Bundle Board of Directors 2 March 2020

1	09:30 - Welcome and Introductions
	Chairman
2	09:32 - Patient Story
	Director of Nursing and Quality
3	09:50 - Board Member's Interests
	Chairman. To consider any changes to the interests of Board Members and any declaration of interests in the agenda.
4	09:52 - Draft Minutes of the Last Meeting
	Chairman. To approve the minutes of the last meeting on 3 February 2020 as a true and accurate record.
5	09:55 - Matters Arising and Action Log- to approve
	Chairman
	5. Board Action Log Public.pdf
6	09:57 - Annual Work Programme - to approve
	Chairman. To approve the Board of Directors Work Programme for 2020/21.
	6.Board Workplan 2020-21 v1.pdf
7	10:00 - Chairman's Announcements - to note a verbal report
	Chairman
7.1	Chairman's Action Report of Use of the Trust Seal - to note
	Deputy Chair. To note the approval given to use the Trust Seal via Chairman's Action.
7.2	Year of the Nurse & Midwife Launch
	Deputy Chair
8	10:05 - Governor's Items - to note a verbal report
	Chairman
8.1	Chat with the Chairman - 25 February 2020
8.2	Governor Cheshire East Council Partnership Governor
9	10:10 - Chief Executive's Report - for discussion
	9. ceo report feb 20.pdf
9.1	10:25 - MIAA Presentation of the Review of Assurance Structures
	Chief Executive. To hear the findings of the Mersey Internal Audit Agency review into governance structures at MCHFT. To be presented by Sarah Blackwell and Ann Highton, MIAA
10	10:40 - Quality, Safety and Experience Report - for discussion
	Director of Nursing & Quality/ Medical Director
11	10:55 - CARING
11.1	10:55 - Draft Quality Governance Committee (QGC) draft notes
	Committee Chair. To note the escalations and meeting notes of QGC on 10 February 2020.
11.2	11:00 - Serious Untoward Incidents and RIDDOR Events - for noting
	Medical Director
12	11:05 - RESPONSIVE
12.1	11:05 - Performance Report - for discussion
	Chief Operating Officer/ Deputy Director of Finance
	12.1 Performance Report January 2020.pdf
12.2	11:20 - Draft Performance and Finance (PAF) Committee Notes - for escalation and noting
	Committee Chair. To note the escalations and meeting notes of PAF on 20 February 2020.
12.2	11:25 - Staff Survey Presentation
	Director of Workforce and OD
13	11:45 - WELL LED
13.1	11:45 - Board Assurance Framework - for discussion
	Medical Director. To approve the Q3 BAF 2019/20.
	13.1 Quarter 3 BAF Summary report 2019 20.pdf
13.2	11:55 - Organisational Risk Register Q3 2019-20 - to note

Medical Director

13.2 ORR Q3 Mar20 Board.pdf

13.3 12:00 - Learning from Deaths Report - for discussion

Medical Director. To note the Q3 2019/20 Learning from Deaths report.

13.3 Learning from Deaths Q3 19-20.pdf

13.4 12:05 - Request to use the Trust Seal - for approval

Director of Finance & Strategic Planning. To approve the use of the Trust Seal.

13.4 Request to use the Trust Seal - League of Friends Lease.pdf

13.5 12:08 - Report on Use of the Trust Seal - for noting

Chief Executive. To note the report on the use of the Trust Seal from December 2019 to February 2020.

13.5 Trust Seal Report Dec 2019 -Feb 2020.pdf

13.6 12:10 - Annual Review of Board Committees - for discussion

Chief Executive

13.6 Board Paper summary Board Committee review 2020.pdf

14 12:20 - EFFECTIVE

14.1 12:20 - Workforce Report

Director of Workforce and OD

14.1 Workforce Board Report February 2020.pdf

14.2 12:25 - Reward and Recognition - for discussion

Director of Workforce and OD

14.2 Reward and recognition.pdfhttps://portal2.ibabs.eu/Agenda/Edit/45a7c0b3-8d3a-4706-8781-c788f320180d#

14.3 12:35 - Transformation and People Committee Notes - for escalation and noting

Committee Chair. To note the escalations and meeting notes of TAP on 6 February 2020.

14.4 12:40 - Consultant Appointments - to note

Medical Director

12:45 - Break

Board Meeting held in Private

Review of the Meeting - to note a verbal review from Mr John Church

Non-Executive Director

Time, Date and Place of Next Meeting

To confirm that the next meeting of the Board of Directors will take place on Monday, 6 April 2020.

Board of Director Meeting held in Public (Action Log)

iBabs ID	Action No	Date of Meeting	Action	Lead	Deadline Date	Comments	Date of Board meeting to be reviewed	Status
45	10.09	03/02/2020	QGC to review the patient experience section of the Board report and consider whether the information provided is providing the right level of assurance to the Board	J Tunney	31/03/2020		06/04/2020	

Board of Directors Workplan 2020/21 Version:1

Item	Board of Directors Meeting												Board Away Day				
	April	*May*	*June*	*July*	*August*	*Sept*	*Oct*	*Nov*	*Dec*	*Jan*	*Feb*	*March*	*Apr*	*Jun*	*Sep*	*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 - inc. Visits and Legal Advice	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					
Cyber Security Report				x						x							
Guardian of Safe Working Hours Report		x			x			x			x						
Doctors Revalidation Report						x											
Responsive																	
Quality Account		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					
Corporate Trustees													x		x		
Freedom to Speak up Guardian		x			x			x			x						
Emergency Preparedness, Resilience& Response (EPPR)							x										
Annual Clinical Excellence Awards Report										x							
Well-Led																	
Annual Budget/Planning/ Budget Pack	x											x					
Annual Report & Accounts (Extra Ordinary Board)		x															
Audit Committee		x	x				x		x			x					
Board Assurance Framework			x			x			x			x					
Quarterly Organisational Risk Register			x			x			x			x					
Learning from Deaths Quarterly Report			x			x			x								
Report on Use of Trust Seal			x			x			x			x					
Trust Strategy	x			x				x							x		x
Well-Led Governance Framework Self Assessment																	x
Corporate Goverance Handbook				x													
Board Sub-Committee Annual Review												x					
Annual Fit and Proper Persons Review								x									
Effective																	
Workforce Report	x	x	x	x	x	x	x	x	x	x	x	x					
Transformation and People Committee	x	x	x	x	x	x	x	x	x	x	x	x					
Consultant Appointments	x	x	x	x	x	x	x	x	x	x	x	x					
Medical Staffing Update (Part II)	x	x	x	x	x	x	x	x	x	x	x	x					
Equality Delivery System					x												
Workforce Race Equality Scheme						x											
Gender Pay Gap Report											x						

CEO Report – February 2020

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

1.0 Key operational issues

1.1 Coronavirus update

The Trust has been issued regular guidance from Public Health England and NHS England on the management of the risk of Coronavirus transmission into hospitals and community services. All actions to date have been completed including the establishment of a safe environment to assess and test patients away from A&E and the required signage and procedures are in place.

1.2 A&E Wait times & Winter plan

A&E waiting times continue to be a significant challenge for the Trust. As reported last month, two commissioned pieces of work have taken place during February and at the time of writing this report results have been returned but not yet analysed.

The first, a patient survey carried out my MORI, will give the Trust useful information as to why people are choosing to attend A&E. The second is a more detailed analysis by the Greater Manchester Utilisation Management team which will be presented back to senior clinicians and managers in March. These two reports will prove critical in developing a system wide recovery plan during the month.

1.3 Financial position – Month 7

The Trust is £128k overspent in month which is £118k off plan. Overspend in month is as expected in that the Laundry was £350k overspent (£466k year to date) due to the operational issues outlined below. The expected overspend by year end for the Laundry will be circa £870k due to the outsourcing costs, transport and purchase of additional linen. There has been an agreed control total increase of £600k with NHSI to compensate for the overspend given the exceptional circumstances.

The Trust is still forecasting that it will deliver against the revised control total, with the key risks being laundry expenditure and costs of escalation areas. Assumption being that these will not deteriorate from current run rates.

1.4 Laundry operational problems

As has been reported in the relevant Board Sub-Committees and at the Board Away Day, the Trust has significant operational issues with its Laundry equipment. At present this means that all general laundry for the Trust, and its partners who the Trust provides a laundry service to, is being outsourced at significant additional cost.

Staff within the Laundry have been redeployed to other roles within the Trust during this period and the CEO and Director of Finance (as the responsible Executive for Estates and Facilities) have been to meet with Laundry staff to keep them up to date on progress. The Board will consider the costs and way forward in a paper in the Private Board session today due to the commercial nature of the content.

2.0 Strategic issues

2.1 CQC Inspection Nov-Dec 19

The Trust has received the draft CQC report and will now review its content and, if required, respond to the CQC with any clarification or challenge on issues raised. The process would then conclude with a final report being issued and published at a later date to be determined.

2.2 South Cheshire Private Hospital Acquisition

The Trust completed its acquisition of the South Cheshire Private Hospital (SCPH) on 14th February 2020 as planned. The successful transfer of 68 BMI staff took place on the same date, commencing with a welcome introduction for our new members of staff. All staff will undertake a period of induction and training as they settle in to their new roles.

2.3 ICP Development

Cheshire East Partners have agreed that MCHFT will become the Host of the ICP for East Cheshire. A partnership agreement is being developed based on the CCICP legal partnership agreement and is currently being reviewed in draft by all Health and Social Care Partners in East Cheshire.

A workshop will take place in April to work with partners on the detail of the governance structure and work programme for 2020/21. This will be overseen by an Operational Group of all partnership members.

2.4 Strategy Development

An additional Board Away Day has been put in place on 13th March to enable the further development of the Trust's new five year strategy which is anticipated to be launched in April.

J. Sumner
Chief Executive Officer
02.03.2020

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

We Care Because You Matter

Quality, Safety and Experience Report

March 2020

(January 2020 data)

Contents

Contents (continued):

Quality & Safety Section:

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

Patient Safety Harm Incidents

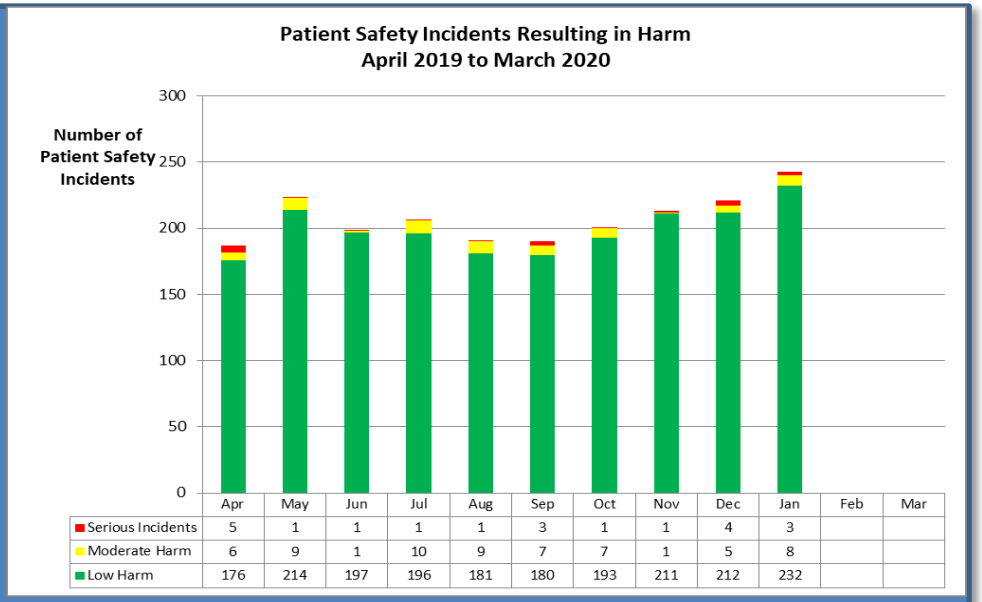
For January 2020, there were a total of 243 patient safety harm incidents:
95.5% (232 incidents) have resulted in low harm
3.3% (8 incidents) have resulted in moderate harm
1.2% (3 incidents) have resulted in serious incidents

In January 2020, the gap between harm and all patient safety incidents was 514. The aim over the twelve month period is to see this gap widening.

Previous 3 months: October saw a gap of 523, November a gap of 456 and December 507.

Improvement actions include;

- Comprehensive investigations are undertaken for all incidents in line with the Trust Incident Reporting, Investigation, Learning and Improvement Policy and National guidance.
- Executive Led review meetings will take place for the StEIS reported incidents and improvement plans will be developed and implemented.

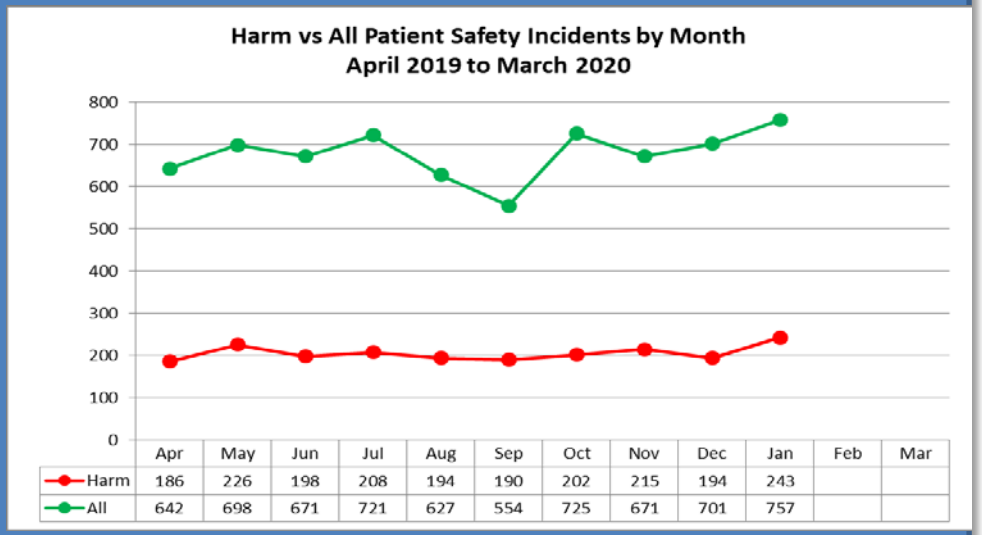


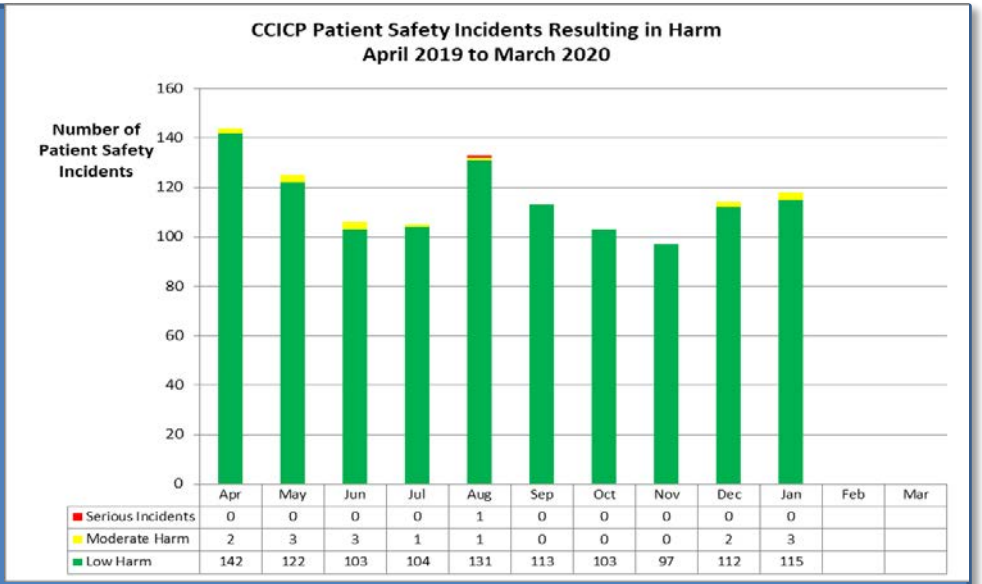
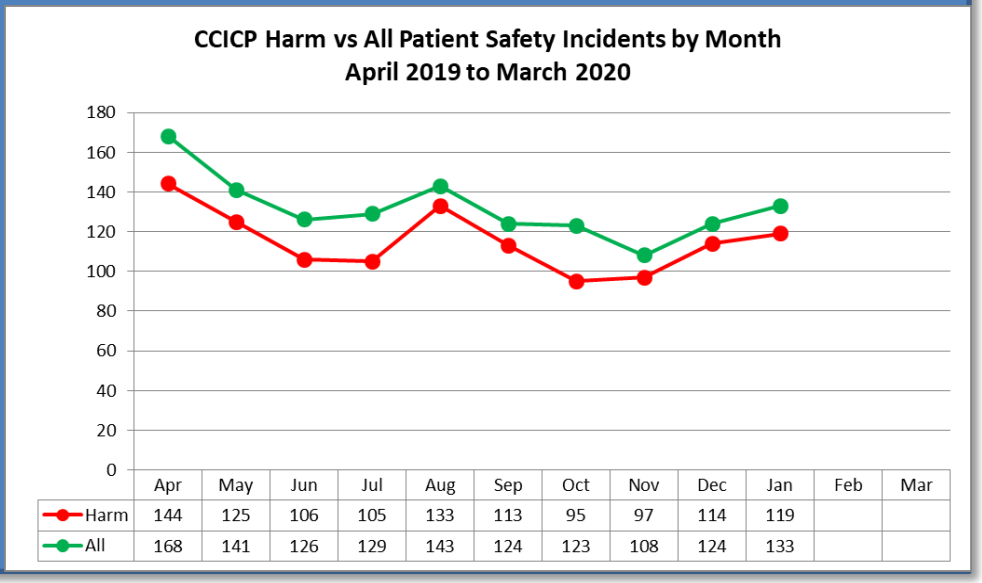
Harm vs All Patient Safety Incidents

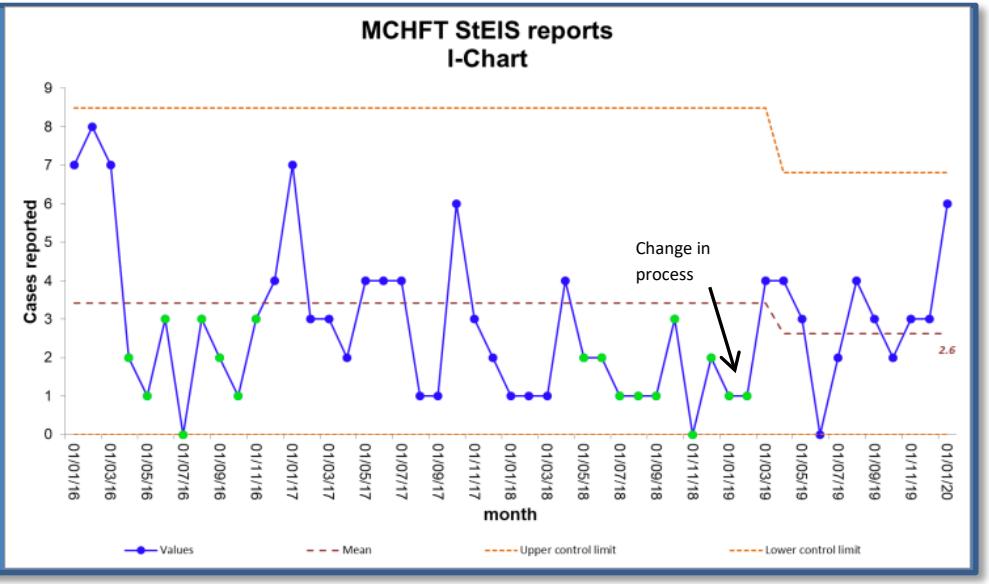
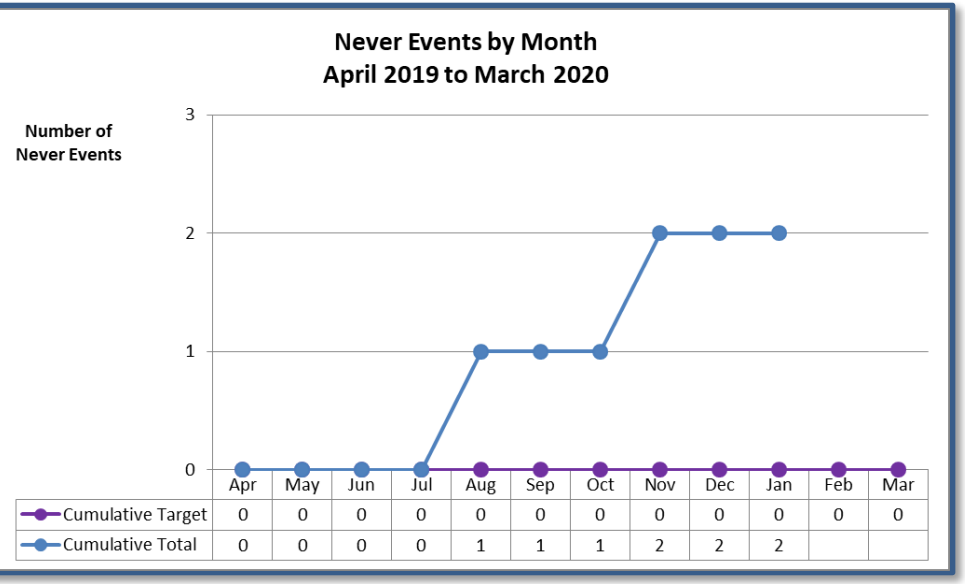
The aim is to maintain / widen the gap between harm and all patient safety incidents reported

Definitions:

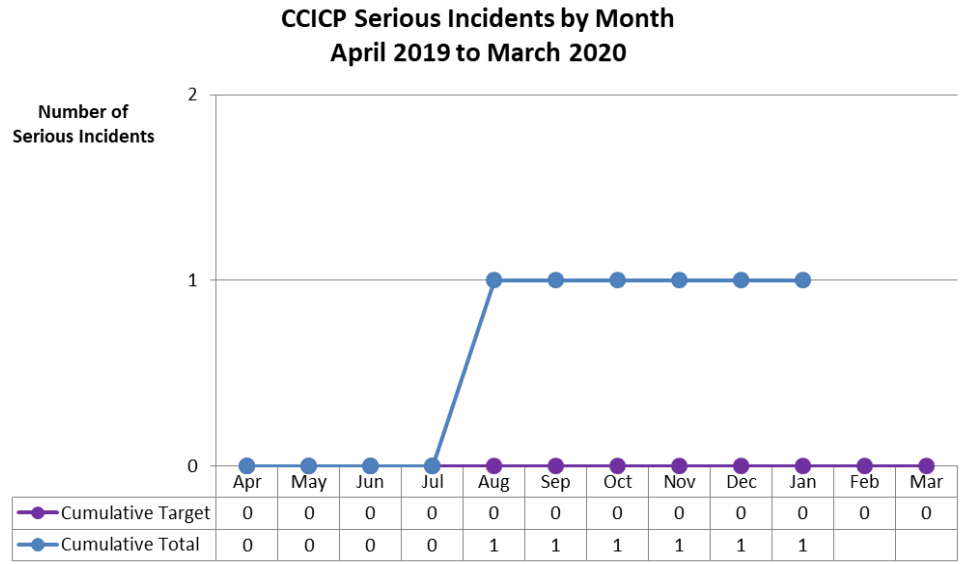
- *Moderate Harm* – any incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm to one or more persons as a direct result of the incident.
- *Major Harm* – any incident that has resulted in permanent harm as a direct result of the incident.
- *Catastrophic* – any incident that directly resulted in the death of one or more persons as a direct result of the incident.



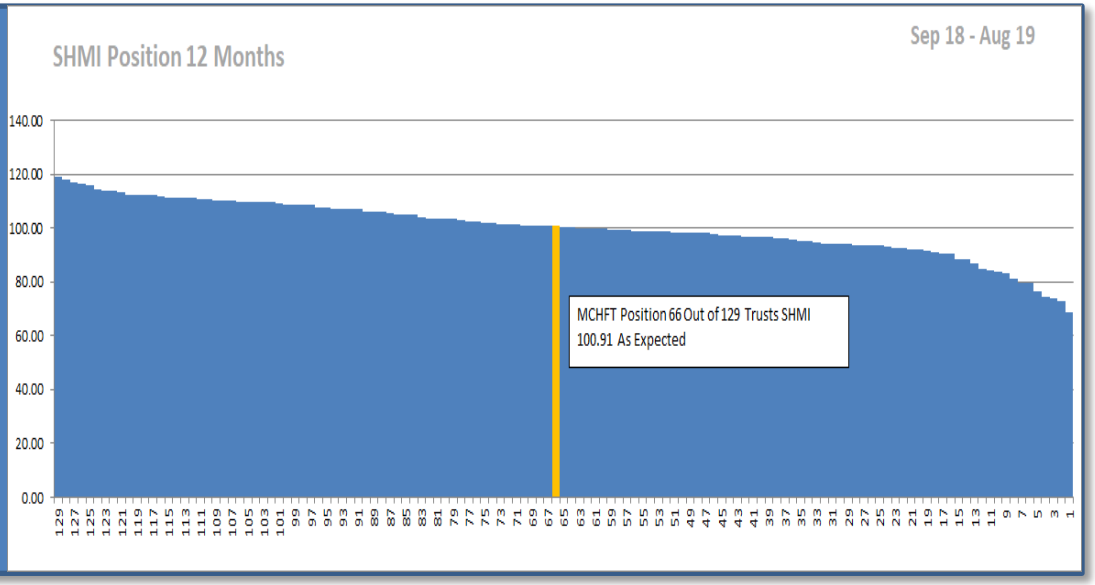
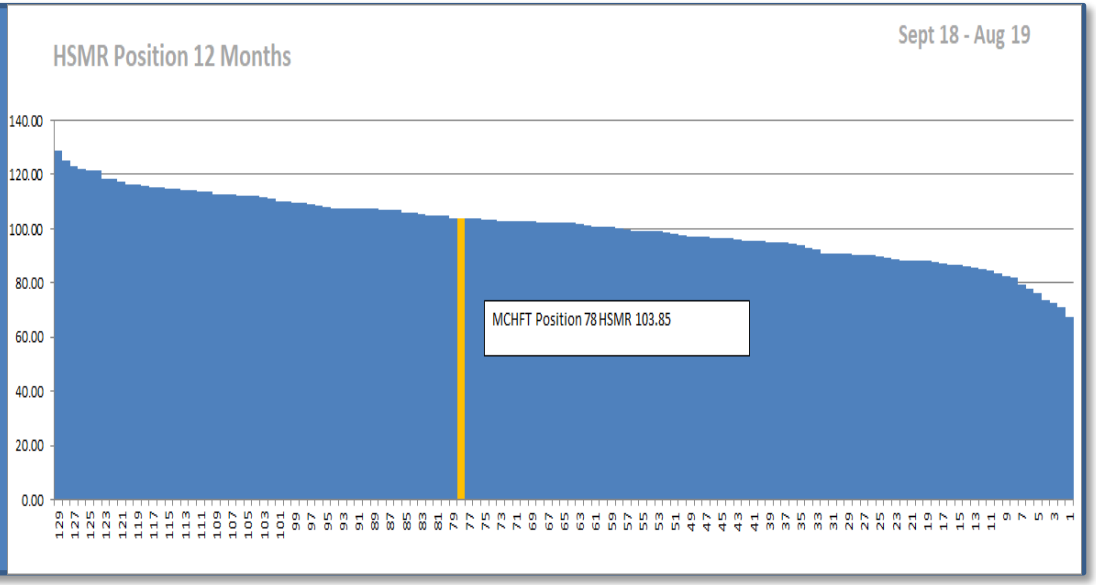
Description	Aggregate Position	Trend
CCICP Patient Safety Harm Incidents	For January 2020, there were a total of 118 patient safety harm incidents: • 97.5% (115 incidents) have resulted in low harm • 2.5% (3 incidents) have resulted in moderate harm • 0% (0 incidents) have resulted in serious harm In January 2020, the gap between harm and all patient safety incidents was 14. For the previous 3 months, October saw a gap of 28, November a gap of 11 and December a gap of 10. To reduce the number of patient safety harm incidents, a number of initiatives are being undertaken. These include: • A rolling programme of incident training continues throughout the Division and an incident reporting presentation has been developed to ensure that consistent information is cascaded across all staff groups within CCICP. The presentation includes examples of incidents and grading of harm, how to complete an incident form, levels of investigation and duty of candour.	
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. reported*		

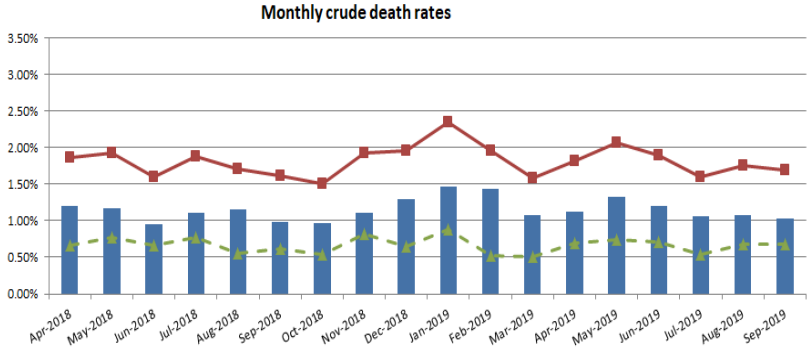
Description	Aggregate Position	Trend
Acute Trust StEIS Reported Incidents	In January 2020, there were 6 incidents reported to StEIS. • A patient fall resulting in a fractured neck of femur • A patient fall resulting in a head injury • Unexpected death x 3 • Surgical complication	
Never Events *The target is to have zero Never Events*	This chart demonstrates the number of Never Events that have been reported. The total for 2019/20 is 2: • Retained foreign object post-operation –August 2019 • Wrong site implant – November 2019	

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative Target	0	0	0	0	0	0	0	0	0	0	0	0
Cumulative Total	0	0	0	0	1	1	1	2	2	2		

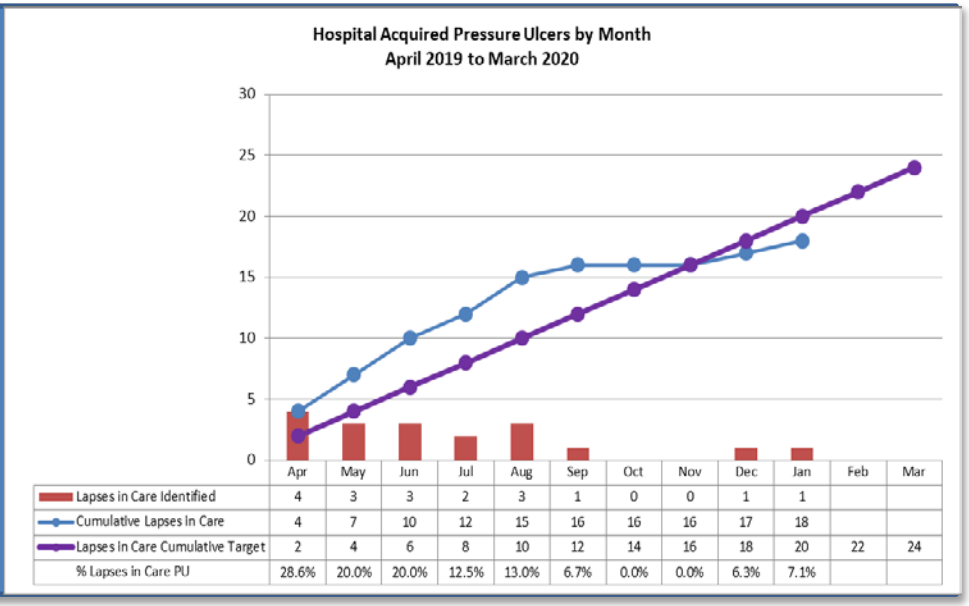
Description	Aggregate Position	Trend
CCICP Serious Incidents *The target is to continue the trend of having zero CCICP patient safety serious by the end of March 2020.*	This chart demonstrates the number of incidents that have resulted in serious harm. For January 2020, there were no serious incidents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

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative Target	0	0	0	0	0	0	0	0	0	0	0	0
Cumulative Total	0	0	0	0	1	1	1	1	1	1		

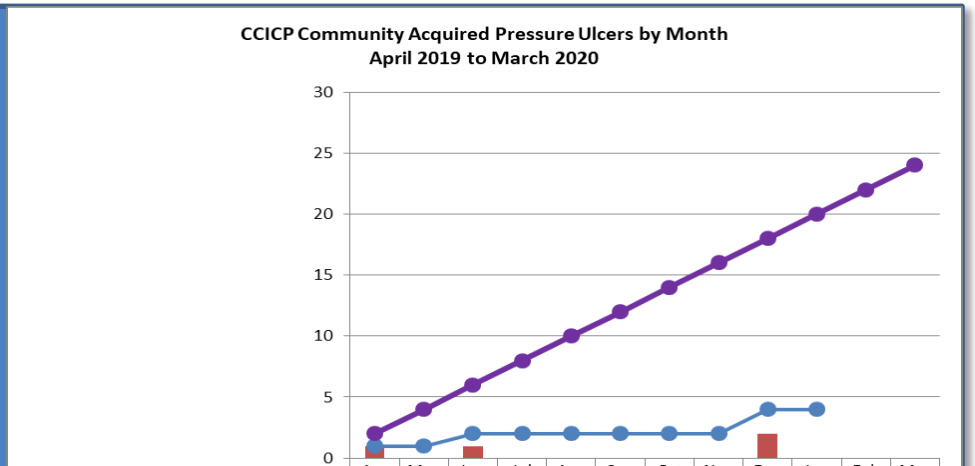
Description	Aggregate Position	Trend
SHMI *12 month rolling position Summary Hospital-Level Mortality Indicator (SHMI) by Trust.*	The chart shows the SHMI and rank of MCHFT for each of the 12 month rolling position submissions for the period September 2018 to August 2019 and is "as expected". The Trust's current position is 66 out of 129 Trusts with SHMI at 100.91.	
Hospital Standardised Mortality Rate (HSMR) by Trust. *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 September 2018 to August 2019 and is "as expected". The Trust's current position is 78 out of 129 Trusts with HSMR at 103.85.	

Description	Aggregate Position	Trend
Crude Death Rates	The chart shows the Trust's crude death rates. In September 2019, the in-hospital crude death rate was 1.03%. This is a decrease from 1.08% in August 2019.	

	Apr-2018	May-2018	Jun-2018	Jul-2018	Aug-2018	Sep-2018	Oct-2018	Nov-2018	Dec-2018	Jan-2019	Feb-2019	Mar-2019	Apr-2019	May-2019	Jun-2019	Jul-2019	Aug-2019	Sep-2019
In-hospital deaths crude rate	1.20%	1.17%	0.95%	1.11%	1.15%	0.99%	0.97%	1.11%	1.30%	1.47%	1.44%	1.08%	1.13%	1.32%	1.20%	1.06%	1.08%	1.03%
within 30 days discharge crude rate	0.67%	0.77%	0.66%	0.77%	0.55%	0.62%	0.54%	0.82%	0.65%	0.88%	0.52%	0.51%	0.69%	0.75%	0.70%	0.54%	0.67%	0.67%
in-hospital and within 30 days discharge crude rate	1.86%	1.93%	1.60%	1.88%	1.71%	1.61%	1.51%	1.93%	1.96%	2.35%	1.97%	1.58%	1.82%	2.07%	1.90%	1.61%	1.75%	1.70%
In-hospital deaths	75	79	62	77	77	64	70	77	82	103	94	76	74	92	80	78	74	70
Community deaths within 30 days discharge	42	52	43	53	37	40	39	57	41	62	34	36	45	52	47	40	46	46
Number of discharges	6,276	6,781	6,553	6,914	6,667	6,452	7,230	6,926	6,289	7,014	6,509	7,068	6,523	6,967	6,677	7,342	6,840	6,825

Description	Aggregate Position	Trend
Acute Trust Pressure Ulcers (PU) – Hospital Acquired	For January 2020, there were a total of 14 hospital acquired pressure ulcers reported. Of the 14 reported, lapses in care were identified for two pressure ulcers. These cases will be presented at the Pressure Ulcer Panel. Improvement actions include; • The Pressure Ulcer Panel continues to meet monthly chaired by the Deputy Director of Nursing. All developed in care skin damage is reviewed including no lapses in care to identify themes, trends and lessons learned. • Production and circulation of an aid memoir to support staff to prevent Moisture Associated skin damage. • Links to React to Red eLearning module have been shared across the organisation.	

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Lapses in Care Identified	4	3	3	2	3	1	0	0	1	1		
Cumulative Lapses In Care	4	7	10	12	15	16	16	16	17	18		
Lapses In Care Cumulative Target	2	4	6	8	10	12	14	16	18	20	22	24
% Lapses in Care PU	28.6%	20.0%	20.0%	12.5%	13.0%	6.7%	0.0%	0.0%	6.3%	7.1%		

	Description	Aggregate Position	Trend
CCICP Pressure Ulcers – Community Acquired	For January 2020, there were a total of 76 community acquired pressure ulcers reported. Of the 76 reported, there are no pressure ulcers as a result of lapses in care. Improvement actions include: • The Tissue Viability Team continues to attend the North West Pressure Ulcer Steering Group meetings to discuss 'Best Practice' and implement new policies and guidelines and information on pressure ulcer prevention to minimise variation in care practice. • The Tissue Viability Team attended the Road show at Richmond Village raising awareness of pressure injury and prevention across the organisation.	

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Lapses in Care Identified	1	0	1	0	0	0	0	0	2	0		
Cumulative Total	1	1	2	2	2	2	2	2	4	4		
Lapses in Care Cumulative Target	2	4	6	8	10	12	14	16	18	20	22	24
% Avoidable PU	1.2%	0.0%	1.6%	0.0%	0.0%	0.0%	0.0%	0.0%	2.6%	0.0%		

Description	Aggregate Position	Trend

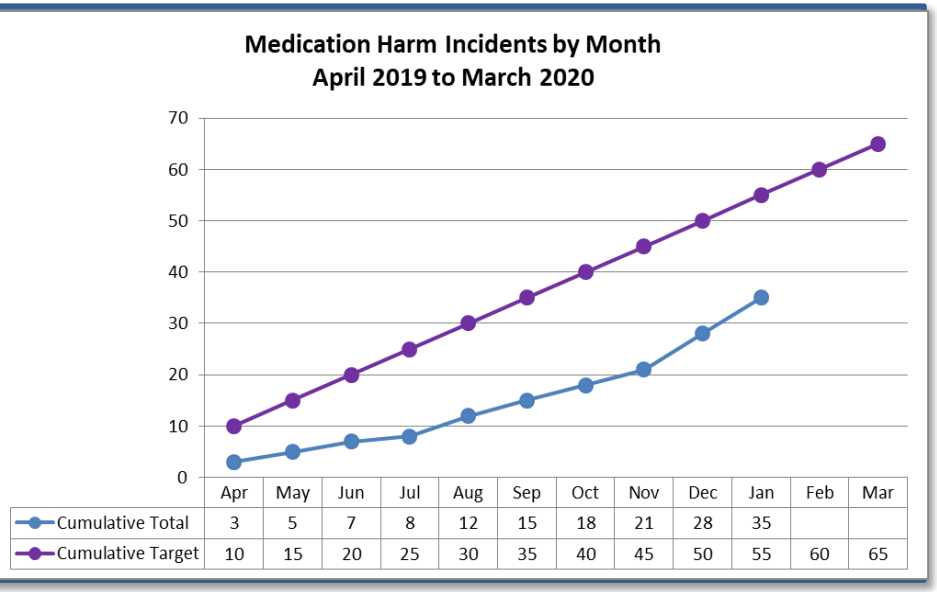
Acute Trust Medication Harm Incidents

For January 2020, there were a total of 7 medication incidents resulting in harm reported:

- 100% (7 medication incidents) have resulted in low harm
- 0% (0 medication incidents) resulted in moderate harm
- 0% (0 medication incidents) resulted in serious harm

Improvement actions include:

- Junior medical staff training and E-learning package is in place
- Medicines management training for registered 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	8	12	15	18	21	28	35		
Cumulative Target	10	15	20	25	30	35	40	45	50	55	60	65

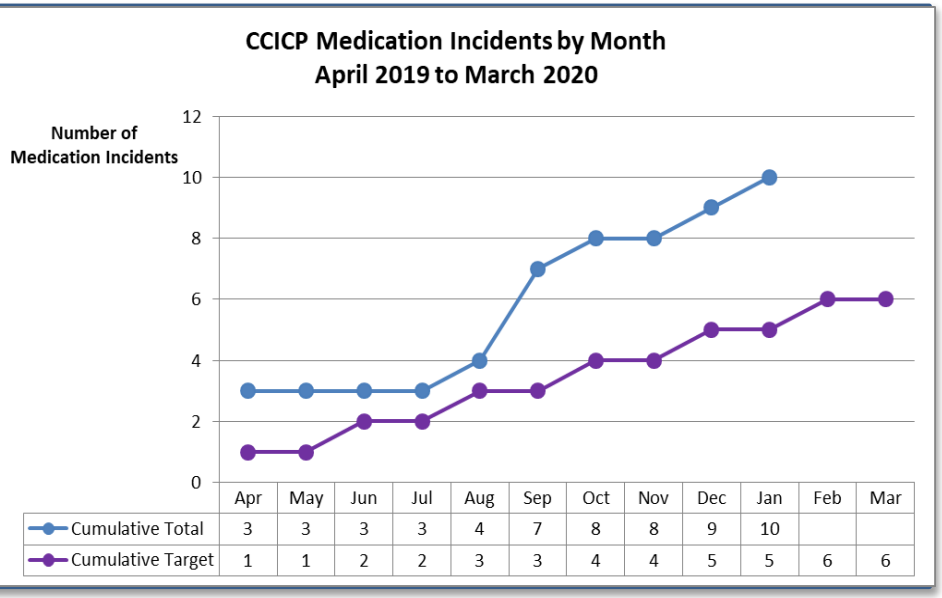
CCICP Medication Harm Incidents.

For January 2020, there was one medication incident reported resulting in harm:

- 100% (1 medication incidents) resulted in low harm
- 0% (0 medication incidents) have resulted in moderate harm
- 0% (0 medication incidents) have resulted in serious harm

Improvement actions include;

- A CCICP Medication Incident Report has been produced for review and discussion at IGG to identify themes and lessons learnt
- A review of practice in GPOOH has been undertaken with positive results around reconciliation of medicines.



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

Description	Aggregate Position	Trend

Inpatient Falls.

In January 2020, there were a total of 23 falls with harm.

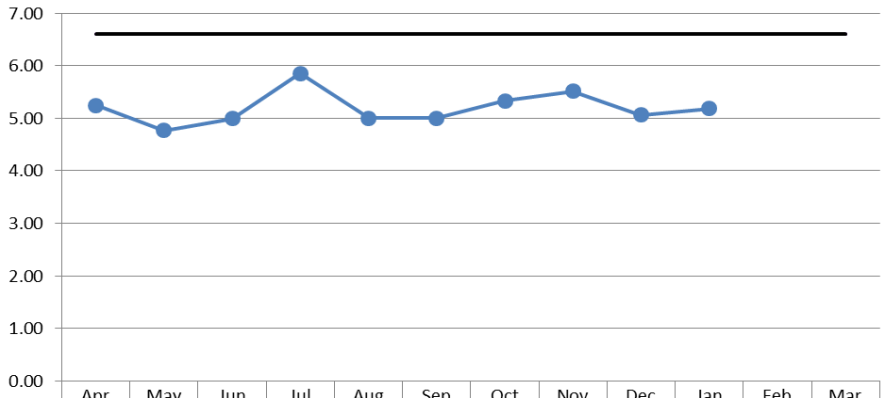
- 87.1% (20) resulting in low harm
- 4.3% (1) resulting in moderate harm
- 4.3% (1) resulting in major harm
- 4.3% (1) resulted in catastrophic harm

Improvement actions include:

- An additional working group has been established to support attainment of the Falls CQUIN 19/20 – Three high impact actions to prevent Hospital Falls. The group has multidisciplinary and cross divisional representation inclusive of representation from the Quality Improvement Team and provides updates to the falls group.
- A Task and Finish Group is being formed to review the Inpatient Falls Prevention Policy and Falls Risk Assessment tool.
- A thematic analysis of low and no harms is being undertaken to strengthen the Trusts learning of preventing falls with harm
- A thematic analysis of falls resulting in fractured NoFs has been undertaken – this is being used to support the learning from all falls with harm – a rapid response alert has been distributed to ensure all staff understood when to reassess a patients falls risk.

