Mid Cheshire Hospitals NHS Foundation Trust

AGENDA

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

Action Key	
A	Approval
I	Information
D	Discussion

Item No	Title of Item	Action	Led By	Page No.
1.	**Welcome and Apologies** To welcome members of the public and attendees and to receive apologies for absence from Board Members. *(to note)*	I	Chairman **09.30**	-
2.	**Patient or Staff Story** *(verbal)*	I/D	Director of Nursing & Quality **09.32**	-
3.	**Board Member's Interests** *(to note)* To **consider** any • Changes to Directors' interests since the last meeting • Conflicts of interest deriving from this agenda	I	Chairman **09.50**	-
4.	**Minutes of the Last Meeting** To **approve** the minutes of the Board of Directors meetings held in Public on Monday 5 August *(attached) (for approval)*	A	Chairman **09.52**	**4-15**
5.	**Matters Arising and Action Log** *(verbal) (to approve)*	A	Chairman **09.55**	**16**
6.	**Annual Work Programme 2019/20** *(attached)* *(to approve)*	I/A	Chairman **09.57**	**17**
7.	**Chairman's Announcements** (*to note a verbal report*) **7.1 Cheshire East Partnership Chairs Meeting**	I	Chairman **10.00**	-
8.	**Governor's Items** (*to note a verbal report*) **8.1 Chat with the Chairman – 5 August** **8.2 Cheshire West and Chester Partnership Governor**	I	Chairman **10.10**	-
9.	**Chief Executive's Report** *(to note a verbal report)* **9.1 System Update**	I	Chief Executive **10.15**	-

Item No		Title of Item	Action	Led By	Page No.
	9.2	**Break Framework**			
	9.3	**100 Day Plan**			
10.	**CARING**				
	10.1	**Quality, Safety & Experience Report** *(attached) (for discussion)*	I/D	Director of Nursing & Quality **10.25**	**18-64**
11.	**SAFE**				
	11.1	**Draft Quality Governance Committee notes from the meeting held on 12 August 2019** *(attached) (to note)*	I	Committee Chair **10.45**	**65-85**
	11.2	**Serious Untoward Incidents and RIDDOR Events** *(verbal)* (*to note*)	I/D	Interim Medical Director **10.50**	
12.	**RESPONSIVE**				
	12.1	**Performance Report** *(attached) (to note)*	I/D	Chief Operating Officer **10.55**	**86-108**
	12.2	**Draft Performance & Finance Committee notes from the meeting held on 22 August 2019** *(to follow) (to note)*	I	Committee Chair **11.05**	**-**
	12.3	**Legal Advice** *(verbal)* (*to note*)	I	Chief Executive **11.10**	**-**
	12.4	**Quarterly Report on Learning from Deaths – Q1 2019/20** *(attached) (to note)*	A/D	Chief Executive **11.15**	**109-125**
13.	**WELL-LED**				
	13.1	**Visits of Accreditation, Inspection or Investigation** *(verbal)* (*to note*)	I	Interim Chief Executive **11.20**	**-**
	13.2	**Board Assurance Framework Q1 2019/20** *(attached) (to note)*	A/D	Director of Nursing and Quality **11.25**	**126-171**
	13.3	**Quarterly Organisational Risk register Q1 2019/20** *(attached) (to note)*	A/D	Director of Nursing and Quality **11.30**	**172-188**
	13.4	**Doctors Revalidation Report** *(attached) (to note)*	I/D	Interim Medical Director **11.35**	**189-198**

Item No	Title of Item	Action	Led By	Page No.
13.5	**Request to use the Trust Seal x 2** *(attached) (to note)*	A/D	Chief Executive **11.40**	**199-203**
14.	**EFFECTIVE**			
14.1	**Workforce Report** *(attached) (to note)*	I/D	Director of Workforce and OD **11.45**	**204-208**
14.2	**Transformation and People Committee notes from the meeting held on 8 August 2019** *(attached) (to note)*	I	Committee Chair **11.55**	**209-225**
14.3	**Consultant Appointments** *(verbal) (to note)*	I	Interim Medical Director **12.00**	**-**
14.4	**Ward 19 Business Case** *(attached) (to approve)*	A/D	Chief Operating Officer **12.05**	**226-251**
15.	**Any Other Business** *(verbal)*	A/I/D	Chairman	**-**
16.	**Time, Date and Place of Next Meeting** To confirm that the next meeting of the Board of Directors will take place in public, in the Boardroom, Leighton Hospital at 9.30am on **Monday, 5 October 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
19/08/14.2.2	05/08/2019	Link to the case highlighted by NHSI/E in regard to the impact of investigations on staff to be circulated	T Brocklebank	31/08/2019	Circulated 08/08/19	02/09/2019	

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						
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					
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

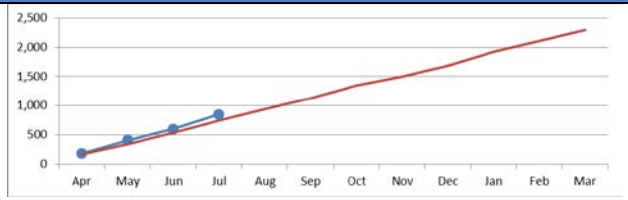
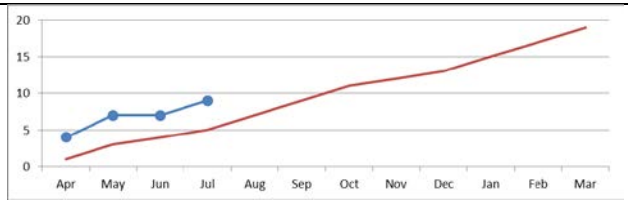
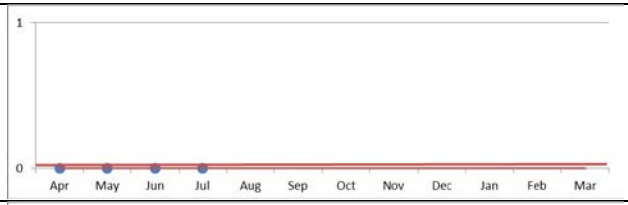
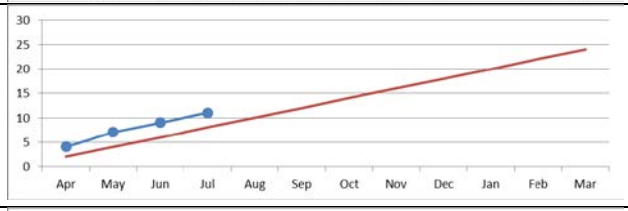
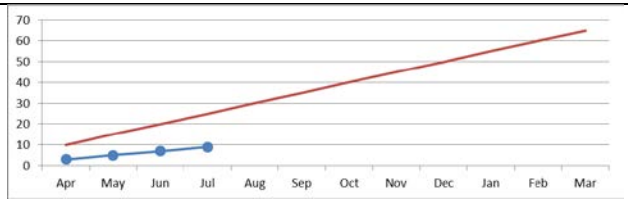
Quality, Safety and Experience Report

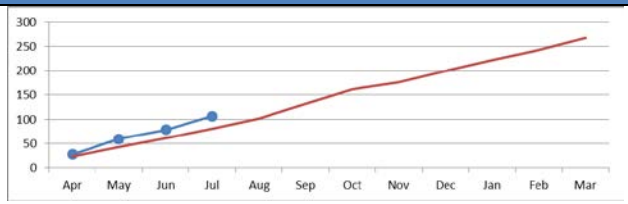
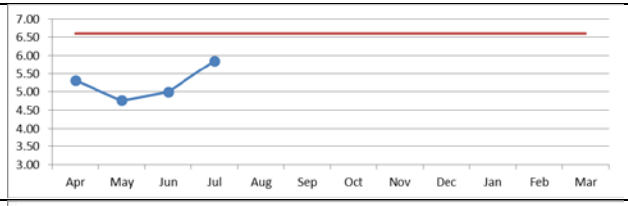
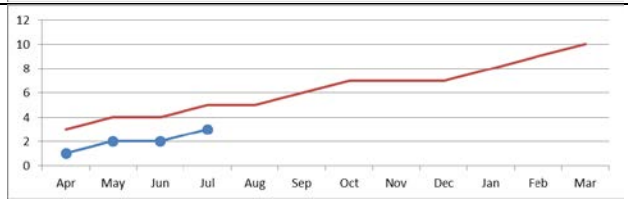
September 2019

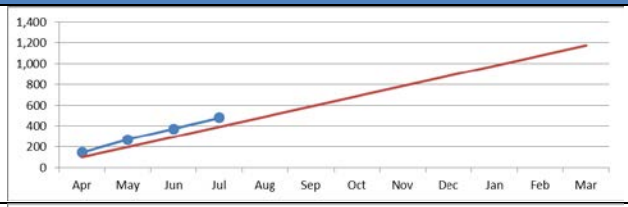
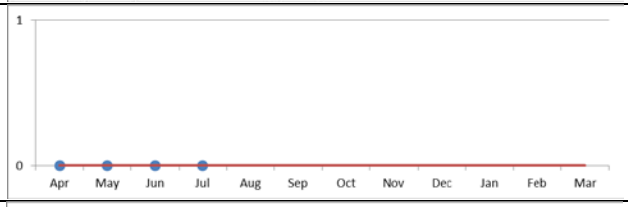
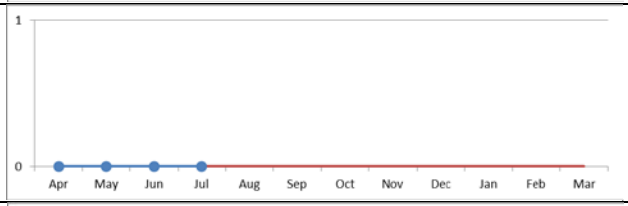
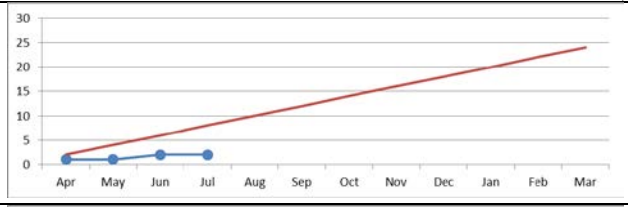
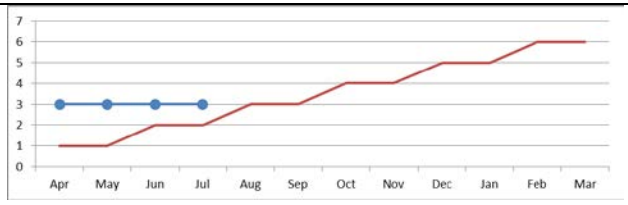
(July 2019 data)

Contents

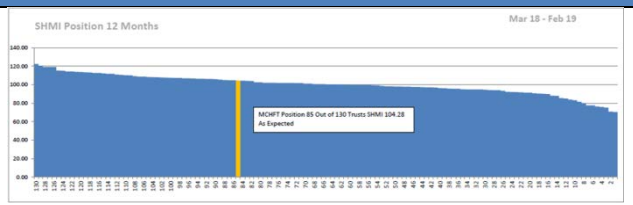
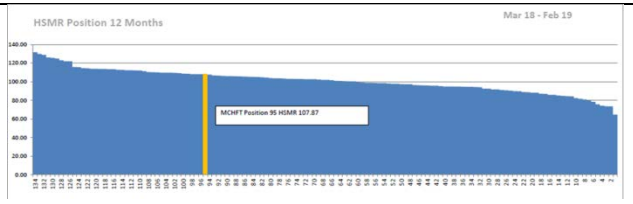
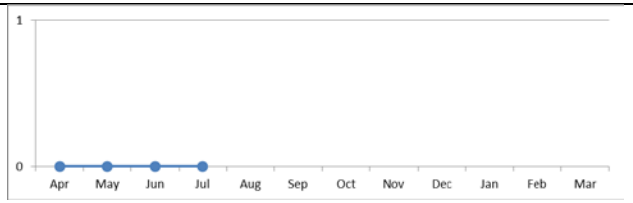
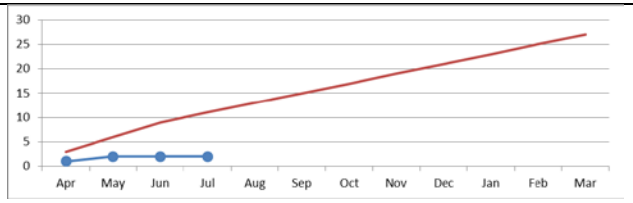
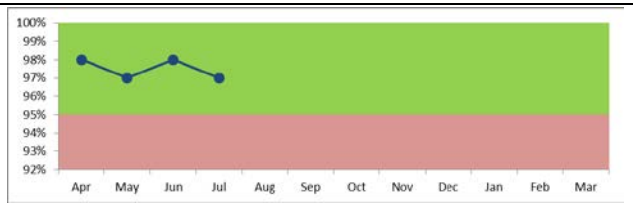
Contents (continued):

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

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

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

Board Papers – Quality, Safety & Experience Section: September 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:

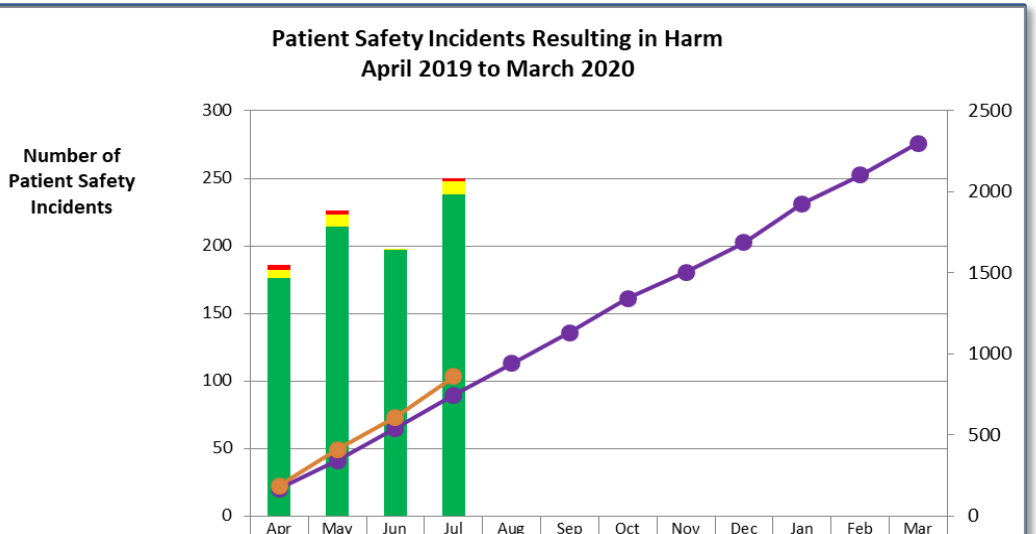
Description	Aggregate Position	Trend

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 July 2019, there were a total of 250 patient safety harm incidents:
95.2% (238 incidents) have resulted in low harm
4% (10 incidents) have resulted in moderate harm
0.8% (2 incidents) have been reported to StEIS
Improvement actions include;

- The Trust continues with twice monthly Patient Safety Summit meetings. Following each Patient Safety Summit a 'Safety Matters' newsletter is developed and distributed across the organisation. The newsletter contains learning from incidents, mortality case note reviews, local or national updates and Summit messages of the week.
- A review of the 48 hour rapid response process has taken place to ensure immediate response/any required action is taken following the reporting of a suspected serious incident.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
StEIS Reported Incidents	4	3	0	2								
Moderate Harm	6	9	1	10								
Low Harm	176	214	197	238								
Target	170	342	541	748	942	1131	1343	1503	1686	1926	2104	2299
Cumulative Total 2019/20	186	412	610	860								

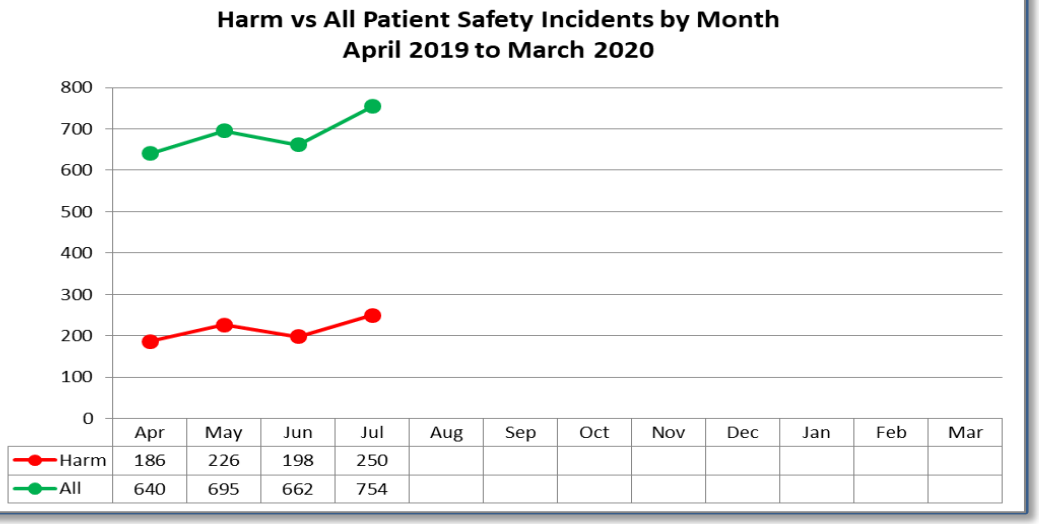
Harm vs All Patient Safety Incidents

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

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

In July 2019, the gap between harm and all patient safety incidents was 504. The aim over the twelve month period is to see this gap widening.

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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Harm	186	226	198	250								
All	640	695	662	754								

Description	Aggregate Position	Trend

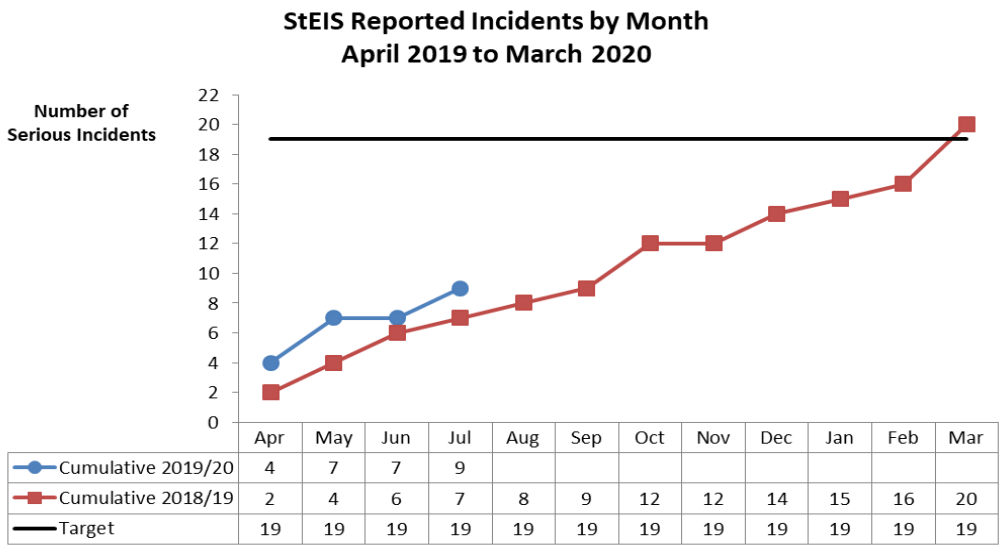
StEIS Reported Incidents

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

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

For July 2019, there were 2 StEIS reported incidents.

- A patient fall outside the renal unit which resulted in a fractured neck of femur
- Delay in review of a patient in Ophthalmology which resulted in potentially avoidable permanent harm



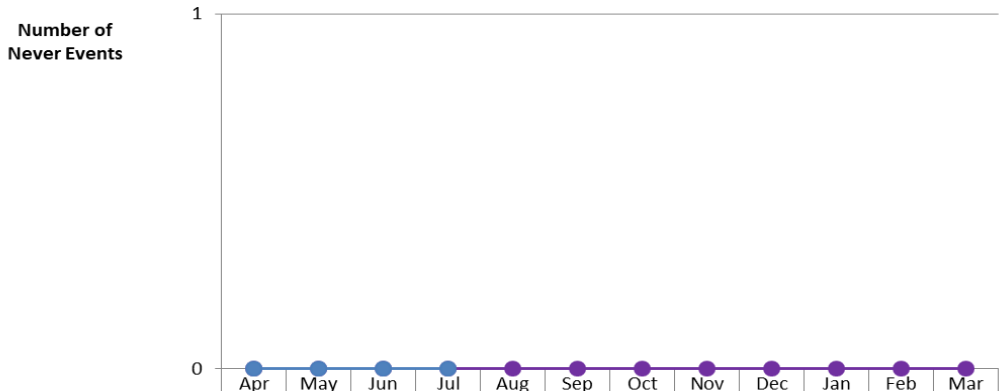
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative 2019/20	4	7	7	9								
Cumulative 2018/19	2	4	6	7	8	9	12	12	14	15	16	20
Target	19	19	19	19	19	19	19	19	19	19	19	19

Never Events

The target is to have zero Never Events

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

For July 2019 no Never Events were reported.



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

Description	Aggregate Position	Trend

Pressure Ulcers (PU) – Hospital Acquired

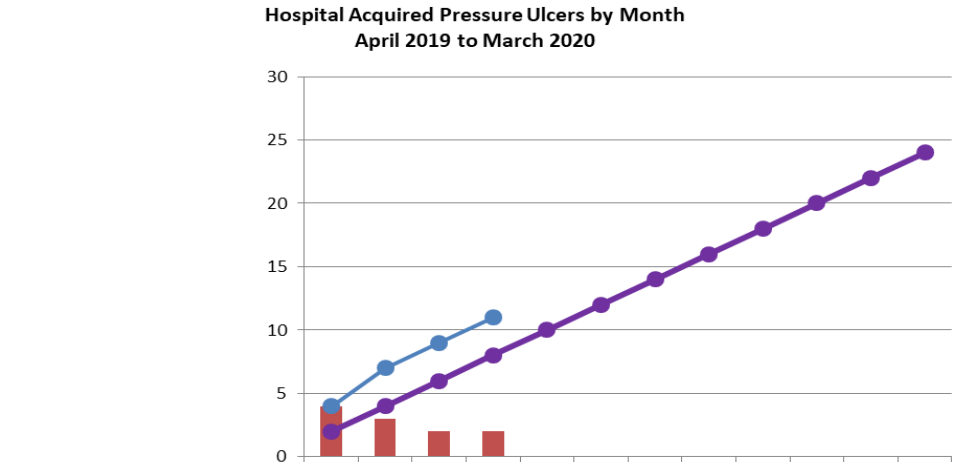
The target is to have no more than 24 pressure ulcers resulting from lapses in care by the end of March 2020.

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

- 11.1% (2 PUs) occurred with lapses in care that did contribute to the PU.
- 11.1% (2 PUs) occurred with lapses in care that did not contribute to the PU.
  27.8% (5 PUs) occurred with no lapses in care identified.
- 22.2% (4 PUs) confirmed but awaiting tool.
- 27.8% (5 PUs) are awaiting confirmation from PUP.

Following an increase in the number of pressure ulcers relating to medical devices in particular cervical collars a number of actions have been taken. This has included:

- The development of an information leaflet on the care of cervical collars
- The development of a cervical collar skin inspection observation chart
- The development of an education programme on the management of patients with cervical collars for clinical teams.
- Education regarding cervical collar care & management will be delivered at the SSKIN Link Nurse Sessions



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Lapses in Care Identified	4	3	2	2								
Cumulative Lapses in Care	4	7	9	11								
Lapses in Care Cumulative Target	2	4	6	8	10	12	14	16	18	20	22	24
% Lapses in Care PU	28.6%	20.0%	13.3%	11.1%								

Medication Harm Incidents

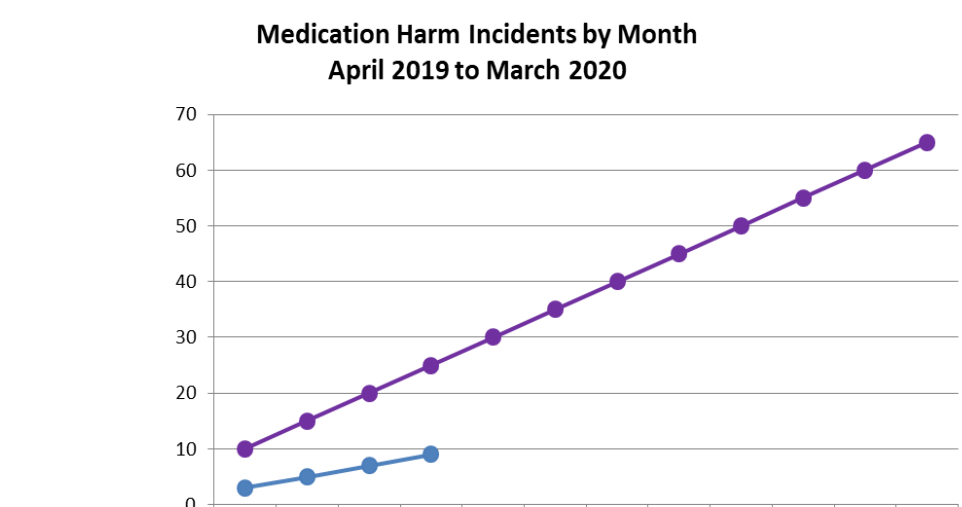
The target is to reduce the total number of medication incidents resulting in harm when compared to the previous financial year by the end of March 2020.

For July 2019, there were a total of 2 medication incidents resulting in harm reported:

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

Improvement actions include:

- Junior medical staff training and E-learning package is in place
- Medicines management training for nurses has been updated
- Monthly lessons learned shared from the Safe Medicines Practice Group
- Pharmacy enablement policy approved which enables pharmacists to amend prescriptions which are unsafe or unclear.

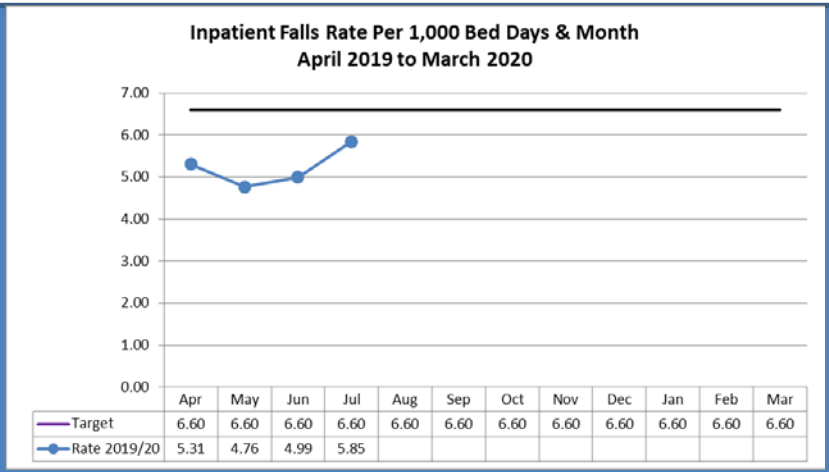


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative Total	3	5	7	9								
Cumulative Target	10	15	20	25	30	35	40	45	50	55	60	65

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

Inpatient Falls.

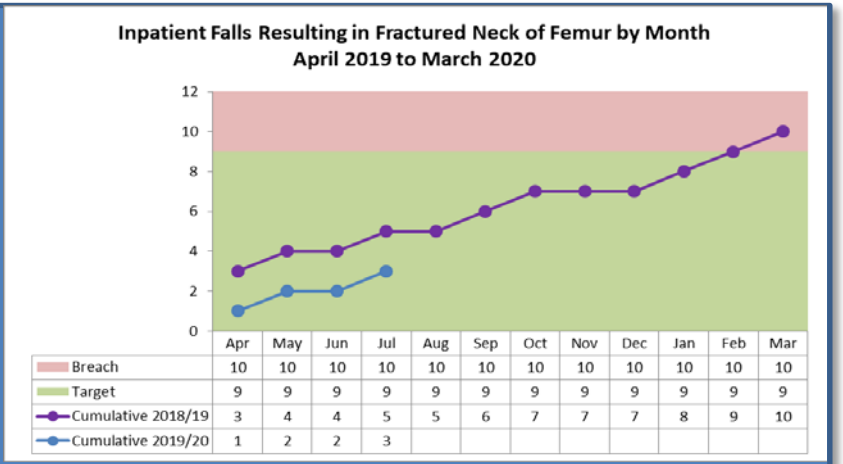
A reduction in the number of falls per 1,000 bed days when compared to the previous financial year (less than 6.6)



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

For July 2019, the falls rate per 1,000 bed days was 5.85.

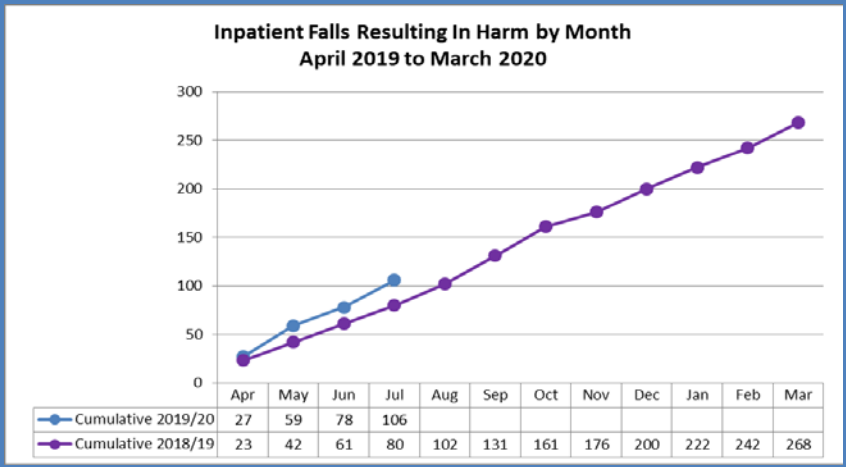
A reduction in the total number of fractured neck of femurs as a result of a fall (less than 10)



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

In July 2019, one fractured neck of femur was reported.

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



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

In July 2019, there were a total of 28 falls with harm.

- 96.4% (27) resulting in low harm
- 0% (0) resulting in moderate harm
- 3.6% (1) resulting in major harm

Improvement actions include:

- A deep dive has commenced into clinical areas with the highest reported number of Falls to inform improvement plans based on trends and themes
- An evaluation of the Footsteps trial on Ward 7 & 21b has commenced.
- A deep dive into no and low harm falls at Elmhurst is being undertaken.

Central Cheshire Integrated Care Partnership (CCICP)

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

CCICP Patient Safety Harm Incidents

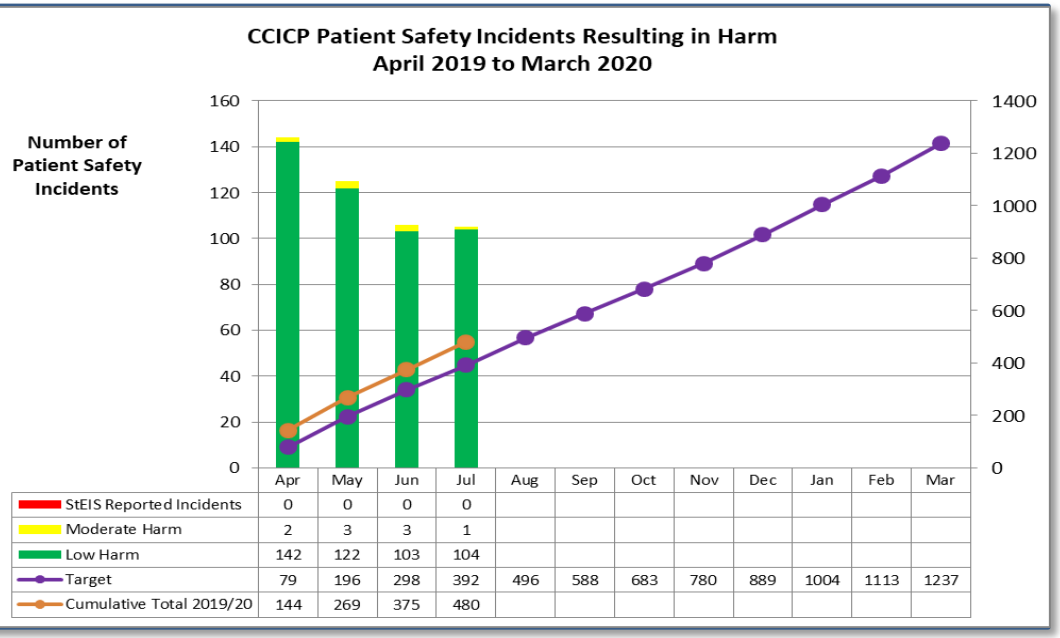
The target is to reduce the total number of CCICP patient safety harm incidents when compared to the previous financial year by the end of March 2020.

For July 2019, there were a total of 105 patient safety harm incidents:

- 99% (104 incidents) have resulted in low harm
- 1% (1 incidents) have resulted in moderate harm
- 0% (0 incidents) have resulted in serious harm

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

- Dissemination and delivery of the CCICP Ulysses training package continues across CCICP to promote an open and positive reporting culture in CCICP together with ensuring a consistent approach to reporting.



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

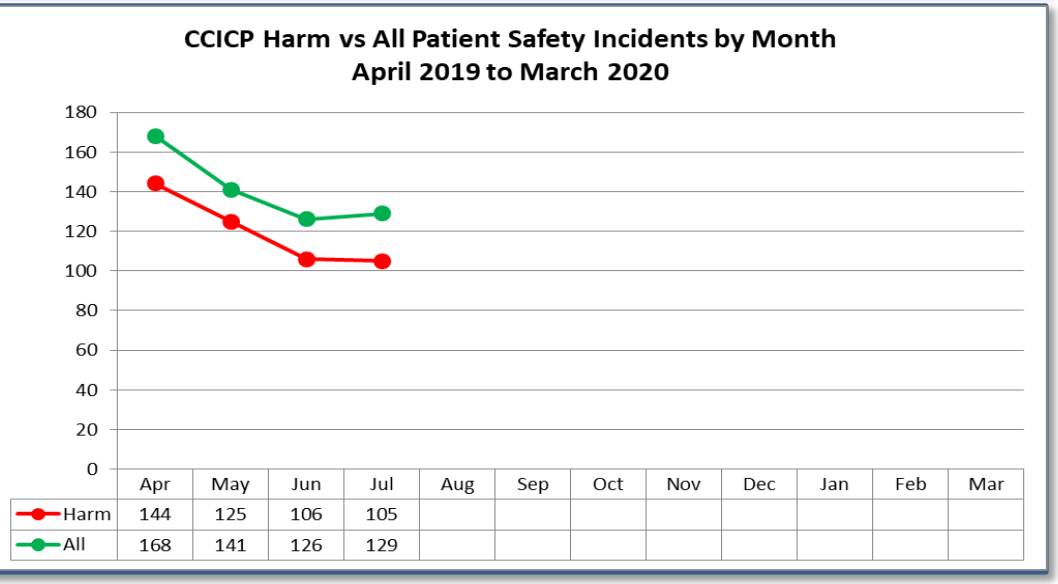
CCICP Harm vs All Patient Safety Incidents

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

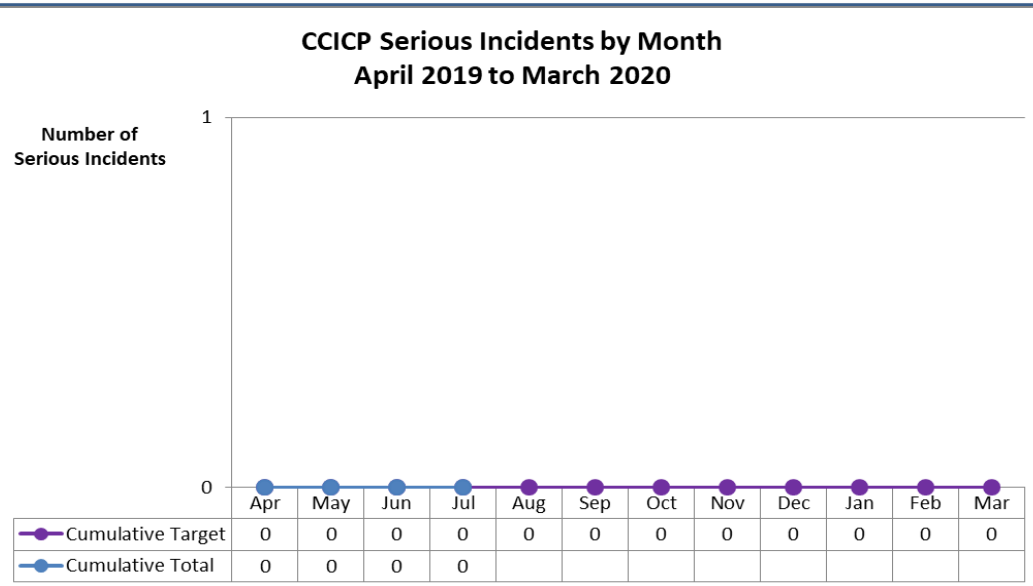
This chart demonstrates the number of incidents that have resulted in harm vs all patient safety incidents.

In July 2019, the gap between harm and all patient safety incidents was 24.

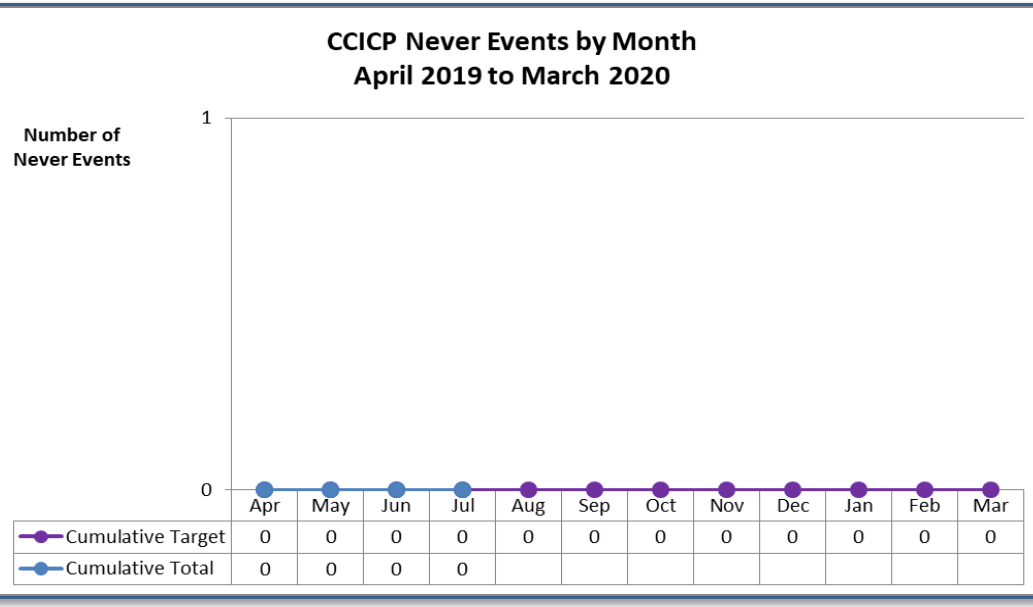
A safety culture survey was undertaken in the Trust in December 2018 to January 2019. The results were shared at the EQGG in April 2019 and divisional improvement plans developed to take into account the feedback received during the survey



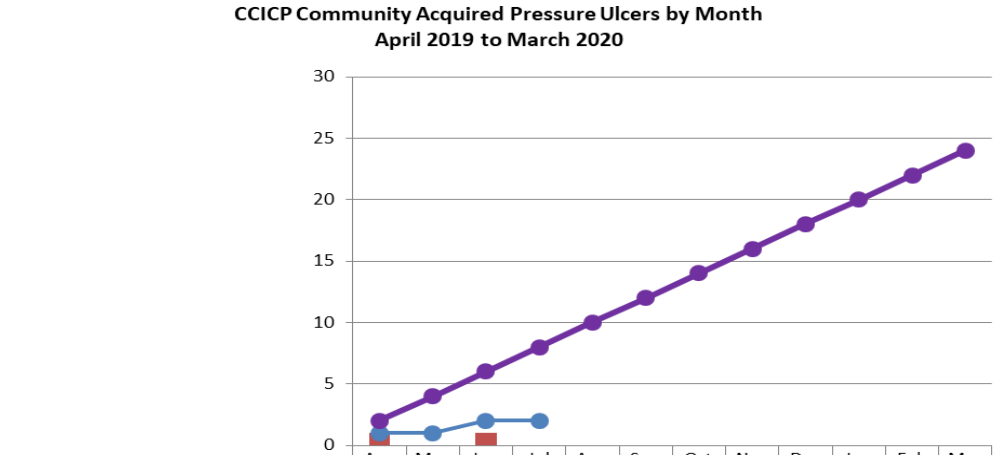
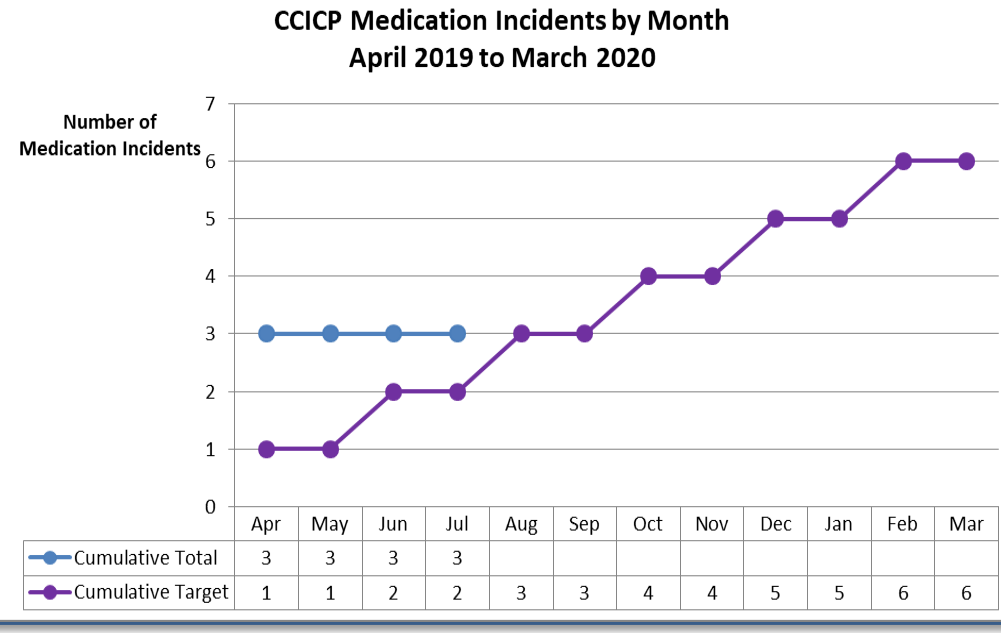
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Harm	144	125	106	105								
All	168	141	126	129								

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 July 2019, there were no serious incidents reported.	

