Board of Directors

1 June 2020
9:30 - 12:48
Virtual - via Microsoft Teams

PRELIMINARY BUSINESS

1 9:320
Welcome & Apologies (v)
Chair

2 9:32
Declarations of Interest (v)
Chair
To receive declarations of interest in agenda items and / or any changes to the register of directors' declarations of interest pursuant to Section 8 of Standing Orders

3 9:35
Draft Minutes of the Last Meeting - 4 May 2020 (d)
Chair
To approve the draft minutes of the last meeting of the Board of Directors, review the action log and discuss any matters arising

4 9:40
Chair's Opening Remarks (v)
Incorporating Governor's items

5 9:50
Chief Executive's Report - (d)
To note

- Covid-19 Update
- Strategic Objectives and Risks 2020/21

QUALITY - Patient Safety, Clinical Effectiveness & Patient Experience

6.1 10:05
Quality Governance Committee (QGC) Chair's Assurance Report - 11 May 2020 - (d)
Committee Chair

7 10:10
Patient Quality, Safety and Experience Report April 2020 (d)
Director of Nursing & Quality / Medical Director
To note

8 10:30
Serious Untoward Incidents and RIDDOR Events (v)
Medical Director
To note

PERFORMANCE

9.1 10:35 **Performance and Finance Committee (PAF) Chair's Assurance Report - 21 May 2020 (d)**
Committee Chair.
To note

- Performance Report - April 2020
  Chief Operating Officer

WELL LED

10.1 10:40 **Transformation and People (TAP) Chair's Assurance Report - 7 May 2020 (d)**
Committee Chair
To note

11 10:45 **Workforce Report - April 2020 (d)**
Director of Workforce and OD
To note

GOVERNANCE

13 10:55 **Audit Committee Chair's Assurance Report (d)**
Committee Chair

- **13.1 11 May 2020**
  To note
- **13.2 21 May 2020 (extraordinary)**
  To note
- **13.3 Annual Report & Accounts 2019/20 (d)**
  To approve

14 11:10 **Board Assurance Framework 2019/20 Q4 (d)**
Medical Director
To note

15 11:15 **Organisational Risk Register 2019/20 Q4 (d)**
Medical Director
To note

16 11:20 **Report on Use of the Trust Seal (d)**
Company Secretary
To note

CONCLUDING BUSINESS

18 11:25 **Any Other Business (v)**
Chair

To consider any other matters of business

19 **Items for the Risk Register/Changes to the Board Assurance Framework (BAF) (v)**

11:35

Chair

To identify any additional items for the Risk Register or changes to the BAF arising from discussions at this meeting

20 **Key Messages from the Board - to agree (v)**

11:40

Chair

To agree

The Board is asked to resolve that in accordance with Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960, representatives of the the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudiced to the public interest.

22 May 2020 11:21

Action Log

Agenda item		Assigned to	Deadline	Status
Board of Directors 04/05/2020 5 Chief Executive's Report - to note				
116.	Chief Executive's Report	Sumner, James	01/06/2020	Pending
	Explanation action item To circulate the NHS resilience wheel to the Board			
117.	Chief Executive's Report	Tunney, Julie	01/06/2020	Pending
	Explanation action item To circulate a summary of the CQC action plan to the Board.			
Board of Directors 04/05/2020 7 Patient Quality, Safety and Experience Report - to note				
118.	Closed complaints	Tunney, Julie	01/06/2020	Pending
	Explanation action item Update to be provided to John Church on what actions have been taken to contact the staff member who is no longer working for the Trust in order to share lessons learnt from a closed complaint.			
Board of Directors 04/05/2020 16 Board Committees' Terms of Reference - to approve				
119.	Committee Terms of Reference	Keating, Caroline	01/06/2020	Pending
	Explanation action item All Committee ToR to be checked to ensure that all updates and proposed changes have been made to the ToR that have been approved by Board			

Chief Executive's Report – June 2020

Regional update

In Part II of the June Board meeting, we will review the Memorandum of Understanding for the development of the Integrated Care Partnership with MCHT acting as the host for its development and on-going provision of infrastructure/support services. The paper sets out the general principles of the joint working across both health and social services and recognises that this is a work in progress moving towards a wide ranging service development and transformation. For noting, the Executive Lead Director for the programme will be Denise Frodsham.

Covid-19

The Trust continues to manage the Covid-19 response. Stocks of PPE are sufficient for the current situation and there are no immediate concerns regarding the levels of supply to wards and departments. As more is understood about Covid-19, the Trust is reacting quickly to any new intelligence. This has seen the Trust create specific Covid-19 contact wards in addition to the Trust's current ward segregation structure previously discussed at Board.

The Trust is currently on plan to commence increasing its elective operating from 1 June, utilising all of the Treatment Centre theatres for non-covid patients and has also identified a ring-fenced elective ward should inpatient stays be required. Increased staff and elective patient swabbing will commence to facilitate this element of the Trust's restart programme.

The number of people attending the A&E department for non-covid related reasons is beginning to increase (as it is across the country); at present, this is at manageable levels and there are sufficient beds available to enable this. Plans are in place, should this increase to previous levels.

Staff, Patients and Community Testing

The Trust is continuing to progress with increased testing across all areas. For w/c 18 May, we tested 875 patients and 328 staff. This is a programme of ensuring segregation of both asymptomatic and symptomatic people in the Trust as well as those small numbers of elective patients who are to receive imminent procedures. For the community satellite service, we have widened the local offer to include face-to-face teaching staff as well as continuing to support local care homes with staff testing. Feedback has been very positive from the local stakeholders.

Our next area of work is to develop an agreed protocol and testing programme for the antibody testing as well as engaging with Public Heath on the integration of our testing service with the local Cheshire track and trace programme

Finance – Month 1 2020/21

As the Board are aware, under the temporary financial arrangements put in place in response to the Covid-19 pandemic, the Trust is now on a block payment system (calculated by NHSI/E). If required, there is a facility for a further "top up" payment to be issued by NHSI/E that is intended to ensure that the Trust will break even for the first 4 months of the year (i.e. until end of July). At month 1, the Trust applied for £1.7m top up which is predominately due to a shortfall in the original block payment calculation and lower income than would normally be expected.

Infection control

An infection control group chaired by the Director of Nursing & Quality is in place which meets several times per week to ensure compliance with all new guidance, benchmark practice against other Trusts in the country and provide a route of escalation for any concerns from staff to be reviewed by those with the appropriate expertise.

Workforce

As the Trust begins to reset, work is continuing to progress the health and wellbeing agenda through the health and wellbeing group. The group is currently implementing the high impact, low cost health and wellbeing initiatives that have been identified during the Covid-19 period, such as the wellbeing rooms, garden space and on-site food provisions. The group is also developing longer term plans to be included as part of the wider Trust Strategy to further enhance the health and wellbeing of staff, create and sustain greater flexible working options through technology and to enable all staff to achieve a positive work life balance.

Key Issues – Regulation & Governance

- **Care Quality Commission (CQC)**

The CQC has developed an emergency support framework that they will follow during the pandemic and for a period of time afterwards. The aim is for the CQC to offer support and be able to check that services are coping during the pandemic. It will take the form of a phone call to discuss 4 areas of focus:

- Safe care and treatment
- Staffing
- Protection from abuse
- Assurance processes/risk management

The Trust would prepare for the CQC call in the same way as for a provider information request. All Divisional senior management teams will be briefed on the framework.

- **Strategic Objectives & Risks**

At the Board Session in May 2020, the Board agreed a set of strategic objectives and risks which will facilitate the development of the Board Assurance Framework for 2020/21. A detailed report is included as an addendum to the CEO Report. The report also outlines the approach for a review of the Trust's Risk Management Framework and the Risk Management Strategy. In parallel with this, the Trust has commissioned a new risk management system to integrate the BAF and the Trust's Risk Management Framework into a single model and approach, built around the risk appetite and strategic risks. The Board will have further opportunity to discuss this topic over the coming months.

James Sumner
Chief Executive
June 2020

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**5.1**	Date of Meeting: 1 June 2020
Report Title	**MCHT Strategic Objectives & Risks 2020/21**	
Executive Lead	James Sumner, Chief Executive	
Lead Officer	Caroline Keating, Company Secretary	
Action Required	To approve	

☒	**Acceptable assurance** General confidence in delivery of existing mechanisms / objectives	☐	**Partial assurance** Some confidence in delivery of existing mechanisms / objectives	☐	**No assurance** No confidence in delivery

Key Messages of this Report

- Strategic objectives identified to facilitate development of the Board Assurance Framework
- Strategic risks identified, including one specifically to manage the Covid-19 pandemic and ensure safe reset of the organisation
- Approach to reviewing the Risk Management Framework outlined

Impact *(is there an impact arising from the report on the following?)*

• Quality	☐	• Risk	☒
• Finance	☐	• Compliance	☐
• Workforce	☐	• Legal	☐
• Equality	☐		

Equality Impact Assessment (*must accompany the following submissions)*

- Strategy ☐ Policy ☐ Service Change ☐

Strategic Objective(s) *(indication of which objective/s the report aligns to)*

• Delivering outstanding clinical quality, safety & experience	☐	• Aspiring to excellence in practice through our workforce	☐
• Being a leading partner in a progressive health economy	☐	• Creating a 21st century infrastructure for transformative health and social care	☒
• Striving for outstanding organisational effectiveness	☐		

Governance *(is the report a…?)*

• Statutory requirement	☐	• Other	☒
• Annual Business Plan Priority	☐	*rationale for Board submission required:*	
• Strategic/BAF Risk	☐	Best practice	
• Service Change	☐		

Next Steps (*actions following agreement by Board/Committee of recommendation/s)*

Implementation Plan for Risk Management Framework review to be developed

REPORT DEVELOPMENT

Committee / Group Name	Date	Report Title	Lead	Brief summary of key issues raised and actions
Executive Directors Away Day	19 May 2020	Strategic Objectives & BAF Risks	J Sumner, CEO	Approach agreed
Board Away Day	21 May 2020	Strategic Objectives & BAF Risks	J Sumner, CEO	Minor amends required to some wording in the strategic objectives and the BAF risks

MCHT Strategic Objectives & Risks 2020/21

Executive Summary

1. The Board Assurance Framework (BAF) is a monitoring tool used by the Board to assess the organisation's capacity to achieve its strategic objectives, and to ensure it has appropriate oversight of the Trust's risk profile and risk management arrangements.

2. This report identifies seven strategic objectives, discussed with the Board at the Board Session in May 2020. Designed to align broadly with the domains of the Care Quality Commission, the majority would be as expected for an acute provider. However, one additional objective has been included to address the situation arising from the Covid-19 pandemic.

3. Following the identification of the strategic objectives, the Exective Team developed a provisional set of strategic risks for 2020/21 which enable the Board to understand the key risks across the Trust and assess their potential to hinder the achievement of strategic objectives. These were also shared with the Board in May 2020 and are included in this paper.

4. The Trust is in the process of commissioning a new risk management system to integrate the BAF and the Trust's Risk Management Framework into a single model and approach, built around the risk appetite and strategic risks. The aim is to ensure that there is sufficient visibility and scrutiny of the Trust's key risk control environment and its on–going effectiveness as well as those more fluid or exceptional risks that may emerge (suddenly) and that may require a new range of risk mitigation or management, be these risks with a negative effect or potential opportunity / positive effect risks.

5. The full detail of the controls and assurances that constitute the MCHT BAF is in development, building on and improving the robustness of the information that underpins it. Analysis of the complete set of controls and assurances will be reported to the Audit Committee prior to Board consideration.

6. In parallel with developing the new BAF, Corporate & Quality Governance will undertake a review of the Trust's Risk Management Framework and its Risk Management Strategy. This will include the development of a training programme for key staff and alignment of all risk based processes. An implemention plan with timeline will be developed and taken forward from July 2020.

7. The Board is asked to approve the strategic objectives and risks for 2020/21 and to note the review of the Trust's Risk Management Framework and Risk Management Strategy.

Introduction

1. Under the NHSI/CQC Well-Led Framework, trusts need to ensure "there is an effective and comprehensive process to identify, understand, monitor and address current and future risks". This should include a Board Assurance Framework (BAF) and dynamic risk registers that are assessed by the Board at least quarterly.

2. The BAF is an important component of the Trust's corporate governance and risk management framework. It is a monitoring tool used by the Board to assess the organisation's capacity to achieve its strategic objectives, and to ensure it has appropriate oversight of the Trust's risk profile and risk management arrangements. It aids transparency and can be used to inform the Annual Governance Statement (AGS) as a means of monitoring the robustness of the systems of internal control. A properly used BAF will also drive the forward work plan and agendas for the Board and its Committees.

3. The Board has recognised that a comprehensive review of its BAF was required which would align with the Trust Strategy for 2021-2024 and the new strategic objectives. The aim of the revised BAF is to ensure there is:

   - clear alignment between strategic objectives, principal risks, key controls and assurance evidence
   - a robust and systematic process using technology to manage the data and facilitate reporting
   - clarity about roles, responsibilities and accountability
   - streamlined reporting on risk that facilitates focused discussion at Board meetings.

4. This report identifies seven strategic objectives (*Appendix I*), six of which broadly align with the domains of the Care Quality Commission – safe, effective, caring, responsive and well-led. These six cover what would be expected of an acute provider with one additional objective which focuses on the management of and safe recovery from the Covid-19 pandemic.

5. The strategic objectives are detailed below, with key areas of focus to support delivery of each objective identified in *Appendix I:*

   - Manage the impact of covid and ensure safe recovery
   - Deliver outstanding care and patient experience focusing on staffing, standardisation and digitalisation
   - Deliver the most effective care to achieve best possible outcomes with the right capacity, latest learning and data driving decision making
   - Ensure MCHFT is the best place to work by ensuring we meet the needs of our staff better than anywhere else
   - Ensure safe and sustainable healthcare to our population by ensuring our estate, infrastructure and planning focuses on the long term
   - Provide strong system leadership by working together in our place, our system and ICS
   - Be well governed and clinically led guided by expertise and capable leaders with clear processes and practices

6. The set of strategic risks for 2020/21 (*Appendix II*) enables the Board to understand the key risks across the Trust and assess their potential to hinder the achievement of the strategic objectives. Each BAF risk has been assigned either to the Board or a Board Committee so

that key controls may be monitored and act as a reference to inform Committee and Board agendas.

7. A new dashboard reporting format (*Appendix III)* is proposed to enable the Board to monitor the key risks across the Trust and assess their potential to hinder the achievement of strategic objectives. The significant operational risks (scored 15+) from all risk registers across the Trust will be mapped to the BAF to enable integrated risk reporting and inform analysis. The accuracy of reporting, however, relies on quality risk information and assurance evidence recorded in the Trust's risk databases. It is important, therefore, that the Trust looks to evolve its risk culture and ensures that training is provided to all relevant staff to help improve risk recording.

8. This report provides the Board with:

- an overview of work to evolve the Trust's Risk Management Framework
- an approach to mapping the detail of the BAF
- a sample reporting dashboard for a strategic risk.

Key Areas

The Risk Management Framework

9. The Trust's Risk Management Framework will be described in the new Risk Management Strategy to be submitted to the Audit Committee and the Board thereafter. The structures, processes and procedures for the management and monitoring of risk will be articulated in a new Risk Management Policy and accompanying procedural guidance, to be developed in collaboration with key stakeholders, including Quality Governance. These documents will provide direction for risk practitioners across the Trust on the steps required to manage risk and the procedures they must follow. They will also set out the risk monitoring and escalation processes to ensure there is appropriate ownership and oversight of risk through the Trust's management and governance structures. A flow chart for this is outlined in *Appendix IV*.

10. The Trust's Risk Management Strategy will be delivered over the next 12 months through a set of activities that will be articulated in an implementation plan, which will include:

- a programme of risk training, tailored and prioritised for different levels and roles
- developing the Board's risk appetite statement
- quality audit of risk records and action to improve
- review of risk management databases and preparation for migration to a single platform
- review of all risk-based processes across the Trust to ensure compliance with Policy
- mapping risk information flows through the governance structure to identify effectiveness and address gaps
- risk maturity assessment as part of the evaluation of the Trust's risk management framework towards the end of 2020/21

11. The plan will be presented to the Audit Committee in July 2020 and progress will be reported quarterly and culminate in July 2021 in an annual Risk Management evaluation report.

12. The risk monitoring and reporting structure will be outlined in the Risk Management Strategy. The Board's Committees will have a key role in obtaining assurance that risks relevant to their remit are being managed appropriately and that controls are implemented effectively. In order to do this, Committees will rely on quality information and assurance evidence pertaining to risk treatment plans and the effectiveness of key controls. *Appendix II* not only shows the principal risks set out in the BAF but also identifies the Committees which will be responsible for monitoring each risk and the associated significant operational risks.

13. An Executive Assurance & Risk Group (EARG), chaired by the Chief Executive, is to be formed with responsibility for setting appropriate frameworks, policies and procedures to support delivery of the strategic objectives and oversee the risks and mitigations to that delivery. It will support delivery of the Risk Management Strategy by using information, predominantly drawn from the Trust's risk registers and the BAF, to check the appropriateness and effectiveness of risk treatment plans and key controls, ensuring that good risk management principles are applied consistently across the Trust. This will allow the Board and its Committees to rely on accurate risk information that is subject to regular quality assurance.

14. An Assurance & Escalation Framework will be developed to set out the arrangements for ensuring that prompt action is taken, at the right level, so that risks are managed appropriately. It will outline key local and divisional responsibilities at all levels of the Trust to facilitate effective escalation and communication of any changes. The Framework will set out that, as a minimum, at the end of each departmental and divisional meeting consideration must be given to any matters that should be escalated on grounds of risk or due to the requirement for additional support.

Board Assurance Framework

15. Each BAF risk has a named accountable Executive Risk Lead (ERL), supported by a Directorate Risk Lead Officer (DRLO) who is responsible for updating information on the controls on the IT system[1]. Corporate Governance will work with the ERLs in utilising this data to provide the Trust Board and its Committees with analysis of the effectiveness of the Trust's key control environment and the robustness of the assurance evidence.

16. Work is required to ensure the detail of MCHT's BAF is at a level that enables this analysis to be undertaken. It will build on the information that already underpins the current BAF and provides a starting point for the ERLs to identify key controls already in place.

17. ERLs will be asked to consider the BAF risks, mapping current key controls and the associated assurance processes. This exercise will inform the reassessment of risk ratings to arrive at a consolidated set of scores. It is recognised that the consolidation of BAF controls will be iterative as strategies, plans, policies, structures and key processes are reviewed/refreshed over time. Once the new IT system is in place, actions will be tracked to ensure transparency about priorities and anticipated timescales for improving the Trust's control environment.

18. During June, the date for completion of the full detail of the BAF will be confirmed. In the meantime, progress will be monitored by the Executive Team, and plans to harmonise controls

[1] This refers to the new IT system that, initially, will only be used for BAF risks. Operational risks will continue to be held on the Trust's Ulysses system

and address control and assurance gaps will be overseen by the Executive Assurance & Risk Group, once established.

Integrated Risk Dashboards

19. The sample dashboard (ultimately there will be one for each strategic objective) in *Appendix III* presents a high level summary of the BAF and high scoring operational risks to bring together a top-down and bottom-up view of the main risks that the Trust carries. This risk profile will be reviewed by the EARG to ensure that risk treatment plans are appropriate, effective, and implemented in a timely manner. The Board will receive them on a quarterly basis with commentary highlighting key matters of note. Committees will see the sections that are relevant to the BAF risks assigned to them *(Appendix II).*

20. The content of the dashboards will be collated by Corporate Governance using information from the new IT system in relation to the BAF and information provided by the Quality Governance team about the latest position on operational risks.

Conclusions/ Next Steps

21. Risk Management implementation plan will be presented to the Audit Committee in July 2020. The date for the completion of the full detail of the BAF will be confirmed in June, together with the timetable for submission to the Board.

Recommendations

22. The Board is asked to:

- approve the Trust's strategic objectives and risks
- note developments relating to the Trust's Risk Management Framework and the BAF

Caroline Keating
Company Secretary

May 2020

Strategic Objective (SO)	Key Areas of Focus
SO1 - Manage the impact of covid and ensure safe recovery	• Deliver high quality response ensuring compliance with national guidance and protecting staff and patients from infection • Understand the key risks identified to the normal business of the organisation that will be most significantly impacted due to covid and create plans to mitigate
SO2 - Deliver outstanding care and patient experience focusing on staffing, standardisation and digitalisation	• Deliver a rapid and innovative approach to resolving the gap in nursing workforce within 18 months • Develop the quality improvement capabilities of the organisation and deliver a collaborative to focus on sepsis with clear aims and analysis • Obtain approval for the EPR business case and begin procurement and implementation
SO3 - Deliver the most effective care to achieve best possible outcomes with the right capacity, latest learning and data driving decision making	• Using the data available & the evidence from covid response, pursue and deliver reset of system capacity to better deliver care to patients in alternative settings to hospital • Put in place a more robust system of clinical audit aligned to the Trust strategy and Quality Improvement • Develop capacity & capability to enable surveillance of the organisation's performance against measures that are meaningful & move to an inch wide/mile deep approach of gaining assurance
SO4 - Ensure MCHFT is the best place to work by ensuring we meet the needs of our staff better than anywhere else	• Deliver our health and well-being strategy more rapidly than previously planned • Equip our staff with the technology to make their job easier, more flexible and support decision making • Develop our leadership teams to be the best they can be • Develop a culture where autonomy is given on day 1 and staff are supported to keep it

Strategic Objective (SO)	Key Areas of Focus
SO5 - Ensure safe and sustainable healthcare to our population by ensuring our estate, infrastructure and planning focuses on the long term	• Create an estates strategy for the future that deals with Victoria Infirmary Northwich, residences and redevelopment of Leighton • Plan the workforce developments for year 2 with single focus, sustainable delivery plans • Ensure the financial controls, levels of authority and governance of CIP delivery is fit for the task • Ensure the Trust's IT systems are safe, secure and up to date
SO6 - Provide strong system leadership by working together in our place, our system and ICS	• Develop strong and clear hosting arrangements for the Cheshire East Integrated Care Partnership (ICP) and provide management support and leadership from MCHFT • Ensure MCHFT plays its part in delivering the Cheshire Financial Recovery Plan across all workstreams
SO7 - Be well governed and clinically led guided by expertise and capable leaders with clear processes and practices	• Develop the corporate governance function to ensure more effective governance systems and processes, moving towards a new Risk Assurance culture within the Trust • Ensure that the arrangements in place for ICP delivery and Cheshire Partnership working are robust and that the Trust is clear of the risks it holds in this regard and its level of accountability

Appendix II – Board Assurance Framework (BAF) Risk

SO1 Manage the impact of the Covid-19 pandemic and ensure safe recovery of the organisation post pandemic by using the established control structure	**SO2 Deliver outstanding care and patient experience** focusing on staffing, standardisation and digitalisation	**SO3 Deliver the most effective care to achieve best possible outcomes** with the right capacity, latest learning and data driving decision making	**SO4 Ensure MCHFT is the best place to work** by ensuring we meet the needs of our staff better than anywhere else	**SO5 Provide safe and sustainable healthcare to our population** by ensuring our estate, infrastructure and planning focuses on the long term	**SO6 Provide strong system leadership by working together** in our place, our system and ICS	**SO7 Be well governed and clinically led** guided by expertise and capable leaders with clear processes and practices
BAF1 - IF arrangements in place to ensure safe management of pandemic against national guidance are inadequate **THEN** patients and staff could be harmed **Chief Operating Officer**	**BAF3 – IF** the widening nurse staffing vacancy gap is not closed **THEN** patient care could be detrimentally impacted **Director of Nursing & Quality**	**BAF7 – IF** the Trust does not provide sufficient capacity to meet demand and achieve operational standards **THEN** it may cause harm to its patients and be unable to meet its regulatory requirements **Chief Operating Officer**	**BAF10 – IF** the Trust cannot attract, retain and support a high performing workforce **THEN** quality of care is likely to deteriorate **Director of Workforce & HR**	**BAF13 – IF** the Trust fails to provide modern, efficient, sustainable estate, infrastructure and equipment **THEN** this could lead to high cost business continuity issues in future **Deputy CEO/Director of Finance**	**BAF16 - IF** the Trust does not focus on enabling a successful Integrated Care Partnership and carry out its hosting responsibility **THEN** this could lead to substandard out of hospital care **Director of Strategic Partnerships**	**BAF19 – IF** the Trust does not have effective governance systems and processes in place to move to a risk assurance culture **THEN** it is less likely to manage its key risks, resulting in quality and financial challenges **Deputy CEO/Director of Finance**
BAF2 - IF arrangements to deliver the mitigations to the risks identified to covid 19 recovery are inadequate **THEN** business continuity could be affected leading to loss of services **Deputy CEO/Director of Finance**	**BAF4 – IF** the Trust does not ensure safe, secure and sustainable environments for staff, patients and visitors **THEN** avoidable harm could occur **Deputy CEO/Director of Finance**	**BAF8 - IF** the Trust does not have robust processes for audit, learning & implementation of new practice **THEN** it may hinder quality improvement and could be unable to meet regulatory requirements **Medical Director**	**BAF11 – IF** the Trust fails to harness the benefits of technology to integrate, streamline and improve systems of working **THEN** this could lead to reduced productivity and safety **Chief Information Officer**	**BAF14 - IF** the Trust does not plan its workforce requirement for the future **THEN** it is likely to create high cost expenditure and lead to workforce gaps which could impact standards of care **Director of Workforce & HR**	**BAF17 – IF** there continues to be Ineffective capacity and demand management across the Health and Social Care system **THEN** the risk to patients of being hospitalised unnecessarily will continue to increase **Chief Operating Officer**	**BAF21 – IF** the Trust fails to establish appropriate governance and risk mitigation around new collaborative, system wide models of working **THEN** it may expose itself to risk of which it is unaware **Chief Executive Officer**
	BAF5 – IF the Trust does not introduce a Quality Improvement approach to its highest risk clinical challenges **THEN** it is less likely to resolve them **Director of Nursing & Quality**	**BAF9 – IF** the Trust does not use high quality activity and patient outcome data to assess the quality of its performance **THEN** it may miss trends and signals and encounter less positive patient outcomes **Medical Director**	**BAF12 – IF** the Trust does not create the conditions for an effective organisational culture **THEN** this could affect quality, efficiency and workforce standards **Chief Executive Officer**	**BAF15 – IF** financial management, budgetary controls and efficiency planning are not robust **THEN** the Trust may not deliver its financial targets **Deputy CEO/Director of Finance**	**BAF18 - IF** the Trust fails to play its part in a successful Cheshire System **THEN** it is unlikely to enable the required reduction in the running costs of the Health System **Chief Executive Officer**	**BAF 22 – IF** the development of leadership capacity and capability throughout the organisation is not a priority **THEN** the Trust's ambitions are unlikely to be met **Director of Workforce & HR**
	BAF6 - IF the Trust is unable to proceed with EPR development and implementation **THEN** the Trust will be unable to improve safety to its desired standard **Chief Information Officer**					