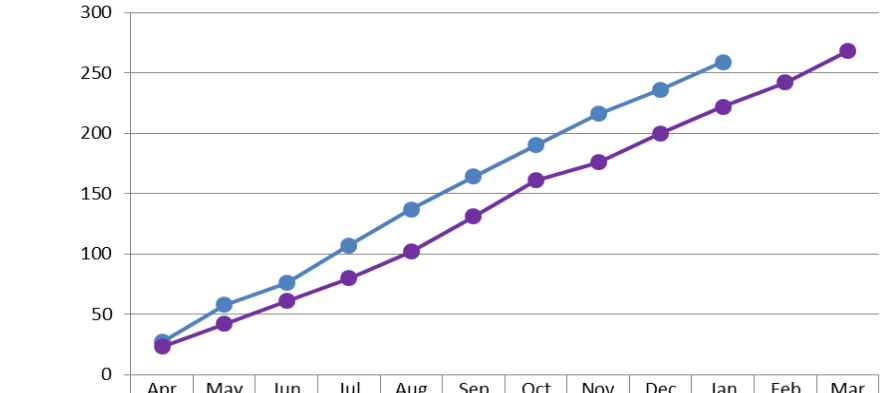
The falls rate per 1,000 bed days was 5.18

Inpatient Falls Rate Per 1,000 Bed Days & Month
April 2019 to March 2020

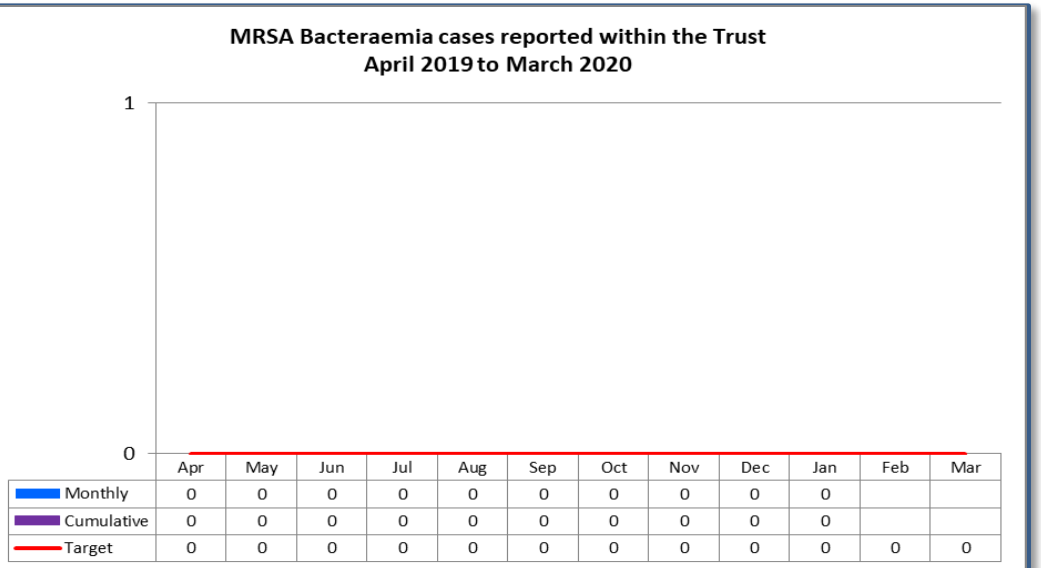


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target	6.60	6.60	6.60	6.60	6.60	6.60	6.60	6.60	6.60	6.60	6.60	6.60
Rate 2019/20	5.24	4.76	4.99	5.85	5.00	5.00	5.33	5.51	5.06	5.18		

Inpatient Falls Resulting In Harm by Month
April 2019 to March 2020

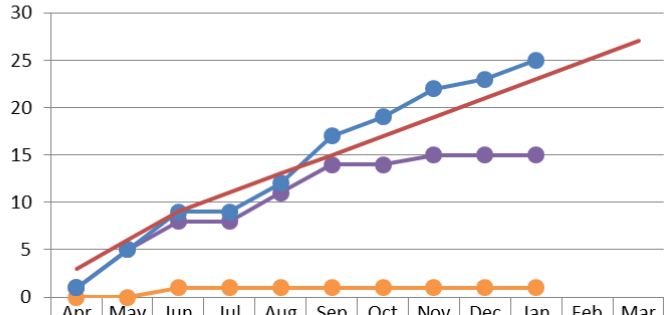


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative 2019/20	27	58	76	107	137	164	190	216	236	259		
Cumulative 2018/19	23	42	61	80	102	131	161	176	200	222	242	268

Description	Aggregate Position	Trend
MRSA Bacteraemia Cases. *Zero tolerance of MRSA cases.*	In January 2020 there were no MRSA bacteraemia cases reported in the Trust. In this financial year there have been no confirmed MRSA bacteraemia cases to date.	

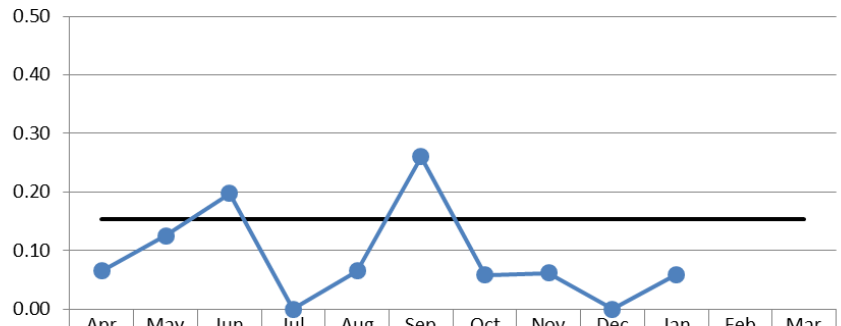
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Monthly	0	0	0	0	0	0	0	0	0	0		
Cumulative	0	0	0	0	0	0	0	0	0	0		
Target	0	0	0	0	0	0	0	0	0	0	0	0

Description	Aggregate Position	Trend
Clostridium Difficile toxin positive cases.	The target is to have 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. In January 2020, there were 2 new cases of C. Diff. One Hospital –onset hospital acquired on ward 14 One Community -onset hospital acquired on AMU To date there have been 25 cases of which one is avoidable. 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.	**Clostridium Difficile Toxin Positive Cases Report Within the Trust April 2019 to March 2020**

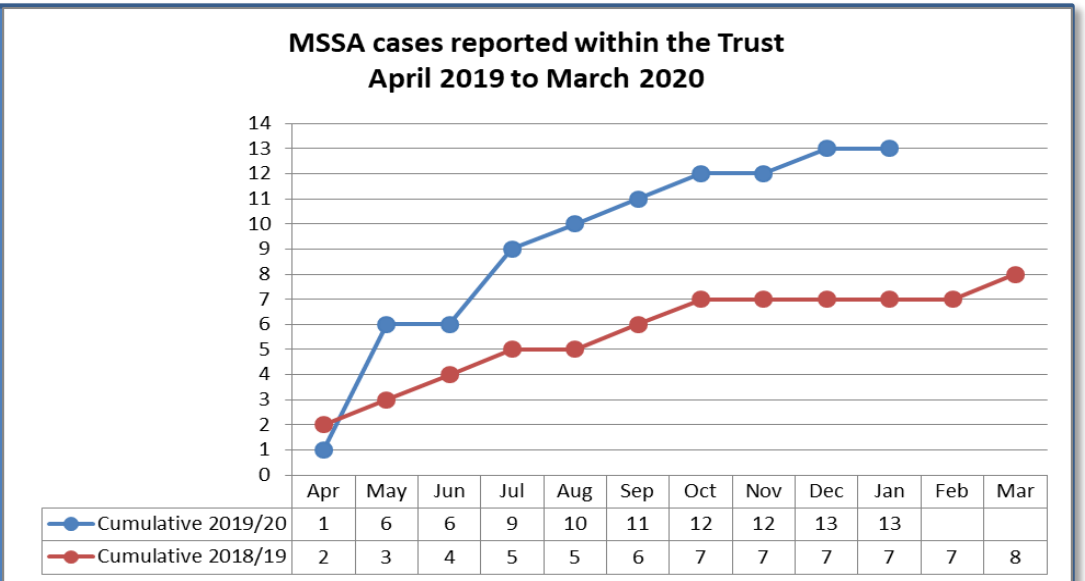


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Awaiting Confirmation in Month	0	0	0	0	0	2	2	2	1	2		
Cumulative Avoidable	0	0	1	1	1	1	1	1	1	1		
Cumulative Unavoidable	1	5	8	8	11	14	14	15	15	15		
Cumulative Total	1	5	9	9	12	17	19	22	23	25		
Cumulative Target	3	6	9	11	13	15	17	19	21	23	25	27

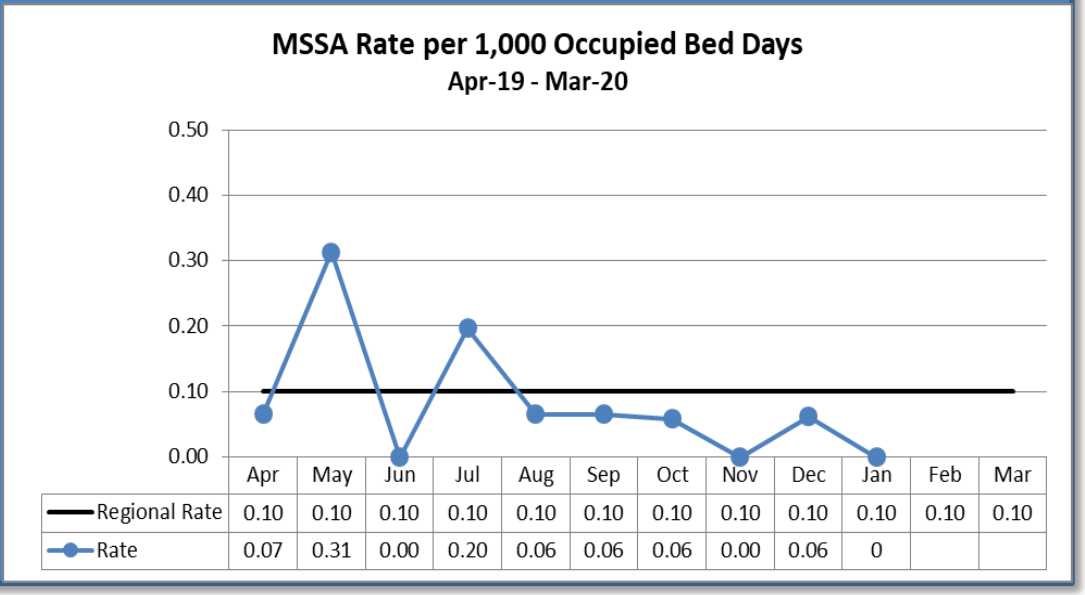
C. Diff Rate per 1,000 Occupied Bed Days
Apr-19 - Mar-20



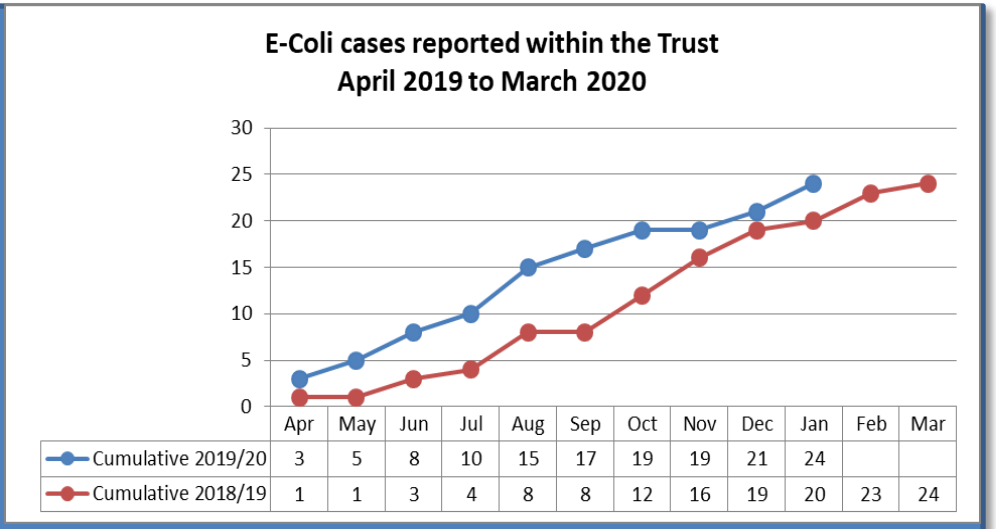
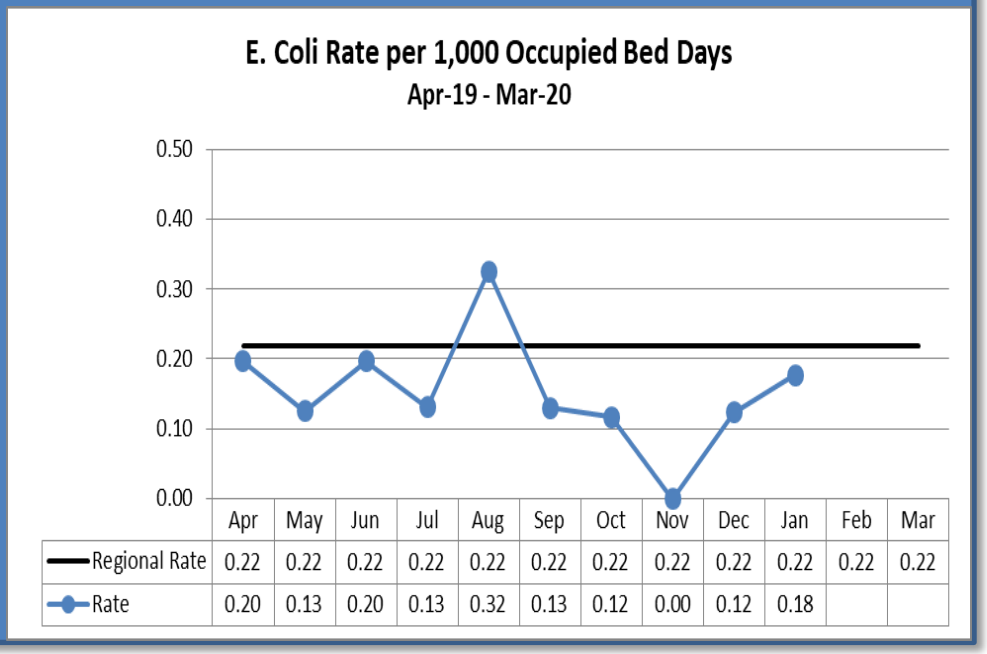
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Regional Rate	0.15	0.15	0.15	0.15	0.15	0.15	0.15	0.15	0.15	0.15	0.15	0.15
Rate	0.07	0.13	0.20	0.00	0.06	0.26	0.06	0.06	0.00	0.06		

Description	Aggregate Position	Trend
MSSA Cases.	To date in the financial year there have been 13 confirmed MSSA cases reported, all are unavoidable. The regional rate is based at 0.10. In January 2020, the rate of MSSA was 0 per 1,000 occupied bed days. In January 2020 there were no MSSA cases reported in the Trust. MSSA cases are reviewed by Consultant Microbiologist and a senior IPCP.	

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative 2019/20	1	6	6	9	10	11	12	12	13	13		
Cumulative 2018/19	2	3	4	5	5	6	7	7	7	7	7	8



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Regional Rate	0.10	0.10	0.10	0.10	0.10	0.10	0.10	0.10	0.10	0.10	0.10	0.10
Rate	0.07	0.31	0.00	0.20	0.06	0.06	0.06	0.00	0.06	0		

Description	Aggregate Position	Trend
E-Coli Cases.	In this financial year there have been 24 confirmed E-Coli cases reported. Of these cases 19 have been male, the national picture in 2018 was that slightly more females were identified as E.Coli than males. In January 2020, three E.Coli cases were reported on Ward 10 – there are no themes identified and all unavoidable. Actions to address E.Coli are; • Post infection reviews and lessons learnt • Introduction of a catheter passport across acute and community services. The regional rate for E.Coli infections is 0.22. In January, the rate of E. Coli was 0.18 per 1,000 occupied bed days.	 Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Cumulative 2019/20: 3 5 8 10 15 17 19 19 21 24 Cumulative 2018/19: 1 1 3 4 8 8 12 16 19 20 23 24  Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Regional Rate: 0.22 0.22 0.22 0.22 0.22 0.22 0.22 0.22 0.22 0.22 0.22 0.22 Rate: 0.20 0.13 0.20 0.13 0.32 0.13 0.12 0.00 0.12 0.18

CQUIN 2019-20 Performance

CQUIN & LEAD(S)	CQUIN Description	RAG Status Q1	RAG Status Q2	RAG Status Q3	RAG Status Q4	% of CQUIN	Financial Value
Prevention of Ill health							
Indicator 1a Antimicrobial Resistance – Lower Urinary Tract Infections in Older People **(minimum 60% - Maximum 90%)**	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.		 £0			Q2 = 33% Q3 = 33% Q4 = 34%	£223,517 £74,506 £74,506 £74,506
Indicator 1b Antibiotic Prophylaxis in Colorectal Surgery **(minimum 60% - Maximum 90%)**	Achieving 90% of antibiotic surgical prophylaxis prescriptions for elective colorectal surgery being a single dose and prescribed in accordance to local antibiotic guidelines.	 Partially £31,665	 Partially £40,978			Q1 = 25% Q2 = 25% Q3 = 25% Q4 = 25%	£223,517 £55,879 £55,879 £55,879 £55,879
Indicator 2 Improving the uptake of flu vaccinations for frontline clinical staff **(minimum 60% - Maximum 80%)**	Achieving an 80% uptake of flu vaccinations by frontline clinical staff.					Q4 = 100% Q4 = 100%	MCHFT £447,030 CCICP £184,318
Indicator 3a Alcohol and Tobacco Screening **(minimum 40% - Maximum 80%)**	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			Q1 = 25% Q2 = 25% Q3 = 25% Q4 = 25%	£149,011 £37,253 £37,253 £37,253 £37,253

Indicator 3b Alcohol and Tobacco – Tobacco Brief Advice **(minimum 50% - Maximum 90%)**	Achieving 90% of identified smokers given brief advice.	✓ Partially £6,054	✓ Partially £12,293			Q1 = 25% Q2 = 25% Q3 = 25% Q4 = 25%	£149,011 £37,253 £37,253 £37,253 £37,253
Indicator 3c Alcohol and Tobacco – Alcohol Brief Advice **(minimum 50% - Maximum 90%)**	Achieving 90% of patients identified as drinking above low risk levels, given brief advice or offered a specialist referral.	✓ Partially £25,425	✓ Partially £13,970			Q1 = 25% Q2 = 25% Q3 = 25% Q4 = 25%	£149,011 £37,253 £37,253 £37,253 £37,253
Patient Safety							
Indicator 7 **3 high impact actions to prevent hospital falls** **(minimum 25% - Maximum 80%)**	Achieving 80% of older inpatients receiving key falls prevention actions are met and recorded: 1. Lying and standing blood pressure recorded at least once. 2. No hypnotics or antipsychotics or anxiolytics given during stay OR rationale for giving hypnotics or antipsychotics or anxiolytics documented (British National Formulary defined hypnotics and anxiolytics and antipsychotics). 3. Mobility assessment documented within 24 hours of admission to inpatient unit stating walking aid not required OR walking aid provided within 24 hours of admission to inpatient unit.		✓ Partially £38,472			Q2 = 33% Q3 = 33% Q4 = 34%	£447,030 £149,010 £149,010 £149,010

Best Practice Pathways							
Indicator 9 Six Month Reviews for Stroke Survivors **(minimum 35% - Maximum 55%)** Community only	Achieving 55% of eligible stroke survivors receiving a six month follow up within 4-8 months of their stroke.	✓ £46,079	✓ £46,079			Q1 = 25% Q2 = 25% Q3 = 25% Q4 = 25%	£184,318 £46,079 £46,079 £46,079 £46,079
Indicator 11a Same Day Emergency Care – Pulmonary Embolus **(minimum 50% - Maximum 75%)**	Achieving 75% of patients with confirmed pulmonary embolus being managed in a same day setting where clinically appropriate.	✓ Partially £5,662	✗ £0			Q1 = 25% Q2 = 25% Q3 = 25% Q4 = 25%	£149,011 £37,253 £37,253 £37,253 £37,253
Indicator 11b Same Day Emergency Care – Tachycardia with Atrial Fibrillation **(minimum 50% - Maximum 75%)**	Achieving 75% of patients with confirmed atrial fibrillation being managed in a same day setting where clinically appropriate.	✓ Partially £14,156	✓ Partially £7,451			Q1 = 25% Q2 = 25% Q3 = 25% Q4 = 25%	£149,011 £37,253 £37,253 £37,253 £37,253
Indicator 11 c Same Day Emergency Care – Community Acquired Pneumonia **(minimum 50% - Maximum 75%)**	Achieving 75% of patients with or confirmed Community Acquired Pneumonia should be managed in a same day setting where clinically appropriate.	✗ £0	✗ £0			Q1 = 25% Q2 = 25% Q3 = 25% Q4 = 25%	£149,011 £37,253 £37,253 £37,253 £37,253
Specialist Commissioning - Hospital Pharmacy Transformation and Medicines Optimisation							
1. **Chemotherapy Waste** 2. **Best Value Medicine2**	Information below. Not required by NHSE until Sep 19	✓ ✓ £9,670	✓ ✓ £9,670			Q1 = 25% Q2 = 25% Q3 = 25% Q4 = 25%	£38,680 £9,670 £9,670 £9,670 £9,670

All Schemes	Achieved	Target	Variance
Q1	£175,965	£335,146	-£159,181
Q2	£206,166	£558,663	-£352,497
Total to date	£382,131	£893,809	-£511,678

Status:

Achieved in Quarter

Failed in Quarter

Milestones not set for this quarter

Data not available yet

No payment available for this quarter

Partially achieved

On Track

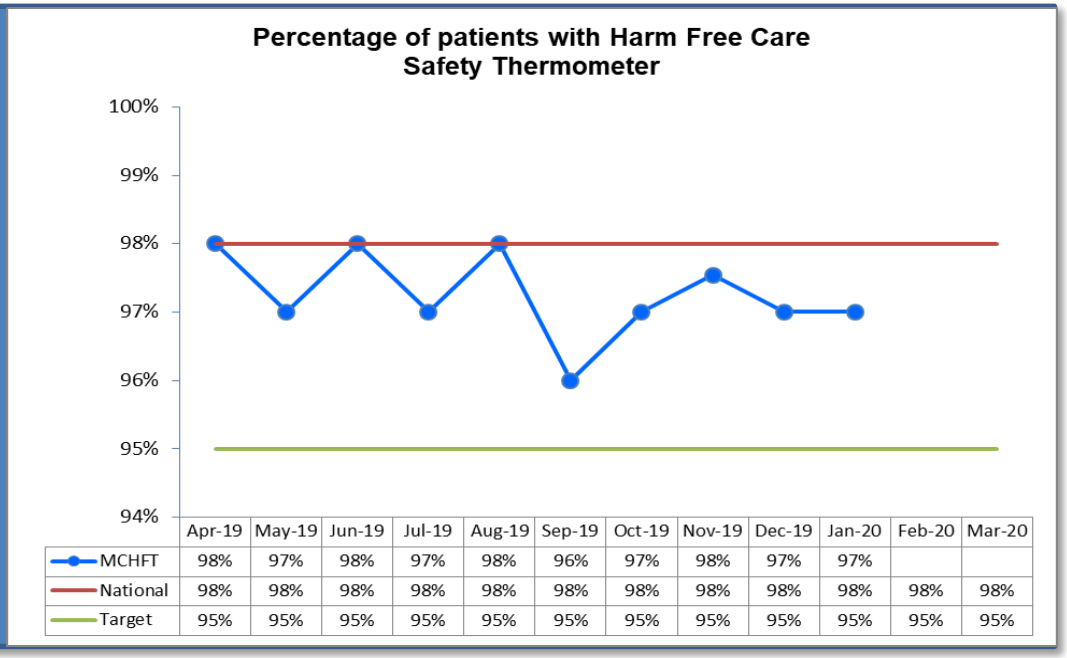
Description	Aggregate Position	Trend

Safety Thermometer - Harm Free Care.

In January 2020, 97% of patients received harm free care as measured by the point prevalence Safety Thermometer.

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

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



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

Board Papers – Quality, Safety & Experience Section: March 2020

Description	Aggregate Position		Trend
Registered Nurses monthly expected hours by shift versus actual monthly hours per shift. Day time shifts only	88.2% of expected Registered Nurse hours were achieved for day shifts. Any registered nurse numbers that fall below 85% are required to have a divisional review and an update of actions provided to the Director of Nursing & Quality and the Deputy Director of Nursing & Quality.	Trend **January 2020: 88.2%** December 2019: 86.97% November 2019: 87.9%	The lowest staffing levels during the day were on CAU at 74.4%
Registered Nurses monthly expected hours by shift versus actual monthly hours per shift. Night time shifts only	92.4% of expected Registered Nurse hours were achieved for night shifts.	Trend **January 2020: 92.4%** December 2019: 89.53% November 2019: 93.9%	The lowest staffing levels during the night were on Ward 5 at 75.1%
Healthcare Assistant monthly expected hours by shift versus actual monthly hours per shift. Day time shifts only	89.7% of expected HCA hours were achieved for day shifts.	Trend **January 2020: 89.7%** December 2019: 88.04% November 2019: 89.7%	The lowest staffing levels during the day were on NICU at 55.4%
Healthcare Assistant monthly expected hours by shift versus actual monthly hours per shift. Night time shifts only	93.5% of expected HCA hours were achieved for night shifts. For areas with over 100% staffing levels for HCA's this is reviewed and is predominately due to wards requiring 1 to 1 specials for patients following a risk assessment or to increase staffing numbers when there are registered nursing gaps that are not filled.	Trend **January 2020: 93.5%** December 2019: 95.36% November 2019: 94.7%	The lowest staffing levels during the night were on Ward 12 at 72.0%
Total number of wards that are lower than 85% RN fill days and nights is 8.	CAU 74.4% (day), Ward 10 75.8% (day), Ward 11 83.6% (day), Ward 21B 81.8% (day), NICU 83.6% (night), Ward 4 83.3% (day), Ward 5 82.7% (day) 75.1% (night), Ward 6 80.2% (night)	• Actions taken: Staffing reviewed on daily basis by Matrons/HoN following Escalation process • Risk assessments taken place to review bed occupancy and patient acuity before transferring staff	

Board Papers – Quality, Safety & Experience Section: March 2020

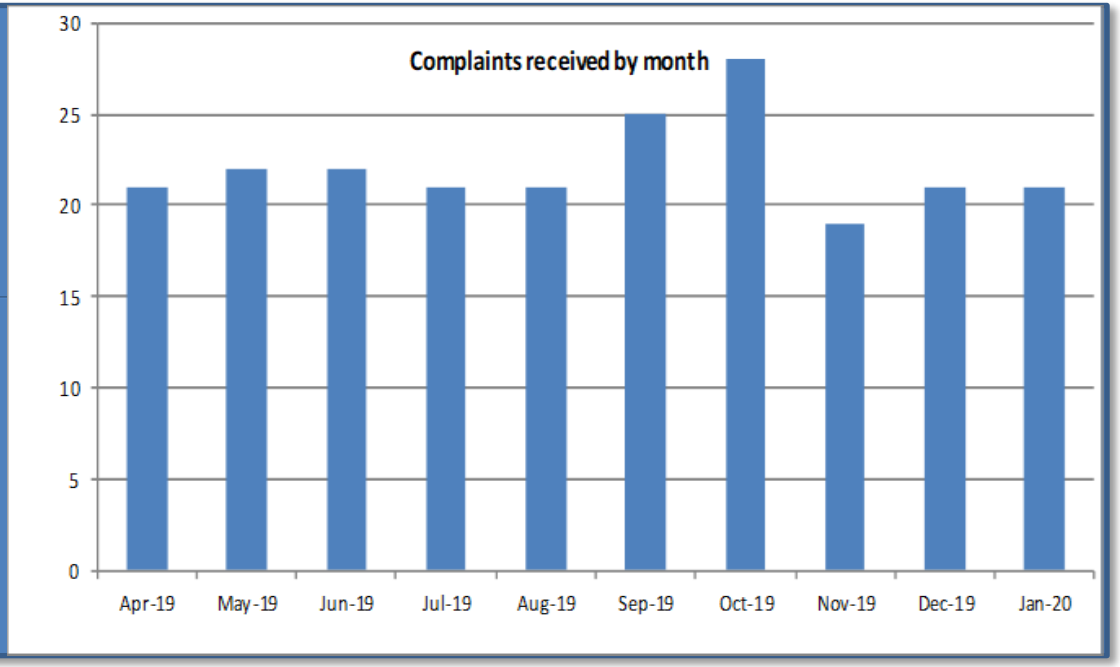
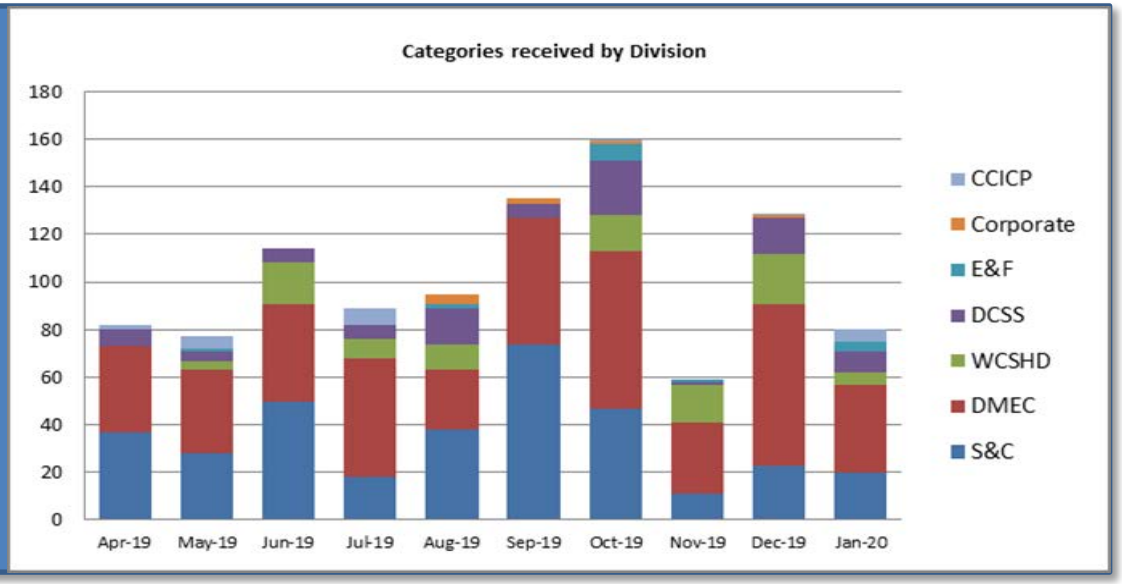
Ward Name	Day				Night				Day		Night		Care Hours Per Patient Day			
	Qualified		Unqualified		Qualified		Unqualified		Qualified	Unqualified	Qualified	Unqualified	Cumulative count over month of pts at 23:59 each day	Qualified	Unqualified	Overall
	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Fill Rate	Fill Rate	Fill Rate	Fill Rate				
MCHFT	43018.5	37930.3	41023.0	36778.1	30600.8	28279.7	24955.1	23321.7	**88.2%**	**89.7%**	**92.4%**	**93.5%**	**17421**	**175.9**	**80.7**	**256.8**
Acute Medical Unit	1747.00	1567.25	2344.50	2276.50	1872.00	1722.50	1512.00	1512.00	89.7%	97.1%	92.0%	100.0%	841	3.9	4.5	8.4
CAU	3299.00	2453.42	1337.58	1163.17	1840.00	1719.08	368.00	321.50	74.4%	87.0%	93.4%	87.4%	460	9.1	3.2	12.3
Critical Care Unit	4098.00	3629.00	732.00	620.80	3792.00	3558.75	0.00	0.00	88.6%	84.8%	93.8%		272	26.4	2.3	28.7
Elmhurst	742.50	745.00	2226.00	2148.50	744.00	745.00	1500.00	1488.00	100.3%	96.5%	100.1%	99.2%	914	1.6	4	5.6
Ward 1 Coronary Care	2129.50	1990.25	1350.00	1200.00	1548.00	1427.00	864.00	826.75	93.5%	88.9%	92.2%	95.7%	951	3.6	2.1	5.7
Ward 10 Ortho Trauma	2499.00	1893.50	2895.25	3019.75	1116.00	1055.50	1856.50	1664.50	75.8%	104.3%	94.6%	89.7%	1146	2.6	4.1	6.7
Ward 12 SAU	1340.00	1200.50	1487.00	1336.00	744.00	731.50	840.00	783.00	89.6%	89.8%	98.3%	93.2%	401	4.8	5.3	10.1
Ward 13 Vascular & Colorectal	1888.00	1621.75	2190.00	2076.00	1164.00	1127.50	1164.00	1128.00	85.9%	94.8%	96.9%	96.9%	976	2.8	3.3	6.1
Ward 14 Gastroenterology	1390.50	1338.83	2112.00	1998.00	1183.75	1058.25	1368.00	1284.00	96.3%	94.6%	89.4%	93.9%	953	2.5	3.4	6
Ward 11 Female Ward	1784.98	1492.98	1903.00	1830.50	1140.00	1054.00	1344.00	1176.00	83.6%	96.2%	92.5%	87.5%	950	2.7	3.2	5.8
Ward 12 SSW	1149.50	1125.50	1192.00	1073.00	768.00	732.00	600.00	432.00	97.9%	90.0%	95.3%	72.0%	479	3.9	3.1	7
Ward 19 Short Stay Rehab	1385.25	1360.33	2432.25	2024.00	1272.00	1260.75	1740.00	1667.83	98.2%	83.2%	99.1%	95.9%	933	2.8	4	6.8
Ward 2 Short Stay	2115.23	1879.25	2445.42	1898.92	1236.00	1161.50	1872.00	1560.00	88.8%	77.7%	94.0%	83.3%	977	3.1	3.5	6.7
Ward 21b Rehabilitation	1134.50	928.00	2418.42	2133.42	756.00	731.50	1212.50	1044.50	81.8%	88.2%	96.8%	86.1%	744	2.2	4.3	6.5
NICU Ward 22	1730.25	1570.15	744.25	412.08	1339.75	1120.33	354.75	484.42	90.7%	55.4%	83.6%	136.6%	318	8.5	2.8	11.3
Ward 23	1116.75	1096.18	785.00	744.50	768.00	752.08	756.00	708.00	98.2%	94.8%	97.9%	93.7%	700	2.6	2.1	4.7
Ward 26 Labour	2866.00	2666.87	710.33	672.17	2184.00	2130.92	372.00	372.00	93.1%	94.6%	97.6%	100.0%	185	25.9	5.6	31.6
Midwifery Led Unit	755.50	711.17	0.00	0.00	761.25	734.75	0.00	0.00	94.1%		96.5%		29	49.9	0	49.9
Ward 4 Elderly	1718.00	1430.33	1959.50	1756.00	828.00	732.00	1496.30	1434.17	83.3%	89.6%	88.4%	95.8%	985	2.2	3.2	5.4
Ward 5 Respiratory	2320.00	1918.00	1960.00	1716.00	1596.00	1199.00	900.00	1104.00	82.7%	87.6%	75.1%	122.7%	968	3.2	2.9	6.1
Ward 6 Rehab	1774.50	1527.50	2316.00	2011.33	1560.00	1250.50	1068.00	900.00	86.1%	86.8%	80.2%	84.3%	856	3.2	3.4	6.6
Ward 7 Gastroenterology	1366.25	1332.25	2472.00	2077.00	756.00	706.00	1596.00	1476.00	97.5%	84.0%	93.4%	92.5%	954	2.1	3.7	5.9
Ward 9 Ortho Elective	1140.00	1062.00	1096.00	1042.00	756.00	720.00	779.00	646.50	93.2%	95.1%	95.2%	83.0%	448	4	3.8	7.7
Ward 15 General Medical	1528.25	1390.25	1914.50	1548.50	876.00	849.25	1392.00	1308.50	91.0%	80.9%	96.9%	94.0%	981	2.3	2.9	5.2

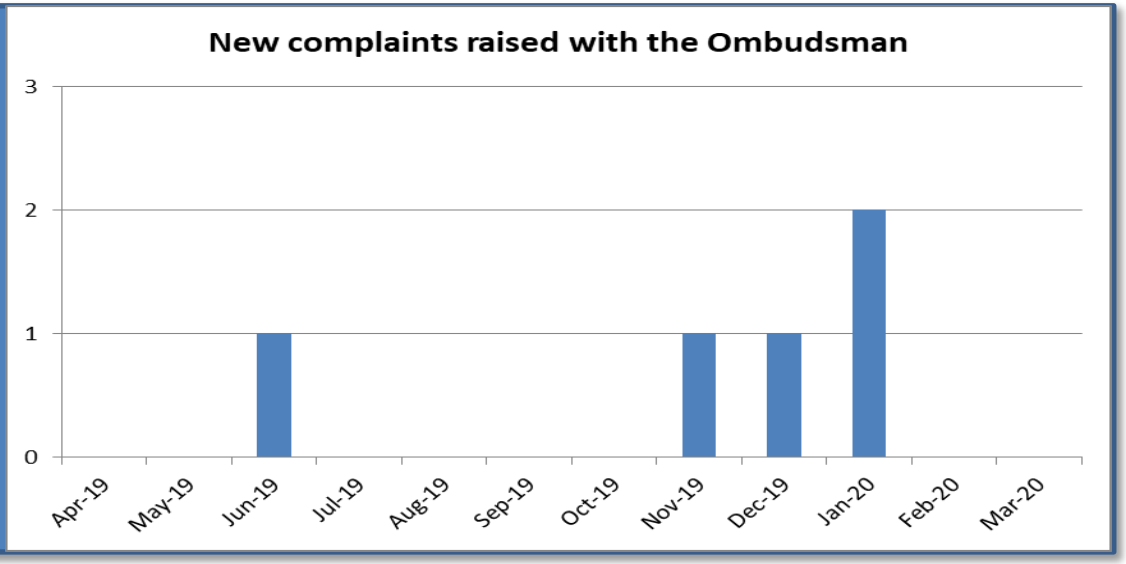
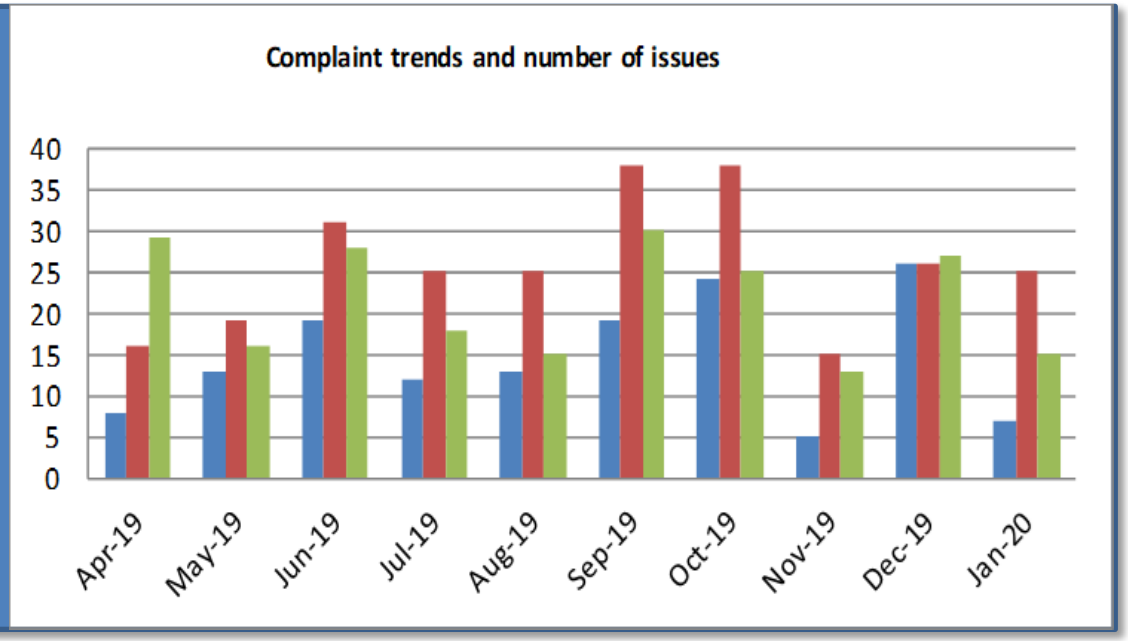
Experience Section:

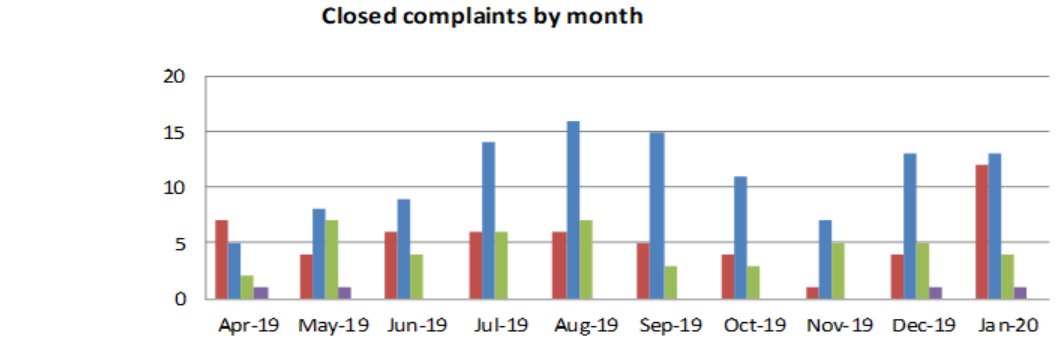
Indicators	YTD 19/20	Oct-19	Nov-19	Dec-19	Jan-20
Complaints received by month	221	28	19	21	21
Complaints being reviewed by the Ombudsman	5	0	1	1	2
Closed complaints by month	216	18	13	23	30
Contacts raising informal concerns	824	90	77	57	99
Compliments received in month	4585	449	486	999	394
Number of new claims received in month	37	2	2	0	8
Number of claims closed	31	5	3	0	2
Number of inquests concluded	8	1	2	1	0
NHS Choices - Number of new postings	64	2	11	6	5
F&FT Response Rate ED, MIU, UCC and Assessment Areas*		15%	15%	15%	16%
Proportion of positive responses ED, MIU, UCC and Assessment Areas		87%	87%	86%	89%
F&FT Response Rate Inpatients and Daycases		34%	43%	33%	33%
Proportion of positive responses Inpatients and Daycases		94%	92%	94%	95%
F&FT Response Rate Outpatients		1%	24%	14%	23%
Proportion of positive responses Outpatients		94%	94%	93%	94%
F&FT Response Rate Maternity - Birth		9%	19%	22%	13%
Proportion of positive responses Maternity - Birth		100%	100%	100%	96%
F&FT Response Rate Community (CCICP)		0%	6%	7%	11%
Proportion of positive responses Community (CCICP)		0%	93%	93%	95%

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

Board Papers – Quality, Safety & Experience Section: March 2020

Description	Aggregate Position/Description	Trend
Monthly formal complaints received by the Trust.	21 complaints were received in January 2020 which covered 80 concerns. There were also 4 re-opened complaints. The highest categories were: • Communication with 25 concerns • Medical with 15 concerns • Nursing with 7 concerns 3 areas receiving the highest numbers of complaints/issues were: • Emergency Department – 4 complaints with 12 concerns • Treatment Centre – 3 complaints with 13 concerns • Gastroenterology Medical Staff - 2 complaints with 6 concerns	
Number of formal complaint issues by division.	This graph shows the breakdown of concerns by month for each division. CCICP: 5 CORP: 0 DMEC: 37 DCSS: 9 E&F: 4 S&C: 20 W&C: 5	

Description	Aggregate Position/Description	Trend
New complaints raised with the Public Health Service Ombudsman	In January, there are two complaints at the assessment stage with the Parliamentary Health Service Ombudsman (PHSO) one for CCICP and DMEC and one for Corporate. In the last rolling 12 months we have had 4 cases with the PHSO with 3 not upheld and one partially upheld.	
Complaint trends and number of issues.	The main trends in January 2020 were:- Communication - 25 concerns raised over 16 complaints. 9 of these concerns were related to communication with patients face to face. Medical Care - 15 concerns raised over 12 complaints. 6 of these concerns related to medical adverse outcome. Nursing Care - 7 concerns raised over 6 complaints. 4 of these concerns related to nursing other.	

