Mid Cheshire Hospitals NHS Foundation Trust

AGENDA

Board of Directors
A meeting will be held in Public at
09.30am on Monday, 3 December 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** *(attached)* To **approve** the minutes of the Board of Directors meeting held in Public on Monday, 5 November 2018	A	Chairman **09.52**	-
5.	**Matters Arising and Action Log** *(attached) (to note)*	A	Chairman **09.55**	**18**
6.	**Annual Work Programme 2018/19** *(attached)* *(to approve)*	I/A	Chairman **09.57**	**19**
7.	**Chairman's Announcements** (*to note a verbal report*) **7.1** **Health & Care Partnership for Cheshire & Merseyside Meeting** **7.2** **Meeting with the Vice Chancellor of University of Chester** **7.3** **Northern Chairs and NED Networking Event** (Deputy Chair)	I	Chairman **10.00**	-
8.	**Governor's Items** (*to note a verbal report*) **8.1** **Governor Strategy Event – 9 November 2018** **8.2** **Chat with the Chairman** **8.3** **NED Recruitment**	I	Chairman **10.10**	-

Item No		Title of Item	Action	Led By	Page No.
9.	**Chief Executive's Report** *(to note a verbal report)*		I	Chief Executive **10.20**	-
	9.1	**System Update**			
	9.2	**Executive Director Away Day**			
	9.3	**CQC Improvement Plan**			
10.	**CARING**				
	10.1	**Quality, Safety & Experience Report** *(attached) (for discussion)*	I/D	Director of Nursing & Quality **10.40**	**20**
	10.2	**CQC Improvement Plan** *(attached) (for discussion)*	I/D	Director of Nursing & Quality **10.50**	**66**
11.	**SAFE**				
	11.1	**Draft Quality Governance Committee notes from the meeting held on 12 November 2018** *(attached) (to note)*	I	Committee Chair **11.00**	-
	11.2	**Quality Governance Committee Chair** *(verbal) (to approve)*	A	Committee Chair **11.05**	-
	11.3	**Serious Untoward Incidents and RIDDOR Events** *(verbal)* (*to note*)	I/D	Deputy Chief Executive/ Medical Director **11.10**	-
12.	**RESPONSIVE**				
	12.1	**Performance Report** *(attached) (to note)*	I/D	Chief Operating Officer **11.15**	**112**
	12.2	**Draft Performance & Finance Committee notes from the meeting held on 22 November 2018** *(attached) (to note)*	I	Committee Chair **11.25**	-
	12.3	**Legal Advice** *(verbal)* (*to note*)	I	Chief Executive **11.30**	-

Item No		Title of Item	Action	Led By	Page No.
13.	**WELL-LED**				
	13.1	**Visits of Accreditation, Inspection or Investigation** *(verbal)* (*to note*)	I	Chief Executive **11.35**	-
	13.2	**Draft Audit Committee notes from the meeting held on 12 November 2018** *(attached) (to note)*	I	Committee Chair **11:40**	-
	13.3	**Board Assurance Framework Q2 2018-19** *(attached) (to note)*	I/D	Deputy Chief Executive/ Medical Director **11.45**	**170**
	13.4	**Learning from Deaths Q2 Report** *(attached) (to note)*	I/D	Deputy Chief Executive/ Medical Director **11.50**	**189**
14.	**EFFECTIVE**				
	14.1	**Workforce Report** *(attached) (to note)*	I/D	Director of Finance **11.55**	**210**
	14.2	**Transformation and People Committee notes from the meeting held on 8 November 2018** *(attached) (to note)*	I	Committee Chair **12.05**	-
	14.3	**Consultant Appointments** *(verbal) (to note)*	I	Deputy Chief Executive/ Medical Director **12.10**	-
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 Boardroom at Leighton Hospital, at 9.30am on **Monday, 7 January 2019**	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
18/11/3.1	05-Nov-18	Board of Directors Register of Interests to be updated	K Dowson	30/11/2018		03/12/2018	
18/11/9.2.2	05-Nov-18	Update on the planning process to be provided to Governors at the next Council meeting	T Bullock	24/01/2019		04/02/2019	

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				

Mid Cheshire Hospitals NHS
NHS Foundation Trust

We Care Because You Matter

Board of Directors

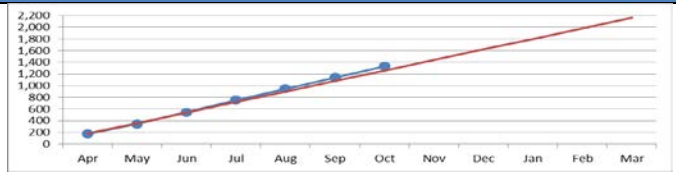
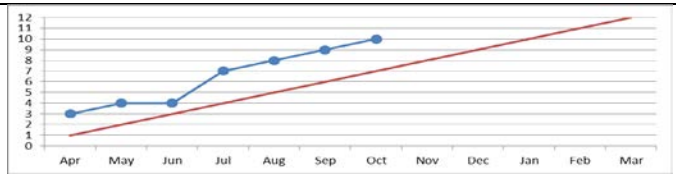
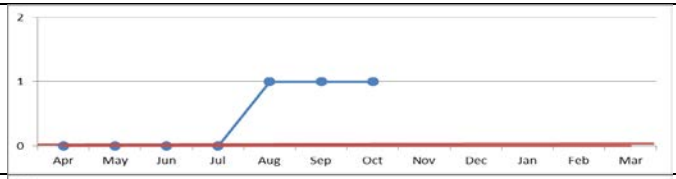
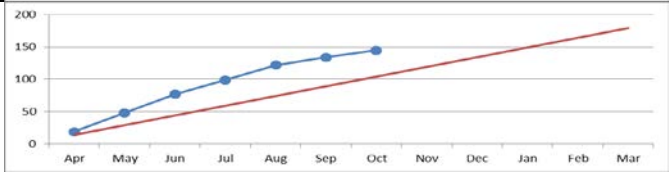
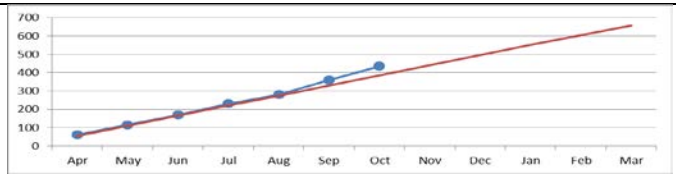
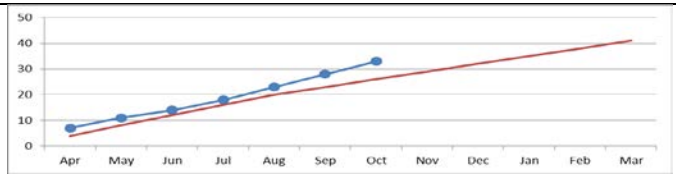
Quality, Safety and Experience Report

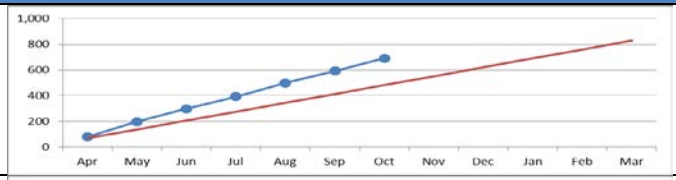
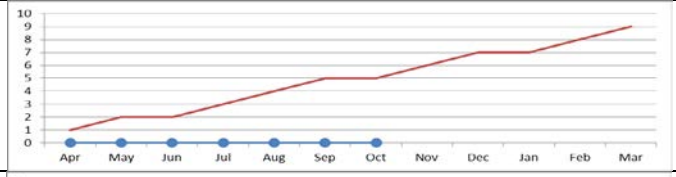
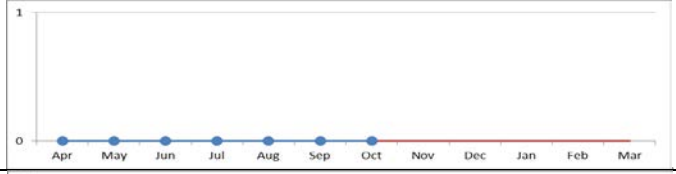
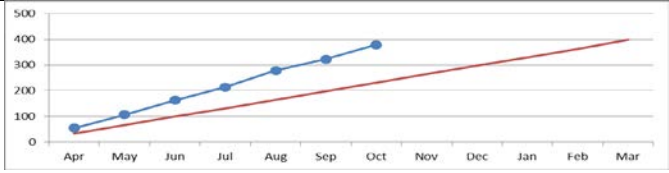
December 2018

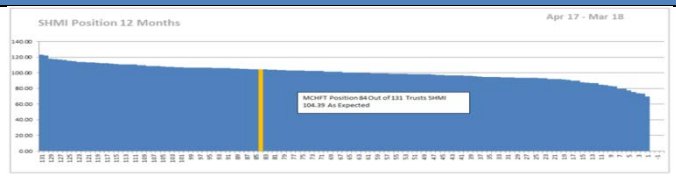
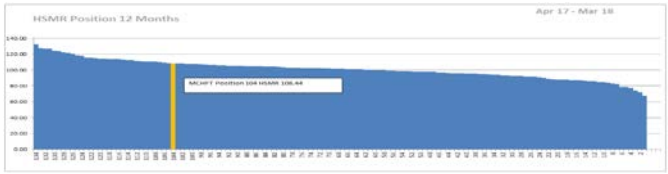
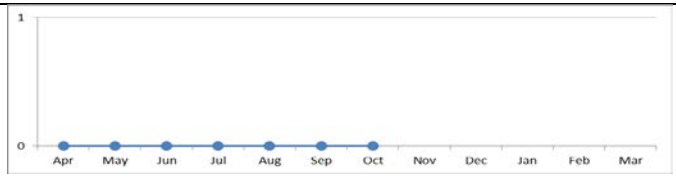
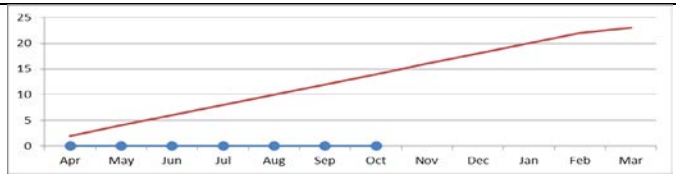
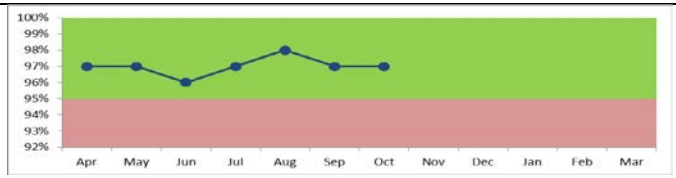
(October 2018 data)

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

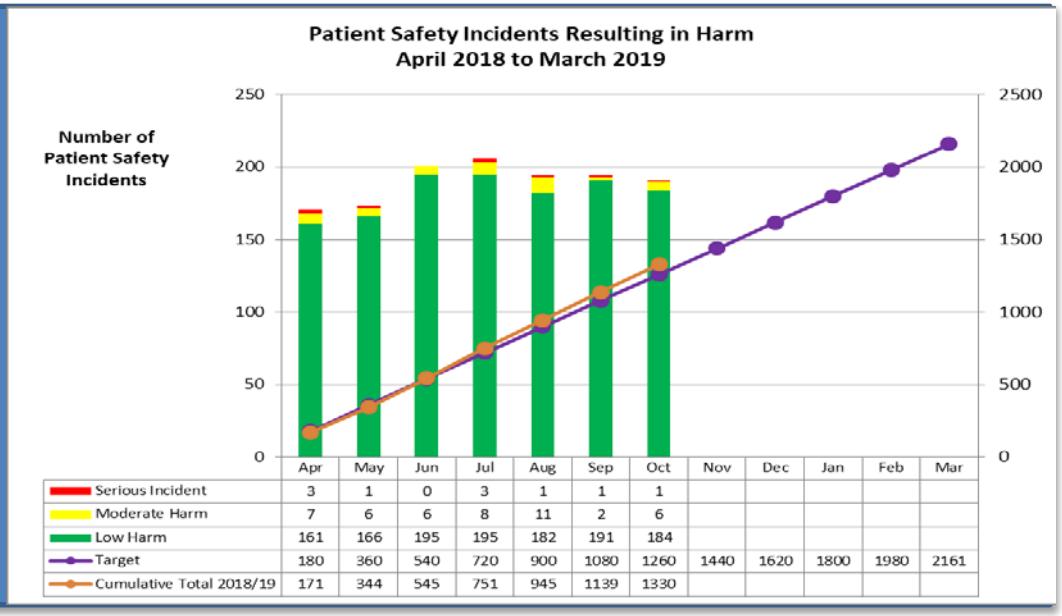
The target is to reduce patient safety harm incidents by 5% when compared to the previous financial year by the end of March 2019.

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

For October 2018, there were a total of 191 patient safety harm incidents:
96.3% (184 incidents) have resulted in low harm
3.1% (6 incidents) have resulted in moderate harm
0.6% (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	3	1	1	1					
Moderate Harm	7	6	6	8	11	2	6					
Low Harm	161	166	195	195	182	191	184					
Target	180	360	540	720	900	1080	1260	1440	1620	1800	1980	2161
Cumulative Total 2018/19	171	344	545	751	945	1139	1330					

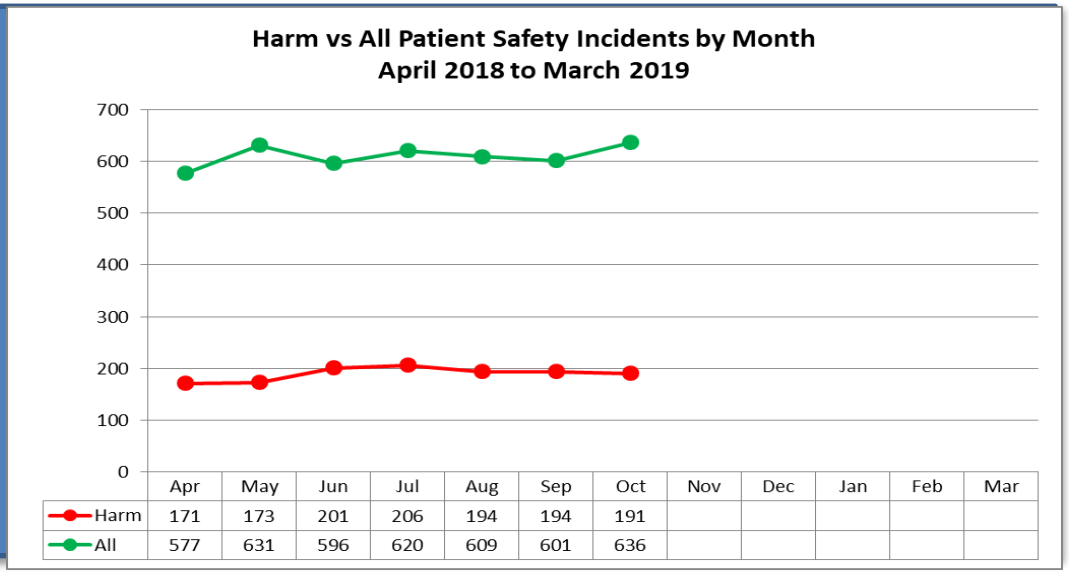
Harm vs All Patient Safety Incidents

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

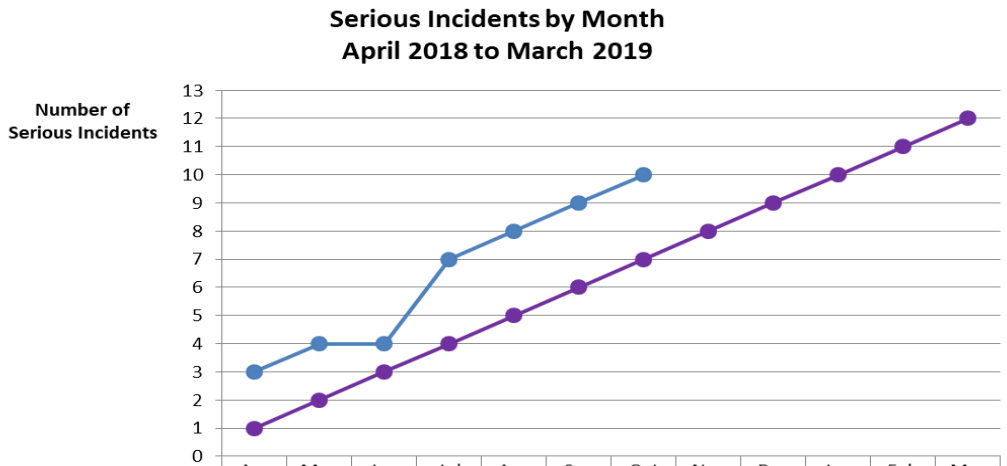
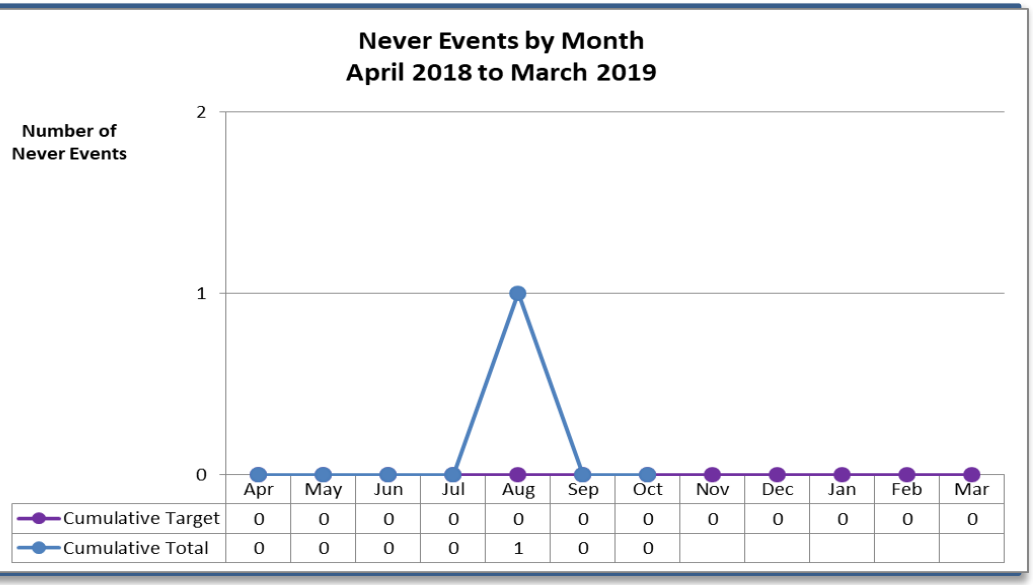
This chart demonstrates the number of incidents that have resulted in harm vs all patient safety incidents.

In October 2018, the gap between harm and all patient safety incidents was 445. 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	171	173	201	206	194	194	191					
All	577	631	596	620	609	601	636					

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 October 2018, there was one serious incident reported. • Patient Fall resulting in fractured neck of femur.	
Never Events *The target is to have zero Never Events*	This chart demonstrates the number of Never Events that have been reported. For October 2018 no Never Events were reported.	

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

	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	1	0	0					

Description	Aggregate Position	Trend

Pressure Ulcers (PU) – Hospital Acquired

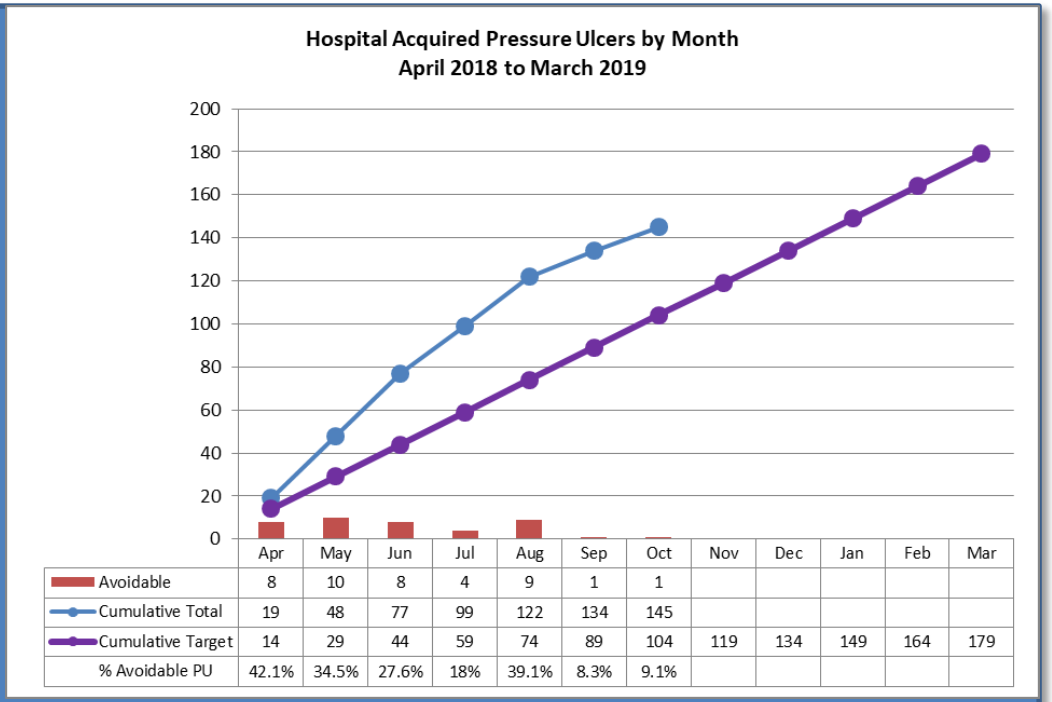
The target is to reduce hospital acquired pressure ulcers by 10% when compared to the previous financial year by the end of March 2019.

For October 2018, there were a total of 11 hospital acquired pressure ulcer incidents:

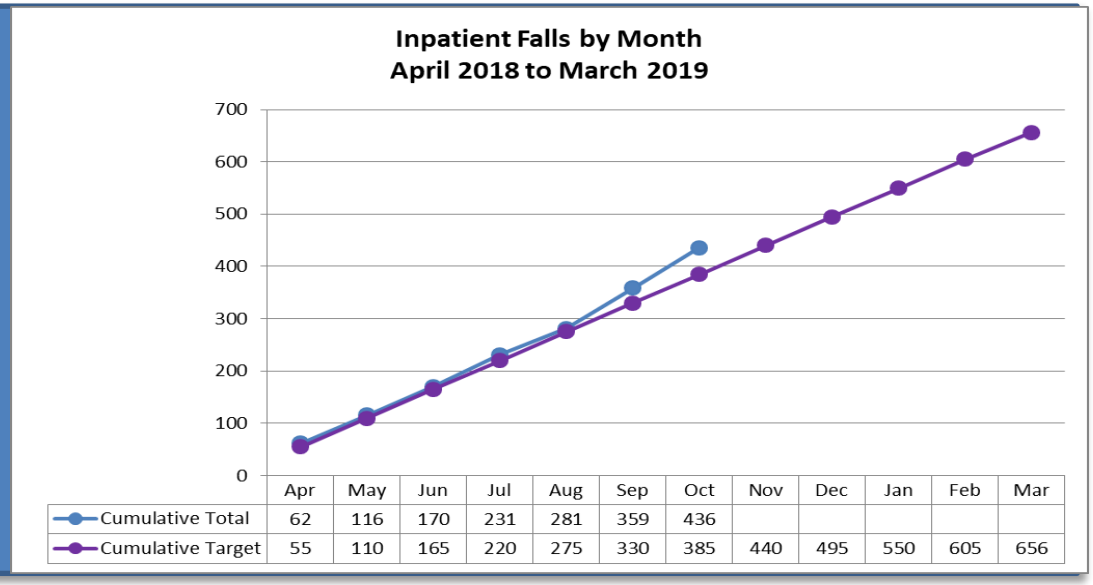
- 9.1% (1 PU) has resulted in avoidable harm. This was a category 2 pressure ulcer. All avoidable pressure ulcers are reviewed at the monthly pressure ulcer panel.
- 81.8% (9 PU's) have been classed as unavoidable following investigation. These were all category 2 pressure ulcers
- 9.1% (1) is currently undergoing investigation prior to confirmation. This is a category 2 pressure ulcer

Improvement actions include

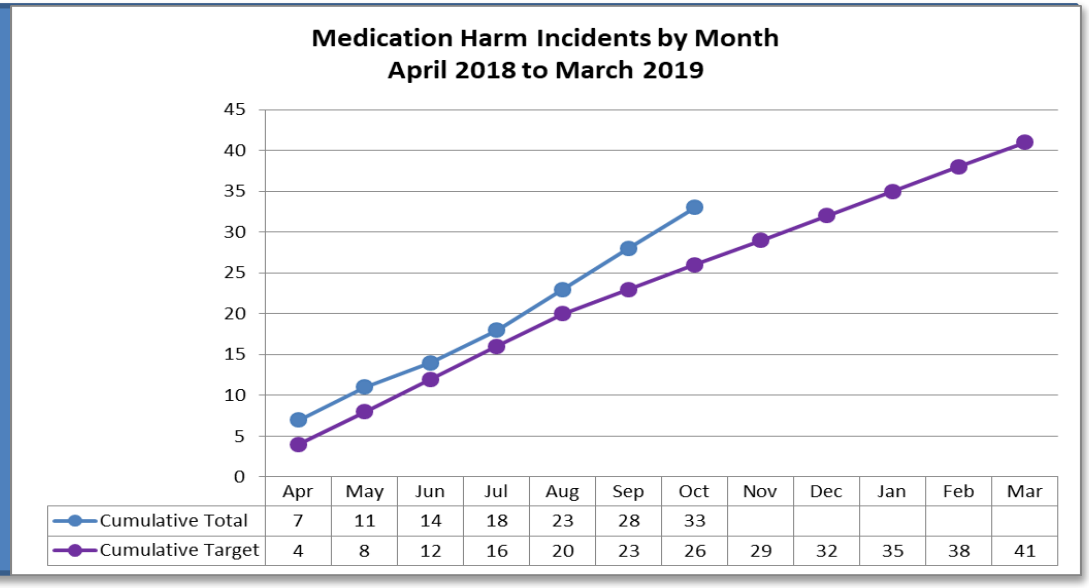
- Daily verification of all reported pressure ulcers by the Tissue Viability Specialist Nurse
- Development of pressure ulcer champions to support 'master classes' in pressure ulcer prevention and support the Tissue Viability Specialist Nurse with 'back to basic' training.
- Divisional actions being instigated include,
  - PU Lead Matron has been nominated in DMEC, and has developed a divisional pressure ulcer panel
  - Surgery and Cancer have instigated a pressure ulcer panel with representation from the divisional link nurses
  - Observational audits are being completed in Surgery and Cancer on the skin bundle with real time feedback to the teams



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Avoidable	8	10	8	4	9	1	1					
Cumulative Total	19	48	77	99	122	134	145					
Cumulative Target	14	29	44	59	74	89	104	119	134	149	164	179
% Avoidable PU	42.1%	34.5%	27.6%	18%	39.1%	8.3%	9.1%					

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 October 2018, there were a total of 77 inpatient falls • 58.4% (47 falls) have resulted in no harm • 32.5% (25 falls) have resulted in low harm • 5.2% (4 falls) have resulted in moderate harm • 3.9% (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	62	116	170	231	281	359	436					
Cumulative Target	55	110	165	220	275	330	385	440	495	550	605	656

Description	Aggregate Position	Trend
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 October 2018, there were a total of 5 medication incidents resulting in harm reported: • 100% (5 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 • Monthly lessons learned shared from the Safer Medicines Practice Group	

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative Total	7	11	14	18	23	28	33					
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

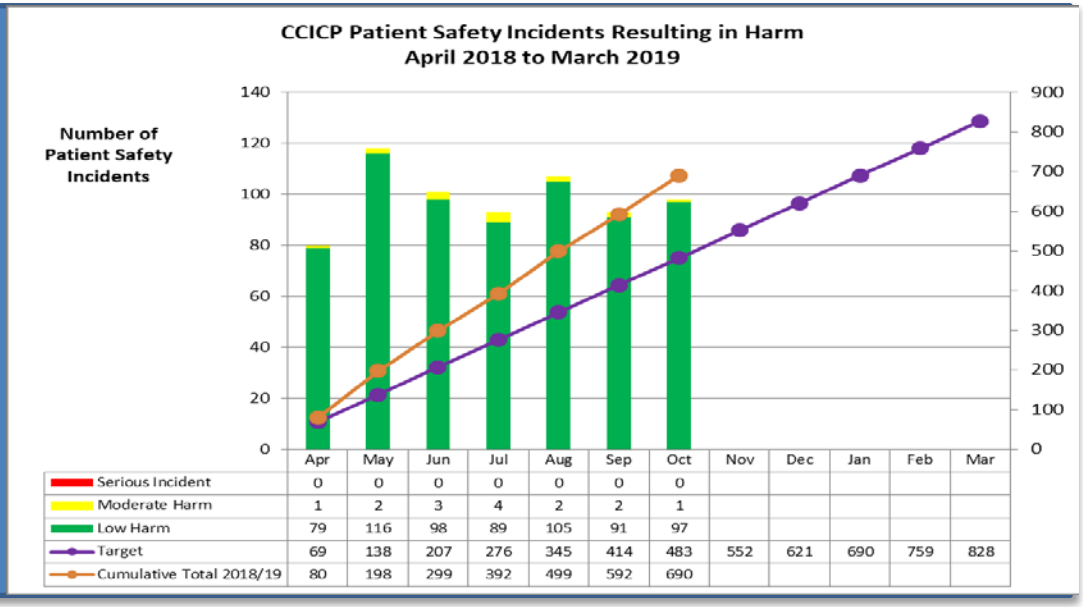
The target is to reduce CCICP patient safety harm incidents by 5% when compared to the previous financial year by the end of March 2019.

For October 2018, there were a total of 98 patient safety harm incidents:

- 99% (97 incidents) have resulted in low harm
- 1% (1 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	0	0	0					
Moderate Harm	1	2	3	4	2	2	1					
Low Harm	79	116	98	89	105	91	97					
Target	69	138	207	276	345	414	483	552	621	690	759	828
Cumulative Total 2018/19	80	198	299	392	499	592	690					

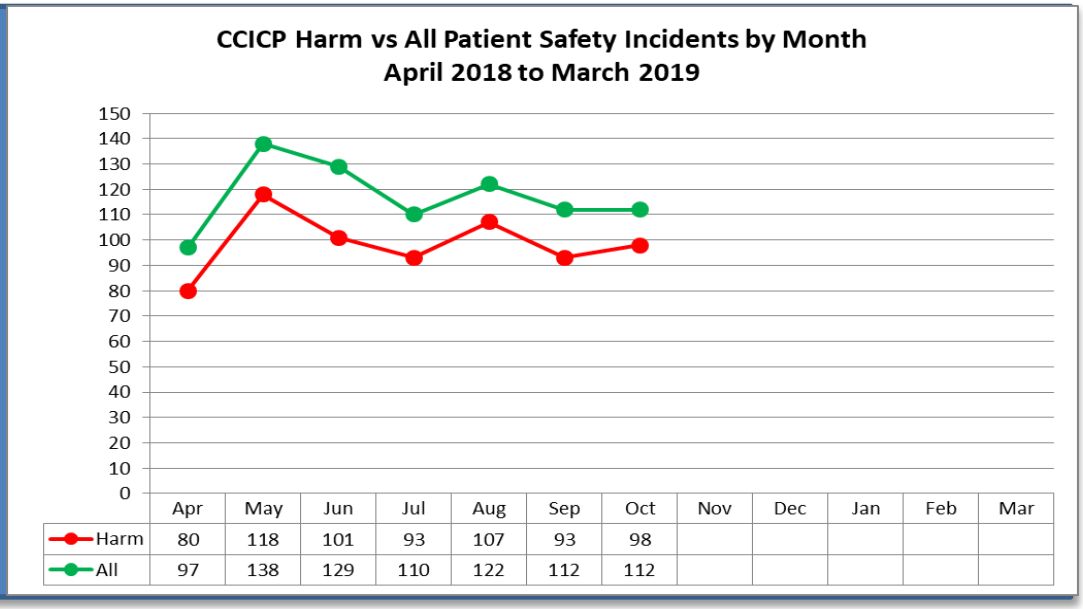
CCICP Harm vs All Patient Safety Incidents

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

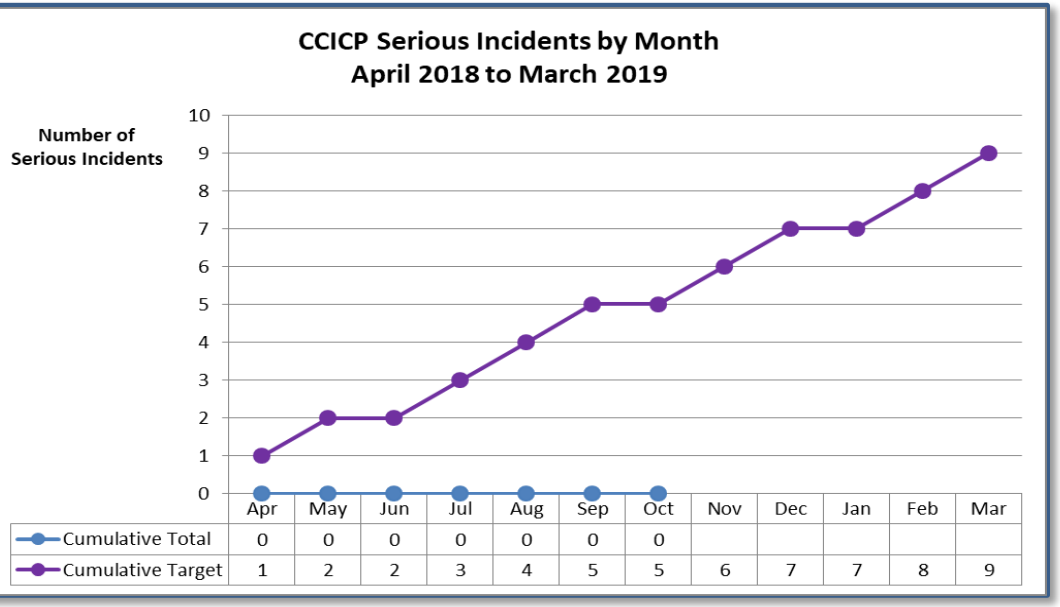
This chart demonstrates the number of incidents that have resulted in harm vs all patient safety incidents.

In October 2018, the gap between harm and all patient safety incidents was 14.

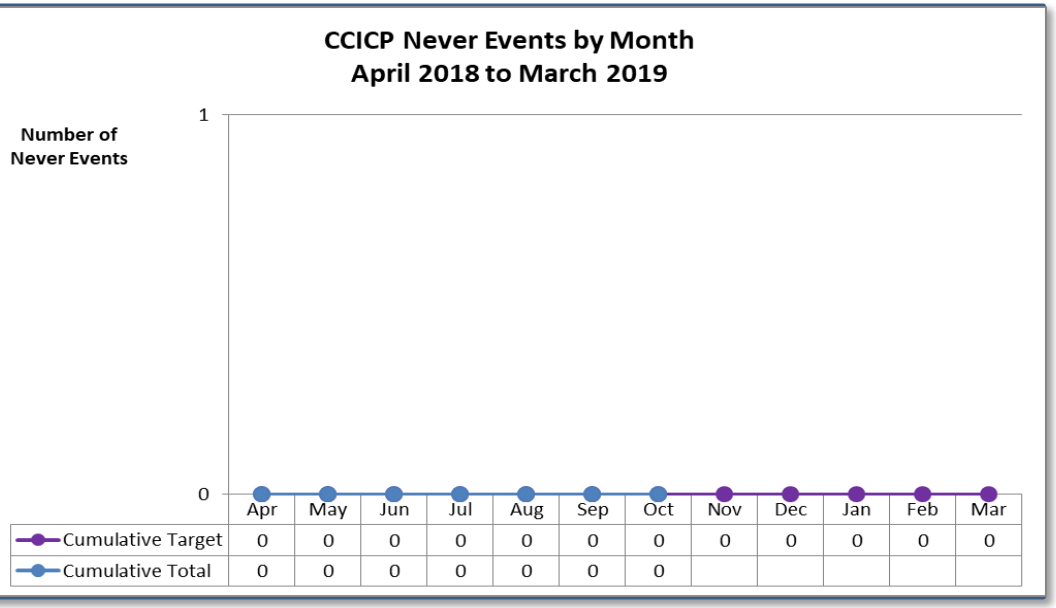
Within healthcare, a safety culture is defined as a "culture where staff have a constant and active awareness of the potential for things to go wrong. It is also a culture that is open and fair and encourages people to speak up about mistakes." An important benefit in a safety culture in the NHS is "A 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	80	118	101	93	107	93	98					
All	97	138	129	110	122	112	112					

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 October 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	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 October 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	0	0	0					

Description	Aggregate Position	Trend

Pressure Ulcers – Community Acquired

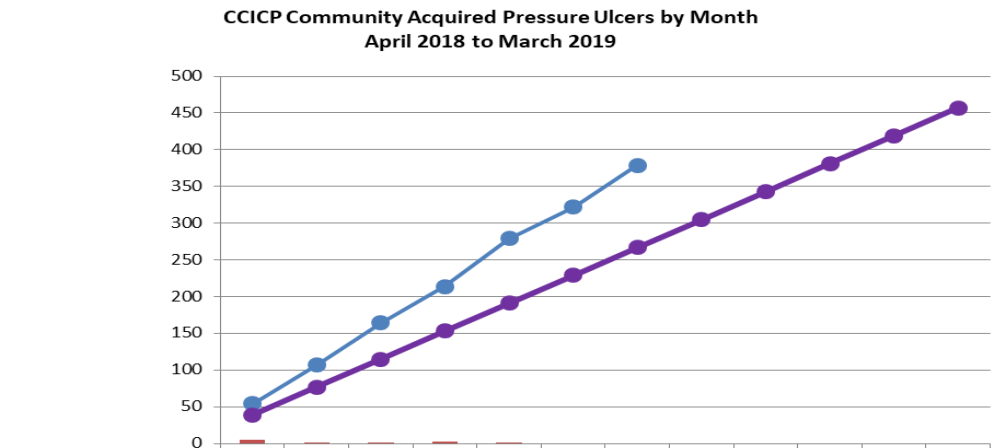
The target is to reduce community acquired pressure ulcers by 10% when compared to the previous financial year by the end of March 2019.