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

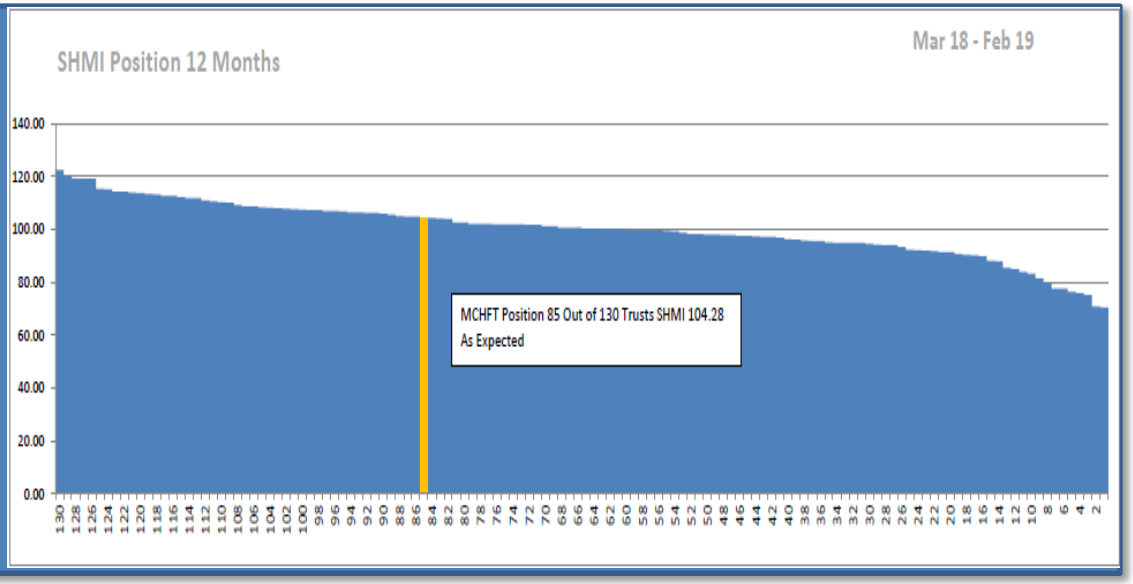
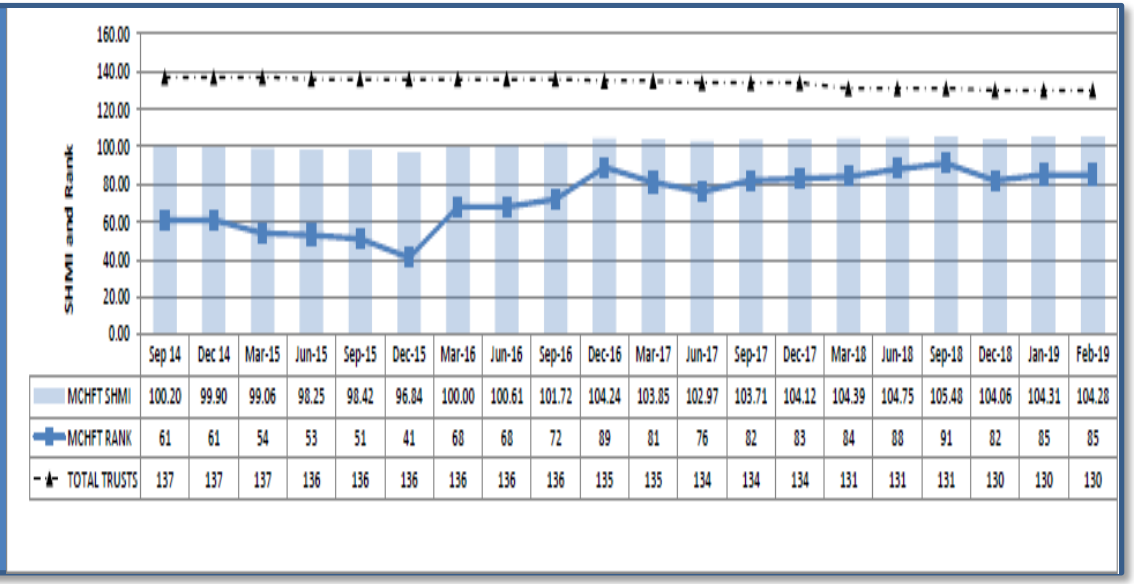
Description	Aggregate Position	Trend
CCICP Never Events *The target is to have zero Never Events*	This chart demonstrates the number of Never Events that have been reported. For July 2019 no Never Events were reported. No Never Events have been reported for CCICP since the merger of the Trust in October 2016.	

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

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 July 2019, there were a total of 61 community acquired pressure ulcer incidents: • 0% (0 PUs) occurred with lapses in care that did contribute to the PU. • 6.6% (4 PUs) occurred with lapses in care that did not contribute to the PU. • 70.5% (43 PUs) occurred with no lapses in care identified. • 22.9% (14 PUs) are awaiting confirmation. Improvement actions include: • The launch of the 100 day challenge for category 3 and 4 pressure ulcers has been cascaded across CCICP. Each team have the number of days free from category 3 and 4 pressure ulcers advertised in teams, together with teams obtaining a certificate when they reach 100 days, a year and 600 days without such incidents.	
CCICP Medication Harm Incidents. *The target is to reduce the total number of medication incidents resulting in harm when compared to the previous financial year by the end of March 2020.*	For July 2019, there were no medication incidents reported resulting in harm: • 0% (0 medication incidents) resulted in low harm • 0% (0 medication incidents) have resulted in moderate harm • 0% (0 medication incidents) have resulted in serious harm Improvement actions include; • CCICP continue to promote a positive culture of reporting medication incidents. • Medication incidents are reviewed each month at IGG to ensure a consistent approach to reviewing incidents and to ensure any lessons learned are cascaded across CCICP. • The CCICP annual face to face medication competency continues to be undertaken for all registered nursing staff.	

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

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

Description	Aggregate Position	Trend
SHMI *The Trust's target is to be at least within the "as expected" bracket.*	The chart benchmarks the Trust's latest SHMI against all NHS Trusts. MCHFT is shown as the yellow bar. The Trust's SHMI is 104.28 for the time period March 2018 to February 2019 and places the Trust 85 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 March 2018 to February 2019 and is "as expected".	

	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	Jan-19	Feb-19
MCHFT SHMI	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	104.31	104.28
MCHFT RANK	61	61	54	53	51	41	68	68	72	89	81	76	82	83	84	88	91	82	85	85
TOTAL TRUSTS	137	137	137	136	136	136	136	136	136	135	135	134	134	134	131	131	131	130	130	130

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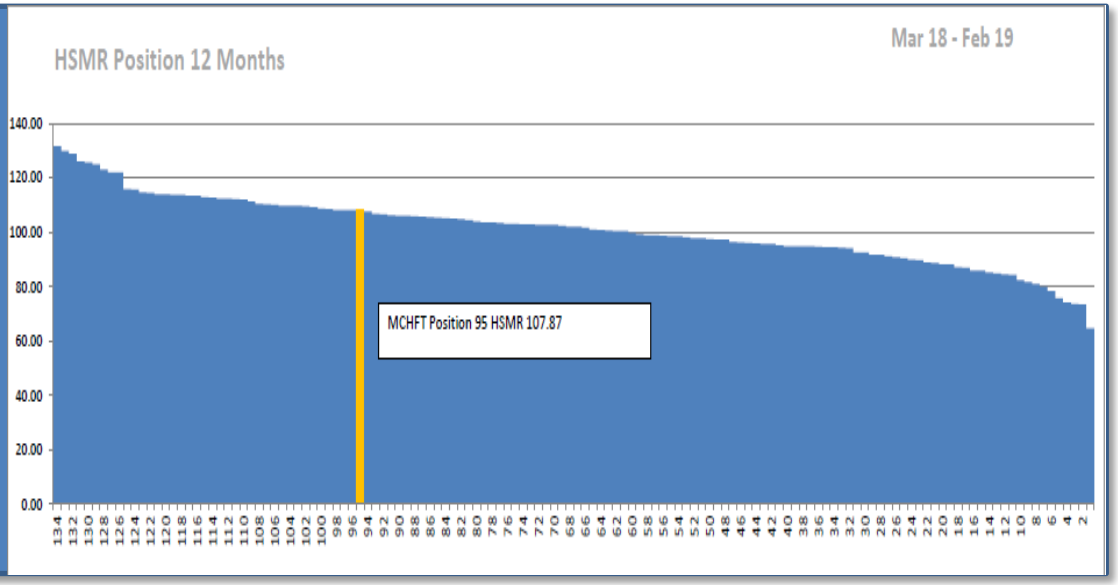
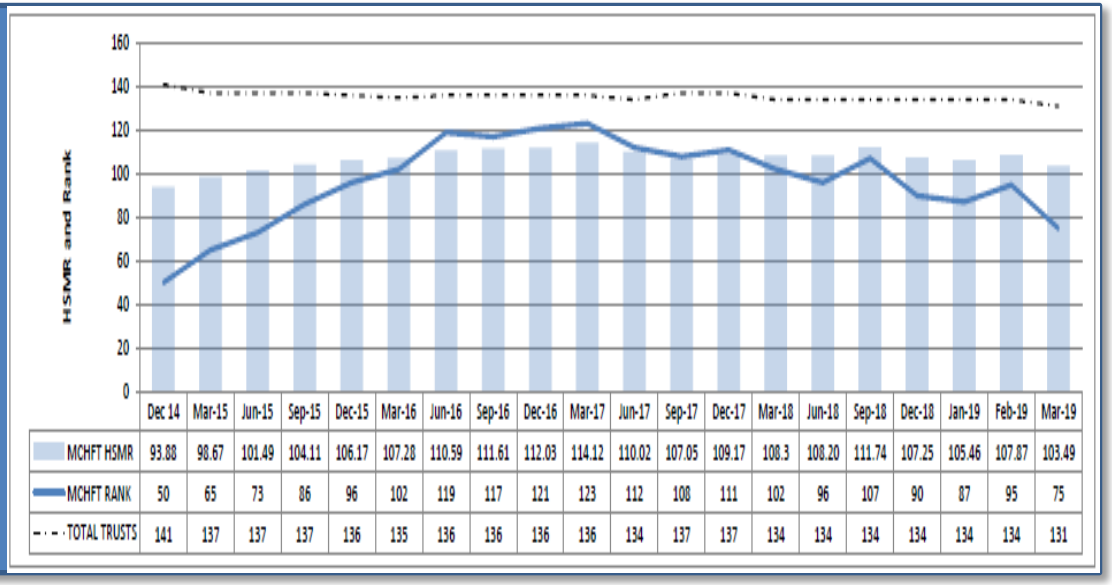
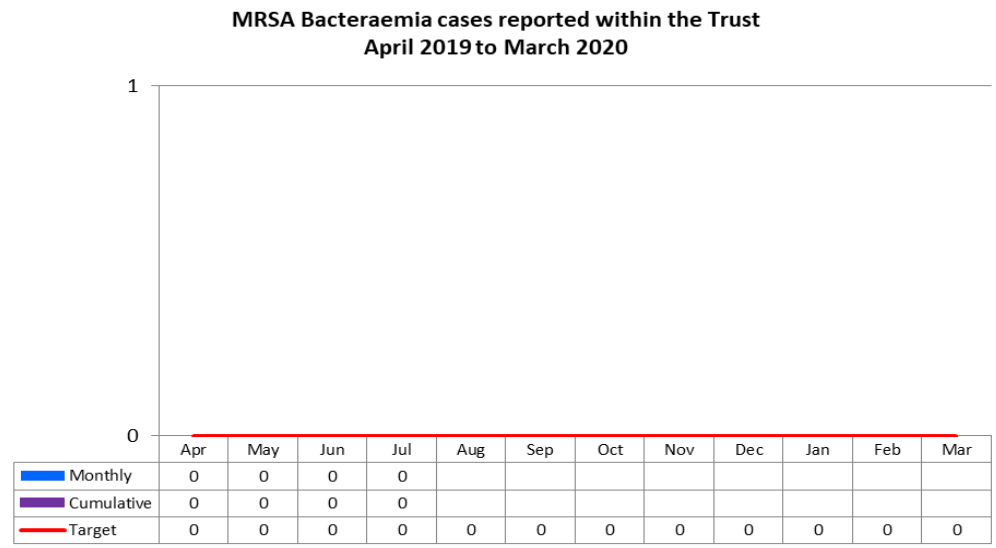
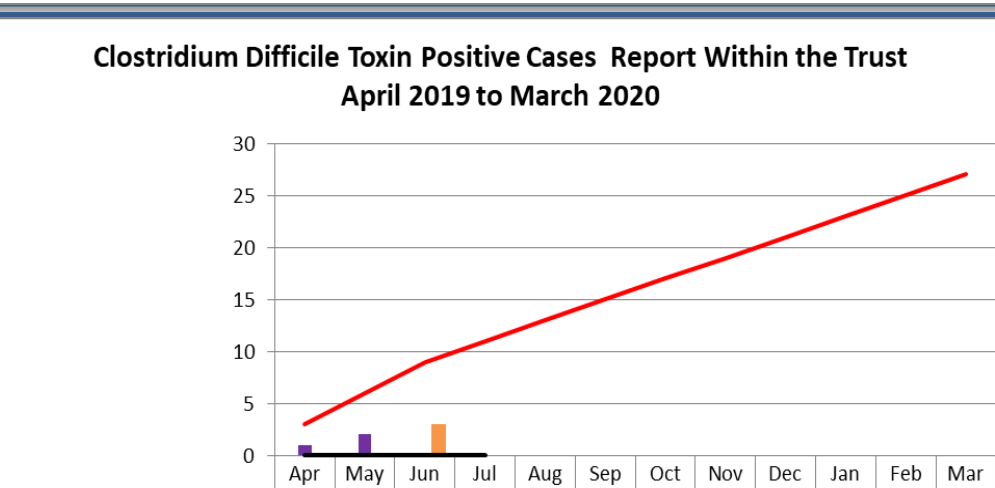
Description	Aggregate Position	Trend
Hospital Standardised Mortality Rate (HSMR) by Trust. *The Trust's target is to be at least within the "as expected" bracket.*	The chart benchmarks the Trust's HSMR against all NHS Trusts. MCHFT is shown by the amber bar. The Trust's HSMR is 107.87 (March 2018 to February 2019) 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 March 2018 to February 2019and is "as expected".	

	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	Jan-19	Feb-19	Mar-19
MCHFT HSMR	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	108.20	111.74	107.25	105.46	107.87	103.49
MCHFT RANK	50	65	73	86	96	102	119	117	121	123	112	108	111	102	96	107	90	87	95	75
TOTAL TRUSTS	141	137	137	137	136	135	136	136	136	136	134	137	137	134	134	134	134	134	134	131

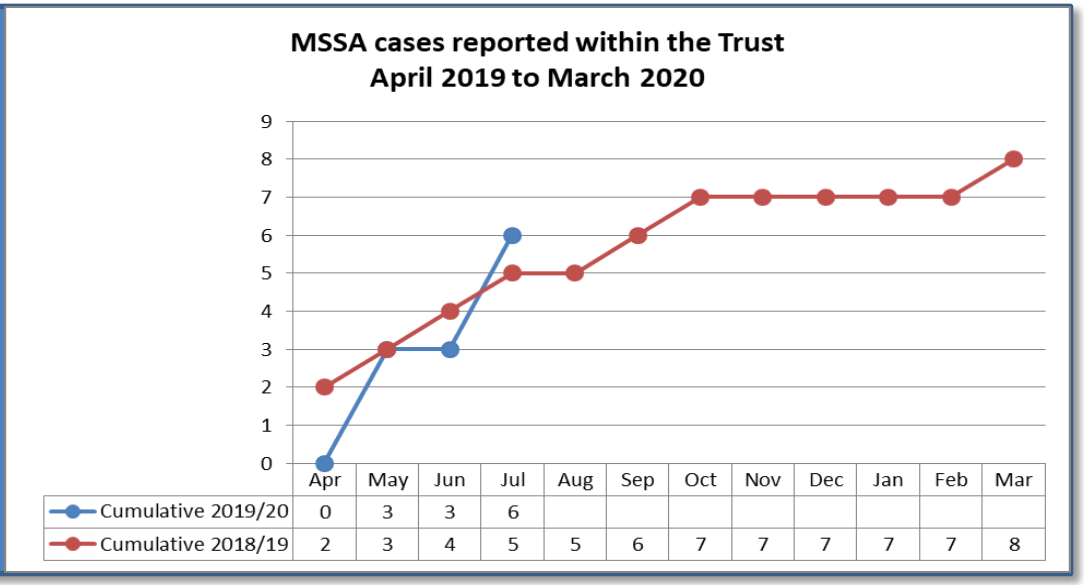
Description	Aggregate Position	Trend
MRSA Bacteraemia Cases. *Zero tolerance of MRSA cases.*	In July 2019, no MRSA bacteraemia cases were reported in the Trust. In this financial year there have been no confirmed MRSA bacteraemia cases to date.	
Clostridium Difficile toxin positive cases. *The target is less than 27 cases of Clostridium Difficile in 2019/20*	In July 2019, no avoidable cases were reported. The target is less than 27 cases of Clostridium Difficile in 2019/20. The target includes cases that 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 • 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.	

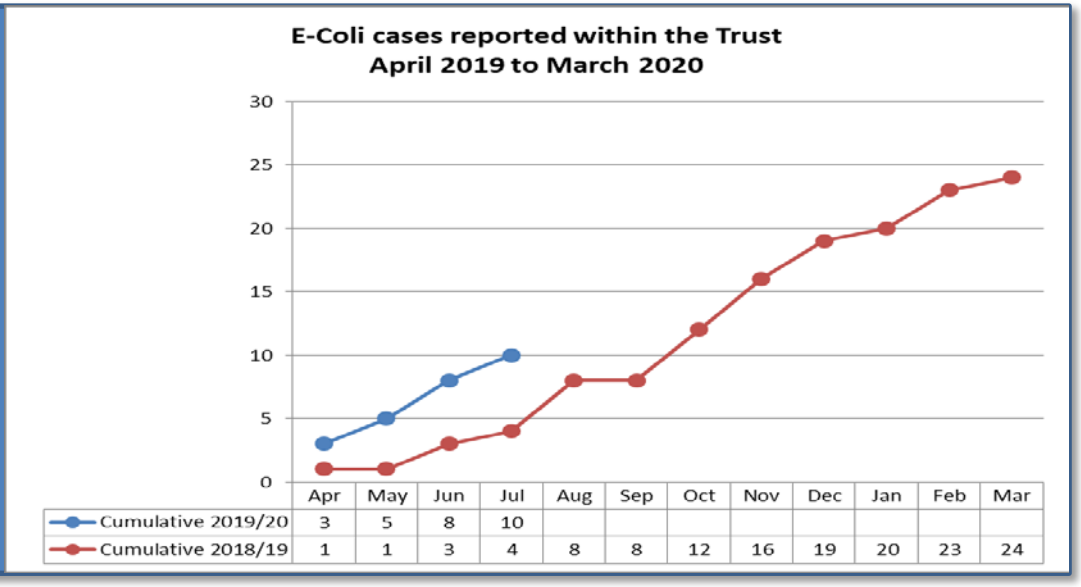
MRSA Bacteraemia cases reported within the Trust, April 2019 to March 2020

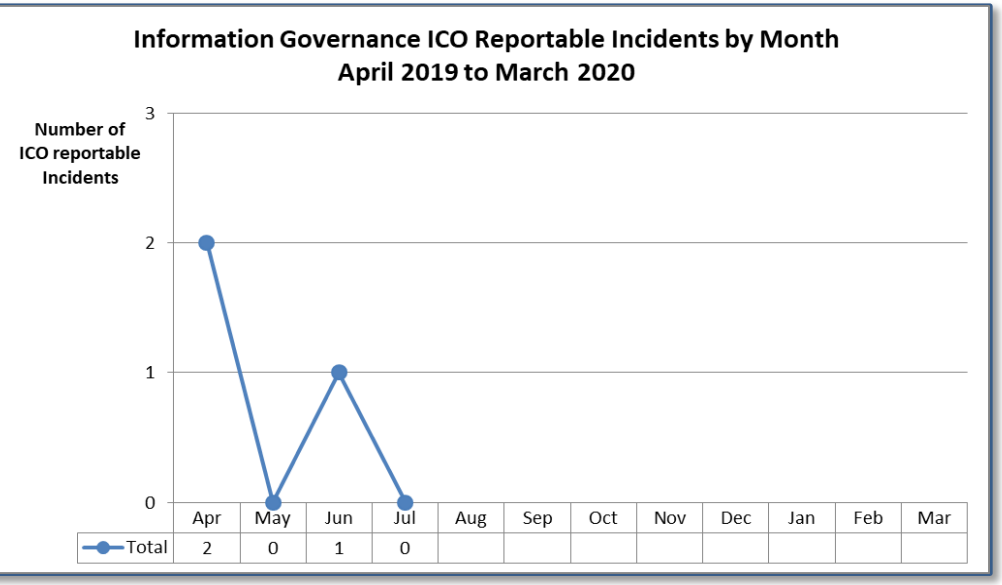
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Monthly	0	0	0	0								
Cumulative	0	0	0	0								
Target	0	0	0	0	0	0	0	0	0	0	0	0

Clostridium Difficile Toxin Positive Cases Report Within the Trust, April 2019 to March 2020

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

Description	Aggregate Position	Trend
MSSA Cases. *The aim is to have a reduction in MSSA cases when compared to the previous financial year, to demonstrate an incremental improvement*	In July 2019, 3 MSSA cases were reported in the Trust. In this financial year there has been 6 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 July 2019, two E-Coli cases were reported. These occurred on Ward 1 and Ward 2. In this financial year there have been ten confirmed E-Coli cases reported.	

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

CQUIN 2019-20 Performance

CQUIN Indicator	Indicator Name	Milestone Achieved								
		Q1	Financial Incentive Achieved	Q2	Financial Incentive Achieved	Q3	Financial Incentive Achieved	Q4	Financial Incentive Achieved	Maximum Value
1a	**Prevention of Ill health** Achieving 90% of antibiotic prescriptions for lower UTI in older people meeting NICE guidance for lower UTI (NG109) and PHE Diagnosis of UTI guidance in terms of diagnosis and treatment.	✗	£55,879 **(£NIL)**		£55,879		£55,879		£55,879	**£223,517**
1b	**Prevention of Ill health** Achieving 90% of antibiotic surgical prophylaxis prescriptions for elective colorectal surgery being a single dose and prescribed in accordance to local antibiotic guidelines.	✓ **Partially**	£55,879 **(£31,665)**		£55,879		£55,879		£55,879	**£223,517**
2	**Prevention of Ill health** Achieving an 80% uptake of flu vaccinations by frontline clinical staff.	NOT REQUIRED	No Payment		No Payment		No Payment		**MCHFT £447,030** **CCICP £184,318**	**MCHFT £447,030** **CCICP £184,318**
3a	**Prevention of Ill health** Achieving 80% of inpatients admitted to an inpatient ward for at least one night who are screened for both smoking and alcohol use	✓	£37,253		£37,253		£37,253		£37,253	**£149,011**
3b	**Prevention of Ill health** Achieving 90% of identified smokers given brief advice.	✓ **Partially**	£37,253 **(£6,054)**		£37,253		£37,253		£37,253	**£149,011**
3c	**Prevention of Ill health** Achieving 90% of patients identified as drinking above low risk levels, given brief advice or offered a specialist referral.	✓ **Partially**	£37,253 **(£25,425)**		£37,253		£37,253		£37,253	**£149,011**

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

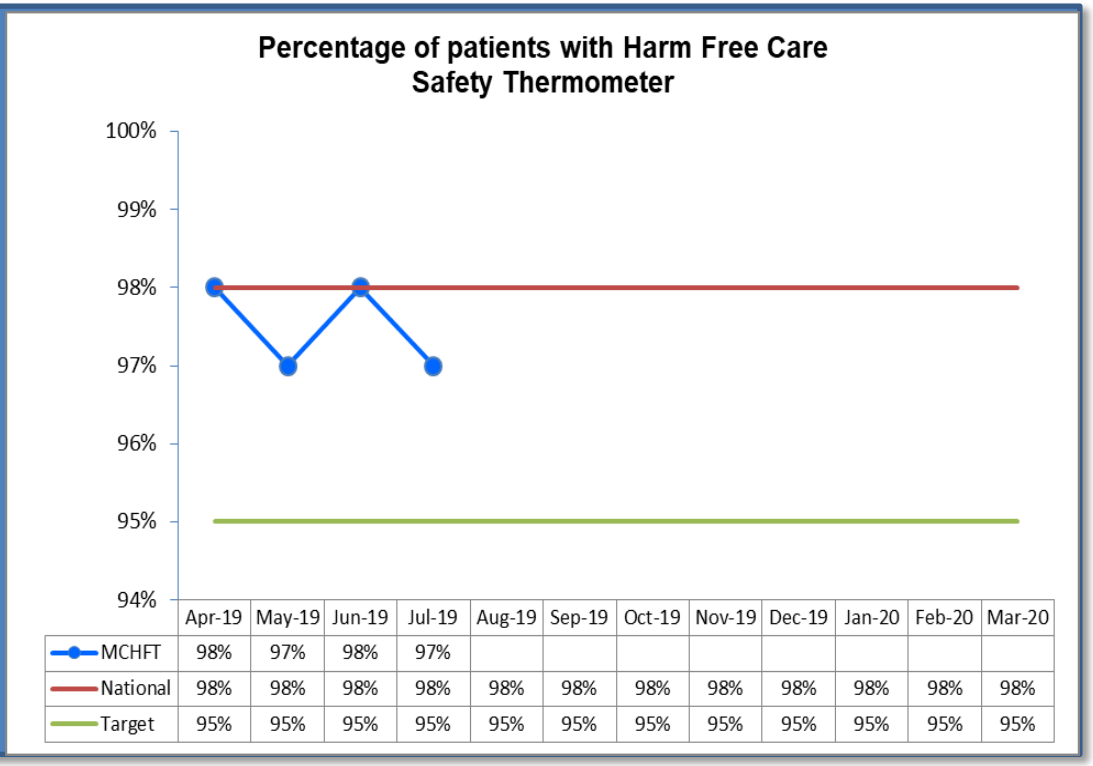
Description	Aggregate Position	Trend

Safety Thermometer - Harm Free Care.

In July 2019, 97% of patients received harm free care as measured by the point prevalence Safety Thermometer.

The Safety Thermometer data is collected during the morning of the first Wednesday of each month and is collected by the nursing staff on duty on the ward/DN caseload assisted by the Senior Nursing Teams. This is applicable to inpatient areas and district nursing caseloads only.

The target is for >95% of patients to receive harm free care as monitored by the Safety Thermometer. The Patient Safety Thermometer process is currently under review nationally.



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

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Description	Aggregate Position		Trend
Registered Nurses monthly expected hours by shift versus actual monthly hours per shift. Day time shifts only	88.3% of expected Registered Nurse hours were achieved for day shifts. Any registered nurse numbers that fall below 85% are required to have a divisional review and an update of actions provided to the Director of Nursing & Quality and the Deputy Director of Nursing & Quality.	Trend **July 2019 88.3%** June 2019 88.6% May 2019 90.6%	The lowest staffing levels during the day were on CAU at 70.2%
Registered Nurses monthly expected hours by shift versus actual monthly hours per shift. Night time shifts only	93.0% of expected Registered Nurse hours were achieved for night shifts.	Trend **July 2019 93.0%** June 2019 95% May 2019 95%	The lowest staffing levels during the night were on Ward 5 at 73.1%
Healthcare Assistant monthly expected hours by shift versus actual monthly hours per shift. Day time shifts only	94.74% of expected HCA hours were achieved for day shifts.	Trend **July 2019 94.74%** June 2019 99.6% May 2019 99.4%	The lowest staffing levels during the day were on NICU at 71%
Healthcare Assistant monthly expected hours by shift versus actual monthly hours per shift. Night time shifts only	100.66% 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 **July 2019 100.66%** June 2019 109.9% May 2019 109%	The lowest staffing levels during the night were on Ward 11 at 88.3%
Total number of wards that are lower than 85% RN fill days and nights is 9.	Ward 10 (day) 83.8%, Ward 11 (day) 82.6%, Ward 13 (day) 84.4%, Ward 2 (day) 82.5%, Ward 21b (day) 84%, Ward 4 (day) 79.3%, Ward 5 (day) 80.7% and (night) 73.1%, Ward 6 (night) 83.1%, CAU winter (day) 70.2%.	• 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	

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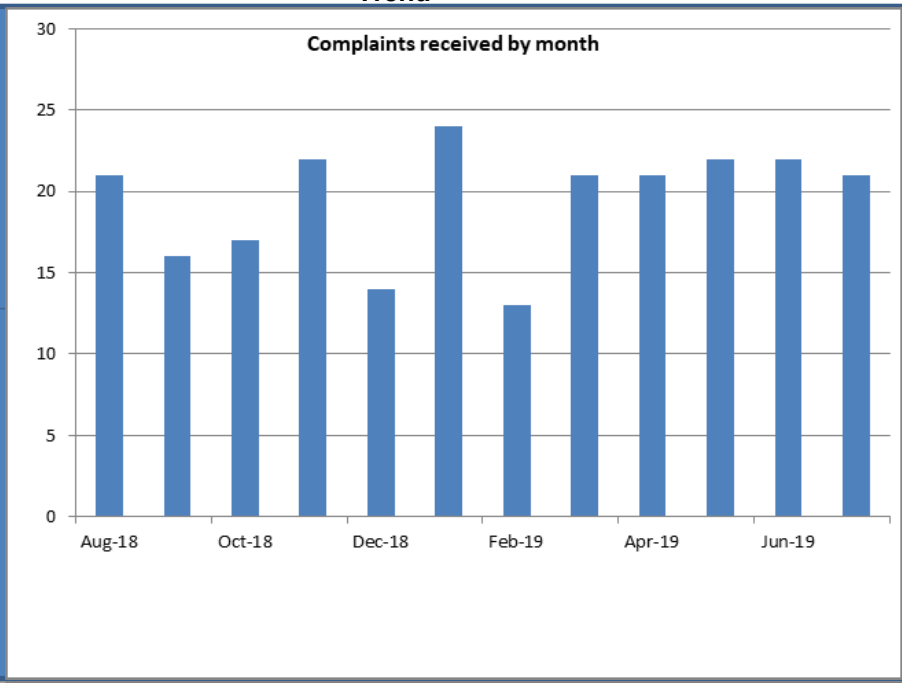
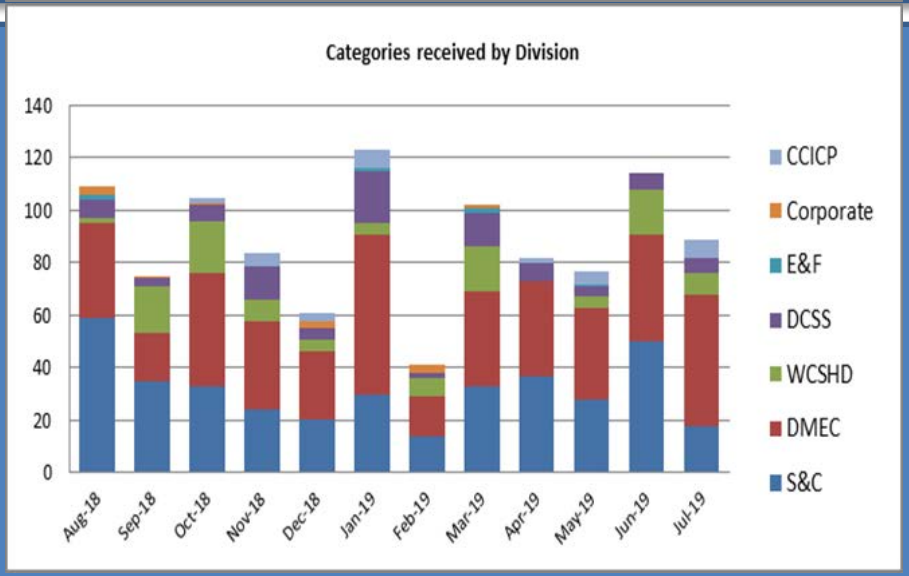
Ward Name	Day				Night				Day		Night		Care Hours Per Patient Day			
	Qualified		Unqualified		Qualified		Unqualified		Qualified	Unqualified	Qualified	Unqualified	Cumulative count over month of pts at 23:59 each day	Qualified	Unqualified	Overall
	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Fill Rate	Fill Rate	Fill Rate	Fill Rate				
MCHFT	38361	33873	34303	32498	27279	25458	20388	20522	88.30%	94.74%	93%	100.66%	15210	167.8	77.2	245.0
Acute Medical Unit	1784	1612	2259	2220	1896	1778	1512	1452	90.3%	98.3%	93.8%	96.0%	806	4.2	4.6	8.8
Elmhurst	744	748	2298	2251	744	744	1548	1607	100.5%	98.0%	100.0%	103.8%	869	1.7	4.4	6.2
Ward 1 Coronary Care	2201	2009	1515	1386	1488	1464	816	824	91.3%	91.5%	98.4%	101.0%	939	3.7	2.4	6.1
Ward 10 Ortho Trauma	2142	1795	3282	3035	1116	1100	1859	1739	83.8%	92.5%	98.6%	93.5%	1131	2.6	4.2	6.8
Ward 11 SAU	1676	1385	1633	1315	1068	923	1116	985	82.6%	80.5%	86.4%	88.3%	532	4.3	4.3	8.7
Ward 13 Vascular & Colorectal	1774	1496	1767	1696	1117	1043	1128	1092	84.4%	96.0%	93.4%	96.8%	951	2.7	2.9	5.6
Ward 14 Gastroenterology	1347	1338	1956	1794	1128	972	1475	1439	99.3%	91.7%	86.1%	97.6%	952	2.4	3.4	5.8
Ward 15 Female Ward	1738	1570	1570	1545	1128	1019	1140	1104	90.4%	98.4%	90.3%	96.8%	926	2.8	2.9	5.7
Ward 18 Surgical Speciality	1379	1207	1140	1124	744	743	744	720	87.5%	98.6%	99.9%	96.8%	667	2.9	2.8	5.7
Ward 2 Short Stay	1770	1461	1813	1735	1127	1129	1200	1296	82.5%	95.7%	100.2%	108.0%	968	2.7	3.1	5.8
Ward 21b Rehabilitation	1014	852	2229	2065	744	732	1116	1092	84.0%	92.7%	98.4%	97.8%	742	2.1	4.3	6.4
Ward 4 Elderly	1713	1358	2125	1987	744	750	1464	1362	79.3%	93.5%	100.7%	93.0%	925	2.3	3.6	5.9
Ward 5 Respiratory	2211	1784	1828	1858	1520	1110	984	1259	80.7%	101.7%	73.1%	127.9%	955	3.0	3.3	6.3
Ward 6 Rehab	1788	1529	2429	2258	1500	1247	996	1285	85.5%	93.0%	83.1%	129.0%	859	3.2	4.1	7.4
Ward 7 Gastroenterology	1514	1360	2490	2361	744	744	1416	1369	89.8%	94.8%	100.0%	96.7%	978	2.2	3.8	6.0
Ward 9 Ortho Elective	816	735	862	838	756	731	372	336	90.0%	97.2%	96.6%	90.3%	254	5.8	4.6	10.4
CAU (Winter)	2325	1632	775	838	1783	1702	357	357	70.2%	108.1%	95.5%	100.0%	427	7.8	2.8	10.6
Critical Care	3832	3832	632	632	2328	2328	0	0	100.0%	100.0%	100.0%	-	218	28.3	2.9	31.1
Ward 23	1238	1200	785	735	765	765	765	765	96.9%	93.6%	100.0%	100.0%	633	3.1	2.4	5.5
NICU	1925	1769	183	130	1783	1564	0	0	91.9%	71.0%	87.7%	-	273	12.2	0.5	12.7
Ward 26 MLU	785	728	0	89	765	728	0	62	92.7%	-	95.2%	-	36	40.4	4.2	44.6
Ward 26 Labour	2647	2476	735	608	2294	2146	382	382	93.5%	82.8%	93.5%	100.0%	169	27.4	5.9	33.2

Experience Section:

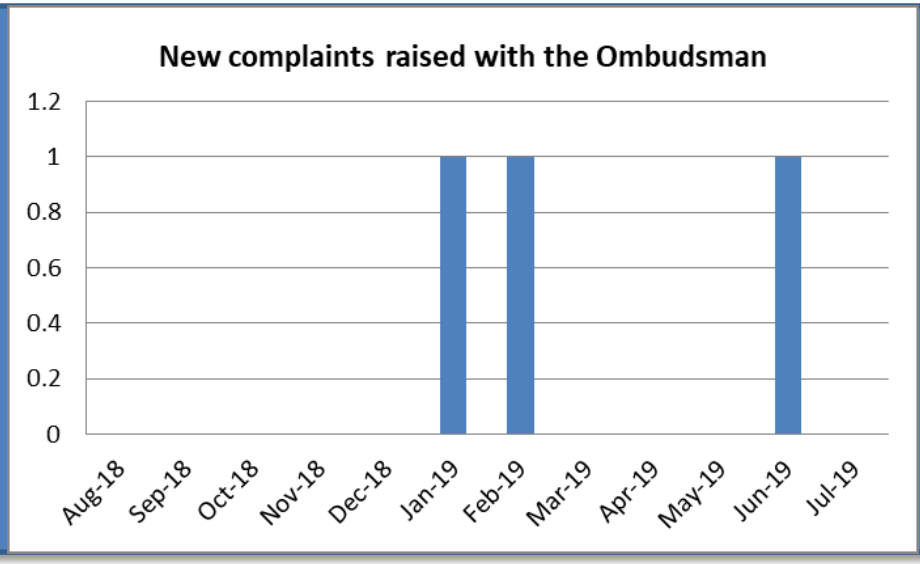
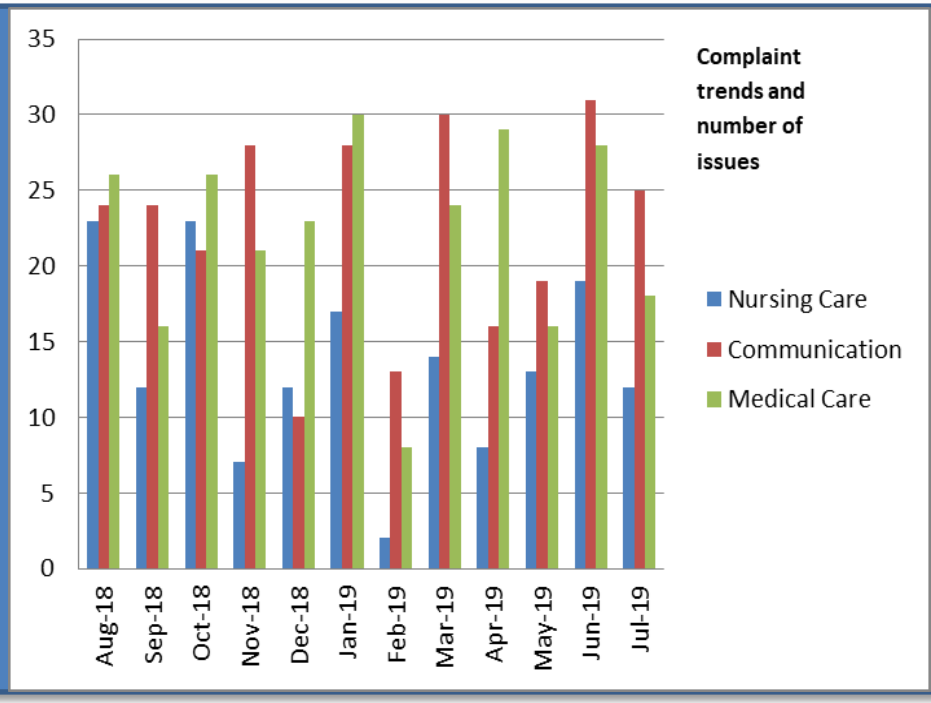
Indicators	April 2019	May 2019	June 2019	July 2019
Complaints received by month	21	22	22	21
Complaints being reviewed by the Ombudsman	0	0	1	0
Closed complaints by month	15	20	19	26
Contacts raising informal concerns	86	103	75	92
Compliments received in month	290	269	453	293
Number of new claims received in month	3	7	7	4
Number of claims closed	2	3	2	4
Number of inquests concluded	1	0	0	3
NHS Choices - Star Ratings (Leighton)	4.5	4.5	4.5	4
NHS Choices - Star Ratings (VIN)	5	5	5	5
NHS Choices - Number of new postings	4	1	7	12
F&FT Response Rate ED, MIU, UCC and Assessment Areas*	17%	16%	17%	16%
Proportion of positive responses ED, MIU, UCC and Assessment Areas	84%	85%	85%	85%
F&FT Response Rate Inpatients and Day cases	36%	38%	39%	42%
Proportion of positive responses Inpatients and Day cases	94%	94%	93%	93%
F&FT Response Rate Outpatients	3%	2%	2%	2%
Proportion of positive responses Outpatients	96%	97%	96%	98%
F&FT Response Rate Maternity - Birth	14%	18%	12%	7%
Proportion of positive responses Maternity - Birth	100%	97%	96%	100%
F&FT Response Rate Community (CCICP)	10%	7%	11%	3%
Proportion of positive responses Community (CCICP)	91%	89%	89%	86%

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

Description	Aggregate Position/Description	Trend
Monthly formal complaints received by the Trust.	21 complaints were received in July 2019 which covered 89 concerns. There were also three re-opened complaints. The highest categories were: • Communication with 25 concerns • Medical with 18 concerns – 10 listed as diagnosis problems • Nursing with 12 concerns - 6 listed as medication delay/other • Appointments with 8 concerns Highest 3 areas receiving complaints/issues were: • Emergency Department - 9 complaints with 23 concerns • Cardiology – with 2 complaints and 6 concerns • Ward 2 – with 3 complaints and 5	
Number of formal complaint issues by division.	This graph shows the breakdown of issues by month for each division. S&C: 18 DCSS: 6 W&CD: 8 DMEC: 50 CCICP: 7 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 July 2019, there were no new complaints opened with the Parliamentary Health Service Ombudsman (PHSO). There are 2 cases which are at the investigation stage. In the last rolling 12 months we have had 3 cases with the PHSO of which none to date have been upheld.	
Complaint trends and number of issues.	The main trends in July 2019 were:- Nursing Care - 12 concerns over 10 complaints. 6 of these were listed as medication delay/other. Communication - 25 concerns over 12 complaints. 10 of these concerns related to communication with patients. Medical Care - 18 concerns over 12 complaints. 10 of these concerns related to diagnosis problems.	

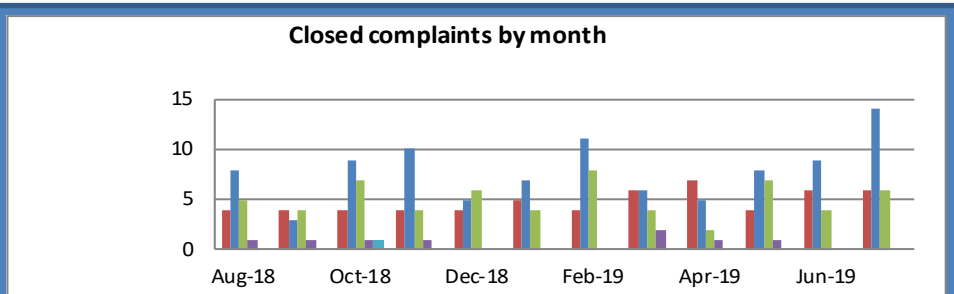
Ombudsman

Complaint Trends

Description	Aggregate Position/Description	Trend

Closed Complaints

In July 2019 26 complaints were closed, 3 of which were re-opened complaints.



