Mid Cheshire Hospitals NHS Foundation Trust

AGENDA

Board of Directors
A meeting will be held in Public at
09.30am on Monday, 3 June 2019
in the Autumn Suite, Hunter's Lodge, Crewe

Action Key	
A	Approval
I	Information
D	Discussion

Item No	Title of Item	Action	Led By	Page No.
1.	**Welcome and Apologies** To welcome members of the public and attendees and to receive apologies for absence from Board Members. *(to note)*	I	Chairman **09.30**	-
2.	**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 **09.32**	-
3.	**Minutes of the Last Meeting** To **approve** the minutes of the Board of Directors meetings held: 3.1 in Public on Tuesday 7 May 2019 3.2 in Private on Monday 20 May 2019 (Extra Ordinary)	A	Chairman **09.35**	 **4** **19**
4.	**Matters Arising** *(verbal) (to approve)*	I	Chairman **09.38**	-
5.	**Action Log** *(attached) (to approve)*	A	Chairman **09.40**	**21**
6.	**Annual Work Programme 2019/20** *(attached)* *(to approve)*	I/A	Chairman **09.42**	**22**
7.	**Chairman's Announcements** (*to note a verbal report*) **No items**	I	Chairman **09.45**	-
8.	**Governor's Items** (*to note a verbal report*) **No items**	I	Chairman **09.45**	-
9.	**Chief Executive's Report** *(to note a verbal report)* **9.1 System Update** **9.2 Joint Executive Meeting with ECT** **9.3 Executive Away Day**	I	Interim Chief Executive **09.45**	-

Item No		Title of Item	Action	Led By	Page No.
10.	**CARING**				
	10.1	**Quality, Safety & Experience Report** *(attached) (for discussion)*	I/D	Director of Nursing & Quality **09.55**	**23**
11.	**SAFE**				
	11.1	**Draft Quality Governance Committee notes from the meeting held on 14 May 2019** *(attached) (to note)*	I	Committee Chair **10.05**	**65**
	11.2	**Serious Untoward Incidents and RIDDOR Events** *(verbal)* (*to note*)	I/D	Interim Medical Director **10.10**	**-**
	11.3	**Guardian of Safe Working Hours Report Q4 2018/19** *(attached) (to note)*	I/D	Director of Workforce and OD **10.15**	**82**
12.	**RESPONSIVE**				
	12.1	**Performance Report** *(attached) (to note)*	I/D	Chief Operating Officer **10.20**	**86**
	12.2	**Draft Performance & Finance Committee notes from the meeting held on 23 May 2019** *(to follow) (to note)*	I	Committee Chair **10.35**	**-**
	12.3	**Legal Advice** *(verbal)* (*to note*)	I	Interim Chief Executive **10.40**	**-**
	12.4	**Therapies Seven Day Services Business Case** *(attached) (to approve)*	A/D	Chief Operating Officer **10.45**	**112**
13.	**WELL-LED**				
	13.1	**Visits of Accreditation, Inspection or Investigation** *(verbal)* (*to note*)	I	Interim Chief Executive **11.05**	**-**
	13.2	**Draft Audit Committee notes from the meeting held on 7 May 2019** *(attached) (to note)*	I/D	Committee Chair **11.10**	**169**
	13.3	**Draft Audit Committee notes from the Extra Ordinary meeting held on 20 May 2019** *(attached) (to note)*	I/D	Committee Chair **11.15**	**187**
	13.4	**Learning from Deaths Report Q4 2018-19** *(attached) (to note)*	I/D	Interim Medical Director **11.20**	**199**

Item No	Title of Item	Action	Led By	Page No.
13.5	**Board Assurance Framework Q4 2018-19** *(attached) (to note)*	I/D	Director of Nursing **11.25**	**216**
13.6	**Quarterly Organisational Risk Register Q4 2018-19** *(attached) (to note)*	I/D	Director of Nursing **11.30**	**236**
14.	**EFFECTIVE**			
14.1	**Workforce Report** *(attached) (to note)*	I/D	Director of Workforce and OD **11.35**	**252**
14.2	**Transformation and People Committee notes from the meeting held on 9 May 2019** *(attached) (to note)*	I	Committee Chair **11.45**	**255**
14.3	**Consultant Appointments** *(verbal) (to note)*	I	Committee Chair **11.50**	**-**
15.	**Patient or Staff Story** *(verbal)*	I/D	Director of Nursing & Quality **11.55**	**-**
15.	**Any Other Business** *(verbal)*	A/I/D	Chairman **12.15**	**-**
16.	**Time, Date and Place of Next Meeting** To confirm that the next meeting of the Board of Directors will take place in public, in the Boardroom, Leighton Hospital at 9.30am on **Monday, 1 July 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
19/03/10/1/10	04-Mar-19	Outcome of the complaints investigation in Urology to be reported to QGC	J Tunney	08-Apr-19	RCA complete - to be reported to QGC in June	07-May-19	Closed
19/05/10.1.3	07/05/2019	List of Wards and their usage to be circulated to NEDs	K Dowson	03-Jun-19	Circulated 10 May	03-Jun-19	
19/05/10.1.10(1)	07/05/2019	To review complaints for any that indicate a lack of compassion	J Tunney	03-Jun-19		03-Jun-19	
19/05/10.1.10(2)	07/05/2019	To feedback to Governors on action 19/05/10.1.10	D Dunn	25-Jul-19		05-Aug-19	
19/05/13.4.3	07/05/2019	Self-certifications on the Provider Licence to be signed and G6 declaration to be published on the Trust website.	K Dowson	03-Jun-19	Completed 10 May	03-Jun-19	

Board of Directors Workplan 2019/20

Version: 3

Item	Board of Directors Meeting												Board Away Day				
	April	*May*	*June*	*July*	*August*	*Sept*	*Oct*	*Nov*	*Dec*	*Jan*	*Feb*	*March*	*Apr*	*Jun*	*Oct*	*Dec*	*Feb*
Patient/Staff Story	x	x	x	x	x	x	x	x	x	x	x	x					
Minutes of the Last Meeting	x	x	x	x	x	x	x	x	x	x	x	x					
Board Actions	x	x	x	x	x	x	x	x	x	x	x	x					
Annual Work Programme	x	x	x	x	x	x	x	x	x	x	x	x					
Chairman's Report	x	x	x	x	x	x	x	x	x	x	x	x					
Governor Items	x	x	x	x	x	x	x	x	x	x	x	x					
Chief Executive's Report	x	x	x	x	x	x	x	x	x	x	x	x					
Caring																	
Nursing and midwifery staffing comprehensive report							x										
Patient Survey Results (National)			x														
Patient Quality Safety and Experience Report	x	x	x	x	x		x	x	x	x	x	x					
Staff Survey		x															
Safe																	
Health & Safety Update to Board														x			
SUI & RIDDOR	x	x	x	x	x	x	x	x	x	x	x	x					
Quality Governance Committee	x	x	x	x	x	x	x	x	x	x	x	x					
Guardian of Safe Working Hours Report	~~x~~→		x	~~x~~→	x		~~x~~→	x		~~x~~→	x						
Responsive																	
Annual Budget/Planning/ Budget Pack	x											x					x
Quality Account		x															
Legal Advice	x	x	x	x	x	x	x	x	x	x	x	x					
Performance & Finance Committee	x	x	x	x	x	x	x	x	x	x	x	x					
Performance Report	x	x	x	x	x	x	x	x	x	x	x	x					
Report on Use of Trust Seal		x			x			x			x						
Corporate Trustee													x		x		
Freedom to Speak up Guardian		x			x			x			x						
Well-Led																	
Annual Budget/Contract Discussions	x											x					
Annual Plan	x	x										x					
Annual Report & Accounts (Extra Ordinary Board)		x															
Audit Committee		x	x				x		x		x						
Board Assurance Framework	x		x	←		x			x			x					
Quarterly Organisational Risk Register	x		x	←			x			x							
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																	
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

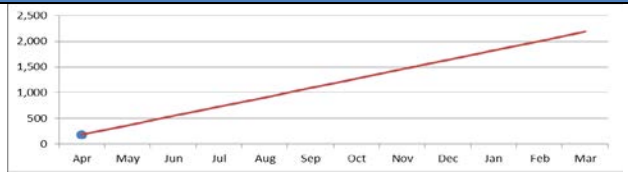
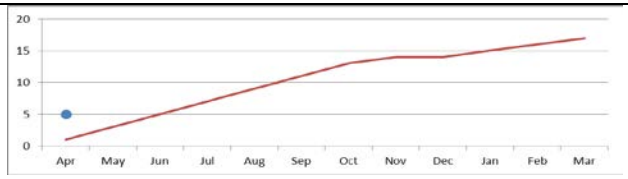
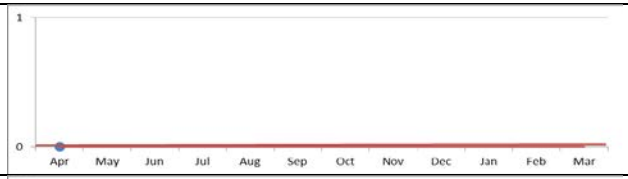
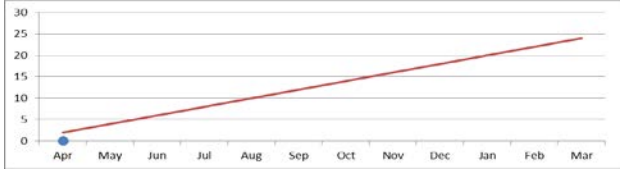
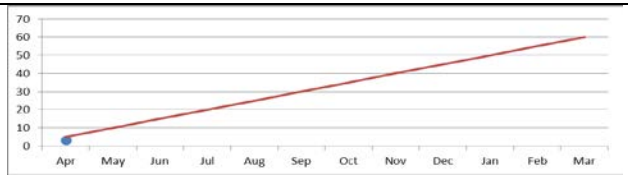
Quality, Safety and Experience Report

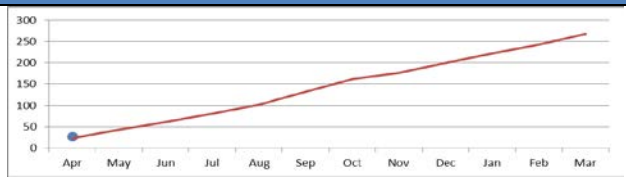
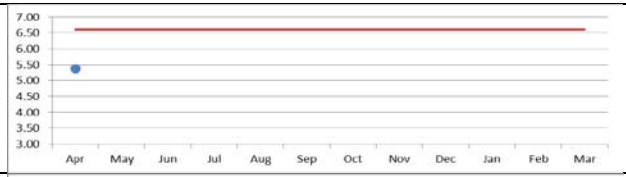
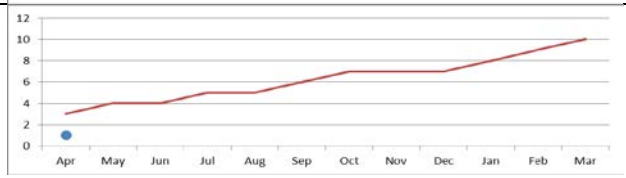
June 2019

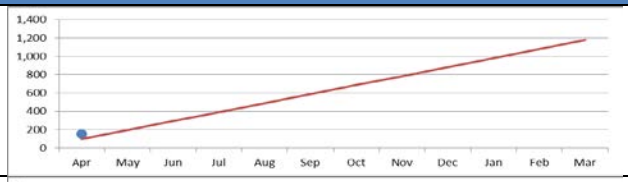
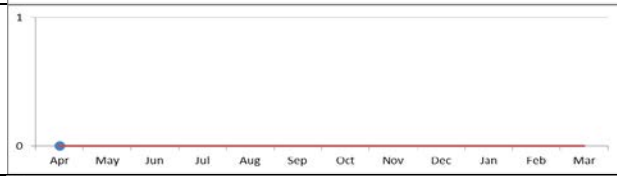
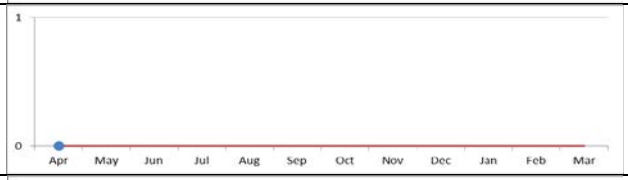
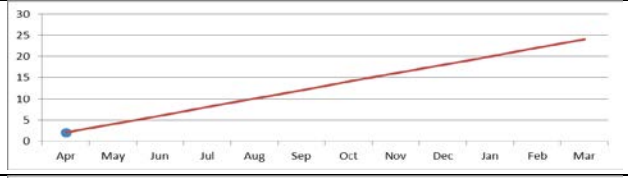
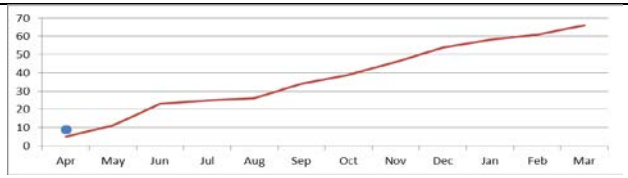
(April 2019 data)

Contents

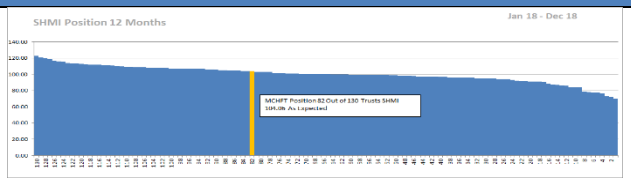
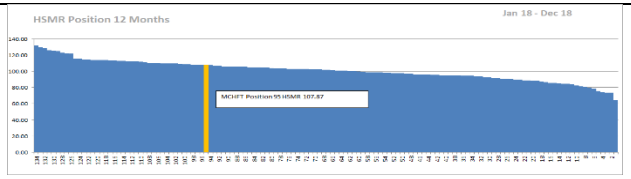
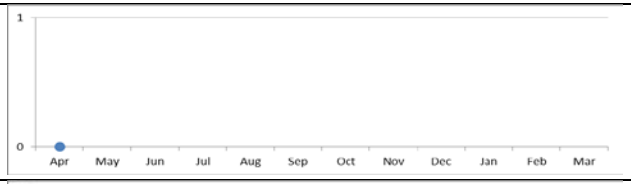
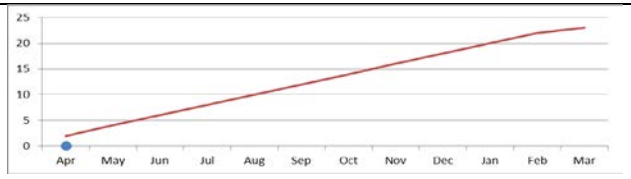
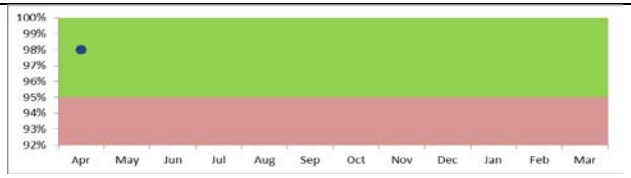
Contents (continued):

Indicators	Target	Trajectory 2019/20
Acute Trust		
Patient Safety Harm Incidents The target is to reduce the total number of patient safety harm incidents when compared to the previous financial year by the end of March 2020.	**Less than 2294 at end of March 2020**	
Serious Incidents The target is to reduce patient safety serious incidents when compared to the previous financial year by the end of March 2020.	**Less than 18 at end of March 2020**	
Never Events Zero tolerance of Never Events.	**Zero**	
Pressure Ulcers – Hospital Acquired The target is to have no more than two lapses in care (avoidable) pressure ulcers per month.	**Less than 24 lapses in care at end of March 2020**	
Medication Harm Incidents The target is to reduce the total number of medication incidents resulting in harm when compared to the previous financial year by the end of March 2020.	**Less than 66 at end of March 2020**	

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

Indicators	Target	Trajectory 2018/19
CCICP		
CCICP Patient Safety Harm Incidents The target is to reduce the total number of CCICP patient safety harm incidents when compared to the previous financial year by the end of March 2020.	**Less than 1238 at end of March 2020**	
CCICP Serious Incidents The target is to continue the trend of having zero CCICP patient safety serious incidents by the end of March 2020.	**Zero**	
CCICP Never Events Zero tolerance of CCICP Never Events.	**Zero**	
CCICP Pressure Ulcers – Community Acquired The target is to have no more than two lapses in care (avoidable) pressure ulcers per month.	**Less than 24 lapses in care at end of March 2020**	
CCICP Medication Incidents The target is to reduce the total number of medication incidents with harm when compared to the previous financial year by the end of March 2020.	**Less than 67 at end of March 2020**	

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

Indicators	Target	Trajectory 2018/19
SHMI The Trust's target is to be at least within the "as expected" bracket. This has been achieved for the latest reporting period.	**As expected**	
HSMR The Trust's target is to be at least within the "as expected" bracket. This has been achieved for the latest reporting period.	**As expected**	
MRSA Zero tolerance of MRSA cases.	**Zero**	
C-Diff The target is less than 27 cases of Clostridium Difficile in 2019/20. The target includes cases who have been identified in the community but had a hospital admission in the previous 28 days.	**Less than 27 at end of March 2020**	
Safety Thermometer The Trust target is that >95% of patients receive harm free care as monitored by the Safety Thermometer.	**>95%**	

Quality & Safety Section:

Description	Aggregate Position	Trend

Patient Safety Harm Incidents

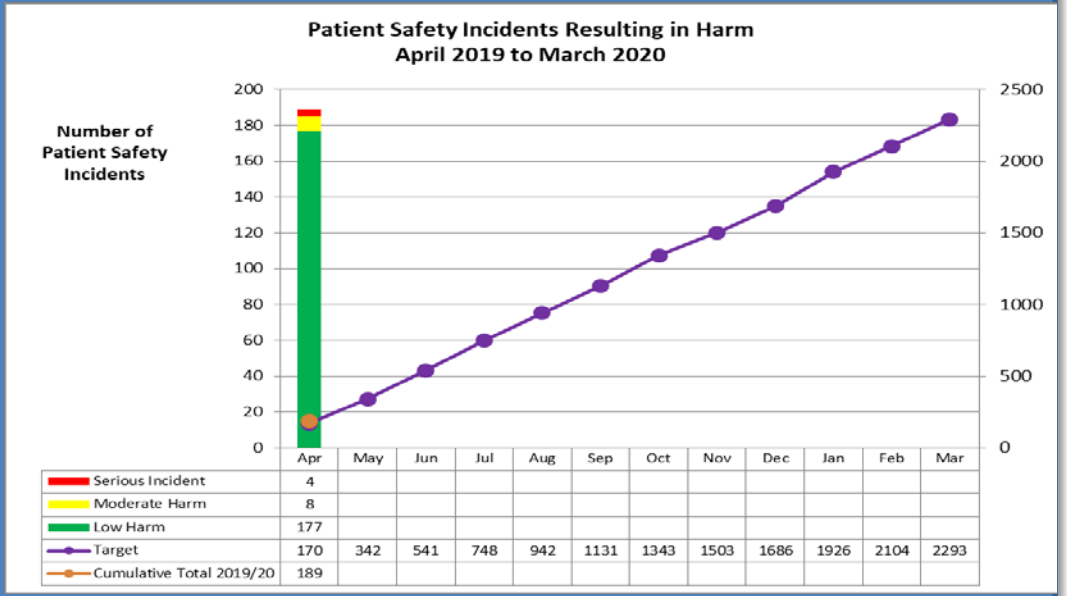
The target is to reduce the total number of patient safety harm incidents when compared to the previous financial year by the end of March 2020.

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

For April 2019, there were a total of 189 patient safety harm incidents:
93.7% (177 incidents) have resulted in low harm
4.2% (8 incidents) have resulted in moderate harm
2.1% (4 incidents) resulted in serious harm

Improvement actions include;

- Review of the 48 hour rapid response to ensure immediate learning takes place following the reporting of a suspected serious incident
- Development of a quarterly Learning from Deaths newsletter which highlights the learning from the Structured Judgement Reviews
- Deep dive into inpatient falls which resulted in fractured neck of femur and development of a joint improvement plan for DMEC and DCSS



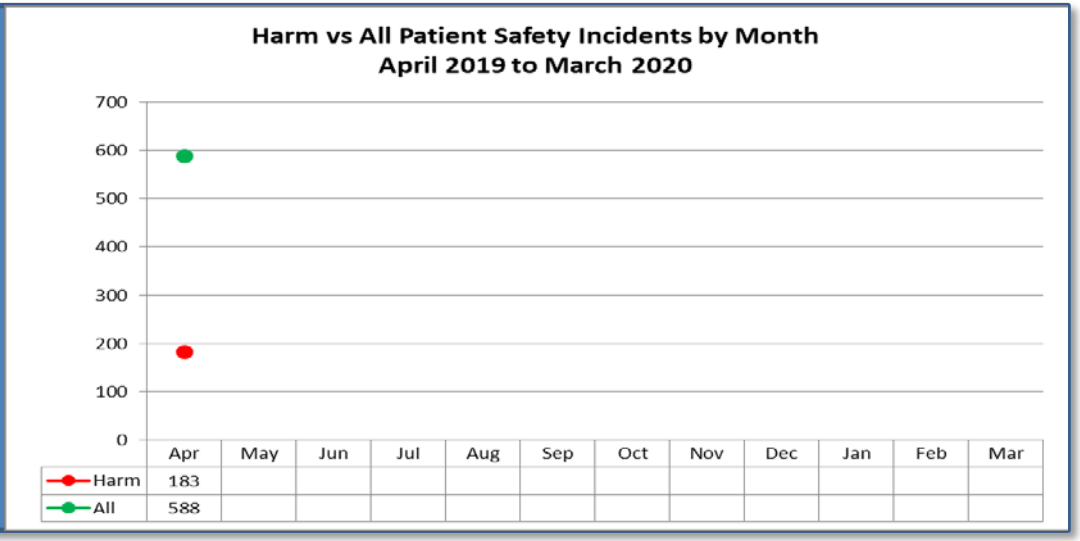
Harm vs All Patient Safety Incidents

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

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

In April 2019, the gap between harm and all patient safety incidents was 405. The aim over the twelve month period is to see this gap widening.

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



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

Description	Aggregate Position	Trend

Serious Incidents

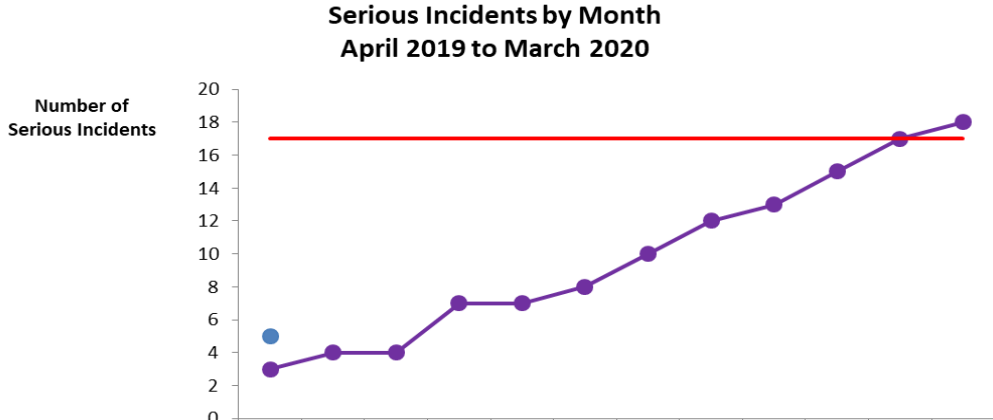
The target is to reduce patient safety serious incidents when compared to the previous financial year by the end of March 2020.

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

For April 2019, there were five serious incidents reported.

- Possible IT failure on Medical Imaging
- Patient fall resulting in fractured neck of femur on Ward 4
- Potential delay in escalation of a sick patient
- Failure in referral, missed diagnosis
- Delay in administering NIV treatment

In April a 6th serious incident was reported. This was a patient fall resulting in a fractured C1. Following review this incident was downgraded.



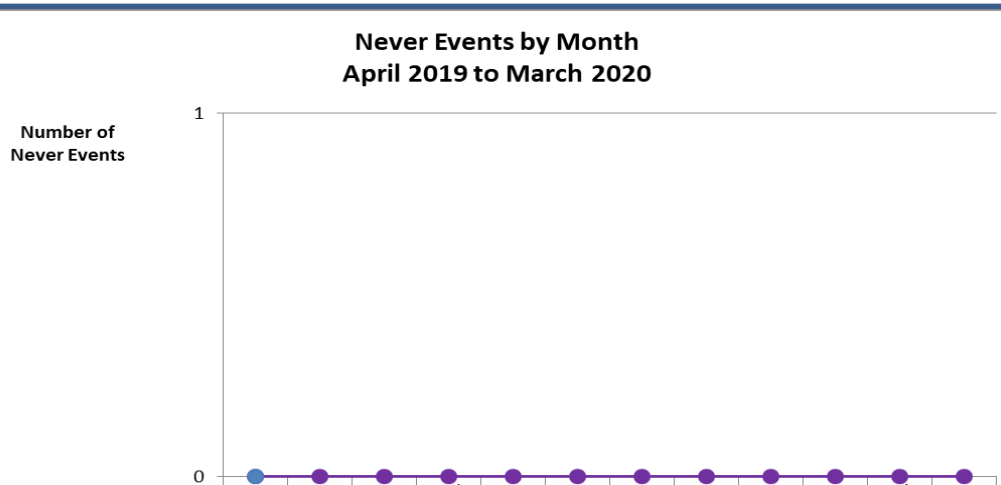
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative 2019/20	5											
Cumulative 2018/19	3	4	4	7	7	8	10	12	13	15	17	18
Target	17	17	17	17	17	17	17	17	17	17	17	17

Never Events

The target is to have zero Never Events

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

For April 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											

Description	Aggregate Position	Trend

Pressure Ulcers (PU) – Hospital Acquired

The target is to have no more than 24 pressure ulcers resulting from lapses in care by the end of March 2020.

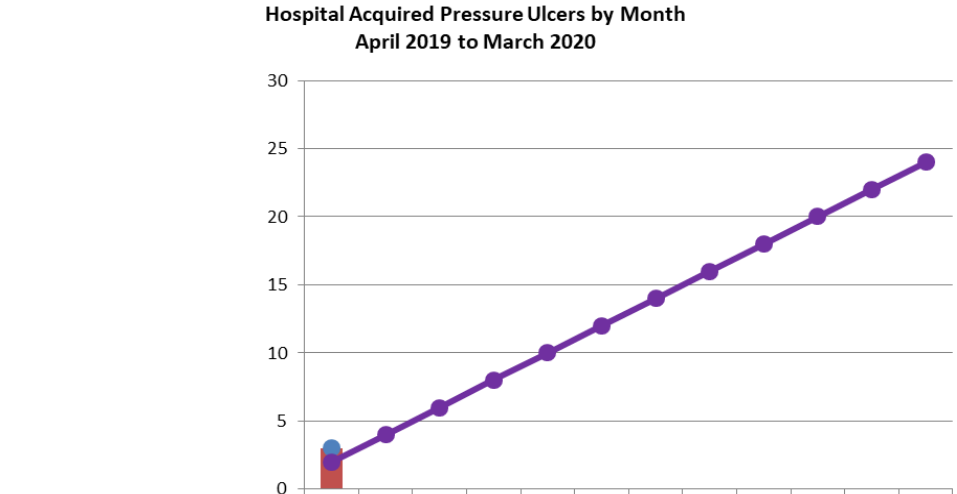
For April 2019, there were a total of 18 hospital acquired pressure ulcer incidents:

- 16.7% (3 PU's) have resulted in lapses in care.
- 44.4% (8 PU's) have been classed as no lapses in care
- 38.9% (7 PU's) are currently undergoing investigation prior to confirmation as to whether the PU was avoidable or unavoidable.

Improvement actions include;

The following guides have been ratified and shared with staff to support pressure ulcer prevention:

- An "React to red" aid memoir has been produced and shared with staff
- "aSSKINg" - The old SSKIN acronym within the SSKIN bundle has been update to include assessment and giving information. This has been shared as part of the Skin Care Group
- "Summer is coming" - An advice leaflet to prevent Moisture associated skin damage has been produced



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Lapses in Care Identified	3											
Cumulative Lapses in Care	3											
Lapses in Care Cumulative Target	2	4	6	8	10	12	14	16	18	20	22	24
% Lapses in Care PU	16.7%											

Medication Harm Incidents

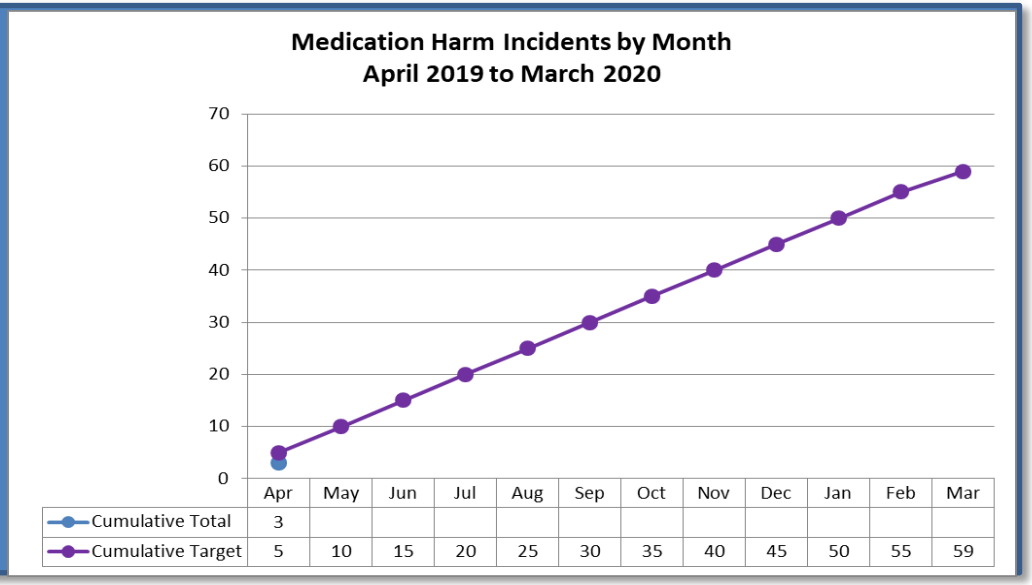
The target is to reduce the total number of medication incidents resulting in harm when compared to the previous financial year by the end of March 2020.

For April 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

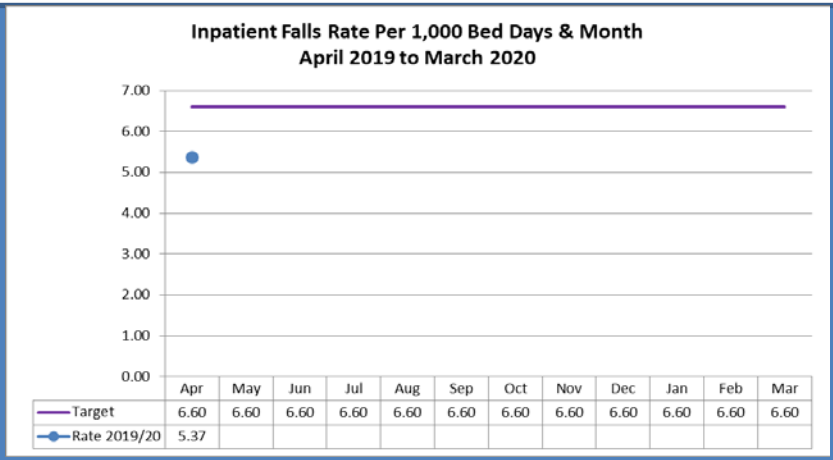


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative Total	3											
Cumulative Target	5	10	15	20	25	30	35	40	45	50	55	59

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

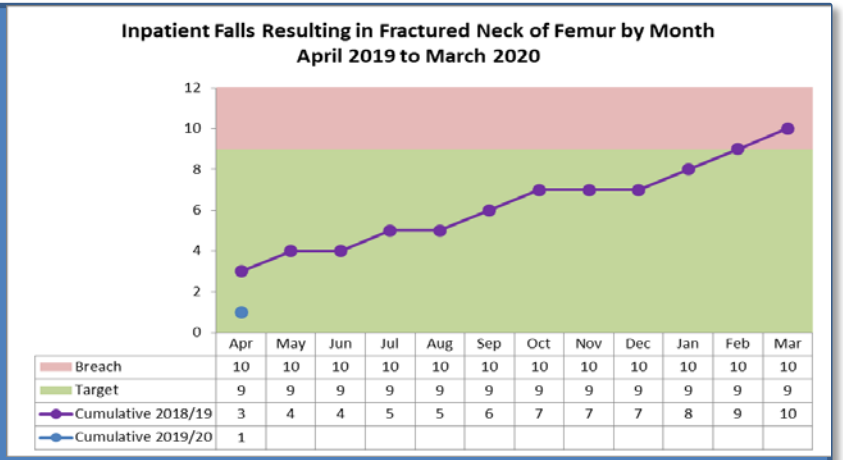
Inpatient Falls.

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



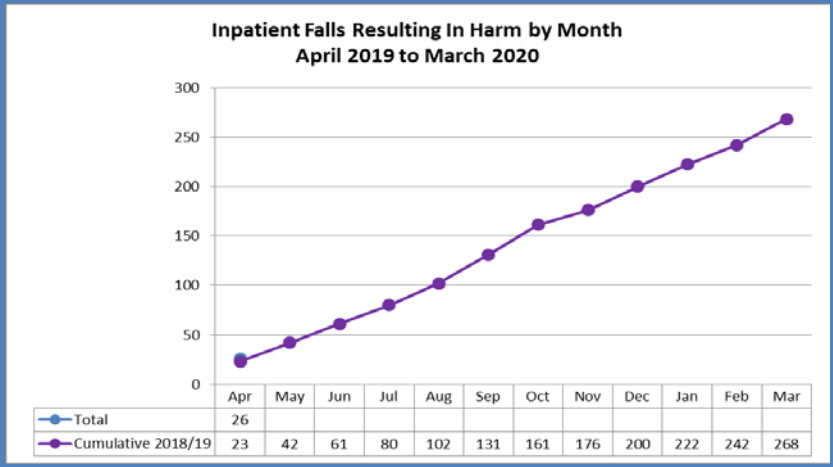
For April 2019, the falls rate per 1,000 bed days was 5.37.

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



In April 2019, there was a total of one fractured neck of femur on Ward 4.

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



In April 2019, there were a total of 26 falls with harm.

- 84.6% (22) resulting in low harm
- 11.5% (3) resulting in moderate harm
- 3.9% (1) resulting in major harm

Improvement actions include:

- Multidisciplinary Falls meeting has been launched to plan role out of Three High Impact Interventions
- National Guidance for lying and standing blood pressure recording shared Trust wide and to be added to all Dynamaps across in patient wards
- Data collection tool in development based on CQUIN targets for 2019-20

Central Cheshire Integrated Care Partnership (CCICP)

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

CCICP Patient Safety Harm Incidents

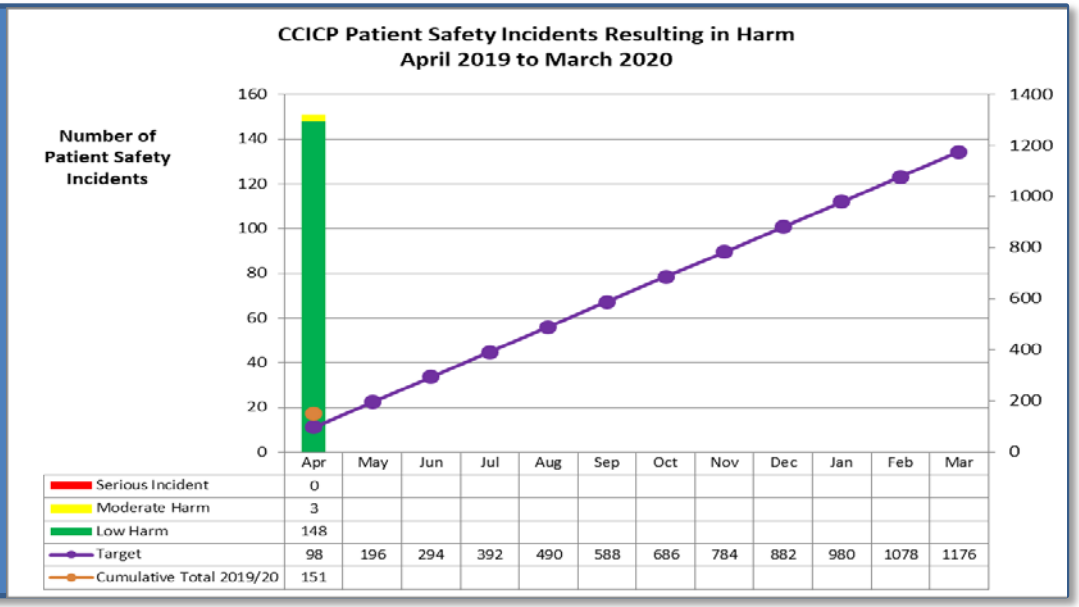
The target is to reduce the total number of CCICP patient safety harm incidents when compared to the previous financial year by the end of March 2020.

For April 2019, there were a total of 151 patient safety harm incidents:

- 98% (148 incidents) have resulted in low harm
- 2% (3 incidents) have resulted in moderate harm
- 0% (0 incidents) have resulted in serious harm

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

- Review of the 48 hour rapid response to ensure immediate learning takes place following the reporting of a suspected serious incident
- Development of a quarterly Learning from Deaths newsletter which highlights the learning from the Structured Judgement Reviews



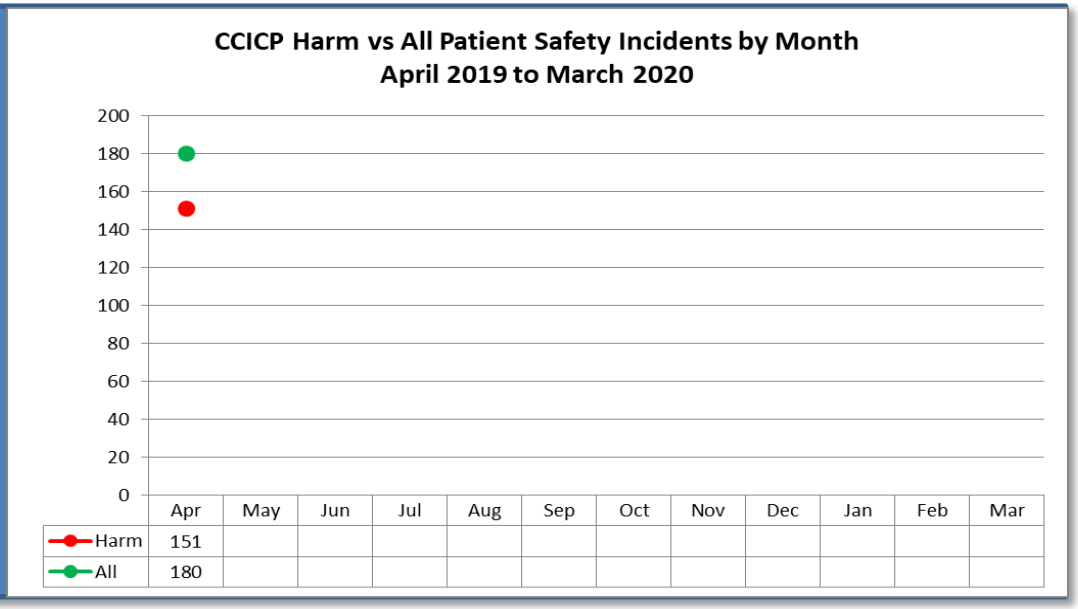
CCICP Harm vs All Patient Safety Incidents

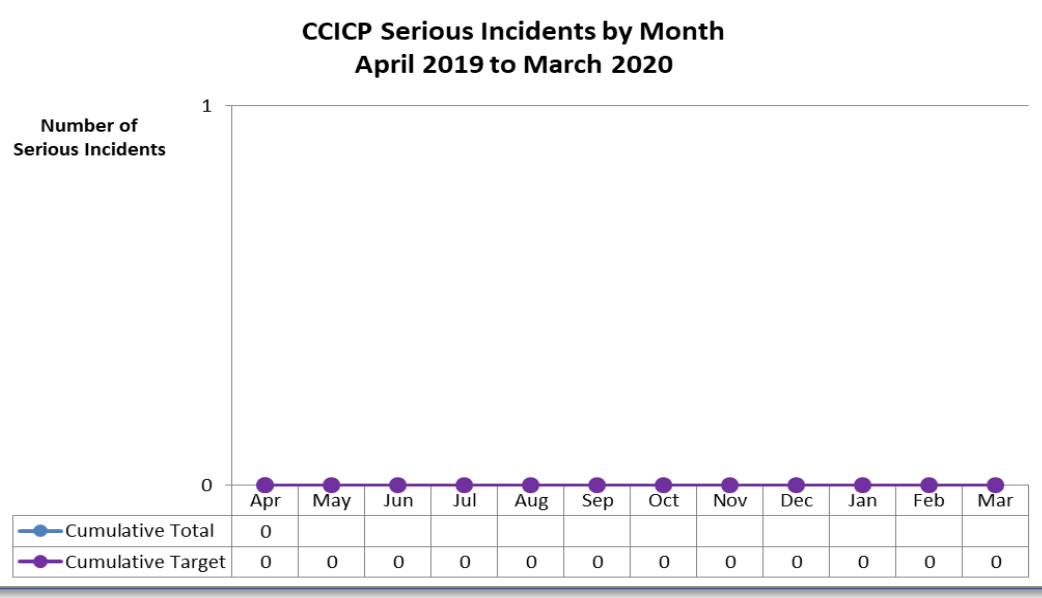
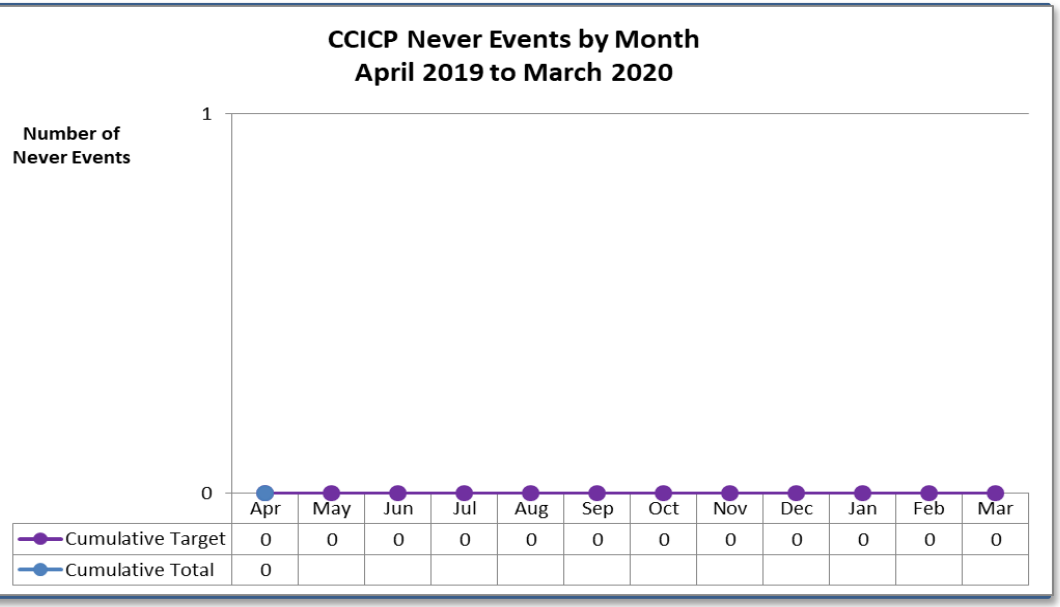
The aim is to increase no harm reporting and eventually widen the gap between harm and all incidents.

