-488	-401	
Variance	1,244	-148	-90	104	99	176	155	185	93	179	111	183	-64	23	
CCICP Actual	0	4	-77	0	0	0	0	0	0	0	0	0	0	0	

From 17/18, CCICP are included in the main figures above.

	Rolling 13 Months												
	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Monthly Trend
Sickness Rate (Rolling 12 mths)	3.95%	3.92%	3.97%	3.99%	4.04%	4.07%	4.14%	4.20%	4.21%	4.23%	4.25%	4.28%	4.28%	
Total Leavers	27	42	31	37	35	45	45	54	45	42	35	45	34	
Turnover (Rolling 12 mths)	9.09%	9.27%	10.69%	10.88%	10.52%	10.12%	10.57%	11.10%	11.08%	10.93%	10.71%	10.70%	10.66%	

Mid Cheshire Hospitals
NHS Foundation Trust

Title of Paper :	Update Report – Trust Strategy 2017/18 with 2020 / 2021 Horizon	
Author:	Denise Frodsham	
Executive Lead:	Denise Frodsham (Chris Oliver following approval of this paper)	
Type of Report:	Concept Paper	
	Strategic Options Paper	
	Business Case	
	Information	X
	Review/Benefits/Audit	

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

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

Positive Benefit:	To provide the Trust Board of Directors assurance as to the progress of the Strategy Implementation and CCICP Plan
Risk:	External factors arise that impact on the delivery of the strategy

To be published on Trust Website –complete version	***Y*** *(delete as appropriate)*
If no, to be published on Trust Website – redacted	***N*** *(delete as appropriate)*
If not to be published complete or redacted, please detail the reason why	
Presented at Board Meeting of:	3rd April 2018

1. Background

The Trust Strategy 2017/18 with 2010/2021 Horizon was approval by the Trust Board of Directors in November 2017, subject to minor grammar amendments. The Board had considered the process by which the strategy has been created noting the high level of engagement by staff, stakeholders, Governors and the Board itself at away days.

The next steps to communicate and implement the strategy to the Trust and to external audiences were also noted as well as the requirement for Divisions to develop detailed action plans behind each plan on a page.

It was recognised in November 2018 that the CCICP plan on a page whilst in draft also encompassed the CCICP vision, principles, values and behaviours of the partnership as well as the objectives going forward and that this work was being supported by NHS Improvement (NHSI) to the Partnership Board development.

This paper therefore provides a summary of the communication and implementation to date of the Trust strategy provides the CCICP plan including the additional information specific for the development of community services and its teams (Appendix 1) and advises of next steps in relation to the detailed action plans being developed by each Division against which progress will be monitored.

The next Trust Board of Directors strategy update will be provided in October 2017 as a progress report

2. Implementation Plan

The following table details the communication plan which has been updated with progress to date and highlights the next actions to complete the roll out of the Strategy

‘Trust Strategy’ - Communications Plan					
Channel	**Lead**	**Action**	**Target Date**	**RAG rating**	**Update/Notes**
Website	Comms lead	• Following approval, update ‘About Us’, ‘Vision and Strategy' and 'Values and Behaviours’ sections • Run searches on site for changes required	9 February 2018		Complete
Chief Executive Briefing	Comms lead	• Briefing to launch the Strategy • Direct staff to full document (website) • Inform staff of 'packs' to be distributed	9 February 2018		Complete
Intranet	Comms lead	• News item on launch • Article to be repeated throughout launch • Run searches on intranet and replace old documents	w/c 12 February 2018		Article has been published to the intranet signposting staff to the website's strategy page. The article can then be republished at regular intervals

NHS Choices Branding	Comms lead	• Review information to ensure it reflects new strategy and values and behaviours	w/c 12 February 2018		The Trust's NHS Choices pages were scanned and there were no mentions of Trust Strategy/vision. There's now the opportunity to edit the pages to ensure this is included.
Branding	Comms lead	• Suite of materials and templates using NHS branding guidelines and Trust strapline • To include letterheads and PowerPoint • Items to be saved in central location along with new Trust logo	23 February 2018		A suite of materials have been designed and approved, including business cards, pull-up banners, posters, email signatures and screensavers. The Trust is currently waiting for delivery (expected 22 March - 26 March) in order to distribute printed items.
Posters	Comms lead	• 3x posters ('packs') to be distributed Trust wide • Values and behaviours, divisional objectives, Trust objectives • Email to SMTs and Managers - support to raise awareness of new Strategy and to place posters in prominent locations • Packs attached to email, also in pigeon holes. Additional printed on request	w/c 26 February / 5 March 2018		Posters have been designed and are now due for delivery. Once received they will be distributed across the Trust and SMTs emailed for support
Display boards	Comms lead	• Values and behaviours posters to be added to Trust's main display boards • Ensure Victoria Infirmary, Elmhurst and CCICP sites included	w/c 5 March 2018		Posters have been designed and are now due for delivery. Once received they added to main display boards
Trust Update	Comms lead	• Launch article on Trust Strategy • To incorporate values and behaviours poster	w/c 5 March 2018		Article has been scheduled for 4 April edition and will include a design of the new values and behaviours and instructions for staff to upload new email signatures and to ensure the distributed posters are in central locations in their areas

Screensavers	Comms lead	• Values and behaviours poster adapted for computers • Permanent - to replace existing slide • Explore possibility of simple slide for overall Trust strategy to improve awareness	w/c 5 March 2018		Complete - old values and behaviours screensavers have been removed and replaced with new designs. A new vision screensaver has also been created.
Payday Press	Comms lead	• Article on Trust Strategy • Different focus to Trust Update	March/April edition		
GP Link	Comms lead	• Short article on new Trust Strategy	March/April edition		On track for completion and distribution at the end of March
Social media	Comms lead	• Facebook and Twitter posts to inform public (and staff) of new Strategy • Link to updated web pages	March 2018 (and then ongoing)		First public posts to follow the launch of posters and designs to staff. On track.
Chief Executive Briefing	Comms lead	• Consider additional briefing on Strategy to coincide with New Year/round-up of 2017	April 2018		
All Together	Comms lead	• Article, possibly incorporated into welcome story, on new Trust strategy	April/May edition		
Events	Comms lead	• Consider incorporating Trust Strategy into future events, such as Forward Thinking			Strategy has been included as part of CEO monthly Chief Executive Engagement sessions, as well as divisional engagement.
Induction	L&D	• Review staff induction materials to ensure new Strategy is reflected • To include Staff Handbook	March/April 2018		Strategy to be reflected in the new staff handbook, which is currently being updated.
Recruitment	Recruitment Manager	• Review job adverts and descriptions to ensure new Strategy is reflected	March/April 2018		

Appraisals	Comms lead/Assistant Director of Education and OD	• Review appraisal documents and process to ensure new Strategy is reflected	March 2018		Complete - a new appraisal front sheet has been developed incorporating the new Trust Strategy and has been distributed.
Patient Information	PPI/Comms Lead	• Review patient information to ensure new strategy is reflected • To include bedside folders, patient letters and patient leaflets	TBC		
Survey	TBC	• Consider Trust survey/engagement to determine staff awareness of Strategy	Q2/Q3 2018/19		

3. CCICP

Following initial discussions with CCICP staff it was agreed to combine the domain objectives with wider information regarding the partnership aims and vison, values, principles and behaviours. Whilst the domain plan on a page has been incorporated now into the overall Trust strategy, the complete CCICP document is included within Appendix 1 for information.

A wide range of engagement sessions have taken place with CCICP staff and this document was approved by the Partnership Board in March 2018. It will now be used to detail the work programme for CCICP for the coming 3 years, subject to annual review and refresh.

4. Next Steps

Monitoring progress against the Strategy will occur through a variety of routes but predominately through the development of Divisional / CCICP and Corporate work programmes which will be overseen and managed through the Trust performance management and risk management frameworks with Executive Team oversight, and assurances to Board Sub-Committees and ultimately Board of Directors.

The next progress report will be presented to the Trust Board of Directors in October 2018 in line with the agreed bi-annual scheduling. The Strategy will undergo a review and be refreshed by the Board of Directors on a minimum of an annual basis; this is planned for April 2019.

Appendix 1 – CCICP

Mid Cheshire Hospitals NHS Foundation Trust

CCICP Overview

Following initial engagement with staff regarding the CCICP Plan on a Page, it has been requested that the plan be presented in a more extended user friendly format so that it can be shared and discussed amongst our wider workforce teams and used as a live usable document.

This plan therefore expands the CCICP Plan on a Page and details for CCICP our

- Partnership Aims.
- Partnership Vision for CCICP Services
- Confirms our agreed Principles and Behaviours
- Details Partnership priorities for 2017/18-2020/21,

The plan highlights key information about how we will continue to improve the quality of care to our patients whilst working within a financially sustainable environment.

Feedback regarding the plan also recognises that the priorities and strategic domains focus largely on our clinical priorities and service developments supported by our back office functions and infrastructure developments.

We will therefore support this plan with a detailed work programme for each Care Community Team, CCICP Specialist Services including paediatrics and our Support Services including our administration teams, to bring the priorities into each team and to each individual through appraisals and ongoing service improvement programmes of work.

CCICP Partnership Aim

'To Transform, Develop and Deliver Health Care Services in the Community that are focused on Delivering High Quality, Person Centred Care'

CCICP Partnership Vision

- ✓ *That care and support is integrated, Person Centred, coordinated and tailored to the needs and preferences of the individual Service User, their carers and family.*

- ✓ *That service's will move away from episodic care and into a more holistic approach to health, care and support needs that puts the needs and experience of Service Users at the centre of how services are organised and delivered.*

- ✓ *That integration revolves around individuals and communities having a better experience of care and support, experiencing less inequality and achieving better outcomes, with the concept of the individual being at the heart of integrated care and support and being the 'organising principle' for provision of the Services.*

CCICP Partnership Principles & Behaviours

- ❖ Collaborate and work together on an inclusive and supportive basis with optimal use of individual and collective strengths and capabilities;
- ❖ Engage in decision making so that all the partners participate in decisions that affect the strategic direction of CCICP and/or the Services, including service redesign and in establishing the direction, culture and tone.
- ❖ Make decisions on a Best for Service basis including workforce planning, strategy, finance and governance
- ❖ Provide excellent Services and outcomes for patients;
- ❖ Be accountable to each other in respect of financial and operational performance.
- ❖ Deploy appropriate resources within respective roles and responsibilities, and make efficient use of those resources;
- ❖ Communicate openly about major concerns, issues or opportunities through the governance structure.
- ❖ Act in a way that is best for the delivery of the Services, and do so in a timely manner
- ❖ Work with stakeholders effectively, following the principles of co-design and co-production.
- ❖ Adopt a transparent approach at all times.
- ❖ Adhere to statutory requirements and best practice at all times.
- ❖ Act reasonably and in good faith to support the delivery of the objectives, and compliance with these Principles.

CCICP Priorities for 2017/18-2020/21

Domain One – Delivering Outstanding Clinical Quality, Safety & Experience

- To aspire to the delivery of Outstanding clinical quality and safety, which is equitable, person and family centred and supported by an effective quality governance framework
- To drive continuous quality improvement and promote research and innovation.

Agreed Priorities

- ✓ Work with Primary Care, Mental Health, Social Care and Acute colleagues to develop priorities for Care Communities that delivers enhanced support to frail and elderly patients, those with mental health and wellbeing issues and those with long term conditions, using new integrated pathways that support patients to remain in the community whether that be home or care homes, as well as supporting earlier and safe discharge where hospital admission has been necessary.
- ✓ Implementing a new model for GP OOHs service that is affordable and sustainable based on results of the service review and that meets service user need
- ✓ Agree and implement new pathways for Musculoskeletal Physiotherapy Service as agreed with Commissioners and in line with recent service review
- ✓ Work with colleagues to improve the delivery of Palliative Care / End of Life services through improved identification of palliative patients and appropriate allocation of staffing resources across community care to deliver a coordinated and streamlined approach that supports preferred place of care
- ✓ Work to develop enhanced services for children, young people and their families including those with learning disabilities, supporting out of hospital care, care closer to home and high quality care across all services including those patients with specialist needs

Domain Two – Being a Leading Partner in a Progressive Health Economy

- To fully engage with all strategic partners to maximise the opportunities and advantages associated with horizontal integration in the designing and delivery of sustainable health services for the population of Central Cheshire
- To work with key stakeholders to deliver a wholly integrated health and social care system, taking on a clear collective responsibility for resources and population health, so that our residents receive better coordinated care within the designated financial envelope

Agreed Priorities

- ✓ Through the Home First principal and in line with CCICP Vision, review the opportunity to expand the potential for shared and integrated working where efficiency, duplication and enhanced service provision can be delivered across organisations. This incorporates for example: joint procurement, shared posts, joined up working.
- ✓ Develop and implement a transformation programme that supports the work of CCICP priorities as well as becoming the enabler to the development of an accountable care system
- ✓ Engage and support the use of clinical senates with patients and health partners to create systems that promotes self-care and prevention, uses funding effectively to optimise patient outcomes and supports sustainability of locally delivered services

CCICP Priorities for 2017/18-2020/21 (Continued)

Domain Three – Striving for Outstanding Organisational Effectiveness

- To ensure full compliance with the NHS Improvement provider licence ensuring financial sustainability, financial efficiency and financial controls, whilst safeguarding the quality of our services
- To Maintain compliance with and aspire to achieve the incremental improvements against the NHS Improvements Single Oversight Framework Operational Performance Metrics, whilst safeguarding the quality of our services

Agreed Priorities

- ✓ Meeting key national targets and standards including those in the NHS constitution including equitable access and service provision
- ✓ Working with partners to bring the health economy back into financial balance through CCICP contribution to the Capped Expenditure Programme
- ✓ Demonstrate Well Led organisation progressing towards Outstanding Care Quality Commission (CQC) ratings
- ✓ Using the IT development programme implement live and robust data information systems to evidence compliance against standards, improved patient outcomes and further opportunities.

Domain Four – Aspiring to Excellence in Practice through our Workforce

- To expand our cadre of patient centred leaders with the ability to continually promote and build upon our open and honest culture by sharing the vision, values, behaviours and objectives from board to care environment
- To develop a flexible and responsive workforce to meet patient needs
- To ensure our staff feel valued and recognised for the work they do whilst being supported to maintain their own health and wellbeing, thus enabling the provision of outstanding quality of care and services

Agreed Priorities

- ✓ Develop both clinical and support staff to have confidence to work within professional boundaries and governance but within a more liberal licence to operate framework ensuring that 'doing the right thing' is at the forefront of everything we do.
- ✓ Develop and implement workforce and organisational development strategies, with detailed implementation plans that ensures we have a fit for purpose workforce that is mobile, flexible, highly skilled and culturally aligned to the values and behaviours that CCICP is aspiring to.
- ✓ Develop and implement sustainability plans, including a training programme for an increased Practitioner and Associate Nurse workforce by reviewing patient's health care needs against the skills and competencies of our staff as well as investing in supervision and CPD for all staff
- ✓ Develop a robust 7 day service plan to make equitable the service offer, through review of the current provision and development of a plan on a service need basis.
- ✓ Monitor and trend HR metrics and other workforce intelligence such as staff survey and engagement feedback, training, appraisals, sickness and turnover to improve staff wellbeing and motivation

CCICP Priorities for 2017/18-2020/21 (Continued)

Domain Five – Creating 21st Century Infrastructure for Transformative Health and Social Care

- To deliver an agreed, costed and phased Estates Strategy which will make the best use of the Trust's estate taking into consideration national and regional agendas, in particular the strategic aim to become an accountable care system
- To deliver an agreed, costed and phased Information Technology (IT) Strategy which supports the provision of seamless, integrated, outstanding patient care, improves staff experience in delivering care and enables continuous quality and service improvements through the intelligent use of secure, real time data.

Agreed Priorities

✓ Work with partners to maximise the utilisation of the estate across the health economy. Ensure co-location of care community teams with primary care services where possible

✓ Support the delivery of the CCICP IT strategy, ensuring delivery of a fit for purpose solution that maximises the benefits of a mobile workforce and ensuring application and use of all modern technological advances where applicable.

CCICP Partnership Board

Date/time: Thursday 15th February 2018

Venue: Boardroom, Ashfields PCC, Sandbach

Chair: Tim Welch, Director of Finance, CWP

Action Notes: Julie Manslow – PA to Senior Management Team (CCICP)

Quorate (Y/N): Yes

No.	Item			
	Present	Mr T Welch ***Chair***	**(TW)**	Director of Finance, CWP
		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
		Dr P A Dodds	**(PAD)**	Medical Director & Deputy Chief Executive. MCHFT
		Mr M Oldham	**(MO)**	Director of Finance & Strategic Planning, MCHFT
		Ms K Moore	**(KM)**	Operational Lead, CCICP
		Mr A Styring	**(AS)**	Director of Operations, CWP
	In attendance	Miss Julie Manslow (Notes)	**(JM)**	PA, CCICP
	Apologies	Dr Anushta Sivananthan	**(NS)**	Medical Director, CWP
		Mrs D Frodsham	**(DF)**	Director of Strategic Partnerships, MCHFT
		Mrs T Cookson	**(TC)**	Clinical Director (Nurse) SC/VR GP Alliance
		Mrs S Hamman	**(SH)**	Head of Quality, Nursing and Professional Leadership, CCICP

Circulation: Mrs D Frodsham -Director Strategic Partnerships, 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	Action	Responsible	Due date
1.	**Welcome and Apologies**	Apologies were noted for NS, DF, TC and SH.			
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 the last meeting**	The minutes of the previous meeting (18th January) were reviewed for accuracy and were approved following minor changes to point 13 AOB:- to be confirmed by JP.	JP		
4.	**Matters Arising/Action Tracker**	The Board reviewed and approved the rolling action log.			
5.	**NHSi Actions**				
5.1	Care Communities – Proposed Approach	There was discussion around the differential size of the Care Communities across Central and Eastern Cheshire. It was noted that there will be eight integrated teams aligned to GP cluster within the five Care Communities (the larger 3 having 2 teams each). It was acknowledged that there may not be equitable allocation of GP lead resource and NP suggested this needed to be looked at. NP to discuss with SMASH locality meeting this afternoon and also with NS.	NP		
5.2	Community Hubs - Workplan				
6.	**Patient Story**	A video clip was discussed in which a current diabetic patient spoke about the positive support he had received from the specialist diabetic team based at Earnswood Medical Centre in Crewe following referral from his GP.			
7.	**Finance**				
7.1	**CCICP Income & Expenditure**	The forecast is now expected to achieve better than the budget break even position.		MO	

8.	**Transformation Programme**	SK presented a transformation update. MSK work stream is currently at red due to communication re new SPA service – this is being addressed. Home First is currently on track. EMIS contract now signed, implementation plan to be finalised It was noted that over 90 people have attended OD sessions so far with overwhelmingly positive feedback. The £5k provided to support delivery of OD sessions is due to end in March 2018. The Board approved funding for a further six months with a formal progress review requested after three months. Quality work stream close down report completed and recommendations taken on board. GPOOHs new model progressed to implementation phase, on track. GP Recruitment and retention strategy to progress to implementation phase. Frailty task and finish group to be created. DF to highlight a MCHT clinical representative at the Home First Steering Group to represent frailty.	DF	SK	
8.1	Workstream Highlight Reports	Report was noted.			
9.	**Performance & Quality Reports**				
9.1	Balanced Scorecard				
	Highlights:-	No serious incidents for the second month running and it was recognised that following national guidance grade 3 and 4 pressure ulcers were being reported differently and only Steised if following peer review were avoidable. GPOOHs KPI “assessment within 60 mins for routine patient at Leighton site” not achieved 95% for December. Pertained to 3 patients performance affected by a numbers of drop ins. All current vacancies are being progressed through ECF. Staff safeguarding training position has improved within the last month and level 3 compliance is now recorded at 80% completion and level 2 at 50-80% completion across all services. Full compliance is expected by the end of March 2018.		KM KM	
9.2	Quality, Safety & Experience Report	Report was noted.			
9.3	Integrated Governance Monthly Exception Report	Report was noted.			

9.4	CQUIN Quarter 3 Report	All milestones met.			
10.	**Operational Lead's Report** **Highlights:-**	A issue was highlighted that the Continence Service have not been compliant with NICE guidelines and ensured all patients in receipt of products have been reviewed annually. This presents both clinical and financial risks and will be added to the risk register. Clinical risk is in relation to potentially ill fitting products causing chaffing and pressure ulceration. This is mitigated as patients do have contact number for the service and are told to contact if issues arise, they may also be known to the community nursing service who who routinely review skin integrity as part of holistic assessment and review. No incidents to date have highlighted continence products as a cause of pressure ulcer ration or skin irritation. Work is progressing to identify all patients who have not had a review in the last 1 year – potentially 1700 although this is expected to reduce once a data cleansing exercise has been completed which will remove RIPs and ensure the database accuracy. It is to be noted that this has been found to be a historic problem and dates back to service provision under East Cheshire Trust although this was never highlighted as part of the transfer of services and due diligence. This was also not raised by a previous Service Manager has been uncovered now by a temporary Service Manager overseeing the Service. An action plan is in place to address completion of reviews following cleansing of the data (additional hours have been sanctioned to clear the backlog) and to put new process in place to ensure the issue does not arise in the future. Harmanns are carrying out reviews for Care Home patients in conjunction with CCICP staff (confirmed by KM after the meeting). Tom Challinor (CCSM SMASH) has identified a manual handling trainer – costs to be confirmed.		KM	
11.	**Any other business**	None to record.			
	Next Meeting: **Date:** Thursday 15th March **Time:** 9am – 11:30am **Venue:** Board Room, Ashfields, Sandbach				

Mid Cheshire Hospitals
NHS Foundation Trust

Title of Paper :	Board Effectiveness Survey – Governors Results	
Author:	Katharine Dowson, Trust Board Secretary	
Executive Lead:	Tracy Bullock	
Type of Report:	Concept Paper	
	Strategic Options Paper	
	Business Case	
	Information	x
	Review/Benefits/Audit	

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

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

Positive Benefit:	Demonstrates that the Board is listening and engaging with Governors
Risk:	None

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:	**3 April 2018**

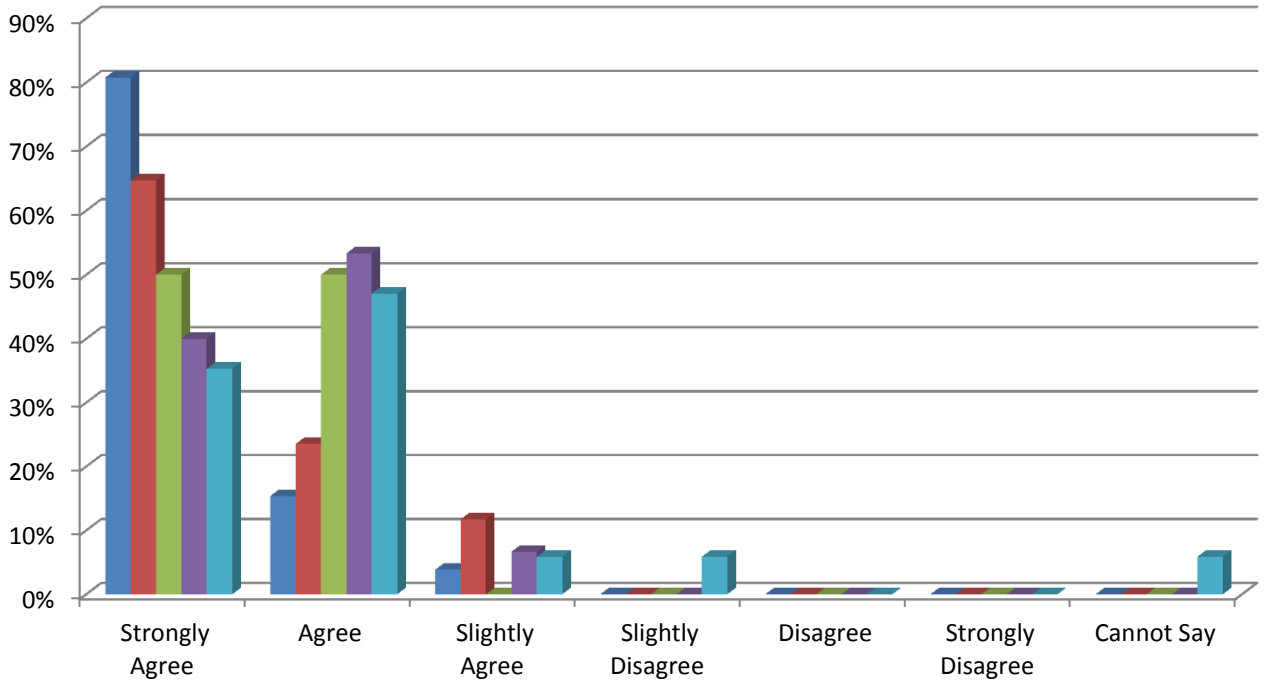
Board Effectiveness Survey

Governors Results

26 responses out of 27 possible (96.3%)

(2017 17 responses (60.7%)

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

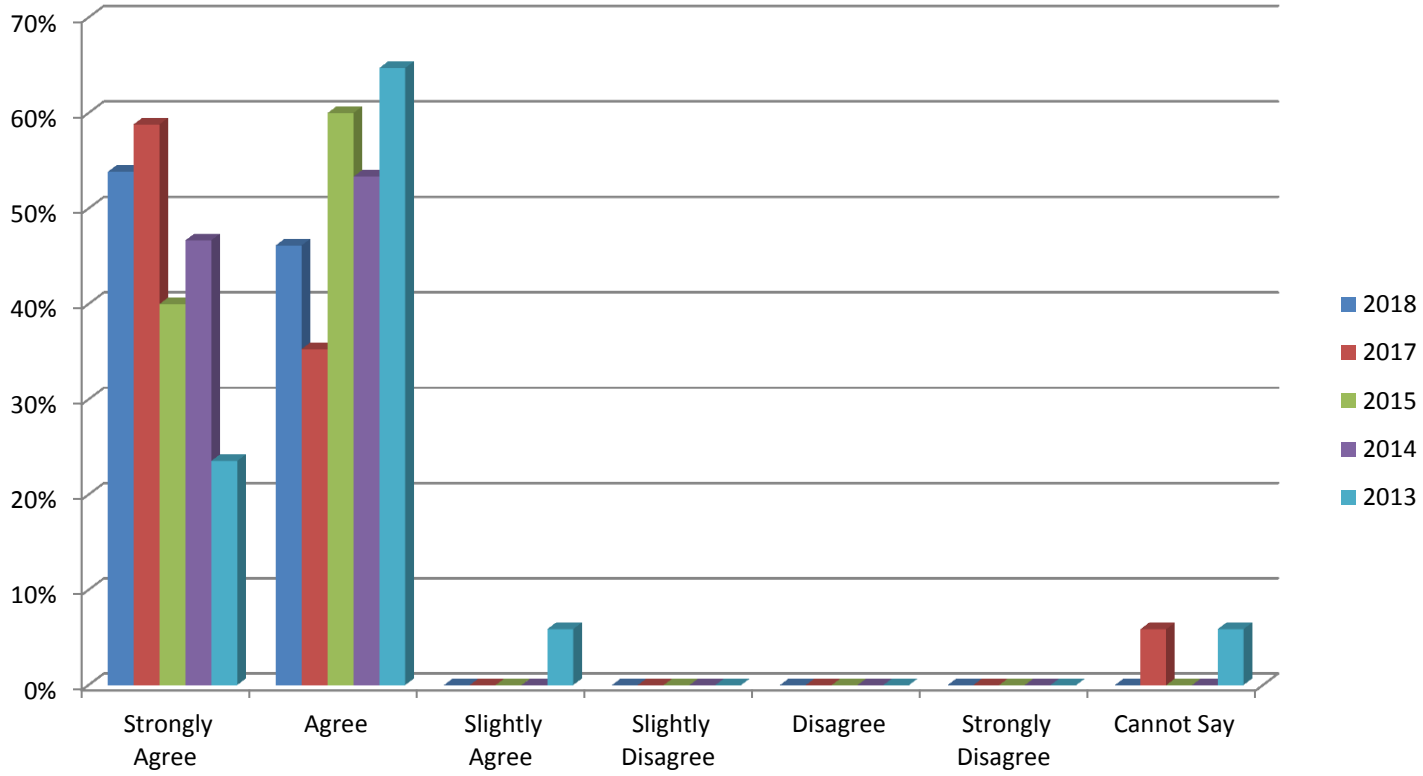


"Presentations by Directors have always been driven by the need to ensure patient care".