COMMITTEE KEY:

BOARD, TRANSFORMATION & PEOPLE, PERFORMANCE & FINANCE, QUALITY GOVERNANCE, AUDIT

Appendix III: Integrated risk dashboard (Example)

Strategic objective	**SO5: Ensure safe and sustainable healthcare to our population** by ensuring our estate, infrastructure and planning focuses on the long term
Risk appetite	Moderate

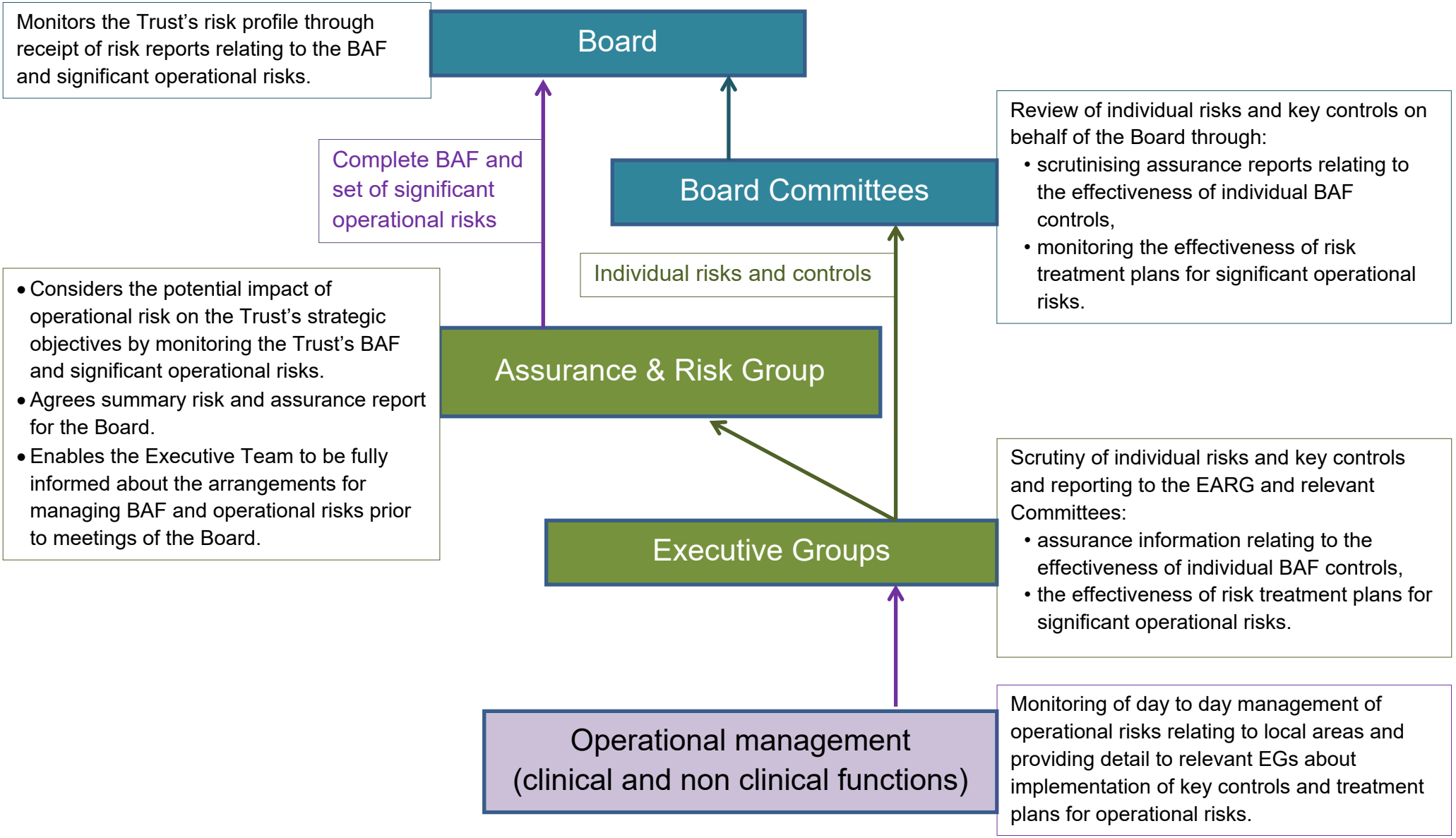
Principal risks (BAF) (Data from BAF system)	RLB risk score
BAF13. Failure to provide modern, efficient, sustainable estate, infrastructure and equipment	16 (4x4)
BAF14. Failure to plan future workforce requirement	12 (4x3)
BAF15. Ineffective financial management, budgetary controls and efficiency planning	20 (4x5)

Ref	High scoring operational risks (15+) (Data from Operational Risk System)	Risk score
1101	xxxxx	20 (4x5) New
1102	xxxxx	15 (4x3)
1301	xxxxx	20 (4x5) New
1302	xxxxx	16 (4x4)
1303	xxxxxx	10 (2x5)

Risk and controls commentary

- A new operational risk () aligned with BAF13 has been added in relation to the impact of ….

Appendix IV: Risk monitoring and reporting



QGC Committee
Chair's Assurance Report
May 2020

Report to	Board of Directors
Date	13 May 2020
Report from	Lesley Massey, Non-Executive Director
Report prepared by	Katharine Dowson, Head of Corporate Governance
Executive Lead/s (Name & Title)	Murray Luckas, Medical Director Julie Tunney, Director of Nursing & Quality
Committee meeting quoracy	Yes ☒ No ☐

KEY AREAS OF ASSURANCE

- **Infection Control Guidance**: work is underway to assess compliance against national guidance and provide assurance through to Board in July. The Trust is thought to be compliant, but work is taking place to compile evidence that the Trust is meeting all elements of the infection assurance framework for the Board.
- **CQC Action Plan:** verbal update received on the overview circulated to Board on 6 May. The plan will be monitored through the Quality Summit with a quarterly report on its implementation submitted to QGC. QGC noted that Victoria Infirmary had a separate action plan. Consideration will be given on how other Board Committees are sighted on relevant areas of the plan.
- **Safeguarding mandatory training:** rates are improving due to new on line training being launched and staff working in areas that have seen less activity taking the opportunity to complete training
- **Learning from Deaths:** this had been suspended locally, on national guidance. All Covid-19 deaths were to be reviewed, with any of concern escalated to Structured Judgement Reviews (SJR). A random 10% of other deaths will also be subject to SJRs. This is ahead of national guidance to restart.
- **Maternity CNST**: a verbal update was given on progress on compliance with the 10 required elements for 2020/21. Three elements were reported as underway and on track for completion. Updates on the remaining other elements will be provided each month at the Committee
- **Quality Governance report:** a summary of themes discussed at patient safety huddles was received, QGC were advised of all StEIS declarations for April and any thematic outcomes of reviews into previous incidents

KEY CONCERNS/RISKS

None identified.

DECISIONS MADE

- N/A

RECOMMENDATION

To note the assurance report.

BOARD OF DIRECTORS

Agenda Item	**7**	Date of Meeting: 01/06/2020
Report Title	Quality, Safety and Patient Experience Report - April 2020	
Executive Lead	Medical Director and Director of Nursing and Quality	
Lead Officer	Associate Director of Quality Governance	
Action Required	To Approve	

X	**Acceptable assurance** General confidence in delivery of existing mechanisms / objectives	☐	**Partial assurance** Some confidence in delivery of existing mechanisms / objectives	☐	**No assurance** No confidence in delivery

Key Messages of this Report

- Significant decrease in incident reporting across the Trust expected due to pandemic causing reduced bed base and activity
- For second month, Trust above regional rate per 1000 bed days for falls, due to reduced bed occupancy and increase in falls reporting during the pandemic.
- Complaint response times not meeting set target. Recovery plan in place

Impact

• Quality	✓	• Risk	✓
• Finance	☐	• Compliance	☐
• Workforce	☐	• Legal	✓
• Equality	☐		

Equality Impact Assessment

- Strategy ☐ Policy ☐ Service Change ☐

Strategic Objective(s)

• Delivering outstanding clinical quality, safety & experience	✓	• Aspiring to excellence in practice through our workforce	☐
• Being a leading partner in a progressive health economy	☐	• Creating a 21st century infrastructure for transformative health and social care	☐
• Striving for outstanding organisational effectiveness	✓		

Governance

• Statutory requirement	✓	• Other	☐
• Annual Business Plan Priority	☐	*rationale for Board submission required:*	
• Strategic/BAF Risk	✓		
• Service Change	☐		

Next Steps (*actions following agreement by Board/Committee of recommendation/s)*

REPORT DEVELOPMENT

Committee / Group Name	Date	Report Title	Lead	Brief summary of key issues raised and actions

Introduction

1. The purpose of this paper is to provide assurance to the Board of Directors on the quality, safety and patient experience outcomes for the organisation. This paper provides the metrics for incidents, serious incidents, mortality, harm data, and patient experience data for April 2020. Where there is variation against benchmarking rates with the data presented, recovery actions are noted.

Background and Analysis

2. In its Strategic objectives, Mid Cheshire Hospitals Trust (MCHT) makes it clear that it is committed to 'Delivering outstanding clinical quality, safety & experience'. An important part of delivering this is by both ensuring that patient safety is a priority and that the Trust is doing its reasonable best to prevent injury, ill-health and harm to patients.

3. This paper is designed to provide assurance to the Board of Directors that patient safety incidents and patient experience metrics are reviewed, managed appropriately and contextualized within the Trust.

4. Appendix 1 provides the April 2020 Trust wide dashboard containing:

- Patient safety incidents – there has been a decrease in incident reporting which is a consequence of the COVID-19 pandemic response which has resulted in the Trust seeing a reduction in the numbers of patients treated in the organisation. This has occurred across both the acute and community services.
- There were 3 StEIS reportable incidents in April 2020
    - **Delay in Treatment**
      There has been a delay identifying the initial abnormality of a patient's kidney and the required follow up.

    - **Treatment delay resulting return to theatre**
      There has been a near miss with a patient who presented with PR bleeding during pregnancy and resulted in a return to theatre and bowel resection following delivery of the baby.

    - **Patient Fall resulting in head injury**
      Patient had a fall resulting in a traumatic head injury, who has sadly passed away, 48 hour review identified variance against the falls policy.
- There were no never events in April 2020; the last reported never event was in November 2019.
- The Trust remains consistently above the VTE target rate of 95%.
- For mortality rates the Trust remains within the 'as expected' range. Within crude mortality rates there is a seasonal spike in December 2019.
- There have been no MRSA cases reported for over 12 months.

- There was 1 case of Clostridium Difficile reported that is currently under review, the Trust remains under the regional rate.
- There were 3 cases of E-Coli reported, following a comprehensive investigation all cases were noted as unavoidable.
- There were no cases of MSSA.
- Inpatient pressure ulcers continue to show no significant variation and are within control limits.
- CCICP pressure ulcers are increasing, an in-depth investigation is currently being undertaken into the increasing number of category 4 pressure ulcers.
- Falls rates have increased above the regional rate; however this is due to the reduction of the bed base which has affected the tolerance per 1000 bed days within the Trust during COVID-19 pandemic.
- Due to several reconfigurations of wards the staffing fill rate numbers are not reflective of the original ward establishments, and staffing requirements have been flexed to meet the needs of new wards during COVID-19 pandemic. NHSE unify staffing submissions have been suspended during the COVID-19 pandemic.
- Complaints have been suspended as per NHS- England guidance since the start of the COVID-19 pandemic, there has been a deterioration of response times as expected. An improvement plan has been agreed to ensure families and complainants receive a quality comprehensive response in agreed timeframes.

Conclusions

5. The quality, safety and patient experience dashboard demonstrates the Trust is monitoring and reviewing patient outcomes, and striving to understand where any variations are to improve patient care and service delivery. The recent data from March and April 2020 need to be read with caution in light of the COVID-19 pandemic and the significant changes the hospital and community have had to put in place to enable an emergency response to the national crisis to ensure that the safety for staff, patients and visitors remained paramount.

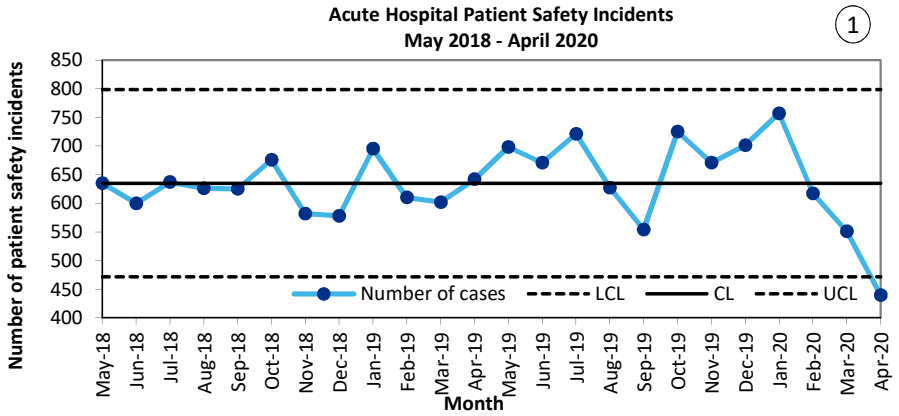
Recommendations

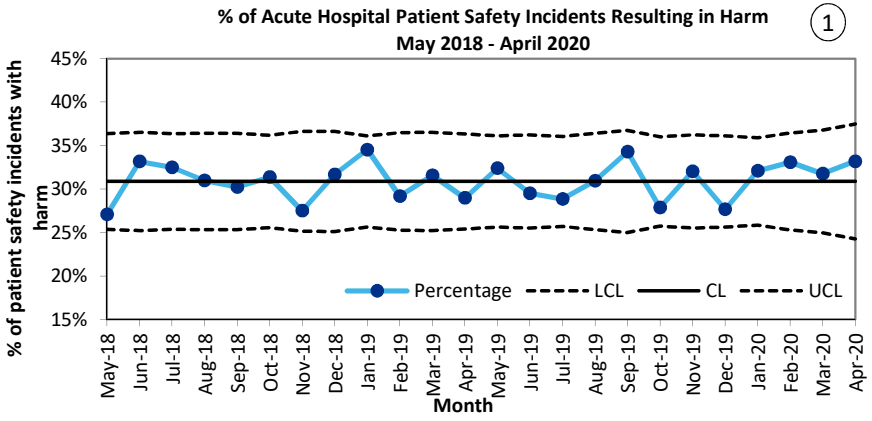
6. To note that the actions set against any variations in totality, provide assurance that actual and latent risks related to patient safety and risks have been appropriately identified and mitigated.

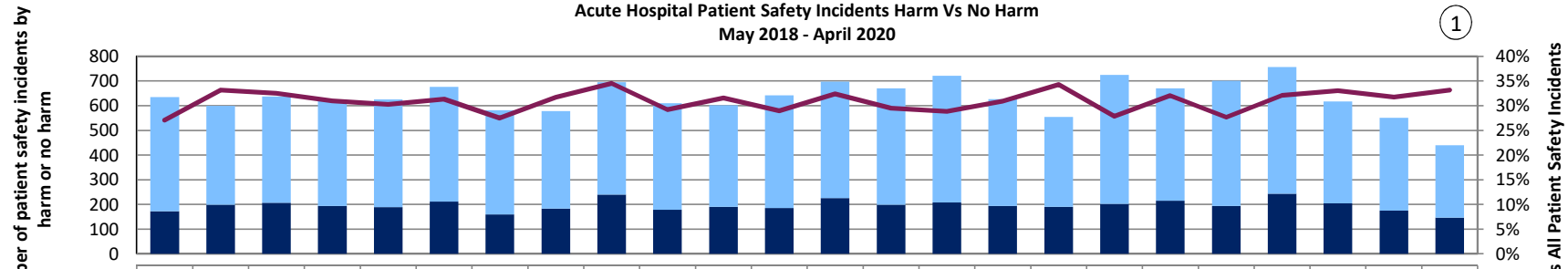
Author: Associate Director of Quality Governance
Date: 21/05/2020

Board Papers - Quality, Safety & Experience

Acute Hospital Patient Safety Incidents







	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
No Harm	463	401	430	432	436	464	422	395	455	432	412	456	472	473	513	433	364	523	456	507	514	413	376	294
Harm	172	199	207	194	189	212	160	183	240	178	190	186	226	198	208	194	190	202	215	194	243	204	175	146
% Harm	27%	33%	32%	31%	30%	31%	27%	32%	35%	29%	32%	29%	32%	30%	29%	31%	34%	28%	32%	28%	32%	33%	32%	33%

Accountable: Murray Luckas

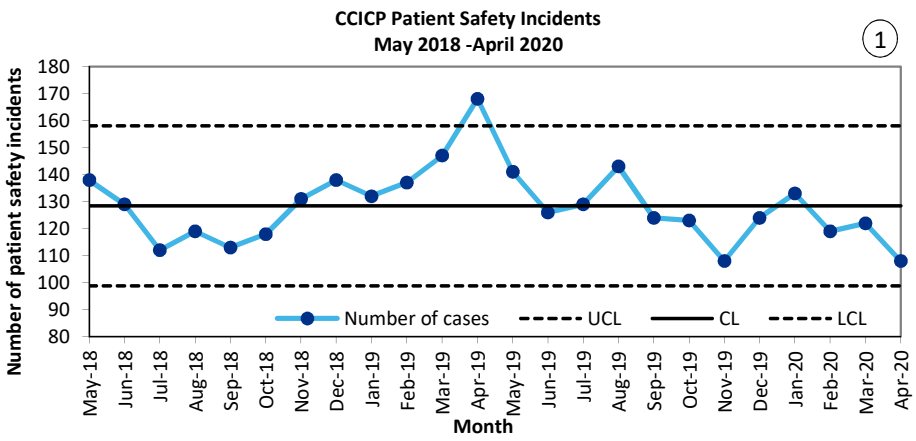
Data Owner: Quality Governance

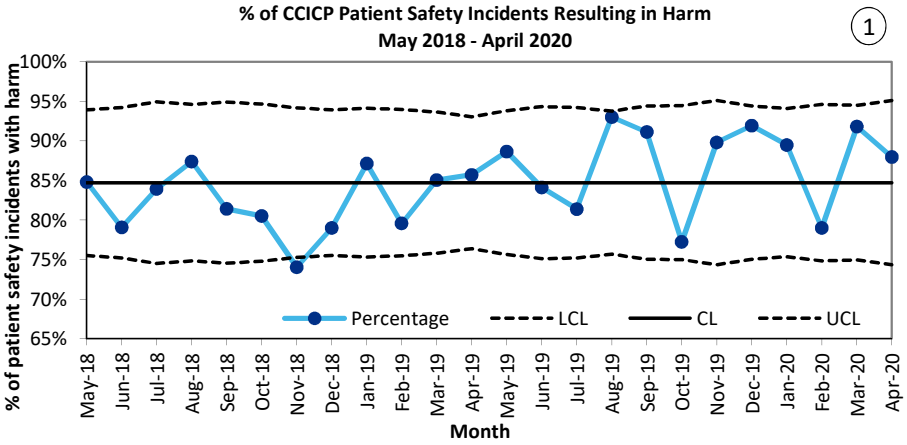
Key Narrative: During April 2020, 440 patient safety incidents were recorded within MCHT. Of these, 146 patient safety incidents resulted in harm accounting for 33% of total incidents. The SPC charts show the total patient safety incidents below the lower control limit and no variation to the % of safety incidents with harm. During the pandemic it is noted that there was a 30-40% reduction in activity and a reduction in bed base that has resulted in a significant decrease in incident reporting.
Low Harm 140, Moderate Harm 3, Serious Incident 3

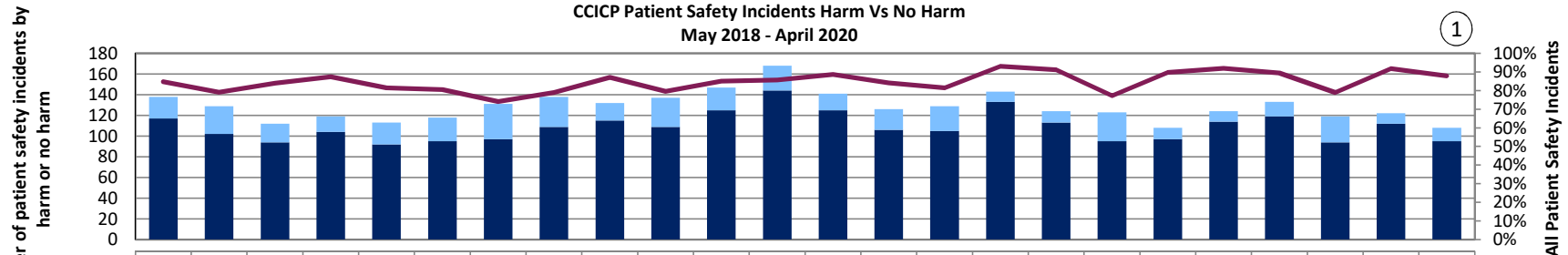
Data Rating: ①captured locally, ②system captured, ③published/benchmarked

Board Papers - Quality, Safety & Experience

Central Cheshire Integrated Care Partnership (CCICP) Patient Safety Incidents







	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
No Harm	21	27	18	15	21	23	34	29	17	28	22	24	16	20	24	10	11	28	11	10	14	25	10	13
Harm	117	102	94	104	92	95	97	109	115	109	125	144	125	106	105	133	113	95	97	114	119	94	112	95
% Harm	85%	79%	84%	87%	81%	81%	74%	79%	87%	80%	85%	86%	89%	84%	81%	93%	91%	77%	90%	92%	89%	79%	92%	88%

Accountable: Murray Luckas

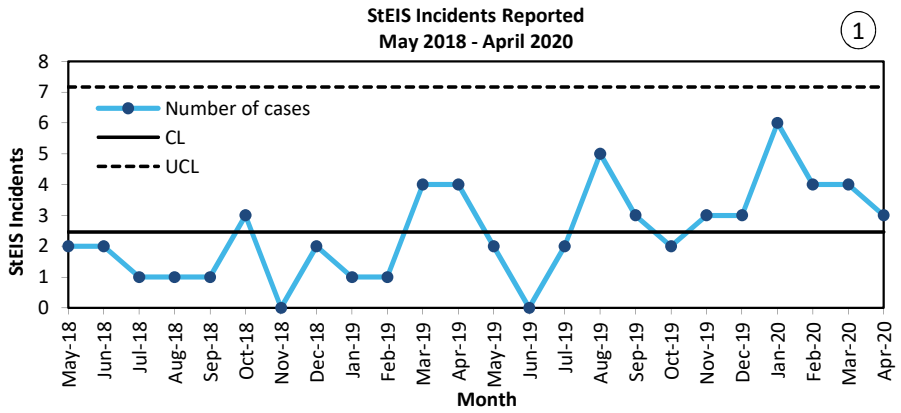
Data Owner: Quality Governance

Key Narrative: During April 2020, 108 patient safety incidents were recorded within CCICP. Of these, 95 patient safety incidents resulted in harm accounting for 88% of total incidents. The SPC charts show no significant variation. To address the low numbers of no harm incidents the quality governance manager has implemented a number of drop in clinics to surgery's across the community services.