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

In April 2019, the gap between harm and all patient safety incidents was 29.

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



Description	Aggregate Position	Trend
CCICP Serious Incidents *The target is to continue the trend of having zero CCICP patient safety serious by the end of March 2020.*	This chart demonstrates the number of incidents that have resulted in serious harm. For April 2019, there were no serious incidents reported.	
CCICP Never Events *The target is to have zero Never Events*	This chart demonstrates the number of Never Events that have been reported. For April 2019 no Never Events were reported. No Never Events have been reported for CCICP since the merger of the Trust in October 2016.	

Description	Aggregate Position	Trend

Pressure Ulcers – Community Acquired

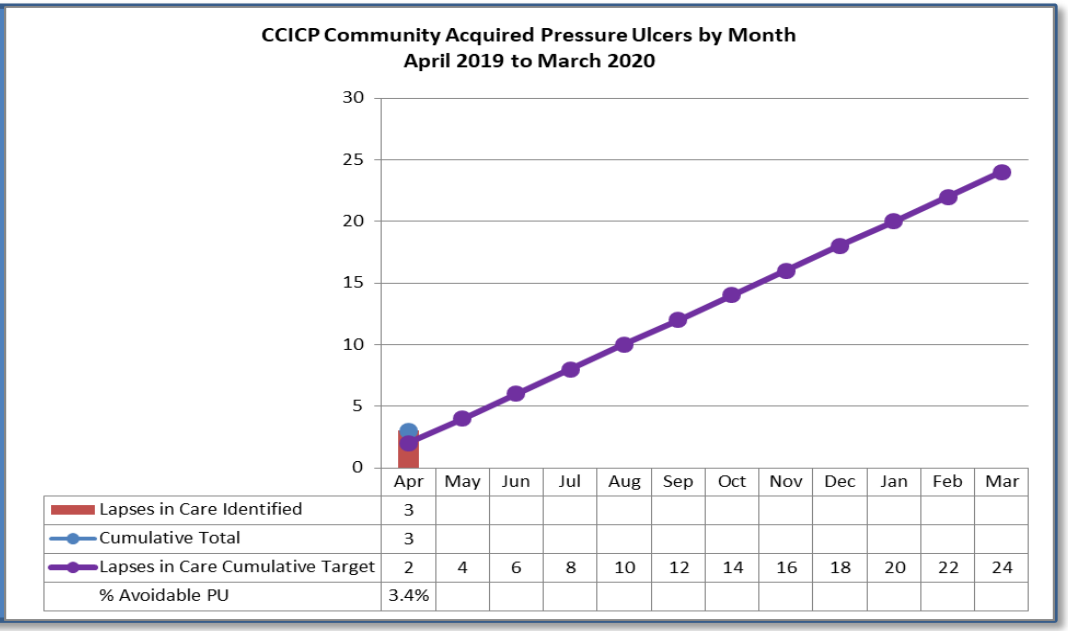
The target is to have no more than 24 pressure ulcers resulting from lapses in care by the end of March 2020.

For April 2019, there were a total of 87 community acquired pressure ulcer incidents:

- 3.4% (3 PU's) have resulted in lapses in care.
- 46% (40 PU's) have been classed as no lapses in care
- 50.6% (44 PU's) are currently undergoing investigation prior to confirmation as to whether the PU was avoidable or unavoidable.

Improvement actions include:

- 'TVN on the Move' drop in sessions at District Nurse bases as part of the quality week to support teams on pressure ulcer care.
- Launch of a Pressure Ulcer Improvement Group raising awareness on prevention across band 4's to band 7's.
- Information boards in nursing homes to educate staff and patients.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Lapses in Care Identified	3											
Cumulative Total	3											
Lapses in Care Cumulative Target	2	4	6	8	10	12	14	16	18	20	22	24
% Avoidable PU	3.4%											

CCICP Medication Incidents.

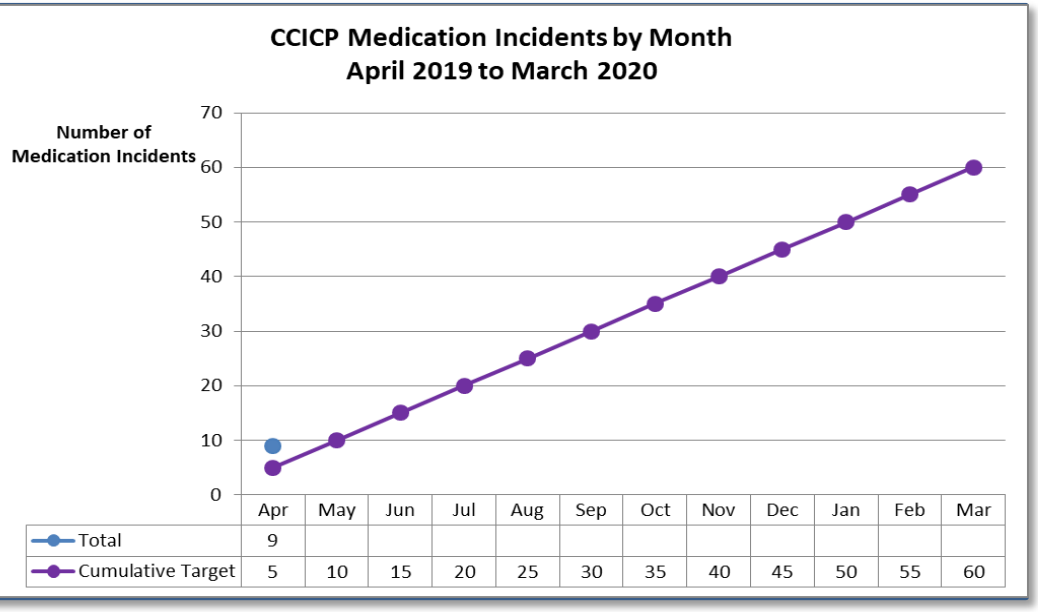
The target is to reduce the total number of medication incidents when compared to the previous financial year by the end of March 2020

For April 2019, there was a total of 9 medication incidents reported:

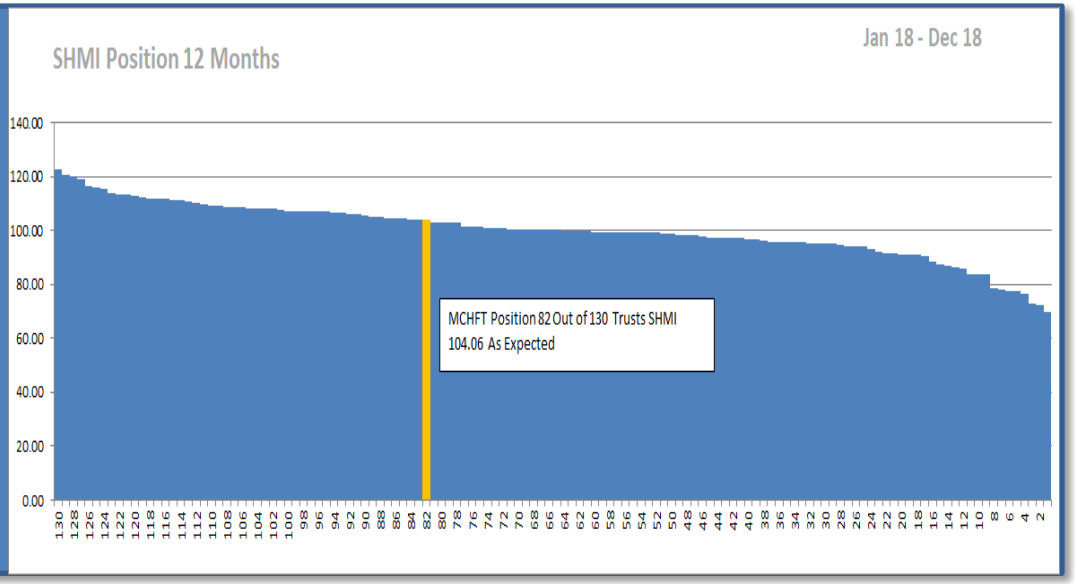
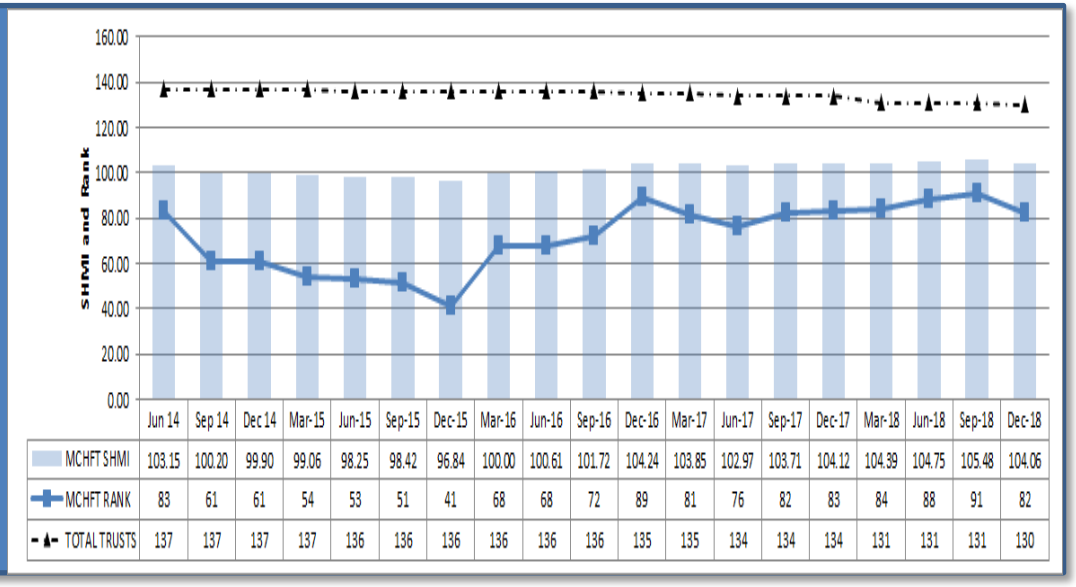
- 88.9% (8 medication incident) resulted in no harm
- 11.1% (1 medication incident) resulted in low harm
- 0% (0 medication incidents) have resulted in moderate harm
- 0% (0 medication incidents) have resulted in serious harm

Improvement actions include;

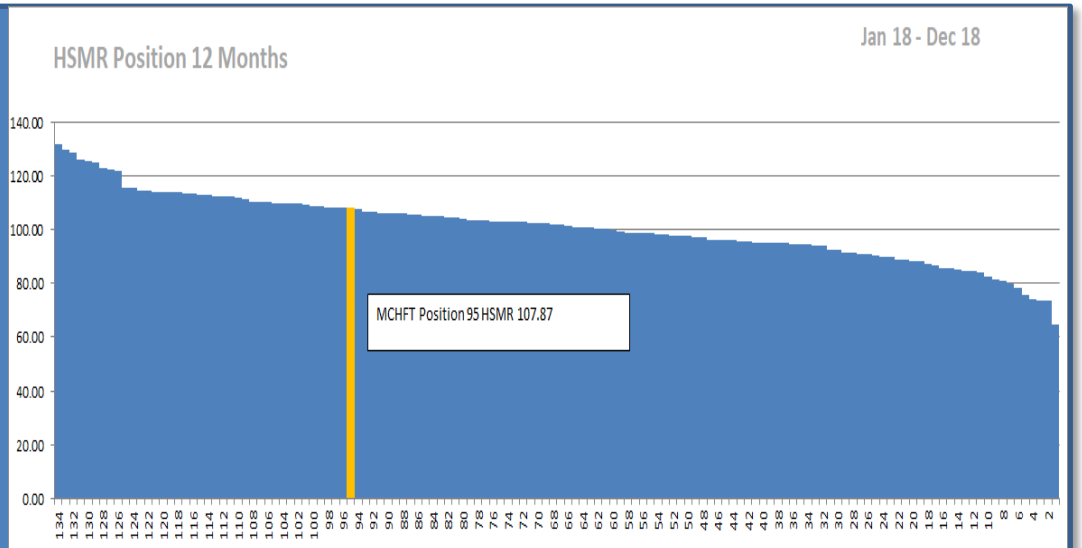
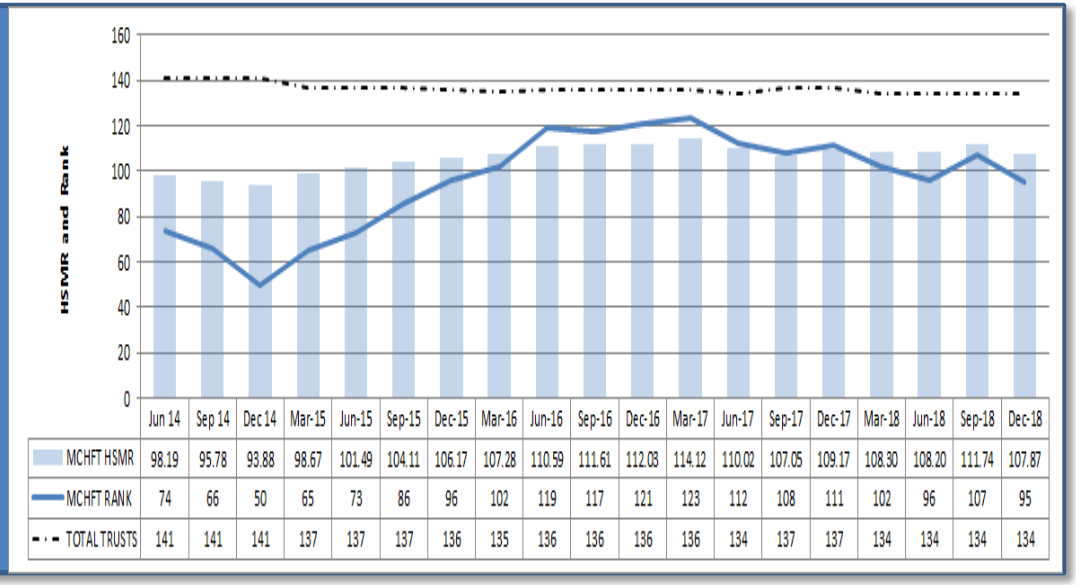
- A CCICP Medication Incident Report has been produced for review and discussion at IGG to identify themes and lessons learnt.
- Updating the administration of insulin SOP



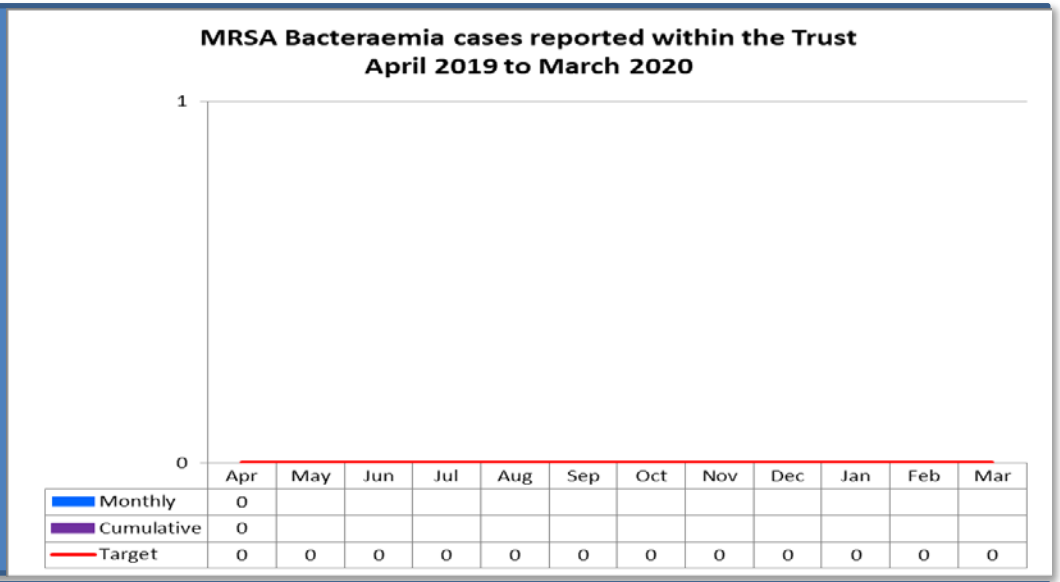
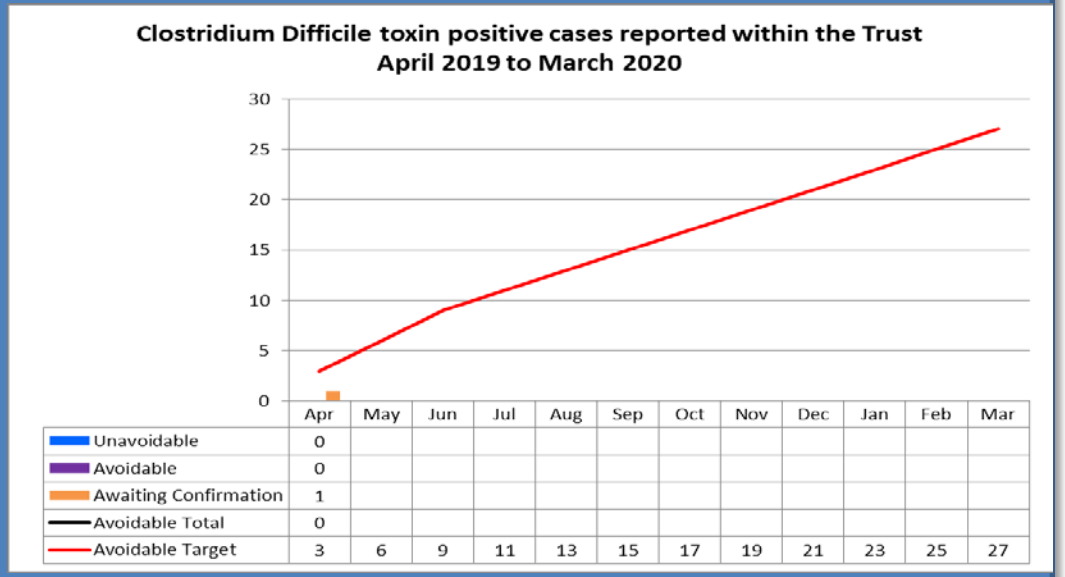
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total	9											
Cumulative Target	5	10	15	20	25	30	35	40	45	50	55	60

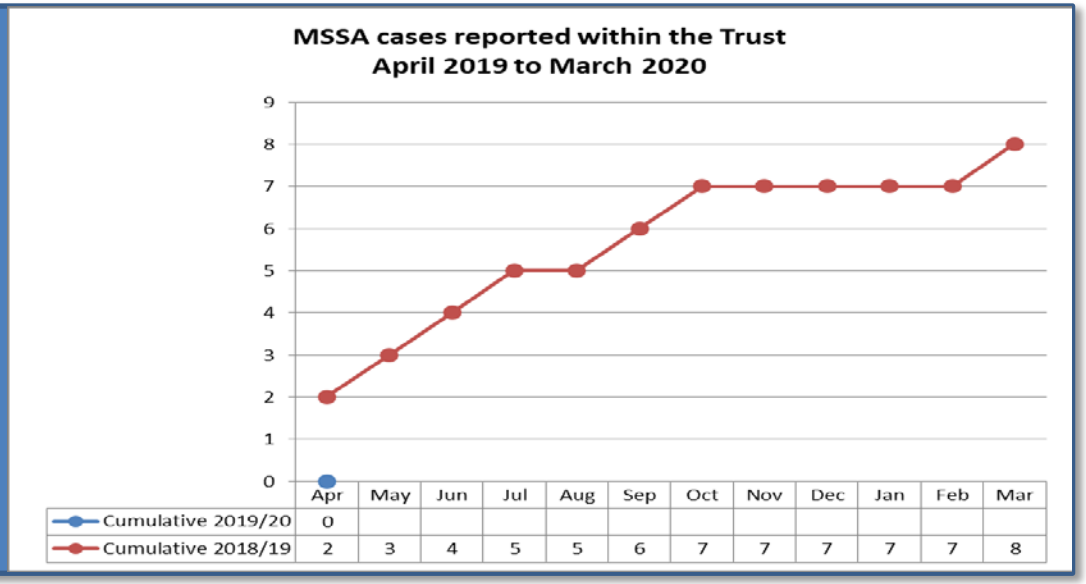
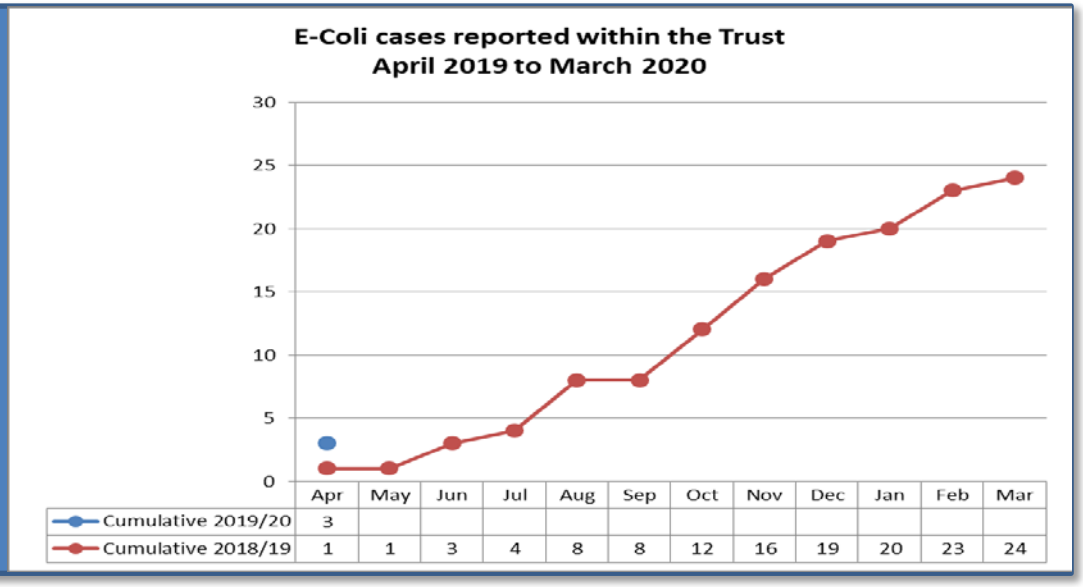
Description	Aggregate Position	Trend
SHMI *The Trust's target is to be at least within the "as expected" bracket.*	The chart benchmarks the Trust's latest SHMI against all NHS Trusts. MCHFT is shown as the yellow bar. The Trust's SHMI is 104.06 for the time period January 2018 to December 2018 and places the Trust 82 out of 130 Trusts and is "as expected".	
MCHFT *12 month rolling position Summary Hospital-Level Mortality Indicator (SHMI) by Trust.*	The chart shows the SHMI and rank of MCHFT for each of the 12 month rolling position submissions for the period January 2018 to December 2018 and is "as expected".	

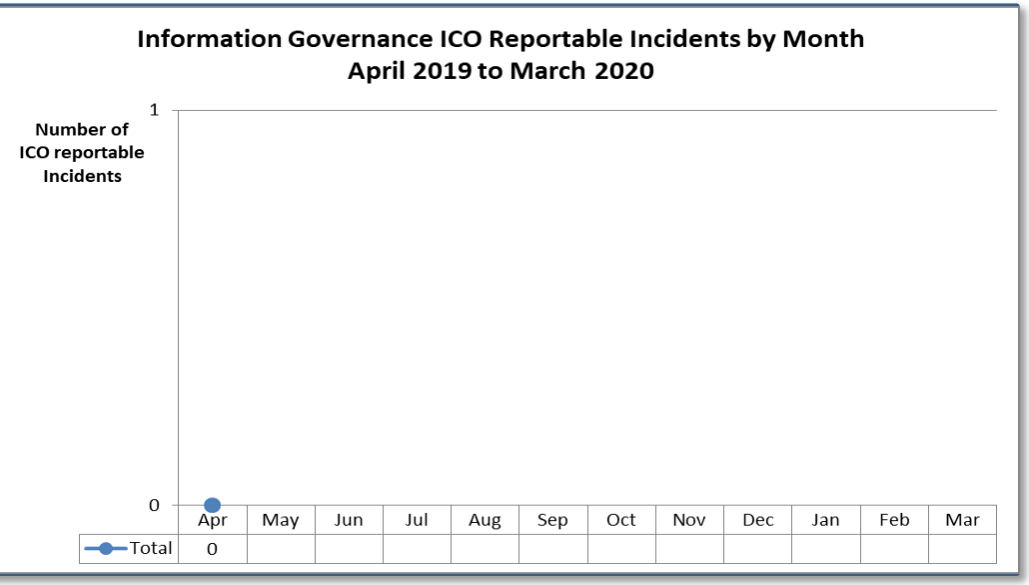
	Jun 14	Sep 14	Dec 14	Mar-15	Jun-15	Sep-15	Dec-15	Mar-16	Jun-16	Sep-16	Dec-16	Mar-17	Jun-17	Sep-17	Dec-17	Mar-18	Jun-18	Sep-18	Dec-18
MCHFT SHMI	103.15	100.20	99.90	99.06	98.25	98.42	96.84	100.00	100.61	101.72	104.24	103.85	102.97	103.71	104.12	104.39	104.75	105.48	104.06
MCHFT RANK	83	61	61	54	53	51	41	68	68	72	89	81	76	82	83	84	88	91	82
TOTAL TRUSTS	137	137	137	137	136	136	136	136	136	136	135	135	134	134	134	131	131	131	130

Description	Aggregate Position	Trend
Hospital Standardised Mortality Rate (HSMR) by Trust. *The Trust's target is to be at least within the "as expected" bracket.*	The chart benchmarks the Trust's HSMR against all NHS Trusts. MCHFT is shown by the amber bar. The Trust's HSMR is 107.87 (January 2018 to December 2018) and places the Trust 95 out of 134 Trusts and is "as expected".	
MCHFT *12 month rolling position for HSMR*	The data in the chart shows the HSMR and rank of MCHFT for each of the 12 month rolling position submissions for the period January 2018 to December 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	Sep-18	Dec-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	108.30	108.20	111.74	107.87
MCHFT RANK	74	66	50	65	73	86	96	102	119	117	121	123	112	108	111	102	96	107	95
TOTAL TRUSTS	141	141	141	137	137	137	136	135	136	136	136	136	134	137	137	134	134	134	134

Description	Aggregate Position	Trend
MRSA Bacteraemia Cases. *Zero tolerance of MRSA cases.*	In April 2019, no MRSA bacteraemia cases were reported in the Trust. In this financial year there have been no confirmed MRSA bacteraemia cases to date.	
Clostridium Difficile toxin positive cases. *The target is less than 27 cases of Clostridium Difficile in 2018/19*	In April 2019, no cases were reported. The target is less than 27 cases of Clostridium Difficile in 2019/20. The target includes cases who have been identified in the community but had a hospital admission in the previous 28 days. Improvement actions include: • Continuing focus on inappropriate anti-microbial prescribing • Working with the Community Public Health Infection Control and requesting information from the GP's to look at all elements of care including acute and community antibiotic prescribing • All cases are subject to post infection reviews in accordance with NHS England requirements. Any lapses in care are addressed through this process • Share lapses in care with individual clinicians involved in patient pathway to ensure 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 April 2019, zero MSSA case was reported in the Trust. In this financial year there has been zero confirmed MSSA cases reported.	
E-Coli Cases. *The aim is to have a reduction in E-Coli cases when compared to the previous financial year, to demonstrate an incremental improvement*	In April 2019, three E-Coli cases were reported. These occurred on Ward 13 (x2) and Ward 1. In this financial year there have been three confirmed E-Coli cases reported.	

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

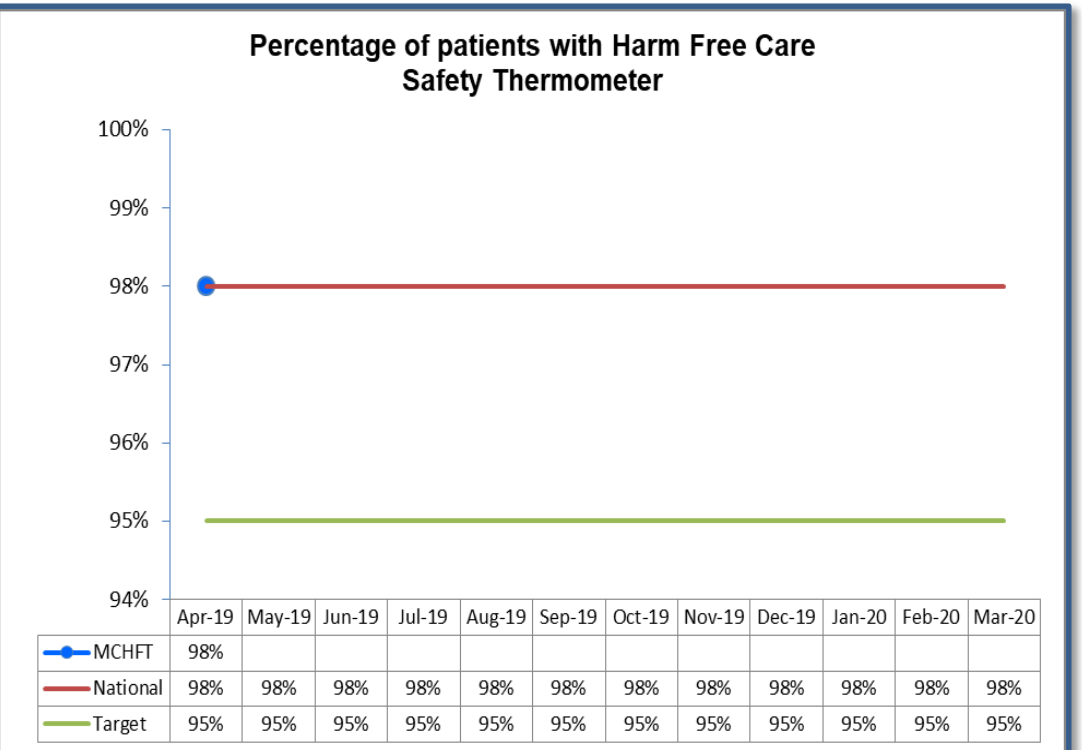
CQUIN Indicator	Indicator Name	Milestone Achieved									
		Q1	Financial Incentive Achieved	Q2	Financial Incentive Achieved	Q3	Financial Incentive Achieved	Q4	Financial Incentive Achieved	Maximum Value	Comments
1a	**Health & Wellbeing** 5% point improvement in two of the three questions on H&W, MSK & Stress		No payment		No payment		No payment		£137,574	**£137,574**	
1b	**Health & Wellbeing** Maintain the four changes for improving healthy food for NHS staff, visitors and patients. Introduce three new changes to food and drink provision.		No payment		No payment		No payment		£137,574	**£137,574**	
1c	**Health & Wellbeing** Achieve an uptake of flu vaccinations of front line clinical staff of 75% by end of February 2019.		No payment		No payment		No payment		£137,574 £137,180	**£137,574** **CCICP £137,180**	
2a	**Sepsis: Identification** The percentage of patients who met the criteria for sepsis screening and were screened for sepsis.	 **Partially**	£25,795 (£10,318 partial payment)	 **Partially**	£25,795 (£10,318 partial payment)	 **Partially**	£25,795 (£10,318 partial payment)	 **Partially**	£25,795 (£10,318 partial payment)	**£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)	 **Partially**	£25,795 (£10,318 partial payment)	 **Partially**	£25,795 (£10,318 partial payment)	**£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**	**Continuation of antimicrobial stewardship and promotion of IV switch to oral**
2d Part 1	**Reduction in antibiotic consumption** Achieve a reduction of x% or more in total antibiotic consumption per 1,000 admissions.		No payment		No payment		No payment		£34,393	**£34,393**	

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

CQUIN Indicator	Indicator Name	Milestone Achieved									
		Q1	Financial Incentive Achieved	Q2	Financial Incentive Achieved	Q3	Financial Incentive Achieved	Q4	Financial Incentive Achieved	Maximum Value	Comments
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 PAYMENTS	No payment	NOT YET AVAILABLE	£34,393	**£34,393**	
2d Part 3	**Reduction in piperacillin tazabactam consumption** Achieve a reduction of x% or more in total piperacillin tazabactam consumption per 1,000 admissions.	✓	No payment	NO PAYMENTS	No payment	NO PAYMENTS	No payment	NOT YET AVAILABLE	£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	NO PAYMENTS	No payment	✓	£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**	**A continued CQUIN in 19/20 with revised milestones. Meetings with divisional reps and leads relaunched to ensure focus. Audit C tool updated and relaunched as part of "love your liver week". Training sessions being delivered in**
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**	

CQUIN Indicator	Indicator Name	Milestone Achieved									
		Q1	Financial Incentive Achieved	Q2	Financial Incentive Achieved	Q3	Financial Incentive Achieved	Q4	Financial Incentive Achieved	Maximum Value	Comments
											Assessment areas
9d	**Alcohol screening** 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**	
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	NOT REQUIRED	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	NOT REQUIRED	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**	

CQUIN Indicator	Indicator Name	Milestone Achieved									
		Q1	Financial Incentive Achieved	Q2	Financial Incentive Achieved	Q3	Financial Incentive Achieved	Q4	Financial Incentive Achieved	Maximum Value	Comments
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 April 2019, 98% of patients received harm free care as measured by the point prevalence Safety Thermometer. The Safety Thermometer data is collected during the morning of the first Wednesday of each month and is collected by the nursing staff on duty on the ward/DN caseload assisted by the Senior Nursing Teams. This is applicable to inpatient areas and district nursing caseloads only. The target is for >95% of patients to receive harm free care as monitored by the Safety Thermometer. The Patient Safety Thermometer process is currently under review nationally.	

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
MCHFT	98%											
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: June 2019

Description	Aggregate Position		Trend
Registered Nurses monthly expected hours by shift versus actual monthly hours per shift. Day time shifts only	90.5% 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 **April 2019 90.5%** March 2019 90.3% February 2019 92.7%	The lowest staffing levels during the day were on Ward 9 at 69.8%
Registered Nurses monthly expected hours by shift versus actual monthly hours per shift. Night time shifts only	92.9% of expected Registered Nurse hours were achieved for night shifts.	Trend **April 2019 92.9%** March 2019 93.2% February 2019 98.6%	The lowest staffing levels during the night were on Ward 5 at 66.7%
Healthcare Assistant monthly expected hours by shift versus actual monthly hours per shift. Day time shifts only	95.3% of expected HCA hours were achieved for day shifts.	Trend **April 2019 95.3%** March 2019 101.6% February 2019 96.2%	The lowest staffing levels during the day were on Ward 9 at 75.8%
Healthcare Assistant monthly expected hours by shift versus actual monthly hours per shift. Night time shifts only	94.1% 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 **April 2019 94.1%** March 2019 110.9% February 2019 97.4%	The lowest staffing levels during the night were on Ward 9 at 55.3%
Total number of wards that are lower than 85% RN fill days and nights is 9.	Ward 3 (AMU) (day) 83.1% and (night) 81.3%, Ward 2 (night) 83.3%, Ward 4 (day) 84.5%, Ward 5 (day) 82.6% and (night) 66.7%, Ward 6 (night) 70.8%, Ward 7 (day) 79%, Ward 9 (day) 69.8%, Ward 14 (night) 84.4% and Ward 15 (night) 75.6%,	• 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	

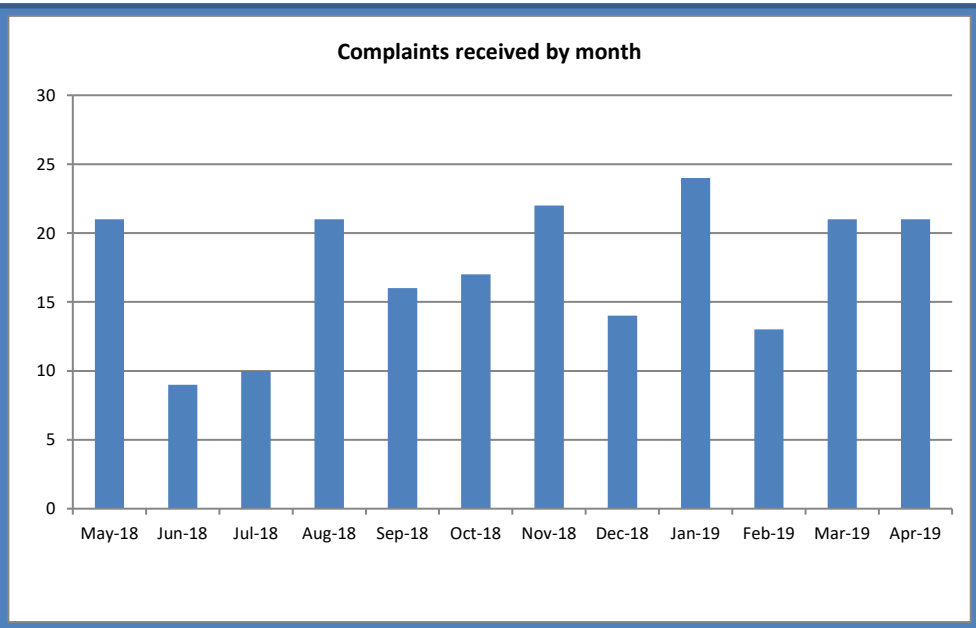
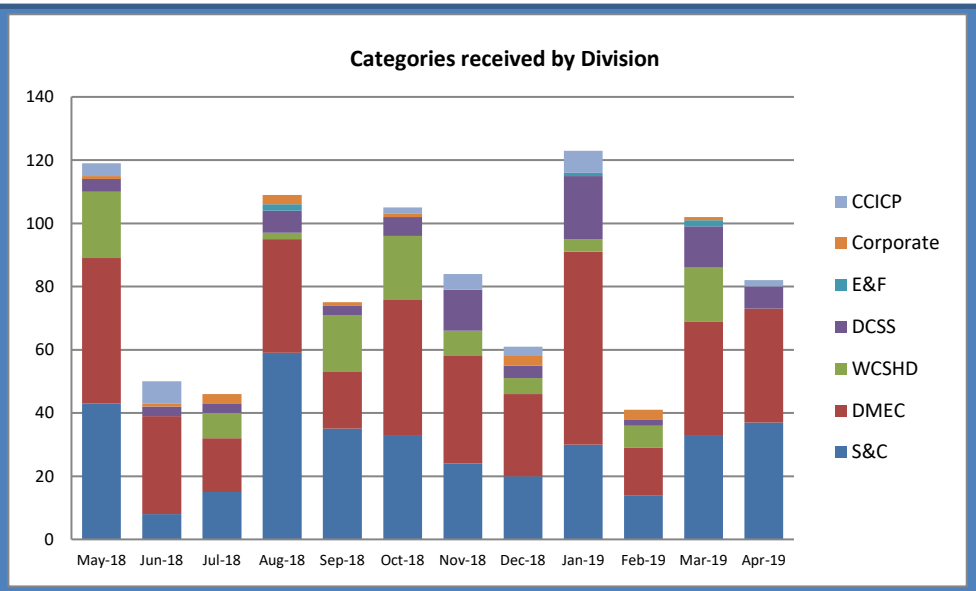
Board Papers – Quality, Safety & Experience Section: June 2019