"They all strive hard to ensure that the Trust provides a high standard of healthcare for our patients . Their commitment is truly to be admired !!"

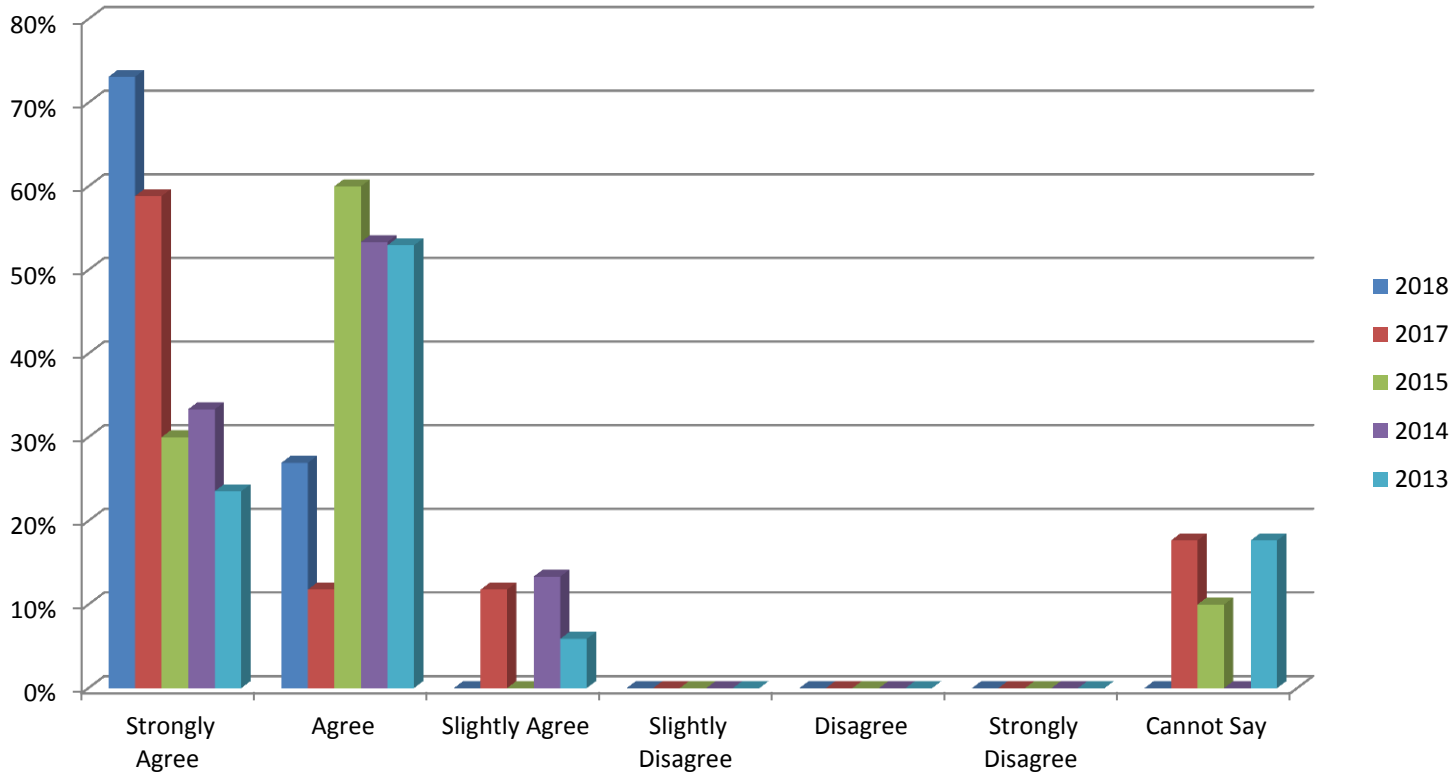
"This has been demonstrated time and again at the Board meetings I have observed."

2. From what I observe, Directors seem to work well together.



"Very professional team atmosphere with collective responsibility."

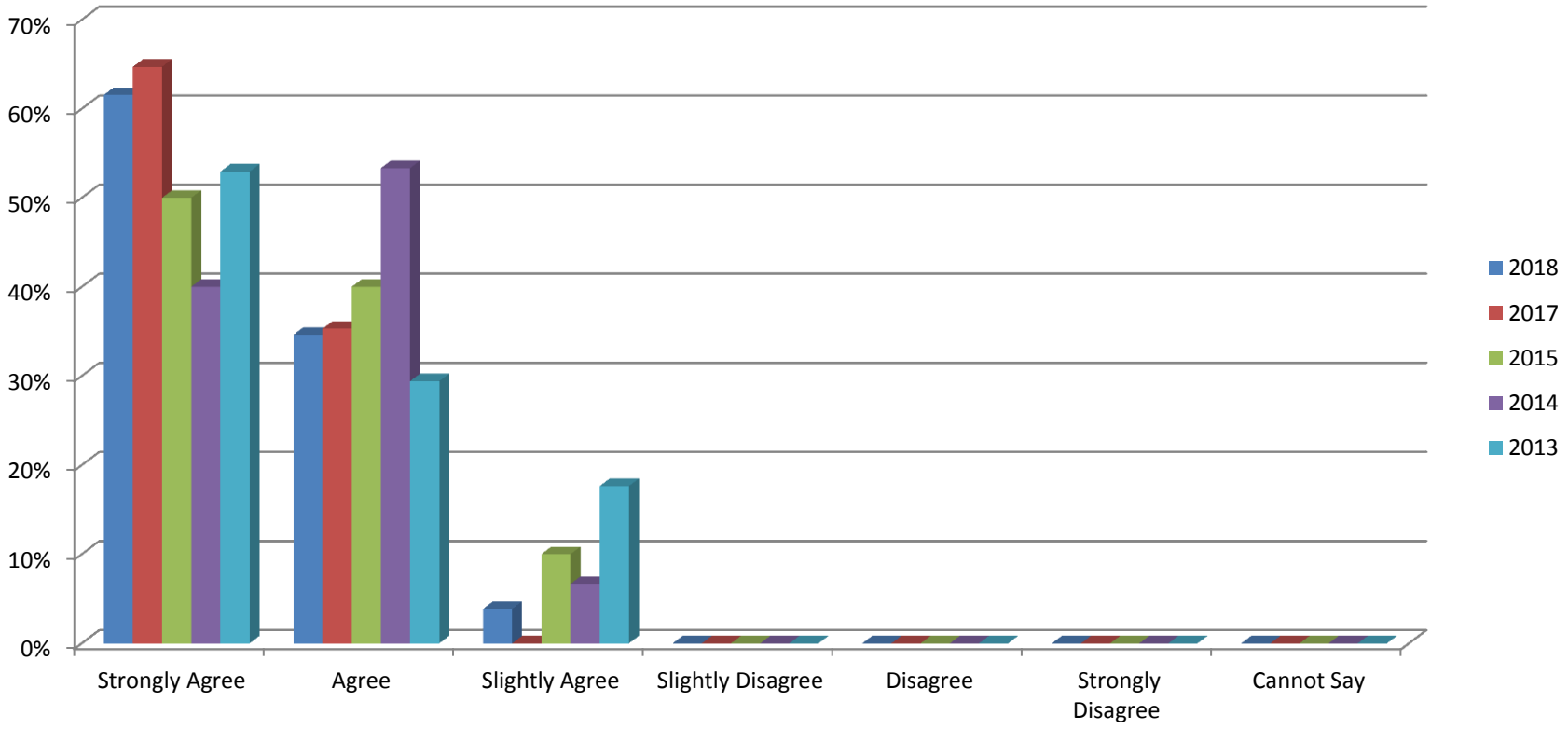
3. Individual Executive and Non-Executive Directors on the Board of Directors appear to be highly capable.



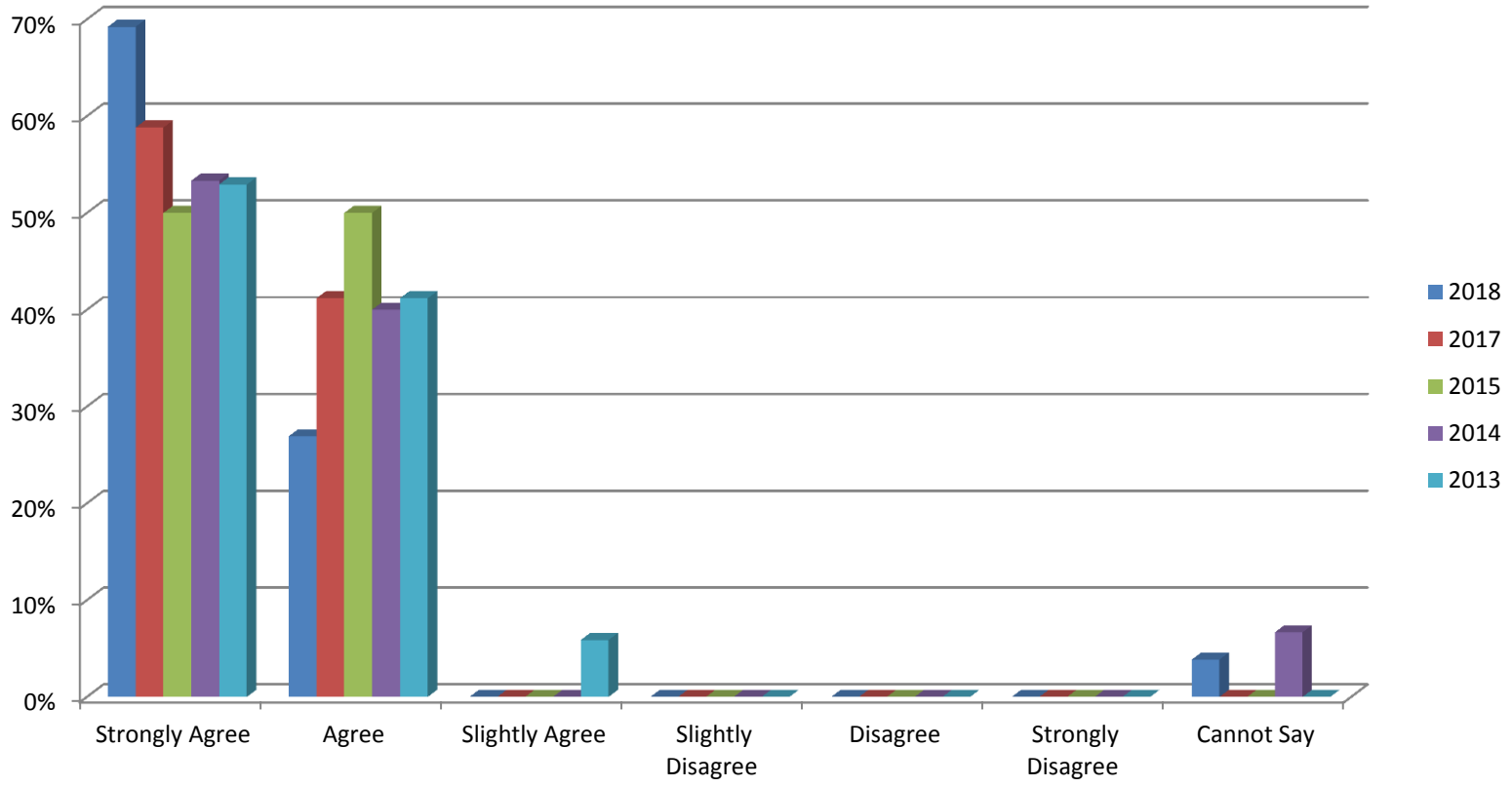
"Perhaps some more than others."

"Very strong professional team."

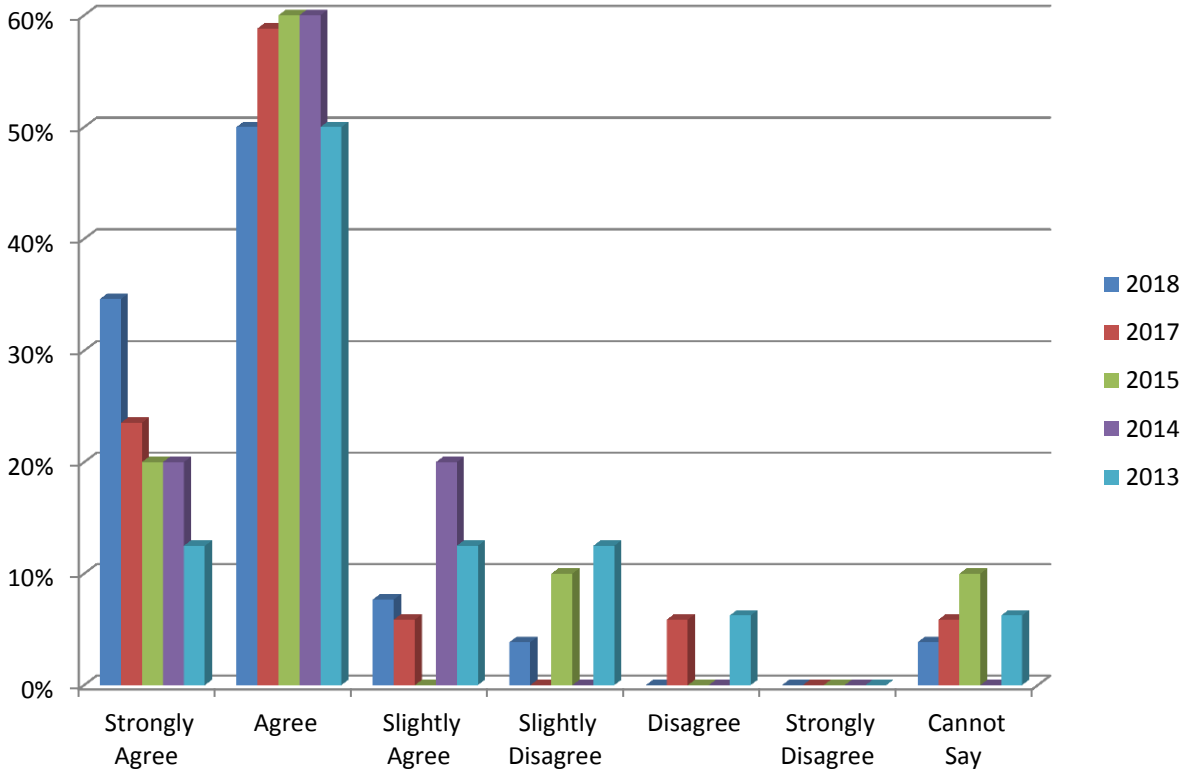
4. As governors, we are regularly briefed on major service developments and issues impacting on the Trust.



5. 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.



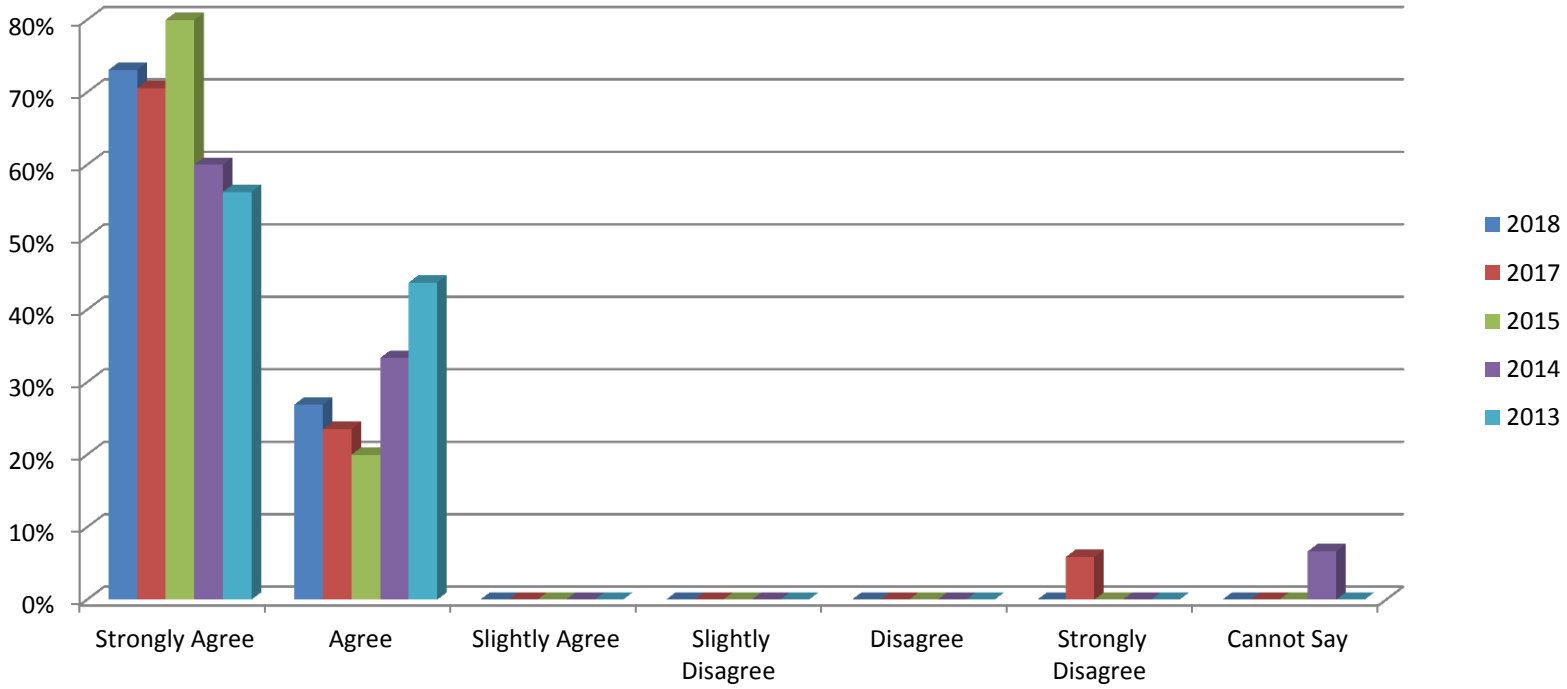
6. What I'm told by Directors matches what I'm told by staff and patient Governors.



"Not had opportunity to confirm this."

"As far as I can ascertain there is a general understanding of information available.. the Chair believes it is important to protect staff from unresolved issues where possible, so that they are unburdened by uncertainty or concern about their jobs, until matters are decided or set in stone."

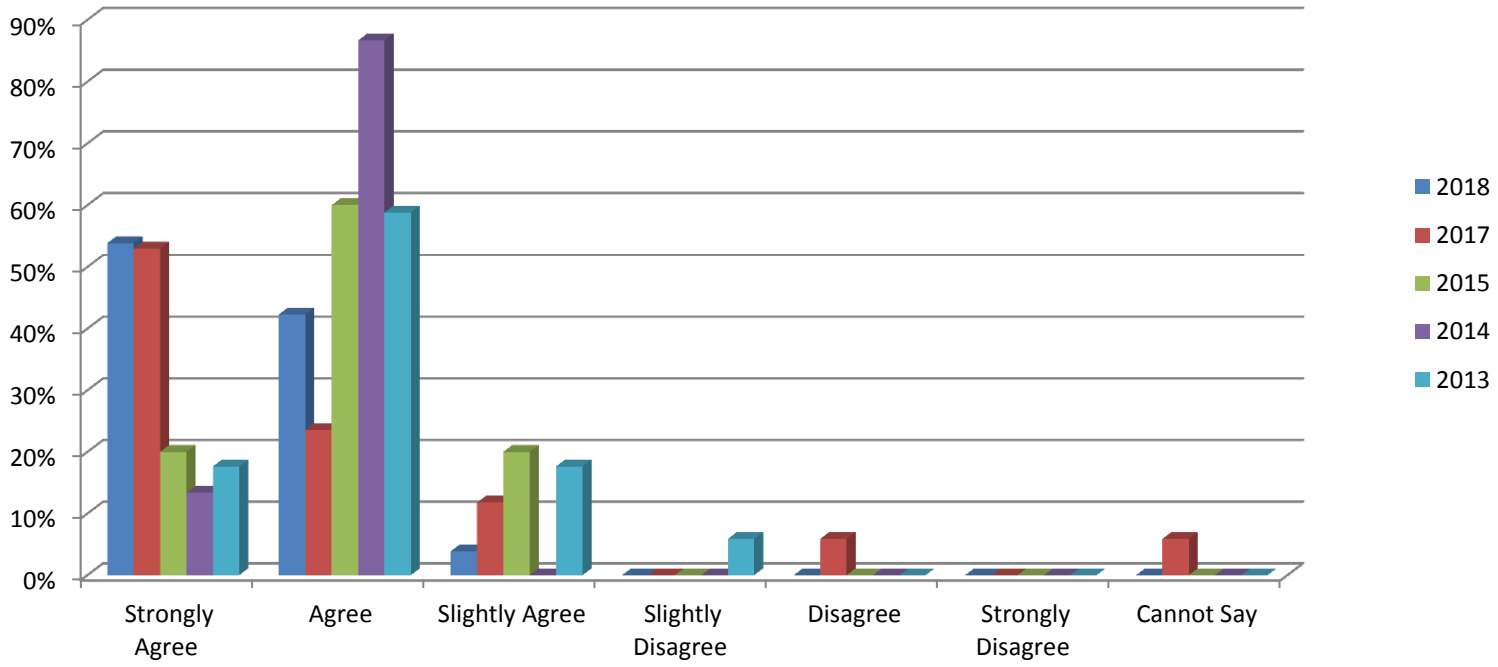
7. The organisation's performance against key targets and key risks facing the Trust are reported to Governors on at least a quarterly basis.



"Always presented in full at Council meetings."

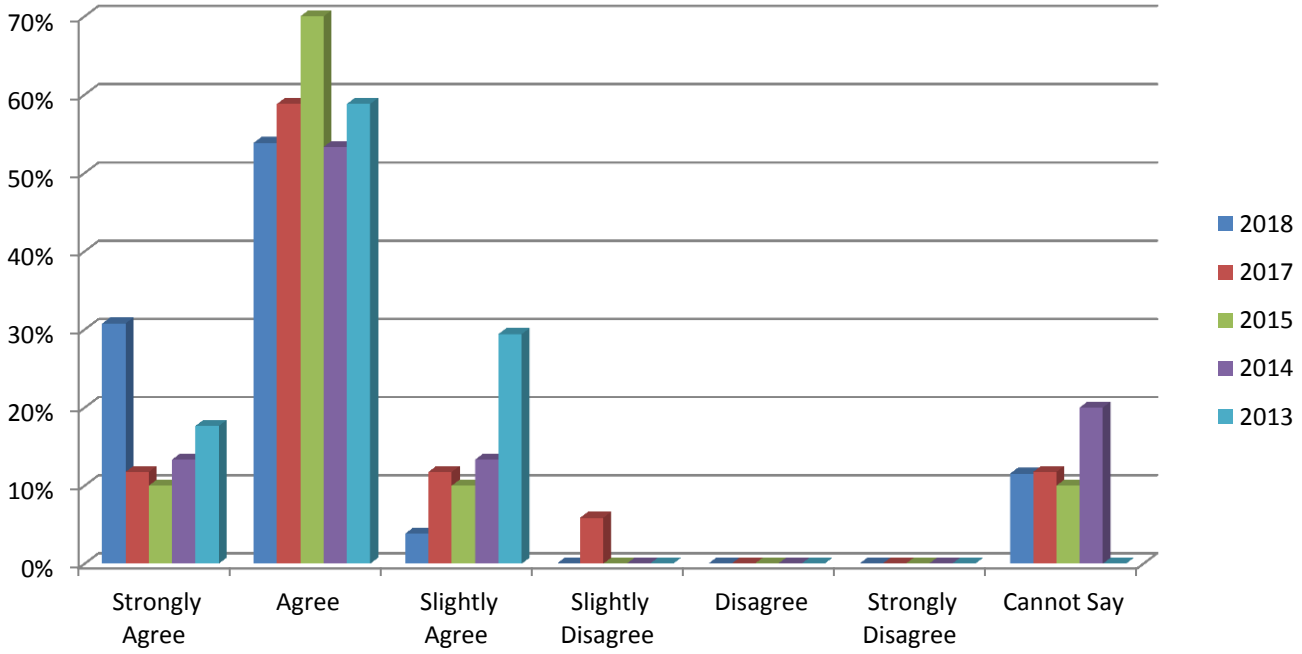
"Key Targets discussed at the monthly board meetings."

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



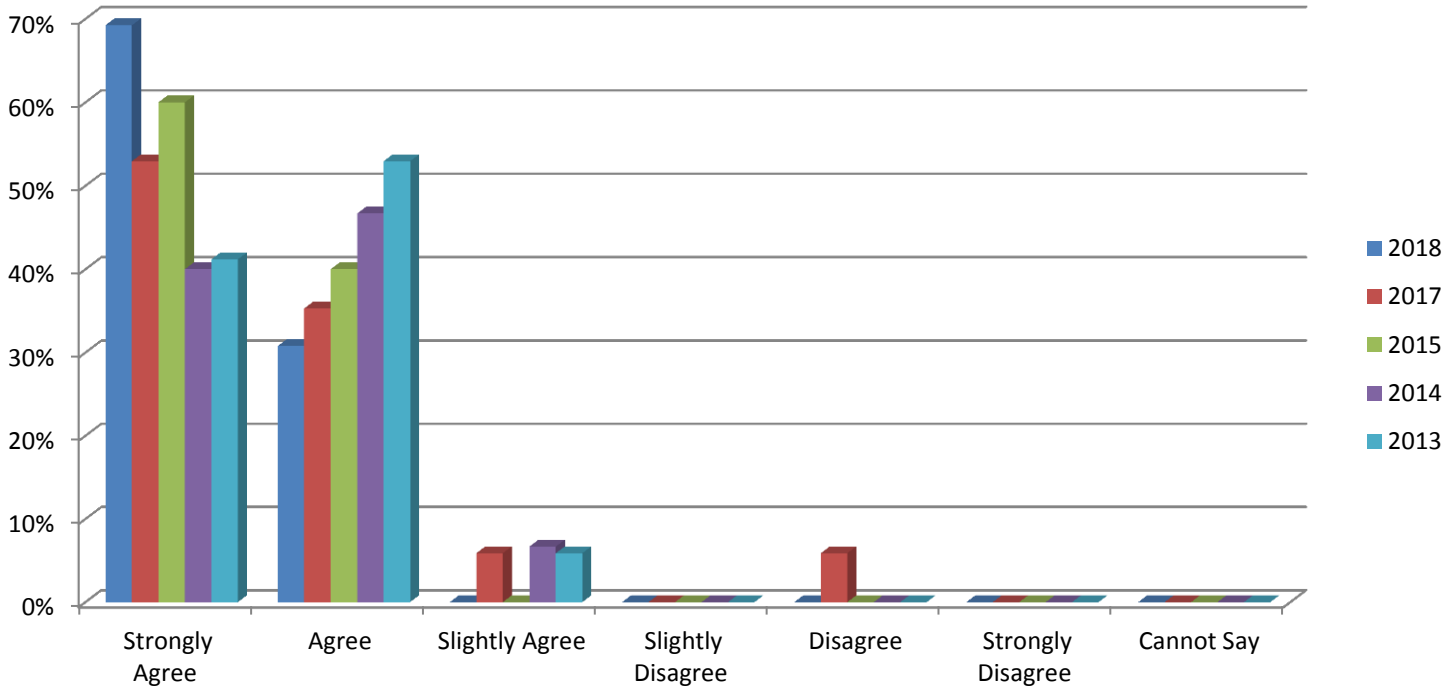
"Information has been given".