For October 2018, there were a total of 57 community acquired pressure ulcer incidents:

- 0% (0 PU's) has resulted in avoidable harm.
- 28.1% (16 PU's) have been classed as unavoidable following investigation.
- 71.9% (41) are currently undergoing investigation prior to confirmation

Improvement actions include:

- Standardisation of skin inspections and nursing assessments across CCICP
- Engagement with care homes
- Development of a business case to provide pressure relieving cushions in patients homes
- Implementation of a PU improvement group



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Avoidable	5	2	2	3	2	0	0					
Cumulative Total	54	107	164	214	279	322	379					
Cumulative Target	39	77	115	153	191	229	267	305	343	381	419	457
% Avoidable PU	9.3%	3.8%	3.5%	6.0%	3.0%	0.0%	0.0%					

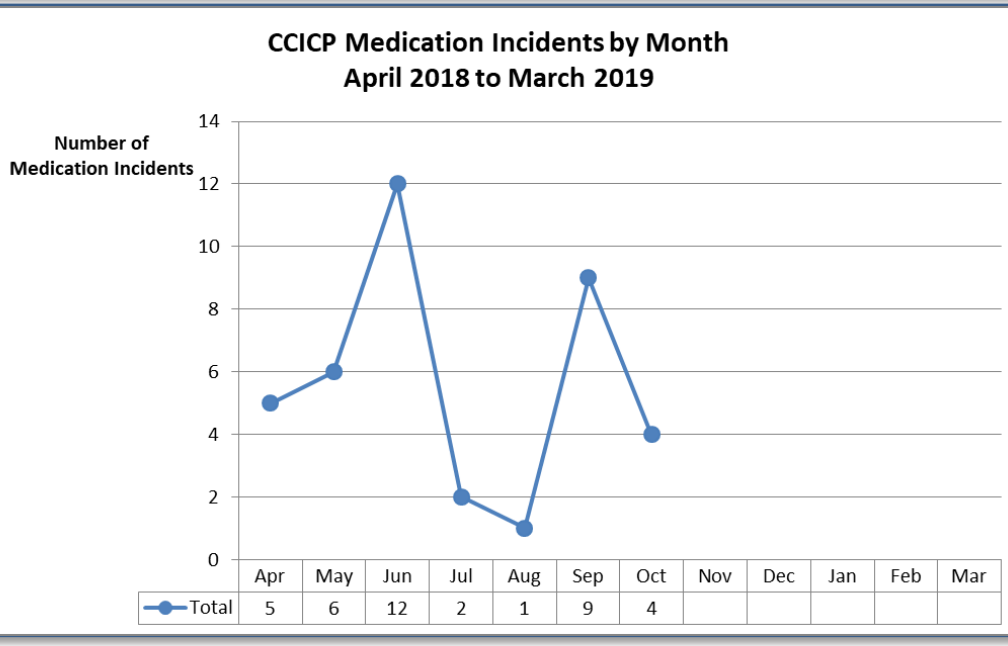
CCICP Medication Incidents.

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

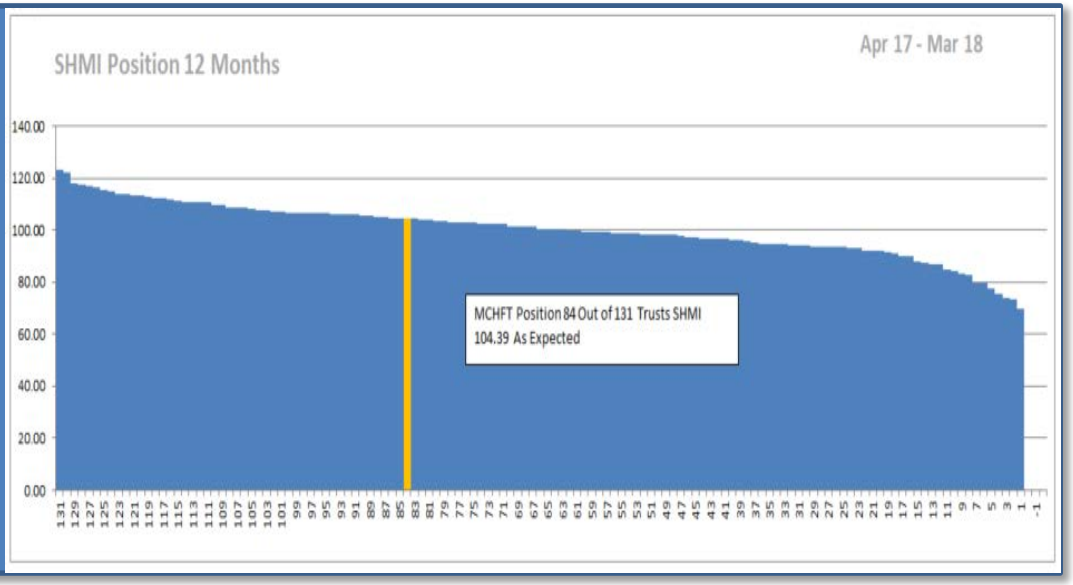
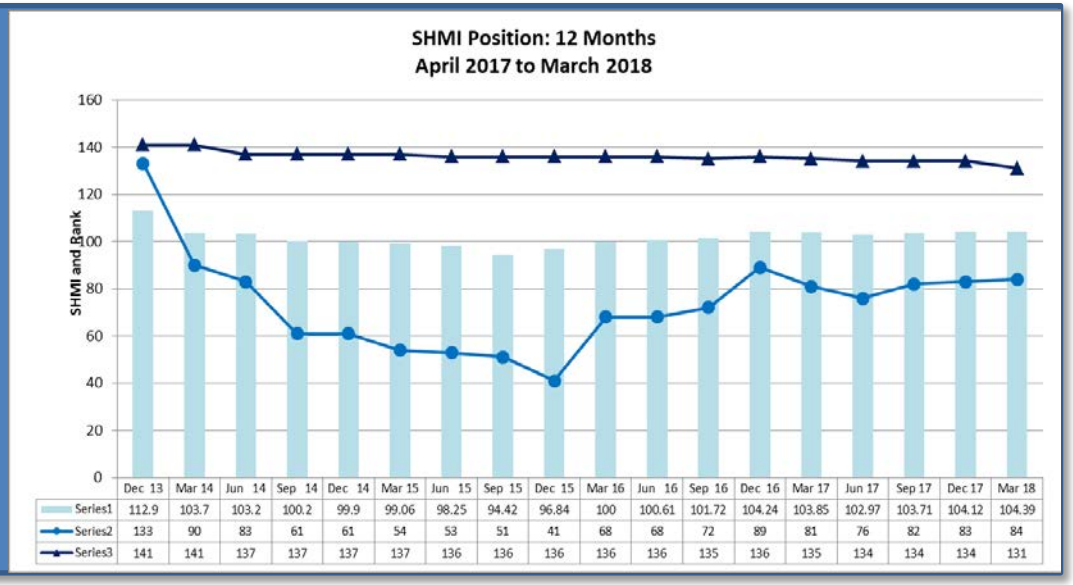
For October 2018, there was a total of 4 medication incidents reported:

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

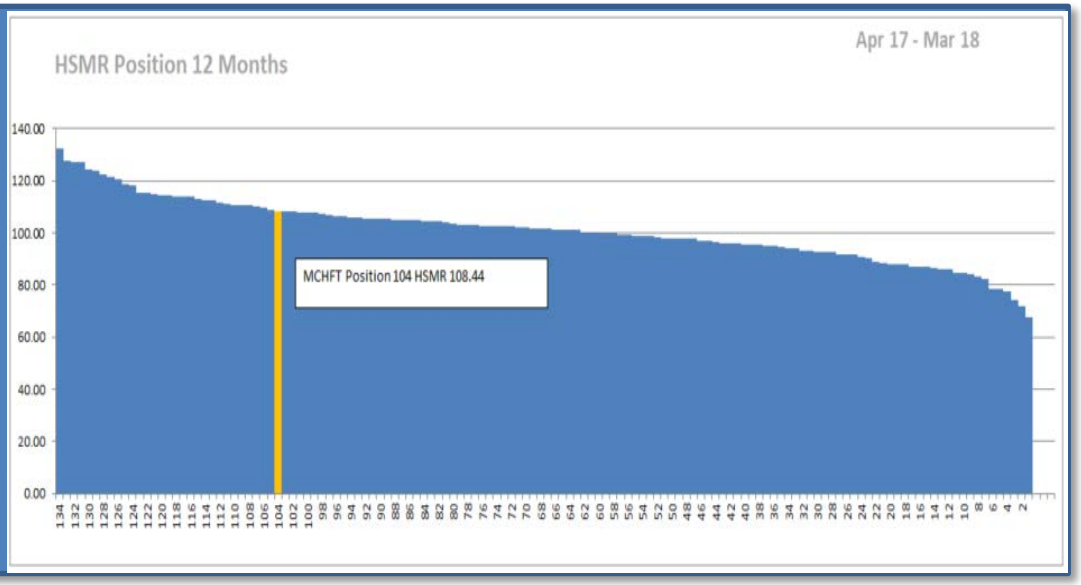
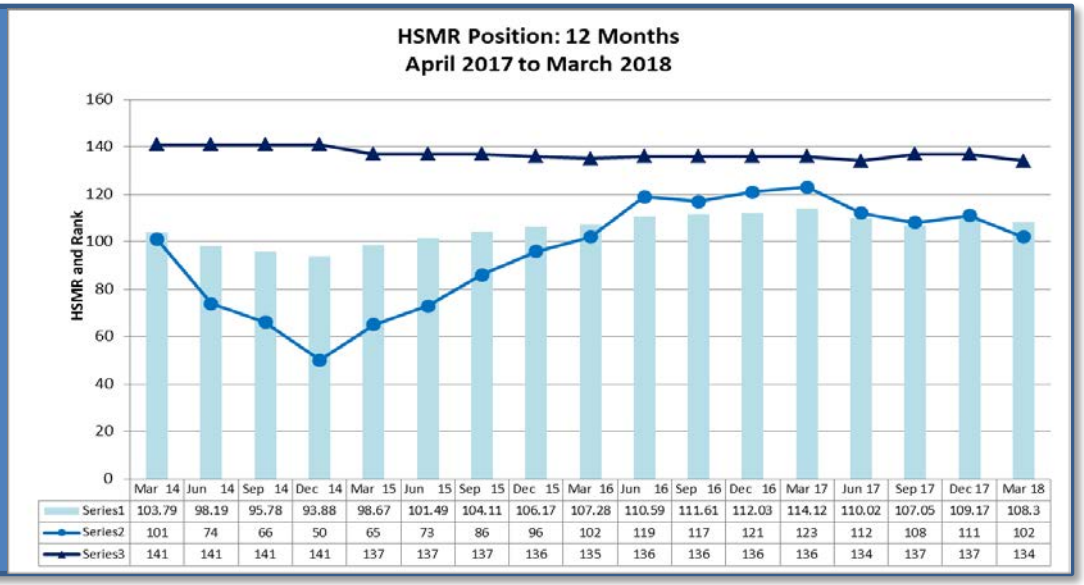
CCICP has a dedicated pharmacy lead who is actively encouraging the reporting of all grades of incidents across all services.



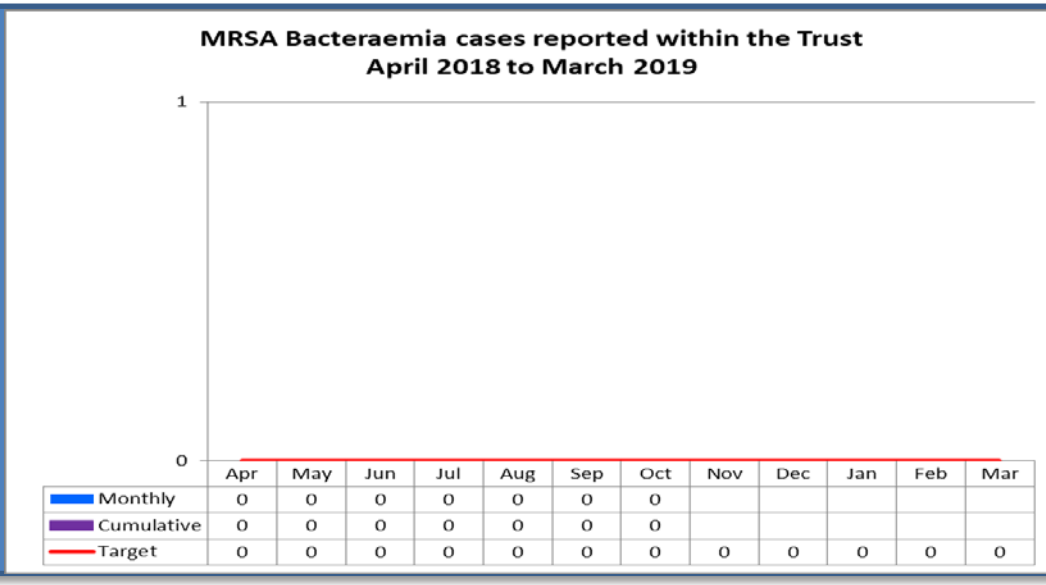
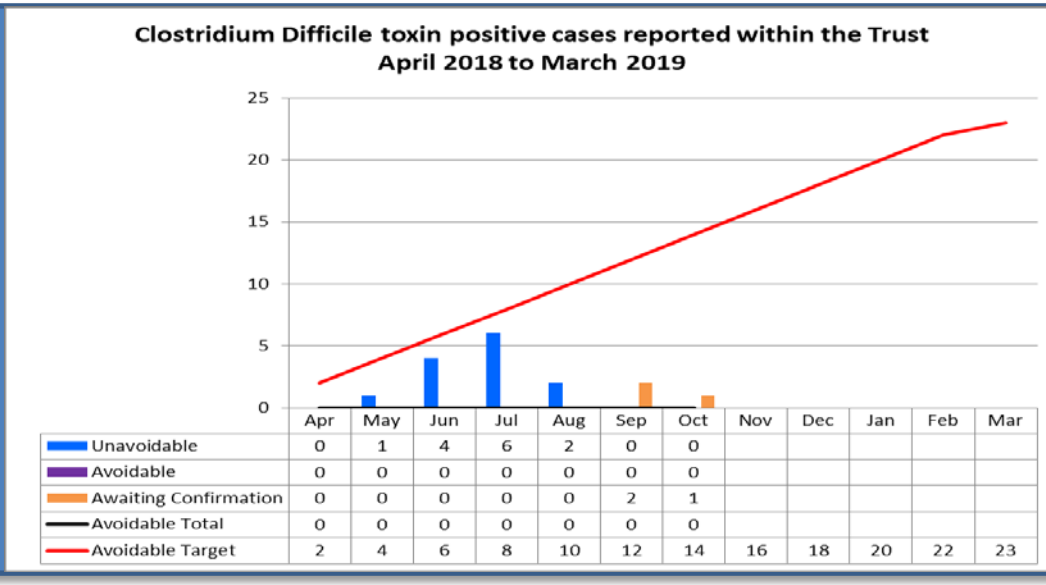
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total	5	6	12	2	1	9	4					

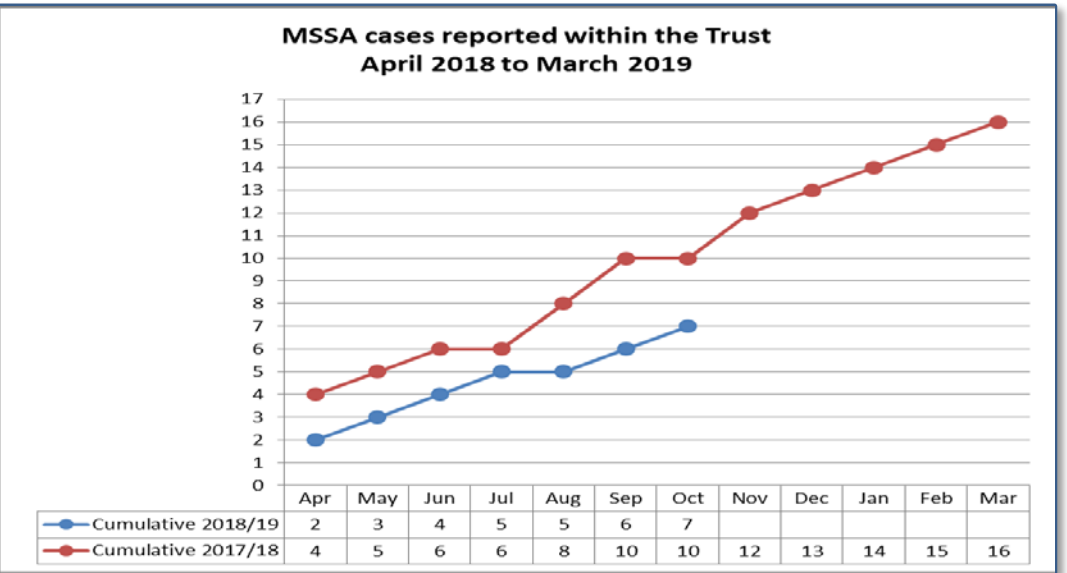
Description	Aggregate Position	Trend
SHMI *The Trust's target is to be at least within the "as expected" bracket.*	The chart benchmarks the Trust's latest SHMI against all NHS Trusts. MCHFT is shown as the yellow bar. The Trust's SHMI is 104.39 for the time period April 2017 to March 2018 and places the Trust 84 out of 131 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 April 2017 to March 2018 and is "as expected".	

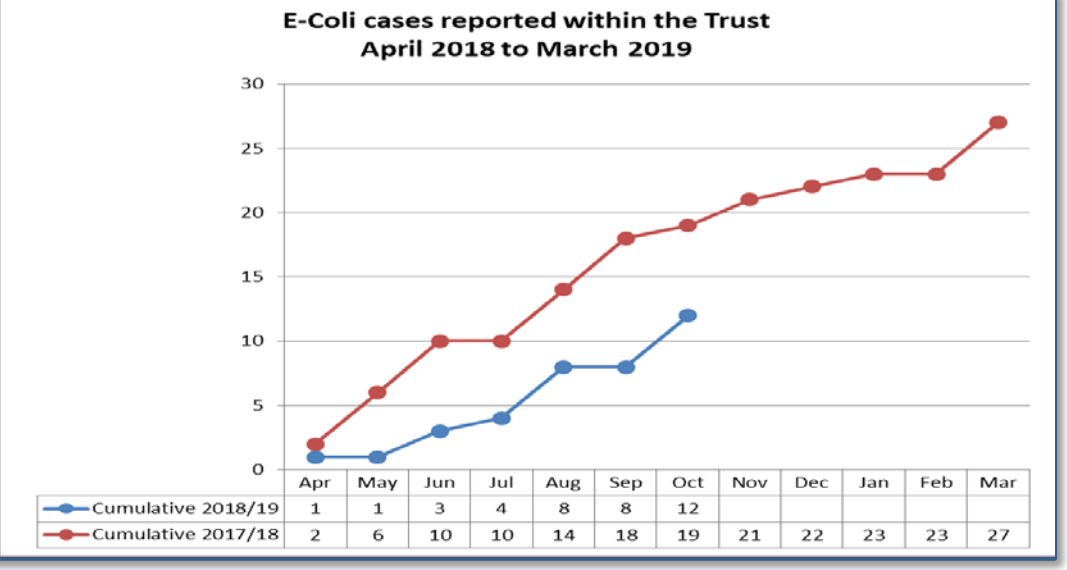
	Dec 13	Mar 14	Jun 14	Sep 14	Dec 14	Mar 15	Jun 15	Sep 15	Dec 15	Mar 16	Jun 16	Sep 16	Dec 16	Mar 17	Jun 17	Sep 17	Dec 17	Mar 18
Series1	112.9	103.7	103.2	100.2	99.9	99.06	98.25	94.42	96.84	100	100.61	101.72	104.24	103.85	102.97	103.71	104.12	104.39
Series2	133	90	83	61	61	54	53	51	41	68	68	72	89	81	76	82	83	84
Series3	141	141	137	137	137	137	136	136	136	136	136	135	136	135	134	134	134	131

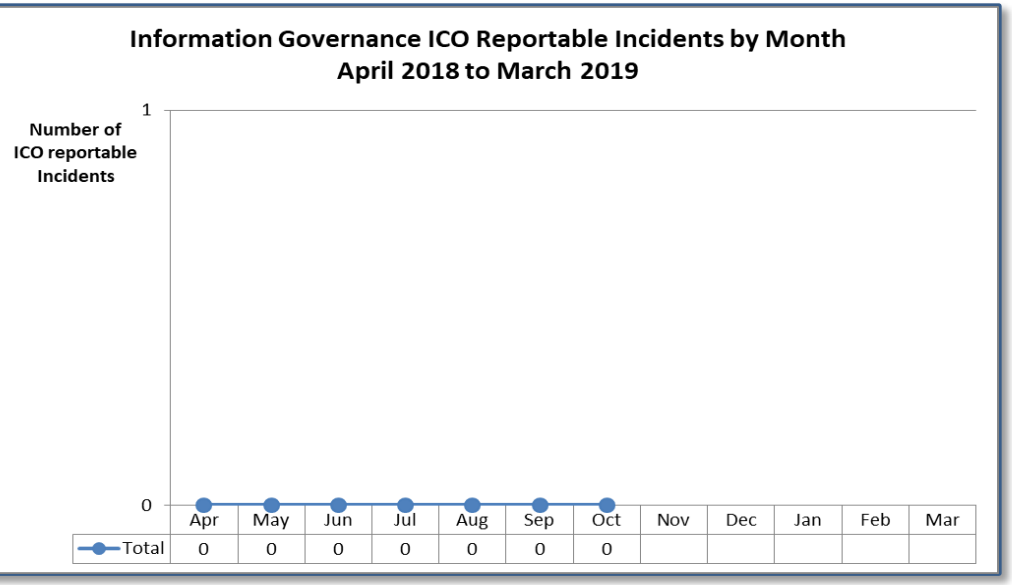
Description	Aggregate Position	Trend
Hospital Standardised Mortality Rate (HSMR) by Trust. *The Trust's target is to be at least within the "as expected" bracket.*	The chart benchmarks the Trust's HSMR against all NHS Trusts. MCHFT is shown by the amber bar. The Trust's HSMR is 108.44 (April 2017 to March 2018) and places the Trust 104 out of 134 Trusts and is "as expected".	
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 April 201`7 to March 2018 and is "as expected".	

	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	Mar 18
Series1	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	108.3
Series2	101	74	66	50	65	73	86	96	102	119	117	121	123	112	108	111	102
Series3	141	141	141	141	137	137	137	136	135	136	136	136	136	134	137	137	134

Description	Aggregate Position	Trend
MRSA Bacteraemia Cases. *Zero tolerance of MRSA cases.*	In October 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 October 2018, no avoidable cases were reported. The total avoidable cases year to date is zero. The total unavoidable is thirteen. 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 October 2018, one MSSA case was reported in the Trust. In this financial year there has been seven confirmed MSSA cases reported.	

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 October 2018, four E-Coli cases were reported. In this financial year there have been twelve confirmed E-Coli cases reported.	

Description	Aggregate Position	Trend
Information Governance Information Commissioners Office (ICO) reportable incidents.	In October 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.	

CQUIN 2018-19 Performance

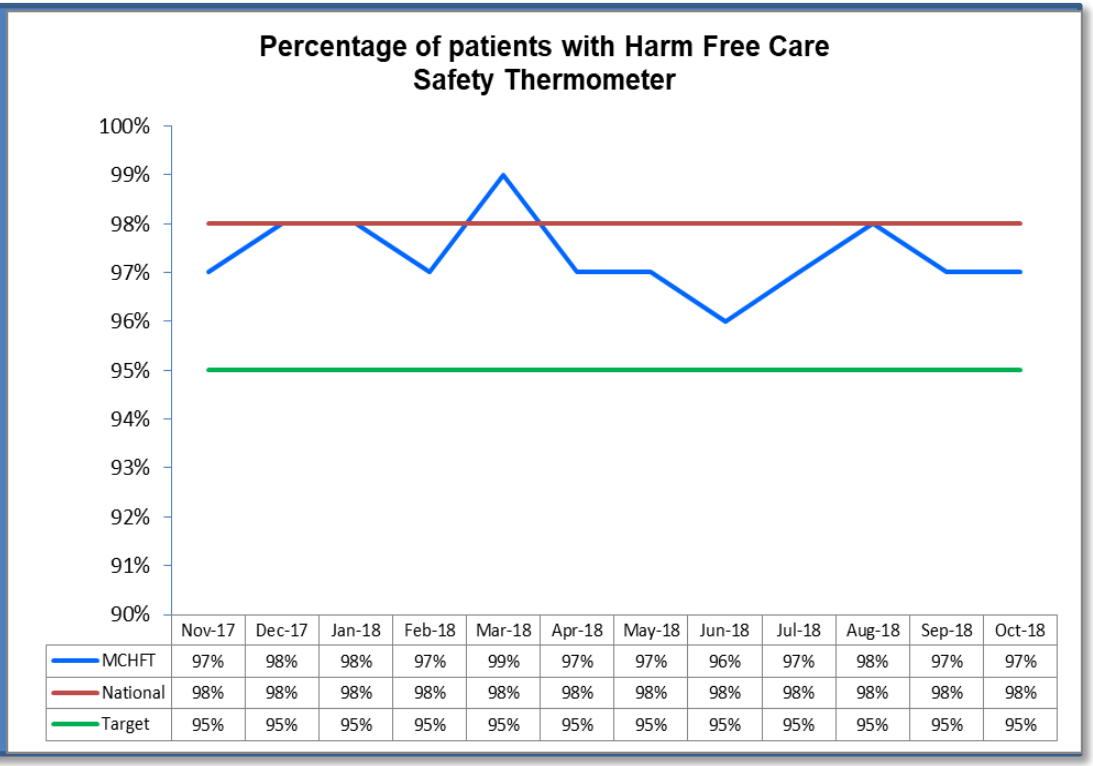
CQUIN Indicator	Indicator Name	Milestone Achieved								
		Q1	Financial Incentive Achieved	Q2	Financial Incentive Achieved	Q3	Financial Incentive Achieved	Q4	Financial Incentive Achieved	Maximum Value
1a	**Health & Wellbeing** 5% point improvement in two of the three questions on H&W, MSK & Stress		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 October 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.	

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

Ward Name	Main Specialties	Safety Thermometer Results September 2018			
		Acquired Pressure Ulcers	Patient Falls resulting in harm	CAUTI	New VTE
MCHFT		**1.95% (16)**	**0.49% (4)**	**0.49% (4)**	**0.12% (1)**
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)	3.12% (1)	0% (0)	0% (0)
SAU	Gen. Surgery	0% (0)	4.35% (1)	0% (0)	0% (0)
SSW	Gen. Surgery & Urology	4.55% (1)	0% (0)	4.55% (1)	0% (0)
Ward 15	Gen. Surgery & Gynae	0% (0)	3.12% (1)	0% (0)	0% (0)
Ward 13	Gen. Surgery	0% (0)	0% (0)	0% (0)	0% (0)
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	9.38% (3)	0% (0)	0% (0)	0% (0)
Ward 21B	Rehab	8.33% (2)	0% (0)	8.33% (2)	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	6.25% (2)	0% (0)	0% (0)	0% (0)
Ward 5	Gen. Medicine	3.33% (1)	0% (0)	0% (0)	0% (0)
Ward 6	Gen. Medicine	0% (0)	0% (0)	0% (0)	3.57% (1)
Ward 7	Gen. Medicine	0% (0)	3.23% (1)	3.23% (1)	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	0% (0)	0% (0)	0% (0)	0% (0)
DN – Ashfields and Haslington	District Nursing	4.88% (2)	0% (0)	0% (0)	0% (0)
DN – Dane Bridge	District Nursing	0% (0)	0% (0)	0% (0)	0% (0)
DN – Eagle Bridge	District Nursing	0% (0)	0% (0)	0% (0)	0% (0)
DN – Firdale	District Nursing	8.33% (3)	0% (0)	0% (0)	0% (0)
DN - Church View	District Nursing	0% (0)	0% (0)	0% (0)	0% (0)
DN OOH	District Nursing	0% (0)	0% (0)	0% (0)	0% (0)
DN – Grosvenor, Hungerford and Rope Green	District Nursing	0% (0)	0% (0)	0% (0)	0% (0)
DN - Winsford	District Nursing	2.947% (1)	0% (0)	0% (0)	0% (0)
Intermediate Care	Intermediate Care	16.67% (1)	0% (0)	0% (0)	0% (0)

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

Description	Aggregate Position		Trend
Registered Nurses monthly expected hours by shift versus actual monthly hours per shift. Day time shifts only	92.9% of expected Registered Nurse hours were achieved for day shifts. Any registered nurse numbers that fall below 85% are required to have a divisional review and an update of actions provided to the Director of Nursing & Quality and the Deputy Director of Nursing & Quality.	Trend **October 2018 92.9%** September 2018 93.2% August 2018 90.4%	The lowest staffing levels during the day were on Ward 9 at 76.1%
Registered Nurses monthly expected hours by shift versus actual monthly hours per shift. Night time shifts only	99% of expected Registered Nurse hours were achieved for night shifts.	Trend **October 2018 99%** September 2018 97.4% August 2018 96.8%	The lowest staffing levels during the night were on Ward 5 at 71%
Healthcare Assistant monthly expected hours by shift versus actual monthly hours per shift. Day time shifts only	100.7% of expected HCA hours were achieved for day shifts.	Trend **October 2018 100.7%** September 2018 100.9% August 2018 98.6%	The lowest staffing levels during the day were on Ward 9 at 59.7%
Healthcare Assistant monthly expected hours by shift versus actual monthly hours per shift. Night time shifts only	103.8% 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 **October 2018 103.8%** September 2018 103.5% August 2018 101.5%	The lowest staffing levels during the night were on Ward 9 at 71%
Total number of wards that are lower than 85% RN fill days and nights is 6.	Ward 4 – 79.4% (day), Ward 5 – 78.5% (day) and 71% (night), Ward 6 – 76.6% (night), Ward 9 – 76.1% (day), Ward 14 – 77.4% (night) and Ward 21B – 78.1% (day).	• 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	

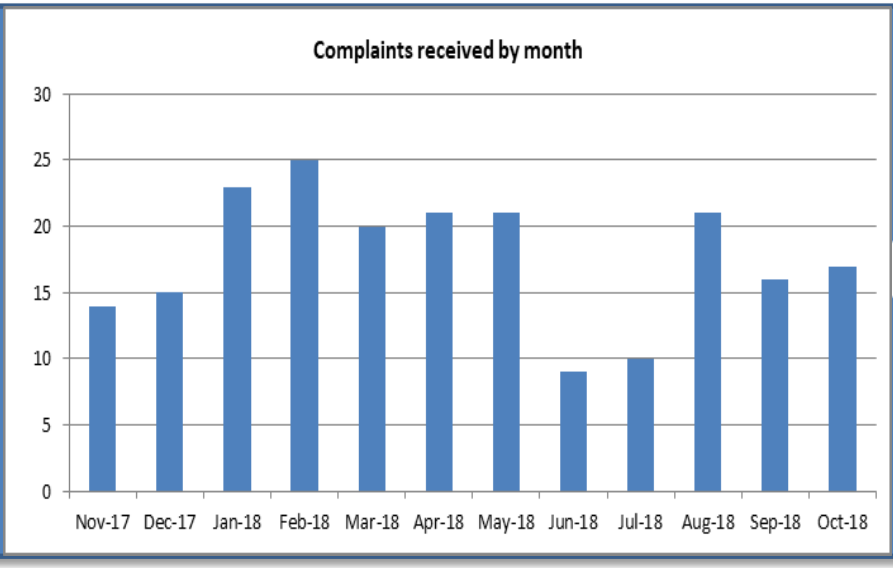
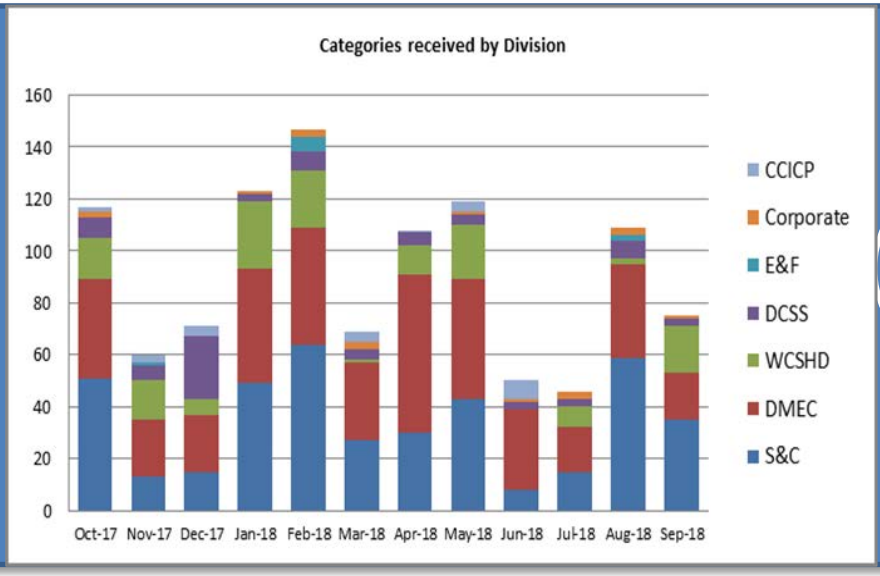
Board Papers – Quality, Safety & Experience Section: October 2018

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	40817.1	37979.5	29919.9	30277.4	25220.1	24242.1	16708.6	19059.2	92.9%	100.7%	99%	103.8%	16064	121.2	62.7	183.9
AMU	2011.3	1876.8	1519	1427.5	1898.8	1751.8	1519	1482.3	93.3%	94.0%	92.3%	97.6%	887	4.1	3.3	7.4
CAU (Winter)	1800.5	1800.5	663	663	1598.5	1598.5	356.5	356.5	100.0%	100.0%	100.0%	100.0%	568	6.0	1.8	7.8
Critical Care	4048.5	4048.5	652.5	652.5	2451	2451	0	0	100.0%	100.0%	100.0%	-	253	25.7	2.6	28.3
Elmhurst	871.5	871.5	2232	2178	775	775	1550	1562.5	100.0%	97.6%	100.0%	100.8%	920	1.8	4.1	5.9
Ward 1	2193.8	2112.5	1162.5	1200	1519	1421	759.5	955.5	96.3%	103.2%	93.5%	125.8%	948	3.7	2.3	6.0
Ward 12	2288	2096	1984	1872	953.3	912.3	635.5	676.5	91.6%	94.4%	95.7%	106.5%	975	3.1	2.6	5.7
Ward 13	1716	1482	1488	1566	744	744	1116	1152	86.4%	105.2%	100.0%	103.2%	966	2.3	2.8	5.1
Ward 14	2168	1856	1984	2048	953.3	738	635.5	871.3	85.6%	103.2%	77.4%	137.1%	973	2.7	3.0	5.7
Ward 2	1806.3	1693.8	1550	1431.3	759.5	882	1139.3	1176	93.8%	92.3%	116.1%	103.2%	973	2.6	2.7	5.3
Ward 21b	1336.5	1044	1813.5	1820	775	775	775	1025	78.1%	100.4%	100.0%	132.3%	744	2.4	3.8	6.3
Ward 23	1238	1225.3	785.3	779	764.7	764.7	764.7	764.7	99.0%	99.2%	100.0%	100.0%	737	2.7	2.1	4.8
Ward 26	3343	3343	696.7	696.7	2775	2775	382.3	382.3	100.0%	100.0%	100.0%	100.0%	256	23.9	4.2	28.1
Ward 4	1716	1362	1860	1974	744	732	1488	1716	79.4%	106.1%	98.4%	115.3%	983	2.1	3.8	5.9
Ward 5	2325	1825	1550	1462.5	1519	1078	759.5	1102.5	78.5%	94.4%	71.0%	145.2%	977	3.0	2.6	5.6
Ward 6	1550	1668.8	1937.5	1956.3	1519	1163.8	759.5	967.8	107.7%	101.0%	76.6%	127.4%	847	3.3	3.5	6.8
Ward 7	1758.8	1496.3	1550	1925	759.5	747.3	1139.3	1506.8	85.1%	124.2%	98.4%	132.3%	956	2.3	3.6	5.9
Ward 9	1206	918	992	592	635.5	574	317.8	225.5	76.1%	59.7%	90.3%	71.0%	237	6.3	3.4	9.7
NICU	1924.6	1717.7	183.4	153.8	1782.5	1610	0	0	89.2%	83.9%	90.3%	-	250	13.3	0.6	13.9
Ward 11 SAU	1500	2077.5	930	1477.5	580.7	1058.4	580.7	1039.7	138.5%	158.9%	182.3%	179.0%	739	4.2	3.4	7.6
Ward 18 SSW	1351.3	1176.3	1162.5	1106.3	759.5	747.3	759.5	722.8	87.0%	95.2%	98.4%	95.2%	682	2.8	2.7	5.5
Ward 10 Ortho	2664	2288	3224	3296	953.3	943	1271	1373.5	85.9%	102.2%	98.9%	108.1%	1193	2.7	3.9	6.6

Experience Section:

Indicators	Last four months			
	Jul-18	Aug-18	Sep-18	Oct-18
Complaints received by month	10	21	16	17
Complaints being reviewed by the Ombudsman	0	0	0	0
Closed complaints by month	14	18	12	22
Contacts raising informal concerns	120	96	93	88
Compliments received in month	257	330	323	239
Number of new claims received in month	7	5	4	3
Number of claims closed	2	6	4	4
Number of inquests concluded	1	0	0	0
NHS Choices - Star Ratings (Leighton)	4.5	4.5	4.5	4.5
NHS Choices - Star Ratings (VIN)	5	5	5	5
NHS Choices - Number of new postings	6	10	6	4
F&FT Response Rate ED, MIU, UCC and Assessment Areas*	25%	25%	23%	24%
Proportion of positive responses ED, MIU, UCC and Assessment Areas	83%	85%	84%	85%
F&FT Response Rate Inpatients and day cases	34%	49%	62%	46%
Proportion of positive responses Inpatients and day cases	97%	96%	97%	96%
F&FT Response Rate Outpatients	4%	5%	3%	2%
Proportion of positive responses Outpatients	96%	96%	96%	96%
F&FT Response Rate Maternity - Birth	18%	18%	17%	12%
Proportion of positive responses Maternity - Birth	100%	99%	100%	100%
F&FT Response Rate Community (CCICP)	19%	12%	26%	11%
Proportion of positive responses Community (CCICP)	93%	92%	93%	96%

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

Description	Aggregate Position/Description	Trend
Monthly complaints received by the Trust.	17 complaints were received in October 2018 which covered 105 concerns. Of the categories, the highest categories were: • Communication • Nursing Care – Medication Delay/Other • Medical Care – Diagnosis Problems Highest 3 areas receiving complaints/issues were: • Emergency Department - 3 complaints/8 issues • Orthopaedic Medical Staff – 4 complaints/5 issues • Ward 14 – 2 complaints/11 issues •	 Formal Complaints
Number of formal complaint issues by division.	This graph shows the breakdown of issues by month for each division. S&C: 33 DCSS: 6 W&CD: 20 DMEC: 43 CCICP: 2 E&F: 0 Corporate Services: 1	 Formal Complaint issues by division

Description	Aggregate Position/Description	Trend

Complaints being reviewed by the Public Health Service Ombudsman

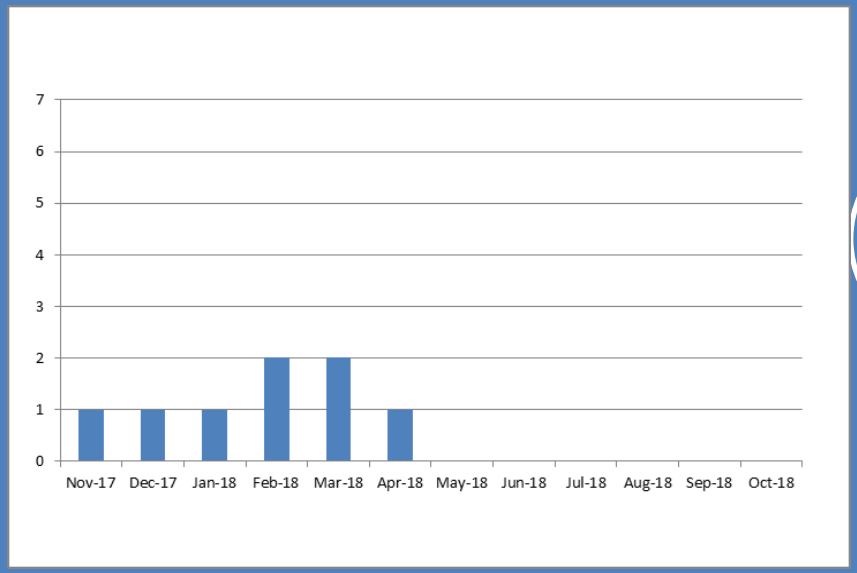
In October 2018, there were no new complaints raised with the PHSO.

