Mid Cheshire Hospitals
NHS Foundation Trust

Board of Directors

Monday 7 September 2020

09:30 am

Virtual – via Microsoft Teams

AGENDA

No	BAF Risk	Item
PRELIMINARY BUSINESS		
1 9:30		**Welcome & Apologies (v)** Deputy Chair • Dennis Dunn, Chairman • Murray Luckas, Medical Director
2 9:32		**Declarations of Interest (v)** Deputy 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		**Staff Story (p)** Director of Nursing & Quality To note
4 9:45		**Draft Minutes of the Last Meeting - 3 August 2020 (d)** Deputy Chair To approve the draft minutes of the last meeting of the Board of Directors, discuss any matters arising and review the action log
5 9:50		**Chair's Opening Remarks (v)** Incorporating Governor's items To note
CONTEXT / OVERVIEW		
6 9:55		**Chief Executive's Report (d)** To note
7 10:05	**BAF19**	**Risk Management Framework (d)** Chief Executive To note

No	BAF Risk	Item
8 10:10	**BAF16**	**Cheshire East Integrated Care Partnership (CEICP) (d)** Director of Strategic Partnerships To note • CEICP Collaboration Agreement • CEICP Terms of Reference
QUALITY - Patient Safety, Clinical Effectiveness & Patient Experience		
9 10:15		**Quality Governance Committee 10 August 2020 Chair's Report (d)** Committee Chair To note
10:20	**BAF9**	• **Learning from Deaths Report Q1 2020/21 (d)** Deputy Medical Director To note
10 10:30		**Quality, Safety and Patient Experience Report July 2020 (d)** Director of Nursing & Quality To note
11 10:40	**BAF9**	**Serious Untoward Incidents and RIDDOR Events (v)** Deputy Medical Director To note
12 10:45	**BAF21**	**Medical Revalidation Annual Report 2019/20 (d)** Deputy Medical Director To approve
PERFORMANCE		
13 10:50		**Performance and Finance Committee 27 August 2020 Chair's Report (d)** Committee Chair To note
10:55		• **Performance Report – July 2020 (d)** Chief Operating Officer / Deputy Chief Executive & Director of Finance To note
WELL LED		
14 11:10		**Transformation and People Committee 6 August 2020 Chair's Report (d)** Committee Chair To note

No	BAF Risk	Item
15 11:15		**Workforce Report July 2020 (d)** Director of Workforce & OD To note
16 11:30	**BAF10**	**Health Education England Self Assessment Report (d)** Director of Workforce and OD To approve
17 11:35		**Health and Safety Annual Report 2019/20 (d)** Deputy Chief Executive/Director of Finance To note
CONCLUDING BUSINESS		
18 11:40		**Any Other Business** Deputy Chair To consider any other matters of business
19 11:50		**Items for the Risk Register/Changes to the Board Assurance Framework (BAF) (v)** Deputy Chair To identify any additional items for the Risk Register or changes to the BAF arising from discussions at this meeting
20 11:55		**Key Messages from the Board (v)** Deputy Chair To agree
		Time, Date and Place of Next Meeting Monday, 5 October 2020, 9.30am

Action Items

Agenda item		Assigned to	Deadline	Status
Board of Directors 03/08/2020 13.1 Performance and Finance (PAF) Committee (23 July 2020) - Chair's Assurance Report (d)				
169.	Circulate to the Board the letter recently received from regulators in regard to revised financial arrangements and performance expectations.	Sumner, James	31/08/2020	Pending Sent 07 Aug

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BOARD OF DIRECTORS

Agenda Item	**6**	Date of Meeting: 07/09/2020
Report Title	**Chief Executive's Report August 2020**	
Executive Lead	James Sumner, Chief Executive	
Lead Officer	Caroline Keating, Company Secretary	
Action Required	To note	

☐	**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)*

- Update on key issues such as Covid-19, workforce, finance and performance
- An update on restoration of services and national planning submission
- The Cheshire East ICP Board Assurance Report is also included

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)*

• Manage the impact of covid and ensure safe recovery	☐	• Provide safe and sustainable healthcare through our estate, infrastructure and planning	☐
• Deliver outstanding care and patient experience Deliver the most effective care to achieve best possible outcomes	☐	• Provide strong system leadership by working together	☐
• Ensure MCHFT is the best place to work	☐	• Be well governed and clinically led	✓

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)*

N/A

REPORT DEVELOPMENT

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

Mid Cheshire Hospitals
NHS Foundation Trust

Chief Executive's Report
Board Meeting – 7 September 2020

National/Regional update

1. Mid Cheshire's Be Safe Be EqiPPEd campaign has been shortlisted for a Nursing Times Award. This comprehensive, multi-layered campaign focused on making the workplace as safe as possible for staff and patients during the Coronavirus pandemic through appropriate and correct use of PPE. It delivered a clear and consistent approach to engaging, training and educating all staff providing patient care.

   As a result of the campaign, the Trust has seen high levels of compliance with donning and doffing, correct use of PPE and FIT checking across its wards.

   Results will be announced on 14 October 2020.

Covid-19

Performance

2. **Covid-19 patients** - at 26 August 2020, there were no confirmed Covid-19 patients in the hospital; however, the hospital remains configured to manage suspected/confirmed Covid-19 patients effectively and safely. This includes the Respiratory Assessment Unit in our Emergency Department and two dedicated wards. The Trust is currently preparing for any possible future increase/spike in Covid-19 cases, which is part of the overall Winter Plan and to ensure that we are adequately prepared.

3. **Restoration of Critical Services** – this is well underway and making progress. The elective routine operating programme resumed on 3 August and all operating theatres are back online with a twofold increase in patients treated compared to July.

   The Trust is required to submit its (restoration) plan in response to the Phase Three Planning letter to NHSE/I via the Cheshire and Merseyside Healthcare Partnership on 21 September 2020. A draft version was submitted to NHSE/I on 1 September and feedback is awaited.

   As the final submission date is before the October Board meeting, the final draft will be circulated by email to the Board for comment prior to deadline.

4. **Winter Plan** – the first iteration of the 2020/21 Winter Plan has been developed and submitted to the Clinical Commissioning Group (CCG). The final version of the plan will be shared with the Board during September. The Winter Plan focuses on a number of key workstreams, including reducing demand on A&E (implementation of NHS111 First), increasing in-hospital bed capacity, improving flow out of the hospital (we have requested 30 additional community beds from Cheshire CCG), and staff health and wellbeing, which includes a comprehensive flu campaign.

5. **National Visiting Guidance** – we are planning for the Trust to be open for visiting from 7 September 2020 and are taking steps to do this safely in line with national guidance. We have been developing a video which will be circulated via social media prior to 7 September and this will encourage visitors to come back to the hospital but in a safe way by everyone acting responsibly, for example through wearing masks on corridors as well as wards.

6. **MRI Scanners** – following the issues at the start of August with the cooling unit and infrastructure that support the MRI scanners, all three scanners are now functioning. Work by the Estates team and outside contractors is underway to further improve the reliability of the cooling unit. Learning from this incident will inform the scope of the independent review of critical infrastructure across the Trust. The Trust is now in the process of reducing the backlog of patients awaiting an MRI and this has been supported by the commissioning of a mobile scanner.

Workforce

7. The Trust's sickness levels continue to fall, benchmarking well across Cheshire and Merseyside with one of the lowest sickness absence percentage rates. The Trust is still struggling to get back on track with its appraisal compliance, which is being managed closely and should be helped by the introduction of the new Motiv8 appraisal system which allows for more informal and regular conversations to take place. Mandatory training compliance and data accuracy remain a concern; a newly formed task and finish group has been put in place, therefore, to address this and will report directly to the Business Continuity Group to manage the risk.

Finance – Month 4 (July) 2020/21

8. The Trust achieved a break-even position for July, after applying for £1.7m reimbursement. Cumulatively, we have applied for £5.6m additional funding from NHSI for April – July although none has yet been received (in-line with all other NHS organisations) as the Centre is validating all national claims. The Trust has incurred £8m of directly identifiable costs in relation to the Covid-19 outbreak (£4.6m pay), with a further £1.4m loss of income through reduced footfall and non-contracted activity. However, these costs have been partly offset by significant savings on non-pay and drugs through the virtual ceasing of the elective programme during the first quarter, resulting in the net £5.6m position. As the restoration programme is implemented, these offsetting savings will reduce month on month, as was seen in July, with drug costs and clinical supplies increasing and hence the reimbursement required to breakeven increased from £1.3m to £1.7m.

9. Further guidance has been received on the financial arrangements, which will apply from 1 September 2020, and on how block payments will flex to reflect the expected near-normal return of elective activity levels from September. Future resources are being provided at a system level (Cheshire & Merseyside) and are determined through a nationally calculated financial envelope. Where the activity delivered is in line with the nationally set levels, funding will be paid in full to the system; where it is below expected levels, 25% (for elective and outpatient procedures) and 20% (for outpatients attendance activity) will be deducted from the system envelope. Where delivery in the period exceeds expected levels, 75% (for elective and outpatient procedures) and 70% (for outpatient attendance activity) of the difference will be added to the system envelope.

10. We await national details of the system's financial envelope and understanding of how this will operate for individual organisations within the system.

Trust 'Business as Usual'

Workforce

- **We are the NHS: People Plan 2020/21**

11. The NHS People Plan was published on 30 July. The Plan sets out, along with 'Our People's Promise', what our NHS people can expect from their leaders and from each other. It builds on the creativity and drive shown by our NHS people in their response, to date, to the COVID-19 pandemic and the interim NHS People Plan. It also focuses on how we must all continue to look after each other and foster a culture of inclusion and belonging, as well as take action to grow our workforce, train our people, and work together differently to deliver patient care.

12. The People Plan has four specific themes:

    - **Looking after our people** – with quality health and wellbeing support for everyone
    - **Belonging in the NHS** – with a particular focus on tackling the discrimination that some staff face
    - **New ways of working and delivering care** – making effective use of the full range of our people's skills and experience
    - **Growing for the future** – how we recruit and keep our people, and welcome back colleagues who want to return

13. These themes will be driven forward by a set of deliverable actions, which will be managed and monitored through the Trust's Executive Workforce Assurance Group with assurance provided to the Workforce & Digital Transformation Committee.

- **Shadow Board**

14. The Trust is due to launch its first Shadow Board programme from September 2020, funded by the NHS North West Leadership Academy and delivered by an expert provider - the Inspiring Leaders Network.

15. A Shadow Board development experience provides a 'real world' developmental 'stretch' opportunity for senior leaders, supporting aspiring executives to step up into Board Room positions. Adopting this approach can help identify those with real Board level potential, enabling a more structured, intentional and strategic succession planning approach and the ability to create a more diverse and inclusive senior leader talent pool.

16. Trevor Brocklebank, Non-Executive Director, will chair the Shadow Board and all Executive Directors will provide one-to-one mentorship to those participating. The purpose of this programme is to help the Trust identify and develop its future leaders, to create a more diverse leadership pool and to provide additional input and insight into existing Trust Board issues.

Cheshire East Integrated Care Partnership (ICP)

17. The monthly Director Report (*Appendix 1*) from the September ICP Board summarises the progress made. The ICP's Terms of Reference and the final version of the Collaboration agreement are submitted to the Board *(Agenda Item 8).* Both documents detail the aims and objectives of the ICP and are also identified in the 18 month ICP Strategy and Transformation Plan which is currently being finalised. An ICP Board development programme is now being scoped and established which will start to embed the objectives into cultural change on how we work in partnership across the system. Further updates will be provided to the Board in the coming months.

Author: James Sumner, Chief Executive
Date: September 2020

APPENDIX I

STANDARDISED DIRECTOR REPORT

CHAIR'S REPORT DETAILS	
Name of meeting:	Cheshire East Integrated Care Partnership Board
Chair of meeting:	Sheena Cumiskey, Chief Executive (CWP)
Executive Director	Denise Frodsham. Director of Strategic Partnerships (MCHFT)
Date of meeting:	13/08/2020

(ESCALATION)

Quality, clinical, care, other risks identified that require escalation:

None for escalation

Areas of risk discussed by CE ICP Board:

- Risk of insufficient resource to deliver at pace the OD Strategy action plans
- Transformation plan identifies the non-recurrent investment of £750,000 to enable change but this does not reflect the investment required to recurrently deliver the new models of care which are still to be developed

(ASSURANCE)

Matters discussed:

- Enabling Work stream – OD strategy and Care Community Action plan presented, providing overview of objectives and achievements to date.
- Transformation Plan – presented in full, the draft plan links the CEICP strategy to transformation work programme for period September 2020 to April 2022. Final paper subject to inclusion of partner comments was well received with final version to be reviewed for approval in September.
- Leadership paper – outlined clinical resource requirements for delivery of Transformation plan as well as detailing Associate Medical Directors for ICP Development and Associate Medical Director for ICP Transformation.

(ACHIEVEMENT)	Achievements:

	• Governance activities progressed
	  • Terms of Reference agreed and signed of
	  • Clinical Leadership paper agreed and signed off
	  • Collaboration agreement (M of U) agreed by health partners and signed off
	• CEICP Strategy incorporating Transformation Plan nearing sign off, subject to final changes
	• Community Voluntary Services Partnership - Chris Hart (CVS Lead) will be an active member of the ICP Board from October; Dan Shelston to provide CVS leadership support to transformation programme.
	• CEICP Transformation Board established for September inauguration as well as all priority theme task and finish groups

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**7**	Date of Meeting: 07/09/2020
Report Title	Board Assurance Framework	
Executive Lead	Caroline Keating, Company Secretary	
Lead Officer	Gilly Conway, Risk & Assurance Consultant	
Action Required	To note	

☐	**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)*

- Outputs from the controls and assurance mapping exercise presented

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)*

• Manage the impact of covid and ensure safe recovery	☐	• Provide safe and sustainable healthcare through our estate, infrastructure and planning	☐
• Deliver outstanding care and patient experience Deliver the most effective care to achieve best possible outcomes	☐	• Provide strong system leadership by working together	☐
• Ensure MCHFT is the best place to work	☐	• Be well governed and clinically led	✓

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)*

Collation of the BAF detail will continue with Executive Risk Leads during September to include consideration of inherent and target risk scores, control gaps and improvements, and assurance ratings.

REPORT DEVELOPMENT

Committee/ Group Name	Date	Report Title	Lead	Brief summary of key issues raised and actions agreed
Audit Committee Task & Finish Group	27 August	Risk & Assurance project update (verbal)	Caroline Keating	Progress with controls and assurance mapping reviewed and direction of travel supported.

Board Assurance Framework

Introduction

1. 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. A properly used BAF will also drive the forward work plan and agendas for the Board and its Committees.

2. The Trust's improved BAF approach has been outlined to the Board in reports in June and August 2020. The new arrangements will provide:
    - 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.

3. Mapping of the full set of controls and assurances aligned with the principal risks has been carried out in consultation with Executive Risk Leads (ERLs). This report provides an overview of current risk scores (see Appendix 1) and presents the BAF detail collated to date (Appendix 2). While there has been good progress made in mapping the controls and assurance for all risks, the content should be considered work in progress.

4. The next areas of focus for completing the detail of the BAF are:
    - available assurance ratings (acceptable/partial/low) to be applied;
    - inherent and target risk scores to be added;
    - actions to be raised to address control and assurance gaps.

Future reporting

5. As reported to the Board in August, future BAF reports will include an overview of notable changes for principal risks and will highlight key messages raised from the new Executive Risk and Assurance Group (ERAG) that will be launched 8 September 2020. The ERAG will be chaired by the Chief Executive and will keep under review the Trust's key risks and the management of risk across all areas of the organisation.

6. Future BAF reports for the Board will also include a suite of strategic risk dashboards providing a summary view of the Trust's key risks for each strategic objective. The dashboards will bring together the principal risks and the highest scoring operational risks (15+), representing a top down and bottom up perspective of the Trust's risk profiles. The ERAG will review these dashboards monthly prior to reporting to the Board on a quarterly basis. As the September Board meeting precedes the inaugural meeting of the ERAG, the dashboards will be presented to the Board in October. To ensure the Board remains informed about the key operational risks, an interim update is provided in the next section of this report.

7. In August, the Board was advised of procedural changes for Committees to improve the visibility of the Trust's risks, key controls and associated assurances. The new agendas have begun to be trialed and, from September, Committee papers will include summary reports from the Chairs of the relevant Executive Group and a BAF reference page highlighting the principal risks assigned to each Committee. It is expected that by October, these new arrangements will have been incorporated for all Committees when they will start receiving quarterly BAF reports for scrutiny as set out in their forward work plans.

8. The Board will begin to develop its approach to risk appetite at its Away Day in September. Risk appetite and tolerance levels will be incorporated in future BAF reporting once the Board's risk appetite has been defined.

Key risks

9. There is no movement in current risk scores to report to the Board. BAF7 remains the highest priority risk, reflecting pressures across a number of services in the wake of Covid. The Trust's plan to address these is in development but restoration of critical services is already underway and making reasonable progress.

10. The following table highlights the key operational risks for the Board to note:

Risk	Current score (LxC)	Next steps
Failure of an RAAC roof plank creating a critical risk to health and safety and/or business continuity	**4x5=20**	The Trust has commenced inspections of the RAAC planks and is planning to vacate buildings that are higher risk where possible and target those that cannot be vacated for earlier inspection.
Shortages of medical staff in medicine could lead to risks to patient care particularly at night	**5x4=20**	As part of the Urgent Care Village design and planning, there needs to be investment in additional medical staffing due to rising numbers of attendances over recent years and the Trust being one of the lowest in terms of medical staff per bed.
Failure to provide sufficient endoscopy capacity due to covid restrictions to ensure cancer pathways are delivered in a timely manner	**4x4=16**	The Trust is now working to the new Cheshire & Merseyside Endoscopy policy in order to improve productivity whilst being covid secure. Additional sessions are being planned where workforce allows.
Lack of sufficient staffing for delivery of the winter plan	**4x4=16**	Incentive rates for bank staff and permanent recruitment to frequent turnover roles are being instigated.
Revenue consequence of new Urgent Care Village development not being met with external funding	**4x4=16**	Should the capital monies be made available for the A&E extension into an Urgent Care Village, this will be an expansion of circa 50% and will therefore have ongoing staffing requirements with revenue consequences. This is being identified currently.

Risk	Current score (LxC)	Next steps
Inability to rehouse staff from residence accommodation increases RAAC risk and could prevent hospital redevelopment case	4x4=16	The Trust executive are working on plans for additional accommodation on and off site for staff to release these building.
Inability to recruit staff for the urgent care village	4x4=16	The workforce and operational teams are currently working through the required staffing numbers and looking at creative ways to achieve this.
Delivery of A&E rebuild in time for winter if capital allocation is delayed	5x3=15	This is out of the Trust's control; however, the risks of rebuilding during winter are being reviewed by the Estates and operational teams.
Inability to carry out key IT and Estate works to previous South Cheshire Hospital estate as it is key capacity for covid surge in winter	5x3=15	If this building is to be used throughout winter which is now almost certain, reviews of critical infrastructure and evacuation procedures will be necessary.
Inability to staff sufficient MIU hours at VIN during covid pressures	5x3=15	The operational teams are looking at other solutions and mitigations to this unavoidable issue at present.
Inability to meet capacity requirement for the backlog of outpatient follow-ups post covid period	5x3=15	This is being worked through as part of the phase 3 planning process currently.
Inability to deliver nurse recruitment strategy due to covid restrictions	3x4=12	Travel restrictions could be a potential block to this. The Trust is working with the national teams and Home Office to unblock this issue.

Conclusions

11. Good progress is being made to map the detail of the BAF and improvements to risk and assurance reporting through the governance structure are expected to increase the visibility of key risks and strengthen the oversight of how risks are managed across the Trust.

Recommendations

12. To note the current status of principal risks and the progress made in mapping controls and assurances. ERLs will answer any questions relating to individual risks within their portfolios.