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



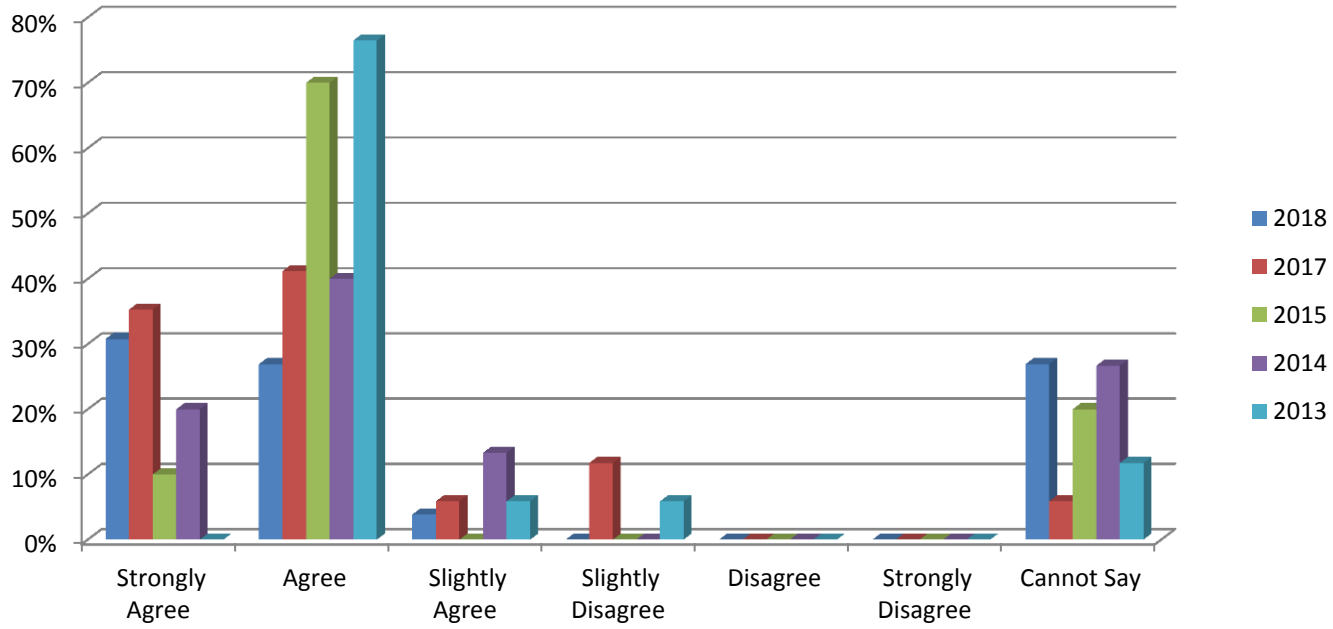
"I agree as much as any organisation can in the present NHS environment."

10. 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.



"Excellent working relationships assisted by joint meetings and joint attendance at Council meetings and Governor observation of Board meetings."

11. 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.

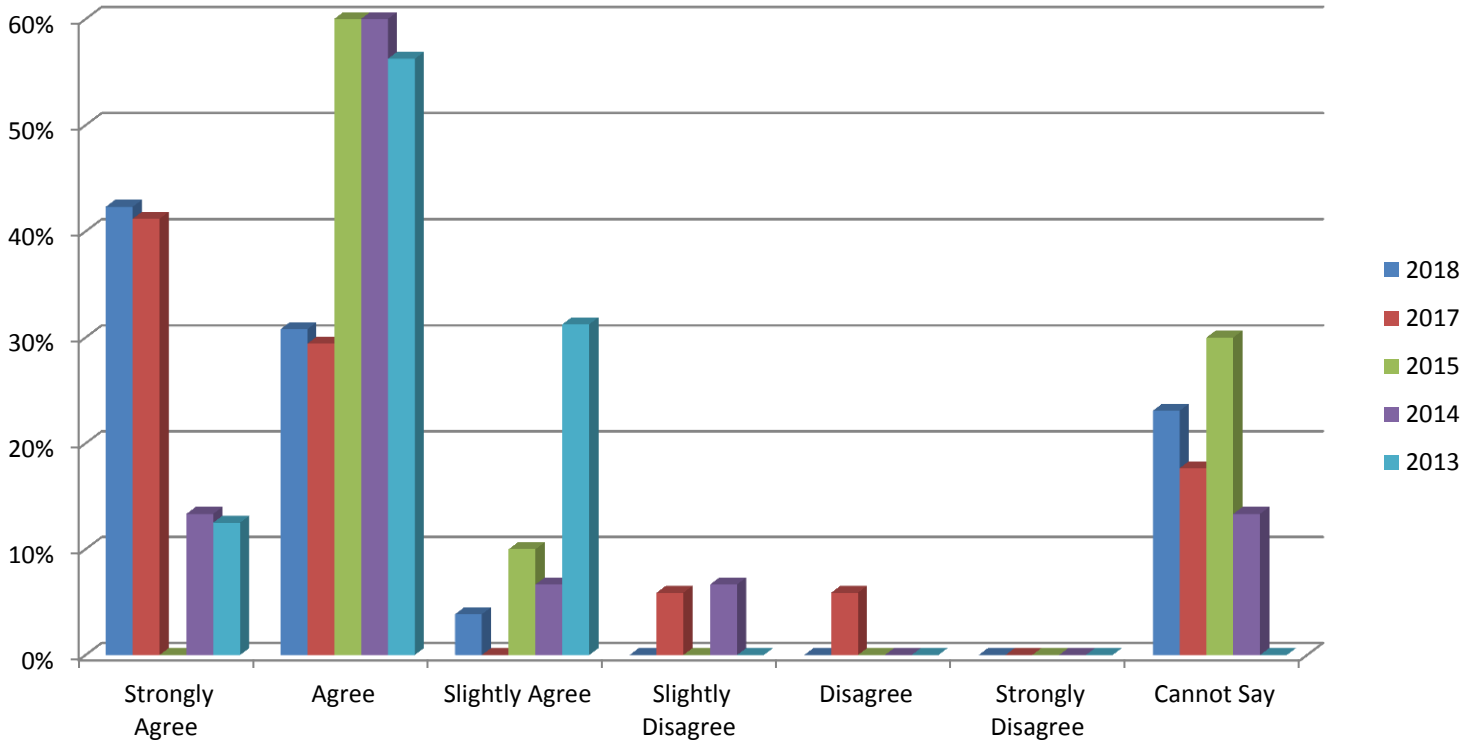


"Can't recall when this has happened".

"This is a rare event at Council meetings because of the approach taken by the Board."

"There has not been a situation where Council's views are not listened to or an explanation given to find agreement."

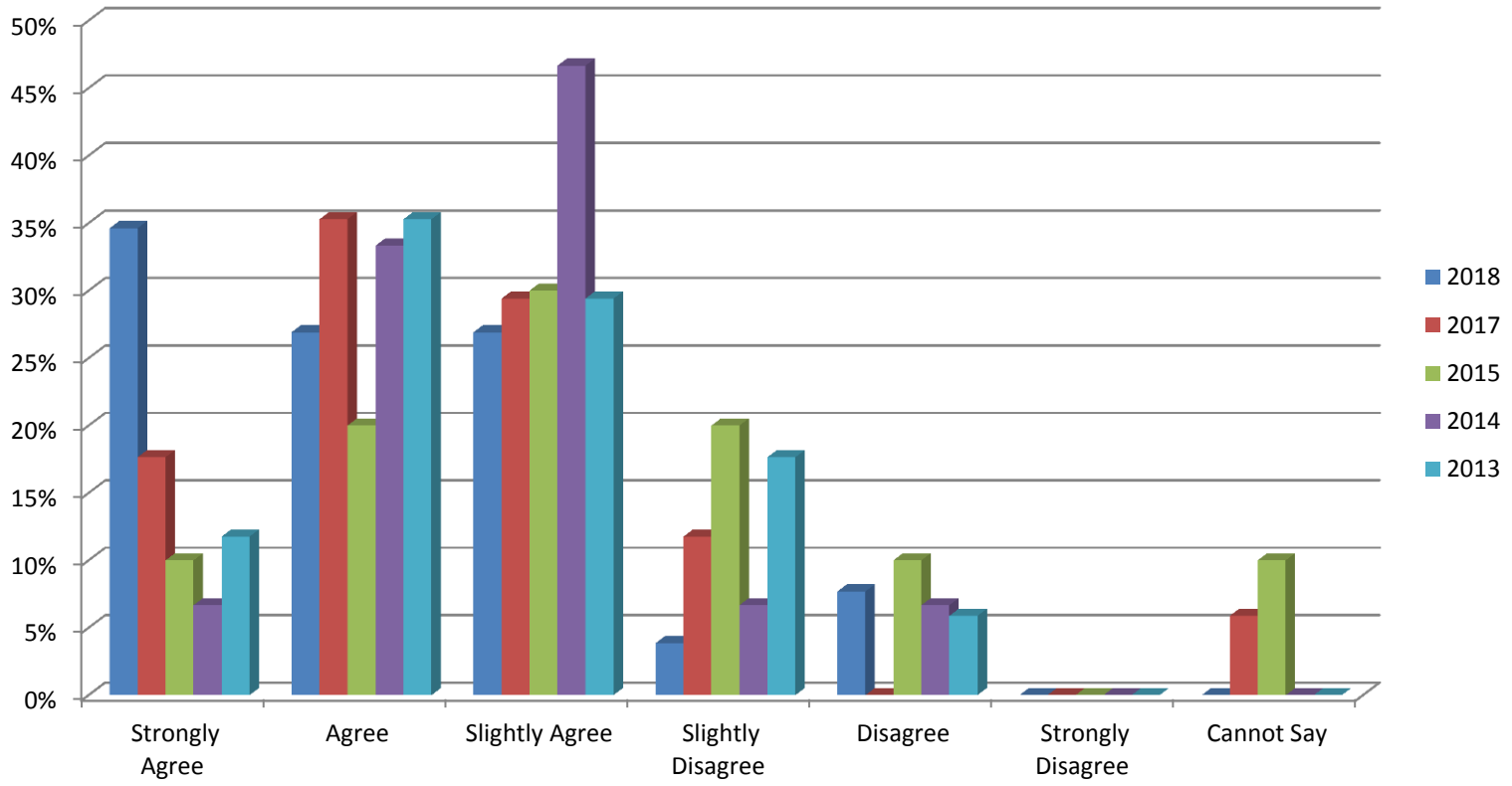
12. Issues I have raised with the Board of Directors have been dealt with promptly and to my satisfaction.



"There is a process for Governors to raise issues, currently being reviewed."

"Very open door policy by the CEO, excellent responses from all Directors."

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



"It is more a case of being presented with the future direction rather than being involved in developing."

More comments on next slide.

Q.13 Comments

"I am not sure that Governors and certainly not membership are sufficiently aware of the options that we could and maybe should influence differently. I am sure this is no different in most FTs but to be truly at the forefront the Governors at least could have wider exposure (I understand the constraints on time) to wider views of what a modern cutting edge FT should become."

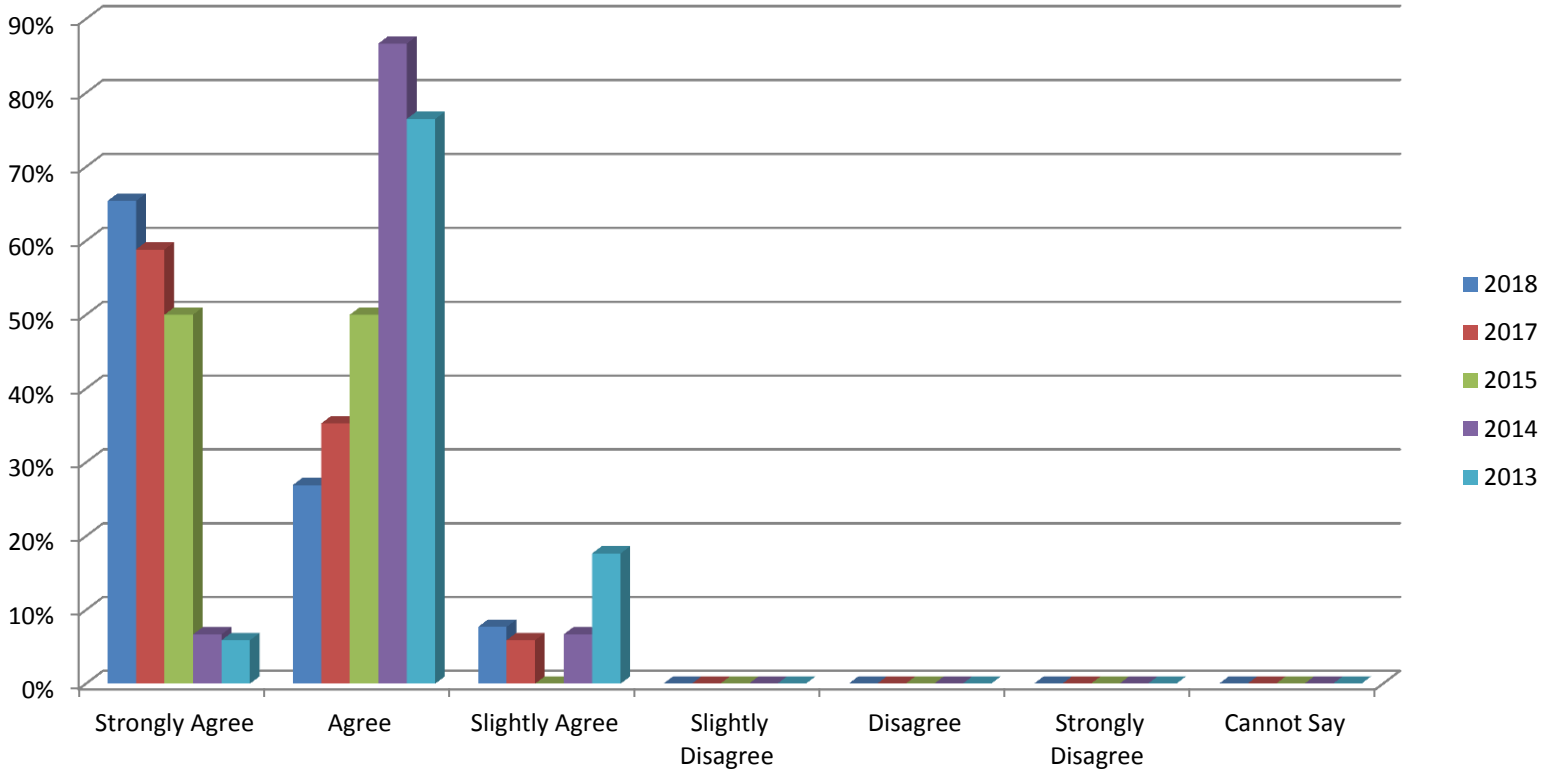
"The STP process has not really been driven by / engaged with Governors and wider membership. We have been kept informed, but do not shape....."

"There is every indication that this is happening."

"Ideally we would BUT the organisation is severely constrained by wider strategic factors (eg CCG finances and STP planning)and so is not always in a position to affect the Change agenda."

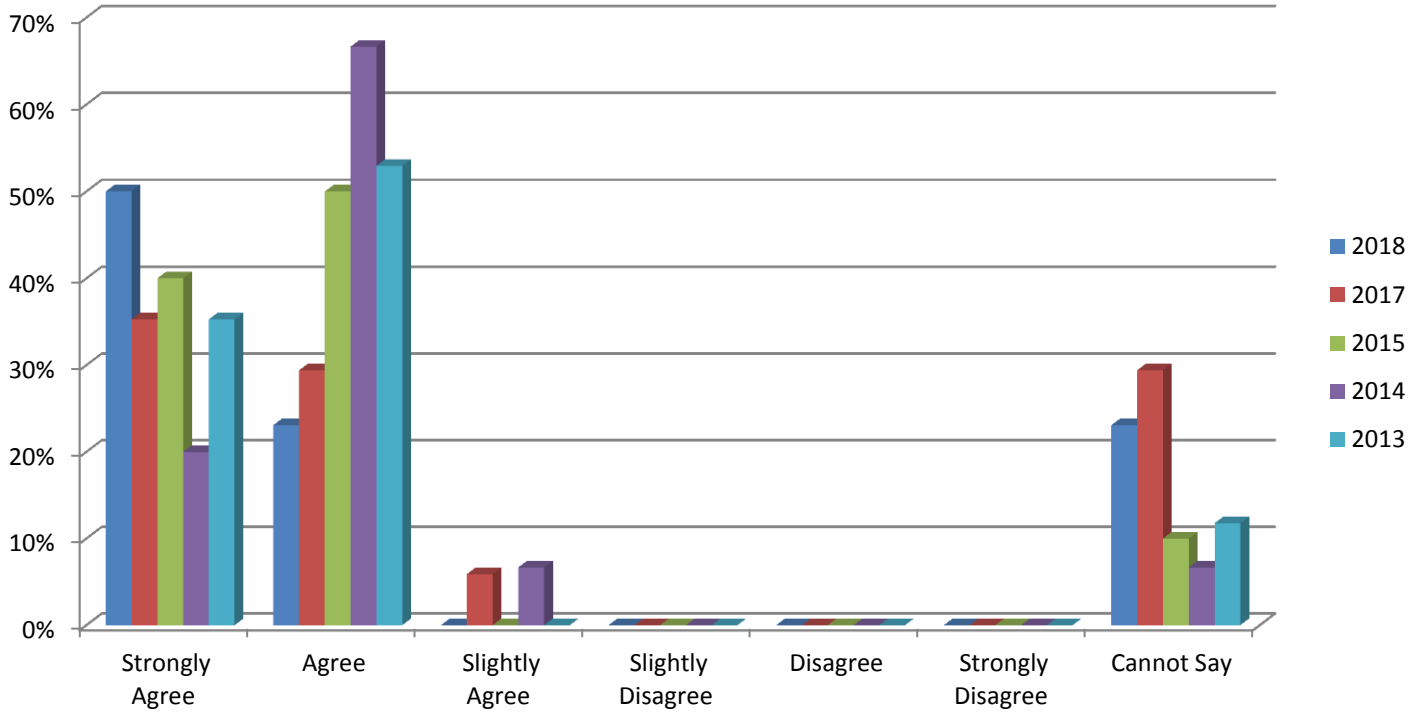
"I have detailed involvement in two working committees."

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



"Definitely."

15. 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.



"Excellent management process very impressive."

Title of Paper :	Gender Pay Gap Report 2017	
Author:	Natalie Wallace, HR Manager – Equality & Diversity and HR Advisory Service	
Executive Lead:	Estelle Carmichael, Director of Workforce and OD	
Type of Report:	Concept Paper	
	Strategic Options Paper	
	Business Case	
	Information	✓
	Review/Benefits/Audit	

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

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

Positive Benefit:	The Trust's approach to Equal Pay and reducing the gender pay gap is acknowledged.
Risk:	Publicity related to current Pay Gap

To be published on Trust Website –complete version	***Yes***
If no, to be published on Trust Website – redacted	***n/a***
If not to be published complete or redacted, please detail the reason why	**n/a**
Presented at Board Meeting of:	**3 April 2018**

Mid Cheshire Hospitals
NHS Foundation Trust

Gender Pay Gap Report 2017

Introduction

Mid Cheshire's Hospitals NHS Foundation Trust' services are committed to ensuring that everyone has an equal chance to live a long and healthy life, regardless of age, disability, gender identity, marital / civil partnership status, pregnancy / maternity, race, religion or belief, sex, or sexual orientation.

It is essential, therefore, that we take steps to ensure that we are a good employer which values and welcomes different ideas and skills of our staff. Our goal is to recruit, engage, develop and retain outstanding people who reflect the communities we serve and who work together to deliver our common aims and objectives.

Gender pay gap legislation was introduced in April 2017 which requires all organisations with 250 or more employees to publish their gender pay gap annually as of 31 March 2017. From April 2017 employers have up to 12 months to publish this information. The information must be published on the organisations website in addition to a government website.

The gender pay gap shows the average difference in the average pay between men and women. Gender pay gap reporting is a valuable tool for assessing levels of equality in the workplace, female and male participation, and how effectively talent is being maximised. This differs from equal pay which looks at the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value.

Job Evaluation

The Trust's pay and grading system and policies are in line with the NHS Agenda for Change (AFC) terms and conditions. Agenda for Change is underpinned by a tailored job evaluation scheme which is a pay and grading system for all NHS staff with the exception of doctors, dentists and some very senior managers.

The job evaluation scheme was specifically developed for the NHS across the UK and it determines the basic pay of all staff covered by the Agenda for Change terms and conditions. This is done by evaluating each job across a range of factors and allocating relevant levels to each factor according to the job role being considered. Each of these levels has an allocated points score; the points total for a job determines the appropriate pay band for that job. This allows jobs in different professions but with overall equal value to be appropriately measured. All new job roles are evaluated under the job evaluation scheme to ensure that they are graded fairly and objectively without gender bias or any other form of discrimination. All evaluated jobs are then placed onto a pay band.

Material Factors Influencing Pay Levels

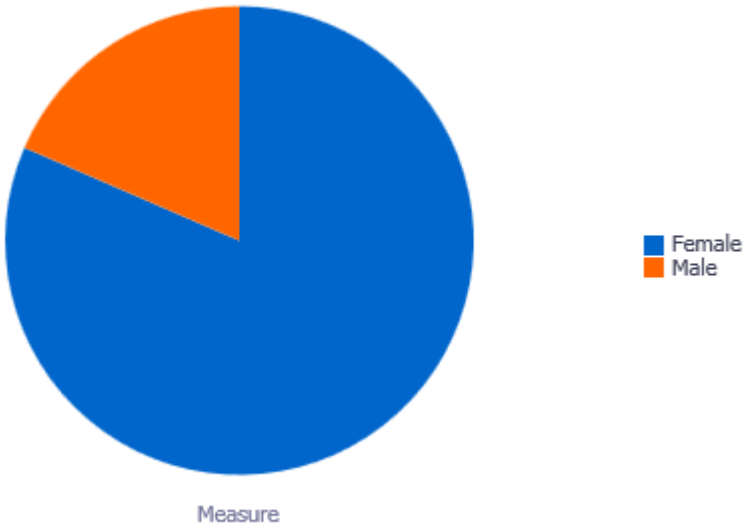
A number of factors can influence pay levels, which occur within the scope of an organisation's pay policies, these are known as material factors and can be used to objectively justify pay and pay variations. Material factors include:

- Length of service;
- Starting pay, pay protection and progression;

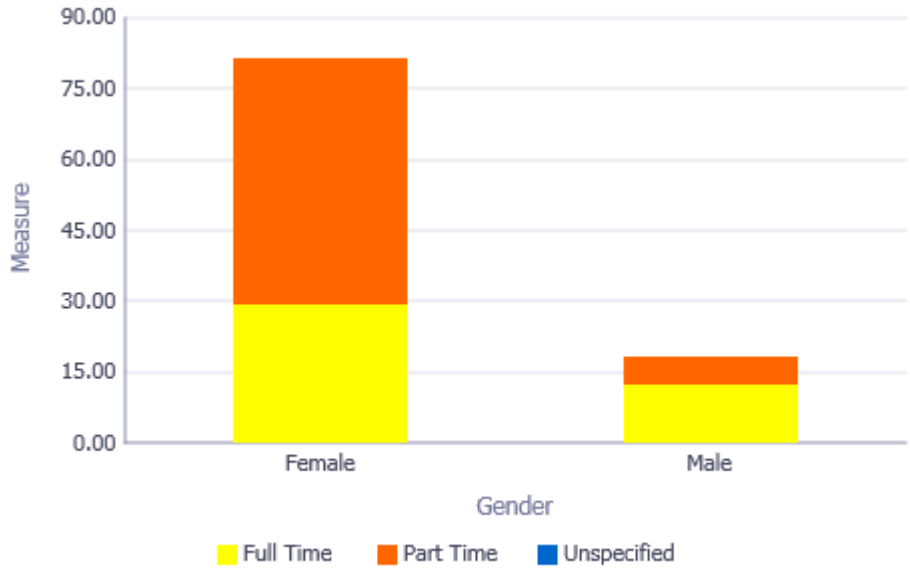
Overall, pay variances between males and females within an organisation can also be influenced by the proportion of males and females within each pay band, i.e. a higher

number of females in the lower pay bands would result in a larger overall pay gap between overall total average pay for male staff and female staff within an organisation. The gender gap remains at a national level due to different ways man and women participate in the labour market. This may be due to choice of occupations and caring responsibilities

Pay and benefits based on length of service are covered specifically by the Equality Act 2010. It permits benefits to be awarded on length of service up to and including five years.



As at 31st March 2017 the gender make up of Mid Cheshire Hospitals consisted of 81.7% female and 18.3% male.

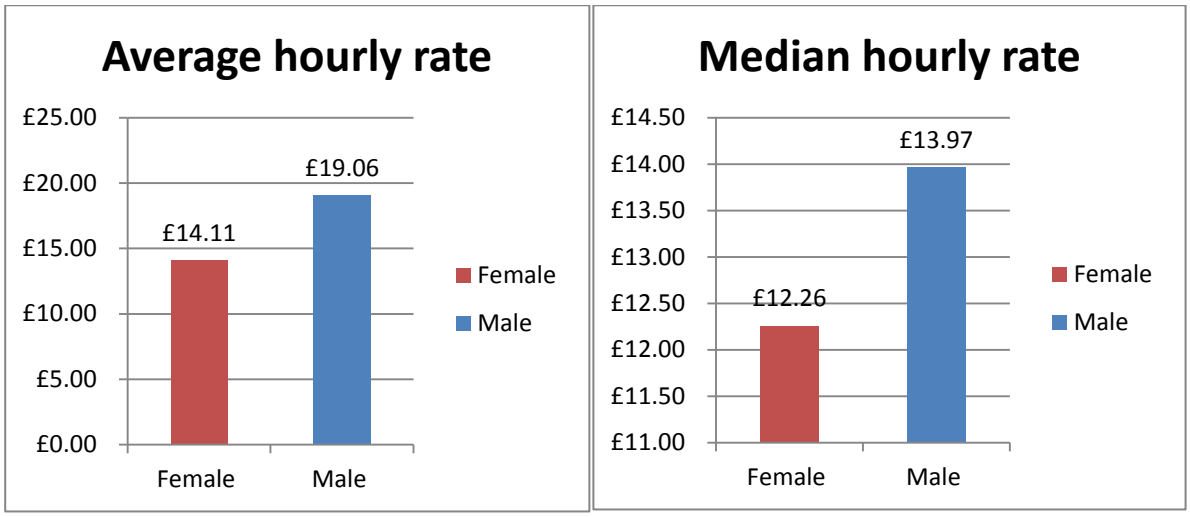


The above graph shows the gender split between full time and part time working. A total of 58% of the workforce work part time hours, 52% of females and 6% of males. For full time working the rates are 29% and 12.5% respectively.

Rates of Pay

The average rate of pay is calculated from a specific pay period; in this case a snap shot date of March 2017 has been used. The data includes both staff on Agenda for Change and staff on non-Agenda for Change terms and conditions. The hourly rate is calculated for each employee based on 'ordinary pay' which includes basic pay, allowances and shift premium pay. The hourly rate for staff has been calculated using the total monthly hours worked. Any overtime payments have been excluded. The median rate is calculated by selecting the average hourly rate at the mid-point for each gender group.

Gender	Average hourly rate	Median hourly rate
Male	£19.06	£13.97
Female	£14.11	£12.26
Difference	£4.95	£1.71
Pay Gap %	25.9%	12.21%



The above shows that the current gap between male and female average hourly pay rates is £4.95 less for females, a difference of nearly 26%. When comparing the median hourly rate the gap decreases with a difference of 12.21% (lower for females) or £1.71.

Quartile	Female	Male	Female %	Male %
1	890	195	82.03	17.97
2	932	154	85.82	14.18
3	919	167	84.62	15.38
4	810	276	74.59	25.51

Note: Q1 low, Q4 high

In order to create the quartile information all staff are sorted by their hourly rate of pay. This list is then split into 4 equal parts.

The information shows that the largest proportion of male staff are paid in the higher quartile. This is as a result of a greater distribution of male employees employed at the Trust in the medical profession than females and is not an unusual trend across the NHS as a whole. In addition, whilst there a slightly fewer males employed overall in senior roles across the Trust than females, this is disproportionate when considering the gender split of the organisation as a whole.