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

Closed Complaints

Closed complaints by Division

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

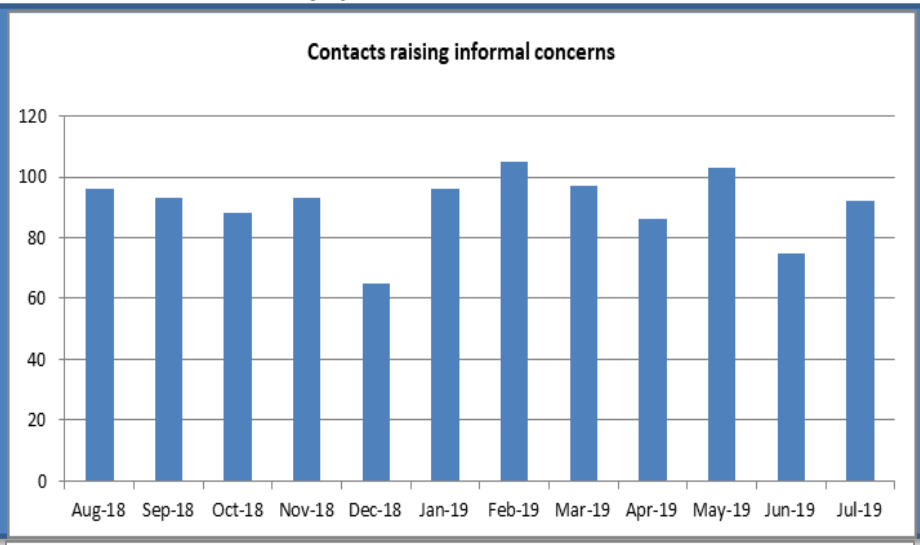
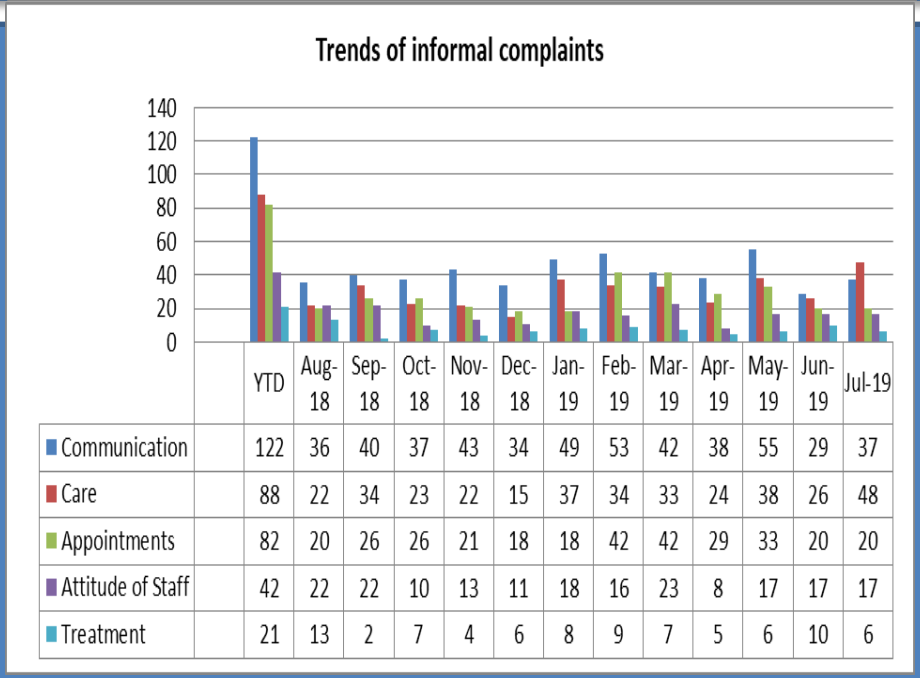
The table also identifies the outcome of the complaint in terms of which complaints were upheld, not upheld, partially upheld or referred to Human Resources (HR)

	Upheld	Partially Upheld	Not Upheld	Withdrawn	Ref HR	Sub-Total
DMEC	5	8	3	0	0	16
Corporate	0	0	0	0	0	0
Surgery & Cancer	0	6	3	0	0	9
Women & Children's	1	0	0	0	0	1
DCSS	0	0	0	0	0	0
CCICP	0	0	0	0	0	0

Total closed = 26

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

Closed Complaints July 2019 - Tables removed under Section 40 of the Freedom of Information Act.

Description	Aggregate Position/Description	Trend
Informal concerns numbers.	The number of contacts raising informal concerns for July 2019 was 92 raising 174 individual concerns. The Division of Medicine and Emergency Care received the highest number of overall concerns at 71, with the Surgery and Cancer Division receiving 46. The Emergency Department received the largest number of individual concerns at 30 which were raised from 15 contacts. Urology received 8 concerns from 4 contacts. Ward 10 received 8 concerns from 3 contacts. Gastroenterology received 8 concerns from 6 contacts. Medical Imaging received 8 concerns from 5 contacts.	
Informal concerns trends.	Care and communication were the highest trends for informal concerns in July 2019. <u>48 care issues raised:</u> 21 related to medical care, of which 4 relate to the Emergency Department and 3 to Urology. 27 relate to nursing care, 8 of which relate to the Emergency Department and 5 to Ward 10. <u>37 communication issues raised:</u> 8 related to communication with patients face to face and 7 to communication with patients written. 11 relate to the Division of Medicine and Emergency Care and 13 to Surgery and Cancer Division	

Informal concerns numbers

	YTD	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19
Communication	122	36	40	37	43	34	49	53	42	38	55	29	37
Care	88	22	34	23	22	15	37	34	33	24	38	26	48
Appointments	82	20	26	26	21	18	18	42	42	29	33	20	20
Attitude of Staff	42	22	22	10	13	11	18	16	23	8	17	17	17
Treatment	21	13	2	7	4	6	8	9	7	5	6	10	6

Informal concerns trends

Description	Aggregate Position/Description	Trend

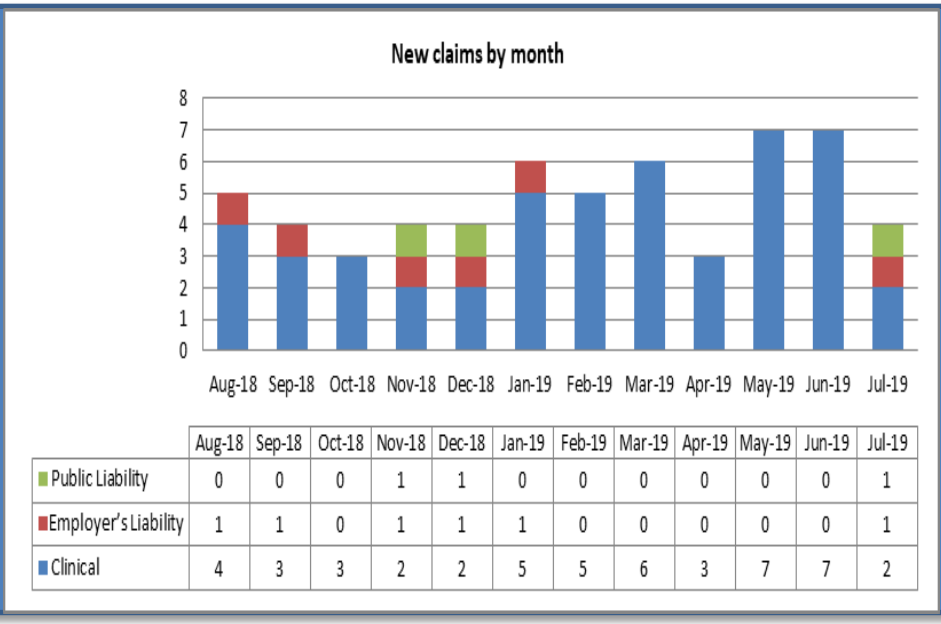
New claims received.

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

Emergency Care - Cardiology (1)
Surgery and Cancer -Ophthalmology (1)

1 new employer's liability claim was received relating to Estates and Facilities.

1 new public liability claim was received relating to Estates and Facilities.



	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19
Public Liability	0	0	0	1	1	0	0	0	0	0	0	1
Employer's Liability	1	1	0	1	1	1	0	0	0	0	0	1
Clinical	4	3	3	2	2	5	5	6	3	7	7	2

Claims

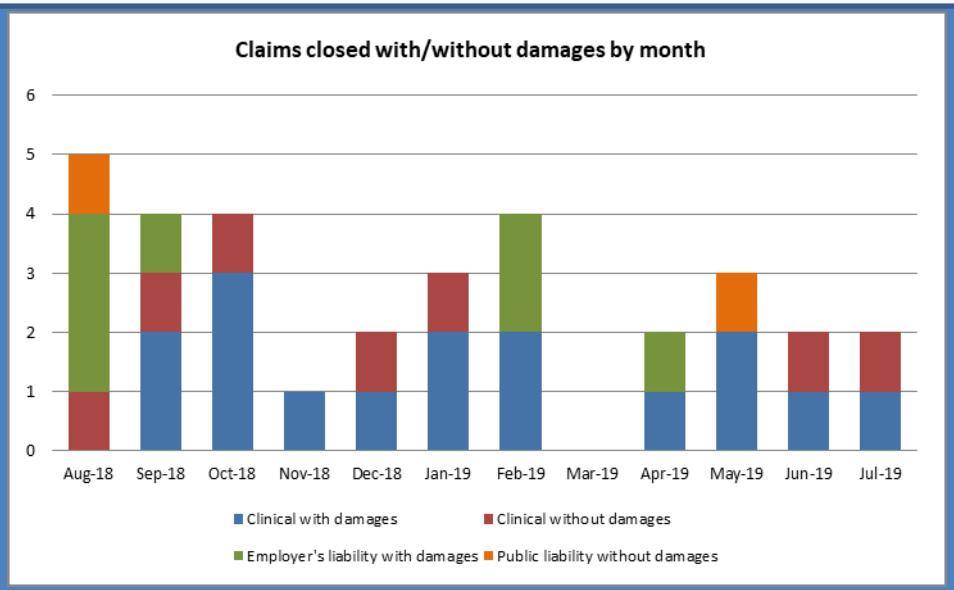
Claims closed with/without damages.

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

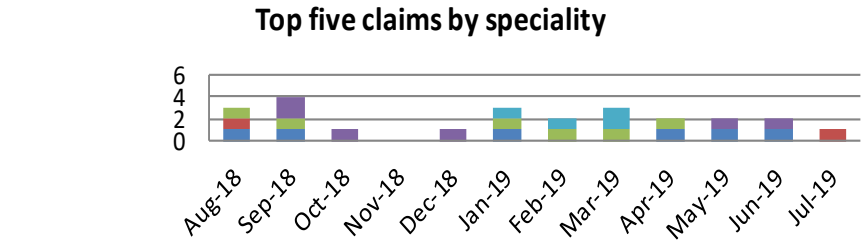
2 clinical negligence claims were closed, 1 of which was upheld.

1 employer's liability claim was closed and this was not upheld.

1 public liability claim was closed and this was not upheld.



Closed Claims

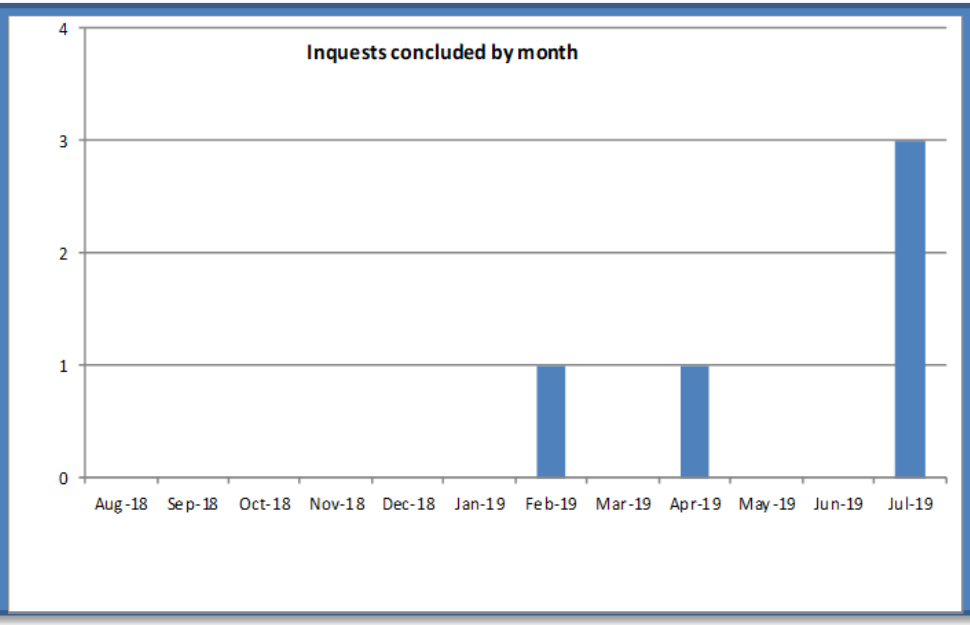
Description	Aggregate Position/Description	Trend
Value of claims closed by month	Narrative removed under Section 40 of the Freedom of Information Act. Outcome: Claim upheld and settled with damages paid. Lessons Learnt: The midwife concerned completed a period of training to further develop her knowledge and skills in measuring symphysis fundal height.	Graph removed under Section 40 of the Freedom of Information Act.
Top five claims by Specialty	In July 2019, 1 new claim was received which relates to the Trust's top five specialties for claims: Ophthalmology Narrative removed under Section 40 of the Freedom of Information Act.	

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

Value of claims

Top 5 claims by specialty

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

Description	Aggregate Position /Description	Trend
Number of Inquests concluded by month	3 inquests were concluded in July 2019. The Coroner's Conclusions were: Accident (2) Natural Causes (1) No changes to practice were identified.	

Inquests

NHS Choices Star Ratings	In July 2019 Leighton Hospital is rated at 4 stars. Victoria Infirmary, Northwich is rated at 5 stars. The above ratings are based on 172 postings	

NHS Choices – Star Ratings

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

Description	Aggregate Position /description

NHS Choices postings

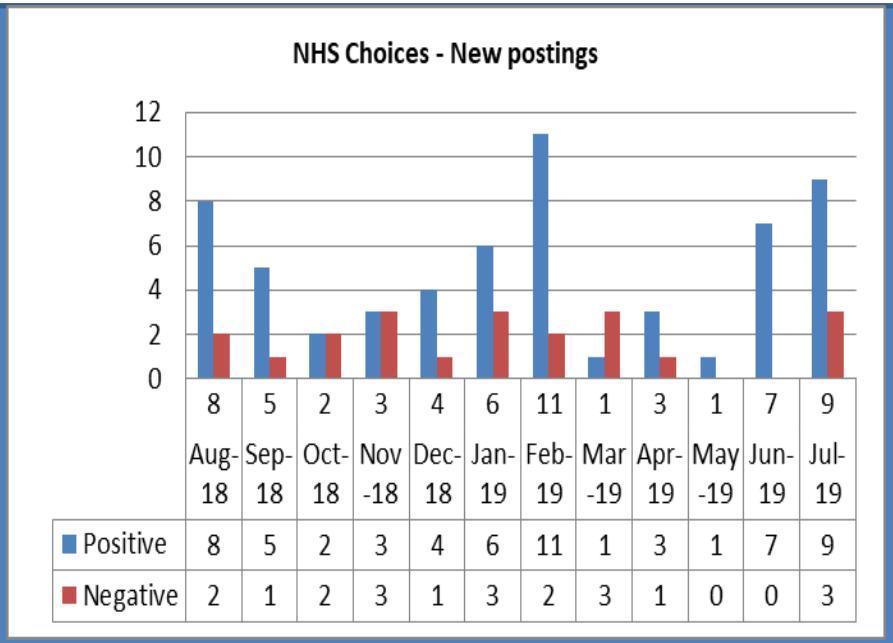
There were 12 postings on NHS Choices in July 2019 of which 9 were positive, and 3 negative. Examples of comments detailed below:

Attended above unit with damaged and infected right index finger nail. Only had half an hour wait, staff extremely pleasant and efficient. (Minor Injuries, Victoria Infirmary)

The quality of care is outstanding. The kindness I received and observed around all patients was genuine and delivered by all members of the staff. Elmhurst has a team of health workers dedicated to the safety and care of all patients. (Elmhurst)

I was treated so warmly and kindly by all staff members in the treatment centre when I went for a sigmoidoscopy today. I was nervous before I went but they really put me at ease and I don't think I could have had a better experience. (Sigmoidoscopy)

Person centred care at its best. I just want to thank the doctors and staff at Leighton hospital that treated my Mum today with the upmost kindness and dignity at a time she felt so poorly and vulnerable. The whole team were professional at all times but one doctor absolutely deserves a special mention. Thank you for the great work you all do. (ED)



	8 Aug-18	5 Sep-18	2 Oct-18	3 Nov-18	4 Dec-18	6 Jan-19	11 Feb-19	1 Mar-19	3 Apr-19	1 May-19	7 Jun-19	9 Jul-19
Positive	8	5	2	3	4	6	11	1	3	1	7	9
Negative	2	1	2	3	1	3	2	3	1	0	0	3

NHS Choices – Postings

The Family and Friends Test.

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

Emergency care /assessment areas 85%;

Inpatients and day cases 93%;

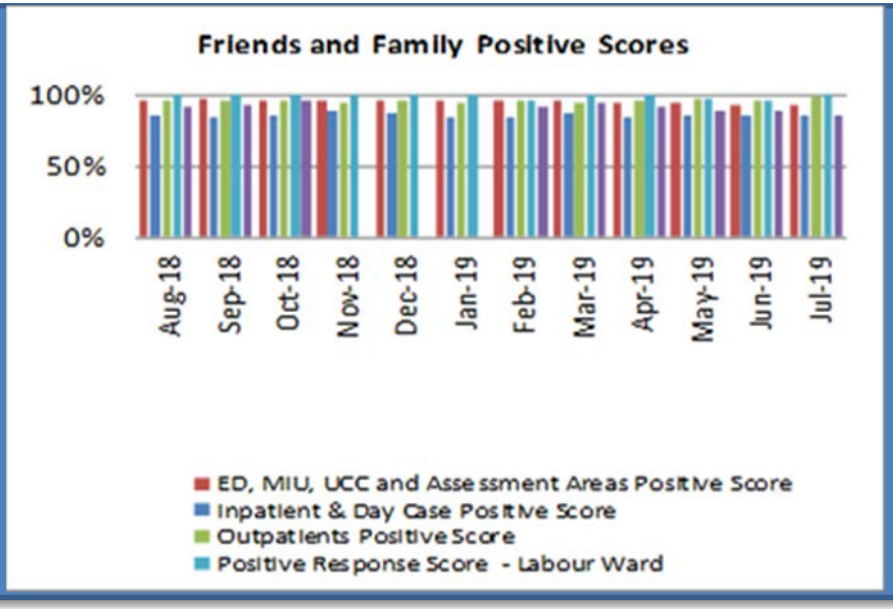
Outpatients 98%;

Maternity (Labour ward) 100%;

CCICP 86%

Text messaging will be in place in all areas by July 2019 with reporting commencing August 2019.

The number of responses for CCICP has increased from 85 in June 2019 to 1034 for July 2019. The low response rates for June were thought to be due to survey fatigue however it has been identified that the problem was due to technical difficulties with extracting the data which is now in the process of being resolved.



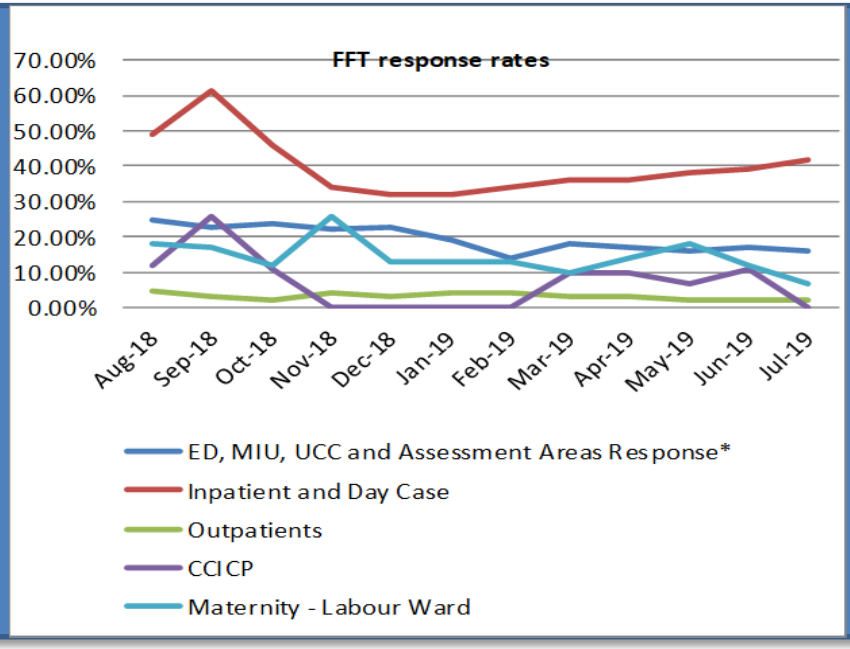
Family & Friends Test

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

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

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

July 2019 Ward/Dept.	% Response	Total responses received	How many would recommend
A&E , UCC & MIU	16%	1044	85%
CCICP	3%	1034	86%
Inpatients & Day cases	42%	1800	93%
Maternity	7%	18	100%
Outpatients	2%	368	98%



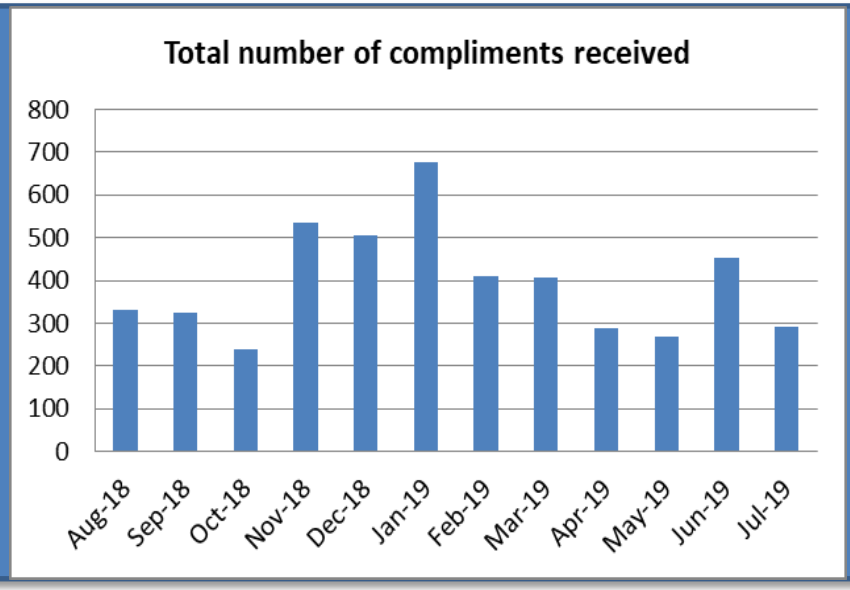
Family & Friends Test

Compliments received

There were 293 compliments received in July 2019.
79 of these were logged by the Customer Care Team and 214 received across the Trust.

'I attended ED recently with my husband who, unfortunately, had ketones in his urine and had become quite poorly. We arrived mid-afternoon and left ambulatory care around 9 o'clock. The treatment received was exemplary. Despite being very busy, the staff were very professional and caring towards all of the patients and relatives.'

'I recently had an appointment for an MRI scan. I would just like to say what a positive experience I had, from the young lady who collected me from the waiting area, to the two radiographers who completed my scan. I was put at ease immediately and I received clear instructions. Thank you.'



Compliments

Mid Cheshire Hospital
NHS Foundation Tru

Board of Directors Performance Report

July 2019

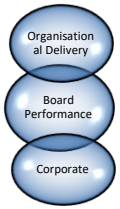
"To Deliver Excellence in Healthcare through Innovation & Collaboration"

Introduction

Performance Report

The MCHT Monthly Performance Report has been developed to integrate key domains of Quality and Safety, Performance and Corporate into one consistently presented report. It has been developed to provide an over arching view of performance against Trust priorities as set out in the NHS Improvement Compliance Framework, NHS Operating Framework, CCG CQuIN and Annual Plan.

The Monthly Performance Report will focus upon delivery of service improvements within 3 key domains:



The delivery of the service improvements within the 3 key domains are also reflected in the Board Assurance Framework which identifies where the organisation has insufficient assurance in delivering the strategic objectives of the organisation.
Within this Performance Report the indicators within each domain are presented on a summary page with the current month and year to date performance given. All indicators are measured against a NHS Improvement, national, peer or locally agreed target. A further analysis of all measures within each domain is then provided with supporting trend information and narrative. Performance against each indicator is rated as either red/green against the year to date or single month/quarter target as appropriate. Supporting narrative is provided on an exception basis.

This report is an evolving summary of overall Trust Performance, therefore measures, targets and reporting periods will be refined over time. A supporting and more detailed quality and safety report will be presented separately. This is also under further review.

James Sumner
Chief Executive

Contents

Headline Measures

Organisational Delivery				
Indicator	**Standard**	**YTD**	**Jul-19**	
Cancer				
Rapid Access Referrals (%) *(seen in 2 wks)*	93.00%	96.73%	96.60%	
Total Patients Seen		*4,185*	*1,207*	
Patients seen >14 days		*137*	*41*	
62 day GP Classic (%)	85.00%	85.52%	88.19%	*
Accountable Patients Treated		*287*	*72*	
No. of Breached Pathways (adjusted)		*38*	*9*	
62 day Screening (%)	90.00%	93.33%	90.63%	*
Accountable Patients Treated		*44*	*16*	
No. of Breached Pathways (adjusted)		*7*	*1.5*	
Unplanned Activity				
4 Hour Access Standard (%)	95.00%	79.42%	79.00%	
A&E Attendances (LH/MIU/UUC) (% to plan)		98.82%	103.63%	
A&E Attendances LH & MIU (Vol)		*33,553*	*8,966*	
Planned Activity				
Incomp Pathways <18wk (%)	92.00%	91.72%	92.06%	
>6wk Diagnostic Waits (%)	1.00%	6.62%	4.04%	
Total Patients Waiting for a First Outpatient Appointment			9,659	

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

Indicator	Standard	YTD
Workforce		
Sickness absence Rolling 12 Month		4.42%
Turnover Rolling 12 Month		9.60%

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	4	0.61	0.64
Liquidity	3	3	3	-13	-13
I&E Margin	3	4	3	-0.70%	-0.70%
Distance from Financial Plan	1	1	1	0.00%	0.00%
Agency Spend	1	2	3	-15.00%	-25.00%

	YTD Target	YTD Actual	YTD Variance	FY Target	FY Forecast	FY Variance
Cost Improvement Schemes Total (£000's)	1,571	1,057	-514	5,342	5,342	0
Commission Contact Income SC & VR (£000's)	56,298	56,298	0			
Contract Income (£'000)	79,266	79,646	380			
Pay to Budget (£000's)	-61,580	-61,464	116			
Non Pay to Budget (£000's)	-24,265	-24,782	-517			
Agency Trajectory (£000's)	-1,900	-2,310	-410			

Exec Summary

In July 2019, the Trust delivered four of the five NHS Improvement Single Oversight Framework performance indicators (Rapid Access Referral, Cancer 62 day, RTT). The indicator not achieved was the 4 hour Access standard.

The RTT Incomplete Pathway standard in July achieved 92.06% against the 92% performance standard. The RTT recovery plans have delivered an improvement over the last quarter with the recovery trajectory being met for the second consecutive month.

The 4 hour Access Standard in July achieved 79% against the 95% performance standard. This performance is a slight deterioration compared to previous month, however there has been a 12% increase in the number of patients attending A&E when compared to June 2019.

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

Diagnostics waiting times for July is 4.04% against a 1.00% threshold. This is an improvement on the previous month following the issues surrounding the Imaging server upgrade performance remains on trajectory to deliver compliant performance in August.

The UoRR metric is 3. If any of the UoRR metrics are 4, then the maximum rating that the trust can achieve is a 3.

The Trusts' I&E performance against the control total is £95k better than the plan.

This position includes the Provider Sustainability Fund (PSF) earned to date, which is dependant 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 NHS Supply Chain savings, improvements to sickness rates within nursing and delays to other programmes of work.

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

Single Oversight Framework

Triggers

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

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

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

Operational Performance

	Current YTD														Monthly Trend
	Target	Actual	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	
Maximum 6 week wait for Diagnostic procedures	1%	6.62%	0.56%	0.31%	0.44%	0.48%	0.17%	0.54%	0.47%	0.42%	0.76%	0.64%	9.34%	7.76%	4.04%	
All Cancers: 62 day GP Classic (%) *	85%	85.52%	91.40%	91.78%	86.11%	86.50%	93.40%	86.90%	85.83%	85.84%	85.60%	86.62%	86.09%	85.95%	88.19%	
All Cancers: 62 day Screening (%) *	90%	93.33%	100.00%	91.84%	100.00%	100.00%	100.00%	81.80%	87.50%	100.00%	95.45%	90.00%	90.00%	61.11%	90.63%	
18 weeks from point of referral to treatment - patients on an incomplete pathway (%)	92%	91.72%	92.97%	93.05%	92.43%	92.82%	92.28%	92.01%	91.30%	91.63%	90.67%	91.05%	91.67%	92.07%	92.06%	
A&E - maximum waiting time of 4 hours from arrival to admission/transfer/discharge (%)	95%	79.42%	84.59%	87.14%	84.61%	85.51%	88.13%	83.57%	78.89%	81.12%	80.41%	79.90%	78.26%	80.60%	79.00%	
STF Trajectory			93.92%	93.92%	93.92%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	0.00%				
Provider Submitted Trajectory													86.10%	86.10%	86.10%	

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

Financial & Resource

		Unit	YE Plan	YE Forecast	YE Rating	YTD Plan	YTD Actual	YTD Rating
Financial Sustainability	Capital Service Capacity	0.0x	0.61	0.64	4	1.02	1.27	3
	Liquidity	days	-13	-13	3	-11	-10	3
Financial Efficiency	I&E Margin	%	-0.70%	-0.70%	3	-1.30%	-1.20%	4
Financial Controls	Distance from Financial Plan	%	0.00%	0.00%	1	0.00%	0.10%	1
	Agency Spend	%	-15.00%	-25.00%	3	-14.00%	22.00%	2
Overall UOR Rating					3			3

Operational Delivery: *Cancer Pathway*

Headline Measures

	Current YTD		Rolling 13 months											
	Target	Actual	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Monthly Trend
Rapid Access Referrals (%) (seen in 2 wks)	93%	96.73%	96.37%	96.73%	96.50%	96.87%	98.36%	97.78%	96.91%	97.66%	97.69%	95.83%	97.66%	96.89%	96.60%	
Total Patients Seen		*4185*	*855*	*887*	*771*	*989*	*917*	*855*	*842*	*940*	*996*	*1031*	*982*	*965*	*1207*	
Patients seen >14 days		*137*	*31*	*29*	*27*	*31*	*15*	*19*	*26*	*22*	*23*	*43*	*23*	*30*	*41*	
% seen within 7 days		*30.3%*	*44.4%*	*35.2%*	*51.4%*	*41.5%*	*34.0%*	*35.4%*	*38.6%*	*38.1%*	*30.5%*	*30.3%*	*39.3%*	*37.5%*	*38.2%*	
62 day GP Classic (%) *	85%	85.52%	91.40%	91.78%	86.11%	86.50%	93.40%	86.90%	85.83%	85.84%	85.60%	86.62%	86.09%	85.95%	88.19%	

** Provisional figures subject to change depending*

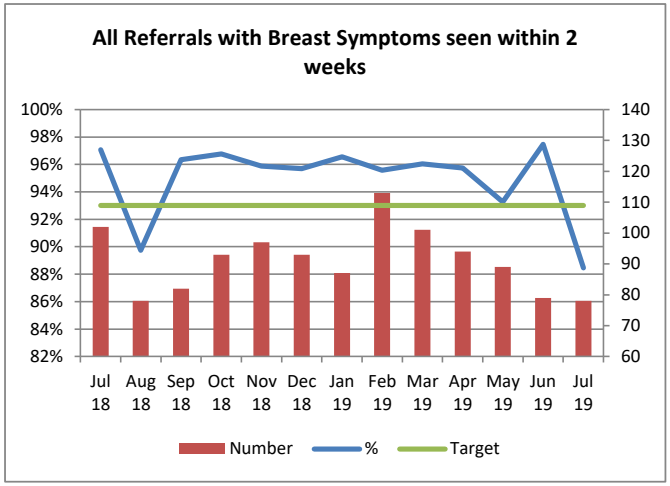
104+ day waits - (Cancer patients treated)	1	0	4	0	0	3	0	1	3	3	5	4	4

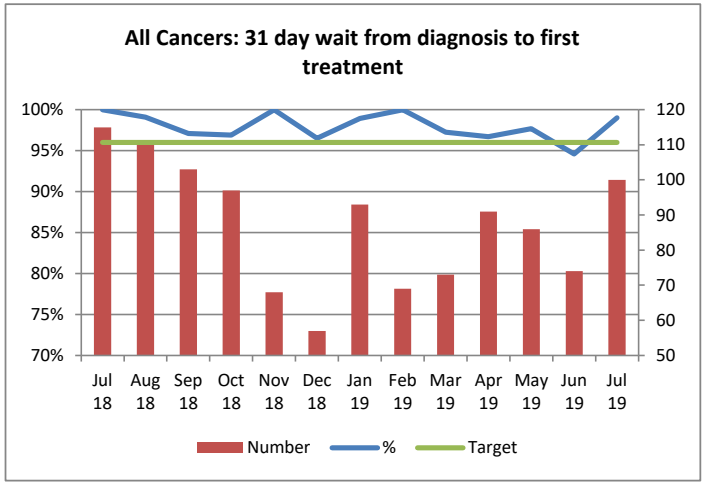
Commentary

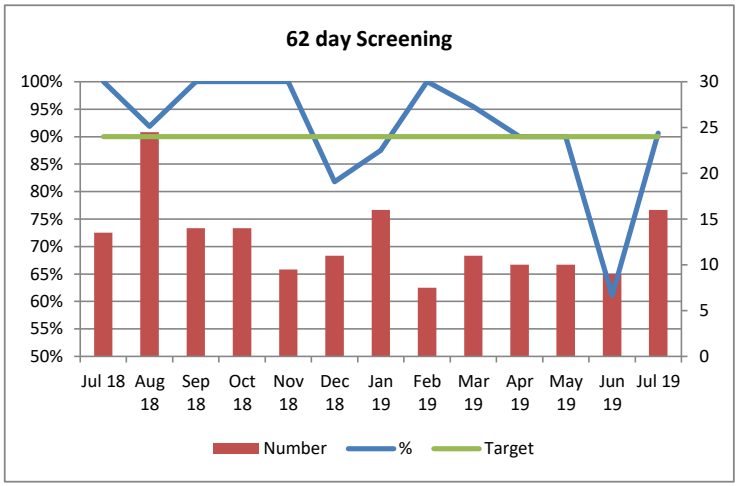
The Trust has achieved all three headline cancer standards during the month of July 2019. The figures presented in this paper reflect the Trust's regulatory performance measures adjusted figures that take into account breach reallocation between providers. From October 2018 the new cancer repatriation policy is in use.
The Trust has continued it's strong performance against the Rapid Access referrals standard, achieving 96.60% for July. This is inspite of a growth in demand of 41% more patients being seen compared to Jul 2018.
The 62 Day GP Classic standard has achieved 88.19% against an 85% target.

The 62 day screening standard has recovered from it's poor performance in June, reaching 90.63% against the 90% standard in July.

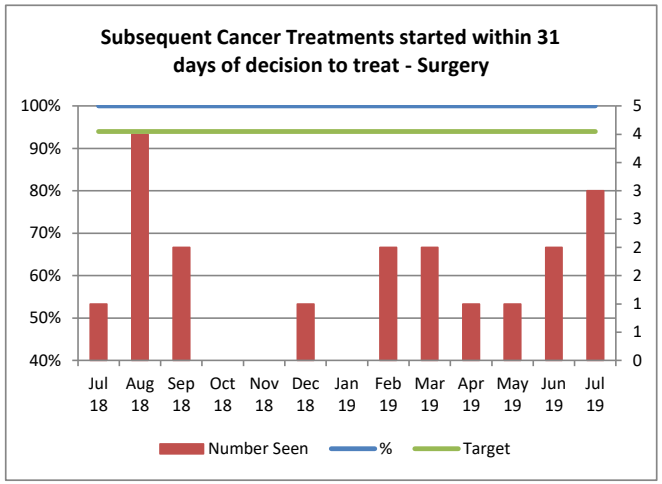
Primary Measures

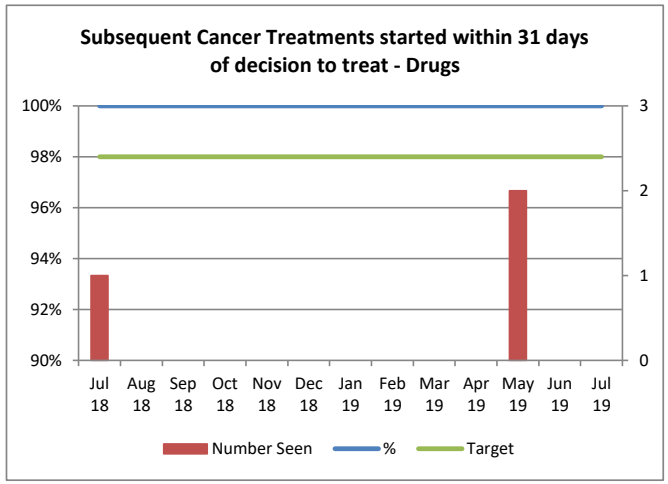


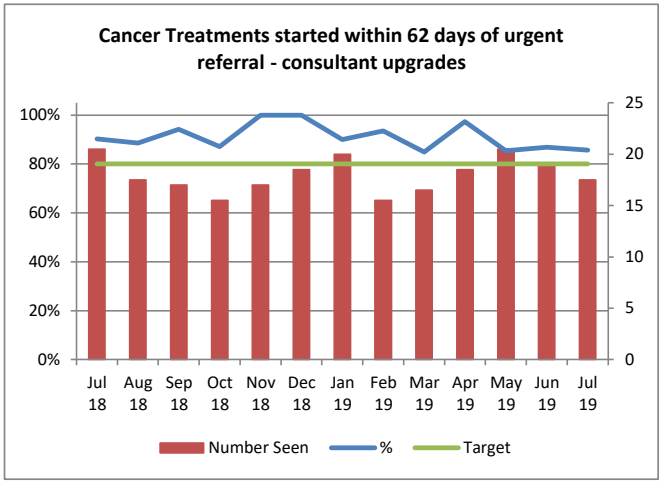




Operational Delivery: *Cancer Pathway*







Operational Delivery: *Unplanned Activity - A&E*

Headline Measures

	Current YTD		Rolling 13 months											
	Target	Actual	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Monthly Trend
A&E - >4 hr wait time from arrival to admission/ transfer/ discharge (% to Target)	95%	79.42%	84.59%	87.14%	84.61%	85.51%	88.13%	83.57%	78.89%	81.12%	80.41%	79.90%	78.26%	80.60%	79.00%	
No. of 4hr breaches		*6,906*	*1,286*	*967*	*1,158*	*1,167*	*884*	*1,209*	*1,621*	*1,349*	*1,574*	*1,642*	*1,822*	*1,559*	*1,883*	

	Plan	Actual	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Monthly Trend
A&E Attendances (LH/MIU/UUC) (% to Plan)		*98.82%*	99.6%	97.7%	94.9%	100.0%	98.4%	95.8%	99.3%	97.0%	95.4%	100.4%	95.2%	96.3%	103.6%	
A&E Attendances (LH/MIU/UUC) (No.)	*32,249*	*33,553*	8,344	7,517	7,524	8,056	7,445	7,358	7,679	7,147	8,034	8,169	8,382	8,036	8,966	
A&E Attendance Case Mix (based on acuity score) — *Major*		*9,541*	*2,168*	*2,380*	*2,228*	*2,455*	*2,269*	*2,235*	*2,392*	*2,170*	*2,341*	*2,351*	*2,540*	2,235	2,415	
Minor		*12,821*	*3,643*	*2,990*	*2,810*	*2,768*	*2,560*	*2,605*	*2,782*	*2,489*	*2,855*	*3,166*	*3,040*	3,045	3,570	
Paediatrics		*6,697*	*1,691*	*1,181*	*1,516*	*1,709*	*1,562*	*1,422*	*1,372*	*1,556*	*1,702*	*1,587*	*1,680*	1,686	1,744	
Resus		*4,490*	*835*	*966*	*969*	*1,120*	*1,048*	*1,095*	*1,128*	*928*	*1,126*	*1,063*	*1,121*	1,070	1,236	
A&E Attendance Location (based on Discharge) — *Major*		*13,123*	*3,121*	*3,225*	*3,090*	*3,413*	*3,187*	*3,176*	*3,354*	*2,983*	*3,317*	*3,245*	*3,405*	*3,142*	*3,331*	
Minor		*12,963*	*3,364*	*2,977*	*2,775*	*2,791*	*2,560*	*2,573*	*2,738*	*2,454*	*2,801*	*3,123*	*3,111*	*3,039*	*3,690*	
Paediatrics		*6,697*	*1,691*	*1,181*	*1,516*	*1,709*	*1,562*	*1,422*	*1,372*	*1,556*	*1,702*	*1,587*	*1,680*	*1,686*	*1,744*	
Resus		*766*	*161*	*134*	*142*	*139*	*130*	*186*	*210*	*150*	*204*	*212*	*185*	*169*	*200*	

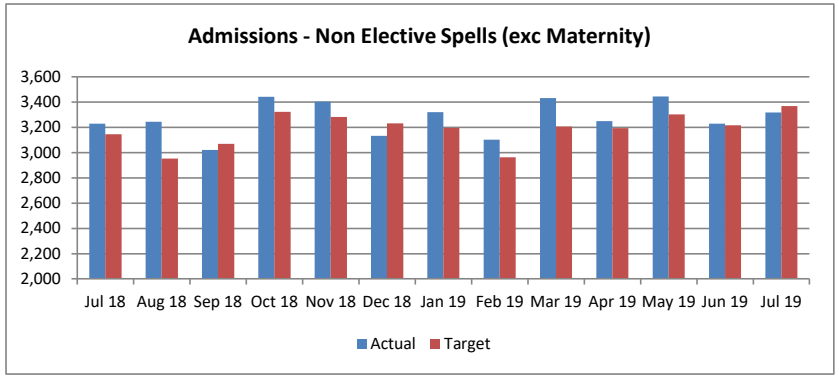
Commentary

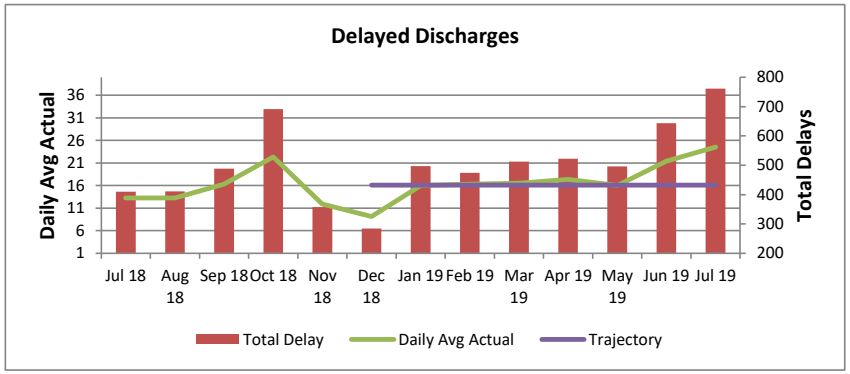
The Trust has achieved 79% against the 4-hour access standard in July 2019, this being a similar percentage against target as June 2019 despite seeing 12% more attendances in July 2019. In addition July 2019 has seen a 10% increase in the higher acuity patients coming into A&E compared to June 2019.

Medical outliers remain above the set threshold at 29.