Author: Gilly Conway, Risk and Governance Consultant
Date: 28 August 2020

Appendix 1 BAF heatmap: current scores

SO1 **Manage the impact of the Covid-19 pandemic and ensure safe recovery**	SO2 **Deliver outstanding care and patient experience**	SO3 **Deliver the most effective care to achieve best possible outcomes**	SO4 **Ensure MCHFT is the best place to work**	SO5 **Provide safe and sustainable healthcare to our population**	SO6 **Provide strong system leadership by working together**	SO7 **Be well governed and clinically led**
BAF1 Inadequate arrangements for safe management of pandemic against national guidance **2 x 4 = 8**	**BAF3** Inability to close the nurse staffing vacancy gap **3 x 4 = 12**	**BAF7** Inability to provide sufficient capacity to meet demand and achieve operational standards **5 x 4 = 20**	**BAF10** Failure to attract, retain and support a high performing workforce **3 x 4 = 12**	**BAF13** Failure to provide modern, efficient, sustainable estate, infrastructure and equipment **3 x 4 = 12**	**BAF16** Failure to enable a successful Integrated Care Partnership and carry out its hosting responsibility **3 x 3 = 9**	**BAF19** Inappropriate governance systems to foster a risk assurance culture **4 x 3 = 12**
BAF2 Failure to manage risks to business continuity identified during Covid **2 x 4 = 8**	**BAF4** The Trust's environments are not adequately safe and secure for staff, patients and visitors **3 x 4 = 12**	**BAF8** Insufficiently robust processes for clinical audit and quality improvement, learning and implementation of new practice **3 x 3 = 9**	**BAF11** Failure to harness the benefits of technology to integrate, streamline and improve systems of working **3 x 4 = 12**	**BAF14** Failure to adequately plan future workforce requirement **3 x 4 = 12**	**BAF17** Ineffective capacity across the Health and Social Care system **3 x 4 = 12**	**BAF20** Failure to establish appropriate governance and risk mitigation around existing and new collaborative models of working **3 x 3 = 9**
	BAF5 The Trust's Quality Improvement approach does not help address the highest clinical challenges **3 x 3 = 9**	**BAF9** Failure to use high quality activity and patient outcome data to assess quality of care **4 x 3 = 12**	**BAF12** Failure to create the conditions for an effective organisational culture **2 x 4 = 8**	**BAF15** Inadequate financial management, budgetary controls, and efficiency planning **2 x 4 = 8**	**BAF18** The Trust fails to play its part in a successful Cheshire System **Inactive***	**BAF21** Failure to develop leadership capacity and capability throughout the organisation **3 x 4 = 12**
	BAF6 Failure to proceed with EPR development and implementation **3 x 4 = 12**					

Risk Rating	Priority
(1 to 3)	Green Very Low
(4 to 6)	Yellow Low
(8 to 12)	Amber Medium
(15 to 16)	Red High
(20 to 25)	Purple Very High

*This risk is not considered to have direct relevance during this financial year but is likely to become an active risk next year

Controls and assurances

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Report Date	28 Aug 2020
Risk Status	Open
Risk Area	Strategic Risks

Controls and assurances

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Strategic Risks

Risk Ref	Risk Title	Cause & Area of Impact	Risk Control	Control Assurance (1st Line Assurance)	Control Assurance (2nd Line Assurance)	Control Assurance (3rd Line Asurance)	Current Rating
BAF 1	IF arrangements in place to ensure safe management of pandemic against national guidance are inadequate THEN patients and staff could be harmed **Executive Risk Lead:** Oliver Bennett **Deputy Risk Lead:** **Last Updated:** 26 Aug 2020	**Cause** **Areas of Impact**	1. **Control Owner:**				C = 4 L = 2 8
BAF 2	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 **Executive Risk Lead:** Russell Favager **Deputy Risk Lead:** **Last Updated:** 26 Aug 2020	**Cause** 1. Poor risk management arrangements 2. Insufficient leadership capacity/capability 3. Resistance to change 4. Inadequate processes for learning from pandemic **Areas of Impact** 1. Patient care and safety 2. Workforce safety and morale 3. Reputation 4. Regulatory	1. Business Continuity Group's programme of work takes a holistic view of COVID-related risks across the Trust (pre-mortem paper agreed by the Board April 2020) **Control Owner:**	Lead Directors provide fortnightly updates to BCG	1. Fortnightly updates to Exec Team..		C = 4 L = 2 8

Controls and assurances

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Strategic Risks

Risk Ref	Risk Title	Cause & Area of Impact	Risk Control	Control Assurance (1st Line Assurance)	Control Assurance (2nd Line Assurance)	Control Assurance (3rd Line Asurance)	Current Rating
BAF 3	IF the widening nurse staffing vacancy gap is not closed THEN patient care could be detrimentally impacted **Executive Risk Lead:** Julie Tunney **Deputy Risk Lead:** **Last Updated:** 24 Aug 2020	**Cause** 1. National shortages 2. Competition between providers 3. Poor perception of pay and working conditions and the impact of COVID experience 4. Geographical location and transport access 5. Impact of Brexit on overseas workforce availability 6. Inability to secure international nurse recruits from overseas due to COVID 7. Inability to attract pre-registration nurses due to lack of bursaries 8. Failure to deliver UK Adaptation Programme 9. Failure to consider alternative opportunities to support nursing workforce **Areas of Impact** 1. Patient care and safety 2. Financial: agency expenditure 3. Workforce morale 4. Reputation as employer / of nursing 5. Regulatory	1. Closing the gap' plan 2023 **Control Owner:** Heather Barnett		1. 'Closing the gap' report bi-monthly to..	CQC assessment	C = 4 L = 3 12
			2. Multi-disciplinary clinical workforce plan includes 3 relevant workstreams: New Ways of Working, Recruitment and Retention, Maximising Potential (DoW) **Control Owner:**	Monthly updates to Multi-disciplinary Clinical Workforce Group			
			3. Our Workforce Matters Strategy 2019-21 (relevant aspects) (DoW) **Control Owner:**	Our Workforce Matters annual report	Nurse workforce metrics included in the..		
			4. Health & Wellbeing agenda (relevant aspects eg. sickness etc) (DoW) **Control Owner:**		Health & Wellbeing quarterly report to EWAG	NHSI/E Organisational Pulse Survey results reported to EWAG and to WTGC	
			5. Bank Incentive Schemes for RNs (DoW) **Control Owner:**	Bank Incentive Scheme review report to AEMG			

Controls and assurances

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Strategic Risks

Risk Ref	Risk Title	Cause & Area of Impact	Risk Control	Control Assurance (1st Line Assurance)	Control Assurance (2nd Line Assurance)	Control Assurance (3rd Line Asurance)	Current Rating
BAF 4	IF the Trust does not ensure safe and secure environments for staff, patients and visitors THEN avoidable harm could occur **Executive Risk Lead:** Russell Favager **Deputy Risk Lead:** **Last Updated:** 26 Jul 2020	**Cause** 1. Inadequate focus on H&S 2. Old buildings / deteriorating physical environment 3. Ineffective security arrangements 4. Asbestos 5. Concrete roof planks 6. Fire safety compliance 7. Contamination with dangerous substances **Areas of Impact** 1. Health & Safety 2. Workforce morale 3. Reputation 4. Legal 5. Financial	Asbestos Management Programme **Control Owner:** Russell Favager				C = 4 L = 3 12
			Backlog Maintenance Plans **Control Owner:** Russell Favager				
			'Control of Substances Hazardous to Health' Guidance **Control Owner:** Russell Favager				
			Fire Management Improvement Plan **Control Owner:** Russell Favager		Workplace Inspections	Cheshire Fire & Rescue (CFR) Audit Programme Sept 2018	
			Health & Safety Policy (Oct 2019) **Control Owner:** Russell Favager	Incident reporting	1. Workplace inspections 2. RIDDOR..		
			Management of Aggressive Behaviour Procedure **Control Owner:** Russell Favager	Incident reporting			

Controls and assurances

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Strategic Risks

Risk Ref	Risk Title	Cause & Area of Impact	Risk Control	Control Assurance (1st Line Assurance)	Control Assurance (2nd Line Assurance)	Control Assurance (3rd Line Asurance)	Current Rating
BAF 5	IF the Trust does not introduce a Quality Improvement approach to its highest risk clinical challenges THEN it is less likely to resolve them **Executive Risk Lead:** Julie Tunney **Deputy Risk Lead:** **Last Updated:** 26 Aug 2020	**Cause** 1. QI methodoogy not embedded throughout organisation 2. Quality improvement not underpinned by evidence 3. Approach not developed in consultation with all relevant stakeholders **Areas of Impact** 1. Patient care, safety and experience 2. Reputation as an employer for clinical staff 3. Regulatory 4. Public perception	1. Quality & Safety Improvement Strategy 2020/21 **Control Owner:** Julie Tunney		1. Quality, Safety & Experience Report to..	1. CQC report May 2020 2. IA Quality Account internal audit – April 2019 (outcome?)	C = 3 L = 3 9
			2. IPC Strategy (DIPC policies/procedures) **Control Owner:**		1. IPC BAF Aug Board approved 2. IPC BAF..	1. CQC inspections 2. MIAA 2018	
			3. Ward accreditation programme **Control Owner:**		Annual Report to Q&SC	1. CQC full inspection 2. MIAA audit 2019	
			4. Dedicated Quality Team deliver Q&SI strategy **Control Owner:**				
			QI Faculty (incl AQUA) **Control Owner:** Murray Luckas				

Controls and assurances

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Strategic Risks

Risk Ref	Risk Title	Cause & Area of Impact	Risk Control	Control Assurance (1st Line Assurance)	Control Assurance (2nd Line Assurance)	Control Assurance (3rd Line Asurance)	Current Rating
BAF 6	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 **Executive Risk Lead:** Amy Freeman **Deputy Risk Lead:** **Last Updated:** 26 Aug 2020	**Cause** 1. Insufficient financing 2. Inadequate business case to meet regulatory requirements 3. Business case approval process changing creating uncertainty 4. Relationship changes lead to affordability issues **Areas of Impact** Fall-back is status quo which is not sustainable and would negatively affect: 1. Patient care and safety 2. Reputation 3. Efficiency benefits 4. Running costs 5. Cyber security 6. Clinical audit	1. Business case development process (with external support) **Control Owner:** Amy Freeman	EPR update reports to W&DTC monthly			C = 4 L = 3 12
			2. Regular engagement with NHSI/E **Control Owner:** Amy Freeman				
			3. TSSM self-asessment for EPR readiness **Control Owner:** Amy Freeman	TSSM self-assessment results			
			4. OGC gateway reviews **Control Owner:** Amy Freeman		OGC gateway review included in Business..		
			5. MoU with partners **Control Owner:** Amy Freeman				
BAF 7	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 **Executive Risk Lead:** Oliver Bennett **Deputy Risk Lead:** **Last Updated:** 05 Aug 2020	**Cause** **Areas of Impact** THEN it may cause harm to its patients and be unable to meet its regulatory requirements	TBC **Control Owner:**				C = 4 L = 5 20

Controls and assurances

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Strategic Risks

Risk Ref	Risk Title	Cause & Area of Impact	Risk Control	Control Assurance (1st Line Assurance)	Control Assurance (2nd Line Assurance)	Control Assurance (3rd Line Asurance)	Current Rating
BAF 8	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 **Executive Risk Lead:** Murray Luckas **Deputy Risk Lead:** **Last Updated:** 26 Aug 2020	**Cause** 1. Lack of coordinated approach 2. Poor dissemination of information 3. Complex Governance processes **Areas of Impact** 1. Patient care and safety 2. Reputation 3. Regulatory	1. Clinical Governance Team annual programme of work incorporating audit, research and QI faculty **Control Owner:**	Clinical Governance Team Annual Report to Audit Committee		Annual Quality Account reviewed by External Audit and reported to Council of Governors; report submitted to QSC and approved by the Board	C = 3 L = 3 9
			2. Programme of National Audits and actions plans **Control Owner:**	Divisional Governance monitoring of action plans and exception reporting to EQGG		1. CQC Good rating - May 2020 2. CQC Insight Report 3. HQUIP Audits 4. GIRFT	
			3. The Trust participates with the Advancing Quality programme (AQuA) and the implementation of recommendations is tracked **Control Owner:**	Advancing Quality workstream reports from QI Faculty?		AQuA annual reports?	
			4. Arrangements for assessing compliance with NICE guidance **Control Owner:**	Compliance included in Divisional governance dashboards reported to EQGG			
BAF 9	IF the Trust does not use high quality activity and patient outcome data to assess the quality of its care THEN it may miss trends and signals and encounter less positive patient outcomes **Executive Risk Lead:** Murray Luckas **Deputy Risk Lead:** **Last Updated:** 26 Aug 2020	**Cause** 1. Accessibility of data 2. Data quality 3. Inadequate data analysis capacity and capability 4. Inadequate data management software 5. Limited scope of existing data to surgical outcomes **Areas of Impact** 1. Patient care 2. Reputation 3. Regulatory	1. Learning from Deaths Policy & Mortality Review Process (Divisional & Corporate) **Control Owner:**	Divisional Mortality reports	Quarterly Learning from Deaths Report to..	1. Nationally benchmarked mortality data 2. AQuA Quarterly Mortality Report	C = 3 L = 4 12
			2. Action planning based on GIRFT findings **Control Owner:**	Departmental plans monitored locally		GIRFT revisit?	
			3. Participation with Outcome Registries **Control Owner:**	Departmental plans monitored locally		Annual registry reports	

Controls and assurances

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Strategic Risks

Risk Ref	Risk Title	Cause & Area of Impact	Risk Control	Control Assurance (1st Line Assurance)	Control Assurance (2nd Line Assurance)	Control Assurance (3rd Line Asurance)	Current Rating
BAF 10	IF the Trust cannot attract, retain and support a high performing workforce THEN quality of care is likely to deteriorate **Executive Risk Lead:** Heather Barnett **Deputy Risk Lead:** **Last Updated:** 24 Aug 2020	**Cause** 1. National shortages 2. Limited flexible working options 3. Competition between providers 4. Geographical location and transport access 5. Perception as an employer 6. Impact of Brexit on overseas workforce availability 7. Inadequate performance management and appraisal processes 8. Limited career pathways 9. Mismatch between skills and learning needs and education provision 10. Lack of University presence to attract students 11. Failure to embrace diversity & inclusion 12. Poor leadership **Areas of Impact** 1. Workforce capacity & capability 2. Organisational resilience 3. Workforce morale 4. Reputation as an employer 5. Regulatory 6. Patient care and experience	1. Our Workforce Matters Strategy 2019-21 (DoW) **Control Owner:**	Our Workforce Matters annual report	'Medical staffing workforce metrics..		C = 4 L = 3 12
			2. Multi-disciplinary clinical workforce plan includes 4 workstreams: New Ways of Working, Recruitment and Retention, Maximising Potential, System Working (DoW) **Control Owner:**	Multi-disciplinary Clinical Workforce Group report to EWAG			
			3. Health & Wellbeing Plan (DoW) **Control Owner:**		'Health & Wellbeing quarterly report to..	NHSI/E Organisational Pulse Survey results reported to EWAG and to WTGC	
			4. Annual Staff Survey process and action planning (DoW) **Control Owner:**		Staff survey results reported to Board and..	Annual National Staff Survey results	
			5. Recruitment policies & process (DoW) **Control Owner:**		MIAA Audit tool results reported to EWAG..	Internal Audit 2020 - vacancies	
			6. Apprenticeship Programmes (DoW) **Control Owner:**		Apprenticeship levy usage report to EWAG..		
			7. E,D&I Strategy (DoW) **Control Owner:**		Annual ED&I report to WDTC and Board	1. National benchmarking WRES and WDES report to WTGC and Board 2. Gender pay gap results to WTGC and Board	
			8. Suite of HR policies that support management of high performing workforce (DoW) **Control Owner:**			Internal Audits reported to WDTC - Electronic Staff Record 2019?	

Controls and assurances

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Strategic Risks

Risk Ref	Risk Title	Cause & Area of Impact	Risk Control	Control Assurance (1st Line Assurance)	Control Assurance (2nd Line Assurance)	Control Assurance (3rd Line Asurance)	Current Rating
BAF 11	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 **Executive Risk Lead:** Amy Freeman **Deputy Risk Lead:** **Last Updated:** 26 Aug 2020	**Cause** 1. Insufficient financing 2. Inadequate business cases 3. Poor prioritisation processes 4. Low digital maturity 5. Limited ability to attract digital skills **Areas of Impact** 1. Patient care, safety and experience 2. Reputation as provider and as an employer 3. Use of resources (efficiency, effectiveness, economy) 4. Workforce morale and productivity 5. Cyber security	1. IT Strategy aligned with DIGIT@LL Strategy (refresh due April 2021) **Control Owner:**	Updates to DTIS and WDTC every six months			C = 4 L = 3 12
			2. Healthcare Information and Management Systems Society (HIMSS) Electronic Medical Record Adoption Model identifies gaps in systems for medical use (June 2020) **Control Owner:**			HIMSS report to WDTC with discussion about priorities	
			3. Horizon scanning events with suppliers to identify innovation in the sector **Control Owner:**	Updates to DTIS and WDTC			
			4. Cyber-security action plan and risk register **Control Owner:**	Cyber report to DTIS every six months		1. Annual penetration tests 2. Internal Audit of cyber security processes 2020	

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Strategic Risks

Risk Ref	Risk Title	Cause & Area of Impact	Risk Control	Control Assurance (1st Line Assurance)	Control Assurance (2nd Line Assurance)	Control Assurance (3rd Line Asurance)	Current Rating
BAF 12	IF the Trust does not create the conditions for an effective organisational culture THEN this could affect quality, efficiency and workforce standards **Executive Risk Lead:** James Sumner **Deputy Risk Lead:** **Last Updated:** 24 Aug 2020	**Cause** 1. Poor leadership (tone from the top) 2. Misalignment of strategy and culture 3. Inadequate strategic focus on culture 4. Inadequate/inappropriate internal communications and cascade mechanisms 5. Poor understanding of overarching culture and sub-cultures 6. Insufficient focus on embedding culture at all levels **Areas of Impact** 1. Workforce behaviours and morale 2. Patient care and experience 3. Reputation as an employer 4. Public perception 5. Regulatory	1. Trust strategic priorities 2020-21 include culture (CEO) **Control Owner:**				C = 4 L = 2 8
			2. Our Workforce Matters Strategy 2019-21 (DoW) **Control Owner:**	Our Workforce Matters annual report	Workforce metrics reporting and analysis..		
			3. Communication and Engagement Strategy (DoW) **Control Owner:**	Comms and Engagement bi-annual report to Workforce Group			
			4. Leadership Framework (DoW) **Control Owner:**	Learning from Covid presentation			
			5. ED&I Strategy (DoW) **Control Owner:**		Annual ED&I report to WDTC and Board		
			6. Annual Staff Survey Process and action planning (DoW) **Control Owner:**		Staff survey results reported to Board and..	Annual National Staff Survey results	
			7. Quality Improvement strategy and action plan include culture elements (DoW) **Control Owner:**		Internal OD Diagnostic reported to Execs..	Annual Patient Survey results includes culture of care and compassion to Board	

Controls and assurances

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Strategic Risks

Risk Ref	Risk Title	Cause & Area of Impact	Risk Control	Control Assurance (1st Line Assurance)	Control Assurance (2nd Line Assurance)	Control Assurance (3rd Line Asurance)	Current Rating
BAF 13	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 **Executive Risk Lead:** Russell Favager **Deputy Risk Lead:** **Last Updated:** 26 Aug 2020	**Cause** 1. Old buildings / deteriorating physical environment 2. Ageing medical equipment 3. Competing priorities for investment 4. Lack of strategic approach to estates planning 5. Environmental sustainability considerations insufficiently embedded 6. Concrete (RAAC) roof planks 7. Unsupported IT systems and databases **Areas of Impact** 1. Patient care, safety and experience 2. Workforce morale 3. Reputation 4. Regulatory	1. Estates Strategy in place to 2020 **Control Owner:**	Estates & Facilities Divisional Assurance Framework reports to Divisional Board	1. Estates Annual report 2. Annual..	New Build Certification	C = 4 L = 3 12
			2. Capital programme expenditure agreed annually (Estates Infrastructure Development Group) **Control Owner:**	Capital Exceptions report to IDG and Divisional Board (cost and programme)			
			3. 6 Facets survey includes environmental performance **Control Owner:**	Self audits against NHS sustainability audit tool (every six months)			
			4. Compliance of Trust's environments with Equalities Act **Control Owner:**			PLACE Assessments (members of the public) reported to Divisional Board (&?) before published nationally	
			5. Survey programme re RAAC beams **Control Owner:**				

