Mid Cheshire Hospitals NHS Foundation Trust

AGENDA

Board of Directors
A meeting will be held in Public at
09.30am on Monday, 3 September 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** To welcome members of the public and attendees and to receive apologies for absence from Board Members. *(to note)*	I	Chairman **09.30**	-
2.	**Patient or Staff Story** *(verbal)*	I/D	Director of Nursing & Quality **09.32**	-
3.	**Board Member's Interests** *(to note)* To **consider** any • Changes to Directors' interests since the last meeting • Conflicts of interest deriving from this agenda	I	Chairman **09.50**	-
4.	**Minutes of the Last Meeting** To **approve** the minutes of the Board of Directors meeting held in Public on Monday, 6 August 2018	A	Chairman **09.52**	-
5.	**Matters Arising and Action Log** *(attached) (to approve)*	A	Chairman **09.55**	**15**
6.	**Annual Work Programme 2018/19 v2** *(attached)* *(to approve)*	A/I	Chairman **09.57**	**16**
7.	**Chairman's Announcements** (*to note a verbal report*) **7.1 UHNM Chairman Meeting** **7.2 NED Recruitment**	I	Chairman **10.00**	-
8.	**Governor's Items** (*to note a verbal report*) **8.1 Governor Election Results**	I	Chairman **10.05**	-
9.	**Chief Executive's Report** *(to note a verbal report)* **9.1 System Update** **9.2 Maternity Incentive Scheme 2018/19** **9.3 ED Workforce**	I	Chief Executive **10.10**	-

Item No	Title of Item	Action	Led By	Page No.
9.4	**CQC Draft Inspection Report**			
9.5	**Stroke Service Developments**			
10.	**CARING**			
10.1	**Quality, Safety & Experience Report** *(attached) (for discussion)*	I/D	Director of Nursing & Quality **10.35**	**17**
11.	**SAFE**			
11.1	**Draft Quality Governance Committee notes from the meeting held on 13 August 2018** *(attached) (to note)*	I	Committee Chair **10.45**	**-**
11.2	**Serious Untoward Incidents and RIDDOR Events** *(verbal)* (*to note*)	I/D	Deputy Chief Executive/ Medical Director **10.50**	**-**
12.	**RESPONSIVE**			
12.1	**General Surgery SACU and Seven Day Services Business Case** *(attached) (to approve)*	A/D	Chief Executive **10.55**	**-**
12.2	**Performance Report** *(attached) (to note)*		Director of Finance **11.15**	**111**
12.3	**Draft Performance & Finance Committee notes from the meeting held on 23 August 2018** *(to follow) (to note)*	I	Committee Chair **11.20**	**-**
12.4	**Legal Advice** *(verbal)* (*to note*)	I	Chief Executive **11.25**	**-**
13.	**WELL-LED**			
13.1	**Visits of Accreditation, Inspection or Investigation** *(verbal)* (*to note*)	I	Committee Chair **11.30**	**-**
13.2	**Board Assurance Framework Q1 2018-19** *(attached) (to note)*	I/D	Medical Director/ Deputy Chief Executive **11.35**	**136**
13.3	**Learning from Deaths Report Q1 2018-19** *(attached) (to note)*	I/D	Medical Director/ Deputy Chief Executive **11.40**	**156**
13.4	**Annual Doctor's Revalidation Report 2017-18** *(attached) (to note)*	I	Medical Director/ Deputy Chief Executive **11.45**	**179**

Item No	Title of Item	Action	Led By	Page No.
14.	**EFFECTIVE**			
14.1	**Workforce Report** *(attached) (to note)*	I/D	Interim Director of Workforce and OD **11.50**	**194**
14.2	**Transformation and People Committee notes from the meeting held on 9 August 2018** *(attached) (to note)*	I	Committee Chair **12.00**	**-**
14.3	**Consultant Appointments** *(verbal) (to note)*	I	Deputy Chief Executive/ Medical Director **12.05**	**-**
15.	**Any Other Business** *(verbal)*	A/I/D	Chairman	**-**
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, 1 October 2018**	I	Chairman	

Board of Director Meeting held in Public (Action Log)

Action No	Date of Meeting	Action	Lead	Deadline Date	Comments	Date of Board meeting to be reviewed	Status
18/08/11.1.2	06-Aug-18	CQC Organisational learning 'Look Back' 2017-18 report to be circulated	C Ralphs	31-Aug-18	Circulated	03-Sep-18	
18/08/13.2.2	06-Aug-18	Audit Committee minutes to be updated to reflect correct attendance	C Ralphs	31-Aug-18	Completed	03-Sep-18	

Board of Directors Workplan 2018/19

Version: 2

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				
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
Freedom to Speak up Guardian		x			x			x			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													
Emergency																
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				

We Care Because You Matter

Board of Directors

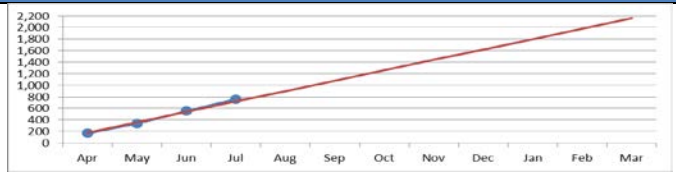
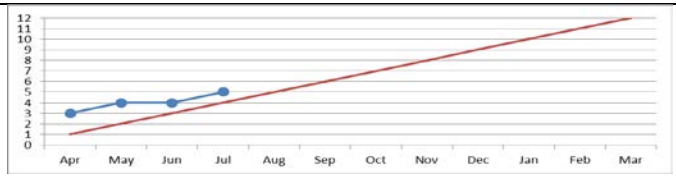
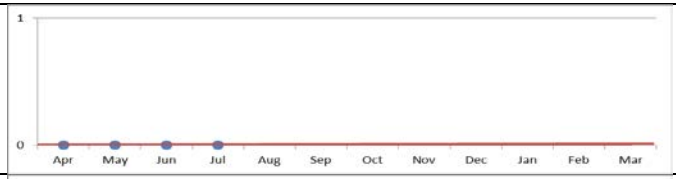
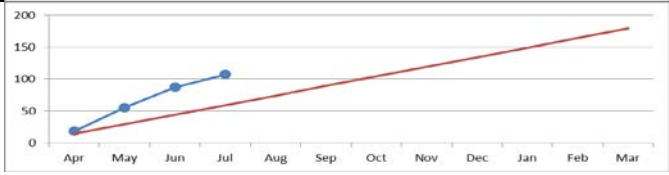
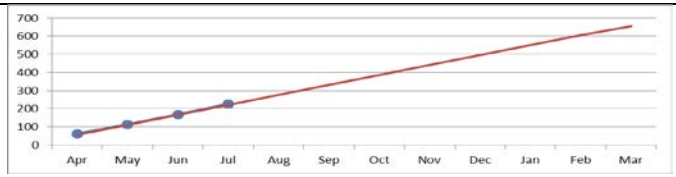
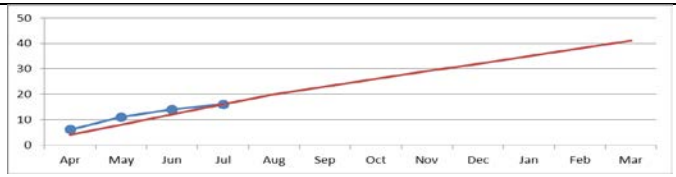
Quality, Safety and Experience Report

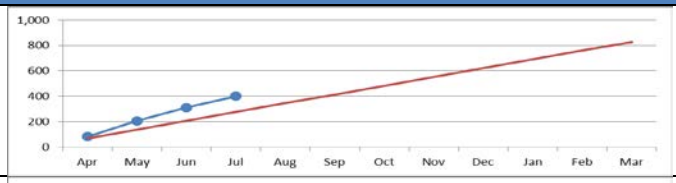
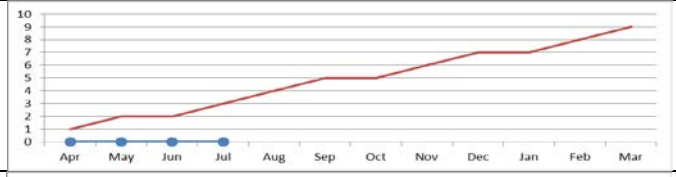
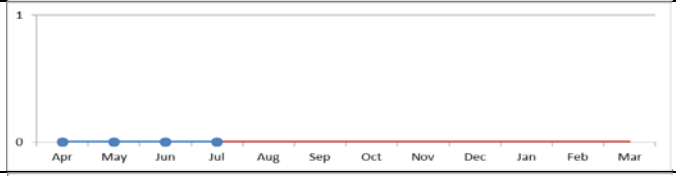
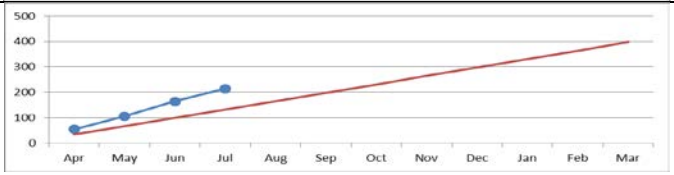
September 2018

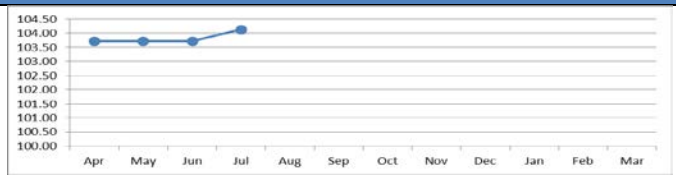
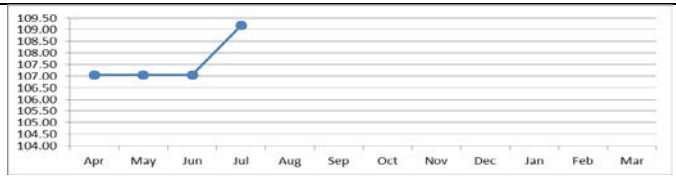
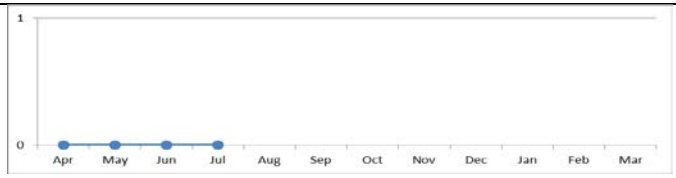
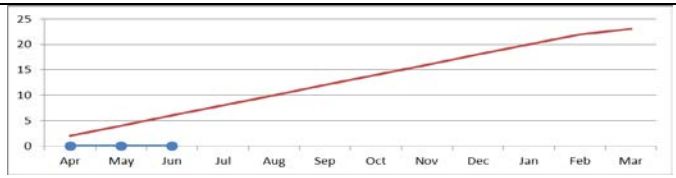
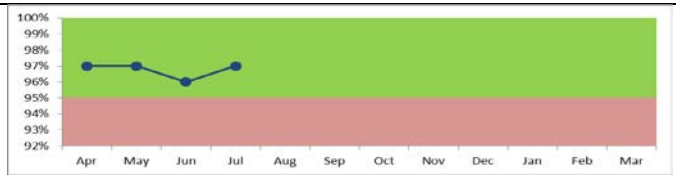
(July 2018 data)

Contents

Contents (continued):

Indicators	Target	Trajectory 2018/19
Acute Trust		
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.	**Less than 2161 at end of March 2019**	
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.	**Less than 12 at end of March 2019**	
Never Events Zero tolerance of Never Events.	**Zero**	
Pressure Ulcers – Hospital Acquired The target is to reduce hospital acquired pressure ulcers by 10% when compared to the previous financial year by the end of March 2019.	**Less than 150 at end of March 2019**	
Inpatient Falls 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 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**	

Indicators	Target	Trajectory 2018/19
CCICP		
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.	**Less than 828 at end of March 2019**	
CCICP Serious Incidents 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 Zero tolerance of CCICP Never Events.	**Zero**	
CCICP Pressure Ulcers – Community Acquired The target is to reduce community acquired pressure ulcers by 10% when compared to the previous financial year by the end of March 2019.	**Less than 398 at end of March 2019**	

Indicators	Target	Trajectory 2018/19
SHMI 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 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 Zero tolerance of MRSA cases.	**Zero**	
C-Diff Avoidable The target is less than 23 avoidable cases of Clostridium Difficile in 2018/19.	**Less than 23 at end of March 2019**	
Safety Thermometer The Trust target is that >95% of patients receive harm free care as monitored by the Safety Thermometer.	**>95%**	

Quality & Safety Section:

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

Patient Safety Harm Incidents

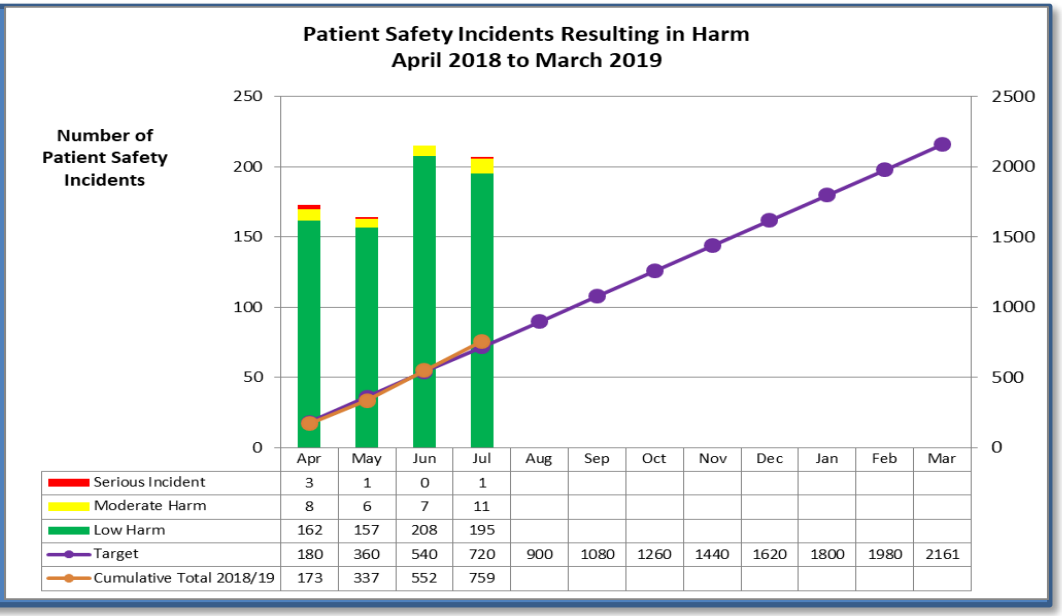
The target is to reduce patient safety harm incidents by 5% when compared to the previous financial year by the end of March 2019.

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

For July 2018, there were a total of 207 patient safety harm incidents:
94.2% (195 incidents) have resulted in low harm
5.3% (11 incidents) have resulted in moderate harm
0.5% (1 incident) 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 on the 5 November 2018



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Serious Incident	3	1	0	1								
Moderate Harm	8	6	7	11								
Low Harm	162	157	208	195								
Target	180	360	540	720	900	1080	1260	1440	1620	1800	1980	2161
Cumulative Total 2018/19	173	337	552	759								

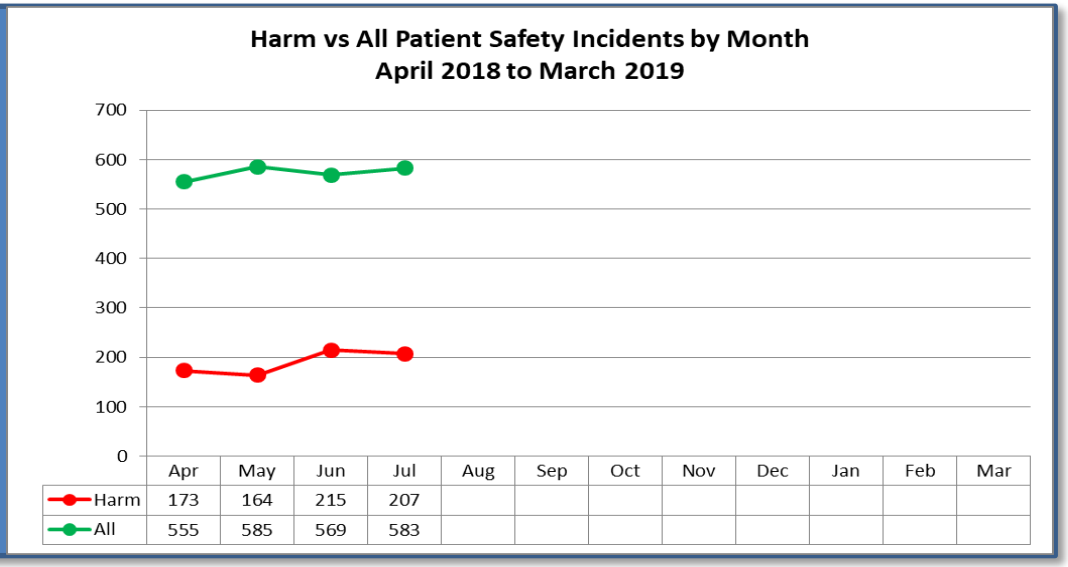
Harm vs All Patient Safety Incidents

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 July 2018, the gap between harm and all patient safety incidents was 376. 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	173	164	215	207								
All	555	585	569	583								

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

Description	Aggregate Position	Trend

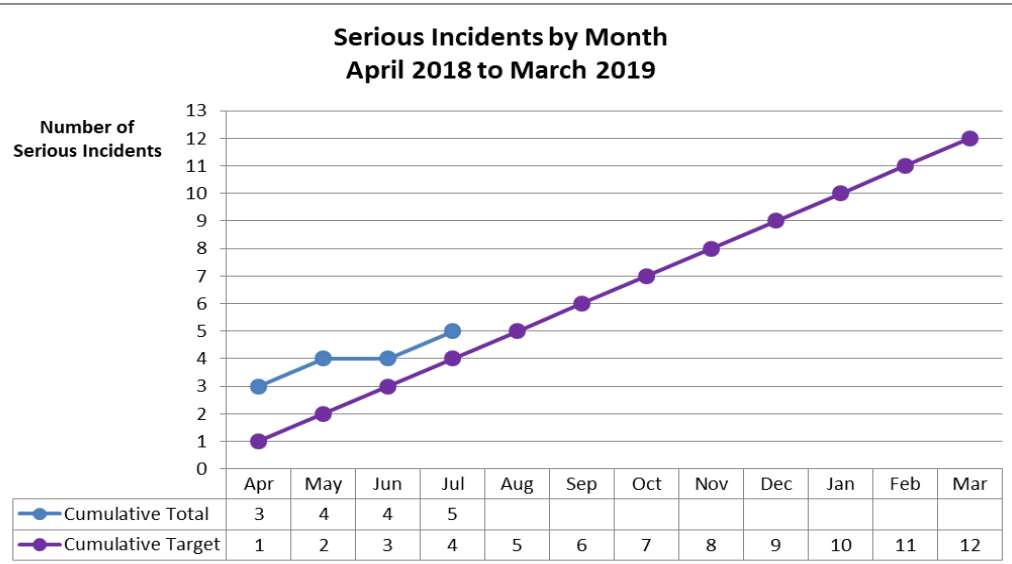
Serious Incidents

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 July 2018, there was one serious incident reported.

- Patient Fall resulting in fractured neck of femur (Ward 21B)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative Total	3	4	4	5								
Cumulative Target	1	2	3	4	5	6	7	8	9	10	11	12

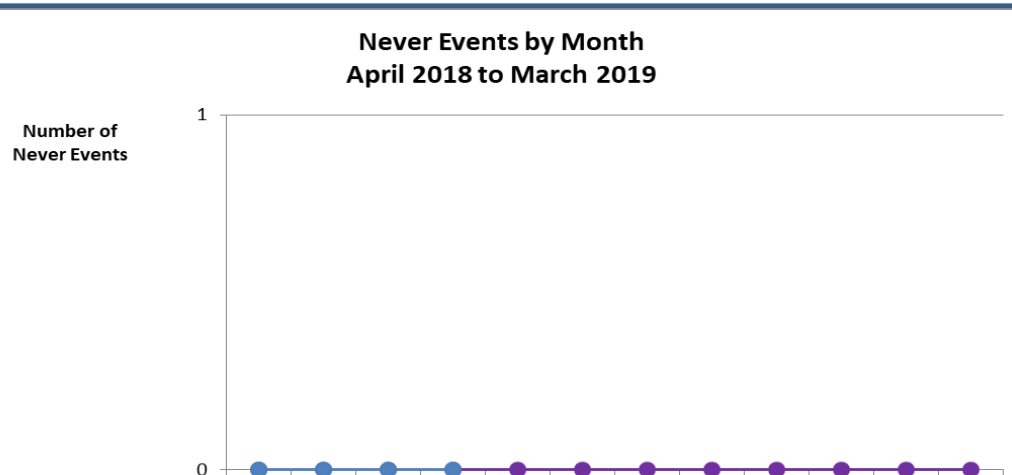
Never Events

The target is to have zero Never Events

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

For July 2018 no Never Events were reported.

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.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative Target	0	0	0	0	0	0	0	0	0	0	0	0
Cumulative Total	0	0	0	0								

Description	Aggregate Position	Trend

Pressure Ulcers – Hospital Acquired

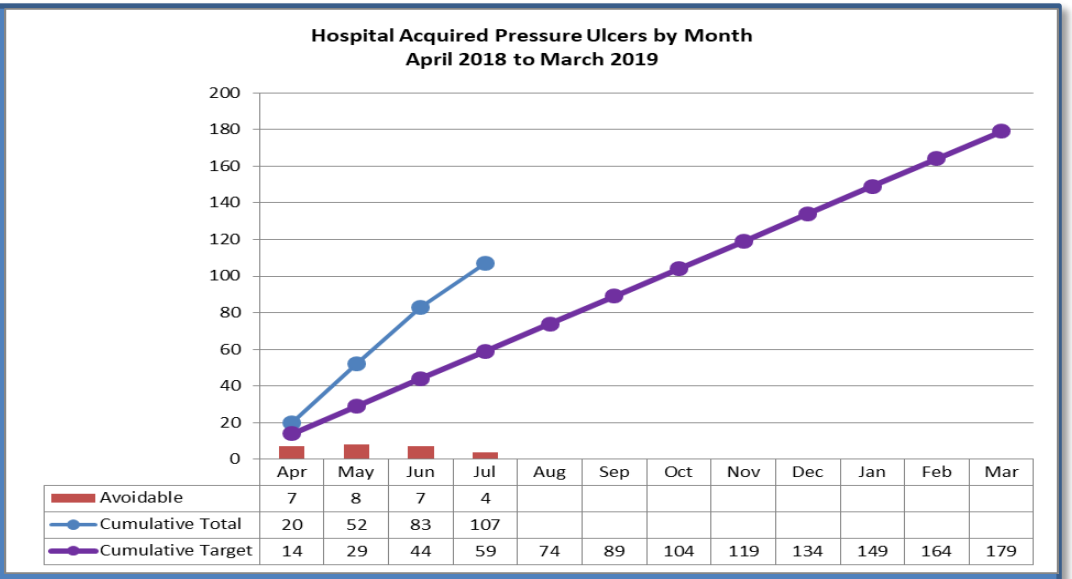
The target is to reduce hospital acquired pressure ulcers by 10% when compared to the previous financial year by the end of March 2019.

For July 2018, there were a total of 24 hospital acquired pressure ulcer incidents:

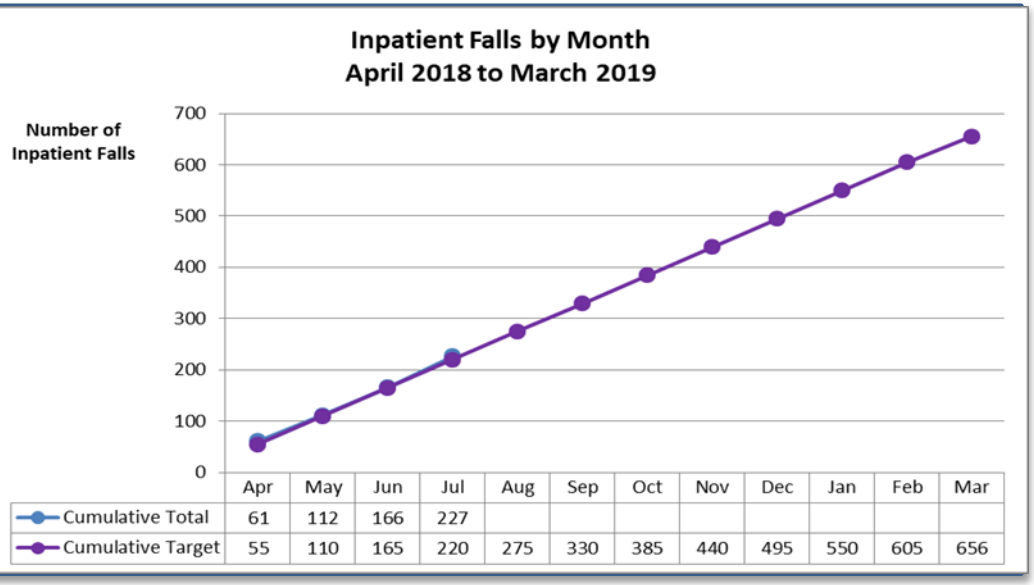
- 17% (4 PU's) have resulted in avoidable harm. Of these 3 were category 2 pressure ulcers and 1 was categorised as unstageable. All avoidable pressure ulcers are reviewed at the monthly pressure ulcer panel.
- 38% (9 PU's) have been classed as unavoidable following investigation. These were all category 2 pressure ulcers
- 46% (11) are currently undergoing investigation prior to confirmation.
-

Improvement actions include

- Implementation of a weekly ward support programme. Allocating daily divisional drop in sessions for all wards on pressure ulcer prevention
- Development of pressure ulcer champions to support 'master classes' in pressure ulcer prevention and support the Tissue Viability Specialist Nurse with 'back to basic' training.
- Implement Trust wide initiatives in pressure ulcer reduction including standardised approach to the location of repositioning charts at the end of each bed.

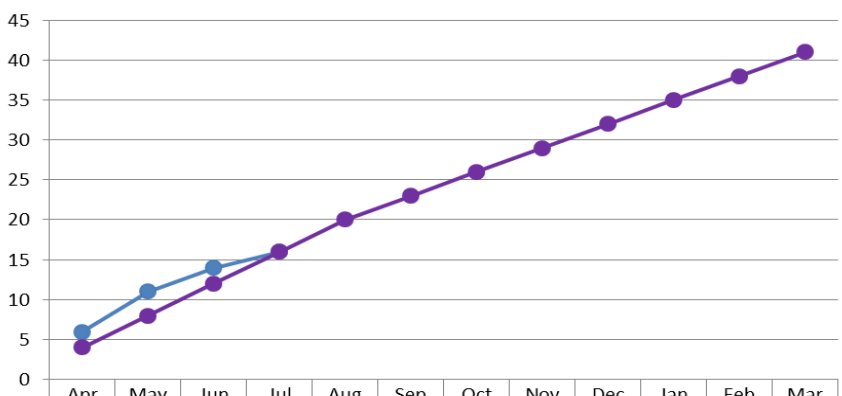


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Avoidable	7	8	7	4								
Cumulative Total	20	52	83	107								
Cumulative Target	14	29	44	59	74	89	104	119	134	149	164	179

Description	Aggregate Position	Trend
Inpatient Falls. *The target is to reduce inpatient falls by 10% when compared to the previous financial year by March 2019*	For July 2018, there were a total of 61 inpatient falls • 68.8% (42 falls) have resulted in no harm • 29.6% (18 falls) have resulted in low harm • 0% (0 falls) resulted in moderate harm • 1.6% (1 fall) has resulted in serious harm Improvement actions include: • Bespoke training where an increase in falls has been identified • Continued review of practice during senior nurse walkabouts	

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative Total	61	112	166	227								
Cumulative Target	55	110	165	220	275	330	385	440	495	550	605	656

	Medication Harm Incidents	Medication Harm Incidents by Month April 2018 to March 2019
	Medication Harm Incidents *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 July 2018, there were a total of 2 medication incidents resulting in harm reported: • 100% (2 medication incidents) have resulted in low harm • 0% (0 medication incidents) have resulted in moderate harm • 0% (0 medication incidents) have resulted in serious harm Improvement actions include: • Junior medical staff training • E-learning package in place • Zero tolerance to prescription anomalies at ward level



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative Total	6	11	14	16								
Cumulative Target	4	8	12	16	20	23	26	29	32	35	38	41

Central Cheshire Integrated Care Partnership (CCICP)

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

CCICP Patient Safety Harm Incidents

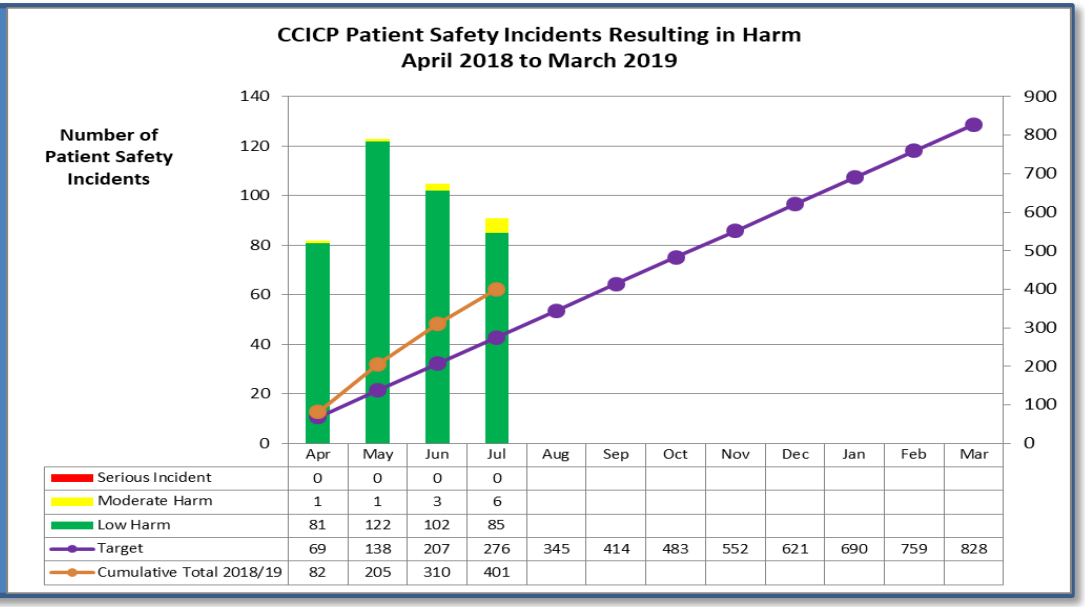
The target is to reduce CCICP patient safety harm incidents by 5% when compared to the previous financial year by the end of March 2019.

For July 2018, there were a total of 91 patient safety harm incidents:

- 93.4% (85 incidents) have resulted in low harm
- 6.6.% (6 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
- Local quality champions introduced



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Serious Incident	0	0	0	0								
Moderate Harm	1	1	3	6								
Low Harm	81	122	102	85								
Target	69	138	207	276	345	414	483	552	621	690	759	828
Cumulative Total 2018/19	82	205	310	401								

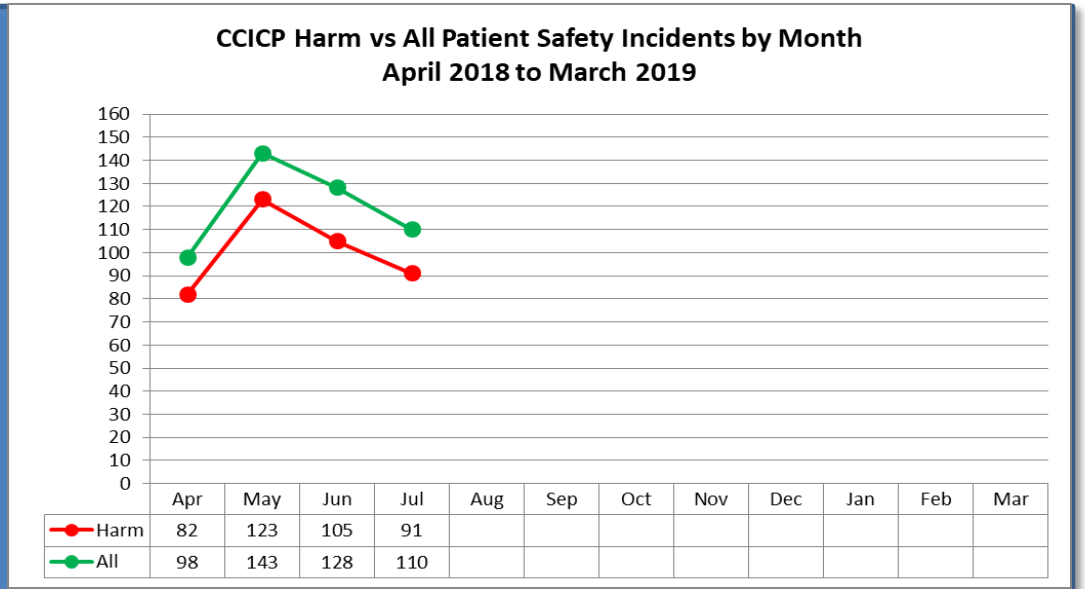
CCICP Harm vs All Patient Safety Incidents

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

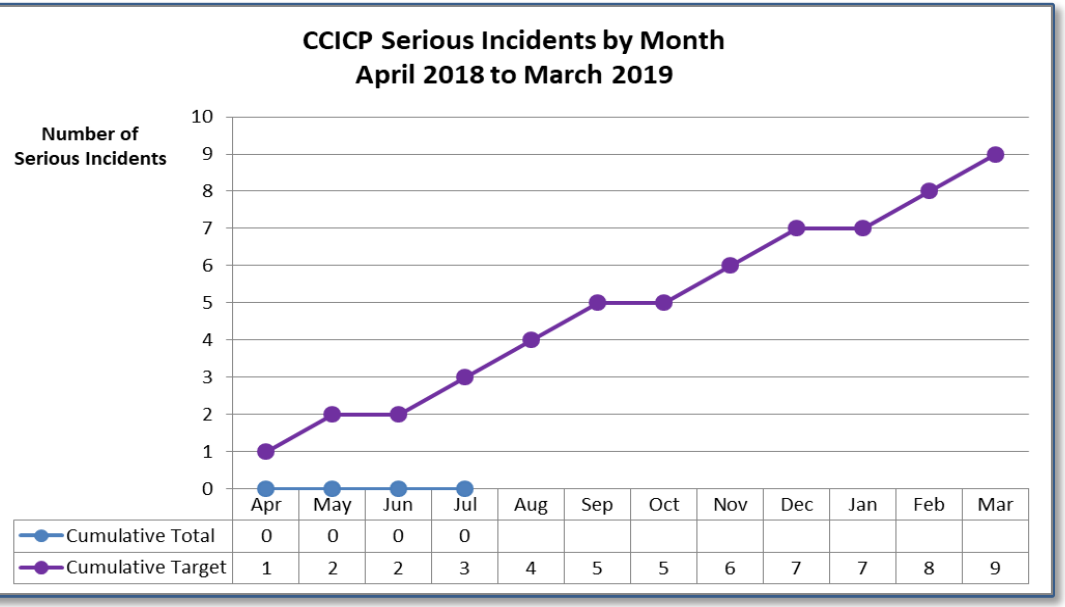
This chart demonstrates the number of incidents that have resulted in harm vs all patient safety incidents.

In July 2018, the gap between harm and all patient safety incidents was 19.

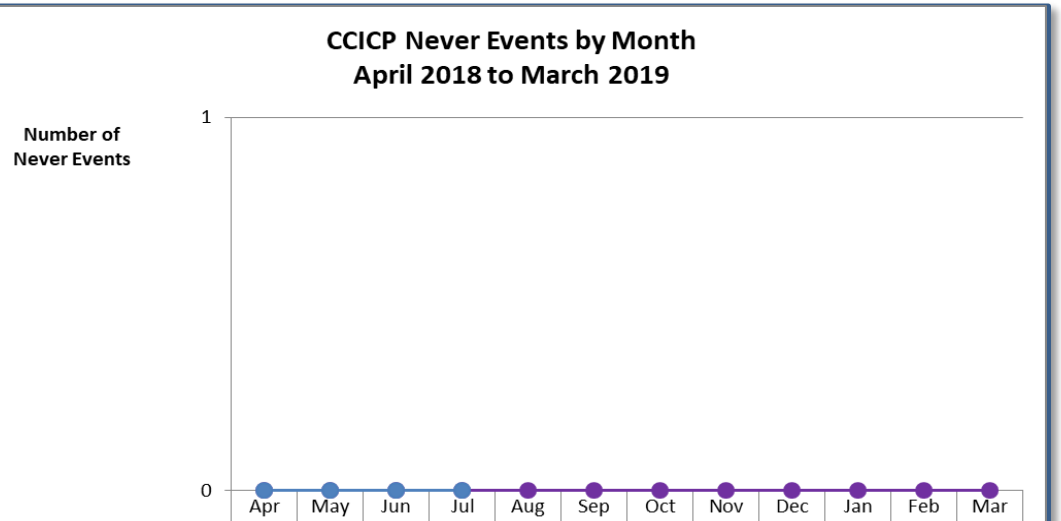
Within healthcare, a safety culture is defined as a "culture where staff have a constant and active awareness of the potential for things to go wrong. It is also a culture that is open and fair and encourages people to speak up about mistakes." An important benefit in a safety culture in the NHS is "A 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	82	123	105	91								
All	98	143	128	110								

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 July 2018, there were no serious incidents reported.	

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative Total	0	0	0	0								
Cumulative Target	1	2	2	3	4	5	5	6	7	7	8	9

	Description	Aggregate Position	Trend
CCICP Never Events *The target is to have zero Never Events*	This chart demonstrates the number of Never Events that have been reported. For July 2018 no Never Events were reported. No Never Events have been reported for CCICP since the merger of the Trust in October 2016.		

