Mid Cheshire Hospitals NHS Foundation Trust

AGENDA

Board of Directors
A meeting will be held in Public at
09.30am on Monday, 4 March 2019
in the Boardroom, Leighton Hospital

Action Key	
A	Approval
I	Information
D	Discussion

Item No	Title of Item	Action	Led By	Page No.
1.	**Welcome and Apologies** To welcome members of the public and attendees and to receive apologies for absence from Board Members. *(to note)*	I	Chairman **09.30**	-
2.	**Patient or Staff Story** *(verbal)*	I/D	Director of Nursing & Quality **09.32**	-
3.	**Board Member's Interests** *(to note)* To **consider** any • Changes to Directors' interests since the last meeting • Conflicts of interest deriving from this agenda	I	Chairman **09.50**	-
4.	**Minutes of the Last Meeting** To **approve** the minutes of the Board of Directors meeting held in Public on Monday, 4 February 2019	A	Chairman **09.52**	**4**
5.	**Matters Arising and Action Log** *(attached) (to approve)*	A	Chairman **09.55**	**16**
6.	**Annual Work Programme 2019/20** *(attached) (to approve)*	I/A	Chairman **09.57**	**17**
7.	**Chairman's Announcements** (*to note a verbal report*)	I	Chairman **10.00**	-
	7.1 Chief Executive Appointment			
	7.2 RemCo – 22 February 2019			
	7.3 Board Committee Membership			
	7.4 Board Away Day – 25 February 2019			
	7.5 Health and Social Care Leader's Summit 2019			
	7.6 Meeting with East Cheshire Trust			
8.	**Governor's Items** (*to note a verbal report*)	I	Chairman **10.15**	-
	8.1 Council of Governors – 24 January 2019			

Item No		Title of Item	Action	Led By	Page No.
	8.2	**Chat with the Chairman – 21 February 2019**			
9.	**Chief Executive's Report** *(to note a verbal report)*				
	9.1	**System Update** - **Exec to Exec with ECT**	I	Chief Executive **10.25**	**-**
10.	**CARING**				
	10.1	**Quality, Safety & Experience Report** *(attached) (for discussion)*	I/D	Director of Nursing & Quality **10.45**	**18**
11.	**SAFE**				
	11.1	**Draft Quality Governance Committee notes from the meeting held on 18 February 2019** *(to follow) (to note)*	I	Committee Chair **10.55**	**-**
	11.2	**Serious Untoward Incidents and RIDDOR Events** *(verbal)* (*to note*)	I/D	Deputy Chief Executive/ Medical Director **11.00**	**-**
12.	**RESPONSIVE**				
	12.1	**Performance Report** *(attached) (to note)*	I/D	Chief Operating Officer **11.05**	**59**
	12.2	**Draft Performance & Finance Committee notes from the meeting held on 21 February 2019** *(to follow) (to note)*	I	Committee Chair **11.15**	**-**
	12.3	**Legal Advice** *(verbal)* (*to note*)	I	Chief Executive **11.20**	**-**
	12.4	**Annual Plan and Budget** *(verbal) (to approve)*	A/D	Director of Finance **11.25**	**-**
	12.5	**Workforce and OD Structure Review Business Case** *(attached) (to approve)*	A/D	Director of Workforce and OD **11.40**	**85**
13.	**WELL-LED**				
	13.1	**Visits of Accreditation, Inspection or Investigation** *(verbal)* (*to note*)	I	Chief Executive **11.55**	**-**
	13.2	**Outline LIMS Business Case** *(to follow) (to approve)*	A/D	Deputy Chief Executive/ Medical Director **12.00**	**-**

Item No		Title of Item	Action	Led By	Page No.
	13.3	**Board Assurance Framework Quarter 3** *(attached) (for discussion)*	I/D	Deputy Chief Executive/ Medical Director **12.15**	**106**
	13.4	**Learning from Deaths Report Quarter 3** *(attached) (for discussion)*	I/D	Deputy Chief Executive/ Medical Director **12.20**	**126**
14.	**EFFECTIVE**				
	14.1	**Workforce Report** *(attached) (to note)*	I/D	Director of Workforce and OD **12.25**	**142**
	14.2	**Transformation and People Committee notes from the meeting held on 7 February 2019** *(attached) (to note)*	I	Committee Chair **12.30**	**145**
	14.3	**Consultant Appointments** *(verbal) (to note)*	I	Deputy Chief Executive/ Medical Director **12.35**	**-**
	14.4	**International Recruitment Business Case** *(attached) (for approval)*	A/D	Director of Nursing & Quality **12.40**	**164**
15.	**Any Other Business** *(verbal)*		A/I/D	Chairman	**-**
16.	**Time, Date and Place of Next Meeting**				
	To confirm that the next meeting of the Board of Directors will take place in public, in the Board Room at Leighton Hospital, at 9.30am on **Monday, 1 April 2019**		I	Chairman	

Board of Director Meeting held in Public (Action Log)

Action No	Date of Meeting	Action	Lead	Deadline Date	Comments	Date of Board meeting to be reviewed	Status
19/02/7.4	04-Feb-19	Cheshire Care Partnership report on Acute Trusts to be ciruclated to NEDs	D Dunn	10-Feb-19	Completed	05-Mar-19	

Board of Directors Workplan 2019/20

Version: 1

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		→					
Responsive																	
Annual Budget/Planning/ Budget Pack	x											x					x
Quality Account		x															
Legal Advice	x	x	x	x	x	x	x	x	x	x	x	x					
Performance & Finance Committee	x	x	x	x	x	x	x	x	x	x	x	x					
Performance Report	x	x	x	x	x	x	x	x	x	x	x	x					
Report on Use of Trust Seal		x			x			x			x						
Corporate Trustee													x		x		x
Freedom to Speak up Guardian		x			x			x			x						
Well-Led																	
Annual Budget/Contract Discussions	x											x					
Annual Plan	x	x										x					
Annual Report & Accounts (Extra Ordinary Board)		x															
Audit Committee		x	x				x		x		x						
Board Assurance Framework	x			x		x			x			x					
Quarterly Organisational Risk Register	x			x			x			x							
Learning from Deaths Quarterly Report			x			x			x			x					
Trust Strategy	→	x						x							x		x
Visits of Accreditation, Inspection or Investigation	x	x	x	x	x	x	x	x	x	x	x	x					
Well-Led Governance Framework Self Assessment																	x
Corporate Goverance Handbook										x							
Board Sub-Committee Annual Review			x														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											x						
Transformation and People Committee	x	x	x	x	x	x	x	x	x	x	x	x					
Consultant Appointments	x	x	x	x	x	x	x	x	x	x	x	x					
Medical Staffing Update (Part II)	x	x	x	x	x	x	x	x	x	x	x	x					

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

We Care Because You Matter

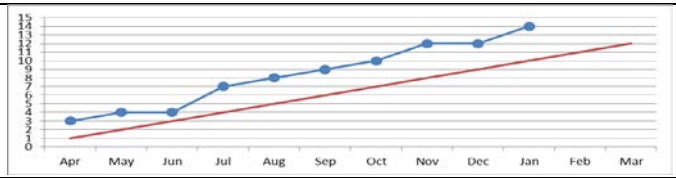
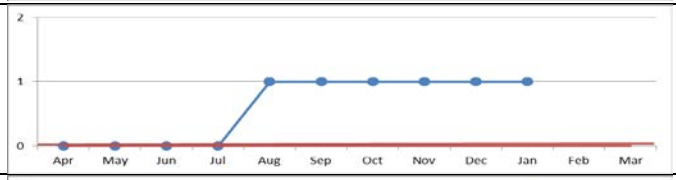
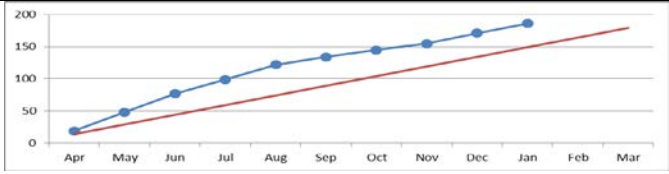
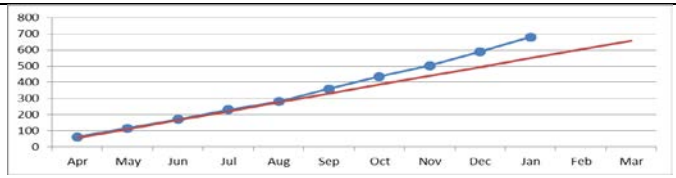
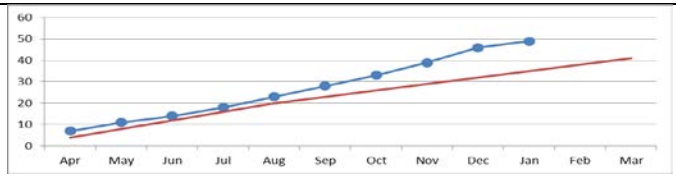
Quality, Safety and Experience Report

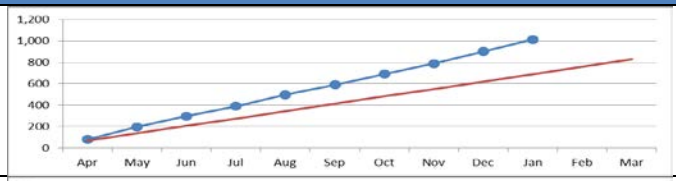
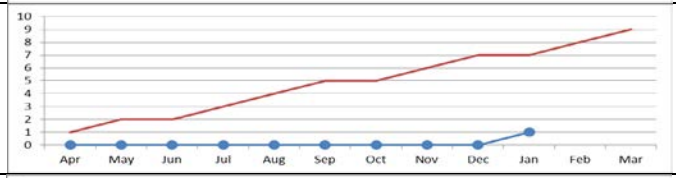
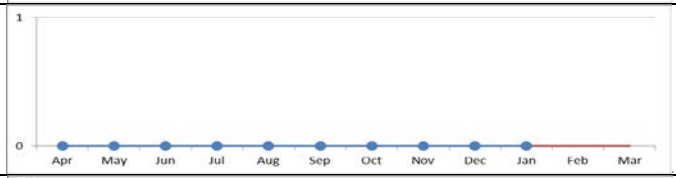
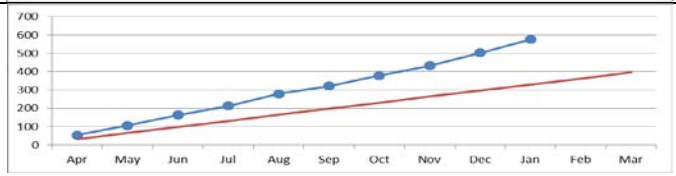
March 2019

(January 2019 data)

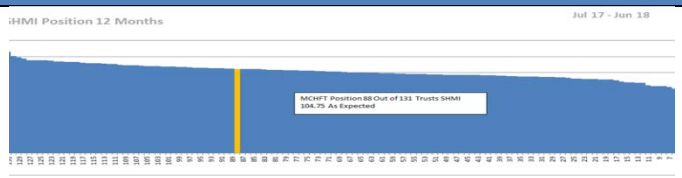
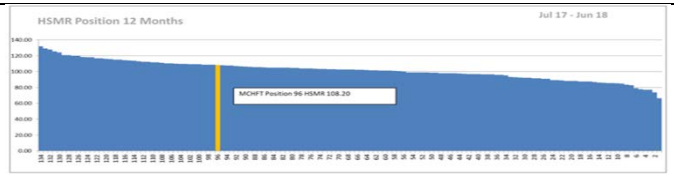
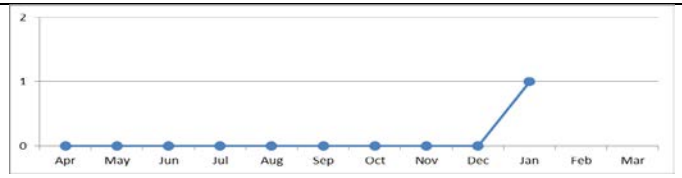
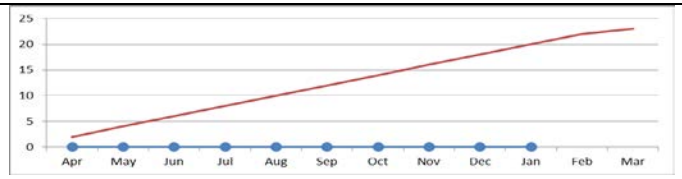
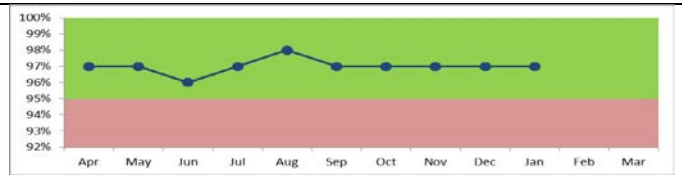
Contents

Contents (continued):

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

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

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

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

Quality & Safety Section:

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

Patient Safety Harm Incidents

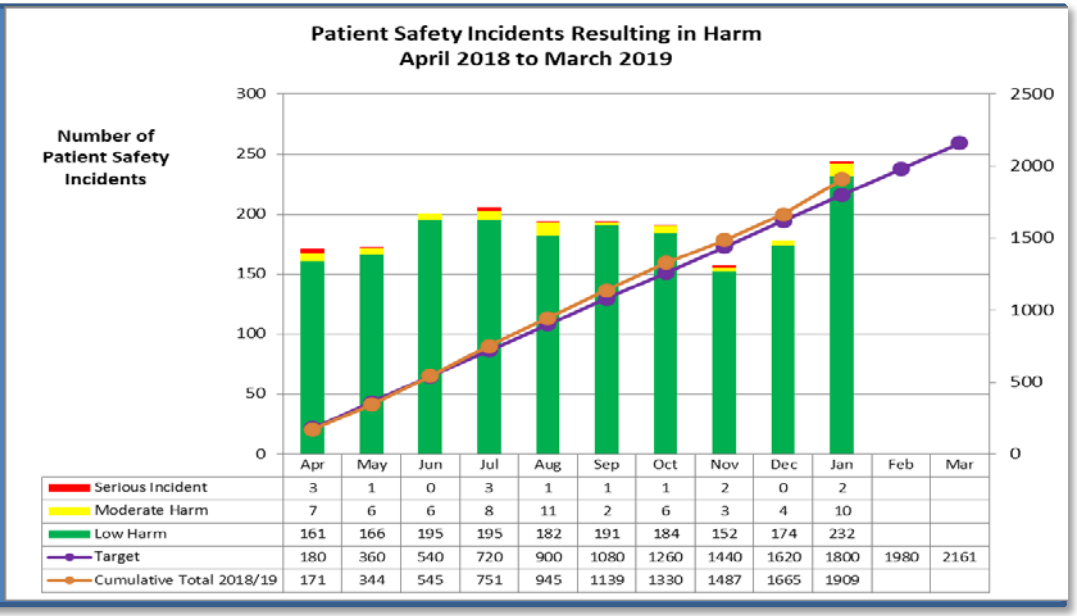
The target is to reduce patient safety harm incidents by 5% when compared to the previous financial year by the end of March 2019.

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

For January 2019, there were a total of 244 patient safety harm incidents:
95.1% (232 incidents) have resulted in low harm
4.1% (10 incidents) have resulted in moderate harm
0.8% (2 incidents) resulted in serious harm

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

- Twice monthly Patient Safety Summit Meetings with Executive & Senior Teams
- Twice monthly Patient Safety Matters newsletter that is delivered Trust wide
- NEWS2 was launched to all inpatient areas on the 5 November 2018.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Serious Incident	3	1	0	3	1	1	1	2	0	2		
Moderate Harm	7	6	6	8	11	2	6	3	4	10		
Low Harm	161	166	195	195	182	191	184	152	174	232		
Target	180	360	540	720	900	1080	1260	1440	1620	1800	1980	2161
Cumulative Total 2018/19	171	344	545	751	945	1139	1330	1487	1665	1909		

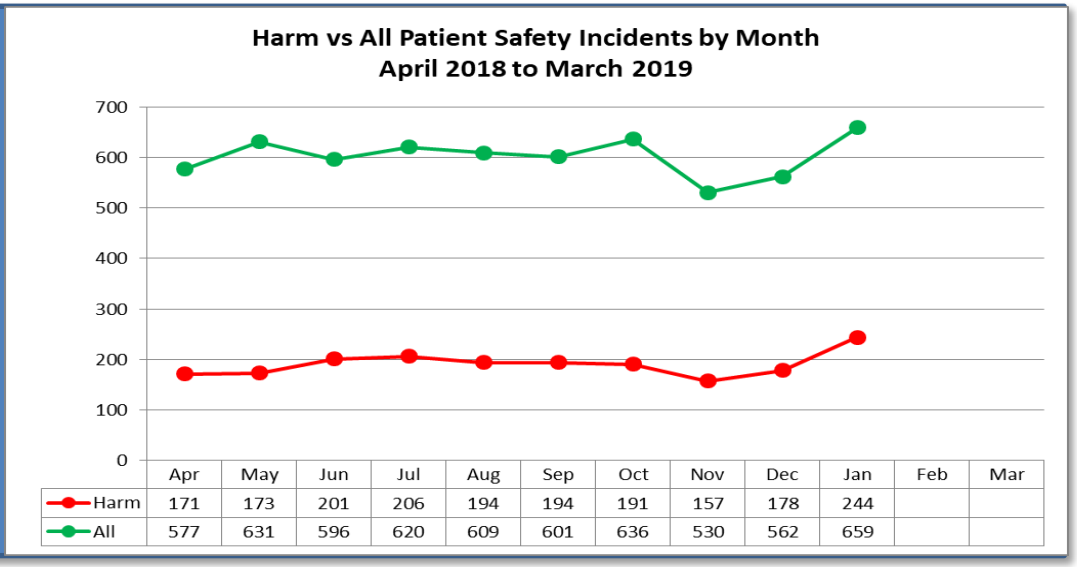
Harm vs All Patient Safety Incidents

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 January 2019, the gap between harm and all patient safety incidents was 415. The aim over the twelve month period is to see this gap widening.

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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Harm	171	173	201	206	194	194	191	157	178	244		
All	577	631	596	620	609	601	636	530	562	659		

Description	Aggregate Position	Trend

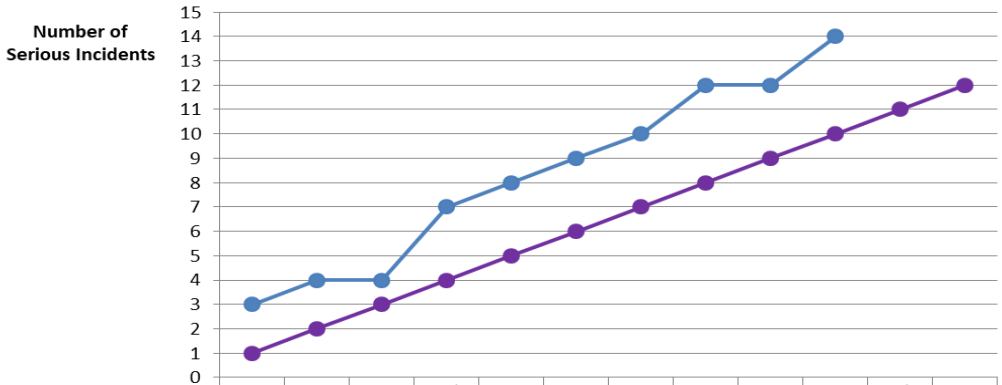
Serious Incidents

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

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

For January 2019, there were two serious incidents reported.

- Patient Fall resulting in fractured neck of femur on Ward 18 (SSW).
- Unexpected death of patient on Ward 1.



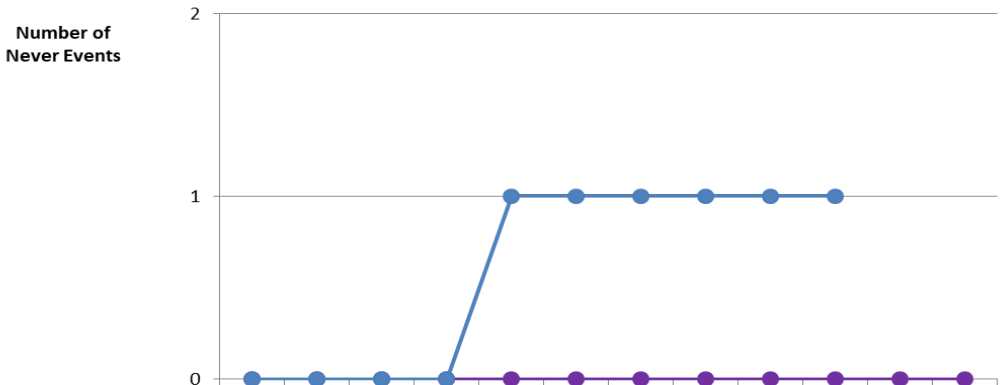
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative Total	3	4	4	7	8	9	10	12	12	14		
Cumulative Target	1	2	3	4	5	6	7	8	9	10	11	12

Never Events

The target is to have zero Never Events

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

For January 2019 no Never Events were 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	1	1	1		

Description	Aggregate Position	Trend

Pressure Ulcers (PU) – Hospital Acquired

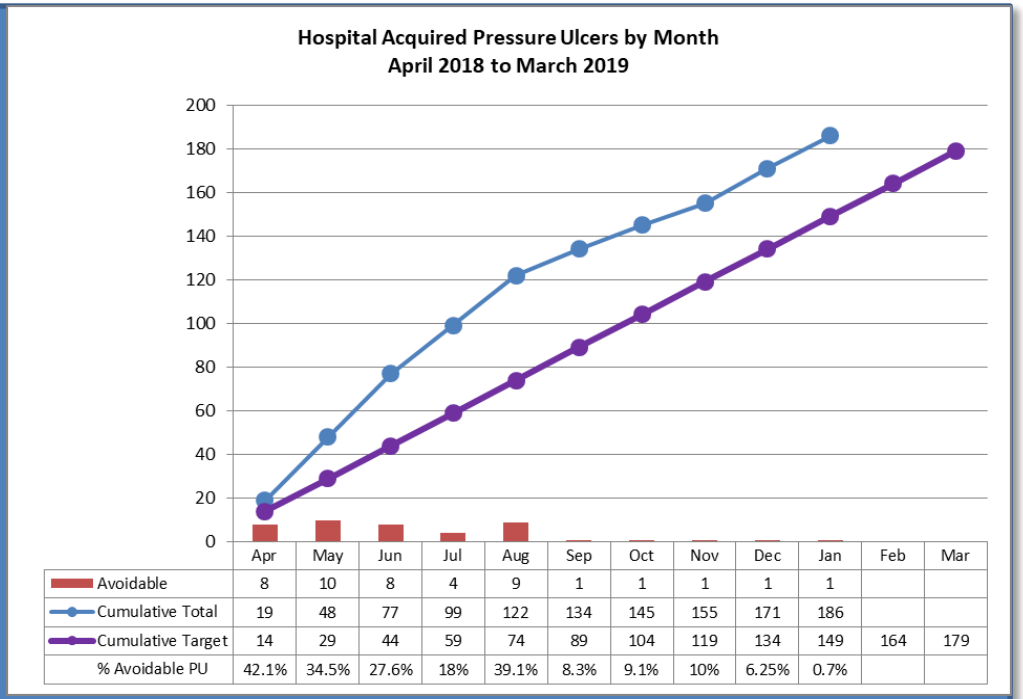
The target is to reduce hospital acquired pressure ulcers by 10% when compared to the previous financial year by the end of March 2019.

For January 2019, there were a total of 15 hospital acquired pressure ulcer incidents:

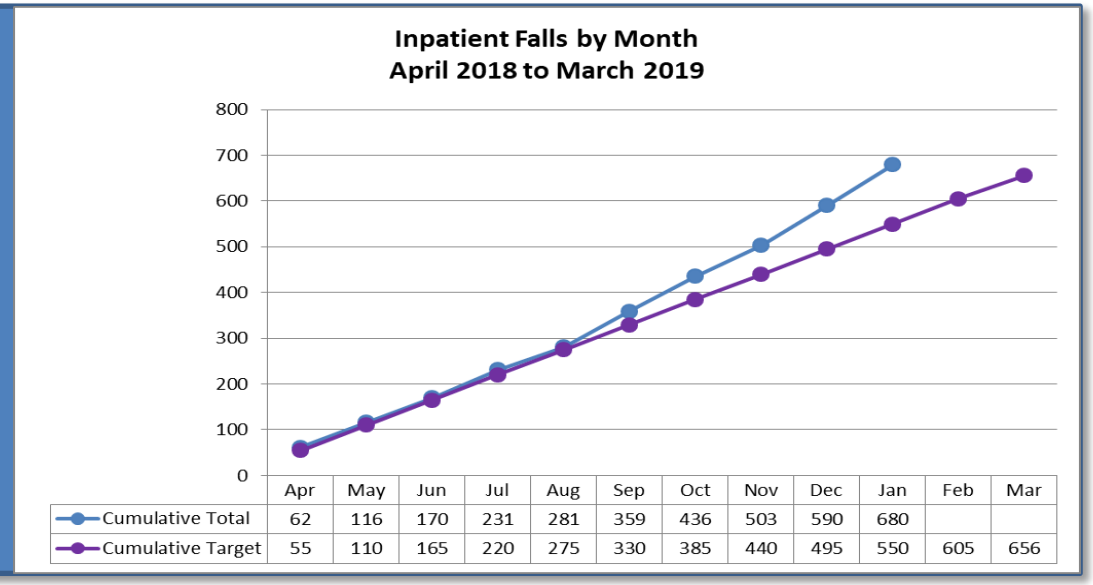
- 6.65% (1 PU) has resulted in avoidable harm. This was an unstageable pressure ulcer. Avoidable pressure ulcers are reviewed at the monthly pressure ulcer panel.
- 86.7% (13 PU's) have been classed as unavoidable following investigation. Twelve were category 2 pressure ulcers, one was a category 3 pressure ulcer and three were unstageable pressure ulcers.
- 6.65% (1 PU) is awaiting confirmation.

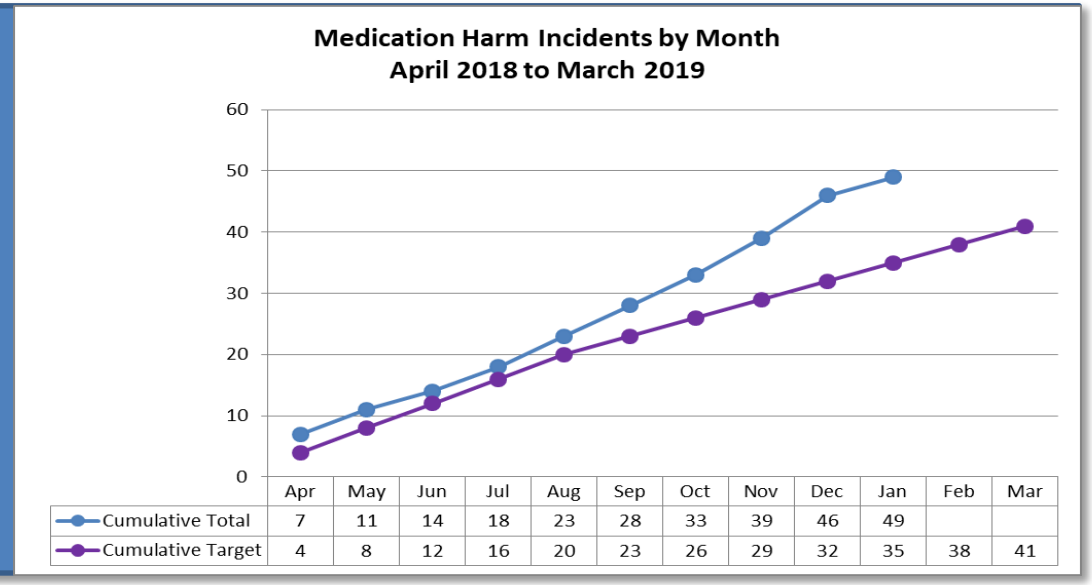
Improvement actions include

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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Avoidable	8	10	8	4	9	1	1	1	1	1		
Cumulative Total	19	48	77	99	122	134	145	155	171	186		
Cumulative Target	14	29	44	59	74	89	104	119	134	149	164	179
% Avoidable PU	42.1%	34.5%	27.6%	18%	39.1%	8.3%	9.1%	10%	6.25%	0.7%		

Description	Aggregate Position	Trend
Inpatient Falls. *The target is to reduce inpatient falls by 10% when compared to the previous financial year by March 2019*	For January 2019, there were a total of 90 inpatient falls • 77.8% (70 falls) have resulted in no harm • 18.9% (17 falls) have resulted in low harm • 2.2% (2 falls) have resulted in moderate harm • 1.1% (1 falls) has resulted in serious harm Improvement actions include: • Bespoke training where an increase in falls has been identified • Continued review of practice during senior nurse walkabouts	

Medication Harm Incidents *The target is to reduce medication incidents resulting in harm by 10% when compared to the previous financial year by the end of March 2019.*	For January 2019, there were a total of 3 medication incidents resulting in harm reported: • 100% (3 medication incidents) have resulted in low harm • 0% (0 medication incidents) have resulted in moderate harm • 0% (0 medication incidents) have resulted in serious harm Improvement actions include: • Junior medical staff training • E-learning package in place • Zero tolerance to prescription anomalies at ward level • Monthly lessons learned shared from the Safer Medicines Practice Group	

Central Cheshire Integrated Care Partnership (CCICP)

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

CCICP Patient Safety Harm Incidents

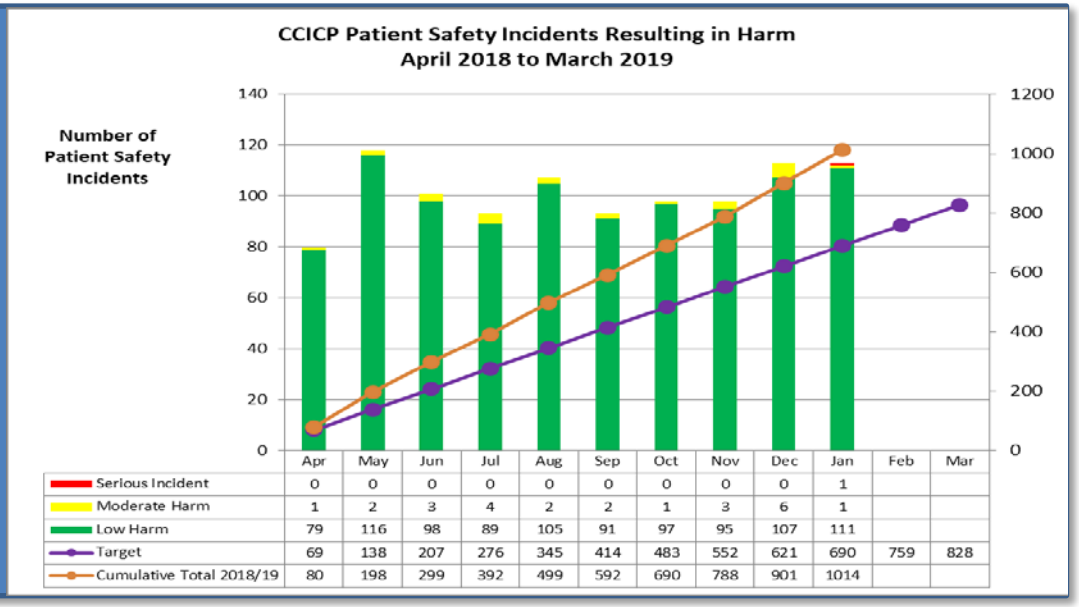
The target is to reduce CCICP patient safety harm incidents by 5% when compared to the previous financial year by the end of March 2019.

For January 2019, there were a total of 113 patient safety harm incidents:

- 98.2% (111 incidents) have resulted in low harm
- 0.9% (1 incidents) have resulted in moderate harm
- 0.9% (1 incidents) have resulted in serious harm

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

- Twice monthly Patient Safety Summit Meetings with Executive & Senior Teams
- Twice monthly Patient Safety Matters newsletter that is delivered Trust wide
- Local quality champions introduced



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Serious Incident	0	0	0	0	0	0	0	0	0	1		
Moderate Harm	1	2	3	4	2	2	1	3	6	1		
Low Harm	79	116	98	89	105	91	97	95	107	111		
Target	69	138	207	276	345	414	483	552	621	690	759	828
Cumulative Total 2018/19	80	198	299	392	499	592	690	788	901	1014		

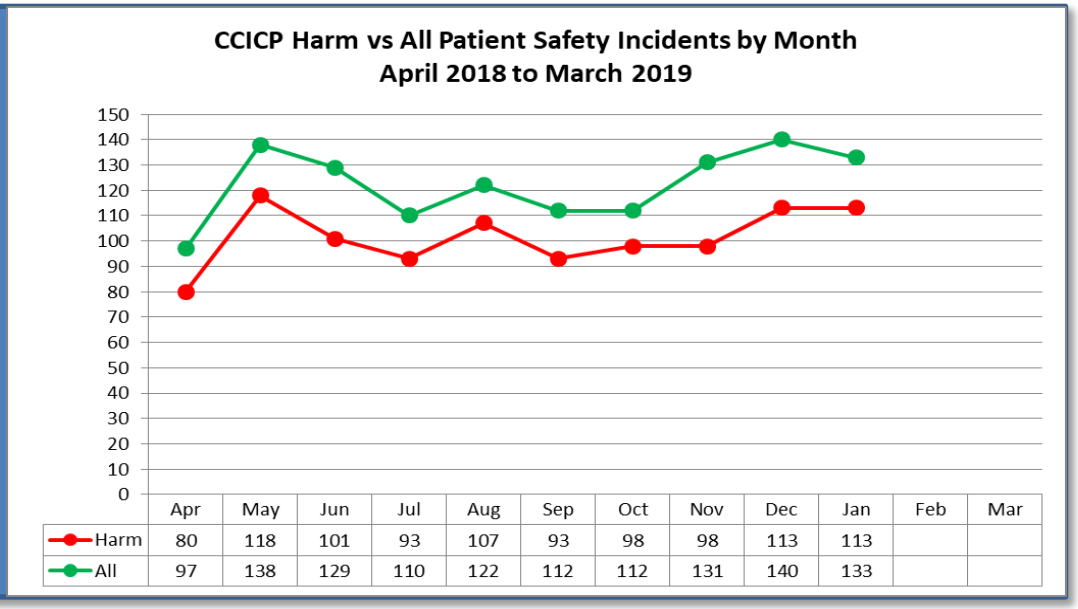
CCICP Harm vs All Patient Safety Incidents

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 January 2019, the gap between harm and all patient safety incidents was 20.