Controls and assurances

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Strategic Risks

Risk Ref	Risk Title	Cause & Area of Impact	Risk Control	Control Assurance (1st Line Assurance)	Control Assurance (2nd Line Assurance)	Control Assurance (3rd Line Asurance)	Current Rating
BAF 14	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 **Executive Risk Lead:** Heather Barnett **Deputy Risk Lead:** **Last Updated:** 24 Aug 2020	**Cause** 1. Poor horizon scanning and forecasting 2. Poor understanding of expectations of young people entering workforce 3. Insufficient consideration of workforce in strategic planning 4. Misalignment of workforce planning, activity and finance 5. Lack of accurate and up-to-date workforce information and data 6. Lack of workforce planning capacity and capability 7. Poor communication between education providers / HEE / Providers **Areas of Impact** 1. Sustainability of services 2. Workforce morale 3. Reputation as an employer 4. Regulatory 5. Patient care and experience	1. Our Workforce Matters Strategy 2019-21 (DoW) **Control Owner:**	Our Workforce Matters annual report	Workforce metrics reporting and analysis..		C = 4 L = 3 12
			2. Annual Workforce Plan reviewed by EWAG and WDTC (DoW) **Control Owner:**	Annual workplan report to WDTC		Annual NHSI/E Workforce plan submission reported to WDTC	
			3. Workforce Systems Project group and action plan (DoW) **Control Owner:**	Quarterly progress report to EWAG and 6 monthly to WDTC			
			4. E-roster project implementation plan (DoW) **Control Owner:**	E-roster reporting on nursing / HCA staff groups	E-roster report to EWAG		
			5. Recruitment Policies and Process (DoW) **Control Owner:**		MIAA Audit tool results reported to EWAG..	Internal Audit 2020 - vacancies	
			6. Education Strategy (DoW) **Control Owner:**	Education, Learning and OD report to EWAG quarterly		HEE Self-Assessment Review (SAR) annual to Board	
			7. Apprentice Programme (DoW) **Control Owner:**		Apprenticeship levy usage report to EWAG..		
			8. Volunteer plan (DoW) **Control Owner:**	Volunteer annual report to WTDG			
			9. Strategic Business case framework (?) **Control Owner:**				

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Strategic Risks

Risk Ref	Risk Title	Cause & Area of Impact	Risk Control	Control Assurance (1st Line Assurance)	Control Assurance (2nd Line Assurance)	Control Assurance (3rd Line Asurance)	Current Rating
BAF 15	IF financial management, budgetary controls and efficiency planning are not robust THEN the Trust may not deliver its financial targets **Executive Risk Lead:** Russell Favager **Deputy Risk Lead:** **Last Updated:** 26 Aug 2020	**Cause** 1. Inappropriate financial planning 2. Poor financial data 3. Low understanding of local budgetary responsibilities 4. Poor compliance with financial controls 5. Cash releasing savings plans that are not fully identified and may not be fully delivered 6. Cost pressures arising from the use of agency staff 7. The use of non-recurrent measures may also contribute to a risk to the Trusts longer term sustainability 8. Failure to agree control total with NHSI/E 9. Inability to invest in development of service **Areas of Impact** 1. Regulatory 2. Sustainability of services 3. Reputation 4. Patient care	1. Corporate Governance Handbook including Standing Financial Instructions and Scheme of Delegation (approved by Audit Committee and Board of Directors) **Control Owner:**		Compliance with SFIs reported to Audit..	Annual Internal Audit Key Financial Controls	C = 4 L = 2 8
			2. Budgetary Controls - each Division has a dedicated financial accountant **Control Owner:**	Monthly divisional meetings with Accountant	Monthly Finance reports to PAF and Board		
			3. Contracts with Commissioners **Control Owner:**	Signed contract with Commissioners	Monthly Contract financial reports to..		
			4. Financial plan **Control Owner:**	Signed off by the PAF and the Board	Monthly monitoring performance via Finance..	Annual Use of Resources (External Audit)	
			5. Annual reference costs **Control Owner:**		Signed off by PAF		
			6. End of year financial accounting processes **Control Owner:**		Annual Accounts scrutinised and signed off..	External Audited Annual Accounts	
			7. Collaboration at scale **Control Owner:**	Directors of Finance meet fortnightly	Monthly Cheshire meetings chaired by the..	Head of Internal Audit Opinion	
			8. Information shared across divisions outlining benchmarking opportunities **Control Owner:**			External Benchmarking information received by the Trust including Model Hospital	
			9. Cheshire System Financial Recovery Plan **Control Owner:**	Monthly CEO and DOF meetings		NHSI/E Performance Meetings	

Controls and assurances

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Strategic Risks

Risk Ref	Risk Title	Cause & Area of Impact	Risk Control	Control Assurance (1st Line Assurance)	Control Assurance (2nd Line Assurance)	Control Assurance (3rd Line Asurance)	Current Rating
BAF 16	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 **Executive Risk Lead:** Denise Frodsham **Deputy Risk Lead:** **Last Updated:** 26 Aug 2020	**Cause** 1. Failure to overcome organisational politics 2. Senior capacity 3. Ineffective governance 4. Lack of agreement of shared goals and plans 5. Poor communication 6. Failure to have single data source across the system **Areas of Impact** 1. Patient care and experience including inequality of provision 2. Reputation 3. Financial 4. Regulatory intervention	1. Dedicated additional resource in place leading on partnerships (DSP) **Control Owner:**				C = 3 L = 3 9
			2. Local transformation funding to support the programme of work (DSP) **Control Owner:**	Task and Finish Groups report to Transformation Board (part of Cheshire East ICP governance structure)			
			3. CEICP Board includes CEO representation from MCHFT (CEO) **Control Owner:**	Monthly risk reports to ERAG (from October)	Monthly report to the Board of Directors..		
			4. Cheshire East Place 5 year plan presented to Board October 2019 (DSP) **Control Owner:**		Update reports go to Place Partnership..		
BAF 17	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 **Executive Risk Lead:** Oliver Bennett **Deputy Risk Lead:** **Last Updated:** 05 Aug 2020	**Cause** **Areas of Impact** THEN the risk to patients of being hospitalised unnecessarily will continue to increase	TBC **Control Owner:**				C = 4 L = 3 12

Controls and assurances

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Strategic Risks

Risk Ref	Risk Title	Cause & Area of Impact	Risk Control	Control Assurance (1st Line Assurance)	Control Assurance (2nd Line Assurance)	Control Assurance (3rd Line Asurance)	Current Rating
BAF 19	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 **Executive Risk Lead:** James Sumner **Deputy Risk Lead:** **Last Updated:** 26 Aug 2020	**Cause** 1. Low openness to change 2. Low understanding of risk & assurance 3. Inability to effect culture change 4. Poor perception of governance requirement 5. Lack of senior buy-in **Areas of Impact** 1. Governance 2. Regulatory 3. Reputation 4. Patient care	1. Phase 1 Risk & Assurance project plan July-Oct 2020 focuses on BAF development and risk & assurance reporting at Executive and Board levels. Design and delivery assisted by external expert resource **Control Owner:**	Company Secretary holds weekly project meetings to review progress	'Monthly Audit Committee Task & Finish..	Internal Audit - Assurance Framework and Risk Management Policy Q4 2020-21	C = 3 L = 4 12
			2. Risk Management Strategy approved by the BoD August 2020 sets the overarching approach **Control Owner:**				
			3. First version Assurance & Escalation Framework approved by the Audit Committee July 2020 documents key mechanisms **Control Owner:**		Internal compliance testing by Governance..		
			4. CQC improvement planning and implementation (DN&Q) **Control Owner:**		Must-dos reported quarterly to QSC		
			5. Redesigned Governance Structure **Control Owner:**	Annual evaluation of effectiveness of Exec Group, Board Committees and the Board of Directors		Well-led governance reviews every 3 years	

Controls and assurances

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Strategic Risks

Risk Ref	Risk Title	Cause & Area of Impact	Risk Control	Control Assurance (1st Line Assurance)	Control Assurance (2nd Line Assurance)	Control Assurance (3rd Line Asurance)	Current Rating
BAF 20	IF the Trust fails to establish appropriate governance and risk mitigation around existing and new collaborative, system wide models of working THEN it may expose itself to risk of which it is unaware **Executive Risk Lead:** James Sumner **Deputy Risk Lead:** **Last Updated:** 24 Aug 2020	**Cause** **Areas of Impact** THEN it may expose itself to risk of which it is unaware	TBC **Control Owner:**				C = 3 L = 3 9

Controls and assurances

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Strategic Risks

Risk Ref	Risk Title	Cause & Area of Impact	Risk Control	Control Assurance (1st Line Assurance)	Control Assurance (2nd Line Assurance)	Control Assurance (3rd Line Asurance)	Current Rating
BAF 21	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 **Executive Risk Lead:** Heather Barnett **Deputy Risk Lead:** **Last Updated:** 24 Aug 2020	**Cause** 1. Inadequate planning of leadership requirement 2. Lack of clarity about development paths 3. Inadequate investment 4. Failure to address leadership culture 5. Low senior engagement 6. Low clinical leadership engagement 7. Lack of capacity to release staff for development 8. Lack of resources to deliver adequate development opportunities 9. Perceived or real cultural barriers for BAME staff **Areas of Impact** 1. Leadership 2. Strategy 3. Change management 4. Culture 5. Workforce morale	1. Leadership Framework (DoW) **Control Owner:**				C = 4 L = 3 12
			2. Leadership Development matrix and implementation plan (DoW) **Control Owner:**	Leadership development plan progress reports to Execs and EWAG			
			3. Our Workforce Matters Strategy (DoW) **Control Owner:**	Our Workforce Matters annual report	Workforce metrics reporting and analysis..		
			4. Coaching & mentoring scheme (DoW) **Control Owner:**	Education, Learning and OD report to EWAG quarterly			
			5. Medical leadership programme (MD) **Control Owner:**	Education Committee?			
			6. Talent Board is in place and succession planning process is aligned to the Divisions (DoW) **Control Owner:**				
			7. Staff Survey Process and action plans are in place (DoW) **Control Owner:**		Staff Survey focus groups and action plan..	Annual National Staff Survey results	
			8. ED&I Strategy and National Workforce Race Equality Scheme (WRES) and National Workforce Disability Equality Scheme (WDES) action plans (DoW) **Control Owner:**		Annual ED&I report to WDTC and Board	1. WRES report to Board 2. WDES report to Board	

BOARD OF DIRECTORS

Agenda Item	**8.1**	Date of Meeting: 07/09/2020
Report Title	Cheshire East Integrated Care Partnership –Collaboration Agreement	
Executive Lead	Denise Frodsham, Director of Strategic Partnerships	
Lead Officer	Denise Frodsham, Director of Strategic Partnerships	
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)*

- To note the Collaboration Agreement which sets out the principles and objectives of the CEICP. This has now been approved by all CEICP Health partners and continues to be progressed through Social Care governance processes.

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)*

• Manage the impact of covid and ensure safe recovery	☐	• Provide safe and sustainable healthcare through our estate, infrastructure and planning	☐
• Deliver outstanding care and patient experience Deliver the most effective care to achieve best possible outcomes	✓	• Provide strong system leadership by working together	✓
• Ensure MCHFT is the best place to work	☐	• Be well governed and clinically led	✓

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)*

To develop and agree the CEICP Board work programme, risk log. To update and complete the draft CEICP strategy including the ICP Transformation plan by September 2020

Private & Confidential

DATED 1st July 2020

Memorandum of Understanding

CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST (1)

AND

CHESHIRE EAST COUNCIL (2)

AND

EAST CHESHIRE NHS TRUST (3)

AND

MID CHESHIRE NHS FOUNDATION TRUST (4)

AND

SOUTH CHESHIRE AND VALE ROYAL GP ALLIANCE LIMITED (5)

AND

VERNOVA HEALTHCARE COMMUNITY INTEREST COMPANY (6)

PROVIDER COLLABORATION AGREEMENT

in relation to the provision of Integrated Care Partnership in Cheshire East

CONTENTS

THIS AGREEMENT is made on the 1st day of July 2020.

BETWEEN:

(1) **CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST**
of Chester Health Park, Liverpool Rd, Chester CH2 1BQ ("**CWP**");

(2) **CHESHIRE EAST COUNCIL**
Of Westfields, Middlewich Road, Sandbach, CW11 1HZ ("**CEC**")

(3) **EAST CHESHIRE NHS TRUST**
Of Victoria Road, Macclesfield, SK10 3BL ("**ECT**")

(4) **MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST**
of Leighton Hospital, Crewe, Cheshire CW1 4QJ ("**MCHFT**");

(5) **SOUTH CHESHIRE AND VALE ROYAL GP ALLIANCE LIMITED**

of Sandison Easson & Co, Rex Buildings, Wilmslow, Cheshire SKP 1HY ("**GPA**");

AND

(6) **VERNOVA HEALTHCARE COMMUNITY INTEREST COMPANY**
of Waters Green Medical Centre, Sunderland Street, Macclesfield, SK11 6JL ("**VGPF**").

together the "**Partners**", each a "**Partner**".

RECITALS

(A) The Partners have agreed to collaborate under the name ' Cheshire East Integrated Care Partnership' (the **"Partnership"**) in order to jointly deliver the Services in an integrated basis to the people of Cheshire East, the population for whom the Services are commissioned. The Partners have agreed that their participation in the Partnership will be in accordance with the following commitments, as reflected in the Partnership Vision, Partnership Objectives, and Partnership Principles and Behaviors set out in this Agreement:

1 We will work together to improve the outcomes of the population we serve.

2 We will work together to support our staff to be the best they can be, working collaboratively for the Partnership.

3 We will work together to identify the best and most appropriate management and leadership of services including organisations that do not form part of this Partnership agreement...

4 We will work together within a common governance framework and within the available resource.

5 We will work together to develop the 'Home First' principal as our chosen model of care.

(B) The Partners have agreed to enter into and execute this Agreement to establish the arrangements between them for the operation of the Partnership and relating to the Services to be entered into between the Commissioners and Partner organisations through a host contract holder, MCHFT

(C) The Commissioners and the Partners have agreed that MCHFT is entering into the Services Contract as 'host' (i.e. Contract holder not sole service provider) for the Partnership and that the Partners will collectively deliver the Services in accordance with the Services Contract and this Agreement.

(D) The Partners have agreed the governance arrangements described in this Agreement including the principle that Partnership decisions will be made on a Best for Service basis.

NOW IT IS AGREED as follows:

1 DEFINITIONS AND INTERPRETATION

The definitions and rules of interpretation set out in Schedule 1 apply in this Agreement.

2 APPROVALS

2.1 The Partners acknowledge and agree that as at the date of this Agreement:

(a) each Partner acknowledges MCHFT as the host and that a Host Contract will be entered into/executed by MCHFT as the host. This will be a work in progress as the ICP develops and contracts are transferred into it but initially this will be to host the PLACE transformation funding for the ICP to use to deliver its programme of work.;

(b) each Partner has obtained approval from its board of directors to enter into this Agreement;

(c) there has been no material adverse change in the business, operations assets, position (finance, trading or otherwise), profits or prospects of any of the Partners

(d) where relevant, each Partner has the requisite registration with the Care Quality Commission or other regulatory bodies required for that Partner to carry out the Services.

3 COMMENCEMENT AND DURATION

3.1 Commencement

The provisions of this Agreement shall take effect on the date hereof July 1st 2020

3.2 Duration

Each Partner confirms its commitment to delivering services within the principals of a Host Contract and/or Partner Sub-contract arrangement within the future development of a Services Contract arrangement, subject to the provisions of clause 20.

4 PARTNERSHIP VISION

4.1 The Partners have agreed to collaborate together on the basis of the Partnership Objectives and the Partnership Principles (both as described more fully below) in order to achieve the following 'Vision' in relation to the Services:

(a) The Partners recognise that for care and support to be 'integrated', it must be Person Centred, coordinated and tailored to the needs and preferences of the individuals, their carers and family. The Partners will move away from episodic care to an approach that focusses on prevention, early intervention, supported self-care and the ability to provide enhanced care and support closer to home. Care and support needs will be personalised and based on Shared Decision making, to improve the experience of care.

(b) The Partners' vision for integration revolves around individuals and communities having a better experience of care and support, experiencing less inequality and achieving improved outcomes within the resources available. The Partnership's approach has fully embraced the concept of the individual lying at the heart of integrated care and support and being the 'organising principle' for provision of the Services.

4.2 In striving to achieve the Vision, the Partners have agreed the following in relation to the provision of the Services:

(a) That integrated care should reduce and, where possible, eliminate gaps and duplications in existing service provision, should improve the safety and effectiveness of the Services and should enhance the experience of our population;

(b) That services of the ICP include both health and care and require dedicated and accountable leadership;

(c) That personnel involved in the delivery of the Services see themselves as part of a multi-disciplinary team working across primary, secondary and community provision in which there is a shared approach to managing individuals' expectations, needs, risks and offering choice;

(d) That the future delivery of services will be developed to mirror the organisation of Care Communities (i.e. the delivery of services will reflect the development of new models of collaboration).

(e) That the Partners will collectively promote and develop a staff and service culture that is population focused and which seeks to reduce unnecessary contacts for Service individuals and their carers / supporters;

(f) That, as part of the Transformation Programme, the Services where appropriate are delivered 'closer to home' in Care Communities.

(g) That funding available for the population is effectively utilised for the delivery of the

Services across the system and can only be used to subsidise or support other services if the Partnership agrees that this is in the interests of wider transformation programme (e.g. a transfer of resources to enhance provision closer to home). This could, for example, be a transfer of acute bed funds into more community-based, rapid response funding, or an integration of primary and community resources (health and / or social care) where duplication can be removed and cost released to improve overall resource capacity. However, this needs to recognise that where decisions are made for the good of the population, partners should not adversely be affected or put into breach of organisational license.

5 PARTNERSHIP OBJECTIVES

5.1 The Partners agree that the objectives of the Partnership are for the Partners to work together at all times as a single, integrated group of providers to deliver the Services for the population:

(a) in accordance with the Transformation themes detailed in Schedule 2, this describes the initial themes to be progressed which have been agreed with Partners for each organisation. This is intended to start the programme of transformation and redesign of the Services but also to support the evolution of relationships and the culture across the health and care economy in Cheshire East;

(b) in accordance with good clinical practice and good industry practice (as applicable) and all applicable laws and regulations;

(c) to effectively manage any risks and issues arising in relation to the provision of the Services and ensure that a robust process for raising and mitigating such risks and issues is in place;

(d) to ensure a safe transition for all individuals previously in receipt of other services through the timely management of the various pathways comprised in the Services;

(e) so as to seek that the Services are provided by the Partner most able to provide the relevant Service component in an efficient and effective manner (recognising that this may involve a shift of activity from one Partner to another and that material changes to the way in which Services are delivered will need to be agreed with the Commissioners);

(f) so as to seek to avoid, where appropriate, elective and non-elective admissions to hospital and to provide more appropriate care closer to home; and

(g) in a manner that supports Person Centred Care and drives value for money,

together the "**Objectives**".