The second largest proportion of males are in the lowest quartile, primarily in support services roles in the Estates and Facilities Division.

Females have higher numbers in quartiles 2 and 3 where the majority of administration and clerical and nursing posts are positioned.

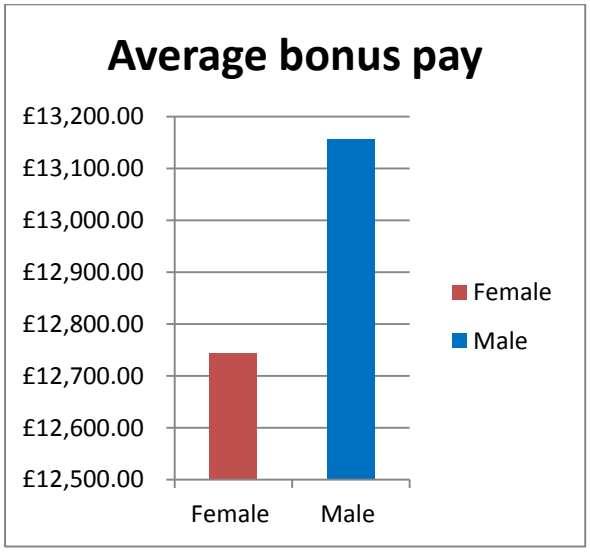
Bonus Pay Gap

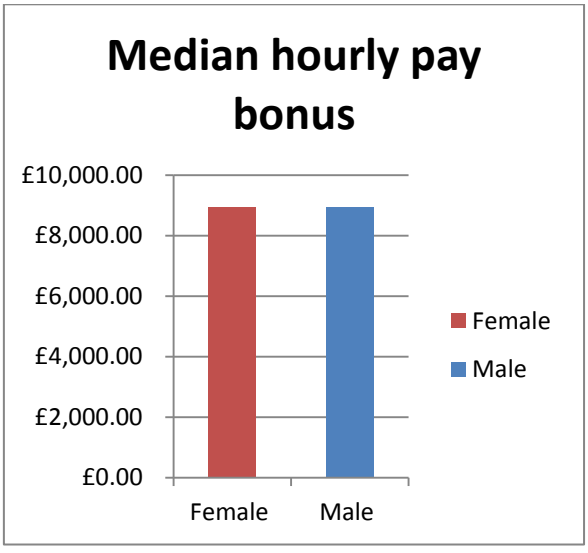
As an NHS organisation the only pay elements that fall under the bonus criteria are Clinical Excellence Awards (CEA's) and Discretionary Points which are only applicable to certain groups of medical staff.

The Clinical Excellence Awards (CEA) scheme is intended to recognise and reward those consultants who contribute most towards the delivery of safe and high quality care to patients and to the continuous improvement of NHS services. In particular, awards are made to consultants who demonstrate sustained commitment to patient care and wellbeing, sustain high standards of both technical and clinical aspects of service while providing patient-focused care and those through active participation in clinical governance contribute to continuous improvement in service organisation and delivery.

The pay elements that are used in this calculation are awarded as a result of recognition of excellent practice over and above contractual requirements and have no gender bias.

Median Pay	Gender	Average Pay
£8950.75	Female	£12,744.17
£8950.75	Male	£13,156.37
	Difference	**£412.20**
	Pay Gap %	**3.13%**





	Employees paid bonus	Total relevant employees	%
Female	7	4120	0.17
Male	43	912	4.71

The information shows that there is a 3.13% bonus gap for bonus payments between males and females although the median pay is equal across the sexes. There is a greater distribution of male employees on the Medical and Dental contract than females. This is not unusual as this depicts a trend that is reflected across most of the NHS whereby a larger proportion of consultant roles are held by males.

Conclusion

The data illustrates that, whilst the equal pay audit has revealed some variation in the pay received between men and woman, analysis of available information does not find it as attributable to any form of discriminatory pay practice.

It is recommended that the gender pay gap is monitored and bench marking analysis is undertaken against other NHS Trusts once the data has been published. Gender pay gap reports will be completed on an annual basis and it will be possible to analyse whether the Trust gap is closing.

It is important to note that job evaluation systems won't address the gender pay gap if the Trust has a majority of men in higher-paid roles. The solution to the pay gap lies in culture changes such embracing more flexible work in senior roles and reducing bias and discrimination in recruitment, promotions and talent management.

The Trust need to review recruitment strategies to bring more women into the medical workforce and senior management positions, in addition to encouraging males into nursing and administrative and clerical roles.

Statement

I confirm that Mid Cheshire Hospitals NHS Foundation Trust is committed to the principle of gender pay equality and has prepared its 2017 gender pay gap results in line with mandatory requirements.

Estelle Carmichael
Director of Workforce and Organisational Development

Mid Cheshire Hospitals
NHS Foundation Trust

Title of Paper :	Corporate Governance Handbook Mid-Year Review	
Author:	Katharine Dowson	
Executive Lead:	Tracy Bullock	
Type of Report:	Concept Paper	
	Strategic Options Paper	
	Business Case	
	Information	x
	Review/Benefits/Audit	

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

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

Positive Benefit:	To ensure the Trust is prepared for the anti-fraud assessment and that governance processes are in line with best practice.
Risk:	Non-compliance

To be published on Trust Website –complete version	***Y*** *(delete as appropriate)*
If no, to be published on Trust Website – redacted	***N*** *(delete as appropriate)*
If not to be published complete or redacted, please detail the reason why	
Presented at Board Meeting of:	3 April 2018

Corporate Governance Handbook 2018 – version 8

Mid Cheshire Hospitals NHS Foundation Trust

Background

The annual review of the Corporate Governance Handbook (CGH) took place at the end of 2017 and was approved at the Board of Directors in January 2018, subject to an amendment in regard to clarity of the separation of the roles of Corporate Trustee and Trust Board Member. These changes have been incorporated and it was agreed by the Chairman of the Trustee Sub Committee that these changes would be formalised at the next review of the CGH.

Subsequently the internal auditor advised that the Trust's Code of Conduct should be updated in regards to fraud and bribery and the new Trust Policy on Counter Fraud, Corruption and Bribery. As there is a forthcoming review of Counter Fraud due in the Trust it was judged that this review should be done immediately with an update provided to Board.

An electronic version of the CGH with tracked changes has been made available to all Board Members prior to the meeting.

The following tables summarise the changes made in the two areas above.

Corporate Trustees

Section	Page	Changes	Comments
Contents	2	Removal of Trustee Sub Committee ToR Section.	
Standing Financial Instructions	55	Section 17. Funds Held on Trust Removal of detail.	This is contained in the Trustee Sub-Committee Governance document
Terms of Reference	93	Removal of Terms of Reference for Sub Committee.	This is not a Board Committee so is not required to be in this section.

Counter-Fraud, Bribery and Corruption

Section	Page	Changes	Comments
Standing Financial Instructions	22	Reference to new policy throughout Anti-Fraud, Bribery and Corruption Policy.	
Standing Financial Instructions	29-31	Removal of process detail for Fraud & Corruption detailed in Anti-Fraud, Bribery and Corruption Policy.	Sections 2.1, 2.3.
Standing Financial Instructions Section 21 Countering Fraud, Bribery and Corruption	58-60	Removal of definitions of Fraud, details of process for reporting and reference to new policy.	Contained in new policy
Code of Conduct for Board of Directors and Staff	184	Reference to new policy added and removal of definitions included in policy.	
Code of Conduct for Board of Directors and Staff	189	Requirement that staff should not work which off sick or suspended	Recommendation from internal audit

Katharine Dowson
Trust Board Secretary
April 2018

Title of Paper :	Board Committee Annual Review	
Author:	Katharine Dowson, Trust Board Secretary	
Executive Lead:	Tracy Bullock	
Type of Report:	Concept Paper	
	Strategic Options Paper	
	Business Case	
	Information	x
	Review/Benefits/Audit	

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

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

Positive Benefit:	Assurance in respect of the effectiveness of Board Committees
Risk:	Insufficient review and assurance of delegated Board duties

To be published on Trust Website –complete version	***Y*** *(delete as appropriate)*
If no, to be published on Trust Website – redacted	***N*** *(delete as appropriate)*
If not to be published complete or redacted, please detail the reason why	
Presented at Board Meeting of:	3 April 2018

Introduction

Each year a review of performance, membership, Terms of Reference (ToR) and Work Plan for each Board sub-committee is undertaken. The review takes place with the Chair of the relevant committee and the Chairman, Chief Executive and Trust Board Secretary.

Members of all committees with the exception of Trustees and RemCo complete a self-assessment questionnaire ahead of the meeting that also provides evidence for the effectiveness of each committee.

As per previous arrangements, the Annual Reports will demonstrate the committee's effectiveness and will be ratified by the relevant Committee before being presented to the Audit Committee.

The committee reviews will be discussed in more detail at the Board Away Day on 23 April 2018

The following committee reviews took place:

Board Sub - Committee	Review date	Chair / Vice Chair
Quality Governance Committee (QGC)	19 February	Chair – Dame P Bacon, Deputy Chair - Mr J Barnes, NED
Appointments & Remuneration Committee	05 March	Chair – Mr D Dunn, Chairman DC – Dame P Bacon, Deputy Chair
Performance and Finance Committee (PAF)	30 January	Chair – Mr M Davis, NED DC – Mr D Hopewell, NED
Transformation and People Committee (TAP)	14 March	Chair – Mrs R McNeil, NED DC – Mr J Church, NED
Audit Committee	19 February	Chair - Mr D Hopewell, NED DC – Mr M Davis, NED*
Trustees Subcommittee	19 February	Chair - Mr D Hopewell, NED DC – Mrs J Tunney , Director of Nursing & Quality
Appointments and Remuneration Committee (RemCo)	5 March	Chair – Mr D Dunn (review conducted with Dame P Bacon Deputy Chair)

The Chair of each committee has now received a follow up letter from the Chairman outlining the key highlights from the discussions. A brief summary report outlining the process undertaken and any key findings will be presented to the Board of Directors (this paper). A fuller paper including the results of the surveys will be discussed at the Board Away Day on 23 April 2018.

Key findings to note:

1) Audit Committee (AC)

- It was noted that AC meets its statutory functions and there is appropriate escalation and delegation between relevant committees
- AC provide constructive and robust challenge which provides assurance to the Board
- The membership of the committee is appropriate and Executive Directors have been invited to attend as required

- The Deputy Chair role should be confirmed by Board at the next opportunity
- The revised work plan for 2018/19 is in place with items that are relevant to the current Trust priorities and the Terms of Reference have not been changed
- AC to consider whether the frequency of meetings is appropriate as 6 +1 meeting is at the upper end of peer practice

2) Trustees Subcommittee

- The Committee has performed well this year although due to changes in the charity team and Executive lead the impetus for the Dementia appeal has been slightly lost and requires a new focus
- The steering group set up to link in to the Dementia appeal has taken some time to establish its purpose and remit which has also contributed to a delay in fully launching the appeal
- The Terms of Reference were reviewed and a minor change to the job title was made and these were subsequently approved in March. There were no proposed changes to the membership or workplan. The Annual Plan for the charity will be presented to Corporate Trustees at the Board Away Day in April

3) Performance and Finance Committee (PAF)

- The Committee provides good assurance to the Board and the survey results were very positive
- The membership of the committee was agreed to be appropriate and works well together
- The improvement in the quality of information and escalations being received from divisions was noted
- Changes were made to the ToR which were subsequently approved by PAF, this includes minor updates and a refresh of the committee purpose to reflect changes in the local and national systems and in regulators requirements. An additional point was included to reflect committee review of results from benchmarking tools such as the Model Hospital
- Some overlap between PAF and TAP has occurred during the year but the Chairs have communicated well to resolve any issues. The work to define when transformation projects become business as usual had been useful in supporting this

4) Quality Governance Committee

- It was noted that QGC has matured and is working well
- QGC had added to its agenda with the Learning from Death report each quarter and will be reviewing the new divisional quarterly quality reports when they are introduced
- The level of assurance provided by the committee is appropriate as are the escalations to both Board and Executive Groups, the work done by QGC for the Board on mortality and Serious Untoward Incidents was noted
- The membership of the committee is working well and does not require any changes
- The only change to the workplan recommended was the addition of the divisional quality reports
- There were no changes proposed to the ToR of the committee and these were approved at QGC in March.
- The positive impact of the new Associate Director – Integrated Governance was recognised

5) Transformation & People Committee (TAP)

- TAP has made considerable progress in its effectiveness as a committee and many of the initial issues have been resolved, this was reflected in the survey results which were generally very positive

- TAP has developed a robust process for transferring transformation projects to business as usual
- Following changes made last year there are no proposed changes this year to the membership but the Director of Strategic Partnerships will be invited to attend on a regular basis given the level of scrutiny of CCICP on TAPs agenda
- The workplan for 2017-18 was reviewed and no changes were proposed although it was agreed that there would be a greater priority given to the development of a Trust wide strategic workforce plan which would require input from the Medical Director and Director of Nursing and Quality
- The ToR had been reviewed relatively recently and no further changes were made. TAP subsequently approved the ToR for 2018 in March.

6) Appointments & Remuneration Committee (RemCo)

- Amendments were made to the ToR to bring them up to date and to include reference to the national guidance on Very Senior Manager pay.
- Business is being conducted in line with these ToR

Over-arching Themes and Conclusions:

- No serious issues or concerns were raised during any of the committee reviews or within the surveys sent out ahead of reviews. Any concerns raised through the surveys were discussed at the reviews
- The committee structure is now established and therefore should not be considered in the context of 'new' arrangements going forward
- Committee membership has been reviewed and it has been agreed that four members is sufficient for the business of the committee although it does increase the risk of not being quorate. In practice this is unusual
- Escalations to the Board, delegations to Executive groups and to other committees are generally appropriate
- The committees align and work across each other well with good communication between Chairs when issues cross committees
- Key performance reports are not reviewed at committee before going to Board and despite a detailed review of timelines the conclusion is that there is insufficient time to enable this
- The survey provides useful insight but where there is disagreement it can be difficult to qualify this in order to provide useful critique and introduce improvement if no narrative has been provided
- The Chairs of TAP and QGC stepped down on 31 March 2018 as their terms of office as Non-Executive Directors come to an end
- Secretarial support to the committee has improved substantially following changes to the Board Secretariat and the introduction of a Committee Secretary role which is providing more consistency and a greater level of professionalism
- The position of Vice Chair for the Audit Committee should be reviewed and ratified annually through this process

Recommendations:

- To note the review of Board sub-committee reports
- To review and ratify the Vice Chair for the Audit Committee

Katharine Dowson
Trust Board Secretary
April 2018

Performance Report Workforce Chapter
Month: Feb-18

Measure	Target	Performance	Description	Narrative	Rolling Trend
Sickness Absence	3.60%	4.28%	Rolling 12m average Sickness Absence described as a Percentage	The rolling average sickness absence level was maintained in February and we saw a significant reduction in the in-month sickness absence rate, which was 5.3% in January and was 4.02% in February. As at 28th February 2018, only 3 staff had been absent for 6 months or more. In addition, it is noted that 75 staff have had more than 4 episodes of absence in the last 12 months, a reduction from the previous month.	=
Appraisal Rate	90.00%	87.40%	Percentage of Staff who have received an appraisal in the last 12 months. Excludes New Staff with less than 12m service and Bank Staff	A very slight decline in the appraisal rate over the January figure of 88.28%. It should also be noted that CCICP are the only clinical service to have achieved the KPI standards of over 90% of appraisals.	↓
Mandatory Training	90.00%	81.99%	Mandatory Training Monthly Rate Excludes Bank Staff, Staff on long term sick & mat. leave.	Mandatory training compliance has improved very slightly from 81.84% in January. With many divisions maintaing circa 80% during February.	↑
Staff Turnover	10.00%	10.66%	Number of Leavers expressed as a percentage of the workforce over a 12m rolling period. Exclude Junior Doctors, Temporary and Fixed term.	Our retention rate continues to improve and is now 89.34%. This provides stability in our workforce that is translated into consistency the way we provide care to our patients.	↓

Measure	Target	Performance	Description	Narrative	Rolling Trend
Agency Spend	(423)	(420)	In month and cumulative total spend for the Trust.	The value of agency usage during February was as anticipated. During February we worked hard to achieve best value rates through effective negotiations with agencies as well as the savings achieved through direct engagement. However, for the first time in almost 2 years, the NUrsing agency spend was higher than that associated with medical agency useage. Our highest spending divisions during February were : - Medicine & Emergency Care and - Surgery & Cancer. These two divisions were responsible for over £270,000 agency spend each and the next highest user of agency staffing was CCICP with a total in month agency spend of £70,000 (mainly associated with GPOoH cover).	↓
NHSI Ceiling	less than 100%	94.8%	Trust Agency Spend as a percentage of the Ceiling Set by NHS Improvement		↓
Over Cap Rates	n/a	42.89%	Number of Agency shifts filled by agency staff that are over the nationally determined capped rates	A total of 148 out of 345 shifts were above the agency cap rates set by NHSI. During February, we have seen a return to a more average number of agency shifts being requested, however there has been a singificant increase in the costs of agency shifts and in particular we have seen a rise in above cap agency shifts for Nursing staff. This has been associated with the continuation of escalation areas within the Trust throughtout Febuary.	↓

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

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

Title of Paper :	Board Assurance Framework (BAF) Report	
Author:	Associate Director-Integrated Governance	
Executive Lead:	Medical Director	
Type of Report:	Concept Paper	
	Strategic Options Paper	
	Business Case	
	Information	
	Review/Benefits/Audit	✓

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

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

Positive Benefit:	A summary report of the BAF following scrutiny of the relevant Strategic Domains at Board Sub-Committee level, with oversight by the Quality Governance Committee. Following the annual review of the BAF further developments will include the addition of controls effectiveness ratings and controls assurance ratings during 2018/19.
Risk:	Gaps in assurances and lack of oversight of key risks to achieving the Strategic Objectives.

To be published on Trust Website – complete version	***Yes***
If no, to be published on Trust Website – redacted	No
If not to be published complete or redacted, please detail the reason why	
Presented at Board Meeting of:	3 April 2018

Board Assurance Framework

Summary Document

2017/18

Quarter 3

Board of Directors

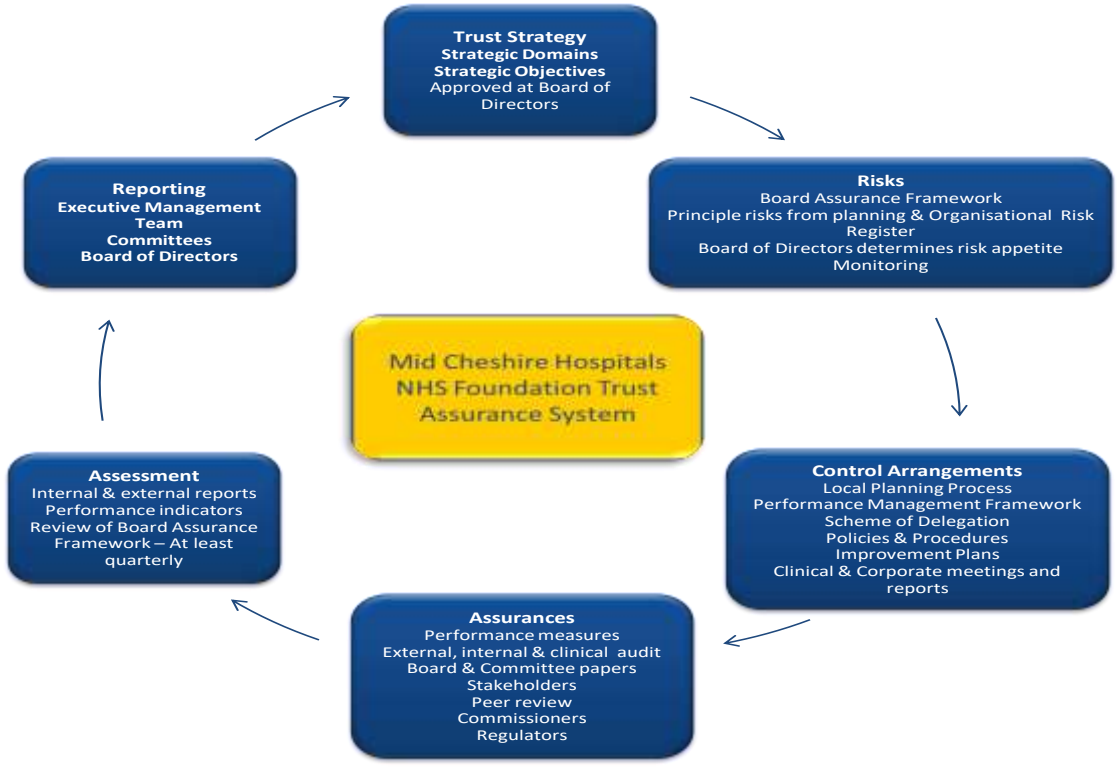
'Delivering Excellence in Healthcare through Innovation and Collaboration'

1. Background & purpose

The requirement for NHS organisations to have Board Assurance Framework (BAF) is well documented, most recently it is cited in the NHS Improvement document *Developmental Reviews of Leadership and Governance using the Well-Led Framework: Guidance for NHS Trusts and NHS Foundation Trusts* (June 2017). The Board of Directors have had a well embedded document in place for a number of years, with reasonable assurances provided. Following an internal review of our risk management systems and processes, feedback from internal audit and Board members a new Risk Management Strategy and Framework 2017/20 has been developed which includes a review and development of the BAF which has considered the following:

- the BAF should be a succinct document of the assurances generated around each strategic objective, rather than principal risks;
- the BAF should record the Board's confidence in achievement of each strategic objective at any given point in time, given all the information available to them;
- the BAF should be 'live' and support effective decision-taking and provide evidence and justification for the decision making process;
- Board agendas should be set according to where the largest gaps are perceived to exist in either a) confidence in current position or b) achievement against strategic objectives;
- every piece of information the Board receives may affect its confidence about the likely achievement of a strategic objective; and
- the BAF document is part of the wider mechanism for managing an organisations assurances and should provide confidence, evidence and certainty to the Board of Directors and management *that what needs to be happening is actually occurring in practice.*

An overview of our Assurance System is depicted below in Fig.1



2. Current position

During July and August 2017 the Board of Directors developed and approved the Trust's five Strategic Domains and underpinning Strategic Objectives, with associated success measures. The *Trust Strategy 2017/18 with 2020/21 Horizon* details the Strategic Objectives and the plans to embed with the development of local objectives and metrics across the Divisions and Central Cheshire Integrated Care Partnership. Section 5 of this report provides a summary version of the full Board Assurance Framework which is aligned to the Three Lines of Defence model and scrutinised at the relevant Board Sub-Committee with delegated authority i.e. Quality Governance Committee (QGC), Performance and Finance Committee (PAF) and Transformation and People Committee (PAF). Oversight of internal audit reports relating to risk management systems and processes occurs at the Audit Committee.

The five Strategic Domains, underpinning Strategic Objectives and success measures are detailed in Appendix A. The Trust risk matrices are included in Appendix B. Appendix C provides a question set for Board Sub-Committees to consider when determining the extent to which they are assured by the evidence presented.

3. Organisational Risk Register

The Organisational Risk Register Report is presented to the Board of Directors on a quarterly basis, accompanying this BAF Summary Report which cross references to the significant risks which may impact achieving the Strategic Objectives. Table 1 below details the top five risks for quarter 3.

Table 1 – Top five organisational risks

Risk Title	Mitigated (With controls) Risk Rating	Shift				Key links to BAF 2017/18
		Q1-17/18	Q2-17/18	Q3-17/18	Q4-17/18	
1.Operational Sustainability of MCHFT	4(C)x4(L) =16	⇔	⇔	⇔		Q1,Q2 E1,E2 P1.P2
2.Sustainability of Vulnerable Clinical Services due to Lack of Resource (people & finance)	5(C)x4(L) =20	⇔	⇔	⇔		Q1,Q2 P1,P2 E2,W2
3.Delivering High Quality Clinical Services 7 Days per Week	5(C)x4(L) =20	⇔	⇔	⇔		Q1,Q2 P1.P2 E2,W2,T1 T2a, T2b
4.Long Term Financial Sustainability of MCHFT	5(C)x4(L) =20	⇔	⇔	⇔		E1,E2 P1,P2,T1 T2a, T2b
5.Delivering the Information Technology Strategy	4(C)x5(L) =20	⇔	⇔	⇔		Q1,Q2 E1,E2

4. Next steps

The development of the new BAF is an iterative process. An annual review of the process will be undertaken in March 2018 and future iterations of the BAF in 2018/19 will include the rating of the effectiveness of key control measures and the risk appetite/tolerance for each Strategic Objective. Additionally a more detailed assurance map will be developed to inform the full version of the BAF.

Governance between partner organisations and associated risks and assurances will also be considered in the 2018/19 BAF, which was identified as a key area in the internal Well Led Developmental Review by the Board of Directors in February 2018.

5. Board Assurance Framework - *Summary Version*

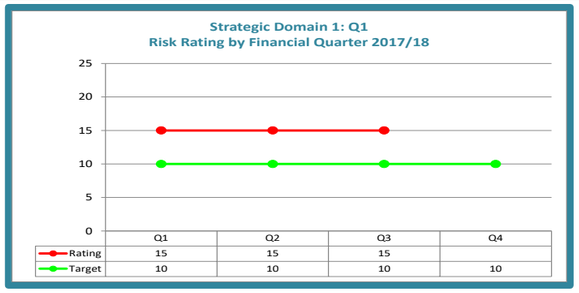
Strategic Domain 1: Delivering Outstanding Clinical Quality, Safety & Experience

Q1	To aspire to the delivery of 'Outstanding' clinical quality and safety, which is equitable, patient and family centred and supported by an effective quality governance framework.

Principal Risk

Risk of not consistently providing the safest, highest quality care due to a lack of an effective quality governance framework.

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHSI Single Oversight F/w	Executive Director	Executive Management Group	Board Committee
June 2017	December 2017	March 2018	Safe, Effective, Responsive, Caring & Well Led NHSI – Quality Metrics	Director of Nursing & Quality	Executive Quality Governance Group (EQGG) Executive Patient Experience Group (EPEG)	Quality Governance Committee (QGC)



Initial Risk Rating(Unmitigated)			Current Risk Rating (Mitigated)			Target Risk Rating (Tolerance / Risk Appetite)			
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Target Date
5	4	**20**	5	3	**15**	5	2	**10**	March 2019

Rationale for the Current Risk Score

The risk score remains the same at the end of quarter 3. Work is progressing but strengthening is required of the risk management and quality assurance frameworks in order to provide sustained demonstrable improvements and associated assurances at ward, department and divisional levels.

Links to BAF objectives

Q2, P1, P2, E1, E2, W1, W2, W3, T1, & T2

Key Links to the Organisational Risk Register

CS0325 – Operational Sustainability of MCHFT	16⇔	CS0326 – Non Delivery of the IT Strategy	20⇔
CS0328 – Sustainability of Vulnerable Clinical Services due to Lack of Resource (People & finance)	20⇔	CS0284 – Nursing Vacancies Across MCHFT	15⇔
CS0327 – Long Term Financial Sustainability of MCHFT	20⇔	DC0887 - Consultant Histopathologist Capacity	16⇩
CS0275 – Delivering High Quality Clinical Services 7/7	20⇔	DC 72 - Lack of breast cancer capacity due to lack of consultants (Radiology)	16⇔
EC0388 - Cardiac Monitoring System	20⇧	EC0327 - Lack of secondary Anaesthetic on-call cover	20⇧

Key Controls/Influences(current performance - what we are currently doing about the risk?)

The Trust has signed up to the Advancing Quality programme for 2018/19 focusing on several care pathways, including sepsis which has seen an overall improvement. The quality reports at ward / department and divisional level have been developed with roll out and Executive led quarterly quality assurance reviews planned in February 2018 for Medicine & Emergency Care Division. The Quality Matters Assurance Framework was approved at Board in December 2017 and will form the basis of the new Quality & Safety Improvement Strategy for 2018/19. The proposed quality priorities will be presented at Quality Governance Committee in March 2018.