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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Harm	80	118	101	93	107	93	98	98	113	113		
All	97	138	129	110	122	112	112	131	140	133		

Description	Aggregate Position	Trend

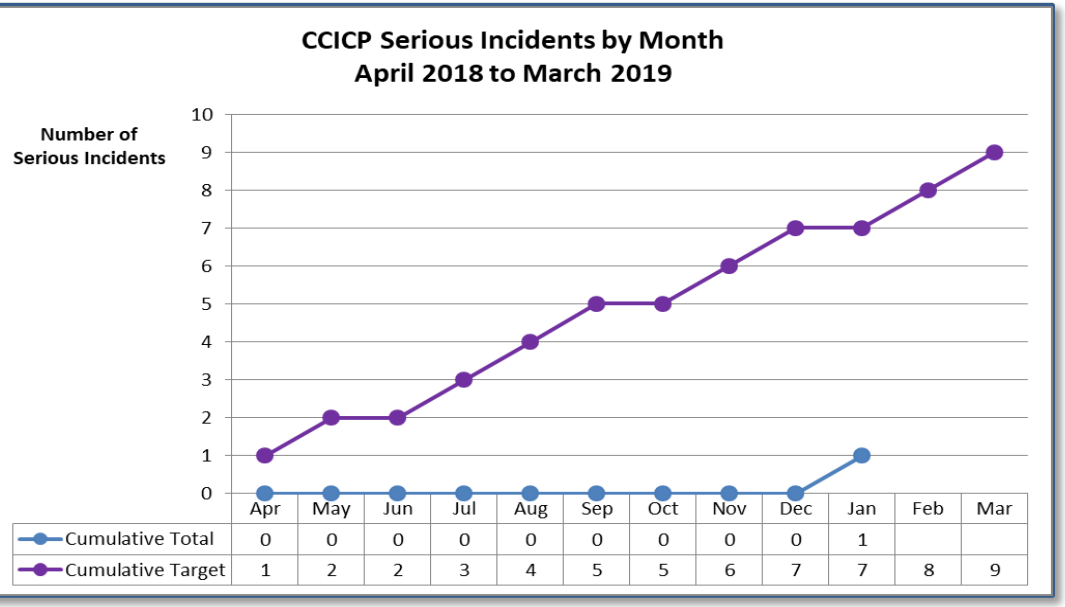
CCICP Serious Incidents

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

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

For January 2019, there was one serious incident reported.

- Developed in Care Category 4 Pressure Ulcer on CCICP - Sandbach DN.



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

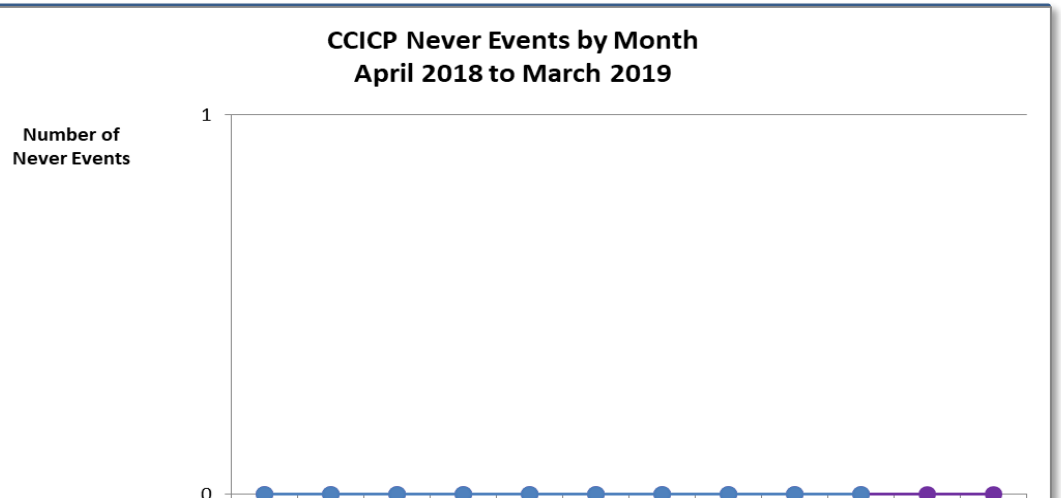
CCICP Never Events

The target is to have zero Never Events

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

For January 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	0	0	0		

Description	Aggregate Position	Trend

Pressure Ulcers – Community Acquired

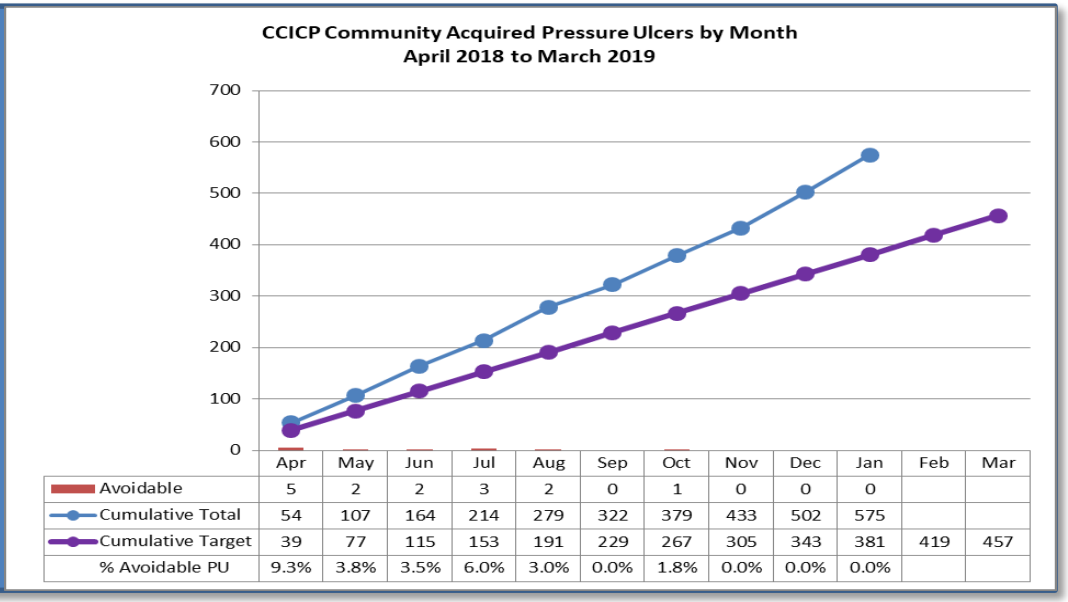
The target is to reduce community acquired pressure ulcers by 10% when compared to the previous financial year by the end of March 2019.

For January 2019, there were a total of 73 community acquired pressure ulcer incidents:

- 0% (0 PU's) has resulted in avoidable harm.
- 58.9% (43 PU's) have been classed as unavoidable
- 41.1% (30 PU's) are currently undergoing investigation prior to confirmation as to whether the PU was avoidable or unavoidable.

Improvement actions include:

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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Avoidable	5	2	2	3	2	0	1	0	0	0		
Cumulative Total	54	107	164	214	279	322	379	433	502	575		
Cumulative Target	39	77	115	153	191	229	267	305	343	381	419	457
% Avoidable PU	9.3%	3.8%	3.5%	6.0%	3.0%	0.0%	1.8%	0.0%	0.0%	0.0%		

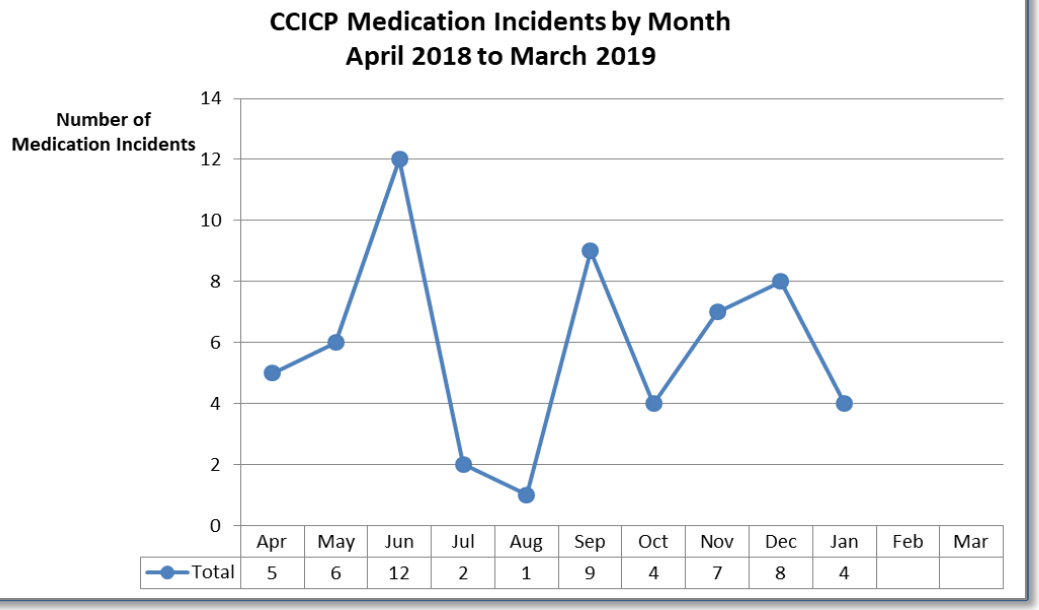
CCICP Medication Incidents.

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

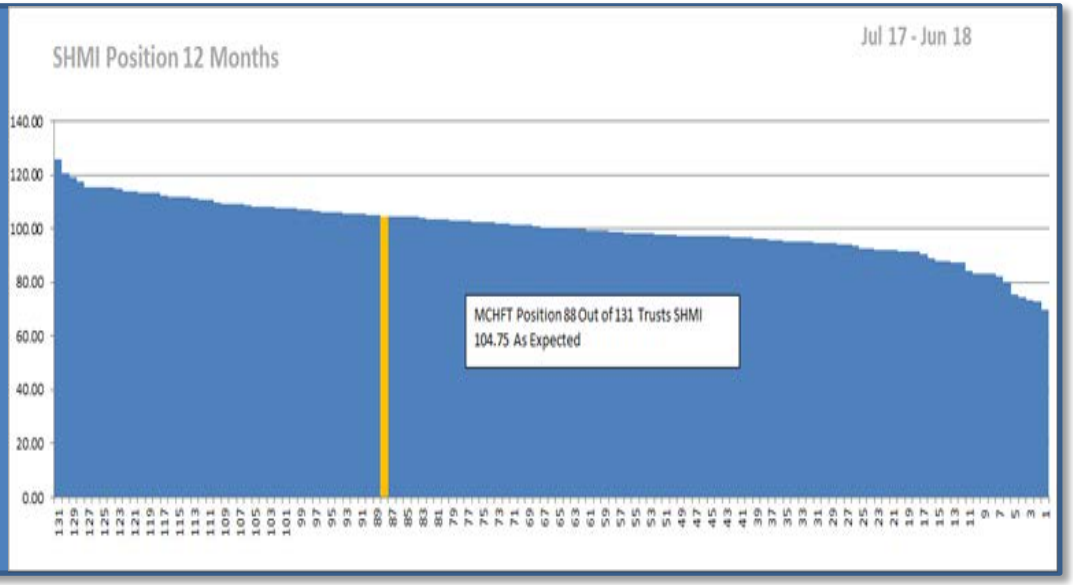
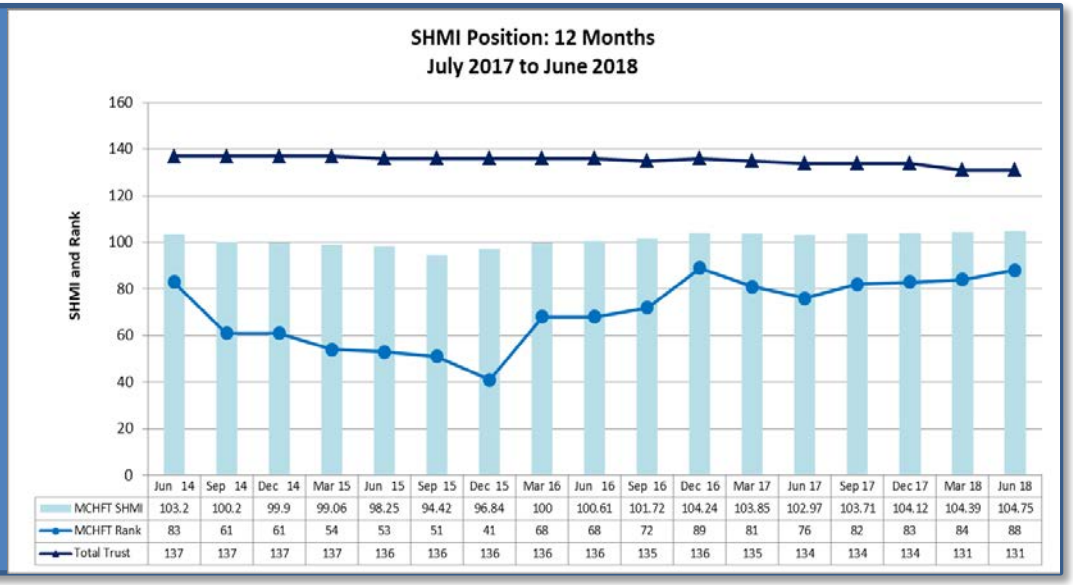
For January 2019, there was a total of 4 medication incidents reported:

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

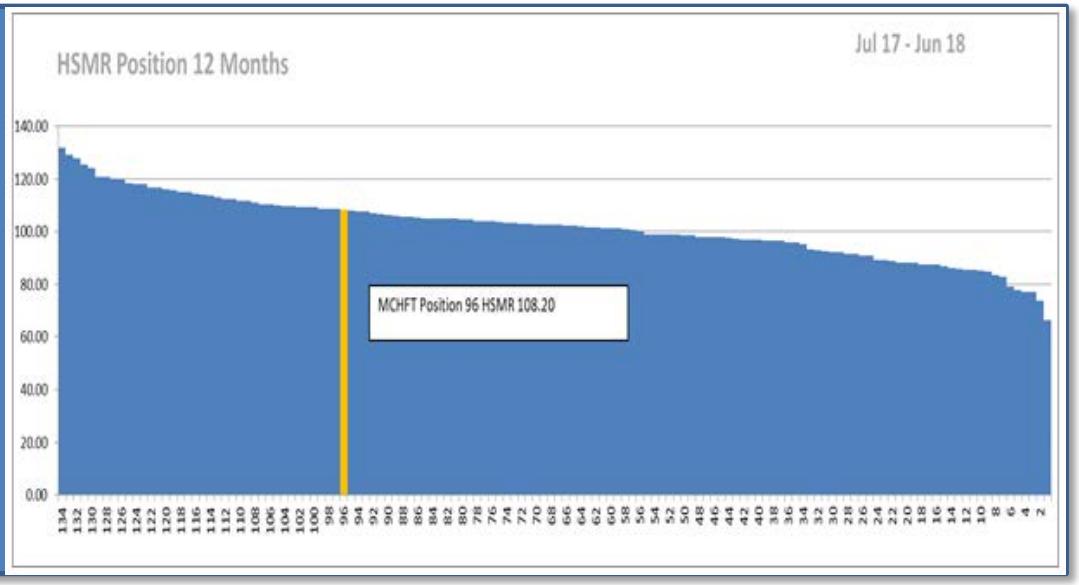
CCICP has a dedicated pharmacy lead who is actively encouraging the reporting of all grades of incidents across all services.

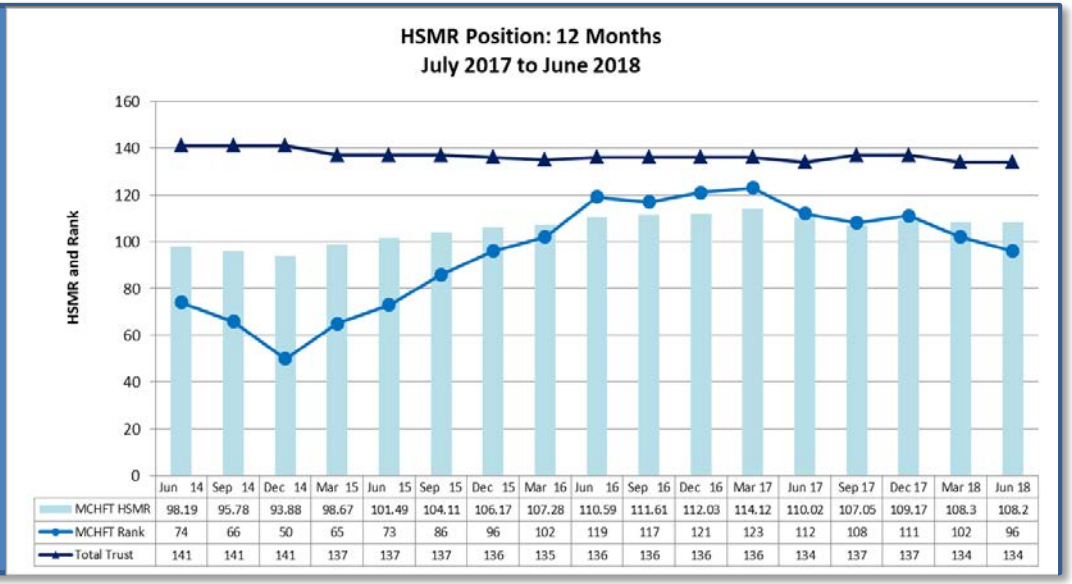


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total	5	6	12	2	1	9	4	7	8	4		

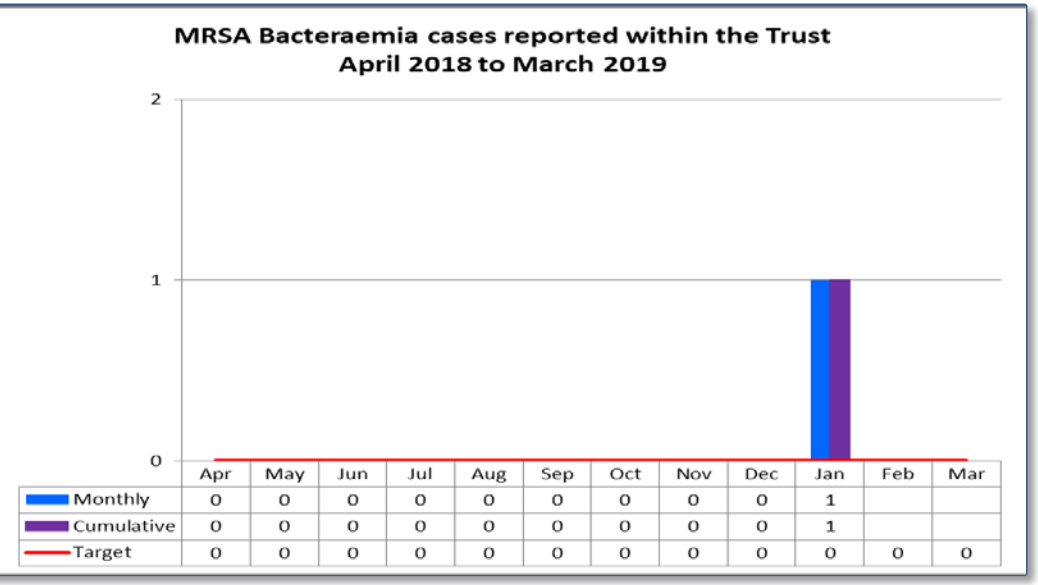
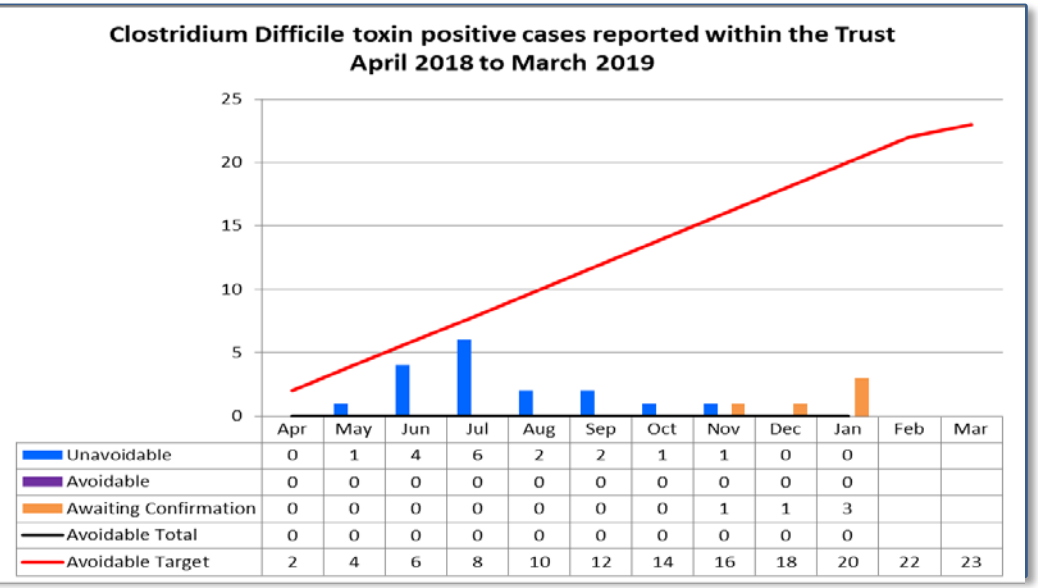
Description	Aggregate Position	Trend
SHMI *The Trust's target is to be at least within the "as expected" bracket.*	The chart benchmarks the Trust's latest SHMI against all NHS Trusts. MCHFT is shown as the yellow bar. The Trust's SHMI is 104.75 for the time period July 2017 to June 2018 and places the Trust 88 out of 131 Trusts and is "as expected".	
MCHFT *12 month rolling position Summary Hospital-Level Mortality Indicator (SHMI) by Trust.*	The chart shows the SHMI and rank of MCHFT for each of the 12 month rolling position submissions for the period July 2017 to June 2018 and is "as expected".	

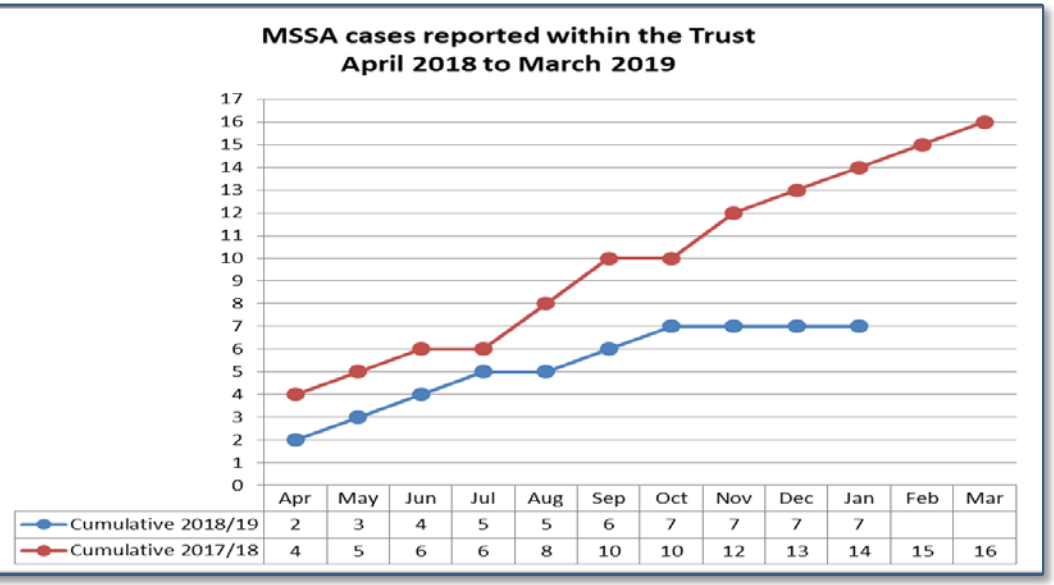
	Jun 14	Sep 14	Dec 14	Mar 15	Jun 15	Sep 15	Dec 15	Mar 16	Jun 16	Sep 16	Dec 16	Mar 17	Jun 17	Sep 17	Dec 17	Mar 18	Jun 18
MCHFT SHMI	103.2	100.2	99.9	99.06	98.25	94.42	96.84	100	100.61	101.72	104.24	103.85	102.97	103.71	104.12	104.39	104.75
MCHFT Rank	83	61	61	54	53	51	41	68	68	72	89	81	76	82	83	84	88
Total Trust	137	137	137	137	136	136	136	136	136	135	136	135	134	134	134	131	131

Description	Aggregate Position	Trend
Hospital Standardised Mortality Rate (HSMR) by Trust. *The Trust's target is to be at least within the "as expected" bracket.*	The chart benchmarks the Trust's HSMR against all NHS Trusts. MCHFT is shown by the amber bar. The Trust's HSMR is 108.20 (July 2017 to June 2018) and places the Trust 96 out of 134 Trusts and is "as expected".	

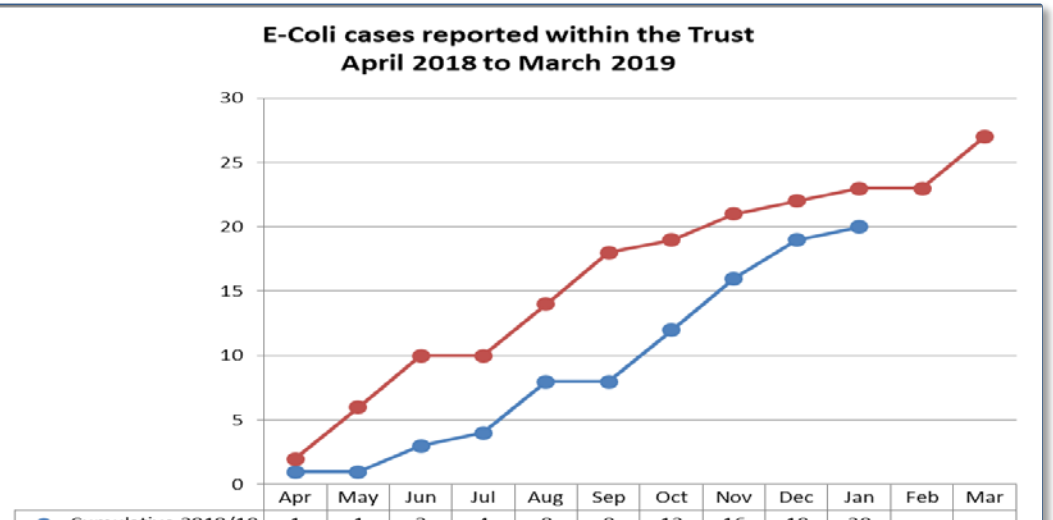
Description	Aggregate Position	Trend
MCHFT *12 month rolling position for HSMR*	The data in the chart shows the HSMR and rank of MCHFT for each of the 12 month rolling position submissions for the period July 2017 to June 2018 and is "as expected".	

	Jun 14	Sep 14	Dec 14	Mar 15	Jun 15	Sep 15	Dec 15	Mar 16	Jun 16	Sep 16	Dec 16	Mar 17	Jun 17	Sep 17	Dec 17	Mar 18	Jun 18
MCHFT HSMR	98.19	95.78	93.88	98.67	101.49	104.11	106.17	107.28	110.59	111.61	112.03	114.12	110.02	107.05	109.17	108.3	108.2
MCHFT Rank	74	66	50	65	73	86	96	102	119	117	121	123	112	108	111	102	96
Total Trust	141	141	141	137	137	137	136	135	136	136	136	136	134	137	137	134	134

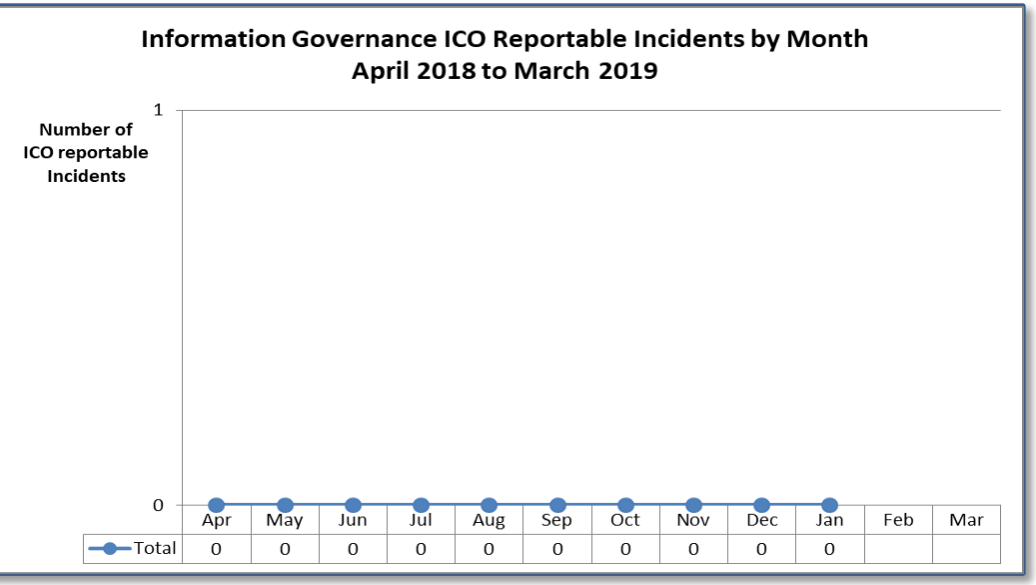
Description	Aggregate Position	Trend
MRSA Bacteraemia Cases. *Zero tolerance of MRSA cases.*	In January 2019, one MRSA bacteraemia cases was reported in the Trust. In this financial year there has been one confirmed MRSA bacteraemia case reported. This was on the Surgical Assessment Unit. A Post Infection Review identified that the case was avoidable. The primary site was urosepsis with other contributory factors. A full report and improvement plan is in place and will be monitored at the Executive Infection Prevention and Control Group.	
Clostridium Difficile toxin positive cases. *The target is less than 23 avoidable cases of Clostridium Difficile in 2018/19*	In January 2019, no avoidable cases were reported. The total avoidable cases year to date is zero. The total unavoidable is fifteen. Improvement actions include: • Bed side reviews are in place on the identification of infection • Consultant level engagement in C-difficile root cause analysis and lessons learnt	

Description	Aggregate Position	Trend
MSSA Cases. *The aim is to have a reduction in MSSA cases when compared to the previous financial year, to demonstrate an incremental improvement*	In January 2019, no MSSA cases were reported in the Trust. In this financial year there has been seven confirmed MSSA cases reported.	

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative 2018/19	2	3	4	5	5	6	7	7	7	7		
Cumulative 2017/18	4	5	6	6	8	10	10	12	13	14	15	16

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 January 2019, one E-Coli case was reported. In this financial year there have been nineteen confirmed E-Coli cases reported.	

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative 2018/19	1	1	3	4	8	8	12	16	19	20		
Cumulative 2017/18	2	6	10	10	14	18	19	21	22	23	23	27

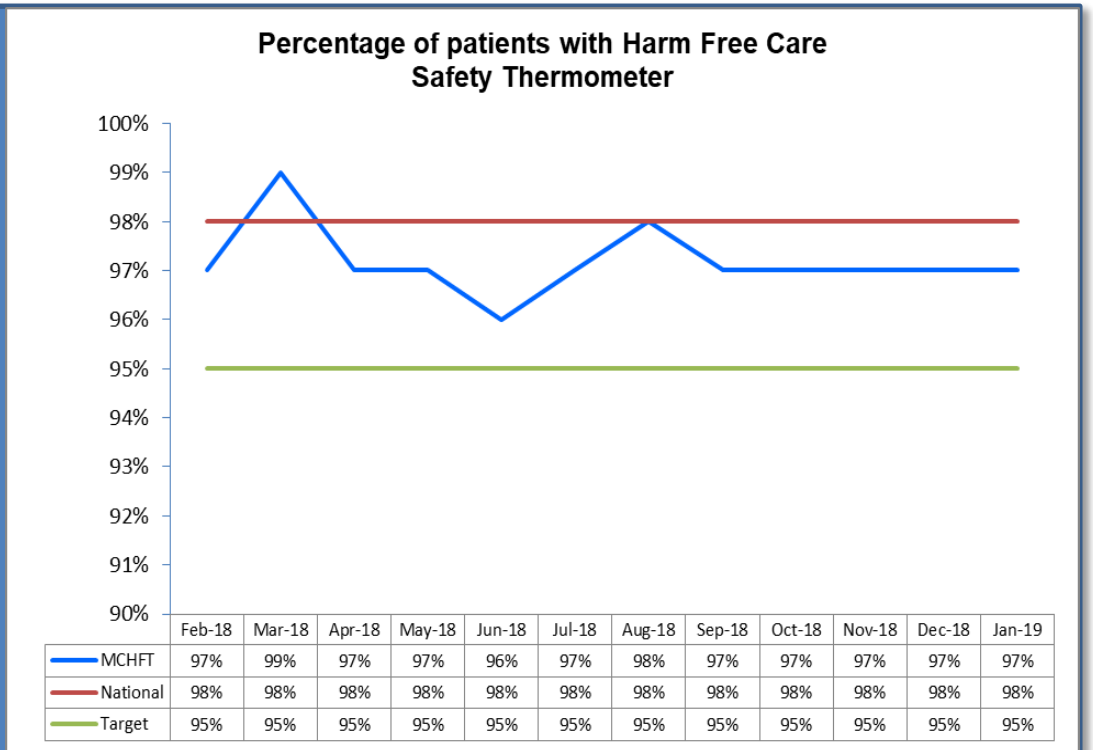
Description	Aggregate Position	Trend
Information Governance Information Commissioners Office (ICO) reportable incidents.	In January 2019, no information governance ICO reportable incidents were reported in the Trust. The Trust has detailed plans in place to address the requirements of the General Data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

CQUIN 2018-19 Performance

CQUIN Indicator	Indicator Name	Milestone Achieved								
		Q1	Financial Incentive Achieved	Q2	Financial Incentive Achieved	Q3	Financial Incentive Achieved	Q4	Financial Incentive Achieved	Maximum Value
1a	**Health & Wellbeing** 5% point improvement in two of the three questions on H&W, MSK & Stress	NO PAYMENTS	No payment	ON TRACK	No payment		No payment		£137,574	**£137,574**
1b	**Health & Wellbeing** Maintain the four changes for improving healthy food for NHS staff, visitors and patients. Introduce three new changes to food and drink provision.	NO PAYMENTS	No payment	ON TRACK	No payment		No payment		£137,574	**£137,574**
1c	**Health & Wellbeing** Achieve an uptake of flu vaccinations of front line clinical staff of 75% by end of February 2019.	NO PAYMENTS	No payment	ON TRACK	No payment		No payment		£137,574 £137,180	**£137,574** **CCICP £137,180**
2a	**Sepsis: Identification** The percentage of patients who met the criteria for sepsis screening and were screened for sepsis.	✓ **Partially**	£25,795 (£10,318 partial payment)	✓ **Partially**	£25,795 (£10,318 partial payment)		£25,795		£25,795	**£103,181**
2b	**Sepsis: Treatment** The percentage of patients who were found to have sepsis and received IV antibiotics within1 hour.	✓ **Partially**	£25,795 (£10,318 partial payment)	✓ **Partially**	£25,795 (£10,318 partial payment)		£25,795		£25,795	**£103,181**
2c	**Sepsis: Antibiotic Review** Percentage of antibiotic prescriptions documented and reviewed by a competent clinician within 72 hours	✓	£25,795	✓	£25,795		£25,795		£25,795	**£103,181**
2d Part 1	**Reduction in antibiotic consumption** Achieve a reduction of x% or more in total antibiotic consumption per 1,000 admissions.	✓	No payment	NO PAYMENTS	No payment		No payment		£34,393	**£34,393**
2d Part 2	**Reduction in carbapenem consumption** Achieve a reduction of x% or more in total carbapenem consumption per 1,000 admissions.	✓	No payment	NO PAYMENTS	No payment		No payment		£34,393	**£34,393**

CQUIN Indicator	Indicator Name	Milestone Achieved								
		Q1	Financial Incentive Achieved	Q2	Financial Incentive Achieved	Q3	Financial Incentive Achieved	Q4	Financial Incentive Achieved	Maximum Value
2d Part 3	**Reduction in piperacillin tazabactam consumption** Achieve a reduction of x% or more in total piperacillin tazabactam consumption per 1,000 admissions.	✓	No payment	NO PAYMENTS	No payment		No payment		£34,393	**£34,393**
4	**Mental Health in Emergency Department** Maintain 20% reduction in attendances to the Emergency Department for people with Mental Health needs.	✓	No Payment	✗	£82,545				£330,178	**£412,723**
6	**Offering advice and guidance** Providers to set up and operate advice and guidance services for non-urgent GP referrals, allowing GPs to access consultant advice prior to referring patients into secondary care.	✓	£65,908	✓	£65,908		£65,908		£226,998	**£412,723**
9a	**Tobacco screening** Percentage of unique adult patients who are screened for smoking status AND whose results are recorded..	✓	£5,159	✓	£5,159		£5,159		£5,159	**£20,636**
9b	**Tobacco brief advice** Percentage of unique patients who smoke AND are given very brief advice	✓	£20,636	✓	£20,636		£20,636		£20,636	**£82,545**
9c	**Tobacco referral and medication offer** Percentage of unique patients who are smokers AND are offered referral to stop smoking services AND offered stop smoking medication.	✓	£25,795	✓	£25,795		£25,795		£25,795	**£103,181**
9d	**Alcohol brief advice or referral** Percentage of unique adult patients who are screened for drinking risk levels AND whose results are recorded in local data systems	✓	£25,795	✓	£25,795		£25,795		£25,795	**£103,181**
9e	**Alcohol brief advice or referral** Percentage of unique patients who drink alcohol above lower-risk levels AND are given brief advice OR offered a specialist referral if the patient is potentially alcohol dependent	✓	£25,795	✓	£25,795		£25,795		£25,795	**£103,181**

CQUIN Indicator	Indicator Name	Milestone Achieved								
		Q1	Financial Incentive Achieved	Q2	Financial Incentive Achieved	Q3	Financial Incentive Achieved	Q4	Financial Incentive Achieved	Maximum Value
10	**Improving the assessment of wounds** **(Community Only)** The indicator aims to increase the number of wounds which have failed to heal after 4 weeks that receive a full wound assessment.	✓	No payment	✓	£68,590		No payment		£68,590	**£137,180**
11	**Personalised Care and Support Planning** **(Community Only)** This CQUIN is to be delivered over two years with an aim of embedding personalised care and support planning for people with long-term conditions	✓	No payment	✓	No payment		No payment		£137,180	**£137,180**
PHE1	**Breast Screening Programme Clerical Staff Development (Health Promotion role)** Update and improve the clerical teams knowledge of health promotion to support clients who access The Breast Screening Unit and key partners involved in the Breast Screening Programme	✓	£3,742.50	✓	£3,742.50		£3,742.50		£3,742.50	**£14,969**
PHE2	**Cancer Screening Programme – reducing professional stress and building resilience** Holistic mapping review of health & wellbeing services and support available to staff within the bowel and breast screening programmes for the management of professional stress and building resilience	✓	£5,822	✓	£5,822		£5,822		£5,822	**£23,288**
SP 1	**Nationally Standardised Dose Banding for Adult Intravenous Systemic Anticancer Therapy (SACT) 38** A tool kit has been developed to support CQUIN. Targets will be set for each of the SACT drugs.	✓	£10,292	✓	£10,292		£10,292		£10,292	**£41,167**
SP 2	**Hospital Pharmacy Transformation and Medicines Optimisation**	✓	£15,437	✓	£15,437		£15,437		£15,437	**£61,749**

Description	Aggregate Position	Trend
Safety Thermometer - Harm Free Care.	In January 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.	