6 PARTNERSHIP PRINCIPLES AND BEHAVIOURS

6.1 The Partners shall work together to achieve the Objectives and, subject to and in accordance

with the provisions of this Agreement and relevant documents referred to in it, shall:

(a) collaborate and work together on an inclusive and supportive basis through the governance structure set out in Schedule 2, with optimal use of their individual and collective strengths and capabilities;

(b) through the governance structure, engage in decision making on the basis that all the Partners will participate in decisions that affect the strategic direction of the Partnership and/or the Services, including service redesign and in establishing the direction, culture and tone of the Partnership. First tier management of the Services and front line delivery of the Services (including day to day operational decisions) will remain the responsibility of the Partner which delivers the relevant Service, subject always to the Reserved Matters set out in Appendix 1;

(c) make decisions on a Best for Service basis;

(d) act in the spirit of partnership in making decisions, evidencing their performance, workforce planning and strategy, finance and governance on an open book basis, as necessary, subject at all times to compliance with applicable competition and procurement law;

(e) provide excellent Services and outcomes for patients and wider population served;

(f) be accountable by taking on, managing and accounting to each other in respect of their financial and operational performance of the respective roles and obligations set out in Schedule 3;

(g) deploy appropriate resources in accordance with respective roles and responsibilities, and make efficient use of those resources;

(h) communicate openly about major concerns, issues or opportunities relating to the Partnership through the governance structure detailed in Schedule 2;

(i) act in a way that is best for the delivery of the Services and the Objectives, and shall do so in a timely manner and respond accordingly to requests for support promptly;

(j) work with stakeholders effectively, following the principles of co- design and co- production;

(k) adopt a transparent approach to all aspects of the Partnership, subject to competition law compliance;

(l) adhere to statutory requirements and best practice, including compliance with applicable laws and standards including procurement rules, competition law, data protection and freedom of information legislation; and

(m) act reasonably and in good faith to each other to support the delivery of the Commissioners' vision for the Services, the achievement of the Objectives, and compliance with these Principles,

together the "**Principles**".

7 OBLIGATIONS OF THE PARTNERS

7.1 The Partners acknowledge and agree that as Partners under this Agreement, each Partner is responsible for:

(a) adhering to the Principles and ensuring that the Principles are reflected in its own organisation;

(b) ensuring that internal governance arrangements are in place in order to consider, sign-off and implement actions required to fulfil the Partner's obligations as set out in this Agreement including:

(i) participating in and acting in accordance with the outcome of discussions about the Reserved Matters set out in Appendix 1 to Schedule 2;

(ii) contributing to and complying with relevant communication and engagement and plans;

(iii) running an internal risk register in relation to their delivery of the Services and associated transitional activities and reporting to the other individual Partners and the Partnership Board; and

(iv) escalating disputes between Partners relating to the provision of the Services and adherence to the Transformation Plan in accordance with clause 11.

(v) giving due notice of not less than 6 months if a partner organisation no longer deems it appropriate to participate in the Integrated Partnership arrangement

7.2 In addition, the Partners shall have the specific obligations in respect of the Services and the achievement of the Transformation Plan as set out in Schedule 4.

8 EMPLOYEES

8.1 Subject to the provisions of the Partner Sub-contracts, each Partner will take responsibility for its own staff and be responsible for the acts and omissions of its own staff and others engaged by it.

8.2 Subject to the provisions of the Partner Sub-contracts, no Partner (**"First Partner"**) shall have any liability in respect of any losses, liabilities, damages, costs, fees and expenses howsoever caused or arising out of or in connection with any act, omission, breach of statutory duty or willful default of an individual for whom any other Partner (**"Responsible Partner"**) is responsible, provided that the First Partner has not caused such losses, liabilities, damages, costs, fees and expenses by acting or omitting to act in such a way towards any employee of the employing Responsible Partner as to place the employing Responsible Partner in breach of its obligations to the relevant employee.

8.3 In the event that TUPE and/or, where relevant, the Cabinet Office Statement apply(ies) or is/are likely to apply by operation of law as a result of any of:

(a) the entry by MCHFT into the Services Contract or the

(b) Partner Sub-contracts;

(c) the entry by CWP, CEC, ECT, G P A or VGPF into the Partner Sub-contracts;

(d) the sharing of staffing arrangements between the Partners in connection with the Services;

(e) any Partner which exits from the arrangements between the Partners or

(f) any other circumstances which give rise to the transfer of staff employed or engaged by a Partner or Partners under TUPE and / or, where relevant, the Cabinet Office Statement,

each Partner undertakes to each of the other Partners that it shall, in order to fulfil the Objectives and in accordance with the Principles, co-operate and negotiate, acting reasonably and in good faith, to determine and agree how all financial, operational, legal and other consequences of such TUPE transfers are shared between the Partners.

9 GOVERNANCE

9.1 The Partners shall establish a Partnership Board which shall comprise a 'partnership of equals' through which the Services are delivered and developed to achieve the Vision and the Objectives.

9.2 The management and governance structures for the Partnership and the proceedings of the Integrated Care Partnership Board (Partnership Board) are set out in Schedule 2.

10 RISK/REWARD SHARE

The Partners will develop risk/reward sharing mechanisms during the development and evolution of the ICP: it is recognised that the risk allocation between the Commissioners and MCHFT under the Services Contract will develop and evolve during the term of the Services Contract and the risk/reward arrangements between the Partners will need to be developed and agreed in light of the arrangements under the Services Contract.

11 DISPUTE RESOLUTION

11.1 In this clause 11, a reference to a Partner's 'Senior Officer' shall mean, in the case of MCHFT ECT, CEC and CWP, their respective Chief Executives and, in the case of GPA and VRGPF, their respective Chair of the Board of Directors or other director nominated to deal with a dispute on that Partner's behalf.

11.2 Where contentious claims relating to this Agreement arise (for example, breach of contract or alleged negligence), the Partners agree that they shall first try to resolve such dispute informally and in good faith:

(a) through each affected Partner's Senior Officer working with the Chair of the Partnership to find a resolution within ten (10) days of the dispute arising, or;

(b) each affected Partner's Senior Officer to find a resolution within ten (10) days of the dispute arising, excluding the Chair if the Chair is unable to act in the best interests of the Partners pursuant to Schedule 2.

11.3 If within ten (10) working days of such dispute arising, the Partners' Senior Officers fail, in accordance with clause 11.2(a) or clause 11.2(b) to resolve the dispute for any reason, it shall be referred for resolution by the Partnership Board in accordance with the dispute resolution procedure set out in Part B of Schedule 2.

12 COMPETITION

12.1 Nothing in this Agreement shall restrict each party's right to continue to conduct its business activities or arrangements that existed on the date of this Agreement or that otherwise come into being outside the scope of this Agreement.

12.2 The Partners may have interests in businesses other than the Partnership business. Neither the Partnership nor any Partner will have any rights to the assets, income or profits of any such other business, venture or transaction.

12.3 Each Partner agrees to disclose to the other Partners the existence of any and all interests which it has in businesses, ventures or transactions other than the Partnership which constitute, or could reasonably constitute, a conflict of interest with the Partnership.

12.4 If, during the term of the Partnership, one or more Partners wish to bid for any tender for services which compete with the Services, it shall inform the other Partners immediately and the Partnership Board shall decide how any conflict of interests arising shall be managed.

13 INTELLECTUAL PROPERTY RIGHTS

13.1 Except as set out in this Agreement, no Partner shall acquire the intellectual property rights of any other Partner.

13.2 Where a Partner has Background IP that will assist the Partnership to achieve the delivery of Services pursuant to the Response and the Services Contract, such Partner shall license the other Partners to use such Background IP free of charge for the duration of this Agreement, subject to the other Partner(s) remaining a Partner and solely for the purposes of delivering the Services and managing the Partnership.

13.3 Any Foreground IP created jointly by the Partners in the course of carrying out these obligations under this Agreement shall be owned by all of the Partners jointly and shall only be used by the Partners for the purposes of delivering the Services and carrying on the Partnership.

13.4 Any Foreground IP created solely by one of the Partners in the course of carrying out its obligations under this Agreement shall be owned solely by the Partner that created it who shall license it to the other Partners free of charge for the duration of this Agreement, subject to the

other Partner(s) remaining a Partner and solely for the purposes of delivering the Services and carrying on the Partnership.

13.5 If any Partner during the term of the Services Contract wishes to use any Foreground IP other than for the purposes of carrying on the Partnership, it must obtain the prior written consent of the Partner owning the relevant Foreground IP and agree reasonable license terms.

13.6 The Partnership Board shall create and maintain registers of any Background IP and any Foreground IP. The Partners have identified relevant Background IP and have established a register of Background IP as at the date of this Agreement.

14 CONFIDENTIALITY AND ANNOUNCEMENTS

14.1 Each Partner shall keep the other Partner's Confidential Information confidential and not:

(a) use such Confidential Information except for the purposes of exercising or performing its rights and obligations under this Agreement; or

(b) disclose such Confidential Information in whole or in part to any third party, except as expressly permitted by this clause.

14.2 A Partner may disclose another Partner's Confidential Information to those of its representatives who need to know such Confidential Information for the purpose of the Partnership, provided that:

(a) it informs such representatives of the confidential nature of the Confidential Information before disclosure; and

(b) it procures that its representatives shall, in relation to any Confidential Information disclosed to them, comply with the obligations set out in this clause as if they were a party to this Agreement,

(c) and at all times, it is liable for the failure of its representatives to comply with the obligations set out in this clause.

14.3 A Partner may disclose Confidential Information to the extent such Confidential Information is required to be disclosed by law, by any governmental or other regulatory authority or by a court or other authority of competent jurisdiction provided that, to the extent it is legally permitted to do so, it gives the other Partner as much notice of such disclosure as possible and, where notice of disclosure is not prohibited and is given in accordance with this clause 14.3, it takes into account the reasonable requests of the other Partner in relation to the content of such disclosure.

14.4 Each Partner reserves all rights in its Confidential Information. No rights or obligations in respect of a Partner's Confidential Information other than those expressly stated in this Agreement are granted to any other Partner, or to be implied from this Agreement.

14.5 On termination of this Agreement, each Partner shall:

(a) return to the relevant other Partner all documents and materials (and any copies containing, reflecting, incorporating or based on the other Partner's Confidential Information;

(b) erase all the other Partner's Confidential Information from computer and communications systems and devices used by it, including such systems and data storage services provided by third parties (to the extent technically practicable); and

(c) certify in writing to each other Partner that it has complied with the requirements of this clause.

14.6 Except as expressly stated in this Agreement, no party makes any express or implied warranty or representation concerning its Confidential Information.

14.7 The provisions of this clause 14 shall survive for a period of five years from termination of this Agreement.

14.8 No Partner shall make, or permit any person to make, any public announcement/communication concerning this Agreement without the prior written consent of all other providers and the Partners shall consent in the Partnership Board on the timing, contents and manner of release of any announcement.

15 PUBLICITY AND BRANDING

15.1 The Partnership shall operate under the name 'Cheshire East Integrated Care Partnership' (the **"Name"**).

15.2 The Partners will ask the Partnership Board to produce and agree a joint branding policy including when and how each Partner shall be permitted to use the Name (in compliance with applicable NHS / Council branding guidelines and requirements).

16 DATA PROTECTION AND FREEDOM OF INFORMATION

16.1 Each Partner shall ensure that it complies with the requirements of all legislation and regulatory requirements in force from time to time relating to the use of personal data, including, without limitation, the Data Protection Act 1998. The Partners will work together co- operatively in relation to the use of personal data and shall ensure that appropriate, technical and organisational security measures are taken against the unauthorised or unlawful processing of personal data and against accidental loss or destruction of or damage to personal data.

16.2 The Partners acknowledge that they and the Commissioners are subject to legal duties under the FOIA which may require them to disclose, on request, information relating to this Agreement and that they are also subject to the Code of Practice on Openness in the NHS (4 August 2003).

16.3 If a Partner receives a Request for Information (as defined in FOIA) about the Partnership or any matters which relate to activities undertaken by the Partnership, then, prior to any disclosure of information to which an exemption to FOIA may apply (**"Potentially Exempt Information"**), it will:

(a) immediately notify all of the other Partners of such Request for Information;

(b) discuss the Request for Information with the other Partners and the Partners shall consider together (i) whether or not FOIA applies and, in the event that FOIA applies, (ii) whether or not an exemption to FOIA applies and the public interest factors both for and against disclosure (if applicable depending upon the potential exemption) in accordance with FOIA to determine whether the public interest in maintaining the exemption outweighs the public interest in disclosing such Potentially Exempt Information;

(c) take into account any representations made by the other Partners in relation to the Request for Information and any possible exemptions; and

(d) consult with the other Partners in relation to any proposed disclosure as to whether any further explanatory material or advice should also be disclosed with the information in question,

16.4 The Partners agree that, provided always that the relevant Partner has complied with its obligations pursuant to clause 16.3, ultimately it will be for that Partner to decide whether to comply with any Request for Information it receives.

17 WARRANTIES

17.1 Each Partner warrants that:

(a) prior to entering into this Agreement it is assured in relation to the Services for the purpose of establishing whether it is able to enter into the Partnership and carry out its respective part of the Services: in doing so the Partners acknowledge that each of the Partners will have taken assurance from the transitional arrangements/mitigations/indemnities agreed with the Commissioners as part of finalising the Services Contract;

(b) it has full capacity and authority to enter into and perform this Agreement;

(c) so far as it is aware, all information, data and materials provided by it under this Agreement and any ancillary agreement will be accurate and complete in all material respects, and it is entitled to provide the same to the others without recourse to any third party, and;

(d) except as expressly provided in this Agreement, there are no conditions, warranties or other terms binding on the Partners with respect to the actions contemplated by this Agreement.

18 LIABILITY AND INDEMNITY

18.1 None of the Partners limits its liability for (a) death or personal injury caused by its negligence and/or (b) fraudulent misrepresentation.

18.2 No Partner shall be liable to the other Partners for any indirect or consequential loss, or any loss of use or loss of profits, business, contracts, revenues or anticipated savings whether arising from tort (including, without limitation, negligence or breach of statutory duty), breach of contract or otherwise in relation to the performance of that Partner's obligations under this Agreement.

18.3 Notwithstanding any other provision of this Agreement, a Partner shall not be entitled to recover compensation or make a claim under this Agreement, in respect of any loss that it has incurred (or any failure of the other Partners) to the extent that it has already been compensated in respect of that loss or failure pursuant to this Agreement, or otherwise.

19 INSURANCE

19.1 Indemnity arrangements in respect of clinical negligence shall be provided for in the Services Contract and in each of the arrangements with the Sub-contractors and any other sub-contractors providing the Services.

19.2 The Partners agree that they shall maintain in force appropriate insurance/indemnity arrangements in relation to:

(a) Employers' liability;

(b) Public liability;

(c) Professional negligence; and

(d) Directors and officers liability.

20 NO PARTNERSHIP

20.1 This Agreement is not intended to create a partnership under the terms of the Partnerships Act 1890.

20.2 Subject to where expressly stated to the contrary in this Agreement or any Partner Sub-contract, each Partner agrees that it has no right to bind any other Partner in contract or otherwise in relation to any third party, and it shall not represent that it has such rights.

21 MISCELLANEOUS

21.1 Assignment

No Partner shall assign, novate, mortgage, charge, and sub-contract or otherwise dispose of any or all of its rights and obligations under this Agreement without the prior written consent of all other Partners, such consent not to be unreasonably withheld or delayed.

21.2 Variations

No variation of this Agreement shall be effective unless it is in writing and signed by all of the Partners.

21.3 Notices

(a) A notice given under this Agreement:

(i) shall be in writing in English;

(ii) shall be sent for the attention of the Senior Officer, and to the address notified by each Partner to the other Partners; and

(iii) shall be:

(A) delivered personally; or

(B) sent by pre-paid first-class post or recorded delivery.

(b) A notice will be deemed to have been received:

(iv) If delivered personally, when left at the address and for the contact referred to in clause 22.3(a)(ii); or

(v) If sent by pre-paid first-class post, on the second business day after posting.

(c) To prove service, it will be sufficient to prove that the envelope containing the notice was properly addressed and posted.

21.4 Waiver

The failure to exercise or delay in exercising a right or remedy provided by a Partner under this Agreement will not constitute a waiver of that right or remedy.

21.5 Entire Agreement

This and the Intra Partner Sub-contracts constitute the entire agreement between the Partners and supersedes any previous agreement, arrangement or understanding between them.

21.6 Third Party Rights

This Agreement and the documents referred to in it are made for the benefit of the Partners and no third party shall have any rights under the Contracts (Rights of Third Parties) Act 1999 to enforce any term of this Agreement

21.7 Severance

If any provision or part-provision of this Agreement becomes invalid, illegal or unenforceable, it shall be deemed modified to the minimum extent necessary to make it valid, legal and enforceable. If such modification is not possible, the relevant provision or part-provision shall be deemed deleted. Any modification to or deletion of a provision or part-provision under this clause shall not affect the validity and enforceability of the rest of this agreement.

21.8 Costs

Each Partner is responsible for its own costs and expenses in connection with the preparation and negotiation of this Agreement and all documents contemplated by it.

21.9 Governing Law and Jurisdiction

Subject to clause 11, this Agreement and any dispute arising out of or in connection with it shall be governed by, and construed in accordance with, the laws of England and the Partners submit irrevocably to the jurisdiction of the Courts of England.

21.10 Counterparts

This Agreement may be executed in counterparts each of which when executed and delivered shall together constitute one agreement.

EXECUTED as a **DEED** by

MID CHESHIRE HOSPITAL NHS FOUNDATION TRUST (4)

Director

Name (in BLOCK CAPITALS)

Date

Address

MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST
LEIGHTON HOSPITAL
CREWE
CHESHIRE CW1 4QJ

EXECUTED as a **DEED** by

CHESHIRE & WIRRAL PARTNERSHIP NHS FOUNDATION TRUST (1)

Director

Name (in BLOCK CAPITALS)

Date

Address

CHESHIRE & WIRRAL PARTNERSHIP NHS FT
TRUST HQ, REDESMERE
COUNTESS OF CHESTER HEALTH PARK
LIVERPOOL ROAD
CHESTER CH2 1BQ

EXECUTED as a **DEED** by

CHESHIRE EAST COUNCIL (2)

Director

Name (in BLOCK CAPITALS)

Date

Address

CHESHIRE EAST COUNCIL
WESTFIELDS
MIDDLEWICH ROAD
SANDBACH CW11 1HZ

EXECUTED as a **DEED** by

EAST CHESHIRE TRUST (3)

Director

Name (in BLOCK CAPITALS)

Date

Address

EAST CHESHIRE NHS TRUST
VICTORIA ROAD
MACCLESFIELD SK10 3BL

EXECUTED as a **DEED** by

SOUTH CHESHIRE AND VALE ROYAL GP ALLIANCE LIMITED (5)

Director

Name (in BLOCK CAPITALS)

Date

Address

C/O SANDISON EASSON & CO
REX BUILDINGS
ALDERLEY ROAD
WILMSLOW SK9 1HY

EXECUTED as a **DEED** by

VERNOVA HEALTHCARE COMMUNITY INTEREST COMPANY (6)

Director

Name (in BLOCK CAPITALS)

Date

Address

WATERS GREEN MEDICAL CENTRE
SUNDERLAND STREET
MACCLESFIELD SK11 6JL

SCHEDULE 1

Definitions

1 **Interpretation**

1.1 The headings in this Agreement will not affect its interpretation.

1.2 Reference to any statute or statutory provision, to law, or to guidance, includes a reference to that statute or statutory provision, law or guidance as from time to time updated, amended, extended, supplemented, re-enacted or replaced.

1.3 Reference to a statutory provision includes any subordinate legislation made from time to time under that provision.

1.4 References to clauses, paragraphs and schedules are to the clauses, paragraphs and schedules of this Agreement, unless expressly stated otherwise.

1.5 References to anybody, orga nisation or office include reference to its applicable successor from time to time.

1.6 this Agreement or those other documents or resources as varied, amended, supplemented, extended, restated and/or re laced from time to time and any reference to a website address for a resource includes reference to any replacement website address for that resource.