1 case has now closed.

2 are provisionally now closed, awaiting outcome in writing.

1 case is waiting outcome of the review of complainants' comments on final report.

1 has been active since 2012/2013 and underwent a review external to the PHSO, update request 29/10/18.



Ombudsman

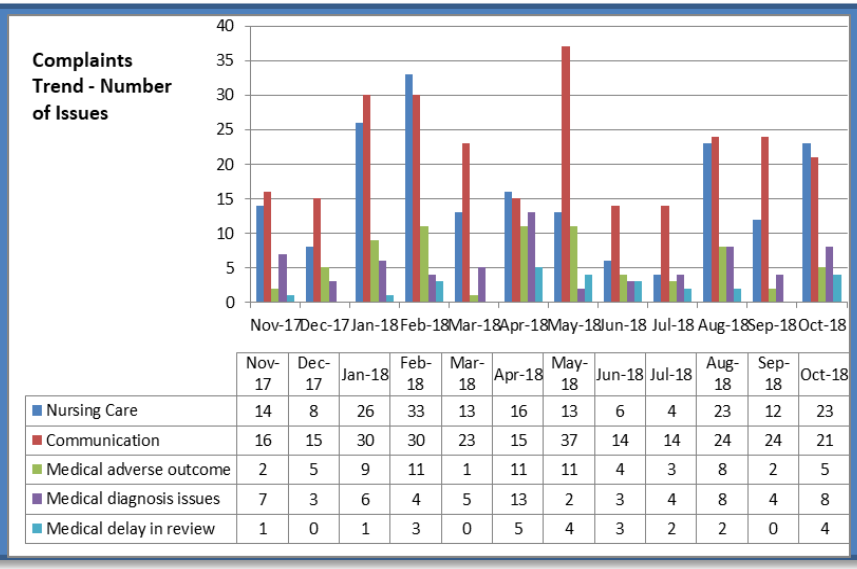
Complaint trends and number of issues.

The main trends in October 2018 were:

Nursing care - 9 complaints raising 23 issues.

Communication - 13 complaints raising 21 issues.

Medical care diagnosis - 5 complaints raising 8 issues.



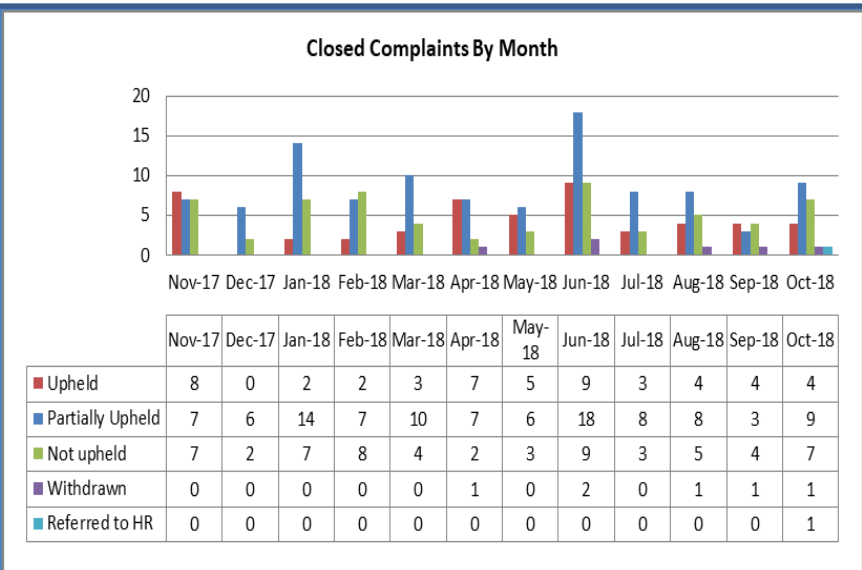
	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Nursing Care	14	8	26	33	13	16	13	6	4	23	12	23
Communication	16	15	30	30	23	15	37	14	14	24	24	21
Medical adverse outcome	2	5	9	11	1	11	11	4	3	8	2	5
Medical diagnosis issues	7	3	6	4	5	13	2	3	4	8	4	8
Medical delay in review	1	0	1	3	0	5	4	3	2	2	0	4

Complaint Trends

Description	Aggregate Position/Description	Trend

Closed Complaints

22 complaints were closed in October 2018.



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

Closed Complaints

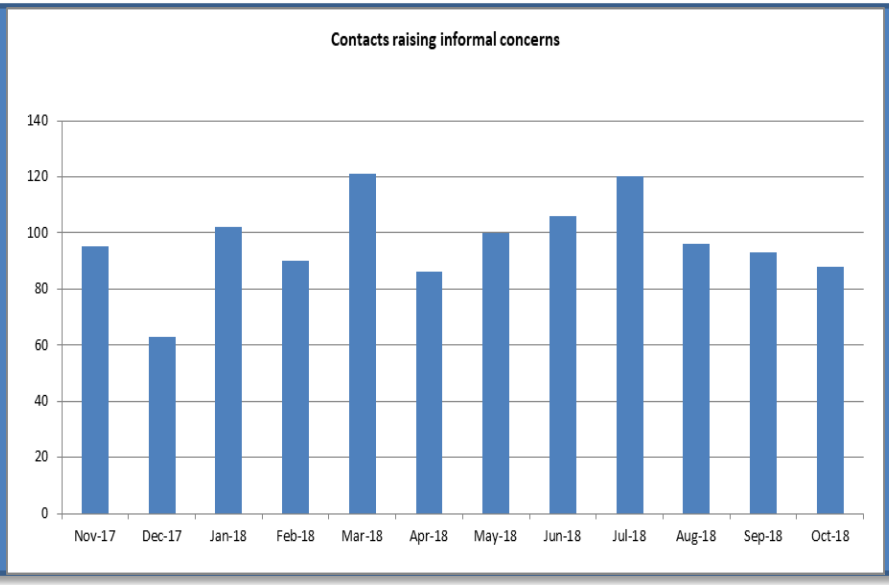
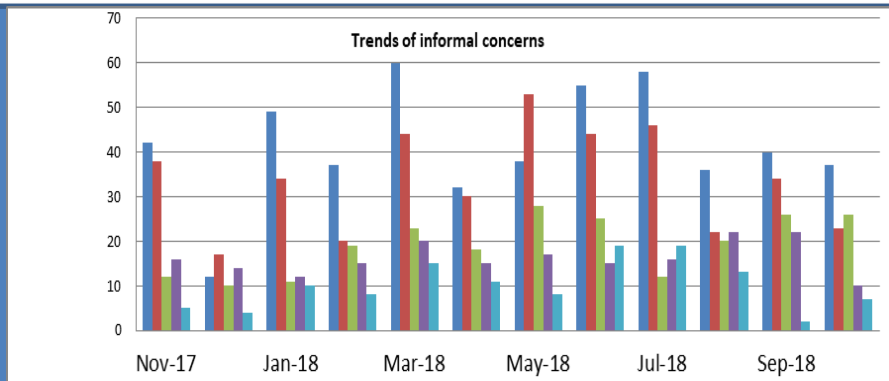
Closed Complaints by Division

The table provides a breakdown of closed complaints by division, demonstrating those complaints which were upheld, not upheld, partially upheld or referred to Human Resources

Division	Upheld	Partially Upheld	Not Upheld	Withdrawn	Ref HR	Sub-Total
DMEC	2	3	3	1	1	10
Corporate	1	0	0	0	0	1
Surgery and Cancer	0	5	3	0	0	8
Women & Children's	0	0	1	0	0	1
DCSS	1	0	0	0	0	1
CCICP	0	1	0	0	0	1
Totals:	**4**	**9**	**7**	**1**	**1**	**22**

CComplaints closed by division for October 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 October 2018 was 88 which is a reduction of 5 from the previous month. The Surgery and Cancer Division has received the largest number of individual concerns raised at 47, with 16 of these individual concerns relate to Orthopaedics and General Surgery respectively.	
Informal Concerns Trends.	Communication was the highest trend for informal concerns in October 2018, with 12 of the issues raised relating to the Surgery and Cancer Division. Of these 12 issues, 3 relate to ward 15. Of the 23 issues relating to care, 11 relate to the Division of Medicine and Emergency Care. Of these 11 issues, 5 relate to the emergency department, 3 being nursing care and 2 relating to medical care.	

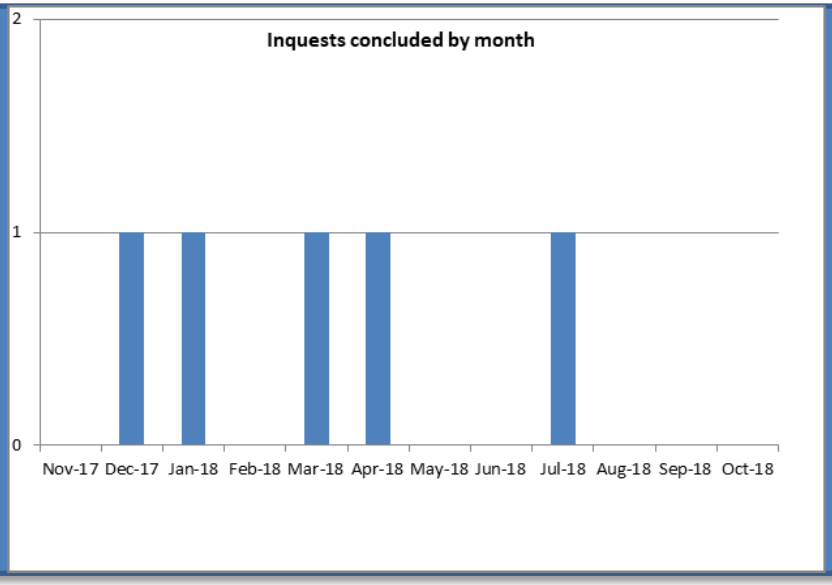
	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Communication	42	12	49	37	60	32	38	55	58	36	40	37
Care	38	17	34	20	44	30	53	44	46	22	34	23
Appointments	12	10	11	19	23	18	28	25	12	20	26	26
Attitude of Staff	16	14	12	15	20	15	17	15	16	22	22	10
Treatment	5	4	10	8	15	11	8	19	19	13	2	7

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
Claims closed with/without damages.	Narrative and Graph removed under Section 43 of the Freedom of Information Act.	Closed Claims

Description	Aggregate Position/Description	Trend
Value of claims closed by month	Narrative and Graph removed under Section 43 of the Freedom of Information Act.	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

Description	Aggregate Position /Description	Trend
Number of Inquests concluded by month	No inquests were concluded in October 2018.	
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 273 postings received to date.	

Inquests

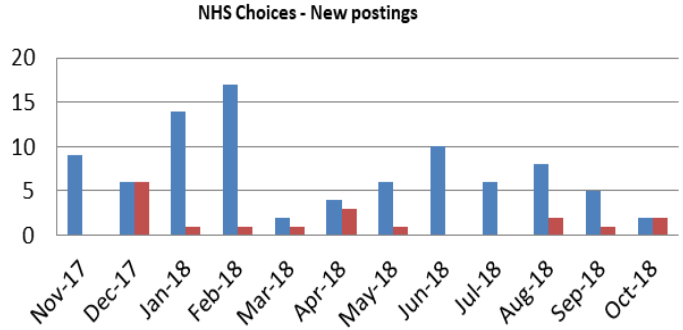
NHS Choices – Star Ratings

Description	Aggregate Position /description	Trend

NHS Choices postings

There were 2 were positive and 2 negative NHS Choices postings in October 2018. Example of positive posting:

My partner and I were seen several times at EPAU for early pregnancy scans and then management of our miscarriage. We must say the care, dignity and respect we were shown was truly first rate and made all the difference. Everything was explained to us very clearly, prompt actions were taken and the team did everything they could to be extremely thorough and careful with such a delicate situation. We were mainly treated by one particular member of staff and she was so caring and great at her job. She made us feel very involved, well cared for and in very safe experienced hands. We can't thank this member of staff and the EPAU team enough for the difference this made to our experience.



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

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

Inpatients and day cases 46%

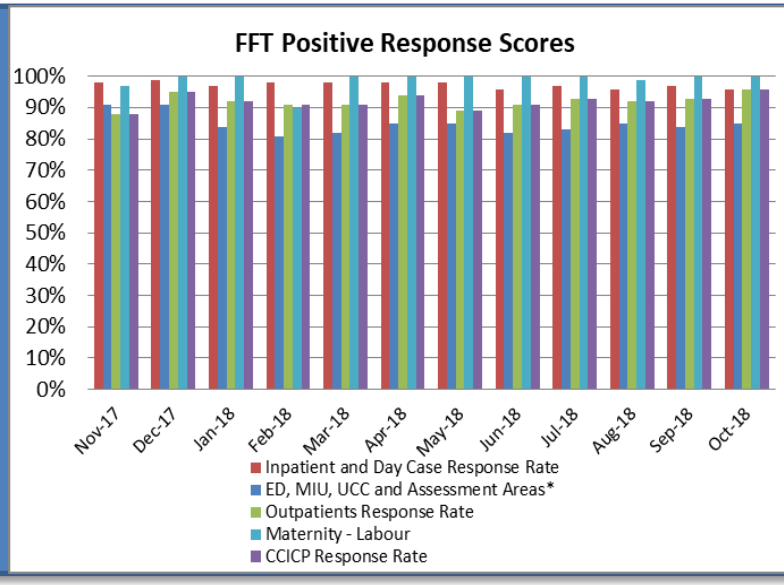
Emergency care /assessment areas 24%

Outpatients 2%

Maternity 12%

CCICP 11%

4384 responses were received and 92% of those patients would recommend our hospital services.

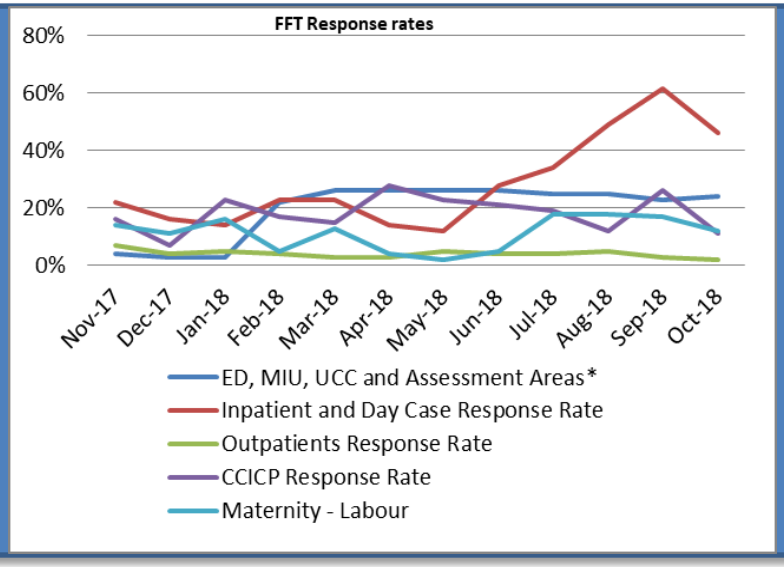


Family & Friends Test

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

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

October 2018 Ward/Dept.	% Response	Total responses received	How many would recommend
A&E , UCC & MIU	24%	1735	85%
Inpatients & Day cases	46%	1869	96%
Maternity	12%	110	97%
Outpatients	2%	485	96%
CCICP	11%	185	96%

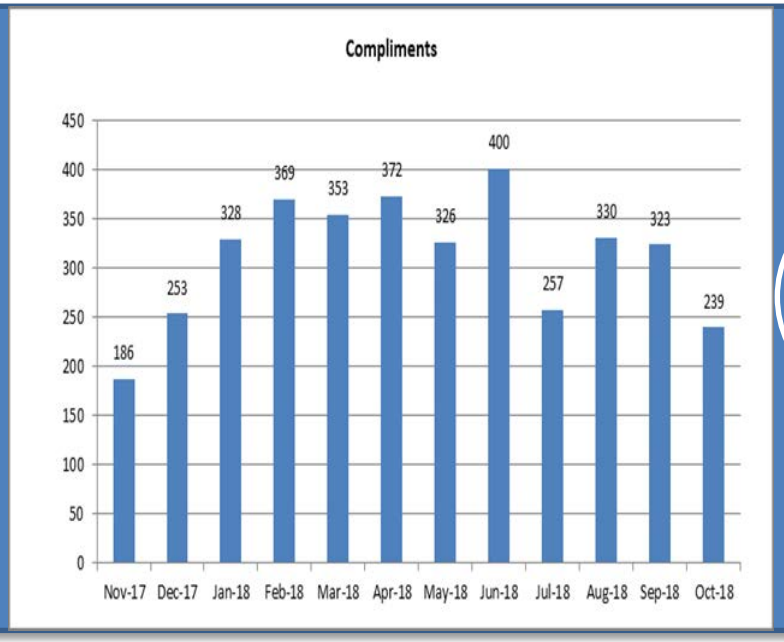


Family & Friends Test

Compliments received

There were 239 compliments received in October 2018. 66 of these were logged by the Customer Care Team and 173 received across the Trust.

'I attended the midwife triage unit and cannot praise the midwife enough for her standard of care and calming and caring nature. I was quite upset coming in but she immediately made me feel at ease, explaining the plan to find out if anything was wrong with my baby. Luckily everything was normal but I was so grateful to have someone who cared as seriously as me about my baby'.



Compliments

Improvement Plan

CQC Quality Report
September 2018

'Delivering Excellence in Healthcare through Innovation and Collaboration'

1. Purpose of this document

Following the CQC inspection in May 2018, the trust was accredited with, and maintained its *"Good"* rating. This Improvement Plan addresses the findings following the inspection and included in the Inspection report and evidences the completion and ongoing monitoring, where required, of the "Must' and *" Should"* actions required to improve services and patient safety within the Trust. This plan will be managed by the Quality Summit group and monitored at the Executive Quality Governance Group for assurance and escalation.

2. Process for monitoring and escalation of benchmark / gap analysis / improvement plan

The overall **Current Progress Rating** will be rated as follows, which shows our position against the improvement planned:

Current Progress Rating		
Colour	**Narrative**	**Description**
B	Blue "Complete/business as usual (BAU)"	Completed: Improvement / action delivered with sustainability assured.
G **(a or b)**	Green "On track"	Improvement on trajectory either: a) On track – not yet completed b) On track – not yet started)
A	Amber "Problematic"	Delivery remains feasible, issues / risks require additional intervention to deliver the required improvement e.g. Milestones breached.
R	Red "Delayed"	Off track / trajectory – milestone / timescales breached. Recovery plan required.

Introduction

This Improvement Plan addresses the findings following the CQC Inspection in May 2018 and evidences the completion and ongoing monitoring, where required, of the Must" and "Should" actions required to improve services and patient safety within the Trust. This plan will be managed by the Quality Summit Group and monitored at the Executive Quality Governance Group for assurance and escalation.

Standard/Process/ Issue/ Recommendation		Improvement Required (What does good look like?)	Executive / Responsible Lead	Division / Core Service	Milestones/ Timescales (by end of)	Current Progress Rating	Responsible Committee/ Group	Evidence (What evidence will be provided to demonstrate sustainable improvement?)
1.	Ensure there is the appropriate number of trained staff to look after children in the emergency department.	a) Further recruitment of the RN (Child) position will take place as part of the wider workforce plan. b) Scope out the opportunity for rotational post from the Children's Department as part of the ongoing workforce development and recruitment days.	**Director of Nursing & Quality (Director of N&Q)** Head of Nursing (HoN)	DMEC – Urgent & Emergency Care	January 2019	On track (not yet completed)	**Quality Summit**	ED currently employs 4.0 WTE paediatric trained registered nurses out of a required total of 5.7 WTE. Recruitment days were held on; • 28 March 2018 • 2nd May 2018 • 31st May 2018 (ED practitioner) • 5th June 2018 (Advanced practitioner) Recruitment days resulted in recruitment of 3 RSCNs, including 1 Advanced Nurse Practitioner. There are 2 nurses as a minimum on every shift trained in APLS, EPALS or PILS. There is a Consultant lead for paediatric services and very good support is provided by paediatric services as required. The Trust has scoped paediatric

Standard/Process/ Issue/ Recommendation		Improvement Required (What does good look like?)	Executive / Responsible Lead	Division / Core Service	Milestones/ Timescales (by end of)	Current Progress Rating	Responsible Committee/ Group	Evidence (What evidence will be provided to demonstrate sustainable improvement?)
								training - an assessment course has been extended to the AMP's and this will be a 2 year course. The Emergency Department is scoping for a play leader through an apprenticeship programme. There has been a review of the Emergency Department and a management of change has been undertaken, including leadership of the department.
2. 3.	Ensure the Emergency Department controls the risk of infection risk and keeps themselves, equipment and the premises clean. Ensure that processes are in place to monitor infection, prevention and control effectively.	a) Include in the senior safety checks. Cleaning rota developed.	**Director of N&Q** Head of Facilities	DMEC – Medical Care W&C – Maternity CCICP - CYP	December 2018	On track (not yet completed)	**Quality Summit**	The cleaning schedule for the Emergency Department has been reviewed with additional hours allocated to the 22.00-6.00 shift to provide capacity to respond to any ad hoc cleaning requests in the Emergency Department and other areas. A check of the toilets and waiting areas in the Emergency Department is carried out every night.  PAS - Work Schedule A&E V2 (All Areas).d In addition to the review of hours

Standard/Process/ Issue/ Recommendation	Improvement Required (What does good look like?)	Executive / Responsible Lead	Division / Core Service	Milestones/ Timescales (by end of)	Current Progress Rating	Responsible Committee/ Group	Evidence (What evidence will be provided to demonstrate sustainable improvement?)
							and schedules there are regular walk rounds of the Emergency Department by a member of the cleaning management team and the Housekeeper. Actions are recorded and signed off. Record of actions from ED walk rounds. A&E C4C audit score sheet for sept-18.pdf C4C returned cleaners actions for s C4C returned nursing&dept staff ac CCICP are developing a Standard Operating Procedure for decontamination of equipment and have implemented weekly cleaning rotas. weekly cleaning rota.docx Quality visit schedules have been implemented into CCICP which will incorporate infection control reviews. Quality Visits 2018-19.xlsx

Standard/Process/ Issue/ Recommendation	Improvement Required (What does good look like?)	Executive / Responsible Lead	Division / Core Service	Milestones/ Timescales (by end of)	Current Progress Rating	Responsible Committee/ Group	Evidence (What evidence will be provided to demonstrate sustainable improvement?)
							Head of Midwifery/Nursing to undertake spot check audit on back to floor days.  Spot Check Tick Sheet Template Paedi  Comments Template Paediatrics 27-09-18. Antenatal clinic are in the process of developing a cleaning rota. Senior safety checklists to be implemented November 2018.
	b) Effective and appropriate handwashing.	**Director of N&Q** Matrons		October 2018	BAU	**Quality Summit**	Divisional handwashing audits are monitored through Executive Infection Control Group.  Performance Report-September 20 CCICP hand hygiene audits to be submitted to IPC quarterly.  community hand hygiene tool 2018.do
	c) Ensure that staff adhere to the Uniform Policy:-	**Director of N&Q** Matrons		October 2018	BAU	**Quality Summit**	Revised uniform policy launched in September 2018.

Standard/Process/ Issue/ Recommendation		Improvement Required (What does good look like?)	Executive / Responsible Lead	Division / Core Service	Milestones/ Timescales (by end of)	Current Progress Rating	Responsible Committee/ Group	Evidence (What evidence will be provided to demonstrate sustainable improvement?)
		• Bare below the elbows • Nail varnish • Acrylic nails Uniform including scrubs.						Uniform policy.pdf Uniform and Dress Code Policy Chief Exe Uniform policy observational audits undertaken monthly within DMEC Example of DMEC ward audits; Ward 4 Corporate Image 6.9.18.pdf AMU Corporate Image 7.9.18.pdf Uniform policy observational audits undertaken within W&C and monitored at ward manager and governance meetings. W&C uniform checks (1).xlsx Uniform observational studies undertaken as part of CCICP Quality visits.
4.	Ensure that sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed on duty	Ensure adequate staffing with the right qualifications, skills, training and experience to keep people safe from avoidable harm.	**Director of N&Q** Divisional Triumvirate	DMEC – Medical Care	October 2018	Complete BAU	**Quality Summit**	Strategic Safe Staffing paper & acuity reviews reported to Executive Board. Strategic Staffing Review Report Octob Quality Safety and Experience Board Rep

Standard/Process/ Issue/ Recommendation		Improvement Required (What does good look like?)	Executive / Responsible Lead	Division / Core Service	Milestones/ Timescales (by end of)	Current Progress Rating	Responsible Committee/ Group	Evidence (What evidence will be provided to demonstrate sustainable improvement?)
	to maintain the comfort and safety of patients.							Divisional daily Safe Staffing meeting undertaken and gaps escalated appropriately.  LHRPS2_MFDXVD00849_0379_001.pdf Monthly staffing incident report generated by divisions. Weekly commitment by the Heads of Nursing to oversee staffing issues and exceptions report.
5.	Ensure that procedures are clear and consistently applied, in accordance with the Mental Health Act 1983 and the Mental Capacity Act 2005, for identifying, assessing, and recording the needs of patients	a) New green folders distributed to all wards/areas. The folders contain records required for assessment of capacity including the two stage process, the application of DoLS and	**Director of N&Q** Deputy Director of Nursing & Quality (N&Q) / Privacy and Dignity Matron	DMEC – Medical Care	October 2018	Complete BAU	**Quality Summit**	Immediately following this concern an initial assessment of clinical areas was undertaken to ensure that records were in place to identify the assessment of patient's capacity as required. These audits clarified the CQC Inspectors findings as current practice is to hold the documentation centrally rather than in the patients' records. Audit completed- actions to be addressed. Audits continue fortnightly as part of

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who lack capacity.	documentation of best interests and best interest decisions made. These decisions will include the criteria for the use of bed rails and documented evidence that the decision to enact a DNACPR is completed with full consent. This suite of documents all support the Trust's Mental Health process.						the Senior team walkabout. Action 5 MCA_DOLs_BI Snaps As of the end of May 2018, every ward has a green folder or access to a folder. This includes Elmhurst, VIN and CCICP. All the documents contained within the folder are on the intranet to download 6 monthly compliance report scheduled to Executive Safeguarding Group Letter to Medical Staff Letter re MCA DOLS 23.04.18.doc **Closed**
	b) An experiential learning video to be developed for all disciplines about the	**Director of N&Q** Deputy Director of N&Q / Privacy and Dignity	DMEC – Medical Care	January 2019	On track (not yet completed)	**Quality Summit**	The training video will be launched at the next Vulnerable Adults study day in January 2019

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		Mental Capacity Act 2005, the Deprivation of Liberty Safeguards and Best Interests process.	Matron					
6.	Ensure patient records are accurate, contemporaneous, maintained securely at all times and undertake regular audits of records keeping.	Regular audits to establish the accuracy and security of patient health records.	**Director of Strategic Partnerships and Director of N&Q** Divisional Triumvirate	DMEC – Medical Care CCICP – Adult CCICP – CYP W&C – CYP	January 2019	On track (not yet started)	**Quality Summit**	Introduction of new Key Performance Indicator (KPI) quality metric measurement tool and ward accreditation system to be launched December 2018. Quality Community documentation audit to be reviewed and revised audit process to be embedded into CCICP by December 2018.
7.	Ensure that the World Health Organization (WHO) maternity five steps to safety surgery checklist is completed fully in theatre.	WHO steps are incorporated within the LocSSIP. To be reviewed and implemented.	**Director of N&Q** Midwifery Matron	W&C Maternity	November 2018	BAU	**Quality Summit**	Observational audits of LocSSIPs. 2367 WHO Gynae DCT 2018-19.xlsx 2142 WHO Maternity DCT 2018-19 V2 Jul1 Actions are monitored through the Obstetrics & Gynaecology Quality Improvement meetings. Minutes available on request.

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8.	Review the arrangements for the care and treatment of children in the department.	Internal review of the care of children in ED.	**Director of N&Q and Medical Director** ED Service Manager	VIN – MIU DMEC - ED	July 2018	**Complete**	**Quality Summit**	Internal review completed. Improvement plan being managed by ED Senior Team. The action plan is reported at Executive Quality Governance Group. Ref 8 IP ED Review (August 2018) JP Ver **Closed**
9.	Undertake regular, local audits to assess, monitor, evaluate and improve practice, including regular effective hand hygiene audits.	Establish a programme of regular audit/monitoring.	**Director of Strategic Partnerships and Director of N&Q** Divisional Triumvirate	CCICP – Adult CCICP – CYP W&C – CYP	October 2018		**Quality Summit**	Refer to Action 2b (Duplicated)
10.	Ensure that accurate, up to date, contemporaneous data collection is undertaken in relation to activities provided to patients.	Ensure that all data is entered in a timely manner and audited.	**Director of Strategic Partnerships and Director of N&Q** Divisional General Managers / Divisional Triumvirate	CCICP – Adult CCICP – CYP W&C – CYP	Commence October 2018		**Quality Summit**	Refer to Action 6 (Duplicated)

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11.	Consider integrated patient records to ensure up to date, MDT care pathways and care plans.	Provide assurance that a multidisciplinary approach to care and treatment is documented effectively and records are clear and concise representation of clinical care given across different specialities.	**Director of Strategic Partnerships and Director of N&Q** Associate Director of CCICP / Head of Quality, Nursing and Professional Leadership Divisional Head of Nursing	CCICP – Adult CCICP – CYP W&C – CYP	Commence November 2018	**On track (not yet started)**	**Quality Summit**	Quality Community documentation audit to be developed and implemented and plan embedded into CCICP. Results to be monitored at CCICP board. The Care Community Assessment template is available upon request. Scoping of patient records for the Home Care Team to utilise one set of records for each patient.
12	Ensure that all risk assessments and monitoring tools are completed in a timely manner and are up to date.	Review documentation to enable MDT pathways and care plans.	**Director of Strategic Partnerships and Director of N&Q** Associate Director of CCICP / Head of Quality, Nursing and Professional Leadership / Quality and Safety Lead	CCICP – Adult CCICP – CYP W&C – CYP	Commence November 2018	**On track (not yet started)**	**Quality Summit**	Quality Community documentation audit to be developed and implemented and plan embedded into CCICP. Results to be monitored through CCICP board. Example of Paediatric Speech & Language Therapy Risk Matrix;  Risk matrix and TOMS info.docx W&C - Currently being reviewed as

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			Divisional Head of Nursing					part of the C&YPHCT 'service review' planned for completion January 2019.
13.	Ensure that all patient care plans are up to date and accurate.	Review documentation to enable MDT pathways and care plans.	**Director of Strategic Partnerships and Director of N&Q** Associate Director of CCICP / Head of Quality, Nursing and Professional Leadership / Quality and Safety Lead Divisional Head of Nursing	CCICP – Adult CCICP – CYP W&C – CYP	Commence November 2018	**On track (not yet started)**	**Quality Summit**	Quality Community documentation audit to be developed and implemented and plan embedded into CCICP. Results to be monitored through CCICP board. C&YPHCT currently updating the care planning process.
14.	Ensure that all serious incidents are reported and investigated in a timely manner, in	Ensure process is reviewed in line with Trust policy.	**Director of Strategic Partnerships and Director of N&Q**	CCICP – Adult CCICP – CYP	October 2018	**Complete BAU**	**Quality Summit**	All serious incidents discussed at fortnightly Patient Safety Summit meetings, with cross divisional representation. Newsletter containing lessons learnt

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	order to identify themes, disseminate lessons learnt and take action to improve safety.		Head of Quality, Nursing and Professional Leadership Divisional Triumvirate	W&C – CYP				disseminated to staff. 14. Patient Safety Summit Action Points 14. Safety Matters Edition 24 V1.pdf
15	Ensure that all medication prescription charts are up to date and accurate and that medication errors are reported as serious incidents and investigated appropriate.	Monitoring of medication omission audits within the acute Trust and scoping of review process for CCICP.	**Director of Strategic Partnerships and Director of N&Q** Head of Quality, Nursing and Professional Leadership Divisional Triumvirate	CCICP – Adult CCICP – CYP W&C – CYP	November 2018	**On track (not yet completed)**	**Quality Summit**	Ulysses reports and managers investigations undertaken for CCICP - incident reports of omitted doses discussed at Safe Medicines Practice Group and overseen and investigated when required by Head of Pharmacy. CCICP Medication Incidents for previous Prescribing and omitted dose audit discussed at Governance meetings.
16.	Ensure that all staff complete mandatory training, including safeguarding training, in line with Trust targets.	Review process and ensure all staff attend mandatory training in line with Trust required targets.	**Director of Strategic Partnerships and Director of N&Q** Head of Quality, Nursing and	W&C Maternity CCICP – Adult CCICP –	October 2018	**BAU**	**Quality Summit**	CCICP training compliance trajectory against training matrix. Training Matrix 2018-19.doc W&C divisional mandatory training policy in place. Quarterly and

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			Professional Leadership Divisional Triumvirate	CYP W&C – CYP				annual training reports monitored at Divisional Governance & Workforce Group.   WC Mandatory Training Guideline V3 WC Annual Training Report 2017-18 Impr
17.	Ensure there is adherence to a centralised system in place for all staff to access if there is a safeguarding concern.	CCICP to ensure a delivery plan.	**Director of Strategic Partnerships and Director of N&Q** Head of Quality, Nursing and Professional Leadership Divisional Triumvirate	CCICP – Adult CCICP – CYP W&C – CYP	October 2018	**On track (not yet completed)**	**Quality Summit**	Safeguarding policy and flow charts in place.   Safeguarding Flowchart - Version A Safeguarding Adult Flow Chart May 2018
18.	Ensure the safety of CCICP staff in home and community settings.	Ensure that all teams have effective systems in place to protect staff who work alone.	**Director of Strategic Partnerships and Director of N&Q** Head of Quality, Nursing and Professional Leadership / Head of Health& Safety Divisional Head	CCICP – Adult CCICP – CYP W&C – CYP	December 2018	**On track (not yet completed)**	**Quality Summit**	CCICP to adopt MCHFT lone working policy and have localised SOP in place developed for lone working. Draft Policy developed and due for approval November 2018.  CCICP SOP - Care Community Lone Wo Quality Visits to review process and its robustness.

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			of Nursing					Community midwifery risk assessment for Lone Worker to be amended to include C&YPHCT. Community midwifery risk assessment in place. Risk Assessment lone working commu
19.	Ensure all staff understand the Mental Capacity Act and their role in making decisions in a patient's best interest.	a) New green folders distributed to all wards/areas. The folders contain records required for assessment of capacity including the two stage process, the application of DoLS and documentation of best interests and best interest decisions made. These decisions will include the	**Director of N&Q** Deputy Director of N&Q / Privacy and Dignity Matron	DMEC – Medical Care / Urgent & Emergency Care VIN	October 2018	On track (Started))	**Quality Summit**	Refer to Action 5 (Duplicated)

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		criteria for the use of bed rails and documented evidence that the decision to enact a DNACPR is completed with full consent. This suite of documents all support the Trust's Mental Health process.						
		b) An experiential learning video to be developed for all disciplines about the Mental Capacity Act 2005, the Deprivation of Liberty Safeguards and Best Interests process.	**Director of N&Q** Deputy Director of N&Q / Privacy and Dignity Matron	DMEC – Medical Care / Urgent & Emergency Care VIN	October 2018	**On track (Started)**	**Quality Summit**	Refer to Action 5 (Duplicated)

Standard/Process/ Issue/ Recommendation		Improvement Required (What does good look like?)	Executive / Responsible Lead	Division / Core Service	Milestones/ Timescales (by end of)	Current Progress Rating	Responsible Committee/ Group	Evidence (What evidence will be provided to demonstrate sustainable improvement?)
20.	Ensure patients have access to food and water whilst in the Emergency Department.	Devise plan to ensure patients have access to food and water whilst in the Emergency Department.	**Director of N&Q** Head of Nursing /Matrons	DMEC – Urgent & Emergency Care VIN	October 2018	**Complete BAU**	**Quality Summit**	Nursing admissions safety checklist implemented in Emergency Department as separate documentation. Safety checklist ensures refreshments offered to patients. Safety checklist to be embedded into the revised CAS Card.
21	Ensure there is accessible/easy read information in Emergency Department.	Devise plan to ensure there is accessible / easy read information in the Emergency Department.	**Chief Operating Officer** Divisional General Managers / Divisional Triumvirate	DMEC – Urgent & Emergency Care	December 2018	**On track (not yet completed)**	**Quality Summit**	Emergency Department Exploring 'Eido 'leaflet range available to the Trust. Progress Update by end of December 2018.
22.	Ensure the mental health assessment room meets the recommendations of the Royal College of Psychiatrists in relation to protecting patient's privacy and dignity and ensuring the room is free from ligature points.	Devise plan to ensure the mental health assessment room meets the recommendations required.	**Chief Operating Officer** Divisional General Manager DMEC	DMEC – Urgent & Emergency Care	November 2018	**On track (not yet completed)**	**Quality Summit**	Emergency Department improvement plan developed to monitor compliance. MCHFT Benchmark Gap Analysis - Mental

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23.	Review the memorandum of understanding for the Mental Health Act administration as this expired on 31 December 2017.	Service Level Agreement to be updated and agreed.	**Director of Finance / Director of N&Q**	DMEC – Urgent & Emergency Care	December 2018	**Complete**	**Quality Summit**	New SLA in place.
24.	Ensure that all hazardous fluids are stored safely in a cupboard within sluice rooms when not in use.	Division to review and adhere to COSHH regulations.	**Director of N&Q** Divisional Triumvirate	DMEC – Medical Care W&C Maternity CCICP - Adults	November 2018	**On track (not yet completed)**	**Quality Summit**	Direction from IPC is to ensure that the large vat of Tristal is to be stored in the locked cleaners' cupboard. Staff access this to fill the decant bottles as required. The decant bottles are placed in a cupboard in the sluice when not in use. Compliance monitored at weekly senior nurse walkabouts. A scoping exercise will be undertaken to look at using wipes which would reduce the need to have chemicals in the sluice by December 2018. Spot check audits carried out in W&C which shows 100% compliance. W&C Spot Check Audits Obs and Gyna W&C Spot Check Audits Paeds.pdf

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25.	Ensure that all staff receive an appraisal every 12 months, which includes providing education and training opportunities to provide high quality care and enhance professional development.	Trust policy to be followed to ensure that all staff receive an annual appraisal.	**Director of N&Q** Divisional Triumvirate	DMEC – Medical Care VIN - MIU W&C – Maternity W&C - CYP CCICP- CYP	October 2018	**BAU**	**Quality Summit**	Appraisal data monitored at the W&C Divisional Workforce Group CCICP Community Care Managers have proactive plan in place for appraisal reviews. DMEC monitor appraisal data through the workforce report. Monitored through the DMEC workforce committee. Data available upon request.
26.	Ensure that all staff have all competencies checked annually.	All staff should receive an annual appraisal and a discussion about competencies if relevant.	**Director of N&Q and Director of Strategic Partnerships** Divisional Triumvirate	DMEC – Medical Care VIN – MIU W&C – Maternity / W&C – CYP CCICP – CYP	**December 2018**	**BAU**	**Quality Summit**	All staff have competencies checked as part of their appraisal process where appropriate. Appraisal data monitored at Divisional Workforce Group as per action point 25 and reviewed locally at ward performance reviews. Task specific competency documents in development for CCICP.  MEDICINE Assessment Communi  CATHETERISATION Competency Doc Pae

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27.	Ensure that complaints are reviewed and responded to within the required 30 day timescale.	Complaints to be reviewed and an improvement trajectory set for compliance to responding within a 30 day timescale.	**Director of N&Q** Divisional Triumvirate	DMEC – Medical Care W&C - Maternity	December 2018	**On track (not yet completed)**	**Quality Summit**	Policy in place for Complaints and Concerns Handling  27. Complaints and Concerns Handling Pc Peer review completed and scoping actions.
28.	Ensure that all equipment is maintained / serviced appropriately.	A process should be in place to ensure that all medical equipment is regularly maintained / serviced.	**Chief Executive Officer** Director of Estates & Facilities	W&C - Maternity CCICP – CYP W&C - CYP	October 2018	**On track (not yet completed)**	**Quality Summit**	Trust process for the Maintenance and servicing of medical equipment ensures; Yearly EBME list of all equipment requiring test/service sent to wards / departments. Monthly further e -mails sent out listing which pieces of equipment are due for test/service that month. Following the scheduled test/service a further e-mail is sent out listing which pieces of equipment have not been tested. Spot check audits carried out in W&C which shows 100% compliance

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								 W&C Spot Check Audits Obs and Gyna  W&C Spot Check Audits Paeds.pdf CCICP Medical equipment inventory for each locality to be developed and a robust process in place for ensuring equipment is cleaned and pat tested and calibrated. Quality visits to review robustness of process.
29.	Ensure staff receive face-to-face moving and handling training.	Produce a programme to ensure that all staff receive face to face moving and handling training.	**Director of Strategic Partnerships** Health & Safety Lead	CCICP - Adult	October 2018	**BAU**	**Quality Summit**	Evidence of staff trained and ongoing plan developed. Four sessions booked weekly for the next three months with 8 staff to attend the sessions. After three months further sessions to be booked.
30.	Continue to promote a positive culture of incident reporting to ensure staff are identifying and raising patient safety incidents appropriately.	Ensure that all staff are aware and have access and training, where appropriate, for completion of incident reporting.	**Director of Strategic Partnerships and Director of N&Q** Divisional Triumvirate	CCICP - Adult	February 2019	**On track (not yet completed)**	**Quality Summit**	Ulysses training plan in place for CCICP. Evidence of increase in reporting culture is being developed.