Description	Aggregate Position/Description	Trend
Closed Complaints	In January 2020, 30 complaints were closed, 3 of which were re-opened complaints and 1 withdrawn complaint.	

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20
Upheld	7	4	6	6	6	5	4	1	4	12
Partially Upheld	5	8	9	14	16	15	11	7	13	13
Not upheld	2	7	4	6	7	3	3	5	5	4
Withdrawn	1	1	0	0	0	0	0	0	1	1
Referred to HR	0	0	0	0	0	0	0	0	0	0

Closed complaints by Division

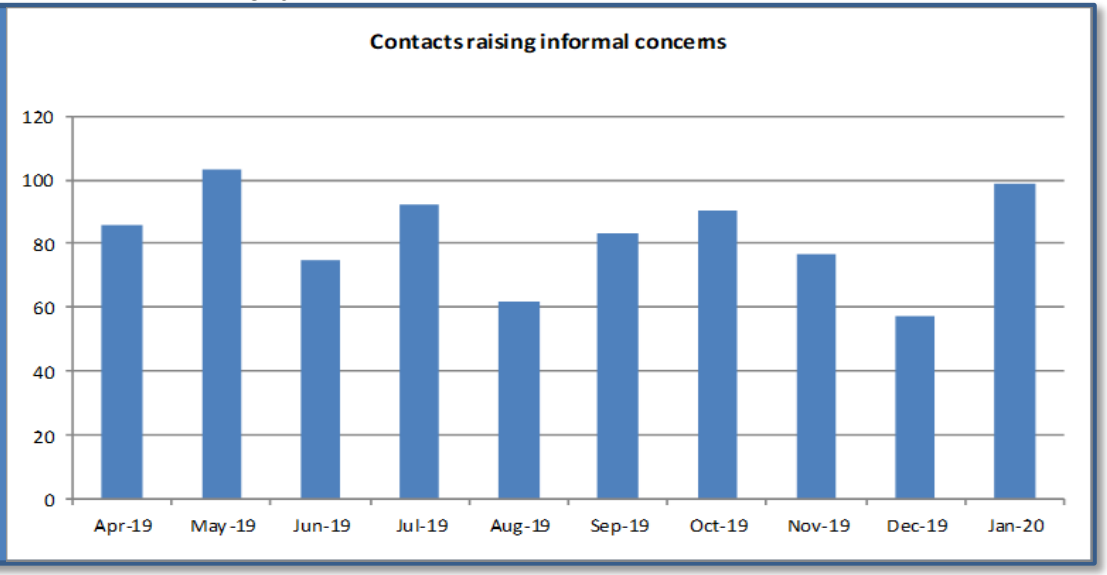
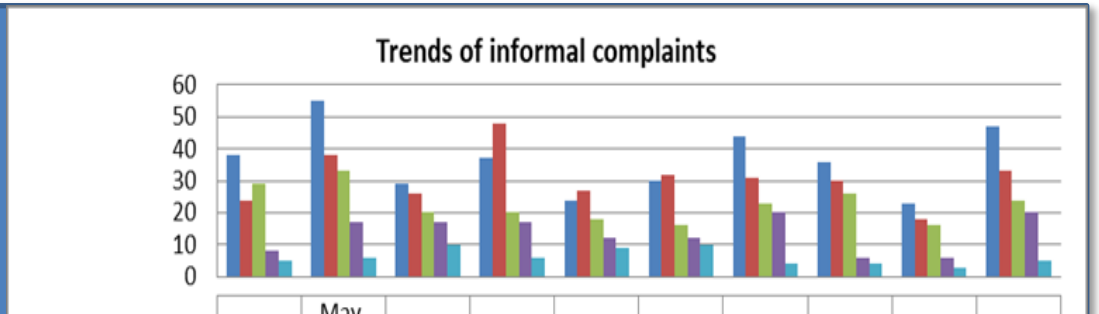
The table provides a breakdown of closed complaints for January 2020 by division.

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

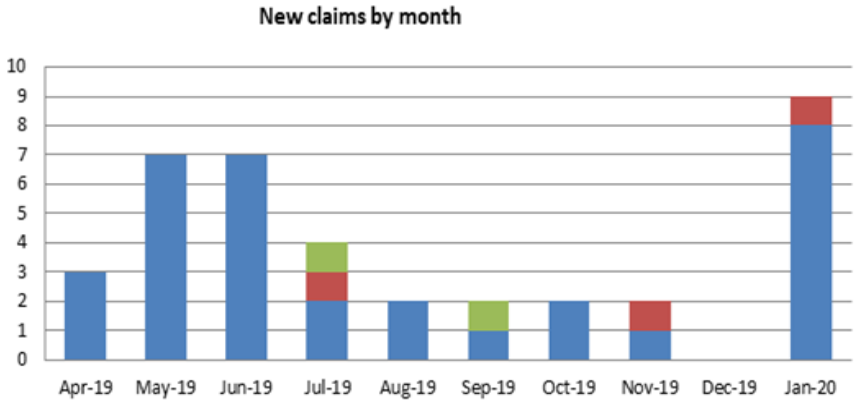
Division	Upheld	Partially Upheld	Not Upheld	Withdrawn	Ref HR	Sub-Total
DMEC	7	7	3	1	0	18
Corporate	1	0	0	0	0	1
Surgery & Cancer	2	3	1	0	0	6
Women & Children's	0	1	0	0	0	1
DCSS	1	1	0	0	0	2
CCICP	0	1	0	0	0	1
Estates & Facilities	1	0	0	0	0	1
					Total closed =	**30**

Board Papers – Quality, Safety & Experience Section: March 2020

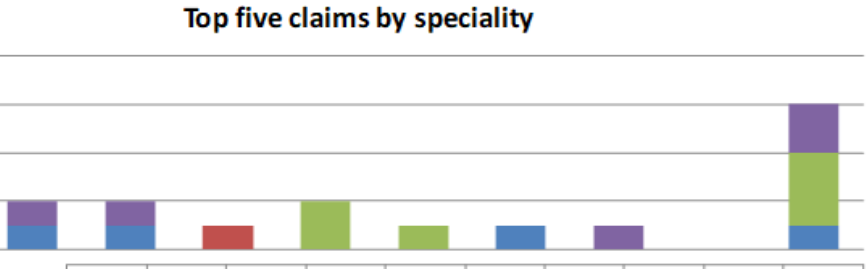
Closed Complaints December 2019 – Tables removed under Section 40 of the Freedom of Information Act.

Description	Aggregate Position/Description	Trend
Informal concerns numbers.	The number of contacts raising informal concerns for January 2020 was 99 raising 167 individual concerns. The Division of Medicine and Emergency Care received the highest number of overall concerns at 94, with the Surgery and Cancer Division receiving 33. Ward 3 and Ward 15 received the largest number of individual concerns at 10 each, raised from 6 and 5 contacts respectively.	
Informal concerns trends.	Care and communication were the highest trends for informal concerns in January 2020. <u>33 care issues raised:</u> 17 issues related to nursing care, of which 3 relate to Ward 2, Ward 5 and Ward 13 respectively. Ward 5 received the most contacts with 3. 15 issues related to medical care of which 5 belong to General Surgery, with 5 contacts. 4 issues relate to medical care other. <u>47 communication issues raised:</u> 4 issues related to ophthalmic administration.	

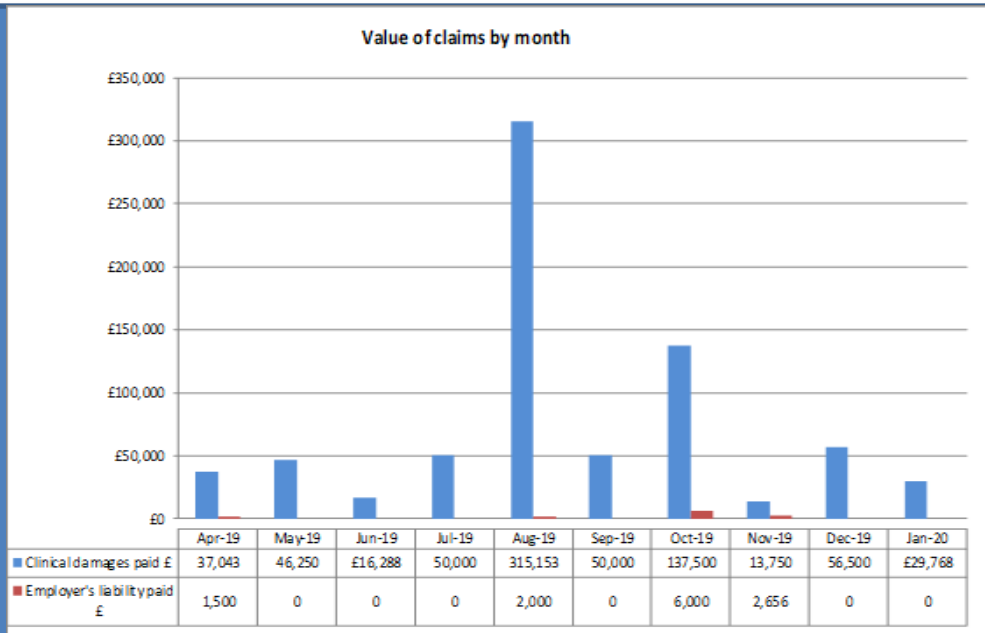
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20
Communication	38	55	29	37	24	30	44	36	23	47
Care	24	38	26	48	27	32	31	30	18	33
Appointments	29	33	20	20	18	16	23	26	16	24
Attitude of Staff	8	17	17	17	12	12	20	6	6	20
Treatment	5	6	10	6	9	10	4	4	3	5

Description	Aggregate Position/Description	Trend
New claims received.	In January 2020, 8 new clinical negligence claims were received. These related to: Medicine and Emergency Care Emergency Care Emergency Department x 3 General Medicine x 1 Women and Children Obstetrics x 2 Surgery and Cancer Orthopaedics x 1 Diagnostics and Clinical Support Services Radiology x 1 1 new employer's liability claim was received which related to Surgery and Cancer. No public liability claims were received.	

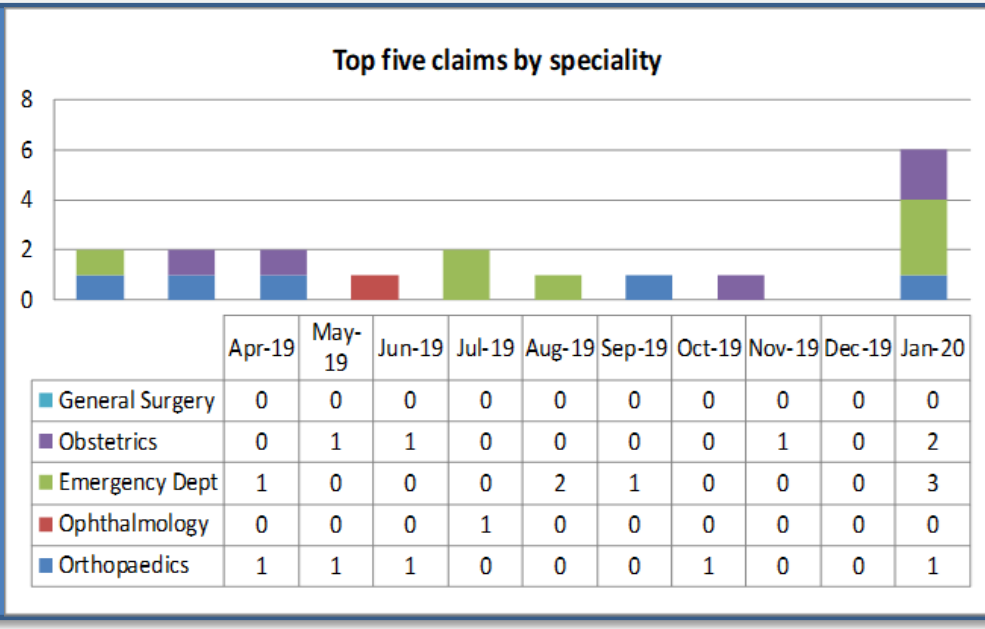
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20
Public Liability	0	0	0	1	0	1	0	0	0	0
Employer's Liability	0	0	0	1	0	0	0	1	0	1
Clinical	3	7	7	2	2	1	2	1	0	8

Claims closed with/without damages.	In January 2020 2 clinical negligence claims were closed, both of which were upheld.	

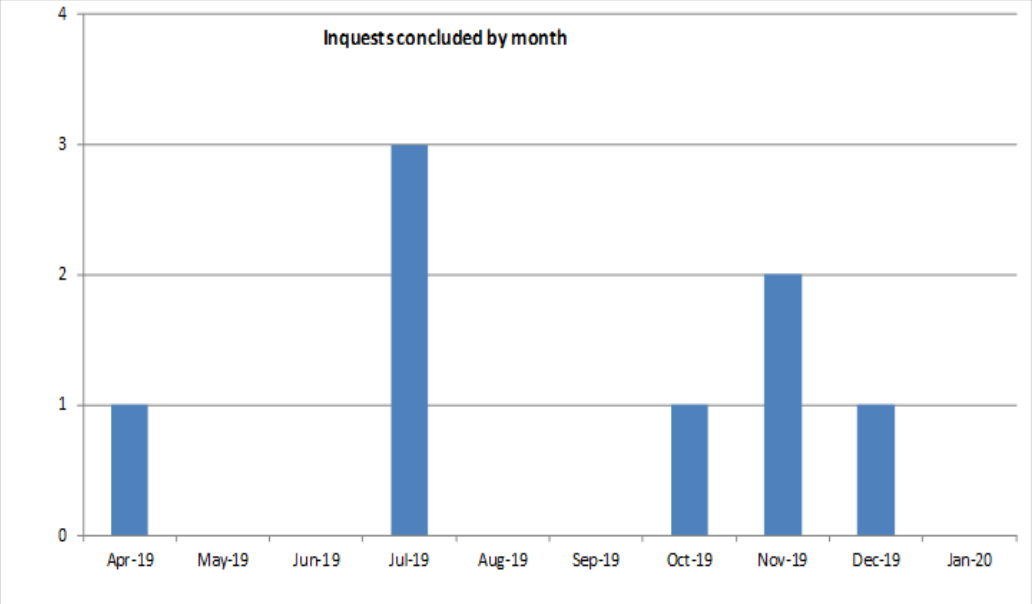
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20
General Surgery	0	0	0	0	0	0	0	0	0	0
Obstetrics	0	1	1	0	0	0	0	1	0	2
Emergency Dept	1	0	0	0	2	1	0	0	0	3
Ophthalmology	0	0	0	1	0	0	0	0	0	
Orthopaedics	1	1	1	0	0	0	1	0	0	1

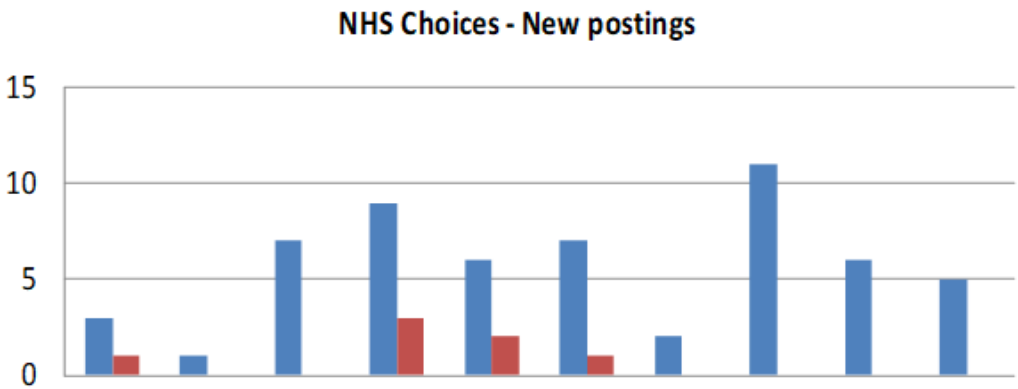
Description	Aggregate Position/Description	Trend
Value of claims closed by month	In January 2020 damages of £29,768 were paid out on 2 clinical negligence claims. Narrative removed under Section 40 of the Freedom of Information Act.	

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20
Clinical damages paid £	37,043	46,250	£16,288	50,000	315,153	50,000	137,500	13,750	56,500	£29,768
Employer's liability paid £	1,500	0	0	0	2,000	0	6,000	2,656	0	0

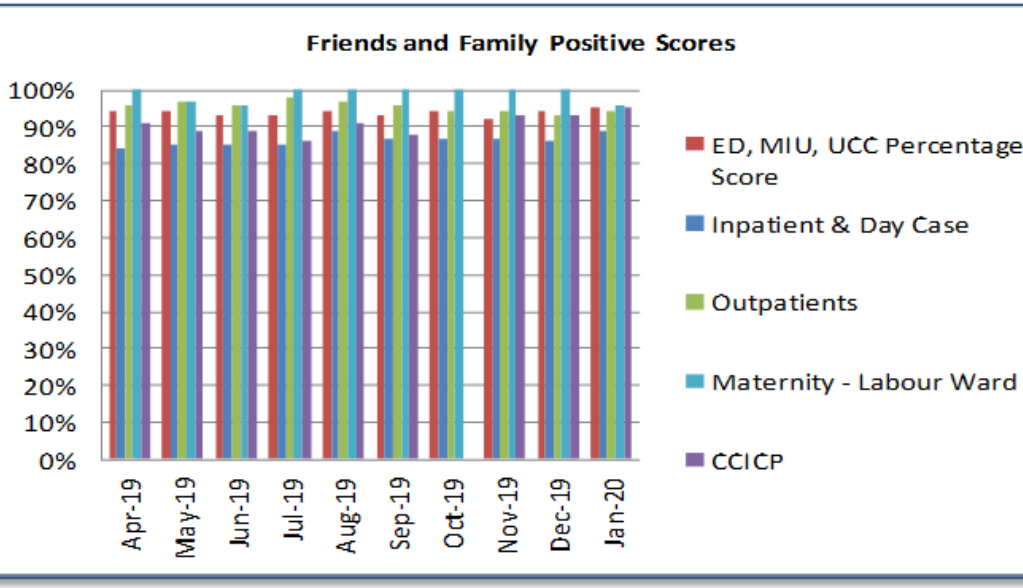
	Top five claims by Specialty	In January 2020, 6 new claims was received which relate to the Trust's top five specialties for claims. Emergency Department x 3 Obstetrics x 2 Orthopaedics Narrative removed under Section 40 of the Freedom of Information Act.	

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20
General Surgery	0	0	0	0	0	0	0	0	0	0
Obstetrics	0	1	1	0	0	0	0	1	0	2
Emergency Dept	1	0	0	0	2	1	0	0	0	3
Ophthalmology	0	0	0	1	0	0	0	0	0	0
Orthopaedics	1	1	1	0	0	0	1	0	0	1

Description	Aggregate Position /Description	Trend
Number of Inquests concluded by month	No inquests were concluded in January 2020.	

Description	Aggregate Position /description	Trend
NHS Choices postings	There were 5 postings on NHS Choices in January 2020, all of which were positive including: Gynaecology: I just want to say what lovely care I have received from a particular member of staff from gynaecology during my recent hysterectomy and appointments prior to the operation I have not had my follow up as yet but have no concerns whatsoever. General Surgery: I had the misfortune to be diagnosed with colon cancer following the return of a testing kit received as part of the cancer screening programme.. Thankfully the surgery was entirely successful. Everyone and everything during my stay at Leighton was absolutely fantastic. My heartfelt thanks to you all. VIN – Minor Injuries: Superb fast treatment. Seen immediately after booking in. Treated and discharged within 15 mins. (Minor scald). Fantastic service with delightful, caring staff. Patients must not lose this LOCAL facility.	

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20
Positive	3	1	7	9	6	7	2	11	6	5
Negative	1	0	0	3	2	1	0	0	0	0

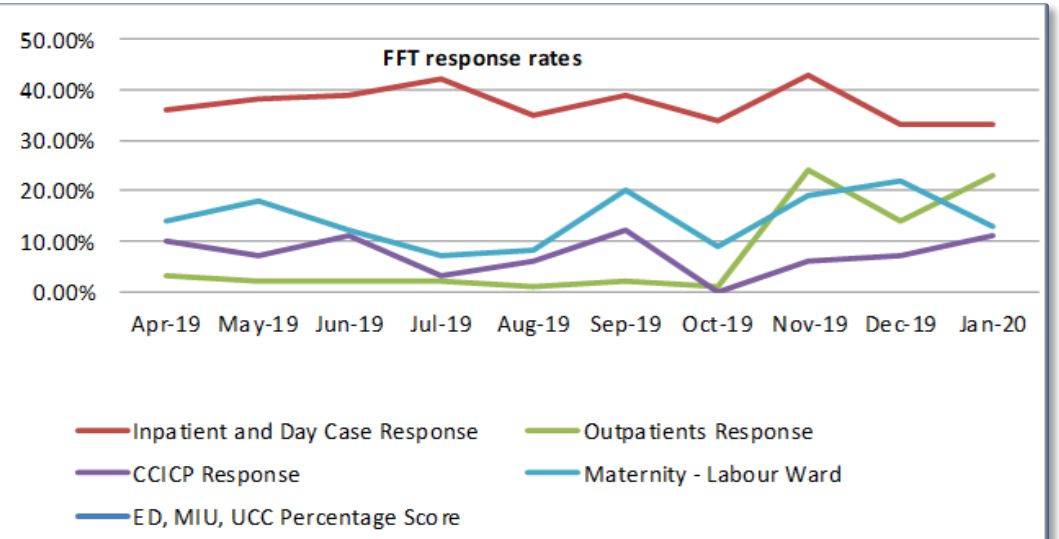
The Family and Friends Test.	In January 2020 the Trust has scored the following positive response scores: Emergency care /assessment areas 89%; Inpatients and day cases 95%; Outpatients 94%; Maternity (Labour ward) 96%; CCICP 95%	

Board Papers – Quality, Safety & Experience Section: March 2020

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

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

Ward/Dept.	% Response	Total responses received	How many would recommend
A&E , UCC & MIU	16%	1092	88%
CCICP	11%	845	95%
Inpatients & Day cases	33%	1544	95%
Maternity	13%	27	96%
Outpatients	23%	4305	94%

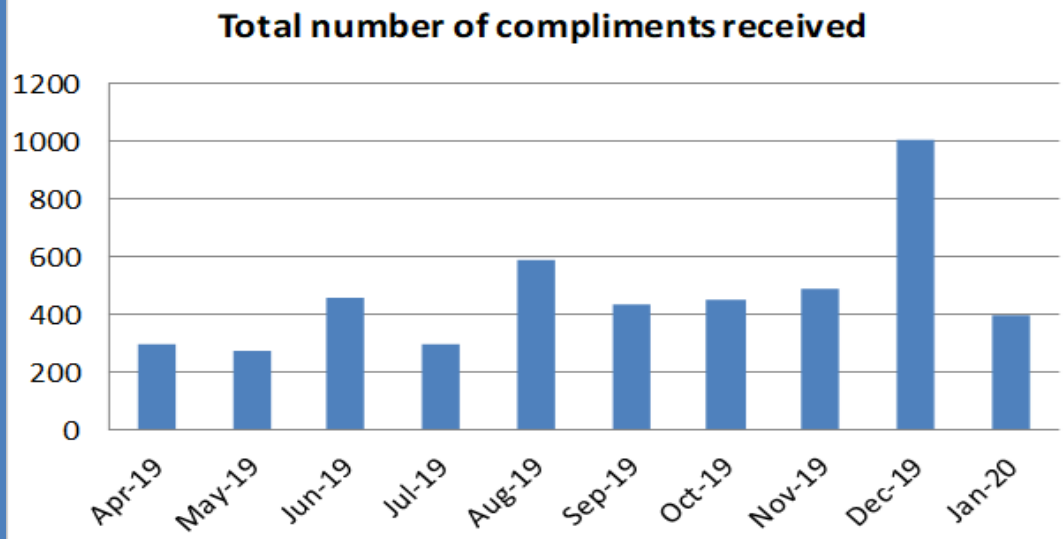


Compliments received

There were 394 compliments received in January 2020.
51 of these were logged by the Customer Care Team and 343 received across the Trust.

'I just wanted to say a big thank you from my 10 year old son and myself for the treatment he received from the team at Leighton Hospital. We went to A&E with a suspected testicular torsion and within 14 hours from arriving he had been accessed, taken down to theatre and discharged back home after a successful operation. The staff right the way through from A&E, Urology, Theatres and the Paediatric ward were fantastic, caring, attentive and making sure my son was involved and understood what was happening.

My son described it as a 5 star service to the ward sister who discharged us'!



Mid Cheshire Hospitals
NHS Foundation Trust

Board of Directors Performance Report

January 2020

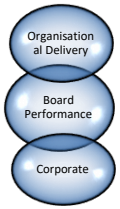
"To Deliver Excellence in Healthcare through Innovation & Collaboration"

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**	**Jan-20**	
Cancer				
Rapid Access Referrals (%) *(seen in 2 wks)*	93.00%	97.35%	97.84%	
Total Patients Seen		*10,062*	*974*	
Patients seen >14 days		*267*	*21*	
62 day GP Classic (%)	85.00%	86.41%	85.00%	*
Accountable Patients Treated		*714*	*80*	
No. of Breached Pathways (adjusted)		*97*	*12*	
62 day Screening (%)	90.00%	89.08%	93.10%	*
Accountable Patients Treated		*119*	*15*	
No. of Breached Pathways (adjusted)		*13*	*1*	
Unplanned Activity				
4 Hour Access Standard (%)	95.00%	75.86%	69.46%	
A&E Attendances (LH/MIU/UUC) (% to plan)		98.16%	93.54%	
A&E Attendances LH & MIU (Vol)		*82,920*	*8,006*	
Planned Activity				
Incomp Pathways <18wk (%)	92.00%	91.79%	90.98%	
>6wk Diagnostic Waits (%)	1.00%	3.22%	0.94%	
Total Patients Waiting for a First Outpatient Appointment			9,536	

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

Indicator	Standard	YTD
Workforce		
Sickness absence Rolling 12 Month		4.08%
Turnover Rolling 12 Month		8.70%

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	4	3	0.61	1.51
Liquidity	3	3	4	-13	-16
I&E Margin	3	3	3	-0.70%	-0.70%
Distance from Financial Plan	1	2	1	0.00%	0.00%
Agency Spend	1	3	3	-15.00%	-20.00%

	YTD Target	YTD Actual	YTD Variance	FY Target	FY Forecast	FY Variance
Cost Improvement Schemes Total (£000's)	4,267	3,560	-707	5,342	4,550	-792
Commission Contact Income SC & VR (£000's)	164,841	165,902	1,061			
Contract Income (£'000)	199,298	202,167	2,869			
Pay to Budget (£000's)	154,082	155,365	-1,283			
Non Pay to Budget (£000's)	61,181	64,240	-3,059			
Agency Trajectory (£000's)	4,750	6,188	-1,438			

Exec Summary

In January the key metrics delivered were:

1. 62 Day Screening Cancer at 93.10% against a target of 90%.
2. 2WW Rapid Access Cancer at 97.84% against a target of 93%
3. 62 Day Classic Cancer at 85% against a target of 85%
4. Six weeks diagnostic at 0.94% against a 1% threshold

The key metric not delivered was:

1. 4hr Emergency Access at 69.46% against a target of 95%
2. RTT Open Pathways at 90.98% against a target of 92% (intermin position)

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 £118k worse than the control total, as a result of operational challenges within laundry and premium costs associated with delivering core services.

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

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

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

Single Oversight Framework

Triggers

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

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

The Trust has achieved a Use of Resource rating of 3, which is on plan - with the Trust anticipating a forecast UoRR of 3.

Operational Performance

	Current YTD														Monthly Trend
	Target	Actual	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	
Maximum 6 week wait for Diagnostic procedures	1%	3.22%	0.47%	0.42%	0.76%	0.64%	9.34%	7.76%	4.04%	3.05%	0.95%	0.84%	0.72%	1.79%	0.94%	
All Cancers: 62 day GP Classic (%) *	85%	86.41%	85.83%	85.84%	85.60%	86.62%	86.09%	86.18%	86.45%	86.72%	88.89%	86.67%	85.11%	86.17%	85.00%	
All Cancers: 62 day Screening (%) *	90%	89.08%	87.50%	100.00%	95.45%	90.00%	90.00%	61.11%	96.77%	90.48%	85.00%	79.41%	100.00%	100.00%	93.10%	
18 weeks from point of referral to treatment - patients on an incomplete pathway (%)	92%	91.79%	91.30%	91.63%	90.67%	91.05%	91.67%	92.07%	92.09%	92.00%	92.46%	92.08%	92.19%	91.29%	90.98%	
A&E - maximum waiting time of 4 hours from arrival to admission/transfer/discharge (%)	95%	75.86%	78.89%	81.12%	80.41%	79.90%	78.26%	80.60%	78.98%	78.02%	77.36%	75.50%	71.82%	68.01%	69.46%	
STF Trajectory			90.00%	90.00%	90.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%				
Provider Submitted Trajectory													88.50%	84.60%	83.60%	

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

Financial & Resource

		Unit	YE Plan	YE Forecast	YE Rating	YTD Rating
Financial Sustainability	Capital Service Capacity	0.0x	0.61	1.51	3	4
	Liquidity	days	-13	-16	4	3
Financial Efficiency	I&E Margin	%	-0.70%	-0.70%	3	3
Financial Controls	Distance from Financial Plan	%	0.00%	0.00%	1	2
	Agency Spend	%	-15.00%	-20.00%	3	3
Overall UOR Rating					3	3

Operational Delivery: *Cancer Pathway*

Headline Measures

	Current YTD		Rolling 13 months											
	Target	Actual	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Monthly Trend
Rapid Access Referrals (%) (seen in 2 wks)	93%	97.35%	96.91%	97.66%	97.69%	95.83%	97.65%	96.99%	96.60%	98.20%	97.39%	98.28%	97.76%	97.07%	97.84%	
Total Patients Seen		*10062*	*842*	*940*	*996*	*1030*	*980*	*963*	*1207*	*1000*	*1036*	*1048*	*936*	*888*	*974*	
Patients seen >14 days		*267*	*26*	*22*	*23*	*43*	*23*	*29*	*41*	*18*	*27*	*18*	*21*	*26*	*21*	
% seen within 7 days		*0.0%*	*38.6%*	*38.1%*	*30.5%*	*30.3%*	*39.4%*	*37.6%*	*38.2%*	*43.3%*	*54.7%*	*59.3%*	*46.3%*	*44.0%*	*56.5%*	
62 day GP Classic (%) *	85%	86.41%	85.83%	85.84%	85.60%	86.62%	86.09%	86.18%	86.45%	86.72%	88.89%	86.67%	85.11%	86.17%	85.00%	

** Provisional figures subject to change depending*

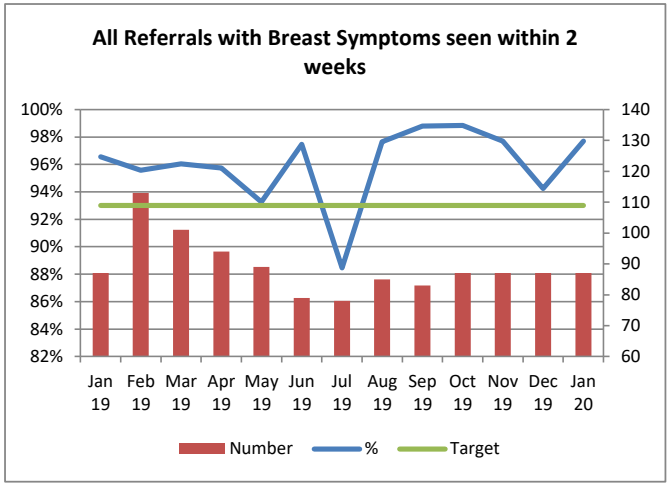
104+ day waits - (Cancer patients treated)	0	1	3	3	5	4	4	4	2	2	2	3	3

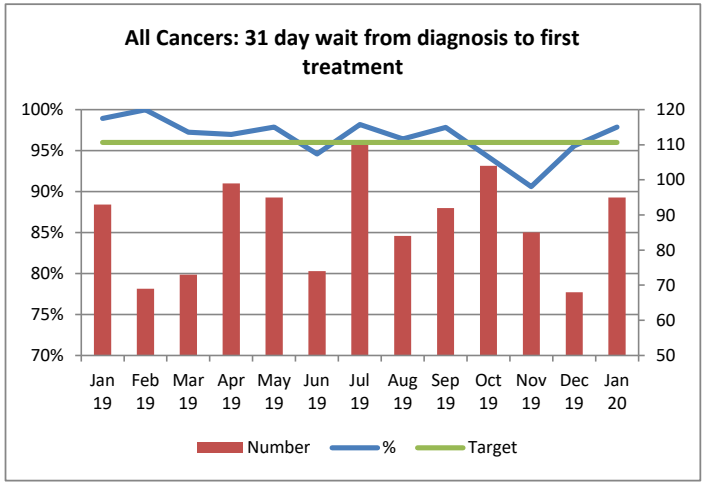
Commentary

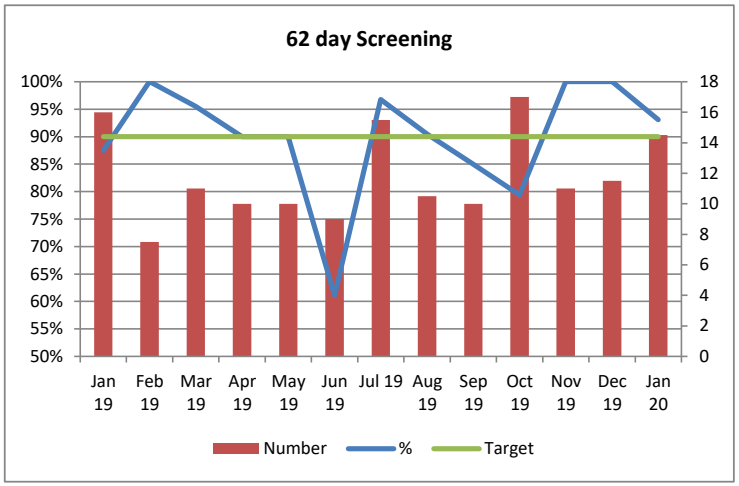
The Trust has achieved all three headline cancer standards during the month of January 2020. The figures presented in this paper reflect the Trust's regulatory performance measures adjusted figures that take into account breach reallocation between providers.

The Trust has continued it's strong performance against the Rapid Access referrals standard, achieving 97.84% for January.
The 62 Day GP Classic standard has achieved the 85% in January, despite an increase of 70% in the number of patients seen during compared to previous month.
The 62 day Screening standard has reached 93.10% performance in January.

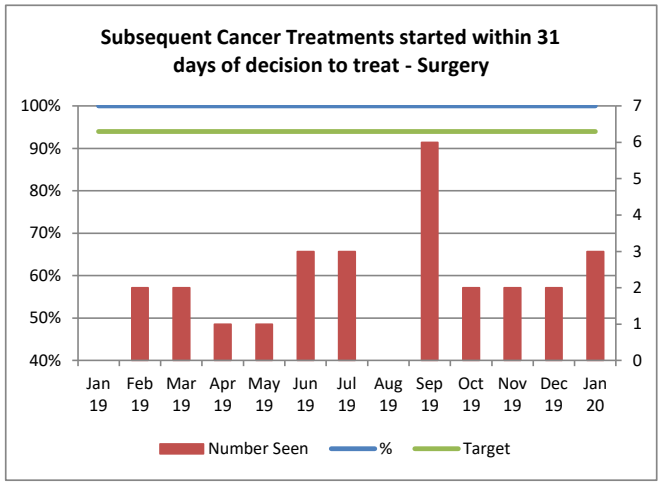
Primary Measures

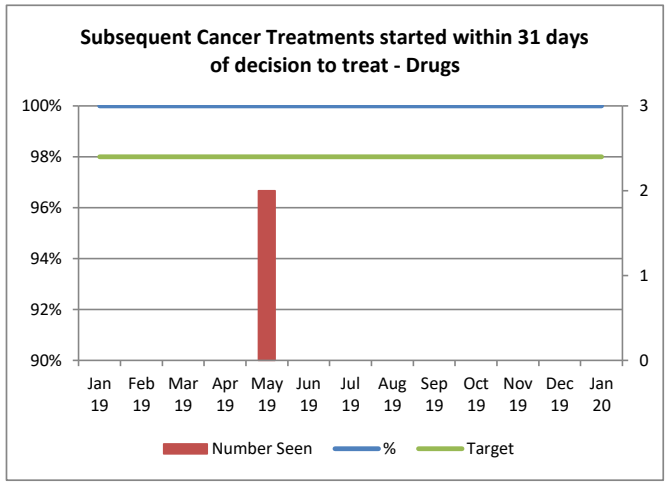


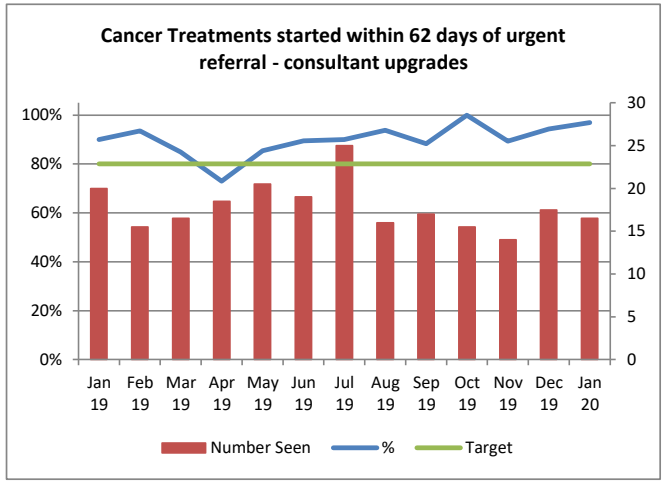




Operational Delivery: *Cancer Pathway*







Operational Delivery: *Unplanned Activity - A&E*

Headline Measures

	Current YTD		Rolling 13 months											
	Target	Actual	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Monthly Trend
A&E - >4 hr wait time from arrival to admission/ transfer/ discharge (% to Target)	95%	75.86%	78.89%	81.12%	80.41%	79.90%	78.26%	80.60%	78.98%	78.02%	77.36%	75.50%	71.82%	68.01%	69.46%	
No. of 4hr breaches		*20,017*	*1,621*	*1,349*	*1,574*	*1,642*	*1,822*	*1,559*	*1,879*	*1,892*	*1,913*	*1,991*	*2,288*	*2,586*	*2,445*	

	Plan	Actual	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Monthly Trend
A&E Attendances (LH/MIU/UUC) (% to Plan)		*98.16%*	99.3%	97.0%	95.4%	100.4%	95.2%	96.3%	103.3%	105.6%	102.9%	95.2%	99.2%	90.9%	93.5%	
A&E Attendances (LH/MIU/UUC) (No.)	*79,521*	*82,920*	7,679	7,147	8,034	8,169	8,382	8,036	8,937	8,607	8,450	8,128	8,120	8,085	8,006	
A&E Attendance Case Mix (based on acuity score) — *Major*		*22,487*	*2,392*	*2,170*	*2,341*	*2,351*	*2,540*	*2,235*	*2,407*	*2,263*	*2,347*	*2,155*	*2,082*	2,040	2,067	
Minor		*31,085*	*2,782*	*2,489*	*2,855*	*3,166*	*3,040*	*3,045*	*3,559*	*3,593*	*3,212*	*2,852*	*2,823*	2,852	2,943	
Paediatrics		*16,321*	*1,372*	*1,556*	*1,702*	*1,587*	*1,680*	*1,686*	*1,739*	*1,363*	*1,721*	*1,745*	*1,745*	1,624	1,431	
Resus		*13,007*	*1,128*	*928*	*1,126*	*1,063*	*1,121*	*1,070*	*1,231*	*1,385*	*1,168*	*1,374*	*1,467*	1,567	1,561	
A&E Attendance Location (based on Discharge) — *Major*		*32,358*	*3,354*	*2,983*	*3,317*	*3,245*	*3,405*	*3,142*	*3,320*	*3,277*	*3,134*	*2,984*	*3,071*	*3,220*	*3,560*	
Minor		*32,196*	*2,738*	*2,454*	*2,801*	*3,123*	*3,111*	*3,039*	*3,677*	*3,788*	*3,394*	*3,182*	*3,069*	*2,991*	*2,822*	
Paediatrics		*16,321*	*1,372*	*1,556*	*1,702*	*1,587*	*1,680*	*1,686*	*1,739*	*1,363*	*1,721*	*1,745*	*1,745*	*1,624*	*1,431*	
Resus		*2,025*	*210*	*150*	*204*	*212*	*185*	*169*	*200*	*176*	*199*	*215*	*232*	*248*	*189*	

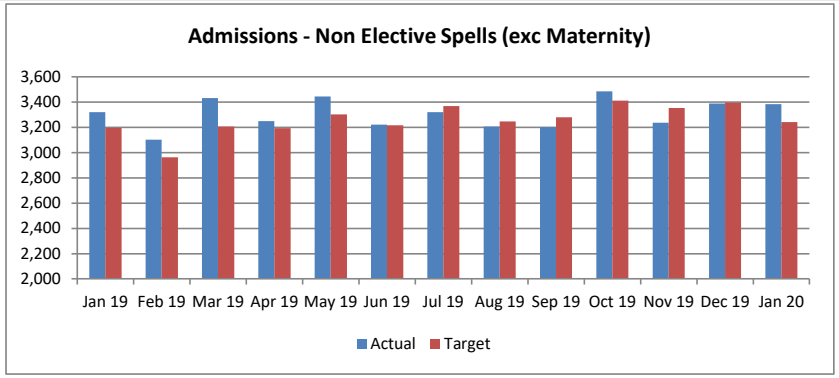
Commentary

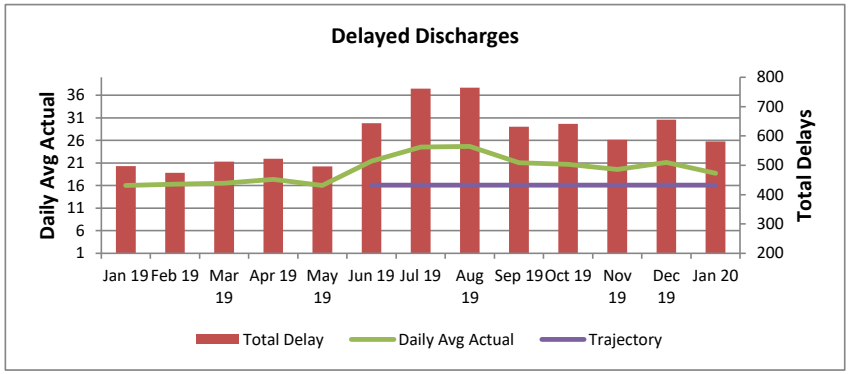
The Trust has achieved 69.46% against the 4-hour access standard in January 2020.

Patients attending A&E continues to be significantly higher than expected levels, impacting on non elective performance;
The Non Elective admission rate has increased in January to 37.27%, the Non Elective spells are higher than plan at 104% and Medical Outliers remains high at 25 against a threshold of 6 for January 2020.

A full diagnostic and clinical walk through has been undertaken in addition to MORI undertaking a patient level survey. The findings of both reviews will be available by the end of February 2020.