1.7 Use of the singular includes he plural and vice versa.

1.8 Use of the masculine include the feminine and vice versa.

1.9 Use of the term “including” o “includes” will be interpreted as being without limitation.

1.10 The following words and phras es have the following meanings:

"Agreement"	means this Agreement;
"Background IP"	means Intellectual Property that is owned by or otherwise in the possession of a Partner at the date of this Agreement or which is created and developed by a Partner other than in the course of carrying out its obligations under this Agreement or expressly for the purposes of the Partnership
"Best for Service"	means best for the achievement of the Objectives on the basis of ensuring coherence with the Principles for the benefit of the population of Cheshire East;
"Breakage Costs"	has the meaning in clause 20.5(a);
"Business Day"	means any day which is not a Saturday, Sunday or a bank or public holiday in the United Kingdom;

"Cabinet Office Statement"	means the Cabinet Office Statement of Practice '*Staff Transfers in the Public Sector*' January 2000;
"CEICP"	means the Partnership, being the Cheshire East Integrated Care Partnership;
"Commissioners"	means NHS Cheshire Clinical Commissioning Group
"Confidential Information"	means the existence of this Agreement, the provisions of this Agreement and all information which is secret or otherwise not publicly available (in both cases in its entirety or in part) including commercial, financial, marketing or technical information, know-how, trade secrets or business methods, in all cases whether disclosed orally or in writing before or after the date of this Agreement;
"FOIA"	means the Freedom of Information Act 2000;
"Foreground IP"	means Intellectual Property created or developed by a Partner or Partners in the course of carrying out its obligations under this Agreement and/or expressly for the purposes of the Partnership;
"Insolvency Event"	means any of the following events or circumstances:

a) where a Partner suspends, or threatens to suspend, payment of its debts (whether principal or interest) or is deemed to be unable to pay its debts within the meaning of Section 123(1) of the Insolvency Act 1986;

b) where a Partner calls a meeting, gives a notice, passes a resolution or files a petition, or an order is made, in connection with the winding up of that Partner (save for the sole purpose of a solvent voluntary reconstruction or amalgamation);

c) where a Partner has an application to appoint an administrator made or a notice of intention to appoint an administrator filed or an administrator is appointed in respect of it or all or any part of its assets;

d) where a Partner has a receiver or administrative receiver appointed over all or any part of its assets or a person becomes entitled to appoint a receiver or administrative receiver over such assets;

e) where a Partner takes any steps in connection with proposing a company voluntary arrangement or a company voluntary arrangement is passed in relation to it, or it commences negotiations with all or any of its creditors with a view to rescheduling any of its debts; or

f) where a Partner has any steps taken by a secured lender to obtain possession of the property on which it has security or otherwise to enforce its security; or

g) where a Partner has any distress, execution or sequestration or other such process levied or enforced on any of its assets which is not discharged within 14 Business Days of it being levied;

h) where a Partner has any proceeding taken, with respect to it in any jurisdiction to which it is subject, or any event happens in such jurisdiction that has an effect equivalent or similar to any of the events listed above; and/or

i) where a Partner substantially or materially ceases to operate, is dissolved, or is de-authorised as an NHS trust or NHS foundation trust;

j) where a Partner is clinically and/or financially unsustainable as a result of any clinical or financial intervention or sanction by the regulator responsible for the independent regulation of NHS trusts or NHS foundation trusts or the Secretary of State and which has a material adverse effect on the delivery of the Services; and

k) where a trust special administrator is appointed in relation to a Partner under the National Health Service Act 2006 or a future analogous event occurs;

"Intellectual Property" means rights in and to inventions, patents, design rights

	(registered or unregistered), copyrights (including rights in software), rights in confidential information, database rights and any similar or analogous rights that exist anywhere in the world and including any application for any registration of the foregoing, but shall not include any rights in an Partner's name, brand or registered trademark;
"MCP"	means the Partners acting together having been identified by the Commissioners as the group of providers which are the most capable provider for the provision of the Services;
"Objectives"	means the objectives set out in clause 4;
"Partner Sub-contract(s)"	means the sub-contract(s) to be entered into between MCHFT (as Services Contract Host) and each of the other Partners as part of the arrangements contemplated by this Agreement;
"Partners"	means MCHFT, CWP, ECT, SCVR GPA, CEC and VGPF (or such of them as the context requires) and '**Partner**' means any one of them;
"Partnership"	means the partnership formed by the Partners pursuant to this Agreement and to be known under the name of 'Cheshire East Integrated Care Partnership'.(CEICP), which, for the avoidance of doubt, is not a legal entity;
"Partnership Board"	means the Board established by the Partners for the oversight and management of the Partnership as more
"Reserved Matters"	means those matters for collective decision by the Partners in accordance with Schedule 2 and as listed in Annex 1 to this Agreement;
"Senior Officer"	has the meaning in clause 11.1;
"Service User"	means a patient or service user for whom the Commissioners has statutory responsibility and who receives Services under the Services Contract;
"Services"	means the community healthcare services to be delivered by the Partners as described more fully in the Services Contract;
"Services Contract"	means the services contract to be entered into between the Commissioners and MCHFT (as Host) on or about the date of this Agreement under which MCHFT will assume responsibility for the hosting of the Partnership arrangements and governance

	infrastructure. and delivery with partners of Services as appropriate;
"Sub-contractors"	means each of CWP, SCVR GPA, CEC and VGPF in their capacity as a contractual sub-contractor to MCHFT (The Host) pursuant to any Partner Sub-contract;
"Transformation Themes"	means the initial key themes agreed between the Partners which sets out how the Transformation and development of Services will evolve so as to achieve the Objectives;
"TUPE"	means the Transfer of Undertakings (Protection of Employment) Regulations 2006 and EC Council Directive 77/187; and
"Vision"	Means the vision of the Partnership for the delivery and transformation of the Services as described more fully in clause 4.

SCHEDULE 2

Governance Arrangements

Part A: Partnership Board Arrangements

1 The following CEICP Partnership Board composition is proposed:

1.1 Mid Cheshire Hospital NHS Foundation Trust –One representative

1.2 Cheshire Wirral Partnership NHS Foundation Trust – One representative

1.3 South Cheshire and Vale Royal GP Alliance– Two representatives including at least one GP* each to ensure representation for South populations

1.4 Vernova GP* Federation– Two representatives including at least one GP to ensure representation for East populations

1.5 East Chehsire NHS Trust –One representative

1.6 Cheshire East Council –One representative

1.7 Community Voluntary Services – One representative

***** One GP will also be Deputy Chair

Board will be supported by:

- ICP Chair
- ICP Director.

The Board will be administered by:

- ICP Director PA

2 Each representative will have delegated authority, within agreed permissions and within financial and clinical governance structures.

3 For community services provision in the South, It should be noted that the representatives include all partners within the Central Cheshire Integrated Care Partnership (SC and VR GP Alliance, CWP and MCHFT).

4 The creation of a Transformation Delivery Group will help to ensure that escalation and reporting will flow into the Clinical Transformation Board and CEICP Partnership Board.

5 Any Partner may remove or replace their respective Partnership Board representative(s) at any time subject to the consent of the other Partners, such consent not to be unreasonably withheld or delayed.

6 Any Partnership Board member may appoint a deputy to act on their behalf. A deputy Partnership Board member will be entitled to attend, be counted in the quorum and make decisions at any meeting at which the Partnership Board member appointing them is not

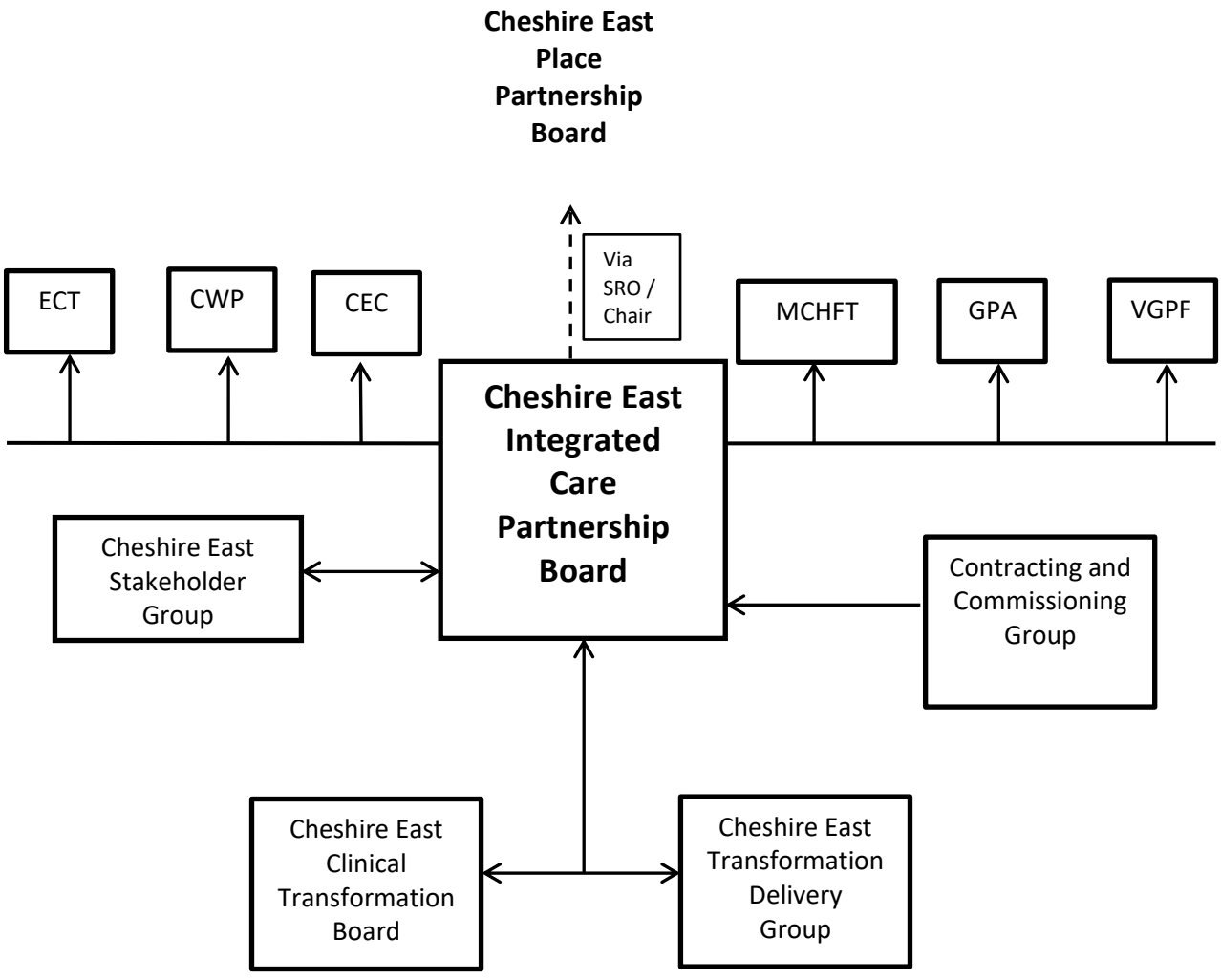
personally present and to do all the things which their appointing Partnership Board Member is entitled to do.

7 As outlined, each of the Partners will have equal representation within the overall CEICP governance structure and on the CEICP Partnership Board. Key activities will move forward when consensus has been reached as opposed to a majority vote.

8 Decisions on Reserved Matters (Appendix 1 to this Agreement) shall require the unanimous decision of all Partners, such decision to be taken in accordance with the Principles.

9 Where there are matters that cannot be resolved by the CEICP Partnership Board, the Partners have agreed to adopt the decision making process set out within Part B of this Schedule 2. Within this, where a consensus cannot be reached, the Partners agree that they shall first try to resolve such dispute informally and in good faith through each Partner's Senior Officers to find a resolution within a defined timescale.

10 For CEICP, the Cheshire East Integrated care Partnership Board members will be accountable to their own organisaton Directors / governing bodies. The CEICP Board will report to the Cheshire East Place Partnership Board.
The diagram below illustrates this arrangement noting that will be reviewed and amended to reflect arrangements in practice as they evolve.



11 The Partnership together with the Commissioners and other key stakeholders including the LMC will sit on the Stakeholder Group. The business of the Stakeholder Group will be to provide engagement, support and influence to the Cheshire East ICP Strategic Plan, to endorse the CEICP annual work plan as well as monitoring progress.

12 Accountability for the delivery of the Services as between MCHFT and the Commissioner will be via the Services Contract. Similarly, accountability for the Services as between MCHFT and any sub-contractors such as CWP, ECT, CEC will be pursuant to any Material Sub-contracts specified in the Services Contract, although the entire Partnership will input into delivery of Services pursuant to their membership of the Partnership and existing contractual arrangements.

13 The day to day delivery of the CEICP activities will be undertaken using the MCHFT governance / infrastructure arrangements as the Host. Assurance and Accountability will be through the ICP Director to the Chair of the Partnership Board and the Board itself.

14 As part of the services review process, the governance arrangements will be reviewed to ensure they meet the developing Services delivery requirements. This will initially be within the first six months of the date of this Agreement and annually thereafter to ensure the arrangements best support the delivery of new care models.

15 The CEICP Board will receive assurance about Partner performance in delivering the Services through reports that are derived from the performance information presented to each Partner's Board; Partners will be accountable for the delivery of the Services through the mechanism of the Services Contract (and, as relevant, Material Sub-contracts).

16 Risk share arrangements

As set out in this Agreement, the Partners will develop risk/reward sharing mechanism during the development of the Services Contract. Within this, it is recognised that the risk allocation between the Commissioners and MCHFT under the Services Contract will develop and evolve during the term of the Services Contract and the risk/reward arrangements between the Partners will need to be further developed and agreed.

17 Partner involvement

The Partners are already part of an established System wide Cheshire East Partnership Board and during the ICP development this will ensure that Partners can assure effective, collaborative working between professional groups, across a wider range of services and providers. It will also contribute to enhancing the existing strong, established relationships with Cheshire West ICP, Cheshire West and Chester Council, NWAS and Voluntary and Community Sector partners.

18 Audit and monitoring arrangements

Whilst external and internal audit and monitoring mechanisms are relatively well defined within the organisations that make up the Partnership, these mechanisms will need to be reviewed to ensure clear performance and monitoring systems are in place that take account of any Partnership responsibilities. The CEICP Partnership Board will work to ensure that these are in place and build on the arrangements set out within a Partnership Framework. The

Partnership Governance itself will be subject to an annual audit review to ensure it continues to follow good governance practice and principles.

Part B – Proceedings of the Partnership Board and Dispute Resolution

19 The Partnership Board will be responsible for, directing and leading the Partnership in accordance with the Principles, setting overall strategic direction in order to meet the Objectives and the Vision.

20 Decisions of Partnership Board are to be taken by the Partners' representatives acting unanimously and making decisions in accordance with the Principles.

21 The Partnership Board will meet as required, but not less than once a month.

22 The Partnership Board members shall agree and appoint a representative (or in his/her absence his/her deputy representative) to be the chair of the Partnership Board (the **"Chair"**). The Partners agree that the role of Chair over future years should be a General Practitioner. The Chair shall have no casting vote given the requirement for consensus and, in the case of Reserved Matters, the need for unanimity.

23 The Partnership Board may regulate their proceedings as they see fit save as set out in this Schedule 2 (Governance).

24 Save as set out in this paragraph 20, no matter will be decided at any meeting unless a quorum is present. A quorum will not be present unless all Organisational Partners are represented at the meeting.

25 A meeting of the Partnership Board may consist of a conference between the Partnership Board members (or their deputy representatives) who are not all in one place, but each of whom is able directly or by telephonic or video communication to speak to each of the others, and to be heard by each of the others simultaneously.

Dispute Resolution

26 The Partners commit to working cooperatively to identify and resolve issues to their mutual satisfaction so as to avoid all forms of dispute or conflict in performing their obligations under this Agreement.

27 The Partners believe that:

(a) by focusing on the Objectives and Principles;

(b) being collectively responsible for all risks; and

(c) fairly sharing risk and rewards as part of any Risk/Reward Mechanism, will reinforce the commitment to avoiding disputes and conflicts arising out of or in connection with the Partnership.

28 The Partners shall promptly notify each other of any dispute or claim or any potential dispute or claim in relation to this Agreement or the operation of the Partnership (each a **"Dispute"**) when it arises.

29 The Partnership Board shall deal proactively with any Dispute on a Best for Service basis in accordance with this Agreement so as to seek to reach a unanimous decision. If the Partnership Board reaches a decision that resolves, or otherwise concludes a Dispute, it will advise the Partners of its decision by written notice. Any decision of the Partnership Board in relation to a Dispute will be final and binding on the Partners.

30 The Partners agree that the Partnership Board, on a Best for Services basis, may determine whatever action it believes is necessary including the following:

(a) If the Partnership Board cannot resolve a Dispute, it may select an independent facilitator to assist with resolving the Dispute; and

(b) The independent facilitator shall:

(i) be provided with any information he or she requests about the Dispute;

(ii) assist the Partnership Board to work towards a consensus decision in respect of the Dispute;

(iii) regulate his or her own procedure and, subject to the terms of this Agreement, the procedure of the Partnership Board at such discussions;

(iv) determine the number of facilitated discussions, provided that there will be not less than three and not more than six facilitated discussions, which must take place within 20 Business Days of the independent facilitator being appointed; and

(v) have its costs and disbursements met by the Partners in equal shares.

(c) If the independent facilitator cannot facilitate the resolution of the Dispute, the Dispute must be considered afresh in accordance with this Schedule 2 and only after such further consideration again fails to resolve the Dispute, the Partnership Board may decide to:

(i) following consultation and agreement with the Commissioners, terminate the Partnership; or

(ii) agree that the Dispute need not be resolved.

31 The Partnership Board shall use its best endeavors to reach its decision under paragraphs 25 or 26 within 3 months of the date the matter was first referred to it.

SCHEDULE 3

Transformation Themes

The Partners have agreed the following initial themes in relation to the development of a programme of transformation and service development. The work programmes for each of these themes will be developed and overseen by the ICP Board through the sub group structure (in development). . These themes will be used to develop, test and amend the development of the work programme for the ICP. Each theme has been chosen in agreement with all partners and reflects key health and care priorities for the population of Cheshire East

- Cardiovascular services
- Children's Hubs
- Respiratory services
- Mental Health and Well Being (focusing on social prescribing)

APPENDIX 1

Reserved Matters

The Partners agree, in accordance with the provisions of clause 6.1(b), that decisions which affect the strategic direction of the Partnership and/or the Services, distinct from decisions about operational aspects of Services delivery, shall be treated as Reserved Matters for the purposes of the governance arrangements, and require the unanimous approval of the Partners. Additionally, the following matters are reserved for the unanimous approval of the Partners.

1 The approval of a new member of the Partnership;

2 The approval of any changes to the Transformational Plan;

3 The approval of any transfer of Services, either from one Partner to another or to a third party;

4 The approval of entering into any new contracts for services by the Partnership, for example as a result of a collective bid by the Partnership (for the avoidance of doubt, this does not prevent any Partner from bidding for new opportunities in its own right);

5 The agreement of any material changes to the Services Contract, to include any changes that affect the specifications, or could have a negative impact on the reputation of any of the Partners, whether individually or collectively;

6 The approval of the risk/reward sharing mechanism (clause 10) and any changes thereto;

7 The approval of the publicity, branding and user-facing communications of the Partnership;

8 The approval of any changes to the Partnership's governance arrangements (Schedule 2).

In making decisions in relation to any reserved matter described in this Appendix 1 the Partners shall act in accordance with the Objectives and Principles.