Low Harm 93, Moderate Harm 2, Serious Incident 0

Board Papers - Quality, Safety & Experience

StEIS Incidents - Trust Total



Accountable: Murray Luckas **Data Owner:** Quality Governance

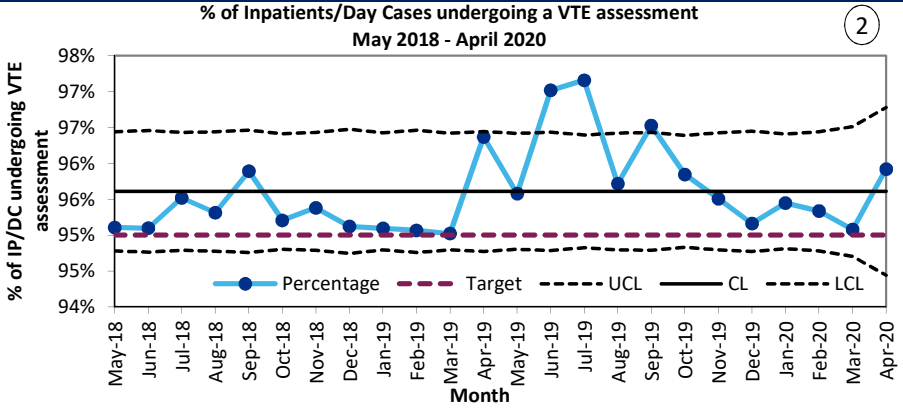
Key Narrative:

Delay in Treatment
(Incident occurred in February 2020 but identified in April 2020)
There has been a delay identifying the initial abnormality of a patient's kidney and the required follow up.

Treatment delay resulting return to theatre
There has been a near miss with a patient who presented with PR bleeding during pregnancy and resulted in a return to theatre and bowel resection following delivery of the baby.

Patient Fall resulting in head injury
Patient had a fall resulting in a traumatic head injury, who has sadly passed away, 48 hour review identified variance against the falls policy.

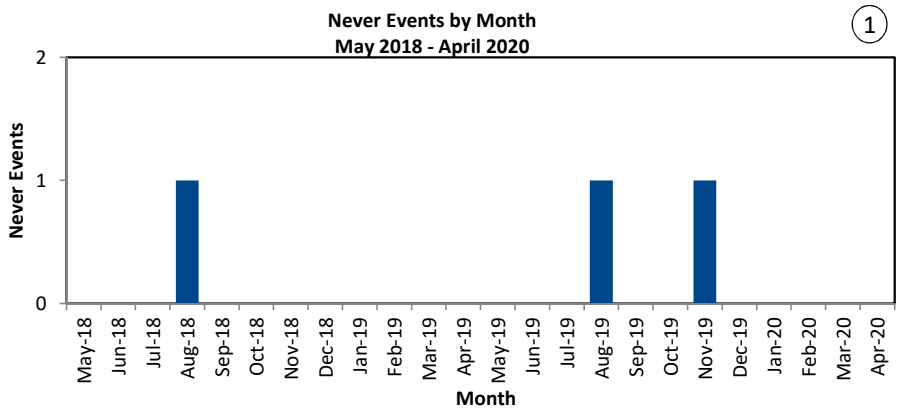
VTE



Accountable: Murray Luckas **Data Owner:** Information Services

Key Narrative: The trust has consistently achieved the 95% target.

Never Events - Trust Total

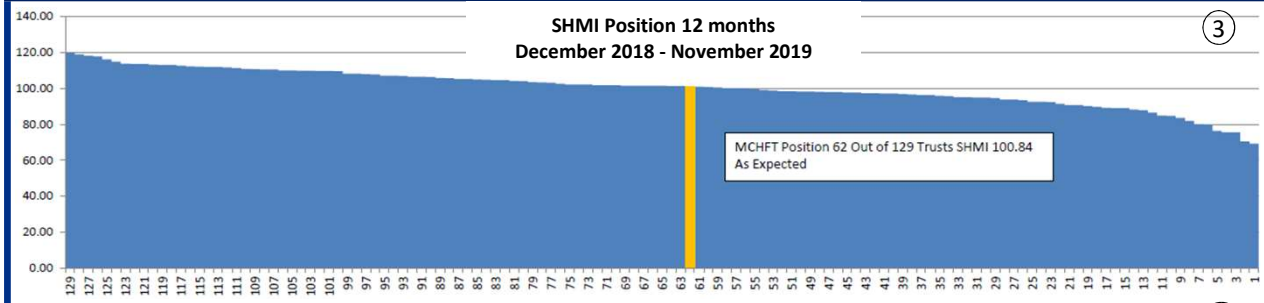


Accountable: Murray Luckas **Data Owner:** Quality Governance

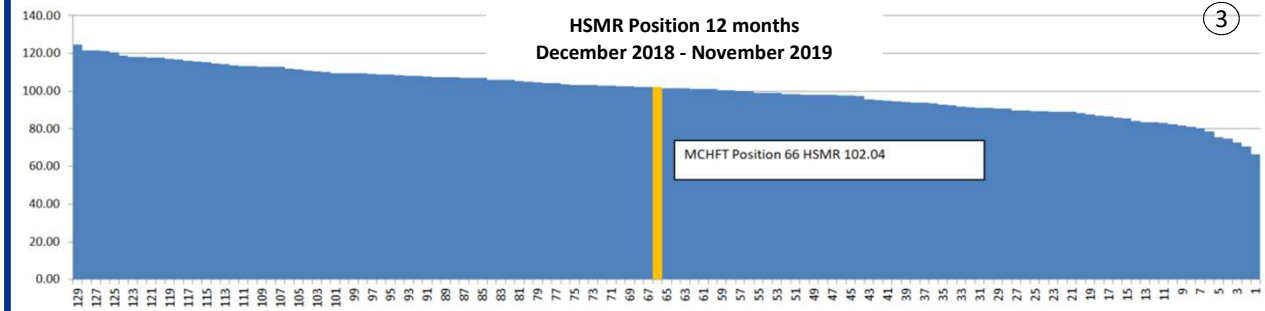
Key Narrative: There were no Never Events in April 2020.

Board Papers - Quality, Safety & Experience

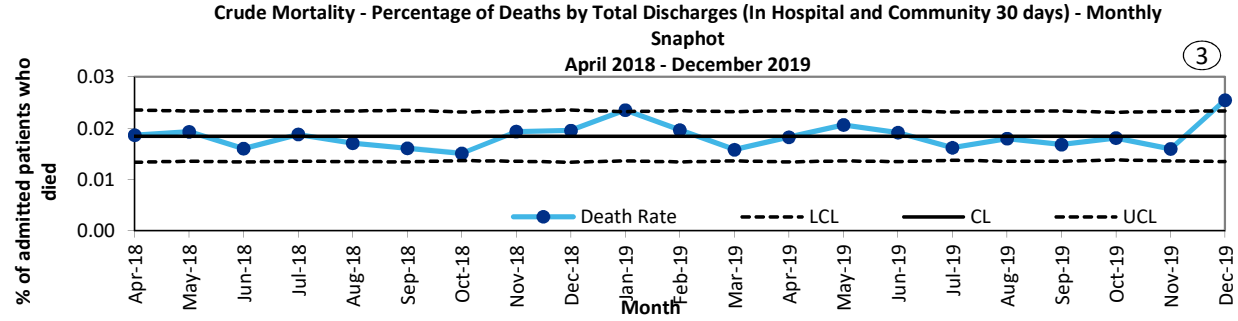
Mortality



Key Narrative: MCHFT SHMI has shown a slight improvement from the November 2018 - October 2019 position, moving from 101.97 to 100.84 and rank 71 to 62 out of 129 submitting Trusts (although is still in the 'as expected' range). Please note that the number of submitting Trusts has dropped from 134 to 129 due to Trust mergers that is now reflected in the data.



Key Narrative: October 2018 to September 2019 represents an improvement in the base HSMR for the Trust from the September 2018 to August 2019 position. The latest data from HED (rebased to October 2019) suggests a continuation in the improving HSMR and ranking.



Key Narrative: In December 2019 there is a variance which is related to a seasonal spike in deaths.

Month	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
In-hospital deaths	75	79	62	77	77	64	70	77	82	103	94	76	74	92	80	78	74	70	81	72	119
Community deaths within 30 days discharge	42	52	43	53	37	40	39	57	41	62	34	36	45	52	48	41	49	45	56	39	51
Number of discharges	6276	6781	6553	6914	6667	6452	7230	6926	6289	7014	6509	7068	6523	6967	6675	7342	6840	6827	7578	6956	6668

Accountable: Murray Luckas
Data Owner: Information Services

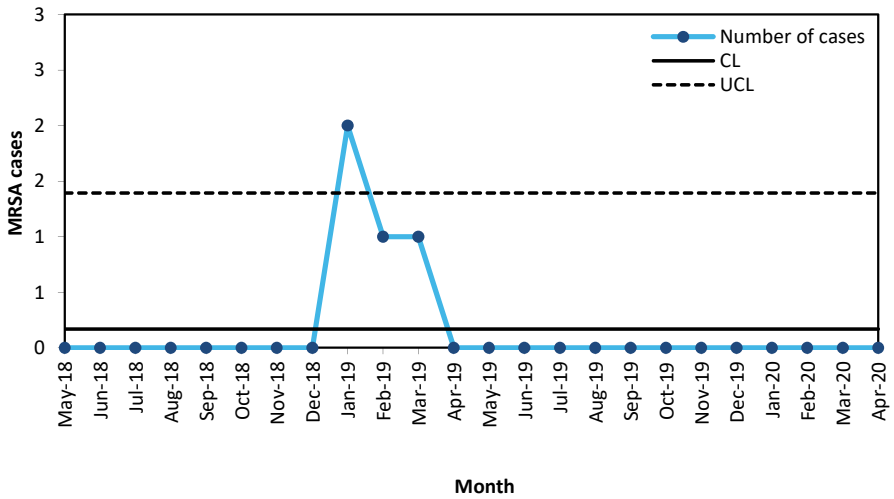
Data Rating: ①captured locally, ②system captured, ③published/benchmarked

Board Papers - Quality, Safety & Experience - Infection Control

MRSA

MRSA Bacteraemia Cases Reported Within the Trust
May 2018 to April 2020

②



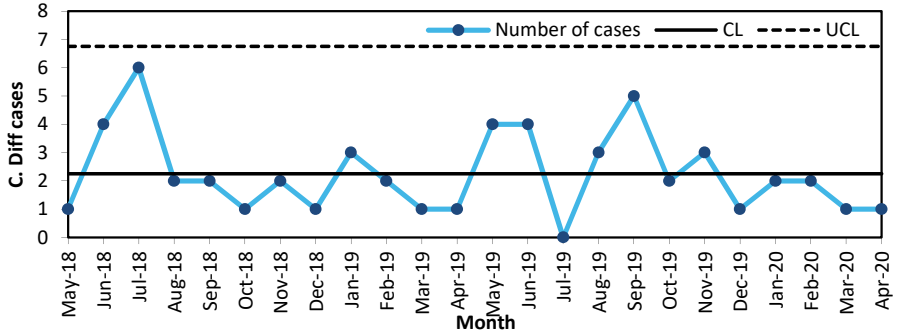
Accountable: Julie Tunney **Data Owner:** Infection Prevention Control Team

Key Narrative: In April 2020 there were no MRSA bacteraemia cases reported in the Trust. There were no confirmed MRSA bacteraemia cases in 2019/20 financial year.

C. Diff Positive Cases

Hospital Acquired C. Diff Cases Reported Within the Trust
May 2018 to April 2020

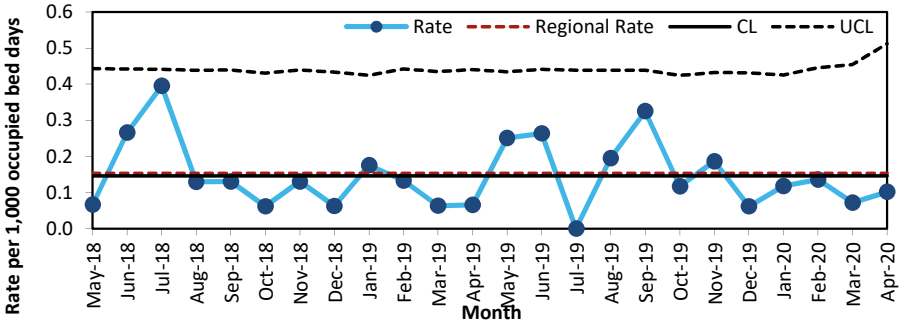
②



	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
Avoidable	0	1	0	0	0	0	0	0	0	0	0	0
Unavoidable	4	3	0	3	5	2	3	1	1	0	0	0
Awaiting Confirmation	0	0	0	0	0	0	0	0	1	2	1	1

Hospital Acquired C.Diff Rate per 1,000 Occupied Bed Days
May 2018 - April 2020

②

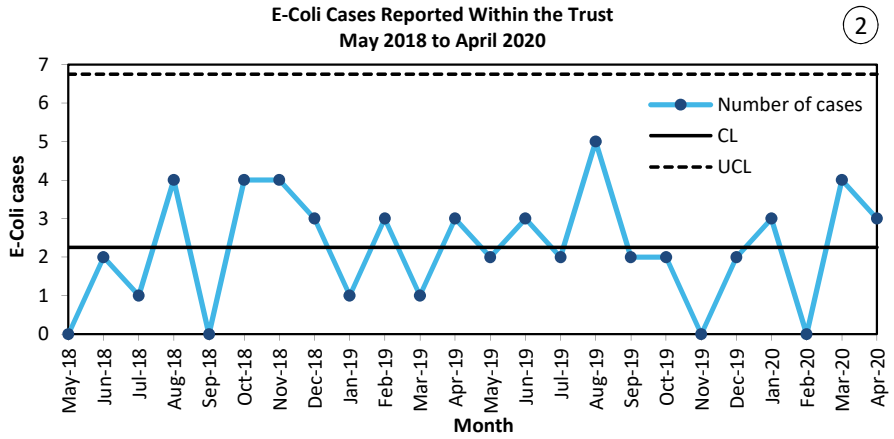


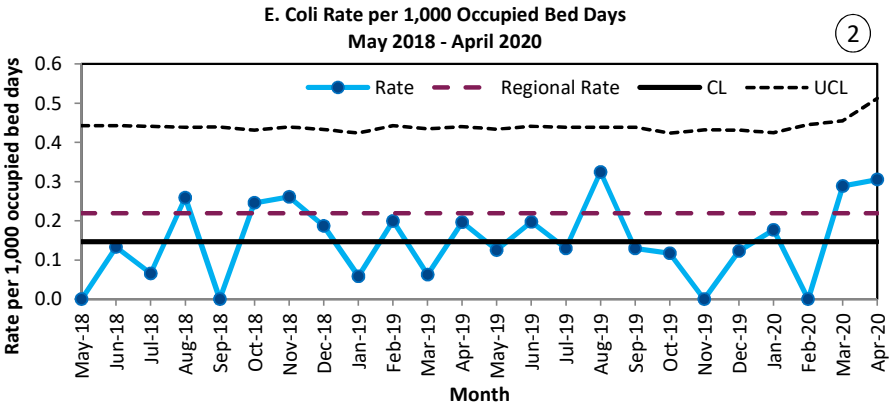
Accountable: Julie Tunney **Data Owner:** Infection Prevention Control Team

Key Narrative: There was 1 case of Hospital Acquired C.Diff in April 2020 which is still under review.

Board Papers - Quality, Safety & Experience - Infection Control

E-Coli Cases

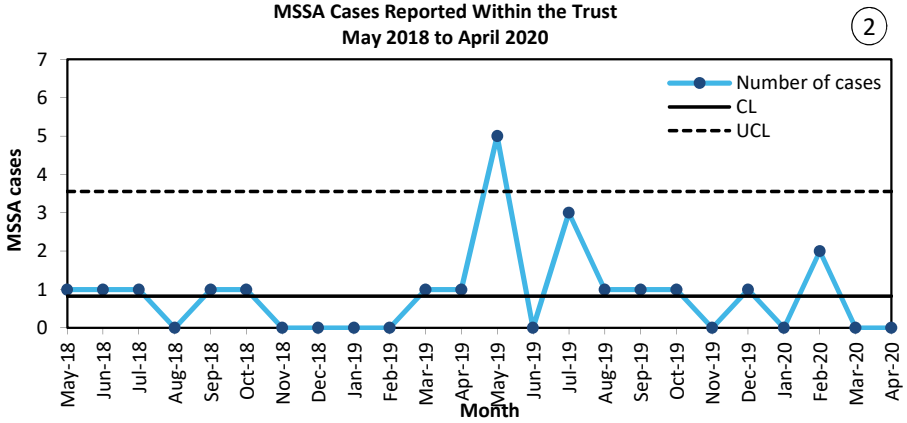


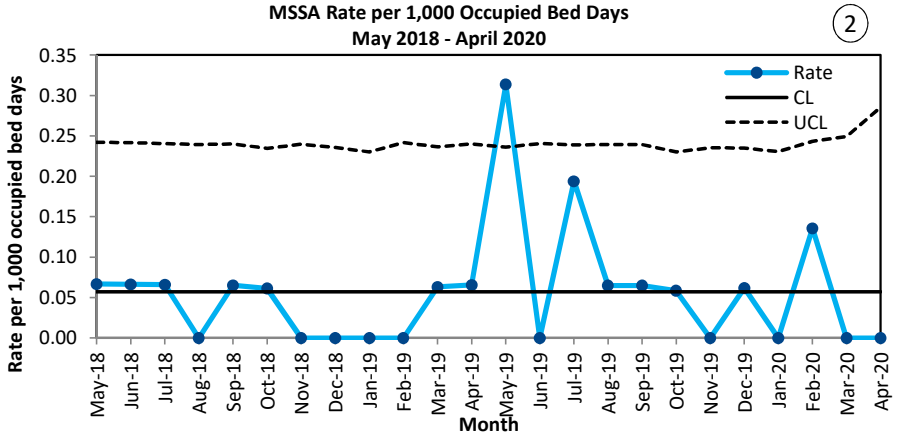


Accountable: Julie Tunney **Data Owner:** Infection Prevention Control Team

Key Narrative: There were 3 E-Coli cases reported in April 2020 all were unavoidable. No specific key themes have been identified but following a data review the group have used a multi-faceted approach including roll out of Catheter Passport and Skip the Dip project using consistent templates, encouraging patient hydration, and an ongoing commitment to antimicrobial prescribing.

MSSA





Accountable: Julie Tunney **Data Owner:** Infection Prevention Control Team

Key Narrative: There were no MSSAs in April 2020.

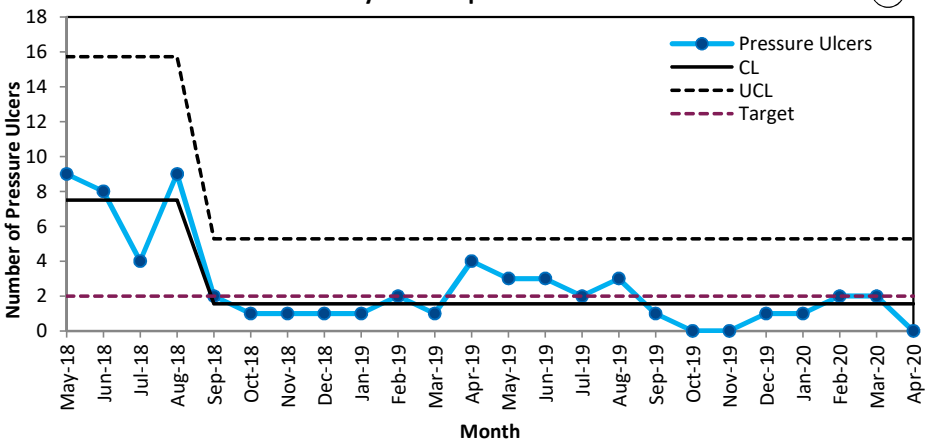
Data Rating: ①captured locally, ②system captured, ③ published/benchmarked

Board Papers - Quality, Safety & Experience

Acute Hospital Pressure Ulcers

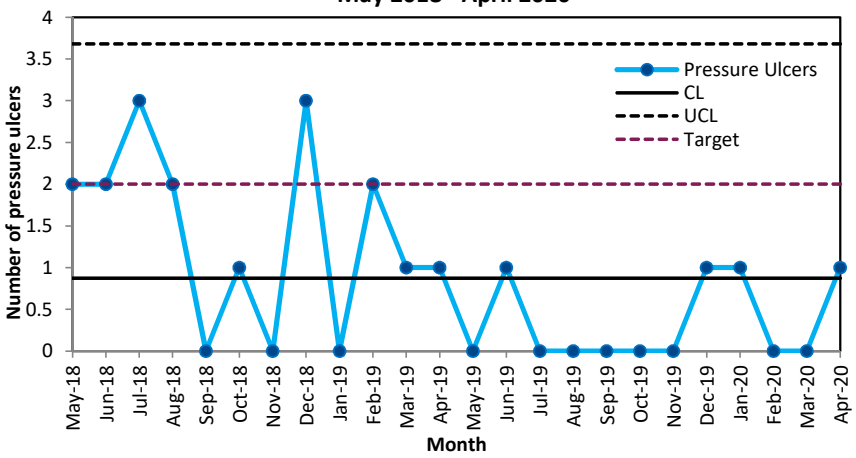
Acute Hospital Pressure Ulcers - Lapses in Care Identified
May 2018 - April 2020

②



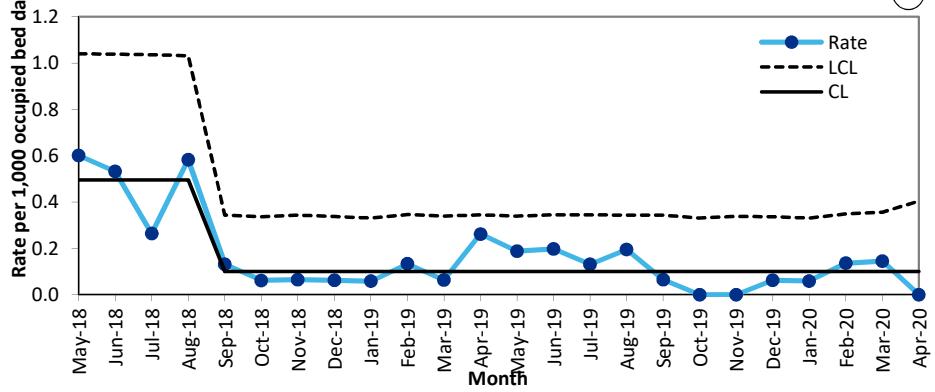
Community Pressure Ulcers - Lapses in Care Identified
May 2018 - April 2020

②



Acute Hospital Pressure Ulcers - Lapses in Care Rate per 1,000 Occupied Bed Days
May 2018 - April 2020

②



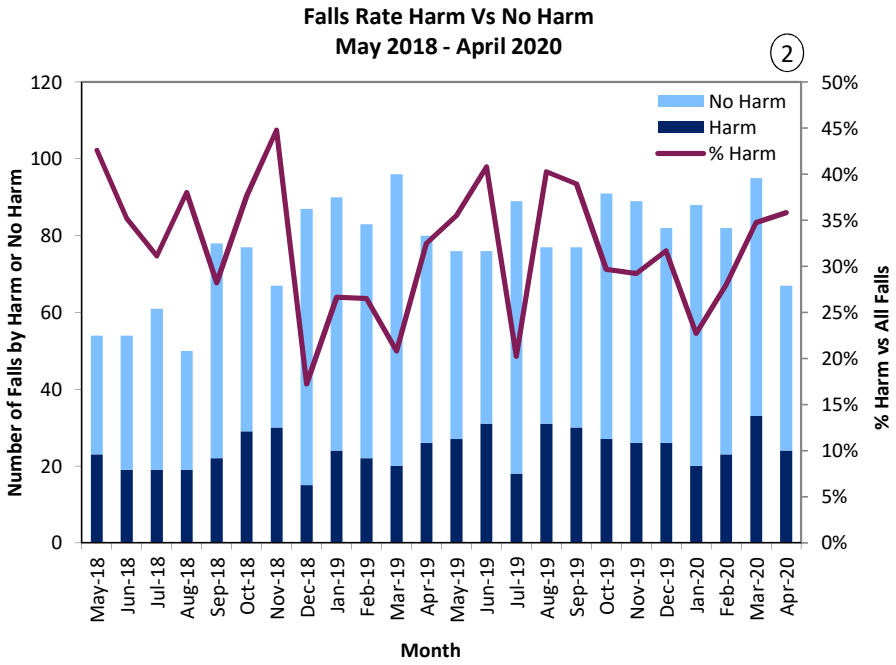
Accountable: Julie Tunney **Data Owner:** Nursing Quality Team

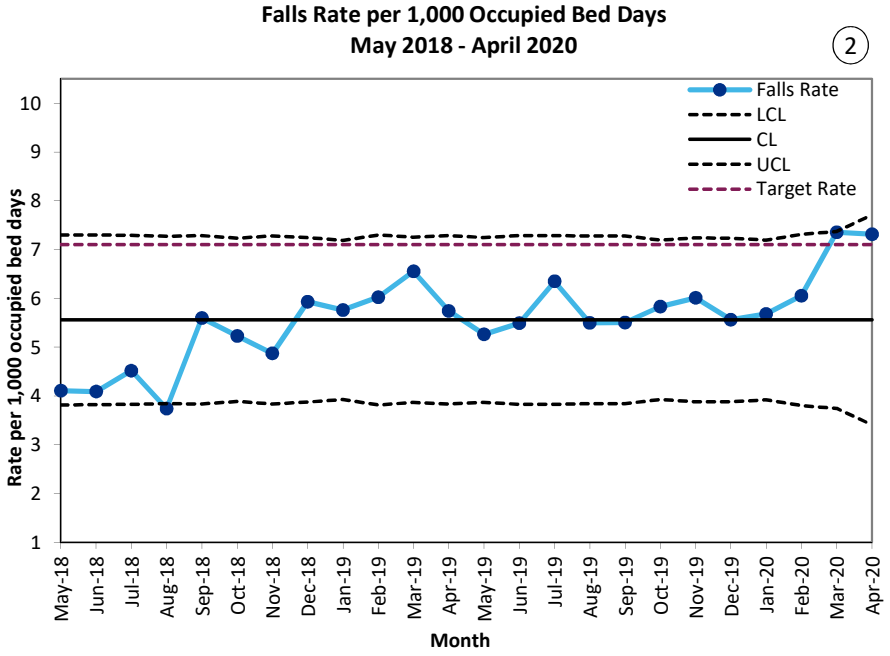
Key Narrative: Community acquired – Director of Nursing and Quality has commissioned an indepth review of all category 4 pressure ulcers which will form a cluster RCA report.