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31.	Review access to and the use of information technology systems in the community.	Review of IT Systems.	**Director of Strategic Partnerships** Associate Director of IT	CCICP - Adult	December 2018	**On track (not yet completed)**	**Quality Summit**	CCICP IT programme concluded October 2018. Development and implementation of EMIS Community System is in place. EMIS Training Plan v.01.pdf
32.	Ensure consistency in patient record keeping. Treatment plans should be fully personalised, holistic and provide sufficient information to inform patients, their families and carers of the care and treatment provided.	Devise plan to review documentation to enable MDT pathways and care plans.	**Director of Strategic Partnerships** Associate Director of CCICP / Head of Quality, Nursing and Professional Leadership	CCICP - Adult	January 2019	**On track (not yet started)**	**Quality Summit**	Quality Community documentation audit to be developed and implemented and plan embedded into CCICP by January 2019.
33.	Review medicines management, prescribing and administration procedures and policies to ensure patients are being kept safe within	Devise plan to review medicines management, prescribing and administration procedures and policies.	**Director of Strategic Partnerships and Director of N&Q** Head of Quality, Nursing and	CCICP - Adult	December 2018	**On track (not yet completed)**	**Quality Summit**	Review of policies as follows; Controlled Drugs Policy for CCICP implemented August 2018 33. CCICP CD policy V1.pdf

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	CCICP.		Professional Leadership / Community Services Pharmacist					Draft CCICP insulin Policy September 2018  Administration of Insulin Policy.doc Draft Medicine code policy October 2018.  OCTOBER CODE.doc McKinley pump policy January 2017  Use of McKinley T34 Policy V2 (4).pdf Annual Community medication competency developed and to be rolled out for all qualified staff in CCICP.
34.	Offer clinical supervision to ensure staff are fit for purpose and developing safe practice.	Document to be developed to describe the current process for clinical supervision which will be	**Director of N&Q** Deputy Director of N&Q / Assistant	CCICP – Adult	December 2018	**On track (Not yet started)**	**Quality Summit**	Scoping of clinical supervision document December 2018. MDT Clinical supervision documents available in CCICP.

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		implemented Trust wide.	Director of OD and Education					clinical supervision form.2016.doc Frequency of supervision - Vale Ro Frequency of supervision - SALT.dc
35.	Continue to review all community services to ensure adequate workforce capacity to provide a high quality of service.	Devise plan to ensure adequate workforce capacity to provide a high quality of service.	**Director of Strategic Partnerships and Director of N&Q** Head of Quality, Nursing and Professional Leadership and Divisional Lead Nurse	CCICP – CYP W&C - CYP	December 2018	**BAU**	**Quality Summit**	Refer to Action 4 (Duplicated)
36.	Ensure that all daily fridge temperatures are recorded clearly and concisely.	Ensure and monitor daily checks on cleanliness and temperature of all fridges in the department.	**Director of Strategic Partnerships and Director of N&Q** Divisional Triumvirate	CCICP – CYP W&C - CYP	December 2018	**On Track (not yet completed)**	**Quality Summit**	Monitored as part of the W&C spot check audits. Spot Check Tick Sheet Template Obs Spot Check Tick Sheet Template Paedi Further audit will be included following introduction of the new KPI quality metrics in December 2018.

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								CCICP Quality Visits to ensure process is robust.  Appendix 3 Fridge temperature check.dc
37.	Continue to review the service provision of the homecare team, in order to provide a 24 hour, seven day a week service.	Review the service provision of the homecare team, in order to provide a 24 hour, seven days a week service.	**Director of N&Q** Divisional General Manager / Divisional Lead Nurse	W&C – CYP	January 2019	**On track (not yet completed)**	**Quality Summit**	Palliative care gap analysis due for completion end of January 2019.
38.	Continue to review the opportunity to develop an acute hospital to home service, within the homecare team.	Review the opportunity to develop an acute hospital to home service, within the homecare team.	**Director of N&Q** Divisional General Manager / Divisional Lead Nurse	W&C – CYP	January 2019	**On track (not yet completed)**	**Quality Summit**	Currently being reviewed as part of the C&YPHCT 'service review' planned for completion January 2019.
39.	Review administration support available to ensure accurate and timely data entry as well as ensuring projects and care plans remain on target.	Devise plan to review administration support.	**Director of Strategic Partnerships and Director of N&Q** Associate Director of CCICP / Head of Quality,	CCICP – CYP W&C - CYP	December 2018	**On track (not yet completed)**	**Quality Summit**	CCICP Admin management of change.  Admin final MOC paper -Version 1.0.pc

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			Nursing and Professional Leadership Divisional General Manager / Divisional Lead Nurse					
40.	Ensure that all policies are up to date	Devise a plan to ensure that all policies are up to date	**Director of Strategic Partnerships and Medical Director** Associate Director of CCICP / Head of Quality, Nursing and Professional Leadership	CCICP – CYP W&C - CYP	February 2019	**On track (not yet started)**	**Quality Summit**	CCICP policies review to commence November 2018 process aligned to Information Governance meetings.
41.	Develop an escalation policy when children become unwell in the community setting for the Homecare team after 4.30pm weekdays and	Develop Escalation policy when children become unwell in the community setting.	**Director of Strategic Partnerships** Associate Director of CCICP / Head of Quality, Nursing and	CCICP – CYP W&C - CYP	March 2019	**On track (not yet started)**	**Quality Summit**	CCICP to scope Paediatric Early Warning Score from Women and Children division to be reviewed to determine if it will fit with CCICP. W&C SOP to be completed to reflect this recommendation. Current escalation process will be

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	weekends.		Professional Leadership Divisional General Manager / Divisional Lead Nurse					dependent on situation; the team / parent / carer will contact GP, 111 or 999.
42.	Continue to review and action outcomes from the most recent staff survey.	Divisional action plans to review and action outcomes from the staff survey.	**Director of Strategic Partnerships and Director of N&Q** Assistant Director of OD & Education / HR Managers	CCICP – CYP W&C - CYP	November 2018	**BAU**	**Quality Summit**	All divisions have developed an action plan, monitored through divisional board meetings.
43.	Develop strategies to improve the friends and family response rates.	Devise a plan to improve the friends and family response rates in specific specialities.	**Director of Strategic Partnerships and Director of N&Q** Divisional General Managers / Divisional Triumvirate	CCICP – CYP W&C - CYP	December 2018	**On track (not yet completed)**	**Quality Summit**	Text messaging service launched in all divisions in October 2018. Monitored as part of the Patient Experience Strategy due for approval November 2018.  PPI Strategy 2018-19 V2.docx Friends and Family embedded within EMIS for CCICP.

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44.	Ensure that patients and their families know how to and are comfortable to, make a complaint or raise a concern and that complaints are handled effectively to ensure openness, transparency, confidentially with regular updates to the complaint in a timely manner.	Ensure the current Trust process is provided and adhered to as per policy.	**Director of Strategic Partnerships and Director of N&Q** Divisional General Managers / Divisional Triumvirate	CCICP – CYP W&C - CYP	October 2018	**BAU**	**Quality Summit**	Complaints & Concerns Handling Policy sets out framework for responding to complaints or concerns raised by service users  Complaints and Concerns Handling Pc Information leaflets provided to patients within CCICP on initial assessment with details of complaint process  Community Nursing Service leaflet CCICP
45.	VIN to review its arrangements for prescribing and administering medication so patients can access their medication, particularly pain relief at the right time.	Internal review of the care of children in the ED has been undertaken in July 2018.	**Director of N&Q** Divisional Head of Nursing / ED Service Manager	VIN – MIU		**Complete**	**Quality Summit**	Internal review completed. Improvement plan being managed by ED Senior Team The action plan is reported at Executive Quality Governance Group. Evidence embedded in action 8. **Closed**

Standard/Process/ Issue/ Recommendation		Improvement Required (What does good look like?)	Executive / Responsible Lead	Division / Core Service	Milestones/ Timescales (by end of)	Current Progress Rating	Responsible Committee/ Group	Evidence (What evidence will be provided to demonstrate sustainable improvement?)
46.	Consider how MIU can collate and monitor patient outcome information and audit performance in order to benchmark and improve the quality and effectiveness of the service provided.	Development of Dashboard to monitor MIU performance.	**Chief Operating Officer** DGM DMEC	VIN – MIU	Scoping by January 2019	**On track (not yet started)**	**Quality Summit**	Scoping exercise underway to develop a dashboard to monitor KPI's against the 4 hour target, Friends and Family feedback, and number of complaints and informal concerns. To be signed off through the divisional governance structure by March 2019.
47.	Staff should be able to identify designated fire wardens.	Identify department fire wardens and ensure staff are aware.	**Director of N&Q** Head of Health and Safety	DMEC Medical Care	October 2018	**BAU**	**Quality Summit**	Fire Warden training is ongoing. 47. Fire Warden 2015-2018.xls The next training course is scheduled for January 2019.
48.	Safety Thermometer information included on quality and safety improvement boards.	Ensure the quality and safety improvement boards are kept up to date on all wards.	**Director of N&Q** Divisional Triumvirate / Matrons	DMEC – Medical Care	December 2018	**On track (not yet completed)**	**Quality Summit**	Observational audits commenced as part of senior nurse walk about.

Standard/Process/ Issue/ Recommendation		Improvement Required (What does good look like?)	Executive / Responsible Lead	Division / Core Service	Milestones/ Timescales (by end of)	Current Progress Rating	Responsible Committee/ Group	Evidence (What evidence will be provided to demonstrate sustainable improvement?)
49.	Incomplete records for daily checking of intubation trolley within maternity theatres.	To commence weekly monitoring of emergency intubation checks from September 2018.	**Director of N&Q** Divisional Triumvirate / Matrons	W&C – Maternity	October 2018	**BAU**	**Quality Summit**	Spot check audits carried out in W&C which shows 100% compliance W&C Spot Check Audits Obs and Gyna The maternity theatre equipment audit is a standard agenda item at the labour ward forum. Maternity Theatre Equipment Audit Sep Labour Ward Forum Action Points 13-09-1
50.	Cardiotocography (CTG) audits not completed in the last 12 months within maternity.	Devise a plan to establish regular CTG audits.	**Director of N&Q** Head of Midwifery	W&C - Maternity	December 2018	**On track (not yet completed)**	**Quality Summit**	Completion of the CTG documentation is included within the maternity 'spot check audit'. 2471 Registration Form.pdf Details of audits available if required.
51.	WHO / LocSSIPs not in use within maternity and the Emergency Department.	WHO steps are incorporated in the LocSSIPS. To be reviewed and implemented.	**Director of N&Q** Divisional General Managers / Divisional Triumvirate	W&C – Maternity DMEC – Urgent and Emergency Care	December 2018	**On track (not yet completed)**	**Quality Summit**	Maternity WHO checklist audit monitored at Labour Ward Forum & Governance. Audit process to be developed and implemented to monitor WHO / LocSSIPs within the Emergency Department by December 2018.

Standard/Process/ Issue/ Recommendation		Improvement Required (What does good look like?)	Executive / Responsible Lead	Division / Core Service	Milestones/ Timescales (by end of)	Current Progress Rating	Responsible Committee/ Group	Evidence (What evidence will be provided to demonstrate sustainable improvement?)
52.	Patients attending Emergency Department were not routinely assessed for VTE.	The Trust follows NICE guidance (NG89) which advises a routine VTE assessment for admitted patients only. Those patients attending ED but not admitted to hospital do not require VTE assessment.	**Medical Director** Consultant Lead and Clinical Lead for Emergency Medicine	DMEC – Urgent and Emergency Care	November 2018	**On track (not yet completed)**	**Quality Summit**	VTE Policy V2_2.pdf VTE performance report is monitored through divisional board.
53.	CDU breaks to be covered by registered nurses only.	Ensure adequate skill mix of staff to relieve each other for breaks.	**Director of N&Q** Divisional Triumvirate	DMEC – Urgent and Emergency Care	October 2018	**BAU**	**Quality Summit**	Immediate action taken - Memo sent to all staff within the Emergency Department. memo template (2).doc Following memo from Head Of Nursing for DMEC SOP in development to enforce changes.
54.	Care rounds did not take place for patients staying in the Emergency department for several hours or overnight.	Care rounds to be documented.	**Director of N&Q** Divisional Triumvirate	DMEC – Urgent and Emergency Care	November 2018	**On track (not yet completed)**		Emergency Department Checklist single sheets currently in place within the Emergency Department. Checklist to be included in the revised CAS card.

Standard/Process/ Issue/ Recommendation		Improvement Required (What does good look like?)	Executive / Responsible Lead	Division / Core Service	Milestones/ Timescales (by end of)	Current Progress Rating	Responsible Committee/ Group	Evidence (What evidence will be provided to demonstrate sustainable improvement?)
								LHRPS2_MFDXVD00849_0380_001.pdf Bi annual audits to be commenced December 2018.

Mid Cheshire Hospital
NHS Foundation Tru

Board of Directors Performance Report

October 2018

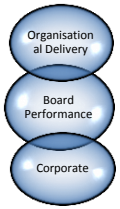
"To Deliver Excellence in Healthcare through Innovation & Collaboration"

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**	**Oct-18**	
Cancer				
Rapid Access Referrals (%) *(seen in 2 wks)*	93.00%	96.71%	96.87%	
Total Patients Seen		*6,079*	*989*	
Patients seen >14 days		*200*	*31*	
62 day GP Classic (%)	85.00%	89.92%	86.55%	*
Accountable Patients Treated		*481*	*60*	
No. of Breached Pathways (adjusted)		*49*	*8*	
62 day Screening (%)	90.00%	95.92%	100.00%	*
Accountable Patients Treated		*98*	*13*	
No. of Breached Pathways (adjusted)		*4*	*0*	
Unplanned Activity				
A&E <4hrs Standard (%)	95.00%	84.49%	85.50%	
A&E Attendances (LH/MIU/UUC) (% to plan)		97.07%	99.97%	
A&E Attendances LH & MIU (Vol)		*54,612*	*8,051*	
Planned Activity				
Incomp Pathways <18wk (%)	92.00%	92.94%	92.71%	
>6wk Diagnostic Waits (%)	1.00%	0.37%	0.48%	
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		4.26%
Turnover Rolling 12 Month		11.25%

Exec Summary

In October 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 October achieved 85.50% against the 95% performance standard. This is a slight increase compared to September.

The Trust has achieved all three headline cancer access standards for October. Rapid access referrals and 62 day treatment pathways have continuously achieved above target for over 12 months.

The Trust continues to achieve the 92% standard for RTT 18 week incomplete pathways, with performance in October 2018 at 92.71%. The Trust is continuing to monitor this standard.

Diagnostics waiting times continue to perform well, with just 0.48% 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	1		
Capital Service Capacity	2	4	2	2.39	2.37
Liquidity	2	2	1	-1	3
I&E Margin	3	4	1	2.10%	1.70%
Distance from Financial Plan	0	2	1	0.00%	-0.40%
Agency Spend	1	2	1	-23.27%	-12.29%

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 £4M which is £4.4M worse than the planned surplus of £0.4M, and it no longer incudes any income from the MOU agreed with the host commissioners, due to the uncertainty that it will be paid.

This position also has a provision against the provider sustainability fund (PSF) for the failure to achieve the A&E target. The Trust has achieved the Q2 financial target for the PSF (£2M).

There is a variation in the CIP scheme, with planned bed closures no longer being progressed, as a result of the need to open escalation beds and challenges around delivering improvements to sickness/recruitment rates within nursing.

The Trust is currently £355K worse than plan for Agency spend – and there is a risk that the Trust could breach the ceiling of £5.7M if the rate of agency to date continues throughout Winter.

	YTD Target	YTD Actual	YTD Variance	FY Target	FY Forecast	FY Variance
Cost Improvement Schemes Total (£000's)	4,063	3,284	-543	6,772	5,806	-966
Commission Contact Income SC & VR (£000's)	107,496	107,496	0			
Contract Income (£'000)	129,889	128,927	-964			
Pay to Budget (£000's)	-99,728	-101,084	-1,356			
Non Pay to Budget (£000's)	-40,278	-41,937	-1,659			
Agency Trajectory (£000's)	-2,555	-2,910	-355			

Single Oversight Framework

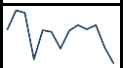
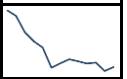
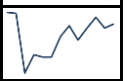
Triggers

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 achieved a Use of Resource rating of 3, which is expected to improve during 2018/19, although it is at risk due to the deteriorating financial position. 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 also above plan for agency use and is now at risk of breaking the agency ceiling rate set.

Operational Performance

	Current YTD														Monthly Trend
	Target	Actual	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	
Maximum 6 week wait for Diagnostic procedures	1%	0.37%	0.24%	0.25%	0.39%	0.53%	0.08%	0.33%	0.26%	0.17%	0.32%	0.56%	0.31%	0.44%	0.48%	
All Cancers: 62 day GP Classic (%) *	85%	89.92%	95.74%	94.50%	96.77%	87.30%	92.06%	94.06%	87.13%	92.91%	92.00%	91.40%	91.78%	86.11%	86.55%	
All Cancers: 62 day Screening (%) *	90%	95.92%	83.33%	94.12%	100.00%	100.00%	100.00%	100.00%	100.00%	89.47%	91.67%	100.00%	91.84%	100.00%	100.00%	
18 weeks from point of referral to treatment - patients on an incomplete pathway (%)	92%	92.94%	96.85%	96.44%	95.25%	94.59%	94.13%	92.65%	93.00%	93.27%	93.14%	92.97%	93.05%	92.43%	92.71%	
A&E - maximum waiting time of 4 hours from arrival to admission/transfer/discharge (%)	95%	84.49%	88.28%	88.05%	74.22%	78.38%	77.91%	77.90%	82.65%	85.14%	81.78%	84.57%	87.14%	84.61%	85.50%	
STF Trajectory			90.52%	90.52%	90.52%	90.52%	90.52%	95.00%	92.72%	92.72%	92.72%	93.92%	93.92%	93.92%	90.00%	
Provider Submitted Trajectory														90.04%	88.12%	

** 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	2.37	2	1.81	0.19	4
	Liquidity	days	-1	3	1	-3	-7	2
Financial Efficiency	I&E Margin	%	2.10%	1.70%	1	-0.20%	-2.70%	4
Financial Controls	Distance from Financial Plan	%	0.00%	-0.40%	1	0.00%	-2.50%	2
	Agency Spend	%	-23.27%	-12.29%	1	-2.85%	10.80%	2
Overall UOR Rating					1			3

Operational Delivery: *Cancer Pathway*

Headline Measures

	Current YTD		Rolling 13 months											
	Target	Actual	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Monthly Trend
Rapid Access Referrals (%) (seen in 2 wks)	93%	96.71%	97.60%	98.23%	95.85%	94.83%	93.05%	98.64%	96.08%	96.76%	97.54%	96.37%	96.73%	96.50%	96.87%	
Total Patients Seen		*6079*	*750*	*736*	*626*	*715*	*806*	*811*	*766*	*956*	*855*	*855*	*887*	*771*	*989*	
Patients seen >14 days		*200*	*18*	*13*	*26*	*37*	*56*	*11*	*30*	*31*	*21*	*31*	*29*	*27*	*31*	
% seen within 7 days		*42.7%*	*54.8%*	*51.4%*	*52.9%*	*54.6%*	*53.1%*	*61.2%*	*45.2%*	*39.6%*	*43.7%*	*44.4%*	*35.2%*	*51.4%*	*41.5%*	
62 day GP Classic (%) *	85%	89.92%	95.74%	94.50%	96.77%	87.30%	92.06%	94.06%	87.13%	92.91%	92.00%	91.40%	91.78%	86.11%	86.55%	

** Provisional figures subject to change depending*

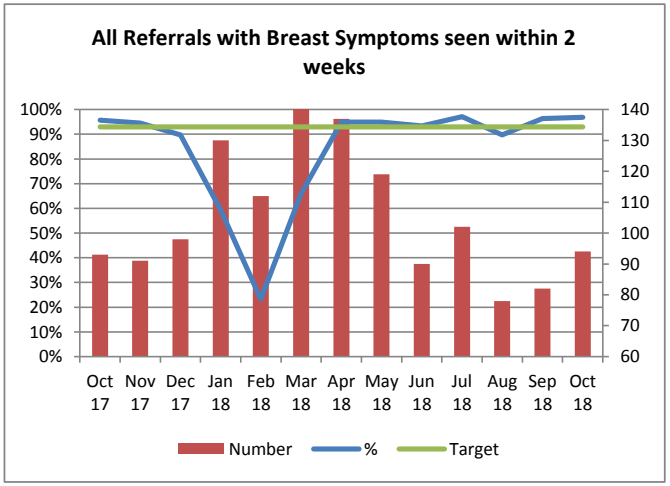
Commentary

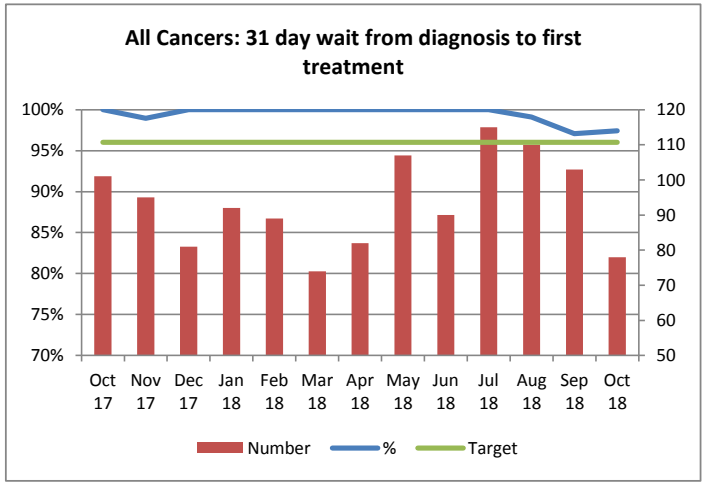
The Trust has achieved all three headline cancer standards during the month of October 2018. The figures presented in this paper reflect the Trust's regulatory performance measures (adjusted figures that take into account breach reallocation between providers). From October the new cancer repatriation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

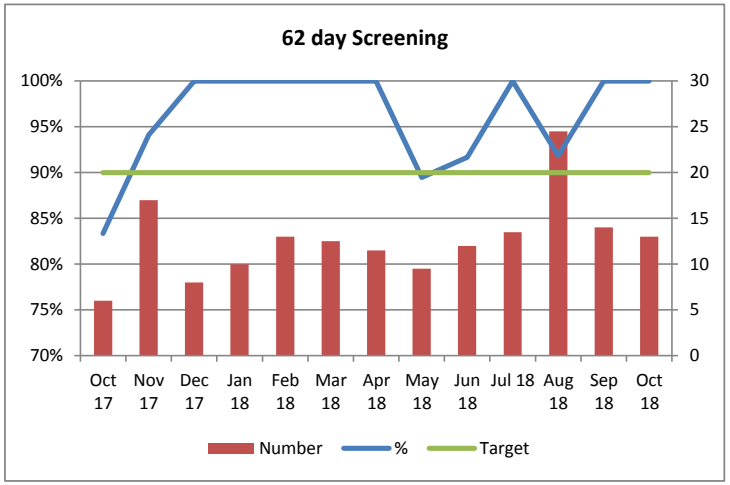
The Trust has continued it's strong performance against the Rapid Access referrals standard achieving 96.87% in October. This is in spite of an increase in demand of 32% on the same month last year.

There were no recorded long wait (104 days and over) for patients on a 62 day cancer pathway in October.

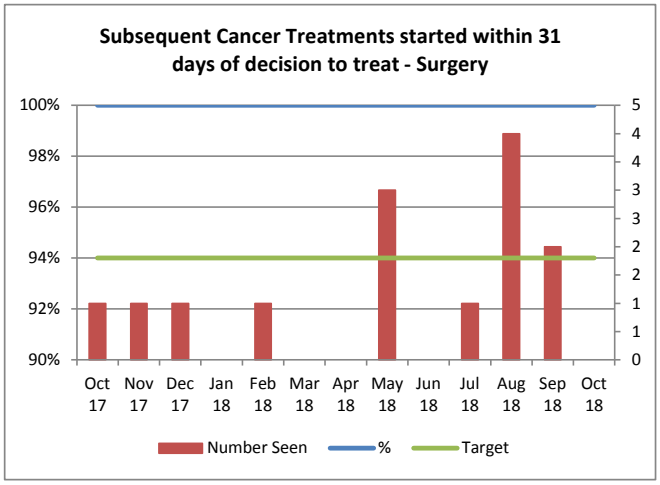
Primary Measures

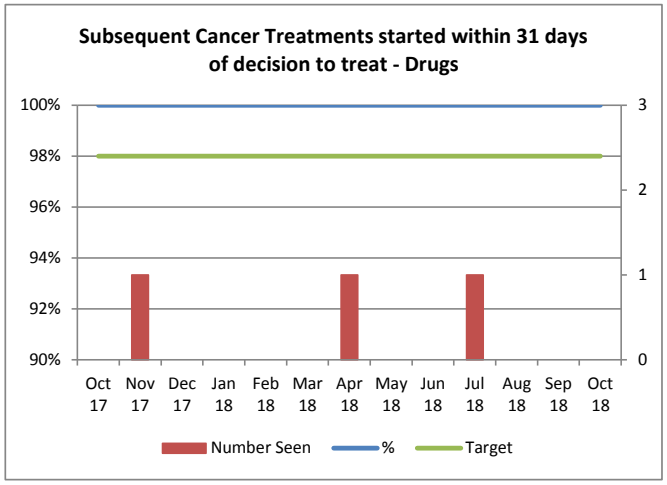


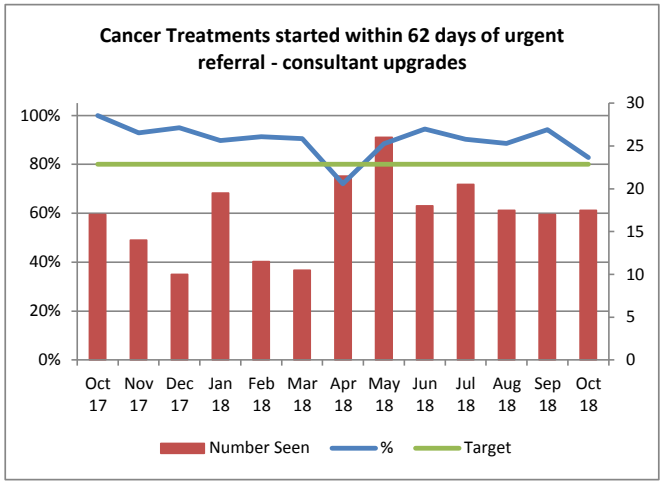




Operational Delivery: *Cancer Pathway*







Operational Delivery: *Unplanned Activity - A&E*

Headline Measures

	Current YTD		Rolling 13 months												
	Target	Actual	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Monthly Trend
A&E - >4 hr wait time from arrival to admission/ transfer/ discharge (% to Target)	95%	84.49%	88.28%	88.05%	74.22%	78.38%	77.91%	77.90%	82.65%	85.14%	81.78%	84.57%	87.14%	84.61%	85.50%	
No. of 4hr breaches		*8,473*	*872*	*851*	*1,920*	*1,543*	*1,469*	*1,679*	*1,244*	*1,179*	*1,472*	*1,286*	*967*	*1,158*	*1,167*	

	Plan	Actual	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Monthly Trend
A&E Attendances (LH/MIU/UUC) (% to Plan)		*97.07%*	99.8%	92.9%	99.3%	97.1%	94.4%	93.6%	93.2%	95.3%	98.9%	99.5%	97.7%	94.8%	100.0%	
A&E Attendances (LH/MIU/UUC) (No.)	*53,463*	*54,612*	7,439	7,119	7,447	7,138	6,649	7,598	7,170	7,933	8,081	8,337	7,517	7,523	8,051	

A&E Attendance Case Mix (based on acuity score)	*Major*		*16,364*	*1,688*	*1,605*	*1,815*	*2,191*	*2,173*	*2,422*	*2,288*	*2,460*	*2,386*	*2,168*	*2,380*	2,228	2,454	
	Minor		*21,327*	*3,198*	*2,936*	*3,324*	*2,940*	*2,474*	*2,886*	*2,799*	*2,992*	*3,325*	*3,643*	*2,990*	2,810	2,768	
	Paediatrics		*10,840*	*1,588*	*1,557*	*1,379*	*1,304*	*1,305*	*1,544*	*1,419*	*1,676*	*1,648*	*1,691*	*1,181*	1,516	1,709	
	Resus		*6,081*	*965*	*1,021*	*929*	*703*	*697*	*746*	*664*	*805*	*722*	*835*	*966*	969	1,120	

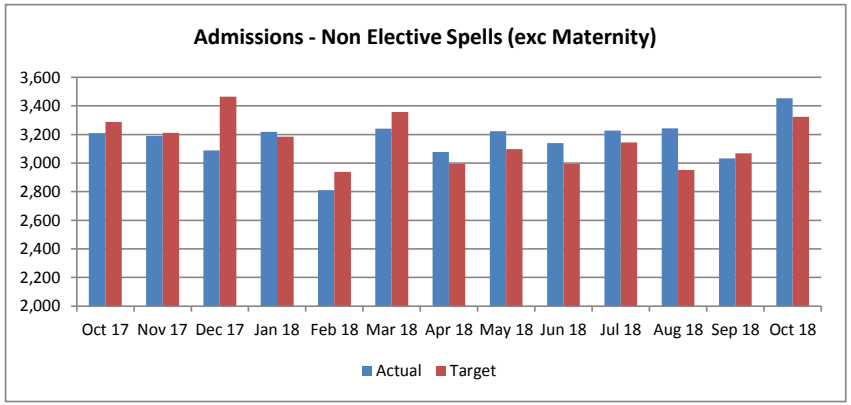
A&E Attendance Location (based on Discharge)	*Major*		*22,111*	*3,011*	*2,776*	*3,201*	*3,038*	*2,761*	*3,204*	*2,957*	*3,170*	*3,136*	*3,121*	*3,225*	*3,090*	*3,412*	
	Minor		*20,635*	*2,731*	*2,659*	*2,661*	*2,617*	*2,403*	*2,650*	*2,623*	*2,948*	*3,157*	*3,364*	*2,977*	*2,775*	*2,791*	
	Paediatrics		*10,840*	*1,588*	*1,557*	*1,379*	*1,304*	*1,305*	*1,544*	*1,419*	*1,676*	*1,648*	*1,691*	*1,181*	*1,516*	*1,709*	
	Resus		*1,026*	*109*	*127*	*206*	*179*	*180*	*200*	*171*	*139*	*140*	*161*	*134*	*142*	*139*	

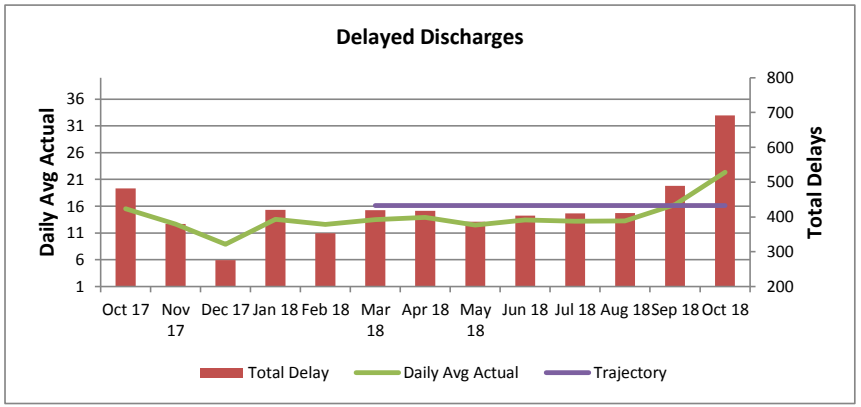
Commentary

The Trust has achieved 85.50% against the 4-hour access standard in October 2018 . This is a slight improvement on September, despite ED having over 500 more attendances than September (7% increase). The number of higher acuity patients (Resus and Majors) arriving in A&E continues to increase again, October seeing 12% more than September and a 35% increase on the same month last year. Despite the levels of ED Attendances increasing and the increase in the higher acuity patients, performance against target has improved since September. As a result of these increases emergency admissions have also increased by 12% compared to previous month.

Medical outliers has reduced for the first month since April to 25 against a threshold of 6. Patients medically fit for discharge has spiked in October to a daily average of 22 against a trajectory of 16.