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	41636.7	37561.9	31148.3	31358.4	26154.0	23885.5	18061.3	19656.8	90.53%	95.30%	92.86%	94.11%	15093	169.68	79.11	248.80
AMU	1950	1620	1470	1464	1837.5	1494.5	1470	1494.5	83.1%	99.6%	81.3%	101.7%	737	4.2	4.0	8.2
CAU (Winter)	1719	1719	675.5	675.5	1564	1564	345	345	100.0%	100.0%	100.0%	100.0%	488	6.7	2.1	8.8
Critical Care	3958.5	3958.5	633	633	2365.5	2365.5	0	0	100.0%	100.0%	100.0%	-	242	26.1	2.6	28.7
Elmhurst	847.5	835.5	2160	2226	750	750	1500	1500	98.6%	103.1%	100.0%	100.0%	851	1.9	4.4	6.2
Ward 1	2125	1931.3	1125	1181.3	1470	1384.3	735	882	90.9%	105.0%	94.2%	120.0%	876	3.8	2.4	6.1
Ward 13	2392	2040	1920	1976	922.5	881.5	922.5	994.3	85.3%	102.9%	95.6%	107.8%	882	3.3	3.4	6.7
Ward 14	1302	1302	1440	1464	1080	912	1080	1092	100.0%	101.7%	84.4%	101.1%	899	2.5	2.8	5.3
Ward 15	2272	1936	1920	1904	922.5	697	922.5	902	85.2%	99.2%	75.6%	97.8%	850	3.1	3.3	6.4
Ward 2	1750	1593.8	1500	1456.3	1102.5	918.8	1102.5	1090.3	91.1%	97.1%	83.3%	98.9%	907	2.8	2.8	5.6
Ward 21b	1154.5	1050.5	1898	1917.5	750	750	750	962.5	91.0%	101.0%	100.0%	128.3%	712	2.5	4.0	6.6
Ward 23	1200	1187.3	760	760	740	740	740	727.7	98.9%	100.0%	100.0%	98.3%	572	3.4	2.6	6.0
Ward 4	1662	1404	1800	1800	720	708	1440	1428	84.5%	100.0%	98.3%	99.2%	942	2.2	3.4	5.7
Ward 5	2377.5	1965	1500	1518.8	1470	980	735	1139.3	82.6%	101.3%	66.7%	155.0%	901	3.3	3.0	6.2
Ward 6	1737.5	1500	1875	1800	1470	1041.3	735	1114.8	86.3%	96.0%	70.8%	151.7%	806	3.2	3.6	6.8
Ward 7	1637.5	1293.8	1500	1881.3	735	735	1102.5	1335.3	79.0%	125.4%	100.0%	121.1%	936	2.2	3.4	5.6
Ward 9	1406	982	960	728	615	574	481.8	266.5	69.8%	75.8%	93.3%	55.3%	212	7.3	4.7	12.0
NICU	1862.5	1731.8	177.5	165.7	1725	1449	0	0	93.0%	93.4%	84.0%	-	252	12.6	0.7	13.3
Ward 11 SAU	1455	1507.5	900	900	562	608.8	562	552.6	103.6%	100.0%	108.3%	98.3%	300	7.1	4.8	11.9
Ward 18 SSW	1445	1251.3	1125	1112.5	735	735	735	735	86.6%	98.9%	100.0%	100.0%	568	3.5	3.3	6.7
Ward 10 Ortho	2752	2424	3600	3472	922.5	902	1230	1230	88.1%	96.4%	97.8%	100.0%	1073	3.1	4.4	7.5
Ward 26 MLU	760	766.3	0	114	740	740	0	61.7	100.8%	-	100.0%	-	40	37.7	4.4	42.1
Ward 26 Labour	2558.7	2362.3	709.3	646	2220	2195.3	370	370	92.3%	91.1%	98.9%	100.0%	182	25.0	5.6	30.6

Experience Section:

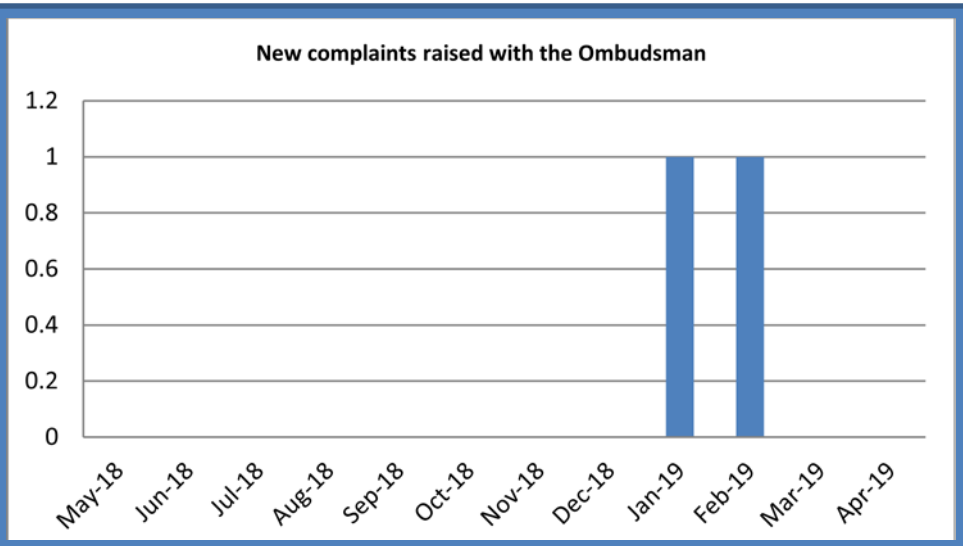
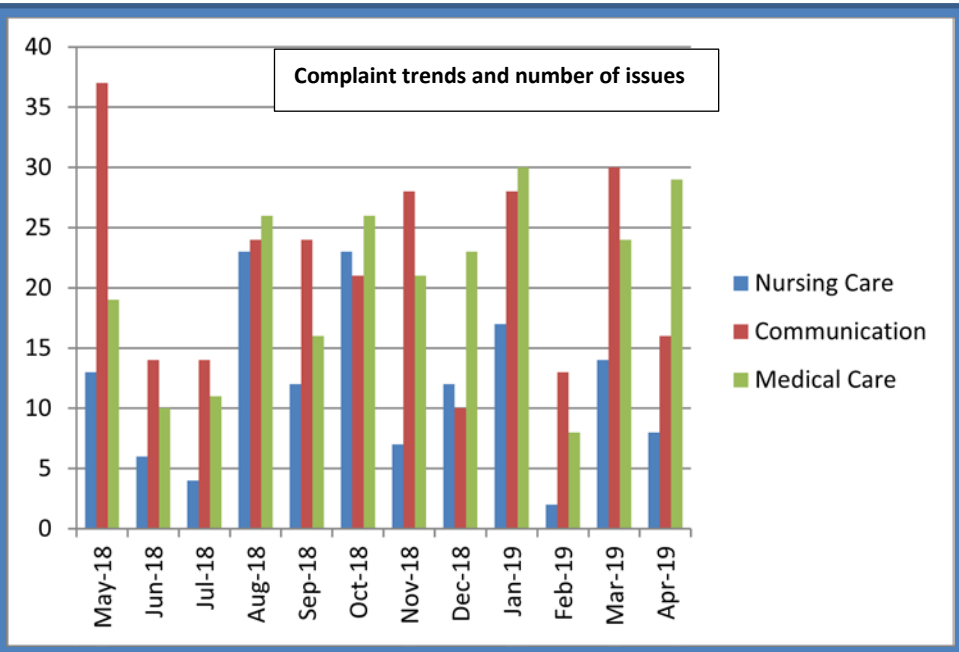
Indicators	Last four months			
	Jan-19	Feb-19	Mar-19	Apr-19
Complaints received by month	24	13	21	21
Complaints being reviewed by the Ombudsman	1	1	0	0
Closed complaints by month	16	23	18	15
Contacts raising informal concerns	96	105	97	86
Compliments received in month	675	409	406	290
Number of new claims received in month	6	5	6	3
Number of claims closed	3	4	1	2
Number of inquests concluded	0	1	0	1
NHS Choices - Star Ratings (Leighton)	4.5	4.5	4.5	4.5
NHS Choices - Star Ratings (VIN)	5	5	5	5
NHS Choices - Number of new postings	9	13	4	4
F&FT Response Rate ED, MIU, UCC and Assessment Areas*	19%	14%	18%	17%
Proportion of positive responses ED, MIU, UCC and Assessment Areas	84%	84%	87%	84%
F&FT Response Rate Inpatients and Day cases	32%	34%	36%	36%
Proportion of positive responses Inpatients and Day cases	95%	94%	95%	94%
F&FT Response Rate Outpatients	4%	4%	3%	3%
Proportion of positive responses Outpatients	94%	95%	94%	96%
F&FT Response Rate Maternity - Birth	13%	13%	10%	14%
Proportion of positive responses Maternity - Birth	100%	100%	100%	100%
F&FT Response Rate Community (CCICP)	0%	91%	10%	8%
Proportion of positive responses Community (CCICP)	0%	n/a	94%	91%

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

Description	Aggregate Position/Description	Trend
Monthly complaints received by the Trust.	21 complaints were received in April 2019 which covered 82 concerns. In addition there was 1 re-opened complaint. The highest categories were: • Communication • Medical – Adverse Outcome Highest 3 areas receiving complaints/issues were: • Emergency Department - 7 complaints with 17 issues • General Medicine - 4 complaints with 13 issues • Urology – 2 complaints with 11 issues	
Number of formal complaint issues by division.	This graph shows the breakdown of issues by month for each division. S&C: 37 DCSS: 7 W&CD: 0 DMEC: 36 CCICP: 2 E&F: 0 Corporate Services: 0	

Formal Complaints

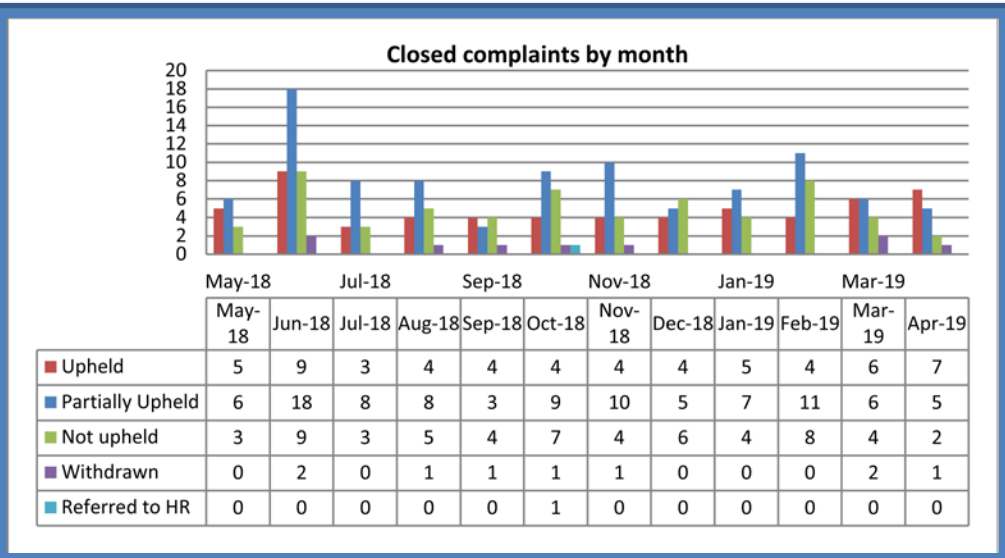
Formal Complaint issues by division

Description	Aggregate Position/Description	Trend
New complaints raised with the Public Health Service Ombudsman	In April 2019, there were no new complaints opened with the PHSO. There was 1 existing case which is at the investigation stage. In addition there was 1 case that remains at the assessment stage. In the last rolling 12 months we have had 2 cases with the PHSO of which none to date have been upheld.	 Ombudsman
Complaint trends and number of issues.	The main trends in April 2019 were:- Nursing care - 7 complaints raising 8 issues. 4 of these were categorised as 'other.' Communication - 10 complaints raising 16 issues. 5 of these issues related to communication with relatives Medical care - 15 complaints raising 29 issues. 14 of these concerns related to Medical adverse outcome	 Complaint Trends

Description	Aggregate Position/Description	Trend

Closed Complaints

In April 2019 15 complaints were closed. One of these was a re-opened complaint.



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

Closed Complaints

Closed complaints by Division

The table provides a breakdown of closed complaints for April 2019 by division, demonstrating those complaints which were upheld, not upheld, partially upheld or referred to Human Resources (HR)

Division	Upheld	Partially Upheld	Not Upheld	Withdrawn	Ref HR	Sub-Total
DMEC	5	2	1	0	0	8
Corporate	0	2	0	0	0	2
Surgery & Cancer	1	1	0	0	0	2
Women & Children's	1	0	0	0	0	1
DCSS	0	0	0	1	0	1
CCICP	0	0	1	0	0	1

Total closed = 15

Closed Complaints April 2019

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

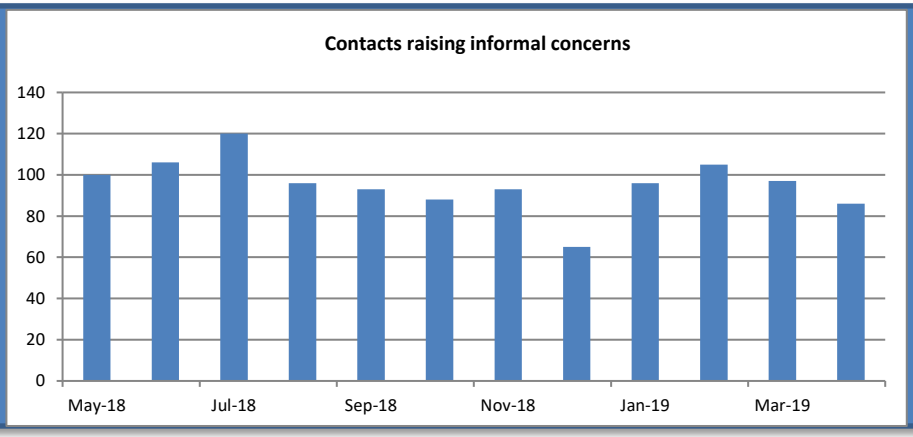
Description	Aggregate Position/Description	Trend

Informal concerns numbers.

The number of contacts raising informal concerns for April 2019 was 86 raising 141 individual concerns.

The Division of Medicine an Emergency Care received the highest number of overall concerns at 45 with Surgery and Cancer Division receiving 43.

General Surgery received the largest number of individual concerns raised at 25. Medical Imaging received 20 concerns and the Emergency Department received 13.



Informal concerns numbers

Informal concerns trends.

Communication and appointments were the highest trends for informal concerns in April 2019.

<u>38 communication issues raised:</u>

10 relate to communication between health professionals

9 relate to the Surgery and Cancer Division

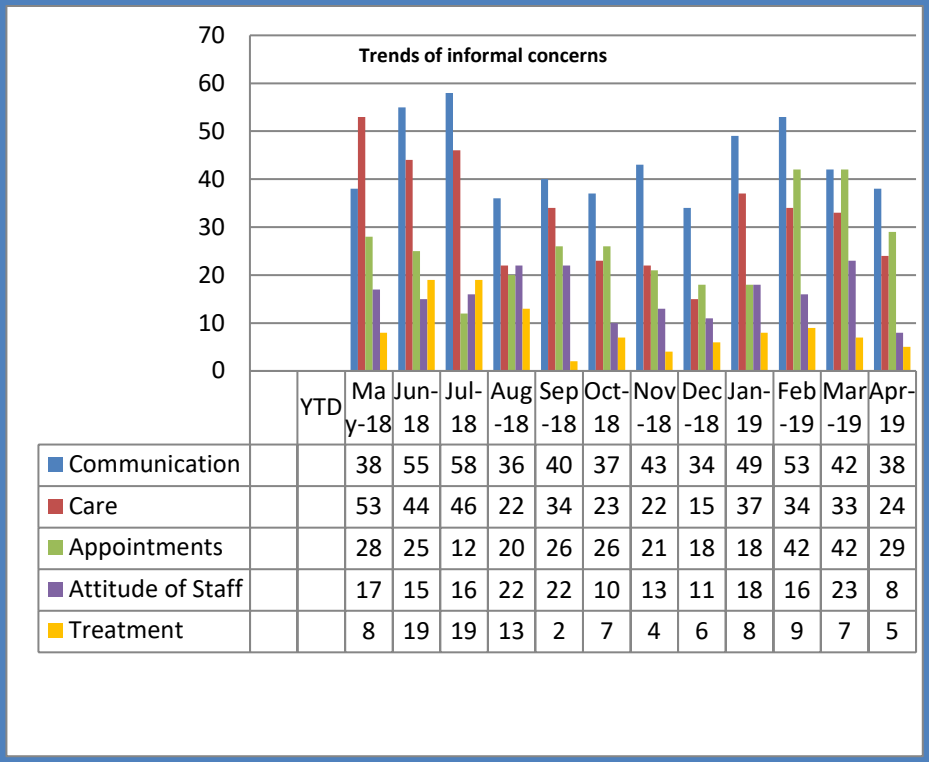
<u>29 appointment issues raised (including appointment delays or cancellations):</u>

4 relate to Gastroenterology, Medical Imaging and Respiratory respectively

<u>24 care issues raised</u>

19 relate to medical care, 5 of which relate to the Emergency Department and 5 to General Surgery

4 issues relate to nursing care, 2 of which relate Ward 13



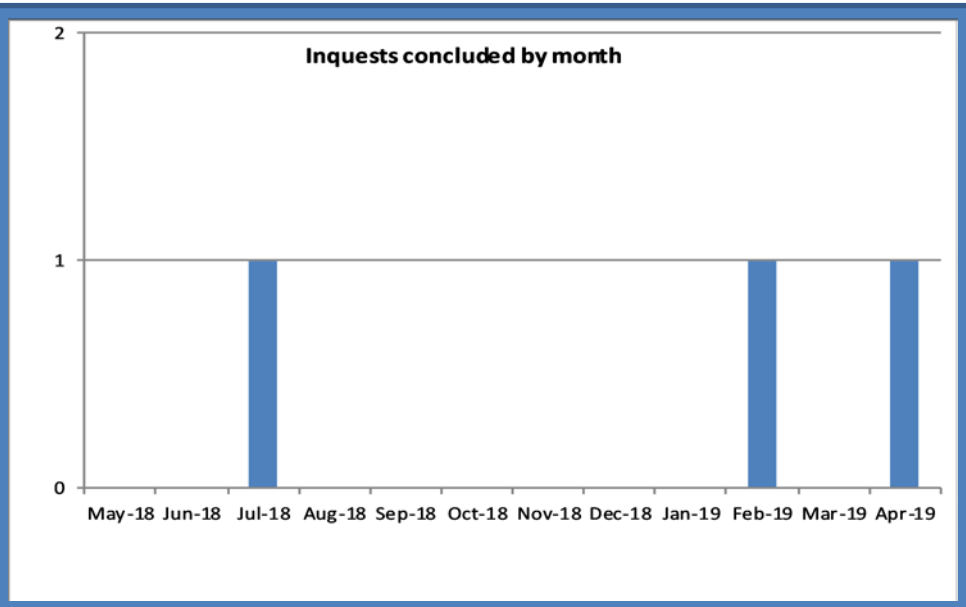
	YTD	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
Communication		38	55	58	36	40	37	43	34	49	53	42	38
Care		53	44	46	22	34	23	22	15	37	34	33	24
Appointments		28	25	12	20	26	26	21	18	18	42	42	29
Attitude of Staff		17	15	16	22	22	10	13	11	18	16	23	8
Treatment		8	19	19	13	2	7	4	6	8	9	7	5

Informal concerns trends

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

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

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

Description	Aggregate Position /Description	Trend
Number of Inquests concluded by month	1 inquest was concluded in April 2019. The Coroner recorded a conclusion of natural causes.	

Inquests

NHS Choices Star Ratings	In April 2019 Leighton Hospital is rated at 4.5 stars. Victoria Infirmary, Northwich is rated at 5 stars. The above ratings are based on 183 postings received to date.	

NHS Choices – Star Ratings

Description	Aggregate Position /description	Trend

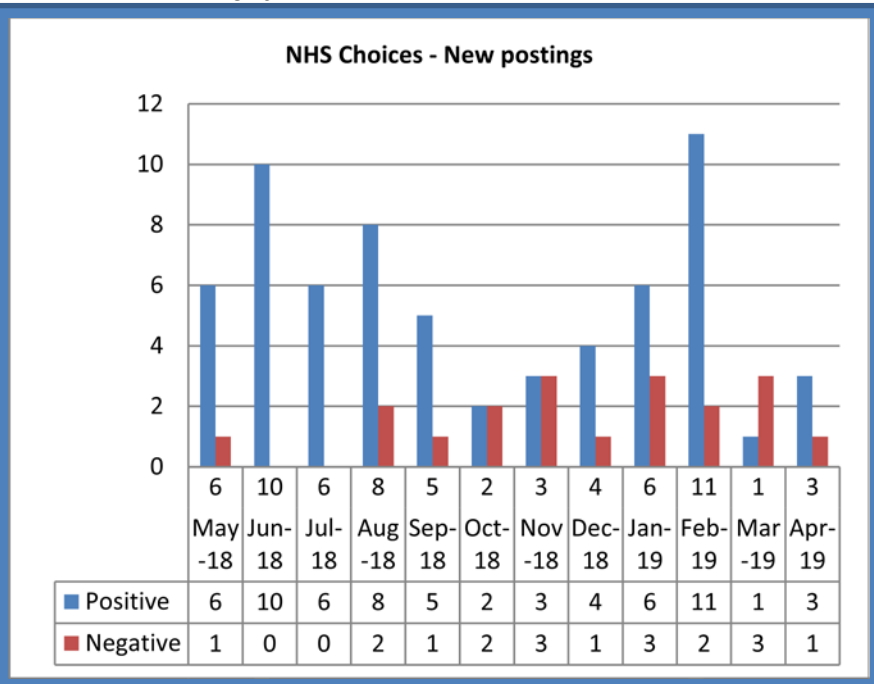
NHS Choices postings

There were 4 postings on NHS Choices in April 2019 of which 3 were positive and 1 was negative. Examples of feedback included:

Throughout the past eleven years, I have without exception received the very best of care from all members of staff who are always so kind, helpful and caring considering the immense pressures the NHS is under at the present time. The hospital management team must be very proud of their staff at Leighton…. I could not have had better care had I have gone privately. (Ophthalmology)

Attended MR department 29/04/19 for a contrast scan of head & eyes. The whole process was quick, efficient & delivered by compassionate, informative & friendly staff from reception, assistants & radiographer. As a fellow member of staff from MCHFT I was completely put at ease as I'll admit I'm an anxious patient when "on the other side!" Thank you again (MRI)

I had my left hip replacement in November 2018. I was so worried but the whole staff on the surgical team of the surgeon and ward 9 staff were brilliant. I was treated so well. Brilliant team.. staff were so caring and professional. The physio team too were brilliant. Great service and a huge thank you as I was so nervous. Thank you so much. (Orthopaedics)



NHS Choices – Postings

The Family and Friends Test.

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

Emergency care /assessment areas 84%;

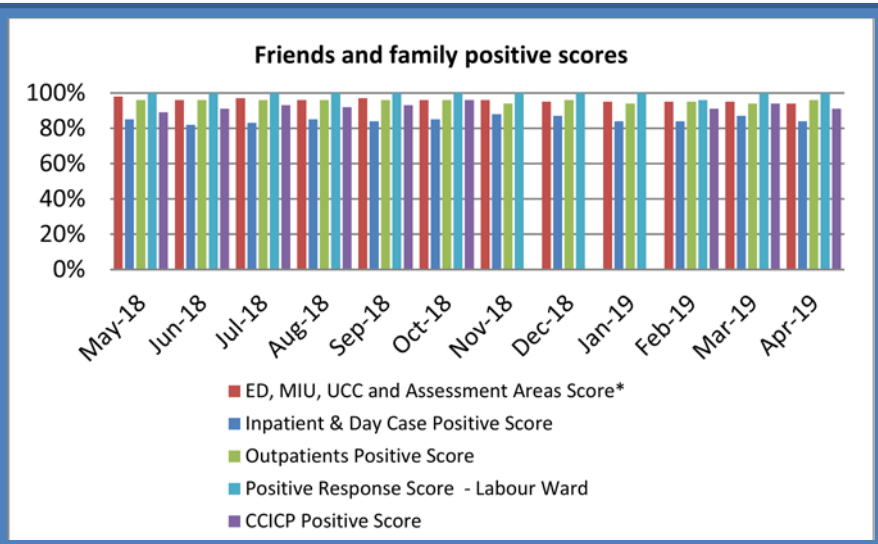
Inpatients and day cases 94%;

Outpatients 96%;

Maternity (Labour ward) 100%;

CCICP 91%.

Text messaging will be in place in all areas by July 2019.



Family & Friends Test

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

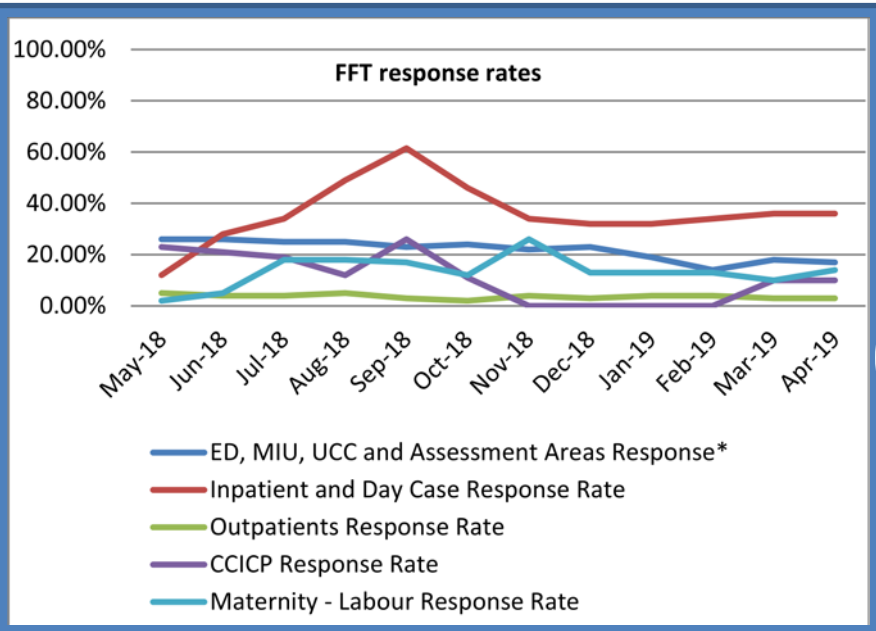
Description

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

Aggregate Position /description

April 2019 Ward/Dept.	% Response	Total responses received	How many would recommend
A&E , UCC & MIU	17%	1045	84%
CCICP	10%	102	94%
Inpatients & Day cases	36%	1511	94%
Maternity	14%	32	100%
Outpatients	3%	545	94%

Trend



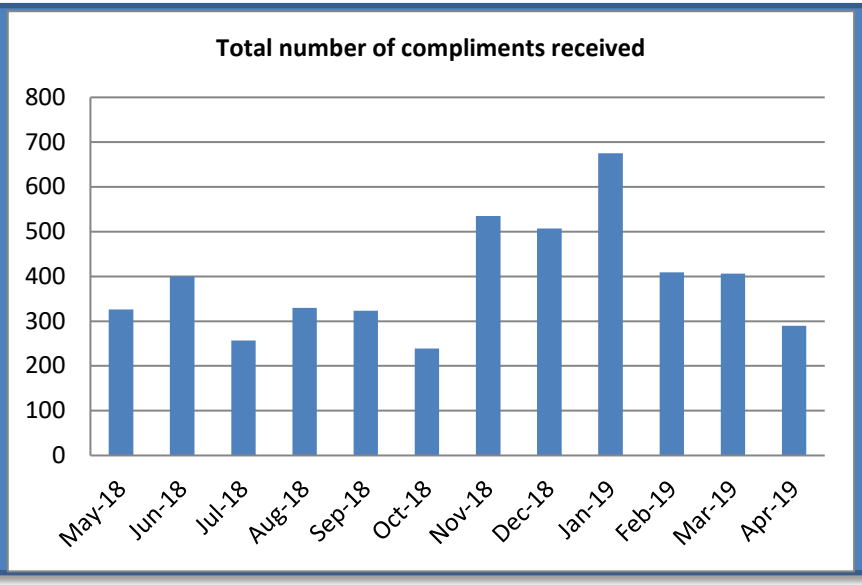
Family & Friends Test

Compliments received

There were 290 compliments received in April 2019. 65 of these were logged by the Customer Care Team and 225 received across the Trust.

'The nurse in ENT is outstanding and a credit to Leighton Hospital. She has always been very friendly and very efficient and always on time. She is a great nurse who has always been really good with me and given me lots of good advice.'

'My son came for a blood test yesterday at the children's outpatients. We were seen quickly and the staff were lovely. I was really impressed with how the centre is set up for children to make their visit as comfortable as possible. Thank you to the team.'



Compliments

Mid Cheshire Hospitals NHS Foundation Trust

Title of Paper:	Guardian of Safe Working Hours Report (Q4)	
Author:	Derek Pegg, Guardian of Safe Working Hours	
Executive Lead:	Heather Barnett, Director of Workforce and OD	
Type of Report:	Concept Paper	
	Strategic Options Paper	
	Business Case	
	Information	✓
	Review/Benefits/Audit	

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

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

Positive Benefit:	Assurance that our Junior Doctors are working in accordance with the agreed Contract
Risk:	Common themes associated with exception reports

To be published on Trust Website –complete version	***Yes***
If no, to be published on Trust Website – redacted	***n/a***
If not to be published complete or redacted, please detail the reason why	**n/a**
Presented at Board Meeting of:	**3 June 2019**

Report from the

Guardian of Safe Working Hours

1st January 2019 – 31st March 2019

1. Introduction

To report progress with the 2016 junior doctors' contract and the work of the Guardian of Safe Working Hours (GoSWH) to the Board.

The GoSWH is required to provide to the Board, a quarterly report which will include details of the including exceptions, fines and rota gaps.

2. Current Position

Since the new Junior Doctor's Contract went live in October 2016, the Trust has assimilated Doctors in Training on to the Contract in accordance with the schedules set out in the final contract agreement. This means that we currently employ doctors in training on both the old and the new contract.

During the February rotation, the most significant changes were in terms of the number of doctors in training rotating to different specialties within the trust.

3. Exception Reporting

The GoSWH is required to provide a Board report on a quarterly basis summarising exception reports being completed and ensuring that the Trust take appropriate action to address any significant issues identified in these reports. The Board has been presented with previous GoSWH reports covering the period 1st April 2018 to 31st December 2018.

Exception reporting is the method for junior doctors to report any unsafe working practices. This mechanism also enables junior doctors to report whether they have been able to take appropriate breaks and that they are able to start and finish on time.

During the period 1st January 2019 – 31st March 2019 a total of 18 exception reports were received from trainee Doctors and the following table is a summary of those exceptions:

Reference	Summary of Exception	hours to be paid	Pay Cost (x1.5)	Fine Cost (x2.5)
01 – 31st January 2019				
52900	Difference in work pattern	No action		
53411	Late finish; unable to achieve breaks	1 hr TOIL granted		
53412	Late finish; unable to achieve breaks	1 hr TOIL granted		
53413	Late finish; unable to attend clinic/theatre session	1 hr TOIL granted		
53414	Late finish; unable to attend clinic	1.5 hr TOIL granted		
53415	Unable to achieve breaks	1hr TOIL granted		
53416	Late finish; unable to attend clinic	1 hr TOIL granted		
53417	Late finish; unable to attend clinic	1 hr TOIL granted		
53418	Late finish; unable to attend clinic	1.5 hr TOIL granted		
53419	Early start; late finish	2 hr TOIL granted		
53420	Early start; late finish	1.5 hr TOIL granted		
54496	Late finish	2 hr TOIL granted		
54497	Late finish	2 hr TOIL granted		
54498	Late finish	1.5 hr TOIL granted		
01 – 28th February 2019				
54499	Late finish; unable to attend clinic session	TOIL granted		
55199	Late finish	TOIL granted		
55623	Late finish	1 hr TOIL granted		
01 – 31st March 2019				
56197	Unable to attend scheduled teaching	No action		
Total Cost to the Trust for the Reporting Period				**£0.00**

Of the 18 exception reports submitted:

16 were closed with TOIL agreed;

The remaining 2 have been closed with no action required.

None of the reports were highlighted as an ‘immediate safety concern’, however, 15 of the reports were submitted by junior doctors on a single rota over a two week period in January 2019.

The GoSWH is responsible for ensuring that these reports are responded to and that Junior Doctors receive appropriate feedback and support following submission of an exception report.

The Trust fines itself for certain exception reports (i.e. if we did not respond in time or if there was no alternative action available to the Junior Doctor). The running total of fines to date for the Trust during the 2018/19 financial year is set out in the below table.

	Fine Costs
Running Total Fines to Date	£159.50

These fines are held by the GoSWH and will be used to improve the working lives of Doctors in Training. The Trust is not permitted to access the fines for any other reason.

4. Conclusion

This is now the ninth report by the GoSWH and it is concluded that the Trust continues to take appropriate steps to implement the new national contract for the relevant junior doctors.

This period has seen a rise in the number of exception reports submitted compared to previous reports and the exceptions reported are coming from a single rota. This has primarily been caused by winter pressures. The issues have been managed by the division and overseen by the GoSWH.

It was reported last time that there were some reported incidents of doctors being unable to access DRS (the Exception Reporting system) despite being sent log in details. This problem has now been resolved by IT and all doctors on the 2016 TCS now have access.

On behalf of Derek Pegg
April 2019

Mid Cheshire Hospital
NHS Foundation Tru

Board of Directors Performance Report

April 2019

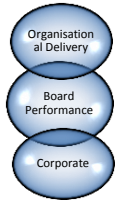
"To Deliver Excellence in Healthcare through Innovation & Collaboration"

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**	**Apr-19**	
Cancer				
Rapid Access Referrals (%) *(seen in 2 wks)*	93.00%	95.83%	95.83%	
Total Patients Seen		*1,031*	*1,031*	
Patients seen >14 days		*43*	*43*	
62 day GP Classic (%)	85.00%	85.52%	85.52%	*
Accountable Patients Treated		*73*	*73*	
No. of Breached Pathways (adjusted)		*11*	*11*	
62 day Screening (%)	90.00%	93.33%	93.33%	*
Accountable Patients Treated		*8*	*8*	
No. of Breached Pathways (adjusted)		*1*	*0.5*	
Unplanned Activity				
4 Hour Access Standard (%)	95.00%	79.90%	79.90%	
A&E Attendances (LH/MIU/UUC) (% to plan)		100.36%	100.36%	
A&E Attendances LH & MIU (Vol)		*8,169*	*8,169*	
Planned Activity				
Incomp Pathways <18wk (%)	92.00%	90.91%	90.91%	
>6wk Diagnostic Waits (%)	1.00%	0.64%	0.64%	
Total Patients Waiting for a First Outpatient Appointment			9,800	

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

Indicator	Standard	YTD
Workforce		
Sickness absence Rolling 12 Month		4.37%
Turnover Rolling 12 Month		9.90%

Corporate					
	YTD Rating		YE Rating	YE Metric	
Indicator	**Plan**	**Actual**	**Forecast**	**Plan**	**Forecast**
Finance					
Use of Resource Rating	3	3	3		
Capital Service Capacity	4	3	3	-1.78	-2.60
Liquidity	3	3	3	-8	-9
I&E Margin	3	4	4	-6.00%	-6.20%
Distance from Financial Plan	1	1	1	0.00%	0.10%
Agency Spend	1	3	1	-14.00%	-14.00%

	YTD Target	YTD Actual	YTD Variance	FY Target	FY Forecast	FY Variance
Cost Improvement Schemes Total (£000's)	378	280	-98	5,342	5,342	0
Commission Contact Income SC & VR (£000's)	15,997	15,870	-127			
Contract Income (£'000)	19,262	18,903	-359			
Pay to Budget (£000's)	-15,818	-15,745	73			
Non Pay to Budget (£000's)	-6,052	-6,026	26			
Agency Trajectory (£000's)	-403	-638	-235			

Exec Summary

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

The RTT Incomplete Pathway standard in April achieved 90.91%, against the 92% performance standard. This is an improvement on March 2019, of 90.67%

The 4 hour Access Standard in April achieved 79.90% against the 95% performance standard. This performance is a deterioration on the same period last year, however is set against 1000 more attendances in month arriving at the department.

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

Diagnostics waiting times continue to perform well, with just 0.64% of patients waiting longer than 6 weeks for their diagnostic test against a regulatory threshold of 1%. However, it should be noted that this months submission does not include imaging data due to the server upgrade issue.

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 £1.5M which is £0.2M worse than the planned deficit of £1.3M.

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

There is a variation in the CIP scheme, with challenges around delivering improvements to sickness rates within nursing and delays to other programmes of work.

Single Oversight Framework

Triggers

Operational	For providers with Sustainability and Transformation Fund (STF) trajectories in any metric: failure to meet the trajectory for this metric for at least two consecutive months (quarterly for quarterly metrics), except where the provider is meeting the NHS Constitution standard.
Finance & Resource	Poor levels of overall financial performance (avg score of 3 or 4). Very poor performance (score of 4) in any individual metric. Potential value for money concerns.

The Trust's operational trigger rating continues as RED as a result of failure of a primary target during the year (A&E 95% 4 hour Access Standard).

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

Operational Performance

	Current YTD													Monthly Trend
	Target	Actual	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	
Maximum 6 week wait for Diagnostic procedures	1%	0.64%	0.26%	0.17%	0.32%	0.56%	0.31%	0.44%	0.48%	0.17%	0.54%	0.47%	0.42%	0.76%	0.64%	
All Cancers: 62 day GP Classic (%) *	85%	85.52%	87.13%	92.91%	92.00%	91.40%	91.78%	86.11%	86.50%	93.40%	86.90%	85.83%	85.84%	85.22%	85.52%	
All Cancers: 62 day Screening (%) *	90%	93.33%	100.00%	89.47%	91.67%	100.00%	91.84%	100.00%	100.00%	100.00%	81.80%	87.50%	100.00%	95.00%	93.33%	
18 weeks from point of referral to treatment - patients on an incomplete pathway (%)	92%	90.91%	93.00%	93.27%	93.14%	92.97%	93.05%	92.43%	92.82%	92.28%	92.01%	91.30%	91.63%	90.67%	90.91%	
A&E - maximum waiting time of 4 hours from arrival to admission/transfer/discharge (%)	95%	79.90%	82.65%	85.15%	81.78%	84.59%	87.14%	84.61%	85.51%	88.13%	83.57%	78.89%	81.12%	80.41%	79.90%	
STF Trajectory			92.72%	92.72%	92.72%	93.92%	93.92%	93.92%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%		
Provider Submitted Trajectory														95.00%	83.60%	

** 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	-1.78	-2.60	3	-1.78	-2.60	3
	Liquidity	days	-8	-9	3	-8	-9	3
Financial Efficiency	I&E Margin	%	-6.00%	-6.20%	4	-6.00%	-6.20%	4
Financial Controls	Distance from Financial Plan	%	0.00%	0.10%	1	0.00%	0.10%	1
	Agency Spend	%	-14.00%	-14.00%	1	-14.00%	35.00%	3
Overall UOR Rating					3			3

Operational Delivery: *Cancer Pathway*

Headline Measures

	Current YTD		Rolling 13 months											
	Target	Actual	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	Monthly Trend
Rapid Access Referrals (%) (seen in 2 wks)	93%	95.83%	96.08%	96.76%	97.54%	96.37%	96.73%	96.50%	96.87%	98.36%	97.78%	96.91%	97.66%	97.69%	95.83%	
Total Patients Seen		*1031*	*766*	*956*	*855*	*855*	*887*	*771*	*989*	*917*	*855*	*842*	*940*	*996*	*1031*	
Patients seen >14 days		*43*	*30*	*31*	*21*	*31*	*29*	*27*	*31*	*15*	*19*	*26*	*22*	*23*	*43*	
% seen within 7 days		*30.3%*	*45.2%*	*39.6%*	*43.7%*	*44.4%*	*35.2%*	*51.4%*	*41.5%*	*34.0%*	*35.4%*	*38.6%*	*38.1%*	*30.5%*	*30.3%*	
62 day GP Classic (%) *	85%	85.52%	87.13%	92.91%	92.00%	91.40%	91.78%	86.11%	86.50%	93.40%	86.90%	85.83%	85.84%	85.22%	85.52%	

** Provisional figures subject to change depending*

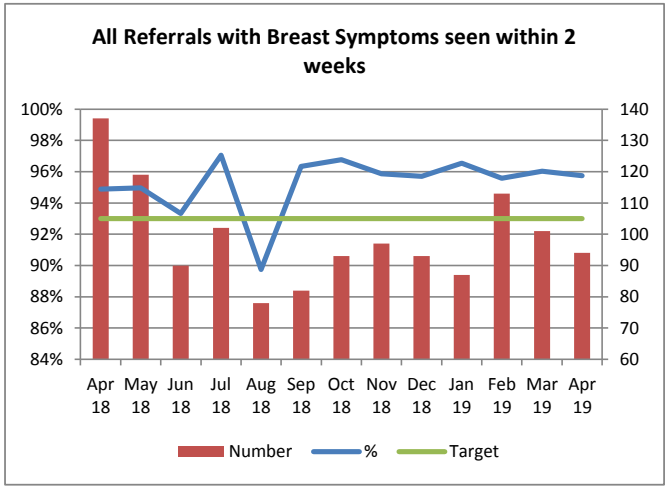
104+ day waits - (Cancer patients treated)	1	1	0	1	0	4	0	0	3	0	1	3	2

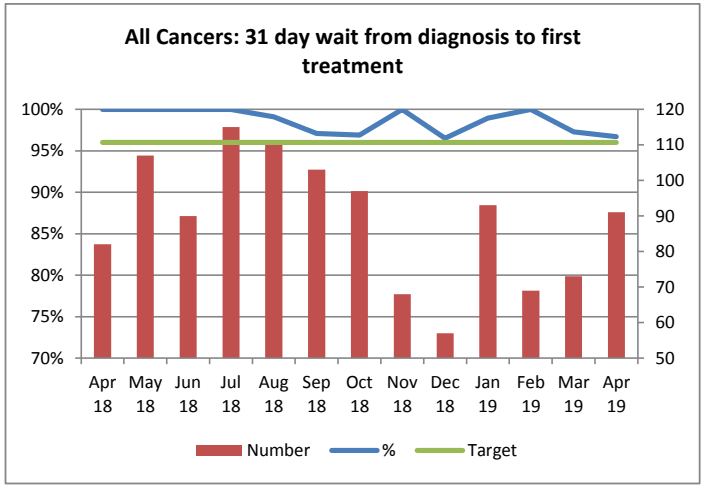
Commentary

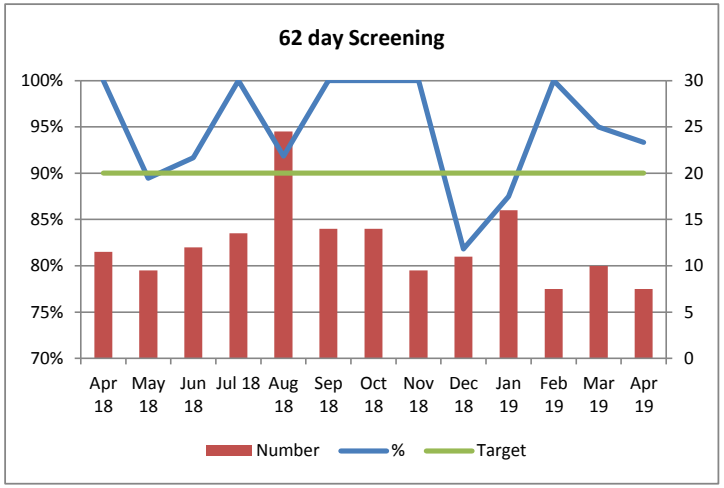
The Trust has achieved all three of the three headline cancer standards during the month of April 2019. The figures presented in this paper reflect the Trust's regulatory performance measures adjusted figures that take into account breach reallocation between providers. From October 2018 the new cancer repatriation policy is in use.