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative Target	0	0	0	0	0	0	0	0	0	0	0	0
Cumulative Total	0	0	0	0								

Description	Aggregate Position	Trend

Pressure Ulcers – Community Acquired

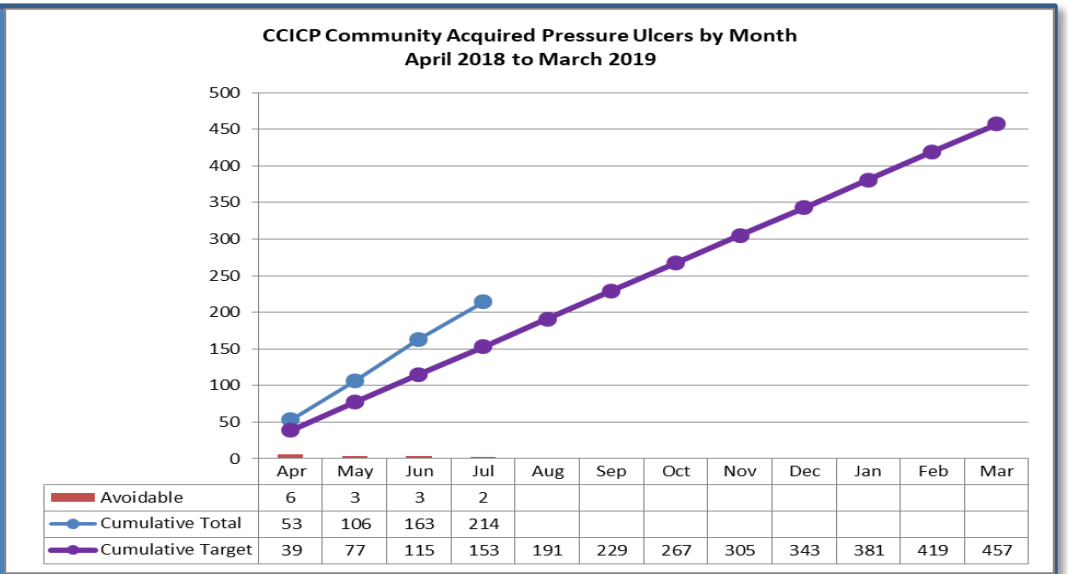
The target is to reduce community acquired pressure ulcers by 10% when compared to the previous financial year by the end of March 2019.

For July 2018, there were a total of 51 community acquired pressure ulcer incidents:

- 3.9% (2 PU's) have resulted in avoidable harm. Of these 1 was a category 2 pressure ulcers and 1 was categorised as unstageable
- 76.5% (39 PU's) have been classed as unavoidable following investigation. Of these 24 were category 2 pressure ulcers and 15 were categorised as unstageable
- 19.6% (10) are currently undergoing investigation prior to confirmation

Improvement actions include:

- React 2 Red teaching sessions are now being delivered in Nursing Homes
- Training is being provided for community stroke rehab team.
- Workshops have been booked to launch new products on the wound formulary
- Posters / leaflets launched in GP surgeries to promote pressure ulcer prevention.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Avoidable	6	3	3	2								
Cumulative Total	53	106	163	214								
Cumulative Target	39	77	115	153	191	229	267	305	343	381	419	457

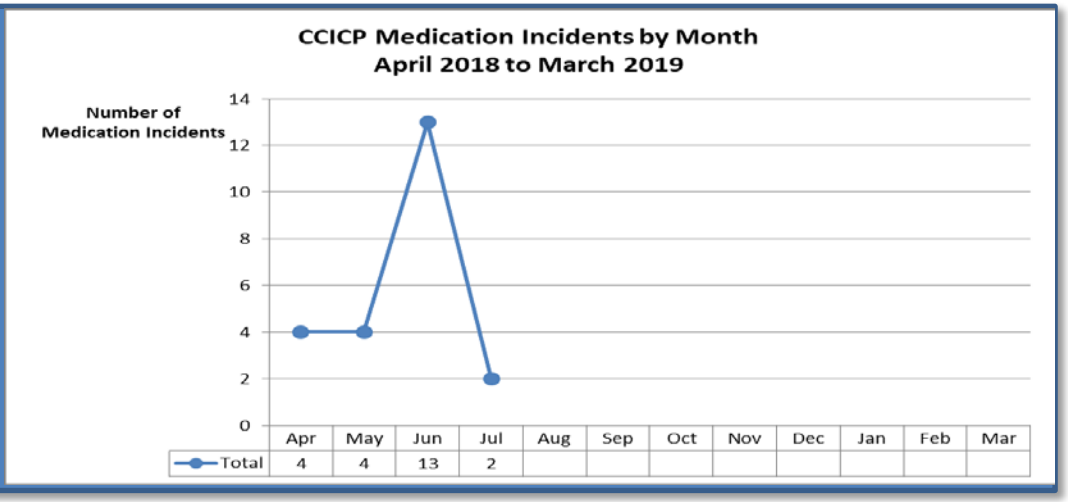
CCICP Medication Incidents.

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

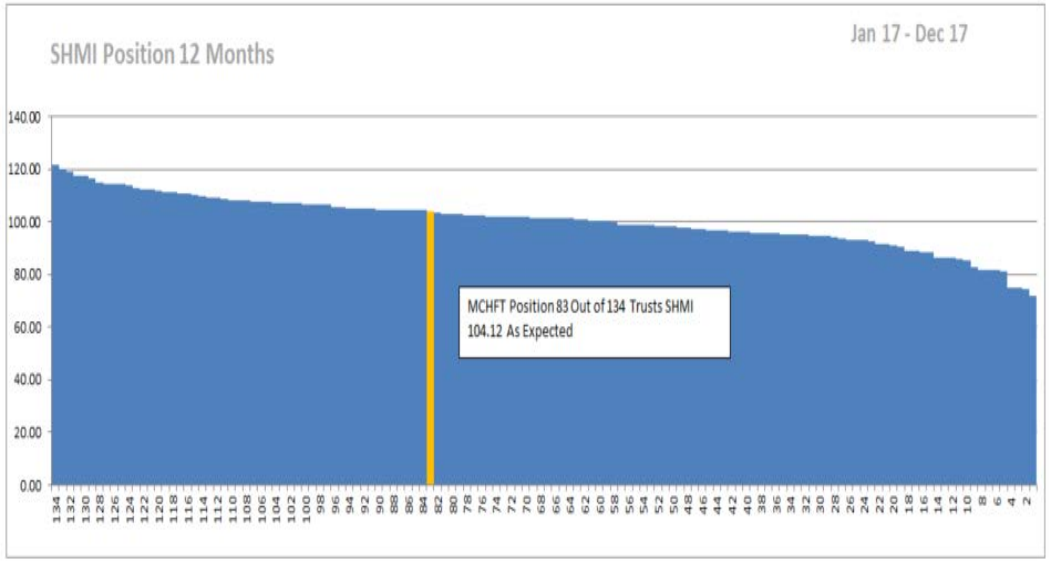
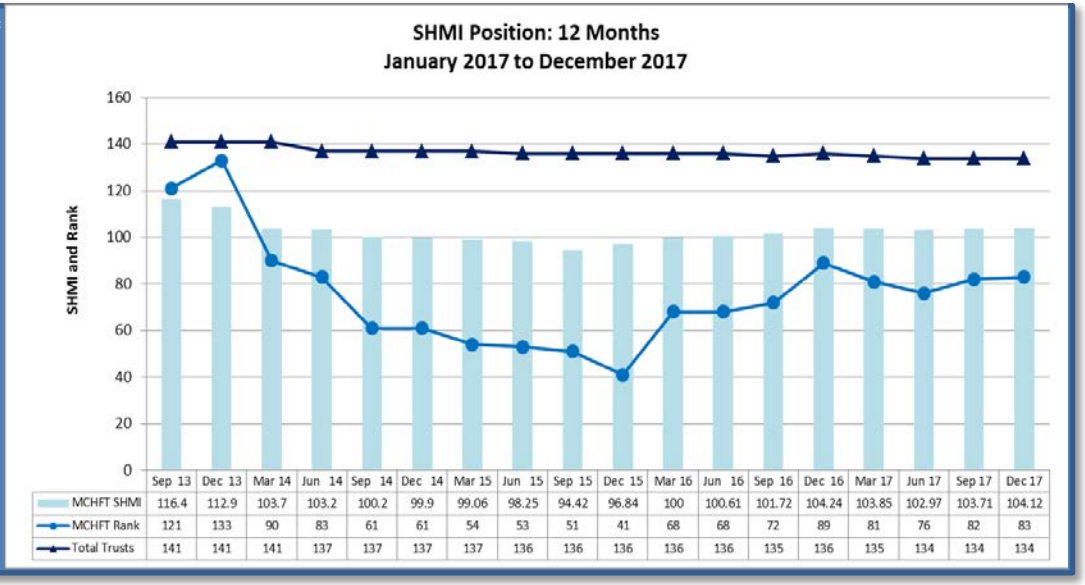
For July 2018, there were a total of 2 medication incidents reported:

- 0% (0 medication incidents) resulted in no harm
- 100% (2 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

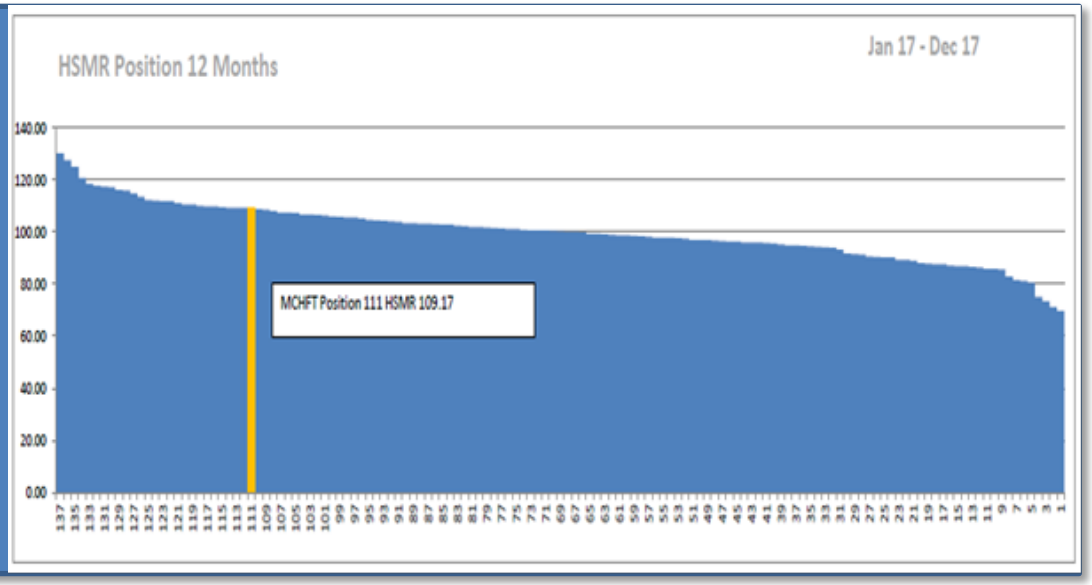
CCICP has a dedicated pharmacy lead who is actively encouraging the reporting of all grades of incidents across all services.

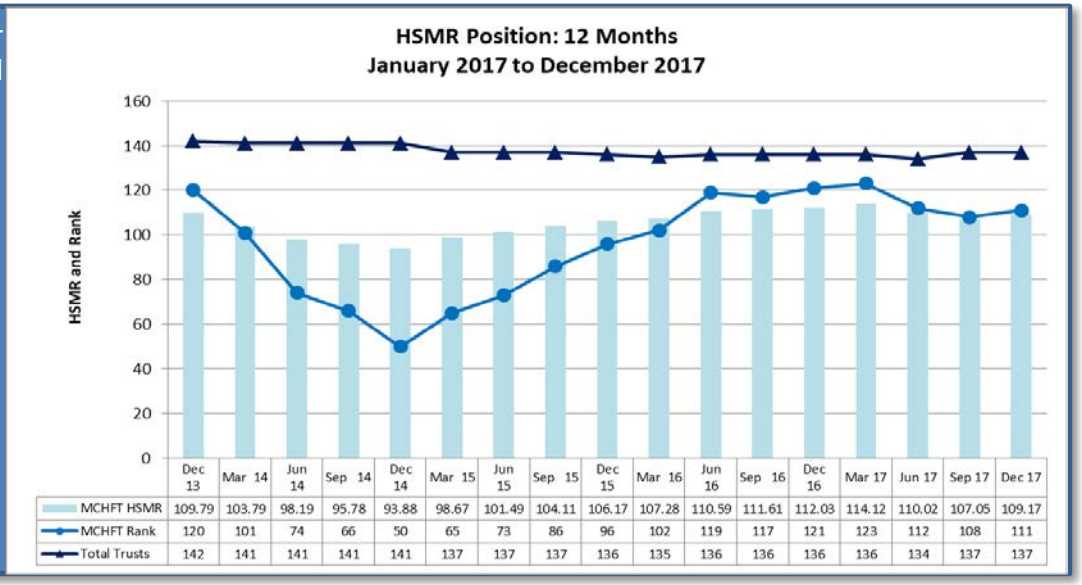


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total	4	4	13	2								

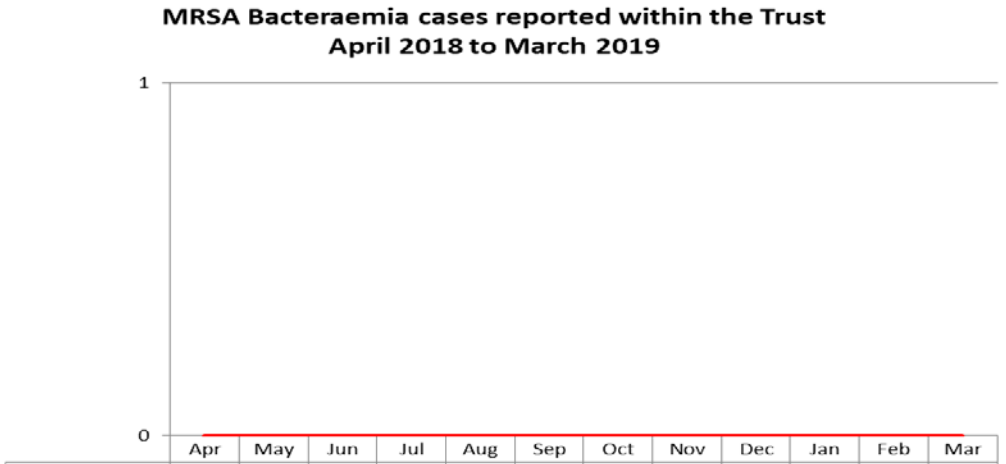
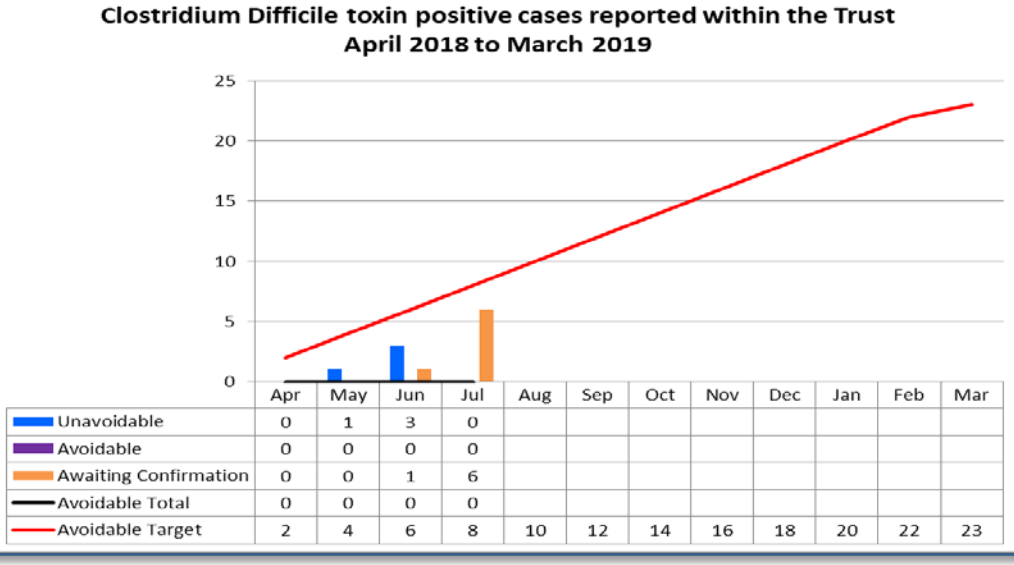
Description	Aggregate Position	Trend
SHMI *The Trust's target is to be at least within the "as expected" bracket.*	The chart benchmarks the Trust's latest SHMI against all NHS Trusts. MCHFT is shown as the yellow bar. The Trust's SHMI is 104.12 for the time period January 2017 to December 2017 and places the Trust 83 out of 134 Trusts and is "as expected".	
MCHFT *12 month rolling position Summary Hospital-Level Mortality Indicator (SHMI) by Trust.*	The chart shows the SHMI and rank of MCHFT for each of the 12 month rolling position submissions for the period January 2017 to December 2017 and is "as expected".	

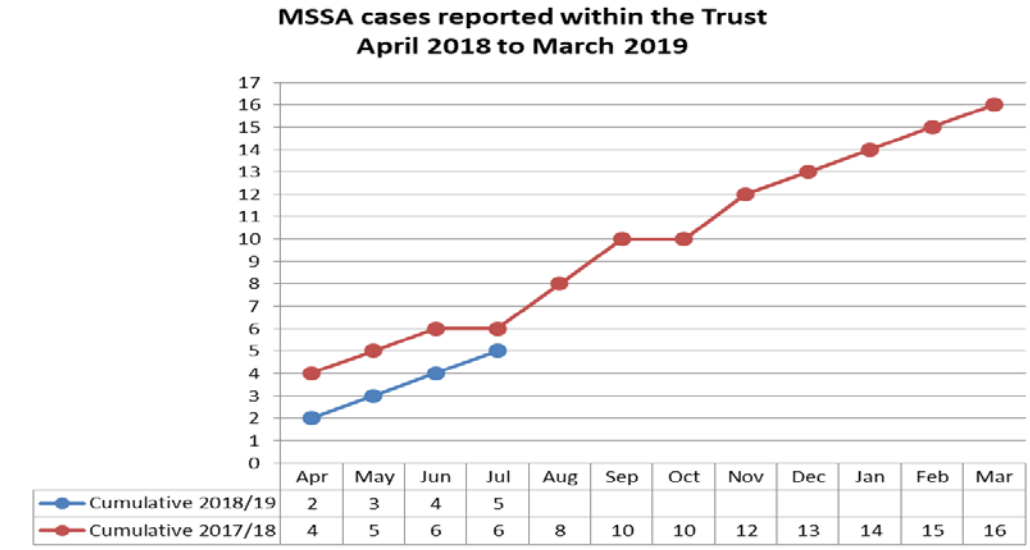
	Sep 13	Dec 13	Mar 14	Jun 14	Sep 14	Dec 14	Mar 15	Jun 15	Sep 15	Dec 15	Mar 16	Jun 16	Sep 16	Dec 16	Mar 17	Jun 17	Sep 17	Dec 17
MCHFT SHMI	116.4	112.9	103.7	103.2	100.2	99.9	99.06	98.25	94.42	96.84	100	100.61	101.72	104.24	103.85	102.97	103.71	104.12
MCHFT Rank	121	133	90	83	61	61	54	53	51	41	68	68	72	89	81	76	82	83
Total Trusts	141	141	141	137	137	137	137	136	136	136	136	136	135	136	135	134	134	134

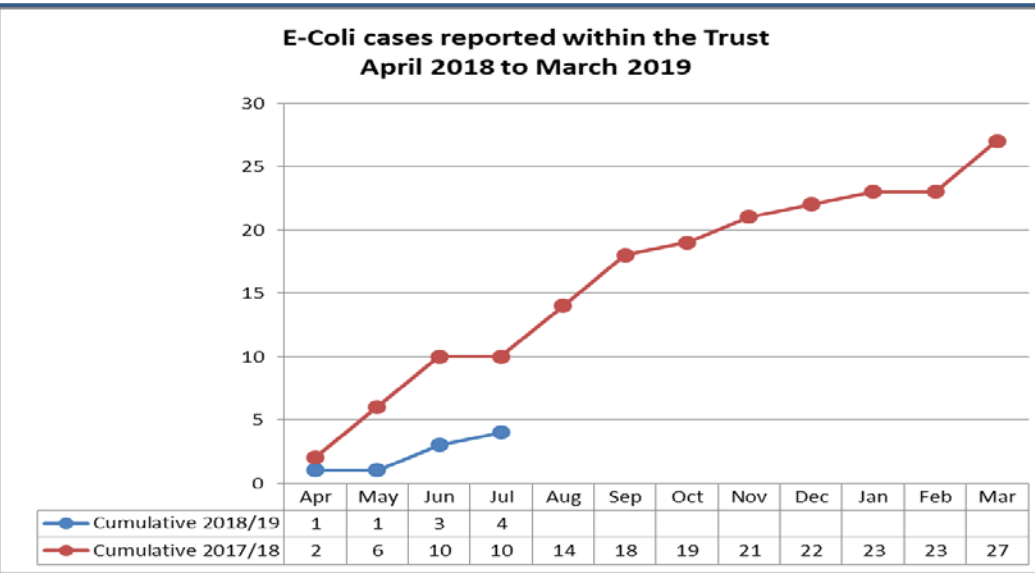
Description	Aggregate Position	Trend
Hospital Standardised Mortality Rate (HSMR) by Trust. *The Trust's target is to be at least within the "as expected" bracket.*	The chart benchmarks the Trust's HSMR against all NHS Trusts. MCHFT is shown by the amber bar. The Trust's HSMR is 109.17 (January 2017 to December 2017) and places the Trust 111 out of 137 Trusts and is "as expected".	

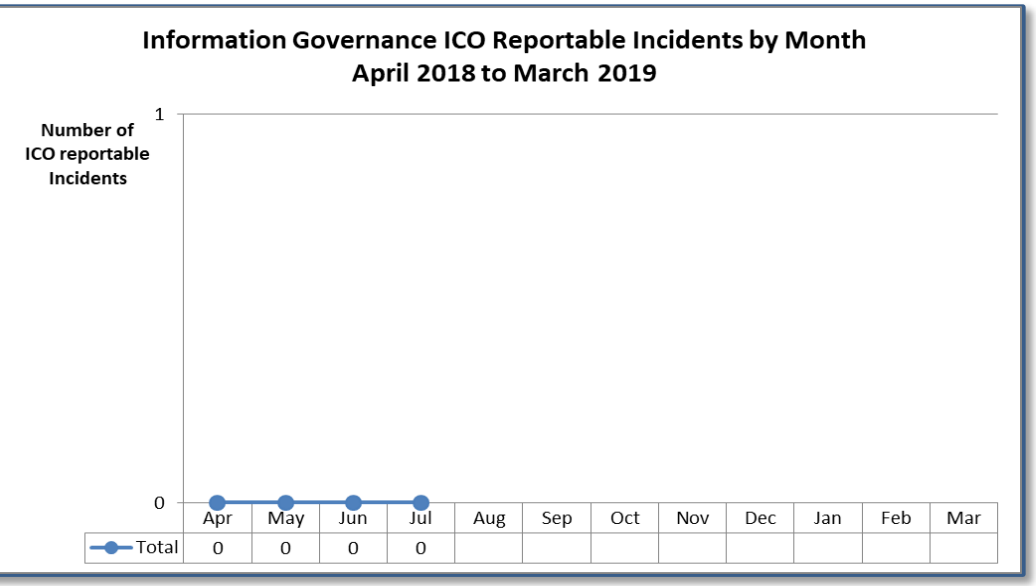
Description	Aggregate Position	Trend
MCHFT *12 month rolling position for HSMR*	The data in the chart shows the HSMR and rank of MCHFT for each of the 12 month rolling position submissions for the period January 2017 to December 2017 and is "as expected".	

	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	Dec 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	109.17
MCHFT Rank	120	101	74	66	50	65	73	86	96	102	119	117	121	123	112	108	111
Total Trusts	142	141	141	141	141	137	137	137	136	135	136	136	136	136	134	137	137

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

Description	Aggregate Position	Trend
MSSA Cases. *The aim is to have a reduction in MSSA cases when compared to the previous financial year, to demonstrate an incremental improvement*	In July 2018, one MSSA case was reported in the Trust. In this financial year there has been five confirmed MSSA cases reported. The one MSSA case in July 2018 occurred on Ward 1.	

E-Coli Cases. *The aim is to have a reduction in E-Coli cases when compared to the previous financial year, to demonstrate an incremental improvement*	In July 2018, one E-Coli case were reported. The case occurred on Critical Care.	

Description	Aggregate Position	Trend
Information Governance Information Commissioners Office (ICO) reportable incidents.	In July 2018, no information governance ICO reportable incidents were reported in the Trust. The Trust has detailed plans 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: July 2018

CQUIN 2018-19 Performance

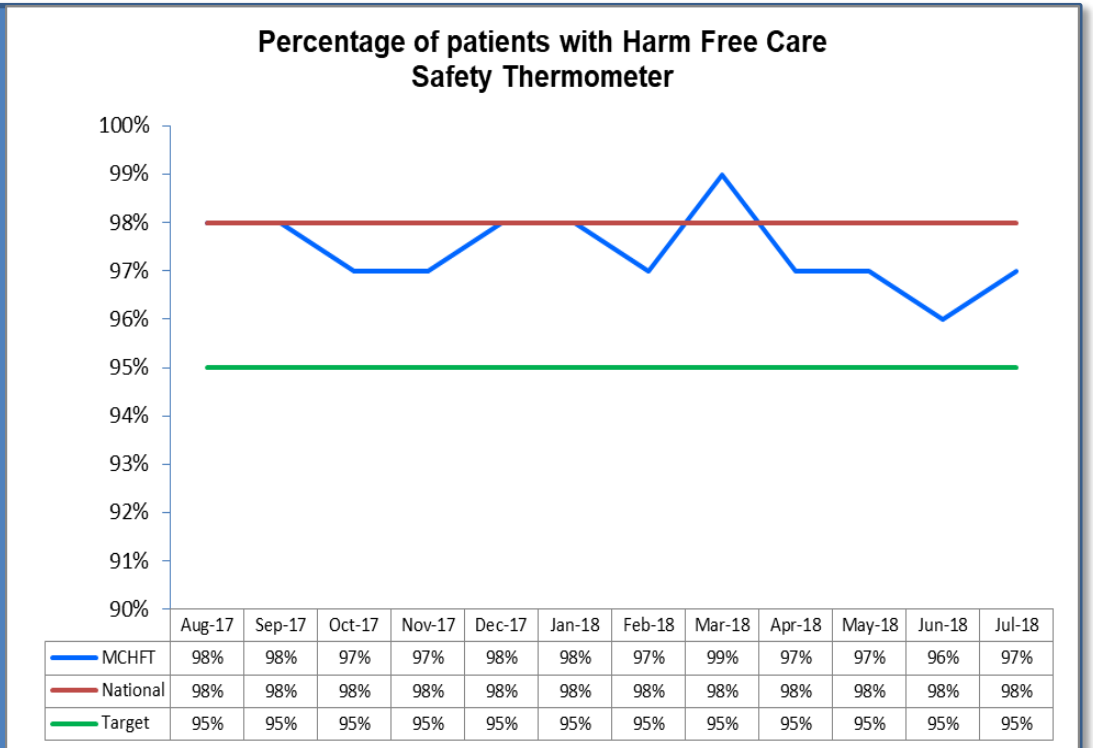
CQUIN Indicator	Indicator Name	Milestone Achieved								
		Q1	Financial Incentive Achieved	Q2	Financial Incentive Achieved	Q3	Financial Incentive Achieved	Q4	Financial Incentive Achieved	Maximum Value
1a	**Health & Wellbeing** 5% point improvement in two of the three questions on H&W, MSK & Stress		No payment		No payment		No payment		£137,574	**£137,574**
1b	**Health & Wellbeing** Maintain the four changes for improving healthy food for NHS staff, visitors and patients. Introduce three new changes to food and drink provision.		No payment		No payment		No payment		£137,574	**£137,574**
1c	**Health & Wellbeing** Achieve an uptake of flu vaccinations of front line clinical staff of 75% by end of February 2019.		No payment		No payment		No payment		£137,574 £137,180	**£137,574** **CCICP £137,180**
2a	**Sepsis: Identification** The percentage of patients who met the criteria for sepsis screening and were screened for sepsis.	 **Partially**	£25,795		£25,795		£25,795		£25,795	**£103,181**
2b	**Sepsis: Treatment** The percentage of patients who were found to have sepsis and received IV antibiotics within1 hour.	 **Partially**	£25,795		£25,795		£25,795		£25,795	**£103,181**
2c	**Sepsis: Antibiotic Review** Percentage of antibiotic prescriptions documented and reviewed by a competent clinician within 72 hours		£25,795		£25,795		£25,795		£25,795	**£103,181**
2d Part 1	**Reduction in antibiotic consumption** Achieve a reduction of x% or more in total antibiotic consumption per 1,000 admissions.		No payment		No payment		No payment		£34,393	**£34,393**
2d Part 2	**Reduction in carbapenem consumption** Achieve a reduction of x% or more in total carbapenem consumption per 1,000 admissions.		No payment		No payment		No payment		£34,393	**£34,393**
2d Part 3	**Reduction in piperacillin tazabactam consumption** Achieve a reduction of x% or more in total piperacillin tazabactam consumption per 1,000 admissions.		No payment		No payment		No payment		£34,393	**£34,393**

CQUIN 2018-19 Performance

CQUIN Indicator	Indicator Name	Milestone Achieved								
		Q1	Financial Incentive Achieved	Q2	Financial Incentive Achieved	Q3	Financial Incentive Achieved	Q4	Financial Incentive Achieved	Maximum Value
4	**Mental Health in Emergency Department** Maintain 20% reduction in attendances to the Emergency Department for people with Mental Health needs.	✓	No Payment				£41,272		£371,451	**£412,723**
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.	✓	£65,908		£65,908		£65,908		£226,998	**£412,723**
9a	**Tobacco screening** Percentage of unique adult patients who are screened for smoking status AND whose results are recorded..	✓	£5,159		£5,159		£5,159		£5,159	**£20,636**
9b	**Tobacco brief advice** Percentage of unique patients who smoke AND are given very brief advice	✓	£20,636		£20,636		£20,636		£20,636	**£82,545**
9c	**Tobacco referral and medication offer** Percentage of unique patients who are smokers AND are offered referral to stop smoking services AND offered stop smoking medication.	✓	£25,795		£25,795		£25,795		£25,795	**£103,181**
9d	**Alcohol brief advice or referral** Percentage of unique adult patients who are screened for drinking risk levels AND whose results are recorded in local data systems	✓	£25,795		£25,795		£25,795		£25,795	**£103,181**
9e	**Alcohol brief advice or referral** Percentage of unique patients who drink alcohol above lower-risk levels AND are given brief advice OR offered a specialist referral if the patient is potentially alcohol dependent	✓	£25,795		£25,795		£25,795		£25,795	**£103,181**

CQUIN 2018-19 Performance

CQUIN Indicator	Indicator Name	Milestone Achieved								
		Q1	Financial Incentive Achieved	Q2	Financial Incentive Achieved	Q3	Financial Incentive Achieved	Q4	Financial Incentive Achieved	Maximum Value
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.	✓	No payment		£68,590		No payment		£68,590	**£137,180**
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	✓	No payment		No payment		No payment		£137,180	**£137,180**
PHE1	**Breast Screening Programme Clerical Staff Development (Health Promotion role)** Update and improve the clerical teams knowledge of health promotion to support clients who access The Breast Screening Unit and key partners involved in the Breast Screening Programme	✓	£3,742.50		£3,742.50		£3,742.50		£3,742.50	**£14,969**
PHE2	**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	✓	£5,822		£5,822		£5,822		£5,822	**£23,288**
SP 1	**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.	✓	£10,292		£10,292		£10,292		£10,292	**£41,167**
SP 2	**Hospital Pharmacy Transformation and Medicines Optimisation**	✓	£15,437		£15,437		£15,437		£15,437	**£61,749**

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

	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18
MCHFT	98%	98%	97%	97%	98%	98%	97%	99%	97%	97%	96%	97%
National	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

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

Ward Name	Main Specialties	Safety Thermometer Results July 2018			
		Acquired Pressure Ulcers	Patient Falls resulting in harm	CAUTI	New VTE
MCHFT		**1.52% (12)**	**1.14% (9)**	**0.25% (2)**	**0.38% (3)**
AMU	Gen. Medicine	0% (0)	0% (0)	0% (0)	0% (0)
CAU	Paediatrics	0% (0)	0% (0)	0% (0)	0% (0)
Critical Care	Gen. Medicine	0% (0)	0% (0)	0% (0)	0% (0)
Elmhurst	Rehab	0% (0)	0% (0)	0% (0)	0% (0)
Ward 1	Gen. Medicine	0% (0)	10.34% (3)	0% (0)	6.9% (2)
SAU	Gen. Surgery	0% (0)	5.56% (1)	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	3.7% (1)	0% (0)	0% (0)	3.7% (1)
Ward 14	Gen. Medicine	0% (0)	0% (0)	0% (0)	0% (0)
Ward 10	Trauma & Ortho	0% (0)	0% (0)	0% (0)	0% (0)
Ward 2	Gen. Medicine	0% (0)	0% (0)	0% (0)	0% (0)
Ward 21B	Rehab	8.33% (2)	0% (0)	0% (0)	0% (0)
Ward 23	Obstetrics	0% (0)	0% (0)	0% (0)	0% (0)
Ward 26	Obstetrics	0% (0)	0% (0)	0% (0)	0% (0)
Ward 4	Gen. Medicine	0% (0)	9.38% (3)	0% (0)	0% (0)
Ward 5	Gen. Medicine	9.68% (3)	0% (0)	0% (0)	0% (0)
Ward 6	Gen. Medicine	8% (2)	0% (0)	0% (0)	0% (0)
Ward 7	Gen. Medicine	0% (0)	0% (0)	6.25% (2)	0% (0)
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	4.17% (1)	0% (0)	0% (0)	0% (0)
DN – Ashfields and Haslington	District Nursing	9.09% (1)	0% (0)	0% (0)	0% (0)
DN – Dane Bridge	District Nursing	0% (0)	0% (0)	0% (0)	0% (0)
DN – Eagle Bridge	District Nursing	2.27% (1)	0% (0)	0% (0)	0% (0)
DN – Firdale	District Nursing	1.89% (1)	0% (0)	0% (0)	0% (0)
DN – Grosvenor, Hungerford and Rope Green		0% (0)	0% (0)	0% (0)	0% (0)
DN - Church View	District Nursing	0% (0)	4.55% (2)	0% (0)	0% (0)
DN – Winsford	District Nursing	0% (0)	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: July 2018

Description	Aggregate Position		Trend
Registered Nurses monthly expected hours by shift versus actual monthly hours per shift. Day time shifts only	90.3% of expected Registered Nurse hours were achieved for day shifts. Any registered nurse numbers that fall below 85% are required to have a divisional review and an update of actions provided to the Director of Nursing & Quality and the Deputy Director of Nursing & Quality.	Trend July 2018 90.3% June 2018 88.9% May 2018 89.8%	The lowest staffing levels during the day were on Ward 9 at 60.8%
Registered Nurses monthly expected hours by shift versus actual monthly hours per shift. Night time shifts only	94.8% of expected Registered Nurse hours were achieved for night shifts.	Trend July 2018 94.8% June 2018 99.3% May 2018 95.9%	The lowest staffing levels during the night were on Ward 12 at 71.0%
Healthcare Assistant monthly expected hours by shift versus actual monthly hours per shift. Day time shifts only	99.3% of expected HCA hours were achieved for day shifts.	Trend July 2018 99.3% June 2018 95.1% May 2018 99.7%	The lowest staffing levels during the day were on Ward 9 at 41.9%
Healthcare Assistant monthly expected hours by shift versus actual monthly hours per shift. Night time shifts only	116.9% of expected HCA hours were achieved for night shifts. For areas with over 100% staffing levels for HCA's this is reviewed and is predominately due to wards requiring 1 to 1 specials for patients following a risk assessment or to increase staffing numbers when there are registered nursing gaps that are not filled.	Trend 116.9% July 2018 June 2018 101.8% May 2018 107.3%	The lowest staffing levels during the night were on Ward 9 at 58.1%
Total number of wards that are lower than 85% RN fill days and nights is 10.	Ward 12 – 81% (day), Ward 13 – 84.6% (day), Ward 21b 84.4% (day), Ward 4 – 79.3% (day), Ward 5 - 80.4% (day), Ward 9 – 60.8% (day), Ward 10 – 84.3% (day). Ward 12 – 71% (night), Ward 5 – 72.6% (night), Ward 6 – 83.1% (night).	• Actions taken: Staffing reviewed on daily basis by Matrons/HoN following Escalation process • Risk assessments taken place to review bed occupancy and patient acuity before transferring staff	

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

Ward Name	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	41486.2	37462.4	30014.5	29818.9	25337.1	24021.8	16316.6	19069.1	90.3%	99.3%	94.8%	116.9%	14994	132.8	66.9	199.8
AMU	2011.3	1852	1519	1445.8	1898.8	1764	1519	1519	92.1%	95.2%	92.9%	100.0%	794	4.6	3.7	8.3
CAU (Winter)	1657.5	1657.5	762.5	762.5	1414.5	1414.5	356.5	356.5	100.0%	100.0%	100.0%	100.0%	367	8.4	3.0	11.4
Critical Care	3890.5	3890.5	583.5	583.5	2384.5	2384.5			100.0%	100.0%	100.0%		251	25.0	2.3	27.3
Elmhurst	871.5	871.5	2232	2142	775	775	1550	1775	100.0%	96.0%	100.0%	114.5%	885	1.9	4.4	6.3
Ward 1	2187.5	2081.3	1162.5	1100	1519	1494.5	759.5	747.3	95.1%	94.6%	98.4%	98.4%	925	3.9	2.0	5.9
Ward 12	2235	1811	1984	1976	953.3	676.5	635.5	830.3	81.0%	99.6%	71.0%	130.7%	860	2.9	3.3	6.2
Ward 13	2280	1928	1984	1968	953.3	871.3	635.5	635.5	84.6%	99.2%	91.4%	100.0%	898	3.1	2.9	6.0
Ward 14	1710	1542	1488	1800	744	744	1116	1524	90.2%	121.0%	100.0%	136.6%	971	2.4	3.4	5.8
Ward 2	1800	1681.3	1550	1512.5	1139.3	992.3	1139.3	1310.8	93.4%	97.6%	87.1%	115.1%	967	2.8	2.9	5.7
Ward 21b	1336.5	1128.5	1813.5	1774.5	775	775	775	775	84.4%	97.8%	100.0%	100.0%	737	2.6	3.5	6.0
Ward 23	1238	1219	785.3	722	764.7	764.7	764.7	752.3	98.5%	91.9%	100.0%	98.4%	652	3.0	2.3	5.3
Ward 26	3311.3	3311.3	652.3	652.3	2762.7	2762.7	370	370	100.0%	100.0%	100.0%	100.0%	214	28.4	4.8	33.2
Ward 10 Ortho	2656	2240	3224	3096	953.3	953.3	1271	1301.8	84.3%	96.0%	100.0%	102.4%	1103	2.9	4.0	6.9
Ward 4	1710	1356	1860	1824	744	744	1488	1476	79.3%	98.1%	100.0%	99.2%	988	2.1	3.3	5.5
Ward 5	2325	1868.8	1550	1475	1519	1102.5	759.5	1114.8	80.4%	95.2%	72.6%	146.8%	950	3.1	2.7	5.9
Ward 6	1937.5	1712.5	1937.5	2031.3	1519	1261.8	759.5	1237.3	88.4%	104.8%	83.1%	162.9%	844	3.5	3.9	7.4
Ward 7	1752.5	1502.5	1550	1837.5	759.5	759.5	1139.3	1580.3	85.7%	118.5%	100.0%	138.7%	977	2.3	3.5	5.8
Ward 9	1694	1030	1488	624	635.5	625.3	317.8	184.5	60.8%	41.9%	98.4%	58.1%	245	6.8	3.3	10.1
NICU	1924.6	1699.9	183.4	197	1782.5	1575.5		23	88.3%	107.4%	88.4%		219	15.0	1.0	16.0
Ward 11 SAU	1500	1777.5	930	1207.5	580.7	833.6	580.7	796.2	118.5%	129.8%	143.6%	137.1%	537	4.9	3.7	8.6
Ward 18 SSW	1345	1188.8	775	1087.5	759.5	747.3	379.8	759.5	88.4%	140.3%	98.4%	200.0%	610	3.2	3.0	6.2

Experience Section:

Indicators	Last four months			
	Apr-18	May-18	Jun-18	Jul-18
Complaints received by month	21	21	9	10
Complaints being reviewed by the Ombudsman	1	0	0	0
Closed complaints by month	17	14	38	14
Contacts raising informal concerns	86	100	106	120
Compliments received in month	151	142	169	105
Number of new claims received in month	3	4	1	7
Number of claims closed	5	4	0	2
Number of inquests concluded	1	0	0	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	7	7	9	6
F&FT Response Rate ED, MIU, UCC and Assessment Areas*	26%	26%	26%	25%
Proportion of positive responses ED, MIU, UCC and Assessment Areas	85%	85%	82%	83%
F&FT Response Rate Inpatients and day cases	14%	12%	28%	34%
Proportion of positive responses Inpatients and day cases	98%	98%	96%	97%
F&FT Response Rate Outpatients	3%	5%	4%	4%
Proportion of positive responses Outpatients	95%	96%	96%	96%
F&FT Response Rate Maternity - Birth	4%	2%	5%	21%
Proportion of positive responses Maternity - Birth	100%	100%	100%	100%
F&FT Response Rate Community (CCICP)	28%	23%	21%	19%
Proportion of positive responses Community (CCICP)	94%	89%	91%	93%

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

Description	Aggregate Position/Description	Trend

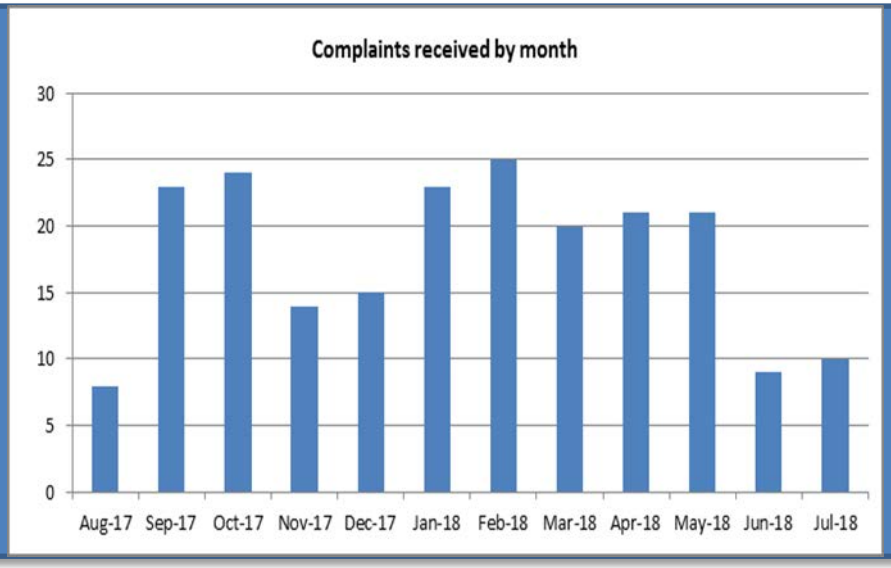
Monthly complaints received by the Trust.