Patients medically optimised for discharge in July has increased to 24.55 against a threshold of 16. This has been an increasing trend since October 2018. This is the second month the system has failed this standard. A change in service provision and care home capacity across both local authorities is the main reason for higher number of medically optimised patients staying longer in acute care. The A&E Delivery Board has tasked partners to compile a robust plan to deliver a reduced level of medically optimised patients during August.

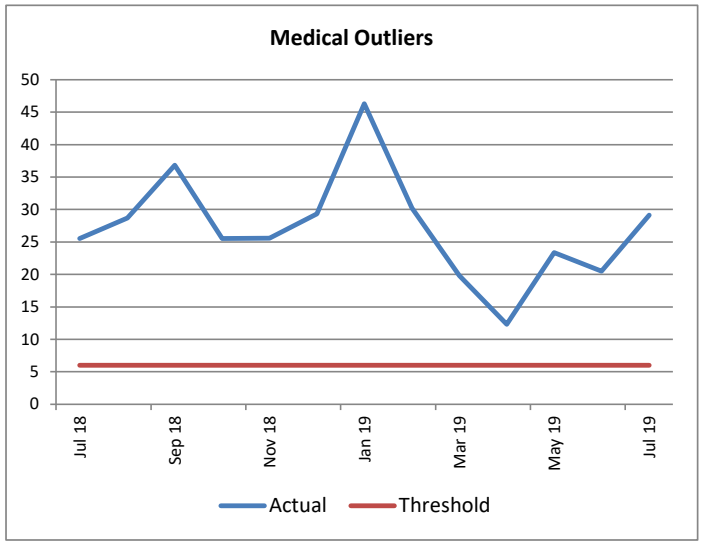
Primary Drivers

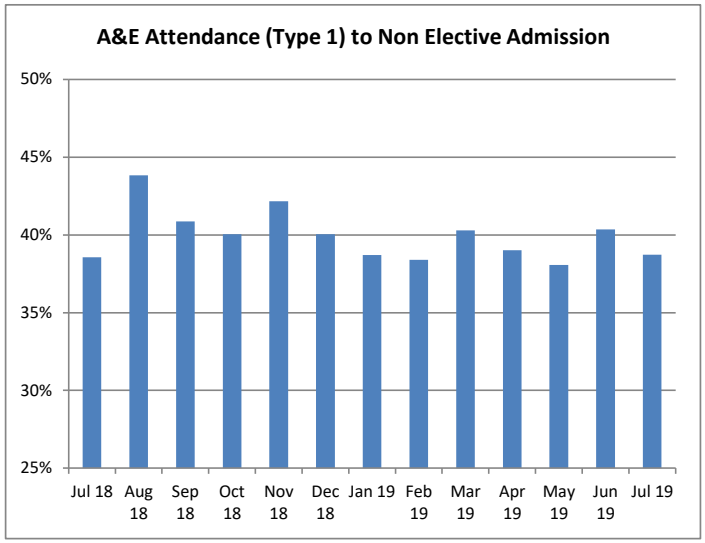


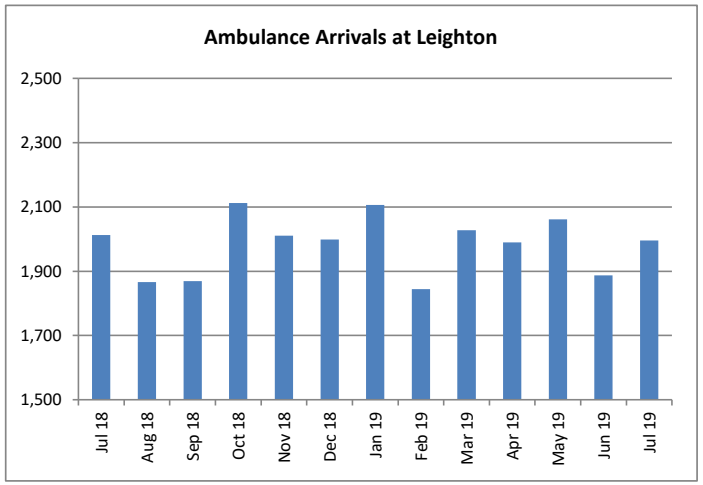


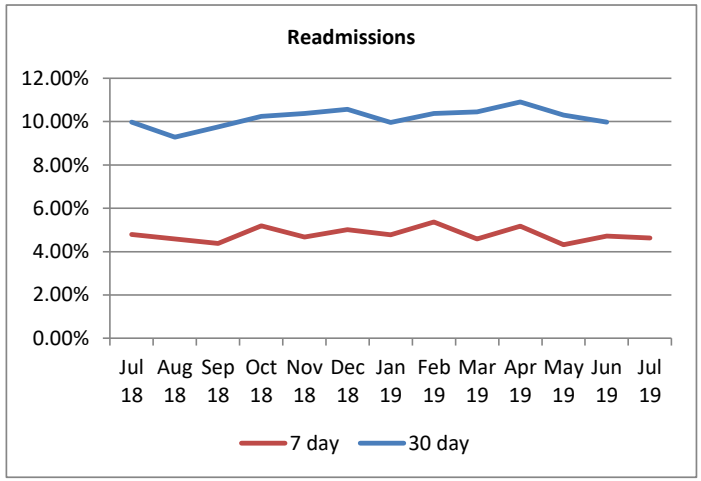
Operational Delivery: *Unplanned Activity A&E*

Secondary Drivers



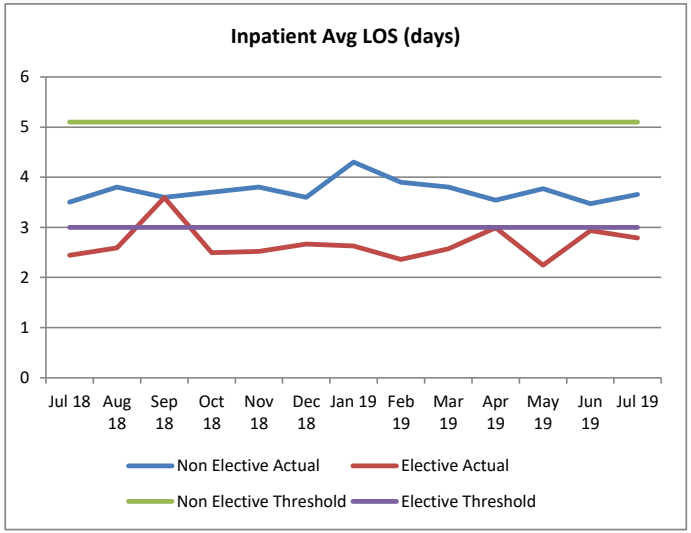


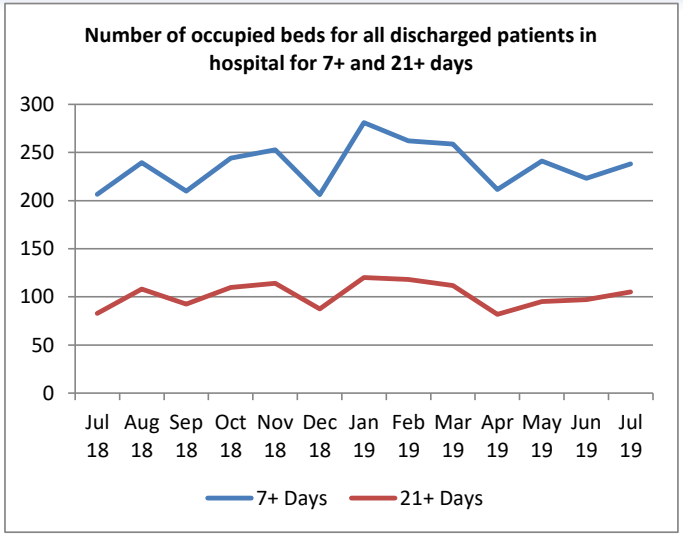


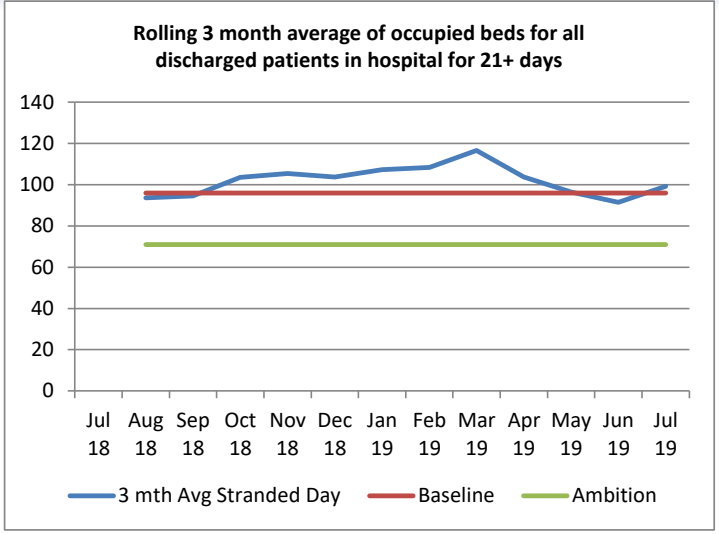


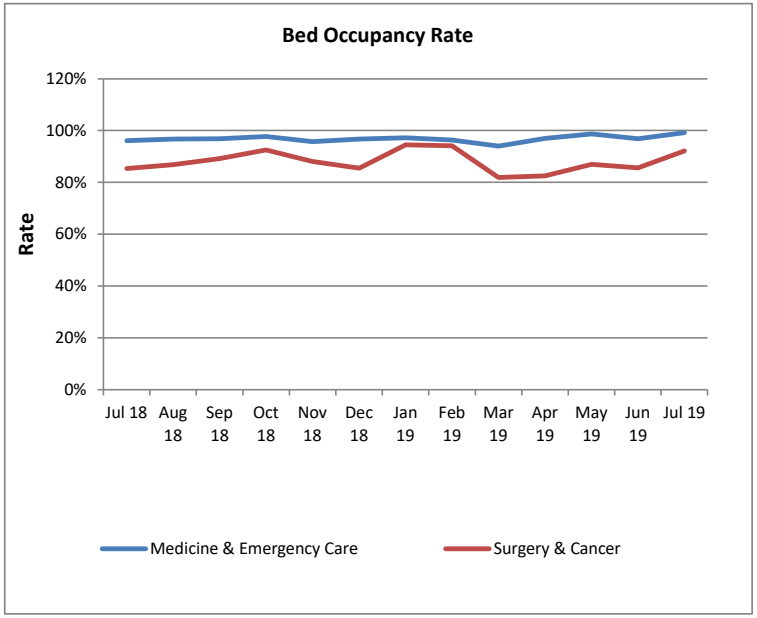
** Readmissions brought in line with national definition*

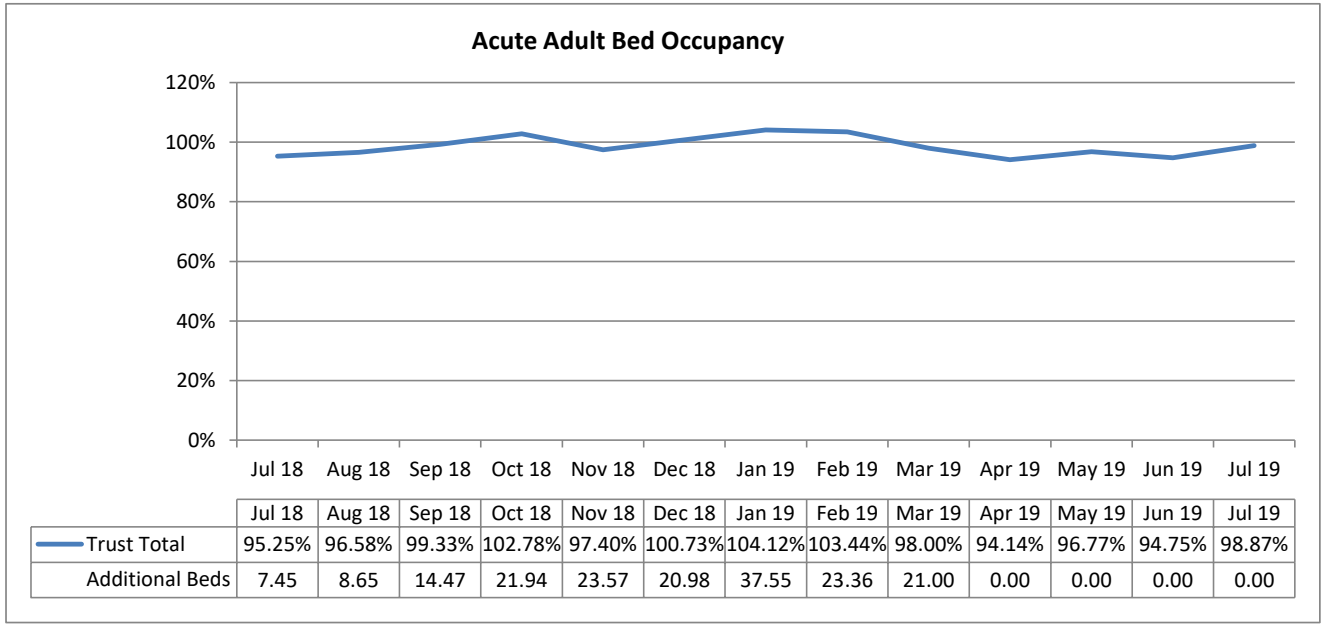
Operational Delivery: *Length of Stay*











	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19
Trust Total	95.25%	96.58%	99.33%	102.78%	97.40%	100.73%	104.12%	103.44%	98.00%	94.14%	96.77%	94.75%	98.87%
Additional Beds	7.45	8.65	14.47	21.94	23.57	20.98	37.55	23.36	21.00	0.00	0.00	0.00	0.00

Operational Delivery: *Planned Activity*

Headline Measures

	Current YTD		Rolling 13 months											
	Target	Actual	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Monthly Trend
18 weeks from Referral to Treatment in Aggregate - Incomplete	92%	91.72%	92.97%	93.05%	92.43%	92.82%	92.28%	92.01%	91.30%	91.63%	90.67%	91.05%	91.67%	92.07%	92.06%	
Total 18 Weeks		*61,345*	14,630	15,373	14,988	14,284	14,331	14,232	14,427	14,505	14,197	14,944	15,219	15,560	15,622	
No. > 18 Weeks		*5,071*	*1,029*	*1,069*	*1,135*	*1,025*	*1,106*	*1,137*	*1,255*	*1,214*	*1,324*	*1,338*	*1,267*	*1,234*	*1,232*	
Open Pathways >39 Weeks Waiting											*10*	*10*	*15*	*15*	*14*	
Diagnostic Waiting Time	1%	6.62%	0.56%	0.31%	0.44%	0.48%	0.17%	0.54%	0.47%	0.42%	0.76%	0.64%	9.34%	7.76%	4.04%	
Total Number of Waiters		*15,715*	*4,257*	*3,814*	*4,105*	*4,168*	*4,017*	*3,870*	*4,029*	*4,785*	*4,749*	*1,091*	*4,809*	*5,065*	*4,750*	
Waiters of 6 Weeks +		*1,041*	*24*	*12*	*18*	*20*	*7*	*21*	*19*	*20*	*36*	*7*	*449*	*393*	*192*	
Total Patients Waiting for a First Outpatient Appointment			9,496	9,851	9,654	9,496	9,430	8,948	9,428	9,823	9,682	9,800	9,981	9,603	9,659	
Longest Wait Time (weeks)											*46*	*48*	*44*	*46*	*48*	

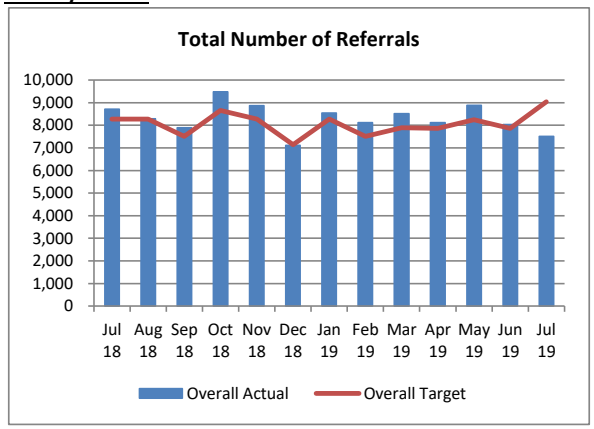
Commentary

The Trust's RTT Incomplete Pathway position is 92.06% for July. Eight specialties have failed to meet the 92% target, these are General Surgery, Urology, Gastroenterology, Cardiology, Dermatology, Thoracic Medicine, Gynaecology and Trauma and Orthopaedics. Detailed improvement plans and trajectories are in place and continue to be reviewed weekly by the Chief Operating Officer and Director of Operations.

Mid Cheshire do not currently have any 52 week breaches for July, there are 14 patients waiting over 39 weeks; (1 in General Surgery, 1 in ENT, 2 in Thoracic Medicine, 1 in Cardiology, 4 in Urology, 4 in Gynae, 1 in Dermatology). All long wait patients are monitored and reviewed weekly at director led performance meetings.

In July 2019, 4.04% of patients waited longer than 6 weeks for their diagnostic tests. The failure of the Diagnostic six week standard is expected as a result of the failed server upgrade and the impact on the soliton system. Improvement from previous month has been seen with full compliance against this standard expected during August 2019.

Primary Drivers

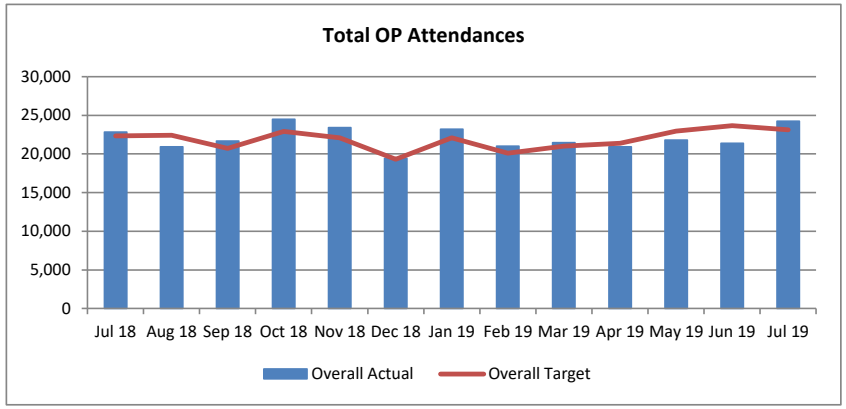


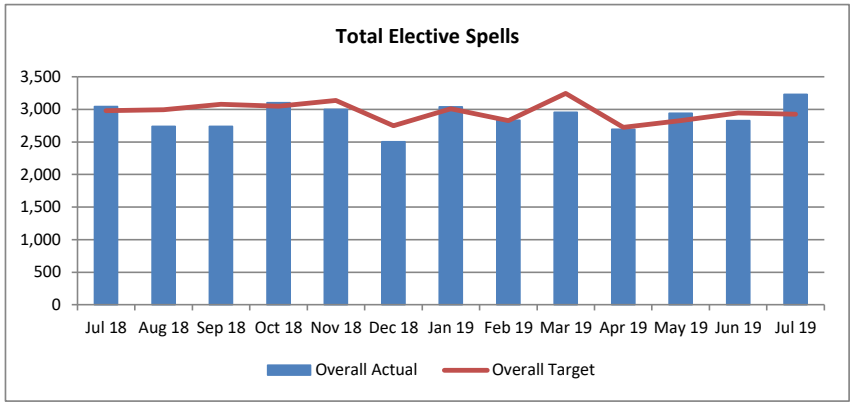
Referral Breakdown

	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Monthly Trend
GP Actual	5,355	5,184	4,925	5,755	5,684	4,412	5,424	4,915	5,270	4,587	5,231	4,583	4,103	
GP Target	5,157	5,157	4,683	5,394	5,157	4,446	5,157	4,683	4,920	4,374	4,593	4,374	5,030	
% to Target	103.8%	100.5%	105.2%	106.7%	110.2%	99.2%	105.2%	105.0%	107.1%	104.9%	113.9%	104.8%	81.6%	
Other Actual	3,352	3,107	2,968	3,714	3,189	2,696	3,118	3,204	3,250	3,524	3,655	3,453	3,411	
Other Target	3,120	3,120	2,833	3,263	3,120	2,689	3,120	2,833	2,976	3,483	3,657	3,483	4,006	
% to Target	107.5%	99.6%	104.8%	113.8%	102.2%	100.3%	100.0%	113.1%	109.2%	101.2%	99.9%	99.1%	85.2%	
Total Actual	8,707	8,291	7,893	9,469	8,873	7,108	8,542	8,119	8,520	8,111	8,886	8,036	7,514	
Total Target	8,276	8,276	7,515	8,657	8,276	7,135	8,276	7,515	7,896	7,857	8,250	7,857	9,036	
% to Target	105.2%	100.2%	105.0%	109.4%	107.2%	99.6%	103.2%	108.0%	107.9%	103.2%	107.7%	102.3%	83.2%	
GP % of Total	61.5%	62.5%	62.4%	60.8%	64.1%	62.1%	63.5%	60.5%	61.9%	56.6%	58.9%	57.0%	54.6%	

Operational Delivery: *Planned Activity*

Primary Drivers



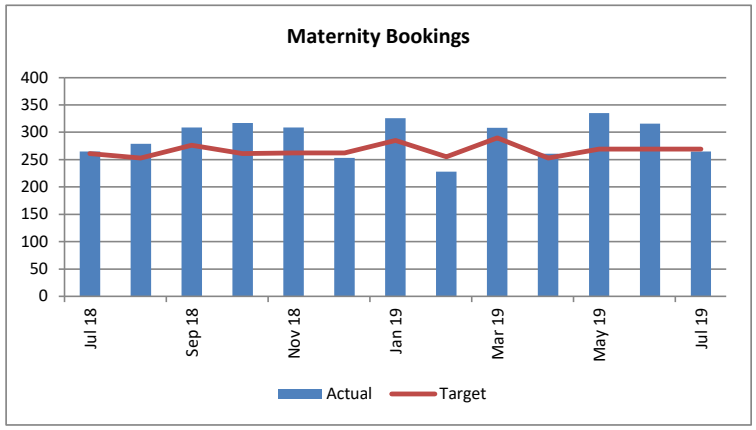


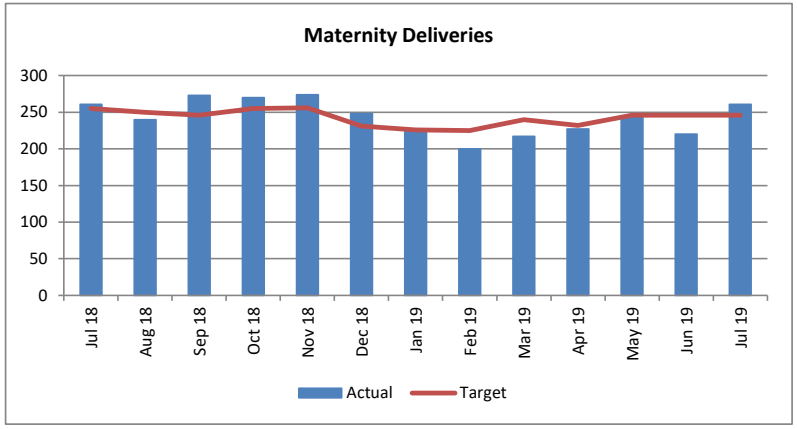
OP Attendance Breakdown	YTD 18 19	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Monthly Trend
New Actual	81,335	7,001	6,211	6,648	7,713	7,203	5,946	6,861	6,397	6,877	6,584	6,956	6,725	7,828	
New Target	74,744	6,495	6,502	5,934	6,778	6,496	5,625	6,496	5,901	6,189	6,416	6,848	7,173	6,817	
% to Target	108.8%	107.8%	95.5%	112.0%	113.8%	110.9%	105.7%	105.6%	108.4%	111.1%	102.6%	101.6%	93.8%	114.8%	
F U Actual	182,101	15,835	14,737	15,014	16,778	16,207	13,493	16,352	14,629	14,583	14,343	14,830	14,642	16,408	
F U Target	181,624	15,844	15,912	14,774	16,157	15,600	13,701	15,604	14,194	14,803	14,988	16,096	16,491	16,286	
% to Target	100.3%	99.9%	92.6%	101.6%	103.8%	103.9%	98.5%	104.8%	103.1%	98.5%	95.7%	92.1%	88.8%	100.8%	
Total Actual	263,436	22,836	20,948	21,662	24,491	23,410	19,439	23,213	21,026	21,460	20,927	21,786	21,367	24,236	
Total Target	256,368	22,339	22,414	20,708	22,935	22,095	19,326	22,100	20,095	20,992	21,403	22,944	23,663	23,102	
% to Target	102.8%	102.2%	93.5%	104.6%	106.8%	105.9%	100.6%	105.0%	104.6%	102.2%	97.8%	95.0%	90.3%	104.9%	
New % of Total	30.9%	30.7%	29.6%	30.7%	31.5%	30.8%	30.6%	29.6%	30.4%	32.0%	31.5%	31.9%	31.5%	32.3%	

Elective Spells Breakdown	YTD 18 19	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Monthly Trend
I P Actual	3,055	276	226	259	284	280	241	157	288	272	225	228	266	263	
I P Target	3,341	271	288	281	308	308	241	181	264	304	263	277	280	277	
% to Target	91.4%	101.9%	78.6%	92.2%	92.3%	91.0%	100.1%	86.9%	109.0%	89.4%	85.6%	82.3%	94.9%	94.9%	
Daycase Actual	31,155	2,766	2,513	2,479	2,817	2,717	2,262	2,882	2,543	2,685	2,467	2,714	2,560	2,965	
Daycase Target	32,775	2,709	2,709	2,795	2,740	2,827	2,507	2,826	2,565	2,942	2,462	2,548	2,666	2,650	
% to Target	95.1%	102.1%	92.8%	88.7%	102.8%	96.1%	90.2%	102.0%	99.1%	91.3%	100.2%	106.5%	96.0%	111.9%	
Total Actual	34,210	3,042	2,739	2,738	3,101	2,997	2,503	3,039	2,831	2,957	2,692	2,942	2,826	3,228	
Total Target	36,116	2,980	2,996	3,076	3,048	3,135	2,748	3,007	2,829	3,247	2,724	2,825	2,946	2,927	
% to Target	94.7%	102.1%	91.4%	89.0%	101.8%	95.6%	91.1%	101.1%	100.1%	91.1%	98.8%	104.1%	95.9%	110.3%	
I P % of Total	8.9%	9.1%	8.3%	9.5%	9.2%	9.3%	9.6%	5.2%	10.2%	9.2%	8.4%	7.7%	9.4%	8.1%	

Operational Delivery: *Planned Activity*

Primary Drivers





Operational Delivery: *Planned Activity*

Secondary Drivers

			Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Monthly Trend
Bed Occupancy Rate	Medicine & Emergency Care		96.1%	96.7%	96.9%	97.7%	95.8%	96.7%	97.3%	96.3%	94.0%	97.0%	98.7%	96.9%	99.2%	
	Surgery & Cancer		85.4%	86.9%	89.2%	92.5%	88.1%	85.5%	94.5%	94.2%	81.9%	82.5%	86.9%	85.6%	92.2%	
Elective Inpatient Avg LOS (Days)			2.4	2.6	3.6	2.5	2.5	2.7	2.6	2.4	2.6	3.0	2.2	2.9	2.8	
Delayed Transfers of Care (MFFD)		16.00	13	13	16	22	12	9	16	17	17	17	16	21	25	
Delayed Transfers of Care (% of Acute Beds)			2.8%	2.8%	3.3%	4.5%	2.4%	1.8%	3.1%	3.3%	3.3%	3.5%	3.2%	4.3%	5.2%	
Medical Outliers			26	29	37	26	26	29	46	31	20	12	23	20	29	
Readmission (Emergency Re-admissions after Planned Surgery)																
	30 Day Rate		3.12%	2.73%	3.01%	3.28%	2.96%	2.87%	2.66%	3.86%	3.29%	3.38%	3.38%	3.03%		
	7 Day Rate		1.42%	1.27%	1.28%	1.16%	1.15%	1.09%	1.06%	1.45%	1.05%	1.41%	1.37%	0.98%	1.06%	
Cancelled Operations - Non Clinical - Cancellation Rate			0.95%	0.95%	0.73%	1.86%	0.63%	1.40%	0.58%	0.60%	0.65%	0.67%	1.17%	0.85%	1.02%	
Theatre Efficiency																
	Main Theatres		76.7%	78.4%	78.4%	77.9%	77.2%	73.9%	74.5%	76.2%	78.5%	76.7%	75.0%	77.4%	78.7%	
	TC Theatres		75.6%	73.2%	73.4%	76.6%	73.5%	72.0%	69.4%	73.0%	73.5%	72.4%	68.2%	74.8%	70.7%	
DNA (OP Efficiency)			6.09%	5.74%	5.55%	5.72%	5.62%	5.95%	5.75%	5.42%	5.41%	5.99%	6.02%	6.55%	5.84%	
Hospital Cancellation Rate (OP Efficiency)			7.03%	7.27%	7.57%	7.65%	7.63%	8.27%	7.65%	7.83%	8.12%	7.91%	7.48%	7.36%	8.10%	

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

Performance and Finance - Headlines July 2019

Current Position	Analysis	Forward View

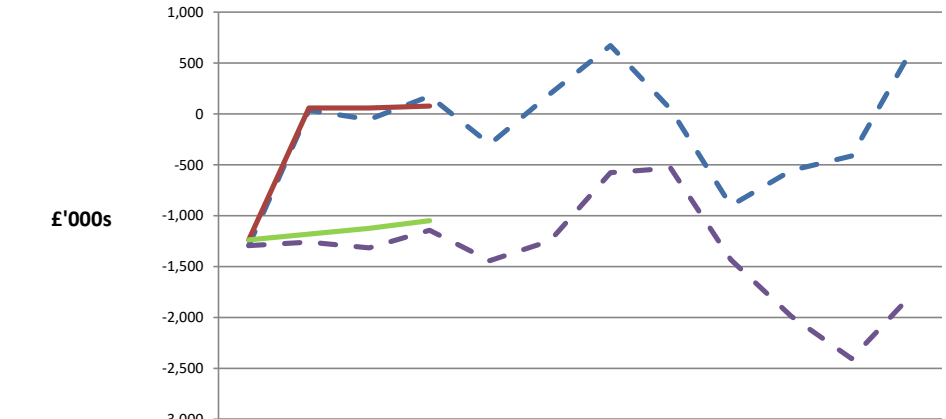
The reported position is cumulatively £95k better than the control total.

CCICP is underspent by £303k, and MCHFT overspent by £208k cumulatively to date

The month 4 (July) position has deteriorated to an overspend of £97k with MCHT being overspent by £193k

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

Financial Performance 2019/20



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
In Month Plan	-1,294	34	-56	173	-298	195	669	44	-900	-556	-413	628
In Month Actual	-1,238	56	58	76								
In Month Variance	56	22	114	-97								
Cumulative Plan	-1,294	-1,260	-1,316	-1,143	-1,441	-1,246	-577	-533	-1,433	-1,989	-2,402	-1,774
Cumulative Actual	-1,238	-1,182	-1,124	-1,048								
Cumulative Variance	56	78	192	95								

	YTD Rating		YE Rating	
Indicator	Plan	Actual	Forecast	Status
Finance				
Use of Resource Rating	3	3	3	
Capital Service Capacity	4	3	4	The planned deficit does not meet the financial commitments
Liquidity	3	3	3	The Trust has enough cash to meet it's obligations
I&E Margin	4	4	3	The current deficit as a percentage of turnover is greater than -2%
Distance from Financial Plan	1	1	1	The trust is currently on plan
Agency Spend	1	2	3	The current leve of spend on agency is greater than the cap.

The expectation is that the Trust will meet the annual plan, and receive both the PSF (£4.216m) and MRET (£3.215m).

Main risks around delivering the control total relate to delivering the CIP targets, delivering the associate contracted activity and managing unscheduled care pressures within the approved budgets and business cases.

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

Performance and Finance - Contract Income July 2019

Current Position

Contract income is £18k above plan year to date with an improvement of £140k in month.

Associate contracts continue to underperform against plan pre-dominantly with Stoke/North Staffs and West Cheshire CCGs (£0.76m to date with in month performance being on trend at £0.2m underperformance).

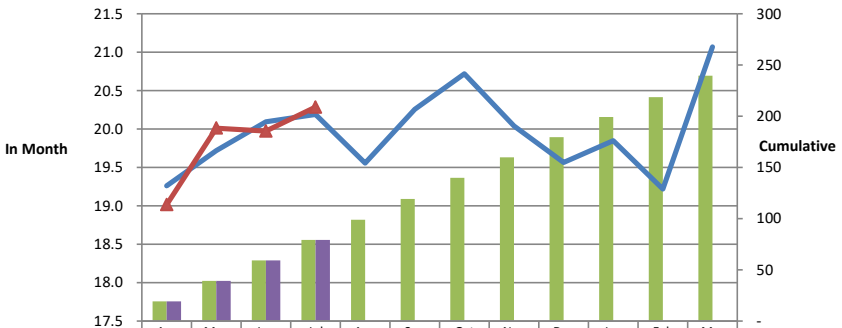
South Cheshire and Vale Royal contracts show no total variance due to the block arrangements. However, unplanned activity is now under plan by £120k year to date, with a deterioration of £170k in month. Planned activity is now on plan, with an improvement of £0.46m in month. CQUIN is reported as £460k below plan.

CQUIN is currently assessed as under plan by £527k (£460k within the block contract)

The 'other' column, includes 4/12 of the additional £500k additional contract income yet to be allocated for South/Vale Royal (£0.17m). Over-performance on high cost drugs within Specialised Commissioning (£0.6m) – offsetting against drugs within non-pay

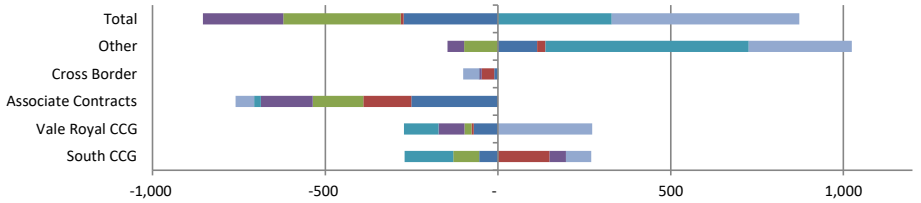
Analysis

Contract Income Performance 2019/20 £'m



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative budget	19.3	39.0	59.1	79.3	98.8	119.1	139.8	159.8	179.4	199.2	218.5	239.5
Cumulative actual	19.0	39.0	59.0	79.3								
In month budget	19.3	19.7	20.1	20.2	19.6	20.3	20.7	20.0	19.6	19.8	19.2	21.1
In month actual	19.0	20.0	20.0	20.3								

Cumulative Variance to Contract Income plan £'000s



	South CCG	Vale Royal CCG	Associate Contracts	Cross Border	Other	Total
Unplanned Care	-54	-70	-251	-11	113	-273
Day case	149	-7	-139	-37	25	-9
Elective	-75	-20	-147	0	-98	-340
Outpatients	48	-75	-150	-7	-48	-232
High cost drugs	-140	-100	-19	-0	588	329
Other	73	272	-54	-47	299	544
Total	-0	0	-760	-101	879	18

Forward View

There is a risk that if the current level of underperformance on associate contracts continues, then this could impact the Trust by between £2m-2.3m.

The Trust has seen an increase in referrals for the first 4 months particularly around the surgical specialties, which the Trust is discussing with the CCG.

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

The underperformance on CQUIN is a concern from both a financial and quality aspect. The 1st quarters report will be scrutinised through the normal governance routes and approraite actions determined.

The additional activity and costs following One To One decision to go into Administration is being negotiated with the CCG

Performance and Finance - Pay Expenditure July 2019

Current Position

Cumulatively Pay is better than plan by £116k, with CCICP being £228k better and MCHFT £112k adverse.

Pay is above budget in Medicine and Emergency Care (£139k), Women and Children's (£118k) and Surgery and Cancer (£117k). There is an underspend within Clinical Support Services and Diagnostics of £195k - which offsets part of the non-pay overspend within the division due to outsourcing.

DMEC overspend is largely due to the Trust wide unallocated/nursing CIPS £27k in month and £107k cumulatively .

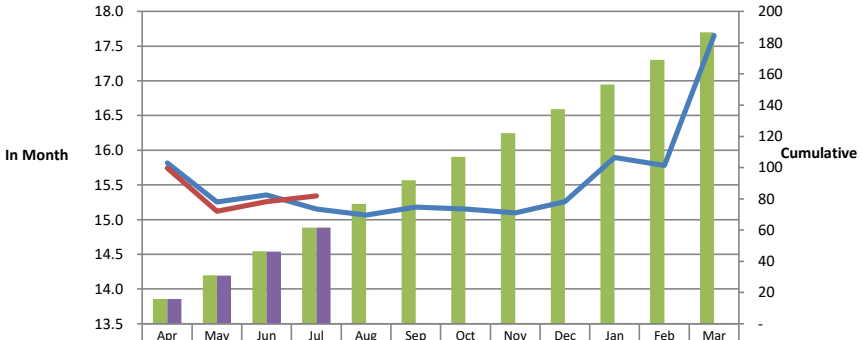
The Women and Children's division currently has a high cost agency doctor in post within Paediatrics and has had high dependency patients in June/July.

In month 4, Surgery and Cancer overspent by £110k, mainly driven by escalation beds on SACU £50k.

Approximately £60k was spent in month on unfunded escalation beds.

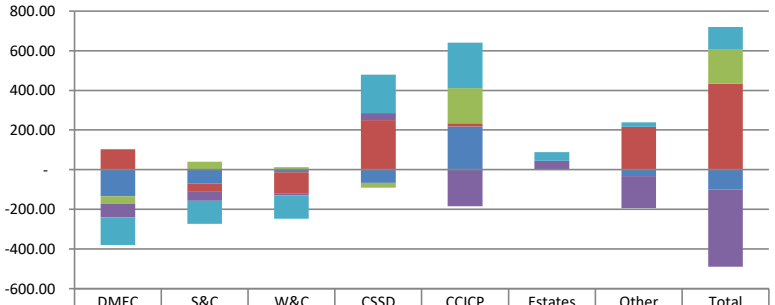
Analysis

Pay Expenditure 2019/20 £'m



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative budget	15.8	31.1	46.4	61.6	76.6	91.8	107.0	122.1	137.3	153.2	169.0	186.7
Cumulative actual	15.7	30.9	46.1	61.5								
In month budget	15.8	15.3	15.4	15.2	15.1	15.2	15.2	15.1	15.3	15.9	15.8	17.7
in month actual	15.7	15.1	15.3	15.3								

Pay Variances by Staff Group and Division £'000s



	DMEC	S&C	W&C	CSSD	CCICP	Estates	Other	Total
Total	-139.02	-116.54	-117.58	194.65	228.23	44.07	21.78	115.60
Infrastructure Support Staff	-69.68	-45.40	-7.74	35.25	-183.78	44.12	-161.53	-388.76
Non Clinical Staff	-37.28	40.59	12.28	-22.80	177.52	-	-0.39	169.91
Medical Staff	102.47	-42.17	-108.07	249.44	16.37	-	216.62	434.67
Nursing Staff	-134.53	-69.57	-14.04	-67.23	218.11	-0.05	-32.92	-100.22

Forward View

CCICP plan to make investments into the service, which is likely to result in the current level of underspend not continuing in future months.

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

a) Opening of unfunded escalation areas. This is being monitored on a weekly basis by the executive team

b) Potential unbudgeted pressures associated with breakdowns with the laundry service

Performance and Finance - Non-Pay Expenditure July 2019

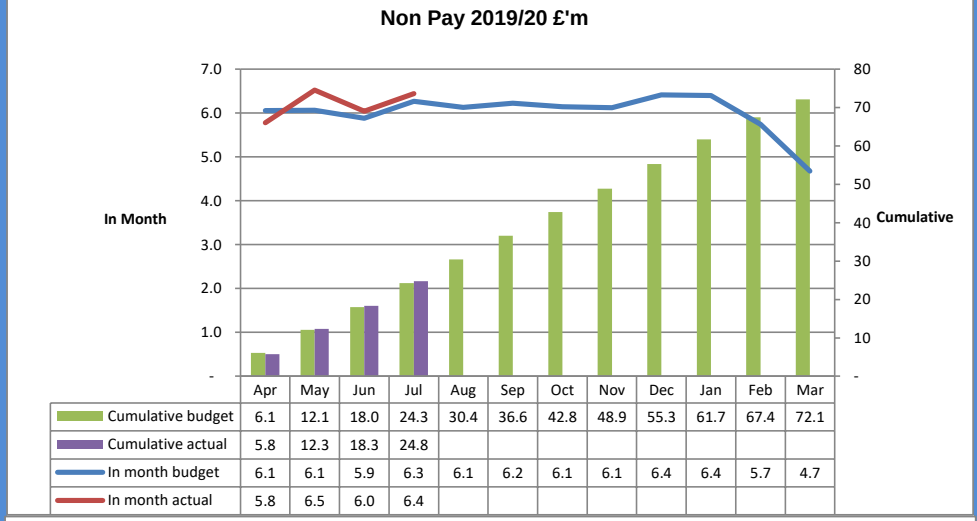
Current Position

Non Pay is above plan by £517k, however in month 1 there was a one off benefit of £140k which related to 18/19 costs, thus the underlying position is £657k above plan.

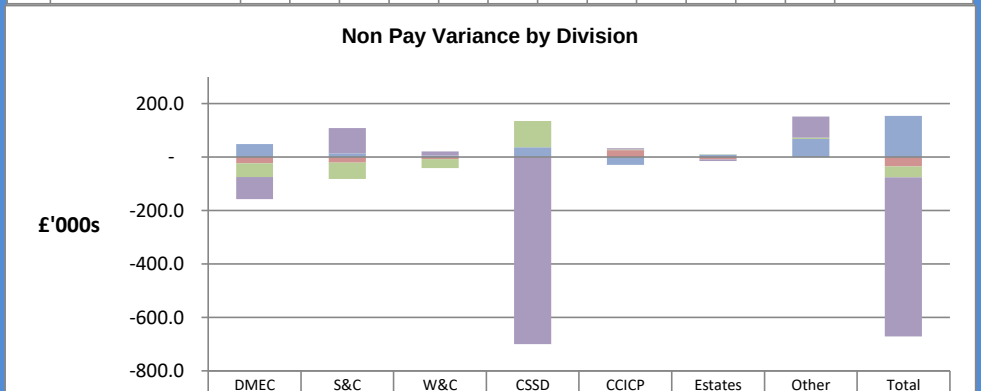
Clinical Support Services are overspent by £565k, £700k in other non pay due to challenges associated with delays to the 3rd MRI/CT scanners (£118k), Soliton server upgrade issue(£132k) and Histopathology cost overspends (£168k) offset by medical pay vacancies. Also, £115k year to date is due to outsourcing of Cardiac CT scans.

Drugs deteriorated in month by £100k due to pass through drugs £72k and general drugs £34k.

Analysis



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative budget	6.1	12.1	18.0	24.3	30.4	36.6	42.8	48.9	55.3	61.7	67.4	72.1
Cumulative actual	5.8	12.3	18.3	24.8								
In month budget	6.1	6.1	5.9	6.3	6.1	6.2	6.1	6.1	6.4	6.4	5.7	4.7
In month actual	5.8	6.5	6.0	6.4								



	DMEC	S&C	W&C	CSSD	CCICP	Estates	Other	Total
Total	-109.2	25.9	-19.2	-564.9	3.9	-5.1	151.4	-517.1
Other Non Pay	-83.3	94.4	15.8	-698.6	3.9	-5.0	78.3	-594.6
Drugs	-51.6	-61.6	-33.2	98.2	2.4	0.1	4.8	-40.9
Non Clinical Supplies	-22.8	-20.6	-7.7	-1.6	26.4	-9.3	0.2	-35.4
Clinical Supplies	48.5	13.8	5.9	37.1	-28.8	9.2	68.1	153.8

Forward View

There are a further £36k costs expected to come through for the Soliton issue.