The Trust has continued it's strong performance against the Rapid Access referrals standard, achieving 95.83% for April, despite a 4% increase in referrals compared to the previous month and a 34% increase on the same period last year, with the highest number seen in April. The increase in demand looks set to continue.
The 62 Day GP Classic standard has achieved 85.52% against an 85% target.
There were two recorded long wait (104 days and over) for patients on a 62 day cancer pathway in April.

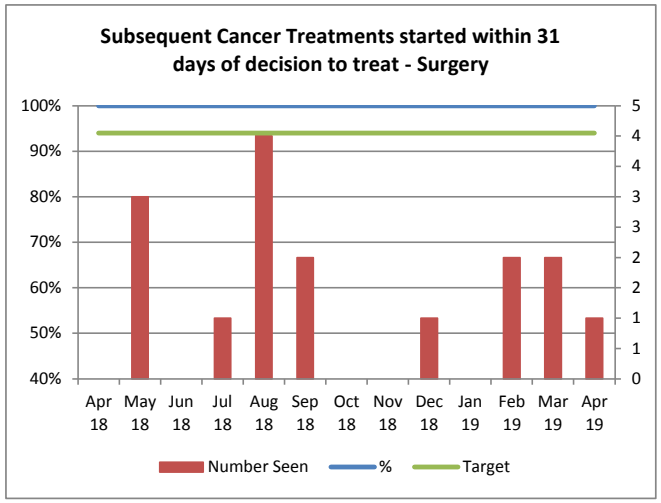
Primary Measures

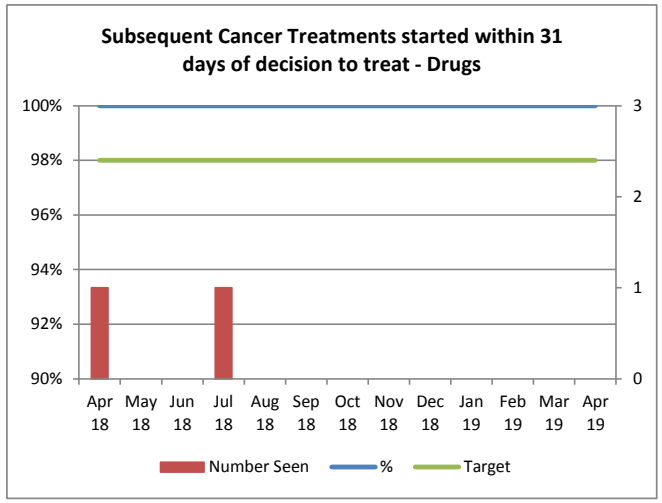


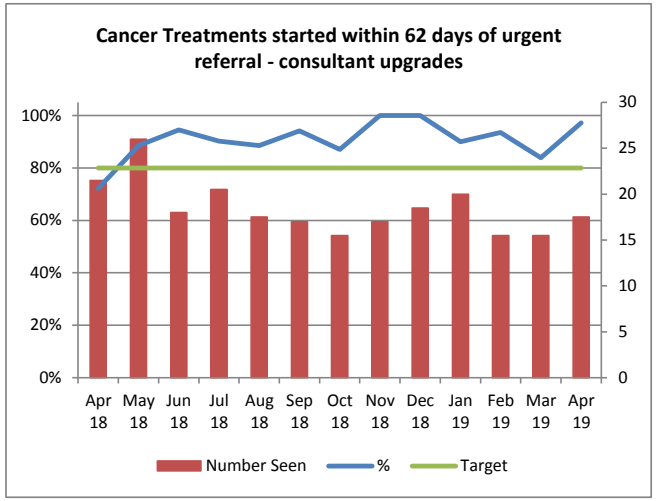




Operational Delivery: *Cancer Pathway*







Operational Delivery: *Unplanned Activity - A&E*

Headline Measures

	Current YTD		Rolling 13 months												
	Target	Actual	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	Monthly Trend
A&E - >4 hr wait time from arrival to admission/ transfer/ discharge (% to Target)	95%	79.90%	82.65%	85.15%	81.78%	84.59%	87.14%	84.61%	85.51%	88.13%	83.57%	78.89%	81.12%	80.41%	79.90%	
No. of 4hr breaches		*1,642*	*1,244*	*1,179*	*1,472*	*1,286*	*967*	*1,158*	*1,167*	*884*	*1,209*	*1,621*	*1,349*	*1,574*	*1,642*	

	Plan	Actual	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	Monthly Trend
A&E Attendances (LH/MIU/UUC) (% to Plan)		*100.36%*	93.2%	95.3%	98.9%	99.6%	97.7%	94.9%	100.0%	98.4%	95.8%	99.3%	97.0%	95.4%	100.4%	
A&E Attendances (LH/MIU/UUC) (No.)	*7,731*	*8,169*	7,170	7,937	8,081	8,344	7,517	7,524	8,056	7,445	7,358	7,679	7,147	8,034	8,169	

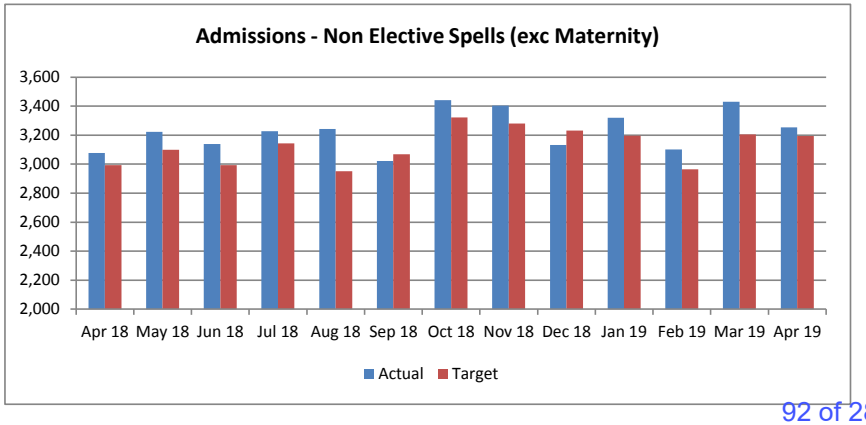
A&E Attendance Case Mix *(based on acuity score)*	*Major*		*2,351*	*2,288*	*2,460*	*2,386*	*2,168*	*2,380*	*2,228*	*2,455*	*2,269*	*2,235*	*2,392*	*2,170*	2,341	2,351	
	Minor		*3,166*	*2,799*	*2,992*	*3,325*	*3,643*	*2,990*	*2,810*	*2,768*	*2,560*	*2,605*	*2,782*	*2,489*	2,855	3,166	
	Paediatrics		*1,587*	*1,419*	*1,676*	*1,648*	*1,691*	*1,181*	*1,516*	*1,709*	*1,562*	*1,422*	*1,372*	*1,556*	1,702	1,587	
	Resus		*1,063*	*664*	*805*	*722*	*835*	*966*	*969*	*1,120*	*1,048*	*1,095*	*1,128*	*928*	1,126	1,063	
A&E Attendance Location *(based on Discharge)*	*Major*		*3,245*	*2,957*	*3,170*	*3,136*	*3,121*	*3,225*	*3,090*	*3,413*	*3,187*	*3,176*	*3,354*	*2,983*	*3,317*	*3,245*	
	Minor		*3,123*	*2,623*	*2,948*	*3,157*	*3,364*	*2,977*	*2,775*	*2,791*	*2,560*	*2,573*	*2,738*	*2,454*	*2,801*	*3,123*	
	Paediatrics		*1,587*	*1,419*	*1,676*	*1,648*	*1,691*	*1,181*	*1,516*	*1,709*	*1,562*	*1,422*	*1,372*	*1,556*	*1,702*	*1,587*	
	Resus		*212*	*171*	*139*	*140*	*161*	*134*	*142*	*139*	*130*	*186*	*210*	*150*	*204*	*212*	

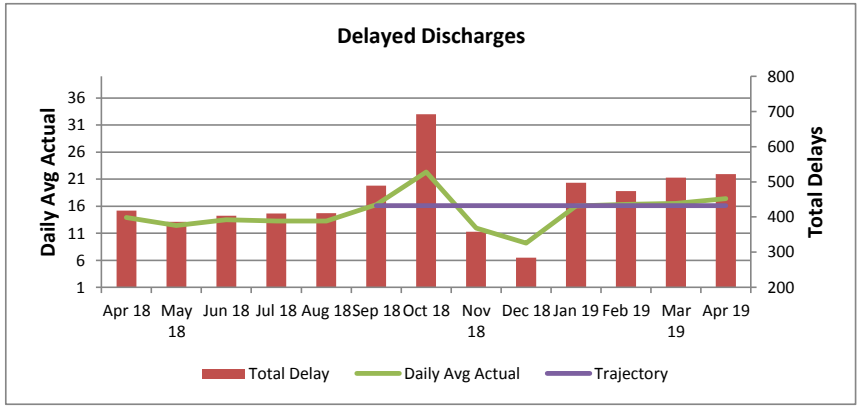
Commentary

The Trust has achieved 79.90% against the 4-hour access standard in April 2019, with a 14% increase in attendances compared to the same period last year. The number of higher acuity patients (Resus and Majors) arriving in A&E continues to rise with 15.7% more than the same period last year. As a result of the increase in higher acuity attendances, emergency admissions are higher than expected for April, at 102% of target. A business case on ED workforce; matching capacity to demand has been presented to the executive team and will progress to Performance and Finance Trust Board.

Patients medically optimised for discharge has increased slightly to 17 against a threshold of 16, although the DTOC standard of 3.5% was achieved.
Medical Outliers have reduced to the lowest level seen since last April.

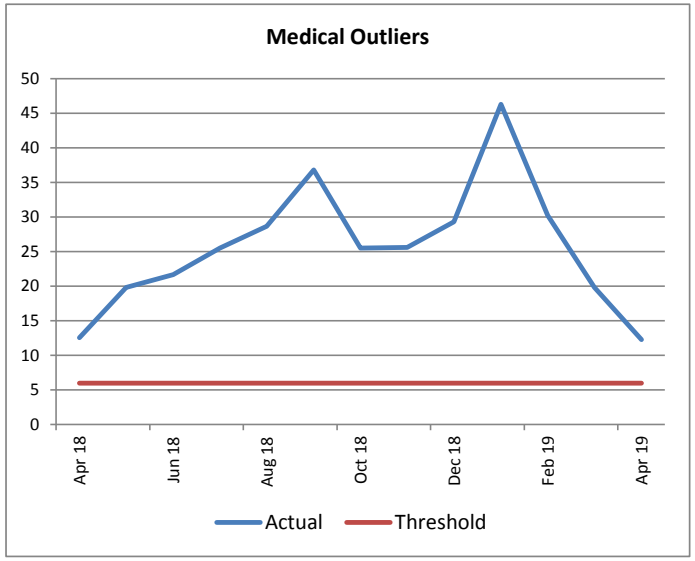
Primary Drivers

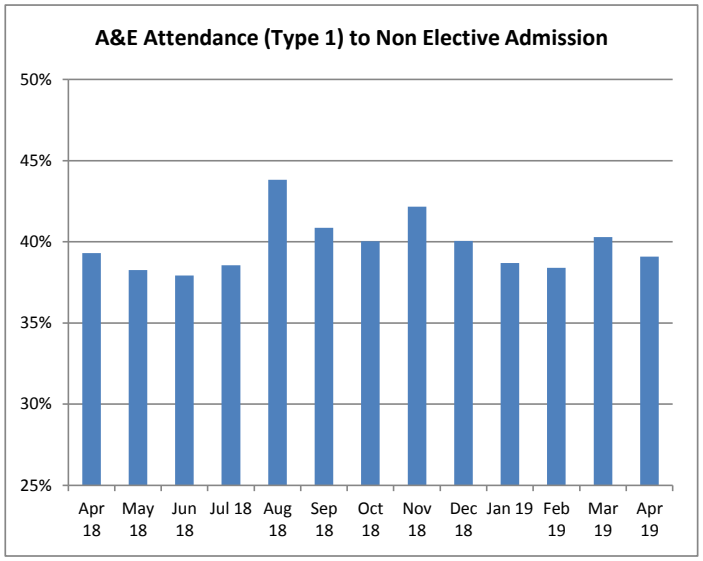


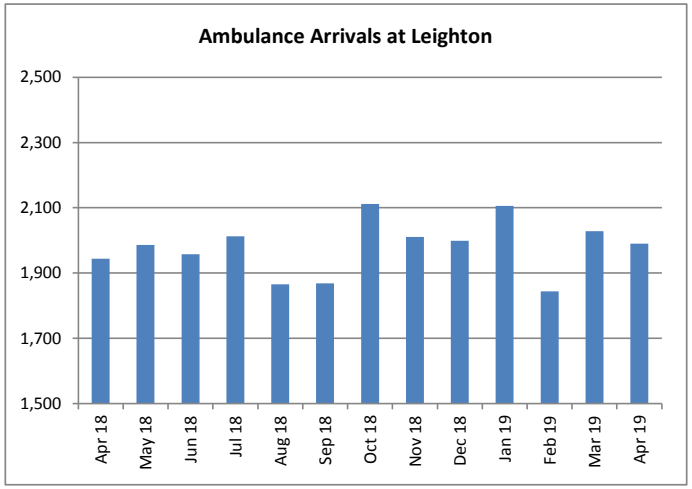


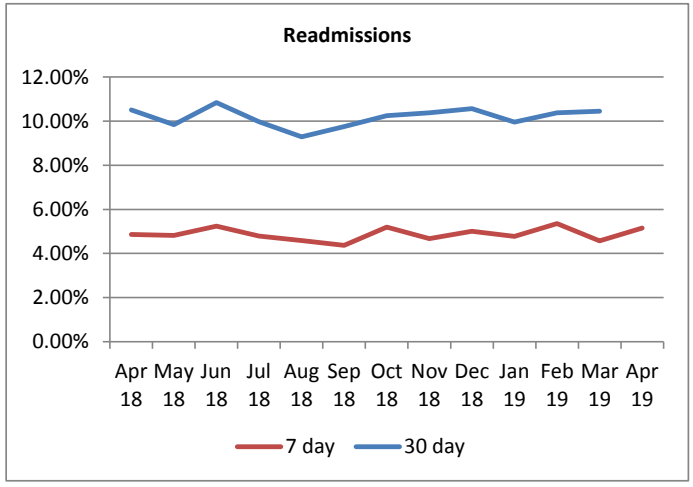
Operational Delivery: *Unplanned Activity A&E*

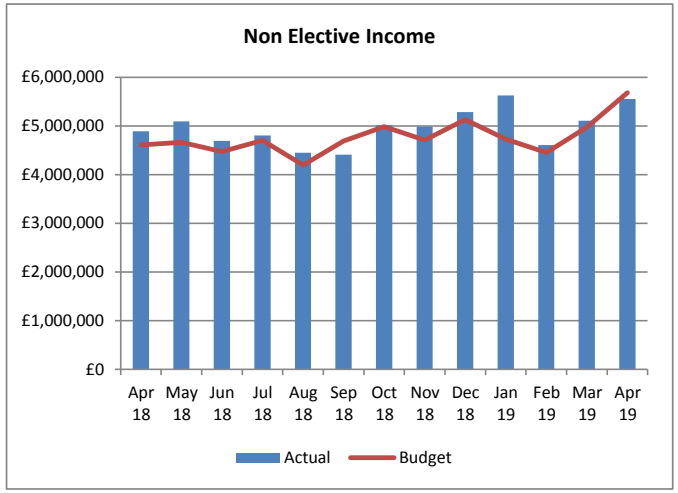
Secondary Drivers





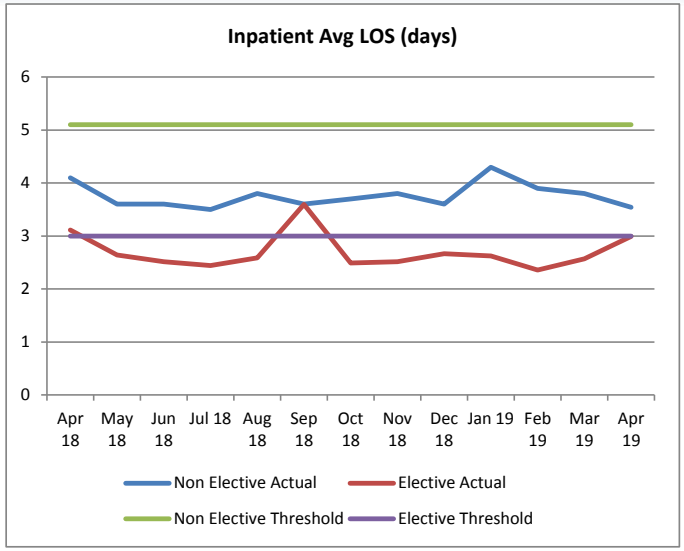


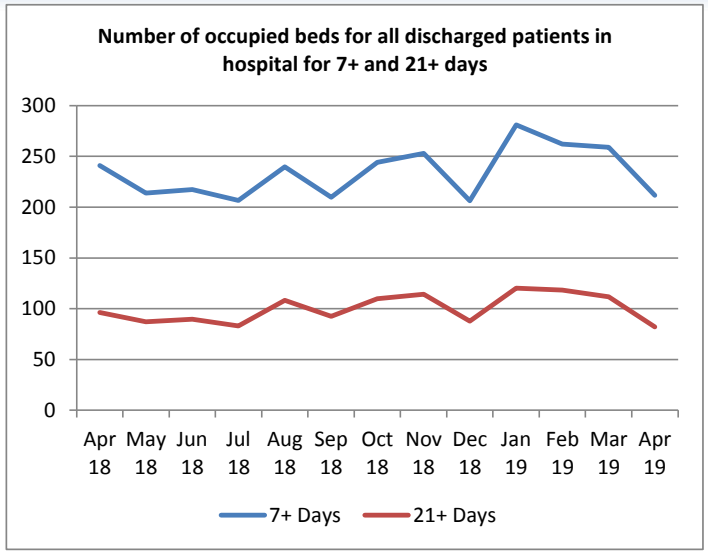


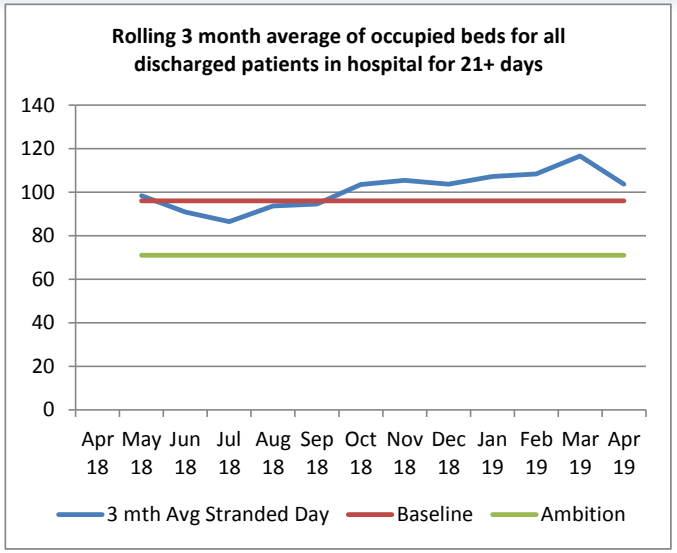


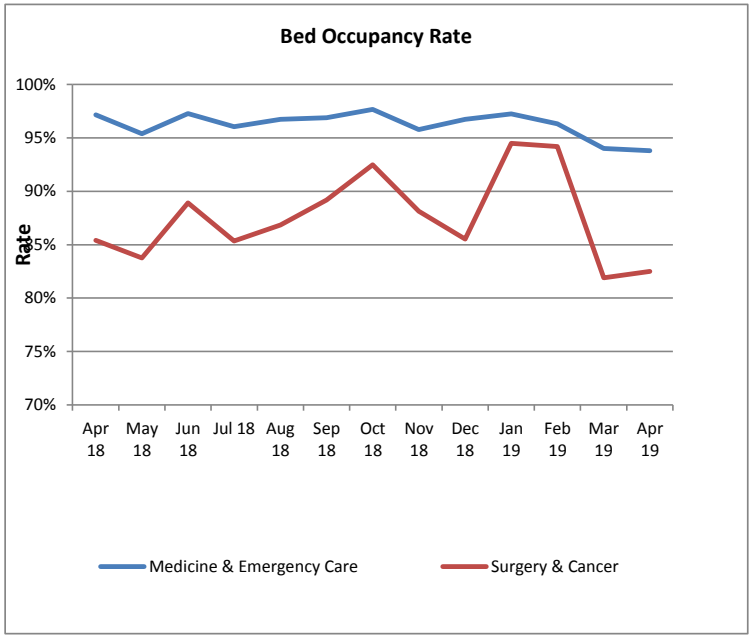
** Readmissions brought in line with national definition*

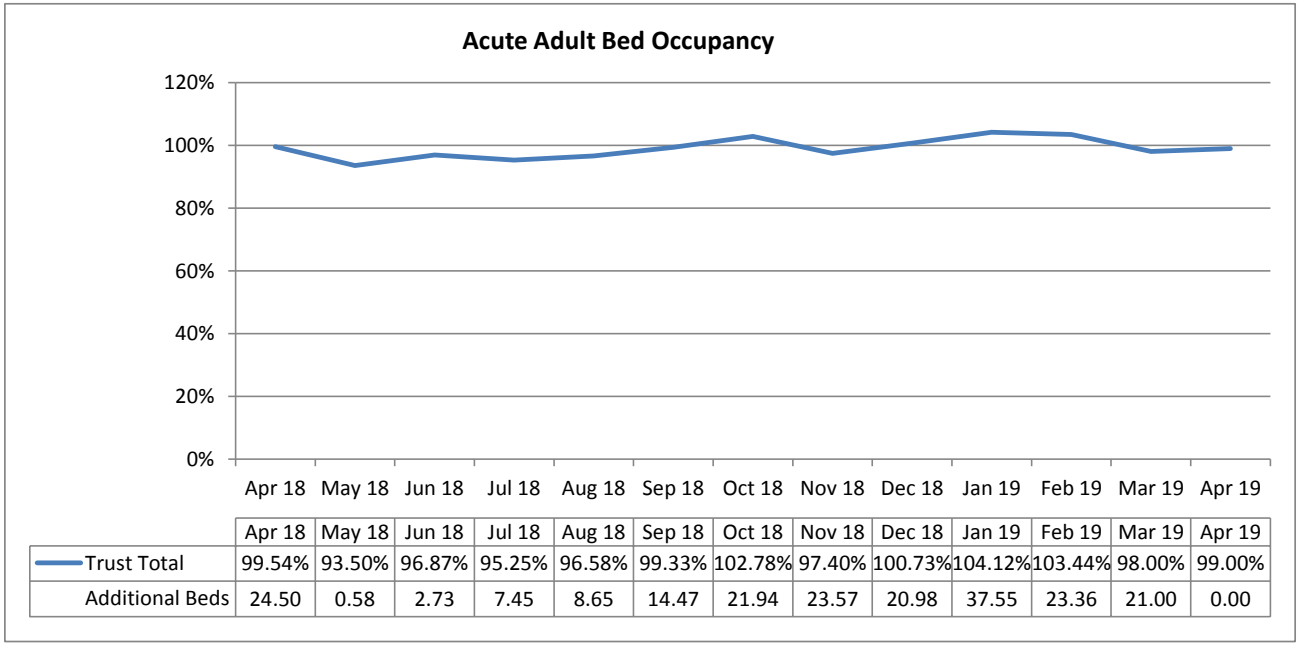
Operational Delivery: *Length of Stay*











	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19
Trust Total	99.54%	93.50%	96.87%	95.25%	96.58%	99.33%	102.78%	97.40%	100.73%	104.12%	103.44%	98.00%	99.00%
Additional Beds	24.50	0.58	2.73	7.45	8.65	14.47	21.94	23.57	20.98	37.55	23.36	21.00	0.00

Operational Delivery: *Planned Activity*

Headline Measures

	Current YTD		Rolling 13 months											
	Target	Actual	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	Monthly Trend
18 weeks from Referral to Treatment in Aggregate - Incomplete	92%	90.91%	93.00%	93.27%	93.14%	92.97%	93.05%	92.43%	92.82%	92.28%	92.01%	91.30%	91.63%	90.67%	90.91%	
Total 18 Weeks		*15,043*	*14,253*	*14,405*	*14,713*	*14,630*	*15,373*	*14,988*	*14,284*	*14,331*	*14,232*	*14,427*	*14,505*	*14,194*	*15,043*	
No. > 18 Weeks		*1,367*	*998*	*969*	*1,010*	*1,029*	*1,069*	*1,135*	*1,025*	*1,106*	*1,137*	*1,255*	*1,214*	*1,324*	*1,367*	
Open Pathways >39 Weeks Waiting											*10*	*11*	*5*	*10*	*10*	
Diagnostic Waiting Time	1%	0.64%	0.26%	0.17%	0.32%	0.56%	0.31%	0.44%	0.48%	0.17%	0.54%	0.47%	0.42%	0.76%	0.64%	
Total Number of Waiters		*1,091*	*4,224*	*4,127*	*4,619*	*4,257*	*3,814*	*4,105*	*4,168*	*4,017*	*3,870*	*4,029*	*4,785*	*4,749*	*1,091*	
Waiters of 6 Weeks +		*7*	*11*	*7*	*15*	*24*	*12*	*18*	*20*	*7*	*21*	*19*	*20*	*36*	*7*	
Total Patients Waiting for a First Outpatient Appointment			9,243	9,579	9,354	9,496	9,851	9,654	9,496	9,430	8,948	9,428	9,823	9,682	9,800	
Longest Wait Time (weeks)											*46*	*47*	*47*	*46*	*48*	

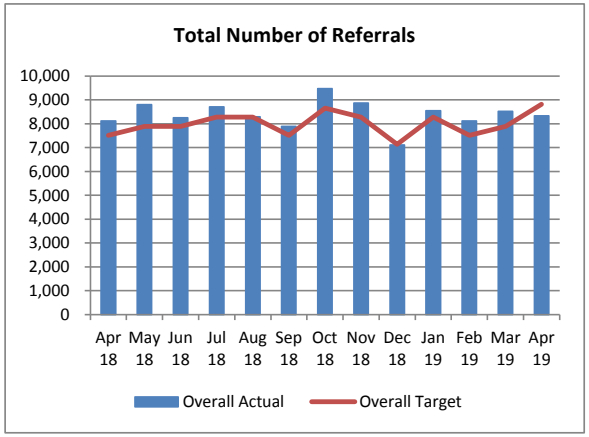
Commentary

The Trust's current RTT Incomplete Pathway position is 90.91% for April. Eight specialties have failed to meet the 92% target in April, these are General Surgery, Urology, Gastroenterology, Cardiology, Dermatology, Thoracic Medicine, Gynaecology and Trauma and Orthopaedics. Detailed improvement plans and trajectories are in place and reviewed weekly by the Chief Operating Officer and Director of Operations. Compliance to 92% is expected no later than June 2019. To also note, in line with other Trusts in Cheshire & Merseyside, patients on the ASI list have now been included within the overall denominator.

Mid Cheshire do not currently have any 52 week breaches for April however there are 10 patients waiting over 39 weeks; (2 in General Surgery, 3 in Gastro, 2 in Cardiology, 1 in Dermatology, 1 in Rheumatology and 1 in Trauma & Orthopaedics). All long wait patients are monitored and reviewed weekly at director led performance meetings.

In April 2019, 0.64% of patients waited longer than 6 weeks for their diagnostic tests. The drop in reported figures from March to April is as a result of the Radiology data being unavailable.

Primary Drivers

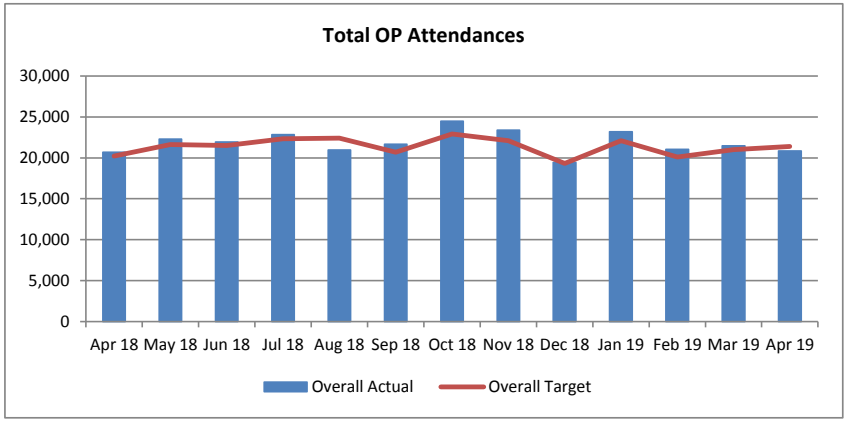


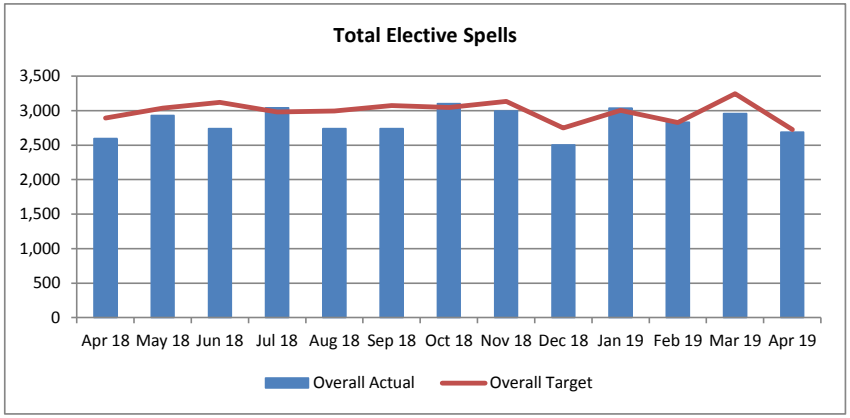
Referral Breakdown

	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	Monthly Trend
GP Actual	4,858	5,400	5,065	5,355	5,184	4,925	5,755	5,684	4,412	5,424	4,915	5,270	5,133	
GP Target	4,683	4,920	4,920	5,157	5,157	4,683	5,394	5,157	4,446	5,157	4,683	4,920	4,829	
% to Target	103.7%	109.8%	103.0%	103.8%	100.5%	105.2%	106.7%	110.2%	99.2%	105.2%	105.0%	107.1%	106.3%	
Other Actual	3,256	3,408	3,186	3,352	3,107	2,968	3,714	3,189	2,696	3,118	3,204	3,250	3,197	
Other Target	2,833	2,976	2,976	3,120	3,120	2,833	3,263	3,120	2,689	3,120	2,833	2,976	3,988	
% to Target	114.9%	114.5%	107.1%	107.5%	99.6%	104.8%	113.8%	102.2%	100.3%	100.0%	113.1%	109.2%	80.2%	
Total Actual	8,114	8,808	8,251	8,707	8,291	7,893	9,469	8,873	7,108	8,542	8,119	8,520	8,330	
Total Target	7,515	7,896	7,896	8,276	8,276	7,515	8,657	8,276	7,135	8,276	7,515	7,896	8,817	
% to Target	108.0%	111.6%	104.5%	105.2%	100.2%	105.0%	109.4%	107.2%	99.6%	103.2%	108.0%	107.9%	94.5%	
GP % of Total	59.9%	61.3%	61.4%	61.5%	62.5%	62.4%	60.8%	64.1%	62.1%	63.5%	60.5%	61.9%	61.6%	

Operational Delivery: *Planned Activity*

Primary Drivers



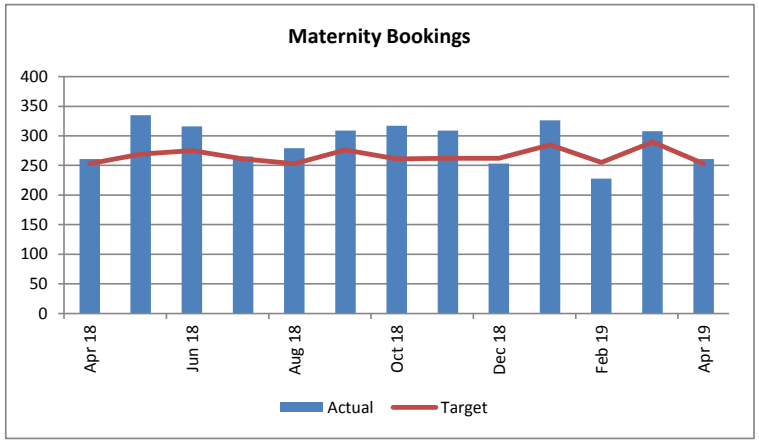


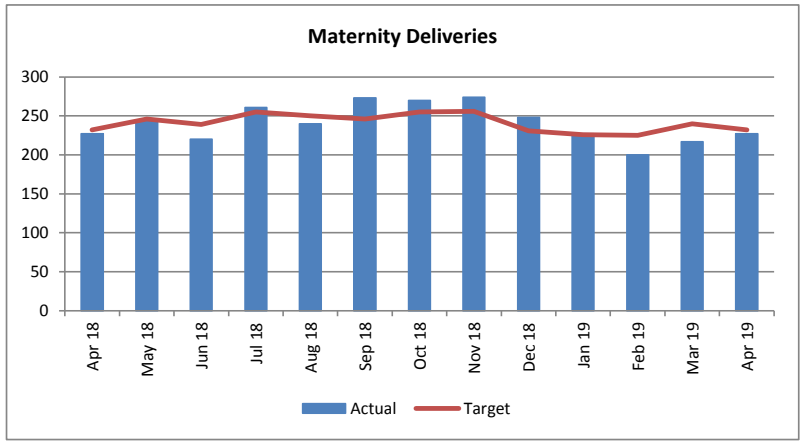
OP Attendance Breakdown	YTD 18 19	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	Monthly Trend
New Actual	0	6,472	7,138	6,868	7,001	6,211	6,648	7,713	7,203	5,946	6,861	6,397	6,877	6,566	
New Target	0	5,892	6,224	6,212	6,495	6,502	5,934	6,778	6,496	5,625	6,496	5,901	6,189	6,416	
% to Target		109.9%	114.7%	110.6%	107.8%	95.5%	112.0%	113.8%	110.9%	105.7%	105.6%	108.4%	111.1%	102.3%	
F U Actual	0	14,214	15,170	15,089	15,835	14,737	15,014	16,778	16,207	13,493	16,352	14,629	14,583	14,286	
F U Target	0	14,346	15,407	15,283	15,844	15,912	14,774	16,157	15,600	13,701	15,604	14,194	14,803	14,988	
% to Target		99.1%	98.5%	98.7%	99.9%	92.6%	101.6%	103.8%	103.9%	98.5%	104.8%	103.1%	98.5%	95.3%	
Total Actual	0	20,686	22,308	21,957	22,836	20,948	21,662	24,491	23,410	19,439	23,213	21,026	21,460	20,852	
Total Target	0	20,237	21,631	21,495	22,339	22,414	20,708	22,935	22,095	19,326	22,100	20,095	20,992	21,403	
% to Target		102.2%	103.1%	102.1%	102.2%	93.5%	104.6%	106.8%	105.9%	100.6%	105.0%	104.6%	102.2%	97.4%	
New % of Total		31.3%	32.0%	31.3%	30.7%	29.6%	30.7%	31.5%	30.8%	30.6%	29.6%	30.4%	32.0%	31.5%	

Elective Spells Breakdown	YTD 18 19	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	Monthly Trend
I P Actual	0	216	293	263	276	226	259	284	280	241	157	288	272	225	
I P Target	0	301	301	294	271	288	281	308	308	241	181	264	304	263	
% to Target		71.8%	97.4%	89.4%	101.9%	78.6%	92.2%	92.3%	91.0%	100.1%	86.9%	109.0%	89.4%	85.6%	
Daycase Actual	0	2,378	2,637	2,476	2,766	2,513	2,479	2,817	2,717	2,262	2,882	2,543	2,685	2,465	
Daycase Target	0	2,593	2,738	2,825	2,709	2,709	2,795	2,740	2,827	2,507	2,826	2,565	2,942	2,462	
% to Target		91.7%	96.3%	87.7%	102.1%	92.8%	88.7%	102.8%	96.1%	90.2%	102.0%	99.1%	91.3%	100.1%	
Total Actual	0	2,594	2,930	2,739	3,042	2,739	2,738	3,101	2,997	2,503	3,039	2,831	2,957	2,690	
Total Target	0	2,894	3,039	3,119	2,980	2,996	3,076	3,048	3,135	2,748	3,007	2,829	3,247	2,724	
% to Target		89.6%	96.4%	87.8%	102.1%	91.4%	89.0%	101.8%	95.6%	91.1%	101.1%	100.1%	91.1%	98.7%	
I P % of Total		8.3%	10.0%	9.6%	9.1%	8.3%	9.5%	9.2%	9.3%	9.6%	5.2%	10.2%	9.2%	8.4%	

Operational Delivery: *Planned Activity*

Primary Drivers



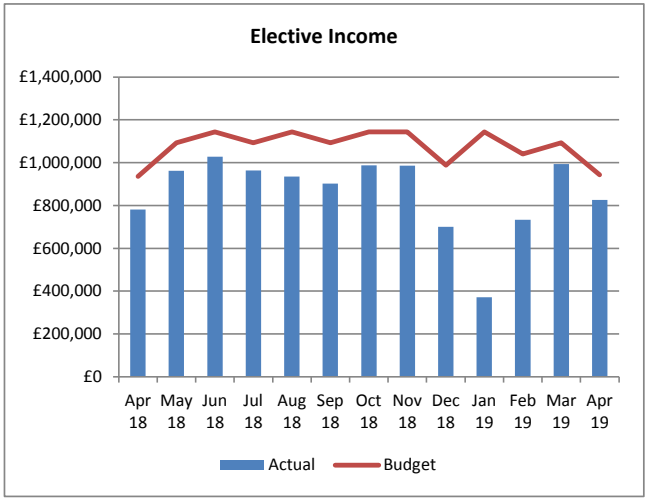


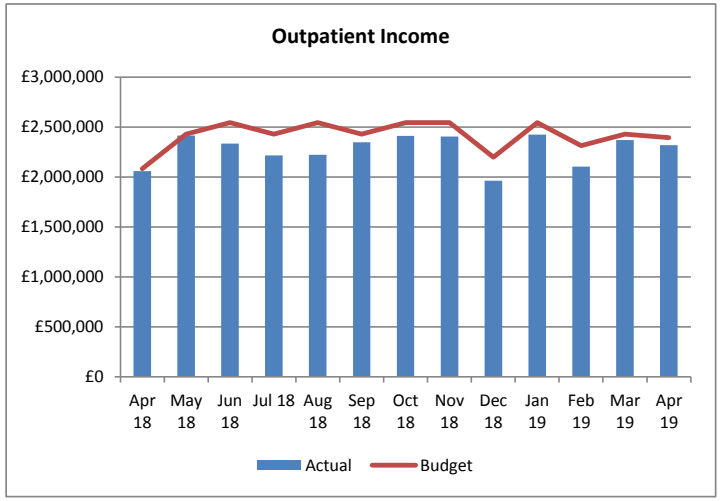
Operational Delivery: *Planned Activity*

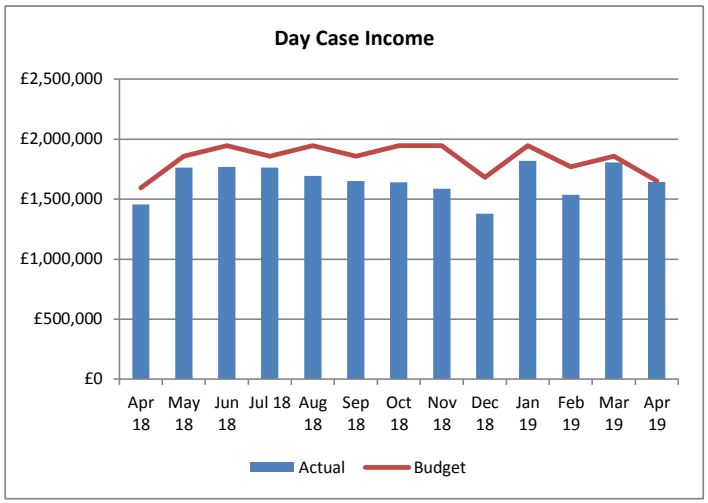
Secondary Drivers

			Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Monthly Trend
Bed Occupancy Rate	Medicine & Emergency Care		97.2%	95.4%	97.3%	96.1%	96.7%	96.9%	97.7%	95.8%	96.7%	97.3%	96.3%	94.0%	93.8%	
	Surgery & Cancer		85.4%	83.8%	88.9%	85.4%	86.9%	89.2%	92.5%	88.1%	85.5%	94.5%	94.2%	81.9%	82.5%	
Elective Inpatient Avg LOS (Days)			3.1	2.6	2.5	2.4	2.6	3.6	2.5	2.5	2.7	2.6	2.4	2.6	3.0	
Delayed Transfers of Care (MFFD)		16.00	14	12	13	13	13	16	22	12	9	16	17	17	17	
Delayed Transfers of Care (% of Acute Beds)			2.8%	2.7%	2.9%	2.8%	2.8%	3.3%	4.5%	2.4%	1.8%	3.1%	3.3%	3.3%	3.5%	
Medical Outliers			13	20	22	26	29	37	26	26	29	46	31	20	12	
Readmission (Emergency Re-admissions after Planned Surgery)																
	30 Day Rate		3.36%	3.35%	2.99%	3.12%	2.73%	3.01%	3.28%	2.96%	2.87%	2.66%	3.86%	3.29%		
	7 Day Rate		1.00%	1.27%	1.03%	1.42%	1.27%	1.28%	1.16%	1.15%	1.09%	1.06%	1.45%	1.05%	1.48%	
Cancelled Operations - Non Clinical - Cancellation Rate			1.40%	1.07%	0.95%	0.95%	0.95%	0.73%	1.86%	0.63%	1.40%	0.58%	0.60%	0.65%	0.67%	
Theatre Efficiency																
	Main Theatres		79.5%	78.9%	78.9%	76.7%	78.4%	78.4%	77.9%	77.2%	73.9%	74.5%	76.2%	78.5%	76.7%	
	TC Theatres		69.0%	74.2%	72.6%	75.6%	73.2%	73.4%	76.6%	73.5%	72.0%	69.4%	73.0%	73.5%	72.4%	
DNA (OP Efficiency)			5.29%	5.92%	5.83%	6.09%	5.74%	5.55%	5.72%	5.62%	5.95%	5.75%	5.42%	5.41%	0.00%	
Hospital Cancellation Rate (OP Efficiency)			6.72%	6.79%	6.80%	7.03%	7.27%	7.57%	7.65%	7.63%	8.27%	7.65%	7.83%	8.12%	7.92%	

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







Financial Performance: Income & Expenditure Position - Aggregated

	Month			Year to Date			Forecast	
	Plan Apr (£'000)	Actual Apr (£'000)	Variance Apr (£'000)	Plan April to Apr (£'000)	Actual April to Apr (£'000)	Variance April to Apr (£'000)	2019/20 (£'000)	Budget 2019/20 £'000
Operating								
Operating Income								
NHS Acute Activity Income								
Elective	943	826	-117	943	826	-117	11,526	11,526
Non-Elective	5,680	5,552	-128	5,680	5,552	-128	68,654	68,654
Maternity	1,034	1,034	0	1,034	1,034	0	13,430	13,430
Day cases	1,651	1,643	-8	1,651	1,643	-8	20,777	20,777
Outpatients	2,394	2,318	-76	2,394	2,318	-76	30,611	30,611
A&E	989	1,063	74	989	1,063	74	12,196	12,196
Other NHS	6,087	5,983	-104	6,087	5,983	-104	74,802	74,802
Total NHS Clinical Revenue	**18,778**	**18,419**	**-359**	**18,778**	**18,419**	**-359**	**231,996**	**231,996**
Other Operating Income	1,938	1,954	16	1,938	1,954	16	25,533	25,533
Inter-Trust Income	0	0	0	0	0	0	0	0
TOTAL OPERATING INCOME	**20,716**	**20,373**	**-343**	**20,716**	**20,373**	**-343**	**257,529**	**257,529**
Operating Expenses								
Employee Benefits Expenses (Pay)	-15,818	-15,745	74	-15,818	-15,745	74	-186,378	-186,378
Drugs	-1,449	-1,412	38	-1,449	-1,412	38	-17,392	-17,392
Clinical Supplies	-1,566	-1,474	92	-1,566	-1,474	92	-18,951	-18,951
Non Clinical Supplies	-303	-335	-32	-303	-335	-32	-3,658	-3,658
Other operating expenses	-2,734	-2,805	-71	-2,734	-2,805	-71	-32,037	-32,037
TOTAL OPERATING EXPENSES	**-21,870**	**-21,771**	**101**	**-21,871**	**-21,771**	**101**	**-258,415**	**-258,415**
EBITDA	**-1,155**	**-1,398**	**-243**	**-1,155**	**-1,398**	**-243**	**-886**	**-886**
Non Operating								
Non Operating Income								
Interest & Asset disposal	3	10	7	3	10	7	-541	-541
Non-Operating Expenses								
Depreciation & Finance Leases	-476	-436	40	-476	-436	40	-5,808	-5,808
PDC Dividend Expense	-166	-166	0	-166	-166	0	-1,989	-1,989
Adjusted Financial Performance surplus/(deficit)	**-1,793**	**-1,990**	**-196**	**-1,793**	**-1,990**	**-196**	**-9,224**	**-9,224**
Provider Sustainability Fund	484	484	0	484	484	0	7,535	7,535
Net Surplus/(deficit) before Exceptional Items	**-1,309**	**-1,506**	**-196**	**-1,309**	**-1,506**	**-196**	**-1,689**	**-1,689**
Donations for purchase of assets	38	18	-20	38	18	-20	216	216
Depreciation on Donated Assets	-23	-23	0	-23	-23	0	-276	-276
Adjustments	0	246	246	0	246	246	0	0
Net Surplus/(deficit) after Exceptional Items	**-1,294**	**-1,265**	**31**	**-1,294**	**-1,265**	**31**	**-1,749**	**-1,749**

The Trust delivered a balance of £1.5M (before exceptional items) against a budget deficit of £1.3M, giving a variance of £0.2M.