10 complaints were received in July 2018 which covered 46 concerns. Of the categories, the highest categories were:

- Communication
- Incorrect Records
- Medical Care – Diagnosis Problems

Highest 3 areas receiving complaints/issues were:

- Ophthalmology - 2 complaints/10 issues
- Ward 3 – 2 complaints/7issues
- Emergency Department – 2 complaints/5 issues

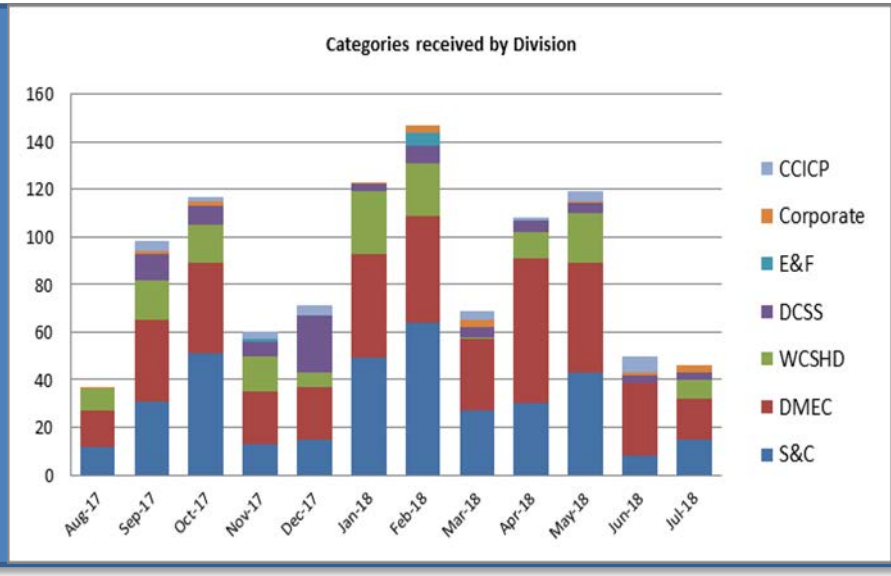


Formal Complaints

Number of formal complaint issues by division.

This graph shows the breakdown of issues by month for e ach division.

- S&C: 15
- DCSS: 3
- W&CD: 8
- DMEC: 17
- CCICP: 0
- E&F: 0
- Corporate Services: 3



Formal Complaint issues by division

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

Description	Aggregate Position/Description	Trend

Complaints being reviewed by the Public Health Service Ombudsman

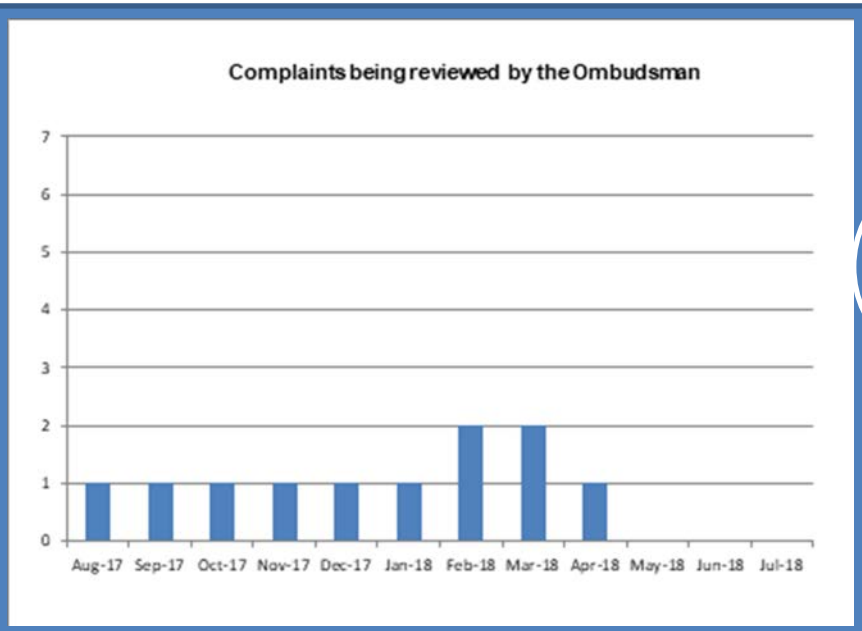
In July 2018, there were no new complaints and 4 complaints which remain active with the PHSO. In addition there is 1 complaint which has been closed in June with the Trust waiting for written confirmation from the PHSO.

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 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 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

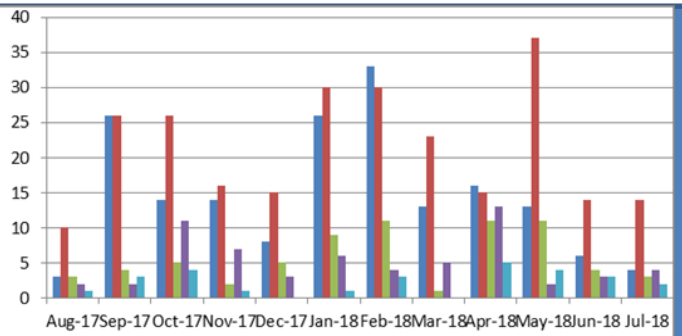
Complaint trends and number of issues.

The main trends in July 2018 were:

Communication with 6 complaints raising 14 issues.

Nursing Care with 3 complaints raising 4 issues.

Medical Care Diagnosis with 3 complaints raising 4 issues.



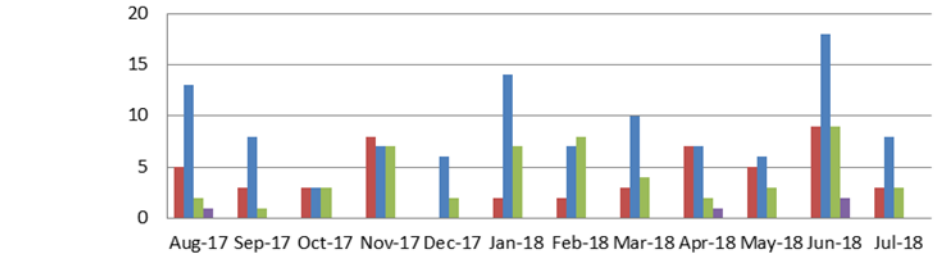
	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18
Nursing Care	3	26	14	14	8	26	33	13	16	13	6	4
Communication	10	26	26	16	15	30	30	23	15	37	14	14
Medical adverse outcome	3	4	5	2	5	9	11	1	11	11	4	3
Medical diagnosis issues	2	2	11	7	3	6	4	5	13	2	3	4
Medical delay in review	1	3	4	1	0	1	3	0	5	4	3	2

Complaint Trends

Description	Aggregate Position/Description	Trend

Closed Complaints

14 complaints were closed in July 2018.



	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18
Upheld	5	3	3	8	0	2	2	3	7	5	9	3
Partially Upheld	13	8	3	7	6	14	7	10	7	6	18	8
Not upheld	2	1	3	7	2	7	8	4	2	3	9	3
Withdrawn	1	0	0	0	0	0	0	0	1	0	2	0
Referred to HR	0	0	0	0	0	0	0	0	0	0	0	0

Closed Complaints

Closed Complaints by Division

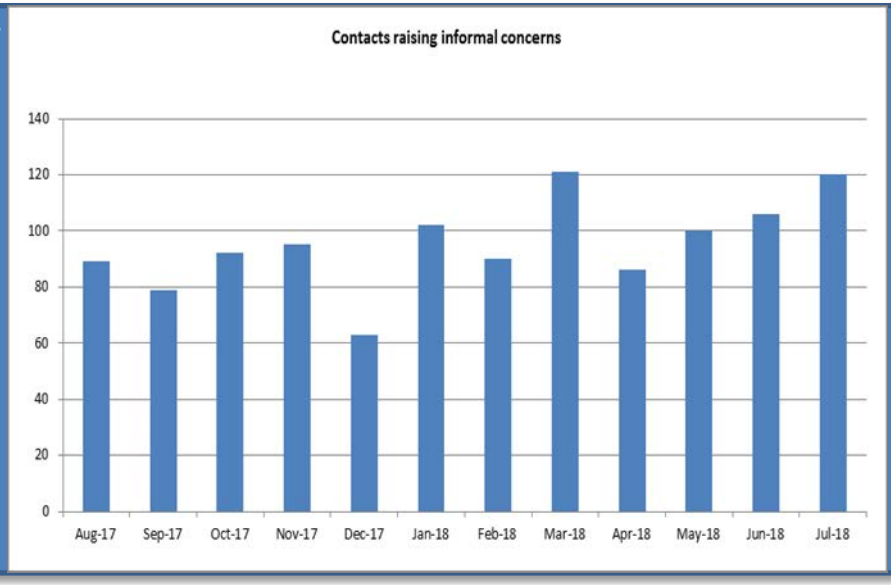
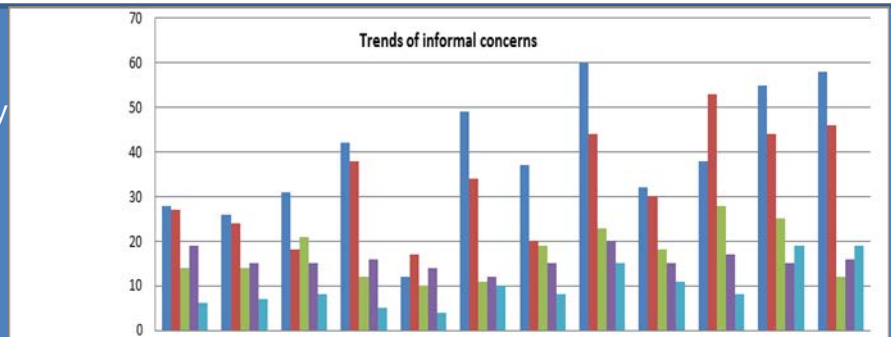
The Table provides a breakdown of closed complaints by division, demonstrating those complaints which were upheld, not upheld or partially upheld.

Division	Upheld	Partially Upheld	Not Upheld	Withdrawn	Ref HR	Sub-Total
DMEC	1	6	1	0	0	8
Corporate	0	0	0	0	0	0
Surgery and Cancer	0	1	2	0	0	3
Women & Children's	0	0	0	0	0	0
DCSS	1	0	0	0	0	1
CCICP	1	1	0	0	0	2
Totals:	**3**	**8**	**3**	**0**	**0**	**14**

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

Complaints closed by division for July 2018

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

Description	Aggregate Position/Description	Trend
Informal Concerns Numbers.	The number of contacts raising informal concerns for July 2018 was 120 which is an increase of 14 from the previous month. The Division of Medicine and Emergency Care has received the largest number of individual concerns raised at 81, with 27 of the individual concerns raised belonging to the Emergency Department.	
Informal Concerns Trends.	Communication was the highest trend for informal concerns in July 2018, with 17 of the issues raised belonging to the Division of Medicine and Emergency Care and the Surgery and Cancer Division respectively. Of these 17 issues raised for the separate Divisions, 3 belonged to cardiology administration, ward 3 and urology medical staff respectively. Of the 46 issues relating to care, 24 belonged to the Division of Medicine and Emergency Care with 10 of the 24 pertaining to Ward 2, 7 of which relate to nursing care.	

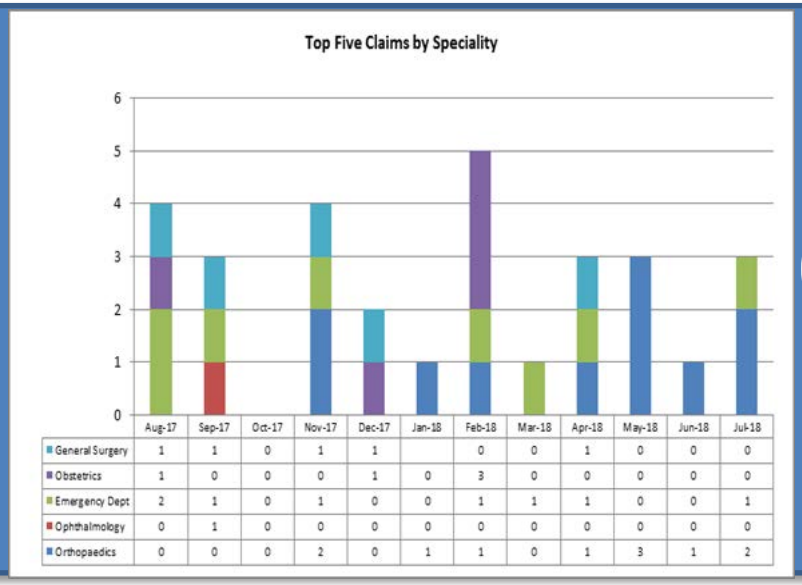
	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18
Communication	28	26	31	42	12	49	37	60	32	38	55	58
Care	27	24	18	38	17	34	20	44	30	53	44	46
Appointments	14	14	21	12	10	11	19	23	18	28	25	12
Attitude of Staff	19	15	15	16	14	12	15	20	15	17	15	16
Treatment	6	7	8	5	4	10	8	15	11	8	19	19

Informal Concerns Feedback

Informal Concerns Trends

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

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

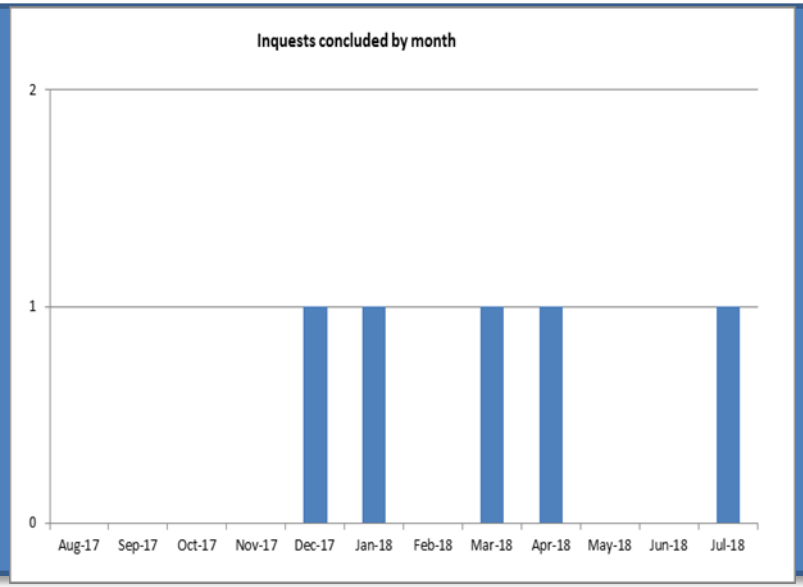


	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18
General Surgery	1	1	0	1	1		0	0	1	0	0	0
Obstetrics	1	0	0	0	1	0	3	0	0	0	0	0
Emergency Dept	2	1	0	1	0	0	1	1	1	0	0	1
Ophthalmology	0	1	0	0	0	0	0	0	0	0	0	0
Orthopaedics	0	0	0	2	0	1	1	0	1	3	1	2

Description	Aggregate Position /Description	Trend

Number of Inquests concluded by month

1 inquest was concluded in July 2018. The Coroner recorded a conclusion of 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 231 postings received to date.

NHS Choices – Star Ratings

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

Description	Aggregate Position /description	Trend

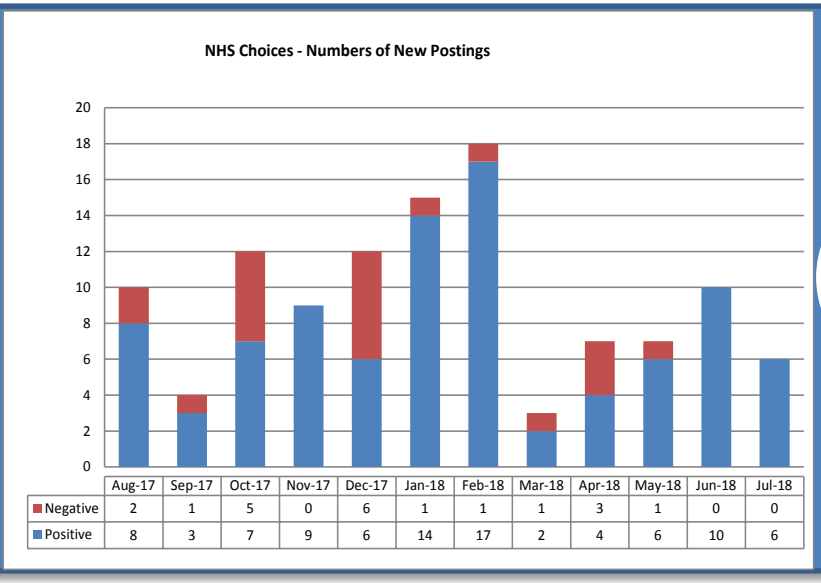
NHS Choices postings

There were 6 postings on NHS Choices in July 2018 of which 0 were negative and 6 were positive. Examples of feedback included:

I am writing to express my complete satisfaction and delight with the efficiency and professionalism of all the staff that dealt with me, from Reception, to Eye test…The entire process was completed in about 45 minutes and at every stage my identity was confirmed and my questions were fully answered. (Ophthalmology)

I can't praise her enough for her professionalism and the kindness and care that Emma (my daughter) received went above and beyond anything..... I can't put into words how grateful we all are.... Big big thanks to all the team on maternity unit. (Maternity, Labour Ward)

Brilliant - I just wanted to show my appreciation for the service I received yesterday. I only had to wait an hour, the cafe and waiting room were spot on, but the treatment I received off one member of staff was outstanding. (Minor Injuries Unit)



	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18
Negative	2	1	5	0	6	1	1	1	3	1	0	0
Positive	8	3	7	9	6	14	17	2	4	6	10	6

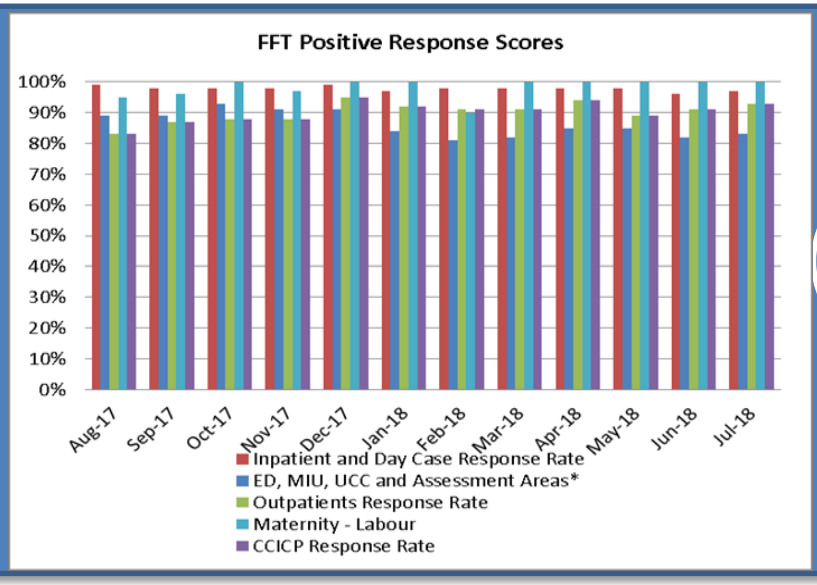
NHS Choices – Postings

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

In July 2018 the Trust has scored the following positive response scores:

Inpatients and day cases	97%
Emergency care /Assessment areas	83%
Outpatients	96%
Maternity	100%
CCICP	93%

5474 responses were received and 92% of those patients would recommend our hospital services.

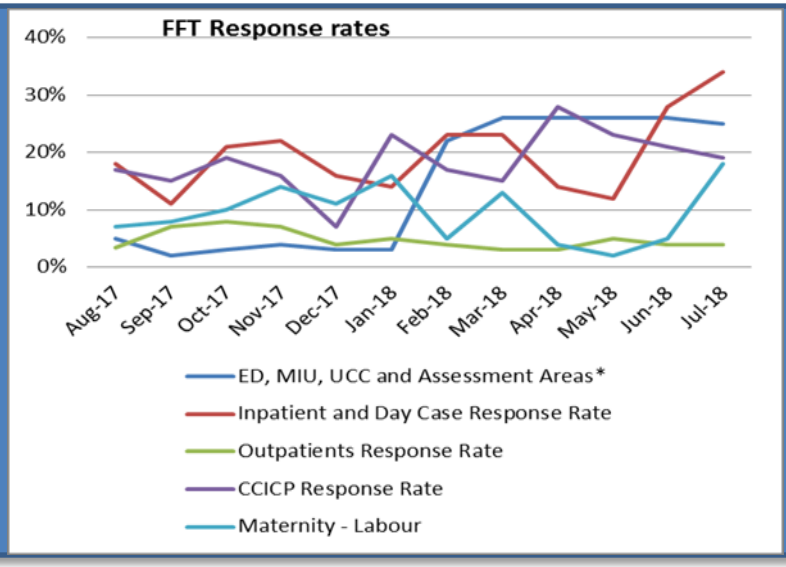


Family & Friends Test

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

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

July 2018 Ward/Dept.	% Response	Total responses received	How many would recommend
A&E , UCC & MIU	25%	1874	1562
Inpatients & Day cases	34%	2236	2159
Maternity	21%	40	40
Outpatients	4%	782	750
CCICP	19%	466	453



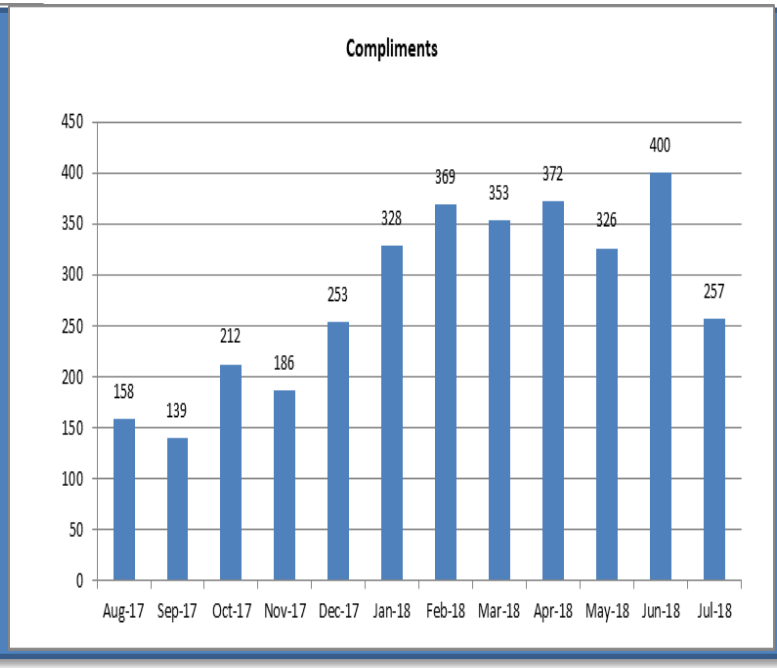
Family & Friends Test

Compliments received

There were 257 compliments/thankyou's received in July 2018.

'I would like to thank the ED team who so efficiently and effectively dealt with my emergency admission for a wasp sting that caused an allergic reaction to my body. At the time, I did not realise how dangerous the situation was. The team were competent, comforting and super-efficient with their treatment.'

'I want to formally commend 3 staff members on Ward 18 for the care and service they provided for both my husband and me. My husband received the most comprehensive care and I received the best support. I requested to be kept regularly informed / involved and they were highly instrumental in implementing this. We are very grateful. Thank you.'



Compliments

Mid Cheshire Hospital
NHS Foundation Tru

Board of Directors Performance Report

July 2018

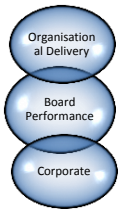
"To Deliver Excellence in Healthcare through Innovation & Collaboration"

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**	**Jul-18**	
Cancer				
Rapid Access Referrals (%) *(seen in 2 wks)*	93.00%	96.68%	96.25%	
Total Patients Seen		*3,431*	*854*	
Patients seen >14 days		*114*	*32*	
62 day GP Classic (%)	85.00%	90.61%	89.68%	*
Accountable Patients Treated		*261*	*78*	
No. of Breached Pathways (adjusted)		*25*	*8*	
62 day Screening (%)	90.00%	95.65%	100.00%	*
Accountable Patients Treated		*46*	*13*	
No. of Breached Pathways (adjusted)		*2*	*0*	
Unplanned Activity				
A&E <4hrs Standard (%)	95.00%	83.56%	84.57%	
A&E Attendances (LH/MIU/UUC) (% to plan)		96.76%	99.47%	
A&E Attendances LH & MIU (Vol)		*31,521*	*8,337*	
Planned Activity				
Incomp Pathways <18wk (%)	92.00%	92.79%	92.71%	
>6wk Diagnostic Waits (%)	1.00%	0.33%	0.56%	
Total Patients Waiting for a First Outpatient Appointment			9,496	

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

Indicator	Standard	YTD
Workforce		
Sickness absence Rolling 12 Month		4.29%
Turnover Rolling 12 Month		11.17%

Exec Summary

In July 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 4hour A&E waiting time target.

The 4-hour A&E standard in July achieved 84.57% against the 95% performance standard. This is a deterioration in performance compared to the same month in 2017 (92.63%), but is set against a rise in admissions and 25 less acute beds and 40 less community beds.

The Trust has achieved all three headline cancer access standards for July. Rapid access referrals and 62 day treatment pathways have continuously achieved above target for over 12 months. All three cancer standards passed quarter 1 and are achieving year to date.

The Trust continues to achieve the 92% standard for RTT 18 week incomplete pathways, with performance in July 2018 at 92.71%. 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 0.56% of patients waiting longer than 6 weeks for their diagnostic test against a regulatory threshold of 1%.

Corporate					
	YTD Rating		YE Rating	YE Metric	
Indicator	**Plan**	**Actual**	**Forecast**	**Plan**	**Forecast**
Finance					
Use of Resource Rating		3	2		
Capital Service Capacity	3	4	2	2.39	2.23
Liquidity	2	2	2	-1	-0
I&E Margin	3	4	1	2.10%	1.70%
Distance from Financial Plan	0	2	2	0.00%	-0.40%
Agency Spend	1	1	1	-23.27%	-23.27%

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 £1.6M which is £1.4M worse than the planned deficit of £0.2M. Part of this is a provision of £0.5M against the provider sustainability fund, for the failure to achieve the A&E target.

There is a variation in the CIP scheme against, with risks around the plans to close beds during the Summer months.

The Trust is currently £54k better than its Agency spend trajectory which includes costs associated with keeping escalation beds open in April.

	YTD Target	YTD Actual	YTD Variance	FY Target	FY Forecast	FY Variance
Cost Improvement Schemes Total (£000's)	2,226	1,994	-230	6,722	5,751	-971
Commission Contact Income SC & VR (£000's)	61,282	61,276	-6			
Contract Income (£'000)	73,692	73,326	-366			
Pay to Budget (£000's)	-56,278	-56,664	-386			
Non Pay to Budget (£000's)	-22,887	-23,531	-644			
Agency Trajectory (£000's)	-1,460	-1,406	54			

Single Oversight Framework

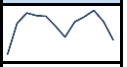
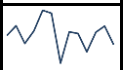
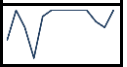
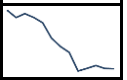
Triggers

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		Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Monthly Trend
	Target	Actual														
Maximum 6 week wait for Diagnostic procedures	1%	0.33%	0.76%	0.34%	0.21%	0.24%	0.25%	0.39%	0.53%	0.08%	0.33%	0.26%	0.17%	0.32%	0.56%	
All Cancers: 62 day GP Classic (%) *	85%	90.61%	93.04%	95.08%	91.67%	95.74%	94.50%	96.77%	87.30%	92.06%	94.06%	87.13%	92.91%	92.00%	89.68%	
All Cancers: 62 day Screening (%) *	90%	95.65%	85.71%	100.00%	91.67%	83.33%	94.12%	100.00%	100.00%	100.00%	100.00%	100.00%	89.47%	91.67%	100.00%	
18 weeks from point of referral to treatment - patients on an incomplete pathway (%)	92%	92.79%	97.37%	96.78%	97.10%	96.79%	96.36%	95.15%	94.46%	94.02%	92.54%	92.73%	92.98%	92.73%	92.71%	
A&E - maximum waiting time of 4 hours from arrival to admission/transfer/discharge (%)	95%	83.56%	92.63%	95.26%	93.99%	88.28%	88.05%	74.22%	78.38%	77.91%	77.90%	82.65%	85.14%	81.78%	84.57%	
STF Trajectory			91.34%	91.34%	91.34%	90.52%	90.52%	90.52%	90.52%	90.52%	95.00%	92.72%	92.72%	92.72%	93.92%	
Provider Submitted Trajectory														85.15%	87.18%	

** 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	2.23	2	1.32	0.56	4
	Liquidity	days	-1	-0	2	-2	-3	2
Financial Efficiency	I&E Margin	%	2.10%	1.70%	1	-0.90%	-1.90%	4
Financial Controls	Distance from Financial Plan	%	0.00%	-0.40%	2	0.00%	-1.00%	2
	Agency Spend	%	-23.27%	-23.27%	1	-9.88%	-12.96%	1
Overall UOR Rating					2			3

Operational Delivery: *Cancer Pathway*

Headline Measures

	Current YTD		Rolling 13 months											
	Target	Actual	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Monthly Trend
Rapid Access Referrals (%) (seen in 2 wks)	93%	96.68%	97.51%	97.35%	96.81%	97.60%	98.23%	95.85%	94.83%	93.05%	98.64%	96.08%	96.76%	97.54%	96.25%	
Total Patients Seen		*3431*	*763*	*793*	*722*	*750*	*736*	*626*	*715*	*806*	*811*	*766*	*956*	*855*	*854*	
Patients seen >14 days		*114*	*19*	*21*	*23*	*18*	*13*	*26*	*37*	*56*	*11*	*30*	*31*	*21*	*32*	
% seen within 7 days		*43.1%*	*44.2%*	*46.2%*	*64.8%*	*54.8%*	*51.4%*	*52.9%*	*54.6%*	*53.1%*	*61.2%*	*45.2%*	*39.6%*	*43.7%*	*44.5%*	
62 day GP Classic (%) *	85%	90.61%	93.04%	95.08%	91.67%	95.74%	94.50%	96.77%	87.30%	92.06%	94.06%	87.13%	92.91%	92.00%	89.68%	

** Provisional figures subject to change depending*

104+ day waits - (Cancer patients treated)			0	1	0	1	1	0	1	2	3	1	1	0	1

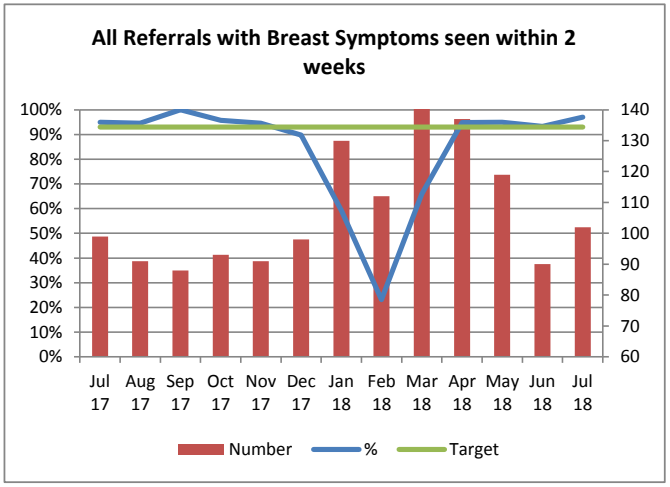
Commentary

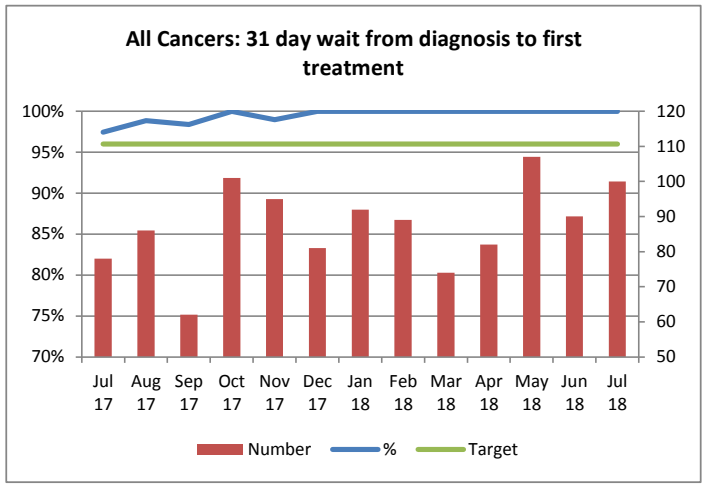
The Trust has achieved all three headline cancer standards during the month of July 2018. The figures presented in this paper reflect the Trust's regulatory performance measures (adjusted figures that take into account breach reallocation between providers).

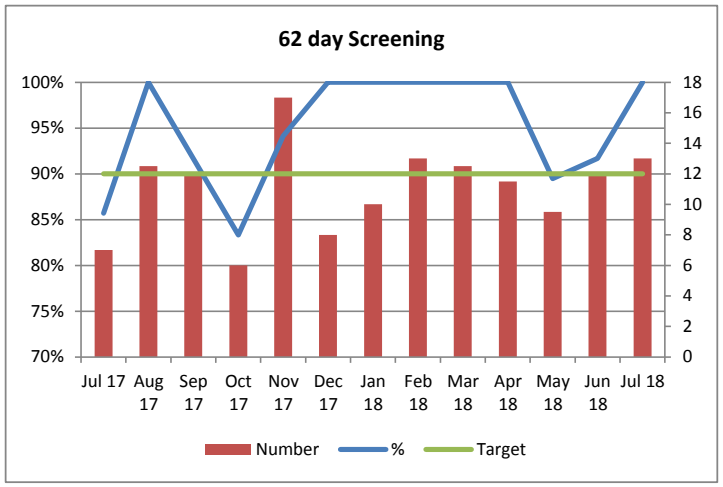
The Trust has continued it's strong performance against the Rapid Access referrals standard achieving 96.25% in July. This is in spite of an increase in demand of 12% on the same month last year.
The 2 week Breast Symptomatic standard - after a dramatic deterioration seen in February's position, performance improved to above the 93% target in April 2018 and has since been sustained. After a significant increase in demand early 2018, July has seen demand returned to that seen in previous years.

There was one recorded long wait (104 days and over) for patients on a 62 day cancer pathway in July. The wait was down to patient choice and therefore deemed unavoidable. All patients treated over 104 days will have a harm review undertaken.