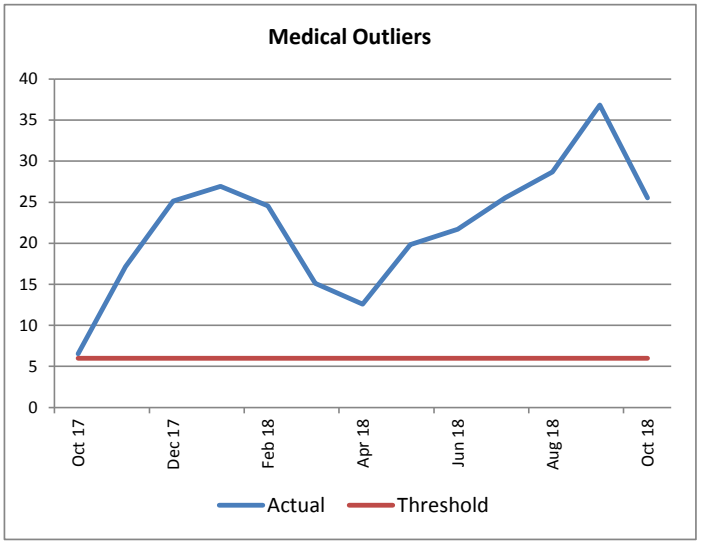
Primary Drivers

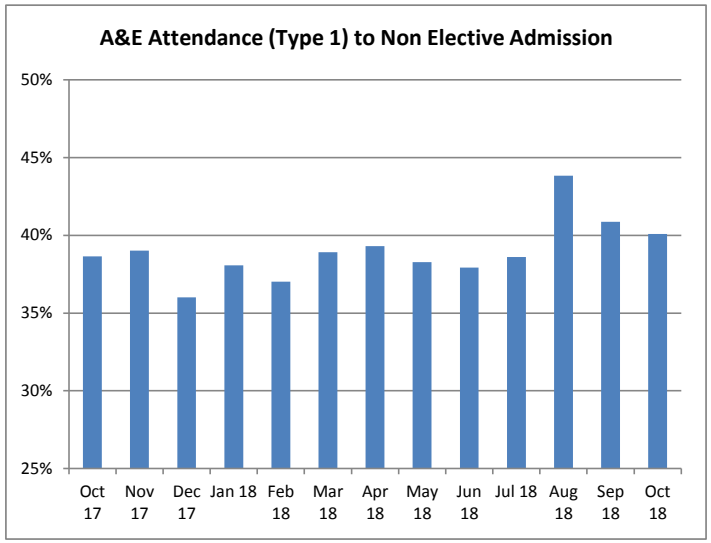


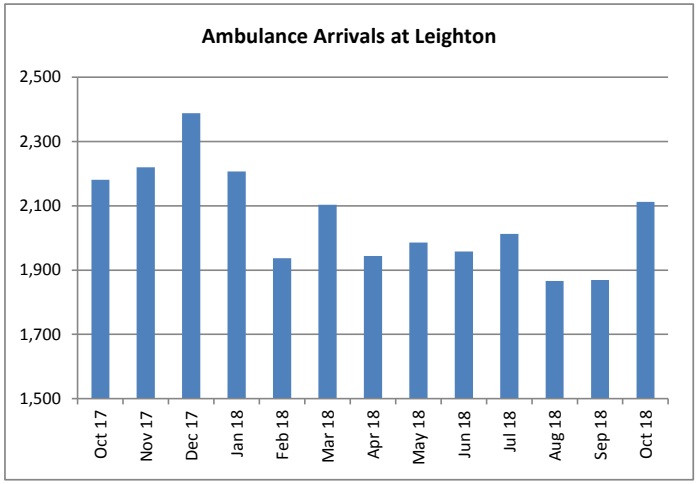


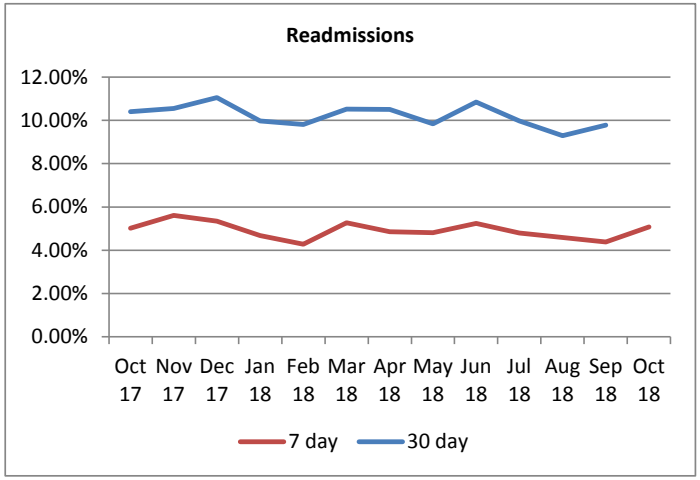
Operational Delivery: *Unplanned Activity A&E*

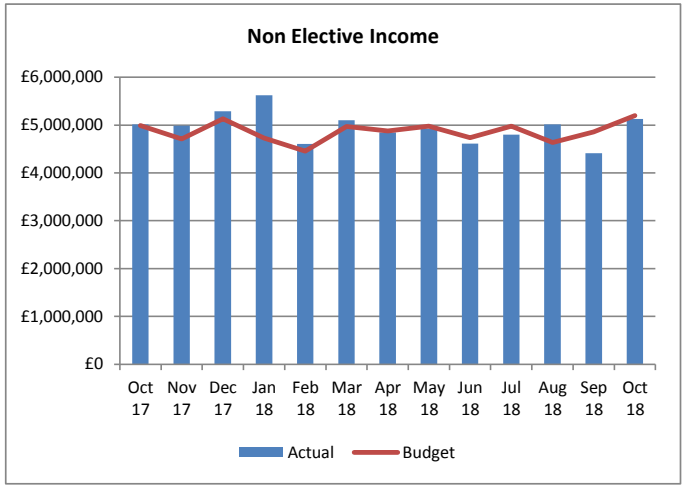
Secondary Drivers





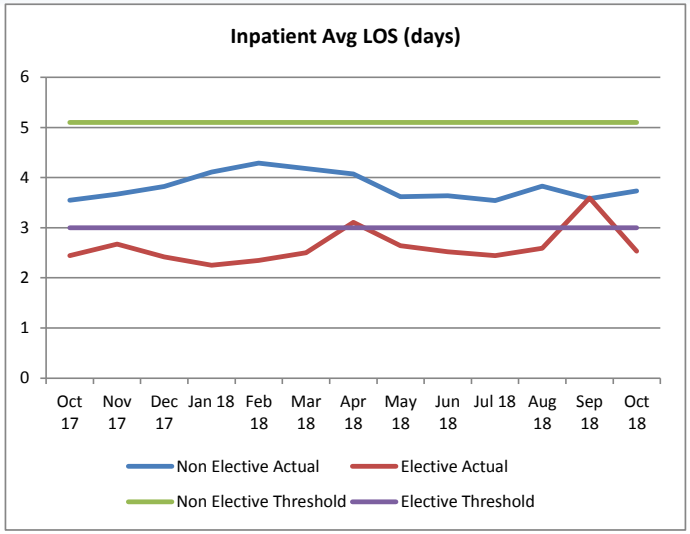


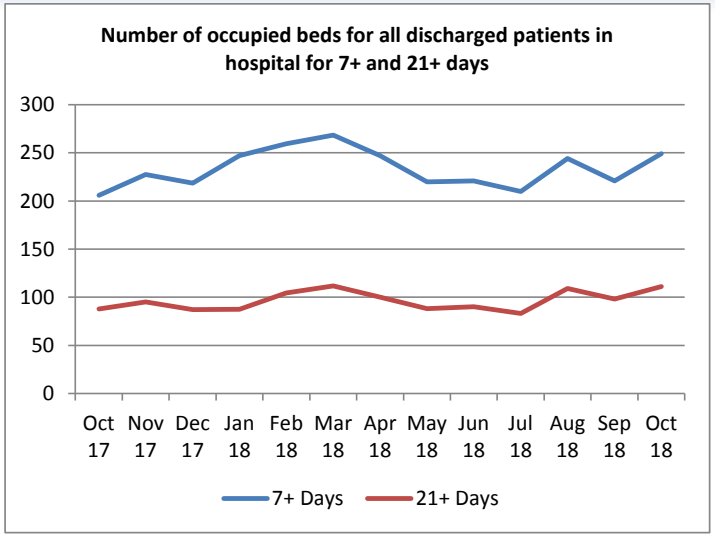


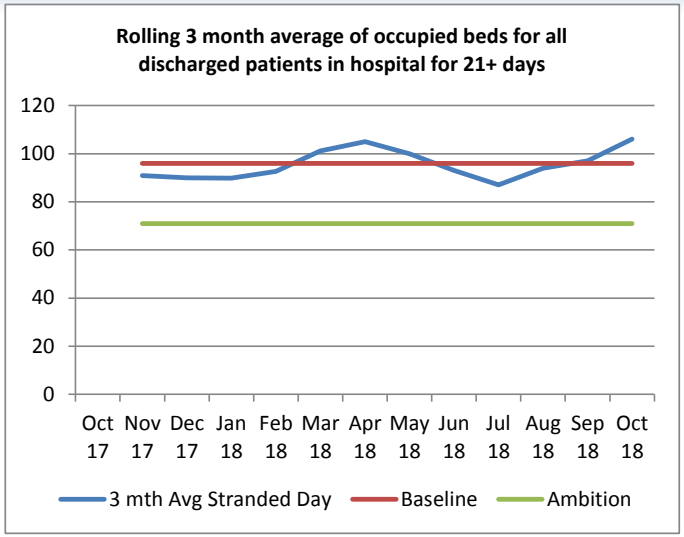


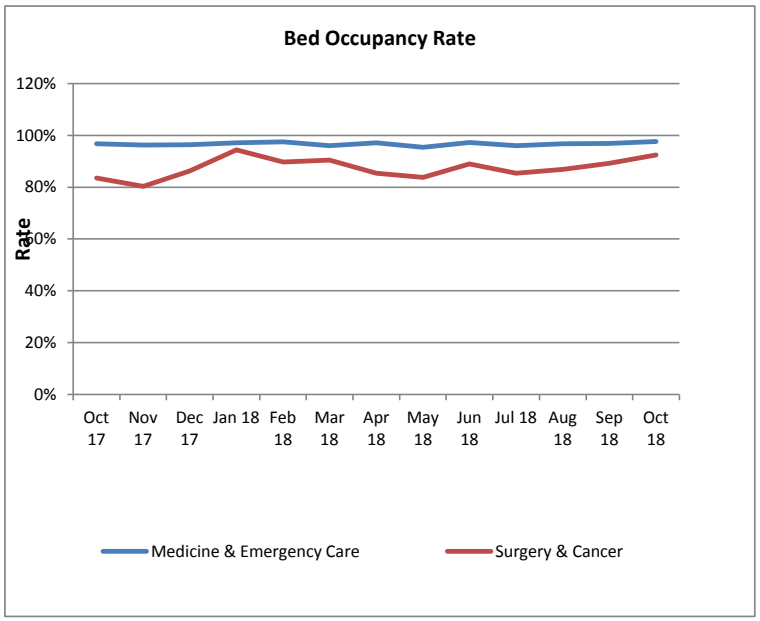
** Readmissions brought in line with national definition*

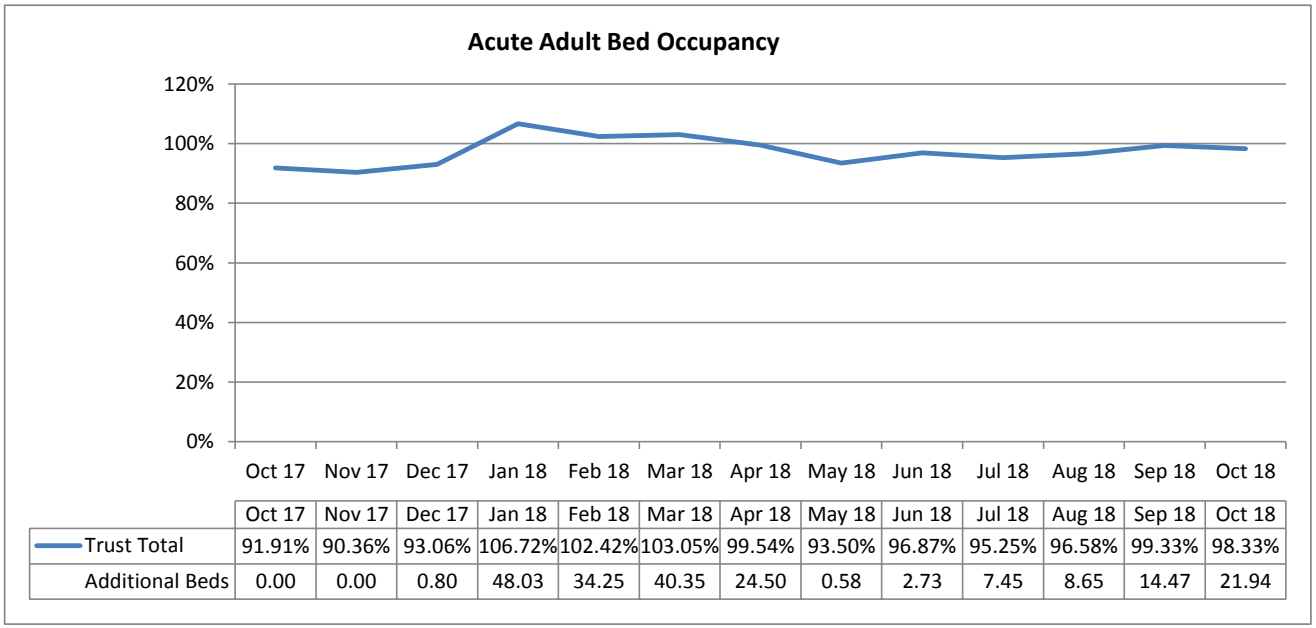
Operational Delivery: *Length of Stay*











	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18
Trust Total	91.91%	90.36%	93.06%	106.72%	102.42%	103.05%	99.54%	93.50%	96.87%	95.25%	96.58%	99.33%	98.33%
Additional Beds	0.00	0.00	0.80	48.03	34.25	40.35	24.50	0.58	2.73	7.45	8.65	14.47	21.94

Operational Delivery: *Planned Activity*

Headline Measures

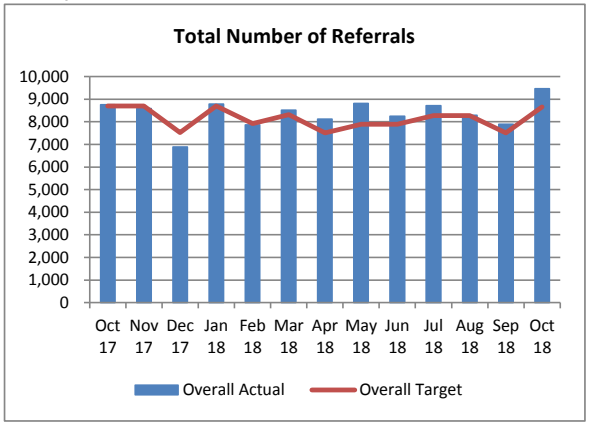
	Current YTD		Rolling 13 months											
	Target	Actual	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Monthly Trend
18 weeks from Referral to Treatment in Aggregate - Incomplete	92%	92.94%	96.85%	96.44%	95.25%	94.59%	94.13%	92.65%	93.00%	93.27%	93.14%	92.97%	93.05%	92.43%	92.71%	
Total 18 Weeks		*102,788*	*12,292*	*12,523*	*12,420*	*13,133*	*13,348*	*13,990*	*14,253*	*14,405*	*14,713*	*14,630*	*15,373*	*14,988*	*14,426*	
No. > 18 Weeks		*7,261*	*387*	*446*	*590*	*711*	*784*	*1,028*	*998*	*969*	*1,010*	*1,029*	*1,069*	*1,135*	*1,051*	
Open Pathways >39 Weeks Waiting														*7*	*5*	
Diagnostic Waiting Time	1%	0.37%	0.24%	0.25%	0.39%	0.53%	0.08%	0.33%	0.26%	0.17%	0.32%	0.56%	0.31%	0.44%	0.48%	
Total Number of Waiters		*29,314*	*3,306*	*3,191*	*3,614*	*3,587*	*3,548*	*4,293*	*4,224*	*4,127*	*4,619*	*4,257*	*3,814*	*4,105*	*4,168*	
Waiters of 6 Weeks +		*107*	*8*	*8*	*14*	*19*	*3*	*14*	*11*	*7*	*15*	*24*	*12*	*18*	*20*	
Total Patients Waiting for a First Outpatient Appointment			7,731	7,916	8,085	8,342	8,501	8,866	9,243	9,579	9,354	9,496	9,851	9,654	9,496	
Longest Wait Time (weeks)											*43*	*43*	*44*	*44*	*45*	

Commentary

In October the Trust reported 92.71% against the 92% incomplete pathways standard for RTT. Five specialties have failed to meet the 92% target, these are General Surgery, Urology, Gastroenterology, Cardiology and Trauma and Orthopaedics.
Mid Cheshire have not reported any 52 week breaches for October however there are 5 patients waiting over 39 weeks; (2 in General Surgery, 1 in Gastroenterology, 1 in Trauma & Orthopaedics and 1 in Gynaecology). All long wait patients are monitored and reviewed weekly at director lead performace meetings.

The Trust has delivered the diagnostic wait time consistently since July 2016. In October 2018, 0.48% of patients waited longer than 6 weeks for their diagnostic tests, with all modalities delivering the standard. Referrals continue to increase with October seeing 109% to plan, this is seen across all referral types.

Primary Drivers

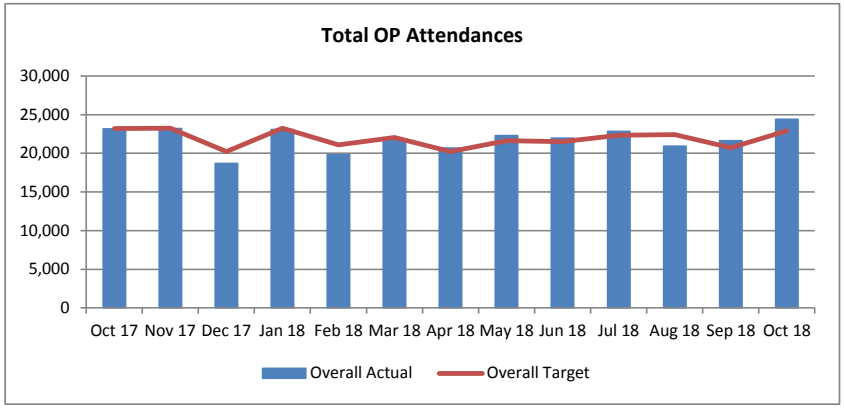


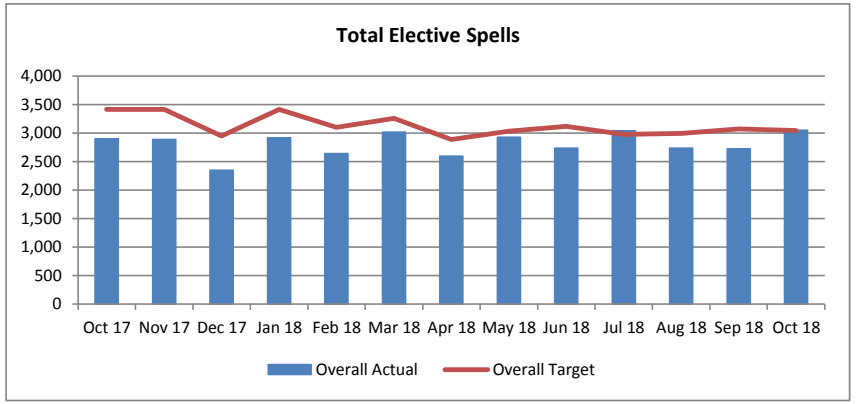
Referral Breakdown

	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Monthly Trend
GP Actual	5,506	5,424	4,157	5,573	4,928	5,388	4,858	5,400	5,065	5,355	5,184	4,925	5,755	
GP Target	5,509	5,509	4,758	5,509	5,008	5,259	4,683	4,920	4,920	5,157	5,157	4,683	5,394	
% to Target	99.9%	98.5%	87.4%	101.2%	98.4%	102.5%	103.7%	109.8%	103.0%	103.8%	100.5%	105.2%	106.7%	
Other Actual	3,252	3,166	2,731	3,205	2,931	3,119	3,256	3,408	3,186	3,352	3,107	2,968	3,711	
Other Target	3,195	3,195	2,759	3,195	2,904	3,050	2,833	2,976	2,976	3,120	3,120	2,833	3,263	
% to Target	101.8%	99.1%	99.0%	100.3%	100.9%	102.3%	114.9%	114.5%	107.1%	107.5%	99.6%	104.8%	113.7%	
Total Actual	8,758	8,590	6,888	8,778	7,859	8,507	8,114	8,808	8,251	8,707	8,291	7,893	9,466	
Total Target	8,704	8,704	7,517	8,704	7,913	8,308	7,515	7,896	7,896	8,276	8,276	7,515	8,657	
% to Target	100.6%	98.7%	91.6%	100.9%	99.3%	102.4%	108.0%	111.6%	104.5%	105.2%	100.2%	105.0%	109.3%	
GP % of Total	62.9%	63.1%	60.4%	63.5%	62.7%	63.3%	59.9%	61.3%	61.4%	61.5%	62.5%	62.4%	60.8%	

Operational Delivery: *Planned Activity*

Primary Drivers



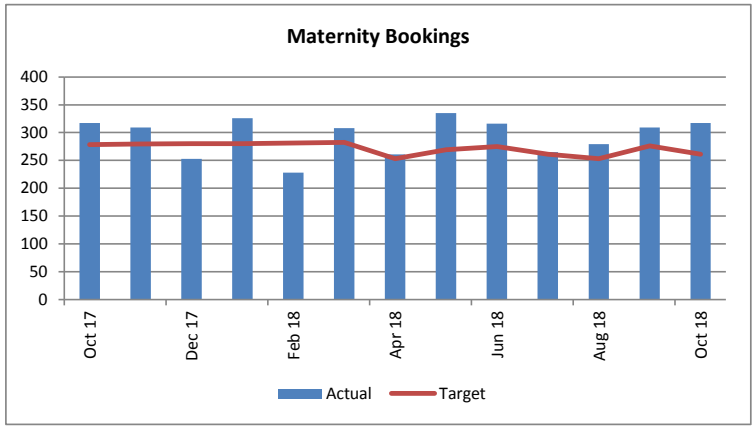


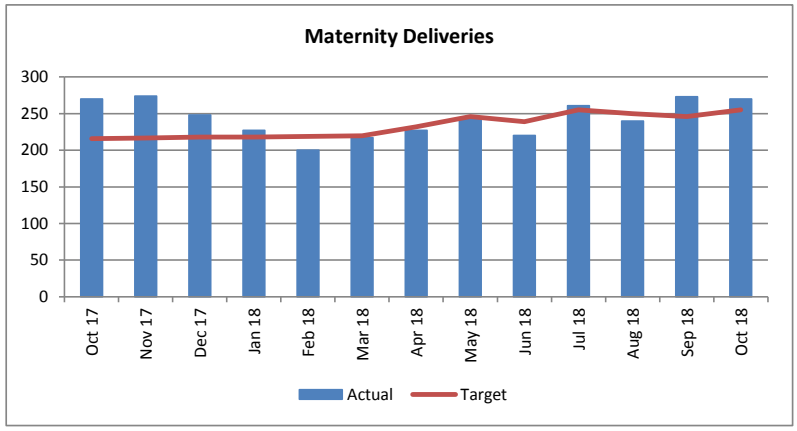
OP Attendance Breakdown	YTD 18 19	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Monthly Trend
New Actual	48,026	6,988	6,910	5,805	6,862	6,217	6,855	6,472	7,137	6,868	7,001	6,211	6,647	7,690	
New Target	44,037	7,250	7,253	6,272	7,253	6,585	6,909	5,892	6,224	6,212	6,495	6,502	5,934	6,778	
% to Target	109.1%	96.4%	95.3%	92.6%	94.6%	94.4%	99.2%	109.9%	114.7%	110.6%	107.8%	95.5%	112.0%	113.4%	
F U Actual	106,765	16,176	16,304	12,892	16,215	13,583	14,927	14,214	15,172	15,090	15,835	14,737	14,996	16,721	
F U Target	107,722	15,955	15,987	13,971	15,991	14,504	15,152	14,346	15,407	15,283	15,844	15,912	14,774	16,157	
% to Target	99.1%	101.4%	102.0%	92.3%	101.4%	93.7%	98.5%	99.1%	98.5%	98.7%	99.9%	92.6%	101.5%	103.5%	
Total Actual	154,791	23,164	23,214	18,697	23,077	19,800	21,782	20,686	22,309	21,958	22,836	20,948	21,643	24,411	
Total Target	151,759	23,205	23,240	20,243	23,244	21,089	22,061	20,237	21,631	21,495	22,339	22,414	20,708	22,935	
% to Target	102.0%	99.8%	99.9%	92.4%	99.3%	93.9%	98.7%	102.2%	103.1%	102.2%	102.2%	93.5%	104.5%	106.4%	
New % of Total	31.0%	30.2%	29.8%	31.0%	29.7%	31.4%	31.5%	31.3%	32.0%	31.3%	30.7%	29.6%	30.7%	31.5%	

Elective Spells Breakdown	YTD 18 19	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Monthly Trend
I P Actual	1,818	299	308	234	164	240	273	216	293	263	276	226	259	285	
I P Target	2,043	346	346	298	346	314	330	301	301	294	271	288	281	308	
% to Target	89.0%	86.5%	89.1%	78.6%	47.4%	76.5%	82.8%	71.8%	97.4%	89.4%	101.9%	78.6%	92.2%	92.6%	
Daycase Actual	18,002	2,603	2,578	2,115	2,753	2,404	2,745	2,378	2,637	2,476	2,766	2,513	2,468	2,764	
Daycase Target	19,086	3,071	3,071	2,650	3,071	2,790	2,931	2,590	2,735	2,822	2,706	2,706	2,792	2,736	
% to Target	94.3%	84.8%	83.9%	79.8%	89.6%	86.2%	93.7%	91.8%	96.4%	87.7%	102.2%	92.9%	88.4%	101.0%	
Total Actual	19,820	2,902	2,886	2,349	2,917	2,644	3,018	2,594	2,930	2,739	3,042	2,739	2,727	3,049	
Total Target	21,130	3,417	3,417	2,947	3,417	3,104	3,260	2,891	3,036	3,116	2,977	2,993	3,073	3,044	
% to Target	93.8%	84.9%	84.5%	79.7%	85.4%	85.2%	92.6%	89.7%	96.5%	87.9%	102.2%	91.5%	88.7%	100.2%	
I P % of Total	9.2%	10.3%	10.7%	10.0%	5.6%	9.1%	9.0%	8.3%	10.0%	9.6%	9.1%	8.3%	9.5%	9.3%	

Operational Delivery: *Planned Activity*

Primary Drivers



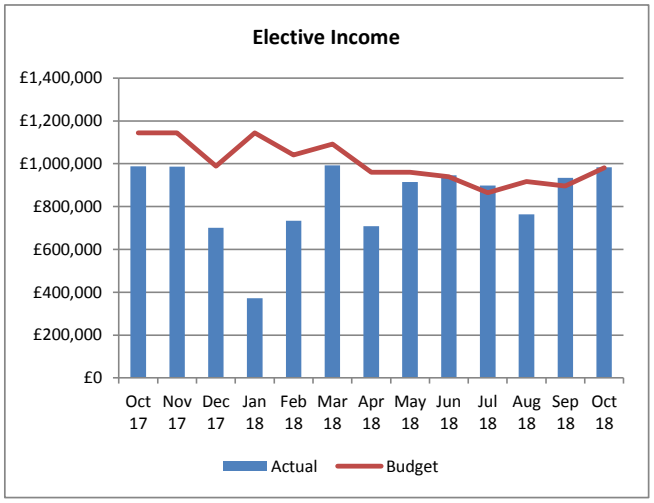


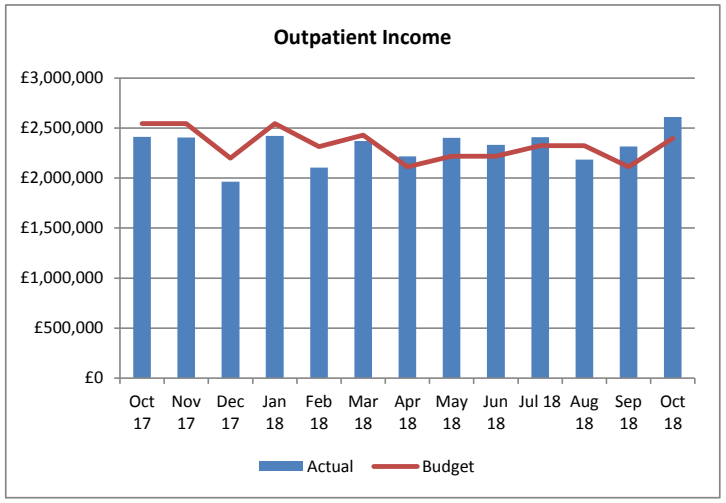
Operational Delivery: *Planned Activity*

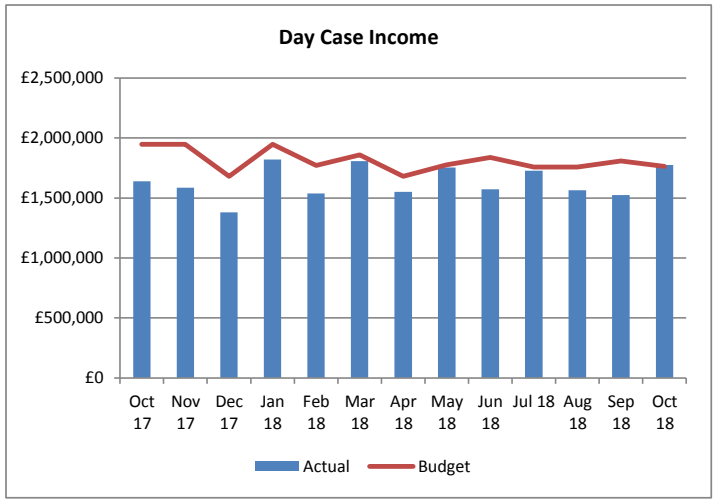
Secondary Drivers

			Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Monthly Trend
Bed Occupancy Rate	Medicine & Emergency Care		96.7%	96.2%	96.4%	97.2%	97.5%	96.0%	97.1%	95.4%	97.3%	96.1%	96.7%	96.9%	97.7%	
	Surgery & Cancer		83.5%	80.3%	86.2%	94.4%	89.6%	90.4%	85.4%	83.8%	88.9%	85.4%	86.9%	89.2%	92.5%	
Elective Inpatient Avg LOS (Days)			2.4	2.7	2.4	2.3	2.4	2.5	3.1	2.6	2.5	2.4	2.6	3.6	2.5	
Delayed Transfers of Care (MFFD)		16.00	16	13	9	14	13	14	14	12	13	13	13	16	22	
Delayed Transfers of Care (% of Acute Beds)			3.4%	2.7%	1.9%	2.6%	2.5%	2.7%	2.8%	2.7%	2.9%	2.8%	2.8%	3.3%	4.5%	
Medical Outliers			7	17	25	27	25	15	13	20	22	26	29	37	26	
Readmission (Emergency Re-admissions after Planned Surgery)																
	30 Day Rate		3.48%	3.44%	3.15%	3.01%	2.56%	3.28%	3.37%	3.35%	2.99%	3.12%	2.73%	3.02%		
	7 Day Rate		1.59%	1.20%	0.88%	1.27%	0.88%	1.41%	1.00%	1.27%	1.03%	1.42%	1.27%	1.28%	1.17%	
Cancelled Operations - Non Clinical - Cancellation Rate			1.27%	0.75%	2.24%	1.01%	1.23%	1.48%	1.40%	1.07%	0.95%	0.95%	0.95%	0.73%	1.91%	
Theatre Efficiency																
	Main Theatres		78.8%	77.0%	74.4%	74.9%	74.2%	76.8%	79.5%	78.9%	78.9%	76.7%	78.4%	78.4%	77.9%	
	TC Theatres		78.1%	75.5%	77.5%	74.5%	71.5%	71.8%	69.0%	74.2%	72.6%	75.6%	73.2%	73.4%	76.6%	
DNA (OP Efficiency)			5.51%	5.27%	6.21%	5.46%	5.17%	5.41%	5.29%	5.91%	5.84%	6.10%	5.75%	5.50%	5.85%	
Hospital Cancellation Rate (OP Efficiency)			6.27%	6.19%	7.18%	7.34%	6.88%	6.43%	6.72%	6.80%	6.80%	7.05%	7.27%	7.61%	7.63%	

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







Financial Performance: Income & Expenditure Position - Aggregated

	Month			Year to Date			Forecast	
	Plan Oct (£'000)	Actual Oct (£'000)	Variance Oct (£'000)	Plan April to Oct (£'000)	Actual April to Oct (£'000)	Variance April to Oct (£'000)	2018/19 (£'000)	Budget 2018/19 £'000
Operating								
Operating Income								
NHS Acute Activity Income								
Elective	982	987	5	6,520	6,148	-372	10,659	10,659
Non-Elective	5,196	5,069	-127	34,258	33,739	-519	59,628	59,628
Maternity	1,179	1,294	115	8,228	8,085	-143	14,000	14,000
Day cases	1,762	1,778	16	12,381	11,468	-913	21,139	21,139
Outpatients	2,399	2,620	221	15,703	16,472	769	26,672	26,672
A&E	859	942	83	6,011	6,240	229	10,139	10,139
Other NHS	6,215	4,817	-1,398	42,994	44,121	1,127	78,037	78,037
Total NHS Clinical Revenue	**18,592**	**17,507**	**-1,085**	**126,096**	**126,273**	**177**	**220,274**	**220,274**
Other Operating Income	2,151	2,262	111	14,939	15,092	153	22,502	22,502
Inter-Trust Income	0	0	0	0	0	0	0	0
TOTAL OPERATING INCOME	**20,743**	**19,769**	**-974**	**141,035**	**141,365**	**330**	**242,776**	**242,776**
Operating Expenses								
Employee Benefits Expenses (Pay)	-14,325	-14,820	-495	-99,728	-101,084	-1,356	-168,313	-168,313
Drugs	-1,379	-1,530	-151	-9,650	-9,744	-94	-15,868	-15,868
Clinical Supplies	-1,528	-1,550	-22	-11,000	-10,687	313	-18,370	-18,370
Non Clinical Supplies	-297	-345	-48	-2,091	-2,251	-160	-3,537	-3,537
Other operating expenses	-2,554	-2,816	-262	-17,537	-19,255	-1,718	-31,419	-31,419
TOTAL OPERATING EXPENSES	**-20,083**	**-21,061**	**-978**	**-140,006**	**-143,021**	**-3,015**	**-237,507**	**-237,507**
EBITDA	**660**	**-1,292**	**-1,952**	**1,029**	**-1,656**	**-2,685**	**5,269**	**5,269**
Non Operating								
Non Operating Income								
Interest & Asset disposal	3	9	6	21	53	32	36	36
Non-Operating Expenses								
Depreciation & Finance Leases	-446	-449	-3	-3,122	-3,091	31	-6,190	-6,190
PDC Dividend Expense	-192	-192	0	-1,344	-1,344	0	-2,300	-2,300
Adjusted Financial Performance surplus/(deficit)	**25**	**-1,924**	**-1,949**	**-3,416**	**-6,038**	**-2,622**	**-3,185**	**-3,185**
Provider Sustainability Fund	843	0	-843	3,792	2,065	-1,727	8,428	8,428
Net Surplus/(deficit) before Exceptional Items	**868**	**-1,924**	**-2,792**	**376**	**-3,974**	**-4,349**	**5,243**	**5,243**
Donations for purchase of assets	24	46	22	168	112	-56	288	288
Depreciation on Donated Assets	-23	-23	0	-161	-161	0	-278	-278
Prior Period Adjustments	0	0	0	0	0	0	0	0
Net Surplus/(deficit) after Exceptional Items	**869**	**-1,901**	**-2,770**	**383**	**-4,023**	**-4,405**	**5,253**	**5,253**

* EBITDA Total excludes Charitable Income

The Trust delivered a cumulative £4M deficit (before exceptional items) against a budget surplus of £0.4M.

Contract income is slightly ahead of plan, but within the month an adjustment has been made to remove the anticipated income relating to the MOU from the CCG, due to the uncertainty that it will be paid.

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

Pay is £1.4M worse than plan. Within nursing and HCA costs – there has been a continued increase in agency costs within the month, relating to escalation beds.

Medical pay, which has been previously underspent has deteriorated in month due to the recruitment of agency locums – which is expected to continue through the Winter months.

Non-Pay is about balanced with a better than budget position showing against clinical supplies reflecting elective performance.

Other operating costs are overspent by £1.5M, of which £0.8M relate to outsourcing in pathology/radiology – and £0.6M relate to Estates costs (Utilities £337K, Carbon credits £160K, Waste £43K, other one off costs £43K).

The Provider Sustainability Fund is off plan due to the failure of the A&E target, and the financial target has only been accounted for in Q1 and Q2. Trust achieved the Financial target (£2M). The full year impact of not reaching the A&E target is £2.4M. The impact of not achieving Q3/4 for the financial element is a loss of £4M.

Financial Performance: Income & Expenditure Position - MCHFT

	Month			Year to Date			Forecast	
	Plan Oct (£'000)	Actual Oct (£'000)	Variance Oct (£'000)	Plan April to Oct (£'000)	Actual April to Oct (£'000)	Variance April to Oct (£'000)	2018/19 (£'000)	Budget 2018/19 £'000
Operating								
Operating Income								
NHS Acute Activity Income								
Elective	982	987	5	6,520	6,148	-372	10,659	10,659
Non-Elective	5,196	5,069	-127	34,258	33,739	-519	59,628	59,628
Maternity	1,179	1,294	115	8,228	8,085	-143	14,000	14,000
Day cases	1,762	1,778	16	12,381	11,468	-913	21,139	21,139
Outpatients	2,399	2,620	221	15,703	16,472	769	26,672	26,672
A&E	859	942	83	6,011	6,240	229	10,139	10,139
Other NHS	3,845	2,417	-1,428	26,404	27,501	1,097	49,574	49,574
Total NHS Clinical Revenue	**16,222**	**15,107**	**-1,115**	**109,506**	**109,653**	**147**	**191,811**	**191,811**
Other Operating Income	2,054	2,160	106	14,285	14,358	73	21,500	21,500
Inter-Trust Income	0	0	0	0	0	0	0	0
TOTAL OPERATING INCOME	**18,276**	**17,267**	**-1,009**	**123,791**	**124,011**	**220**	**213,311**	**213,311**
Operating Expenses								
Employee Benefits Expenses (Pay)	-12,515	-13,055	-540	-86,973	-88,759	-1,786	-146,930	-146,930
Drugs	-1,377	-1,526	-149	-9,636	-9,727	-91	-15,844	-15,844
Clinical Supplies	-1,443	-1,452	-9	-10,403	-10,046	357	-17,353	-17,353
Non Clinical Supplies	-216	-261	-45	-1,524	-1,669	-145	-2,568	-2,568
Other operating expenses	-2,170	-2,390	-220	-14,704	-16,580	-1,876	-26,706	-26,706
Inter-Trust Charges	114	-123	-237	797	891	94	1,364	1,364
TOTAL OPERATING EXPENSES	**-17,607**	**-18,807**	**-1,200**	**-122,443**	**-125,890**	**-3,447**	**-208,037**	**-208,037**
EBITDA	**669**	**-1,540**	**-2,209**	**1,348**	**-1,879**	**-3,227**	**5,274**	**5,274**
Non Operating								
Non Operating Income								
Interest & Asset disposal	3	9	6	21	53	32	36	36
Non-Operating Expenses								
Depreciation & Finance Leases	-446	-449	-3	-3,122	-3,091	31	-6,190	-6,190
PDC Dividend Expense	-192	-192	0	-1,344	-1,344	0	-2,300	-2,300
Net Surplus/(deficit) before STF/Exceptional Items	**34**	**-2,172**	**-2,206**	**-3,097**	**-6,261**	**-3,164**	**-3,180**	**-3,180**
Provider Sustainability Fund	843	0	-843	3,792	2,065	-1,727	8,428	**8,428**
Net Surplus/(deficit) before Exceptional Items	**877**	**-2,172**	**-3,049**	**695**	**-4,197**	**-4,891**	**5,248**	**5,248**
Donations for purchase of assets	24	46	22	168	112	-56	288	288
Depreciation on Donated Assets	-23	-23	0	-161	-161	0	-278	-278
Prior Period Adjustments	0	0	0	0	0	0	0	0
Net Surplus/(deficit) after Exceptional Items	**878**	**-2,149**	**-3,027**	**702**	**-4,246**	**-4,947**	**5,258**	**5,258**

The Trust excluding Community Services, delivered a £4.2M deficit against a planned surplus of £0.7M year to date - giving a £4.9M variance against plan cumulatively.

Contract income and other operating income are slightly better than plan, largely due to the funding for escalation beds in April.

Pay is £1.8M worse than plan cumulative as a result of higher spend on Nursing HCAs, which has increased in the month particularly in agency use, notably within Medicine & Emergency Care and Surgery & Cancer - where there are a number of medical outliers.

Medical pay, is overspent in the month relating to the increased use of high cost agency medical doctors covering gaps.
Clinical supplies are underspent by £0.4M, reflecting an overall underperformance in planned activity.

Other Operating Expenses is £1.9M worse as a result of continued outsourcing pressures in Diagnostics and Radiology (£0.8M) and pressures within estates (£0.6M).

There is a cumulative reflection of the A&E performance provided for within the provider sustainability fund. The financial target is not being accrued for month 7, due to the uncertainty of the trust receiving the full MOU value from the CCG.

Financial Performance: Income & Expenditure Position - CCICP

	Month			Year to Date			Forecast	
	Plan Oct (£'000)	Actual Oct (£'000)	Variance Oct (£'000)	Plan April to Oct (£'000)	Actual April to Oct (£'000)	Variance April to Oct (£'000)	2018/19 (£'000)	Budget 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	2,400	30	16,590	16,620	30	28,463	28,463
Total NHS Clinical Revenue	**2,370**	**2,400**	**30**	**16,590**	**16,620**	**30**	**28,463**	**28,463**
Other Operating Income	97	102	5	654	734	80	1,002	1,002
Inter-Trust Income	0	0	0	0	0	0	0	0
TOTAL OPERATING INCOME	**2,467**	**2,502**	**35**	**17,244**	**17,354**	**110**	**29,465**	**29,465**
Operating Expenses								
Employee Benefits Expenses (Pay)	-1,810	-1,765	45	-12,755	-12,325	430	-21,383	-21,383
Drugs	-2	-4	-2	-14	-17	-3	-24	-24
Clinical Supplies	-85	-98	-13	-597	-641	-44	-1,017	-1,017
Non Clinical Supplies	-81	-84	-3	-567	-582	-15	-969	-969
Other operating expenses	-384	-426	-42	-2,833	-2,675	158	-4,713	-4,713
Inter-Trust Charges	-114	123	237	-797	-891	-94	-1,364	-1,364
TOTAL OPERATING EXPENSES	**-2,476**	**-2,254**	**222**	**-17,563**	**-17,131**	**432**	**-29,470**	**-29,470**
EBITDA	**-9**	**248**	**257**	**-319**	**223**	**542**	**-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)	**-9**	**248**	**257**	**-319**	**223**	**542**	**-5**	**-5**
Provider Sustainability Fund	0	0	0	0	0	0	0	**0**
Net Surplus/(deficit) before Exceptional Items	**-9**	**248**	**257**	**-319**	**223**	**542**	**-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	**-9**	**248**	**257**	**-319**	**223**	**542**	**-5**	**-5**

Community Services delivered a £257K surplus cumulative against a planned deficit position.

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

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, and some non-recurrent gains on 1718 income.

Pay is £430K better than plan cumulative as a result of unfilled vacancies partly clinical and partly corporate, continuing the trend from 2017/18 and also relating to slippage on the commencement of new services.

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.

Inter-trust recharges reflect a review of vacancies which is subject to review with CCICP.