Key Gaps in Controls/Influences/Assurances (how are we addressing the gaps?)

- Roll out of Quality Reports and Quarterly Quality Assurance Reviews Trust wide by October 2018
- Review of Infection, Prevention & Control Services by March 2018
- Internal Well-Led Review due by March 2018

Board Assurance Framework 2017-18

Supporting our Journey from 'Good' to 'Outstanding'

by Delivering Excellence in Healthcare through Innovation and Collaboration.

Mid Cheshire Hospitals NHS Foundation Trust

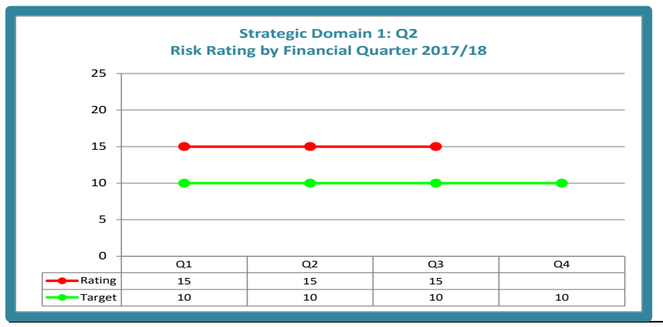
Strategic Domain 1: Delivering Outstanding Clinical Quality, Safety & Experience

Q2	To drive continuous quality improvement and promote research and innovation, whilst reducing unwarranted clinical variation and progressing from a 'Good' to 'Outstanding' organisation.

Principal Risk

Risk that the Trust fails to pursue and embed the opportunities brought by the quality improvement and research and innovation agendas, resulting in a failure to improve the quality of care and reducing unwarranted variation.

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHS Improvement Single Oversight Framework	Executive Director	Executive Management Group	Board Committee
June 2017	December 2017	March 2018	Safe, Effective, Responsive, Caring & Well Led NHSI - Quality Metrics	Medical Director	Executive Quality Governance Group (EQGG)	Quality Governance Committee (QGC)



Initial Risk Rating (Unmitigated)			Current Risk Rating (Mitigated)			Target Risk Rating (Tolerance / Risk Appetite)			
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Target Date
5	4	**20**	5	3	**15**	5	2	**10**	March 2019

Rationale for the Current Risk Score

Risk score remains at 15 for quarter 3 for a number of reasons. The Integrated Governance team including patient safety and clinical audit are currently undergoing organisational change. The proposed restructure aims to build upon research / quality improvement capability and capacity. SHMI & HSMR are going in the right direction, but still more improvements to be made. The Research & Development team currently have gaps in the Division of Medicine and Emergency Care limiting clinical trials in this area.

Links to BAF Objectives

Q2, P1, P2, E1, E2, W1, W2, W3, T1, & T2

Key Links to the Organisational Risk Register

CS0325 – Operational Sustainability of MCHFT	16⇔	CS0326 – Non Delivery of the IT Strategy	20⇔
CS0328 – Sustainability of Vulnerable Clinical Services due to Lack of Resource (People & finance)	20⇔	CS0284 – Nursing Vacancies Across MCHFT	15⇔
CS0327 – Long Term Financial Sustainability of MCHFT	20⇔	DC0887 - Consultant Histopathologist Capacity	16⇩
CS0275 – Delivering High Quality Clinical Services 7/7	20⇔	DC 72 - Lack of breast cancer capacity due to lack of consultants (Radiology)	16⇔
EC0388 - Cardiac Monitoring System	20⇧	EC0327 - Lack of secondary Anaesthetic on-call cover	20⇧

Key Controls/Influences (current performance - what we are currently doing about the risk?)

In line with national guidance our Learning from Deaths Report (Q1 & Q2) containing the nationally mandated dashboard was presented at Board in December 2017 and details the breadth of improvements in place. The 7 Day Services Working Group led by the Medical Director focuses on the delivery of the national four clinical priority standards and the national bi-annual return, following the focus on consultant reviews within 14 hours in the recent return, improvement plans are being developed by divisional leads. The Deteriorating Patient Steering Group meets again in March 2018 with one focus being the implementation of the recently published NEWS 2. The Trust has sought the support of the NHS Innovation Agency for NEWS 2 and quality improvement support, a meeting is planned on 24 January 2018.

Key Gaps in Controls/Influences/Assurances (how are we addressing the gaps?)

- Roll out of Quality Reports and Quarterly Quality Assurance Reviews Trust wide by October 2018
- Structured Judgement Reviews for mortality cases to commence in April 2018
- Development of Clinical Trials portfolio by March 2019
- Development of QI capability & capacity Trust wide by March 2019 (Driving partial assurance rating)

Board Assurance Framework 2017-18

Supporting our Journey from 'Good' to 'Outstanding'

by Delivering Excellence in Healthcare through Innovation and Collaboration.

We Care Because You Matter

Mid Cheshire Hospitals NHS Foundation Trust

Strategic Domain 2: Being a Leading Partner in a Progressive Health Economy

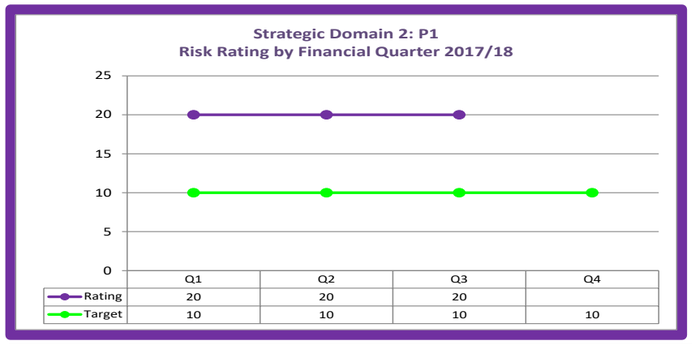
P1	To fully engage with all strategic partners to maximise the opportunities and advantages associated with horizontal integration in the designing and delivery of sustainable health services for the population of Central and Eastern Cheshire, whilst acknowledging and responding to: - National and regional strategies. - The need for sustainable high quality clinical services. - Favourable economies of scale and removal of unwarranted variation. - The cost effective sustainable use of resources.

Principal Risk

Risk of not continuing to develop effective external partnerships and alliances leading to failure to improve the long term clinical and financial sustainability and viability due to:

- Lack of full engagement – being a key partner
- Failure to engage effectively and lead the development across organisations that provide healthcare
- Lack of pace and appropriate scale to recognise the quality, economics and clinical benefits of change
- Partner perceptions of working relationships with MCHFT
- Impact of the Capped Expenditure programme and NHS Improvement Long Term Sustainability review

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHS Improvement Single Oversight Framework	Executive Director	Executive Management Group	Board Committee
June 2017	January 2018	March 2018	Well Led NHSI - Use of Resources	CEO	Board of Directors	Performance & Finance



Initial Risk Rating (Unmitigated)			Current Risk Rating (Mitigated)			Target Risk Rating (Tolerance / Risk Appetite)			
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Target Date
5	5	**25**	5	4	**20**	5	2	**10**	March 2019

Rationale for the Current Risk Score

Current risk rating retained due to pace of change – UHNM Stronger Together programme meetings to be re-established and dates are secured. New and existing partnerships will also be fashioned to support delivery of the Cheshire & Mersey as part of the acute sustainability review. Mrs Bullock has been appointed as the Senior Responsible Officer for the acute sustainability work stream for NHS Cheshire and Mersey. East Cheshire horizontal integration - one facilitated session through NHS Improvement has taken place and actions are being progressed between executive team members. The work stream scope is being developed by the SRO. Horizontal partnership agreements with other organisations are working well, with further partnerships being developed as a result of CEP e.g. Shrewsbury & Telford NHS Trust and Betsi Cadwaladr University Health Board continued working well.

Links to BAF Objectives

Q1, Q2, P2, E1, E2, W1, W2, W3, T1 & T2

Key Links to the Organisational Risk Register

CS0328 – Sustainability of Vulnerable Clinical Services due to Lack of Resource (People & finance)	20⇔	CS0327 – Long Term Financial Sustainability of MCHFT	20⇔

Key Controls/Influences(current performance - what we are currently doing about the risk?)

The Trust has a proven track record of delivery and partnering with other organisations to sustain services, maintain or improve quality and safety and reduce unacceptable variation. New and existing partnerships will also be fashioned to support delivery of the Cheshire & Mersey work streams. Future collaboration and partnerships will lead to a more complex and integrated landscape in which the Trust will have a key role. The new Trust Strategy was approved at the Board of Directors in December 2017 with 'Plans on a Page' developed by the divisions. Trust wide Strategy launch is planned for February 2018.

Key Gaps in Controls/Influences/Assurances (how are we addressing the gaps?)

- Re-launching UHNM / MCHFT Stronger Together Programme meetings
- Trust Strategy launch February 2018

Strategic Domain 2: Being a Leading Partner in a Progressive Health Economy

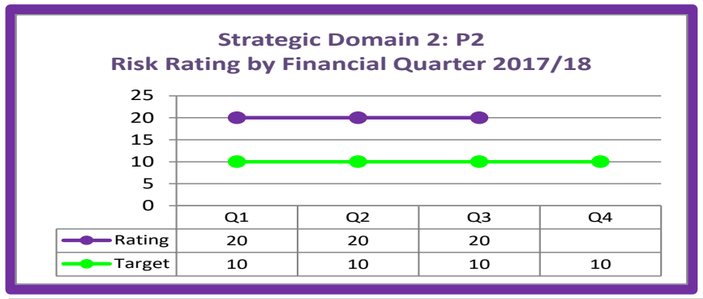
P2	To work with all key stakeholders to deliver a wholly integrated health and social care system, taking on clear collective responsibility for resources and population health, so that our residents receive better coordinated care within the designated financial envelope, whilst ensuring: - National and regional strategies are implemented. - The sustainable use of resources to deliver agreed health outcomes. - The development of a collective decision making and governance structure. - Sustainable clinical services through the development of Accountable Care Systems (ACS) / Organisations (ACO) and the implementation of new models of care (e.g. Home first principles).

Principal Risk

Risk of not continuing to develop effective external partnerships and alliances leading to failure to improve the health of the local population and reduce health inequalities, failure to develop new care pathways and failure to achieve long term clinical and financial sustainability and viability due to:

- Lack of full engagement – being a key partner
- Failure to engage effectively and lead the development of the local health economy
- Lack of pace and appropriate scale to recognise the quality, economics and clinical benefits of change
- Partners perceptions of working relationships with MCHFT
- Impact of Capped Expenditure programme and NHS Improvement Long Term Sustainability review

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHS Improvement Single Oversight Framework	Executive Director	Executive Management Group	Board Committee
June 2017	January 2018	March 2018	Well Led / NHSI - Use of Resources	CEO	Board of Directors	Performance & Finance



Initial Risk Rating (Unmitigated)			Current Risk Rating (Mitigated)			Target Risk Rating (Tolerance / Risk Appetite)			
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Target Date
5	5	**25**	5	4	**20**	5	2	**10**	March 2019

Rationale for the Current Risk Score

Current risk score maintained due to pace of change. Vertical integration: Accountable Care System developments with Positive STP Executive Chair going forward. Central & East Cheshire Caring Together & Connecting Care now have a joint chair appointed. CCICP opportunities with process facilitated sessions by NHSI to improve the partnership working and agreeing a vision & strategic objectives with an independent chair.
Fortnightly health economy meetings in place: 2 work streams integration of primary and community care development. Developing scopes – reporting monthly to the new Integrated Board from February 2018.

Links to BAF Objectives

Q1, Q2, P2, E1, E2, W1, W2, W3, T1 & T2

Key Links to the Organisational Risk Register

CS0328 – Sustainability of Vulnerable Clinical Services due to Lack of Resource (People & finance)	20⇔	CS0327 – Long Term Financial Sustainability of MCHFT	20⇔

Key Controls/Influences(current performance - what we are currently doing about the risk?)

It is recognised that the new and complex landscape will include working with all partners and stakeholders across the health economy to deliver greater integrated care. As such, the Trust will play a leading role in supporting the development of an Accountable Care System and therefore enabling high quality care to be delivered by the right professional in the right place at the right time. The new Trust Strategy was approved at the Board of Directors in December 2017 with 'Plans on a Page' developed by the divisions.

Key Gaps in Controls/Influences/Assurances (how are we addressing the gaps?)

- Trust Strategy launch February 2018
- Re-launching UHNM / MCHFT Stronger Together Programme meetings
- NHSI facilitated meetings - actions monitored at CCICP Board

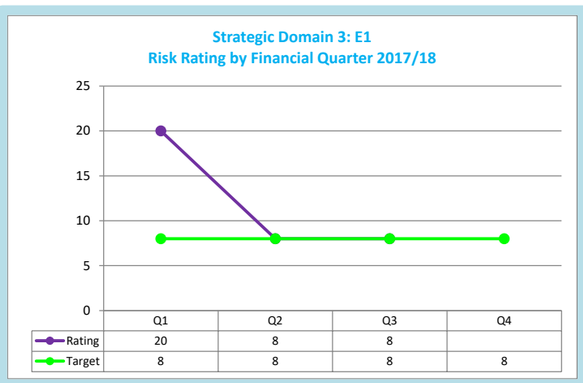
Strategic Domain 3: Striving for Outstanding Organisational Effectiveness

E1	To ensure full compliance with the NHS Improvement Provider Licence, ensuring financial sustainability, financial efficiency and financial controls, whilst safeguarding the quality of our services.

Principal Risk

Risk of failure to maintain financial stability which may impact on the Trust's compliance with the NHS Improvement Provider Licence.

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHS Improvement Single Oversight Framework	Executive Director	Executive Management Group	Board Committee
June 2017	December 2017	March 2018	Well Led NHSI - Use of Resources	Director of Finance and Planning	Divisional Finance & Activity Performance Group	Performance & Finance Committee



Initial Risk Rating (Unmitigated)			Current Risk Rating (Mitigated)			Target Risk Rating (Tolerance / Risk Appetite)			
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Target Date
4	5	**20**	4	2	**8**	4	2	**8**	March 2018

Rationale for the Current Risk Score

Score reduced in quarter 2 from 20 to 8 to reflect the reduced risk to the Trust following the participation in the system wide Capped Expenditure Programme (CEP), with NHS Improvement and / NHS England joint meetings in place. Target Control Total agreed with NHS Improvement.

Links to BAF Objectives

Q1, Q2, P1, P2, E2, W1, W2, W3, T1 & T2

Key Links to the Organisational Risk Register

CS0325 – Operational Sustainability of MCHFT	16⇔	CS0328 – Sustainability of Vulnerable Clinical Services due to Lack of Resource (People & finance)	20⇔
CS0327 – Long Term Financial Sustainability of MCHFT	20⇔	CS0275 – Delivering High Quality Clinical Services 7/7	20⇔
CS0326 – Non Delivery of the IT Strategy	20⇔		

Key Controls/Influences (current performance - what we are currently doing about the risk?)

The Trust's financial performance has been consistently strong delivering against its target Control Total in 2016/17 and 100% of the cost improvement target. Cash has remained positive all year with borrowings now in place to support elements of the capital programme and improved cash flow from the Trusts commissioners. Access to Capital nationally coupled with significant investment needs is currently stifling further capital development. The Trust's participation in the Capped Expenditure Programme in 2017/18 has been positive improving the health economies position through better join up planning and opportunity to deliver increased efficiencies across all providers. The Trust remains at NHS Improvement Segment 2 as of January 2018.

Key Gaps in Controls/Influences/Assurances (how are we addressing the gaps?)

- Re-launch Connecting Care Board
- Transformation programmes

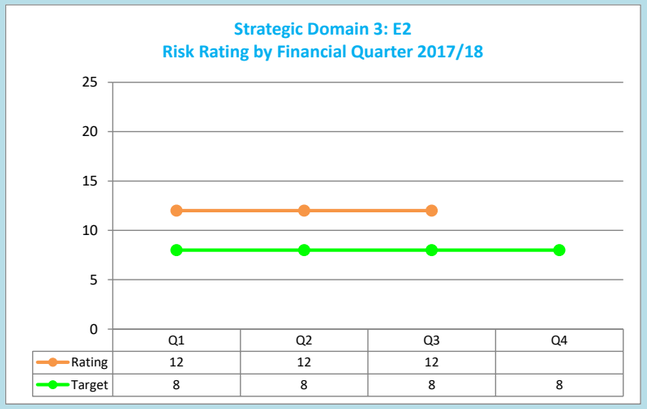
Strategic Domain 3: Striving for Outstanding Organisational Effectiveness

E2	To maintain compliance with, and aspire to achieve incremental improvements against, the NHS Improvement Single Oversight Framework Operational Performance Metrics, whilst safeguarding the quality of our services.

Principal Risk

Risk of not delivering the NHS Improvement Single Oversight Framework Operational Performance Metrics impacting on the quality of care we provide, patient and staff experience and the Trust's provider licence.

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHS Improvement Single Oversight Framework	Executive Director	Executive Management Group	Board Committee
June 2017	December 2017	March 2018	Responsive Care & Effective Care NHSI - Operational Performance Metrics	Chief Operating Officer	Divisional Finance & Activity Performance Group	Performance & Finance Committee



Initial Risk Rating (Unmitigated)			Current Risk Rating (Mitigated)			Target Risk Rating (Tolerance / Risk Appetite)			
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Target Date
4	5	**20**	4	3	**12**	4	2	**8**	March 2019

Executive Commentary for the Current Risk Score

Risk score remains at 12. Whilst the Trust has a strong record of compliance against the Single Oversight Framework with the exception of the A&E 4 hour standard. There are significant external factors outside of the Trust's direct control which can directly impact on the Trust's ability to maintain compliance. The main external areas would be community capacity within the care home and domiciliary care market, with any restriction or reduction requiring medically fit patients to remain in acute beds. In turn this would increase the Trust's occupancy levels and may impact on the elective programme and performance against RTT and cancer standards.

The Trust is working within an economy wide Capped Expenditure Programme which is designed to reduce cost or bring in income from outside the Central Cheshire economy. There will be schemes that are developed which may as the Trust moves further into the programme impact on compliance with the NHSI single oversight framework, an example would be limiting the amount paid to agency locums in hard to fill specialities and the impact this may have on Cancer Standards for example. The Capped Expenditure Programme has also reduced the amount of funding available to build resilience within the non-elective pathway during the winter period. Therefore performance against the 4 hour standard has reduced to below 90% in October and November. A&E The STF trajectory will now not be achieved in Q3 2017/18.

Links to BAF Objectives

Q1, Q2, P1, P2, E2, W1, W2, W3, T1 & T2

Key Links to the Organisational Risk Register

CS0325 – Operational Sustainability of MCHFT	16⇔	CS0326 – Non Delivery of the IT Strategy	20⇔
CS0328 – Sustainability of Vulnerable Clinical Services due to Lack of Resource (People & finance)	20⇔	CS0284 – Nursing Vacancies Across MCHFT	15⇔
CS0327 – Long Term Financial Sustainability of MCHFT	20⇔	DC0887 - Consultant Histopathologist Capacity	16⇩
CS0275 – Delivering High Quality Clinical Services 7/7	20⇔	DC 72 - Lack of breast cancer capacity due to lack of consultants (Radiology)	16⇔
EC0388 - Cardiac Monitoring System	20⇧	EC0327 - Lack of secondary Anaesthetic on-call cover	20⇧

Key Controls/Influences (current performance - what we are currently doing about the risk?)

The Trust has consistently delivered four of the five standards within the NHS Improvement Single Oversight Framework, with the exception being performance against the four hour emergency access standard. Nationally the majority of economies are challenged against the four hour emergency access standard. The Trust has a solid foundation of quality and improving the timely flow of our non-elective activity which it is building upon at a time of increased pressure within the system to deliver compliance against the 4 hour standard.

Key Gaps in Controls/Influences/Assurances (how are we addressing the gaps?)

- Partnership working and agreeing actions to support future compliance.
- Review and update of Performance Management Framework by September 2018.

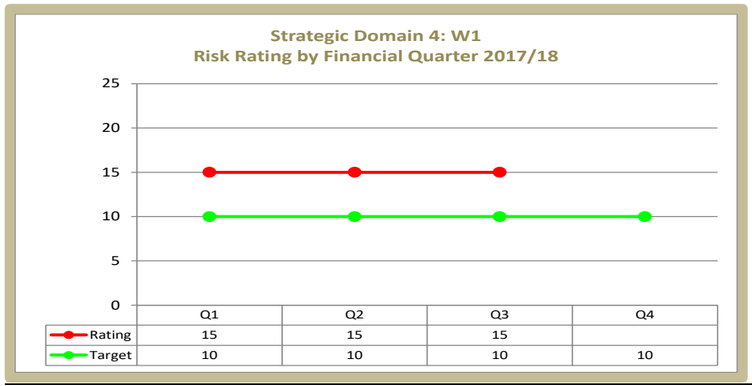
Strategic Domain 4: Aspiring to Excellence in Practice through Our Workforce

W1	Our cadre of patient centred leaders will be skilled in continually promoting and building upon our open and honest culture. This will be achieved through sharing the Trust's vision, values, behaviours and objectives from Board to ward.

Principal Risk

Risk of lack of patient centred leaders to continually embed and build upon our open and honest culture impacting on the quality of our services and patient and staff experience.

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHS Improvement Single Oversight Framework	Executive Director	Executive Management Group	Board Committee
June 2017	January 2018	April 2018	Well Led Framework NHSI Organisational Health Metrics	Director of Workforce & Organisational Development	Executive Workforce Assurance Group	Transformation & People Committee



Initial Risk Rating (Unmitigated)			Current Risk Rating (Mitigated)			Target Risk Rating (Tolerance / Risk Appetite)			
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Target Date
5	5	**25**	5	3	**15**	5	2	**10**	March 2019

Rationale for the Current Risk Score

To maintain risk score at 15 whilst ability to recruit to senior leadership posts remains a challenge. Reduction in risk will occur when there is a shift from locum cover to filling posts substantively.

Links to BAF Objectives

Q1, Q2, P1, P2, E1, E2, W2, W3, T1 & T2

Key Links to the Organisational Risk Register

CS0325 – Operational Sustainability of MCHFT	16⇔	CS0328 – Sustainability of Vulnerable Clinical Services due to Lack of Resource (People & finance)	20⇔
CS0327 – Long Term Financial Sustainability of MCHFT	20⇔	CS0275 – Delivering High Quality Clinical Services 7/7	20⇔
CS0326 – Non Delivery of the IT Strategy	20⇔	CS0284 – Nursing Vacancies Across MCHFT	15⇔
EC0327 - Lack of secondary Anaesthetic on-call cover	20⇧	DC 72 - Lack of breast cancer capacity due to lack of consultants (Radiology)	16⇔
DC0887 - Consultant Histopathologist capacity	16⇩		

Key Controls/Influences (current performance - what we are currently doing about the risk?)

Central to our Workforce Matters Strategy (In development) is our ability to establish a culture which helps grow and develop our own leaders from within the organisation, enabling us to retain and nurture talent from an engaged workforce that is passionate about providing excellent clinical practice in their care of our patients. A senior leadership event is arranged in January 2018 with Chris Hopson CEO from NHS providers presenting.

Key Gaps in Controls/Influences/Assurances (how are we addressing the gaps?)

- Review of Workforce & OD Strategy (Workforce Matters) by March 2018
- Review of Education Governance framework by April 2018
- Development of senior leadership team community in MCHFT by March 2018
- Local development of improvement plans following the National Staff Survey results – Review at TAP by December 2017

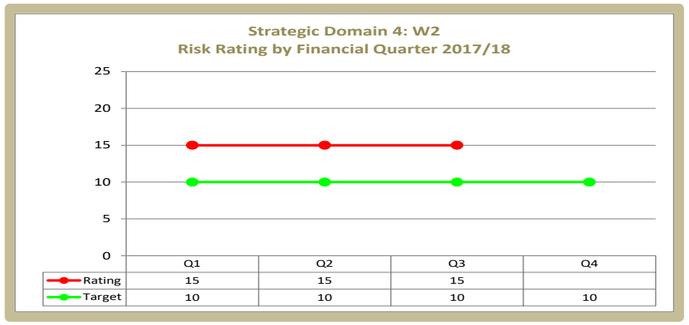
Strategic Domain 4: Aspiring to Excellence in Practice through Our Workforce

W2	We will have in place a flexible and responsive workforce to meet patient needs by ensuring: - We have sufficient workforce numbers, with the right skills, in the right place, at the right time to meet the demands of our services across seven days. - Staff continually engaging in professional development regardless of their role. - Effective workforce planning to secure existing, and mitigate against anticipated shortages in skills. - We take a proactive approach to developing our future workforce by engaging with the local community and education providers

Principal Risk

Risk that the Trust does not have an agile and responsive workforce to meet the future local health needs / accountable care systems model.

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHS Improvement Single Oversight Framework	Executive Director	Executive Management Group	Board Committee
June 2017	January 2018	April 2018	Well Led Framework NHSI Organisational Health Metrics	Director of Workforce & Organisational Development	Executive Workforce Assurance Group	Transformation & People Committee



Initial Risk Rating (Unmitigated)			Current Risk Rating (Mitigated)			Target Risk Rating (Tolerance / Risk Appetite)			
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Target Date
5	5	**25**	5	3	**15**	5	2	**10**	March 2019

Rationale for the Current Risk Score

Rating of 15 for Q3 as although the Trust has low levels of vacancies there are hot spots e.g. radiology and although mandatory training uptake is progressing needs improvement. Additionally long term recruitment plans are good, however short term recruitment needs continues to be a challenge.

Links to BAF Objectives

Q1, Q2, P1, P2, E1, E2, W2, W3, T1 & T2

Key Links to the Organisational Risk Register

CS0325 – Operational Sustainability of MCHFT	16⇔	CS0328 – Sustainability of Vulnerable Clinical Services due to Lack of Resource (People & finance)	20⇔
CS0327 – Long Term Financial Sustainability of MCHFT	20⇔	CS0275 – Delivering High Quality Clinical Services 7/7	20⇔
CS0326 – Non Delivery of the IT Strategy	20⇔	CS0284 – Nursing Vacancies Across MCHFT	15⇔
EC0327 - Lack of secondary Anaesthetic on-call cover	20⇧	DC 72 - Lack of breast cancer capacity due to lack of consultants (Radiology)	16⇔
DC0887 - Consultant Histopathologist capacity	16⇩		

Key Controls/Influences (current performance - what we are currently doing about the risk?)

Mandatory training compliance was 82.86% in December and has dipped slightly from 83% in November therefore further improvement is required to reach the target of 90% year end. A very slight increase in the appraisal rate (88.75%) was seen in December 2017.

Key Gaps in Controls/Influences/Assurances (how are we addressing the gaps?)

- Review of Workforce & OD Strategy (Workforce Matters) by March 2018
- Review of Education Governance framework by April 2018
- Development of senior leadership team community in MCHFT by March 2018
- Local development of improvement plans following the National Staff Survey results – Review at TAP by December 2017
- Talent management & succession planning programme planned

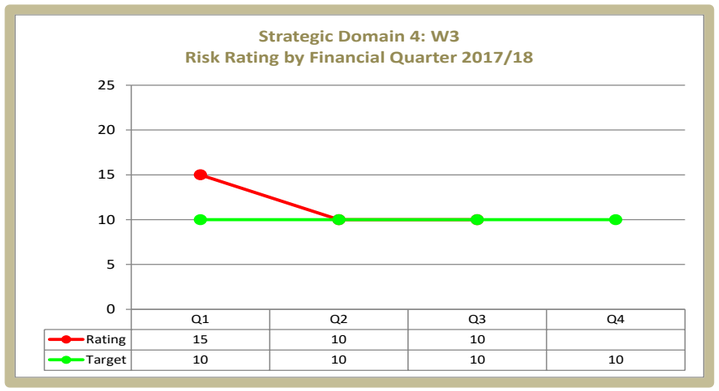
Strategic Domain 4: Aspiring to Excellence in Practice through our Workforce

W3	Our staff will feel valued and recognised for the work they do. They will also feel engaged as both employees and members of the Trust. We will encourage our staff to improve and maintain their own health and well-being, ensuring that MCHFT, as an organisation sets our own example for delivering excellence in quality care and services.