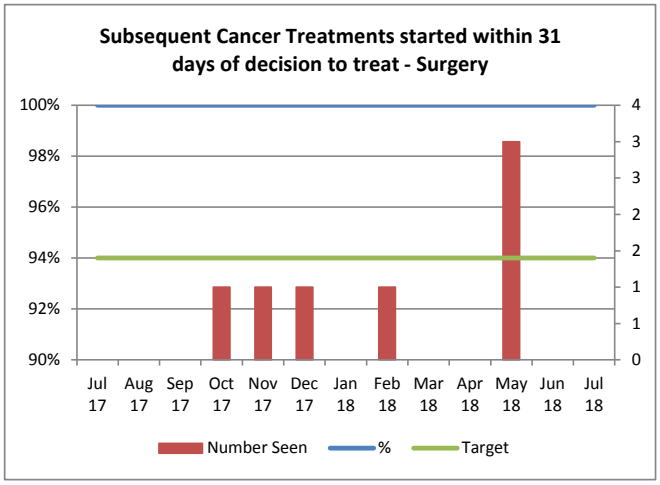
Primary Measures

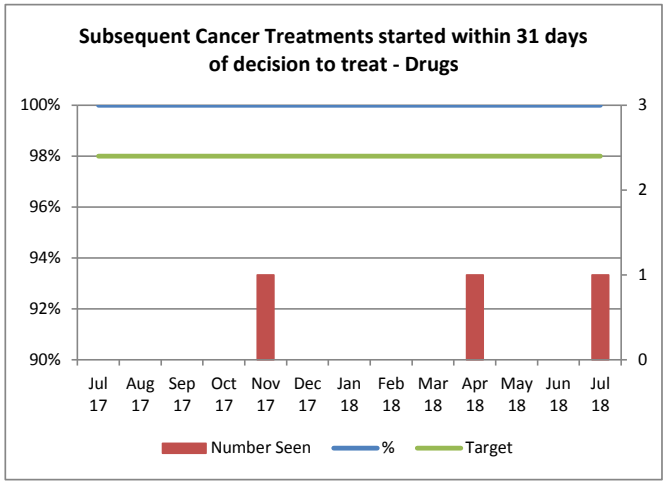


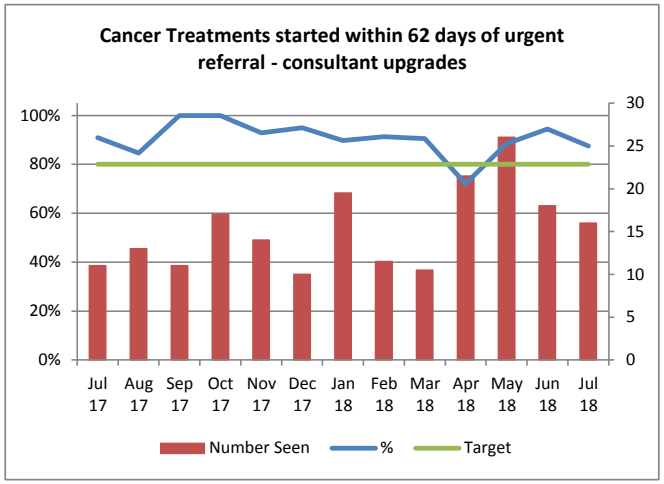




Operational Delivery: *Cancer Pathway*







Operational Delivery: *Unplanned Activity - A&E*

Headline Measures

	Current YTD		Rolling 13 months											
	Target	Actual	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Monthly Trend
A&E - >4 hr wait time from arrival to admission/ transfer/ discharge (% to Target)	95%	83.56%	92.63%	95.26%	93.99%	88.28%	88.05%	74.22%	78.38%	77.91%	77.90%	82.65%	85.14%	81.78%	84.57%	
No. of 4hr breaches		*5,181*	*567*	*332*	*422*	*872*	*851*	*1,920*	*1,543*	*1,469*	*1,679*	*1,244*	*1,179*	*1,472*	*1,286*	

	Plan	Actual	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Monthly Trend
A&E Attendances (LH/MIU/UUC) (% to Plan)		*96.76%*	*96.3%*	*93.1%*	*97.1%*	*99.8%*	*92.9%*	*99.3%*	*97.1%*	*94.4%*	*93.6%*	*93.2%*	*95.3%*	*98.9%*	*99.5%*	
A&E Attendances (LH/MIU/UUC) (No.)	*88,209*	*31,521*	7,697	7,011	7,023	7,439	7,119	7,447	7,138	6,649	7,598	7,170	7,933	8,081	8,337	

A&E Attendance Case Mix (based on acuity score)	*Major*		*9,302*	*1,743*	*1,769*	*1,724*	*1,688*	*1,605*	*1,815*	*2,191*	*2,173*	*2,422*	*2,288*	*2,460*	*2,386*	*2,168*	
	Minor		*12,759*	*3,345*	*3,152*	*2,939*	*3,198*	*2,936*	*3,324*	*2,940*	*2,474*	*2,886*	*2,799*	*2,992*	*3,325*	*3,643*	
	Paediatrics		*6,434*	*1,626*	*1,182*	*1,416*	*1,588*	*1,557*	*1,379*	*1,304*	*1,305*	*1,544*	*1,419*	*1,676*	*1,648*	*1,691*	
	Resus		*3,026*	*983*	*908*	*944*	*965*	*1,021*	*929*	*703*	*697*	*746*	*664*	*805*	*722*	*835*	

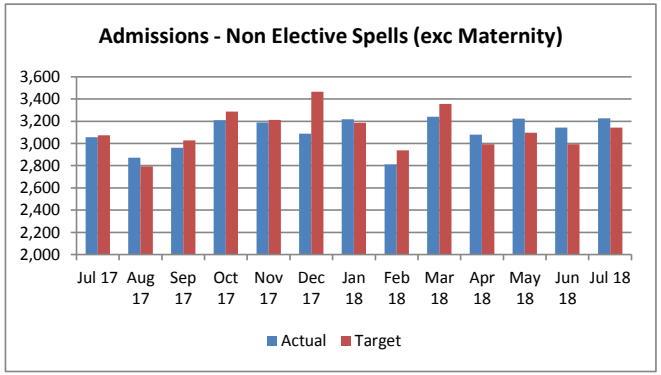
A&E Attendance Location (based on Discharge)	*Major*		*12,384*	*2,978*	*2,898*	*2,899*	*3,011*	*2,776*	*3,201*	*3,038*	*2,761*	*3,204*	*2,957*	*3,170*	*3,136*	*3,121*	
	Minor		*12,092*	*2,960*	*2,815*	*2,600*	*2,731*	*2,659*	*2,661*	*2,617*	*2,403*	*2,650*	*2,623*	*2,948*	*3,157*	*3,364*	
	Paediatrics		*6,434*	*1,626*	*1,182*	*1,416*	*1,588*	*1,557*	*1,379*	*1,304*	*1,305*	*1,544*	*1,419*	*1,676*	*1,648*	*1,691*	
	Resus		*611*	*133*	*116*	*108*	*109*	*127*	*206*	*179*	*180*	*200*	*171*	*139*	*140*	*161*	

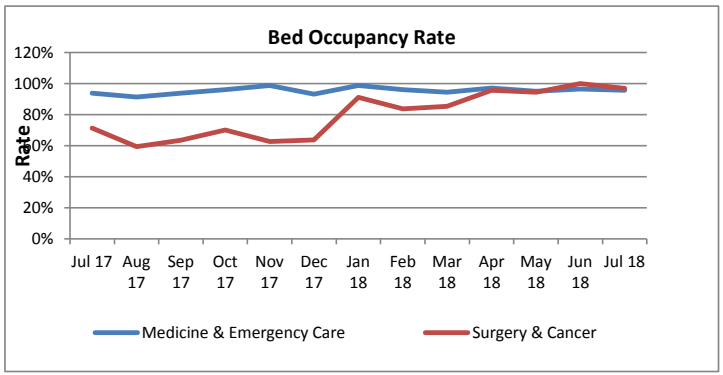
Commentary

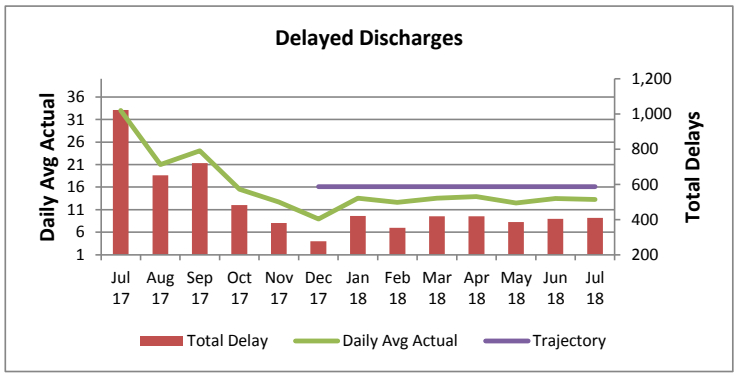
The Trust has achieved 84.57% against the 4-hour access standard in July 2018 with ED attendances seeing a 8.7% increase on July 2017. July 2018 has seen the highest number of attendances ever recorded for a full month at Mid Cheshire Hospitals. Poor performance has been driven not only by the higher demand but a higher acuity of patients arriving at A&E. Comparatively July 2018 has seen an 10% increase in higher acuity patients than July 2017 (Case mix Major or Resus). This is also set against 25 less acute beds and 40 less community beds than in previous years.

Non elective admissions in July were 5.5% higher than for the same period last year, driven by the higher acuity of patient. The Type 1 conversion rate remains high at 38.6%. Medical outliers also remain high at 26 in July. Delayed transfers of care continues to be below the target set averaging 13.

Primary Drivers

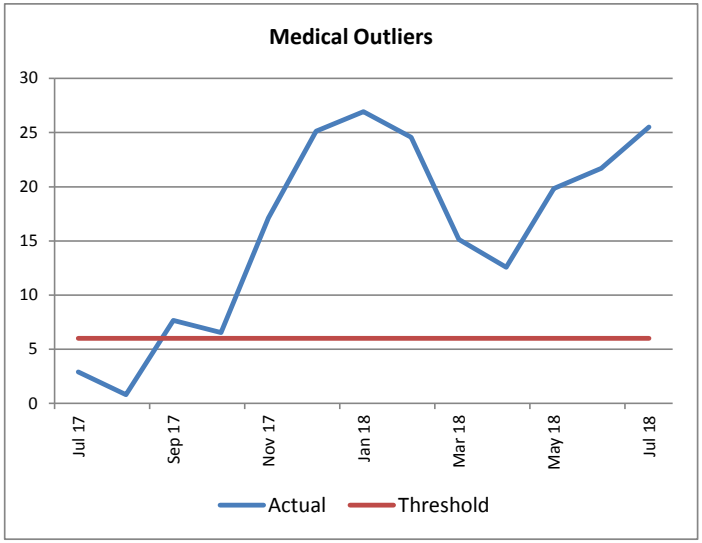


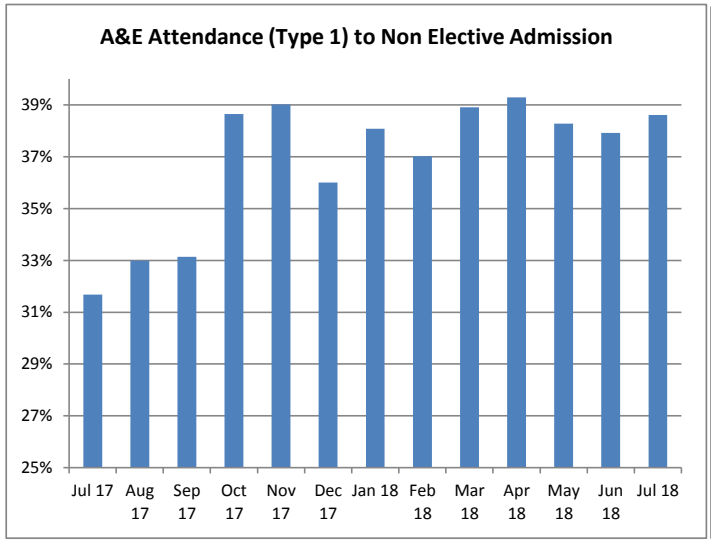


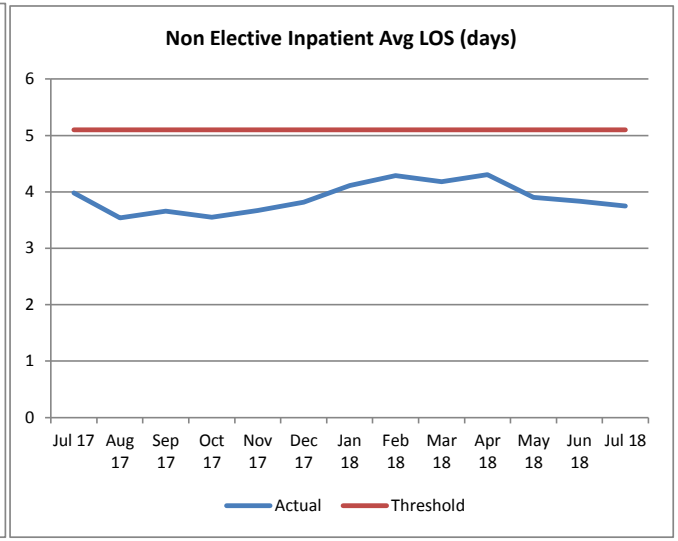


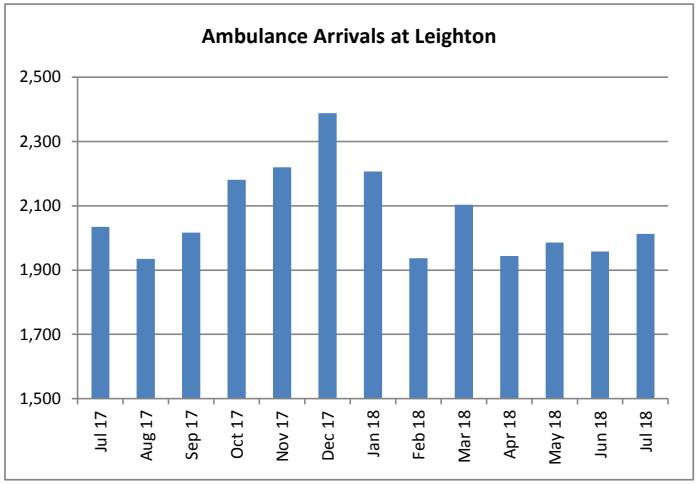
Operational Delivery: *Unplanned Activity A&E*

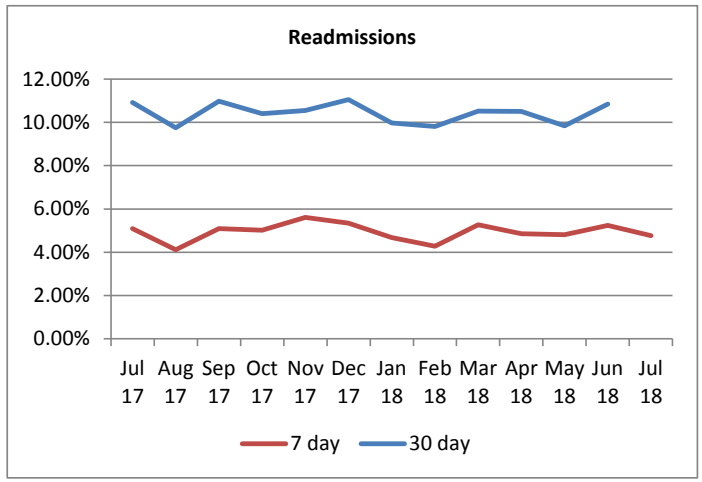
Secondary Drivers

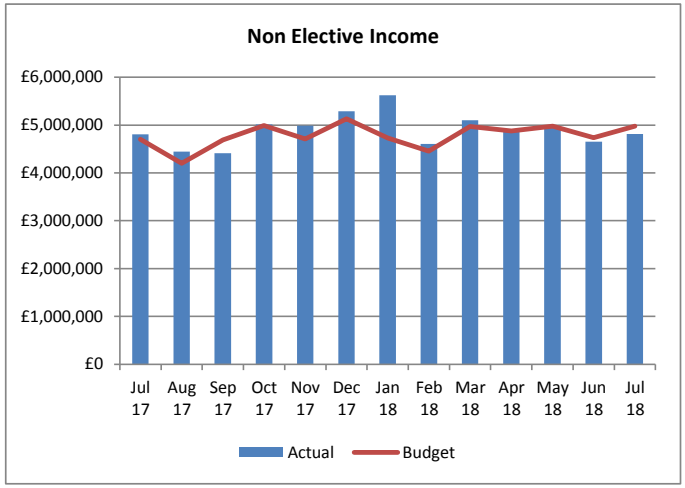












** Readmissions and LOS metrics brought in line with national definitions*

Operational Delivery: *Planned Activity*

Headline Measures

	Current YTD		Rolling 13 months											
	Target	Actual	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Monthly Trend
18 weeks from Referral to Treatment in Aggregate - Incomplete	92%	92.79%	97.37%	96.78%	97.10%	96.79%	96.36%	95.15%	94.46%	94.02%	92.54%	92.73%	92.98%	92.73%	92.71%	
Total 18 Weeks		*55,335*	*11,576*	*12,431*	*12,297*	*12,054*	*12,258*	*12,158*	*12,845*	*13,105*	*13,771*	*13,729*	*13,801*	*13,893*	*13,912*	
No. > 18 Weeks		*3,991*	*305*	*400*	*356*	*387*	*446*	*590*	*711*	*784*	*1,028*	*998*	*969*	*1,010*	*1,014*	
Diagnostic Waiting Time	1%	0.33%	0.76%	0.34%	0.21%	0.24%	0.25%	0.39%	0.53%	0.08%	0.33%	0.26%	0.17%	0.32%	0.56%	
Total Number of Waiters		*17,227*	*3,560*	*3,189*	*3,380*	*3,306*	*3,191*	*3,614*	*3,587*	*3,548*	*4,293*	*4,224*	*4,127*	*4,619*	*4,257*	
Waiters of 6 Weeks +		*57*	*27*	*11*	*7*	*8*	*8*	*14*	*19*	*3*	*14*	*11*	*7*	*15*	*24*	
Total Patients Waiting for a First Outpatient Appointment			7,643	8,029	7,809	7,731	7,916	8,085	8,342	8,501	8,866	9,243	9,579	9,354	9,496	
Longest Wait Time (weeks)											*42*	*45*	*49*	*43*	*43*	

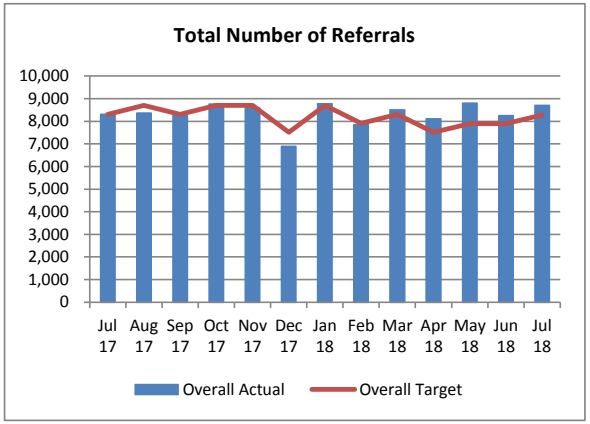
Commentary

The Trust reported 92.71% 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. All failing specialities have developed a trajectory and plan for RTT compliance which will be monitored via the Trust performance systems. 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 of 2017/18.

The Trust has delivered the diagnostic wait time consistently since July 2016. In July 2018, 0.56% 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.

Growth in referrals has been above planned levels across both GP and Other referrals in 2018/19.

Primary Drivers

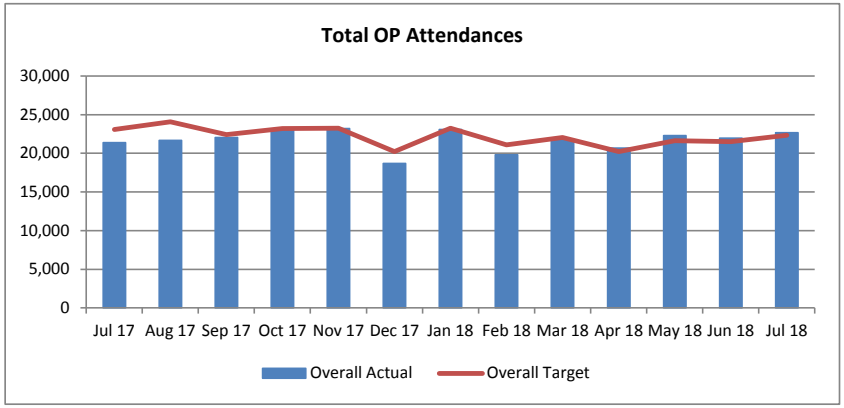


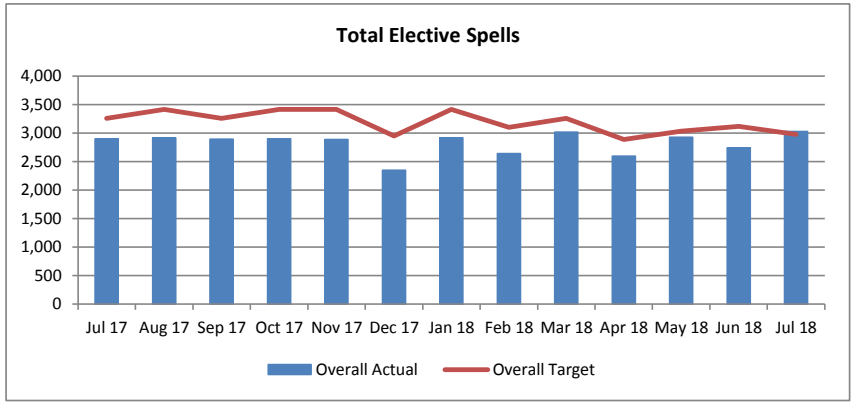
Referral Breakdown

	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Monthly Trend
GP Actual	5,115	5,211	5,277	5,506	5,424	4,157	5,573	4,928	5,388	4,858	5,400	5,065	5,354	
GP Target	5,259	5,509	5,259	5,509	5,509	4,758	5,509	5,008	5,259	4,683	4,920	4,920	5,157	
% to Target	97.3%	94.6%	100.3%	99.9%	98.5%	87.4%	101.2%	98.4%	102.5%	103.7%	109.8%	103.0%	103.8%	
Other Actual	3,191	3,156	2,969	3,252	3,166	2,731	3,205	2,931	3,119	3,253	3,407	3,186	3,352	
Other Target	3,050	3,195	3,050	3,195	3,195	2,759	3,195	2,904	3,050	2,833	2,976	2,976	3,120	
% to Target	104.6%	98.8%	97.4%	101.8%	99.1%	99.0%	100.3%	100.9%	102.3%	114.8%	114.5%	107.1%	107.5%	
Total Actual	8,306	8,367	8,246	8,758	8,590	6,888	8,778	7,859	8,507	8,111	8,807	8,251	8,706	
Total Target	8,308	8,704	8,308	8,704	8,704	7,517	8,704	7,913	8,308	7,515	7,896	7,896	8,276	
% to Target	100.0%	96.1%	99.3%	100.6%	98.7%	91.6%	100.9%	99.3%	102.4%	107.9%	111.5%	104.5%	105.2%	
GP % of Total	61.6%	62.3%	64.0%	62.9%	63.1%	60.4%	63.5%	62.7%	63.3%	59.9%	61.3%	61.4%	61.5%	

Operational Delivery: *Planned Activity*

Primary Drivers



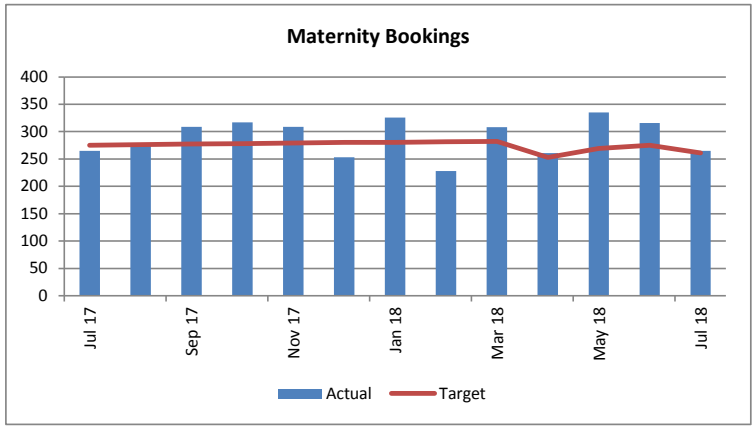


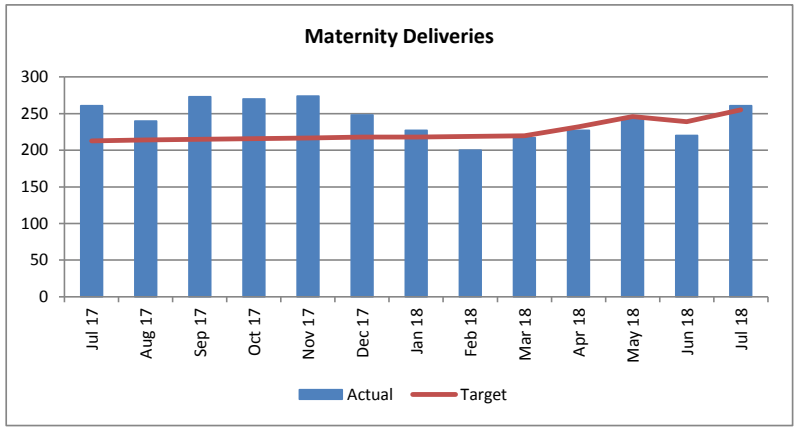
OP Attendance Breakdown	YTD 18 19	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Monthly Trend
New Actual	27,410	6,191	6,421	6,821	6,988	6,910	5,805	6,862	6,217	6,855	6,472	7,137	6,868	6,933	
New Target	24,823	7,098	7,427	6,941	7,250	7,253	6,272	7,253	6,585	6,909	5,892	6,224	6,212	6,495	
% to Target	110.4%	87.2%	86.5%	98.3%	96.4%	95.3%	92.6%	94.6%	94.4%	99.2%	109.9%	114.7%	110.6%	106.7%	
F U Actual	60,211	15,181	15,236	15,239	16,176	16,304	12,892	16,215	13,583	14,927	14,214	15,172	15,091	15,734	
F U Target	60,879	15,967	16,663	15,462	15,955	15,987	13,971	15,991	14,504	15,152	14,346	15,407	15,283	15,844	
% to Target	98.9%	95.1%	91.4%	98.6%	101.4%	102.0%	92.3%	101.4%	93.7%	98.5%	99.1%	98.5%	98.7%	99.3%	
Total Actual	87,621	21,372	21,657	22,060	23,164	23,214	18,697	23,077	19,800	21,782	20,686	22,309	21,959	22,667	
Total Target	85,703	23,065	24,090	22,403	23,205	23,240	20,243	23,244	21,089	22,061	20,237	21,631	21,495	22,339	
% to Target	102.2%	92.7%	89.9%	98.5%	99.8%	99.9%	92.4%	99.3%	93.9%	98.7%	102.2%	103.1%	102.2%	101.5%	
New % of Total	31.3%	29.0%	29.6%	30.9%	30.2%	29.8%	31.0%	29.7%	31.4%	31.5%	31.3%	32.0%	31.3%	30.6%	

Elective Spells Breakdown	YTD 18 19	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Monthly Trend
I P Actual	1,049	266	298	279	299	308	234	164	240	273	216	293	263	277	
I P Target	1,167	330	346	330	346	346	298	346	314	330	301	301	294	271	
% to Target	89.9%	80.7%	86.2%	84.6%	86.5%	89.1%	78.6%	47.4%	76.5%	82.8%	71.8%	97.4%	89.4%	102.3%	
Daycase Actual	10,245	2,636	2,619	2,616	2,603	2,578	2,115	2,753	2,404	2,745	2,378	2,637	2,480	2,750	
Daycase Target	10,852	2,931	3,071	2,931	3,071	3,071	2,650	3,071	2,790	2,931	2,590	2,735	2,822	2,706	
% to Target	94.4%	89.9%	85.3%	89.3%	84.8%	83.9%	79.8%	89.6%	86.2%	93.7%	91.8%	96.4%	87.9%	101.6%	
Total Actual	11,294	2,902	2,917	2,895	2,902	2,886	2,349	2,917	2,644	3,018	2,594	2,930	2,743	3,027	
Total Target	12,020	3,260	3,417	3,260	3,417	3,417	2,947	3,417	3,104	3,260	2,891	3,036	3,116	2,977	
% to Target	94.0%	89.0%	85.4%	88.8%	84.9%	84.5%	79.7%	85.4%	85.2%	92.6%	89.7%	96.5%	88.0%	101.7%	
I P % of Total	9.3%	9.2%	10.2%	9.6%	10.3%	10.7%	10.0%	5.6%	9.1%	9.0%	8.3%	10.0%	9.6%	9.2%	

Operational Delivery: *Planned Activity*

Primary Drivers



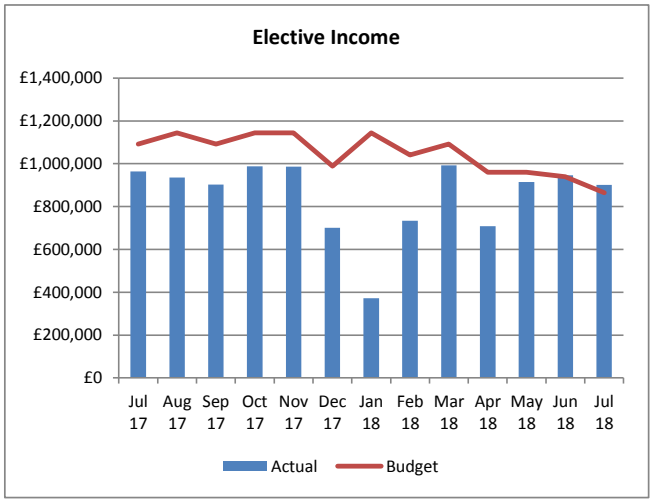


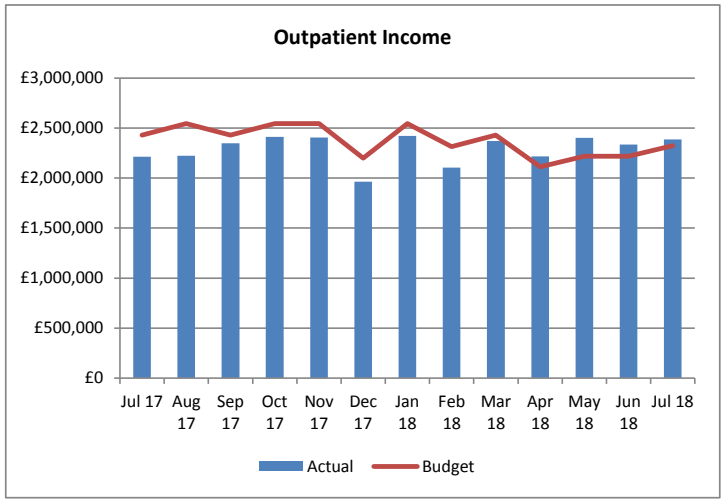
Operational Delivery: *Planned Activity*

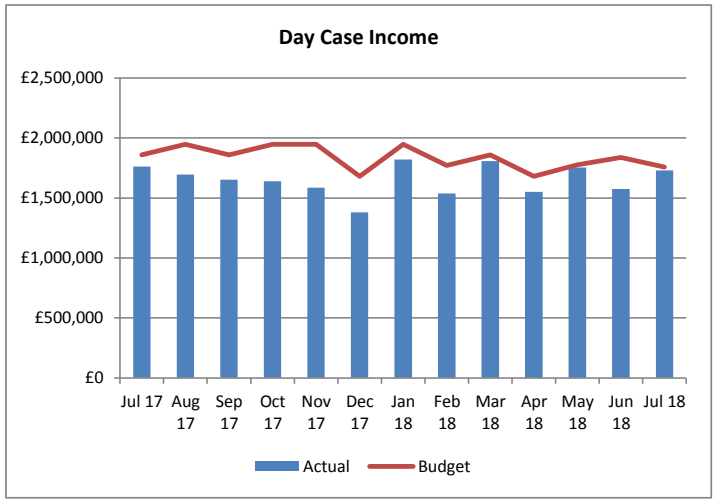
Secondary Drivers

			Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Monthly Trend
Bed Occupancy Rate	Medicine & Emergency Care		93.7%	91.4%	93.8%	96.1%	98.8%	93.3%	98.7%	96.1%	94.4%	97.1%	95.1%	96.6%	95.7%	
	Surgery & Cancer		71.3%	59.3%	63.5%	70.1%	62.7%	63.7%	91.1%	83.7%	85.4%	95.8%	94.5%	100.0%	96.9%	
Elective Inpatient Avg LOS (Days)			3.7	2.6	2.3	2.4	2.7	2.4	2.3	2.4	2.5	3.1	2.7	2.5	2.5	
Delayed Transfers of Care (MFFD)		16.00	33	21	24	16	13	9	14	13	14	14	12	13	13	
Delayed Transfers of Care (% of Acute Beds)			7.1%	4.6%	5.2%	3.4%	2.7%	1.9%	2.6%	2.5%	2.7%	2.8%	2.7%	2.9%	2.8%	
Medical Outliers			3	1	8	7	17	25	27	25	15	13	20	22	26	
Readmission (Emergency Re-admissions after Planned Surgery)																
	30 Day Rate		2.93%	3.40%	3.84%	3.48%	3.44%	3.15%	3.01%	2.56%	3.28%	3.37%	3.35%	3.00%		
	7 Day Rate		1.09%	1.02%	1.32%	1.59%	1.20%	0.88%	1.27%	0.88%	1.41%	1.00%	1.27%	1.03%	1.38%	
Cancelled Operations - Non Clinical - Cancellation Rate			0.86%	0.40%	0.57%	1.27%	0.75%	2.24%	1.01%	1.23%	1.48%	1.40%	1.07%	0.95%	0.99%	
Theatre Efficiency																
	Main Theatres		77.9%	78.6%	80.5%	78.8%	77.0%	74.4%	74.9%	74.2%	76.8%	79.5%	78.9%	78.9%	76.7%	
	TC Theatres		75.0%	76.0%	71.5%	78.1%	75.5%	77.5%	74.5%	71.5%	71.8%	69.0%	74.2%	72.6%	75.6%	
DNA (OP Efficiency)			5.83%	5.71%	5.83%	5.51%	5.27%	6.21%	5.46%	5.17%	5.41%	5.25%	6.02%	5.91%	6.13%	
Hospital Cancellation Rate (OP Efficiency)			7.94%	7.58%	6.11%	6.27%	6.19%	7.18%	7.34%	6.88%	6.43%	6.72%	6.80%	6.80%	7.05%	

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







Financial Performance: Income & Expenditure Position - Aggregated

	Month			Year to Date			Forecast	
	Plan Jul (£'000)	Actual Jul (£'000)	Variance Jul (£'000)	Plan April to Jul (£'000)	Actual April to Jul (£'000)	Variance April to Jul (£'000)	2018/19 (£'000)	Budget 2018/19 £'000
Operating								
Operating Income								
NHS Acute Activity Income								
Elective	864	887	23	3,724	3,469	-254	10,659	10,659
Non-Elective	4,974	4,842	-132	19,569	19,316	-253	59,628	59,628
Maternity	1,187	1,098	-89	4,676	4,468	-209	14,000	14,000
Day cases	1,758	1,724	-34	7,052	6,609	-443	21,139	21,139
Outpatients	2,323	2,402	79	8,869	9,337	468	26,672	26,672
A&E	887	942	55	3,477	3,508	31	10,139	10,139
Other NHS	6,176	6,063	-113	24,498	25,341	843	78,037	78,037
Total NHS Clinical Revenue	**18,169**	**17,958**	**-211**	**71,866**	**72,049**	**183**	**220,274**	**220,274**
Other Operating Income	2,131	2,236	105	7,822	7,807	-15	22,502	22,502
Inter-Trust Income	0	0	0	0	0	0	0	0
TOTAL OPERATING INCOME	**20,300**	**20,194**	**-106**	**79,688**	**79,856**	**168**	**242,776**	**242,776**
Operating Expenses								
Employee Benefits Expenses (Pay)	-14,158	-14,183	-25	-56,278	-56,664	-386	-168,313	-168,313
Drugs	-1,212	-1,139	73	-5,347	-5,323	24	-15,868	-15,868
Clinical Supplies	-1,528	-1,572	-44	-6,264	-5,979	285	-18,370	-18,370
Non Clinical Supplies	-306	-343	-37	-1,194	-1,235	-41	-3,537	-3,537
Other operating expenses	-2,514	-2,863	-349	-10,082	-10,994	-912	-31,419	-31,419
TOTAL OPERATING EXPENSES	**-19,718**	**-20,100**	**-382**	**-79,165**	**-80,195**	**-1,030**	**-237,507**	**-237,507**
EBITDA	**582**	**94**	**-488**	**523**	**-339**	**-862**	**5,269**	**5,269**
Non Operating								
Non Operating Income								
Interest & Asset disposal	3	6	3	12	23	11	36	36
Non-Operating Expenses								
Depreciation & Finance Leases	-446	-438	8	-1,784	-1,785	-1	-6,190	-6,190
PDC Dividend Expense	-192	-192	0	-768	-768	0	-2,300	-2,300
Adjusted Financial Performance surplus/(deficit)	**-53**	**-530**	**-477**	**-2,017**	**-2,870**	**-852**	**-3,185**	**-3,185**
Provider Sustainability Fund	562	393	-169	1,825	1,278	-548	8,428	8,428
Net Surplus/(deficit) before Exceptional Items	**509**	**-137**	**-646**	**-192**	**-1,592**	**-1,400**	**5,243**	**5,243**
Donations for purchase of assets	24	10	-14	96	50	-46	288	288
Depreciation on Donated Assets	-23	-23	0	-92	-92	0	-278	-278
Prior Period Adjustments	0	0	0	0	0	0	0	0
Net Surplus/(deficit) after Exceptional Items	**510**	**-150**	**-660**	**-188**	**-1,634**	**-1,446**	**5,253**	**5,253**

The Trust delivered a cumulative £1.6m deficit (before exceptional items) against a budget deficit of £0.2m.

Contract income is above plan, due to additional funding for escalation beds in April. Planned income has improved in May/June in surgical specialties.

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

Pay is £0.4M worse than plan. The key impacts are a higher spend on nursing and HCAs than plan offset by vacancies and unfilled posts within the community. Medical vacancies continue to contribute to an underspend, however there have been some backdated pay costs which are expected to be one off occur in May.

Non-Pay is £0.6M worse than plan. Clinical supplies spend is lower than budget reflecting the elective performance.