Data Rating: ①captured locally, ②system captured, ③ published/benchmarked

Board Papers - Quality, Safety & Experience

Falls



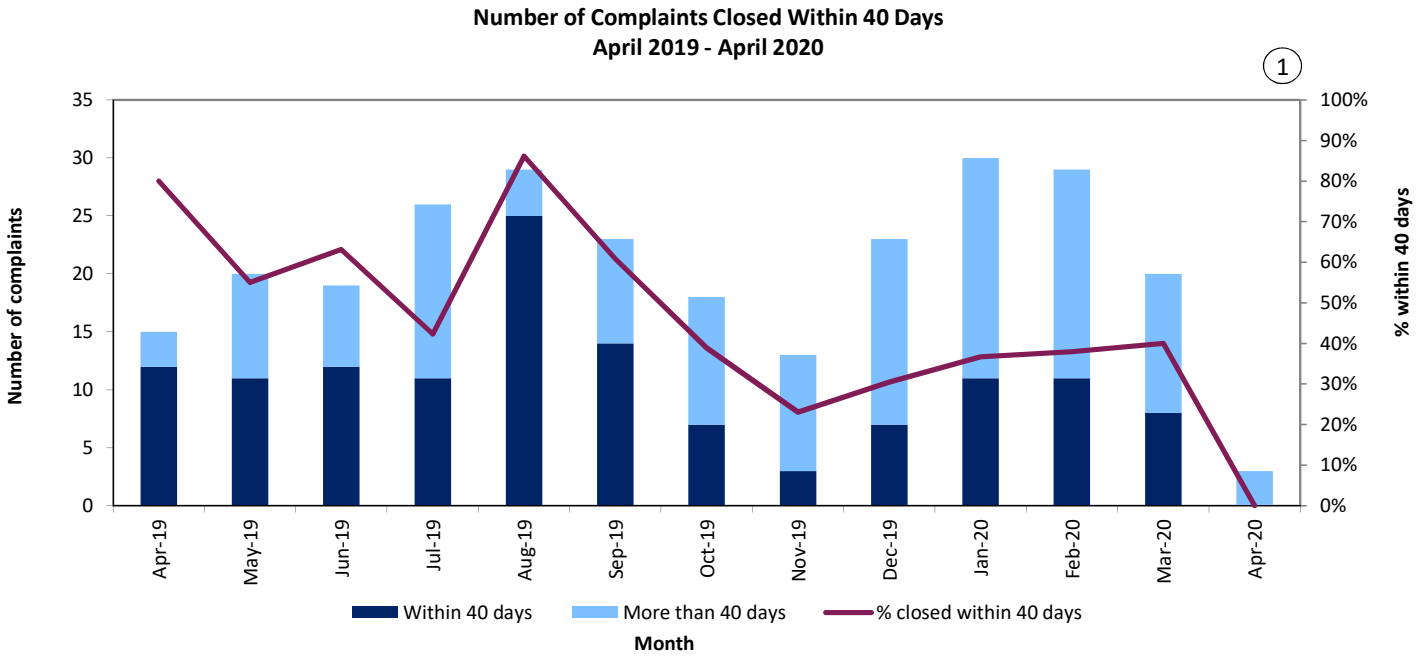


Accountable: Julie Tunney
Data Owner: Nursing Quality Team

Key Narrative: The falls rate is at 6.42 falls per 1,000 occupied bed days and this is the second month where the Trust has gone above the regional rate. This is a result of the change in bed base within the organisation and reduction in activity during the pandemic. The falls policy and falls risk assessment has been redrafted in line with learning from incidents.

Board Papers - Quality, Safety & Experience

Written Complaints



Accountable: Julie Tunney
Data Owner: Customer Care Team

Key Narrative: The complaint target of 40 day for responses to be completed in April 2020 is 0 due to the Trust following the national guidance on suspending complaint responses for 3 months during the pandemic.
There is a recovery plan in place with additional leadership support going forward to ensure the Trust post pandemic will meet the 40 day target for response times.

Performance and Finance Committee
Chair's Assurance Report
May 2020

Report to	Board of Directors
Date	21 May 2020
Report from	Trevor Brocklebank, Non-Executive Director
Report prepared by	Katharine Dowson, Head of Corporate Governance
Executive Lead/s (Name & Title)	Russell Favager, Deputy Chief Executive and Director of Finance Chris Oliver, Chief Operating Officer
Committee meeting quoracy	Yes ☒ No ☐

KEY AREAS OF ASSURANCE

- **Finance:** an overview of the proposed national strategic approach to finance and financial planning for the remainder of 2020/21 and beyond and its impact on the Trust was outlined following the receipt of a letter from NHS Improvement and NHS England. The second 'phase' (May-July) has now started, more Central control and prescriptive around reimbursement than the first phase (March-April) in the immediate response to Covid-19. In future, all Covid capital expenditure would be authorised centrally as part of a return towards financial grip and control. Further phases would focus on returning providers to a more sustainable footing as well as future financial planning. Month 1 position discussed which saw 'top up' reimbursement of £1.7m required from NHSI/E to breakeven and understanding that due to the methodology used by NHSI for the block payment calculation likely to be a shortfall each month.
- **Performance:** the increase in patient and staff testing at the Trust was highlighted as was the success of recruitment to clinical trials which had raised the Trust's national profile. Non-Covid work was now increasing again, with bed occupancy also going up but the Trust was managing this as staff sickness rates had improved and three wards remained closed. April performance figures reflected the stopping of elective work for eight weeks with many headline performance measures not met in-month; the exception to this being the 4-hour transit time target which had been achieved for the first time for many months, with demand coming back into line with funded workforce capacity.
- **Recovery Plan for Performance:** the impact of Covid-19 on performance measures including 52-week waits was outlined. The recovery strategy to manage waiting lists for elective, diagnostic, cancer treatment and outpatient activity, supported by digital innovation, was explained. The PAF committee will now monitor a range of additional metrics which will illustrate the Trust's improvement journey back to compliance levels previously delivered by the Trust.
- **Covid-19 Approach:** the reflection on the management of Covid-19 using the command and control approach was intended to capture good practice and lessons learnt to use for a second phase or a future pandemic.
- **Executive Infrastructure Development Group:** two escalations were noted - the strategic future of the South Cheshire Private Hospital building and the need to complete refurbishment; and a solution for the Residencies.

KEY CONCERNS/RISKS

- The impact on patients and targets if the significant backlog that has built up over the last eight weeks is not addressed appropriately
- The national proposed block funding would leave the Trust with a monthly shortfall because of the methodology used to calculate funding. Although there might be a process to challenge this, it was not yet clear how this would work

DECISIONS MADE

N/A

RECOMMENDATION TO BOARD

To note the report.

Mid Cheshire Hospitals
NHS Foundation Trust

Board of Directors Performance Report

April 2020

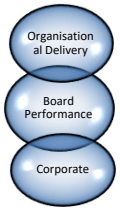
"To Deliver Excellence in Healthcare through Innovation & Collaboration"

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**	**Apr-20**	
Cancer				
Rapid Access Referrals (%) *(seen in 2 wks)*	93.00%	88.98%	88.98%	
Total Patients Seen		*481*	*481*	
Patients seen >14 days		*53*	*53*	
62 day GP Classic (%)	85.00%	75.93%	75.93%	*
Accountable Patients Treated		*54*	*54*	
No. of Breached Pathways (adjusted)		*13*	*13*	
62 day Screening (%)	90.00%	100.00%	100.00%	*
Accountable Patients Treated		*12*	*12*	
No. of Breached Pathways (adjusted)		*0*	*0*	
Unplanned Activity				
4 Hour Access Standard (%)	95.00%	98.27%	98.27%	
A&E Attendances (LH/MIU/UUC) (% to plan)		48.59%	48.59%	
A&E Attendances LH & MIU (Vol)		*4,343*	*4,343*	
Planned Activity				
Incomp Pathways <18wk (%)	92.00%	0.00%	79.14%	
>6wk Diagnostic Waits (%)	1.00%	0.00%	65.18%	
Total Patients Waiting for a First Outpatient Appointment			10,005	

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

Indicator	**Standard**	**YTD**
Workforce		
Sickness absence Rolling 12 Month		5.10%
Turnover Rolling 12 Month		8.77%

	YTD Target	**YTD Actual**	**YTD Variance**	**FY Target**	**FY Forecast**	**FY Variance**
Financial Position (£000's)	0	0	0			

Exec Summary

Performance across all measures is significantly different to recent months due to the Coronavirus pandemic. Where performance has previously been strong it has significantly reduced, albeit in line with national trend. Where MCHFT has previously underperformed against standard, namely against the 4 hour Access Standard, we are now seeing full compliance and whilst the national trend is upwards not all Trusts are delivering compliance against this standard.

In April the key metrics delivered were:

1. 62 Day Screening Cancer at 100.00% against a target of 90%
2. 4hr Emergency Access at 98.27% against a target of 95%

The key metrics not delivered were:

1. 2WW Rapid Access Cancer at 88.98% against a target of 93%
2. 62 Day Classic Cancer at 75.93% against a target of 85%
3. Six weeks diagnostic at 65.18% against a 1% threshold
4. RTT Open Pathways at 79.14% against a target of 92% (intermin position)

Following national guidance the Trust is on a block arrangement with commissioners, with the expectation that the funding received ensures a balanced position for months 1-4.

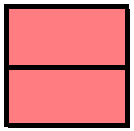
At month 1 the Trust was £1.7m over the nationally calculate block contract amount and has therefore applied for a 'top up' payment from NHSI/E in order to produce a breakeven position. The £1.7m reflects additional costs association with Covid-19, which are pre-dominantly within pay (additional non pay costs being offset by reduced planned care expenditure) but also lower income than would normally be expected (from a combination of the national calculation and reduced footfall to the Trust).

As a result of the Covid-19 pandemic, Cost Improvement Schemes and Use of Resources are not reported as Trusts do not have agreed plans and CIPs have been suspended as part of the support measures to Trusts for months 1-4.

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).

Operational Performance

	Current YTD													Monthly Trend
	Target	Actual	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	
Maximum 6 week wait for Diagnostic procedures	1%	0.00%	0.64%	9.34%	7.76%	4.04%	3.05%	0.95%	0.84%	0.72%	1.79%	0.94%	1.05%	16.94%	65.18%	
All Cancers: 62 day GP Classic (%) *	85%	75.93%	86.62%	86.09%	86.18%	86.45%	86.72%	88.89%	86.67%	85.11%	86.17%	85.54%	83.82%	86.13%	75.93%	
All Cancers: 62 day Screening (%) *	90%	100.00%	90.00%	90.00%	61.11%	96.77%	90.48%	85.00%	79.41%	100.00%	100.00%	94.44%	86.11%	92.59%	100.00%	
18 weeks from point of referral to treatment - patients on an incomplete pathway (%)	92%	0.00%	91.05%	91.67%	92.07%	92.09%	92.00%	92.46%	92.08%	92.19%	91.29%	90.98%	90.68%	87.54%	79.14%	
A&E - maximum waiting time of 4 hours from arrival to admission/transfer/discharge (%)	95%	98.27%	79.90%	78.26%	80.60%	78.98%	78.02%	77.36%	75.50%	71.82%	68.01%	69.45%	79.17%	86.03%	98.27%	
STF Trajectory			0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%				
Provider Submitted Trajectory													88.10%	95.00%	78.60%	

** 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	0.00	0.00	0	0
	Liquidity	days	0	0	0	0
Financial Efficiency	I&E Margin	%	0.00%	0.00%	0	0
Financial Controls	Distance from Financial Plan	%	0.00%	0.00%	0	0
	Agency Spend	%	0.00%	0.00%	0	0
Overall UOR Rating					0	0

Operational Delivery: *Cancer Pathway*

Headline Measures

	Current YTD		Rolling 13 months											
	Target	Actual	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	Monthly Trend
Rapid Access Referrals (%) (seen in 2 wks)	93%	88.98%	95.83%	97.65%	96.99%	96.60%	98.20%	97.39%	98.28%	97.76%	97.07%	97.84%	97.31%	98.45%	88.98%	
Total Patients Seen		*481*	*1030*	*980*	*963*	*1207*	*1000*	*1036*	*1048*	*936*	*888*	*974*	*1040*	*967*	*481*	
Patients seen >14 days		*53*	*43*	*23*	*29*	*41*	*18*	*27*	*18*	*21*	*26*	*21*	*28*	*15*	*53*	
% seen within 7 days		*0.0%*	*30.3%*	*39.4%*	*37.6%*	*38.2%*	*43.3%*	*54.7%*	*59.3%*	*46.3%*	*44.0%*	*56.5%*	*38.7%*	*36.1%*	*56.1%*	
62 day GP Classic (%) *	85%	75.93%	86.62%	86.09%	86.18%	86.45%	86.72%	88.89%	86.67%	85.11%	86.17%	85.54%	83.82%	86.13%	75.93%	

** Provisional figures subject to change depending*

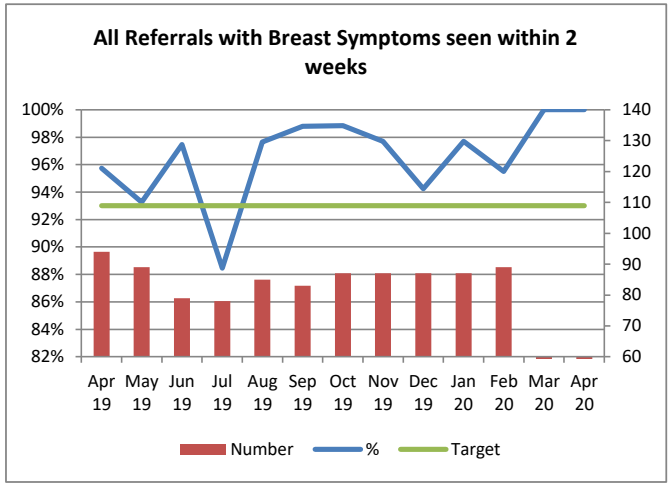
104+ day waits - (Cancer patients treated)	3	5	4	4	4	2	2	2	3	3	0	3	2

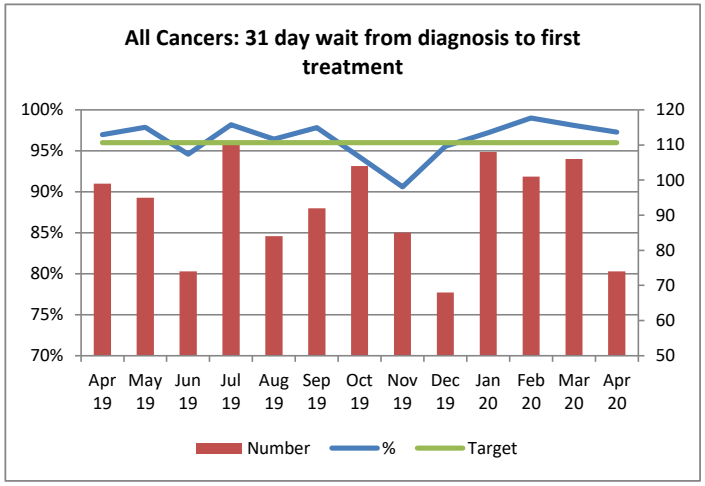
Commentary

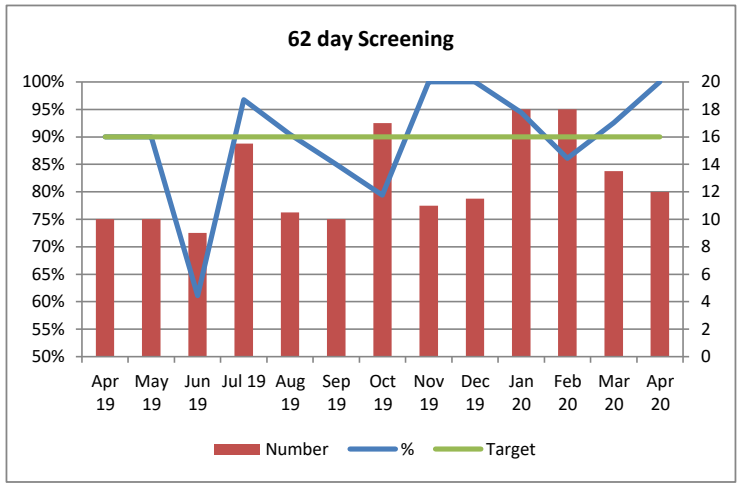
The Trust has achieved one of the three headline cancer standards during the month of April 2020, this being the 62 Day Screening standard. The figures presented in this paper reflect the Trust's regulatory performance measures adjusted figures that take into account breach reallocation between providers.

Although the Trust was able to mobilise a level of virtual clinics and undertake some cancer theatre activity at the Spire Regency Macclesfield, this capacity was not sufficient to deliver the usual strong performance against the cancer standards, which patients at MCHFT have become used to.
Rapid Access standard delivered performance of 88.98%.
The 62 Day GP Classic standard delivered performance of 75.93%.
The 62 day Screening standard has reached 100% performance in April.

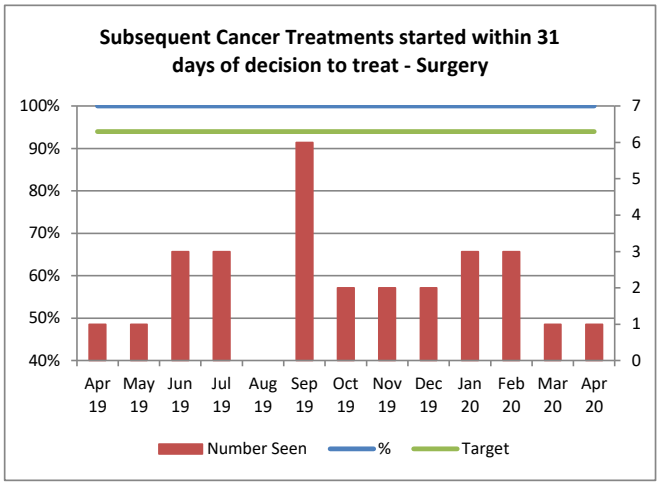
Primary Measures

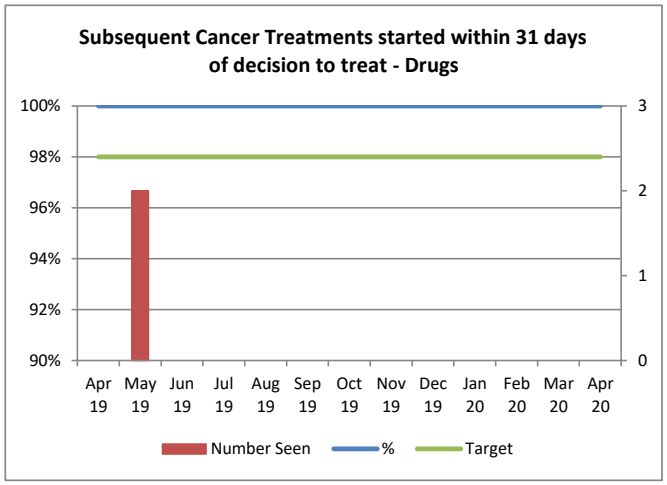


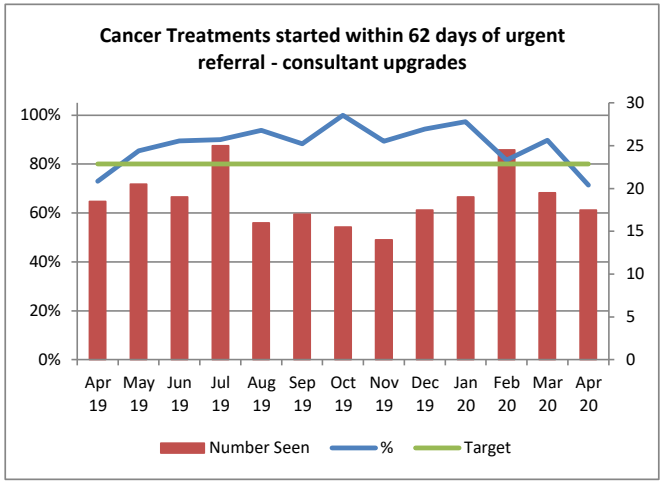




Operational Delivery: *Cancer Pathway*







Operational Delivery: *Unplanned Activity - A&E*

Headline Measures

	Current YTD		Rolling 13 months											
	Target	Actual	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	Monthly Trend
A&E - >4 hr wait time from arrival to admission/ transfer/ discharge (% to Target)	95%	98.27%	79.90%	78.26%	80.60%	78.98%	78.02%	77.36%	75.50%	71.82%	68.01%	69.45%	79.17%	86.03%	98.27%	
No. of 4hr breaches		*75*	*1,642*	*1,822*	*1,559*	*1,879*	*1,892*	*1,913*	*1,991*	*2,288*	*2,586*	*2,443*	*1,568*	*890*	*75*	

	Plan	Actual	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	Monthly Trend
A&E Attendances (LH/MIU/UUC) (% to Plan)		*48.59%*	100.4%	95.2%	96.3%	103.3%	105.6%	102.9%	95.2%	99.2%	90.9%	93.5%	94.9%	71.4%	48.6%	
A&E Attendances (LH/MIU/UUC) (No.)	*8,622*	*4,343*	8,169	8,382	8,036	8,937	8,607	8,450	8,128	8,120	8,085	7,998	7,528	6,373	4,343	

A&E Attendance Case Mix (based on acuity score)	*Major*	*50%*	*1,206*	*2,351*	*2,540*	*2,235*	*2,407*	*2,263*	*2,347*	*2,155*	*2,082*	*2,040*	*2,066*	*2,131*	1,725	1,206	
	Minor	*46%*	*1,537*	*3,166*	*3,040*	*3,045*	*3,559*	*3,593*	*3,212*	*2,852*	*2,823*	*2,852*	*2,940*	*2,669*	2,137	1,537	
	Paediatrics		*626*	*1,587*	*1,680*	*1,686*	*1,739*	*1,363*	*1,721*	*1,745*	*1,745*	*1,624*	*1,428*	*1,421*	1,306	626	
	Resus		*974*	*1,063*	*1,121*	*1,070*	*1,231*	*1,385*	*1,168*	*1,374*	*1,467*	*1,567*	*1,560*	*1,299*	1,196	974	

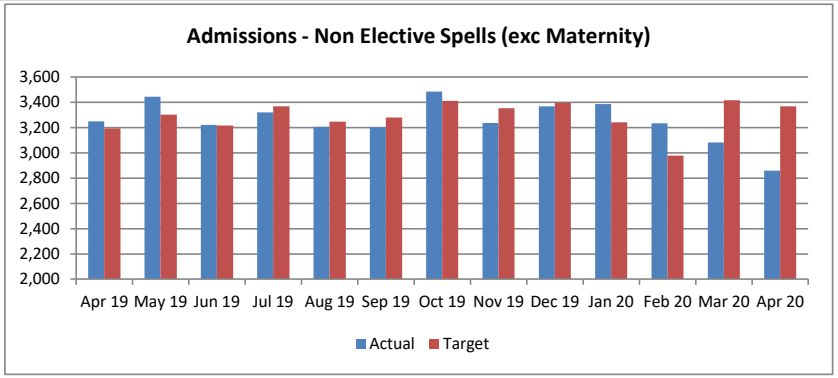
A&E Attendance Location (based on Discharge)	*Major*		*1,914*	*3,245*	*3,405*	*3,142*	*3,320*	*3,277*	*3,134*	*2,984*	*3,071*	*3,220*	*3,559*	*3,188*	*2,775*	*1,914*	
	Minor		*1,685*	*3,123*	*3,111*	*3,039*	*3,677*	*3,788*	*3,394*	*3,182*	*3,069*	*2,991*	*2,818*	*2,773*	*2,144*	*1,685*	
	Paediatrics		*626*	*1,587*	*1,680*	*1,686*	*1,739*	*1,363*	*1,721*	*1,745*	*1,745*	*1,624*	*1,428*	*1,421*	*1,306*	*626*	
	Resus		*118*	*212*	*185*	*169*	*200*	*176*	*199*	*215*	*232*	*248*	*189*	*138*	*139*	*118*	

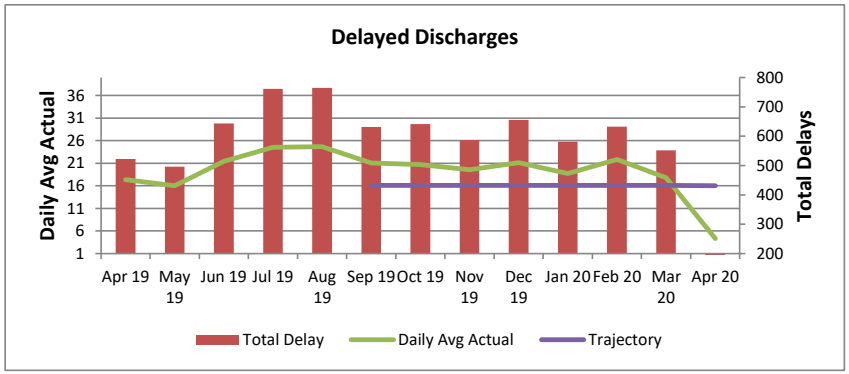
Commentary

The Trust has achieved the 4-hour access standard in April 2020, at 98.27% as expected due 50% reduction in A&E attendances when compared to April 2019 and only 75 breaches for the month.
Despite the overall attendances reducing, there has been an increase in the proportion of higher acuity attendances (Resus and Majors) representing 50% of all attendances during April. The majority of these attendances were patients attending with COVID symptoms, which resulted in an emergency admission, thus seeing an increase in the attendance to admission conversion rate to 57% for April.