Vacancies in Histopathology will continue to cause a pressure in Non Pay (offset being in Pay).

Performance and Finance - Cost Improvement Programme July 2019

Current Position

The CIP programme is behind plan by £0.5m, although this is within the reported £95k surplus to-date.

This relates to the following schemes

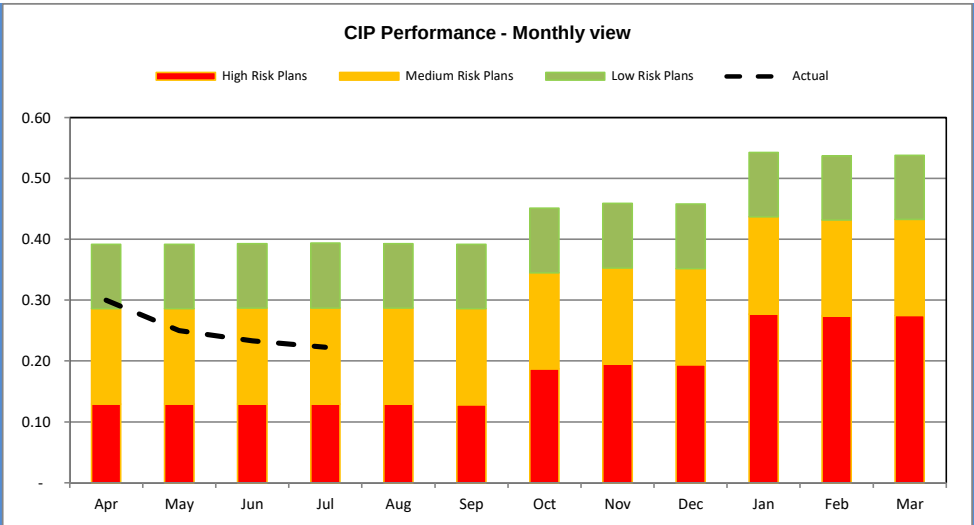
- Nurse savings on sickness/turnover (£83k)
- NHS Supply Chain (£166k)
- Unallocated Capital to Revenue scheme (£122k)
- Unallocated CIP Plans (£67k) in DMEC

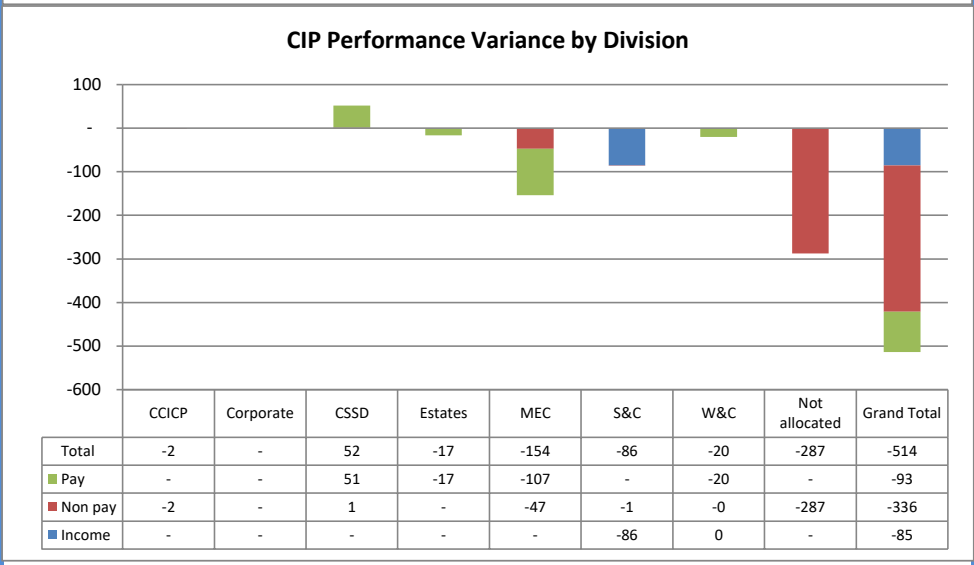
The NHS Supply Chain and Capital to Revenue schemes have not been allocated to Divisions.

Whilst Surgery and Cancer are currently behind, their 2 key schemes have been delayed - which are expected to catch up in September/October.

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

Analysis





	CCICP	Corporate	CSSD	Estates	MEC	S&C	W&C	Not allocated	Grand Total
Total	-2	-	52	-17	-154	-86	-20	-287	-514
Pay	-	-	51	-17	-107	-	-20	-	-93
Non pay	-2	-	1	-	-47	-1	-0	-287	-336
Income	-	-	-	-	-	-86	0	-	-85

Forward View

There is a risk profile to the CIP plan which increases in Q3 (Nursing pay schemes £0.4m).

There is a £0.3m risk associated with the capital to revenue transfer scheme.

Performance and Finance - Agency Spend July 2019

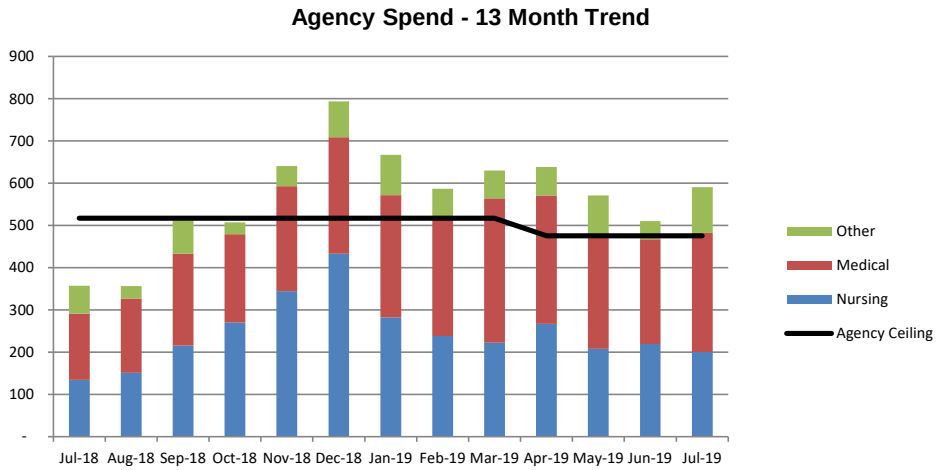
Current Position

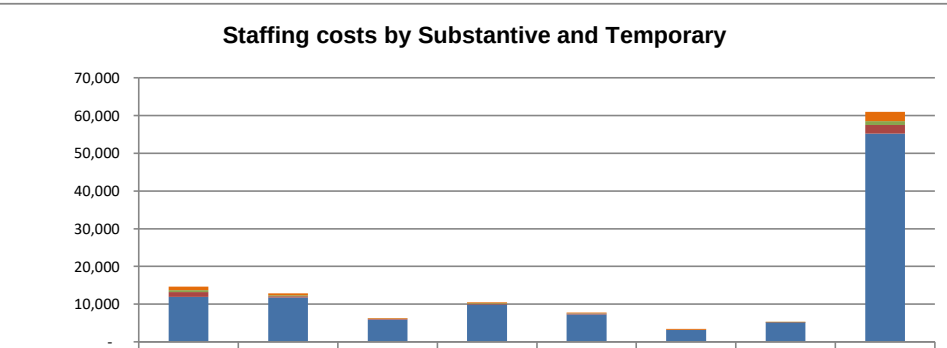
Agency Spend as a run rate is projected to exceed the contract ceiling of £5.7m, which is a lower level than 2018/19.

The overall percentage of temporary staff (bank/agency) is 9% of the pay bill.

The Division of Medicine and Emergency Care has the highest percentage of temporary staff costs at 18%.

Analysis





	DMEC	S&C	W&C	CSSD	CCICP	Estates	Other	Total
Total	14,862	13,074	6,303	10,649	7,789	3,478	5,313	61,469
Waiting Lists	165	191	1	138	-	-	-	495
Bank	945	534	216	246	143	296	86	2,465
Locum	523	217	10	159	72	-	11	991
Agency	1,279	377	146	182	319	-	6	2,310
Substantive	11,951	11,754	5,930	9,925	7,256	3,182	5,209	55,208

Forward View

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

Medical staff above cap and use of Thornbury agency use are reviewed by execs weekly.

Performance and Finance - Divisional Performance July 2019

Current Position

DMEC is the most challenged division being £0.24m overspent against plan to-date, with challenges in relation to achieving the activity targets set within the plan and pay pressure, in part due to non delivery of their CIP schemes.

Surgery has seen a £0.2m in month improvement from Outpatient/Day Case activity, however pay costs have worsened by £0.1m, mainly through escalation bed issues.

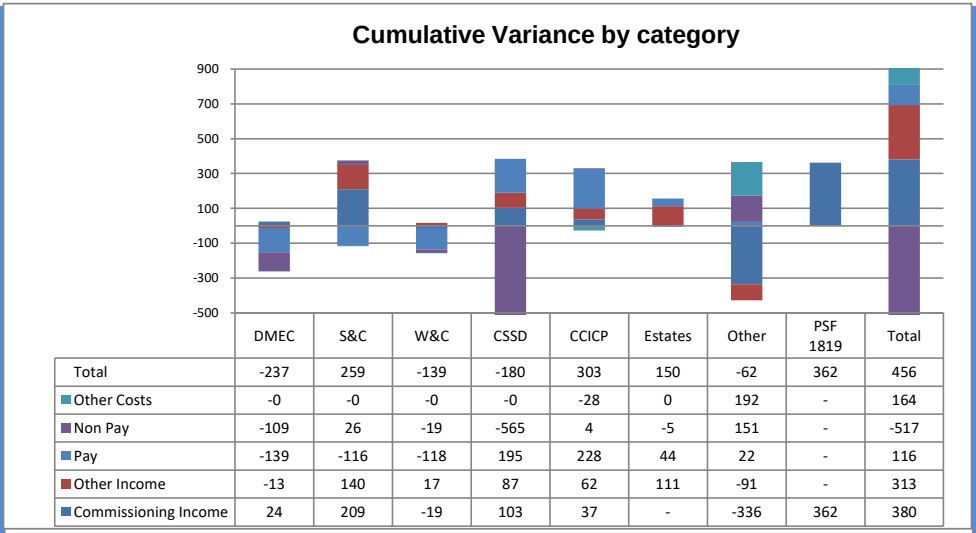
Women's and Children's has seen an improvement in month in Maternity activity, however this has been partially offset by increased pay costs in Paediatrics through agency and high dependency patients.

Clinical Support Services and Diagnostics is £0.2m overspent mainly due to the Soliton and MR/CT delays presenting in Non Pay.

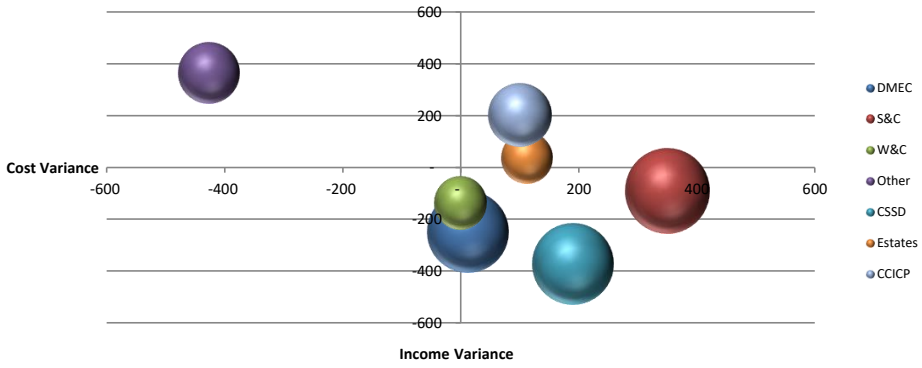
CCICP continues currently to be better than budget, principally around pay.

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

Analysis



	DMEC	S&C	W&C	CSSD	CCICP	Estates	Other	PSF 1819	Total
Total	-237	259	-139	-180	303	150	-62	362	456
Other Costs	-0	-0	-0	-0	-28	0	192	-	164
Non Pay	-109	26	-19	-565	4	-5	151	-	-517
Pay	-139	-116	-118	195	228	44	22	-	116
Other Income	-13	140	17	87	62	111	-91	-	313
Commissioning Income	24	209	-19	103	37	-	-336	362	380



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

Forward View

The Trust is currently expecting to meet the plan, however there are some emerging financial risks that are not within the plan:-

- Additional Escalation costs over and above the plans

- Premium costs being required to deliver core services

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

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

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

- Financial risk within the wider Cheshire system which requires a Cheshire system financial recovery plan involving all NHS organisations.

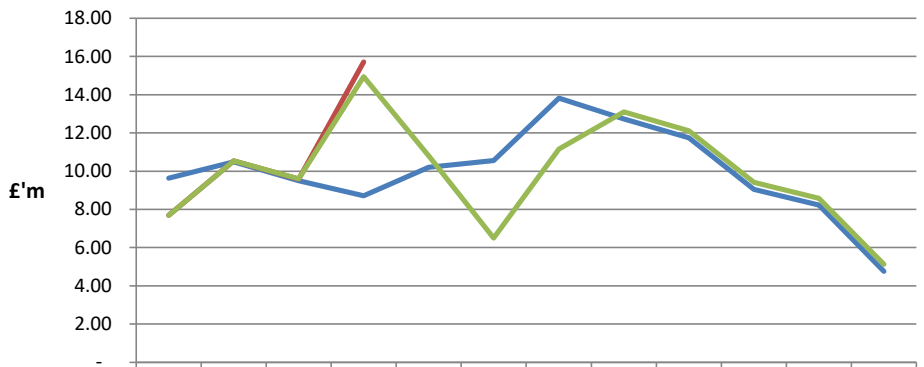
Performance and Finance - Cash July 2019

Current Position

Cash Position
Cash is better than plan by £7m.
This is mainly due to due to 18/19 Q4 PSF being paid one month earlier than anticipated. In addition the Trust has seen lower finance lease payments due to delays in the CT Scanner and a delay in the purchase of South Cheshire Private Hospital.

Analysis

Cash Position



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Plan	9.64	10.49	9.50	8.72	10.21	10.55	13.81	12.73	11.75	9.05	8.22	4.76
Actual	7.68	10.54	9.58	15.72								
Forecast	7.68	10.54	9.60	14.94	10.80	6.50	11.15	13.10	12.11	9.41	8.58	5.12

Cash Flow Movements

	Operating Surplus / (Deficit)	Increase / (Decrease) in Working Capital	Net Cash Inflow / (Outflow) from Capital Expenditure	Net Cash Inflow / (Outflow) from Borrowings
Variance	-38	7,574	-818	279

Forward View

Cash is forecasted to be above target at the year end due to the £0.4m extra 2018/19 PSF. However there is a risk due to the capital loan of £4.2m still to be approved by DOH

Performance and Finance - Capital Expenditure July 2019

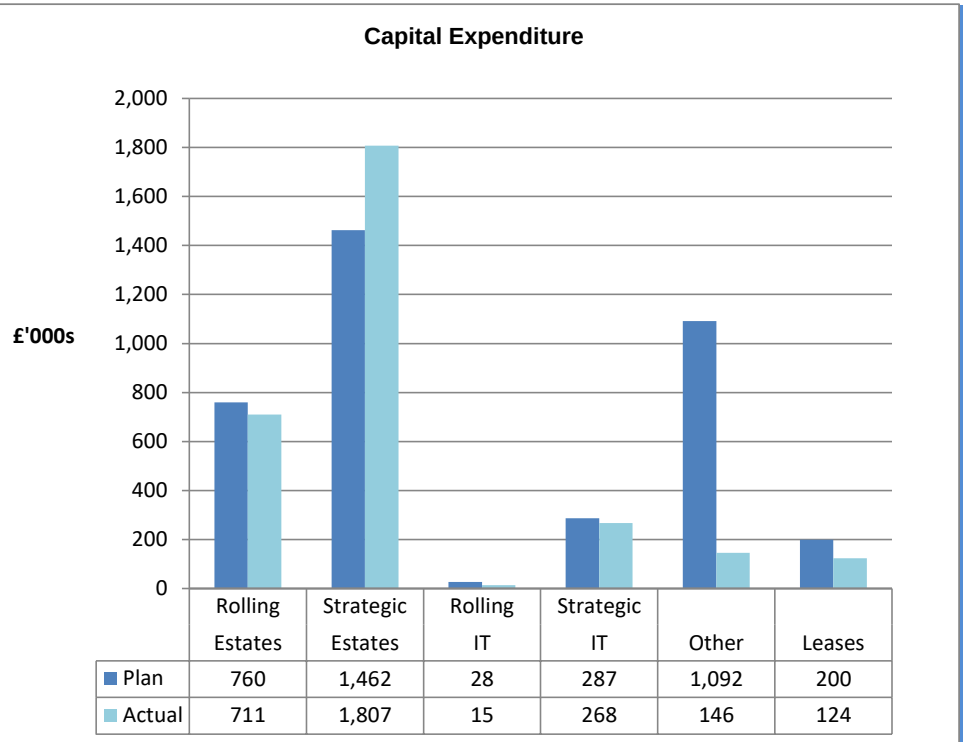
Current Position

The capital programme is £0.8m less than anticipated which is mainly due to:

(£1.0m) Purchase of South Cheshire Private Hospital
£0.6m Third MRI Scanner build
(£0.2m) Third CT Enabling
(£0.1m) High Impact Stand Alone IT Systems
(£0.1m) Equipment Leases

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

Analysis



		Year to Date £'000s			Year End £'000s		
		Plan	Actual	Variance	Plan	Forecast	Variance
Estates	Rolling	760	711	-49	2,490	2,490	0
Estates	Strategic	1,462	1,807	345	6,551	6,551	0
IT	Rolling	28	15	-13	90	90	0
IT	Strategic	287	268	-19	3,968	3,946	-22
Other		1,092	146	-946	1,742	1,903	161
Leases		200	124	-76	347	347	0
		3,829	**3,071**	**-758**	**15,188**	**15,327**	**139**

Forward View

The Trust is forecasting an additional £0.1m to plan due to the replacement of Laundry equipment and some additional equipment not in the capital programme funded via external money.

The Trust has been asked by DOH to reduce it's capital programme by £3.0m, which has been reflected in the forecast.

Performance and Finance - Statement of Financial Position July 2019

Current Position | Analysis | Forward View

Assets Non-Current
The capital programme expenditure is £0.8m less than anticipated due to a delay in the purchase of South Cheshire Private Hospital. In addition to this, there has been a delay in Finance Lease purchases.

Assets Current
NHS Receivables is £2.2m lower than plan due to 18/19 Q4 PSF being paid one month earlier than anticipated. This is offset by outstanding debts with Christies £1.1m, £0.5m from East Cheshire Council and Chester and West Cheshire Council. In addition, prepayments for operating leases are higher than anticipated due to a switch from finance lease to operating leases.

Current Liabilities
These are higher than anticipated as the two main CCG's contract payments are £5.1m more than the plan. This is offset by Trade Creditors less than anticipated.

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

	Plan Apr to July (£'000)	Actual Apr to July (£'000)	Variance (£'000)	Forecast 2019/20 (£'000)
Assets				
Assets, Non-Current	96,555	94,295	-2,260	101,849
Assets, Current	25,750	31,691	5,941	20,112
ASSETS, TOTAL	**122,305**	**125,986**	**3,681**	**121,961**
Liabilities				
Liabilities, Current	-29,846	-34,917	-5,071	-24,508
Liabilities, Non Current	-14,598	-12,859	1,739	-20,058
TOTAL ASSETS EMPLOYED	**77,861**	**78,209**	**348**	**77,395**
Taxpayers' and Others' Equity				
Taxpayers Equity	77,861	78,209	348	77,395
TOTAL FUNDS EMPLOYED	**77,861**	**78,209**	**348**	**77,395**

The Statement of Financial position is forecast mainly on plan. However the Trust has been asked by DOH to reduce it's capital programme by £3.0m. This has reduced the value of the Asset, Non-Current forecast. In addition Asset, current has improve by £0.4m due to the extra 2018/19 PSF. However there is a risk on the current assets due to the capital loan of £4.2m still to be approved by DOH.

Mid Cheshire Hospitals
NHS Foundation Trust

Title of Paper:	Learning from Deaths Quarterly Report (Q1 2019/20)	
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:	2 September 2019

Learning from Deaths Quarterly Report Q1 2019/20

July 2019

'Delivering Excellence in Healthcare through Innovation and Collaboration'

Contents

1.0 Introduction

Background

During 2016/17 a number of national documents were published relating to mortality and learning from deaths. The Care Quality Commission's (CQC) report "*Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England"* was published in December 2016 and, in response, the Trust completed a gap analysis to determine our position and improvement opportunities. In March 2017, the National Quality Board published the **"***National Guidance on Learning from Deaths"* document, which aims to initiate a standardised national approach to learning from deaths. A subsequent document was published in July 2017 by NHS Improvement detailing key areas of focus for Trust Boards which included:

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

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

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

Purpose

This is the eighth iteration of our Learning from Deaths Report covering Quarter 1 of 2019/20.

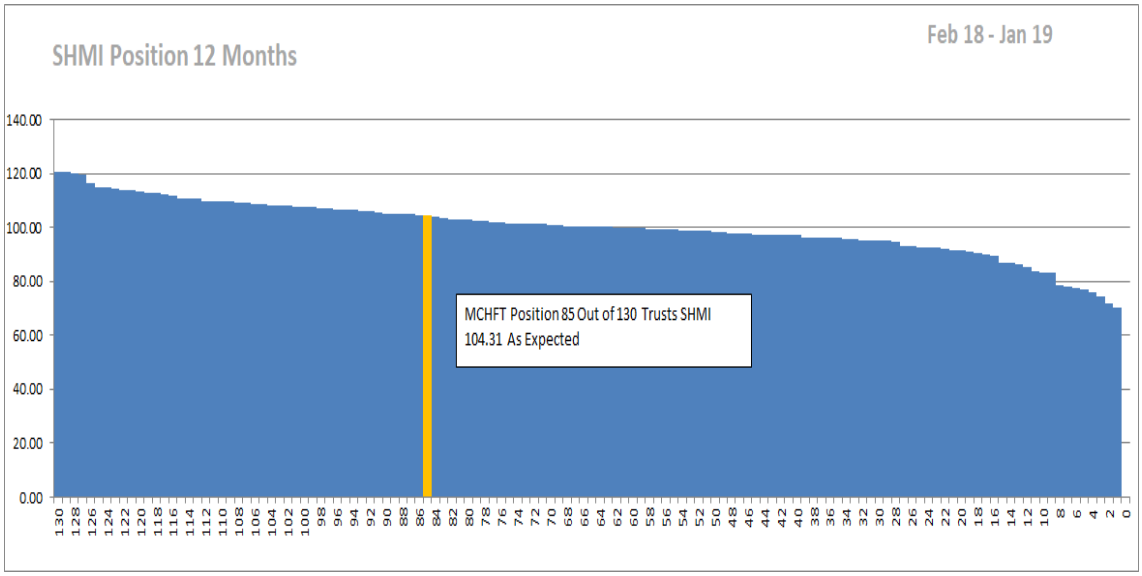
The report aims to provide assurance on how the organisation, through the work of the Hospital Mortality Reduction Group (HMRG) and other linking groups, is triangulating data and information to embed the learning from in-patient deaths, with the goal of seeing a sustained reduction in the Trust's mortality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

Appendices 6.2 and 6.3 provide a glossary of key terms.

2.0 Trust Mortality Data

2.1 Summary Hospital-level Mortality Indicator (SHMI) February 2018 to January 2019

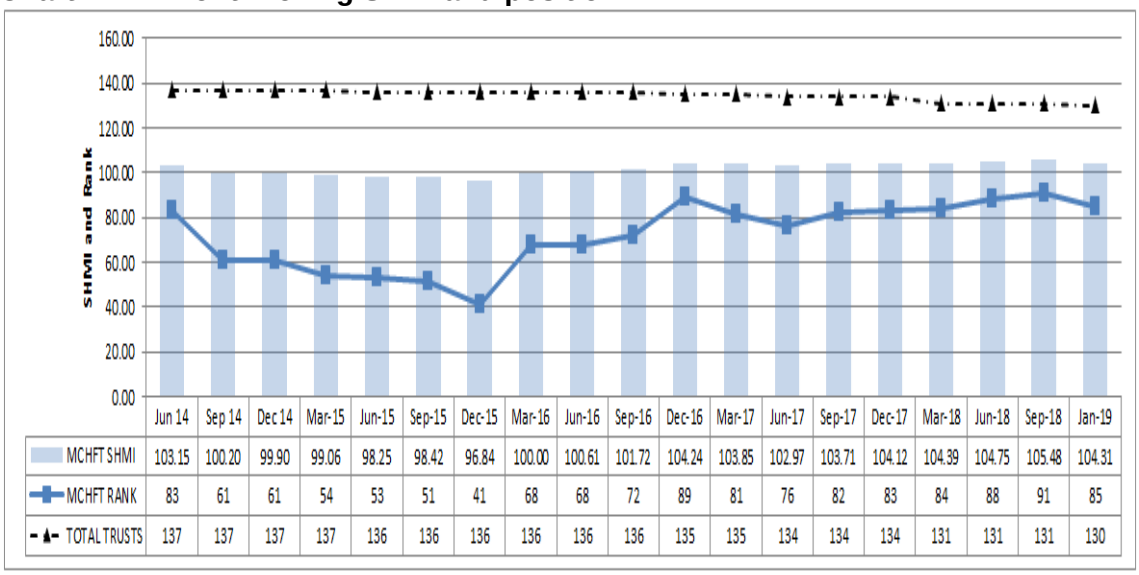
Chart 1 - SHMI Position



(Source NHS Digital, 2019)

Chart 1 demonstrates the SHMI position for the reporting period February 2018 to January 2019. The SHMI is currently 104.31 and is in the 'as expected' range. This currently places the Trust 85 out of 130 Trusts.

Chart 2 - 12 month rolling SHMI and position



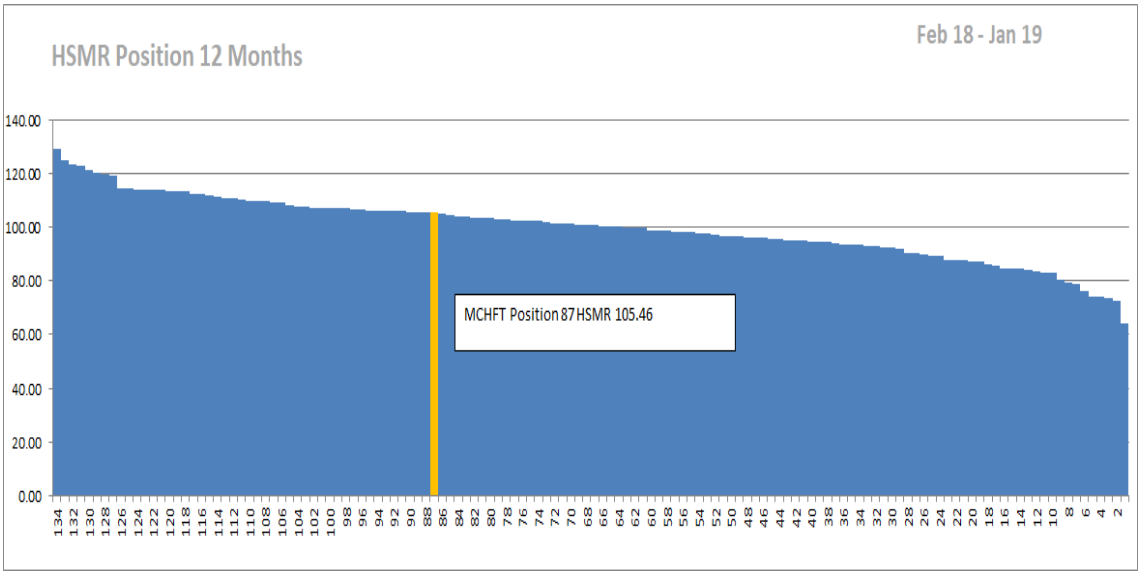
	Jun 14	Sep 14	Dec 14	Mar-15	Jun-15	Sep-15	Dec-15	Mar-16	Jun-16	Sep-16	Dec-16	Mar-17	Jun-17	Sep-17	Dec-17	Mar-18	Jun-18	Sep-18	Jan-19
MCHFT SHMI	103.15	100.20	99.90	99.06	98.25	98.42	96.84	100.00	100.61	101.72	104.24	103.85	102.97	103.71	104.12	104.39	104.75	105.48	104.31
MCHFT RANK	83	61	61	54	53	51	41	68	68	72	89	81	76	82	83	84	88	91	85
TOTAL TRUSTS	137	137	137	137	136	136	136	136	136	136	135	135	134	134	134	131	131	131	130

(Source NHS Digital, 2019)

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

2.2 Hospital Standardised Mortality Rate (HSMR) February 2018 to January 2019

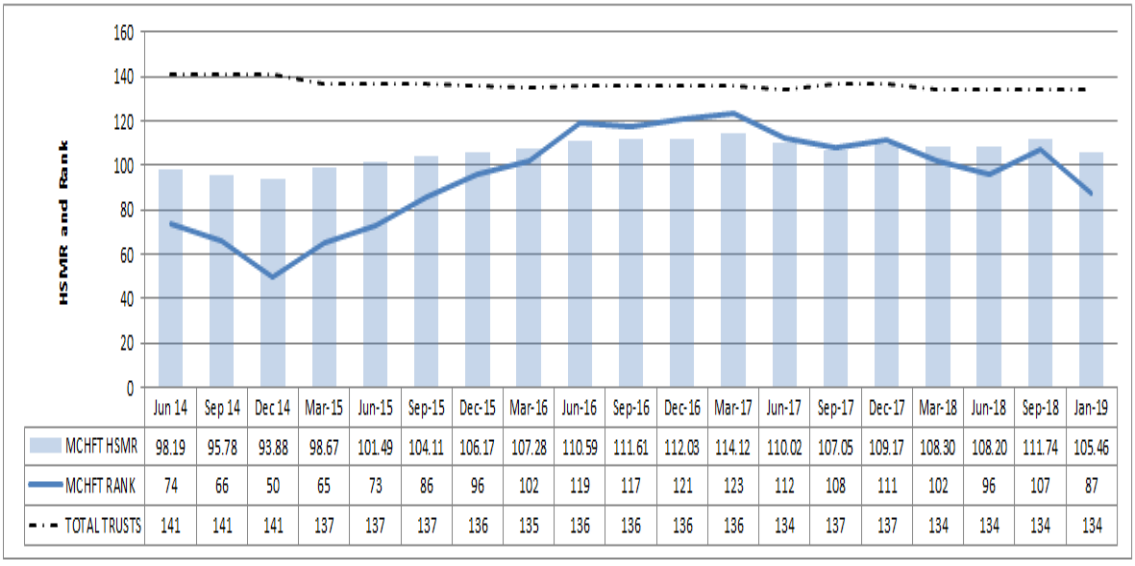
Chart 3 - HSMR Position



(Source HED, 2019)

Chart 3 demonstrates the HSMR position for the reporting period February 2018 to January 2019. The HSMR is currently 105.46 and places the Trust 87 out of 134 Trusts.

Chart 4 - 12 month rolling HSMR and position



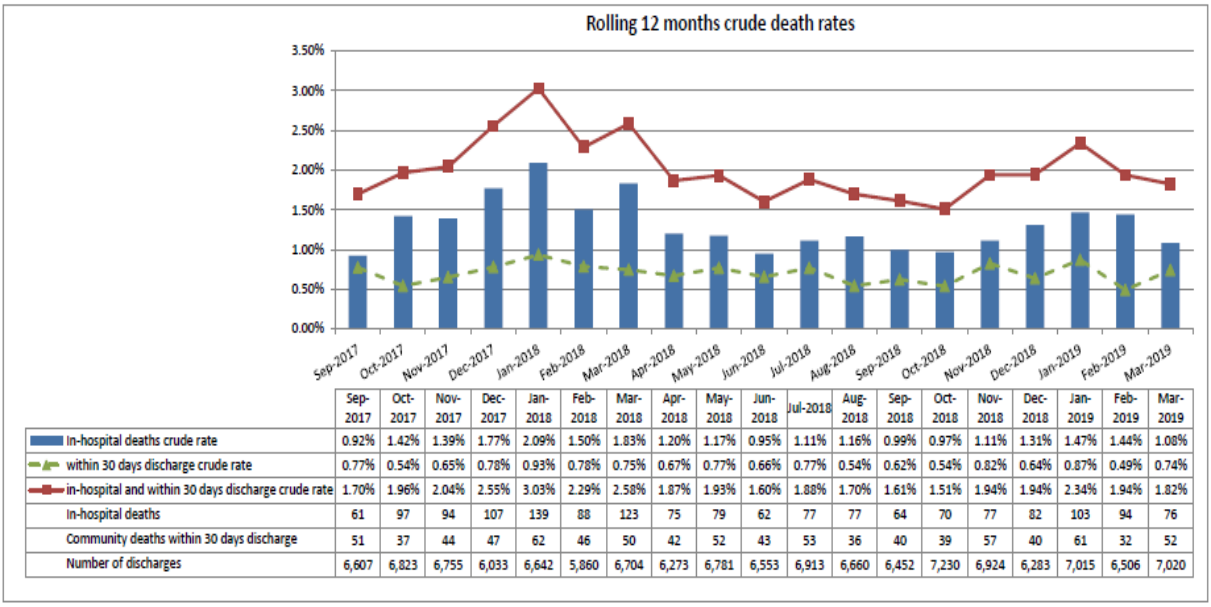
	Jun 14	Sep 14	Dec 14	Mar-15	Jun-15	Sep-15	Dec-15	Mar-16	Jun-16	Sep-16	Dec-16	Mar-17	Jun-17	Sep-17	Dec-17	Mar-18	Jun-18	Sep-18	Jan-19
MCHFT HSMR	98.19	95.78	93.88	98.67	101.49	104.11	106.17	107.28	110.59	111.61	112.03	114.12	110.02	107.05	109.17	108.30	108.20	111.74	105.46
MCHFT RANK	74	66	50	65	73	86	96	102	119	117	121	123	112	108	111	102	96	107	87
TOTAL TRUSTS	141	141	141	137	137	137	136	135	136	136	136	136	134	137	137	134	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 Crude Mortality – Rolling 12 months

Chart 5 - Crude Mortality



	Sep-2017	Oct-2017	Nov-2017	Dec-2017	Jan-2018	Feb-2018	Mar-2018	Apr-2018	May-2018	Jun-2018	Jul-2018	Aug-2018	Sep-2018	Oct-2018	Nov-2018	Dec-2018	Jan-2019	Feb-2019	Mar-2019
In-hospital deaths crude rate	0.92%	1.42%	1.39%	1.77%	2.09%	1.50%	1.83%	1.20%	1.17%	0.95%	1.11%	1.16%	0.99%	0.97%	1.11%	1.31%	1.47%	1.44%	1.08%
within 30 days discharge crude rate	0.77%	0.54%	0.65%	0.78%	0.93%	0.78%	0.75%	0.67%	0.77%	0.66%	0.77%	0.54%	0.62%	0.54%	0.82%	0.64%	0.87%	0.49%	0.74%
in-hospital and within 30 days discharge crude rate	1.70%	1.96%	2.04%	2.55%	3.03%	2.29%	2.58%	1.87%	1.93%	1.60%	1.88%	1.70%	1.61%	1.51%	1.94%	1.94%	2.34%	1.94%	1.82%
In-hospital deaths	61	97	94	107	139	88	123	75	79	62	77	77	64	70	77	82	103	94	76
Community deaths within 30 days discharge	51	37	44	47	62	46	50	42	52	43	53	36	40	39	57	40	61	32	52
Number of discharges	6,607	6,823	6,755	6,033	6,642	5,860	6,704	6,273	6,781	6,553	6,913	6,660	6,452	7,230	6,924	6,283	7,015	6,506	7,020

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

2.4 Learning from Deaths Dashboard – Part 1

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

Please note: Due to the time allowed for the coding process, the total number of deaths in scope and the total number of reviews will not be completely aligned.

The 6 avoidable deaths in 2018 / 19 were identified and reported following comprehensive incident investigations.

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

Total Number of Deaths in Scope		Total Deaths Reviewed using the Trust Mortality Tool		Total Deaths reviewed using SJR		Total Number of deaths considered to have been potentially avoidable (RCP<=3) using SJR		Total Number of deaths considered to have been potentially avoidable via alternative source (e.g. incident investigation)	
This Month	Last Month	This Month	Last Month	This Month	Last Month	This Month	Last Month	This Month	Last Month
82	91	69	86	11	4	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
249	277	200	217	15	32	0	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
249	938	200	832	15	114	0	1	0	6

2.4 Learning from Deaths Dashboard – Part 2

Evidence suggests from the Confidential Inquiry of 2010-2013 that people with learning disabilities currently have a life expectancy at least 15 to 20 years shorter than other people. A concerning finding was that assumptions were sometimes made that the death of a person with learning disabilities was 'expected' or even inevitable. In response, a Learning Disabilities Mortality Review (LeDeR) programme was commissioned by the Healthcare Quality Improvement Partnership (HQIP) following the deaths of people with learning disabilities aged 4 to 74 years of age. Reviews at the Trust undertaken as part of this programme are conducted by trained reviewers.

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

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
0	6	0	6	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
0	15	0	15	0	0

3.0 Care Quality Commission (CQC) Mortality Outlier Alerts

The information below is sourced from the latest version of the CQC Insight document (7 July 2019). The Trust undertakes an in-depth case note review in response to any Mortality Outlier Alert.

Key Messages

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

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

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

Mortality Outliers – Active Alerts

Cases under consideration by the Outlier Panel

- There are currently no active mortality alerts

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

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

Cases for review by inspection team

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

Maternity Outliers – Active Alerts

Cases under consideration by the Outlier Panel

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

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

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

Cases for review by inspection team

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

4.0 Learning from Deaths and Improvements

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

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

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

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

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

Organisational learning from this process must be dynamic, with immediate actions and improvements undertaken in a timely manner to prevent reoccurrence. Short - medium term improvements, identified through organisational learning, are introduced through the Trust's governance structure. In the longer term organisational learning will take place through the triangulation and theming of data and information. The Trust's incident reporting, investigation and organisational learning processes describe our approach to organisational learning.

The Trust has a well-established HMRG led by the Medical Director. This group leads the Trust's mortality reduction programme and, on a quarterly basis, meets with the Divisional Mortality Reduction Groups to ensure a unified approach to mortality reduction across the Trust and to share learning opportunities.

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

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

4.1 Quarterly Deep Dive – Structured Judgment Reviews undertaken during 2018/19

The SJR process was developed by the Royal College of Physicians (RCP). SJR 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 and to make explicit written comments about care for each phase. The result is a relatively short, but rich, set of information about each case in a form that can also be aggregated to produce knowledge about clinical services and systems of care.

The objective of the review method is to look for strengths and weaknesses in the caring process, to provide information about what can be learnt about the hospital systems where care goes well and to identify points where they may be gaps, problems or difficulty in the care process.

The SJR produces two types of data:

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

The phases of care which are reviewed are:

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

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

The SJR process commenced at the Trust in April 2018. In 2018/19 114 SJR's were undertaken.
The charts below outlines the findings of the structured judgement reviews completed in 2018/19.

Chart 6

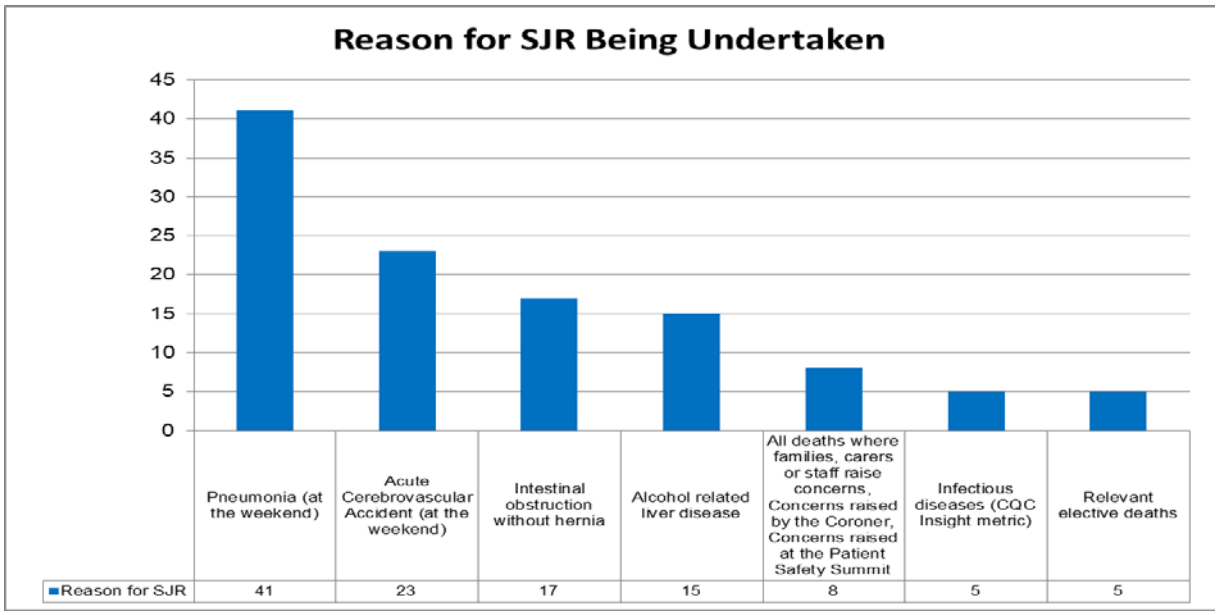


Chart 6 shows the reasons for an SJR being commenced in 2018/19. 36% were commenced for the pneumonia at weekend category.

