Mid Cheshire Hospitals NHS Foundation Trust

AGENDA

Board of Directors
A meeting will be held in Public at
09.30am on Monday, 2 December 2019
in the Boardroom, Leighton Hospital, Crewe

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	Chief Operating Officer **09.32**	-
3.	**Board Member's Interests** *(to note)* To **consider** any • Changes to Directors' interests since the last meeting • Conflicts of interest deriving from this agenda	I	Chairman **09.50**	-
4.	**Minutes of the Last Meeting** To **approve** the minutes of the Board of Directors meetings held in Public on Monday 4 November *(attached) (for approval)*	A	Chairman **09.52**	**4**
5.	**Matters Arising and Action Log** *(verbal) (to approve)*	A	Chairman **09.55**	-
6.	**Annual Work Programme 2019/20** *(attached)* *(to approve)*	I/A	Chairman **09.57**	**17**
7.	**Chairman's Announcements** (*to note a verbal report*) **7.1 Lord Lieutenant's Visit – 12 November 2019** **7.2 NHS Providers Non-Executive Director Network** *(Ms Butcher)*	I	Chairman **10.00**	-
8.	**Governor's Items** (*to note a verbal report*) **8.1 NED Recruitment** **8.2 Chat with the Chairman – 19 November 2019**	I	Chairman **10.10**	-
9.	**Chief Executive's Report** *(attached)(to note)*	I/D	Chief Operating Officer **10.15**	**18**

Item No		Title of Item	Action	Led By	Page No.
10.	**CARING**				
	10.1	**Quality, Safety & Experience Report** *(attached) (for discussion)*	I/D	Deputy Director of Nursing **10.30**	**21**
11.	**SAFE**				
	11.1	**Draft Quality Governance Committee notes from the meeting held on 11 November 2019** *(attached) (to note)*	I/D	Committee Chair **10.40**	**69**
	11.2	**Serious Untoward Incidents and RIDDOR Events** *(verbal)* (*to note*)	I/D	Medical Director **10.45**	**-**
12.	**RESPONSIVE**				
	12.1	**Performance Report** *(attached) (to note)*	I/D	Chief Operating Officer/ Director of Finance **10.50**	**81**
	12.2	**Draft Performance & Finance Committee notes from the meeting held on 21 November 2019** *(to follow) (to note)*	I/D	Committee Chair **11.00**	**-**
	12.3	**Breast Screening Programme Business Case** *(attached) (to approve)*	A/D	Director of Strategic Partnerships **11.05**	**104**
	12.4	**Learning from Deaths Quarterly Report Q2 2019/20** *(attached) (to note)*	I/D	Medical Director **11.20**	**151**
	12.5	**Report of Use of the Trust Seal** *(attached) (to note)*	I/D	Chief Operating Officer **11.25**	**169**
	12.6	**Legal Advice** *(verbal) (to note)*	I/D	Chief Operating Officer **11.30**	**-**
13.	**WELL-LED**				
	13.1	**Visits of Accreditation, Inspection or Investigation** *(verbal)* (*to note*)	I	Chief Operating Officer **11.35**	**-**
	13.2	**Board Assurance Framework Q2 2019-20** *(attached) (to note)*	I/D	Medical Director **11.40**	**171**
	13.3	**Organisational Risk Register Q2 2019-20** *(attached) (to approve)*	I/D	Medical Director **11.45**	**217**

Item No		Title of Item	Action	Led By	Page No.
	13.4	**Audit Committee notes from the meeting held on 11 December 2019** *(attached) (to note)*	I/D	Committee Chair **11.50**	**235**
14.	**EFFECTIVE**				
	14.1	**Workforce Report** *(attached) (to note)*	I/D	Director of Workforce and OD **11.55**	**253**
	14.2	**Transformation and People Committee notes from the meeting held on 7 November 2019** *(attached) (to note)*	I/D	Committee Chair **12.05**	**258**
	14.3	**Consultant Appointments** *(verbal) (to note)*	I	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, Leighton Hospital at 9.30am on **Monday, 6 January 2020**	I	Chairman	

Board of Directors Workplan 2019/20

Version: 3

Item	Board of Directors Meeting												Board Away Day				
	April	*May*	*June*	*July*	*August*	*Sept*	*Oct*	*Nov*	*Dec*	*Jan*	*Feb*	*March*	*Apr*	*Jun*	*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 ←	~~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		
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 ←	~~x~~							
Learning from Deaths Quarterly Report			x			x			x			x					
Trust Strategy				x				x	~~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 Preparedness, Resilience& Response (EPPR)							x										
Doctors Revalidation Report						x											
Effective																	
Workforce Report	x	x	x	x	x	x	x	x	x	x	x	x					
Equality Delivery System					x												
Workforce Race Equality Scheme						x											
Gender Pay Gap Report																	
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					

CEO Report – November 2019

This report outlines the key operational and strategic issues during the reporting period.

1.0 Key operational issues

1.1 A&E Wait times & Winter plan

As reported to the Board last month, due to the significant increase in A&E attendances year to date and an increase in the number of delayed transfers of care due to lack of domiciliary care and care home capacity, the trust has escalated the winter plan over and above that agreed with commissioners earlier in the year. This has resulted in the requirement to open an additional ward area which has significantly increased nursing agency spend. The Executive Team have developed plans to reduce spend on agency staff and also plans to tackle the pressures described. This will be discussed in the performance report section of the Board Meeting.

1.2 Financial position – Month 7

Month 7 was a challenging month being £431k overspent in month and cumulatively £427k away from control total. The main drivers for the overspend are unfunded escalation beds, staffed by high cost agency and additional activity delivered at premium costs. The outsourcing costs of radiology are also a particular concern. Bank incentive schemes are being worked up to mitigate the use of high cost agency. The associated impact of the demand increase is that the host block contract over performing by circa £1m mainly due to A&E and diagnostics and an urgent meeting has been arranged with the CCG to discuss this.

1.3 Infection Control Metrics

Following the last Board meeting, there was an action to look at the Infection Control metrics which were showing deterioration against trajectory. It was agreed that it would be more beneficial to look at whether there was a statistical difference and also whether the rate had increased (i.e. taking into account increasing levels of activity). In all three cases (C-Diff, E-coli and MSSA) there are no statistically significant deteriorations in the number of infections and all are within normal control limits with rates comparable to the regional average. All of this evidence supports the view that performance is stable and not of concern at present.

1.4 Complaints metrics

As reported at the September Board meeting, formal complaints are showing a statistical increase and work is ongoing on establishing the causation. The Director of Nursing will update the Board during the Quality and Safety report at the Board on progress with this, however, further investigation has concluded this is not related to A&E pressures.

1.5 Workforce metrics

The Trust has been analysing the statistical change in the last year regarding absence. This has been worked through to a departmental level and there are focus group sessions being held with Theatres and Ward 18 during late November to try and understand the changes in these areas. Of note is that both

areas are now improved and the overall absence metrics are improving as a result. It is intended to redefine the workforce dashboard incorporating better use of statistical analysis in the new year.

1.6 Flu Campaign

Ensuring staff are vaccinated remains a top priority for the Trust. There has been improvement in that the vaccination rate has now improved from being 10% behind last year (due to a later start with vaccine supply) to only 5% behind last year. Concerted efforts are being made to catch up and exceed last year's rate. The Trust currently has 57% of healthcare workers immunised as at 22nd November.

2.0 Strategic issues

2.1 Use of Resources Assessment

The Trust underwent its Use of Resources assessment on the 14th November. The review went well and there were several areas of noted good practice such as IT solutions, workforce and clinical support functions. The Trust will receive the outcome of its UoR assessment as part of the final CQC report.

2.2 CQC unannounced clinical inspection

The unannounced CQC inspection of the Trust commenced on 19th November with the CQC visiting team reviewing Urgent Care across both Leighton Hospital and Victoria Infirmary. At the time of writing there were no 'must do' issues flagged during the feedback sessions. The Trust has been notified of the CQC's intention to visit Community Children's Services the following week on 26-28th November. An update will be given at the Trust Board Meeting on any feedback from this part of the assessment.

2.3 Cheshire system FRP

The CEO and DOF continue to meet partners on a fortnightly basis to develop and refine the plans and delivery for the current year which shows a gap of £35m to reach the Cheshire wide control total. £11.2m of opportunities have been identified which are being monitored by the grip and control workstream. There are some high risk areas within this figure and some emerging in year material operational and activity pressures which are negating some of these benefits. Other workstreams of the financial plan are about delivery in years 1-5 and are around collaboration at scale, acute sustainability and transformation (using Place as the driver).

2.4 Five year financial plan

The Trust, along with other Cheshire organisations submitted their 5 year financial plan on 15th November. A collaborative and consistent approach was agreed across Cheshire which saw most organisations include a 2.1% CIP (£5m, similar to this year) for 2020/21 (guidance was 1.6%) and no growth investment assumptions from 2021/22 (with exception of Mental Health and Community Services) on the basis the Financial recovery workstreams identified above would mitigate any projected growth expenditure. This is for planning purposes only as the schemes to prevent and manage this activity outside of an acute setting still need to be worked up. PAF Committee have been and will continue to scrutinise the details of the plan as it develops further.

2.5 Breast screening

The Breast Screening business case is being submitted for Board approval. The case recognises that the South Cheshire and Vale Royal population served is not large enough and furthermore the workforce sustainably is also a risk with retirements over the previous few years and in the near future. The clinical team have worked well to develop the case and this has been supported by project resources funded by commissioners. Overall this case supports the change in moving from a standalone service to being part of the East Cheshire Programme with future opportunities for workforce redesign and improved quality of care. Further detail will be provided in the business case later in the meeting.

2.6 Estate planning

The Executive Team, Divisions and Corporate Teams met on 26th November to commence the construction of a five year site strategy for Leighton Hospital to look at key risks and alternative methods of delivery given the challenges on the capital budget. Mr Mike Davies, Non-Executive Director attended to provide challenge and input to the session. The product of this will be worked up into a future Board presentation.

J. Sumner
Chief Executive Officer
25.11.19

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

We Care Because You Matter

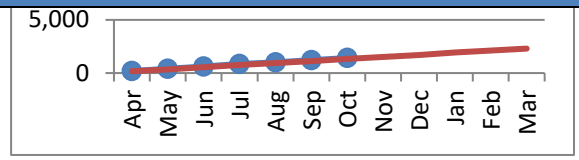
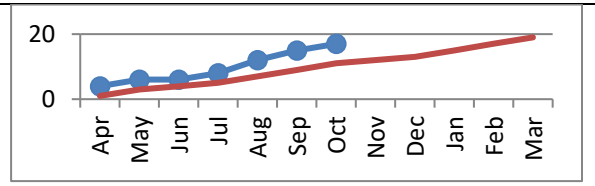
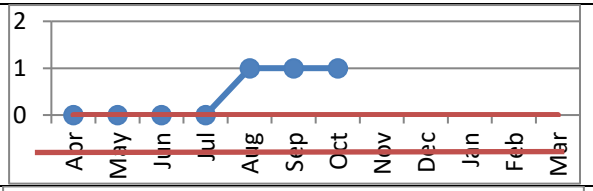
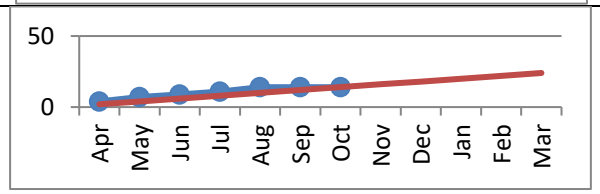
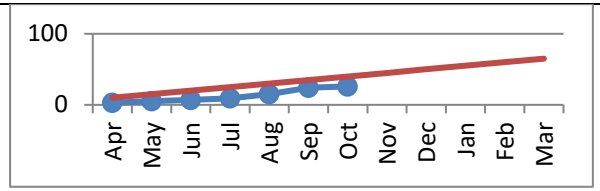
Quality, Safety and Experience Report

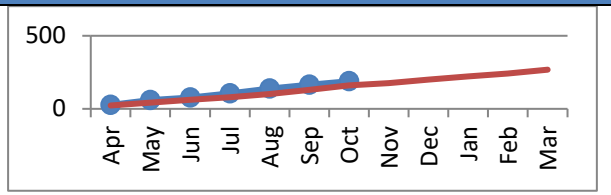
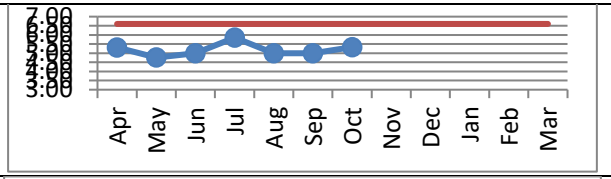
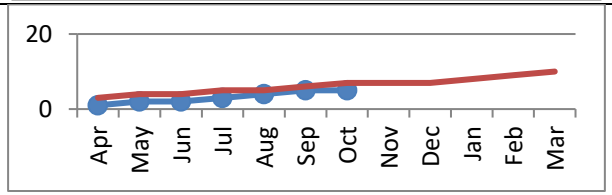
December 2019

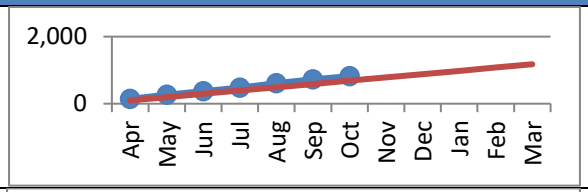
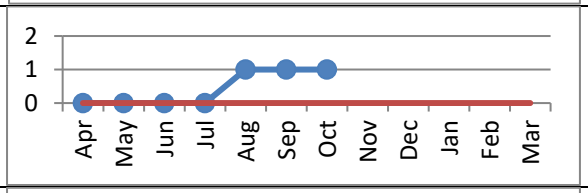
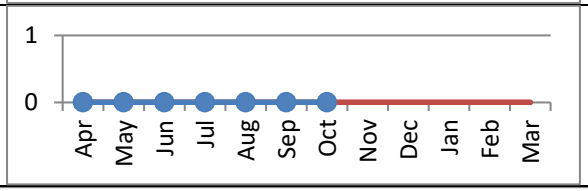
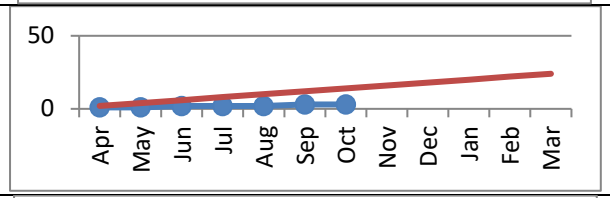
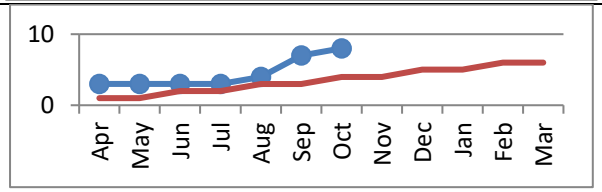
(October 2019 data)

Contents

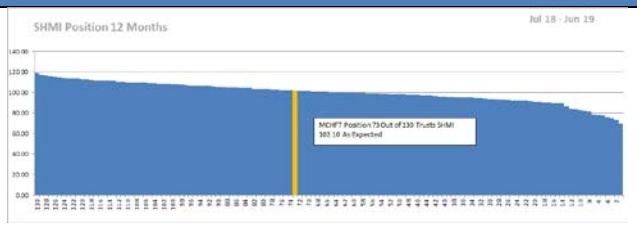
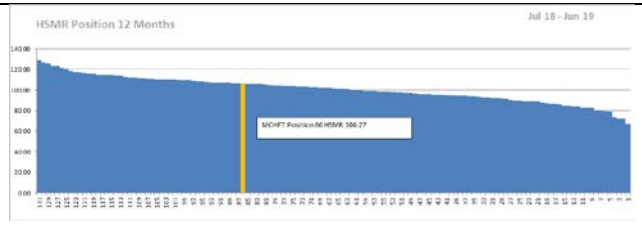
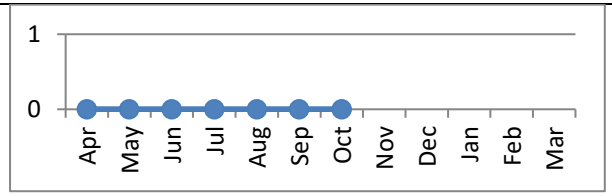
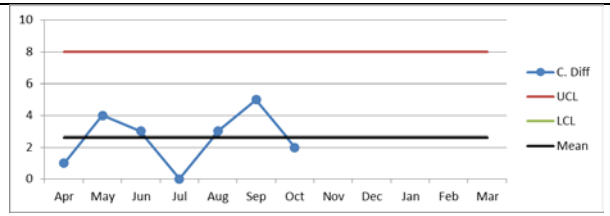
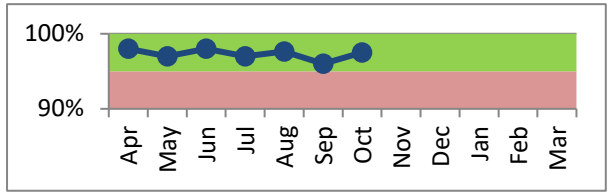
Contents (continued):

Indicators	Target	Trajectory 2019/20
Acute Trust		
Patient Safety Harm Incidents The target is to reduce the total number of patient safety harm incidents when compared to the previous financial year by the end of March 2020.	**Less than 2300 at end of March 2020**	
StEIS Reported Incidents The target is to reduce StEIS reported incidents when compared to the previous financial year by the end of March 2020.	**Less than 19 at end of March 2020**	
Never Events Zero tolerance of Never Events.	**Zero**	
Pressure Ulcers – Hospital Acquired The target is to have no more than two lapses in care (avoidable) pressure ulcers per month.	**Less than 24 lapses in care at end of March 2020**	
Medication Harm Incidents The target is to reduce the total number of medication incidents resulting in harm when compared to the previous financial year by the end of March 2020.	**Less than 66 at end of March 2020**	

Indicators	Target	Trajectory 2019/20
Acute Trust		
Inpatient Falls - Harm The target is to have a reduction in harm from patient falls when compared to the previous financial year.	**Less than 268 at end of March 2020**	
Inpatient Falls – Rate Per 1,000 Bed Days A reduction in the number of falls per 1,000 bed days when compared to the RCP National Audit 2015 (average number of patient falls per 1,000 bed days).	**Ratio less than 6.6**	
Inpatient Falls – Fractured NOF A reduction in the number of fractured NOF resulting from patient falls when compared to the previous financial year.	**Less than 10 at end of March 2020**	

Indicators	Target	Trajectory 2018/19
CCICP		
CCICP Patient Safety Harm Incidents The target is to reduce the total number of CCICP patient safety harm incidents when compared to the previous financial year by the end of March 2020.	**Less than 1238 at end of March 2020**	
CCICP Serious Incidents The target is to continue the trend of having zero CCICP patient safety serious incidents by the end of March 2020.	**Zero**	
CCICP Never Events Zero tolerance of CCICP Never Events.	**Zero**	
CCICP Pressure Ulcers – Community Acquired The target is to have no more than two lapses in care (avoidable) pressure ulcers per month.	**Less than 24 lapses in care at end of March 2020**	
CCICP Medication Harm Incidents The target is to reduce the total number of medication incidents resulting in harm when compared to the previous financial year by the end of March 2020.	**Less than 7 at end of March 2020**	

Board Papers – Quality, Safety & Experience Section: December 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 The target is less than 27 cases of Clostridium Difficile in 2019/20. The target includes cases who have been identified in the community but had a hospital admission in the previous 28 days.	**Less than 27 at end of March 2020**	
Safety Thermometer The Trust target is that >95% of patients receive harm free care as monitored by the Safety Thermometer.	**>95%**	

Quality & Safety Section:

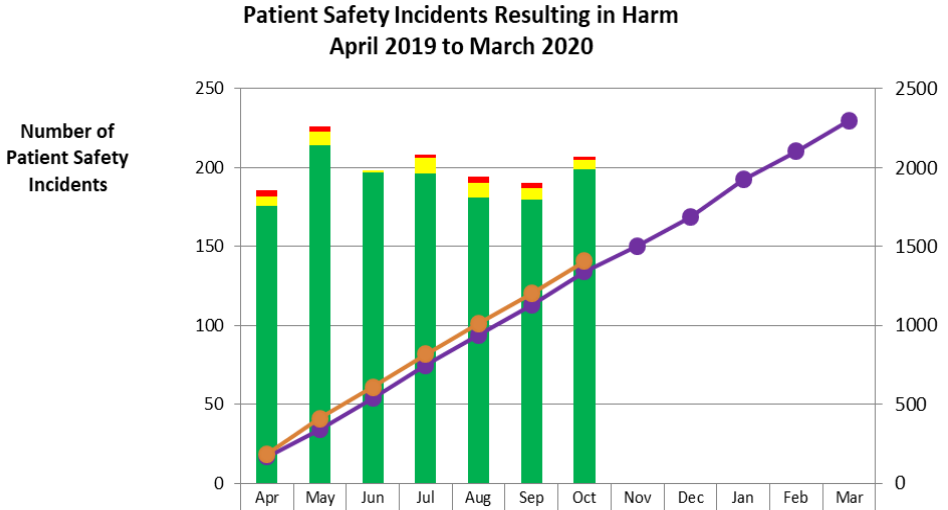
Description	Aggregate Position	Trend

Patient Safety Harm Incidents

The target is to reduce the total number of patient safety harm incidents when compared to the previous financial year by the end of March 2020.

This chart demonstrates the total number of reported patient safety harm incidents.
For October 2019, there were a total of 207 patient safety harm incidents:
96.1% (199 incidents) have resulted in low harm
2.9% (6 incidents) have resulted in moderate harm
1.0% (2 incidents) have been reported to StEIS
Improvement actions include;

- A revised lessons learned template is distributed sharing learning from incidents. Lessons learned include highlighting the root cause of the incident, good practice, areas for improvement and learning points.
- Continued teaching with the Junior Medical Teams to promote incident reporting and learning from serious incidents.
- Development of a quarterly Learning from Deaths Newsletter.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
StEIS Reported Incidents	4	3	0	2	4	3	2					
Moderate Harm	6	9	1	10	9	7	6					
Low Harm	176	214	197	196	181	180	199					
Target	170	342	541	748	942	1131	1343	1503	1686	1926	2104	2299
Cumulative Total 2019/20	186	412	610	818	1012	1202	1409					

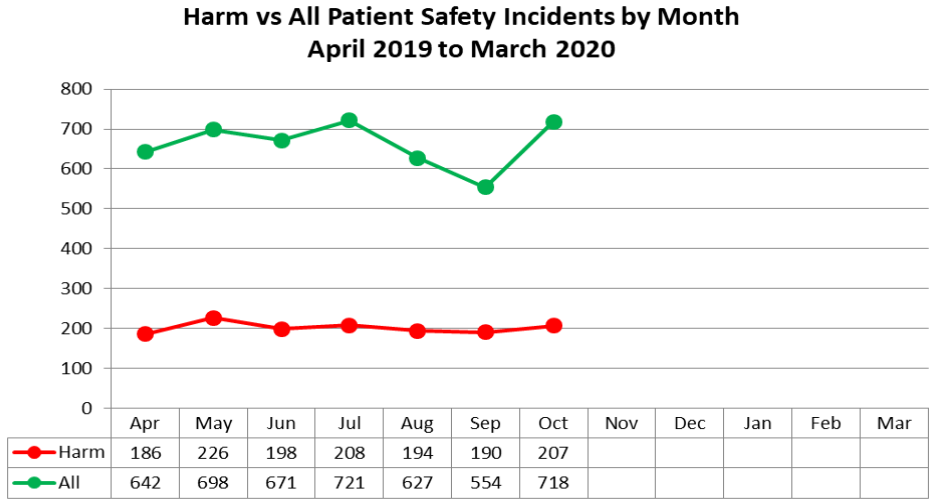
Harm vs All Patient Safety Incidents

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 2019, the gap between harm and all patient safety incidents was 511. The aim over the twelve month period is to see this gap widening.

A safety culture survey was undertaken in the Trust in December 2018 to January 2019. The results were shared at the EQGG in April 2019 and divisional improvement plans developed to take into account the feedback received during the survey.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Harm	186	226	198	208	194	190	207					
All	642	698	671	721	627	554	718					

Description	Aggregate Position	Trend

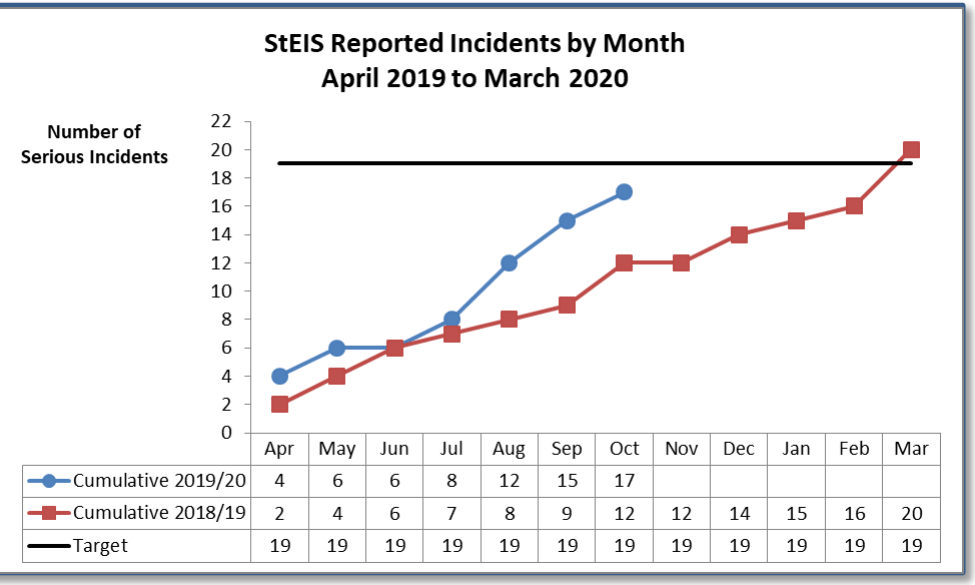
StEIS Reported Incidents

The target is to reduce the number of StEIS reported incidents when compared to the previous financial year by the end of March 2020.

This chart demonstrates the number of incidents that have resulted been StEIS reported.

For October 2019, there were 2 StEIS reported incidents;

- Potential treatment delay post cataract surgery meeting SI criteria
- Delay in CT report resulting in potential delay in diagnosis



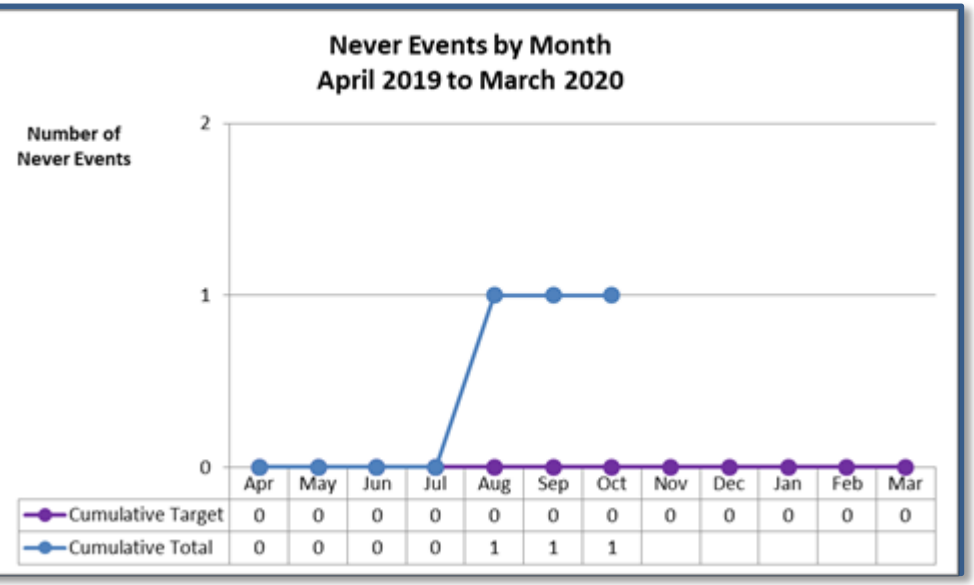
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative 2019/20	4	6	6	8	12	15	17					
Cumulative 2018/19	2	4	6	7	8	9	12	12	14	15	16	20
Target	19	19	19	19	19	19	19	19	19	19	19	19

Never Events

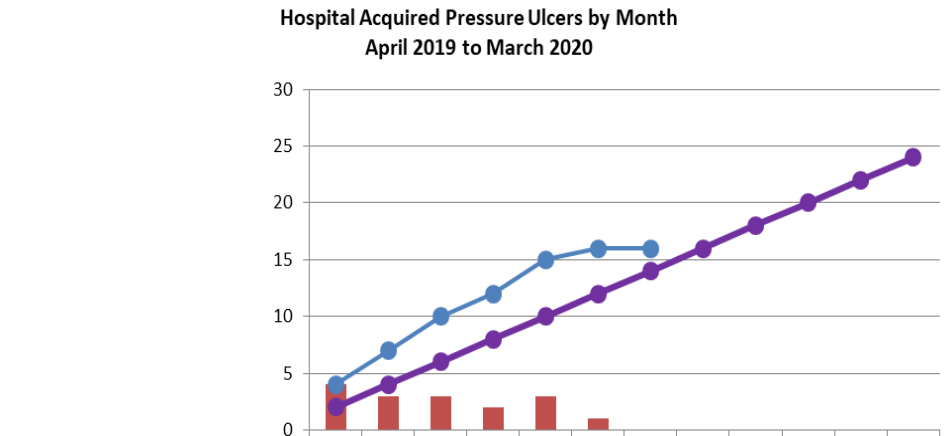
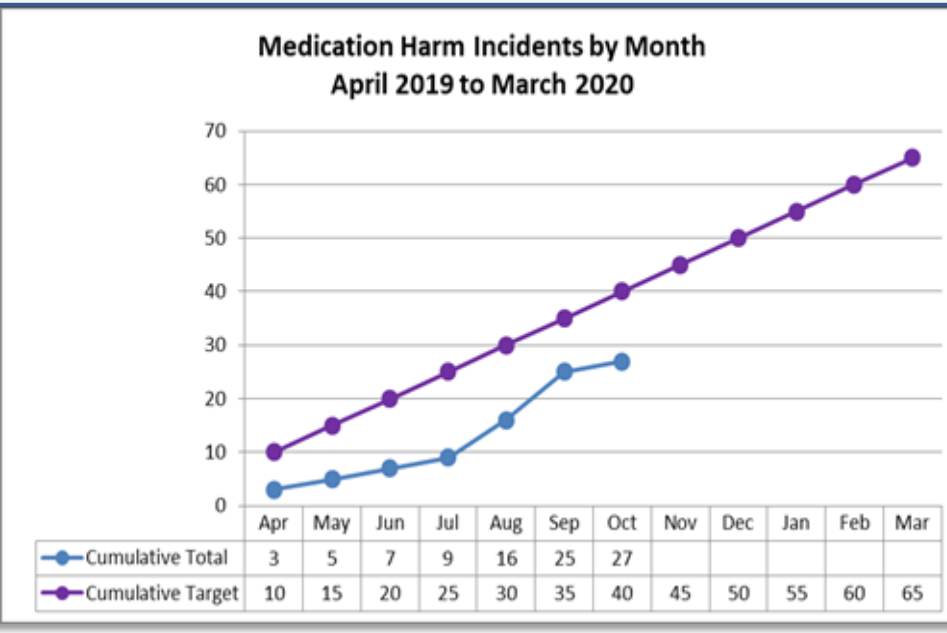
The target is to have zero Never Events

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

For October 2019 there were no Never Events reported;



	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	1	1					

Description	Aggregate Position	Trend
Pressure Ulcers (PU) – Hospital Acquired *The target is to have no more than 24 pressure ulcers resulting from lapses in care by the end of March 2020.*	For October 2019, there were a total of 9 hospital acquired pressure ulcer incidents: • 0% (0 PUs) occurred with lapses in care that did contribute to the PU. • 22.2% (2 PUs) occurred with lapses in care that did not contribute to the PU. • 44.4% (4 PUs) occurred with no lapses in care identified. • 22.2% (2 PUs) confirmed but awaiting tool. • 11.1% (1 PUs) are awaiting verification. Improvement actions include; The following guides have been ratified and shared with staff to support pressure ulcer prevention: • Divisional panel meetings are embedded and learning is shared at Skin Care Meetings. • Analysis of the previous six months data for moisture associated skin damage. • Face to face training on the wards delivered by the Clinical Nurse Advisor. • Benchmarking with other organisations via the Cheshire & Merseyside pressure ulcer prevention steering group and TVN networks.	
Medication Harm Incidents *The target is to reduce the total number of medication incidents resulting in harm when compared to the previous financial year by the end of March 2020.*	For October 2019, there were a total of 2 medication incidents resulting in harm reported: • 100% (2 medication incidents) have resulted in low harm • 0% (0 medication incidents) have resulted in moderate harm • 0% (0 medication incidents) have resulted in serious harm Improvement actions include: • Junior medical staff training and E-learning package is in place • Medicines management training for nurses has been updated • Monthly lessons learned shared from the Safe Medicines Practice Group • Pharmacy enablement policy approved which enables pharmacists to amend prescriptions which are unsafe or unclear.	

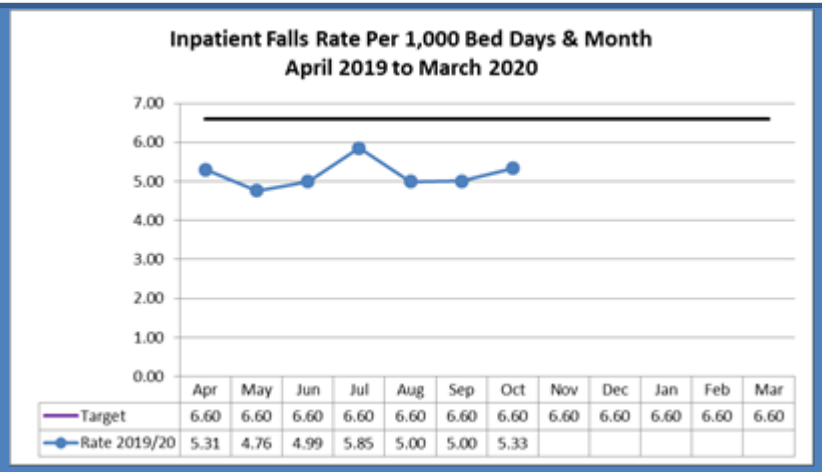
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Lapses in Care Identified	4	3	3	2	3	1	0					
Cumulative Lapses in Care	4	7	10	12	15	16	16					
Lapses in Care Cumulative Target	2	4	6	8	10	12	14	16	18	20	22	24
% Lapses in Care PU	28.6%	20.0%	20.0%	12.5%	13.0%	6.7%	0.0%					

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative Total	3	5	7	9	16	25	27					
Cumulative Target	10	15	20	25	30	35	40	45	50	55	60	65

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

Inpatient Falls.

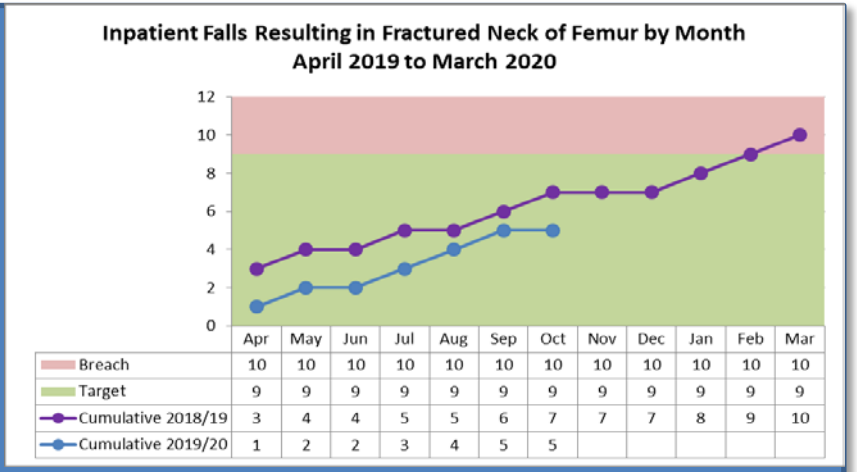
A reduction in the number of falls per 1,000 bed days when compared to the previous financial year (less than 6.6)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target	6.60	6.60	6.60	6.60	6.60	6.60	6.60	6.60	6.60	6.60	6.60	6.60
Rate 2019/20	5.31	4.76	4.99	5.85	5.00	5.00	5.33					

For October 2019, the falls rate per 1,000 bed days was 5.33.

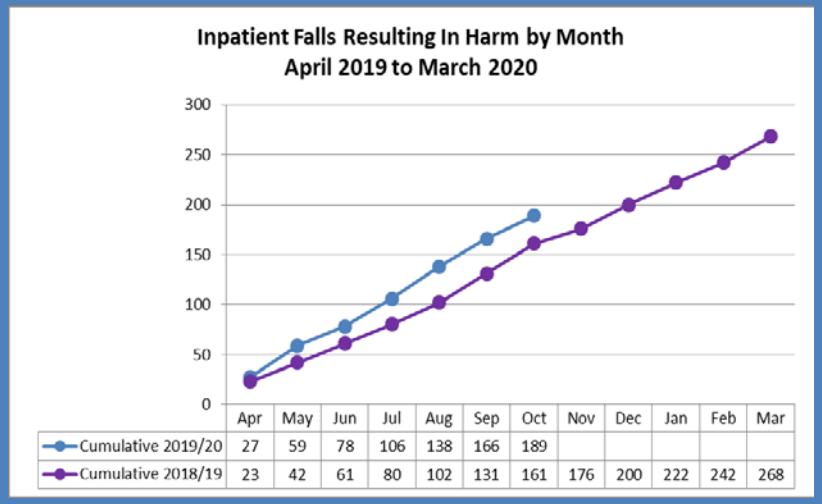
A reduction in the total number of fractured neck of femurs as a result of a fall (less than 10)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Breach	10	10	10	10	10	10	10	10	10	10	10	10
Target	9	9	9	9	9	9	9	9	9	9	9	9
Cumulative 2018/19	3	4	4	5	5	6	7	7	7	8	9	10
Cumulative 2019/20	1	2	2	3	4	5	5					

In October 2019, there were no neck of femur fractures reported

A reduction in the total number of falls with harm compared to previous year (less than 268)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative 2019/20	27	59	78	106	138	166	189					
Cumulative 2018/19	23	42	61	80	102	131	161	176	200	222	242	268

In October 2019, there were a total of 23 falls with harm.

- 87.0% (20) resulting in low harm
- 13.0% (3) resulting in moderate harm
- 0% (0) resulting in major harm

Improvement actions include:

- A Quality Improvement bay tagging project has been registered and is in development for implementation on Ward 1
- Evaluation of the footsteps trial on Ward 7 and 21b
- Staff education – The Trust took part in the National Falls Awareness Campaign with daily engagement sessions at the crossroads
- A review and redesign of the falls risk assessment tool is being undertaken.

Central Cheshire Integrated Care Partnership (CCICP)

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

CCICP Patient Safety Harm Incidents

The target is to reduce the total number of CCICP patient safety harm incidents when compared to the previous financial year by the end of March 2020.

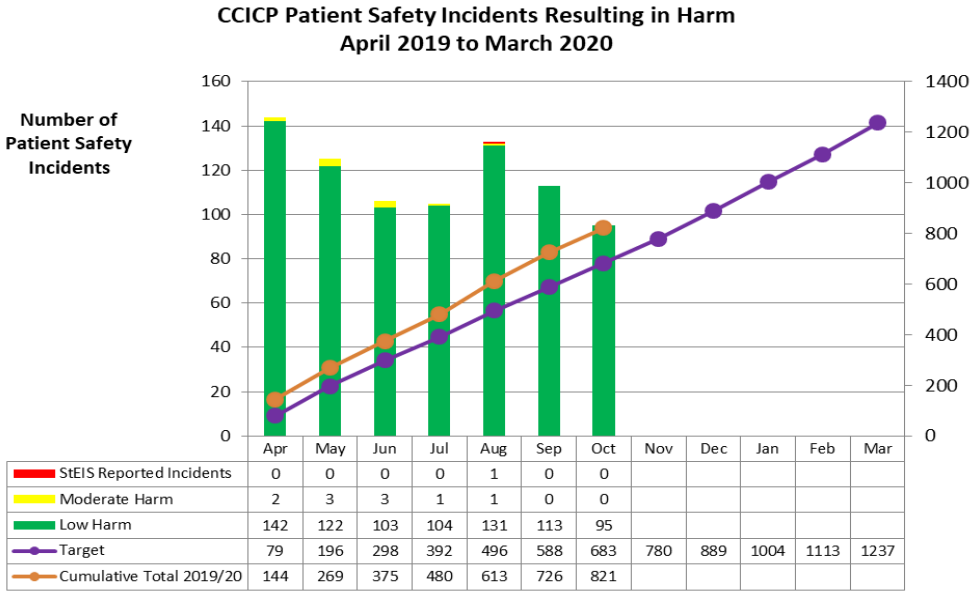
For October 2019, there were a total of 95 patient safety harm incidents:

- 100% (95 incidents) have resulted in low harm
- 0% (0 incidents) have resulted in moderate harm
- 0% (0 incidents) have resulted in serious harm

To reduce the number of patient safety harm incidents, a number of initiatives are being undertaken.

These include:

- A daily Safety Huddle has been introduced within the District Nurse teams where patients with complex care needs are discussed and concerns raised.
- A Freedom to Speak Up box has been placed in each area to enable staff the opportunity to raise concerns.
- All moderate and above incidents are discussed at Patient Safety Summit.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
StEIS Reported Incidents	0	0	0	0	1	0	0					
Moderate Harm	2	3	3	1	1	0	0					
Low Harm	142	122	103	104	131	113	95					
Target	79	196	298	392	496	588	683	780	889	1004	1113	1237
Cumulative Total 2019/20	144	269	375	480	613	726	821					

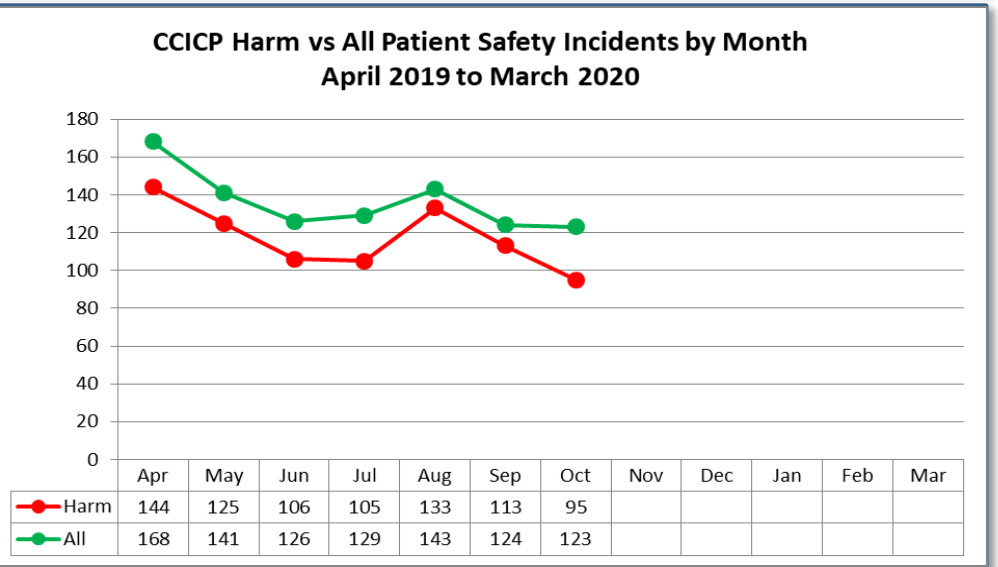
CCICP Harm vs All Patient Safety Incidents

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

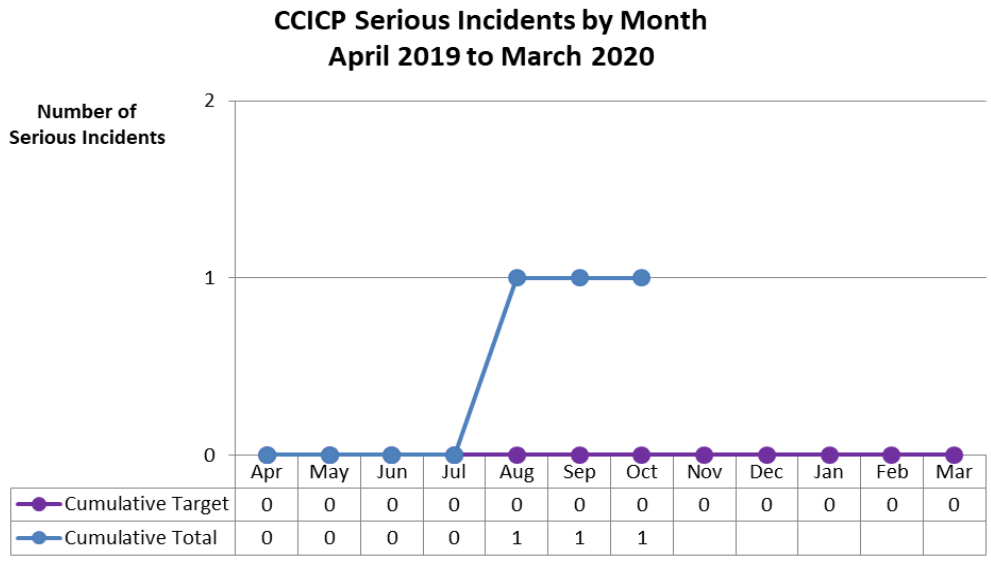
This chart demonstrates the number of incidents that have resulted in harm vs all patient safety incidents.

In October 2019, the gap between harm and all patient safety incidents was 28.

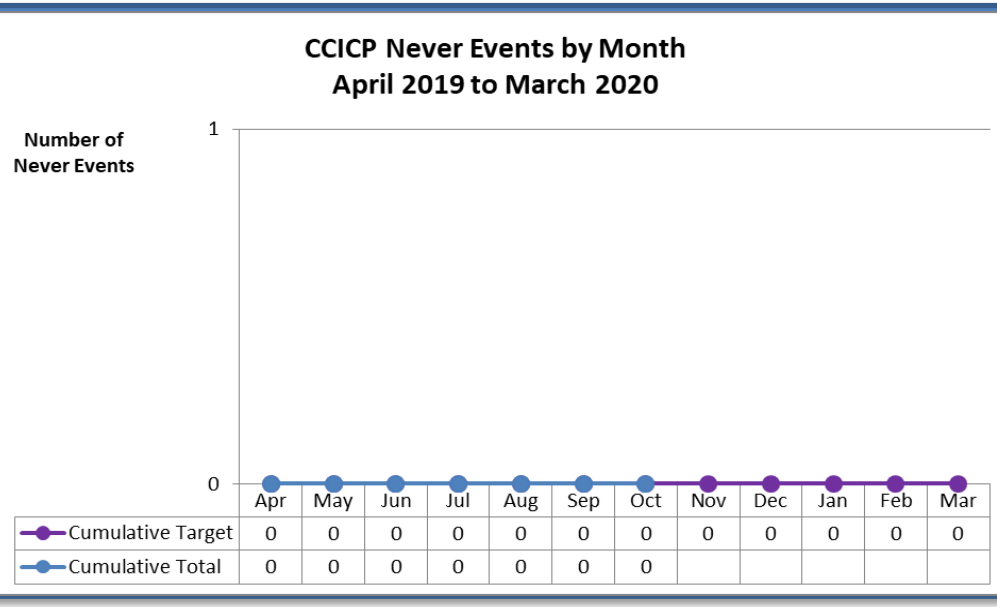
A safety culture survey was undertaken in the Trust in December 2018 to January 2019. The results were shared at the EQGG in April 2019 and divisional improvement plans developed to take into account the feedback received during the survey



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Harm	144	125	106	105	133	113	95					
All	168	141	126	129	143	124	123					

Description	Aggregate Position	Trend
CCICP Serious Incidents *The target is to continue the trend of having zero CCICP patient safety serious by the end of March 2020.*	This chart demonstrates the number of incidents that have resulted in serious harm. For October 2019, there were no serious incidents reported.	

	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	1	1					

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 2019 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 have no more than 24 pressure ulcers resulting from lapses in care by the end of March 2020.

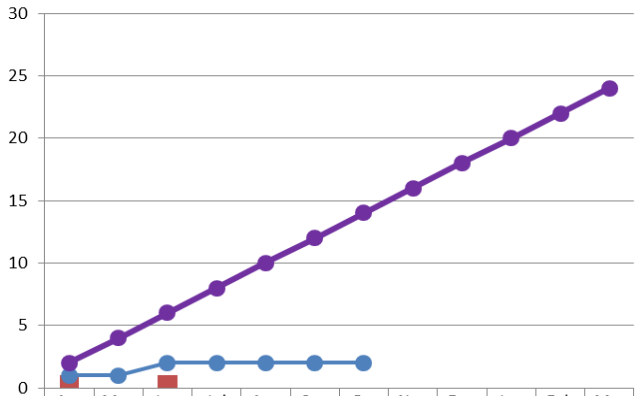
For October 2019, there were a total of 59 community acquired pressure ulcer incidents:

- 0% (0 PUs) occurred with lapses in care that did contribute to the PU.
- 1.7% (1 PUs) occurred with lapses in care that did not contribute to the PU.
- 78.0% (46 PUs) occurred with no lapses in care identified.
- 0% (0 PUs) confirmed but awaiting tool.
- 16.9% (10 PUs) are awaiting confirmation from PUP.
- 3.4% (2 PUs) are awaiting verification.

Improvement actions include:

- TVN joint visits with the District Nurses / Nursing homes to provide 'Face to Face' informal education to improve knowledge and understanding of pressure injury, prevention and categorising pressure injury.
- Contribution to the Pressure Ulcer Summit, including sharing of lessons learned and presentations on patient journeys.
- A review of CCICP tissue viability team has been undertaken and a proposal has been submitted to increase staffing within the service.

CCICP Community Acquired Pressure Ulcers by Month
April 2019 to March 2020



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Lapses in Care Identified	1	0	1	0	0	0	0					
Cumulative Total	1	1	2	2	2	2	2					
Lapses in Care Cumulative Target	2	4	6	8	10	12	14	16	18	20	22	24
% Avoidable PU	1.2%	0.0%	1.6%	0.0%	0.0%	0.0%	0.0%					

CCICP Medication Harm Incidents.

The target is to reduce the total number of medication incidents resulting in harm when compared to the previous financial year by the end of March 2020.

