Mid Cheshire Hospitals NHS Foundation Trust

# AGENDA

**Board of Directors**
**A meeting will be held in Public at**
**09.30am on Monday, 4 June 2018**
**in the Boardroom, Leighton Hospital**

| Action Key | |
|---|---|
| A | Approval |
| I | Information |
| D | Discussion |

| Item No | Title of Item | Action | Led By | Page No. |
|---|---|---|---|---|
| 1. | **Welcome and Apologies**<br>To welcome members of the public and attendees and to receive apologies for absence from Board Members.<br>*(to note)* | I | Chairman<br>**09.30** | - |
| 2. | **Patient or Staff Story** *(verbal)* | I/D | Director of Nursing & Quality<br>**09.32** | - |
| 3. | **Board Member's Interests** *(to note)*<br>To **consider** any<br>• Changes to Directors' interests since the last meeting<br>• Conflicts of interest deriving from this agenda | I | Chairman<br>**09.50** | - |
| 4. | **Minutes of the Last Meeting**<br>To **approve** the minutes of<br>• The Board of Directors meeting held in Public on Tuesday, 8 May 2018 *(attached) (to approve)*<br>• The Extra Ordinary Board of Directors meeting held in private on Monday, 21 May 2018 *(attached) (to approve)* | A | Chairman<br>**09.52** | -<br>- |
| 5. | **Matters Arising and Action Log**<br>*(verbal) (to approve)* | A | Chairman<br>**09.55** | - |
| 6. | **Annual Work Programme 2018/19** *(attached)*<br>*(to approve)* | I/A | Chairman<br>**09.57** | **24** |
| 7. | **Chairman's Announcements**<br>(*to note a verbal report*)<br>**7.1 Meeting with the Vice Chancellor of the University of Chester**<br>**7.2 Joint Organisational Development with the CCGs**<br>**7.3 Meeting with Laura Smith MP** | I | Chairman<br>**10.00** | - |
| 8. | **Governor's Items**<br>(*to note a verbal report*)<br>**8.1 Nominations and Remuneration Committee 8 May 2018** | I | Chairman<br>**10.05** | - |

| Item No | Title of Item | Action | Led By | Page No. |
|---|---|---|---|---|
| 8.2 | **Governor Elections 2018** | | | |
| 8.3 | **Chat with the Chairman – 21 May 2018** | | | |
| **9.** | **Chief Executive's Report**<br>*(to note a verbal report)* | I | Chief Executive<br>**10.10** | - |
| 9.1 | **System Update** | | | |
| 9.2 | **CQC Well Led Inspection** | | | |
| 9.3 | **Director of Workforce and Organisational Development Appointment** | | | |
| 9.4 | **Executive Director Away Day** | | | |
| **10.** | **CARING** | | | |
| 10.1 | **Quality, Safety & Experience Report**<br>*(attached) (for discussion)* | I/D | Director of Nursing & Quality<br>**10.25** | **25** |
| **11.** | **SAFE** | | | |
| 11.1 | **Draft Quality Governance Committee notes from the meeting held on 14 May 2018**<br>*(attached) (to note)* | I | Committee Chair<br>**10.35** | - |
| 11.2 | **Serious Untoward Incidents and RIDDOR Events** *(verbal)* (*to note*) | I/D | Deputy Chief Executive/ Medical Director<br>**10.40** | - |
| 11.3 | **CNST Safer Maternity Care**<br>*(attached) (to approve)*<br>Mark Wilde, Divisional General Manager | A/D | Director of Nursing & Quality<br>**10.45** | **79** |
| **12.** | **RESPONSIVE** | | | |
| 12.1 | **Performance Report**<br>*(attached) (to note)* | I/D | Director of Finance<br>**10.55** | **297** |
| 12.2 | **Draft Performance & Finance Committee notes from the meeting held on 24 May 2018** *(to follow)*<br>*(to note)* | I | Committee Chair<br>**11.05** | - |
| 12.3 | **Legal Advice** *(verbal)* (*to note*) | I | Chief Executive<br>**11.10** | - |
| **13.** | **WELL-LED** | | | |
| 13.1 | **Draft Audit Committee notes from the meetings held on:** | | Committee Chair<br>**11.15** | |
| | • **14 May 2018** | I | | - |

| Item No | | Title of Item | Action | Led By | Page No. |
|---|---|---|---|---|---|
| | | • **21 May 2018 (Extra Ordinary)** | I | | - |
| | 13.2 | **Visits of Accreditation, Inspection or Investigation** *(verbal)* (*to note*) | I | Chief Executive **11.20** | - |
| | 13.3 | **CCICP Partnership Board:**<br>• **Notes from the meeting held on 12 April** *(attached) (to note)*<br>• **Future governance pathway for minutes and escalations** | I | Director of Strategic Partnerships **11.25** | **368**<br>- |
| | 13.4 | **Board Assurance Framework Quarter 4 2017-18** *(attached) (to note)* | | Deputy Chief Executive/ Medical Director **11.35** | **374** |
| | 13.5 | **Learning from Deaths Review Quarter 4 2017-18** *(attached) (to note)* | | Deputy Chief Executive/ Medical Director **11.40** | **395** |
| | 13.6 | **Cheshire East Place Memorandum of Understanding** *(attached) (to approve)* | | Chief Executive **11.45** | **417** |
| **14.** | **EFFECTIVE** | | | | |
| | 14.1 | **Workforce Report** *(attached) (to note)* | I | Interim Director of Workforce and OD **11.55** | **426** |
| | 14.2 | **Transformation and People Committee notes from the meeting held on 3 May 2018** *(attached) (to note)* | | Committee Chair **12.05** | - |
| | 14.3 | **Consultant Appointments** *(verbal) (to note)* | I | Deputy Chief Executive/ Medical Director **12.10** | - |
| **15.** | **Any Other Business** *(verbal)* | | I/A/D | Chairman **12.15** | - |
| **16.** | **Time, Date and Place of Next Meeting** | | | | |
| | | To confirm that the next meeting of the Board of Directors will take place in public, in the Board Room at Leighton Hospital, at 9.30am on **Monday, 2 July 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 | | | | |
| *Minutes of the Last Meeting* | x | x | x | x | x | x | x | x | x | x | x | x | | | | |
| *Board Actions* | x | x | x | x | x | x | x | x | x | x | x | x | | | | |
| *Annual Work Programme* | 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 Items* | x | x | x | x | x | x | x | x | x | x | x | x | | | | |
| *Chief Executive's 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 | | | | |
| | | | | | | | | | | | | | | | | |
| **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 | | | | | | |
| *Board Sub-Committee Annual Review* | | | x | | | | | | | | | | | | | |
| *Doctors Revalidation Report* | | | | | | x | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| **Effective** | | | | | | | | | | | | | | | | |
| *Workforce Report* | x | x | x | x | x | x | x | x | x | x | x | x | | | | |
| *Transformation and People Committee* | x | x | x | x | x | x | x | x | x | x | x | x | | | | |
| *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 | | | | |
| | | | | | | | | | | | | | | | | |

Mid Cheshire Hospitals
NHS Foundation Trust

# Board of Directors

# Quality, Safety and Experience Report

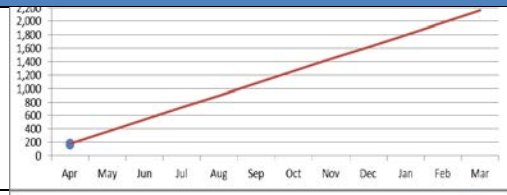
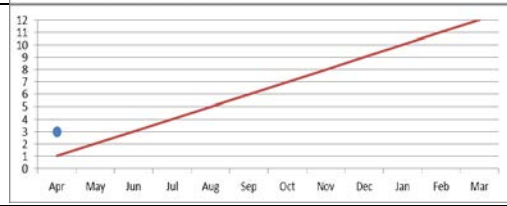
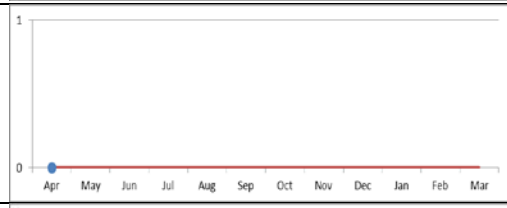
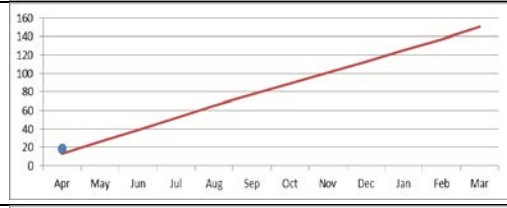
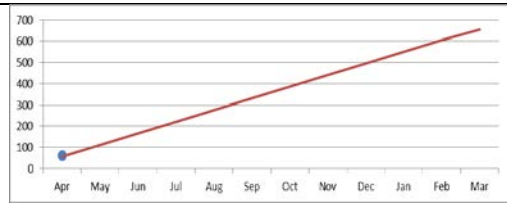
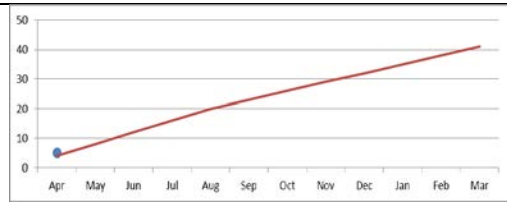
## June 2018

## (April 2018 data)

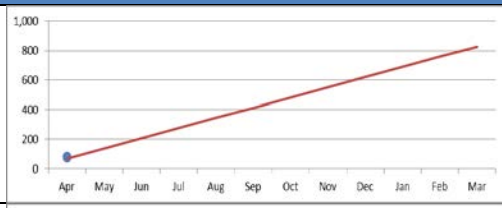
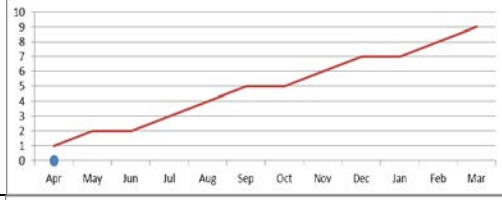
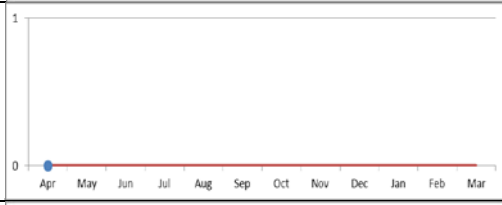
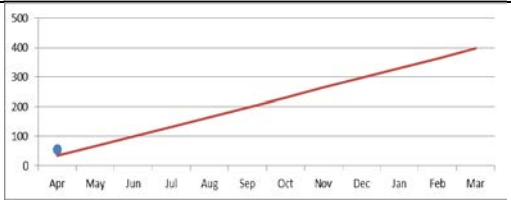
**Contents**

**Contents (continued):**

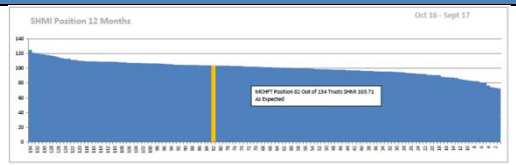
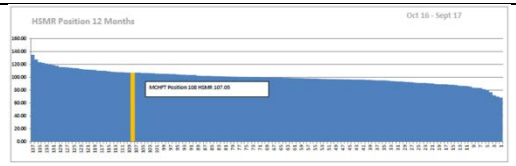
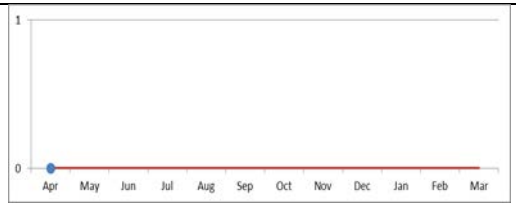
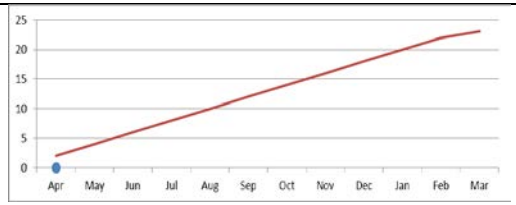
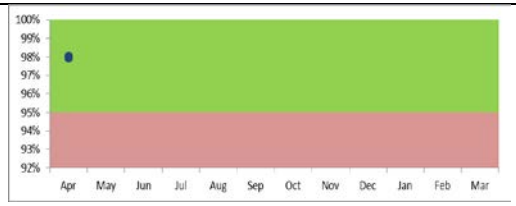
## Board Papers – Quality, Safety & Experience Section: June 2018

| Indicators | Target | Trajectory 2018/19 |
|---|---|---|
| ***Acute Trust*** | | |
| **Patient Safety Harm Incidents**<br>The target is to reduce patient safety harm incidents by 5% when compared to the previous financial year by the end of March 2019. | **Less than 2161 at end of March 2019** |  |
| **Serious Incidents**<br>The target is to reduce patient safety serious incidents by 10% when compared to the previous financial year by the end of March 2019. | **Less than 12 at end of March 2019** |  |
| **Never Events**<br>Zero tolerance of Never Events. | **Zero** |  |
| **Pressure Ulcers – Hospital Acquired**<br>The target is to reduce hospital acquired pressure ulcers by 20% when compared to the previous financial year by the end of March 2019. | **Less than 150 at end of March 2019** |  |
| **Inpatient Falls**<br>The target is to reduce inpatient falls by 10% when compared to the previous financial year by the end of March 2019. | **Less than 656 at end of March 2019** |  |
| **Medication Harm Incidents**<br>The target is to reduce medication incidents resulting in harm by 10% when compared to the previous financial year by the end of March 2019. | **Less than 41 at end of March 2019** |  |

# Board Papers – Quality, Safety & Experience Section: June 2018

| Indicators | Target | Trajectory 2018/19 |
|---|---|---|
| *CCICP* | | |
| **CCICP Patient Safety Harm Incidents**<br>The target is to reduce CCICP patient safety harm incidents by 5% when compared to the previous financial year by the end of March 2019. | **Less than 828 at end of March 2019** |  |
| **CCICP Serious Incidents**<br>The target is to reduce CCICP patient safety serious incidents by 10% when compared to the previous financial year by the end of March 2019. | **Less than 9 at end of March 2019** |  |
| **CCICP Never Events**<br>Zero tolerance of CCICP Never Events. | **Zero** |  |
| **CCICP Pressure Ulcers – Community Acquired**<br>The target is to reduce community acquired pressure ulcers by 20% when compared to the previous financial year by the end of March 2019. | **Less than 398 at end of March 2019** |  |

# Board Papers – Quality, Safety & Experience Section: June 2018

| Indicators | Target | Trajectory 2018/19 |
|---|---|---|
| **SHMI**<br>The Trust's target is to be at least within the "as expected" bracket. This has been achieved for the latest reporting period. | **As expected** |  |
| **HSMR**<br>The Trust's target is to be at least within the "as expected" bracket. This has been achieved for the latest reporting period. | **As expected** |  |
| **MRSA**<br>Zero tolerance of MRSA cases. | **Zero** |  |
| **C-Diff Avoidable**<br>The target is less than 23 avoidable cases of Clostridium Difficile in 2018/19. | **Less than 23 at end of March 2019** |  |
| **Safety Thermometer**<br>The Trust target is that >95% of patients receive harm free care as monitored by the Safety Thermometer. | **>95%** |  |

# Board Papers – Quality, Safety & Experience Section: June 2018

## Quality & Safety Section:

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

### Patient Safety Harm Incidents

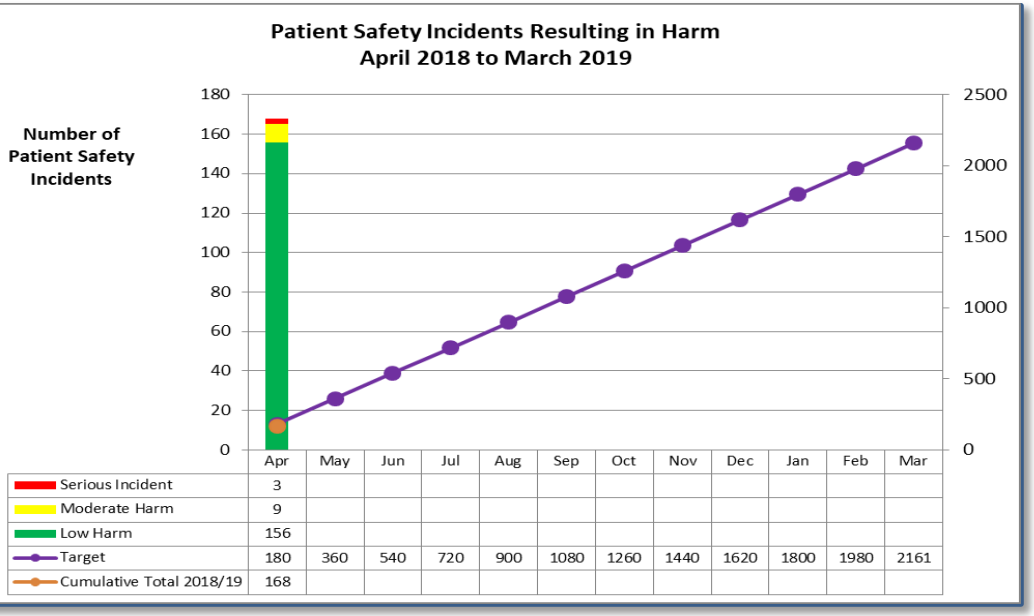
*The target is to reduce patient safety harm incidents by 5% when compared to the previous financial year by the end of March 2019.*

This chart demonstrates the total number of reported patient safety harm incidents.

For April 2018, there were a total of 168 patient safety harm incidents:
92.9% (156 incidents) have resulted in low harm
5.4% (9 incidents) have resulted in moderate harm
1.8% (3 incidents) 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
- Deteriorating Patient Steering Group formed to implement NEWS2.




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Serious Incident | 3 | | | | | | | | | | | |
| Moderate Harm | 9 | | | | | | | | | | | |
| Low Harm | 156 | | | | | | | | | | | |
| Target | 180 | 360 | 540 | 720 | 900 | 1080 | 1260 | 1440 | 1620 | 1800 | 1980 | 2161 |
| Cumulative Total 2018/19 | 168 | | | | | | | | | | | |

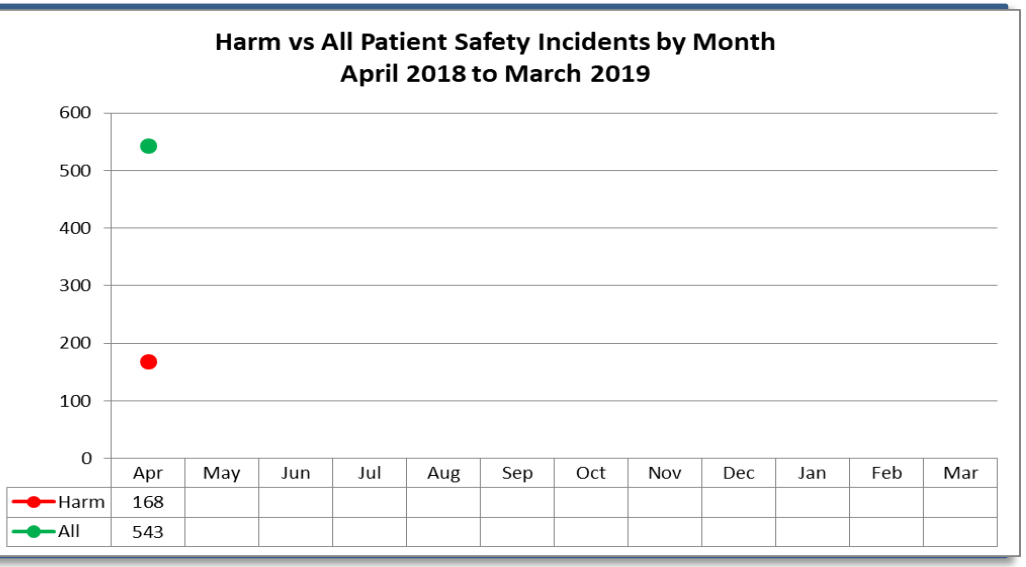
### Harm vs All Patient Safety Incidents

*The aim is to maintain / widen the gap between harm and all patient safety incidents reported*

This chart demonstrates the number of incidents that have resulted in harm vs all patient safety incidents.

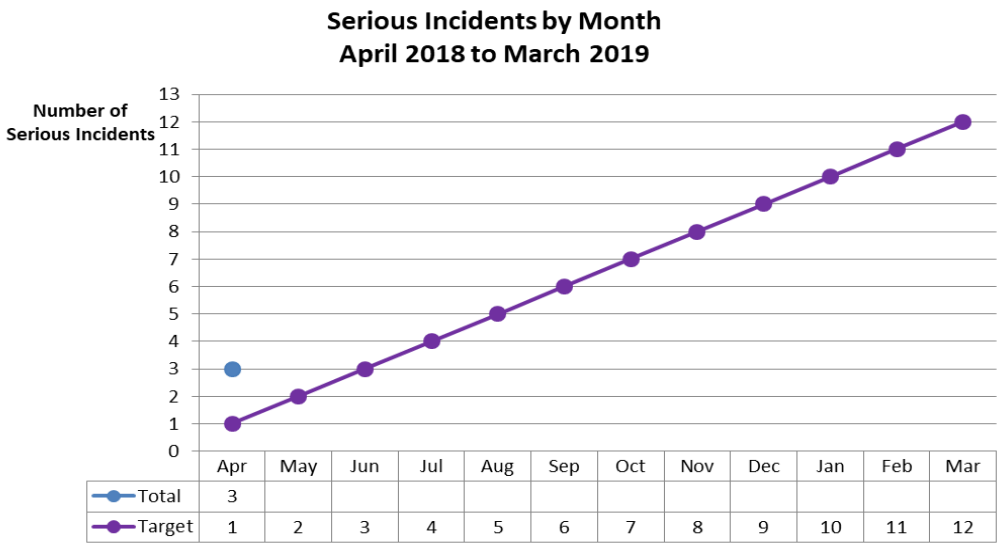
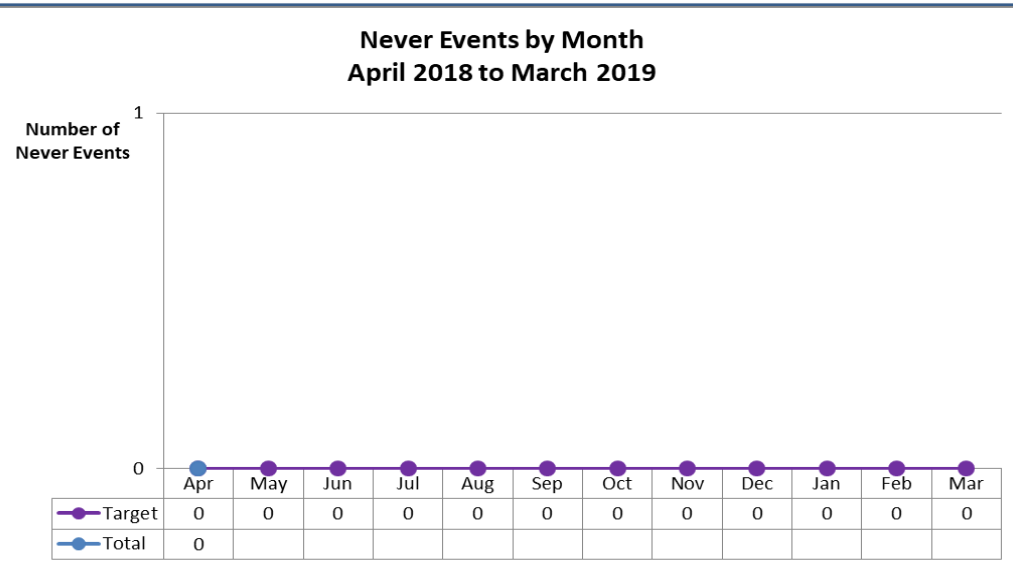
In April 2018, the gap between harm and all patient safety incidents was 375. The aim over the twelve month period is to see this gap widening.

Within healthcare, a safety culture is defined as a "culture where staff has a constant and active awareness of the potential for things to go wrong. It is also a culture that is open and fair and encourages people to speak up about mistakes." An important benefit in a safety culture in the NHS is "A potential reduction in the recurrence and in the severity of patient safety incidents through increased reporting and organisational learning" *Source: 7 steps to patient safety, NPSA, 2004*

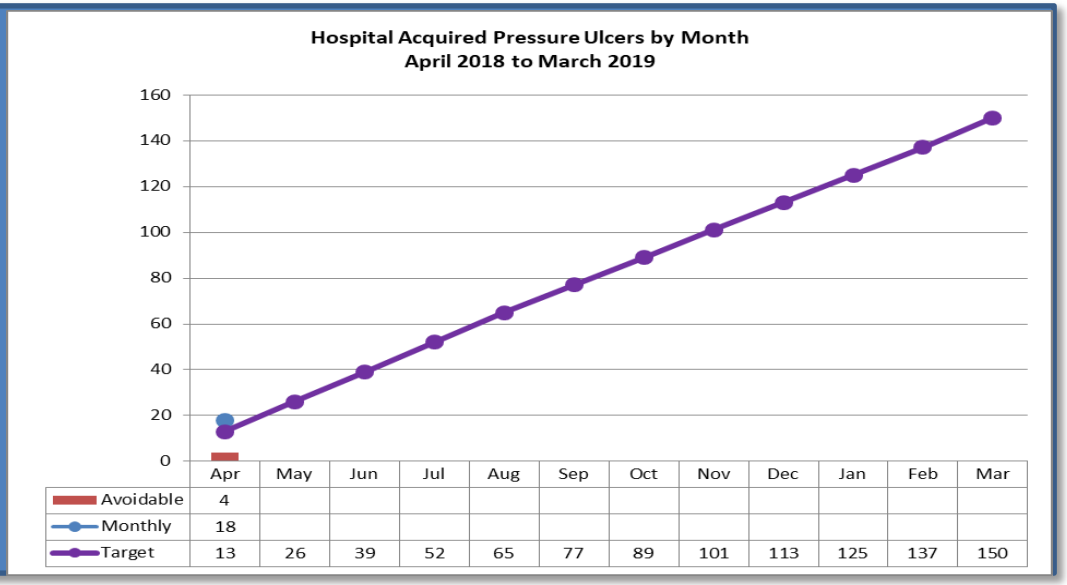



| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Harm | 168 | | | | | | | | | | | |
| All | 543 | | | | | | | | | | | |

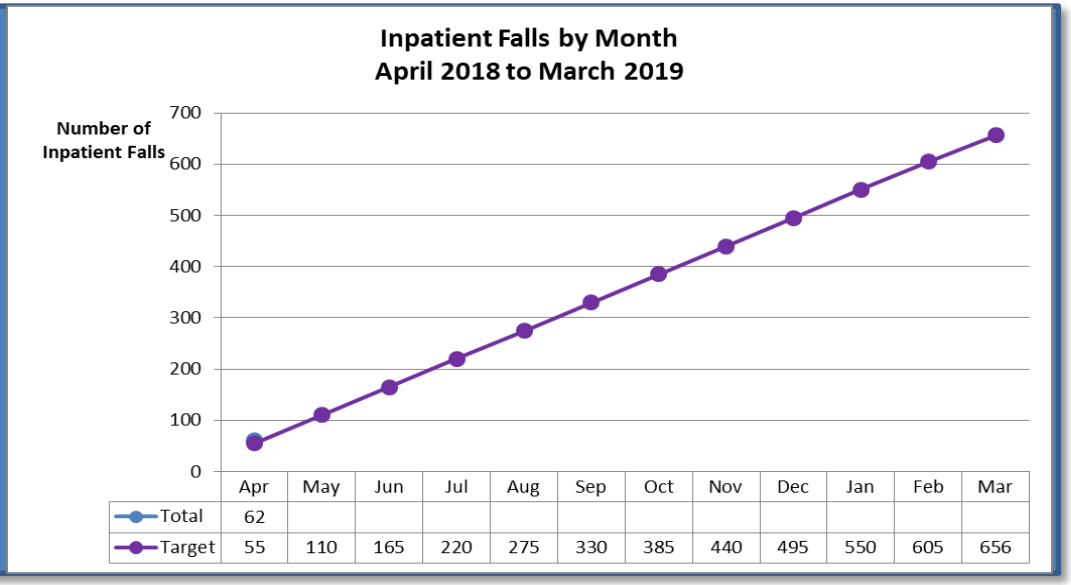
# Board Papers – Quality, Safety & Experience Section: June 2018

| Description | Aggregate Position | Trend |
|---|---|---|
| Serious Incidents<br><br>*The target is to reduce patient safety serious incidents by 10% when compared to the previous financial year by the end of March 2019.* | This chart demonstrates the number of incidents that have resulted in serious harm.<br><br>For April 2018, there were three serious incidents reported:<br><br>• Patient Fall resulting in fractured neck of femur (Elmhurst)<br>• Patient Fall resulting in fractured neck of femur (Emergency Department)<br>• Patient Fall resulting in fractured neck of femur (Ward 4) |  |
| Never Events<br><br>*The target is to have zero Never Events* | This chart demonstrates the number of Never Events that have been reported.<br><br>For April 2018 no Never Events were reported.<br><br>The last reported Never Event was in November 2016 which related to a wrong site anaesthetic block.<br><br>A Never Event assurance paper was presented to the Quality Governance Committee in May 2018 following escalation from the Executive Quality Governance Group. The paper outlined the Trust position against the fourteen Never Events applicable to acute trusts to ensure the Trust has the correct policies and procedures in place to prevent future Never Events. |  |

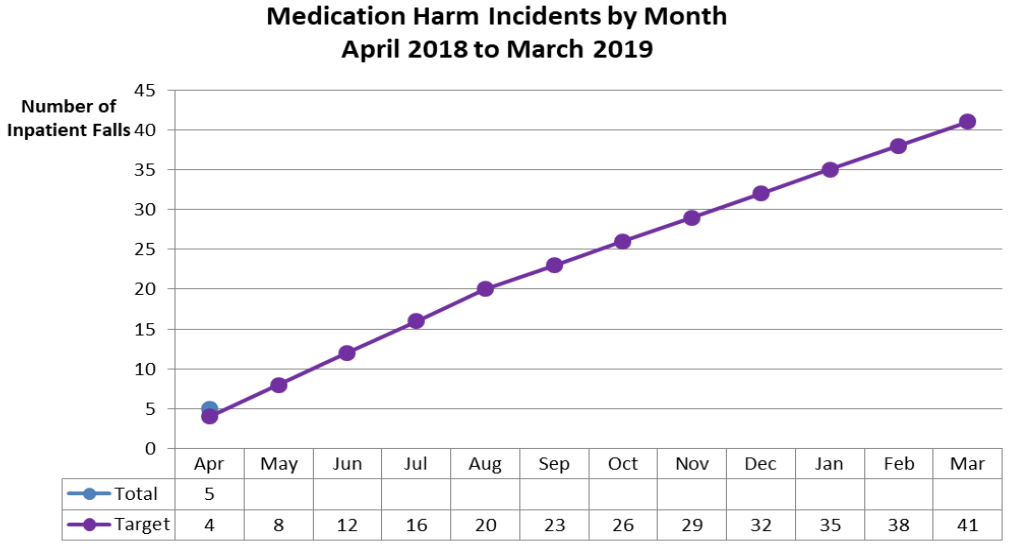
# Board Papers – Quality, Safety & Experience Section: June 2018

| Description | Aggregate Position | Trend |
|---|---|---|
| Pressure Ulcers – Hospital Acquired<br>*The target is to reduce hospital acquired pressure ulcers by 20% when compared to the previous financial year by the end of March 2019.* | For April 2018, there were a total of 18 hospital acquired pressure ulcer incidents:<br>• 22.2% (4 PU's) have resulted in avoidable harm. The 4 avoidable pressure ulcers occurred on Ward 3 (AMU) x2, Ward 2 and Ward 5.<br><br>Improvement actions include:<br>• There is an ongoing education programme led by the Pressure Ulcer Prevention team<br>• Introduction of a pressure ulcer prevention panel in April 2018.<br>• Lessons learned to be shared following the pressure ulcer prevention panel |  |



| Description | Aggregate Position | Trend |
|---|---|---|
| Inpatient Falls.<br><br>*The target is to reduce inpatient falls by 10% when compared to the previous financial year by March 2019* | For April 2018, there were a total of 62 inpatient falls<br>• 62.9% (39 falls) have resulted in no harm<br>• 27.4% (17 falls) have resulted in low harm<br>• 4.8% (3 falls) has resulted in moderate harm<br>• 4.8% (3 falls) have resulted in serious harm<br><br>The 3 serious harm inpatient falls occurred on Elmhurst, Emergency Department and Ward 4.<br><br>Improvement actions include:<br>• Bespoke training where an increase in falls has been identified<br>• Continued review of practice during senior nurse walkabout |  |

# Board Papers – Quality, Safety & Experience Section: June 2018

| Description | Aggregate Position | Trend |
|---|---|---|
| Medication Harm Incidents<br>*The target is to reduce medication incidents resulting in harm by 10% when compared to the previous financial year by the end of March 2019.* | For April 2018, there were a total of 5 medication incidents resulting in harm reported:<br>• 100% (5 medication incidents) have resulted in low harm<br>• 0% (0 medication incidents) have resulted in moderate harm<br>• 0% (0 medication incidents) have resulted in serious harm<br><br>Improvement actions include:<br>• Junior medical staff training<br>• E-learning package in place<br>• Zero tolerance to prescription anomalies at ward level |  |

## Central Cheshire Integrated Care Partnership (CCICP)

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

CCICP Patient Safety Harm Incidents

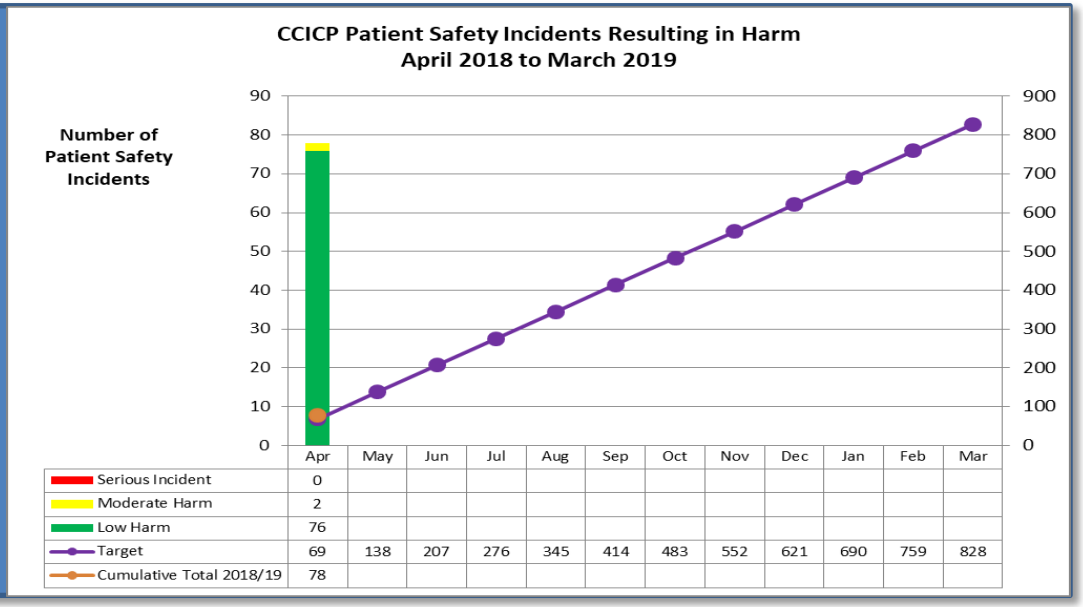
*The target is to reduce CCICP patient safety harm incidents by 5% when compared to the previous financial year by the end of March 2019.*

For April 2018, there were a total of 78 patient safety incidents:

- 97.4% (76 incidents) have resulted in low harm
- 2.6% (2 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:

- 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 | | | | | | | | | | | |
| Moderate Harm | 2 | | | | | | | | | | | |
| Low Harm | 76 | | | | | | | | | | | |
| Target | 69 | 138 | 207 | 276 | 345 | 414 | 483 | 552 | 621 | 690 | 759 | 828 |
| Cumulative Total 2018/19 | 78 | | | | | | | | | | | |

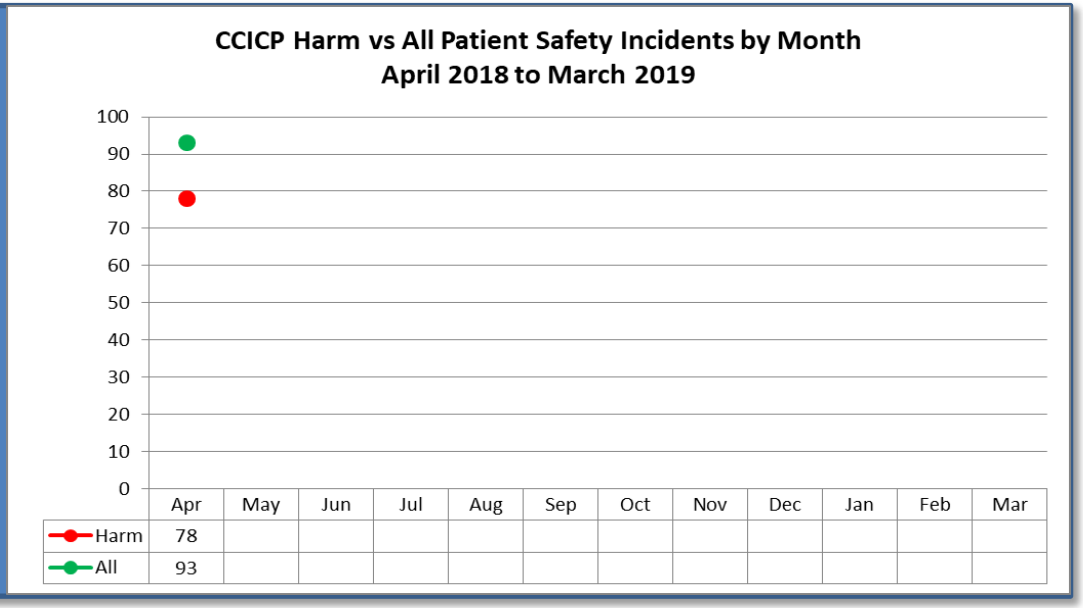
CCICP Harm vs All Patient Safety Incidents

*The aim is to increase no harm reporting and eventually widen the gap between harm and all incidents.*

This chart demonstrates the number of incidents that have resulted in harm vs all patient safety incidents.

In April 2018, the gap between harm and all patient safety incidents was 15.

Within healthcare, a safety culture is defined as a "culture where staff have a constant and active awareness of the potential for things to go wrong. It is also a culture that is open and fair and encourages people to speak up about mistakes." An important benefit in a safety culture in the NHS is "A potential reduction in the recurrence and in the severity of patient safety incidents through increased reporting and organisational learning" *Source: 7 steps to patient safety, NPSA, 2004*




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Harm | 78 | | | | | | | | | | | |
| All | 93 | | | | | | | | | | | |

# Board Papers – Quality, Safety & Experience Section: June 2018

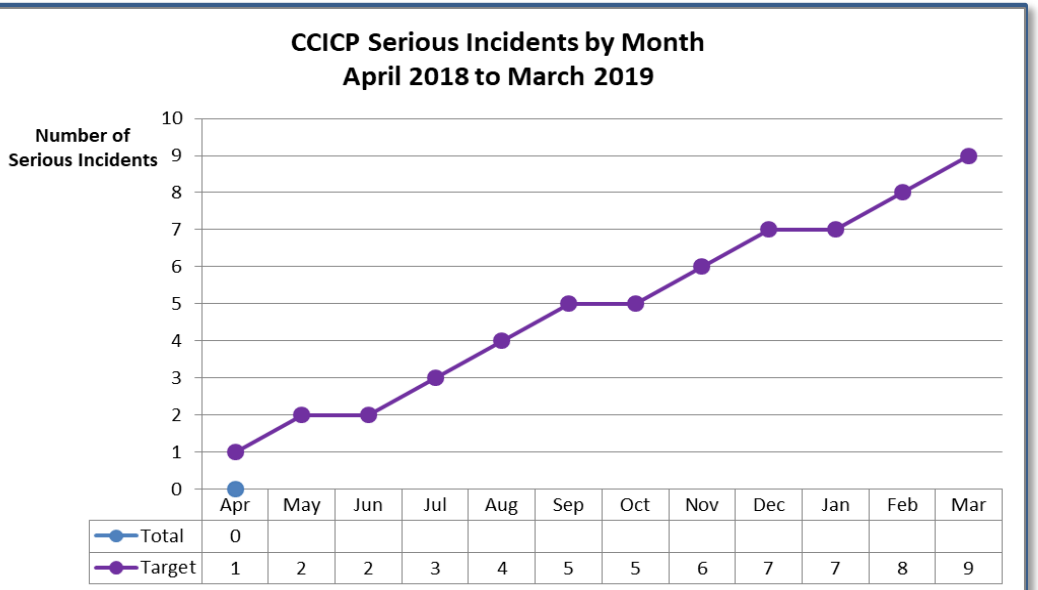
| Description | Aggregate Position | Trend |
|---|---|---|

## CCICP Serious Incidents

*The target is to reduce patient safety serious incidents by 10% when compared to the previous financial year by the end of March 2019.*

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

For April 2018, there were no serious incidents reported.



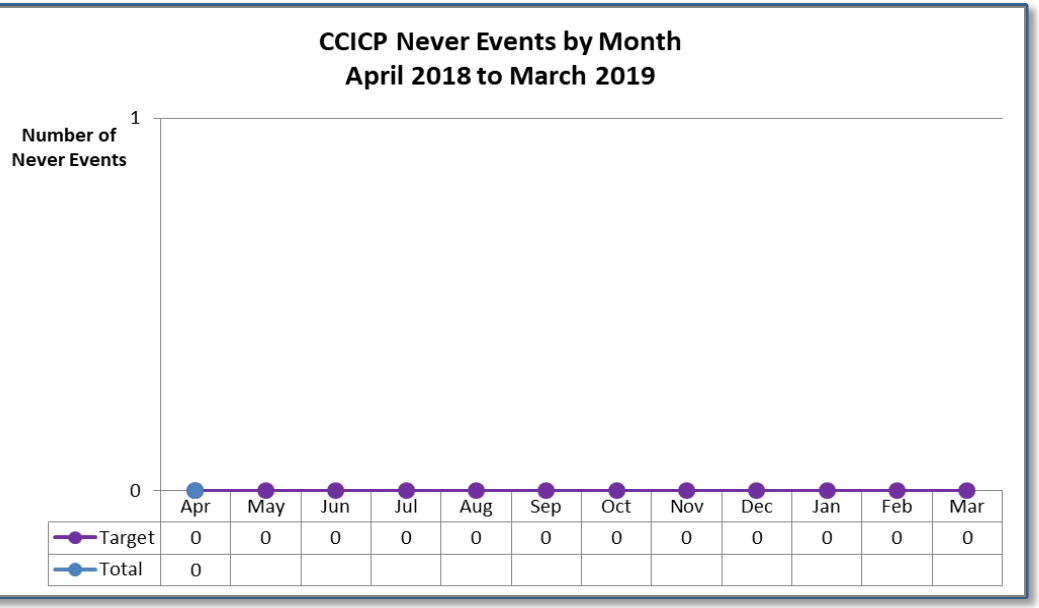

## CCICP Never Events

*The target is to have zero Never Events*

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

For April 2018 no Never Events were reported.

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



# Board Papers – Quality, Safety & Experience Section: June 2018

| Description | Aggregate Position | Trend |
|---|---|---|

## Pressure Ulcers – Community Acquired

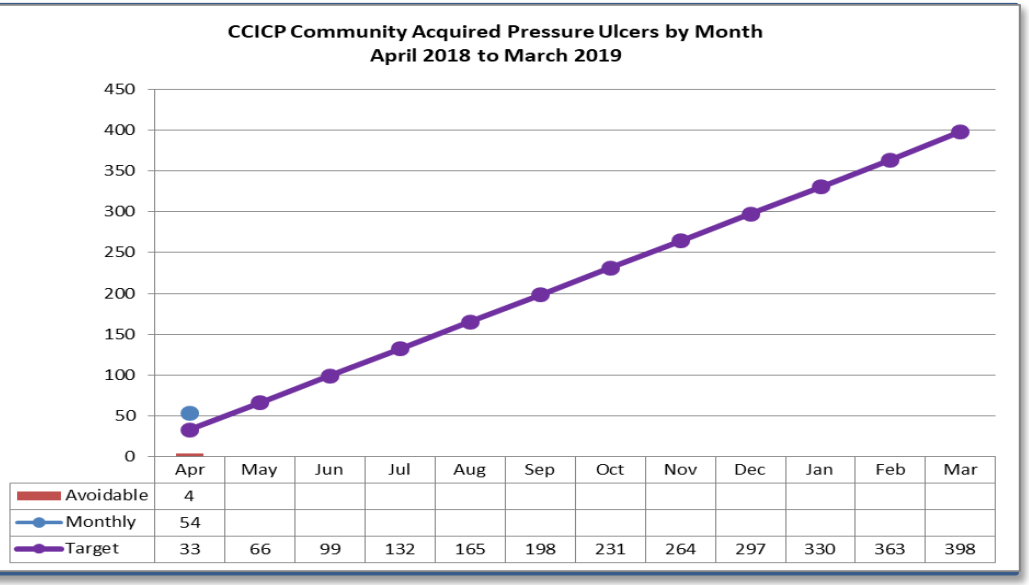
*The target is to reduce community acquired pressure ulcers by 20% when compared to the previous financial year by the end of March 2019.*

For April 2018, there were a total of 54 community acquired pressure ulcer incidents:

- 7.4% (4 PU's) have resulted in avoidable harm. The 4 avoidable pressure ulcers occurred at Church View x3 and Dane bridge.