Chart 7

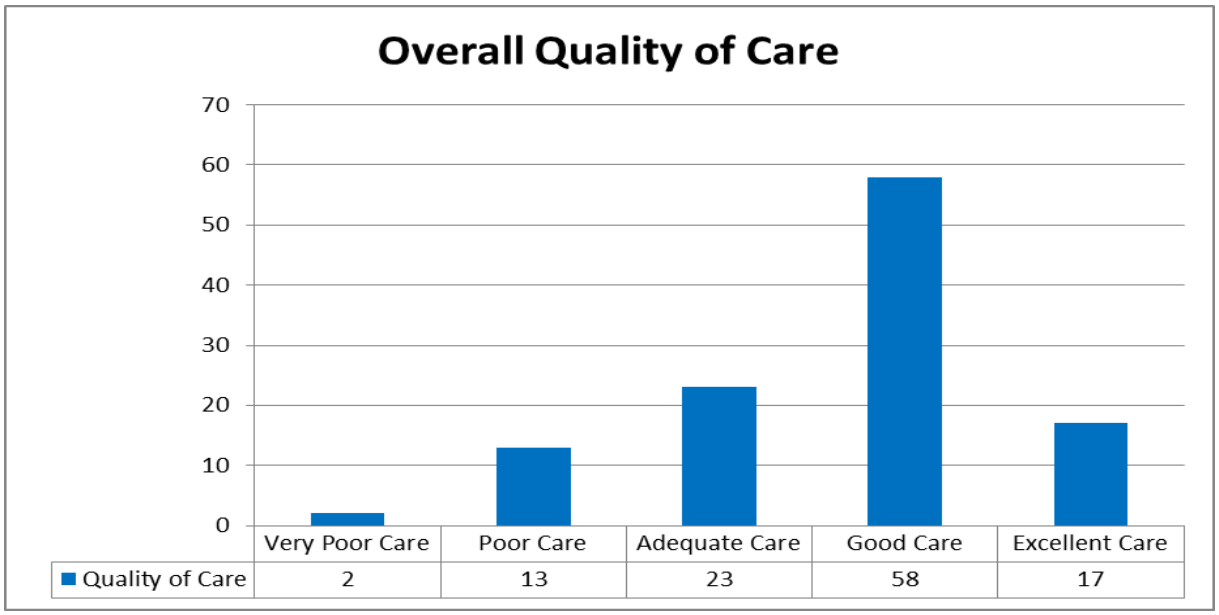
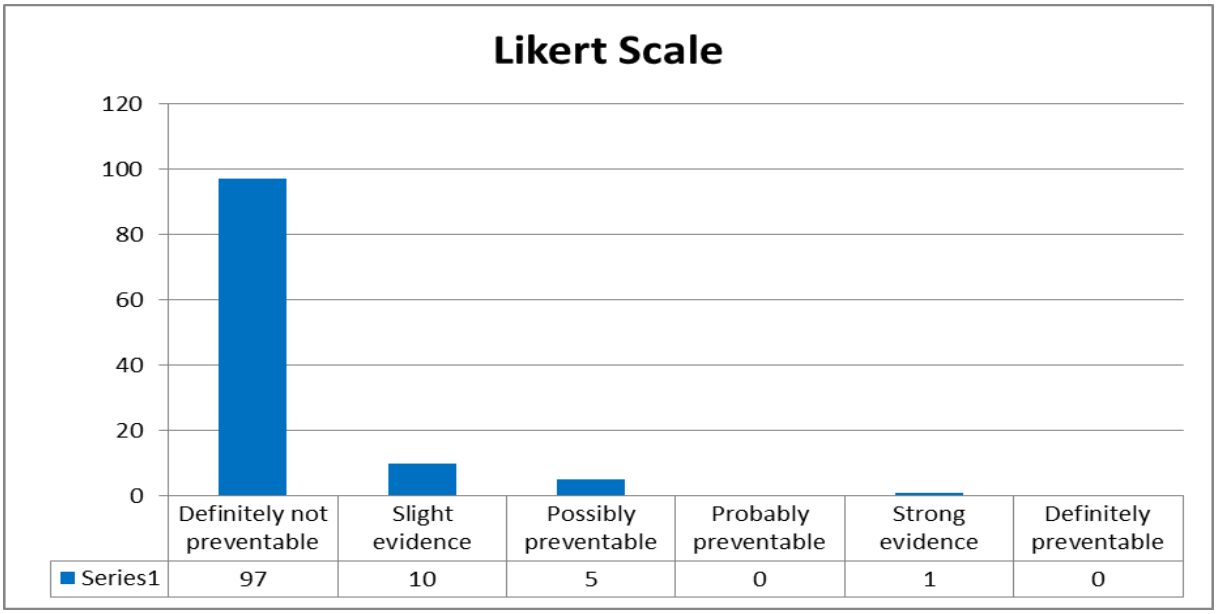


Chart 7 shows the overall quality of care as assessed during the SJR process. 66% of patients care was scored overall as good or excellent.

Chart 8



As part of the national guidance on learning from deaths, the Trust also has to report any avoidable deaths on the quarterly dashboard. Therefore at the end of each review the team is asked to make a judgement on the preventability of the death. A six-point scale, the LIKERT Preventability scale, is used. The scale ranges from 1 (definitely not preventable) to 6 (definitely preventable).

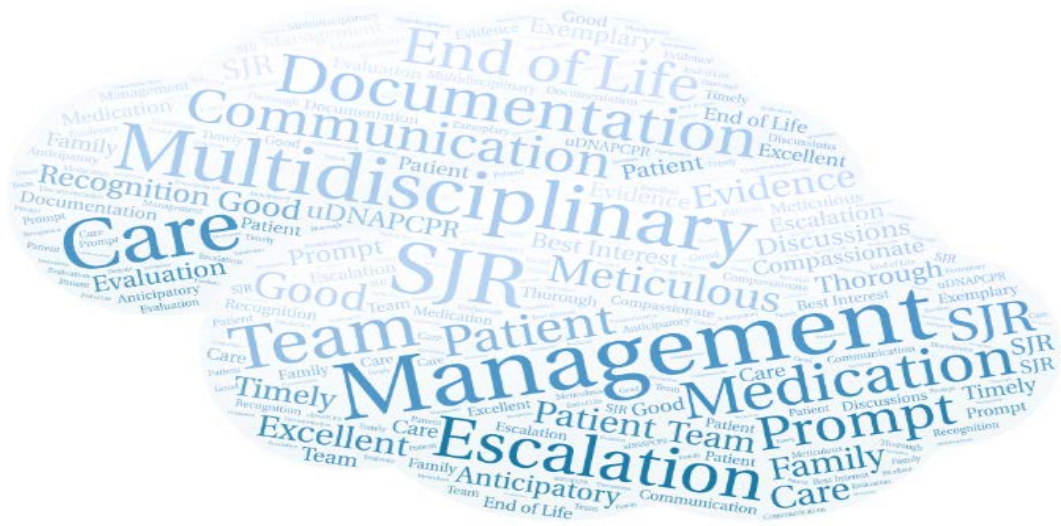
86% of the cases reviewed were classed as definitely not preventable. In one case there was strong evidence of preventability. This case had previously been reported as a Serious Incident and an executive-led comprehensive investigation completed. An improvement plan was developed and completion is monitored through the governance processes.

Learning from the reviews

As outlined above, during the SJR the reviewers will also highlight positive judgments about the care provided. Below are a number of the positive comments made during the 2018/19 reviews

- Excellent practice and documentation
- Excellent communication with the family
- Anticipatory recognition and management of end of life care exemplary
- Excellent multidisciplinary communication and referral occurred
- Meticulous care from stroke & therapy teams
- Good involvement of family in end of life discussions
- Excellent care delivered to patient during high activity in the Emergency Department
- Team working for patient best interest and plans appropriate really good
- Great communication and compassion

Word cloud



The RCP within their guidance recommend word cloud analysis to review the results. The above word cloud demonstrates a selection of the positive comments made in the reviews in 2018/19

The SJRs undertaken in 2018/19 have identified the following learning themes:

- End of life care plan not being fully completed
- The number of patient moves
- Failure to escalate the deteriorating patient.
- Poor completion of documentation
- Poor completion of fluid balance
- Lack of documentation of ceilings of care

Improvement work is ongoing in relation to the identified themes and these are monitored through the Quality & Safety Improvement Strategy and the Deteriorating Patient Steering Group.

Lessons learned are produced and shared across the organisation in the form of a quarterly learning from deaths newsletter. The learning is also shared at the Trust Mortality Reduction Group and the Divisional Boards through this report.

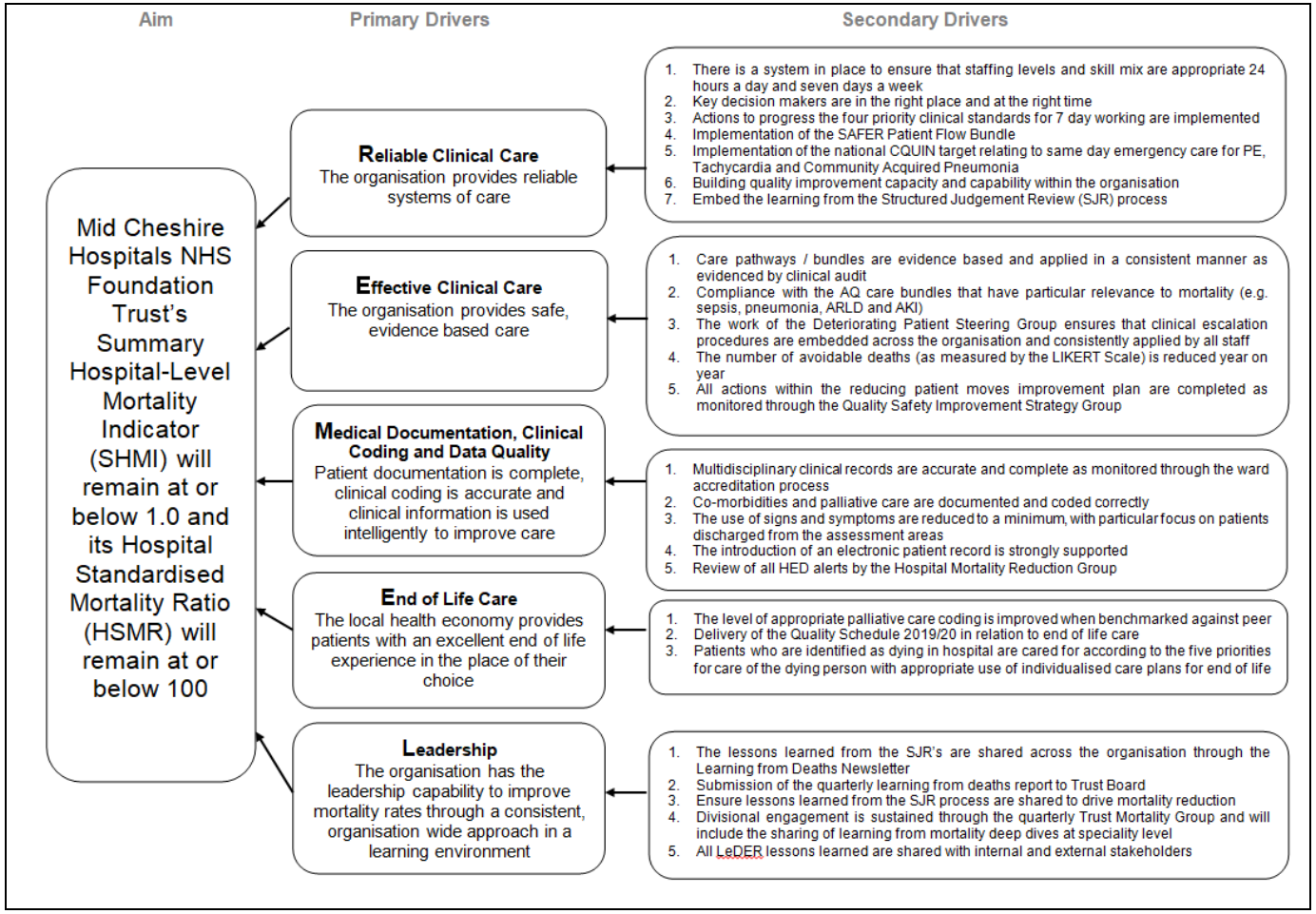
The SJR reviewers meet on a 6 monthly basis with the Medical Director to share their learning from the process, review the data gathered and to discuss how the SJR process and learning can be further developed.

5.0 Next steps

- Deep dive into CCS Groups

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

Mid Cheshire Hospitals NHS Foundation Trust

Title of Paper:	Board Assurance Framework (BAF) Report Q1 19/20	
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:	A summary report of the BAF following scrutiny of the relevant Strategic Domains at Board Sub-Committee level, with oversight by the Quality Governance Committee.
Risk:	Gaps in assurances and lack of oversight of key risks to achieving the Strategic Objectives.

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

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

Board Assurance Framework 2019/20

Quarter 1

Summary Version

Delivering Excellence in Healthcare through Innovation and Collaboration'

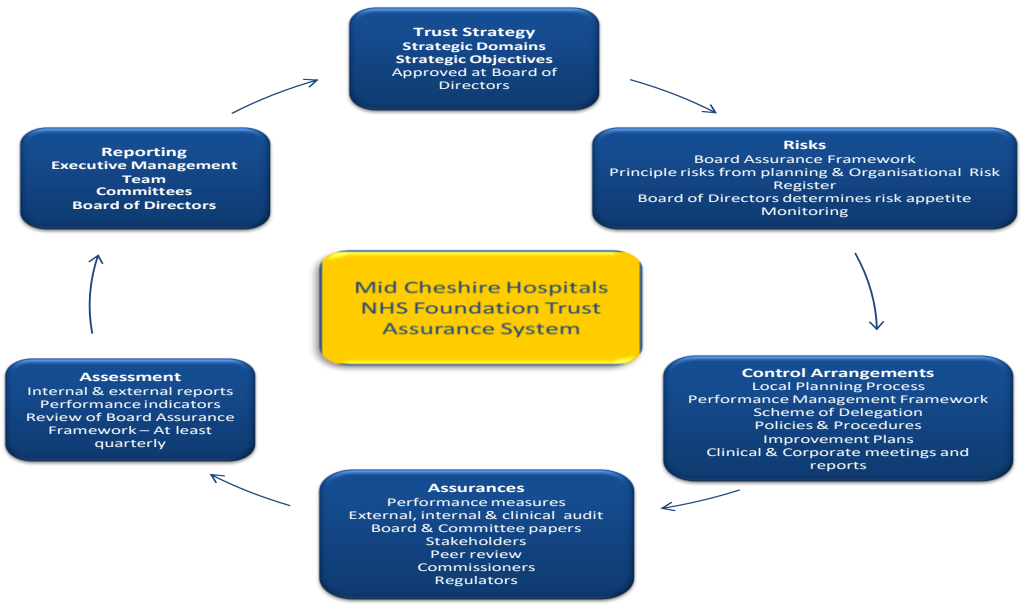
Contents

1. Background & purpose

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

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

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



2. Current position

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

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

3. Organisational Risk Register

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

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

Risk Title	Mitigated (with controls) Risk Rating	SHIFT				Key links to BAF 2019/20
		Q1	Q2	Q3	Q4	
Delivery of key local and National targets and standards, in particular the 4 hour standard in A&E	5(C) x 4(L) = 20	20 ⇔				Q1,Q2,E1,E2,P1, P2
Workforce capacity and skill mix to consistently deliver high quality care, seven days a week	5(C) x 4(L) = 20	20 ⇔				Q1,Q2,P1,P2,E2, W2
Lack of pace in the significant transformational change required to deliver the Cheshire East Place Strategy and consequently the Health and Care Partnership (HCP) for Cheshire & Mersey	4(C) x 4(L) = 16	16 ⇔				Q1,Q2,P1,P2,E2, W2,T1,T2a,T2b
The Long Term Financial Sustainability of the Trust.	4(C) x 3(L) = 12	12 ⇩				E1,E2,P1,P2,T1,T 2a,T2b
Cyber Security	4(C) x 4(L) = 16	16 ⇔				Q1,Q2,E1,E2,T2a, T2b
Proposed acquisition of the South Cheshire Private Hospital	Under Review					

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 to the BAF development process for 2019/20.

5. BAF & Linked Risks Heatmap

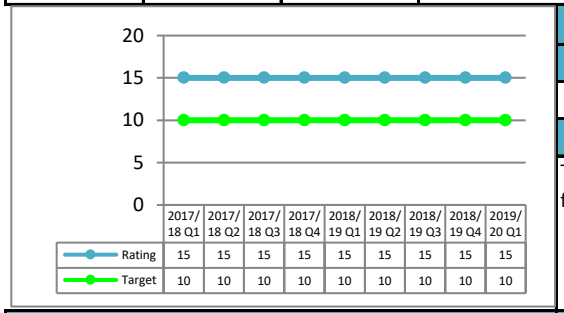
BAF Domain	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Q1	15											
Q2	10											
P1	12											
P2	12											
E1	15											
E2	16											
T1	15											
T2a	15											
T2b	12											
W1	15											
W2	15											
W3	15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

Strategic Domain 1: Delivering Outstanding Clinical Quality, Safety & Experience	
Q1	**To aspire to the delivery of 'Outstanding' clinical quality and safety, which is equitable, patient and family centred and supported by an effective quality governance framework.**

Principle Risk

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

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHSI Single Oversight F/w	Executive Director	Executive Management Group	Board Committee
June 2019	June 2019	Sept 2019	Safe, Effective, Responsive, Caring & Well Led NHSI – Quality Metrics	Director of Nursing & Quality	Executive Quality Governance Group (EQGG) Executive Patient Experience Group (EPEG)	Quality Governance Committee (QGC)



Initial Risk Rating (Unmitigated)			Current Risk Rating (Mitigated)			Target Risk Rating (Tolerance/Risk Appetite)			
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Target Date
5	4	20	5	3	**15**	5	2	**10**	March 2020

Rationale for the Current Risk Score

The risk score remains the same at the end of quarter 1. Work is progressing but strengthening is required of the risk management and quality assurance frameworks in order to provide sustained demonstrable improvements and associated assurances at ward, department and divisional levels.

Links to BAF objectives

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

Key Links to the Organisational Risk Register

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

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

The Trust is progressing the Advancing Quality Programme for 2019/20 focusing on several care pathways. The quality reports at ward / department and divisional level have been developed and rolled out across all divisions. Executive led quarterly quality reviews have commenced in all divisions with a lessons learnt cross divisional process in place. 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 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 commenced in May 2019 with a total of 6 wards accredited at end of quarter 1.

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

- Continuation and embedding of Quality Reports and Quarterly Quality Assurance Reviews Trust wide.
- Ward accreditation scheme launched in May 2019 and a programme to assess all in patient wards is in place for 2019
- Internal Well-Led Review improvement actions – quarterly oversight at Quality Governance Committee.
- A Nursing & Midwifery AHP Strategy is under development and due to be launched in July 2019.
- NHS Resolution Maternity Incentive Scheme, new indicators achieved for 2019-2020

Strategic Domain 1: Delivering Outstanding Clinical Quality, Safety & Experience						
Q1	**To aspire to the delivery of 'Outstanding' clinical quality and safety, which is equitable, patient and family centred and supported by an effective quality governance framework.**					
Key Controls / Influences Established (What are we currently doing about the risk?)	Key Gaps in Controls / Influences (What additional controls should we seek?)	Assurance Providers 2018/19 (How do we know if the things we are doing are having an impact?)			Gaps in Assurances on Controls / Influences (What additional assurances should we seek?)	Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)
		Local Management (1st Line of Defence)	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)		
1. Processes in place to deliver the CQUINs & Quality Schedule	• Data access & collective intelligence • Quarterly Quality Reviews (To be rolled out in CCICP)	• 1:1 / Team Meetings • Safety Collaborative • Quality Matters Programme	• Quality Safety & Improvement Strategy Group (QSIS) • EQGG • QGC • Board of Directors • QGC minutes • Monthly Quality, Safety & Experience Report (CQUIN) • Quality Account-April 2019	• CQC Good rating-Sept 2018 • CCG Contract meetings monthly • CCG Quality Visits • CQUIN Q3 Report exceptions: Sepsis treatment and antibiotic consumption Internal Audit Programme • Internal audit of IP&C processes • Compliance with MCA and DoLS registered annually 2019	• Implementation of formal quarterly quality review process • Data collection requirements for elements of 2018/19 CQUINs	• Quality Schedule / data collection requirements to be finalised for 2019/20and associated resources • internal audit of e-rostering roll out programme complete March 2019
2. Infection Prevention & Control (IPC) Team and supporting strategies & policies		• 1:1 / Team Meetings • Monthly Divisional Boards/CCICP reports	• IPC Audit Programme • Executive IPC • QGC • Board of Directors • QGC minutes • Monthly Quality, Safety & Experience Report • Monthly Serious Events /IPC • Quality Account-April 2019	• CQC Good rating-Sept 2018 • CCG Contract meetings monthly • CCG Quality Visits • PHE/NHSE/NHSI Feedback Internal Audit Programme • Internal audit of IP&C processes	• KPMG Internal Audit Dec 2018 with all actions in place 2019	90 day improvement plan in place June 2019 External review completed April 2019 Actions within 90 day improvement plan
3. Maternity Dashboard	• Quarterly Quality Reviews To be rolled out in CCICP	• 1:1 / Team Meetings • Monthly W&C Divisional Board Report	• EQGG • QGC • Board of Directors • QGC minutes • Quality Account-April 2019 • Quality Summit – monitoring of detailed CQC improvement plan • Director of Nursing and Quality – executive Maternity Safety Champion	• CQC Good rating Sept 2018 • CCG Quality Visits • Advancing Quality Reports • NHSE/NHSI Feedback Internal Audit Programme • Internal audit of IP&C processes • CQC report on compliance with IRMER in Radiology in December 2018.	• Implementation of formal quarterly quality review process	• Quarterly quality reviews and reports are fully rolled out including CCICP • Head of Midwifery to monitor compliance against "Better Births" CNST2 Board agreement in place 2019-2020

Strategic Domain 1: Delivering Outstanding Clinical Quality, Safety & Experience						
Q1	**To aspire to the delivery of 'Outstanding' clinical quality and safety, which is equitable, patient and family centred and supported by an effective quality governance framework.**					
Key Controls / Influences Established (What are we currently doing about the risk?)	Key Gaps in Controls / Influences (What additional controls should we seek?)	Assurance Providers 2018/19 (How do we know if the things we are doing are having an impact?)			Gaps in Assurances on Controls / Influences (What additional assurances should we seek?)	Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)
		Local Management (1st Line of Defence)	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)		
4. Quality & Safety Improvement Strategy 2019-20 implementation	• Quarterly Quality Reviews To be rolled out in CCICP • Implementation of new Quality & Safety Improvement Strategy 2018/19	• 1:1 / Team Meetings • Quality Matters Programme • Monthly Divisional Boards/CCICP reports	• Deteriorating Patient Steering Group • Hospital Mortality Reduction Group • QSIS Group. EQGG. QGC • Board of Directors • QGC minutes • Patient / Staff Stories • Board Walkaround Programme • Monthly Quality, Safety & Experience Report • Monthly Serious Events / IPC • Quality Account-April 2019 • CQC Improvement Plan monitored at Quality Summit	• CQC Good rating-Sept 2018 • CCG Quality Visits • Advancing Quality Reports • External accreditation e.g. UKAS, JAG • CQC Inpatient Survey-June 2018 'About the same as other Trusts overall'-reduction on previous year Internal Audit Programme • Internal audit of IP&C processes	• Implementation of formal quarterly quality review process • New strategy, metrics and monitoring	• Quarterly quality reviews and reports are rolled out across in-patient areas completed April 2019 • Quality metrics, monthly results to are displayed on wards from May 2019.
5. Patient & Public Involvement Strategy implementation		• 1:1 / Team Meetings • Membership Office • Monthly Divisional Boards/CCICP reports	• Patient / Staff Stories • EPEG • QGC • Board of Governors • Board of Directors • Governors reports & feedback • QGC minutes • Quality Account-April 2019	• CQC Patient Survey-May 2017 • CQC Good rating- Sept 2018 • Healthwatch feedback • Patient representative groups Internal Audit Programme • Internal audit of IP&C processes		
6. Patient Safety Team established with objectives and associated policies & procedures	• Quarterly Quality Reviews to be rolled out in CCICP	• 1:1 / Team Meetings • Monthly Divisional Boards/CCICP reports	• Patient Safety Summit • Deteriorating Patient Steering Group • EQGG. QGC • Board of Directors • QGC minutes • Monthly Quality, Safety & Experience Report • Monthly serious events / IPC • Quality Account-April 2019	• CQC Good rating-Sept 2018 • CCG contract meetings monthly • Quarterly Advancing Quality Reports Internal Audit Programme • Internal audit of IP&C processes	• Implementation of formal quarterly quality review process	• Quarterly quality reviews and reports are fully rolled out • Development of quality reports / data collection in progress

Strategic Domain 1: Delivering Outstanding Clinical Quality, Safety & Experience						
Q1	**To aspire to the delivery of 'Outstanding' clinical quality and safety, which is equitable, patient and family centred and supported by an effective quality governance framework.**					
Key Controls / Influences Established (What are we currently doing about the risk?)	Key Gaps in Controls / Influences (What additional controls should we seek?)	Assurance Providers 2018/19 (How do we know if the things we are doing are having an impact?)			Gaps in Assurances on Controls / Influences (What additional assurances should we seek?)	Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)
		Local Management (1st Line of Defence)	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)		
7. Risk Management Strategy & Framework 2017/20 6 key priorities	• Revised quarterly risk register reports at divisional/corporate level in development. • Risk management systems review	• 1:1 Meetings • Team Meetings • Monthly Divisional Boards/CCICP reports	• EQGG. QGC. Trust Board • QGC minutes • Quarterly BAF / Risk Register Report • Well-Led Reviews June 2017 and April 2018	• Internal Audit Programme • Annual Governance Statement-March 2018 • Risk Management and BAF internal audit report: Significant Assurance- with minor opportunities for improvement - January 2019 • CCICP Governance-December 2017 • Externally facilitated Developmental Review NHSI Well Led Framework Completed January 2019		• Source external Well-Led reviewer • Implementation of Well Led Improvement Plan
8. Quality Impact Assessment (QIA) Process	• QIA process to be fully established	• Programme/Project Team • Monthly Divisional Boards/CCICP reports	• Medical Director & Director of Nursing& Quality reviews • EQGG • QGC • Board of Directors • QGC minutes • Quality Account April 2019	• CQC Good rating- Sept 2018 • CCG contract meetings monthly Internal Audit Programme • Quality Account-April 2019	• Strengthen reporting and monitoring of QIA process	• Roll out of new QIA process by July 2019
9. Adult & Child Safeguarding Team & policies & procedures.		• 1:1 / Team Meetings • Monthly Divisional Boards/CCICP reports	• Executive Safeguarding Group • QGC • Board of Directors • QGC minutes	• Local Safeguarding Adult's Board • Local Safeguarding Children's Board		External reporting of statutory audits

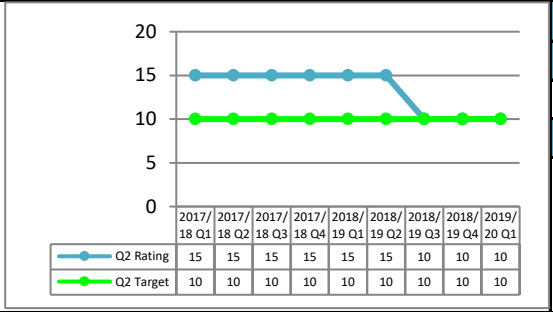
Strategic Domain 1: Delivering Outstanding Clinical Quality, Safety & Experience						
Q1	**To aspire to the delivery of 'Outstanding' clinical quality and safety, which is equitable, patient and family centred and supported by an effective quality governance framework.**					
Key Controls / Influences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

Strategic Domain 1: Delivering Outstanding Clinical Quality, Safety & Experience	
Q2	**To drive continuous quality improvement and promote research and innovation, whilst reducing unwarranted clinical variation and progressing from a 'Good' to 'Outstanding' organisation.**

Principle Risk

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

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHSI Single Oversight F/w	Executive Director	Executive Management Group	Board Committee
June 2017	June 2019	Sept 2019	Safe, Effective, Responsive, Caring & Well Led NHSI – Quality Metrics	Medical Director / Deputy CEO	Executive Quality Governance Group (EQGG)	Quality Governance Committee (QGC)



Initial Risk Rating (Unmitigated)			Current Risk Rating (Mitigated)			Target Risk Rating (Tolerance/Risk Appetite)			
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Target Date
5	4	20	5	2	**10**	5	2	**10**	March 2020

Rationale for the Current Risk Score

Risk score has remained at 10 for Quarter 1. The likelihood of not improving the quality of care with all the key controls in place is unlikely.

Links to BAF objectives

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

Key Links to the Organisational Risk Register

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

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

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

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

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

Strategic Domain 1: Delivering Outstanding Clinical Quality, Safety & Experience						
Q2	**To drive continuous quality improvement and promote research and innovation, whilst reducing unwarranted clinical variation and progressing from a 'Good' to 'Outstanding' organisation.**					
Key Controls / Influences Established (What are we currently doing about the risk?)	Key Gaps in Controls / Influences (What additional controls should we seek?)	Assurance Providers 2018/19 (How do we know if the things we are doing are having an impact?)			Gaps in Assurances on Controls / Influences (What additional assurances should we seek?)	Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)
		Local Management (1st Line of Defence)	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)		
1. Quality & Safety Improvement Strategy 2019/20 implementation	• Data access & collective intelligence • Reports by CQC Domains • Quarterly Quality Reviews To be rolled out in CCICP	• 1:1 Meetings • Monthly Divisional Boards/CCICP reports	• Effective Clinical Practice Group • QSIS Group • EQGG. QGC • Board of Directors • Monthly Quality, Safety & Experience Report • Monthly Quality Report • QQR Process • QGC Minutes • Quality Account-April 2019	• CQC Good rating-Sept 2018 • CCG contract meetings monthly • CCG Quality Visits • Advancing Quality Reports • CQC Inpatient Survey-May 2017 'About the same as other Trusts overall'-reduction on previous year Internal Audit Programme • Quality Account-April 2019	• Implementation of formal quarterly quality review process in CCICP • Findings from CQC inspection report – Sept 2018	• A new one day process for Quarterly Quality Reviews to be established in 2019. Complete and includes CCICP • Development of reports / data collection in progress including Model Hospital data.
2. Clinical Audit Team in place and annual clinical audit programme & participation in national programmes e.g. GIRFT	• Quality Improvement capacity & capability.	• 1:1 / Team meetings • Local Audit Meetings • Monthly Divisional Boards/CCICP reports	• Effective Clinical Practice Group • EQGG • QGC • Board of Directors • QGC Minutes • Quality Account-April 2019 • QQR Monitoring	• CQC Good rating-Sept 2018 • CQC Insight Report • HQUIP-National Audits • Advancing Quality Programme Reports Internal Audit Programme • Quality Account-April 2019	• Implementation of formal quarterly quality review process in CCICP	• Development of reports / data collection in progress
3. Advancing Quality programme	• Data access & collective intelligence. • Quarterly Quality Reviews. To be rolled out in CCICP	• 1:1 / Team meetings • Monthly Divisional Boards/CCICP reports	• Care Pathways Group • EQGG • QGC • Board of Directors • QGC Minutes • Monthly Quality Report • QQR Process • Quality Account-April 2019	• HQUIP-National Audits Feedback • Advancing Quality Programme Reports Internal Audit Programme • Quality Account-April 2019	• Implementation of formal quarterly quality review process in CCICP • Some CQUINs not achieved in quarter	• Improving Quality Together Programme proposal to QGC in May 2019. Strategy was presented to QGC in June 2019 • Development of reports / data collection in progress including Model Hospital data.

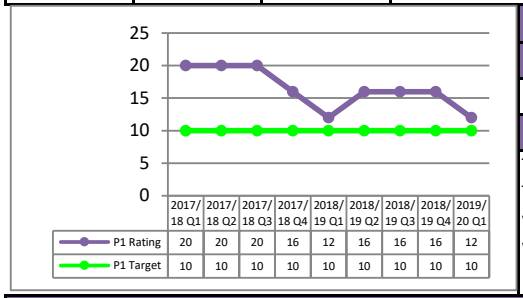
Strategic Domain 1: Delivering Outstanding Clinical Quality, Safety & Experience						
Q2	**To drive continuous quality improvement and promote research and innovation, whilst reducing unwarranted clinical variation and progressing from a 'Good' to 'Outstanding' organisation.**					
Key Controls / Influences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

Strategic Domain 2: Being a Leading Partner in a Progressive Health Economy	
P1	**To fully engage with all strategic partners to maximise the opportunities and advantages associated with horizontal integration in the designing and delivery of sustainable health services for the population of Central and Eastern Cheshire, whilst acknowledging and responding to:** **- National and regional strategies.** **- The need for sustainable high quality clinical services.** **- Favourable economies of scale and removal of unwarranted variation.** **- The cost effective sustainable use of resources.**

Principle Risk

Risk of not continuing to develop effective external partnerships and alliances leading to failure to improve the long term clinical and financial sustainability and viability due to:
- Lack of full engagement – being a key partner
- Failure to engage effectively and lead the development across organisations that provide healthcare
- Lack of pace and appropriate scale to recognise the quality, economics and clinical benefits of change
- Partner perceptions of working relationships with MCHFT
- Impact of the Capped Expenditure programme and NHS Improvement Long Term Sustainability review

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHSI Single Oversight F/w	Executive Director	Executive Management Group	Board Committee
June 2017	June 2019	Sept 2019	Well Led NHSI – Use of Resoruces	CEO	Board of Directors	Quality Governance Committee (QGC)



Initial Risk Rating (Unmitigated)			Current Risk Rating (Mitigated)			Target Risk Rating (Tolerance/Risk Appetite)			
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Target Date
5	5	25	4	3	**12**	5	2	**10**	March 2020

Rationale for the Current Risk Score

The risk score has decreased from 16 to 12 at quarter 1.
The Trust ended 18-19 in a positive financial position, having agreed its control total with NHSI and a block contract with CCGs. Relationships remain good with East Cheshire Trust and include the introduction of Board to Board meetings alongside monthly Exec to Exec meetings. New CEO is due to commence with MCHFT on 29 July 2019. There are opportunities to strengthen working relationships with UHNM on the commencement of the new CEO at UHNM.

Links to BAF objectives

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

Key Links to the Organisational Risk Register

TW0003 – Workforce capacity and skill mix to consistently deliver high quality care, seven days a week	**20**	TW0002 – Long Term Financial Sustainability of MCHFT	**12**
TW0006 - Lack of pace in the significant transformational change required to deliver the Cheshire East Place strategy and consequently the Health and Care Partnership (HCP) for Cheshire & Mersey	**16**		

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

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. The CE Place draft strategy will form the basis for 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. Where opportunities arise consideration will be given to closer collaborative working with East Cheshire and UHNM (clinical services/corporate/clinical roles).

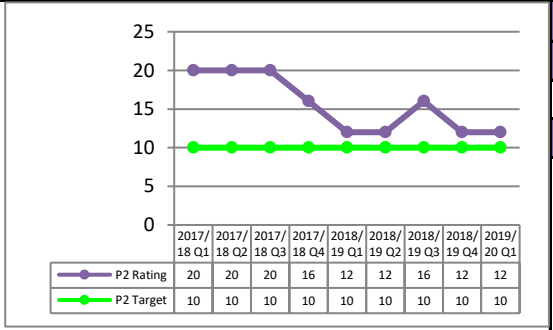
Strategic Domain 2: Being a Leading Partner in a Progressive Health Economy						
P1	**To fully engage with all strategic partners to maximise the opportunities and advantages associated with horizontal integration in the designing and delivery of sustainable health services for the population of Central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

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

Principle Risk

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

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHSI Single Oversight F/w	Executive Director	Executive Management Group	Board Committee
June 2017	June 2019	Sept 2019	Well Led / NHSI – Use of Resoruces	CEO	Board of Directors	Quality Governance Committee (QGC)



Initial Risk Rating (Unmitigated)			Current Risk Rating (Mitigated)			Target Risk Rating (Tolerance/Risk Appetite)			
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Target Date
5	5	25	4	3	**12**	4	2	**8**	March 2020

Rationale for the Current Risk Score

The risk score has remained at 12 to reflect the continued increase in confidence.
Target risk rating has been reduced to 8, due to significant progress being made with external partnerships and alliances.
An independent Chair has commenced in post and Programme Director (SRO) for ICP is in place.
Options paper around the development of a Cheshire East Integrated Care Partnership is to be presented to the Cheshire East Place Partnership Board in June 2019. Increased collaboration and positive working relationships with GP Alliance and Primary Care has resulted in significant progress in the delivery of high quality community services.

Links to BAF objectives

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

Key Links to the Organisational Risk Register

TW0003 – Workforce capacity and skill mix to consistently deliver high quality care, seven days a week	**20**	TW0002 – Long Term Financial Sustainability of MCHFT	**12**
TW0006 - Lack of pace in the significant transformational change required to deliver the Cheshire East Place strategy and consequently the Health and Care Partnership (HCP) for Cheshire & Mersey	**16**		

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

Cheshire East Place secured £500K funding from Cheshire & Merseyside HCP to support integrated working. Externally facilitated session around Integrated Care Partnerships to be delivered at Board away day on 24 June 2019.

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

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

Strategic Domain 2: Being a Leading Partner in a Progressive Health Economy						
P2	**To work with all key stakeholders to deliver a wholly integrated health and social care system, taking on clear collective responsibility for resources and population health, so that our residents receive better coordinated care within the designated financial envelope, whilst ensuring:** **- National and regional strategies are implemented.** **- The sustainable use of resources to deliver agreed health outcomes.** **- The development of a collective decision making and governance structure.** **- Sustainable clinical services through the development of Accountable Care Systems (ACS) / Organisations (ACO) and the implementation of new models of care (e.g. Home first principles).**					
Key Controls / Influences Established (What are we currently doing about the risk?)	Key Gaps in Controls / Influences (What additional controls should we seek?)	Assurance Providers 2018/19 (How do we know if the things we are doing are having an impact?)			Gaps in Assurances on Controls / Influences (What additional assurances should we seek?)	Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)
		Local Management (1st Line of Defence)	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)		
1. Delivery of transformation & change agendas		• 1:1s • Team Meetings	• Transformation & People Committee (TAP) • Board of Directors • CEO Update • TAP Minutes	• External Well Led review, including CCICP	• Scale & pace of change • Capacity to deliver the CEP, Health & Care Partnership for Cheshire & Mersey & ACO • Relationship building with GP Federations	1. Re-launching UHNM / MCHFT Stronger Together Programme meetings
2. Engagement in Cheshire East Partnership Board and Executive Group	• Currently undergoing review and re-launch	• 1:1s • Team Meetings	• TAP Committee • Board of Directors • CEO Update • TAP Minutes			
3. Engagement in Cheshire East and Cheshire West & Chester Health and Wellbeing Boards		• CEO	• Board of Directors • CEO Update			
4. CCICP Board	• Partner relationships	• 1:1 • Team Meetings	• Board of Directors • CEO Update • CCICP Board minutes	• Internal Audit Programme: CCICP Governance review December 2017		
5. 5YFV Oversight for delivery at C&M level and C&W level	• Governance at C&M and C&W for 5YFV and LDSP is not robust	• CEO	• Board of Directors • CEO Update	• NHS Improvement / NHS England oversight		

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

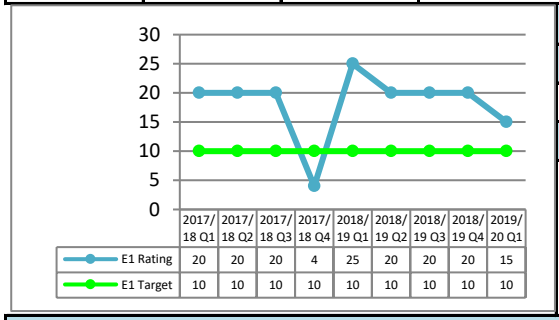
Key Controls / Influences Established (What are we currently doing about the risk?)	Key Gaps in Controls / Influences (What additional controls should we seek?)	Assurance Providers 2018/19 (How do we know if the things we are doing are having an impact?)			Gaps in Assurances on Controls / Influences (What additional assurances should we seek?)	Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)
		Local Management (1st Line of Defence)	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)		
6. System Financial Executive (CFE), previously referenced as Capped Expenditure Programme (CEP) delivery programme and governance	• New process and governance being established	• 1:1 • Team Meetings	• Board of Directors • CEO Update	• Cheshire East Partnership Board	• Scale & pace of change • Capacity to deliver the CEP, Health & Care Partnership for Cheshire & Mersey & ACO • Relationship building with GP Federations	1. Re-launching UHNM / MCHFT Stronger Together Programme meetings
7. Dedicated Director in place leading on partnerships		• 1: 1s	• Board of Directors • CEO Update			

Strategic Domain 3: Striving for Outstanding Organisational Effectiveness	
E1	**To ensure full compliance with the NHS Improvement Provider Licence, ensuring financial sustainability, financial efficiency and financial controls, whilst safeguarding the quality of our services.**

Principle Risk

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

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHSI Single Oversight F/w	Executive Director	Executive Management Group	Board Committee
June 2017	June 2019	Sept 2019	Well Led NHSI – Use of Resoruces	Director of Finance & Strategic Planning	Divisional Finance & Activity Performance Group	Performance & Finance



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

Rationale for the Current Risk Score

At the end of Quarter 1 2019/20 the risk score was reduced to 15. The Trust has agreed a control total with NHSI of £9.2m, which if delivered will secure funding of £7.5m from the PSF and MRET, leaving a deficit of £1.7m. The Trust has agreed a block contract with the local commissioner which makes a material amount of the budgeted income secure. Influencing factors on the ability to deliver the financial plan include any additional costs of delivering required waiting time targets and delivery of CIP targets.

Links to BAF objectives

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

Key Links to the Organisational Risk Register

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

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

Work on internal transformation programmes to improve efficiencies has continued alongside the wider collaborations of "Stronger Together" Programme with the University Hospitals of North Midlands and the wider engagement at all levels with the Health & Care Partnership for Cheshire & Mersey, specifically the STP and IPC work programmes. The Trust underwent a NHS Improvement Use of Resources assessment in March 2018 and has been rated as good. NHS Improvement segment 2 in February 2019, indicating performance is still on track. Currently a system-wide recovery plan is being developed for submission to NHS Improvement by 26 July 2019.

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 being reviewed.

Strategic Domain 3: Striving for Outstanding Organisational Effectiveness							
E1	**To ensure full compliance with the NHS Improvement Provider Licence, ensuring financial sustainability, financial efficiency and financial controls, whilst safeguarding the quality of our services.**						
Key Controls / Influences Established (What are we currently doing about the risk?)	Key Gaps in Controls / Influences (What additional controls should we seek?)	Assurance Providers 2018/19 (How do we know if the things we are doing are having an impact?)			Gaps in Assurances on Controls / Influences (What additional assurances should we seek?)	Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)	
		Local Management (1st Line of Defence)	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)			
1. Annual Plan & delegated budgets	• Availability / access to capital funding • Agency spending – medical & nursing • Capped expenditure programme outputs • Long term health economy with clear governance structure	• 1:1 / Team Meetings • Divisional Accountants 1:1s • Monthly Divisional Boards/CCICP reports	• Divisional Finance & Activity Performance Group • Performance & Finance Committee • Internal Audit Reports to: Audit Committee Audit Committee minutes • Board of Directors • PAF Minutes • Annual budget/planning April 2018 • Monthly Performance Report • Corporate Governance Handbook approval December 2018	• NHS Improvement Segment February 2019) (Segment 2 = Providers offered targeted support) & quarterly meetings. • NHS Improvement-submitted annual plans & feedback provided (No actions outstanding) • Funding agreed by NHS Improvement & control total agreed Internal Audit Programme: • Core Financial Controls 2018/19 Significant Assurance Next review-January 2020 • Financial Management & Financial Reporting- Significant Assurance, (September 2017) • Data Quality 2018/19 Significant Assurance with minor improvements required • Risk Management & Corporate Governance Report: Significant Assurance with minor improvements-April 2019 Next review-January 2020 • NHSI Use of Resources Assessment March 2018; rated as Good.		1. Transformation projects continue 2. Follow-up on loan applications for capital spend Awaiting HM Treasury decision. 3. Internal audit programme to be finalised.
2							
3. Monthly finance & activity review meetings							
4. Performance management systems	New Performance Management Framework to be reviewed						
5. Job descriptions contain financial responsibilities							
6. CCG Contract		• Recruitment process					
7. CQUIN Schemes & process to deliver		• Monthly CCG Meetings					
8. Monthly Performance Report		• Monthly CCG Meetings					
9. Capped expenditure programme outputs		• 1:1 / Team Meetings • Monthly Divisional Boards/CCICP reports					

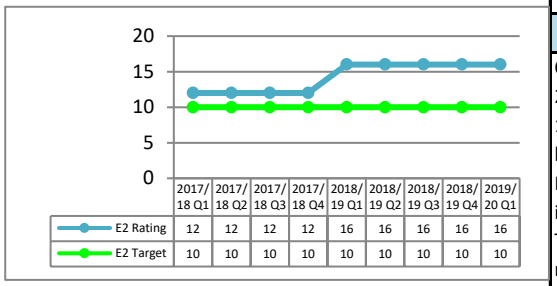
Strategic Domain 3: Striving for Outstanding Organisational Effectiveness							
E1	**To ensure full compliance with the NHS Improvement Provider Licence, ensuring financial sustainability, financial efficiency and financial controls, whilst safeguarding the quality of our services.**						
Key Controls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

Strategic Domain 3: Striving for Outstanding Organisational Effectiveness	
E2	**To maintain compliance with, and aspire to achieve incremental improvements against, the NHS Improvement Single Oversight Framework Operational Performance Metrics, whilst safeguarding the quality of our services.**

Principle Risk

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

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHSI Single Oversight F/w	Executive Director	Executive Management Group	Board Committee
June 2017	June 2019	Sept 2019	Responsive Care & Effective Care NHSI - Operational Performance Metrics	Chief Operating Officer	Divisional Finance & Activity Performance Group	Performance & Finance



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

Rationale for the Current Risk Score

Quarter 4 and the start of Quarter 1, 2019/20, have been challenging for the Trust with regards to operational metrics. Although the Trust improved on its 2017/18 four hour performance, 2018/19 did not deliver the required performance of >90%. The Trust continues to see increased attendances at ED with a 13% increase during the start of Quarter 1. There have also been challenges in the community to support discharges from hospital. Therefore, occupancy levels across care wards have increased.