	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
MCHFT	97%	99%	97%	97%	96%	97%	98%	97%	97%	97%	97%	97%
National	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

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

Ward Name	Main Specialties	Safety Thermometer Results January 2019			
		Acquired Pressure Ulcers	Patient Falls resulting in harm	CAUTI	New VTE
MCHFT		**1.52% (14)**	**0.11% (1)**	**1.3% (12)**	**0.11% (1)**
AMU	Gen. Medicine	0% (0)	0% (0)	0% (0)	0% (0)
CAU	Paediatrics	0% (0)	0% (0)	0% (0)	0% (0)
Critical Care	Gen. Medicine	0% (0)	0% (0)	0% (0)	0% (0)
Elmhurst	Rehab	0% (0)	0% (0)	0% (0)	0% (0)
Ward 1	Gen. Medicine	0% (0)	0% (0)	0% (0)	0% (0)
SAU	Gen. Surgery	3.45% (1)	0% (0)	3.45% (1)	0% (0)
SSW	Gen. Surgery & Urology	4.35% (1)	0% (0)	4.35% (1)	0% (0)
Ward 15	Gen. Surgery & Gynae	0% (0)	0% (0)	3.12% (1)	0% (0)
Ward 13	Gen. Surgery	0% (0)	0% (0)	0% (0)	0% (0)
Ward 14	Gen. Medicine	0% (0)	0% (0)	0% (0)	0% (0)
Ward 10	Trauma & Ortho	7.69% (3)	0% (0)	0% (0)	0% (0)
Ward 2	Gen. Medicine	0% (0)	0% (0)	0% (0)	0% (0)
Ward 21B	Rehab	0% (0)	0% (0)	0% (0)	0% (0)
Ward 23	Obstetrics	0% (0)	0% (0)	0% (0)	0% (0)
Ward 26	Obstetrics	0% (0)	0% (0)	0% (0)	0% (0)
Ward 4	Gen. Medicine	0% (0)	0% (0)	6.25% (2)	0% (0)
Ward 5	Gen. Medicine	0% (0)	0% (0)	0% (0)	0% (0)
Ward 6	Gen. Medicine	0% (0)	0% (0)	17.86% (5)	0% (0)
Ward 7	Gen. Medicine	0% (0)	0% (0)	0% (0)	3.12% (1)
Ward 9	Trauma & Ortho	0% (0)	0% (0)	0% (0)	0% (0)
NICU	Paediatrics	0% (0)	0% (0)	0% (0)	0% (0)
DN – Ashfields and Haslington	District Nursing	0% (0)	0% (0)	0% (0)	
DN – Dane Bridge	District Nursing	1.35% (1)	0% (0)	1.35% (1)	0% (0)
DN – Eagle Bridge	District Nursing	0% (0)	0% (0)	0% (0)	0% (0)
DN – Firdale	District Nursing	3.12% (2)	0% (0)	1.56% (1)	0% (0)
DN – Grosvenor, Hungerford & Rope Green	District Nursing	5.36% (3)	1.79% (1)	0% (0)	0% (0)
DN - Church View	District Nursing	1.67% (1)	0% (0)	0% (0)	0% (0)
DN – Winsford	District Nursing	3.39% (2)	0% (0)	0% (0)	0% (0)
DN – Middlewich	District Nursing	0% (0)	0% (0)	0% (0)	0% (0)
DN OOH	District Nursing	0% (0)	0% (0)	0% (0)	0% (0)

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

Description	Aggregate Position		Trend
Registered Nurses monthly expected hours by shift versus actual monthly hours per shift. Day time shifts only	95.08% 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 **January 2019 95.08%** December 2018 93.23% November 2018 93.9%	The lowest staffing levels during the day were on Ward 9 at 82.4%
Registered Nurses monthly expected hours by shift versus actual monthly hours per shift. Night time shifts only	100.88% of expected Registered Nurse hours were achieved for night shifts.	Trend **January 2019 100.88%** December 2018 97.72% November 2018 99.4%	The lowest staffing levels during the night were on Ward 5 at 75%
Healthcare Assistant monthly expected hours by shift versus actual monthly hours per shift. Day time shifts only	100.5% of expected HCA hours were achieved for day shifts.	Trend **January 2019 100.5%** December 2018 94.33% November 2018 96.8%	The lowest staffing levels during the day were on Ward 10 at 90.8%
Healthcare Assistant monthly expected hours by shift versus actual monthly hours per shift. Night time shifts only	97.06% 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 **January 2019 97.06%** December 2018 95.76% November 2018 96%	The lowest staffing levels during the night were on Ward 13 at 91.4%
Total number of wards that are lower than 85% RN fill days and nights is 6.	Ward 9 (day) 82.4%, Ward 10 (day) 84%, Ward 21B (day) 83%, Ward 5 (night) 75%, Ward 6 (night) 79.8%, Ward 15 (night) 82.8%.	• 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: March 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	41818.9	39486.6	30359.9	31304.5	25853.3	25273.8	17538.9	19287.4	95.08%	100.5%	100.88%	97.06%	**15794**	**175.29**	**66.98**	**242.27**
AMU	2011.3	1858.5	1519	1519.3	1898.8	1788.5	1519	1519	92.4%	100.0%	94.2%	100.0%	864	4.2	3.5	7.7
CAU (Winter)	1695.5	1695.5	769	769	1805.5	1805.5	356.5	356.5	100.0%	100.0%	100.0%	100.0%	463	7.6	2.4	10.0
Critical Care	4209	4209	452.5	452.5	2593.5	2593.5	0	0	100.0%	100.0%	100.0%	-	283	24.0	1.6	25.6
Elmhurst	871.5	871.5	2232	2286	775	775	1550	1650	100.0%	102.4%	100.0%	106.5%	907	1.8	4.3	6.2
Ward 1	2193.8	2068.8	1162.5	1162.5	1519	1433.3	759.5	722.8	94.3%	100.0%	94.4%	95.2%	941	3.7	2.0	5.7
Ward 13	2472	2144	1984	1960	953.3	871.3	953.3	871.3	86.7%	98.8%	91.4%	91.4%	958	3.1	3.0	6.1
Ward 14	1716	1500	1488	1554	744	744	1116	1224	87.4%	104.4%	100.0%	109.7%	948	2.4	2.9	5.3
Ward 15	2352	2008	1984	1952	953.3	789.3	953.3	973.8	85.4%	98.4%	82.8%	102.2%	955	2.9	3.1	6.0
Ward 2	1806.3	1818.8	1550	1481.3	759.5	1029	1139.3	1127	100.7%	95.6%	135.5%	98.9%	960	3.0	2.7	5.7
Ward 21b	1187	985.5	1813.5	2184	775	775	775	1125	83.0%	120.4%	100.0%	145.2%	743	2.4	4.5	6.8
Ward 23	1238	1206.3	785.3	772.7	764.7	764.7	764.7	764.7	97.4%	98.4%	100.0%	100.0%	512	3.8	3.0	6.9
Ward 4	1716	1512	1860	1788	744	768	1488	1524	88.1%	96.1%	103.2%	102.4%	981	2.3	3.4	5.7
Ward 5	2452.5	2121.3	1550	1650	1519	1139.3	759.5	1274	86.5%	106.5%	75.0%	167.7%	959	3.4	3.0	6.4
Ward 6	1550	1675	1937.5	1875	1519	1212.8	759.5	1053.5	108.1%	96.8%	79.8%	138.7%	854	3.4	3.4	6.8
Ward 7	1693.8	1512.5	1550	1600	759.5	771.8	1139.3	1176	89.3%	103.2%	101.6%	103.2%	965	2.4	2.9	5.2
Ward 9	1454	1198	992	1248	635.5	574	512.5	512.5	82.4%	125.8%	90.3%	100.0%	439	4.0	4.0	8.0
NICU	1924.6	1670.3	183.4	190.4	1782.5	1564	0	0	86.8%	103.8%	87.7%	-	177	18.3	1.1	19.3
Ward 11 SAU	1500	2242.5	930	1687.5	580.7	1086.5	580.7	1021	149.5%	181.5%	187.1%	175.8%	822	4.0	3.3	7.3
Ward 18 SSW	1495	1313.8	1162.5	1125	759.5	722.8	759.5	759.5	87.9%	96.8%	95.2%	100.0%	696	2.9	2.7	5.6
Ward 10 Ortho	2848	2392	3720	3376	953.3	932.8	1271	1250.5	84.0%	90.8%	97.8%	98.4%	1160	2.9	4.0	6.9
Ward 26 MLU	785.3	785.3	0	0	764.7	764.7	0	0	100.0%	-	100.0%	-	36	43.1	0.0	43.1
Ward 26 Labour	2647.3	2698	734.7	671.3	2294	2368	382.3	382.3	101.9%	91.4%	103.2%	100.0%	171	29.6	6.2	35.8

Experience Section:

Indicators	Last four months			
	Oct-18	Nov-18	Dec-18	Jan-19
Complaints received by month	17	22	14	24
Complaints being reviewed by the Ombudsman	0	0	0	1
Closed complaints by month	22	19	15	16
Contacts raising informal concerns	88	93	65	96
Compliments received in month	239	535	507	675
Number of new claims received in month	3	4	4	6
Number of claims closed	4	1	2	3
Number of inquests concluded	0	0	1	0
NHS Choices - Star Ratings (Leighton)	4.5	4.5	4.5	4.5
NHS Choices - Star Ratings (VIN)	5	5	5	5
NHS Choices - Number of new postings	4	6	4	9
F&FT Response Rate ED, MIU, UCC and Assessment Areas*	24%	22%	23%	19%
Proportion of positive responses ED, MIU, UCC and Assessment Areas	85%	88%	87%	84%
F&FT Response Rate Inpatients and Daycases	46%	34%	32%	32%
Proportion of positive responses Inpatients and Daycases	96%	96%	95%	95%
F&FT Response Rate Outpatients	2%	4%	3%	4%
Proportion of positive responses Outpatients	96%	94%	96%	94%
F&FT Response Rate Maternity - Birth	12%	26%	13%	13%
Proportion of positive responses Maternity - Birth	100%	100%	100%	100%
F&FT Response Rate Community (CCICP)	11%	0%	0%	0%
Proportion of positive responses Community (CCICP)	96%	0%	0%	0%

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

Description	Aggregate Position/Description	Trend

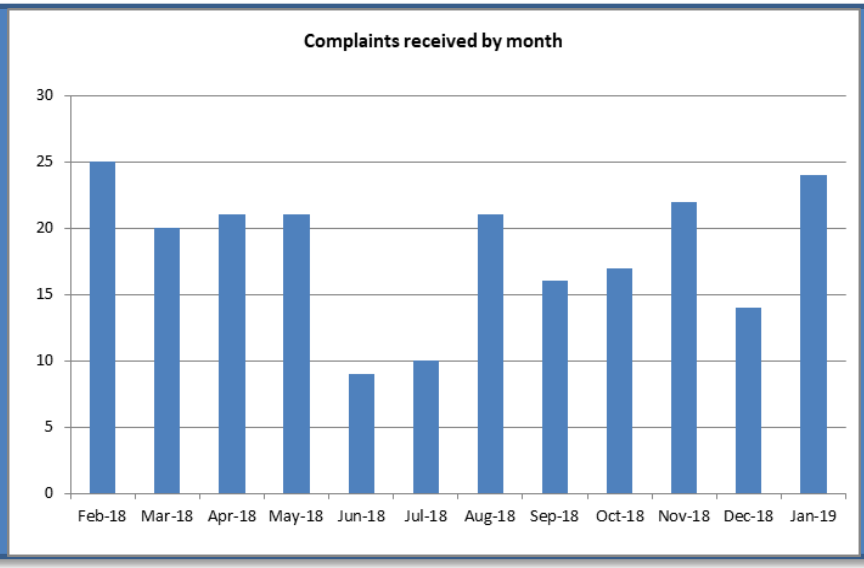
Monthly complaints received by the Trust.

24 complaints were received in January 2019 which covered 123 concerns. The highest categories were:

- Medical – Adverse Outcome
- Staff Attitude
- Nursing – Other
- Communication

Highest 3 areas receiving complaints/issues were:

- Emergency Department - 8 complaints with 15 issues
- Ward 7 - 2 complaints with 12 issues
- Ward 21b – 1 complaints with 9 issues



Formal Complaints

Number of formal complaint issues by division.

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

S&C: 30

DCSS: 20

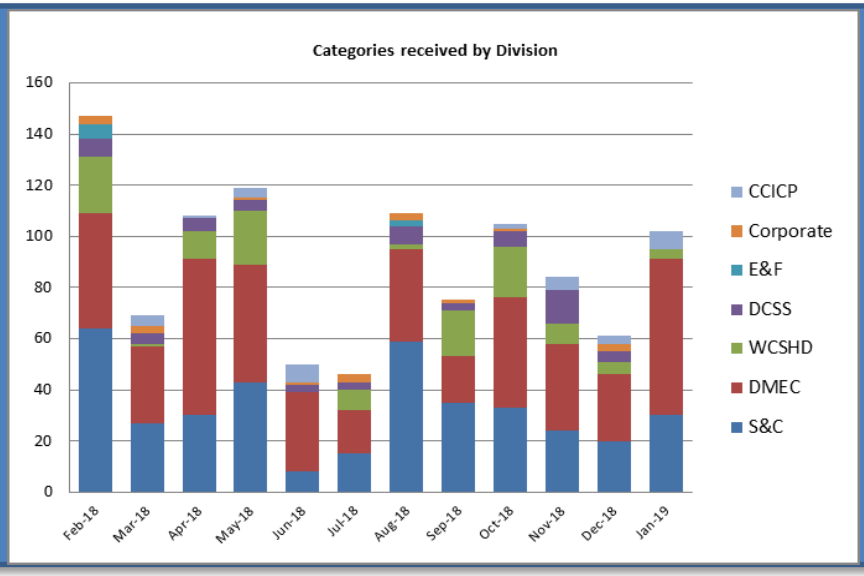
W&CD: 4

DMEC: 61

CCICP: 7

E&F: 1

Corporate Services: 0



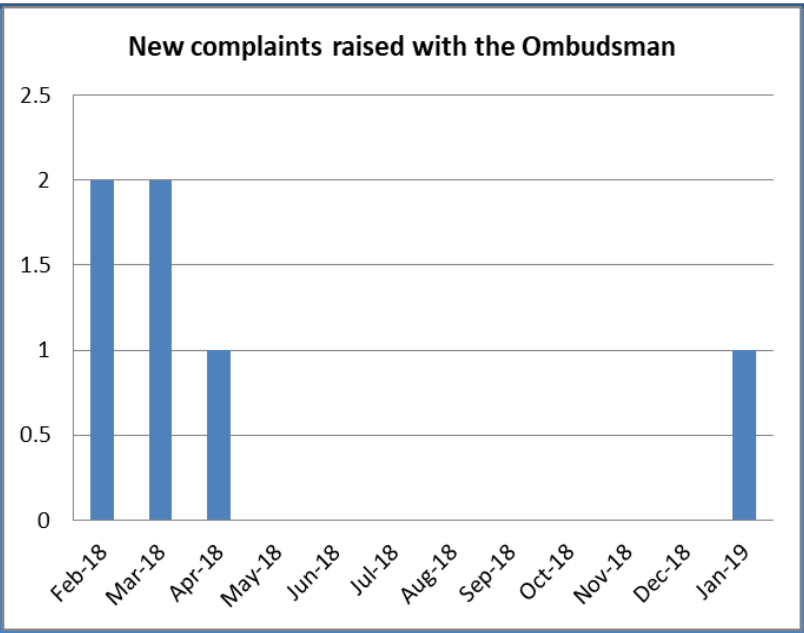
Formal Complaint issues by division

Description	Aggregate Position/Description	Trend

Complaints being reviewed by the Public Health Service Ombudsman

In January 2019, there was 1 new complaint opened with the PHSO. This case is as the assessment stage.

In the last rolling 12 months we have had 6 cases with the PHSO of which none to date have been upheld.



Ombudsman

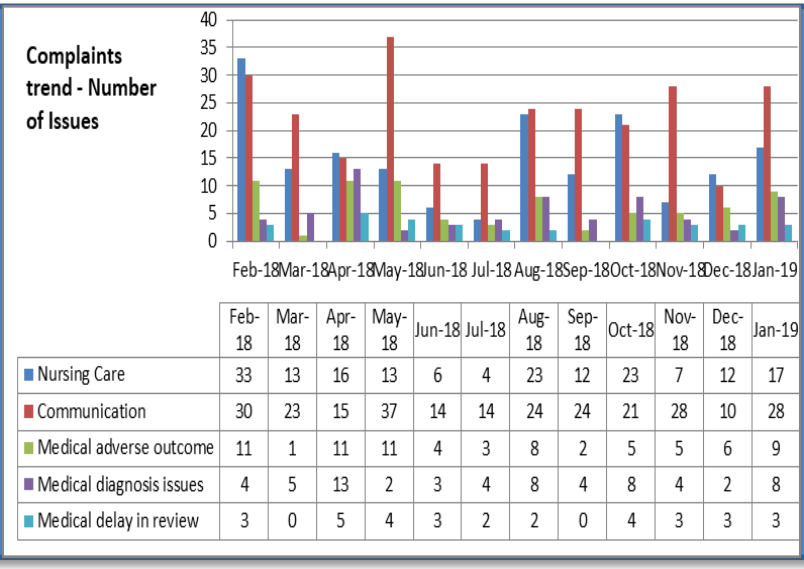
Complaint trends and number of issues.

The main trends in January 2019 were:

Nursing care - 7 complaints raising 17 issues.

Communication - 13 complaints raising 28 issues.

Medical adverse outcome - 8 complaints raising 9 issues.



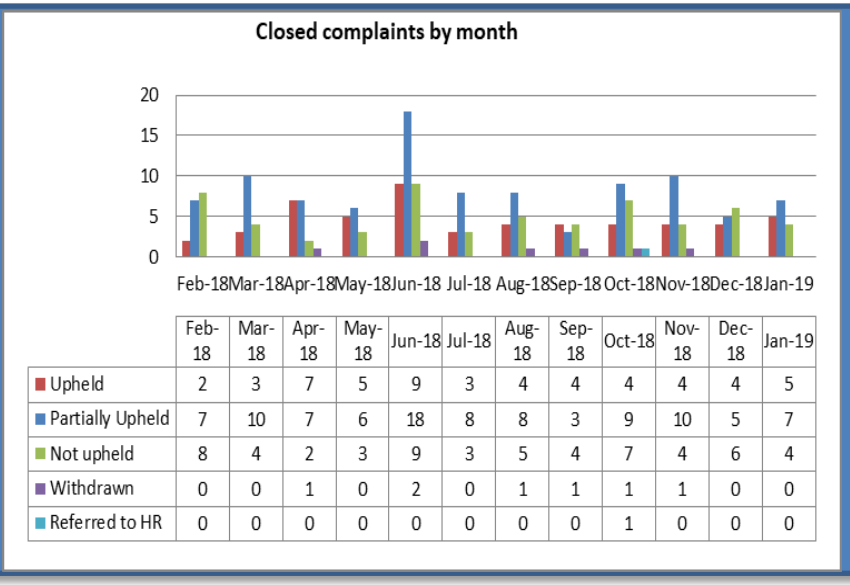
	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
Nursing Care	33	13	16	13	6	4	23	12	23	7	12	17
Communication	30	23	15	37	14	14	24	24	21	28	10	28
Medical adverse outcome	11	1	11	11	4	3	8	2	5	5	6	9
Medical diagnosis issues	4	5	13	2	3	4	8	4	8	4	2	8
Medical delay in review	3	0	5	4	3	2	2	0	4	3	3	3

Complaint Trends

Description	Aggregate Position/Description	Trend

Closed Complaints

16 complaints were closed In January 2019.



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

Closed Complaints

Closed Complaints by Division

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

Division	Upheld	Partially Upheld	Not Upheld	Withdrawn	Ref HR	Sub-Total
DMEC	0	1	1	0	0	2
Corporate	0	0	0	0	0	0
Surgery &Cancer	2	3	0	0	0	5
Women & Children's	0	1	3	0	0	4
DCSS	2	2	0	0	0	4
CCICP	1	0	0	0	0	1
					Total closed	**16**

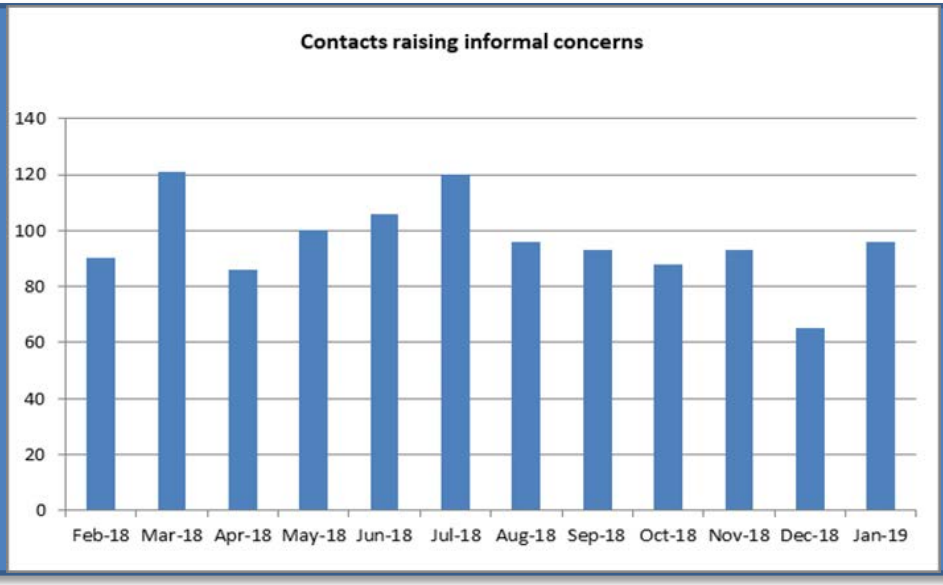
Complaints closed by Division for January 2019 - Tables removed under Section 40 of the Freedom of Information Act
No Complaints for Estates and Facilities or Corporate Services

Description	Aggregate Position/Description	Trend

Informal Concerns Numbers.

The number of contacts raising informal concerns for January 2019 was 96 which is an increase of 31 from the previous month.

The Division of Medicine and Emergency Care has received the largest number of individual concerns raised at 97, with 31 of these individual concerns relating to the Emergency Department.

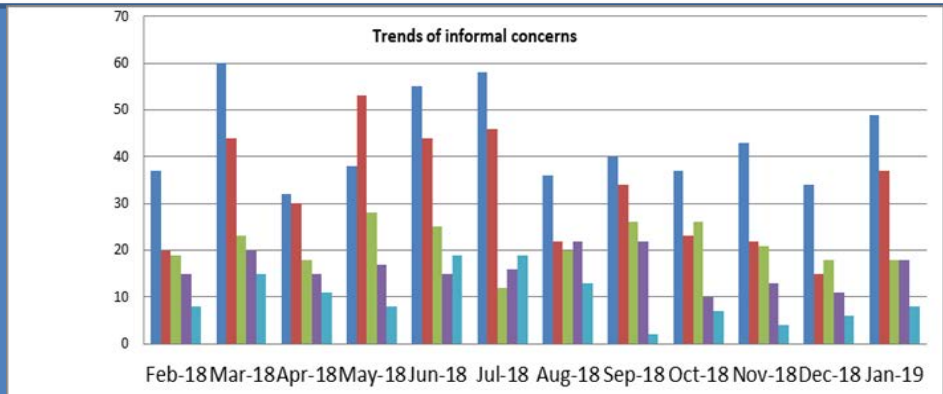


Informal Concerns Feedback

Informal Concerns Trends.

Communication was the highest trend for informal concerns in January 2019, with 21 of the 49 issues raised relating to the Division of Medicine and Emergency Care. Of these 21 issues, 4 relate to ward 7 and 3 belong to wards 2 and 3 respectively.

Of the 37 issues relating to care, 19 were regarding nursing care. Fourteen of the 19 issues relate to the Division of Medicine and Emergency Care with 4 for ward 7. Of the 17 issues relating to medical care, 12 relate to the Division of Medicine and Emergency Care with 4 belonging to the Emergency Department.



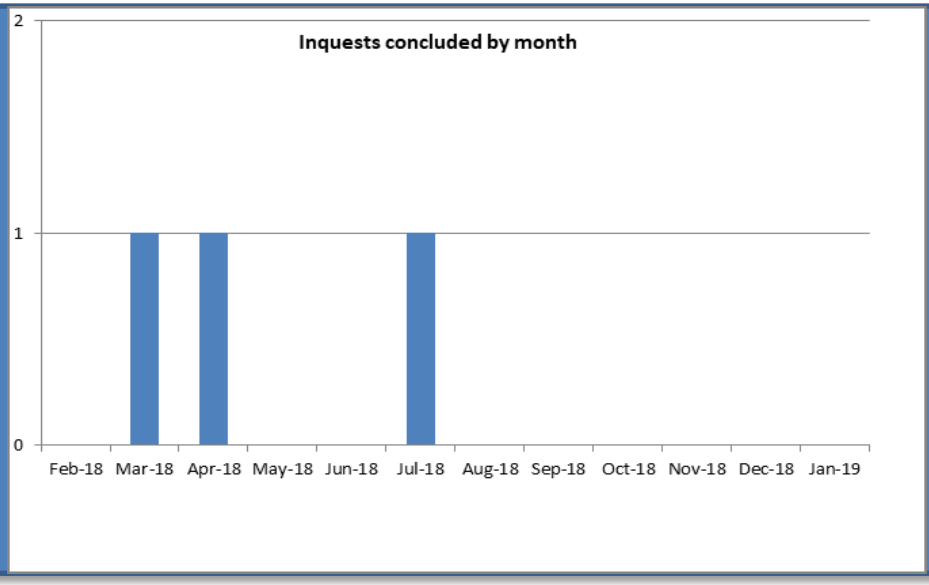
	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
Communication	37	60	32	38	55	58	36	40	37	43	34	49
Care	20	44	30	53	44	46	22	34	23	22	15	37
Appointments	19	23	18	28	25	12	20	26	26	21	18	18
Attitude of Staff	15	20	15	17	15	16	22	22	10	13	11	18
Treatment	8	15	11	8	19	19	13	2	7	4	6	8

Informal Concerns Trends

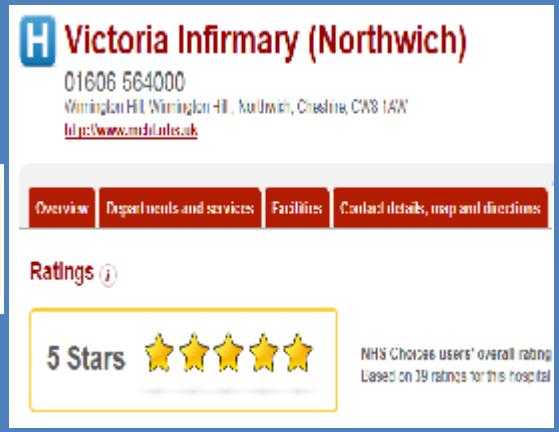
Description	Aggregate Position/Description	Trend
New claims received.	Narrative and graph removed under Section 43 of the Freedom of Information Act.	
Claims closed with/without damages.	Narrative and graph removed under Section 43 of the Freedom of Information Act.	

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

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

Description	Aggregate Position /Description	Trend
Number of Inquests concluded by month	No inquests were concluded in January 2019.	

Inquests

NHS Choices Star Ratings	Leighton Hospital is rated at 4.5 stars. Victoria Infirmary, Northwich is rated at 5 stars. The above ratings are based on 205 postings received within the previous 12 months.	 

NHS Choices – Star Ratings

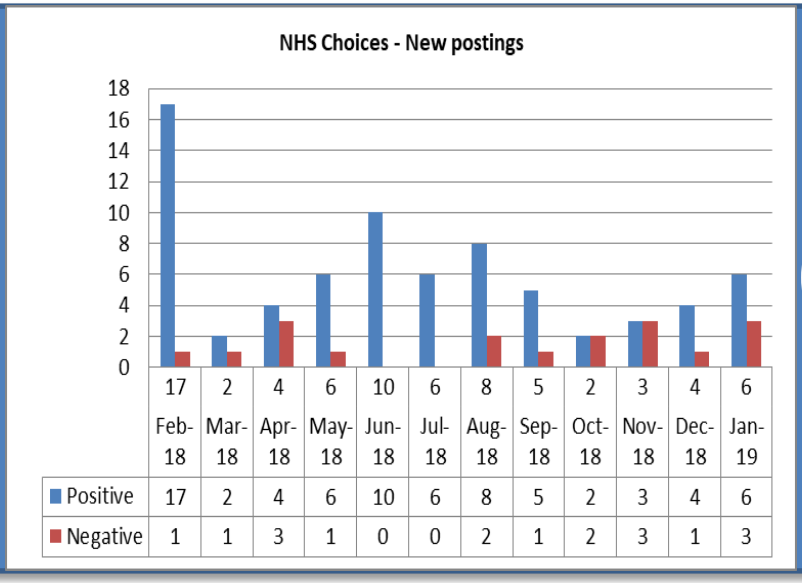
Description	Aggregate Position /description	Trend

NHS Choices postings

There were 9 postings on NHS Choices in January 2019 of which 6 were positive and 3 were negative. Examples of feedback included:

"I attended a bowel cancer screening appointment this morning and have left feeling thoroughly impressed with the professionalism and efficiency of the whole operation…… From the chap on reception, through to the consultant and the whole team, I felt assured and in safe hands" (Bowel Screening)

We were recently were cared for by an amazing team of people when our 10 year old daughter was admitted via ambulance to A&E and then transferred to Ward 17 for 4 days….. All your staff made us all feel that we were in safe hands and that we had the help to carry on. Thank you all so much for all you've done for our family, we are forever grateful." (CAU)



	17 Feb-18	2 Mar-18	4 Apr-18	6 May-18	10 Jun-18	6 Jul-18	8 Aug-18	5 Sep-18	2 Oct-18	3 Nov-18	4 Dec-18	6 Jan-19
Positive	17	2	4	6	10	6	8	5	2	3	4	6
Negative	1	1	3	1	0	0	2	1	2	3	1	3

NHS Choices – Postings

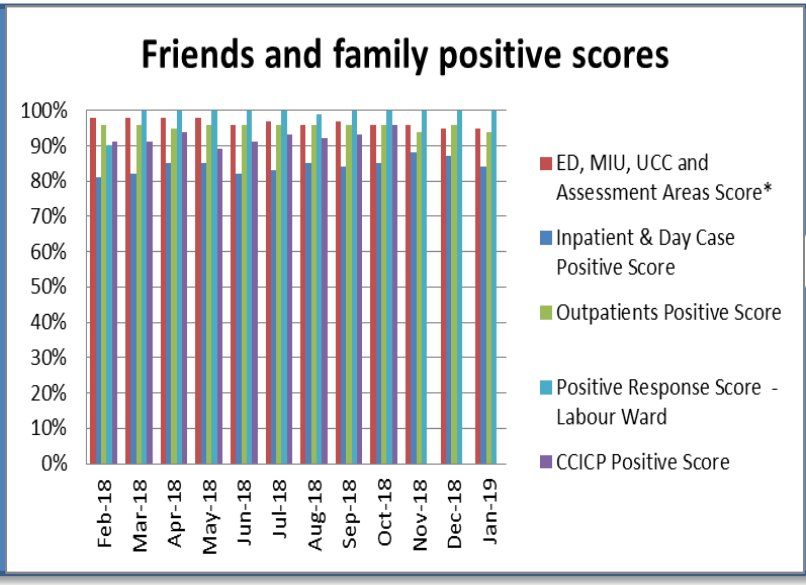
The Family and Friends Test asks patients if this would recommend our hospital services to a friend or relative based on their treatment and experience

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

Inpatients and day cases 96%; Emergency care /assessment areas 87%; Outpatients 94; Maternity 100%; CCICP 0%

The Trust has migrated community services systems from a database at East Cheshire to one for CCICP managed by computer services. The data extract required for FFT is being produced as part of the EMIS project and should be completed mid-January with data available from February onwards.

FFT text messaging will not commence until Feb 2019 due to a delay in the order submission for this service.