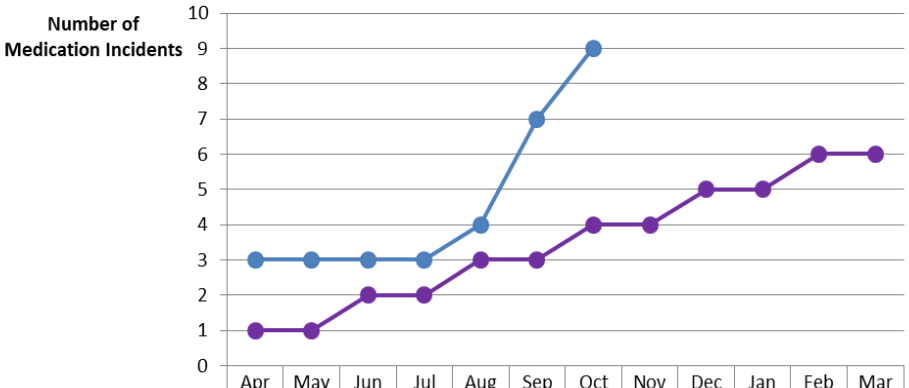
For October 2019, there were 2 medication incidents reported resulting in harm:

- 100% (2 medication incidents) resulted in low harm
- 0% (0 medication incidents) have resulted in moderate harm
- 0% (0 medication incidents) have resulted in serious harm

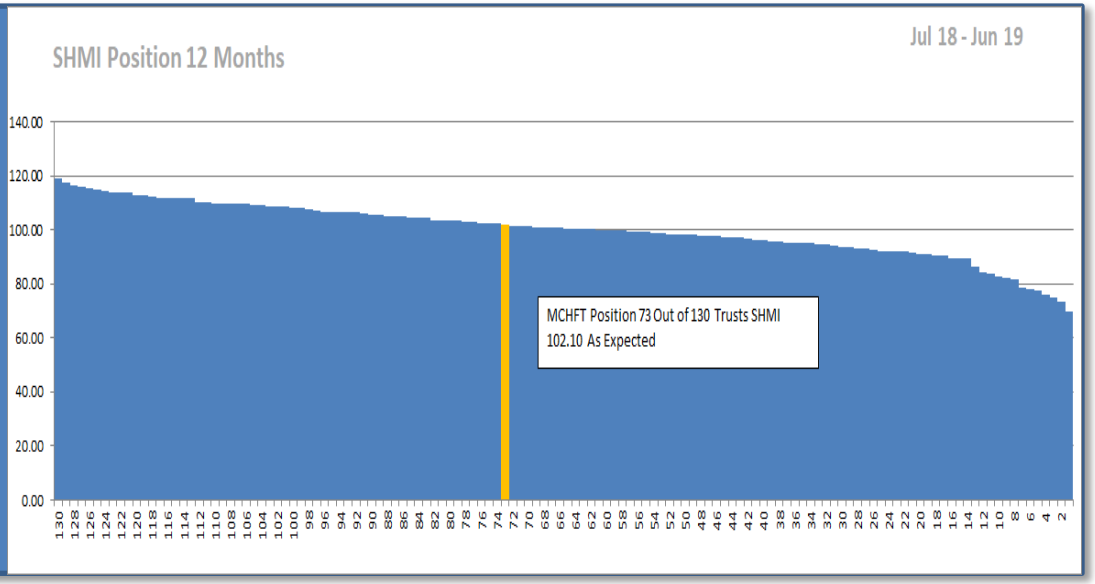
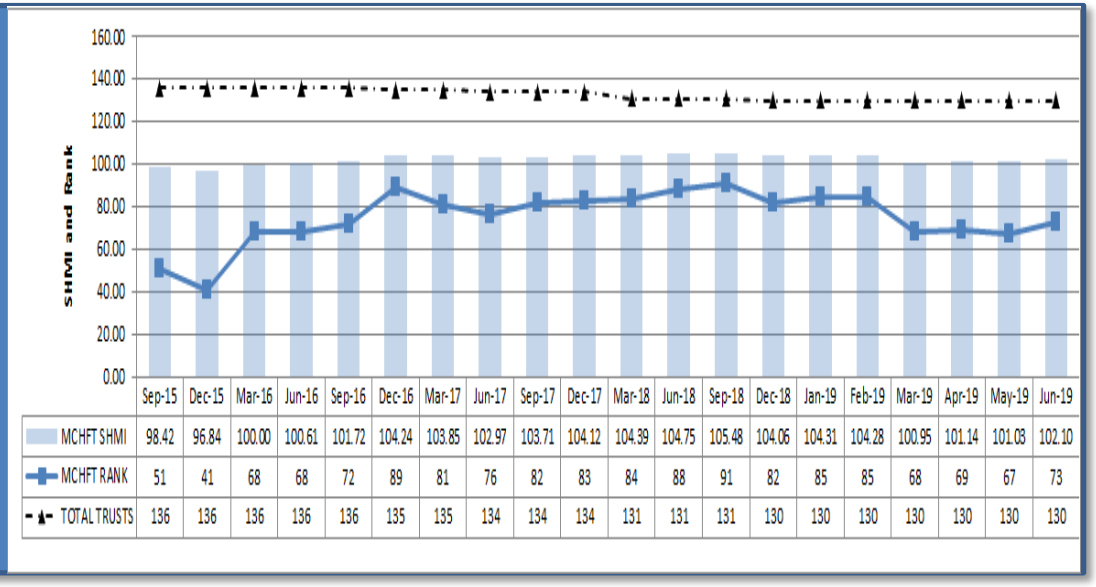
Improvement actions include;

- A CCICP Medication Incident Report has been produced for review and discussion at IGG to identify themes and lessons learnt
- Medication errors are reviewed by team leaders, any necessary action is taken and lessons learned shared.
-

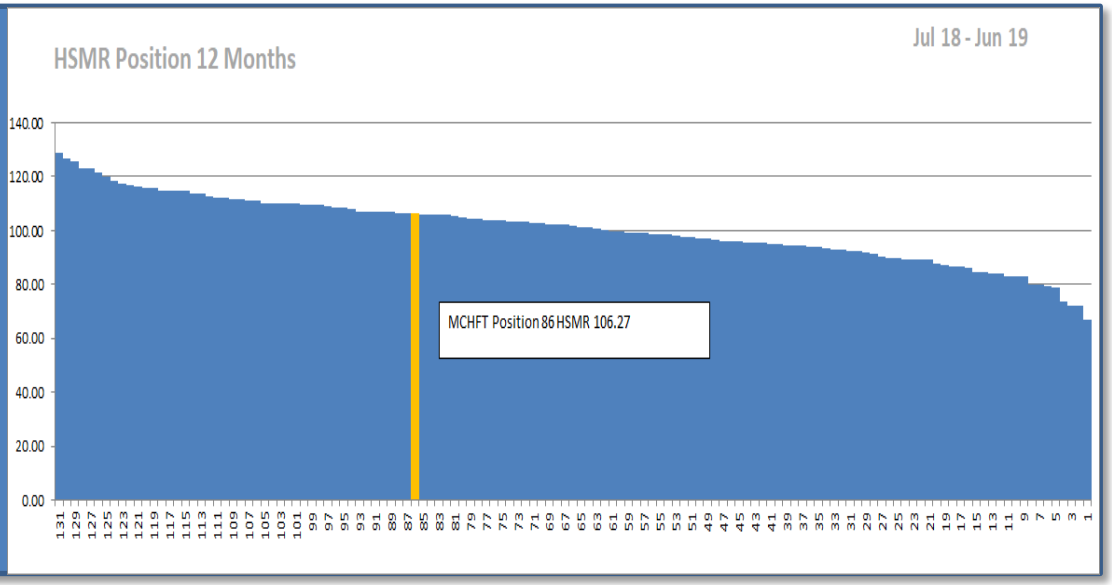
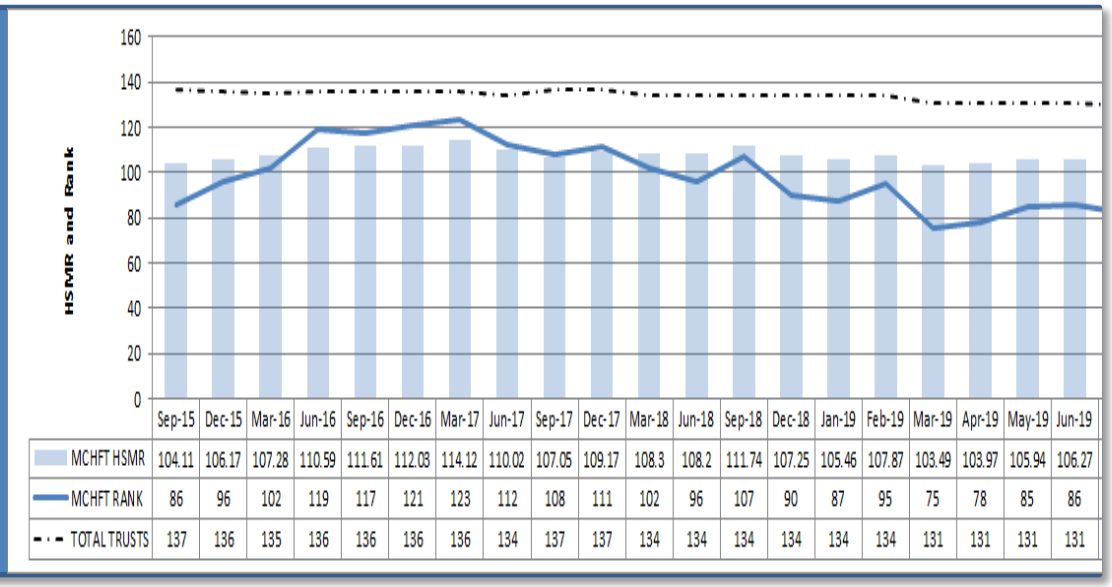
CCICP Medication Incidents by Month
April 2019 to March 2020



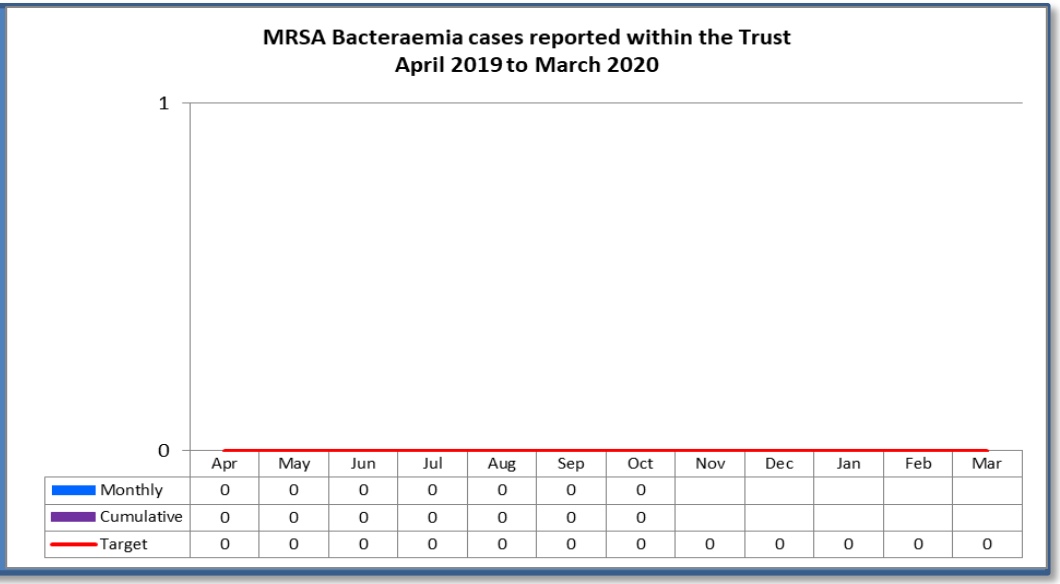
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative Total	3	3	3	3	4	7	9					
Cumulative Target	1	1	2	2	3	3	4	4	5	5	6	6

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 102.10 for the time period July 2018 to June 2019 and places the Trust 73 out of 130 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 July 2018 to June 2019 and is "as expected".	

	Sep-15	Dec-15	Mar-16	Jun-16	Sep-16	Dec-16	Mar-17	Jun-17	Sep-17	Dec-17	Mar-18	Jun-18	Sep-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
MCHFT SHMI	98.42	96.84	100.00	100.61	101.72	104.24	103.85	102.97	103.71	104.12	104.39	104.75	105.48	104.06	104.31	104.28	100.95	101.14	101.03	102.10
MCHFT RANK	51	41	68	68	72	89	81	76	82	83	84	88	91	82	85	85	68	69	67	73
TOTAL TRUSTS	136	136	136	136	136	135	135	134	134	134	131	131	131	130	130	130	130	130	130	130

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 106.27 (July 2018 to June 2019) and places the Trust 86 out of 131 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 July 2018 to June 2019 and is "as expected".	

	Sep-15	Dec-15	Mar-16	Jun-16	Sep-16	Dec-16	Mar-17	Jun-17	Sep-17	Dec-17	Mar-18	Jun-18	Sep-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
MCHFT HSMR	104.11	106.17	107.28	110.59	111.61	112.03	114.12	110.02	107.05	109.17	108.3	108.2	111.74	107.25	105.46	107.87	103.49	103.97	105.94	106.27
MCHFT RANK	86	96	102	119	117	121	123	112	108	111	102	96	107	90	87	95	75	78	85	86
TOTAL TRUSTS	137	136	135	136	136	136	136	134	137	137	134	134	134	134	134	134	131	131	131	131

Description	Aggregate Position	Trend
MRSA Bacteraemia Cases. *Zero tolerance of MRSA cases.*	In October 2019, no MRSA bacteraemia cases were reported in the Trust. In this financial year there have been no confirmed MRSA bacteraemia cases to date.	

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

Description

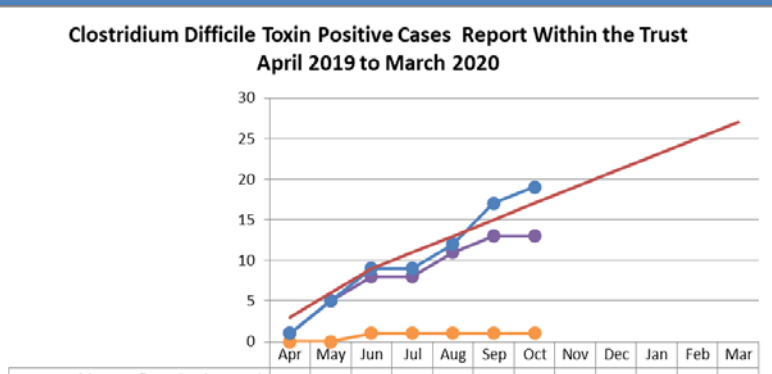
Clostridium Difficile toxin positive cases.

The target is less than 27 cases of Clostridium Difficile in 2019/20

Aggregate Position

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Regional Rate	0.15	0.15	0.15	0.15	0.15	0.15	0.15	0.15	0.15	0.15	0.15	0.15
Rate	0.07	0.25	0.20	0.00	0.19	0.32	0.12					

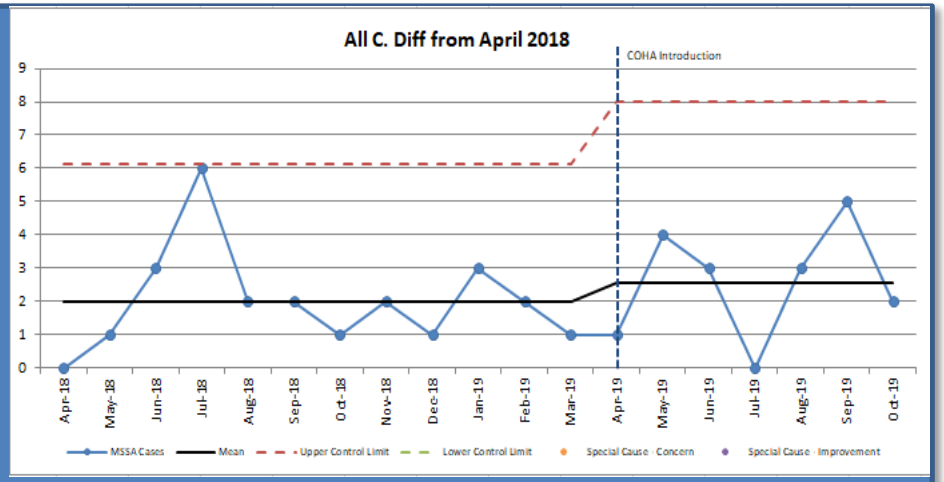
In October 2019, there were 2 cases of C. Diff



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Awaiting Confirmation in Month	0	0	0	0	0	3	2					
Cumulative Avoidable	0	0	1	1	1	1	1					
Cumulative Unavoidable	1	5	8	8	11	13	13					
Cumulative Total	1	5	9	9	12	17	19					
Cumulative Target	3	6	9	11	13	15	17	19	21	23	25	27

In October 2019, there were 2 C. Diff cases. The avoidability of both cases is yet to be determined.

Trend



Summary of data presented:

The cumulative number of C Diff cases YTD is slightly higher than the target set at the beginning of the year however:

- The Rate per 1000 bed days is consistent with the average for the region i.e. when the increasing activity at MCHFT is taken into account there is no statistical change in occurrence. When compared to other Trusts in the region our rate is very similar.
- Trend analysis shows no statistical change (other than the introduction of community services counting in the numbers from April 19) i.e. We can see that there are no statistical anomalies other than a slight increase in the mean due to adding community numbers into the count.

Description	Aggregate Position	Trend

MSSA Cases.

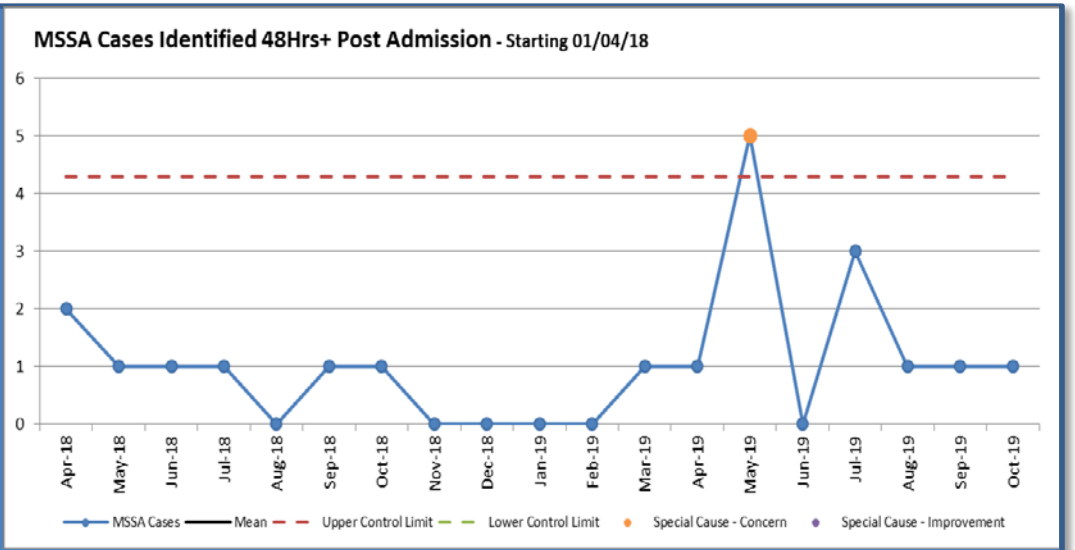
The aim is to have a reduction in MSSA cases when compared to the previous financial year, to demonstrate an incremental improvement

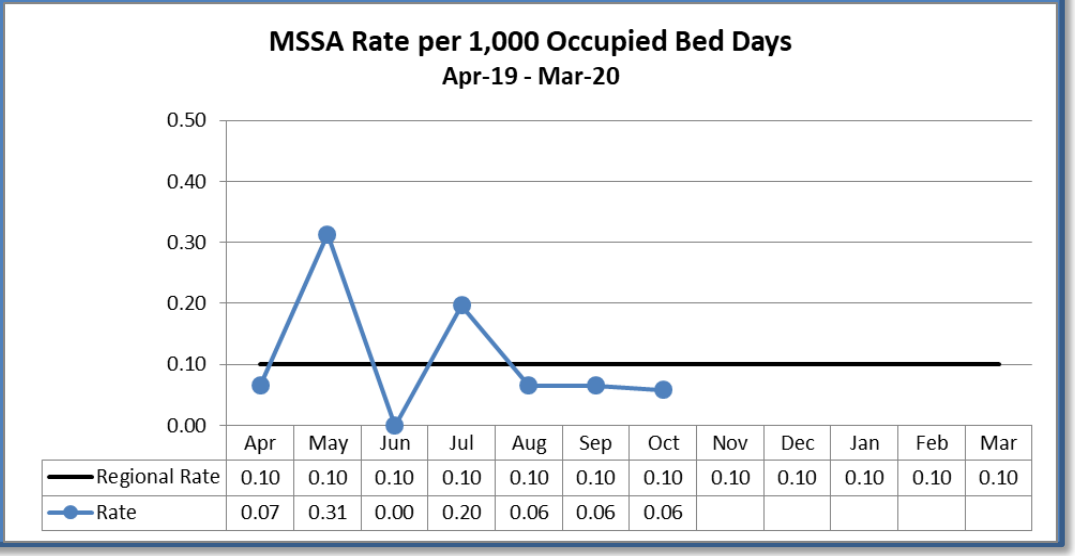
In October 2019, 1 MSSA case was reported in the Trust. This occurred on Ward 15

In this financial year there have been 12 confirmed MSSA cases reported.

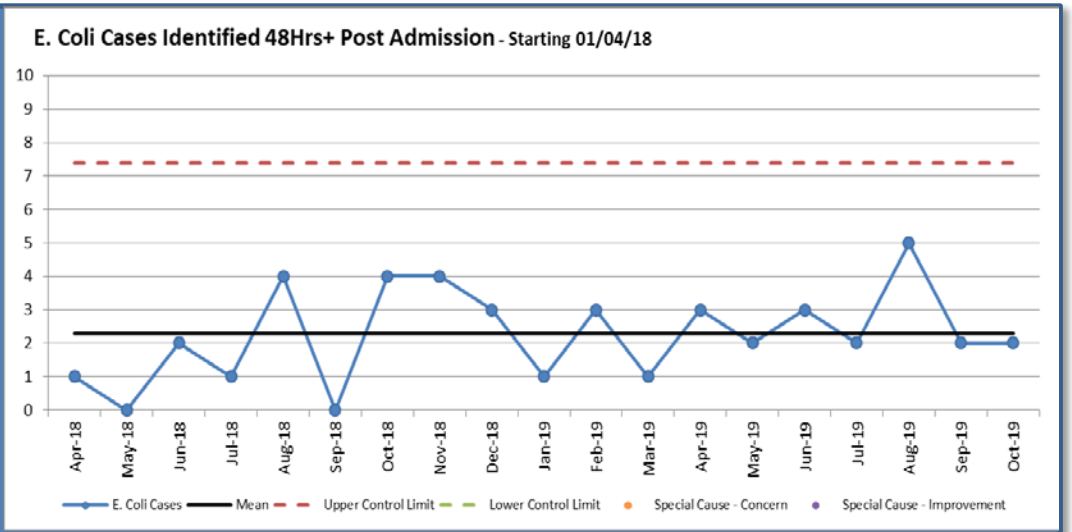
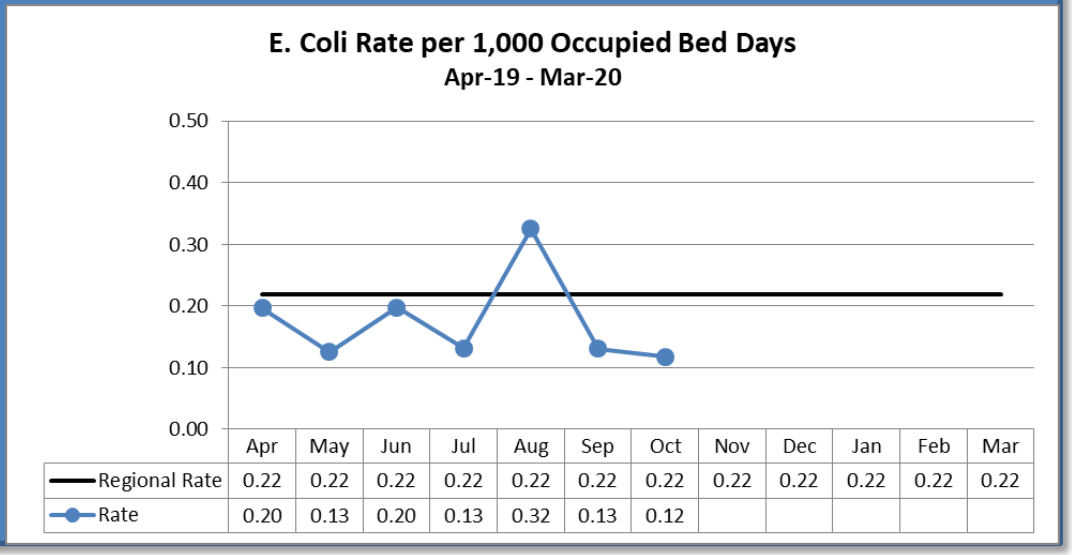
Summary of data presented:

- There is no statistically relevant change in the data over the last 18 months which means that the number of cases is stable
- The regional rate of MSSA is 0.10 (as an average of the full year). Using the rate takes into account increased activity within the Trust. Currently the Trust's average would be equivalent to the regional average at month 7. The variation shown at this stage is of no

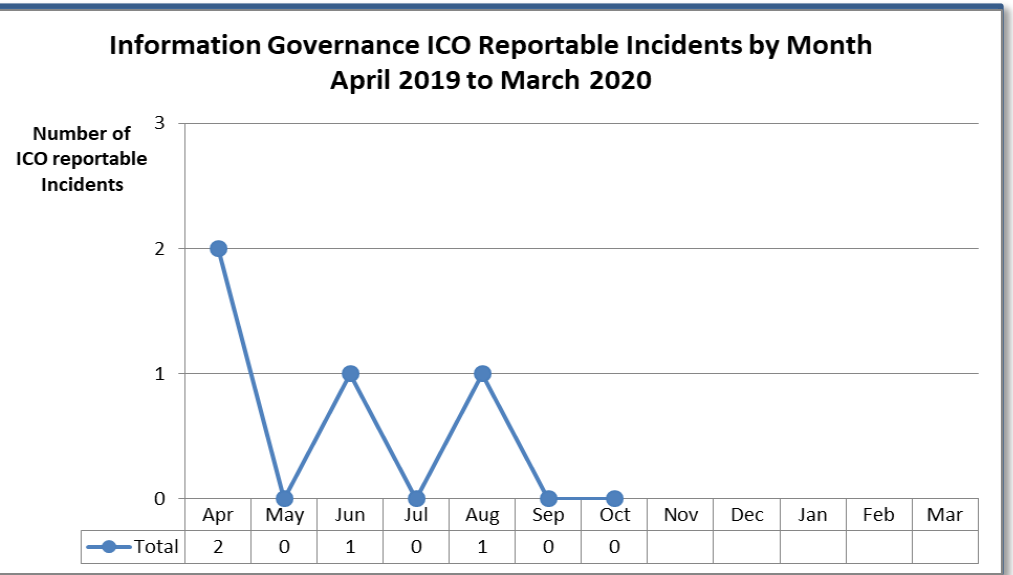




	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Regional Rate	0.10	0.10	0.10	0.10	0.10	0.10	0.10	0.10	0.10	0.10	0.10	0.10
Rate	0.07	0.31	0.00	0.20	0.06	0.06	0.06					

Description	Aggregate Position	Trend
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 2019, 2 E.Coli cases were reported. These occurred on Ward 2 and Ward 18. In this financial year there have been 19 confirmed E-Coli cases reported. <u>Summary of data presented:</u> • The number of E-coli cases has remained within normal variation over the last 18 months • The Rate (taking into account increased activity within the Trust) is slightly lower than the regional average rate at month 7 which is positive. The variation is within normal limits which suggests this is stable.	 

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Regional Rate	0.22	0.22	0.22	0.22	0.22	0.22	0.22	0.22	0.22	0.22	0.22	0.22
Rate	0.20	0.13	0.20	0.13	0.32	0.13	0.12					

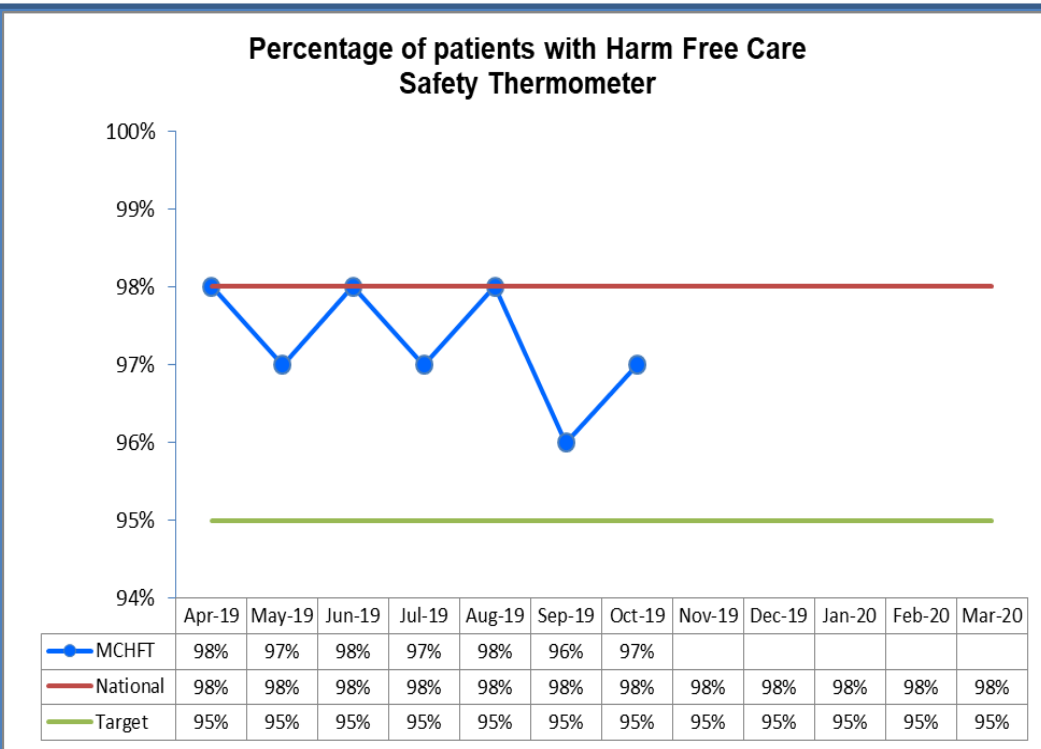
Description	Aggregate Position	Trend
Information Governance Information Commissioners Office (ICO) reportable incidents.	In October 2019, no information governance ICO reportable incidents were reported in the Trust. The Trust has detailed plans in place to address the requirements of the General Data Protection Regulations (GDPR) which is overseen by the Information Governance Group.	

CQUIN 2019-20 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	**Prevention of Ill health** Achieving 90% of antibiotic prescriptions for lower UTI in older people meeting NICE guidance for lower UTI (NG109) and PHE Diagnosis of UTI guidance in terms of diagnosis and treatment.	✗	£55,879 **(£NIL)**		£55,879		£55,879		£55,879	**£223,517**
1b	**Prevention of Ill health** Achieving 90% of antibiotic surgical prophylaxis prescriptions for elective colorectal surgery being a single dose and prescribed in accordance to local antibiotic guidelines.	✓ **Partially**	£55,879 **(£31,665)**		£55,879		£55,879		£55,879	**£223,517**
2	**Prevention of Ill health** Achieving an 80% uptake of flu vaccinations by frontline clinical staff.	NOT REQUIRED	No Payment		No Payment		No Payment		**MCHFT £447,030** **CCICP £184,318**	**MCHFT £447,030** **CCICP £184,318**
3a	**Prevention of Ill health** Achieving 80% of inpatients admitted to an inpatient ward for at least one night who are screened for both smoking and alcohol use	✓	£37,253		£37,253		£37,253		£37,253	**£149,011**
3b	**Prevention of Ill health** Achieving 90% of identified smokers given brief advice.	✓ **Partially**	£37,253 **(£6,054)**		£37,253		£37,253		£37,253	**£149,011**
3c	**Prevention of Ill health** Achieving 90% of patients identified as drinking above low risk levels, given brief advice or offered a specialist referral.	✓ **Partially**	£37,253 **(£25,425)**		£37,253		£37,253		£37,253	**£149,011**

Board Papers – Quality, Safety & Experience Section: December 2019

CQUIN Indicator	Indicator Name	Milestone Achieved								
		Q1	Financial Incentive Achieved	Q2	Financial Incentive Achieved	Q3	Financial Incentive Achieved	Q4	Financial Incentive Achieved	Maximum Value
7	**Patient Safety** Achieving 80% of older inpatients receiving key falls prevention actions are met and recorded	✓ **Partially**	£111,757 **(£19,101)**		£111,757		£111,757		£111,757	£447,030
9	**Best Practice Pathways** Achieving 55% of eligible stroke survivors receiving a six month follow up within 4-8 months of their stroke	✓	£46,079		£46,079		£46,079		£46,079	**£184,318**
11a	**Best Practice Pathways** Achieving 75% of patients with confirmed pulmonary embolus being managed in a same day setting where clinically appropriate.	✓ **Partially**	£37,253 **(£5,662)**		£37,253		£37,253		£37,253	**£149,011**
11b	**Best Practice Pathways** Achieving 75% of patients with confirmed atrial fibrillation being managed in a same day setting where clinically appropriate.	✓ **Partially**	£37,253 **(£14,156)**		£37,253		£37,253		£37,253	**£149,011**
11c	**Best Practice Pathways** Patients with or confirmed Community Acquired Pneumonia should be managed in a same day setting where clinically appropriate.	✗	£37,253 **(£NIL)**		£37,253		£37,253		£37,253	**£149,011**
SP1	**Hospital Pharmacy Transformation and Medicines Optimisation**	✓	**£9,670**		**£9,670**		**£9,670**		**£9,670**	**£38,680**

Description	Aggregate Position	Trend
Safety Thermometer - Harm Free Care.	In October 2019, 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.	

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
MCHFT	98%	97%	98%	97%	98%	96%	97%					
National	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

Board Papers – Quality, Safety & Experience Section: December 2019

Description	Aggregate Position		Trend
Registered Nurses monthly expected hours by shift versus actual monthly hours per shift. Day time shifts only	86.8% 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 2019: 86.8%** September 2019: 88.3% August 2019: 89.8%	The lowest staffing levels during the day were on Ward 2 at 70.6%
Registered Nurses monthly expected hours by shift versus actual monthly hours per shift. Night time shifts only	92.8% of expected Registered Nurse hours were achieved for night shifts.	Trend **October 2019: 92.8%** September 2019: 93.0% August 2019: 92.5%	The lowest staffing levels during the night were on Ward 5 at 73.0%
Healthcare Assistant monthly expected hours by shift versus actual monthly hours per shift. Day time shifts only	90.7% of expected HCA hours were achieved for day shifts.	Trend **October 2019: 90.7%** September 2019: 91.6% August 2019 92.9%	The lowest staffing levels during the day were on NICU at 48.7%
Healthcare Assistant monthly expected hours by shift versus actual monthly hours per shift. Night time shifts only	96.3% of expected HCA hours were achieved for night shifts. For areas with over 100% staffing levels for HCA's this is reviewed and is predominately due to wards requiring 1 to 1 specials for patients following a risk assessment or to increase staffing numbers when there are registered nursing gaps that are not filled.	Trend **October 2019: 96.3%** September 2019: 98.6% August 2019: 97.5%	The lowest staffing levels during the night were on Ward 6 at 86.4%
Total number of wards that are lower than 85% RN fill days and nights is 10.	Critical Care 83.9% (Day), Ward 10 74.2% (Day), Ward 14 80.7% (Night), Ward 19 83.1% (Day), Ward 2 70.6 (Day), Ward 21B 82.8% (Day), Ward 4 79.1% (Day), Ward 5 79.5% (Day) 73.0% (Night), Ward 6 80.4% (Day), 79.2% (Night), CAU 84.4% (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: December 2019

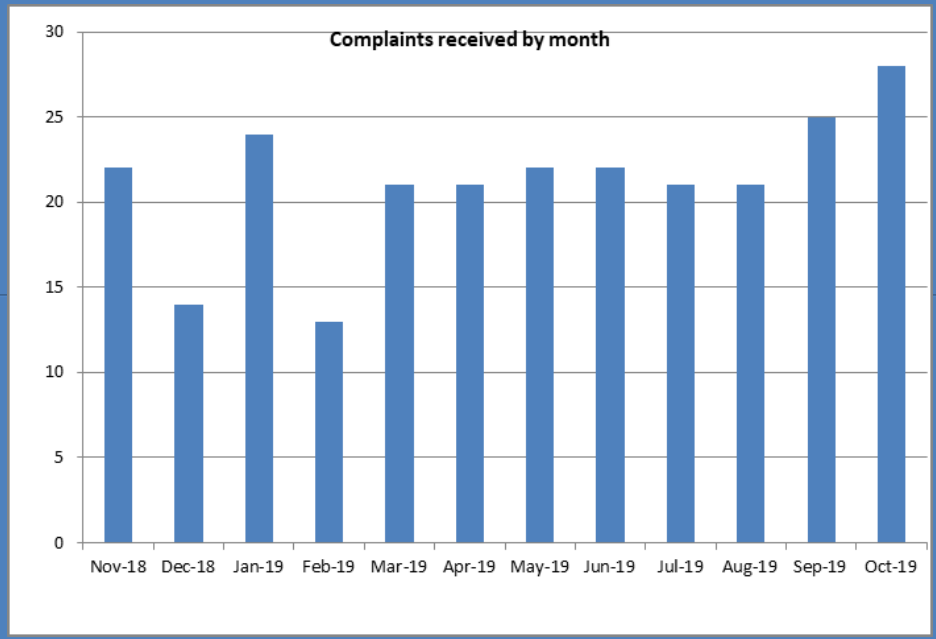
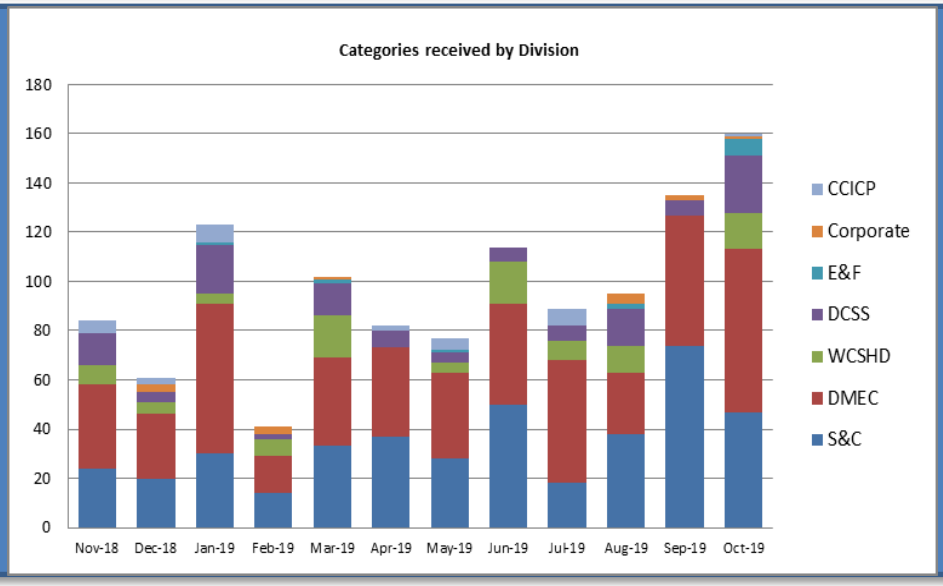
Ward Name	Day				Night				Day		Night		Care Hours Per Patient Day			
	Qualified		Unqualified		Qualified		Unqualified		Qualified	Unqualified	Qualified	Unqualified	Cumulative count over month of pts at 23:59 each day	Qualified	Unqualified	Overall
	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Fill Rate	Fill Rate	Fill Rate	Fill Rate				
MCHFT	41312.4	35856.5	36428.3	33029.3	30205.7	28043.6	22912.3	22057.6	86.8%	90.7%	92.8%	96.3%	16023	189.13	136.32	325.45
Acute Medical Unit	1716.5	1647.3	1872.3	1732.8	1872.0	1747.8	1488.0	1461.3	96.0%	92.5%	93.4%	98.2%	846	4.01	3.78	7.79
Critical Care	4309.0	3615.2	582.0	468.0	3756.0	3239.0	0.0	12.0	83.9%	80.4%	86.2%	-	267	25.67	1.80	27.47
Elmhurst	786.0	782.0	2393.3	2275.9	744.0	745.3	1548.0	1524.0	99.5%	95.1%	100.2%	98.4%	921	1.66	4.13	5.78
Ward 1 Coronary Care	2186.0	1952.3	1217.0	1125.3	1512.0	1475.0	804.0	780.0	89.3%	92.5%	97.6%	97.0%	934	3.67	2.04	5.71
Ward 10 Ortho Trauma	2386.5	1770.0	3150.0	2980.0	1128.0	1091.5	1575.0	1527.0	74.2%	94.6%	96.8%	97.0%	1114	2.57	4.05	6.61
Ward 11 SAU	2012.2	1746.5	2024.5	1773.5	1560.0	1461.0	1536.0	1377.0	86.8%	87.6%	93.7%	89.6%	42	76.37	75.01	151.38
Ward 13 Vascular & Colorectal	1942.5	1707.0	1601.5	1534.3	1116.0	1110.5	1128.0	1013.0	87.9%	95.8%	99.5%	89.8%	967	2.91	2.63	5.55
Ward 14 Gastroenterology	1354.5	1344.3	1596.0	1482.0	1115.5	900.0	1296.0	1260.0	99.2%	92.9%	80.7%	97.2%	952	2.36	2.88	5.24
Ward 15 Female Ward	1876.0	1699.5	1884.0	1663.0	1159.5	1006.5	1176.0	1116.0	90.6%	88.3%	86.8%	94.9%	927	2.92	3.00	5.92
Ward 18 Surgical Speciality	1386.5	1201.8	1362.0	1240.8	756.0	766.5	960.0	852.0	86.7%	91.1%	101.4%	88.8%	632	3.11	3.31	6.43
Ward 19 Winter Ward	1181.3	981.8	1542.0	1492.8	855.5	908.0	1115.5	1218.5	83.1%	96.8%	106.1%	109.2%	837	2.26	3.24	5.50
Ward 2 Short Stay	2159.8	1524.3	1959.5	2032.0	1128.0	1128.0	1380.0	1212.0	70.6%	103.7%	100.0%	87.8%	967	2.74	3.35	6.10
Ward 21b Rehabilitation	1110.0	919.0	2349.0	2075.5	792.0	743.0	1116.0	1078.5	82.8%	88.4%	93.8%	96.6%	741	2.24	4.26	6.50
Ward 4 Elderly	1692.3	1339.0	2707.5	2235.8	763.5	751.0	2051.0	1830.0	79.1%	82.6%	98.4%	89.2%	976	2.14	4.17	6.31
Ward 5 Respiratory	2284.8	1816.8	1603.3	1454.8	1512.0	1103.5	816.0	1161.5	79.5%	90.7%	73.0%	142.3%	954	3.06	2.74	5.80
Ward 6 Rehab	1826.5	1468.0	2412.5	2177.0	1560.0	1235.5	1332.0	1151.5	80.4%	90.2%	79.2%	86.4%	824	3.28	4.04	7.32
Ward 7 Gastroenterology	1350.0	1294.0	2681.5	2184.0	744.0	744.0	1728.0	1668.0	95.9%	81.4%	100.0%	96.5%	971	2.10	3.97	6.07
Ward 9 Ortho Elective	870.0	816.5	1037.3	906.8	768.0	708.0	384.0	348.0	93.9%	87.4%	92.2%	90.6%	342	4.46	3.67	8.13
Child & Adolescent Unit	2325.0	1962.5	775.0	700.0	1782.5	1725.0	356.5	345.0	84.4%	90.3%	96.8%	96.8%	605	6.10	1.73	7.82
Ward 23	1200.0	1187.3	760.0	722.0	740.0	752.3	740.0	740.0	98.9%	95.0%	101.7%	100.0%	795	2.44	1.84	4.28
NICU	1924.6	1731.3	183.4	89.3	1782.5	1656.0	0.0	0.0	90.0%	48.7%	92.9%	-	127	26.67	0.70	27.37
Ward 26 MLU	785.3	791.7	0.0	0.0	764.7	740.0	0.0	0.0	100.8%	-	96.8%	-	240	6.38	0.00	6.38
Ward 26 Labour	2647.3	2558.7	734.7	684.0	2294.0	2306.3	382.3	382.3	96.7%	93.1%	100.5%	100.0%	42	115.83	25.39	141.22

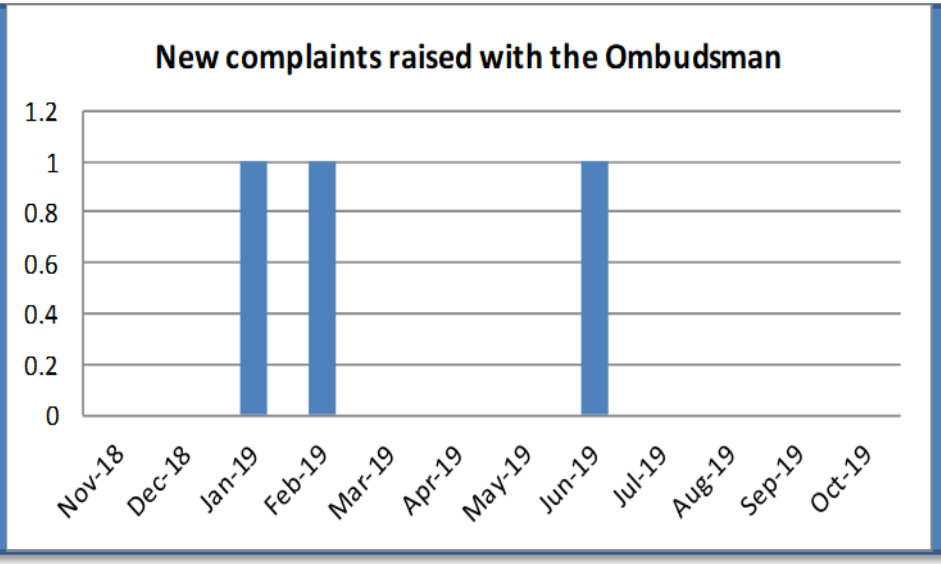
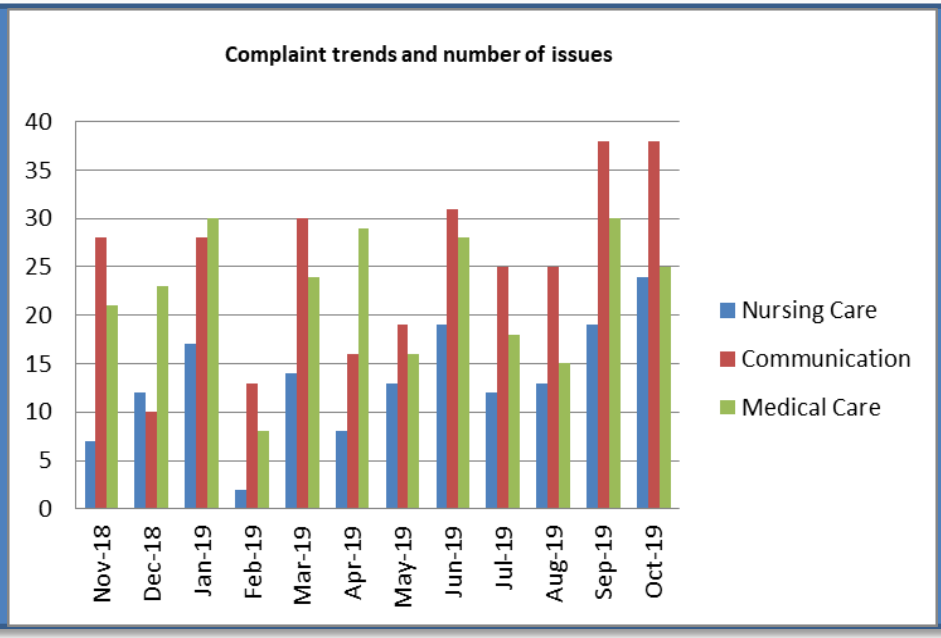
Experience Section:

Indicators	YTD 19/20	Jul-19	Aug-19	Sep-19	Oct-19
Complaints received by month	185	21	21	25	28
Complaints being reviewed by the Ombudsman	1	0	0	0	0
Closed complaints by month	173	26	29	23	18
Contacts raising informal concerns	674	92	62	83	90
Compliments received in month	3202	293	584	432	449
Number of new claims received in month	31	4	2	2	2
Number of claims closed	30	4	6	4	5
Number of inquests concluded	6	3	0	0	1
NHS Choices - Number of new postings	50	12	8	8	2
F&FT Response Rate ED, MIU, UCC and Assessment Areas*		16%	17%	17%	15%
Proportion of positive responses ED, MIU, UCC and Assessment Areas		85%	89%	87%	87%
F&FT Response Rate Inpatients and Daycases		42%	35%	39%	34%
Proportion of positive responses Inpatients and Daycases		93%	94%	93%	94%
F&FT Response Rate Outpatients		2%	1%	2%	1%
Proportion of positive responses Outpatients		98%	97%	96%	94%
F&FT Response Rate Maternity - Birth		7%	8%	20%	9%
Proportion of positive responses Maternity - Birth		100%	100%	100%	100%
F&FT Response Rate Community (CCICP)		3%	6%	12%	0%
Proportion of positive responses Community (CCICP)		86%	91%	88%	0%

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

Board Papers – Quality, Safety & Experience Section: December 2019

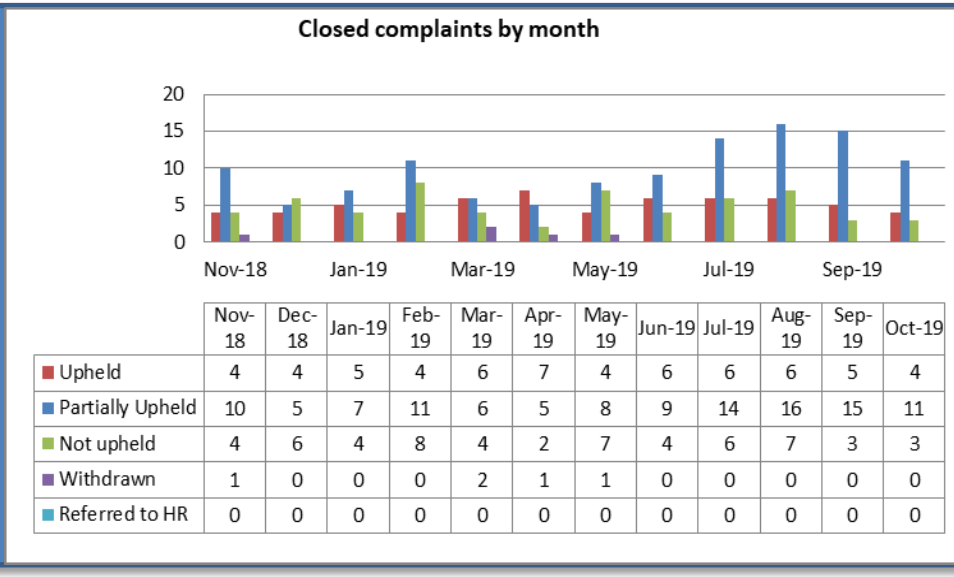
Description	Aggregate Position/Description	Trend
Monthly formal complaints received by the Trust.	28 complaints were received in October 2019 which covered 160 concerns. There were also 3 re-opened complaints. The highest categories were: • Communication with 38 concerns • Medical with 25 concerns • Nursing with 24 concerns 3 areas receiving the highest numbers of complaints/issues were: • Emergency Department - 6 complaints with 24 concerns • Ward 11 (SACU) - 2 complaints with 14 concerns • Ward 3 - 4 Complaints with 6 concerns	 Formal Complaints
Number of formal complaint issues by division.	This graph shows the breakdown of concerns by month for each division. CCICP: 1 CORP: 1 DMEC: 66 DCSS: 23 E&F: 7 S&C: 47 W&CD: 15	 Formal Complaint issues by division

Description	Aggregate Position/Description	Trend	
New complaints raised with the Public Health Service Ombudsman	In October 2019, there were no new complaints opened with the Parliamentary Health Service Ombudsman (PHSO). The PHSO have completed their investigations on one case which they have decided to partially uphold. The case is with DMEC to develop an action plan and response. There is 1 case at the investigation stage. In the last rolling 12 months we have had 3 cases with the PHSO of which none to date have been upheld.		Ombudsman
Complaint trends and number of issues.	The main trends in October 19 were:- Communication - 38 concerns raised over 16 complaints. 14 of these concerns were related to communication with patients face to face. Medical Care - 25 concerns raised over 12 complaints. 7 of these concerns related to medical diagnosis problems. Nursing Care - 24 concerns raised over 13 complaints. 10 of these concerns related to nursing care 'other.'		Complaint Trends

Description	Aggregate Position/Description	Trend

Closed Complaints

In October 2019, 18 complaints were closed, 1 of which was a re-opened complaint.