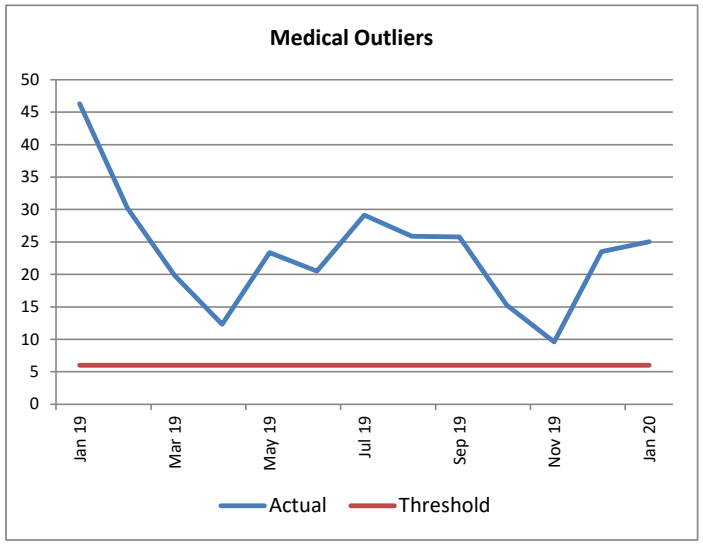
Primary Drivers

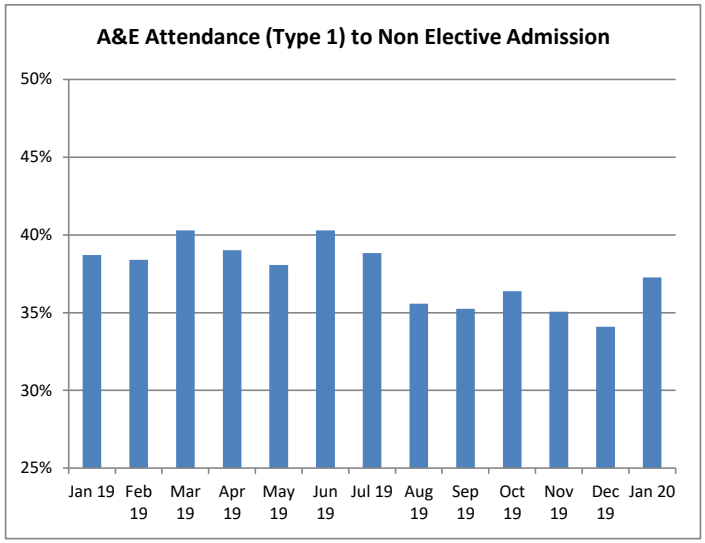


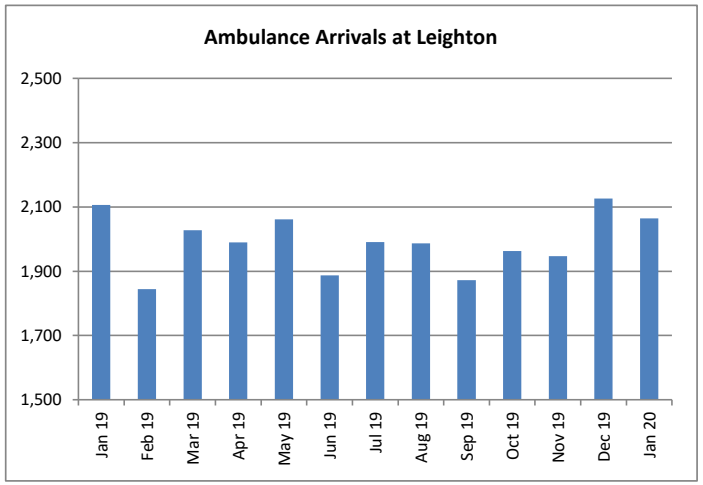


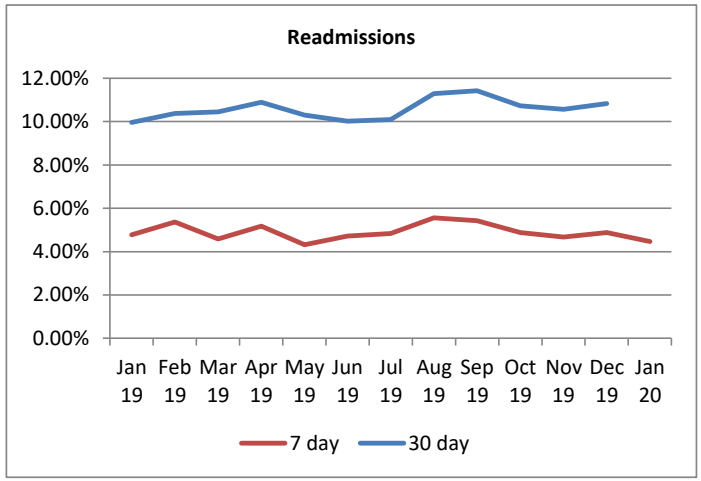
Operational Delivery: *Unplanned Activity A&E*

Secondary Drivers



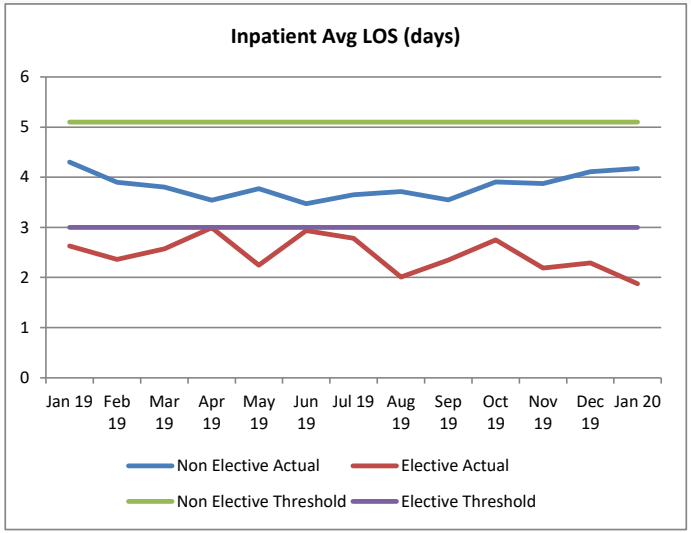


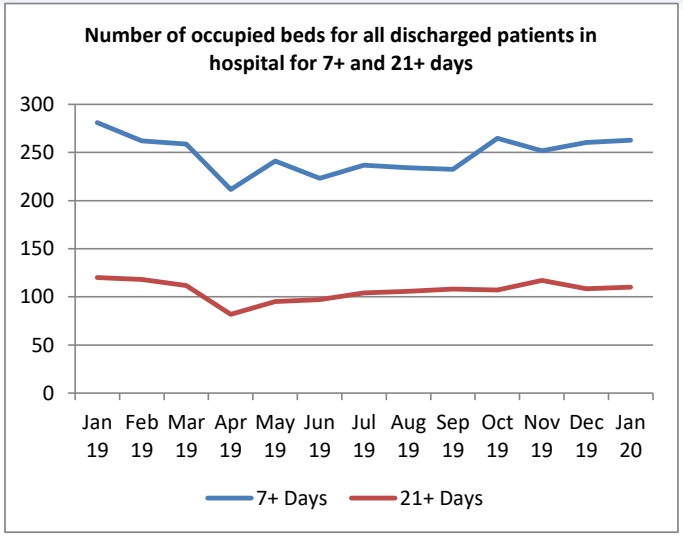


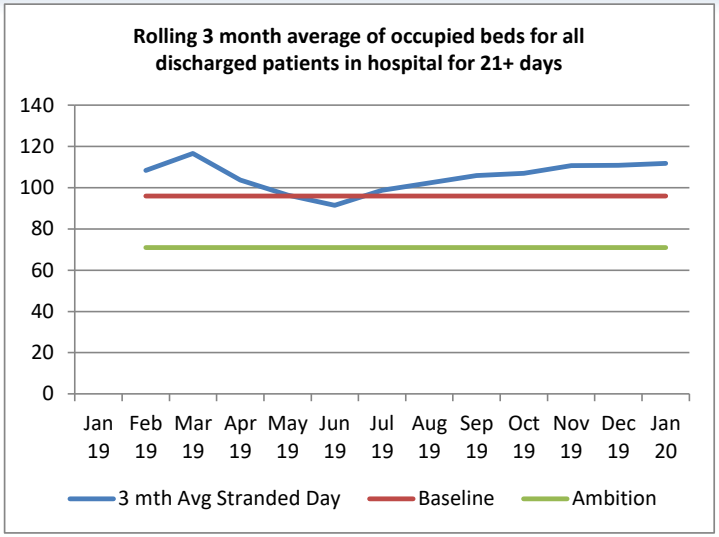


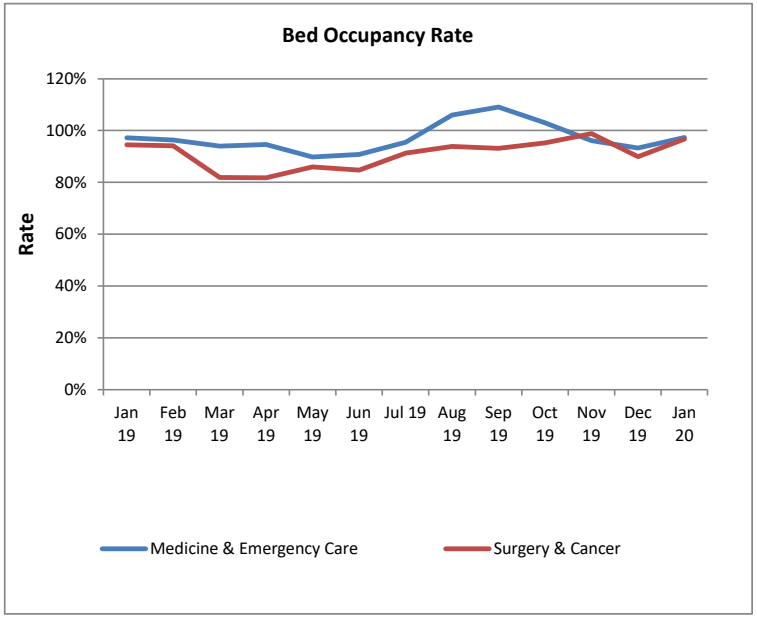
** Readmissions brought in line with national definition*

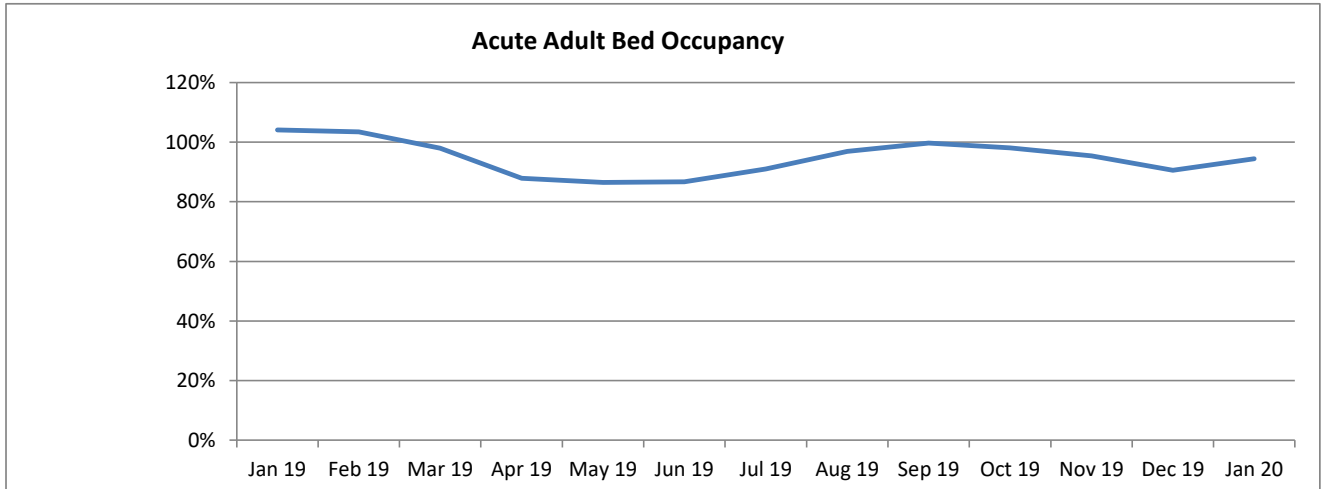
Operational Delivery: *Length of Stay*











	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20
Trust Total	104.12%	103.44%	98.00%	87.94%	86.50%	86.73%	90.96%	96.88%	99.73%	98.12%	95.39%	90.61%	94.46%
Additional Beds	37.55	23.36	21.00	1.13	2.32	1.50	2.52	6.71	10.40	11.61	19.73	23.42	41.94

Operational Delivery: *Planned Activity*

Headline Measures

	Current YTD		Rolling 13 months											
	Target	Actual	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Monthly Trend
18 weeks from Referral to Treatment in Aggregate - Incomplete	92%	91.79%	91.30%	91.63%	90.67%	91.05%	91.67%	92.07%	92.09%	92.00%	92.46%	92.08%	92.19%	91.29%	90.98%	
Total 18 Weeks		*151,580*	14,427	14,505	14,197	14,944	15,219	15,560	15,426	15,432	15,190	14,668	14,707	14,899	15,535	
No. > 18 Weeks		*12,443*	*1,255*	*1,214*	*1,324*	*1,338*	*1,267*	*1,234*	*1,216*	*1,234*	*1,146*	*1,161*	*1,149*	*1,297*	*1,401*	
Open Pathways >39 Weeks Waiting											*18*	*21*	*18*	*37*	*36*	
Diagnostic Waiting Time	1%	3.22%	0.47%	0.42%	0.76%	0.64%	9.34%	7.76%	4.04%	3.05%	0.95%	0.84%	0.72%	1.79%	0.94%	
Total Number of Waiters		*44,005*	*4,029*	*4,785*	*4,749*	*1,091*	*4,809*	*5,065*	*4,750*	*3,903*	*4,434*	*5,014*	*5,023*	*5,146*	*4,770*	
Waiters of 6 Weeks +		*1,417*	*19*	*20*	*36*	*7*	*449*	*393*	*192*	*119*	*42*	*42*	*36*	*92*	*45*	
Total Patients Waiting for a First Outpatient Appointment			9,428	9,823	9,682	9,800	9,981	9,603	9,659	9,523	9,452	9,033	8,813	9,001	9,536	
Longest Wait Time (weeks)											*49*	*55*	*47*	*49*	*48*	

Commentary

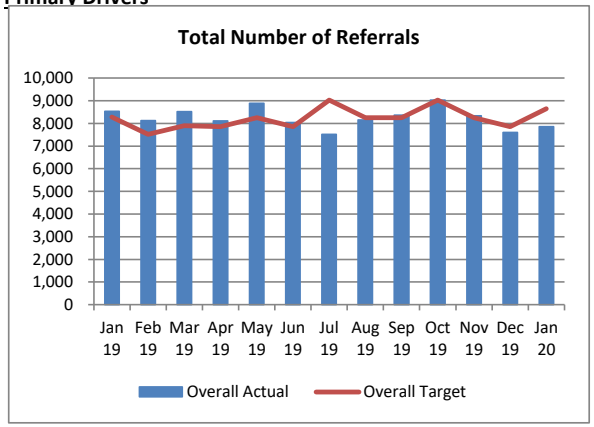
The Trust's RTT Incomplete Pathway current position is 90.98% for January, pathways continue to be validated until submission deadline. Currently there are seven specialties that have failed to meet the 92% target, these are General Surgery, Urology, Gastroenterology, Cardiology, Geriatric Medicine, 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.
The suspension of the elective Orthopaedics continued longer than planned due to the non elective pressures, which has impacted on the RTT performance.

In January there were no 52+ week breaches. There are 36 patients waiting over 39 weeks, all long wait patients are monitored and reviewed weekly at director led performance meetings.

In January 2020, the current position for patients waiting over 6 weeks for their diagnostic test is 0.94% of total patients.

The number of Elective spells has increased during January due to the patients from South Cheshire Private Hospital transferring to Mid Cheshire, January was 113% of plan.

Primary Drivers

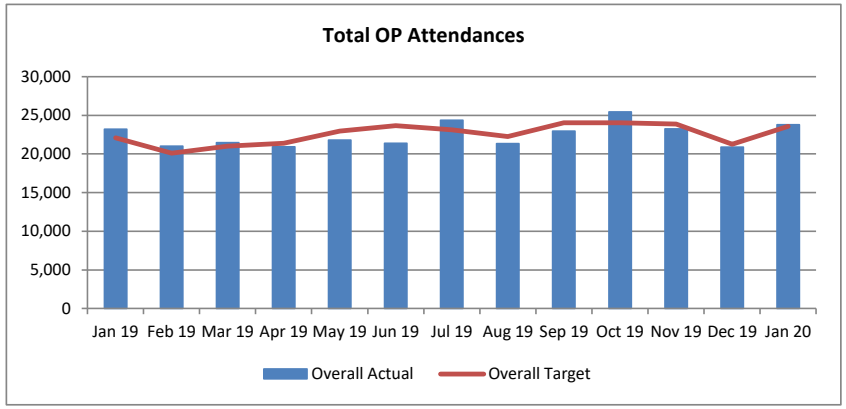


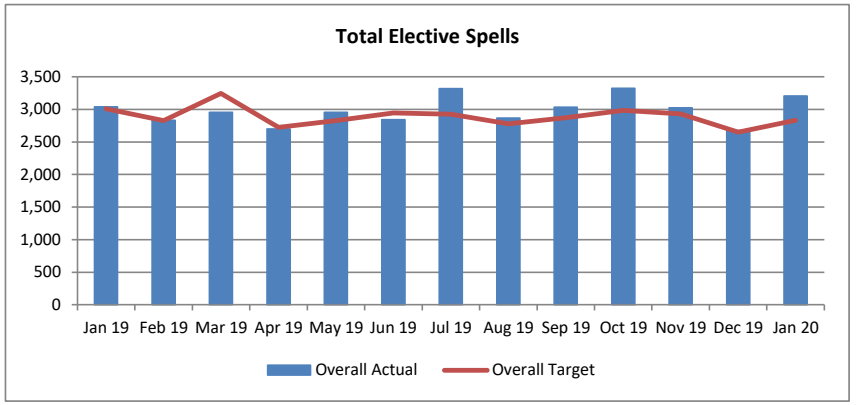
Referral Breakdown

	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Monthly Trend
GP Actual	5,424	4,915	5,270	4,587	5,231	4,583	4,103	4,497	4,800	5,141	4,838	4,245	4,434	
GP Target	5,157	4,683	4,920	4,374	4,593	4,374	5,030	4,593	4,593	5,030	4,593	4,374	4,811	
% to Target	105.2%	105.0%	107.1%	104.9%	113.9%	104.8%	81.6%	97.9%	104.5%	102.2%	105.3%	97.1%	92.2%	
Other Actual	3,118	3,204	3,250	3,524	3,655	3,453	3,410	3,654	3,561	3,882	3,494	3,358	3,417	
Other Target	3,120	2,833	2,976	3,483	3,657	3,483	4,006	3,657	3,657	4,006	3,657	3,483	3,832	
% to Target	100.0%	113.1%	109.2%	101.2%	99.9%	99.1%	85.1%	99.9%	97.4%	96.9%	95.5%	96.4%	89.2%	
Total Actual	8,542	8,119	8,520	8,111	8,886	8,036	7,513	8,151	8,361	9,023	8,332	7,603	7,851	
Total Target	8,276	7,515	7,896	7,857	8,250	7,857	9,036	8,250	8,250	9,036	8,250	7,857	8,643	
% to Target	103.2%	108.0%	107.9%	103.2%	107.7%	102.3%	83.1%	98.8%	101.3%	99.9%	101.0%	96.8%	90.8%	
GP % of Total	63.5%	60.5%	61.9%	56.6%	58.9%	57.0%	54.6%	55.2%	57.4%	57.0%	58.1%	55.8%	56.5%	

Operational Delivery: *Planned Activity*

Primary Drivers





OP Attendance Breakdown

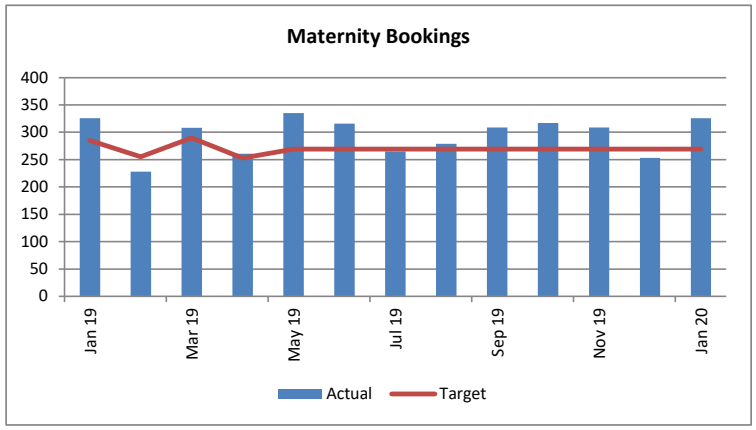
	YTD 18 19	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Monthly Trend
New Actual	81,335	6,861	6,397	6,877	6,584	6,956	6,725	7,866	6,712	7,284	7,833	6,976	6,308	7,364	
New Target	74,744	6,496	5,901	6,189	6,416	6,848	7,173	6,817	6,588	7,267	7,214	6,982	6,325	6,817	
% to Target	108.8%	105.6%	108.4%	111.1%	102.6%	101.6%	93.8%	115.4%	101.9%	100.2%	108.6%	99.9%	99.7%	108.0%	
F U Actual	182,101	16,352	14,629	14,583	14,343	14,830	14,642	16,519	14,633	15,681	17,592	16,264	14,561	16,408	
F U Target	181,624	15,604	14,194	14,803	14,988	16,096	16,491	16,286	15,659	16,779	16,823	16,886	14,918	16,777	
% to Target	100.3%	104.8%	103.1%	98.5%	95.7%	92.1%	88.8%	101.4%	93.4%	93.5%	104.6%	96.3%	97.6%	97.8%	
Total Actual	263,436	23,213	21,026	21,460	20,927	21,786	21,367	24,385	21,345	22,965	25,425	23,240	20,869	23,772	
Total Target	256,368	22,100	20,095	20,992	21,403	22,944	23,663	23,102	22,247	24,046	24,037	23,868	21,243	23,595	
% to Target	102.8%	105.0%	104.6%	102.2%	97.8%	95.0%	90.3%	105.6%	95.9%	95.5%	105.8%	97.4%	98.2%	100.8%	
New % of Total	30.9%	29.6%	30.4%	32.0%	31.5%	31.9%	31.5%	32.3%	31.4%	31.7%	30.8%	30.0%	30.2%	31.0%	

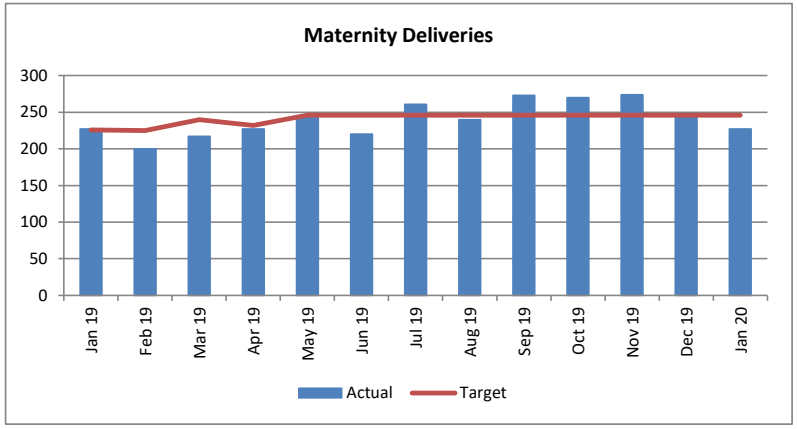
Elective Spells Breakdown

	YTD 18 19	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Monthly Trend
I P Actual	3,055	157	288	272	225	228	266	267	291	254	329	353	200	225	
I P Target	3,341	181	264	304	263	277	280	277	249	270	310	305	239	204	
% to Target	91.4%	86.9%	109.0%	89.4%	85.6%	82.3%	94.9%	96.4%	116.7%	94.1%	106.1%	115.8%	83.7%	110.3%	
Daycase Actual	31,155	2,882	2,543	2,685	2,475	2,727	2,575	3,050	2,576	2,778	2,995	2,670	2,475	2,980	
Daycase Target	32,775	2,826	2,565	2,942	2,462	2,548	2,666	2,650	2,530	2,601	2,672	2,626	2,409	2,626	
% to Target	95.1%	102.0%	99.1%	91.3%	100.5%	107.0%	96.6%	115.1%	101.8%	106.8%	112.1%	101.7%	102.7%	113.5%	
Total Actual	34,210	3,039	2,831	2,957	2,700	2,955	2,841	3,317	2,867	3,032	3,324	3,023	2,675	3,205	
Total Target	36,116	3,007	2,829	3,247	2,724	2,825	2,946	2,927	2,779	2,871	2,982	2,931	2,648	2,830	
% to Target	94.7%	101.1%	100.1%	91.1%	99.1%	104.6%	96.4%	113.3%	103.2%	105.6%	111.5%	103.2%	101.0%	113.3%	
I P % of Total	8.9%	5.2%	10.2%	9.2%	8.3%	7.7%	9.4%	8.0%	10.1%	8.4%	9.9%	11.7%	7.5%	7.0%	

Operational Delivery: *Planned Activity*

Primary Drivers





Operational Delivery: *Planned Activity*

Secondary Drivers

			Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Monthly Trend
Bed Occupancy Rate	Medicine & Emergency Care		97.3%	96.3%	94.0%	94.6%	89.8%	90.7%	95.5%	106.0%	109.0%	103.1%	96.1%	93.3%	97.4%	
	Surgery & Cancer		94.5%	94.2%	81.9%	81.8%	86.0%	84.8%	91.3%	93.9%	93.2%	95.3%	98.8%	89.9%	96.8%	
Elective Inpatient Avg LOS (Days)			2.6	2.4	2.6	3.0	2.2	2.9	2.8	2.0	2.3	2.7	2.2	2.3	1.9	
Delayed Transfers of Care (MFFD)		16.00	16	17	17	17	16	21	25	25	20	21	19	21	19	
Delayed Transfers of Care (% of Acute Beds)			3.1%	3.3%	3.3%	3.5%	3.2%	4.3%	5.2%	5.1%	4.4%	4.2%	3.8%	4.0%	3.5%	
Medical Outliers			46	31	20	12	23	20	29	26	25	15	9	24	25	
Readmission (Emergency Re-admissions after Planned Surgery)																
	30 Day Rate		2.66%	3.86%	3.29%	3.38%	3.38%	3.10%	2.83%	3.30%	4.32%	3.32%	3.53%	2.87%		
	7 Day Rate		1.06%	1.45%	1.05%	1.41%	1.37%	1.00%	1.07%	1.36%	1.68%	1.21%	1.16%	0.83%	1.06%	
Cancelled Operations - Non Clinical - Cancellation Rate			0.58%	0.60%	0.65%	0.67%	1.17%	0.85%	1.30%	1.29%	0.04%	0.00%	0.97%	1.61%	0.75%	
Theatre Efficiency																
	Main Theatres		74.5%	76.2%	78.5%	76.7%	75.0%	77.4%	78.7%	78.3%	76.7%	77.1%	77.9%	68.2%	73.4%	
	TC Theatres		69.4%	73.0%	73.5%	72.4%	68.2%	74.8%	70.7%	71.9%	72.4%	73.3%	71.3%	70.2%	71.5%	
DNA (OP Efficiency)			5.75%	5.42%	5.41%	6.00%	6.02%	6.57%	5.89%	5.60%	5.77%	5.68%	5.80%	6.08%	5.64%	
Hospital Cancellation Rate (OP Efficiency)			7.65%	7.83%	8.12%	7.90%	7.51%	7.36%	8.11%	7.70%	7.98%	7.64%	8.42%	7.87%	7.97%	

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

Performance and Finance - Headlines January 2020

Current Position | Analysis | Forward View

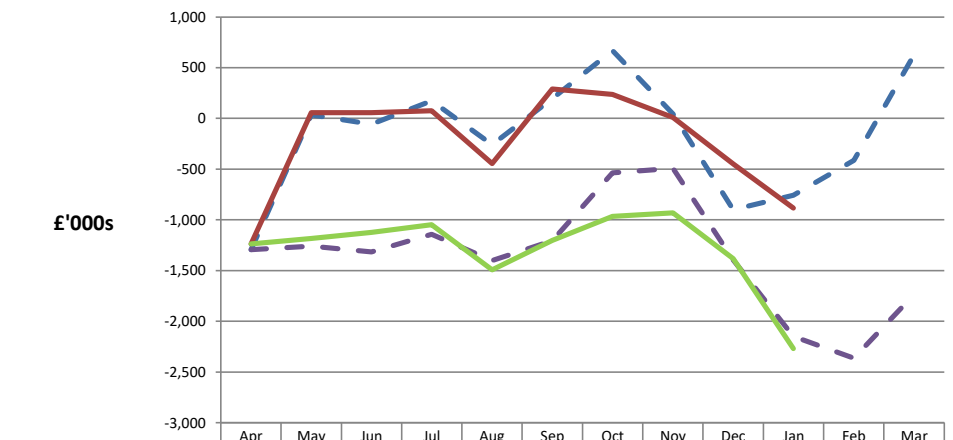
The reported position is cumulatively £118k worse than the control total, which is an in month deterioration of £128k.

The significant impact within the month has been the operational issues associated with the laundry services – which has produced an in month pressure of £350k.

Discussions with NHSI have led to an adjustment of the control total – however within month this has not fully covered the pressures.

There has also been a continuation of the previous months financial challenges, particularly around unscheduled care, which have seen further escalations within the hospital of which the additional funding received has not fully covered, and has seen a further challenge to the nursing costs.

The overall use of resources rating for the Trust is currently 3 which is as expected.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
In Month Plan	-1,294	34	-56	173	-258	195	669	44	-900	-756	-413	628
In Month Actual	-1,238	56	58	76	-445	291	238	10	-447	-884		
In Month Variance	56	22	114	-97	-187	96	-431	-34	453	-128		
Cumulative Plan	-1,294	-1,260	-1,316	-1,143	-1,401	-1,206	-537	-493	-1,393	-2,149	-2,362	-1,734
Cumulative Actual	-1,238	-1,182	-1,124	-1,048	-1,493	-1,202	-964	-930	-1,383	-2,267		
Cumulative Variance	56	78	192	95	-92	4	-427	-437	10	-118		

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

Any negative variation against the control total at the end of a qtr will put at risk the £1.5m PSF support for Q4, with the first 3 quarters secured. The MRET funding of £3.215m by contrast is guaranteed to the Trust.

The most significant risk to delivering the control total is managing the above plan unscheduled care pressures, in part as a result of limitations of services outside of hospital resulting in the need being met by the Trust through additional escalation beds. The additional areas that had been opened in January have now closed.

Operational issues within the Laundry service are expected to form a material challenge to the final quarter of 2019/20, despite the movement in control total by regulators by £0.6m.

Increasing dependency on premium costs to deliver core activity in some specialties is both a financial challenge now but also looking forward to next year.

The Cheshire Health economy financial recovery plan to eliminate the deficit across the Cheshire footprint will have implications for MCHFT either directly or indirectly through commissioner actions.

The Trust is expecting to have a year end use of resources rating of 3.

Performance and Finance - Contract Income January 2020

Current Position

Contract income is £2.87m above plan year to date with an improvement of £0.78m in month.

The improvement within month is attributable to £0.21m income from NHSI (proportion of the £0.92m), and also £0.3m (proportion of the £1.5m) agreed with local commissioners.

High cost drug over-performance against Specialised Commissioning is £0.142m in month.

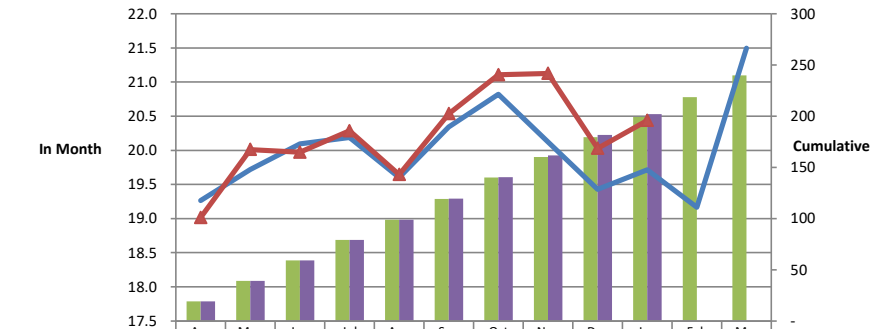
Associate contracts continue to underperform against plan pre-dominantly with Stoke/North Staffs and West Cheshire CCGs (£1.3m to date), with a slowing of the previous months declining trends, mostly within the Cheshire contracts not on block (East and West Cheshire).

The over performance shown against the host contract relates to additional NHSI funding (share of the £0.92m) and £0.35m of escalation beds.

Within the 'other' column over-performance on high cost drugs within Specialised Commissioning (£1.15m) offsets against drugs spend within non-pay.

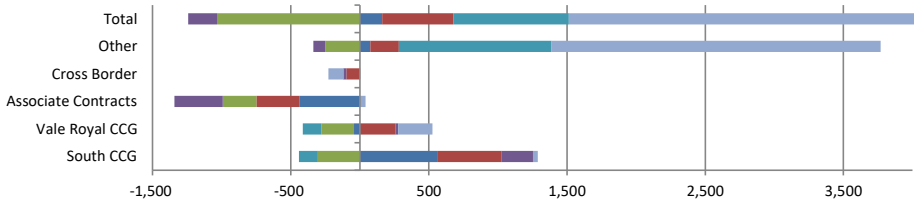
Analysis

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	98.9	119.2	140.0	160.2	179.6	199.3	218.6	239.9
Cumulative actual	19.0	39.0	59.0	79.3	98.9	119.5	140.6	161.7	181.7	202.2		
In month budget	19.3	19.7	20.1	20.2	19.6	20.3	20.8	20.1	19.4	19.7	19.2	21.5
In month actual	19.0	20.0	20.0	20.3	19.6	20.5	21.1	21.1	20.0	20.4		

Cumulative Variance to Contract Income plan £'000s



	South CCG	Vale Royal CCG	Associate Contracts	Cross Border	Other	Total
Unplanned Care	565	-42	-437	1	75	161
Day case	458	258	-311	-97	207	515
Elective	-303	-238	-244	0	-250	-1,035
Outpatients	230	19	-350	-21	-85	-207
High cost drugs	-137	-133	1	-0	1,106	836
Other	34	249	41	-108	2,382	2,598
Total	847	114	-1,300	-226	3,435	2,869

Forward View

The Trust has seen an increase in referrals for the throughout the year particularly around the surgical specialties. This has been offset by an under performance within the associate contracts, which is expected to have an impact of £1.5m this year.

Whilst the block contract arrangement is currently over-performing the current assessment around CQUIN would somewhat negate this position by around £1m. The achievement of the Flu CQUIN target has improved this forecast by £0.2m.

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.

Performance and Finance - Pay Expenditure January 2020

Current Position

Cumulatively Pay is worse than plan by £1.3m, with CCICP being £0.4m better and MCHFT £1.7m, with a further underlying deterioration in month of £0.4m within MCHFT.

The additional winter pressure monies received offset a proportion of this overspend.

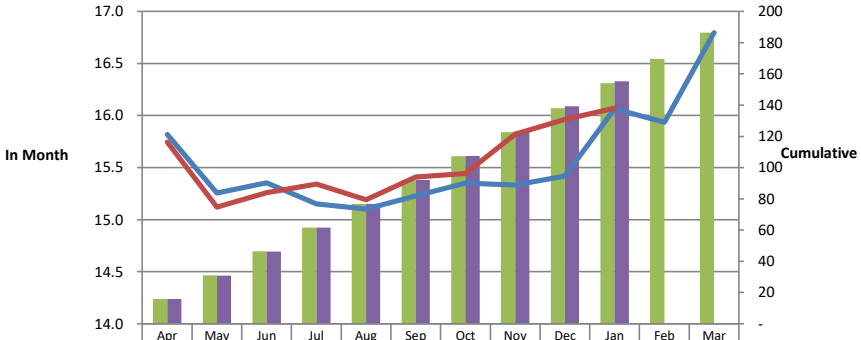
Nursing pay continues to be under pressure, as a result of further temporary unfunded escalations to support the impact of Winter. This has led to a further increase in nursing spend in month by £0.2m.

Whilst not as material, there have been increases in both medical pay and infrastructure pay as a result of opening ward 15.

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

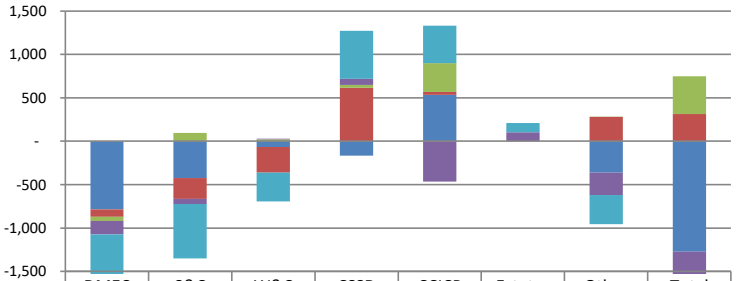
Analysis

Pay Expenditure 2019/20 £'m



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative budget	15.8	31.1	46.4	61.6	76.7	91.9	107.3	122.6	138.0	154.1	169.7	186.5
Cumulative actual	15.7	30.9	46.1	61.5	76.7	92.1	107.5	123.3	139.3	155.4		
In month budget	15.8	15.3	15.4	15.2	15.1	15.2	15.4	15.3	15.4	16.1	15.9	16.8
in month actual	15.7	15.1	15.3	15.3	15.2	15.4	15.4	15.8	16.0	16.1		

Pay Variances by Staff Group and Division £'000s



	DMEC	S&C	W&C	CSSD	CCICP	Estates	Other	Total
Total	-1,074	-628	-332	552	433	105	-336	-1,280
Infrastructure Support Staff	-155	-59	9	69	-465	105	-258	-754
Non Clinical Staff	-48	94	22	33	329	-	4	434
Medical Staff	-84	-237	-295	617	33	-	280	314
Nursing Staff	-787	-426	-68	-167	536	-	-362	-1,274

Forward View

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

a) Escalation areas – In order to meet the current demands within unplanned care, in November the Trust opened an additional ward

b) Continued dependency on premium costs to deliver core activity. Diagnostics is a particular concern with service reviews, including demand and capacity analysis will be undertaken

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

Premium costs will be challenging to manage within nursing until substantive appointments to vacancies are made, various incentive schemes are currently being introduced.

Looking to next year the nurses that were successfully appointed to as part of the International Recruitment have been deployed on the wards as supernummery but from Q1 of 2020/21 will be part of the establishment.

Performance and Finance - Non-Pay Expenditure January 2020

Current Position

Non Pay is above plan by £3.0m, which includes the release of provisions of £0.4m year to date.

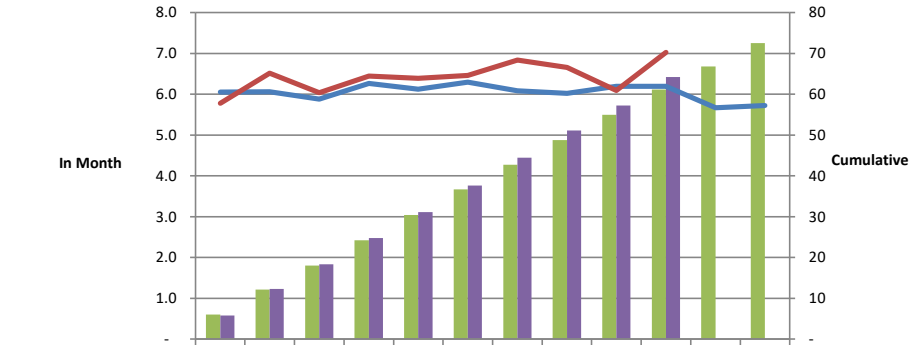
For CCICP the overspend is £0.4m, MCHFT is £2.6m - with the operational issues associated with the laundry materialising in month and creating a £0.35m pressure. This pressure is as a result of having to outsource services to meet both MCHFT demand and also the Shropshire consortium.

Where medical vacancies are procured as a service from external companies, they are included as other non-pay, and offset by medical pay underspends. This is a material pressure within CSSD, (at mth 10 is a £0.35m pressure), but there is a smaller but growing pressure with DMEC due to outsourcing of services to meet core demand.

Whilst drugs are overspent, the most significant amount is within oncology drugs which are offset against additional contract income.

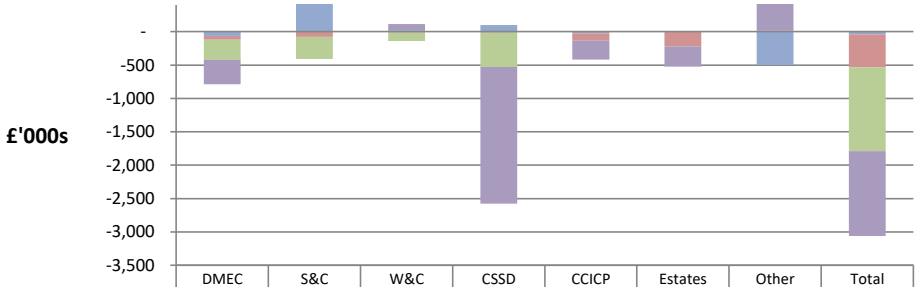
Analysis

Non Pay 2019/20 £'m



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative budget	6.1	12.1	18.0	24.3	30.4	36.7	42.8	48.8	54.99	61.2	66.8	72.6
Cumulative actual	5.8	12.3	18.3	24.8	31.2	37.6	44.5	51.1	57.22	64.2		
In month budget	6.1	6.1	5.9	6.3	6.1	6.3	6.1	6.0	6.2	6.2	5.7	5.7
In month actual	5.8	6.5	6.0	6.4	6.4	6.5	6.8	6.7	6.1	7.0		

Non Pay Variance by Division



	DMEC	S&C	W&C	CSSD	CCICP	Estates	Other	Total
Total	-787	29	-24	-2,475	-415	-517	1,130	-3,059
Other Non Pay	-363	13	90	-2,045	-283	-300	1,617	-1,271
Drugs	-302	-331	-123	-517	3	0	13	-1,257
Non Clinical Supplies	-60	-76	-15	-13	-107	-223	0	-494
Clinical Supplies	-62	422	24	99	-27	6	-500	-37

Forward View

During the first week in January, there was a stepped change in the significant operational challenges within the Trusts laundry service, which whilst under review is likely to have a material impact on the final quarter.

The growing reliance on external companies to provide services to cover activity at the Trust comes at a premium rate, which year to date the Trust has spent £1.45m more than in 18/19.

The Diagnostics division has outsourced circa £3m of work year to-date which has incurred a premium cost of circa £0.35m.

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

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

Performance and Finance - Cost Improvement Programme January 2020

Current Position

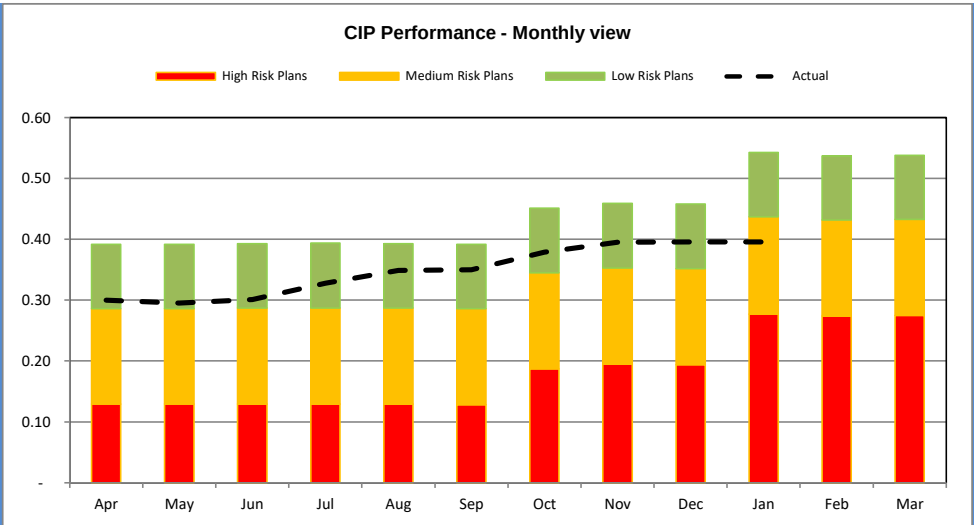
The CIP programme is behind plan by £0.7m, although this is within the reported position to-date.

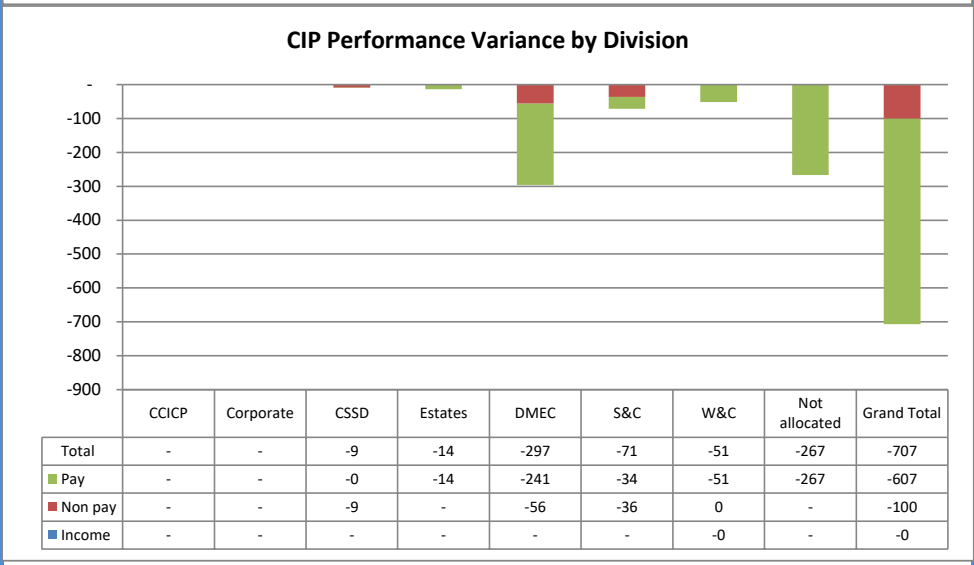
This relates to the following schemes

- Nursing (£0.45m)
- Unallocated CIP Plans (£0.25m) in DMEC

The Division of Medicine and Emergency Care have had challenges all year 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 very little of their £0.7m CIP target (with exception of NHS supply chain savings).