Improvement actions include:

- Membership at the Trust Skin Care Group has been expanded to include representatives from CCICP
- Identification of a cohort of patients with established chronic wounds
- Introduction of a pressure ulcer prevention panel in April 2018.



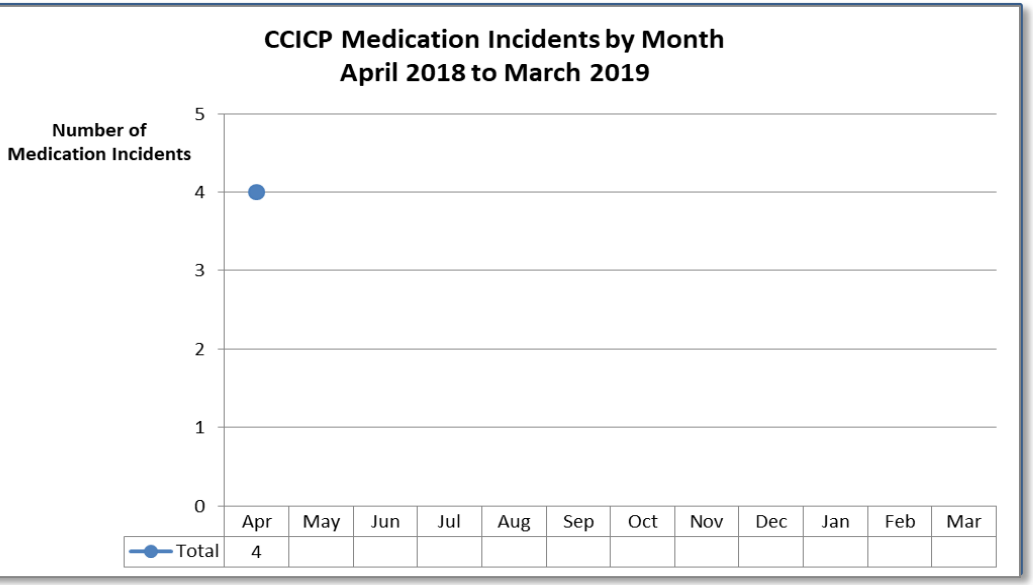

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Avoidable | 4 | | | | | | | | | | | |
| Monthly | 54 | | | | | | | | | | | |
| Target | 33 | 66 | 99 | 132 | 165 | 198 | 231 | 264 | 297 | 330 | 363 | 398 |

## CCICP Medication Incidents.

*The aim is to increase no harm reporting of Medication Incidents.*

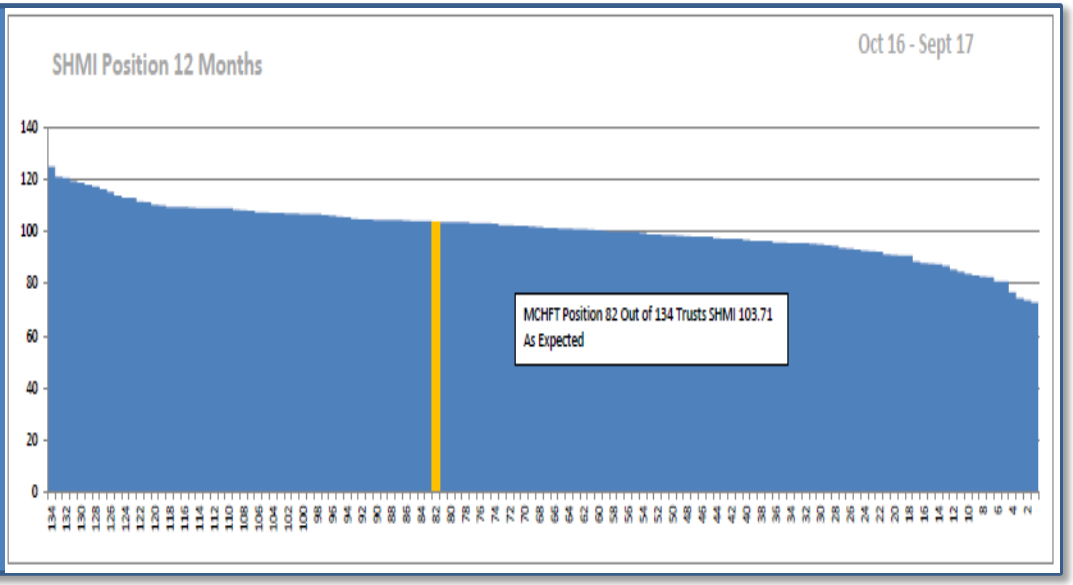
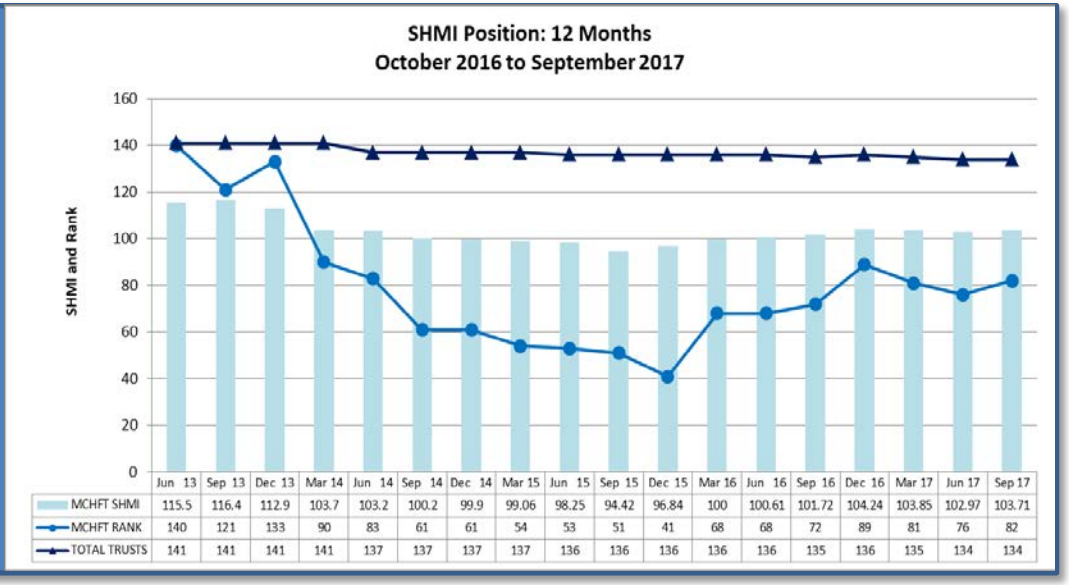
For April 2018, there were a total of 4 medication incidents reported:

- 100% (4 medication incidents) have resulted in no harm
- 0% (0 medication incidents) have resulted in low harm
- 0% (0 medication incidents) have resulted in moderate harm
- 0% (0 medication incidents) have resulted in serious harm



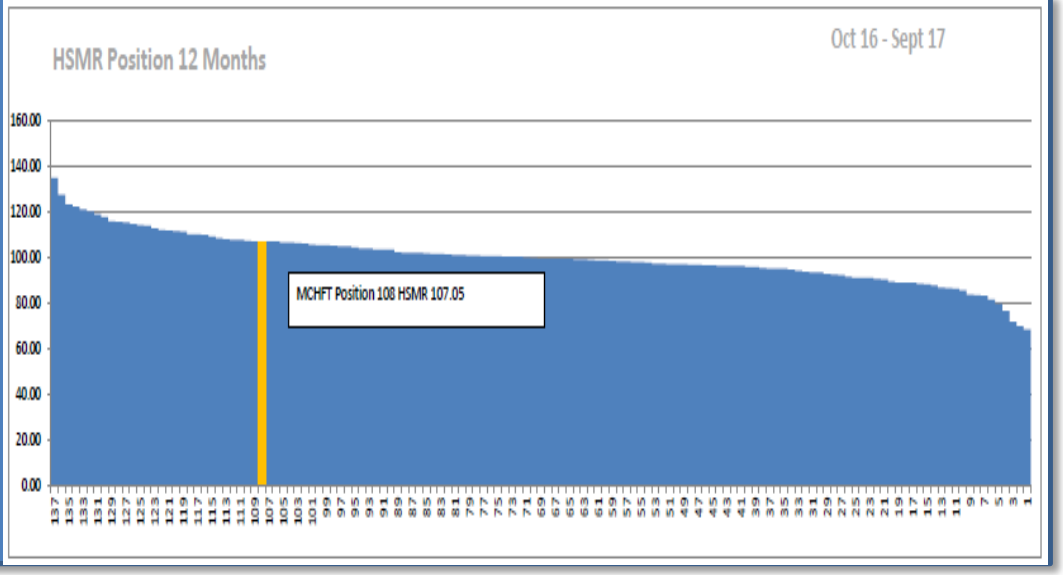

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total | 4 | | | | | | | | | | | |

# Board Papers – Quality, Safety & Experience Section: June 2018

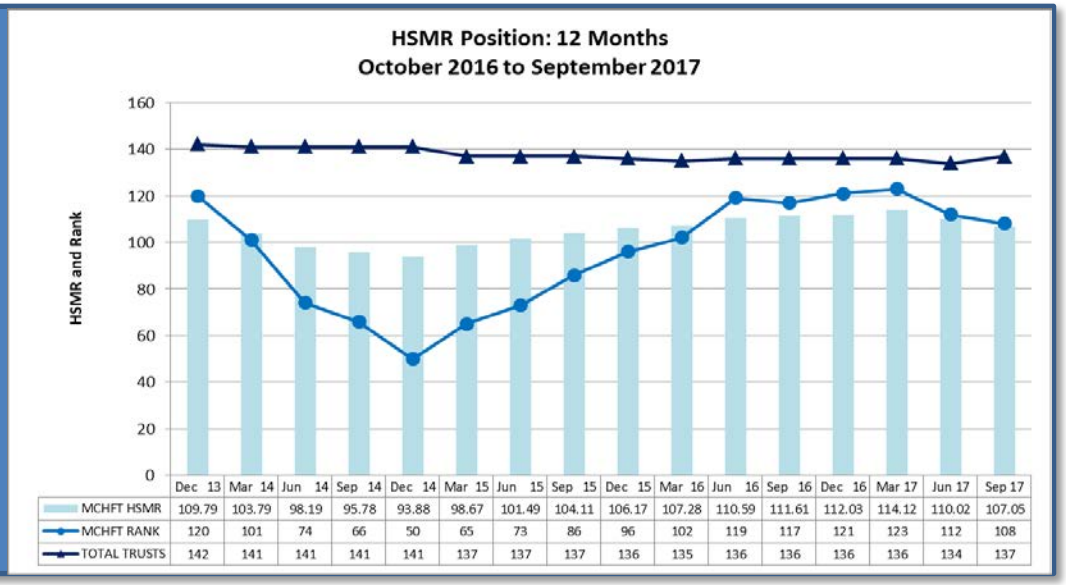
| Description | Aggregate Position | Trend |
|---|---|---|
| SHMI<br><br>*The Trust's target is to be at least within the "as expected" bracket.* | The chart benchmarks the Trust's latest SHMI against all NHS Trusts.<br><br>MCHFT is shown as the yellow bar.<br><br>The Trust's SHMI is 103.71 for the time period October 2016 to September 2017 and places the Trust 82 out of 134 Trusts and is "as expected". |  |
| MCHFT<br><br>*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 October 2016 to September 2017 and is "as expected". |  |

| | 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 | Sep 17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| MCHFT SHMI | 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 | 103.71 |
| MCHFT RANK | 140 | 121 | 133 | 90 | 83 | 61 | 61 | 54 | 53 | 51 | 41 | 68 | 68 | 72 | 89 | 81 | 76 | 82 |
| TOTAL TRUSTS | 141 | 141 | 141 | 141 | 137 | 137 | 137 | 137 | 136 | 136 | 136 | 136 | 136 | 135 | 136 | 135 | 134 | 134 |

# Board Papers – Quality, Safety & Experience Section: June 2018

| Description | Aggregate Position | Trend |
|---|---|---|
| Hospital Standardised Mortality Rate (HSMR) by Trust.<br><br>*The Trust's target is to be at least within the "as expected" bracket.* | The chart benchmarks the Trust's HSMR against all NHS Trusts.<br><br>MCHFT is shown by the amber bar.<br><br>The Trust's HSMR is 107.05 (October 2016 to September 2017) and places the Trust 108 out of 137 Trusts and is "as expected". |  |

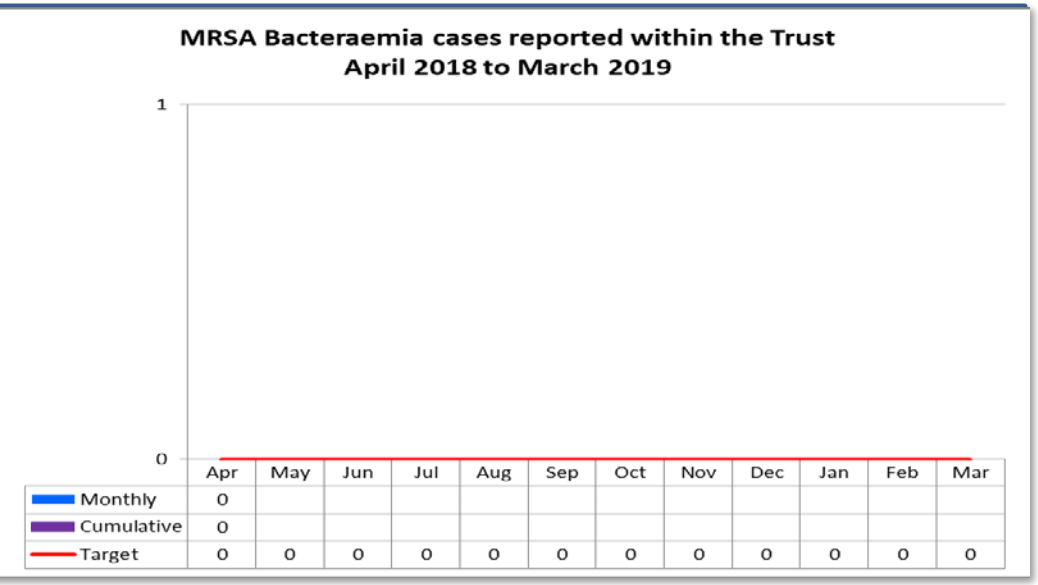
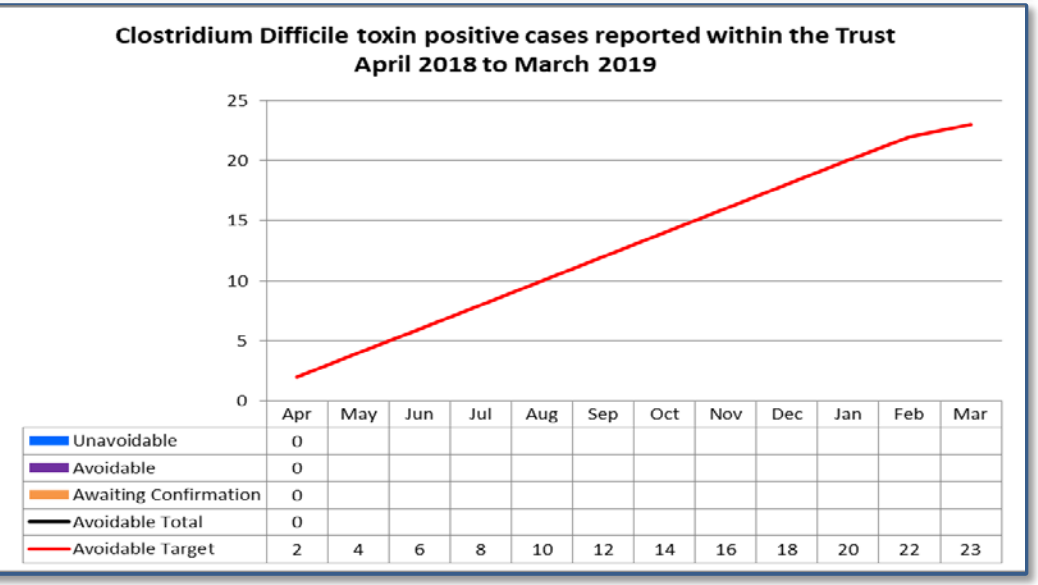


| | | |
|---|---|---|
| MCHFT<br><br>*12 month rolling position for HSMR* | The data in the chart shows the HSMR and rank of MCHFT for each of the 12 month rolling position submissions for the period October 2016 to September 2017 and is "as expected". |  |

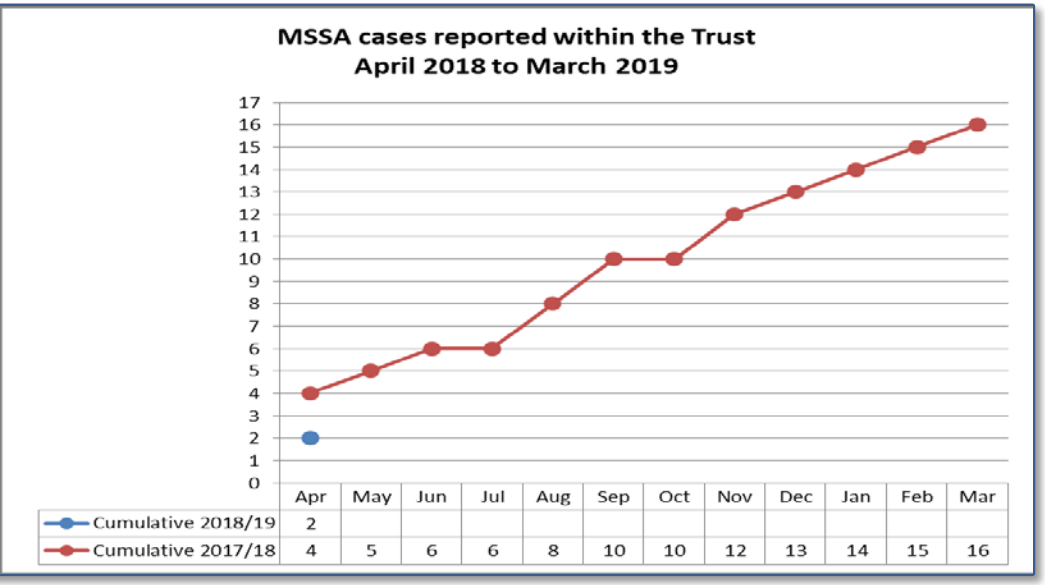
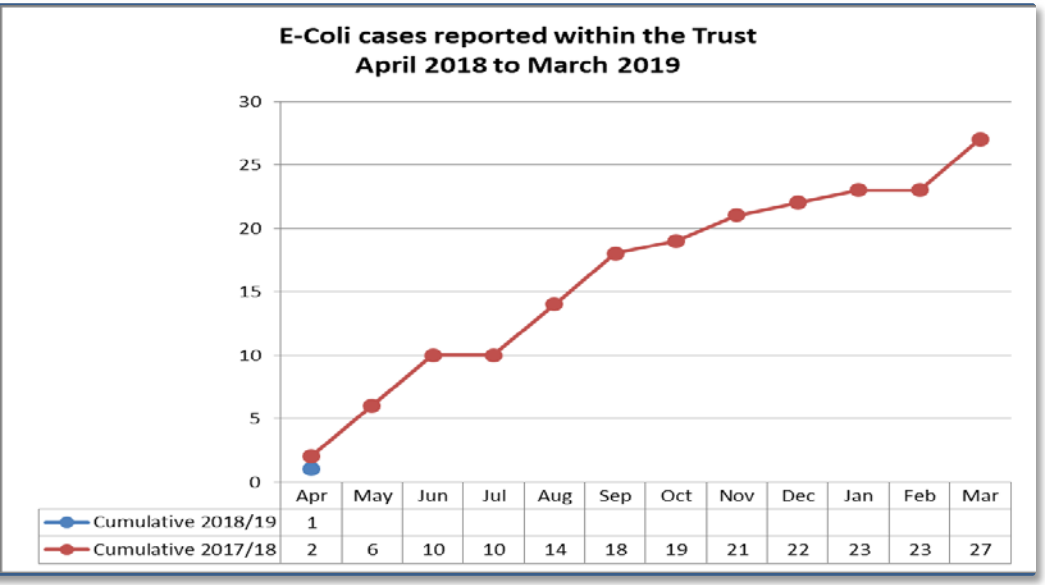


| | Dec 13 | Mar 14 | Jun 14 | Sep 14 | Dec 14 | Mar 15 | Jun 15 | Sep 15 | Dec 15 | Mar 16 | Jun 16 | Sep 16 | Dec 16 | Mar 17 | Jun 17 | Sep 17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| MCHFT HSMR | 109.79 | 103.79 | 98.19 | 95.78 | 93.88 | 98.67 | 101.49 | 104.11 | 106.17 | 107.28 | 110.59 | 111.61 | 112.03 | 114.12 | 110.02 | 107.05 |
| MCHFT RANK | 120 | 101 | 74 | 66 | 50 | 65 | 73 | 86 | 96 | 102 | 119 | 117 | 121 | 123 | 112 | 108 |
| TOTAL TRUSTS | 142 | 141 | 141 | 141 | 141 | 137 | 137 | 137 | 136 | 135 | 136 | 136 | 136 | 136 | 134 | 137 |

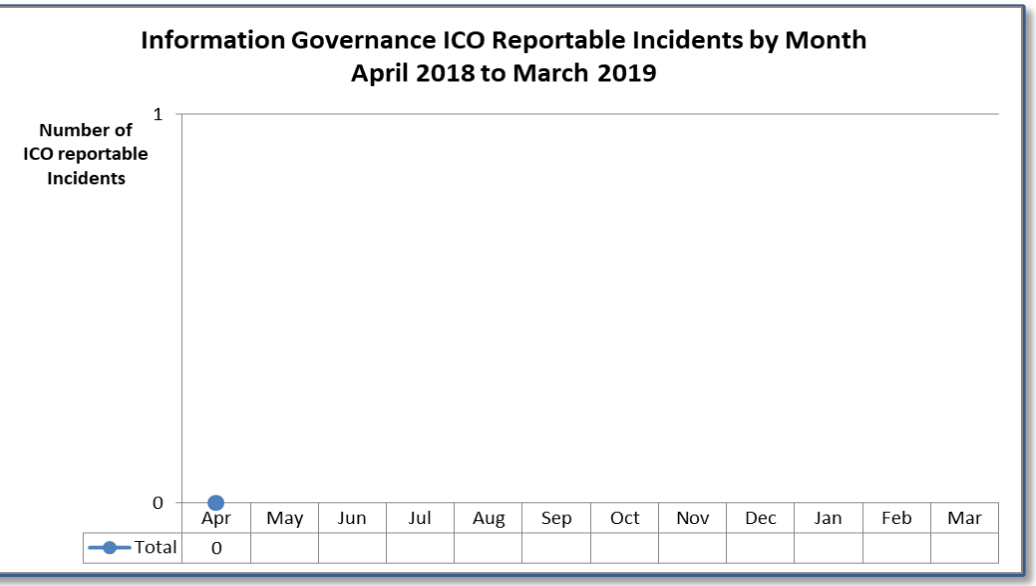
# Board Papers – Quality, Safety & Experience Section: June 2018

| Description | Aggregate Position | Trend |
|---|---|---|
| MRSA Bacteraemia Cases.<br><br>*Zero tolerance of MRSA cases.* | In April 2018, no MRSA bacteraemia cases were reported in the Trust.<br><br>In this financial year there has been no confirmed MRSA bacteraemia cases reported. |  |
| Clostridium Difficile toxin positive cases.<br><br>*The target is less than 23 avoidable cases of Clostridium Difficile in 2018/19* | In April 2018, no avoidable cases were reported.<br><br>The total avoidable cases year to date is zero.<br><br>Improvement actions include:<br><br>• Bed side reviews are in place on the identification of infection<br>• Consultant level engagement in C-difficile root cause analysis |  |

# Board Papers – Quality, Safety & Experience Section: June 2018

| Description | Aggregate Position | Trend |
|---|---|---|
| MSSA Cases.<br><br>*The aim is to have a reduction in MSSA cases when compared to the previous financial year, to demonstrate an incremental improvement* | In April 2018, two MSSA cases were reported in the Trust.<br><br>In this financial year there has been two confirmed MSSA cases reported.<br><br>The 2 MSSA cases occurred on Ward 13 and Ward 14. |  |
| E-Coli Cases.<br><br>*The aim is to have a reduction in E-Coli cases when compared to the previous financial year, to demonstrate an incremental improvement* | In April 2018, one E-Coli case was reported.<br><br>The E-Coli case occurred on Ward 23. |  |

# Board Papers – Quality, Safety & Experience Section: June 2018

| Description | Aggregate Position | Trend |
|---|---|---|
| Information Governance Information Commissioners Office (ICO) reportable incidents. | In April 2018, no information governance ICO reportable incidents were reported in the Trust.<br><br>The Trust has a detailed plan in place to address the requirements of the General Data Protection Regulations (GDPR) which is overseen by the Information Governance Group. |  |

# Board Papers – Quality, Safety & Experience Section: June 2018

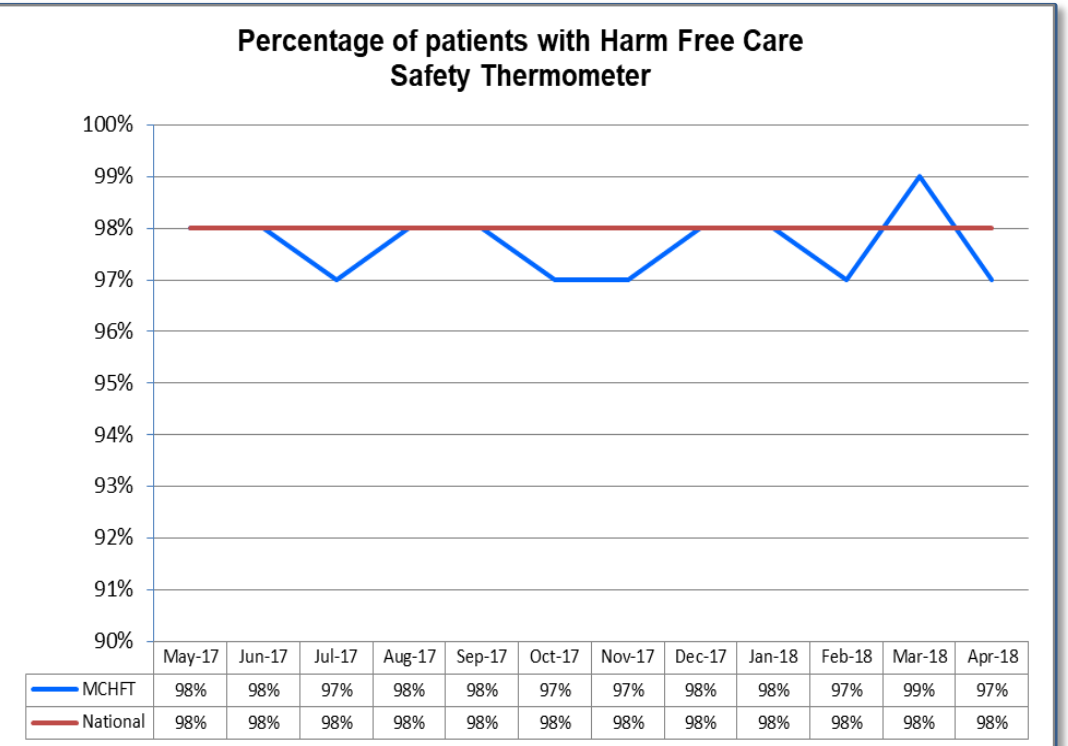
| CQUIN Indicator | Indicator Name | Milestone Achieved | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Q1 | Financial Incentive Achieved | Q2 | Financial Incentive Achieved | Q3 | Financial Incentive Achieved | Q4 | Financial Incentive Achieved | Maximum Value |
| 1a | **Health & Wellbeing**<br>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 | **£144,109** |
| 1b | **Health & Wellbeing**<br>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 | **£144,109** |
| 1c | **Health & Wellbeing**<br>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 | ✓ | MCHFT: £144,109 CCICP £23,171 | **£167, 280** |
| 2a | **Sepsis: Identification**<br>Greater than 90% of eligible patients to have a timely identification of sepsis by the end of quarter four 2017/18. | ✓ Partially | £27,020 | ✓ Partially | £27,020 | ✓ Partially | £27,020 | ✓ Partially | £27,020 | **£108,082** |
| 2b | **Sepsis: Treatment**<br>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 | £27,020 | ✓ Partially | £27,020 | ✓ Partially | £27,020 | **£108,082** |
| 2c | **Sepsis: Antibiotic Review**<br>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 | ✓ | £27,020 | **£108,082** |
| 2d Part 1 | **Reduction in antibiotic consumption**<br>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 | ✗ | Payment not achieved | **£36,027** |
| 2d Part 2 | **Reduction in carbapenem consumption**<br>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 | **£36,027** |
| 2d Part 3 | **Reduction in piperacillin tazabactam consumption**<br>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 | **£36,027** |
| 4 | **Mental Health in Emergency Department**<br>Achieve a 20% reduction in attendances to the Emergency Department for people with Mental Health needs. | ✓ | £43,233 | ✓ | £172,931 | ✓ | £43,233 | ✓ | £172,931 | **£432,328** |

# Board Papers – Quality, Safety & Experience Section: June 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 | ✓ | £108,082 | **£432,328** |
| 7 | **NHS e-Referrals** Availability of services and appointments for e-Referral service. | ✓ | £108,082 | ✓ Partially | £64,849 | ✓ | £108,082 | ✓ | £108,082 | **£432,328** |
| 8a | **Supporting proactive and safe discharge** Acute providers. | ✓ | £64,849 | ✓ | £172,931 | ✓ | £21,616 | ✗ | Payment not achieved | **£432,328** |
| 8b | **Supporting Proactive and Safe Discharge –** Community Providers | NOT REQUIRED | No Payment in Q1 | ✓ | £83,415 | NOT REQUIRED | No Payment in Q3 | ✗ | Payment not achieved | **£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 | ✓ | £69,512 | **£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 | ✓ | £83,415 | **£139,025** |
| PH1 | **Breast Screening Programme Clerical Staff Development (Health Promotion role)** Update and improve the clerical teams knowledge of health promotion to support clients | ✓ | £3,401.50 | ✓ | £3,401.50 | ✓ | £3,401.50 | ✓ | £3,401.50 | **£13,606** |

| CQUIN Indicator | Indicator Name | Milestone Achieved | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Q1 | Financial Incentive Achieved | Q2 | Financial Incentive Achieved | Q3 | Financial Incentive Achieved | Q4 | Financial Incentive Achieved | Maximum Value |
| | who access The Breast Screening Unit and key partners involved in the Breast Screening Programme | | | | | | | | | |
| **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 | ✓ | £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 | ✓ | £7,656.60 | **£38,283** |
| **SC2** | **Hospital Pharmacy Transformation and Medicines Optimisation** | ✓ | | ✓ | | ✓ | | ✓ | £57,424 | **£57,424** |

# Board Papers – Quality, Safety & Experience Section: June 2018

| Description | Aggregate Position | Trend |
|---|---|---|
| Safety Thermometer - Harm Free Care. | In April 2018, 97% of patients received harm free care as measured by the point prevalence Safety Thermometer.<br><br>The Safety Thermometer data is collected during the morning of the first Wednesday of each month and is collected by the nursing staff on duty on the ward/DN caseload assisted by the Senior Nursing Teams. This is applicable to inpatient areas and district nursing caseloads only.<br><br>The target is for >95% of patients to receive harm free care as monitored by the Safety Thermometer. |  |



| | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| MCHFT | 98% | 98% | 97% | 98% | 98% | 97% | 97% | 98% | 98% | 97% | 99% | 97% |
| National | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% |

# Board Papers – Quality, Safety & Experience Section: June 2018

| Ward Name | Main Specialties | Safety Thermometer Results April 2018 | | | |
|---|---|---|---|---|---|
| | | Acquired Pressure Ulcers | Patient Falls resulting in harm | CAUTI | New VTE |
| **MCHFT** | | **1.24% (11)** | **0.56% (5)** | **0.56% (5)** | **0.23% (2)** |
| AMU | Gen. Medicine | 0% (0) | 4.35% (1) | 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 | 3.12% (1) | 0% (0) | 0% (0) | 0% (0) |
| SAU | Gen. Surgery | 0% (0) | 0% (0) | 0% (0) | 0% (0) |
| 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) | 3.12% (1) |
| Ward 14 | Gen. Medicine | 0% (0) | 0% (0) | 0% (0) | 0% (0) |
| Ward 10 | Trauma & Ortho | 8.11% (3) | 0% (0) | 2.7% (1) | 0% (0) |
| Ward 2 | Gen. Medicine | 3.23% (1) | 0% (0) | 0% (0) | 0% (0) |
| Ward 21B | Rehab | 0% (0) | 0% (0) | 4.17% (1) | 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) | 9.68% (3) | 0% (0) | 0% (0) |
| Ward 5 | Gen. Medicine | 3.33% (1) | 0% (0) | 0% (0) | 0% (0) |
| Ward 6 | Gen. Medicine | 0% (0) | 0% (0) | 3.57% (1) | 0% (0) |
| Ward 7 | Gen. Medicine | 0% (0) | 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 | 6.06% (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 | 3.33% (1) | 0% (0) | 0% (0) | 0% (0) |
| DN – Firdale | District Nursing | 0% (0) | 1.28% (1) | 0% (0) | 0% (0) |
| DN – Grosvenor & Hungerford & Rope Green | District Nursing | 0% (0) | 0% (0) | 1.56% (1) | 0% (0) |
| DN – Middlewich | District Nursing | 0% (0) | 0% (0) | 0% (0) | 0% (0) |
| DN - Church View | District Nursing | 2.17% (1) | 0% (0) | 0% (0) | 0% (0) |
| DN – Winsford | District Nursing | 2.56% (1) | 0% (0) | 0% (0) | 0% (0) |
| Intermediate care | Intermediate Care | 0% (0) | 0% (0) | 0% (0) | 0% (0) |
| DN OOH | District Nursing | 0% (0) | 0% (0) | 0% (0) | 0% (0) |

## Board Papers – Quality, Safety & Experience Section: June 2018

| Description | Aggregate Position | | Trend |
|---|---|---|---|
| Registered Nurses monthly expected hours by shift versus actual monthly hours per shift. Day time shifts only | 91.3% of expected Registered Nurse hours were achieved for day shifts.<br><br>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<br><br>**April 2018 91.3%**<br><br>March 2018 89.8%<br><br>February 2018 89.33% | The lowest staffing levels during the day were on Ward 9 at 55.1% |
| Registered Nurses monthly expected hours by shift versus actual monthly hours per shift. Night time shifts only | 98.9% of expected Registered Nurse hours were achieved for night shifts. | Trend<br><br>**April 2018 98.9%**<br><br>March 2018 95.9%<br><br>February 2018 95.97% | The lowest staffing levels during the night were on Ward 13 at 70% |
| Healthcare Assistant monthly expected hours by shift versus actual monthly hours per shift. Day time shifts only | 95.5% of expected HCA hours were achieved for day shifts. | Trend<br><br>**April 2018 95.5%**<br><br>March 2018 100.2%<br><br>February 2018 97.14% | The lowest staffing levels during the day were on Ward 9 at 28.9% |
| Healthcare Assistant monthly expected hours by shift versus actual monthly hours per shift. Night time shifts only | 105.8% of expected HCA hours were achieved for night shifts.<br>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<br><br>**April 2018 105.8%**<br><br>March 2018 110.1%<br><br>February 2018 105.45% | The lowest staffing levels during the night were on Ward 9 at 50% |
| Total number of wards that are lower than 85% RN fill rate is 5. | Ward 12 (night) 82.2%, Ward 5 (night) 73.3%, Ward 13 (night) 70%, Ward 4 (day) 84.4%, Ward 9 (day) 55.1% and (night) 85% | • Actions taken: Staffing reviewed on daily basis by Matrons/HoN following Escalation process<br>• Risk assessments taken place to review bed occupancy and patient acuity before transferring staff | |

# Board Papers – Quality, Safety & Experience Section: June 2018

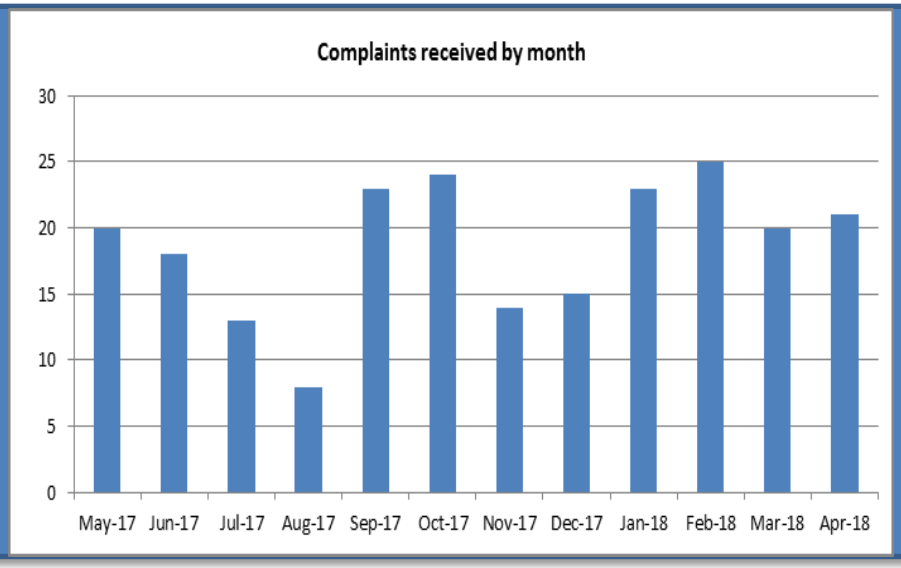
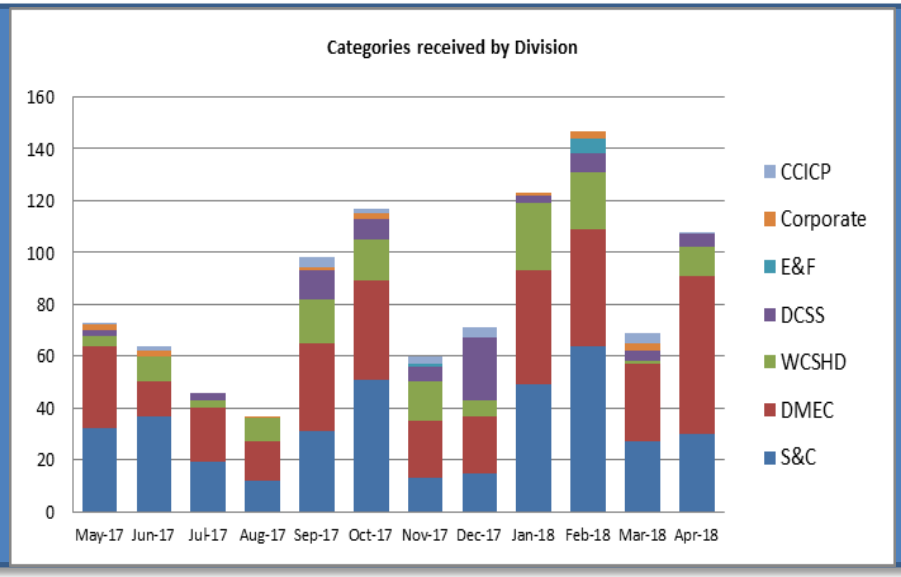
| Ward Name | Main Specialties | Day | | | | Night | | | | Day | | Night | | Care Hours Per Patient Day | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Qualified | | Unqualified | | Qualified | | Unqualified | | Qualified | Unqualified | Qualified | Unqualified | 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** | | 39944.0 | 36654.8 | 28980.7 | 28031.5 | 24143.2 | 22926.4 | 15566.2 | 17509.2 | 91.3% | 98.9% | 95.5% | 105.8% | 14713 | 137.1 | 65.2 | 202.3 |
| AMU | GEN. MEDICINE | 1950 | 1803 | 1470 | 1390.3 | 1837.5 | 1715 | 1470 | 1445.5 | 92.5% | 94.6% | 93.3% | 98.3% | 836 | 4.2 | 3.4 | 7.6 |
| CAU (Winter) | PAEDIATRICS | 1688 | 1688 | 700.5 | 700.5 | 1391.5 | 1391.5 | 402.5 | 402.5 | 100.0% | 100.0% | 100.0% | 100.0% | 516 | 6.0 | 2.1 | 8.1 |
| Critical Care | GEN. SURGERY | 3703 | 3703 | 661 | 661 | 2261 | 2261 | 0 | 0 | 100.0% | 100.0% | 100.0% | - | 232 | 25.7 | 2.8 | 28.6 |
| Elmhurst | REHABILITATION | 847.5 | 835.5 | 2160 | 2082 | 750 | 750 | 1500 | 1637.5 | 98.6% | 96.4% | 100.0% | 109.2% | 887 | 1.8 | 4.2 | 6.0 |
| Ward 1 | GEN. MEDICINE | 2118.8 | 2081.3 | 1125 | 1118.8 | 1470 | 1445.5 | 735 | 722.8 | 98.2% | 99.4% | 98.3% | 98.3% | 918 | 3.8 | 2.0 | 5.8 |
| Ward 12 | GEN. SURGERY | 2163 | 1891 | 1920 | 1800 | 922.5 | 758.5 | 615 | 604.8 | 87.4% | 93.8% | 82.2% | 98.3% | 863 | 3.1 | 2.8 | 5.9 |
| Ward 13 | GEN. SURGERY | 2208 | 1960 | 1920 | 1864 | 922.5 | 645.8 | 615 | 727.8 | 88.8% | 97.1% | 70.0% | 118.3% | 909 | 2.9 | 2.9 | 5.7 |
| Ward 14 | GEN. MEDICINE | 1656 | 1446 | 1440 | 1548 | 720 | 720 | 1080 | 1164 | 87.3% | 107.5% | 100.0% | 107.8% | 960 | 2.3 | 2.8 | 5.1 |
| Ward 2 | GEN. SURGERY | 1743.8 | 1681.3 | 1500 | 1431.3 | 735 | 943.3 | 1102.5 | 1127 | 96.4% | 95.4% | 128.3% | 102.2% | 938 | 2.8 | 2.7 | 5.5 |
| Ward 21b | GEN. MEDICINE | 1297.5 | 1167.5 | 1755 | 1787.5 | 750 | 737.5 | 750 | 875 | 90.0% | 101.9% | 98.3% | 116.7% | 719 | 2.6 | 3.7 | 6.4 |
| Ward 23 | OBSTETRICS | 1200 | 1174.7 | 760 | 747.3 | 740 | 740 | 740 | 740 | 97.9% | 98.3% | 100.0% | 100.0% | 576 | 3.3 | 2.6 | 5.9 |
| Ward 26 | OBSTETRICS | 3216.3 | 3216.3 | 506.7 | 506.7 | 2688.7 | 2688.7 | 357.7 | 357.7 | 100.0% | 100.0% | 100.0% | 100.0% | 161 | 36.7 | 5.4 | 42.0 |
| Ward 4 | GEN. MEDICINE | 1656 | 1398 | 1800 | 1614 | 720 | 708 | 1440 | 1428 | 84.4% | 89.7% | 98.3% | 99.2% | 952 | 2.2 | 3.2 | 5.4 |
| Ward 5 | GEN. MEDICINE | 2250 | 1918.8 | 1500 | 1437.5 | 1470 | 1078 | 735 | 1090.3 | 85.3% | 95.8% | 73.3% | 148.3% | 923 | 3.2 | 2.7 | 6.0 |
| Ward 6 | GEN. MEDICINE | 1875 | 1687.5 | 1875 | 1925 | 1470 | 1298.5 | 735 | 882 | 90.0% | 102.7% | 88.3% | 120.0% | 799 | 3.7 | 3.5 | 7.3 |
| Ward 7 | GEN. MEDICINE | 1696.3 | 1571.3 | 1500 | 1818.8 | 735 | 735 | 1102.5 | 1519 | 92.6% | 121.3% | 100.0% | 137.8% | 951 | 2.4 | 3.5 | 5.9 |
| Ward 9 | TRAUMA & ORTHOPAEDICS | 1638 | 902 | 1440 | 416 | 615 | 522.8 | 307.5 | 153.8 | 55.1% | 28.9% | 85.0% | 50.0% | 188 | 7.6 | 3.0 | 10.6 |
| NICU | PAEDIATRICS | 1862.5 | 1793.3 | 177.5 | 192.8 | 1725 | 1598.5 | 0 | 57.5 | 96.3% | 108.6% | 92.7% | - | 291 | 11.7 | 0.9 | 12.5 |
| Ward 11 SAU | GEN. SURGERY | 1350 | 1275 | 900 | 892.5 | 562 | 562 | 281 | 515.2 | 94.4% | 99.2% | 100.0% | 183.3% | 356 | 5.2 | 4.0 | 9.1 |
| Ward 18 SSW | GEN. MEDICINE | 1256.3 | 1181.3 | 750 | 1137.5 | 735 | 735 | 367.5 | 869.8 | 94.0% | 151.7% | 100.0% | 236.7% | 615 | 3.1 | 3.3 | 6.4 |
| Ward 10 Ortho | GEN. SURGERY | 2568 | 2280 | 3120 | 2960 | 922.5 | 891.8 | 1230 | 1189 | 88.8% | 94.9% | 96.7% | 96.7% | 1123 | 2.8 | 3.7 | 6.5 |

## Experience Section:

| Indicators | Last four months | | | |
|---|---|---|---|---|
| | Jan-18 | Feb-18 | Mar-18 | Apr-18 |
| Complaints received by month | 23 | 25 | 20 | 21 |
| Complaints being reviewed by the Ombudsman | 1 | 2 | 2 | 1 |
| Closed complaints by month | 23 | 17 | 17 | 17 |
| Contacts raising informal concerns | 102 | 90 | 121 | 86 |
| Compliments received in month | 138 | 155 | 170 | 151 |
| Number of new claims received in month | 5 | 7 | 1 | 3 |
| Number of claims closed | 1 | 3 | 5 | 5 |
| Number of inquests concluded | 1 | 0 | 1 | 1 |
| 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 | 15 | 18 | 3 | 7 |
| F&FT Response Rate ED, MIU, UCC and Assessment Areas* | 3% | 22% | 26% | 26% |
| Proportion of positive responses ED, MIU, UCC and Assessment Areas | 84% | 81% | 82% | 85% |
| F&FT Response Rate Inpatients and day cases | 14% | 23% | 23% | 14% |
| Proportion of positive responses Inpatients and day cases | 97% | 98% | 98% | 98% |
| F&FT Response Rate Outpatients | 5% | 4% | 3% | 3% |
| Proportion of positive responses Outpatients | 97% | 96% | 96% | 95% |
| F&FT Response Rate Maternity - Birth | 16% | 5% | 13% | 4% |
| Proportion of positive responses Maternity - Birth | 100% | 90% | 100% | 100% |
| F&FT Response Rate Community (CCICP) | 23% | 17% | 15% | 28% |
| Proportion of positive responses Community (CCICP) | 92% | 91% | 91% | 94% |

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

# Board Papers – Quality, Safety & Experience Section: June 2018

| Description | Aggregate Position/Description | Trend |
|---|---|---|
| Monthly complaints received by the Trust. | 21 complaints were received in April 2018 which covered 108 concerns. Of the categories, the highest categories were:<br>• Communication<br>• Medical – Diagnosis Problems<br>• Medical – Adverse Outcome<br><br>Highest 3 areas receiving complaints/issues were:<br>• Emergency Department - 11complaints / 33 issues<br>• General Surgery – 3 complaints / 9 issues<br>• Ward 3 – 2 complaints / 8 issues |  Formal Complaints |
| Number of formal complaint issues by division. | This graph shows the breakdown of issues by month for e ach division.<br><br>S&C: 30<br><br>DCSS: 5<br><br>W&CD: 11<br><br>DMEC: 61<br><br>CCICP: 1<br><br>E&F: 0<br><br>Corporate Services: 0 |  Formal Complaint issues by division |

# Board Papers – Quality, Safety & Experience Section: June 2018

| Description | Aggregate Position/Description | Trend |
|---|---|---|

## Complaints being reviewed by the Public Health Service Ombudsman

**In April 2018, 5 complaints were active with the PHSO.**

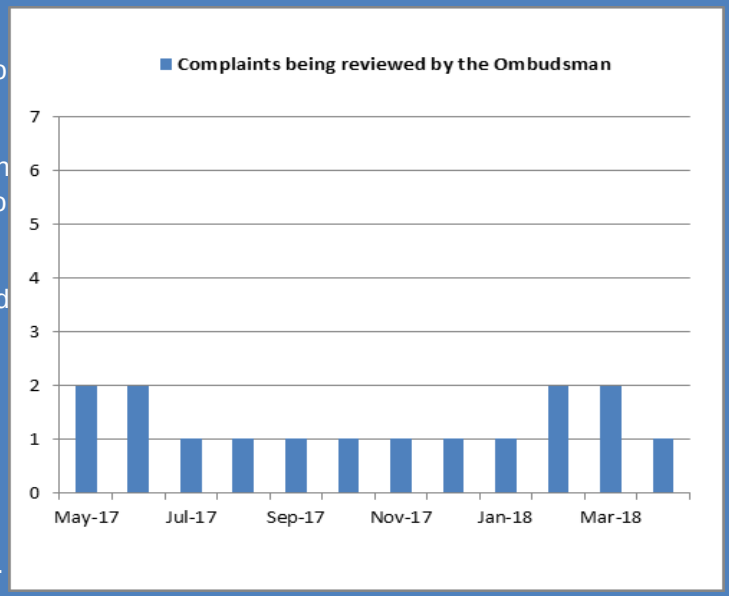
1 has been active since 2012/2013 and is undergoing a review external to the PHSO

1 case agreed for investigation in February 2018. All information has been shared with the PHSO. The concern was with regard to care leading up to the patient's death.