	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Upheld	4	4	5	4	6	7	4	6	6	6	5	4
Partially Upheld	10	5	7	11	6	5	8	9	14	16	15	11
Not upheld	4	6	4	8	4	2	7	4	6	7	3	3
Withdrawn	1	0	0	0	2	1	1	0	0	0	0	0
Referred to HR	0	0	0	0	0	0	0	0	0	0	0	0

Closed Complaints

Closed complaints by Division

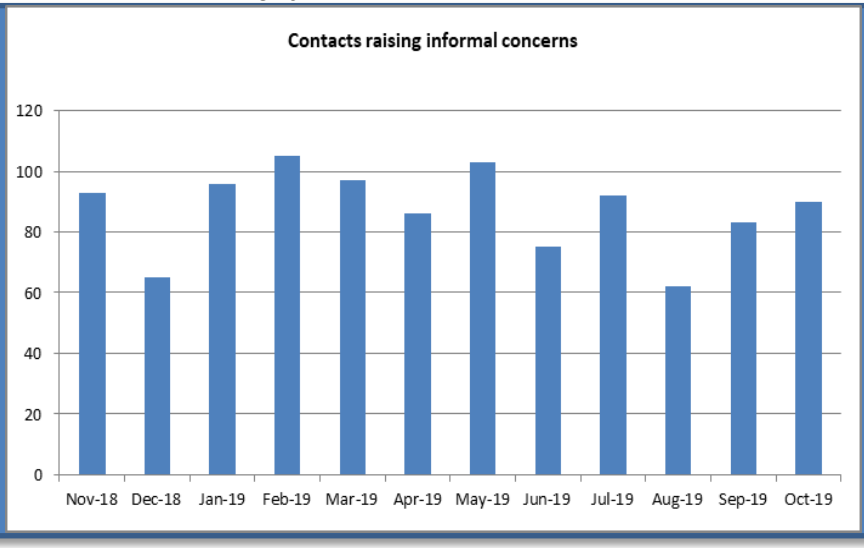
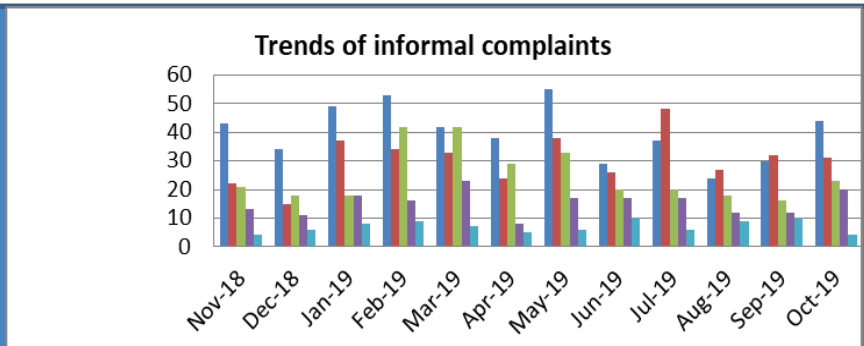
The table provides a breakdown of closed complaints for October 2019 by division.

The table also identifies the outcome of the complaint in terms of which complaints were upheld, not upheld, partially upheld or referred to Human Resources (HR).

Division	Upheld	Partially Upheld	Not Upheld	Withdrawn	Ref HR	Sub-Total
DMEC	3	4	2	0	0	9
Corporate	0	0	0	0	0	0
Surgery & Cancer	0	3	0	0	0	3
Women & Children's	1	1	0	0	0	2
DCSS	0	3	1	0	0	4
CCICP	0	0	0	0	0	0

Total closed = 18

Closed Complaints October 2019 – Tabled redacted 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 2019 was 90 raising 171 individual concerns. The Division of Medicine and Emergency Care received the highest number of overall concerns at 65, with the Surgery and Cancer Division receiving 44. The Emergency Department received the largest number of individual concerns at 28 which were raised from 12 contacts. Gynaecology received 14 concerns from 7 contacts. Ophthalmology received 12 concerns from 6 contacts. Orthopaedic and Gynaecology each received 6 concerns from 5 contacts. The Eye Care Centre and Dermatology each received 6 concerns from 3 contacts	 Informal concerns numbers
Informal concerns trends.	Care and communication were the highest trends for informal concerns in October 2019. 31 care issues raised: 22 related to medical care, of which 4 relate to the Emergency Department and 4 to General Surgery. 8 relate to nursing care, 2 of which relate to the Ward 3. 44 communication issues raised: 14 related to communication with patients face to face, 8 to communication with relatives face to face 8 with patients written. 18 issues relate to the Division of Medicine and Emergency Care and 11 to Surgery and Cancer Division.	

	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Communication	43	34	49	53	42	38	55	29	37	24	30	44
Care	22	15	37	34	33	24	38	26	48	27	32	31
Appointments	21	18	18	42	42	29	33	20	20	18	16	23
Attitude of Staff	13	11	18	16	23	8	17	17	17	12	12	20
Treatment	4	6	8	9	7	5	6	10	6	9	10	4

Informal concerns trends

Description	Aggregate Position/Description	Trend

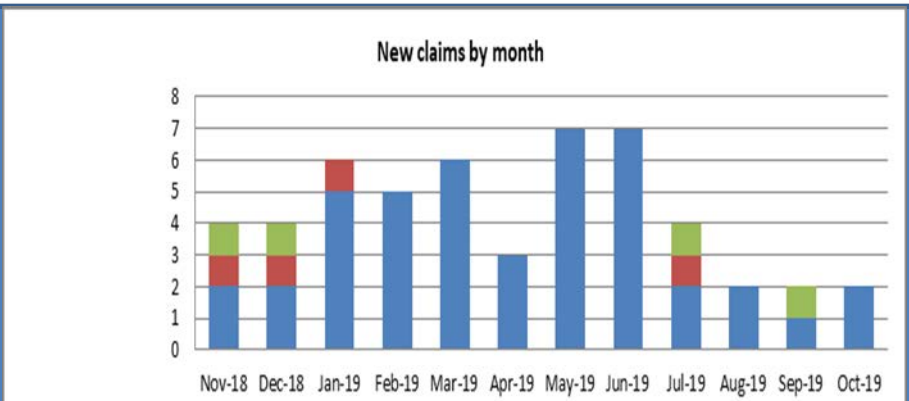
New claims received.

In October 2019, 2 new clinical negligence claims were received. These related to:

- Surgery and Cancer – Urology
- Surgery and Cancer - Orthopaedics

No new employer's liability claims were received.

No new public liability claims were received.



	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Public Liability	1	1	0	0	0	0	0	0	1	0	1	0
Employer's Liability	1	1	1	0	0	0	0	0	1	0	0	0
Clinical	2	2	5	5	6	3	7	7	2	2	1	2

Claims

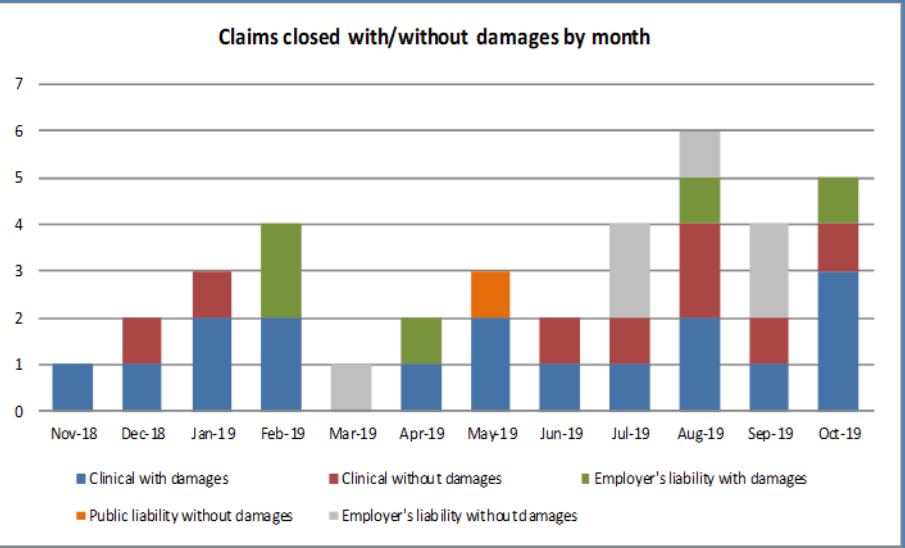
Claims closed with/without damages.

In October 2019 the following claims were closed with/without damages:-

5 clinical negligence claims were closed, 3 of which were upheld.

1 employer's liability claim was closed and this was upheld.

No public liability claims were closed.



Closed Claims

Board Papers – Quality, Safety & Experience Section: December 2019

Description	Aggregate Position/Description	Trend

Value of claims closed by month

In October 2019 damages of £137.500 were paid out on 3 clinical negligence claims and £6,000 on 1 employer's liability claim.

General Surgery

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

Lessons Learnt: RCA undertaken and all actions completed.

Medical, Surgical and Elmhurst

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

Lessons Learnt: RCA undertaken and all actions implemented.

Histopathology

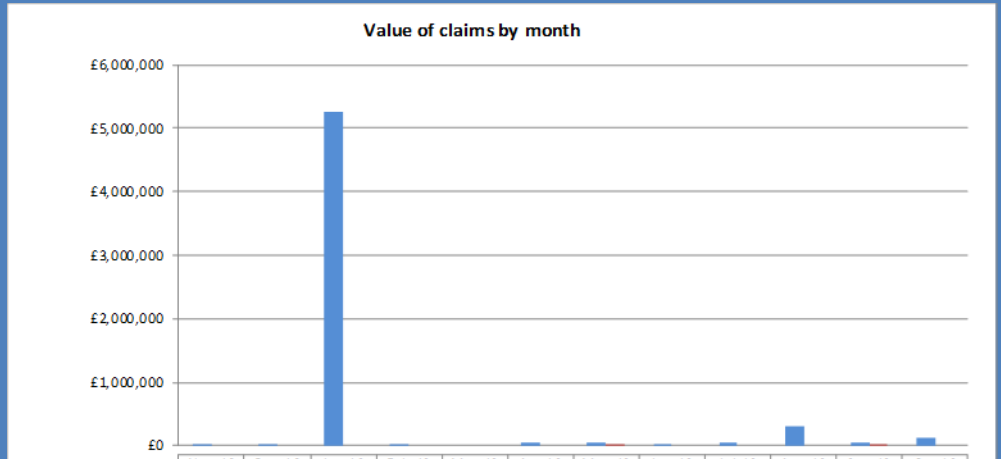
Sentence removed under Section 40 of the Freedom of Information Act.

No admissions made but settled due to a litigation risk.

Corporate

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

Lessons Learnt: Fault has now been rectified.



	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Clinical damages paid £	5,000	5,585	5,251,78	30,103	0	37,043	46,250	£16,288	50,000	315,153	50,000	137,500
Employer's liability paid £	0	0	0	0	0	0	1,500	0	0	0	2,000	0

Value of claims

Top five claims by Specialty

In October 2019, 1 new claim was received which relates to the Trust's top five specialties for claims:

Orthopaedics

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

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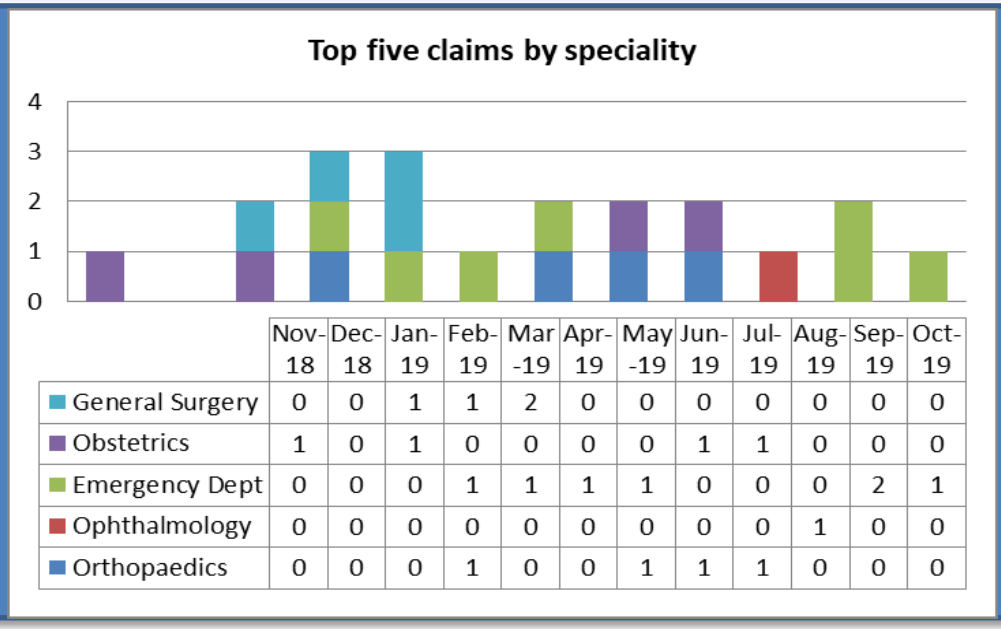
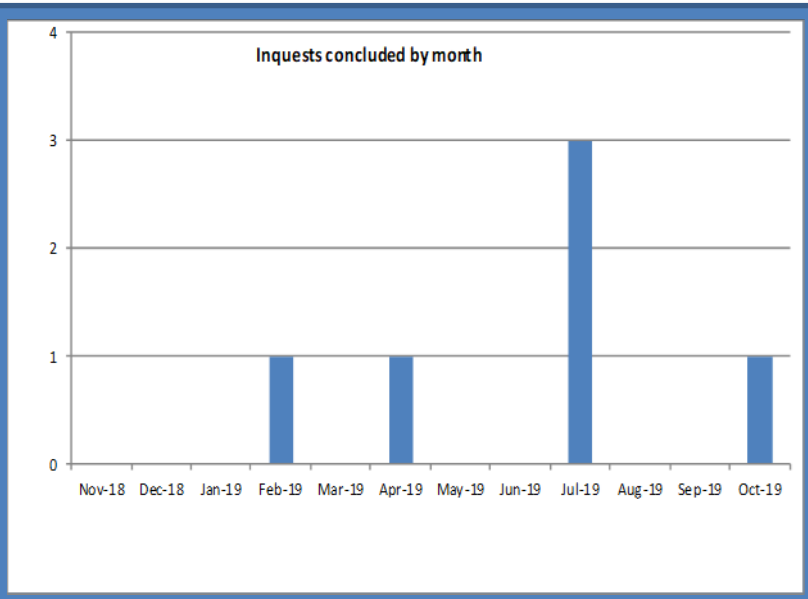
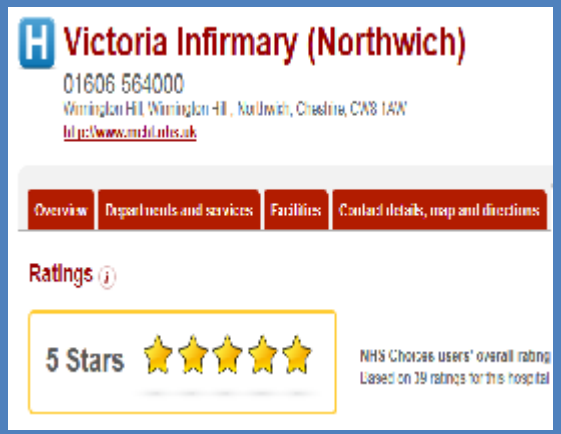


	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
General Surgery	0	0	1	1	2	0	0	0	0	0	0	0
Obstetrics	1	0	1	0	0	0	0	1	1	0	0	0
Emergency Dept	0	0	0	1	1	1	1	0	0	0	2	1
Ophthalmology	0	0	0	0	0	0	0	0	0	1	0	0
Orthopaedics	0	0	0	1	0	0	1	1	1	0	0	0

Top 5 claims by specialty

Description	Aggregate Position /Description	Trend
Number of Inquests concluded by month	1 inquest was concluded in October 2019. The Coroner's Conclusion was Natural Causes.	

Inquests

NHS Choices Star Ratings	NHS choices have decided to remove the average star ratings from the NHS website. Patients can still give star ratings for their individual experience in the same manner, but the overall star rating has been removed for the interim period. NHS choices will be completing further research to identify what users think is the appropriate solution that gives a better indication of the service.	

NHS Choices – Star Ratings

Description	Aggregate Position /description	Trend

NHS Choices postings

There were 2 postings on NHS Choices in October 2019 of which both were positive :

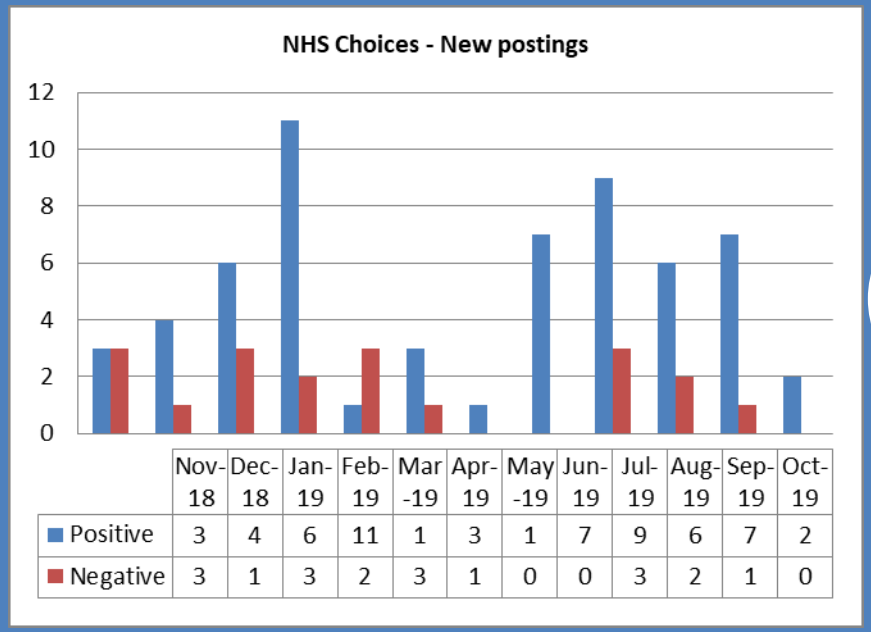
Treatment Centre

I visited Leighton Hospital for a colonoscopy procedure. The care I received was incredibly good. The news I was given following the procedure was not what I had hoped for but every person I came into contact with made me feel they really cared about my well-being. They were all: professional, thoughtful, helpful and very efficient - exactly what a patient needs when they are feeling nervous.

VIN – Minor Injuries

Thank you. Great care after an accident which required stitches. Despite being really busy the staff were great.

The NHS choices website was under maintenance for a period of time during October hence lower than usual feedback numbers.



	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Positive	3	4	6	11	1	3	1	7	9	6	7	2
Negative	3	1	3	2	3	1	0	0	3	2	1	0

NHS Choices – Postings

The Family and Friends Test.

In October 2019 the Trust has scored the following positive response scores:

Emergency care /assessment areas 87%;

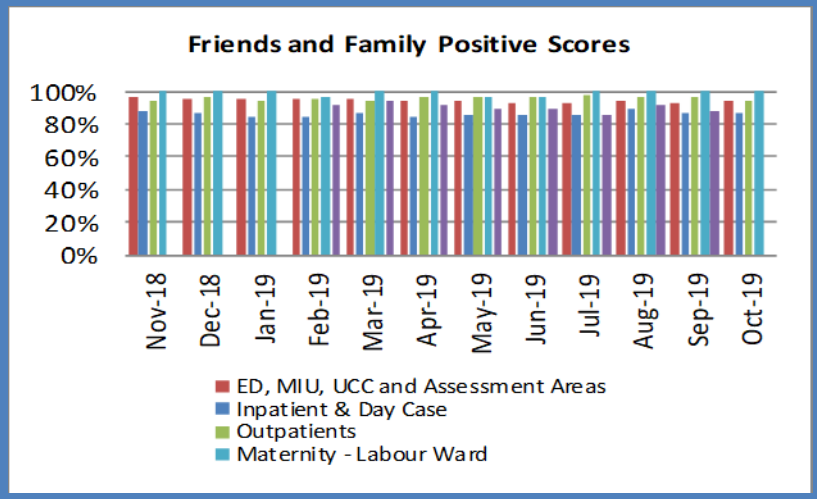
Inpatients and day cases 94%;

Outpatients 94%;

Maternity (Labour ward) 100%;

CCICP 0% - SMS messaging was put on hold at request of Division due to a complaint from a patient and will restart in November.

Outpatients 94%. Due to complex technical difficulties SMS text delayed from the due start date and revised date going live November.

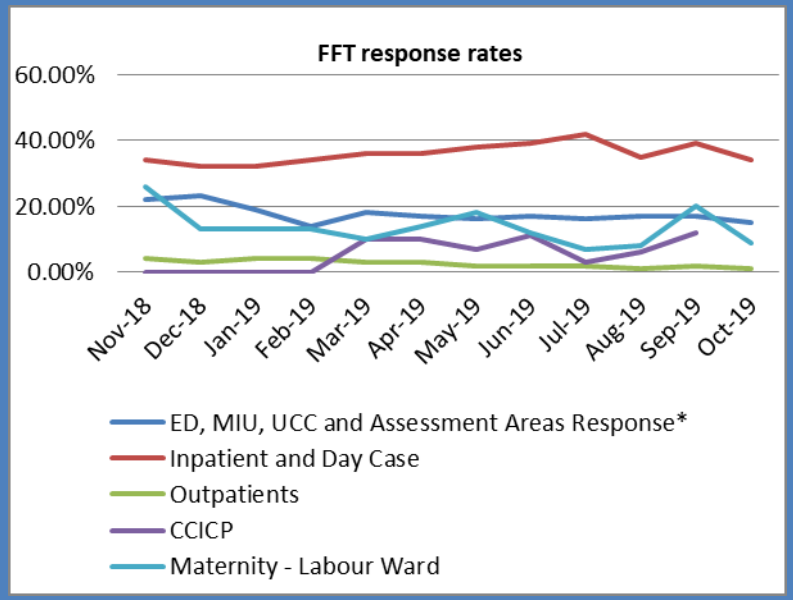


Family & Friends Test

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

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

October 2019 Ward/Dept.	% Response	Total responses received	How many would recommend
A&E , UCC & MIU	15%	1044	904
CCICP	0%	0	0
Inpatients & Day cases	34%	1697	1591
Maternity	9%	25	25
Outpatients	1%	239	224



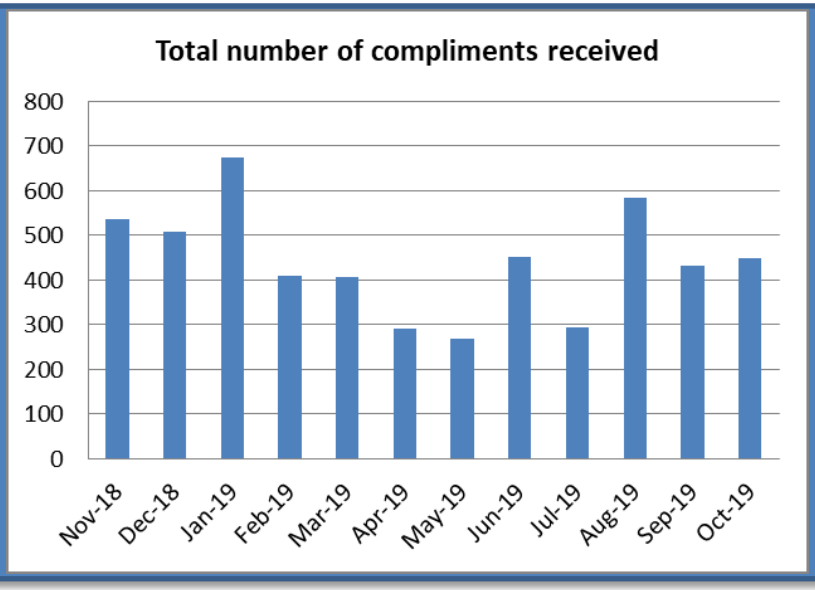
Family & Friends Test

Compliments received

There were 449 compliments received in September 2019. 36 of these were logged by the Customer Care Team and 413 received across the Trust.

"I was an inpatient on Ward 18 in July with Urosepsis. The treatment I received from Urology was first class and I have nothing but praise for the way I was treated. I even found the food to be excellent."

"I visited the satellite outpatient unit this afternoon for a minor op appointment. I am currently on a fast track pathway and was very nervous about the appointment. Both the doctor and the nurses in the minor op clinic were absolutely lovely and made me feel at ease. Although the clinic was running behind they made the time to make sure I was ok and understood what was happening throughout the procedure. Please pass on my thanks to them as they really made a difference to my visit."



Compliments

Mid Cheshire Hospitals
NHS Foundation Trust

Board of Directors Performance Report

October 2019

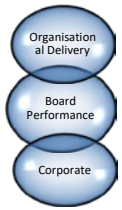
"To Deliver Excellence in Healthcare through Innovation & Collaboration"

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.

James Sumner
Chief Executive

Contents

Headline Measures

Organisational Delivery				
Indicator	**Standard**	**YTD**	**Oct-19**	
Cancer				
Rapid Access Referrals (%) *(seen in 2 wks)*	93.00%	97.25%	98.29%	
Total Patients Seen		*7,267*	*1,052*	
Patients seen >14 days		*200*	*18*	
62 day GP Classic (%)	85.00%	86.82%	86.62%	*
Accountable Patients Treated		*512*	*79*	
No. of Breached Pathways (adjusted)		*68*	*11*	
62 day Screening (%)	90.00%	85.37%	79.41%	*
Accountable Patients Treated		*82*	*17*	
No. of Breached Pathways (adjusted)		*12*	*3.5*	
Unplanned Activity				
4 Hour Access Standard (%)	95.00%	78.37%	75.50%	
A&E Attendances (LH/MIU/UUC) (% to plan)		99.79%	95.48%	
A&E Attendances LH & MIU (Vol)		*58,735*	*8,154*	
Planned Activity				
Incomp Pathways <18wk (%)	92.00%	91.95%	92.32%	
>6wk Diagnostic Waits (%)	1.00%	4.28%	0.84%	
Total Patients Waiting for a First Outpatient Appointment			9,033	

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

Indicator	Standard	YTD
Workforce		
Sickness absence Rolling 12 Month		4.62%
Turnover Rolling 12 Month		9.14%

Corporate					
	YTD Rating		YE Rating	YE Metric	
Indicator	**Plan**	**Actual**	**Forecast**	**Plan**	**Forecast**
Finance					
Use of Resource Rating	3	3	3		
Capital Service Capacity	3	3	3	0.61	1.47
Liquidity	3	3	4	-13	-17
I&E Margin	3	3	3	-0.70%	-0.70%
Distance from Financial Plan	1	2	1	0.00%	0.00%
Agency Spend	1	2	2	-15.00%	4.00%

	YTD Target	YTD Actual	YTD Variance
Cost Improvement Schemes Total (£000's)	2,837	2,249	-588
Commission Contact Income SC & VR (£000's)	99,504	99,504	0
Contract Income (£'000)	140,019	140,577	558
Pay to Budget (£000's)	-107,265	-107,508	-243
Non Pay to Budget (£000's)	-42,771	-44,463	-1,692
Agency Trajectory (£000's)	-2,826	-3,836	-1,010

Exec Summary

In October the following operational standards within the revised 2019/20 oversight framework are:

Above required standard:
1. RTT position delivered 92.32% against 92%
2. Rapid Access Cancer standard at 98.29% against 93%
3. 62 Day cancer from GP referral 86.62% against 85%
4. Six weeks diagnostic at 0.84% against a threshold of 1%

Below required standard:
1. 4hr Emergency access delivered 75.50% against a target a target of 95%

No longer mandated within the oversight framework, but still monitored by the Trust:
1. 62 Day Screening Cancer delivered 79.41% against a target of 90%

The UoRR metric is 3.

The Trusts' I&E performance against the control total is £427k worse than the plan.

This position includes the Provider Sustainability Fund (PSF) earned to date, which is dependent on meeting the financial control total and also the Marginal Rate Emergency Threshold (MRET).

There key challenge to the Trust financial position lies within delivering services using premium cost, which is exacerbated by increased unplanned care demand. There is in addition a variation in the CIP scheme, with challenges around delivering improvements to sickness rates within nursing and delays to other programmes of work.

The rate of agency use remains above the ceiling rate set by NHS, which increases the likelihood of this Use of Resource Rating deteriorating.

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 Access Standard).

The Trust has achieved a Use of Resource rating of 3, which is expected to maintain at this level throughout 2019/20.

Operational Performance

	Current YTD													Monthly Trend
	Target	Actual	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	
Maximum 6 week wait for Diagnostic procedures	1%	4.28%	0.48%	0.17%	0.54%	0.47%	0.42%	0.76%	0.64%	9.34%	7.76%	4.04%	3.05%	0.95%	0.84%	
All Cancers: 62 day GP Classic (%) *	85%	86.82%	86.50%	93.40%	86.90%	85.83%	85.84%	85.60%	86.62%	86.09%	86.18%	86.45%	86.72%	88.89%	86.62%	
All Cancers: 62 day Screening (%) *	90%	85.37%	100.00%	100.00%	81.80%	87.50%	100.00%	95.45%	90.00%	90.00%	61.11%	96.77%	90.48%	85.00%	79.41%	
18 weeks from point of referral to treatment - patients on an incomplete pathway (%)	92%	91.95%	92.82%	92.28%	92.01%	91.30%	91.63%	90.67%	91.05%	91.67%	92.07%	92.09%	92.00%	92.46%	92.32%	
A&E - maximum waiting time of 4 hours from arrival to admission/transfer/discharge (%)	95%	78.37%	85.51%	88.13%	83.57%	78.89%	81.12%	80.41%	79.90%	78.26%	80.60%	78.98%	78.02%	77.36%	75.50%	
STF Trajectory			90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	0.00%	0.00%	0.00%	0.00%				
Provider Submitted Trajectory													88.10%	88.10%	86.50%	

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

Financial & Resource

		Unit	YE Plan	YE Forecast	YE Rating	YTD Plan	YTD Actual	YTD Rating
Financial Sustainability	Capital Service Capacity	0.0x	0.61	1.47	3	1.48	1.60	3
	Liquidity	days	-13	-17	4	-10	-11	3
Financial Efficiency	I&E Margin	%	-0.70%	-0.70%	3	-0.30%	-0.60%	3
Financial Controls	Distance from Financial Plan	%	0.00%	0.00%	1	0.00%	-0.30%	2
	Agency Spend	%	-15.00%	4.00%	2	-14.00%	16.00%	2
Overall UOR Rating					3			3

Operational Delivery: *Cancer Pathway*

Headline Measures

	Current YTD		Rolling 13 months											
	Target	Actual	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Monthly Trend
Rapid Access Referrals (%) (seen in 2 wks)	93%	97.25%	96.87%	98.36%	97.78%	96.91%	97.66%	97.69%	95.83%	97.65%	96.99%	96.60%	98.20%	97.29%	98.29%	
Total Patients Seen		*7267*	*989*	*917*	*855*	*842*	*940*	*996*	*1030*	*980*	*963*	*1207*	*1000*	*1035*	*1052*	
Patients seen >14 days		*200*	*31*	*15*	*19*	*26*	*22*	*23*	*43*	*23*	*29*	*41*	*18*	*28*	*18*	
% seen within 7 days		*0.0%*	*41.5%*	*34.0%*	*35.4%*	*38.6%*	*38.1%*	*30.5%*	*30.3%*	*39.4%*	*37.6%*	*38.2%*	*43.3%*	*54.7%*	*59.2%*	
62 day GP Classic (%) *	85%	86.82%	86.50%	93.40%	86.90%	85.83%	85.84%	85.60%	86.62%	86.09%	86.18%	86.45%	86.72%	88.89%	86.62%	

** Provisional figures subject to change depending*

104+ day waits - (Cancer patients treated)	0	0	3	0	1	3	3	5	4	4	4	2	2

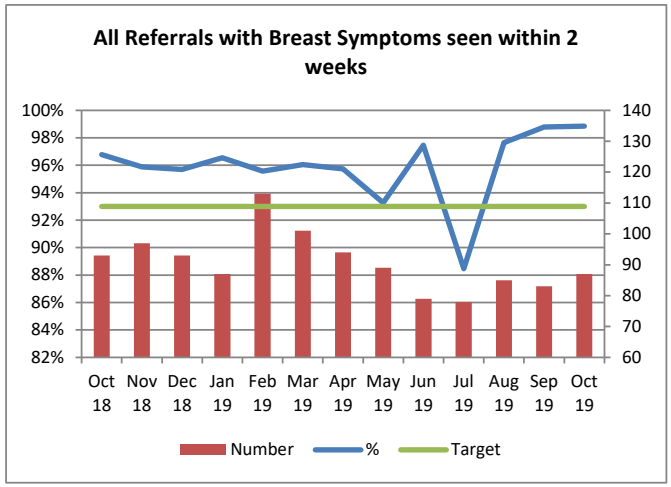
Commentary

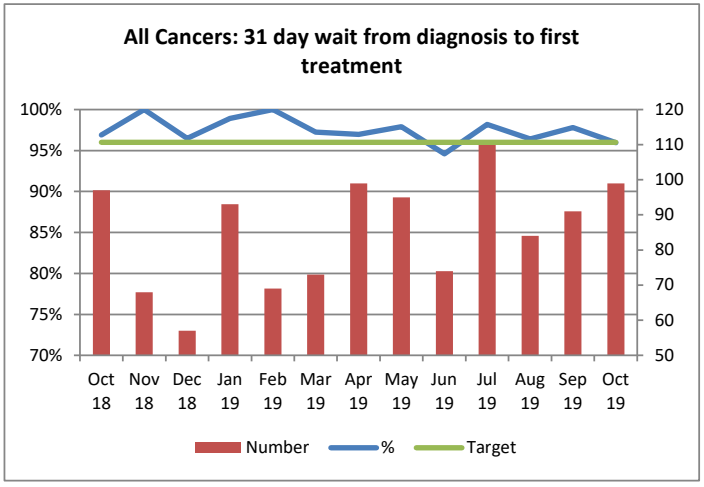
The Trust has achieved two of the three headline cancer standards during the month of October 2019. The figures presented in this paper reflect the Trust's regulatory performance measures adjusted figures that take into account breach reallocation between providers.
The Trust has continued it's strong performance against the Rapid Access referrals standard, achieving 98.29% for October. This is inspite of an increasing trend of patients being referred over the last 3 months.

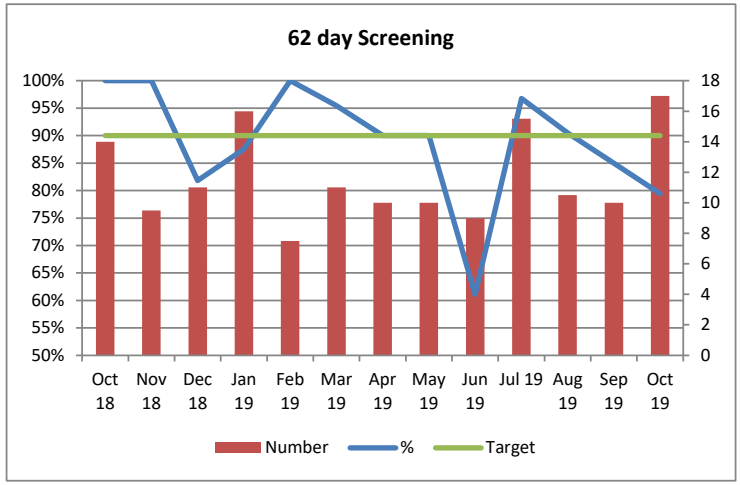
The 62 Day GP Classic standard also continues it's strong performance, achieving 86.62% against an 85% target.

The 62 day screening standard has failed the 90% standard in October, at 79.41%. This predominantly relates to patient choice for endoscopy procedure within the Bowel Cancer Screening programme. There were 3.5 breaches in-month with 13.5 compliant treats and 17 total treats.

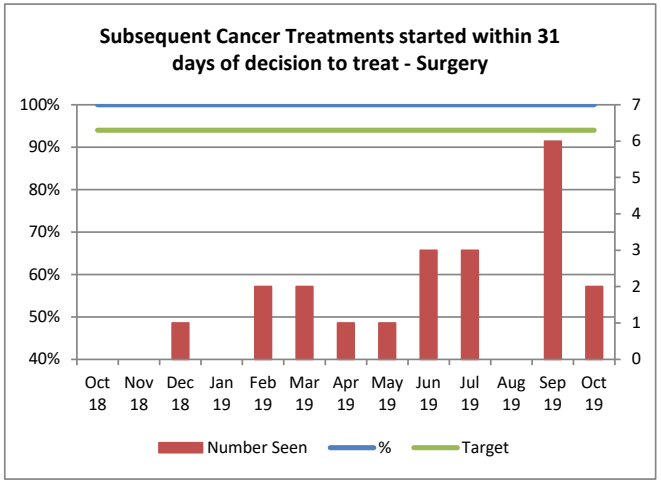
Primary Measures

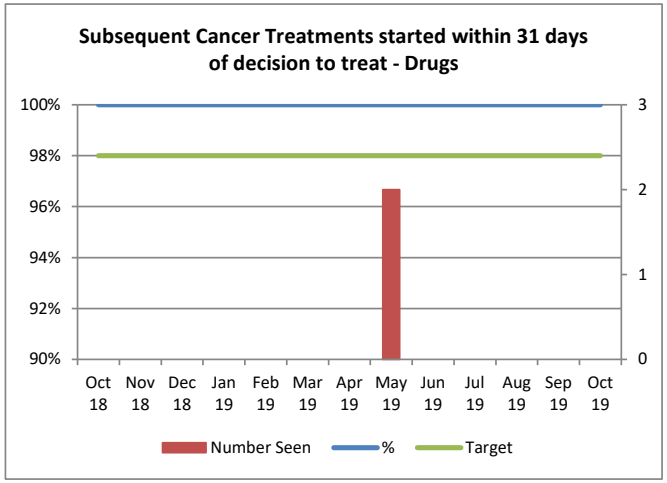


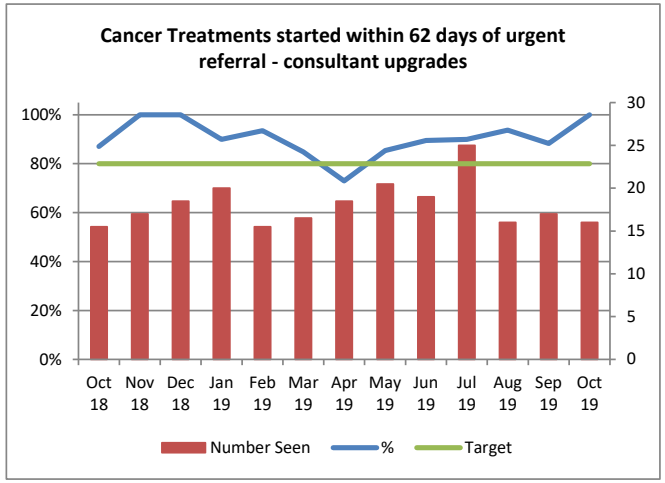




Operational Delivery: *Cancer Pathway*







Operational Delivery: *Unplanned Activity - A&E*

Headline Measures

	Current YTD		Rolling 13 months												
	Target	Actual	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Monthly Trend
A&E - >4 hr wait time from arrival to admission/ transfer/ discharge (% to Target)	95%	78.37%	85.51%	88.13%	83.57%	78.89%	81.12%	80.41%	79.90%	78.26%	80.60%	78.98%	78.02%	77.36%	75.50%	
No. of 4hr breaches		*12,705*	*1,167*	*884*	*1,209*	*1,621*	*1,349*	*1,574*	*1,642*	*1,822*	*1,559*	*1,879*	*1,892*	*1,913*	*1,998*	

	Plan	Actual	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Monthly Trend
A&E Attendances (LH/MIU/UUC) (% to Plan)		*99.79%*	100.0%	98.4%	95.8%	99.3%	97.0%	95.4%	100.4%	95.2%	96.3%	103.3%	105.6%	102.9%	95.5%	
A&E Attendances (LH/MIU/UUC) (No.)	*55,756*	*58,735*	8,056	7,445	7,358	7,679	7,147	8,034	8,169	8,382	8,036	8,937	8,607	8,450	8,154	

A&E Attendance Case Mix (based on acuity score)	*Major*		*16,304*	*2,455*	*2,269*	*2,235*	*2,392*	*2,170*	*2,341*	*2,351*	*2,540*	*2,235*	*2,407*	*2,263*	2,347	2,161	
	Minor		*22,477*	*2,768*	*2,560*	*2,605*	*2,782*	*2,489*	*2,855*	*3,166*	*3,040*	*3,045*	*3,559*	*3,593*	3,212	2,862	
	Paediatrics		*11,522*	*1,709*	*1,562*	*1,422*	*1,372*	*1,556*	*1,702*	*1,587*	*1,680*	*1,686*	*1,739*	*1,363*	1,721	1,746	
	Resus		*8,421*	*1,120*	*1,048*	*1,095*	*1,128*	*928*	*1,126*	*1,063*	*1,121*	*1,070*	*1,231*	*1,385*	1,168	1,383	

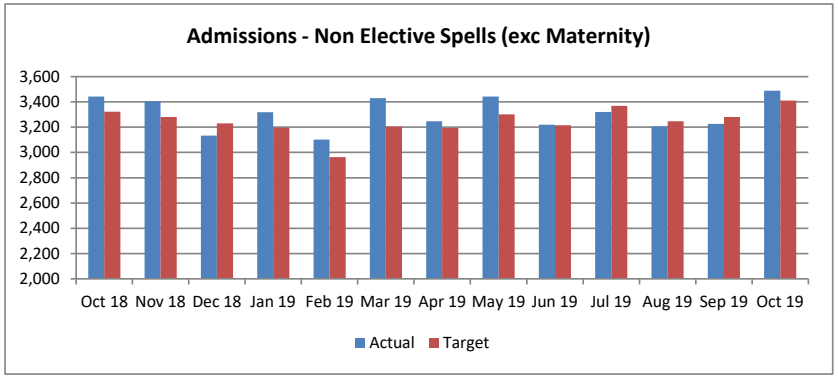
A&E Attendance Location (based on Discharge)	*Major*		*22,519*	*3,413*	*3,187*	*3,176*	*3,354*	*2,983*	*3,317*	*3,245*	*3,405*	*3,142*	*3,320*	*3,277*	*3,134*	*2,996*	
	Minor		*23,326*	*2,791*	*2,560*	*2,573*	*2,738*	*2,454*	*2,801*	*3,123*	*3,111*	*3,039*	*3,677*	*3,788*	*3,394*	*3,194*	
	Paediatrics		*11,522*	*1,709*	*1,562*	*1,422*	*1,372*	*1,556*	*1,702*	*1,587*	*1,680*	*1,686*	*1,739*	*1,363*	*1,721*	*1,746*	
	Resus		*1,357*	*139*	*130*	*186*	*210*	*150*	*204*	*212*	*185*	*169*	*200*	*176*	*199*	*216*	

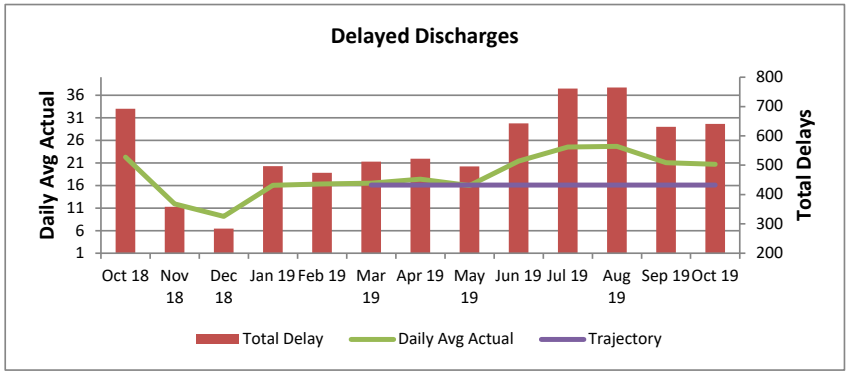
Commentary

The Trust has achieved 75.50% against the 4-hour access standard in October 2019, with similar attendances as the same period last year, the acuity mix is also similar to the acuity mix for the same period last year.
A&E attendance to Non Elective admission conversion has dropped at 36% for October, compared to 40% in the same period last year.
Medical outliers have reduced to the lowest level since May 19, currently at 15.

Patients medically optimised for discharge in October has remained stable for the second month at 21, against a threshold of 16. The increase in all medically optimised patients, not just DTOC is putting significant pressure on the bed stock with LOS increasing pushing occupancy above 100%.
The reason for delays can be split for each local authority. CEC delays focus on care home placements, not helped by the absence of a Trusted assessor for the local authority. CWAC delays focus on care provision at home, with CCICP now supporting the discharge of some long stay patients.