BOARD OF DIRECTORS

Agenda Item	**8.2**	Date of Meeting: 07/09/2020
Report Title	Cheshire East Integrated Care Partnership – Terms of Reference	
Executive Lead	Denise Frodsham, Director of Strategic Partnerships	
Lead Officer	Denise Frodsham, Director of Strategic Partnerships	
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)*	
To note the terms of reference in line with governance requirements of the ICP to each Provider Board	
Impact *(is there an impact arising from the report on the following?)*	
• Quality ☐ • Finance ☐ • Workforce ☐ • Equality ☐	• Risk ☐ • Compliance ✓ • Legal ☐
Equality Impact Assessment (*must accompany the following submissions)*	
• Strategy ☐ Policy ☐ Service Change ☐	

Strategic Objective(s) *(indication of which objective/s the report aligns to)*	
• Manage the impact of covid and ensure safe recovery ☐ • Deliver outstanding care and patient experience Deliver the most effective care to achieve best possible outcomes ✓ • Ensure MCHFT is the best place to work ☐	• Provide safe and sustainable healthcare through our estate, infrastructure and planning ☐ • Provide strong system leadership by working together ✓ • Be well governed and clinically led ✓
Governance *(is the report a…?)*	
• Statutory requirement ☐ • Annual Business Plan Priority ✓ • Strategic/BAF Risk ☐ • Service Change ☐	• Other ☐ *rationale for Board submission required:*
Next Steps (*actions following agreement by Board/Committee of recommendation/s)*	
To develop and agree the CEICP Board work programme, risk log. To update and complete the draft CEICP strategy including the ICP Transformation plan by September 20	

CHESHIRE EAST INTEGRATED CARE PARTNERSHIP BOARD

TERMS OF REFERENCE

1. Formation of this Board

The Partners have established a Board, known as the Cheshire East Integrated Care Partnership Board (CEICP), accountable to each of the Partner Boards of Directors (MCHFT, CWP and ECT), Cheshire East Council and the governing bodies of South Cheshire Vale Royal GP Alliance Ltd and Vernova Healthcare Community Interest Company and reporting to the Cheshire East Place Partnership Board. The Community and Voluntary Services Lead will also be in attendance and reporting back to their representative organisation

The Board is a partnership of equals, responsible for directing and leading the development of the Integrated Care Programme for Cheshire East, setting the strategic direction, vision and objectives in accordance with the principles described within the Partnership Agreement (Memorandum of Understanding) and Place Plan. The Board will play a leading part in supporting, capturing and implementing innovation to improve the outcomes for the population of Cheshire East.

The Board has authority of its partner organisations within agreed delegated matters for undertaking this work as well as providing information and assurances to each Board of Directors or Governing Body as necessary.

2. Purpose

The purpose of Board is to bring together senior leaders from each partnership organisation to ensure an agreed approach to reduce existing health inequalities and deliver safe, high quality services that are sustainable in the long term and will derive long term benefits for patients and communities it serves.

It will do this by:

- Working within an integrated and shared governance structure to reduce and manage risk, particularly with regard to unwarranted variation and spend within a culture of encouraging innovation and learning from things that go well and equally don't go well.

- Establishing effective communication and deliver strategies which ensures staff, patient and community engagement and involvement is effective so as to create an integrated workforce and culture that embraces change and secures the implementation of new service models and ways of working.

- Ensures standardisation and levelling up of quality and service provision by reducing unwarranted variation, ensuring equity and service stabilisation as well as supporting the Care Community freedoms to offer care based on identification of local health and social care needs. Using best practice and benchmarked data to identify the quality and efficiency benefits that can be achieved across the population, specific patient groups and pathways of care.

- Promote a strong focus on population health, prevention of ill health, and self-care, supporting and mobilising patients and communities.

- Developing person centred integrated care pathways with a bias and high ambition for out of hospital delivery and creating the opportunity to integrate physical and mental health assessment and services to offer improved person centered decision making.

- Focusing on transformation and staff led innovation to deliver new models of care - integrated community based teams of GPs and physicians, social care professionals, pharmacists, physical and mental health nurses and therapists; redesigning outpatients, older peoples and long term conditions care, and diagnostics as part of extended community based teams. The ICP Principles for transformation to include:

    - Care delivery for the population will occur through services that are:

        - Aligned with PCNs (30-50K)

        - Coordinated around PCNs (50k)

        - Specialist (>250k)

    - The triple aim of improving individual quality of care, delivering improved outcomes for the population and delivering value for money.

    - Delivery of new models of outpatient care, including reduction of "routine" outpatient follow ups, and increased digitally enabled consultation/support to General Practice.

    - Improved responsiveness of community health services to deliver timely crisis support and reablement.

    - Increased delivery of same day urgent and emergency care.

    - To use the "Jonkoping approach" where clinicians work together to deliver integrated care for individuals and their local population.

    - Use of QI methodology to improve, measure improvement and transform services.

- Workforce development to actively seek new opportunities to train, develop and support staff, improve staff resilience, enable new ways of working, utilising technology and creating new roles that focus on upskilling the generalist workforce to keep services and pathways of care locally delivered where appropriate to do so.

3. Authority of Board

The CEICP Board undertakes an ongoing programme of work commencing formally from July 1st 2020. The strategy, work programme and Terms of Reference of the Board will be reviewed and updated annually unless they are required to be reviewed earlier.

4. Membership

The Board will be made up of Chair, ICP Director, Director Level representatives from each organisation with one member from MCHFT, CWP, ECT, CEC and two each from SCVR GP Alliance and Vernova GPCIC to ensure valuable clinical leadership to deliver the transformation agenda. In attendance will be the CVS lead and ICP communications and engagement lead.

The representatives are as follows:

Chair

Sheena Cumiskey – Chief Executive (Non voting)

ICP Director

Denise Frodsham – Director Strategic Partnerships, ICP Director (Non voting)

MCHFT (One vote)

Chief Executive Officer (CEICP Host)

CWP (One vote)

Medical Director

ECT (One vote)

Chief Executive Officer

CEC (One vote)

Interim Strategic Director of Adult Social Care and Health

SCVR GP Alliance (One collective vote)

GP

GP, Associate Medical Director ICP Transformation

VGPF (One collective vote)

GP, Associate Medical Director ICP Board

Chief Executive Officer

5. Frequency of Meetings

Meetings shall be held monthly with additional meetings held on an exception basis at the request of the Chair on behalf of the Board.

6. Administration of the meeting

The ICP Director will make arrangements to ensure that the Board is supported administratively. Duties in this respect will include development and monitoring of the approved Work Programme, agenda setting, overseeing accurate records of minutes and providing appropriate support to the Chair and Board members.

7. Chair, ICP Director and Deputy Chair

Chair -Sheena Cumiskey, Chief Executive Officer, CWP

Deputy Chair – Dr Paddy Kearns, VGPF

As the host of the ICP it is agreed that MCHFT will not hold the office of these positons.

ICP Director – Denise Frodsham, Director Strategic Partnerships, MCHFT

The positions of Chair and Deputy Chair will be subject to annual review

8. Quorum

The quorum shall be at least one partner member from each of the organisations. The Board shall also have as a minimum one clinical member of the Board in attendance.

If a deputy is representing a Member of the Board, then that individual will be expected to be able to make and approve decisions on behalf of the formal member.

9. Attendance at Meetings

Each member is required to attend at least 75% of meetings per annum to ensure adequate representation to the Board. Where the member is unable to attend, a deputy is required to ensure quoracy which is 100% of member organisation representation.

Members can attend by two way audio link, including telephone, video or computer link (excepting email communication). Participation in this way will be deemed to constitute presence in person at the meeting and count towards the quorum)

Other senior employees / stakeholders may be invited to attend by the Chair either on a standing basis or as and when required according to the needs of the Board. There will be a standing invitation to the Communications and Engagement Lead for CEICP and Community Voluntary Services lead for East Cheshire

10. Notice of Meetings

Meetings of the Board shall be called at the request of the chair. Notice of each meeting, including an agenda and supporting papers shall be forwarded to each member of the Board not less than 7 calendar days before the date of the meeting.

11. Agenda and Action Points

The agenda and action points of all meetings of the Board shall be produced in the standard agreed format and kept by the Personal Assistant

12. Reporting Arrangements

The proceedings of each meeting of the Board shall be reported (either in full or via escalation) to the next meeting of each of the Partner Board of Directors / Governing Bodies. Each Lead Director shall report any issues that require escalation or disclosure. The minutes will be reported via the Chair to the Cheshire East Place Partnership Board

13. Responsibilities of the Board

The Partners agree, in accordance with the provisions of Partnership Agreement that the Board are responsible for

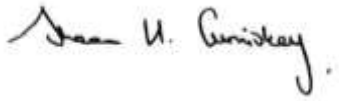
- All decisions which affect the strategic development and implementation of the ICP Partnership activities, distinct from decisions about operational aspects of Services delivery, and these shall be the core responsibilities for the Board. For the purposes of the

governance arrangements, these decisions require the unanimous approval of the Partners.

Additionally, the following matters are the responsibility of the Board and require unanimous approval of the Partners.

- The approval of a new member of the Partnership;
- The approval of any changes to the Transformational Plan;
- The approval of the PLACE Transformation funding allocation
- The approval of entering into any new contracts for services by the Partnership, for example as a result of a collective bid by the Partnership (for the avoidance of doubt, this does not prevent any Partner from bidding for new opportunities in its own right);
- The agreement of any material changes to the ICP Host Contract, relating to ICP matters, to include any changes that affect the specifications, or could have a negative impact on the reputation of any of the Partners, whether individually or collectively;
- The approval of the publicity, branding and user-facing communications of the ICP;
- The approval of any changes to the ICPs governance arrangements:
- In making decisions in relation to the above the Partners shall act in accordance with the Objectives and Principles laid out in the Partnership Agreement and summarised in these Terms of Reference.

Signed (Chair on behalf of Board):



Name: Sheena Cumiskey

Date: 17/08/20

QGC Committee
Chair's Assurance Report
August 2020

Report to	Board of Directors
Date	10 August 2020
Report from	Lesley Massey, NED Chair
Report prepared by	Katharine Dowson, Head of Corporate Governance
Executive Lead/s	Julie Tunney, Director of Nursing & Quality Murray Luckas, Medical Director
Committee meeting quoracy	Yes ☒ No ☐

KEY AREAS OF ASSURANCE

- **Covid Update** – one positive coronavirus patient in the hospital with 142 discharged; 49 days without a hospital-acquired transmission. Work underway to restore elective activity with focus on winter planning; A&E attendances returning to pre-Covid levels presented a significant challenge and public communication regarding use of the Emergency Department was considered important
- **Board Assurance Framework:** Committee advised of next steps in the revised risk management approach, including agendas aligned to the BAF Committee-delegated risks
- **Quality Governance Oversight Report - acceptable assurance:** three StEIS declarations in July, reviewed through Patient Safety Summit with learning shared across divisions
- **CQC Improvement Plan – acceptable assurance:** the majority of 'must-dos' requirements would be completed by end September, with the 'should dos' taken forward subsequently. Monitoring of the improvement plan is through the Quality Summit
- **Learning from Deaths Q1 2019/20 - acceptable assurance:** reporting re-started following suspension due to Covid. Work underway to understand the continued improvement in Summary Healthcare Mortality Indicator (SHMI) in the 'as expected' range (98.85) whilst the Hospital Standardised Mortality Ratio (HSMR) continued to deterioriate (105.13). The in-hospital crude death rate increased during Covid-19 as expected; a review was underway of all Covid-19 related deaths with any concerns escalated to the IPC Group. A potential avoidable death had been subject to root-cause analysis with the outcome that this was not an avoidable death
- **Medical Examiner Position - acceptable assurance:** progress made in moving towards national compliance with recruitment for a medical examiner and medical examiner's assistant underway
- **Clinical Audit Annual Report - acceptable assurance:** main focus in 2019/20 was on national clinical audits. A new clinical audit policy and standard operating procedures currently being developed and overseen by the Clinical Audit Task & Finish Group, set up to address issues identified in the CQC Improvement Plan
- **Director of Infection Prevention & Control (DIPC) Annual Report 2019/20:** key highlights included no Methicillin-resistant Staphylococcus Aureus (MRSA) blood stream infections attributable to the Trust reported; 28 cases of Clostridium Difficile Infections (CDI) against a trajectory of 27; Escherichia coli Bacteraemia (Ecoli) infections remained a challenge. The

significant impact on Infection Prevention & Control (IPC) with the onset of Covid-19 pandemic had been recognised by the Trust and investments made in support

- **Concerns, Complaints and Compliments Annual Report 2019/20:** recurring theme to majority of complaints was communication. Work underway to understand how exemplar organisations addressed this innovatively, as well as developing a civility improvement programme.

KEY CONCERNS/RISKS

None identified.

Priority Areas: DECISIONS MADE

None.

RECOMMENDATION

- Board of Directors requested to approve the Learning from Deaths Q1 2019/20 report

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

Board of Directors

Agenda Item	**9.1**	Date of Meeting: 07/09/2020
Report Title	Learning from Deaths Report Q1 2020/21	
Executive Lead	Murray Luckas, Medical Director	
Lead Officer	Becky Shenton, Patient Safety Lead	
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)*

- To note the Learning From Deaths Dashboard which describes the reported potentially avoidable deaths
- To note the Trust Mortality rates which remain a stable position

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)*

• Manage the impact of covid and ensure safe recovery	☐	• Provide safe and sustainable healthcare through our estate, infrastructure and planning	☐
• Deliver outstanding care and patient experience Deliver the most effective care to achieve best possible outcomes	✓	• Provide strong system leadership by working together	☐
• Ensure MCHFT is the best place to work	☐	• Be well governed and clinically led	✓

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)*

Review of the Learning from Deaths Policy

Introduction of the Medical Examiners role

Review of the Terms of Reference for the Hospital and Trust Mortality Reduction Groups with the Trust Mortality Reduction Group becoming more clinically case review focused

REPORT DEVELOPMENT

Committee/ Group Name	Date	Report Title	Lead	Brief summary of key issues raised and actions agreed
Hospital Mortality Reduction Group	26/06/20	Q1 2020/21 Learning From Deaths Report	Patient Safety Lead	Noted that the Trust Mortality rates which remain a stable position. 1 potentially avoidable death reported in the financial year 2020/21. Description of the case included in the report.

Learning from Deaths Quarterly Report Q1 2020/21

July 2020

'Delivering Excellence in Healthcare through Innovation and Collaboration'

Contents

1.0 Introduction

Background

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

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

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

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

Purpose

This is the twelfth iteration of our Learning from Deaths Report covering Quarter 1 of 2020/21.

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

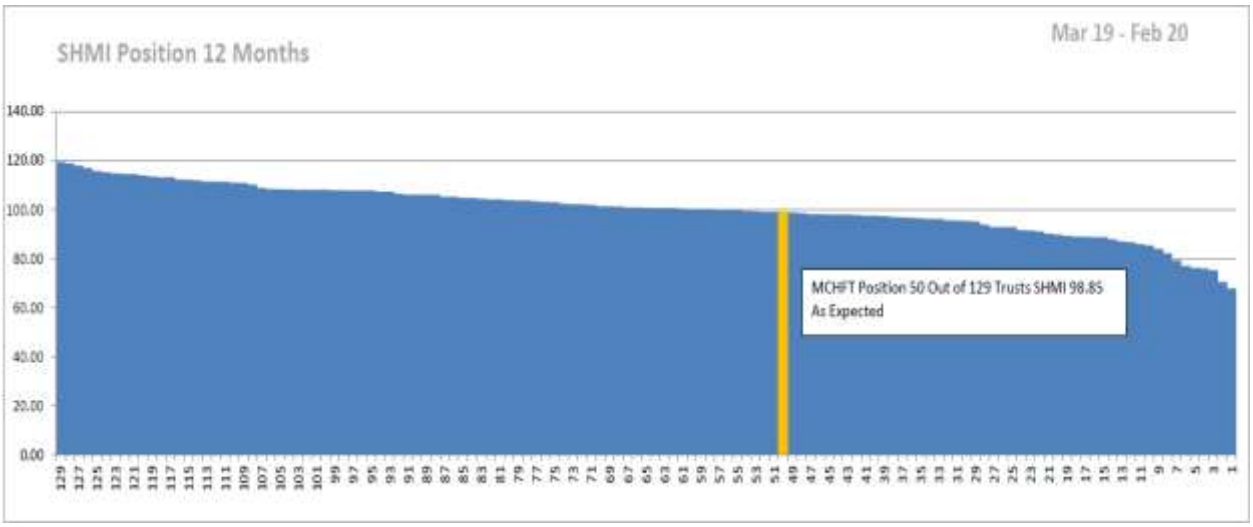
Appendices 6.2 and 6.3 provide a glossary of key terms.

In March 2020, the Learning from Deaths programme was suspended nationally due to the COVID-19 pandemic. The Trust continued to review all Learning Disability Deaths in line with the LeDeR programme. Potentially avoidable deaths were identified through the incident reporting framework and continued to be reported externally in line with the national Serious Incident Framework.

2.0 Trust Mortality Data

2.1 Summary Hospital-level Mortality Indicator (SHMI) March 2019 to February 2020

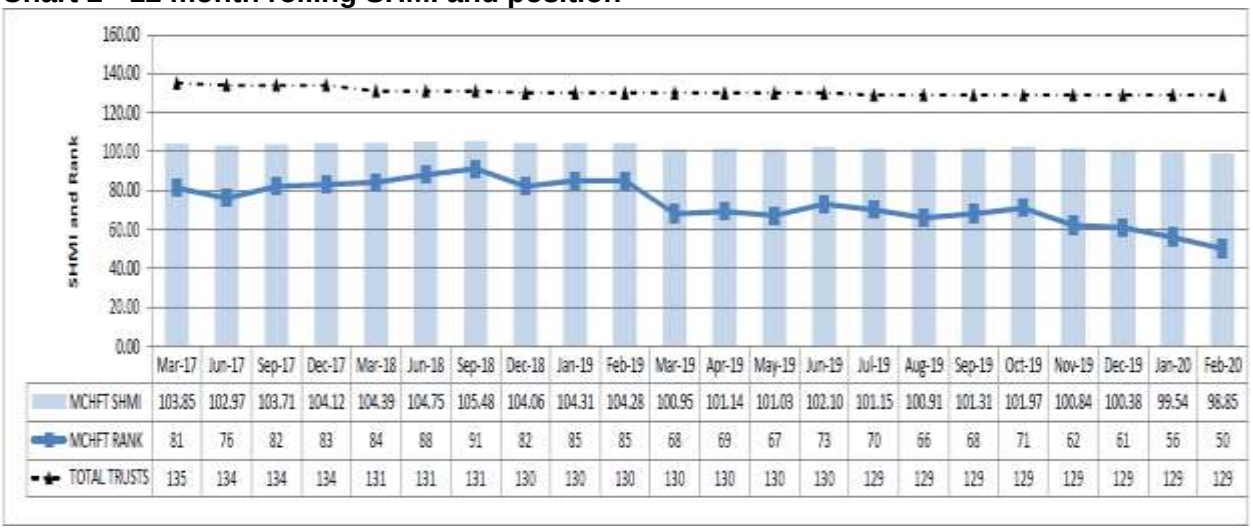
Chart 1 - SHMI Position



(Source NHS Digital, 2020)

Chart 1 demonstrates the SHMI position for the reporting period March 2019 to February 2020. The SHMI is currently 98.85 and is as 'expected'. This currently places the Trust 50 out of 129 Trusts, a stable position**.**

Chart 2 - 12 month rolling SHMI and position



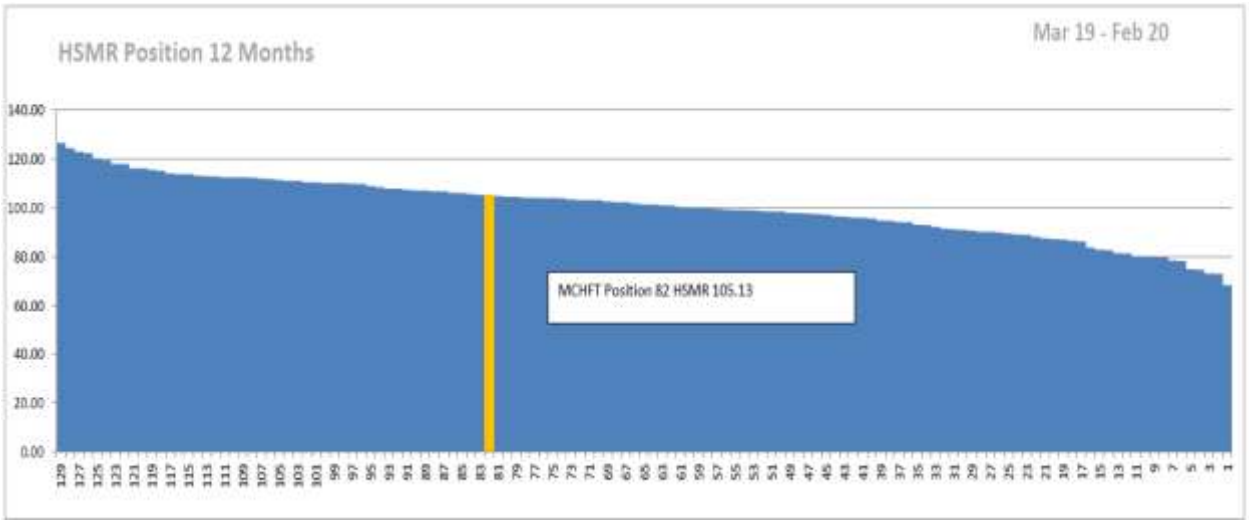
	Mar-17	Jun-17	Sep-17	Dec-17	Mar-18	Jun-18	Sep-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20
MCHFT SHMI	103.85	102.97	103.71	104.12	104.39	104.75	105.48	104.06	104.31	104.28	100.95	101.14	101.03	102.10	101.15	100.91	101.31	101.97	100.84	100.38	99.54	98.85
MCHFT RANK	81	76	82	83	84	88	91	82	85	85	68	69	67	73	70	66	68	71	62	61	56	50
TOTAL TRUSTS	135	134	134	134	131	131	131	130	130	130	130	130	130	130	129	129	129	129	129	129	129	129

(Source NHS Digital, 2020)

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

2.2 Hospital Standardised Mortality Rate (HSMR) March 2019 to February 2020

Chart 3 - HSMR Position



(Source HED, 2020)

Chart 3 demonstrates the HSMR position for the reporting period March 2019 to February 2020. The HSMR is currently 105.13 and is as 'expected, this places the Trust 82 out of 129 Trusts, a stable position.