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	(29)	(582)	(557)	(48)	(51)	(631)	(636)
Endoscopy	Endoscopy	3,690	1	(341)	(1,413)	125	(714)	211	1,564	(6)
General Surgery Directorate	General Surgery	10,102	58	331	(5,502)	(142)	(1,080)	(68)	3,577	121
Head & Neck Directorate	Head & Neck	3,125	243	(208)	(1,453)	115	(406)	64	1,509	(30)
Macmillan Cancer Centre	Macmillan Cancer Centre	378	1,137	274	(586)	(44)	(1,055)	(213)	(126)	17
Ophthalmology	Ophthalmology	7,188	34	355	(2,543)	(21)	(2,142)	(177)	2,537	157
Orthopaedic Directorate	Orthopaedics	10,610	149	(193)	(3,810)	93	(2,019)	(45)	4,930	(144)
Theatres & TC	Theatres & TC	0	202	(2)	(4,333)	32	(1,630)	(155)	(5,762)	(125)
Urology Directorate	Urology	3,291	30	8	(1,716)	(106)	(351)	(75)	1,253	(173)
Surgical and Cancer Division	**Surgery & Cancer**	**38,384**	**1,854**	**194**	**(21,940)**	**(504)**	**(9,447)**	**(509)**	**8,851**	**(819)**

The Surgical Division is £819K worse than plan year to date. Pay is £504K worse than budget, with overspends on HCA bank and agency nursing costs high as a result of medical outliers - which have led to the failure to physically close a Surgical ward as planned, despite the division managing to work within a lower bed base. Whilst non pay is overspent by £509K, £235K of this is offset by increased charges to the Christie as part of their SLA recharges. The balance of the overspend relating to increased ward costs associated with medical outliers. Although the trust in on a contract block with host commissioners there is a current underperformance on income of £118K relating to endoscopy (£342K), orthopaedics (£217K) and ENT (£218K).

		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	1	1	(1,317)	(329)	(52)	(13)	(1,368)	(341)
Accident & Emergency Dir	Emergency Department	9,343	472	44	(3,900)	(261)	(460)	(70)	5,456	(287)
Anaesthetics & Critical Care	Anaesthetics & Critical Care	3,778	35	16	(4,526)	279	(657)	62	(1,371)	357
Medical Directorate	General Medicine	24,677	105	(83)	(13,826)	(676)	(2,445)	318	8,512	(441)
Urgent Care Centre	Urgent Care Centre	0	0	0	(416)	3	0	47	(416)	51
Emergency Services Division	**Medicine & Emergency Care**	**37,799**	**612**	**(22)**	**(23,984)**	**(983)**	**(3,613)**	**345**	**10,813**	**(661)**

The Medicine and Emergency Care Division are £661K worse than plan. The key issue for the division remains related to pay, with nursing pay and HCA spend continuing to reflect the cost of unfunded escalation beds, and increased 1 to 1 care. Medical pay costs have worsened in the month due to the employment of a number of high cost agency doctors who are filling key gaps within the rotas for the division.

		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	1	1	(781)	16	(80)	17	(859)	34
Gum clinic	Gum clinic	0	0	0	0	0	(1)	(1)	(1)	(1)
Obstetric & Gynaecology Dir	Obstetrics & Gynaecology	10,502	73	(377)	(5,060)	48	(806)	(19)	4,708	(348)
Paediatric Directorate	Paediatrics	6,671	62	(347)	(4,659)	(191)	(595)	38	1,480	(499)
Women and Childrens Division	**Women and Children**	**17,173**	**136**	**(723)**	**(10,500)**	**(127)**	**(1,482)**	**36**	**5,328**	**(814)**

The Women's and Children's Division is £814K worse than plan. Contract income continues to be significantly below plan for both Gynaecology and Obstetrics - both as a result of lower than planned activity, and reduced market share for gynaecology. Paediatric income is also below plan, however it is expected to recover to some degree, as the profile of paediatric emergency activity is quite different to a general emergency care - which was used for the plan. The pay pressure within paediatrics relates to ANPs and NICU.

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	(167)	23	(18)	(69)	(185)	(47)
Dermatology	Dermatology	1,058	11	(1)	(588)	30	(195)	(5)	287	23
ECG department	ECG	235	12	(3)	(594)	60	(48)	(1)	(395)	57
Elmhurst	Elmhurst	1,165	103	2	(950)	(55)	(92)	18	227	(35)
Integrated Discharge	Integrated Discharge	0	23	23	(182)	(15)	(4)	(2)	(163)	6
Medical Records Department	Medical Records Department	0	0	(1)	(1,056)	(35)	(130)	(0)	(1,186)	(37)
Outpatients	Outpatients	0	81	(17)	(326)	9	(37)	(5)	(282)	(14)
Pathology Directorate	Pathology	6,895	2,345	323	(5,676)	229	(5,140)	(446)	(1,577)	107
Pharmacy Departments	Pharmacy	2,146	106	(19)	(1,994)	(53)	(2,206)	(167)	(1,948)	(239)
Radiology Directorate	Radiology	1,794	488	(30)	(3,798)	(29)	(1,481)	(362)	(2,997)	(421)
Therapeutic Departments	Therapies	0	1	1	(1,255)	1	(35)	22	(1,289)	24
Victoria Infirmary Northwich	Victoria Infirmary Northwich	1,199	2	(48)	(1,029)	(13)	(167)	6	5	(56)
Diagnostics and Support Divisi	**Diagnostics and Support**	**14,492**	**3,172**	**229**	**(17,616)**	**152**	**(9,552)**	**(1,013)**	**(9,504)**	**(632)**

The Diagnostics Division is £632K worse than plan year to date, with the key pressures being with the outsourced radiology and pathology tests £622K (net of medical vacancies), although there has been an increase to the charges that are made to East Cheshire trust this month which offset the 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
Estates & Facilities Div Mgnt	Divisional Management E&F	0	0	0	(308)	13	(132)	(7)	(440)	6
Catering Directorate	Catering	0	804	11	(1,021)	(68)	(843)	(75)	(1,061)	(132)
Estates Departments	Estates Departments	0	274	(4)	(929)	3	(4,238)	(541)	(4,894)	(543)
Hotel Services	Domestics	0	0	0	(806)	(3)	(10)	(3)	(816)	(6)
Laundry Services Departments	Laundry	0	676	(45)	(671)	(37)	(484)	(24)	(479)	(106)
Security	Security	0	1,011	23	(431)	18	(408)	(60)	173	(19)
Site Services	Porters	0	0	0	(1,710)	(9)	(45)	2	(1,755)	(7)
Estates & Facilities Division	**Estates & Facilities Division**	**0**	**2,765**	**(15)**	**(5,877)**	**(83)**	**(6,160)**	**(710)**	**(9,272)**	**(808)**

The Estates and Facilities Division is £710K worse than plan. Within non pay there are some 17/18 costs (Carbon Credits £160K, Gritting £13K and one off costs (£40K wastage, £16K fixture and fitting, £14K overspend on barrier repairs) and the loss of £40K SLA contract within Laundry. Utilities are £337K and expected to be £567K over by year end - which are a significant ongoing financial pressure.

		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	10	10	(897)	(6)	(407)	(42)	(1,294)	(39)
Computer Services	Computer Services	0	15	9	(891)	24	(1,684)	(275)	(2,560)	(242)
Finance & Information	Finance & Information	0	27	9	(1,741)	81	(443)	3	(2,157)	93
Human Resources	Human Resources	0	295	15	(1,446)	38	(288)	65	(1,439)	118
Risk Manangement & R&D	Risk Management & R&D	0	287	(28)	(889)	47	(67)	(9)	(669)	10
Quality Assurance Departments	Nurse Management	0	139	76	(1,624)	(103)	(4,629)	51	(6,114)	23
Trust Central Expenditure	Trust Central Expenditure	4,445	5,022	(800)	(1,206)	(278)	(152)	246	8,112	(833)
Other Departments	Other Departments	14	137	74	(150)	(43)	(98)	59	(97)	91
	Corporate	**4,459**	**5,932**	**(636)**	**(8,844)**	**(240)**	**(7,768)**	**97**	**(6,219)**	**(779)**

The Corporate Division is £779K worse than budget - as the impact of the removal of the MOU is realised against trust central.

Community Services		**16,620**	**734**	**110**	**(12,325)**	**429**	**(3,914)**	**95**	**1,115**	**634**
EBITDA		**128,927**	**15,204**	**(863)**	**(101,084)**	**(1,356)**	**(41,937)**	**(1,659)**	**1,111**	**(3,878)**

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	4,713	0	4,642	-71
NHS Eastern Cheshire CCG Community	412	240	0	240	0
NHS South Cheshire CCG Community	17,254	10,048	0	10,048	0
NHS South Cheshire CCG	101,698	59,246	403	59,246	0
NHS Vale Royal CCG	55,052	32,099	-716	32,099	0
NHS Vale Royal CCG Community	10,482	6,103	0	6,103	0
NHS Warrington CCG	284	169	0	184	15
NHS West Cheshire CCG	3,537	2,059	0	2,091	32
NHS West Cheshire CCG Community	191	111	0	111	0
NHS North Staffordshire CCG	2,307	1,357	0	1,508	151
NHS Shropshire CCG	892	522	0	458	-64
NHS Stoke on Trent CCG	1,609	948	0	987	38
Public Health England	1,541	815	0	809	-6
NHS Commissioning Board	1,597	920	0	920	0
Specialist Commissioning Group	8,645	5,073	0	4,522	-551
Non Contract Activity	2,007	1,164	0	1,274	110
Cross Border Flows (non Betsi)	149	86	0	73	-14
Betsi	229	133	0	517	384
Non-Commissioner Specific	12,729	4,083	0	3,095	-988
TOTAL	**228,703**	**129,889**	**-313**	**128,927**	**-964**

Other Contract Income	FY Target (£'000)	YTD Target (£'000)	YTD Actual (£'000)	Final Variance (£'000)
Bed Based Services	5,962	3,478	3,416	-62
Adult & Neonatal Critical Care	7,896	4,630	4,729	99
Community Paediatrics	1,303	760	760	0
Direct Access Services	9,509	5,601	5,651	50
Unbundled Radiology	3,505	2,064	2,074	10
High Cost Drugs	9,762	5,903	5,813	-89
Screening Programmes	1,530	893	919	26
Audiology	1,167	681	614	-67
IVF	258	151	115	-35
CQUIN	4,312	1,858	1,621	-238
PSV	0	0	0	0
Community Services	28,426	16,582	16,491	-91
CEP	-2,817	-1,643	-367	1,276
WINTER FUNDING	750	437	345	-92
Other	6,623	1,605	1,941	336
TOTAL	**78,186**	**43,000**	**44,122**	**1,123**

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 a continuing trend seen in previous months, although due to the move away from undertaking Welsh work both contracts have over performed in month.

Other commissioners, except East Cheshire, and Shropshire CCGs are in the main over performing against plan. East Cheshire underperformance is in unplanned care (£17K), and within surgical specialties for planned care (£128K), offset by an over-performance in Direct Access (£95K).

Specialist Commissioning has a negative variance being the result of a high cost drug rebate of £551K 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 – which is work completed in the early months of this financial year and not expected to continue.

Other contract income is showing £1.1M better than plan.

Within Other - the £850K for the memorandum of understanding has been taken out of the position.

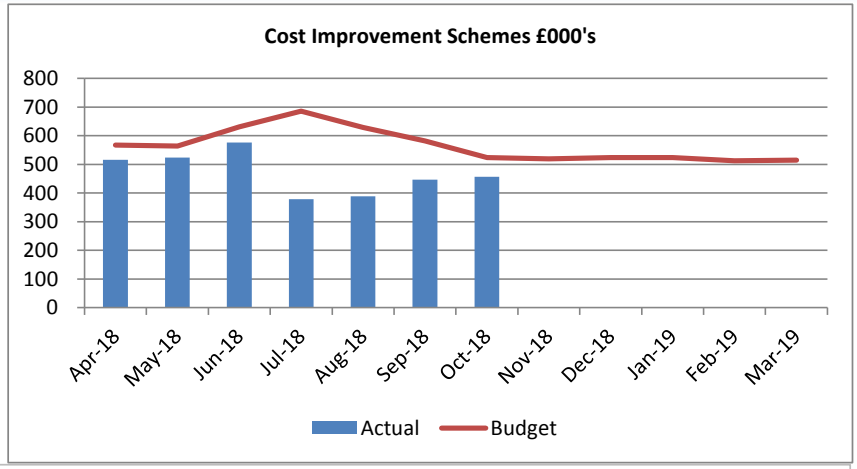
An analysis of the key service lines identifies that, aside the CEP adjustment there were gains against the un-coded prior year spells valuation (£140K), CQUIN is £238K behind plan based on most recent forecasts of achievement,.

High cost drug income excluding the rebate is £227K above plan, and non-performance of the A&E target has been recognised year to date within the PSV accrual.

The impact of the CEP is less than expected year to date by £1.3M, although there is marked difference between the two 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	420	335	-85	524	439	-85
Commercial	99	112	12	195	254	59
Drugs	413	175	0	657	657	0
Medical Workforce	832	716	-117	1,550	881	-669
Non-Pay Efficiency	796	822	26	1,228	1,625	397
Nursing Workforce	548	399	-149	974	688	-286
Procurement	400	297	-103	684	479	-205
Theatres Efficiency	58	58	0	100	100	0
Service redesign	310	242	-68	540	463	-77
Market Share	187	128	-59	320	220	-100
Total (£'000)	**4,063**	**3,284**	**-543**	**6,772**	**5,806**	**-966**



The CIP achievement year to date is £543K worse than plan with the failure to close a ward being the key reason to date - however it has been recognised that Surgery and Cancer were in effect able to close a ward - but for the increase in medical patients requiring beds. The CIPs for the following schemes are also failing to deliver at month 7 - improvement of nurse/HCA sickness (£142K), reduction in WLIs (£102K), the Medical Vacancy factor in Surgery and Cancer (£141K) and theatres related CIPs (£11 2K consumables/review of staffing model).

There is also a further risk associated with drugs scheme due to the potential delays for release of new bio-similars (£357K), due to the regional NHSE procurement exercise. There are a number of CCICP efficiencies that are over performing which offset the under-performing MCHFT schemes.

Capped Expenditure Schemes (£'000's)						
Scheme Category	**YTD Target**	**YTD Actual**	**YTD**	**FY Target**	**FY Forecast**	**FY Variance**
TeleDerm	41	0	-41	70	0	-70
Non-Pay Efficiency	58	58	0	100	100	0
Drugs	29	29	0	50	50	0
Commercial	117	0	-117	200	0	-200
Procurement	58	0	-58	100	0	-100
Elective	651	391	-260	1,116	391	-725
Total (£'000)	**954**	**478**	**-476**	**1,636**	**541**	**-1,095**

The CEP schemes rolled over from 1718 are under achieving by £476K, 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.

As a result of the regulatory direction to keep waiting list levels at March 2018 levels - the plan to deliver further income from out of area contracts in Wales has been stopped, which has led to a deterioration of the forecast for this legacy value.

Financial Performance: Capital Report

SCHEME	BOARD APPROVED	FUNDING SOURCE	FUNDING APPROVED	EXPENDITURE BROUGHT FORWARD	2018/19 ANNUAL BUDGET	2018/19 CUMULATIVE BUDGET TO DATE	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	16	0	16		60	60	60
BISTRO & 2 OFFICES	Yes	Internal	Yes	120	58	58	58	0	58		178	178	178
UNDER / OVERS CAPITAL SCHEMES 17/18	Yes	Internal	Yes		0	0	7	-7	0		7	0	0
WARD REFURBISHMENT	Yes	Loan	Yes	224	1864	1864	2068	-204	1864	8600	2292	10,688	10,688
MRI SCANNER 3RD BUILD	Yes	Internal/Loan	Yes	174	1475	1400	0	1400	1475	0	174	1,649	1,649
WASTE COMPOUND AND SEGREGATION	Yes	Internal	Yes		350	200	0	200	350		0	350	350
TURNKEY FOR REPLACEMENT CT SCANNERS	No	Internal	Yes		165	165	0	165	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	70	14	56	100	1800	14	2,200	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	100	8	92	100		8	100	100
SSD ENABLING *	Yes	Loan	Not yet approved		668	0	0	0	0	668	0	1,336	668
WARD REFURBUISHMENT *	No	Loan	Not yet approved		1600	250	58	192	1400	200	58	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**	**4123**	**2228.7123**	**1894**	**5628**	**14338**	**2790.7123**	**22296**	**20528**
IT													
UNDER / OVERS CAPITAL SCHEMES 17/18	Yes	Internal	Yes		0	0	0	0	0		0	0	0
UPS	Yes	Internal	Yes		250	0	0	0	0	250	0	500	250
Q PULSE	Yes	Internal	Yes	25	37	37	0	37	9	28	25	90	62
HIGH IMPACT STAND ALONE IT SYSTEMS	Yes	Internal	Yes	88	112	62	20	42	112	400	108	600	600
REPLACEMENT BUSINESS INTELLIGANCE SYSTEM	Yes	Internal	Yes		80	80	54	26	80		54	80	80
CONFIGURATION MANAGEMENT SYSTEM	Yes	Internal	Yes		35	35	0	35	0		0	35	0
CORE INFRASTRUCTURE UPGRADE	yes	PDC	Yes		538	246	139	107	418	180	139	718	598
CYBER SECURITY	Yes	PDC	Yes	17	291	291	291	0	291		308	308	308
X-RAY MACHINE STORAGE	Yes	Internal	Yes		100	0	75	-75	100		75	100	100
SEQUEL / WINDOWS LICENCES	Yes	Internal	Yes		80	0	0	0	80		0	80	80
VIRTUAL DESKTOP	No	Internal	Yes		400	0	0	0	100	100	0	500	200
VIRTUAL CLINICS	No	Internal	Yes		50	50	0	50	50		0	50	50
VPN	Yes	PDC	Yes		70	70	0	70	70		0	70	70
VOICE OVER IP	Yes	Internal	Yes	466	100	58	12	46	75	100	478	666	641
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	0		0	85	0
DIGITAL DICTATION	Yes	Internal	Yes		60	0	0	0	60	73	0	133	133
DOCMAN	Yes	Internal	Yes		52	52	0	52	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**	**981**	**591**	**390**	**1497**	**3921**	1187	**7657**	**6,014**
TOTAL STRATEGIC INVESTMENTS				**1158**	**10536**	**5104**	**2820**	**2284**	**7125**	**18259**	**3978**	**29,953**	**26,542**

The Estates strategic investments capital spend is £1,894K underspent mainy due to the and Third MRI Scanner £1,400K , a supplier has now been choosen and design workhas started. In addition the ward 12 refurbishment schemesa is underspent. but has now started. Also there is a delay in the Turnkey works for the replacement CT scanner and the Waste Compound scheme. These are due to start later in the financial year. The IT Strategic investments projects are £390 K which is mainly due to Core Infrastructure upgrade £107K and VPN £70K which is being trialed at the moment.

Financial Performance: Capital Report

SCHEME	BOARD APPROVED	FUNDING SOURCE	FUNDING APPROVED	EXPENDITURE BROUGHT FORWARD	2018/19 ANNUAL BUDGET	2018/19 CUMULATIVE BUDGET TO DATE	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	126	34	92	135	736	34	1,007	871
DESIGN TEAM	Yes	Internal	Yes		313	172	185	-13	313	1252	185	1,565	1,565
CT / VT - HEATING INFRASTRUCTURE	Yes	Internal	Yes		459	232	13	219	150	1009	13	1,468	1,159
BACKLOG GENERAL PROVISION	Yes	Internal/Loan	Yes		2650	1611	1131	480	1,600	7799	1131	10,449	9,399
TOTAL				**0**	**3,693**	**2,141**	**1,363**	**778**	**2,198**	**10,796**	**1363**	**14,489**	**12,994**
IT													
INTERSITE CONNECTIVITY	Yes	Internal	Yes		50	25	16	9	50		16	50	50
INTERFACING	Yes	Internal	Yes		151	41	82	-41	101	390	82	541	491
IT APPLICATIONS	Yes	Internal	Yes		193	77	17	60	143	475	17	668	618
STORAGE & BACKUP	No	Internal	Yes							250		250	250
TOTAL				**0**	**394**	**143**	**115**	**28**	**294**	**1115**	**115**	**1,509**	**1,409**
TOTAL ROLLING ALLOCATIONS				**0**	**4,087**	**2,284**	**1,477**	**807**	**2,492**	**11,911**	**1,477**	**15,998**	**14,403**
ADDITIONAL													
EQUIPMENT	Yes	Internal	Yes		0	0	90	-90	90		90	0	90
PUBLIC WiFi					0	0	0	0	205		0	0	205
ACQUISITION OF SCPH					0	0	0	0	1000		0	0	1,000
PERSONAL CARE PORTAL					0	0	0	0	70		0	0	70
MEDICAL RECORDS RACKING	Yes	Internal	Yes		43	43	60	-17	60		60	43	60
CANCER MDT	Yes	PDC	Yes		30	30	0	30	0		0	30	0
GP STREAMING ESTATES	Yes	PDC	Yes	12	488	488	463	25	488		475	500	500
GP STREAMING IT FRONT OF HOUSE	Yes	PDC	Yes	108	142	0	0	0	0		108	250	108
COMMUNITY SERVICES	Yes	Internal	Yes	105	630	560	465	95	630		570	735	735
LEASING INVESTMENTS													
EQUIPMENT	Yes	Internal	Yes		600	273	273	0	522	78	273	678	600
3RD CT SCANNER	No	Internal	Not yet approved		531	0	0	0	0		0	531	0
REPLACEMENT CT SCANNER	No	Internal	Not yet approved		532	0	0	0	0		0	532	0
3RD MRI SCANNER	Yes	Internal	Yes		600	0	0	0	0		0	600	0
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	0	320	0	640	320
TOTAL LEASING INVESTMENTS				**0**	**2833**	**273**	**273**	**0**	**772**	**398**	273	**3231**	**1170**
TOTAL CAPITAL PROGRAMME (EXCLUDING LEASES)				**1,383**	**15,956**	**8,509**	**5,375**	**3,134**	**12,160**	**30,170**	**6,758**	**47,509**	**43,713**
TOTAL CAPTIAL PROGRAMME				**1,383**	**18,789**	**8,782**	**5,648**	**3,134**	**12,932**	**30,568**	**7,031**	**50,740**	**44,883**

The rolling allocation is £807K underspent due to the delay in some of the backlog maintenance and Constant Temperature Variable Temperature replacement and Asbestos replacement.

The forecast spend has been reduced by the following: Asbestos £136K, Backlog Maintenance £1,080K, Ward refurbishment £200K, Endoscopy Washer Build £250K. EPR Project office £350K , Virtual Desktop £200, Car Park Land purchase £300K, CCTV £157K, CTVT £152K, Replacement SSD washers build work £668K, UPs £250K, Virtual Clinics £100K , Lab Centre Upgrade £800K 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. Also three schemes have been added Personal Care Portal £70K and Public Wifi £205K which are funded via external money and the acquisition of South Cheshire Private Hospital £1,000K

Financial Performance: Statement of Financial Position

	Plan Apr to Oct (£'000)	Actual Apr to Oct (£'000)	Variance (£'000)	Forecast 2018/19 (£'000)
Assets				
Assets, Non-Current	**103,123**	**99,623**	**-3,500**	**106,454**
Assets, Current				
Trade and other Receivables	7,254	7,285	31	9,055
Other Assets (including Inventories & Prepayments)	5,954	6,412	458	6,600
Cash and Cash Equivalents	10,136	10,781	645	12,205
Total Assets, Current	**23,344**	**24,477**	**1,133**	**27,860**
ASSETS, TOTAL	**126,467**	**124,101**	**-2,366**	**134,314**
Liabilities				
Liabilities, Current				
Finance Lease, Current	-990	-587	403	-2,147
Loans Commercial Current	-228	-256	-28	-667
Trade and Other Payables, Current	-13,702	-14,440	-738	-13,505
Provisions, Current	-146	-148	-2	-225
Other Financial Liabilities	-6,869	-9,762	-2,893	-6,552
Total Liabilities, Current	**-21,935**	**-25,192**	**-3,257**	**-23,096**
Net Current Assets/(Liabilities)	**1,409**	**-715**	**-2,124**	**4,764**
Liabilities, Non Current				
Finance Lease, Non Current	-5,097	-4,516	581	-4,077
Loans Commercial Non-Current	-13,390	-12,040	1,350	-16,504
Provisions, Non-Current	-1,604	-1,586	18	-1,489
Trade and Other Payables, Non-Current	0	0	0	**0**
Total Liabilities Non-Current	**-20,091**	**-18,142**	**1,949**	**-22,070**
TOTAL ASSETS EMPLOYED	**84,441**	**80,766**	**-3,675**	**89,148**
Taxpayers' and Others' Equity				
Taxpayers Equity				
Public dividend capital	76,791	76,791	0	76,791
Retained Earnings	-7,942	-11,618	-3,676	-3,236
Donated asset reserve	0	0	0	0
Revaluation Reserve	15,592	15,592	0	15,592
TOTAL TAXPAYERS EQUITY	**84,441**	**80,766**	**-3,675**	**89,147**
TOTAL FUNDS EMPLOYED	**84,441**	**80,766**	**-3,675**	**89,147**

Assets Non-Current
The main reason for the variance is that the plan is the capital programme expenditure being £3,134K less than which is mainly due to a delay in the third MRI Scanner build £1,400K, Backlog maintenance £489K , Waste Compound £200K, CT Infrastructure £165K, Core Infrastructure Upgrade £107K, CTVT £162K and a delay in the renewal of some finance leases £691K. This is offset by an underspend on the depreciation charge.

Trade and other Receivables
NHS Trade Receivables are lower than anticipated due to the A&E PSF for Quarter 2 and October's not being accrued as the A&E target has not been achieved £759K. In addition the October finance PSF has not been accrued whilst the CCG is saying that it will not pay the MOU. This is offset by outstanding debts from University of North Midlands Trust £100k, NHS England £329K, One to One Nursing £96K and The Christies £429K.

Other Assets
This higher than anticipated due to higher than expected Drug Stocks .

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

Trade and other Payables
Trade and other payables are more than anticipated mainly due to the advance payment by South cheshire and Vale Royal CCG's £2,582K.

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 in particular CCICP rental invoices which are now sitting in Trade and other Payables.

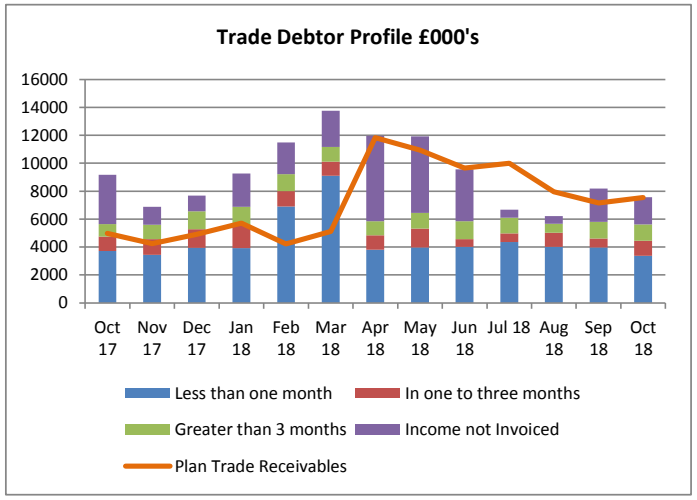
Finance Lease Non- Current
This due to the delay in the replacement of finance leases.

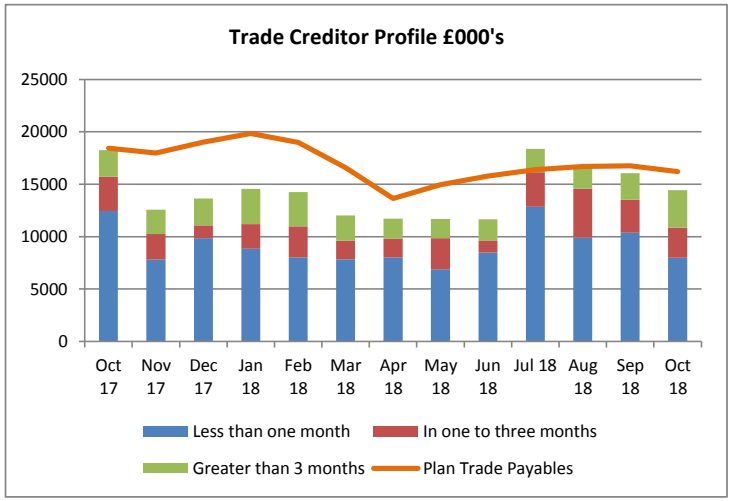
Loans Commercial Non-Current
This is due to the delay in the drawing down of an approved loan for the ward refurbishment and the third MRI scanner.

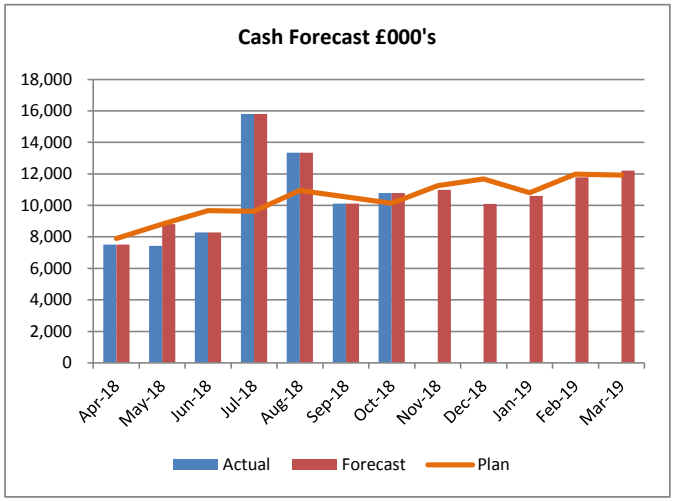
Financial Performance: Cash Position and Working Capital

	Plan Apr to Oct (£'000)	Actual Apr to Oct (£'000)	Variance
Surplus/(deficit) after tax	**-338**	**-4,023**	**-3,685**
Non-cash flows in operating Surplus/(deficit) total	3,533	3,208	-325
Operating cash flows before movements in working capital	**3,195**	**-815**	**-4,010**
Increase/(Decrease) in working capital Total	6,527	10,464	3,937
Net cash inflow/(outflow) from operating activities	**9,722**	**9,649**	**-73**
Net cash inflow/(outflow) from investing activities total	-7,636	-5,313	2,323
Net Cash inflow/(outflow) before financing	**2,086**	**4,336**	**2,250**
Net cash inflow/(outflow) from financing activities Total	289	-1,317	-1,606
Net increase/(decrease) in cash and cash equivalents	**2,375**	**3,019**	**644**
Opening cash balance	**7,761**	**7,761**	**0**
Closing cash balance	**10,136**	**10,780**	**644**

Cash is £645K is more than anticipated; this mainly due to the failure of the Q1 A&E target £379K. In addition the delay in the capital payment is improving the cash position but this is offset by £1,350K of a capital loan for the ward refurbishment and the MRI Scanner which has not been drawn down. Working capital has improved due to the increase in trade creditors offset by a significant deficit against plan due to the CCG's decision not to pay against the Memorandum of Understanding. The CCG's decision to not pay the MOU will mean that the Trust will require a significant working capital loan at the end of the year.







Finance: *Staff Costs*

Headline Measures

	YTD £000's	Rolling 13 months £000's													
		Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Monthly Trend
Pay Budget	99,729	13,774	13,799	13,721	13,916	13,817	13,785	14,001	14,112	14,008	14,158	14,900	14,225	14,325	
Pay Actual	101,085	13,947	13,826	13,692	14,278	14,017	14,133	14,094	14,152	14,237	14,183	14,960	14,639	14,820	
Variance	-1,356	-173	-27	29	-362	-200	-348	-93	-40	-229	-25	-60	-414	-495	
% to Budget	*101.4%*	*101.3%*	*100.2%*	*99.8%*	*102.6%*	*101.4%*	*102.5%*	*100.7%*	*100.3%*	*101.6%*	*100.2%*	*100.4%*	*102.9%*	*103.5%*	
Nursing Staff % to Budget	102.2%	101.6%	102.9%	102.4%	105.9%	104.7%	105.0%	101.7%	99.9%	102.1%	100.5%	103.5%	103.1%	104.3%	
Medical Staff % to Budget	99.4%	102.6%	97.4%	95.3%	98.5%	97.1%	103.2%	95.4%	100.5%	99.2%	97.3%	92.0%	104.2%	107.2%	
Other Staff % to Budget	101.7%	100.1%	99.1%	99.8%	101.6%	100.7%	99.5%	102.8%	100.6%	102.7%	101.6%	102.0%	102.0%	100.3%	

Figures exclude Community Services for 2016/17

Commentary

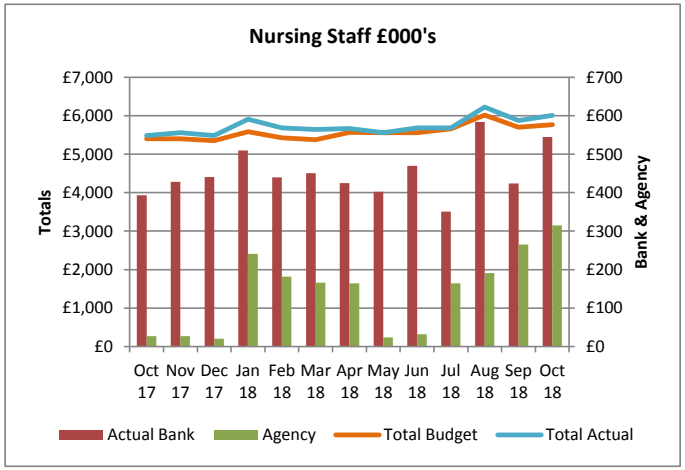
Pay is worse than budget by £1.4M year to date.

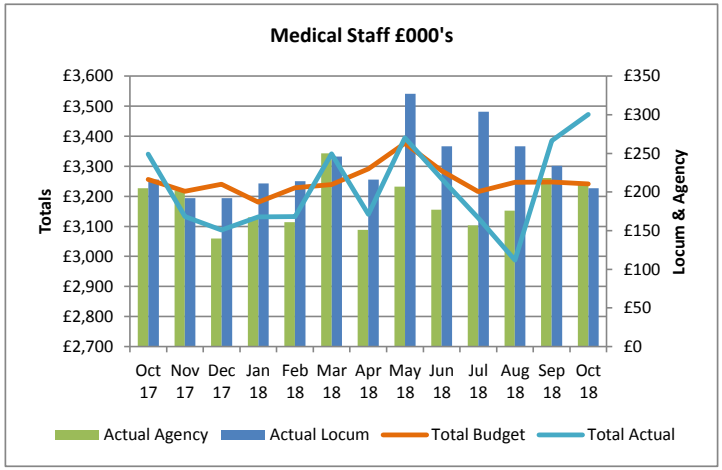
Nursing costs associated with keeping escalation beds/CAU assessment area open in April have been offset against agreed additional Winter money funding within contract income, however the recent escalation beds from the Summer which have remained open are unfunded. Bank use for HCAs continues to support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

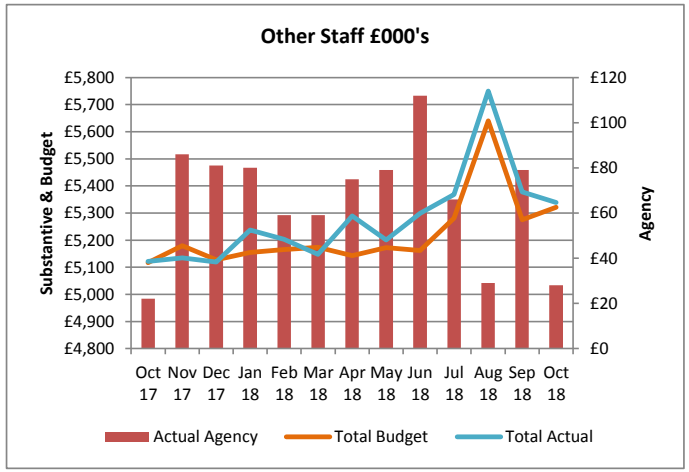
Medical pay is worse than budget in month, (£232K) due to the use of high cost agency doctors in Medicine & Emergency Care, covering vacancies - which is likely to continue throughout the coming Winter months.

The agency spend in continuing to exceed the plan in October. For every 1% of nursing staff where the shift cannot be covered, without incurring premium cost, the trust will have to cover this using bank or agency at a cost of the order of £1M.

Primary Drivers

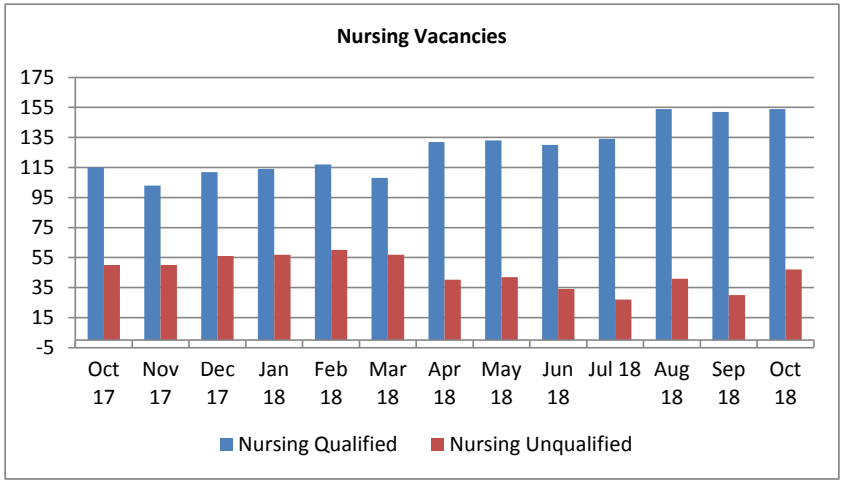






Finance: *Staff Costs*

Secondary Drivers



Medical vacancies under review

Agency Trajectory

	YTD	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Monthly Trend
Plan	-2,555	-495	-477	-506	-495	-470	-484	-365	-365	-365	-365	-365	-365	-365	
Actual	-2,910	-699	-721	-572	-668	-618	-574	-389	-310	-320	-387	-395	-563	-546	
Variance	-355	-204	-244	-66	-173	-148	-90	-24	55	45	-22	-30	-198	-181	
CCICP Actual	0	-69	-77	-152	-210	4	-77	0	0	0	0	0	0	0	

	Rolling 13 Months													
	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Monthly Trend
Sickness Rate (Rolling 12 mths)	4.21%	4.23%	4.25%	4.28%	4.28%	4.38%	4.38%	4.37%	4.30%	4.29%	4.27%	4.27%	4.26%	
Total Leavers	49	39	33	46	37	59	39	41	38	38	63	48	34	
Turnover (Rolling 12 mths)	11.08%	10.93%	10.71%	10.70%	10.66%	11.18%	11.33%	11.28%	11.33%	11.17%	11.67%	11.54%	11.25%	

Quality Governance

Board Assurance Framework

2018/19

Full Version

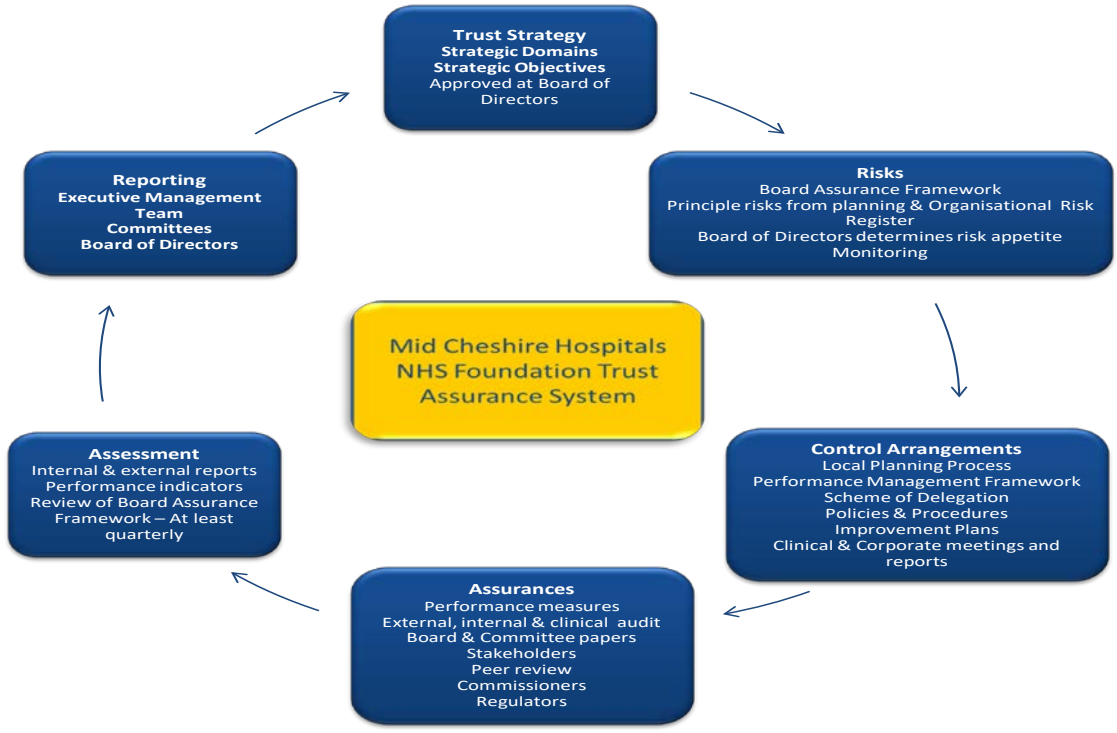
Quarter 2

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. 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 2, 2018/19.