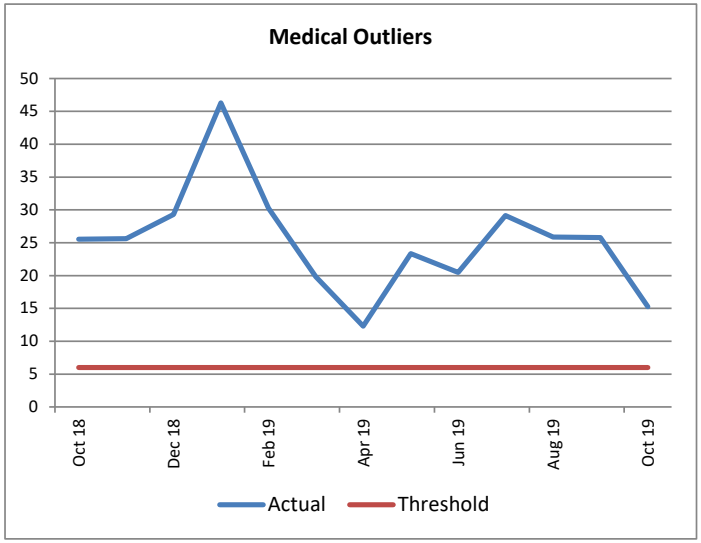
Primary Drivers

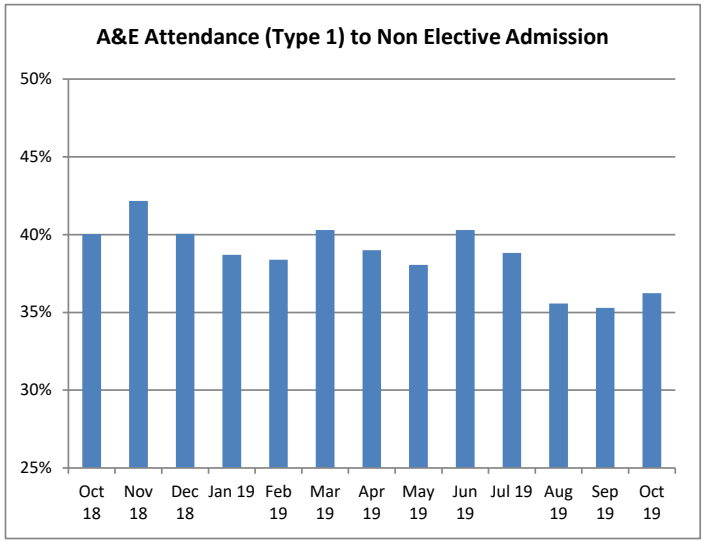


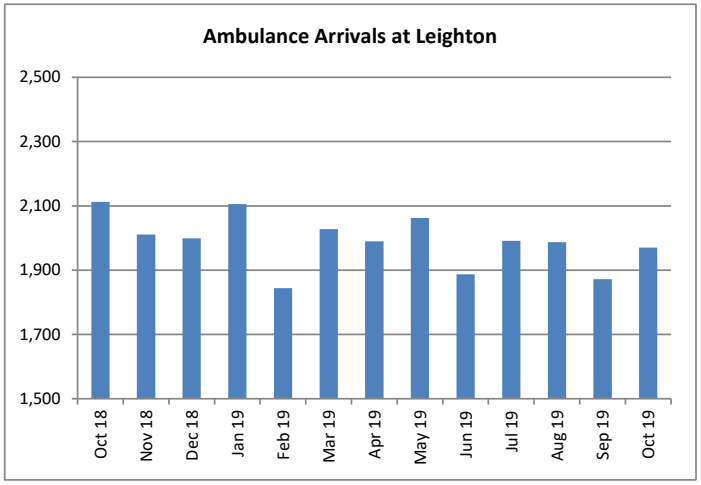


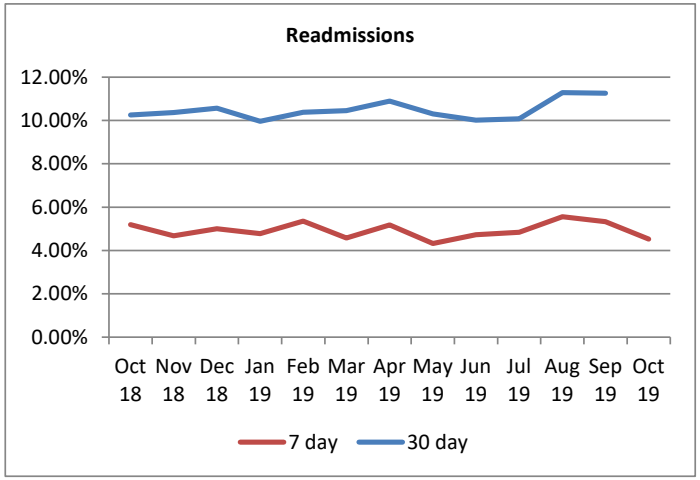
Operational Delivery: *Unplanned Activity A&E*

Secondary Drivers



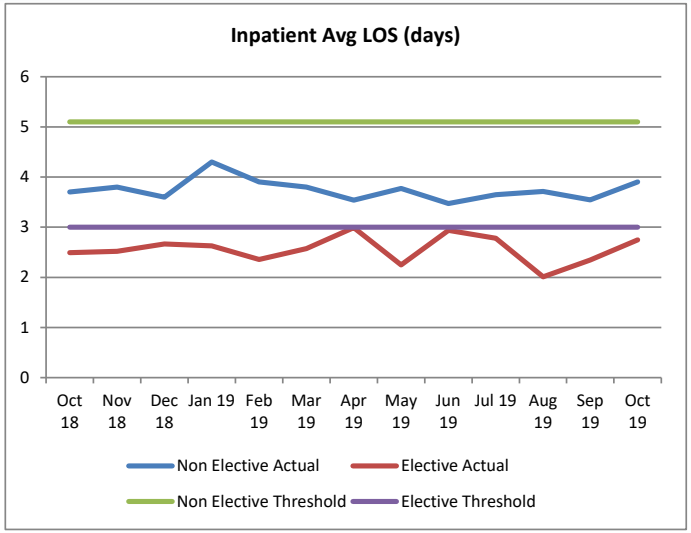


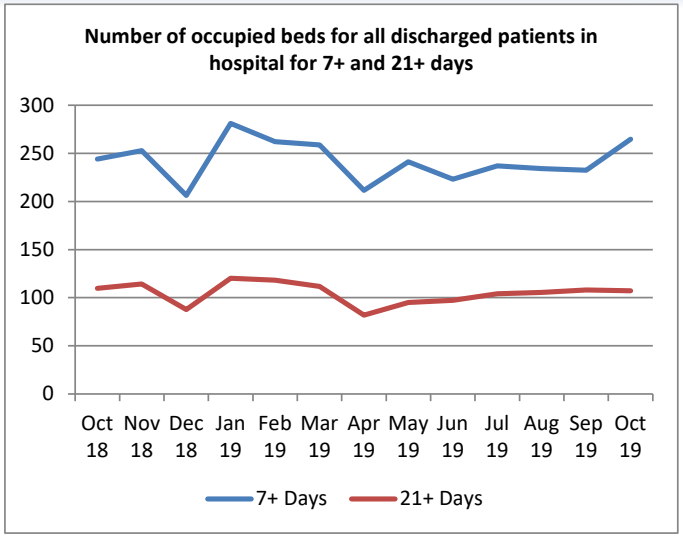


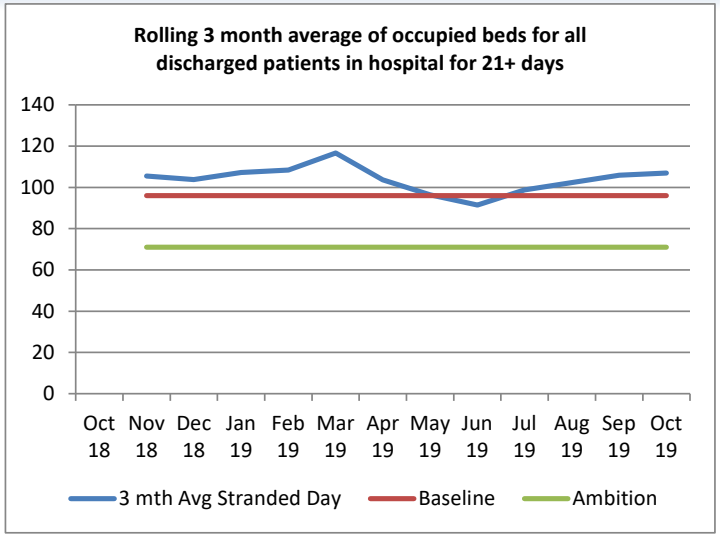


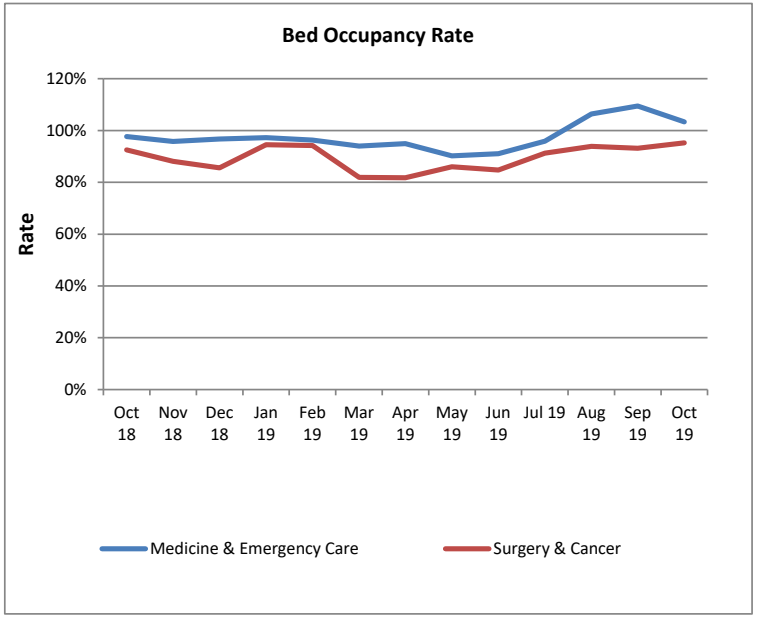
** Readmissions brought in line with national definition*

Operational Delivery: *Length of Stay*

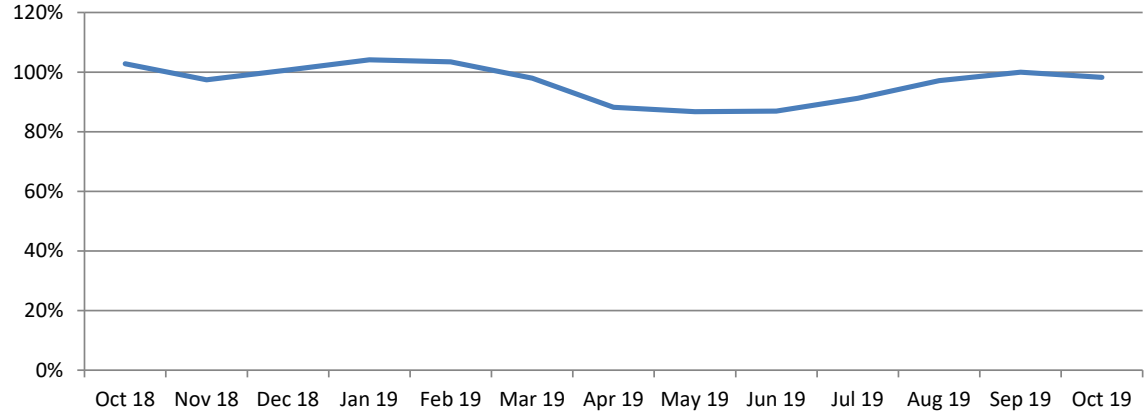








Acute Adult Bed Occupancy



	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19
Trust Total	102.78%	97.40%	100.73%	104.12%	103.44%	98.00%	88.16%	86.72%	86.95%	91.19%	97.11%	99.95%	98.26%
Additional Beds	21.94	23.57	20.98	37.55	23.36	21.00	1.13	2.32	1.50	2.52	6.71	10.40	11.61

Operational Delivery: *Planned Activity*

Headline Measures

	Current YTD		Rolling 13 months											
	Target	Actual	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Monthly Trend
18 weeks from Referral to Treatment in Aggregate - Incomplete	92%	91.95%	92.82%	92.28%	92.01%	91.30%	91.63%	90.67%	91.05%	91.67%	92.07%	92.09%	92.00%	92.46%	92.32%	
Total 18 Weeks		*106,997*	14,284	14,331	14,232	14,427	14,505	14,197	14,944	15,219	15,560	15,426	15,432	15,190	15,226	
No. > 18 Weeks		*8,604*	*1,025*	*1,106*	*1,137*	*1,255*	*1,214*	*1,324*	*1,338*	*1,267*	*1,234*	*1,216*	*1,234*	*1,146*	*1,169*	
Open Pathways >39 Weeks Waiting											*15*	*14*	*12*	*18*	*21*	
Diagnostic Waiting Time	1%	4.28%	0.48%	0.17%	0.54%	0.47%	0.42%	0.76%	0.64%	9.34%	7.76%	4.04%	3.05%	0.95%	0.84%	
Total Number of Waiters		*29,066*	*4,168*	*4,017*	*3,870*	*4,029*	*4,785*	*4,749*	*1,091*	*4,809*	*5,065*	*4,750*	*3,903*	*4,434*	*5,014*	
Waiters of 6 Weeks +		*1,244*	*20*	*7*	*21*	*19*	*20*	*36*	*7*	*449*	*393*	*192*	*119*	*42*	*42*	
Total Patients Waiting for a First Outpatient Appointment			9,496	9,430	8,948	9,428	9,823	9,682	9,800	9,981	9,603	9,659	9,523	9,452	9,033	
Longest Wait Time (weeks)											*46*	*48*	*46*	*49*	*55*	

Commentary

The Trust's RTT Incomplete Pathway position is 92.32% for October.. Six specialties have failed to meet the 92% target, these are General Surgery, Urology, Gastroenterology, Cardiology, Gynaecology and Trauma and Orthopaedics. Detailed improvement plans and trajectories are in place and continue to be reviewed weekly by the Chief Operating Officer and Director of Operations.

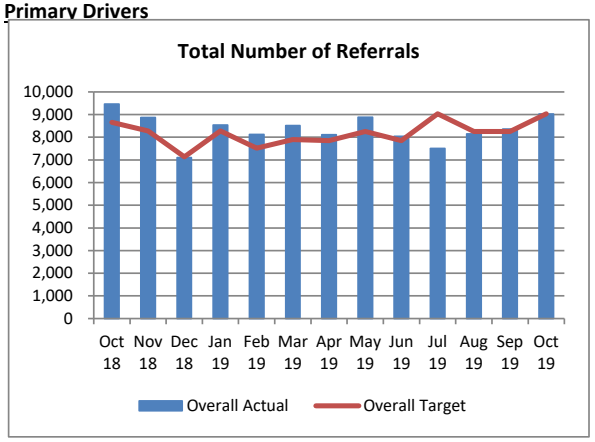
In October there were two 52 week breaches, these were within ENT and Dermatology specialties. There are 21 patients waiting over 39 weeks; (3 in General Surgery, 1 in Ophthalmology, 1 in General Medicine, 8 in Urology, 1 in Gynae, 2 in ENT, 2 in Cardiology, 3 in Dermatology). All long wait patients are monitored and reviewed weekly at director led performance meetings.

In October 2019, 0.84% of patients waited longer than 6 weeks for their diagnostic tests.

The number of patients waiting for their first outpatient appointment has dropped by 4% in October compared to the previous month from c.9,500 to c.9,000.

Overall Referral volumes continue to increase as expected against plan, however GP Referral volumes are slightly higher than expect for October at 102% of plan. GP referrals are 11% lower than the same period last year.

Primary Drivers

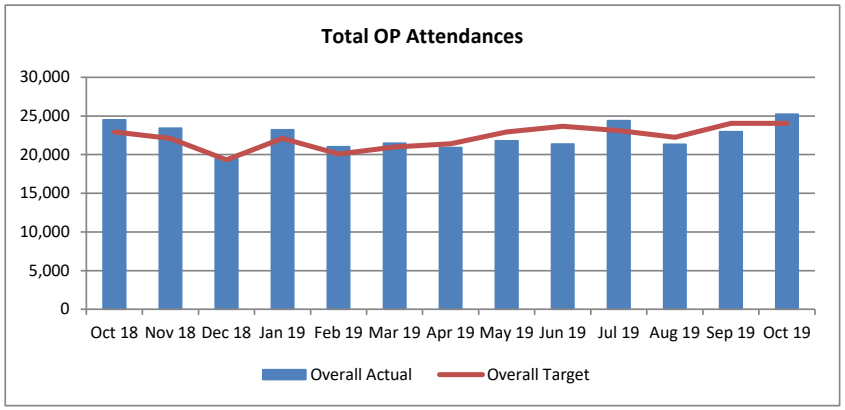


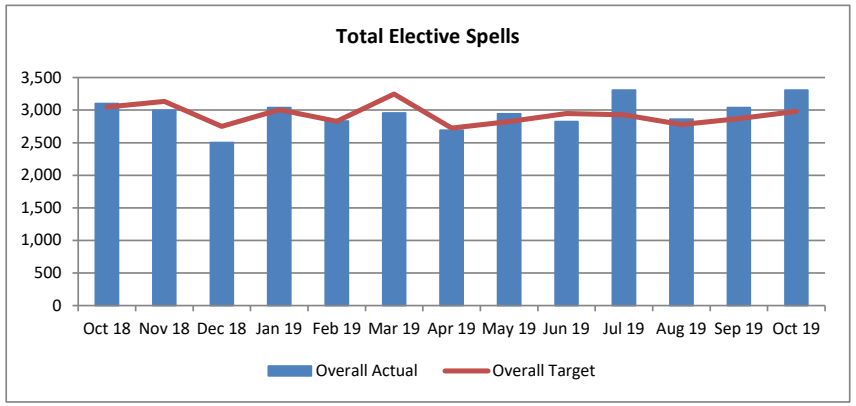
Referral Breakdown

	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Monthly Trend
GP Actual	5,755	5,684	4,412	5,424	4,915	5,270	4,587	5,231	4,583	4,103	4,497	4,800	5,141	
GP Target	5,394	5,157	4,446	5,157	4,683	4,920	4,374	4,593	4,374	5,030	4,593	4,593	5,030	
% to Target	106.7%	110.2%	99.2%	105.2%	105.0%	107.1%	104.9%	113.9%	104.8%	81.6%	97.9%	104.5%	102.2%	
Other Actual	3,714	3,189	2,696	3,118	3,204	3,250	3,524	3,655	3,453	3,410	3,654	3,561	3,882	
Other Target	3,263	3,120	2,689	3,120	2,833	2,976	3,483	3,657	3,483	4,006	3,657	3,657	4,006	
% to Target	113.8%	102.2%	100.3%	100.0%	113.1%	109.2%	101.2%	99.9%	99.1%	85.1%	99.9%	97.4%	96.9%	
Total Actual	9,469	8,873	7,108	8,542	8,119	8,520	8,111	8,886	8,036	7,513	8,151	8,361	9,023	
Total Target	8,657	8,276	7,135	8,276	7,515	7,896	7,857	8,250	7,857	9,036	8,250	8,250	9,036	
% to Target	109.4%	107.2%	99.6%	103.2%	108.0%	107.9%	103.2%	107.7%	102.3%	83.1%	98.8%	101.3%	99.9%	
GP % of Total	60.8%	64.1%	62.1%	63.5%	60.5%	61.9%	56.6%	58.9%	57.0%	54.6%	55.2%	57.4%	57.0%	

Operational Delivery: *Planned Activity*

Primary Drivers





OP Attendance Breakdown

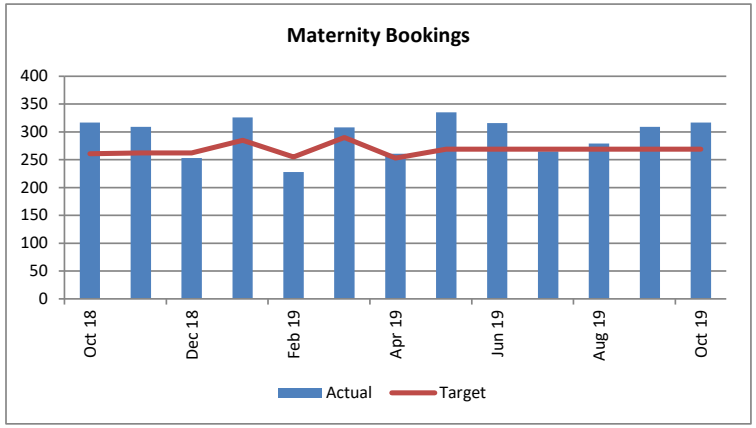
	YTD 18 19	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Monthly Trend
New Actual	81,335	7,713	7,203	5,946	6,861	6,397	6,877	6,584	6,956	6,725	7,866	6,712	7,284	7,800	
New Target	74,744	6,778	6,496	5,625	6,496	5,901	6,189	6,416	6,848	7,173	6,817	6,588	7,267	7,214	
% to Target	108.8%	113.8%	110.9%	105.7%	105.6%	108.4%	111.1%	102.6%	101.6%	93.8%	115.4%	101.9%	100.2%	108.1%	
F U Actual	182,101	16,778	16,207	13,493	16,352	14,629	14,583	14,343	14,830	14,642	16,519	14,633	15,676	17,415	
F U Target	181,624	16,157	15,600	13,701	15,604	14,194	14,803	14,988	16,096	16,491	16,286	15,659	16,779	16,823	
% to Target	100.3%	103.8%	103.9%	98.5%	104.8%	103.1%	98.5%	95.7%	92.1%	88.8%	101.4%	93.4%	93.4%	103.5%	
Total Actual	263,436	24,491	23,410	19,439	23,213	21,026	21,460	20,927	21,786	21,367	24,385	21,345	22,960	25,215	
Total Target	256,368	22,935	22,095	19,326	22,100	20,095	20,992	21,403	22,944	23,663	23,102	22,247	24,046	24,037	
% to Target	102.8%	106.8%	105.9%	100.6%	105.0%	104.6%	102.2%	97.8%	95.0%	90.3%	105.6%	95.9%	95.5%	104.9%	
New % of Total	30.9%	31.5%	30.8%	30.6%	29.6%	30.4%	32.0%	31.5%	31.9%	31.5%	32.3%	31.4%	31.7%	30.9%	

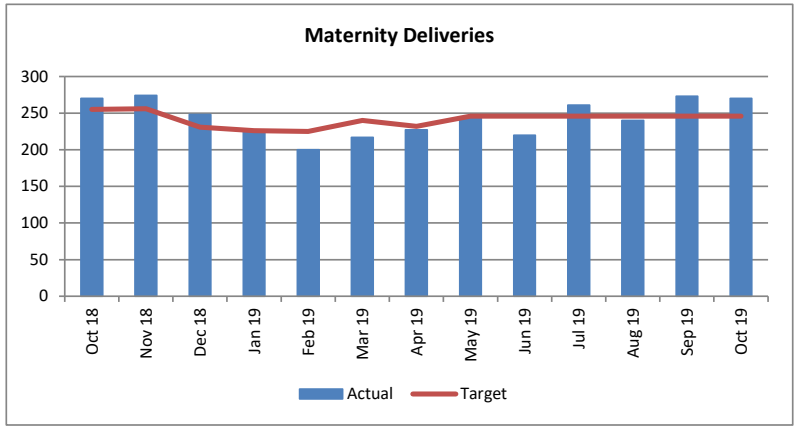
Elective Spells Breakdown

	YTD 18 19	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Monthly Trend
I P Actual	3,055	284	280	241	157	288	272	225	228	266	267	291	256	332	
I P Target	3,341	308	308	241	181	264	304	263	277	280	277	249	270	310	
% to Target	91.4%	92.3%	91.0%	100.1%	86.9%	109.0%	89.4%	85.6%	82.3%	94.9%	96.4%	116.7%	94.8%	107.1%	
Daycase Actual	31,155	2,817	2,717	2,262	2,882	2,543	2,685	2,467	2,714	2,560	3,041	2,571	2,781	2,974	
Daycase Target	32,775	2,740	2,827	2,507	2,826	2,565	2,942	2,462	2,548	2,666	2,650	2,530	2,601	2,672	
% to Target	95.1%	102.8%	96.1%	90.2%	102.0%	99.1%	91.3%	100.2%	106.5%	96.0%	114.7%	101.6%	106.9%	111.3%	
Total Actual	34,210	3,101	2,997	2,503	3,039	2,831	2,957	2,692	2,942	2,826	3,308	2,862	3,037	3,306	
Total Target	36,116	3,048	3,135	2,748	3,007	2,829	3,247	2,724	2,825	2,946	2,927	2,779	2,871	2,982	
% to Target	94.7%	101.8%	95.6%	91.1%	101.1%	100.1%	91.1%	98.8%	104.1%	95.9%	113.0%	103.0%	105.8%	110.9%	
I P % of Total	8.9%	9.2%	9.3%	9.6%	5.2%	10.2%	9.2%	8.4%	7.7%	9.4%	8.1%	10.2%	8.4%	10.0%	

Operational Delivery: *Planned Activity*

Primary Drivers





Operational Delivery: *Planned Activity*

Secondary Drivers

			Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Monthly Trend
Bed Occupancy Rate	Medicine & Emergency Care		97.7%	95.8%	96.7%	97.3%	96.3%	94.0%	95.0%	90.2%	91.1%	95.9%	106.4%	109.5%	103.3%	
	Surgery & Cancer		92.5%	88.1%	85.5%	94.5%	94.2%	81.9%	81.8%	86.0%	84.8%	91.3%	93.9%	93.2%	95.2%	
Elective Inpatient Avg LOS (Days)			2.5	2.5	2.7	2.6	2.4	2.6	3.0	2.2	2.9	2.8	2.0	2.3	2.7	
Delayed Transfers of Care (MFFD)		16.00	22	12	9	16	17	17	17	16	21	25	25	20	21	
Delayed Transfers of Care (% of Acute Beds)			4.5%	2.4%	1.8%	3.1%	3.3%	3.3%	3.5%	3.2%	4.3%	5.2%	5.1%	4.4%	4.2%	
Medical Outliers			26	26	29	46	31	20	12	23	20	29	26	25	15	
Readmission (Emergency Re-admissions after Planned Surgery)																
	30 Day Rate		3.28%	2.96%	2.87%	2.66%	3.86%	3.29%	3.38%	3.38%	3.10%	2.83%	3.30%	4.23%		
	7 Day Rate		1.16%	1.15%	1.09%	1.06%	1.45%	1.05%	1.41%	1.37%	1.00%	1.07%	1.36%	1.63%	1.14%	
Cancelled Operations - Non Clinical - Cancellation Rate			1.86%	0.63%	1.40%	0.58%	0.60%	0.65%	0.67%	1.17%	0.85%	1.30%	1.29%	0.33%	1.05%	
Theatre Efficiency																
	Main Theatres		77.9%	77.2%	73.9%	74.5%	76.2%	78.5%	76.7%	75.0%	77.4%	78.7%	78.3%	76.7%	77.1%	
	TC Theatres		76.6%	73.5%	72.0%	69.4%	73.0%	73.5%	72.4%	68.2%	74.8%	70.7%	71.9%	72.4%	73.3%	
DNA (OP Efficiency)			5.72%	5.62%	5.95%	5.75%	5.42%	5.41%	6.00%	6.02%	6.56%	5.88%	5.60%	5.74%	5.59%	
Hospital Cancellation Rate (OP Efficiency)			7.65%	7.63%	8.27%	7.65%	7.83%	8.12%	7.90%	7.51%	7.36%	8.10%	7.69%	7.89%	7.60%	

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

Performance and Finance - Headlines October 2019

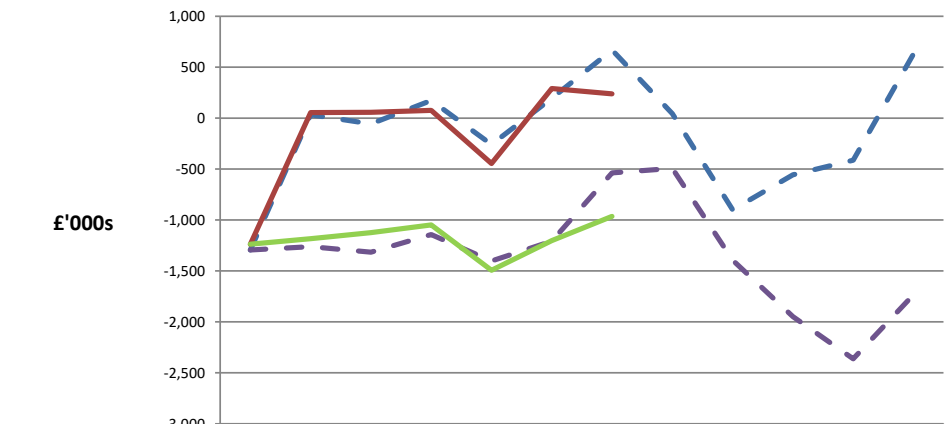
Current Position	Analysis	Forward View

The reported position is cumulatively £427k worse than the control total, which is a deterioration in month of £431k.

CCICP is underspent by £0.3m, and MCHFT overspent by £0.7m cumulatively to date.

In month 7 (October) there has been a worsening of £0.5m within MCHFT

The overall use of resources rating for the Trust is currently 3 in line with expectations.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
In Month Plan	-1,294	34	-56	173	-258	195	669	44	-900	-556	-413	628
In Month Actual	-1,238	56	58	76	-445	291	238					
In Month Variance	56	22	114	-97	-187	96	-431					
Cumulative Plan	-1,294	-1,260	-1,316	-1,143	-1,401	-1,206	-537	-493	-1,393	-1,949	-2,362	-1,734
Cumulative Actual	-1,238	-1,182	-1,124	-1,048	-1,493	-1,202	-964					
Cumulative Variance	56	78	192	95	-92	4	-427					

	YTD Rating		YE Rating	
Indicator	**Plan**	**Actual**	**Forecast**	**Status**
Finance				
Use of Resource Rating	3	3	3	
Capital Service Capacity	3	3	3	The planned deficit does not meet the financial commitments
Liquidity	3	3	4	The Trust has enough cash to meet it's obligations
I&E Margin	3	3	3	The Trust is in a deficit position
Distance from Financial Plan	1	2	1	The Trust is currently off plan, but within the threshold of a level 2
Agency Spend	1	2	2	The current level of spend on agency is greater than the cap.

A variation against the control total the Trust will put at risk the PSF support of £1.3m for Q3 and £1.5m of Q4. The MRET funding of £3.215m by contrast is guaranteed to the Trust.

The most significant risk to delivering the control total is managing unscheduled care pressures, although there are also challenges to meeting CIP targets and the ongoing issues with a contraction of the associate contract activity.

Emerging concerns around increasing dependency on premium costs to deliver core activity, which will be the main challenge with delivering additional unplanned care over the Winter period.

The Cheshire Health economy is currently developing a financial recovery plan to mitigate the risks in the systems. This may have implications for MCHFT either directly or indirectly through commissioner actions.

The Trust is expected to maintain the use of resources rating at a 3.

Performance and Finance - Contract Income October 2019

Current Position

Contract income is £0.56m above plan year to date with an improvement of £0.3m in month.

Associate contracts continue to underperform against plan pre-dominantly with Stoke/North Staffs and West Cheshire CCGs (£1.1m to date).

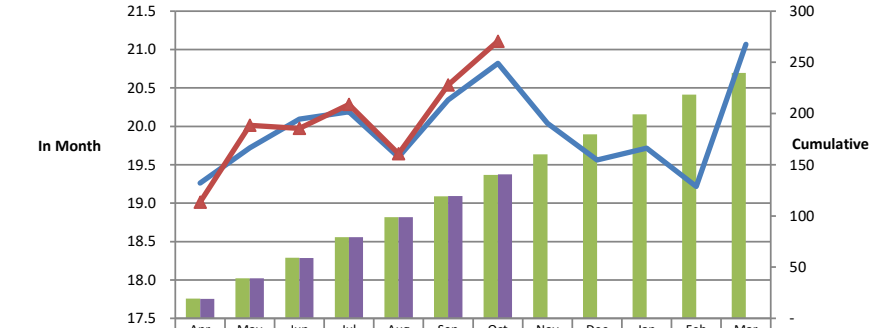
South Cheshire CCG is over-performing on contract compared to the contract value by £0.6m, and Vale Royal CCG over performing by £28k, however no total variance is shown due to the block arrangements.

Within the host contract there is over-performance within diagnostics, A&E and Maternity - with South CCG being significantly under pressure.

Within the 'other' column over-performance on high cost drugs within Specialised Commissioning (£0.8m) offsets against drugs spend within non-pay. There is also an element of anticipated income for Winter and additional costs for midwifery from the CCG.

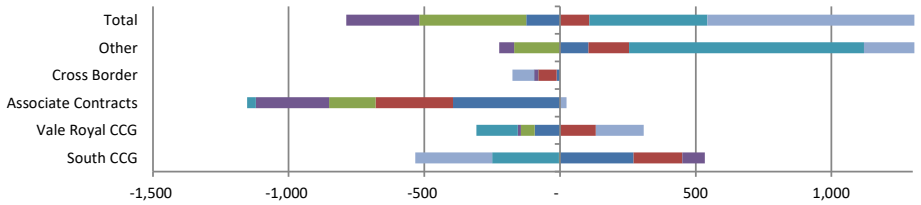
Analysis

Contract Income Performance 2019/20 £'m



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative budget	19.3	39.0	59.1	79.3	98.9	119.2	140.0	160.1	179.6	199.3	218.6	239.6
Cumulative actual	19.0	39.0	59.0	79.3	98.9	119.5	140.6					
In month budget	19.3	19.7	20.1	20.2	19.6	20.3	20.8	20.0	19.6	19.7	19.2	21.1
In month actual	19.0	20.0	20.0	20.3	19.6	20.5	21.1					

Cumulative Variance to Contract Income plan £'000s



	South CCG	Vale Royal CCG	Associate Contracts	Cross Border	Other	Total
Unplanned Care	271	-93	-394	-13	105	-124
Day case	180	132	-286	-67	150	109
Elective	-4	-51	-171	-1	-169	-395
Outpatients	83	-12	-270	-15	-55	-269
High cost drugs	-246	-152	-33	-0	865	434
Other	-283	177	24	-81	963	800
Total	0	0	-1,130	-176	1,860	554

Forward View

There is a risk that if the current level of underperformance on associate contracts continues, then this could impact the Trust by between £2m-2.5m.

The Trust has seen an increase in referrals for the first half of the year particularly around the surgical specialties, which the Trust is discussing with the CCG.

Whilst the block contract arrangement is currently over-performing the current assessment around CQUIN would negate this position.

Increase in the growth around diagnostics and cost of delivering the activity needs to be carefully managed.

The over performance on high cost drugs will remain at the current levels until the aseptic unit is re-opened, this is however funded by Specialised commissioners.

The additional activity and costs associated with the independent provider ceasing trading has now been agreed with the CCG, and is awaiting variation into the contract.

Performance and Finance - Pay Expenditure October 2019

Current Position

Cumulatively Pay is worse than plan by £243k, with CCICP being £75k better in month (£394k ytd), and MCHFT £166k worse in month (£637k ytd).

In month the 19/20 Medical Pay deal for Trainee Grades came into effect, which has resulted in £58k of back pay.

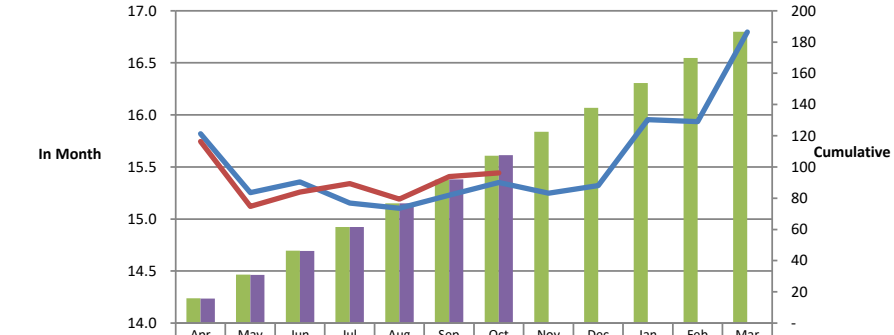
Nursing pay continues to be under pressure with the reliance on agency to support rotas, and there has been a concerning growing dependence on high cost agencies in the last couple of months as a result of having additional beds open.

The cost of opening unfunded escalation beds in month is DMEC £58k ytd and S&C (£56k in month, £241k ytd), which have been opened in addition to ward 19 re-opening in October.

There is also an underlying underperformance on pay CIPs, and the CCICP vacancy factor is reflected on the infrastucture support line.

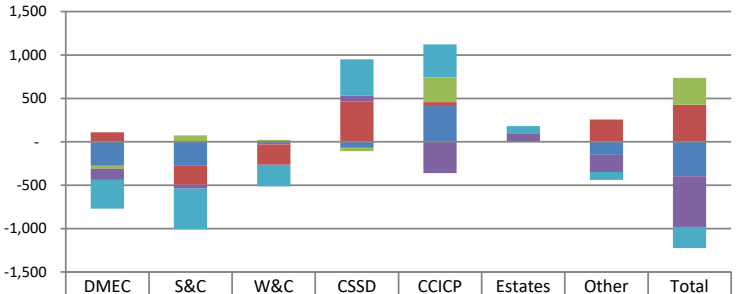
Analysis

Pay Expenditure 2019/20 £'m



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative budget	15.8	31.1	46.4	61.6	76.7	91.9	107.3	122.5	137.8	153.8	169.7	186.5
Cumulative actual	15.7	30.9	46.1	61.5	76.7	92.1	107.5					
In month budget	15.8	15.3	15.4	15.2	15.1	15.2	15.4	15.2	15.3	16.0	15.9	16.8
in month actual	15.7	15.1	15.3	15.3	15.2	15.4	15.4					

Pay Variances by Staff Group and Division £'000s



	DMEC	S&C	W&C	CSSD	CCICP	Estates	Other	Total
Total	-330	-467	-246	420	381	91	-92	-243
Infrastructure Support Staff	-131	-46	-3	64	-360	91	-199	-584
Non Clinical Staff	-30	73	22	-40	284	-	1	310
Medical Staff	109	-216	-234	466	47	-	256	427
Nursing Staff	-278	-277	-31	-70	411	-	-150	-396

Forward View

There are expected to be some pay pressures in the coming months in relation to the following areas:-

a) Unfunded escalation areas – In order to meet the current demands within unplanned care, in November the Trust opened ward 18 which will incur significant additional costs that are not within the plan.

b) Continued dependency on premium costs to deliver core activity. Further analysis at a detailed level is being undertaken to fully understand the premium costs associated with delivering core activity, and whether there are alternative options available, which also support the sustainability of the services.

c) Continued premium costs associated with intensive/specialist support for patients.

Premium costs will be challenging to manage within nursing until substantive appointments to vacancies are made, however the nurses that were successfully appointed to as part of the International Recruitment have been deployed on the wards – although they will be supernummery until Q1 of 2020/21.

Performance and Finance - Non-Pay Expenditure October 2019

Current Position

Non Pay is above plan by £1.7m. For CCICP the overspend is £0.3m, MCHFT is £1.4m. The in month deterioration within MCHFT is £0.7m.

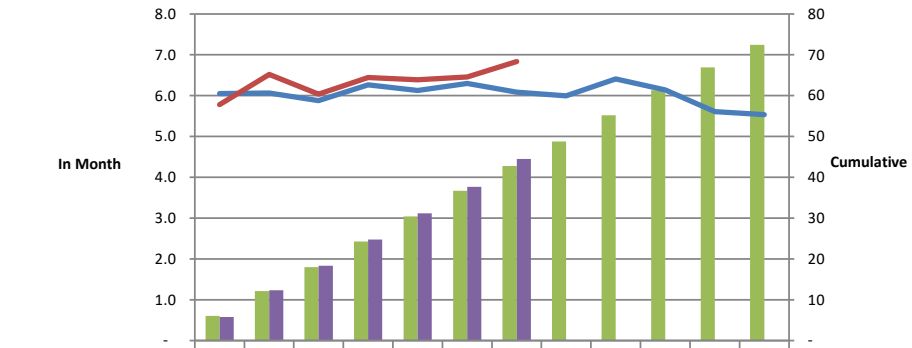
Where medical vacancies are procured as a service from external companies, they are included as other non-pay, and offset by medical pay underspends. This is a material pressure within CSSD, which up to month 6 was a pressure on the trust of £0.17m a month on average - which has increased in month by a further £40k.

Whilst drugs are overspent, the most significant amount is within oncology drugs which are offset against contracts. However in month there has been an increase in drug spend which impacts the trust costs of £0.25m and relates to increased pressure on unplanned care and increased planned care within the month.

Estates have incurred increases in cost within the month as a result of the backlog maintenance programme.

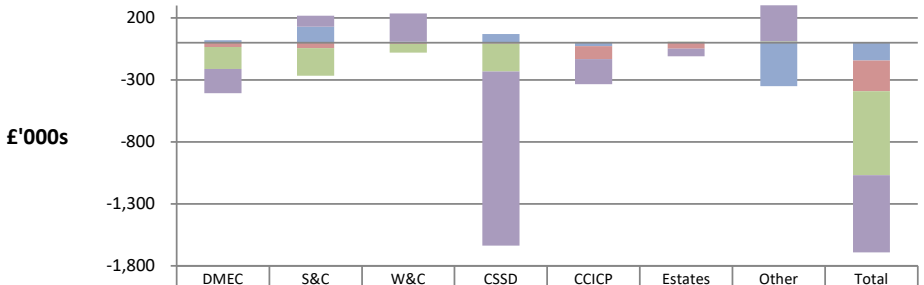
Analysis

Non Pay 2019/20 £'m



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative budget	6.1	12.1	18.0	24.3	30.4	36.7	42.8	48.8	55.2	61.3	66.9	72.5
Cumulative actual	5.8	12.3	18.3	24.8	31.2	37.6	44.5					
In month budget	6.1	6.1	5.9	6.3	6.1	6.3	6.1	6.0	6.4	6.1	5.6	5.5
In month actual	5.8	6.5	6.0	6.4	6.4	6.5	6.8					

Non Pay Variance by Division



	DMEC	S&C	W&C	CSSD	CCICP	Estates	Other	Total
Total	-386	-49	155	-1,566	-328	-103	584	-1,692
Other Non Pay	-196	89	227	-1,404	-201	-62	924	-624
Drugs	-177	-223	-71	-225	6	0	11	-678
Non Clinical Supplies	-34	-43	-10	-7	-106	-47	0	-247
Clinical Supplies	20	128	9	70	-27	6	-351	-143

Forward View

The growing reliance on external companies to provide services to cover activity at the Trust comes at a premium rate, which year to date the Trust has spent £0.7m more than in 18/19.

The Diagnostics division has outsourced circa £2.6m of work year to-date which has incurred a premium cost of circa £0.35m.

There is active engagement with the N8 pathology collaborative with UHNM/ECT which should provide a long term clinical and financially sustainable service for pathology.

Radiology has become increasing reliant on external companies with an increase on the first half of 18/19. The Divisions are reviewing the short, medium and long term plans as part of the annual plan process.

Within the medical specialties, the net impact of increasing medical vacancies being offset by external companies is not going to be financially sustainable going forward and other clinical options need to be considered.

Performance and Finance - Cost Improvement Programme October 2019

Current Position

The CIP programme is behind plan by £0.6m, although this is within the reported postion to-date.

This relates to the following schemes

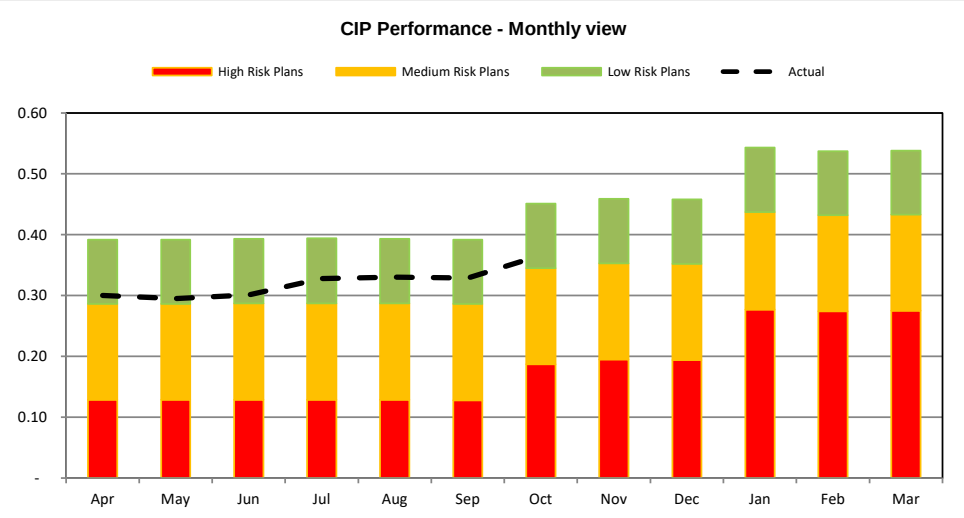
- Nurse savings on sickness/turnover etc (£208)
- Unallocated Capital to Revenue scheme (£92k)
- Unallocated CIP Plans (£145k) in DMEC

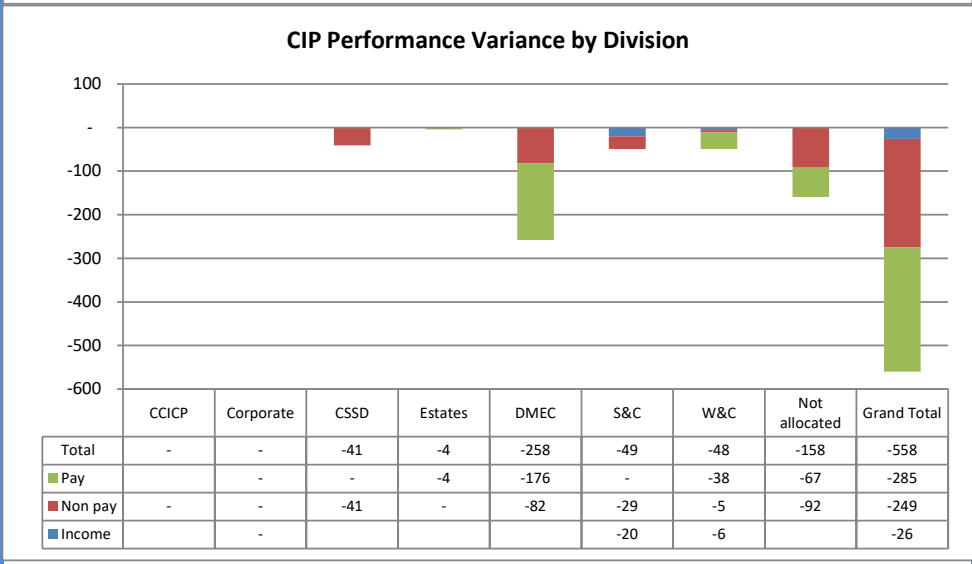
The Capital to Revenue scheme has not been allocated to Divisions.

Whilst Surgery and Cancer are currently behind, their 2 key schemes have had delays - which are expected to catch up in the third quarter, with contracts commencing in December.

The Division of Medicine and Emergency Care have challenges with identifying and delivering their CIP schemes around drugs, nursing savings and the additional CIP allocated to all divisions. This is causing them a pressure in overspend to-date and they have identified or delivered little of their £663k CIP target (with exception of NHS supply chain savings).

Analysis





	CCICP	Corporate	CSSD	Estates	DMEC	S&C	W&C	Not allocated	Grand Total
Total	-	-	-41	-4	-258	-49	-48	-158	-558
Pay		-	-	-4	-176	-	-38	-67	-285
Non pay	-	-	-41	-	-82	-29	-5	-92	-249
Income		-				-20	-6		-26

Forward View

There was a risk profile to the CIP plan which increased in Q3 due to non delivery of pay schemes.

There is a £0.3m risk associated with the capital to revenue transfer scheme although this is included in the current run rate.

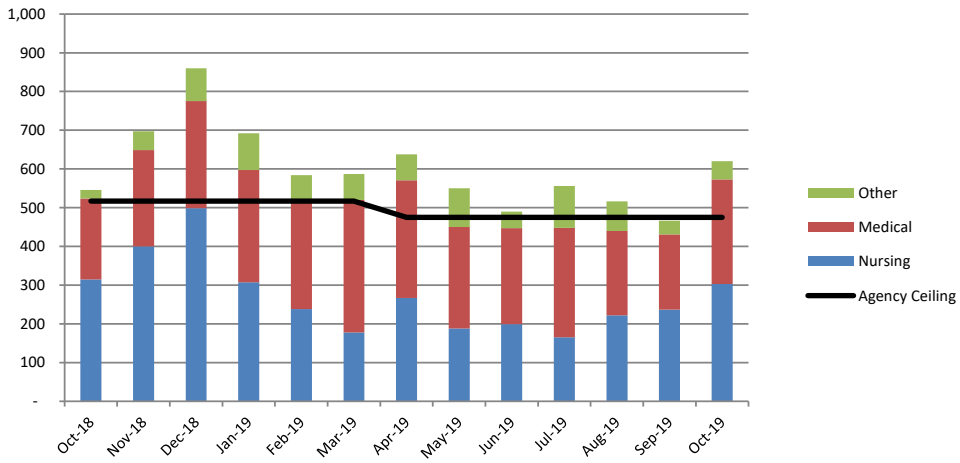
Performance and Finance - Agency Spend October 2019

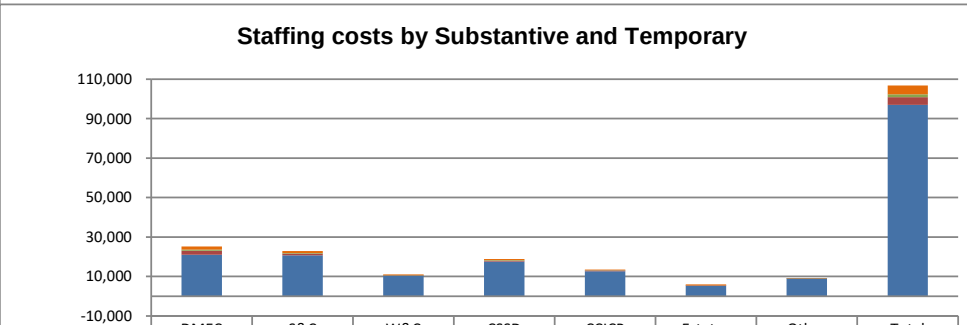
Current Position

When the element of cost that is associated with non pay is included, the Trust reliance on non-substantive arrangements comes to 10%, with DMEC 22% and CSSD 18%

Agency costs for nursing increased in the month, which including a step increase in the volume of high cost agency bookings in order to ensure safe staffing levels.

Analysis





	DMEC	S&C	W&C	CSSD	CCICP	Estates	Other	Total
Total	25,514	23,122	11,059	19,016	13,518	6,030	9,255	107,515
Waiting Lists	223	256	1	167	-	-	-	647
Bank	1,587	944	382	570	257	561	157	4,458
Locum	703	370	8	294	120	-	23	1,518
Agency	1,905	797	214	408	502	1	9	3,836
Substantive	21,096	20,757	10,454	17,577	12,639	5,468	9,066	97,056

Forward View

Agency Spend as a run rate is projected to exceed the contract ceiling of £5.7m, which is a lower level than the £6.2m 2018/19 level.

The Trust has developed some metrics to examine spend against budget in relation to registered and unregistered nursing, incorporating sickness/turnover and bank/agency shift data by reason code which are being used by the COO/DoN and DoF with the divisions.

Medical staff above cap and use of Thornbury agency use are reviewed by execs weekly. As a result of the increase in shifts booked with high cost agencies, the trust is reviewing the incentives for staff in order to encourage uptake on the hospital bank.

Performance and Finance - Divisional Performance October 2019

Current Position

The over-performance on contract income is offset within Other, which will an increasing performance against commissioning income is why some of the divisions have improved within the month.

DMEC, S&C and W&C are pre-dominantly challenged within pay pressures as a result of escalation beds and reliance on premium costs particularly within nursing pay.

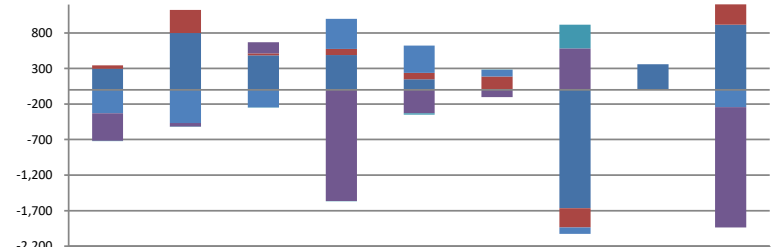
In contract CSSD has pressure from premium costs materialising within non-pay.

CCICP continues to be better than budget, although has some challenges around non pay.

Estates are better than plan as a result of an increase in the income received from car parking income and catering.