Principal Risk

There is a risk if our staff do not feel valued and supported to maintain their own health & well-being that this will impact on the quality of services we provide and we will not be the employer of choice in the area.

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHS Improvement Single Oversight Framework	Executive Director	Executive Management Group	Board Committee
June 2017	January 2018	April 2018	Well Led Framework NHSI Organisational Health Metrics	Director of Workforce & Organisational Development	Executive Workforce Assurance Group	Transformation & People Committee



Initial Risk Rating (Unmitigated)			Current Risk Rating (Mitigated)			Target Risk Rating (Tolerance / Risk Appetite)			
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Target Date
5	5	**25**	5	2	**10**	5	2	**10**	March 2018

Rationale for the Current Risk Score

Very positive National Staff Survey results (March 2017) top Trust with no areas rated in the bottom 20%. For the second consecutive month there has been a small increase in both the rolling average sickness absence as well as the in month sickness absence rate in December 2017 being 4.89%. The most common cause of absence continues to be stress, depression or anxiety and musculoskeletal absences.

Links to BAF Objectives

Q1, Q2, P1, P2, E1, E2, W2, W3, T1 & T2

Key Links to the Organisational Risk Register

CS0325 – Operational Sustainability of MCHFT	16⇔	CS0328 – Sustainability of Vulnerable Clinical Services due to Lack of Resource (People & finance)	20⇔
CS0327 – Long Term Financial Sustainability of MCHFT	20⇔	CS0275 – Delivering High Quality Clinical Services 7/7	20⇔
CS0326 – Non Delivery of the IT Strategy	20⇔	CS0284 – Nursing Vacancies Across MCHFT	15⇔

Key Controls/Influences (current performance - what we are currently doing about the risk?)

Very positive National Staff Survey results (March 2017) top Trust with no areas rated in the bottom 20%. For the second consecutive month there has been a small increase in both the rolling average sickness absence as well as the in month sickness absence rate in December 2017 being 4.89%. The most common cause of absence continues to be stress, depression or anxiety and musculoskeletal absences. Plan in relation to managing sickness progressing.

Key Gaps in Controls/Influences/Assurances (how are we addressing the gaps?)

- Talent management & succession planning programme planned
- Community bespoke Flu campaign in progress
- Divisional improvement plans to respond to staff surveys – EWAG in progress

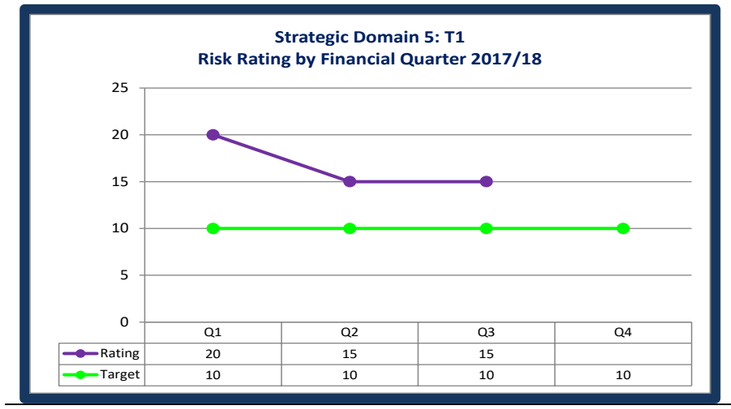
Strategic Domain 5: Creating a 21st Century Infrastructure for Transformative Health and Social Care

T1	To deliver an agreed, costed and phased Estates Strategy which will make the best use of the Trust's estate taking into consideration the entire estate across the Central Cheshire system, national and regional agendas and in particular the strategic aim of the system to become an Accountable Care System.

Principal Risk

Risk that the physical infrastructure is not of a sufficient standard resulting in aged, deteriorating physical assets impacting on patient and staff experience reducing due to challenges in delivering backlog and capital programmes due to financial circumstances.

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHS Improvement Single Oversight Framework	Executive Director	Executive Management Group	Board Committee
19.06.2017	January 2018	March 2018	Well Led Framework Use of Resources	CEO	Executive Infrastructure Development Group	Performance & Finance



Initial Risk Rating (Unmitigated)			Current Risk Rating (Mitigated)			Target Risk Rating (Tolerance / Risk Appetite)			
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Target Date
5	5	25	5	3	15	5	2	10	March 2019

Rationale for the Current Risk Score

The risk score reduced from 20 to 15 in quarter 2 to reflect the approval of the loan by NHS Improvement to support the ward refurbishment programme. Remains a high risk overall at 15 due to long term backlog maintenance requirements.

Links to BAF Objectives

Q1, Q2, P1, P2, E1, E2, W1, W2, W3 & T2

Key Links to the Organisational Risk Register

CS0327 – Long Term Financial Sustainability of MCHFT	20⇔	CS0325 – Operational Sustainability of MCHFT	16⇔

Key Controls/Influences (current performance - what we are currently doing about the risk?)

The Trust has undertaken the development of a clinically led 5 year Estate Strategy encompassing estate managed on behalf of community services. This will support the understanding of the current estate infrastructure and future needs as the partners of Central Cheshire move towards an Accountable Care System. The main challenge to delivering the Estate Strategy is the financial affordability, particularly as the Trust has long term backlog requirements and much of the community estate is bound by long term PFI agreements. Divisional Director of Estates SRO for Estates developments & opportunities across the Cheshire East foot print.

Key Gaps in Controls/Influences/Assurances (how are we addressing the gaps?)

- Refresh of Estates Strategy in progress
- Asbestos Management Group – oversight of new contractors in progress

Strategic Domain 5: Creating a 21st Century Infrastructure for Transformative Health and Social Care

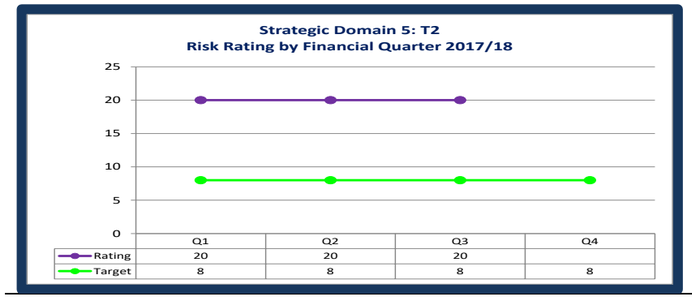
T2a	**To deliver an agreed, costed and phased Information Technology (IT) Strategy which supports the provision of seamless, integrated, outstanding patient care, improves staff experience in delivering care and enables continuous quality and service improvements through the intelligent use of secure, real time data.**

Principal Risk

Risk of failure to fully implement the Information Technology Strategy due to lack of capital / revenue funding will result in:

- Missed opportunities to improve the quality of care we provide, leading to poor patient and staff experience (E.g. E Prescribing & E Rostering)
- Inability to modernise services (E.g. E Prescribing & E Rostering)
- Delays in delivering horizontal and vertical integration – Accountable Care Systems
- Failure to meet Legislative requirements and associated reputational risks e.g. GDPR
- Failure to reduce unwarranted variation (Carter – Model Hospital work)

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHS Improvement Single Oversight Framework	Executive Director	Executive Management Group	Board Committee
June 2017	December 2017	March 2018	Well Led Framework Use of Resources	Medical Director / Deputy CEO	Executive Infrastructure Development Group	Performance & Finance Committee



Initial Risk Rating (Unmitigated)			Current Risk Rating (Mitigated)			Target Risk Rating (Tolerance / Risk Appetite)			
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Target Date
4	5	**20**	4	5	**20**	4	2	**8**	March 2019

Rationale for the Current Risk Score

Retaining a risk score of 20 based upon that the business case is progressing with approval at Performance & Finance Committee in December 2017 and the Board of Directors in January 2018.

Links to BAF Objectives

Q1, Q2, P1, P2, E1, E2, W1, W2, W3, T1 & T2b

Key Links to the Organisational Risk Register

CS0327 – Long Term Financial Sustainability of MCHFT	20⇔	CS0302 – Information Governance	20⇔

Key Controls/Influences (current performance - what we are currently doing about the risk?)

The Trust has developed a clinically led Information Technology Strategy that is centred around an electronic patient record, and supports whole system service transformation and integration as we move towards an Accountable Care System. The main challenge to delivering the Information Technology Strategy is the financial affordability, particularly as the Trust is part of a Capped Expenditure Programme, although the Board of Directors does not underestimate the level of organisational development support that will be required for the organisation to undergo the necessary culture change. A Chief Nursing Information Officer and Chief Clinical Information Officer have been appointed to support the EPR. The Executive Lead for Cyber Security is the Medical Director / Deputy CEO.

Key Gaps in Controls/Influences/Assurances (how are we addressing the gaps?)

- Progress EPR Business Case
- Business case to participate in Cheshire & Merseyside PACs Collaborative as a fund saving initiative progressing
- Undertake 10 Steps to Cyber Security gap analysis in Quarter 4 2017/18
- GDPR gap analysis & plan in Quarter 4 2017/18

Board Assurance Framework 2017-18

Supporting our Journey from 'Good' to 'Outstanding'

by Delivering Excellence in Healthcare through Innovation and Collaboration.

Mid Cheshire Hospitals NHS Foundation Trust

Strategic Domain 5: Creating a 21st Century Infrastructure for Transformative Health and Social Care

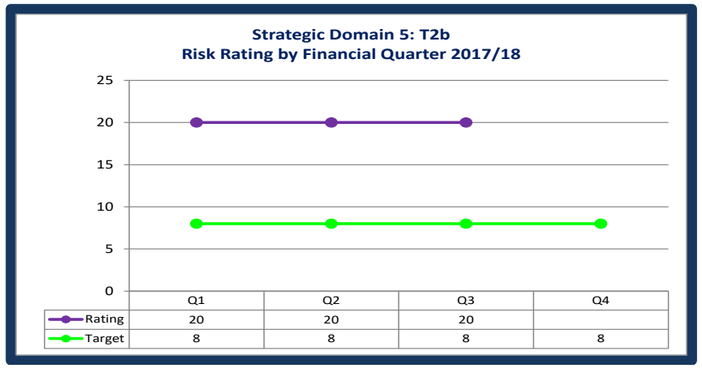
T2b	To deliver an agreed, costed and phased Information Technology (IT) Strategy which supports the provision of seamless, integrated, outstanding patient care, improves staff experience in delivering care and enables continuous quality and service improvements through the intelligent use of secure, real time data.

Principal Risk

Risk of failure to fully implement the Information Technology Strategy due organisational culture regarding digital awareness / capability resulting in sickness / data quality issues / recruitment impacts leading to:

- Missed opportunities to improve the quality of care we provide, leading to poor patient and staff experience (E.g. E Prescribing & E Rostering)
- Inability to modernise services (E.g. E Prescribing & E Rostering)
- Failure to meet Legislative requirements and associated reputational risks e.g. GDPR
- Failure to reduce unwarranted variation (Carter – Model Hospital work)

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHS Improvement Single Oversight Framework	Executive Director	Executive Management Group	Board Committee
June 2017	December 2017	March 2018	Well Led Framework Use of Resources	Medical Director / Deputy CEO	Executive Infrastructure Development Group	Performance & Finance Committee



Initial Risk Rating (Unmitigated)			Current Risk Rating (Mitigated)			Target Risk Rating (Tolerance / Risk Appetite)			
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Target Date
4	5	**20**	4	5	**20**	4	2	**8**	March 2019

Rationale for the Current Risk Score

Retain current score in quarter 3 as the business case is progressing and organisational development dependencies.

Links to BAF Objectives

Q1, Q2, P1, P2, E1, E2, W1, W2, W3, T1 & T2a

Links to the Organisational Risk Register (Current Risk Rating 15 & above)

CS0327 – Long Term Financial Sustainability of MCHFT	20⇔	CS0302 – Information Governance	20⇔

Key Controls/Influences (current performance - what we are currently doing about the risk?)

Phased implementation of Office 365 with support and training has commenced on track. Corporate funding on a lease basis agreed to replace old hardware across the organisation.

Key Gaps in Controls/Influences/Assurances (how are we addressing the gaps?)

- Office 365 implementation-on track
- 6/12 digital awareness programmes planned
- Review of job description content re digital age
- Recruitment assessment process and underpinning support programme to be introduced.
- QA process for train the trainer to be introduced.

Appendix A – Objectives & Success Measures	**Domain One: Delivering Outstanding Clinical Quality, Safety & Experience**
Objective Q1. To aspire to the delivery of 'outstanding' clinical quality and safety, which is equitable, patient and family centred and supported by an effective quality governance framework	**We will know when we have succeeded by measuring what matters and through:** • Implementing the Quality and Safety Improvement Strategy making this inclusive of all staff • Ensuring compliance with all legal and regulatory requirements • Using local and national benchmarking data to demonstrate consistently high quality clinical care with no unwarranted variation and top quartile performance. • Delivering top quartile performance for national staff and patient surveys as well as consistent positive feedback, greater than 90%, from patients, family members, carers and patient groups, targeting specifically those groups likely to be subject to less equitable services. • Progressing the continuous learning culture through recognised processes of good governance to evidence sustainable improvements to patient safety, quality of care and outcomes. • Working with clinical teams to ensure documentation and record keeping are robust and accurate
Objective Q2. To drive continuous quality improvement and promote research and innovation, whilst reducing unwarranted clinical variation and progressing from a 'good' to 'outstanding' organisation.	**We will know when we have succeeded by measuring what matters and through:** • Progressing towards an 'Outstanding' CQC rating through a clinical quality improvement programme that is Executive led and clinically owned and supported • Engaging with wider stakeholders to ensure further development of clinical pathways to deliver services that are clinically aligned with the needs of the local population and connect across health and social care • Leading on local and national safety collaborations to achieve best practice through influencing national directives and local practice • Ensuring clinical service needs where required are delivered equitably across 7 days • Encouraging and promoting involvement in research and innovation, including academic research and partners, showcasing participation to internal and external stakeholders and sharing outcomes with others. • Use evidence led accreditation in research & innovation to support research studies
Domain Two: Being a Leading Partner in a Progressive Health Economy	
Objective P1 To fully engage with all strategic partners to maximise the opportunities and advantages associated with horizontal integration in the designing and delivery of sustainable health services for the population of Central and Eastern Cheshire, whilst acknowledging and responding to: - National and regional strategies. - The need for sustainable high quality clinical services. - Favourable economies of scale and removal of unwarranted variation. - The cost effective sustainable use of resources.	**We will know when we have succeeded by measuring what matters and through:** • Playing a leading role in implementing the NHS Cheshire & Merseyside Plan with demonstrable outputs and outcomes: - Supporting and leading developments within Cheshire & Wirral and Cheshire & Mersey to enable greater collaboration in relation to back office functions, clinical support services and where appropriate, clinical services. - Supporting the development and delivery of the NHS Cheshire & Mersey, Cheshire & Wirral work streams • Playing a leading role in the delivery of the Capped Expenditure Programme to ensure the appropriate transformation of health and social care to ensure the economic sustainability for Central (& Eastern) Cheshire • Playing a leading role in shaping and delivering the Long Term Sustainability Review: - Mapping the current delivery of services and work with partners, in particular ECT and UHNM, to change the delivery model where improved patient benefit and sustainable provision can be provided by the Trust or others. - With health economy partners, consider longer term options and develop the case to enable MCHFT to provide long term sustainability for ECT - Developing a more flexible workforce that can be deployed differently to lead and support the developing and delivery of high quality integrated horizontal pathways for our patients • Providing sustainable high quality services that are valued by the population served and enhancing the reputation of the Trust to keep services local
Objective P2. To work with all key stakeholders to deliver a wholly integrated health and social care system, taking on clear collective responsibility for resources and population health, so that our residents receive better coordinated care within the designated financial envelope, whilst ensuring: - National and regional strategies are implemented. - The sustainable use of resources to deliver agreed health outcomes. - The development of a collective decision making and governance structure. - Sustainable clinical services through the development of Accountable Care Systems (ACS) /Organisations (ACO) and the implementation of new models of care (e.g. Home first principles)	**We will know when we have succeeded by measuring what matters and through:** • The Central Cheshire Integrated Care Partnership (CCICP) developing and implementing a transformation programme that enhances and integrates care locally and is an enabler to the development of an Accountable Care System: - Care Communities and Primary Care Home through GP clusters for populations of 30 – 50k - Integrated pathways across primary, secondary and community teams, social care and mental health recognising the roles and responsibilities of providing core integrated care, urgent responsive care and specialist care, taking account of the latest treatments and advances in medicine - Enabling infrastructure that transforms the organisational development and culture of the workforce. • Using clinical senate forums, and with health economy partners, playing a leading role in developing and implementing ACS/Os with demonstrable outputs and outcomes, therefore, creating a system that: - Promotes self care and prevention including vaccination and screening programmes alongside education to make our population healthier - Ensures the Health Economy lives within its means and funds are used in the most effective way to optimise patient outcomes. - Provide sustainable high quality local clinical services that are valued by the population of Central Cheshire. • Ensuring the provision of integrated care is inclusive of all partners including the third sector

Board Assurance Framework 2017-18

Supporting our Journey from 'Good' to 'Outstanding'

by Delivering Excellence in Healthcare through Innovation and Collaboration.

Mid Cheshire Hospitals NHS Foundation Trust

Domain Three: Striving for Outstanding Organisational Effectiveness	
Objective E1. To ensure full compliance with the NHS Improvement Provider Licence, ensuring financial sustainability, financial efficiency and financial controls, whilst safeguarding the quality of our services	**We will know when we have succeeded by measuring what matters and through:** • Meeting the key national targets and standards including those in the NHS Constitution. • Working with Partners to bring the system back into economic balance through the effective delivery of the Capped Expenditure Programme and fully develop the long term sustainability plan. • Delivering the efficiencies identified through the model hospital and reduce unwarranted variation across a range of productivity and clinical effectiveness measures. • Achieving Segment 1 against the NHSI Single Oversight Framework. • Demonstrating a Well Led organisation with good organisational health metrics. • Progressing from a 'Good' to 'Outstanding' Care Quality Commission (CQC) rating. • Developing and using live data to prove compliance through robust demonstrable based information.
Objective E2. To maintain compliance with, and aspire to achieve incremental improvements against, the NHS Improvement Single Oversight Framework Operational Performance Metrics, whilst safeguarding the quality of our services	
Domain Four: Aspiring to Excellence in Practice through our Workforce	
Objective W1. Our cadre of patient centred leaders will be skilled in continually promoting and building upon our open and honest culture. This will be achieved through sharing the Trust's vision, values, behaviours and objectives from Board to ward / care environment.	**We will know when we have succeeded by measuring what matters and through:** • Becoming an exemplar organisation for developing new clinical roles that respond to population needs across the health economy, 7 days a week. • Enhancing skills for existing staff to widen their repertoire of competence. • Embedding the Trust's vision, values, behaviours and objectives across the organisation with local implementation and adaptation. • Achieving the workforce ambitions set out in our Equality Delivery Scheme Plan, including those associated with the Workforce Race Equality Standard (WRES) and Gender Equality. • Further developing our culture and reputation as a caring organisation • Continuing to improve our staff survey results and maintain our position to be in the top quartile nationally. • Demonstrating a Well Led organisation with good organisational health metrics. • Progressing from a 'Good' to 'Outstanding' Care Quality Commission (CQC) rating.
Objective W2. We will have in place a flexible and responsive workforce to meet patient needs by ensuring: - We have sufficient workforce numbers, with the right skills, in the right place, at the right time to meet the demands of our services across seven days. - Representing the diversity of our local population. - Staff continually engaging in professional development regardless of their role. - Effective workforce planning to secure existing, and mitigate against anticipated - Take a proactive approach to developing our future workforce by engaging with the local community and education providers.	
Objective W3. Our staff will feel valued and recognised for the work they do. They will also feel engaged as both employees and members of the Trust. We will encourage our staff to improve and maintain their own health and well-being, ensuring that MCHFT, as an organisation sets our own example for delivering excellence in quality care and services.	

Domain Five: Creating a 21st Century Infrastructure for Transformative Health and Social Care	
Objective T1. To deliver an agreed, costed and phased Estates Strategy which will make the best use of the Trusts estate taking into consideration the entire estate across the central Cheshire system, national and regional agendas and in particular the strategic aim of the system to become an Accountable Care System.	**We will know when we have succeeded by measuring what matters and through:** • Undertaking the development of a 5 year estate strategy which encompasses community services estate and where possible, works with stakeholders to consider the best options for all of the estate within Central Cheshire. • Working with health economy partners to maximise estate utilisation for properties owned / not owned by MCHFT / CCICP. • Understanding and using the IT developments in CCICP as a baseline for the transformation interdependencies of IT and Estates Infrastructure • Providing a modern, safe, fit for purpose environment to deliver outstanding quality care in the most appropriate location. • Supporting clinical teams to transfer services into the community where it is appropriate to do so and at the same time ensure the estate is effectively utilised. • Working with external stakeholders to ensure external factors e.g. roads, houses, multi-purpose building developments are understood and MCHFT / CCICP views are listened to and considered. • Being a key partner in supporting the developments of an Accountable Care System and adjusting the estate strategy as the models of care are developed.
Objective T2. To deliver an agreed, costed and phased Information Technology (IT) Strategy which supports the provision of seamless, integrated, outstanding patient care, improves staff experience in delivering care and enables continuous quality and service improvements through the intelligent use of secure, real time data	**We will know when we have succeeded by measuring what matters and through:** • Implementing advances in Information Technology, centred on a shared electronic patient record across health and social care, which will support our journey of continuous improvement in collaboration with CCICP and ensure that the required whole system service transformation delivers an Accountable Care System. • Use the CCICP IT strategy to develop wider opportunities to support staff and patients, examples include: e community tracking systems to support lone working patterns, virtual consultations in GP OOHs to support consolidation and better use of workforce resource • Develop and use live dashboards to provide intelligence to the system and transformation programme needs

Appendix B – Risk matrices

Consequence / Likelihood	1	2	3	4	5
1	1	2	3	4	5
2	2	4	6	8	10
3	3	6	9	12	15
4	4	8	12	16	20
5	5	10	15	20	25

Likelihood	Definition	Estimated Probability	Lessons Learned
Almost certain	This event may be imminent or there are strong indications it will occur in the future. Not confident risk can be managed at this level and contingency is required	More than 80% chance of occurring	A regular occurrence. Circumstances found frequently
Likely	This event is likely to occur in most circumstances. Requires additional mitigation/contingency. Little confidence risk can be managed at this level.	51% to 80% chance of occurring	Has occurred from time to time and may do so again in the future
Possible	This event is likely to occur at some time even if controls operate normally. Confident risk can be managed at this level.	21% to 50% chance of occurring	Has occurred previously but not often, and may have been in a limited way
Unlikely	Not expected, this event has a small chance of occurring at some time	6% to 20% chance of occurring	Has not happened, or happened in a very limited way
Rare	Highly unlikely; will occur only in very exceptional circumstances. Very confident risk can be managed at this level. Controls operate normally	Less than a 5% chance of occurring	Has rarely happened

Appendix C – Questions for Board Sub-Committees

Assurance:

Provides: Confidence / evidence / certainty
To: Board / managers / stakeholders
That: That which needs to be done is being done

In order to make this assessment, Committees may wish to consider the following questions, based on the evidence provided on the BAF for each objective

- To what extent are the key controls (i.e. existing controls) effective?
- What are the gaps in the controls, how significant are they in relation to the current risk score?
- What internal assurances and independent external assurances are in place? Are they sufficient / adequate and are there any gaps? Are additional assurances required?
- Are there any areas where assurance is duplicated, repeated or excessive when compared to the activity undertaken?
- What actions are there in place to further mitigate the risk to the agreed tolerated level? Are they current and active? Are they adequate? Does more need to be done?

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

Title of Paper :	Organisational Risk Register Report Q3 2017/18	
Author:	Associate Director-Integrated Governance	
Executive Lead:	Medical Director	
Type of Report:	Concept Paper	
	Strategic Options Paper	
	Business Case	
	Information	
	Review/Benefits/Audit	✓

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

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

Positive Benefit:	Provides a position statement of the organisational risks for quarter 3, with oversight by the Quality Governance Committee. Further work is progressing with the development of divisional board and CCICP quarterly reports.
Risk:	Lack of oversight of key risks to achieving the Strategic Objectives.

To be published on Trust Website – complete version	***Yes***
If no, to be published on Trust Website – redacted	
If not to be published complete or redacted, please detail the reason why	
Presented at Board Meeting of:	3 April 2018

Quarterly Organisational Risk Register Report 2017/18

Quarter 3

'Delivering Excellence in Healthcare through Innovation and Collaboration'

Contents

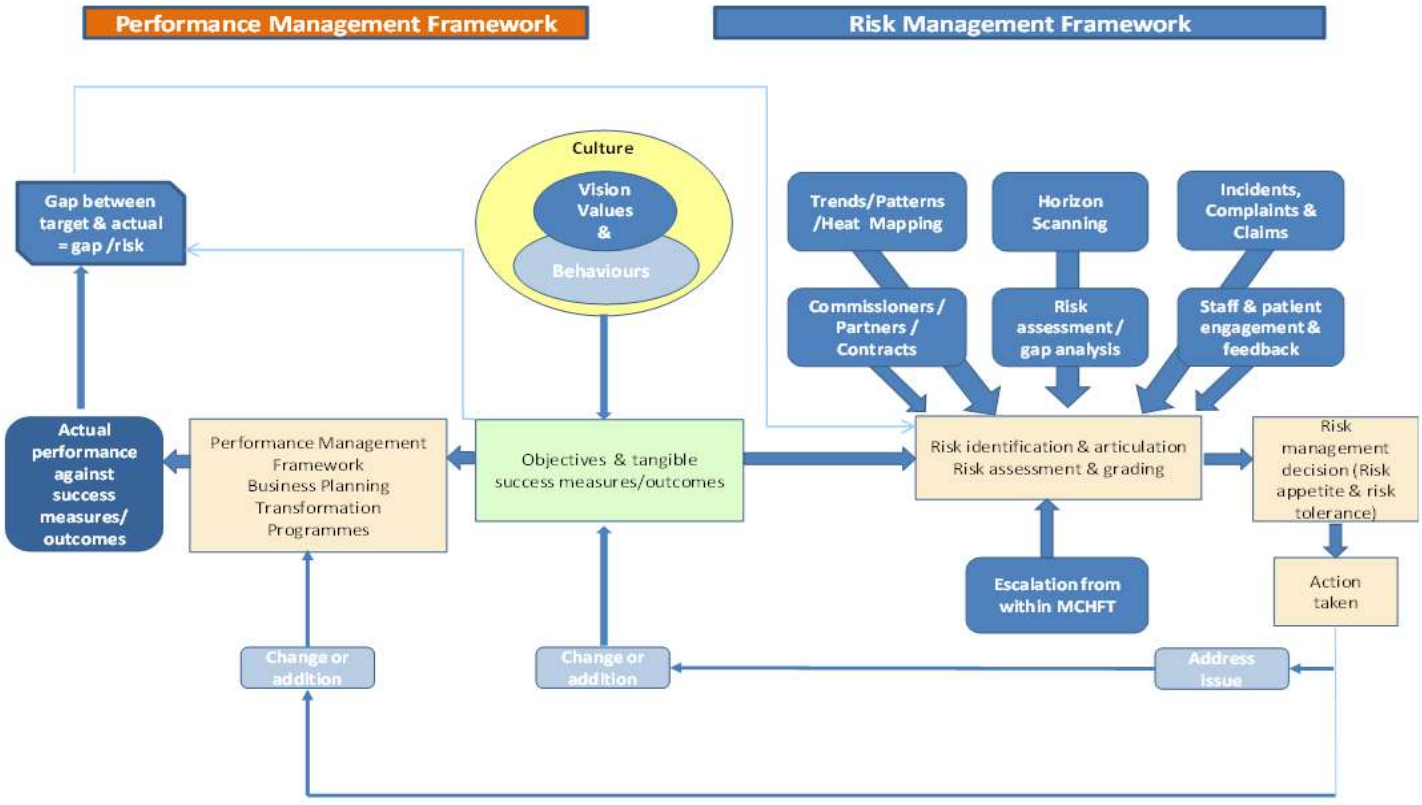
1. Purpose

The new *Risk Management Strategy & Framework 2017/20* was approved in August 2017 and forms part of the Trust's wider internal control and governance arrangements. Work on the Trust's risk management processes will be iterative over the lifetime of the strategy & framework. This report provides an overview of organisational risks rated 15 and above (guide) and a summary of progress, with detailed risks rated 20 and above included in Appendix A. Appendix B provides a progress update against the six key priorities detailed in the *Risk Management Strategy & Framework 2017/20* and Appendix C provides the summary risk matrices.