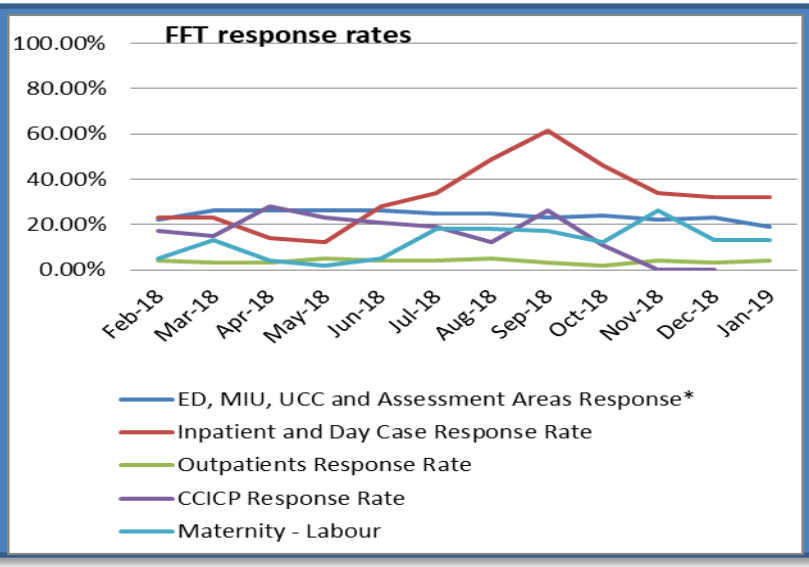
Family & Friends Test

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

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

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

January 2019 Ward/Dept.	% Response	Total responses received	How many would recommend
A&E , UCC & MIU	23%	1238	84%
Inpatients & Day cases	32%	1423	95%
Maternity	13%	98	99%
Outpatients	4%	722	94%
CCICP	0%	0	0%



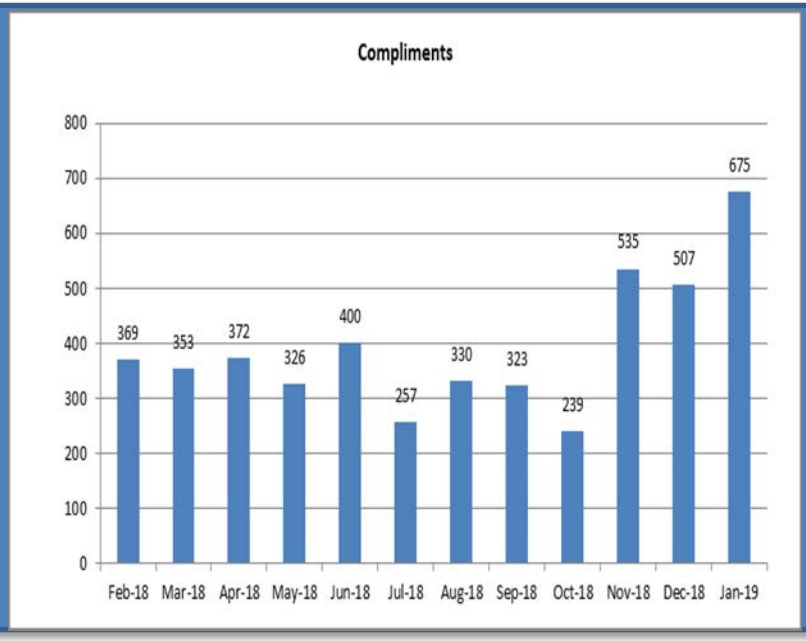
Family & Friends Test

Compliments received

There were 675 compliments received in January 2019. 37 of these were logged by the Customer Care Team and 638 (Christmas information received late) received across the Trust.

'I would just like to thank the wonderful staff on ward 2 for the care I received after being admitted with sepsis. All the staff were absolutely wonderful and I thank all of you involved in my treatment.'

'I had an appointment at the Orthopaedic Clinic and had to go for X-rays prior to being seen. The radiograph was very pleasant and friendly. She ensured I was comfortable at all times during the various foot X-rays taken. Please pass on my compliments!'



Compliments

Mid Cheshire Hospital
NHS Foundation Tru

Board of Directors Performance Report

January 2019

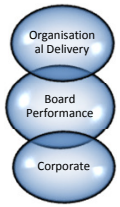
"To Deliver Excellence in Healthcare through Innovation & Collaboration"

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.

Tracy Bullock
Chief Executive

Contents

Headline Measures

Organisational Delivery				
Indicator	**Standard**	**YTD**	**Jan-19**	
Cancer				
Rapid Access Referrals (%) *(seen in 2 wks)*	93.00%	96.98%	96.59%	
Total Patients Seen		*8,673*	*822*	
Patients seen >14 days		*262*	*28*	
62 day GP Classic (%)	85.00%	89.62%	85.60%	*
Accountable Patients Treated		*636*	*52*	
No. of Breached Pathways (adjusted)		*66*	*8*	
62 day Screening (%)	90.00%	94.03%	86.20%	*
Accountable Patients Treated		*134*	*15*	
No. of Breached Pathways (adjusted)		*8*	*2*	
Unplanned Activity				
4 Hour Access Standard (%)	95.00%	84.20%	78.89%	
A&E Attendances (LH/MIU/UUC) (% to plan)		97.31%	99.25%	
A&E Attendances LH & MIU (Vol)		*77,111*	*7,679*	
Planned Activity				
Incomp Pathways <18wk (%)	92.00%	92.63%	91.30%	
>6wk Diagnostic Waits (%)	1.00%	0.37%	0.47%	
Total Patients Waiting for a First Outpatient Appointment			9,428	

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

Indicator	Standard	YTD
Workforce		
Sickness absence Rolling 12 Month		4.27%
Turnover Rolling 12 Month		10.60%

Corporate					
	YTD Rating		YE Rating	YE Metric	
Indicator	**Plan**	**Actual**	**Forecast**	**Plan**	**Forecast**
Finance					
Use of Resource Rating		3	3		
Capital Service Capacity	2	4	4	2.39	0.81
Liquidity	2	2	3	-1	-14
I&E Margin	2	4	4	2.10%	-1.50%
Distance from Financial Plan	0	3	4	0.00%	-3.60%
Agency Spend	1	1	2	-23.27%	4.94%

	YTD Target	YTD Actual	YTD Variance	FY Target	FY Forecast	FY Variance
Cost Improvement Schemes Total (£000's)	5,746	4,878	-794	6,772	5,588	-1,184
Commission Contact Income SC & VR (£000's)	153,711	153,711	0			
Contract Income (£'000)	186,668	188,246	1,578			
Pay to Budget (£000's)	-142,923	-145,763	-2,840			
Non Pay to Budget (£000's)	-57,870	-60,654	-2,784			
Agency Trajectory (£000's)	-3,650	-5,159	-1,509			

Exec Summary

In January 2019, the Trust delivered two of the five NHS Improvement Single Oversight Framework performance indicators (62 Day GP Classic and Rapid Access referrals). The indicators not achieved were the 4 hour Access standard, 62 day Screening standard and the RTT Incomplete Pathway standard.

To note the RTT Incomplete Pathway performance is an interim figure as validation of pathways continue until the monthly statutory submission deadline.

The 4 hour Access Standard in January achieved 78.89% against the 95% performance standard.
The Trust has achieved two of the three headline cancer access standards for January. Rapid access referrals and 62 day GP Classic treatment pathways have continuously achieved above target for over 12 months. However 62 day Screening has achieved 86.20% against the 90% target.

Diagnostics waiting times continue to perform well, with just 0.47% of patients waiting longer than 6 weeks for their diagnostic test against a regulatory threshold of 1%.

The UoRR metric is 3, primarily a consequence of the override resulting from the impact of the Trust's ability to service DH loans from revenues and depreciation.

The Trusts' I&E position, before exceptional items is a deficit of £2.2M which is £2.8M worse than the planned surplus of £0.6M, with the position including £3.75M of the MOU with South/Vale Royal CCGs, which has now been settled and agreed.

This position has a provision against the provider sustainability fund (PSF) for the failure to achieve the A&E target (£1.6M). The Trust has met the control total for the first three quarters and therefore this is including within the position – however given the MOU settlement it is not expected to achieve the final quarter for the financial target.

There is a variation in the CIP scheme, with challenges around delivering improvements to sickness rates within nursing and maintaining the medical vacancy factor.

The Trust is currently £1.5M worse than plan for Agency spend – and it is now expected that Trust will breach the ceiling of £5.7M if the rate of agency to date continues throughout Winter.

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 improve during 2018/19, although, is at risk due to the deteriorating financial position. This results in a 'trigger' on the Finance & Resource theme. This is primarily driven by the capital service capacity metric which will improve when short term loans required to support liquidity are repaid in the year. Based on the settlement of the MOU, it is expected that whilst there will be a further deterioration of some of the metrics as indicated – the Trust should maintain its overall Use of Resources Rating of 3.

Operational Performance

	Current YTD													Monthly Trend
	Target	Actual	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	
Maximum 6 week wait for Diagnostic procedures	1%	0.37%	0.53%	0.08%	0.33%	0.26%	0.17%	0.32%	0.56%	0.31%	0.44%	0.48%	0.17%	0.54%	0.47%	
All Cancers: 62 day GP Classic (%) *	85%	89.62%	87.30%	92.06%	94.06%	87.13%	92.91%	92.00%	91.40%	91.78%	86.11%	86.50%	93.40%	86.90%	85.60%	
All Cancers: 62 day Screening (%) *	90%	94.03%	100.00%	100.00%	100.00%	100.00%	89.47%	91.67%	100.00%	91.84%	100.00%	100.00%	100.00%	81.80%	86.20%	
18 weeks from point of referral to treatment - patients on an incomplete pathway (%)	92%	92.63%	94.59%	94.13%	92.65%	93.00%	93.27%	93.14%	92.97%	93.05%	92.43%	92.82%	92.28%	92.01%	91.30%	
A&E - maximum waiting time of 4 hours from arrival to admission/transfer/discharge (%)	95%	84.20%	78.38%	77.91%	77.90%	82.65%	85.15%	81.78%	84.59%	87.14%	84.61%	85.51%	88.13%	83.57%	78.89%	
STF Trajectory			90.52%	90.52%	95.00%	92.72%	92.72%	92.72%	93.92%	93.92%	93.92%	90.00%	90.00%	90.00%	90.00%	
Provider Submitted Trajectory														88.10%	85.15%	

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

Financial & Resource

		Unit	YE Plan	YE Forecast	YE Rating	YTD Plan	YTD Actual	YTD Rating
Financial Sustainability	Capital Service Capacity	0.0x	2.39	0.81	4	1.80	1.12	4
	Liquidity	days	-1	-14	3	-4	-4	2
Financial Efficiency	I&E Margin	%	2.10%	-1.50%	4	0.10%	-1.10%	4
Financial Controls	Distance from Financial Plan	%	0.00%	-3.60%	4	0.00%	-1.20%	3
	Agency Spend	%	-23.27%	4.94%	2	-9.65%	-100.00%	1
Overall UOR Rating					3			3

Operational Delivery: *Cancer Pathway*

Headline Measures

	Current YTD		Rolling 13 months											
	Target	Actual	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Monthly Trend
Rapid Access Referrals (%) (seen in 2 wks)	93%	96.98%	94.83%	93.05%	98.64%	96.08%	96.76%	97.54%	96.37%	96.73%	96.50%	96.87%	98.36%	97.78%	96.59%	
Total Patients Seen		*8673*	*715*	*806*	*811*	*766*	*956*	*855*	*855*	*887*	*771*	*989*	*917*	*855*	*822*	
Patients seen >14 days		*262*	*37*	*56*	*11*	*30*	*31*	*21*	*31*	*29*	*27*	*31*	*15*	*19*	*28*	
% seen within 7 days		*40.8%*	*54.6%*	*53.1%*	*61.2%*	*45.2%*	*39.6%*	*43.7%*	*44.4%*	*35.2%*	*51.4%*	*41.5%*	*34.0%*	*35.4%*	*39.5%*	
62 day GP Classic (%) *	85%	89.62%	87.30%	92.06%	94.06%	87.13%	92.91%	92.00%	91.40%	91.78%	86.11%	86.50%	93.40%	86.90%	85.60%	

** Provisional figures subject to change depending*

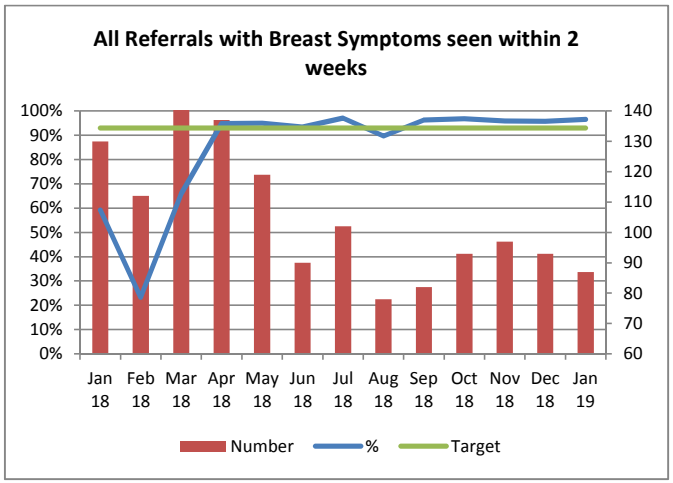
104+ day waits - (Cancer patients treated)	1	2	3	1	1	0	1	0	4	0	0	3	0

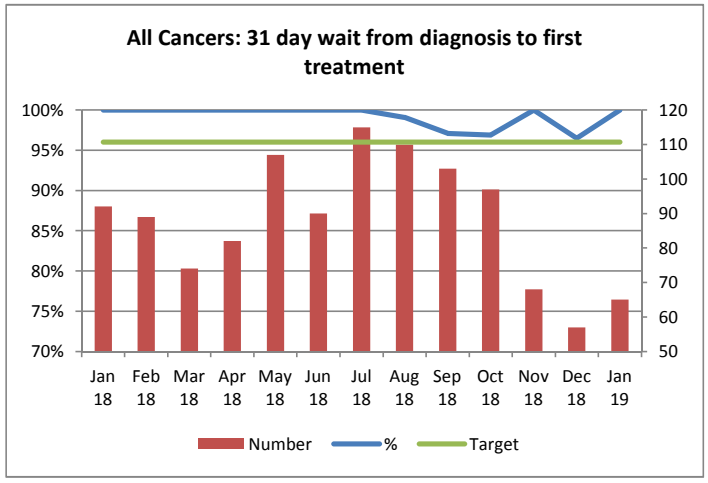
Commentary

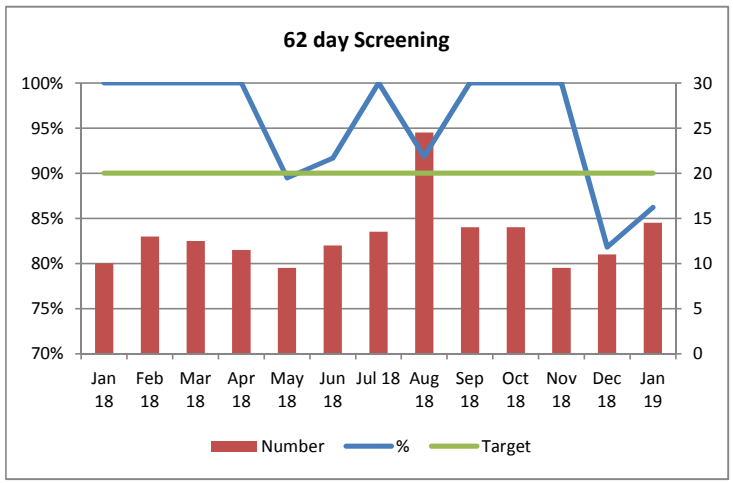
The Trust has achieved two of the three headline cancer standards during the month of January 2019. The figures presented in this paper reflect the Trust's regulatory performance measures adjusted figures that take into account breach reallocation between providers). From October the new cancer repatriation policy is in use.

The Trust has continued it's strong performance against the Rapid Access referrals standard achieving 96.98% in January. However 62 day Screening has achieved 86.20% against a 90% target, with two patients out of 14.5 patients breaching. This standard is monitored monthly but reported quarterly with quarter four expected to deliver compliance against this standard.

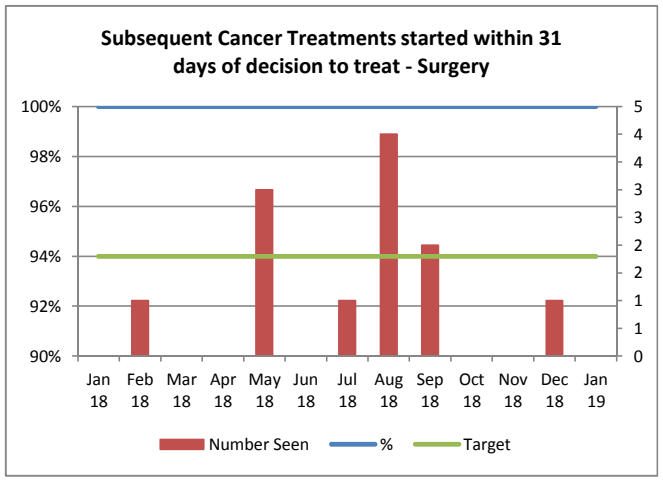
Primary Measures

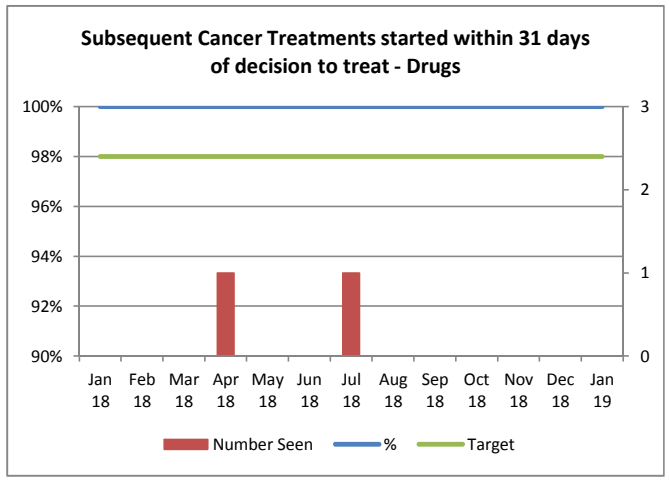


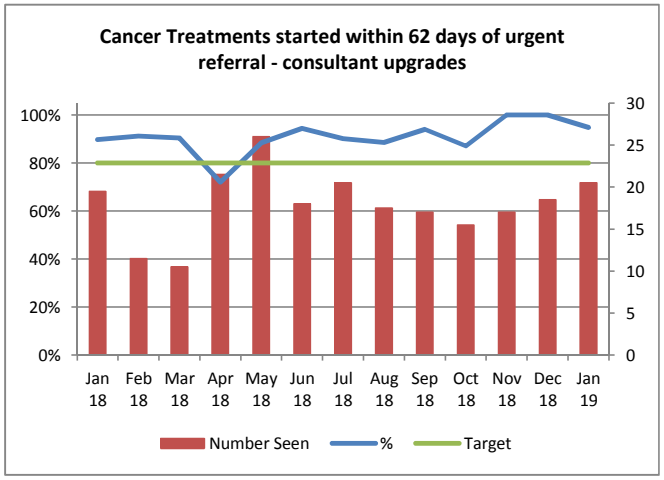




Operational Delivery: *Cancer Pathway*







Operational Delivery: *Unplanned Activity - A&E*

Headline Measures

	Current YTD		Rolling 13 months												
	Target	Actual	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Monthly Trend
A&E - >4 hr wait time from arrival to admission/ transfer/ discharge (% to Target)	95%	84.20%	78.38%	77.91%	77.90%	82.65%	85.15%	81.78%	84.59%	87.14%	84.61%	85.51%	88.13%	83.57%	78.89%	
No. of 4hr breaches		*12,187*	*1,543*	*1,469*	*1,679*	*1,244*	*1,179*	*1,472*	*1,286*	*967*	*1,158*	*1,167*	*884*	*1,209*	*1,621*	

	Plan	Actual	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Monthly Trend
A&E Attendances (LH/MIU/UUC) (% to Plan)		*97.31%*	97.1%	94.4%	93.6%	93.2%	95.3%	98.9%	99.6%	97.7%	94.9%	100.0%	98.4%	95.8%	99.3%	
A&E Attendances (LH/MIU/UUC) (No.)	*75,237*	*77,111*	7,138	6,649	7,598	7,170	7,937	8,081	8,344	7,517	7,524	8,056	7,445	7,358	7,679	

A&E Attendance Case Mix (based on acuity score)	*Major*		*23,261*	*2,191*	*2,173*	*2,422*	*2,288*	*2,460*	*2,386*	*2,168*	*2,380*	*2,228*	*2,455*	*2,269*	2,235	2,392	
	Minor		*29,274*	*2,940*	*2,474*	*2,886*	*2,799*	*2,992*	*3,325*	*3,643*	*2,990*	*2,810*	*2,768*	*2,560*	2,605	2,782	
	Paediatrics		*15,196*	*1,304*	*1,305*	*1,544*	*1,419*	*1,676*	*1,648*	*1,691*	*1,181*	*1,516*	*1,709*	*1,562*	1,422	1,372	
	Resus		*9,352*	*703*	*697*	*746*	*664*	*805*	*722*	*835*	*966*	*969*	*1,120*	*1,048*	1,095	1,128	

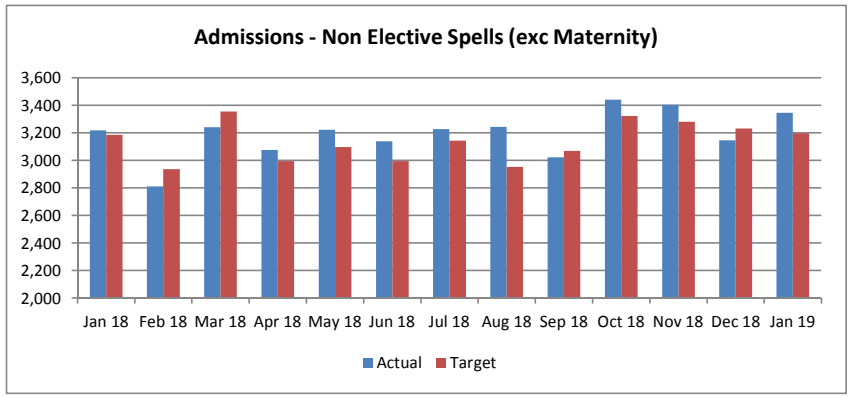
A&E Attendance Location (based on Discharge)	*Major*		*31,829*	*3,038*	*2,761*	*3,204*	*2,957*	*3,170*	*3,136*	*3,121*	*3,225*	*3,090*	*3,413*	*3,187*	*3,176*	*3,354*	
	Minor		*28,506*	*2,617*	*2,403*	*2,650*	*2,623*	*2,948*	*3,157*	*3,364*	*2,977*	*2,775*	*2,791*	*2,560*	*2,573*	*2,738*	
	Paediatrics		*15,196*	*1,304*	*1,305*	*1,544*	*1,419*	*1,676*	*1,648*	*1,691*	*1,181*	*1,516*	*1,709*	*1,562*	*1,422*	*1,372*	
	Resus		*1,552*	*179*	*180*	*200*	*171*	*139*	*140*	*161*	*134*	*142*	*139*	*130*	*186*	*210*	

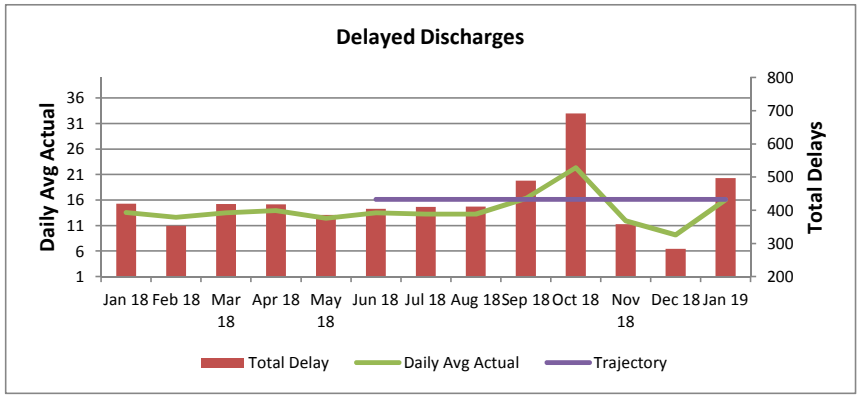
Commentary

The Trust has achieved 78.89% against the 4-hour access standard in January 2019. This is similar to the same month last year at 78.38%, despite seeing over 500 more attendances in January 19, an increase of 8%. The number of higher acuity patients (Resus and Majors) arriving in A&E has continued an upward trend each month since September 2018, for January these types of attendances represent 46% of total attendances.
Despite the increase in acuity mix, emergency admissions are within target in January.

Patients medically optimised for discharge has increased in January compared to December, however is still within the DTOC threshold of 16. The biggest area of growth in delays is with Cheshire East Council. In addition Medical Outliers has spiked to 46, compared to 29 in December.

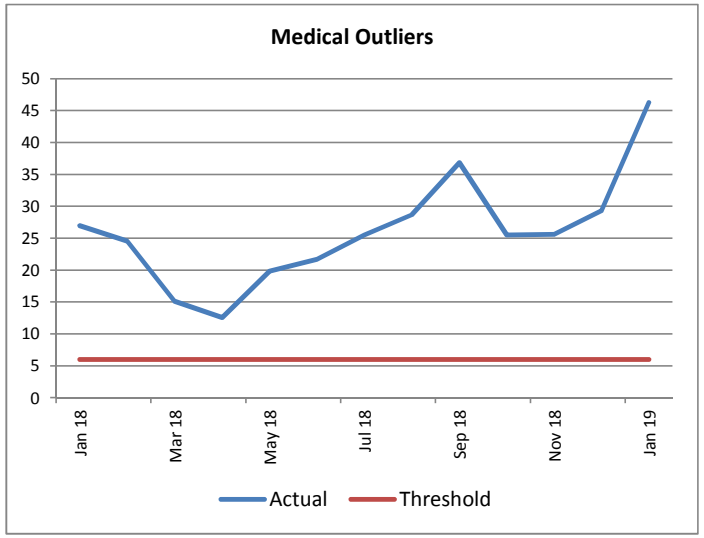
Primary Drivers

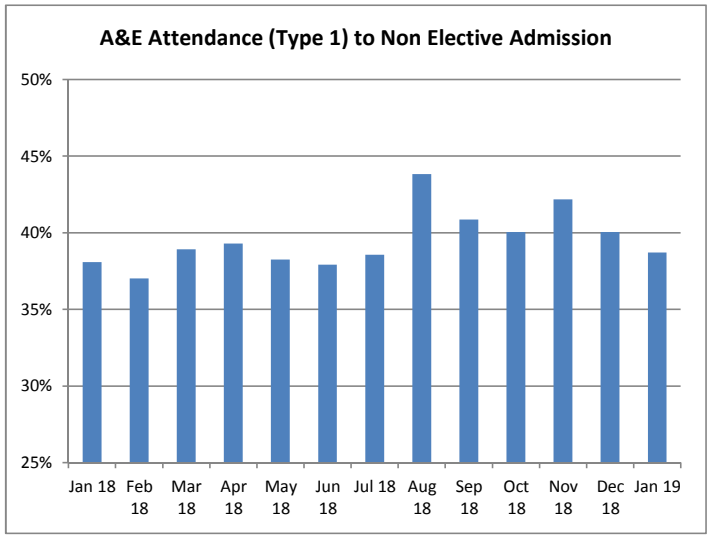


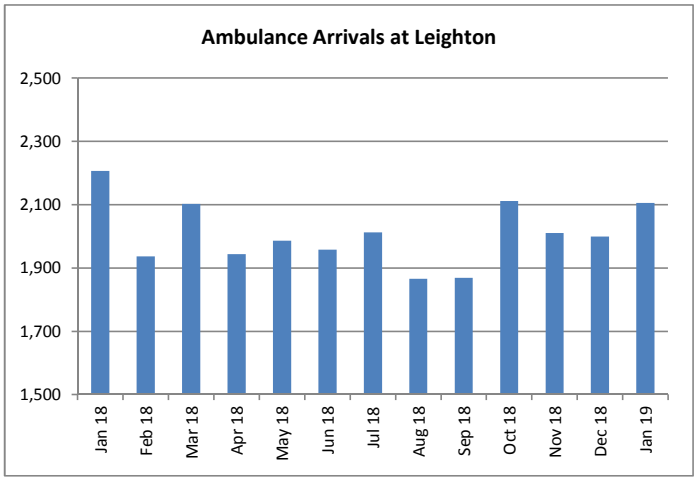


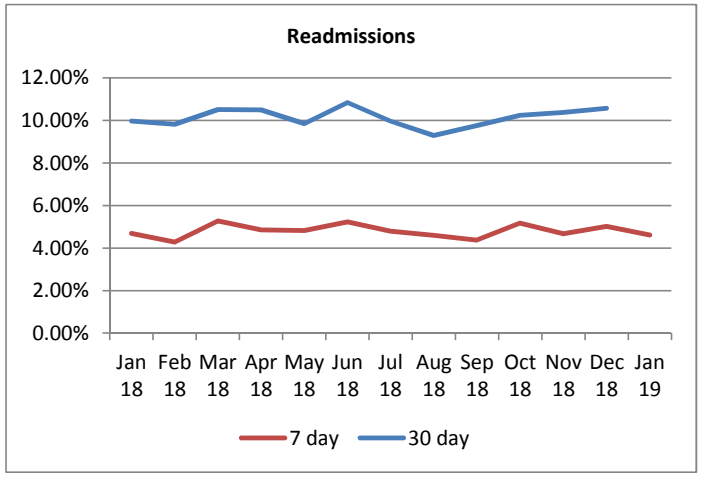
Operational Delivery: *Unplanned Activity A&E*

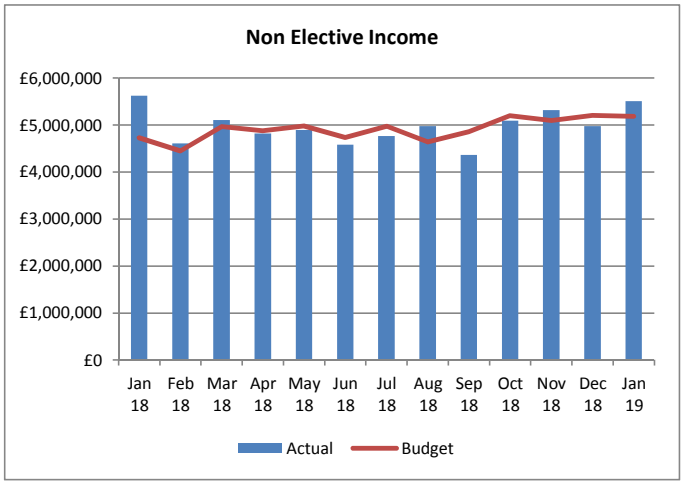
Secondary Drivers





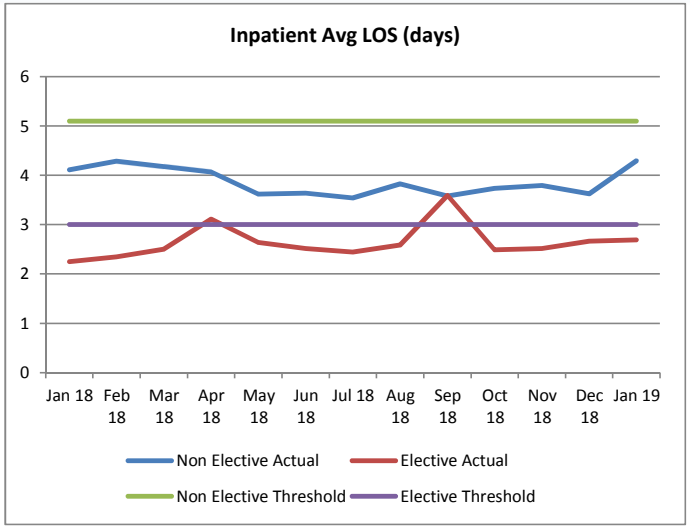


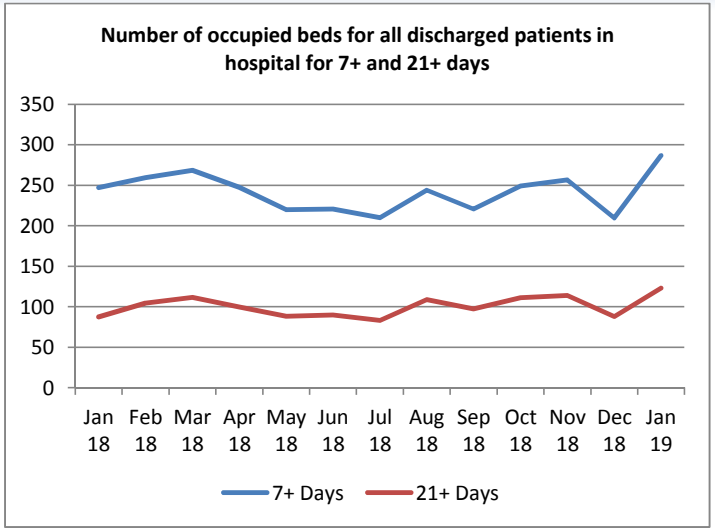


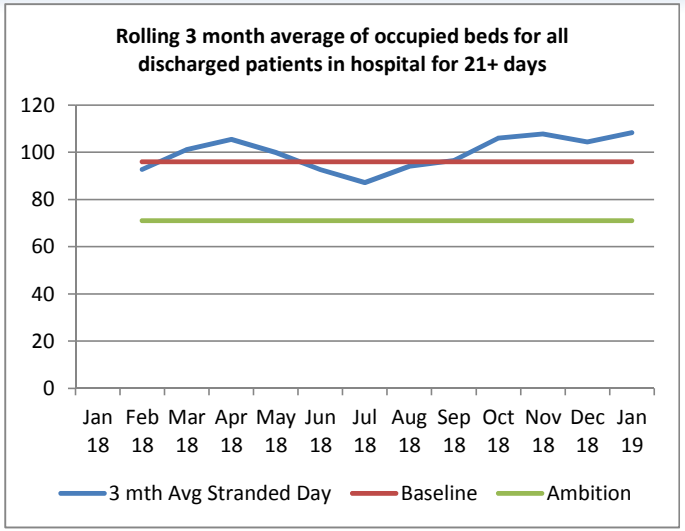


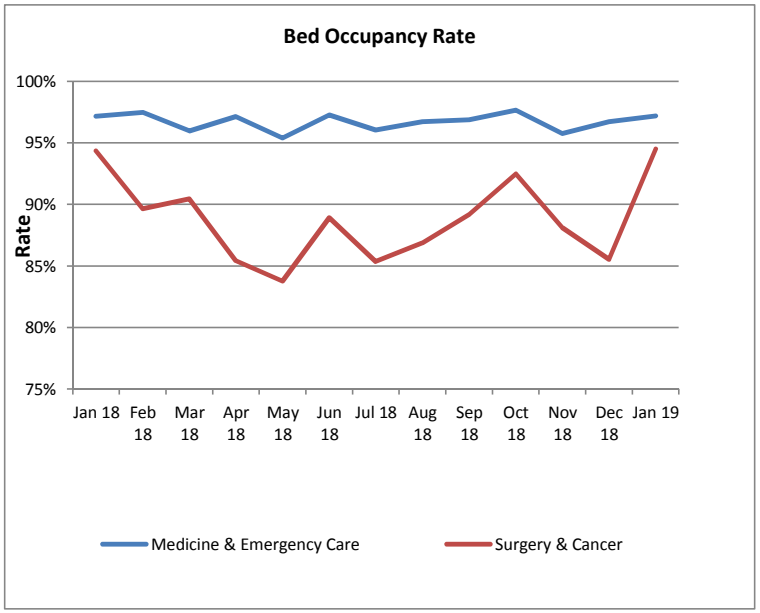
** Readmissions brought in line with national definition*