Chart 4 - 12 month rolling HSMR and position

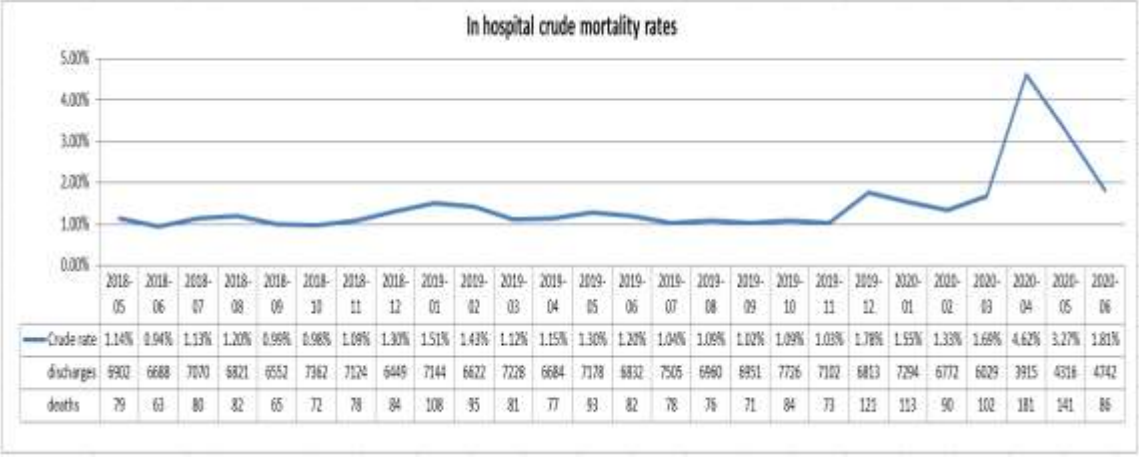
	Mar-17	Jun-17	Sep-17	Dec-17	Mar-18	Jun-18	Sep-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Feb-20
MCHFT HSMR	114.12	110.02	107.05	109.17	108.3	108.2	111.74	107.25	105.46	107.87	103.49	103.97	105.94	106.27	105.13	103.85	103.84	102.66	102.04	103.41	105.13
MCHFT RANK	123	112	108	111	102	96	107	90	87	95	75	78	85	86	81	78	74	71	66	70	82
TOTAL TRUSTS	136	134	137	137	134	134	134	134	134	134	131	131	131	131	129	129	129	129	129	129	129

(Source HED, 2020)

Chart 4 demonstrates the HSMR and rank of the Trust over time, up to the latest reporting period. Work is currently underway to try and understand why our SHMI is improving whilst our HSMR appears to be deteriorating.

2.3 Crude Mortality – Rolling 12 months

Chart 5 - Crude Mortality



	2018-05	2018-06	2018-07	2018-08	2018-09	2018-10	2018-11	2018-12	2019-01	2019-02	2019-03	2019-04	2019-05	2019-06	2019-07	2019-08	2019-09	2019-10	2019-11	2019-12	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06
Crude rate	1.14%	0.94%	1.13%	1.20%	0.99%	0.98%	1.08%	1.30%	1.51%	1.43%	1.12%	1.15%	1.30%	1.28%	1.04%	1.09%	1.02%	1.09%	1.03%	1.78%	1.55%	1.33%	1.69%	4.62%	3.27%	1.81%
discharges	6902	6688	7070	6821	6552	7362	7124	6449	7144	6822	7228	6684	7178	6832	7505	6960	6951	7726	7102	6813	7294	6772	6029	3915	4316	4742
deaths	79	63	80	82	65	72	78	84	108	95	81	77	93	82	78	76	71	84	73	121	113	90	102	181	141	86

(Source HED, 2020)

Chart 5 demonstrates the crude death rate for the period up to March 2020. The above graph shows the in-hospital crude death rate, crude death rate within 30 days of discharge and the overall in-hospital and within 30 days of discharge crude death rate combined

The in-hospital crude death rate increased during the Covid-19 pandemic as expected.

2.4 Learning from Deaths Dashboard – Part 1

The Trust has adopted the national Learning from Deaths Dashboard produced by the Department of Health. The dashboard is a tool to aid the systematic recording of deaths and learning and will be used to record the number of in-patient deaths, the number of deaths reviewed and the number of potentially avoidable deaths. Part 1 of the dashboard is presented below and includes all adult in-patient deaths, excluding maternal deaths and patients with a learning disability (see Part 2). The national guidance suggests the adoption of a Structured Judgement Review (SJR) process to review in-patient deaths, but this process does not assess the potential avoidability of the death. Therefore the "Likert preventability scale" has been added to the SJR process, in an attempt to assess whether the death was potentially avoidable. The Trust has trained a cohort of multi-disciplinary clinicians in the SJR methodology. A summary of the avoidable deaths can be seen in section 4.1. A review of all Covid related deaths is currently underway and will be presented to the Organisation in October.

Please note: The Learning from Deaths programme was suspended nationally for quarter 1 of 2020/21 due to the Covid-19 Pandemic

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

Total Number of Deaths in Scope		Total Deaths Reviewed using the Trust Mortality Tool		Total Deaths reviewed using SJR		Total Number of deaths considered to have been potentially avoidable (RCP<=3) using SJR		Total Number of deaths considered to have been potentially avoidable via alternative source (e.g. incident investigation)	
This Month	Last Month	This Month	Last Month	This Month	Last Month	This Month	Last Month	This Month	Last Month
83	139	0	0	0	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
399	296	0	70	0	33	0	0	1	3
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
399	1033	0	621	0	129	0	0	1	9

2.4 Learning from Deaths Dashboard – Part 2

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

One learning disability death was reported as a serious incident in 2019/20. A comprehensive investigation was undertaken, following which the incident was downgraded and not classified as a potentially avoidable death. The case has been reviewed through the LeDeR programme. An SJR was not undertaken as a comprehensive investigation was commenced following identification of the incident and presentation at Patient Safety Summit.

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

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
1	2	1	2	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1	5	1	5	0	0

3.0 Care Quality Commission (CQC) Mortality Outlier Alerts

The information below is sourced from the latest version of the CQC Insight document (16 July 2020). The Trust undertakes an in-depth case note review in response to any Mortality Outlier Alert.

Key Messages

- There is currently 1 active mortality alerts for the Trust.
- There are currently 0 active maternity alerts for the Trust.

Number of outlier alerts for this Trust as at 1 May 2020:

	Active alerts			Closed cases	Total
	Cases under consideration by Outliers Panel	Cases where action plans are being followed up by local inspection team	Cases for review by inspection team		
Mortality	1	0	0	11	12
Maternity	0	0	0	2	2

Mortality Outliers – Active Alerts

Cases under consideration by the Outlier Panel

- Acute cerebrovascular disease (Dr Foster, Nov 19) - New case - pending consideration (On hold as of 26/03/20 due to Covid-19)

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

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

Cases for review by inspection team

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

Maternity Outliers – Active Alerts

Cases under consideration by the Outlier Panel

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

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

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

Cases for review by inspection team

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

4.0 Learning from Deaths and Improvements

The Trust's Learning from Deaths Policy outlines the process for reviewing all in-hospital deaths. The policy is currently being review during quarter 2 of 2020/21.

The Trust learns from inpatient deaths by undertaking mortality reviews using the Royal College of Physicians Structured Judgement Review (SJR) Process. SJRs are undertaken by a cohort of senior medical and nursing staff trained in the SJR Process.

SJR blends traditional, clinical judgement-based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase. The result is a relatively short but rich set of information about each case in a form that can also be aggregated to produce knowledge about clinical services and systems of care.

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

SJRs are undertaken on all deaths which meet the criteria below:

- Deaths where families, carers or staff raise concerns
- Deaths where concerns are raised by the Coroner
- Deaths where concerns are raised at the Patient Safety Summit
- All Learning Difficulty Deaths
- All patient deaths who have a diagnosed Serious Mental Health Illness
- Outlier data deaths (This is reviewed annually by the Hospital Mortality Reduction Group
- Divisional Review Concerns

Organisation learning from the Divisional Reviews, RCA's and the SJR process must be dynamic, with immediate actions and improvements undertaken in a timely manner to prevent reoccurrence. The Trust's Incident Reporting, Management, Learning and Improvement policy describes the approach to organisational learning.
Learning from the SJR Process is shared within the organisation through a quarterly Learning from Deaths Report and Newsletter.
The quarterly Learning from Deaths Report contains the national Learning from Deaths Dashboard which is reported to Trust Board through the Trust Governance structure.
The Trust also holds a six monthly meeting for all SJR reviewers. The purpose of the meeting is to share the learning from the SJR process and also provide additional support for the SJR reviewers.
Learning from the reviews is shared through a number of other forums including at Grand Rounds, Divisional Quality Improvement Sessions and Medical Training Sessions
The Trust has a well-established HMRG led by the Medical Director. This group leads the Trust's mortality reduction programme and, on a quarterly basis, meets with the Divisional Mortality Reduction Groups to ensure a unified approach to mortality reduction across the Trust and to share learning opportunities.

4.1 Learning from Deaths Programme

Due to the Covid-19 pandemic the Learning from Deaths programme has been suspended nationally. The programme will be reinstated following the pandemic.

4.2 Summary of avoidable deaths in 2020/21

One potentially avoidable death has been reported by the Trust in quarter 1 of 2020/21.

- A female patient was admitted to Mid Cheshire Hospitals NHS Foundation Trust on the 7 April 2020, with a history of abdominal pain, distention and vomiting. A CT scan was undertaken which showed a sigmoid volvulus. The patient was transferred to theatre for a rigid sigmoidoscopy. The procedure was halted as the patient was not tolerating the rigid sigmoidoscopy and a flatus tube placement was achieved.
  The patient was transferred back to the ward for care to continue overnight with a plan for a flexi-sigmoidoscopy the following morning. The patient had regular observations overnight. The patient was found to be deceased by the consultant on the ward round at 09:30 on 8 April 2020.
  The investigation is currently ongoing. Lessons learned will be shared following the investigation review.
  There has been immediate learning with the clinical team in relation to:
  - *The calculation and escalation of deteriorating NEWS2*
  - *The review of a patient by registrar level if a patient is not improving overnight*
  - *Escalation of unwell patients to the consultant team prior to the ward round to enable early consultant review*

4.4 Next Steps

The Learning from Deaths policy is currently under review in line with changes to national guidance and the introduction of the Medical Examiners (ME) role to the Trust.

The Trust ME System is part of the Department of Health and Social Care's (DHSC's) death certification reforms programme for England and Wales. Under this programme, every Acute Trust is obliged to establish a Medical Examiner System to provide scrutiny to all deaths occurring in acute trusts. The Medical Examiner System provides safeguards for the public by ensuring proper scrutiny of all deaths, ensures the appropriate direction of deaths to the coroner and provides a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased. It improves the quality of death certification and mortality data.
ME's are appropriately trained doctors who will scrutinise all deaths occurring within the Trust. Where they have concern about the care provided to the deceased, they will escalate the case for SJR. They will also escalate significant concerns directly to the Medical Director.

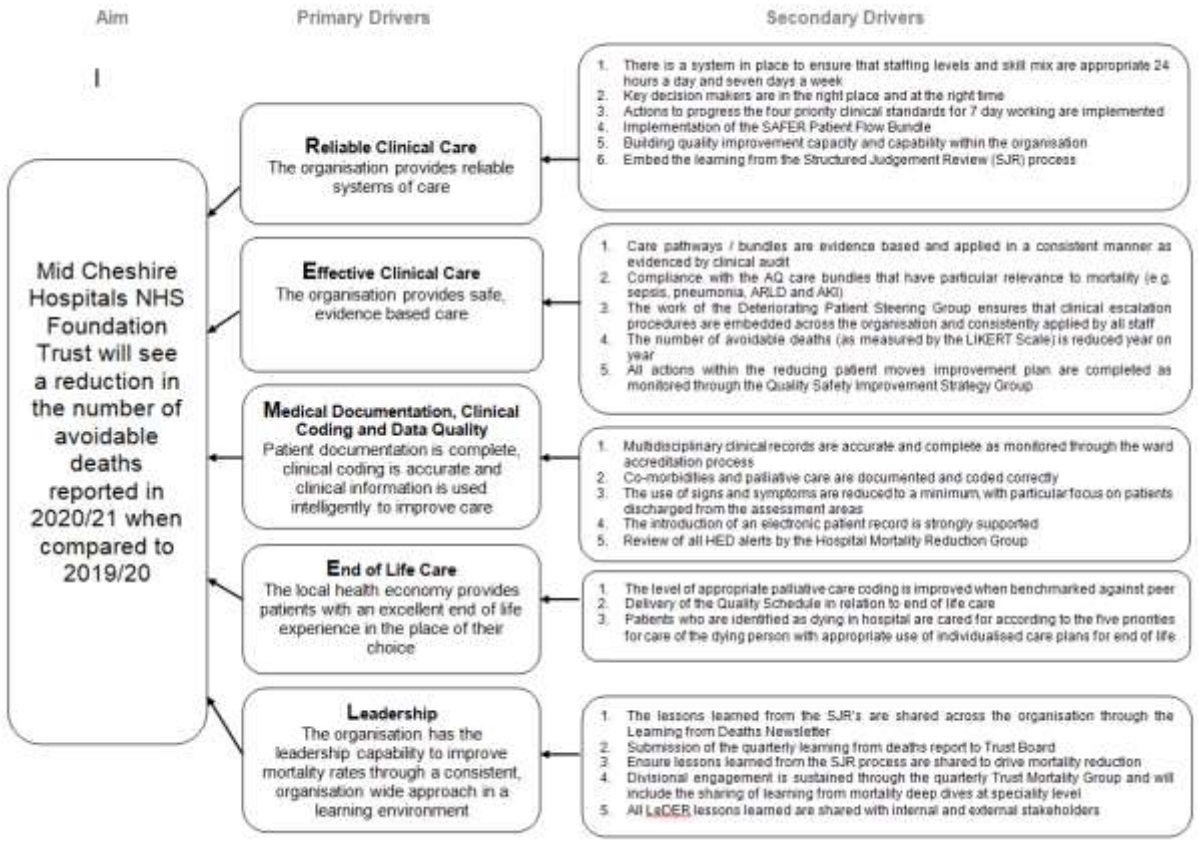
The Terms of reference for the Hospital and Trust Mortality Reduction Groups will be reviewed to introduce the changes which are being made to the Learning from Deaths policy.

The Structured Judgement Review process will be recommenced following the Covid-19 pandemic.

A review of deaths which occurred during the Covid-19 pandemic is being undertaken and will include all deaths related to Covid-19 and a sample of all other deaths from the same period. Learning will be shared from the reviews in line with the Learning from Deaths Policy.

5.0 Appendices

5.1 Appendix 1 Driver Diagram



5.2 Appendix 2 - Glossary

Healthcare Evaluation Data (HED)

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

Hospital Standardised Mortality Ratio (HSMR)

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

LIKERT Scale

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

LIKERT Scale

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

Summary Hospital-level Mortality Indicator (SHMI)

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

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

5.3 Appendix 3: Understanding the difference between SHMI and HSMR

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

BOARD OF DIRECTORS

Agenda Item	**10**	Date of Meeting: 07/09/2020
Report Title	Quality, Safety and Patient Experience Report – July 2020	
Executive Lead	Murray Luckas, Medical Director and Julie Tunney, Director of Nursing & Quality	
Lead Officer	Sheila Kasaven, 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 *(2/3 headlines only)*

- There have been 3 reportable StEIS incidents
- Incident reporting continued to improve to pre-covid-19 times
- Crude mortality is returning to a similar rate to July 2019
- Complaints performance against 40 day KPI continued to improve

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)*

• Manage the impact of covid and ensure safe recovery	☐	• Provide safe and sustainable healthcare through our estate, infrastructure and planning	☐
• Deliver outstanding care and patient experience Deliver the most effective care to achieve best possible outcomes	✓	• Provide strong system leadership by working together	☐
• Ensure MCHFT is the best place to work	☐	• Be well governed and clinically led	✓

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)*

N/A

REPORT DEVELOPMENT

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

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 reported data for incidents, serious incidents, mortality, harm metrics, and patient experience data for July 2020. Where there is variation against benchmarking rates with the data presented, recovery actions are noted.

Background and Analysis

2. Within 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 July 2020 Trust wide dashboard containing:

- Patient safety incidents – Incident reporting is continues to be reflective of pre COVID-19 times and the harm ration has reduced in both inpatients and CCICP.
- There were 3 StEIS reportable incidents in July 2020
  - **Division of Medicine:** Due to inadequate monitoring, a patient suffered a kidney injury requiring dialysis.
  - **Womens and Childrens:** A baby was born in poor condition due to inadequate monitoring. The baby has made a full recovery.
  - **Diagnostics and Clinical Support Services**: An inpatient on ward 4 developed a pressure ulcer, lapses in care have been identified.
- There were no never event in July 2020.
- The Trust remains consistently above the VTE target rate of 95%.
- For mortality rates the Trust remains within the 'as expected' range. Crude mortality rates are reflective of the rate seen in July 2019.
- There have been no MRSA cases reported for over 12 months.
- There was 1 case of hospital acquired Clostridium Difficile reported, Post incident review meeting booked. The Trust remains under the regional rate.
- There were no cases of E-Coli reported in July 2020.
- There were no cases of MSSA.

- Inpatient pressure ulcers continue to show no significant variation and are within control limits.
- Due to the change in the acuity of patients with long term conditions coupled with lifestyle choices (patients wanting to be cared for in their own homes), there is an increase in the prevalence of patients with a deterioration of skin care.
  In response to this a cluster RCA investigation has been undertaken and the lessons learned have been implemented.
- The Trust falls rate is now in line with the national target rate following the peak of COVID-19 pandemic which showed the Trust breach the target between March – May 2020.
- 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 the COVID-19 pandemic.
- The complaints recovery plan continues and the 40 day response time standard has increased to 69%.

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 through to May 2020 needs 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. The metrics in July 2020 are continuing to recover and reflect reporting numbers from pre COVID-19 pandemic.