Other operating costs are overspent by £0.9M which have had someone off costs associated with the refurbishment and 1718 costs within estates , along with the continued pressure of outsourcing diagnostic tests within radiology/pathology.

The Provider Sustainability Fund is off plan due to the failure of the A&E target. The full year impact of not reaching the A&E target is £2.4m.

* EBITDA Total excludes Charitable Income

Financial Performance: Income & Expenditure Position - MCHFT

	Month			Year to Date			Forecast	
	Plan Jul (£'000)	Actual Jul (£'000)	Variance Jul (£'000)	Plan April to Jul (£'000)	Actual April to Jul (£'000)	Variance April to Jul (£'000)	2018/19 (£'000)	Budget 2018/19 £'000
Operating								
Operating Income								
NHS Acute Activity Income								
Elective	864	887	23	3,724	3,469	-254	10,659	10,659
Non-Elective	4,974	4,842	-132	19,569	19,316	-253	59,628	59,628
Maternity	1,187	1,098	-89	4,676	4,468	-209	14,000	14,000
Day cases	1,758	1,724	-34	7,052	6,609	-443	21,139	21,139
Outpatients	2,323	2,402	79	8,869	9,337	468	26,672	26,672
A&E	887	942	55	3,477	3,508	31	10,139	10,139
Other NHS	3,806	3,693	-113	15,018	15,861	843	49,574	49,574
Total NHS Clinical Revenue	**15,799**	**15,588**	**-211**	**62,386**	**62,569**	**183**	**191,811**	**191,811**
Other Operating Income	2,040	2,118	78	7,453	7,364	-89	21,500	21,500
Inter-Trust Income	0	0	0	0	0	0	0	0
TOTAL OPERATING INCOME	**17,839**	**17,706**	**-133**	**69,839**	**69,933**	**94**	**213,311**	**213,311**
Operating Expenses								
Employee Benefits Expenses (Pay)	-12,341	-12,427	-86	-49,054	-49,681	-627	-146,930	-146,930
Drugs	-1,210	-1,138	72	-5,339	-5,316	23	-15,844	-15,844
Clinical Supplies	-1,443	-1,492	-49	-5,923	-5,608	315	-17,353	-17,353
Non Clinical Supplies	-225	-259	-34	-870	-948	-78	-2,568	-2,568
Other operating expenses	-2,106	-2,480	-374	-8,448	-9,488	-1,040	-26,706	-26,706
Inter-Trust Charges	114	114	0	455	455	0	1,364	1,364
TOTAL OPERATING EXPENSES	**-17,211**	**-17,682**	**-471**	**-69,179**	**-70,586**	**-1,407**	**-208,037**	**-208,037**
EBITDA	**628**	**24**	**-604**	**660**	**-653**	**-1,313**	**5,274**	**5,274**
Non Operating								
Non Operating Income								
Interest & Asset disposal	3	6	3	12	23	11	36	36
Non-Operating Expenses								
Depreciation & Finance Leases	-446	-438	8	-1,784	-1,785	-1	-6,190	-6,190
PDC Dividend Expense	-192	-192	0	-768	-768	0	-2,300	-2,300
Net Surplus/(deficit) before STF/Exceptional Items	**-7**	**-600**	**-593**	**-1,880**	**-3,184**	**-1,303**	**-3,180**	**-3,180**
Provider Sustainability Fund	562	393	-169	1,825	1,278	-548	8,428	**8,428**
Net Surplus/(deficit) before Exceptional Items	**555**	**-207**	**-762**	**-55**	**-1,906**	**-1,851**	**5,248**	**5,248**
Donations for purchase of assets	24	10	-14	96	50	-46	288	288
Depreciation on Donated Assets	-23	-23	0	-92	-92	0	-278	-278
Prior Period Adjustments	0	0	0	0	0	0	0	0
Net Surplus/(deficit) after Exceptional Items	**556**	**-220**	**-776**	**-51**	**-1,948**	**-1,897**	**5,258**	**5,258**

The Trust excluding Community Services, delivered a £1.9M deficit against a planned deficit of £0.05M in the month - giving a £1.9M variance against plan cumulatively.

Contract income and other operating income are £0.2M better than plan - largely as a result of funding for escalation beds kept open in April.

Pay is £0.6M worse than plan cumulative as a result of higher spend on Nursing & HCAs, which has increased n the month, notably within Medicine & Emergency Care.

Clinical supplies is overspent in the month, but below plan cumulatively, reflecting an under performance performance in elective activity.

Other Operating Expenses is £1.0M worse as a result of continuing outsourcing pressures in diagnostics (£422K) and pressures within estates (1718 costs (£173K), one of costs (£30k) and in year issues (£277k).

There is a cumulative reflection of the A&E performance provided for within the provider sustainability fund.

Financial Performance: Income & Expenditure Position - CCICP

	Month			Year to Date			Forecast	Budget
	Plan Jul (£'000)	Actual Jul (£'000)	Variance Jul (£'000)	Plan April to Jul (£'000)	Actual April to Jul (£'000)	Variance April to Jul (£'000)	2018/19 (£'000)	2018/19 £'000
Operating								
Operating Income								
NHS Acute Activity Income								
Elective	0	0	0	0	0	0	0	
Non-Elective	0	0	0	0	0	0	0	
Maternity	0	0	0	0	0	0	0	
Day cases	0	0	0	0	0	0	0	
Outpatients	0	0	0	0	0	0	0	
A&E	0	0	0	0	0	0	0	
Other NHS	2,370	2,370	0	9,480	9,480	0	28,463	28,463
Total NHS Clinical Revenue	**2,370**	**2,370**	**0**	**9,480**	**9,480**	**0**	**28,463**	**28,463**
Other Operating Income	91	118	27	369	443	74	1,002	1,002
Inter-Trust Income	0	0	0	0	0	0	0	0
TOTAL OPERATING INCOME	**2,461**	**2,488**	**27**	**9,849**	**9,923**	**74**	**29,465**	**29,465**
Operating Expenses								
Employee Benefits Expenses (Pay)	-1,817	-1,756	61	-7,224	-6,983	241	-21,383	-21,383
Drugs	-2	-1	1	-8	-7	1	-24	-24
Clinical Supplies	-85	-80	5	-341	-371	-30	-1,017	-1,017
Non Clinical Supplies	-81	-84	-3	-324	-287	37	-969	-969
Other operating expenses	-408	-383	25	-1,634	-1,506	128	-4,713	-4,713
Inter-Trust Charges	-114	-114	0	-455	-455	0	-1,364	-1,364
TOTAL OPERATING EXPENSES	**-2,507**	**-2,418**	**89**	**-9,986**	**-9,609**	**377**	**-29,470**	**-29,470**
EBITDA	**-46**	**70**	**116**	**-137**	**314**	**451**	**-5**	**-5**
Non Operating								
Non Operating Income								
Interest & Asset disposal	0	0	0	0	0	0	0	
Non-Operating Expenses								
Depreciation & Finance Leases	0	0	0	0	0	0	0	
PDC Dividend Expense	0	0	0	0	0	0	0	
Adjusted Financial Performance surplus/(deficit)	**-46**	**70**	**116**	**-137**	**314**	**451**	**-5**	**-5**
Provider Sustainability Fund	0	0	0	0	0	0	0	**0**
Net Surplus/(deficit) before Exceptional Items	**-46**	**70**	**116**	**-137**	**314**	**451**	**-5**	**-5**
Donations for purchase of assets	0	0	0	0	0	0	0	0
Depreciation on Donated Assets	0	0	0	0	0	0	0	0
Prior Period Adjustments	0	0	0	0	0	0	0	0
Net Surplus/(deficit) after Exceptional Items	**-46**	**70**	**116**	**-137**	**314**	**451**	**-5**	**-5**

Community Services delivered a £314k surplus cumulative against a planned deficit 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 £241k better than plan cumulative as a result of unfilled vacancies partly clinical and partly corporate, continuing the trend from 2017/18.

The only area of pay that raises a concern continues to be GP out of hours, where recruitment is underway for permanent staff, under new terms, which is planned to reduce the agency cost ultimately.

Non pay is largely better than budget, however there are overspends for NHS rents, and continence costs.

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	(17)	(351)	(336)	(33)	(34)	(384)	(387)
Endoscopy	Endoscopy	2,067	1	(216)	(793)	71	(388)	139	886	(6)
General Surgery Directorate	General Surgery	5,748	46	192	(2,946)	85	(637)	(61)	2,211	216
Head & Neck Directorate	Head & Neck	1,775	137	(121)	(836)	50	(235)	34	842	(37)
Macmillan Cancer Centre	Macmillan Cancer Centre	224	601	116	(327)	(23)	(540)	(58)	(42)	35
Ophthalmology	Ophthalmology	4,045	20	167	(1,441)	(14)	(1,182)	(60)	1,441	94
Orthopaedic Directorate	Orthopaedics	6,107	90	(53)	(2,139)	68	(1,123)	(3)	2,936	12
Theatres & TC	Theatres & TC	0	115	(2)	(2,465)	(15)	(925)	(87)	(3,275)	(103)
Urology Directorate	Urology	1,895	18	29	(969)	(75)	(182)	(25)	762	(70)
Surgical and Cancer Division	**Surgery & Cancer**	**21,861**	**1,027**	**97**	**(12,268)**	**(188)**	**(5,243)**	**(156)**	**5,377**	**(247)**

The Surgical Division is £247k worse than plan year to date. Pay is £188k worse than budget, with backdated pay for on call payments for orthopaedics, and a grade appeal within ophthalmology within medical pay, and acuity on ward 18 requiring additional HCA support.

		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	(740)	(177)	(28)	(6)	(769)	(183)
Accident & Emergency Dir	Emergency Department	5,236	254	(101)	(2,075)	(20)	(266)	(43)	3,149	(163)
Anaesthetics & Critical Care	Anaesthetics & Critical Care	2,133	25	(11)	(2,535)	166	(373)	38	(750)	194
Medical Directorate	General Medicine	14,112	49	(67)	(7,565)	(106)	(1,465)	113	5,130	(60)
Urgent Care Centre	Urgent Care Centre	0	0	0	(205)	32	0	26	(205)	58
Emergency Services Division	**Medicine & Emergency Care**	**21,481**	**327**	**(179)**	**(13,121)**	**(104)**	**(2,132)**	**129**	**6,555**	**(154)**

The Medicine and Emergency Care Division are £154k worse than plan. The variances on income relate to un-coded A&E attendances, and an underperformance on non-elective activity/pass through drugs offset by an over performance within outpatients. Pay costs, which have been under pressure particularly around nursing/HCA costs have worsened in the month - with increases in bank usage in both areas, and also an increase in bedwatch charges.

		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	(430)	19	(41)	14	(471)	33
Gum clinic	Gum clinic	0	0	0	0	0	0	0	0	0
Obstetric & Gynaecology Dir	Obstetrics & Gynaecology	5,836	46	(340)	(2,928)	(37)	(448)	2	2,506	(375)
Paediatric Directorate	Paediatrics	3,899	32	(84)	(2,644)	(104)	(337)	24	950	(164)
Women and Childrens Division	**Women and Children**	**9,735**	**78**	**(424)**	**(6,002)**	**(122)**	**(826)**	**40**	**2,985**	**(506)**

The Women's and Children's Division is £506k worse than plan. Contract income continues to be below plan for Gynaecology and Obstetrics - both as a result of lower than plan activity. Pay pressures are a result of midwifery over establishment, which is expected to reduce as vacancies have started to arise.

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	(94)	13	(10)	(39)	(104)	(25)
Dermatology	Dermatology	604	7	7	(325)	25	(118)	(10)	168	22
ECG department	ECG	133	5	(3)	(347)	22	(27)	0	(235)	19
Elmhurst	Elmhurst	666	55	(4)	(520)	(20)	(53)	11	147	(12)
Integrated Discharge	Integrated Discharge	0	0	0	(104)	(10)	(2)	(1)	(106)	(11)
Medical Records Department	Medical Records Department	0	0	(1)	(581)	(15)	(74)	0	(655)	(16)
Outpatients	Outpatients	0	46	(10)	(182)	5	(18)	0	(155)	(6)
Pathology Directorate	Pathology	3,749	1,339	31	(3,312)	19	(2,752)	(237)	(976)	(187)
Pharmacy Departments	Pharmacy	1,196	68	(35)	(1,116)	(22)	(1,198)	(33)	(1,050)	(89)
Radiology Directorate	Radiology	964	290	(57)	(2,140)	7	(825)	(185)	(1,711)	(236)
Therapeutic Departments	Therapies	0	0	0	(717)	(10)	(16)	16	(733)	6
Victoria Infirmary Northwich	Victoria Infirmary Northwich	673	1	(39)	(579)	(16)	(98)	1	(3)	(55)
Diagnostics and Support Divisi	**Diagnostics and Support**	**7,986**	**1,809**	**(111)**	**(10,017)**	**(3)**	**(5,191)**	**(476)**	**(5,413)**	**(590)**

The Diagnostics Division is £590k worse than plan year to date. Radiology has seen a deterioration in income, relating to activity as well as an increase in outsource costs within non pay leading to the £236k adverse variance, year to date. Pathology has a £44k pay pressure for for Clinical Haematology from UHNM.

		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	(173)	7	(63)	8	(236)	15
Catering Directorate	Catering	0	440	(12)	(552)	(28)	(487)	(49)	(599)	(89)
Estates Departments	Estates Departments	0	153	(6)	(523)	(3)	(2,437)	(332)	(2,807)	(340)
Hotel Services	Domestics	0	0	0	(449)	(4)	(6)	(2)	(454)	(5)
Laundry Services Departments	Laundry	0	377	(18)	(356)	(13)	(304)	(41)	(283)	(72)
Security	Security	0	552	(13)	(243)	10	(257)	(58)	52	(62)
Site Services	Porters	0	0	0	(953)	(14)	(24)	3	(977)	(12)
Estates & Facilities Division	**Estates & Facilities Division**	**0**	**1,523**	**(49)**	**(3,249)**	**(44)**	**(3,578)**	**(471)**	**(5,305)**	**(565)**

The Estates and Facilities Division is £565k worse than plan. Within non pay there are some 1718 costs (Carbon Credits £160k, Gritting £13k) and some one off costs a (£16k fixture and fitting, £14k overspend on barrier repairs). Utilities are £98k over as a result of problems with the combined heat and power - which have been resolved in July, and the issues around waste contamination (£26k YTD) have been resolved at the end of June.

		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	4	4	(510)	(1)	(200)	8	(705)	12
Computer Services	Computer Services	0	10	7	(507)	10	(939)	(178)	(1,435)	(161)
Finance & Information	Finance & Information	0	17	6	(1,013)	14	(216)	39	(1,212)	59
Human Resources	Human Resources	0	162	2	(792)	44	(142)	61	(772)	108
Risk Manangement & R&D	Risk Management & R&D	0	148	(32)	(498)	29	(34)	(1)	(385)	(4)
Quality Assurance Departments	Nurse Management	0	84	48	(930)	(89)	(2,730)	40	(3,576)	(2)
Trust Central Expenditure	Trust Central Expenditure	2,776	2,167	114	(688)	(147)	(55)	174	4,201	141
Other Departments	Other Departments	7	59	20	(86)	(25)	(73)	14	(94)	8
	Corporate	**2,783**	**2,651**	**169**	**(5,025)**	**(165)**	**(4,389)**	**158**	**(3,978)**	**161**

The Corporate Division is £161k better than budget, the pay award is no longer held centrally. Computer Services require budget to be transferred from Trust Central.

Community Services		**9,480**	**442**	**73**	**(6,983)**	**241**	**(2,172)**	**132**	**767**	**446**
EBITDA		**73,326**	**7,857**	**(425)**	**(56,665)**	**(386)**	**(23,531)**	**(644)**	**988**	**(1,455)**

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	2,677	0	2,587	-89
NHS Eastern Cheshire CCG Community	412	137	0	137	0
NHS South Cheshire CCG Community	17,192	5,731	0	5,727	-4
NHS South Cheshire CCG	101,698	33,770	599	33,770	0
NHS Vale Royal CCG	55,052	18,301	-562	18,301	0
NHS Vale Royal CCG Community	10,441	3,480	0	3,478	-3
NHS Warrington CCG	284	96	0	114	18
NHS West Cheshire CCG	3,537	1,174	0	1,197	22
NHS West Cheshire CCG Community	191	64	0	64	0
NHS North Staffordshire CCG	2,307	772	0	878	106
NHS Shropshire CCG	892	297	0	266	-31
NHS Stoke on Trent CCG	1,609	540	0	602	62
Public Health England	1,541	445	0	435	-10
NHS Commissioning Board	1,569	523	0	523	0
Specialist Commissioning Group	8,645	2,883	0	2,415	-467
Non Contract Activity	2,007	665	0	661	-4
Cross Border Flows	149	49	0	45	-5
BCULHB	229	76	0	384	308
Non-Commissioner Specific	12,861	2,012	0	1,743	-268
TOTAL	**228,702**	**73,692**	**37**	**73,326**	**-366**

Other Contract Income	FY Target (£'000)	YTD Target (£'000)	YTD Actual (£'000)	Final Variance (£'000)
Bed Based Services	5,962	1,987	1,917	-70
Adult & Neonatal Critical Care	7,896	2,635	2,694	59
Community Paediatrics	1,303	434	434	0
Direct Access Services	9,509	3,157	3,164	7
Unbundled Radiology	3,505	1,164	1,177	13
High Cost Drugs	9,762	3,373	3,147	-225
Screening Programmes	1,530	510	510	0
Audiology	1,167	389	351	-38
IVF	258	86	58	-28
CQUIN	4,312	1,061	905	-156
PSV	8,428	1,825	1,278	-548
Community Services	28,426	9,400	9,400	0
CEP	-2,817	-939	37	976
WINTER FUNDING	750	250	395	145
Other	6,623	992	1,138	146
TOTAL	**86,614**	**26,324**	**26,605**	**281**

South Cheshire CCG is currently performing below the contract value set , and Vale Royal above - if the contract were set on PbR tariffs - which is continuing the trend of the first quarter.

Other commissioners, except East Cheshire CCG are in the main over performing against plan. East Cheshire underperformance is in unplanned care (£45k), and within surgical specialties for planned care (£73k).

Specialist Commissioning has a negative variance being the result of a high cost drug rebate of £442k in July.

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

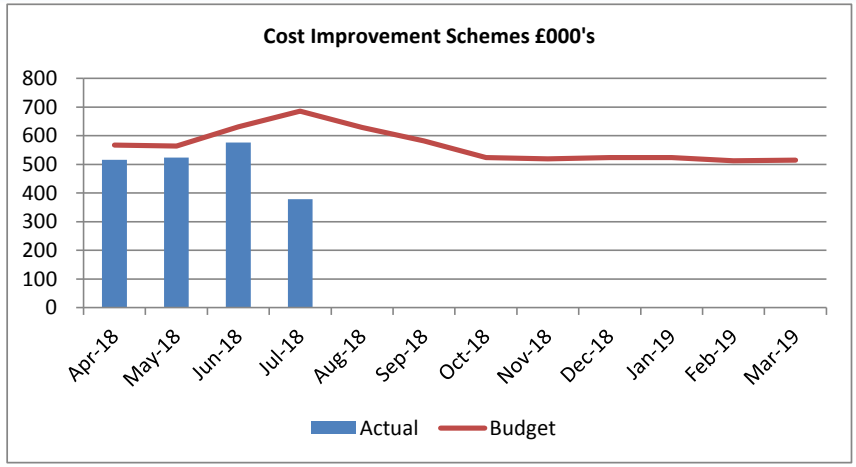
Other contract income is showing £0.3M better than plan.

An analysis of the key service lines identifies that, aside the CEP adjustment there were gains against the un coded prior year spells valuation (£120k), Winter funding for quarter 1 (£145k), CQUIN is £156k behind plan based on most recent forecasts of achievement, High cost drug income excluding the rebate is £215k above plan, Non-performance of the A&E target has been recognised year to date.

The impact of the CEP is less than expected year to date by £1m, although there is marked difference between the 2 CCGs in under and over performance of A&E and NEL admissions.

Financial Performance: Efficiencies

Cost Improvement Schemes (£'000's)						
Scheme Category	**YTD Target**	**YTD Actual**	**YTD**	**FY Target**	**FY Forecast**	**FY Variance**
Access & Flow	315	189	-126	524	189	-335
Commercial	57	70	13	195	215	20
Drugs	100	100	0	657	657	0
Medical Workforce	517	532	15	1,550	1,234	-316
Non-Pay Efficiency	356	541	186	1,178	1,470	292
Nursing Workforce	324	239	-85	974	778	-196
Procurement	229	169	-59	684	500	-184
Theatres Efficiency	33	0	-33	100	25	-75
Service redesign	180	154	-26	540	463	-77
Market Share	115	0	-115	320	220	-100
Total (£'000)	**2,226**	**1,994**	**-230**	**6,722**	**5,751**	**-971**



The CIP achievement year to date is £230k worse than budget with key schemes around the improvement of nurse/HCA sickness, r eduction in WLIs either not currently delivering/partially delivering.
The closure of beds are a key CIP for the summer months, which are now recognised as not being achievable of which £126 is within the Junlyposition with a further £209k still to come through. There is also a further risk associated with drugs scheme due to the potential delays for release of new bio-similars (£357k).
There are a number of CCICP efficiencies that are over performing which offset against the non-pay efficiency and nursing workforce CIP within the hospital.

Capped Expenditure Schemes (£'000's)						
Scheme Category	**YTD Target**	**YTD Actual**	**YTD**	**FY Target**	**FY Forecast**	**FY Variance**
TeleDerm	18	0	-18	70	70	0
Non-Pay Efficiency	25	25	0	100	100	0
Drugs	13	13	0	50	50	0
Commercial	50	0	-50	200	200	0
Procurement	25	0	-25	100	100	0
Elective	279	165	-114	1,116	1,116	0
Total (£'000)	**410**	**203**	**-207**	**1,636**	**1,636**	**0**

The CEP schemes rolled over from 1718 are under achieving by £207k, with key issues around delivering planned cost savings in IVF, and work with East Cheshire in relation to births /out of hours contracts, as these are legacy CEP schemes these are being discussed with commissioners .A review of the potential for further out of area work is underway in order to achieve the elective CIP.

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	57	-41	16		101	60	60
BISTRO & 2 OFFICES	Yes	Internal	Yes	120	58	58	151	-93	58		271	178	178
UNDER / OVERS CAPITAL SCHEMES 17/18	Yes	Internal	Yes		0	0	1	-1	0		1	0	0
WARD REFURBISHMENT	Yes	Loan	Yes	224	1864	1340	1497	-157	1864	8600	1721	10,688	10,688
MRI SCANNER 3RD BUILD	Yes	Internal/Loan	Yes	174	1475	400	0	400	1475	0	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	50	10	40	400	1500	10	1,900	1,900
EPR PROJECT ACCOMODATION *	Yes	Loan	Not yet approved		350	0	0	0	0		0	350	0
ENDOSCOPY WASHER BUILD *	No	Loan	Not yet approved		250	0	0	0	0	500	0	750	500
PATHOLOGY RISKS	Yes	Internal	Yes		100	90	0	90	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	1400	200	0	1,800	1,600
DEMENTIA APPEAL	No	Donated	Not yet approved							1500		1,500	1,500
3RD CT ENABLING	No	Internal	Not yet approved							935		935	935
TOTAL				**562**	**7396**	**1954**	**1715**	**239**	**6596**	**13370**	**2277**	**21328**	**20528**
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	32	0	32	37		25	62	62
HIGH IMPACT STAND ALONE IT SYSTEMS	Yes	Internal	Yes	88	112	12	2	10	112	400	90	600	600
REPLACEMENT BUSINESS INTELLIGANCE SYSTEM	Yes	Internal	Yes		80	80	31	49	80		31	80	80
CONFIGURATION MANAGEMENT SYSTEM	Yes	Internal	Yes		35	0	0	0	0		0	35	0
CORE INFRASTRUCTURE UPGRADE	yes	PDC	Yes		538	188	0	188	538	180	0	718	718
CYBER SECURITY	Yes	PDC	Yes	17	291	291	291	0	291		308	308	308
X-RAY MACHINE STORAGE	Yes	Internal	Yes		100	0	52	-52	100		52	100	100
SEQUEL / WINDOWS LICENCES	Yes	Internal	Yes		80	0	0	0	80		0	80	80
VIRTUAL DESKTOP	No	Internal	Yes		400	0	125	-125	400		125	400	400
VIRTUAL CLINICS	No	Internal	Yes		50	25	0	25	50		0	50	50
VPN	Yes	PDC	Yes		70	0	0	0	70		0	70	70
VOICE OVER IP	Yes	Internal	Yes	466	100	32	1	31	100	100	467	666	666
SYSTEM REFRESH / REPLACEMENT													
LAB CENTRE PATHOLOGY	No	Internal	Yes		800	0	0	0	0	1600	0	2,400	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				**596**	**3140**	**660**	**503**	**157**	**2305**	**3543**	1099	**7279**	**6,444**
TOTAL STRATEGIC INVESTMENTS				**1158**	**10536**	**2614**	**2218**	**396**	**8901**	**16913**	**3376**	**28,607**	**26,972**

The Estates strategic investments capital spend is £239K underspent mainy due to the and Third MRI Scanner £400K where Estates, a supplier has now been choosen and design work has starte.This is offset by overspends to date in the Ward 17 refurbishment and the Bistro. However some costs for the Bistro need to be charged to backlog which will be moved when the information is provided.

The IT Strategic investments projects are £157K which is mainly due to Core Infrastructure upgrade £188K and BIU Replacment system88K. Thisis offset by Virtual Dessktop which has been purchased earlier than anticiapted

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	39	0	39	135	736	0	1,007	871
DESIGN TEAM	Yes	Internal	Yes		313	96	92	4	313	1252	92	1,565	1,565
CT / VT - HEATING INFRASTRUCTURE	Yes	Internal	Yes		459	100	8	92	150	1009	8	1,468	1,159
BACKLOG GENERAL PROVISION	Yes	Internal/Loan	Yes		2650	990	694	296	1,600	7799	694	10,449	9,399
TOTAL				**0**	**3,693**	**1,225**	**794**	**431**	**2,198**	**10,796**	**794**	**14,489**	**12,994**
IT													
INTERSITE CONNECTIVITY	Yes	Internal	Yes		50	25	16	9	50		16	50	50
INTERFACING	Yes	Internal	Yes		151	10	70	-60	151	340	70	491	491
IT APPLICATIONS	Yes	Internal	Yes		193	37	0	37	193	400	0	593	593
STORAGE & BACKUP	No	Internal	Yes							250		250	250
TOTAL				**0**	**394**	**72**	**85**	**-13**	**394**	**990**	**85**	**1,384**	**1,384**
TOTAL ROLLING ALLOCATIONS				**0**	**4,087**	**1,297**	**880**	**417**	**2,592**	**11,786**	**880**	**15,873**	**14,378**
ADDITIONAL													
EQUIPMENT	Yes	Internal	Yes		0	0	32	-32	32		32	0	32
MEDICAL RECORDS RACKING	Yes	Internal	Yes		43	43	0	43	43		0	43	43
CANCER MDT	Yes	PDC	Yes		30	30	0	30	30		0	30	30
GP STREAMING ESTATES	Yes	PDC	Yes	12	488	488	280	208	488		292	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	230	348	-118	630		453	735	735
LEASING INVESTMENTS													
EQUIPMENT	Yes	Internal	Yes		600	269	269	0	600		269	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**	**269**	**269**	**0**	**2833**	**0**	269	**2833**	**2833**
TOTAL CAPITAL PROGRAMME (EXCLUDING LEASES)				**1,383**	**15,956**	**4,702**	**3,758**	**944**	**12,858**	**28,699**	**5,141**	**46,038**	**42,940**
TOTAL CAPTIAL PROGRAMME				**1,383**	**18,789**	**4,971**	**4,027**	**944**	**15,691**	**28,699**	**5,410**	**48,871**	**45,773**

The rolling allocation is £417K underspent due to the delay in some of the backlog maintenance and CTVT replacement

The forecast spend has been reduced by the following: Asbestos £136K, Backlog Maintenance £1,050K, Ward Efurbishment £200K and Endoscopy Washer Build £250K. This cost have been moved to 2019/20. In respect of the Ward Refurbishment and the Endoscopy Build these are funded via loans and therefore the loans will be drawn down accordingly.

Financial Performance: Statement of Financial Position

	Plan Apr to Jul (£'000)	Actual Apr to Jul (£'000)	Variance (£'000)	Forecast 2018/19 (£'000)
Assets				
Assets, Non-Current	**100,610**	**98,940**	**-1,670**	**109,674**
Assets, Current				
Trade and other Receivables	9,702	6,394	-3,308	9,055
Other Assets (including Inventories & Prepayments)	6,072	6,680	608	6,600
Cash and Cash Equivalents	9,617	15,812	6,195	11,700
Total Assets, Current	**25,391**	**28,886**	**3,495**	**27,355**
ASSETS, TOTAL	**126,001**	**127,826**	**1,825**	**137,029**
Liabilities				
Liabilities, Current				
Finance Lease, Current	-1,101	-674	427	-2,147
Loans Commercial Current	-382	-355	27	-667
Trade and Other Payables, Current	-13,057	-18,372	-5,315	-14,107
Provisions, Current	-179	-182	-3	-225
Other Financial Liabilities	-8,332	-7,250	1,082	-6,552
Total Liabilities, Current	**-23,051**	**-26,833**	**-3,782**	**-23,698**
Net Current Assets/(Liabilities)	**2,340**	**2,053**	**-287**	**3,657**
Liabilities, Non Current				
Finance Lease, Non Current	-4,969	-4,214	755	-5,840
Loans Commercial Non-Current	-12,340	-12,040	300	-16,854
Provisions, Non-Current	-1,604	-1,586	18	-1,489
Trade and Other Payables, Non-Current	0	0	0	**0**
Total Liabilities Non-Current	**-18,913**	**-17,840**	**1,073**	**-24,183**
TOTAL ASSETS EMPLOYED	**84,037**	**83,153**	**-884**	**89,148**
Taxpayers' and Others' Equity				
Taxpayers Equity				
Public dividend capital	76,791	76,791	0	76,791
Retained Earnings	-8,347	-9,231	-884	-3,236
Donated asset reserve	0	0	0	0
Revaluation Reserve	15,592	15,592	0	15,592
TOTAL TAXPAYERS EQUITY	**84,036**	**83,152**	**-884**	**89,147**
TOTAL FUNDS EMPLOYED	**84,036**	**83,152**	**-884**	**89,147**

Assets Non-Current
The main reason for the variance is that the plan is the capital programme expenditure being £944K less than which is mainly due to a delay in the GP Streaming Project £208K, third MRI Scanner build £400K, Backlog maintenance £165K , IT Core Infrastructure £188K and a delay in the renewal of some finance leases £645K. These include Endoscopy Washers £169K, Ultrasound Equipment £66K, Washer disinfectors £212K and operating tables £168K

Trade and other Receivables
NHS Trade Receivables are lower than anticipated as the 2017/18 STF assumed in the plan was paid in July and was anticipated in August £4,950K. This is offset by a number of other outstanding debts. These are Christies Hospital £186K, NHS England £416K, Salford Foundation Trust £104K (£48K received early August), Eastern Cheshire CCG £505K (Payment received in early August). In addition there are outstanding debts with South Cheshire Private Hospital £47K and One to One nursing £78K

Other Assets
This higher than anticipated due to higher than expected Drug Stocks £418K and It Maintenance and Radiology Maintenance contract.

Finance Lease Current
This mainly due to a finance lease being paid earlier than anticipated.

Trade and other Payables
This is mainly due the Q4 STF being paid earlier than anticipated and South Cheshire and Vale Royal providing a cash advance to cover this. However this was anticipated to be paid back in August. In addition Trade Creditors is higher due to the payment run being made early August instead of late July.

Other Financial Liabilities
This is mainly due to Accruals being less than expected mainly due to the plan being based on last years accruals. There are fewer accruals in 2018/19 for CCICP expected expenditure, Pharmacy invoice accruals, Social worker invoices outstanding and CCICP rental invoices.

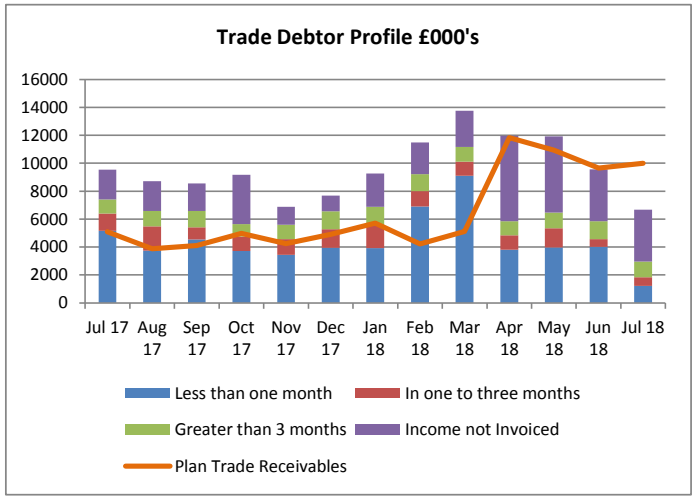
Finance Lease Non- Current
This due to the delay in the replacement of finance leases.

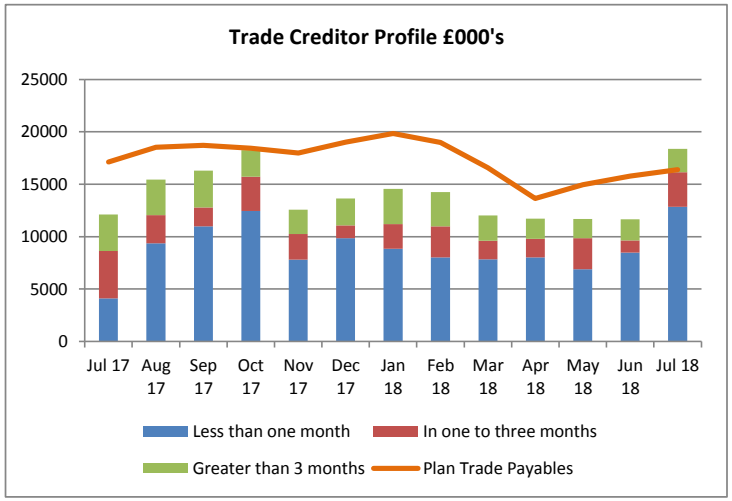
Loans Commercial Non-Current
This is due to the delay in the drawing down of an approved loan for the ward refurbishment and the third MRI scanner.

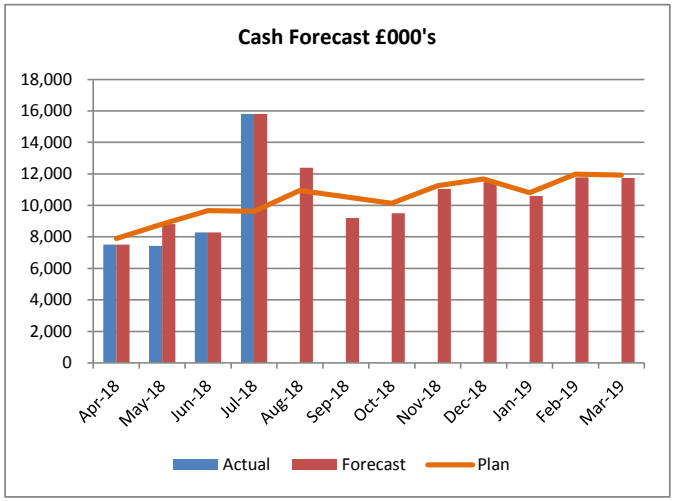
Financial Performance: Cash Position and Working Capital

	Plan Apr to Jul (£'000)	Actual Apr to Jul (£'000)	Variance
Surplus/(deficit) after tax	**-743**	**-1,638**	**-895**
Non-cash flows in operating Surplus/(deficit) total	2,008	1,862	-146
Operating cash flows before movements in working capital	**1,265**	**224**	**-1,041**
Increase/(Decrease) in working capital Total	4,577	11,462	6,885
Net cash inflow/(outflow) from operating activities	**5,842**	**11,686**	**5,844**
Net cash inflow/(outflow) from investing activities total	-3,594	-2,615	979
Net Cash inflow/(outflow) before financing	**2,248**	**9,072**	**6,824**
Net cash inflow/(outflow) from financing activities Total	-393	-1,025	-632
Net increase/(decrease) in cash and cash equivalents	**1,855**	**8,047**	**6,192**
Opening cash balance	**7,761**	**7,761**	**0**
Closing cash balance	**9,616**	**15,808**	**6,192**

Cash is £6,195K more than anticipated, this mainly due the earlier than anticipated payment of the Q4 STF. In addition the delay in the capital payment is improving the cash position but this is offset by £300K of a capital loan for the ward refurbishment which has not been drawn down. Also there is a negative impact on the cash flow due to a worse than anticipated operating surplus position.







Finance: *Staff Costs*

Headline Measures

	YTD £000's	Rolling 13 months £000's													
		Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Monthly Trend
Pay Budget	56,279	13,577	13,688	13,730	13,774	13,799	13,721	13,916	13,817	13,785	14,001	14,112	14,008	14,158	
Pay Actual	56,666	13,649	13,843	13,875	13,947	13,826	13,692	14,278	14,017	14,133	14,094	14,152	14,237	14,183	
Variance	-387	-72	-155	-145	-173	-27	29	-362	-200	-348	-93	-40	-229	-25	
% to Budget	*100.7%*	*100.5%*	*101.1%*	*101.1%*	*101.3%*	*100.2%*	*99.8%*	*102.6%*	*101.4%*	*102.5%*	*100.7%*	*100.3%*	*101.6%*	*100.2%*	
Nursing Staff % to Budget	101.1%	102.5%	97.5%	99.3%	101.6%	102.9%	102.4%	105.9%	104.7%	105.0%	101.7%	99.9%	102.1%	100.5%	
Medical Staff % to Budget	98.1%	98.0%	108.2%	103.5%	102.6%	97.4%	95.3%	98.5%	97.1%	103.2%	95.4%	100.5%	99.2%	97.3%	
Other Staff % to Budget	101.9%	100.1%	100.9%	101.4%	100.1%	99.1%	99.8%	101.6%	100.7%	99.5%	102.9%	100.6%	102.7%	101.6%	

Figures exclude Community Services for 2016/17

Commentary

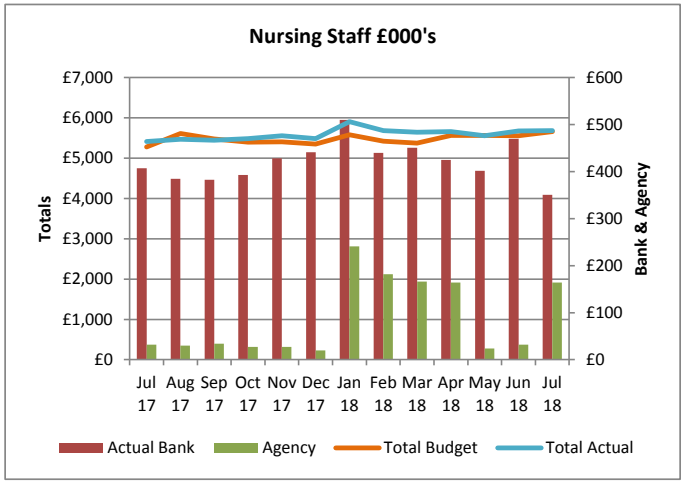
Pay is worse than budget by £0.4M year to date.