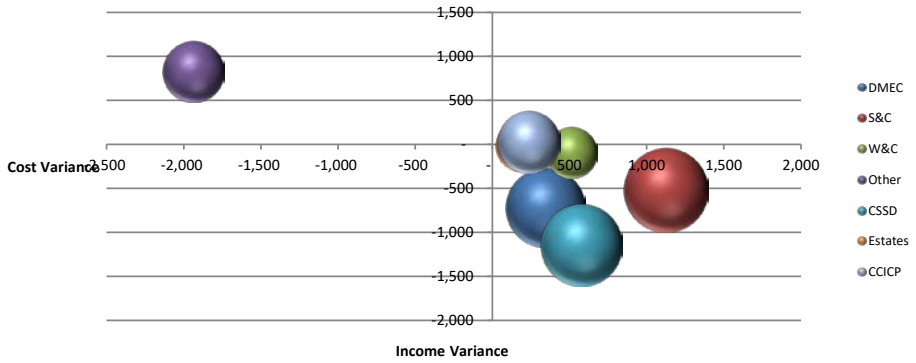
Analysis

Cumulative Variance by category



	DMEC	S&C	W&C	CSSD	CCICP	Estates	Other	PSF 1819	Total
Total	-373	609	423	-568	273	177	-1,112	362	-209
Other Costs	-0	-0	-0	-0	-20	0	332	-	312
Non Pay	-386	-49	155	-1,566	-328	-103	584	-	-1,692
Pay	-330	-467	-246	420	381	91	-92	-	-243
Other Income	44	326	29	89	92	189	-271	-	498
Commissioning Income	299	799	485	489	148	-	-1,665	362	917

Divisional Performance 2019/20



The bubble chart shows the financial performance of each division, in terms of income and cost variance – with the size of the bubble reflecting the overall budget
- Top right represents a positive performance that is better than plan for both costs and income
- The bottom left represents a performance that is worse than plan for both income and costs

Forward View

The Trust is currently planning to meet its control total, however there are some material financial risks that have arisen in October and are not within the plan which, unchecked, will severely challenge delivery of the financial plan :-

- Additional Escalation costs over and above the plans.

- Premium costs being required to deliver core services, materialising in non pay.

- Challenges for some Trust wide and individual Divisions CIP programmes, specifically around pay and supplies.

- Greater unscheduled care demand being experienced in the system than was originally planned for when setting the financial plan.

- Increasing GP referrals from host contracts (block contract), contrasting with a reduction from associate contracts (PbR contract).

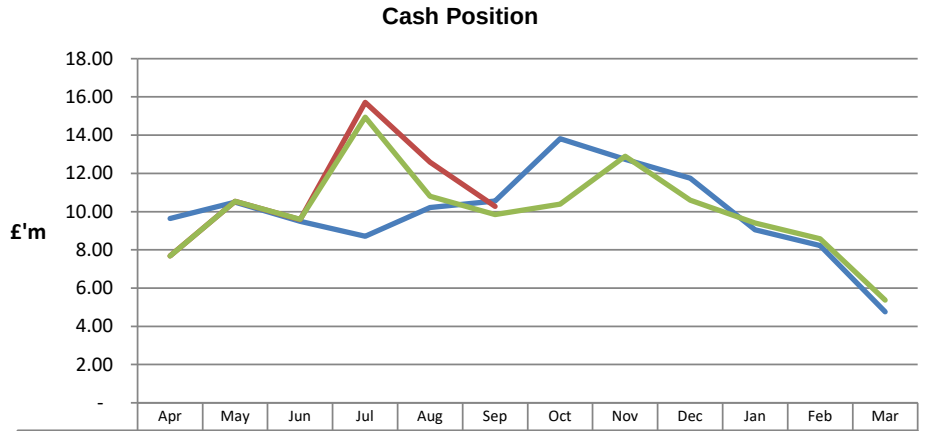
- Financial risk within the wider Cheshire system which requires a

Performance and Finance - Cash October 2019

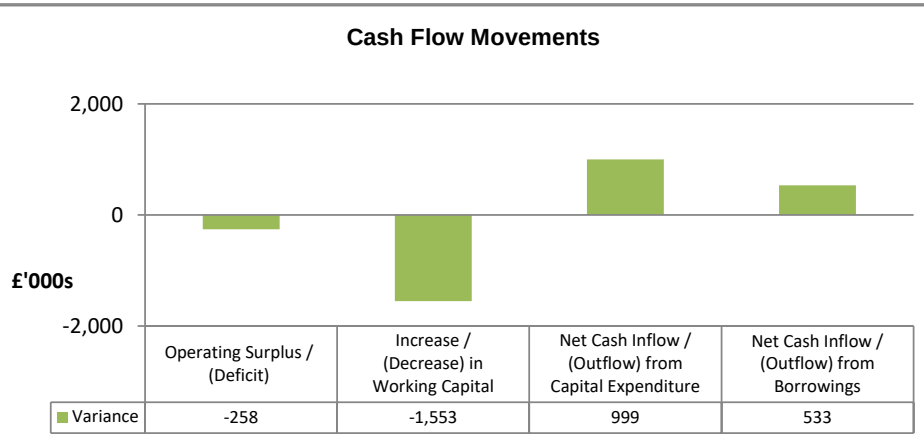
Current Position

Cash Position
Cash is worse than plan by £0.3m.
The main movements to plan are surplus cash due to lower finance lease payments due to delays in the CT Scanner, and a delay in the purchase of South Cheshire Private Hospital. This is offset by higher Trade Receivables due to higher than anticipated debts with Christies and Local Authorities.

Analysis



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Plan	9.64	10.49	9.50	8.72	10.21	10.55	13.81	12.73	11.75	9.05	8.22	4.76
Actual	7.68	10.54	9.58	15.72	12.58	10.27						
Forecast	7.68	10.54	9.60	14.94	10.80	9.85	10.39	12.90	10.60	9.41	8.58	5.37



	Operating Surplus / (Deficit)	Increase / (Decrease) in Working Capital	Net Cash Inflow / (Outflow) from Capital Expenditure	Net Cash Inflow / (Outflow) from Borrowings
Variance	-258	-1,553	999	533

Forward View

Cash is forecasted to be above target at the year end due to the £0.6m extra 2018/19 PSF.

Performance and Finance - Capital Expenditure October 2019

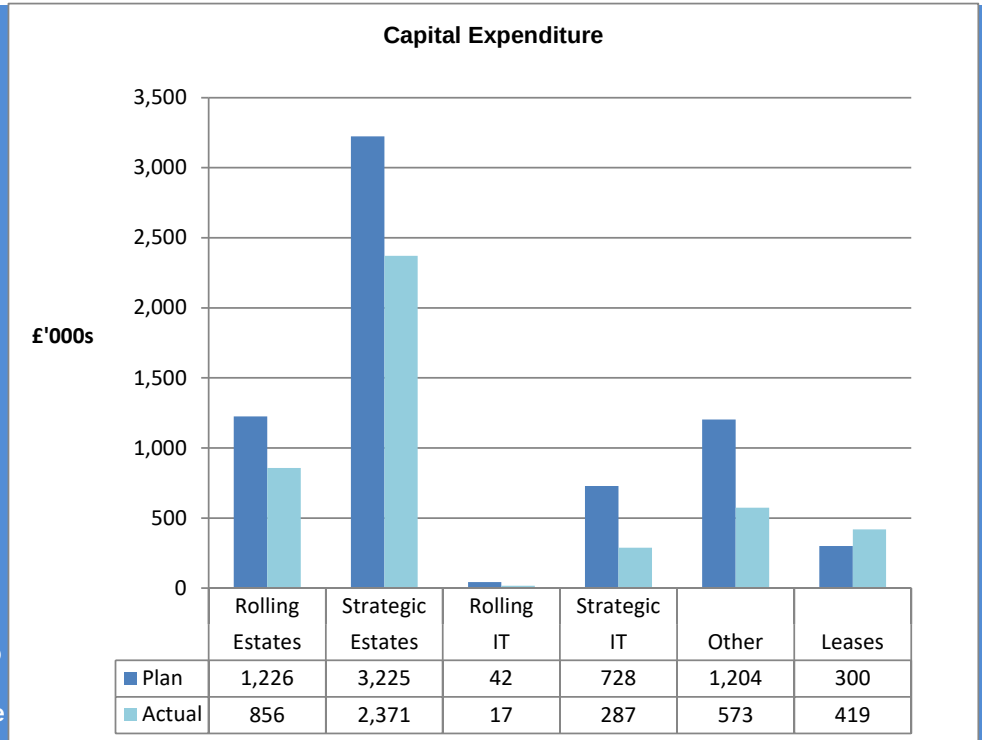
Current Position

The capital programme is £2.2m less than anticipated which is mainly due to:

(£1.1m) Purchase and updating of South Cheshire Private Hospital
(£0.5m) Third CT Enabling
(£0.2m) Backlog Maintenance
(£0.3m) UPS upgrade
(£0.4m) EPR Project
(£0.1m) Equipment Leases
£0.4m Third MRI Scanner build

The underspend is mainly due to a delay in the purchase of South Cheshire Private Hospital, which was originally expected to complete in July 2019. The main overspend is the Third MRI Scanner where the spend profile in the NHSI return has the scheme completing in December 2019. Whereas the Third MRI Scanner has completed in July 2019 and was delivered within budget.

Analysis



		Year to Date £'000s			Year End £'000s		
		Plan	Actual	Variance	Plan	Forecast	Variance
Estates	Rolling	1,226	856	-370	2,490	2,340	-150
Estates	Strategic	3,225	2,371	-854	6,551	5,910	-641
IT	Rolling	42	17	-25	90	90	0
IT	Strategic	728	287	-441	3,968	3,902	-66
Other		1,204	573	-631	1,742	3,844	2,102
Leases		300	419	119	347	600	253
		6,725	**4,523**	**-2,202**	**15,188**	**16,686**	**1,498**

Forward View

The Trust is forecasting an underspend of £0.6m to plan due to slippage in the schemes for EPR Project Accomodation of £0.3m and ICU Conversion of £0.2m.

The Trust had been asked by DOH to reduce it's capital programme by £3.0m. Although this request has now been retracted by the DOH, the forecast has still been reduced by £3m in anticipation of an underspend against capital.

ED Majors extension £1.8m is included within the spend forecast resulting in an overspend against the plan. This is funded by PDC.

Performance and Finance - Statement of Financial Position October 2019

Current Position | Analysis | Forward View

Assets Non-Current
The capital programme expenditure is £2.2m less than anticipated mainly due to a delay in the purchase of South Cheshire Private Hospital. In addition to this, there has been a delay in Finance Lease purchases.

Assets Current
Trade and Other Receivables is £2.5m higher than plan, mainly due to outstanding debts with Christies £1.6m (£1.3m agreed to be paid), £0.5m from East Cheshire Council and Chester and West Cheshire Council (£250k paid in October). In addition, prepayments for operating leases are higher than anticipated due to a switch from finance lease to operating leases.

Current Liabilities
Deferred Income is higher than anticipated as the two main CCG's contract payments are £1.8m ahead of plan. In addition, accruals are £0.5m higher than plan. This is offset by Trade Creditors being £2.5m lower than plan, mainly due to the lower/delayed capital creditors of £1.3m.

Non-Current Liabilities
This is due to the CT Scanner & MRI Scanner in the plan was assumed to be a finance lease and has now been assessed as an operating lease. Also there are some delays in finance leases.

	Plan Apr to Sept (£'000)	Actual Apr to Sept (£'000)	Variance (£'000)	Forecast 2019/20 (£'000)
Assets				
Assets, Non-Current	99,127	94,740	-4,387	104,231
Assets, Current	23,730	26,254	2,524	20,729
ASSETS, TOTAL	**122,857**	**120,994**	**-1,863**	**124,960**
Liabilities				
Liabilities, Current	-29,889	-29,949	-60	-24,208
Liabilities, Non Current	-15,210	-13,035	2,175	-21,195
TOTAL ASSETS EMPLOYED	**77,758**	**78,009**	**251**	**79,557**
Taxpayers' and Others' Equity				
Taxpayers Equity	77,758	78,009	251	79,557
TOTAL FUNDS EMPLOYED	**77,758**	**78,009**	**251**	**79,557**

The Statement of Financial position is forecast mainly on plan.

The Trust had been asked by DOH to reduce it's capital programme by £3.0m. Although this request has now been retracted by the DOH, the forecast has still been reduced by £3m in anticipation of an underspend against capital. This has reduced the value of the Asset, Non-Current forecast.

In addition Asset, Current has improved by £0.4m due to the extra 2018/19 PSF.

The capital loan of £4.2m still to be approved by DOH, however paperwork has been received and the loan should be finalised in the near future.

Title of Paper:	Learning from Deaths Quarterly Report (Q2 2019/20)	
Author:	Patient Safety Lead	
Executive Lead:	Medical Director	
Type of Report:	Concept Paper	
	Strategic Options Paper	
	Business Case	
	Information	
	Review/Benefits/Audit	✓

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

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

Positive Benefit:	An oversight of our mortality information, how we share the learning arising from the review of in-patient deaths and the projects in place to drive quality improvement.
Risk:	Gaps in assurances and lack of oversight of key areas impacting on the quality of the care we deliver and associated reputational risks.

To be published on Trust Website –complete version	✓
If no, to be published on Trust Website – redacted	-
If not to be published complete or redacted, please detail the reason why	-
Presented at Board Meeting of:	**2 December 2019**

Learning from Deaths Quarterly Report Q2 2019/20

October 2019

'Delivering Excellence in Healthcare through Innovation and Collaboration'

Contents

1.0 Introduction

Background

During 2016/17 a number of national documents were published relating to mortality and learning from deaths. The Care Quality Commission's (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. 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 included:

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

In line with national requirements we published our *Learning from Deaths Policy* on the Trust internet in September 2017. This policy built upon the existing policy and embedded associated processes, outlined the process for reviewing deaths and explained how the organisation learns from these reviews.

In March 2019, the Care Quality Commission (CQC) published the *Learning from Deaths – a review of the first year of NHS trusts implementing the national guidance*, as a part of their commitment to the Learning from Deaths Programme Board. The report reviewed the CQC inspector's observations from the first year of assessing how well Trusts had implemented the national guidance on learning from deaths.

Purpose

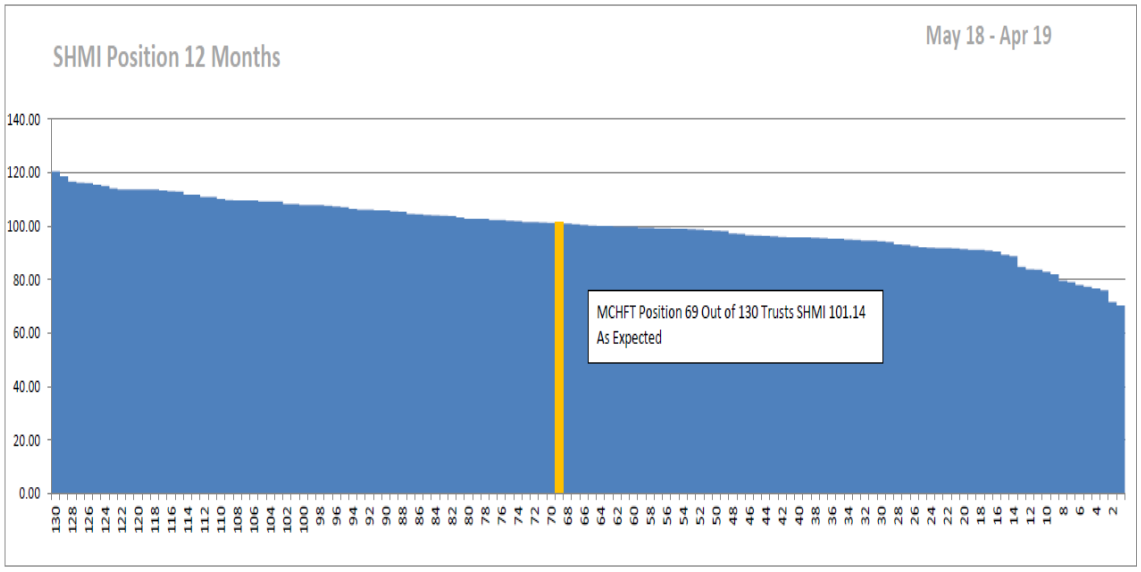
This is the ninth iteration of our Learning from Deaths Report covering Quarter 2 of 2019/20.

The report aims to provide assurance on how the organisation, through the work of the Hospital Mortality Reduction Group (HMRG) and other linking groups, is triangulating data and information to embed the learning from in-patient deaths, with the goal of seeing a sustained reduction in the Trust's mortality rates.

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) May 2018 to April 2019

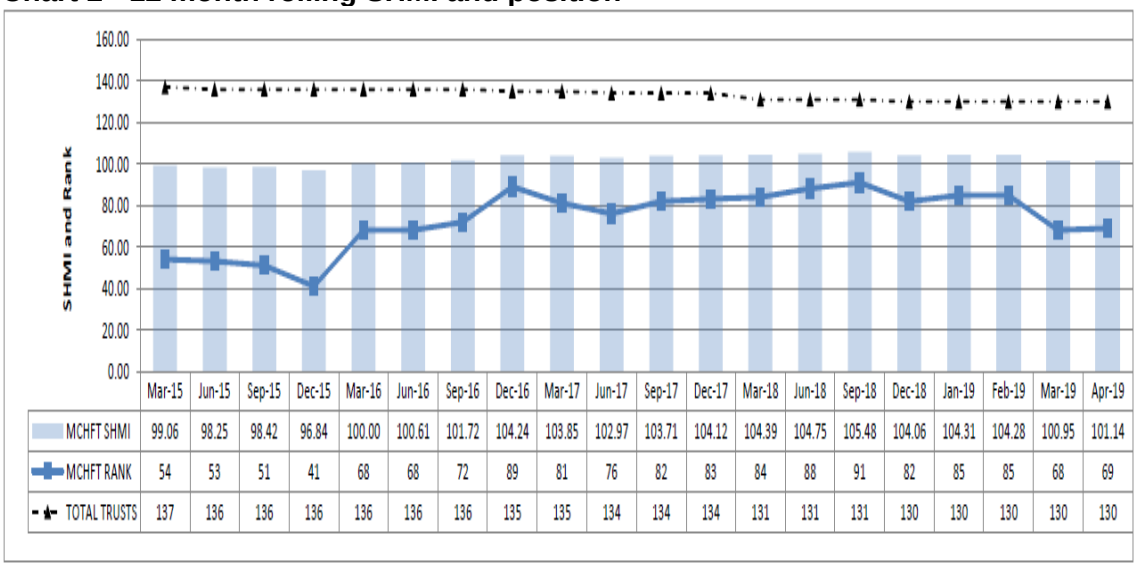
Chart 1 - SHMI Position



(Source NHS Digital, 2019)

Chart 1 demonstrates the SHMI position for the reporting period May 2018 to April 2019. The SHMI is currently 101.14 and is in the 'as expected' range. This currently places the Trust 69 out of 130 Trusts.

Chart 2 - 12 month rolling SHMI and position



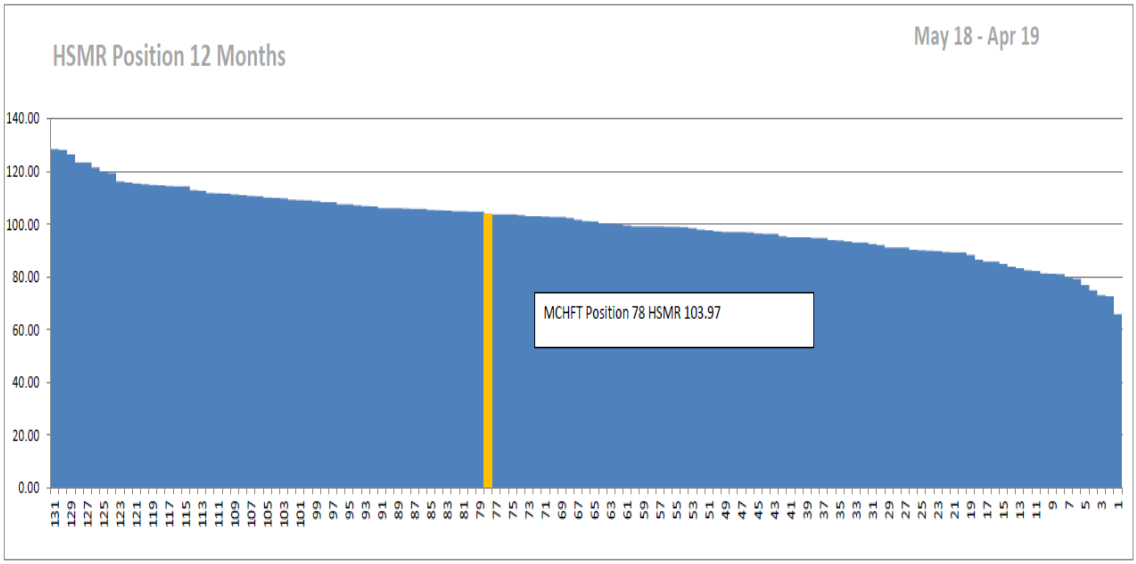
	Mar-15	Jun-15	Sep-15	Dec-15	Mar-16	Jun-16	Sep-16	Dec-16	Mar-17	Jun-17	Sep-17	Dec-17	Mar-18	Jun-18	Sep-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
MCHFT SHMI	99.06	98.25	98.42	96.84	100.00	100.61	101.72	104.24	103.85	102.97	103.71	104.12	104.39	104.75	105.48	104.06	104.31	104.28	100.95	101.14
MCHFT RANK	54	53	51	41	68	68	72	89	81	76	82	83	84	88	91	82	85	85	68	69
TOTAL TRUSTS	137	136	136	136	136	136	136	135	135	134	134	134	131	131	131	130	130	130	130	130

(Source NHS Digital, 2019)

Chart 2 demonstrates the SHMI and rank of the Trust over time, up to latest reporting period.

2.2 Hospital Standardised Mortality Rate (HSMR) May 2018 to April 2019

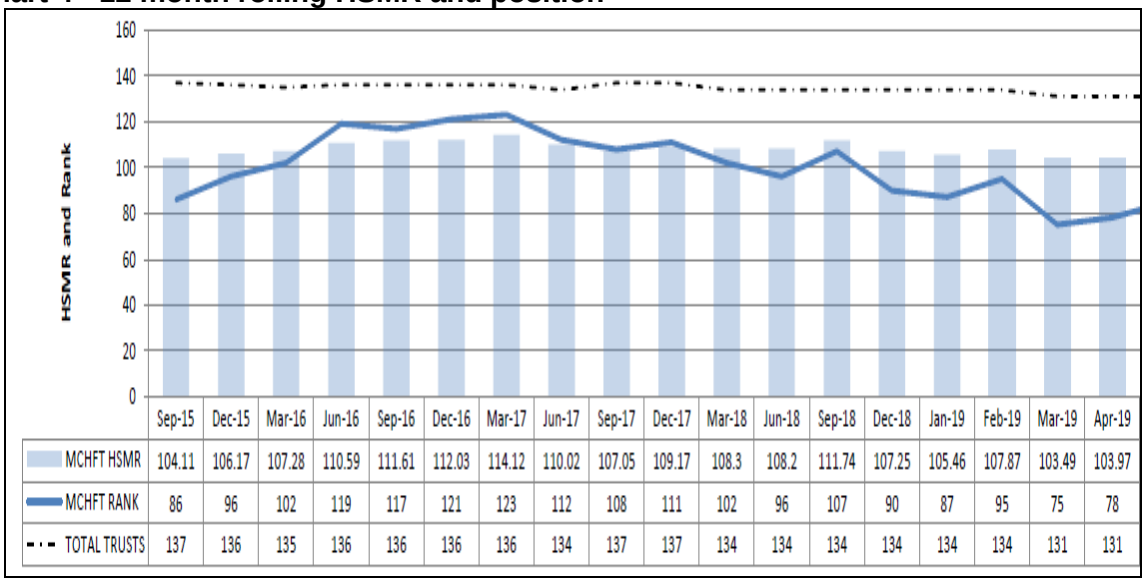
Chart 3 - HSMR Position



(Source HED, 2019)

Chart 3 demonstrates the HSMR position for the reporting period May 2018 to April 2019. The HSMR is currently 103.97 and places the Trust 78 out of 131 Trusts.

Chart 4 - 12 month rolling HSMR and position



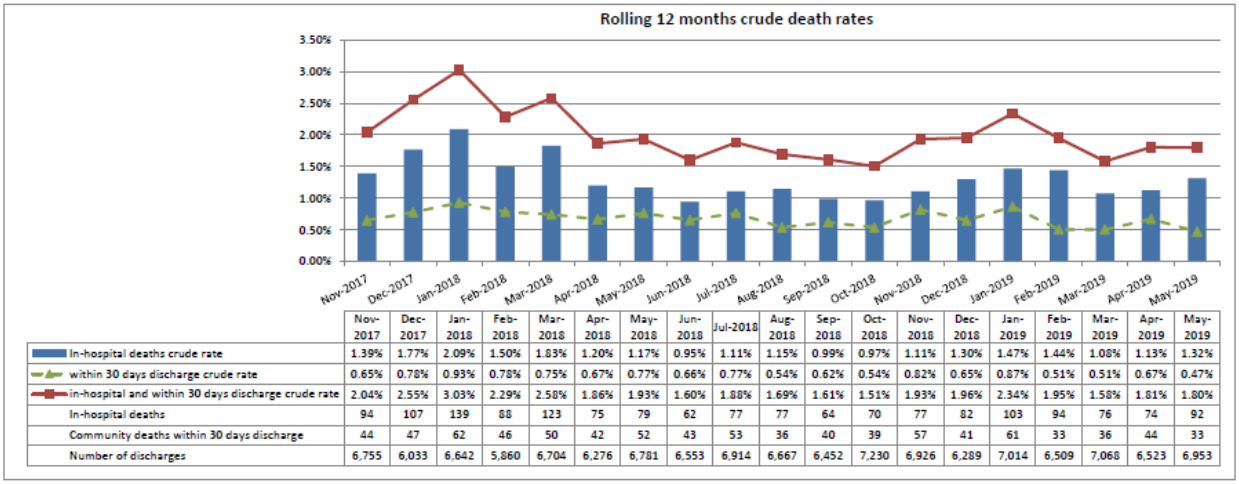
	Sep-15	Dec-15	Mar-16	Jun-16	Sep-16	Dec-16	Mar-17	Jun-17	Sep-17	Dec-17	Mar-18	Jun-18	Sep-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
MCHFT HSMR	104.11	106.17	107.28	110.59	111.61	112.03	114.12	110.02	107.05	109.17	108.3	108.2	111.74	107.25	105.46	107.87	103.49	103.97
MCHFT RANK	86	96	102	119	117	121	123	112	108	111	102	96	107	90	87	95	75	78
TOTAL TRUSTS	137	136	135	136	136	136	136	134	137	137	134	134	134	134	134	134	131	131

(Source HED, 2019)

Chart 4 demonstrates the HSMR and rank of the Trust over time, up to the latest reporting period.

2.3 Crude Mortality – Rolling 12 months

Chart 5 - Crude Mortality



	Nov-2017	Dec-2017	Jan-2018	Feb-2018	Mar-2018	Apr-2018	May-2018	Jun-2018	Jul-2018	Aug-2018	Sep-2018	Oct-2018	Nov-2018	Dec-2018	Jan-2019	Feb-2019	Mar-2019	Apr-2019	May-2019
In-hospital deaths crude rate	1.39%	1.77%	2.09%	1.50%	1.83%	1.20%	1.17%	0.95%	1.11%	1.15%	0.99%	0.97%	1.11%	1.30%	1.47%	1.44%	1.08%	1.13%	1.32%
within 30 days discharge crude rate	0.65%	0.78%	0.93%	0.78%	0.75%	0.67%	0.77%	0.66%	0.77%	0.54%	0.62%	0.54%	0.82%	0.65%	0.87%	0.51%	0.51%	0.67%	0.47%
In-hospital and within 30 days discharge crude rate	2.04%	2.55%	3.03%	2.29%	2.58%	1.86%	1.93%	1.60%	1.88%	1.69%	1.61%	1.51%	1.93%	1.96%	2.34%	1.95%	1.58%	1.81%	1.80%
In-hospital deaths	94	107	139	88	123	75	79	62	77	77	64	70	77	82	103	94	76	74	92
Community deaths within 30 days discharge	44	47	62	46	50	42	52	43	53	36	40	39	57	41	61	33	36	44	33
Number of discharges	6,755	6,033	6,642	5,860	6,704	6,276	6,781	6,553	6,914	6,667	6,452	7,230	6,926	6,289	7,014	6,509	7,068	6,523	6,953

Chart 5 demonstrates the crude death rate for the period up to May 2019. The above graph shows the in-hospital crude death rate, crude death rate within 30 days of discharge and the overall in-hospital and within 30 days of discharge crude death rate combined.

2.4 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 the number of in-patient deaths, the number of deaths reviewed and the number of potentially avoidable deaths. Part 1 of the dashboard is presented below and includes all adult in-patient deaths, excluding maternal deaths and patients with a learning disability (see Part 2). The national guidance suggests the adoption of a Structured Judgement Review (SJR) process to review in-patient deaths, but this process does not assess the potential avoidability of the death. Therefore the "Likert preventability scale" has been added to the SJR process, in an attempt to assess whether the death was potentially avoidable. The Trust trained a cohort of multi-disciplinary clinicians in the SJR methodology in February 2018 and the process commenced in April 2018. A second cohort of multi-disciplinary clinicians received training in January 2019 to allow the process to be expanded from April 2019.

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 6 avoidable deaths in 2018 / 19 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) using SJR		Total Number of deaths considered to have been potentially avoidable via alternative source (e.g. incident investigation)	
This Month	Last Month	This Month	Last Month	This Month	Last Month	This Month	Last Month	This Month	Last Month
69	75	43	115	15	15	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
219	249	213	200	48	15	0	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
	938	413	832	63	114	0	1	0	6

2.4 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 (HQIP) following the deaths of people with learning disabilities aged 4 to 74 years of age. Reviews at the Trust undertaken as part of this programme are conducted by trained reviewers.

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

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
0	0	0	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
0	15	0	15	0	0

3.0 Care Quality Commission (CQC) Mortality Outlier Alerts

The information below is sourced from the latest version of the CQC Insight document (8 September 2019). The Trust undertakes an in-depth case note review in response to any Mortality Outlier Alert.

Key Messages

- There are currently 0 active mortality alerts for the Trust.
- There are currently 0 active maternity alerts for the Trust.

Number of outlier alerts for this Trust as at 2 September 2019:

	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	0	0	0	11	11
Maternity	0	0	0	2	2

Mortality Outliers – Active Alerts

Cases under consideration by the Outlier Panel

- There are currently no active mortality alerts

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

- There are currently no mortality alerts where action plans are being followed up by the local 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's 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 Judgement Review (SJR). The Consultant looking after the patient is also asked to provide their written reflection on the quality of the patient's care.

SJRs are undertaken by a cohort of senior medical and nursing staff trained in the SJR Process.

In addition to the escalations from the weekly reviews, in line with national guidance, the HMRG has agreed a number of other clinical conditions / criteria that will result in an in-patient death undergoing a SJR. These will be reviewed on an annual basis and currently include for 2019/20:

- All deaths where families, carers or staff raise concerns
- Deaths where concerns are raised by the Coroner
- Deaths where concerns are raised at the Patient Safety Summit
- Deaths due to alcohol related liver disease
- Relevant elective deaths
- Deaths due to septicaemia (at the weekend)
- Deaths due to congestive heart failure – non-hypertensive (at the weekend)
- Deaths due to an acute myocardial infarction
- Deaths from admissions on a Monday

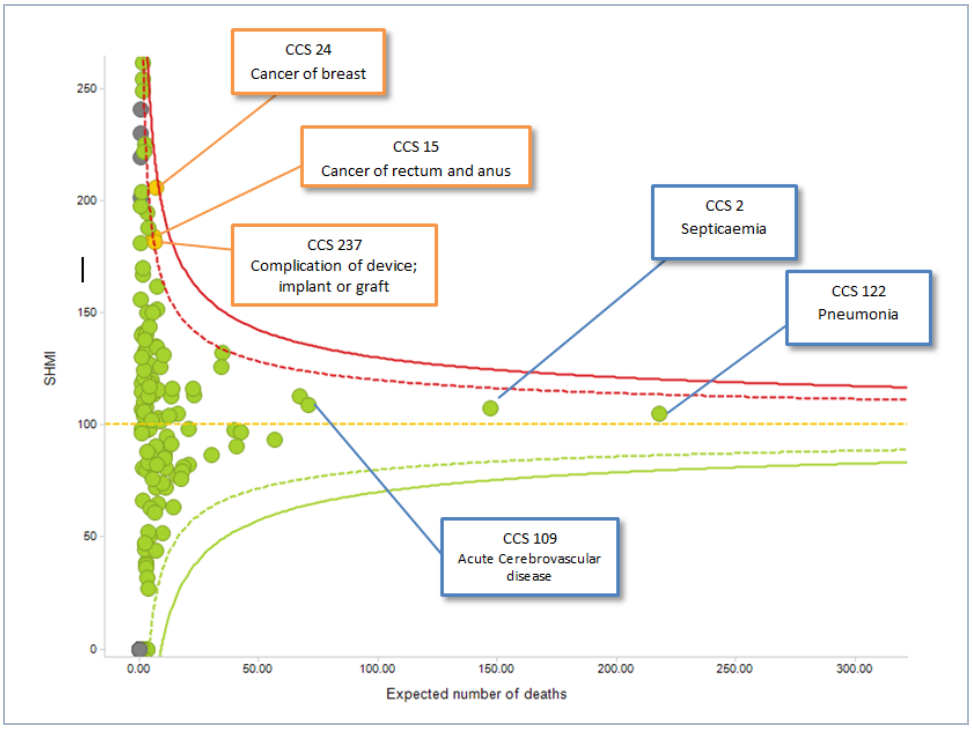
Organisational learning from this process must be dynamic, with immediate actions and improvements undertaken in a timely manner to prevent reoccurrence. Short - medium term improvements, identified through organisational learning, are introduced through the Trust's governance structure. In the longer 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 Trust has a well-established HMRG led by the Medical Director. This group leads the Trust's mortality reduction programme and, on a quarterly basis, meets with the Divisional Mortality Reduction Groups to ensure a unified approach to mortality reduction across the Trust and to share learning opportunities.

The Trust's mortality reduction programme is succinctly described in a driver diagram that was most recently updated in March 2019, (see Appendix 1). The five primary drivers to reducing the Trust's mortality rates are:

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

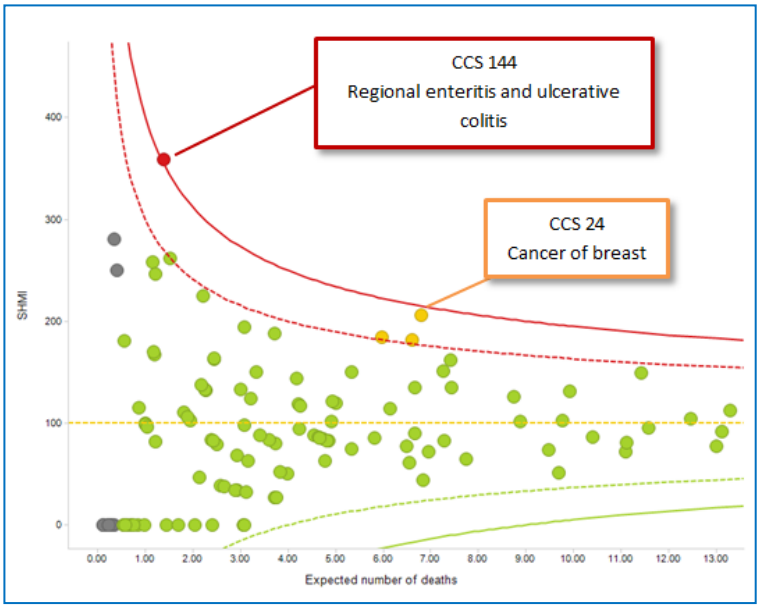
4.1 Quarterly Deep Dive – SHMI Diagnostic Group (CCS) Review



(Source: BIU, 2019)

High volume diagnostic groups such as Pneumonia and Septicaemia are well within the 'as expected' range. It is only once looking at some of the groups with small volumes of patients in them that some CCS groups are being flagged as warranting further investigation

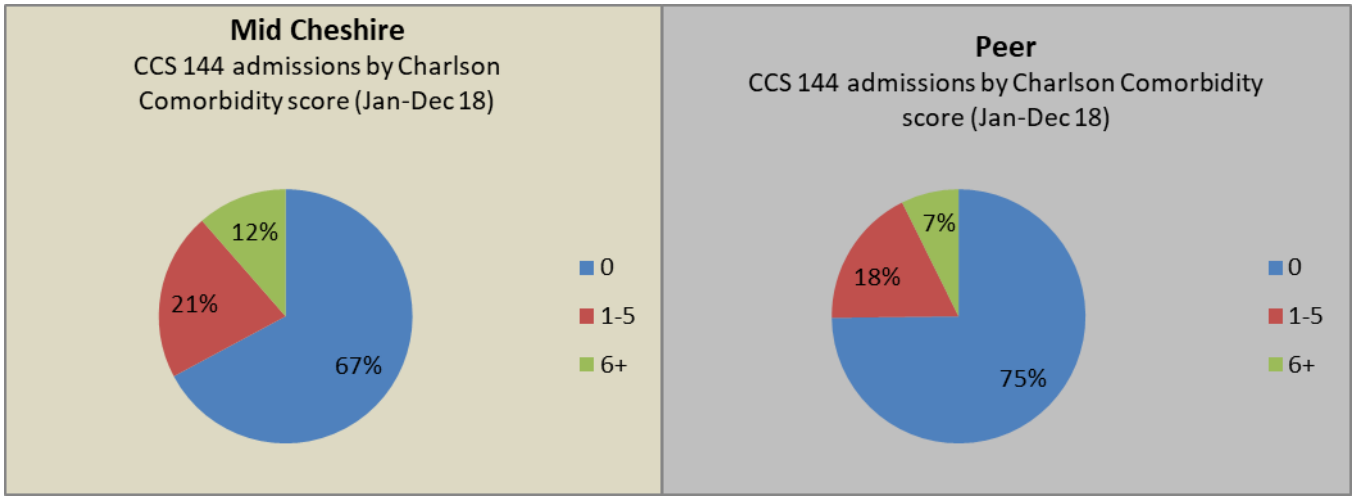
A more focused view of the above shows there is one SHMI diagnostic group that is deemed outside the expected range for deaths in the period January to December 2018. This is SHMI Diagnostic group 88 or CCS group 144 – Regional enteritis and ulcerative colitis.



(Source: BIU, 2019)

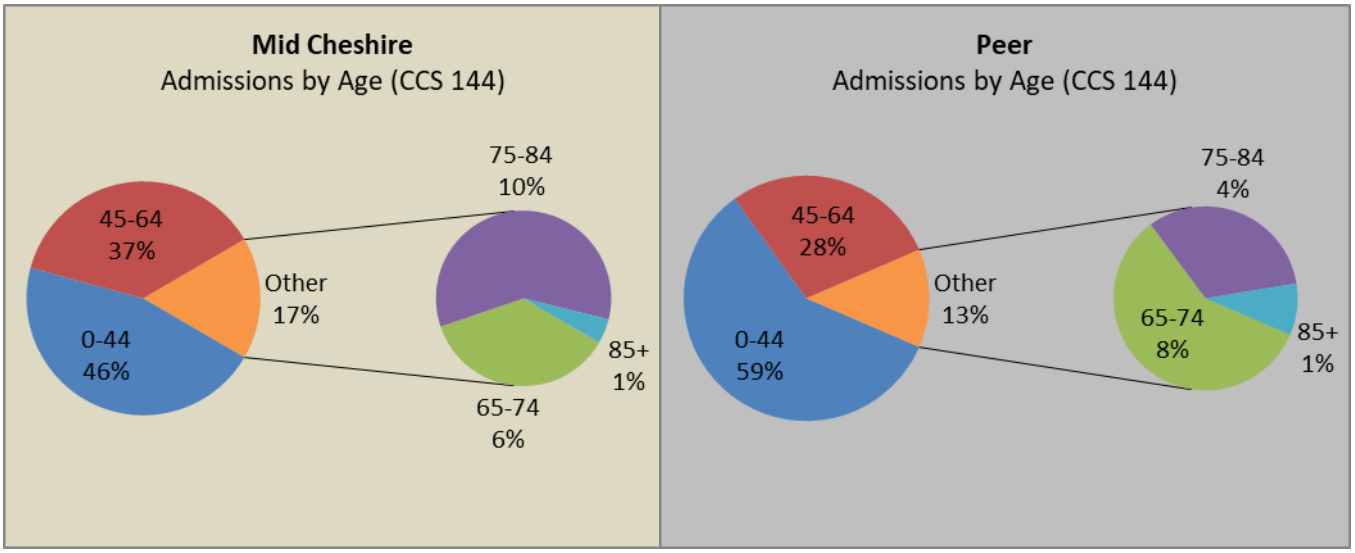
Complexity/case mix

Based on the Charlson comorbidity scores given to patients, the case mix at Mid Cheshire Hospitals NHS Foundation Trust (MCHFT) for patients in CCS group 144 has been more complex. It is seen that 12% of the patients at MCHFT had a score of 6 or more compared with 7% at peer Trusts.



Age groups

Grouping all admissions for CCS group 144 in to age brackets shows MCHFT tend to have an older mix of patients than peer Trusts. With 11% of patients being 75 years old or over at MCHFT compared with 5% at peer Trusts.

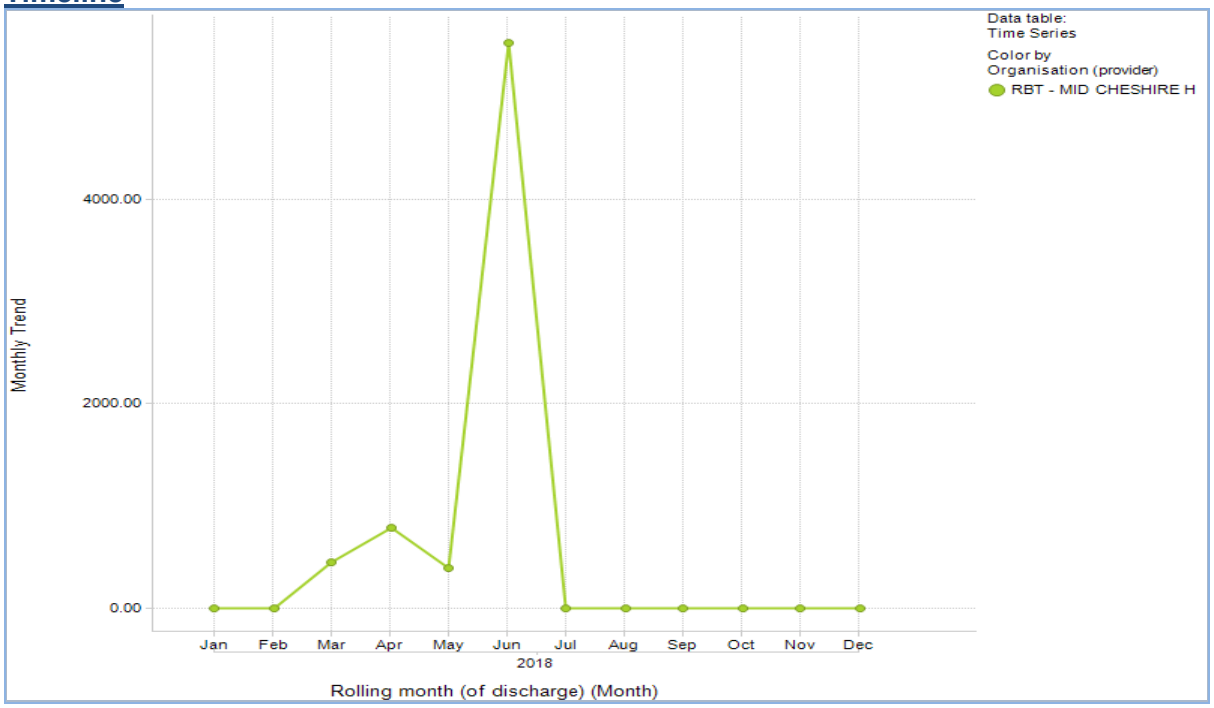


Length of Stay

LOS (6 bands)	Expected Deaths	Observed Deaths	Spells
0 day	0.2	0	22
1-6 days	0.5	0	52
7-13 days	0.4	0	30
14-20 days	0.0	0	9
21-27 days	0.1	4	8
28+ days	0.2	1	10
Grand total	**1.392155**	**5**	**131**

All of the deaths in this diagnostic group for the period January 2018 – December 2018 were after a long length of stay in hospital. 4 deaths after a length of stay between 21 and 27 days with one spell lasting over 28 days.

Timeline



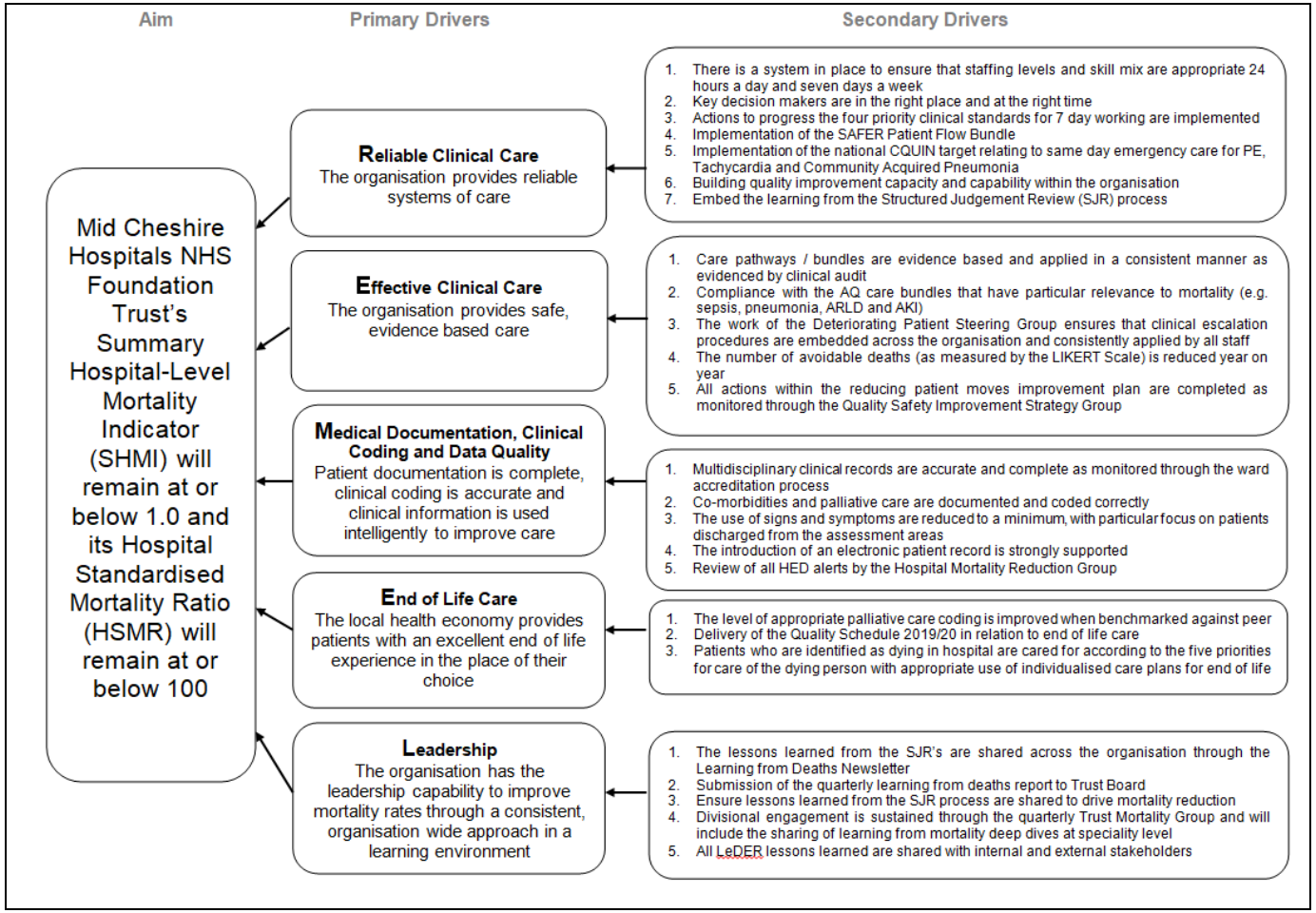
Assurance can be taken from the isolated SHMI over time. The monthly breakdown above shows the SHMI has been zero (no attributable deaths) since July 2018. The Spike in July was as a result of two deaths both of which took place outside of hospital within 30 days of the patients discharge.

5.0 Next steps

- 6 monthly review of the SJR process

5.0 Appendices

5.1 Appendix 1 Driver Diagram



5.2 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).

5.3 Appendix 3: Understanding the difference between SHMI and HSMR

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

Title of Paper:	Report of Use of the Trust Seal			
Author:	Katharine Dowson			
Executive Lead:	James Sumner			
Type of Report:	Concept Paper			
	Strategic Options Paper			
	Business Case			
	Information	X		
	Review/Benefits/Audit			
Link to Strategic Domains:			***Link to Domain:***	
Delivering Outstanding Clinical Quality, Safety & Experience			Safe	
Being a Leading partner in a Progressive Health Economy			Effective	
Striving for Outstanding Organisational Effectiveness	X		Caring	
Aspiring to Excellence in Practice Through Our Workforce			Responsive	
Creating a 21st Century Infrastructure for Transformative Health and Social Care			Well-Led	X
Link to Board Responsibility:	Performance			
	Accountability	X		
	Strategy			
	Implementation			
Action Required:	Decide			
	Approve	X		
	Note			
	Recommend			
	Delegate			
Positive Benefit:	Board oversight of the use of the Trust Seal			
Risk:	Non-compliance with Trust Constitution			
To be published on Trust Website –complete version		***Y*** *(delete as appropriate)*		
If no, to be published on Trust Website – redacted				
If not to be published complete or redacted, please detail the reason why				
Presented at Board Meeting of:	2 December 2019			

Recommendation

The Board of Directors are asked to note the sealings that have taken place since the last Board report in August 2019. This report notes subsequent sealings to 30 November 2019 as required by the Trust Constitution.

Quarterly Report of Sealings for the period 1 August 2019 to 30 November 2019

Seal Number	***Description***	***Date of Board Approval***	***Date of Sealing***
102	Renewal of lease with Barclays Bank	2 September 2019	2 September 2019

Title of Paper:	Board Assurance Framework (BAF) Report Q2 19/20	
Author:	Interim Associate Director-Quality Governance	
Executive Lead:	Medical Director	
Type of Report:	Concept Paper	
	Strategic Options Paper	
	Business Case	
	Information	
	Review/Benefits/Audit	✓

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

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

Positive Benefit:	A summary report of the BAF following scrutiny of the relevant Strategic Domains at Board Sub-Committee level, with oversight by the Quality Governance Committee.
Risk:	Gaps in assurances and lack of oversight of key risks to achieving the Strategic Objectives.