1 new case, relating to communication. This was regarding diagnosis and concerns with infection issues. Opened 14/03/18.

1 new case relating to treatment required following caesarean section which resulted in critical care stay. Opened 23/03/18, all information sent to PHSO and the case is at assessment stage.

1 new case relating to concerns with the referral for vascular review and nursing issues. Opened 14/04/2018 and the case is at assessment stage.




Ombudsman

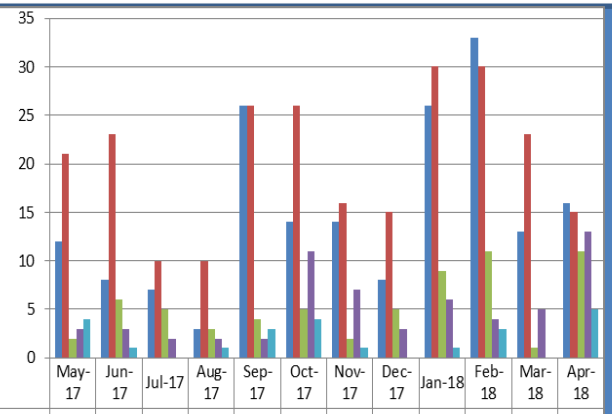
## Complaint trends and number of issues.

The main trends in April 2018 were:

Communication, with 10 complaints raising 15 issues

Nursing Care, with 8 complaints raising 16 issues.

Medical Adverse Outcome, with 9 complaints raising 11 issues




| | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Nursing Care | 12 | 8 | 7 | 3 | 26 | 14 | 14 | 8 | 26 | 33 | 13 | 16 |
| Communication | 21 | 23 | 10 | 10 | 26 | 26 | 16 | 15 | 30 | 30 | 23 | 15 |
| Medical adverse outcome | 2 | 6 | 5 | 3 | 4 | 5 | 2 | 5 | 9 | 11 | 1 | 11 |
| Medical diagnosis issues | 3 | 3 | 2 | 2 | 2 | 11 | 7 | 3 | 6 | 4 | 5 | 13 |
| Medical delay in review | 4 | 1 | 0 | 1 | 3 | 4 | 1 | 0 | 1 | 3 | 0 | 5 |

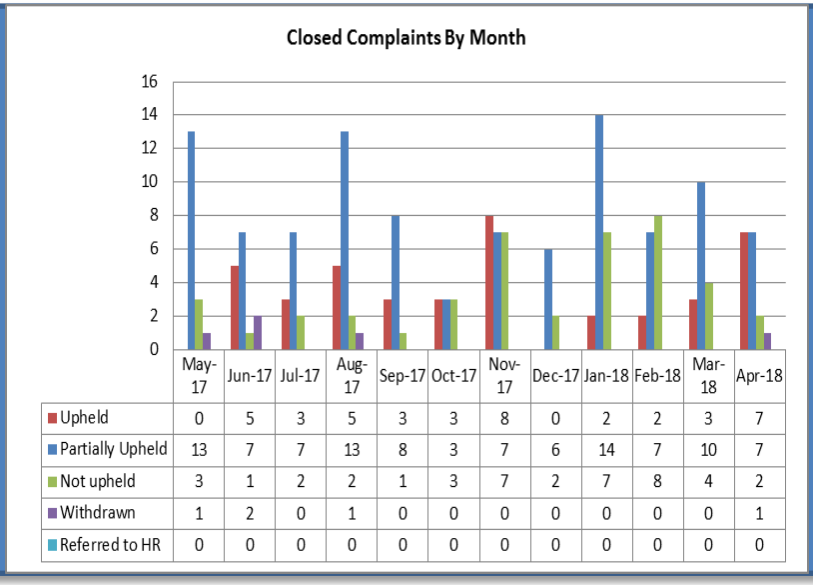
Complaint Trends

# Board Papers – Quality, Safety & Experience Section: June 2018

| Description | Aggregate Position/Description | Trend |
|---|---|---|

## Closed Complaints

17 complaints were closed in April 2018.




| | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Upheld | 0 | 5 | 3 | 5 | 3 | 3 | 8 | 0 | 2 | 2 | 3 | 7 |
| Partially Upheld | 13 | 7 | 7 | 13 | 8 | 3 | 7 | 6 | 14 | 7 | 10 | 7 |
| Not upheld | 3 | 1 | 2 | 2 | 1 | 3 | 7 | 2 | 7 | 8 | 4 | 2 |
| Withdrawn | 1 | 2 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Referred to HR | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

Closed Complaints

## 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 |
|---|---|---|---|---|---|---|
| DMEC | 5 | 2 | 1 | 0 | 0 | 8 |
| Corporate | 0 | 0 | 0 | 0 | 0 | 0 |
| Surgery and Cancer | 1 | 3 | 0 | 1 | 0 | 5 |
| Women & Children's | 0 | 1 | 1 | 0 | 0 | 2 |
| DCSS | 1 | 0 | 0 | 0 | 0 | 1 |
| CCICP | 0 | 1 | 0 | 0 | 0 | 1 |
| | | | | **Total closed** | | **17** |

## Complaints closed by division for April 2018

**Tables removed under Section 40 of the Freedom of Information Act.**

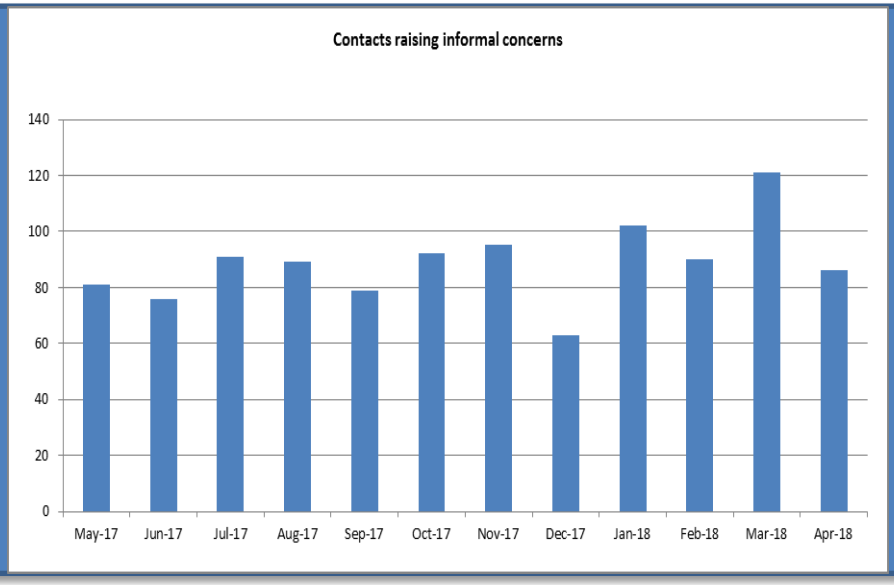
# Board Papers – Quality, Safety & Experience Section: June 2018

| Description | Aggregate Position/Description | Trend |
|---|---|---|

## Informal Concerns Numbers.

The number of contacts raising informal concerns for April 2018 was 86 which is a decrease of 35 from the previous month.

The Division of Medicine and Emergency Care has received the largest number of individual concerns raised at 55, with 17 of the individual concerns raised belonging to the Emergency Department.

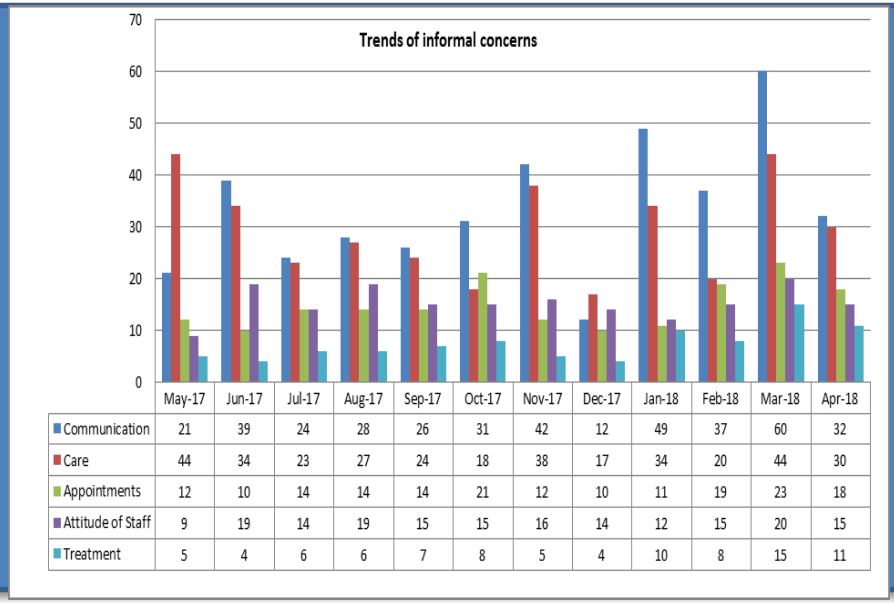



Informal Concerns Feedback

## Informal Concerns Trends.

Communication was the highest trend for informal concerns in April 2018, with 15 of the 32 issues raised belonging to the Surgery and Cancer Division. Three of these 15 concerns belong to the Treatment Centre and Ward 10 respectively.

Of the 30 issues regarding care, 13 belong to the Surgery and Cancer Division. Seven of these relate to Ward 13, 4 being nursing care.




| | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Communication | 21 | 39 | 24 | 28 | 26 | 31 | 42 | 12 | 49 | 37 | 60 | 32 |
| Care | 44 | 34 | 23 | 27 | 24 | 18 | 38 | 17 | 34 | 20 | 44 | 30 |
| Appointments | 12 | 10 | 14 | 14 | 14 | 21 | 12 | 10 | 11 | 19 | 23 | 18 |
| Attitude of Staff | 9 | 19 | 14 | 19 | 15 | 15 | 16 | 14 | 12 | 15 | 20 | 15 |
| Treatment | 5 | 4 | 6 | 6 | 7 | 8 | 5 | 4 | 10 | 8 | 15 | 11 |

Informal Concerns Trends

| Description | Aggregate Position/Description | Trend |
|---|---|---|
| New claims received. | Narrative and Chart removed under Section 43 of the Freedom of Information Act. |   |
| Claims closed with/without damages. | Narrative and Chart removed under Section 43 of the Freedom of Information Act. |   |

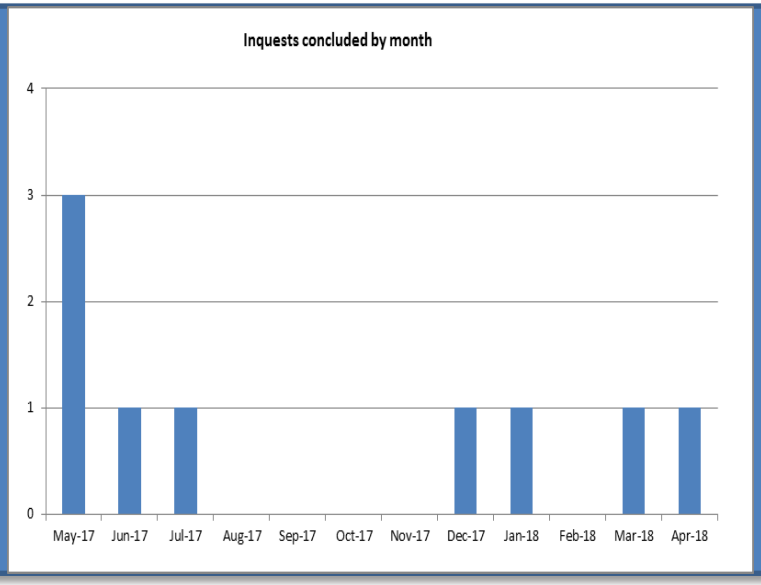
| Description | Aggregate Position/Description | Trend |
|---|---|---|
| Value of claims closed by month | Narrative and Chart removed under Section 43 of the Freedom of Information Act. | Value of Claims |
| Top five claims by Specialty | Narrative and Chart removed under Section 43 of the Freedom of Information Act. | Top 5 Claims by Specialty |

# Board Papers – Quality, Safety & Experience Section: June 2018

| Description | Aggregate Position /Description | Trend |
|---|---|---|

Number of Inquests concluded by month

1 inquest was concluded in April 2018. The Coroner recorded natural causes.



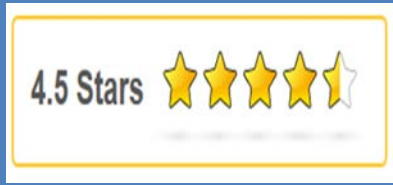

Inquests

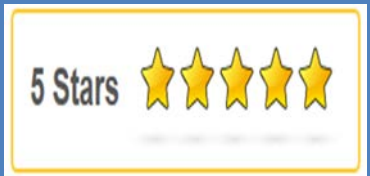
NHS Choices Star Ratings

Leighton Hospital is rated at 4.5 stars.

Victoria Infirmary, Northwich is rated at 5 stars.

The above ratings are based on 232 postings received to date.




NHS Choices – Star Ratings

# Board Papers – Quality, Safety & Experience Section: June 2018

| Description | Aggregate Position /description | Trend |
|---|---|---|

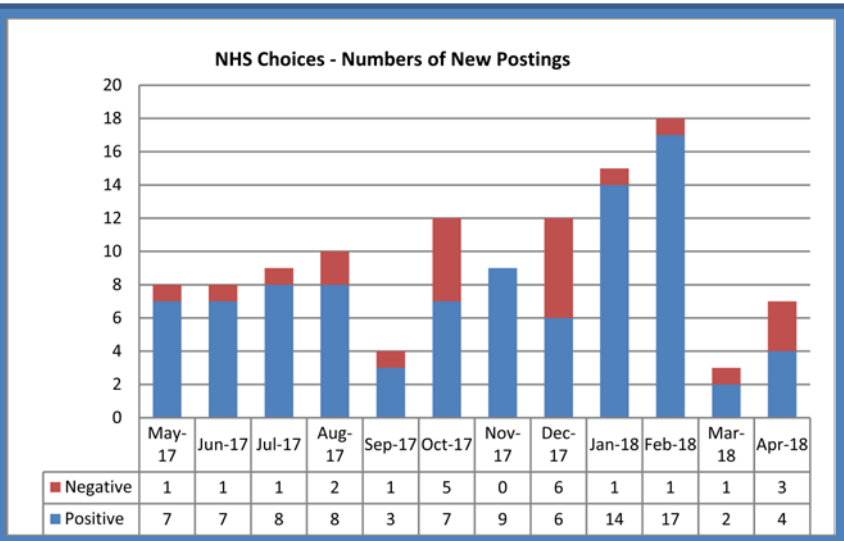
## NHS Choices postings

There were 7 postings on NHS Choices in April 2018 of which 3 were negative and 4 positive. Examples of feedback included:

On her return journey home via ambulance transport she had faeces all over her leg - may I add this is a patient who was tested positive for clostridium difficile bacteria - and so on returning home she had to be washed in the shower immediately. This is when the gravity of the situation was revealed - an old woman covered in her own faeces. (Dementia Care)

Daughter had an appointment today which was on time. Very pleased how she was treated at reception & by all staff there. Staff very pleasant & helpful. Consultant explained everything properly (Dermatology)

Everyone that looked after me was first class and I was so impressed with my care. I was discharged from Ward 5. All the doctors, nurses and staff looked after me so well at each stage of my treatment. I am very grateful for all the care provided to me. Another word of praise for is the catering. The food was always very good and I found something I could manage on the menu. Well done Leighton. (Ward 1 and 5)




| | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Negative | 1 | 1 | 1 | 2 | 1 | 5 | 0 | 6 | 1 | 1 | 1 | 3 |
| Positive | 7 | 7 | 8 | 8 | 3 | 7 | 9 | 6 | 14 | 17 | 2 | 4 |

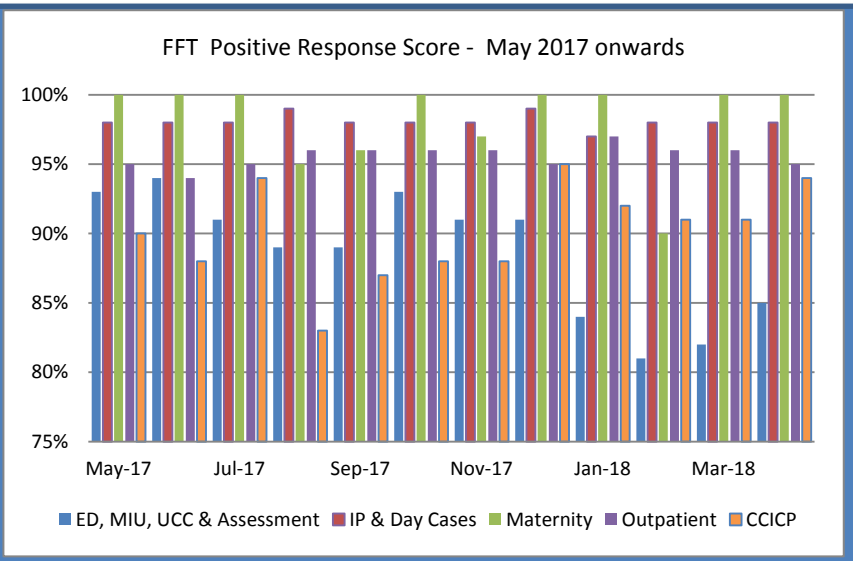
NHS Choices – Postings

## 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 April 2018 the Trust has scored the following positive response scores:

| | |
|---|---|
| Inpatients and day cases | 98% |
| Emergency care /Assessment areas | 85% |
| Outpatients | 95% |
| Maternity | 100% |
| CCICP | 94% |

2996 responses were received and 90% of those patients would recommend our hospital services.



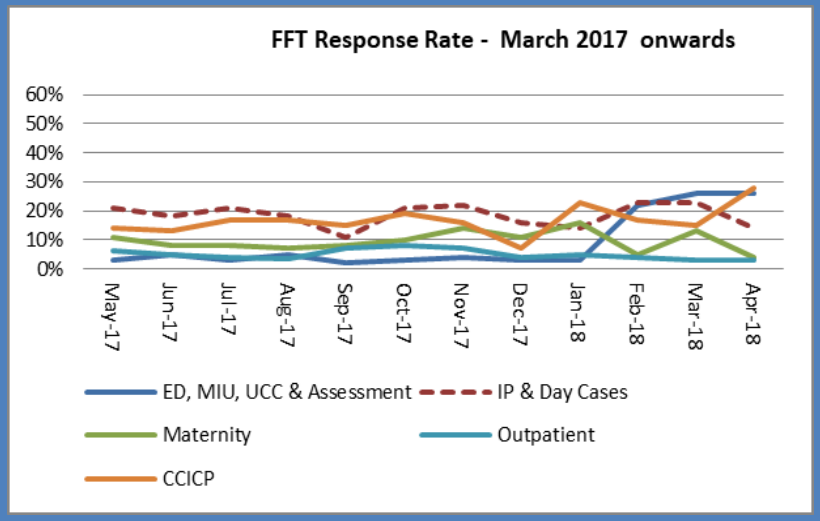

Family & Friends Test

# Board Papers – Quality, Safety & Experience Section: June 2018

**Description** | **Aggregate Position /description** | **Trend**

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

| April 2018<br>Ward/Dept. | % Response | Total responses received | How many would recommend |
|---|---|---|---|
| A&E , UCC & MIU | 26% | 1555 | 1318 |
| Inpatients & Day cases | 14% | 530 | 521 |
| Maternity | 4% | 35 | 34 |
| Outpatients | 3% | 516 | 489 |
| CCICP | 28% | 359 | 337 |



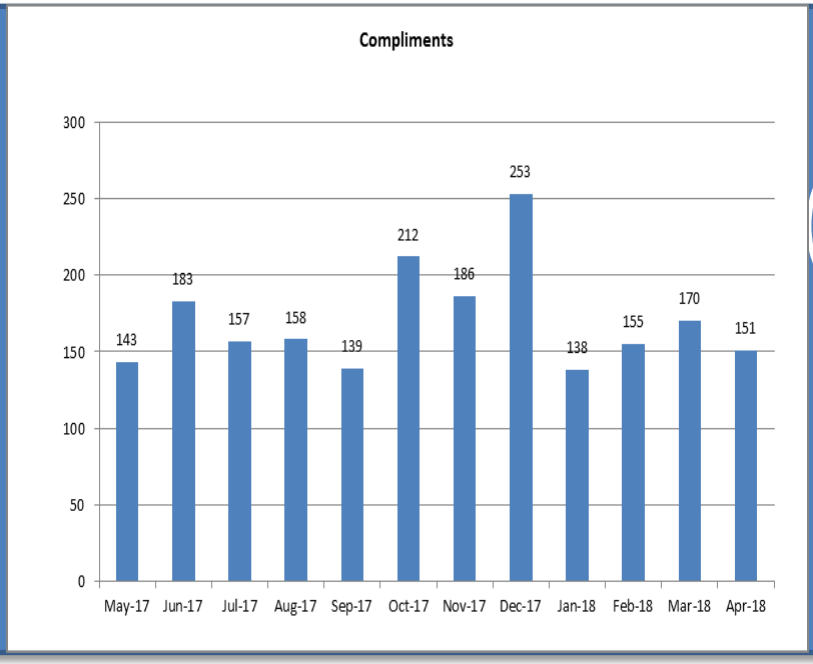

Family & Friends Test

Compliments received

There were 151 compliments/thankyou's which were received in April.

'Thank you for the superb care you gave me for my cataract surgery. It was fast, painless and I had no complication. The staff were professional, yet friendly and reassuring as I was nervous.'

'Thank you to all the staff in CT scanning who were kind and helpful and fended off my fears of having contrast for my scan. I was very nervous but with the help of staff I felt more settled.'




Compliments

| | | |
|---|---|---|
| ***Title of Paper :*** | Maternity CNST Premium Incentivisation Scheme 2018/19 | |
| ***Author:*** | Natasha King, Midwifery Matron | |
| ***Executive Lead:*** | Julie Tunney, Director of Nursing and Quality | |
| ***Type of Report:*** | Concept Paper | |
| | Strategic Options Paper | |
| | Business Case | |
| | Information | ✓ |
| | Review/Benefits/Audit | |

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

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

| | |
|---|---|
| ***Positive Benefit:*** | Proven compliance with national indicators that contribute to safer maternity care. Full compliance leads to a reduction in CNST premiums of £190k for MCHFT. |
| ***Risk:*** | N/A |

| | |
|---|---|
| ***To be published on Trust Website – complete version*** | *Board Paper - not Appendicies* |
| ***If no, to be published on Trust Website – redacted*** | Y |
| ***If not to be published complete or redacted, please detail the reason why*** | Commercially Sensitive Information |
| ***Presented at Board Meeting of:*** | 4 June 2018 |

## SECTION A: Evidence of Trust's progress against 10 safety actions:

**Please note that trusts with multiple sites will need to provide evidence of each individual site's performance against the required standard. Evidence should be provided to Trust Boards only. Do not send the evidential appendices through to NHS Resolution as it will not be considered.**

| Safety action – please see the guidance for the detail required for each action | Evidence of Trust's progress | | Action met? (Y/N) |
|---|---|---|---|
| **1). Are you using the National Perinatal Mortality Review Tool (NPMRT) to review perinatal deaths?** | From January 2018 to April 2018 10 cases were added to MBRRACE NPMRT which is used by MCHFT to review these perinatal mortality cases. These cases are currently at various stages of review within the tool. | 1. a) NPMRT Anonymised Screen Shot of Cases | **Yes** |
| **2). Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?** | MSDS data was submitted in January and February 2018 where compliance with the criteria was 8/10 and 9/10 respectively and so met this standard. Data for March 2018 is currently being submitted by all Trusts. | 2. a) MSDS Compliance Information by Trust. | **Yes** |
| **3). Can you demonstrate that you have transitional care facilities that are in place and operational to support the implementation of the ATAIN Programme?** | MCHFT provides Transitional Care on the postnatal ward, for babies requiring intravenous antibiotics, and on the Neonatal Unit. This latter service is supported by a clinical guideline.<br><br>The Transitional Care data is not currently recorded on BadgerNet, which the Neonatal Operational Delivery Network (ODN) uses to verify the activity. Local evidence is provided in the embedded evidence and MCHFT will be recording the data on BadgerNet from July 2018 and making a manual submission to the ODN for May and June 2018. | 3. a) Transitional care SOP V2 (Final).pdf<br>3. b) Neonatal Transitional Care Babies Audit Re<br>3. c) Neo-natal activity 3 years.pdf | **Yes** |
| **4). Can you demonstrate an effective system of medical workforce planning?** | During the 4 consecutive week audit only two twilight shifts (10 hours in total) were covered by a consultant instead a middle grade. At 1.5% of the total hours covered this is within the 20% target allowance. | 4. a) cnst-workforce-data-collection-tool-reporti | **Yes** |

| Safety action – please see the guidance for the detail required for each action | Evidence of Trust's progress | | Action met? (Y/N) |
|---|---|---|---|
| **5). Can you demonstrate an effective system of midwifery workforce planning?** | MCHFT has completed a systematic review of midwifery staffing using Birthrate Plus® Midwifery rota's are compliant with the standard that the labour ward coordinator is supernumerary and there is a clear escalation policy based on acuity. The Neonatal workforce has also been reviewed against BAPM standards and communicated to the Specialist Commissioners. | 5. a) Midwifery Staffing Review (Nov-17).pdf<br>5. b) Maternity Escalation Policy Version 4.1 (Fir<br>5. c) Midwife and Midwifery Staffing in<br>5. d) Final Neonatal Review January 2017 | **Yes** |
| **6). Can you demonstrate compliance with all 4 elements of the Saving Babies' Lives (SBL) care bundle?** | Based on the Gap Analysis (March 2016) MCHFT was compliant with 3 of the 4 elements in the SBL care bundle i.e. Reducing Smoking in Pregnancy, Raising Awareness of Fetal Movements and Effective Fetal Monitoring During Labour. The one area of none compliance was element 2, Risk Assessment and Surveillance for Fetal Growth Restriction, which following the business case for additional sonographer capacity, and subsequent recruitment, the Trust will be compliant with from 1st June 2018. | 6. a) Saving Babies' Lives GAP Analysis V1 (Fina<br>6. b) Sonographer BC Version V2 Feb 17.do<br>6. c) Scanning and Saving babies lives meeting 4<br>6. d) Fetal Monitoring Competency 2018-19 | **Yes** |

| Safety action – please see the guidance for the detail required for each action | Evidence of Trust's progress | | Action met? (Y/N) |
|---|---|---|---|
| **7). Can you demonstrate that you have a patient feedback mechanism for maternity services, such as the Maternity Voices Partnership Forum, and that you regularly act on feedback?** | MCHFT has established and is running a Maternity Voices Partnership Forum as a patient involvement and feedback mechanism. The maternity service also has a Facebook page (https://en-gb.facebook.com/leightonhospitalmaternityunit/) which is used for feedback.<br><br>Partners being allowed to stay overnight on the ante/postnatal ward and the introduction of partitions and doors for the induction bays are examples of the service responding to feedback. | 7. a) Draft Terms of Reference January 2(<br>7. b) Maternity Voices Minutes (2018.03.12)<br>7. c) Maternity Voices Poster.pdf | **Yes** |
| **8). Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?** | MCHFT achieved 94% overall and was above the 90% target across each professional group (Midwives, Obstetricians, Anaesthetists, HCAs and Other) in multi-professional maternity emergencies training. | 8. a) Skills and Drills 05.2017-04.2018.pdf<br>8. b) Maternity-Safety-CNST-local-training-reco<br>8. c) Skills & Drills inc. PROMPT Itinerary 20<br>8. d) Skills & Drills inc. PROMPT Itinerary 20<br>8. e) Skills & Drills Itinerary 2018-19 (2018.04.24 | **Yes** |

| Safety action – please see the guidance for the detail required for each action | Evidence of Trust's progress | | Action met? (Y/N) |
|---|---|---|---|
| **9). Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?** | MCHFT has established meetings throughout 2018-19 where the Head of Midwifery and Obstetric Clinical Lead meet with the Director of Nursing & Quality (as the Board level maternity champion). MCHFT also has a fortnightly Patient Safety Summit where moderate and above incidents are escalated to for discussion and review. | 9. a) Trust Safety Champions Meeting D<br>9. b) saftey champions April 2018 (1).pdf<br>9. c) saftey champions meeting.pdf<br>9. d) Safety Matters Edition 9 V1.pdf | **Yes** |
| **10). Have you reported 100% of qualifying 2017/18 incidents under NHS Resolution's Early Notification scheme?** | There are 4 incidents in 2017/18 from MCHFT that fulfil the criteria for reporting to the NHS Resolution's Early Notification Scheme and all these were reported by April 2018. | N/A | **Yes** |

**SECTION B: Further action required:**

*If the Trust is unable to demonstrate the required progress against any of the 10 maternity safety actions, please complete an action plan template for each safety action, setting out a detailed plan for how the Trust intends to achieve the required progress and over what time period. Where possible, please also include an estimate of the additional costs of delivering the plan. A completed action plan is required even where Trusts have already completed this section. However, if this section hasn't been completed, the action plan template alone will be sufficient. The National Maternity Safety Champions and Steering group will review these details and NHS Resolution, at its absolute discretion, will agree whether any reimbursement of CNST contributions is to be made to the Trust. Any such payments would be at a much lower level than for those trusts able to demonstrate the required progress against the 10 actions and the 10% of the maternity contribution used to create the fund.*

## SECTION C: Sign-off

**For and on behalf of the Board of *Mid Cheshire Hospitals NHS Foundation Trust* confirming that:**

**…….**

- **The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets the required standards and that the self-certification is accurate.**
- **The content of this report has been shared with the commissioner(s) of the Trust's maternity services**
- **If applicable, the Board agrees that any reimbursement of CNST funds will be used to deliver the action(s) referred to in Section B**

**Signature: .....**

**Position: …….**

**Date: …4 June 2018.……**

**We expect trust Boards to self-certify the Trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the Steering group will escalate to the appropriate arm's length body/NHS System leader.**

Mid Cheshire Hospitals
NHS Foundation Trust

# Board of Directors Performance Report

## April 2018

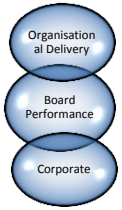
"To Deliver Excellence in Healthcare through Innovation & Collaboration"

# 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** | **Apr-18** | |
| **Cancer** | | | | |
| Rapid Access Referrals (%) *(seen in 2 wks)* | 93.00% | 95.96% | 95.96% | |
| *Total Patients Seen* | | *768* | *768* | |
| *Patients seen >14 days* | | *31* | *31* | |
| 62 day GP Classic (%) | 85.00% | 91.57% | 91.57% | * |
| *Accountable Patients Treated* | | *42* | *42* | |
| *No. of Breached Pathways (adjusted)* | | *4* | *4* | |
| 62 day Screening (%) | 90.00% | 100.00% | 100.00% | * |
| *Accountable Patients Treated* | | *12* | *12* | |
| *No. of Breached Pathways (adjusted)* | | *0* | *0* | |
| **Unplanned Activity** | | | | |
| A&E <4hrs Standard (%) | 95.00% | 82.65% | 82.65% | |
| A&E Attendances (LH/MIU/UUC) (% to plan) | | 93.18% | 93.18% | |
| *A&E Attendances LH & MIU (Vol)* | | *7,170* | *7,170* | |
| **Planned Activity** | | | | |
| Incomp Pathways <18wk (%) | 92.00% | 92.77% | 92.77% | |
| >6wk Diagnostic Waits (%) | 1.00% | 0.26% | 0.26% | |
| Total Patients Waiting for a First Outpatient Appointment | | | 9,243 | |

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

| Indicator | Standard | YTD |
|---|---|---|
| **Workforce** | | |
| Sickness absence Rolling 12 Month | | 4.38% |
| Turnover Rolling 12 Month | | 11.33% |

| Corporate | | | | | |
|---|---|---|---|---|---|
| | YTD Rating | | YE Rating | YE Metric | |
| **Indicator** | **Plan** | **Actual** | **Forecast** | **Plan** | **Forecast** |
| **Finance** | | | | | |
| **Use of Resource Rating** | | 3 | 1 | | |
| Capital Service Capacity | 4 | 4 | 2 | 2.39 | 2.39 |
| Liquidity | 1 | 1 | 2 | -1 | -1 |
| I&E Margin | 4 | 4 | 1 | 2.10% | 2.10% |
| Distance from Financial Plan | 1 | 1 | 1 | 0.00% | 0.00% |
| Agency Spend | 1 | 1 | 1 | -23.30% | -23.30% |

| | YTD Target | YTD Actual | YTD Variance | FY Target | FY Forecast | FY Variance |
|---|---|---|---|---|---|---|
| Cost Improvement Schemes Total (£000's) | 546 | 517 | -29 | 6,772 | 6,772 | 0 |
| Commission Contact Income SC & VR (£000's) | 14,995 | 14,995 | 0 | | | |
| Contract Income (£'000) | 18,013 | 17,894 | -119 | | | |
| Pay to Budget (£000's) | -14,001 | -14,095 | -94 | | | |
| Non Pay to Budget (£000's) | -5,697 | -5,443 | 254 | | | |
| Agency Trajectory (£000's) | -365 | -389 | -24 | | | |

**Exec Summary**

In April 2018, the Trust delivered four of the five NHS Improvement Single Oversight Framework performance indicators (three cancer standards, A&E and RTT). The indicator not achieved was The 4 hour A&E waiting time target.

The 4-hour A&E standard in April achieved 82.65% against the 95% performance standard. This is a deterioration in performance compared to the same month in 2017 (93.37%), but is set against a rise in admissions and 24 less acute beds and 17 less community beds.

The Trust has achieved all three headline cancer access standards for April. 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.

The Trust continues to achieve the 92% standard for RTT 18 week incomplete pathways, with performance in April 2018 at 92.77%. The Trust is continuing to monitor this standard, with specific reference to managing the level of 'over performance' previously being delivered against 92%.

Diagnostics waiting times continue to perform well, with just 0.26% 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 Trusts's I&E position is a deficit of £394k which is £46k better against a planned deficit of £440k.

There is a small variation in the CIP scheme in April.

# 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 acheived a Use of Resource rating of 3, which is expected to improved during 2018/19. This results in a 'trigger' on the Finance & Resource theme. This is primarily driven by the capital service capacity metric which will improve when short term loans required to support liquidity are repaid in the year. The trust is currently above planned agency spend, however it was still below the control total.

**Operational Performance**

| | Current YTD | | | | | | | | | | | | | | Monthly Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Target | Actual | Apr 17 | May 17 | Jun 17 | Jul 17 | Aug 17 | Sep 17 | Oct 17 | Nov 17 | Dec 17 | Jan 18 | Feb 18 | Mar 18 | Apr 18 | |
| Maximum 6 week wait for Diagnostic procedures | 1% | 0.26% | 0.04% | 0.17% | 0.44% | 0.76% | 0.34% | 0.21% | 0.24% | 0.25% | 0.39% | 0.53% | 0.08% | 0.33% | 0.26% | |
| All Cancers: 62 day GP Classic (%) * | 85% | 91.57% | 96.83% | 92.81% | 94.00% | 93.04% | 95.08% | 91.67% | 95.74% | 94.50% | 96.77% | 87.30% | 92.06% | 94.06% | 91.57% | |
| All Cancers: 62 day Screening (%) * | 90% | 100.00% | 100.00% | 100.00% | 100.00% | 85.71% | 100.00% | 91.67% | 83.33% | 94.12% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | |
| 18 weeks from point of referral to treatment - patients on an incomplete pathway (%) | 92% | 92.77% | 96.69% | 96.98% | 97.57% | 97.37% | 96.78% | 97.10% | 96.79% | 96.36% | 95.15% | 94.46% | 94.02% | 92.54% | 92.77% | |
| A&E - maximum waiting time of 4 hours from arrival to admission/transfer/discharge (%) | 95% | 82.65% | 93.37% | 90.66% | 94.24% | 92.63% | 95.26% | 93.99% | 88.28% | 88.05% | 74.22% | 78.38% | 77.91% | 77.90% | 82.65% | |
| STF Trajectory | | | 91.72% | 91.72% | 91.72% | 91.34% | 91.34% | 91.34% | 90.52% | 90.52% | 90.52% | 90.52% | 90.52% | 95.00% | 92.72% | |
| Provider Submitted Trajectory | | | | | | | | | | | | | | | 80.05% | |

** 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 | 2.39 | 2.39 | 2 | 0.12 | 0.40 | 4 |
| | Liquidity | days | -1 | -1 | 2 | 2 | 3 | 1 |
| Financial Efficiency | I&E Margin | % | 2.10% | 2.10% | 1 | -3.10% | -1.90% | 4 |
| Financial Controls | Distance from Financial Plan | % | 0.00% | 0.00% | 1 | -5.30% | 1.20% | 1 |
| | Agency Spend | % | -23.30% | -23.30% | 1 | -8.80% | -0.25% | 1 |
| **Overall UOR Rating** | | | | | 1 | | | 3 |

# Operational Delivery: *Cancer Pathway*

**Headline Measures**

| | Current YTD | | Rolling 13 months | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Target | Actual | Apr 17 | May 17 | Jun 17 | Jul 17 | Aug 17 | Sep 17 | Oct 17 | Nov 17 | Dec 17 | Jan 18 | Feb 18 | Mar 18 | Apr 18 | Monthly Trend |
| Rapid Access Referrals (%) (seen in 2 wks) | 93% | 95.96% | 97.14% | 97.84% | 97.20% | 97.51% | 97.35% | 96.81% | 97.60% | 98.23% | 95.85% | 94.83% | 93.05% | 98.64% | 95.96% | |
| *Total Patients Seen* | | *768* | *665* | *742* | *785* | *763* | *793* | *722* | *750* | *736* | *626* | *715* | *806* | *811* | *768* | |
| *Patients seen >14 days* | | *31* | *19* | *16* | *22* | *19* | *21* | *23* | *18* | *13* | *26* | *37* | *56* | *11* | *31* | |
| *% seen within 7 days* | | *45.1%* | *55.6%* | *53.5%* | *48.7%* | *44.2%* | *46.2%* | *64.8%* | *54.8%* | *51.4%* | *52.9%* | *54.6%* | *53.1%* | *61.2%* | *45.1%* | |
| 62 day GP Classic (%) * | 85% | 91.57% | 96.83% | 92.81% | 94.00% | 93.04% | 95.08% | 91.67% | 95.74% | 94.50% | 96.77% | 87.30% | 92.06% | 94.06% | 91.57% | |

** Provisional figures subject to change depending*

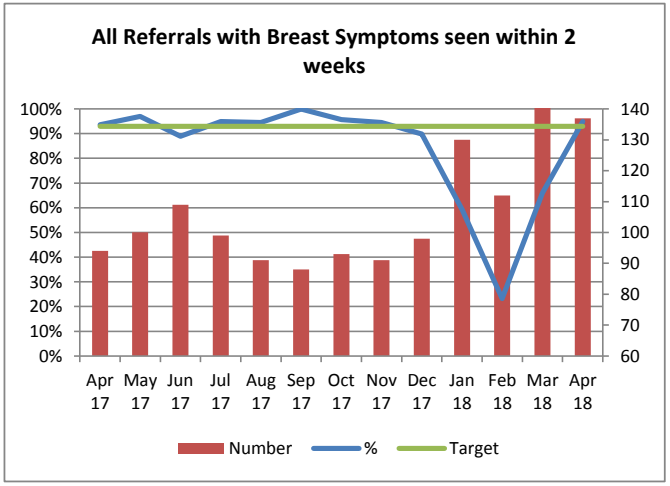
**Commentary**

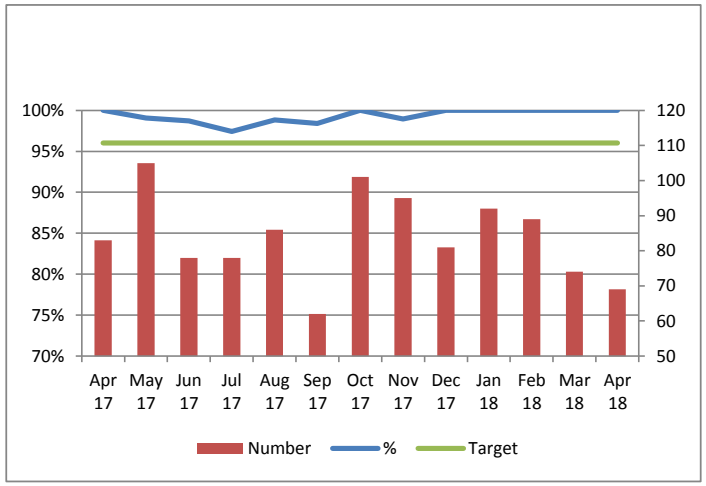
The Trust has achieved all three headline cancer standards during the month of April 2018. The figures presented in this paper reflect the Trust's regulatory performance measures (adjusted figures that take into account breach reallocation between providers).
The Trust has continued it's strong performance against the Rapid Access referrals standard achieving 95.96% in April. This is in spite of an increase in demand of 15.4% on the same month last year.