Table 1 – Top five organisational risks

Risk Title	Mitigated (With Controls) Risk Rating	SHIFT				Key links to BAF 2018/19
		Q1	Q2	Q3	Q4	
Delivery of key local and National targets and standards, in particular the 4 hour standard in A&E	5(C) x 4(L) = 20	Under Review	⇔			Q1,Q2,E1,E2, P1,P2
Workforce capacity and skill mix to consistently deliver high quality care, seven days a week	5(C) x 4(L) = 20	Under Review	⇔			Q1,Q2,P1,P2, E2,W2
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) x 4(L) = 16	Under Review	⇔			Q1,Q2,P1,P2, E2,W2,T1,T2a ,T2b
The Long Term Financial Sustainability of the Trust.	5(C) x 4(L) = 20	Under Review	⇔			E1,E2,P1,P2,T 1,T2a,T2b
A Lack of funding to Implement the Information Management and Technology Strategy.	3(C) x 4(L) = 12	Under Review	⇩			Q1,Q2,E1,E2, T2a,T2b

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 in 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.

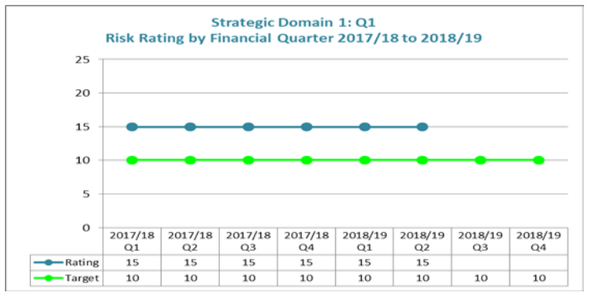
Strategic Domain 1: Delivering Outstanding Clinical Quality, Safety & Experience

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	September 2018	December 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 2. 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 A&E	20	CS0328 – Workforce capacity and skill mix to consistently deliver high quality care, seven days a week	20
CS0327 – Long Term Financial Sustainability of MCHFT	20	CS0326 – Lack of funding to deliver the IM&T Strategy	12 ⇩

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 AHP Strategy is under development. On-going implementation plans and monitoring of National/regulatory guidance.

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.
- Ward accreditation scheme under development, to be launched in April 19
- Trust-wide e-roster project to commence in November 18
- Internal Well-Led Review improvement actions – quarterly oversight at Quality Governance Committee.
- The Nursing & Midwifery AHP Strategy is in the early stages of implementation, and will be launched in April 18.

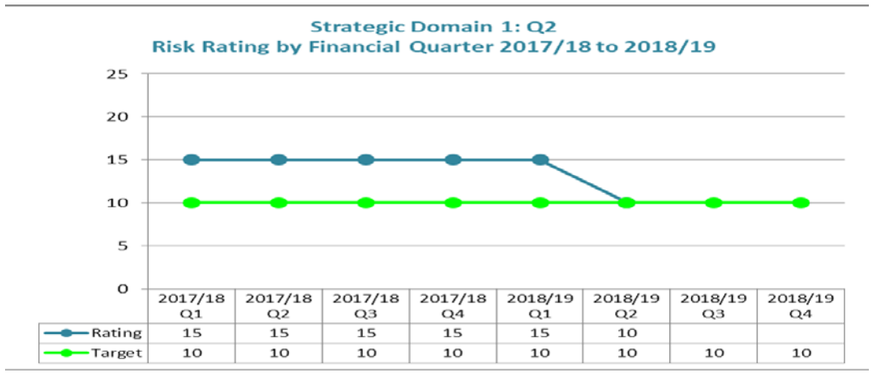
Strategic Domain 1: Delivering Outstanding Clinical Quality, Safety & Experience

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	September 2018	December 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	2	**10**	5	2	**10**	March 2019

Rationale for the Current Risk Score

Risk score has been reduced to 10 for quarter 2. The likelihood of not improving the quality of care with all the key controls in place is unlikely. 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. The QQAR process is now taking place across all divisions, except CCICP.

Links to BAF Objectives

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

Key Links to the Organisational Risk Register

CS0326 – Lack of funding to deliver the IM&T Strategy	12 ⇩	CS0328 – Workforce capacity and skill mix to consistently deliver high quality care, seven days a week	20
CS0327 – Long Term Financial Sustainability of MCHFT	20		

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

HSMR/SHMI mortality indicators are within expected range. The SJR Process is in established within the Trust, with plans in place to train more staff in the process. 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. National clinical audits benchmarking performance, and Trust participation in all relevant National audits to benchmark performance. MEDC, S&C, DCSS and W&C have been subject to Quality Assurance Reviews. Trust active participation in GIRFT programme led by CEO and MD. Progression of Quality, service improvement and redesign (QSIR) initiative. Trust benchmarks adherence to clinical pathways performance as part of Regional advancing quality programme.

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 2019
- Innovation agenda to be developed
- Lack of funding for education and participation in clinical trials

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.

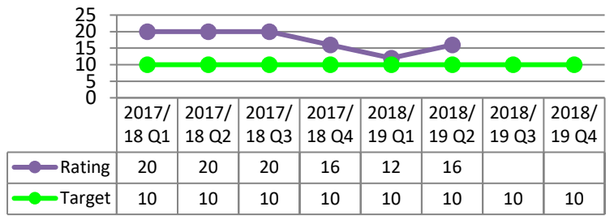
Principal Risk

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	September 2018	December 2018	Well Led NHSI - Use of Resources	CEO	Board of Directors	Quality Governance Committee

Strategic Domain 2: P1
Risk Rating by Financial Quarter 2017/18 to 2018/19



	2017/18 Q1	2017/18 Q2	2017/18 Q3	2017/18 Q4	2018/19 Q1	2018/19 Q2	2018/19 Q3	2018/19 Q4
Rating	20	20	20	16	12	16		
Target	10	10	10	10	10	10	10	10

Initial Risk Rating (Unmitigated)			Current Risk Rating (Mitigated)			Target Risk Rating (Tolerance / Risk Appetite)			
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Target Date
5	5	**25**	4	4	**⇧16**	5	2	**10**	March 2019

Rationale for the Current Risk Score

The risk score for quarter 2 has been increased from 12 to 16. Due to winter pressures the financial position has deteriorated significantly and on-going risk related to Trust contracts with commissioners as a result of an agreed MOU. The relationship remains strong with commissioners with a desire to find collective system solutions. Relationships with East Cheshire NHS Trust are good, however; progress is slow, with a lack of desire on their part.

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	20	CS0327 – Long Term Financial Sustainability of MCHFT	20
CS0374 - 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	16		

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. AQUA facilitated workshop on the development of integrated care partnerships.

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; regulators have asked for additional detail by end of October. Integrated care partnerships; recruitment of full time programme director.

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).**

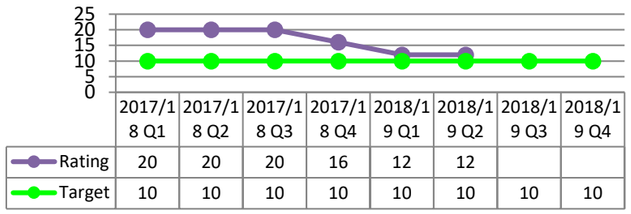
Principal Risk

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	September 2018	December 2018	Well Led / NHSI - Use of Resources	CEO	Board of Directors	Quality Governance Committee

Strategic Domain 2: P2
Risk Rating by Financial Quarter 2017/18 to 2018/19



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 to remain the same. Currently recruiting a new independent chair for the partnership board and a programme director for integrated care partnerships.

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	20	CS0327 – Long Term Financial Sustainability of MCHFT	20
CS0374 - 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	16		

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

AQUA facilitated workshop on the development of integrated care partnerships.

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. Full time dedicated resource to lead ICP.

Strategic Domain 3: Striving for Outstanding Organisational Effectiveness

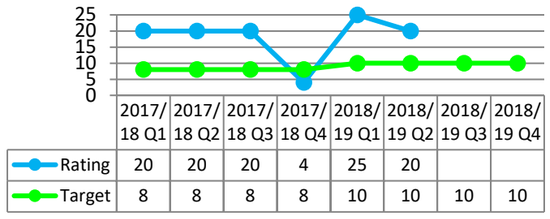
E1	To ensure full compliance with the NHS Improvement Provider Licence, ensuring financial sustainability, financial efficiency and financial controls, whilst safeguarding the quality of our services.

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	September 2018	December 2018	Well Led NHSI - Use of Resources	Director of Finance and Strategic Planning	Divisional Finance & Activity Performance Group	Performance & Finance

Strategic Domain 3: E1
Risk Rating by Financial Quarter 2017/18 to 2018/19



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

Rationale for the Current Risk Score

At the end of Quarter 1 of 2018/19 the risk score was raised to 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. The risk score has been reduced to 20 for Quarter 2 as early indicators are the MOU will be honoured.

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 A&E	20⇔	CS0326 – Lack of funding to deliver the IM&T Strategy	12 ⇩
CS0327 – Long Term Financial Sustainability of MCHFT	20⇔	CS 0284 - Registered Nurse staff shortages	16⇔

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 a NHS Improvement Use of Resources assessment in March 2018 and has been rated as good.

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 at PAF in October and implemented.

Strategic Domain 3: Striving for Outstanding Organisational Effectiveness

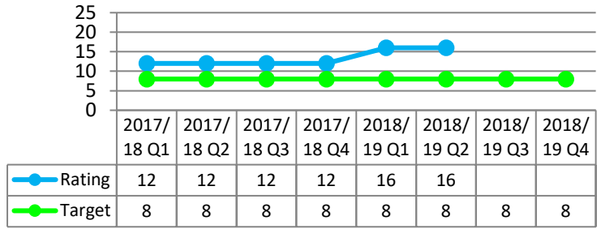
E2	To maintain compliance with, and aspire to achieve incremental improvements against, the NHS Improvement Single Oversight Framework Operational Performance Metrics, whilst safeguarding the quality of our services.

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	September 2018	December 2018	Responsive Care & Effective Care NHSI - Operational Performance Metrics	Chief Operating Officer	Divisional Finance & Activity Performance Group	Performance & Finance

Strategic Domain 3: E2
Risk Rating by Financial Quarter 2017/18 to 2018/19



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 for Quarter 2 remains the same at 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 A&E	20⇔	CS0326 – Lack of funding to deliver the IM&T Strategy	12 ⇩
CS0328 – Workforce capacity and skill mix to consistently deliver high quality care, seven days a week	20⇔	CS0284 – Registered nurse staff shortages	16⇔
CS0327 – Long Term Financial Sustainability of MCHFT	20⇔	DC 72 - Lack of breast cancer capacity due to lack of consultants (Radiology)	16⇔
CS0375 - Delayed routine outpatient follow-up	U/R		

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. System improvement is led at director level through the A&E Delivery Board, with steering groups reporting into it. The recent CQC report saw an improvement in the Responsive domain, from 'requires improvement ' to 'good'. This is in addition to an NHSI Use of Resources rating of Good in March 2018. However; there continues to be pressures regarding responsiveness following an increase in referrals, reduced capacity (via CEP), resulting in a number of follow-ups being delayed.

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 October 2018.

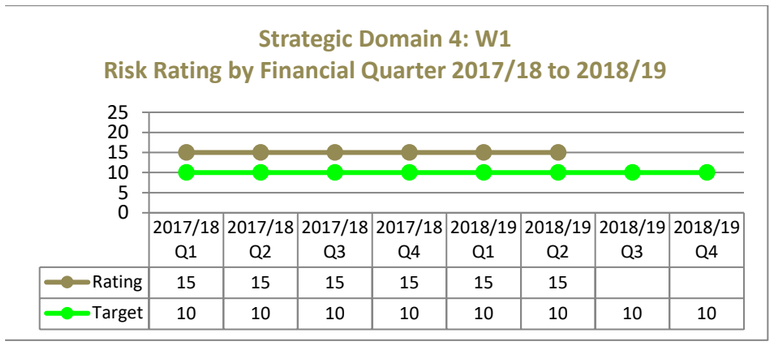
Strategic Domain 4: Aspiring to Excellence in Practice through Our Workforce

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	September 2018	December 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 A&E	20	CS0328 – Workforce capacity and skill mix to consistently deliver high quality care, seven days a week	20
CS0327 – Long Term Financial Sustainability of MCHFT	20	CS0284 – Registered nurse staff shortages	16
CS0326 – Lack of funding to deliver the IM&T Strategy	12 ⇩	DC0887 - Consultant Histopathologist capacity	16 ⇔
EC0327 - Lack of secondary Anaesthetic on-call cover	20 ⇔		

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

Central to our new Our Workforce Matters Strategy 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. Clinical and Non-clinical talent management and succession planning is being rolled out across the Trust. Well led self- assessment process. Local development of improvement plans following the National Staff Survey results. Freedom to Speak Up self-review tool now established.

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 and to Board for approval in November 2019.
- Review of Education Governance Framework by April 2019
- In some specialities there are gaps in senior clinical leadership
- Two divisions to attend EWG to present improvement plans following the National Staff Survey

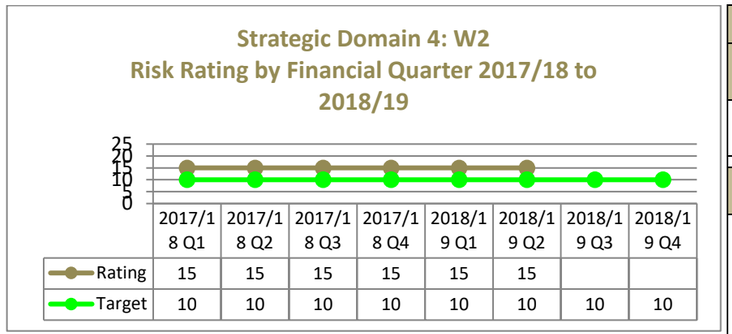
Strategic Domain 4: Aspiring to Excellence in Practice through Our Workforce

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 / Integrated Care Partnerships (ICP)

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	September 2018	December 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 A&E	20	CS0328 – Workforce capacity and skill mix to consistently deliver high quality care, seven days a week	20
CS0327 – Long Term Financial Sustainability of MCHFT	20	CS0284 – Registered nurse staff shortages	16
CS0326 – Lack of funding to deliver the IM&T Strategy	12 ⇩	DC0887 - Consultant Histopathologist capacity	16 ⇔
EC0327 - Lack of secondary Anaesthetic on-call cover	20 ⇔		

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

Comprehensive review of mandatory data, with each division working to action plans for mandatory training and appraisals. Review of Education Governance framework.

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

- Workforce & OD Strategy (Our Workforce Matters Strategy) is not expected to be fully through the governance process until November 2018.
- Local development of improvement plans following the National Staff Survey results.
- Talent management & succession planning programme planned.
- Lack of confidence in the validity of mandatory training data.

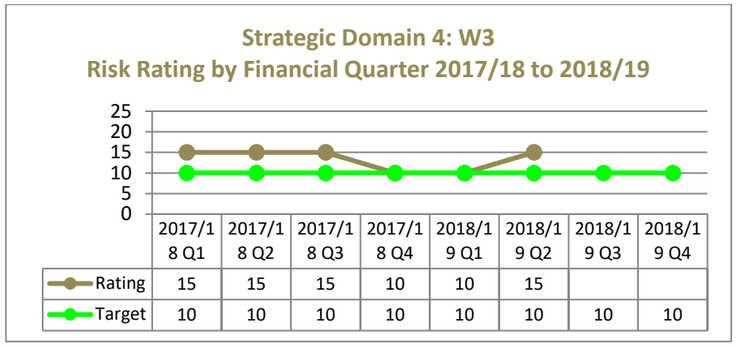
Strategic Domain 4: Aspiring to Excellence in Practice through our Workforce

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	September 2018	December 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

Risk score has increased to 15, to reflect the work required to implement Our Workforce Matters following approval by Board in November 2018, and current sickness absence levels.

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 A&E	**20**	CS0328 – Workforce capacity and skill mix to consistently deliver high quality care, seven days a week	20
CS0327 – Long Term Financial Sustainability of MCHFT	**20**	CS0284 – Registered nurse staff shortages	16
CS0326 – Lack of funding to deliver the IM&T Strategy	12 ⇩	DC0887 - Consultant Histopathologist capacity	16 ⇔

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

Sickness Absence Policy has been reviewed and a training plan is in place to support roll out. Guardian of Safe Working Hours. A task and finish cross-divisional group has been established to oversee sickness absence. Freedom to Speak Up self-review tool completed in August 2018.

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.

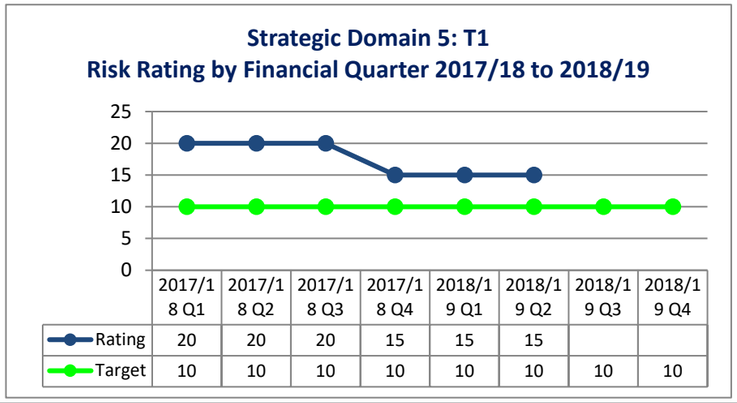
Strategic Domain 5: Creating a 21st Century Infrastructure for Transformative Health and Social Care

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
June 2017	September 2018	December 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. There may be opportunities to receive capital revenue that is not being made available currently.

Links to BAF Objectives

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

Key Links to the Organisational Risk Register

CS0327 – Long Term Financial Sustainability of MCHFT	20⇔	CS0325 – Delivery of key local and National targets and standards, in particular the 4 hour standard in A&E	20⇔

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. Potential recruitment of Director of E&F with systems focus.

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

Asbestos Management Group – oversight of new contractors in progress. Recruitment of new Director of Estates and Facilities.

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

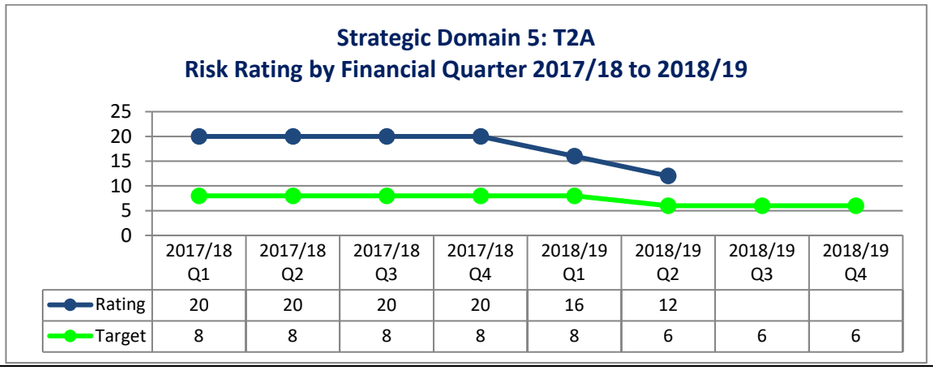
T2a	To deliver an agreed, costed and phased Information Technology (IT) Strategy which supports the provision of seamless, integrated, outstanding patient care, improves staff experience in delivering care and enables continuous quality and service improvements through the intelligent use of secure, 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	September 2018	December 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⇔	3	4	12⇩	3	2	⇩6	March 2019

Rationale for the Current Risk Score

The current risk score has been reduced from 16 to 12. Actual impact on patient care has been reconsidered. Pockets of funding contingencies to be identified, in combination with EC NHS Trust. £3M of National funding to support the clinical systems business case. The clinical systems business case has been approved by NHSI. 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	20⇔	Cyber Security	16⇔
CS0326 – Lack of funding to implement the IM&T Strategy	12⇩		

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 on an electronic patient record, and supports whole system service transformation and integration as we move towards Integrated Care Systems. This strategy has recently been updated to align with the regional Healthcare Partnership IG Strategy. 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. Funding to replace aged hardware across the Trust has been identified, and the replacement has now commenced. The E-Rostering project has now commenced and is on track to deliver within timescales. The Trust scored 91% (Satisfactory) for the Information Governance Toolkit in March 2018. Cyber security across the Trust is being improved the aid of National funding and the appointment of a new cyber security engineer.

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

- Deficient progress on the EPR Business Case
- Overarching Cyber Security implementation plan to be presented to ITSG in December 2018

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.

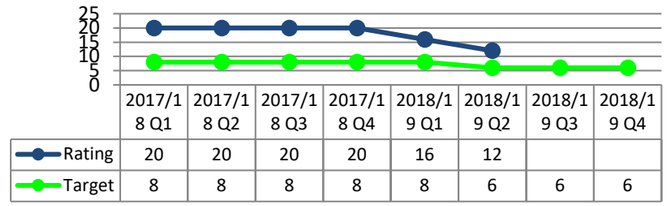
Principal Risk

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	September 2018	December 2018	Well Led Framework Use of Resources	Medical Director / Deputy CEO	Executive Infrastructure Development Group	Performance & Finance

Strategic Domain 5: T2B
Risk Rating by Financial Quarter 2017/18 to 2018/19



	2017/18 Q1	2017/18 Q2	2017/18 Q3	2017/18 Q4	2018/19 Q1	2018/19 Q2	2018/19 Q3	2018/19 Q4
Rating	20	20	20	20	16	12		
Target	8	8	8	8	8	6	6	6

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**	3	4	**12⇩**	3	2	**⇩6**	March 2019

Rationale for the Current Risk Score

The current risk score has been reduced from 16 to12, on the basis that the business case has been approved by the NHSI to move to the next step. £3M of National funding to support the clinical systems business case.

Links to BAF Objectives

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

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

CS0327 – Long Term Financial Sustainability of MCHFT	20	Cyber Security	16⇔
CS0326 – Lack of funding to implement the IM&T Strategy	**12⇩**		

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

Funding to replace aged hardware across the Trust has been identified, and the replacement has now commenced. The E-Rostering project has now commenced and is on track to deliver within timescales. The IT Team hold intermittent drop-in sessions for staff across the Trust to directly discuss IT issues. Annual update of IG training is part of mandatory training. Computer confidence courses are available for all staff. QA process for train the trainer has been introduced, and surveys for staff trained by core trainers has been established to measure the effectiveness of the training.

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

- Review of job description content re digital age
- Recruitment assessment process and underpinning support programme 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

<table>
<tr><th colspan="2">Domain Three: Striving for Outstanding Organisational Effectiveness</th></tr>
<tr><td>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</td><td>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.</td></tr>
<tr><th colspan="2">Domain Four: Aspiring to Excellence in Practice through our Workforce</th></tr>
<tr><td>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.</td><td>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.</td></tr>
</table>

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?

Learning from Deaths Quarterly Report Q2 2018/19

November 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 fifth iteration of our Learning from Deaths Report covering quarter 2 of 2018/19.

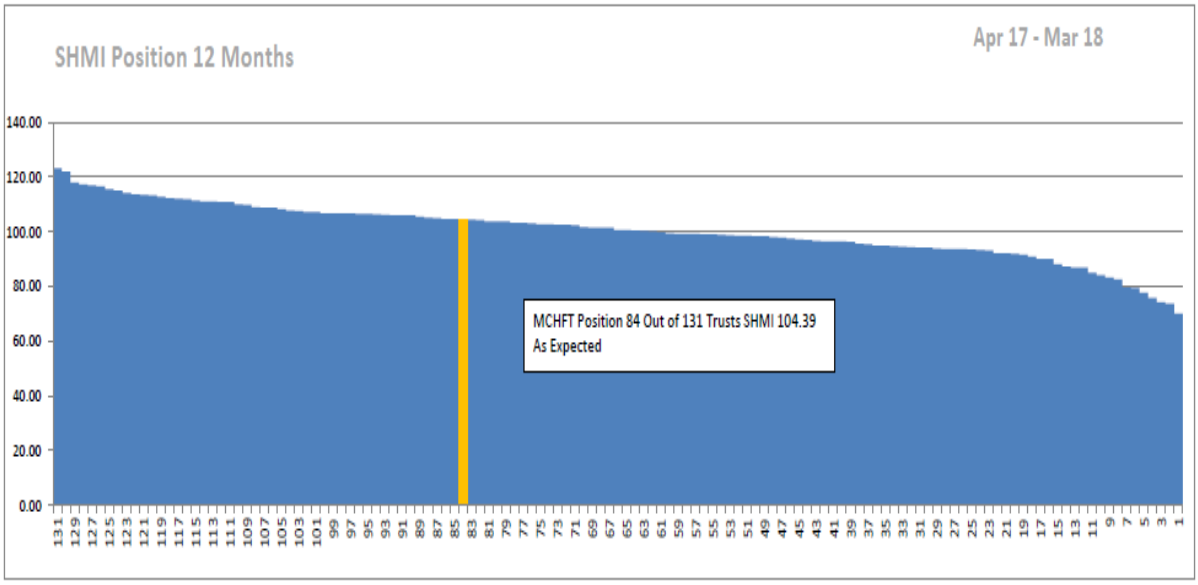
The report will be produced and developed on a quarterly basis and aims to provide assurance on how the organisation, through the work of the HMRG and other linking groups, is triangulating data and information to enable sustained learning from deaths, with the goal of seeing a sustained reduction in 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) April 2017 to March 2018

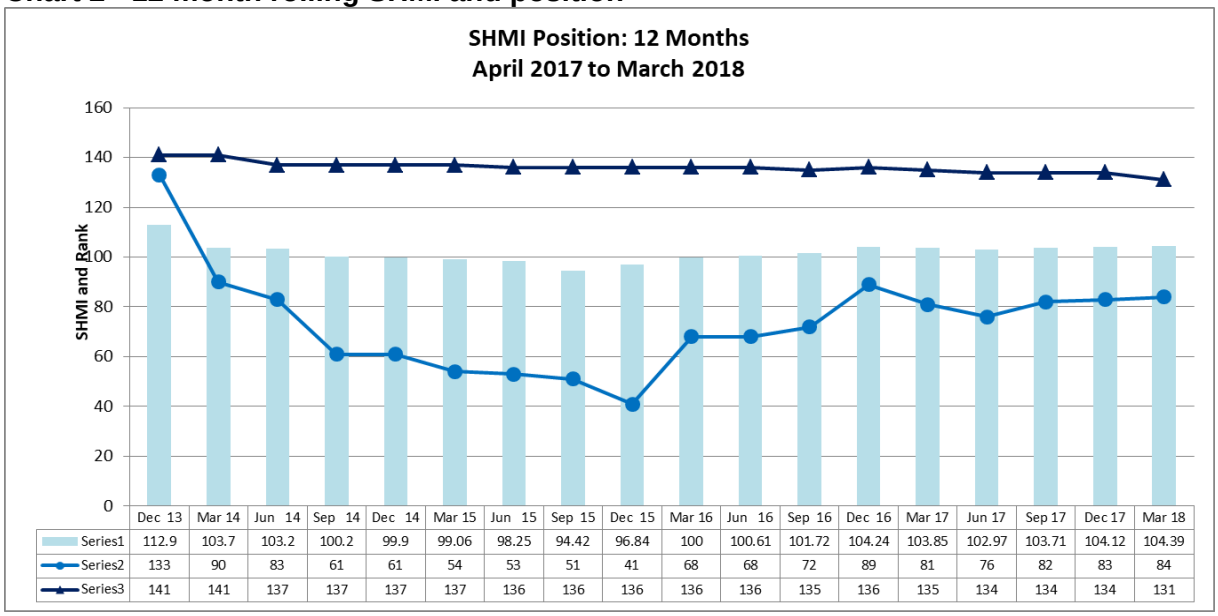
Chart 1 - SHMI Position



(Source NHS Digital, 2018)

Chart 1 demonstrates the SHMI position for the reporting period April 2017 to March 2018. The SHMI is currently 104.39 and is in the 'as expected' range. This currently places the Trust 84 out of 131. This is compared to the previous reporting period when the SHMI was 104.12 with a position of 83 out of 134 Trusts.

Chart 2 - 12 month rolling SHMI and position

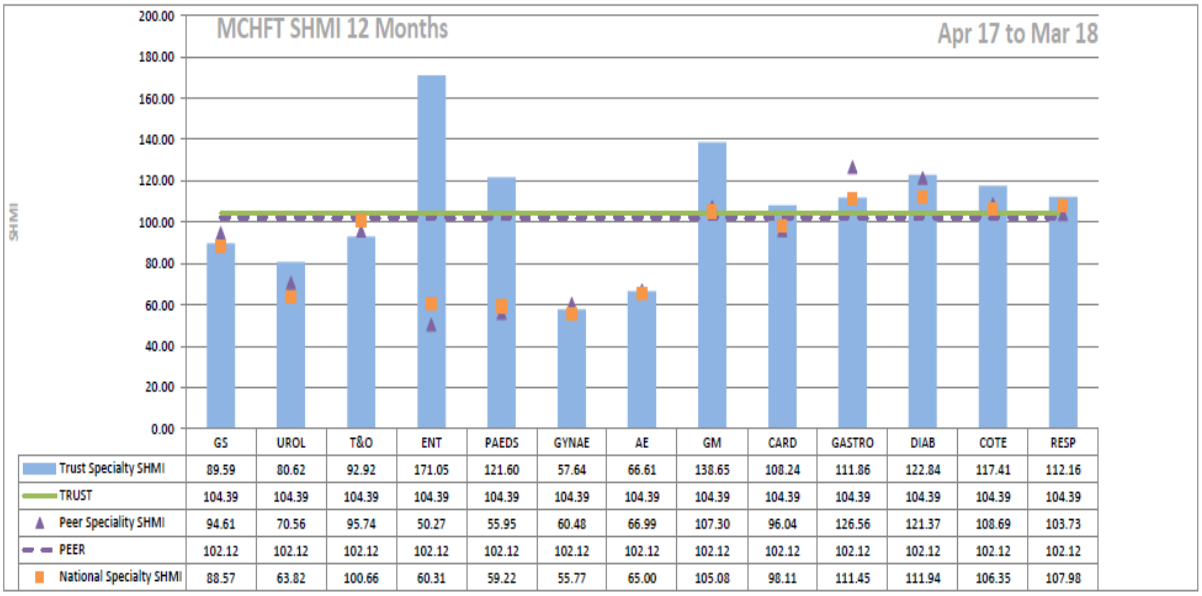


	Dec 13	Mar 14	Jun 14	Sep 14	Dec 14	Mar 15	Jun 15	Sep 15	Dec 15	Mar 16	Jun 16	Sep 16	Dec 16	Mar 17	Jun 17	Sep 17	Dec 17	Mar 18
Series1	112.9	103.7	103.2	100.2	99.9	99.06	98.25	94.42	96.84	100	100.61	101.72	104.24	103.85	102.97	103.71	104.12	104.39
Series2	133	90	83	61	61	54	53	51	41	68	68	72	89	81	76	82	83	84
Series3	141	141	137	137	137	137	136	136	136	136	136	135	136	135	134	134	134	131

(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 April 2017 to March 2018.

Chart 3 - SHMI by Speciality



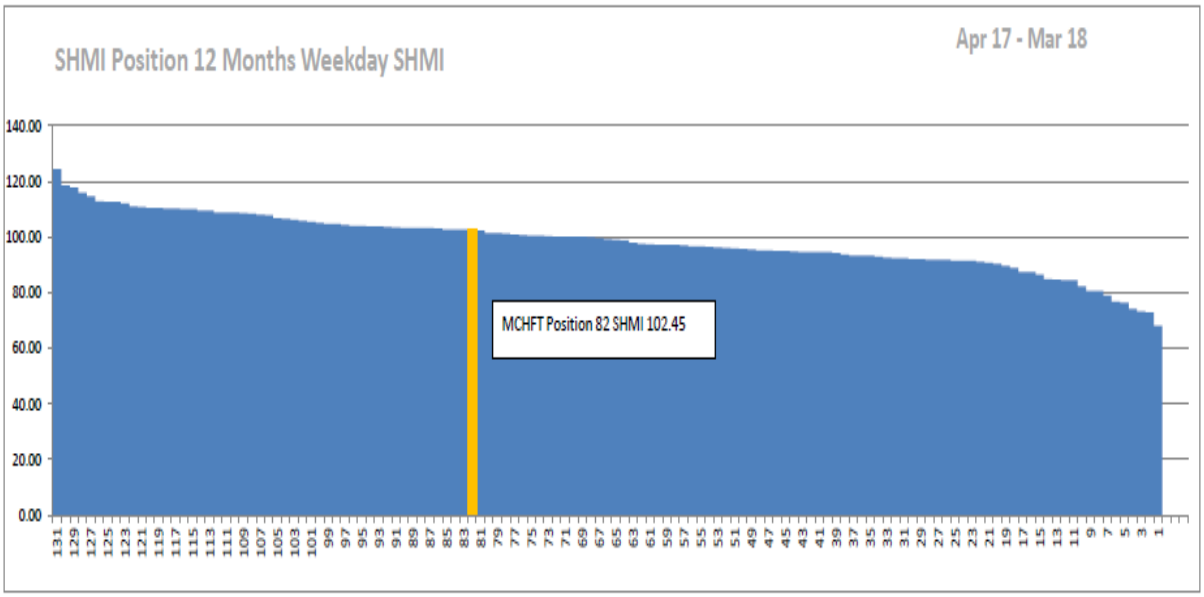
	GS	UROL	T&O	ENT	PAEDS	GYNAE	AE	GM	CARD	GASTRO	DIAB	COTE	RESP
Trust Specialty SHMI	89.59	80.62	92.92	171.05	121.60	57.64	66.61	138.65	108.24	111.86	122.84	117.41	112.16
TRUST	104.39	104.39	104.39	104.39	104.39	104.39	104.39	104.39	104.39	104.39	104.39	104.39	104.39
Peer Speciality SHMI	94.61	70.56	95.74	50.27	55.95	60.48	66.99	107.30	96.04	126.56	121.37	108.69	103.73
PEER	102.12	102.12	102.12	102.12	102.12	102.12	102.12	102.12	102.12	102.12	102.12	102.12	102.12
National Specialty SHMI	88.57	63.82	100.66	60.31	59.22	55.77	65.00	105.08	98.11	111.45	111.94	106.35	107.98

(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, Paediatrics, General Medicine, Cardiology, Diabetology, Care of the Elderly and Respiratory.

A&E, Gastroenterology, Gynaecology and General Surgery are above the national average but below peer. Trauma and Orthopaedics is below both the national average and peer.

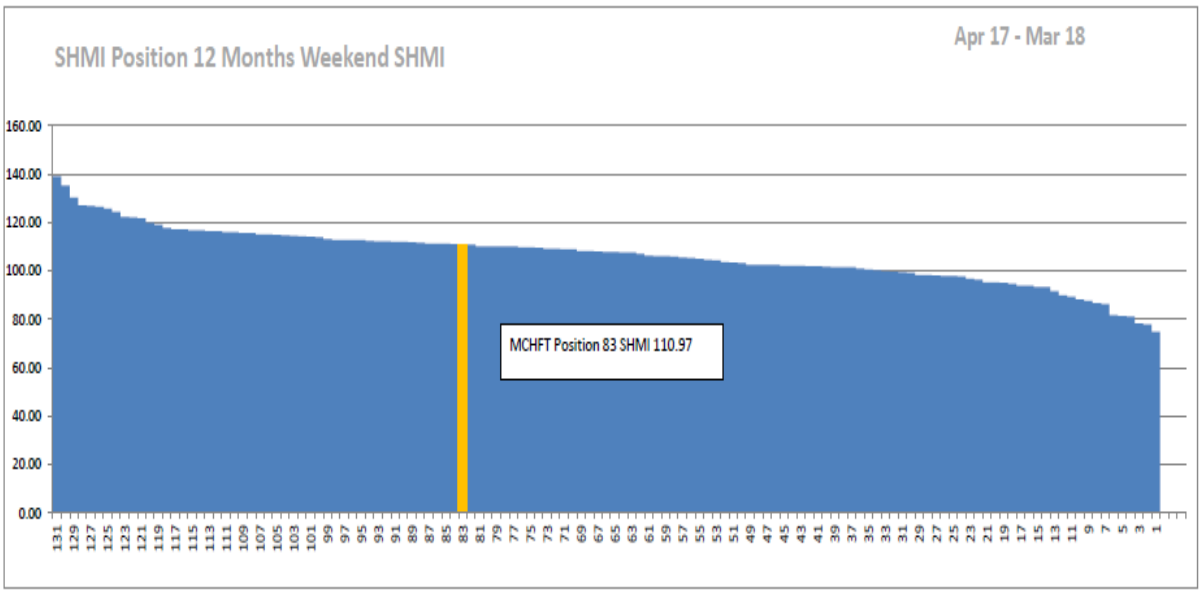
Chart 4 - Weekday SHMI



(Source HED, 2018)

Chart 4 demonstrates the weekday SHMI position for the reporting period April 2017 to March 2018. The weekday SHMI is currently 102.45 and places the Trust 82 out of 131.