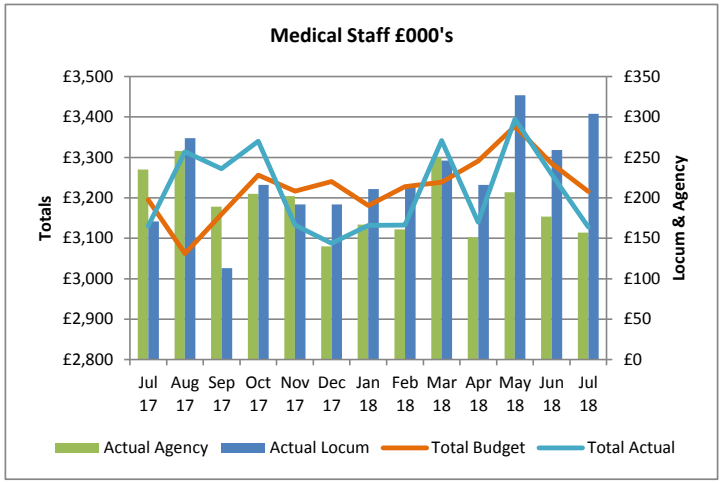
Nursing costs associated with keeping escalation beds/CAU assessment area open have been offset against agreed additional Winter money funding within contract income, Bank use over establishment for HCAs continues to support one to one patient supervision and is a financial pressure. Nursing vacancies and sickness levels have remained static in the month.

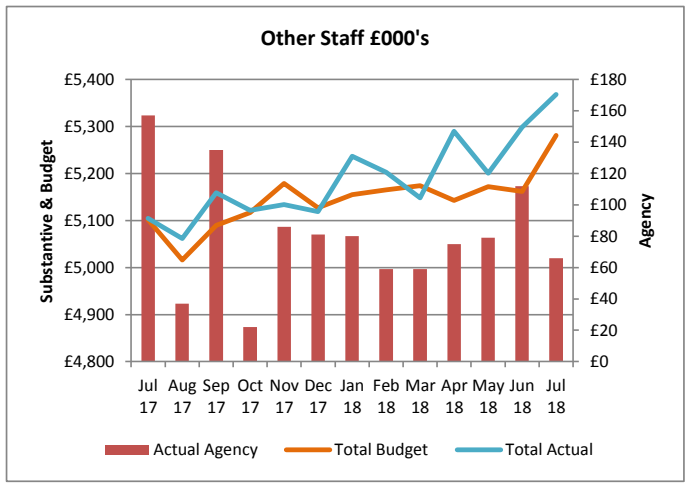
Medical pay is better than budget in month, and year to date due to vacancies most notably in Medicine & Emergency Care.

The Agency trajectory has improved as a result of the closure of the escalation beds, however , there has been a significant increase in nursing agency spend iduring July. Total agency spend remains below planned level.

Primary Drivers

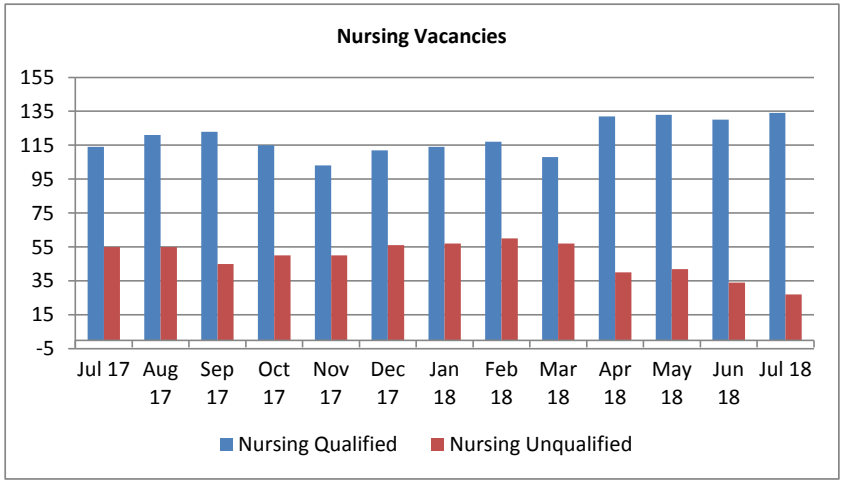






Finance: *Staff Costs*

Secondary Drivers



Medical vacancies under review

Agency Trajectory

	YTD	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Monthly Trend
Plan	-1,460	-515	-563	-525	-495	-477	-506	-495	-470	-484	-365	-365	-365	-365	
Actual	-1,406	-611	-568	-540	-699	-721	-572	-668	-618	-574	-389	-310	-320	-387	
Variance	54	-96	-5	-15	-204	-244	-66	-173	-148	-90	-24	55	45	-22	
CCICP Actual	0	0	0	0	-69	-77	-152	-210	4	-77	0	0	0	0	

	Rolling 13 Months													
	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Monthly Trend
Sickness Rate (Rolling 12 mths)	4.07%	4.14%	4.20%	4.21%	4.23%	4.25%	4.28%	4.28%	4.38%	4.38%	4.37%	4.30%	4.29%	
Total Leavers	47	45	54	45	39	33	46	37	59	39	41	37	36	
Turnover (Rolling 12 mths)	10.12%	10.57%	11.10%	11.08%	10.93%	10.71%	10.70%	10.66%	11.18%	11.33%	11.28%	11.33%	11.17%	

Title of Paper :	Board Assurance Framework (BAF) Report Q1 18/19	
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.
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:	3 September 2018

Board Assurance Framework

2018/19

Quarter 1

Summary Version

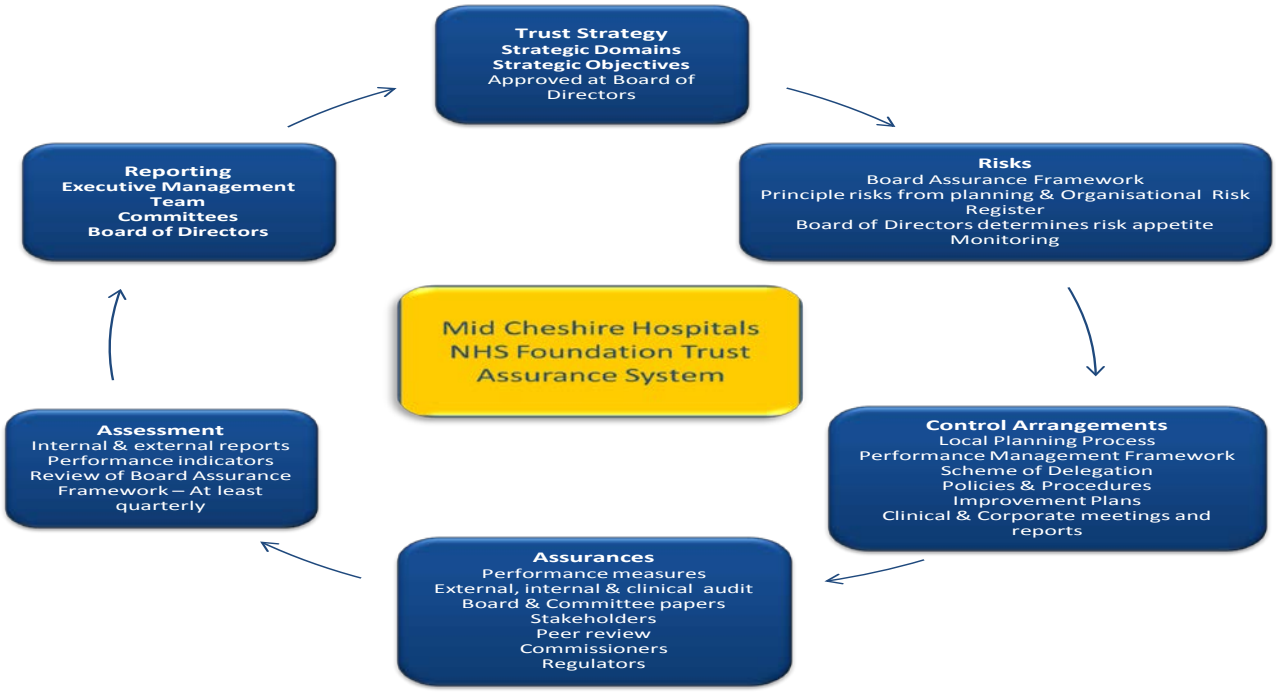
'Delivering Excellence in Healthcare through Innovation and Collaboration'

1. Background & purpose

The requirement for NHS organisations to have Board Assurance Framework (BAF) is well documented, most recently it is cited in the NHS Improvement document *Developmental Reviews of Leadership and Governance using the Well-Led Framework: Guidance for NHS Trusts and NHS Foundation Trusts* (June 2017). The Board of Directors have had a well embedded document in place for a number of years, with reasonable assurances provided. Following an internal review of our risk management systems and processes, feedback from internal audit and Board members a 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. Quarterly 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 1 2018/19.

Table 1 – Top five organisational risks

	Risk Title	Mitigated (With controls) Risk Rating	Key Links to BAF 2018/19	Comments
1	**Workforce capacity and skill mix to consistently deliver high quality care, seven days a week.**	5(C)x4(L)=20	Q1,Q2,P1,P2, E2,W1,W2,W3, T2a,T2b	This is a new risk which replaces CS0275 "Delivering high quality clinical care 7 days a week" and CS0328 "Sustainability of vulnerable clinical services."
2	**Delivery of key local and national targets and standards, in particular the 4 hour Standard in A&E.**	5(C)x4(L)=20	Q1,Q2,E1,E2, P1,P2	This is a refresh of risk CS0325 "Operational sustainability of MCHFT."
3	**A lack of funding to implement the Information Management and Technology strategy.**	5(C)x4(L)=20	Q1,Q2,E1,E2, T2a,T2b	This is a refresh of risk CS0326 "Risk to the Trust of not delivering the IM&T Strategy."
4	**Lack of pace in the significant transformational change required to deliver the Cheshire East Place Strategy and consequently the Health and Care Partnership (HCP) for Cheshire & Mersey.**	4(C)x4(L)=16	Q1,Q2,P1,P2, E1,E2,W2,T1	This is a new risk.
5	**The long term financial sustainability of the Trust.**	5(C)x4(L)=20	E1,E2,P1,P2, T1,T2a,T2b	This is a refresh of risk CS0327 "Financial sustainability of MCHFT."

4. Next steps

The development of the BAF is an iterative process. Governance between partner organisations and associated risks and assurances will also be considered in future iterations of the BAF. This was identified as a key area in the internal Well Led Developmental Review by the Board of Directors in February 2018, and will be an area of focus for the externally facilitated review which has now been commissioned and planned to take place in quarter 3 2018/19.

In April 2018 the 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.

5. Summary

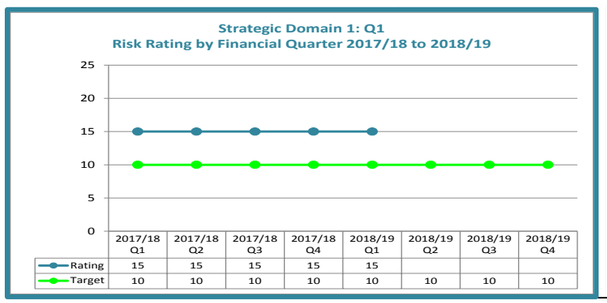
Strategic Domain 1: Delivering Outstanding Clinical Quality, Safety & Experience

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	June 2018	September 2018	Safe, Effective, Responsive, Caring & Well Led NHSI – Quality Metrics	Director of Nursing & Quality	Executive Quality Governance Group (EQGG) Executive Patient Experience Group (EPEG)	Quality Governance Committee (QGC)



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

Rationale for the Current Risk Score

The risk score remains the same at the end of quarter 1. 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 – Delivery of Key Local and National Targets and Standards, In Particular the 4 Hour Standard in ED: 5(C)x4(L)=20	CS0326 – Lack of Funding to Implement the IM&T Strategy:5(C)x4(L)=20
CS0328 – Workforce Capacity and Skill Mix To Consistently Deliver High Quality Care, Seven Days A Week: 5(C)x4(L)=20	CS0284 – Nursing Vacancies Across MCHFT:4(C)x4(L)=16
CS0327 – Long Term Financial Sustainability of the Trust: 5(C)x4(L)=20	DC0887 - Consultant Histopathologist Capacity:5(C)x4(L)=20
EC0327 - Lack of Secondary Anaesthetic On-Call Cover: 5(C)x4(L)=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. The quality reports at ward / department and divisional level have been developed and rolled out across all divisions. New Executive led quarterly quality assurance reviews have commenced and DMEC and S&C reviews have taken place. The new Quality & Safety Improvement Strategy for 2018/19 has been implemented. Quality priorities have been presented and approved at Quality Governance Committee in April 2018. A Well Led self-assessment process has been developed with findings from the initial reviews presented to the Trust Board. Review of Infection, Prevention & Control Services completed. The Director of Nursing & Quality has been appointed as the new Trust Safety Champion for Maternity Services. A Nursing, Midwifery and Allied Health Care Professionals Strategy has been developed.

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

- Full roll out of Quality Reports and Quarterly Quality Assurance Reviews Trust wide, including CCICP by December 2018.
- The new Quality & Safety Improvement Strategy 2018/19 is in the early stages of implementation.
- Implementation of revised quality impact assessment process.
- Internal Well-Led Review improvement actions – quarterly oversight at Quality Governance Committee.
- The Nursing, Midwifery and Allied Health Care Professionals Strategy is in the early stages of implementation.

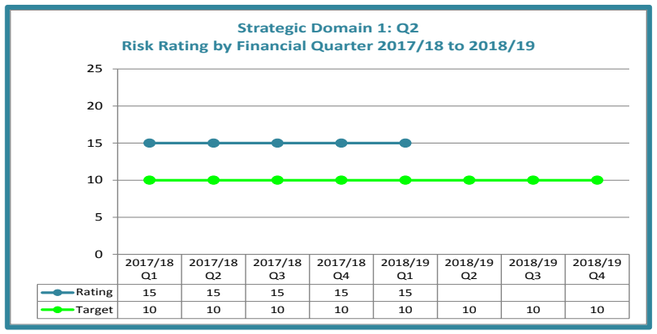
Strategic Domain 1: Delivering Outstanding Clinical Quality, Safety & Experience

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

Principal Risk

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

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHS Improvement Single Oversight Framework	Executive Director	Executive Management Group	Board Committee
June 2017	June 2018	September 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 1. The Quality Governance team has undergone organisational change, however; these changes are still to be established. The Research & Development team have strengthened gaps in the Division of Medicine and Emergency Care, however; clinical trials in this area require further improvements.

Links to BAF Objectives

Q1, P1, P2, E1, E2, W1, W2, W3, T1, & T2

Key Links to the Organisational Risk Register

CS0325 – Delivery of Key Local and National Targets and Standards, In Particular the 4 Hour Standard in ED: 5(C)x4(L)=20	CS0326 – Lack of Funding to Implement the IM&T Strategy:5(C)x4(L)=20
CS0328 – Workforce Capacity and Skill Mix To Consistently Deliver High Quality Care, Seven Days A Week: 5(C)x4(L)=20	CS0284 – Nursing Vacancies Across MCHFT:4(C)x4(L)=16
CS0327 – Long Term Financial Sustainability of the Trust: 5(C)x4(L)=20	DC0887 - Consultant Histopathologist Capacity:5(C)x4(L)=20
EC0327 - Lack of Secondary Anaesthetic On-Call Cover: 5(C)x4(L)=20	

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

HSMR/SHMI mortality indicators are within expected range. 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 Deteriorating Patient Steering Group has agreed a launch date of 5 November 2018 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 was undertaken in April 2018 with roll out planned. The Trust has been accepted onto the AQUA Deteriorating Patient Safety Collaborative spanning 2018/19. Structured Judgement Reviews for mortality cases commenced in April 2018. National clinical audits benchmarking performance. MEDC and S&C have been subject to Quality Assurance Reviews. GIRFT review action plans. Adherence to clinical pathways reviewed.

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

- Full roll out of Quality Reports and Quarterly Quality Assurance Reviews Trust wide, including CCICP by December 2018.
- Development of Clinical Trials portfolio by March 2019.
- Development of QI capability & capacity Trust wide by March 2020.
- Innovation agenda to be developed.

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

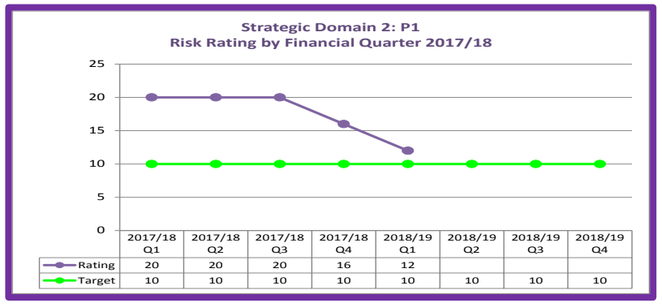
P1	To fully engage with all strategic partners to maximise the opportunities and advantages associated with horizontal integration in the designing and delivery of sustainable health services for the population of Central and Eastern Cheshire, whilst acknowledging and responding to: - National and regional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

Principal Risk

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

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

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHS Improvement Single Oversight Framework	Executive Director	Executive Management Group	Board Committee
June 2017	June 2018	September 2018	Well Led NHSI - Use of Resources	CEO	Board of Directors	Quality Governance 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**	4	3	**⇩12**	5	2	**10**	March 2019

Rationale for the Current Risk Score

The risk score for quarter 1 has been reduced to reflect the progress made to date. Impact of CEP financial surplus on accounts so little impact. The health economy is in balance with significant strides to achieving this. Strengthened relationships with the CCG. UHNM have approached the Trust to open negotiations around elective work through the Stronger Together Programme. The Trust is engaging with other organisations and health economies in view of attracting out of area work to assist our financial economy.

Links to BAF Objectives

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

Key Links to the Organisational Risk Register

CS0328 – Workforce capacity and skill mix to consistently deliver high quality care, seven days a week: 5(C)x4(L)=20	CS0327 – Long Term Financial Sustainability of MCHFT: 5(C)x4(L)=20
New - Lack of Pace in the Significant Transformational Change Required to Deliver The Cheshire East Place Strategy and Consequently the Health and Care Partnership (HCP) For Cheshire & Mersey.	

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.

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

- We are awaiting a KPMG review of East Cheshire and Southport and Ormskirk NHS Trusts which will feed into the acute sustainability programme for the Health & Care Partnership for Cheshire & Mersey.

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

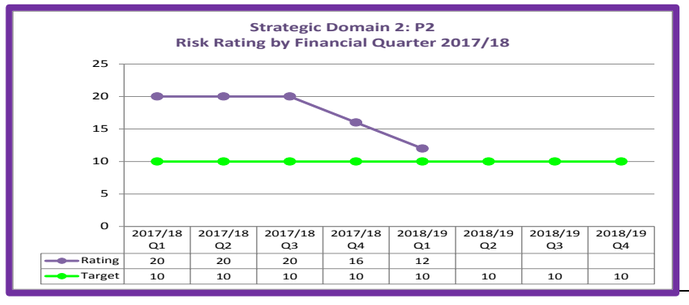
P2	**To work with all key stakeholders to deliver a wholly integrated health and social care system, taking on clear collective responsibility for resources and population health, so that our residents receive better coordinated care within the designated financial envelope, whilst ensuring:** - **National and regional strategies are implemented.** - **The sustainable use of resources to deliver agreed health outcomes.** - **The development of a collective decision making and governance structure.** - **Sustainable clinical services through the development of 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	June 2018	September 2018	Well Led / NHSI - Use of Resources	CEO	Board of Directors	Quality Governance 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**	4	3	⇩12	5	2	**10**	March 2019

Rationale for the Current Risk Score

The risk score reduced to reflect progression in quarter 1. Central & East Cheshire Single Partnership Board now have a joint independent chair in post, with an executive oversight group chaired by Mrs Bullock. Significant progress has been made in CCICP with the five care groups including the roll out of the EMIS system. The Trust participated in a care pathways event held by East Cheshire NHS Trust with representation from MCHFT divisions. Discussions have been held with UHNM in relation to strengthening stroke pathways. The implementation of the new PACS system is in its infancy and allows radiologists to work across sites.

Links to BAF Objectives

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

Key Links to the Organisational Risk Register

CS0328 – Workforce capacity and skill mix to consistently deliver high quality care, seven days a week: : 5(C)x4(L)=20	CS0327 – Long Term Financial Sustainability of MCHFT: : 5(C)x4(L)=20

New - Lack of Pace in the Significant Transformational Change Required to Deliver The Cheshire East Place Strategy and Consequently the Health and Care Partnership (HCP) For Cheshire & Mersey: 4(C)x4(L)=16

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.

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

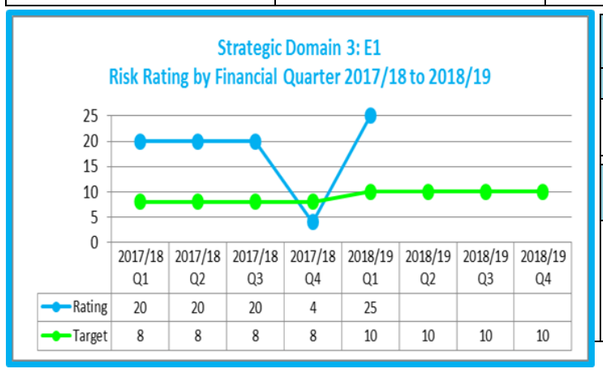
Strategic Domain 3: Striving for Outstanding Organisational Effectiveness

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

Principal Risk

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

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHS Improvement Single Oversight Framework	Executive Director	Executive Management Group	Board Committee
June 2017	July 2018	October 2018	Well Led 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**	5	5	**⇧25**	5	2	**10**	March 2019

Rationale for the Current Risk Score

At the end of Quarter 4 the risk score had been reduced to 4 to reflect the Trusts achievement of its financial controls and targets for 2017/18. The risk has been reconsidered in Quarter 1 of 2018/19 and scored as 25. Influencing factors for the increase in risk score include; anticipated costs of achieving the A&E response time targets, potential not to achieve STF funding and the knock on impact on the MOU with CCG. It is anticipated that there will be a significant impact on capital programmes and service provision as a result.

Links to BAF Objectives

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

Key Links to the Organisational Risk Register

CS0325 – Delivery of Key Local and National Targets and Standards, In Particular the 4 Hour Standard in ED: 5(C)x4(L)=20	CS0326 – Lack of Funding to Implement the IM&T Strategy:5(C)x4(L)=20
CS0328 – Workforce Capacity and Skill Mix To Consistently Deliver High Quality Care, Seven Days A Week: 5(C)x4(L)=20	CS0284 – Nursing Vacancies Across MCHFT: 4(C)x4(L)=16
CS0327 – Long Term Financial Sustainability of the Trust: 5(C)x4(L)=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. A Performance Management Framework has been developed.

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.
- Performance Management Framework to be approved in September 2018 and implemented.

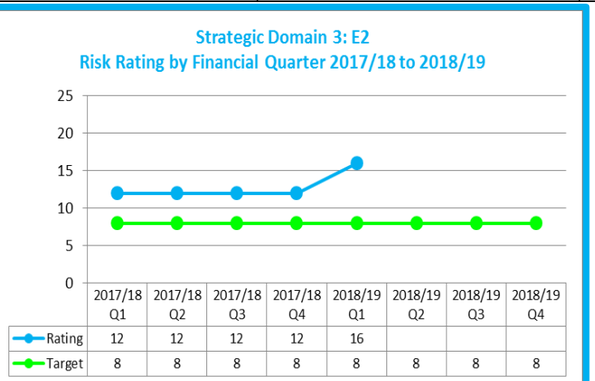
Strategic Domain 3: Striving for Outstanding Organisational Effectiveness

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	July 2018	October 2018	Responsive Care & Effective Care 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	4	**⇧16**	4	2	**8**	March 2019

Executive Commentary for the Current Risk Score

Risk score has increased to 16. 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 Trust has developed a winter pressures plan, which currently identifies a deficit of capacity to meet expected demand required to deliver 92% Trust occupancy and 90% performance against the 4 hour standard. Options are now being developed to mitigate the above risk, however given the financial resource required the schemes will need full system approval. Should the Trust's occupancy levels increase this will impact on the elective programme and performance against RTT and possibly cancer standards.

Links to BAF Objectives

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

Key Links to the Organisational Risk Register

CS0325 – Delivery of Key Local and National Targets and Standards, in Particular the 4 Hour Standard in ED: 5(C)x4(L)=20	CS0326 – Lack of Funding to Implement the IM&T Strategy: 5(C)x4(L)=20
CS0328 – Workforce Capacity and Skill Mix to Consistently Deliver High Quality Care, Seven Days a Week: 5(C)x4(L)=20	CS0284 – Nursing Vacancies Across MCHFT: 4(C)x4(L)=16
CS0327 – Long Term Financial Sustainability of the Trust: 5(C)x4(L)=20	DC0887 - Consultant Histopathologist Capacity: 4(C)x4(L)=16

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. The Trust has a comprehensive driver diagram which details the actions being taken to improve performance against this standard. Performance against the driver diagram is monitored but internally at a system wide level.

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

- Partnership working and agreeing actions to support future compliance.
- Performance Management Framework is in the final stages of completion and will be presented to the Trust's Performance & Finance Committee in September 2018.

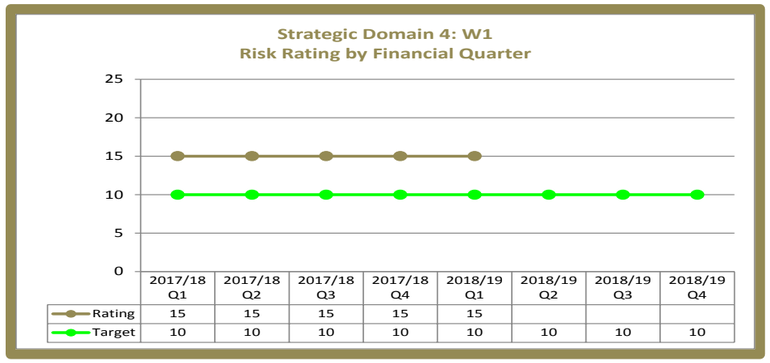
Strategic Domain 4: Aspiring to Excellence in Practice through Our Workforce

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

Principal Risk

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

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



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

Rationale for the Current Risk Score

To maintain risk score at 15 whilst ability to recruit to senior clinical 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 – Delivery of Key Local and National Targets and Standards, In Particular the 4 Hour Standard in ED: 5(C)x4(L)=20	CS0326 – Lack of Funding to Implement the IM&T Strategy: 5(C)x4(L)=20
CS0328 – Workforce Capacity and Skill Mix To Consistently Deliver High Quality Care, Seven Days A Week: 5(C)x4(L)=20	CS0284 – Nursing Vacancies Across MCHFT: 4(C)x4(L)=16
CS0327 – Long Term Financial Sustainability of the Trust: 5(C)x4(L)=20	DC0887 - Consultant Histopathologist Capacity: 4(C)x4(L)=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 embed 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. The Trust participates in a rolling programme of senior leadership development. Talent management and succession planning plan implemented. Well led self- assessment process. Local development of improvement plans following the National Staff Survey results.

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

- Workforce & OD Strategy (Workforce Matters Strategy) is not expected to be fully through the governance process until August/September 2018
- Review of Education Governance Framework by April 2018
- In some specialities there are gaps in senior clinical leadership
- Two divisions to attend EWG to present improvement plans following the National Staff Survey
- Freedom to Speak Up self-review tool to be completed by August 2018.

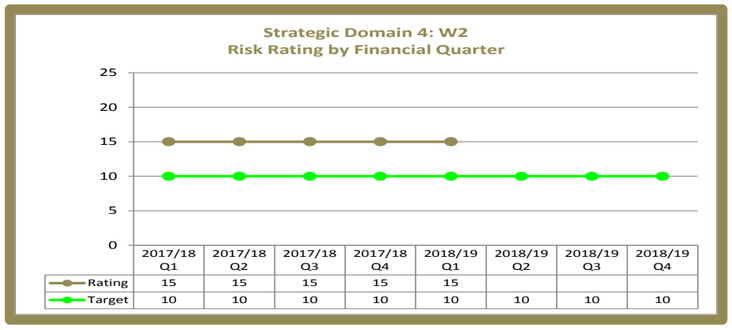
Strategic Domain 4: Aspiring to Excellence in Practice through Our Workforce

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

Principal Risk

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

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



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

Rationale for the Current Risk Score

Rating of 15 remains for Q1 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 – Delivery of Key Local and National Targets and Standards, In Particular the 4 Hour Standard in ED: 5(C)x4(L)=20	CS0326 – Lack of Funding to Implement the IM&T Strategy: 5(C)x4(L)=20
CS0328 – Workforce Capacity and Skill Mix To Consistently Deliver High Quality Care, Seven Days A Week: 5(C)x4(L)=20	CS0284 – Nursing Vacancies Across MCHFT: 4(C)x4(L)=16
CS0327 – Long Term Financial Sustainability of the Trust: 5(C)x4(L)=20	DC0887 - Consultant Histopathologist Capacity: 4(C)x4(L)=16
EC0327 - Lack of Secondary Anaesthetic On-Call Cover: 5(C)x4(L)=20	

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?)

- Workforce & OD Strategy (Workforce Matters Strategy) is not expected to be fully through the governance process until August/September 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.

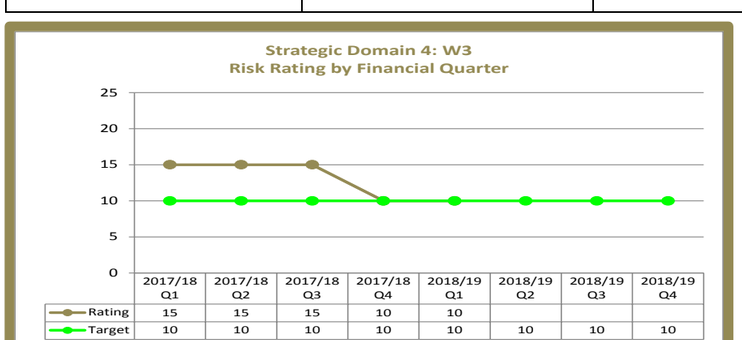
Strategic Domain 4: Aspiring to Excellence in Practice through our Workforce

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	June 2018	September 2018	Well Led Framework NHSI Organisational Health Metrics	Director of Workforce & Organisational Development	Executive Workforce Assurance Group	Transformation & People Committee



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

Rationale for the Current Risk Score

Risk score remains the same for quarter 1. The Workforce & OD Strategy (Workforce Matters) implementation has been delayed until Aug/Sept 2018.

Links to BAF Objectives	
Q1, Q2, P1, P2, E1, E2, W2, W3, T1 & T2	
Key Links to the Organisational Risk Register	
CS0325 – Delivery of Key Local and National Targets and Standards, In Particular the 4 Hour Standard in ED: 5(C)x4(L)=20	CS0326 – Lack of Funding to Implement the IM&T Strategy: 5(C)x4(L)=20
CS0328 – Workforce Capacity and Skill Mix To Consistently Deliver High Quality Care, Seven Days A Week: 5(C)x4(L)=20	CS0284 – Nursing Vacancies Across MCHFT: 4(C)x4(L)=16
CS0327 – Long Term Financial Sustainability of the Trust: 5(C)x4(L)=20	

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.
Guardian of Safe Working.

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

- Talent management & succession planning programme to be embedded.
- Local development of improvement plans following the National Staff Survey results.
- Review of Sickness Absence Policy.
- Freedom to Speak Up self-review tool to be completed by August 2018.

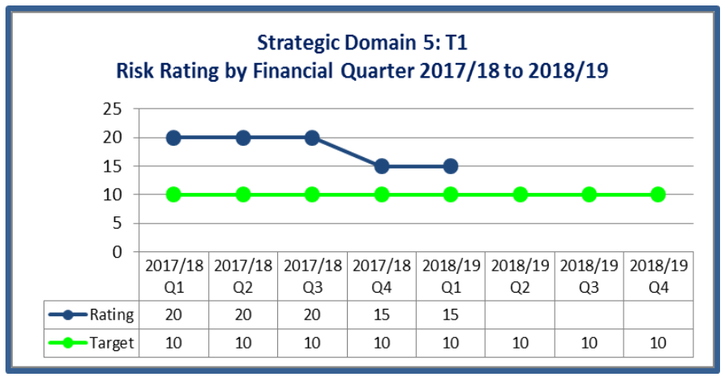
Strategic Domain 5: Creating a 21st Century Infrastructure for Transformative Health and Social Care

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	June 2018	September 2018	Well Led Framework Use of Resources	CEO	Executive Infrastructure Development Group	Performance & Finance



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

Rationale for the Current Risk Score

The risk score remains a high risk overall at 15 due to long term backlog maintenance requirements and the ability to raise the finances necessary 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: 5(C)x4(L)=20	New - Lack of Pace in the Significant Transformational Change Required to Deliver The Cheshire East Place Strategy and Consequently the Health and Care Partnership (HCP) For Cheshire & Mersey: 4(C)x4(L)=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. Estates Strategy in place with Board sign-off.

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

- Asbestos Management Group – oversight of new contractors in progress

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

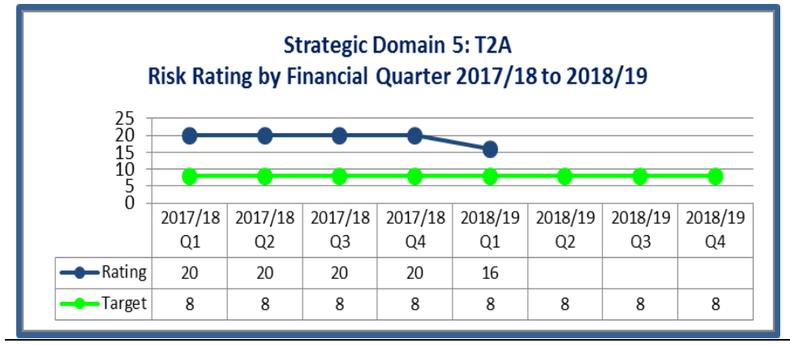
T2a	To deliver an agreed, costed and phased Information Technology (IT) Strategy which supports the provision of seamless, integrated, outstanding patient care, improves staff experience in delivering care and enables continuous quality and service improvements through the intelligent use of secure, 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	July 2018	October 2018	Well Led Framework 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	4	**⇩16**	4	2	**8**	March 2019

Rationale for the Current Risk Score

The current risk score has been reduced from 20 to 16, on the basis that the business case is progressing with approval at the Board of Directors and subsequently NHS Digital, with a recommendation to NHSI to approve. The GDPR and 10 Steps to Cyber Security gap analysis documents have been completed and work is in progress to implement the local delivery plan.

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: 5(C)x4(L)=20	CS0302 – Information Governance : 5(C)x4(L)=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 implementation 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
- GDPR and 10 Steps to Cyber Security local delivery plan in early stages of implementation

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

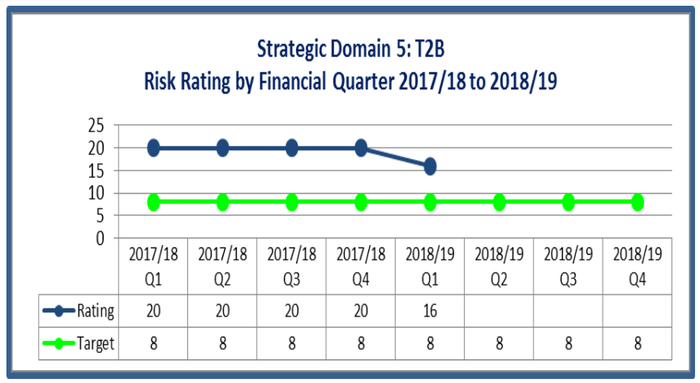
T2b	To deliver an agreed, costed and phased Information Technology (IT) Strategy which supports the provision of seamless, integrated, outstanding patient care, improves staff experience in delivering care and enables continuous quality and service improvements through the intelligent use of secure, 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	July 2018	October 2018	Well Led Framework 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	4	**⇩16**	4	2	**8**	March 2019

Rationale for the Current Risk Score

The current risk score has been reduced from 20 to 16, on the basis that the business case is progressing with approval at the Board of Directors and subsequently NHS Digital, with a recommendation to NHSI to approve.

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	CS0302 – Information Governance

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

Phased implementation of Office 365 with support and training has been completed. Corporate funding on a lease basis agreed to replace old hardware across the organisation. E- Rostering commenced in quarter 1 2018/19.

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

- 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.