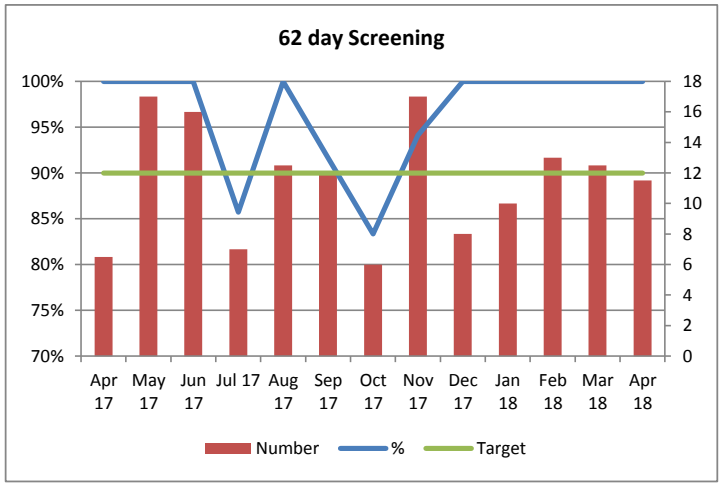
The 2 week Breast Symptomatic standard after a dramatic deterioration seen in February's position to 66%, performance has improved to above the 93% target in April 2018. April also saw the number of referrals with breast symptoms reach 137 which is a 45% increase on previous year to date and a continued increase since January 2018.

The screening 62 day standard was met in April with no breach recorded since November 2017.

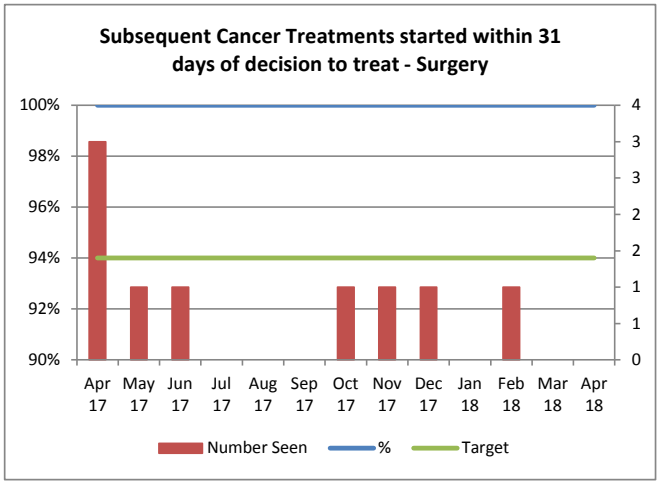
**Primary Measures**

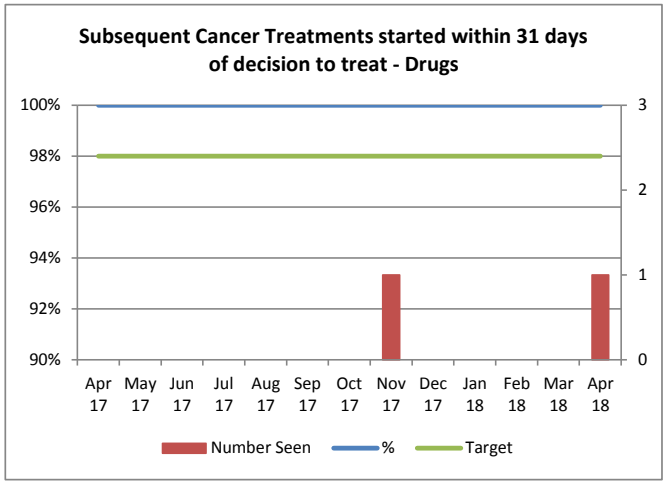


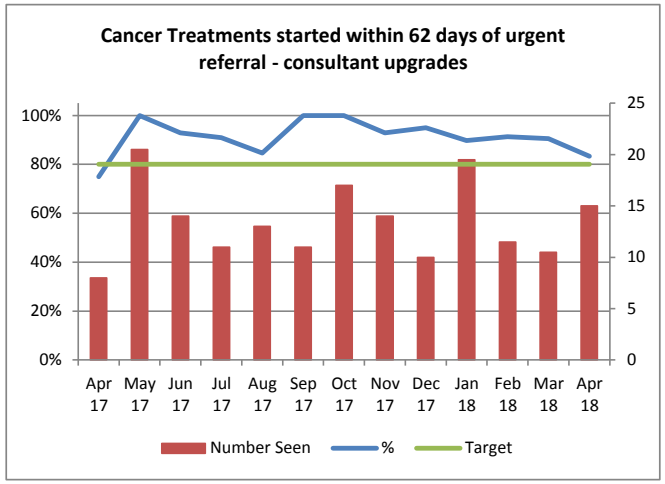



# Operational Delivery: *Cancer Pathway*



# Operational Delivery: *Unplanned Activity - A&E*

**Headline Measures**

| | Current YTD | | Rolling 13 months | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Target | Actual | Apr 17 | May 17 | Jun 17 | Jul 17 | Aug 17 | Sep 17 | Oct 17 | Nov 17 | Dec 17 | Jan 18 | Feb 18 | Mar 18 | Apr 18 | Monthly Trend |
| A&E - >4 hr wait time from arrival to admission/ transfer/ discharge (% to Target) | 95% | 82.65% | 93.37% | 90.66% | 94.24% | 92.63% | 95.26% | 93.99% | 88.28% | 88.05% | 74.22% | 78.38% | 77.91% | 77.90% | 82.65% | |
| *No. of 4hr breaches* | | *1,244* | *474* | *737* | *437* | *567* | *332* | *422* | *872* | *851* | *1,920* | *1,543* | *1,469* | *1,679* | *1,244* | |

| | Plan | Actual | Apr 17 | May 17 | Jun 17 | Jul 17 | Aug 17 | Sep 17 | Oct 17 | Nov 17 | Dec 17 | Jan 18 | Feb 18 | Mar 18 | Apr 18 | Monthly Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| *A&E Attendances (LH/MIU/UUC) (% to Plan)* | | *93.18%* | *98.2%* | *101.8%* | *99.9%* | *96.3%* | *93.1%* | *97.1%* | *99.8%* | *92.9%* | *99.3%* | *97.1%* | *94.4%* | *93.6%* | *93.2%* | |
| *A&E Attendances (LH/MIU/UUC) (No.)* | *88,209* | *7,170* | 7,144 | 7,890 | 7,593 | 7,697 | 7,011 | 7,023 | 7,439 | 7,119 | 7,447 | 7,138 | 6,649 | 7,598 | 7,170 | |

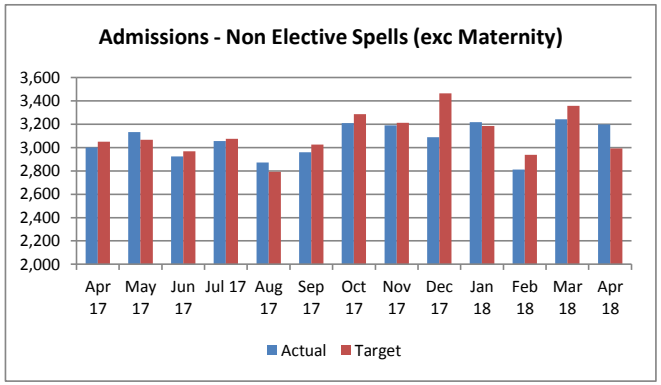
| | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| *A&E Attendance Case Mix (based on acuity score)* | *Major* | | *2,288* | *1,652* | *1,740* | *1,727* | *1,743* | *1,769* | *1,724* | *1,688* | *1,605* | *1,815* | *2,191* | *2,173* | *2,422* | *2,288* | |
| | *Minor* | | *2,799* | *3,141* | *3,442* | *3,421* | *3,345* | *3,152* | *2,939* | *3,198* | *2,936* | *3,324* | *2,940* | *2,474* | *2,886* | *2,799* | |
| | *Paediatrics* | | *1,419* | *1,433* | *1,674* | *1,568* | *1,626* | *1,182* | *1,416* | *1,588* | *1,557* | *1,379* | *1,304* | *1,305* | *1,544* | *1,419* | |
| | *Resus* | | *664* | *918* | *1,034* | *877* | *983* | *908* | *944* | *965* | *1,021* | *929* | *703* | *697* | *746* | *664* | |
| *A&E Attendance Location (based on Discharge)* | *Major* | | *2,957* | *2,810* | *2,943* | *2,875* | *2,978* | *2,898* | *2,899* | *3,011* | *2,776* | *3,201* | *3,038* | *2,761* | *3,204* | *2,957* | |
| | *Minor* | | *2,623* | *2,754* | *3,112* | *2,996* | *2,960* | *2,815* | *2,600* | *2,731* | *2,659* | *2,661* | *2,617* | *2,403* | *2,650* | *2,623* | |
| | *Paediatrics* | | *1,419* | *1,433* | *1,674* | *1,568* | *1,626* | *1,182* | *1,416* | *1,588* | *1,557* | *1,379* | *1,304* | *1,305* | *1,544* | *1,419* | |
| | *Resus* | | *171* | *147* | *161* | *154* | *133* | *116* | *108* | *109* | *127* | *206* | *179* | *180* | *200* | *171* | |

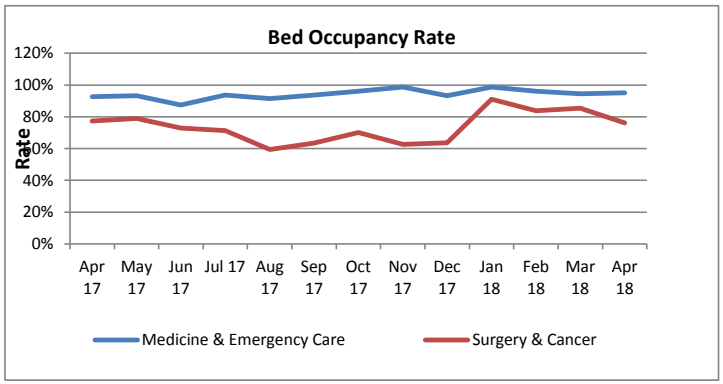
**Commentary**

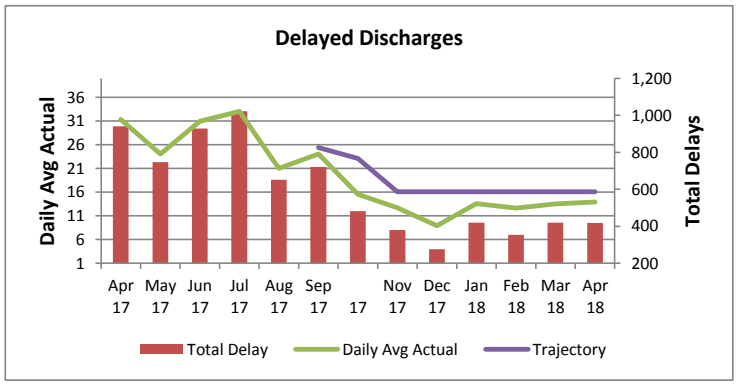
ED attendances in April saw a slight drop from March 2018 and is in line with April 2017. The Trust achieved 82.65% against the 4-hour access standard in April. Poor performance has been driven by a higher acuity of patients arriving at A&E and this is reflected in an increase in admissions . Comparatively ,April 2017 saw 1,652 patients with an acuity score of "major" versus April 2018 which saw 2,288. Escalation beds were utilised and open for a period in April but closed on 25th April and have remain closed since.

Non elective admissions in April were 6.6% higher than for the same period last year, driven by the higher acuity of patient. The Type 1 conversion rate from A&E rose to 39.31% the highest seen since the change in classification of the Urgent Care Centre in October. Medical outliers continues to decrease, 13 in April. Delayed transfers of care continues to be below the target set averaging 14.

**Primary Drivers**

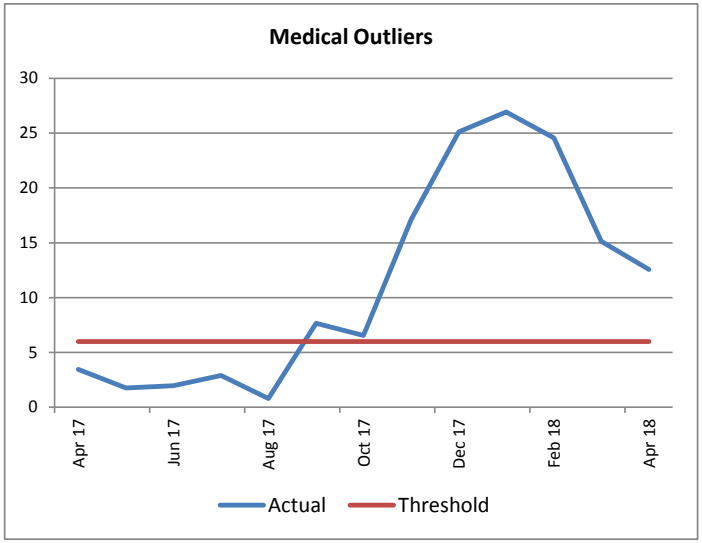


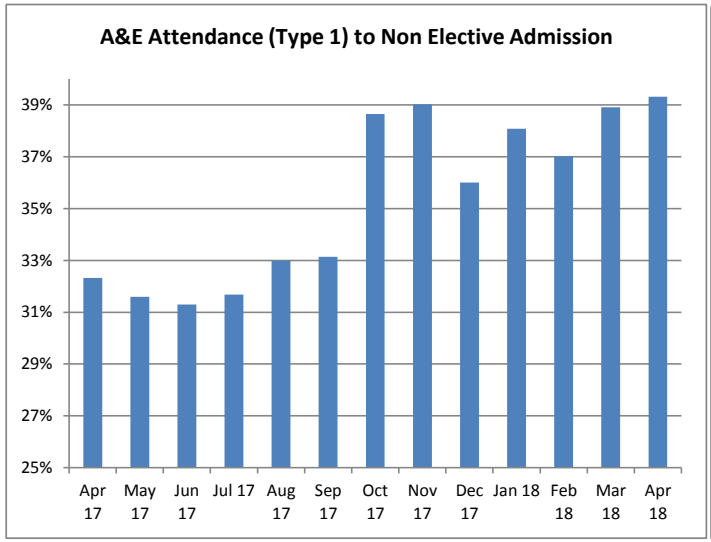



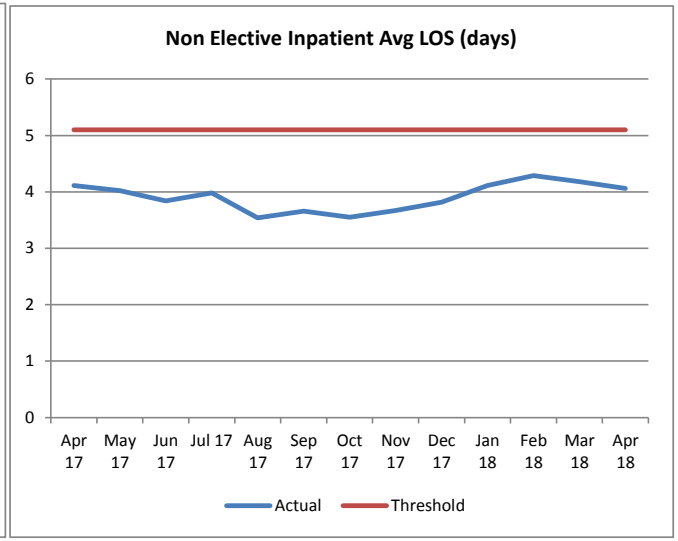



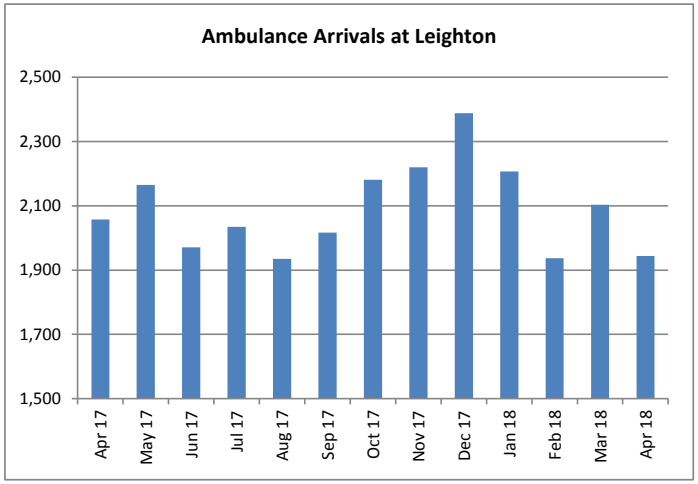
# Operational Delivery: *Unplanned Activity A&E*

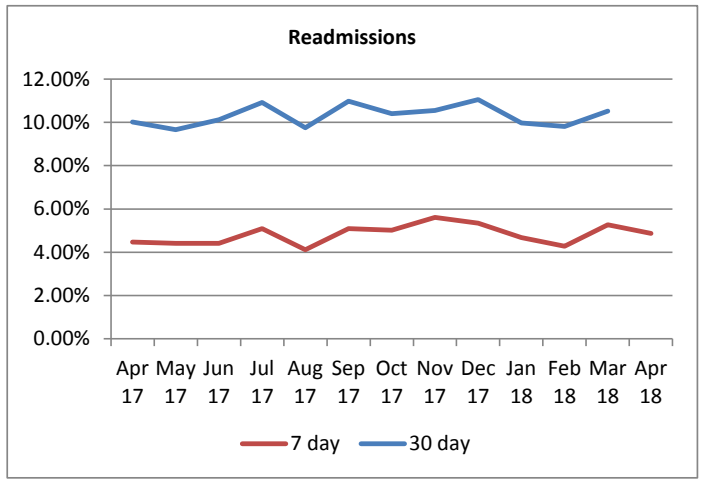
**Secondary Drivers**

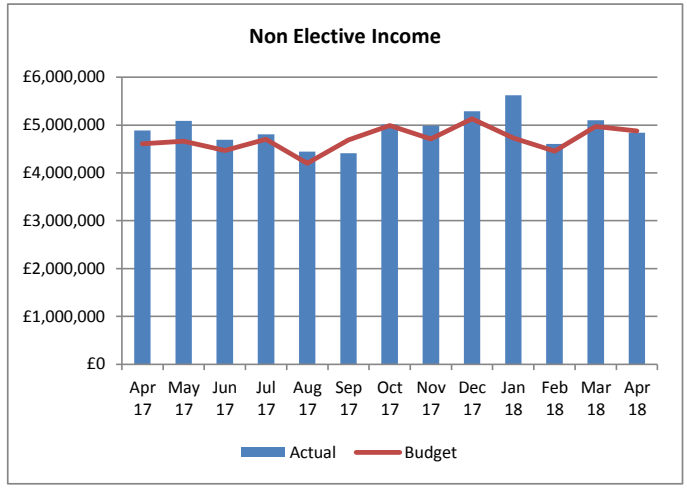



** Readmissions and LOS metrics brought in line with national definitions*

# Operational Delivery: *Planned Activity*

## Headline Measures

| | Current YTD | | Rolling 13 months | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Target | Actual | Apr 17 | May 17 | Jun 17 | Jul 17 | Aug 17 | Sep 17 | Oct 17 | Nov 17 | Dec 17 | Jan 18 | Feb 18 | Mar 18 | Apr 18 | Monthly Trend |
| 18 weeks from Referral to Treatment in Aggregate - Incomplete | 92% | 92.77% | 96.69% | 96.98% | 97.57% | 97.37% | 96.78% | 97.10% | 96.79% | 96.36% | 95.15% | 94.46% | 94.02% | 92.54% | 92.77% | |
| *Total 18 Weeks* | | *13,764* | *11,564* | *10,990* | *11,165* | *11,576* | *12,431* | *12,297* | *12,054* | *12,258* | *12,158* | *12,845* | *13,105* | *13,771* | *13,764* | |
| *No. > 18 Weeks* | | *995* | *383* | *332* | *271* | *305* | *400* | *356* | *387* | *446* | *590* | *711* | *784* | *1,028* | *995* | |
| Diagnostic Waiting Time | 1% | 0.26% | 0.04% | 0.17% | 0.44% | 0.76% | 0.34% | 0.21% | 0.24% | 0.25% | | 0.53% | 0.08% | 0.33% | 0.26% | |
| *Total Number of Waiters* | | *4,224* | *4,582* | *4,192* | *4,090* | *3,560* | *3,189* | *3,380* | *3,306* | *3,191* | *3,614* | *3,587* | *3,548* | *4,293* | *4,224* | |
| *Waiters of 6 Weeks +* | | *11* | *2* | *7* | *18* | *27* | *11* | *7* | *8* | *8* | *14* | *19* | *3* | *14* | *11* | |
| Total Patients Waiting for a First Outpatient Appointment | | | 7,223 | 7,172 | 7,352 | 7,643 | 8,029 | 7,809 | 7,731 | 7,916 | 8,085 | 8,342 | 8,501 | 8,866 | 9,243 | |
| *Longest Wait Time (weeks)* | | | | | | | | | | | *42* | *40* | *41* | *42* | *45* | |

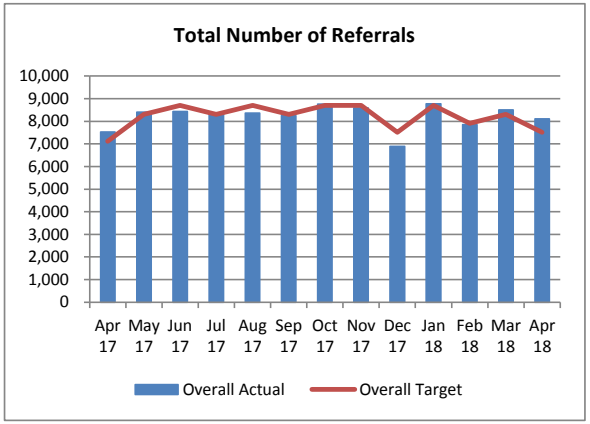
## Commentary

The Trust reported 92.77% against the 92% incomplete pathways standard for RTT. Four specialties have failed to meet the 92% at specialty level. These are General Surgery, Cardiology, Trauma and Orthopaedics and Community Paediatrics. The Divisions have recovery plans in place which are monitored through PMG. The Trust has successfully managed the level of over performance against this standard in light of the Capped Expenditure Programme with the aim of reducing the level of over performance across last few months.

The Trust has delivered the diagnostic wait time consistently since July 2016. In April 2018, 0.26% 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.

A year on year comparison of GP referrals shows a 9.6% increase in GP referrals from April 2017 to April 2018. The drop seen in April last year has not reoccured this year.

## Primary Drivers

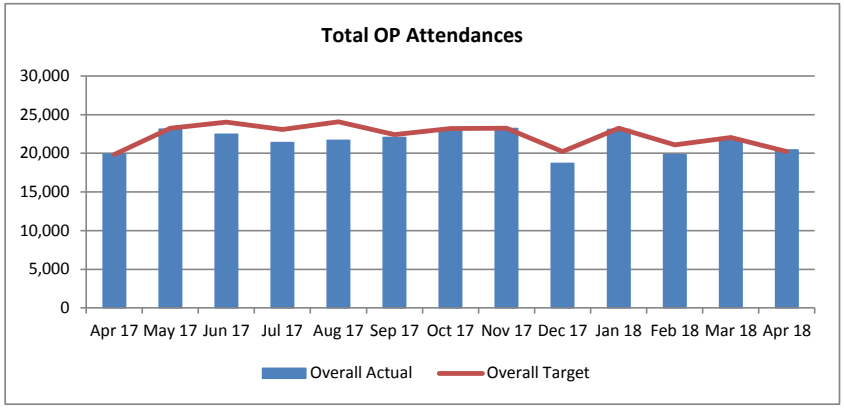


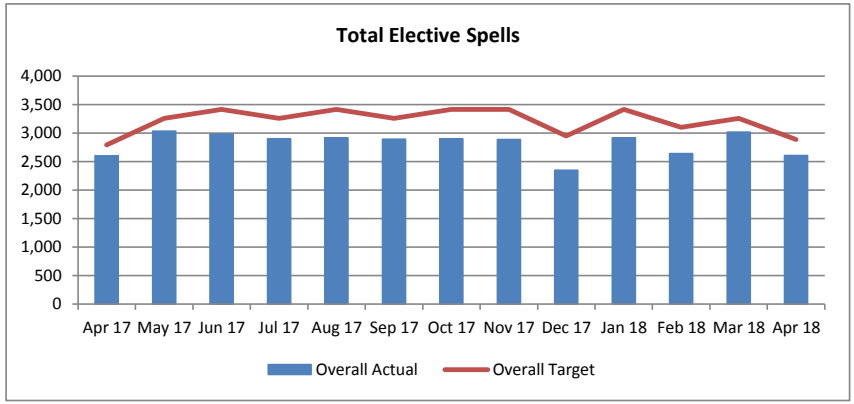

### Referral Breakdown

| | Apr 17 | May 17 | Jun 17 | Jul 17 | Aug 17 | Sep 17 | Oct 17 | Nov 17 | Dec 17 | Jan 18 | Feb 18 | Mar 18 | Apr 18 | Monthly Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| GP Actual | 4,427 | 4,779 | 5,248 | 5,115 | 5,211 | 5,277 | 5,506 | 5,424 | 4,157 | 5,573 | 4,928 | 5,388 | 4,856 | |
| GP Target | 4,507 | 5,259 | 5,509 | 5,259 | 5,509 | 5,259 | 5,509 | 5,509 | 4,758 | 5,509 | 5,008 | 5,259 | 4,683 | |
| % to Target | 98.2% | 90.9% | 95.3% | 97.3% | 94.6% | 100.3% | 99.9% | 98.5% | 87.4% | 101.2% | 98.4% | 102.5% | 103.7% | |
| Other Actual | 3,101 | 3,632 | 3,179 | 3,191 | 3,156 | 2,969 | 3,252 | 3,166 | 2,731 | 3,205 | 2,931 | 3,119 | 3,253 | |
| Other Target | 2,614 | 3,050 | 3,195 | 3,050 | 3,195 | 3,050 | 3,195 | 3,195 | 2,759 | 3,195 | 2,904 | 3,050 | 2,833 | |
| % to Target | 118.6% | 119.1% | 99.5% | 104.6% | 98.8% | 97.4% | 101.8% | 99.1% | 99.0% | 100.3% | 100.9% | 102.3% | 114.8% | |
| Total Actual | 7,528 | 8,411 | 8,427 | 8,306 | 8,367 | 8,246 | 8,758 | 8,590 | 6,888 | 8,778 | 7,859 | 8,507 | 8,109 | |
| Total Target | 7,121 | 8,308 | 8,704 | 8,308 | 8,704 | 8,308 | 8,704 | 8,704 | 7,517 | 8,704 | 7,913 | 8,308 | 7,515 | |
| % to Target | 105.7% | 101.2% | 96.8% | 100.0% | 96.1% | 99.3% | 100.6% | 98.7% | 91.6% | 100.9% | 99.3% | 102.4% | 107.9% | |
| GP % of Total | 58.8% | 56.8% | 62.3% | 61.6% | 62.3% | 64.0% | 62.9% | 63.1% | 60.4% | 63.5% | 62.7% | 63.3% | 59.9% | |

# Operational Delivery: *Planned Activity*

**Primary Drivers**



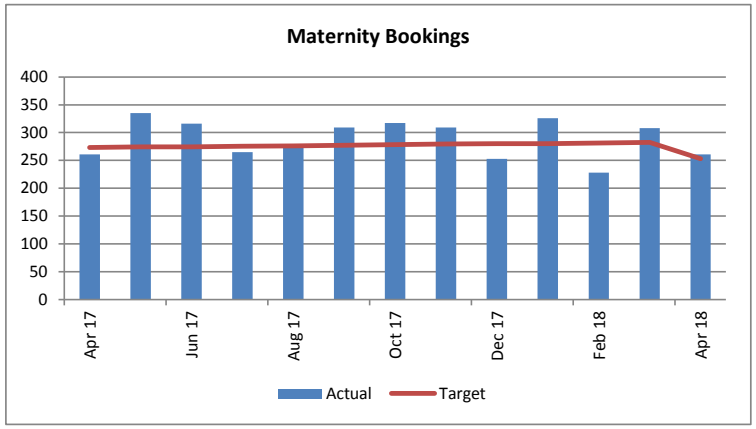



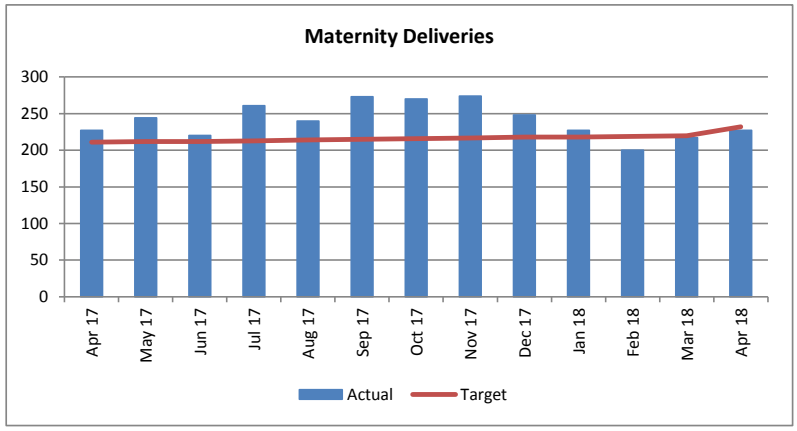

| OP Attendance Breakdown | YTD 18 19 | Apr 17 | May 17 | Jun 17 | Jul 17 | Aug 17 | Sep 17 | Oct 17 | Nov 17 | Dec 17 | Jan 18 | Feb 18 | Mar 18 | Apr 18 | Monthly Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| New Actual | 6,455 | 5,727 | 6,787 | 6,746 | 6,191 | 6,421 | 6,821 | 6,988 | 6,910 | 5,805 | 6,862 | 6,217 | 6,855 | 6,455 | |
| New Target | 5,892 | 6,098 | 7,113 | 7,423 | 7,098 | 7,427 | 6,941 | 7,250 | 7,253 | 6,272 | 7,253 | 6,585 | 6,909 | 5,892 | |
| % to Target | 109.6% | 93.9% | 95.4% | 90.9% | 87.2% | 86.5% | 98.3% | 96.4% | 95.3% | 92.6% | 94.6% | 94.4% | 99.2% | 109.6% | |
| F U Actual | 13,982 | 14,147 | 16,325 | 15,723 | 15,181 | 15,236 | 15,239 | 16,176 | 16,304 | 12,892 | 16,215 | 13,583 | 14,927 | 13,982 | |
| F U Target | 14,346 | 13,765 | 16,118 | 16,623 | 15,967 | 16,663 | 15,462 | | 15,987 | 13,971 | 15,991 | 14,504 | 15,152 | 14,346 | |
| % to Target | 97.5% | 102.8% | 101.3% | 94.6% | 95.1% | 91.4% | 98.6% | 101.4% | 102.0% | 92.3% | 101.4% | 93.7% | 98.5% | 97.5% | |
| Total Actual | 20,437 | 19,874 | 23,112 | 22,469 | 21,372 | 21,657 | 22,060 | 23,164 | 23,214 | 18,697 | 23,077 | 19,800 | 21,782 | 20,437 | |
| Total Target | 20,237 | 19,862 | 23,231 | 24,046 | 23,065 | 24,090 | 22,403 | 23,205 | 23,240 | 20,243 | 23,244 | 21,089 | 22,061 | 20,237 | |
| % to Target | 101.0% | 100.1% | 99.5% | 93.4% | 92.7% | 89.9% | 98.5% | 99.8% | 99.9% | 92.4% | 99.3% | 93.9% | 98.7% | 101.0% | |
| New % of Total | 31.6% | 28.8% | 29.4% | 30.0% | 29.0% | 29.6% | 30.9% | 30.2% | 29.8% | 31.0% | 29.7% | 31.4% | 31.5% | 31.6% | |

| Elective Spells Breakdown | YTD 18 19 | Apr 17 | May 17 | Jun 17 | Jul 17 | Aug 17 | Sep 17 | Oct 17 | Nov 17 | Dec 17 | Jan 18 | Feb 18 | Mar 18 | Apr 18 | Monthly Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| I P Actual | 217 | 260 | 307 | 294 | 266 | 298 | 279 | 299 | 308 | 234 | 164 | 240 | 273 | 217 | |
| I P Target | 301 | 281 | 330 | 346 | 330 | 346 | 330 | 346 | 346 | 298 | 346 | 314 | 330 | 301 | |
| % to Target | 72.1% | 92.4% | 93.1% | 85.1% | 80.7% | 86.2% | 84.6% | 86.5% | 89.1% | 78.6% | 47.4% | 76.5% | 82.8% | 72.1% | |
| Daycase Actual | 2,388 | 2,342 | 2,728 | 2,689 | 2,636 | 2,619 | 2,616 | 2,603 | 2,578 | 2,115 | 2,753 | 2,404 | 2,745 | 2,388 | |
| Daycase Target | 2,590 | 2,509 | 2,931 | 3,071 | 2,931 | 3,071 | 2,931 | 3,071 | 3,071 | 2,650 | 3,071 | 2,790 | 2,931 | 2,590 | |
| % to Target | 92.2% | 93.3% | 93.1% | 87.6% | 89.9% | 85.3% | 89.3% | 84.8% | 83.9% | 79.8% | 89.6% | 86.2% | 93.7% | 92.2% | |
| Total Actual | 2,605 | 2,602 | 3,035 | 2,983 | 2,902 | 2,917 | 2,895 | 2,902 | 2,886 | 2,349 | 2,917 | 2,644 | 3,018 | 2,605 | |
| Total Target | 2,891 | 2,791 | 3,260 | 3,417 | 3,260 | 3,417 | 3,260 | 3,417 | 3,417 | 2,947 | 3,417 | 3,104 | 3,260 | 2,891 | |
| % to Target | 90.1% | 93.2% | 93.1% | 87.3% | 89.0% | 85.4% | 88.8% | 84.9% | 84.5% | 79.7% | 85.4% | 85.2% | 92.6% | 90.1% | |
| I P % of Total | 8.3% | 10.0% | 10.1% | 9.9% | 9.2% | 10.2% | 9.6% | 10.3% | 10.7% | 10.0% | 5.6% | 9.1% | 9.0% | 8.3% | |

# Operational Delivery: *Planned Activity*

**Primary Drivers**



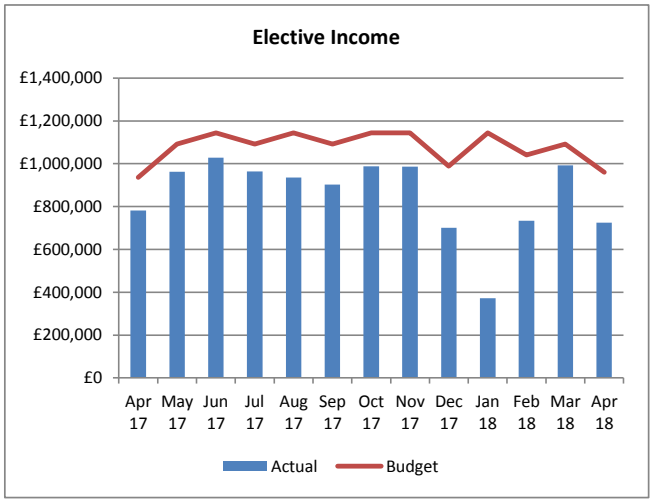



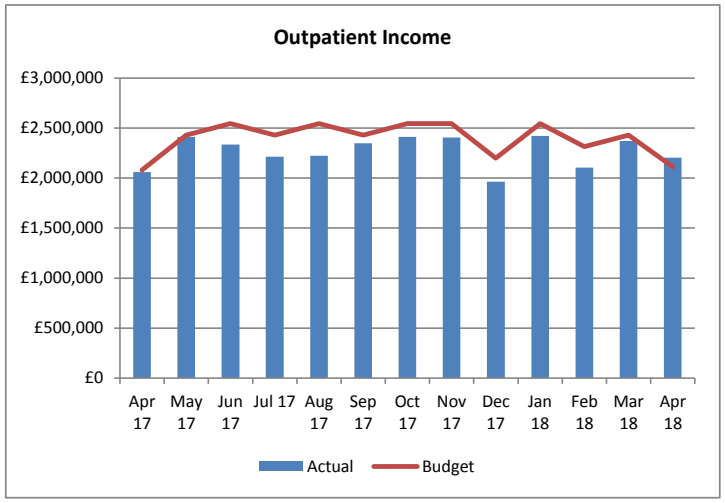
# Operational Delivery: *Planned Activity*

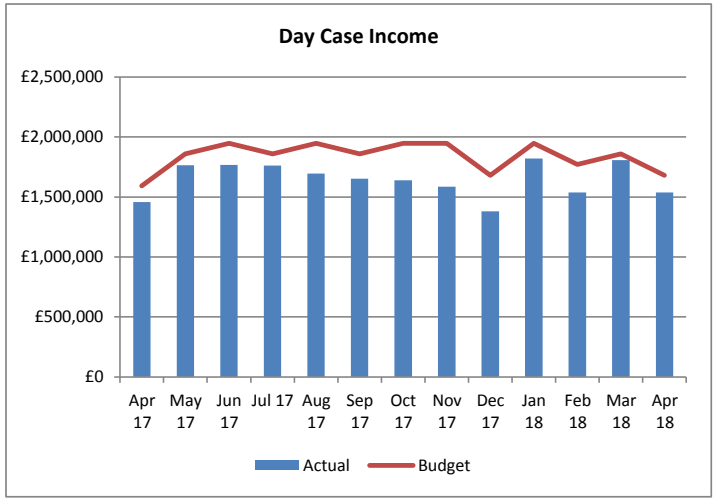
**Secondary Drivers**

| | | | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 | Monthly Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Bed Occupancy Rate | Medicine & Emergency Care | | 92.6% | 93.3% | 87.4% | 93.7% | 91.4% | 93.8% | 96.1% | 98.8% | 93.3% | 98.7% | 96.1% | 94.4% | 95.0% | |
| | Surgery & Cancer | | 77.3% | 78.9% | 72.9% | 71.3% | 59.3% | 63.5% | 70.1% | 62.7% | 63.7% | 91.1% | 83.7% | 85.4% | 76.1% | |
| Elective Inpatient Avg LOS (Days) | | | 3.4 | 2.9 | 3.1 | 3.7 | 2.6 | 2.3 | 2.4 | 2.7 | 2.4 | 2.3 | 2.4 | 2.5 | 3.1 | |
| Delayed Transfers of Care (MFFD) | | 16.00 | 31 | 24 | 31 | 33 | 21 | 24 | 16 | 13 | 9 | 14 | 13 | 14 | 14 | |
| Delayed Transfers of Care (% of Acute Beds) | | | 6.4% | | 6.6% | 7.1% | 4.6% | 5.2% | 3.4% | 2.7% | 1.9% | 2.6% | 2.5% | 2.7% | 2.8% | |
| Medical Outliers | | | 3 | 2 | 2 | 3 | 1 | 8 | 7 | 17 | 25 | 27 | 25 | 15 | 13 | |
| Readmission (Emergency Re-admissions after Planned Surgery) | | | | | | | | | | | | | | | | |
| | 30 Day Rate | | 3.72% | 3.81% | 3.58% | 2.93% | 3.40% | 3.84% | 3.48% | 3.44% | 3.15% | 3.01% | 2.56% | 3.28% | | |
| | 7 Day Rate | | 1.72% | 1.48% | 1.30% | 1.09% | 1.02% | 1.32% | 1.59% | 1.20% | 0.88% | 1.27% | 0.88% | 1.41% | 0.89% | |
| Cancelled Operations - Non Clinical - Cancellation Rate | | | 1.30% | 1.06% | 0.80% | 0.86% | 0.40% | 0.57% | 1.27% | 0.75% | 2.24% | 1.01% | 1.23% | 1.48% | 1.36% | |
| Theatre Efficiency | | | | | | | | | | | | | | | | |
| | Main Theatres | | 77.5% | 79.5% | 78.4% | 77.9% | 78.6% | 80.5% | 78.8% | 77.0% | 74.4% | 74.9% | 74.2% | 76.8% | 79.5% | |
| | TC Theatres | | 75.6% | 79.6% | 72.7% | 75.0% | 76.0% | 71.5% | 78.1% | 75.5% | 77.5% | 74.5% | 71.5% | 71.8% | 69.0% | |
| DNA (OP Efficiency) | | | 5.73% | 5.77% | 6.52% | 5.83% | 5.71% | 5.83% | 5.51% | 5.27% | 6.21% | 5.46% | 5.17% | 5.41% | 5.25% | |
| Hospital Cancellation Rate (OP Efficiency) | | | 6.57% | 7.63% | 7.51% | 7.94% | 7.58% | 6.11% | 6.27% | 6.19% | 7.18% | 7.34% | 6.88% | 6.43% | 6.72% | |

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



# Financial Performance: Income & Expenditure Position - Aggregated

| | Month | | | Year to Date | | | Forecast | |
|---|---|---|---|---|---|---|---|---|
| | Plan April (£'000) | Actual April (£'000) | Variance April (£'000) | Plan April to April (£'000) | Actual April to April (£'000) | Variance April to April (£'000) | 2018/19 (£'000) | Budget 2018/19 £'000 |
| **Operating** | | | | | | | | |
| **Operating Income** | | | | | | | | |
| *NHS Acute Activity Income* | | | | | | | | |
| Elective | 960 | 724 | -236 | 960 | 724 | -236 | 10,659 | 10,659 |
| Non-Elective | 4,878 | 4,841 | -37 | 4,878 | 4,841 | -37 | 59,628 | 59,628 |
| Maternity | 1,072 | 1,068 | -4 | 1,072 | 1,068 | -4 | 14,000 | 14,000 |
| Day cases | 1,679 | 1,538 | -142 | 1,679 | 1,538 | -142 | 21,139 | 21,139 |
| Outpatients | 2,112 | 2,202 | 91 | 2,112 | 2,202 | 91 | 26,672 | 26,672 |
| A&E | 822 | 798 | -24 | 822 | 798 | -24 | 10,139 | 10,139 |
| Other NHS | 6,067 | 6,427 | 360 | 6,067 | 6,427 | 360 | | 78,037 |
| **Total NHS Clinical Revenue** | **17,592** | **17,599** | **8** | **17,592** | **17,599** | **8** | **220,274** | **220,274** |
| *Other Operating Income* | 1,882 | 1,925 | 43 | 1,882 | 1,925 | 43 | 22,502 | 22,502 |
| **TOTAL OPERATING INCOME** | **19,474** | **19,524** | **51** | **19,474** | **19,524** | **51** | **242,776** | **242,776** |
| **Operating Expenses** | | | | | | | | |
| Employee Benefits Expenses (Pay) | -14,001 | -14,095 | -94 | -14,001 | -14,095 | -94 | -168,313 | -168,313 |
| Drugs | -1,350 | -1,287 | 63 | -1,350 | -1,287 | 63 | -15,868 | -15,868 |
| Clinical Supplies | -1,534 | -1,339 | 195 | -1,534 | -1,339 | 195 | -18,370 | -18,370 |
| Non Clinical Supplies | -294 | -295 | -1 | -294 | -295 | -1 | -3,537 | -3,537 |
| Other operating expenses | -2,519 | -2,522 | -3 | -2,519 | -2,522 | -3 | -31,419 | -31,419 |
| **TOTAL OPERATING EXPENSES** | **-19,698** | **-19,538** | **160** | **-19,698** | **-19,538** | **160** | **-237,507** | **-237,507** |
| **EBITDA** | **-224** | **-14** | **211** | **-224** | **-14** | **211** | **5,269** | **5,269** |
| **Non Operating** | | | | | | | | |
| **Non Operating Income** | | | | | | | | |
| Interest & Asset disposal | 3 | 6 | 3 | 3 | 6 | 3 | 36 | 36 |
| **Non-Operating Expenses** | | | | | | | | |
| Depreciation & Finance Leases | -446 | -466 | -20 | -446 | -466 | -20 | -6,190 | -6,190 |
| PDC Dividend Expense | -192 | -192 | 0 | -192 | -192 | 0 | -2,300 | -2,300 |
| **Net Surplus/(deficit) before STF/Exceptional Items** | **-859** | **-666** | **194** | **-859** | **-666** | **194** | **-3,185** | **-3,185** |
| **Provider Sustainability Fund** | 421 | 295 | -126 | 421 | 295 | -126 | 8,428 | 8,428 |
| **Net Surplus/(deficit) before Exceptional Items** | **-438** | **-371** | **67** | **-438** | **-371** | **67** | **5,243** | **5,243** |
| Donations for purchase of assets | 21 | 0 | -21 | 21 | 0 | -21 | 288 | 288 |
| Depreciation on Donated Assets | -23 | -23 | 0 | -23 | -23 | 0 | -278 | -278 |
| Prior Period Adjustments | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Net Surplus/(deficit) after Exceptional Items** | **-440** | **-394** | **46** | **-440** | **-394** | **46** | **5,253** | **5,253** |

The Trust delivered a £0.39m deficit (before exceptional items) in month against a budget of £0.44m.

Contract income is on plan. The planned income underperformance , is offset by the capped expenditure adjustment, and critical care over prerformance within Other NHS.