Commissioning is below plan by £0.3M, in part due to delays in projects (£76K), but also a level of underperformance against both planned activity (£0.2M), unplanned admissions (£0.1M) and high cost drugs.

Pay is better than plan, however nursing continues to show some challenges on the wards. This is offset by vacancies within medical pay, especially within diagnostics.

Drugs are underspent in relation to high cost drugs which are offset against contract income. Clinical Supplies are underspent as a result of the underperformance on the elective programme.

Other operating costs are overspent by £71K, within the month – there have been some higher than expected costs within radiology associated with the CT scanner replacement and also some additional reporting costs as a result of supporting the data validation associated with the data breech.

The Provider Sustainability Fund, and the Marginal Rate Emergency Threshold have been included within the month.

Within the month there have also been some one off accrual adjustments whcih are reflected within the adjustments line.

* EBITDA Total excludes Charitable Income

Financial Performance: Income & Expenditure Position - MCHFT

	Month			Year to Date			Forecast	Budget
	Plan Apr (£'000)	Actual Apr (£'000)	Variance Apr (£'000)	Plan April to Apr (£'000)	Actual April to Apr (£'000)	Variance April to Apr (£'000)	2019/20 (£'000)	2019/20 £'000
Operating								
Operating Income								
NHS Acute Activity Income								
Elective	943	826	-117	943	826	-117	11,526	11,526
Non-Elective	5,680	5,552	-128	5,680	5,552	-128	68,654	68,654
Maternity	1,034	1,034	0	1,034	1,034	0	13,430	13,430
Day cases	1,651	1,643	-8	1,651	1,643	-8	20,777	20,777
Outpatients	2,394	2,318	-76	2,394	2,318	-76	30,611	30,611
A&E	989	1,063	74	989	1,063	74	12,196	12,196
Other NHS	3,575	3,517	-58	3,575	3,517	-58	44,664	44,664
Total NHS Clinical Revenue	**16,266**	**15,953**	**-313**	**16,266**	**15,953**	**-313**	**201,858**	**201,858**
Other Operating Income	1,820	1,842	23	1,820	1,842	23	24,165	24,165
Inter-Trust Income	0	0	0	0	0	0	0	0
TOTAL OPERATING INCOME	**18,086**	**17,795**	**-290**	**18,086**	**17,795**	**-290**	**226,023**	**226,023**
Operating Expenses								
Employee Benefits Expenses (Pay)	-13,677	-13,733	-56	-13,677	-13,733	-56	-162,157	-162,157
Drugs	-1,447	-1,409	38	-1,447	-1,409	38	-17,360	-17,360
Clinical Supplies	-1,469	-1,377	92	-1,469	-1,377	92	-17,791	-17,791
Non Clinical Supplies	-218	-242	-24	-218	-242	-24	-2,644	-2,644
Other operating expenses	-2,373	-2,460	-87	-2,373	-2,460	-87	-27,726	-27,726
Inter-Trust Charges	63	56	-7	63	56	-7	755	755
TOTAL OPERATING EXPENSES	**-19,121**	**-19,165**	**-44**	**-19,121**	**-19,165**	**-44**	**-226,924**	**-226,924**
EBITDA	**-1,036**	**-1,370**	**-334**	**-1,036**	**-1,370**	**-334**	**-901**	**-901**
Non Operating								
Non Operating Income								
Interest & Asset disposal	3	10	7	3	10	7	-541	-541
Non-Operating Expenses								
Depreciation & Finance Leases	-475	-435	40	-475	-435	40	-5,801	-5,801
PDC Dividend Expense	-166	-166	0	-166	-166	0	-1,989	-1,989
Net Surplus/(deficit) before PSF/Exceptional Items	**-1,674**	**-1,961**	**-287**	**-1,674**	**-1,961**	**-287**	**-9,232**	**-9,232**
Provider Sustainability Fund	484	484	0	484	484	0	7,535	**7,535**
Net Surplus/(deficit) before Exceptional Items	**-1,190**	**-1,477**	**-287**	**-1,190**	**-1,477**	**-287**	**-1,697**	**-1,697**
Donations for purchase of assets	38	18	-20	38	18	-20	216	216
Depreciation on Donated Assets	-23	-23	0	-23	-23	0	-276	-276
Adjustments	0	246	246	0	246	246	0	0
Net Surplus/(deficit) after Exceptional Items	**-1,175**	**-1,236**	**-61**	**-1,175**	**-1,236**	**-61**	**-1,757**	**-1,757**

The Trust excluding Community Services, delivered a £1.5M deficit against a planned deficit of £1.2M - giving a £0.3M variance against plan cumulatively, excluding the impact of the provider sustainability fund (PSF).

Contract income is below plan by £0.3M, and relates to non-elective admissions, planned care and delays to the commencement of the FIT roll out.

Pay is worse than budget, with pressures on the nursing pay offset by medical vacancies.

Clinical supplies are better than budget as a result of the lower than budget activity levels.

Other Operating Expenses are £87K worse as a result of additional costs associated with the CT van and also additional reporting costs in April in relation to the Solitan data breech. Pathology costs are also showing a pressure in month 1, which is in line with the final quarter volumes from 1819.

There are some one adjustments to accruals that have impacted month 1, which have supported the month 1 position. Both the PSF and the MRET have been accrued into the position for April.

Financial Performance: Income & Expenditure Position - CCICP

	Month			Year to Date			Forecast	Budget
	Plan Apr (£'000)	Actual Apr (£'000)	Variance Apr (£'000)	Plan April to Apr (£'000)	Actual April to Apr (£'000)	Variance April to Apr (£'000)	2019/20 (£'000)	2019/20 £'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	2,512	2,466	-46	2,512	2,466	-46	30,138	30,138
Total NHS Clinical Revenue	**2,512**	**2,466**	**-46**	**2,512**	**2,466**	**-46**	**30,138**	**30,138**
Other Operating Income	118	112	-7	118	112	-7	1,368	1,368
Inter-Trust Income	0	0	0	0	0	0	0	0
TOTAL OPERATING INCOME	**2,630**	**2,578**	**-53**	**2,630**	**2,578**	**-53**	**31,506**	**31,506**
Operating Expenses								
Employee Benefits Expenses (Pay)	-2,141	-2,011	130	-2,141	-2,011	130	-24,221	-24,221
Drugs	-3	-3	0	-3	-3	0	-32	-32
Clinical Supplies	-97	-97	-1	-97	-97	-1	-1,159	-1,159
Non Clinical Supplies	-84	-93	-8	-84	-93	-8	-1,013	-1,013
Other operating expenses	-361	-345	17	-361	-345	17	-4,311	-4,311
Inter-Trust Charges	-63	-56	7	-63	-56	7	-755	-755
TOTAL OPERATING EXPENSES	**-2,749**	**-2,606**	**144**	**-2,749**	**-2,606**	**144**	**-31,492**	**-31,492**
EBITDA	**-119**	**-28**	**91**	**-119**	**-28**	**91**	**14**	**14**
Non Operating								
Non Operating Income								
Interest & Asset disposal	0	0	0	0	0	0	0	0
Non-Operating Expenses								
Depreciation & Finance Leases	-1	-1	0	-1	-1	0	-7	-7
PDC Dividend Expense	0	0	0	0	0	0	0	0
Adjusted Financial Performance surplus/(deficit)	**-119**	**-28**	**91**	**-119**	**-28**	**91**	**7**	**7**
Provider Sustainability Fund	0	0	0	0	0	0	0	**0**
Net Surplus/(deficit) before Exceptional Items	**-119**	**-28**	**91**	**-119**	**-28**	**91**	**7**	**7**
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	**-119**	**-28**	**91**	**-119**	**-28**	**91**	**7**	**7**

Community Services delivered a £0.91M surplus against the planned position.

Contract income is below plan (£46K), with the final part of 1920 investments expected to be approved in June. Other operating income is in line with the plan.

Pay is £130K better than plan, partly as an offset against contract income relating to delayed investments – but also with underlying vacancies, with some levels of slippage not expected to continue throughout the year.

Inter-trust recharges reflect the 1920 proposed charges agreed at the partnership board.

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	(1)	(89)	(51)	(5)	(1)	(94)	(53)
Endoscopy	Endoscopy	468	0	(52)	(173)	(5)	(55)	19	240	(38)
General Surgery Directorate	General Surgery	1,579	4	0	(807)	14	(185)	(22)	591	(8)
Head & Neck Directorate	Head & Neck	454	32	(1)	(229)	1	(58)	15	198	15
Macmillan Cancer Centre	Macmillan Cancer Centre	58	197	42	(96)	6	(175)	(8)	(16)	39
Ophthalmology	Ophthalmology	963	9	5	(359)	22	(360)	(27)	254	0
Orthopaedic Directorate	Orthopaedics	1,577	(2)	14	(608)	(20)	(263)	21	704	14
Theatres & TC	Theatres & TC	0	35	4	(672)	(1)	(183)	(29)	(820)	(26)
Urology Directorate	Urology	420	0	(95)	(244)	27	(61)	(3)	115	(71)
Bowel Cancer Screening Prog	Bowel Cancer Screening Prog	60	0	60	(62)	8	(36)	41	(37)	110
Surgical and Cancer Division	**Surgery & Cancer**	**5,579**	**275**	**(26)**	**(3,339)**	**2**	**(1,381)**	**5**	**1,135**	**(19)**

The division is £19K worse than plan for April. Contract income is below plan by £46K, with the division below activity on planned care (£114K) - which is partly offset by an over performance of non-elective activity (£85K). Other income is above plan by £20k, and relates to an over-performance on recharges to other providers in relation to drugs. Pay whilst balanced, has an overspend on both nursing (£11K) and Medical (£10K) – offset by a below budget spend on admin & clerical and HCAs (£23K). Non pay is below budget pre-dominantly as a result of the lower activity volumes. Within the CIP programme for the division, there has been a delay to the out of area work, which will have impacted the income target by £21K within the month.

		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	4	4	(206)	73	(9)	(4)	(211)	74
Accident & Emergency Dir	Emergency Department	1,661	58	80	(590)	(19)	(63)	(7)	1,066	55
Anaesthetics & Critical Care	Anaesthetics & Critical Care	568	1	12	(745)	(11)	(81)	11	(257)	11
Medical Directorate	General Medicine	3,808	11	(243)	(2,220)	(242)	(352)	4	1,248	(481)
Urgent Care Centre	Urgent Care Centre	0	0	0	(58)	3	0	6	(58)	9
Emergency Services Division	**Medicine & Emergency Care**	**6,036**	**74**	**(146)**	**(3,818)**	**(195)**	**(504)**	**10**	**1,788**	**(331)**

The Medicine and Emergency Care Division are £0.3M worse than plan. Contract income is below budget by £137K – with an over-performance within A&E (£74K), offset by an underperformance on non-elective activity & adult critical care (£143K) and planned care (£60K). Nursing pay is £153K overspent – however ward 19 funding is yet to be allocated to the division, which would equate to £100K of this overspend. Medical pay is also overspent by £26K, with key areas being with A&E and Anaesthetics – with some high cost locums within the medical specialties also contributing. The division is due to be allocated a share of the nursing CIPs in relation to sickness/improving vacancies.

		Income			Expenditure				NET TOTAL	
		Contract	Variable	Better/ (Worse) than Budget	Pay	Better/ (Worse) than Budget	Non-Pay	Better/ (Worse) than Budget	Total	Better/ (Worse) than Budget
Wom Chil & sexl hlth Div Magmn	Divisional Mangement W&C	0	0	0	(114)	4	(6)	6	(120)	10
Gum clinic	Gum clinic	0	0	0	0	0	0	0	0	0
Obstetric & Gynaecology Dir	Obstetrics & Gynaecology	1,376	3	(12)	(776)	18	(115)	(15)	488	(9)
Paediatric Directorate	Paediatrics	1,065	1	35	(715)	(17)	(80)	3	272	22
Women and Childrens Division	**Women and Children**	**2,442**	**4**	**23**	**(1,604)**	**5**	**(202)**	**(6)**	**639**	**22**

The Women's and Children's Division is £22K better than plan. Contract income is £33K better than budget, largely as a result of above plan non elective activity (£54K) within Paediatrics and Gynae, and Paediatric audiology outpatients, offset by planned activity within the Gynae and Paediatrics (£41K). Pay is on plan, however the division is using agency locums within Paediatrics covering vacancies. The division has also recently agreed to use the Hewitt centre to support the IVF service, as a result of a vacancy – so it is expected that there will be some pressure in relation to this.

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	(28)	4	(1)	(9)	(30)	(5)
Dermatology	Dermatology	154	2	(11)	(80)	20	(33)	(5)	43	4
ECG department	ECG	36	2	(7)	(94)	7	(6)	2	(61)	2
Elmhurst	Elmhurst	172	14	0	(143)	(3)	(15)	0	29	(4)
Integrated Discharge	Integrated Discharge	0	0	0	(29)	(2)	0	0	(29)	(1)
Medical Records Department	Medical Records Department	0	0	0	(161)	8	(22)	(3)	(183)	4
Outpatients	Outpatients	0	13	(1)	(47)	5	(5)	0	(39)	3
Pathology Directorate	Pathology	1,055	337	69	(884)	48	(788)	(41)	(279)	77
Pharmacy Departments	Pharmacy	251	23	(42)	(320)	(9)	(189)	122	(235)	70
Radiology Directorate	Radiology	320	37	10	(588)	39	(271)	(45)	(501)	3
Therapeutic Departments	Therapies	0	0	0	(202)	(3)	(3)	4	(204)	1
Victoria Infirmary Northwich	Victoria Infirmary Northwich	170	0	(7)	(161)	(6)	(24)	1	(14)	(12)
Diagnostics and Support Divisi	**Diagnostics and Support**	**2,159**	**430**	**11**	**(2,736)**	**108**	**(1,356)**	**25**	**(1,503)**	**143**

TThe Diagnostics Division is £143K better than plan in April. Contract income is balanced, and other income is above plan in relation to additional income against plan for ECT. Pay is better than budget largely due to medical vacancies (Dermatology, Pathology and Radiology). For Pathology these costs are offset against the non-pay overspends, and Dermatology are expecting to utilise the funding with SHS to deliver additional capacity. Radiology is overspent as a result of higher than expected costs for the CT mobile unit, which is expected to continue into May and potentially June.

		Income			Expenditure				NET TOTAL	
		Contract	Variable	Better/ (Worse) than Budget	Pay	Better/ (Worse) than Budget	Non-Pay	Better/ (Worse) than Budget	Total	Better/ (Worse) than Budget
Estates & Facilities Div Mgnt	Divisional Management E&F	0	5	5	(47)	(3)	(4)	10	(46)	11
Catering Directorate	Catering	0	130	19	(152)	0	(118)	(8)	(139)	11
Estates Departments	Estates Departments	0	41	1	(147)	18	(560)	(2)	(667)	17
Hotel Services	Domestics	0	0	0	(118)	7	(1)	0	(119)	7
Laundry Services Departments	Laundry	0	93	3	(100)	2	(79)	(11)	(86)	(6)
Security	Security	0	149	8	(65)	5	(65)	(6)	18	6
Site Services	Porters	0	0	0	(258)	8	(6)	0	(264)	9
Estates & Facilities Division	**Estates & Facilities Division**	**0**	**417**	**36**	**(887)**	**37**	**(832)**	**(17)**	**(1,302)**	**56**

The Estates and Facilities Division is £56K better than plan. Other income is better than plan as a result of increased takings within car parking. Within non pay there are additional costs associated with car park barrier repairs, increased cost of provisions within catering, and purchases of non-disposable bedding.

		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	2	2	(137)	(2)	(44)	8	(179)	8
Computer Services	Computer Services	0	6	3	(131)	9	(264)	6	(388)	18
Finance & Information	Finance & Information	0	6	4	(276)	9	(66)	(6)	(335)	6
Human Resources	Human Resources	0	52	12	(218)	29	(39)	12	(205)	53
Risk Manangement & R&D	Risk Management & R&D	0	32	(13)	(143)	2	(4)	4	(115)	(7)
Quality Assurance Departments	Nurse Management	0	(1)	(18)	(244)	(5)	(740)	2	(984)	(21)
Trust Central Expenditure	Trust Central Expenditure	219	475	(273)	(173)	(50)	199	211	719	(112)
Other Departments	Other Departments	2	87	74	(26)	(4)	(11)	12	52	82
	Corporate	**220**	**660**	**(209)**	**(1,349)**	**(13)**	**(967)**	**249**	**(1,435)**	**26**

The Corporate Division is £26K better than budget – however there are a number of CIPs that need to allocated to the divisions, such as the NHS supply chain non-pay savings and nursing, and the unallocated CIP. The impact of the blended payment on non-elective income (£138K) is held centrally in month 1, which will be due to be allocated to the divisions.

Community Services		**2,466**	**112**	**(52)**	**(2,011)**	**130**	**(538)**	**7**	**29**	**85**
EBITDA		**18,903**	**1,972**	**(363)**	**(15,745)**	**74**	**(5,780)**	**273**	**(649)**	**(16)**

Financial Performance: Commissioner Income Analysis

Commissioner	FY Target (£'000)	YTD Target (£'000)	CEP Adjustmt	Final Actual (£'000)	Final Variance (£'000)
NHS Eastern Cheshire CCG	8,409	674	0	666	-8
NHS Eastern Cheshire CCG Community	423	35	0	35	0
NHS South Cheshire CCG Community	18,156	1,513	0	1,486	-27
NHS South Cheshire CCG	107,294	8,650	0	8,649	-1
NHS Vale Royal CCG	60,957	4,912	0	4,831	-81
NHS Vale Royal CCG Community	11,065	922	0	904	-18
NHS Warrington CCG	338	27	0	32	4
NHS West Cheshire CCG	3,803	310	0	238	-72
NHS West Cheshire CCG Community	215	18	0	18	0
NHS North Staffordshire CCG	2,763	222	0	148	-75
NHS Shropshire CCG	788	63	0	72	8
NHS Stoke on Trent CCG	1,805	145	0	102	-43
Public Health England	1,196	95	0	107	12
NHS Commissioning Board	2,125	177	0	141	-36
Specialist Commissioning Group	8,688	691	0	713	22
Non Contract Activity	2,202	179	0	183	4
Cross Border Flows (non Betsi)	117	9	0	2	-8
Betsi	294	24	0	8	-16
Non-Commissioner Specific	8,892	595	0	570	-25
TOTAL	**239,531**	**19,262**	**0**	**18,903**	**-359**

Contract income is below plan for the host commissioners, with the under-performance resting with Vale Royal CCG.

Other associate contracts are below plans, with Stoke/North Staffs/West Cheshire significantly down – which is a step change from the 1819 performance, and trend over the final quarter of last year. This follows a change in GP referral pattern beginning in February 2019.

Specialist Commissioning is over-performing as a result of the continued use of 3rd party suppliers for aseptic products. Both Community and the NHS commissioning board are below plan as a result in delays in project commencement (CCICP investments and roll out of the FIT programme), which are offset against pay savings.

Cross border flows includes Welsh commissioners where the Trust has a CIP of £0.25M to undertake planned activity – as the dispute over the rate to be paid for activity for Welsh health boards has now been concluded, the Trust has re-started the discussion over volumes that the Trust can complete here.

Other Contract Income	FY Target (£'000)	YTD Target (£'000)	YTD Actual (£'000)	Final Variance (£'000)
Bed Based Services	6,048	504	516	12
Adult & Neonatal Critical Care	8,719	702	670	-32
Urgent Care Centre	0	0	0	0
Community Paediatrics	1,350	113	113	0
Direct Access Services	9,548	750	763	12
Unbundled Radiology	2,942	231	272	41
High Cost Drugs	10,589	882	859	-24
Screening Programmes	1,593	133	133	0
Audiology	1,086	90	82	-9
IVF	199	17	21	5
CQUIN	2,321	193	192	-1
Provider Sustainability Fund	0	0	0	0
Community Services	28,225	2,352	2,352	0
Capped Expenditure Programme	0	0	0	0
Winter funding	750	0	0	0
Marginal Rate Emergency Threshold	0	0	0	0
Other	9,766	472	363	-108
TOTAL	**83,136**	**6,439**	**6,336**	**-104**

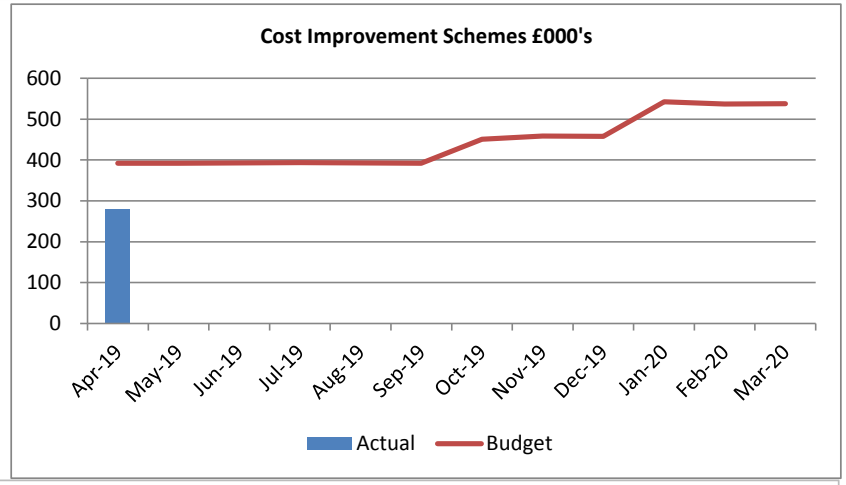
Other contract income is worse by £0.1M than plan.

Both the PSF, which relates to meeting the financial target and the MRET, the removal of the marginal rate emergency tariff have been met within the month.

Diagnostics are showing an over-performance against the plan, which offset an underperformance of critical care and IVF, and other – which relates to the CCICP/FIT delayed programmes.

Financial Performance: Efficiencies

Cost Improvement Schemes (£'000's)						
Scheme Category	**YTD Target**	**YTD Actual**	**YTD**	**FY Target**	**FY Forecast**	**FY Variance**
Commercial	34	34	0	468	468	0
Drugs	25	25	0	300	300	0
Medical Workforce	0	0	0	146	146	0
Nursing Workforce	33	0	-33	800	800	0
Other Worforce	91	91	0	1,089	1,089	0
Non Pay efficiencies	16	5	-11	189	189	0
Procurement	156	125	-31	1,825	1,825	0
Theatres Efficiency	0	0	0	0	0	0
Service redesign	0	0	0	0	0	0
Market Share	23	0	-23	525	525	0
Total (£'000)	**378**	**280**	**-98**	**5,342**	**5,342**	**0**



The CIP achievement has been £294K within the month. Key CIPs that are under performing are nursing (£33K), delay to part of the NHS supply chain savings (£31K) and plans to expand out of area work (£23K). Discussions have re-commenced with Wales about taking planned activity, and the NHS supply chain reports indicate that the savings are expected in the latter part of the year.

Financial Performance: Capital Report

SCHEME	BOARD APPROVED	FUNDING SOURCE	FUNDING APPROVED	EXPENDITURE BROUGHT FORWARD	2019/20 ANNUAL BUDGET	2019/20 CUMULATIVE BUDGET TO DATE	2019/20 CUMULATIVE ACTUAL	2019/20 BETTER/WORSE THAN BUDGET	2019/20 FORECAST	2019/20 + FORECAST	WHOLE PROJECT ACTUAL TO DATE	WHOLE PROJECT PROPOSED PLAN	TOTAL FORECAST
STRATEGIC INVESTMENTS (Requires individual signoff)													
ESTATES													
3RD CT ENABLING	Yes	Internal	Yes		1000	0	0	0	1000	0	0	1,000	1,000
A&E BUILD										13000	0	13,000	13,000
ACCESS CONTROL	Yes	Internal	Yes		170	0	0	0	170	0	0	170	170
CAR PARK LAND *	Yes	Loan	Yes	62	338	0	0	0	338		62	400	400
CARDIO RESPIRATORY 3 CLINICAL ROOMS					100	0	0	0	100		0	100	100
CHLORINE DIOXIDE GENERATORS					12	0	0	0	12		0	12	12
DEMENTIA APPEAL	No	Donated	Not yet approved					0		1500	0	1,500	1,500
ENDOSCOPY WASHER BUILD *	No	Loan	Not yet approved					0		270	0	270	270
EPR PROJECT ACCOMODATION *	Yes	Internal	Not yet approved		350	0	0	0	350		0	350	350
ICU CONVERSION *					1200	0	0	0	1200		0	1,200	1,200
MRI SCANNER 3RD BUILD	Yes	Internal/Loan	Yes	182	933	78	127	-49	933		309	1,115	1,115
PATHOLOGY RISKS	Yes	Internal	Yes	83	17	0	0	0	17		83	100	100
PHARMACY ROBOT ENABLING					200	0	0	0	200		0	200	200
SSD ENABLING *	Yes	Loan	Yes		668	0	4	-4	668		4	668	668
TURNKEY FOR REPLACEMENT CT SCANNERS	No	Internal	Yes	38	127	0	46	-46	127		84	165	165
TURNKEY OPTIMA SCANNER					135	0	0	0	135		0	135	135
UNDER / OVERS CAPITAL SCHEMES 18/19	Yes	Internal	Yes		0	0	5	-5	0		5	0	0
VIN JAG COMPLIANT					44	0	0	0	44		0	44	44
WARD REFURBISHMENT	Yes	Loan	Yes	343	1257	150	5	145	1257	10250	348	11,850	11,850
WASTE COMPOUND AND SEGREGATION	Yes	Internal	Yes							350	0	350	350
TOTAL				**708**	**6551**	**228**	**187**	**41**	**6551**	**25370**	**895**	**32629**	**32629**
IT													
CORE INFRASTRUCTURE UPGRADE	yes	PDC	Yes		291	24	137	-113	291	180	137	471	471
CYBER SECURITY	Yes	PDC	Yes					0			0	0	0
HIGH IMPACT STAND ALONE IT SYSTEMS	Yes	Internal	Yes	35	77	0	0	0	77	400	35	512	512
NET CALL / CALL CENTRE	Yes	Internal	Yes							80	0	80	80
REPLACEMENT BUSINESS INTELLIGANCE SYSTEM	Yes	Internal	Yes	93	28	7	10	-3	28		103	121	121
SEQUEL / WINDOWS LICENCES	Yes	Internal	Yes		100	0	0	0	100	200	0	300	300
UNDER / OVERS CAPITAL SCHEMES 18/19	Yes	Internal	Yes		0	0	0	0	0		0	0	0
UPS	Yes	Internal	Yes		250	0	0	0	250		0	250	250
VENDOR NEUTRAL ARCHIVE								0		350	0	350	350
VIRTUAL CLINICS	Yes	Internal	Yes		45	4	4	0	45		4	45	45
VIRTUAL DESKTOP	No	Internal	Yes					0		400	0	400	400
VOICE OVER IP	Yes	Internal	Yes		30	0	0	0	30	395	0	425	425
VPN	Yes	PDC	Yes		70	0	0	0	70		0	70	70
SYSTEM REFRESH / REPLACEMENT													
BADGERNET	Yes	Internal	Yes							45	0	45	45
BLOOD TRACKING SYSTEM	No	Internal	Yes		140	0	0	0	140		0	140	140
CARDIO RESPIRATORY SYSTEM	No	Internal	Yes					0		350	0	350	350
CHEMOCARE	yes	Internal	Yes		85	0	0	0	85		0	85	85
DOCMAN	Yes	Internal	Yes		52	0	0	0	52		0	52	52
EPMA *					1500	0	0	0	1500		0	1,500	1,500
EPR					500	0	0	0	500	750	0	1,250	1,250
EPR IMPLEMENTATION COSTS										3200	0	3,200	3,200
LABCENTRE UPGRADE					800	0	0	0	800		0	800	800
PHARMACY ASCRIBE	No	Internal	Yes							200	0	200	200
SOLITON REPLACEMENT RIS										350	0	350	350
STAFF WIFI	No	Internal	Yes							100	0	100	100
TOTAL				**128**	**3968**	**35**	**151**	**-116**	**3968**	**7000**	**279**	**10996**	**10996**
TOTAL STRATEGIC INVESTMENTS				**836**	**10519**	**263**	**338**	**-75**	**10519**	**32370**	**1174**	**43,625**	**43,625**

Financial Performance: Capital Report

SCHEME	BOARD APPROVED	FUNDING SOURCE	FUNDING APPROVED	EXPENDITURE BROUGHT FORWARD	2019/20 ANNUAL BUDGET	2019/20 CUMULATIVE BUDGET TO DATE	2019/20 CUMULATIVE ACTUAL	2019/20 BETTER/WORSE THAN BUDGET	2019/20 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		342	28	4	24	342	800	4	1,142	1,142
BACKLOG GENERAL PROVISION	Yes	Internal/Loan	Yes		1626	135	127	8	1,626	8600	127	10,226	10,226
CT / VT - HEATING INFRASTRUCTURE	Yes	Internal	Yes		209	0	0	0	209	1100	0	1,309	1,309
DESIGN TEAM	Yes	Internal	Yes		313	26	23	3	313	1252	23	1,565	1,565
TOTAL				**0**	**2,490**	**189**	**155**	**34**	**2,490**	**11,752**	**155**	**14,242**	**14,242**
IT													
INTERFACING	Yes	Internal	Yes		40	3	0	3	40	440	0	480	480
IT APPLICATIONS	Yes	Internal	Yes		50	4	0	4	50	500	0	550	550
TOTAL				**0**	**90**	**7**	**0**	**7**	**90**	**940**	**0**	**1,030**	**1,030**
TOTAL ROLLING ALLOCATIONS				**0**	**2,580**	**196**	**155**	**41**	**2,580**	**12,692**	**155**	**15,272**	**15,272**
ADDITIONAL													
EQUIPMENT	Yes	Internal	Yes		0	0	0	0	0		0	0	0
ACQUISITION OF SCPH					1000	0	0	0	1000		0	1,000	1,000
COMMUNITY SERVICES	Yes	Internal	Yes		500	0	0	0	500		0	500	500
GP STREAMING IT FRONT OF HOUSE	Yes	PDC	Yes	108	142	12	0	12	142		108	250	250
ORDER COMMS					106	0	0	0	106				
SCPH ENABLING					400	0	0	0	400		0	400	400
LEASING INVESTMENTS													
3RD CT SCANNER	No	Internal	Yes		1159	0	0	0	1159		0	1,159	1,159
3RD MRI SCANNER	Yes	Internal	Yes		406	0	0	0	406		0	406	406
EQUIPMENT	Yes	Internal	Yes		2748	88	0	88	2748		0	2,748	2,748
LAUNDRY EQUIPMENT					566	0	0	0	566		0	566	566
MRI SCANNER DONATED								0		850	0	850	850
PORTABLE X-RAY MACHINE *3								0		360	0	360	360
REPLACEMENT CT SCANNER *2	No	Internal	Yes		916	0	0	0	916	406	0	1,322	1,322
ROOM 2 X-RAY	No	Internal	Not yet approved		500	0	0	0	500		0	500	500
SSD WASHERS	No	Internal	Yes		0	0	0	0	0		0	0	0
TOTAL LEASING INVESTMENTS				**0**	**6295**	**88**	**0**	**88**	**6295**	**1616**	**0**	**7911**	**7911**
TOTAL CAPITAL PROGRAMME (EXCLUDING LEASES)				**944**	**15,247**	**471**	**493**	**-22**	**15,247**	**45,062**	**1,437**	**61,047**	**61,047**
TOTAL CAPTIAL PROGRAMME				**944**	**21,542**	**559**	**493**	**66**	**21,542**	**46,678**	**1,437**	**68,958**	**68,958**

Financial Performance: Statement of Financial Position

	Plan Apr to Apr (£'000)	Actual Apr to Apr (£'000)	Variance (£'000)	Forecast 2019/20 (£'000)
Assets				
Assets, Non-Current	**92,947**	**92,953**	**6**	**92,953**
Assets, Current				
Trade and other Receivables	9,254	11,345	2,091	11,345
Other Assets (including Inventories & Prepayments)	5,863	6,287	424	6,287
Cash and Cash Equivalents	9,635	7,684	-1,951	7,684
Total Assets, Current	**24,752**	**25,316**	**564**	**25,316**
ASSETS, TOTAL	**117,699**	**118,269**	**570**	**118,269**
Liabilities				
Liabilities, Current				
Finance Lease, Current	-1,142	-1,474	-332	-1,474
Loans Commercial Current	-5,622	-5,598	24	-5,598
Trade and Other Payables, Current	-12,014	-12,278	-264	-12,278
Provisions, Current	-325	-335	-10	-335
Other Financial Liabilities	-7,873	-8,221	-348	-8,221
Total Liabilities, Current	**-26,976**	**-27,905**	**-929**	**-27,905**
Net Current Assets/(Liabilities)	**-2,224**	**-2,589**	**-365**	**-2,589**
Liabilities, Non Current				
Finance Lease, Non Current	-3,562	-3,182	380	-3,182
Loans Commercial Non-Current	-8,049	-8,049	0	-8,049
Provisions, Non-Current	-1,423	-1,423	0	-1,423
Trade and Other Payables, Non-Current	0	0	0	**0**
Total Liabilities Non-Current	**-13,034**	**-12,654**	**380**	**-12,654**
TOTAL ASSETS EMPLOYED	**77,689**	**77,709**	**20**	**77,709**
Taxpayers' and Others' Equity				
Taxpayers Equity				
Public dividend capital	77,508	77,508	0	77,508
Retained Earnings	-13,233	-13,221	12	-13,221
Donated asset reserve	0	0	0	0
Revaluation Reserve	13,414	13,422	8	13,422
TOTAL TAXPAYERS EQUITY	**77,689**	**77,709**	**20**	**77,709**
TOTAL FUNDS EMPLOYED	**77,689**	**77,709**	**20**	**77,709**

Trade and other Receivables
NHS Trade Receivables are higher than anticipated which is mainly due to the East Cheshire CCG £0.7M (paid in May), North Staffordshire CCG £0.2M Paid early May), Stoke on Trent CCG £0.2M (Paid early May) not paying the month 1 contract invoices. The remainder relates to Health Education Invoice £0.6M April invoice not being paid until May.

Other Assets
This is lhigher than anticipated due to Operating leases prepayed earlier than anticipated .

Finance Lease Current
This mainly due to a delay in the payment in finance leases.

Other Financial Liabilities
This is mainly due to accruals being higher due to a large accrual for utilities and an accrual for the April Beckman Manage Service Contract.

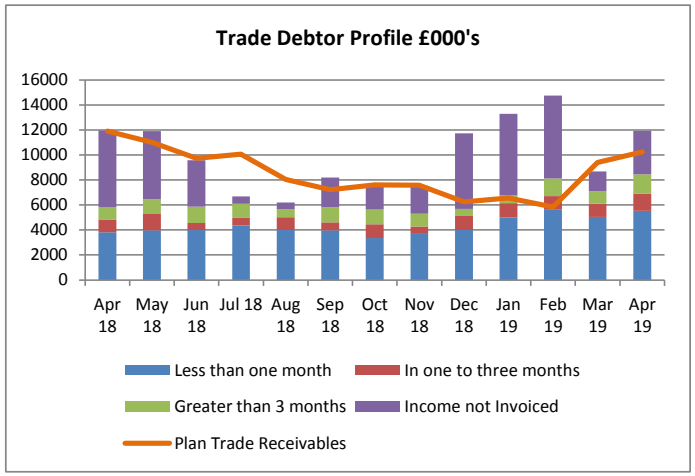
Finance Lease Non- Current
This due to the delay in the replacement of finance leases.

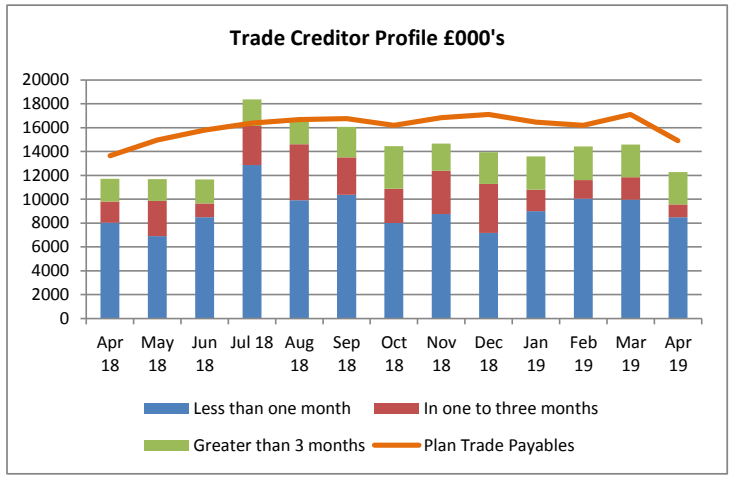
Loans Commercial Non-Current
This is due to the delay in the drawing down of an approved loan for the ward refurbishments, Backlog Maintenance and the replacment SSD Washers. In addition the working capital loan has moved to loans current..