Patients medically fit for discharge has reduced to 4 against a threshold of 16.

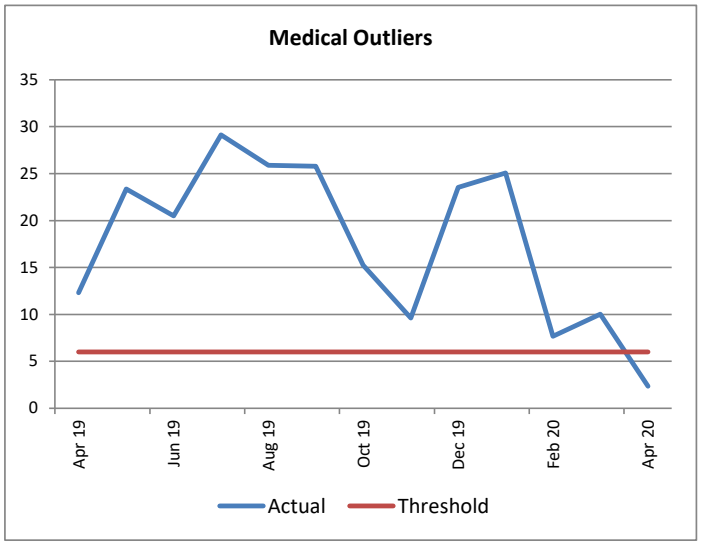
Primary Drivers

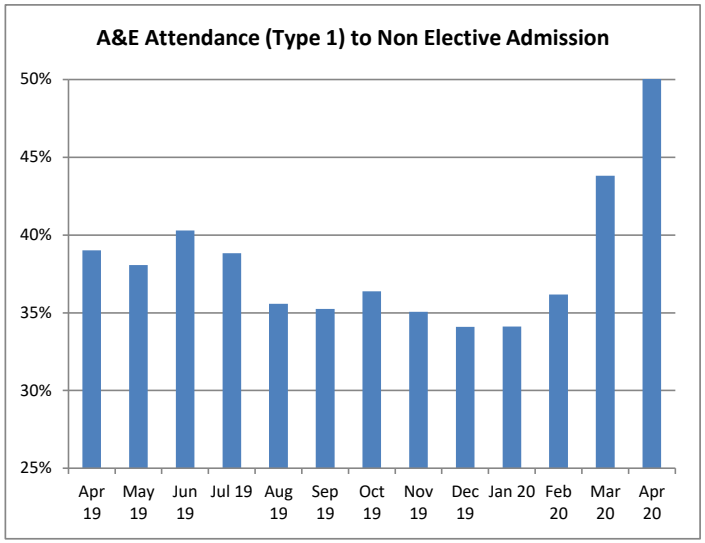


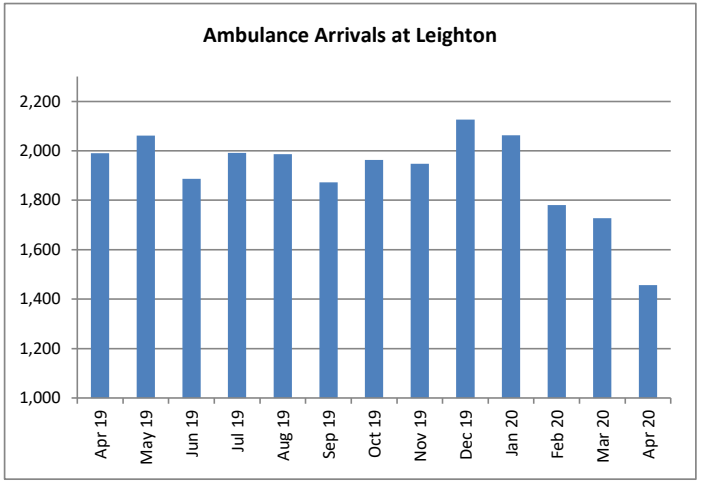


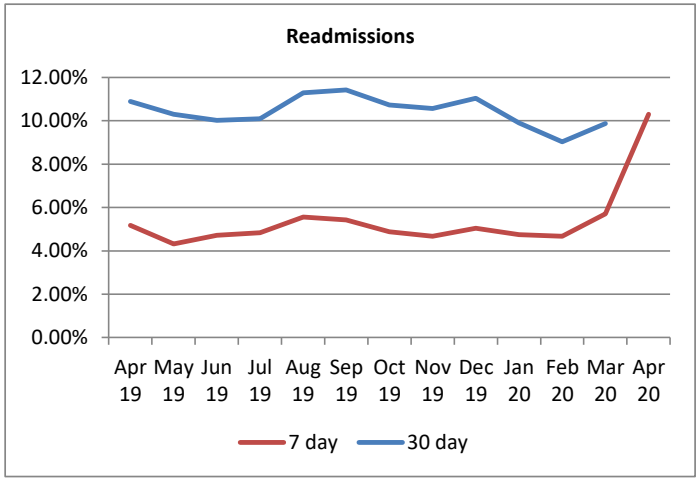
Operational Delivery: *Unplanned Activity A&E*

Secondary Drivers



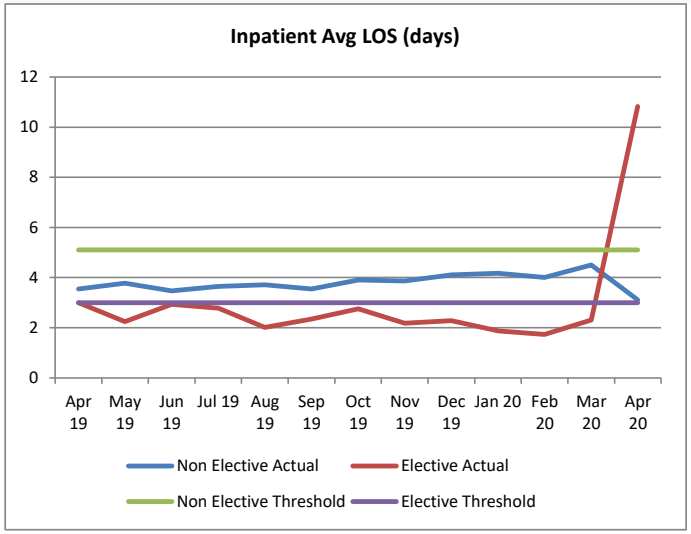


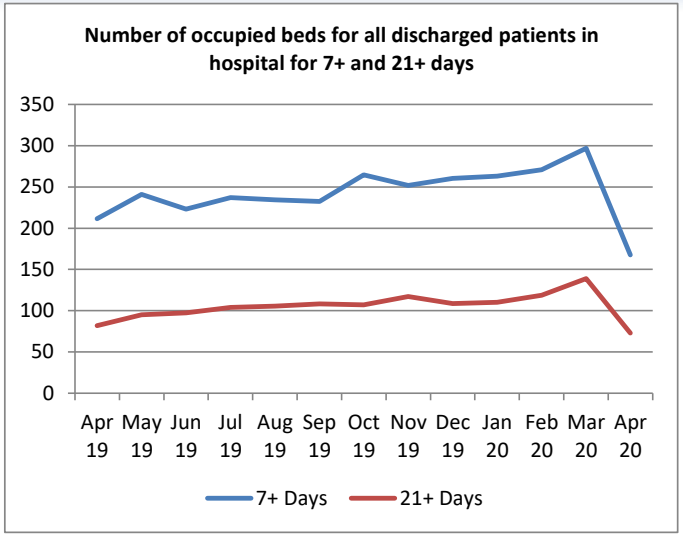


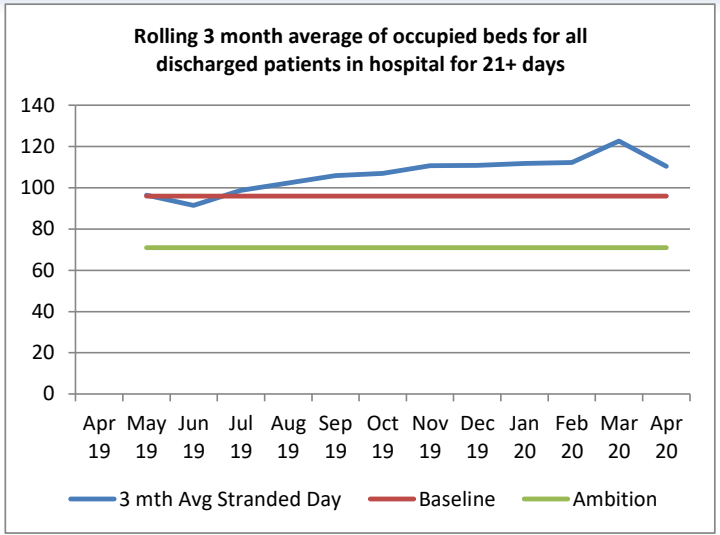


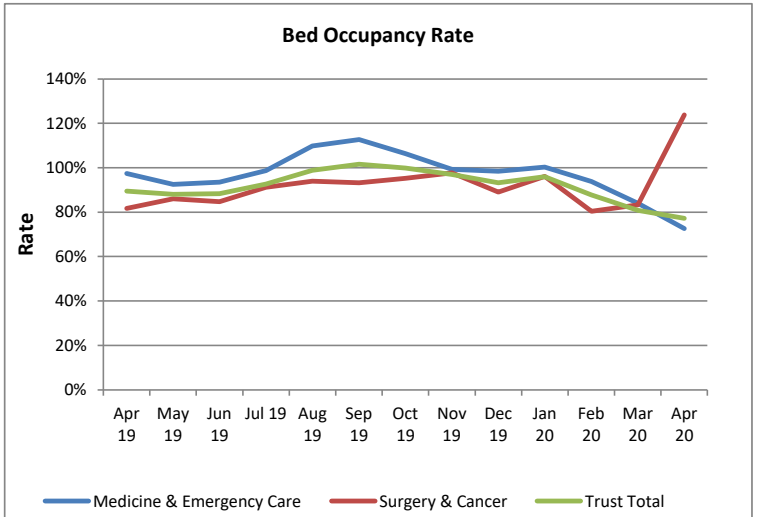
** Readmissions brought in line with national definition*

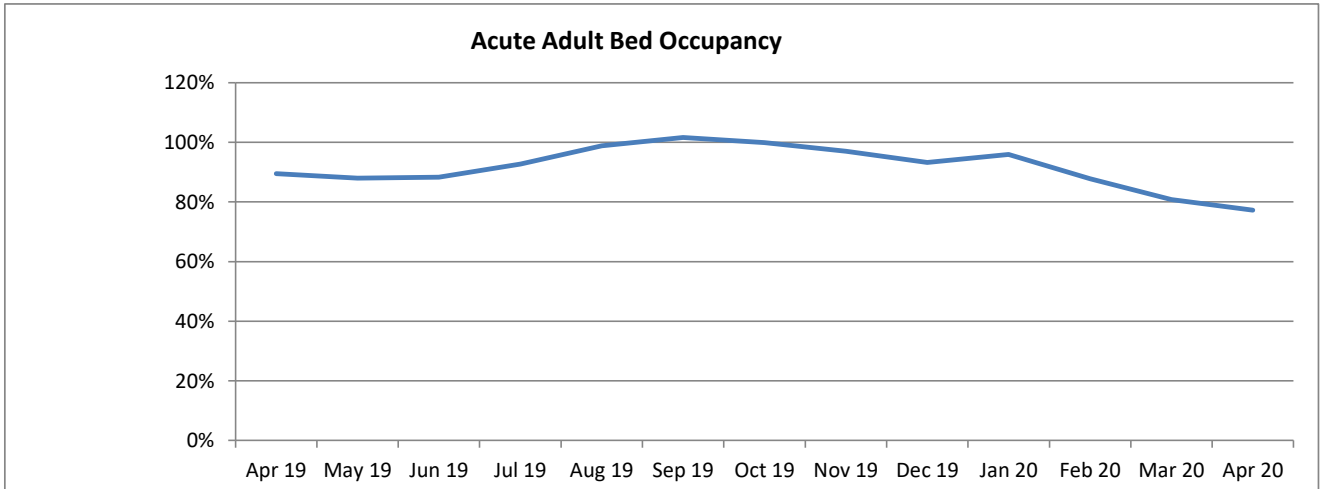
Operational Delivery: *Length of Stay*











	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20
Trust Total	89.49%	88.03%	88.28%	92.68%	98.80%	101.62%	99.92%	97.00%	93.30%	95.95%	87.79%	80.85%	77.25%
Additional Beds	0.73	1.45	1.50	1.71	3.32	7.67	8.13	7.47	0.13	1.48	22.07	27.81	2.00

Operational Delivery: *Planned Activity*

Headline Measures

	Current YTD		Rolling 13 months											
	Target	Actual	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	Monthly Trend
18 weeks from Referral to Treatment in Aggregate - Incomplete	92%	0.00%	91.05%	91.67%	92.07%	92.09%	92.00%	92.46%	92.08%	92.19%	91.29%	90.98%	90.68%	87.54%	79.14%	
Total 18 Weeks		*0*	14,944	15,219	15,560	15,426	15,432	15,190	14,668	14,707	14,899	15,535	15,488	14,617	13,995	
No. > 18 Weeks		*0*	*1,338*	*1,267*	*1,234*	*1,216*	*1,234*	*1,146*	*1,161*	*1,149*	*1,297*	*1,401*	*1,443*	*1,822*	*2,919*	
Open Pathways >39 Weeks Waiting											*37*	*36*	*49*	*54*	*107*	
Diagnostic Waiting Time	1%	0.00%	0.64%	9.34%	7.76%	4.04%	3.05%	0.95%	0.84%	0.72%	1.79%	0.94%	1.05%	16.94%	65.18%	
Total Number of Waiters		*0*	*1,091*	*4,809*	*5,065*	*4,750*	*3,903*	*4,434*	*5,014*	*5,023*	*5,146*	*4,770*	*5,130*	*4,373*	*5,687*	
Waiters of 6 Weeks +		*0*	*7*	*449*	*393*	*192*	*119*	*42*	*42*	*36*	*92*	*45*	*54*	*741*	*3,707*	
Total Patients Waiting for a First Outpatient Appointment			9,800	9,981	9,603	9,659	9,523	9,452	9,033	8,813	9,001	9,536	10,289	9,801	10,005	
Longest Wait Time (weeks)											*49*	*48*	*51*	*55*	*0*	

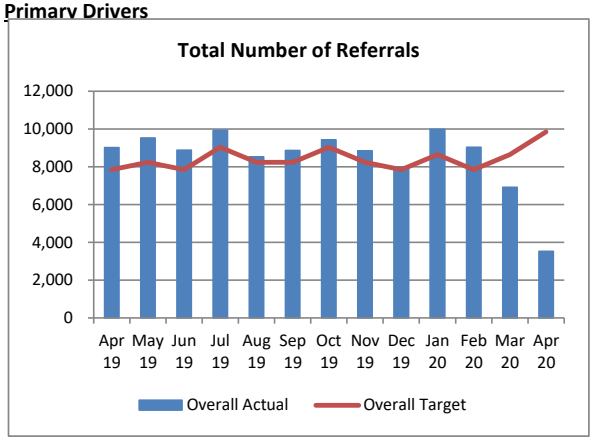
Commentary

The Trust's RTT Incomplete Pathway position was 79.14% for April. All Specialties have failed this measure in April, with the exception of General Medicine.

There were seven 52 week breaches in April, and 107 patients waiting over 39 weeks.

In April 2020, 65.18% of patients waited longer than 6 weeks for their diagnostic tests. The failure of the Diagnostic six week standard was expected as a result of routine appointments and tests being cancelled. Diagnostic performance for April has been benchmarked and is aligned to other local Trusts performance. The Trust has already started it's reset and restart programme as well as participating in the Cheshire and Merseyside elective restart planning work.

Primary Drivers

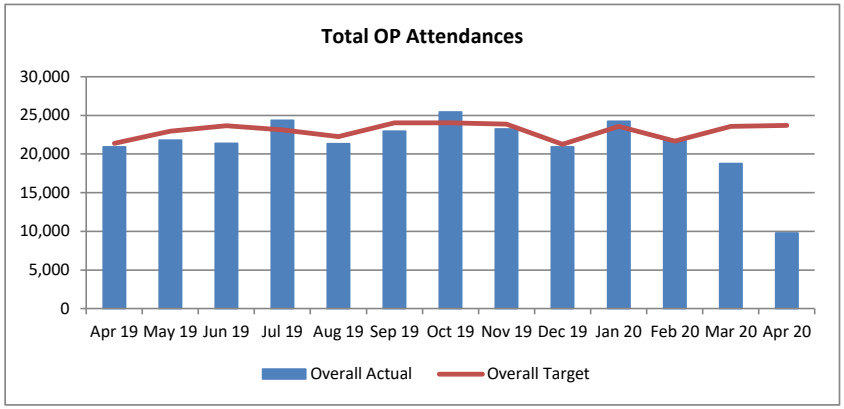


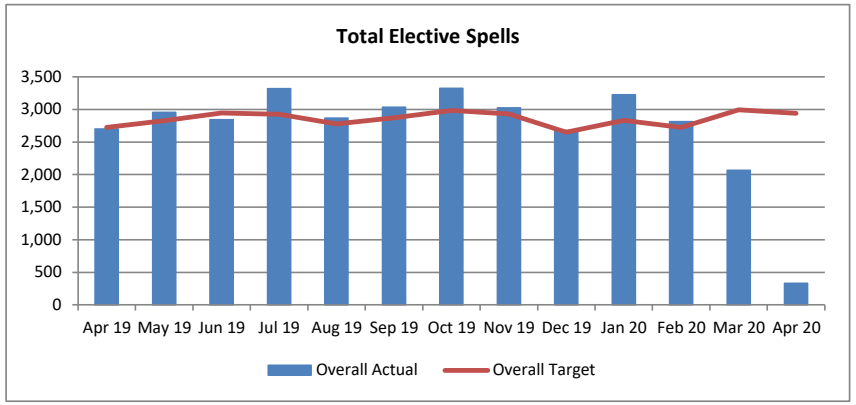
Referral Breakdown

	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	Monthly Trend
GP Actual	5,212	5,552	5,134	5,354	4,659	4,977	5,285	5,028	4,355	5,568	5,090	3,729	1,628	
GP Target	4,374	4,593	4,374	5,030	4,593	4,593	5,030	4,593	4,374	4,811	4,374	4,811	5,535	
% to Target	119.2%	120.9%	117.4%	106.4%	101.4%	108.4%	105.1%	109.5%	99.6%	115.7%	116.4%	77.5%	29.4%	
Other Actual	3,806	3,971	3,752	4,578	3,868	3,887	4,148	3,818	3,627	4,419	3,956	3,194	1,902	
Other Target	3,483	3,657	3,483	4,006	3,657	3,657	4,006	3,657	3,483	3,832	3,483	3,832	4,308	
% to Target	109.3%	108.6%	107.7%	114.3%	105.8%	106.3%	103.6%	104.4%	104.1%	115.3%	113.6%	83.4%	44.1%	
Total Actual	9,018	9,523	8,886	9,932	8,527	8,864	9,433	8,846	7,982	9,987	9,046	6,923	3,530	
Total Target	7,857	8,250	7,857	9,036	8,250	8,250	9,036	8,250	7,857	8,643	7,857	8,643	9,844	
% to Target	114.8%	115.4%	113.1%	109.9%	103.4%	107.4%	104.4%	107.2%	101.6%	115.6%	115.1%	80.1%	35.9%	
GP % of Total	57.8%	58.3%	57.8%	53.9%	54.6%	56.1%	56.0%	56.8%	54.6%	55.8%	56.3%	53.9%	46.1%	

Operational Delivery: *Planned Activity*

Primary Drivers





OP Attendance Breakdown

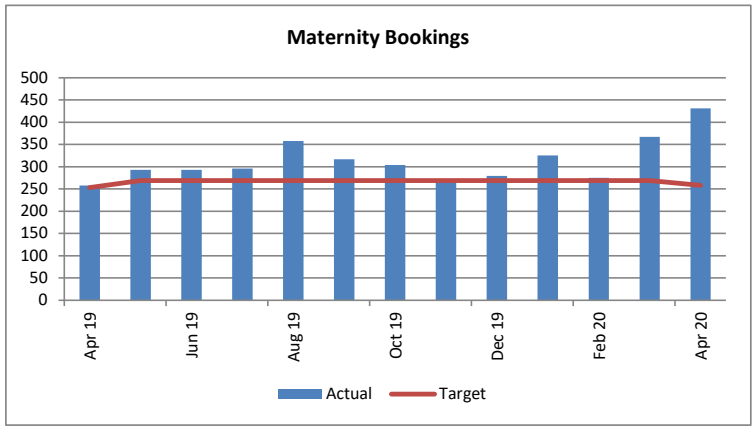
	YTD 18 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	Monthly Trend
New Actual	83,277	6,584	6,956	6,725	7,866	6,712	7,284	7,833	6,976	6,316	7,406	6,676	5,943	2,789	
New Target	81,785	6,416	6,848	7,173	6,817	6,588	7,267	7,214	6,982	6,325	6,817	6,339	7,000	7,443	
% to Target	101.8%	102.6%	101.6%	93.8%	115.4%	101.9%	100.2%	108.6%	99.9%	99.9%	108.6%	105.3%	84.9%	37.5%	
F U Actual	183,854	14,343	14,830	14,642	16,519	14,633	15,681	17,592	16,264	14,591	16,814	15,134	12,811	7,008	
F U Target	193,611	14,988	16,096	16,491	16,286	15,659	16,779	16,823	16,886	14,918	16,777	15,340	16,569	16,253	
% to Target	95.0%	95.7%	92.1%	88.8%	101.4%	93.4%	93.5%	104.6%	96.3%	97.8%	100.2%	98.7%	77.3%	43.1%	
Total Actual	267,131	20,927	21,786	21,367	24,385	21,345	22,965	25,425	23,240	20,907	24,220	21,810	18,754	9,797	
Total Target	275,397	21,403	22,944	23,663	23,102	22,247	24,046	24,037	23,868	21,243	23,595	21,679	23,569	23,696	
% to Target	97.0%	97.8%	95.0%	90.3%	105.6%	95.9%	95.5%	105.8%	97.4%	98.4%	102.6%	100.6%	79.6%	41.3%	
New % of Total	31.2%	31.5%	31.9%	31.5%	32.3%	31.4%	31.7%	30.8%	30.0%	30.2%	30.6%	30.6%	31.7%	28.5%	

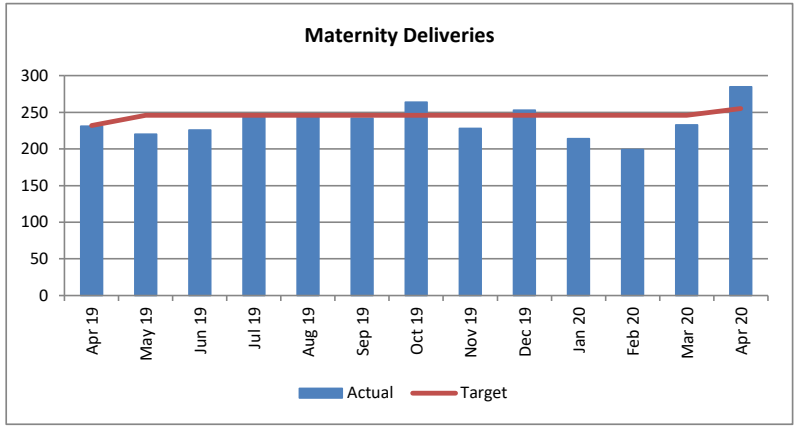
Elective Spells Breakdown

	YTD 18 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	Monthly Trend
I P Actual	3,201	225	228	266	267	291	254	329	353	201	225	307	255	43	
I P Target	3,213	263	277	280	277	249	270	310	305	239	204	249	290	294	
% to Target	99.6%	85.6%	82.3%	94.9%	96.4%	116.7%	94.1%	106.1%	115.8%	84.1%	110.3%	123.1%	88.1%	14.6%	
Daycase Actual	31,634	2,475	2,727	2,575	3,050	2,576	2,778	2,995	2,670	2,472	2,999	2,507	1,810	286	
Daycase Target	30,969	2,462	2,548	2,666	2,650	2,530	2,601	2,672	2,626	2,409	2,626	2,474	2,706	2,645	
% to Target	102.1%	100.5%	107.0%	96.6%	115.1%	101.8%	106.8%	112.1%	101.7%	102.6%	114.2%	101.3%	66.9%	10.8%	
Total Actual	34,835	2,700	2,955	2,841	3,317	2,867	3,032	3,324	3,023	2,673	3,224	2,814	2,065	329	
Total Target	34,182	2,724	2,825	2,946	2,927	2,779	2,871	2,982	2,931	2,648	2,830	2,723	2,996	2,939	
% to Target	101.9%	99.1%	104.6%	96.4%	113.3%	103.2%	105.6%	111.5%	103.2%	100.9%	113.9%	103.3%	68.9%	11.2%	
I P % of Total	9.2%	8.3%	7.7%	9.4%	8.0%	10.1%	8.4%	9.9%	11.7%	7.5%	7.0%	10.9%	12.3%	13.1%	