RTT performance continues to recover in Quarter 1, following a pause in the elective programme in Quarter 4 due to non-elective pressures. Full compliance is due in June 2019.

The Trust has maintained its strong cancer performance through 2017/18 being within the top 5 Trusts nationally. However, an administrative error has meant a number of patients who should have been tracked against the 62 day screening pathway weren't, and so will breach the 62 day pathway, therefore given the low number of treats against this pathway the standard will be failed in May, June and July 2019. A clinical harm review has been undertaken and no harm has been attributed to the delay.

The DM01 six week diagnostic standard has not been delivered in May 2019, and will fail in June 2019. The cause is due to a server upgrade and transfer of data. Full compliance is due by July 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	TW0003 – Workforce capacity and skill mix to consistently deliver high quality care, seven days a week	20
TW0002 – Long Term Financial Sustainability of MCHFT	12	CS0375 - Delayed routine outpatient follow-up	15

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

There is a full economy working plan re: ED performance. A review of the 13% increase in ED attendance has been commissioned by the A&E Delivery Board.

RTT performance is above trajectory and expected to deliver above the 92% standard in June 2019. A full investigation is underway regarding 62 day cancer screening. DM01 compliance will be delivered in July 2019.

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

• Partnership working and agreeing actions to support future compliance.

Strategic Domain 3: Striving for Outstanding Organisational Effectiveness						
E2	**To maintain compliance with, and aspire to achieve incremental improvements against, the NHS Improvement Single Oversight Framework Operational Performance Metrics, whilst safeguarding the quality of our services.**					
Key Controls / Influences Established (What are we currently doing about the risk?)	Key Gaps in Controls / Influences (What additional controls should we seek?)	Assurance Providers 2018/19 (How do we know if the things we are doing are having an impact?)			Gaps in Assurances on Controls / Influences (What additional assurances should we seek?)	Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)
		Local Management (1st Line of Defence)	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)		
1. Monthly Performance Reports	• External influences on medically fit for discharge patients • Insufficient community capacity • Failure to deliver sustainable GP out of hours service • Increase in working age, low acuity patients attending ED	• 1:1/ 2:1 meetings • Team Meetings • Monthly Divisional Boards/CCICP reports • Monthly Performance Management Group Meetings (DGMs) • Quarterly away days	• Divisional Finance & Activity Performance Group • Performance & Finance Committee • Audit Committee • Board of Directors • Monthly Performance Report • PAF Minutes	• CQC Good rating overall (Responsive: Rated 'Good' September 18 • NHSI Use of Resources rated as Good March 2018 • NHSI Quarterly Meetings • Cancer Peer Review • Monthly CCG Contract Meetings • A&E Delivery Board • 1:1 with NHSI • External audit (MIAA) review of inpatient length of stay and readmissions • HED benchmarking data • External audit RTT compliance • Internal Audit Programme: • CQC Good rating • Monthly CCG meetings • NHSI Oversight		1. Partnership working and agreeing actions to support future compliance in line with ECIST action plan 2. New Front of House senior management team to review breach analysis process and develop SOP. 3. As per ECIST action plan paper which went to TAP Dec 2018 4. Review performance and knowledge at Cancer Board and weekly PMG
2. Breach Analysis Reports / Timely dashboard data	• Ensure robust staff training given to new starters					
3. Urgent Care ECIST actions	• Increase streaming from ED • Implement SAFER • Expand Dom Care pathway 3	• Urgent care Streaming Group • Project meetings • A&E Delivery Board	• Executive Transformation Steering Group • Transformation & People Committee • Board of Directors • Monthly Performance Report			
4. Agreed Relocation Policy across Cancer Network	• Embed changes across the Trust	• PMG weekly meetings • Director of Ops Manchester meeting	• Performance & Finance Committee			

Strategic Domain 3: Striving for Outstanding Organisational Effectiveness						
E2	**To maintain compliance with, and aspire to achieve incremental improvements against, the NHS Improvement Single Oversight Framework Operational Performance Metrics, whilst safeguarding the quality of our services.**					
Key Controls / Influences Established (What are we currently doing about the risk?)	Key Gaps in Controls / Influences (What additional controls should we seek?)	Assurance Providers 2018/19 (How do we know if the things we are doing are having an impact?)			Gaps in Assurances on Controls / Influences (What additional assurances should we seek?)	Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)
		Local Management (1st Line of Defence)	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)		
5. Use of external providers, locums and waiting list initiatives as required.		• 1-2-1 meetings with DGM's	• Performance & Finance Committee • Transformation & People Committee	• CQC Good rating overall (Responsive: Rated 'Good' September 18 • NHSI Use of Resources rated as Good March 2018 • NHSI Quarterly Meetings • Cancer Peer Review • Monthly CCG Contract Meetings • A&E Delivery Board • 1:1 with NHSI • External audit (MIAA) review of inpatient length of stay and readmissions • HED benchmarking data • External audit RTT compliance • Internal Audit Programme: • CQC Good rating • Monthly CCG meetings • NHSI Oversight		1. Partnership working and agreeing actions to support future compliance in line with ECIST action plan 2. New Front of House senior management team to review breach analysis process and develop SOP. 3. As per ECIST action plan paper which went to TAP Dec 2018 4. Review performance and knowledge at Cancer Board and weekly PMG
6. Implementation of Trust Strategy 2017/2018 & Divisional Plans and actions		• 1/ 2:1 meetings • Team Meetings • Monthly Divisional Boards/CCICP reports • AEMB • CCICP Partnership Board	• Performance & Finance Committee • Audit Committee • Board of Directors • Monthly Performance Report • Transformation & People Committee			
7. Quality Impact Assessment Process	• Divisions to use new process and QIA form as part of planning for 19/20	• 1/ 2:1 meetings • Team Meetings • Monthly Divisional • Boards/CCICP reports	• Medical Director and Director of Nursing & Quality approval of QIAs • CEP Oversight Group • CEP Connecting Care Oversight Group • Board of Directors • Quality, Safety & Experience Report		• Strengthen reporting and monitoring of QIA process	1. QIA Procedure implemented in June 2018. Process to be established.

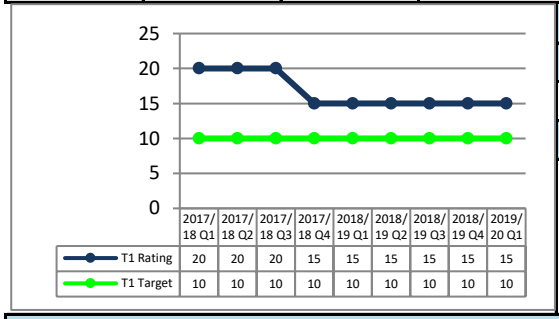
Strategic Domain 3: Striving for Outstanding Organisational Effectiveness						
E2	**To maintain compliance with, and aspire to achieve incremental improvements against, the NHS Improvement Single Oversight Framework Operational Performance Metrics, whilst safeguarding the quality of our services.**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

Strategic Domain 5: Creating a 21st Century Infrastructure for Transformative Health and Social Care	
T1	**To deliver an agreed, costed and phased Estates Strategy which will make the best use of the Trust's estate taking into consideration the entire estate across the Central Cheshire system, national and regional agendas and in particular the strategic aim of the system to become an Accountable Care System.**

Principle Risk

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

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHSI Single Oversight F/w	Executive Director	Executive Management Group	Board Committee
June 2017	June 2019	Sept 2019	Well Led Framework Use of Resoruces	Director of Finance & Strategic Planning	Executive Infrastructure Development Group	Performance & Finance



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

Rationale for the Current Risk Score

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

Links to BAF objectives

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

Key Links to the Organisational Risk Register

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

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

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

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

Asbestos Management Group – oversight of new contractors in progress.

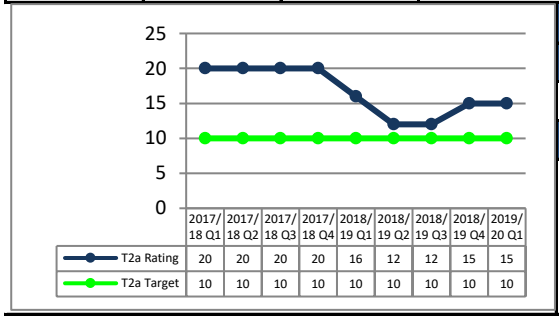
Strategic Domain 5: Creating a 21st Century Infrastructure for Transformative Health and Social Care						
T1	**To deliver an agreed, costed and phased Estates Strategy which will make the best use of the Trust's estate taking into consideration the entire estate across the Central Cheshire system, national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

Strategic Domain 5: Creating a 21st Century Infrastructure for Transformative Health and Social Care	
T2a	**To deliver an agreed, costed and phased Information Technology (IT) Strategy which supports the provision of seamless, integrated, outstanding patient care, improves staff experience in delivering care and enables continuous quality and service improvements through the intelligent use of secure, real time data.**

Principle Risk

Risk of failure to fully implement the Information Technology Strategy due to lack of capital / revenue funding will result in:
- Missed opportunities to improve the quality of care we provide, leading to poor patient and staff experience (E.g. E-Prescribing)
- Inability to modernise services (E.g. E -Prescribing)
- Delays in delivering horizontal and vertical integration – Accountable Care Systems
- Failure to meet legislative requirements with the associated reputational risks (e.g. GDPR)
- Failure to reduce unwarranted variation (Carter, Model Hospital work)

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHSI Single Oversight F/w	Executive Director	Executive Management Group	Board Committee
June 2017	June 2019	Sept 2019	Well Led Framework Use of Resoruces	Medical Director / Deputy CEO	Information Technology Strategy Group	Performance & Finance



Initial Risk Rating (Unmitigated)			Current Risk Rating (Mitigated)			Target Risk Rating (Tolerance/Risk Appetite)			
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Target Date
4	5	20	3	5	15	3	2	6	March 2020

Rationale for the Current Risk Score

The risk score remains at 15 for Quarter 1. 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. Outline Business Case also shared with and approved by East Cheshire Trust Board. Full business case is being prepared for submission 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	12	CS0380 - Cyber Security	16
TW0010 - Legacy Operating Systems Software	16		

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

The main challenge to delivering the DIGIT@LL Technology Strategy is the financial affordability. However the Board of Directors does not underestimate the level of organisational development support that will be required for the organisation to undergo the necessary culture change. A Chief Nursing Information Officer and Chief Clinical Information Officer have been appointed to support the EPR. The Executive Lead for Cyber Security is the Interim 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 was reviewed by the internal auditors in February 2019, all standards, with the exception of the IG training compliance rate, have been met. Improvement plan is in place to achieve the 95% compliance rate by July 2019. CCICP has gone live with EMIS Community which has been configured specifically to support care communities. There is an appetite to develop this as an NHS Digital blueprint. Trust Board has received independent cyber security training.

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

- Delivery of the overarching Cyber Security implementation plan.

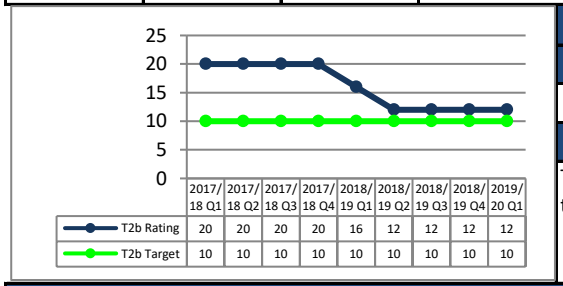
Strategic Domain 5: Creating a 21st Century Infrastructure for Transformative Health and Social Care						
T2a	**To deliver an agreed, costed and phased Information Technology (IT) Strategy which supports the provision of seamless, integrated, outstanding patient care, improves staff experience in delivering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

Strategic Domain 5: Creating a 21st Century Infrastructure for Transformative Health and Social Care	
T2b	**To deliver an agreed, costed and phased Information Technology (IT) Strategy which supports the provision of seamless, integrated, outstanding patient care, improves staff experience in delivering care and enables continuous quality and service improvements through the intelligent use of secure, real time data.**

Principle Risk

Risk of failure to fully implement the Information Technology Strategy due organisational culture regarding digital awareness / capability resulting in sickness / data quality issues / recruitment impacts leading to:
- Missed opportunities to improve the quality of care we provide, leading to poor patient and staff experience (E.g. E-Prescribing)
- Inability to modernise services (E.g. E-Prescribing)
- Failure to meet legislative requirements with the associated reputational risks (e.g. GDPR)
- Failure to reduce unwarranted variation (Carter, Model Hospital work)

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHSI Single Oversight F/w	Executive Director	Executive Management Group	Board Committee
June 2017	June 2019	Sept 2019	Well Led Framework Use of Resources	Medical Director / Deputy CEO	Information Technology Strategy Group	Performance & Finance



Initial Risk Rating (Unmitigated)			Current Risk Rating (Mitigated)			Target Risk Rating (Tolerance/Risk Appetite)			
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Target Date
4	5	20	3	4	12	3	2	6	March 2020

Rationale for the Current Risk Score

The current risk score has remained at 12 for Quarter 1, on the basis that the Clinical Systems Strategic Outline Case has been approved by NHSI to move to the next step.

Links to BAF objectives

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

Key Links to the Organisational Risk Register

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

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

The E-Rostering project is been rolled out across 17 nursing and midwifery wards, 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. A business case has been prepared for training for healthcare professionals eg: Physiotherapists / Pharmacy Technicians.

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

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

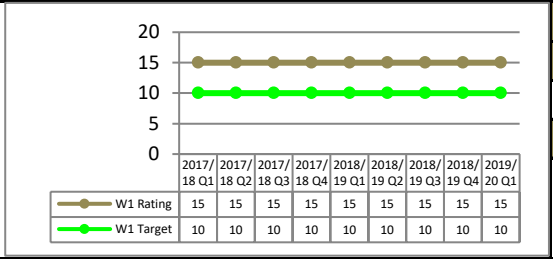
Strategic Domain 5: Creating a 21st Century Infrastructure for Transformative Health and Social Care							
T2b	**To deliver an agreed, costed and phased Information Technology (IT) Strategy which supports the provision of seamless, integrated, outstanding patient care, improves staff experience in delivering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

Strategic Domain 4: Aspiring to Excellence in Practice through Our Workforce	
W1	**Our cadre of patient centred leaders will be skilled in continually promoting and building upon our open and honest culture. This will be achieved through sharing the Trust's vision, values, behaviours and objectives from Board to ward.**

Principle Risk

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

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



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

Rationale for the Current Risk Score

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

Links to BAF objectives

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

Key Links to the Organisational Risk Register

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

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

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

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

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

Strategic Domain 4: Aspiring to Excellence in Practice through Our Workforce							
W1	**Our cadre of patient centred leaders will be skilled in continually promoting and building upon our open and honest culture. This will be achieved through sharing the Trust's vision, values, behaviours and objectives from Board to ward.**						
Key Controls / Influences Established (What are we currently doing about the risk?)	Key Gaps in Controls / Influences (What additional controls should we seek?)	Assurance Providers 2018/19 (How do we know if the things we are doing are having an impact?)			Gaps in Assurances on Controls / Influences (What additional assurances should we seek?)	Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)	
		Local Management (1st Line of Defence)	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)			
1. Trust Strategy 2017 with 2020 Horizon		• 1:1 / Team Meetings • Divisional Workforce Groups • Monthly Divisional Boards/CCICP reports • Consultant Foundation Programme	• Professional Advisory Group • Executive Workforce Assurance Group • Transformation and People (TAP) Committee (Minutes) • Board of Directors • Monthly Workforce Report • Annual Report on the Appraisal and Revalidation of Medical Practitioners at MCHFT-September 2017 • Workforce Race Equality Scheme Annual Review-November 2018 • Strategic Nursing & Midwifery Staffing Review-October 2018 • Monthly Quality, Safety & Experience Report (Nurse staffing) • Medical staffing workforce metrics included in the Workforce Report reported via TAP to Board of Directors • Freedom to Speak Up Guardian Report Quarterly to TAP, annually to Board • Findings from Freedom to Speak Up Review • Staff survey results reported to Board and TAP, and also reported to JCNC	• Sub Regional Workforce Planning and Development Network • Staff Survey March 2018 • Health Education England reviews. ED/Training self-assessment July 2018 • Chester College reviews • Royal College reviews	BIU reporting following discontinuation of DISCO reporting	1. Our Workforce Matters Strategy to be fully implemented. 2. Review of Education Governance framework. Framework to be reviewed. 3. Consultation for W&OD team to be undertaken and implementation plan in place Q1 2019-20 4. Occupational Health service level agreement and strategic priorities to be reviewed during Q1 2019-20. 5. ESR system project to be established during Q1 6. Work to improve data quality. Project plan/business case to improve ESR links compliance. Deliver in 3 to 12 months (Dec 2019 latest) 7. Establish local talent boards to inform regional and National talent boards. 2 talent boards to have been held by Q2 2019/20 8. Review apprenticeship programme and establish clear links to strategy
2. Our Workforce Matters Strategy implementation	• to be fully implemented	• 1:1 / Team Meetings • Divisional Workforce Groups • Monthly Divisional Boards/CCICP reports					

Strategic Domain 4: Aspiring to Excellence in Practice through Our Workforce							
W1	**Our cadre of patient centred leaders will be skilled in continually promoting and building upon our open and honest culture. This will be achieved through sharing the Trust's vision, values, behaviours and objectives from Board to ward.**						
Key Controls / Influences Established (What are we currently doing about the risk?)	Key Gaps in Controls / Influences (What additional controls should we seek?)	Assurance Providers 2018/19 (How do we know if the things we are doing are having an impact?)			Gaps in Assurances on Controls / Influences (What additional assurances should we seek?)	Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)	
		Local Management (1st Line of Defence)	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)			
3. Education Governance Framework	• Framework requires review	• 1:1 / Team Meetings • Divisional Workforce Groups • Monthly Divisional Boards/CCICP reports • Consultant Foundation Programme	• Professional Advisory Group • Executive Workforce Assurance Group • Transformation and People (TAP) Committee (Minutes) • Board of Directors • Monthly Workforce Report • Annual Report on the Appraisal and Revalidation of Medical Practitioners at MCHFT- September 2017 • Workforce Race Equality Scheme Annual Review- November 2018 • Strategic Nursing & Midwifery Staffing Review-October 2018 • Monthly Quality, Safety & Experience Report (Nurse staffing) • Medical staffing workforce metrics included in the Workforce Report reported via TAP to Board of Directors • Freedom to Speak Up Guardian Report Quarterly to TAP, annually to Board • Findings from Freedom to Speak Up Review • Staff survey results reported to Board and TAP, and also reported to JCNC	• Sub Regional Workforce Planning and Development Network • Staff Survey March 2018 • Health Education England reviews. ED/Training self-assessment July 2018 • Chester College reviews • Royal College reviews	BIU reporting following discontinuation of DISCO reporting	1. Our Workforce Matters Strategy to be fully implemented. 2. Review of Education Governance framework. Framework to be reviewed. 3. Consultation for W&OD team to be undertaken and implementation plan in place Q1 2019-20 4. Occupational Health service level agreement and strategic priorities to be reviewed during Q1 2019-20. 5. ESR system project to be established during Q1 6. Work to improve data quality. Project plan/business case to improve ESR links compliance. Deliver in 3 to 12 months (Dec 2019 latest) 7. Establish local talent boards to inform regional and National talent boards. 2 talent boards to have been held by Q2 2019/20 8. Review apprenticeship programme and establish clear links to strategy
4. Staff Survey results and action planning	• Delivery of divisional action plans • Feedback from divisions with any changes made. • To be reported to EWAG	• 1:1 / Team Meetings • Divisional Workforce Groups • Monthly Divisional Boards/CCICP reports					

Strategic Domain 4: Aspiring to Excellence in Practice through Our Workforce							
W1	**Our cadre of patient centred leaders will be skilled in continually promoting and building upon our open and honest culture. This will be achieved through sharing the Trust's vision, values, behaviours and objectives from Board to ward.**						
Key Controls / Influences Established (What are we currently doing about the risk?)	Key Gaps in Controls / Influences (What additional controls should we seek?)	Assurance Providers 2018/19 (How do we know if the things we are doing are having an impact?)			Gaps in Assurances on Controls / Influences (What additional assurances should we seek?)	Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)	
		Local Management (1st Line of Defence)	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)			
5. Recruitment Policies		• 1:1 / Team Meetings • Divisional Workforce Groups • Monthly Divisional Boards/CCICP reports • Consultant Foundation Programme • 1:1 / Team Meetings • Divisional Workforce Groups • Monthly Divisional Boards/CCICP reports	• Professional Advisory Group • Executive Workforce Assurance Group • Transformation and People Committee • Board of Directors • Monthly Workforce Report • Strategic Nursing & Midwifery Staffing Review-October 2018 • Monthly Quality, Safety & Experience Report (Nurse staffing) • Annual Report on the Appraisal and Revalidation of Medical Practitioners at MCHFT-September 2018 • Workforce Race Equality Scheme Annual Review-November 2018 • Annual Equality & Diversity Report 2018 • TAP Minutes • Multi-Disciplinary Workforce Strategy Group	• Sub Regional Workforce Planning and Development Network • Staff Survey March 2018 • Health Education England reviews. ED/Training self-assessment July 2018 • Chester College reviews • Royal College reviews	BIU reporting following discontinuation of DISCO reporting	1. Our Workforce Matters Strategy to be fully implemented. 2. Review of Education Governance framework. Framework to be reviewed. 3. Consultation for W&OD team to be undertaken and implementation plan in place Q1 2019-20 4. Occupational Health service level agreement and strategic priorities to be reviewed during Q1 2019-20. 5. ESR system project to be established during Q1 6. Work to improve data quality. Project plan/business case to improve ESR links compliance. Deliver in 3 to 12 months (Dec 2019 latest) 7. Establish local talent boards to inform regional and National talent boards. 2 talent boards to have been held by Q2 2019/20 8. Review apprenticeship programme and establish clear links to strategy
6. Statutory / mandatory training monitoring	• Data quality						
7. Leadership Development Programmes in place, including Board Development programme	• Talent management & succession planning programme to be embedded						
8. Coaching & mentoring scheme is implemented							
9. Apprenticeship Programmes in place	• Apprenticeship programme linked to overarching Trust agreed strategy for apprentices.						
10. Developing alternative roles i.e. Physicians Associates and Advanced Nurse Practitioners	• Workforce programme						

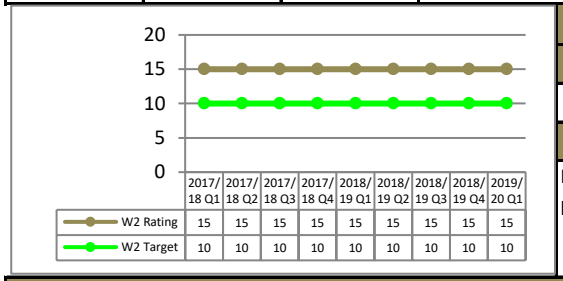
Strategic Domain 4: Aspiring to Excellence in Practice through Our Workforce						
W1	**Our cadre of patient centred leaders will be skilled in continually promoting and building upon our open and honest culture. This will be achieved through sharing the Trust's vision, values, behaviours and objectives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

Strategic Domain 4: Aspiring to Excellence in Practice through Our Workforce	
W2	**We will have in place a flexible and responsive workforce to meet patient needs by ensuring:** **- We have sufficient workforce numbers, with the right skills, in the right place, at the right time to meet the demands of our services across seven days.** **- Staff continually engaging in professional development regardless of their role.** **- Effective workforce planning to secure existing, and mitigate against anticipated shortages in skills.** **- We take a proactive approach to developing our future workforce by engaging with the local community and education providers**

Principle Risk

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

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



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

Rationale for the Current Risk Score

Rating of 15 remains for Q1 as although the Trust has low levels of vacancies there are hot spots e.g. radiology and although mandatory training uptake is progressing needs improvement. Additionally long term recruitment plans are good, however short term recruitment continues to be a challenge.

Links to BAF objectives

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

Key Links to the Organisational Risk Register

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

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

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

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

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

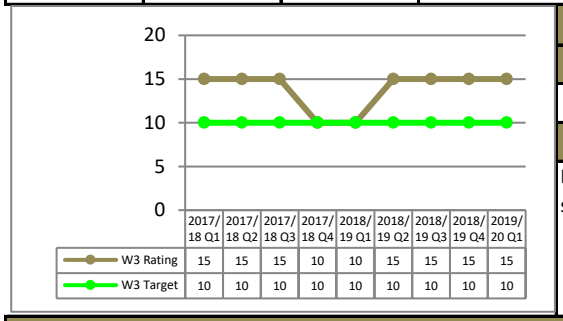
Strategic Domain 4: Aspiring to Excellence in Practice through Our Workforce							
W2	**We will have in place a flexible and responsive workforce to meet patient needs by ensuring:** **- We have sufficient workforce numbers, with the right skills, in the right place, at the right time to meet the demands of our services across seven days** **- Staff continually engaging in professional development regardless of their role** **- Effective workforce planning to secure existing, and mitigate against anticipated shortages in skills** **- We take a proactive approach to developing our future workforce by engaging with the local community and education providers**						
Key Controls / Influences Established (What are we currently doing about the risk?)	Key Gaps in Controls / Influences (What additional controls should we seek?)	Assurance Providers 2018/19 (How do we know if the things we are doing are having an impact?)			Gaps in Assurances on Controls / Influences (What additional assurances should we seek?)	Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)	
		Local Management (1st Line of Defence)	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)			
1. Annual Workforce planning process and Trust Strategy	• Gaps in nursing & medical posts Trust wide • Recruitment plans for key vacancy hotspots • Strategy for advanced practitioners and physician associates	• 1:1/Team Meetings • Divisional HR representatives • Divisional Workforce Groups • Monthly Divisional Boards/CCICP reports • Divisional workforce plans • Guardian of Safe Working	• Learning & Development Group • 7 Day Services Group • Professional Advisory Group • Executive Workforce Assurance Group • Transformation and People Committee (TAP) (Minutes) • Board of Directors • Monthly Workforce Report • Monthly Nurse Staffing Report • Monthly Medical Staffing Update and Consultant Appointments • Annual Nursing & Midwifery Staffing Comprehensive Report due November 2018 • Workforce Race Equality Scheme October 2018 • Guardian of Safe Working Hours Report • Annual Report on the Appraisal and Revalidation of Medical Practitioners at MCHFT- September 2018 • Multi-Disciplinary Workforce Strategy Group	• Sub regional workforce planning and development network • Staff Survey March 2018 • Health Education England reviews • Chester College Reviews • Local Workforce Assurance Board – QA Process • GMC Survey: Junior medical staff – July 2018		1. Education Governance Framework – under review and action plan in place 2. North West Streamlining Programme – now complete 3. Work to improve data quality. Project plan/business case to improve ESR links compliance. Deliver in 3 to 12 months (Dec 2019 latest) 4. Local development of improvement plans following the National Staff Survey results to be presented EWAG. 5. Strategy for advanced practitioners and physician associates).As part of workforce planning work 6. BIU and HA working together to strengthen validity of data. 7. Review of workforce and OD, to include both physical and governance structure.
2. Our Workforce Matters Strategy	• Full implementation of Our Workforce Matters Strategy						
3. HR Team & policies & procedures in place	• Capacity gap in HR team						
4. Statutory / mandatory training monitoring	• Release of staff to complete • Data quality						
5. Developing alternative roles i.e. Physicians Associates and Advanced Nurse Practitioners	• Health & Social Care C&M Workforce planning programme						
6. Return to Nursing Practice programmes							
7. Nurse staffing reviews							
8. IT Strategy	• Strategy to be implemented	• Financial affordability	• IT Strategy Implementation Group	• C&M IT STP Group			

Strategic Domain 4: Aspiring to Excellence in Practice through Our Workforce	
W3	**Our staff will feel valued and recognised for the work they do. They will also feel engaged as both employees and members of the Trust. We will encourage our staff to improve and maintain their own health and well-being, ensuring that MCHFT, as an organisation sets our own example for delivering excellence in quality care and services.**

Principle Risk

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

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



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

Rationale for the Current Risk Score

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

Links to BAF objectives

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

Key Links to the Organisational Risk Register

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

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

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

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

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

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

Appendix A - Strategic Objectives & Success Measures 2018/19	Domain One: Delivering Outstanding Clinical Quality, Safety & Experience
Objective Q1. **To aspire to the delivery of 'outstanding' clinical quality and safety, which is equitable, patient and family centred and supported by an effective quality governance framework**	**We will know when we have succeeded by measuring what matters and through:** **• Implementing the Quality and Safety Improvement Strategy making this inclusive of all staff** **• Ensuring compliance with all legal and regulatory requirements** **• Using local and national benchmarking data to demonstrate consistently high quality clinical care with no unwarranted variation and top quartile performance.** **• Delivering top quartile performance for national staff and patient surveys as well as consistent positive feedback, greater than 90%, from patients, family members, carers and patient groups, targeting specifically those groups likely to be subject to less equitable services.** **• Progressing the continuous learning culture through recognised processes of good governance to evidence sustainable improvements to patient safety, quality of care and outcomes.** **• Working with clinical teams to ensure documentation and record keeping are robust and accurate**
Objective Q2. **To drive continuous quality improvement and promote research and innovation, whilst reducing unwarranted clinical variation and progressing from a 'good' to 'outstanding' organisation.**	**We will know when we have succeeded by measuring what matters and through:** **• Progressing towards an 'Outstanding' CQC rating through a clinical quality improvement programme that is Executive led and clinically owned and supported** **• Engaging with wider stakeholders to ensure further development of clinical pathways to deliver services that are clinically aligned with the needs of the local population and connect across health and social care** **• Leading on local and national safety collaborations to achieve best practice through influencing national directives and local practice** **• Ensuring clinical service needs where required are delivered equitably across 7 days** **• Encouraging and promoting involvement in research and innovation, including academic research and partners, showcasing participation to internal and external stakeholders and sharing outcomes with others.** **• Use evidence led accreditation in research & innovation to support research studies**

Domain Two: Being a Leading Partner in a Progressive Health Economy	
Objective P1. To fully engage with all strategic partners to maximise the opportunities and advantages associated with horizontal integration in the designing and delivery of sustainable health services for the population of Central and Eastern Cheshire, whilst acknowledging and responding to: - National and regional strategies. - The need for sustainable high quality clinical services. - Favourable economies of scale and removal of unwarranted variation. - The cost effective sustainable use of resources.	We will know when we have succeeded by measuring what matters and through: • Playing a leading role in implementing the NHS Cheshire & Merseyside Plan with demonstrable outputs and outcomes: - Supporting and leading developments within Cheshire & Wirral and Cheshire & Mersey to enable greater collaboration in relation to back office functions, clinical support services and where appropriate, clinical services. - Supporting the development and delivery of the NHS Cheshire & Mersey, Cheshire & Wirral work streams • Playing a leading role in the delivery of the Capped Expenditure Programme to ensure the appropriate transformation of health and social care to ensure the economic sustainability for Central (& Eastern) Cheshire • Playing a leading role in shaping and delivering the Long Term Sustainability Review: - Mapping the current delivery of services and work with partners, in particular ECT and UHNM, to change the delivery model where improved patient benefit and sustainable provision can be provided by the Trust or others. - With health economy partners, consider longer term options and develop the case to enable MCHFT to provide long term sustainability for ECT - Developing a more flexible workforce that can be deployed differently to lead and support the developing and delivery of high quality integrated horizontal pathways for our patients • Providing sustainable high quality services that are valued by the population served and enhancing the reputation of the Trust to keep services local
Objective P2. To work with all key stakeholders to deliver a wholly integrated health and social care system, taking on clear collective responsibility for resources and population health, so that our residents receive better coordinated care within the designated financial envelope, whilst ensuring: - National and regional strategies are implemented. - The sustainable use of resources to deliver agreed health outcomes. - The development of a collective decision making and governance structure. - Sustainable clinical services through the development of Accountable Care Systems (ACS) /Organisations (ACO) and the implementation of new models of care (e.g. Home first principles)	We will know when we have succeeded by measuring what matters and through: • The Central Cheshire Integrated Care Partnership (CCICP) developing and implementing a transformation programme that enhances and integrates care locally and is an enabler to the development of an Accountable Care System: - Care Communities and Primary Care Home through GP clusters for populations of 30 – 50k - Integrated pathways across primary, secondary and community teams, social care and mental health recognising the roles and responsibilities of providing core integrated care, urgent responsive care and specialist care, taking account of the latest treatments and advances in medicine - Enabling infrastructure that transforms the organisational development and culture of the workforce. • Using clinical senate forums, and with health economy partners, playing a leading role in developing and implementing ACS/Os with demonstrable outputs and outcomes, therefore, creating a system that: - Promotes self-care and prevention including vaccination and screening programmes alongside education to make our population healthier - Ensures the Health Economy lives within its means and funds are used in the most effective way to optimise patient outcomes. - Provide sustainable high quality local clinical services that are valued by the population of Central Cheshire.

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

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

Appendix B - Risk Matrices

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

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

Appendix C - Questions for Board Sub-Committees

Assurance:

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

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

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

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

Mid Cheshire Hospitals
NHS Foundation Trust

Title of Paper :	Organisational Quarterly Risk Register Report Q1 2019/20	
Author:	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:	Provides a position statement of the organisational risks for Quarter 1, 2019/20. Detailed report providing assurance of effective risk management.
Risk:	Lack of oversight of key risks to achieving the Strategic Objectives.

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

Quality Governance

Organisational Quarterly Risk Register Report

Report date: 01/04/2019 to 30/06/2019

Contents

1. Purpose

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

2. Current position

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

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

- A full review was undertaken during quarter 4 201819 of the content of the Trust risk register. Following this the organisational risk register was cleansed and revised to focus only on those risks that pose issues for divisional and corporate objectives.
- Quality Governance Managers (QGM) continue to support the new web based system and processes as they embed within Divisions. QGMs received training on the new system and are delivering cascade training for the new system to risk assessors across all Divisions.
- A system of tighter control over risk assessment and how risks are uploaded on to the organisational risk register was implemented. Practice in line with the Risk Management and Assurance Framework is in place: Divisional Boards have oversight and approve risks rated 12 or above for inclusion, and where a risk is rated 15 or above oversight is provided by EQGG before the risk is accepted for inclusion on to the organisational risk register.
- Divisional and organisational risk register reports are now routinely available, and these risk register reports can also be produced automatically at frontline from the Ulysses web-based data management system. Risk register reports can be produced for specialist groups; H&SG, Information Governance Working Group (IGWG) and Infection, Prevention & Control (IP&C). Further development work is underway to develop risk register reports for other specialist groups, such as; Emergency Preparedness Group (EPG) and Executive Workforce Assurance Group (EWAG).
- A Web-based Risk Management System User Guide has been developed and made available across the Trust. Broader education of managers has been undertaken through discussion at management meetings on the development of risk management systems, including; risk assessments, registers and governance arrangements.

3. External / Internal Audit Opinion

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

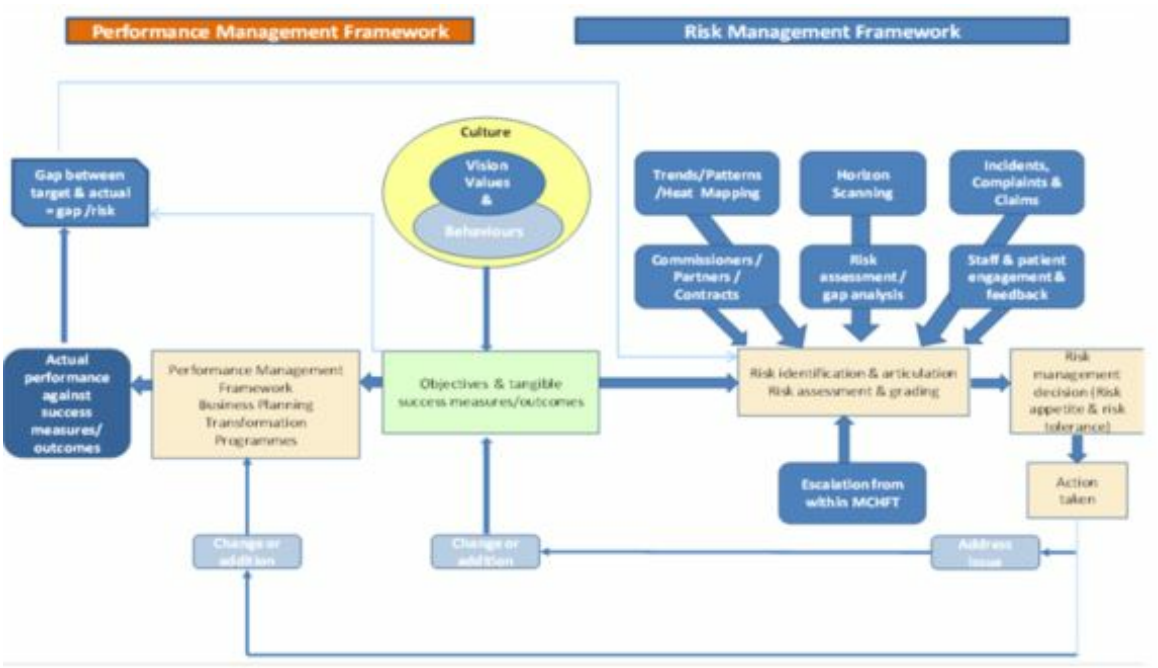
KPMG provided internal audit opinion for 2018/19. The outcome from this audit was 'Significant assurance with minor improvement opportunities'. The audit covered:

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

4. Executive level oversight

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

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



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

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

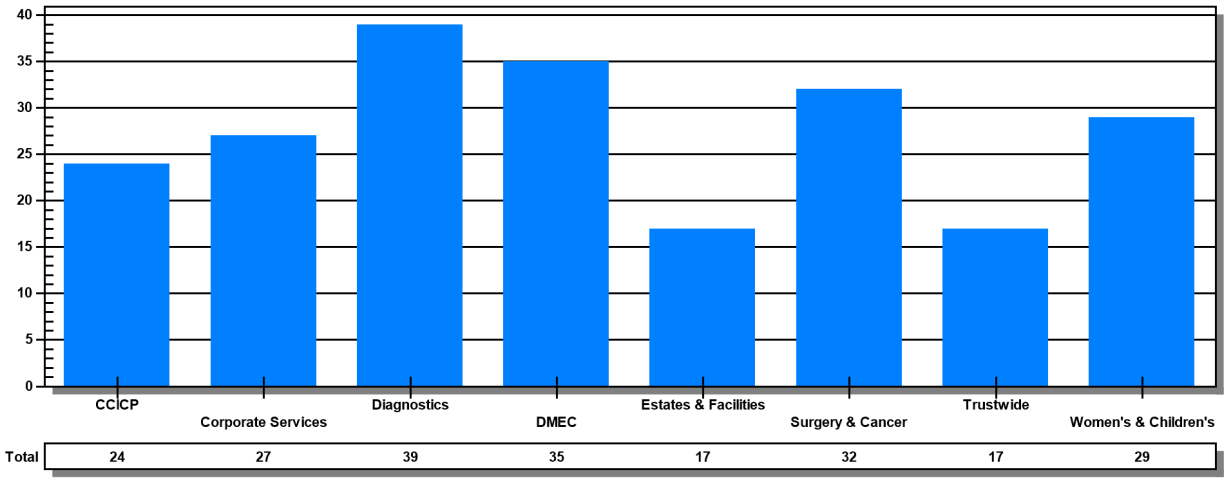
Priority	Key areas 2017/19	Position	Commentary
1. New Risk Management Strategy & Framework 2017/20	• Categorisation matrix review (Part of the Incident Report & Management Policy)	Completed	• Executive Quality Governance Group (EQGG) December 2017
	• Revise Risk Assessment Procedure	Completed	• Planned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

Priority	Key areas 2017/19	Position	Commentary
3. Review of Risk Registers	• Develop sources on web based system	Completed	• By March 2019
	• Undertake TNA for risk management	Completed	• Training to dovetail with web based system by March 2019
4. Governance Structure Group Reporting	• Review the information flows and functions of the groups reporting into the Executive Quality Governance Group.	Completed	• To include as part of the Well –Led Developmental Review in February 2018 with Board oversight in April 2018 by May 2018.
	• Review annually	Completed	• Review March 2019
5. Safety Culture Assessment	• Undertake initial assessment	Completed	• Initial assessments as part of the Well – Led Developmental Review in February 2018 with Board oversight in April 2018. • Trust rolling programme from July 2018
6. Ulysses – Web Based Solution for risk management and improvement planning	• Review of all fields to include controls assurance rating, cost benefit analysis, risk proximity and risk profiling • Education & training programme • Cleansing of all grades of risks • Quality improvement, audit and national guidance gap analysis system to be developed	On track: Not yet completed	• Potential delays due to resourcing issues • Delay in Ulysses provision of improvement / action module • CCICP services will need reconfiguring on the system post change to care groups • Dependency on recruitment process to new Quality Governance Team (Quality Governance Analyst) • This action is included in the risk management internal audit report for completion by March 2018 – **moved to by March 2019**

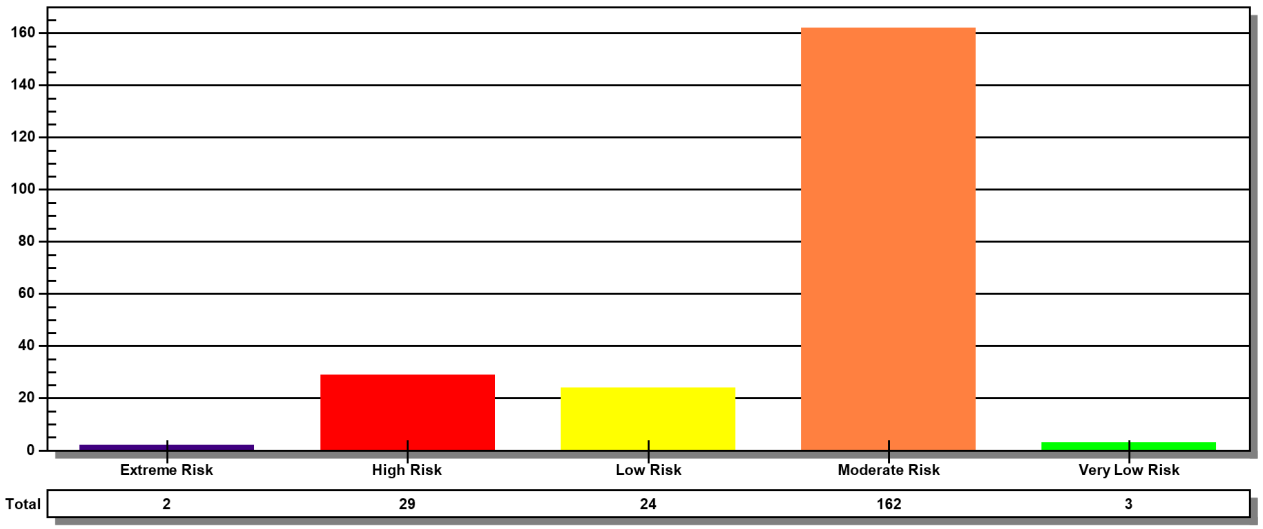
6. Six Key Risks for the Trust in 2019/20

Risk Title	Mitigated (With Controls) Risk Rating	Shift				Key links to BAF 2019/20
		Q1 – 19/20	Q2 – 19/20	Q3 – 19/20	Q4 – 19/20	
Delivery of key local and National targets and standards, in particular the 4 hour standard in A&E	5(C) x 4 (L) = 20	⇔				Q1, Q2, E1, E2, P1, P2
Workforce capacity and skill mix to consistently deliver high quality care, seven days a week	5(C) x 4 (L) = 20	⇔				Q1, Q2, P1, P2, E2, W2
Lack of space in the significant transformational change required to deliver the Cheshire East Place Strategy and consequently the Health and Care Partnership (HCP) for Cheshire & Mersey	4(C) x 4 (L) = 16	⇔				Q1, Q2, P1, P2, E2, W2, T1, T2a, T2B
The Long Term Financial Sustainability of the Trust	4(C) x 3 (L) = 12	⇩				E1, E2, P1, P2, T1, T2a, T2B
Cyber Security	4(C) x 4 (L) = 16	⇔				Q1, Q2, E1, E2, T2a, T2B
The acquisition of the South Cheshire Private Hospital	Under review					

7. Risk Register Overview Summary - all open risks



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



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

8. New risks in quarter rated 15 and above

Ref.	Title	Division	Risk Score	Risk Rating	Target
DC1054	Cardio-Respiratory Department staffing	Diagnostics	15	High Risk	5
DC1056	Lack of aseptic service at MCHFT	Diagnostics	15	High Risk	5

9. New risks in quarter pending approval

Ref.	Title	Division	Risk Score	Risk Rating	Target
208	Information governance - records management	CCICP	16	High Risk	4
239	Podiatry Staffing	CCICP	12	Moderate Risk	4
242	Partnership working	CCICP	15	High Risk	0
212	Inability to comply with 2 aspects of Alcohol Related Liver Disease (ARLD) Improvement Plan	DMEC	12	Moderate Risk	6
215	Insufficient staffing within Inpatient locations	DMEC	16	High Risk	6
217	Risks associated with inadequate Staffing levels on ward 7	DMEC	16	High Risk	4
218	Risks associated with inadequate Staffing levels - Ward 3 (AMU)	DMEC	16	High Risk	6
229	Management of difficult patients on Ward 14	DMEC	20	Extreme Risk	16
234	Assessment of Divisional risk of ligature points in inpatient areas following Estates & Facilities Alert EFA/2018/005	DMEC	12	Moderate Risk	12
243	Preoperative service (POAC)	DMEC	12	Moderate Risk	4
223	6 Monthly High Voltage (HV) Switching	Estates & Facilities	6	Low Risk	0
EF0554	Condition of Office Accommodation in MD40,41,42, 43,44	Estates & Facilities	16	High Risk	4
213	Loss of Unisoft data between 8th March to 8th April 2019	Surgery & Cancer	12	Moderate Risk	4
214	Loss of call bells post planned generator testing- Wards 10 and 13	Surgery & Cancer	8	Moderate Risk	4
228	Lack of resources e.g. capacity and staffing within the Chemotherapy Unit to treat increased demand for Upper GI systemic anti-cancer treatment	Surgery & Cancer	20	Extreme Risk	10
233	Chaperone availability in community paediatrics	Women's & Children's	20	Extreme Risk	8

10. Risks past the review date rated 15 and above

Ref.	Title	Division	Risk Score	Risk Rating	Target
EC0399	Increased patient dependency when caring for 4 dependent Respiratory patients, which may be a combination of Non Invasive Ventilation and Tracheostomy patients	DMEC	16	High Risk	6

11. Escalated risks

Ref.	Title	Division	Risk Score	Risk Rating	Target
TW0014	Compliance with the Estates and Facilities Alert EFA/2018/005 - Assessment of Ligature Points	Trustwide	15	High Risk	15

12. Closed/de-escalaed risks

No risks closed or de-escalated during this period.