2. Current position & next steps

This is the second version of the revised quarterly organisational risk register report. In parallel divisional/CCICP level reports are being developed and presented at Divisional/CCICP Boards as iterative documents for discussion and feedback. Work on revising the current approach to defining risk statements to a *"There is a risk that <risk event> as a result of <cause> which may lead to <effect/impact>"* is progressing with a focus on risks rated 15 and above. With the introduction of the web based risk system and supportive education and training the aim is that all grades of risks will be revised as they are due for review. Roll out of risk web is planned by March 2019.

The diagram below details the relationship between the performance and planning and risk management frameworks and the linkages across. Future versions of the divisional/CCICP reports will map the risks to the local objectives (*Trust Strategy 2017 with 2020 Horizon*: Plans on a Page).



3. Top five organisational risks

The top five organisational risks mapped to the Board Assurance Framework are detailed below.

Risk Title	Mitigated (With controls) Risk Rating	Shift					Key links to BAF 2017/18
		Q4 – 16/17	Q1-17/18	Q2-17/18	Q3-17/18	Q4-17/18	
Operational Sustainability of MCHFT	4(C)x4(L)=16	⇔	⇔	⇔	⇔		Q1,Q2 E1,E2 P1.P2
Sustainability of Vulnerable Clinical Services due to Lack of Resource (People & finance)	5(C)x4(L)=20	⇔	⇔	⇔	⇔		Q1,Q2 P1,P2 E2,W2
Delivering High Quality Clinical Services 7 Days per Week	5(C)x4(L)=20	⇔	⇔	⇔	⇔		Q1,Q2 P1.P2 E2,W2,T1 T2a, T2b
Long Term Financial Sustainability of MCHFT	5(C)x4(L)=20	⇔	⇔	⇔	⇔		E1,E2 P1,P2 T1 T2a, T2b
Delivering the Information Technology Strategy	4(C)x5(L)=20	⇔	⇔	⇔	⇔		Q1,Q2 E1,E2 T2a,T2b

4. New risks in the quarter 3 rated 15 & above

- Critical Care Nurse in charge not supernumerary
- Potential Impact if NIV is unable to be provided on Ward 5

5. Risks past the review date rated 15 & above

- None

6. Closed / de-escalated risks previously rated 15 & above

* In development

Ref	Lead	Divisional Objective*	Title	Date of Initial Assessment	Rating with existing control measures (CxL)							Rationale De-escalation / Closure	Date
					Controls Assurance Rating*	Q4 16/17	Q1	Q2	Q3	Q4	Target Rating		
EC0331	**AMD** Doug Robertson		Vacancies in a number of difficult to recruit Consultant posts within the Division	03/06/2015		4x5 = 20	4x5 = 20	4x5 = 20			4x2 = 8	*Speciality specific risk assessments developed.*	30/09/2017
EC0367	**Matron** Betty Lodge		Risks associated with bedding patients within majors not in a designated cubicle	12/05/2016		4x4 = 16	4x4 = 16	4x4 = 16			4x2 = 8	*Closure based on incident data.*	30/09/2017
EC0369	**HoN** Linda Ormson		The risks associated with the Gastroenterology Ward being located on the 1st floor	14/07/2016		5x3 = 15	5x3 = 15	5x3 = 15	5x3 = 15		5x2 = 10	*Structural work completed in Q2 and training & education embedded in practice.*	31/10/2017

Ref	Lead	Divisional Objective*	Title	Date of Initial Assessment	Rating with existing control measures (CxL)							Rationale De-escalation / Closure	Date
					Controls Assurance Rating*	Q4 16/17	Q1	Q2	Q3	Q4	Target Rating		
EC0213	**HoN** Linda Ormson		The management of patients who are voicing suicidal thoughts	18/06/2010		**5x3 = 15**	**5x3 = 15**	**5x3 = 15**	**5x2 = 10**		**5x2 = 10**	*Risk rating reduced as no reported incidents.*	23/11/2017
EC0375	**Resuscitation Officer** Susan Barber		Automated External Defibrillator (AED)	18/11/2016		**5x3 = 15**	**5x3 = 15**	**5x3 = 15**	**5x2 = 10**		**5x2 = 10**	*Risk rating has reduced following commencement of the training programmes and no incident data.*	01/12/2017
EC0378	**Theatre Manager** Emma Reay		Use of gravity fluid administration sets	15/11/2016		**5x3 = 15**	**5x3 = 15**	**5x3 = 15**	**5x2 = 10**		**5x2 = 10**	*Training now embedded and no incidents reported therefore risk rating reduced.*	16/11/2017

Ref	Lead	Divisional Objective*	Title	Date of Initial Assessment	Rating with existing control measures (CxL)							Rationale De-escalation / Closure	Date
					Controls Assurance Rating*	Q4 16/17	Q1	Q2	Q3	Q4	Target Rating		
SC0579	**Endoscopy Service Manager**		Endoscopy Capacity and Bowel Cancer Screening 2016 and beyond	13/09/2017		4x4 = 16	4x4 = 16	4x4 = 16			-	*Risk assessment superseded*	October 2017
PG0057	**Consultant** Dr Pyper		Inadequate Availability of Medical Staff within Paediatrics	22/04/2009		5x3 = 15	5x3 = 15	5x3 = 15	5x2 = 10		-	*Decision made and documented at November's Paed Governance Group that the risk rating can be reduced at present down to 5x2 from 5x3 as well staffed up till March 18. Continue to monitor through governance group on monthly basis.*	21/11/2017
EF0291	**Head of Estates** Paul Dyche		Estates Maintenance Staff - Lone Worker	24/02/2011		5x3 = 15	5x3 = 15	5x3 = 15	5x2 = 10		5x2 = 10	*Actions completed*	December 2017
EF0321	**Head of Facilities** Miriam Hickman		Packaging, Storage, Transportation and Disposal of Infectious Waste (burn)	13/04/2012		5x3 = 15	5x3 = 15	5x3 = 15	5x2 = 10		5x2 = 10	*Actions completed*	December 2017

7. Potential new risks awaiting assessment / horizon scanning

7.1 Medicine & Emergency Care

- UCC clerical staff vacancies
- Medical staff in relation to winter escalation beds
- Care of the Elderly Consultant vacancies
- Stroke Consultant vacancies

7.2 Surgery & Cancer

- Capped expenditure programme and potential associated impacts on quality of care and operational performance metrics (NHSI Single Oversight Framework)
- Individual assessments for staffing levels on in-patient locations currently in progress with ward managers/matrons
- Review of governance between organisations with network partners
- Potential risks associated with outputs from reviews of NICE guidance and quality standards
- Ward 12 Staffing

7.3 Diagnostics & Clinical Support Services

- Haematology Capacity
- Cardio-Respiratory Accommodation
- Reporting of Breast Screening Mammograms by Advanced Practitioners
- Non-compliance for Skin Cancer MDT
- Assurance from External Partners for NICE Guidance
- Replacement CT Scanner
- CT Cardiac Service Capacity
- Clinical Record Keeping
- Implementation of new PACS System
- Pharmacy Dispensary Workload
- In-patient Chemotherapy Prescribing by Junior Doctors
- CCG proposal for Discharge to assess beds at Elmhurst

7.4 Women & Children's

- No supernumerary Shift Co-ordinator on CAU
- Medical and Nursing Staffing of the Neonatal Unit

7.5 CCICP

- Work is in progress to review and identify risk across all service lines in CCICP. Initial assessments indicate higher risk areas include manual handling and staffing levels in the Urgent Care (Out of Hours) unit.
- Medicines management

7.6 Estates & Facilities

- No high level risks identified through horizon scanning / audit processes

7.7 Corporate Services

- Risks identified through CEP / planning processes for 2018/19
- General Data Protection Regulations – May 2018

8. Organisational Risk Register - Summary on a page

The total number of risks on the risk register currently is **469**. The scores of the mitigated assessed risks are depicted in the total column on the matrix below. Detailed risks rated 20 and above are presented in Appendix A. As work on the risk register progresses to apply a more consistent approach to both the articulation of the risk, the grading and centralisation of improvement actions, it is expected a shift will be seen in the overall risk profile of the organisation.

Total number of risks – Organisational															469
Risk Matrix	**Likelihood**														
Impact	**1**			**2**			**3**			**4**			**5**		
	Rare			**Unlikely**			**Possible**			**Likely**			**Almost certain**		
	Score	**Total**	**%**	**Score**	**Total**	**%**	**Score**	**Total**	**%**	**Score**	**Total**	**%**	**Score**	**Total**	**%**
5 Catastrophic	5	26	5.5%	10	113	23.9%	15	14	2.9%	20	4	0.8%	25	-	-
4 Major	4	10	2.1%	8	87	18.5%	12	84	17.9%	16	11	2.3%	20	6	1.2%
3 Moderate	3	8	1.6%	6	54	11.5%	9	21	4.4%	12	9	1.9%	15	3	0.6%
2 Minor	2	1	0.2%	4	6	1.2%	6	4	0.8%	8	3	0.6%	10	3	0.6%
1 Negligible	1	-	-	2	-	-	3	1	0.2%	4	1	0.2%	5	-	-

9. Risks by Division, by mitigated risk score

Division	Risks rated 20 & above	Risks rated 16	Risks rated 15	Risks rated 12	Risks rated 10 & below	Total
Medicine & Emergency Care	5	1	2	13	29	50
Surgery & Cancer	0	2	1	19	25	47
Diagnostics & Clinical Support Services	0	3	0	15	17	35
Women & Children's	0	0	1	20	56	77
CCICP	0	1	1	3	16	21
Estates & Facilities	0	3	5	12	146	166
Corporate Services	5	1	7	11	49	73
Total	10	11	17	93	338	469

10. Summary of the Organisational Risk Register by mitigated risk score (Rated 15 & above)

* In development

Reference	Lead	Divisional Objective*	Risk Title	Date of Initial Assessment	Rating with existing control measures (CxL)						Position Statement
					Controls Assurance Rating*	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Target Rating	
CS0275	**Medical Director** Dr Paul Dodds		Delivering High Quality Clinical Services 7 days per Week	29/05/2012		5x4 = 20	5x4 = 20	5x4 = 20	5x4 = 20		5x1 = 5	*The 7 Day Services Working Group focuses on the delivery of the national four clinical priority standards and the national bi-annual return. The Audit focused on consultant reviews within 14 hours, for all patients admitted as an emergency and divisional improvement plans are in development.*
CS0302	**Head of Information Governance** Cora Suckley		Information Governance Overarching Risk Assessment	08/08/2014		5x4 = 20	5x4 = 20	5x4 = 20	5x4 = 20		5x2 = 10	*Population of the Information Governance Toolkit has commenced for the March 2018 return, with oversight by the Information Governance Group. Detailed plans for GDPR & Cyber Security have been developed. Risk under review currently. Risk based on financial penalties.*

Reference	Lead	Divisional Objective*	Risk Title	Date of Initial Assessment	Rating with existing control measures (CxL)							Position Statement
					Controls Assurance Rating*	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Target Rating	
CS0326	**Medical Director** Dr Paul Dodds		Delivering the Information Technology Strategy	07/09/2015		4x5 = 20	4x5 = 20	4x5 = 20	4x5 = 20		4x2 = 8	*Retaining a risk score of 20 based upon that the business case process is still progressing.*
CS0327	**Director of Finance** Mark Oldham		Long Term Financial Sustainability of MCHFT	02/09/2015		5x5 = 25	5x5 = 25	5x4 = 20	5x4 = 20		5x2 = 10	*2017/18 position reduced in quarter 2 from 20 to 8 to reflect the reduced risk to the Trust following the participation in the system wide Capped Expenditure Programme (CEP), with NHS Improvement and / NHS England joint meetings in place. Long term plans- risk remains high.*
EC0379	**Matron** Ali Barnes		Risks associated with inadequate staffing levels - Ward 2	10/11/2016		4x5 = 20	4x5 = 20	4x5 = 20	4x5 = 20		4x2 = 8	*The number of Registered Nurse vacancies are 3.26WTE. However concerns have been raised regarding the continued number of vacancies which is now resulting in the increased number of incidents with an associated increased level of harm.*
EC0327	**Consultant Anaesthetist** Michelle Green		Lack of secondary Anaesthetic on-call cover	31/07/2010		4x4 = 16	4x4 = 16	4x4 = 16	4x5 = 20		4x2 = 8	*The business case is being progressed. There has been an increase in the number of incidents relating to the lack of a spilt rota. Therefore the risk rating has increased.*

Reference	Lead	Divisional Objective*	Risk Title	Date of Initial Assessment	Rating with existing control measures (CxL)							Position Statement
					Controls Assurance Rating*	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Target Rating	
EC0397	**Matron** Ali Barnes		Risks associated with inadequate staffing levels on Ward 5	19/06/2017			4x5 = 20	4x5 = 20	4x5 = 20		4x2 = 8	*There has been escalation within the Division by the ward manager expressing her concerns regarding the acuity Vs staffing on Ward 5. There are currently 28 Registered Nurse shift vacancies per week. A risk assessment has been produced regarding the potential impact if NIV is unable to be provided on Ward 5 given the staffing vacancies. There are 9.86 WTE Registered Nurse vacancies which includes maternity leave.*
EC0287	**AMD** Doug Robertson		Risks associated with insufficient numbers of junior doctors across the ECD Division	01/03/2013		5x4 = 20	5x4 = 20	5x4 = 20	5x4 = 20		5x2 = 10	*The number of Junior Doctor vacancies within the Division is unchanged from quarter 2; however there has been a significant increase in the bed base due to the opening of escalation areas in quarter 3.*
EC0388	**Matron** Ali Barnes		Cardiac Monitoring System	13/06/2017			5x3 = 15	5x3 = 15	5x4 = 20		5x2 = 10	*The risk assessment has been re-opened and updated to incorporate the new issues which are still ongoing and has been escalated via the Patient Safety Summit and the Medical Equipment Group. The issues with the loss of monitoring have been reported again to the MHRA. There a meeting arranged for 24/1/18 with the DGM and Philips to discuss the current SLA and issues experienced.*
CS0328	**Medical Director** Dr Dodds		Sustainability of Vulnerable Clinical Services due to Lack of Resource (People & finance)	24/09/2015		5x4 = 20	5x4 = 20	5x4 = 20	5x4 = 20		5x2 = 10	*Ability to recruit to senior leadership posts remains a challenge. Reduction in risk will occur when there is a shift from locum cover to filling posts substantively.*

Reference	Lead	Divisional Objective*	Risk Title	Date of Initial Assessment	Rating with existing control measures (CxL)							Position Statement
					Controls Assurance Rating*	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Target Rating	
SC0479	**Clinical Nurse Manager Bowel Screening**		Bowel Cancer Screening capacity	31/10/2017					4x4 = 16		4x3 = 12	*New risk following the review of Endoscopy Capacity and Bowel Cancer Screening 2016 and beyond. To be split into individual risk assessments.*
SC0568	**DGM** Daniel Moore		Risks associated with reduced numbers of middle / junior grade medical staff	08/09/2017		4x3 = 12	4x3 = 12	4x4 = 16	4x4 = 16		4x3 = 12	*Workforce planning reviews include the development of alternative roles e.g. advanced nurse practitioners and associates.*
EC0387	**DGM** Tony Mayer		Lack of service provision within Respiratory	23/03/2017		4x5 = 20	4x5 = 20	4x5 = 20	4x4 = 16		4x2 = 8	*There is now an NHS Locum Consultant working within Respiratory. There is a joint post where the job description has been written and is awaiting feedback from the Royal College. The ANP position was approved and has been appointed to but a start date is awaited. Risk rating has been reduced based on no reported incidents relating to the lack of service provision.*
EC0384	**DGM** Tony Mayer		Lack of service provision within Cardiology	29/11/2016		4x5 = 20	4x5 = 20	4x5 = 20	4x4 = 16		4x3 = 12	*There is an Agency Locum Consultant awaiting a commencement date. The Division is pursuing joint recruitment with UHNM and the job description is being updated by the Division. The risk rating has been reduced based on no reported incidents relating to the lack of service provision.*

Reference	Lead	Divisional Objective*	Risk Title	Date of Initial Assessment	Rating with existing control measures (CxL)							Position Statement
					Controls Assurance Rating*	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Target Rating	
EC0329	**ED Service Manager** Verity Lockett		Failure to deliver National Access Targets within ED and the increasing level of delays impacting upon patient flow and quality of care / patient experience.	03/06/2015		4x4 = 16	4x4 = 16	4x4 = 16	4x4 = 16		4x3 = 12	*There has been an unprecedented demand within the Trust since the Christmas period which has impacted upon the delivery of the 4 hour standard. Nationally pre-planned surgery and routine outpatient appointments have been deferred.*
EC0402	**DGM** Tony Mayer		Lack of Service Provision within Diabetes	23/03/2017					4x4 = 16		4x2 = 8	*Risk assessments have been spilt into specialty in Q3. The capacity of the antenatal diabetology clinic has had a significant increase with has an impact across 3 Divisions and is currently undergoing a full review.*
EC0386	**DGM** Tony Mayer		Lack of Service Provision within Endocrinology	23/03/2017					4x4 = 16		4x2 = 8	*Risk assessments have been spilt into specialty in Q3. Currently there is one Clinician who can provide support to the Endocrinology service.*
EC0399	**Matron** Ali Barnes		Non-Invasive Ventilation and Tracheostomy patients on Ward 5	12/09/2017					4x4 = 16		4x3 = 12	*Links to risk EC0397. A risk assessment has been produced regarding the potential impact if NIV is unable to be provided on Ward 5 given the staffing vacancies. There are 9.86 WTE Registered Nurse Vacancies which includes maternity leave. Risk reflects the fragility of the service.*
DC0887	**AMD** David Butterworth		Consultant Histopathologist Capacity	24/03/2015		4x4 = 16	4x4 = 16	4x4 = 16	4x4 = 16		4x2 = 8	*Advert out for substantive consultant. In the process of recruiting overseas middle grade doctors*

Reference	Lead	Divisional Objective*	Risk Title	Date of Initial Assessment	Rating with existing control measures (CxL)							Position Statement
					Controls Assurance Rating*	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Target Rating	
72	**Service Manager Medical Imaging** David Stokes		Lack of breast cancer capacity due to lack of consultants	27/04/2017			4x4 = 16	4x4 = 16	4x4 = 16		4x1 = 4	*Advert out for substantive consultant interviews to be held 1st March 2018*
129	**Professional Lead Diagnostics** Ruth Heaton		CCG proposal for discharge to assess beds at Elmhurst	05/12/2017					4x4 = 16		4x1 = 4	*New Risk added this Quarter*
CP0057	**Quality & Safety Lead** CCICP		Moving & Handling Training	31/12/2017					4x4 = 16		4x2 = 8	*New Risk added this Quarter*
CP0058	**Quality Governance Manager** CCICP		Staff shortages in the OOH Service	31/10/2017					4x4 = 16		4x1 = 4	*New Risk added this Quarter*
CS0325	**Chief Operating Officer** Chris Oliver		Operational Sustainability of MCHFT	29/09/2016		4x4 = 16	4x4 = 16	4x4 = 16	4x4 = 16		4x3 = 12	*Strong record of compliance against the Single Oversight Framework with the exception of the A&E 4 hour standard, although performance over the last twelve months has seen performance against this standard increase. There are however, significant external factors outside of the Trust's direct control which can directly impact on the Trust's ability to maintain compliance.*

Reference	Lead	Divisional Objective*	Risk Title	Date of Initial Assessment	Rating with existing control measures (CxL)						Position Statement
					Controls Assurance Rating*	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Target Rating	
EF0258	**Head of Facilities** Miriam Hickman		Work Place Risk Assessment, External Waste Hold	03/03/2010		4x4 = 16	4x4 = 16	4x4 = 16	4x4 = 16		4x2 = 8	*No change - Awaiting funding for new Waste compound.*
EF0260	**Director of E&F** Mike Babb		Loss of Mechanical Infrastructure and Associated Resources: Leighton Hospital	25/05/2010		4x4 = 16	4x4 = 16	4x4 = 16	4x4 = 16		4x1 = 4	*No change – Awaiting Asbestos removal.*
EF0404	**Head of Facilities** Miriam Hickman		Potential Claims relating to Reportable Occupational Disease - including Mesothelioma & Noise induced Hearing Loss	13/11/2014		4x4 = 16	4x4 = 16	4x4 = 16	4x4 = 16		4x2 = 8	*No change. No claims during Q1 & Q2 received.*
CS0284	**Director of Nursing & Quality** Julie Tunney		Recruitment to the number of Nursing Vacancies across MCHFT	02/01/2013		5x3 = 15	5x3 = 15	5x3 = 15	5x3 = 15		5x2 = 10	*Workforce Matters Strategy in development, workforce planning programmes including international recruitment and return to nursing schemes.*
CS0314	**H&S Lead** Wendy Astle-Rowe		Trust Wide Fire Risk Assessment	28/04/2015		5x2 = 10	5x2 = 10	5x3 = 15	5x3 = 15		5x2 = 10	*This relates to the over-arching rating for the Trust relating to infrastructure and fire safety provisions. This is rated as a 15 mainly due to the infrastructure status in non-refurbished wards.*

Reference	Lead	Divisional Objective*	Risk Title	Date of Initial Assessment	Rating with existing control measures (CxL)						Position Statement
					Controls Assurance Rating*	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Target Rating	
MS0153	**DGM** Mark Wilde		Fetal Anomaly Scanning	29/06/2016		3x5 = 15	3x5 = 15	3x5 = 15	3x5 = 15		3x1 = 3	*The Trust is an outlier nationally. Mitigations in place include regular training and local audit of fetal abnormalities and detection rates. No history of associated incidents reported to date. Links to DCSS Risk DCO974. Locum sonographer route explored but recruitment unsuccessful. Plan is to re-advertise for a substantive post.*
MS0155	**Home Birth & MLU Lead** Sarah Wedgewood		Drugs and gases intended for use at homebirth	21/09/2016		3x5 = 15	3x5 = 15	3x5 = 15	3x5 = 15		3x1 = 3	*Planned mitigated actions have been completed and following review it is likely the target rating will be reached.*

Reference	Lead	Divisional Objective*	Risk Title	Date of Initial Assessment	Rating with existing control measures (CxL)						Position Statement
					Controls Assurance Rating*	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Target Rating	
PG0272	**Clinical Lead** Karen Mckintyre		Inadequate availability of medical staff to cover rotas - Obs and Gynae	08/06/2016		**4x3 = 12**	**5x3 = 15**	**5x3 = 15**	**5x3 = 15**		**5x2 = 10**	*This risk assessment was discussed at the Gynae Governance Group on the 9.11.17. DGM and Obs and Gynae Clinical Lead confirmed the following; There have now been 2 locums employed for service for 12 months, therefore approximately 0.6 junior doctor gap which is much improved. Situation may deteriorate again in Jan 18 as will be losing 2 middle grades. There are issues with the 1st on call rota due to gaps and sickness, which is impacting on care delivery on the gynae ward and also creating difficulties with the provision of assistants in gynae theatre. An advert is currently out for 1 SHO position for which there are 2 applicants. Discussions took place relating to Physician's Assistants and whether this would be beneficial. Further discussions to take place in relation to this. Decision to keep this risk as 15 extreme due to the above ongoing issues.*
SC0443	**Surgical Matron** Sue Sarson		Insufficient staffing within Inpatient locations: Ward 15	01/09/2011		**5x3 = 15**	**5x3 = 15**	**5x3 = 15**	**5x3 = 15**		**5x2 = 10**	*Staffing for this location is much improved and currently has 2 qualified vacancies. Revised following transfer to Ward 10 December 2017. Risk reduction expected next quarter.*

Reference	Lead	Divisional Objective*	Risk Title	Date of Initial Assessment	Rating with existing control measures (CxL)						Position Statement
					Controls Assurance Rating*	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Target Rating	
EC0317	**Clinical Service Manager** Sian Axon		Delayed discharge from Critical Care	01/02/2010		3x5 = 15	3x5 = 15	3x5 = 15	3x5 = 15		5x2 = 10	*There has been an incident regarding a delayed discharged from Critical Care which is currently undergoing a comprehensive investigation which will be chaired by the Medical Director. The ICNARC report was discussed at Divisional Mortality which highlighted that as a Trust we are an outlier regarding delayed discharged from Critical Care.*
EC0381	**Matron** Ali Barnes		Risks associated with insufficient advanced life support (ALS) covered registered nurses in the coronary care unit (CCU)	21/11/2016		5x3 = 15	5x3 = 15	5x3 = 15	5x3 = 15		5x2 = 10	*Four Registered Nurses have recently completed the ALS training but still require ongoing support when in CCU. There is a training programme in place – CCU competency programme with ALS mentor. However there are two forthcoming vacancies with staff who are also trained and competent within CCU.*
EF0411	**Head of Facilities** Miriam Hickman		Injury to Pedestrians from the Treatment Centre Pay on Foot Car Park Barriers	05/11/2014		5x3 = 15	5x3 = 15	5x3 = 15	5x3 = 15		5x2 = 10	*No change currently but likely to reduce in next 6 months upon installation of new barrier equipment.*
EF0415	**Head of Estates** Paul Dyche		Risk Master	15/12/2014		5x3 = 15	5x3 = 15	5x3 = 15	5x3 = 15		5x2 = 10	*No change – Awaiting Asbestos removal. Back log maintenance.*
EF0418	**Engineering Manager**		Infusion Pump Availability	09/01/2015		5x3 = 15	5x3 = 15	5x3 = 15	5x3 = 15		5x2 = 10	*No change – dependant on better system (Medical Equipment Library) being introduced.*

Reference	Lead	Divisional Objective*	Risk Title	Date of Initial Assessment	Rating with existing control measures (CxL)							Position Statement
					Controls Assurance Rating*	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Target Rating	
EF0101	**Head of Estates** Paul Dyche		Legionella- Water Distribution / Temperature at Leighton Hospital	09/12/2010		5x3 = 15	5x3 = 15	5x3 = 15	5x3 = 15		5x1 = 5	*No change - Work continuing as part of ward /street/dept. refurbishment programme.*
EF0393	**Head of Estates & Facilities** Mike Babb		Risks to the Continuity of MCHFT Critical Functions identified by the Estates and Facilities Division	14/03/2016		5x3 = 15	5x3 = 15	5x3 = 15	5x3 = 15		5x1 = 5	

11. Risks with partner organisations (Governance / partnerships between organisations)

As part of the Risk Management Strategy & Framework 2017/20 work across partner organisations will be undertaken to understand shared risks which may impact on the quality / performance of services provided at the Trust these include:

- University Hospitals of North Midlands NHS Trust
- CCICP Partners
- East Cheshire NHS Trust
- Local Authorities
- 'One to One' Midwifery

As part of the internal NHSI Well Led Developmental Review process governance between organisations was highlighted as a key area for review by the external review team.