Strategic Objectives & Success Measures **2018/19**	**Domain One: Delivering Outstanding Clinical Quality, Safety & Experience**
Objective Q1. To aspire to the delivery of 'outstanding' clinical quality and safety, which is equitable, patient and family centred and supported by an effective quality governance framework	**We will know when we have succeeded by measuring what matters and through:** • Implementing the Quality and Safety Improvement Strategy making this inclusive of all staff • Ensuring compliance with all legal and regulatory requirements • Using local and national benchmarking data to demonstrate consistently high quality clinical care with no unwarranted variation and top quartile performance. • Delivering top quartile performance for national staff and patient surveys as well as consistent positive feedback, greater than 90%, from patients, family members, carers and patient groups, targeting specifically those groups likely to be subject to less equitable services. • Progressing the continuous learning culture through recognised processes of good governance to evidence sustainable improvements to patient safety, quality of care and outcomes. • Working with clinical teams to ensure documentation and record keeping are robust and accurate
Objective Q2. To drive continuous quality improvement and promote research and innovation, whilst reducing unwarranted clinical variation and progressing from a 'good' to 'outstanding' organisation.	**We will know when we have succeeded by measuring what matters and through:** • Progressing towards an 'Outstanding' CQC rating through a clinical quality improvement programme that is Executive led and clinically owned and supported • Engaging with wider stakeholders to ensure further development of clinical pathways to deliver services that are clinically aligned with the needs of the local population and connect across health and social care • Leading on local and national safety collaborations to achieve best practice through influencing national directives and local practice • Ensuring clinical service needs where required are delivered equitably across 7 days • Encouraging and promoting involvement in research and innovation, including academic research and partners, showcasing participation to internal and external stakeholders and sharing outcomes with others. • Use evidence led accreditation in research & innovation to support research studies
Domain Two: Being a Leading Partner in a Progressive Health Economy	
Objective P1. To fully engage with all strategic partners to maximise the opportunities and advantages associated with horizontal integration in the designing and delivery of sustainable health services for the population of Central and Eastern Cheshire, whilst acknowledging and responding to: - National and regional strategies. - The need for sustainable high quality clinical services. - Favourable economies of scale and removal of unwarranted variation. - The cost effective sustainable use of resources.	**We will know when we have succeeded by measuring what matters and through:** • Playing a leading role in implementing the NHS Cheshire & Merseyside Plan with demonstrable outputs and outcomes: - Supporting and leading developments within Cheshire & Wirral and Cheshire & Mersey to enable greater collaboration in relation to back office functions, clinical support services and where appropriate, clinical services. - Supporting the development and delivery of the NHS Cheshire & Mersey, Cheshire & Wirral work streams • Playing a leading role in the delivery of the Capped Expenditure Programme to ensure the appropriate transformation of health and social care to ensure the economic sustainability for Central (& Eastern) Cheshire • Playing a leading role in shaping and delivering the Long Term Sustainability Review: - Mapping the current delivery of services and work with partners, in particular ECT and UHNM, to change the delivery model where improved patient benefit and sustainable provision can be provided by the Trust or others. - With health economy partners, consider longer term options and develop the case to enable MCHFT to provide long term sustainability for ECT - Developing a more flexible workforce that can be deployed differently to lead and support the developing and delivery of high quality integrated horizontal pathways for our patients • Providing sustainable high quality services that are valued by the population served and enhancing the reputation of the Trust to keep services local
Objective P2. To work with all key stakeholders to deliver a wholly integrated health and social care system, taking on clear collective responsibility for resources and population health, so that our residents receive better coordinated care within the designated financial envelope, whilst ensuring: - National and regional strategies are implemented. - The sustainable use of resources to deliver agreed health outcomes. - The development of a collective decision making and governance structure. - Sustainable clinical services through the development of Accountable Care Systems (ACS) /Organisations (ACO) and the implementation of new models of care (e.g. Home first principles)	**We will know when we have succeeded by measuring what matters and through:** • The Central Cheshire Integrated Care Partnership (CCICP) developing and implementing a transformation programme that enhances and integrates care locally and is an enabler to the development of an Accountable Care System: - Care Communities and Primary Care Home through GP clusters for populations of 30 – 50k - Integrated pathways across primary, secondary and community teams, social care and mental health recognising the roles and responsibilities of providing core integrated care, urgent responsive care and specialist care, taking account of the latest treatments and advances in medicine - Enabling infrastructure that transforms the organisational development and culture of the workforce. • Using clinical senate forums, and with health economy partners, playing a leading role in developing and implementing ACS/Os with demonstrable outputs and outcomes, therefore, creating a system that: - Promotes self-care and prevention including vaccination and screening programmes alongside education to make our population healthier - Ensures the Health Economy lives within its means and funds are used in the most effective way to optimise patient outcomes. - Provide sustainable high quality local clinical services that are valued by the population of Central Cheshire. • Ensuring the provision of integrated care is inclusive of all partners including the third sector

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

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

Appendix B – Risk matrices

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

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

Appendix C – Questions for Board Sub-Committees

Assurance:

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

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

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

Title of Paper:	Learning from Deaths Quarterly Report (Q1 2018/19)	
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:	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:	3 September 2018

Learning from Deaths Quarterly Report Q1 2018/19

August 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 fourth iteration of our Learning from Deaths Report covering quarter 1 of 2018/19.

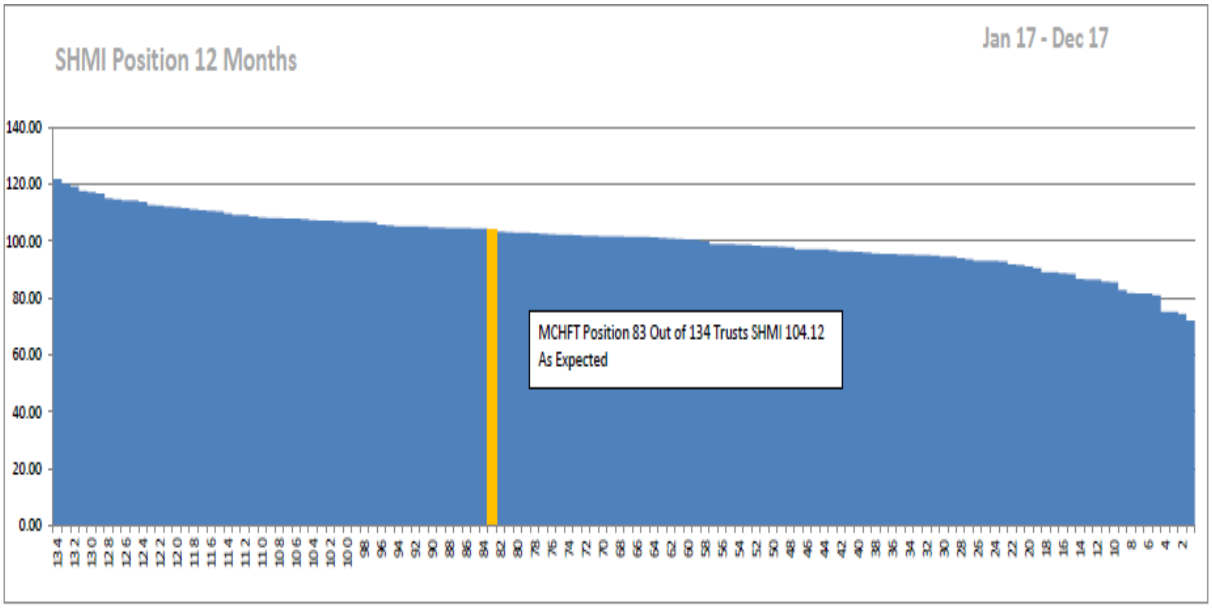
The report will be produced and developed on a quarterly basis and aims to provide assurance on how the organisation, through the work of the HMRG and other linking groups, is triangulating data and information to enable sustained learning from deaths, with the goal of seeing a sustained reduction in 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) January 2017 to December 2017

Chart 1 - SHMI Position



(Source NHS Digital, 2018)

Chart 1 demonstrates the SHMI position for the reporting period January 2017 to December 2017. The SHMI is currently 104.12 and is in the 'as expected' range. This currently places the Trust 83 out of 134. This is compared to the previous reporting period when the SHMI was 103.71 with a position of 82 out of 134 Trusts.

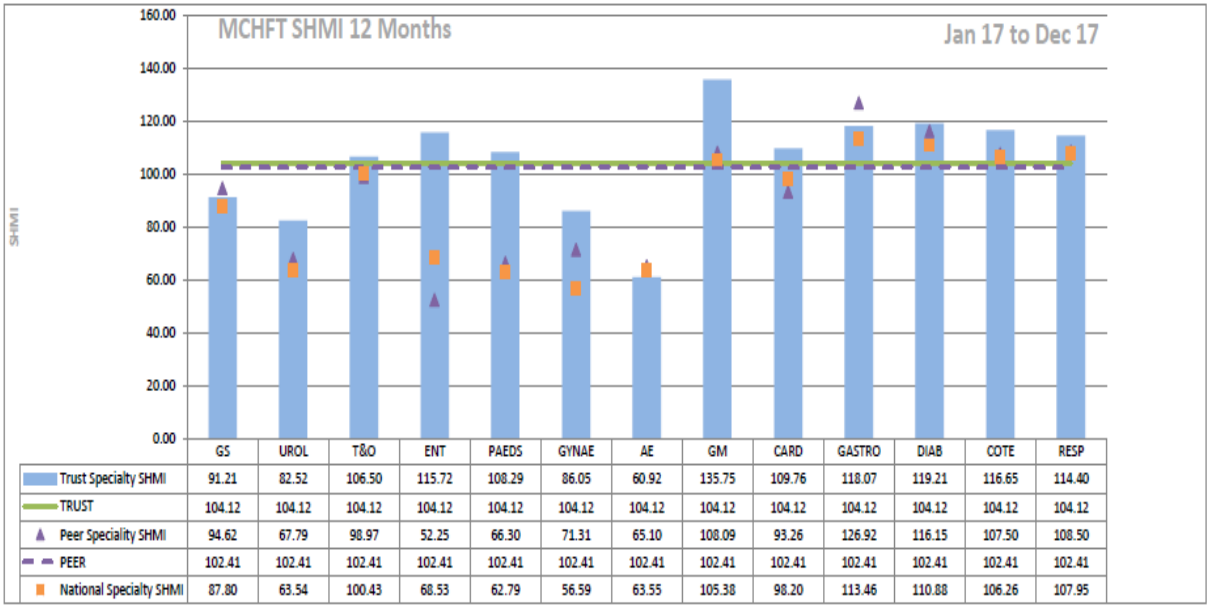
Chart 2 - 12 month rolling SHMI and position

	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	Dec 17
MCHFT SHMI	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	104.12
MCHFT Rank	121	133	90	83	61	61	54	53	51	41	68	68	72	89	81	76	82	83
Total Trusts	141	141	141	137	137	137	137	136	136	136	136	136	135	136	135	134	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 January 2017 to December 2017.

Chart 3 - SHMI by Speciality

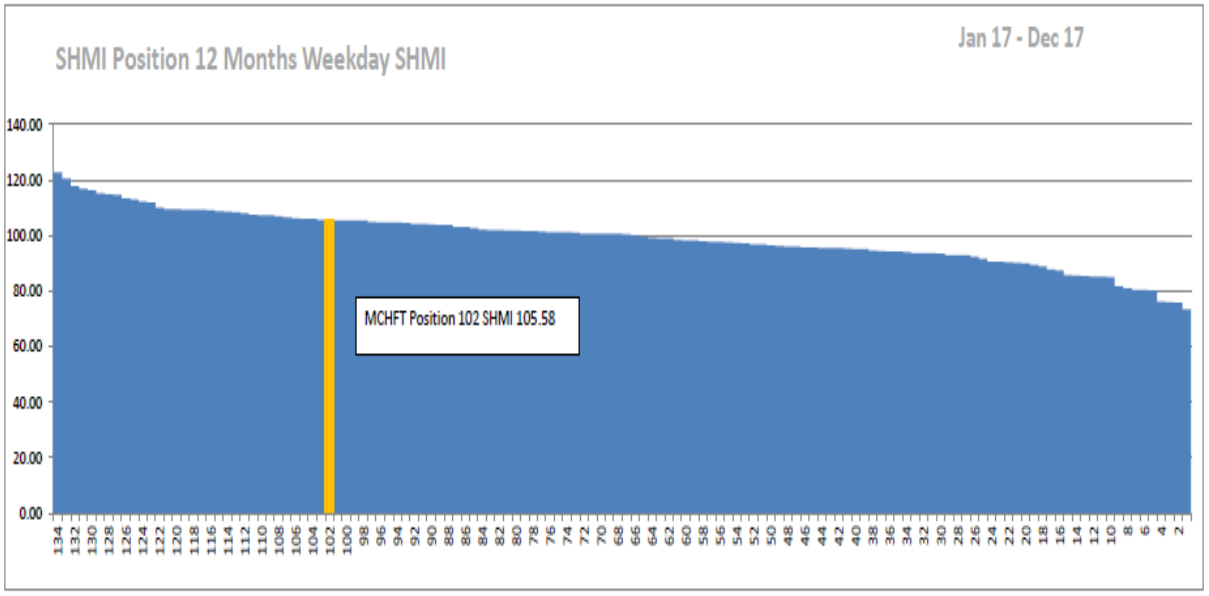


	GS	UROL	T&O	ENT	PAEDS	GYNAE	AE	GM	CARD	GASTRO	DIAB	COTE	RESP
Trust Specialty SHMI	91.21	82.52	106.50	115.72	108.29	86.05	60.92	135.75	109.76	118.07	119.21	116.65	114.40
TRUST	104.12	104.12	104.12	104.12	104.12	104.12	104.12	104.12	104.12	104.12	104.12	104.12	104.12
Peer Speciality SHMI	94.62	67.79	98.97	52.25	66.30	71.31	65.10	108.09	93.26	126.92	116.15	107.50	108.50
PEER	102.41	102.41	102.41	102.41	102.41	102.41	102.41	102.41	102.41	102.41	102.41	102.41	102.41
National Specialty SHMI	87.80	63.54	100.43	68.53	62.79	56.59	63.55	105.38	98.20	113.46	110.88	106.26	107.95

(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, Diabetology, Care of the Elderly and Respiratory.
Gastroenterology and General Surgery are above the national average but below peer. A&E is below both the national average and peer.

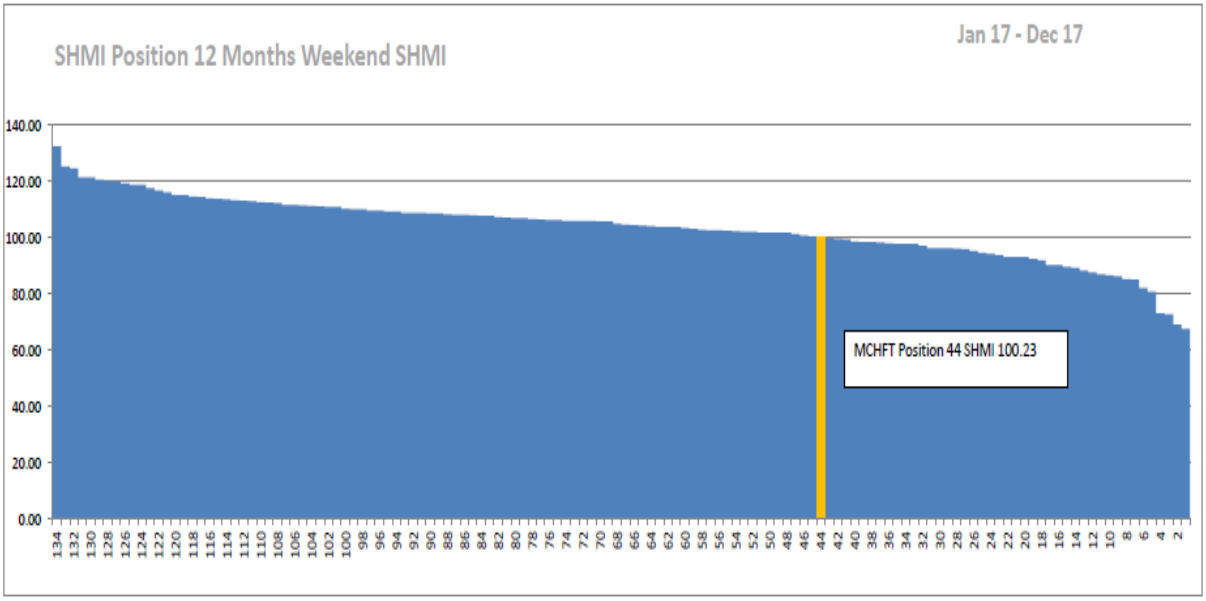
Chart 4 - Weekday SHMI



(Source HED, 2018)

Chart 4 demonstrates the weekday SHMI position for the reporting period January 2017 to December 2017. The weekday SHMI is currently 105.58 and places the Trust 102 out of 134.

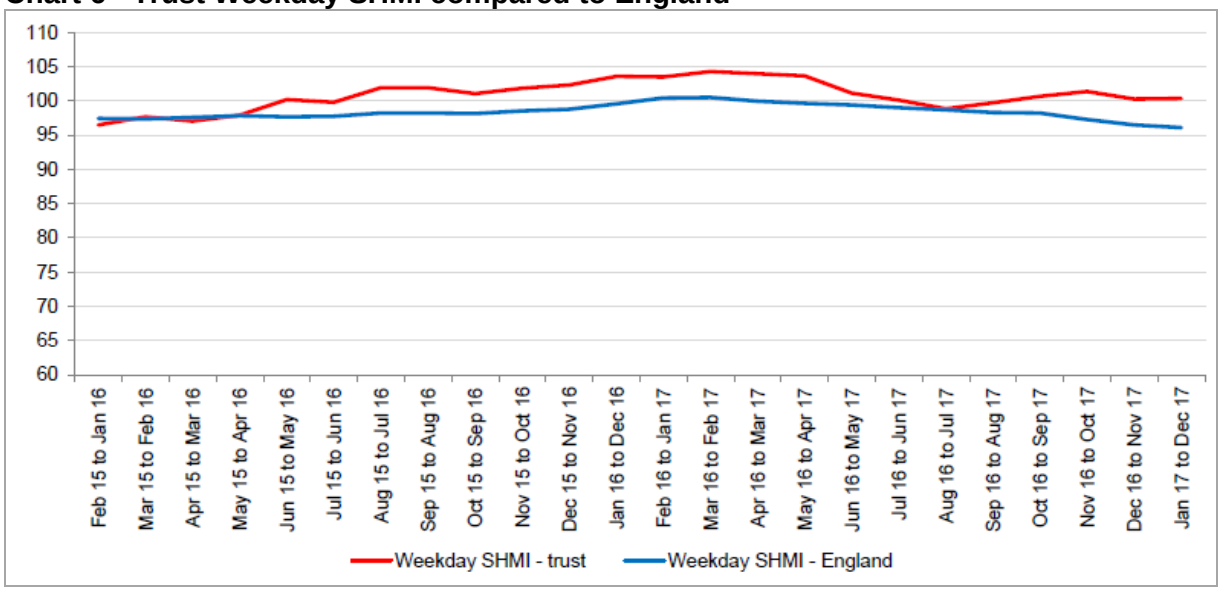
Chart 5 - Weekend SHMI



(Source HED, 2018)

Chart 5 demonstrates the weekend SHMI position for the reporting period January 2017 to December 2017. The weekend SHMI is currently 100.23 and places the Trust 44 out of 134.

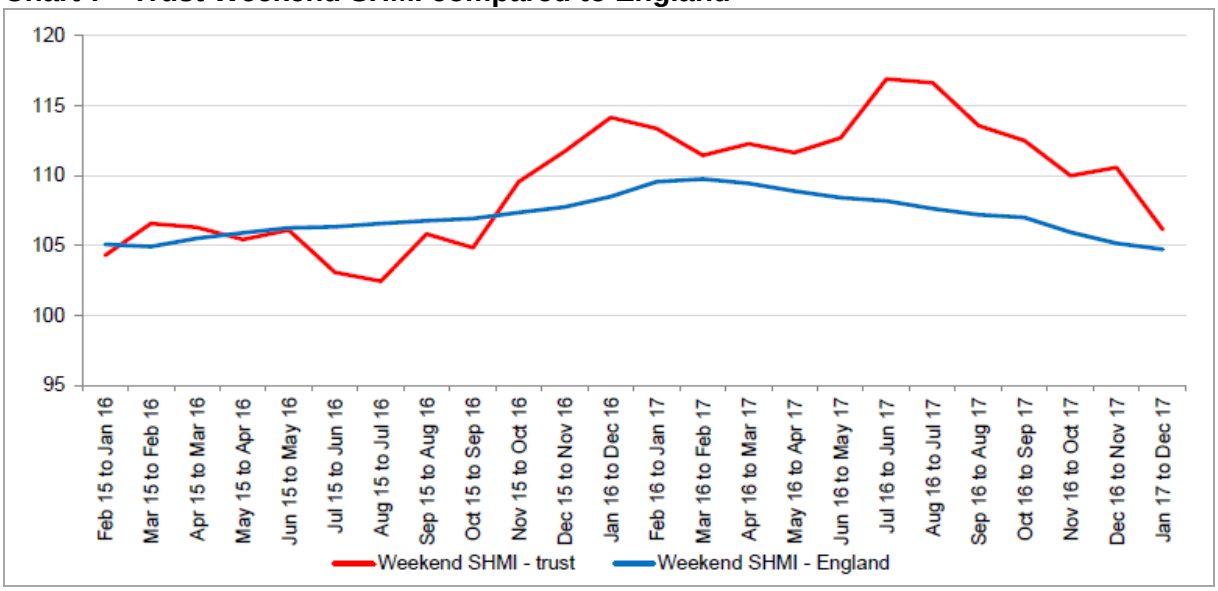
Chart 6 - Trust Weekday SHMI compared to England



(Source NHS Improvement, 2018)

Chart 6 demonstrates the Trust weekday SHMI compared to England for the period January 2017 to December 2017.

Chart 7 - Trust Weekend SHMI compared to England

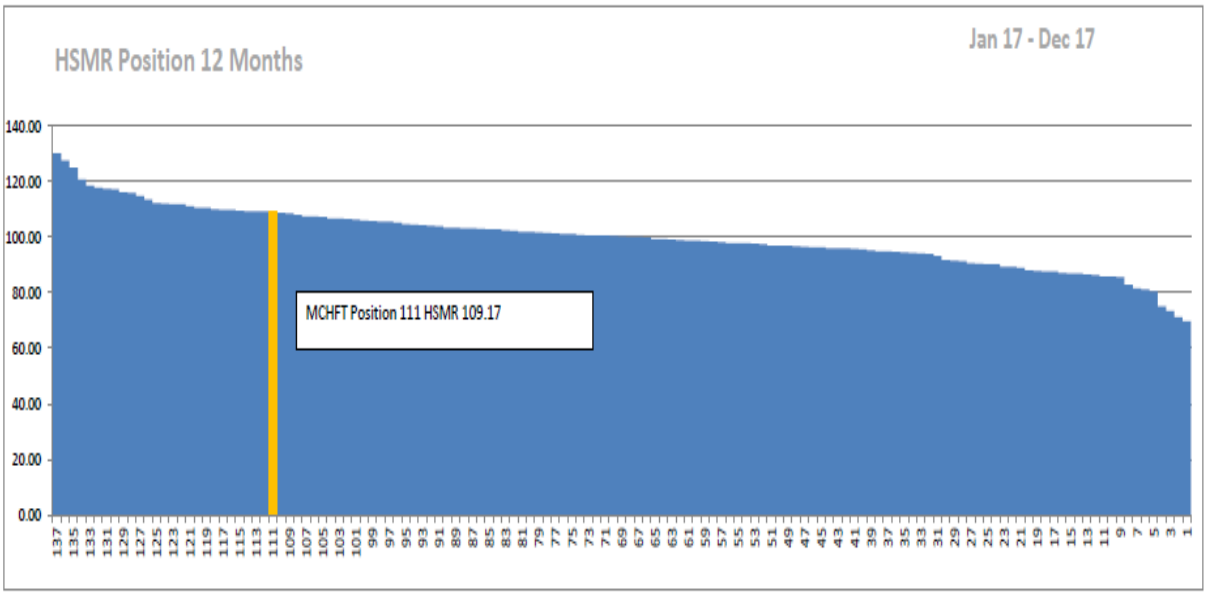


(Source NHS Improvement, 2018)

Chart 7 demonstrates the Trust weekend SHMI compared to England for the period January 2017 to December 2017.

2.2 Hospital Standardised Mortality Rate (HSMR) January 2017 to December 2017

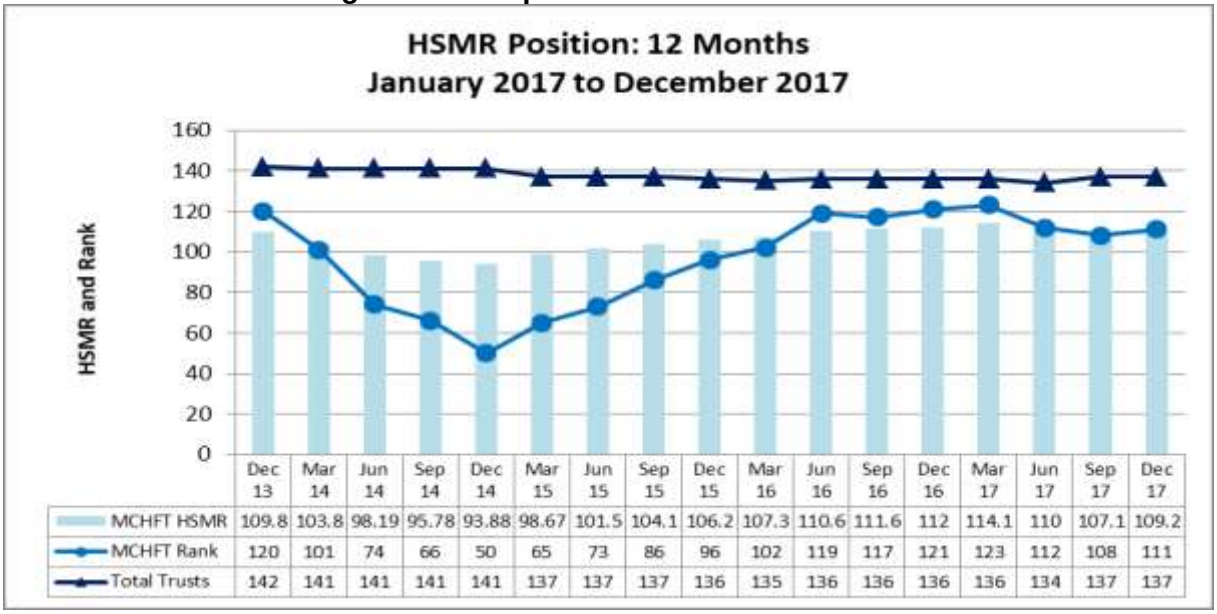
Chart 8 - HSMR Position



(Source HED, 2018)

Chart 8 demonstrates the HSMR position for the reporting period January 2017 to December 2017. The HSMR is currently 109.17. This currently places the Trust 111 out of 137. This is compared to the previous reporting period when the HSMR was 107.1 with a position of 108 out of 137 Trusts.

Chart 9 - 12 month rolling HSMR and position

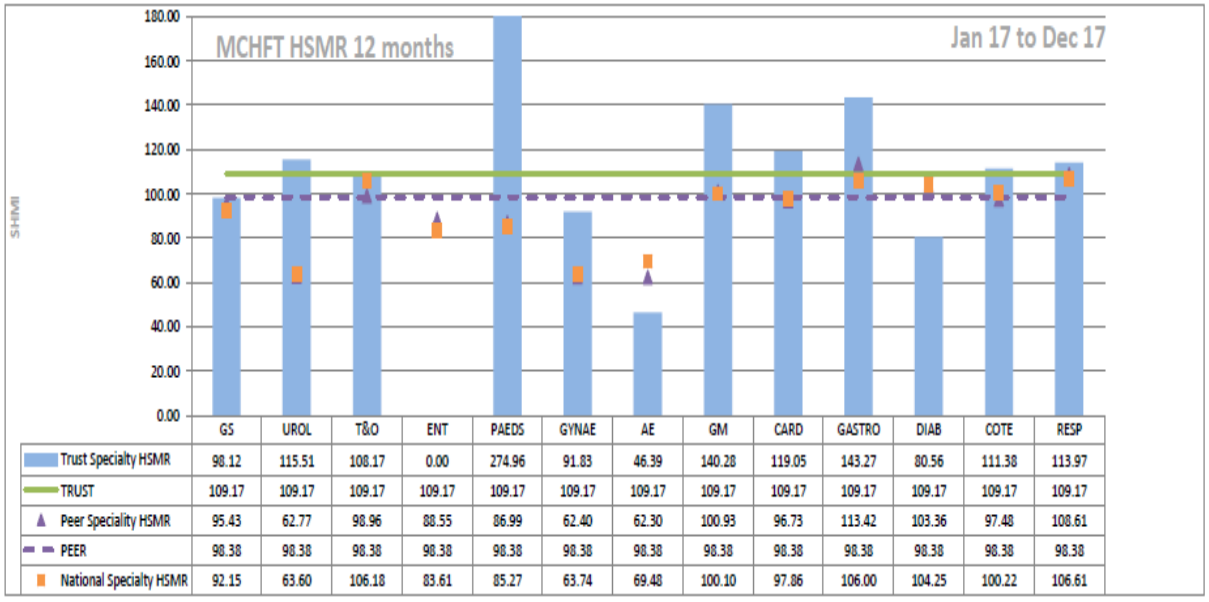


	Dec 13	Mar 14	Jun 14	Sep 14	Dec 14	Mar 15	Jun 15	Sep 15	Dec 15	Mar 16	Jun 16	Sep 16	Dec 16	Mar 17	Jun 17	Sep 17	Dec 17
MCHFT HSMR	109.8	103.8	98.19	95.78	93.88	98.67	101.5	104.1	106.2	107.3	110.6	111.6	112	114.1	110	107.1	109.2
MCHFT Rank	120	101	74	66	50	65	73	86	96	102	119	117	121	123	112	108	111
Total Trusts	142	141	141	141	141	137	137	137	136	135	136	136	136	136	134	137	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 January 2017 to December 2017.

Chart 10 - HSMR by Speciality

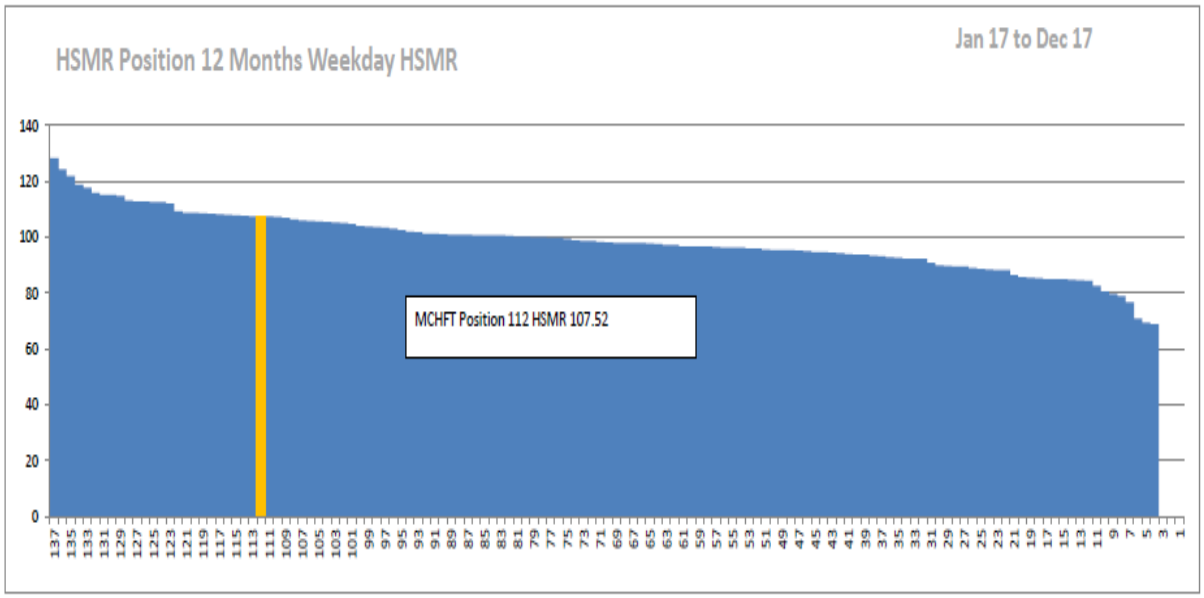


	GS	UROL	T&O	ENT	PAEDS	GYNAE	AE	GM	CARD	GASTRO	DIAB	COTE	RESP
Trust Specialty HSMR	98.12	115.51	108.17	0.00	274.96	91.83	46.39	140.28	119.05	143.27	80.56	111.38	113.97
TRUST	109.17	109.17	109.17	109.17	109.17	109.17	109.17	109.17	109.17	109.17	109.17	109.17	109.17
Peer Speciality HSMR	95.43	62.77	98.96	88.55	86.99	62.40	62.30	100.93	96.73	113.42	103.36	97.48	108.61
PEER	98.38	98.38	98.38	98.38	98.38	98.38	98.38	98.38	98.38	98.38	98.38	98.38	98.38
National Specialty HSMR	92.15	63.60	106.18	83.61	85.27	63.74	69.48	100.10	97.86	106.00	104.25	100.22	106.61

(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 General Surgery, Urology, Trauma and Orthopaedics, Paediatrics, Gynaecology, General Medicine, Cardiology, Gastroenterology, Care of the Elderly and Respiratory.

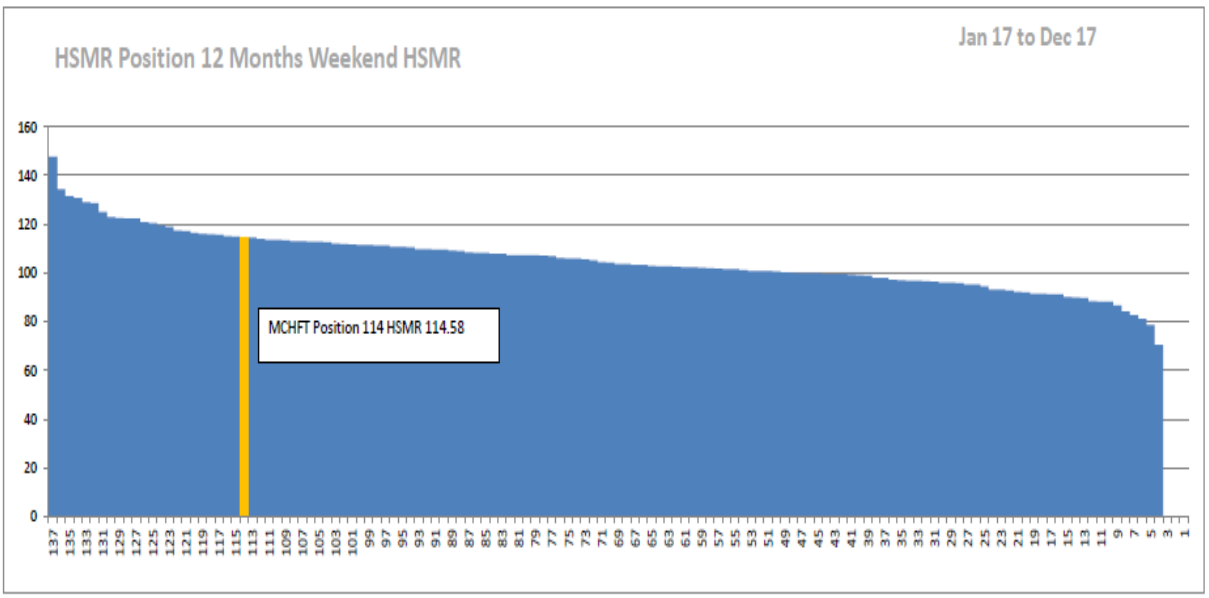
Chart 11 - Weekday HSMR



(Source HED, 2018)

Chart 11 demonstrates the weekday HSMR position for the reporting period January 2017 to December 2017. The weekday HSMR is currently 107.52 and places the Trust 112 out of 137.