To be published on Trust Website – complete version	***Yes***
If no, to be published on Trust Website – redacted	
If not to be published complete or redacted, please detail the reason why	
Presented at Board Meeting of:	2 December 2019

Mid Cheshire Hospitals
NHS Foundation Trust

Board Assurance Framework 2019/20

Quarter 2

Summary Version

Delivering Excellence in Healthcare through Innovation and Collaboration'

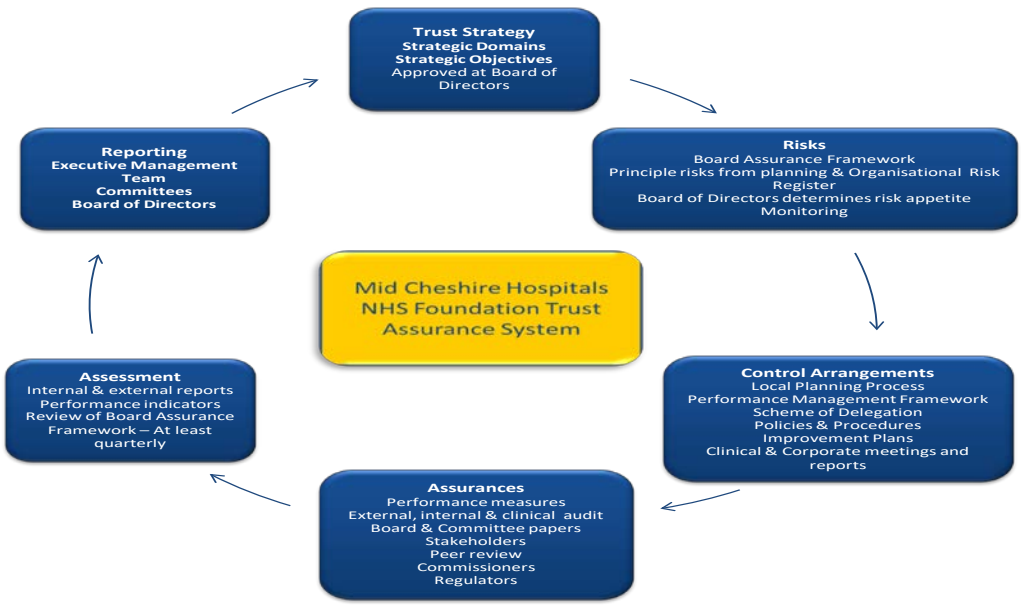
Contents

1. Background & purpose

The requirement for NHS organisations to have Board Assurance Framework (BAF) is well documented, most recently it is cited in the NHS Improvement document Developmental Reviews of Leadership and Governance using the Well-Led Framework: Guidance for NHS Trusts and NHS Foundation Trusts (June 2017). The Board of Directors have had a well embedded document in place for a number of years, with reasonable assurances provided. Following an internal review of our risk management systems and processes, feedback from internal audit and Board members a 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 detailed 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 key risks as of quarter 1, 2019/20.

Table 1 – Six key risks for the Trust in 2019/10

Risk Title	Mitigated (with controls) Risk Rating	SHIFT				Key links to BAF 2019/20
		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	20 ⇔	20 ⇔			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	20 ⇔	20 ⇔			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	16 ⇔	16 ⇔			Q1,Q2,P1,P2,E2, W2,T1,T2a,T2b
The Long Term Financial Sustainability of the Trust.	4(C) x 3(L) = 12	12 ⇩	12 ⇔			E1,E2,P1,P2,T1,T 2a,T2b
Cyber Security	4(C) x 4(L) = 16	16 ⇔	16 ⇔			Q1,Q2,E1,E2,T2a, T2b
Proposed acquisition of the South Cheshire Private Hospital	5(c) x 2(L) = 10	New	10 ⇔			

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 was an area of focus for the externally facilitated review in 2018/19.

In April 2019 the KPMG Internal Audit Report on the BAF provided significant assurance with minor improvement opportunities and the recommendations have been incorporated in to the BAF development process for 2019/20.

5. BAF & Linked Risks Heatmap

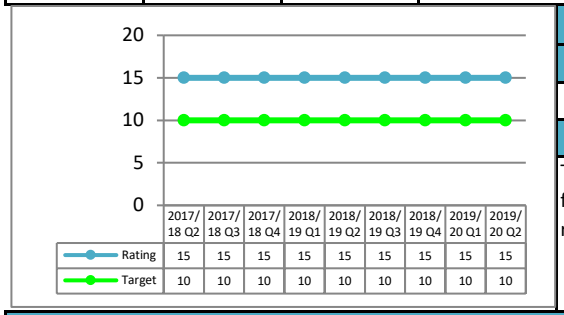
BAF Domain	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Q1	15			15								
Q2	10			10								
P1	12			16								
P2	12			12								
E1	15			15								
E2	16			16								
T1	15			15								
T2a	15			15								
T2b	12			12								
W1	15			15								
W2	15			15								
W3	15			15								
Linked Risks												
TW0001 – Delivery of key local and National targets and standards, in particular the 4 hour standard in A&E	20	20	20	20	20	20						
TW0002 – Long Term Financial Sustainability of MCHFT	12	12	12	12	12	12						
TW0003 – Workforce capacity and skill mix to consistently deliver high quality care, seven days a week	20	20	20	20	20	20						
TW0004 - Registered Nurse staff shortages	16	16	16	16	16	16						
TW0006 - 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	16	16	16	16	16						
TW0010 - Legacy Operating Systems Software	16	16	16	16	16	16						
CS0380 - Cyber Security	16	16	16	16	16	16						

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.**

Principle Risk

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

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHSI Single Oversight F/w	Executive Director	Executive Management Group	Board Committee
June 2017	June 2019	Sept 2019	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 2020

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, this includes safe registered nurse staffing levels and work outlined in Key Control number 10.

Links to BAF objectives

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

Key Links to the Organisational Risk Register

TW0001 – Delivery of key local and National targets and standards, in particular the 4 hour standard in A&E	**20**	TW0003 – Workforce capacity and skill mix to consistently deliver high quality care, seven days a week	**20**
TW0002 – Long Term Financial Sustainability of MCHFT	**12**	TW0004 - Registered Nurse staff shortages	**16**

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

The Trust is progressing the Advancing Quality Programme for 2019/20 focusing on several care pathways. The quality reports at ward/department /divisional level have been rolled out across all divisions. Exec led quarterly quality reviews have commenced in all divisions with a lessons learnt cross divisional process in place. Quality & Safety Improvement Strategy for 2019/20 is in place. Quality priorities presented and approved at Quality Governance Committee, February 2019. Well Led self-assessment process completed,findings from initial reviews presented to Trust Board, and action plan developed. Review of Infection, Prevention & Control Services has been completed, gaps identified, improvement plan developed. Director of Nursing & Quality is Trust Safety Champion for Maternity Services and actively involved in delivery of 'Better Births'. On-going implementation plans and monitoring of National/regulatory guidance. Trust-wide e-roster project commenced in November 2018, a total of 20 wards are now on e-roster, KPIs are in development. NHS Resolution Maternity Incentive Scheme – all indicators achieved in 2018, plan now in place. Quality metrics programme launched January 2019. Ward accreditation programme commenced May 2019 with a total of 16 wards accredited at end of quarter 2.

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

- Ward accreditation scheme launched in May 2019 and a programme to assess all in patient wards is in place for 2019
- Internal Well-Led Review improvement actions – quarterly oversight at Quality Governance Committee.
- Nursing & Midwifery AHP Strategy due to be launched in November 2019.
- CQC Mock Inspection to be undertaken during October 2019
- NHS Resolution Maternity Incentive Scheme, new indicators achieved for 2019-2020

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.**					
Key Controls / Influences Established (What are we currently doing about the risk?)	Key Gaps in Controls / Influences (What additional controls should we seek?)	Assurance Providers 2018/19 (How do we know if the things we are doing are having an impact?)			Gaps in Assurances on Controls / Influences (What additional assurances should we seek?)	Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)
		Local Management (1st Line of Defence)	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)		
1. Processes in place to deliver the CQUINs & Quality Schedule	• Data access & collective intelligence • Quarterly Quality Reviews (To be rolled out in CCICP)	• 1:1 / Team Meetings • Safety Collaborative • Quality Matters Programme	• Quality Safety & Improvement Strategy Group (QSIS) • EQGG • QGC • Board of Directors • QGC minutes • Monthly Quality, Safety & Experience Report (CQUIN) • Quality Account-April 2019	• CQC Good rating-Sept 2018 • CCG Contract meetings monthly • CCG Quality Visits • CQUIN Q3 Report exceptions: Sepsis treatment and antibiotic consumption Internal Audit Programme • Internal audit of IP&C processes • Compliance with MCA and DoLS registered annually 2019	• Implementation of formal quarterly quality review process • Data collection requirements for elements of 2018/19 CQUINs	• Quality Schedule / data collection requirements to be finalised for 2019/20and associated resources • internal audit of e-rostering roll out programme complete March 2019
2. Infection Prevention & Control (IPC) Team and supporting strategies & policies		• 1:1 / Team Meetings • Monthly Divisional Boards/CCICP reports	• IPC Audit Programme • Executive IPC • QGC • Board of Directors • QGC minutes • Monthly Quality, Safety & Experience Report • Monthly Serious Events /IPC • Quality Account-April 2019	• CQC Good rating-Sept 2018 • CCG Contract meetings monthly • CCG Quality Visits • PHE/NHSE/NHSI Feedback Internal Audit Programme • Internal audit of IP&C processes	• KPMG Internal Audit Dec 2018 with all actions in place 2019	90 day improvement plan in place June 2019 External review completed April 2019 Actions within 90 day improvement plan
3. Maternity Dashboard	• Quarterly Quality Reviews To be rolled out in CCICP	• 1:1 / Team Meetings • Monthly W&C Divisional Board Report	• EQGG • QGC • Board of Directors • QGC minutes • Quality Account-April 2019 • Quality Summit – monitoring of detailed CQC improvement plan • Director of Nursing and Quality – executive Maternity Safety Champion	• CQC Good rating Sept 2018 • CCG Quality Visits • Advancing Quality Reports • NHSE/NHSI Feedback Internal Audit Programme • Internal audit of IP&C processes • CQC report on compliance with IRMER in Radiology in December 2018.	• Implementation of formal quarterly quality review process	• Quarterly quality reviews and reports are fully rolled out including CCICP • Head of Midwifery to monitor compliance against "Better Births" CNST2 Board agreement in place 2019-2020

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.**					
Key Controls / Influences Established (What are we currently doing about the risk?)	Key Gaps in Controls / Influences (What additional controls should we seek?)	Assurance Providers 2018/19 (How do we know if the things we are doing are having an impact?)			Gaps in Assurances on Controls / Influences (What additional assurances should we seek?)	Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)
		Local Management (1st Line of Defence)	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)		
4. Quality & Safety Improvement Strategy 2019-20 implementation	• Quarterly Quality Reviews To be rolled out in CCICP • Implementation of new Quality & Safety Improvement Strategy 2018/19	• 1:1 / Team Meetings • Quality Matters Programme • Monthly Divisional Boards/CCICP reports	• Deteriorating Patient Steering Group • Hospital Mortality Reduction Group • QSIS Group. EQGG. QGC • Board of Directors • QGC minutes • Patient / Staff Stories • Board Walkaround Programme • Monthly Quality, Safety & Experience Report • Monthly Serious Events / IPC • Quality Account-April 2019 • CQC Improvement Plan monitored at Quality Summit	• CQC Good rating-Sept 18 • CCG Quality Visits • Advancing Quality Reports • External accreditation e.g. UKAS, JAG • CQC Inpatient Survey-June 2018 'About the same as other Trusts overall'-reduction on previous year Internal Audit Programme • Internal audit of IP&C processes	• Implementation of formal quarterly quality review process • New strategy, metrics and monitoring	• Quarterly quality reviews and reports are rolled out across in-patient areas completed April 2019 • Quality metrics, monthly results to are displayed on wards from May 2019. • New Quality Boards in place • QI Projects presented at Quality Summit by Ward Managers
5. Patient & Public Involvement Strategy implementation		• 1:1 / Team Meetings • Membership Office • Monthly Divisional Boards/CCICP reports	• Patient / Staff Stories • EPEG • QGC • Board of Governors • Board of Directors • Governors reports & feedback • QGC minutes • Quality Account-April 2019	• CQC Patient Survey-May 2017 • CQC Good rating- Sept 2018 • Healthwatch feedback • Patient representative groups Internal Audit Programme • Internal audit of IP&C processes		
6. Patient Safety Team established with objectives and associated policies & procedures	• Quarterly Quality Reviews to be rolled out in CCICP	• 1:1 / Team Meetings • Monthly Divisional Boards/CCICP reports	• Patient Safety Summit • Deteriorating Patient Steering Group • EQGG. QGC • Board of Directors • QGC minutes • Monthly Quality, Safety & Experience Report • Monthly serious events / IPC • Quality Account-April 2019	• CQC Good rating-Sept 2018 • CCG contract meetings monthly • Quarterly Advancing Quality Reports Internal Audit Programme • Internal audit of IP&C processes	• Implementation of formal quarterly quality review process	• Quarterly quality reviews and reports are fully rolled out • Development of quality reports / data collection in place

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.**					
Key Controls / Influences Established (What are we currently doing about the risk?)	Key Gaps in Controls / Influences (What additional controls should we seek?)	Assurance Providers 2018/19 (How do we know if the things we are doing are having an impact?)			Gaps in Assurances on Controls / Influences (What additional assurances should we seek?)	Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)
		Local Management (1st Line of Defence)	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)		
7. Risk Management Strategy & Framework 2017/20 6 key priorities	• Revised quarterly risk register reports at divisional/corporate level in development. • Risk management systems review	• 1:1 Meetings • Team Meetings • Monthly Divisional Boards/CCICP reports	• EQGG. QGC. Trust Board • QGC minutes • Quarterly BAF / Risk Register Report • Well-Led Reviews June 2017 and April 2018	• Internal Audit Programme • Annual Governance Statement-March 2018 • Risk Management and BAF internal audit report: Significant Assurance- with minor opportunities for improvement - January 2019 • CCICP Governance-December 2017 • Externally facilitated Developmental Review NHSI Well Led Framework Completed January 2019		• Source external Well-Led reviewer • Implementation of Well Led Improvement Plan • Well led interviews planned for November 2019
8. Quality Impact Assessment (QIA) Process	• QIA process to be fully established	• Programme/Project Team • Monthly Divisional Boards/CCICP reports	• Medical Director & Director of Nursing& Quality reviews • EQGG • QGC • Board of Directors • QGC minutes • Quality Account April 2019	• CQC Good rating- Sept 2018 • CCG contract meetings monthly Internal Audit Programme • Quality Account-April 2019	• Strengthen reporting and monitoring of QIA process	• Roll out of new QIA process by July 2019
9. Adult & Child Safeguarding Team & policies & procedures.		• 1:1 / Team Meetings • Monthly Divisional Boards/CCICP reports	• Executive Safeguarding Group • QGC • Board of Directors • QGC minutes	• Local Safeguarding Adult's Board • Local Safeguarding Children's Board		External reporting of statutory audits

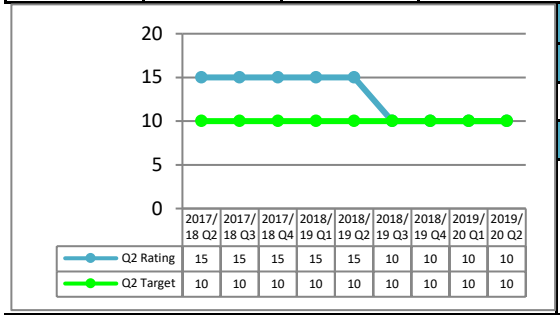
Strategic Domain 1: Delivering Outstanding Clinical Quality, Safety & Experience						
Q1	**To aspire to the delivery of 'Outstanding' clinical quality and safety, which is equitable, patient and family centred and supported by an effective quality governance framework.**					
Key Controls / Influences Established (What are we currently doing about the risk?)	Key Gaps in Controls / Influences (What additional controls should we seek?)	Assurance Providers 2018/19 (How do we know if the things we are doing are having an impact?)			Gaps in Assurances on Controls / Influences (What additional assurances should we seek?)	Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)
		Local Management (1st Line of Defence)	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)		
10. Nursing, Midwifery & AHPs Strategy, Collaborative & Nursing Care Indicators	• To be reviewed and implemented by May 2019	• 1:1 / Team Meetings • Monthly Divisional Boards/CCICP reports	• Nurse Leadership walkarounds • MCHFT Cares Programme • Professional Advisory Group • EWAG/EQGG • Board of Directors • QGC minutes • Monthly Workforce Report • Monthly Quality, Safety & Experience Report (Staffing) • Annual report on Appraisal and Revalidation that was sent to the Board in September 2018.	• Royal College reports	• Implementation of formal quarterly quality review process	• Launch of new ward accreditation scheme and quality metrics programme by May 2019 • NHS Resolution Maternity Incentive Scheme – all indicators achieved for 2018. Evidence for indicators for CNST2 in place June 2019 • Launch of Nursing, Midwifery and Allied Health Proffessional Strategy

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.**

Principle 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 / NHSI Single Oversight F/w	Executive Director	Executive Management Group	Board Committee
June 2017	June 2019	Sept 2019	Safe, Effective, Responsive, Caring & Well Led NHSI – Quality Metrics	Medical Director / Deputy CEO	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 2020

Rationale for the Current Risk Score

Risk score has remained at 10 for Quarter 2. The likelihood of not improving the quality of care with all the key controls in place is unlikely.

Links to BAF objectives

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

Key Links to the Organisational Risk Register

TW0002 – Long Term Financial Sustainability of MCHFT	**12**	TW0003 – Workforce capacity and skill mix to consistently deliver high quality care, seven days a week	**20**

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

HSMR/SHMI mortality indicators are 'within expected range'. The crude mortality rate is significantly lower for 2018/19 compared to 2017/18. Second year of SJR process is up and running utilising new intelligently identified cohorts. The Trust has been accepted onto the AQUA Deteriorating Patient Safety Collaborative for 2018/19. Trust participation in all relevant National Clinical Audits and Regional Advancing Quality Programme to benchmark performance. Monthly Quality Reports are produced for all the Divisions and are reviewed at the Executive led Quarterly Quality Reviews. Trust's active participation in GIRFT programme led by CEO and MD. Progression of Quality, Service Improvement and Redesign (QSIR) initiative. Trust wide development opportunities following the recent Well Led Development Review. Improving Quality Together strategy document presented to QGC in June 2019. Significant improvement in 7 Day Services audit results.

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

- One day process for Quarterly Quality Reviews is now in place.
- Clinical Trials portfolio has been developed.
- Develop plans to increase QI capability & capacity Trust wide (Included in Improving Quality Together programme proposal document)
- Lack of integration between Service Development and QI teams to be addressed as part of the Trust wide plans. (Included in Improving Quality Together programme proposal document)

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.**					
Key Controls / Influences Established (What are we currently doing about the risk?)	Key Gaps in Controls / Influences (What additional controls should we seek?)	Assurance Providers 2018/19 (How do we know if the things we are doing are having an impact?)			Gaps in Assurances on Controls / Influences (What additional assurances should we seek?)	Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)
		Local Management (1st Line of Defence)	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)		
1. Quality & Safety Improvement Strategy 2019/20 implementation	• Data access & collective intelligence • Reports by CQC Domains • Quarterly Quality Reviews To be rolled out in CCICP	• 1:1 Meetings • Monthly Divisional Boards/CCICP reports	• Effective Clinical Practice Group • QSIS Group • EQGG. QGC • Board of Directors • Monthly Quality, Safety & Experience Report • Monthly Quality Report • QQR Process • QGC Minutes • Quality Account-April 2019	• CQC Good rating-Sept 2018 • CCG contract meetings monthly • CCG Quality Visits • Advancing Quality Reports • CQC Inpatient Survey-May 2017 'About the same as other Trusts overall'-reduction on previous year Internal Audit Programme • Quality Account-April 2019	• Implementation of formal quarterly quality review process in CCICP • Findings from CQC inspection report – Sept 2018	• A new one day process for Quarterly Quality Reviews to be established in 2019. Complete and includes CCICP • Development of reports / data collection in progress including Model Hospital data.
2. Clinical Audit Team in place with annual clinical audit programme that includes national programmes, in addition to this full participation with GIRFT programme.	• Quality Improvement capacity & capability.	• 1:1 / Team meetings • Local Audit Meetings • Monthly Divisional Boards/CCICP reports	• Effective Clinical Practice Group • EQGG • QGC • Board of Directors • QGC Minutes • Quality Account-April 2019 • QQR Monitoring	• CQC Good rating-Sept 2018 • CQC Insight Report • HQUIP-National Audits • Advancing Quality Programme Reports Internal Audit Programme • Quality Account-April 2019	• Implementation of formal quarterly quality review process in CCICP	• Development of reports / data collection in progress
3. Advancing Quality programme	• Data access & collective intelligence. • Quarterly Quality Reviews. To be rolled out in CCICP	• 1:1 / Team meetings • Monthly Divisional Boards/CCICP reports	• Care Pathways Group • EQGG • QGC • Board of Directors • QGC Minutes • Monthly Quality Report • QQR Process • Quality Account-April 2019	• HQUIP-National Audits Feedback • Advancing Quality Programme Reports Internal Audit Programme • Quality Account-April 2019	• Implementation of formal quarterly quality review process in CCICP • Some CQUINs not achieved in quarter	• Improving Quality Together Programme proposal to QGC in May 2019. Strategy was presented to QGC in June 2019 • Development of reports / data collection in progress including Model Hospital data.

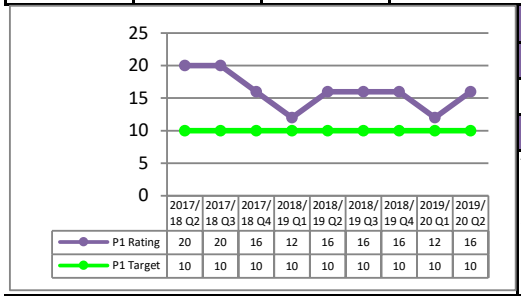
Strategic Domain 1: Delivering Outstanding Clinical Quality, Safety & Experience						
Q2	**To drive continuous quality improvement and promote research and innovation, whilst reducing unwarranted clinical variation and progressing from a 'Good' to 'Outstanding' organisation.**					
Key Controls / Influences Established (What are we currently doing about the risk?)	Key Gaps in Controls / Influences (What additional controls should we seek?)	Assurance Providers 2018/19 (How do we know if the things we are doing are having an impact?)			Gaps in Assurances on Controls / Influences (What additional assurances should we seek?)	Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)
		Local Management (1st Line of Defence)	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)		
4. Clinical Trials Team with research governance team in place	• Lack of capacity of team reducing opportunities to participate in NHS & commercial trials. • Raising profile Trust-wide	• 1:1 /Team meetings	• Research & Development • EQGG • QGC • Board of Directors • Divisional Quality Reports • Quality Account 2018/19	• Clinical Research Network Feedback & governance systems	Reporting progress against clinical trials portfolio via governance structure.	• Reports via governance structure from April 2018 • Development of clinical trials portfolios by March 2019 Complete
5. Learning from Deaths Policy & Mortality Review Process (Divisional & Corporate)		• Weekly Mortality Reviews • Divisional level reviews	• Care Pathways Group • Deteriorating Patient Steering Group • 7 Days Working Group • Trust/Hospital Mortality Reduction Group • BIU data & reports • EQGG • QGC • Board of Directors • Quarterly Learning from Deaths Report from November 2018QGC Minutes • Monthly Quality, Safety & Experience Report • Quality Account-April 2019 • Monitoring of lessons learned from SJR process	• CQC Good rating-Sept 2018 • NHS Improvement data • CCG Contract meetings monthly • CCG Quality Visits • CQUIN Q1 Report (Exceptions: Sepsis treatment and antibiotic consumption) • CQC Outlier Alert process • Nationally benchmarked mortality data • Advancing Quality Reports • Internal Audit Programme:		
6. 7 Day Clinical Services		• 1:1 / Team meetings • DGM Lead • Monthly Divisional Boards/CCICP reports	• 7 Day Services Working Group • HRMG • EQGG • QGC • 7DS Board Assurance Framework (BAF)	• National data return to NHSE- 6 monthly • National NHSE benchmarking data • 7DS survey undertaken as part of National survey April 2018	• 7DS BAF in early stages of implementation	• Full implementation of 7DS BAF by June 2019

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.**

Principle 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 / NHSI Single Oversight F/w	Executive Director	Executive Management Group	Board Committee
June 2017	June 2019	Sept 2019	Well Led NHSI – Use of Resources	CEO	Board of Directors	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	5	25	4	4	**16**	5	2	**10**	March 2020

Rationale for the Current Risk Score

The risk score has been increased from 12 to 16 due to the changes in the system landscape experienced in Q2. The Trust continues to work well with the Cheshire East Partnership and East Cheshire Trust, however, the decision to bring the Cheshire System together to review its financial challenges and sustainability complicates the landscape and governance introducing potential short term delay.

Links to BAF objectives

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

Key Links to the Organisational Risk Register

TW0003 – Workforce capacity and skill mix to consistently deliver high quality care, seven days a week	**20**	TW0002 – Long Term Financial Sustainability of MCHFT	**12**
TW0006 - 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 Cheshire System CEOs/AO have created a new system wide meeting to discuss the delivery of the Financial Recovery Plan and also the architecture that will allow the two PLACE plans to deliver alongside the requirement for increased cash releasing benefits across the system. This is embrionic therefore the risk score has increased in the short term until the mechanisms are more developed.

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

At present the key gap is the need for a consistent clear view of how the Cheshire System will deliver its financial recovery in the context of the two PLACE governance structures and emerging Primary Care Networks. The CEO of MCHT is meeting with the CEOs to develop that consistent view over the coming period.

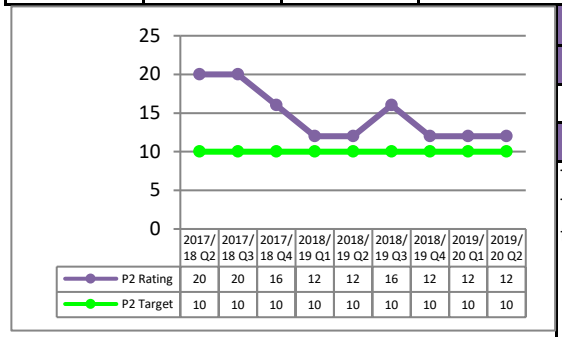
Strategic Domain 2: Being a Leading Partner in a Progressive Health Economy						
P1	**To fully engage with all strategic partners to maximise the opportunities and advantages associated with horizontal integration in the designing and delivery of sustainable health services for the population of Central 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.**					
Key Controls / Influences Established (What are we currently doing about the risk?)	Key Gaps in Controls / Influences (What additional controls should we seek?)	Assurance Providers 2018/19 (How do we know if the things we are doing are having an impact?)			Gaps in Assurances on Controls / Influences (What additional assurances should we seek?)	Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)
		Local Management (1st Line of Defence)	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)		
1. Dedicated Director in place leading on partnerships		• 1:1s • Team Meetings	• Board of Directors • Monthly CEO Update • Monthly CCICP Board minutes • CCICP Annual Review- September 2017		• Scale & pace of change • CEP, Health & Care Partnership for Cheshire & Mersey & ICP will be a challenge	1. Re-launching UHNM / MCHFT Stronger Together Programme
2. BIU to support delivery		• 1:1 • Team Meetings	• Performance & Finance Committee • Board of Directors • Monthly CEO Update	• Internal Audit:	• Scale & pace of change • CEP, Health & Care Partnership for Cheshire & Mersey & ICP will be a challenge	1. Re-launching UHNM / MCHFT Stronger Together Programme

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).**

Principle 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 / NHSI Single Oversight F/w	Executive Director	Executive Management Group	Board Committee
June 2017	June 2019	Sept 2019	Well Led / NHSI – Use of Resoruces	CEO	Board of Directors	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	5	25	4	3	**12**	4	2	**8**	March 2020

Rationale for the Current Risk Score

The risk score remains at 12 as despite the challenges in the wider Cheshire System, the Cheshire East ICP plans are continuing to develop.
The governance remains solid and the partnership board are now beginning to receive more detailed assessments of potential future ICP configuration. The future relationship between ECT, MCHT and Greater Manchester is also clearer.

Links to BAF objectives

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

Key Links to the Organisational Risk Register

TW0003 – Workforce capacity and skill mix to consistently deliver high quality care, seven days a week	**20**	TW0002 – Long Term Financial Sustainability of MCHFT	**12**
TW0006 - 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 Partnership Board and Executive Group are continuing to progress the plans and there is a PLACE programme risk register in use.

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

Director of Strategic Partnerships playing a leading role in development of the Cheshire East Integrated Care Partnership.

Strategic Domain 2: Being a Leading Partner in a Progressive Health Economy	
P2	**To work with all key stakeholders to deliver a wholly integrated health and social care system, taking on clear collective responsibility for resources and population health, so that our residents receive better coordinated care within the designated financial envelope, whilst ensuring:** **- National and regional strategies are implemented.** **- The sustainable use of resources to deliver agreed health outcomes.** **- The development of a collective decision making and governance structure.** **- Sustainable clinical services through the development of Accountable Care Systems (ACS) / Organisations (ACO) and the implementation of new models of care (e.g. Home first principles).**

Key Controls / Influences Established (What are we currently doing about the risk?)	Key Gaps in Controls / Influences (What additional controls should we seek?)	Assurance Providers 2018/19 (How do we know if the things we are doing are having an impact?)			Gaps in Assurances on Controls / Influences (What additional assurances should we seek?)	Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)
		Local Management (1st Line of Defence)	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)		
1. Delivery of transformation & change agendas		• 1:1s • Team Meetings	• Transformation & People Committee (TAP) • Board of Directors • CEO Update • TAP Minutes	• External Well Led review, including CCICP	• Scale & pace of change • Capacity to deliver the CEP, Health & Care Partnership for Cheshire & Mersey & ACO • Relationship building with GP Federations	1. Re-launching UHNM / MCHFT Stronger Together Programme meetings
2. Engagement in Cheshire East Partnership Board and Executive Group	• Currently undergoing review and re-launch	• 1:1s • Team Meetings	• TAP Committee • Board of Directors • CEO Update • TAP Minutes			
3. Engagement in Cheshire East and Cheshire West & Chester Health and Wellbeing Boards		• CEO	• Board of Directors • CEO Update			
4. CCICP Board	• Partner relationships	• 1:1 • Team Meetings	• Board of Directors • CEO Update • CCICP Board minutes	• Internal Audit Programme: CCICP Governance review December 2017		
5. 5YFV Oversight for delivery at C&M level and C&W level	• Governance at C&M and C&W for 5YFV and LDSP is not robust	• CEO	• Board of Directors • CEO Update	• NHS Improvement / NHS England oversight		

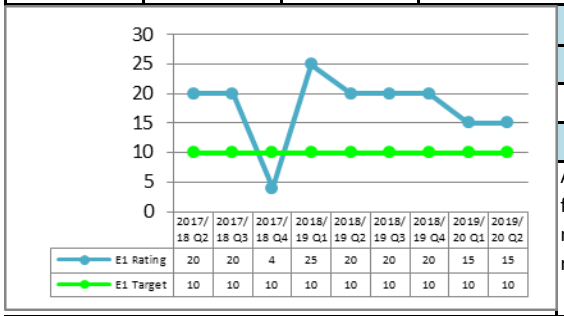
Strategic Domain 2: Being a Leading Partner in a Progressive Health Economy							
P2	**To work with all key stakeholders to deliver a wholly integrated health and social care system, taking on clear collective responsibility for resources and population health, so that our residents receive better coordinated care within the designated financial envelope, whilst ensuring:** **- National and regional strategies are implemented.** **- The sustainable use of resources to deliver agreed health outcomes.** **- The development of a collective decision making and governance structure.** **- Sustainable clinical services through the development of Accountable Care Systems (ACS) / Organisations (ACO) and the implementation of new models of care (e.g. Home first principles).**						
Key Controls / Influences Established (What are we currently doing about the risk?)	Key Gaps in Controls / Influences (What additional controls should we seek?)	Assurance Providers 2018/19 (How do we know if the things we are doing are having an impact?)			Gaps in Assurances on Controls / Influences (What additional assurances should we seek?)	Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)	
		Local Management (1st Line of Defence)	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)			
6. System Financial Executive (CFE), previously referenced as Capped Expenditure Programme (CEP) delivery programme and governance	• New process and governance being established	• 1:1 • Team Meetings	• Board of Directors • CEO Update	• Cheshire East Partnership Board	• Scale & pace of change • Capacity to deliver the CEP, Health & Care Partnership for Cheshire & Mersey & ACO • Relationship building with GP Federations	1. Re-launching UHNM / MCHFT Stronger Together Programme meetings	
7. Dedicated Director in place leading on partnerships		• 1: 1s	• Board of Directors • CEO Update				

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.**

Principle 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 / NHSI Single Oversight F/w	Executive Director	Executive Management Group	Board Committee
June 2017	June 2019	Sept 2019	Well Led NHSI – Use of Resoruces	Director of Finance & Strategic Planning	Divisional Finance & Activity Performance Group	Performance & Finance



Initial Risk Rating (Unmitigated)			Current Risk Rating (Mitigated)			Target Risk Rating (Tolerance/Risk Appetite)			
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Target Date
5	5	25	5	3	15	5	2	10	March 2020

Rationale for the Current Risk Score

At the end of Quarter 2 2019/20 the risk score was reduced to 15. The Trust has agreed a control total with NHSI of £9.2m, which if delivered will secure funding of £7.5m from the PSF and MRET, leaving a deficit of £1.7m. The Trust has agreed a block contract with the local commissioner which makes a material amount of the budgeted income secure. Influencing factors on the ability to deliver the financial plan include any additional costs of delivering required waiting time targets and delivery of CIP targets.

Links to BAF objectives

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

Key Links to the Organisational Risk Register

TW0001 – Delivery of key local and National targets and standards, in particular the 4 hour standard in A&E	20	TW0004 - Registered Nurse staff shortages	16
TW0002 – Long Term Financial Sustainability of MCHFT	12		

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, specifically the STP and IPC work programmes. The Trust underwent a NHS Improvement Use of Resources assessment in March 2018 and has been rated as good. NHS Improvement segment 2 in September 2019, indicating performance is still on track. The Long term (5 year) financial plan has been developed in draft format for the Cheshire system in readiness for final submission in November 2019.

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

- Completion of the Long Term Plan
- Transformation programmes in place including Alternatives to Admissions, Ward Processes (Reducing Length of Stay) and Improving Discharge Processes.
- Performance Management Framework being reviewed.

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.**						
Key Controls / Influences Established (What are we currently doing about the risk?)	Key Gaps in Controls / Influences (What additional controls should we seek?)	Assurance Providers 2018/19 (How do we know if the things we are doing are having an impact?)			Gaps in Assurances on Controls / Influences (What additional assurances should we seek?)	Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)	
		Local Management (1st Line of Defence)	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)			
1. Annual Plan & delegated budgets	• Availability / access to capital funding • Agency spending – medical & nursing • Capped expenditure programme outputs • Long term health economy with clear governance structure	• 1:1 / Team Meetings • Divisional Accountants 1:1s • Monthly Divisional Boards/CCICP reports	• Divisional Finance & Activity Performance Group • Performance & Finance Committee • Internal Audit Reports to: Audit Committee Audit Committee minutes • Board of Directors • PAF Minutes • Annual budget/planning April 2018 • Monthly Performance Report • Corporate Governance Handbook approval December 2018	• NHS Improvement Segment September 2019) (Segment 2 = Providers offered targeted support) & quarterly meetings. • NHS Improvement-submitted annual plans & feedback provided (No actions outstanding) • Funding agreed by NHS Improvement & control total agreed Internal Audit Programme: • Core Financial Controls 2018/19 Significant Assurance Next review-January 2020 • Financial Management & Financial Reporting- Significant Assurance, (September 2017) • Data Quality 2018/19 Significant Assurance with minor improvements required • Risk Management & Corporate Governance Report: Significant Assurance with minor improvements-April 2019 Next review-January 2020 • NHSI Use of Resources Assessment March 2018; rated as Good.		1. Transformation projects continue 2. Follow-up on loan applications for capital spend Awaiting HM Treasury decision. 3. Internal audit programme to be finalised.
2. Identified CIP schemes	Review of CIP planning and delivery						
3. Monthly finance & activity review meetings							
4. Performance management systems	New Performance Management Framework to be reviewed						
5. Job descriptions contain financial responsibilities							
6. CCG Contract		• Recruitment process					
7. CQUIN Schemes & process to deliver		• Monthly CCG Meetings					
8. Monthly Performance Report		• Monthly CCG Meetings					
9. Capped expenditure programme outputs		• 1:1 / Team Meetings • Monthly Divisional Boards/CCICP reports					

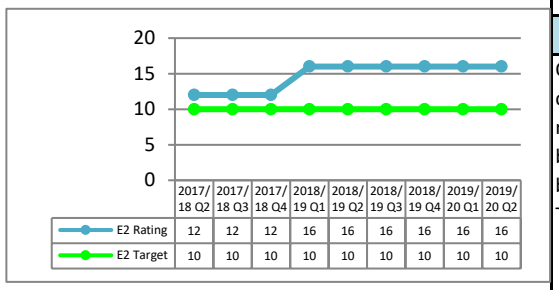
Strategic Domain 3: Striving for Outstanding Organisational Effectiveness							
E1	**To ensure full compliance with the NHS Improvement Provider Licence, ensuring financial sustainability, financial efficiency and financial controls, whilst safeguarding the quality of our services.**						
Key Controls / Influences Established (What are we currently doing about the risk?)	Key Gaps in Controls / Influences (What additional controls should we seek?)	Assurance Providers 2018/19 (How do we know if the things we are doing are having an impact?)			Gaps in Assurances on Controls / Influences (What additional assurances should we seek?)	Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)	
		Local Management (1st Line of Defence)	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)			
10. Treasury Policy			• Divisional Finance & Activity Performance Group • Performance & Finance Committee • Internal Audit Reports to: Audit Committee Audit Committee minutes • Board of Directors • PAF Minutes • Annual budget/planning April 2018 • Monthly Performance Report • Corporate Governance Handbook approval December 2018	• NHS Improvement Segment September 2019) (Segment 2 = Providers offered targeted support) & quarterly meetings. • NHS Improvement-submitted annual plans & feedback provided (No actions outstanding) • Funding agreed by NHS Improvement & control total agreed Internal Audit Programme: • Core Financial Controls 2018/19 Significant Assurance Next review-January 2020 • Financial Management & Financial Reporting- Significant Assurance, (September 2017) • Data Quality 2018/19 Significant Assurance with minor improvements required • Risk Management & Corporate Governance Report: Significant Assurance with minor improvements-April 2019 Next review-January 2020 • NHSI Use of Resources Assessment March 2018; rated as Good.		Review by PAF – Completed June 2019
11. Cheshire system review						PcBC to be completed Transformation funding to support PcBC	

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.**

Principle 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 / NHSI Single Oversight F/w	Executive Director	Executive Management Group	Board Committee
June 2017	June 2019	Sept 2019	Responsive Care & Effective Care NHSI - Operational Performance Metrics	Chief Operating Officer	Divisional Finance & Activity Performance Group	Performance & Finance



Initial Risk Rating (Unmitigated)			Current Risk Rating (Mitigated)			Target Risk Rating (Tolerance/Risk Appetite)			
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Target Date
4	5	20	4	4	16	4	2	8	March 2020

Rationale for the Current Risk Score

Quarter 2 has seen the Trust recover from under performance in RTT and diagnostic standards. For quarter 2 there was full compliance against, RTT and cancer standards, with diagnostics delivering performance in September following the Soliton failure. The Trust continues to be significantly challenged with regards to the four hour access standard and is recording increased attendances at ED with a 10% increase during the first half of 19/20. There have also been challenges in the community to support discharges from hospital. Therefore, occupancy levels across care wards have increased, with additional beds being opened at inflated costs as a consequence.
The Trust has maintained its strong cancer performance through19/20.

Links to BAF objectives

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

Key Links to the Organisational Risk Register

TW0001 – Delivery of key local and National targets and standards, in particular the 4 hour standard in A&E	20	TW0003 – Workforce capacity and skill mix to consistently deliver high quality care, seven days a week	20
TW0002 – Long Term Financial Sustainability of MCHFT	12	CS0375 - Delayed routine outpatient follow-up	15

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

There is a full economy working plan re: ED performance. A review of the 13% increase in ED attendance has been commissioned by the A&E Delivery Board.
RTT performance is above trajectory and expected to deliver above the 92% standard in June 2019. A full investigation is underway regarding 62 day cancer screening. DM01 compliance will be delivered in July 2019.

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

• Partnership working and agreeing actions to support future compliance.

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.**						
Key Controls / Influences Established (What are we currently doing about the risk?)	Key Gaps in Controls / Influences (What additional controls should we seek?)	Assurance Providers 2018/19 (How do we know if the things we are doing are having an impact?)			Gaps in Assurances on Controls / Influences (What additional assurances should we seek?)	Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)	
		Local Management (1st Line of Defence)	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)			
1. Monthly Performance Reports	• External influences on medically fit for discharge patients • Insufficient community capacity • Failure to deliver sustainable GP out of hours service • Increase in working age, low acuity patients attending ED	• 1:1/ 2:1 meetings • Team Meetings • Monthly Divisional Boards/CCICP reports • Monthly Performance Management Group Meetings (DGMs) • Quarterly away days	• Divisional Finance & Activity Performance Group • Performance & Finance Committee • Audit Committee • Board of Directors • Monthly Performance Report • PAF Minutes	• CQC Good rating overall (Responsive: Rated 'Good' September 18 • NHSI Use of Resources rated as Good March 2018 • NHSI Quarterly Meetings • Cancer Peer Review • Monthly CCG Contract Meetings • A&E Delivery Board • 1:1 with NHSI • External audit (MIAA) review of inpatient length of stay and readmissions • HED benchmarking data • External audit RTT compliance • Internal Audit Programme: • CQC Good rating • Monthly CCG meetings • NHSI Oversight		1. Partnership working and agreeing actions to support future compliance in line with ECIST action plan 2. New Front of House senior management team to review breach analysis process and develop SOP. 3. As per ECIST action plan paper which went to TAP Dec 2018 4. Review performance and knowledge at Cancer Board and weekly PMG
2. Breach Analysis Reports / Timely dashboard data	• Ensure robust staff training given to new starters						
3. Urgent Care ECIST actions	• Increase streaming from ED • Implement SAFER • Expand Dom Care pathway 3	• Urgent care Streaming Group • Project meetings • A&E Delivery Board	• Executive Transformation Steering Group • Transformation & People Committee • Board of Directors • Monthly Performance Report				
4. Agreed Relocation Policy across Cancer Network	• Embed changes across the Trust	• PMG weekly meetings • Director of Ops Manchester meeting	• Performance & Finance Committee				

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.**					
Key Controls / Influences Established (What are we currently doing about the risk?)	Key Gaps in Controls / Influences (What additional controls should we seek?)	Assurance Providers 2018/19 (How do we know if the things we are doing are having an impact?)			Gaps in Assurances on Controls / Influences (What additional assurances should we seek?)	Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)
		Local Management (1st Line of Defence)	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)		
5. Use of external providers, locums and waiting list initiatives as required.		• 1-2-1 meetings with DGM's	• Performance & Finance Committee • Transformation & People Committee	• CQC Good rating overall (Responsive: Rated 'Good' September 18 • NHSI Use of Resources rated as Good March 2018 • NHSI Quarterly Meetings • Cancer Peer Review • Monthly CCG Contract Meetings • A&E Delivery Board • 1:1 with NHSI • External audit (MIAA) review of inpatient length of stay and readmissions • HED benchmarking data • External audit RTT compliance • Internal Audit Programme: • CQC Good rating • Monthly CCG meetings • NHSI Oversight		1. Partnership working and agreeing actions to support future compliance in line with ECIST action plan 2. New Front of House senior management team to review breach analysis process and develop SOP. 3. As per ECIST action plan paper which went to TAP Dec 2018 4. Review performance and knowledge at Cancer Board and weekly PMG
6. Implementation of Trust Strategy 2017/2018 & Divisional Plans and actions		• 1/ 2:1 meetings • Team Meetings • Monthly Divisional Boards/CCICP reports • AEMB • CCICP Partnership Board	• Performance & Finance Committee • Audit Committee • Board of Directors • Monthly Performance Report • Transformation & People Committee			
7. Quality Impact Assessment Process	• Divisions to use new process and QIA form as part of planning for 19/20	• 1/ 2:1 meetings • Team Meetings • Monthly Divisional • Boards/CCICP reports	• Medical Director and Director of Nursing & Quality approval of QIAs • CEP Oversight Group • CEP Connecting Care Oversight Group • Board of Directors • Quality, Safety & Experience Report		• Strengthen reporting and monitoring of QIA process	1. QIA Procedure implemented in June 2018. Process to be established.

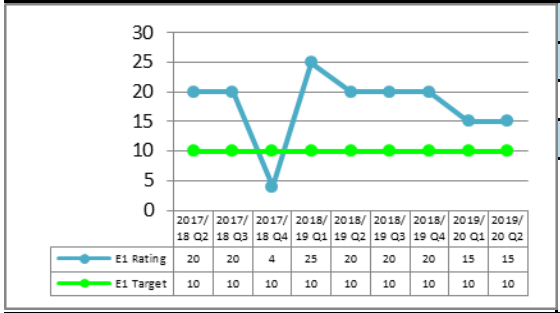
Strategic Domain 3: Striving for Outstanding Organisational Effectiveness						
E2	**To maintain compliance with, and aspire to achieve incremental improvements against, the NHS Improvement Single Oversight Framework Operational Performance Metrics, whilst safeguarding the quality of our services.**					
Key Controls / Influences Established (What are we currently doing about the risk?)	Key Gaps in Controls / Influences (What additional controls should we seek?)	Assurance Providers 2018/19 (How do we know if the things we are doing are having an impact?)			Gaps in Assurances on Controls / Influences (What additional assurances should we seek?)	Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)
		Local Management (1st Line of Defence)	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)		
8. Emergency Planning (EP) & Business Continuity systems and processes with EP/BC Lead	• Ensure that all BCP's have been updated	• Divisional SMT meetings • Desktop exercises	• Emergency Planning Group • Board of Directors • NHSE Emergency Preparedness, Resilience and Response Self-Assessment Substantial Assurance Return-October 2018	• Emergency Preparedness, Resilience and Response NHS England submitted-October 2018	• Business Continuity Plans to be brought up to date	1. All divisions to review BCP's and update by Feb 2019 2. NF to develop plan for full BCP compliance

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.**

Principle 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 / NHSI Single Oversight F/w	Executive Director	Executive Management Group	Board Committee
June 2017	June 2019	Sept 2019	Well Led Framework Use of Resoruces	Director of Finance & Strategic Planning	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 2020

Rationale for the Current Risk Score

The risk score remains a high risk overall at 15 due to long term backlog maintenance requirements, of £43m, and the ability to raise the finances necessary to service these. The Director of Estates and Facilities is a shared post with joint responsibility for East Cheshire Hospital and MCHFT.
There is currently a national over commitment of capital, and all organisations have been requested to reduce their capital commitments by 20%

Links to BAF objectives

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

Key Links to the Organisational Risk Register

TW0001 – Delivery of key local and National targets and standards, in particular the 4 hour standard in A&E	**20**	TW0002 – Long Term Financial Sustainability of MCHFT	**12**

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

The Trust has a clinically led 5 year Estate Strategy. Cheshire East Place has a specific resource which has established an overview estate managed on behalf of community services. This will support the understanding of the current estate infrastructure and future needs as the partners of Cheshire East move towards an Integrated Care Partnership. The main challenge to delivering the internal Estate Strategy is the financial affordability, particularly as the Trust has long term backlog requirements. Much of the community estate is bound by long term lease agreements which add complexity. Estates Strategy in place with Board sign-off. MCHFT has a joint Estate Director with ECT. There are various local and regional estates groups looking at potential collaboration between organisations, these include those led through the STP and ICP programmes of work.

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

Asbestos Management Group – oversight of new contractors in progress.

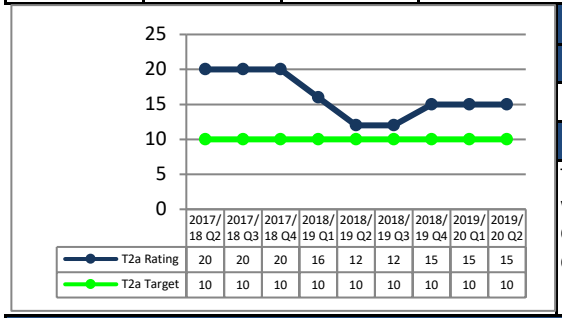
Strategic Domain 5: Creating a 21st Century Infrastructure for Transformative Health and Social Care						
T1	**To deliver an agreed, costed and phased Estates Strategy which will make the best use of the Trust's estate taking into consideration the entire estate across the Central Cheshire system, national and regional agendas and in particular the strategic aim of the system to become an Accountable Care System.**					
Key Controls / Influences Established (What are we currently doing about the risk?)	Key Gaps in Controls / Influences (What additional controls should we seek?)	Assurance Providers 2018/19 (How do we know if the things we are doing are having an impact?)			Gaps in Assurances on Controls / Influences (What additional assurances should we seek?)	Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)
		Local Management (1st Line of Defence)	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)		
1. Estates Strategy in place		• 1:1 / Team Meetings • Estates Strategy Implementation Group • Estates & Facilities Divisional Assurance Framework • Estates & Facilities Divisional Board	• Executive Infrastructure Development Group • Performance & Finance Committee (PAF) Committee audit against ToR and annual workplan Annual report provides auditable evidence of effectiveness • Board of Directors • PAF Minutes • Monthly Performance Report • CEO Update	• New Build Certification	1. Monitoring of Estates Strategy and annual review. 2. Asbestos management / registers	1. Asbestos Management Group – oversight of contractors in progress 2. Over the next five years the (current) plan is to invest some £12.7m of Trust funds and to borrow a further £4.1m for ward refurbishments 3. As at end of 2017/18 £10m of £43m backlog maintenance was deemed significant risk. In 2019/20 £4.5m of this is to be addressed.
2. Backlog Maintenance Plans						
3. Fire Management Improvement Plan		• 1:1 / Team Meetings • Monthly Meetings with Cheshire, Fire & Rescue • Monthly Estates & Integrated Governance meetings		• Cheshire Fire & Rescue (CFR) Audit Programme Sept 2018-Positive Audit Feedback.		
4. Capital programme expenditure agreed annually.		• 1:1 / Team Meetings • Estates & Facilities Divisional Assurance Framework • Estates & Facilities Divisional Board		• NHS Improvement feedback		
5. Asbestos Management Programme	• Asbestos management / registers	• 1:1 / Team Meetings • Asbestos Management Group • Estates & Facilities Divisional Assurance Framework • Estates & Facilities Divisional Board		• NHSI Use of Resources Report, rated as 'Good'		

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.**

Principle 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 with the 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 / NHSI Single Oversight F/w	Executive Director	Executive Management Group	Board Committee
June 2017	June 2019	Sept 2019	Well Led Framework Use of Resoruces	Medical Director / Deputy CEO	Information Technology Strategy 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	5	15	3	2	6	March 2020

Rationale for the Current Risk Score

The risk score remains at 15 for Quarter 2. Longer timescales for the approval of business cases is leading to the potential failure of more systems and withdrawal of support from suppliers. £3M of national funding obtained to support the Clinical Systems Business Case. The Clinical Systems Outline Business Case was presented to the Board of Directors in January 2019 and approved. Outline Business Case approved by Board of Directors at MCHFT and East Cheshire Trust Board and is now under review by NHSI. . Board approved Digital Strategy 2018-2022. EPMA bid shortlisted.