Other income is on plan with some variances as a result of Training income, RTA income , CCICP contract variations and nhs recharges.

Pay is £0.94M worse than plan. The key impacts are a higher spend on nursing and HCAs than plan offset by vacancies and unfilled posts within the commnity. Medical vacancies continuing to contribute to the medical pay underspend.

Non-Pay is £0.25M better than plan. The key impacts are reduced spend on clinical supplies, which is not expected to continue at the same rate and less than budget gerneral drugs spend. Although only a small agrregate overspend there continues to be continuing outsourcing pressures within other operating expenses.

* EBITDA Total excludes Charitable Income

# Financial Performance: Income & Expenditure Position - MCHFT

| | Month | | | Year to Date | | | Forecast | |
|---|---|---|---|---|---|---|---|---|
| | Plan April (£'000) | Actual April (£'000) | Variance April (£'000) | Plan April to April (£'000) | Actual April to April (£'000) | Variance April to April (£'000) | 2018/19 (£'000) | Budget 2018/19 £'000 |
| **Operating** | | | | | | | | |
| **Operating Income** | | | | | | | | |
| *NHS Acute Activity Income* | | | | | | | | |
| Elective | 960 | 724 | -236 | 960 | 724 | -236 | 10,659 | 10,659 |
| Non-Elective | 4,878 | 4,841 | -37 | 4,878 | 4,841 | -37 | 59,628 | 59,628 |
| Maternity | 1,072 | 1,068 | -4 | 1,072 | 1,068 | -4 | 14,000 | 14,000 |
| Day cases | 1,679 | 1,538 | -142 | 1,679 | 1,538 | -142 | 21,139 | 21,139 |
| Outpatients | 2,112 | 2,202 | 91 | 2,112 | 2,202 | 91 | 26,672 | 26,672 |
| A&E | 822 | 798 | -24 | 822 | 798 | -24 | | 10,139 |
| Other NHS | 3,697 | 4,057 | 360 | 3,697 | 4,057 | 360 | 49,574 | 49,574 |
| **Total NHS Clinical Revenue** | **15,222** | **15,229** | **8** | **15,222** | **15,229** | **8** | **191,811** | **191,811** |
| *Other Operating Income* | 1,794 | 1,813 | 19 | 1,794 | 1,813 | 19 | 21,502 | 21,502 |
| *Inter-Trust Income* | -33 | -33 | 0 | -33 | -33 | 0 | -400 | -400 |
| **TOTAL OPERATING INCOME** | **16,982** | **17,009** | **27** | **16,982** | **17,009** | **27** | **212,913** | **212,913** |
| **Operating Expenses** | | | | | | | | |
| Employee Benefits Expenses (Pay) | -12,206 | -12,361 | -155 | -12,206 | -12,361 | -155 | -146,770 | -146,770 |
| Drugs | -1,348 | -1,285 | 63 | -1,348 | -1,285 | 63 | -15,815 | -15,815 |
| Clinical Supplies | -1,455 | -1,248 | 207 | -1,455 | -1,248 | 207 | -17,353 | -17,353 |
| Non Clinical Supplies | -213 | -216 | -3 | -213 | -216 | -3 | -2,583 | -2,583 |
| Other operating expenses | -2,120 | -2,162 | -42 | -2,120 | -2,162 | -42 | -26,786 | -26,786 |
| Inter-Trust Charges | 136 | 136 | 0 | 136 | 136 | 0 | 1,663 | 1,663 |
| **TOTAL OPERATING EXPENSES** | **-17,206** | **-17,136** | **70** | **-17,206** | **-17,136** | **70** | **-207,644** | **-207,644** |
| **EBITDA** | **-224** | **-128** | **97** | **-224** | **-128** | **97** | **5,269** | **5,269** |
| **Non Operating** | | | | | | | | |
| **Non Operating Income** | | | | | | | | |
| Interest & Asset disposal | 3 | 6 | 3 | 3 | 6 | 3 | 36 | 36 |
| **Non-Operating Expenses** | | | | | | | | |
| Depreciation & Finance Leases | -446 | -466 | -20 | -446 | -466 | -20 | -6,190 | -6,190 |
| PDC Dividend Expense | -192 | -192 | 0 | -192 | -192 | 0 | -2,300 | -2,300 |
| **Net Surplus/(deficit) before STF/Exceptional Items** | **-859** | **-780** | **80** | **-859** | **-780** | **80** | **-3,185** | **-3,185** |
| **Provider Sustainability Fund** | 421 | 295 | -126 | 421 | 295 | -126 | 8,428 | **8,428** |
| **Net Surplus/(deficit) before Exceptional Items** | **-438** | **-485** | **-47** | **-438** | **-485** | **-47** | **5,243** | **5,243** |
| Revaluation (impairment reversal) | 21 | 0 | -21 | 21 | 0 | -21 | 288 | 288 |
| | -23 | -23 | 0 | -23 | -23 | 0 | -278 | -278 |
| Charitable income | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Net Surplus/(deficit) after Exceptional Items** | **-440** | **-508** | **-68** | **-440** | **-508** | **-68** | **5,253** | **5,253** |

The Trust excluding Community Services, delivered a £0.78m deficit position cumulative against a planned £0.86Mmdeficit. (prior to charitable income and )

Contract income is on plan.Key variances include planned activity being lower than expected activity levels, and better than budget income for critical care , out of area contracts and the CEP adjustment required being lower than plan..

Other income is £19k better than plan in relation to recharged contracts.

Pay is £155k worse than plan cumulative as a result of higher spend on Nursing & HCAs, net of medical pay vacancy savings

Non-Pay is £0225k better than plan as a result of clinical supplies, which in part due to the underperformance of orthopaedic planned surgery.

Other Operating Expenses is £42k worse as a result of continuing outsourcing pressures in diagnostics from staffing gaps.

There is a reflection of the &AE performance provided for within the provider sustainability fund.

# Financial Performance: Income & Expenditure Position - CCICP

| | Month | | | Year to Date | | | Forecast | |
|---|---|---|---|---|---|---|---|---|
| | Plan April (£'000) | Actual April (£'000) | Variance April (£'000) | Plan April to April (£'000) | Actual April to April (£'000) | Variance April to April (£'000) | 2018/19 (£'000) | Budget 2018/19 £'000 |
| **Operating** | | | | | | | | |
| **Operating Income** | | | | | | | | |
| *NHS Acute Activity Income* | | | | | | | | |
| Elective | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Non-Elective | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Maternity | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Day cases | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Outpatients | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| A&E | 0 | 0 | 0 | 0 | 0 | | 0 | 0 |
| Other NHS | 2,370 | 2,370 | 0 | 2,370 | 2,370 | 0 | 28,463 | 28,463 |
| **Total NHS Clinical Revenue** | **2,370** | **2,370** | **0** | **2,370** | **2,370** | **0** | **28,463** | **28,463** |
| *Other Operating Income* | 88 | 112 | 24 | 88 | 112 | 24 | 1,000 | 1,000 |
| *Inter-Trust Income* | 33 | 33 | 0 | 33 | 33 | 0 | 400 | 400 |
| **TOTAL OPERATING INCOME** | **2,491** | **2,515** | **24** | **2,491** | **2,515** | **24** | **29,863** | **29,863** |
| **Operating Expenses** | | | | | | | | |
| Employee Benefits Expenses (Pay) | -1,795 | -1,734 | 61 | -1,795 | -1,734 | 61 | -21,543 | -21,543 |
| Drugs | -2 | -2 | 0 | -2 | -2 | 0 | -53 | -53 |
| Clinical Supplies | -79 | -91 | -12 | -79 | -91 | -12 | -1,017 | -1,017 |
| Non Clinical Supplies | -81 | -79 | 2 | -81 | -79 | 2 | -954 | -954 |
| Other operating expenses | -399 | -360 | 39 | -399 | -360 | 39 | -4,633 | -4,633 |
| Inter-Trust Charges | -136 | -136 | 0 | -136 | -136 | 0 | -1,663 | -1,663 |
| **TOTAL OPERATING EXPENSES** | **-2,492** | **-2,402** | **90** | **-2,492** | **-2,402** | **90** | **-29,863** | **-29,863** |
| **EBITDA** | **0** | **114** | **114** | **0** | **114** | **114** | **0** | **0** |
| **Non Operating** | | | | | | | | |
| **Non Operating Income** | | | | | | | | |
| Interest & Asset disposal | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Non-Operating Expenses** | | | | | | | | |
| Depreciation & Finance Leases | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| PDC Dividend Expense | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Net Surplus/(deficit) before Exceptional Items** | **0** | **114** | **114** | **0** | **114** | **114** | **0** | **0** |
| Provider Sustainability Fund | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| **Net Surplus/(deficit) before Exceptional Items** | **0** | **114** | **114** | **0** | **114** | **114** | **0** | **0** |
| Prior Period Adjustment | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Net Surplus/(deficit) after Exceptional Items** | **0** | **114** | **114** | **0** | **114** | **114** | **0** | **0** |

Community Services delivered a £114k surplus cumulative against a planned break even position.

Contract income is on plan ., with expected variations in progress with the CCG around Stoma care and Pain.

Other Operating income is better than budget as a result of an increase in charges within estates, which is offset by an increase in cost in non pay.

Pay is £61k better than plan cumulative as a result of unfilled vacancies partly clinical and partly corporate., continuing the trend from 2017/18.

# 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 | (4) | (119) | (115) | (11) | (12) | (130) | (130) |
| Endoscopy | Endoscopy | 409 | 0 | (146) | (203) | 12 | (92) | 35 | 114 | (99) |
| General Surgery Directorate | General Surgery | 1,426 | 19 | 64 | (722) | 34 | (148) | (0) | 575 | 98 |
| Head & Neck Directorate | Head & Neck | 455 | 28 | (13) | (212) | 9 | (58) | 6 | 212 | 1 |
| Macmillan Cancer Centre | Macmillan Cancer Centre | 54 | 191 | 70 | (77) | (1) | (121) | | 47 | 68 |
| Ophthalmology | Ophthalmology | 940 | 4 | 7 | (354) | 1 | (289) | (11) | 301 | (3) |
| Orthopaedic Directorate | Orthopaedics | 1,382 | 44 | (127) | (501) | 49 | (194) | 72 | 731 | (6) |
| Theatres & TC | Theatres & TC | 0 | 30 | 1 | (604) | 5 | (196) | 9 | (770) | 15 |
| Urology Directorate | Urology | 436 | 4 | (18) | (231) | (9) | (48) | (20) | 161 | (47) |
| **Surgical and Cancer Division** | **Surgery & Cancer** | **5,103** | **321** | **(167)** | **(3,025)** | **(16)** | **(1,157)** | **79** | **1,242** | **(105)** |

The Surgical Division is £0.1M worse than plan. Contract income is below plan for planned activity in orthopaedics and endoscopy, due to annual leave and sickness. Increases in the drugs recharges to The Christie have resulted in a better than budget performance against income within the Cancer Centre. Non pay in underspent largely due to the underperformance of orthopaedics.

| | | 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 | 0 | 0 | (174) | (32) | 2 | 6 | (172) | (26) |
| Accident & Emergency Dir | Emergency Department | 1,186 | 65 | (78) | (484) | 30 | (55) | 0 | 713 | (48) |
| Anaesthetics & Critical Care | Anaesthetics & Critical Care | 618 | 2 | 81 | (632) | 43 | (107) | (4) | (119) | 120 |
| Medical Directorate | General Medicine | 3,595 | 22 | 73 | (1,882) | (37) | (341) | 53 | 1,394 | 89 |
| Urgent Care Centre | Urgent Care Centre | 0 | 0 | 0 | (49) | 9 | 0 | 7 | (49) | 16 |
| **Emergency Services Division** | **Medicine & Emergency Care** | **5,399** | **89** | **76** | **(3,221)** | **14** | **(500)** | **61** | **1,767** | **152** |

The Medicine and Emergency Care Division are £0.15M better than plan. The variances on income relate to uncoded A&E attendances, a higher than planed number of patient discharged in the month with relatively long lengths of stay, including some with a significant period on critical care. Key variances within 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, due to vacancies. Non-pay is better than budget, with key variances being clinical supplies and 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 |
| Wom Chil & sexl hlth Div Magmn | Divisional Mangement W&C | 0 | 0 | 0 | (113) | (2) | (8) | 3 | (121) | 2 |
| Gum clinic | Gum clinic | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Obstetric & Gynaecology Dir | Obstetrics & Gynaecology | 1,380 | 19 | (48) | (736) | (14) | (92) | 12 | 572 | (51) |
| Paediatric Directorate | Paediatrics | 976 | 7 | 16 | (666) | (22) | (73) | 16 | 243 | 11 |
| **Women and Childrens Division** | **Women and Children** | **2,356** | **26** | **(32)** | **(1,515)** | **(38)** | **(174)** | **31** | **693** | **(39)** |

The Womens and Childrens Division is £39k worse than plan. Contract income is below plan for Gynaecology. Pay pressures are a result of midwifery and medical over-establishment, and CAU being open in April which has now closed.

# 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 | (27) | 0 | (2) | (11) | (29) | (11) |
| Dermatology | Dermatology | 151 | 2 | 8 | (80) | 8 | (33) | (6) | 40 | 10 |
| ECG department | ECG | 32 | (2) | (4) | (82) | 9 | (5) | 2 | (57) | 8 |
| Elmhurst | | 166 | 13 | (1) | (127) | (2) | (14) | 2 | 40 | (1) |
| Integrated Discharge | Integrated Discharge | 0 | 0 | 0 | (28) | (4) | (1) | (0) | (28) | (5) |
| Medical Records Department | Medical Records Department | 0 | 0 | (0) | (143) | (3) | (21) | (3) | (164) | (6) |
| Outpatients | Outpatients | 0 | 12 | (2) | (44) | 3 | (3) | 1 | (34) | 3 |
| Pathology Directorate | Pathology | 980 | 324 | 74 | (808) | 22 | (707) | (15) | (210) | 81 |
| Pharmacy Departments | Pharmacy | 297 | 18 | (4) | (280) | (14) | (230) | 62 | (195) | 44 |
| Radiology Directorate | Radiology | 246 | 75 | 3 | (506) | 23 | (176) | (16) | (362) | 10 |
| Therapeutic Departments | Therapies | 0 | (0) | (0) | (171) | 4 | (4) | 5 | (175) | 9 |
| Victoria Infirmary Northwich | Victoria Infirmary Northwich | 171 | 0 | (7) | (149) | (9) | (26) | (1) | (3) | (17) |
| **Diagnostics and Support Divisi** | **Diagnostics and Support** | **2,043** | **442** | **69** | **(2,443)** | **36** | **(1,220)** | **19** | **(1,178)** | **124** |

The Diagnostics Division is £0.12M better than plan. The key variances include better than plan on pay from staffing gaps in Pathology and Radiology which are offset by outsourcing costs in non pay in those areas. General drugs are showing as £0.1M better than budget.

| | | 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 | (44) | 1 | (19) | (9) | (62) | (8) |
| Catering Directorate | Catering | 0 | 116 | 5 | (133) | (3) | (113) | (6) | (130) | (4) |
| Estates Departments | Estates Departments | 0 | 39 | (1) | (131) | (2) | (549) | (17) | (641) | (19) |
| Hotel Services | Domestics | 0 | 0 | 0 | (101) | 9 | (1) | (0) | (102) | 9 |
| Laundry Services Departments | Laundry | 0 | 94 | 1 | (85) | (1) | (75) | (10) | (67) | (10) |
| Security | Security | 0 | 110 | (31) | (62) | 1 | (74) | (25) | (26) | (55) |
| Site Services | Porters | 0 | 0 | 0 | (231) | 1 | (4) | 2 | (235) | 3 |
| **Estates & Facilities Division** | **Estates & Facilities Division** | **0** | **359** | **(25)** | **(787)** | **5** | **(836)** | **(64)** | **(1,264)** | **(84)** |

The Estates and Facilities Division is £0.1M worse than plan. The key variance relates to security and the installation of the new barriers, which has led to shortfall of £31k on income in the month and a £9k overpend on the 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 | (125) | 2 | (44) | 8 | (169) | 10 |
| Computer Services | Computer Services | 0 | 1 | 1 | (125) | 3 | (220) | (31) | (344) | (27) |
| Finance & Information | Finance & Information | 0 | 6 | 4 | (261) | (6) | (53) | 11 | (308) | 9 |
| Human Resources | Human Resources | 0 | 21 | (18) | (198) | 10 | (20) | 45 | (197) | 37 |
| Risk Manangement & R&D | Risk Management & R&D | 0 | 36 | (9) | (121) | 10 | (4) | 4 | (89) | 5 |
| Quality Assurance Departments | Nurse Management | 0 | 29 | 20 | (220) | (10) | (677) | 15 | (867) | 26 |
| Trust Central Expenditure | Trust Central Expenditure | 674 | 466 | 8 | (298) | (160) | 13 | 44 | 854 | (108) |
| Other Departments | Other Departments | 2 | 16 | 6 | (22) | (6) | (18) | 3 | (22) | 3 |
| | **Corporate** | **676** | **576** | **11** | **(1,370)** | **(156)** | **(1,023)** | **100** | **(1,141)** | **(45)** |

The Corporate Division is £0.45M worse than budget. The pay award is being held centrally on Trust Central resulting in the £160k overspend.

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Community Services** | **2,317** | **112** | **(28)** | **(1,734)** | **60** | **(531)** | **29** | **164** | **62** |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **EBITDA** | **17,894** | **1,925** | **(97)** | **(14,095)** | **(93)** | **(5,442)** | **255** | **282** | **65** |

# Financial Performance: Commissioner Income Analysis

| Commissioner | FY Target (£'000) | YTD Target (£'000) | CEP Adjustmt | Final Actual (£'000) | Final Variance (£'000) |
|---|---|---|---|---|---|
| NHS Eastern Cheshire CCG | 8,088 | 649 | 0 | 593 | -56 |
| NHS Eastern Cheshire CCG Community | 412 | 34 | 0 | 34 | 0 |
| NHS South Cheshire CCG Community | 17,024 | 1,419 | 0 | 1,419 | 0 |
| NHS South Cheshire CCG | 100,754 | 8,246 | 170 | 8,246 | 0 |
| NHS Vale Royal CCG | 55,996 | 4,469 | -184 | 4,469 | 0 |
| NHS Vale Royal CCG Community | 10,330 | 861 | 0 | 861 | 0 |
| NHS Warrington CCG | 284 | 24 | 0 | 11 | -13 |
| NHS West Cheshire CCG | 3,537 | 287 | 0 | 286 | -1 |
| NHS West Cheshire CCG Community | 191 | 16 | 0 | 16 | 0 |
| NHS North Staffordshire CCG | 2,307 | 188 | 0 | 205 | 17 |
| | 892 | 72 | 0 | 58 | -14 |
| NHS Stoke on Trent CCG | 1,609 | 131 | 0 | 161 | 30 |
| Public Health England | 1,541 | 111 | 0 | 84 | -27 |
| NHS Commissioning Board | 1,569 | 131 | 0 | 131 | 0 |
| Specialist Commissioning Group | 8,645 | 693 | 0 | 651 | -42 |
| Non Contract Activity | 2,007 | 162 | 0 | 153 | -9 |
| Cross Border Flows | 378 | 31 | 0 | 163 | 132 |
| Non-Commissioner Specific | 13,140 | 489 | 0 | 353 | -136 |
| **TOTAL** | **228,702** | **18,013** | **-14** | **17,894** | **-119** |

The South Cheshire is currently performing below the contract value set , and Vale Royal above - when the contract is valued at PbR.

Other commissioners, except Stoke CCG and North Staffs CCG are worse than plan and relate to planned activity in General Surgery and Orthopaedics.

Specialist Commissioning has a negative variance being the result of having less specialised admissions than plan.

Cross border flows includes Welsh commissioners where the Trust is continuing to the North Welsh Health board, pre-dominently in orthopaedic surgery.

| Other Contract Income | FY Target (£'000) | YTD Target (£'000) | YTD Actual (£'000) | Final Variance (£'000) |
|---|---|---|---|---|
| Bed Based Services | 5,962 | 497 | 485 | -12 |
| Adult & Neonatal Critical Care | 7,896 | 637 | 745 | 108 |
| Community Paediatrics | 1,303 | 109 | 109 | 0 |
| Direct Access Services | 9,509 | 751 | 764 | 13 |
| Unbundled Radiology | 3,505 | 277 | 301 | 24 |
| High Cost Drugs | 9,762 | 843 | 854 | 11 |
| Screening Programmes | 1,530 | 128 | 128 | 0 |
| Audiology | 1,167 | 97 | 96 | -2 |
| IVF | 258 | 22 | 12 | -9 |
| CQUIN | 4,312 | 281 | 281 | 0 |
| STF | 8,428 | 421 | 295 | -126 |
| Community Services | 28,426 | 2,327 | 2,327 | 0 |
| CEP | -2,817 | -235 | -14 | 220 |
| WINTER FUNDING | 750 | 62 | 62 | 0 |
| Other | 6,623 | 271 | 277 | 6 |
| **TOTAL** | **86,614** | **6,488** | **6,722** | **233** |

Other contract income is showing £0.23M better than plan.

An analysis of the key service lines identifies that this is primarily the result of adult critical care - where there were a number of long stay patient discharged in April.

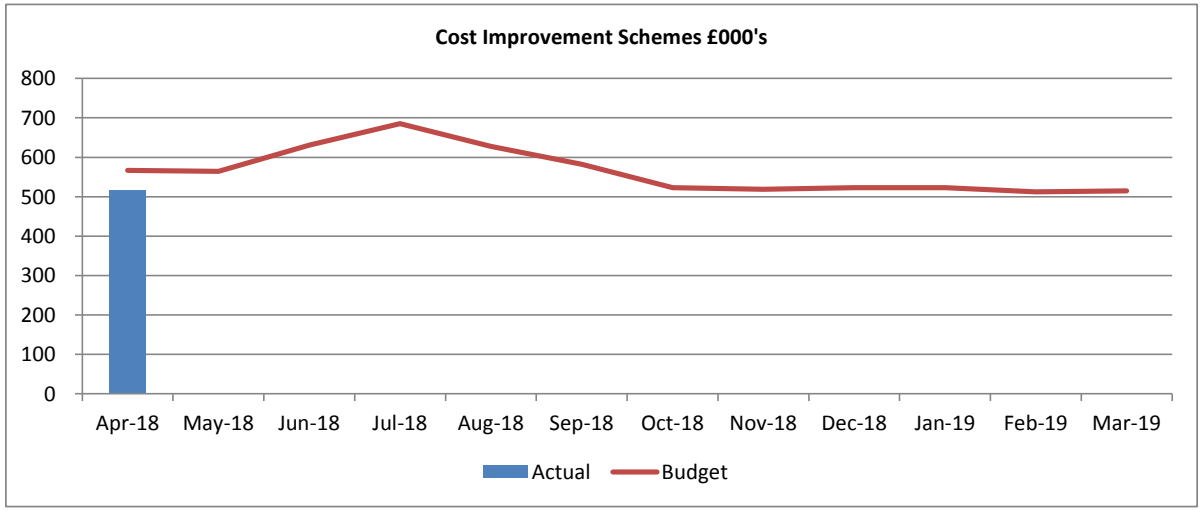
Non-performance of the A&E target has been recognised in month.

The impact of the CEP is less than expected for April.

Winter funding associated with month 1, agreed at the A&E delviery board - has not been varied into the contract, which is expected to increase the £0.75m.

# Financial Performance: Efficiencies

| Cost Improvement Schemes | | | | | | |
|---|---|---|---|---|---|---|
| **Scheme Category** | **YTD Target** | **YTD Actual** | **YTD** | **FY Target** | **FY Forecast** | **FY Variance** |
| Access & Flow | 84 | 63 | -21 | 524 | 524 | 0 |
| Commercial | 13 | 11 | -2 | 195 | 195 | 0 |
| Drugs | 25 | 25 | 0 | 657 | 657 | 0 |
| Medical Workforce | 129 | 164 | 35 | 1,550 | 1,550 | 0 |
| Non-Pay Efficiency | 83 | 75 | -8 | 1,234 | 1,234 | 0 |
| Nursing Workforce | 81 | 60 | -21 | 974 | | 0 |
| Procurement | 57 | 57 | 0 | 684 | 684 | 0 |
| Theatres Efficiency | 8 | 5 | -3 | 100 | 100 | 0 |
| Service redesign | 45 | 36 | -9 | 534 | 534 | 0 |
| Market Share | 21 | 21 | 0 | 320 | 320 | 0 |
| **Total (£'000)** | **546** | **517** | **-29** | **6,772** | **6,772** | **0** |




The CIP achievment in month, is £29k worse than budget with key schemes around the improvement of nurse/HCA sickness, reduction in WLIs either not currently delivering/partially delivering.

The closure of beds are a key CIP for the summer months, which are flagged as at risk of not achiving the full value (£335k). There is also a further risk associated with drugs scheme due to the potential delays for new bio-similars (£357k).

To mitigate this, there gains on cross border flows that were not accounted for in the plan that have been recently agreed (£134k in month).

# Financial Performance: Capital Report

| SCHEME | BOARD APPROVED | FUNDING SOURCE | FUNDING APPROVED | EXPENDITURE | 2018/19 | 2018/19 | 2018/19 CUMULATIVE ACTUAL | 2018/19 BETTER/WORSE THAN BUDGET | 2018/19 FORECAST | 2019/20 + FORECAST | WHOLE PROJECT ACTUAL TO DATE | WHOLE PROJECT PROPOSED PLAN | TOTAL FORECAST |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **STRATEGIC INVESTMENTS (Requires individual signoff)** | | | | | | | | | | | | | |
| **ESTATES** | | | | | | | | | | | | | |
| CAR PARK BARRIERS | Yes | Internal | Yes | 44 | 16 | 16 | 10 | 6 | 16 | | 54 | 60 | 60 |
| BISTRO & 2 OFFICES | Yes | Internal | Yes | 120 | 58 | 34 | 0 | 34 | 58 | | 120 | 178 | 178 |
| UNDER / OVERS CAPITAL SCHEMES 17/18 | Yes | Internal | Yes | | 0 | 0 | | 0 | 0 | | 0 | 0 | 0 |
| WARD REFURBISHMENT | Yes | Loan | Yes | 224 | 1864 | 290 | 234 | 56 | 1864 | 8600 | 458 | 10,688 | 10,688 |
| MRI SCANNER 3RD BUILD | Yes | Internal/Loan | Yes | 174 | 1475 | 0 | 0 | 0 | 1475 | | 174 | 1,649 | 1,649 |
| WASTE COMPOUND AND SEGREGATION | Yes | Internal | Yes | | 350 | 0 | 0 | 0 | 350 | | 0 | 350 | 350 |
| TURNKEY FOR REPLACEMENT CT SCANNERS | No | Internal | Yes | | 165 | 0 | 0 | 0 | 165 | 135 | 0 | 300 | 300 |
| BARRIER ACCESS CONTROL | Yes | Internal | Yes | | 100 | 0 | 0 | 0 | 100 | | 0 | 100 | 100 |
| CAR PARK LAND * | Yes | Loan | Not yet approved | | 400 | 10 | 0 | 10 | 400 | 1500 | 0 | 1,900 | 1,900 |
| EPR PROJECT ACCOMODATION * | Yes | Loan | Not yet approved | | 350 | 0 | 0 | 0 | 350 | | 0 | 350 | 350 |
| ENDOSCOPY WASHER BUILD * | No | Loan | Not yet approved | | 250 | 0 | 0 | 0 | 250 | 250 | 0 | 500 | 500 |
| PATHOLOGY RISKS | Yes | Internal | Yes | | 100 | 0 | 0 | 0 | 100 | | 0 | 100 | 100 |
| SSD ENABLING * | Yes | Loan | Not yet approved | | 668 | 0 | 0 | 0 | 668 | | 0 | 668 | 668 |
| WARD REFURBUISHMENT * | No | Loan | Not yet approved | | 1600 | 0 | 0 | 0 | 1600 | | 0 | 1,600 | 1,600 |
| DEMENTIA APPEAL | No | Donated | Not yet approved | | | | | | | 1500 | | | |
| 3RD CT ENABLING | No | Internal | Not yet approved | | | | | | | 935 | | | |
| **TOTAL** | | | | **562** | **7396** | **350** | **243.95166** | **106** | **7396** | **12920** | **805.95166** | **18443** | **18443** |
| **IT** | | | | | | | | | | | | | |
| UNDER / OVERS CAPITAL SCHEMES 17/18 | Yes | Internal | Yes | | 0 | 0 | 1 | -1 | 0 | | 1 | 0 | 0 |
| UPS | Yes | Internal | Yes | | 250 | 0 | 0 | 0 | 250 | | 0 | 250 | 250 |
| Q PULSE | Yes | Internal | Yes | 25 | 37 | 0 | 0 | 0 | 37 | | 25 | 62 | 62 |
| HIGH IMPACT STAND ALONE IT SYSTEMS | Yes | Internal | Yes | 88 | 112 | 0 | 0 | 0 | 112 | 400 | 88 | 600 | 600 |
| REPLACEMENT BUSINESS INTELLIGANCE SYSTEM | Yes | Internal | Yes | | 80 | 20 | 0 | 20 | 80 | | 0 | 80 | 80 |
| CONFIGURATION MANAGEMENT SYSTEM | Yes | Internal | Yes | | 35 | 0 | 0 | 0 | 35 | | 0 | 35 | 35 |
| CORE INFRASTRUCTURE UPGRADE | yes | PDC | Yes | | 538 | 50 | 0 | 50 | 538 | 180 | 0 | 718 | 718 |
| CYBER SECURITY | Yes | PDC | Yes | 17 | 291 | 50 | 0 | 50 | 291 | | 17 | 308 | 308 |
| X-RAY MACHINE STORAGE | Yes | Internal | Yes | | 100 | 0 | 0 | 0 | 100 | | 0 | 100 | 100 |
| SEQUEL / WINDOWS LICENCES | Yes | Internal | Yes | | 80 | 0 | 0 | 0 | 80 | | 0 | 80 | 80 |
| VIRTUAL DESKTOP | No | Internal | Yes | | 400 | 0 | 0 | 0 | 400 | | 0 | 400 | 400 |
| VIRTUAL CLINICS | No | Internal | Yes | | 50 | 0 | 0 | 0 | 50 | | 0 | 50 | 50 |
| VPN | Yes | PDC | Yes | | 70 | 0 | 0 | 0 | 70 | | 0 | 70 | 70 |
| VOICE OVER IP | Yes | Internal | Yes | 466 | 100 | 8 | 0 | 8 | 100 | 100 | 466 | 666 | 666 |
| **SYSTEM REFRESH / REPLACEMENT** | | | | | | | | | | | | | |
| LAB CENTRE PATHOLOGY | No | Internal | Yes | | 800 | 0 | 0 | 0 | 800 | 800 | 0 | 1,600 | 1,600 |
| CHEMOCARE | yes | Internal | Yes | | 85 | 0 | 0 | 0 | 85 | | 0 | 85 | 85 |
| DIGITAL DICTATION | Yes | Internal | Yes | | 60 | 0 | 0 | 0 | 60 | 73 | 0 | 133 | 133 |
| DOCMAN | Yes | Internal | Yes | | 52 | 0 | 0 | 0 | 52 | | 0 | 52 | 52 |
| WIRELESS UPGRADE /N3 UPGRADE | Yes | Internal | Yes | | | | | | | 65 | 0 | 65 | 65 |
| PHARMACY ASCRIBE | No | Internal | Yes | | | | | | | 200 | 0 | 200 | 200 |
| STAFF WIFI | No | Internal | Yes | | | | | | | 80 | 0 | 80 | 80 |
| SOLITON MEDICAL IMAGING | No | Internal | Yes | | | | | | | 250 | 0 | 250 | 250 |
| BADGERNET | Yes | Internal | Yes | | | | | | | 45 | 0 | 45 | 45 |
| BLOOD TRACKING SYSTEM | No | Internal | Yes | | | | | | | 200 | 0 | 200 | 200 |
| CARDIO RESPIRATORY SYSTEM | No | Internal | Yes | | | | | | | 350 | 0 | 350 | 350 |
| **TOTAL** | | | | **113** | **3140** | **128** | **1** | **127** | **3140** | **2743** | **597** | **5289** | **5,289** |
| **TOTAL STRATEGIC INVESTMENTS** | | | | **675** | **10536** | **478** | **245** | **233** | **10536** | **15663** | **920** | **23732** | **23732** |

The Estates strategic investments capital spend is £106K underspent mainy due to the Ward 17 Refurbishment £56K and Bistro Offices £34K

The IT Strategic investments projects are £127K which is mainly due to Core Infrastructure upgrade £50K and Cyber Security £50K

# Financial Performance: Capital Report

| SCHEME | BOARD APPROVED | FUNDING SOURCE | FUNDING APPROVED | EXPENDITURE | 2018/19 | 2018/19 | 2018/19 CUMULATIVE ACTUAL | 2018/19 BETTER/WORSE THAN BUDGET | 2018/19 FORECAST | 2019/20 + FORECAST | WHOLE PROJECT ACTUAL TO DATE | WHOLE PROJECT PROPOSED PLAN | TOTAL FORECAST |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **ROLLING ALLOCATIONS (Approved Delegated Budgets)** | | | | | | | | | | | | | |
| **ESTATES** | | | | | | | | | | | | | |
| ASBESTOS REMOVAL | Yes | Internal | Yes | | 271 | 0 | 0 | 0 | 271 | 600 | 0 | 871 | 871 |
| DESIGN TEAM | Yes | Internal | Yes | | 313 | 24 | 20 | 4 | 313 | 1252 | 20 | 1,565 | 1,565 |
| CT / VT - HEATING INFRASTRUCTURE | Yes | Internal | Yes | | 459 | 25 | 8 | 17 | 459 | 700 | 8 | 1,159 | 1,159 |
| BACKLOG GENERAL PROVISION | Yes | Internal/Loan | Yes | | 2650 | 235 | 80 | 155 | 2,650 | 6749 | 80 | 9,399 | 9,399 |
| **TOTAL** | | | | **0** | **3,693** | **284** | **108** | **176** | **3,693** | **9,301** | **108** | **12,994** | **12,994** |
| | | | | | | | | | | | | | |
| **IT** | | | | | | | | | | | | | |
| INTERSITE CONNECTIVITY | Yes | Internal | Yes | | 50 | 0 | | 0 | 50 | | 0 | 50 | 50 |
| INTERFACING | Yes | Internal | Yes | | 151 | 0 | 0 | 0 | 151 | 340 | 0 | 491 | 491 |
| IT APPLICATIONS | Yes | Internal | Yes | | 193 | 0 | 0 | 0 | 193 | 400 | 0 | 593 | 593 |
| STORAGE & BACKUP | No | Internal | Yes | | | | | | | 250 | | | |
| | | | | | | | | | | | | | |
| **TOTAL** | | | | **0** | **394** | **0** | **0** | **0** | **394** | **990** | **0** | **1134** | **1134** |
| | | | | | | | | | | | | | |
| **TOTAL ROLLING ALLOCATIONS** | | | | **0** | **4,087** | **284** | **108** | **176** | **4,087** | **10,291** | **108** | **14,128** | **14,128** |
| | | | | | | | | | | | | | |
| **ADDITIONAL** | | | | | | | | | | | | | |
| EQUIPMENT | Yes | Internal | Yes | | 0 | 0 | 0 | 0 | 0 | | 0 | 0 | 0 |
| MEDICAL RECORDS RACKING | Yes | Internal | Yes | | 43 | 0 | 0 | 0 | 43 | | | | |
| CANCER MDT | Yes | PDC | Yes | | 30 | 0 | 0 | 0 | 30 | | | | |
| GP STREAMING ESTATES | Yes | PDC | Yes | 12 | 488 | 100 | 0 | 100 | 488 | | 12 | 500 | 500 |
| GP STREAMING IT FRONT OF HOUSE | Yes | PDC | Yes | 108 | 142 | 0 | 0 | 0 | 142 | | 108 | 250 | 250 |
| COMMUNITY SERVICES | Yes | Internal | Yes | 105 | 630 | 0 | 10 | -10 | 630 | | 115 | 735 | 735 |
| **LEASING INVESTMENTS** | | | | | | | | | | | | | |
| EQUIPMENT | Yes | Internal | Yes | | 600 | 0 | 0 | 0 | 600 | | 0 | 600 | 600 |
| 3RD CT SCANNER | No | Internal | Not yet approved | | 531 | 0 | 0 | 0 | 531 | | 0 | 531 | 531 |
| REPLACEMENT CT SCANNER | No | Internal | Not yet approved | | 532 | 0 | 0 | 0 | 532 | | 0 | 532 | 532 |
| 3RD MRI SCANNER | Yes | Internal | Yes | | 600 | 0 | 0 | 0 | 600 | | 0 | 600 | 600 |
| ROOM 2 X-RAY | No | Internal | Not yet approved | | 250 | 0 | 0 | 0 | 250 | | 0 | 250 | 250 |
| SSD WASHERS | No | Internal | Not yet approved | | 320 | 0 | 0 | 0 | 320 | | 0 | 320 | 320 |
| | | | | | | | | | | | | | |
| **TOTAL LEASING INVESTMENTS** | | | | **0** | **2833** | **0** | **0** | **0** | **2833** | **0** | 0 | **2833** | **2833** |
| | | | | | | | | | | | | | |
| **TOTAL CAPITAL PROGRAMME (EXCLUDING LEASES)** | | | | **900** | **15,956** | **862** | **362** | **500** | **15,956** | **25,954** | **1,262** | **39,345** | **39,345** |
| | | | | | | | | | | | | | |
| **TOTAL CAPTIAL PROGRAMME** | | | | **900** | **18,789** | **862** | **362** | **500** | **18,789** | **25,954** | **1,262** | **42,178** | **42,178** |

In addition to the strategic capital schemes the rolling and additional schemes are £176K underspent mainly due to Backlog maintenance

# Financial Performance: Statement of Financial Position

| | Plan Apr to Apr (£'000) | Actual Apr to Apr (£'000) | Variance (£'000) | Forecast 2018/19 (£'000) |
|---|---|---|---|---|
| **Assets** | | | | |
| **Assets, Non-Current** | **97,491** | **96,971** | **-520** | **96,971** |
| **Assets, Current** | | | | |
| Trade and other Receivables | 11,418 | 11,673 | 255 | 11,673 |
| Other Assets (including Inventories & Prepayments) | 5,529 | 5,774 | 245 | 5,774 |
| Cash and Cash Equivalents | 7,889 | 7,521 | -368 | 7,521 |
| **Total Assets, Current** | **24,836** | **24,968** | **132** | **24,968** |
| **ASSETS, TOTAL** | **122,327** | **121,939** | **-388** | **121,939** |
| **Liabilities** | | | | |
| **Liabilities, Current** | | | | |
| Finance Lease, Current | -1,411 | -1,006 | 405 | -1,006 |
| Loans Commercial Current | -429 | -428 | 1 | -428 |
| Trade and Other Payables, Current | -11,209 | -11,707 | -498 | -11,707 |
| Provisions, Current | -212 | -195 | 17 | -195 |
| Other Financial Liabilities | -6,927 | -6,380 | 547 | -6,188 |
| **Total Liabilities, Current** | | **-19,716** | **472** | **-19,524** |
| **Net Current Assets/(Liabilities)** | **4,648** | **5,252** | **604** | **5,444** |
| **Liabilities, Non Current** | | | | |
| Finance Lease, Non Current | -4,350 | -4,207 | 143 | -4,207 |
| Loans Commercial Non-Current | -12,040 | -12,040 | 0 | -12,040 |
| Provisions, Non-Current | -1,586 | -1,586 | 0 | -1,586 |
| Trade and Other Payables, Non-Current | 0 | 0 | 0 | **0** |
| **Total Liabilities Non-Current** | **-17,976** | **-17,833** | **143** | **-17,833** |
| **TOTAL ASSETS EMPLOYED** | **84,163** | **84,390** | **227** | **84,582** |
| **Taxpayers' and Others' Equity** | | | | |
| **Taxpayers Equity** | | | | |
| Public dividend capital | 76,791 | 76,791 | 0 | 76,791 |
| Retained Earnings | -8,221 | -7,994 | 227 | -7,994 |
| Donated asset reserve | 0 | 0 | 0 | 0 |
| Revaluation Reserve | 15,592 | 15,592 | 0 | 15,592 |
| **TOTAL TAXPAYERS EQUITY** | **84,162** | **84,390** | **228** | **84,390** |
| **TOTAL FUNDS EMPLOYED** | **84,162** | **84,390** | **228** | **84,390** |

The main reason for the variance is that the plan is the capital programme expenditure being £520K less than anticipated which is mainly due delays in backlog maintenance £155K, Ward 17 refurbishment £56K, Cyber Security £50K and Core infrastructure upgrade £50K. The remainnig is due to a delay in the renewal of two finance leases.

Trade Receivables are higher than anticipated due to an outstanding amount from Welsh Health Bodies, £329K was paid in early May.

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 .

Current Finace Leases is due to the Endoscopy Lease being paid earlier than anticipated.

Trade and other payables are due to Trade Paybles being higer than anticipated but offset by lower than anticipated capital creditors

Other Finacial liabiliteis is due to lower then anticipated accruals, however this is offset by the higer trade payables above.

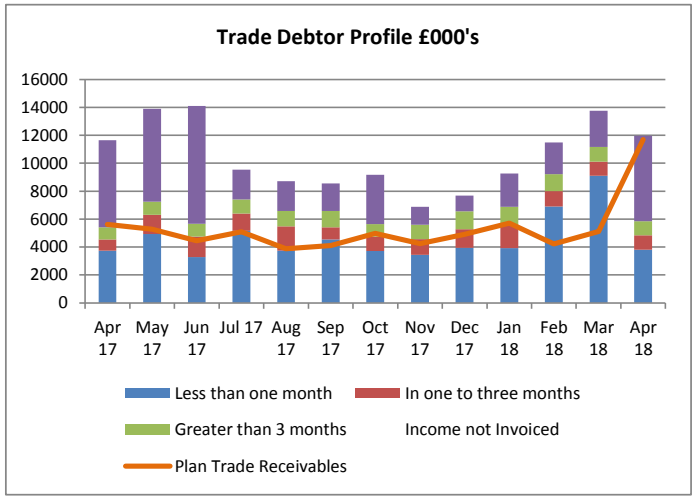
Non Current Finance Leases is due to the delay in the renewal of two finance lease s which haven't been renewed as reflected in non-current assets above

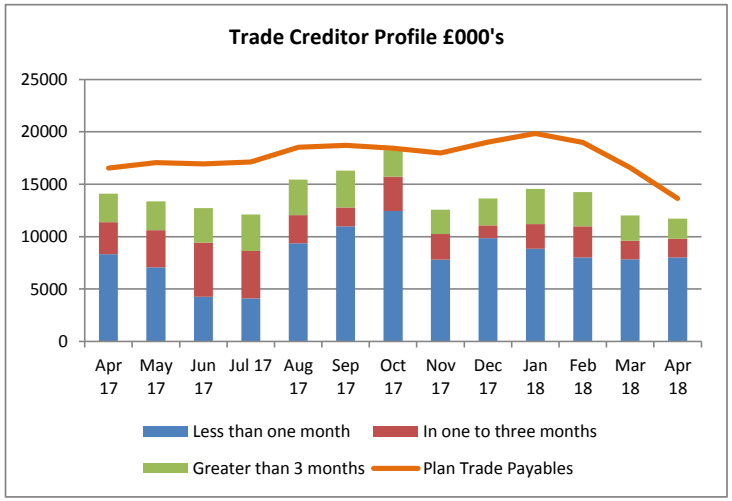
Retained Earnings is due to the better than anticipated financial position

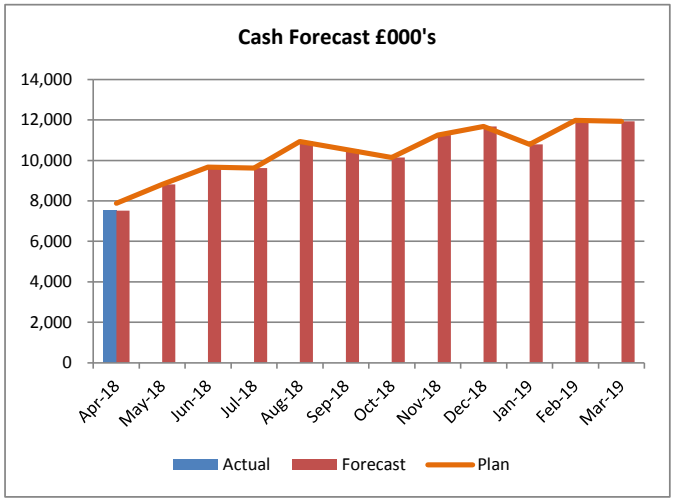
# Financial Performance: Cash Position and Working Capital

| | Plan Apr to Apr (£'000) | Actual Apr to Apr (£'000) | Variance |
|---|---|---|---|
| **Surplus/(deficit) after tax** | **-617** | **-394** | **223** |
| Non-cash flows in operating Surplus/(deficit) total | 487 | 483 | -4 |
| **Operating cash flows before movements in working capital** | **-130** | **89** | **219** |
| Increase/(Decrease) in working capital Total | 704 | 772 | 68 |
| **Net cash inflow/(outflow) from operating activities** | **574** | **861** | **287** |
| Net cash inflow/(outflow) from investing activities total | -292 | -563 | -271 |
| **Net Cash inflow/(outflow) before financing** | **282** | **298** | **16** |
| Net cash inflow/(outflow) from financing activities Total | -155 | -538 | -383 |
| **Net increase/(decrease) in cash and cash equivalents** | **127** | **-240** | **-367** |
| **Opening cash balance** | **7,761** | **7,761** | **0** |
| **Closing cash balance** | **7,888** | **7,521** | **-367** |

Cash is £367K less than anticipated. This mainly due to the increase in capital creditors being less than anticipated and in addition due to the early than anticipated payment of the endoscopy lease.