Appendix A: Detailed Risks Rated 20 & above (*In development)

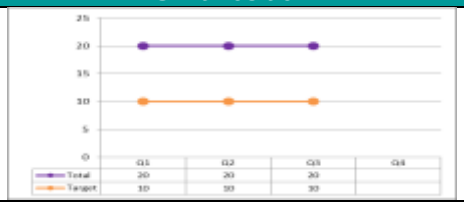
CS0275 – Delivering High Quality Clinical Services 7 Days per Week	Very Low Risk			Low Risk			Moderate Risk			High Risk		Extreme Risk	
	1	2	3	4	5	6	8	10	12	15	16	20	25
					T (5x1)							C (5x4)	I (5x5)

Potential Risk "There is a risk that <risk event> as a result of <cause> which may lead to <effect/impact>"	Lead	Control Measures	Controls Assurance Rating*	Position Statement	Original Date
Risk: Risk of harm to patient's including increased mortality rates or a delay in treatment and diagnosis **Cause:** Reduced weekend, bank holidays and out of hours services **Effect/Impact:** • Reduced bed capacity and patient flow • Poor patient experience • Poor patient outcomes • Increase in staff sickness and absence • Non delivery of NHSI Single Oversight Performance Standards • Increased length of stay	**Medical Director** Dr Paul Dodds	1. Trust Escalation Policy 2. Clinical pathways 3. 7 days/week for emergency and critically ill patients 4. 7 Day Services Working Group 5. Access to diagnostics out of hours 6. On call pharmacist. 7. Level 2 and Level 3 critical care beds 8. Consultants rotas provide 7 days/week on call 9. Exec / SMOC 7 days/week on call cover 10. Critical care outreach service 7 days/week 11. Night Nurse Practitioner service 12. Clinical Site Managers. 13. 7 days/week medical and nursing cover. 14. Increasing shop floor time for ED Consultants "out of hours". 15. Doubling up of Consultant Physicians for part of weekend. 16. Separating of Consultant Anaesthetist rotas to establish specific Critical Care on call rota. 17. Command and control structure to communicate with the wider healthcare community regarding capacity issues. 18. Urgent Care Centre 19. Daily Bed Management 20. Dedicated discharge liaison team		*The 7 Day Services Working Group focuses on the delivery of the national four clinical priority standards and the national bi-annual return. The Audit focused on consultant reviews within 14 hours, for all patients admitted as an emergency and divisional improvement plans are in development.*	29/05/2012 **Review Frequency** Monthly **Monitoring Group** Executive Quality Governance Group **Risk Source** Risk Assessment **Version** 4 **BAF Links** Q1, Q2, E1, E2, W1, W2, W3 **Shift** **2016-17** Q1 20 ► Q2 20 ► Q3 20 ► Q4 20 ► **2017-18** Q1 20 ► Q2 20 ► Q3 20 ► Q4 **Shift Position** 

Key: I = Initial Risk Rating C = Current Risk Rating T = Target Risk Rating

▲ = Risk rating has increased since previous quarter ► = No change from previous quarter ▼ = Risk rating has decreased since previous quarter

Summary: CS0302 – Information Governance Overarching Risk Assessment (Under review)	Very Low Risk			Low Risk			Moderate Risk			High Risk		Extreme Risk	
	1	2	3	4	5	6	8	10	12	15	16	20	25
								T (5x2)				C (5x4)	I (5x5)

Potential Risk "There is a risk that <risk event> as a result of <cause> which may lead to <effect/impact>"	Lead	Control Measures	Controls Assurance Rating	Position Statement	Original Date
Risk: Risk of a breach of the obligation to process information fairly and lawfully in line with the principles of the Data Protection Act 1998 and other associated regulations. **Cause:** Failure to adequately protect data/information in line with regulations. **Effect/Impact:** • Unsatisfactory Information Governance Toolkit rating • Reporting required to Information Commissioners Office • Financial penalties • Reputational risks	**Head of Information Governance** Cora Suckley	1. Privacy Impact Assessment Procedure 2. Information Governance Training 3. Confidentiality and Data Protection Policy 4. Information Governance Handbook 5. Information Governance and Clinical Audit Guidance leaflet for staff 6. Bedside Folder (containing relevant paragraphs) relating to the management of personal information 7. Information sharing agreements signed off by Caldecott Guardian for all sharing of information. 8. Health Records Management Policy 9. Corporate Records Management Policy 10. Access to Health Records Policy 11. Confidentiality and Data Protection Policy 12. ICT Policies 13. Audits can be run on Patient Administration System if concerns are raised. 14. Websense software implemented 15. Review of IG Toolkit. Toolkit Action Plan drawn up and leads identified. Toolkit progress is monitored at Information Governance Group.		*The 7 Day Services Working Group focuses on the delivery of the national four clinical priority standards and the national bi-annual return. The Audit focused on consultant reviews within 14 hours, for all patients admitted as an emergency and divisional improvement plans are in development.*	08/08/2014 **Review Frequency** Monthly **Monitoring Group** Executive Quality Governance Group **Risk Source** Risk Assessment **Version** 2 **BAF Links** T2 a & b **Shift** **2016-17** Q1 15 ► Q2 20 ▲ Q3 20 ► Q4 20 ► **2017-18** Q1 20 ► Q2 20 ► Q3 20 ► Q4 **Shift Position** 

Key:

I = Initial Risk Rating
▲ = Risk rating has increased since previous quarter

C = Current Risk Rating
► = No change from previous quarter

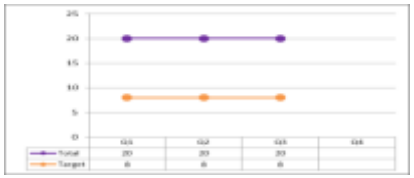
T = Target Risk Rating
▼ = Risk rating has decreased since previous quarter

CS0326 – Delivering the Information Technology Strategy	Very Low Risk			Low Risk			Moderate Risk			High Risk		Extreme Risk	
	1	2	3	4	5	6	8	10	12	15	16	20	25
							T (4x2)					I & C (4x5)	

Potential Risk "There is a risk that <risk event> as a result of <cause> which may lead to <effect/impact>"	Lead	Control Measures	Controls Assurance Rating	Position Statement	Original Date
Risk: Failure to improve the quality of care and patient safety due to not being able to share information quickly and effectively, there is a potential to inadvertently incorrectly treat a patient. **Cause:** Continuing to rely on the use of paper records. **Effect/Impact:** • Poor quality of care • Poor patient experience • Inability to transform and modernise services • Delays in completing horizontal and vertical integration • Continued lack of access to the medical records from home leading to delays • Reputational risks • We will not be seen as 'progressive' and could possibly miss out on other external funding streams. • Difficulty in recruiting clinical staff who expect EPR system to be in place.	**Medical Director** Dr Paul Dodds	1. GP patient record electronically via Docman. 2. Case notes are tracked using the Trust's Patient Administration System 3. Major investments in IT infrastructure. These include Trust-Wide Wi-Fi, new core network and virtualised server infrastructure which has increased our disaster recovery capabilities 4. Policies & procedures for Health Records		*Retaining a risk score of 20 based upon that the business case process is still progressing.*	07/09/2015 **Review Frequency** Monthly **Monitoring Group** Executive Quality Governance Group **Risk Source** Risk Assessment **Version** 1 **BAF Links** T2a, T2b & E2

Shift		
2016-17		
Q1	20	►
Q2	20	►
Q3	20	►
Q4	20	►
2017-18		
Q1	20	►
Q2	20	►
Q3	20	►
Q4		

Shift Position



Key: I = Initial Risk Rating ▲ = Risk rating has increased since previous quarter

C = Current Risk Rating ► = No change from previous quarter

T = Target Risk Rating ▼ = Risk rating has decreased since previous quarter

CS0327 – Long Term Financial Sustainability of MCHFT	Very Low Risk			Low Risk			Moderate Risk			High Risk		Extreme Risk	
	1	2	3	4	5	6	8	10	12	15	16	20	25
								T (5x2)				C (5x4)	I (5x5)

Potential Risk "There is a risk that <risk event> as a result of <cause> which may lead to <effect/impact>"	Lead	Control Measures	Controls Assurance Rating	Position Statement	Original Date
Risk: The Trust becomes financially unsustainable **Cause:** • Non Delivery of CIP targets • Underperformance on Elective Activity • Increasing premium costs of staff to cover gaps • Non Electivity Demand outstripping bed capacity • Loss of contracts due to competition • Increasing efficiency requirements in the National Tariff **Effect/Impact:** • Cash flow implications of deteriorating trading position • Quality & performance of services	**Director of Finance** Mark Oldham	1. Monthly CIP performance meetings 2. Quality Impact Assessment of CIP schemes 3. Theatre Productivity Group plans 4. Cash flow monitoring and debt collection processes 5. Budget meetings on monthly basis 6. Recruitment initiatives (foreign and domestic) and Premia incentives 7. Tendering for services (new and existing) 8. Stronger Together Programme 9. Weekly performance meetings re: activity delivery 10. Annual Plan 11. Trust Strategy & local plans 12. Borrowings in place for key schemes		*2017/18 position reduced in quarter 2 from 20 to 8 to reflect the reduced risk to the Trust following the participation in the system wide Capped Expenditure Programme (CEP), with NHS Improvement and / NHS England joint meetings in place. Long term plans- risk remains high.*	29/05/2012 **Review Frequency** Monthly **Monitoring Group** Executive Quality Governance Group **Risk Source** Risk Assessment **Version** 2 **BAF Links** Q1, Q2, P1, P2, E1, E2, W1, T1, T2a, T2b

Shift		
2016-17		
Q1	25	►
Q2	25	►
Q3	25	►
Q4	25	►
2017-18		
Q1	25	►
Q2	20	▼
Q3	20	►
Q4		

Shift Position

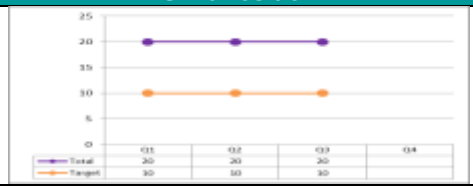
Key: I = Initial Risk Rating ▲ = Risk rating has increased since previous quarter | C = Current Risk Rating ► = No change from previous quarter | T = Target Risk Rating ▼ = Risk rating has decreased since previous quarter

CS0328 – Sustainability of Vulnerable Clinical Services due to Lack of Resource (People & finance)	Very Low Risk			Low Risk			Moderate Risk			High Risk		Extreme Risk	
	1	2	3	4	5	6	8	10	12	15	16	20	25
								T (5x2)				C (5x4)	I (5x5)

Potential Risk "There is a risk that <risk event> as a result of <cause> which may lead to <effect/impact>"	Lead	Control Measures	Controls Assurance Rating	Position Statement	Original Date
Risk: Failure to maintain essential clinical services **Cause:** Vulnerability of key clinical specialities – difficult to recruit posts (e.g. Gastroenterology; Histopathology and Radiology) **Effect/Impact:** • Poor quality of care and lack of services • Significant financial impact to the Trust due to the vulnerability of the identified clinical services	**Medical Director** Dr Paul Dodds	1. Stronger Together Programme. 2. Annual Plan. 3. Trust Strategy. 4. Recruitment initiatives (foreign and domestic) and Premia incentives. 5. Workforce planning – alternative roles 6. Partnership working		*Ability to recruit to senior leadership posts remains a challenge. Reduction in risk will occur when there is a shift from locum cover to filling posts substantively.*	24/09/2015 **Review Frequency** Monthly **Monitoring Group** Executive Quality Governance Group **Risk Source** Risk Assessment **Version** 2 **BAF Links** Q1, Q2, P1, P2, E1, E2, W1, W2, W3

Shift		
2016-17		
Q1	20	►
Q2	20	►
Q3	20	►
Q4	20	►
2017-18		
Q1	20	►
Q2	20	►
Q3	20	►
Q4		

Shift Position



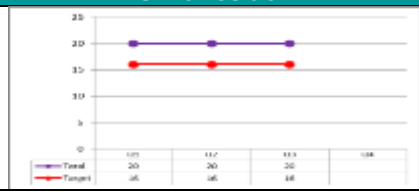
Key:

I = Initial Risk Rating
▲ = Risk rating has increased since previous quarter

C = Current Risk Rating
► = No change from previous quarter

T = Target Risk Rating
▼ = Risk rating has decreased since previous quarter

EC0379 – Risks associated with inadequate staffing levels – Ward 2	Very Low Risk			Low Risk			Moderate Risk			High Risk		Extreme Risk	
	1	2	3	4	5	6	8	10	12	15	16	20	25
							T (4x2)					I&C (4x5)	

Potential Risk "There is a risk that <risk event> as a result of <cause> which may lead to <impact>"	Lead	Control Measures	Confidence in Controls	Position Statement	Original Date
Risk: Inadequate staffing ratio on ward 2. **Cause:** Due to the impact of long/short term sick leave. **Effect/impact:** • Potential impact on service provision, quality of care and patient experience. • Potential patient safety harm due to delays in nursing review/intervention. • Reduced quality of care. • Increased work related stress. • Higher incident reporting. • Increased length of stay. • Financial implications with increased use of agency staff. • Potential delays in the completion of training and staff appraisals. • Potential for inappropriate skill mix.	**Matron** Ali Barnes	1. Daily staffing review undertaken by the Matrons within the Division. 2. Ward escalation to Matrons when gaps present in rota. 3. Ward Managers within the Division review off duty to review the skill mix. 4. Ward 2 co-ordinator/Band 6 will attend AMU to review patients prior to transfer to assess the suitability. 5. Use of Nurse Bank and Agency staff. 6. Pharmacy technician utilised on ward 2. 7. Ward Manager can refer staff to Occupational Health following episodes of sickness. 8. Return to work interviews completed. 9. Safety huddles.		*The number of Registered Nurse vacancies are 3.26WTE. However concerns have been raised regarding the continued number of vacancies which is now resulting in the increased number of incidents with an associated increased level of harm.*	10/11/2016 **Review Frequency** Monthly **Monitoring Group** Executive Quality Governance Group **Risk Source** Risk Assessment **Version** 2 **BAF Links** **Shift** **2016-17** Q1 ; Q2 ; Q3 20 ► ; Q4 20 ► **2017-18** Q1 20 ► ; Q2 20 ► ; Q3 20 ► ; Q4 **Shift Position** 

Key: I = Initial Risk Rating C = Current Risk Rating T = Target Risk Rating

▲ = Risk rating has increased since previous quarter ► = No change from previous quarter ▼ = Risk rating has decreased since previous quarter

EC0327 – Lack of secondary Anaesthetic on-call cover	Very Low Risk			Low Risk			Moderate Risk			High Risk		Extreme Risk	
	1	2	3	4	5	6	8	10	12	15	16	20	25
							T (4x2)					I&C (4x5)	

Potential Risk "There is a risk that <risk event> as a result of <cause> which may lead to <impact>"	Lead	Control Measures	Confidence in Controls	Position Statement	Original Date
Risk: Insufficient secondary on call cover for anaesthetics out of hours (Monday - Thursday 18:00-08:00). **Cause:** Critical Care & Maternity share 'second on' rota provision. **Effect/impact:** • Anaesthetic service unable to meet demand. • Reduced quality of care. • Potential patient safety harm due to delays in treatment • Unable to support off site transfers • None compliance with National Guidelines. • Failure to achieve Anaesthetic Clinical Service Accreditation. • Increased cost due to utilisation of Consultant cover. • Increase in work related stress. • Non-compliance with Deanery regulations regarding breaks.	**Clinical Lead** Michelle Green	1. First on rota (lower ST's doctor) anaesthetist provision. However don't always have Critical Care or Obstetric competencies. 2. Consultant Anaesthetist available 24/7 & general and Intensivist Consultant Anaesthetist split rota 3. Specialty/ Hospital Grades and Higher ST doctor rota on as second -on; 4. Specialty doctor & Higher ST 1:12 combined rota which is split at the weekends 5. Access to Consultant on-call- Out of hours. 6. Access to Critical Care Outreach Service- Nurses are not supernumerary which does not guarantee support. 7. Trainee Doctor bank provision. 8. Rota planning sent to Medical Staffing to support with any vacancy shifts. 9. Business case approved within MCHFT for splitting of the rota which is to be presented to the commissioners.		*The business case is being progressed. There has been an increase in the number of incidents relating to the lack of a spilt rota. Therefore the risk rating has increased.*	31/07/2010 **Review Frequency** Quarterly **Monitoring Group** Executive Quality Governance Group **Risk Source** Risk Assessment **Version** 6 **BAF Links** **Shift** **2016-17** Q1 15 ► Q2 15 ► Q3 15 ► Q4 15 ► **2017-18** Q1 16 ▲ Q2 16 ► Q3 20 ▲ Q4 **Shift Position** 

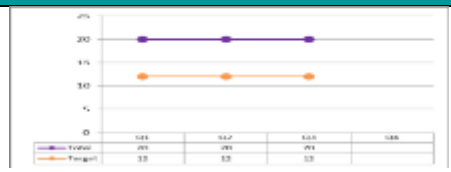
Key: I = Initial Risk Rating; C = Current Risk Rating; T = Target Risk Rating

▲ = Risk rating has increased since previous quarter

► = No change from previous quarter

▼ = Risk rating has decreased since previous quarter

EC0397 – Risks associated with inadequate staffing levels on Ward 5	Very Low Risk			Low Risk			Moderate Risk			High Risk		Extreme Risk	
	1	2	3	4	5	6	8	10	12	15	16	20	25
									T (4x3)			I&C (4x5)	

Potential Risk "There is a risk that <risk event> as a result of <cause> which may lead to <impact>"	Lead	Control Measures	Confidence in Controls	Position Statement	Original Date
Risk: Inadequate staffing ratio on ward 5. **Cause:** Due to the budgeted establishment not being achieved. **Effect/impact:** • Potential impact on service provision, quality of care and patient experience. • Potential patient safety harm due to delays in nursing review/intervention. • Reduced quality of care. • Increased work related stress. • Higher incident reporting. • Increased length of stay. • Financial implications with increased use of agency staff. • Potential delays in the completion of training and staff appraisals. • Potential for inappropriate skill mix. • Unable to facilitate NIV treatment.	**Matron** Ali Barnes	1. On-going recruitment. 2. Daily staffing review undertaken by the Matrons within the Division. 3. Ward escalation to Matrons when gaps present in rota. 4. Ward Managers within the Division review off duty to review the skill mix. 5. Use of Nurse Bank and Agency staff. 6. Planned implementation for a Pharmacy technician to be utilised on ward 5. 7. Safety huddles. 8. Involvement of Critical Care to facilitate NIV where appropriate. 9. ANP business case approval.		*There has been escalation within the Division by the ward manager expressing her concerns regarding the acuity Vs staffing on ward 5. There are currently 28 Registered Nurse shift vacancies per week. A risk assessment has been produced regarding the potential impact if NIV is unable to be provided on Ward 5 given the staffing vacancies. There are 9.86 WTE Registered Nurse vacancies which includes maternity leave.*	19/06/2017 **Review Frequency** Monthly **Monitoring Group** Executive Quality Governance Group **Risk Source** Risk Assessment **Version** 1 **BAF Links** **Shift** **2016-17** Q1 Q2 Q3 Q4 **2017-18** Q1 20 ► Q2 20 ► Q3 20 ► Q4 **Shift Position** 

Key: I = Initial Risk Rating C = Current Risk Rating T = Target Risk Rating

▲ = Risk rating has increased since previous quarter ► = No change from previous quarter ▼ = Risk rating has decreased since previous quarter

EC0287 – Risks associated with insufficient numbers of junior doctors across the ECD Division	Very Low Risk			Low Risk			Moderate Risk			High Risk		Extreme Risk	
	1	2	3	4	5	6	8	10	12	15	16	20	25
							T (4x2)					C (5x4)	I (5x5)

Potential Risk "There is a risk that <risk event> as a result of <cause> which may lead to <impact>"	Lead	Control Measures	Confidence in Controls	Position Statement	Original Date
Risk: Insufficient numbers of junior Doctors across the Division. **Cause:** Lack of sufficient medical workforce due to vacancies. **Effect/impact:** • Potential patient safety harm due to delays in medical review/treatment • Non-compliance with National Guidance and Best Practice Standards for patient care. • Reduced quality of care. • Reduction in access and flow targets. • Potential breaches within European Working Time directives. • Potential breaches with RTT. • Potential lack of on call cover. • Potential impact on service provision, quality of care and patient experience. • Financial implications due to increased use of locum agency.	**AMD** Doug Robertson	1. Use of locum agencies. 2. Ongoing recruitment. 3. Ongoing job planning within the Division. 4. Forward planning of on call rota. 5. Consultant to cover when no Medical Registrar available. 6. Access and flow meetings and length of stay monitored. 7. RTT monitored within the Division.		*The number of Junior Doctor vacancies within the Division is unchanged from quarter 2; however there has been a significant increase in the bed base due to the opening of escalation areas in quarter 3.*	01/03/2013 **Review Frequency** Monthly **Monitoring Group** Executive Quality Governance Group **Risk Source** Risk Assessment **Version** 8 **BAF Links** Q1, Q2, E2, W1, W2, W3

Shift		
2016-17		
Q1	20	►
Q2	20	►
Q3	20	►
Q4	20	►
2017-18		
Q1	20	►
Q2	20	►
Q3	20	►
Q4		

Shift Position

Key: I = Initial Risk Rating C = Current Risk Rating T = Target Risk Rating

▲ = Risk rating has increased since previous quarter ► = No change from previous quarter ▼ = Risk rating has decreased since previous quarter

EC0388 - The risks associated with the loss of the cardiac monitoring system	Very Low Risk			Low Risk			Moderate Risk			High Risk		Extreme Risk	
	1	2	3	4	5	6	8	10	12	15	16	20	25
								T (5x2)				I & C (5x4)	

Potential Risk "There is a risk that <risk event> as a result of <cause> which may lead to <impact>"	Lead	Control Measures	Confidence in Controls	Position Statement	Original Date
Risk: Inability to motor cardiac patients via the telemetry system. **Cause:** The loss of the central cardiac monitoring system (Philips). **Effect/impact:** • Potential patient safety harm due to loss of monitoring. • Undetected arrhythmia resulting in delays in treatment/management. • Reduced quality of care. • Higher incident reporting. • Increased length of stay. • Potential impact on service provision, quality of care and patient experience. • Increased work related stress.	**Matron** Ali Barnes	1. Inclusion within the BCP regarding actions which are to be taken in the event of a loss of cardiac monitoring. 2. To alert senior cardiology doctors regarding the loss of cardiac monitoring. 3. Out of hours to inform the Clinical Site Manager & senior medical doctors regarding the loss of cardiac monitoring. 4. Issues identified with the cardiac monitoring system is to be escalated to EBME who will contact Philips.		*The risk assessment was initially closed as no further issues had been experienced following the work undertaken by Philips. However there has been significant issues where the monitors have been freezing and telemetry monitoring not being able to be facilitated. The risk assessment has therefore been re-opened and updated to incorporate the new issues which are still ongoing and has been escalated via the Patient Safety Summit and the Medical Equipment Group. The issues with the loss of monitoring have been reported again to the MHRA. There a meeting arranged for 24/1/18 with the DGM and Philips to discuss the current SLA and issues experienced.*	13/06/2017 **Review Frequency** Monthly **Monitoring Group** Executive Quality Governance Group **Risk Source** Risk Assessment **Version** 1 **BAF Links**

Shift		
2016-17		
Q1		
Q2		
Q3		
Q4		
2017-18		
Q1	15	►
Q2	15	►
Q3	20	▲
Q4		

Shift Position

Key: I = Initial Risk Rating; C = Current Risk Rating; T = Target Risk Rating

▲ = Risk rating has increased since previous quarter

► = No change from previous quarter

▼ = Risk rating has decreased since previous quarter

Appendix B - Progress against the Risk Management Strategy & Framework (2017/20) priorities

Progress against the key priorities for 2017/18 is detailed below, with the classification of progress included in Table 1 above.

Priority	Key areas 2017/19	Position	Commentary
1. New Risk Management Strategy & Framework 2017/20	• Categorisation matrix review (Part of the Incident Report & Management Policy)	Completed	• Executive Quality Governance Group (EQGG) December 2017
	• Revise Risk Assessment Procedure	On track: Not yet started	• Planned May 2018
	• Review governance between organisations	On track: Not yet completed	• Part of NHSI Well Led Developmental Review
	• Revise organisational quarterly risk register report	Completed	• First iteration to EQGG November 2017 • Quality Governance Committee (QGC)December 2017 • Board of Directors January 2018
	• Implement quarterly divisional / CCICP risk register reports	Completed	• First iterations to Boards in November / December 2017
	• Implement risk approval process for risk rated 15 & above	Completed	• Standing agenda item on EQGG. Gate keeper system in place for approval at Divisional Boards/CCICP
	• Develop training needs analysis and risk based approach	On track: Not yet completed	• Roll out with web based by March 2019
	• Review the Risk Management Early Warning System	On track: Not yet started	• Planned May 2018
2. New Board Assurance Framework (BAF)	• Development of a new dynamic BAF aligned to the 'Three Lines of Defence' model and mapping process	On track: Not yet completed	• First iteration to Board of Directors – November 2017 • Sub-committee review in detail • Summary version to Board of Directors from Q3 2017/18 • Quarterly assurance mapping process commenced
3. Review of Risk Registers	• Apply new approach to risk descriptors: "There is a risk that <risk event> as a result of <cause> which may lead to <effect/impact>"	Completed	• Risks rated 15 & above prioritised and all new risks described as per strategy & framework. All risks to be re written through review process. Web based solution will aid this.
	• Link to organisational or divisional objectives	On track: Not yet completed	• Risk rated 12 & above prioritised – Q4 2017/18
	• Initial review of divisional risk registers	Completed	• Initial reviews undertaken with plans in place
	• Review process for high impact risks with low likelihood	On track: Not yet started	• Planned May 2018
	• Develop a register of risk registers	On track: Not yet started	• Web based solution by March 2019
	• Develop a risk profiling process	On track: Not yet started	• Web based solution by March 2019
	• Triangulate risk information in quality reports / mortality reports	On track: Not yet completed	• Initial reports to be developed for February 2018 Quality Assurance reviews

Appendix B - Progress against the Risk Management Strategy & Framework (2017/20) priorities

Priority	Key areas 2017/19	Position	Commentary
3. Review of Risk Registers	• Develop sources on web based system	On track: Not yet started	• By March 2019
	• Undertake TNA for risk management	On track: Not yet started	• Training to dovetail with web based system by March 2019
4. Governance Structure Group Reporting	• Review the information flows and functions of the groups reporting into the Executive Quality Governance Group.	On track: Not yet completed	• To include as part of the Well –Led Developmental Review in February 2018 with Board oversight in April 2018 by May 2018.
	• Review annually	On track: Not yet started	• Review March 2019
5. Safety Culture Assessment	• Undertake initial assessment	On track: Not yet started	• Initial assessments as part of the Well –Led Developmental Review in February 2018 with Board oversight in April 2018. • Trust rolling programme from July 2018
6. Ulysses – Web Based Solution for risk management and improvement planning	• Review of all fields to include controls assurance rating, cost benefit analysis, risk proximity and risk profiling • Education & training programme • Cleansing of all grades of risks • Quality improvement, audit and national guidance gap analysis system to be developed	Delivery remains feasible but potential risk to delivery within original timescales (Now by March 2019)	• Potential delays due to resourcing issues • Delay in Ulysses provision of improvement / action module • CCICP services will need reconfiguring on the system post change to care groups • Dependency on recruitment process to new Quality Governance Team (Quality Governance Analyst) • This action is included in the risk management internal audit report for completion by March 2018 – **moved to by March 2019**

Appendix C – Risk Matrices

Consequence / Likelihood	1	2	3	4	5
1	1	2	3	4	5
2	2	4	6	8	10
3	3	6	9	12	15
4	4	8	12	16	20
5	5	10	15	20	25

Likelihood	Definition	Estimated Probability	Lessons Learned
Almost certain	This event may be imminent or there are strong indications it will occur in the future. Not confident risk can be managed at this level and contingency is required	More than 80% chance of occurring	A regular occurrence. Circumstances found frequently
Likely	This event is likely to occur in most circumstances. Requires additional mitigation/contingency. Little confidence risk can be managed at this level.	51% to 80% chance of occurring	Has occurred from time to time and may do so again in the future
Possible	This event is likely to occur at some time even if controls operate normally. Confident risk can be managed at this level	21% to 50% chance of occurring	Has occurred previously but not often, and may have been in a limited way
Unlikely	Not expected, this event has a small chance of occurring at some time	6% to 20% chance of occurring	Has not happened, or happened in a very limited way
Rare	Highly unlikely, will occur only in very exceptional circumstances. Very confident risk can be managed at this level. Controls operate normally	Less than a 5% chance of occurring	Has rarely happened