Links to BAF objectives

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

Key Links to the Organisational Risk Register

TW0002 – Long Term Financial Sustainability of MCHFT	12	CS0380 - Cyber Security	16
TW0010 - Legacy Operating Systems Software	16		

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

The main challenge to delivering the DIGIT@LL Technology Strategy is the financial affordability. However 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 Chief Executive. Funding to replace aged hardware across the Trust has been identified, and the replacement has now commenced. The E-Rostering project has commenced and is on track to deliver within timescales. Cyber security across the Trust is being improved the aid of national funding and the appointment of a new cyber security engineer. DSP Toolkit compliance was reviewed by the internal auditors in February 2019, all standards, with the exception of the IG training compliance rate, have been met. Improvement plan is in place to achieve the 95% compliance rate by July 2019. CCICP has gone live with EMIS Community which has been configured specifically to support care communities. There is an appetite to develop this as an NHS Digital blueprint. Trust Board has received independent cyber security training.

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

- Delivery of the overarching Cyber Security implementation plan.

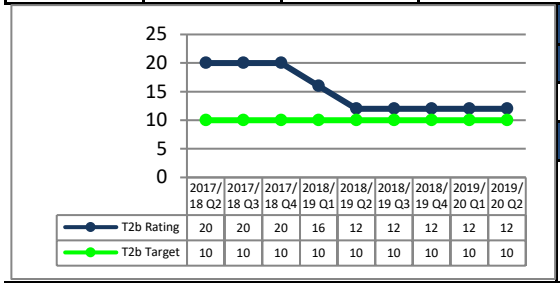
Strategic Domain 5: Creating a 21st Century Infrastructure for Transformative Health and Social Care							
T2a	**To deliver an agreed, costed and phased Information Technology (IT) Strategy which supports the provision of seamless, integrated, outstanding patient care, improves staff experience in delivering care and enables continuous quality and service improvements through the intelligent use of secure, real time data.**						
Key Controls / Influences Established (What are we currently doing about the risk?)	Key Gaps in Controls / Influences (What additional controls should we seek?)	Assurance Providers 2018/19 (How do we know if the things we are doing are having an impact?)			Gaps in Assurances on Controls / Influences (What additional assurances should we seek?)	Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)	
		Local Management (1st Line of Defence)	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)			
1. IT Strategy Aligned with DIGIT@LL Strategy	• Financial affordability • NHSI Review outputs • Appropriate contracts in place	• 1:1s • Team Meetings • Monthly Divisional Boards/CCICP reports • Silverlink to provide on-call assistance to support PACS • Ascribe system – agreement reached with external company to provide ongoing support. • LIMs (pathology system)	• IT Strategy Implementation Group approved strategy • Information Governance Group • Performance & Finance Committee (PAF) • Board of Directors • PAF Minutes • Strategic Outline case approved at PAF December 2017 and Board of Directors January 2018 NHSD July 2018, NHSI October 2018.	• Cheshire & Mersey IT STP Group • National Infrastructure Maturity Level 3 • NHSI / NHS Digital oversight • Internal Audit Programme IG Toolkit 2018/19 Significant Assurance with minor improvement opportunities (Not CCICP) Next review January 2020 • Cyber Maturity Assessment August 2018 Scored 1.58 out of 4 • NHS Digital IT Security April 2018. Issues identified subject to action plan with ITSG • HSLI Digital funding agreed with STP and NHSE	• Monitoring of Strategy and annual review.	1. Overarching Cyber Security implementation plan to be presented to ITSG in February 2019, Bid for EPMA funds from NHSI. Through regional rounds and now at National stage.
2. Revenue & capital costs performance monitored							
3. Data Security and Protection Tookit (MCHFT & CCICP)	• Impacts of General Data Protection Regulations (GDPR) Act – May 2018						
4. Network Infrastructure Maturity Model	• Gap analysis required						
5. SLAs across the Divisions and Corporate Services	• Work in progress						
6. IT Team in place & supporting policies & procedures	• Capacity / capability • Development of workforce						
7. Ten Steps to Cyber Security gap analysis & improvement plan	• Capacity to deliver						
8. GDPR gap analysis and improvement plan	• Capacity to deliver						

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.**

Principle 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 with the 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 / NHSI Single Oversight F/w	Executive Director	Executive Management Group	Board Committee
June 2017	June 2019	Sept 2019	Well Led Framework Use of Resources	Medical Director / Deputy CEO	Information Technology Strategy 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 2020

Rationale for the Current Risk Score

The current risk score has remained at 12 for Quarter 2, on the basis that the Clinical Systems Strategic Outline Case has been approved by NHSI to move to the next step.

Links to BAF objectives

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

Key Links to the Organisational Risk Register

TW0002 – Long Term Financial Sustainability of MCHFT	**12**	CS0380 - Cyber Security	**16**
TW0010 - Legacy Operating Systems Software	**16**		

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

The E-Rostering project is been rolled out across all nursing and midwifery wards. 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 have been established to measure the effectiveness of the training. Digital clinical systems demonstration to raise awareness of digital future. Trust Board has received independent cyber security training. ED now using electronic screen. All consultants have been issued with laptops in readiness for new clinical system. A business case has been prepared for training for healthcare professionals eg: Physiotherapists / Pharmacy Technicians.

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

- Review of job description content Trust wide re digital age
- Recruitment assessment process and underpinning support programme to be introduced.
- Staff availability and identification of relevant staff groups required to attend

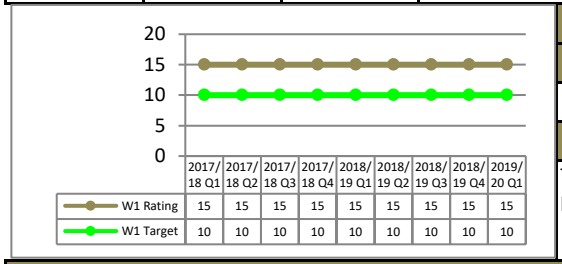
Strategic Domain 5: Creating a 21st Century Infrastructure for Transformative Health and Social Care							
T2b	**To deliver an agreed, costed and phased Information Technology (IT) Strategy which supports the provision of seamless, integrated, outstanding patient care, improves staff experience in delivering care and enables continuous quality and service improvements through the intelligent use of secure, real time data.**						
Key Controls / Influences Established (What are we currently doing about the risk?)	Key Gaps in Controls / Influences (What additional controls should we seek?)	Assurance Providers 2018/19 (How do we know if the things we are doing are having an impact?)			Gaps in Assurances on Controls / Influences (What additional assurances should we seek?)	Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)	
		Local Management (1st Line of Defence)	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)			
1. Digital awareness sessions	• 6/12 programme ongoing	• IT Team Meetings • Staff feedback • Evaluation of training programmes • Appraisal – assurance framework (IT Training Manager objectives) • Monthly Divisional Boards/CCICP reports. • Computer confidence courses are available for all staff • Review of job description content re digital age • Consultant led monthly newsletter for IT. • Identified Divisional champions for IT • Workshops / demos of IT systems. • Consultation with Divisions re: what do they want/need from an EPR. • Monitored by ITSG.	• Learning & Development Group • EWAG • Transformation and People Committee (TAP) • Board of Directors • TAP Minutes			1. Recruitment assessment process and underpinning support programme to be introduced in CCICP. As a pilot site and then to be rolled out across the Trust 2. 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. 3. Review of job description content	
2. Divisional presentations	• Annual programme ongoing						
3. Education programmes in place	• Staff release to undertake the training – impacted by operational pressures						
4. Training campaign - online							
5. Job Descriptions to reflect digital age.	• JDs – planned						
6. Recruitment assessment	• Recruitment assessment – assessment capability required and support programme.						
7. Joint newsletter							
8. Gold champions							
9. Clinical systems train the trainer in place	• QA process required						

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.**

Principle 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 / NHSI Single Oversight F/w	Executive Director	Executive Management Group	Board Committee
June 2017	June 2019	Sept 2019	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 2020

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

TW0001 – Delivery of key local and National targets and standards, in particular the 4 hour standard in A&E	20	TW0003 – Workforce capacity and skill mix to consistently deliver high quality care, seven days a week	20
TW0002 – Long Term Financial Sustainability of MCHFT	12	TW0004 – Registered nurse staff shortages	16

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

Workforce & OD Strategy (Our Workforce Matters Strategy) has been approved by the Board of Directors. 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?)

- Restructure of the W&OD teams is expected in 2019/20 to maximise the ability to deliver the Workforce Matters Strategy
- Workforce & OD Strategy (Workforce Matters Strategy) strategic action plan is in place and monitored through TAP quarterly.
- ESR Systems require significant development to maintain the ability to report workforce metrics accurately and to provide Divisions with up to date workforce data.
- 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
- Training programme to be put in place for the HR team to increase medical workforce and OD knowledge.

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.**						
Key Controls / Influences Established (What are we currently doing about the risk?)	Key Gaps in Controls / Influences (What additional controls should we seek?)	Assurance Providers 2018/19 (How do we know if the things we are doing are having an impact?)			Gaps in Assurances on Controls / Influences (What additional assurances should we seek?)	Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)	
		Local Management (1st Line of Defence)	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)			
1. Trust Strategy 2017 with 2020 Horizon		• 1:1 / Team Meetings • Divisional Workforce Groups • Monthly Divisional Boards/CCICP reports • Consultant Foundation Programme	• Professional Advisory Group • Executive Workforce Assurance Group • Transformation and People (TAP) Committee (Minutes) • Board of Directors • Monthly Workforce Report • Annual Report on the Appraisal and Revalidation of Medical Practitioners at MCHFT-September 2017 • Workforce Race Equality Scheme Annual Review-November 2018 • Strategic Nursing & Midwifery Staffing Review-October 2018 • Monthly Quality, Safety & Experience Report (Nurse staffing) • Medical staffing workforce metrics included in the Workforce Report reported via TAP to Board of Directors • Freedom to Speak Up Guardian Report Quarterly to TAP, annually to Board • Findings from Freedom to Speak Up Review • Staff survey results reported to Board and TAP, and also reported to JCNC	• Sub Regional Workforce Planning and Development Network • Staff Survey March 2018 • Health Education England reviews. ED/Training self-assessment July 2018 • Chester College reviews • Royal College reviews	1. BIU reporting following discontinuation of DISCO reporting 2. Monitored at TAP and EWAG	1. Our Workforce Matters Strategy to be fully implemented. 2. Review of Education Governance complete. 3. Restructure of W&OD team undertaken. Implementation plan in place Q3 2019-20 4. Occupational Health service level agreement and strategic priorities to be reviewed during Q3 2019-20. 5. ESR system project in place Q3. 6. Work to improve data quality. Project plan/business case to improve ESR links compliance. Deliver in 3 to 12 months (March 2020) 7. Talent boards to inform regional and National talent boards. 3 talent boards to have been held by Q3 2019/20 8. Review apprenticeship programme and establish clear links to strategy
2. Our Workforce Matters Strategy implementation	• to be fully implemented	• 1:1 / Team Meetings • Divisional Workforce Groups • Monthly Divisional Boards/CCICP reports					

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.**						
Key Controls / Influences Established (What are we currently doing about the risk?)	Key Gaps in Controls / Influences (What additional controls should we seek?)	Assurance Providers 2018/19 (How do we know if the things we are doing are having an impact?)			Gaps in Assurances on Controls / Influences (What additional assurances should we seek?)	Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)	
		Local Management (1st Line of Defence)	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)			
3. Education Governance Framework	• Framework requires review	• 1:1 / Team Meetings • Divisional Workforce Groups • Monthly Divisional Boards/CCICP reports • Consultant Foundation Programme	• Professional Advisory Group • Executive Workforce Assurance Group • Transformation and People (TAP) Committee (Minutes) • Board of Directors • Monthly Workforce Report • Annual Report on the Appraisal and Revalidation of Medical Practitioners at MCHFT- September 2017 • Workforce Race Equality Scheme Annual Review- November 2018 • Strategic Nursing & Midwifery Staffing Review-October 2018 • Monthly Quality, Safety & Experience Report (Nurse staffing) • Medical staffing workforce metrics included in the Workforce Report reported via TAP to Board of Directors • Freedom to Speak Up Guardian Report Quarterly to TAP, annually to Board • Findings from Freedom to Speak Up Review • Staff survey results reported to Board and TAP, and also reported to JCNC	• Sub Regional Workforce Planning and Development Network • Staff Survey March 2018 • Health Education England reviews. ED/Training self-assessment July 2018 • Chester College reviews • Royal College reviews	1. BIU reporting following discontinuation of DISCO reporting 2. Monitored at TAP and EWAG	1. Our Workforce Matters Strategy to be fully implemented. 2. Review of Education Governance framework complete. 3. Restructure of W&OD team undertaken. Implementation plan in place Q3 2019-20 4. Occupational Health service level agreement and strategic priorities to be reviewed during Q3 2019-20. 5. ESR system project in place Q3. 6. Work to improve data quality. Project plan/business case to improve ESR links compliance. Deliver in 3 to 12 months (March 2020) 7. Local talent boards established to inform regional and National talent boards. 3 talent boards to have been held by Q3 2019/20 8. Review apprenticeship programme and establish clear links to strategy
4. Staff Survey results and action planning	• Delivery of divisional action plans • Feedback from divisions with any changes made. • To be reported to EWAG	• 1:1 / Team Meetings • Divisional Workforce Groups • Monthly Divisional Boards/CCICP reports					

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.**						
Key Controls / Influences Established (What are we currently doing about the risk?)	Key Gaps in Controls / Influences (What additional controls should we seek?)	Assurance Providers 2018/19 (How do we know if the things we are doing are having an impact?)			Gaps in Assurances on Controls / Influences (What additional assurances should we seek?)	Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)	
		Local Management (1st Line of Defence)	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)			
5. Recruitment Policies		• 1:1 / Team Meetings • Divisional Workforce Groups • Monthly Divisional Boards/CCICP reports • Consultant Foundation Programme • 1:1 / Team Meetings • Divisional Workforce Groups • Monthly Divisional Boards/CCICP reports	• Professional Advisory Group • Executive Workforce Assurance Group • Transformation and People Committee • Board of Directors • Monthly Workforce Report • Strategic Nursing & Midwifery Staffing Review-October 2018 • Monthly Quality, Safety & Experience Report (Nurse staffing) • Annual Report on the Appraisal and Revalidation of Medical Practitioners at MCHFT-September 2018 • Workforce Race Equality Scheme Annual Review-November 2018 • Annual Equality & Diversity Report 2018 • TAP Minutes • Multi-Disciplinary Workforce Strategy Group	• Sub Regional Workforce Planning and Development Network • Staff Survey March 2018 • Health Education England reviews. ED/Training self-assessment July 2018 • Chester College reviews • Royal College reviews	1. BIU reporting following discontinuation of DISCO reporting 2. Monitored at TAP and EWAG	1. Our Workforce Matters Strategy to be fully implemented. 2. Review of Education Governance framework complete. 3. Restructure of W&OD team undertaken. Implementation plan in place Q3 2019-20. 4. Occupational Health service level agreement and strategic priorities to be reviewed during Q1 2019-20. 5. ESR system project in place Q3. 6. Work to improve data quality. Project plan/business case to improve ESR links compliance. Deliver in 3 to 12 months (March 2020) 7. Llocal talent boards established to inform regional and National talent boards. 3 talent boards to have been held by Q3 2019/20 8. Review apprenticeship programme and establish clear links to strategy
6. Statutory / mandatory training monitoring	• Data quality						
7. Leadership Development Programmes in place, including Board Development programme	• Talent management & succession planning programme to be embedded						
8. Coaching & mentoring scheme is implemented							
9. Apprenticeship Programmes in place	• Apprenticeship programme linked to overarching Trust agreed strategy for apprentices.						
10. Developing alternative roles i.e. Physicians Associates and Advanced Nurse Practitioners	• Workforce programme						

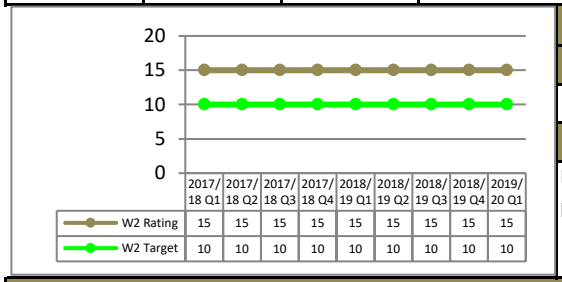
Strategic Domain 4: Aspiring to Excellence in Practice through Our Workforce						
W1	**Our cadre of patient centred leaders will be skilled in continually promoting and building upon our open and honest culture. This will be achieved through sharing the Trust's vision, values, behaviours and objectives from Board to ward.**					
Key Controls / Influences Established (What are we currently doing about the risk?)	Key Gaps in Controls / Influences (What additional controls should we seek?)	Assurance Providers 2018/19 (How do we know if the things we are doing are having an impact?)			Gaps in Assurances on Controls / Influences (What additional assurances should we seek?)	Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)
		Local Management (1st Line of Defence)	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)		
11. Whistleblowing Policy	• Requires update to adopt terminology of 'Freedom to Speak Up'		• TAP			1. Review and update Whistleblowing Policy to adopt Freedom to Speak Up principles and terminology

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**

Principle 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 / NHSI Single Oversight F/w	Executive Director	Executive Management Group	Board Committee
June 2017	June 2019	Sept 2019	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 2020

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 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

TW0003 – Workforce capacity and skill mix to consistently deliver high quality care, seven days a week	**20**	TW0004 – Registered nurse staff shortages	**16**

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?)

- Local development of improvement plans following the National Staff Survey results.
- Talent management & succession planning programme is in place.
- Lack of confidence in the validity of mandatory training data remains a concern.
- Workforce and OD Strategy (Workforce Matters Strategy) strategic action plan is in place and monitored through TAP quarterly.
- Training programme put in place for HR to increase medical workforce & OD knowledge.
- Check and challenge meetings being undertaken with mandatory training SMEs to ensure appropriate course content/learning outcomes/training frequency, to optimise mandatory training offer.

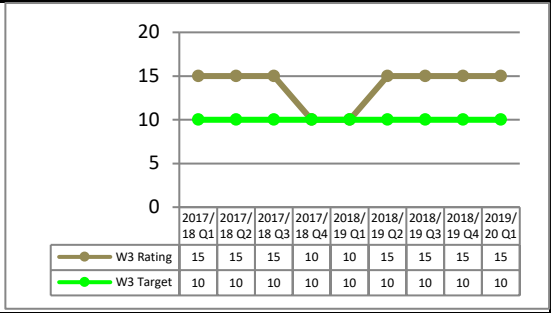
Strategic Domain 4: Aspiring to Excellence in Practice through Our Workforce							
W2	**We will have in place a flexible and responsive workforce to meet patient needs by ensuring:** **- We have sufficient workforce numbers, with the right skills, in the right place, at the right time to meet the demands 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**						
Key Controls / Influences Established (What are we currently doing about the risk?)	Key Gaps in Controls / Influences (What additional controls should we seek?)	Assurance Providers 2018/19 (How do we know if the things we are doing are having an impact?)			Gaps in Assurances on Controls / Influences (What additional assurances should we seek?)	Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)	
		Local Management (1st Line of Defence)	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)			
1. Annual Workforce planning process and Trust Strategy	• Gaps in nursing & medical posts Trust wide • Recruitment plans for key vacancy hotspots • Strategy for advanced practitioners and physician associates	• 1:1/Team Meetings • Divisional HR representatives • Divisional Workforce Groups • Monthly Divisional Boards/CCICP reports • Divisional workforce plans • Guardian of Safe Working	• Learning & Development Group • 7 Day Services Group • Professional Advisory Group • Executive Workforce Assurance Group • Transformation and People Committee (TAP) (Minutes) • Board of Directors • Monthly Workforce Report • Monthly Nurse Staffing Report • Monthly Medical Staffing Update and Consultant Appointments • Annual Nursing & Midwifery Staffing Comprehensive Report due November 2018 • Workforce Race Equality Scheme October 2018 • Guardian of Safe Working Hours Report • Annual Report on the Appraisal and Revalidation of Medical Practitioners at MCHFT- September 2018 • Multi-Disciplinary Workforce Strategy Group	• Sub regional workforce planning and development network • Staff Survey March 2018 • Health Education England reviews • Chester College Reviews • Local Workforce Assurance Board – QA Process • GMC Survey: Junior medical staff – July 2018		1.Review of Education Governance Framework complete. 2. North West Streamlining Programme – now complete 3. Work to improve data quality. Project plan/business case to improve ESR links compliance. Deliver in 3 to 12 months (March 2020) 4. Local development of improvement plans following the National Staff Survey results presented at EWAG. 5. Strategy for advanced practitioners and physician associates as part of workforce planning work 6. BIU and HA working together to strengthen validity of data. 7. Review of workforce and OD, to include both physical and governance structure.
2. Our Workforce Matters Strategy	• Full implementation of Our Workforce Matters Strategy						
3. HR Team & policies & procedures in place	• Capacity gap in HR team						
4. Statutory / mandatory training monitoring	• Release of staff to complete • Data quality						
5. Developing alternative roles i.e. Physicians Associates and Advanced Nurse Practitioners	• Health & Social Care C&M Workforce planning programme						
6. Return to Nursing Practice programmes							
7. Nurse staffing reviews							
8. IT Strategy	• Strategy to be implemented	• Financial affordability	• IT Strategy Implementation Group	• C&M IT STP Group			

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.**

Principle 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 / NHSI Single Oversight F/w	Executive Director	Executive Management Group	Board Committee
June 2017	June 2019	Sept 2019	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 2020

Rationale for the Current Risk Score

Risk score has remained at 15 for Q1, to reflect the work required to implement Our Workforce Matters Strategy, and current sickness absence levels. The situation has clearly improved, however; it is too soon to note that positive trend is embedded.

Links to BAF objectives

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

Key Links to the Organisational Risk Register

TW0004 – Registered nurse staff shortages	**16**	TW0003 – Workforce capacity and skill mix to consistently deliver high quality care, seven days a week	**20**
TW0002 – Long Term Financial Sustainability of MCHFT	**12**		

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.
- Additional resources now identified as part of the annual plan.

Strategic Domain 4: Aspiring to Excellence in Practice through Our Workforce							
W2	**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.**						
Key Controls / Influences Established (What are we currently doing about the risk?)	Key Gaps in Controls / Influences (What additional controls should we seek?)	Assurance Providers 2018/19 (How do we know if the things we are doing are having an impact?)			Gaps in Assurances on Controls / Influences (What additional assurances should we seek?)	Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)
		Local Management (1st Line of Defence)	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)		
1. Our Workforce Matters Strategy 2. HR Team & policies & procedures in place 3. Health & Well Being Strategy implementation/ initiatives 4. Coaching & Mentorship Frameworks 5. Occupational Health Services (Cheshire) 6. Resilience Training & Support 7. Counselling Services 8. Succession Planning 9. Leadership Development Programmes 10. Staff Survey results and action planning 11. Recruitment Policies 12. Absence Management Policies 13. Statutory / mandatory training monitoring 14. Guardian of Safe Working 15. Health and Well-being promotional work 16. Walk in rapid access to physiotherapy (From Oct 18)	• Improvements to address staff survey results • Full implementation of Our Workforce Matters Strategy	• 1:1 / Team Meetings • Workforce Performance Groups • Divisional Staff Survey improvement plans • Divisional Workforce Groups • Monthly Divisional Boards/CCICP reports • Monitoring trajectories for Flu vaccination	• Learning & Development Group • Health & Well Being Group • Professional Advisory Group • Executive Workforce Assurance Group • Transformation and People Committee • Board of Directors • Monthly Workforce Report • Quarterly Guardian of Safe Working Hours Report • Monthly RIDDOR updates • Annual Health & Safety Update-April 2018 • Equality Delivery System Self-assessment: Achieving or excelling-July 2017 • Freedom to Speak Up Guardian Report (March 2018) • Deep dive into sickness/absence levels to TAP • Oversight by JCNC for policy review work plan for all workforce policies	• Sub regional workforce planning and development network • Staff Survey-March 2018= Positive result with 19 out of 32 indicators scoring better than average. HEE Reviews • Chester College Reviews • Safe, Effective, Quality Occupational Health Service (SEQUOHS) Accreditation (July 2017 – 5 year accreditation) • Occupational Health Services rated as Good • Royal Society for the Prevention of Accidents (ROSPA) Gold Accreditation (July 2018-1 year accreditation) • CCG contract meeting CQUIN Health & Well Being Internal Audit Programme • Recruitment 2016/17 Significant Assurance with minor improvement opportunities • IR35 Processes reviewed		• Divisional improvement plans to respond to staff surveys in progress to be embedded. Complete • Full implementation of Our Workforce Matters Strategy. • Initial review of Walk in Rapid Access Physio to be undertaken. Completed – will be reviewed again August 2019. • Staff survey 2018 out for completion. • Staff survey Focus Grouos in place. • H&WB Trust Wide review underway

Appendix A - 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.

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

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

Appendix B - Risk Matrices

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

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

Appendix C - Questions for Board Sub-Committees

Assurance:

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

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

- To what extent are the key controls (i.e. existing controls) effective?
- What are the gaps in the controls, how significant are they in relation to the current risk score?
- What internal assurances and independent external assurances are in place? Are they sufficient / adequate and are there any gaps?

  Are additional assurances required?
- Are there any areas where assurance is duplicated, repeated or excessive when compared to the activity undertaken?
- What actions are there in place to further mitigate the risk to the agreed tolerated level? Are they current and active? Are they adequate? Does more need to be done?

Title of Paper :	Organisational Quarterly Risk Register Report Q2 2019/20	
Author:	Interim Associate Director-Quality Governance	
Executive Lead:	Medical Director	
Type of Report:	Concept Paper	
	Strategic Options Paper	
	Business Case	
	Information	
	Review/Benefits/Audit	✓

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

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

Positive Benefit:	Provides a position statement of the organisational risks for Quarter 2, 2019/20. Detailed report providing assurance of effective risk management.
Risk:	Lack of oversight of key risks to achieving the Strategic Objectives.

To be published on Trust Website – complete version	***Yes***
If no, to be published on Trust Website – redacted	
If not to be published complete or redacted, please detail the reason why	
Presented at Board Meeting of:	2 December 2019

Quality Governance

Organisational Quarterly Risk Register Report

Report date: 01/07/2019 to 30/09/2019

Contents

1. Purpose

The Risk Management Strategy & Assurance Framework 2017/20 (RMS&AF) forms part of the Trust's wider internal control and governance arrangements. It defines the strategy, policy, principles and mandatory requirements for how we manage risks across the organisation. The RMS&AF highlights key aspects of the risk management and assurance process, and identifies the main reporting and escalation procedures. Successful management of existing and emerging risks is critical to the achievement of our strategic objectives. The risk register addresses risk management in four key steps: (1) identifying the risk, (2) evaluating the severity of any identified risks, (3) applying possible solutions to those risks and (4) monitoring and analysing the effectiveness of any subsequent steps taken. The purpose of this report is to provide evidence of this process in practice, and to provide assurance on the effectiveness of our governance arrangements for the management of risk.

2. Current position

In April 2018 the Trust commenced a comprehensive review of its risk management systems and processes, with the aim of developing a web-based risk management system (Risk Web) with supportive education and training. Following a successful pilot with Estates and Facilities Division and the CCICP Division, the new Risk Web application was implemented Trust wide during May 2019

The following details the improvements and developments that have been undertake as a result of the comprehensive review, further work will be undertaken during 2019-20 to fully establish the new system and processes, this work will incorporate recommendations made by KPMG following their audit of Risk Management and BAF internal audit report from 2018/19.

• A full review was undertaken during quarter 4 201819 of the content of the Trust risk register. Following this the organisational risk register was cleansed and revised to focus only on those risks that pose issues for divisional and corporate objectives.

• Quality Governance Managers (QGM) continue to support the new web based system and processes as they embed within Divisions. QGMs received training on the new system and are delivering cascade training for the new system to risk assessors across all Divisions.

• A system of tighter control over risk assessment and how risks are uploaded on to the organisational risk register was implemented. Practice in line with the Risk Management and Assurance Framework is in place: Divisional Boards have oversight and approve risks rated 12 or above for inclusion, and where a risk is rated 15 or above oversight is provided by EQGG before the risk is accepted for inclusion on to the organisational risk register.

• Divisional and organisational risk register reports are now routinely available, and these risk register reports can also be produced automatically at frontline from the Ulysses web-based data management system. Risk register reports can be produced for specialist groups; H&SG, Information Governance Working Group (IGWG) and Infection, Prevention & Control (IP&C). Further development work is underway to develop risk register reports for other specialist groups, such as; Emergency Preparedness Group (EPG) and Executive Workforce Assurance Group (EWAG).

• A Web-based Risk Management System User Guide has been developed and made available across the Trust. Broader education of managers has been undertaken through discussion at management meetings on the development of risk management systems, including; risk assessments, registers and governance arrangements.

3. External / Internal Audit Opinion

External opinion on the Trust's risk assurance framework and systems of internal control is favourable. Deloitte presented their report to the Audit Committee on their 2018/19 audit of the financial statements, within which they reported no significant findings from their observations of the Trust's internal control environment.

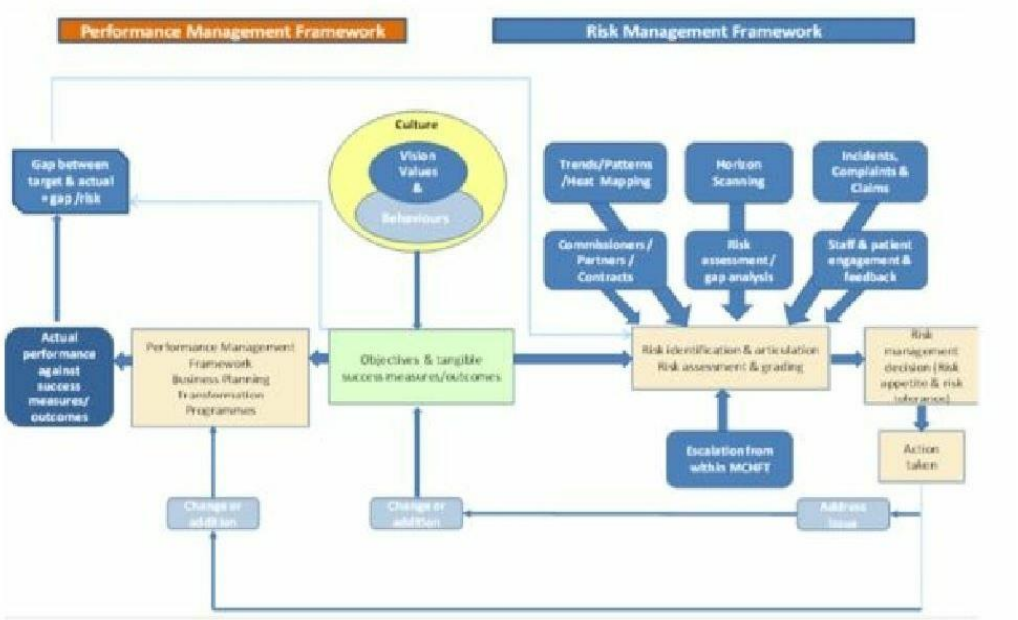
KPMG provided internal audit opinion for 2018/19. The outcome from this audit was 'Significant assurance with minor improvement opportunities'. The audit covered:

• How risks are escalated;
• Identification and central documentation of risks;
• Management and mitigation of risks;
• Design and operation of the Board Assurance Framework.

4. Executive level oversight

Areas of good practice were identified though the KPMG review, along with areas for development. Recommendations were made, and Quality Governance Committee has oversight of implementation of these improvement plans. 4 of the 8 recommendations are complete; the 4 remaining are on track to be delivered by the October 2019 timeframes.

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



5. Progress against the Risk Management Strategy & Assurance Framework (2017/20) Priorities

Progress against the key priorities for 2017/19 is detailed below.

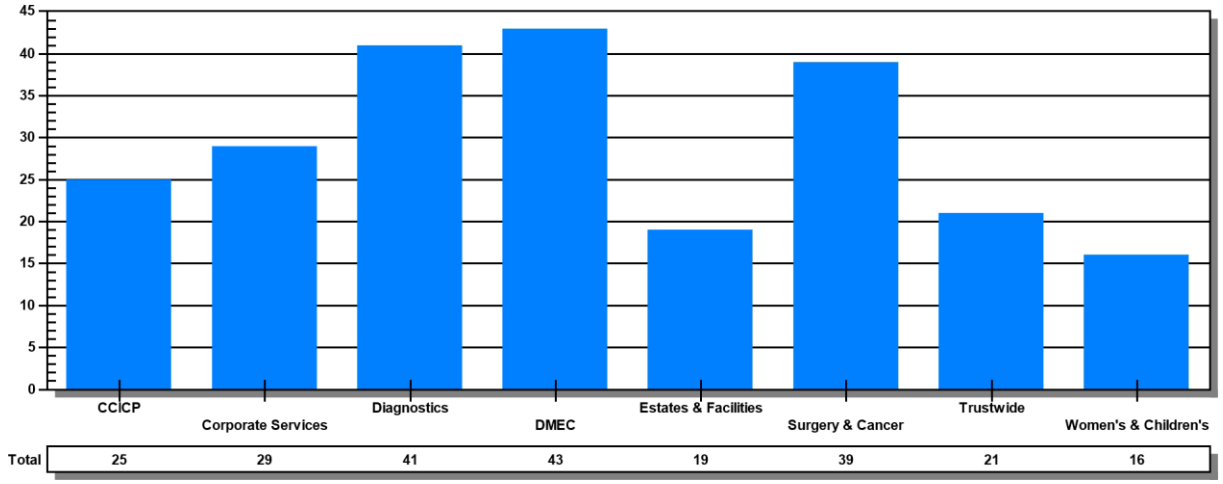
Priority	Key areas 2017/19	Position	Commentary
1. New Risk Management Strategy & Framework 2017/20	• Categorisation matrix review (Part of the Incident Report & Management Policy)	Completed	• Executive Quality Governance Group (EQGG) December 2017
	• Revise Risk Assessment Procedure	Completed	• Planned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

Priority	Key areas 2017/19	Position	Commentary
3. Review of Risk Registers	• Develop sources on web based system	Completed	• By March 2019
	• Undertake TNA for risk management	Completed	• Training to dovetail with web based system by March 2019
4. Governance Structure Group Reporting	• Review the information flows and functions of the groups reporting into the Executive Quality Governance Group.	Completed	• To include as part of the Well –Led Developmental Review in February 2018 with Board oversight in April 2018 by May 2018.
	• Review annually	Completed	• Review March 2019
5. Safety Culture Assessment	• Undertake initial assessment	Completed	• Initial assessments as part of the Well – Led Developmental Review in February 2018 with Board oversight in April 2018. • Trust rolling programme from July 2018
6. Ulysses – Web Based Solution for risk management and improvement planning	• Review of all fields to include controls assurance rating, cost benefit analysis, risk proximity and risk profiling • Education & training programme • Cleansing of all grades of risks • Quality improvement, audit and national guidance gap analysis system to be developed	Completed	• Potential delays due to resourcing issues • Delay in Ulysses provision of improvement / action module • CCICP services will need reconfiguring on the system post change to care groups • Dependency on recruitment process to new Quality Governance Team (Quality Governance Analyst) • This action is included in the risk management internal audit report for completion by March 2018 – **moved to by March 2019**

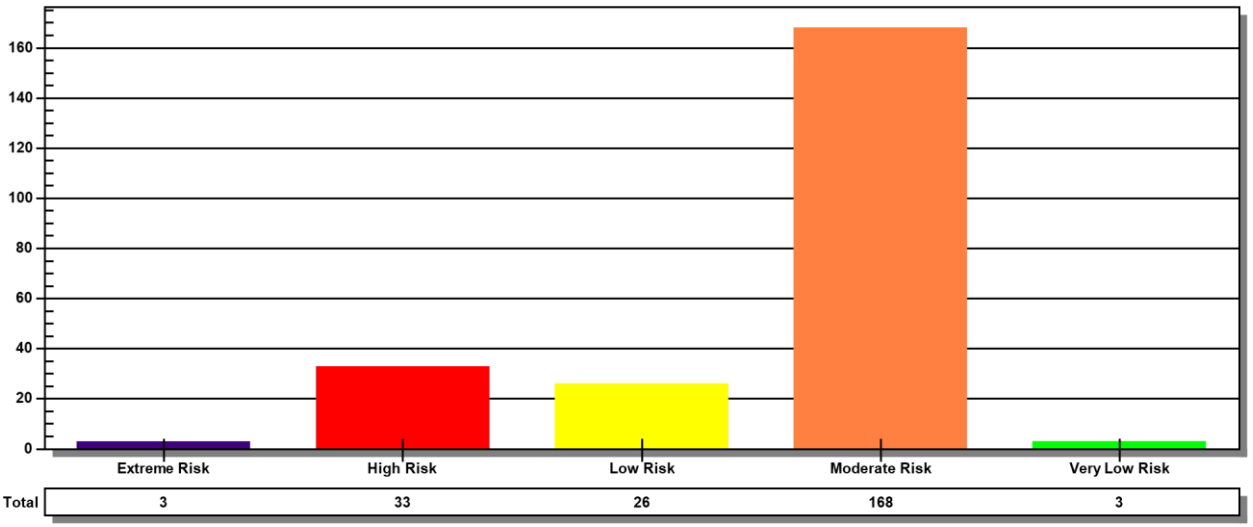
6. Six Key Risks for the Trust in 2019/20

Risk Title	Mitigated (With Controls) Risk Rating	Shift				Key links to BAF 2019/20
		Q1 – 19/20	Q2 – 19/20	Q3 – 19/20	Q4 – 19/20	
Delivery of key local and National targets and standards, in particular the 4 hour standard in A&E	5 (C) x 4 (L) = 20	⇔				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	⇔				Q1, Q2, P1, P2, E2, W2
Lack of space 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	⇔				Q1, Q2, P1, P2, E2, W2, T1, T2a, T2B
The Long Term Financial Sustainability of the Trust	4 (C) x 3 (L) = 12	⇩				E1, E2, P1, P2, T1, T2a, T2B
Cyber Security	4 (C) x 4 (L) = 16	⇔				Q1, Q2, E1, E2, T2a, T2B
The acquisition of South Cheshire Private Hospital	5 (C) x 2 (L) = 10	New				

7. Risk Register Overview Summary - all open risks



The above chart shows a breakdown of the risk register by Division



The above chart shows a breakdown of the risk register by risk rating. Moderate Risk has the highest portion of the register. These are the risks that score between 8 and 12.

8. New risks in quarter rated 15 and above

Ref.	Title	Division	Risk Score	Risk Rating	Target
EF0556	Infrastructure Pipework Failure - Ward 1	Estates & Facilities	16	High Risk	4
SC0636	Lack of surgical capacity for renal and ureteric stones cases	Surgery & Cancer	16	High Risk	12
SC0638	Lack of image capture within the Unisoft system	Surgery & Cancer	16	High Risk	0
TW0023	Patching of CISCO kit	Trustwide	16	High Risk	6
TW0021	Management of adoption health records	Trustwide	15	High Risk	6

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

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

- University Hospitals of North Midlands NHS Trust
- CCICP Partners
- East Cheshire NHS Trust
- Local Authorities

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

10. Summary of the Organisational Risk Register

Extreme Risk

Ref	Initial Date	Title	Description	Controls	Current Rating	Owner	Actions		Target Rating	Progress Update	Next Review Date
							Description	Target			
SC0616	19/10/2018	Histology backlog issues impacted on Endoscopy Services	Risk of adverse outcomes for patients due to histology samples not being turned around within agreed timeframes.	Post endoscopy procedure the case notes are held within Endoscopy Services until the endoscopy report is received and signed off by the Endoscopist/Consultant. A Risk assessment has been developed by Diagnostics and Clinical Support Services which has been escalated to the Executive Team - DC0887 1 speciality grade medical staff is able to report histology outcomes unsupported. 1 speciality doctor and 1 LAS doctor are undergoing peer support to develop the skill of a lone reporter An Advanced Practitioner (AP) has been appointed to support sample dissection. A further Senior BMS in Tissue Dissection has been appointed and is currently undergoing appropriate training to become an AP. 2 Additional pathology staff are undergoing upskilling in the role of dissection. Additional Histology Consultant support is available at weekends via Waiting List Activity. Additional training for Consultant Histopathology staff to support gastrointestinal requirements are under development. Business Continuity activity of access to external Pathology Services for reporting with a 4 day turn around confirmed. External reports have to be copied and pasted into MCHFT systems. Further communication via trust information system.	20 4 x 5	Manager	1 A further Senior BMS in Tissue Dissection has been appointed and is currently undergoing appropriate training to become an AP. 2 2 Additional pathology staff are undergoing upskilling in the role of dissection. 3 Additional Histology Consultant support is available at weekends via Waiting List Activity. 4 Additional training for Consultant Histopathology staff to support gastrointestinal requirements are under development.	1 9/10/2019 19/10/2019 19/10/2019 19/10/2019	8 4 x 2	The risk has been reviewed and no further changes are required at this time.	09/05/2020
TW0001	09/09/2015	Delivery of key local and National targets and standards, in particular the 4 hour standard in A&E	There is a risk that National standards, performance targets and commissioner contractual requirements may not be achieved, as a result of an increasing demand on Trust services, which may lead to regulatory sanction and financial penalties.	1. Corporate governance infrastructure, systems and processes. 2. An Escalation Policy and a number of clinical pathways in place. 3. Performance management framework 4. Monitoring of performance at Trust Board, Audit Committee, PAFC and divisional boards 5. Monitoring of performance by CCG's 6. Quality, Safety and Improvement Strategy 2018/19 7. Fortnightly meetings with DGMs 8. Monthly finance and activity review meetings 9. Daily monitoring and 4 x daily bed management meetings with site reports populated 7 times a day 10. Weekly performance review meeting (PMG) 11. Breach analysis weekly 12. Urgent care steering group 13. A&E Delivery Board 14. Horizon scanning, agility and ability to respond 15. RTT Task and Finish group and action plan 16. Quarterly elective capacity and demand internal meetings 17. Cancer Performance Management (PTL) Meetings 18. Annual Capacity and Demand Planning Process 19. Cancer Board 20. Cancer Task & Finish Group 21. Development of the perfomance management framework	20 5 x 4	Chief Operating Officer	1 Complete and implement Risk Management Systems Review	31/03/2020	10 5 x 2	13/08/19 Risk reviewed and updated accordingly	11/11/2019
TW0003	24/09/2015	Workforce capacity and skill mix to consistently deliver high quality care, seven days a week	There is a risk that patients may not receive timely, high quality care, as a result of a failure to provide adequate numbers of staff with the appropriate skills seven days a week, which may lead to an adverse impact on patient safety, patient experience and clinical outcomes.	1. Recruitment to additional Consultant posts in the major acute specialties. 2. Divisional business cases in development to support the expansion of Consultant numbers to deliver the Seven Day Services Clinical Standards 3. Annual review of Consultant job plans to increase on site "out of hours" Consultant presence where pos 4. Recruitment to additional roles (e.g. Advanced Nurse Practitioners) to supplement the "out of hours" clinical medical workforce. 5. Critical Care Outreach Service available 24/7 6. Development of the Acute Care Model for inclusion in the potential investments for 2019/20 7. Prompt access to diagnostic services, including medical imaging and pathology. 8. Implementation of NEWS2 9. Policy for Adult In-patient Vital Signs and NEWS2 Monitoring 10. Advancing Quality programme. 11. Development of clinical pathways with external partners to ensure that patients receive appropriate, high quality care "out of hours" (e.g. stroke thrombolysis with the University Hospitals of North Midlands). 12. Engagement in the Getting It Right First Time (GIRFT) national programme - ongoing 13. Quality governance infrastructure, systems and processes. 14. Patient Safety Summit 15. Seven Day Services Steering Group 16. Deteriorating Patient Steering Group 17. Implementation of the Structured Judgement Review process to review in-patient deaths 18. Quality and Safety Improvement Strategy 2018/19 19. On-call rotas for Executives and clinical support services (e.g. Pharmacy) 20. Trust Escalation Policy 21. Bank and agency staffing arrangements	e 20 5 x 4	Consultant	4 Implementation of lessons learned from SJR process 5 Explore the opportunities for closer clinical collaboration with East Cheshire Trust	31/03/2020 31/03/2020	10 5 x 2		12/12/2019

10. Summary of the Organisational Risk Register

High Risk

Ref	Initial Date	Title	Description	Controls	Current Rating	Owner	Actions		Target Rating	Progress Update	Next Review Date
							Description	Target			
CS0380	19/10/2018	Cyber Security	There is a risk that essential ICT functions may be impaired and services affected, as a result of a cyber-attack, which may lead to an adverse impact on patient safety and clinical care.	1. IT Starters and Leavers Processes 2. Mandatory Training 3. Physical security access controls 4. Removal media port lockdown for Trust IT equipment 5. Microsoft Patch Management 6. Password complexity for AD 7. VPN 8. Encryption to Trust owned device 9. Airwatch for Mobile devices 10. Cyber-security audits - KPMG/NHSD 11. 10 steps to cyber security Action Plan 12. IG Toolkit Compliance 13. Configuration Manager appointed Network is currently monitored by exception 14. Resource required to support software and hardware asset management processes 15. Ensure standard equipment build 16. Configuration management of assets/ process 17. Funding has enabled all equipment over 10 years of age replaced 18. Senior IT Technician - Cyber now in place 19. Overarching Cyber security improvement plan in place and monitored regularly	16 4 x 4	Associate Director Of IT	7 Physical security access audits 14 Develop TNA to assess further internal cyber security knowledge and expertise requirements 3 Port Lockdown on non-IT equipment (for example medical devices) 4 Internal network segmentation 8 NHSD Audit remediation plan completed 11 Conduct regular vulnerability scans on the network 19 IT to complete suite of documents identified in draft policy framework following audit	31/03/2019 31/03/2019 30/04/2019 30/04/2019 31/12/2019 31/03/2020 31/12/2019	8 4 x 2	08/05/19 reviewed and updated with Amy Freeman, outstanding actions remain, owners to be reminded	06/08/2019
DC0887	24/03/2015	Consultant Histopathologist Capacity	There is a risk of increased turnaround times for histology and diagnostic cytology specimens as a result of inadequate numbers of consultants which may lead to delays in diagnosis and treatment with poor outcomes for patients.	Locum Consultants are employed. Consultants to P code and triage cases. Waiting list initiative sessions. External reporting of non-urgent cases. 1 WTE Band 8A Biomedical Scientist Advanced Practitioner and 1 WTE Band 7 (dissector) employed to free up Consultant time.	16 4 x 4	Pathology Service Manager	2 Ongoing recruitment campaign for substantive Consultants. 3 Training given to Pathology staff in additional procedures. 1 Joint recruitment process with University Hospital of North Midlands (UHNM): International recruitment being undertaken. 5 Explore opportunities to transfer work via Pathology Network to UHNM.	31/03/2020 31/07/2019 28/02/2019 / /	8 4 x 2		15/10/2019
DC1010	05/03/2018	Breast Care Unit & Screening Programme	There is a risk that patients may not receive breast imaging in a timely manner, as a result of a shortage of radiologists and radiographers with an interest in breast imaging, which may lead to an adverse impact on clinical outcomes for patients following referral to the breast symptomatic / 2 week wait service.	1. Introduction of Ultrasound only session 2. Divisional recruitment and retention strategy in place 3. Reporting insourcing by Substantive Consultants 4. External dual reporting for MRI images (high risk patients) 5. Locum Radiologist employed 6. Locum Radiographic Consultant employed on a sessional basis 7. Weekly monitoring of compliance with QA/Cancer standards 8. Substantive Radiologist undertaking in-house training	16 4 x 4	Manager	1 Recruitment to all vacant posts 2 2. Extend working day for screening services 3 3. Increase capacity in core hours in line with surgical teams 4 4. Improve access to all patients referred to the Breast Unit 5 5. Increase funding from Public Health England to support recruitment of radiographic staff 6 6. Alternative Partnership to be agreed to support National Service specification compliance	30/06/2018 30/06/2018 30/06/2018 30/06/2018 / /	4 4 x 1	The Unit is now better staffed as both radiographer posts have been recruited to and a locum Consultant Radiologist has also been appointed. Talks are ongoing with East Cheshire Trust regarding merging the services and the proposed date for this is April, 2020.	02/10/2019
DC1032	05/03/2018	Control of the backlog of patient's awaiting routine follow up in Dermatology	There is a risk that there is a delay to follow up reviews as an Outpatient as a result of increasing numbers of patients being added to the backlog list which may lead to an adverse impact on patient care and experience.	1. Clinical review of the longest waiting patients to appropriately prioritise appointments 2. Separate two week wait lists 3. Nurse led Biologics lists for Cancer pathway/high drug patients 4. Ensure all clinics are maximised 5. Service closed to out of area referrals 6. 2018/19 follow-up capacity increased by 1,000 slots	16 4 x 4	Deputy Divisional General Manager	1 Ensure all clinics are maximised to avoid loss of vital capacity 2 Validate the waiting list for duplicates and for those patients who have been seen since their follow-up due date 3 Increase follow-up capacity as consequence of reduction in GP referrals 4 Telephone consultations 5 Waiting List Initiatives 6 Recruitment of a fifth Consultant Dermatologist 7 Recruitment of an additional Dermatology Specialist Nurse	31/03/2019 31/03/2019 31/03/2019 31/03/2019 31/03/2019 31/03/2019 31/03/2019	8 4 x 2	Validation is continuing, firstly by a Consultant and followed up by Administration who then contact the patient to ascertain the need for an appointment. Some long term follow-ups are also being outsourced. A slight reduction has been seen.	27/08/2019