# Finance: *Staff Costs*

**Headline Measures**

| | YTD £000's | Rolling 13 months £000's | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Apr 17 | May 17 | Jun 17 | Jul 17 | Aug 17 | Sep 17 | Oct 17 | Nov 17 | Dec 17 | Jan 18 | Feb 18 | Mar 18 | Apr 18 | Monthly Trend |
| Pay Budget | 14,001 | 13,770 | 14,030 | 13,678 | 13,577 | 13,688 | 13,730 | 13,774 | 13,799 | 13,721 | 13,916 | 13,817 | 13,785 | 14,001 | |
| Pay Actual | 14,094 | 13,549 | 14,070 | 13,715 | 13,649 | 13,843 | 13,875 | 13,947 | 13,826 | 13,692 | 14,278 | 14,017 | 14,133 | 14,094 | |
| Variance | -93 | | -40 | -37 | -72 | -155 | -145 | -173 | -27 | 29 | -362 | -200 | -348 | -93 | |
| *% to Budget* | *100.7%* | *98.4%* | *100.3%* | *100.3%* | *100.5%* | *101.1%* | *101.1%* | *101.3%* | *100.2%* | *99.8%* | *102.6%* | *101.4%* | *102.5%* | *100.7%* | |
| Nursing Staff % to Budget | 101.7% | 101.8% | 104.4% | 99.8% | 102.5% | 97.5% | 99.3% | 101.6% | 102.9% | 102.4% | 105.9% | 104.7% | 105.0% | 101.7% | |
| Medical Staff % to Budget | 95.4% | 90.5% | 101.9% | 98.8% | 98.0% | 108.2% | 103.5% | 102.6% | 97.4% | 95.3% | 98.5% | 97.1% | 103.2% | 95.4% | |
| Other Staff % to Budget | 102.8% | 100.1% | 95.1% | 101.7% | 100.1% | 100.9% | 101.4% | 100.1% | 99.1% | 99.8% | 101.6% | 100.7% | 99.5% | 102.8% | |

**Commentary**

***Figures exclude Community Services for 2016/17***

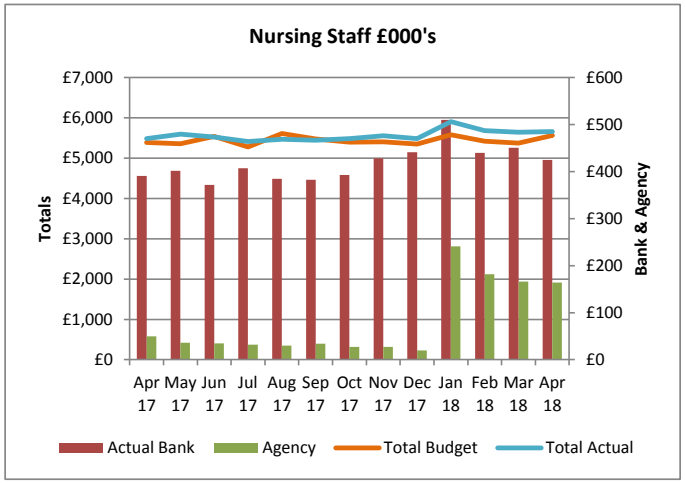
Pay is worse than budget by £0.93M in April.

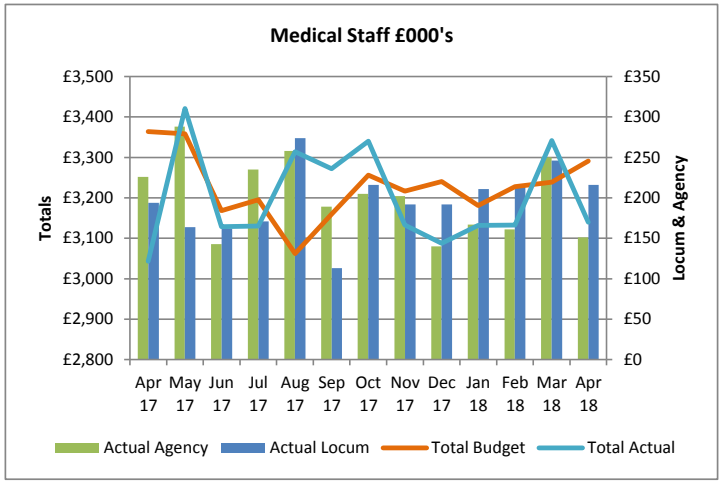
Nursing costs are higher than plan in Emergency Care as a result of continued acuity and the delay in closing in the escalation beds, Women and Children's is higher than plan due to the CAU assessment area open in April, subsequently closed in May. Nursing vacancies have increased in the month, with sickness remaining at the same levels. 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,

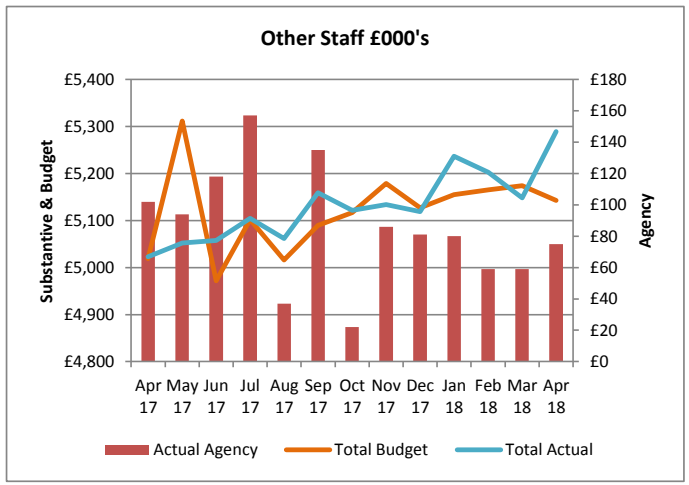
Medical pay is better than budget, most notebly within the Emergency Care division due to vacancies.

The Agency trajectory is worse than the plan by £24k, due to the delay in closure of the esalation beds.

**Primary Drivers**

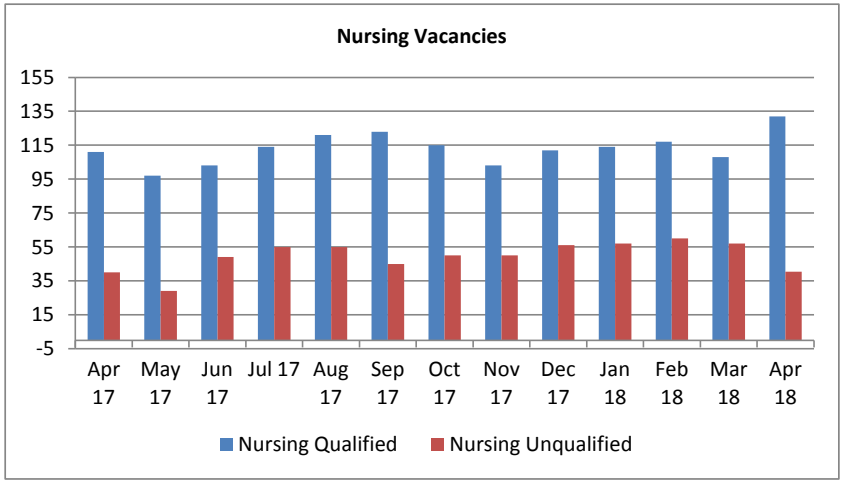


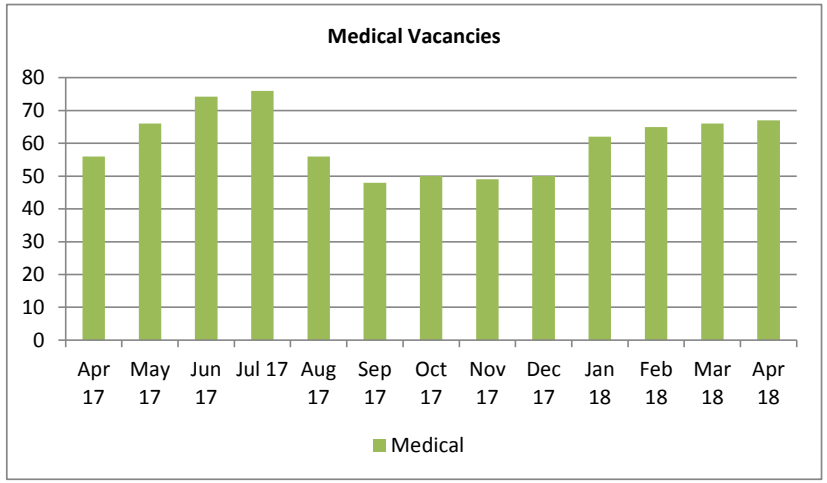



# Finance: *Staff Costs*

**Secondary Drivers**




**Agency Trajectory**

| | YTD | Apr 17 | May 17 | Jun 17 | Jul 17 | Aug 17 | Sep 17 | Oct 17 | Nov 17 | Dec 17 | Jan 18 | Feb 18 | Mar 18 | Apr 18 | Monthly Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Plan** | -365 | -539 | -572 | -561 | -515 | -563 | -525 | -495 | -477 | -506 | -495 | -470 | -484 | -365 | |
| **Actual** | -389 | -638 | -416 | -570 | -611 | -568 | -540 | -699 | -721 | -572 | -668 | -618 | -574 | -389 | |
| **Variance** | -24 | -99 | 156 | -9 | -96 | -5 | -15 | -204 | -244 | -66 | -173 | -148 | -90 | -24 | |
| | | | | | | | | | | | | | | | |
| **CCICP Actual** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | -69 | -77 | -152 | -210 | 4 | -77 | 0 | |

| | Rolling 13 Months | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Apr 17 | May 17 | Jun 17 | Jul 17 | Aug 17 | Sep 17 | Oct 17 | Nov 17 | Dec 17 | Jan 18 | Feb 18 | Mar 18 | Apr 18 | Monthly Trend |
| Sickness Rate (Rolling 12 mths) | 3.96% | 3.99% | 4.04% | 4.07% | 4.14% | 4.20% | 4.21% | 4.23% | 4.25% | 4.28% | 4.28% | 4.38% | 4.38% | |
| | | | | | | | | | | | | | | |
| Total Leavers | 31 | 37 | 35 | 45 | 45 | 54 | 45 | 39 | 33 | 46 | 37 | 61 | 39 | |
| Turnover (Rolling 12 mths) | 10.87% | 11.06% | 10.52% | 10.12% | 10.57% | 11.10% | 11.08% | 10.93% | 10.71% | 10.70% | 10.66% | 11.18% | 11.33% | |

# CCICP Partnership Board

**Date/time:** Thursday 12th April 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 P A Dodds | **(PAD)** | Medical Director & Deputy Chief Executive. MCHFT |
| | | Dr N Paul | **(NP)** | GP, Ashfields Primary Care Centre & Director Howbeck Healthcare |
| | | Mr M Oldham | **(MO)** | Director of Finance & Strategic Planning, MCHFT |
| | | Ms K Moore | **(KM)** | Operational Lead, CCICP |
| | | Mrs D Frodsham | **(DF)** | Director of Strategic Partnerships, MCHFT |
| | | Mrs T Cookson | **(TC)** | Nurse Director - South Cheshire & Vale Royal GP Alliance |
| | | Mrs S Hamman | **(SH)** | Head of Quality, Nursing & Professional Leadership, CCICP |
| | **In attendance** | Miss Julie Manslow (Minutes) | **(JM)** | PA, CCICP |
| | **Apologies** | Dr Anushta Sivananthan | **(NS)** | Medical Director, CWP |
| | | Mr A Styring | **(AS)** | Director of Operations, CWP |
| | | Dr J Price | **(JP)** | Director – South Cheshire & Vale Royal GP Alliance |



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 – Director – South Cheshire & Vale Royal GP Alliance; Mrs T Cookson – Nurse Director – South Cheshire & Vale Royal 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 | Responsible | Due date |
|---|---|---|---|---|
| **1.** | **Welcome and Apologies** | Apologies were noted. | | |
| **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 (15th March 2018) were reviewed for accuracy. DF to review section 8 regarding "CCICP Strategy Document". Minutes to be updated and re-sent to members. | DF | |
| **4.** | **Matters Arising/Action Tracker** | The Board reviewed and approved the rolling action log. | | |
| **5.** | **Transformation Programme Report**<br><br>GPOOH<br><br><br><br><br><br><br>MSK<br><br><br><br><br><br><br>Home First | <u>Work stream highlight reports</u><br><br>GPOOH Currently at green status. It was expected that this programme would be stepped down from the transformation programme following presentation at the CCG CEC and therefore would be removed from the highlight report moving forward. An operational update will be provided on a regular basis within the Associate Director report.<br><br>The GP OOHs recruitment paper was finalised in March. The VIN review, paper has been submitted for CCE and is now on agenda for next CCE meeting. Pharmacy support for OOH has been re-advertised, candidates have been shortlisted and interviews are progressing.<br><br>A benefits realisation and closure paper will go to the Transformation Board in April. Work continues with the communication plan and roll out, good activity and progress noted within Vale Royal GP practices. Communications plan refreshed with a view to improving activity in the southern GP practice locations. This is being supported by Dr Andrew Wilson. Data collection / review has been challenging, plan in place to progress. It was noted that between Jan – Feb there was an increase of 106 patients triaged into physio services, further update to be provided to Partnership Board in May 18.<br><br>Home First strategy presented to patient register group on 22.03.18. Governance structure and | | |

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| | Estates<br><br>IT<br><br>Organisational Development | Home First principles agreed and signed off. Home First charter reviewed for 2018/19 and approved.<br><br>First proposals for where care communities will be co-located, awaiting sign off by CCSMs. Where there are challenges an options paper is to be investigated by CCSMs and Estate teams. The principal of maintaining community team presence aligned to GP practices will be the focus of any activities.<br><br>IT is rated as Amber due to the ongoing workload required for implementation of the programme. IT trainer contracted for 6 months from 03 April. Flow mapping task and finish group, all services completed. Revised high level timeline / care community implementation to take place in phases between June – September 2018.<br><br>OD rated as red due to resilience sessions not being well attended by staff due to programme and operational pressures. Meeting taken place with Lisa Gresty and CCSMs and a further meeting arranged to discuss plan of action with Tony Mayer.<br><br>The work of the IT Group was acknowledged by the Board in particular the person-centered approach and the single care plan was noted.<br><br>SK provided an area of concern regarding mental health & wellbeing. Meeting took place Mon 09.04.18 with CWP to progress plans and to prepare a briefing ahead of May Partnership Board as per Action 191 in the log. Whilst this is very positive, it was recognised that there was a need to deep dive into mental health resource funding and how it is utilised in SC and VR areas. TW agreed to discuss this with CWP colleagues and to provide an update at May meeting | TW | May 18 |
| **6.** | **Forthcoming Tenders** | No new tenders reported. | | |
| **7.** | **Workforce Report** | CCICP leavers rolling figure has reduced from 15.25% to 14.6%. It was recognised that the CCICP community workforce is 10% older overall. There were no overall concerns with the current percentage as it was expected that this would continue to reduce but would be monitored. | | |
| **8.**<br><br>1.1 | **Finance Report** | The position for year end is expected to hit forecast with the significant underspends previously reported. The run rate on pay is remaining stable. Discussions are continuing regarding next year's budget.<br><br>MO updated the Board to report that the system expectation is that CEP is recurrent. For 2018/19 it was considered that there was a need to consolidate all investments. It was recognised that IT / E- | | |

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| | | community may open up more capacity. There may be further opportunities with the review of Intermediate Care and Community Rehab to realign some resources to where demands are greater. Further clarity is required regarding opportunities for investment. MO updated the Board regarding the proposed budget for 18/19, and highlighted that a break even budget had been developed and this was deliverable with a higher level of vacancy factor but that this was still significantly less than current actual vacancies. All pressures and IT investment was included including a modest amount of corporate investment where the Trust were struggling to deliver against the CCICP needs. This will come back to Partnership Board in May for final sign off.<br><br>Report in progress to be added to the agenda for Partnership Board 17th May 2018.<br><br>MO / Simon Kent to investigate board structure and terms of reference and provide a paper to the June meeting | MO<br><br>MO/SK | May 18<br><br>June 18 |
| **9.** | **Training Compliance Update**<br><br>Safeguarding Level 3<br><br>Safeguarding Level 2<br><br>Tri Stat<br><br>Moving & Handling | <br><br>Paediatric Physio / OT currently 97% compliant, Special School Nursing 45% compliant. Plan in place for 100% of staff to reach compliance by 17 May 2018. It was noted that all staff have been receiving regular safeguarding supervision in their place of work since 2017 including safeguarding updates.<br><br>Services compliant within 70-100%. The lower levels within the District Nurse teams have been highlighted to CCSMS. All services (with the exception of Intermediate Care) have a plan to be compliant within the next 6 weeks. Discussion with Tom Challinor regarding plan for Intermediate Care ongoing.<br><br>Services 70-100% compliant with some exceptions noted around Macmillan nursing due to issues with access.<br><br>IT issues recorded with both smartcards and access to training identified. Fundamental issue in this process currently not resolved. Clarity required regarding ownership. DF to escalate within MCHFT and learning and development team and report back to May Partnership Board meeting. | <br><br><br><br><br><br>DF | <br><br><br><br><br><br>17.05.18 |
| **10.** | **CQC Update** | SH provided an update following the recent inspection completed within Mid Cheshire. Lessons learnt to be brought forward and disseminated within CCICP services. Notice of expected CCICP visit to be given on a Friday with the inspection taking place the following Tues-Thurs. | | |

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| **11.** | **Performance & Quality Reports**<br><br>Pressure Ulcers<br><br>Complaints<br><br>Safety Thermometer<br><br>Vacancies / Sickness<br><br>Appraisal Figures<br><br>KPI Figures<br><br>Quality Safety & Experience Report<br><br>Integrated Governance Monthly Exception Report | KM gave an overview of the following report highlights.<br><br>Thirty two pressure ulcers were reported within Feb, twenty two of which were stage 2. There were no serious harm incidents reported for the third month concurrently.<br><br>No complaints received during February which is the same as the previous month of January. Ten informal concerns were received in February. Five of these are due to waiting time for Podiatry appointments. Details of informal concerns will be discussed with the relevant CCSMs.<br>Currently at Green status.<br><br>Vacancies increased slightly in February. Sickness decreased and remains very low for community services at 3.5%<br><br>No concerns regarding appraisal figures.<br><br>All KPI met in February.<br><br>It was noted that End of Life care is within the list of top five reported incidents, largely due to the current availability of district nursing team with the verification of death competence in OOHs. DF confirmed that she had requested a monthly action plan and report regarding the verification of death incidents.<br><br>There were four no harm medication incidents in Feb 2018.<br><br>The report was noted. | | |
| **12.** | **Operational Lead Report** | KM gave an overview of the following report highlights.<br><br>A joint SEND Ofsted inspection took place on the 12.03.18. CCICP staff were involved in a number of focus groups and case notes were reviewed by the inspection team. Formal feedback is due 33 days post inspection. However, no significant issues were highlighted for CCICP requiring immediate action and the inspector commented that there was evidence that health teams were providing good contribution to the SEND process / offer.<br><br>New Enteral Feeds contract is to be awarded to Abbott Laboratories Ltd who is the current provider.<br><br>Agreed and due to sign SLA with CWP for Continence Band 7 input to continue for another year, | | |

| | | | | |
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| | | noting the expectation of the onsite level of attendance within the CCICP teams.<br><br>Three red risks of 16 and above reported:- GPOOH staff shortages, Moving & Handling training and a new red risk re:- lack of controlled drugs management framework was highlighted.<br><br>DF confirmed that the Intermediate care and community rehabilitation service reviews have been completed with the paper currently being finalised. DF to bring paper to next board. | DF | 17.05.18 |
| **11.** | **Any other business** | TC:- It was confirmed that three candidates have been shortlisted for the position of Independent Chair with interviews due to take place next Thursday 19th April 2018. | | |
| | **Next Meeting:**<br><br>**Date:** Thurs 17th May<br>**Time:** 9am – 11:30am<br>**Venue:** Board Room, Ashfields, Sandbach | | | |

| | | |
|---|---|---|
| ***Title of Paper :*** | Board Assurance Framework (BAF) Report Q4 | |
| ***Author:*** | Associate Director-Quality 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*** | |
| ***If not to be published complete or redacted, please detail the reason why*** | |
| ***Presented at Board Meeting of:*** | 4 June 2018 |

# Board Assurance Framework

# 2017/18

## Summary Version

## Quarter 4

*'Delivering Excellence in Healthcare through Innovation and Collaboration'*

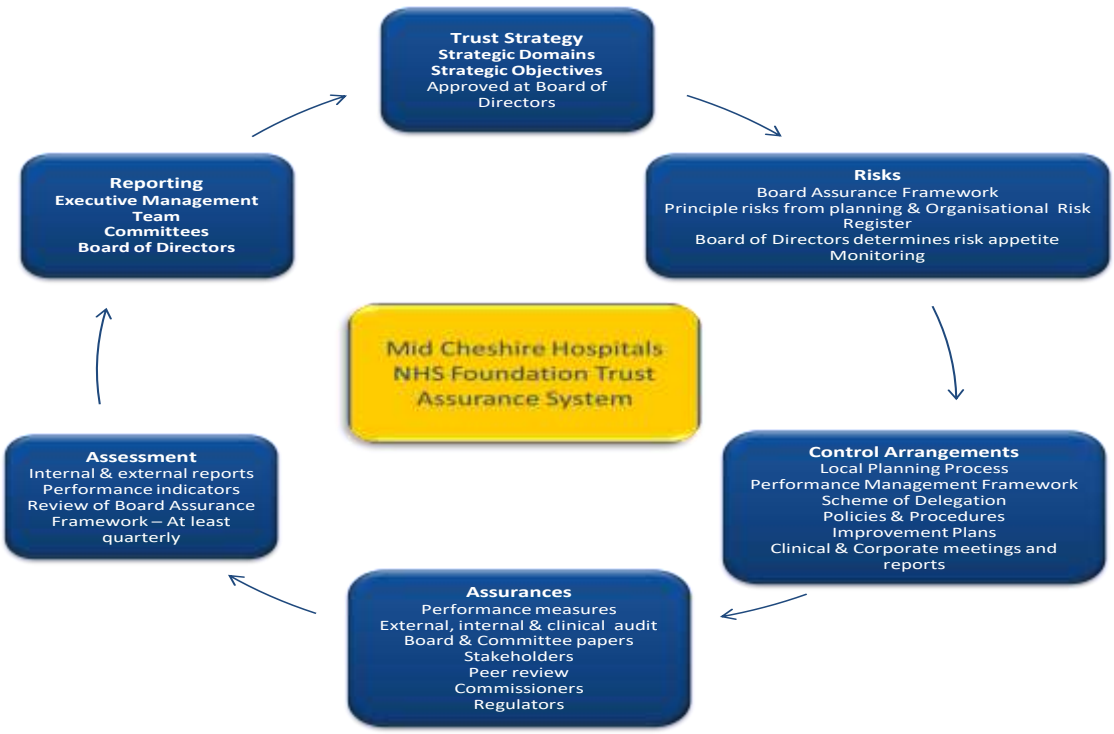
# Contents

## 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. Table 1 below details the top five risks as of quarter 4.

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 | |
| 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. Next steps

The development of the new BAF is an iterative process. An annual review of the process will be undertaken in May 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.

A recent KPMG Internal Audit Report on the BAF provided significant assurance with minor improvement opportunities and the recommendations will be incorporated in the BAF development process for 2018/19.

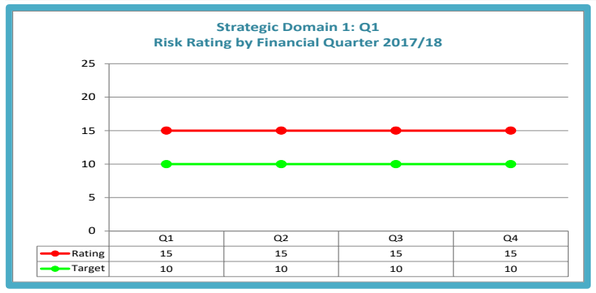
# Strategic Domain 1: Delivering Outstanding Clinical Quality, Safety & Experience

| 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 | March 2018 | June 2018 | Safe, Effective, Responsive, Caring & Well Led<br>NHSI – Quality Metrics | Director of Nursing & Quality | Executive Quality Governance Group (EQGG)<br>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 4. 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 with positive feedback received from NHS England. The quality reports at ward / department and divisional level have been developed with roll out and Executive led quarterly quality assurance reviews planned to be in place by October 2018. The new Quality & Safety Improvement Strategy for 2018/19 is in development following an engagement process. The proposed quality priorities will be presented at Quality Governance Committee in April 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
- Development of new Quality & Safety Improvement Strategy 2018/19
- Internal Well-Led Review improvement actions – quarterly oversight at Quality Governance Committee

# Board Assurance Framework 2017-18

*Supporting our Journey from 'Good' to 'Outstanding'*
*by Delivering Excellence in Healthcare through Innovation and Collaboration.*

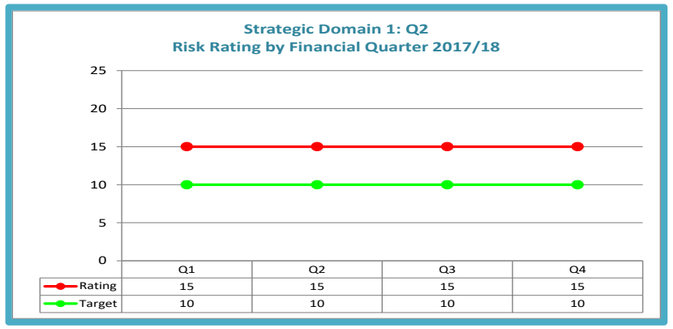
Mid Cheshire Hospitals NHS Foundation Trust

## 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. |
|---|---|

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 | March 2018 | June 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 4 for a number of reasons. The Quality 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 (Q3) containing the nationally mandated dashboard was presented at Board in March 2018 and details the breadth of improvements in place and current position with HSMR/SHMI.

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 and improvement plans have been developed by the divisions. The next submission will cover Friday 13 April 2018 – Thursday 19 April 2018

The Deteriorating Patient Steering Group met again in March 2018 and a launch date of 5 November 2018 was agreed for NEWS 2. The Trust has sought the support of the NHS Innovation Agency for NEWS 2 and onsite education and training on the QI Life System has been arranged for April 2018. The Trust has also applied to send a team to the AQUA Deteriorating Patient Safety Collaborative spanning 2018/19.

**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

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

| | |
|---|---|
| **P1** | on in the designing and delivery of sustainable health services for the population of Central and Eastern Cheshire, whilst acknowledging and responding to:<br>- National and regional strategies.<br>- The need for sustainable high quality clinical services.<br>- Favourable economies of scale and removal of unwarranted variation.<br>- 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 | April 2018 | June 2018 | Well Led NHSI - Use of Resources | CEO | Board of Directors | Performance & Finance |

**Strategic Domain 2: P1**
**Risk Rating by Financial Quarter 2017/18**


| | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|
| Rating | 20 | 20 | 20 | 16 |
| Target | 10 | 10 | 10 | 10 |

| 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 | **⇩16** | 5 | 2 | **10** | March 2019 |

**Rationale for the Current Risk Score (Quarter 4)**

The risk score for quarter 4 has been reduced to reflect the progress made to date. The Pathology Collaborative is progressing service by service with short, medium and long term actions. Agreements made not to progress elective work with UHNM currently. The Director of Strategic Partnerships is progressing the breast screening programme with East Cheshire Trust. New and existing partnerships will also be fashioned to support delivery of the Health & Care Partnership for Cheshire & Mersey (H&CP for C&M), as part of the acute sustainability programme. Mrs Bullock has been appointed as the Senior Responsible Officer for the acute sustainability programme for the H&CP for C&M. The programme scopes are developed and programmes are underway. Horizontal partnership agreements with other organisations are working well, with further partnerships being developed as a result of CEP e.g. Betsi Cadwaladr University Health Board with a contract agreed for next year. East Cheshire pace is slower with tripartite meetings to be set up with Stockport, East and Mid Cheshire to agree services.

**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. 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 took place in February 2018. Following the approval of the new Trust Strategy and supporting divisional and CCICP plans a communications plan update was received at the April Board of Directors.

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

- Trust Strategy launch February 2018 with communications plan to Board of Directors 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 2: Being a Leading Partner in a Progressive Health Economy

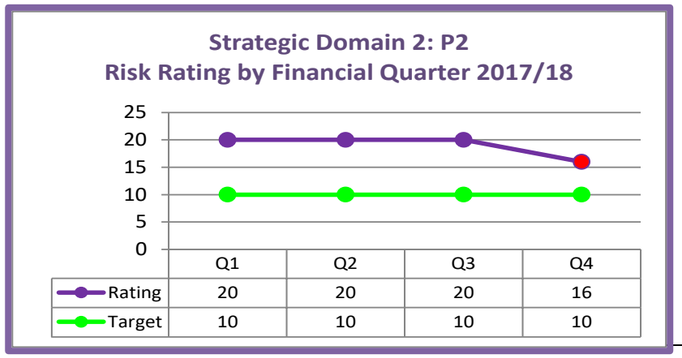
| | |
|---|---|
| **P2** | **To work with all key stakeholders to deliver a wholly integrated health and social care system, taking on clear collective responsibility for resources and population health, so that our residents receive better coordinated care within the designated financial envelope, whilst ensuring:**<br>- **National and regional strategies are implemented.**<br>- **The sustainable use of resources to deliver agreed health outcomes.**<br>- **The development of a collective decision making and governance structure.**<br>- **Sustainable clinical services through the development of Integrated Care Systems / 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 | April 2018 | June 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 | **⇩16** | 5 | 2 | **10** | March 2019 |

**Rationale for the Current Risk Score**

The risk score reduced to reflect progression in quarter 4. Central & East Cheshire Single Partnership Board now have a joint independent chair appointed, with an executive oversight group chaired by Mrs Bullock. Key workstream SROs and scopes are developed and identified with monitoring through the PMO. Fortnightly executive oversight group meetings are in place monitoring the 5 key work streams and enabling workstreams. Key are the workstreams in relation to the integration of primary and community care and development of the ICO. Both report to the fortnightly executive group with deep dives undertaken at the monthly Board meeting. CCICP underwent facilitated sessions by NHSI to improve the partnership working and agree a vision & strategic objectives. It was also agreed that an independent chair should be sought and interviews will be held on 19 April 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 a Health & Care Partnership for Cheshire & Mersey enabling high quality care to be delivered by the right professional in the right place at the right time. PMO establishment supported by NHS England in place with each organisation contributing.

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

- Re-launching UHNM / MCHFT Stronger Together Programme meetings
- NHSI facilitated meetings - actions monitored at CCICP Board
- Fully established PMO

# Board Assurance Framework 2017-18

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We Care Because You Matter

Mid Cheshire Hospitals NHS Foundation Trust

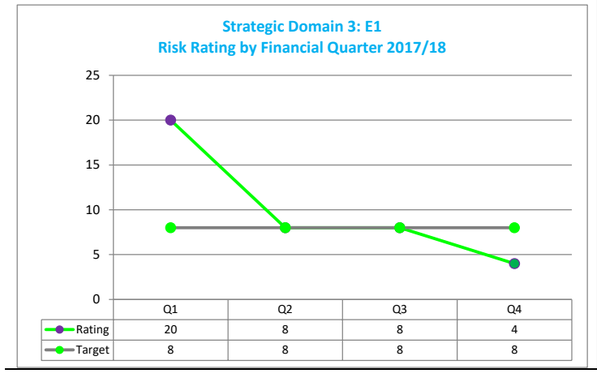
## Strategic Domain 3: Striving for Outstanding Organisational Effectiveness

| E1 | To ensure full compliance with the NHS Improvement Provider Licence, ensuring financial sustainability, financial efficiency 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 | April 2018 | June 2018 | Well Led<br>NHSI - Use of Resources | Director of Finance and Strategic Planning | Divisional Finance & Activity Performance 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 |
| 4 | 5 | **20** | 4 | ⇩1 | **⇩4** | 4 | 2 | **8** | March 2018 |

**Rationale for the Current Risk Score**

The Trust has delivered its financial control total for 2017/18 and agreed a contract for 2018/19 which supports the delivery of the 2018/19 financial target. The Trust has delivered a range of cost improvement programmes and as part of the Capped Expenditure Programme delivered significant further savings across the health economy. Risk score reduced to 4 in quarter 4.

**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?)**

Work on internal transformation programmes to improve efficiencies has continued alongside the wider collaborations of "Stronger Together" Programme with the University Hospitals of North Midlands and the wider engagement at all levels with the Health & Care Partnership for Cheshire & Mersey. The Trust underwent an NHS Improvement Use of Resources assessment in March 2018 and the formal report is awaited.

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

- Re-launch Connecting Care Board
- Transformation programmes in place including Alternatives to Admissions, Ward Processes (Reducing Length of Stay) and Improving Discharge Processes.

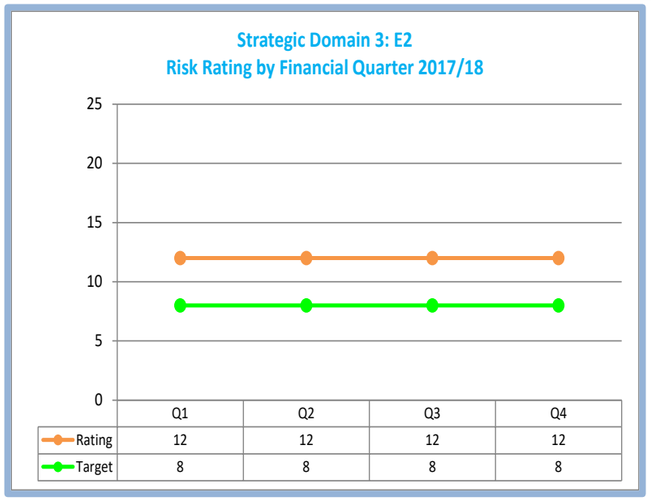
## Strategic Domain 3: Striving for Outstanding Organisational Effectiveness

| 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 | April 2018 | June 2018 | Responsive Care & Effective Care<br>NHSI - Operational Performance Metrics | Chief Operating Officer | Divisional Finance & Activity Performance 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 |
| 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. However increases in outpatient referrals or emergency admissions may have an impact on delivery of the Single Oversight Framework.

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 STF trajectory was not achieved in Q3 or Q4.

**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 June 2018.

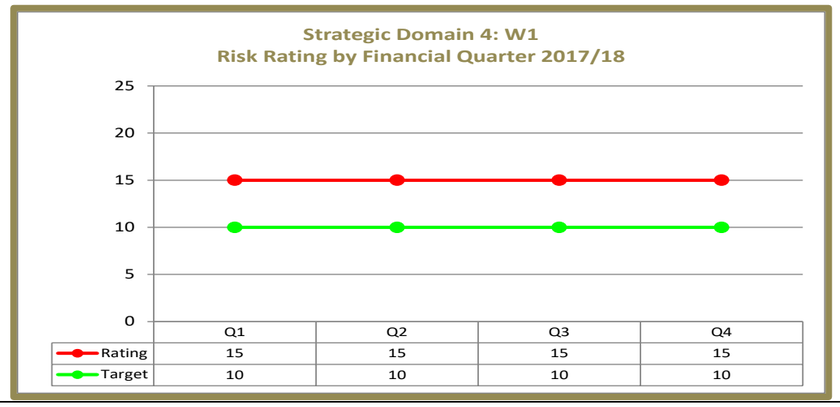
## Strategic Domain 4: Aspiring to Excellence in Practice through Our Workforce

| W1 | 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 | April 2018 | June 2018 | Well Led Framework<br>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 consultant 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 was held in January 2018 with Chris Hopson CEO from NHS providers presenting with further leadership development sessions planned.

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

- Approval of Workforce & OD Strategy (Workforce Matters Strategy) in June 2018
- Review of Education Governance framework by April 2018
- Local development of improvement plans following the National Staff Survey results

# Board Assurance Framework 2017-18

*Delivering Excellence in Healthcare through Innovation and Collaboration.*

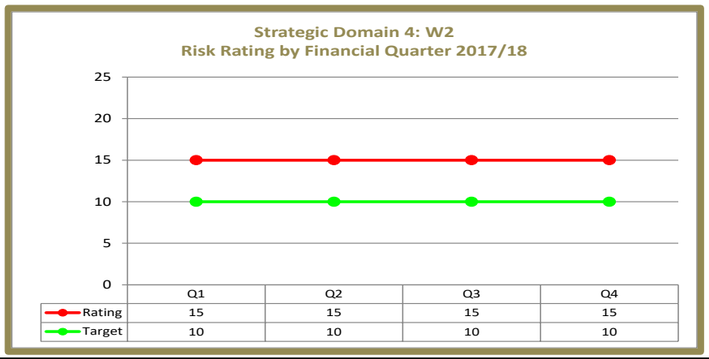
## Strategic Domain 4: Aspiring to Excellence in Practice through Our Workforce

| | |
|---|---|
| W2 | We will have in place a flexible and responsive workforce to meet patient needs by ensuring:<br>- services across seven days.<br>- Staff continually engaging in professional development regardless of their role.<br>- Effective workforce planning to secure existing, and mitigate against anticipated shortages in skills.<br>- 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 | April 2018 | June 2018 | Well Led Framework<br>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 remains for Q4 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 81.84% in January 2018 and therefore further improvement required to meet the target of 90% year end. CCICP have now achieved 93% from a very low starting position in April 2017. A very slight decline in the appraisal rate at 81.84% against a target of 90% in January 2018. Oversight by local human resources managers continues.

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

- Approval of Workforce & OD Strategy (Workforce Matters) by March 2018
- Review of Education Governance framework by April 2018
- Local development of improvement plans following the National Staff Survey results
- Talent management & succession planning programme planned

# Board Assurance Framework 2017-18

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We Care Because You Matter

NHS Mid Cheshire Hospitals NHS Foundation Trust

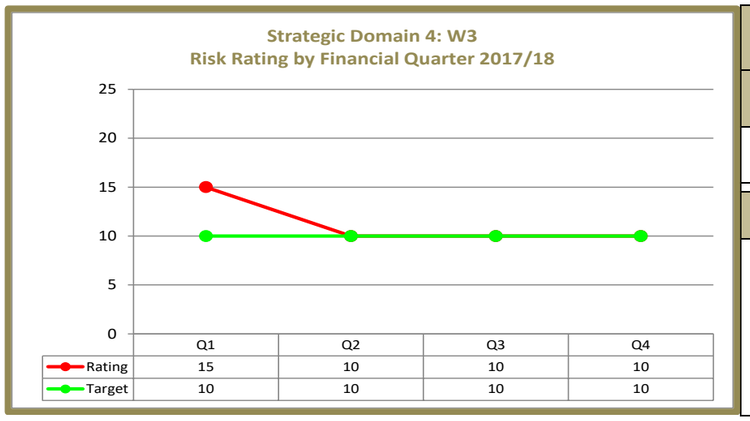
## Strategic Domain 4: Aspiring to Excellence in Practice through our Workforce

| | |
|---|---|
| **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 | April 2018 | June 2018 | Well Led Framework<br>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**

Risk score remains the same for quarter 4. For the third consecutive month there has been a small increase in both the rolling average sickness absence (4.28% against a target of 3.60%) and the in-month sickness absence rate in January 2018, which was 5.3%.

**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?)**

A review of the Sickness Absence Policy has been brought forward to develop a more robust approach for short-term absence management. As at 31st January 2018, only 2 staff had been absent for 6 months or more. In addition, it is noted that 90 staff have had more than 4 episode of absence in the last 12 months.

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

- Talent management & succession planning programme planned
- Divisional improvement plans to respond to staff surveys
- Review of Sickness Absence Policy

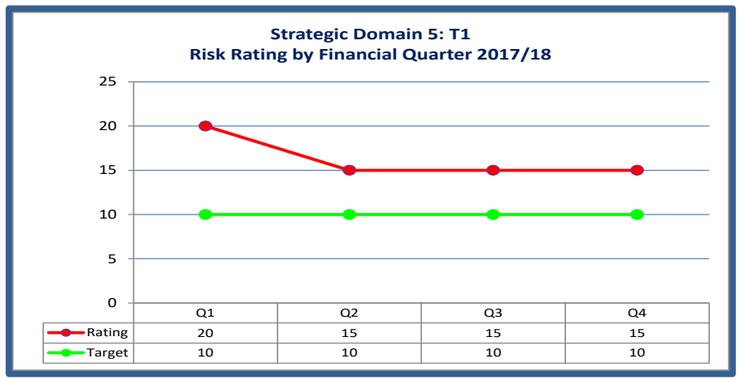
## Strategic Domain 5: Creating a 21st Century Infrastructure for Transformative Health and Social Care

| | |
|---|---|
| **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 | April 2018 | June 2018 | Well Led Framework<br>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 and the ability to raise cash to service these.

**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 recently refreshed the 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 lease agreements. The Divisional Director of Estates is the SRO for Estates developments & opportunities across the Cheshire East foot print and represents the local Place within the C&M system estates group.

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

- Refresh of the Estates Strategy in progress with oversight at Executive Infrastructure Development Group
- Asbestos Management Group – oversight of new contractors in progress

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

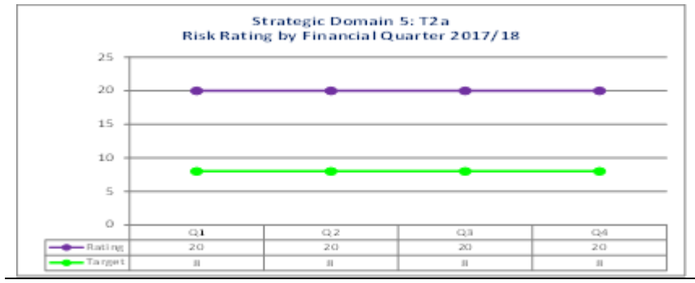
| T2a | To deliver an agreed, costed and phased Information Technology (IT) Strategy which supports the provision of seamless, integrated, outstanding patient care, improves staff experience in delivering care and enables continuous quality and service improvements through the intelligent use of secure, 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)
- Inability to modernise services (E.g. E Prescribing)
- 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 | April 2018 | June 2018 | Well Led Framework<br>Use of Resources | Medical Director / Deputy 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 |
| 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 the Board of Directors in January 2018 and submitted to NHSI / NHS Digital. Feedback has been received from both NHSI & NHS Digital and the business case has been updated & resubmitted.

**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 Integrated Care Systems / Organisations (ACO). 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. A business case to replace aged hardware across the organisation will be submitted to the EMT in early 2018/19. This is a revenue based model and does not require capital monies. An E-rostering project revenue based model has been included in the developments for 2018/19 and will be commenced in Q1. The Trust has been awarded £900,000 national funding to improve cyber security measures across the Trust. The Trust scored 91% (Satisfactory) for the Information Governance Toolkit in March 2018.