Operational Delivery: *Planned Activity*

Primary Drivers





Operational Delivery: *Planned Activity*

Secondary Drivers

			Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	Monthly Trend
Bed Occupancy Rate	Medicine & Emergency Care		97.5%	92.6%	93.5%	98.7%	109.8%	112.8%	106.4%	99.3%	98.4%	100.3%	93.8%	84.0%	72.6%	
	Surgery & Cancer		81.8%	86.0%	84.8%	91.3%	93.9%	93.2%	95.3%	97.8%	89.0%	96.1%	80.4%	83.3%	123.8%	
Elective Inpatient Avg LOS (Days)			3.0	2.2	2.9	2.8	2.0	2.3	2.7	2.2	2.3	1.9	1.7	2.3	10.8	
Delayed Transfers of Care (MFFD)		16.00	17	16	21	25	25	21	21	20	21	19	22	18	4	
Delayed Transfers of Care (% of Acute Beds)			3.5%	3.2%	4.3%	5.2%	5.1%	4.4%	4.2%	3.8%	4.0%	3.5%	4.1%	3.4%	0.9%	
Medical Outliers			12	23	21	29	26	26	15	10	24	25	8	10	2	
Readmission (Emergency Re-admissions after Planned Surgery)																
	30 Day Rate		3.38%	3.38%	3.10%	2.83%	3.30%	4.32%	3.31%	3.54%	2.87%	2.80%	3.90%		4.38%	
	7 Day Rate		1.41%	1.37%	1.00%	1.07%	1.36%	1.68%	1.20%	1.17%	0.90%	1.01%	1.76%	1.29%	3.13%	
Cancelled Operations - Non Clinical - Cancellation Rate			0.67%	1.17%	0.85%	1.30%	1.29%	0.04%	0.00%	0.97%	1.61%	0.74%	0.85%	1.39%	0.61%	
Theatre Efficiency																
	Main Theatres		76.7%	75.0%	77.4%	78.7%	78.3%	76.7%	77.1%	77.9%	68.2%	73.4%	71.5%	73.3%	69.1%	
	TC Theatres		72.4%	68.2%	74.8%	70.7%	71.9%	72.4%	73.3%	71.3%	70.2%	71.5%	70.8%	68.1%	53.6%	
DNA (OP Efficiency)			6.00%	6.02%	6.57%	5.89%	5.61%	5.77%	5.70%	5.82%	6.12%	5.68%	4.92%	6.01%	4.87%	
Hospital Cancellation Rate (OP Efficiency)			7.90%	7.51%	7.36%	8.11%	7.70%	7.97%	7.69%	8.44%	7.93%	7.97%	8.36%	18.43%	41.50%	

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

Mid Cheshire Hospitals NHS Foundation Trust

TAP Committee
Chair's Assurance Report
May 2020

Report to	Board of Directors
Date	7 May 2020
Report from	Lorraine Butcher, Non-Executive Director
Report prepared by	Katharine Dowson, Head of Corporate Governance
Executive Lead/s	Heather Barnett, Director of Workforce and OD Chris Oliver, Chief Operating Officer Amy Freeman, Chief Information Officer
Committee meeting quoracy	Yes ☒ No ☐

KEY AREAS OF ASSURANCE

Impact of Covid-19 on Transformation & Workforce provided detail of how Covid-19 has been managed and the committee took assurance from the reports of Executives that the focus is now turning to getting back to business as usual. Transformation and workforce strategies will now be revisited in light of Covid-19.

- Silver Response to Covid-19 – presentation given which highlighted the operational response to Covid-19. From a workforce perspective, further work to be undertaken to understand the impact on staff, lessons learnt, and which innovations and good practice will be retained and built upon. This work will feed into a new transformation strategy, due this summer.
- The Committee will also look at national Covid-19 guidance in relation to workforce to ensure it receives assurance that all applicable guidance has been acted upon

Workforce Report

- Update provided which outlined the ongoing activity to support the workforce through homeworking, donations and health and wellbeing initiatives. Current focus is on returning staff to substantive posts from redeployment, encouraging staff to take annual leave and ensuring all staff are sufficiently risk assessed given the new guidance about increased risks to those with a BAME background.
- Nursing recruitment is a high priority for the business continuity work and the Trust is working to understand when international recruitment can resume as well as moving forward with recruitment for the nurse apprenticeship scheme in September. The Committee noted the increased interest in the nurse apprenticeship scheme and consideration will be given to the possibility of increasing the number of places available from the current 20

Digital Report

- Update provided on IT as an enabler for the Trust during Covid-19. More staff have been set up to work from home and workforce data has now been included in the data warehouse to enable submission of SITREPS. Video consultation for outpatient clinics has been established successfully. The demand on IT to support change and staff remains high.

KEY CONCERNS/RISKS

- **International Recruitment Plan 2020/21**: should international travel restrictions remain in place, delivery of the current Plan would be at risk. The Plan was being re-profiled and the risk assessment revisited
- **Priority Areas:** mandatory training and workforce data is a priority and TAP will receive a report at the next meeting in regard to how to build on the increase in use of online platforms, noting that there has been an unanticipated improvement in the uptake of mandatory training in April.

DECISIONS MADE

None

RECOMMENDATION

To note this assurance report.

We Care Because You Matter

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

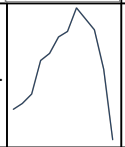
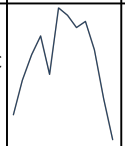
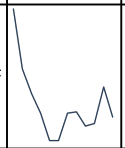
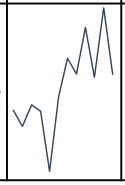
Board of Directors

Workforce Report

June 2020

(April 2020 data)

Performance Report Workforce Chapter
Month: Apr-20

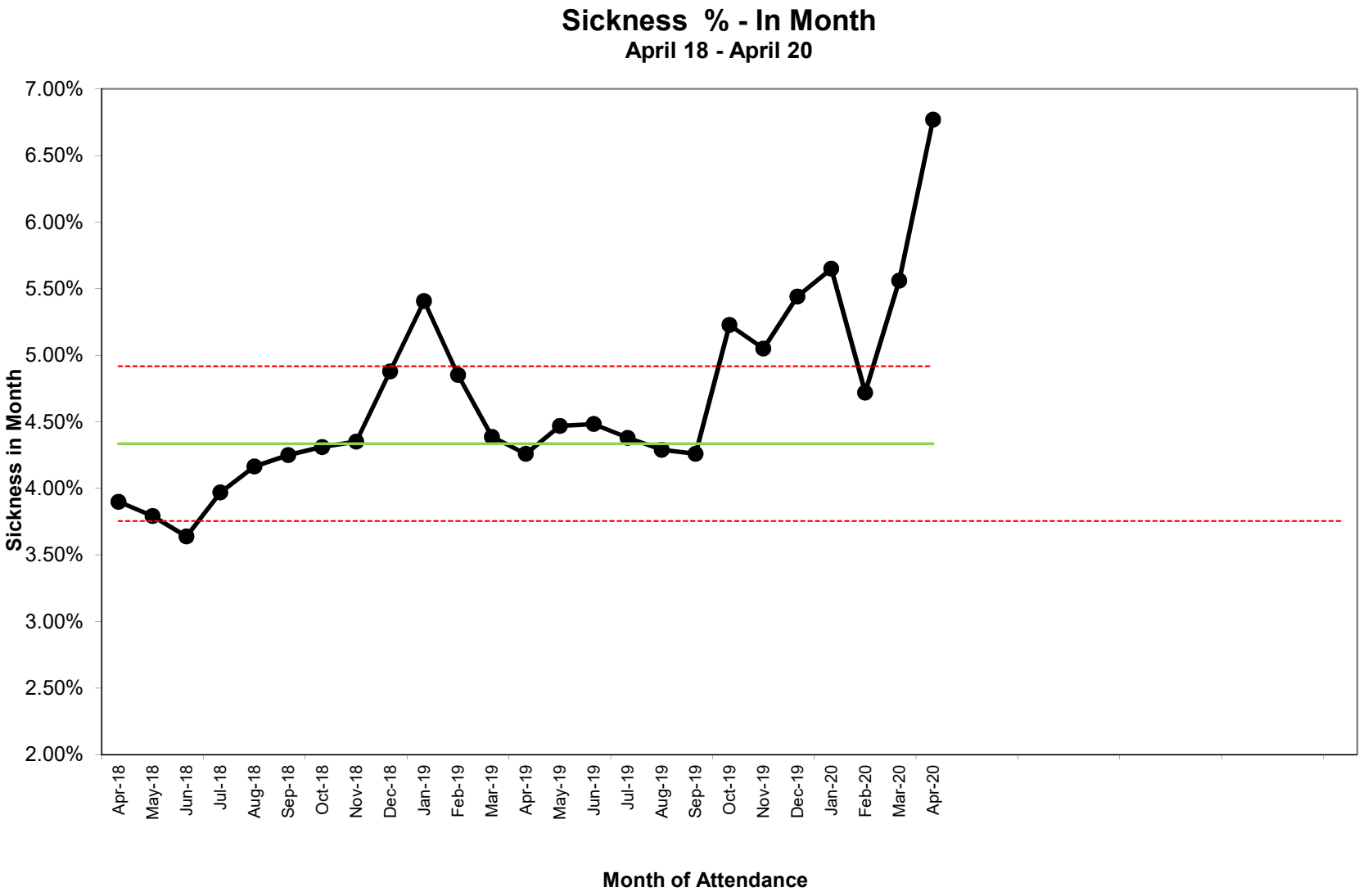
Measure	Target	Performance	Description	Narrative	Rolling Trend	Trend	C&W Average (Feb 2020)
In-Month Sickness Absence	N/A	6.77%	In-month Sickness Absence described as a Percentage	Sickness absence increased in all divisions with the exception of Corporate. The most significant increase was in EF (1.48%) followed by SC (1.43%). Corporate, MEC and EF are all now Red against target. Covid related absence peaked during April and this had a sigificant effect on performance.		↑	5.31%
Appraisal Rate	90.00%	78.82%	Percentage of Staff who have received an appraisal in the last 12 months. Excludes New Staff with less than 12m service and Bank Staff	Appraisal compliance dropped in April (-3.84%) across all divisios with the exceptio of WC. The most significant reduction was in EF (-14.16%) followed by Corporate (-7.01%). MEC remains Green against target, other divisions are now Amber or Red (Red- Corporate and EF).		↓	86.99%
Mandatory Training	90.00%	78.42%	Mandatory Training Monthly Rate Excludes Bank Staff, Staff on long term sick & mat. leave.	Mandatory training compliance dropped in April (-2.44%) across all divisions. The most significant reduction was in MEC (-4.42%) followed by WC (-3.05%).All divisios are now Amber or Red (Red- Corporate, MEC, SC and WC)).		↓	89.37%
Staff Turnover	10.00%	8.77%	Number of Leavers expressed as a percentage of the workforce over a 12m rolling period. Exclude Junior Doctors, Temporary and Fixed term.	Turnover increased slightly in month (+0.28%). All divisions experienced an increase in turnover with the exceptions of EF and WC. The most significant increase was in DCCS (1.21%)		↓	10.99%
Agency Spend	(403)	(705)	In month total spend for the Trust against plan	Agency spend reduced in April (-£250k). Nursing and Midwifery spend reduced by £166k and this contributed to the overall position. MEC agency spend was £219k. Corporate contributed to the agency spend usage by utilising £73k in month.		↑	N/A

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

Agency Spend Dashboard 2020/21

£ 000's

	March	April	May	June	July	August	September	October	November	December	January	February	March
Trust Level Summary													
Target Agency Spend	(404)	(403)	(403)	(404)	(404)	(404)	(404)	(404)	(404)	(404)	(404)	(404)	(404)
Actual Agency Spend	(955)	(705)											
In month Difference	(551)	(302)											
Cumulative Difference	(551)	(302)											
Breakdown of Trust Spend													
By Professional Group													
Medical & Dental	(264)	(187)											
Nursing & Midwifery	(573)	(407)											
Allied Health Professionals	(45)	(33)											
Health Care Scientists	(21)	(15)											
Healthcare Support Workers	0	0											
Admin & Clerical	(52)	(64)											
Other (i.e. Management)	0	0											
CCICP	(51)	(41)											
Diagnostics and Clinical Support Services	(98)	(58)											
Estates & Facilities	0	0											
Medicine and Emergency Care	(595)	(376)											
Surgery & Cancer	(138)	(144)											
Womens & Childrens	(41)	(13)											
Corporate Services	(32)	(73)											


Sickness % - In Month
April 18 - April 20
Sickness in Month
7.00%
6.50%
6.00%
5.50%
5.00%
4.50%
4.00%
3.50%
3.00%
2.50%
2.00%
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
Month of Attendance

Audit Committee
Chair's Assurance Report
11 May 2020

Report to	Board of Directors
Date	11 May 2020
Report from	Les Philpott, Non-Executive Director
Report prepared by	Katharine Dowson, Head of Corporate Governance
Executive Lead/s (Name & Title)	Russell Favager, Deputy Chief Executive and Director of Finance
Committee meeting quoracy	Yes ☒ No ☐

KEY AREAS OF ASSURANCE

- **Annual Governance Statement (AGS).** The CEO as the Trust's Accountable Officer presented the AGS. It sets out the approach and system for internal control and managing risk at the Trust and contained a judgement as to how these had been applied during 2019/20. The Committee agreed with the statement with one minor amendment
- **Board Assurance Framework (BAF):** The BAF for 2020/21 is currently under development and being aligned with revised strategic objectives following discussions about the Trust strategy by the Board earlier in the year. These were due to be discussed by the Board on 21 May.
- **Annual Report & Accounts – timetable**: it was noted that the Trust was on track but delays in national guidance to External Auditors due to Covid-19 might cause delays to the approval of the final document. However, it was noted that the national deadlines for final submission have been extended and the Trust was in the position to meet those deadlines
- **Impairment Review**: national guidance on wording is awaited to satisfy External Auditors
- **Conformance Report**: this illustrated compliance with Standing Financial Instructions
- **Head of Internal Audit's Report Opinion**: the Head of Internal Audit's report gave an opinion of substantial assurance for the 2019/20 year.
- **Anti-Fraud Bribery & Corruption**: the updated policy was noted and approved; assurance was provided through the Annual Report for 2019/20
- The Audit Committee members held a private meeting with the Auditors.

KEY CONCERNS/RISKS

Concern/Risk Identified

- Cyber-Security to be reviewed by Audit Committee in July.

DECISIONS MADE

- Audit Committee Annual Report for 2019/20 was approved
- Anti-Fraud Bribery & Corruption Policy was approved
- Cyber-Security to report to the Audit Committee

RECOMMENDATION

To note the attached assurance report.

Extra Ordinary Audit Committee
Chair's Assurance Report
21 May 2020

Report to	Board of Directors
Date	21 May 2020
Report from	Les Philpott, Non-Executive Director/Audit Chair
Report prepared by	Katharine Dowson, Head of Corporate Governance
Executive Lead/s (Name & Title)	Russell Favager, Deputy Chief Executive and Director of Finance
Committee meeting quoracy	Yes ☒ No ☐

KEY AREAS OF ASSURANCE

- **MCHFT Representation Letter:** External Auditor, KPMG, provided assurance that this was a standard response and content and did not reflect any concerns with financial management at the Trust.
- **External Auditors Year End Report 2019/20:**
  - The only issues of note raised by Auditors were those common to the sector as a whole, the committee took assurance that Auditors had identified no issues particular to the Trust
  - Auditors expect to issue an overall unqualified audit opinion in relation to the financial statements for 2019/20
  - As a Quality Report is not now required due to Covid-19, this would not form part of the audit opinion
  - **Value for money** to be an "except for" qualified opinion, due to the forward position in regard to sustainable resource deployment. Although the Trust would have continued to work to close the forecast deficit gap for 2020/21, auditors made a judgement at the point when financial planning was suspended by regulators in March. The sustainability question was not just about 2020/21 but the next 5 years and the financial position of the system not just MCHFT. Reassurance was provided by the Auditor who advised that this was a similar position for all regional non-specialist providers, and it was expected that all auditors would apply the same criteria
  - **Going Concern** is a national issue and an agreed form of wording is still awaited which would ensure that there were guarantees from the Department of Health and Social Care that interim emergency working capital would be available until June 2021 to support cash flow, if required by Trusts, given the uncertainty Covid-19 brings
  - Auditors encouraged the Committee to focus on interim arrangements in place to deal with Covid-19 to ensure efficacy and understanding of the financial impact of these
  - Auditors thanked the finance team for their support and co-operation and welcomed the flow of information and responsiveness. Auditors noted that MCHFT audit was the first of their clients regionally to have completed their audit of accounts with only national issues outstanding.
- **Annual Report & Accounts 2019/20:** the Committee suggested some of the key highlights could be emphasised more strongly, but the report nevertheless reflected the considerable

achievements of the past year and that the Committee would recommend that the Board of Directors approve it

- **Communication with Governors:** The Chairman and Governors would be appraised by the Audit Chair of the key points made by the External Auditor (going concern and value for money) and, at the same time, advised what to expect to see and when in relation to the Annual Report & Accounts. The Committee Chair would be writing to the Chairman and Governors to explain this and set out the next steps.

KEY CONCERNS/RISKS

N/A

DECISIONS MADE

- Annual Report and Accounts for 2019/20 recommended to the Board for approval

RECOMMENDATION

To note the report.

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**13**	Date of Meeting: 01/06/2020
Report Title	Quarter 4 2019/20: Board Assurance Framework	
Executive Lead	Murray Luckas, Medical Director	
Lead Officer	Sheila Kasaven, Associate Director, Quality Governance	
Action Required	To Note	

X	**Acceptable assurance** General confidence in delivery of existing mechanisms / objectives	☐	**Partial assurance** Some confidence in delivery of existing mechanisms / objectives	☐	**No assurance** No confidence in delivery

Key Messages of this Report *(2/3 headlines only)*

- The attached provides a position statement of the organisational risks for Quarter 4, 2019/20
- Report provides assurance of effective management of risks across the organisation

Impact *(is there an impact arising from the report on the following?)*

• Quality	✓	• Risk	✓
• Finance	✓	• Compliance	✓
• Workforce	✓	• Legal	✓
• Equality	✓		

Equality Impact Assessment (*must accompany the following submissions)*

- Strategy ☐ Policy ☐ Service Change ☐

Strategic Objective(s) *(indication of which objective/s the report aligns to)*

• Delivering outstanding clinical quality, safety & experience	✓	• Aspiring to excellence in practice through our workforce	✓
• Being a leading partner in a progressive health economy	✓	• Creating a 21st century infrastructure for transformative health and social care	✓
• Striving for outstanding organisational effectiveness	✓		

Governance *(is the report a…?)*

• Statutory requirement	☐	• Other	☐
• Annual Business Plan Priority	☐	*rationale for Board submission required:*	
• Strategic/BAF Risk	✓		
• Service Change	☐		

Next Steps (*actions following agreement by Board/Committee of recommendation/s)*

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

Board Assurance Framework 2019/20

Quarter 4

Summary Version

Delivering Excellence in Healthcare through Innovation and Collaboration'

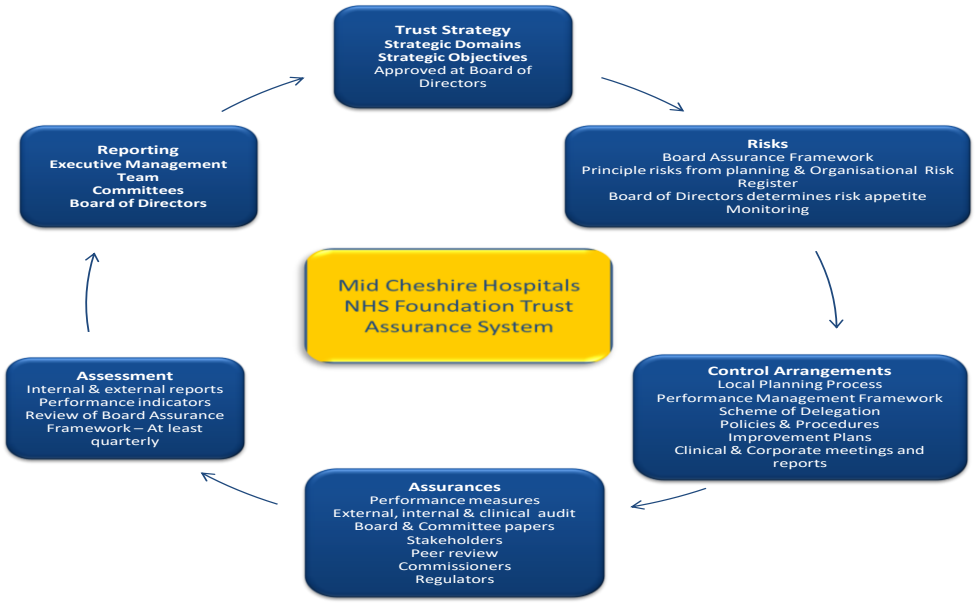
Contents

1. Background & purpose

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

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

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



2. Current position

During July and August 2017 the Board of Directors developed and approved the Trust's five Strategic Domains and underpinning Strategic Objectives, with associated success measures. The Trust Strategy 2017/18 with 2020/21 Horizon 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 4, 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 ⇔	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 ⇔	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 ⇔	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⇔	12⇔	E1,E2,P1,P2,T1,T2a,T2b
Obsolete IT Equipment	4(C) x 4(L) = 16	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 ⇔	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

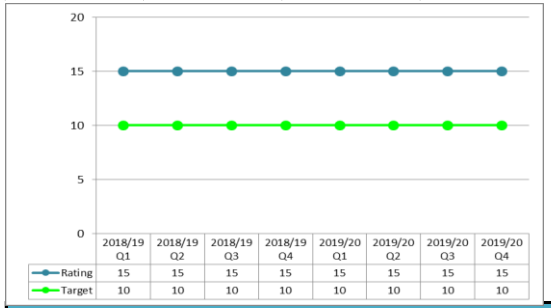
BAF Domain	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Q1	15			15			15			15		
Q2	10			10			10			10		
P1	12			16			16			15		
P2	12			12			12			15		
E1	15			15			15			10		
E2	16			16			16			16		
T1	15			15			15			15		
T2a	15			15			15			12		
T2b	12			12			12			12		
W1	15			15			15			15		
W2	15			15			15			15		
W3	15			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	20	20	20
TW0002 – Long Term Financial Sustainability of MCHFT	12	12	12	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	20	20	20
TW0004 - Registered Nurse staff shortages	16	16	16	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	16	16	16
TW0010 - Legacy Operating Systems Software	16	16	16	16	16	16	16	16	16	16	16	16
CS0380 - Obsolete IT Equipment	16	16	16	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	Mar 2020	Jun 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 4. 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 QI projects at ward level. The risk score remains the same due to the current gaps in establishments for Registered Nurses, difficulties in recruitment and 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?)

- Quarterly Quality reports and review meetings in all Divisions with a review of key risks at each meeting
- Embedding of Ward Accreditation Programme, QI projects and care evidenced by monthly metrics, including phase 2, ED and VIN.
- Scoping of the Quality Safety and Improvement Strategy (2020 - 2021).
- 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 27 wards on E-Roster - KPIs in development and assurance process in draft
- Successful attainment of CNST2 2019-2020, plans in place to achieve CNST3
- Internal Well-Led Review improvement actions – quarterly oversight at Quality Governance Committee review of quality metrics
- Improvement plan (2020) to be monitored at Quality Summit
- 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 2019/20 (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 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 BAF • 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: April 2019 90 day improvement plan - completed Management of Change being undertaken.
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 May 2020 • 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 - achieved.