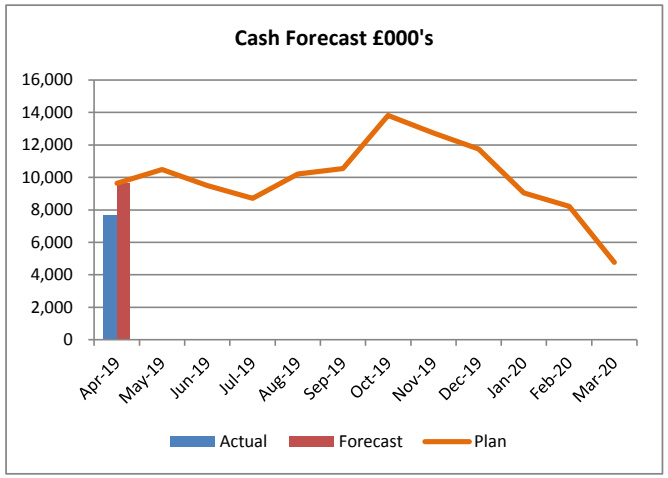
Financial Performance: Cash Position and Working Capital

	Plan Apr to Apr (£'000)	Actual Apr to Apr (£'000)	Variance
Surplus/(deficit) after tax	**-1,278**	**-1,263**	**15**
Non-cash flows in operating Surplus/(deficit) total	534	452	-82
Operating cash flows before movements in working capital	**-744**	**-811**	**-67**
Increase/(Decrease) in working capital Total	-371	-1,920	-1,549
Net cash inflow/(outflow) from operating activities	**-1,115**	**-2,731**	**-1,616**
Net cash inflow/(outflow) from investing activities total	-355	-723	-368
Net Cash inflow/(outflow) before financing	**-1,470**	**-3,454**	**-1,984**
Net cash inflow/(outflow) from financing activities Total	-144	-110	17
Net increase/(decrease) in cash and cash equivalents	**-1,614**	**-3,564**	**-1,967**
Opening cash balance	**11,249**	**11,249**	**0**
Closing cash balance	**9,635**	**7,685**	**-1,950**

Cash is £1.95M less than anticipated. It is mainly due to East Cheshire CCG £0.7M (paid in May), North Staffordshire CCG £0.2M Paid early May), Stoke on Trent CCG £0.2M (Paid early May) not paying the month 1 contract invoices. The remainder relates to Health Education Invoice £0.6M April invoice not being paid until May.







Finance: *Staff Costs*

Headline Measures

	YTD £000's	Rolling 13 months £000's													
		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	Monthly Trend
Pay Budget	15,818	14,001	14,112	14,008	14,158	14,900	14,225	14,325	14,219	14,361	14,616	14,424	14,642	15,818	
Pay Actual	15,744	14,094	14,152	14,237	14,183	14,960	14,639	14,820	14,682	15,094	14,902	14,875	14,859	15,744	
Variance	74	-93	-40	-229	-25	-60	-414	-495	-463	-733	-286	-451	-217	74	
% to Budget	*99.5%*	*100.7%*	*100.3%*	*101.6%*	*100.2%*	*100.4%*	*102.9%*	*103.5%*	*103.3%*	*105.1%*	*102.0%*	*103.1%*	*101.5%*	*99.5%*	
Nursing Staff % to Budget	102.7%	101.7%	99.9%	102.1%	99.9%	102.8%	102.2%	103.5%	106.0%	104.8%	100.5%	101.9%	102.8%	102.7%	
Medical Staff % to Budget	95.3%	95.4%	100.5%	99.2%	97.3%	92.0%	104.2%	107.2%	100.0%	108.7%	102.3%	105.6%	107.6%	95.3%	
Other Staff % to Budget	98.8%	102.9%	100.6%	102.7%	101.6%	102.0%	102.0%	100.3%	101.4%	102.0%	102.9%	103.0%	101.9%	98.8%	

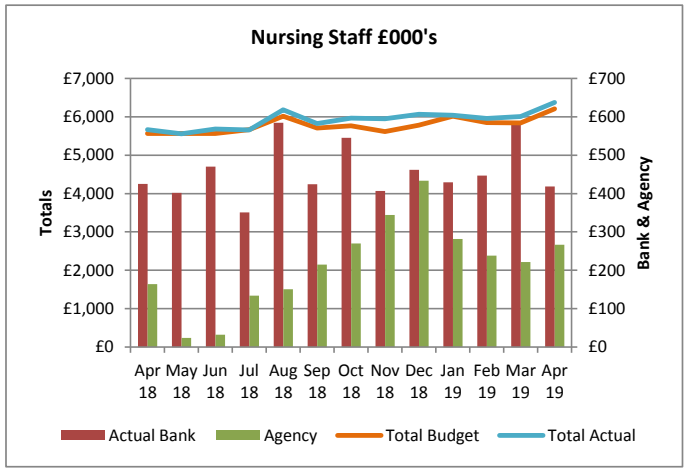
Commentary

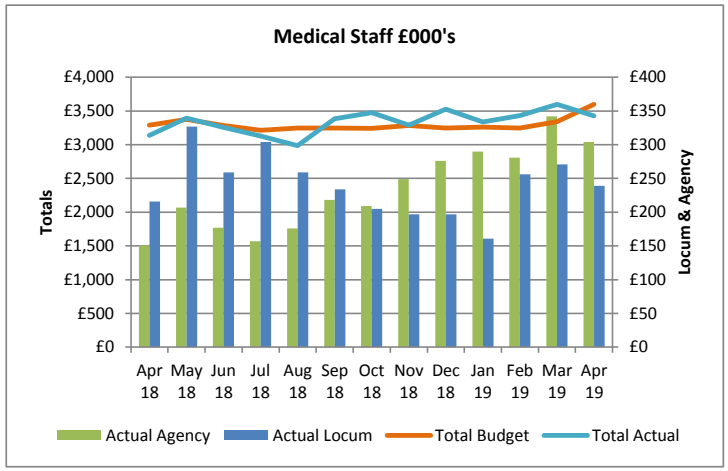
Pay is better than budget by £74K in April.

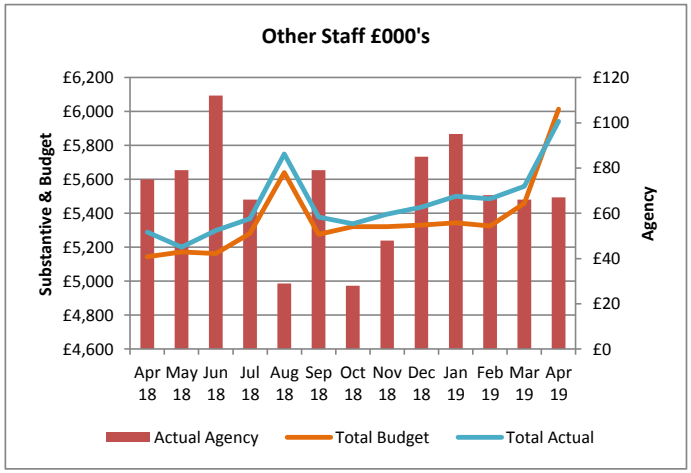
Nursing costs are overspent within the Trust, partly as a result of the remaining CIPs left to be allocated, however there remain some underlying pressures particularly within the medical wards. Medical pay is underspent particularly within the diagnostics areas, which are offset against Medical and Surgical specialties.

The NHSI agency ceiling has reduced to £5.7M for the Trust for 2019/20, down from £6.2M

Primary Drivers

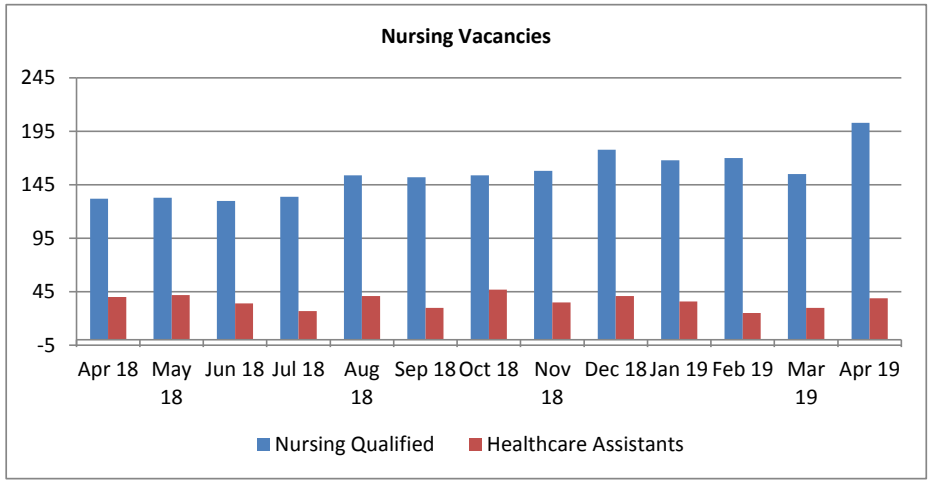






Finance: *Staff Costs*

Secondary Drivers



Medical vacancies under review

Agency Trajectory

	YTD	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	Monthly Trend
Plan	-403	-539	-572	-561	-515	-563	-525	-495	-477	-506	-495	-470	-484	-403	
Actual	-638	-638	-416	-570	-611	-568	-540	-699	-721	-572	-668	-618	-574	-638	
Variance	-235	-99	156	-9	-96	-5	-15	-204	-244	-66	-173	-148	-90	-235	
MCHFT Actual	-530	-523	-217	-525	-542	-518	-492	-645	-676	-408	-459	-379	-370	-530	
CCICP Actual	-108	0	-79	-45	-69	-50	-48	-54	-45	-87	-104	-134	-99	-108	
Planned Winter Escalations	0	-115	-120	0	0	0	0	0	0	-77	-105	-105	-105	0	

	Rolling 13 Months													
	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	Monthly Trend
Sickness Rate (Rolling 12 mths)	4.38%	4.37%	4.30%	4.29%	4.27%	4.27%	4.26%	4.24%	4.30%	4.27%	4.32%	4.33%	4.37%	
Sickness FTE	146.64	143.13	137.51	150.24	157.85	161.00	163.87	170.79	197.97	209.20	192.17	171.32	169.20	
Total Leavers	39	41	38	38	63	48	34	34	23	25	21	37	35	
Turnover (Rolling 12 mths)	11.33%	11.28%	11.33%	11.17%	11.67%	11.54%	11.25%	11.03%	10.89%	10.60%	10.03%	9.94%	9.90%	

Title of Paper:	Learning from Deaths Quarterly Report (Q4 2018/19)	
Author:	Interim Associate Director - Quality Governance	
Executive Lead:	Interim Medical Director	
Type of Report:	Concept Paper	
	Strategic Options Paper	
	Business Case	
	Information	
	Review/Benefits/Audit	✓

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

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

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

To be published on Trust Website – complete version	***Yes***
If no, to be published on Trust Website – redacted	
If not to be published complete or redacted, please detail the reason why	
Presented at Board Meeting of:	3 June 2019

Learning from Deaths Quarterly Report Q4 2018/19

April 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 seventh iteration of our Learning from Deaths Report covering Quarter 4 of 2018/19.

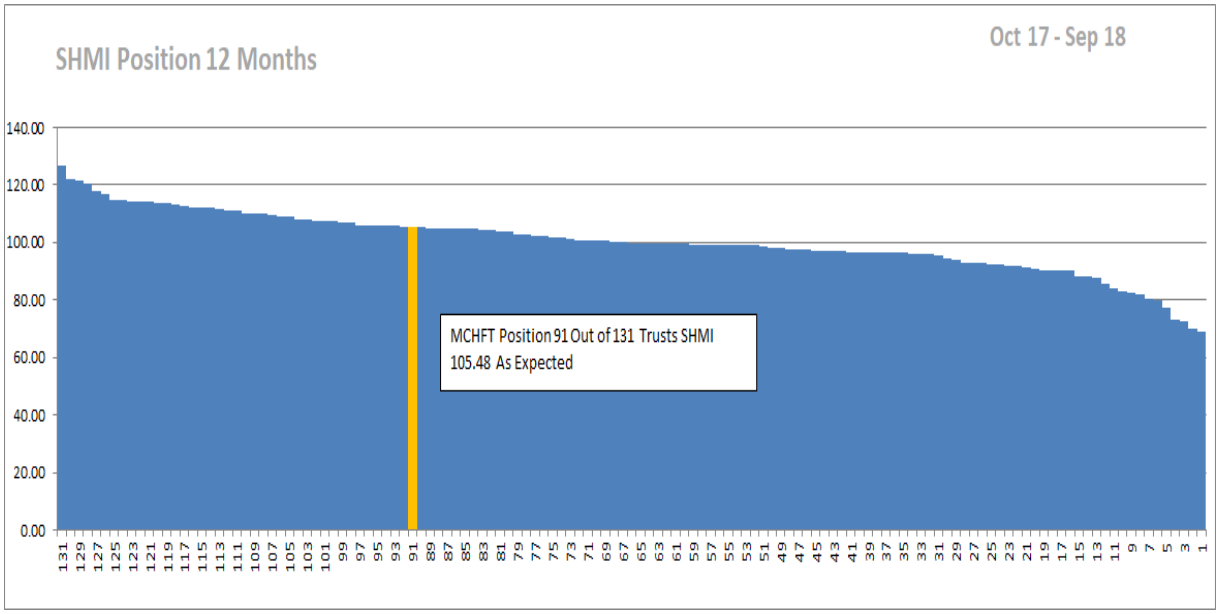
The report aims to provide assurance on how the organisation, through the work of the Hospital Mortality Reduction Group (HMRG) and other linking groups, is triangulating data and information to embed the learning from in-patient deaths, with the goal of seeing a sustained reduction in the Trust's mortality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

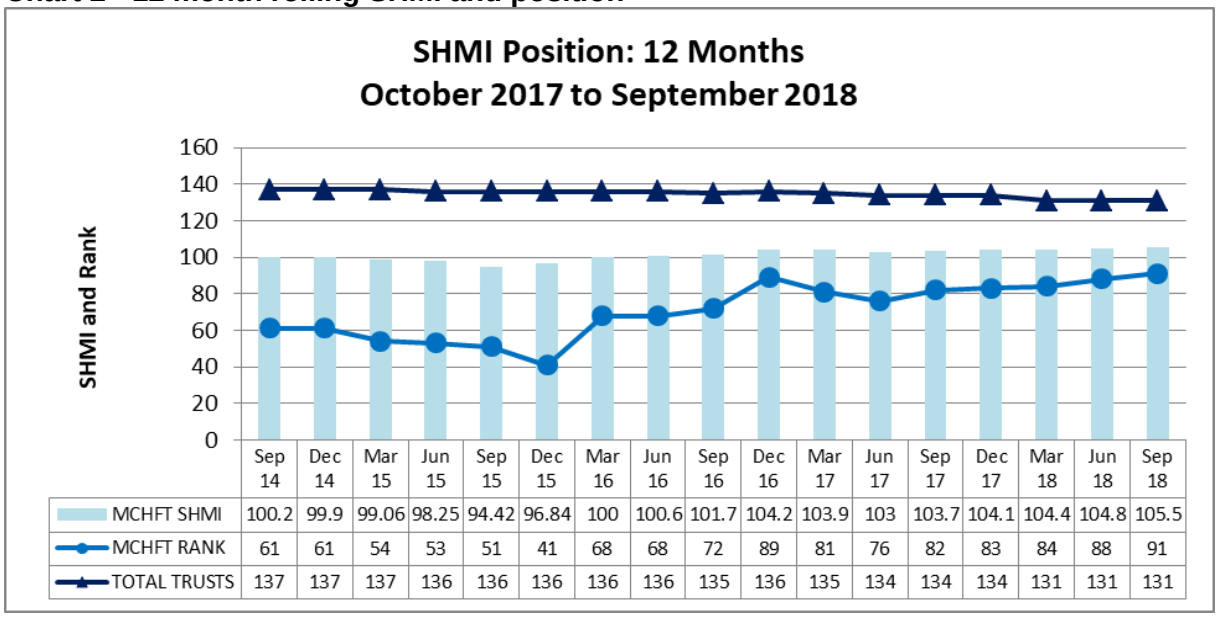
Chart 1 - SHMI Position



(Source NHS Digital, 2019)

Chart 1 demonstrates the SHMI position for the reporting period October 2017 - September 2018. The SHMI is currently 105.48 and is in the 'as expected' range. This currently places the Trust 91 out of 131 Trusts.

Chart 2 - 12 month rolling SHMI and position



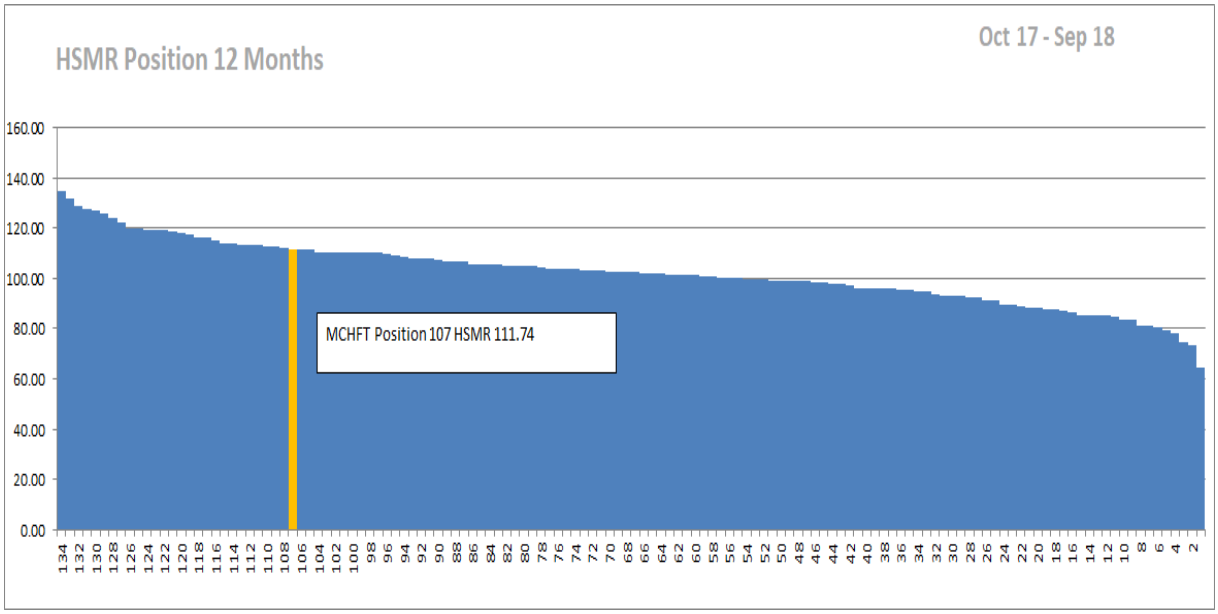
	Sep 14	Dec 14	Mar 15	Jun 15	Sep 15	Dec 15	Mar 16	Jun 16	Sep 16	Dec 16	Mar 17	Jun 17	Sep 17	Dec 17	Mar 18	Jun 18	Sep 18
MCHFT SHMI	100.2	99.9	99.06	98.25	94.42	96.84	100	100.6	101.7	104.2	103.9	103	103.7	104.1	104.4	104.8	105.5
MCHFT RANK	61	61	54	53	51	41	68	68	72	89	81	76	82	83	84	88	91
TOTAL TRUSTS	137	137	137	136	136	136	136	136	135	136	135	134	134	134	131	131	131

(Source NHS Digital, 2019)

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

2.2 Hospital Standardised Mortality Rate (HSMR) October 2017 - September 2018

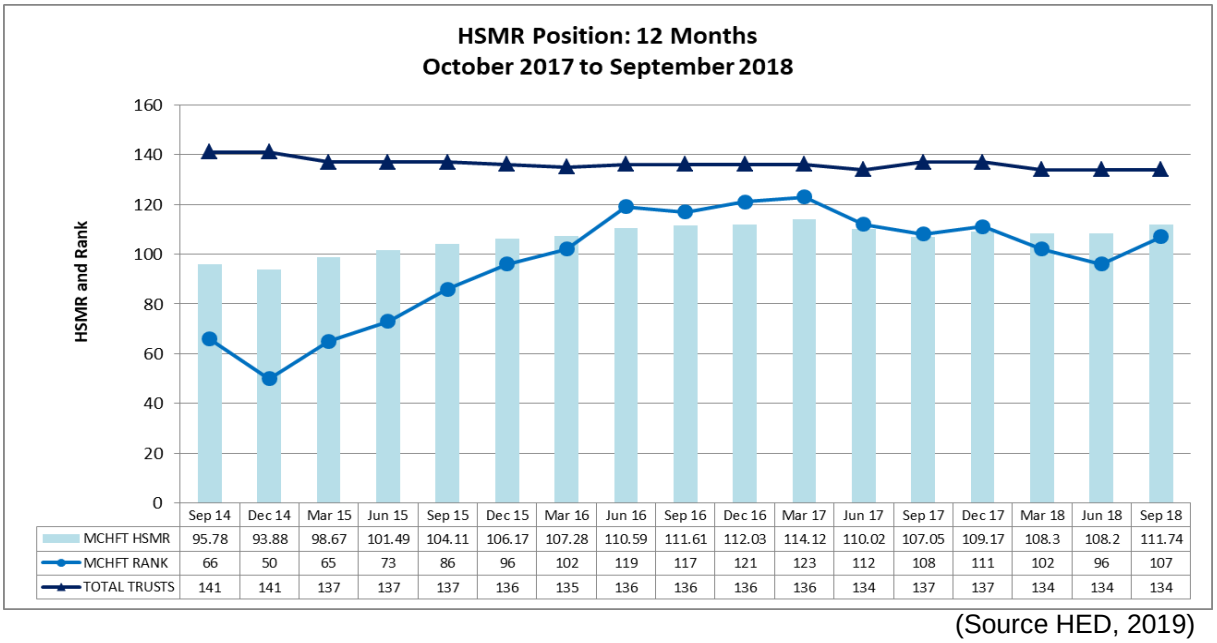
Chart 3 - HSMR Position



(Source HED, 2019)

Chart 3 demonstrates the HSMR position for the reporting period October 2017 - September 2018. The HSMR is currently 111.74 and places the Trust 107 out of 134 Trusts.

Chart 4 - 12 month rolling HSMR and position



	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	Sep 18
MCHFT HSMR	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	111.74
MCHFT RANK	66	50	65	73	86	96	102	119	117	121	123	112	108	111	102	96	107
TOTAL TRUSTS	141	141	137	137	137	136	135	136	136	136	136	134	137	137	134	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 6 avoidable deaths in 2018 / 19 were identified and reported following comprehensive incident investigations.*

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

Total Number of Deaths in Scope		Total Deaths Reviewed using the Trust Mortality Tool		Total Deaths reviewed using SJR		Total Number of deaths considered to have been potentially avoidable (RCP<=3) using SJR		Total Number of deaths considered to have been potentially avoidable via alternative source (e.g. incident investigation)	
This Month	Last Month	This Month	Last Month	This Month	Last Month	This Month	Last Month	This Month	Last Month
78	92	82	71	15	8	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
277	223	217	216	32	24	0	0	0	3
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
938	1117	832	889	94	N/A	0	N/A	6	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
3	2	3	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
6	5	4	5	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
15	11	13	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 (15 April 2019). The Trust undertakes an in-depth case note review in response to any Mortality Outlier Alert.

Key Messages

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

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

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

Mortality Outliers – Active Alerts

Cases under consideration by the Outlier Panel

- There are currently no active mortality alerts

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

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

Cases for review by inspection team

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

Maternity Outliers – Active Alerts

Cases under consideration by the Outlier Panel

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

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

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

Cases for review by inspection team

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

4.0 Learning from Deaths and Improvements

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

All in-patient deaths are reviewed on a weekly basis by a team of Consultants, led by the Lead Consultant for Patient Safety. A short mortality case note review form is completed and, if a death is identified where clinical care could potentially have been more appropriate, the case is referred for a Structured Judgement Review (SJR). The Consultant looking after the patient is also asked to provide their written reflection on the quality of the patient's care.

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

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

- 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 March 2019, (see Appendix 1). The five primary drivers to reducing the Trust's mortality rates are:

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

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 has been launched in Theatres, Treatment Centre, Ambulatory Care Unit, Planned Interventions Unit, Outpatients Department and Elmhurst as part of the roll out programme in April 2019

4.2 Actions to reduce the number of avoidable deaths

- In Quarter 4 of 2018/19 thirty-two SJRs have been completed
- Ninety-four SJRs have been completed in 2018/19
- The SJR process has not identified any potentially avoidable deaths to date
- The 6 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)

4.3 Reducing patient moves improvement plan are completed as monitored through the Quality Safety Improvement Strategy Group

The following work streams have been put into place to support the reduction of patient moves and improve the quality and safety when patients are moved:

- Trust-wide bed modelling review to assess capacity & demand
- The National Emergency Intensive Support Team (ECIST) are providing assistance with the safe admission and discharge processes in the Trust
- Implementation of the safe flex bundle which supports a holistic assessment criteria
- Live visibility around patient moves to support decision making

4.4 Structured Judgemental Review (SJR) process

The HMRG has agreed the clinical conditions / criteria that will result in an in-patient death undergoing a SJR for 2019/20. These are:

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

4.4 Quarterly Deep Dive – Learning Disabilities Mortality Reviews

A deep dive has been undertaken into the learning disabilities mortality reviews which are undertaken at the Trust.

The Learning Disabilities Mortality Review (LeDeR) programme is a national programme aimed at making improvements to the lives of people with learning disabilities. Reviews are being carried out with a view to improve the standard and quality of care for people with learning disabilities.

The Trust reviews all deaths of patients that were diagnosed with a learning disability. All reviews are undertaken by the Trust Privacy and Dignity Matron. Each review includes:

- A pen portrait
- A timeline of events
- Identification of potentially avoidable factors
- Identification of potentially avoidable factors person and or/their environment
- Identification of potentially avoidable contributory factors in relation to care
- Identification of potentially avoidable contributory factors in relation to services
- Identification of whether the death, on balance, was potentially avoidable
- Any lessons which have been learned as a result of this review
- Any changes to local practices
- Are wider recommendations that should be considered
- Any good practice identified

In 2018/19 thirteen reviews were completed in the Trust, with fifteen deaths identified. The outstanding reviews will be completed in quarter 1 of 2019/20. This is due to the time allowed for the coding process meaning that the total number of deaths and the total number of reviews are not completely aligned each quarter.
No avoidable deaths were identified through the review process.

Identified learning themes:

- There was a delay in ascertaining who was the next of kin and making contact initially to discuss prognosis. This has been escalated to the Heads of Nursing to action
- Earlier identification that advocacy was required. There were frequent references to discussing the patient's pathway with the next of kin of which there was none and an advocate was required. This has been highlighted at the Trust Mortality Group for cross divisional learning
- Delay in commencing the end of life care plan. This has been highlighted through the learning from deaths newsletter
- Potential inappropriate admission to the Trust when the patient was on the gold standard framework. This has been reported as a professional concern to the Clinical Commissioning Group

Areas of good practice identified

- There was excellent documentation regarding capacity assessments and discussions with the family. There was an appropriate referral to the palliative care team and conversations in relation to preferred place of care
- The end of life pathway was commenced and care delivered in line with the pathway
- The patient's learning disability passport was in the healthcare record
- There was excellent evidence of referrals to specialities including SALT, Macmillan, Diabetes Specialist Nurse and the Privacy and Dignity Matron
- Excellent communication with the carers
- Prompt referral to advocacy
- Good evidence of best interest decision making
- Dignity Matron supported the patient and family in the final hours of the patient's life
- Prompt involvement of the palliate care team and use of the green sticker in the medical notes

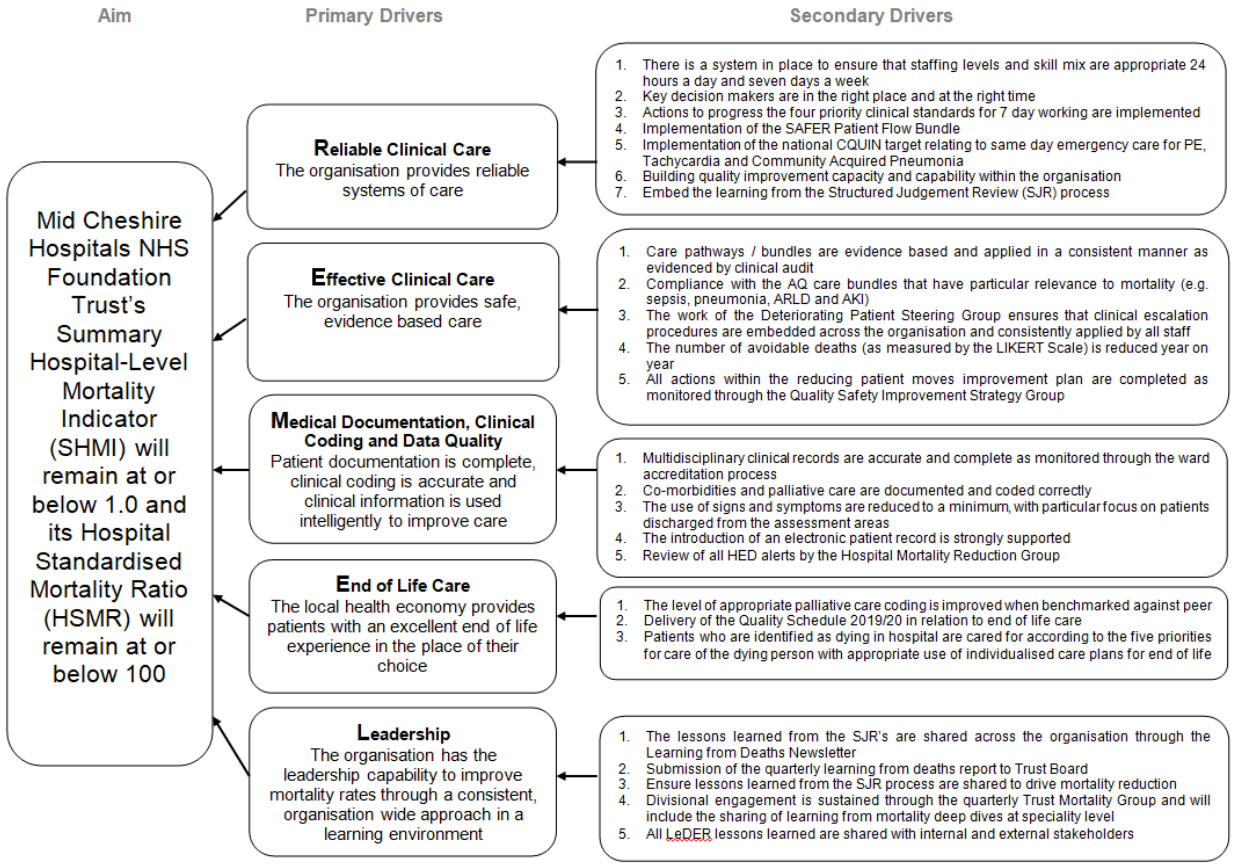
All Learning Disability mortality reviews are shared at the Hospital and Trust Mortality Groups to ensure cross-divisional learning.

4.5 Next steps

- Deep dive into the SJR reviews completed in 2018/19

5.0 Appendices

5.1 Appendix 1 Driver Diagram



5.2 Appendix 2 - Glossary

Healthcare Evaluation Data (HED)

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

Hospital Standardised Mortality Ratio (HSMR)

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

LIKERT Scale

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

LIKERT Scale

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

Summary Hospital-level Mortality Indicator (SHMI)

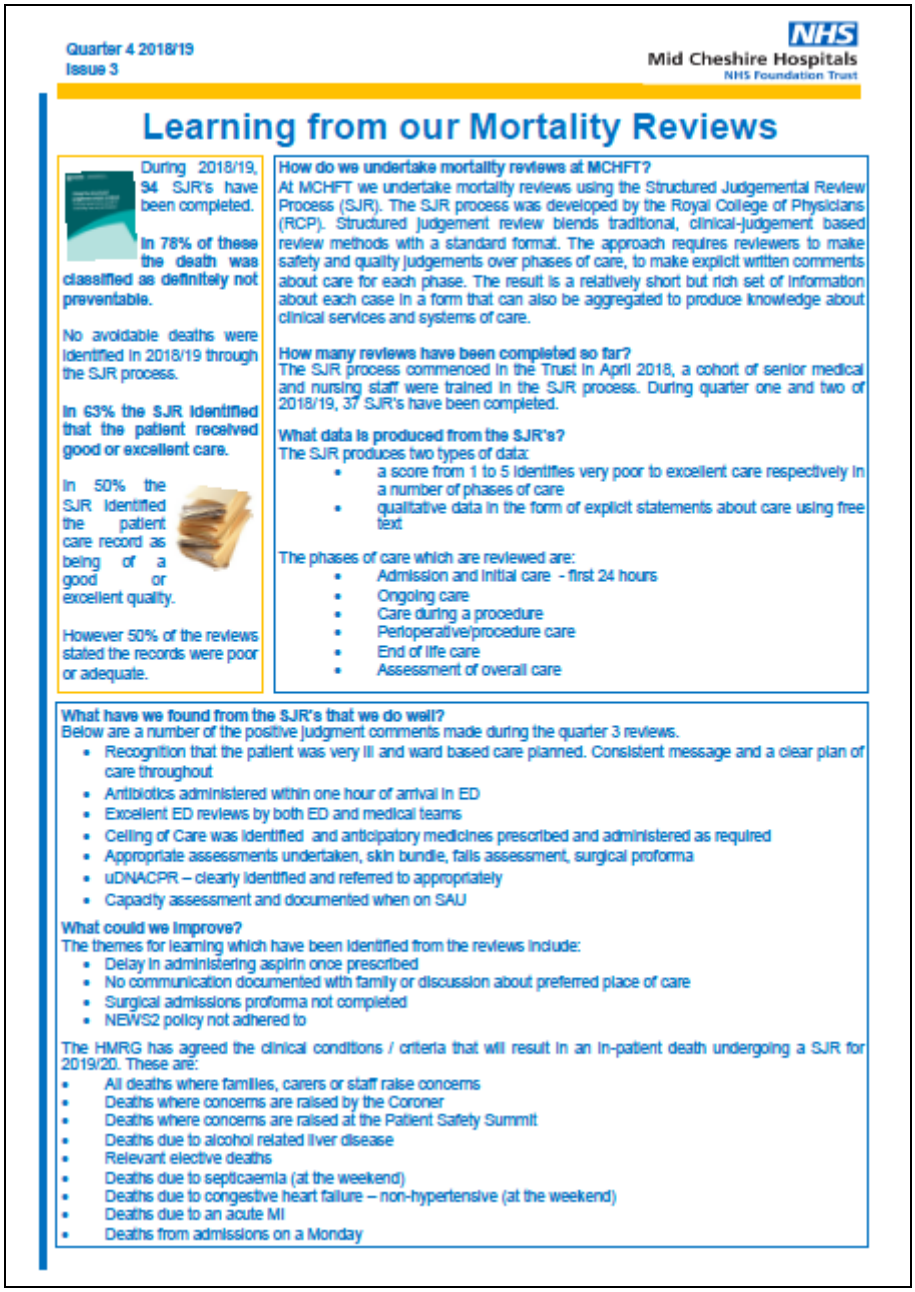
SHMI reports on mortality at trust level across the NHS in England. This indicator is produced and published quarterly as an official statistic. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the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

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

5.3 Appendix 3: Understanding the difference between SHMI and HSMR

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

5.4 Appendix 4: Quarter 4 Learning from Mortality Reviews Newsletter



Quarter 4 2018/19
Issue 3

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

Learning from our Mortality Reviews

During 2018/19, 94 SJR's have been completed.

In 78% of these the death was classified as definitely not preventable.

No avoidable deaths were identified in 2018/19 through the SJR process.

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

In 50% the SJR identified the patient care record as being of a good or excellent quality.

However 50% of the reviews stated the records were poor or adequate.

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 judgment comments made during the quarter 3 reviews.

- Recognition that the patient was very ill and ward based care planned. Consistent message and a clear plan of care throughout
- Antibiotics administered within one hour of arrival in ED
- Excellent ED reviews by both ED and medical teams
- Ceiling of Care was identified and anticipatory medicines prescribed and administered as required
- Appropriate assessments undertaken, skin bundle, falls assessment, surgical proforma
- uDNACPR – clearly identified and referred to appropriately
- Capacity assessment and documented when on SAU

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

- Delay in administering aspirin once prescribed
- No communication documented with family or discussion about preferred place of care
- Surgical admissions proforma not completed
- NEWS2 policy not adhered to

The HMRG has agreed the clinical conditions / criteria that will result in an in-patient death undergoing a SJR for 2019/20. These are:

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

Title of Paper:	Board Assurance Framework (BAF) Report Q4 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:	

Board Assurance Framework 2018/19

Quarter 4

Summary Version

'Delivering Excellence in Healthcare through Innovation and Collaboration'

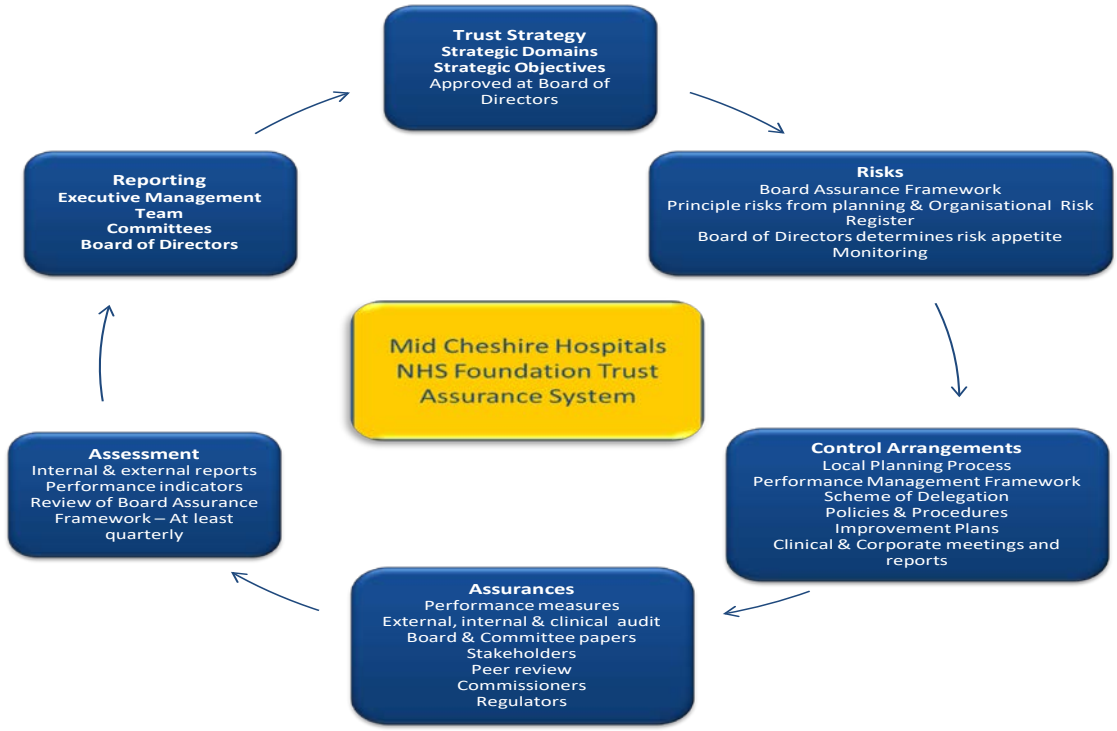
Contents

1. Background & purpose

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

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

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



2. Current position

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

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

3. Organisational Risk Register

The Organisational Risk Register Report is presented to the Board of Directors on a quarterly basis. Table 1 below details the top five risks as of quarter 4, 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 ⇔	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 2019 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 2019/20.

5. Summary

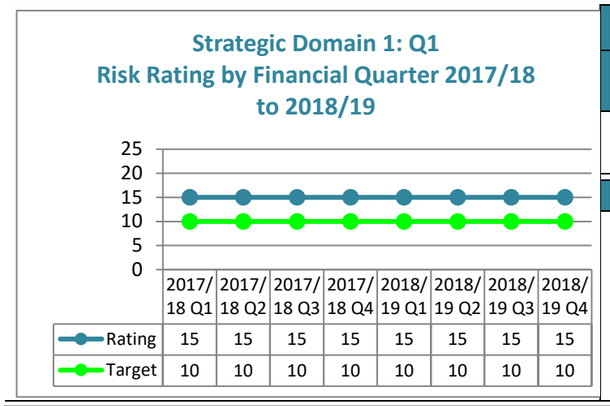
Strategic Domain 1: Delivering Outstanding Clinical Quality, Safety & Experience

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

Principal Risk

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

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHSI Single Oversight F/w	Executive Director	Executive Management Group	Board Committee
June 2017	March 2019	June 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 4. Work is progressing but strengthening is required of the risk management and quality assurance frameworks in order to provide sustained demonstrable improvements and associated assurances at ward, department and divisional levels.

Links to BAF objectives

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

Key Links to the Organisational Risk Register

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

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

The Trust is progressing the Advancing Quality Programme for 2019/20 focusing on several care pathways. The quality reports at ward / department and divisional level have been developed and rolled out across all divisions. New Executive led quarterly quality reviews have commenced in all divisions. The Quality & Safety Improvement Strategy for 2019/20 is being implemented. Quality priorities have been presented and approved at Quality Governance Committee in February 2019. A Well Led self-assessment process has been completed and findings from the initial reviews presented to the Trust Board, and an action plan has now been developed. Review of Infection, Prevention & Control Services has been completed, gaps identified and an improvement plan developed. The Director of Nursing & Quality has been appointed as the Trust Safety Champion for Maternity Services and is actively involved in the delivery of 'Better Births'. 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 in 2018 and scoping in place for 2019. Quality metrics programme launched in January 2019. Ward accreditation programme to commence in May 2019.

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 and due to be launched in June 2019.
- NHS Resolution Maternity Incentive Scheme, new indicators in 2019/20

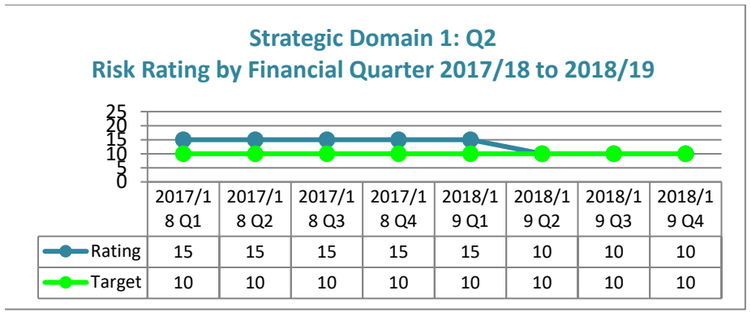
Strategic Domain 1: Delivering Outstanding Clinical Quality, Safety & Experience

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	March 2019	June 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 4. The likelihood of not improving the quality of care with all the key controls in place is unlikely.