Analysis





	CCICP	Corporate	CSSD	Estates	DMEC	S&C	W&C	Not allocated	Grand Total
Total	-	-	-9	-14	-297	-71	-51	-267	-707
Pay	-	-	-0	-14	-241	-34	-51	-267	-607
Non pay	-	-	-9	-	-56	-36	0	-	-100
Income	-	-	-	-	-	-	-0	-	-0

Forward View

Consideration on the deliverability of some CIP plans needs to be tested before being included in next years financial plans.

Future years CIP plans need to be more focused on cost reduction than income generation given the financial deficit within the cheshire system

Performance and Finance - Agency Spend January 2020

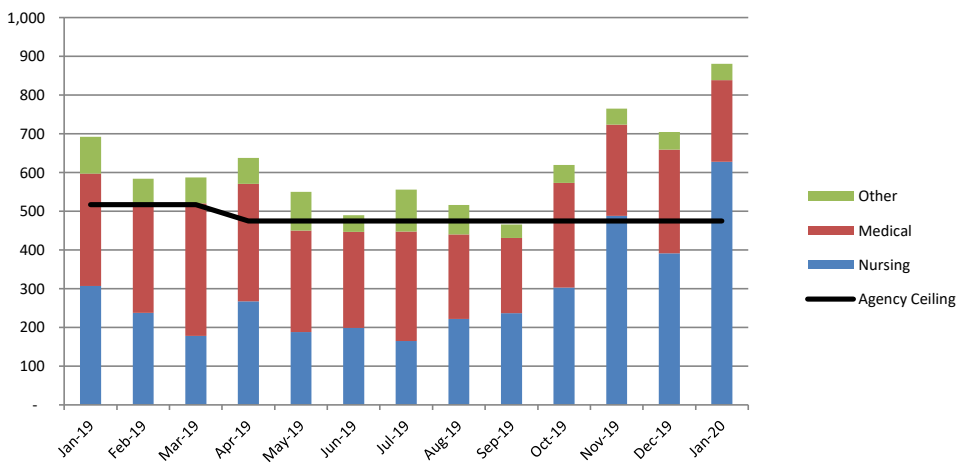
Current Position

When the element of cost that is associated with non pay is included, the Trust reliance on non-substantive arrangements comes to 13%, with DMEC 26% and CSSD 18%

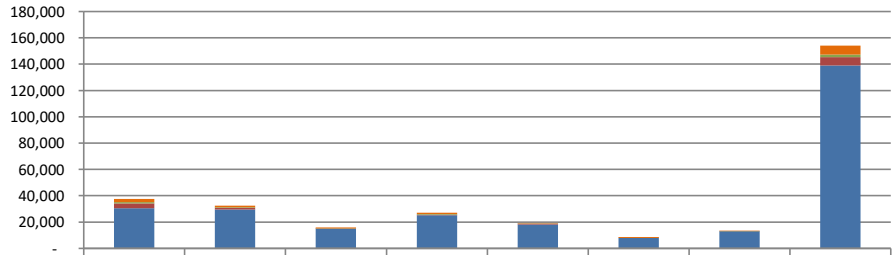
Agency costs for nursing increased in the month, as a result of Ward 18 and James Cross escalation areas being opening within the month – and also an increase in the use of high cost agencies particularly within ED.

Analysis

Agency Spend - 13 Month Trend



Staffing costs by Substantive and Temporary



	DMEC	S&C	W&C	CSSD	CCICP	Estates	Other	Total
Total	37,860	33,065	15,807	27,291	19,354	8,610	13,377	155,365
Waiting Lists	421	544	2	297	-	-	-	1,263
Bank	2,454	1,280	617	894	370	864	270	6,749
Locum	957	471	5	390	217	-	33	2,073
Agency	3,444	1,155	280	605	674	2	30	6,188
Substantive	30,585	29,615	14,903	25,106	18,094	7,744	13,045	139,092

Forward View

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

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

As a result of the increase in shifts booked with high cost agencies, the Trust has review the incentives for staff in order to encourage uptake on the hospital bank and commenced 2 keys schemes in December /January which are aimed at reducing agency and improving shift cover.

Agency spend is currently forecast to be £7.3m, which exceeds the threshold for a rating of 3. It is not expected that it will exceed £8.5m which would be the threshold for a UoRR of 4.

Performance and Finance - Divisional Performance January 2020

Current Position

The over-performance on contract income is offset within Other.

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

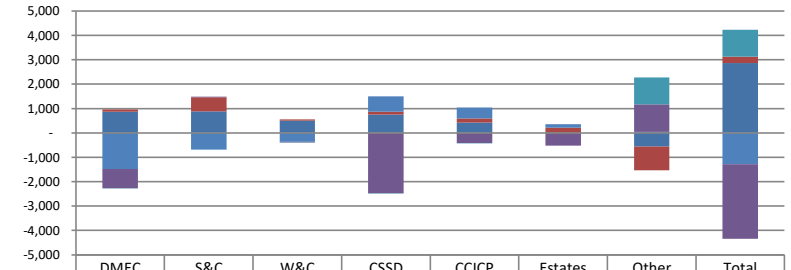
In contract CSSD has pressure from premium costs materialising within non-pay.

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

Estates are worse than plan as a result of the outsourcing of laundry.

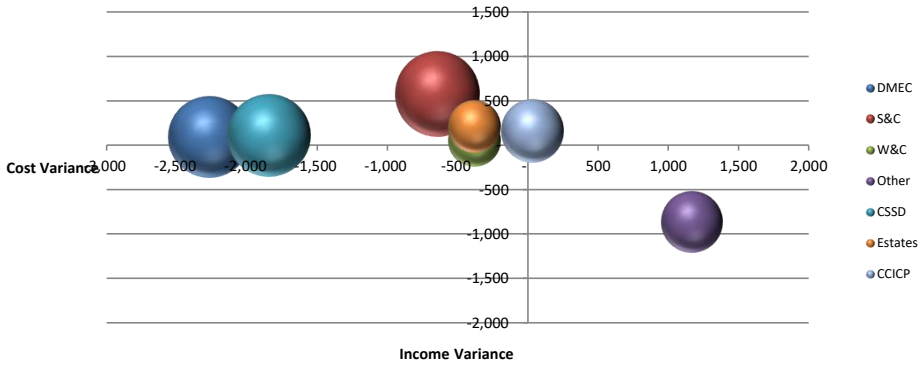
Analysis

Cumulative Variance by category



	DMEC	S&C	W&C	CSSD	CCICP	Estates	Other	Total
Total	-1,314	814	173	-982	602	-163	751	-118
Other Costs	-0	-0	-0	-0	-20	0	1,112	1,092
Non Pay	-787	29	-24	-2,475	-415	-517	1,130	-3,059
Pay	-1,486	-677	-364	626	443	136	39	-1,282
Other Income	96	576	57	115	167	218	-966	263
Commissioning Income	864	886	504	752	427		-564	2,869

Divisional Performance 2019/20



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

Forward View

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

- Additional bed escalation costs over and above the plan and agreed additional resources, and the associated agency costs of delivering that activity

- Challenges with significant breakdowns within the laundry department

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

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

- 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

Performance and Finance - Cash January 2020

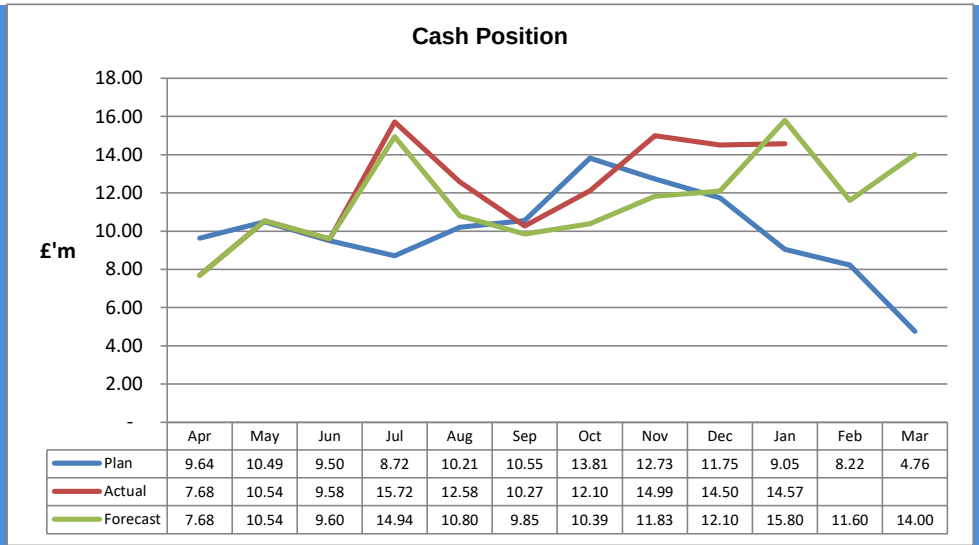
Current Position

Cash Position
Cash is better than plan by £5.5m.

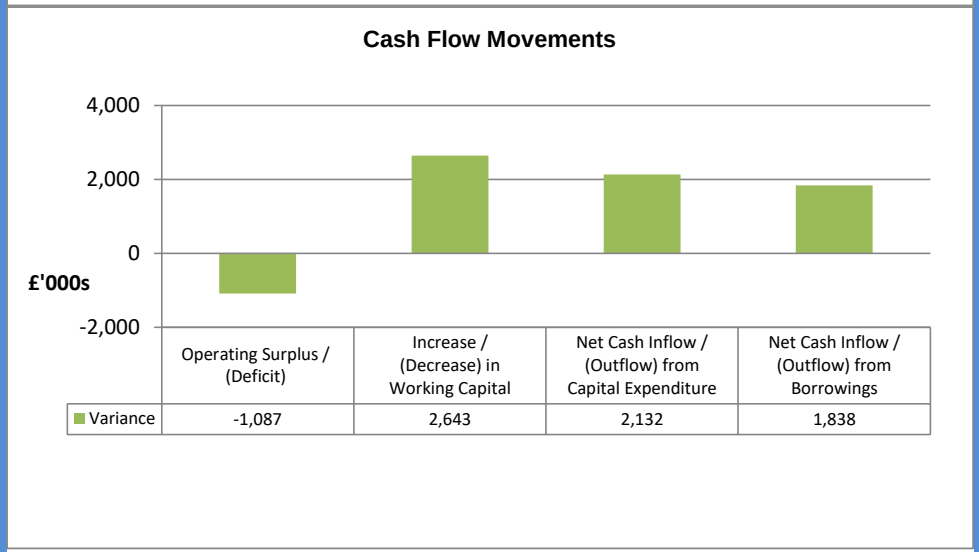
The main movement to plan is due slippage in the capital programme which has a cash impact of £3.3m and the receipt of £1.8m PDC as part of the ED Majors extension.

The trust has drawn down £3.4m of the £4.2m capital loan, with the remainder to be drawn down in line with spend.

Analysis



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Plan	9.64	10.49	9.50	8.72	10.21	10.55	13.81	12.73	11.75	9.05	8.22	4.76
Actual	7.68	10.54	9.58	15.72	12.58	10.27	12.10	14.99	14.50	14.57		
Forecast	7.68	10.54	9.60	14.94	10.80	9.85	10.39	11.83	12.10	15.80	11.60	14.00



	Operating Surplus / (Deficit)	Increase / (Decrease) in Working Capital	Net Cash Inflow / (Outflow) from Capital Expenditure	Net Cash Inflow / (Outflow) from Borrowings
Variance	-1,087	2,643	2,132	1,838

Forward View

Cash is forecasted to be above target at the year end mainly due to the delay in the capital programme and additional PDC of £3.2m for EPR/EPMA projects which will not be spent in this financial year.

Performance and Finance - Capital Expenditure January 2020

Current Position

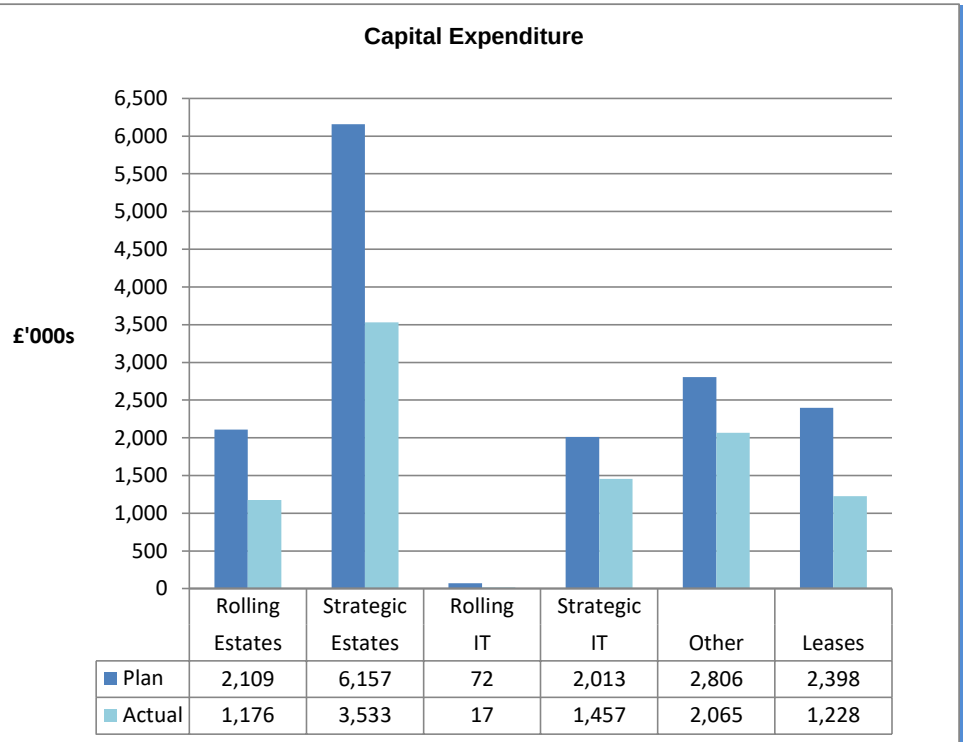
The capital programme (excluding leases) is £4.9m less than anticipated which is mainly due to:

(£1.3m) Purchase and updating of South Cheshire Private Hospital
(£1.2m) EPR & EPMA Project
(£1.0m) ICU Conversion
(£0.7m) Third CT Enabling
(£0.6m) Backlog Maintenance

The underspend is due to a number of delayed capital schemes, in particular the purchase of South Cheshire Private Hospital, which is now due to complete in February 2020.

Leases are £1.2m underspent, this is due to the CT Scanner & MRI Scanner being assumed to be a finance lease and has now been assessed as an operating lease.

Analysis



		Year to Date £'000s			Year End £'000s		
		Plan	Actual	Variance	Plan	Forecast	Variance
Estates	Rolling	2,109	1,176	-933	2,490	2,340	-150
Estates	Strategic	6,157	3,533	-2,624	6,551	4,763	-1,788
IT	Rolling	72	17	-55	90	90	0
IT	Strategic	2,013	1,457	-556	3,968	2,187	-1,781
Other		2,806	2,065	-741	1,848	3,671	1,823
Leases		2,398	1,228	-1,170	3,047	1,500	-1,547
		15,555	**9,476**	**-6,079**	**17,994**	**14,551**	**-3,443**

Forward View

The Trust is forecasting an underspend of £1.9m on the capital programme (excluding leases) due to slippage in the scheme for EPMA £1.5m and EPR £0.5m.

The ED Majors extension of £1.8m which is included within the spend forecast and is funded by PDC.

Leases are forecast to be underspent due to the CT Scanner & MRI Scanner being assumed to be a finance lease and has now been assessed as an operating lease.

Performance and Finance - Statement of Financial Position January 2020

Current Position | Analysis | Forward View

Assets Non-Current
The capital programme expenditure is £6.1m less than anticipated due to slippage in a number of schemes. In addition to this, there has been a delay in Finance Lease purchases.

Assets Current
Trade and Other Receivables is £3.1m higher than plan, mainly due to additional accrued income of £2.9m from host CCG's. In addition, prepayments for operating leases are higher than anticipated due to a switch from finance lease to operating leases.

Current Liabilities
Loans are higher than plan due to the repayment of the £5m working capital loan being deferred. Deferred Income is higher than anticipated as the two main CCG's contract payments are £3.8m ahead of plan.

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 a proportion of the £4.2m capital loan will now be drawn down in line with expenditure.

Taxpayers Equity
PDC has been received of £1.8m for the ED expansion.

	Plan Apr to January (£'000)	Actual Apr to January (£'000)	Variance (£'000)	Forecast 2019/20 (£'000)
Assets				
Assets, Non-Current	103,538	98,071	-5,467	104,387
Assets, Current	23,200	31,652	8,452	21,964
ASSETS, TOTAL	**126,738**	**129,723**	**2,986**	**126,351**
Liabilities				
Liabilities, Current	-25,754	-33,913	-8,159	-29,607
Liabilities, Non Current	-23,970	-17,157	6,813	-17,347
TOTAL ASSETS EMPLOYED	**77,014**	**78,653**	**1,639**	**79,397**
Taxpayers' and Others' Equity				
Taxpayers Equity	77,014	78,653	1,639	79,397
TOTAL FUNDS EMPLOYED	**77,014**	**78,653**	**1,639**	**79,397**

The Statement of Financial position is forecast mainly on plan.

The Asset, Non-Current forecast has been adjusted for the anticipated delay in some of the capital schemes and the ED expansion. In addition the value of the Finance leases are lower than planned.

Cash is forecasted to be above target at the year end mainly due to the delay in the capital programme and additional PDC of £3.2m for EPR/EPMA projects which will not be spent in this financial year.

The Public Dividend Capital forecast has increased by £1.8m due to the ED Expansion.

"Delivering Excellence in Healthcare through Innovation and Collaboration"

NHS Mid Cheshire Hospitals NHS Foundation Trust

Performance and Finance - Statement of Financial Position January 2020

Current Position | Analysis | Forward View

Assets Non-Current
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	Plan Apr to January (£'000)	Actual Apr to January (£'000)	Variance (£'000)	Forecast 2019/20 (£'000)
Assets				
Assets, Non-Current	**103,538**	**98,071**	**-5,467**	**104,387**
Assets, Current				
Trade and other Receivables	8,033	11,183	3,150	9,255
Other Assets (including Inventories & Prepayments)	6,121	5,898	-223	6,097
Cash and Cash Equivalents	9,046	14,572	5,526	6,612
Total Assets, Current	**23,200**	**31,652**	**8,452**	**21,964**
ASSETS, TOTAL	**126,738**	**129,723**	**2,986**	**126,351**
Liabilities				
Liabilities, Current				
Finance Lease, Current	-451	-473	-22	-1,700
Loans Commercial Current	-1,790	-5,280	-3,490	-5,472
Trade and Other Payables, Current	-15,105	-15,599	-493	-13,290
Provisions, Current	-157	-312	-155	-325
Other Financial Liabilities	-8,251	-12,249	-3,998	-8,820
Total Liabilities, Current	**-25,754**	**-33,913**	**-8,159**	**-29,607**
Net Current Assets/(Liabilities)	**-2,554**	**-2,261**	**293**	**-7,643**
Liabilities, Non Current				
Finance Lease, Non Current	-6,866	-4,285	2,581	-4,332
Loans Commercial Non-Current	-15,663	-11,449	4,214	-11,769
Provisions, Non-Current	-1,441	-1,423	18	-1,246
Trade and Other Payables, Non-Current	0	0	0	0
Total Liabilities Non-Current	**-23,970**	**-17,157**	**6,813**	**-17,347**
TOTAL ASSETS EMPLOYED	**77,014**	**78,653**	**1,639**	**79,397**
Taxpayers' and Others' Equity				
Taxpayers Equity				
Public dividend capital	77,508	79,308	1,800	79,308
Retained Earnings	-13,908	-14,044	-136	-13,325
Donated asset reserve	0	0	0	0
Revaluation Reserve	13,414	13,389	-25	13,414
TOTAL TAXPAYERS EQUITY	**77,014**	**78,653**	**1,639**	**79,397**
TOTAL FUNDS EMPLOYED	**77,014**	**78,653**	**1,639**	**79,397**

The Statement of Financial position is forecast mainly on plan.

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The Public Dividend Capital forecast has increased by £1.8m due to the ED Expansion .

Mid Cheshire Hospitals NHS Foundation Trust

Title of Paper:	Board Assurance Framework (BAF) Report Q3 19/20	
Author:	Associate Director, Quality Governance	
Executive Lead:	Medical Director	
Type of Report:	Concept Paper	
	Strategic Options Paper	
	Business Case	
	Information	
	Review/Benefits/Audit	✓

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

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

Positive Benefit:	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:	Monday 2 March 2020

Mid Cheshire Hospitals
NHS Foundation Trust

Board Assurance Framework 2019/20

Quarter 3

Summary Version

Delivering Excellence in Healthcare through Innovation and Collaboration'

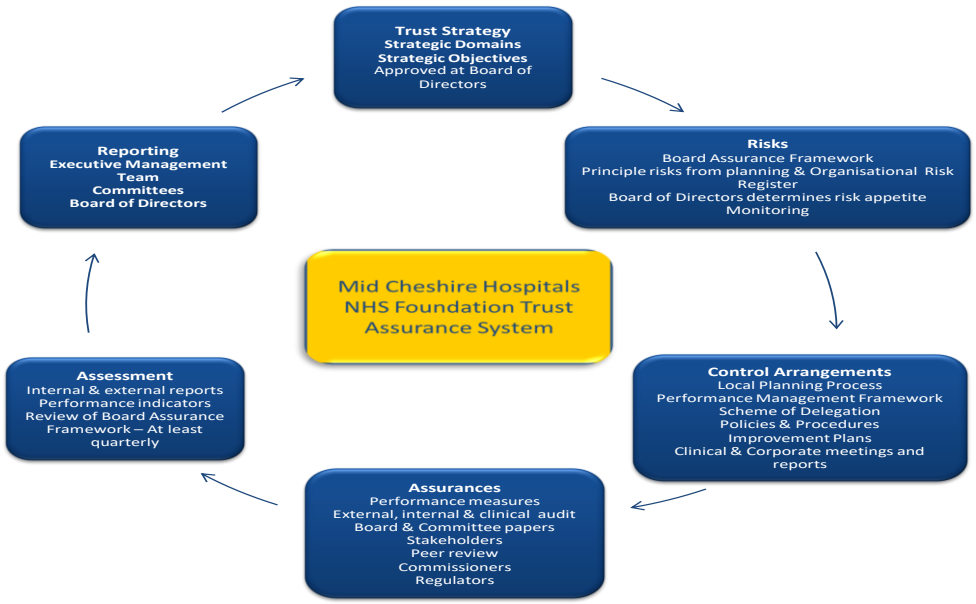
Contents

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 3, 2019/20.

Table 1 – Six key risks for the Trust in 2019/20

Risk Title	Mitigated (with controls) Risk Rating	SHIFT				Key links to BAF 2019/20
		Q1	Q2	Q3	Q4	
Delivery of key local and National targets and standards, in particular the 4 hour standard in A&E	5(C) x 4(L) = 20	20 ⇔	20 ⇔	20 ⇔		Q1,Q2,E1,E2,P1,P2
Workforce capacity and skill mix to consistently deliver high quality care, seven days a week	5(C) x 4(L) = 20	20 ⇔	20 ⇔	20 ⇔		Q1,Q2,P1,P2,E2,W2
Lack of pace in the significant transformational change required to deliver the Cheshire East Place Strategy and consequently the Health and Care Partnership (HCP) for Cheshire & Mersey	4(C) x 4(L) = 16	16 ⇔	16 ⇔	16 ⇔		Q1,Q2,P1,P2,E2,W2,T1,T2a,T2b
The Long Term Financial Sustainability of the Trust.	4(C) x 3(L) = 12	12 ⇩	12⇔	12⇔		E1,E2,P1,P2,T1,T2a,T2b
Obsolete IT Equipment	4(C) x 4(L) = 16	16 ⇔	16 ⇔	16 ⇔		Q1,Q2,E1,E2,T2a,T2b
Proposed acquisition of the South Cheshire Private Hospital	5(C) x 2(L) = 10	Under review	10 ⇔	10 ⇔		

4. Next steps

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

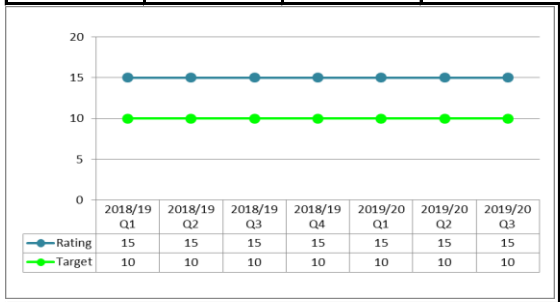
BAF Domain	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Q1	15			15			15					
Q2	10			10			10					
P1	12			16			16					
P2	12			12			12					
E1	15			15			15					
E2	16			16			16					
T1	15			15			15					
T2a	15			15			15					
T2b	12			12			12					
W1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

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

Principle Risk

Risk of not consistently providing the safest, highest quality care.

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	Dec 2019	Mar 2020	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 3. Work is now in progress and is being embedded in terms of the risk management and quality assurance frameworks in order to provide sustained demonstrable improvements and associated assurances at ward, department and divisional levels, this includes the embedding of the Ward Accreditation Programme and commencement of Q1 projects at ward level. The risk score remains the same due to the current gaps in establishments for Registered Nurses, difficulties in recruitment and the national gap in supply.

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?)

- Roll out and embedding of Quarterly Quality reports across all divisions.
- Roll out and embedding of Ward Accreditation Programme, QI projects and care evidenced by monthly metrics.
- Scoping of the Quality Safety and Improvement Strategy (2020 - 2021).
- Completion of 2019 CQC inspection and a focused improvement in the SAFE domain
- Completion of mock CQC inspection October 2019 and subsequent implementation plan. The mock CQC inspection will be annual from 2020.
- Launch of NMAP Strategy November 2019
- Short, medium and long term RN recruitment strategy in place and includes recruitment of international nurses, UK adaption and RN Apprenticeship training.
- Completion of 26 wards on E-Roster - KPI's in development.
- Successful attainment of CNST2 2019-2020
- Internal Well-Led Review improvement actions – quarterly oversight at Quality Governance Committee review of quality metrics
- CQC Mock Inspection to be undertaken annually from 2020
- 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 2020	• 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 2019/20 CQUINs	• Quality Schedule / data collection requirements to be finalised for 2020/21and associated resources • internal audit of e-rostering roll out programme complete March 2019
2. Infection Prevention & Control (IPC) Team and supporting strategies & policies	* Recruitment for full time HON IPC post	• 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 2020	• 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 - completed	90 day improvement plan in place June 2019 - completed External review completed April 2019 Actions within 90 day improvement plan - completed
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	• 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.**					
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		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 • Implementation of new Quality & Safety Improvement Strategy 2019/20	• 1:1 / Team Meetings • Quality Matters Programme • Monthly Divisional Boards/CCICP reports	• Deteriorating Patient Steering Group • Hospital Mortality Reduction Group • QSIS Group. EQGG. QGC • Board of Directors • QGC minutes • Patient / Staff Stories • Board Walkaround Programme • Monthly Quality, Safety & Experience Report • Monthly Serious Events / IPC • Quality Account-April 2019 • CQC Improvement Plan monitored at Quality Summit	• CQC Good rating-Sept 18 • CCG Quality Visits • Advancing Quality Reports • External accreditation e.g. UKAS, JAG • CQC Inpatient Survey-June 2019 'About the same as other Trusts overall'-reduction on previous year Internal Audit Programme • Internal audit of IP&C processes	• Implementation of formal quarterly quality review process • New strategy, metrics and monitoring	• Quarterly quality reviews and reports are rolled out across in-patient areas completed April 2019 • Quality metrics, monthly results to are displayed on wards from May 2019. • New Quality Boards in place - 2019 • QI Projects presented at Quality Summit by Ward Managers - 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 2018 • 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 all divisions in place	• 1:1 / Team Meetings • Monthly Divisional Boards/CCICP reports	• Patient Safety Summit • Deteriorating Patient Steering Group • EQGG. QGC • Board of Directors • QGC minutes • Monthly Quality, Safety & Experience Report • Monthly serious events / IPC • Quality Account-April 2019	• CQC Good rating-Sept 2018 • CCG contract meetings monthly • Quarterly Advancing Quality Reports Internal Audit Programme • Internal audit of IP&C processes	• Implementation of formal quarterly quality review process	• Quarterly quality reviews and reports are fully rolled out • Development of quality reports / data collection in place • Review of Quality dashboard January 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.**					
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		Local Management (1st Line of Defence)	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)		
7. Risk Management Strategy & Framework 2018/19 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 and December 2019.	• Internal Audit Programme • Annual Governance Statement-March 2019 • Risk Management and BAF internal audit report: Significant Assurance- with minor opportunities for improvement - January 2019 • Externally facilitated Developmental Review NHSI Well Led Framework Completed January 2019		• Source external Well-Led reviewer - January 2019 • Implementation of Well Led Improvement Plan • Well led interviews completed November 2019
8. Quality Impact Assessment (QIA) Process	• QIA process to be fully established	• Programme/Project Team • Monthly Divisional Boards/CCICP reports	• Medical Director & Director of Nursing& Quality reviews • EQGG • QGC • Board of Directors • QGC minutes • Quality Account April 2019	• CQC Good rating- Sept 2018 • CCG contract meetings monthly Internal Audit Programme • Quality Account-April 2019	• Strengthen reporting and monitoring of QIA process	• Roll out of new QIA process January 2020 complete
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

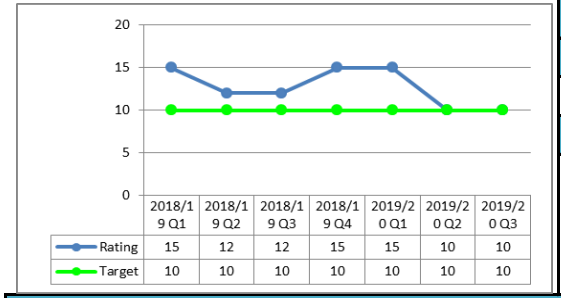
Strategic Domain 1: Delivering Outstanding Clinical Quality, Safety & Experience						
Q1	**To aspire to the delivery of 'Outstanding' clinical quality and safety, which is equitable, patient and family centred and supported by an effective quality governance framework.**					
Key Controls / Influences 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 complete December 2019. • NHS Resolution Maternity Incentive Scheme – all indicators achieved for 2019. • Launch of Nursing, Midwifery and Allied Health Proffessional Strategy November 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	Dec 2019	Mar 2020	Safe, Effective, Responsive, Caring & Well Led NHSI – Quality Metrics	Medical Director	Executive Quality Governance Group (EQGG)	Quality Governance Committee (QGC)



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

Rationale for the Current Risk Score

Risk score has remained at 10 for Quarter 3. The likelihood of not improving the quality of care with all the key controls in place is unlikely.

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**
CS0380 - Obsolete IT Equipment	**16**		

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

HSMR/SHMI mortality indicators are 'within expected range'. Second year of SJR process is up and running utilising new intelligently identified cohorts. 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, strengthened processes for tracking actions and escalation/excpetion reporting against GIRFT improvement plans. Progression of Quality, Service Improvement and Redesign (QSIR) initiative. Significant improvement in 7 Day Services audit results.

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

- Clinical Trials portfolio has been developed, plan for future 3 year strategy.
- QI Faculty in place: Focus on culture and capability
- Lack of integration between Service Development and QI teams to be addressed as part of the Trust wide plans. (Included in Improving Quality Together programme proposal document)

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

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

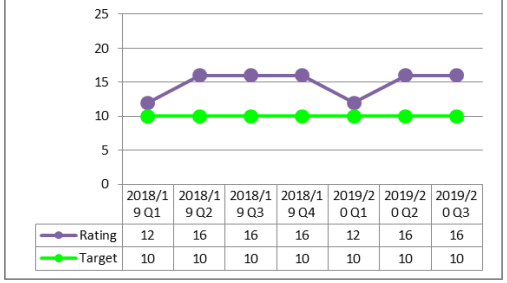
Strategic Domain 2: Being a Leading Partner in a Progressive Health Economy	
P1	**To fully engage with all strategic partners to maximise the opportunities and advantages associated with horizontal integration in the designing and delivery of sustainable health services for the population of Central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

Principle Risk

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

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

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHSI Single Oversight F/w	Executive Director	Executive Management Group	Board Committee
June 2017	Dec 2019	Mar 2020	Well Led NHSI – Use of Resources	CEO	Board of Directors	Quality Governance Committee (QGC)



Initial Risk Rating (Unmitigated)			Current Risk Rating (Mitigated)			Target Risk Rating (Tolerance/Risk Appetite)			
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Target Date
5	5	25	4	4	**16**	5	2	**10**	March 2020

Rationale for the Current Risk Score

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

Links to BAF objectives

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

Key Links to the Organisational Risk Register

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

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

The Cheshire System CEOs/AO have created a new system wide meeting to discuss the delivery of the Financial Recovery Plan. There is a key workshop on 5th Feb within Cheshire East Place to clarify governance arrangements and the ability of the new direction of larger systems to complement PLACE delivery.

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

At present the key gap is the need for a consistent clear view of how the Cheshire System will deliver its financial recovery in the context of the two PLACE governance structures and emerging Primary Care Networks. The CEO of MCHT is still working with other system AOs to clarify this.

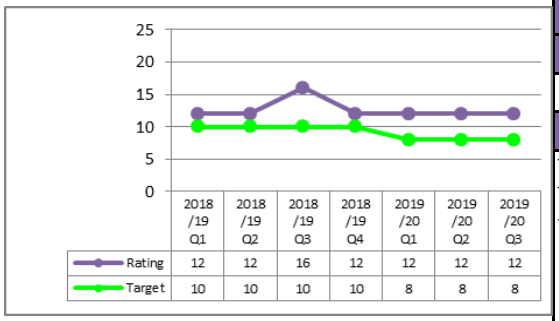
Strategic Domain 2: Being a Leading Partner in a Progressive Health Economy						
P1	**To fully engage with all strategic partners to maximise the opportunities and advantages associated with horizontal integration in the designing and delivery of sustainable health services for the population of Central 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	Dec 2019	Mar 2020	Well Led / NHSI – Use of Resoruces	CEO	Board of Directors	Quality Governance Committee (QGC)



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

Rationale for the Current Risk Score

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

Links to BAF objectives

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

Key Links to the Organisational Risk Register

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

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

The Partnership Board and Executive Group are continuing to progress the plans and there is a PLACE programme risk register in use.

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

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

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

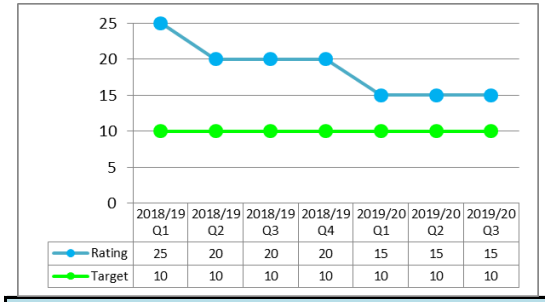
Strategic Domain 2: Being a Leading Partner in a Progressive Health Economy						
P2	**To work with all key stakeholders to deliver a wholly integrated health and social care system, taking on clear collective responsibility for resources and population health, so that our residents receive better coordinated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

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

Principle Risk

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

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHSI Single Oversight F/w	Executive Director	Executive Management Group	Board Committee
June 2017	Dec 2019	Mar 2020	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 3 2019/20 the risk score remains at 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	CS0380 - Obsolete IT Equipment	16

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

Trust has submitted a 5 year draft financial plan to NHSi and is working alongside other organisations, within the Cheshire system, on a financial recovery plan for both the current and future years. This plan includes 3 specific elements 1: Grip and control 2: Collaboration at scale and 3: Transformational change. At month 8 the financial position is £437k off plan. However, an additional £1.5m urgent care pressure funding has been agreed with CCG, and £800k from NHSi. Therefore the current forecast is that the Trust will deliver its control total. The Trust is working in collaboration with a number of system/organisations around future sustainability including Cheshire & Merseyside HCP and North Midlands UHNM. The Trust underwent a use of resources assesment in November 2019, and while the formal outcomes are still awaited,informal indications are very positive. NHS Improvement Segment 2 in September 2019, indicating performance is still on track.

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

- Finalisation of the Long Term Plan
- The Cheshire system currently has a financial gap of £35m in 2019/20 and £44m in 2020/21 wich is being addressed by the Cheshire system financial recovery plan. The collaboration at scale schemes and transformational changes required to support financial sustainability are currently being established, but are not yet in place.
- Performance Management Framework being reviewed.

Strategic Domain 3: Striving for Outstanding Organisational Effectiveness							
E1	**To ensure full compliance with the NHS Improvement Provider Licence, ensuring financial sustainability, financial efficiency and financial controls, whilst safeguarding the quality of our services.**						
Key Controls / Influences Established (What are we currently doing about the risk?)	Key Gaps in Controls / Influences (What additional controls should we seek?)	Assurance Providers 2018/19 (How do we know if the things we are doing are having an impact?)			Gaps in Assurances on Controls / Influences (What additional assurances should we seek?)	Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)	
		Local Management (1st Line of Defence)	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)			
1. Annual Plan & delegated budgets	• Availability / access to capital funding • Agency spending – medical & nursing • Capped expenditure programme outputs • Long term health economy with clear governance structure	• 1:1 / Team Meetings • Divisional Accountants 1:1s • Monthly Divisional Boards/CCICP reports	• Divisional Finance & Activity Performance Group • Performance & Finance Committee • Internal Audit Reports to: Audit Committee Audit Committee minutes • Board of Directors • PAF Minutes • Annual budget/planning April 2018 • Monthly Performance Report • Corporate Governance Handbook approval December 2018	• NHS Improvement Segment September 2019) (Segment 2 = Providers offered targeted support) & quarterly meetings. • NHS Improvement- submitted annual plans & feedback provided (No actions outstanding) • Funding agreed by NHS Improvement & control total agreed Internal Audit Programme: • Core Financial Controls 2018/19 Significant Assurance Next review-January 2020 • Financial Management & Financial Reporting- Significant Assurance, (September 2017) • Data Quality 2018/19 Significant Assurance with minor improvements required • Risk Management & Corporate Governance Report: Significant Assurance with minor improvements-April 2019 Next review-January 2020 • NHSI Use of Resources Assessment November 2019; rate awaited.		1. Collaboration at scale schemes and transformational changes required to support financial sustainability are currently being established, but not yet in place. 2. Follow-up on loan applications for capital spend Awaiting HM Treasury decision. 3. Internal audit programme to be finalised.
2. Identified CIP schemes	Review of CIP planning and delivery						
3. Monthly finance & activity review meetings							
4. Performance management systems	New Performance Management Framework to be reviewed						
5. Job descriptions contain financial responsibilities							
6. CCG Contract		• Recruitment process					
7. CQUIN Schemes & process to deliver		• Monthly CCG Meetings					
8. Monthly Performance Report		• Monthly CCG Meetings					

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	• 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		Review by PAF – Completed June 2019	

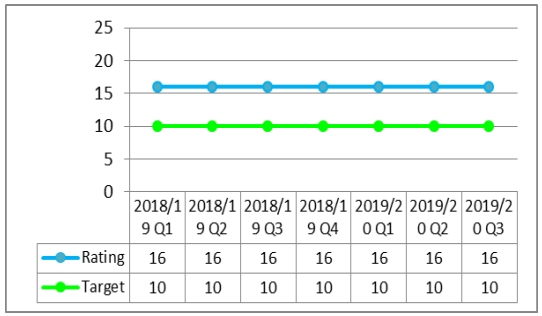
11. Cheshire East Place review			Committee • Internal Audit Reports to: Audit Committee Audit Committee minutes • Board of Directors • PAF Minutes • Annual budget/planning April 2018 • Monthly Performance Report • Corporate Governance Handbook approval December 2018	Internal Audit Programme: • Core Financial 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.		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	Dec 2019	Mar 2020	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	10	March 2020

Rationale for the Current Risk Score

Quarter 3 has seen the Trust recover from under performance in RTT and diagnostic standards. For quarter 3 there was full compliance against cancer standards. RTT performance whilst compliant in October and November did fall below 92% due to the early cessation of elective orthopaedic activity as a result of non-elective pressures. Diagnostics again delivered in October and November but due to server downtime and an increase in cardiac CT demand failed in December. The Trust continues to be significantly challenged with regards to the four hour access standard and is recording increased attendances at ED with a 10% increase YTD. There have also been challenges in the community to support discharges from hospital, with December seeing record levels of medically optimised patients being cared for in acute care. Therefore, occupancy levels across care wards have increased, with additional beds being opened at inflated costs as a consequence, although slightly offset by additional NHSE funding.
The Trust has maintained its strong cancer performance through19/20.

Links to BAF objectives

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

Key Links to the Organisational Risk Register

TW0001 – Delivery of key local and National targets and standards, in particular the 4 hour standard in A&E	20	TW0003 – Workforce capacity and skill mix to consistently deliver high quality care, seven days a week	20
TW0002 – Long Term Financial Sustainability of MCHFT	12	CS0375 - Delayed routine outpatient follow-up	15
CS0380 - Obsolete IT Equipment	16		

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 was commissioned by the A&E Delivery Board, which focus on local of community capacity impacting on acute care. Diagnostic standard is due to deliver in January. An external review of front of house processes and why patients are presenting to ED in their increased level. RTT will be a similar challenge to 2019/20 with performance impacted by winter non-elective pressures. The acquisition of the SCPH will mitigate the loss of elective activity in Winter 2019/20.

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.

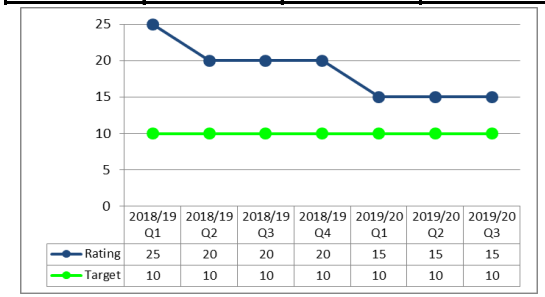
Strategic Domain 3: Striving for Outstanding Organisational Effectiveness						
E2	**To maintain compliance with, and aspire to achieve incremental improvements against, the NHS Improvement Single Oversight Framework Operational Performance Metrics, whilst safeguarding the quality of our services.**					
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 - now in place 2. NF to develop plan for full BCP compliance - now in place

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	Dec 2019	Mar 2020	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.
Potential loss of ability to produce Linen at MCHFT - Risk assessment in progress
Defective planks - Risk Assessment in progress: Structural Engineers visiting site (29/30 January 2020) to undertake visual inspections, and professional survey company using laser levels across ceilings and noting any deflection. A Report will follow these inspections.

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'		

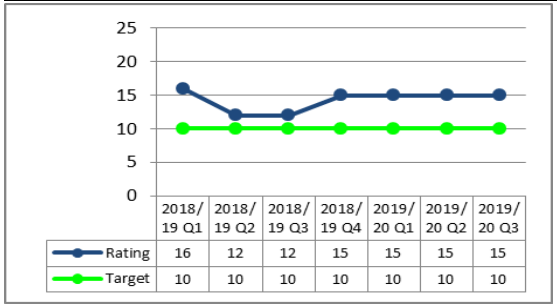
Strategic Domain 5: Creating a 21st Century Infrastructure for Transformative Health and Social Care	
T2a	**To deliver an agreed, costed and phased Information Technology (IT) Strategy which supports the provision of seamless, integrated, outstanding patient care, improves staff experience in delivering 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	Dec 2019	Mar 2020	Well Led Framework Use of Resoruces	Medical Director	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	10	March 2020

Rationale for the Current Risk Score

The risk score remains at 15 for Quarter 3. Longer timescales for the approval of business cases is leading to the potential failure of more systems and withdrawal of support from suppliers. £3M of national funding obtained to support the Clinical Systems Business Case. The Clinical Systems Outline Business Case was presented to the Board of Directors in January 2019 and approved. Outline Business Case approved by NHSI Regional Team, now awaiting NHSI National team approval, expected by end of February 2020.