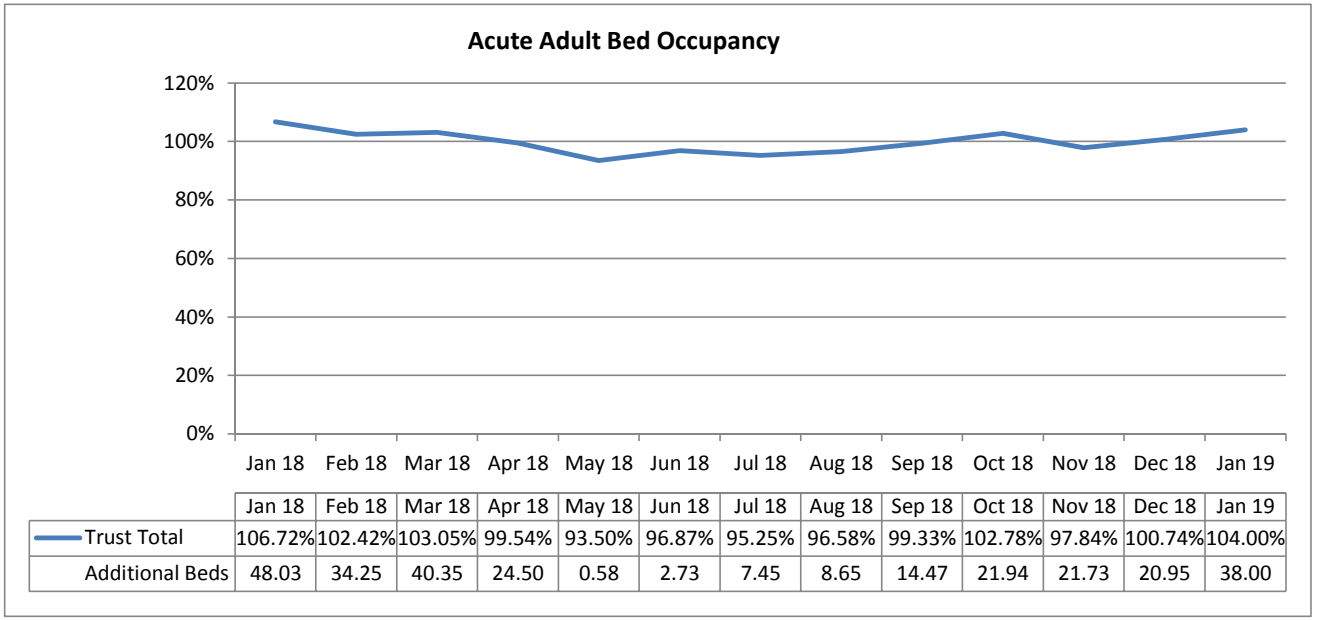
Operational Delivery: *Length of Stay*











	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19
Trust Total	106.72%	102.42%	103.05%	99.54%	93.50%	96.87%	95.25%	96.58%	99.33%	102.78%	97.84%	100.74%	104.00%
Additional Beds	48.03	34.25	40.35	24.50	0.58	2.73	7.45	8.65	14.47	21.94	21.73	20.95	38.00

Operational Delivery: *Planned Activity*

Headline Measures

	Current YTD		Rolling 13 months											
	Target	Actual	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Monthly Trend
18 weeks from Referral to Treatment in Aggregate - Incomplete	92%	92.63%	94.59%	94.13%	92.65%	93.00%	93.27%	93.14%	92.97%	93.05%	92.43%	92.82%	92.28%	92.01%	91.30%	
Total 18 Weeks		*145,636*	*13,133*	*13,348*	*13,990*	*14,253*	*14,405*	*14,713*	*14,630*	*15,373*	*14,988*	*14,284*	*14,331*	*14,232*	*14,427*	
No. > 18 Weeks		*10,733*	*711*	*784*	*1,028*	*998*	*969*	*1,010*	*1,029*	*1,069*	*1,135*	*1,025*	*1,106*	*1,137*	*1,255*	
Open Pathways >39 Weeks Waiting											*7*	*5*	*7*	*10*	*11*	
Diagnostic Waiting Time	1%	0.37%	0.53%	0.08%	0.33%	0.26%	0.17%	0.32%	0.56%	0.31%	0.44%	0.48%	0.17%	0.54%	0.47%	
Total Number of Waiters		*41,230*	*3,587*	*3,548*	*4,293*	*4,224*	*4,127*	*4,619*	*4,257*	*3,814*	*4,105*	*4,168*	*4,017*	*3,870*	*4,029*	
Waiters of 6 Weeks +		*154*	*19*	*3*	*14*	*11*	*7*	*15*	*24*	*12*	*18*	*20*	*7*	*21*	*19*	
Total Patients Waiting for a First Outpatient Appointment			8,342	8,501	8,866	9,243	9,579	9,354	9,496	9,851	9,654	9,496	9,430	8,948	9,428	
Longest Wait Time (weeks)											*44*	*45*	*44*	*46*	*47*	

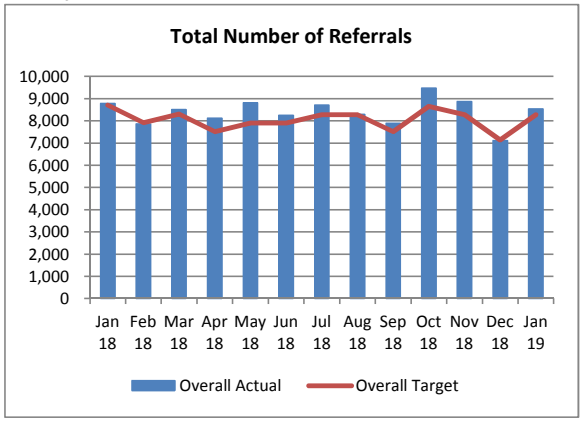
Commentary

The Trust's current RTT Incomplete Pathway position is 91.30% for January. This is an interim performance figure and pathways continue to be validated upto the statutory deadline. Currently six specialties have failed to meet the 92% target in January, these are General Surgery, Urology, Gastroenterology, Dermatology, Cardiology and Trauma and Orthopaedics.

Mid Cheshire do not currently have any 52 week breaches for January however there are 11 patients waiting over 39 weeks; (5 in General Surgery, 1 in Urology , 1 in ENT, 1 in Cardiology, 1in Gastroenterology, 1 in Gynaecology and 1 in Trauma & Orthopaedics). All long wait patients are monitored and reviewed weekly at director led performance meetings.

The Trust has delivered the diagnostic wait time consistently since July 2016. In January 2019, 0.47% of patients waited longer than 6 weeks for their diagnostic tests, with all modalities delivering the standard.

Primary Drivers

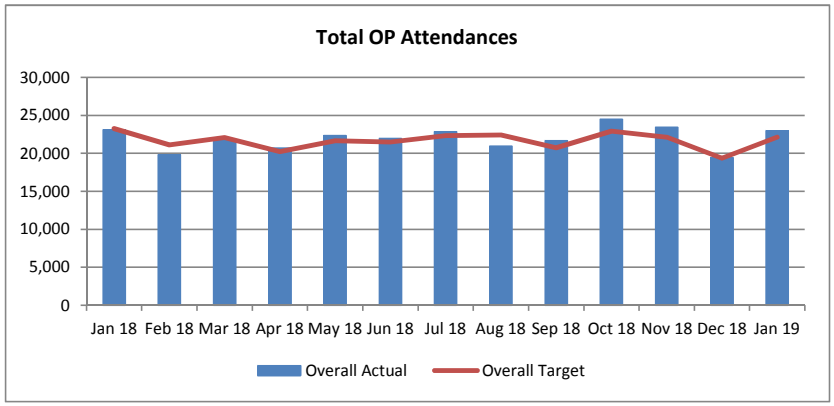


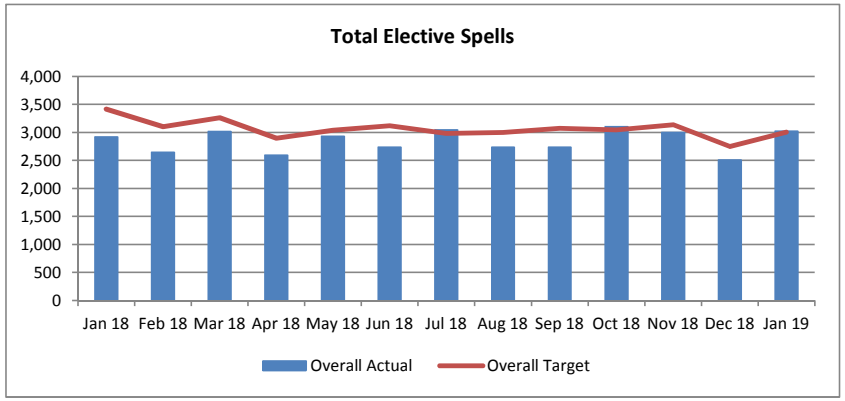
Referral Breakdown

	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Monthly Trend
GP Actual	5,573	4,928	5,388	4,858	5,400	5,065	5,355	5,184	4,925	5,755	5,684	4,411	5,424	
GP Target	5,509	5,008	5,259	4,683	4,920	4,920	5,157	5,157	4,683	5,394	5,157	4,446	5,157	
% to Target	101.2%	98.4%	102.5%	103.7%	109.8%	103.0%	103.8%	100.5%	105.2%	106.7%	110.2%	99.2%	105.2%	
Other Actual	3,205	2,931	3,119	3,256	3,408	3,186	3,352	3,107	2,968	3,714	3,189	2,696	3,118	
Other Target	3,195	2,904	3,050	2,833	2,976	2,976	3,120	3,120	2,833	3,263	3,120	2,689	3,120	
% to Target	100.3%	100.9%	102.3%	114.9%	114.5%	107.1%	107.5%	99.6%	104.8%	113.8%	102.2%	100.3%	100.0%	
Total Actual	8,778	7,859	8,507	8,114	8,808	8,251	8,707	8,291	7,893	9,469	8,873	7,107	8,542	
Total Target	8,704	7,913	8,308	7,515	7,896	7,896	8,276	8,276	7,515	8,657	8,276	7,135	8,276	
% to Target	100.9%	99.3%	102.4%	108.0%	111.6%	104.5%	105.2%	100.2%	105.0%	109.4%	107.2%	99.6%	103.2%	
GP % of Total	63.5%	62.7%	63.3%	59.9%	61.3%	61.4%	61.5%	62.5%	62.4%	60.8%	64.1%	62.1%	63.5%	

Operational Delivery: *Planned Activity*

Primary Drivers



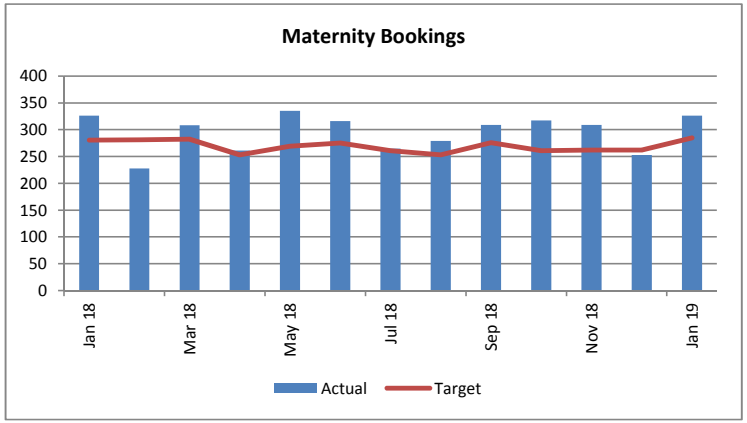


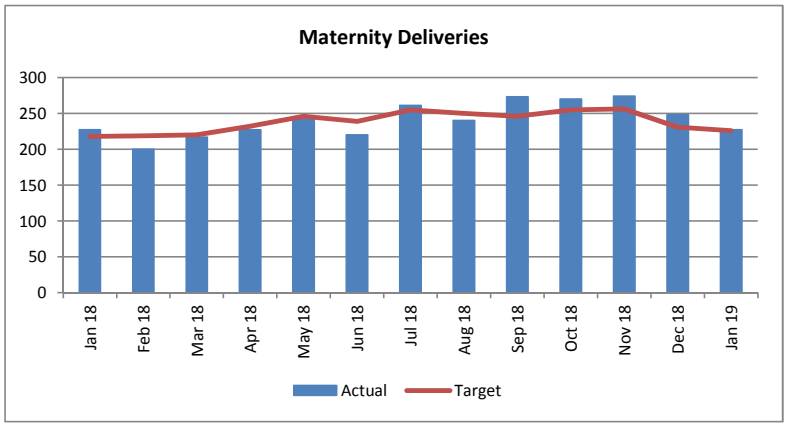
OP Attendance Breakdown	YTD 18 19	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Monthly Trend
New Actual	67,971	6,862	6,217	6,855	6,472	7,138	6,868	7,001	6,211	6,648	7,713	7,203	5,946	6,771	
New Target	62,654	7,253	6,585	6,909	5,892	6,224	6,212	6,495	6,502	5,934	6,778	6,496	5,625	6,496	
% to Target	108.5%	94.6%	94.4%	99.2%	109.9%	114.7%	110.6%	107.8%	95.5%	112.0%	113.8%	110.9%	105.7%	104.2%	
F U Actual	152,719	16,215	13,583	14,927	14,214	15,170	15,089	15,835	14,737	15,014	16,778	16,207	13,492	16,183	
F U Target	152,627	15,991	14,504	15,152	14,346	15,407	15,283	15,844	15,912	14,774	16,157	15,600	13,701	15,604	
% to Target	100.1%	101.4%	93.7%	98.5%	99.1%	98.5%	98.7%	99.9%	92.6%	101.6%	103.8%	103.9%	98.5%	103.7%	
Total Actual	220,690	23,077	19,800	21,782	20,686	22,308	21,957	22,836	20,948	21,662	24,491	23,410	19,438	22,954	
Total Target	215,281	23,244	21,089	22,061	20,237	21,631	21,495	22,339	22,414	20,708	22,935	22,095	19,326	22,100	
% to Target	102.5%	99.3%	93.9%	98.7%	102.2%	103.1%	102.1%	102.2%	93.5%	104.6%	106.8%	105.9%	100.6%	103.9%	
New % of Total	30.8%	29.7%	31.4%	31.5%	31.3%	32.0%	31.3%	30.7%	29.6%	30.7%	31.5%	30.8%	30.6%	29.5%	

Elective Spells Breakdown	YTD 18 19	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Monthly Trend
I P Actual	2,498	164	240	273	216	293	263	276	226	259	284	280	241	160	
I P Target	2,772	346	314	330	301	301	294	271	288	281	308	308	241	181	
% to Target	90.1%	47.4%	76.5%	82.8%	71.8%	97.4%	89.4%	101.9%	78.6%	92.2%	92.3%	91.0%	100.1%	88.6%	
Daycase Actual	25,914	2,753	2,404	2,745	2,378	2,637	2,476	2,766	2,513	2,479	2,817	2,717	2,268	2,863	
Daycase Target	27,268	3,071	2,790	2,931	2,593	2,738	2,825	2,709	2,709	2,795	2,740	2,827	2,507	2,826	
% to Target	95.0%	89.6%	86.2%	93.7%	91.7%	96.3%	87.7%	102.1%	92.8%	88.7%	102.8%	96.1%	90.5%	101.3%	
Total Actual	28,412	2,917	2,644	3,018	2,594	2,930	2,739	3,042	2,739	2,738	3,101	2,997	2,509	3,023	
Total Target	30,040	3,417	3,104	3,260	2,894	3,039	3,119	2,980	2,996	3,076	3,048	3,135	2,748	3,007	
% to Target	94.6%	85.4%	85.2%	92.6%	89.6%	96.4%	87.8%	102.1%	91.4%	89.0%	101.8%	95.6%	91.3%	100.5%	
I P % of Total	8.8%	5.6%	9.1%	9.0%	8.3%	10.0%	9.6%	9.1%	8.3%	9.5%	9.2%	9.3%	9.6%	5.3%	

Operational Delivery: *Planned Activity*

Primary Drivers



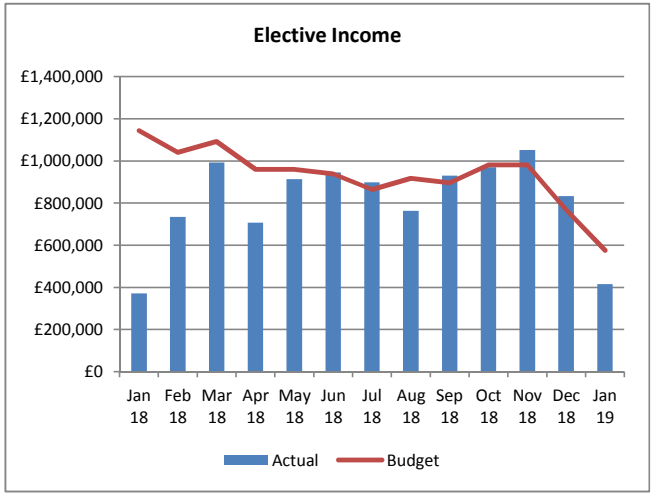


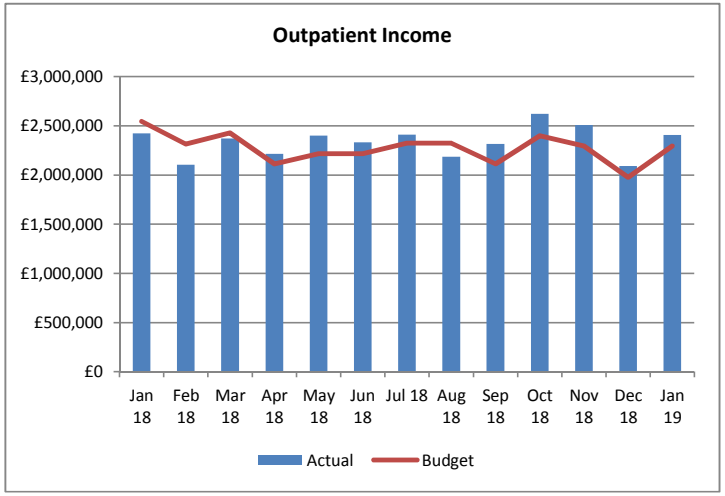
Operational Delivery: *Planned Activity*

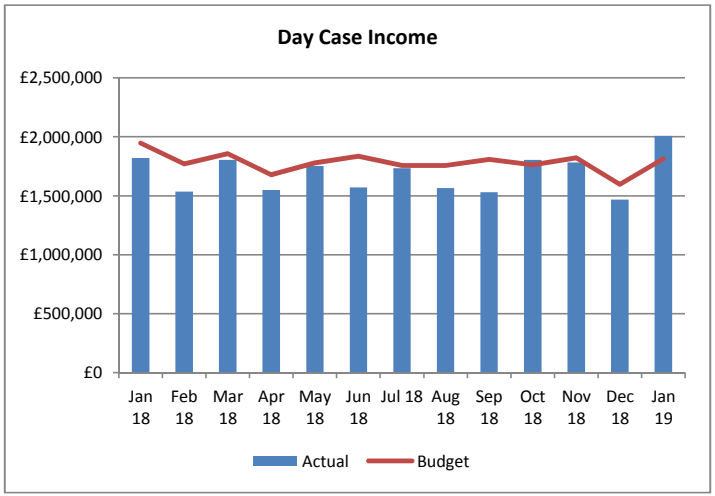
Secondary Drivers

			Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Monthly Trend
Bed Occupancy Rate	Medicine & Emergency Care		97.2%	97.5%	96.0%	97.1%	95.4%	97.3%	96.1%	96.7%	96.9%	97.7%	95.8%	96.7%	97.2%	
	Surgery & Cancer		94.4%	89.6%	90.4%	85.4%	83.8%	88.9%	85.4%	86.9%	89.2%	92.5%	88.1%	85.5%	94.5%	
Elective Inpatient Avg LOS (Days)			2.3	2.4	2.5	3.1	2.6	2.5	2.4	2.6	3.6	2.5	2.5	2.7	2.7	
Delayed Transfers of Care (MFFD)		16.00	14	13	14	14	12	13	13	13	16	22	12	9	16	
Delayed Transfers of Care (% of Acute Beds)			2.6%	2.5%	2.7%	2.8%	2.7%	2.9%	2.8%	2.8%	3.3%	4.5%	2.4%	1.8%	3.1%	
Medical Outliers			27	25	15	13	20	22	26	29	37	26	26	29	46	
Readmission (Emergency Re-admissions after Planned Surgery)																
	30 Day Rate		3.01%	2.56%	3.28%	3.36%	3.35%	2.99%	3.12%	2.73%	3.01%	3.28%	2.96%	2.91%		
	7 Day Rate		1.27%	0.88%	1.41%	1.00%	1.27%	1.03%	1.42%	1.27%	1.28%	1.16%	1.15%	1.13%	1.01%	
Cancelled Operations - Non Clinical - Cancellation Rate			1.01%	1.23%	1.48%	1.40%	1.07%	0.95%	0.95%	0.95%	0.73%	1.86%	0.63%	1.40%	0.63%	
Theatre Efficiency																
	Main Theatres		74.9%	74.2%	76.8%	79.5%	78.9%	78.9%	76.7%	78.4%	78.4%	77.9%	77.2%	73.9%	74.5%	
	TC Theatres		74.5%	71.5%	71.8%	69.0%	74.2%	72.6%	75.6%	73.2%	73.4%	76.6%	73.5%	72.0%	69.4%	
DNA (OP Efficiency)			5.46%	5.17%	5.41%	5.29%	5.92%	5.83%	6.09%	5.74%	5.55%	5.71%	5.62%	5.95%	5.73%	
Hospital Cancellation Rate (OP Efficiency)			7.34%	6.88%	6.43%	6.72%	6.79%	6.80%	7.03%	7.27%	7.58%	7.62%	7.64%	8.25%	7.64%	

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







Financial Performance: Income & Expenditure Position - Aggregated

	Month			Year to Date			Forecast	
	Plan Jan (£'000)	Actual Jan (£'000)	Variance Jan (£'000)	Plan April to Jan (£'000)	Actual April to Jan (£'000)	Variance April to Jan (£'000)	2018/19 (£'000)	Budget 2018/19 £'000
Operating								
Operating Income								
NHS Acute Activity Income								
Elective	576	439	-137	8,845	8,430	-415	10,797	10,659
Non-Elective	5,188	5,471	283	49,753	49,311	-442	59,026	59,628
Maternity	1,234	1,111	-123	11,730	11,376	-353	13,454	14,000
Day cases	1,813	2,014	201	17,611	16,771	-840	19,848	21,139
Outpatients	2,297	2,416	119	22,275	23,492	1,217	28,550	26,672
A&E	823	869	46	8,459	8,788	329	10,198	10,139
Other NHS	6,478	6,367	-111	61,532	66,243	4,711	79,721	78,037
Total NHS Clinical Revenue	**18,409**	**18,689**	**280**	**180,206**	**184,411**	**4,205**	**221,594**	**220,274**
Other Operating Income	2,151	2,448	297	21,349	22,169	820	26,947	25,355
Inter-Trust Income	0	0	0	0	0	0	0	0
TOTAL OPERATING INCOME	**20,560**	**21,137**	**577**	**201,555**	**206,581**	**5,026**	**248,541**	**245,629**
Operating Expenses								
Employee Benefits Expenses (Pay)	-14,615	-14,903	-288	-142,923	-145,763	-2,840	-175,781	-171,166
Drugs	-1,289	-1,607	-318	-13,607	-14,337	-730	-16,871	-15,868
Clinical Supplies	-1,534	-1,348	186	-15,842	-15,323	519	-17,859	-18,370
Non Clinical Supplies	-297	-332	-35	-2,993	-3,297	-304	-3,982	-3,537
Other operating expenses	-2,588	-2,738	-150	-25,428	-27,697	-2,269	-34,055	-31,419
TOTAL OPERATING EXPENSES	**-20,323**	**-20,928**	**-605**	**-200,793**	**-206,416**	**-5,623**	**-248,548**	**-240,360**
EBITDA	**237**	**209**	**-28**	**762**	**164**	**-598**	**-7**	**5,269**
Non Operating								
Non Operating Income								
Interest & Asset disposal	3	9	6	30	83	53	90	36
Non-Operating Expenses								
Depreciation & Finance Leases	-725	-411	314	-4,741	-4,396	345	-5,613	-6,190
PDC Dividend Expense	-192	-192	0	-1,917	-1,917	0	-2,150	-2,300
Adjusted Financial Performance surplus/(deficit)	**-677**	**-385**	**292**	**-5,866**	**-6,066**	**-200**	**-7,680**	**-3,185**
Provider Sustainability Fund	983	0	-983	6,461	3,835	-2,626	3,835	8,428
Net Surplus/(deficit) before Exceptional Items	**306**	**-385**	**-691**	**595**	**-2,232**	**-2,827**	**-3,845**	**5,243**
Donations for purchase of assets	24	80	56	237	250	13	288	288
Depreciation on Donated Assets	-23	-23	0	-232	-232	0	-278	-278
Prior Period Adjustments	0	0	0	0	0	0	0	0
Net Surplus/(deficit) after Exceptional Items	**307**	**-328**	**-635**	**600**	**-2,214**	**-2,814**	**-3,835**	**5,253**

The Trust delivered a cumulative £2.8M deficit (before exceptional items) against a budget surplus of £0.595M, giving a variance of £2.8M. This includes an accrual £3.75M, reflecting the MOU – which has now been settled with the host commissioners.

Commissioning/Other income are above plan by £0.8M with the drugs recharges offsetting an increased non pay cost.

Pay is £2.8M worse than plan. Within nursing and HCA costs – there has been a continued use of agency nurses, to support unfunded escalation beds despite the planned Winter ward. Medical pay, which had been previously underspending is now overspending due to the employment of high cost agency doctors, and is expected to carry on into the final 2 months of the year.

Drugs are overspending as a result of increased use by external contracts, which are offset within other operating income. Clinical supplies continue to be underspent, which is linked to elective under performance.

Other operating costs are overspent by £2.3M, of which £1.4M relate to outsourcing in pathology/radiology – and £0.7M relate to Estates costs (Utilities £161K, Provisions £70K, Carbon credits £160K, Waste £43K, other one off costs £43K).

The Provider Sustainability Fund is off plan due to the failure of the A&E target (FY £2.5M), and it is forecast the trust will not achieve the Q4 financial target.

The forecast has been updated to reflect the settlement of the contract and expected forecast to the year end.

* EBITDA Total excludes Charitable Income

Financial Performance: Income & Expenditure Position - MCHFT

	Month			Year to Date			Forecast	
	Plan Jan (£'000)	Actual Jan (£'000)	Variance Jan (£'000)	Plan April to Jan (£'000)	Actual April to Jan (£'000)	Variance April to Jan (£'000)	2018/19 (£'000)	Budget 2018/19 £'000
Operating								
Operating Income								
NHS Acute Activity Income								
Elective	576	439	-137	8,845	8,430	-415	10,797	10,659
Non-Elective	5,188	5,471	283	49,753	49,311	-442	59,026	59,628
Maternity	1,234	1,111	-123	11,730	11,376	-353	13,454	14,000
Day cases	1,813	2,014	201	17,611	16,771	-840	19,848	21,139
Outpatients	2,297	2,416	119	22,275	23,492	1,217	28,550	26,672
A&E	823	869	46	8,459	8,788	329	10,198	10,139
Other NHS	4,108	3,984	-124	37,832	42,367	4,535	51,082	49,574
Total NHS Clinical Revenue	**16,039**	**16,306**	**267**	**156,506**	**160,536**	**4,030**	**192,955**	**191,811**
Other Operating Income	2,054	2,312	258	20,404	21,090	686	25,803	24,353
Inter-Trust Income	0	0	0	0	0	0	0	0
TOTAL OPERATING INCOME	**18,093**	**18,618**	**525**	**176,910**	**181,626**	**4,716**	**218,758**	**213,311**
Operating Expenses								
Employee Benefits Expenses (Pay)	-12,784	-13,007	-223	-124,716	-127,870	-3,154	-154,767	-149,513
Drugs	-1,287	-1,605	-318	-13,587	-14,310	-723	-16,839	-15,844
Clinical Supplies	-1,449	-1,265	184	-14,990	-14,415	575	-16,775	-17,353
Non Clinical Supplies	-216	-224	-8	-2,183	-2,450	-267	-2,969	-2,568
Other operating expenses	-2,203	-2,369	-166	-21,440	-23,830	-2,390	-29,486	-26,706
Inter-Trust Charges	111	122	11	1,114	1,247	133	1,527	1,364
TOTAL OPERATING EXPENSES	**-17,828**	**-18,348**	**-520**	**-175,802**	**-181,629**	**-5,827**	**-219,309**	**-208,037**
EBITDA	**265**	**270**	**5**	**1,108**	**-3**	**-1,111**	**-551**	**5,274**
Non Operating								
Non Operating Income								
Interest & Asset disposal	3	9	6	30	83	53	90	36
Non-Operating Expenses								
Depreciation & Finance Leases	-725	-411	314	-4,741	-4,396	345	-5,613	-6,190
PDC Dividend Expense	-192	-192	0	-1,917	-1,917	0	-2,150	-2,300
Net Surplus/(deficit) before PSF/Exceptional Items	**-649**	**-324**	**325**	**-5,520**	**-6,234**	**-714**	**-8,224**	**-3,180**
Provider Sustainability Fund	983	0	-983	6,461	3,835	-2,626	5,900	**8,428**
Net Surplus/(deficit) before Exceptional Items	**334**	**-324**	**-658**	**941**	**-2,399**	**-3,340**	**-2,324**	**5,248**
Donations for purchase of assets	24	80	56	237	250	13	288	288
Depreciation on Donated Assets	-23	-23	0	-232	-232	0	-278	-278
Prior Period Adjustments	0	0	0	0	0	0	0	0
Net Surplus/(deficit) after Exceptional Items	**335**	**-267**	**-602**	**946**	**-2,381**	**-3,327**	**-2,314**	**5,258**

The Trust excluding Community Services, delivered a £6.2M deficit against a planned deficit of £5.5M year to date - giving a £0.7M variance against plan cumulatively, excluding the impact of the provider sustainability fund (PSF).

The trust has accrued £3.75M of the MOU into the position, outside of this there are gains on other operating income associated with increased use of drugs from external contracts which are offset by drug costs.

Pay is £3.1M worse than plan cumulative as a result of higher spend on Nursing, due to un-funded escalation beds during the Summer months leading into Winter, being on top of the planned Winter ward. Medical pay, is also under pressure as a result of gaps being filled with high cost agency staff.

The underspend in clinical supplies of £0.6M is an offset of planned underperformance and the overspend on drugs is offset against increased other operating income.

Other Operating Expenses is £2.4M worse as a result of continuing outsourcing pressures in Diagnostics and Radiology (£1.4M) and pressures within Estates (£0.7M).

There is a cumulative reflection of the A&E performance provided for within the PSF, and it is assumed that the control total has been met for the first

Financial Performance: Income & Expenditure Position - CCICP

	Month			Year to Date			Forecast	
	Plan Jan (£'000)	Actual Jan (£'000)	Variance Jan (£'000)	Plan April to Jan (£'000)	Actual April to Jan (£'000)	Variance April to Jan (£'000)	2018/19 (£'000)	Budget 2018/19 £'000
Operating								
Operating Income								
NHS Acute Activity Income								
Elective	0	0	0	0	0	0	0	0
Non-Elective	0	0	0	0	0	0	0	0
Maternity	0	0	0	0	0	0	0	0
Day cases	0	0	0	0	0	0	0	0
Outpatients	0	0	0	0	0	0	0	0
A&E	0	0	0	0	0	0	0	0
Other NHS	2,370	2,384	14	23,700	23,876	176	28,639	28,463
Total NHS Clinical Revenue	**2,370**	**2,384**	**14**	**23,700**	**23,876**	**176**	**28,639**	**28,463**
Other Operating Income	97	136	39	945	1,079	134	1,144	1,002
Inter-Trust Income	0	0	0	0	0	0	0	0
TOTAL OPERATING INCOME	**2,467**	**2,520**	**53**	**24,645**	**24,955**	**310**	**29,783**	**29,465**
Operating Expenses								
Employee Benefits Expenses (Pay)	-1,831	-1,896	-65	-18,207	-17,893	314	-21,014	-21,383
Drugs	-2	-2	0	-20	-27	-7	-32	-24
Clinical Supplies	-85	-83	2	-852	-908	-56	-1,084	-1,017
Non Clinical Supplies	-81	-108	-27	-810	-847	-37	-1,013	-969
Other operating expenses	-385	-369	16	-3,988	-3,866	121	-4,569	-4,713
Inter-Trust Charges	-111	-122	-11	-1,114	-1,247	-133	-1,527	-1,364
TOTAL OPERATING EXPENSES	**-2,495**	**-2,580**	**-85**	**-24,991**	**-24,788**	**203**	**-29,239**	**-29,470**
EBITDA	**-28**	**-60**	**-32**	**-346**	**167**	**513**	**544**	**-5**
Non Operating								
Non Operating Income								
Interest & Asset disposal	0	0	0	0	0	0	0	0
Non-Operating Expenses								
Depreciation & Finance Leases	0	0	0	0	0	0	0	0
PDC Dividend Expense	0	0	0	0	0	0	0	0
Adjusted Financial Performance surplus/(deficit)	**-28**	**-60**	**-32**	**-346**	**167**	**513**	**544**	**-5**
Provider Sustainability Fund	0	0	0	0	0	0	0	**0**
Net Surplus/(deficit) before Exceptional Items	**-28**	**-60**	**-32**	**-346**	**167**	**513**	**544**	**-5**
Donations for purchase of assets	0	0	0	0	0	0	0	0
Depreciation on Donated Assets	0	0	0	0	0	0	0	0
Prior Period Adjustments	0	0	0	0	0	0	0	0
Net Surplus/(deficit) after Exceptional Items	**-28**	**-60**	**-32**	**-346**	**167**	**513**	**544**	**-5**

Community Services delivered a £0.5M surplus cumulative against a planned deficit position of £0.35M.

Contract income is above plan (£176K), with expected variations in progress with the CCG around Stoma care, Pain and MCATS – being the main reason for variances.

Other Operating income is better than budget as a result of an increase in charges within Estates, which is offset by an increase in cost in non-pay, and some non-recurrent gains on 1718 income.

Pay is £314K better than plan cumulative as a result of unfilled vacancies partly clinical and partly corporate, continuing the trend from 2017/18 and also relating to slippage on the commencement of new services.