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

- Progress EPR Business Case
- Undertake 10 Steps to Cyber Security gap analysis in Quarter 4 2017/18
- GDPR gap analysis & plan in Quarter 4 2017/18
- Hardware business case – replacement of aged hardware in development
- E-Rostering programme to commence quarter 1 2018/19

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

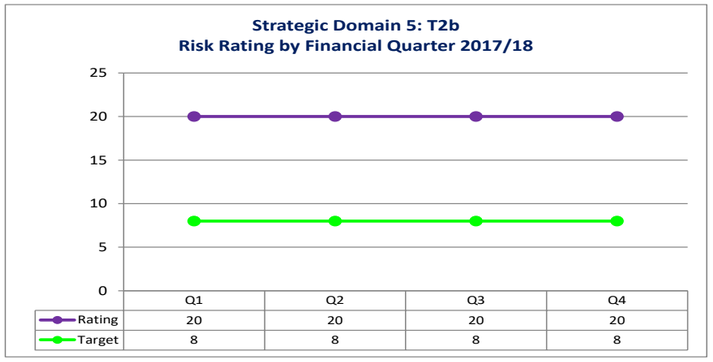
| | |
|---|---|
| **T2b** | To deliver an agreed, costed and phased Information Technology (IT) Strategy which supports the provision of seamless, integrated, outstanding patient care, improves staff experience in delivering care and enables continuous quality and service improvements through the intelligent 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)
- Inability to modernise services (E.g. E Prescribing)
- 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 | April 2018 | June 2018 | Well Led Framework<br>Use of Resources | Medical Director / Deputy 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 |
| 4 | 5 | 20 | 4 | 5 | 20 | 4 | 2 | 8 | March 2019 |

**Rationale for the Current Risk Score**

Retain current score in quarter 4 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.
- E- Rostering to commence quarter 1 2018/19

| Appendix 1: Strategic Objectives & Success Measures 2018/19 | Domain One: Delivering Outstanding Clinical Quality, Safety & Experience |
|---|---|
| **Objective Q1.**<br>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:**<br>• Implementing the Quality and Safety Improvement Strategy making this inclusive of all staff<br>• Ensuring compliance with all legal and regulatory requirements<br>• Using local and national benchmarking data to demonstrate consistently high quality clinical care with no unwarranted variation and top quartile performance.<br>• 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.<br>• Progressing the continuous learning culture through recognised processes of good governance to evidence sustainable improvements to patient safety, quality of care and outcomes.<br>• Working with clinical teams to ensure documentation and record keeping are robust and accurate |
| **Objective Q2.**<br>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:**<br>• Progressing towards an 'Outstanding' CQC rating through a clinical quality improvement programme that is Executive led and clinically owned and supported<br>• 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<br>• Leading on local and national safety collaborations to achieve best practice through influencing national directives and local practice<br>• Ensuring clinical service needs where required are delivered equitably across 7 days<br>• 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.<br>• Use evidence led accreditation in research & innovation to support research studies |
| **Domain Two: Being a Leading Partner in a Progressive Health Economy** | |
| **Objective P1.**<br>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:<br>National and regional strategies.<br>- The need for sustainable high quality clinical services.<br>- Favourable economies of scale and removal of unwarranted variation.<br>- The cost effective sustainable use of resources. | **We will know when we have succeeded by measuring what matters and through:**<br>• Playing a leading role in implementing the NHS Cheshire & Merseyside Plan with demonstrable outputs and outcomes:<br>- 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.<br>- Supporting the development and delivery of the NHS Cheshire & Mersey, Cheshire & Wirral work streams<br>• 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<br>• Playing a leading role in shaping and delivering the Long Term Sustainability Review:<br>- 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.<br>- With health economy partners, consider longer term options and develop the case to enable MCHFT to provide long term sustainability for ECT<br>- 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<br>• 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.**<br>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:<br>- National and regional strategies are implemented.<br>- The sustainable use of resources to deliver agreed health outcomes.<br>- The development of a collective decision making and governance structure.<br>- 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:**<br>• 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:<br>- Care Communities and Primary Care Home through GP clusters for populations of 30 – 50k<br>- 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<br>- Enabling infrastructure that transforms the organisational development and culture of the workforce.<br>• 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:<br>- Promotes self care and prevention including vaccination and screening programmes alongside education to make our population healthier<br>- Ensures the Health Economy lives within its means and funds are used in the most effective way to optimise patient outcomes.<br>- Provide sustainable high quality local clinical services that are valued by the population of Central Cheshire.<br>• 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.**<br>To ensure full compliance with the NHS Improvement Provider Licence, ensuring financial sustainability, financial efficiency and financial controls, whilst safeguarding | **We will know when we have succeeded by measuring what matters and through:**<br>• Meeting the key national targets and standards including those in the NHS Constitution.<br>• 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.<br>• Delivering the efficiencies identified through the model hospital and reduce unwarranted variation across a range of productivity and clinical effectiveness measures.<br>• Achieving Segment 1 against the NHSI Single Oversight Framework.<br>• Demonstrating a Well Led organisation with good organisational health metrics.<br>• Progressing from a 'Good' to 'Outstanding' Care Quality Commission (CQC) rating.<br>• Developing and using live data to prove compliance through robust demonstrable based information. |
| **Objective E2.**<br>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.**<br>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:**<br>• Becoming an exemplar organisation for developing new clinical roles that respond to population needs across the health economy, 7 days a week.,<br>• Enhancing skills for existing staff to widen their repertoire of competence.<br>• Embedding the Trust's vision, values, behaviours and objectives across the organisation with local implementation and adaptation.<br>• 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.<br>• Further developing our culture and reputation as a caring organisation<br>• Continuing to improve our staff survey results and maintain our position to be in the top quartile nationally.<br>• Demonstrating a Well Led organisation with good organisational health metrics.<br>• Progressing from a 'Good' to 'Outstanding' Care Quality Commission (CQC) rating. |
| **Objective W2.**<br>We will have in place a flexible and responsive workforce to meet patient needs by ensuring:<br>- 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.<br>- Representing the diversity of our local population<br>- Staff continually engaging in professional development regardless of their role.<br>- Effective workforce planning to secure existing, and mitigate against anticipated<br>- Take a proactive approach to developing our future workforce by engaging with the local community and education providers. | |
| **Objective W3.**<br>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. | |

# 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 Five: Creating a 21st Century Infrastructure for Transformative Health and Social Care | |
|---|---|
| **Objective T1.**<br>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:**<br>• 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.<br>• Working with health economy partners to maximise estate utilisation for properties owned / not owned by MCHFT / CCICP.<br>• Understanding and using the IT developments in CCICP as a baseline for the transformation interdependencies of IT and Estates Infrastructure<br>• Providing a modern, safe, fit for purpose environment to deliver outstanding quality care in the most appropriate location.<br>• 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.<br>• 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.<br>• 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.**<br>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:**<br>• 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.<br>• 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<br>• 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.<br>Not confident risk can be managed at this level and contingency is required | More than 80% chance of occurring | A regular occurrence.<br>Circumstances found frequently |
| Likely | This event is likely to occur in most circumstances.<br>Requires additional mitigation/contingency.<br>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.<br>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.<br>Very confident risk can be managed at this level.<br>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?

| | | |
|---|---|---|
| ***Title of Paper :*** | Learning from Deaths Quarterly Report (Q4 2017/18) | |
| ***Author:*** | Associate Director of Quality 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:*** | To provide the Board with an oversight of our mortality information, how we share the learning arising from the review of in-patient deaths and the projects in place to drive quality improvement. |
| ***Risk:*** | Gaps in assurances and lack of oversight of key areas impacting on the quality of the care we deliver and associated reputational risks. |

| | |
|---|---|
| ***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:*** | 4 June 2018 |

# Learning from Deaths Quarterly Report Q4 2017/2018

## May 2018

*'Delivering Excellence in Healthcare through Innovation and Collaboration'*

## Contents

## 1.0 Introduction

### Background

During 2016/17 a number of national documents have been published relating to mortality and learning from deaths. The Care Quality Commission (CQC) report, *Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England* was published in December 2016 and in response, the Trust completed a gap analysis to determine our position and improvement opportunities, which are monitored through the Hospital Mortality Reduction Group (HMRG). Later in March 2017, the National Quality Board published the *National Guidance on Learning from Deaths* document, which aims to initiate a standardised national approach to learning from deaths. A subsequent document was published in July 2017 by NHS Improvement detailing key areas of focus for trust boards which includes:

- policy publication requirements;
- case selection and review methods;
- responding to the death of particular patients;
- selection of deaths to investigate; and
- engagement with families/carers.

In line with national requirements we published our *Learning from Deaths Policy* on the Trust internet in September 2017, completing a confirmation of action return to NHS England. This policy builds upon the existing policy and embedded associated processes and outlines the process for reviewing deaths and how the organisation learns from these reviews.

### Purpose

This is the third iteration of our Learning from Deaths Report covering quarter 4.

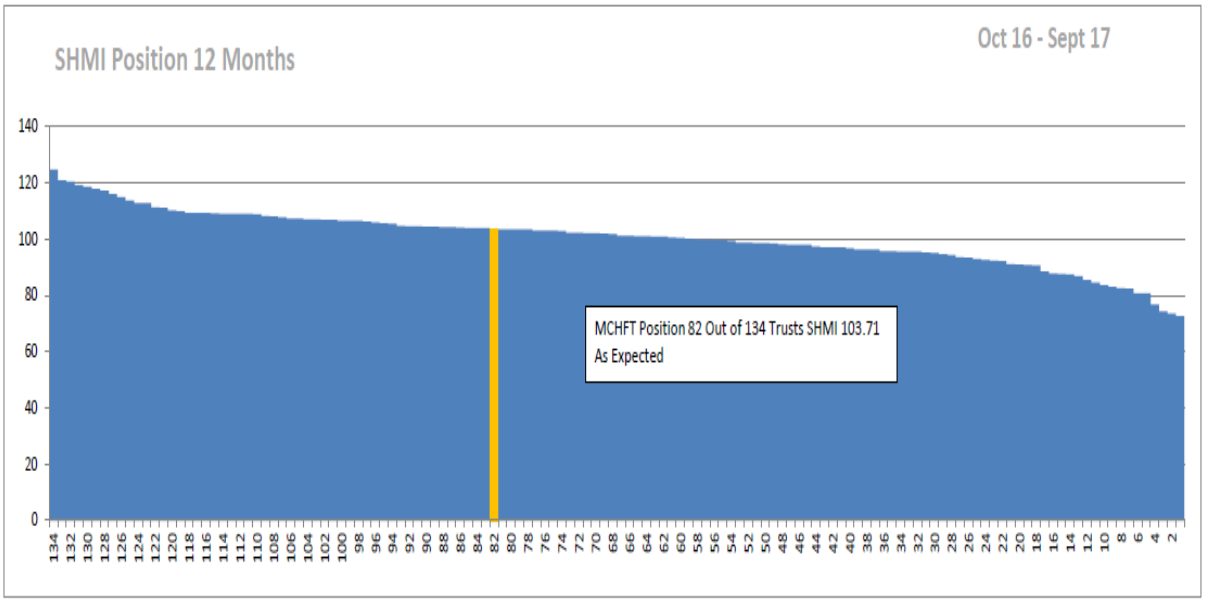
The report will be produced and developed on a quarterly basis and aims to provide assurance on how the organisation, through the work of the HMRG and other linking groups, is triangulating data and information to enable sustained learning from deaths, with the goal of seeing a sustained reduction in mortality figures.

Appendices 6.2 and 6.3 provide a glossary of key terms.

## 2.0 Trust Mortality Data

## 2.1 Summary Hospital-level Mortality Indicator (SHMI) October 2016 to September 2017

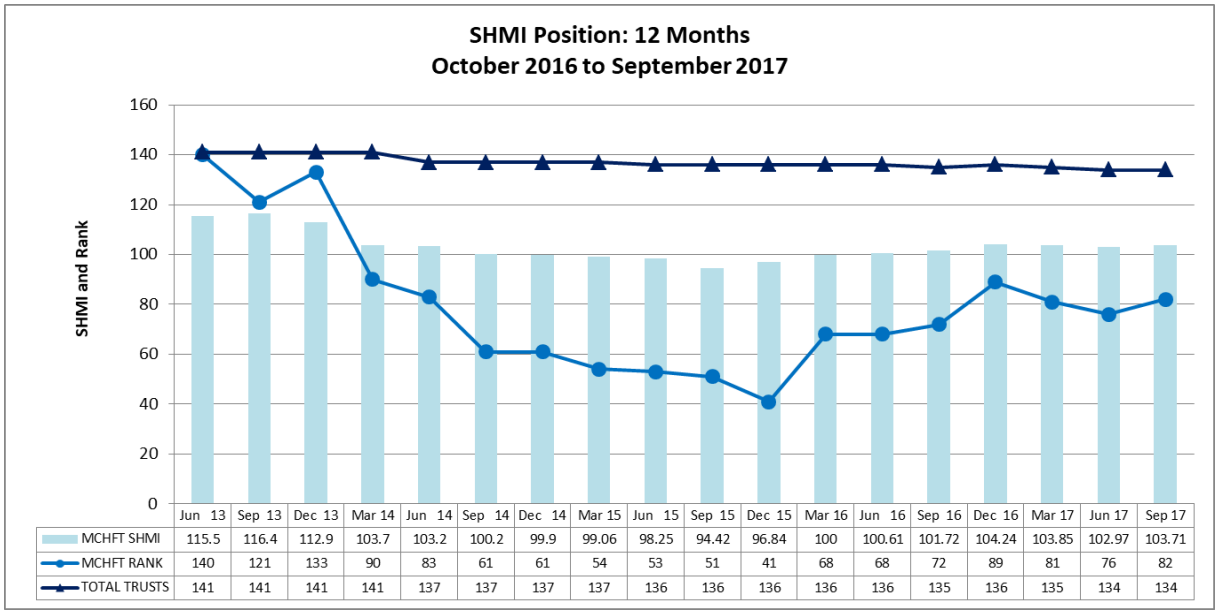
### Chart 1 - SHMI Position




(Source NHS Digital, 2018)

Chart 1 demonstrates the SHMI position for the reporting period October 2016 to September 2017. The SHMI is currently 103.71 and is in the 'as expected' range. This currently places the Trust 82 out of 134. This is compared to the previous reporting period of July 2016 to June 2017, when the SHMI was 102.97 with a position of 76 out of 134 Trusts.

### Chart 2 - 12 month rolling SHMI and position

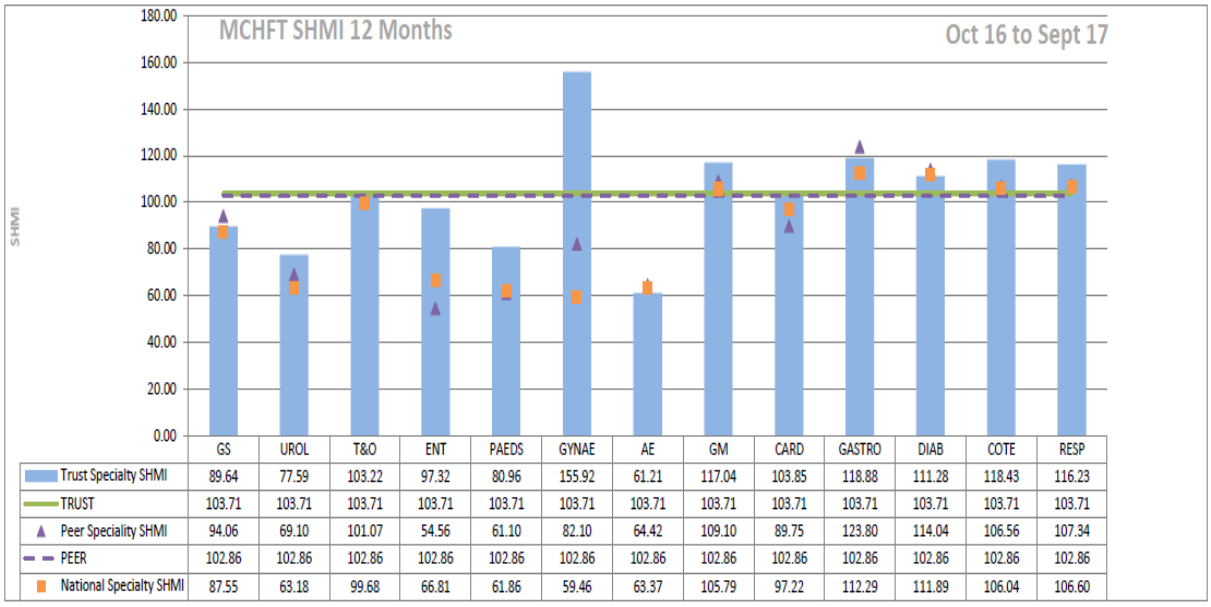



| | Jun 13 | Sep 13 | Dec 13 | Mar 14 | Jun 14 | Sep 14 | Dec 14 | Mar 15 | Jun 15 | Sep 15 | Dec 15 | Mar 16 | Jun 16 | Sep 16 | Dec 16 | Mar 17 | Jun 17 | Sep 17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| MCHFT SHMI | 115.5 | 116.4 | 112.9 | 103.7 | 103.2 | 100.2 | 99.9 | 99.06 | 98.25 | 94.42 | 96.84 | 100 | 100.61 | 101.72 | 104.24 | 103.85 | 102.97 | 103.71 |
| MCHFT RANK | 140 | 121 | 133 | 90 | 83 | 61 | 61 | 54 | 53 | 51 | 41 | 68 | 68 | 72 | 89 | 81 | 76 | 82 |
| TOTAL TRUSTS | 141 | 141 | 141 | 141 | 137 | 137 | 137 | 137 | 136 | 136 | 136 | 136 | 136 | 135 | 136 | 135 | 134 | 134 |

(Source NHS Digital, 2018)

Chart 2 demonstrates the SHMI and rank of the Trust for each of the 12 month rolling position submissions for the period to the latest submission October 2016 to September 2017.

**Chart 3 - SHMI by Speciality**




| | GS | UROL | T&O | ENT | PAEDS | GYNAE | AE | GM | CARD | GASTRO | DIAB | COTE | RESP |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Trust Specialty SHMI | 89.64 | 77.59 | 103.22 | 97.32 | 80.96 | 155.92 | 61.21 | 117.04 | 103.85 | 118.88 | 111.28 | 118.43 | 116.23 |
| TRUST | 103.71 | 103.71 | 103.71 | 103.71 | 103.71 | 103.71 | 103.71 | 103.71 | 103.71 | 103.71 | 103.71 | 103.71 | 103.71 |
| Peer Speciality SHMI | 94.06 | 69.10 | 101.07 | 54.56 | 61.10 | 82.10 | 64.42 | 109.10 | 89.75 | 123.80 | 114.04 | 106.56 | 107.34 |
| PEER | 102.86 | 102.86 | 102.86 | 102.86 | 102.86 | 102.86 | 102.86 | 102.86 | 102.86 | 102.86 | 102.86 | 102.86 | 102.86 |
| National Specialty SHMI | 87.55 | 63.18 | 99.68 | 66.81 | 61.86 | 59.46 | 63.37 | 105.79 | 97.22 | 112.29 | 111.89 | 106.04 | 106.60 |

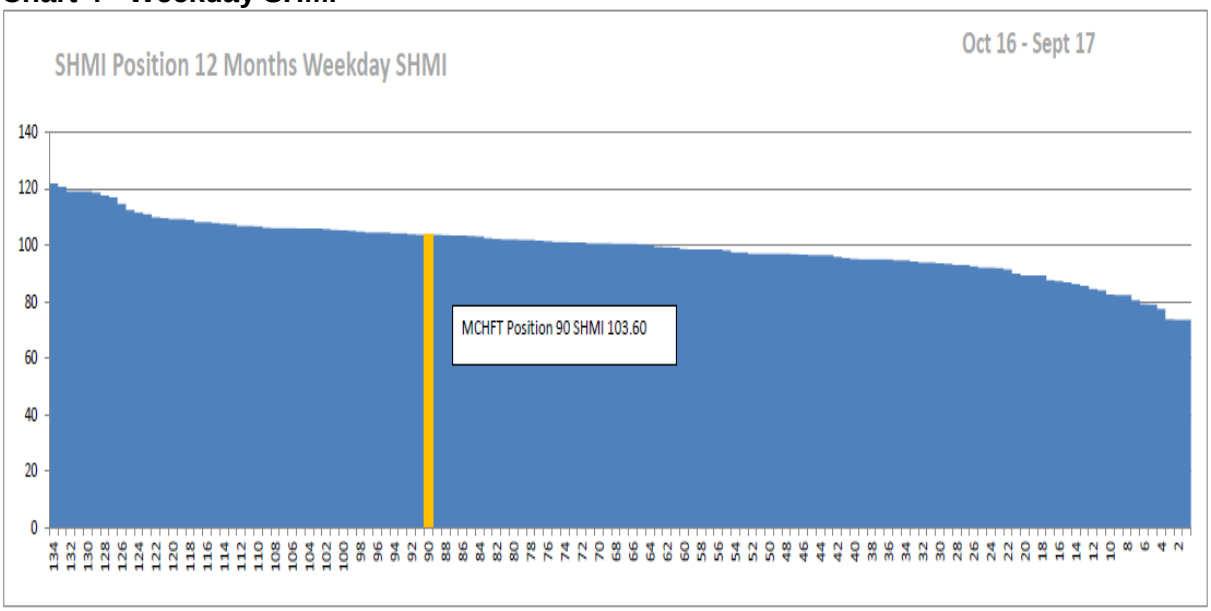
(Source HED, 2018)

Chart 3 demonstrates the SHMI by Specialty monthly HED position against peer and the national average. The data is derived from the quarterly SHMI release from NHS Digital processed by HED. The specialties, which are currently above both national average and peer, are Urology, ENT, Trauma & Orthopaedics, Paediatrics, Gynaecology, General Medicine, Cardiology, Care of the Elderly and Respiratory.

Gastroenterology and General Surgery are above the national average but below peer. Diabetology, A&E and Urology are below both the national average and peer.

A deep dive has been undertaken by the HMRG to look at the SHMI for gynaecology. The details of the deep dive will be included in the quarter 1 report for 2018/2019.

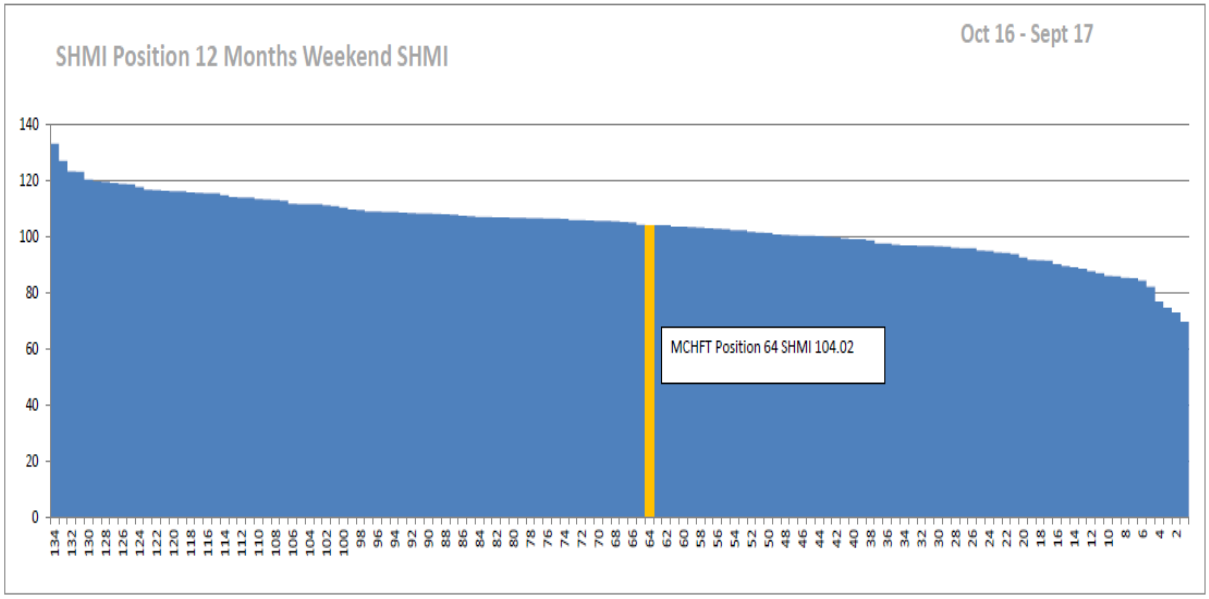
**Chart 4 - Weekday SHMI**




(Source HED, 2018)

Chart 4 demonstrates the weekday SHMI position for the reporting period October 2016 to September 2017. The weekday SHMI is currently 103.6 and places the Trust 90 out of 134.

**Chart 5 - Weekend SHMI**




(Source HED, 2018)

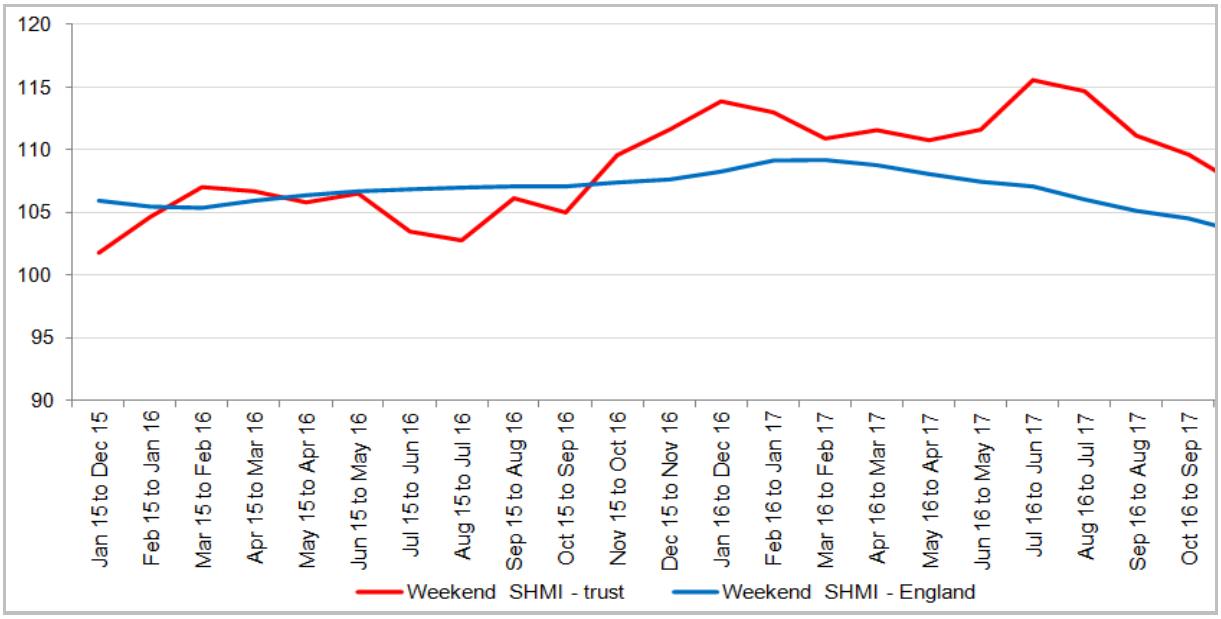
Chart 5 demonstrates the weekend SHMI position for the reporting period October 2016 to September 2017. The weekend SHMI is currently 104.02 and places the Trust 64 out of 134.

**Chart 6 - Trust Weekday SHMI compared to England**

(Source NHS Improvement, 2018)

Chart 6 demonstrates the Trust weekday SHMI compared to England for the period October 2016 to September 2017.

**Chart 7 - Trust Weekend SHMI compared to England**

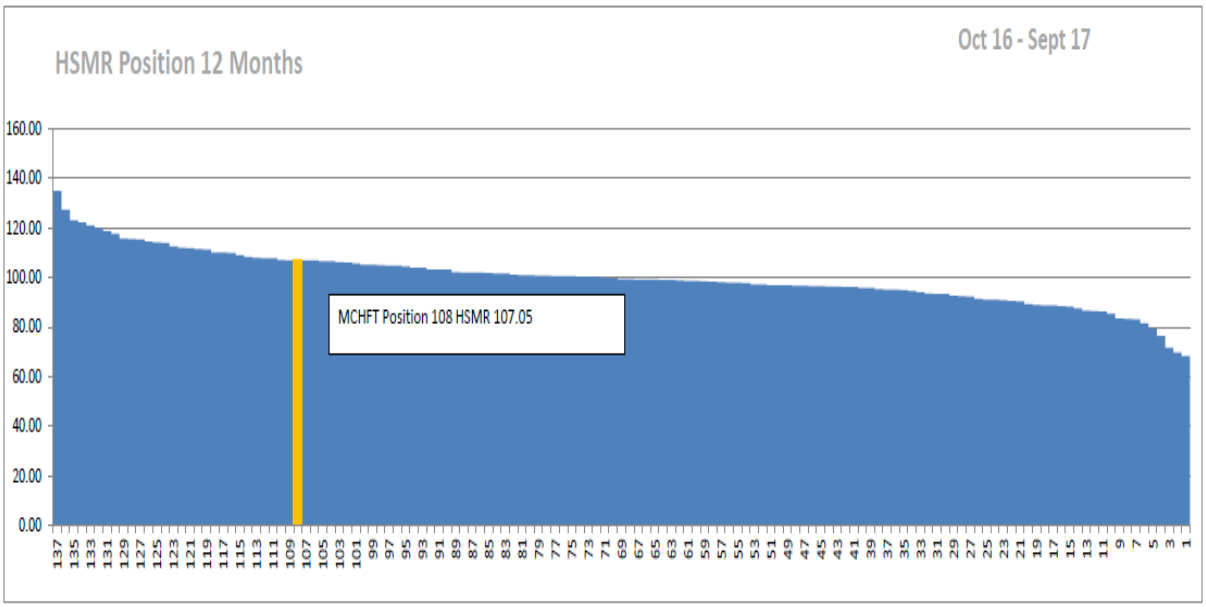



(Source NHS Improvement, 2018)

Chart 7 demonstrates the Trust weekend SHMI compared to England for the period October 2016 to September 2017.

## 2.2 Hospital Standardised Mortality Rate (HSMR) October 2016 to September 2017

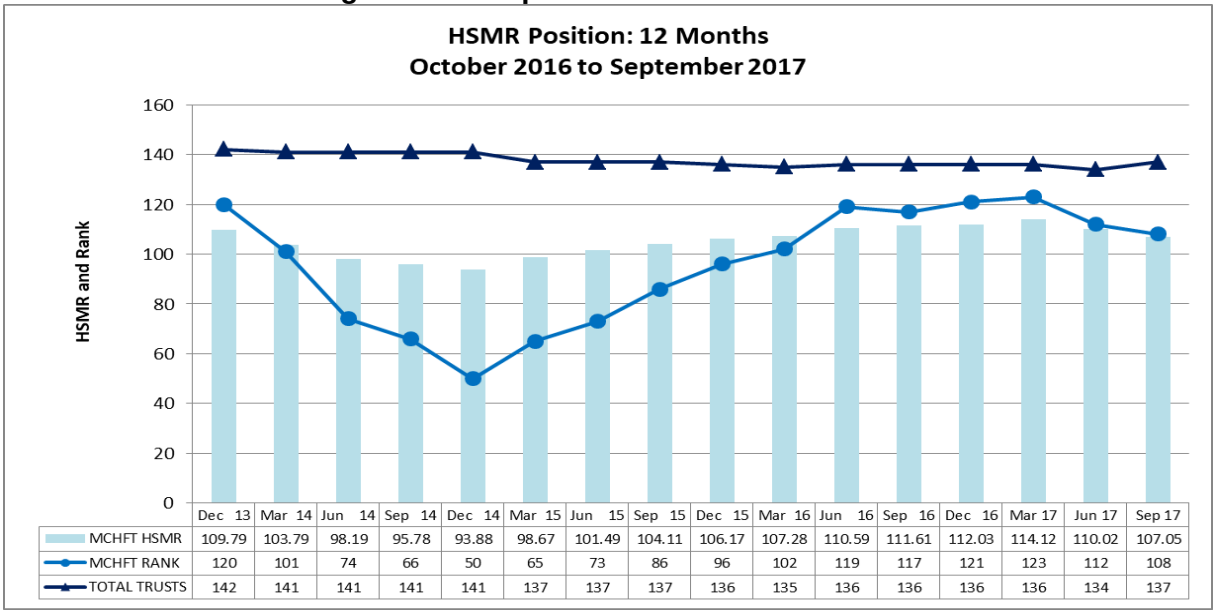
**Chart 8 - HSMR Position**




(Source HED, 2018)

Chart 8 demonstrates the HSMR position for the reporting period October 2016 to September 2017. The HSMR is currently 107.05. This currently places the Trust 108 out of 137. This demonstrates an improving picture compared to the previous reporting period of July 2016 to June 2017, when the HSMR was 110.02 with a position of 112 out of 136 Trusts.

**Chart 9 - 12 month rolling HSMR and position**

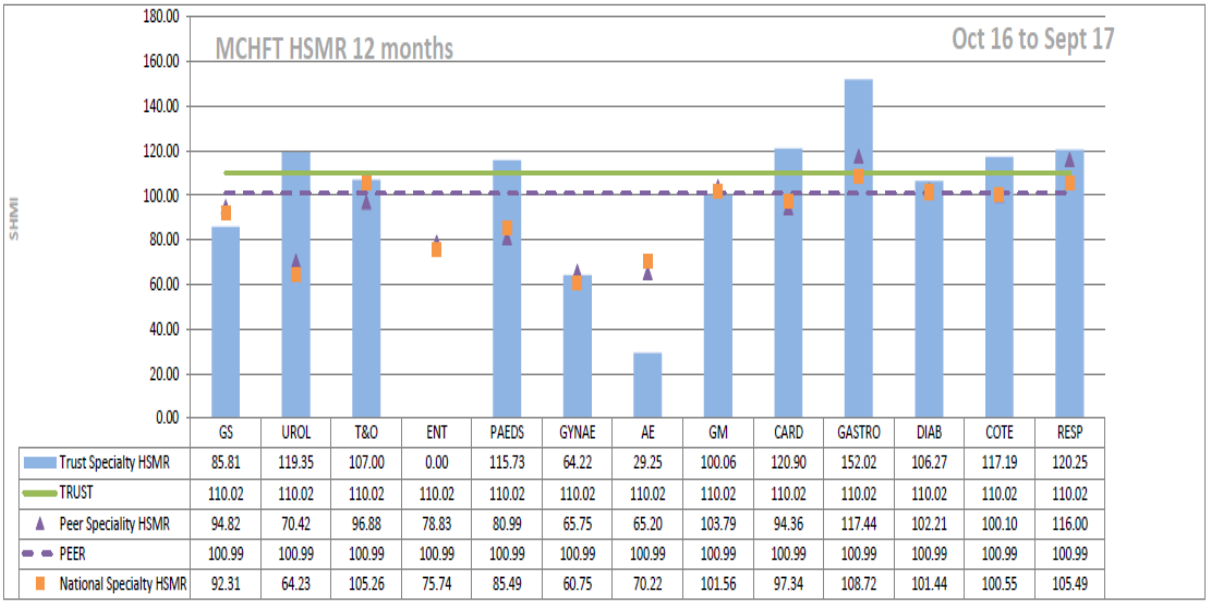



| | Dec 13 | Mar 14 | Jun 14 | Sep 14 | Dec 14 | Mar 15 | Jun 15 | Sep 15 | Dec 15 | Mar 16 | Jun 16 | Sep 16 | Dec 16 | Mar 17 | Jun 17 | Sep 17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| MCHFT HSMR | 109.79 | 103.79 | 98.19 | 95.78 | 93.88 | 98.67 | 101.49 | 104.11 | 106.17 | 107.28 | 110.59 | 111.61 | 112.03 | 114.12 | 110.02 | 107.05 |
| MCHFT RANK | 120 | 101 | 74 | 66 | 50 | 65 | 73 | 86 | 96 | 102 | 119 | 117 | 121 | 123 | 112 | 108 |
| TOTAL TRUSTS | 142 | 141 | 141 | 141 | 141 | 137 | 137 | 137 | 136 | 135 | 136 | 136 | 136 | 136 | 134 | 137 |

(Source HED, 2018)

Chart 9 demonstrates the HSMR and rank of the Trust for each of the 12 month rolling position submissions for the period to the latest submission October 2016 to September 2017.

**Chart 10 - HSMR by Speciality**

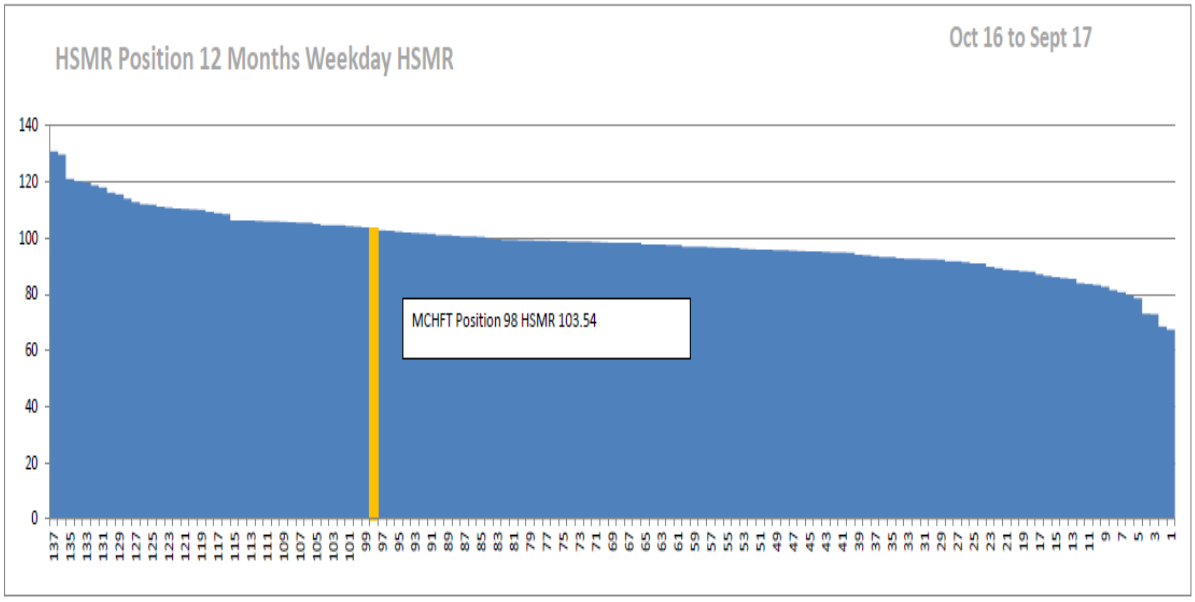



| | GS | UROL | T&O | ENT | PAEDS | GYNAE | AE | GM | CARD | GASTRO | DIAB | COTE | RESP |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Trust Specialty HSMR | 85.81 | 119.35 | 107.00 | 0.00 | 115.73 | 64.22 | 29.25 | 100.06 | 120.90 | 152.02 | 106.27 | 117.19 | 120.25 |
| TRUST | 110.02 | 110.02 | 110.02 | 110.02 | 110.02 | 110.02 | 110.02 | 110.02 | 110.02 | 110.02 | 110.02 | 110.02 | 110.02 |
| Peer Speciality HSMR | 94.82 | 70.42 | 96.88 | 78.83 | 80.99 | 65.75 | 65.20 | 103.79 | 94.36 | 117.44 | 102.21 | 100.10 | 116.00 |
| PEER | 100.99 | 100.99 | 100.99 | 100.99 | 100.99 | 100.99 | 100.99 | 100.99 | 100.99 | 100.99 | 100.99 | 100.99 | 100.99 |
| National Specialty HSMR | 92.31 | 64.23 | 105.26 | 75.74 | 85.49 | 60.75 | 70.22 | 101.56 | 97.34 | 108.72 | 101.44 | 100.55 | 105.49 |

(Source HED, 2018)

Chart 10 demonstrates the HSMR by Specialty against peer and the national average.
The specialties, which are currently above both peer and the national average are, Urology, Trauma and Orthopaedics, Paediatrics, Cardiology, Gastroenterology, Diabetology, Care of the Elderly and Respiratory.

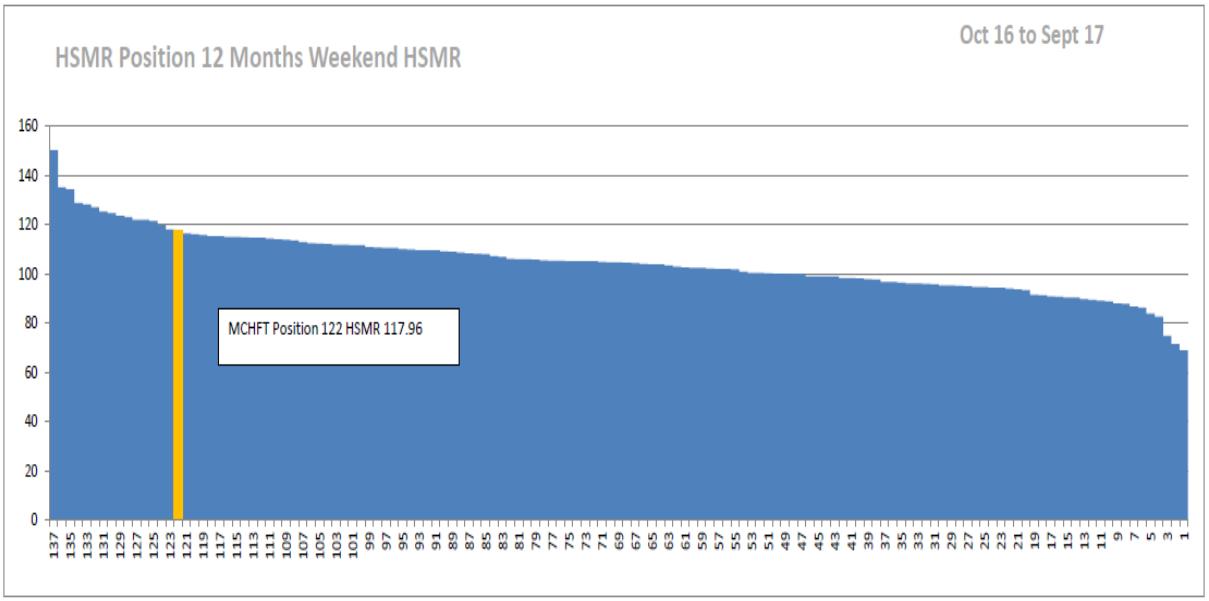
**Chart 11 - Weekday HSMR**




(Source HED, 2018)

Chart 11 demonstrates the weekday HSMR position for the reporting period October 2016 to September 2017. The weekday HSMR is currently 103.54 and places the Trust 98 out of 137.

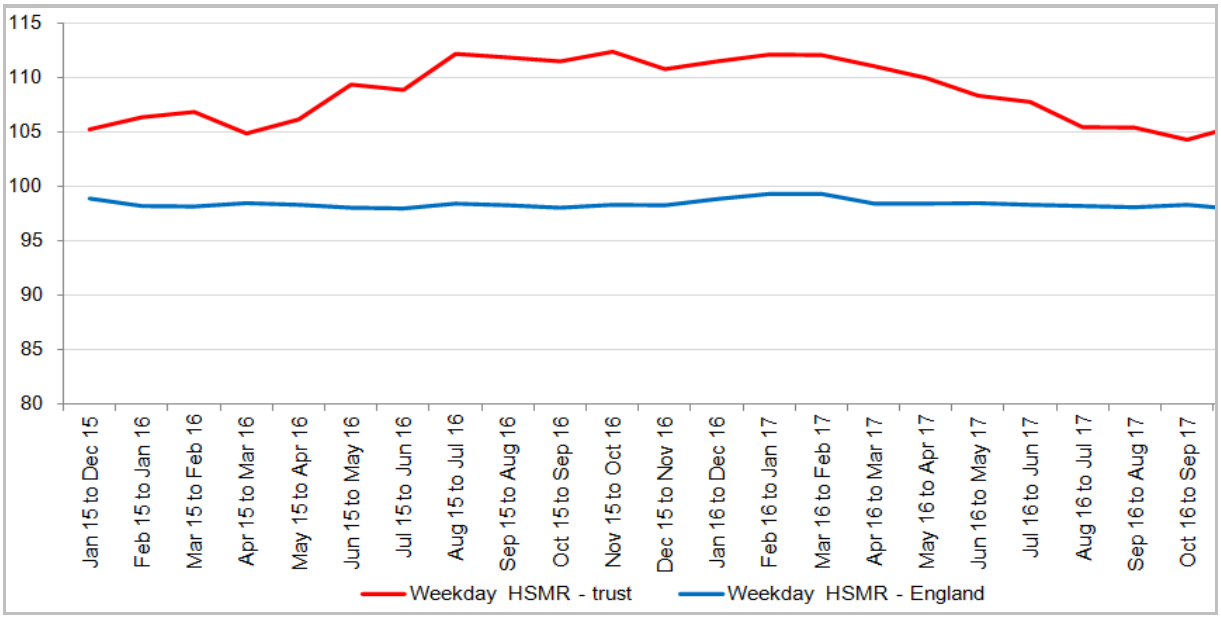
**Chart 12 - Weekend HSMR**




(Source HED, 2018)

Chart 12 demonstrates the weekend HSMR position for the reporting period October 2016 to September 2017. The weekend HSMR is currently 117.96 and places the Trust 122 out of 137

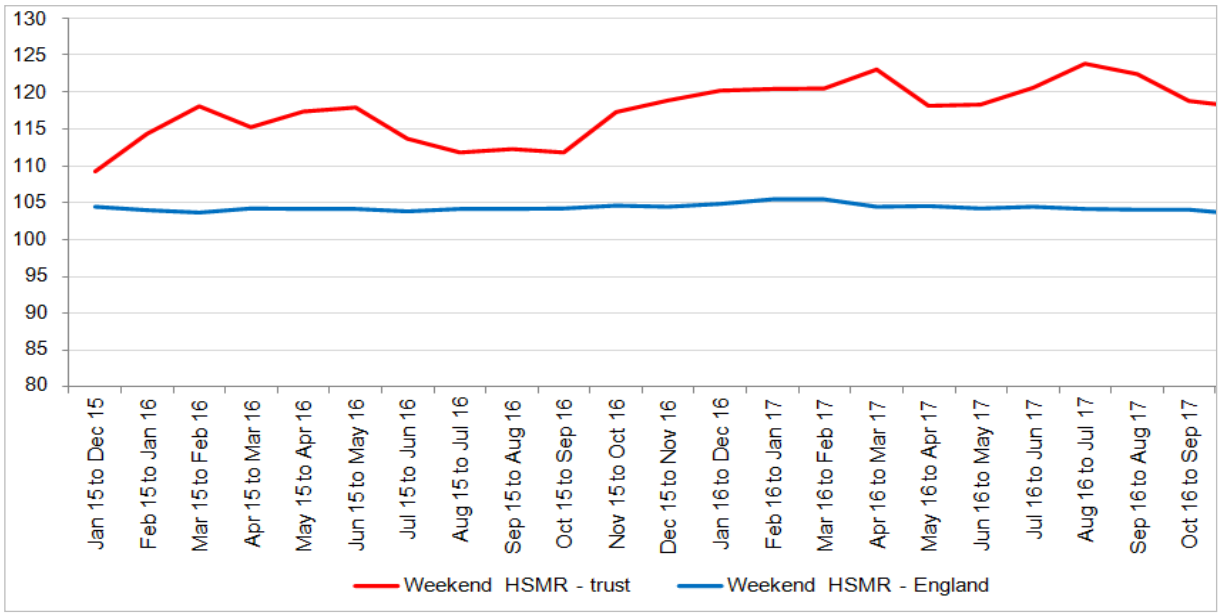
**Chart 13 - Trust Weekday HSMR compared to England**




(Source NHS Improvement, 2018)

Chart 13 demonstrates the Trust weekday HSMR compared to England for the period October 2016 to September 2017.