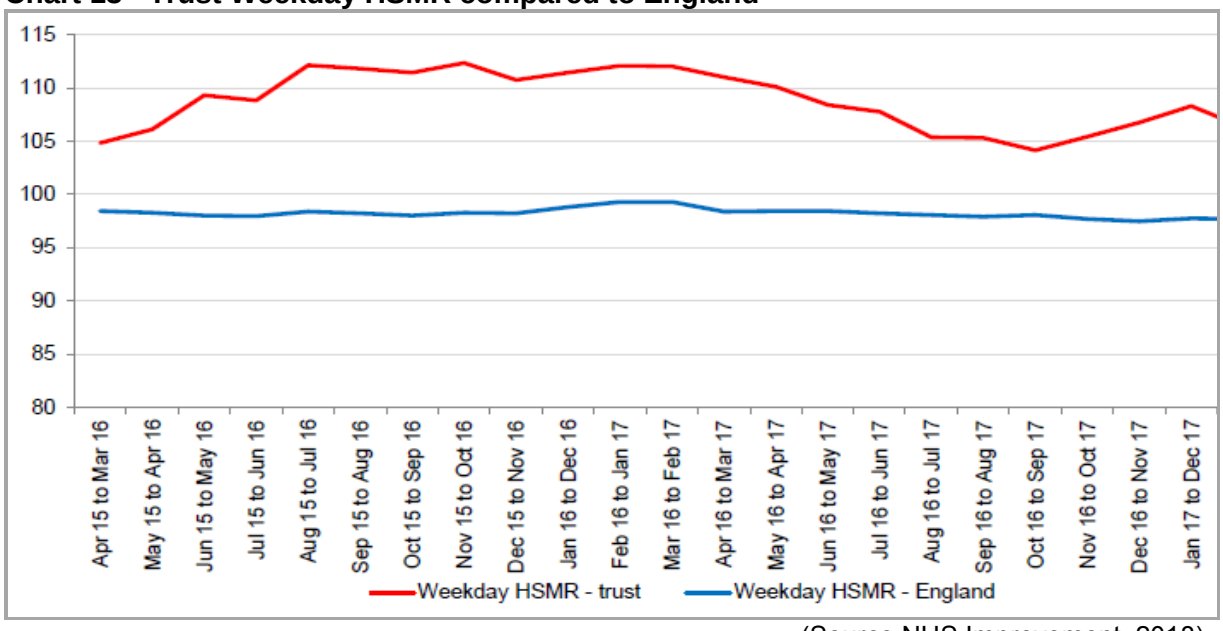
Chart 12 - Weekend HSMR



(Source HED, 2018)

Chart 12 demonstrates the weekend HSMR position for the reporting period January 2017 to December 2017. The weekend HSMR is currently 114.58 and places the Trust 114 out of 137

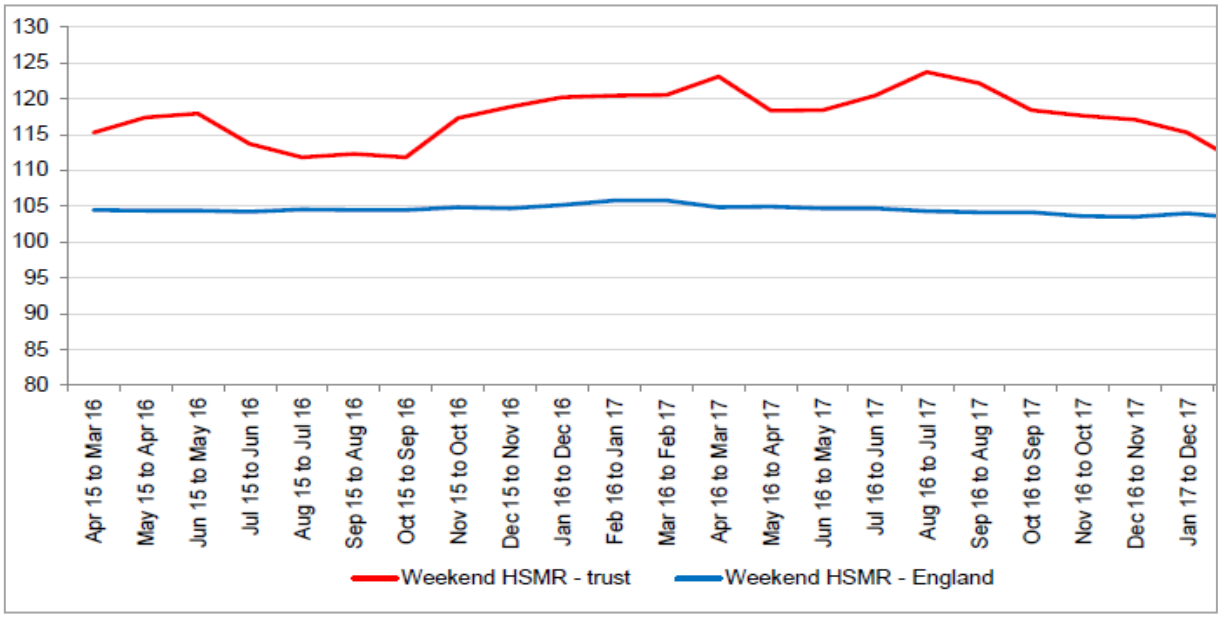
Chart 13 - Trust Weekday HSMR compared to England



(Source NHS Improvement, 2018)

Chart 13 demonstrates the Trust weekday HSMR compared to England for the period January 2017 to December 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 January 2017 to December 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. The data for the total deaths reviewed using the Trust mortality tool will include deaths from 2017/18.*

NHS — Department of Health

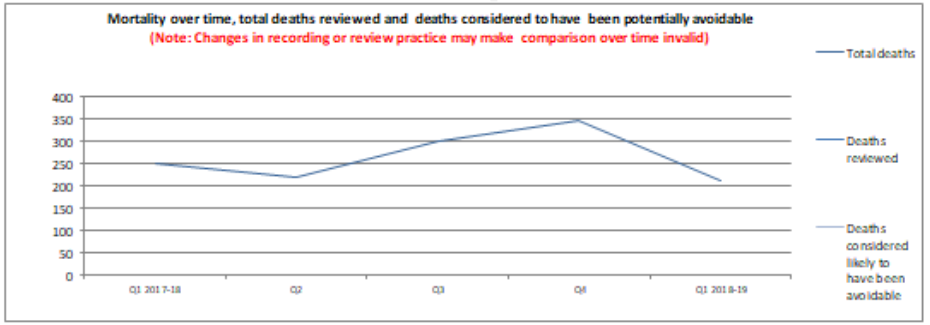
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

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 using the Trust Mortality Tool		Total Deaths reviewed using SJR		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month	This Month	Last Month
61	76	87	59	5	5	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter	Last Quarter	This Quarter (QTD)	Last Quarter
213	346	221	231	10	N/A	0	N/A
This Year	Last Year	This Year	Last Year	This Year	Last Year	This Year	Last Year
213	1117	221	889	10	N/A	0	N/A

Time Series: Start date 2017-18 Q1 End date 2018-19 Q1



2.3 Learning from Deaths Dashboard – Part 2

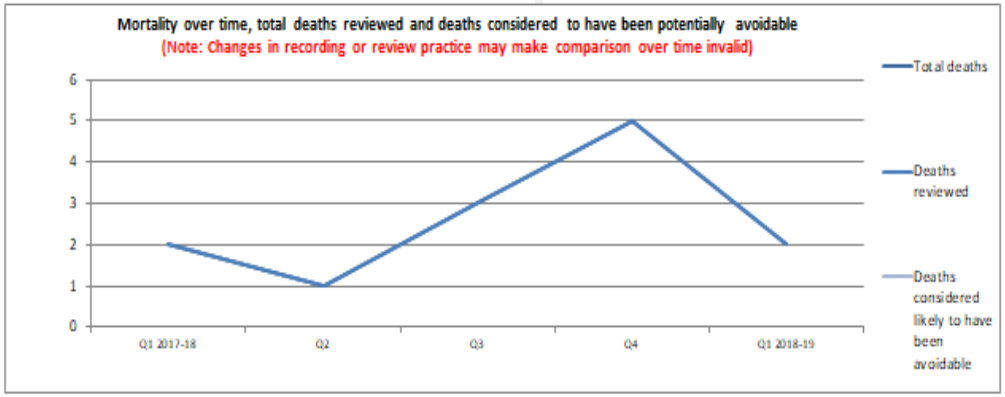
Evidence suggests from the Confidential Inquiry of 2010-2013 that people with learning disabilities currently have a life expectancy at least 15 to 20 years shorter than other people. A concerning finding was that assumptions were sometimes made that the death of a person with learning disabilities was '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
0	2	0	2	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
2	5	2	5	0	0
This Year	Last Year	This Year	Last Year	This Year (YTD)	Last Year
2	11	2	11	0	N/A

Time Series: Start date 2017-18 Q1 End date 2018-19 Q1



3.0 Care Quality Commission (CQC) Mortality Outlier Alerts

The information below is sourced from the latest version of the CQC Insight document (20 June 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.
- There are currently 0 active maternity alerts for this trust.

Number of outlier alerts for this trust as at 29 May 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:

- Submitting data from the March / April 2018 survey centrally.
- A business case for general surgery to support seven day working is scheduled for the Board of Directors in September 2018.

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

- The Structured Judgemental Review Process commenced in April 2018.
- The learning from these reviews is being collated and will be included in future versions of the Safety Matters Newsletter'.
- A quarterly junior doctor newsletter is being developed to share the learning from incidents and the Structured Judgemental Review Process.

4.3 Actions to implement learning lessons

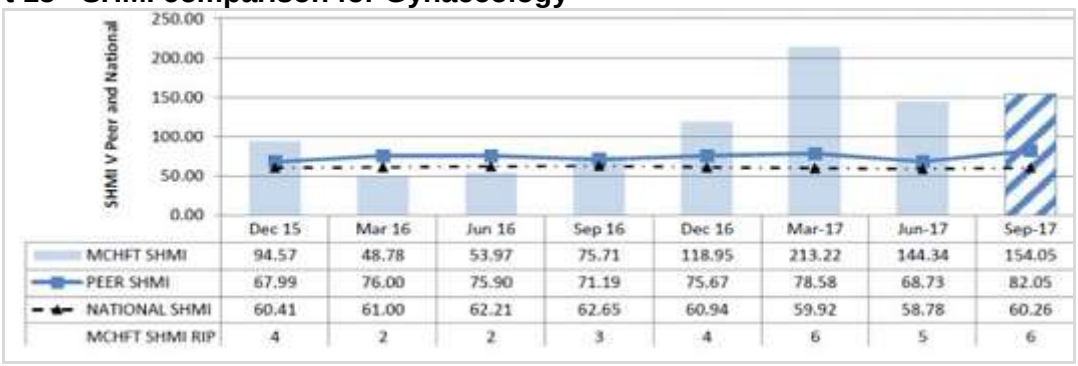
- The structure of the twice monthly Patient Safety Summit has been reviewed to include specific sections for each Division to feedback on learning from incident investigations and case note reviews.

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

- The Executive Led Deteriorating Patient Steering Group is continuing to meet and work toward the launch of National Early Warning Score (NEWS 2) in the Trust on the 5 November 2018.
- The organisation is attending the AQuA Deteriorating Patient Collaborative which commenced on the 12 July 2018.
- The Trust has joined the NHS England NEWS2 Champion Network.
- A revised vital signs chart, which incorporates NEWS2, has been developed and approved by the Deteriorating Patient Steering Group. This chart will now be piloted as part of the implementation plan.
- A training implementation plan has been developed and approved by the Deteriorating Patient Steering Group.

5.0 Quarterly Deep Dive – Gynaecology Mortality Rates

Chart 15 - SHMI comparison for Gynaecology



	Dec 15	Mar 16	Jun 16	Sep 16	Dec 16	Mar-17	Jun-17	Sep-17
MCHFT SHMI	94.57	48.78	53.97	75.71	118.95	213.22	144.34	154.05
PEER SHMI	67.99	76.00	75.90	71.19	75.67	78.58	68.73	82.05
NATIONAL SHMI	60.41	61.00	62.21	62.65	60.94	59.92	58.78	60.26
MCHFT SHMI RIP	4	2	2	3	4	6	5	6

Chart 16 - HSMR comparison for Gynaecology

	Dec 15	Mar 16	Jun 16	Sep 16	Dec-16	Mar-17	Jun-17	Sep-17	Oct-17
MCHFT HSMR	329.51	252.07	261.60	146.98	129.23	131.32	64.22	152.15	215.37
PEER HSMR	56.49	64.01	56.68	50.43	79.95	74.52	65.75	67.85	73.57
NATIONAL HSMR	67.68	73.60	70.22	68.98	71.54	59.72	60.75	64.77	67.53
MCHFT HSMR RIP	4	2	2	2	2	2	1	2	2

Chart 15 and 16 demonstrate that after a period of the Trust having a low SHMI and a high HSMR (December 15 - September 16), the HSMR reduced close to the peer average, whilst the SHMI rose. Although there are low numbers in terms of deaths in gynaecology, the Trust have been regularly above the peer average in the HSMR.

Understanding the reduction in the HSMR

The HSMR is worked out as the number of observed deaths divided by the expected number of deaths for the period. This means that for the HSMR to reduce, either the number of observed deaths must reduce, or the expected number must increase.

To better understand what was driving the reduction in the HSMR over time the observed and expected deaths were plotted in Chart 17.

Chart 17 – Gynaecology Spells Contributing to the HSMR

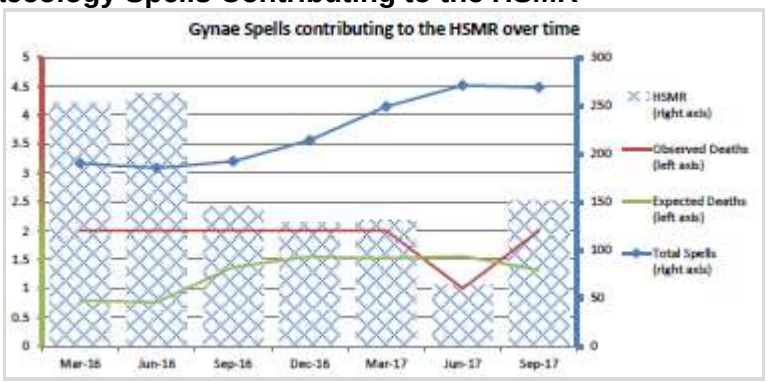
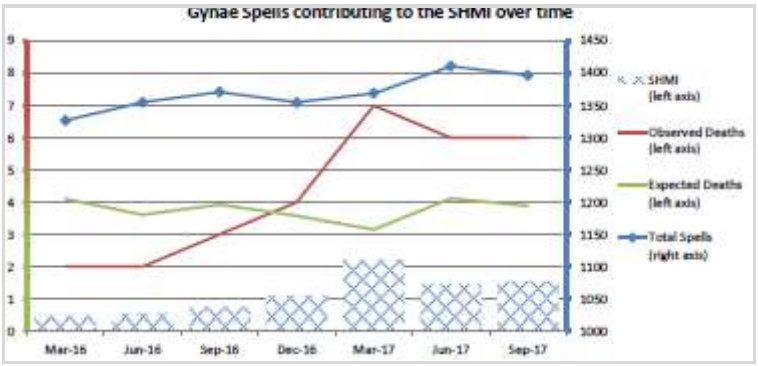


Chart 17 shows that the total spells being recorded under Gynaecology has increased over time. Around 75 more patients were coded under gynaecology in the 12 months up to September 2017 than in the 12 months up to June 2016.
The observed number of deaths over time has not fluctuated (as seen by the red line). Instead, it is the expected number of deaths that has grown.
The increase in expected deaths is caused by the growth in the number of spells being recorded. With more patients seen, a higher expected rate and no increase in observed deaths; this has resulted in a lower HSMR.

Understanding the rise in the SHMI
When looking at the same data and time period but for the SHMI, Chart 18 shows the observed number of deaths has increased over time whist there has been little growth in the expected number of deaths.

Chart 18 – Gynaecology Spells Contributing to the SHMI

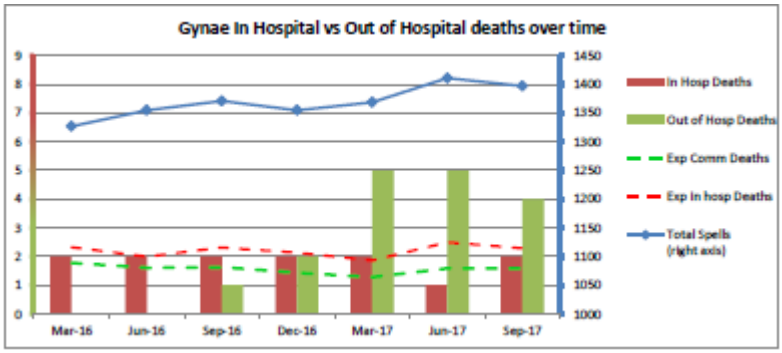


With a rise in 'observed deaths' seen in the SHMI but not in the HSMR (as shown by the red lines in Chart 17 & Chart 18) this indicates why the SHMI has increased over the same period the HSMR has reduced.
Table 1 and corresponding Chart 19 below show the deaths contributing to the SHMI split by 'in hospital' deaths and 'out of hospital' deaths. The HSMR does not take account of 'out of hospital' deaths.
In Table 1 and Chart 19 it is seen that the number of out of hospital deaths has increased (green bars in Chart 19) whilst the expected deaths has remained static (green dash in Chart 19). This is driving the increase in SHMI for Gynaecology and explains why the rise is not seen in the HSMR.

Table 1 - 'In Hospital' and 'Out of Hospital' deaths

12 months ending	Total Spells	Expected Deaths (in Hosp)	Observed Deaths (in Hosp)	Expected Deaths (Community)	Observed Deaths (Community)
Mar-16	1327	2.32	2	1.78	0
Jun-16	1355	2	2	1.61	0
Sep-16	1371	2.31	2	1.63	1
Dec-16	1355	2.13	2	1.44	2
Mar-17	1369	1.86	2	1.28	5
Jun-17	1411	2.5	1	1.59	5
Sep-17	1397	2.29	2	1.58	4

Chart 19 – Gynaecology In-hospital Versus Out of Hospital Deaths



When breaking down the SHMI it is possible to get a good indication of what elements of the SHMI fall into the HSMR and what parts do not.
Table 2 below indicates that now the number of spells has increased in the HSMR (discussed above), the Trust has a similar number of spells on average to its Peers. The cause for the Trust being consistently above peer for the HSMR is therefore down to the number of deaths attributed. Peer trusts are averaging one death under Gynaecology, whereas MCHFT are averaging two.

Table 2 – Breakdown of SHMI compared to peer

Table 2. SHMI breakdown

		Mid Cheshire					Peer					
		Spells	Expected Number of Deaths	Observed Number of Deaths	Obs - Exp	SHMI	Spells	Average spell per peer Trust	Expected Number of Deaths	Observed Number of Deaths	Exp - Obs	SHMI
56 CCS	Deaths in Hospital		1.34	2.00	0.7	149.25			28.61	18.00	-10.6	62.92
	Death Out of Hospital	196	0.89	2.00	1.1	224.72	3128	184	19.39	24.00	4.6	123.78
Other CCS	Deaths in Hospital		0.94	0.00	-0.9	0.00			25.00	14.00	-11.0	56.00
	Death Out of Hospital	1201	0.71	2.00	1.3	281.69	25848	1520	18.34	19.00	0.7	103.60
	Total	1397	3.88*	6	2.1	154.05	28976	1704	91.34	75	-16.3	82.11

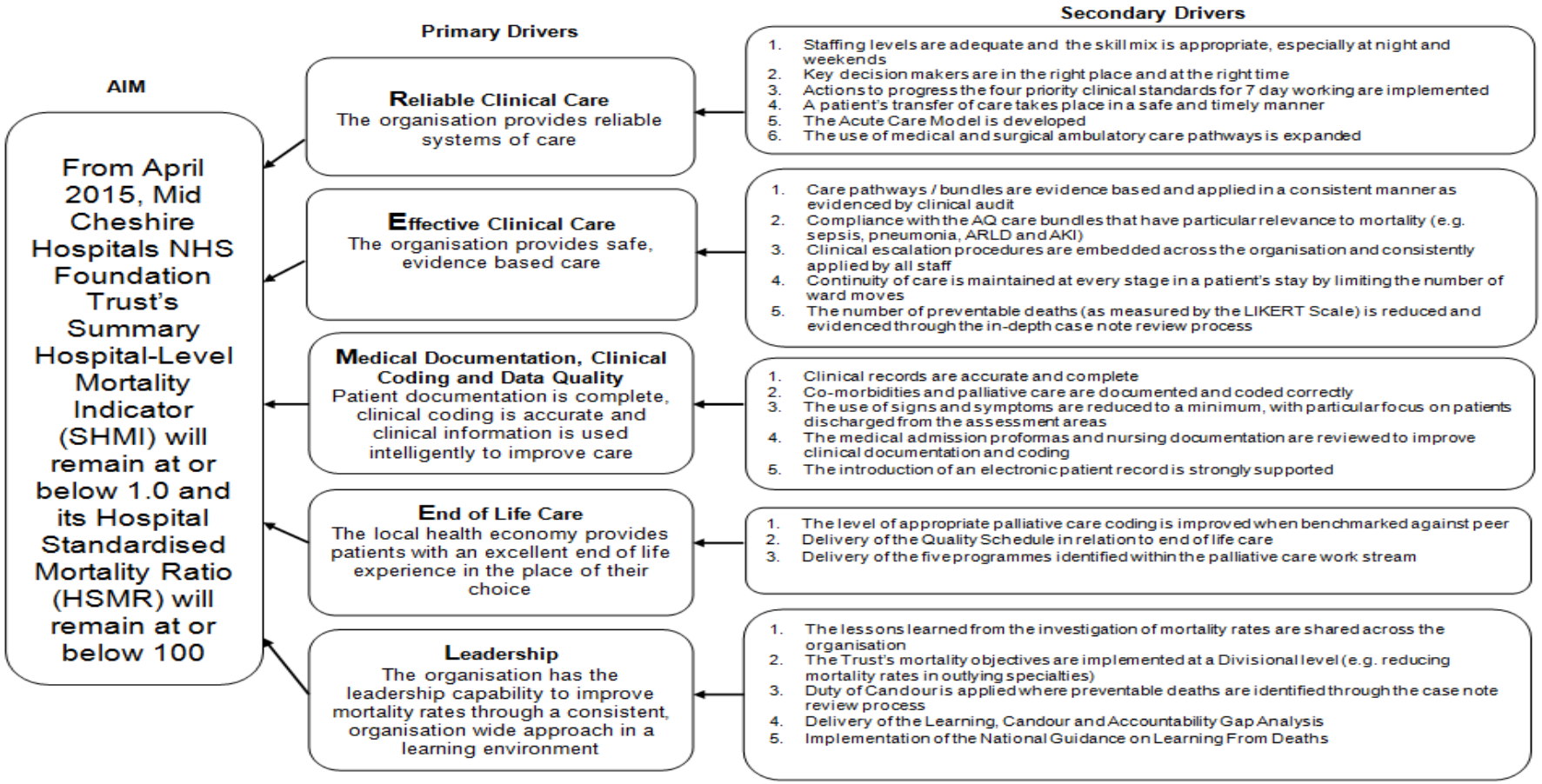
*due to very low risk numbers being rounded above, the true expected number of deaths is closer to 3.89

6.0 Next steps include:

- A deep dive will be undertaken into the Structured Judgemental Review Process and the learning, feedback and assurance process.

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 *Calculated using a 36-month data set to get the risk estimate*	Expected number of deaths
Adjustments	• Gender • Age group • Admission method • Co-morbidity • Year of dataset • Diagnosis group *Details of the categories can be referenced from the methodology specification document* ***	• Gender • Age in bands of five up to 90+ • Admission method • Source of admission • History of previous emergency admissions in last 12 months • Month of admission • Socio economic deprivation quintile (using Carstairs) • Primary diagnosis based on the clinical classification system • Diagnosis sub-group • Co-morbidities based on Charlson score • Palliative care • Year of discharge
Exclusions	• Specialist, community, mental health and independent sector hospitals • Stillbirths • 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. Data attributed to Trust in which patient died or was discharged from	All England provider Trusts via SUS Data attributed to all Trusts within a "super-spell" of activity that ends in death

Title of Paper :	Annual Report on the Appraisal and Revalidation of Medical Practitioners at MCHFT	
Author:	Miss Nikki Phillips Revalidation Support Manager	
Executive Lead:	Dr Paul Dodds Responsible Officer / Medical Director / Deputy CEO	
Type of Report:	Concept Paper	
	Strategic Options Paper	
	Business Case	
	Information	
	Review/Benefits/Audit	✓

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

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

Positive Benefit:	The Trust maintains a fit for purpose appraisal system that is operating effectively and satisfies the statutory requirements around revalidation
Risk:	Failure to maintain a robust appraisal system could result in a breach of statutory requirements around revalidation

To be published on Trust Website –complete version	***Y***
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:	3rd September 2018

Purpose of the Report

The purpose of this report for 2017 / 2018 is to provide assurance to the Board of Directors that the appraisal system for medical practitioners employed by Mid Cheshire Hospitals NHS Foundation Trust (MCHFT) is robust, supports the revalidation agenda and is operating effectively.

Background

Medical revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

Designated Bodies (which includes MCHFT) have a statutory duty to appoint a Responsible Officer (RO) and then provide the RO with sufficient funds and other resources to discharge their duties. In the case of MCHFT, the RO is the Medical Director.

The statutory duties of a RO include:

- Undertaking appropriate employment checks for medical appointments
- Maintaining a list of doctors for whom they are responsible
- Ensuring there is an integrated system for
    - Monitoring doctors' performance
    - Encouraging and supporting development and learning
- Ensuring that effective systems and processes for appraisal are in place
- Taking appropriate, timely action when concerns about the performance or conduct of a doctor is identified

Licensed doctors have to revalidate usually every 5 years, by having an annual appraisal based on the GMC's core guidance for doctors "Good Medical Practice". The framework consists of four domains which cover the spectrum of medical practice. These are:

1. Knowledge, skills and performance
2. Safety and quality
3. Communication, partnership and teamwork
4. Maintaining trust

When a doctor's revalidation date arrives, that doctor's RO is asked to make an evidence based recommendation to the GMC about the doctor's revalidation by submitting one of three formal statutory statements:

- A recommendation that the doctor is up to date and fit to practise and should be revalidated

- A request to defer the date of the RO's recommendation due to the doctor:

    - being engaged in the systems and processes that support revalidation, but about whom there is incomplete information on which to base a recommendation to revalidate (this will be where a doctor has not been able to gather all of the required supporting information by the time the submission date falls due)

- participating in an ongoing local human resources or disciplinary process, the outcome of which is material to the evaluation of the doctor's fitness to practise and that will need to be considered prior to making a recommendation.

- A notification of the doctor's non-engagement in revalidation, which should be made if a doctor has not engaged "sufficiently" with revalidation

The GMC then uses the RO's recommendation as the basis for its decision about the doctor's revalidation.

Governance Arrangements

At MCHFT the RO role is predominantly supported by the Revalidation Support Manager. However other members of the Medical Resourcing Team play an important role in ensuring that the RO delivers his statutory duties around revalidation, particularly in relation to employing doctors.

The Trust appraisal and revalidation policies are included in the specific "revalidation" site on the Trust's internet. This portal also contains a wide range of national and local guidance to support doctors with appraisal and revalidation.

A crucial element of the revalidation process is a doctor's annual appraisal. The Trust has a cohort of externally trained medical appraisers (including Consultants and SAS doctors) with specific time allocated in their job plans to undertake appraisals. These appraisers receive ongoing individual feedback reports on their performance from both appraisee feedback and feedback on the electronic appraisal summaries, as part of the appraisal process. Appraisers also meet with the RO on a quarterly basis as part of a peer support network.

The Trust is in its fourth year of using an electronic appraisal solution to securely manage all the required information for a robust and transparent appraisal and revalidation system for both the Trust and the doctors. The system continues to:

- support a structured appraisal process for all doctors in line with Good Medical Practice
- ensures efficient appraisal monitoring and management of resources
- provides 24/7 access to information for doctors, appraisers and authorised personnel
- support local and national reporting
- improve collaboration and communication between the RO, appraisers and doctors

As part of the quality assurance process around medical appraisals, the Revalidation Support Manager reviews all appraisal documentation and appraiser summaries. The RO also randomly selects 20% of all medical appraisals undertaken each year for an in-depth review. The aims of these reviews include ensuring that the medical appraisals at the Trust are being undertaken in accordance with the Good Medical Practice framework and the Trust's Consultant and SAS Doctor Appraisal Policy. Compliance with a portfolio checklist of essential pieces of information to be discussed as part of the appraisal process is audited and the findings from this review are then presented to the Trust's appraisers as part of the drive to improve the standard of medical appraisals each year.

The developments outlined in the 2016 / 2017 Annual Report were:

- Implementing the recommendations arising from the peer review process

  In agreement with NHS England, a peer review process involving the Salford Royal, Royal Bolton and Mid Cheshire Hospitals NHS Foundation Trusts took place in June – August 2017. This included reviewing the policies and procedures, reporting arrangements, documentation and on-site reviews. The outcome was positive and the recommendations received resulted in the Action Plan included as Appendix 1.

  These recommendations led to the following changes:

  - *The annual appraisal period has been brought forward by 2 months to ensure that more timely data is reviewed at the doctor's appraisal*
  - *The Appraisal Portfolio Information has been updated to include a declaration of any issues occurring just prior to the doctor's appraisal meeting*
  - *The Appraisal Policy has been updated to provide further clarification regarding a doctor's non-engagement in revalidation*
  - *The Trust's Appraisal Guidance has been updated to reflect these changes*

- Undertaking regular audit on the quality of medical appraisals to ensure compliance with national requirements and promote a cycle of continuous improvement.

  All appraisals and appraiser summaries have been audited and the findings will be presented at the quarterly Appraisers Meeting with the RO in September 2018. The audit findings were generally positive but highlighted some recurrent themes around the quality of documentation included in an appraisee's portfolio (e.g. standard of reflective practice).

- Training additional appraisers to ensure that MCHFT has the required cohort of trained appraisers to manage the increased number of prescribed connections and natural appraiser turnover.

  Six new appraisers have been trained and are undertaking appraisals in 2018 / 2019.

Medical Appraisal Performance for 2017 / 2018

The completed appraisals within the national Annual Organisational Audit data are reported under the following two measures:

- Category 1a – this measure is one where the appraisal meeting has taken place in the three months preceding the agreed appraisal date, the outputs of the appraisal have been agreed and signed off by the appraiser and the doctor within 28 days of the appraisal meeting, and the entire process occurred between 1 April and 31 March. For doctors who have recently completed training, it should be noted that their final ARCP equates to an appraisal in this context.
- Category 1b – this measure is one in which the appraisal meeting took place in the appraisal year between 1 April and 31 March, and the outputs of appraisal have been agreed and signed off by the appraiser and the doctor, but one or more of the following apply:
  - The appraisal did not take place in the window of three months preceding the appraisal due date

- The outputs of the appraisal have been agreed and signed off by the appraiser and doctor between 1 April and 28 April of the following appraisal year
- The outputs of appraisal have been agreed and signed off by the appraiser and the doctor more than 28 days after the appraisal meeting.

However in the judgement of the RO the appraisal has been satisfactorily completed to the standard required to support an effective revalidation recommendation.

The national appraisal completion rate (Categories 1a and 1b combined) set by NHS England is 90%. The appraisal rate for MCHFT for 2017 / 18 is as follows:

Appraisal		**Number**
Completed	1a	138
	1b	64
Missed / Incomplete	Approved	1
	Unapproved	1
Total		204
Appraisal Completion Rate (Categories 1a and 1b combined)		202/204 99.01%

The Trust's appraisal rates for the past 6 years have been:

	2012/13	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**
Number of Completed Appraisals (Category 1a and 1b)	124	134	175	196	208	202
Missed / Incomplete Approved	NR	4	1	8	8	1
Missed / Incomplete Unapproved	NR	31	4	0	1	1
Total	166	169	180	204	217	204
Completion rate (%)	74%	79.2%	97.2%	96.1%	95.9%	99.01%

Each year a national Annual Organisational Audit (AOA) is undertaken by NHS England. The benchmarked performance for MCHFT for the year ending 31st March 2018 is outlined below:

2017 / 18 AOA Appraisal Indicator	MCHFT's Response	Same Sector Number of DBs in Sector = 99	All Sectors Number of DBs in all Sectors = 834
	Completed appraisals (1a & 1b)		
Number of doctors with whom the Designated Body has a prescribed connection on 31 March 2018 who had a completed annual appraisal between 1 April 2017 – 31 March 2018	MCHFT's response and (%) calculated appraisal rate	Same sector appraisal rate	All Sectors appraisal rate
Consultants	126 (99.2%)	92%	92.7%
Staff Grade, Associate Specialist, Speciality Doctor	34 (100%)	88.4%	88.9%
Doctors on Performers List	N/A	71.4%	94.7%
Doctors with practising privileges	N/A	66.7%	93%
Temporary or short-term contract holders	41 (97.6%)	77.2%	82.8%
Other doctors with a prescribed connection to this designated body	1 (100%)	63.9%	87.1%
Total number of doctors who had a completed annual appraisal	202 (99%)	88.3%	91.3%

As part of the ongoing quality improvement process, real time auditing of appraisals is undertaken by the Revalidation Support Manager. In 2017 / 2018 the reasons for Category 1b appraisals being reported at MCHFT were:

Category 1b	
No of Appraisals	**Reason**
47	Appraisals not completed "3 months preceding the agreed date"
11	Appraiser did not sign off the appraisal within 28 days, due to information required for revalidation not being included in the appraisal
3	Appraisee did not sign off the appraisal within 28 days, due to information required for revalidation not being included in the appraisal
2	Appraisee request for new appraiser
1	Issues with electronic appraisal system

Missed / Incomplete Appraisals - Approved	
No of Appraisals	**Reason**
1	Maternity leave

Missed / Incomplete Appraisals - Unapproved	
No of Appraisals	**Reason**
1	Appraisal not signed off by appraisee before 31 March 2018

Revalidation Recommendations for 2017 / 2018

In 2017 / 2018 the RO made 20 revalidation recommendations to the GMC. This number remains low as the first 5 year revalidation cycle is coming to an end and the majority of doctors nationally had their revalidation date "front – loaded" towards the beginning of the revalidation cycle.

Recommendation	2017/18	2016/17	2015/16	2014/15
On Time	20	10	80	73
Late	0	0	0	0
Missed	0	0	0	0
Positive	18 (90%)	7 (70%)	74 (92.5%)	50 (68.5%)
Defer • Insufficient Information • On-going process	1 (5%) 1 (5%)	3 (30%) 0	4 (5%) 1 (1.25%)	15 (20.5%) 5 (6.9%)
Deferred for insufficient information and later revalidated	0	0	1 (1.25%)	3 (4.1%)
Non-engagement	0	0	0	0
Total	20	10	80	73

The following table benchmarks the Trust's total number of revalidation recommendations for the period 2012 – 2017 against neighbouring Trusts

	No of Approved Recommendations	No of approved recommendations to revalidate	No of approved requests for deferral (insufficient information)	No of approved requests for deferral (ongoing process)	No of approved recommendations of non-engagement	Average deferral (days)	No of late recommendations
Mid Cheshire Hospitals NHS Foundation Trust	196	166 (85%)	26 (13.2%)	4 (2%)	0	314	0
Countess of Chester Hospital NHS Foundation Trust	242	215 (89%)	25 (9.5%)	2 (0.9%)	0	220	2
East Cheshire NHS Trust	166	134 (80.7%)	29 (17.5%)	3 (1.8%)	0	188	4
University Hospitals of North Midlands NHS Trust	417	337 (80%)	71 (17%)	3 (0.7%)	2	270	5

Planned Developments for 2018 / 2019

The developments planned for the appraisal and revalidation of medical practitioners at MCHFT in 2018 / 2019 include:

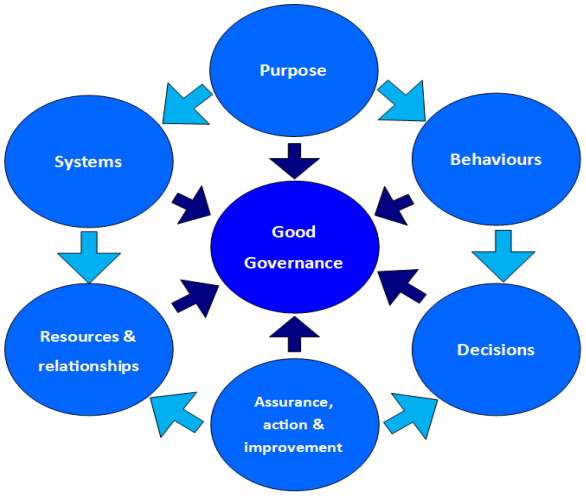
- Undertake another Appraisal Quality Audit of all appraisals and review against previous year's audit results to identify recurrent themes and / or doctors who require further training
- Review the appraisal training process for appraisees in consultation with internal users and reviewing best practice at other Trusts
- Training additional appraisers to ensure that MCHFT has the required cohort of trained appraisers to manage the increased number of prescribed connections and natural appraiser turnover.

Appendix 1

Mid Cheshire Hospitals NHS Foundation Trust

Action Plan
Appraisal and Revalidation Peer Review 2017

Good Governance Institute Body of Knowledge



Mid Cheshire Hospitals NHS Foundation Trust Action Plan for Appraisal and Revalidation Peer Review 2017

RAG: **Compliant CLOSED** | **Partial - Compliance** | **Non - Compliant**

INTRODUCTION:

In agreement with NHS England, a peer review process involving the Salford Royal, Royal Bolton and Mid Cheshire Hospitals NHS Foundation Trusts took place in June – August 2017. This included reviewing the policies and procedures, reporting arrangements, documentation and on-site reviews. The following issues were identified in the review process;

Standard/Process/ Issue/Gap Identified	Action Required	*RAG Rating	Responsible Lead	Timescales (by end of):	Responsible Committee / Group	Progress / Closure Date & Evidence (embed evidence into document)
Inclusion of a flow chart for the escalation relating to appraisal non-compliance within the Medical Appraisal Policy	Develop a flowchart using the example provided by Bolton		PAD / NCP	December 2017		Following a discussion at the Appraisers Meeting, it was decided not to include a flowchart but appropriate changes have been made to the Consultant and SAS Doctor Medical Appraisal Policy to ensure escalation processes are clear

Standard/Process/ Issue/Gap Identified	Action Required	*RAG Rating	Responsible Lead	Timescales (by end of):	Responsible Committee / Group	Progress / Closure Date & Evidence (embed evidence into document)
Absence of a formal 360 Feedback Policy and / or Guidance	Revisit the e-360 guidance and update as necessary following discussion at the Appraisers Meeting		NCP	December 2017		Included as part of the Trust's Appraisal Guidance
Appraisals review previous financial year's data and run from July – December each year - is there assurance that more recent issues are discussed? - is this 6 month appraisal period each year reasonable?	To review whether the "appraisal year" should remain aligned to the financial year To consider how to provide assurance that more recent issues are discussed at the appraisal meeting To consider adjusting the 6 month appraisal period		PAD	December 2017		Following a discussion at the Appraisers Meeting it was decided: - the appraisal year would remain aligned to the financial year - the 6 month appraisal period would be brought forward by 2 months and would run from May – October - doctors would be specifically asked to declare any issues that had occurred just prior to their appraisal

9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licenced medical practitioners[2] have qualifications and experience appropriate to the work performed; and

Comments:

10. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations.

Comments:

Signed on behalf of the Designated Body

Name: Tracy Bullock

Signed: TBullock

Chief Executive

Date: 07 August 2018

We Care Because You Matter

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

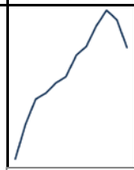
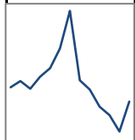
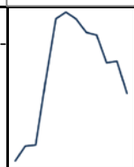
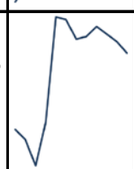
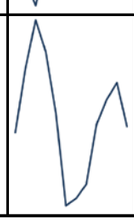
Board of Directors

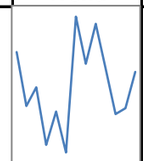
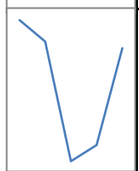
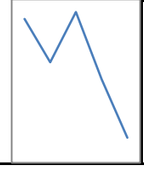
Workforce Report

September 2018

(July 2018 data)

Performance Report Workforce Chapter
Month: Jul-18

Measure	Target	Performance	Description	Narrative	Rolling Trend	Trend	C&W Average
Sickness Absence	3.40%	4.29%	Rolling 12m average Sickness Absence described as a Percentage	Rolling sickness absence has shown a small improvement from the June 2018 postion. MEC, EF, WC and CCICP all experienced a reduction in their rolling sickness absence. The in-month sickness absence rate is 4.00% which is a increase of 0.46% from the June in-month position.		↓	
In-Month Sickness Absence	N/A	4.00%	In-month 12m average Sickness Absence described as a Percentage			↑	
Appraisal Rate	90.00%	83.42%	Percentage of Staff who have received an appraisal in the last 12 months. Excludes New Staff with less than 12m service and Bank Staff	Appraisal rates have remained fairly static during July 2018 (-0.06%). WC are currently achieving the target and saw a 7% improvement in-month. Corporate experienced the most significant reduction (-4%)		↓	
Mandatory Training	90.00%	81.00%	Mandatory Training Monthly Rate Excludes Bank Staff, Staff on long term sick & mat. leave.	Mandatory training compliance rates have remained fairly static during July 2018 (-0.13%). DCSS remain above the 90% target. The Trust's dashboard is currently being updated to ensure that it is reflective of changes to training requirements.		↓	
Staff Turnover	10.00%	11.17%	Number of Leavers expressed as a percentage of the workforce over a 12m rolling period. Exclude Junior Doctors, Temporary and Fixed term.	Staff turnover has reduced from 11.33% in June 2018. The Probationary Period Policy is being reviewed at present to ensure that new starters are supported to meet their objectives and are successfully integrated into the workforce. A specific piece of work is being undertaken to review turnover within the qualified nursing staff group.		↓	

Measure	Target	Performance	Description	Narrative	Rolling Trend		
Agency Spend	(365)	(387)	In month and cumulative total spend for the Trust.	The agency target was exceeded in July 2018. Whilst the percentage of over-cap agency shifts was lower in July than June, the overall number of agency shifts used was higher which accounts for the increased overall cost.		↑	N/A
NHSI Ceiling	less than 100%	106.0%	Trust Agency Spend as a percentage of the Ceiling Set by NHS Improvement			↑	N/A
Over Cap Rates	N/A	38%	Number of Agency shifts filled by agency staff that are over the nationally determined capped rates			↓	N/A

Key

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