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 - Obsolete IT Equipment	16
TW0010 - Legacy Operating Systems Software	16		

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

The main challenge to delivering the DIGIT@LL Technology Strategy is the financial affordability. However the Board of Directors does not underestimate the level of organisational development support that will be required for the organisation to undergo the necessary culture change. A Chief Nursing Information Officer and Chief Clinical Information Officer have been appointed to support the EPR. The Executive Lead for Cyber Security is the Chief Executive. Funding to replace aged hardware across the Trust has been identified, and the replacement has now commenced. The E-Rostering project has commenced and is on track to deliver within timescales. Cyber security across the Trust is being improved the aid of national funding and the appointment of a new cyber security engineer. 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. Health Service-Led Initiative monies have been received: 2018/19 - £500k, 2019/20 - £600k, Also, Electronic Precribing (EPMA) monies of £2.5m were received in 2019/20.

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

- Delivery of the overarching Cyber Security implementation plan.

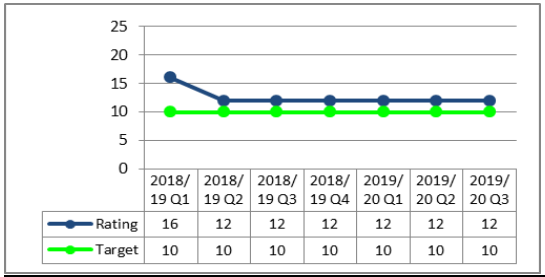
Strategic Domain 5: Creating a 21st Century Infrastructure for Transformative Health and Social Care							
T2a	**To deliver an agreed, costed and phased Information Technology (IT) Strategy which supports the provision of seamless, integrated, outstanding patient care, improves staff experience in delivering 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 to 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	Dec 2019	Mar 2020	Well Led Framework Use of Resources	Medical Director	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	**10**	March 2020

Rationale for the Current Risk Score

The current risk score has remained at 12 for Quarter 3, on the basis that the Clinical Systems Strategic Outline Case has been approved by NHSI to move to the next step.

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 - Obsolete IT Equipment	**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 being rolled out across all nursing and midwifery wards. The IT Team hold intermittent drop-in sessions for staff across the Trust to directly discuss IT issues. Annual update of IG training is part of mandatory training. Computer confidence courses are available for all staff. QA process for 'train the trainer' has been introduced, surveys for staff trained by core trainers have been established to measure the effectiveness of the training. Digital clinical systems demonstration to raise awareness of digital future. Trust Board has received independent cyber security training. ED now using electronic screen. All consultants have been issued with laptops in readiness for new clinical system. A business case has been prepared for training for healthcare professionals eg: Physiotherapists / Pharmacy Technicians. Digital training course being delivered to cohort of international nurses. Digital Nursing Group in development: appropriate staff to be identified to support digital agenda within the Trust, to also attend Cerner European Collaborative Conference (Feb 2020) and the Digital Nursing Conference (Mar 2020).

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

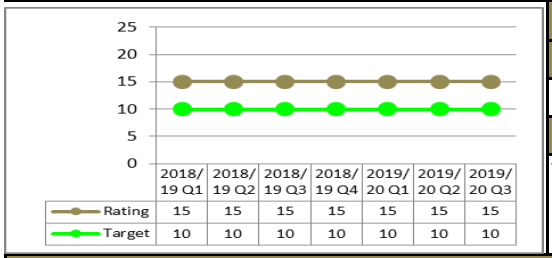
Strategic Domain 5: Creating a 21st Century Infrastructure for Transformative Health and Social Care						
T2b	**To deliver an agreed, costed and phased Information Technology (IT) Strategy which supports the provision of seamless, integrated, outstanding patient care, improves staff experience in delivering 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	Dec 2019	Mar 2020	Well Led Framework NHSI Organisational Health Metrics	Director of Workforce & Organisational Development	Executive Workforce Assurance Group	Transformation & People Committee



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

Rationale for the Current Risk Score

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

Links to BAF objectives

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

Key Links to the Organisational Risk Register

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

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

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

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

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

Strategic Domain 4: Aspiring to Excellence in Practice through Our Workforce							
W1	**Our cadre of patient centred leaders will be skilled in continually promoting and building upon our open and honest culture. This will be achieved through sharing the Trust's vision, values, behaviours and objectives from Board to ward.**						
Key Controls / Influences Established (What are we currently doing about the risk?)	Key Gaps in Controls / Influences (What additional controls should we seek?)	Assurance Providers 2018/19 (How do we know if the things we are doing are having an impact?)			Gaps in Assurances on Controls / Influences (What additional assurances should we seek?)	Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)	
		Local Management (1st Line of Defence)	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)			
1. Trust Strategy 2017 with 2020 Horizon		• 1:1 / Team Meetings • Divisional Workforce Groups • Monthly Divisional Boards/CCICP reports • Consultant Foundation Programme	• Professional Advisory Group • Executive Workforce Assurance Group • Transformation and People (TAP) Committee (Minutes) • Board of Directors • Monthly Workforce Report • Annual Report on the Appraisal and Revalidation of Medical Practitioners at MCHFT-September 2017 • Workforce Race Equality Scheme Annual Review-November 2018 • Strategic Nursing & Midwifery Staffing Review-October 2018 • Monthly Quality, Safety & Experience Report (Nurse staffing) • Medical staffing workforce metrics included in the Workforce Report reported via TAP to Board of Directors • Freedom to Speak Up Guardian Report Quarterly to TAP, annually to Board • Findings from Freedom to Speak Up Review • Staff survey results reported to Board and TAP, and also reported to JCNC	• Sub Regional Workforce Planning and Development Network • Staff Survey March 2018 • Health Education England reviews. ED/Training self-assessment July 2018 • Chester College reviews • Royal College reviews	1. BIU reporting following discontinuation of DISCO reporting 2. Monitored at TAP and EWAG	1. Our Workforce Matters Strategy to be fully implemented. 2. Review of Education Governance complete. 3. Restructure of W&OD team undertaken. Implementation plan in place Q3 2019-20 4. Occupational Health service level agreement and strategic priorities to be reviewed during Q3 2019-20. 5. ESR system project in place Q3. 6. Work to improve data quality. Project plan/business case to improve ESR links compliance. Deliver in 3 to 12 months (March 2020) 7. Talent boards to inform regional and National talent boards. 3 talent boards to have been held by Q3 2019/20 8. Review apprenticeship programme and establish clear links to strategy
2. Our Workforce Matters Strategy implementation	• to be fully implemented	• 1:1 / Team Meetings • Divisional Workforce Groups • Monthly Divisional Boards/CCICP reports					

Strategic Domain 4: Aspiring to Excellence in Practice through Our Workforce						
W1	**Our cadre of patient centred leaders will be skilled in continually promoting and building upon our open and honest culture. This will be achieved through sharing the Trust's vision, values, behaviours and objectives from Board to ward.**					
Key Controls / Influences Established (What are we currently doing about the risk?)	Key Gaps in Controls / Influences (What additional controls should we seek?)	Assurance Providers 2018/19 (How do we know if the things we are doing are having an impact?)			Gaps in Assurances on Controls / Influences (What additional assurances should we seek?)	Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)
		Local Management (1st Line of Defence)	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)		
3. Education Governance Framework	• Framework requires review	• 1:1 / Team Meetings • Divisional Workforce Groups • Monthly Divisional Boards/CCICP reports • Consultant Foundation Programme	• Professional Advisory Group • Executive Workforce Assurance Group • Transformation and People (TAP) Committee (Minutes) • Board of Directors • Monthly Workforce Report • Annual Report on the Appraisal and Revalidation of Medical Practitioners at MCHFT-September 2017 • Workforce Race Equality Scheme Annual Review-November 2018 • Strategic Nursing & Midwifery Staffing Review-October 2018 • Monthly Quality, Safety & Experience Report (Nurse staffing) • Medical staffing workforce metrics included in the Workforce Report reported via TAP to Board of Directors • Freedom to Speak Up Guardian Report Quarterly to TAP, annually to Board • Findings from Freedom to Speak Up Review • Staff survey results reported to Board and TAP, and also reported to JCNC	• Sub Regional Workforce Planning and Development Network • Staff Survey March 2018 • Health Education England reviews. ED/Training self-assessment July 2018 • Chester College reviews • Royal College reviews	1. BIU reporting following discontinuation of DISCO reporting 2. Monitored at TAP and EWAG	1. Our Workforce Matters Strategy to be fully implemented. 2. Review of Education Governance framework complete. 3. Restructure of W&OD team undertaken. Implementation plan in place Q3 2019-20 4. Occupational Health service level agreement and strategic priorities to be reviewed during Q3 2019-20. 5. ESR system project in place Q3. 6. Work to improve data quality. Project plan/business case to improve ESR links compliance. Deliver in 3 to 12 months (March 2020) 7. Local talent boards established to inform regional and National talent boards. 3 talent boards to have been held by Q3 2019/20 8. Review apprenticeship programme and establish clear links to strategy
4. Staff Survey results and action planning	• Delivery of divisional action plans • Feedback from divisions with any changes made. • To be reported to EWAG	• 1:1 / Team Meetings • Divisional Workforce Groups • Monthly Divisional Boards/CCICP reports				

Strategic Domain 4: Aspiring to Excellence in Practice through Our Workforce							
W1	**Our cadre of patient centred leaders will be skilled in continually promoting and building upon our open and honest culture. This will be achieved through sharing the Trust's vision, values, behaviours and objectives from Board to ward.**						
Key Controls / Influences Established (What are we currently doing about the risk?)	Key Gaps in Controls / Influences (What additional controls should we seek?)	Assurance Providers 2018/19 (How do we know if the things we are doing are having an impact?)			Gaps in Assurances on Controls / Influences (What additional assurances should we seek?)	Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)	
		Local Management (1st Line of Defence)	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)			
5. Recruitment Policies		• 1:1 / Team Meetings • Divisional Workforce Groups • Monthly Divisional Boards/CCICP reports • Consultant Foundation Programme • 1:1 / Team Meetings • Divisional Workforce Groups • Monthly Divisional Boards/CCICP reports	• Professional Advisory Group • Executive Workforce Assurance Group • Transformation and People Committee • Board of Directors • Monthly Workforce Report • Strategic Nursing & Midwifery Staffing Review-October 2018 • Monthly Quality, Safety & Experience Report (Nurse staffing) • Annual Report on the Appraisal and Revalidation of Medical Practitioners at MCHFT-September 2018 • Workforce Race Equality Scheme Annual Review-November 2018 • Annual Equality & Diversity Report 2018 • TAP Minutes • Multi-Disciplinary Workforce Strategy Group	• Sub Regional Workforce Planning and Development Network • Staff Survey March 2018 • Health Education England reviews. ED/Training self-assessment July 2018 • Chester College reviews • Royal College reviews	1. BIU reporting following discontinuation of DISCO reporting 2. Monitored at TAP and EWAG	1. Our Workforce Matters Strategy to be fully implemented. 2. Review of Education Governance framework complete. 3. Restructure of W&OD team undertaken. Implementation plan in place Q3 2019-20. 4. Occupational Health service level agreement and strategic priorities to be reviewed during Q1 2019-20. 5. ESR system project in place Q3. 6. Work to improve data quality. Project plan/business case to improve ESR links compliance. Deliver in 3 to 12 months (March 2020) 7. Llocal talent boards established to inform regional and National talent boards. 3 talent boards to have been held by Q3 2019/20 8. Review apprenticeship programme and establish clear links to strategy
6. Statutory / mandatory training monitoring	• Data quality						
7. Leadership Development Programmes in place, including Board Development programme	• Talent management & succession planning programme to be embedded						
8. Coaching & mentoring scheme is implemented							
9. Apprenticeship Programmes in place	• Apprenticeship programme linked to overarching Trust agreed strategy for apprentices.						
10. Developing alternative roles i.e. Physicians Associates and Advanced Nurse Practitioners	• Workforce programme						

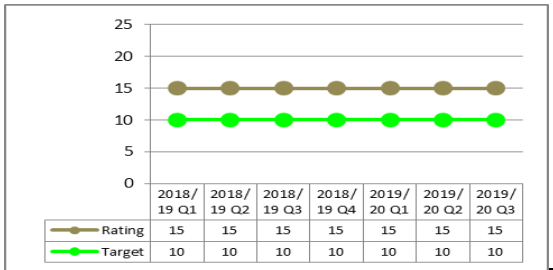
Strategic Domain 4: Aspiring to Excellence in Practice through Our Workforce						
W1	**Our cadre of patient centred leaders will be skilled in continually promoting and building upon our open and honest culture. This will be achieved through sharing the Trust's vision, values, behaviours and objectives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

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

Principle Risk

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

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHSI Single Oversight F/w	Executive Director	Executive Management Group	Board Committee
June 2017	Dec 2019	Mar 2020	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 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.
- Short, medium and long term RN recruitment strategy in place and includes recruitment of international nurses, UK adaption and RN Apprenticeship training.
- Training programme put in place for HR to increase medical workforce & OD knowledge.
- Check and challenge meetings being undertaken with mandatory training SMEs to ensure appropriate course content/learning outcomes/training frequency, to optimise mandatory training offer.

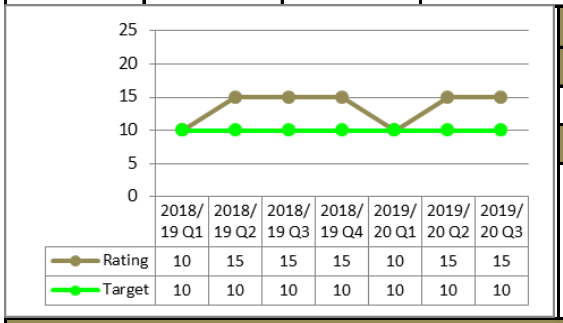
Strategic Domain 4: Aspiring to Excellence in Practice through Our Workforce						
W2	**We will have in place a flexible and responsive workforce to meet patient needs by ensuring:** **- We have sufficient workforce numbers, with the right skills, in the right place, at the right time to meet the demands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

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

Principle Risk

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

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHSI Single Oversight F/w	Executive Director	Executive Management Group	Board Committee
June 2017	Dec 2019	Mar 2020	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 to reflect the work required to implement Our Workforce Matters Strategy, and current sickness absence levels. The situation has clearly improved, however; it is too soon to note that positive trend is embedded.

Links to BAF objectives

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

Key Links to the Organisational Risk Register

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

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

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

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

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

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

Appendix A - Strategic Objectives & Success Measures	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.** **- Representing the diversity of our local population**	
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 Q3 2019/20	
Author:	Associate Director-Quality Governance	
Executive Lead:	Medical Director	
Type of Report:	Concept Paper	
	Strategic Options Paper	
	Business Case	
	Information	
	Review/Benefits/Audit	✓

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

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

Positive Benefit:	Provides a position statement of the organisational risks for Quarter 3, 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 March 2020

Quality Governance

Organisational Quarterly Risk Register Report

Report date: 01/10/2019 to 31/12/2019

Contents

1. Purpose

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

2. Current position

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

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

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

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

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

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

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

3. External / Internal Audit Opinion

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

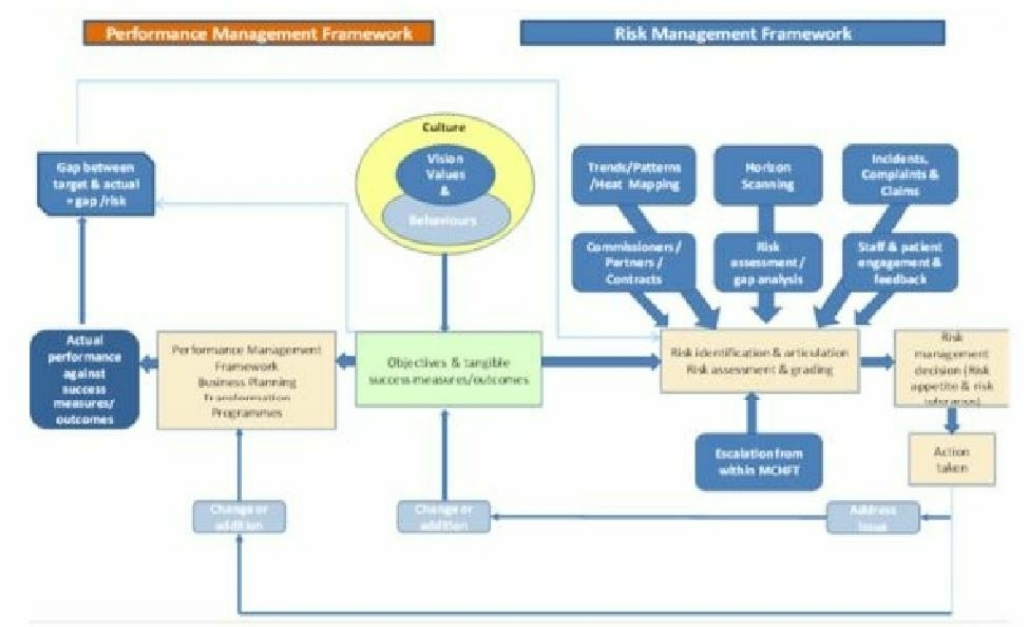
KPMG provided internal audit opinion for 2018/19. The outcome from this audit was 'Significant assurance with minor improvement opportunities'. The audit covered:

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

4. Executive level oversight

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

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



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

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

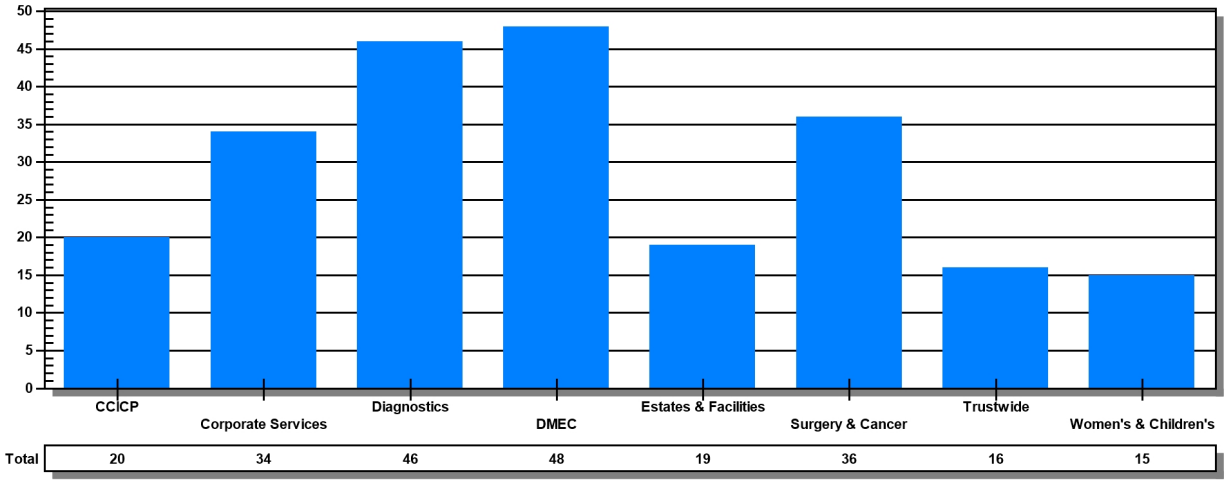
Priority	Key areas 2017/19	Position	Commentary
1. New Risk Management Strategy & Framework 2017/20	• Categorisation matrix review (Part of the Incident Report & Management Policy)	Completed	• Executive Quality Governance Group (EQGG) December 2017
	• Revise Risk Assessment Procedure	Completed	• Planned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

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

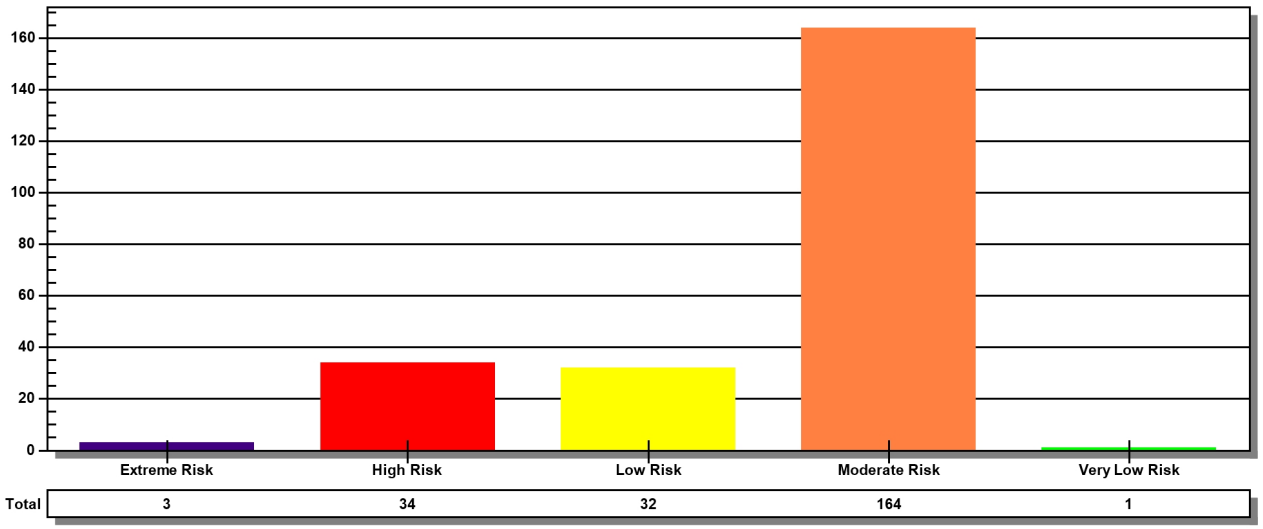
6. Five Key Risks for the Trust in 2019/20

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	20 ▶	20 ▶	20 ▶		Q1, Q2, E1, E2, P1, P2
Workforce capacity and skill mix to consistently deliver high quality care, seven days a week	5 (C) x 4(L) = 20	20 ▶	20 ▶	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	16 ▶	16 ▶	16 ▶		Q1, Q2, P1, P2, E2, W2, T1, T2a, T2b
The Long Term Financial Sustainability of the Trust	4 (C) x 3(L) = 12	12 ▶	12 ▶	12 ▶		E1, E2, P1, P2, T1, T2a, T2b
Obsolete IT Equipment	4 (C) x 4(L) = 16	16 ▶	16 ▶	16 ▶		Q1, Q2, E1, E2, T2a, T2b

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

None reported during this quarter

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

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

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

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

10. Summary of the Organisational Risk Register

Extreme Risk

Ref	Initial Date	Title	Description	Controls	Current Rating	Owner	Actions		Target Rating	Progress Update	Next Review Date
							Description	Target			
SC0616	19/10/2018	Histology backlog issues impacted on Endoscopy Services	Risk of adverse outcomes for patients due to histology samples not being turned around within agreed timeframes.	Post endoscopy procedure the case notes are held within Endoscopy Services until the endoscopy report is received and signed off by the Endoscopist/Consultant. A Risk assessment has been developed by Diagnostics and Clinical Support Services which has been escalated to the Executive Team - DC0887 1 speciality grade medical staff is able to report histology outcomes unsupported. 1 speciality doctor and 1 LAS doctor are undergoing peer support to develop the skill of a lone reporter An Advanced Practitioner (AP) has been appointed to support sample dissection. A further Senior BMS in Tissue Dissection has been appointed and is currently undergoing appropriate training to become an AP. 2 Additional pathology staff are undergoing upskilling in the role of dissection. Additional Histology Consultant support is available at weekends via Waiting List Activity. Additional training for Consultant Histopathology staff to support gastrointestinal requirements are under development. Business Continuity activity of access to external Pathology Services for reporting with a 4 day turn around confirmed. External reports have to be copied and pasted into MCHFT systems. Further communication via trust information system.	20 4 x 5	Manager	1 1. A further Senior BMS in Tissue Dissection has been appointed and is currently undergoing appropriate training to become an AP. 2 2. 2 Additional pathology staff are undergoing upskilling in the role of dissection. 3 3. Additional Histology Consultant support is available at weekends via Waiting List Activity. 4 4. Additional training for Consultant Histopathology staff to support gastrointestinal requirements are under development.	19/10/2019 19/10/2019 19/10/2019 19/10/2019	8 4 x 2	The risk has been reviewed and no further changes are required at this time.	09/05/2020
TW0001	09/09/2015	Delivery of key local and National targets and standards, in particular the 4 hour standard in A&E	There is a risk that National standards, performance targets and commissioner contractual requirements may not be achieved, as a result of an increasing demand on Trust services, which may lead to regulatory sanction and financial penalties.	1. Corporate governance infrastructure, systems and processes. 2. An Escalation Policy and a number of clinical pathways in place. 3. Performance management framework 4. Monitoring of performance at Trust Board, Audit Committee, PAFC and divisional boards 5. Monitoring of performance by CCG's 6. Quality, Safety and Improvement Strategy 2018/19 7. Fortnightly meetings with DGMs 8. Monthly finance and activity review meetings 9. Daily monitoring and 4 x daily bed management meetings with site reports populated 7 times a day 10. Weekly performance review meeting (PMG) 11. 4 hour perfomance meeting 12. Urgent care steering group 13. A&E Delivery Board 14. Horizon scanning, agility and ability to respond 15. RTT Task and Finish group and action plan 16. Quarterly elective capacity and demand internal meetings 17. Cancer Performance Management (PTL) Meetings 18. Annual Capacity and Demand Planning Process 19. Cancer Board 20. Cancer Task & Finish Group 21. Development of the perfomance management framework 22. ED checklist completion & audit	20 5 x 4	Chief Operating Officer	1 Complete and implement Risk Management Systems Review	31/03/2020	10 5 x 2	11/12/19 updated by COO. Further controls added. Risk rating remains the same	10/03/2020
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, this may in turn lead to an adverse impact on patient safety, 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 possible 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. Commencement of the Acute Care Team to support the deteriorating patient 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 22. Trustwide workforce plan to model service sustainability	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	29/01/20 No changes	28/02/2020

10. Summary of the Organisational Risk Register

High Risk

Ref	Initial Date	Title	Description	Controls	Current Rating	Owner	Actions		Target Rating	Progress Update	Next Review Date
							Description	Target			
CS0380	19/10/2018	Obsolete IT Equipment	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	Reviewed and title changed at request of Medical Director	19/05/2020
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	Risk assessment reviewed and updated, therefore new version created, to reflect the risk consequence of there being a lack of Consultant Histopathologist attendance at MDT as a core member.	03/05/2020
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

10. Summary of the Organisational Risk Register

High Risk

Ref	Initial Date	Title	Description	Controls	Current Rating	Owner	Actions		Target Rating	Progress Update	Next Review Date
							Description	Target			
DC1046	25/03/2019	Radiographer Staffing levels	There is a risk that the Medical Imaging Department will not be able to support or provide Diagnostic Imaging, as a result of the Trust being unable to recruit to vacancies which may lead to patients not being seen from all specialties within timescales.	- 2 x 1.0 wte locums recruited until March 2020. - 1 x 1.0 wte locums recruited until 31.12.2019. - Further locums working on an ad-hoc basis. - Bank Radiographer available to support at VIN 2 days - Deputy Service Manager working clinically to support - Constant staffing reviews - Clinical risk at VIN mitigated as patients attending Minor Injuries Unit can access the medical Imaging Service at Leighton Hospital site. - Outsourcing of physical scanning. - Increased reliance on senior staff to cover rotas.	16 4 x 4	Director ate Manager	1 Decision required as to which services the department can safely provide 2 Recruitment of Radiology Staff, including the exploration regarding the possibility of international recruitment. 3 Explore the option of outsourcing batches of activity to reduce waiting times 4 Service manager to explore the option of using monies from Medical staffing vacancies to support in the short term. 5 Explore the feasibility of developing alternative roles in the department and Assistant Practitioners. 6 Development of a Radiographic staff 'bench'. 7 Development of a Medical Imaging Recruitment and Retention Strategy.	31/12/2019 31/03/2020 31/03/2020 31/12/2019 31/03/2020 31/03/2020 28/02/2020	8 4 x 2	Risk review undertaken, by the DGM, in view of the financial impact to the Division, ie: use of agency, locums, outsourcing etc, as current risk score not felt to be representative of the current situation. New version created with adjustment to the consequence/overall risk rating to reflect the current financial pressures and challenges.	05/02/2020
EC0397	19/06/2017	Risks associated with inadequate Staffing levels on ward 5	There is a risk that patients may not receive timely, high quality care as a result of low staffing levels on ward 5, which may lead to an adverse impact on patient safety, experience and outcomes.	1.On-going recruitment- international recruitment 2.Daily staffing review undertaken by the Matrons within the Division. 3.Ward escalation to Matrons when gaps present in rota. 4.Ward Managers within the Division review off duty to review the skill mix. 5.Use of Nurse Bank and Agency staff. 6.Implementation of Pharmacy technician role within ward 5. 7.Safety huddles. 8.Involvement of Critical Care to facilitate NIV where appropriate. 9. Implementation of the TNA role on ward 5.	16 4 x 4	Matron	1 Ongoing recruitment. To be reviewed at Respriatory Sub-Divisional Governance in March 2020.	31/03/2020	4 2 x 2	Updated action and control measures but the risk rating has remained the unchanged.	21/01/2020
EC0399	12/09/2017	Increased patient dependency when caring for 4 dependent Respiratory patients, which may be a combination of Non Invasive Ventilation and Tracheostomy patients	There is a risk of patient harm as a result of increased patient dependency/acuity when 4 dependant respiratory patients, who may require complex intervention e.g. Non Invasive Ventilation or Tracheostomy patients, are nursed on the ward when there are significant nursing vacancies or unavailable beds, which may lead to adverse clinical outcomes for patients.	1. If no NIV beds are available a referral will be made to a Critical Care Registrar/Consultant to see if they can take the patient. A review of patients currently on NIV on Ward 5 may also be undertaken as one of these patients may be a more appropriate Critical Care transfer. Critical Care operational policy has this stated within it and the SOP for ward 5 also refers to the option of Critical care when capacity / staffing / equipment is rendering no further beds. 2. On-going recruitment. 3. Daily staffing review undertaken by the Matrons within the Division (this may be done more often throughout a day dependant on staffing and acuity). 4. Ward escalation to Matrons when gaps present in rota. 5. Ward Managers within the Division review off duty to review the skill mix. 6. Use of Nurse Bank and Agency staff. 7. Safety huddles completed daily with Medics. 8. Involvement of Critical Care to facilitate NIV where appropriate. 9. Daily assessment of the ward acuity. 10. Selected location for NIV and tracheostomy patients to be nursed - will be cohorted if possible. 11. Critical Care Outreach Service (CCOS) referrals. 12. Trust EWS Escalation Guidelines.	16 4 x 4	Matron	1 New NIV machines to be bought for the Ward to replace the older machines 2 Training on the new NIV machines to be undertaken for all staff 3 A service review is required. The review should consider (amongst other things) the delivery of the service, step down/ ceilings of care, Consultant to Consultant escalation, the number of NIV machines within the Trust, contingency plans if high numbers of NIV patients are in the Trust and escalation / transfer processes.	28/02/2019 28/02/2019 31/01/2020	6 3 x 2	Risk reviewed and remains unchanged due to number of vacancies currently on ward 5. There is a plan for the vacancies which includes TNAs and international recruits. There is currently a service review underway being lead by the Matron for Critical care.	30/01/2020
EC0438	29/03/2019	Lack of service provision within Rheumatology	There is a risk that patients may not receive timely and appropriate care as a result of Consultant vacancies within the Rheumatology Service which may lead to major harm to patients	1. Closed off external referrals in to the trust (out of area patients) 2. Use of Agency Locums 3. Waiting List initiatives to meet demand and manage risk 4. SHS (extremal recruiting company) undertaking additional clinics 5. Out to recruitment for a B7 physician associate (12 month fixed term). Recruited to post and start date January 2020. 6. Pharmacist to increase hours to full time to give additional clinic capacity 7. Clinical harm review 8. Pharmacist increased hours in Sep 2019 9. SHS (External Resourcing) working at weekends since Aug 2019	16 4 x 4		3 Explore partnership working with other specialties within the Trust - Substantive Post recruitment 1 Secure locum position 2 Explore partnership working with other specialties within the Trust - Physician Associate	29/02/2020 31/03/2020 31/01/2020	8 4 x 2	The action owner has been updated. The progress against the actions has been updated. The scores have remained the same	22/03/2020
EC0440	11/09/2019	Risks associated with insufficient Coronary Care Unit (CCU) covered nurses providing ALS support should there be a cardiac event in the CCU	There is a risk that a cardiac event, including patients being monitored via telemetry, will be missed on CCU as a result of a lack of covered nurses to staff the CCU as of October 2019 which will impact the service delivery to Cardiology patients which may lead to adverse clinical impact on patient care/safety.	Rota planning to ensure existing covered staffs annual leave Support to CCU from ACP / Cardiac Rehab Staff / Critical Care Succession planning constantly of staff as part of a progression plan Daily consultant CCU ward rounds Robust review of telemetry patients in CCU and other areas Clear training plans including ALS and in house delivery Pull in ACP's for support	16 4 x 4	Matron	6 A paper to the Executives is to be produced to set out the risk and the actions that are required to ensure a safe service can be maintained. 7 Telemetry standard operating procedure (SOP) to be updated 1 Three members of staff currently on ALS training to complete the course 2 Newly trained ALS staff to ensure time is spent in CCU to make sure they have gained appropriate competencies for CCU. 3 Registrar to provide ECG training to all relevant staff, including covered nurses. 4 Consideration of incentives for staff that work above their current role as a covered nurse at short notice 8 Consideration of a long term appropriately trained CCU nurse from an agency 5 A review of the existing workforce (including ACP, Cardiac Rehab and Critical Care) to take place to see how the CCU can be supported	30/09/2019 31/10/2019 31/10/2019 31/12/2019 31/12/2019 30/11/2019 31/10/2019 31/10/2019	2 2 x 1	Risk reviewed following presenting at EQGG. Control measure and actions updated.	23/01/2020

10. Summary of the Organisational Risk Register

High Risk

Ref	Initial Date	Title	Description	Controls	Current Rating	Owner	Actions		Target Rating	Progress Update	Next Review Date
							Description	Target			
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	Further repairs & replacements being completed throughout trust domestic hot & cold water system on an almost daily basis.Replacement project to domestic hot & cold water system currently being considered to address ongoing temperature and corrosion issues	20/02/2020
EF0556	16/07/2019	Infrastructure Pipework Failure - Ward 1	There is an increased risk that the incoming domestic hot water pipework (located above the ceiling tiles) feeding ward 1 could fail and would be unable to be repaired as a result of no access being allowed above ceiling height in certain locations on ward 1 due to the existence of asbestos material. Therefore should the leak be a serious one it would warrant the isolation of the water to prevent further damage or injury, this in turn will lead to a complete loss of hot water to both ward 1 & 9 (as ward 9 fed from same pipework).	Experienced maintenance staff on site 24/7 Ability to repair leaks in non-asbestos areas Ability to isolate completely the main incoming water to ward 1 (but also ward 9).	16 4 x 4	Head Of Estates	1 1.Decant part or all of ward 1 to allow asbestos removal and subsequent replacement of old pipework. 2 2.Prioritise Ward 1 refurbishment 3.Consideration to be given to refurbishing wards 1 & 9 together to lessen impact of isolation of shared services. 3 4.Replace pipework within Ward 1 (can only be actioned once action 1 above has been completed)	19/07/2022 19/07/2022 19/07/2022	4 4 x 1		18/02/2020
EF0560	05/02/2020	Potential loss of ability to produce Linen at MCHFT	There is a risk that existing laundry production equipment (and steam infrastructure) used within the laundry will breakdown (and be unable to be fixed) as a result of their current age and subsequent poor and deteriorating condition. This is due to a lack of investment and will in turn lead to further breakdowns or complete loss of linen equipment and a subsequent inability to meet the linen requirements not only of MCHFT but also the Shropshire Linen contract (worth approx. £1.2m in revenue).	1. On site Estates maintenance can only provide reactive response to "first line" breakdowns, steam/electrical issues. 2. External contractors engaged to enable resolution of more complex breakdowns (where they can due to age and inability to source spares) 3. Contingency plans in place to address short term issues with other external laundries (while running at reduced capacity and also if both washers fail, but at a substantial additional cost to the trust) please see embedded programme 4. Short term ability to run extra shifts within laundry to help meet demand for linen (again at an additional cost to the trust). 5. Purchase of New Linen for any shortfall to cover service user requirements	16 4 x 4	Manager	1 1.Continue to programme laundry going off site for next 1/2 months 3 3. Produce business case identifying options for MCHFT (Medium/ Long Term)	30/08/2020 30/04/2020	8 4 x 2	05/02/20 New risk added	05/05/2020
PG0305	22/05/2019	Chaperone availability in community paediatrics	There is a risk that MCHFT community paediatricians are unable to fully comply with guidance of having a chaperone present for intimate examinations of children, due to lack of availability of staff to perform chaperone duties, which may result in noncompliance with Trust and national guidance with inappropriate people conducting chaperone duties and allegations of inappropriate intimate examinations being conducted on children by staff.	1. Reliant upon staff being available in a clinic - if they may be released from their clinic duties. 2. SOP developed to support staff in new process 3. Where a chaperone is not present in a community clinic where a child protection examination is required, these appointments must be redirected to the KCC / Ward for the Community On-Call Consultant Paediatrician/SAS doctor to conduct	16 4 x 4	Head Of Midwifery	3 3. Contact School Nursing Team to request assistance for the provision of a chaperone as required for examinations conducted in Special Schools. Confirm the arrangement in writing. 6 6. Reconfigure all clinics to form a cluster for each area to reduce the number of chaperones required 7 7. Produce a Business Case to secure funding for the required number of Band 2 Clinical Assistants required to assist in chaperone duties, following the reconfiguration of clinics and staff review 9 9. Remove the wording "wherever possible" from the chaperone policy, as previously requested by Consultant Paediatrician as it has been decided that for safeguarding of children/young people and staff a chaperone should always be present. 8 8. Once Business case approved, recruit required Band 2 Clinical Assistants to vacant posts. If not approved review staffing allocation and clinic reconfiguration to ensure that intimate examinations are only conducted at clinics where a there are permanent chaperone assistants available.	31/01/2020 30/10/2019 30/11/2019 30/12/2019 28/02/2020	4 4 x 1		20/01/2020

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SC0535	30/11/2014	Insufficient staffing within Inpatient locations	There is a risk that there may be insufficient registered nursing staff within the surgical inpatient locations, to fully meet the needs of patients, due to a high vacancy factor. This may lead to adverse patient outcomes.	1. Minimum staffing levels agreed within division for inpatient locations. 2. Escalation of staffing issues to designated divisional co-ordinator 3. Escalation to Clinical Site Manager or Hospital at Night Team out of hours 4. Escalation to Senior Manager on-call if remains a risk/patient safety issue 5. Local, divisional review of all staffing incidents, reported via the incident reporting system, with wider corporat oversight 6. Two whole time equivaalent staff were offered and accepted posts at the Feb. 2019 Recruitment day to start in May 2019. 7. The organisation has decided to proceed with the option of internal recruitment of Registered Nurses to support MCHFT vacancy gaps. 8. UK adaption program due to complete end 2019 which should generate x5 Registered Nurses	16 4 x 4	Head Of Nursing	4 Utilising the investment agreed at Executive level to support the introduction of 12 hour shift patterns in to the Surgery & Cancer Division 7 There is Executive agreement to utilise registered agency nursing staff when staffing levels have reached a critical point via an agreed escalation process 5 Offer and support existing and new staff the opportunity to work their contracted hours in a more flexible way, therefore addressing the current challenges relating to the recruitment and retention issues 9 The Director of Nursing has introduced a multidisciplinary clinical workforce group to address the recruitment and retention challenges that the organisation must overcome; ? Ongoing recruitment ? Supporting Transition Into Acute Roles ? Return to Practice ? UK adaptation programme ? Rotational recruitment ? Trainee Nursing Associates/Nursing Apprenticeships ? Allied Health Professionals ? International Recruitment 10 Successful recruitment to registered nurse vacancies within the division.	30/09/2019 31/10/2019 23/01/2020 23/01/2020 23/01/2020	8 4 x 2	The risk remains as it is and will not change until the international recruitment programme has provided the staffing numbers forecast to support the division needs.	01/03/2020
SC0605	23/01/2018	Endoscopy Capacity	There is a risk of insufficient endoscopy capacity as a result of vacant posts wit in gastroenterology, general surgery and non-medical Endoscopist roles which may lead to failure to meet expected treatment timeframes, impact on the NHS operating framework and JAG accreditation. There is an escalation of the risk during August 2019 due to 3 of the 5 consultant gastroenterologists being on AL (1 agency, 1 was pre booked leave prior to commencing with the Trust). There is also an increased pressure on the remaining team due to the capacity issues of the implementation of a new testing kit (FIT) in the Bowel Screening Service necessitating additional sessions to meet the increase in demand. This will impact on the number of endoscopy sessions/slots available for: □ Complex therapeutic procedures - clinically urgent and cancer suspect/confirmed □ Emergency inpatient procedures □ Bowel screening □ Supervision of non-medical endoscopists and trainees There may be urgent, routine and surveillance breeches due to reduced sessions available There is a risk of insufficient endoscopy capacity as a result of vacant posts in gastroenterology, general surgery and non-medical Endoscopist roles which may lead to failure to meet expected treatment timeframes and the potential to impact on the NHS operating framework and JAG accreditation.	1. Replacement capacity created by on-going Waiting List and locum sessions using vacancy and non-recurrent funding. 2. Considerin sourcing capacity. 3 Additional capacity from a combination of temporary, fixed term and permanent sessions. 4. JAG operating standards which outline compliance levels to achieve accreditation. 5. Support in place with partnership arrangement with neighbouring Trust (UHNM) 6 Nurse Endoscopist vacancy has been appointed to. In addition 2 nurse endoscopists have been supported 'retire and return' on reduced hours to retian their skills, knowledge and experience within the department 7. Endoscopist work plan which identifies the activities that should be undertaken that week. On-going robus management of capacity by Endoscopy Service. 8. Gaps in staffing are escalated to the Endoscopy Service Manager and Medicine & Emergency Care Servic Manager covering gastroenterology for further action 9. Unresolved service issues are escalated to the S&C and DMEC Divisional Senior Management Team 10. Activity and forecasted gaps are discussed at weekly planning meeting 11. Training programme in place for existing staff to increase numbers of competent Endoscopists to undertake colonoscopy and therapeutic procedures. 12. Recruitment programme in progress for vacant posts.	16 4 x 4	Manager	1 Recruitment plan for the 3 vacant substantive Consultant Gastroenterologist posts to bring a total of 5 which is the funded establishment or consider long term locum support if substantive recruitment is not successful 5 Consider long term locum support if substantive recruitment is not successful 6 Recruitment of substantive Consultant Surgeon to remaining vacant post or consider long term locum support if substantive recruitment is not successful 7 Recruit to an additional Nurse Endoscopist post using vacant hours	31/03/2020 31/03/2020 31/03/2020 31/03/2020	8 4 x 2		02/04/2020