Chart 5 - Weekend SHMI

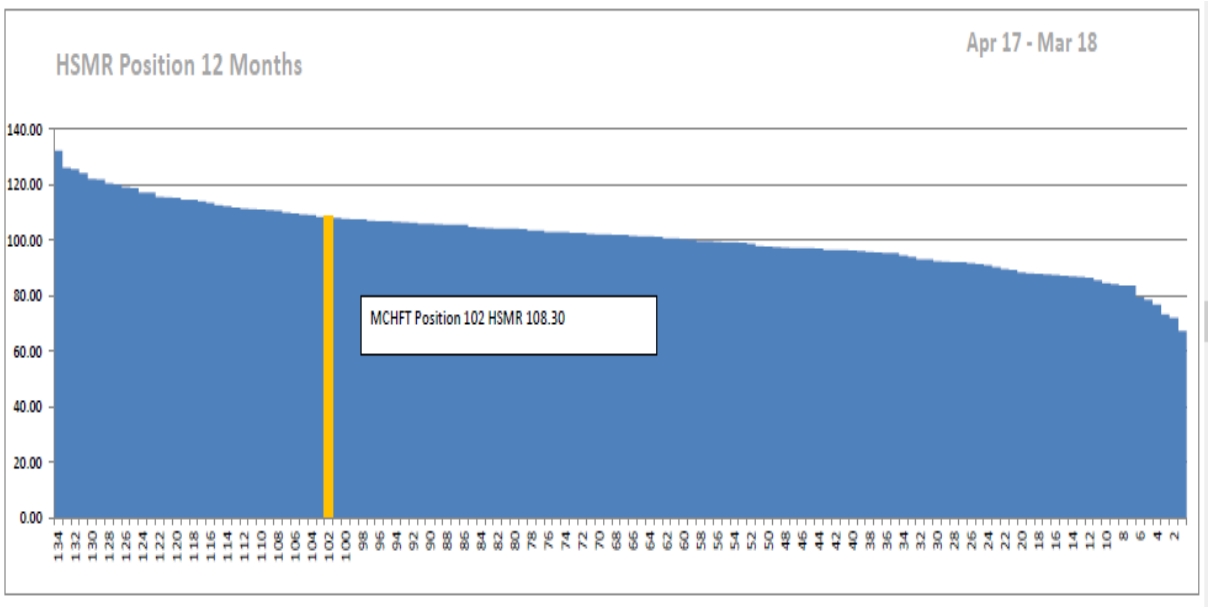


(Source HED, 2018)

Chart 5 demonstrates the weekend SHMI position for the reporting period April 2017 to March 2018. The weekend SHMI is currently 110.97 and places the Trust 83 out of 131.

2.2 Hospital Standardised Mortality Rate (HSMR) April 2017 to March 2018

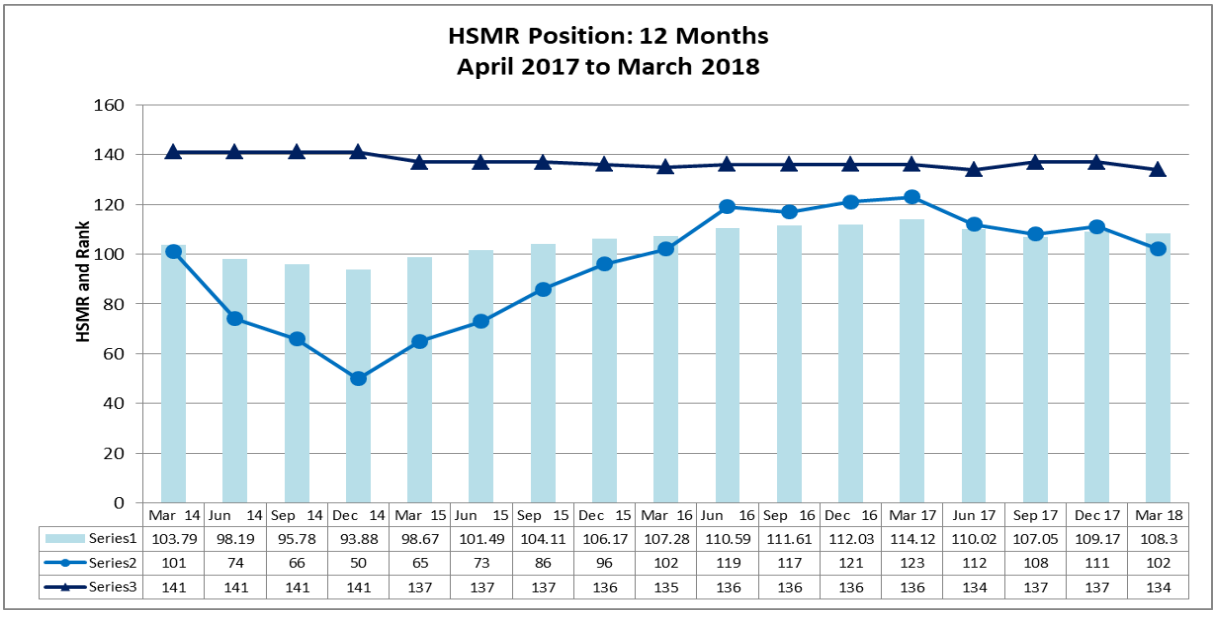
Chart 6 - HSMR Position



(Source HED, 2018)

Chart 6 demonstrates the HSMR position for the reporting period April 2017 to March 2018. The HSMR is currently 108.3. This currently places the Trust 102 out of 134. This is compared to the previous reporting period when the HSMR was 109.17 with a position of 111 out of 137 Trusts.

Chart 7 - 12 month rolling HSMR and position

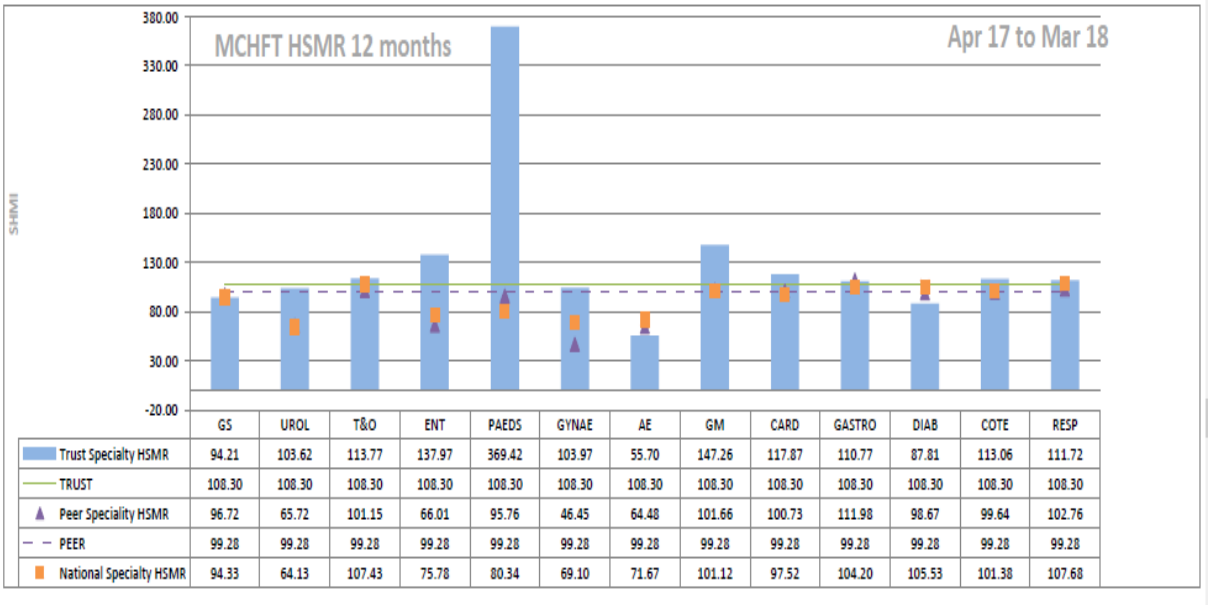


	Mar 14	Jun 14	Sep 14	Dec 14	Mar 15	Jun 15	Sep 15	Dec 15	Mar 16	Jun 16	Sep 16	Dec 16	Mar 17	Jun 17	Sep 17	Dec 17	Mar 18
Series1	103.79	98.19	95.78	93.88	98.67	101.49	104.11	106.17	107.28	110.59	111.61	112.03	114.12	110.02	107.05	109.17	108.3
Series2	101	74	66	50	65	73	86	96	102	119	117	121	123	112	108	111	102
Series3	141	141	141	141	137	137	137	136	135	136	136	136	136	134	137	137	134

(Source HED, 2018)

Chart 7 demonstrates the HSMR and rank of the Trust for each of the 12 month rolling position submissions for the period to the latest submission April 2017 to March 2018.

Chart 8 - HSMR by Speciality

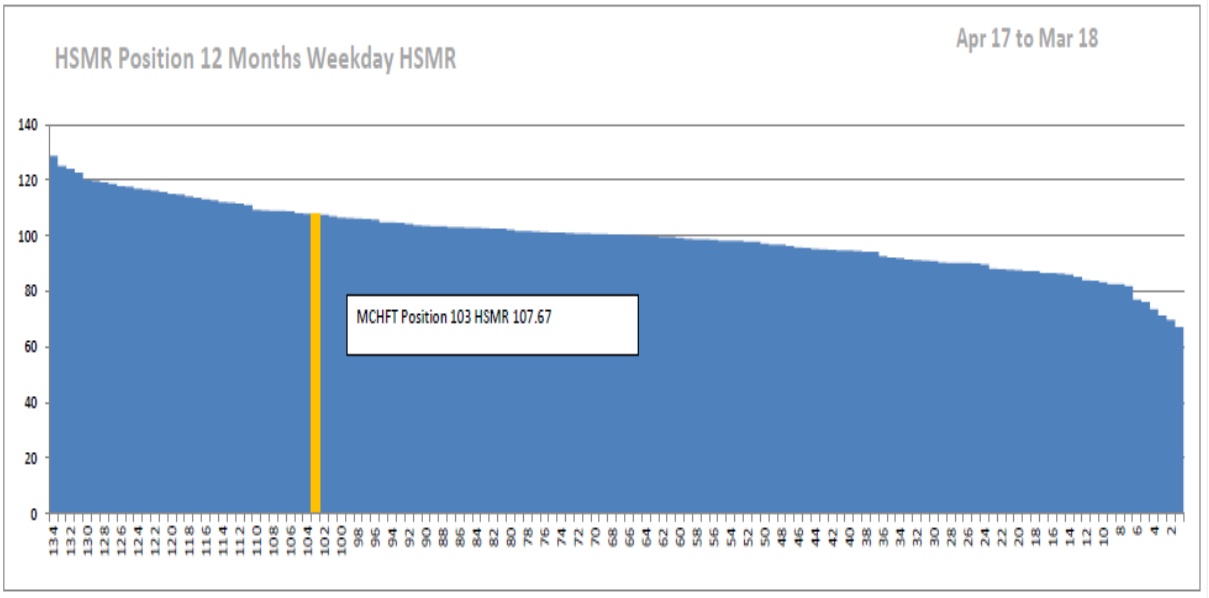


	GS	UROL	T&O	ENT	PAEDS	GYNAE	AE	GM	CARD	GASTRO	DIAB	COTE	RESP
Trust Specialty HSMR	94.21	103.62	113.77	137.97	369.42	103.97	55.70	147.26	117.87	110.77	87.81	113.06	111.72
TRUST	108.30	108.30	108.30	108.30	108.30	108.30	108.30	108.30	108.30	108.30	108.30	108.30	108.30
Peer Speciality HSMR	96.72	65.72	101.15	66.01	95.76	46.45	64.48	101.66	100.73	111.98	98.67	99.64	102.76
PEER	99.28	99.28	99.28	99.28	99.28	99.28	99.28	99.28	99.28	99.28	99.28	99.28	99.28
National Specialty HSMR	94.33	64.13	107.43	75.78	80.34	69.10	71.67	101.12	97.52	104.20	105.53	101.38	107.68

(Source HED, 2018)

Chart 8 demonstrates the HSMR by Specialty against peer and the national average.
The specialties, which are currently above both peer and the national average are Urology, Trauma and Orthopaedics, ENT, Paediatrics, Gynaecology, General Medicine, Cardiology, Gastroenterology, Care of the Elderly and Respiratory.

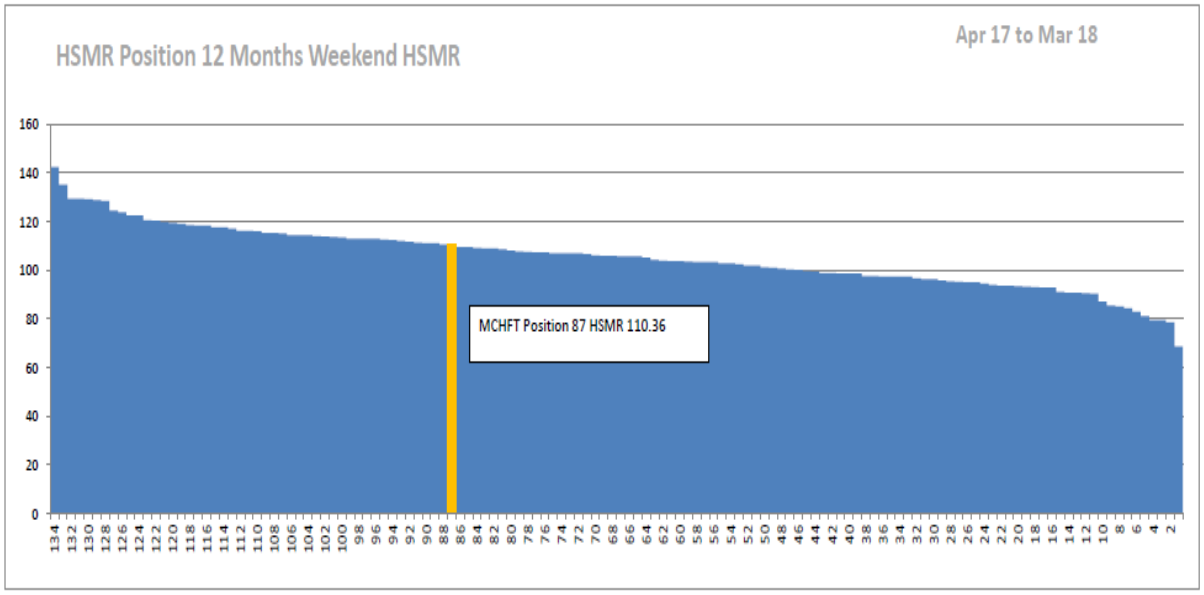
Chart 9 - Weekday HSMR



(Source HED, 2018)

Chart 9 demonstrates the weekday HSMR position for the reporting period April 2017 to March 2018. The weekday HSMR is currently 107.67 and places the Trust 103 out of 134.

Chart 10 - Weekend HSMR



(Source HED, 2018)

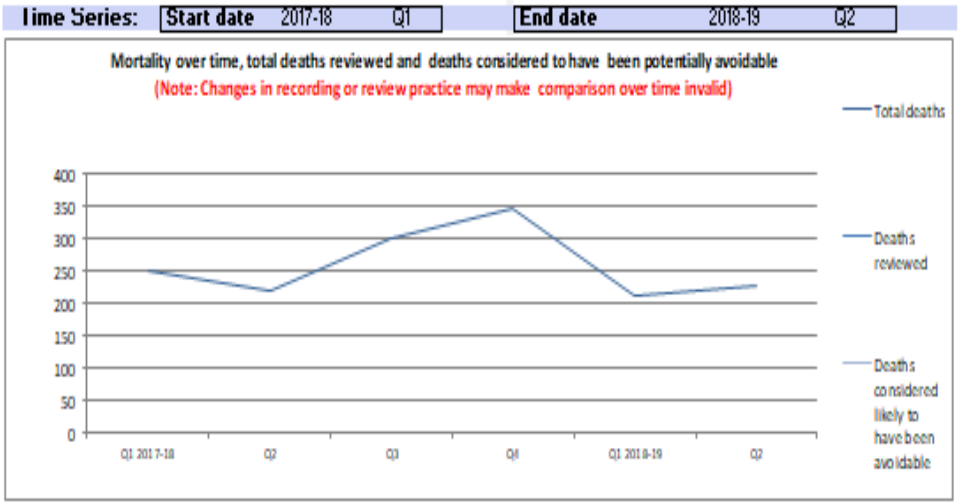
Chart 10 demonstrates the weekend HSMR position for the reporting period April 2017 to March 2018. The weekend HSMR is currently 110.36 and places the Trust 87 out of 134.

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 2 avoidable deaths were identified and reported following comprehensive incident investigations.*

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
63	82	43	73	6	20	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter	Last Quarter	This Quarter (QTD)	Last Quarter
225	213	178	221	33	4	2	N/A
This Year	Last Year	This Year	Last Year	This Year	Last Year	This Year	Last Year
438	1117	399	889	37	N/A	2	N/A

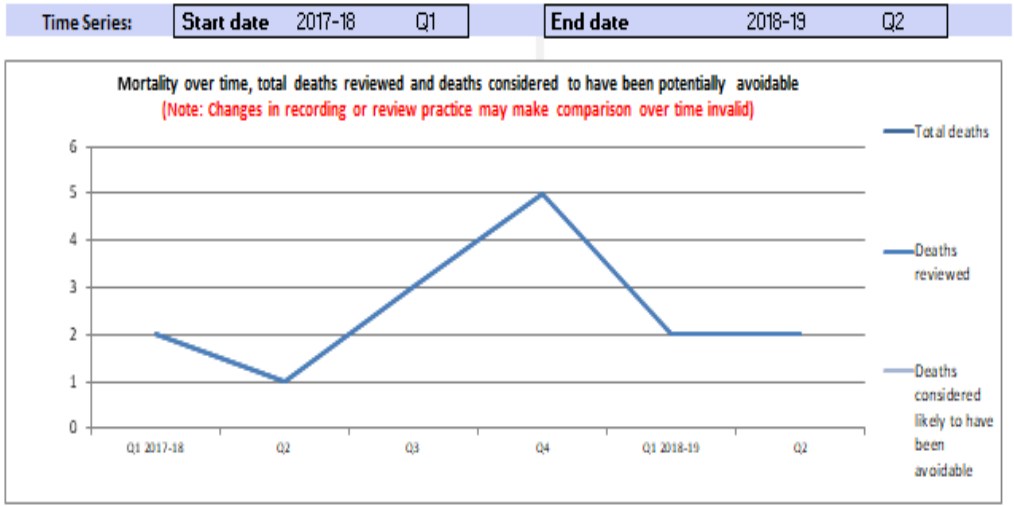


2.3 Learning from Deaths Dashboard – Part 2

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.

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
2	0	2	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
2	2	2	2	0	0
This Year	Last Year	This Year	Last Year	This Year (YTD)	Last Year
4	11	4	11	0	N/A



3.0 Care Quality Commission (CQC) Mortality Outlier Alerts

The information below is sourced from the latest version of the CQC Insight document (12 October 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 10 September 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 a Structured Judgemental Review (SJR).

SJR's are undertaken by a cohort of senior medical and nursing staff. The cohort has been trained in the SJR Process.

A number of clinical conditions are referred for an SJR; these were agreed by the HMRG in line with national guidance.
The clinical conditions selected include:

- Acute Cerebrovascular Accident (at the weekend)
- Pneumonia (at the weekend)
- Intestinal obstruction without hernia
- Alcohol related liver disease
- Infectious diseases (CQC Insight metric)
- All deaths where families, carers or staff raise concerns
- Concerns raised by the Coroner
- Concerns raised at the Patient Safety Summit
- Concerns raised during the Friday mortality screening process
- Relevant elective deaths

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 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 September 2018, (see Appendix 1). The 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 implement and embed the learning from the SJR Process:

- The initial learning from quarter 1 and 2 of the SJRs has been collated and included in a 'Learning from our Mortality Reviews' newsletter. See appendix 4.
- A deep dive on the SJR process has been included in this report.
- A quarterly junior doctor newsletter is being developed to share the learning from incidents and the SJR Process.

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

- The National Early Warning Score 2 (NEWS2) was launched in the Emergency Department and inpatient ward areas on the 5 November 2018.
- The Trust Adult Vital Signs & NEWS2 Policy has been developed and was approved prior to the launch.
- The Adult vital signs chart has been revised to include NEWS2, neurological observations, sepsis and AKI guidance.
- The Emergency Department admissions card has been revised to incorporate NEWS2.
- Divisional admission proforma's have been revised again to incorporate NEWS2.
- A training programme has taken place across the organisation prior to the launch of NWS2.
- The 2018 Trust Quality Improvement Session, which was held on the 19 October, focused on the care of the deteriorating patient and NEWS2.
- NEWS2 will next be launched in Theatres and the Treatment Centre.

4.3 Actions planned to build quality improvement capacity and capability within the organisation through the introduction of the Quality, Service improvement and Redesign (QSIR) programme

- Identifying a cohort of staff to undertake the QSIR Practitioner programme to progress the MCHFT QSIR College.
- Further develop the quality improvement driver diagram.
- Identify and engage with staff who have previously undertaken improvement training
- Include quality improvement on the Trust's leadership and development programmes as part of the 'dosing approach' including:-
    - Bands 3 & 4 - Learning to Lead
    - Bands 5, 6, 7 - Developing Leadership Programme
    - Newly appointed Consultants - Consultant Foundation Programme
    - Clinical leads, aspiring clinical leads - Clinical Leaders Development Programme
    - Apprenticeships in leadership from Level 3 Team Leader to Level 7 Master's degree
    - Board Development Programme
    - Senior Leaders Development Programme
    - Talent Management and Succession Planning (Aspirant Senior Leaders) Programme
- Include a baseline introduction to improvement on the Trust induction and in staff information handbooks.
- Ensure closer alignment across corporate teams e.g. Quality and Service Transformation Teams.
- Raise the profile and QI networking across the Trust and wider health community.
- Engaging across the wider health and social care system in improvement activities.

4.4 Actions taken to ensure all LeDeR reviews are shared with internal and external stakeholders

- All learning disability deaths undergo a case note review using the Learning Disabilities Mortality Review (LeDeR) process. These are conducted by the Privacy and Dignity Matron who is trained in the LeDeR process.
- All learning disability reviews are submitted to the national programme.
- All learning disability reviews are presented to the Hospital and Trust Mortality Reduction Groups to ensure learning is shared.

5.0 Quarterly Deep Dive – Structured Judgemental Review Process

The SJR process was developed by the Royal College of Physicians (RCP). Structured judgement review blends traditional, clinical-judgement based review methods with a standard format. The approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase. The result is a relatively short but rich set of information about each case in a form that can also be aggregated to produce knowledge about clinical services and systems of care.
The objective of the review method is to look for strengths and weaknesses in the caring process, to provide information about what can be learnt about the hospital systems where care goes well, and to identify points where they may be gaps, problems or difficulty in the care process.

The SJR produces two types of data:

1. a score from 1 to 5 identifies very poor to excellent care respectively in a number of phases of care
2. qualitative data in the form of explicit statements about care using free text

The phases of care which are reviewed are:

- Admission and initial care - first 24 hours
- Ongoing care
- Care during a procedure
- Perioperative/procedure care
- End of life care
- Assessment of overall care

The SJR process commenced in the Trust in April 2018, a cohort of senior medical and nursing staff were trained in the SJR process. During quarter one and two of 2018/19, 37 SJR's have been completed.

The overall quality of care is assessed during the SJR process. Care scores are recorded after the judgement comments have been written. One score is given to each phase of care. The reviewers then judge their overall decision on the overall quality of care. The table below outlines the findings of the reviews.

Quality of care	Percentage of SJRs as classified using the quality of care ratings
Very poor care	0%
Poor care	12%
Adequate care	17%
Good care	54%
Excellent care	17%

Case note review depends on the content and legibility of the patient record. Safety of care also depends to some extent on good record keeping. Therefore, as part of the overall care assessment, the reviewer is also asked to record their judgement on the quality and legibility of the records.

The table below outlines the findings of the reviews completed in quarters 1 and 2. In 61% of the reviews the quality of the patient record was judged to be good. No reviews identified the records as being of a very poor quality.

Quality of patient record	Percentage of SJRs as classified using the quality of patient record ratings
Very poor	0%
Poor	12%
Adequate	17%
Good	61%
Excellent	10%

As part of the national guidance on learning from deaths the Trust also has to report any avoidable deaths on the quarterly dashboard. Therefore at the end of each review the team are asked to make a judgement on the preventability of the death. A six-point scale, the LIKERT Preventability scale, is used. The scale ranges from one (definitely not preventable) to six (definitely preventable).
In 83% of the deaths reviewed, they were classified as definitely not preventable following the SJR process.

LIKERT Preventability Scale	Percentage of SJRs as classified using the Likert Scale
Definitely not preventable	83%
Slight evidence for preventability	12%
Possibly preventable but not very likely, less than 50-50 but close call	5%
Probably preventable, more than 50-50 but close call	0%
Strong evidence for preventability	0%
Definitely preventable	0%

No avoidable deaths have been identified from the SJR process during quarters 1 and 2.
Two avoidable deaths have been reported on the quarter 2 learning from deaths dashboard. These were identified through the incident investigation process. Both incidents have undergone a comprehensive investigation with an Executive Led Review Meeting. Improvement plans have been developed following each review to ensure lessons are learned and preventative measures are implemented, the incidents have been reported externally in line with national guidance and Duty of Candour completed.

As outlined above the reviewers will highlight positive judgments about the care provided. Below are a number of the positive comments made during the quarter 1 and 2 reviews.

- Excellent care provided
- Multi-specialty working
- Excellent prescribing of anticipatory medications

- Excellent communication with the family
- Risks of surgery well documented
- Excellent set of clinical records
- Good documentation and use of the fractured neck of femur pathway
- Good evidence of both nursing and medical reviews
- Medical review in emergency department well completed with a thorough history taken, medication and allergies recorded. Chest and abdominal examination recorded. VTE risk assessment completed
- Good documentation of discussions with relatives regarding end of life care and ceilings of care
- Good assessment of patient's capacity and requirement for a DoLs

The themes for learning which have been identified from the reviews include:

- Poor completion of pathways within the trust including, acute kidney injury, sepsis management, pneumonia and end of life
- Delays in medication administration
- Clinical observations not recorded in line with Trust guidance
- Failure to identify the deteriorating patient
- Failure to respond to the deteriorating patient
- Delays in medical reviews
- Poor completion of fluid balance monitoring
- unified Do Not Attempt Cardio Respiratory Pulmonary Resuscitation (uDNACPR) not considered or completed promptly

A lessons learned document has been produced (see appendix 4) to share the learning from the reviews. This will be shared across the organisation. The learning is also shared at the Trust Mortality Reduction Group through this report.

On the 5 November 2018, the Trust launched NEWS 2 with the aim to address the failures to identify and respond to the deteriorating patient. The revised vital signs chart includes guidance on sepsis management, fluid balance management and escalation of the deteriorating patient.

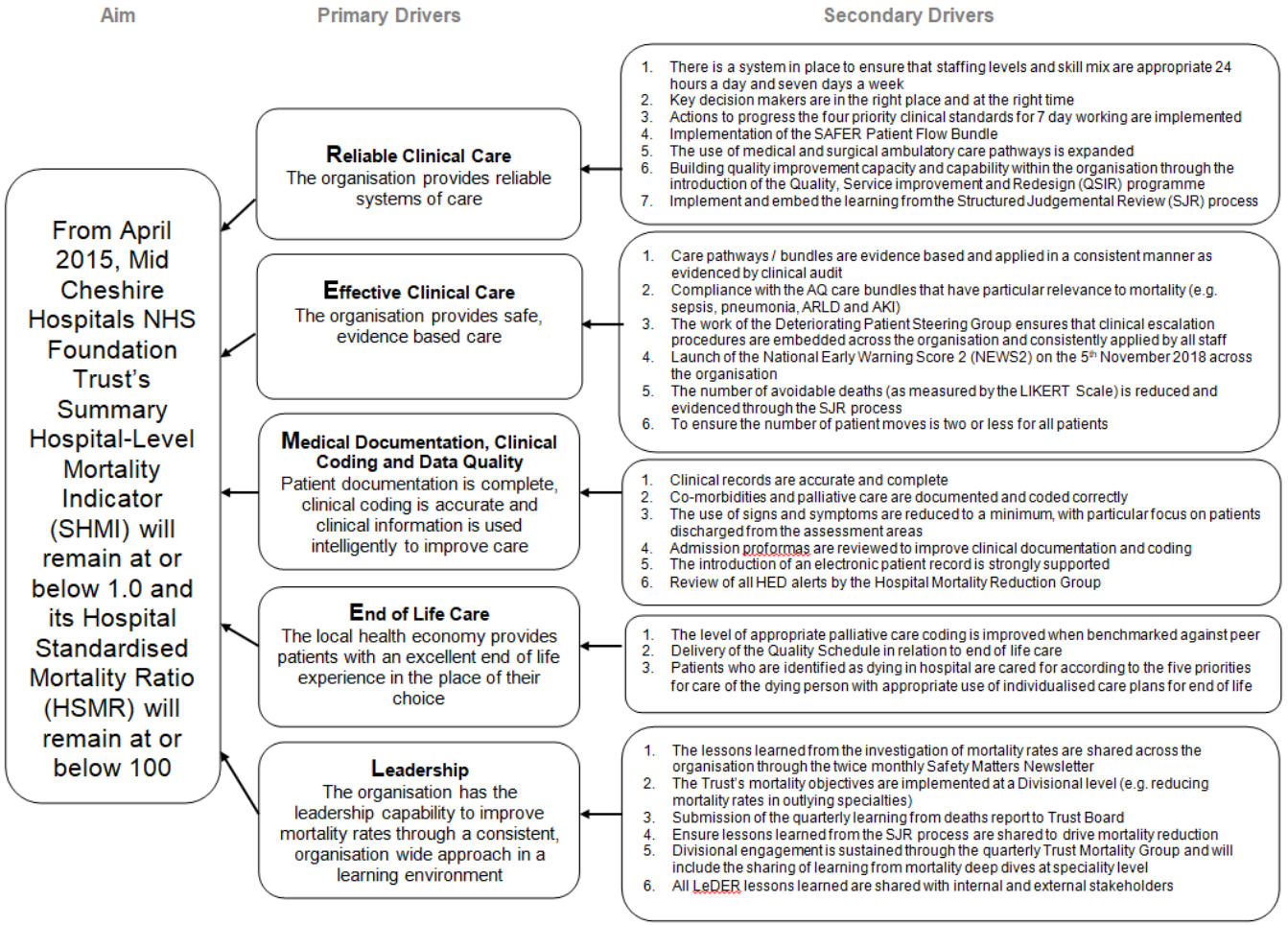
Learning has been included on the two weekly Patient Safety Matters newsletter regarding the completion of pathways, uDNACPR and delays in medication administration.

6.0 Next steps include:

- Deep dive into mortality rates in paediatrics
- Deep dive into mortality rates in General Medicine

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)

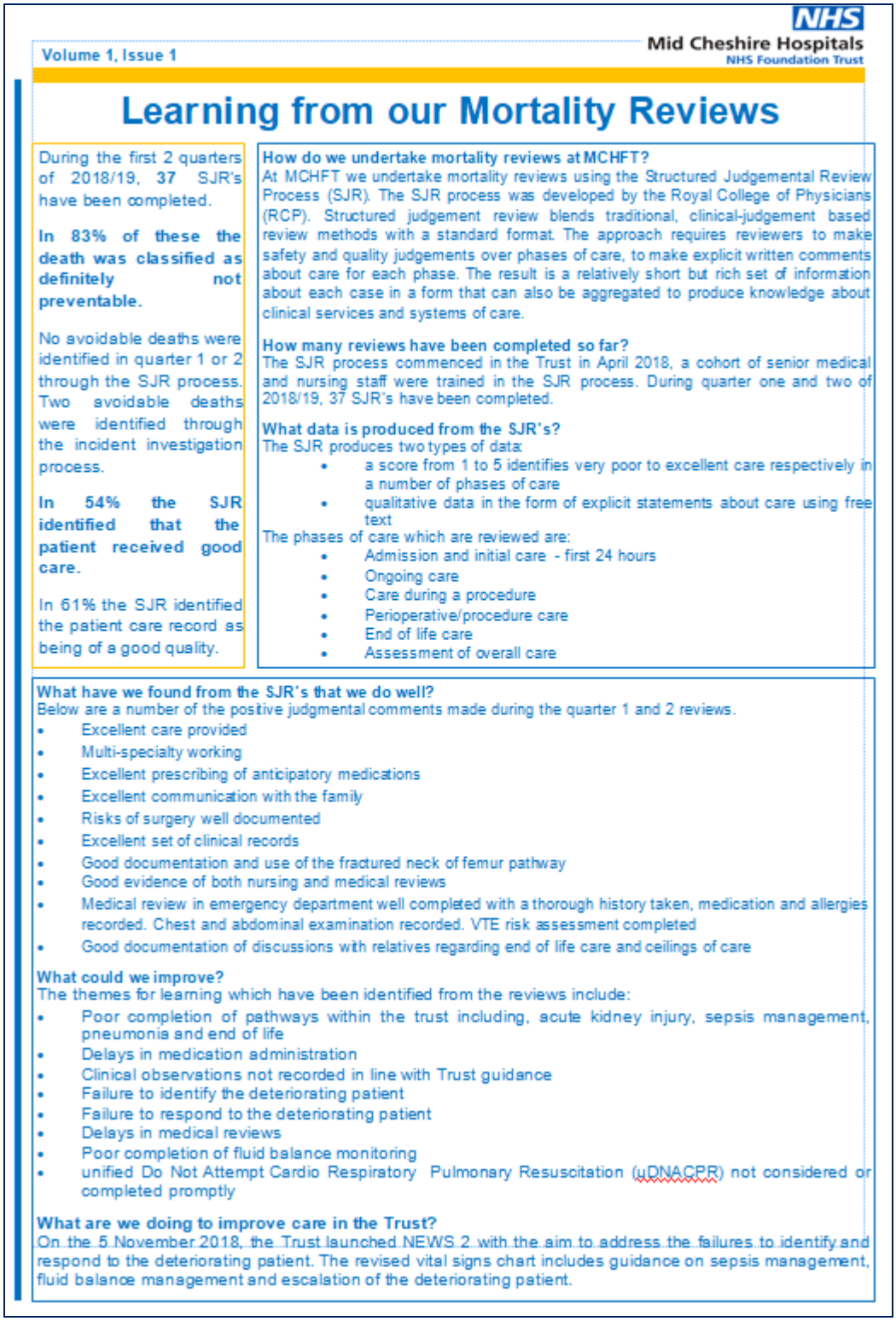
SHMI reports on mortality at trust level across the NHS in England. This indicator is produced and published quarterly as an official statistic. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the 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

6.4 Appendix 4: Example of the Learning from Mortality Reviews Newsletter



NHS
Mid Cheshire Hospitals
NHS Foundation Trust

Volume 1, Issue 1

Learning from our Mortality Reviews

During the first 2 quarters of 2018/19, **37** SJR's have been completed.

In 83% of these the death was classified as definitely not preventable.

No avoidable deaths were identified in quarter 1 or 2 through the SJR process. Two avoidable deaths were identified through the incident investigation process.

In 54% the SJR identified that the patient received good care.

In 61% the SJR identified the patient care record as being of a good quality.

How do we undertake mortality reviews at MCHFT?
At MCHFT we undertake mortality reviews using the Structured Judgemental Review Process (SJR). The SJR process was developed by the Royal College of Physicians (RCP). Structured judgement review blends traditional, clinical-judgement based review methods with a standard format. The approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase. The result is a relatively short but rich set of information about each case in a form that can also be aggregated to produce knowledge about clinical services and systems of care.

How many reviews have been completed so far?
The SJR process commenced in the Trust in April 2018, a cohort of senior medical and nursing staff were trained in the SJR process. During quarter one and two of 2018/19, 37 SJR's have been completed.

What data is produced from the SJR's?
The SJR produces two types of data:

- a score from 1 to 5 identifies very poor to excellent care respectively in a number of phases of care
- qualitative data in the form of explicit statements about care using free text

The phases of care which are reviewed are:

- Admission and initial care - first 24 hours
- Ongoing care
- Care during a procedure
- Perioperative/procedure care
- End of life care
- Assessment of overall care

What have we found from the SJR's that we do well?
Below are a number of the positive judgmental comments made during the quarter 1 and 2 reviews.

- Excellent care provided
- Multi-specialty working
- Excellent prescribing of anticipatory medications
- Excellent communication with the family
- Risks of surgery well documented
- Excellent set of clinical records
- Good documentation and use of the fractured neck of femur pathway
- Good evidence of both nursing and medical reviews
- Medical review in emergency department well completed with a thorough history taken, medication and allergies recorded. Chest and abdominal examination recorded. VTE risk assessment completed
- Good documentation of discussions with relatives regarding end of life care and ceilings of care

What could we improve?
The themes for learning which have been identified from the reviews include:

- Poor completion of pathways within the trust including, acute kidney injury, sepsis management, pneumonia and end of life
- Delays in medication administration
- Clinical observations not recorded in line with Trust guidance
- Failure to identify the deteriorating patient
- Failure to respond to the deteriorating patient
- Delays in medical reviews
- Poor completion of fluid balance monitoring
- unified Do Not Attempt Cardio Respiratory Pulmonary Resuscitation (uDNACPR) not considered or completed promptly

What are we doing to improve care in the Trust?
On the 5 November 2018, the Trust launched NEWS 2 with the aim to address the failures to identify and respond to the deteriorating patient. The revised vital signs chart includes guidance on sepsis management, fluid balance management and escalation of the deteriorating patient.

We Care Because You Matter

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

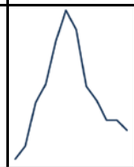
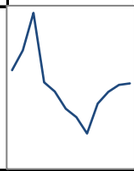
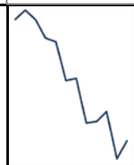
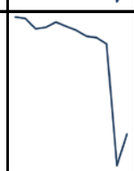
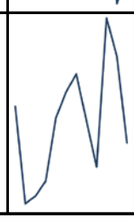
Board of Directors

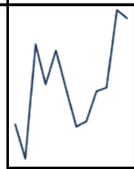
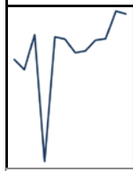
Workforce Report

December 2018

(Oct 2018 data)

Performance Report Month: Workforce Chapter
Oct-18

Measure	Target	Performance	Description	Narrative	Rolling Trend	Trend	C&W Average Sept 18
Sickness Absence	3.40%	4.26%	Rolling 12m average Sickness Absence described as a Percentage	The rolling position has reducds slightly from the previous month. Corporate is currently meeting the target and DCSS and CCICP are amber.		↓	4.85%
In-Month Sickness Absence	N/A	4.31%	In-month 12m average Sickness Absence described as a Percentage	The in-month position increased slightly (0.02%). Four divisions experienced reduced sickness absence levels in October.		↑	4.86%
Appraisal Rate	90.00%	82.52%	Percentage of Staff who have received an appraisal in the last 12 months. Excludes New Staff with less than 12m service and Bank Staff	Overall, there was a 0.88% improvement in the appraisal rates across the Trust. All divisions are amber with the exception of MEC and CCICP who are red.		↑	84.80%
Mandatory Training	90.00%	71.73%	Mandatory Training Monthly Rate Excludes Bank Staff, Staff on long term sick & mat. leave.	Training complaince increased by 3.07% in October. All divisions delivered an improvement with the exception of EF. CCICP and Corporate divisions delivered good improvement at 7% and 5% respectively.		↑	85.31%
Staff Turnover	10.00%	11.25%	Number of Leavers expressed as a percentage of the workforce over a 12m rolling period. Exclude Junior Doctors, Temporary and Fixed term.	Turnover again reduced across all divisons in October and WC are currently green against target.		↓	11.21%

Measure	Target	Performance	Description	Narrative	Rolling Trend		
Agency Spend	(365)	(545)	In month and cumulative total spend for the Trust.	Agency spend was less in October than September however the agency spend target and NHSI ceiling target were both exceeded. Medical and allied health professional agency spend reduced from September's position but nursing agency spend increased by £50k. £29k of this was within the MEC division.		↓	N/A
NHSI Ceiling	less than 100%	149.3%	Trust Agency Spend as a percentage of the Ceiling Set by NHS Improvement			↓	N/A
Over Cap Rates	N/A	62%	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	↑↓=