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

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

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

Financial Performance: Income & Expenditure Position

		Income			Expenditure				NET TOTAL	
		Contract	Variable	Better/ (Worse) than Budget	Pay	Better/ (Worse) than Budget	Non-Pay	Better/ (Worse) than Budget	Total	Better/ (Worse) than Budget
Surgical & Cancer Div Mgt	Divisional Management S&C	0	0	(41)	(812)	(792)	(73)	(74)	(886)	(908)
Endoscopy	Endoscopy	5,235	5	(548)	(2,027)	173	(1,053)	269	2,159	(107)
General Surgery Directorate	General Surgery	14,422	70	476	(8,002)	(321)	(1,567)	(118)	4,923	37
Head & Neck Directorate	Head & Neck	4,456	358	(251)	(2,099)	143	(561)	113	2,155	5
Macmillan Cancer Centre	Macmillan Cancer Centre	535	1,781	544	(846)	(71)	(1,582)	(378)	(113)	94
Ophthalmology	Ophthalmology	10,311	52	596	(3,646)	(42)	(3,112)	(304)	3,604	250
Orthopaedic Directorate	Orthopaedics	15,334	201	108	(5,540)	59	(2,864)	(36)	7,131	131
Theatres & TC	Theatres & TC	0	297	6	(6,169)	66	(2,353)	(241)	(8,225)	(169)
Urology Directorate	Urology	4,651	47	(7)	(2,452)	(132)	(489)	(94)	1,757	(233)
Surgical and Cancer Division	**Surgery & Cancer**	**54,943**	**2,812**	**883**	**(31,594)**	**(918)**	**(13,655)**	**(864)**	**12,506**	**(898)**

The Surgical Division is £0.9M worse than plan year to date. Pay is £0.9M worse than budget, with overspends on HCA bank and agency nursing costs high as a result of medical outliers which have resulted in a failure to close a surgical ward during the Summer months – despite the division requiring fewer beds. Overspends within the division also relate to acuity with Urology, and waiting lists within the General Surgery specialties and Ophthalmology, relating to supporting the opening of SACU, and out of area work. Whilst non pay is overspent by £0.9M, £0.6M of this is offset by increased charges to the Christie as part of their SLA. The balance of the overspend relating to increased ward costs associated with medical outliers.

		Income			Expenditure				NET TOTAL	
		Contract	Variable	Better/ (Worse) than Budget	Pay	Better/ (Worse) than Budget	Non-Pay	Better/ (Worse) than Budget	Total	Better/ (Worse) than Budget
Emergency Care Divisional Mgmn	Divisional Mangement M&EC	0	2	2	(1,895)	(495)	(75)	(17)	(1,969)	(510)
Accident & Emergency Dir	Emergency Department	13,135	672	(84)	(5,621)	(369)	(671)	(113)	7,515	(566)
Anaesthetics & Critical Care	Anaesthetics & Critical Care	5,289	39	(90)	(6,654)	248	(954)	74	(2,279)	231
Medical Directorate	General Medicine	36,314	309	742	(20,244)	(1,386)	(3,641)	307	12,739	(337)
Urgent Care Centre	Urgent Care Centre	0	0	0	(625)	(25)	0	68	(625)	42
Emergency Services Division	**Medicine & Emergency Care**	**54,738**	**1,022**	**570**	**(35,038)**	**(2,027)**	**(5,340)**	**318**	**15,382**	**(1,140)**

The Medicine and Emergency Care Division are £1.1M worse than plan. The key issue for the division remains related to pay, with nursing pay and HCA spend continuing to reflect the cost of unfunded escalation beds, coupled with an increased need to use agency at above cap rates. Medical pay costs are overspent (£0.2M in month, £0.95M YTD), which is expect to continue in the final quarter due to the employment of a number of high cost agency doctors who are filling key gaps within the rotas for the division.

		Income			Expenditure				NET TOTAL	
		Contract	Variable	Better/ (Worse) than Budget	Pay	Better/ (Worse) than Budget	Non-Pay	Better/ (Worse) than Budget	Total	Better/ (Worse) than Budget
Wom Chil & sexl hlth Div Magmn	Divisional Mangement W&C	0	4	4	(1,088)	38	(112)	18	(1,195)	60
Gum clinic	Gum clinic	0	0	0	0	0	(1)	(1)	(1)	(1)
Obstetric & Gynaecology Dir	Obstetrics & Gynaecology	14,795	109	(681)	(7,230)	78	(1,166)	(44)	6,508	(647)
Paediatric Directorate	Paediatrics	9,676	91	(400)	(6,643)	(205)	(896)	9	2,229	(596)
Women and Childrens Division	**Women and Children**	**24,471**	**205**	**(1,077)**	**(14,960)**	**(89)**	**(2,175)**	**(18)**	**7,541**	**(1,183)**

The Women's and Children's Division is £1.1M worse than plan. Contract income continues to be significantly below plan for both Gynaecology and Obstetrics - both as a result of lower than planned activity, and reduced market share for Gynaecology. Paediatric income is also below plan (£0.4M), however it is expected to recover to some degree in the final quarter, as the profile of paediatric emergency activity is quite different to a general emergency care - which was the profile used for the plan. The pay pressure within paediatrics relates to ANPs and NICU.

Financial Performance: Income & Expenditure Position

		Income			Expenditure				NET TOTAL	
		Contract	Variable	Better/ (Worse) than Budget	Pay	Better/ (Worse) than Budget	Non-Pay	Better/ (Worse) than Budget	Total	Better/ (Worse) than Budget
Diag & Clinc Spt Sv Div Mgmnt	Divisional Management D&S	0	0	0	(244)	27	(33)	(103)	(277)	(76)
Dermatology	Dermatology	1,461	18	(45)	(823)	61	(278)	(8)	377	8
ECG department	ECG	329	17	(9)	(828)	109	(65)	2	(546)	102
Elmhurst	Elmhurst	1,664	144	(1)	(1,382)	(100)	(143)	10	283	(92)
Integrated Discharge	Integrated Discharge	0	23	23	(264)	(24)	(5)	(3)	(246)	(4)
Medical Records Department	Medical Records Department	0	0	(2)	(1,486)	(26)	(183)	2	(1,669)	(25)
Outpatients	Outpatients	0	129	(11)	(460)	18	(53)	(8)	(385)	0
Pathology Directorate	Pathology	10,016	3,336	646	(8,132)	316	(7,624)	(917)	(2,404)	45
Pharmacy Departments	Pharmacy	2,864	161	(42)	(2,881)	(104)	(3,072)	(338)	(2,929)	(484)
Radiology Directorate	Radiology	2,617	654	(20)	(5,383)	(6)	(2,156)	(558)	(4,267)	(583)
Therapeutic Departments	Therapies	0	0	0	(1,814)	(16)	(52)	29	(1,865)	13
Victoria Infirmary Northwich	Victoria Infirmary Northwich	1,698	2	(84)	(1,514)	(61)	(240)	6	(55)	(139)
Diagnostics and Support Divisi	**Diagnostics and Support**	**20,649**	**4,484**	**454**	**(25,211)**	**194**	**(13,904)**	**(1,884)**	**(13,982)**	**(1,236)**

The Diagnostics Division is £1M worse than plan year to date, with the key pressures continue to lie with the outsourced radiology and pathology tests £0.2M (net of medical vacancies). There has been an increase to the charges that are made to East Cheshire Trust which offset the position within pathology.

		Income			Expenditure				NET TOTAL	
		Contract	Variable	Better/ (Worse) than Budget	Pay	Better/ (Worse) than Budget	Non-Pay	Better/ (Worse) than Budget	Total	Better/ (Worse) than Budget
Estates & Facilities Div Mgnt	Divisional Management E&F	0	9	9	(441)	17	(169)	9	(601)	36
Catering Directorate	Catering	0	1,221	88	(1,443)	(82)	(1,211)	(109)	(1,434)	(102)
Estates Departments	Estates Departments	0	393	(5)	(1,318)	13	(6,092)	(527)	(7,017)	(519)
Hotel Services	Domestics	0	0	0	(1,145)	3	(13)	(3)	(1,157)	0
Laundry Services Departments	Laundry	0	972	(51)	(963)	(57)	(688)	(31)	(679)	(140)
Security	Security	0	1,456	45	(619)	21	(605)	(108)	232	(42)
Site Services	Porters	0	0	0	(2,423)	8	(67)	(1)	(2,490)	7
Estates & Facilities Division	**Estates & Facilities Division**	**0**	**4,051**	**87**	**(8,353)**	**(78)**	**(8,844)**	**(769)**	**(13,146)**	**(760)**

The Estates and Facilities Division is £0.8M worse than plan. Within non pay there are some 1718 costs (£173K) and one off costs (£70K) and the loss of £40K SLA contract within Laundry. Utilities are £2895Kworse than budget and expected to be £360K over by year end - which are significant ongoing financial pressure.

		Income			Expenditure				NET TOTAL	
		Contract	Variable	Better/ (Worse) than Budget	Pay	Better/ (Worse) than Budget	Non-Pay	Better/ (Worse) than Budget	Total	Better/ (Worse) than Budget
Executive Management	Executive Management	0	16	16	(1,292)	(19)	(557)	(36)	(1,834)	(40)
Computer Services	Computer Services	0	70	62	(1,260)	37	(2,398)	(244)	(3,587)	(145)
Finance & Information	Finance & Information	0	37	11	(2,489)	126	(644)	(6)	(3,096)	131
Human Resources	Human Resources	0	464	65	(2,088)	35	(429)	75	(2,053)	175
Risk Manangement & R&D	Risk Management & R&D	0	412	(38)	(1,301)	37	(74)	9	(963)	8
Quality Assurance Departments	Nurse Management	0	197	106	(2,333)	(77)	(6,587)	145	(8,724)	175
Trust Central Expenditure	Trust Central Expenditure	9,551	7,384	851	(1,734)	(313)	(228)	440	14,974	979
Other Departments	Other Departments	17	187	89	(216)	(61)	(173)	49	(186)	77
	Corporate	**9,568**	**8,767**	**1,161**	**(12,713)**	**(234)**	**(11,090)**	**432**	**(5,468)**	**1,360**

The Corporate Division is £2.4M better than budget – which includes the accrual for the MOU of £3.75M, and an offset of the PSF not achieved year to date (£2.6M)

	Community Services	**23,876**	**1,079**	**333**	**(17,893)**	**313**	**(5,645)**	**26**	**1,417**	**672**
	EBITDA	**188,246**	**22,419**	**2,411**	**(145,762)**	**(2,838)**	**(60,654)**	**(2,759)**	**4,250**	**(3,186)**

Financial Performance: Commissioner Income Analysis

Commissioner	FY Target (£'000)	YTD Target (£'000)	CEP Adjustmt	Final Actual (£'000)	Final Variance (£'000)
NHS Eastern Cheshire CCG	8,096	6,745	0	6,737	-8
NHS Eastern Cheshire CCG Community	412	343	0	343	0
NHS South Cheshire CCG Community	17,336	14,432	0	14,432	0
NHS South Cheshire CCG	101,698	84,685	-576	84,685	0
NHS Vale Royal CCG	55,052	45,841	-776	45,841	0
NHS Vale Royal CCG Community	10,515	8,753	0	8,753	0
NHS Warrington CCG	284	238	0	260	21
NHS West Cheshire CCG	3,537	2,944	0	2,932	-12
NHS West Cheshire CCG Community	191	159	0	159	0
NHS North Staffordshire CCG	2,307	1,922	0	2,147	225
NHS Shropshire CCG	892	743	0	628	-115
NHS Stoke on Trent CCG	1,609	1,339	0	1,376	37
Public Health England	1,540	1,245	0	1,067	-178
NHS Commissioning Board	1,604	1,332	0	1,332	0
Specialist Commissioning Group	8,645	7,235	0	6,604	-631
Non Contract Activity	2,007	1,669	0	1,744	75
Cross Border Flows (non Betsi)	149	124	0	88	-36
Betsi	229	191	0	612	422
Non-Commissioner Specific	12,600	6,727	0	8,506	1,779
TOTAL	**228,702**	**186,668**	**-1,352**	**188,246**	**1,578**

Other Contract Income	FY Target (£'000)	YTD Target (£'000)	YTD Actual (£'000)	Final Variance (£'000)
Bed Based Services	5,962	4,968	4,867	-101
Adult & Neonatal Critical Care	7,896	6,605	6,634	28
Urgent Care Centre	0	0	0	0
Community Paediatrics	1,303	1,086	1,086	0
Direct Access Services	9,509	7,969	8,073	104
Unbundled Radiology	3,505	2,937	2,922	-16
High Cost Drugs	9,762	8,254	8,402	148
Screening Programmes	1,530	1,275	1,311	35
Audiology	1,167	972	849	-123
IVF	258	215	153	-63
CQUIN	4,312	3,027	2,786	-241
PSF	8,428	6,461	3,835	-2,626
Community Services	28,308	23,578	23,589	11
CEP	-2,817	-2,348	-1,911	437
WINTER FUNDING	750	625	869	244
Memorandum of Understanding	3,990	0	3,750	3,750
Other	2,752	2,379	2,864	485
TOTAL	**86,615**	**68,003**	**70,079**	**2,072**

The MOU between the Trust and the CCG has now been settled at £4.5M, of which £3.75M has been accrued into the position year to date. Had the Trust been on a PbR contract this year, the Trust would have been worse off year to date by £2.4M. It is expected that there will continue to be performance increase against South and Vale Royal as a result of the activity with North Wales ceasing in month 6 – at which point the Trust was better off under the contract cap by £0.3M.

Other associate commissioners combined are showing an over-performance of £148K. The growing underperformance on the Public Health England contract relates to the delay in starting lists at East Cheshire Trust, in relation to the bowel scope programme.

Specialist Commissioning has a negative variance being the result of a high cost drug rebate of £0.5M in July, and a lower than expected volume of emergency patients who meet the criteria of specialised care, particularly within Paediatrics.

Cross border flows includes Welsh commissioners where the Trust has completed work with the North Welsh Health board, pre-dominantly in orthopaedic surgery, and ophthalmology. This has now ceased as

Other contract income is showing £2.072M better than plan.

The trust has accrued £3.75M of the MOU in relation to South/Vale Royal contracts, which matches against costs which have been incurred year to date.

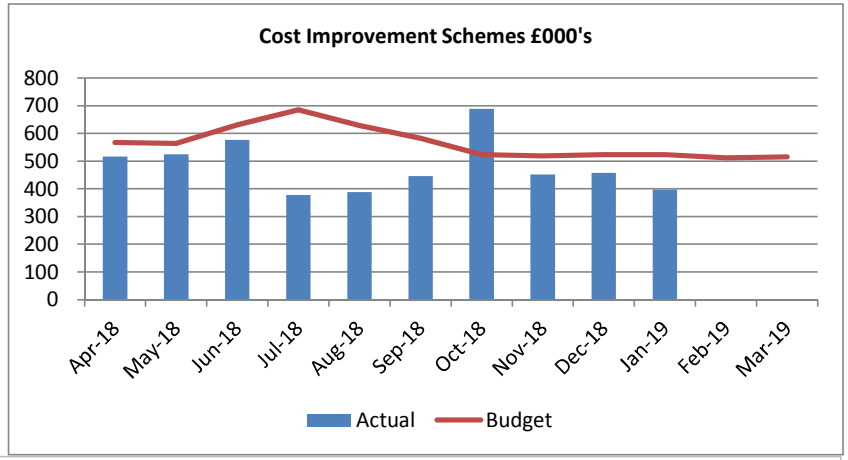
The remainder of the performance against plan is in large part due to expected increases in activity within the plan have not materialised – and where the trust was expecting to have a material CEP adjustment YTD of £2.4M the adjustment on the South and Vale Royal contracts has only been £1.9M.

Aside the CEP adjustment there were gains against the un-coded prior year spells valuation (£140k), Direct Access Services with East Cheshire CCG (£104K), and Adult Critical Care (£28k) offset by anticipated CQUIN income (£241K) and High cost drugs (£148K) – with the rebate of £551K, passed directly onto Specialised Commissioning offsetting an over performance on home care drugs and AMD drugs.

The PSF reflects the achievement of the financial target only, for the first 3 quarters of the year. The PSF element associated with meeting the A&E standard & the final quarter of the financial target are not expected to be met.

Financial Performance: Efficiencies

Cost Improvement Schemes (£'000's)						
Scheme Category	**YTD Target**	**YTD Actual**	**YTD**	**FY Target**	**FY Forecast**	**FY Variance**
Access & Flow	482	397	-85	524	439	-85
Commercial	180	213	61	195	291	96
Drugs	548	548	0	657	657	0
Medical Workforce	1,243	877	-342	1,550	944	-606
Non-Pay Efficiency	1,058	1,294	233	1,228	1,422	194
Nursing Workforce	812	574	-218	974	688	-286
Procurement	623	323	-301	684	364	-320
Theatres Efficiency	83	83	0	100	100	0
Service redesign	450	386	-59	540	463	-77
Market Share	267	183	-83	320	220	-100
Total (£'000)	**5,746**	**4,878**	**-794**	**6,772**	**5,588**	**-1,184**



The CIP achievement year to date is £0.8M worse than plan with the challenges to the following CIP schemes:- improvement of nurse/HCA sickness within Emergency Care (£0.188M), reduction in WLIs (£0.15M), and the Medical Vacancy factor in Surgery and Cancer (£0.15M). It is expected that the trust will be £1.2M below targeted CIP for the year end.

There are a number of CCICP efficiencies that are over performing which offset the under-performances elsewhere.

Capped Expenditure Schemes (£'000's)						
Scheme Category	**YTD Target**	**YTD Actual**	**YTD**	**FY Target**	**FY Forecast**	**FY Variance**
TeleDerm	58	0	-58	70	0	-70
Non-Pay Efficiency	83	83	0	100	100	0
Drugs	42	42	0	50	50	0
Commercial	167	0	-167	200	0	-200
Procurement	83	0	-83	100	0	-100
Elective	930	442	-520	1,116	460	-656
Total (£'000)	**1,363**	**567**	**-828**	**1,636**	**610**	**-1,026**

The CEP schemes rolled over from 1718 are under achieving by £0.8M, with key issues around delivering planned cost savings in IVF, and work with East Cheshire in relation to births /out of hours contracts, as these are legacy CEP schemes these are being discussed with commissioners.

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

Financial Performance: Capital Report

SCHEME	BOARD APPROVED	FUNDING SOURCE	FUNDING APPROVED	EXPENDITURE BROUGHT FORWARD	2018/19 ANNUAL BUDGET	2018/19 CUMULATIVE BUDGET TO DATE	2018/19 CUMULATIVE ACTUAL	2018/19 BETTER/WORSE THAN BUDGET	2018/19 FORECAST	2019/20 + FORECAST	WHOLE PROJECT ACTUAL TO DATE	WHOLE PROJECT PROPOSED PLAN	TOTAL FORECAST
STRATEGIC INVESTMENTS (Requires individual signoff)													
ESTATES													
CAR PARK BARRIERS	Yes	Internal	Yes	44	16	16	16	0	16		60	60	60
BISTRO & 2 OFFICES	Yes	Internal	Yes	120	58	58	58	0	58		178	178	178
UNDER / OVERS CAPITAL SCHEMES 17/18	Yes	Internal	Yes		0	0	7	-7	7		7	0	7
WARD REFURBISHMENT	Yes	Loan	Yes	224	1864	1864	2099	-235	2099	8600	2323	10,688	10,923
MRI SCANNER 3RD BUILD	Yes	Internal/Loan	Yes	174	1475	1475	1	1474	1115	0	175	1,649	1,289
WASTE COMPOUND AND SEGREGATION	Yes	Internal	Yes		350	350	0	350	0	350	0	700	350
TURNKEY FOR REPLACEMENT CT SCANNERS	No	Internal	Yes		165	165	0	165	165	135	0	300	300
BARRIER ACCESS CONTROL	Yes	Internal	Yes		100	100	0	100	0	100	0	200	100
CAR PARK LAND *	Yes	Loan	Not yet approved		400	130	14	116	40	1860	14	2,260	1,900
EPR PROJECT ACCOMODATION *	Yes	Loan	Not yet approved		350	100	0	100	0		0	350	0
ENDOSCOPY WASHER BUILD *	No	Loan	Not yet approved		250	0	0	0	0	500	0	750	500
PATHOLOGY RISKS	Yes	Internal	Yes		100	100	8	92	100		8	100	100
SSD ENABLING *	Yes	Loan	Not yet approved		668	300	0	300	0	668	0	1,336	668
WARD REFURBUISHMENT *	No	Loan	Not yet approved		1600	1200	234	966	700	900	234	2,500	1,600
DEMENTIA APPEAL	No	Donated	Not yet approved							1500		1,500	1,500
3RD CT ENABLING	No	Internal	Not yet approved							935		935	935
TOTAL				**562**	**7396**	**5858**	**2437**	**3421**	**4300**	**15548**	**2999**	**23506**	**20410**
IT													
UNDER / OVERS CAPITAL SCHEMES 17/18	Yes	Internal	Yes		0	0	1	-1	0		1	0	0
UPS	Yes	Internal	Yes		250	100	0	100	0	250	0	500	250
Q PULSE	Yes	Internal	Yes	25	37	37	0	37	9	28	25	90	62
HIGH IMPACT STAND ALONE IT SYSTEMS	Yes	Internal	Yes	88	112	112	39	73	112	400	127	600	600
REPLACEMENT BUSINESS INTELLIGANCE SYSTEM	Yes	Internal	Yes		80	80	88	-8	80		88	80	80
CONFIGURATION MANAGEMENT SYSTEM	Yes	Internal	Yes		35	35	0	35	0		0	35	0
CORE INFRASTRUCTURE UPGRADE	yes	PDC	Yes		538	420	222	198	418	180	222	718	598
CYBER SECURITY	Yes	PDC	Yes	17	291	291	291	0	291		308	308	308
X-RAY MACHINE STORAGE	Yes	Internal	Yes		100	50	113	-63	113		113	100	113
SEQUEL / WINDOWS LICENCES	Yes	Internal	Yes		80	80	0	80	0	80	0	160	80
VIRTUAL DESKTOP	No	Internal	Yes		400	200	0	200	0	200	0	600	200
VIRTUAL CLINICS	No	Internal	Yes		50	50	4	46	50		4	50	50
VPN	Yes	PDC	Yes		70	70	0	70	70		0	70	70
VOICE OVER IP	Yes	Internal	Yes	466	100	83	6	77	75	100	472	666	641
SYSTEM REFRESH / REPLACEMENT													
LAB CENTRE PATHOLOGY	No	Internal	Yes		800	0	0	0	0	1600	0	2,400	1,600
CHEMOCARE	yes	Internal	Yes		85	85	0	85	0		0	85	0
DIGITAL DICTATION	Yes	Internal	Yes		60	60	0	60	60	73	0	133	133
DOCMAN	Yes	Internal	Yes		52	52	0	52	52		0	52	52
WIRELESS UPGRADE /N3 UPGRADE	Yes	Internal	Yes							65	0	65	65
PHARMACY ASCRIBE	No	Internal	Yes							200	0	200	200
STAFF WIFI	No	Internal	Yes							80	0	80	80
SOLITON MEDICAL IMAGING	No	Internal	Yes							250	0	250	250
BADGERNET	Yes	Internal	Yes							45	0	45	45
BLOOD TRACKING SYSTEM	No	Internal	Yes							200	0	200	200
CARDIO RESPIRATORY SYSTEM	No	Internal	Yes							350	0	350	350
TOTAL				**596**	**3140**	**1805**	**764**	**1041**	**1330**	**4101**	1360	**7837**	**6,027**
TOTAL STRATEGIC INVESTMENTS				**1158**	**10536**	**7663**	**3201**	**4462**	**5630**	**19649**	**4359**	**31,343**	**26,437**

The Estates strategic investments capital spend is £3.4M underspent mainly due to the third MRI Scanner £1.5M, a supplier has now been chosen and design work has started. In addition the ward 12 refurbishment schemes is underspent, but has now started. Also there is a delay in the Turnkey works for the replacement CT scanner and the Waste Compound scheme. These are due to start later in the financial year but completion may be in the new financial year. The IT Strategic investments projects are £0.8M underspent which is mainly due to Core Infrastructure upgrade (£0.2M) and Virtual Hospital (£0.2M) with the remaining variance across a number of schemes.

Financial Performance: Capital Report

SCHEME	BOARD APPROVED	FUNDING SOURCE	FUNDING APPROVED	EXPENDITURE BROUGHT FORWARD	2018/19 ANNUAL BUDGET	2018/19 CUMULATIVE BUDGET TO DATE	2018/19 CUMULATIVE ACTUAL	2018/19 BETTER/WORSE THAN BUDGET	2018/19 FORECAST	2019/20 + FORECAST	WHOLE PROJECT ACTUAL TO DATE	WHOLE PROJECT PROPOSED PLAN	TOTAL FORECAST
ROLLING ALLOCATIONS (Approved Delegated Budgets)													
ESTATES													
ASBESTOS REMOVAL	Yes	Internal	Yes		271	213	79	134	135	736	79	1,007	871
DESIGN TEAM	Yes	Internal	Yes		313	256	238	18	313	1252	238	1,565	1,565
CT / VT - HEATING INFRASTRUCTURE	Yes	Internal	Yes		459	407	13	394	50	1109	13	1,568	1,159
BACKLOG GENERAL PROVISION	Yes	Internal/Loan	Yes		2650	2234	1368	866	1,736	7873	1368	10,523	9,609
TOTAL				**0**	**3,693**	**3,110**	**1,698**	**1412**	**2,234**	**10,970**	**1698**	**14,663**	**13,204**
IT													
INTERSITE CONNECTIVITY	Yes	Internal	Yes		50	50	17	33	50		17	50	50
INTERFACING	Yes	Internal	Yes		151	101	87	14	101	390	87	541	491
IT APPLICATIONS	Yes	Internal	Yes		193	157	17	140	83	475	17	668	558
STORAGE & BACKUP	No	Internal	Yes							250		250	250
TOTAL				**0**	**394**	**308**	**120**	**188**	**234**	**1115**	**120**	**1,509**	**1,349**
TOTAL ROLLING ALLOCATIONS				**0**	**4,087**	**3,418**	**1,818**	**1,600**	**2,468**	**12,085**	**1,818**	**16,172**	**14,553**
ADDITIONAL													
EQUIPMENT	Yes	Internal	Yes		0	0	136	-136	90		136	0	90
MOBILE SCANNER CABIN									89				
PUBLIC WiFi					0	0	0	0	0		0	0	0
ACQUISITION OF SCPH					0	0	0	0	0	1000	0	1,000	1,000
PERSONAL CARE PORTAL					0	0	0	0	0		0	0	0
MEDICAL RECORDS RACKING	Yes	Internal	Yes		43	43	60	-17	60		60	43	60
CANCER MDT	Yes	PDC	Yes		30	30	0	30	0		0	30	0
GP STREAMING ESTATES	Yes	PDC	Yes	12	488	488	565	-77	488		577	500	500
GP STREAMING IT FRONT OF HOUSE	Yes	PDC	Yes	108	142	0	0	0	0		108	250	108
COMMUNITY SERVICES	Yes	Internal	Yes	105	630	630	495	135	495		600	735	600
LEASING INVESTMENTS													
EQUIPMENT	Yes	Internal	Yes		600	273	218	55	522	78	218	678	600
3RD CT SCANNER	No	Internal	Not yet approved		531	0	0	0	0		0	531	0
REPLACEMENT CT SCANNER	No	Internal	Not yet approved		532	0	0	0	0		0	532	0
3RD MRI SCANNER	Yes	Internal	Yes		600	0	0	0	0		0	600	0
ROOM 2 X-RAY	No	Internal	Not yet approved		250	0	0	0	250		0	250	250
SSD WASHERS	No	Internal	Not yet approved		320	0	0	0	0	320	0	640	320
TOTAL LEASING INVESTMENTS				**0**	**2833**	**273**	**218**	**55**	**772**	**398**	218	**3231**	**1170**
TOTAL CAPITAL PROGRAMME (EXCLUDING LEASES)				**1,383**	**15,956**	**12,272**	**6,276**	**5,996**	**9,320**	**32,734**	**7,659**	**50,073**	**43,348**
TOTAL CAPTIAL PROGRAMME				**1,383**	**18,789**	**12,545**	**6,494**	**6,051**	**10,092**	**33,132**	**7,877**	**53,304**	**44,518**

The rolling allocation is £1.6M underspent due to the delay in some of the backlog maintenance and CTVT replacement, Asbestos replacement and IT Applications.

The forecast spend has been reduced by the following: Asbestos £0.136M, Backlog Maintenance £1.08M , Ward Refurbishment £0.2M , Endoscopy Washer Build £0.25M, EPR Project office £0.35M, Virtual Desktop £0.2M, Car Park Land purchase £0.3M, CCTV £0.15M, CTVT £0.15M, Replacement SSD washers build work £0.7M, UPs £0.25M, Virtual Clinics £0.1M, Lab Centre Upgrade £0.8M This cost have been moved to 2019/20. In respect of the Ward Refurbishment and the Endoscopy Build these are funded via loans and therefore the loans will be drawn down accordingly.

There have been three schemes added in year Personal Care Portal £70K and Public Wi-Fi £0.2M which are funded via external money. In addition the acquisition of South Cheshire Private Hospital £1Mwhere the expenditure is anticipated to now be in the next financial year.

Financial Performance: Statement of Financial Position

	Plan Apr to Jan (£'000)	Actual Apr to Jan (£'000)	Variance (£'000)	Forecast 2018/19 (£'000)
Assets				
Assets, Non-Current	**106,996**	**99,472**	**-7,524**	**102,313**
Assets, Current				
Trade and other Receivables	6,282	12,919	6,637	6,521
Other Assets (including Inventories & Prepayments)	6,311	6,311	0	6,600
Cash and Cash Equivalents	10,796	7,903	-2,893	9,008
Total Assets, Current	**23,389**	**27,133**	**3,744**	**22,129**
ASSETS, TOTAL	**130,385**	**126,605**	**-3,780**	**124,442**
Liabilities				
Liabilities, Current				
Finance Lease, Current	-463	-226	237	-1,548
Loans Commercial Current	-210	-213	-3	-5,673
Trade and Other Payables, Current	-14,458	-13,593	865	-11,771
Provisions, Current	-113	-133	-20	-225
Other Financial Liabilities	-6,894	-11,578	-4,684	-6,585
Total Liabilities, Current	**-22,138**	**-25,743**	**-3,605**	**-25,802**
Net Current Assets/(Liabilities)	**1,251**	**1,389**	**138**	**-3,673**
Liabilities, Non Current				
Finance Lease, Non Current	-6,442	-4,574	1,868	-3,517
Loans Commercial Non-Current	-15,140	-12,040	3,100	-10,430
Provisions, Non-Current	-1,604	-1,609	-5	-1,489
Trade and Other Payables, Non-Current	0	0	0	**0**
Total Liabilities Non-Current	**-23,186**	**-18,223**	**4,963**	**-15,436**
TOTAL ASSETS EMPLOYED	**85,061**	**82,639**	**-2,422**	**83,204**
Taxpayers' and Others' Equity				
Taxpayers Equity				
Public dividend capital	76,791	76,791	0	76,996
Retained Earnings	-7,322	-9,722	-2,400	-9,384
Donated asset reserve	0	1	1	0
Revaluation Reserve	15,592	15,568	-24	15,592
TOTAL TAXPAYERS EQUITY	**85,061**	**82,638**	**-2,423**	**83,204**
TOTAL FUNDS EMPLOYED	**85,061**	**82,638**	**-2,423**	**83,204**

Assets Non-Current
The main reason for the variance is that the plan is the capital programme expenditure being £7.5M less than anticipated which is mainly due to a delay in the third MRI Scanner build £1.48M, Backlog maintenance £0.78M, Waste Compound £0.35M, CTVT £0.24M, Ward Refurbishment £0.67M, Virtual Desktop £0.250M, SSD Washers £0.30M, other minor Estates schemes £1.48M and other minor IT schemes £1.00M. The remainder is delay in the renewal of some finance leases in particular is the third MRI Scanner and the replacement CT scanner and an underspend on the depreciation charge.

Trade and other Receivables
NHS Trade Receivables are higher than anticipated due to an accrual for the MOU with South Cheshire & Vale Royal CCG's this is offset by the A&E PSF for quarter 3 and month 10 not being accrued as the A&E target has not been achieved. In addition outstanding invoiced debts include University of North Midlands Trust £0.14M, Aintree £0.19M, Cheshire East Council £0.15M, South Cheshire CCG £0.29M, Vale Royal CCG £0.11M, NHS Property Services £0.18M One to One Nursing £0.10M and The Christies £0.72M and Health Education England £0.57M (£0.56M paid in February).

Other Assets
This higher than anticipated due to higher than expected Drug Stocks offset by lower prepayments due to delay in maintenance contracts for the new MRI Scanner and some operating leases.

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

Other Financial Liabilities
This is mainly due to Accruals more than expected mainly due to the plan being based on last year's accruals. There are higher accruals for Agency £0.50M, Utilities £0.10M and CCICP £0.21M. This is offset by an advance payment by South Cheshire and Vale Royal CCG's £3.50M which has been prepaid out.

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

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

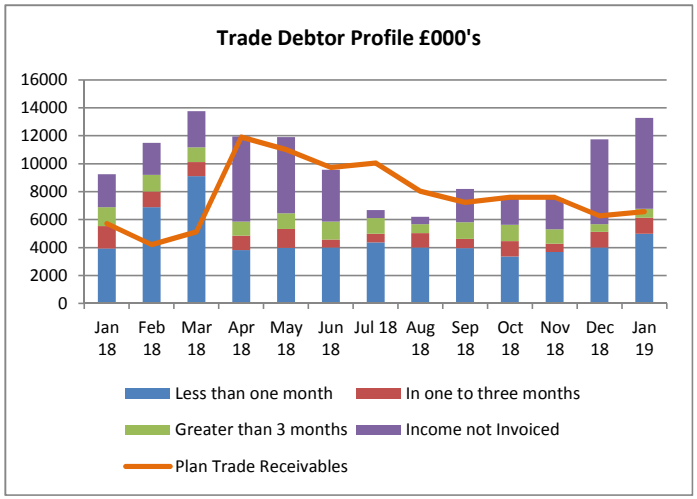
Financial Performance: Cash Position and Working Capital

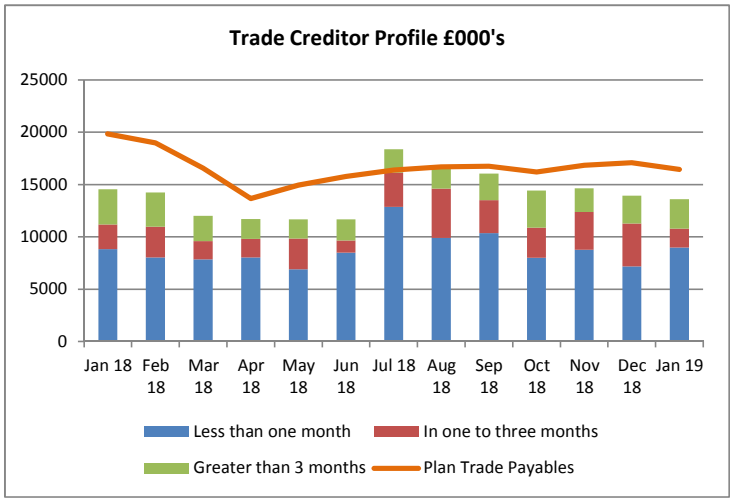
	Plan Apr to Jan (£'000)	Actual Apr to Jan (£'000)	Variance
Surplus/(deficit) after tax	**214**	**-2,211**	**-2,425**
Non-cash flows in operating Surplus/(deficit) total	5,087	4,564	-523
Operating cash flows before movements in working capital	**5,301**	**2,353**	**-2,948**
Increase/(Decrease) in working capital Total	7,750	6,324	-1,426
Net cash inflow/(outflow) from operating activities	**13,051**	**8,677**	**-4,374**
Net cash inflow/(outflow) from investing activities total	-11,162	-6,654	4,508
Net Cash inflow/(outflow) before financing	**1,889**	**2,023**	**134**
Net cash inflow/(outflow) from financing activities Total	1,146	-1,882	-3,028
Net increase/(decrease) in cash and cash equivalents	**3,035**	**141**	**-2,894**
Opening cash balance	**7,761**	**7,761**	**0**
Closing cash balance	**10,796**	**7,902**	**-2,894**

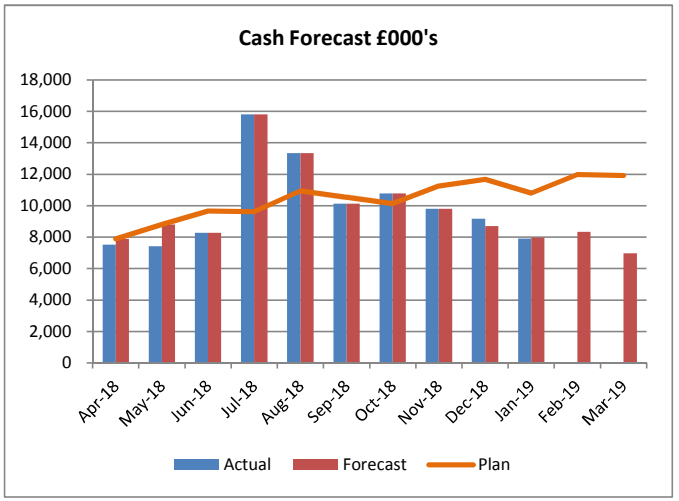
Cash is £2.9M less than anticipated; this is mainly due to the failure of the Q1 & Q2 and month 10 A&E target (£1.9M).