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Ref	Initial Date	Title	Description	Controls	Current Rating	Owner	Actions		Target Rating	Progress Update	Next Review Date
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SC0618	19/10/2018	Bowel Cancer Screening - Introduction of FIT to the Programme	There is a risk that the Bowel Cancer Screening team will be unable to deliver the Faecal Immunochemical (FIT) Screening Programme as a result of lack of capacity and resources which may lead to breaches in the screening programme and adverse clinical outcomes.	Current Control Measures for the gFOBt Programme: Lack of capacity leading to loss of service and non-compliance with the wait time targets outlined within the NHS Operating Framework and Cancer pathway resulting in the risk of the Trust not maintaining the Joint Advisory Group (JAG) and Bowel Cancer Screening Programme. 1. Colonoscopy Capacity at all sites to ensure availability of sessions and slots to reduce the number of breache within the programme. 2. Incorporating additional capacity for the Implementation of the FIT across all sites, additional clinic and colonoscopy capacity. 3. Working with Partner Trusts to attempt to recover plan if required. 4. Reviewing alternative solutions. Financial risk to the Trust of not achieving the objective of the FIT programme and the continuing implementation of the plan for Bowel Scope Screening (BoSS) Programme in 2018/19. Risk to the continuation of existing sessions. 1. Endoscopist work plan which identifies the activities that should be undertaken within the SLA 2. Unresolved service issues are escalated to the S&C and DMEC Divisional Senior Management Team 3. Explore if there is any additional capacity during the current year Failing the national targets e.g. rapid access diagnostic wait times due to a lack of endoscopy capacity. 1. Endoscopist work plan which identifies the activities that should be undertaken within the SLA 2. Unresolved service issues are escalated to the S&C and DMEC Divisional Senior Management Team Delayed access to diagnostic and surveillance colonoscopy procedures due to insufficient colonoscopy slots staffed by Screening Colonoscopist's. NB this may be associated with issues relating to the effective management of annual leave / On-call arrangements. 1. Explore if there is any additional capacity during the current year Delayed diagnosis to patients who have had a positive test kit result and attended an SSP Clinic having their colonoscopy procedure appointment. Risk of delays to planned colonoscopy and pathology reporting. 1. Explore if Additional List Initiatives commissioned to support effective patient outcomes and experience ca be funded. 2. All available screening slots are maximised to their full potential. 3. Activity and forecasted gaps are discussed at weekly planning meeting and business meeting. 4. Explore if Additional Waiting List Initiatives commissioned to support effective patient outcomes and experience can be funded at the Trusts 'old rate'. 5. All available screening slots are maximised to their full potential. 6. Activity and forecasted gaps are discussed at weekly planning meeting and business meeting.	16 4 x 4	Support Worker	1 Develop a FIT implementation Group to: □ All sites to consider plans for the successful implementation and delivery of the FIT Programme to negate the need for waiting lists. For instance: □ Secure additional Assessment Clinic for those who have a positive FIT test □ Secure additional Screening Colonoscopy Sessions for those who attend the assessment clinic and wish to go on to screening colonoscopy □ Secure additional radiology for those who have a positive FIT test but are deemed unfit for screening colonoscopy, have a failed screening colonoscopy, or require staging. □ Secure additional pathology resource for the additional specimens expected following FIT Implementation. □ Use of accredited screening Colonoscopist's flexibly and from other sites - COCH, Macclesfield and UHNM □ Use of accredited screening Colonoscopist's to deliver Bowel-scope □ Consider reinstating Endoscopy Waiting List sessions at the 'old rates' □ Create Honorary contracts for additional screening Colonoscopist's to undertake sessions at our sites	30/03/2019	6 3 x 2	The risk has been reviewed and revised.	21/03/2020
SC0636	23/09/2019	Lack of surgical capacity for renal and ureteric stones cases	There is a risk that patients with renal and ureteric stones who require surgical intervention will be adversely affected as a result of insufficient theatre capacity, which may lead to patent harm occurring. There are 96 patients awaiting stone surgery on the Priority Target Waiting (PTL) list (as of 16/09/19) on either an open 18-week Referral to Treatment (RTT) pathway or a closed pathway. _63 patients on waiting list as Urgent of which only 13 patients have confirmed TCI dates (longest patient waiting time is 304 days / 43 weeks) _33 patients on waiting list as Routine of which only 1 patient has a confirmed TCI (longest waiting time is 282 days / 40 weeks) _20 theatre sessions required to operate on 50 urgent cases awaiting TCI (based on 240 min session) _14.8 theatre sessions required to operate on 32 routine cases awaiting TCI (based on 240 min session)	1.Urology Service Manager / Support Manager monitors PTL (Patient target List) weekly and works with Scheduler to prioritise urgent stone cases 2.Urology planner reflects 6-week forward view 3.Surgical sessions allocated to other Consultants or senior Trainees to cross cover periods of leave 4.Long-waiting patients (on open 18-week (Referral to Treatment Time) RTT pathways) only are monitored through weekly Performance Management Group (PMG) 5.Escalation of symptomatic patients to Consultant 6.Computed Tomography Kidneys, Ureters, Bladder undertaken 72-hours pre-surgery to ensure surgery still required and to enable time to re-schedule another patient to protect theatre time 7.Quarterly sub-divisional review with Divisional Senior Management Team	16 4 x 4	Service Manager	1 Identify additional theatre capacity to address urgent long-waiters 30/11/2019 2 Convert outpatient activity to theatre activity (dropped lists from other sub-specialties) 30/11/2019 3 Identify what if any additional funding is required to support additional theatre capacity 30/11/2019 4 Submit paper for 6th Consultant Urological Surgeon investment for 2020/21 (annual planning process) 30/11/2019		12 4 x 3	The issues remains a a concern for the sub-division as this is not in line with NICE NG118. A business case is required to support further development of the team to comply with NICE gudiance.	22/04/2020
SC0637	23/09/2019	Lack of Upper Gastrointestinal MDT membership	There is a risk that the Upper Gastrointestinal Multidisciplinary Team will not have the necessary core members present at each meeting to make effective treatment plan decisions as a result of lack of cover for core MDT members e.g. Histolpathology and Radiology, which may lead to unacceptable treatment delays and the clinical outcome for patient's being affected. Local Upper GI Team at Leighton Hospital Self Declaration 2019/2020 - is at 66.7%	Current MDT membership and frequency of attendance follows national guidance (95% of meetings is quorate by core member attendance and / or cover) If the MDT meeting is not quorate and key members are absent patients will be discussed at the next weekly meeting. In the absence of Histopathologist a printed copy of the report is made available for consideration by the MDT and / or the Upper GI MDT lead will liaise directly with the Histopathologist before or after the MDT meeting to prevent treatment planning delays. In the absence of Radiologist there is the ability to discuss cases outside of the MDT. However, this is far from ideal for diagnostic purposes. The Upper GI MDT Lead Clinician will raise poor attendance levels with respective individuals / management teams There are risk assessments developed for gaps with Radiological (DC0785) and Histopathology medical staff(DC0887)	16 4 x 4	Consultant	1 Business continuity plan for cover arrangements for Histopathologist and Radiologist core memberships to ensure 95% attendance for core / cover. 31/12/2019 2 Review of current MDT timings to support attendance in absence of core membership 31/12/2019 3 Monitor attendance of core members and cover 31/12/2019		8 4 x 2	This remains an ongoing challenger for the division but has not resulted in patient harm occurring but however is not at the standard required for validation purposes.	09/04/2020

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SC0638	23/09/2019	Lack of image capture within the Unisoft system	There is a risk that the current version of the Unisoft endoscopy reporting system does not fully support the ability to capture and download images as a result of a technical issue not yet fully understood by the supplier which may lead to sup-optimal management of patients having endoscopy procedures. The images form part of the information that is reviewed by the consultant manager to decide on a treatment plan and for case reviews in complex polyp MDT and cancer MDT. The failures are intermittent across the endoscopy clinical rooms (5 rooms) with different endoscopists at different times which has made it difficult to identify the root cause of the problems and hence a solution. Hard copy photos can be taken via the Olympus endoscopy system but are often inferior quality and take time to print; they also cannot be saved onto the electronic report (UNISOFT).	1.Endoscopy capture is installed in all endoscopy rooms the EBME and IT teams attempt to make the system work each time it fails. 2.There is a support team that can be contacted at Unisoft 3.Where consultants need to send cases for complex therapy to external Trusts the images form part of the referral. The endoscopist can take polaroid hard copies but they are time consuming, not available electronically and may not be filed in the patient records	16 4 x 4	Manager	2 Ascertain the associated costs of replacing the current Unisoft system with the latest version and purchase the upgraded wireless system. Unisoft is launching a new generation software and image capture box in the Autumn	30/05/2020	9 3 x 3		13/07/2020
TW0004	02/01/2013	Registered Nurse staff shortages	There is a risk that patients may not receive timely interventions to address their clinical needs, as a result of a reduced staffing capacity of registered nurses, which may lead to adverse impact on patient safety and clinical outcomes.	1. Trust Escalation Policy with revised staff escalation matrix, includes: Delivery of a daily staffing meeting with the aim of identifying staff to address gaps Consideration given to the use of agency staff following executive authorisation. 2. The Trust has the following 24/7 support services available: Senior Manager On-Call proving advice Clinical site managers Executive on-call 3. Embedded multi-disciplinary clinical workforce group (Consisting of task and finish groups to recruit RN roles and roles outside of the traditional RN recruitment.) This group reports progress to the Executive Workforce Group. 4. Revised and active recruitment of newly qualified nurses, as part of a multi-disciplinary clinical workforce gr 5. Fast tracking of ECF's to reduce delays in the recruitment process. 6. Use of exit interview data to inform retention strategies. 7. Trust promotional information added to job descriptions on NHS Jobs. 8. New ways of job advertising including use of social media. 9. Adverts revised to include set interview days. 10. Set of monthly arranged recruitment days across quarter 2. Those offered posts are then invited to 'Keep in Touch Days' 11. Temporary staffing efficiencies programme, specifically targeted at: Robust recruitment plan in place Efficient rota management, with the implementation of an electronic roster and KPI's to monitor 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 18. Staff incentive payments to increase bank fill rate until March 2020	16 4 x 4	Deputy Director Of Nursing & Quality	1 1. Develop a programme to recruit Trainee/Advanced Nurse Proactitioner posts 2 2. Recruit further cohorts of Trainee Nursing Associate posts 4 4. Consideration of Internal Nurse recruitment 5 5. Implementation of Registered Nurse training in conjunction with Higher Education Institutes using the apprentice levy 6 6. Continue and Implement Return to Practice programme 7 7. International recruitment - 3rd Cohort 8 8. Develop and launch the recruitment and Retention Strategy 9 9. HR policies pertaining to worklife balance, flexibility and career progression to be reviewed with a renewed focus on health & wellbeing and support provided to staff eg bereavement leave -3 days 11 11. Career clinics replaced by Talent Management and Succession planning to be broken down by divisions 12 12. Career clinics replaced by Talent Management and Succession planning to be broken down by divisions - this is an action on the Trust staff recruitment risk assessment allocated to you. 13 13. Career clinics replaced by Talent Management and Succession planning to be broken down by divisions - this is an action on the Trust staff recruitment risk assessment allocated to you. 15 15. Career clinics replaced by Talent Management and Succession planning to be broken down by divisions - this is an action on the Trust staff recruitment risk assessment allocated to you. 16 16. Career clinics replaced by Talent Management and Succession planning to be broken down by divisions - this is an action on the Trust staff recruitment risk assessment allocated to you.	31/12/2020 31/12/2020 30/12/2020 31/12/2020 31/12/2020 31/12/2020 31/12/2020 30/06/2020 30/06/2020 30/06/2020 30/06/2020 30/06/2020 30/06/2020	8 4 x 2	reviewed and actions amended and added to mitigate the risk	06/04/2020

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TW0006	09/08/2018	Lack of pace in the significant transformational change required to deliver the Cheshire East Place strategy and consequently the Health and Care Partnership (HCP) for Cheshire & Mersey	There is a risk that the Trust and system may not undertake transformational change within the timeframes required to deliver the Cheshire East Strategy as a result of growing demand and increased financial pressures, which may lead to an adverse impact on patient safety, care and experience.	1. Quality, Safety and Improvement Strategy 2. Risk Management Strategy & Framework 3. Patient and Public Involvement Strategy 4. Transformation and change programmes 5. Quality Impact Assessment Process 6. Transformation & People Committee 7. Health and Care Partnership for Cheshire & Mersey 8. Estates Strategy 9. 7 day clinical services 10. Cheshire East Place strategy under development 11. Place Governance in place 12. CEO is a lead for the C&M Acute Sustainability work therefore is able to keep informed and influence 13. Place strategy implemented which will include the development of an Integrated Care Partnership (ICP) 14. Outcomes for the East Cheshire Trust Service Change Proposals	16 4 x 4	Chief Executive	1 ICP organisational form and governance to be developed 2 ICP to be implemented 3 ECT Service Change Proposal. Pre-consultation business case	31/12/2019 30/04/2021 30/10/2019	8 4 x 2	05/06/19 reviewed with Dr Dodds - actions updated. Risk rating remains the same.	03/09/2019
TW0010	12/12/2018	Medical Devices Running Legacy Operating System Software	There is a risk that Trust IM&T systems will fail to function efficiently and effectively, as a result of a cyber-attack targeting unsupported operating systems such as Windows 2000, Windows XP or unpatched medical devices, which may lead to an adverse impact on patient care and safety	1. Patch devices that are managed by ICT Services. 2. Procurement of new systems - DPIA Procedure in place	16 4 x 4	Associate Director Of IT	2 Segment the network to limit the reach of a cyber-exploit. 6 On receipt of medical device asset register migrate devices to new medical devices network	30/06/2020 31/01/2020	8 4 x 2	19/09/19 Work has begun on implementing a medical device network which is segmented from the main Trust network however due to technical issues the completion date for this work is now 30th June 2020	13/01/2020
TW0023	23/07/2019	Patching of CISCO kit	There is a risk of failure of the IT network along with the systems connected to it, within the Trust due to insufficient experience and resources to develop and maintain a patching process of the CISCO network equipment which may lead to a total IT failure which will effect patient care. This risk materialised at UHNM and Liverpool Heart and Chest.	1. New kit is currently being installed but capacity to do this at pace is challenging. 2. New kit being installed is patched as it is deployed however the processes to maintain patch levels is not in place.	16 4 x 4	Associate Director Of IT	1 Ensure all new switches are patched and up to date prior to installation. 2 Request funds from Execs to secure temporary networking resource to complete the network kit deployment. 3 Develop a Case of Need for an Assistant Networking Engineer band 5 to undertake the regular patching. 4 Obtain agreement for a regular patching window to enable downtime to take place when patching is due. 5 Obtain a quote for dual fibre link between the 2 on premise data centres to allow dual running servers to not be affected by switch patching and reboots.	20/09/2019 30/09/2019 30/11/2019 28/11/2019 30/09/2019	6 3 x 2		05/01/2020
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.	- Outsourcing of ECG tape analysis - Ongoing recruitment campaign - 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 Continue to advertise vacancies and actively seek recruitment opportunities. 2 Continue to liaise with locum agencies regarding the employment of locums to support the substantive team. 3 Continue waiting list initiatives. 4 Review of current skill mix of the substantive team, 5 Explore the option of recruiting Apprenticeship trainees to the department and, if feasible, recruitment of the same.	29/05/2020 30/04/2020 29/05/2020 28/02/2020 30/10/2020	5 5 x 1	Risk reviewed with the Cardio-Respiratory Dept. Service Manager and new version created to reflect the updates.	27/02/2020

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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
DC1060	25/09/2019	Consequences to Medical Imaging patients from the failure of the Virtual Server	There is a risk that imaging, reports and associated data will not be available for patients as a result of the failure of the Virtual Server which hosts Soliton, which may lead to delays in patient diagnoses and treatment with the prospect of patient harm, complaints, claims and reputational damage.	1. Cross-referencing of all associated software packages and systems 2. Prior to each CT scan and plain film, Radiographer checks on PACS for images taken in last 2 weeks and any queries that arise are directed to a Radiologist 3. Bloods are being found in ICE and transferred to Soliton and checks are being made with Radiologists that contrast is necessary 4. Input from Soliton to re-find the end dates for planned surveillance imaging with provision of lists by Cancer Services 5. Provision of additional equipment by IT to scan in request cards 6. Fielding of telephone calls by Switchboard and Customer Care 7. Case by case management of bookings 8. Additional staff resource from Medical Records and IT 9. Single point of contact for Cancer bookings 10. Tactical Incident Room in place with regular update meetings held each day Al previous gaps (below) have been addressed: 1, 2, 3 Potential for human error and missed information 4 Failure to recover end dates despite endeavours of Soliton 1 Lack of critical skill set to aid a swift recovery 5 Finite staffing resource to scan cards and errors made in haste 6 Switchboard and Customer Care unable to answer specific concerns of patients, relatives and carers calling 7 Volume of patient imaging records to be corrected - unknown 8, 9 Wellbeing of staff working in stressful environments 10 Recovery Date unknown due to complexity of the issue Risk Accepted	15 5 x 3	Manager			15 5 x 3	05/11/19 uipdated by Julie Weir. All actions closed risk controlled at 15. Risk not closed as Trust is not yet aware of how many individuals this incident affected and may not know for several years.	05/12/2019
EC0342	15/06/2015	Failure to Meet Access Targets Across the Specialities within the Division	There is a risk of non compliance with national targets as a result of Consultant vacancies which may lead to financial penalties and adverse clinical outcomes for patients.	> Weekly monitoring of the use of waiting list initiatives > The use of external agencies for virtual clinics > General practitioners with specialist interest to assist with clinics.	15 3 x 5	Divisional General Manager	4 Service reviews taking place in Gastro, Respiratory and Diabetes to look at alternative service models, as demand still outstripping capacity even in those specialties where posts are filled	31/03/2020	10 2 x 5	Reviewed and no changes required	12/03/2020
EF0512	23/01/2019	Water Distribution / Temperature	There is a risk of Legionella Pneumophilia bacteria build up within the trust domestic hot water system as a result of water temperatures at the extremities of the site and "A" wards tailing off below 55 degrees Celsius at times of little use. Which may lead to water flow problems likely to be caused by system imbalance due to balancing valves being altered and additional loads on the system?	□ Chlorine Dioxide dosing of potable raw & domestic hot water □ Temperature control regime in compliance with ACOP L8, HSG 274 & HTM 04-01 □ Monitoring & Management as required by ACOP L8, HSG 274 & HTM 04-01 in place □ Flushing regimes carried out by individual wards & departments □ Domestic hot water plate exchanger temperature control raised to 62 deg C in order to achieve a minimum 60deg C supply to each ward & department	15 5 x 3	Head Of Estates	1 Ongoing Trust refurbishment programme to include work to balance and ensure flow & return temperatures are greater than 55° C throughout site HW distribution systems (including wards & departments).	23/01/2020	5 5 x 1	Ward 20/21 project required to be re-tendered and this is currently ongoing. Further project being considered to replace Trust domestic hot & cold water system to resolve pipework corrosion and temperature issues.	20/02/2020
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 Manag emen	1 Consideration be given to either increasing the backlog maintenance funding or ring fencing all or part of the monies	25/01/2020	9 3 x 3	6 Facet survey completed and information passed to Head of Division who is currently reviewing data. No further changes at this time.	20/02/2020

10. Summary of the Organisational Risk Register

High Risk

Ref	Initial Date	Title	Description	Controls	Current Rating	Owner	Actions		Target Rating	Progress Update	Next Review Date
							Description	Target			
PG0272	08/06/2016	Inadequate availability of medical staff to cover rotas - Obs and Gynae	There is a risk that Obstetrics and Gynaecology are unable to cover the rotas as a result of a current national shortfall to the number of doctors, which may lead to an adverse impact for staff, patients and the Trust.	1. Full complement of Junior Trainees. Gaps in rotas identified well in advance by Rota Co-ordinator who then liaises with Gynae Assistant Service Manager(now aware of gaps until August 16). All attempts made to fill gaps - advertise with Medical Resourcing 4-6 weeks prior to gap. E mails sent out to all trainees including AMPs to identify any staff able to fill gap. Advertisment of shift at higher level (still within Monitor rate). Escalation to Consultants within 1 week of the gap if still unable to fill. 2. There is always a Consultant on call available. Full complement of Junior Trainees. Gaps in rotas identified well in advance by Rota Co-ordinator who then liaises with Gynae Assistant Service Manager(now aware of gaps until August 16). All attempts made to fill gaps - advertise with Medical Resourcing 4-6 weeks prior to gap. Staff in Maternity have access to AMPs for advice or clinical review if required. E mails sent out to all trainees including AMPs to identify any staff able to fill gap. Advertisement of shift at higher level (still within Monitor rate). Escalation to Consultants within 1 week of the gap if still unable to fill. Obs/Gynae escalation plan in place. All qualified staff work within their NMC Code of Conduct and are aware not to undertake duties that they are not competent to carry out. 3. Full complement of Junior Trainees. Gaps in rotas identified well in advance by the Rota Co-ordinator who then liaises with the Gynae Assistant Service Manager. All attempts made to fill gaps which are advertised with Medical Resourcing 4-6 weeks prior to the gap. E mails are sent out to all trainees including AMPs to identify any staff able to fill the gap. Shifts can be advertised at a higher level (still within Monitor rate). Escalation to Consultants within 1 week of the gap if still unable to fill. 4. Quality review meetings focusing on CQC domains. Staffing issues discussed monthly at divisional governance meetings and Labour Ward forum. Staffing incidents also discussed at the fortnightly Patient Safety Summit. Gaps in rotas examined on daily basis and issues escalated. Senior Management team aware of staffing situation.	15 5 x 3	Obstetric Consultant - Risk Lead			10 5 x 2	09/10 19 The availability of medical staff was very repetitive but will remain the same score.	13/01/2020
SC0626	31/12/2018	Control of the backlog of patient's awaiting routine follow up - General Surgery	There is a risk that there is a delay to follow up reviews as an Outpatient as a result of increasing numbers of patients being added to the backlog list which may lead to adverse impact or a patient safety and patient experience	1. Weekly Performance Management Group report to Divisional Senior Management Team. 2. Ensure all clinics are maximised. 3. Advertisements have been publishing advertising for an additional Upper GI consultant. 4. Non-clinical validation of waiting list to remove those where follow up Is not required with in General 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	The divisional position has not improved and the risk remains the same as previous. This is discussed at sub-divisional performance reviews and remains an ongoing concern for the SMT moving forward.	09/04/2020
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 6. Speciality risk assessments completed 7. Trust detailed review undertaken 8. Paper to be presented to sub board committee 9. Paper to be presented to CCG 10. Full transformation programme initiated	15 3 x 5	Chief Operating Officer	6 Investments to be confirmed 7 Consider outpatient transformation programme	01/02/2020 01/01/2020	6 3 x 2	11/12/19 updated by COO. Further actions added	10/03/2020
TW0021	25/09/2019	Management of adoption health records	There is a risk that patient identifiable data may be exposed, as a result of a lack of structured process for the management of health records for patients who have been adopted, which may lead to regulatory sanction	1. Management of Health Records Policy is available	15 3 x 5	Manager	6 Prepare and approve SOP for the Management of adoption health records 7 Update Health records policy with mangement of adoption patient records process 8 Employ/second a member of staff to work through the current notes for adopted children to address the backlog and ensure confidentiality is maintained	30/03/2020 30/03/2020 30/04/2020	6 3 x 2	29/01/20 review by K Brown - staff identified for training in the new process and to deal with the backlog, commencing end of February 20	19/02/2020

Board of Directors

Title of Paper:	Learning from Deaths Quarterly Report (Q3 2019/20)	
Author:	Patient Safety Lead	
Executive Lead:	Medical Director	
Type of Report:	Concept Paper	
	Strategic Options Paper	
	Business Case	
	Information	
	Review/Benefits/Audit	✓

Link to Strategic Domains:		***Link to 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 of Directors 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.

Presented at Trust Board	2 March 2020

Learning from Deaths Quarterly Report Q3 2019/20

January 2020

'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 tenth iteration of our Learning from Deaths Report covering Quarter 3 of 2019/20.

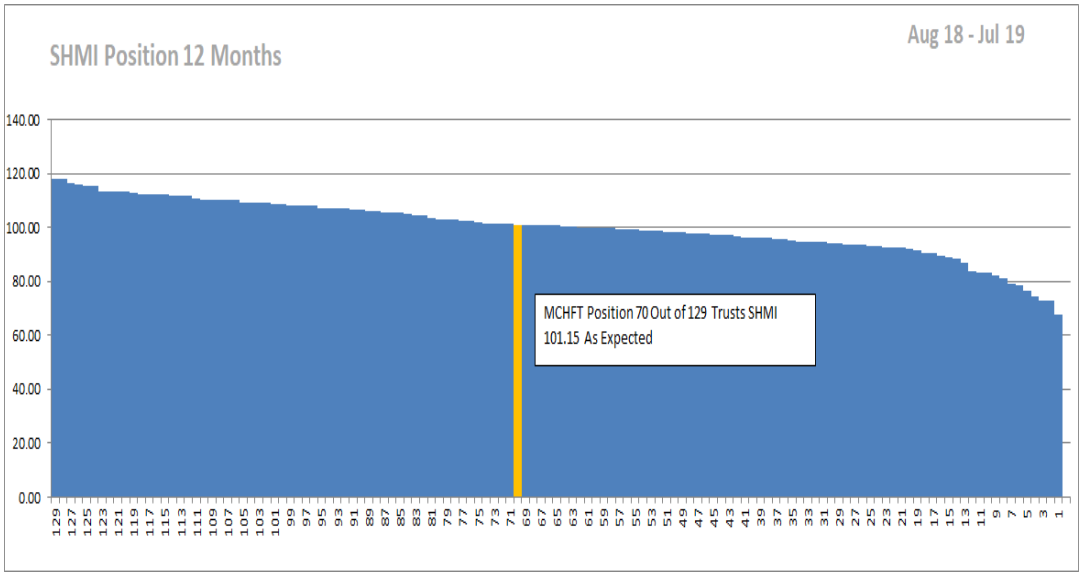
The report aims to provide assurance on how the organisation, through the work of the Hospital Mortality Reduction Group (HMRG) and other linking groups, is triangulating data and information to embed the learning from in-patient deaths, with the goal of seeing a sustained reduction in the Trust's mortality 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) August 2018 to July 2019

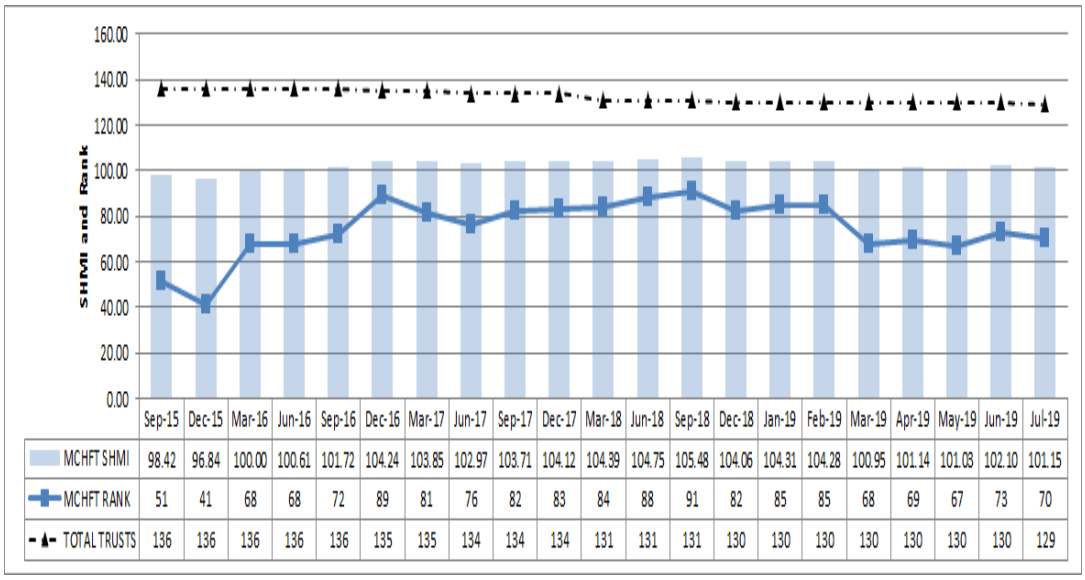
Chart 1 - SHMI Position



(Source NHS Digital, 2020)

Chart 1 demonstrates the SHMI position for the reporting period August 2018 to July 2019. The SHMI is currently 101.15 and is as 'expected'. This currently places the Trust 70 out of 129 Trusts.

Chart 2 - 12 month rolling SHMI and position



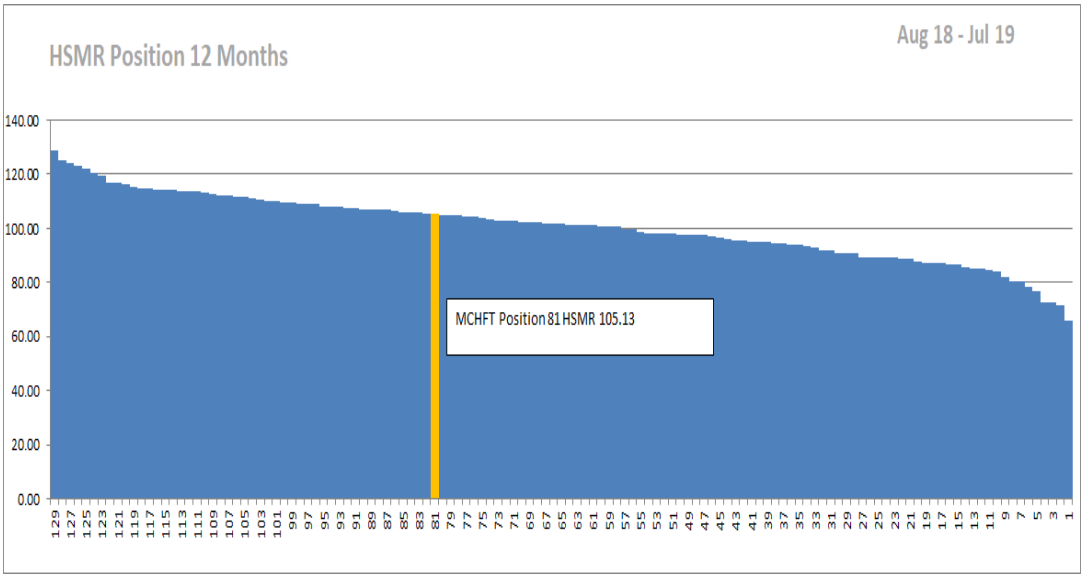
	Sep-15	Dec-15	Mar-16	Jun-16	Sep-16	Dec-16	Mar-17	Jun-17	Sep-17	Dec-17	Mar-18	Jun-18	Sep-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19
MCHFT SHMI	98.42	96.84	100.00	100.61	101.72	104.24	103.85	102.97	103.71	104.12	104.39	104.75	105.48	104.06	104.31	104.28	100.95	101.14	101.03	102.10	101.15
MCHFT RANK	51	41	68	68	72	89	81	76	82	83	84	88	91	82	85	85	68	69	67	73	70
TOTAL TRUSTS	136	136	136	136	136	135	135	134	134	134	131	131	131	130	130	130	130	130	130	130	129

(Source NHS Digital, 2020)

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

2.2 Hospital Standardised Mortality Rate (HSMR) August 2018 to July 2019

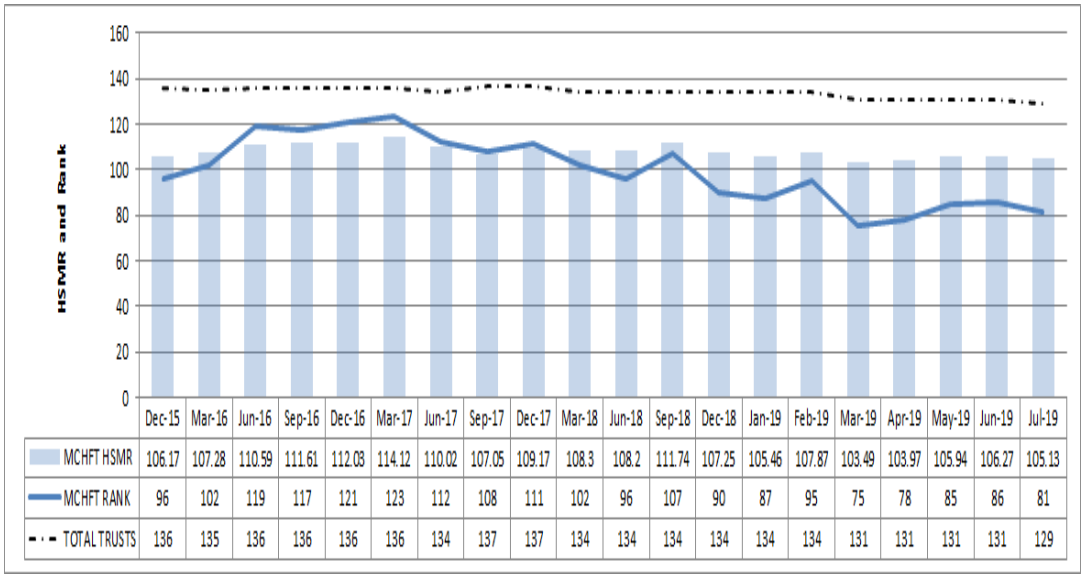
Chart 3 - HSMR Position



(Source HED, 2020)

Chart 3 demonstrates the HSMR position for the reporting period August 2018 to July 2019. The HSMR is currently 105.13 and is as 'expected, this places the Trust 81 out of 129 Trusts.

Chart 4 - 12 month rolling HSMR and position



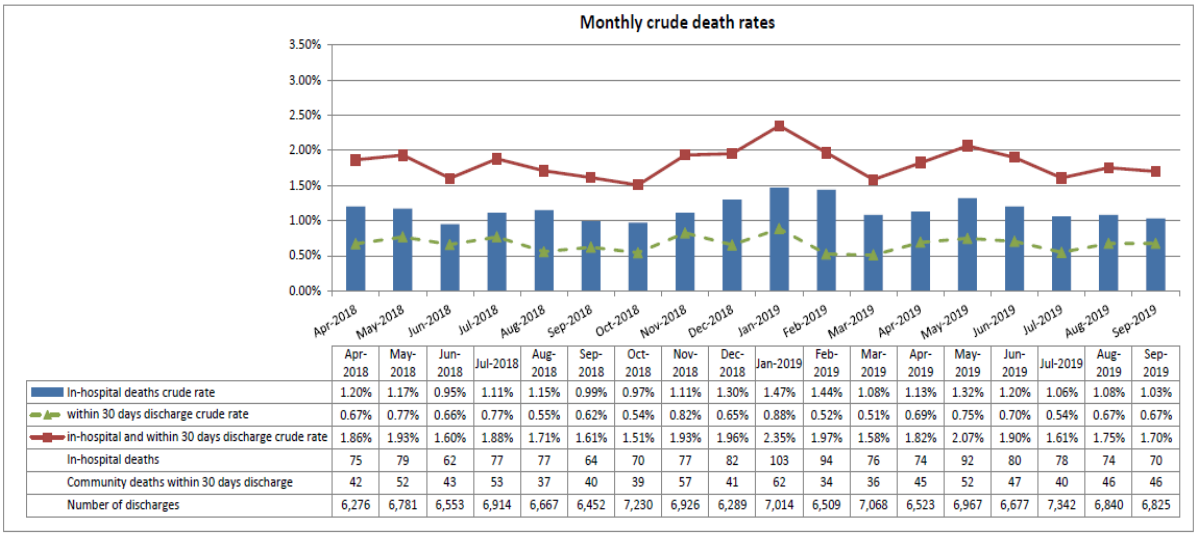
	Dec-15	Mar-16	Jun-16	Sep-16	Dec-16	Mar-17	Jun-17	Sep-17	Dec-17	Mar-18	Jun-18	Sep-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19
MCHFT HSMR	106.17	107.28	110.59	111.61	112.03	114.12	110.02	107.05	109.17	108.3	108.2	111.74	107.25	105.46	107.87	103.49	103.97	105.94	106.27	105.13
MCHFT RANK	96	102	119	117	121	123	112	108	111	102	96	107	90	87	95	75	78	85	86	81
TOTAL TRUSTS	136	135	136	136	136	136	134	137	137	134	134	134	134	134	134	131	131	131	131	129

(Source HED, 2020)

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



	Apr-2018	May-2018	Jun-2018	Jul-2018	Aug-2018	Sep-2018	Oct-2018	Nov-2018	Dec-2018	Jan-2019	Feb-2019	Mar-2019	Apr-2019	May-2019	Jun-2019	Jul-2019	Aug-2019	Sep-2019
In-hospital deaths crude rate	1.20%	1.17%	0.95%	1.11%	1.15%	0.99%	0.97%	1.11%	1.30%	1.47%	1.44%	1.08%	1.13%	1.32%	1.20%	1.06%	1.08%	1.03%
within 30 days discharge crude rate	0.67%	0.77%	0.66%	0.77%	0.55%	0.62%	0.54%	0.82%	0.65%	0.88%	0.52%	0.51%	0.69%	0.75%	0.70%	0.54%	0.67%	0.67%
in-hospital and within 30 days discharge crude rate	1.86%	1.93%	1.60%	1.88%	1.71%	1.61%	1.51%	1.93%	1.96%	2.35%	1.97%	1.58%	1.82%	2.07%	1.90%	1.61%	1.75%	1.70%
In-hospital deaths	75	79	62	77	77	64	70	77	82	103	94	76	74	92	80	78	74	70
Community deaths within 30 days discharge	42	52	43	53	37	40	39	57	41	62	34	36	45	52	47	40	46	46
Number of discharges	6,276	6,781	6,553	6,914	6,667	6,452	7,230	6,926	6,289	7,014	6,509	7,068	6,523	6,967	6,677	7,342	6,840	6,825

(Source HED, 2020)

Chart 5 demonstrates the crude death rate for the period up to September 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

In September 2019, the in-hospital crude death rate was 1.03%. This is a decrease from 1.08% in August 2019.

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.

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
115	75	36	47	13	11	0	0	3	1
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
269	219	138	213	33	48	0	0	4	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
737	938	551	832	97	114	0	1	6	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
2	1	2	1	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
3	0	3	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
3	15	3	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 December 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 1 November 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 –6 month review of the SJR process

The quarter 3 deep dive is looking at the results of the SJR process for quarters 1, 2 and 3 of 2019/2020. 97 SJR's have been completed in the first 3 quarters of 2019/2020.

Chart 6

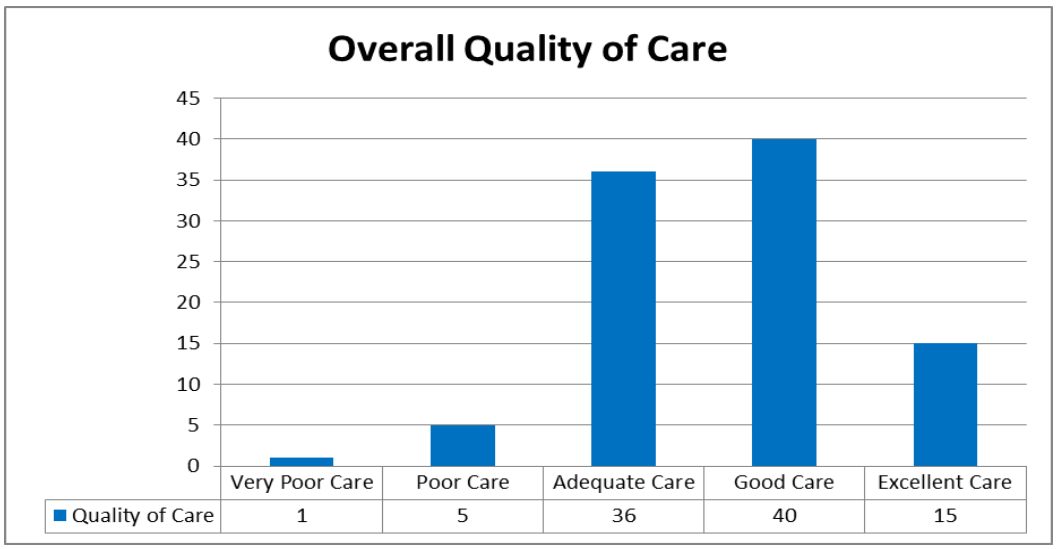
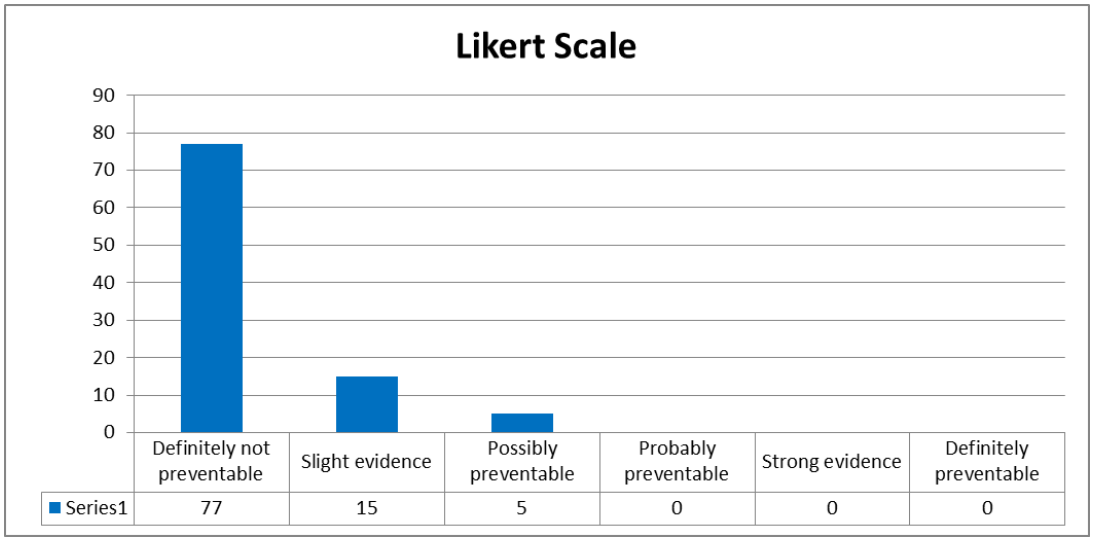


Chart 6 shows the overall quality of care as assessed during the SJR process. 57% of patients care was scored overall as good or excellent.

Chart 7



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).

80% of the cases reviewed were classed as definitely not preventable.

Four potentially avoidable deaths have been identified through the incident investigation process in quarter 3. These will undergo comprehensive executive led investigations in line with Trust policy. The incidents have been reported externally as required.

Learning from the reviews

During the SJR process the reviewers will highlight positive judgments about the care provided. Below are a number of the positive comments made during the reporting period.

- Excellent Advance Nurse Practitioner Reviews
- Excellent evidence of Jehovah Witness Advocacy
- Good evidence of use of the LOCSIPPS
- Excellent Macmillan support
- There were a number of examples of excellent communication with patients and their families
- Evidence of excellent multi-disciplinary team approach to patient care
- Evidence of good planning and preparation for end of life care with regular family input
- Excellent continuity with medical care and escalation of care needs as appropriate.

The SJRs undertaken in Q1, 2 &3 have identified the following learning themes:

- Delays in commencement of end of life care plans
- End of life care plans not fully completed
- Ceilings of care not documented
- Sepsis pathways not completed
- Antibiotics not given in timely manner when sepsis suspected
- Emergency Department checklist not fully completed for the patients stay in the department
- Poor completion of the admission proforma's and documentation

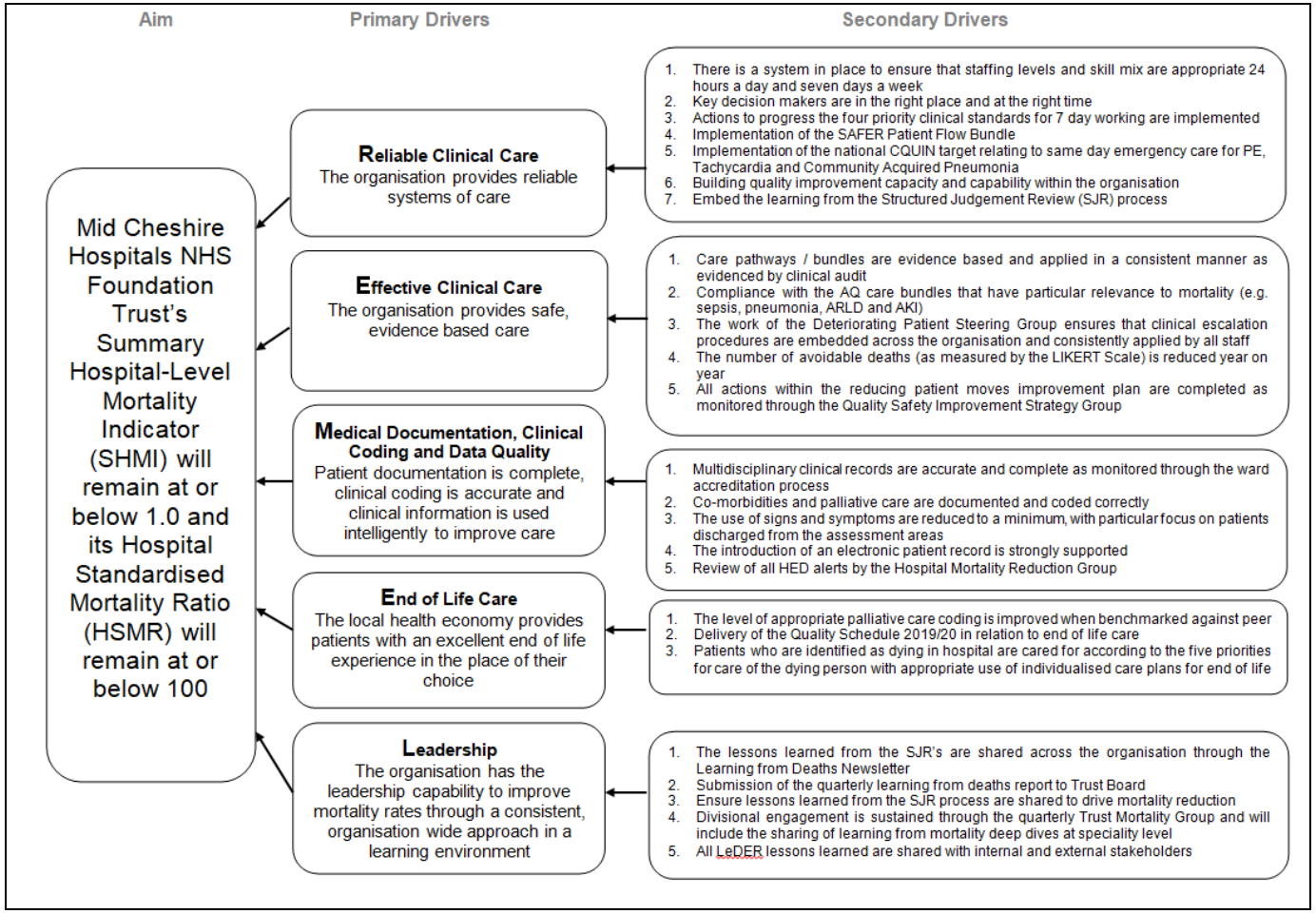
Improvement work is ongoing in relation to the identified themes and these are monitored through the Quality & Safety Improvement Strategy and the Deteriorating Patient Steering Group.