Links to BAF Objectives

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

Key Links to the Organisational Risk Register

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

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

HSMR/SHMI mortality indicators are 'within expected range'. The SJR Process is established; second cohort of multi-disciplinary clinicians was trained in January 2019. The Trust has been accepted onto the AQUA Deteriorating Patient Safety Collaborative for 2018/19. Trust participation in all relevant National Clinical Audits and Regional Advancing Quality Programme to benchmark performance. Monthly Quality Reports are produced for all the Divisions and are reviewed at the Executive led Quarterly Quality Reviews. Trust's active participation in GIRFT programme led by CEO and MD. Progression of Quality, Service Improvement and Redesign (QSIR) initiative. Trust wide development opportunities following the recent Well Led Development Review. The Trust is finalising a proposal document around the Improving Quality Together programme at MCHFT. The proposal document is due to be presented to QGC in May 2019.

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

- A new one day process for Quarterly Quality Reviews to be established in 2019.
- Development of Clinical Trials portfolio by March 2019
- Develop plans to increase QI capability & capacity Trust wide (Included in Improving Quality Together programme proposal document)
- Lack of integration between Service Development and QI teams to be addressed as part of the Trust wide plans. (Included in Improving Quality Together programme proposal document)

Strategic Domain 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.

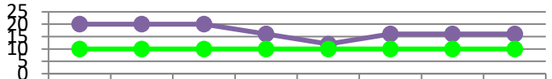
Principal Risk

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	March 2019	June 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	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 4. 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. Issues have now been resolved and agreement reached with commissioners. Relationships with East Cheshire NHS Trust are good, however; progress is slow, with a perceived lack of desire on their part. The recruitment process for a new CEO at MCHFT is now well under way with a strong field of applicants.

Links to BAF Objectives

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

Key Links to the Organisational Risk Register

TW0003 – Workforce capacity and skill mix to consistently deliver high quality care, seven days a week	20⇔	TW0002 – Long Term Financial Sustainability of MCHFT	20 ⇔
TW0006 - Lack of pace in the significant transformational change required to deliver the Cheshire East Place strategy and consequently the Health and Care Partnership (HCP) for Cheshire & Mersey	16⇔		

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

The 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. Collaboration and partnerships have led to a more complex and integrated landscape in which the Trust plays a key role. HCP provided £700K to undertake pre-consultation business case. 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. Review further developed into wider CE Place strategy. The CE Place draft strategy will form the basis for future pre-consultation business case.

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

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).

Board Assurance Framework 2018-19

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

NHS Mid Cheshire Hospitals NHS Foundation Trust

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

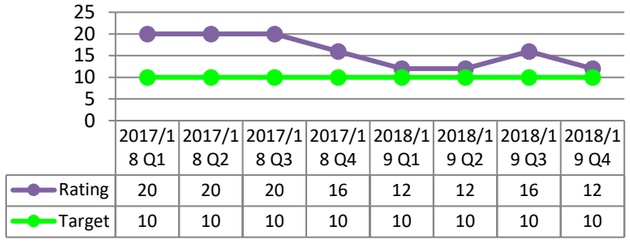
P2	**To work with all key stakeholders to deliver a wholly integrated health and social care system, taking on clear collective responsibility for resources and population health, so that our residents receive better coordinated care within the designated financial envelope, whilst ensuring:** - **National 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	March 2019	June 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	12
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	3	**12⇩**	5	2	**10**	March 2019

Rationale for the Current Risk Score

The risk score has been decreased to 12 to reflect the recent increase in confidence. An independent Chair has been appointed and the Programme Director (SRO) for ICP is in place.

Links to BAF Objectives

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

Key Links to the Organisational Risk Register

TW0003 – Workforce capacity and skill mix to consistently deliver high quality care, seven days a week	20⇔	TW0002 – Long Term Financial Sustainability of MCHFT	20⇔
TW0006 - Lack of pace in the significant transformational change required to deliver the Cheshire East Place strategy and consequently the Health and Care Partnership (HCP) for Cheshire & Mersey	16⇔		

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

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

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

- Re-launching UHNM / MCHFT Stronger Together Programme meetings.
- Anxiety from GP membership.

Strategic Domain 3: Striving for Outstanding Organisational Effectiveness

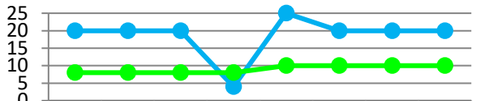
E1	To ensure full compliance with the NHS Improvement Provider Licence, ensuring financial sustainability, financial efficiency and financial controls, whilst safeguarding the quality of our services.

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	March 2019	June 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	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 4 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

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

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

Work on internal transformation programmes to improve efficiencies has continued alongside the wider collaborations of "Stronger Together" Programme with the University Hospitals of North Midlands and the wider engagement at all levels with the Health & Care Partnership for Cheshire & Mersey. The Trust underwent 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 February 2019, indicating performance is still on track. The next stage is the development of a system-wide recovery plan by the Autumn.

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

- Completion of the Cheshire East Plan
- 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.
- Completion of KPMG Internal Audit Plan

Strategic Domain 3: Striving for Outstanding Organisational Effectiveness

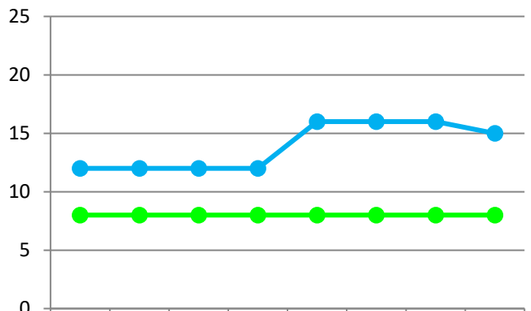
E2	To maintain compliance with, and aspire to achieve incremental improvements against, the NHS Improvement Single Oversight Framework Operational Performance Metrics, whilst safeguarding the quality of our services.

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	March 2019	June 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	15
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**	3	4	**15⇩**	4	2	**8**	March 2019

Executive Commentary for the Current Risk Score

Risk scores have been changed (consequence from 4 to 3, likelihood from 3 to 4), this has been based on changes to performance notably RTT delivery and the fact that PSF allocation in 19/20 has no link to 4 hour ED performance. Whilst MCHFT has a strong record of compliance against the Single Oversight Framework with the exception of the 4 hour ED standard, there has been a decline in RTT performance over 18/19; in part this was mandated by NHSI and the CCGs as part of the Capped Expenditure Programme which took performance from 97% down to 92%. However, during 2018/19 the Trust saw a 4% increase in OP referrals and due to block contract constraints was not able to flex capacity to meet this increased demand, this on top of an extended pause on routine elective operating during December and January due to non-elective pressures has seen a further decline to just under 91% against a 92% standard. 4 Hour ED performance whilst still a distance from the 95% standard, in Q4 2018/19 delivered better performance every month than the previous year and when comparing 2018/19 to 17/18 saw an increase of over 5,000 more patients or 5% attending urgent care services, which increased to just under 8% for those patients attending ED. Q1 19/20 will see a challenging start for the diagnostic 6 week standard (DM01) due to an issue with an IT virtual server upgrade which will mean failure to deliver this standard in April and May 2019.

Links to BAF Objectives

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

Key Links to the Organisational Risk Register

TW0001 – Delivery of key local and National targets and standards, in particular the 4 hour standard in A&E	20⇔	TW0002 – Long Term Financial Sustainability of MCHFT	20⇔
TW0003 – 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 continues to engage with the Emergency Care Intensive Support Team notably across three projects 1) Streaming from ED, 2) SAFER deployment and 3) Domiciliary Care for Stroke Patients (Pathway 3) in addition the Trust has also taken support from FourEyes, a consultancy company specialising in supporting NHS efficiency through elective services.

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

- Partnership working and agreeing actions to support future compliance.

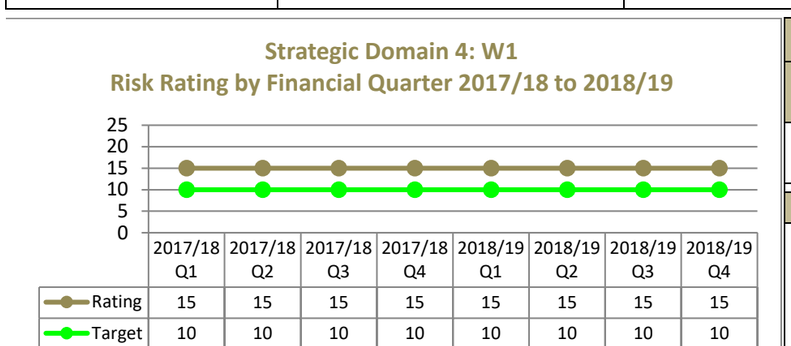
Strategic Domain 4: Aspiring to Excellence in Practice through Our Workforce

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	March 2019	June 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

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⇔

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

Workforce & OD Strategy (Our Workforce Matters Strategy) has been approved by the Board of Directors. Central to our new Our Workforce Matters Strategy is our ability to embed a culture which helps grow and develop our own leaders from within the organisation, enabling us to retain and nurture talent from an engaged workforce that is passionate about providing excellent clinical practice in their care of our patients. The Trust participates in a rolling programme of senior leadership development. Clinical and Non-clinical talent management and succession planning is being rolled out across the Trust. Well led self- assessment process. Local development of improvement plans following the National Staff Survey results. Freedom to Speak Up self-review tool now established.

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

- Restructure of the W&OD teams is expected in 2019/20 to maximise the ability to deliver the Workforce Matters Strategy
- Workforce & OD Strategy (Workforce Matters Strategy) Strategic action plan is in place and monitored through TAP quarterly
- ESR Systems require significant development to maintain the ability to report workforce metrics accurately and to provide Divisions with up to date workforce data.
- Review of Education Governance Framework by April 2019
- In some specialities there are gaps in senior clinical leadership
- Two divisions to attend EWAG to present improvement plans following the National Staff Survey
- Training programme to be put in place for the HR team to increase medical workforce and OD knowledge.

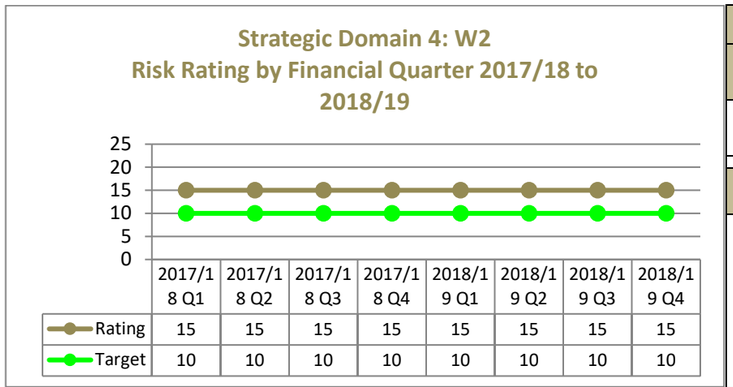
Strategic Domain 4: Aspiring to Excellence in Practice through Our Workforce

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	March 2019	June 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 Q4 as although the Trust has low levels of vacancies there are hot spots e.g. radiology and although mandatory training uptake is progressing needs improvement. Additionally long term recruitment plans are good, however short term recruitment 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?)

- Local development of improvement plans following the National Staff Survey results.
- Talent management & succession planning programme is in place.
- Lack of confidence in the validity of mandatory training data remains a concern.
- Workforce and OD Strategy (Workforce Matters Strategy) Strategic action plan is in place and monitored through TAP quarterly
- Training programme put in place for HR to increase medical workforce & OD knowledge.

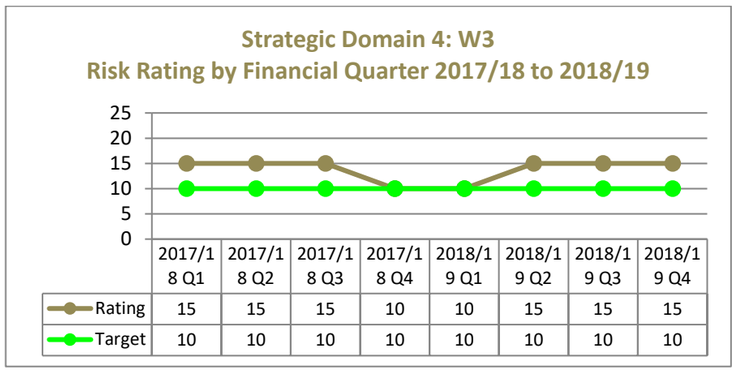
Strategic Domain 4: Aspiring to Excellence in Practice through our Workforce

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	March 2019	June 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 Q4, 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⇔

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

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

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

- Talent management & succession planning programme to be embedded.
- Local development of improvement plans following the National Staff Survey results.
- Additional resources now identified as part of the annual plan.

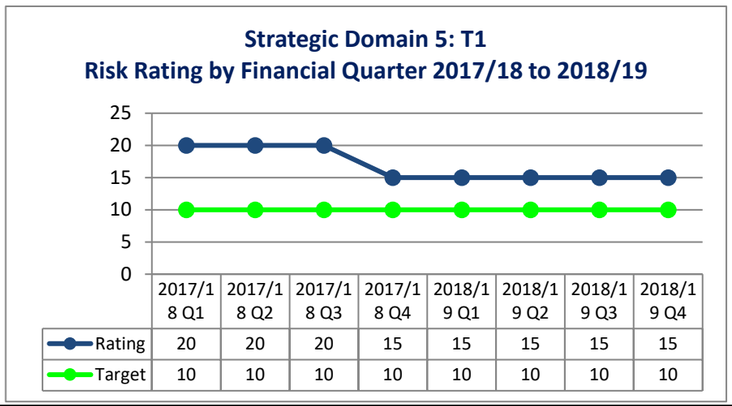
Strategic Domain 5: Creating a 21st Century Infrastructure for Transformative Health and Social Care

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	March 2019	June 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.

Links to BAF Objectives

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

Key Links to the Organisational Risk Register

TW0002 – Long Term Financial Sustainability of MCHFT	20⇔	TW0001 – 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.

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.**

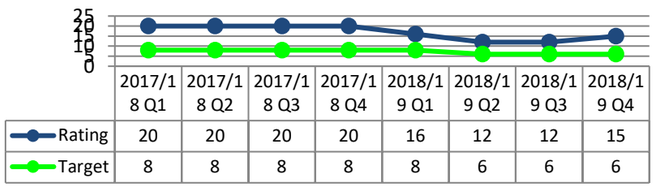
Principal Risk

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	March 2019	June 2019	Well Led Framework Use of Resources	Medical Director / Deputy CEO	Information Technology Strategy Group	Performance & Finance

Strategic Domain 5: T2A
Risk Rating by Financial Quarter 2017/18 to 2018/19



	2017/18 Q1	2017/18 Q2	2017/18 Q3	2017/18 Q4	2018/19 Q1	2018/19 Q2	2018/19 Q3	2018/19 Q4
Rating	20	20	20	20	16	12	12	15
Target	8	8	8	8	8	6	6	6

Initial Risk Rating (Unmitigated)			Current Risk Rating (Mitigated)			Target Risk Rating (Tolerance / Risk Appetite)			
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Target Date
4	5	**20⇔**	3	5	**15⇧**	3	2	**6**	March 2019

Rationale for the Current Risk Score

The current risk score has increased to15 for Quarter 4. Longer timescales for the approval of business cases is leading to the failure of more systems and withdrawal of support from suppliers. £3M of national funding obtained to support the Clinical Systems Business Case. The Clinical Systems Outline Business Case was presented to the Board of Directors in January 2019 and approved. This has now gone to NHSI for approval. Board approved Digital Strategy 2018-2022. EPMA bid shortlisted.

Links to BAF Objectives

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

Key Links to the Organisational Risk Register

TW0002 – Long Term Financial Sustainability of MCHFT	20⇔	CS0380 - Cyber Security	16⇔
		TW0010 - Legacy Operating Systems Software	16⇔

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

The main challenge to delivering the DIGIT@LL Technology Strategy is the financial affordability. However the Board of Directors does not underestimate the level of organisational development support that will be required for the organisation to undergo the necessary culture change. A Chief Nursing Information Officer and Chief Clinical Information Officer have been appointed to support the EPR. The Executive Lead for Cyber Security is the Medical Director. 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 February 2019. CCICP has gone live with EMIS Community which has been configured specifically to support care communities. There is an appetite to develop this as an NHS Digital blueprint. Trust Board has received independent cyber security training.

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

- Delivery of the overarching Cyber Security implementation plan.

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

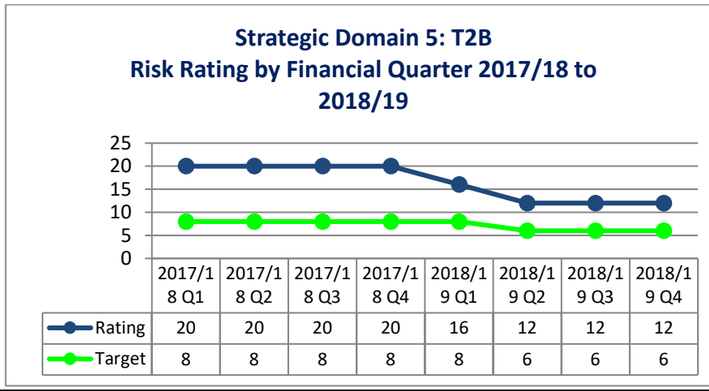
T2b	To deliver an agreed, costed and phased Information Technology (IT) Strategy which supports the provision of seamless, integrated, outstanding patient care, improves staff experience in delivering care and enables continuous quality and service improvements through the intelligent use of secure, 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	March 2019	June 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 4, on the basis that the Clinical Systems Strategic Outline Case has been approved by NHSI to move to the next step.

Links to BAF Objectives

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

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

TW0002 – Long Term Financial Sustainability of MCHFT	20⇔	CS0380 - Cyber Security	16⇔
		TW0010 - Legacy Operating Systems Software	16

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

The E-Rostering project 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. Digital clinical systems demonstration to raise awareness of digital future. Trust Board has received independent cyber security training. ED now using electronic screen. The majority of consultants have been issued with laptops in readiness for new clinical system.

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

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

Appendix A - Strategic Objectives & Success Measures 2018/19	Domain One: Delivering Outstanding Clinical Quality, Safety & Experience
Objective Q1. To aspire to the delivery of 'outstanding' clinical quality and safety, which is equitable, patient and family centred and supported by an effective quality governance framework	**We will know when we have succeeded by measuring what matters and through:** • Implementing the Quality and Safety Improvement Strategy making this inclusive of all staff • Ensuring compliance with all legal and regulatory requirements • Using local and national benchmarking data to demonstrate consistently high quality clinical care with no unwarranted variation and top quartile performance. • Delivering top quartile performance for national staff and patient surveys as well as consistent positive feedback, greater than 90%, from patients, family members, carers and patient groups, targeting specifically those groups likely to be subject to less equitable services. • Progressing the continuous learning culture through recognised processes of good governance to evidence sustainable improvements to patient safety, quality of care and outcomes. • Working with clinical teams to ensure documentation and record keeping are robust and accurate
Objective Q2. To drive continuous quality improvement and promote research and innovation, whilst reducing unwarranted clinical variation and progressing from a 'good' to 'outstanding' organisation.	**We will know when we have succeeded by measuring what matters and through:** • Progressing towards an 'Outstanding' CQC rating through a clinical quality improvement programme that is Executive led and clinically owned and supported • Engaging with wider stakeholders to ensure further development of clinical pathways to deliver services that are clinically aligned with the needs of the local population and connect across health and social care • Leading on local and national safety collaborations to achieve best practice through influencing national directives and local practice • Ensuring clinical service needs where required are delivered equitably across 7 days • Encouraging and promoting involvement in research and innovation, including academic research and partners, showcasing participation to internal and external stakeholders and sharing outcomes with others. • Use evidence led accreditation in research & innovation to support research studies
Domain Two: Being a Leading Partner in a Progressive Health Economy	
Objective P1. To fully engage with all strategic partners to maximise the opportunities and advantages associated with horizontal integration in the designing and delivery of sustainable health services for the population of Central and Eastern Cheshire, whilst acknowledging and responding to: - National and regional strategies. - The need for sustainable high quality clinical services. - Favourable economies of scale and removal of unwarranted variation. - The cost effective sustainable use of resources.	**We will know when we have succeeded by measuring what matters and through:** • Playing a leading role in implementing the NHS Cheshire & Merseyside Plan with demonstrable outputs and outcomes: - Supporting and leading developments within Cheshire & Wirral and Cheshire & Mersey to enable greater collaboration in relation to back office functions, clinical support services and where appropriate, clinical services. - Supporting the development and delivery of the NHS Cheshire & Mersey, Cheshire & Wirral work streams • Playing a leading role in the delivery of the Capped Expenditure Programme to ensure the appropriate transformation of health and social care to ensure the economic sustainability for Central (& Eastern) Cheshire • Playing a leading role in shaping and delivering the Long Term Sustainability Review: - Mapping the current delivery of services and work with partners, in particular ECT and UHNM, to change the delivery model where improved patient benefit and sustainable provision can be provided by the Trust or others. - With health economy partners, consider longer term options and develop the case to enable MCHFT to provide long term sustainability for ECT - Developing a more flexible workforce that can be deployed differently to lead and support the developing and delivery of high quality integrated horizontal pathways for our patients • Providing sustainable high quality services that are valued by the population served and enhancing the reputation of the Trust to keep services local
Objective P2. To work with all key stakeholders to deliver a wholly integrated health and social care system, taking on clear collective responsibility for resources and population health, so that our residents receive better coordinated care within the designated financial envelope, whilst ensuring: - National and regional strategies are implemented. - The sustainable use of resources to deliver agreed health outcomes. - The development of a collective decision making and governance structure. - Sustainable clinical services through the development of Accountable Care Systems (ACS) /Organisations (ACO) and the implementation of new models of care (e.g. Home first principles)	**We will know when we have succeeded by measuring what matters and through:** • The Central Cheshire Integrated Care Partnership (CCICP) developing and implementing a transformation programme that enhances and integrates care locally and is an enabler to the development of an Accountable Care System: - Care Communities and Primary Care Home through GP clusters for populations of 30 – 50k - Integrated pathways across primary, secondary and community teams, social care and mental health recognising the roles and responsibilities of providing core integrated care, urgent responsive care and specialist care, taking account of the latest treatments and advances in medicine - Enabling infrastructure that transforms the organisational development and culture of the workforce. • Using clinical senate forums, and with health economy partners, playing a leading role in developing and implementing ACS/Os with demonstrable outputs and outcomes, therefore, creating a system that: - Promotes self-care and prevention including vaccination and screening programmes alongside education to make our population healthier - Ensures the Health Economy lives within its means and funds are used in the most effective way to optimise patient outcomes. - Provide sustainable high quality local clinical services that are valued by the population of Central Cheshire. • 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 :	Organisational Quarterly Risk Register Report Q4 18/19	
Author:	Associate Director-Quality Governance	
Executive Lead:	Medical Director	
Type of Report:	Concept Paper	
	Strategic Options Paper	
	Business Case	
	Information	
	Review/Benefits/Audit	✓

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

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

Positive Benefit:	Provides a position statement of the organisational risks for Quarter 4, 2018/19. Detailed report providing assurance of effective risk management.
Risk:	Lack of oversight of key risks to achieving the Strategic Objectives.

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

Quality Governance

Organisational Quarterly Risk Register Report

Report date: 01/01/2019 to 31/03/2019

Contents

1. Purpose

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

2. Current position

In April 2019 the Trust commenced a comprehensive review of its risk management systems and processes, with the aim of developing a web-based risk management system (Risk Web) with supportive education and training. The implementation of Risk Web is planned for March 2019, with further work to be undertaken during 2019-20 to fully establish the new system and processes.

A review has been undertaken on the content of the Trust risk register. The review identified that the risk register contained the details of over 600 risks, many of which could be classified as task or workplace specific. The risk register has been cleansed and now only contains the details of risks to divisional and corporate objectives. A bespoke risk register risk assessment form, task/event risk assessment form and workplace health and safety risk assessment form have been developed, and are now in use across the Trust. Appropriate storage arrangements have been established for both task specific and workplace risk assessments.

Pilot sites in the Estates and Facilities department and CCICP have been working to establish risk assessment web based reporting, and to trial the new task/event and workplace risk assessment forms; completion and storage.

Work on defining risk statements as described in the RMS&AF; "There is a risk that <risk event> as a result of <cause> which may lead to <effect/impact>", is progressing with a focus on risks rated 15 and above. All new risks are now written on the bespoke risk register risk assessment form, as described in the RMS&AF.

A new Risk Assessment Procedure, which includes reference to all types of risk assessments, has been created to replace the original Health & Safety Risk Assessment Procedure. This document will be finalised by the end of March 2019 to take account of feedback from the pilot sites, Health & Safety Group (H&SG) and Quality Governance team.

New divisional and organisational risk register reports have been developed. The new risk register reports can be produced automatically from the Ulysses web-based data management system. Risk register reports can also be produced for specialist groups; H&SG, Information Governance Working Group (IGWG) and Infection, Prevention & Control (IP&C). Further development work is underway to develop risk register reports for other specialist groups, such as; Emergency Preparedness Group (EPG) and Executive Workforce Assurance Group (EWAG).

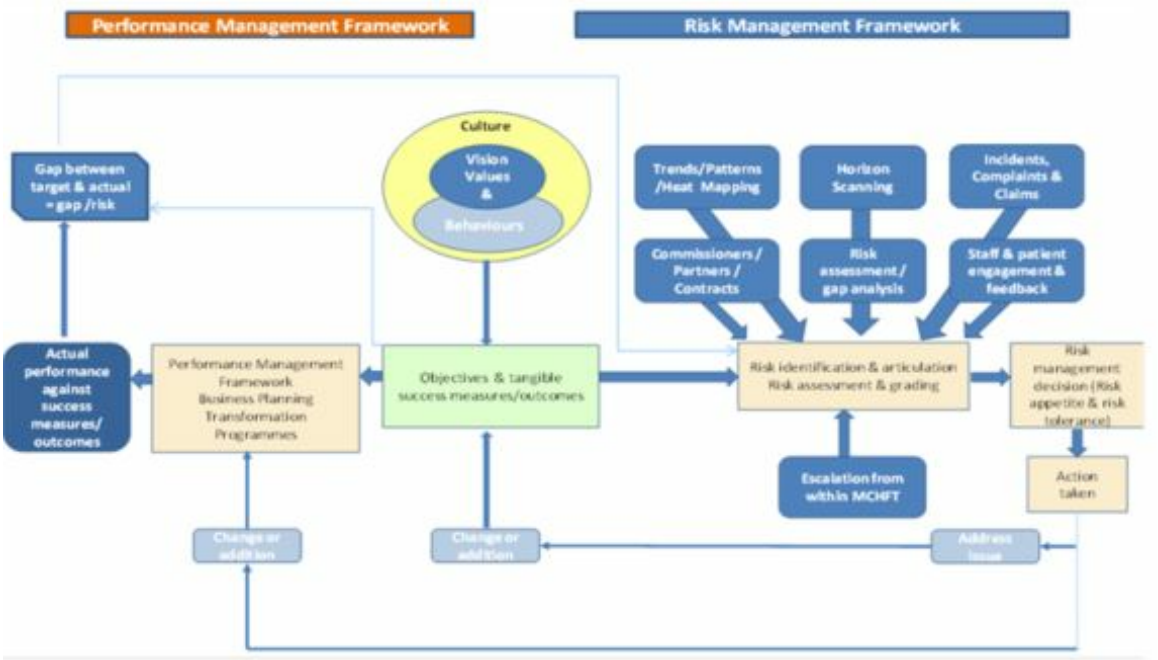
A web-based risk register risk assessment form has been developed based on the hard copy version. Both pilot sites are utilising this form to log new risks into Ulysses; this methodology has also been used to create the IP&C risk register report and to update all corporate services risks rated 15 and above.

A 'Web-based Risk Management System' development session is being prepared for members of the Quality Governance team. A Web-based Risk Management System User Guide is also in the early stages of development. The aim of the session will be to equip them with the skills and knowledge to effectively guide managers through the risk assessment process. To educate managers in the risk assessment process, members of the Quality Governance Team will guide them through the completion of actual risk assessments, as they are required.

Broader education of managers has been undertaken through discussion at management meetings on the development of risk management systems, including; risk assessments, registers and governance arrangements.

This report builds on the work previously undertaken to develop quarterly organisational risk register reports and reflects the progress that has been made in developing a web-based risk management system. In parallel divisional/CCICP level reports are being further developed and presented at Divisional/CCICP Boards as iterative documents for discussion and feedback.

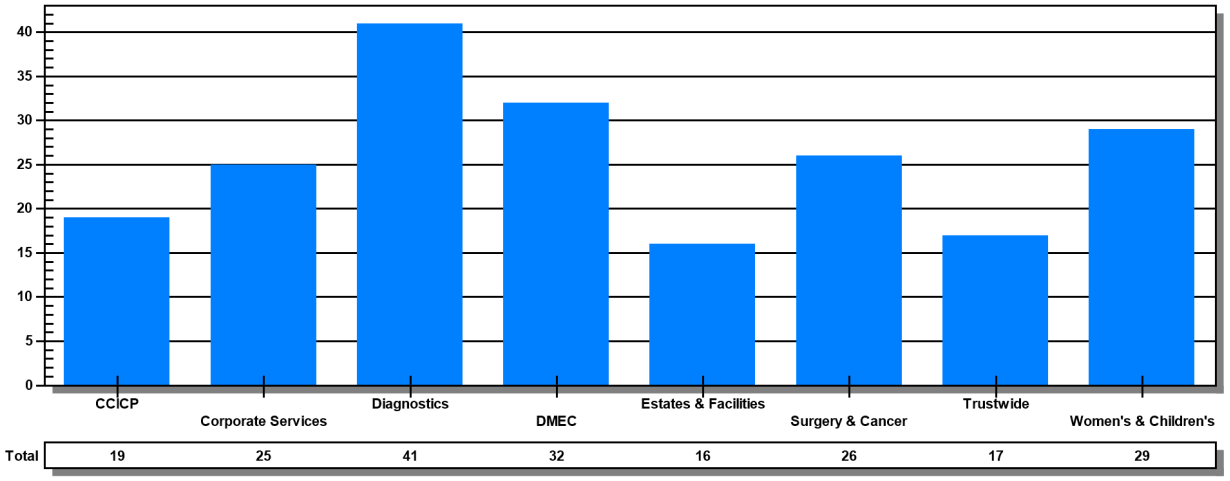
The diagram below details the relationship between the performance and planning and risk management frameworks and the linkages across. Future versions of the divisional/CCICP reports will map the risks to the local objectives (Trust Strategy 2017 with 2020 Horizon: Plans on a Page).



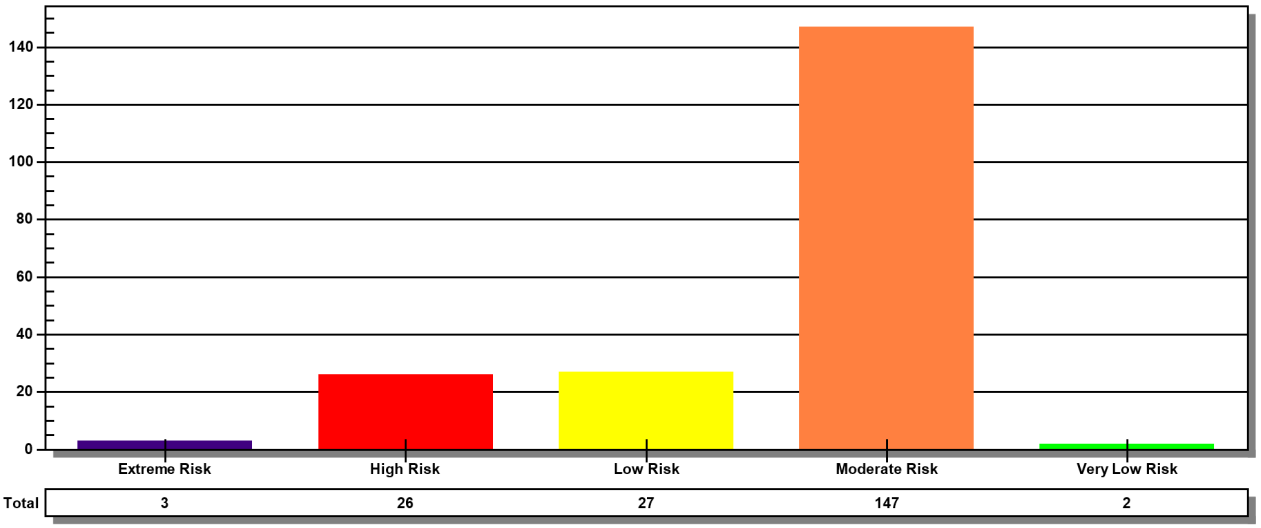
4. Top 5 Organisational Risks

Risk Title	Mitigated (With Controls) Risk Rating	SHIFT Q1	SHIFT Q2	SHIFT Q3	SHIFT Q4	Key links to BAF 2018/19
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 ⇔	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 ⇔	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 ⇔	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 ⇔	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 ⇔	12 ⇔	Q1,Q2,E1,E2, T2a,T2b

5. Risk Register Overview Summary - all open risks



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



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

6. New risks in quarter rated 15 and above

Ref.	Title	Division	Risk Score	Risk Rating
EF0505	Loss of Mechanical Infrastructure and Associated Resources: Leighton Hospital	Estates & Facilities	16	High Risk
EF0512	Water Distribution / Temperature	Estates & Facilities	15	High Risk
EF0548	Critical Risk Adjusted Backlog Maintenance	Estates & Facilities	15	High Risk
SC0621	Histology backlog issues impacted on Endoscopy Services	Surgery & Cancer	16	High Risk

7. New risks in quarter pending approval

Ref.	Title	Division	Risk Score	Risk Rating
176	Risk Assessment to obtain an extension lead	CCICP	2	Very Low Risk
178	Extension Lead Required	CCICP	1	Very Low Risk
194	Lack of service provision within Rheumatology	DMEC	20	Extreme Risk

8. Risks past the review date rated 15 and above

Ref.	Title	Division	Risk Score	Risk Rating	Review Date
EC0397	Risks associated with inadequate Staffing levels on ward 5	DMEC	16	High Risk	04/03/2019
TW0001	Delivery of key local and National targets and standards, in particular the 4 hour standard in A&E	Trustwide	20	Extreme Risk	12/02/2019
TW0007	Delayed routine outpatient follow-up	Trustwide	15	High Risk	24/03/2019
TW0010	Medical Devices Running Legacy Operating System Software	Trustwide	16	High Risk	28/03/2019

9. Escalated risks

Ref.	Title	Division	Risk Score	Risk Rating	Date Closed
SC0535	Insufficient staffing within Inpatient locations	Surgery & Cancer	16	High Risk	30/06/2019
PG0294	Lack of Paediatric Audiology Staff	Women's & Children's	16	High Risk	29/07/2019

10. Closed/de-escalated risks

Ref.	Title	Division	Risk Score	Risk Rating	Date Closed
CS0370	Potential Claims relating to Reportable Occupational Disease - including Mesothelioma & Noise induced Hearing Loss	Corporate Services	16	High Risk	17/01/2019
CS0378	Resuscitation Training	Corporate Services	15	High Risk	30/01/2019
EF0101	Legionella- Water distribution/temperature at Leighton Hospital	Estates & Facilities	15	High Risk	23/01/2019
EF0260	Loss of Mechanical Infrastructure and associated resources: Leighton Hospital	Estates & Facilities	16	High Risk	23/01/2019
EF0351	Strategic Backlog Maintenance	Estates & Facilities	15	High Risk	25/01/2019
SC0600	Insufficient staffing within Inpatient locations - Ward 13	Surgery & Cancer	16	High Risk	06/02/2019
SC0601	Insufficient staffing within Inpatient locations - Ward 15 (Formerly ward 12)	Surgery & Cancer	16	High Risk	06/02/2019
SC0611	Insufficient staffing within Inpatient locations - Ward 11	Surgery & Cancer	16	High Risk	06/02/2019
SC0620	Insufficient staffing within Inpatient locations - Ward 10	Surgery & Cancer	16	High Risk	06/02/2019

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

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

- University Hospitals of North Midlands NHS Trust
- CCICP Partners
- East Cheshire NHS Trust
- Local Authorities
- 'One to One' Midwifery

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

12. Summary of the Organisational Risk Register

Extreme Risk

Ref	Initial Date	Title	Description	Controls	Current Rating	Owner	Actions		Target Rating	Progress Update	Next Review Date
							Description	Target			
TW0001	09/09/2015	Delivery of key local and National targets and standards, in particular the 4 hour standard in A&E	There is a risk that National standards, performance targets and commissioner contractual requirements may not be achieved, as a result of an increasing demand on Trust services, which may lead to regulatory sanction and financial penalties.	1. Corporate governance infrastructure, systems and processes. 2. An Escalation Policy and a number of clinical pathways in place. 3. Performance management framework 4. Monitoring of performance at Trust Board, Audit Committee, PAFC and divisional boards 5. Monitoring of performance by CCG's 6. Quality, Safety and Improvement Strategy 2018/19 7. Fortnightly meetings with DGMs 8. Monthly finance and activity review meetings 9. Daily monitoring and 4 x daily bed management meetings with site reports populated 7 times a day 10. Weekly performance review meeting (PMG) 11. Breach analysis weekly 12. Urgent care steering group 13. A&E Delivery Board 14. Horizon scanning, agility and ability to respond 15. RTT Task and Finish group and action plan 16. Quarterly elective capacity and demand internal meetings 17. Cancer Performance Management (PTL) and Board Meetings 18. Annual Capacity and Demand Planning Process	20 5 x 4	Chief Operating Officer	1 Complete and implement Risk Management Systems Review 2 Further develop the performance management framework	31/03/2019 31/03/2019	10 5 x 2	This risk was previously titled 'Operational Sustainability of MCHFT'. The risk has been reviewed and rescored with the focus being on the Trust's target for the 4 hour standard in A&E. The risk will be reviewed at the next Executive review meeting, scheduled for December 2018.	12/02/2019
TW0002	02/09/2015	Long Term Financial Sustainability of MCHFT	There is a risk that the Trust may incur increased costs and a loss of income, as a result of inefficiencies in financial management, which may lead to the loss of long term financial sustainability.	1. Capped Expenditure Programme, delivered significant further savings across the health economy. 2. 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 and Care Partnership for Cheshire & Merseyside. 3. As part of a partnership, during 2017/18 the Trust strengthened its financial position through further efficienc opportunities which that presented. 4. The Trust underwent an NHS Improvement Use of Resources assessment in March 2018. 5. Performance management framework 6. Monitoring of performance at Trust Board, Audit Committee, PAFC and divisional boards 7. Monitoring of performance by CCG's of PbR contract 8. Monthly CIP performance meetings 9. Quality Impact Assessment Procedure 10. Theatre Productivity Group plan 11. Cash Flow monitoring and debt collection processes 12. Budget meetings on monthly basis 13. Recruitment initiatives (foreign and domestic) and Premia incentives 14. Tendering for services (new and existing) 15. Weekly performance meetings re: activity delivery 16. Winter Funding schemes through SRG 17. Implementation of Integrated Community Teams 18. Annual Plan 19. Clinical Services Strategy 20. Borrowings in place for key schemes 21. Successful Expert Determination concluded 22. Robust Cash Flow processes in place 23. Agreed Distress funding in place with Department of Health 24. Integrated Community Teams delivering controls on non-elective activity	20 5 x 4	Director Of Finance	6 Complete a review of Community Services governance 11 Develop an system-wide Recovery Plan	31/05/2019 30/09/2019	10 5 x 2	Risk updated.	27/04/2019
TW0003	24/09/2015	Workforce capacity and skill mix to consistently deliver high quality care, seven days a week	There is a risk that patients may not receive timely, high quality care, as a result of a failure to provide adequate numbers of staff with the appropriate skills seven days a week, which may lead to an adverse impact on patient safety, patient experience and clinical outcomes.	1. Recruitment to additional Consultant posts in the major acute specialties. 2. Divisional business cases in development to support the expansion of Consultant numbers to deliver the Seven Day Services Clinical Standards 3. Annual review of Consultant job plans to increase on site "out of hours" Consultant presence where pos 4. Recruitment to additional roles (e.g. Advanced Nurse Practitioners) to supplement the "out of hours" clinical medical workforce. 5. Critical Care Outreach Service available 24/7 6. Development of the Acute Care Model for inclusion in the potential investments for 2019/20 7. Prompt access to diagnostic services, including medical imaging and pathology. 8. Implementation of NEWS2 9. Policy for Adult In-patient Vital Signs and NEWS2 Monitoring 10. Advancing Quality programme. 11. Development of clinical pathways with external partners to ensure that patients receive appropriate, high quality care "out of hours" (e.g. stroke thrombolysis with the University Hospitals of North Midlands). 12. Engagement in the Getting It Right First Time (GIRFT) national programme 13. Quality governance infrastructure, systems and processes. 14. Patient Safety Summit 15. Seven Day Services Steering Group 16. Deteriorating Patient Steering Group 17. Implementation of the Structured Judgement Review process to review in-patient deaths 18. Quality and Safety Improvement Strategy 2018/19 19. On-call rotas for Executives and clinical support services (e.g. Pharmacy) 20. Trust Escalation Policy 21. Bank and agency staffing arrangements	20 5 x 4	Consultant	1 Approval with funding of business cases to expand Consultant numbers 2 Approval with funding of business cases to increase additional roles (e.g. Acute Care Model) 3 Continued engagement in the Getting It Right First Time (GIRFT) national programme 4 Implementation of lessons learned from SJR process 5 Explore the opportunities for closer clinical collaboration with East Cheshire Trust	31/03/2019 31/03/2019 31/03/2020 31/03/2020 31/03/2020	10 5 x 2	Risk updated.	27/04/2019