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 2019/20 (How do we know if the things we are doing are having an impact?)			Gaps in Assurances on Controls / Influences (What additional assurances should we seek?)	Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)
		Local Management (1st Line of Defence)	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)		
4. Quality & Safety Improvement Strategy 2019-20 implementation	• Quarterly Quality Reviews • Implementation of new Quality & Safety Improvement Strategy 2020/21	• 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 across in-patient areas completed April 2019 • Quality metrics, monthly results to are displayed on wards from May 2019. • New Quality Boards in place - complete • QI Projects presented at Quality Summit by Ward Managers - 2019 • Quality metrics under review due to COVID 19. • COVID metrics developed - in place by May 2020
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 • CQC Good rating- May 2020 • Healthwatch feedback • Patient reps 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.**					
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 2019/20 (How do we know if the things we are doing are having an impact?)			Gaps in Assurances on Controls / Influences (What additional assurances should we seek?)	Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)
		Local Management (1st Line of Defence)	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)		
7. Risk Management Strategy & Framework 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 • Interim Governance arrangements approved March 2020 - to support COVID response
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- May 2020 • CCG contract meetings monthly Internal Audit Programme • Quality Account-April 2019	• Strengthen reporting and monitoring of QIA process	• Roll out of new QIA process approved in January 2020 via EQGG
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

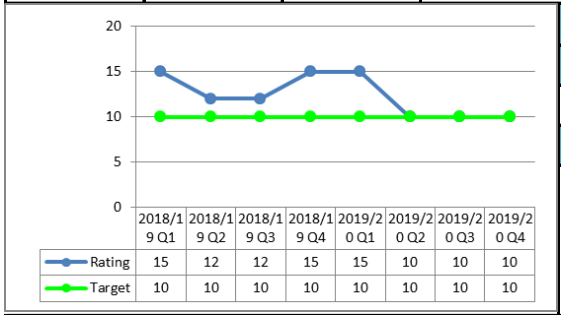
Strategic Domain 1: Delivering Outstanding Clinical Quality, Safety & Experience						
Q1	**To aspire to the delivery of 'Outstanding' clinical quality and safety, which is equitable, patient and family centred and supported by an effective quality governance framework.**					
Key Controls / Influences Established (What are we currently doing about the risk?)	Key Gaps in Controls / Influences (What additional controls should we seek?)	Assurance Providers 2019/20 (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 • Updated position and benefits report to EWAG - from May 2020

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	Mar 2020	Jun 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

The emergency pandemic response to COVID-19 has interrupted the development of the QI Faculty. However dealing with the pandemic has enhanced opportunities for QI methodology to be implemented at service delivery level.
The profile of Trust's Research Programme and Research Team has been boosted by involvement in national COVID-19 research studies.
Risk score has remained at 10 for Quarter 4. The likelihood of not improving the quality of care with all the key controls in place is unlikely.

Links to BAF objectives

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

Key Links to the Organisational Risk Register

TW0002 – Long Term Financial Sustainability of MCHFT	**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 2019/20 (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 • QGC Minutes • Monthly Quality, Safety & Experience Report • Quality Account-April 2019 • Monitoring of lessons learned from SJR process	• CQC Good rating • 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

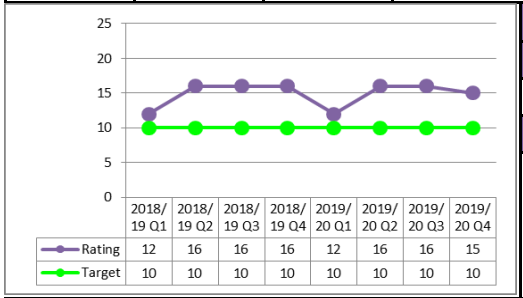
Strategic Domain 1: Delivering Outstanding Clinical Quality, Safety & Experience						
Q2	**To drive continuous quality improvement and promote research and innovation, whilst reducing unwarranted clinical variation and progressing from a 'Good' to 'Outstanding' organisation.**					
Key Controls / Influences Established (What are we currently doing about the risk?)	Key Gaps in Controls / Influences (What additional controls should we seek?)	Assurance Providers 2019/20 (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 - May 2020 • 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 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	Mar 2020	Jun 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	5	3	**15**	5	2	**10**	March 2020

Rationale for the Current Risk Score

The risk score has been decreased to 15 due to closer partnership working, the emergence of the Cheshire sysytem working together as a financial recovery planning footprint and collaboration at scale progress. Progress is also being made on the Cheshire East ICP. This risk has not reached its target rating as of yet but is progressing in that direction as of now.

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?)

There is now a programme delivery office in place across cheshire and clearer governance across the system. We are continuing this as best as possible during the Covid Pandemic and there are also regular CEO meetings which were not in place prior.

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

The key gap in controls remains the absence of signed agreements to the ICP developments, however this is in progress and being discussed by boards in June. There is also a requirement for deliver against the Cheshire FRP plans and this is still in early stages and not yet evident.

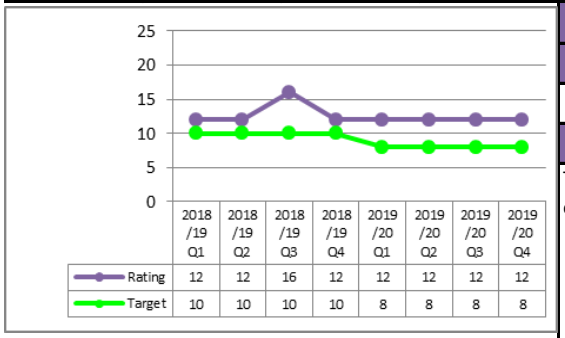
Strategic Domain 2: Being a Leading Partner in a Progressive Health Economy						
P1	**To fully engage with all strategic partners to maximise the opportunities and advantages associated with horizontal integration in the designing and delivery of sustainable health services for the population of Central 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 2019/20 (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	Mar 2020	Jun 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	5	3	**15**	5	2	**8**	March 2020

Rationale for the Current Risk Score

The risk score is currently at 15 due to the delays in progress due to the covid pandemic. Whilst the system is still on track, there is inevitable slowdown as operational priorities take centre view.

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?)

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 2019/20 (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		

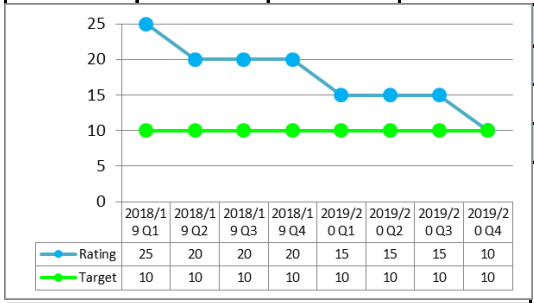
Strategic Domain 2: Being a Leading Partner in a Progressive Health Economy							
P2	**To work with all key stakeholders to deliver a wholly integrated health and social care system, taking on clear collective responsibility for resources and population health, so that our residents receive better coordinated 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 2019/20 (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	May 2020	May 2020	Well Led NHSI – Use of Resoruces	Deputy Chief Executive & Director of Finance	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	2	**10**	5	2	**10**	March 2020

Rationale for the Current Risk Score

At the end of 2019/20 the risk score has reduced to 10. The reason for this is that, after exceptional items, the Trust delivered a surplus of £407k for 2019/20 (£50k surplus pre exceptional items) and thus exceeded its financial control total and received an additional Incentive Financial Recovery Funding payment, termed deficit reduction of £2.367m. Looking forward the Trust and Cheshire Health system has an underlying financial deficit which will be picked up in the new Board Assurance Risks

Links to BAF objectives

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

Key Links to the Organisational Risk Register

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

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

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. Under the arrangements put in place in response to the covid 19 pandemic the trust is now on a block arrangement with its commissioners (calculated by NHSI/E) until at least the end of July but is likely to be until the end of Octover if not later. The national intention is that this should enable the Trust to breakeven on a monthly basis. Work on the longer term Collaboration at Scale continues. The Trust is also 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 was rated Good.Performance and Finance Committee review future plans including the draft 2020/21 Operational Plan.

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

- Finalisation of the Trusts Strategy and long term plan to accompany it to ensure the Trusts remains financially sustainable
- Pre Covid the Cheshire system had a financial gap of circa £100m in 2020/21 which was being addressed by the Cheshire system financial recovery plan. The collaboration at scale schemes and transformational changes required to support financial sustainability were being developed, but not all were in place.
- Internal Performance Management Framework within the Trust is 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					

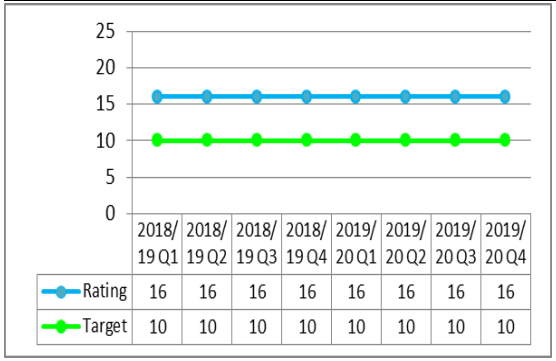
Strategic Domain 3: Striving for Outstanding Organisational Effectiveness							
E1	**To ensure full compliance with the NHS Improvement Provider Licence, ensuring financial sustainability, financial efficiency and financial controls, whilst safeguarding the quality of our services.**						
Key Controls / 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 • 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 Prog: • 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		Review by PAF – Completed June 2019
11. Cheshire system review						PcBC to be completed Transformation funding to support PcBC	

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

Principle Risk

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

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHSI Single Oversight F/w	Executive Director	Executive Management Group	Board Committee
June 2017	Mar 2020	Jun 2020	Responsive Care & Effective Care NHSI - Operational Performance Metrics	Chief Operating Officer	Divisional Finance & Activity Performance Group	Performance & Finance



	2018/19 Q1	2018/19 Q2	2018/19 Q3	2018/19 Q4	2019/20 Q1	2019/20 Q2	2019/20 Q3	2019/20 Q4
Rating	16	16	16	16	16	16	16	16
Target	10	10	10	10	10	10	10	10

Initial Risk Rating (Unmitigated)			Current Risk Rating (Mitigated)			Target Risk Rating (Tolerance/Risk Appetite)			
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Target Date
4	5	20	4	4	16	4	2	10	March 2020

Rationale for the Current Risk Score

Quarter 4 performance oversight metrics saw a decline from the improvement seen in Quarter 3, in part due to the impact of the early stages of the COVID-19 pandemic which saw a significant reduction in the Trust's elective programme. As attendance to ED reduced back to match workforce capacity during March 2020 the Trust's performance increased to 86% the highest level in 2019/20. The Trust delivered all Quarter 4 cancer metrics.

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. The report has not yet been widely discussed within the Trust due to impact of COVID-19, however, this will be addressed during 2020/21

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 2019/20 (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 2019/20 (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		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	• 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		
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.

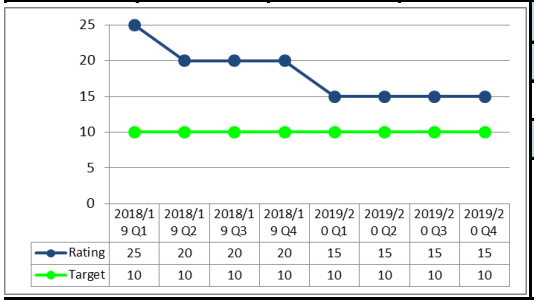
Strategic Domain 3: Striving for Outstanding Organisational Effectiveness						
E2	**To maintain compliance with, and aspire to achieve incremental improvements against, the NHS Improvement Single Oversight Framework Operational Performance Metrics, whilst safeguarding the quality of our services.**					
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 2019/20 (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	May 2020	May 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. In the last quarter of 2019/20 the Trust appointed an experienced full time Director of Estates and Facilities which will give extra capacity around the future Estates Strategy which is part of the Trusts Strategic Objectives for 2020/21. Despite there being a national over commitment of capital in 2020/21 the Trust continues to progress a pace plans around the future infrastructure which will deal with Victoria Infirmary, redevlopment of the Leighton site and the residences on the Leighton site.

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?)

Creating an Estates Strategic is part of the Strategic Objectives of the Trust and will thus be monitored regularly by the Board. The main challenge to delivering the Estate Strategy will be financial affordability, particularly as the Trust has long term backlog requirements. However the Trust is dealing with partners such as local Council, Universities, Commissioners and NHSI around solutions to this issues. Much of the community estate is bound by long term lease agreements which add complexity. The Executive Infrastructure Development Group, which reports into the Performance and Finance Committee and the Business Continuity Group which reports in the Executive Group continue to monitor progress around these startegies. Additionally there are various local and regional estates groups looking at potential collaboration between organisations, these include those led through the HCP 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.
Defective planks - Risk Assessment in progress and being montiored by NHSI

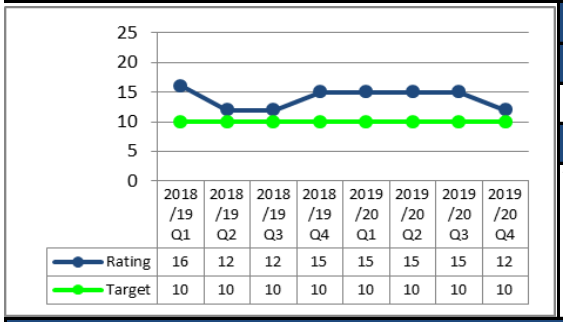
Strategic Domain 5: Creating a 21st Century Infrastructure for Transformative Health and Social Care						
T1	**To deliver an agreed, costed and phased Estates Strategy which will make the best use of the Trust's estate taking into consideration the entire estate across the Central Cheshire system, national 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 2019/20 (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	4	12	3	2	10	March 2020

Rationale for the Current Risk Score

The risk likelihood score has reduced to 4 from 5 for Quarter 4, due to business case approval from both NHSI Regional and National teams.
Current risk rating has therefore reduced to 12.

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.

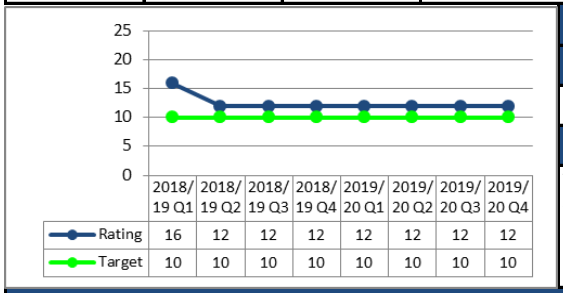
Strategic Domain 5: Creating a 21st Century Infrastructure for Transformative Health and Social Care							
T2a	**To deliver an agreed, costed and phased Information Technology (IT) Strategy which supports the provision of seamless, integrated, outstanding patient care, improves staff experience in delivering 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 2019/20 (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	Mar 2020	Jun 2020	Well Led Framework Use of Resources	Medical Director	Information Technology Strategy Group	Performance & Finance



	2018/19 Q1	2018/19 Q2	2018/19 Q3	2018/19 Q4	2019/20 Q1	2019/20 Q2	2019/20 Q3	2019/20 Q4
Rating	16	12	12	12	12	12	12	12
Target	10	10	10	10	10	10	10	10

Initial Risk Rating (Unmitigated)			Current Risk Rating (Mitigated)			Target Risk Rating (Tolerance/Risk Appetite)			
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Target Date
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 4, on the basis that the Clinical Systems Strategic Outline Case has been approved by NHSI to move to the next step.

Links to BAF objectives

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

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

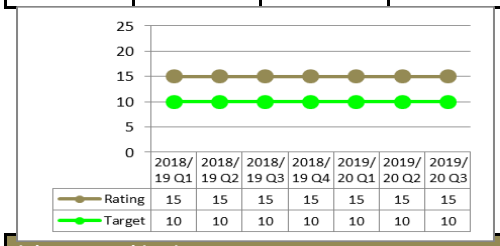
Strategic Domain 5: Creating a 21st Century Infrastructure for Transformative Health and Social Care							
T2b	**To deliver an agreed, costed and phased Information Technology (IT) Strategy which supports the provision of seamless, integrated, outstanding patient care, improves staff experience in delivering 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 2019/20 (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	Mar 2020	Jun 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 complete, this maximises our 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 complete
- 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 2019/20 (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 2. Our Workforce Matters Strategy to be fully implemented		• 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 (TAP) Committee (Minutes) • Board of Directors • Monthly Workforce Report • Annual Report on the Appraisal and Revalidation of Medical Practitioners at MCHFT • Workforce Race Equality Scheme Annual Review • Strategic Nursing & Midwifery Staffing Review • 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 • National Staff Survey • Health Education England reviews. ED/Training self-assessment • 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 Q4 2019-20. 5. ESR system project in place 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	

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 2019/20 (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 • 1:1 / Team Meetings • Divisional Workforce Groups • Monthly Divisional Boards/CCICP reports	• 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 • Workforce Race Equality Scheme Annual Review • Strategic Nursing & Midwifery Staffing Review • 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 • National Staff Survey • Health Education England reviews. ED/Training self-assessment • 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					

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 2019/20 (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 • Monthly Quality, Safety & Experience Report (Nurse staffing) • Annual Report on the Appraisal and Revalidation of Medical Practitioners at MCHFT • Workforce Race Equality Scheme Annual Review • Annual Equality & Diversity Report • TAP Minutes • Multi-Disciplinary Workforce Strategy Group	• Sub Regional Workforce Planning and Development Network • Staff Survey • Health Education England reviews. ED/Training self-assessment • 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
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					

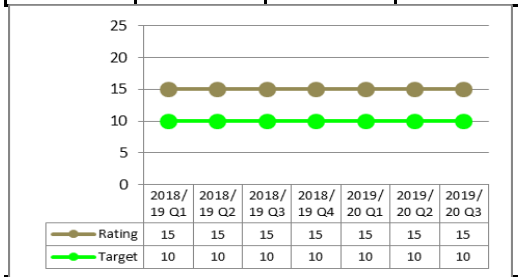
Strategic Domain 4: Aspiring to Excellence in Practice through Our Workforce							
W1	**Our cadre of patient centred leaders will be skilled in continually promoting and building upon our open and honest culture. This will be achieved through sharing the Trust's vision, values, behaviours and objectives 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 2019/20 (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'	Divisional Workforce Groups	Transformation & People Committee	National Staff Survey		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	Mar 2020	Jun 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.
- 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.

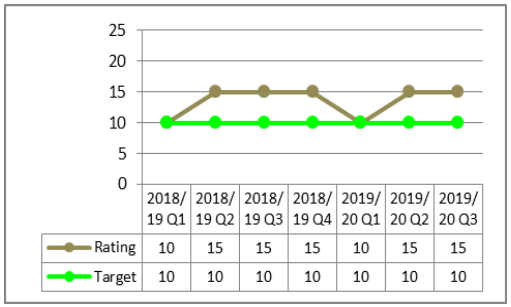
Strategic Domain 4: Aspiring to Excellence in Practice through Our Workforce							
W2	**We will have in place a flexible and responsive workforce to meet patient needs by ensuring:** **- We have sufficient workforce numbers, with the right skills, in the right place, at the right time to meet the demands 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 2019/20 (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 • Workforce Race Equality Scheme Annual Review • Guardian of Safe Working Hours Report • Annual Report on the Appraisal and Revalidation of Medical Practitioners at MCHFT • Multi-Disciplinary Workforce Strategy Group	• Sub regional workforce planning and development network • Staff Survey • Health Education England reviews • Chester College Reviews • Local Workforce Assurance Board – QA Process • GMC Survey: Junior medical staff		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	Mar 2020	Jun 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 2019/20 (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 • Equality Delivery System Self-assessment: Achieving • Freedom to Speak Up Guardian Report • 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 • National Staff Survey • 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 (2020-1 year accreditation) • CCG contract meeting CQUIN Health & Well Being MIAA Internal Audit Programme • 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 completed – will be reviewed again August 2020. • Staff survey 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	8% 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?

REPORT DEVELOPMENT

Committee / Group Name	Date	Report Title	Lead	Brief summary of key issues raised and actions

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**14**	Date of Meeting: 01/06/2020
Report Title	Quarter 4 2019/20: Organisational Risk Register	
Executive Lead	Murray Luckas, Medical Director	
Lead Officer	Sheila Kasaven, Associate Director of Quality Governance	
Action Required	To Note	

X	**Acceptable assurance** General confidence in delivery of existing mechanisms / objectives	☐	**Partial assurance** Some confidence in delivery of existing mechanisms / objectives	☐	**No assurance** No confidence in delivery

Key Messages of this Report

- The attached provides a position statement of the organisational risks for Quarter 4, 2019/20
- Report provides assurance of effective management of risks across the organisation

Impact

• Quality	✓	• Risk	✓
• Finance	✓	• Compliance	✓
• Workforce	✓	• Legal	✓
• Equality	✓		

Equality Impact Assessment

• Strategy ☐ Policy ☐ Service Change ☐

Strategic Objective(s)

• Delivering outstanding clinical quality, safety & experience	✓	• Aspiring to excellence in practice through our workforce	☐
• Being a leading partner in a progressive health economy	☐	• Creating a 21st century infrastructure for transformative health and social care	☐
• Striving for outstanding organisational effectiveness	☐		

Governance

• Statutory requirement	✓	• Other	☐
• Annual Business Plan Priority	☐		
• Strategic/BAF Risk	✓		
• Service Change	☐		

Next Steps

REPORT DEVELOPMENT

Committee / Group Name	Date	Report Title	Lead	Brief summary of key issues raised and actions
EQGG	15/04/20	Q4 2019/20: Organisational Risk Register	Sheila Kasaven	No issues/actions raised
QGC	11/05/20	Q4 2019/20: Organisational Risk Register	Sheila Kasaven	No issues/actions raised

Quality Governance

Organisational Quarterly Risk Register Report

Report date: 01/01/2020 to 31/03/2020

Mid Cheshire Hospitals NHS Foundation Trust

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.

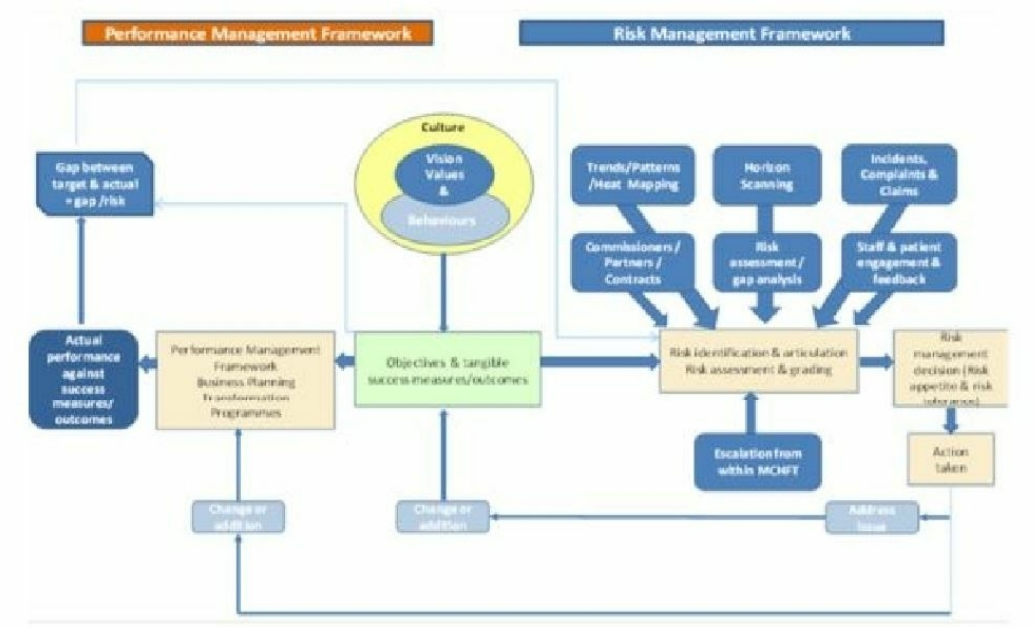
KPMG provided internal audit opinion for 2018/19. The outcome from this audit was 'Significant assurance with minor improvement opportunities'. The audit covered:

• 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.