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. The next meeting will be held in February 2020.

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
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 – *1 Year Duration from completion*

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: 20.2.2020.

To be completed by Trust Secretary

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

Seal Applied *(date)*_____

Seal Number _____

HILL DICKINSON

Dated DO NOT DATE 2020

LEASE

Between

(1) Mid Cheshire Hospitals NHS Foundation Trust

and

(2) Leighton Hospital League of Friends

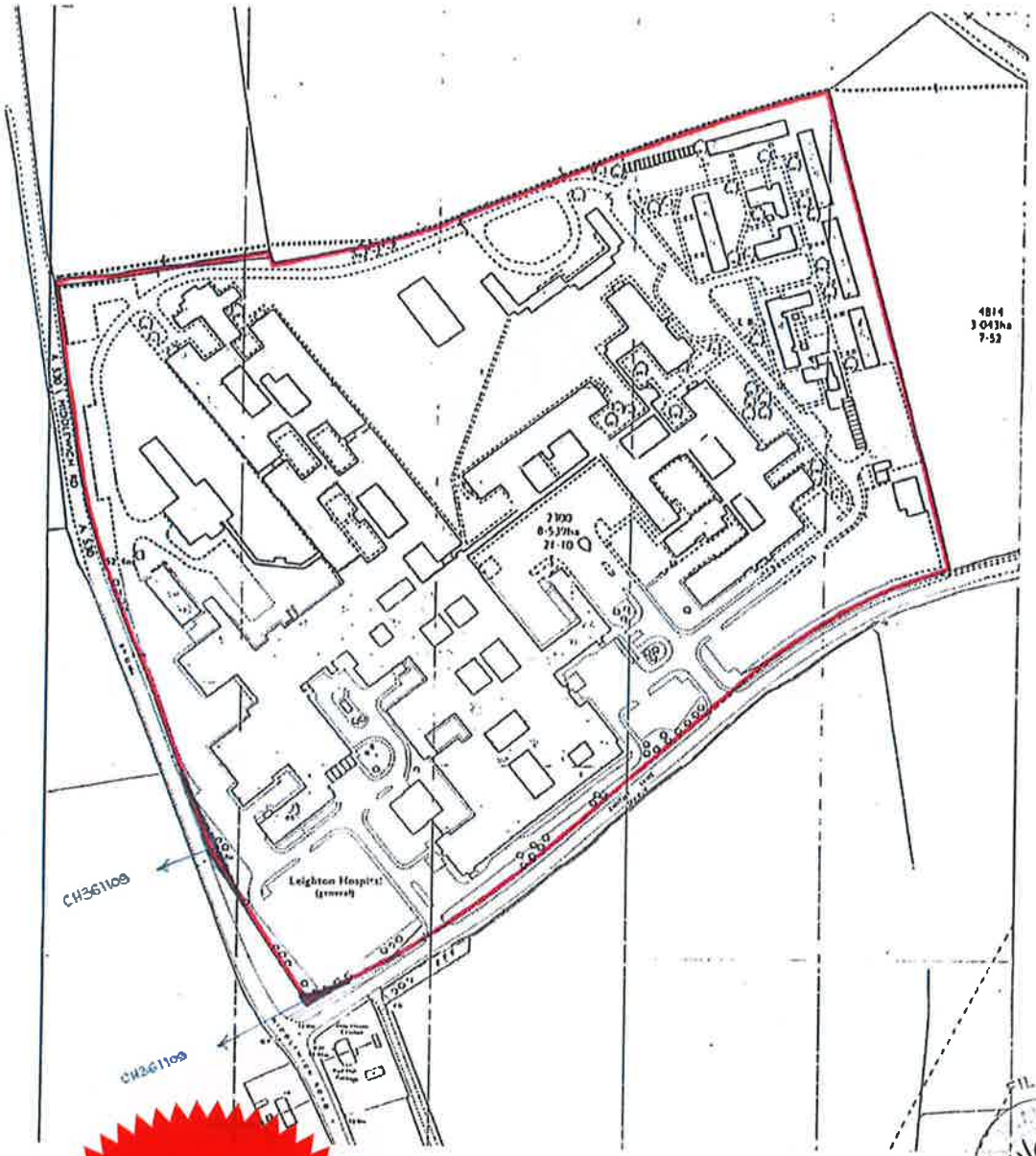
Relating to
Premises at Leighton Hospital
Leighton
Crewe
Cheshire
CW1 4QJ

Hill Dickinson LLP
No. 1 St. Paul's Square
Liverpool
L3 9SJ
www.hilldickinson.com

H.M. LAND REGISTRY

TITLE NUMBER			
CH346590			
ORDNANCE SURVEY PLAN REFERENCE	SJ6857 SJ6858	SECTION	Scale 1/2500
COUNTY CHESHIRE	DISTRICT CREWE AND NANTWICH		© Crown copyright

NOTE: AREAS ON THIS PLAN ARE EXPRESSED IN ACRES AND HECTARES.



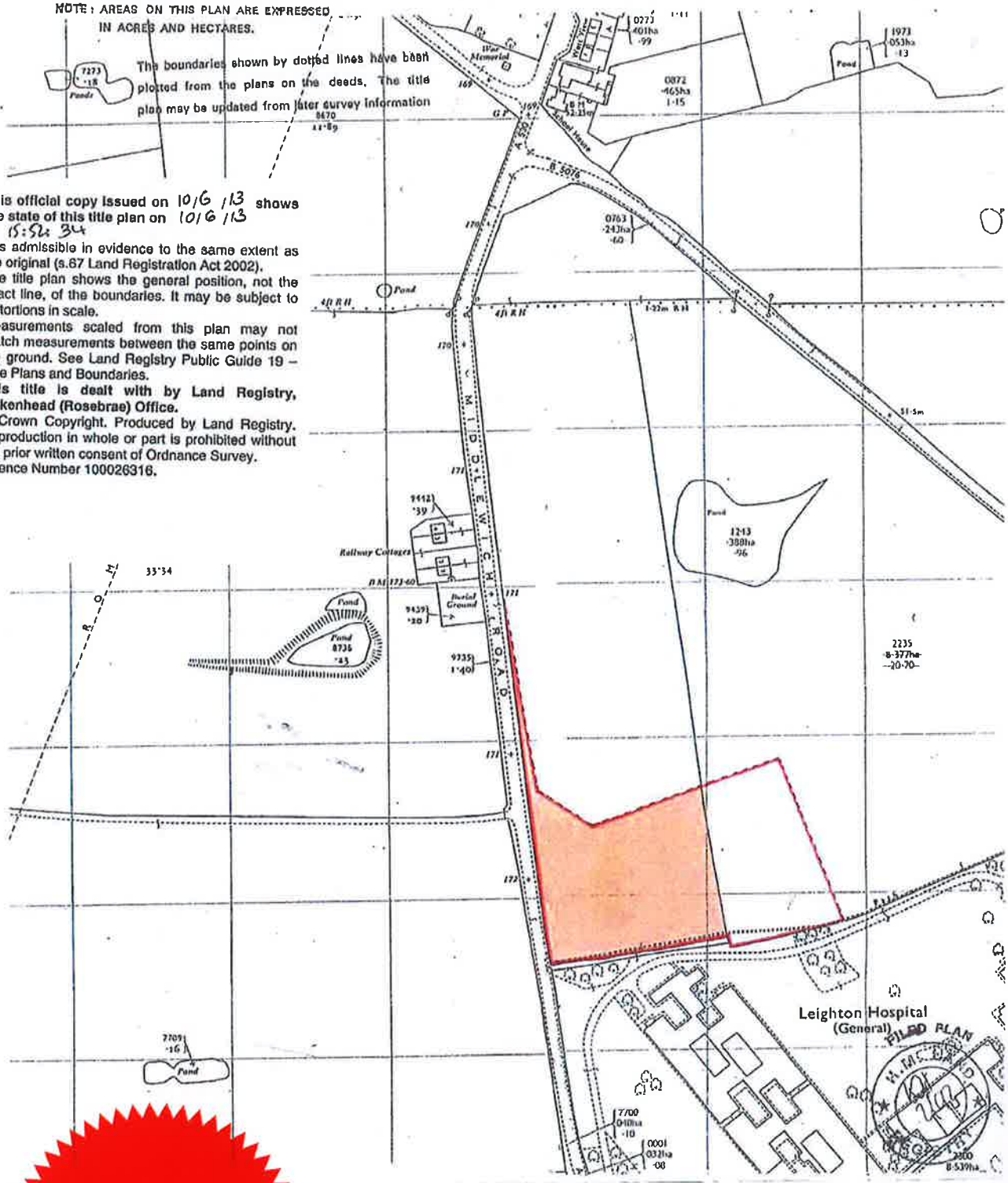
Plan 1

H.M. LAND REGISTRY

TITLE NUMBER	
CH 347597	
ORDNANCE SURVEY PLAN REFERENCE: SJ 6758 SJ 6858	SECTION / Scale 1/2500
COUNTY CHESHIRE	DISTRICT CREWE AND NANTWICH
	© Crown copyright

NOTE: AREAS ON THIS PLAN ARE EXPRESSED IN ACRES AND HECTARES.

The boundaries shown by dotted lines have been plotted from the plans on the deeds. The title plan may be updated from later survey information



This official copy issued on 10/6/13 shows the state of this title plan on 10/6/13 at 15:52:34

It is admissible in evidence to the same extent as the original (s.67 Land Registration Act 2002).

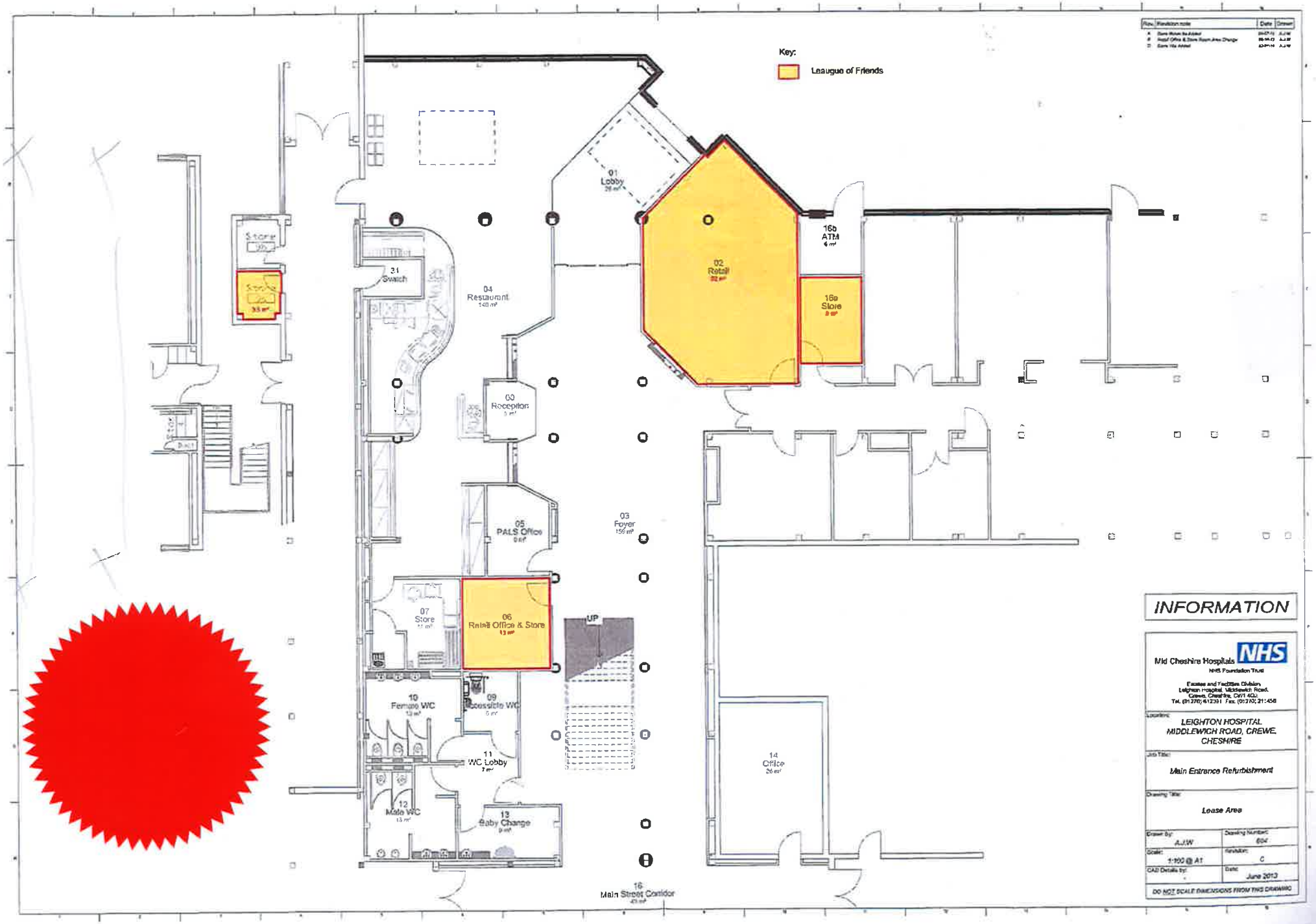
The title plan shows the general position, not the exact line, of the boundaries. It may be subject to distortions in scale.

Measurements scaled from this plan may not match measurements between the same points on the ground. See Land Registry Public Guide 19 – Title Plans and Boundaries.

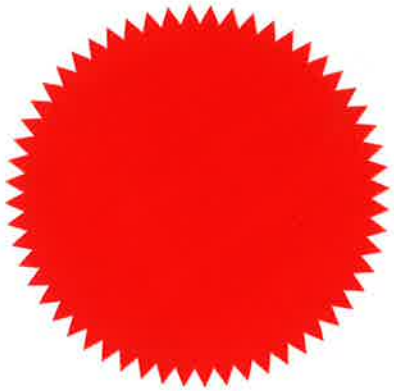
This title is dealt with by Land Registry, Birkenhead (Rosebrae) Office.

Plan 2

Plan 3


Key:
Leaugue of Friends
01 Lobby
02 Retail
16b ATM
16a Store
04 Restaurant
03 Reception
05 PALS Office
03 Foyer
06 Retail Office & Store
07 Store
UP
10 Female WC
09 Accessible WC
11 WC Lobby
12 Male WC
13 Baby Change
14 Office
16 Main Street Corridor
INFORMATION
Mid Cheshire Hospitals NHS
NHS Foundation Trust
Estates and Facilities Division
Leighton Hospital, Middlewich Road,
Crewe, Cheshire, CW1 4QJ
Tel. (01270) 612391 Fax. (01270) 211456
LEIGHTON HOSPITAL
MIDDLEWICH ROAD, CREWE,
CHESHIRE
Main Entrance Refurbishment
Lease Area
A.J.W
1:100 @ A1
June 2013
DO NOT SCALE DIMENSIONS FROM THIS DRAWING

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



Signature of director

Name of director

Signature of director/secretary

Name of director/secretary

SIGNED as a Deed by **LEIGHTON HOSPITAL LEAGUE OF FRIENDS** acting by two authorised signatories:)
)
)

Authorised Signatory

PRINT NAME

Authorised Signatory

PRINT NAME

Mid Cheshire Hospitals
NHS Foundation Trust

Title of Paper:	Report of Use of the Trust Seal	
Author:	Katharine Dowson	
Executive Lead:	James Sumner	
Type of Report:	Concept Paper	
	Strategic Options Paper	
	Business Case	
	Information	X
	Review/Benefits/Audit	

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

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

Positive Benefit:	Board oversight of the use of the Trust Seal
Risk:	Non-compliance with Trust Constitution

To be published on Trust Website –complete version	***Y*** *(delete as appropriate)*
If no, to be published on Trust Website – redacted	
If not to be published complete or redacted, please detail the reason why	
Presented at Board Meeting of:	2 March 2020

Mid Cheshire Hospitals
NHS Foundation Trust

Recommendation

The Board of Directors are asked to note the sealings that have taken place since the last Board report in November 2019. This report notes subsequent sealings to 29 February 2020 as required by the Trust Constitution.

Quarterly Report of Sealings for the period 1 December 2019 to 29 February 2020

Seal Number	***Description***	***Date of Board Approval***	***Date of Sealing***
103	Agreement to purchase additional land for car parking.	03 February 2020	03 February 2020
104	Deed of Surrender for the purchase of South Cheshire Private Hospital building	Approved by Chairman's Action on 13 February 2020 (reported to Board on 2 March 2020)	13 February 2020

Title of Paper :	Board Committee Annual Review	
Author:	Katharine Dowson, Head of Corporate Governance	
Executive Lead:	James Sumner, CEO	
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	
	Note	x
	Recommend	
	Delegate	

Positive Benefit:	Assurance in respect of the effectiveness of Board Committees
Risk:	Insufficient review and assurance of delegated Board duties

To be published on Trust Website –complete version	***Y*** *(delete as appropriate)*
If no, to be published on Trust Website – redacted	***N*** *(delete as appropriate)*
If not to be published complete or redacted, please detail the reason why	
Presented at Board Meeting of:	2 March 2020

Introduction

Each year a review of performance, membership, Terms of Reference (ToR) and Work Plan for each Board sub-committee is undertaken. The review takes place with the Chair of the relevant committee and the Chairman, Chief Executive and Trust Board Secretary.

Members of all committees with the exception of RemCo complete a self-assessment questionnaire ahead of the meeting that also provides evidence for the effectiveness of each committee.

Process and next steps

- The Chair of each committee has received a follow up letter from the Chairman outlining the key highlights of the discussions.
- Changes discussed have been incorporated into draft Terms of Reference for each committee which should be discussed at committee and agreed before 13 March.
- The Committee's Annual Reports will focus on the committee's effectiveness and will be ratified by each Committee before being presented to the Audit Committee in May 2020 so need to be approved at April meetings. The Audit Committee annual report will be reported to Board in June.
- Committees should also produce an annual plan for 2020/21 by 31 March 2020 for the year beginning 1 April to be discussed at the Board Strategy Day on 13 March 2020 along with reviewed Terms of Reference
- Every committee that reports into Board Committees should produce a workplan, terms of reference and annual report to the committee.
- Review of the Standing Orders for Delegation of Powers to Board Committees as part of the Corporate Governance Handbook review in the summer.

The following committee reviews took place:

Board Committee	**Review date**	**Chair / Vice Chair 2019-20**
Quality Governance Committee (QGC)	03 February 2020	Chair – Lesley Massey VC - Trevor Brocklebank, NED
Appointments & Remuneration Committee (RemCo)	03 February 2020	Chair – Mr D Dunn, Chairman VC – John Church, Deputy Chair
Performance and Finance Committee (PAF)	23 January 2020	Chair – Mike Davis, NED (to 31 January 2020) VC – Les Philpott, NED
Transformation and People Committee (TAP)	06 February 2020	Chair – Lorraine Butcher, NED VC – Mr J Church, NED
Audit Committee	23 January 2020	Chair – Les Philpott, NED VC – Mike Davis, NED (to 31 January 2020)
Trustees Subcommittee	20 January 2020	Chair – John Church VC – Dennis Dunn

This paper summarises key findings and any themes that have emerged.

Over-arching Themes and Conclusions:

- No serious issues or concerns were raised during any of the committee reviews or within the surveys sent out ahead of reviews. Any minor concerns raised through the surveys were discussed at the reviews
- Escalations to the Board, delegations to Executive groups and to other committees are generally appropriate and the committees are all chaired very well
- The committees align and work across each other well with good communication between Chairs when issues cut cross committees
- Audit, QGC, TAP and Trustees all had new chairs from 1 February 2019 and the transition has been smooth, changes to committee membership in general have been managed well and causes minimum disruption
- The way the Trust manages risk and shares this with Board via the Board Assurance Framework is subject to an ongoing review. The Board will review the BAF with Audit Committee providing assurance on the risk management process in general. Board will delegate risks to committees as appropriate
- The Head of Corporate Governance will attend all Board Committees (with the exception of Trustees) as a regular attendee to formalise reporting to the Board and support the Chair to align the agenda of the Committee to the BAF.

Key findings to note:

1) Audit Committee (AC)

- It was noted that AC meets its statutory functions and there is appropriate escalation and delegation between relevant committees. The proposed additional more formal reporting from other Committees will be established once the new Corporate Governance Team structure is in place in April 2020
- AC provide constructive and robust challenge which provides assurance to the Board
- The transition to the new Chair has been smooth and positive for the functioning of the Committee
- Mr Andy Vernon, newly appointed NED was confirmed in the Vice Chair role at the January Board
- The Committees oversight of risk and a greater role for the committee will be reviewed by the Company Secretary as part of the work in regard to the BAF
- The Non-Executive membership of the committee is to be reviewed as it is not standard practice to have all NEDs on the committee. Executive Directors will continue to be invited to attend as required and the CEO will now attend on a regular basis as well as the Company Secretary and Head of Corporate Governance
- The Corporate Governance team is to review the number of meetings the AC has per year as it is at the upper end of peer practice and suggest a new pattern of meetings based on the requirements of end of year accounts and the BAF

2) Trustees Subcommittee

- The Committee has performed well this year and has steered the charity towards a new approach to appeal spread across a few designed to appeal to many rather than one major appeal
- The Committee will be looking to develop closer links with the transformation team and the health and wellbeing work to support new initiatives and projects
- The membership of the committee requires some review as the current structure with a clinical led steering group is based on having one major appeal. Regular clinical representation would be welcomed on the main committee
- It was agreed that there was no requirement for the Deputy Director to be a regular member now that the Director of Finance is a member however there is a

requirement for 2 Executives or Trustees to be members so it has been suggested that the Director of Nursing nominates a clinical representative to attend on a regular basis as her deputy
- The Annual Plan for the charity will be presented to Corporate Trustees at the Board Away Day in April

3) Performance and Finance Committee (PAF)
- The Committee provides good assurance to the Board and the survey results were very positive
- The new Chair of the Committee has been attending PAF for three months and was well prepared to take on the role from February 2020
- The membership of the committee was agreed to be appropriate and works well
- The Terms of Reference require some updating as some key responsibilities are no long relevant
- Some overlap between PAF and TAP has occurred during the year but the Chairs have communicated well to resolve any issues. The work to define when transformation projects become business as usual had been useful in supporting this
- The digital agenda will be moving to TAP, with capital IT and cyber security staying at PAF

4) Quality Governance Committee
- It was noted that QGC has managed the change in Executive leads well and there has been a change in the committee towards a greater focus on strategy rather than detail
- The membership of the committee is working well, the Chief Executive will no longer be on the committee which leaves two Executives, this is in line with other committees
- There is likely to be substantial changes to the remit of the committee to focus on safety and clinical and quality governance as the oversight of risk, BAF and corporate governance will be moving to Audit Committee

5) Transformation & People Committee (TAP)
- TAP has made considerable progress in aligning the workforce and transformation aspects of the committee together
- TAP will be responsible for the digital agenda as this ties into both transformation and workforce development closely, as a result the Chief Information Office will be joining the committee. Capital projects and Cyber Security will stay with PAF
- Volunteers will have a higher profile at TAP with the committee responsible for ensuring a new volunteer's strategy is developed

6) Appointments & Remuneration Committee (RemCo)
There were no changes made to the ToR or membership.

Recommendations for Board:
- To review the role of the committee in providing assurance on risk to the Board through the BAF once the Company Secretary is in post
- To note the annual review of Board Committees and the assurance provided
- To consider at the Trust Strategy Day in March the workplans and ToR of the committees as a whole

Katharine Dowson
Head of Corporate Governance and Trust Secretary
February 2020

We Care Because You Matter

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

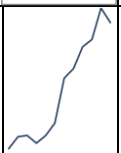
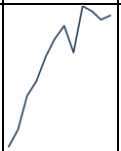
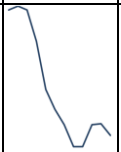
Board of Directors

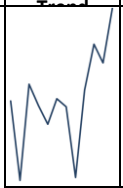
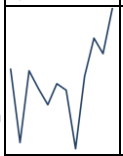
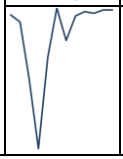
Workforce Report

March 2020

(January 2020 data)

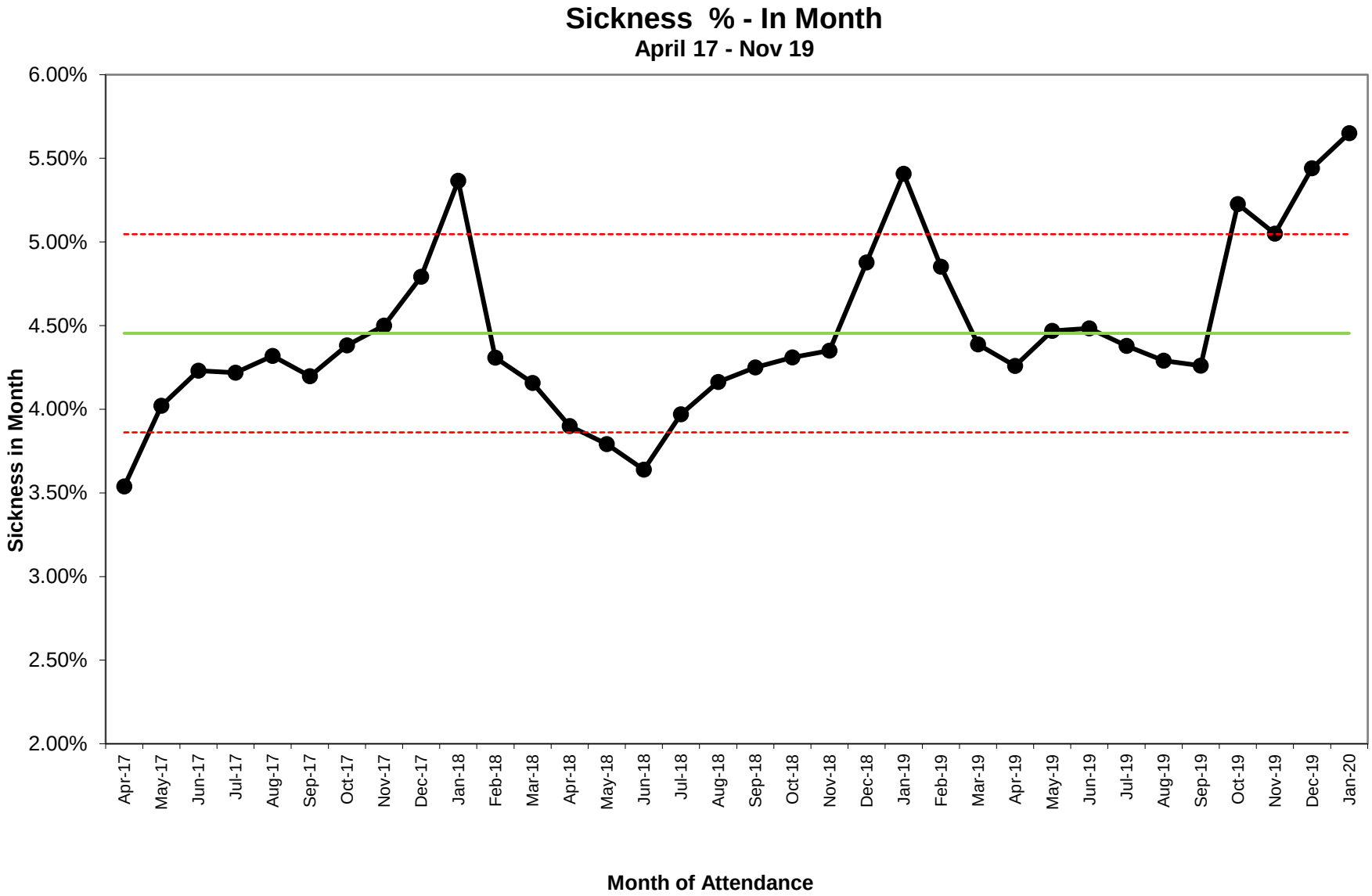
Performance Report Workforce Chapter
Month: Jan-20

Measure	Target	Performance	Description	Narrative	Rolling Trend	Trend	C&W Average (Dec 19)
In-Month Sickness Absence	N/A	5.65%	In-month 12m average Sickness Absence described as a Percentage	Overall, sickness was 0.21% higher in month. Two divisions experienced an improvement in compliance (EF and WC). MEC experienced the most significant increase in sickness rates (0.86%)		↑	5.73%
Appraisal Rate	90.00%	90.53%	Percentage of Staff who have received an appraisal in the last 12 months. Excludes New Staff with less than 12m service and Bank Staff	Overall, there was a 1.08% worsening in the appraisal rates across the Trust. Two divisions experienced an improvement in compliance (WC and CCICP). Corporate, SC and WC slipped into Amber positions.		↓	85.92%
Mandatory Training	90.00%	84.32%	Mandatory Training Monthly Rate Excludes Bank Staff, Staff on long term sick & mat. leave.	Overall mandatory training compliance improved in month (0.31%) and four divisions experienced an improvement (DCSS, MEC, EF and CCICP). All divisions are Amber with the exception of EF who are Green. MEC have moved into an Amber position from Red the previous month.		↑	88.82%
Staff Turnover	10.00%	8.70%	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 (0.11%). Turnover improved in four divisions (Corporate, MEC, EF and SC) All divisions are now Green against target with the exception of EF who are Amber (10.03%) and CCICP who are Red (12.22%)		↓	10.75%

Measure	Target	Performance	Description	Narrative	Rolling Trend		
Agency Spend	(404)	(881)	In month total spend for the Trust against plan	Agency spend increased in month (£175k more than the previous month). The agency spend target was not met. Agency spend reduced in medical & dental (-£57k) but increased by £237k in nursing and midwifery . Four divisions had a higher spend than in the previous month (DCSS, MEC, SC and Corp). MEC saw the biggest increase (£156k more than the previous month).		↑	N/A
NHSI Planned Agency	less than 100%	218.07%	In month Trust Agency Spend as a percentage of the Planned Agency Spend			↑	N/A
Over Cap Rates	N/A	67%	Number of Agency shifts filled by agency staff that are over the nationally determined capped rates			↑↓=	N/A

Key

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


Sickness % - In Month
April 17 - Nov 19
6.00%
5.50%
5.00%
4.50%
4.00%
3.50%
3.00%
2.50%
2.00%
Sickness in Month
Apr-17
May-17
Jun-17
Jul-17
Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
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May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Month of Attendance

Trust Name	Mid Cheshire	13.02.20

412 Corporate	Staffing Group Headcount	Total	% of Staff Group
DOCTORS	6	5	83.33%
NURSES	76	67	88.16%
PROFESSIONALS	1	1	100.00%
SUPPORT TO CLINICAL STAFF (HCAs/Admin/Ancillary/WorksEtc)	12	11	91.67%
NHS INFRASTRUCTURE SUPPORT (not reported to ImmForm)	329	220	66.87%
TOTAL (Front Line Healthcare Workers only)	95	84	88.42%
TOTAL (All Employees)	424	304	71.70%

412 Diagnostics and SupportDivisi	Staffing Group Headcount	Total	% of Staff Group
DOCTORS	25	14	56.00%
NURSES	54	38	70.37%
PROFESSIONALS	281	195	69.40%
SUPPORT TO CLINICAL STAFF (HCAs/Admin/Ancillary/WorksEtc)	346	258	74.57%
NHS INFRASTRUCTURE SUPPORT (not reported to ImmForm)	201	113	56.22%
TOTAL (Front Line Healthcare Workers only)	706	505	71.53%
TOTAL (All Employees)	907	618	68.14%

412 Medicine & Emergency Care Division	Staffing Group Headcount	Total	% of Staff Group
DOCTORS	152	132	86.84%
NURSES	345	290	84.06%
PROFESSIONALS	5	5	100.00%
SUPPORT TO CLINICAL STAFF (HCAs/Admin/Ancillary/WorksEtc)	242	192	79.34%
NHS INFRASTRUCTURE SUPPORT (not reported to ImmForm)	116	59	50.86%
TOTAL (Front Line Healthcare Workers only)	744	619	83.20%
TOTAL (All Employees)	860	678	78.84%

412 Estates & FacilitiesDivision	Staffing Group Headcount	Total	% of Staff Group
DOCTORS	0	0	
NURSES	0	0	
PROFESSIONALS	0	0	
SUPPORT TO CLINICAL STAFF (HCAs/Admin/Ancillary/WorksEtc)	66	47	71.21%
NHS INFRASTRUCTURE SUPPORT (not reported to ImmForm)	339	168	49.56%
TOTAL (Front Line Healthcare Workers only)	66	47	71.21%
TOTAL (All Employees)	405	215	53.09%

412 Surgical and CancerDivision	Staffing Group Headcount	Total	% of Staff Group
DOCTORS	79	60	75.95%
NURSES	282	228	80.85%
PROFESSIONALS	140	105	75.00%
SUPPORT TO CLINICAL STAFF (HCAs/Admin/Ancillary/WorksEtc)	284	224	78.87%
NHS INFRASTRUCTURE SUPPORT (not reported to ImmForm)	193	134	69.43%
TOTAL (Front Line Healthcare Workers only)	785	617	78.60%
TOTAL (All Employees)	978	751	76.79%

412 Women and ChildrensDivision	Staffing Group Headcount	Total	% of Staff Group
DOCTORS	38	37	97.37%
NURSES	210	183	87.14%
PROFESSIONALS	6	6	100.00%
SUPPORT TO CLINICAL STAFF (HCAs/Admin/Ancillary/WorksEtc)	63	56	88.89%
NHS INFRASTRUCTURE SUPPORT (not reported to ImmForm)	74	50	67.57%
TOTAL (Front Line Healthcare Workers only)	317	282	88.96%
TOTAL (All Employees)	391	332	84.91%

412 CCICP	Staffing Group Headcount	**Total**	**% of Staff Group**
DOCTORS	15	13	86.67%
NURSES	201	150	74.63%
PROFESSIONALS	9	8	88.89%
SUPPORT TO CLINICAL STAFF (HCAs/Admin/Ancillary/WorksEtc)	312	229	73.40%
NHS INFRASTRUCTURE SUPPORT (not reported to ImmForm)	114	74	64.91%
TOTAL (Front Line Healthcare Workers only)	537	400	74.49%
TOTAL (All Employees)	651	474	72.81%

Grand Total (Inc Substantive, Community, Bank and Additional)	Staffing Group Headcount	**Total**	**% of Staff Group**
DOCTORS	386	332	86.01%
NURSES	1287	1075	83.53%
PROFESSIONALS	468	346	73.93%
SUPPORT TO CLINICAL STAFF (HCAs/Admin/Ancillary/WorksEtc)	1534	1226	79.92%
NHS INFRASTRUCTURE SUPPORT (not reported to ImmForm)	1518	970	63.90%
TOTAL (Front Line Healthcare Workers only)	3675	2979	81.06%
TOTAL (All Employees)	**5193**	**3949**	**76.04%**

Mid Cheshire Hospitals NHS Foundation Trust

Title of Paper:	Reward and Recognition Plan	
Author:	Alexa Traynor, Associate Director of Communications and Engagement	
Executive Lead:	Heather Barnett, Director of Workforce & OD	
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		Caring	
Aspiring to Excellence in Practice Through Our Workforce	X	Responsive	
Creating a 21st Century Infrastructure for Transformative Health and Social Care		Well-Led	X

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

Positive Benefit:	This plan looks to create a culture of appreciation at MCHFT where successes, both big and small are openly celebrated and to encourage and enable participation from a diverse range of staff to help remove barriers to involvement.
Risk:	N/A

To be published on Trust Website –complete version	***x***
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 March 2020**

Reward and Recognition Plan

The vision for reward and recognition within MCHFT is for all staff to be highly engaged and motivated to achieve outstanding results as they feel valued and rewarded for doing an outstanding job both individually and collectively.

Having the right reward and recognition design and processes in place will support retention of staff within the Trust and is also important in attracting new people into the organisation. It is essential if MCHFT is to meet its strategic ambition of being an employer of choice.

This plan looks to create a culture of appreciation at MCHFT where successes, both big and small are openly celebrated and to encourage and enable participation from a diverse range of staff to help remove barriers to involvement.

Background

In September 2019 the Celebration of Achievement (COA) Project Group ran a survey and held two focus groups to assess whether the current reward and recognition models/schemes were effective and reflected how MCHFT staff would want to celebrate their successes.

This plan has been developed to reflect the feedback gathered which clearly showed that a new approach to recognition and reward would be beneficial for the organisation.

Summarised below are the main findings of the review:

- Individual recognition and being personally thanked is extremely important to our staff
- Staff want an informal, larger event which is open to all staff rather than a formal awards ceremony
- Staff want to be involved in the judging of awards
- Celebration of long service and attendance needs to be more personal and celebratory

Our Values

Our values have a key influence on shaping our workplace in terms of culture and behaviours.

This recognition and reward programme has therefore been designed to reinforce Trust values and behaviours by recognising and rewarding those staff who innovate, and go above and beyond their roles to deliver excellence and support the Trust's values.

The reward and recognition plan will be supported by a programme of communications activities to refresh the presentation of the Trust vision and values which will ensure they are concise, visible and relatable to every member of staff at every level.

The new reward and recognition approach will include a range of rebranded materials following a 'stars' theme to develop a cohesive programme of reward and recognition which will encourage greater recognition across the Trust.

This design will be an extension of a new corporate visual identity for MCHFT (currently in development) to be used across all internal and external communications and marketing activity including Trust strategy, recruitment materials, vision and values, staff health and wellbeing programme.

Uniting all these elements will:

- Firmly embed the vision and values within the organisation
- Bring Trust strategy to life for staff so it feels relevant to their everyday work
- Ensure staff understand how they contribute to achieving strategic objectives
- Make staff feel their efforts and contribution are valued and rewarded
- Develop a strong employer brand to support recruitment and retention

How will we structure our initiatives on Reward and Recognition

A new Awards Team Group has formed that is currently meeting monthly and that also has three sub groups to focus on different strands of reward and recognition.

These are:

- Trust event
- Local awards (divisional and Trust-wide)
- Individual recognition and reward

Trust Event

The event aims to thank the whole organisation for their continuous hard work, reaching potentially all staff (around 4600) rather than just 250 who would attend the previous annual awards event.

The event will be a family fun day in September (date tbc) open to all staff and their families with the aim of bringing staff together to celebrate and recognise the great work that they do. The day would also provide an opportunity for us to focus on staff health and wellbeing and the value of spending social time together.

Event details:

- 'Country fair' style event with child-friendly activities, stalls, 'chill out'/afternoon tea tent and a main stage for entertainment such as live music
- Venue options: A – Bentley, B – the former MMU Crewe campus, Venue C – South Cheshire College (not been approached yet)
- Event open and free to all staff, £5 for family/friends (children up to 12 free)
- To use booking site Eventbrite to be able gauge number of attendees
- The Cat Radio and Rapid Relief Team (provide free refreshments and barbeques for NHS staff https://www.rapidreliefteam.org/) will provide refreshments
- Potential to link in staff 'Hidden Talents' variety show on main stage (linked in to the Year of the Nurse and Midwife celebrations)
- External event planners will support with pre event management and managing on the day at approximate cost of £1200.

Individual reward and recognition

The Trust's current recognition schemes were launched in 2014 as a way to recognise staff who go above and beyond what is expected. These were an Employee of the Month scheme and a 'Thank You' scheme

A Shining Example (previously thank you scheme)

The 'Thank You' scheme is currently open to staff and patients/public and invites people to write a thank you message on a card and give it directly to the person they would like to thank. An online version is also available.

The 'Thank You' scheme will become 'A Shining Example' which will involve the distribution of pin badge stars as a token thank you that members of staff receive and ultimately pass onto someone they then wish to thank. The idea is that this recognition can be quick and immediate and, because staff will wear the badge, it will spark conversation.

Pin badges will be drip fed into the organisation and ad hoc 'spot events' will be held that invite those with badges at a particular moment in time to come together and celebrate the reason(s) why they have been given a badge.

Star of the Month (previously employee/team of the month)

Employee of the Month will become 'Star of the Month'. The process will remain similar to how it currently stands but, for the first time, will be open to public, patients and visitors. Having a regular and permanent recognition scheme like this, that is promoted both internally and externally, will support an increase in the number of nominations.

Staff will be nominated against a Trust value that they have reflected.

All nominees will be notified and a shortlist of three will be selected by a staff panel for the Chief Executive to select the overall winner.

Winners will receive a small gift (e.g. branded mug) and a certificate presented to them by the Chief Executive.

Their photo will be displayed on Star of the Month boards in key Trust locations, featured on social media and All Together magazine and they will be acknowledged in the monthly Team Brief. Where news worthy, Star of the Month stories will also be shared with local press.

Time to Shine Awards

Staff awards provide an excellent opportunity to celebrate and recognise hard working staff that have gone above and beyond for the organisation. Whilst the Celebration of Achievement (COA) awards will be replaced with a Family Fun Day to enable more staff to be recognised, the Trust wide annual awards programme will continue.

The COA event will be rebranded to 'Time to Shine Awards'. Categories for the awards (which have been developed to reflect Trust Vision and Values) will be:

Trust-wide awards

- Volunteer of the Year
- MCH Charity Award
- Bright Ideas Award*
- Chairman's Award
- Public Choice Award

Divisional/CCICP awards *(each division/CCICP will have individual winners – these winners then go head-to-head in a judging panel who then decide an overall winner across the divisions/CCICP)*

- Outstanding Contribution to Patient Service and Care
- Outstanding Contribution to Quality and Safety
- Leadership Award
- Rising Star*
- Unsung Hero*
- Employee of the Year
- Team of the Year

**These awards are new or have been named to better reflect the Trust's values and behaviours and ensure they consider the wider workforce*

Nominations for the awards will open at the end of March and will close at the beginning of May.

Judging panels will take place in the middle of May to decide winners.

Each division/CCICP will be expected to hold an awards ceremony to celebrate staff nominated and to hand trophies, which will also be star themed, to divisional winners. Divisions will be provided with £400 budget to spend as they wish but will be required to provide refreshments for staff. The awards group will be providing trophies, certificate templates and presentation templates to ensure all ceremonies are consistent.

The awards team will be meeting with DGM's to explain the new format and provide them with an 'Awards Pack' which will have further information about the new process.

Once Trust-wide and overall winners have been decided by a judging panel, overall winners of the awards will be visited by Executive Directors and the Chairman throughout June/July who will present winners with their trophies in the workplace in front of colleagues. These winners will then be celebrated at the Family Fun Day as their picture and award nomination will be displayed in either a programme or stand at the day.

The awards team will also be approaching external organisations to seek sponsorship for the staff awards. This money will then go towards funding the Family Fun Day.

Follow up

The awards team will be exploring materials to support staff, particularly management, on how to say thank you and to regularly promote the recognition schemes available.

The group will also be looking at/reviewing several other topics once the new schemes have been embedded, including long service awards and how the Trust can better support individuals and departments to enter regional and national awards.

Outcomes

- The people who recommend the organisation as a place to work improves (current score 70.6% - NHS Staff Survey 2020);
- The satisfaction level of staff for getting recognition of good work improves (current score 61.2% - NHS staff survey 2020)
- The extent to which staff feel the organisation values their work improves (current score 51% - NHS staff survey 2020)
- Reduction in the % turnover rate across all staff groups improving retention of our people
- Annual staff awards now recognise both individual & team performance across the breadth of the Trust
- Trust's values and behaviours are demonstrably lived by our staff