In addition the delay in the capital payment is improving the cash position but this is offset by £3.1M of a capital loan for the ward refurbishment and the MRI Scanner which has not been drawn down.

Working capital less than plan due to the accrual of the Memorandum of Understanding offset by a movement in creditors better than expected.







Finance: *Staff Costs*

Headline Measures

	YTD £000's	Rolling 13 months £000's													
		Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Monthly Trend
Pay Budget	142,925	13,916	13,817	13,785	14,001	14,112	14,008	14,158	14,900	14,225	14,325	14,219	14,361	14,616	
Pay Actual	145,763	14,278	14,017	14,133	14,094	14,152	14,237	14,183	14,960	14,639	14,820	14,682	15,094	14,902	
Variance	-2,838	-362	-200	-348	-93	-40	-229	-25	-60	-414	-495	-463	-733	-286	
% to Budget	*102.0%*	*102.6%*	*101.4%*	*102.5%*	*100.7%*	*100.3%*	*101.6%*	*100.2%*	*100.4%*	*102.9%*	*103.5%*	*103.3%*	*105.1%*	*102.0%*	
Nursing Staff % to Budget	102.9%	105.9%	104.7%	105.0%	101.7%	99.9%	102.1%	100.5%	103.5%	103.1%	104.3%	107.0%	105.9%	100.9%	
Medical Staff % to Budget	100.7%	98.5%	97.1%	103.2%	95.4%	100.5%	99.2%	97.3%	92.0%	104.2%	107.2%	100.0%	108.7%	102.3%	
Other Staff % to Budget	101.8%	101.6%	100.7%	99.5%	102.9%	100.6%	102.7%	101.6%	102.0%	102.0%	100.3%	101.4%	102.0%	102.9%	

Commentary

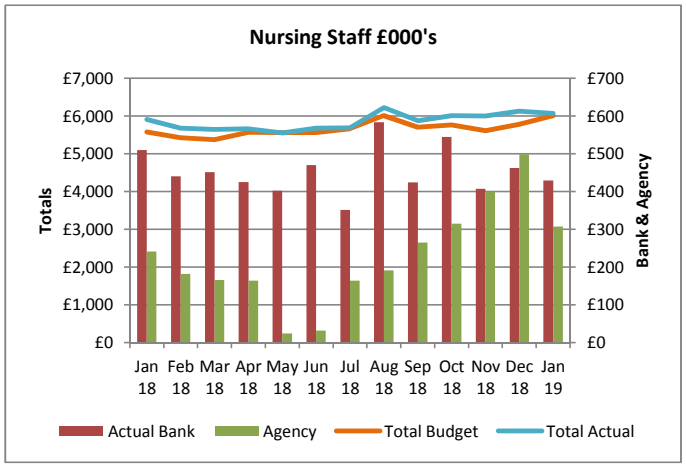
Pay is worse than budget by £2.8M year to date, however in January this has reduced to £0.3M above budget – partially as a result of phasing, but also a reduction in spend in January.

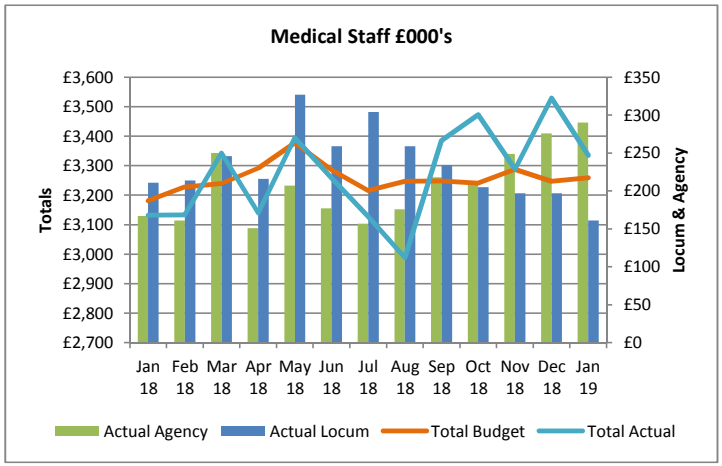
Nursing costs associated with keeping escalation beds/CAU assessment area open in April have been offset against agreed additional Winter money funding within contract income, however the further escalations over the Summer which have continued are unfunded. Whilst in November the planned Winter ward was opened, there are escalation beds which have been opened on top of this – which have further increased the financial pressure. For the period of October to December this has been consistently at an additional 21 beds.

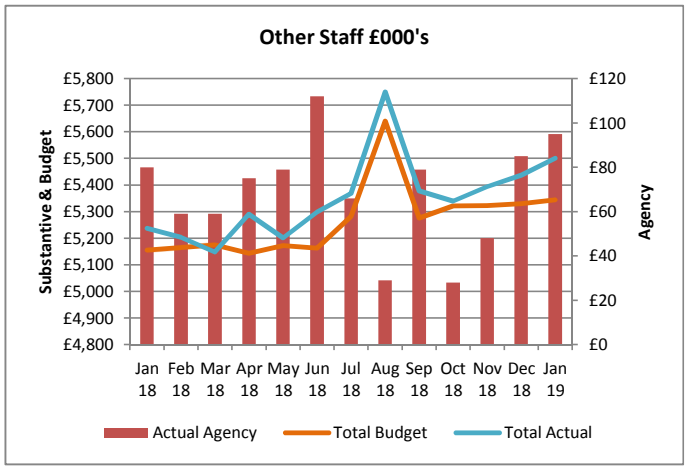
Medical pay is overspent within the month, largely as a result of agency use of doctors to fill gaps in rotas, particularly within Medicine & Emergency Care.

The agency spend is continuing to exceed the plan in January, and it is now expected that the trust will exceed the agency ceiling set out within the contract - of which only a proportion relates to the planned escalation beds for the Winter.

Primary Drivers

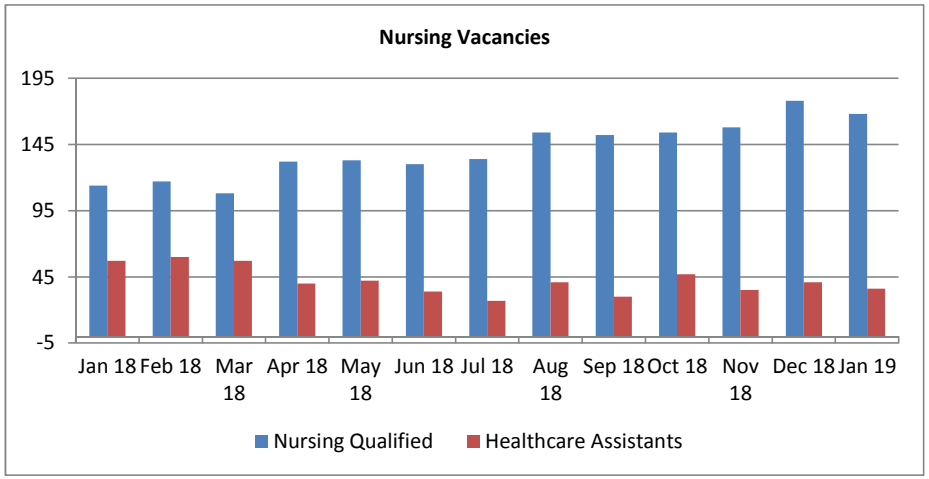






Finance: *Staff Costs*

Secondary Drivers



Medical vacancies under review

Agency Trajectory

	YTD	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Monthly Trend
Plan	-3,650	-495	-470	-484	-365	-365	-365	-365	-365	-365	-365	-365	-365	-365	
Actual	-5,159	-668	-618	-574	-389	-310	-320	-387	-395	-563	-546	-697	-860	-692	
Variance	-1,509	-173	-148	-90	-24	55	45	-22	-30	-198	-181	-332	-495	-327	
MCHFT Actual	-4,031	-380	-544	-419	-232	-265	-251	-337	-347	-509	-501	-533	-651	-405	
CCICP Actual	-715	-210	4	-77	-79	-45	-69	-50	-48	-54	-45	-87	-104	-134	
Planned Winter Escalations	-413	-78	-78	-78	-78	0	0	0	0	0	0	-77	-105	-153	

	Rolling 13 Months													
	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Monthly Trend
Sickness Rate (Rolling 12 mths)	4.28%	4.28%	4.38%	4.38%	4.37%	4.30%	4.29%	4.27%	4.27%	4.26%	4.24%	4.30%	4.27%	
Total Leavers	46	37	59	39	41	38	38	63	48	34	34	23	25	
Turnover (Rolling 12 mths)	10.70%	10.66%	11.18%	11.33%	11.28%	11.33%	11.17%	11.67%	11.54%	11.25%	11.03%	10.89%	10.60%	

Title of Paper :	Board Assurance Framework (BAF) Report Q3 18/19	
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:	4 March 2019

Quality Governance

Board Assurance Framework

2018/19

Summary Version

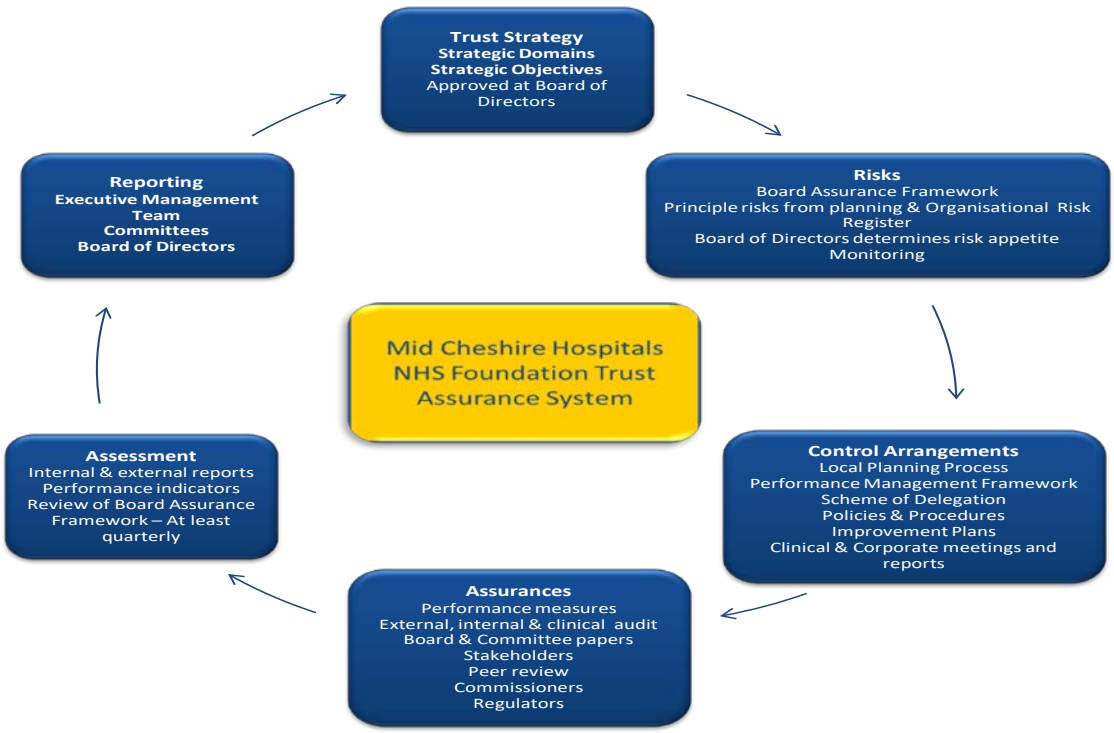
Quarter 3

1. Background & purpose

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

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

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



2. Current position

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

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

3. Organisational Risk Register

The Organisational Risk Register Report is presented to the Board of Directors on a quarterly basis. Table 1 below details the top five risks as of quarter 3, 2018/19.

Table 1 – Top five organisational risks

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

4. Next steps

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

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

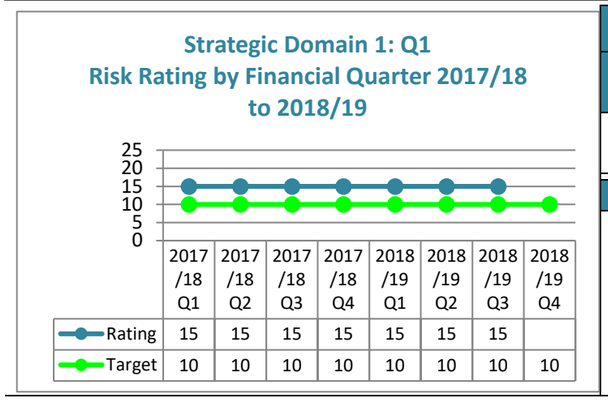
Strategic Domain 1: Delivering Outstanding Clinical Quality, Safety & Experience

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

Principal Risk

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

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHSI Single Oversight F/w	Executive Director	Executive Management Group	Board Committee
June 2017	December 2018	March 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 2019

Rationale for the Current Risk Score

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

Links to BAF objectives

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

Key Links to the Organisational Risk Register

CS0325 – Delivery of key local and National targets and standards, in particular the 4 hour standard in A&E	20⇔	CS0328 – Workforce capacity and skill mix to consistently deliver high quality care, seven days a week	20⇔
CS0327 – Long Term Financial Sustainability of MCHFT	20⇔	CS0284 - Registered Nurse staff shortages	16⇔

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

The Trust is progressing the Advancing Quality Programme for 2018/19 focusing on several care pathways, including sepsis. The quality reports at ward / department and divisional level have been developed and rolled out across all divisions. New Executive led quarterly quality reviews have commenced in all divisions except CCICP. The Quality & Safety Improvement Strategy for 2018/19 has been implemented. Quality priorities have been presented and approved at Quality Governance Committee in April 2018. A Well Led self-assessment process has been developed with findings from the initial reviews presented to the Trust Board. Review of Infection, Prevention & Control Services completed. The Director of Nursing & Quality has been appointed as the Trust Safety Champion for Maternity Services. On-going implementation plans and monitoring of National/regulatory guidance. Trust-wide e-roster project commenced in November 2018. NHS Resolution Maternity Incentive Scheme – all indicators achieved. Quality metrics programme launched in January 2019. CQC report on compliance with IRMER in Radiology in December 2018.

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

- Full roll out of Quality Reports and Quarterly Quality Assurance Reviews Trust wide, including CCICP by March 2019.
- Ward accreditation scheme under development, to be launched in May 2019
- Internal Well-Led Review improvement actions – quarterly oversight at Quality Governance Committee.
- A Nursing & Midwifery AHP Strategy is under development
- NHS Resolution Maternity Incentive Scheme, new indicators in 2019/20

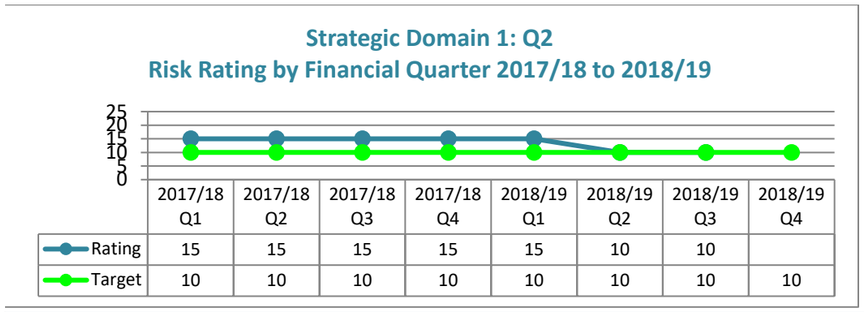
Strategic Domain 1: Delivering Outstanding Clinical Quality, Safety & Experience

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

Principal Risk

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

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHS Improvement Single Oversight Framework	Executive Director	Executive Management Group	Board Committee
June 2017	December 2018	March 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 2019

Rationale for the Current Risk Score

Risk score has remained at 10 for Quarter 3. The likelihood of not improving the quality of care with all the key controls in place is unlikely. The Quarterly Quality Review (QQR) process is now taking place across all Divisions and will include CCICP by March 2019.

Links to BAF Objectives

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

Key Links to the Organisational Risk Register

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

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

HSMR/SHMI mortality indicators are 'within expected range'. The SJR Process is established, with plans in place to train more staff in the process. The National Early Warning Score 2 (NEWS2) has been launched. The Trust has sought the support of the NHS Innovation Agency for NEWS 2 and onsite education and training on the Life QI System was undertaken in April 2018. 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 arising from the recent Well Led Development Review are being considered.

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

- Full roll out of Quarterly Quality Reviews by March 2019.
- Development of Clinical Trials portfolio by March 2019
- Develop plans to increase QI capability & capacity Trust wide by March 2019
- Lack of integration between Service Development and QI teams to be addressed as part of the Trust wide plans.

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

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

Principal Risk

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

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

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHS Improvement Single Oversight Framework	Executive Director	Executive Management Group	Board Committee
June 2017	December 2018	March 2019	Well Led NHSI - Use of Resources	CEO	Board of Directors	Quality Governance Committee

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

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

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

Rationale for the Current Risk Score

The risk score remains at 16 for quarter 3. Due to winter pressures the financial position has deteriorated significantly and on-going risk related to Trust contracts with commissioners as a result of an agreed MOU. The relationship remains strong with commissioners with a desire to find collective system solutions. Relationships with East Cheshire NHS Trust are good, however; progress is slow, with a perceived lack of desire on their part. Following the resignation of the current CEO, there is the potential for future interim and long term arrangements to create anxieties and potential risks within the system.

Links to BAF Objectives

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

Key Links to the Organisational Risk Register

CS0328 – Workforce capacity and skill mix to consistently deliver high quality care, seven days a week	20⇔	CS0327 – Long Term Financial Sustainability of MCHFT	20 ⇔
CS0374 - Lack of pace in the significant transformational change required to deliver the Cheshire East Place strategy and consequently the Health and Care Partnership (HCP) for Cheshire & Mersey	16⇔		

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

The Trust has a proven track record of delivery and partnering with other organisations to sustain services, maintain or improve quality and safety and reduce unacceptable variation. Future collaboration and partnerships will lead to a more complex and integrated landscape in which the Trust will have a key role. AQUA facilitated workshop on the development of integrated care partnerships completed. KPMG review of East Cheshire and Southport and Ormskirk NHS Trusts which will feed into the acute sustainability programme for the Health & Care Partnership for Cheshire & Mersey is complete.

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

New strategy for Cheshire East place is under development with a final draft presented to regulators. The next stage is the development of a PCBC. Recruitment of new CEO is underway. Where opportunities arise consideration will be given to closer collaborative working with East Cheshire (clinical services/corporate/clinical roles).

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

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

Principal Risk

Risk of not continuing to develop effective external partnerships and alliances leading to failure to improve the health of the local population and reduce health inequalities, failure to develop new care pathways and failure to achieve long term clinical and financial sustainability and viability due to: Lack of full engagement – being a key partner; Failure to engage effectively and lead the development of the local health economy; Lack of pace and appropriate scale to recognise the quality, economics and clinical benefits of change; Partners perceptions of working relationships with MCHFT; Impact of Capped Expenditure programme and NHS Improvement Long Term Sustainability review

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHS Improvement Single Oversight Framework	Executive Director	Executive Management Group	Board Committee
June 2017	December 2018	March 2019	Well Led / NHSI - Use of Resources	CEO	Board of Directors	Quality Governance Committee

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

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

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

Rationale for the Current Risk Score

The risk score has been increased to 16 to reflect the recent increase in East Cheshire GP anxiety and the need to recruit a new independent chair for the Partnership Board and a full time Programme Director for Integrated Care Partnerships.

Links to BAF Objectives

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

Key Links to the Organisational Risk Register

CS0328 – Workforce capacity and skill mix to consistently deliver high quality care, seven days a week	20⇔	CS0327 – Long Term Financial Sustainability of MCHFT	20⇔
CS0374 - Lack of pace in the significant transformational change required to deliver the Cheshire East Place strategy and consequently the Health and Care Partnership (HCP) for Cheshire & Mersey	16⇔		

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

AQUA facilitated workshop on the development of integrated care partnerships complete. Cheshire East Place secured £500K funding from Cheshire & Merseyside HCP to support integrated working. NHSI facilitated meetings - actions monitored at CCICP Board.
PMO established but with limited resource. Full time dedicated resource to lead ICP – Recruitment underway.

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

- Re-launching UHNM / MCHFT Stronger Together Programme meetings.
- Integrated care partnerships; recruitment of full time programme director.
- Anxiety from GP membership.

Strategic Domain 3: Striving for Outstanding Organisational Effectiveness

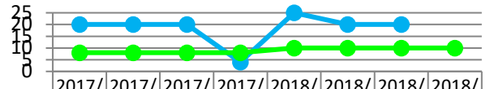
E1	To ensure full compliance with the NHS Improvement Provider Licence, ensuring financial sustainability, financial efficiency and financial controls, whilst safeguarding the quality of our services.

Principal Risk

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

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHS Improvement Single Oversight Framework	Executive Director	Executive Management Group	Board Committee
June 2017	December 2018	March 2019	Well Led NHSI - Use of Resources	Director of Finance and Strategic Planning	Divisional Finance & Activity Performance Group	Performance & Finance

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



	2017/18 Q1	2017/18 Q2	2017/18 Q3	2017/18 Q4	2018/19 Q1	2018/19 Q2	2018/19 Q3	2018/19 Q4
Rating	20	20	20	4	25	20	20	
Target	8	8	8	8	10	10	10	10

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

Rationale for the Current Risk Score

At the end of Quarter 1 of 2018/19 the risk score was raised to 25. Influencing factors for the increase in risk score include; anticipated costs of achieving the A&E response time targets, potential not to achieve STF funding and the knock on impact on the MOU with CCG. It is anticipated that there will be a significant impact on capital programmes and service provision as a result. The risk score remains at 20 for Quarter 3 as early indicators are the MOU will be honoured.

Links to BAF Objectives

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

Key Links to the Organisational Risk Register

CS0325 – Delivery of key local and National targets and standards, in particular the 4 hour standard in A&E	20⇔	CS0326 – Lack of funding to deliver the IM&T Strategy	12⇔
CS0327 – Long Term Financial Sustainability of MCHFT	20⇔	CS0284 - Registered Nurse staff shortages	16⇔

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

Work on internal transformation programmes to improve efficiencies has continued alongside the wider collaborations of "Stronger Together" Programme with the University Hospitals of North Midlands and the wider engagement at all levels with the Health & Care Partnership for Cheshire & Mersey. The Trust underwent a NHS Improvement Use of Resources assessment in March 2018 and has been rated as good. The Trust has received up to £500k of transformation funding from HCP. NHS Improvement segment 2 in November 2018, indicating performance is still on track.

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

- Re-launch Connecting Care Board
- Transformation programmes in place including Alternatives to Admissions, Ward Processes (Reducing Length of Stay) and Improving Discharge Processes.
- Performance Management Framework to be fully implemented.
- Lack of planning guidance and long term NHS plan (delayed)

Strategic Domain 3: Striving for Outstanding Organisational Effectiveness

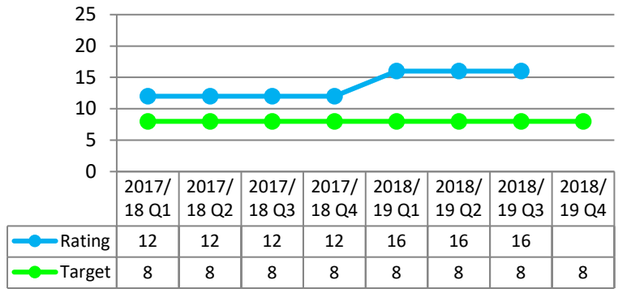
E2	To maintain compliance with, and aspire to achieve incremental improvements against, the NHS Improvement Single Oversight Framework Operational Performance Metrics, whilst safeguarding the quality of our services.

Principal Risk

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

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHS Improvement Single Oversight Framework	Executive Director	Executive Management Group	Board Committee
June 2017	December 2018	March 2019	Responsive Care & Effective Care NHSI - Operational Performance Metrics	Chief Operating Officer	Divisional Finance & Activity Performance Group	Performance & Finance

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



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

Initial Risk Rating (Unmitigated)			Current Risk Rating (Mitigated)			Target Risk Rating (Tolerance / Risk Appetite)			
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Target Date
4	5	20	4	4	16⇔	4	2	8	March 2019

Executive Commentary for the Current Risk Score

Risk score for Quarter 3 remains the same at 16. Whilst the Trust has a strong record of compliance against the Single Oversight Framework with the exception of the A&E 4 hour standard. There are significant external factors outside of the Trust's direct control which can directly impact on the Trust's ability to maintain compliance. The Trust has enacted a winter pressures plan, which currently identifies a deficit of capacity to meet expected demand required to deliver 92% Trust occupancy and 90% performance against the 4 hour standard. Options are now being developed to mitigate the above risk, however given the financial resource required the schemes will need full system approval. Should the Trust's occupancy levels increase this will impact on the elective programme and performance against RTT and possibly cancer standards. The Trust has engaged with NHS England's Emergency care Intensive Support Team (ECIST) to focus on three key areas to support non-elective flow; 1. Streaming from the ED. 2. SAFER implementation. 3. Dom Care Pathway expansion.

Links to BAF Objectives

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

Key Links to the Organisational Risk Register

CS0325 – Delivery of key local and National targets and standards, in particular the 4 hour standard in A&E	20⇔	CS0327 – Long Term Financial Sustainability of MCHFT	20⇔
CS0328 – Workforce capacity and skill mix to consistently deliver high quality care, seven days a week	20⇔	CS0375 - Delayed routine outpatient follow-up	15⇔

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

The Trust has consistently delivered four of the five standards within the NHS Improvement Single Oversight Framework, with the exception being performance against the four hour emergency access standard. Nationally the majority of economies are challenged against the four hour emergency access standard. The Trust has a solid foundation of quality and improving the timely flow of our non-elective activity which it is building upon at a time of increased pressure within the system to deliver compliance against the 4 hour standard. System improvement is led at director level through the A&E Delivery Board, with steering groups reporting into it. The recent CQC report saw an improvement in the Responsive domain, from 'requires improvement ' to 'good'. This is in addition to an NHSI Use of Resources rating of Good in March 2018. However; there continues to be pressures regarding responsiveness following an increase in referrals, reduced capacity (via CEP), resulting in a number of follow-ups being delayed. Performance Management framework approved by PAF in October 2018. External audit action plan regarding RTT reviewed by the executive team in December 2018.

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

- Partnership working and agreeing actions to support future compliance.

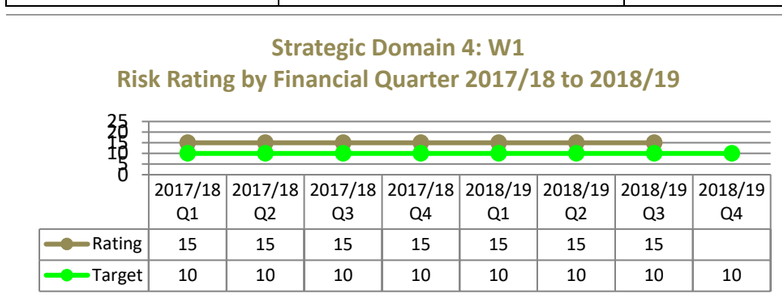
Strategic Domain 4: Aspiring to Excellence in Practice through Our Workforce

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

Principal Risk

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

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHS Improvement Single Oversight Framework	Executive Director	Executive Management Group	Board Committee
June 2017	December 2018	March 2019	Well Led Framework NHSI Organisational Health Metrics	Director of Workforce & Organisational Development	Executive Workforce Assurance Group	Transformation & People Committee



	2017/18 Q1	2017/18 Q2	2017/18 Q3	2017/18 Q4	2018/19 Q1	2018/19 Q2	2018/19 Q3	2018/19 Q4
Rating	15	15	15	15	15	15	15	
Target	10	10	10	10	10	10	10	10

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

Rationale for the Current Risk Score

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

Links to BAF Objectives

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

Key Links to the Organisational Risk Register

CS0325 – Delivery of key local and National targets and standards, in particular the 4 hour standard in A&E	20⇔	CS0328 – Workforce capacity and skill mix to consistently deliver high quality care, seven days a week	20⇔
CS0327 – Long Term Financial Sustainability of MCHFT	20⇔	CS0284 – Registered nurse staff shortages	16⇔
DC0887 - Consultant Histopathologist capacity	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) is not expected to be fully implemented.
- 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

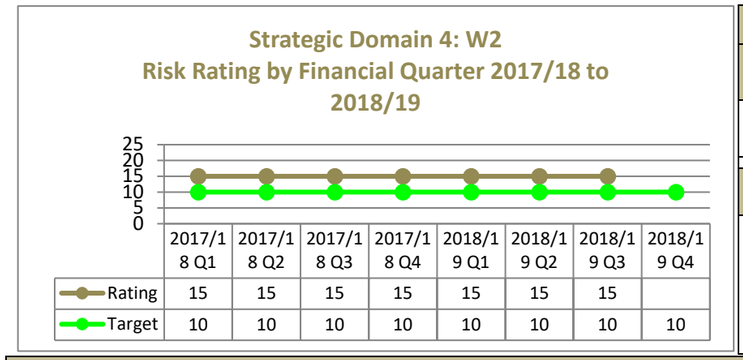
Strategic Domain 4: Aspiring to Excellence in Practice through Our Workforce

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

Principal Risk

Risk that the Trust does not have an agile and responsive workforce to meet the future local health needs / Integrated Care Partnerships (ICP)

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHS Improvement Single Oversight Framework	Executive Director	Executive Management Group	Board Committee
June 2017	December 2018	March 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 2019

Rationale for the Current Risk Score

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

Links to BAF Objectives

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

Key Links to the Organisational Risk Register

CS0328 – Workforce capacity and skill mix to consistently deliver high quality care, seven days a week	20⇔	CS0284 – 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?)

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

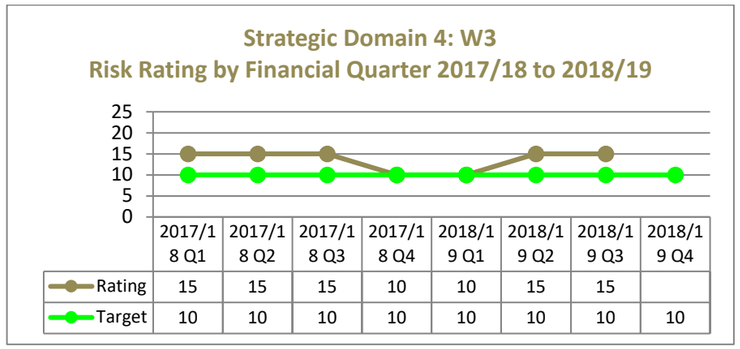
Strategic Domain 4: Aspiring to Excellence in Practice through Our Workforce

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

Principal Risk

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

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHS Improvement Single Oversight Framework	Executive Director	Executive Management Group	Board Committee
June 2017	December 2018	March 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 2019

Rationale for the Current Risk Score

Risk score has remained at 15 for Q3, 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

CS0284 – Registered nurse staff shortages	16⇔	CS0328 – Workforce capacity and skill mix to consistently deliver high quality care, seven days a week	20⇔
CS0327 – Long Term Financial Sustainability of MCHFT	**20⇔**	CS0284 – Registered nurse staff shortages	16⇔
DC0887 - Consultant Histopathologist capacity	16⇔		

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

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

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

- Talent management & succession planning programme to be embedded.
- Local development of improvement plans following the National Staff Survey results.

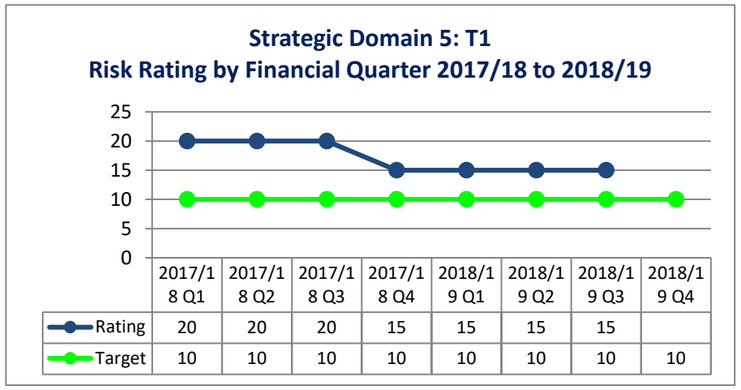
Strategic Domain 5: Creating a 21st Century Infrastructure for Transformative Health and Social Care

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

Principal Risk

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

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHS Improvement Single Oversight Framework	Executive Director	Executive Management Group	Board Committee
June 2017	December 2018	March 2019	Well Led Framework Use of Resources	CEO	Executive Infrastructure Development Group	Performance & Finance



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

Rationale for the Current Risk Score

The risk score remains a high risk overall at 15 due to long term backlog maintenance requirements and the ability to raise the finances necessary to service these. There may be opportunities to receive capital that is not being made available currently. The Director of Estates and Facilities has retired and the new director is a shared post with joint responsibility for East Cheshire Hospital and MCHFT. The new director will require some time to become familiar with the role and associated estate risks for MCHFT.

Links to BAF Objectives

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

Key Links to the Organisational Risk Register

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

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

The Trust has 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. The retired Divisional Director of Estates is now the SRO for Estates developments & opportunities across the Cheshire East foot print and represents the local Place within the C&M system estates group. Estates Strategy in place with Board sign-off. MCHFT now has a joint Estate Director with ECT.

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

Asbestos Management Group – oversight of new contractors in progress.
The new Director of Estates and Facilities will require some time to become familiar with the role and associated risks.