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High Risk

Ref	Initial Date	Title	Description	Controls	Current Rating	Owner	Actions		Target Rating	Progress Update	Next Review Date
							Description	Target			
EC0397	19/06/2017	Risks associated with inadequate Staffing levels on ward 5	There is a risk that patients may not receive timely, high quality care as a result of low staffing levels on ward 5, which may lead to an adverse impact on patient safety, experience and outcomes.	1. On-going recruitment- international recruitment 2. Daily staffing review undertaken by the Matrons within the Division. 3.Ward escalation to Matrons when gaps present in rota. 4.Ward Managers within the Division review off duty to review the skill mix. 5.Use of Nurse Bank and Agency staff. 6.Implementation of Pharmacy technician role within ward 5. 7.Safety huddles. 8. Involvement of Critical Care to facilitate NIV where appropriate. 9. Implementation of the TNA role on ward 5.	16 4 x 4	Matron	1 Ongoing recruitment. To be reviewed at Respriatory Sub-Divisional Governance in March 2020.	31/03/2020	4 2 x 2	Updated action and control measures but the risk rating has remained the unchanged.	21/01/2020
EC0399	12/09/2017	Increased patient dependency when caring for 4 dependent Respiratory patients, which may be a combination of Non Invasive Ventilation and Tracheostomy patients	There is a risk of patient harm as a result of increased patient dependency/acuity when 4 dependant respiratory patients, who may require complex intervention e.g. Non Invasive Ventilation or Tracheostomy patients, are nursed on the ward when there are significant nursing vacancies or unavailable beds, which may lead to adverse clinical outcomes for patients.	1. If no NIV beds are available a referral will be made to a Critical Care Registrar/Consultant to see if they can take the patient. A review of patients currently on NIV on Ward 5 may also be undertaken as one of these patients may be a more appropriate Critical Care transfer. Critical Care operational policy has this stated within it and the SOP for ward 5 also refers to the option of Critical care when capacity / staffing / equipment is rendering no further beds. 2. On-going recruitment. 3. Daily staffing review undertaken by the Matrons within the Division (this may be done more often throughout a day dependant on staffing and acuity). 4. Ward escalation to Matrons when gaps present in rota. 5. Ward Managers within the Division review off duty to review the skill mix. 6. Use of Nurse Bank and Agency staff. 7. Safety huddles completed daily with Medics. 8. Involvement of Critical Care to facilitate NIV where appropriate. 9. Daily assessment of the ward acuity. 10. Selected location for NIV and tracheostomy patients to be nursed - will be cohorted if possible. 11. Critical Care Outreach Service (CCOS) referrals. 12. Trust EWS Escalation Guidelines.	16 4 x 4	Matron	1 New NIV machines to be bought for the Ward to replace the older machines 2 Training on the new NIV machines to be undertaken for all staff 3 A service review is required. The review should consider (amongst other things) the delivery of the service, step down/ ceilings of care, Consultant to Consultant escalation, the number of NIV machines within the Trust, contingency plans if high numbers of NIV patients are in the Trust and escalation / transfer processes.	28/02/2019 28/02/2019 31/01/2020	6 3 x 2	Risk reviewed and remains unchanged due to number of vacancies currently on ward 5. There is a plan for the vacancies which includes TNAs and international recruits. There is currently a service review underway being lead by the Matron for Critical care.	30/01/2020
EC0438	29/03/2019	Lack of service provision within Rheumatology	There is a risk that patients may not receive timely and appropriate care as a result of Consultant vacancies within the Rheumatology Service which may lead to major harm to patients	1. Closed off external referrals in to the trust (out of area patients) 2. Use of Agency Locums 3. Waiting List initiatives to meet demand and manage risk 4. SHS (extremal recruiting company) undertaking additional clinics 5. Out to recruitment for a B7 physician associate (12 month fixed term) 6. Pharmacist to increase hours to full time to give additional clinic capacity 7. Clinical harm review 8. Pharmacist increased hours in Sep 2019 9. SHS (External Resourcing) working at weekends since Aug 2019	16 4 x 4	Manager	1 Secure locum position 2 Explore partnership working with other specialties within the Trust - Physician Associate 3 Explore partnership working with other specialties within the Trust - Substantive Post recruitment	31/03/2020 31/01/2020 29/02/2020	8 4 x 2	Approved at EQGG with minor changes to actions and controls	17/12/2019
EC0440	11/09/2019	Risks associated with insufficient Coronary Care Unit (CCU) covered nurses providing ALS support should there be a cardiac event in the CCU	There is a risk that a cardiac event, including patients being monitored via telemetry, will be missed on CCU as a result of a lack of covered nurses to staff the CCU as of October 2019 which will impact the service delivery to Cardiology patients which may lead to adverse clinical impact on patient care/safety.	Rota planning to ensure existing covered staffs annual leave Support to CCU from ACP / Cardiac Rehab Staff / Critical Care Succession planning constantly of staff as part of a progression plan Daily consultant CCU ward rounds Robust review of telemetry patients in CCU and other areas Clear training plans including ALS and in house delivery Pull in ACP's for support	16 4 x 4	Matron	6 A paper to the Executives is to be produced to set out the risk and the actions that are required to ensure a safe service can be maintained. 7 Telemetry standard operating procedure (SOP) to be updated 1 Three members of staff currently on ALS training to complete the course 2 Newly trained ALS staff to ensure time is spent in CCU to make sure they have gained appropriate competencies for CCU. 3 Registrar to provide ECG training to all relevant staff, including covered nurses. 4 Consideration of incentives for staff that work above their current role as a covered nurse at short notice 8 Consideration of a long term appropriately trained CCU nurse from an agency 5 A review of the existing workforce (including ACP, Cardiac Rehab and Critical Care) to take place to see how the CCU can be supported	30/09/2019 31/10/2019 31/10/2019 31/12/2019 31/12/2019 30/11/2019 31/10/2019 31/10/2019	2 2 x 1	Risk reviewed following presenting at EQGG. Control measure and actions updated.	23/01/2020

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High Risk

Ref	Initial Date	Title	Description	Controls	Current Rating	Owner	Actions		Target Rating	Progress Update	Next Review Date
							Description	Target			
EF0505	23/01/2019	Loss of Mechanical Infrastructure and Associated Resources: Leighton Hospital	There is a risk that utility pipeline equipment (expansion bellows, valves and actuators ect) connected to the Trust water, steam, or heating system may fail as a result of age, condition and no PPM(Including the regular exercising of valves) being carried out on which may lead to one of the major distributed services being unavailable within wards & departments?	Ongoing replacement programme in place Reactive 24/7 Estates maintenance staff on site Trust staff report new issues via Estates Helpdesk for further investigation/action Planned and "ad hoc" removal of asbestos from identified areas ongoing in order to allow isolation of fa ult valves/components for replacement or repair.	16 4 x 4	Head Of Estates	1 Continued repair or renewal of all existing valves/components etc. to be completed during refurbishment programme Planned Preventative Maintenance schedule for the inspection and maintenance of all valves/components (after asbestos has been removed).	23/01/2020	4 4 x 1	Replacment programme still ongoing, further specific RA written to identify risks within ward 1 of infrastructure failure (EF0556)	18/11/2019
EF0556	16/07/2019	Infrastructure Pipework Failure - Ward 1	There is an increased risk that the incoming domestic hot water pipework (located above the ceiling tiles) feeding ward 1 could fail and would be unable to be repaired as a result of no access being allowed above ceiling height in certain locations on ward 1 due to the existence of asbestos material. Therefore should the leak be a serious one it would warrant the isolation of the water to prevent further damage or injury, this in turn will lead to a complete loss of hot water to both ward 1 & 9 (as ward 9 fed from same pipework).	Experienced maintenance staff on site 24/7 Ability to repair leaks in non-asbestos areas Ability to isolate completely the main incoming water to ward 1 (but also ward 9).	16 4 x 4	Head Of Estates	1 1.Decant part or all of ward 1 to allow asbestos removal and subsequent replacement of old pipework. 2 2.Prioritise Ward 1 refurbishment 3.Consideration to be given to refurbishing wards 1 & 9 together to lessen impact of isolation of shared services. 3 4.Replace pipework within Ward 1 (can only be actioned once action 1 above has been completed)	19/07/2022 19/07/2022 19/07/2022	4 4 x 1		23/10/2019
PG0305	22/05/2019	Chaperone availability in community paediatrics	There is a risk that MCHFT community paediatricians are unable to fully comply with guidance of having a chaperone present for intimate examinations of children, due to lack of availability of staff to perform chaperone duties, which may result in noncompliance with Trust and national guidance with inappropriate people conducting chaperone duties and allegations of inappropriate intimate examinations being conducted on children by staff.	Reliant upon staff being available in a clinic - if they may be released from their clinic duties. Utilisation of Social worker Utilisation of parents if appropriate.	16 4 x 4		3 3. Contact School Nursing Team to request assistance for the provision of a chaperone as required for examinations conducted in Special Schools. Confirm the arrangement in writing. 6 6. Reconfigure all clinics to form a cluster for each area to reduce the number of chaperones required 7 7. Produce a Business Case to secure funding for the required number of Band 2 Clinical Assistants required to assist in chaperone duties, following the reconfiguration of clinics and staff review 8 8. Once Business case approved, recruit required Band 2 Clinical Assistants to vacant posts. If not approved review staffing allocation and clinic reconfiguration to ensure that intimate examinations are only conducted at clinics where a there are permanent chaperone assistants available. 9 9. Remove the wording "wherever possible" from the chaperone policy, as previously requested by Consultant Paediatrician as it has been decided that for safeguarding of children/young people and staff a chaperone should always be present.	30/09/2019 30/10/2019 30/11/2019 28/02/2020 30/12/2019	4 4 x 1		20/01/2020
SC0535	30/11/2014	Insufficient staffing within Inpatient locations	There is a risk that there may be insufficient registered nursing staff within the surgical inpatient locations, to fully meet the needs of patients, due to a high vacancy factor. This may lead to adverse patient outcomes.	1. Minimum staffing levels agreed within division for inpatient locations. 2. Escalation of staffing issues to designated divisional co-ordinator 3. Escalation to Clinical Site Manager or Hospital at Night Team out of hours 4. Escalation to Senior Manager on-call if remains a risk/patient safety issue 5. Local, divisional review of all staffing incidents, reported via the incident reporting system, with wider corporat oversight 6. Two whole time equivaalent staff were offered and accepted posts at the Feb. 2019 Recruitment day to start in May 2019. 7. The organisation has decided to proceed with the option of internal recruitment of Registered Nurses to support MCHFT vacancy gaps. 8. UK adaption program due to complete end 2019 which should generate x5 Registered Nurses	16 4 x 4	Head Of Nursing	4 Utilising the investment agreed at Executive level to support the introduction of 12 hour shift patterns in to the Surgery & Cancer Division 7 There is Executive agreement to utilise registered agency nursing staff when staffing levels have reached a critical point via an agreed escalation process 5 Offer and support existing and new staff the opportunity to work their contracted hours in a more flexible way, therefore addressing the current challenges relating to the recruitment and retention issues 9 The Director of Nursing has introduced a multidisciplinary clinical workforce group to address the recruitment and retention challenges that the organisation must overcome; ? Ongoing recruitment ? Supporting Transition Into Acute Roles ? Return to Practice ? UK adaptation programme ? Rotational recruitment ? Trainee Nursing Associates/Nursing Apprenticeships ? Allied Health Professionals ? International Recruitment 10 Successful recruitment to registered nurse vacancies within the division.	30/09/2019 31/10/2019 23/01/2020 23/01/2020 23/01/2020	8 4 x 2	Risk reveiwed and additional control measure relating to UK adaptation program included.	22/12/2019

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High Risk

Ref	Initial Date	Title	Description	Controls	Current Rating	Owner	Actions		Target Rating	Progress Update	Next Review Date
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SC0605	23/01/2018	Endoscopy Capacity	There is a risk of insufficient endoscopy capacity as a result of vacant posts wit in gastroenterology, general surgery and non-medical Endoscopist roles which may lead to failure to meet expected treatment timeframes, impact on the NHS operating framework and JAG accreditation. There is an escalation of the risk during August 2019 due to 3 of the 5 consultant gastroenterologists being on AL (1 agency, 1 was pre booked leave prior to commencing with the Trust). There is also an increased pressure on the remaining team due to the capacity issues of the implementation of a new testing kit (FIT) in the Bowel Screening Service necessitating additional sessions to meet the increase in demand. This will impact on the number of endoscopy sessions/slots available for: Complex therapeutic procedures - clinically urgent and cancer suspect/confirmed Emergency inpatient procedures Bowel screening Supervision of non-medical endoscopists and trainees There may be urgent, routine and surveillance breeches due to reduced sessions available There is a risk of insufficient endoscopy capacity as a result of vacant posts in gastroenterology, general surgery and non-medical Endoscopist roles which may lead to failure to meet expected treatment timeframes and the potential to impact on the NHS operating framework and JAG accreditation.	1. Replacement capacity created by on-going Waiting List and locum sessions using vacancy and non-recurre funding. 2. Additional capacity from a combination of temporary, fixed term and permanent sessions. 3. JAG operating standards which outline compliance levels to achieve accreditation. 4. Support in place with partnership arrangement with neighbouring Trust (UHNM) 5. Nurse Endoscopist vacancy has been appointed to. In addition 2 nurse endoscopists have been supported t 'retire and return' on reduced hours to retian their skills, knowledge and experience within the department 6. Endoscopist work plan which identifies the activities that should be undertaken that week. On-going robus management of capacity by Endoscopy Service. 7. Gaps in staffing are escalated to the Endoscopy Service Manager and Medicine & Emergency Care Servic Manager covering gastroenterology for further action 8. Unresolved service issues are escalated to the S&C and DMEC Divisional Senior Management Team 9. Activity and forecasted gaps are discussed at weekly planning meeting 10. Training programme in place for existing staff to increase numbers of competent Endoscopists to undertake colonoscopy and therapeutic procedures.	16 4 x 4	Manager	1 Recruitment plan for the 3 vacant substantive Consultant Gastroenterologist posts to bring a total of 5 which is the funded establishment or consider long term locum support if substantive recruitment is not successful 5 Consider long term locum support if substantive recruitment is not successful 6 Recruitment of substantive Consultant Surgeon to remaining vacant post or consider long term locum support if substantive recruitment is not successful 7 Recruit to an additional Nurse Endoscopist post using vacant hours	31/03/2020 31/03/2020 31/03/2020 31/03/2020	8 4 x 2		30/11/2019
SC0618	19/10/2018	Bowel Cancer Screening - Introduction of FIT to the Programme	There is a risk that the Bowel Cancer Screening team will be unable to deliver the Faecal Immunochemical (FIT) Screening Programme as a result of lack of capacity and resources which may lead to breaches in the screening programme and adverse clinical outcomes.	Current Control Measures for the gFOBt Programme: Lack of capacity leading to loss of service and non-compliance with the wait time targets outlined within the NHS Operating Framework and Cancer pathway resulting in the risk of the Trust not maintaining the Joint Advisory Group (JAG) and Bowel Cancer Screening Programme. 1. Colonoscopy Capacity at all sites to ensure availability of sessions and slots to reduce the number of breache within the programme. 2. Incorporating additional capacity for the Implementation of the FIT across all sites, additional clinic and colonoscopy capacity. 3. Working with Partner Trusts to attempt to recover plan if required. 4. Reviewing alternative solutions. Financial risk to the Trust of not achieving the objective of the FIT programme and the continuing implementation of the plan for Bowel Scope Screening (BoSS) Programme in 2018/19. Risk to the continuation of existing sessions. 1. Endoscopist work plan which identifies the activities that should be undertaken within the SLA 2. Unresolved service issues are escalated to the S&C and DMEC Divisional Senior Management Team 3. Explore if there is any additional capacity during the current year Failing the national targets e.g. rapid access diagnostic wait times due to a lack of endoscopy capacity. 1. Endoscopist work plan which identifies the activities that should be undertaken within the SLA 2. Unresolved service issues are escalated to the S&C and DMEC Divisional Senior Management Team Delayed access to diagnostic and surveillance colonoscopy procedures due to insufficient colonoscopy slots staffed by Screening Colonoscopist's. NB this may be associated with issues relating to the effective management of annual leave / On-call arrangements. 1. Explore if there is any additional capacity during the current year Delayed diagnosis to patients who have had a positive test kit result and attended an SSP Clinic having their colonoscopy procedure appointment. Risk of delays to planned colonoscopy and pathology reporting. 1. Explore if Additional List Initiatives commissioned to support effective patient outcomes and experience c a be funded. 2. All available screening slots are maximised to their full potential. 3. Activity and forecasted gaps are discussed at weekly planning meeting and business meeting. 4. Explore if Additional Waiting List Initiatives commissioned to support effective patient outcomes and experience can be funded at the Trusts 'old rate'. 5. All available screening slots are maximised to their full potential. 6. Activity and forecasted gaps are discussed at weekly planning meeting and business meeting.	16 4 x 4	Support Worker	1 Develop a FIT implementation Group to: All sites to consider plans for the successful implementation and delivery of the FIT Programme to negate the need for waiting lists. For instance: Secure additional Assessment Clinic for those who have a positive FIT test Secure additional Screening Colonoscopy Sessions for those who attend the assessment clinic and wish to go on to screening colonoscopy Secure additional radiology for those who have a positive FIT test but are deemed unfit for screening colonoscopy, have a failed screening colonoscopy, or require staging. Secure additional pathology resource for the additional specimens expected following FIT Implementation. Use of accredited screening Colonoscopist's flexibly and from other sites - COCH, Macclesfield and UHNM Use of accredited screening Colonoscopist's to deliver Bowel-scope Consider reinstating Endoscopy Waiting List sessions at the 'old rates' Create Honorary contracts for additional screening Colonoscopist's to undertake sessions at our sites	30/03/2019	6 3 x 2	The risk has been reviewed and revised.	21/03/2020

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High Risk

Ref	Initial Date	Title	Description	Controls	Current Rating	Owner	Actions		Target Rating	Progress Update	Next Review Date
							Description	Target			
SC0636	23/09/2019	Lack of surgical capacity for renal and ureteric stones cases	There is a risk that patients with renal and ureteric stones who require surgical intervention will be adversely affected as a result of insufficient theatre capacity, which may lead to patent harm occurring. There are 96 patients awaiting stone surgery on the Priority Target Waiting (PTL) list (as of 16/09/19) on either an open 18-week Referral to Treatment (RTT) pathway or a closed pathway. _63 patients on waiting list as Urgent of which only 13 patients have confirmed TCI dates (longest patient waiting time is 304 days / 43 weeks) _33 patients on waiting list as Routine of which only 1 patient has a confirmed TCI (longest waiting time is 282 days / 40 weeks) _20 theatre sessions required to operate on 50 urgent cases awaiting TCI (based on 240 min session) _14.8 theatre sessions required to operate on 32 routine cases awaiting TCI (based on 240 min session)	1. Urology Service Manager / Support Manager monitors PTL (Patient target List) weekly and works with Scheduler to prioritise urgent stone cases 2. Urology planner reflects 6-week forward view 3. Surgical sessions allocated to other Consultants or senior Trainees to cross cover periods of leave 4.Long-waiting patients (on open 18-week (Referral to Treatment Time) RTT pathways) only are monitored through weekly Performance Management Group (PMG) 5. Escalation of symptomatic patients to Consultant 6. Computed Tomography Kidneys, Ureters, Bladder undertaken 72-hours pre-surgery to ensure surgery still required and to enable time to re-schedule another patient to protect theatre time 7. Quarterly sub-divisional review with Divisional Senior Management Team	16 4 x 4	Matron	1 Identify additional theatre capacity to address urgent long-waiters 2 Convert outpatient activity to theatre activity (dropped lists from other sub-specialties) 3 Identify what if any additional funding is required to support additional theatre capacity 4 Submit paper for 6th Consultant Urological Surgeon investment for 2020/21 (annual planning process)	30/11/2019 30/11/2019 30/11/2019 30/11/2019	12 4 x 3		22/12/2019
SC0637	23/09/2019	Lack of Upper Gastrointestinal MDT membership	There is a risk that the Upper Gastrointestinal Multidisciplinary Team will not have the necessary core members present at each meeting to make effective treatment plan decisions as a result of lack of cover for core MDT members e.g. Histolpathology and Radiology, which may lead to unacceptable treatment delays and the clinical outcome for patient's being affected. Local Upper GI Team at Leighton Hospital Self Declaration 2019/2020 - is at 66.7%	Current MDT membership and frequency of attendance follows national guidance (95% of meetings is quorate by core member attendance and / or cover) If the MDT meeting is not quorate and key members are absent patients will be discussed at the next weekly meeting. In the absence of Histopathologist a printed copy of the report is made available for consideration by the MDT and / or the Upper GI MDT lead will liaise directly with the Histopathologist before or after the MDT meeting to prevent treatment planning delays. In the absence of Radiologist there is the ability to discuss cases outside of the MDT. However, this is far from ideal for diagnostic purposes. The Upper GI MDT Lead Clinician will raise poor attendance levels with respective individuals / management teams There are risk assessments developed for gaps with Radiological (DC0785) and Histopathology medical staff(DC0887)	16 4 x 4	Consultant	1 Business continuity plan for cover arrangements for Histopathologist and Radiologist core memberships to ensure 95% attendance for core / cover. 2 Review of current MDT timings to support attendance in absence of core membership 3 Monitor attendance of core members and cover	31/12/2019 31/12/2019 31/12/2019	8 4 x 2		22/12/2019
SC0638	23/09/2019	Lack of image capture within the Unisoft system	There is a risk that the current version of the Unisoft endoscopy reporting system does not fully support the ability to capture and download images as a result of a technical issue not yet fully understood by the supplier which may lead to sup-optimal management of patients having endoscopy procedures. The images form part of the information that is reviewed by the consultant manager to decide on a treatment plan and for case reviews in complex polyp MDT and cancer MDT. The failures are intermittent across the endoscopy clinical rooms (5 rooms) with different endoscopists at different times which has made it difficult to identify the root cause of the problems and hence a solution. Hard copy photos can be taken via the Olympus endoscopy system but are often inferior quality and take time to print; they also cannot be saved onto the electronic report (UNISOFT).	1. Endoscopy capture is installed in all endoscopy rooms the EBME and IT teams attempt to make the system work each time it fails. 2. There is a support team that can be contacted at Unisoft 3. Where consultants need to send cases for complex therapy to external Trusts the images form part of the referral. The endoscopist can take polaroid hard copies but they are time consuming, not available electronically and may not be filed in the patient records	16 4 x 4	Manager	2 Ascertain the associated costs of replacing the current Unisoft system with the latest version and purchase the upgraded wireless system. Unisoft is launching a new generation software and image capture box in the Autumn 6 Review of contract with Unisoft to ascertain the level of support which should be provided against that which is actually currently being received.	31/12/2019 31/10/2019	0 0 x 0		21/03/2020
TW0004	02/01/2013	Registered Nurse staff shortages	There is a risk that patients may not receive timely interventions to address their clinical needs, as a result of a reduced staffing capacity of registered nurses, which may lead to adverse impact on patient safety and clinical outcomes.	1. Trust Escalation Policy with revised staff escalation matrix, includes: Delivery of a daily staffing meeting with the aim of identifying staff to address gaps Consideration given to the use of agency staff following executive authorisation. 2. The Trust has the following 24/7 support services available: Senior Manager On-Call proving advice Clinical site managers Executive on-call 3. Embedded multi-disciplinary clinical workforce group (Consisting of task and finish groups to recruit RN roles and roles outside of the traditional RN recruitment.) This group reports progress to the Executive Workforce Group. 4. Revised and active recruitment of newly qualified nurses, as part of a multi-disciplinary clinical workforce gr 5. Fast tracking of ECF's to reduce delays in the recruitment process. 6. Use of exit interview data to inform retention strategies. 7. Trust promotional information added to job descriptions on NHS Jobs. 8. New ways of job advertising including use of social media. 9. Adverts revised to include set interview days. 10. Set of monthly arranged recruitment days across quarter 2. Those offered posts are then invited to 'Keep in Touch Days' 11. Temporary staffing efficiencies programme, specifically targeted at: Robust recruitment plan in place Efficient rota management, with the implementation of an electronic roster and KPI's to monitor perform a Improved ways of working for hospital bank SBAR tool in place to provide rationale for usage of off-framework agencies Awareness of agency cap and internal trajectory. Transgressions authorised by the executive team are reported to the Transformation and People Committee 12. Set of monthly arranged recruitment days across quarter 3. Those offered posts are then invited to 'Keep in Touch Days' 13. Revision of hospital bank service, including ways of recruitment, registered and unregistered fill rate. 14. Establish a process for collecting data from exit interviews and providing reports to divisional boards for	16 4 x 4	Deputy Director Of Nursing & Quality	5 Develop a marketing strategy for nurse bank 9 Scoping of Registered Nurse Training in conjunction with Health Education Institutes using the apprentice levy 16 International recruitment programme underway for September 2019, although staff will not be clinically in place until September 2020	31/12/2019 30/09/2019 30/09/2020	8 4 x 2		10/02/2020

10. Summary of the Organisational Risk Register

High Risk

Ref	Initial Date	Title	Description	Controls	Current Rating	Owner	Actions		Target Rating	Progress Update	Next Review Date
							Description	Target			
				consideration and action 15. Develop an annual recruitment plan, to include; open days, advertising etc. (including divisions) 16. Divisional CIP to reduce sickness and absence to support the vacancy gap 17. Development of a Health and Welfare Strategy to support retention of staff and the vacancy gap						
TW0006	09/08/2018	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	There is a risk that the Trust and system may not undertake transformational change within the timeframes required to deliver the Cheshire East Strategy as a result of growing demand and increased financial pressures, which may lead to an adverse impact on patient safety, care and experience.	1. Quality, Safety and Improvement Strategy 2. Risk Management Strategy & Framework 3. Patient and Public Involvement Strategy 4. Transformation and change programmes 5. Quality Impact Assessment Process 6. Transformation & People Committee 7. Health and Care Partnership for Cheshire & Mersey 8. Estates Strategy 9. 7 day clinical services 10. Cheshire East Place strategy under development 11. Place Governance in place 12. CEO is a lead for the C&M Acute Sustainability work therefore is able to keep informed and influence 13. Place strategy implemented which will include the development of an Integrated Care Partnership (ICP) 14. Outcomes for the East Cheshire Trust Service Change Proposals	16 4 x 4	Chief Executive	1 ICP organisational form and governance to be developed 2 ICP to be implemented 3 ECT Service Change Proposal. Pre-consultation business case	31/12/2019 30/04/2021 30/10/2019	8 4 x 2	05/06/19 reviewed with Dr Dodds - actions updated. Risk rating remains the same.	03/09/2019
TW0010	12/12/2018	Medical Devices Running Legacy Operating System Software	There is a risk that Trust IM&T systems will fail to function efficiently and effectively, as a result of a cyber-attack targeting unsupported operating systems such as Windows 2000, Windows XP or unpatched medical devices, which may lead to an adverse impact on patient care and safety	1. Patch devices that are managed by ICT Services. 2. Procurement of new systems - DPIA Procedure in place	16 4 x 4	Associate Director Of IT	2 Segment the network to limit the reach of a cyber-exploit. 6 On receipt of medical device asset register migrate devices to new medical devices network	30/06/2020 31/01/2020	8 4 x 2	19/09/19 Work has begun on implementing a medical device network which is segmented from the main Trust network however due to technical issues the completion date for this work is now 30th June 2020	13/01/2020
TW0023	23/07/2019	Patching of CISCO kit	There is a risk of failure of the IT network along with the systems connected to it, within the Trust due to insufficient experience and resources to develop and maintain a patching process of the CISCO network equipment which may lead to a total IT failure which will effect patient care. This risk materialised at UHNM and Liverpool Heart and Chest.	1. New kit is currently being installed but capacity to do this at pace is challenging. 2. New kit being installed is patched as it is deployed however the processes to maintain patch levels is not in place.	16 4 x 4	Associate Director Of IT	1 Ensure all new switches are patched and up to date prior to installation. 2 Request funds from Execs to secure temporary networking resource to complete the network kit deployment. 3 Develop a Case of Need for an Assistant Networking Engineer band 5 to undertake the regular patching. 4 Obtain agreement for a regular patching window to enable downtime to take place when patching is due. 5 Obtain a quote for dual fibre link between the 2 on premise data centres to allow dual running servers to not be affected by switch patching and reboots.	20/09/2019 30/09/2019 30/11/2019 28/11/2019 30/09/2019	6 3 x 2		05/01/2020
DC0160	25/09/2019	Consequences to Medical Imaging patients from the failure of the Virtual Server	There is a risk that imaging, reports and associated data will not be available for patients as a result of the failure of the Virtual Server which hosts Soliton, which may lead to delays in patient diagnoses and treatment with the prospect of patient harm, complaints, claims and reputational damage.	1. Cross-referencing of all associated software packages and systems 2. Prior to each CT scan and plain film, Radiographer checks on PACS for images taken in last 2 weeks and any queries that arise are directed to a Radiologist 3. Bloods are being found in ICE and transferred to Soliton and checks are being made with Radiologists that contrast is necessary 4. Input from Soliton to re-find the end dates for planned surveillance imaging with provision of lists by Cancer Services 5. Provision of additional equipment by IT to scan in request cards 6. Fielding of telephone calls by Switchboard and Customer Care 7. Case by case management of bookings 8. Additional staff resource from Medical Records and IT 9. Single point of contact for Cancer bookings 10. Tactical Incident Room in place with regular update meetings held each day Al previous gaps (below) have been addressed: 1, 2, 3 Potential for human error and missed information 4 Failure to recover end dates despite endeavours of Soliton 1 Lack of critical skill set to aid a swift recovery 5 Finite staffing resource to scan cards and errors made in haste 6 Switchboard and Customer Care unable to answer specific concerns of patients, relatives and carers calling 7 Volume of patient imaging records to be corrected - unknown 8, 9 Wellbeing of staff working in stressful environments 10 Recovery Date unknown due to complexity of the issue Risk Accepted	15 5 x 3	Manager			15 5 x 3	05/11/19 uipdated by Julie Weir. All actions closed risk controlled at 15. Risk not closed as Trust is not yet aware of how many individuals this incident affected and may not know for several years.	05/12/2019

10. Summary of the Organisational Risk Register

High Risk

Ref	Initial Date	Title	Description	Controls	Current Rating	Owner	Actions		Target Rating	Progress Update	Next Review Date
							Description	Target			
DC1025	16/01/2018	CT Scanning Equipment	There is a risk of delay in patient diagnosis, as a result of insufficient CT capacity to meet the demand, which may result in adverse patient clinical outcome.	1. Clinical examination and judgement to priortise CT scanning requirements 2. Outsourcing undertaken where appropriate 3. Maintenance contract in place until March 18 and agreement with manufacturer that post March 18 repairs will be made on a best endeavours basis	15 5 x 3	Director ate Manager	1 Develop and submit a Business Case for a replacement Lightspeed scanner and the procurement of an additional scanner with replacement of the second existing scanner over a three year period.	16/01/2019	5 5 x 1	The Lightspeed scanner has now been replaced with the Aquillion 1 Genesis, which is now scanning patients. The mobile CT unit is being removed tomorrow (02/07/2019).	29/09/2019
DC1044	14/11/2018	Laboratory Information Management System (LIMS) for Pathology - End of Life	There is a risk that LIMS could fail, as a result of Clinisys the supplier, sunsetting (gradual phase out) the LIMS from 2022, which may lead to an adverse impact on clinical outcomes.	1. Upgrade to the latest version of Labcentre i.e. version 1.14 in October 2018. This upgrade includes al National Standards/guidelines to date. 2. Full maintenance/support currently being provided by Clinisys. 3. Visits commenced to other institutions to identify possible replacement LIMS and demos organised with Suppliers.	15 5 x 3	Patholo gy Service Manager	1 Complete Strategic options Case (SOC) and submit to relevant Trust Boards 2 Complete procurement/implementation prior to Labcentre end of Life	31/03/2019 31/12/2022	5 5 x 1	The outline business case was approved by both MCHFT and UHNM Boards for joint procurement. It is now out to procurement, after which the full business case will be written by the end of July 2019 to go to the Boards again in September 2019. The target go-live date is January 2021.	12/01/2020
DC1054	24/04/2019	Cardio-Respiratory Department staffing	There is a risk of delays in diagnosis for patients undergoing investigations by the cardio-respiratory department as a result of a national shortage of appropriately skilled staff (identified in the Getting It Right First Time) which may lead to delays in treatment and harm to patients.	Ongoing recruitment campaign Recruitment & retention policy Waiting list initiatives Use of locum staff until recruitment to substantive post. This will be reviewed every three months	15 5 x 3	Manager	1 Advertise vacancy Continue to liaise with locum agencies Continue with waiting list initiatives Robust management of diaries Upskilling of existing staff 2 Consider outsourcing reporting of ECG monitoring	30/09/2019 30/09/2019	5 5 x 1		23/07/2019
DC1056	23/05/2019	Lack of aseptic service at MCHFT	There is a risk that patients may not receive aseptically prepared products for example, Parenteral Nutrition, Chemotherapy, Monoclonal Antibodies as a result of the temporary closure of the aseptic unit due to adverse environmental trends and on-going computer software problems which may lead to patient transfer to other trusts (Neonatal patient, Macmillan patient) for treatment or a delay in treatment or further work (MAB'S) being prepared at ward level.	All preparation in the aseptic to cease. Enforcement notice received from MHRA stopping manufacture under MS licence. All products must be sourced from external suppliers, Bath ASU, Baxter, University Hospital North Staffords hi	15 5 x 3	Director Of Pharma cy	7 Seek advice from Quality Assurance team at QCNW and Quality Assurance North West regarding action plan 8 Seek advice from MHRA regarding actions and evidence 9 Resubmit licence application (dependent on validation of suitable computer system as well as satisfactory environmental monitoring results)	01/05/2019 01/05/2019 01/05/2019	5 5 x 1		21/08/2019
EC0342	15/06/2015	Failure to Meet Access Targets Across the Specialities within the Division	There is a risk of non compliance with national targets as a result of Consultant vacancies which may lead to financial penalties and adverse clinical outcomes for patients.	> Weekly monitoring of the use of waiting list initiatives > The use of external agencies for virtual clinics > General practitioners with specialist interest to assist with clinics.	15 3 x 5	Divisional General Manager	4 Service reviews taking place in Gastro, Respiratory and Diabetes to look at alternative service models, as demand still outstripping capacity even in those specialties where posts are filled	31/03/2020	10 2 x 5	added a new action with two completed ones closed	17/12/2019
EF0512	23/01/2019	Water Distribution / Temperature	There is a risk of Legionella Pneumophilia bacteria build up within the trust domestic hot water system as a result of water temperatures at the extremities of the site and "A" wards tailing off below 55 degrees Celsius at times of little use. Which may lead to water flow problems likely to be caused by system imbalance due to balancing valves being altered and additional loads on the system?	Chlorine Dioxide dosing of potable raw & domestic hot water Temperature control regime in compliance with ACOP L8, HSG 274 & HTM 04-01 Monitoring & Management as required by ACOP L8, HSG 274 & HTM 04-01 in place Flushing regimes carried out by individual wards & departments Domestic hot water plate exchanger temperature control raised to 62 deg C in order to achieve a minimum 60deg C supply to each ward & department	15 5 x 3	Head Of Estates	1 Ongoing Trust refurbishment programme to include work to balance and ensure flow & return temperatures are greater than 55° C throughout site HW distribution systems (including wards & departments).	23/01/2020	5 5 x 1	Ward 21/22 tender quotes will be reviewd on 2 sep and once contract awrded work will commence	18/11/2019
EF0548	25/01/2019	Critical Risk Adjusted Backlog Maintenance	There is an increasing year on year risk that the building and estate infrastructure will deteriorate beyond repair or fail due to Insufficient funding of the Trust backlog maintenance programme and an Increased use of existing estate resulting in failure of infrastructure (building & plant) adverse external audits, impact on service delivery, cancelled lists, poor working conditions for staff and or Injury. Estimated time to failure may be circa <5 years.	Reactive breakdown maintenance via Estates helpdesk Planned Preventative Maintenance programme Capital Development Programme Backlog Maintenance Programme	15 3 x 5	Associa te Director Of Estates & Property Manag emen	1 Consideration be given to either increasing the backlog maintenance funding or ring fencing all or part of the monies	25/01/2020	9 3 x 3	a 6 facet survey is shortly due to be completed by Nifes on behalf of the HoD once complete the backlog programme will then be finalised	18/11/2019

10. Summary of the Organisational Risk Register

High Risk

Ref	Initial Date	Title	Description	Controls	Current Rating	Owner	Actions		Target Rating	Progress Update	Next Review Date
							Description	Target			
PG0272	08/06/2016	Inadequate availability of medical staff to cover rotas - Obs and Gynae	There is a risk that Obstetrics and Gynaecology are unable to cover the rotas as a result of a current national shortfall to the number of doctors, which may lead to an adverse impact for staff, patients and the Trust.	1. Full complement of Junior Trainees. Gaps in rotas identified well in advance by Rota Co-ordinator who then liaises with Gynae Assistant Service Manager(now aware of gaps until August 16). All attempts made to fill gaps - advertise with Medical Resourcing 4-6 weeks prior to gap. E mails sent out to all trainees including AMPs to identify any staff able to fill gap. Advertisment of shift at higher level (still within Monitor rate). Escalation to Consultants within 1 week of the gap if still unable to fill. 2. There is always a Consultant on call available. Full complement of Junior Trainees. Gaps in rotas identified well in advance by Rota Co-ordinator who then liaises with Gynae Assistant Service Manager(now aware of gaps until August 16). All attempts made to fill gaps - advertise with Medical Resourcing 4-6 weeks prior to gap. Staff in Maternity have access to AMPs for advice or clinical review if required. E mails sent out to all trainees including AMPs to identify any staff able to fill gap. Advertisement of shift at higher level (still within Monitor rate). Escalation to Consultants within 1 week of the gap if still unable to fill. Obs/Gynae escalation plan in place. All qualified staff work within their NMC Code of Conduct and are aware not to undertake duties that they are not competent to carry out. 3. Full complement of Junior Trainees. Gaps in rotas identified well in advance by the Rota Co-ordinator who then liaises with the Gynae Assistant Service Manager. All attempts made to fill gaps which are advertised with Medical Resourcing 4-6 weeks prior to the gap. E mails are sent out to all trainees including AMPs to identify any staff able to fill the gap. Shifts can be advertised at a higher level (still within Monitor rate). Escalation to Consultants within 1 week of the gap if still unable to fill. 4. Quality review meetings focusing on CQC domains. Staffing issues discussed monthly at divisional governance meetings and Labour Ward forum. Staffing incidents also discussed at the fortnightly Patient Safety Summit. Gaps in rotas examined on daily basis and issues escalated. Senior Management team aware of staffing situation.	15 5 x 3	Obstetric Consultant - Risk Lead			10 5 x 2	09/10 19 The availability of medical staff was very repetitive but will remain the same score.	13/01/2020
SC0626	31/12/2018	Control of the backlog of patient's awaiting routine follow up - General Surgery	There is a risk that there is a delay to follow up reviews as an Outpatient as a result of increasing numbers of patients being added to the backlog list which may lead to adverse impact or a patient safety and patient experience	1. Weekly Performance Management Group report to Divisional Senior Management Team. 2. Ensure all clinics are maximised. 3. Advertisements have been publishing advertising for an additional Upper GI consultant. 4. Non-clinical validation of waiting list to remove those where follow up Is not required with in General Surg er has been completed and continues to be validated on a fortnightly basis. 5. The BIU have been asked to deliver a weekly report for each tumour group which includes a cancer tag identifier also. 6. ECF waiting lists have been applied for by General Surgery. 7. Capacity and Demand analysis has been completed and agreement of way forward to be agreed 8. Monthly validation continues. 9. Review of new routine capacity to follow up and outline the impact. 10. Additional capacity and medical staff required to reduce the backlog. 11. The department are therefore trying to put in additional registrars to the clinics to see the follow up backlog patients, however, this only equates to two clinics per month at 8 patients per clinic. 12. Review of use of nurse led follow up clinics; seen by the Clinical Nurse Specialist following Colorectal risk stratification	15 3 x 5	Service Manager	2 Exploring use of virtual clinics in colorectal.	31/08/2019	6 3 x 2	Risk further reviwed and updated 19/08/2019	16/12/2019
TW0007	07/09/2018	Delayed routine outpatient follow-up	There is a risk that routine outpatient reviews will not be followed up in a timely manner, as a result of demand exceeding capacity, which may lead to an adverse impact on patient safety and clinical outcomes.	1. Eight speciality risk assessments have been drafted and/or updated, including; Gastroenterology, Cardiology, Dermatology, Respiratory, Rheumatology, Orthopaedics, Urology and General Surgery. 2. Executive review of speciality risk assessments and progress on actions. Trust executive team updated quarterly. 3. Backlog risk assessments within divisions/specialities 4. External providers assisting with the backlog 5. Harm reviews in specialities were reviewed by Execs in April 2019 and for further review in July 2019	15 3 x 5	Chief Operating Officer	4 SHS to assist with backlogs 5 Waiting List Initiative in urology and general surgery	31/12/2019 31/12/2019	6 3 x 2	14/5/19 Risk reviewed and updated - remains the same. Further actions added	12/08/2019
TW0021	25/09/2019	Management of adoption health records	There is a risk that patient identifiable data may be exposed, as a result of a lack of structured process for the management of health records for patients who have been adopted, which may lead to regulatory sanction	1. Management of Health Records Policy is available 2. Availability of specialise advice from the Information Governance Lead	15 3 x 5	Deputy Divisional General Manager	2 Agree terms of reference for multi-disciplinary working group 3 Set-up regular sessions for the working group to draft the Trust procedure 4 IT to confirm how records can be amended or redacted to ensure accurate patient demographics/identifiable data is stored on all documentation within all available systems 5 Procedure ratified by appropriate forums	30/06/2019 30/06/2019 30/06/2019 30/09/2019	6 3 x 2		24/12/2019

We Care Because You Matter

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

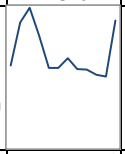
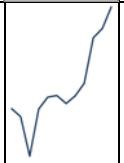
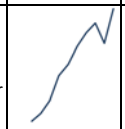
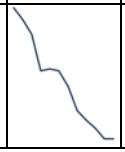
Board of Directors

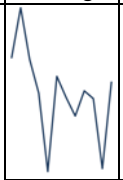
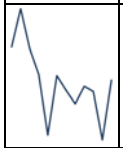
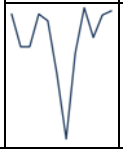
Workforce Report

December 2019

(October 2019 data)

Performance Report Workforce Chapter
Month: Nov-19

Measure	Target	Performance	Description	Narrative	Rolling Trend	Trend	C&W Average
In-Month Sickness Absence	N/A	5.23%	In-month 12m average Sickness Absence described as a Percentage	In-month sickness absence increased from the previous month (0.97%). All of the divisions (with the exception of Corporate) experienced increased sickness absence levels ranging from 0.85% (DCSS) to 1.53% (EF). In month sickness in October 2018 was 4.31%		↑	
Appraisal Rate	90.00%	88.79%	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 1.59% improvement in the appraisal rates across the Trust. 5 divisions experienced an improvement in compliance (DCSS, MEC, EF, SC and CCICP). The most significant improvement was in CCICP (3.50%). Corporate and EF remain Green and the remaining divisions are Amber.		↑	
Mandatory Training	90.00%	84.99%	Mandatory Training Monthly Rate Excludes Bank Staff, Staff on long term sick & mat. leave.	Overall mandatory training compliance improved in month (3.31%) and all divisions experienced an improvement. WC saw the biggest improvement (8.97%). All divisions are Amber with the 3exception of EF who are Green.		↑	
Staff Turnover	10.00%	8.59%	Number of Leavers expressed as a percentage of the workforce over a 12m rolling period. Exclude Junior Doctors, Temporary and Fixed term.	The rolling position for turnover remained static in month. Turnover reduced in 4 divisions (Corporate, MEC, EF and WC. All divisions are now Green aganst target with the exception of CCICP who are Red (11.90%)		↓	

Measure	Target	Performance	Description	Narrative	Rolling		
Agency Spend	(404)	(619)	In month total spend for the Trust against plan	Agency spend increased in month (£278k more than the previous month however spend was affected last month by the rate adjustment). The agency spend target was not met. Agency spend increased across all staff groups, most significantly in N&M which was £190k more than the previous month. All divisions had a higher spend than in the previous month with the exception of CCICP. MEC saw the biggest increase (£176k more than previous month).		↑	N/A
NHSI Planned Agency	less than 100%	153.22%	In month Trust Agency Spend as a percentage of the Planned Agency Spend			↑	N/A
Over Cap Rates	N/A	67%	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	↑↓=

Flu

Trust Name	Mid Cheshire	14.11.19

412 Corporate	Staffing Group Headcount	Total	% of Staff Group
DOCTORS	6	0	0.00%
NURSES	76	52	68.42%
PROFESSIONALS	0	0	
SUPPORT TO CLINICAL STAFF (HCAs/Admin/Ancillary/WorksEtc)	11	5	45.45%
NHS INFRASTRUCTURE SUPPORT (not reported to ImmForm)	328	195	59.45%
TOTAL (Front Line Healthcare Workers only)	93	57	61.29%
TOTAL (All Employees)	421	252	59.86%

412 Diagnostics and SupportDivisi	Staffing Group Headcount	Total	% of Staff Group
DOCTORS	24	11	45.83%
NURSES	56	23	41.07%
PROFESSIONALS	282	134	47.52%
SUPPORT TO CLINICAL STAFF (HCAs/Admin/Ancillary/WorksEtc)	353	160	45.33%
NHS INFRASTRUCTURE SUPPORT (not reported to ImmForm)	198	96	48.48%
TOTAL (Front Line Healthcare Workers only)	715	328	45.87%
TOTAL (All Employees)	913	424	46.44%

412 Medicine & Emergency Care Division	Staffing Group Headcount	Total	% of Staff Group
DOCTORS	135	90	66.67%
NURSES	366	151	41.26%
PROFESSIONALS	1	1	100.00%
SUPPORT TO CLINICAL STAFF (HCAs/Admin/Ancillary/WorksEtc)	260	100	38.46%
NHS INFRASTRUCTURE SUPPORT (not reported to ImmForm)	113	38	33.63%
TOTAL (Front Line Healthcare Workers only)	762	342	44.88%
TOTAL (All Employees)	875	380	43.43%

412 Estates & FacilitiesDivision	Staffing Group Headcount	Total	% of Staff Group
DOCTORS	0	0	
NURSES	0	0	
PROFESSIONALS	0	0	
SUPPORT TO CLINICAL STAFF (HCAs/Admin/Ancillary/WorksEtc)	58	22	37.93%
NHS INFRASTRUCTURE SUPPORT (not reported to ImmForm)	335	112	33.43%
TOTAL (Front Line Healthcare Workers only)	58	22	37.93%
TOTAL (All Employees)	393	134	34.10%

412 Surgical and CancerDivision	Staffing Group Headcount	Total	% of Staff Group
DOCTORS	82	43	52.44%
NURSES	287	148	51.57%
PROFESSIONALS	149	64	42.95%
SUPPORT TO CLINICAL STAFF (HCAs/Admin/Ancillary/WorksEtc)	293	143	48.81%
NHS INFRASTRUCTURE SUPPORT (not reported to ImmForm)	192	113	58.85%
TOTAL (Front Line Healthcare Workers only)	811	398	49.08%
TOTAL (All Employees)	1003	511	50.95%

412 Women and ChildrensDivision	Staffing Group Headcount	Total	% of Staff Group
DOCTORS	38	24	63.16%
NURSES	222	119	53.60%
PROFESSIONALS	4	4	100.00%
SUPPORT TO CLINICAL STAFF (HCAs/Admin/Ancillary/WorksEtc)	68	32	47.06%
NHS INFRASTRUCTURE SUPPORT (not reported to ImmForm)	76	37	48.68%
TOTAL (Front Line Healthcare Workers only)	332	179	53.92%
TOTAL (All Employees)	408	216	52.94%

412 CCICP	Staffing Group Headcount	Total	% of Staff Group
DOCTORS	16	10	62.50%
NURSES	208	60	28.85%
PROFESSIONALS	5	4	80.00%
SUPPORT TO CLINICAL STAFF (HCAs/Admin/Ancillary/WorksEtc)	326	139	42.64%
NHS INFRASTRUCTURE SUPPORT (not reported to ImmForm)	119	50	42.02%
TOTAL (Front Line Healthcare Workers only)	555	213	38.38%
TOTAL (All Employees)	674	263	39.02%

Grand Total (Inc Substantive, Community, Bank and Additional)	Staffing Group Headcount	Total	% of Staff Group
DOCTORS	348	225	64.66%
NURSES	1249	587	47.00%
PROFESSIONALS	451	217	48.12%
SUPPORT TO CLINICAL STAFF (HCAs/Admin/Ancillary/WorksEtc)	1473	705	47.86%
NHS INFRASTRUCTURE SUPPORT (not reported to ImmForm)	1392	672	48.28%
TOTAL (Front Line Healthcare Workers only)	3521	1734	49.25%
TOTAL (All Employees)	**4913**	**2406**	**48.97%**

Trust Position for the same week last year at 16.11.18

Grand Total (Inc Substantive, Community, Bank and Additional)	Staffing Group Headcount	Total	% of Staff Group
DOCTORS	346	248	71.68%
NURSES	1324	753	56.87%
PROFESSIONALS	444	259	58.33%
SUPPORT TO CLINICAL STAFF (HCAs/Admin/Ancillary/WorksEtc)	1419	826	58.21%
NHS INFRASTRUCTURE SUPPORT (not reported to ImmForm)	1567	945	60.31%
TOTAL (Front Line Healthcare Workers only)	3533	2086	59.04%
TOTAL (All Employees)	**5100**	**3031**	**59.43%**

We are just under 10% points behind the same week last year.
Jab at the Hut sessions continue daily throughout November
Peer Vaccinators have been given details of staff still to be vaccinated so that they can target their activity more effectively.