**Chart 14 - Trust Weekend HSMR compared to England**




(Source NHS Improvement, 2018)

Chart 14 demonstrates the Trust weekend HSMR compared to England for the period October 2016 to September 2017.

## 2.3 Learning from Deaths Dashboard – Part 1

The Trust has adopted the national Learning from Deaths Dashboard produced by the Department of Health. The dashboard is a tool to aid the systematic recording of deaths and learning and will be used to record relevant incidents of mortality, deaths reviewed and lessons learnt to drive sustained improvements. The first section of the dashboard is presented below and includes all adult inpatient deaths, excluding maternal deaths and patients with a learning disability (Section 2). The national guidance suggests the adoption of a Structured Judgement Review (SJR) but this process does not assess the potential avoidability of the death. The Trust therefore is seeking further clarification around this issue. The Trust educated a cohort of clinicians in the SJR methodology in February 2018 and the process commenced in April 2018. *Please note: Due to the time allowed for the coding process the total number of deaths in scope and the total number of reviews will not be completely aligned.*

NHS — Department of Health

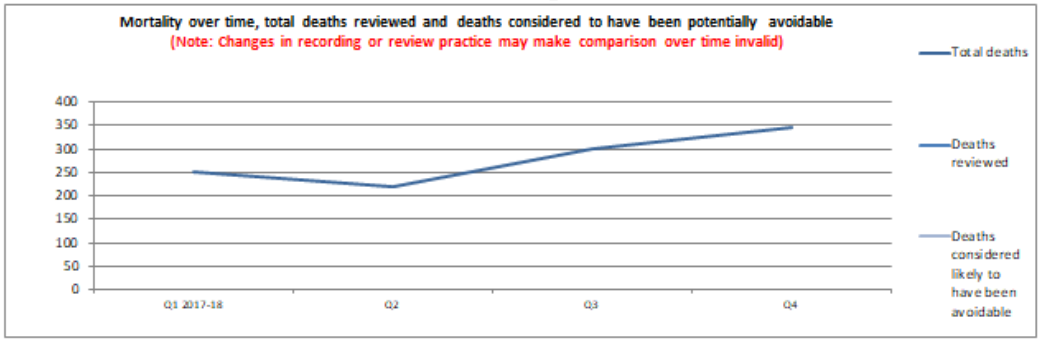
**Description:**
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

**Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review Methodology**

**Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities)**

| Total Number of Deaths in Scope | | Total Deaths Reviewed | | Total Number of deaths considered to have been potentially avoidable (RCP<=3) | |
|---|---|---|---|---|---|
| This Month | Last Month | This Month | Last Month | This Month | Last Month |
| 121 | 85 | 67 | 88 | 0 | 0 |
| This Quarter (QTD) | Last Quarter | This Quarter (QTD) | Last Quarter | This Quarter (QTD) | Last Quarter |
| 346 | 300 | 231 | 232 | 0 | 0 |
| This Year | Last Year | This Year | Last Year | This Year (YTD) | Last Year |
| 1117 | N/A | 889 | N/A | 0 | N/A |

Time Series: Start date 2017-18 Q1 End date 2017-18 Q4




**Total Deaths Reviewed by RCP Methodology Score**

| Score 1 Definitely avoidable | | | Score 2 Strong evidence of avoidability | | | Score 3 Probably avoidable (more than 50:50) | | | Score 4 Probably avoidable but not very likely | | | Score 5 Slight evidence of avoidability | | | Score 6 Definitely not avoidable | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| This Month | 0 | - | This Month | 0 | - | This Month | 0 | - | This Month | 0 | - | This Month | 0 | - | This Month | 0 | - |
| This Quarter (Q | 0 | - | This Quarter (Q | 0 | - | This Quarter (QTI | 0 | - | This Quarter (QTD) | 0 | - | This Quarter (QTD | 0 | - | This Quarter ( | 0 | - |
| This Year (YTD) | 0 | - | This Year (YTD | 0 | - | This Year (YTD) | 0 | - | This Year (YTD) | 0 | - | This Year (YTD) | 0 | - | This Year (YT | 0 | - |

## 2.3 Learning from Deaths Dashboard – Part 2

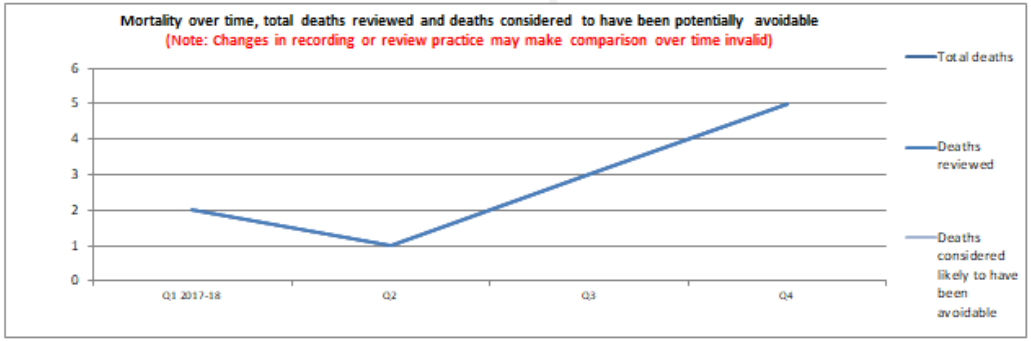
Evidence suggests from the Confidential Inquiry of 2010-2013 that people with learning disabilities currently have a life expectancy at least 15 to 20 years shorter than other people. A concerning finding was that assumptions were sometimes made that the death of a person with learning disabilities was 'expected' or even inevitable. In response a Learning Disabilities Mortality review (LeDeR) programme was commissioned by the Healthcare Quality Improvement Partnership (HQUIP) following the deaths of people with learning disabilities aged 4 to 74 years of age. These reviews are conducted by trained reviewers at the Trust.

**Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology**

**Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities**

| Total Number of Deaths in scope | | Total Deaths Reviewed Through the LeDeR Methodology (or equivalent) | | Total Number of deaths considered to have been potentially avoidable | |
|---|---|---|---|---|---|
| This Month | Last Month | This Month | Last Month | This Month | Last Month |
| 1 | 3 | 1 | 3 | 0 | 0 |
| This Quarter (QTD) | Last Quarter | This Quarter (QTD) | Last Quarter | This Quarter (QTD) | Last Quarter |
| 5 | 3 | 5 | 3 | 0 | 0 |
| This Year | Last Year | This Year | Last Year | This Year (YTD) | Last Year |
| 11 | N/A | 11 | N/A | 0 | N/A |

Time Series: Start date 2017-18 Q1 End date 2017-18 Q4



## 3.0 Care Quality Commission (CQC) Mortality Outlier Alerts

The information below is sourced from the latest version of the CQC Insight document (25 April 2018). The Trust undertakes an in-depth case note review in response to any data which indicates a higher than average mortality rate.

### Key Messages

- There are currently 2 active mortality alerts for this trust.

Number of outlier alerts for this trust as at 31 January 2018:

| | Active alerts | | | Closed cases | Total |
|---|---|---|---|---|---|
| | Cases under consideration by Outliers Panel | Cases where action plans are being followed up by local inspection team | Cases for review by inspection team | | |
| Mortality | 1 | 1 | 0 | 9 | 11 |
| Maternity | 0 | 0 | 0 | 2 | 2 |

### Mortality Outliers – Active Alerts

**Cases under consideration by the Outlier Panel**

- Liver disease, alcohol related (Dr Foster, June 2017) - Known concern relating to recent alert

**Cases where action plans are being followed up by local inspection team**

- Liver disease, alcohol related (Dr Foster, January 2016) – Action plans being followed up by inspection team

**Cases for review by inspection team**

- There are currently no mortality alerts for review by inspection team

### Maternity Outliers – Active Alerts

**Cases under consideration by the Outlier Panel**

- There are currently no maternity alerts under consideration by outliers panel

**Cases where action plans are being followed up by local inspection team**

- There are currently no maternity alerts where action plans are being followed up by the local inspection team

**Cases for review by inspection team**

- There are currently no maternity alerts for review by inspection team

## 4.0 Learning from Deaths and Improvements

The Trust Learning from Deaths Policy has built upon the Mortality Case Note Review Standard Operating Procedure, which outlined the existing embedded process for reviewing all in-hospital deaths.

All in-patient deaths are reviewed on a weekly basis by a team of consultants led by the Lead Consultant for Patient Safety. A short mortality case note review form is completed and if a death is identified where clinical care could potentially have been more appropriate, the case is referred for an in-depth review.

Cases referred for an in-depth review are reviewed by a senior consultant and senior nurse using the Trust's mortality case note review form. Simultaneously the Medical Director asks the consultant supervising the patients care to provide a written report on the care provided.

The information derived from these two parallel processes is reviewed at the HMRG, where a decision is made about what, if any, further action is required and the lessons learned from the case are collated.

Organisational learning from this process must be dynamic, with immediate actions and improvements undertaken in a timely manner to prevent reoccurrence. Short - medium term improvements identified through organisational learning are introduced through the Trust's governance structure. In the longer term organisational learning will take place through the triangulation and theming of data and information. The Trust's incident reporting, investigation and organisational learning processes describe our approach to organisational learning.

The Divisional Mortality Reduction Groups undertake mortality case note reviews in line with their terms of reference.

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

The HMRG developed a reducing hospital mortality rates driver diagram, which has been reviewed and approved in July 2017, (see Appendix 1). There are five primary drivers are:

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

The main areas of focus from the driver diagram currently are:

### 4.1 Actions to progress the four priority clinical standards for 7 day working in the last quarter include:

- The NHS England team have visited the paediatric department and discussed the process for the robust documentation of time to admission. They also discussed and provided clarity around the exclusion criteria in relation to the 7 day services data submission.
- NHS Improvement has published a guidance document on the challenges and solutions for 7 day services. The divisional teams are reviewing this to identify any learning to implement locally.

### 4.2 Actions to implement the Structured Judgemental Review Process in line with national guidance:

- The Medical Director and Clinical Lead for Patient Safety have undertaken two sessions to educate a cohort of senior medical and nursing staff on how to undertake the Structured Judgemental Review Process.
- The clinical conditions that will be included within the SJR process have been agreed by the HMRG in line with national guidance. The clinical conditions selected include:
    - Acute Cerebrovascular Accident (at the weekend)
    - Pneumonia (at the weekend)
    - Intestinal obstruction without hernia
    - Alcohol related liver disease
    - Infectious diseases (CQC Insight metric)
    - All deaths where families, carers or staff raise concerns
    - Concerns raised by the Coroner
    - Concerns raised at the Patient Safety Summit
    - Concerns raised during the Friday mortality screening process
    - Relevant elective deaths
- The Structured Judgemental Review Process commenced in April 2018.

### 4.3 Actions to progress the use of care pathways / bundles which are evidence based and applied in a consistent manner, as evidenced by clinical audit and include:

- The Trust re-joined the Advancing Quality (AQ) programme in April 2017 and has signed up for a further year in 2018/19
- The four pathways chosen are:
    - Sepsis
    - Alcohol related liver disease (ARLD)
    - Pneumonia
    - Acute Kidney Injury (AKI)
- Clinical leads have been identified for each of the pathways and monitoring is undertaken by the Care Pathway Group, reporting to the Quality and Safety Improvement Strategy Group with escalation to the Executive Quality Governance Group and assurances to the Quality Governance Committee

### 4.4 Actions to improve the recognition of and the response to the acutely deteriorating patient include:

- The Executive Led Deteriorating Patient Steering Group was formed in November 2017. The group has cross-divisional representation, is chaired by the Medical Director and reports to the TMRG and up through the committee structure to Board as appropriate.
- The group has six work streams with a nominated lead for each:
    - Acute Care Model
    - Unplanned Admissions to the Critical Care Unit
    - Education and Training
    - Quality Improvement Projects
    - Policy
    - Lines
- National Early Warning Score (NEWS 2) will be launched in the Trust on the 5 November 2018.
- The organisation has applied to attend the AQuA Deteriorating Patient Collaborative

## 5.0 Quarterly Deep Dive – Palliative Care

The Trust has historically had a palliative care coding rate below that of both executive peer and England average and a deep dive was undertaken to see if this was having a negative impact on the HSMR.

A review of the Palliative Care Service identified that,

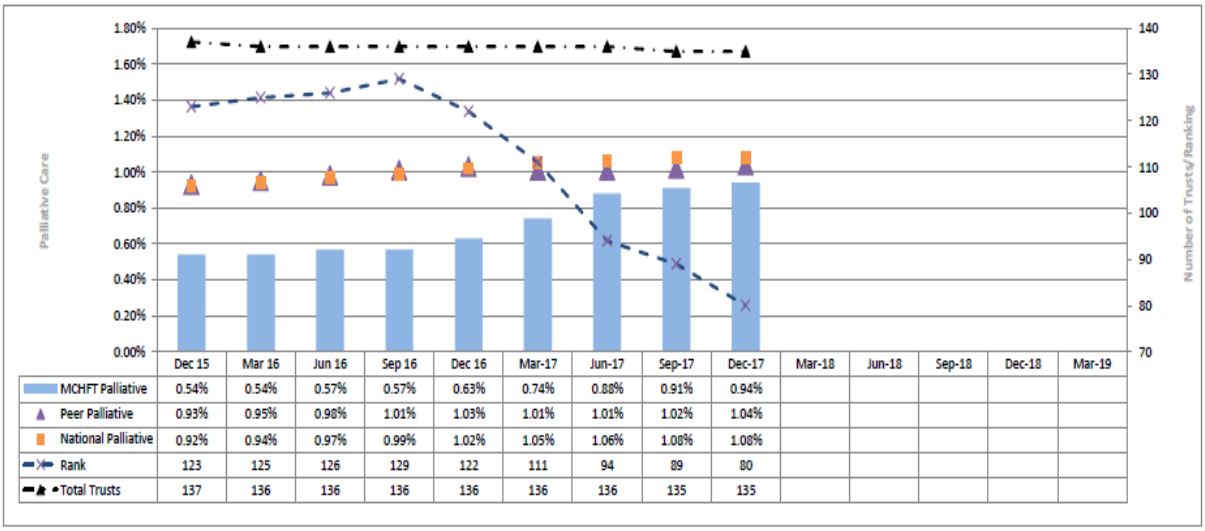
- the Palliative Care Specialist Nurses were unable to review all patients that would benefit from a palliative care review due to a lack of resource
- referrals could have been made earlier into the service and not all patients who could benefit from a palliative care review were being referred into the service
- the palliative care team could not in-reach into the acute admission areas to identify patients who would benefit from being seen and that the team were unable to spend sufficient time on the wards due to undertaking administration duties that were required as part of the service

In August 2017, it was agreed to temporarily fund a full whole time equivalent Band 6 Palliative Care Nurse and 0.6 whole time equivalent band 3 clerical officer as a pilot to support the existing team. The additional nurse focussed on the acute admission areas and the Emergency Department whilst the clerical member of staff took over the administrative duties. The impact of this additional resource has been a steady yet significant increase in palliative care referrals, resulting in an increase in the number of patients reviewed by the team and subsequently coded as 'Palliative'. This change has resulted in an improvement in the quality of care for our patients and an improvement in the Trust's HSMR.

A palliative care 'green' sticker has also been introduced. This is placed in the patients' healthcare records when the patient receives a palliative care review and assists the clinical coding team when they are undertaking the coding of the patients admission to ensure the data is captured accurately.

A business case has been developed to fund these posts on a permanent basis and this has been included in the 2018/19 investment bids.

**Chart 15 - Palliative Care Coding Rolling Position**

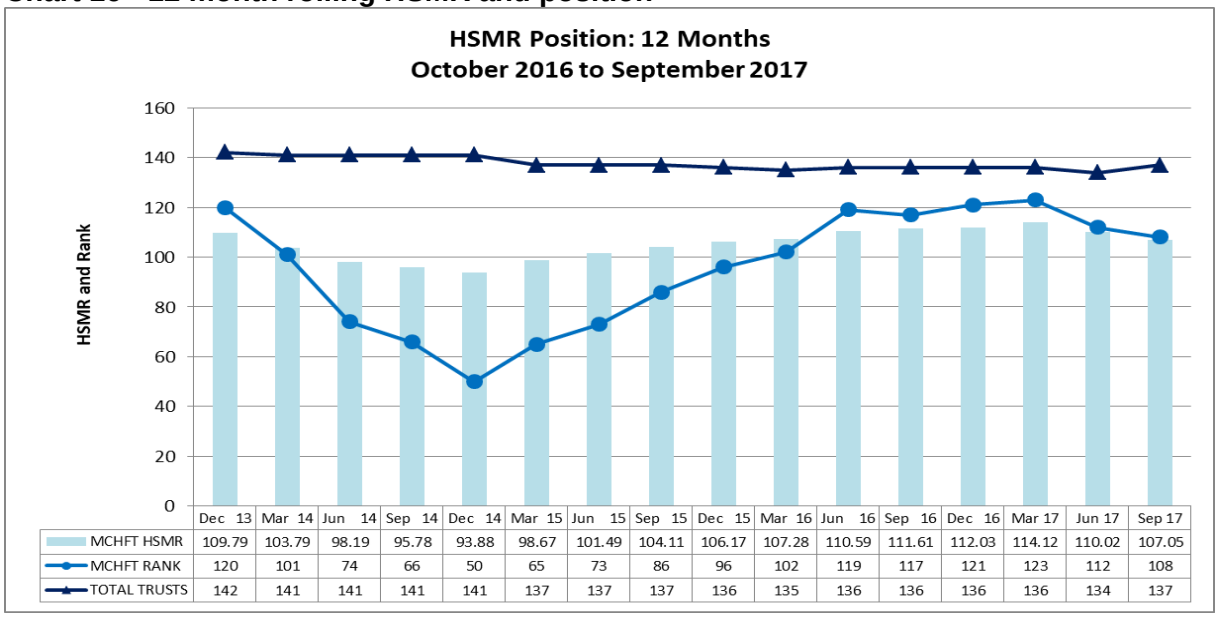



| | Dec 15 | Mar 16 | Jun 16 | Sep 16 | Dec 16 | Mar-17 | Jun-17 | Sep-17 | Dec-17 | Mar-18 | Jun-18 | Sep-18 | Dec-18 | Mar-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| MCHFT Palliative | 0.54% | 0.54% | 0.57% | 0.57% | 0.63% | 0.74% | 0.88% | 0.91% | 0.94% | | | | | |
| Peer Palliative | 0.93% | 0.95% | 0.98% | 1.01% | 1.03% | 1.01% | 1.01% | 1.02% | 1.04% | | | | | |
| National Palliative | 0.92% | 0.94% | 0.97% | 0.99% | 1.02% | 1.05% | 1.06% | 1.08% | 1.08% | | | | | |
| Rank | 123 | 125 | 126 | 129 | 122 | 111 | 94 | 89 | 80 | | | | | |
| Total Trusts | 137 | 136 | 136 | 136 | 136 | 136 | 136 | 135 | 135 | | | | | |

(Source HED, 2018)

Chart 15 shows that the rate of palliative care coding, as demonstrated by the blue bar, has increased from 0.57% in September 2016 to 0.94% in December 2017.

**Chart 16 - 12 month rolling HSMR and position**




| | 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 | Sep 17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| MCHFT HSMR | 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 | 107.05 |
| MCHFT RANK | 120 | 101 | 74 | 66 | 50 | 65 | 73 | 86 | 96 | 102 | 119 | 117 | 121 | 123 | 112 | 108 |
| TOTAL TRUSTS | 142 | 141 | 141 | 141 | 141 | 137 | 137 | 137 | 136 | 135 | 136 | 136 | 136 | 136 | 134 | 137 |

(Source HED, 2018)

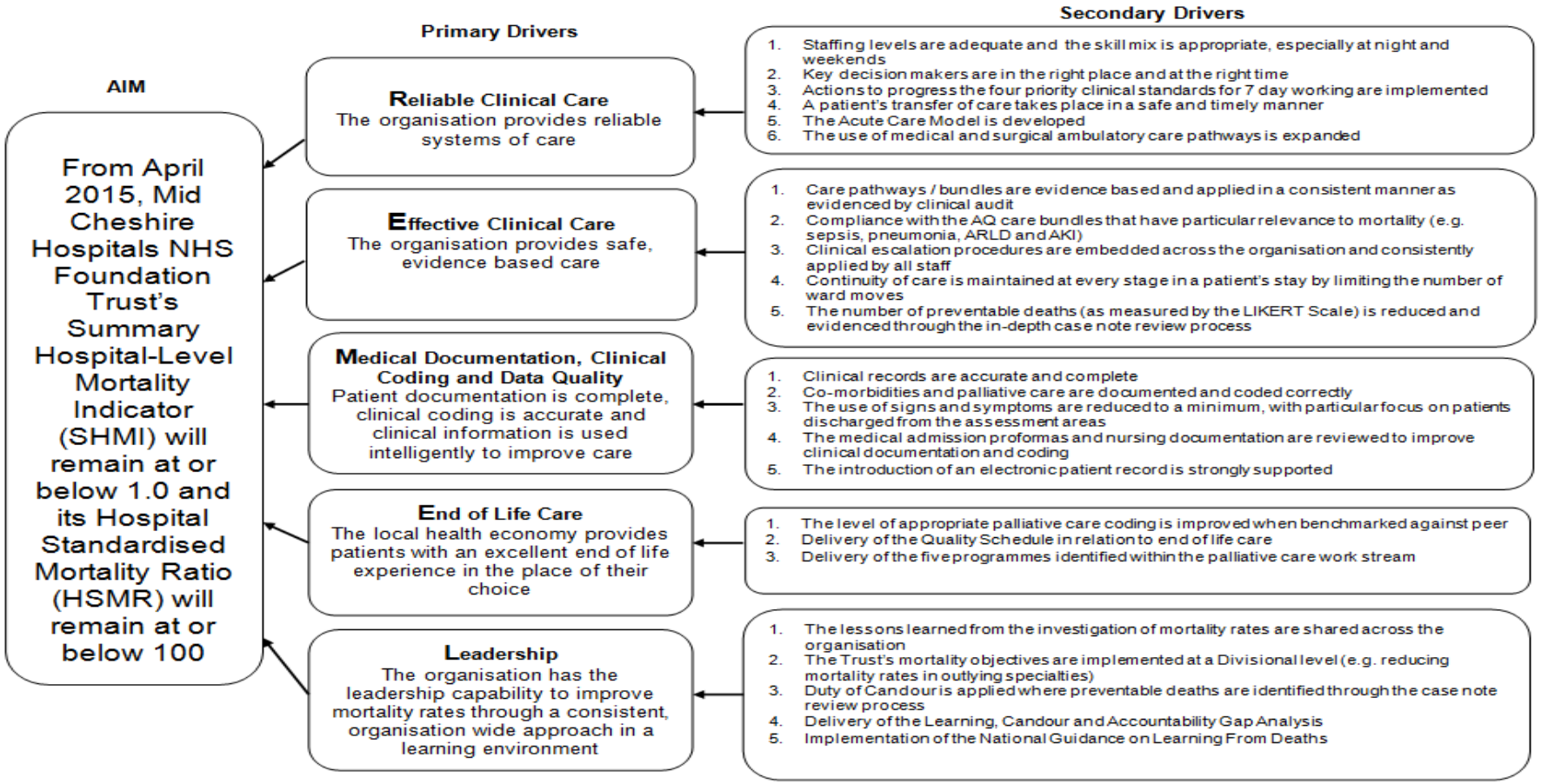
Chart 16 demonstrates the improvement in the Trust HSMR, as demonstrated by the blue bar, since March 2017.

## 6.0 Next steps include:

1. A deep dive will be undertaken into gynaecology mortality rates
2. Review of the Patient Safety Summit format and how sharing of learning from incidents and mortality reviews can be further developed

## 6.0 Appendices

### 6.1 Appendix 1 Driver Diagram



## 6.2 Appendix 2 - Glossary

### Healthcare Evaluation Data (HED)

HED is online data analysis and benchmarking tool published by the University of Birmingham.

### Hospital Standardised Mortality Ratio (HSMR)

HSMR is produced by Dr. Foster and is the ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in-hospital deaths at the end of a continuous inpatient spell for 56 specific Clinical Classification System (CCS) groups.

### LIKERT Scale

A tool used to judge the preventability of a patient's death using a six-point scale ranging from one (definitely not preventable) to six (definitely preventable).

LIKERT Scale

1. Definitely not preventable
2. Slight evidence for preventability
3. Possibly preventable but not very likely, less than 50-50 but close call
4. Probably preventable, more than 50-50 but close call
5. Strong evidence for preventability
6. Definitely preventable

### Summary Hospital-level Mortality Indicator (SHMI)

SHMI reports on mortality at trust level across the NHS in England. This indicator is produced and published quarterly as an official statistic. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It covers all deaths reported for patients who were admitted to non-specialist acute trusts in England and either die while in hospital or within 30 days of discharge.

The expected number of deaths is calculated from statistical models derived to estimate the risk of mortality based on the characteristics of the patients (including the condition the patient is in hospital for, other underlying conditions the patient suffers from, age, gender and method of admission to hospital).

### 6.3 Appendix 3: Understanding the difference between SHMI and HSMR

| | Summary Hospital-level Mortality Indicator (SHMI) ** | Hospital Standardised Mortality Rate (HSMR) |
|---|---|---|
| Observed | Number of observed in-hospital deaths plus deaths out of hospital within 30 days of discharge | All spells culminating in death at the end of the patient pathway, defined by specific diagnosis codes for the primary diagnosis of the spell; uses 56 diagnosis groups which contribute to approx. 80% of in hospital deaths in England |
| Expected | Expected number of deaths<br>*Calculated using a 36-month data set to get the risk estimate* | Expected number of deaths |
| Adjustments | • Gender<br>• Age group<br>• Admission method<br>• Co-morbidity<br>• Year of dataset<br>• Diagnosis group<br>*Details of the categories can be referenced from the methodology specification document* *** | • Gender<br>• Age in bands of five up to 90+<br>• Admission method<br>• Source of admission<br>• History of previous emergency admissions in last 12 months<br>• Month of admission<br>• Socio economic deprivation quintile (using Carstairs)<br>• Primary diagnosis based on the clinical classification system<br>• Diagnosis sub-group<br>• Co-morbidities based on Charlson score<br>• Palliative care<br>• Year of discharge |
| Exclusions | • Specialist, community, mental health and independent sector hospitals<br>• Stillbirths<br>• Day cases, regular day and night attenders | Excludes day cases and regular attendees |
| Whose data is being compared and how much data is used for comparison e.g. all Trusts or certain proportion etc. | All England non-specialist acute Trusts except mental health, community and independent sector hospitals.<br>Data attributed to Trust in which patient died or was discharged from | All England provider Trusts via SUS<br>Data attributed to all Trusts within a “super-spell” of activity that ends in death |

| | | |
|---|---|---|
| ***Title of Paper :*** | Cheshire East Place Memorandum of Understanding | |
| ***Author:*** | Cheshire East Partnership Board | |
| ***Executive Lead:*** | Tracy Bullock, Chief Executive | |
| ***Type of Report:*** | Concept Paper | |
| | Strategic Options Paper | |
| | | |
| | 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 | | Caring | x |
| Aspiring to Excellence in Practice Through Our Workforce | | Responsive | x |
| Creating a 21st Century Infrastructure for Transformative Health and Social Care | x | Well-Led | x |

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

| | |
|---|---|
| ***Positive Benefit:*** | To agree a shared approach and delegated authorities to enable the delivery of integrated care across Cheshire East health and social care organisations through a Partnership Board. |
| ***Risk:*** | Delegation of certain authorities to enable devolved decision making |

| | |
|---|---|
| ***To be published on Trust Website –complete version*** | **Y** |
| ***If no, to be published on Trust Website – redacted*** | **n/a** |
| ***If not to be published complete or redacted, please detail the reason why*** | |
| ***Presented at Board Meeting of:*** | **4 June 2018** |

# CHESHIRE EAST PARTNERSHIP BOARD

# MEMORANDUM OF UNDERSTANDING

## Dated May 2018

## 1. THE PARTNERSHIP

This Memorandum of Understanding (MoU) relates to our collective aspirations for the future of care services in Cheshire East and the collaborative working of the organisations listed below, referred to from this point as the Partners:

- Cheshire East Council
- Cheshire and Wirral Partnership NHS Foundation Trust
- East Cheshire NHS Trust
- Eastern Cheshire Clinical Commissioning Group
- Mid Cheshire Hospitals NHS Foundation Trust
- South Cheshire Clinical Commissioning Group
- South Cheshire and Vale Royal GP Alliance and
- Vernova Healthcare CIC.

**We will provide collective system leadership** through a Partnership Board to deliver strong, visible and collective leadership across a single co-ordinated programme of work. Our Partnership Board will provide a forum for our organisational leaders to agree, support and guide the transformation needed to achieve sustainable services supported by an improved financial position.

## 2. OUR VISION

***To improve the health and wellbeing of local communities enabling them to live longer and healthier lives, through creating safe, integrated and sustainable services that meet people's needs by the best use of the assets and resources available.***

Our Vision for the future of care services has been borne out of the achievements to date and our local transformation programmes; and our ambition to implement new, integrated care arrangements that achieve the best possible health and wellbeing for our residents.

In creating our 'place-based' vision we aim to meet our local ambitions within the context of the Health & Care Partnership of Cheshire and Merseyside; and its commitments of improving the health and wellbeing of the 2.6 million population of Cheshire and Merseyside and creating **a strong, safe and sustainable health and care system** that is fit for the future.

## 3. OUR AMBITION

Our ambition is to develop a single Integrated Care Partnership, operating:

- At the whole population level; aiming to address the wider determinants of health and wellbeing and to tackle inequalities
- As a place-based response to the development of sustainable services for local populations
- For people with episodic conditions; it will help build and form part of a more coherent and effective local network of urgent care
- For people with ongoing care needs; it will provide a broader range of services in the community that are more joined up between primary, physical, mental health and social care and services will be better tailored to meeting their needs including integrated personal commissioning and personal health budgets.

**Above all our priority is to deliver the right care for our local population and for those that use our services including:**

- Keeping services local for local people;

- Supporting local people to take an active and full role in their own health and wellbeing;
- Preventing health deterioration and promoting independence;
- Promoting social capital;
- Embracing prevention and early intervention across all areas including the voluntary, community and faith sectors;
- Using the best, evidence-based, means to deliver on outcomes that matter; and
- Focusing on what adds value (and stopping what doesn't).

## 4.0 SYSTEM OBJECTIVES AND DELIVERABLES

The Partnership's principal objectives will be developed into detailed workplans for creating integrated delivery of health and care services built from natural care communities. The principal objectives are:

1. For specialist mental health services, deliver the NHS *Five Year Forward View* and provide more care closer to home, based around existing communities.
2. Support the transformation of General Practice as a core foundation of our care communities including delivery of the NHS GP Forward View and the vision of Primary Care home.
3. Develop a range of preventative health and care services that helps support healthy day-to-day living.
4. Create the optimum environment to enable and accelerate the development and implementation of new models of integrated care built from the aforementioned local health and care communities.
5. Established our Integrated Care Partnership with responsibility for ensuring the provision of services that deliver the best choice, access and outcomes for patients and service users within the available resources.
6. The development of an Integrated Care Partnership will be supported by new integrated commissioning and contracting arrangements built on the work being taken forward by the Cheshire CCGs' and the two Local Authorities.
7. Establish a collaborative approach to financial improvement building on our learning to date including an absolute commitment to reduce all non-clinical costs where possible.
8. As soon as realistically possible operate as a system within the total available financial resources as defined by partners' agreed financial control totals.
9. Agree a model of sustainable hospital services that link to other components of integrated health and care services for local people and their communities.

## 5. PRINCIPLES AND BEHAVIOURS

We, 'the Partners' recognise the scale of change required to deliver sustainable health and care services for our population and acknowledge that cultural change is a key enabler, within and between the partner organisations.

We will continue to build and promote trusting relationships, mutual understanding and where appropriate, take decisions together. All members of our Partnership Board will support and promote system behaviours for the benefit of the local population and care users including:

- Working together and not undermining each other;
- Working with integrity and the highest professional standards;
- Behaving well, especially when things go wrong;
- Engaging in honest and open discussion;
- Speaking well of each other and not undermining each other;
- Upholding decisions made by the Partnership;

- Seeing success as collective, and
- Sticking to decisions once made.

We agree to deliver a person-centred care model and system that meets the current and emergent needs of our population. We agree that this principle must override our individual or organisational self-interest, unless statutory or regulatory requirements preclude this. To ensure this is not forgotten, the voice and views of the public and patients will be embedded at all levels of our programme of work.

The key principles that we, "the Partners", are committed to in relation to **system finances** are:

- To work towards being able to live within our overall available financial envelope by focusing on value-based prioritisation and reprioritisation of expenditure;
- To focus on collectively improving the system-wide financial position rather than our individual organisations' financial positions, but operating with the principle of separate overall NHS control totals for Central Cheshire and Eastern Cheshire for reporting purposes;
- To use collective commissioning and buying opportunities to improve delivery outcomes and/or system savings;
- To focus on reducing costs across the system ensuring that funding is given to the right place, and
- To explore and develop pooled budgets across health and social care.

The key principles that we, "the Partners", are committed to in relation to **system leadership** are:

- To act collectively and deliver on today's business whilst also delivering transformation for the future;
- Where appropriate, to act as if part of a single leadership team, to coordinate system improvements for the benefits of the local population and care users;
- To carry out implementation at pace; and
- To influence the view of regulators and external assurance bodies regarding the primacy of the clinical and financial sustainability of our systems, to achieve the best outcomes for our populations, and our joint commitment to it.

The key principles that we, 'the Partners', are committed to in relation **to sharing information and aligning resources** are:

- To share information in a timely manner, in line with relevant Information Governance requirements, when needed to support development of our Partner's business cases and savings plans, and
- To align human, financial, estate and digital resources to deliver system work where this adds value.

## 6. GOVERNANCE ARRANGEMENTS

Through this Memorandum of Understanding and associated Terms of Reference the partners have collectively agreed to the establishment of a **Partnership Board.**

The Partnership Board will consist of system leaders drawn from NHS and local authority partners and will be chaired by an Independent Chair. The Partnership Board will be accountable to the Boards and Governing Bodies of the Partners. Individual members of the Partnership Board will ensure that they have the necessary delegated permissions and that processes are in place for them to act on behalf of the organisations which they represent.

Declarations of interest will be declared by all individual members attending a Partnership Board meeting prior to commencement of the meeting.

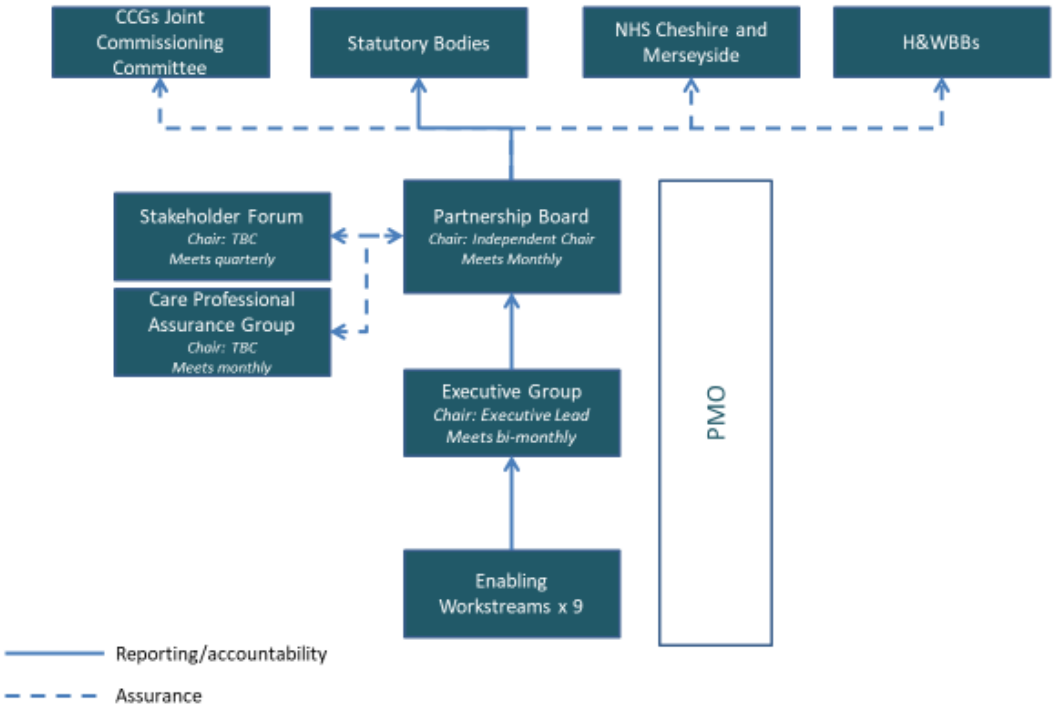
The Partnership Board is required to take into account the requirements and expectations of the following statutory organisations/Boards/Committees:

- **Health & Care Partnership for Cheshire & Merseyside:** Our Partnership Board is required to report progress against objectives and an agreed timetable to the Health & Care Partnership providing them with regular updates.
- **Greater Manchester Health and Social Care Partnership:** Greater Manchester Health and Social Care Partnership will nominate a senior individual who will attend our Partnership Board, and act as its representative on all matters to do with this work. Our Partnership Board is responsible for ensuring that that representative is engaged in all work that will impact the health and social care system of Manchester.
- **Health and Wellbeing Boards:** Our Partnership Board is required to engage with and keep the Health and Wellbeing Boards informed of progress and provide them with information and regular updates.
- **Overview and Scrutiny Committees:** Our Partnership Board is responsible for working closely with the relevant Overview and Scrutiny Committees and ensuring they are informed and, where necessary, consulted around all aspects of potential service changes.

In addition, the Partnership Board is also responsible for engaging with and supporting the following groups:

- **Stakeholder Forum:** To engage with stakeholders within and outwith the partnership in order to keep the wider health and care community, and third and related sectors, informed of progress and thinking.
- **Care Professional Assurance Group:** All proposals for service change will be considered by a group of care professionals who will be required to agree all proposals for change before they are formally submitted to the Partnership Board.

**Governance and Accountability structure**




The Partnership Board will be supported by a **Programme Executive Group (PEG),** chaired by the Executive Lead, responsible for the day-to-day management of the Programme. The PEG will be supported by a **Programme Management Office (PMO)** across the Programme, overseen by a Programme Director.

## 7. DELEGATIONS FROM STATUTORY ORGANISATIONS

We have agreed the following principles regarding the delegation of authority from our statutory organisations to this Partnership Board: The Partnership Board will be:

- Accountable for the co-ordination of a system programme of work to deliver improvements for the benefits of the local population and care users
- Collectively responsible for holding each of the Partners to account for the delivery of their components of the programme of work.
- Accountable for the planning and delivery of the programmes of work delivered by the Programme Executive Group, including those previously identified in the July 2017 NHSI report, the two CEP programmes and the previous transformation Boards.

The Partnership Board has the authority to:

- take all decisions about the programme of work that will be taken forward, in terms of the structure, priorities and processes of that work programme
- take all decisions about the use of any resources that have been identified as being at its disposal as determined by the partners
- make decisions that benefit all parties. However, we recognise that may not always be possible. The principle we have agreed is that on a cumulative basis for each financial year the Partnership Board will not make decisions that will financially disadvantage any of our individual organisations, unless mechanisms can be put in place to balance that financial disadvantage

Where decisions of a financial or sensitive nature are being considered, papers will be circulated sufficiently in advance of meetings for individual organisations to have time to discuss internally and agree a mandated position in advance of the meeting.

The Partnership Board will not take any decisions on issues that are a statutory requirement for an organisation and have not been and/or cannot be formally delegated to the Partnership Board by that partner organisation(s).

## 8. DECISION MAKING

- The Partnership Board will seek to make decisions by consensus.
- All decisions that have a direct financial and/or strategic impact on an organisation will require the support of that organisation.
- All other decisions will be taken on the basis of a majority view.
- If necessary, the Independent Chair will use whatever support is available to unblock major decision-making.

## 9. RESOURCES

We, the Partners, will work to identify and use resources as follows:

- **Internal:** We will aim to identify and maximise the use of internal, existing resources where possible.
- **NHS Cheshire and Merseyside:** We will aim to gather support from NHS Cheshire and Merseyside and utilise any resources that are available.
- **External:** Where necessary we will procure additional support, externally and maximise this resource to ensure value for money is gained.

The Programme Director will be accountable for developing proposals for an annual resource budget which will need to be approved unanimously by contributing Partners at the Partnership Board.

## 10. CONFIDENTIALITY

- We the Partners recognise that, from time to time, we will need to share commercially sensitive information in order to progress the intended programme of work
- Commercially sensitive information provided by each Partner as part of this programme is provided in confidence and is only to be disclosed to those who need to see it for the purposes of taking this programme forward. If any Partner suspects that this confidentiality has been breached they are to inform the other party as soon as is practically possible.
- Commercially sensitive information is considered to be exempt from disclosure under the Freedom of Information Act 2000, unless that information is already available in the public domain or comes into the public domain through no fault of any of the Partners.

## 11. COMMUNICATIONS AND ENGAGEMENT

The Partnership Board will jointly develop and manage a single and consistent communications plan throughout the duration of this MoU. The Partners agree to deliver an inclusive communications and engagement strategy, tailored and targeted to key stakeholders, including to:

- Maintain a core narrative, messages and independently branded materials for all staff and the public
- Develop a communications and engagement programme targeted at supporting sustainable health and well-being for the population of Central and Eastern Cheshire, and

- Take full responsibility for making sure our staff, are well briefed on system improvement work, drawing from system messages and materials.

**12. DURATION**

This MoU, or subsequent iterations of this MoU, will last for a period of five years with a review annually to determine its applicability for future years.

**13. AGREEMENT**

This Memorandum of Understanding is signed on behalf of the Partners by the following:

| **Organisation** | **Representative and Position** | **Signed on behalf of organisation** |
|---|---|---|
| East Cheshire NHS Trust | | |
| Mid Cheshire Hospitals NHS FT | | |
| NHS Eastern Cheshire CCG | | |
| NHS South Cheshire CCG | | |
| Cheshire and Wirral Partnership NHS FT | | |
| Cheshire East Council | | |
| South Cheshire and Vale Royal GP Alliance | | |
| Vernova Healthcare CIC | | |

We Care Because You Matter

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

# Board of Directors

# Workforce Report

## June 2018

## (April 2018 data)

**Performance Report** Workforce
**Month:** Apr-18

| Measure | Target | Performance | Description | Narrative | Rolling Trend |
|---|---|---|---|---|---|
| Sickness Absence | 3.60% | 4.38% | Rolling 12m average Sickness Absence described as a Percentage | Rolling sickness absence has remained static from the March 2018 postion. The in month sickness absence rate is 3.89% which is a reduction of 0.3% from the March in month position. All divisions experienced a reduction in their in month sickness absence with the exception of Corporate and Women and Childrens. | ↓↑ |
| Appraisal Rate | 90.00% | 85.39% | Percentage of Staff who have received an appraisal in the last 12 months.<br>Excludes New Staff with less than 12m service and Bank Staff | There has been a small reduction in the appraisal rate during April 2018 (-1.85) and whilst this is an overall reduction, it should be noted that the following divisions have seen an increase in their appraisal rates: Corporate +3.97% Estates and Facilities +1.03% CCICP experienced the most significant reduction (-6.76%) due to a number of appraisals having been completed in April 2017 but not repeated in April 2018. Four key hotspot areas have been identified in the division and improvement plans have been put in place. | ↓ |
| Mandatory Training | 90.00% | 82.11% | Mandatory Training Monthly Rate<br>Excludes Bank Staff, Staff on long term sick & mat. leave. | Mandatory training compliance has seen a small reduction in month (-0.39%). Both DCSS and Estates and Facilities remain above the 90% target. CCICP remains an outlier at 68% with challenges in achieving targets in Manual Handling and Medicines Management training. The division are aware and are endeavouring to resolve the barriers to completion. | ↓ |
| Staff Turnover | 10.00% | 11.33% | Number of Leavers expressed as a percentage of the workforce over a 12m rolling period.<br>Exclude Junior Doctors, Temporary and Fixed term. | Staff turnover remains within an acceptable range at 11.33%. We continue to monitor the reasons for leaving to identify areas where we can improve the experience of staff to support retention. Any areas of concern raised in exit interviews are escalated to the relevant HR Manager, A quarterly report is completed and reviewed at EWAG. The main reasons for leaving were identified as being: working hours, career progression and travel time. | ↓ |

| Measure | Target | Performance | Description | Narrative | Rolling Trend |
|---|---|---|---|---|---|
| Agency Spend | (365) | (393) | In month and cumulative total spend for the Trust. | The agency target for April 2018 has been exceeded by 10.76%. The cause of this is multi-factorial although the most significant causes are vacancy rates for consultants, nursing and junior doctor roles and continued use of escalation beds throughout April 2018. Work is ongoing to review medical rotas in high agency useage areas and identify exit strategies for high cost off-framework agencies. | ↑ |
| NHSI Ceiling | less than 100% | 107.7% | Trust Agency Spend as a percentage of the Ceiling Set by NHS Improvement | | ↑ |
| Over Cap Rates | N/A | 41% | Number of Agency shifts filled by agency staff that are over the nationally determined capped rates | | ↑ |