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

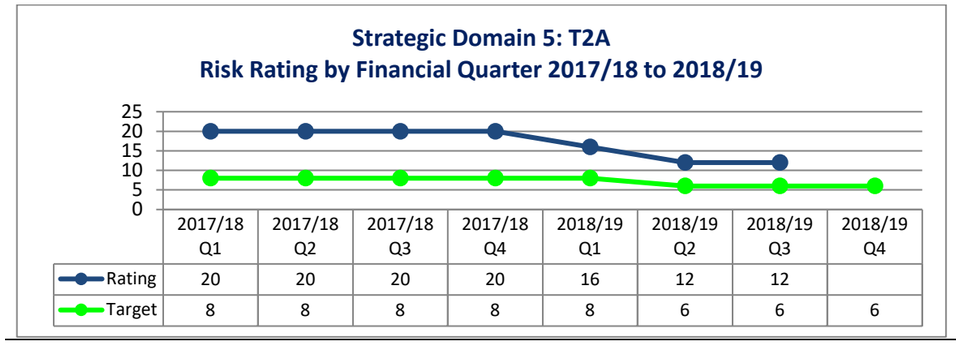
T2a	To deliver an agreed, costed and phased Information Technology (IT) Strategy which supports the provision of seamless, integrated, outstanding patient care, improves staff experience in delivering care and enables continuous quality and service improvements through the intelligent use of secure,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

Principal Risk

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

- Missed opportunities to improve the quality of care we provide, leading to poor patient and staff experience (E.g. E-Prescribing)
- Inability to modernise services (E.g. E -Prescribing)
- Delays in delivering horizontal and vertical integration – Accountable Care Systems
- Failure to meet legislative requirements 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 / NHS Improvement Single Oversight Framework	Executive Director	Executive Management Group	Board Committee
June 2017	December 2018	March 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 2019

Rationale for the Current Risk Score

The current risk score has remained at a score of 12 for Quarter 3. Pockets of funding to be identified in combination with East Cheshire NHS Trust. £3M of national funding obtained to support the Clinical Systems Business Case. The Clinical Systems Strategic Outline Case has received national approval from the NHSI. The Outline Business Case will be presented to the Board of Directors in January 2019.The Trust has produced a Digital Strategy 2018-2022.

Links to BAF Objectives

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

Key Links to the Organisational Risk Register

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

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

The Trust has implemented a clinically led Information Technology Strategy that is centred on an electronic patient record, and supports whole system service transformation and integration as we move towards Integrated Care Systems. The main challenge to delivering the Information Technology Strategy is the financial affordability, particularly as the Trust is part of a Capped Expenditure Programme. 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 Medical Director / Deputy CEO. Funding to replace aged hardware across the Trust has been identified, and the replacement has now commenced. The E-Rostering project has 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 will be reviewed by the internal auditors in January 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.

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

- Overarching Cyber Security implementation plan to be presented to ITSG in February 2019.

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

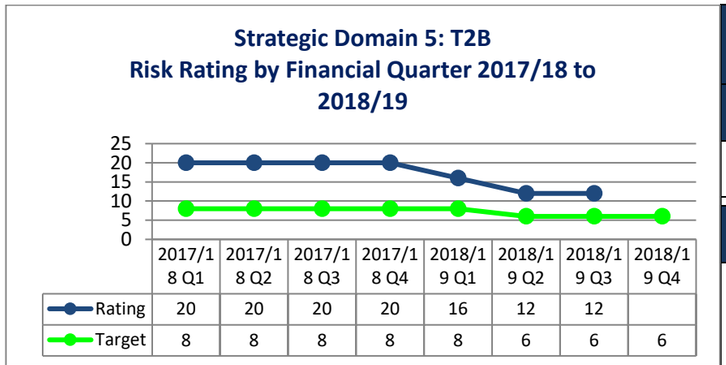
T2b	To deliver an agreed, costed and phased Information Technology (IT) Strategy which supports the provision of seamless, integrated, outstanding patient care, improves staff experience in delivering care and enables continuous quality and service improvements through the intelligent use of secure,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

Principal Risk

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

- Missed opportunities to improve the quality of care we provide, leading to poor patient and staff experience (E.g. E-Prescribing)
- Inability to modernise services (E.g. E-Prescribing)
- Failure to meet legislative requirements 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 / NHS Improvement Single Oversight Framework	Executive Director	Executive Management Group	Board Committee
June 2017	December 2018	March 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 2019

Rationale for the Current Risk Score

The current risk score has remained at 12 for Quarter 3, on the basis that the Clinical Systems Strategic Outline Case has been approved by NHSI to move to the next step. £3M of national funding to support the clinical systems business case has been obtained.

Links to BAF Objectives

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

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

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

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

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

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

- Review of job description content Trust wide re digital age
- Recruitment assessment process and underpinning support programme to be introduced.

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

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

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

Appendix B – Risk matrices

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

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

Appendix C – Questions for Board Sub-Committees

Assurance:

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

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

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

Title of Paper:	Learning from Deaths Quarterly Report (Q3 2018/19)	
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:	To provide the Board with an oversight of our mortality information, how we share the learning arising from the review of in-patient deaths and the projects in place to drive quality improvement.
Risk:	Gaps in assurances and lack of oversight of key areas impacting on the quality of the care we deliver and associated reputational risks.

To be published on Trust Website – complete version	***Yes***
If no, to be published on Trust Website – redacted	
If not to be published complete or redacted, please detail the reason why	
Presented at Board Meeting of:	4 March 2019

Learning from Deaths Quarterly Report Q3 2018/19

February 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 include:

- 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 builds upon the existing policy and embedded associated processes, outlines the process for reviewing deaths and explains how the organisation learns from these reviews.

Purpose

This is the sixth iteration of our Learning from Deaths Report covering Quarter 3 of 2018/19.

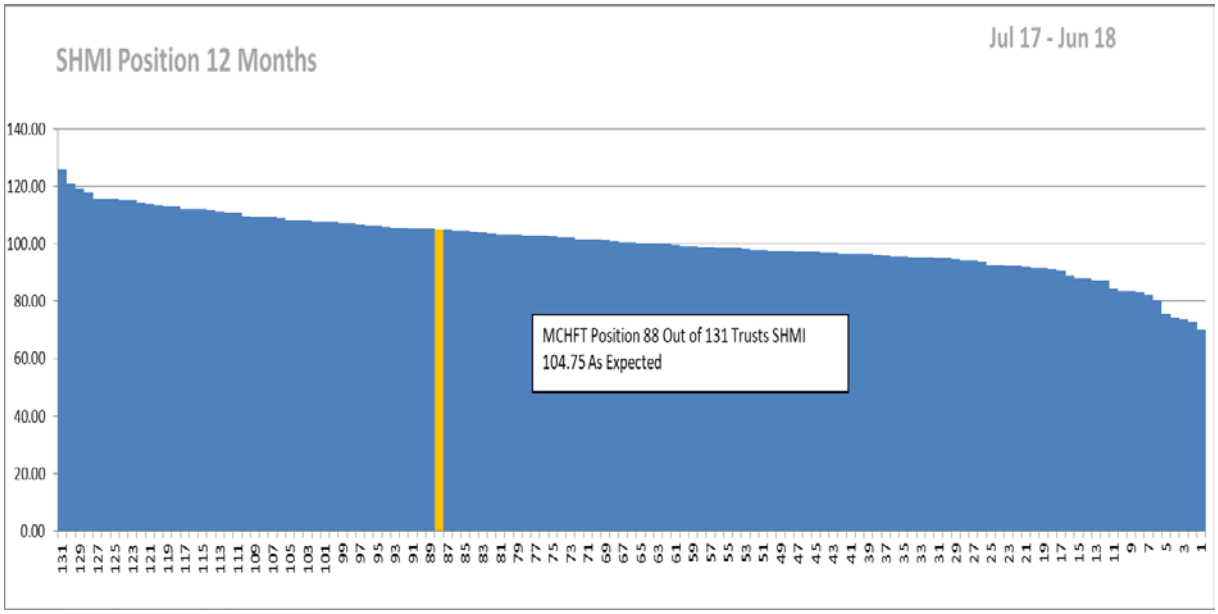
The report aims to provide assurance on how the organisation, through the work of the Hospital Mortality Reduction Group (HMRG) and other linking groups, is triangulating data and information to embed the learning from in-patient deaths, with the goal of seeing a sustained reduction in the Trust's mortality 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) July 2017 - June 2018

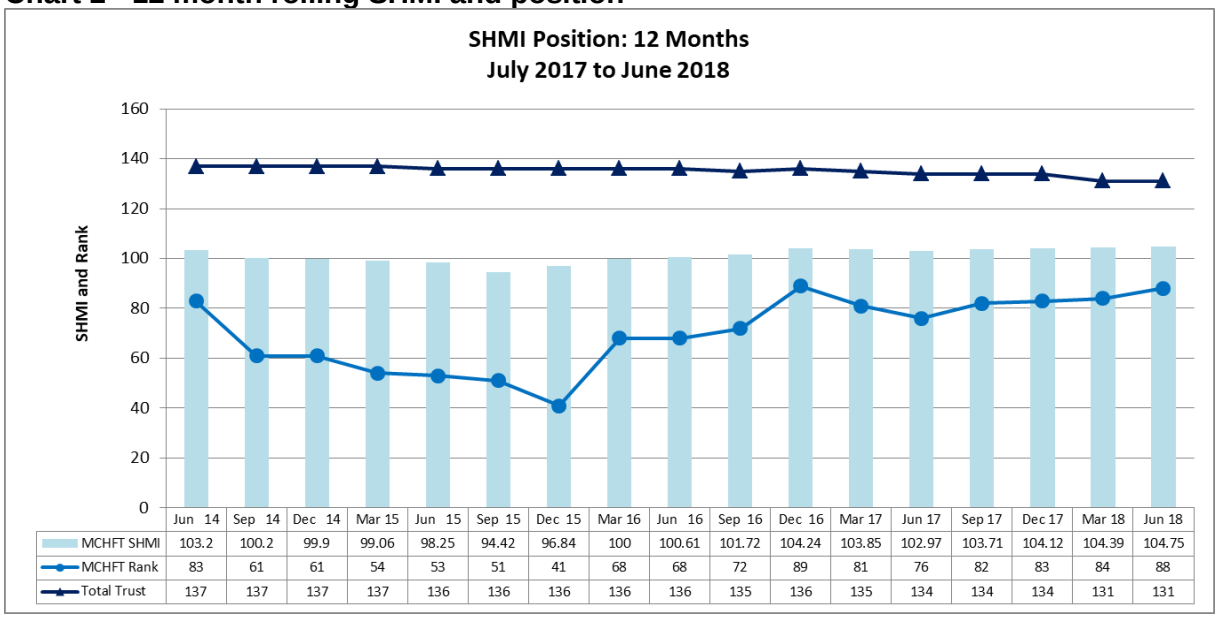
Chart 1 - SHMI Position



(Source NHS Digital, 2018)

Chart 1 demonstrates the SHMI position for the reporting period July 2017 - June 2018. The SHMI is currently 104.75 and is in the 'as expected' range. This currently places the Trust 88 out of 131 Trusts.

Chart 2 - 12 month rolling SHMI and position



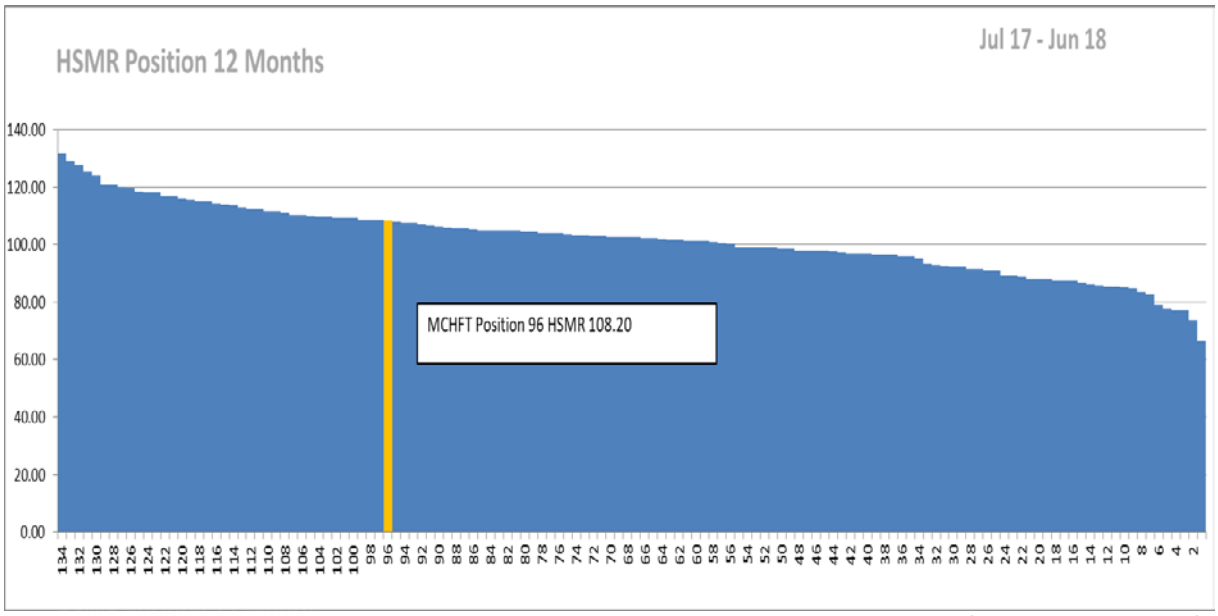
	Jun 14	Sep 14	Dec 14	Mar 15	Jun 15	Sep 15	Dec 15	Mar 16	Jun 16	Sep 16	Dec 16	Mar 17	Jun 17	Sep 17	Dec 17	Mar 18	Jun 18
MCHFT SHMI	103.2	100.2	99.9	99.06	98.25	94.42	96.84	100	100.61	101.72	104.24	103.85	102.97	103.71	104.12	104.39	104.75
MCHFT Rank	83	61	61	54	53	51	41	68	68	72	89	81	76	82	83	84	88
Total Trust	137	137	137	137	136	136	136	136	136	135	136	135	134	134	134	131	131

(Source NHS Digital, 2018)

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

2.2 Hospital Standardised Mortality Rate (HSMR) July 2017 - June 2018

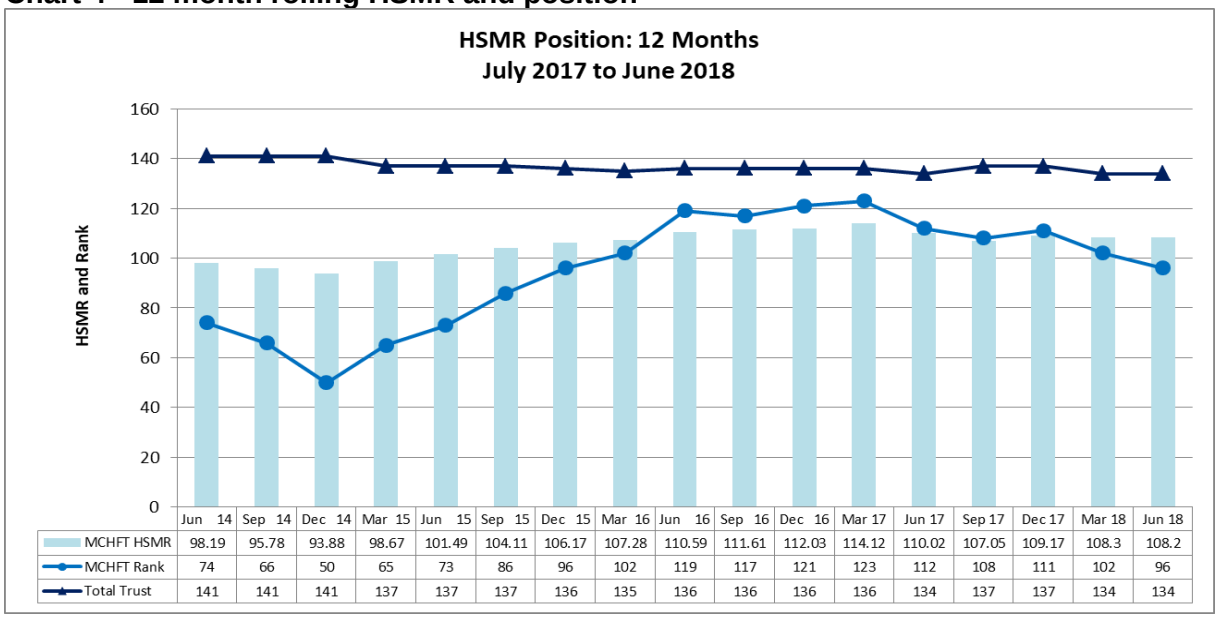
Chart 3 - HSMR Position



(Source HED, 2019)

Chart 3 demonstrates the HSMR position for the reporting period July 2017 - June 2018. The HSMR is currently 108.20 and places the Trust 96 out of 134 Trusts.

Chart 4 - 12 month rolling HSMR and position



	Jun 14	Sep 14	Dec 14	Mar 15	Jun 15	Sep 15	Dec 15	Mar 16	Jun 16	Sep 16	Dec 16	Mar 17	Jun 17	Sep 17	Dec 17	Mar 18	Jun 18
MCHFT HSMR	98.19	95.78	93.88	98.67	101.49	104.11	106.17	107.28	110.59	111.61	112.03	114.12	110.02	107.05	109.17	108.3	108.2
MCHFT Rank	74	66	50	65	73	86	96	102	119	117	121	123	112	108	111	102	96
Total Trust	141	141	141	137	137	137	136	135	136	136	136	136	134	137	137	134	134

(Source HED, 2019)

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

2.3 Learning from Deaths Dashboard – Part 1

The Trust has adopted the national Learning from Deaths Dashboard produced by the Department of Health. The dashboard is a tool to aid the systematic recording of deaths and learning and will be used to record 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 3 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
79	73	72	83	8	8	0	0	0	1
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
223	225	216	178	25	33	0	0	1	2
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
661	1117	615	889	62	N/A	0	N/A	3	2

2.3 Learning from Deaths Dashboard – Part 2

Evidence suggests from the Confidential Inquiry of 2010-2013 that people with learning disabilities currently have a life expectancy at least 15 to 20 years shorter than other people. A concerning finding was that assumptions were sometimes made that the death of a person with learning disabilities was 'expected' or even inevitable. In response, a Learning Disabilities Mortality Review (LeDeR) programme was commissioned by the Healthcare Quality Improvement Partnership (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.

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.

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

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
2	3	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
5	2	0	2	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
9	11	4	11	0	N/A

3.0 Care Quality Commission (CQC) Mortality Outlier Alerts

The information below is sourced from the latest version of the CQC Insight document (12 January 2019). The Trust undertakes an in-depth case note review in response to any Mortality Outlier Alert.

Key Messages

- There are currently 2 active mortality alerts for this Trust.
- There are currently 0 active maternity alerts for this Trust.

Number of outlier alerts for this Trust as at 4 December 2018:

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

Mortality Outliers – Active Alerts

Cases under consideration by the Outlier Panel

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

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

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

The improvement plans arising from these 2 mortality outlier alerts have been delivered apart from the commissioning of a health promotion initiative for an external provider to deliver an alcohol liaison service. As the commissioning of this service is out with the Trust's control, we have asked the CQC to close the 2 alerts.

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:

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

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 September 2018, (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

The current main areas of focus on the driver diagram are:

4.1 Actions to improve the recognition of, and the response to, the acutely deteriorating patient

- Following a large scale training programme across the organisation, the National Early Warning Score 2 (NEWS2) was launched in the Emergency Department and in-patient ward areas on the 5 November 2018.
- NEWS2 will be launched in Theatres, Treatment Centre, Ambulatory Care Unit, Planned Interventions Unit, Outpatients Department and Elmhurst as part of the roll out programme on the 5 March 2019.

4.2 Actions to share learning from mortality deep dives at speciality levels

- Deep dives have been undertaken into, for example:
    - Paediatrics
    - General Medicine
    - Gynaecology
    - Cardiology

  Learning from mortality deep dives is shared at the Trust Mortality Reduction Group.

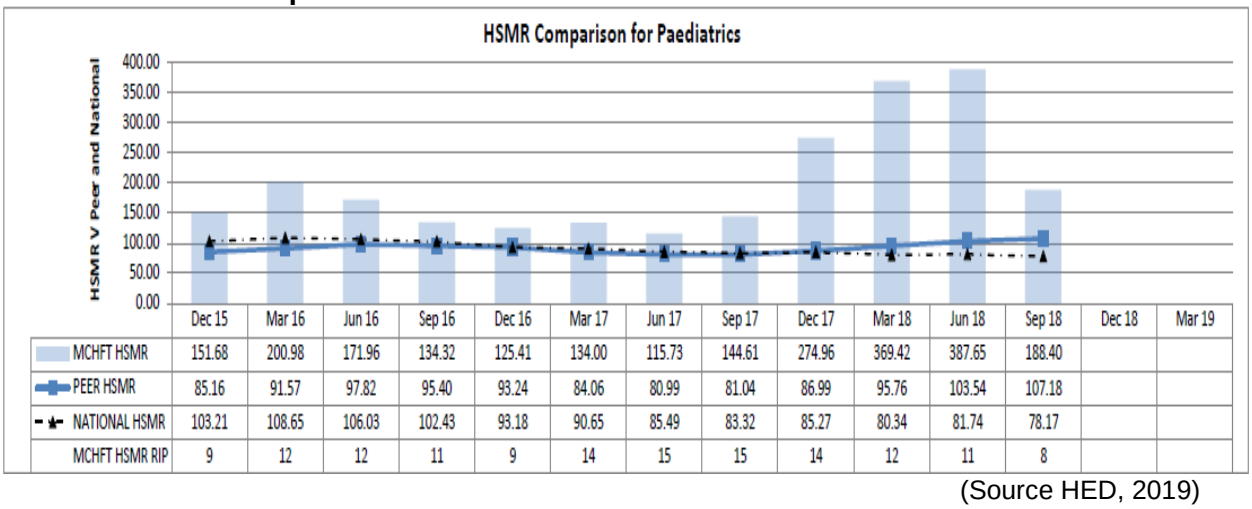
4.3 Actions to reduce the number of avoidable deaths

- In Quarter 3 of 2018/19 twenty-five SJRs have been completed.
- Sixty two SJRs have been completed year to date.
- The SJR process has not identified any potentially avoidable deaths to date
- The 3 potentially avoidable deaths identified in 2018 / 19 to date were highlighted through the incident investigation process.
- Learning from the SJR process is shared through a quarterly newsletter (See appendix 4).

4.4 Quarterly Deep Dive – Paediatrics Mortality Rates

A deep dive has been undertaken into the reason why the HSMR for paediatrics has been consistently above both peer and national average.

Chart 5 - HSMR Comparison for Paediatrics



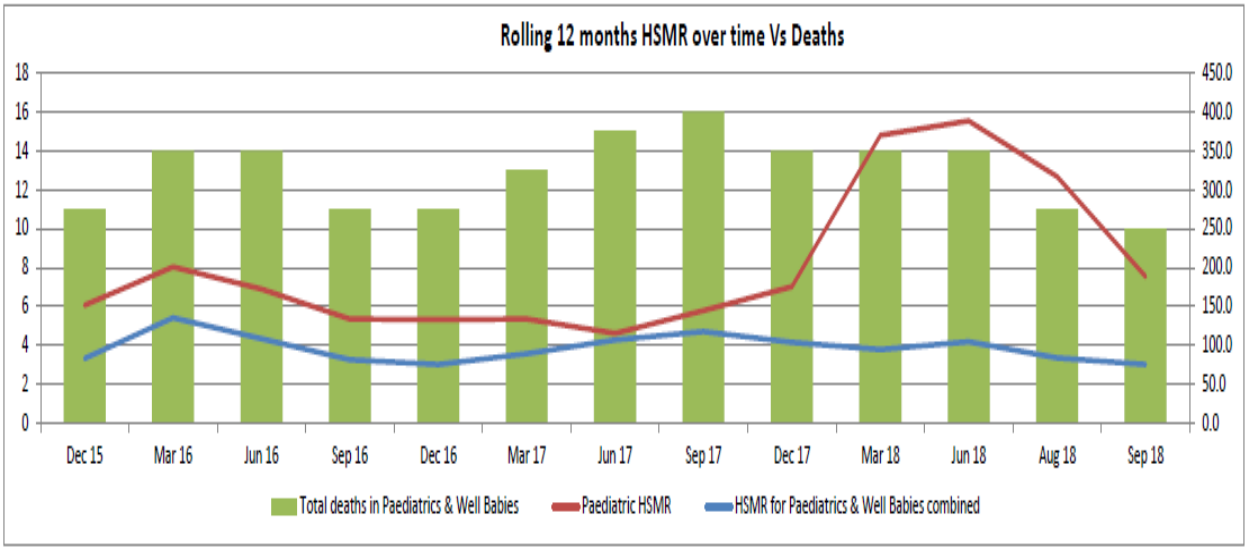
	Dec 15	Mar 16	Jun 16	Sep 16	Dec 16	Mar 17	Jun 17	Sep 17	Dec 17	Mar 18	Jun 18	Sep 18	Dec 18	Mar 19
MCHFT HSMR	151.68	200.98	171.96	134.32	125.41	134.00	115.73	144.61	274.96	369.42	387.65	188.40		
PEER HSMR	85.16	91.57	97.82	95.40	93.24	84.06	80.99	81.04	86.99	95.76	103.54	107.18		
NATIONAL HSMR	103.21	108.65	106.03	102.43	93.18	90.65	85.49	83.32	85.27	80.34	81.74	78.17		
MCHFT HSMR RIP	9	12	12	11	9	14	15	15	14	12	11	8		

(Source HED, 2019)

Chart 5 demonstrates that the Trust HSMR has been above peer and national average for paediatrics for the period December 2015 to September 2018. The specialty of paediatrics saw a dramatic rise in its HSMR approximately 12 months ago which triggered a deep dive into the specialty data, combined with a case note review.

The deep dive into the specialty data revealed that a data recording issue appeared at the start of the 2017/18 financial year. A data quality automation check, which normally ensures that "un-well babies" are coded to paediatrics, failed to work following the release of a new tariff HRG grouper. As a result “un-well babies” were actually coded to the “well babies” group. This resulted in a fall in the number of expected deaths in paediatrics, whilst the number of actual deaths remained relatively constant. Consequently the HSMR for paediatrics rose significantly. The failure of the data quality automation check was corrected in August 2018, since when the HSMR for paediatrics has been reducing.

Chart 6 – Rolling 12 Months HSMR over time versus deaths.



(Source HED, 2019)

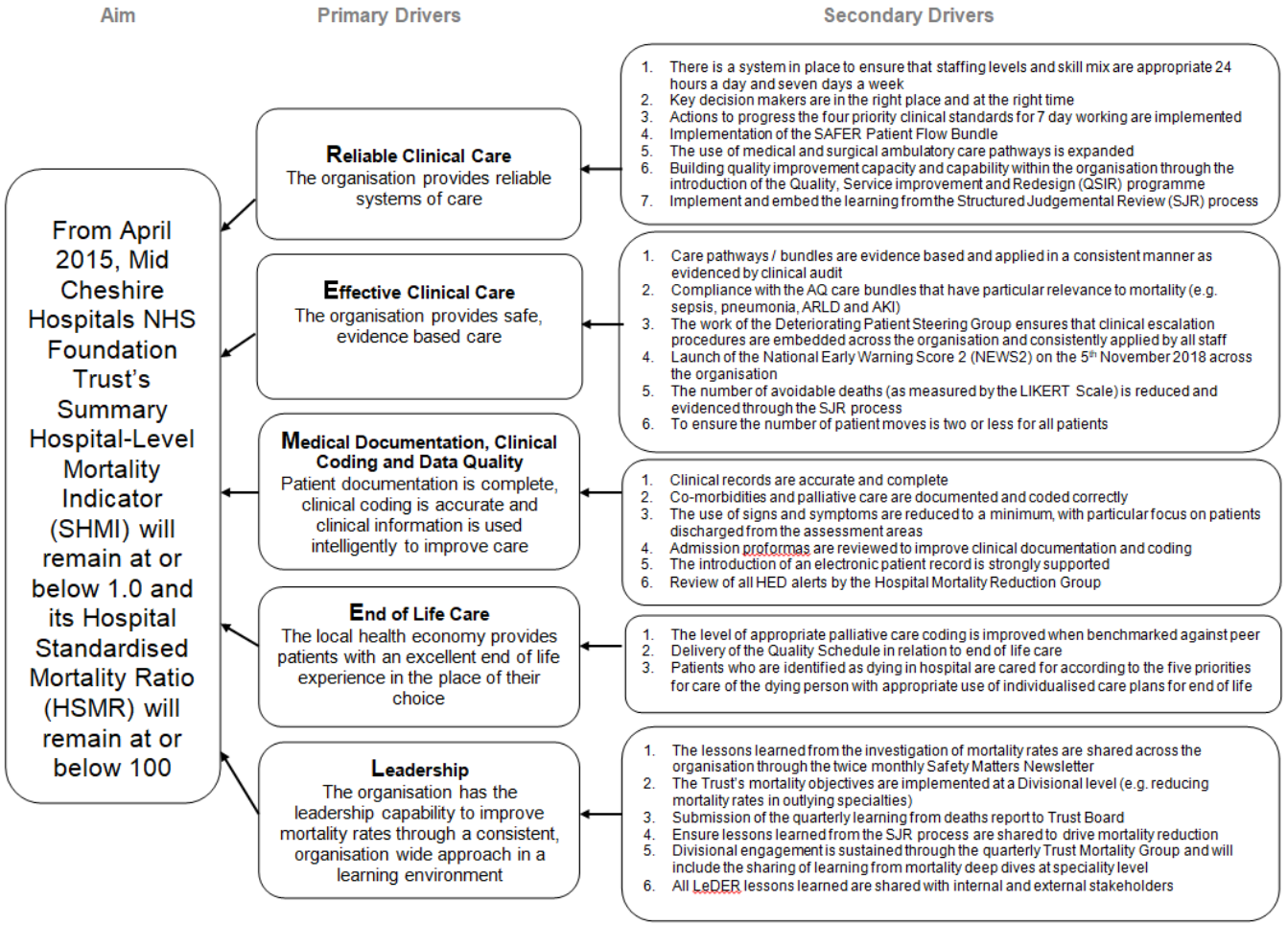
In parallel with the deep dive into the specialty data, the Clinical Lead for Paediatrics led a case note review into the paediatric deaths during the same time period. The results of the case note reviews has been presented to the Trust Mortality Reduction Group and no significant gaps in care were identified.

5.0 Next steps

Deep dive into the learning arising from the reviews of learning disability deaths.

6.0 Appendices

6.1 Appendix 1 Driver Diagram



6.2 Appendix 2 - Glossary

Healthcare Evaluation Data (HED)

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

Hospital Standardised Mortality Ratio (HSMR)

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

LIKERT Scale

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

LIKERT Scale

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

Summary Hospital-level Mortality Indicator (SHMI)

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

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

6.3 Appendix 3: Understanding the difference between SHMI and HSMR

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

6.4 Appendix 4: Quarter 3 Learning from Mortality Reviews Newsletter

Quarter 3 2018/19
Issue 2

Mid Cheshire Hospitals NHS Foundation Trust

Learning from our Mortality Reviews

During the first 3 quarters of 2018/19, 56 SJR's have been completed.

In 79% of these the death was classified as definitely not preventable.

No avoidable deaths were identified in quarter 1, 2 or 3 through the SJR process.

In 63% the SJR identified that the patient received good or excellent care.

In 59% the SJR identified the patient care record as being of a good or excellent quality.

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

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

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

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

The phases of care which are reviewed are:

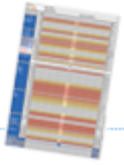
- Admission and initial care - first 24 hours
- Ongoing care
- Care during a procedure
- Perioperative/procedure care
- End of life care
- Assessment of overall care

What have we found from the SJR's that we do well?
Below are a number of the positive judgmental comments made during the quarter 3 reviews.

- Early treatment of sepsis
- Good team working to ensure the patient's best interest and appropriate plans were in place
- Appropriate end of life decisions and plans
- Prompt assessment and treatment in the Emergency Department
- Good involvement of family in end of life discussions
- Great communication and compassion
- Excellent practice and documentation
- Excellent multidisciplinary team working
- Prompt review by speciality teams when internal referrals completed

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

- Early recognition and implementation of end of life pathway is essential with early involvement of palliative care team
- Medical proforma poorly completed, documentation not signed, dated or timed
- Care pathways not utilised
- Ceilings of care not in place
- Delay in completion of uDNACPR
- Failure to escalate raised NEWS2
- Failure to follow NEWS2 policy regarding recording observations



We Care Because You Matter

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

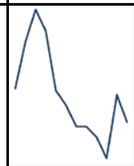
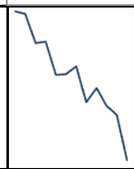
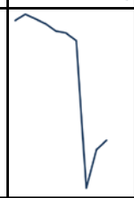
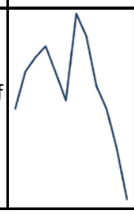
Board of Directors

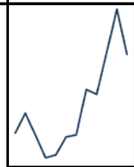
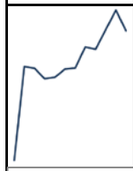
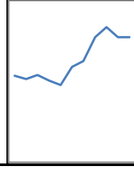
Workforce Report

March 2019

(Jan 2019 data)

Performance Report Month: Workforce Chapter
Jan-19

Measure	Target	Performance	Description	Narrative	Rolling Trend	Trend	C&W Average (Dec 18)
Sickness Absence	3.40%	4.27%	Rolling 12m average Sickness Absence described as a Percentage	The rolling position improved slightly (-0.03%) from the previous month and remains Amber. Corporate is currently Green and meeting the divisional target and DCSS, WC and CCICP are Amber.		↓	4.89%
In-Month Sickness Absence	N/A	5.45%	In-month 12m average Sickness Absence described as a Percentage	The in-month position increased slightly (+0.25%). EF experienced reduced sickness absence levels. All other divisions experienced an increase in sickness in.		↑	5.19%
Appraisal Rate	90.00%	77.96%	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 2.87% reduction in the appraisal rates across the Trust. DCSS, SC and CCICP are Amber. All divisions experienced a reduction in compliance, the most significant being Corporate (-8.49%)		↓	86.29%
Mandatory Training	90.00%	74.26%	Mandatory Training Monthly Rate Excludes Bank Staff, Staff on long term sick & mat. leave.	Training compliance increased by 0.26% in month. WC are now Amber at 83%. Other divisions remain Red		↑	86.09%
Staff Turnover	10.00%	10.60%	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 improved in month (-0.29). Turnover reduced in all divisions with the exception of EF and WC. EF, WC and DCSS are Green against target. Corporate and SC are Amber.		↓	11.18%

Measure	Target	Performance	Description	Narrative	Rolling Trend		
Agency Spend	(365)	(692)	In month and cumulative total spend for the Trust.	Agency spend reduced in month but the agency spend target and NHSI ceiling target were both exceeded. Medical agency increased from last month by £14k and nursing agency spend decreased from last month by £192k. CCICP experienced the most significant increase in agency spend (£30k on the previous month). Agency spend reduced in MEC by £145k and in SC by £52k		↓	N/A
NHSI Ceiling	less than 100%	189.6%	Trust Agency Spend as a percentage of the Ceiling Set by NHS Improvement			↓	N/A
Over Cap Rates	N/A	62%	Number of Agency shifts filled by agency staff that are over the nationally determined capped rates			↑↓=	N/A

Key

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