12. Summary of the Organisational Risk Register

High Risk

Ref	Initial Date	Title	Description	Controls	Current Rating	Owner	Actions		Target Rating	Progress Update	Next Review Date
							Description	Target			
CS0380	19/10/2018	Cyber Security	There is a risk that essential ICT functions may be impaired and services affected, as a result of a cyber-attack, which may lead to an adverse impact on patient safety and clinical care.	1. IT Starters and Leavers Processes 2. Mandatory Training 3. Physical security access controls 4. Removal media port lockdown for Trust IT equipment 5. Microsoft Patch Management 6. Password complexity for AD 7. VPN 8. Encryption to Trust owned device 9. Airwatch for Mobile devices 10. Cyber-security audits - KPMG/NHSD 11. 10 steps to cyber security Action Plan 12. IG Toolkit Compliance 13. Configuration Manager appointed Network is currently monitored by exception 14. Resource required to support software and hardware asset management processes 15. Ensure standard equipment build 16. Configuration management of assets/ process	16 4 x 4	Associate Director Of IT	7 Physical security access audits 8 NHSD Audit remediation plan completed 10 Cyber essentials review/action plan required 13 Review policy suit and consider what policies required 14 Develop TNA to assess further internal cyber security knowledge and expertise requirements 16 Disciplinary policy to be updated to reflect sanctions for cyber-security events 17 Replace AAS - Produce clinical systems business case for approval 18 Replace LIMS - Produce business case for approval 3 Port Lockdown on non-IT equipment (for example medical devices) 4 Internal network segmentation 11 Conduct regular vulnerability scans on the network	31/03/2019 31/12/2019 31/03/2020 31/03/2019 31/03/2019 31/03/2019 31/03/2019 31/03/2019 30/04/2019 30/04/2019 31/03/2020	8 4 x 2	Updated risk.	26/06/2019
DC0887	24/03/2015	Consultant Histopathologist Capacity	There is a risk that patient treament may be delayed due to delays in histology and diagnostic services, as a result of inadequate numbers of Consultant Histopathologists, which may lead to adverse clinical outcomes.	1. Locum Consultants are employed when available. Consultants to P code and triage cases. Consultants perform waiting list initiative sessions. External reporting of non-urgent cases 1WTE band 8A BMS Advanced Practitioner commenced 1/9/16. 1WTE band 7 (dissector) is to start on the 24/10/16 who will perform specimen dissection, freeing up Consultant time for reporting and MDT attendance etc. Investigating possibility of joint Consultant appointments at alternative trusts. 2. Business Continuity Plan (BCP09) for Consultant Histopathologist vacancies. Locum Consultants are employed when available. Consultants to P code and triage cases. Consultants perform waiting list initiative sessions. External reporting of non-urgent cases. 1WTE band 8A BMS Advanced Practitioner commenced 1/9/16. 1WTE band 7 (dissector) is to start on the 24/10/16 who will perform specimen dissection, freeing up Consultant time for reporting and MDT attendance etc. Investigating possibility of joint Consultant appointments with alternative trusts. Business Continuity Plan (BCP09) for Consultant Histopathologist vacancies. 3. Locum Consultants are employed when available. Consultants to P code and triage cases. Consultants perform waiting list initiative sessions. External reporting of non-urgent cases. 1WTE band 8A BMS Advanced Practitioner commenced 1/9/16. 1WTE band 7 (dissector) is to start on the 24/10/16 who will perform specimen dissection, freeing up Consultant time for reporting and MDT attendance etc. Investigating possibility of joint Consultant appointments with alternative trusts. Business Continuity Plan (BCP09) for Consultant Histopathologist vacancies. Communication sent to users regarding organisation of cases at MDT to minimise time required by Pathologists 4. Locum Consultants are employed when available. Investigating alternative ways of working, to free up Consultant time- advanced practitioners /senior BMS dissectors. Meeting arranged with Coroner to look at solutions in collaboration with local hospitals. Investigating possibility of joint Consultant appointments with other trusts. Business Continuity Plan (BCP09) for Consultant Histopathologist vacancies. 5. Locum Consultants are employed when available. Investigating possibility of joint Consultant appointments with other trusts. 6. Use of Bank staff as required, if available. Training in additional procedures. 7. Consultant of the week' to be rostered as a point of Contact for technical staff queries.	16 4 x 4	Pathology Service Manager	1 To continue to try to recruit to vacant Consultant Histopathology positions. 2 To continue to recruit to locum positions. 3 Investigate the possibility of obtaining support in certain specialties from other trusts	30/03/2020 30/03/2020 30/03/2020	8 4 x 2	There has been no progress with regards to this risk, as no new consultants have been recruited and the recruitment campaign remains in progress with the University Hospitals of North Midlands.	04/07/2019
DC1032	05/03/2018	Control of the backlog of patient's awaiting routine follow up in Dermatology	There is a risk that there is a delay to follow up reviews as an Outpatient as a result of increasing numbers of patients being added to the backlog list which may lead to an adverse impact on patient care and experience.	1. Clinical review of the longest waiting patients to appropriately prioritise appointments 2. Separate two week wait lists 3. Nurse led Biologics lists for Cancer pathway/high drug patients 4. Ensure all clinics are maximised 5. Service closed to out of area referrals 6. 2018/19 follow-up capacity increased by 1,000 slots	16 4 x 4	Deputy Divisional General Manager	1 Ensure all clinics are maximised to avoid loss of vital capacity 2 Validate the waiting list for duplicates and for those patients who have been seen since their follow-up due date 3 Increase follow-up capacity as consequence of reduction in GP referrals 4 Telephone consultations 5 Waiting List Initiatives 6 Recruitment of a fifth Consultant Dermatologist 7 Recruitment of an additional Dermatology Specialist Nurse	31/03/2019 31/03/2019 31/03/2019 31/03/2019 31/03/2019 31/03/2019 31/03/2019	8 4 x 2	29/01/19 Risk rating reviewed and increased in view of recent incidents where patient have been found in the backlog who have developed malignancies. A backlogs audit is being undertaken across the trust which will review any harm	29/04/2019

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							Description	Target			
EC0379	10/11/2016	Risks associated with inadequate Staffing levels - Ward 2	There is a risk that patients may not receive timely, high quality care as a result of low staffing levels on Ward 2, which may lead to an adverse impact on patient safety, experience, outcomes and overall quality of care.	1. Agency and Bank staff used on Ward 2. Matrons reviewing staffing across Wards on a shift by shift basis to see if staff can be re-allocated to support low staffed areas 3. Ward Manager working in the staffing numbers to provide patient care 4. Trust recruitment drives to get additional staff in to the Trust 5. Agreement now in place tio ensure third qualified nurse on night wont be taken off the ward unless it is for a critical situation.	16 4 x 4	Matron	1 Ward 2, AMU and ACU to arrange their own recruitment drive and advert to include rotation roleas across the areas	31/03/2019	6 2 x 3	The risk score as agreed to stay as 16 (has been this since 01/10/18) as there are still 6.69wte vacancies for qualified nurses from an establishment of 17.67wte.	25/04/2019
EC0387	23/03/2017	Lack of service provision within Respiratory	There is a risk of delay in patient treatment for inpatients/outpatients as a result of a lack of service provision within Respiratory Medicine due to vacancies at Consultant level which may lead to adverse clinical outcomes for patients.	1. NHS Locum and agency staff continually being sought 2. Developed joint post with UHSM - commences June 2019	16 4 x 4	Divisional General Manager	1 There is ongoing recruitment for the Respiratory Consultant vacancy. 2 Explore partnership working with External Trust for further joint posts 3 Exploring partnership working with other specialities within MCHT - discussion with Critical Care with regards to a joint post. 4 Explore ways of delivering the service e.g. implementation of additional ANPs/clinical nurse specialist	30/06/2019 30/06/2019 30/06/2019 30/06/2019	8 4 x 2	Joint post with UHSM to start June 2019. Exploration ongoing in to partnership working with other Trusts and internally for additional joint posts	10/06/2019
EC0397	19/06/2017	Risks associated with inadequate Staffing levels on ward 5	There is a risk that patients may not receive timely, high quality care as a result of low staffing levels on ward 5, which may lead to an adverse impacy on patient safety, experience and outcomes.	1. On-going recruitment. 2. Daily staffing review undertaken by the Matrons within the Division. 3. Ward escalation to Matrons when gaps present in rota. 4. Ward Managers within the Division review off duty to review the skill mix. 5. Use of Nurse Bank and Agency staff. 6. Planned implementation for a Pharmacy technician to be utilised on ward 5. 7. Safety huddles. 8. Involvement of Critical Care to facilitate NIV where appropriate.	16 4 x 4	Matron	1 Ongoing recruitment. To be reviewed at Respriatory Sub-Divisional Governance in March 2019.	31/03/2019	4 2 x 2	Changed from catastrophic to Major.	04/03/2019
EC0399	12/09/2017	Increased patient dependency when caring for 4 dependent Respiratory patients, which may be a combination of Non Invasive Ventilation and Tracheostomy patients	There is a risk of patient harm as a result of increased patient dependency/acuity when 4 dependant respiratory patients, who may require complex intervention e.g. Non Invasive Ventilation or Tracheostomy patients, are nursed on the ward when there are significant nursing vacancies or unavailable beds, which may lead to adverse clinical outcomes for patients.	1. If no NIV beds are available a referral will be made to a Critical Care Registrar/Consultant to see if they can take the patient. A review of patients currently on NIV on Ward 5 may also be undertaken as one of these patients may be a more appropriate Critical Care transfer. Critical Care operational policy has this stated within it and the SOP for ward 5 also refers to the option of Critical care when capacity / staffing / equipment is rendering no further beds. 2. On-going recruitment. 3. Daily staffing review undertaken by the Matrons within the Division (this may be done more often throughout a day dependant on staffing and acuity). 4. Ward escalation to Matrons when gaps present in rota. 5. Ward Managers within the Division review off duty to review the skill mix. 6. Use of Nurse Bank and Agency staff. 7. Safety huddles completed daily with Medics. 8. Involvement of Critical Care to facilitate NIV where appropriate. 9. Daily assessment of the ward acuity. 10. Selected location for NIV and tracheostomy patients to be nursed - will be cohorted if possible. 11. Critical Care Outreach Service (CCOS) referrals. 12. Trust EWS Escalation Guidelines.	16 4 x 4	Matron	1 New NIV machines to be bought for the Ward to replace the older machines 2 Training on the new NIV machines to be undertaken for all staff 3 A service review is required. The review should consider (amongst other things) the delivery of the service, step down/ ceilings of care, Consultant to Consultant escalation, the number of NIV machines within the Trust, contingency plans if high numbers of NIV patients are in the Trust and escalation / transfer processes.	28/02/2019 28/02/2019 31/03/2019	6 3 x 2	The Risk was reviewed and a new version created to include the risk of not having enough NIV beds available if required. The score was agreed as the same.	24/04/2019
EF0505	23/01/2019	Loss of Mechanical Infrastructure and Associated Resources: Leighton Hospital	There is a risk that utility pipeline equipment (expansion bellows, valves and actuators ect) connected to the Trust water, steam, or heating system may fail as a result of age, condition and no PPM(Including the regular exercising of valves) being carried out on which may lead to one of the major distributed services being unavailable within wards & departments?	Ongoing replacement programme in place Reactive 24/7 Estates maintenance staff on site Trust staff report new issues via Estates Helpdesk for further investigation/action Planned and "ad hoc" removal of asbestos from identified areas ongoing in order to allow isolation of faul valves/components for replacement or repair.	16 4 x 4	Head Of Estates	1 Continued repair or renewal of all existing valves/components etc. to be completed during refurbishment programme Planned Preventative Maintenance schedule for the inspection and maintenance of all valves/components (after asbestos has been removed).	23/01/2020	4 4 x 1		23/04/2019
PG0081	07/10/2009	Safety of Children and Staff on CAU in relation to staffing:	There is a risk of unsafe staffing levels/skill mix as a result of unforseen periods of increased activity and dependancy, leading to adverse impact for the safety of children and staff.	1. Duty rota completed with adequate coverage in a timely manner. Any gaps at this time are addressed proactively. Clear organisation of care at the beginning of each shift & adjusted accordingly. Co-ordinator escalates concerns to ward manager/consultant/senior manager. Multidisciplinary team working and joint decision making. Prioritising of care delivery. All attempts made to obtain Bank staff at times of high acuity. Continued goodwill of staff to work extra hours and under stress. STEAM acuity tool in place which provides appropriate escalation. Escalation plan in place. Paediatric bed management policy, ongoing recruitment campaign for appropriately skilled nurses with experience in paediatrics in conjunction with trust recruitment for trained nurses payment to contracted staff for extra duties at their normal rate. Staffing levels reviewed weekly against occupancy and dependency. Skill mix now includes 2 band 4 Paediatric Assistant Practitioners that have received appropriate Paediatric training. These staff rotate across days/nights. CAU Manager/Deputy attend Trust Recruitment Days to represent Paediatrics. 2. Current establishment allows for one HDU bed to be staffed (1:1). All staff attend PILS training annually. TNA shows requests for places on APLS course. Staff trained & competent to use HDU equipment, supported by practice educator. Ward co-ordinator manages shift based on patient needs and risk. Children requiring long periods of assisted ventilatory support are transferred via NWTS to appropriate tertiary centre. Considering options of transferring children out to other hospitals. Option of closing/relocating assessment to enhance staffing numbers presence. STEAM acuity tool in place which identifies appropriate escalation. Escalation plan in place. Payment to contracted staff for extra duties at their normal rate. Staffing levels reviewed against occupancy and dependency. All attempts now made to have 5 trained members of staff on nights plus 1 HCA. 3. CAU staff (listed on the bank) are asked to do extra shifts to cover. staff (non substantive) with experience in paediatrics. Bank system allows for text communication of available shifts at late notice..Escalation plan in place. Payment to contracted staff for extra duties at their normal rate. Staffing levels reviewed against occupancy and dependency. 4. Co-ordinator assesses and makes decision about most appropriate person to escort child. Plans then have to be put in place to ensure that the unit remains covered during the transfer. Escalation plan in place. Assistant Practitioners have knowledge which allows them to transfer low risk children. 'Treat and Transfer' agreed to avoid divert. 5. Ongoing review of acuity to monitor fluctuations in dependency. Dedicated Paediatric Bank (limited) available to cover unforeseen gaps. Escalation and triage of patients as required in line with escalation plan. Weekly staff availability lists within both areas. . All attempts now made to provide a supernumary shift co-ordinator on day shifts. Ward Manager and Deputy Ward Manager available to provide supernumary shift co-ordination in times of	16 4 x 4	Matron	1 Discussion at Acute Paediatrics Governance Committee regarding staffing levels on the new unit 2 Discussion at Acuity meeting with Head of Nursing As no beds being taken out in the summer due to reduced beds on the new unit, discussion needs to be had to enable staffing levels to remain the same throughout the year. Ref (RCN Defining Staffing Levels for Children and Young Peoples Services 2013)	01/03/2019 01/03/2019	8 4 x 2	This risk has increased from moderate to high risk over th past 12 months due to issues with staffing levels during the refurbishment and the staffing of two separate wards. Issues with staffing levels now need addressing on the new unit.	12/05/2019

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				high acuity and to cover unforeseen increases in acuity and gaps in staffing. 6. Design of new unit allows for improved patient flow and co-horting of patients, so pressure of siderooms is relieved. Provision of safe rooms allows safer admission for patients with Mental Health concerns and a reduction of 1:1 staffing for these patients may be possible. 7. Bank and agency staff are booked to cover when required. Uplift is monitored and discussed at 6 monthly actuiy meetings with the Director of Nursing. 8. Paediatric Matron in post who holds a registered children's nursing qualification and is available Monday - Friday (8-4). Majority of staff on the unit are Paediatric trained with PILS training. There is always a Band 6 in charge of the ward or senior band 5 in exceptional circumstances and a member of the medical team is always available for advice.						
PG0294	15/05/2018	Lack of Paediatric Audiology Staff	There is a risk that detection of hearing loss is delayed as a result of lack of audiology staff to man clinics, which may lead to learning, speech, behavioural and developmental problems which require treatment in a timely manner.	Staff are currently working over-time to prevent breaches in Trust targets and National guidance - not sustainable Weekend clinics being undertaken Administration relating to clinics, CPD and audits put on hold in times of annual leave The adult audiology service have agreed to release their staff to work on Paed clinics Temporary contracts & bank hours have been offered to audiologists to provide cover of routine services which will release the Clinical Specialist to cover specialist clinics 20 Saturday clinics (over 10 days) have been set up between April and July to help with demand for specialist clinics Clinical Scientist has begun triaging review appointments to identify patients who are being monitored due to professional concern rather than in line with a national protocol (e.g. NICE Glue ear guidelines, PHE NHSP surveillance protocols). These appointments will be delayed until there is sufficient staff in place, to help meet national and Trust targets	16 4 x 4	Clinical Scientist	2 Initial interviews were unsuccessful therefore to re-advertise for the scientist in April / May, to attempt to attract a newly registered scientist. a Consultant from Manchester has been asked to consider locuming in the interim	30/05/2019	8 4 x 2	Clinical Scientist has confirmed that that hearing loss identification and treatment will be delayed due to lack of staff- see attached e mail	29/07/2019
SC0535	30/11/2014	Insufficient staffing within Inpatient locations	There is a risk that there may be insufficient registered nursing staff within the surgical inpatient locations, to fully meet the needs of patients, due to a high vacancy factor. This may lead to adverse patient outcomes.	1. Minimum staffing levels agreed within division for inpatient locations. 2. Escalation of staffing issues to designated divisional co-ordinator 3. Escalation to Clinical Site Manager or Hospital at Night Team out of hours 4. Escalation to Senior Manager on-call if remains a risk/patient safety issue 5. Local, divisional review of all staffing incidents, reported via the incident reporting system, with wider corporat oversight 6. Two whole time equivaalent staff were offered and accepted posts at the Feb. 2019 Recruitment day to start in May 2019. 7. The organisation has decided to proceed with the option of internal recruitment of Registered Nurses to support MCHFT vacancy gaps.	16 4 x 4	Head Of Nursing	4 Utilising the investment agreed at Executive level to support the introduction of 12 hour shift patterns in to the Surgery & Cancer Division 7 There is Executive agreement to utilise registered agency nursing staff when staffing levels have reached a critical point via an agreed escalation process 1 Staffing incidents form part of the Divisional Quality Report which is presented to Divisional Board on a monthly basis. 2 Quality Report reviewed as part of Quality Performance review by the Executive team quarterly. 3 Staffing risk assessments have been developed for each surgical inpatient location to underpin this risk assessment and are to be reviewed and updated as per policy; Ward 9 - SC0610 Ward 10 - SC0569 Ward 11 - SC0601 Ward 13 - SC0600 Ward 15 - SC0601 Ward 18 - SC0609 5 Offer and support existing and new staff the opportunity to work their contracted hours in a more flexible way, therefore addressing the current challenges relating to the recruitment and retention issues 9 The Director of Nursing has introduced a multidisciplinary clinical workforce group to address the recruitment and retention challenges that the organisation must overcome; ? Ongoing recruitment ? Supporting Transition Into Acute Roles ? Return to Practice ? UK adaptation programme ? Rotational recruitment ? Trainee Nursing Associates/Nursing Apprenticeships ? Allied Health Professionals ? International Recruitment 10 Successful recruitment to registered nurse vacancies within the division.	30/09/2019 31/10/2019 23/01/2020 23/01/2020 23/01/2020 23/01/2020 23/01/2020 23/01/2020	8 4 x 2	Risk reviewed and remains as a 4x4=16. Action plan reviewed and updated with two actions closed.	30/06/2019

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SC0621	24/01/2019	Histology backlog issues impacted on Endoscopy Services	There is a risk that delays to treatment may occur as a result of Histology specimens not being reviewed within agreed timeframes which may lead to adverse outcomes for patients.	1. Post endoscopy procedure the case notes are held within Endoscopy Services until the endoscopy report is received and signed off by the Endoscopist/Consultant. 2. A number of controls have been developed by the Diagnostics and Clinical Support Services as reference within risk assessment - DC0887 3. 1 speciality grade medical staff is able to report histology outcomes unsupported. 4. 1 speciality doctor and 1 LAS doctor are undergoing peer support to develop the skill of a lone reporter 5. An Advanced Practitioner (AP) has been appointed to support sample dissection with Histopathology 6. A further Senior BMS in Tissue Dissection has been appointed and is currently undergoing appropriate training to become an AP. 7. 2 Additional pathology staff are undergoing upskilling in the role of dissection. 8. Additional Histology Consultant support is available at weekends via Waiting List Activity. 9. Additional training for Consultant Histopathology staff to support gastrointestinal requirements are unde development. 10. Business Continuity activity of access to external Pathology Services for reporting with a 4 day turn around confirmed 11. External reports have to be copied and pasted into MCHFT systems. 12. Further communication via trust information system. 13. A further Senior BMS in Tissue Dissection has been appointed and is currently undergoing appropriate training to become an AP 14. Additional pathology staff have undergoing upskilling in the role of dissection. 15. Additional Histology Consultant support is available at weekends via Waiting List Activity 08/2018 the current position is showing that sample turnaround is currently achieved as: 7 day - 46.5% compliant 10 day - 70.6% compliant 20 days - 97.5% compliant 42 days - 100% compliant	16 4 x 4	Manager	1 Pathology Services; 1. Additional training for Consultant Histopathology staff to support gastrointestinal requirements are under development	30/04/2019	8 4 x 2	Agreed at April EQGG	25/07/2019
TW0004	02/01/2013	Registered Nurse staff shortages	There is a risk that patients may not receive timely interventions to address their clinical needs, as a result of a reduced staffing capacity of registered nurses, which may lead to adverse impact on patient safety and clinical outcomes.	1. Trust Escalation Policy with revised staff escalation matrix, includes: Delivery of a daily staffing meeting with the aim of identifying staff to address gaps Consideration given to the use of agency staff following executive authorisation. 2. The Trust has the following 24/7 support services available: Senior Manager On-Call proving advice Clinical site managers Executive on-call 3. Embedded multi-disciplinary clinical workforce group (Consisting of task and finish groups to recruit RN role and roles outside of the traditional RN recruitment.) This group reports progress to the Executive Workforce Group. 4. Revised and active recruitment of newly qualified nurses, as part of a multi-disciplinary clinical workforc group 5. Fast tracking of ECF's to reduce delays in the recruitment process. 6. Use of exit interview data to inform retention strategies. 7. Trust promotional information added to job descriptions on NHS Jobs. 8. New ways of job advertising including use of social media. 9. Adverts revised to include set interview days. 10. Set of monthly arranged recruitment days across quarter 2. Those offered posts are then invited to 'Keep in Touch Days' 11. Temporary staffing efficiencies programme, specifically targeted at: Robust recruitment plan in place Efficient rota management, with the implementation of an electronic roster and KPI's to monitor perform e Improved ways of working for hospital bank SBAR tool in place to provide rationale for usage of off-framework agencies Awareness of agency cap and internal trajectory. Transgressions authorised by the executive team are reported to the Transformation and People Committee 12. Set of monthly arranged recruitment days across quarter 3. Those offered posts are then invited to 'Keep in Touch Days' 13. Revision of hospital bank service, including ways of recruitment, registered and unregistered fill rate. 14. Establish a process for collecting data from exit interviews and providing reports to divisional boards for consideration and action 15. Develop an annual recruitment plan, to include; open days, advertising etc. (including divisions)	16 4 x 4	Director Of Nursing & Quality	2 Recruit to vacant Registered Nurse posts. 3 Recruit to Trainee/Advanced Nurse Practitioner posts 4 Recruit trainee nursing associate posts 5 Develop a marketing strategy for nurse bank 6 Launch of career clinics 7 Launch of UK Adaption Programme 8 Consideration of internal nurse recruitment 9 Scoping of Registered Nurse Training in conjunction with Health Education Institutes using the apprentice levy 10 Consider the impact of Brexit on recruitment	31/03/2019 31/03/2019 31/03/2019 31/03/2019 31/03/2019 31/03/2019 31/03/2019 31/03/2019 31/03/2019	8 4 x 2	Risk updated.	27/04/2019

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							Description	Target			
TW0005	01/02/2010	Lone Working	There is a risk that staff may be subject to assault, as a result of failing to follow Trust procedural documents and guidance, which may lead to an adverse impact on staff safety	1. Lone Working Policy 2. Management of Aggressive behaviour Guideline 3. Security Policy 4. Personal Safety Guideline for the Lone, Isolated and Community Worker 5. CCTV on Leighton and Northwich sites 6. Digital locks to external entrances 7. 24hr Security on Leighton site Access controls to Wards 8. Window restrictors 9. Assistance button to car park barriers 10. Divisional Lone Worker risk assessments 11. Some divisions issue lone worker protection devices for lone workers in the community or off site 12. Audit of Lone Worker incidents to monitor trends 13. Conflict resolution training in place	16 4 x 4	Director Of Nursing & Quality	1 1. Ensure Lone Worker protection devices are available to staff as required / requested 2. Establish training programmes for lone workers 3. Implement system of work for Lone Workers according to Trust Policy	30/04/2019	4 4 x 1		17/04/2019
TW0006	09/08/2018	Lack of pace in the significant transformational change required to deliver the Cheshire East Place strategy and consequently the Health and Care Partnership (HCP) for Cheshire & Mersey	There is a risk that the Trust and system may not undertake transformational change within the timeframes required to deliver the Cheshire East Strategy as a result of growing demand and increased financial pressures, which may lead to an adverse impact on patient safety, care and experience.	1. Quality, Safety and Improvement Strategy 2. Risk Management Strategy & Framework 3. Patient and Public Involvement Strategy 4. Transformation and change programmes 5. Quality Impact Assessment Process 6. Transformation & People Committee 7. Health and Care Partnership for Cheshire & Mersey 8. Estates Strategy 9. 7 day clinical services 10. Cheshire East Place strategy under development 11. Place Governance in place 12. CEO is a lead for the C&M Acute Sustainability work therefore is able to keep informed and influence 13. Place strategy implemented which will include the development of an Integrated Care Partnership (ICP) 14. Outcomes for the East Cheshire Trust Service Change Proposals	16 4 x 4	Medical Director	1 ICP organisational form and governance to be developed 2 ICP to be implemented 3 ECT Service Change Proposal. Pre-consultation business case 5 Resolve anxieties raised by GP membership	31/12/2019 30/04/2021 30/10/2019 30/06/2019	8 4 x 2	Risk updated	26/06/2019
TW0010	12/12/2018	Medical Devices Running Legacy Operating System Software	There is a risk that Trust IM&T systems will fail to function efficiently and effectively, as a result of a cyber-attack targeting unsupported operating systems such as Windows 2000, Windows XP or unpatched medical devices, which may lead to an adverse impact on patient care and safety	1. Patch devices that are managed by ICT Services. 2. Procurement of new systems - DPIA Procedure in place	16 4 x 4	Associate Director Of IT	1 Secure funds to replace medical devices that operate on unsupported operating systems. 2 Segment the network to limit the reach of a cyber-exploit. 3 Identify unsupported or unmanaged medical devices. 4 Upgrade firewall to improve perimeter security. 5 Liaise with medical suppliers about the upgrade path or patching process.	31/03/2019 31/01/2019 31/01/2019 31/01/2019 31/01/2019	8 4 x 2		28/03/2019
DC1025	16/01/2018	CT Scanning Equipment	There is a risk of delay in patient diagnosis, as a result of insufficient CT capacity to meet the demand, which may result in adverse patient clinical outcome.	1. Clinical examination and judgement to priortise CT scanning requirements 2. Outsourcing undertaken where appropriate 3. Maintenance contract in place until March 18 and agreement with manufacturer that post March 18 repairs will be made on a best endeavours basis	15 5 x 3	Director ate Manager	1 Develop and submit a Business Case for a replacement Lightspeed scanner and the procurement of an additional scanner with replacement of the second existing scanner over a three year period.	16/01/2019	5 5 x 1	Replacement works commenced in March 2019 and are currently in progress.	04/07/2019
DC1044	14/11/2018	Laboratory Information Management System (LIMS) for Pathology - End of Life	There is a risk that LIMS could fail, as a result of Clinisys the supplier, sunsetting (gradual phase out) the LIMS from 2022, which may lead to an adverse impact on clinical outcomes.	1. Upgrade to the latest version of Labcentre i.e. version 1.14 in October 2018. This upgrade includes all National Standards/guidelines to date. 2. Full maintenance/support currently being provided by Clinisys. 3. Visits commenced to other institutions to identify possible replacement LIMS and demos organised with Suppliers.	15 5 x 3	Pathology Service Manager	1 Complete Strategic options Case (SOC) and submit to relevant Trust Boards 2 Complete procurement/implementation prior to Labcentre end of Life	31/03/2019 31/12/2022	5 5 x 1		14/05/2019
DC1054	24/04/2019	Cardio-Respiratory Department staffing	There is a risk of delays in diagnosis for patients undergoing investigations by the cardio-respiratory department as a result of a national shortage of appropriately skilled staff (identified in the Getting It Right First Time) which may lead to delays in treatment and harm to patients.	Ongoing recruitment campaign Recruitment & retention policy Waiting list initiatives Use of locum staff until recruitment to substantive post. This will be reviewed every three months	15 5 x 3	Manager	1 Advertise vacancy Continue to liaise with locum agencies Continue with waiting list initiatives Robust management of diaries Upskilling of existing staff 2 Consider outsourcing reporting of ECG monitoring	30/09/2019 30/09/2019	5 5 x 1		23/07/2019

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EC0342	15/06/2015	Failure to Meet Access Targets Across the Specialities within the Division	There is a risk of non compliance with national targets as a result of Consultant vacancies which may lead to financial penalties and adverse clinical outcomes for patients.	> Weekly monitoring of the use of waiting list initiatives > The use of external agencies for virtual clinics > General practitioners with specialist interest to assist with clinics.	15 3 x 5	Divisional General Manager	3 Locum cover for substantive Gastroenterology Consultant vacancy 2 Discussions taking place with UHNM and External Compamny to review hw the Cardiology service is provided	30/06/2019 28/02/2019	10 2 x 5	Business Case and service review undertaken for Cardiology for additional ACP & HF. Awaiting to see if this will be financed through investment rounds.	10/06/2019
EF0512	23/01/2019	Water Distribution / Temperature	There is a risk of Legionella Pneumophilia bacteria build up within the trust domestic hot water system as a result of water temperatures at the extremities of the site and "A" wards tailing off below 55 degrees Celsius at times of little use. Which may lead to water flow problems likely to be caused by system imbalance due to balancing valves being altered and additional loads on the system?	Chlorine Dioxide dosing of potable raw & domestic hot water Temperature control regime in compliance with ACOP L8, HSG 274 & HTM 04-01 Monitoring & Management as required by ACOP L8, HSG 274 & HTM 04-01 in place Flushing regimes carried out by individual wards & departments Domestic hot water plate exchanger temperature control raised to 62 deg C in order to achieve a minimum 60deg C supply to each ward & department	15 5 x 3	Head Of Estates	1 Ongoing Trust refurbishment programme to include work to balance and ensure flow & return temperatures are greater than 55° C throughout site HW distribution systems (including wards & departments).	23/01/2020	5 5 x 1		23/04/2019
EF0548	25/01/2019	Critical Risk Adjusted Backlog Maintenance	There is an increasing year on year risk that the building and estate infrastructure will deteriorate beyond repair or fail due to Insufficient funding of the Trust backlog maintenance programme and an Increased use of existing estate resulting in failure of infrastructure (building & plant) adverse external audits, impact on service delivery, cancelled lists, poor working conditions for staff and or Injury. Estimated time to failure may be circa <5 years.	Reactive breakdown maintenance via Estates helpdesk Planned Preventative Maintenance programme Capital Development Programme Backlog Maintenance Programme	15 3 x 5	Associate Director Of Estates & Property Managemen	1 Consideration be given to either increasing the backlog maintenance funding or ring fencing all or part of the monies	25/01/2020	9 3 x 3		25/04/2019
PG0057	22/04/2009	Inadequate Availability of Medical Staff within Paediatrics	There is a risk that Paediatrics and Neonatology are unable to cover the rotas as a result of a current national shortfall to the number of doctors, leading to adverse impact for staff, patients and the Trust.	1. Locum cover provided where available. 2. Existing consultants and medical staff working over and above expected shifts to alleviate some of the shortfall. This is not sustainable. 3. Medical staffing continue to attempt to recruit to vacancies. Clinics reduced or cancelled if no middle grades available, priority given to ward and emergency work. 4. Neonatal and Paediatric ANPs placed on medical rota to address gaps. 5. Nursing staff aware of requirement to work to NMC Code of Conduct. Locum cover provided where available. Existing consultants and medical staff working over and above expected shifts to alleviate some of the shortall. This is not sustainable. Medical staffing continueto attempt to recruit to vacancies. Clinics reduced or cancelled if no middle grades available, priority given to ward and emergency work. 6. Staffing issues discussed monthly at divisional governance meetings. Gaps in rotas examined on daily basis and issues escalated. Senior Management team aware of staffing situation.	15 5 x 3	Consultant Paediatrician	1 Meetings and discussions continue to take place examining all possible solutions to cover shortfalls. Issues around annual leave, provision of locums and WTD being taken into account.	31/01/2019	5 5 x 1	Clinical Lead has provided the following update; Planned to interview for the diabetes post tomorrow but the candidate has withdrawn this afternoon so unable to drop the risk severity yet. Interviews for the CF 10PA post on 9th April. Hopefully w able to interview for the diabetes post again that day too (possibly have someone interested). About to advertise for a 6 month part-time post if the ECF gets approval tomorrow. Should also be advertising shortly for a substantive part time post to do the rest of JDr Ellison's job but also preparing a business plan to potentially make a full time post.	17/04/2019
PG0272	08/06/2016	Inadequate availability of medical staff to cover rotas - Obs and Gynae	There is a risk that Obstetrics and Gynaecology are unable to cover the rotas as a result of a current national shortfall to the number of doctors, which may lead to an adverse impact for staff, patients and the Trust.	1. Full complement of Junior Trainees. Gaps in rotas identified well in advance by Rota Co-ordinator who then liaises with Gynae Assistant Service Manager(now aware of gaps until August 16). All attempts made to fill gaps - advertise with Medical Resourcing 4-6 weeks prior to gap. E mails sent out to all trainees including AMPs to identify any staff able to fill gap. Advertisment of shift at higher level (still within Monitor rate). Escalation to Consultants within 1 week of the gap if still unable to fill. 2. There is always a Consultant on call available. Full complement of Junior Trainees. Gaps in rotas identified well in advance by Rota Co-ordinator who then liaises with Gynae Assistant Service Manager(now aware of gaps until August 16). All attempts made to fill gaps - advertise with Medical Resourcing 4-6 weeks prior to gap. Staff in Maternity have access to AMPs for advice or clinical review if required. E mails sent out to all trainees including AMPs to identify any staff able to fill gap. Advertisement of shift at higher level (still within Monitor rate). Escalation to Consultants within 1 week of the gap if still unable to fill. Obs/Gynae escalation plan in place. All qualified staff work within their NMC Code of Conduct and are aware not to undertake duties that they are not competent to carry out. 3. Full complement of Junior Trainees. Gaps in rotas identified well in advance by the Rota Co-ordinator who then liaises with the Gynae Assistant Service Manager. All attempts made to fill gaps which are advertised with Medical Resourcing 4-6 weeks prior to the gap. E mails are sent out to all trainees including AMPs to identify any staff able to fill the gap. Shifts can be advertised at a higher level (still within Monitor rate). Escalation to Consultants within 1 week of the gap if still unable to fill. 4. Quality review meetings focusing on CQC domains. Staffing issues discussed monthly at divisional governance meetings and Labour Ward forum. Staffing incidents also discussed at the fortnightly Patient Safety Summit. Gaps in rotas examined on daily basis and issues escalated. Senior Management team aware of staffing situation.	15 5 x 3	Obstetric Consultant - Risk Lead	1 Post out on rolling basis for speciality doctor, live on NHS jobs Adverts out for long term locums with medical staffing ongoing Vanguard Meetings continue examining service provision within the NW To continue monitoring this issue at monthly governance meetings and DECP fortnightly meetings.	31/01/2018	10 5 x 2	The Middle grades are better now but the juniors we are going to have a 3.4 gap from February - covering with locums so keep grading as it is at present.	16/04/2019

12. Summary of the Organisational Risk Register

High Risk

Ref	Initial Date	Title	Description	Controls	Current Rating	Owner	Actions		Target Rating	Progress Update	Next Review Date
							Description	Target			
SC0626	31/12/2018	Control of the backlog of patient's awaiting routine follow up - General Surgery	There is a risk that there is a delay to follow up reviews as an Outpatient as a result of increasing numbers of patients being added to the backlog list which may lead to adverse impact or a patient safety and patient experience	1. Weekly Performance Management Group report to Divisional Senior Management Team. 2. Ensure all clinics are maximised. 3. Advertisements have been publishing advertising for an additional Upper GI consultant. 4. Non-clinical validation of waiting list to remove those where follow up Is not required with in General Surger has been completed and continues to be validated on a fortnightly basis. 5. The BIU have been asked to deliver a weekly report for each tumour group which includes a cancer ta identifier also. 6. ECF waiting lists have been applied for by General Surgery. 7. Capacity and Demand analysis has been completed and agreement of way forward to be agreed 8. Monthly validation continues. 9. Review of new routine capacity to follow up and outline the impact. 10. Additional capacity and medical staff required to reduce the backlog. 11. The department are therefore trying to put in additional registrars to the clinics to see the follow up backlog patients, however, this only equates to two clinics per month at 8 patients per clinic. 12. Review of use of nurse led follow up clinics; seen by the Clinical Nurse Specialist following Colorectal risk stratification	15 3 x 5	Service Manager	2 Exploring use of virtual clinics in colorectal.	31/08/2019	6 3 x 2	Agreed at EQGG April 2019	25/07/2019
TW0007	07/09/2018	Delayed routine outpatient follow-up	There is a risk that routine outpatient reviews will not be followed up in a timely manner, as a result of demand exceeding capacity, which may lead to an adverse impact on patient safety and clinical outcomes.	1. Eight speciality risk assessments have been drafted and/or updated, including; Gastroenterology, Cardiology, Dermatology, Respiratory, Rheumatology, Orthopaedics, Urology and General Surgery. 2. Executive review of speciality risk assessments and progress on actions. Trust executive team update quarterly.	15 3 x 5	Chief Operating Officer	1 To create backlog risk assessments for each speciality; Gastroenterology Cardiology Respiratory Rheumatology Urology General Surgery 2 Update executive team on position 3 Source additional external consultancy capacity; a) Place tender on NHS Portal for additional external consultancy capacity via managerial service b) Award contract to external provider c) Commence with external support	31/01/2019 31/01/2019 28/02/2019	6 3 x 2		24/03/2019

We Care Because You Matter

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

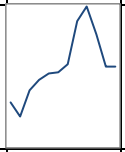
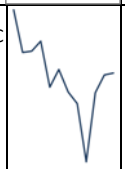
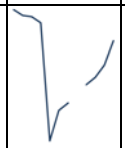
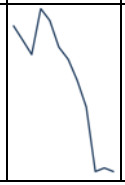
Board of Directors

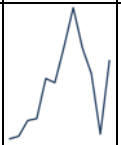
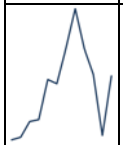
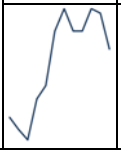
Workforce Report

June 2019

(April 2019 data)

Performance Report Workforce Chapter
Month: Apr-19

Measure	Target	Performance	Description	Narrative	Rolling Trend	Trend	C&W Average*
Sickness Absence	3.90%	4.37%	Rolling 12m average Sickness Absence described as a Percentage	The rolling position declined slightly (+0.04%) from the previous month but remains Amber. Corp and CCICP improved their rolling position. Corporate is currently Green and meeting the divisional target and DCSS, WC and CCICP are Amber. MEC, EF and SC are Red (5.36%, 5.00%, 4.72%)		↑	4.92%
In-Month Sickness Absence	N/A	4.41%	In-month 12m average Sickness Absence described as a Percentage	The in-month position improved from the previous month (-0.04%). All divisions experienced reduced sickness absence levels with the exception of DC (+0.15%), EF (+1.23%), and CCICP (+0.45%)		↓	4.88%
Appraisal Rate	90.00%	82.35%	Percentage of Staff who have received an appraisal in the last 12 months. Excludes New Staff with less than 12m service and Bank Staff	Overall, there was a 0.10% improvement in the appraisal rates across the Trust. All divisions with the exception of MEC (-6.91%), EF (-0.16%), and CCICP (-1.60%) experienced an improvement in compliance, the most significant being Corporate (+6.29%).DCSS are now Green and the remaining divisions are Amber with the exception of MEC who are Red (58.43%)		↑	89.35%
Mandatory Training	90.00%	78.60%	Mandatory Training Monthly Rate Excludes Bank Staff, Staff on long term sick & mat. leave.	Training compliance increased by 2.39% in month and all divisions secured an improvement. DCSS, SC and WC are Amber. Other divisions remain Red. MEC are the most challenged by this target (70.70%) but imporoved their position this month.		↑	88.43%
Staff Turnover	10.00%	9.90%	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 turnoverimproved slightly in month (-0.04%). Turnover reduced in Corporate, DC, MEC, and CCICP. All divisions are Green against target with the exception of MEC and CCICP (13.05% and 11.13%)		↓	10.74%

Measure	Target	Performance	Description	Narrative	Rolling Trend		
Agency Spend	(403)	(638)	In month and cumulative total spend for the Trust.	Agency spend reduced in month (£253k less than the previous month) and the agency spend target and NHSI ceiling target were both met. Medical and Dental agency spend remained static but nurse agency increased back to previous levels. All divisions saw increased agency spend.		↑	N/A
NHSI Ceiling	less than 100%	158.31%	Trust Agency Spend as a percentage of the Ceiling Set by NHS Improvement			↑	N/A
Over Cap Rates	N/A	58%	Number of Agency shifts filled by agency staff that are over the nationally determined capped rates			↓	N/A

*As at March 2019 (latest available)

Key

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