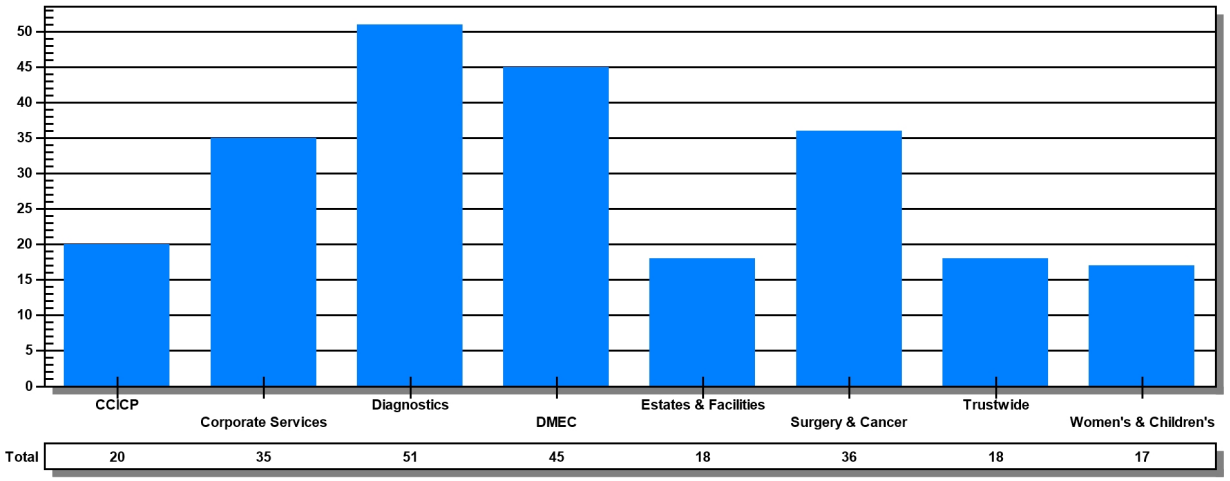
Priority	Key areas 2017/19	Position	Commentary
1. New Risk Management Strategy & Framework 2017/20	• Categorisation matrix review (Part of the Incident Report & Management Policy)	Completed	• Executive Quality Governance Group (EQGG) December 2017
	• Revise Risk Assessment Procedure	Completed	• Planned 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**

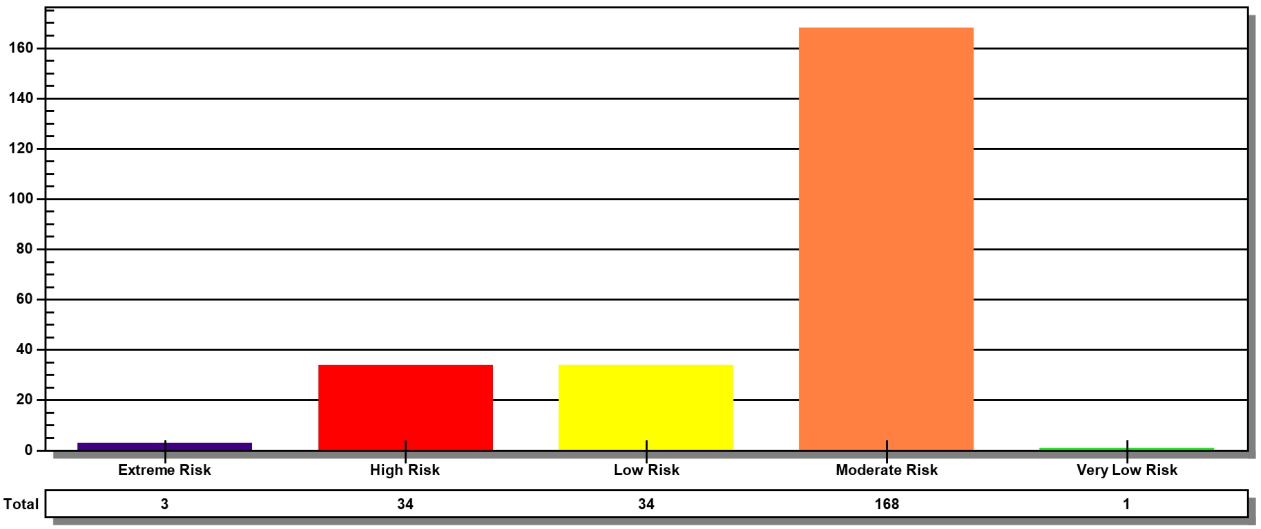
6. Five Key Risks for the Trust in 2019/20

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 ▶	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 ▶	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 ▶	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 ▶	12 ▶	E1, E2, P1, P2, T1, T2a, T2b
Obsolete IT Equipment	4 (C) x 4(L) = 16	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

Ref.	Title	Division	Risk Score	Risk Rating	Target
DC1070	Insufficient Biomedical Scientific Staff Resource to Provide a Quality Haematology & Blood Transfusion Service at Macclesfield Hospital.	Diagnostics	16	High Risk	4
TW0028	COVID-19 Pandemic	Trustwide	15	High Risk	10

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.	1. Post endoscopy procedure the case notes are held within Endoscopy Services until the endoscopy report is received and signed off by the Endoscopist/Consultant. 2. A number of controls have been developed by the Diagnostics and Clinical Support Services as reference within risk assessment - DC0887 3. A recently appointed Consultant Histopathologist specialises in breast and GI 4. Current recruitment campaign to appoint 2 Specialty Doctors 5. Awaiting start date for LED 6. Network progressing with UHNM - to include joint recruitment; new automation to reduce TATs and digita pathology 7. Two technical staff (an Advanced Practitioner (AP) and a Senior BMS in Tissue Dissection) perform specime dissection; The latter is progressing towards AP status. 8. 1 Additional pathology staff member is undergoing upskilling in the role of dissection. 9. Cellular Pathology Business Continuity plan for Histopathologist absence (insert BCP) 10. SLA with external reporting provider; KPIs relating to this Contract 11. Business Continuity Plans include use of external Pathology Services for reporting 12. Part time Locum Consultant Histopathologist undertaking 1 afternoon per week reporting 13. Further communication via trust information system. 14. Bowel cancer screening program cases are processed and reported at the Countess of Chester Hospital, Chester. 01/2020 the position is showing that sample turnaround is currently achieved as: 7 day - 44.1 % compliant The college standard is - 80% 10 day - 62.4 % compliant The college standard is - 90% 20 days - 92.7 % compliant The college standard is - 100% 42 days - 99.5 % compliant -	20 4 x 5	Manager	4. Additional training for Consultant Histopathology staff to support gastrointestinal requirements are under development.	30/10/2020	8 4 x 2	The risk has been reveiwed and updated where required.	19/10/2020
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	30/09/2020	10 5 x 2	15/04/20 - delay in RMS review due to COVID-19 Pandemic	10/03/2020

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			
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

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 cases. - 1 WTE Band 8A Biomedical Scientist Advanced Practitioner and 1 WTE Band 7 (dissector) employed to free up Consultant time. - 1 Specialist BMS recruited, competent to dissect Category B & C specimens. - 2 Speciality Doctors recruited.	16 4 x 4	Manager	2 Ongoing recruitment campaign for substantive Consultants. 1 Joint recruitment process with University Hospital of North Midlands (UHNM): International recruitment being undertaken. 6 Further BMS staff are to be trained in dissection of non-complex specimens.	31/03/2020 28/02/2019 30/09/2020	8 4 x 2	Risk assessment reviewed and updated. new version created to reflect updated controls/gaps in controls and action updates.	19/08/2020

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			
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	Divisional General 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
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
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

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			
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	7 Telemetry standard operating procedure (SOP) to be updated	31/03/2020	2 2 x 1	Actions updated with Matron Jenkins	24/05/2020
EF0505	23/01/2019	Loss of Mechanical Infrastructure and Associated Resources: Leighton Hospital	There is a risk that utility pipeline equipment (expansion bellows, valves and actuators ect) connected to the Trust water, steam, or heating system may fail as a result of age, condition and no PPM(Including the regular exercising of valves) being carried out on which may lead to one of the major distributed services being unavailable within wards & departments?	Ongoing replacement programme in place Reactive 24/7 Estates maintenance staff on site Trust staff report new issues via Estates Helpdesk for further investigation/action Planned and "ad hoc" removal of asbestos from identified areas ongoing in order to allow isolation of faul valves/components for replacement or repair.	16 4 x 4	Head Of Estates	1 Continued repair or renewal of all existing valves/components etc. to be completed during refurbishment programme Planned Preventative Maintenance schedule for the inspection and maintenance of all valves/components (after asbestos has been removed).	23/01/2020	4 4 x 1	Work to replace valves and leaks in Cal House ongoing. Capital design on new works suspended due to ED works and now Covid-19 situation and othere clinical projects.	30/06/2020
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	Assessment reviewed and no change to assessment at this time	30/06/2020
SC0535	30/11/2014	Insufficient staffing within Inpatient locations	There is a risk that there may be insufficient registered nursing staff within the surgical inpatient locations, to fully meet the needs of patients, due to a high vacancy factor. This may lead to adverse patient outcomes.	1. Minimum staffing levels agreed within division for inpatient locations. 2. Escalation of staffing issues to designated divisional co-ordinator 3. Escalation to Clinical Site Manager or Hospital at Night Team out of hours 4. Escalation to Senior Manager on-call if remains a risk/patient safety issue 5. Local, divisional review of all staffing incidents, reported via the incident reporting system, with wider corporat oversight 6. Two whole time equivaalent staff were offered and accepted posts at the Feb. 2019 Recruitment day to start in May 2019. 7. The organisation has decided to proceed with the option of internal recruitment of Registered Nurses to support MCHFT vacancy gaps. 8. UK adaption program due to complete end 2019 which should generate x5 Registered Nurses	16 4 x 4	Surgical Matron	4 Utilising the investment agreed at Executive level to support the introduction of 12 hour shift patterns in to the Surgery & Cancer Division 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 10 Successful recruitment to registered nurse vacancies within the division.	30/09/2019 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.	30/09/2020
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	30/09/2020 30/09/2020 31/03/2020 30/09/2020	8 4 x 2	The risk has been reviewed and the action plan updated.	19/07/2020

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			
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: a. All sites to consider plans for the successful implementation and delivery of the FIT Programme to negate the need for waiting lists. For instance: 1. Secure additional Assessment Clinic for those who have a positive FIT test 2. Secure additional Screening Colonoscopy Sessions for those who attend the assessment clinic and wish to go on to screening colonoscopy 3. 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. 4. Secure additional pathology resource for the additional specimens expected following FIT Implementation. 5. Use of accredited screening Colonoscopist's flexibly and from other sites - COCH, Macclesfield and UHNM 6. Use of accredited screening Colonoscopist's to deliver Bowel-scope b. Consider reinstating Endoscopy Waiting List sessions at the 'old rates'- Compleetd 09/20-19 c. Create Honorary contracts for additional screening Colonoscopist's to undertake sessions at our sites -completed 09/2019	30/10/2020	6 3 x 2		30/09/2020
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 2 Convert outpatient activity to theatre activity (dropped lists from other sub-specialties) 3 Identify what if any additional funding is required to support additional theatre capacity 4 Submit paper for 6th Consultant Urological Surgeon investment for 2020/21 (annual planning process)	30/11/2019 30/11/2019 30/11/2019 30/11/2019	12 4 x 3	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
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	30/06/2020	9 3 x 3		13/07/2020

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			
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	Head Of Nursing	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
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

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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
CS0314	28/04/2015	Trustwide Fire Risk Assessment - Regulatory Compliance with the Regulatory Reform (Fire Safety) Order 2005	There is a risk that fire and smoke will spread in the event of a fire as a result of breaching in compartmentation and sub-compartmentation in some wards and departments which may lead to adverse impact on the safety of patients, visitors or staff.	1. Fire Safety Policy incorporating the Fire Safety Strategy 2. Employment of competent persons in relation to fire safety arrangements 3. Fire Safety Management Group who attend Bi- monthly meetings 4. Programme of fire risk assessments for all locations prioritised according to risk 5. Refurbishment programme in place upgrading Wards to required compartmentation standards by 2023 6. Capital programme which ensures locations other than Wards are brought up to current standards when they are refurbished 7. Competant advise provided/sought at planning stage of any refurbishment/construction work 8. Access to Fire Engineers when required 9. Verification of fire stopping/compartmentation undertaken in refurbished areas 10.Inventory of fire stopping undertaken in refurbished locations. Inventory of fire and smoke dampers in refurbished locations 11.Management of Fire Safety Assessment completed by Ward/Department Managers 12.Automatic fire alarm and detection system linked to an Alarm Receiving Centre (L1 detection in high risk areas and L2 in lower risk areas) 13.Statutory testing of the fire alarm and detection system 14.All fires and automatic fire alarm activations investigated and learning identified and progressed 15.5 year fixed electrical testing programme 16.Thermal Imaging undertaken in locations where is not possible to undertake 5 year fixed installation testing 17. Portable Appliance Testing (PAT) 18. Hydrants 19. Dry riser provision 20 .Pre-Planned Maintenance Programme in place which includes fire doors, aspirators, fire-fighting equipment etc. 21. Fire Evacuation Procedure containing Fire Action Cards for Continuous and Intermittent Alarm events and arrangements for evacuation to internal Holding Areas and external Muster Points 22. Fire Response Teams (Leighton and VIN) 23. Emergency Lighting and signage on all evacuation routes and at final exit doors 24. Emergency Lighting testing 25. Fire Extinguishers and Fire Blankets positioned appropriate to risk 26. Evacuation Aid Equipment (Albac Evac Mats and Evac Chairs) provided in Wards with external fire escape routes and staff in those areas trained appropriately 27. COSHH Procedure 28. COSHH Assessors who undertake COSHH Assessments of which include flammable substances 29. Flammable substances stored within required flammables cabinets 30. Smoking Policy 31. Work Equipment Procedure 32. Full training programme incorporating Induction for new staff, local Induction (Fire Orientation Checklists) for all staff, and Statutory and Mandatory training (annually for clinical staff and trii-ennial for non-clinical staff), programme of fire drills. 33. Fire Wardens trained in the use of fire extinguishers and who undertake Fire Warden Inspection on a monthly basis 34. Fire extinquisher contract to meet Trust needs in place, including additional CO2 extinguishers in high O2 use locations 35. Firesafe nozzles purchased to be fitted on O2 pipelines which will fail safe in the event of a fire cutting off the oxygen supply 36. Programme of Fire Extinguisher training developed and commenced 37. Fire Safety Manuals in place in each Ward/Department, Trust Major Incident Plan in place. 38. System in place with Procurement which ensures compliance of the purchase of fire retardant materials in line with Healthcare Technical Memorandum. 39. Contract for the maintenance of fire fighting equipment. 40. Ad-hoc observations of effectiveness of cause and effect of automatic door closure upon attendance at locations where unwanted alarm activations occur 41. Monthly Fire Warden inspections which include checks on automatic door closure within wards and departments (excludes Hospital Streets) 42. Cause and effect testing only undertaken upon wards and departments being refurbished (prior to re-occupation following works) and no Trust wide plan for C&E in line with HTM	15 5 x 3	Head Of Health & Safety	1 Non-refurbished wards will need to re-furbished to current fire standards. 2 Inventory of all fire stopping and all fire and smoke dampers is required. All wards and other locations subject of a refurbishment are marked on verified fire drawings. All sleeping risk areas are due for completion by 2023. A risk based approach in line with the Capital Programme for all other areas is required and be ongoing. 3 Develop and implement a maintenance programme for fire and smoke dampers in refurbished locations 4 Establish a programme of Cause and Effect testing 5 Refurbishemnt of Old South Cheshire Hospital 6 Establish costs for initial audit by a fire engineer (Authorised Engineer) 7 Review feasibility of assessing Street door closures weekly in line with HTM 8 Establish costs to fulfilTrusts requirements of the role of Authorising Engineer based on findings of the initial audit 9 Fire safety nozzles to be fitted in all locations where high levels of O2 treatment place	31/12/2023 31/12/2023 30/12/2023 30/05/2020 30/12/2020 30/05/2020 30/12/2020 30/07/2020 30/05/2020	5 5 x 1	21/04/20 review and updated by WAR. Risk rating raised to 15 with repsect of acquisition of the Old South Cheshire Hospital site	01/11/2020

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DC1044	14/11/2018	Laboratory Information Management System (LIMS) for Pathology - End of Life	There is a risk that LIMS could fail, as a result of Clinisys the supplier, sunsetting (gradual phase out) the LIMS from 2022, which may lead to an adverse impact on clinical outcomes.	1. Upgrade to the latest version of Labcentre i.e. version 1.14 in October 2018. This upgrade includes all National Standards/guidelines to date. 2. Full maintenance/support currently being provided by Clinisys. 3. Visits commenced to other institutions to identify possible replacement LIMS and demos organised with Suppliers.	15 5 x 3	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	Divisional General 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. 6 Current review of skill mix being undertaken. Development of apprentice roles to start in Sept 2020. Job matching paper work completed to recruit a Band 5 to address the most pressing risk of tape analysis.	29/05/2020 30/04/2020 29/05/2020 28/02/2020 30/10/2020 19/03/2020	5 5 x 1	Risk reviewed with the Cardio-Respiratory Dept. Service Manager and new version created to reflect the updates.	27/02/2020
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	Divisional General 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

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DC1069	04/12/2019	Clinical Haematology Service	There is a risk that patient care may be delayed or compromised due to current service pressures in Clinical Haematology which may lead to patient harm.	1. Interim service support from Pathology Manager, Dermatology PA, and Patient Access Manager 2. Increased Clinical Lead engagement 3. Review and validation of patients waiting 4. Clinical prioritisation of patients by clinical lead 5. Additional Clinical Capacity 6. Weekly meetings with clinical lead to maintain links and prioritise focus. 7. Using B7 Vacancy to fund adhoc Agency for Chemotherapy patients to reduce waiting times. 8. Relocation of Registrar clinics to Macmillan unit - with access to Chemocare 9. Recruitment process for CNS post, Band 6 10. Ongoing review of administration systems and processes.	15 5 x 3	Manager	1 Review of the Clinical Haematology Service 2 Review of the SLA with UHNM 3 Actively seek to recruit Band 6 CNS. 4 A business case is to be developed to extend the Chemotherapy Unit hours.	30/04/2020 30/04/2020 28/02/2020 30/04/2020	5 5 x 1		03/01/2020
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	25/05/2020
EC0451	22/04/2020	The provision of escalated ventilator support in response to COVID-19 National Emergency	There is a risk that Mid Cheshire Hospitals may need to escalate its Critical Care provision to provide ventilated respiratory support as a direct response to the clinical needs of patients presenting with respiratory failure as a result of exposure to the COVID-19 virus which may lead to MCHFT developing additional capacity for Critical Care support which may require the temporary sensation of other Major Incident capacity e.g. emergency theatre provision.	1. The Critical Care has a Business Continuity Plan but this does not take into account the need to respond to a National Emergency. 2. Trust Major incident plan does not account for the response to a National Emergency 3. The Surgery & Cancer Business Continuity plan covers the provision of emergency surgery within a Major incident response.	15 5 x 3	Head Of Nursing			10 5 x 2		22/05/2020
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 replacement work started but now suspended due to Covid-19. General replacement of Domestic hot & cold water delayed due to ED work, Covid-19 and othere clinical projects	30/06/2020
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 in Sep 19 was only a partial survey due to cost. New Head of E&F to review situation and determine course of action	30/06/2020
GY0272	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	Currently in middle of Covid Pandemic. Gaps have been solved by Juniors now working an emergency rota which is more intense. Predicted to have juniors rotate in August 2020. Unsure of numbers at that point. At present risks are mitigated through doctors working different patterns. This is not sustainable due to intensity, unable to take annual leave and lack of training.	20/08/2020

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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
SC0642	15/04/2020	The use of temporal artery thermometers within the Eye Care Centre (ECC) in response to COVID-19	There is a risk of the possible exposure of staff to the COVID-19 virus due to the need to check the temperature of all patients attending the ECC to reduce the risk of positive COVID-19 patients coming into contact with the ECC staff and patients awaiting clinical review.	1. There are posters at each entrance instructing patients not to come to hospital if they are exhibiting COVID-19 symptoms 2. The trust text reminder service also supports instructing patients not to come to hospital if they are exhibiting COVID-19 symptoms 3. The temporal artery thermometer is less effective than the standard tympanic thermometer but offers an increased level of protection for staff in relation to COVID-19 4. Patients are being screened and no delivery of care is based on the results of their temperature. 5. The outpatient processes include a check on patients who have symptoms to confirm if their appointment is urgent enough to go ahead even with symptoms 6. Approval for use has been agreed and authorised by the COVID-19 Outpatients Planning Group 7. Staff will wear approved personal Protective equipment (PPE) in line with local and national guidance for COVID-19 8. That any patient highlighted to have a temp and still needs to be urgently seen is then seen in isolated	15 5 x 3		1 Develop a Planned Preventative Maintenance (PPM) program to ensure that temporal Artery Thermometers operate within agreed ranges as referenced within the manufacturer's instructions 2 Ensure all staff are taught to operate the thermometer in line with the manufacturer's instructions and there training is appropriately recorded. 3 Ensure the devices are checked by Medical Engineering prior to use and have a PPM schedule implemented. 4 The temporal artery thermometer is to be added to the medical devices log for the department and all staff are to be trained in its safe and effective use.	30/04/2020 30/04/2020 30/04/2020 30/04/2020	5 5 x 1		30/09/2020
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	30/10/2020 30/09/2020 30/10/2020	6 3 x 2	06/05/20 No changes to risk rating at present, actions in progress	04/08/2020
TW0028	18/03/2020	COVID-19 Pandemic	The Trust is not able to cope with a pandemic and will not be able to sustain its normal operational services, due to widespread infection across staff, patients and visitors from COVID-19, which may lead to the invoking of business continuity plans and a declaration of an internal major Incident.	CONTROLS: Operational: 1. Daily tactical meeting to oversee all potential and actual risks as well as operational changes required - using up to date PHE and Government direction/guidance 2. Trust operations changed in line with Government/PHE/National advice 3. Opening of isolation wards - surveillance and COVID+ve wards 4. Site bed meetings to review patient impact and moves across the hospital 5. Early swabbing and communication with care homes for discharge process to prevent delays in discharging care home patients back to their residences due to a change in policy that requires a negative swab before discharge 6. Communications through social media advising that patients should still attend ED to prevent patients being at higher risk of deterioration from non-covid conditions due to presenting very late to ED 7. Routine elective surgery delayed 8. Outpatient appointments and flow reviewed 9. Oncology service reviewed 10 The Trust has been divided into red, amber and green areas: Red - are areas that are 'high risk', such as Critical Care/Respiratory Assessment Unit (ED), Amber - are areas for patients symptomatic of Coronavirus , Green -are areas for a-symptomatic patients Communication: 11. Regular staff communication - at least once a day, as incidents occur and advice from PHE /Government is released 12. Clear capacity for all staff that communicates National guidance re: Social distancing (EC0448 / SC0642 / DC1073) Environment:	15 5 x 3	Chief Operating Officer	4 10. Development / Updating of Divisional / Departmental Risk Assessments / BCPs / Quality Improvement Plans related to COVID-19. These will aid the recovery process to ensure that the Trust is able to resume normal service asap. 7 13. Use Anaesthetic machines as Ventilators 8 14.Use of CPCP machines to assist breathing to reduce use/need of ventilators 9 15. Divisions to capture changes required to BCPs in preparation of updating them after the incident. Assurance that changes and updates have been made will be managed via the Emergency Preparedness Group	30/05/2020 30/05/2020 30/05/2020 30/10/2020	10 5 x 2		24/05/2020

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Ref	Initial Date	Title	Description	Controls	Current Rating	Owner	Actions		Target Rating	Progress Update	Next Review Date
							Description	Target			
				13. Restricted visiting 14. Maximise respiratory support capacity through environment of oxygen supply (EC0450/ EC0449/ EC0451) and available equipment. PPE: 15. PPE stock overseen and ordered as soon as low numbers identified - escalation procedure in place 16. PPE fit testing in place and an upscaling of staff plan in place 17. Clear guidance (National PPE guidance) for staff on levels of PPE to be used for COVID positive/suspicion 18. PPE grab bags to be located for incidents of CPR on positive patients 19. FFP2 masks to be used in replacement of surgical masks in line with MCHFT Standard Operating Procedure for the use of FFP2 Masks. Use of these masks will give staff better protection on COVID and surveillance wards, and is above the national guidance. 20. The Trust will continue to accept donations of PPE from private sources. The risk of not having sufficient PPE whilst there is a national demand outweighs the risks of coming in from outside the Trust procurement process/supplies lines Staffing: 21. All frontline staff have been risk assessed in line with National Guidance, using the "Individual Staff Risk Assessment Checklist for COVID-19, Pregnant or Other At-Risk Staff Groups" document from Cheshire Occupational Health 22. Swabbing of symptomatic staff, or family members, to aid staff in returning to work as soon as possible Training: 23. Training staff pre first wave of +ve patients for working across boundaries 24. Ongoing Occupational Health, IPC and Microbiology advice/training 25. Training given to staff who require a higher amount of training to meet competencies for working across speciality boundaries e.g. PPE, FIT testing, CPAP Governance: 26. Non-essential meetings stood down with tracked actions and appropriate governance 27. Ward Quality metrics process stood down - replaced with Safety Dashboard, monitored by, and actions by exception, by Quality Governance Team. Plan-on-a-Page reports will be produced for all wards for information only. 28. Trust Major Incident Plan 29. Trust Pandemic Flu Plan 30. Divisional / Service delivery Business Continuity Plans 31. Divisional / Service delivery Risk Assessments						

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**15**	Date of Meeting: 01/06/2020
Report Title	Use of the Trust Seal	
Executive Lead	James Sumner, Chief Executive	
Lead Officer	Katharine Dowson, Head of Corporate Governance	
Action Required	To Note	

X	**Acceptable assurance** General confidence in delivery of existing mechanisms / objectives	☐	**Partial assurance** Some confidence in delivery of existing mechanisms / objectives	☐	**No assurance** No confidence in delivery

Key Messages of this Report *(2/3 headlines only)*

- Compliance with the requirement to report us of the Trust Seal.

Impact *(is there an impact arising from the report on the following?)*

• Quality	☐	• Risk	☐
• Finance	☐	• Compliance	✓
• Workforce	☐	• Legal	☐
• Equality	☐		

Equality Impact Assessment (*must accompany the following submissions)*

- Strategy ☐ Policy ☐ Service Change ☐

Strategic Objective(s) *(indication of which objective/s the report aligns to)*

• Delivering outstanding clinical quality, safety & experience	☐	• Aspiring to excellence in practice through our workforce	☐
• Being a leading partner in a progressive health economy	☐	• Creating a 21st century infrastructure for transformative health and social care	☐
• Striving for outstanding organisational effectiveness	✓		

Governance *(is the report a…?)*

• Statutory requirement	✓	• Other	☐
• Annual Business Plan Priority	☐	*rationale for Board submission required:*	
• Strategic/BAF Risk	☐		
• Service Change	☐		

Next Steps (*actions following agreement by Board/Committee of recommendation/s)*

None required.

Recommendation

The Board of Directors are asked to note the sealings that have taken place since the last Board report in March 2020. This report notes subsequent sealings to 31 May 2020 as required by Standing Order 9 of the Trust Constitution.

Quarterly Report of Sealings for the period 1 March to 31 May 2020

Seal Number	***Description***	***Date of Board Approval***	***Date of Sealing***
105	Agreement to renew the lease for premises for the League of Friends at Leighton Hospital	02 March 2020	03 March 2020