13. 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.

14. 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) Meetings 18. Annual Capacity and Demand Planning Process 19. Cancer Board 20. Cancer Task & Finish Group	20 5 x 4	Chief Operating Officer	1 Complete and implement Risk Management Systems Review	31/03/2020	10 5 x 2	14/5/19 reviewed - risk remains the same	15/08/2019
TW0003	24/09/2015	Workforce capacity and skill mix to consistently deliver high quality care, seven days a week	There is a risk that patients may not receive timely, high quality care, as a result of a failure to provide adequate numbers of staff with the appropriate skills seven days a week, which may lead to an adverse impact on patient safety, patient experience and clinical outcomes.	1. Recruitment to additional Consultant posts in the major acute specialties. 2. Divisional business cases in development to support the expansion of Consultant numbers to deliver the Seven Day Services Clinical Standards 3. Annual review of Consultant job plans to increase on site "out of hours" Consultant presence where pos 4. Recruitment to additional roles (e.g. Advanced Nurse Practitioners) to supplement the "out of hours" clinical medical workforce. 5. Critical Care Outreach Service available 24/7 6. Development of the Acute Care Model for inclusion in the potential investments for 2019/20 7. Prompt access to diagnostic services, including medical imaging and pathology. 8. Implementation of NEWS2 9. Policy for Adult In-patient Vital Signs and NEWS2 Monitoring 10. Advancing Quality programme. 11. Development of clinical pathways with external partners to ensure that patients receive appropriate, high quality care "out of hours" (e.g. stroke thrombolysis with the University Hospitals of North Midlands). 12. Engagement in the Getting It Right First Time (GIRFT) national programme - ongoing 13. Quality governance infrastructure, systems and processes. 14. Patient Safety Summit 15. Seven Day Services Steering Group 16. Deteriorating Patient Steering Group 17. Implementation of the Structured Judgement Review process to review in-patient deaths 18. Quality and Safety Improvement Strategy 2018/19 19. On-call rotas for Executives and clinical support services (e.g. Pharmacy) 20. Trust Escalation Policy 21. Bank and agency staffing arrangements	20 5 x 4	Consultant	4 Implementation of lessons learned from SJR process 5 Explore the opportunities for closer clinical collaboration with East Cheshire Trust	31/03/2020 31/03/2020	10 5 x 2	RISK REVIEWED	03/08/2019

High Risk

Ref	Initial Date	Title	Description	Controls	Current Rating	Owner	Actions		Target Rating	Progress Update	Next Review Date
							Description	Target			
CS0380	19/10/2018	Cyber Security	There is a risk that essential ICT functions may be impaired and services affected, as a result of a cyber-attack, which may lead to an adverse impact on patient safety and clinical care.	1. IT Starters and Leavers Processes 2. Mandatory Training 3. Physical security access controls 4. Removal media port lockdown for Trust IT equipment 5. Microsoft Patch Management 6. Password complexity for AD 7. VPN 8. Encryption to Trust owned device 9. Airwatch for Mobile devices 10. Cyber-security audits - KPMG/NHSD 11. 10 steps to cyber security Action Plan 12. IG Toolkit Compliance 13. Configuration Manager appointed Network is currently monitored by exception 14. Resource required to support software and hardware asset management processes 15. Ensure standard equipment build 16. Configuration management of assets/ process 17. Funding has enabled all equipment over 10 years of age replaced 18. Senior IT Technician - Cyber now in place 19. Overarching Cyber security improvement plan in place and monitored regularly	16 4 x 4	Associate Director Of IT	7 Physical security access audits 14 Develop TNA to assess further internal cyber security knowledge and expertise requirements 3 Port Lockdown on non-IT equipment (for example medical devices) 4 Internal network segmentation 8 NHSD Audit remediation plan completed 11 Conduct regular vulnerability scans on the network 19 IT to complete suite of documents identified in draft policy framework following audit	31/03/2019 31/03/2019 30/04/2019 30/04/2019 31/12/2019 31/03/2020 31/12/2019	8 4 x 2	08/05/19 reviewed and updated with Amy Freeman, outstanding actions remain, owners to be reminded	06/08/2019

14. 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			
DC0887	24/03/2015	Consultant Histopathologist Capacity	There is a risk of increased turnaround times for histology and diagnostic cytology specimens as a result of inadequate numbers of consultants which may lead to delays in diagnosis and treatment with poor outcomes for patients.	Locum Consultants are employed. Consultants to P code and triage cases. Waiting list initiative sessions. External reporting of non-urgent cases. 1 WTE Band 8A Biomedical Scientist Advanced Practitioner and 1 WTE Band 7 (dissector) employed to free up Consultant time.	16 4 x 4	Pathology Service Manager	2 Ongoing recruitment campaign for substantive Consultants. 3 Training given to Pathology staff in additional procedures. 1 Joint recruitment process with University Hospital of North Midlands (UHNM): International recruitment being undertaken. 5 Explore opportunities to transfer work via Pathology Network to UHNM.	31/03/2020 31/07/2019 28/02/2019 / /	8 4 x 2		15/10/2019
DC1010	05/03/2018	Breast Care Unit & Screening Programme	There is a risk that patients may not receive breast imaging in a timely manner, as a result of a shortage of radiologists and radiographers with an interest in breast imaging, which may lead to an adverse impact on clinical outcomes for patients following referral to the breast symptomatic / 2 week wait service.	1. Introduction of Ultrasound only session 2. Divisional recruitment and retention strategy in place 3. Reporting insourcing by Substantive Consultants 4. External dual reporting for MRI images (high risk patients) 5. Locum Radiologist employed 6. Locum Radiographic Consultant employed on a sessional basis 7. Weekly monitoring of compliance with QA/Cancer standards 8. Substantive Radiologist undertaking in-house training	16 4 x 4	Manager	1 Recruitment to all vacant posts 2 2. Extend working day for screening services 3 3. Increase capacity in core hours in line with surgical teams 4 4. Improve access to all patients referred to the Breast Unit 5 5. Increase funding from Public Health England to support recruitment of radiographic staff 6 6. Alternative Partnership to be agreed to support National Service specification compliance	30/06/2018 30/06/2018 30/06/2018 30/06/2018 30/06/2018 / /	4 4 x 1	The Unit is now better staffed as both radiographer posts have been recruited to and a locum Consultant Radiologist has also been appointed. Talks are ongoing with East Cheshire Trust regarding merging the services and the proposed date for this is April, 2020.	02/10/2019
DC1032	05/03/2018	Control of the backlog of patient's awaiting routine follow up in Dermatology	There is a risk that there is a delay to follow up reviews as an Outpatient as a result of increasing numbers of patients being added to the backlog list which may lead to an adverse impact on patient care and experience.	1. Clinical review of the longest waiting patients to appropriately prioritise appointments 2. Separate two week wait lists 3. Nurse led Biologics lists for Cancer pathway/high drug patients 4. Ensure all clinics are maximised 5. Service closed to out of area referrals 6. 2018/19 follow-up capacity increased by 1,000 slots	16 4 x 4	Deputy Divisional General Manager	1 Ensure all clinics are maximised to avoid loss of vital capacity 2 Validate the waiting list for duplicates and for those patients who have been seen since their follow-up due date 3 Increase follow-up capacity as consequence of reduction in GP referrals 4 Telephone consultations 5 Waiting List Initiatives 6 Recruitment of a fifth Consultant Dermatologist 7 Recruitment of an additional Dermatology Specialist Nurse	31/03/2019 31/03/2019 31/03/2019 31/03/2019 31/03/2019 31/03/2019 31/03/2019	8 4 x 2	Validation is continuing, firstly by a Consultant and followed up by Administration who then contact the patient to ascertain the need for an appointment. Some long term follow-ups are also being outsourced. A slight reduction has been seen.	27/08/2019
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. Escalation process in place for shift requests to be sent to off cap agencies. 5.Trust recruitment drives to get additional staff in to the Trust 6. Agreement now in place to ensure third qualified nurse on night wont be taken off the ward unless it is for a critical situation. 7. E rostering now implemented	16 4 x 4	Matron	2 Recruitment event planned for June 2019. Recruitment is ongoing to continue to fill remaining vacancies.	31/07/2019	6 2 x 3	Control measures and control gaps updated. Score remains the same	17/09/2019
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	17/09/2019

14. 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			
EC0397	19/06/2017	Risks associated with inadequate Staffing levels on ward 5	There is a risk that patients may not receive timely, high quality care as a result of low staffing levels on ward 5, which may lead to an adverse impact on patient safety, experience and outcomes.	1. On-going recruitment. 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.	31/07/2019	4 2 x 2	Vacancies less due to recruitment of staff/rotational post. Now 7.0WTE vacant . Recruitment evident in June	17/09/2019
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 fault 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	Capital Development have replaced a number of valves (throughout the trust) as required for ongoing project work. They are currently in the process of drafting a programme of works it replace to elements of the infrastructure that need replacing	21/08/2019
EF0556	16/07/2019	Infrastructure Pipework Failure - Ward 1	There is an increased risk that the incoming domestic hot water pipework (located above the ceiling tiles) feeding ward 1 could fail and would be unable to be repaired as a result of no access being allowed above ceiling height in certain locations on ward 1 due to the existence of asbestos material. Therefore should the leak be a serious one it would warrant the isolation of the water to prevent further damage or injury, this in turn will lead to a complete loss of hot water to both ward 1 & 9 (as ward 9 fed from same pipework).	□ Experienced maintenance staff on site 24/7 □ Ability to repair leaks in non-asbestos areas □ Ability to isolate completely the main incoming water to ward 1 (but also ward 9).	16 4 x 4	Head Of Estates	1 1.Decant part or all of ward 1 to allow asbestos removal and subsequent replacement of old pipework. 2 2.Prioritise Ward 1 refurbishment 3.Consideration to be given to refurbishing wards 1 & 9 together to lessen impact of isolation of shared services. 3 4.Replace pipework within Ward 1 (can only be actioned once action 1 above has been completed)	19/07/2022 19/07/2022 19/07/2022	0 0 x 0		23/10/2019
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 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 -	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.	01/09/2019

14. 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
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				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	26/11/2019
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 5 Offer and support existing and new staff the opportunity to work their contracted hours in a more flexible way, therefore addressing the current challenges relating to the recruitment and retention issues 9 The Director of Nursing has introduced a multidisciplinary clinical workforce group to address the recruitment and retention challenges that the organisation must overcome; ? Ongoing recruitment ? Supporting Transition Into Acute Roles ? Return to Practice ? UK adaptation programme ? Rotational recruitment ? Trainee Nursing Associates/Nursing Apprenticeships ? Allied Health Professionals ? International Recruitment 10 Successful recruitment to registered nurse vacancies within the division.	30/09/2019 31/10/2019 23/01/2020 23/01/2020 23/01/2020	8 4 x 2	The risk remains active and their are no further changes to the risk assessment at this time.	17/09/2019
SC0589	30/06/2017	Control of the backlog of patient's awaiting routine follow up	There is a risk that there will be delays in planned clinical review with expected timescales indicated by the Ophthalmic medical staff, as a result of increasing numbers of patients being added to the backlog list, which may lead to adverse impact on patient care and clinical outcomes for ophthalmic patients.	1. Weekly Performance Management Group report to Divisional Senior Management Team. 2. Ensure all clinics are maximised to avoid the loss of vital capacity. 3. Appointed to specialty Doctor vacancy x 2, commenced on 01.07.18 and 24.09.18 4. High risk patients have been prioritised 5. ECF waiting lists have been applied for and approved on month by month basis 6. Full rotation of Junior Doctors in place 7. Trajectory in place for reduction and currently achieving against it 8. Ensure all clinics are maximised to avoid loss of vital capacity	16 4 x 4	Service Manager	2 Continue WLI each month where staffing willing to support extra hours 3 Review the ability to appoint a suitable locum who has visited the department who could back fill until 02.2020 4 Speciality doctor returning from maternity leave 09/2019 5 Conversion to follow ups of any unused new capacity 6 For named consultant only appointments, capacity flexed where possible and extras added to clinics where safe to do so 8 Ophthalmology review and provide additional capacity for high risk on a weekly basis. 9 Clinical Lead to continue as Clinical Lead for Ophthalmology Elective Care programme and is reviewing best practice for management of follow up patients which may generate ideas to reduce and provide sustainability. 10 To arrange for an audit review of backlog to ascertian fuerrhter issues	30/04/2020 30/10/2019 30/09/2019 30/10/2019 30/10/2019 30/10/2019 30/10/2019 30/11/2019	6 3 x 2		24/10/2019

14. Summary of the Organisational Risk Register

High Risk

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TW0004	02/01/2013	Registered Nurse staff shortages	There is a risk that patients may not receive timely interventions to address their clinical needs, as a result of a reduced staffing capacity of registered nurses, which may lead to adverse impact on patient safety and clinical outcomes.	1. Trust Escalation Policy with revised staff escalation matrix, includes: Delivery of a daily staffing meeting with the aim of identifying staff to address gaps Consideration given to the use of agency staff following executive authorisation. 2. The Trust has the following 24/7 support services available: Senior Manager On-Call proving advice Clinical site managers Executive on-call 3. Embedded multi-disciplinary clinical workforce group (Consisting of task and finish groups to recruit RN roles and roles outside of the traditional RN recruitment.) This group reports progress to the Executive Workforce Group. 4. Revised and active recruitment of newly qualified nurses, as part of a multi-disciplinary clinical workforce gr 5. Fast tracking of ECF's to reduce delays in the recruitment process. 6. Use of exit interview data to inform retention strategies. 7. Trust promotional information added to job descriptions on NHS Jobs. 8. New ways of job advertising including use of social media. 9. Adverts revised to include set interview days. 10. Set of monthly arranged recruitment days across quarter 2. Those offered posts are then invited to 'Keep in Touch Days' 11. Temporary staffing efficiencies programme, specifically targeted at: Robust recruitment plan in place Efficient rota management, with the implementation of an electronic roster and KPI's to monitor performar 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. Divisional CIP to reduce sickness and absence to support the vacancy gap 17. Development of a Health and Welfare Strategy to support retention of staff and the vacancy gap	16 4 x 4	Deputy Director Of Nursing & Quality	5 Develop a marketing strategy for nurse bank 9 Scoping of Registered Nurse Training in conjunction with Health Education Institutes using the apprentice levy 16 International recruitment programme underway for September 2019, although staff will not be clinically in place until September 2020	31/12/2019 30/09/2019 30/09/2020	8 4 x 2		21/10/2019
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	Chief Executive	1 ICP organisational form and governance to be developed 2 ICP to be implemented 3 ECT Service Change Proposal. Pre-consultation business case	31/12/2019 30/04/2021 30/10/2019	8 4 x 2	05/06/19 reviewed with Dr Dodds - actions updated. Risk rating remains the same.	03/09/2019
TW0010	12/12/2018	Medical Devices Running Legacy Operating System Software	There is a risk that Trust IM&T systems will fail to function efficiently and effectively, as a result of a cyber-attack targeting unsupported operating systems such as Windows 2000, Windows XP or unpatched medical devices, which may lead to an adverse impact on patient care and safety	1. Patch devices that are managed by ICT Services. 2. Procurement of new systems - DPIA Procedure in place	16 4 x 4	Associate Director Of IT	2 Segment the network to limit the reach of a cyber-exploit. 6 On receipt of medical device asset register migrate devices to new medical devices network	31/01/2019 30/09/2019	8 4 x 2	08/05/19 reviewed and updated with Amy Freeman. Additional action added.	06/08/2019
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	Directorate Manager	1 Develop and submit a Business Case for a replacement Lightspeed scanner and the procurement of an additional scanner with replacement of the second existing scanner over a three year period.	16/01/2019	5 5 x 1	The Lightspeed scanner has now been replaced with the Aquillion 1 Genesis, which is now scanning patients. The mobile CT unit is being removed tomorrow (02/07/2019).	29/09/2019

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High Risk

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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	The outline business case was approved by both MCHFT and UHNM Boards for joint procurement. It is now out to procurement, after which the full business case will be written by the end of July 2019 to go to the Boards again in September 2019. The target go-live date is January 2021.	12/01/2020
DC1054	24/04/2019	Cardio-Respiratory Department staffing	There is a risk of delays in diagnosis for patients undergoing investigations by the cardio-respiratory department as a result of a national shortage of appropriately skilled staff (identified in the Getting It Right First Time) which may lead to delays in treatment and harm to patients.	□ Ongoing recruitment campaign □ Recruitment & retention policy □ Waiting list initiatives □ Use of locum staff until recruitment to substantive post. This will be reviewed every three months	15 5 x 3	Manager	1 □ Advertise vacancy □ Continue to liaise with locum agencies □ Continue with waiting list initiatives □ Robust management of diaries □ Upskilling of existing staff 2 Consider outsourcing reporting of ECG monitoring	30/09/2019 30/09/2019	5 5 x 1		23/07/2019
DC1056	23/05/2019	Lack of aseptic service at MCHFT	There is a risk that patients may not receive aseptically prepared products for example, Parenteral Nutrition, Chemotherapy, Monoclonal Antibodies as a result of the temporary closure of the aseptic unit due to adverse environmental trends and on-going computer software problems which may lead to patient transfer to other trusts (Neonatal patient, Macmillan patient) for treatment or a delay in treatment or further work (MAB'S) being prepared at ward level.	All preparation in the aseptic to cease. Enforcement notice received from MHRA stopping manufacture under MS licence. All products must be sourced from external suppliers, Bath ASU, Baxter, University Hospital North Staffordshi	15 5 x 3	Director Of Pharmacy	7 Seek advice from Quality Assurance team at QCNW and Quality Assurance North West regarding action plan 8 Seek advice from MHRA regarding actions and evidence 9 Resubmit licence application (dependent on validation of suitable computer system as well as satisfactory environmental monitoring results)	01/05/2019 01/05/2019 01/05/2019	5 5 x 1		21/08/2019
EC0342	15/06/2015	Failure to Meet Access Targets Across the Specialities within the Division	There is a risk of non compliance with national targets as a result of Consultant vacancies which may lead to financial penalties and adverse clinical outcomes for patients.	> Weekly monitoring of the use of waiting list initiatives > The use of external agencies for virtual clinics > General practitioners with specialist interest to assist with clinics.	15 3 x 5	Divisional General Manager	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.	15/09/2019
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	Proposed upgrades within the Domestic hot & cold water systems within wards 20 & 21 are going to tender on 30 May 2019. These works when complete will reduce the potential in this area of the trust.	21/08/2019
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 Management	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	Review of the Estates Backlog Risk assessment is currently being undertaken by the HoE. Once complete this will inform the 2019/20 backlog programme	21/08/2019
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 update: Junior staffing is now good but consultant cover is a significant risk - one vacancy covered by agency consultant so risk they could leave at any time. Another gap covered by ST8 trainee acting up but not covering the oncall. I dont think we can therefore reduce the risk at present. I would suggest review in September when we have a new consultant starting and may have an update on the other vacancy. Update from DGM - Agree we cannot reduce score currently. Jo - can you add into the control measure - working with Alder Hey to provide Diabetes clinic cover for 1 clinic a week. Also exploration of joint appointments.	13/08/2019

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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.	12/08/2019
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 tag identifier also. 6. ECF waiting lists have been applied for by General Surgery. 7. Capacity and Demand analysis has been completed and agreement of way forward to be agreed 8. Monthly validation continues. 9. Review of new routine capacity to follow up and outline the impact. 10. Additional capacity and medical staff required to reduce the backlog. 11. The department are therefore trying to put in additional registrars to the clinics to see the follow up backlog patients, however, this only equates to two clinics per month at 8 patients per clinic. 12. Review of use of nurse led follow up clinics; seen by the Clinical Nurse Specialist following Colorectal risk stratification	15 3 x 5	Service Manager	2 Exploring use of virtual clinics in colorectal.	31/08/2019	6 3 x 2	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 updated quarterly. 3. Backlog risk assessments within divisions/specialities 4. External providers assisting with the backlog 5. Harm reviews in specialities were reviewed by Execs in April 2019 and for further review in July 2019	15 3 x 5	Chief Operating Officer	4 SHS to assist with backlogs 31/12/2019 5 Waiting List Initiative in urology and general surgery 31/12/2019		6 3 x 2	14/5/19 Risk reviewed and updated - remains the same. Further actions added	12/08/2019
TW0014	21/12/2018	Compliance with the Estates and Facilities Alert EFA/2018/005 - Assessment of Ligature Points	There is a risk that patients being treated within the Trust who also have a mental health condition may be put at risk from having access to ligature points as a result concerns identified following the issue of EFA/2018/005 which may lead to patient harm.	1. Patient Admissions Documentation has a question regarding whether a patients has psychological issues 2. Emergency Department - use the Adult Mental Health Triage form for any patient brought in with Mental Health issues 3. There is a Mental Health Assessment room (A&E dept.) were patients are mainly accompanied but not a 4. Child and Adolescent Unit has two 'Safe Rooms' which have been designed as anti-ligature 5. Patient placement policy states that patients identified at high risk of self-harm should be placed in a bed o the ground floor under the care of the speciality team and appropriately supported with 1-1 nursing if applicable 6. The Patient Placement Policy also states that patients at risk of suicide should be notified to the Bed Managers who must risk assess the environment and wherever possible they should be nursed in refurbished locations where anti-ligature tracks, coat hooks and other fitments have been fitted	15 5 x 3	Head Of Health & Safety	2 Amend the Mental Health Triage Form to include risk of suicide 30/06/2019 3 Remove soap and hand towel fitments and replace with anti-ligature fitments 31/07/2019 1 Design out ligature points in Mental Health Assessment room 30/11/2019 8 Develop annual audit of potential ligature points 30/09/2019 10 Decide from the locations identified as housing high risk patients which ones will be included in the bed placement policy 30/09/2019 11 Actions identified in localised high risk assessments to be completed 30/03/2020 12 Actions identified in localised high risk assessments to be completed 30/03/2020 13 Actions identified in localised high risk assessments to be completed 30/03/2020 14 Actions identified in localised high risk assessments to be completed 30/03/2020 15 Actions identified in localised high risk assessments to be completed 30/03/2020 16 Actions identified in localised high risk assessments to be completed 30/03/2020		15 5 x 3	20/03/2019 Action plan updated with extensions as required	21/08/2019

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

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

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

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

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

Purpose of the Report

The purpose of this report for 2018 / 2019 is to provide assurance to the Board of Directors that the appraisal system for medical practitioners employed by Mid Cheshire Hospitals NHS Foundation Trust (MCHFT) is robust, supports the revalidation agenda and is operating effectively.

Background

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

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

The statutory duties of a RO include:

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

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

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

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

- A recommendation that the doctor is up to date and fit to practise and should be revalidated
- A request to defer the date of the RO's recommendation due to the doctor:
    - being engaged in the systems and processes that support revalidation, but about whom there is incomplete information on which to base a recommendation to revalidate (this will be where a doctor has not been able to gather all of the required supporting information by the time the submission date falls due)
    - participating in an ongoing local human resources or disciplinary process, the outcome of which is material to the evaluation of the doctor's fitness to practise and that will need to be considered prior to making a recommendation.
- A notification of the doctor's non-engagement in revalidation, which should be made if a doctor has not engaged "sufficiently" with revalidation

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

Governance Arrangements

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

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

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

The Trust has an electronic appraisal solution to securely manage all the required information for a robust and transparent appraisal and revalidation system for both the Trust and the doctors. The system:

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

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

The developments outlined in the 2017 / 2018 Annual Report were:

- Undertake a further Appraisal Quality Audit of all appraisals and review against previous year's audits to identify repeat issues/possible Doctors who require further training and review the appraisal training process both internally and externally.

  An audit of the past three years Appraisal Quality Audits was undertaken and the findings were presented to the Appraiser's Meeting in June 2019 for discussion and actions were agreed. It was noted that the audit had provided no unexpected issues.

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

  Five new Appraisers were trained and are undertaking appraisals in 2019-2020.

Medical Appraisal Performance for 2018 / 2019

The completed appraisals within the Annual Organisational Audit data were changed in 2018-2019 and were reported under the following two measures:

- Category 1 – Completed medical appraisal

  A *completed annual medical appraisal* is one where either:

  a) All of the following three standards are met:
  i. the appraisal meeting has taken place in the three months preceding the agreed appraisal due date*,
  ii. the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor within 28 days of the appraisal meeting,
  iii. the entire process occurred between 1 April and 31 March.

Or

b) the appraisal meeting took place in the appraisal year between 1 April and 31 March, and the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor, but one or more of the three standards in a) has been missed. However, the judgement of the responsible officer is that the appraisal has been satisfactorily completed to the standard required to support an effective revalidation recommendation. For doctors who have recently completed training, it should be noted that their final ACRP equates to an appraisal in this context.

- Category 1a – completed medical appraisal

  This measure is one for designated bodies who wish to and can report this figure, this is the number of completed medical appraisals that meet all **three** standards defined in measure 1 a) above. This figure is not reported nationally and is intended to inform the internal quality processes of the designated body

The Annual Organisational Audit data was submitted to NHS England on 16th May 2019.

The national appraisal completion rate (category 1) set by NHS England is 90%. The appraisal rate for MCHFT for 2018 / 19 is as follows:

Appraisal		Number
Completed	1	212
	1a	135
Missed / Incomplete	Approved	4
	Unapproved	0
Total		216
Appraisal Completion Rate (Category 1)		212/216 98.01%

The Trust's appraisal rates for the past 7 years have been:

	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/2019
Number of Completed Appraisals (Category 1)	124	134	175	196	208	202	212
Missed / Incomplete Approved	NR	4	1	8	8	1	4
Missed / Incomplete Unapproved	NR	31	4	0	1	1	0
Total	166	169	180	204	217	204	216
Completion rate (%)	74%	79.2%	97.2%	96.1%	95.9%	99.01%	98.01%

Each year a national Annual Organisational Audit (AOA) is undertaken by NHS England. The benchmarked performance for MCHFT for the year ending 31st March 2019 is outlined below:

2018 / 19 AOA Appraisal Indicator	**MCHFT's Response**	**Same Sector Appraisal Rate** **Number of DBs in all Sectors = 96**	**All Sectors** **Number of DBs in all Sectors = 862**
	Completed appraisals (1)		
Number of doctors with whom the designated body has a prescribed connection on 31 March 2019 who had a completed annual appraisal between 1 April 2018 – 31 March 2019	MCHFT's response and (%) calculated appraisal rate	Same sector appraisal rate	All Sectors appraisal rate
Consultants	126 (99.2%)	93.5%	93.7%
Staff Grade, Associate Specialist, Speciality Doctor	35 (100%)	88.8%	88.2%
Doctors on Performers List	N/A	91.4%	95.2%
Doctors with practising privileges	N/A	100%	92.7%
Temporary or short-term contract holders	50 (94.3%)	77.8%	91.8%
Other doctors with a prescribed connection to this designated body	1 (100%)	72.1%	87.9%
Total number of doctors who had a completed annual appraisal	212 (98.1%)	89.3%	91.5%

As part of the ongoing quality improvement process, real time auditing of appraisals is undertaken by the Revalidation Support Manager. In 2018 / 2019 the reasons for Category 1b appraisals being reported at MCHFT were:

Appraisals completed but not classified as Category 1A (previously Category 1b)	
No of Appraisals	**Reason**
57	Appraisals not completed "3 months preceding the agreed date"
14	Appraiser did not sign off the appraisal within 28 days, due to information required for revalidation not included in the appraisal
4	Appraisee did not sign off the appraisal within 28 days, due to information required for revalidation not included in the appraisal
2	Change of Appraiser

Missed / Incomplete Appraisals - Approved	
No of Appraisals	**Reason**
1	Maternity leave
1	Overseas
1	Disciplinary procedure
1	Started with Trust too late for appraisal and not done by Previous Trust

Missed / Incomplete Appraisals - Unapproved
No of Appraisals
0

Revalidation Recommendations for 2018 / 2019

In 2018 / 2019 the RO made 29 revalidation recommendations to the GMC.

Recommendation	2018/2019	2017/18	2016/17	2015/16	2014/15
On Time	29	20	10	80	73
Late	0	0	0	0	0
Missed	0	0	0	0	0
Positive	26 (90%)	18 (90%)	7 (70%)	74 (92.5%)	50 (68.5%)
Defer • Insufficient Information • On-going process	3(10%) 0	1 (5%) 1 (5%)	3 (30%) 0	4 (5%) 1 (1.25%)	15 (20.5%) 5 (6.9%)
Deferred for insufficient information and later revalidated	0	0	0	1 (1.25%)	3 (4.1%)
Non-engagement	0	0	0	0	0
Total	29	20	10	80	73

The following table benchmarks the Trust's total number of revalidation recommendations for the period 2012 – 2019 against neighbouring Trusts

	No of Approved Recommendations	No of approved recommendations to revalidate	No of approved requests for deferral (insufficient information)	No of approved recommendations of non-engagement	No of late recommendations
Mid Cheshire Hospitals NHS Foundation Trust	205	173 (84.4%)	32 (15.6%)	0	0
Countess of Chester Hospital NHS Foundation Trust	258	228 (88.4%)	30 (11.6%)	3 (1.2%)	0
East Cheshire NHS Trust	176	141 (80.1%)	35 (19.9%)	0	5 (2.8%)
University Hospitals of North Midlands NHS Trust	544	457 (84.0%)	84 (15.4%)	3 (0.55%)	8 (1.5%)

Planned Developments for 2019 / 2020

The developments planned for the appraisal and revalidation of medical practitioners at MCHFT in 2019 / 2020 are:

- Continue the Appraisal Quality Audit of all appraisals to monitor and report issues/possible Doctors who require further training and monitor the appraisal training processes, internally and externally.
- Train additional appraisers to ensure that MCHFT has the required cohort of trained appraisers to manage the increased number of prescribed connections and natural appraiser turnover.
- Maintain Appraisal and Revalidation processes and outcomes during the transformation of the interim/new Senior Medical Team.
- Collate the outcomes and actions from 2019-2020 appraisals to meet the new requirements of the "NHS England Framework of Quality Assurance for Responsible Officers and Revalidation, Annex D - Annual Board Report and Statement of Compliance".

Designated Body Statement of Compliance

The Board of Directors of Mid Cheshire Hospitals NHS Foundation Trust has carried out and submitted an annual organisational audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   Comments:

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   Comments:

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   Comments:

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent);

   Comments:

5. All licensed medical practitioners[1] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   Comments:

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1], which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;

   Comments:

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

   Comments:

8. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

   Comments:

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

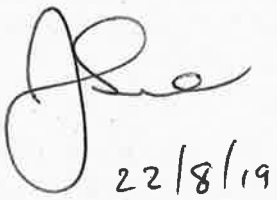
Comments:

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

Comments:

Signed on behalf of the Designated Body

Name: James Sumner

Signed: 

Chief Executive

Date: 22/8/19

Title of Paper:	Request to Affix Trust Seal	
Author:	Rob Few, Associate Director of Estates & Property Management	
Executive Lead:	Russ Favager	
Type of Report:	Concept Paper	
	Strategic Options Paper	
	Business Case	
	Information	X
	Review/Benefits/Audit	

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

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

Positive Benefit:	Ongoing tenancy of the League of Friends
Risk:	Change of occupancy

To be published on Trust Website –complete version	***Y*** *(delete as appropriate)*
If no, to be published on Trust Website – redacted	***Y*** *(delete as appropriate)*
If not to be published complete or redacted, please detail the reason why	
Presented at Board Meeting of:	2 September 2019

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Estates & Facilities Division

Capital Procedures

Form CF31 – Request to affix Trust Seal
(Version 1.0 – February 2013)

In line with the provisions Trust Standing Order Section 17 (Sealing of Documents), we request approval to affix the Trust Seal to the following document –

Type of Documents – Property Lease Renewal

Title of Document – Lease Renewal between Mid Cheshire Hospitals Foundation Trust and Leighton Hospital league of Friends relating to premises at Leighton Hospital

Reason for Trust Seal – Engrossment of a lease renewal to shop, office and stores located within Leighton Hospital. The accommodation has a GIA of 77.5 sqm

Please note - this document is a request to affix the Trust Seal, the content of the Lease has been agreed and authorised

Number of copies to be sealed – One copy of Lease Renewal

The seal is to be applied to –
3 x plans between Pages 17 and 18 & Page 26

Parties to Agreement - The parties are Mid Cheshire Hospitals NHS Foundation Trust and Leighton Hospital league of Friends

Value – Rental income - Nil

Rob Few
Associate Director of Estates & Property Management

Date: 18/07/19

To be completed by Trust Secretary

Approval minuted at Board meeting of *(date)*_____

Seal Applied *(date)*_____

Seal Number _____

EXECUTED AS A DEED by affixing the common seal of **MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST** in the presence of:)

R. A. Favager
MR RUSSELL FAVAGER

Signature of director

Name of director

Signature of director/secretary

Name of director/secretary

SIGNED as a Deed by **LEIGHTON HOSPITAL LEAGUE OF FRIENDS** in the presence of:)

Signature of director

Name of director

Signature of director/secretary

Name of director/secretary

Title of Paper:	Request to Affix Trust Seal	
Author:	Rob Few, Associate Director of Estates & Property Management	
Executive Lead:	Russ Favager	
Type of Report:	Concept Paper	
	Strategic Options Paper	
	Business Case	
	Information	X
	Review/Benefits/Audit	

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

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

Positive Benefit:	Ongoing tenancy of the Barclays ATM Machine
Risk:	Loss of ATM Machine

To be published on Trust Website –complete version	***Y*** *(delete as appropriate)*
If no, to be published on Trust Website – redacted	***Y*** *(delete as appropriate)*
If not to be published complete or redacted, please detail the reason why	
Presented at Board Meeting of:	2 September 2019

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Estates & Facilities Division

Capital Procedures

Form CF13 – Request to affix Trust Seal
(Version 1.0 – February 2013)

In line with the provisions Trust Standing Order Section 17 (Sealing of Documents), we request approval to affix the Trust Seal to the following document –

Type of Documents – ATM Property Agreement Renewal

Title of Document – An ATM Property Agreement Renewal between Mid Cheshire Hospitals Foundation Trust and Barclays Bank **PLC**

Reason for Trust Seal – Engrossment of an Agreement Renewal for an ATM located within the main entrance at Leighton Hospital consisting of a wall mounted ATM and a room of 5.75 sqm GIA directly behind it for access. This is a 5 year agreement.

Please note - this document is a request to affix the Trust Seal, the content of the Agreement has been agreed and authorised

Number of copies to be sealed – One copy of the ATM Agreement

The seal is to be applied to – Page/s 12/15 on the Agreement

Parties to Agreement - The parties are Mid Cheshire Hospitals NHS Foundation Trust and Barclays Bank PLC

Value – Rental income of one peppercorn per annum

Rob Few
Associate Director of Estates & Property Management

Date: 22nd August 2019

To be completed by Trust Secretary

Approval minuted at Board meeting of *(date)*_____

Seal Applied *(date)*_____

Seal Number _____

We Care Because You Matter

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

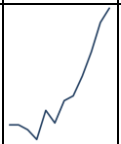
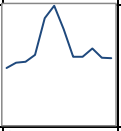
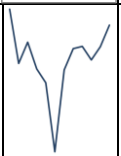
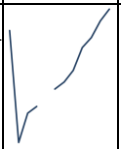
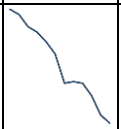
Board of Directors

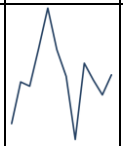
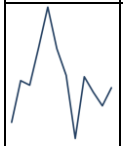
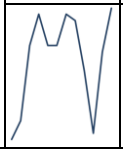
Workforce Report

September 2019

(July 2019 data)

Performance Report Workforce Chapter
Month: Jul-19

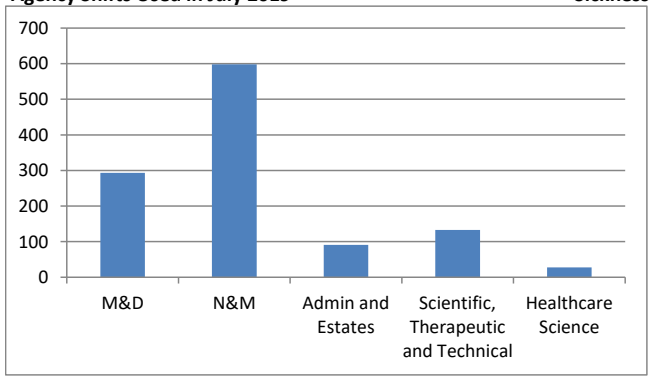
Measure	Target	Performance	Description	Narrative	Rolling Trend	Trend	C&W Average (June 2019)
SICKNESS ABSENCE	3.90%	4.51%	Rolling 12m average Sickness Absence described as a Percentage	Rolling sickness absence increased slightly in month (+0.03%) from the previous month and remains in an Amber position. DCSS, MED and S&C improved their rolling position. All divisions remained very similar to the previous month (within 0.20%)		↑	5.02%
IN MONTH SICKNESS ABSENCE	N/A	4.38%	In-month 12m average Sickness Absence described as a Percentage	In-month sickness absence slightly decreased from the previous month (-0.01%). Two divisions experienced reduced sickness absence levels: DCSS and SC		↓	4.90%
APPRAISAL RATES	90.00%	83.23%	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 0.89% improvement in the appraisal rates across the Trust. Three divisions experienced an improvement in compliance, the most significant being MEC (9.76%). Corporate and EF are Green and the remaining divisions are Amber with the exception of MEC (76.05%) WC (76.18%) and CCICP (74.49%).		↑	77.05%
MANDATORY TRAINING	90.00%	82.66%	Mandatory Training Monthly Rate Excludes Bank Staff, Staff on long term sick & mat. leave.	Training compliance increased by 1.27% in month and all divisions secured an improvement with the exception of WC (-1.72%). DCSS, SC and WC, and CCICP are Amber. Other divisions remain Red. MEC remain the most challenged by this target (77.32%) but improved their position again this month (+3.83%).		↑	90.19%
STAFF TURNOVER	10.00%	8.95%	Number of Leavers expressed as a percentage of the workforce over a 12m rolling period. Exclude Junior Doctors, Temporary and Fixed term.	The rolling position for turnover improved slightly in month (0.19%). Turnover reduced in all divisions. All divisions are Green against target with the exception of MEC (10.91%) and CCICP (10.99%)		↓	10.57%

Measure	Target	Performance	Description	Narrative	Rolling Trend		
AGENCY SPEND	(404)	(591)	In month total spend for the Trust against plan	Agency spend increased in month (£81k more than the previous month) and the agency spend target was not met. Medical and Dental agency spend increased (£35k) as did Allied Health Practitioners (£39k) and Admin and Clerical (£26k). DCSS, SC had a higher spend than in the previous month		↑	N/A
NHSI PLANNED AGENCY	less than 100%	146.29%	Trust Agency Spend as a percentage of the planned agency expenditure			↑	N/A
OVER CAP RATES	N/A	68%	Number of Agency shifts filled by agency staff that are over the nationally determined capped rates			↑	N/A

Key

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

Agency Shifts Used in July 2019



Sickness Absence