Recommendations

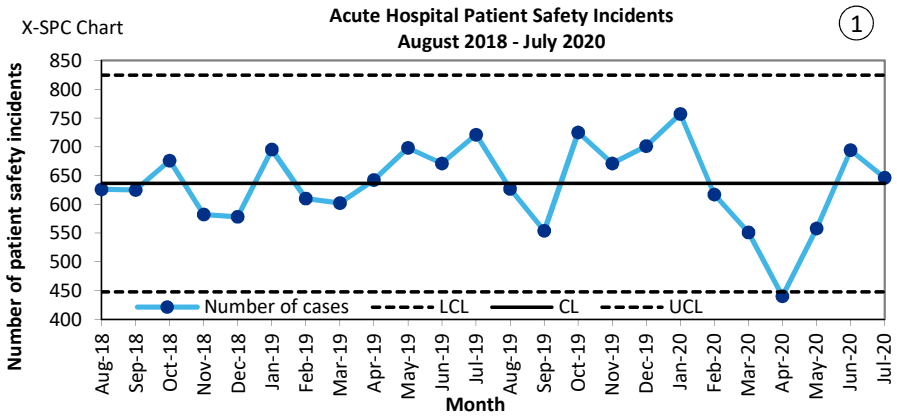
6. To agree that the actions set against any variations in totality, provide assurance that actual and latent risks related to patient safety and risks have been appropriately identified and mitigated.

Author: Associate Director of Quality Governance
Date: 27/08/2020

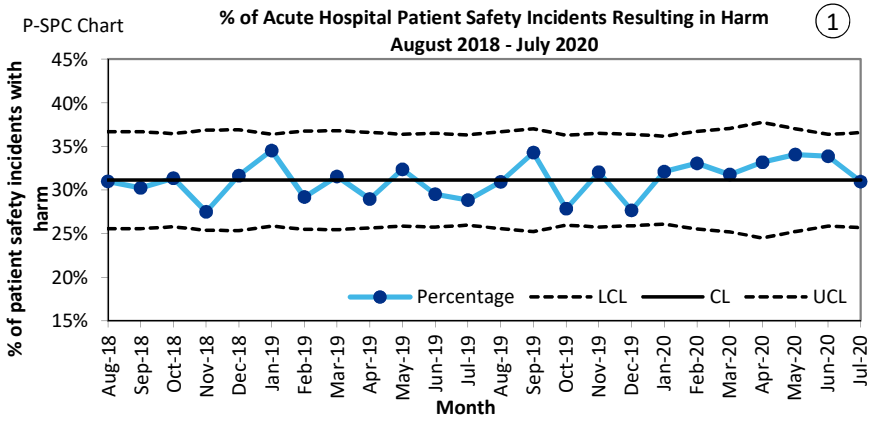
Board Papers - Quality, Safety & Experience

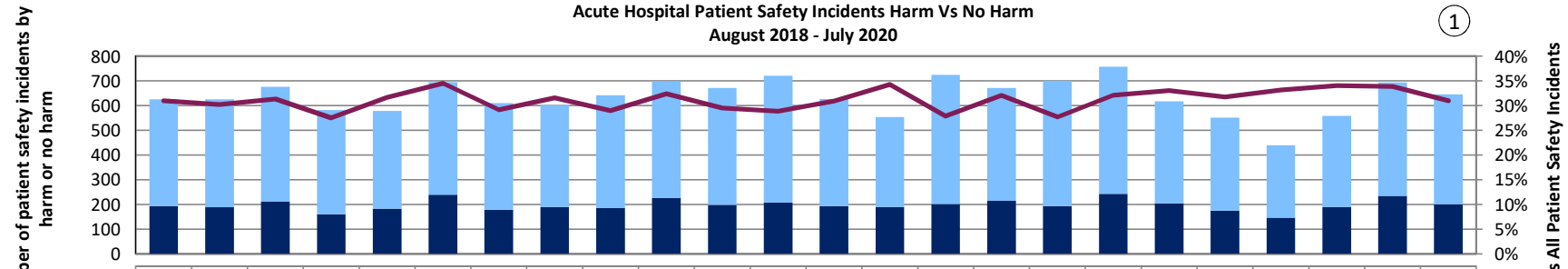
Acute Hospital Patient Safety Incidents

X-SPC Chart



P-SPC Chart





	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	May-20	Jun-20	Jul-20
No Harm	432	436	464	422	395	455	432	412	456	472	473	513	433	364	523	456	507	514	413	376	294	368	459	446
Harm	194	189	212	160	183	240	178	190	186	226	198	208	194	190	202	215	194	243	204	175	146	190	235	200
% Harm	31%	30%	31%	27%	32%	35%	29%	32%	29%	32%	30%	29%	31%	34%	28%	32%	28%	32%	33%	32%	33%	34%	34%	31%

Accountable: Medical Director
Data Owner: Quality Governance
To note: P-SPC charts adjust the control limits to take into account each month's denominator.

Key Narrative: July 2020 saw a slight fall in the total number of Acute Hospital Patient safety incidents. In month there was a reduction in the proportion of those incidents resulting in harm, down to 31% of all reported incidents, which is the mean value for the dataset.

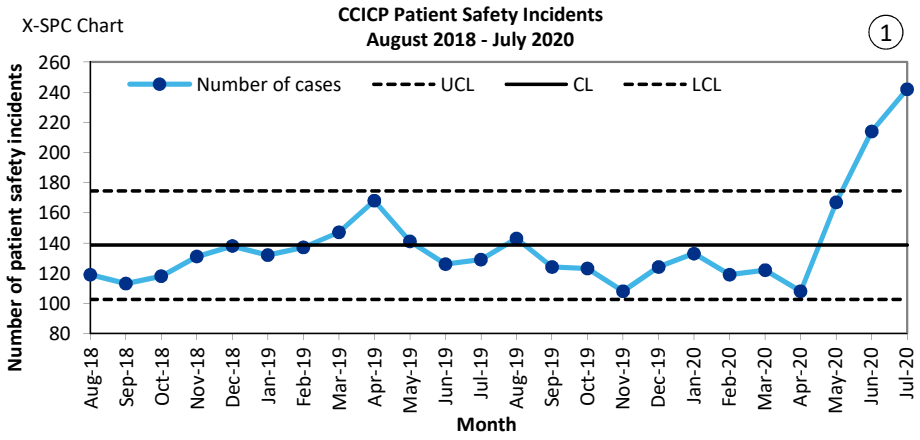
Low Harm 196, Moderate Harm 4, Serious Incident 0

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

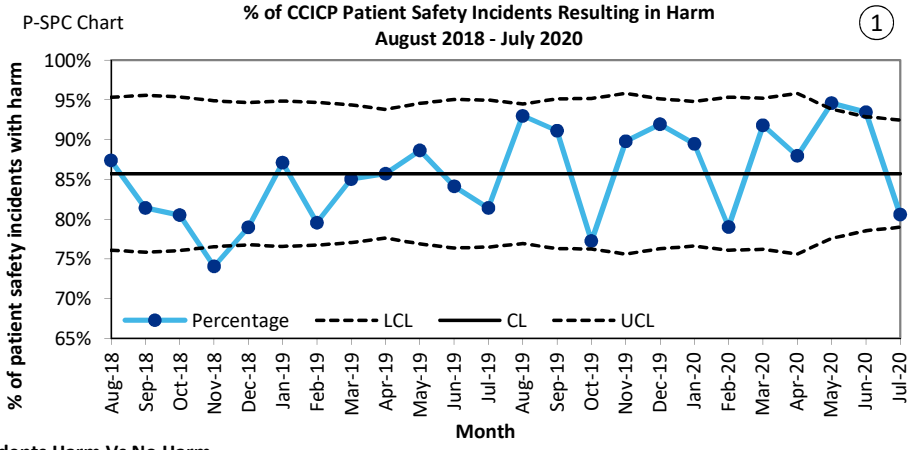
Board Papers - Quality, Safety & Experience

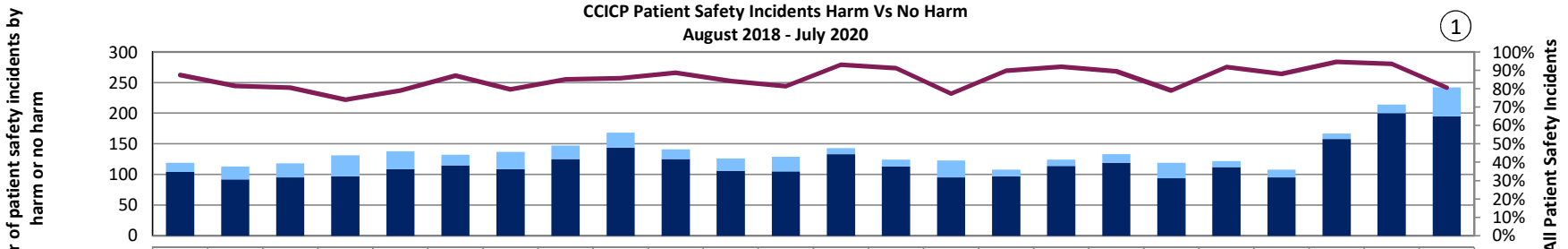
Central Cheshire Integrated Care Partnership (CCICP) Patient Safety Incidents

X-SPC Chart



P-SPC Chart





	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	May-20	Jun-20	Jul-20
No Harm	15	21	23	34	29	17	28	22	24	16	20	24	10	11	28	11	10	14	25	10	13	9	14	47
Harm	104	92	95	97	109	115	109	125	144	125	106	105	133	113	95	97	114	119	94	112	95	158	200	195
% Harm	87%	81%	81%	74%	79%	87%	80%	85%	86%	89%	84%	81%	93%	91%	77%	90%	92%	89%	79%	92%	88%	95%	93%	81%

Accountable: Medical Director
Data Owner: Quality Governance
To note: P-SPC charts adjust the control limits to take into account each month's denominator.

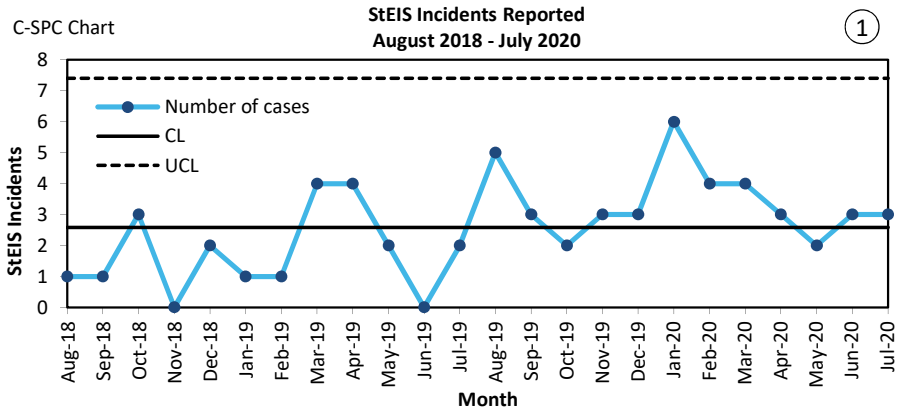
Key Narrative: July 2020 saw a sustained rise in patient safety incidents which represents a significant increase. As previosuly reported, it is highly likely that this is a result of a package of training delivered over the last 6 months within CCICP aimed at an increased reporting rate of safety incidents. Of interest is that the percentage of those incidents resulting in harm fell for the first time in 5 months.

Low Harm 191, Moderate Harm 4, Serious Incident 0

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

Board Papers - Quality, Safety & Experience

StEIS Incidents - Trust Total



Accountable: Medical Director **Data Owner:** Quality Governance

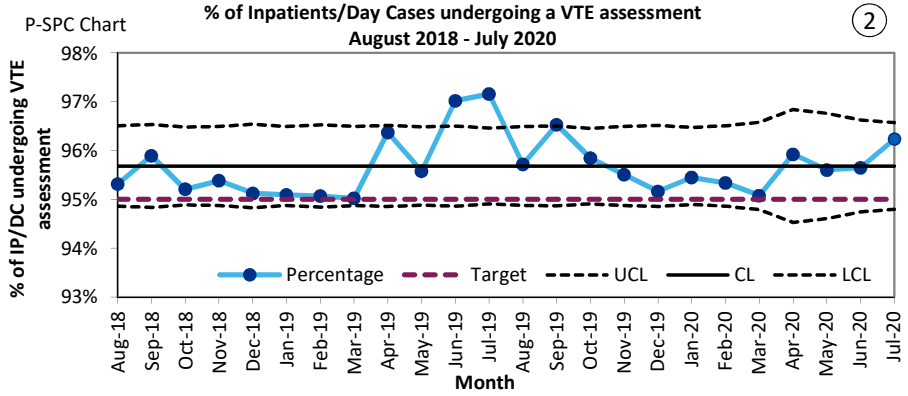
Key Narrative: In July 2020 there were 3 serious incidents declared to StEIS:

Division of Medicine: Due to inadequate monitoring, a patient suffered a kidney injury requiring dialysis. An RCA has been undertaken and lessons implemented. This incident was verbally reported to Board with the June 2020 Cohort of incidents but was registered with StEIS in July 2020.

Womens and Childrens: A baby was born in poor condition due to inadequate monitoring. The baby has made a full recovery again allowing the incident to be downgraded.

Diagnostics and Clinical Support Services: An inpatient on ward 4 developed a pressure ulcer, lapses in care have been identified and an RCA will be undertaken.

VTE

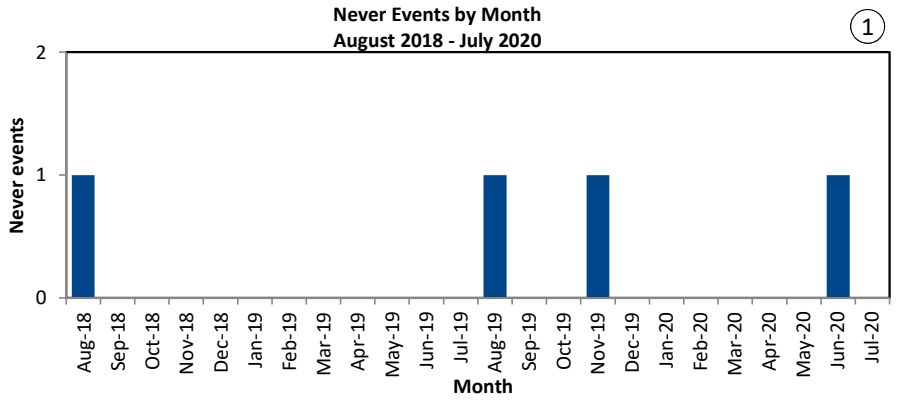


Accountable: Medical Director **Data Owner:** Information Services

Key Narrative: Compliance remains within tolerance.

To note: P-SPC charts adjust the control limits to take into account each month's denominator.

Never Events - Trust Total



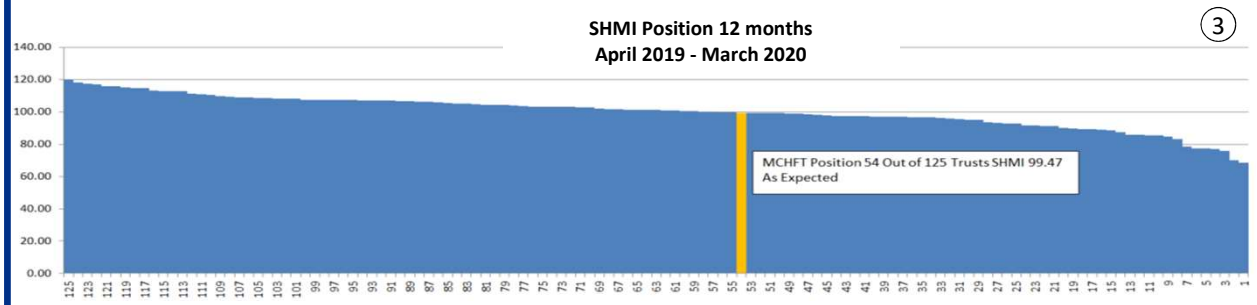
Accountable: Medical Director **Data Owner:** Quality Governance

Key Narrative: There were no Never Events reported during July 2020.

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

Board Papers - Quality, Safety & Experience

Mortality

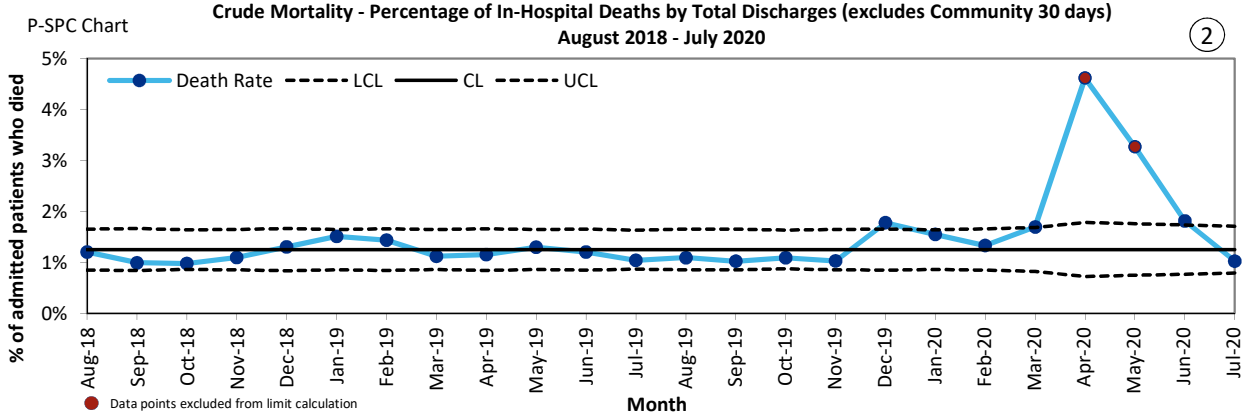


③

Key Narrative: The latest release of SHMI is 99.47 (rank 54) against the previous value of 98.85 (rank 50). Please note that the number of submitting Trusts has dropped from 129 to 125 due to Trust mergers that is now reflected in the data.

③

Key Narrative: The latest HSMR release is 108.98, again within the as expected range. Recent releases have shown a deterioration in HSMR which is likely to be the result of low rates of palliative coding compared to other Trusts.



②

Key Narrative: Crude mortality has remained largely consistent over the time period; exceptions are December 2019 & March-June 2020 where the rate increased and shows special cause variation on the chart. The latter period represents the beginning of the Coronavirus pandemic, resulting in a reduced number of inpatients within the Trust overall but an increase in the severity of illness and resultant mortality amongst the inpatient cohort.
The most recent rate for July 2020 shows a return to a level similar to July 2019.

Accountable: Medical Director
Data Owner: Quality Governance
To note: P-SPC charts adjust the control limits to take into account each month's denominator.

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

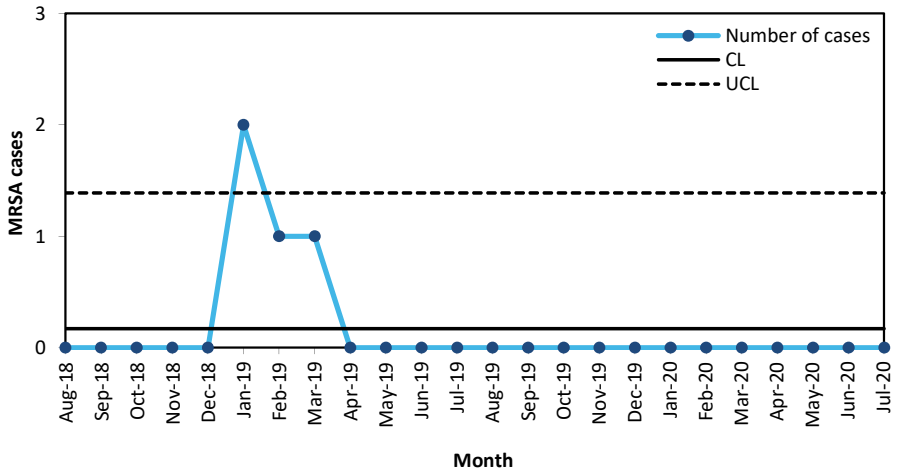
Board Papers - Quality, Safety & Experience - Infection Control

MRSA

C-SPC Chart

MRSA Bacteraemia Cases Reported Within the Trust
August 2018 - July 2020

②



Accountable: Director of Nursing and Quality
Data Owner: Infection Prevention Control Team

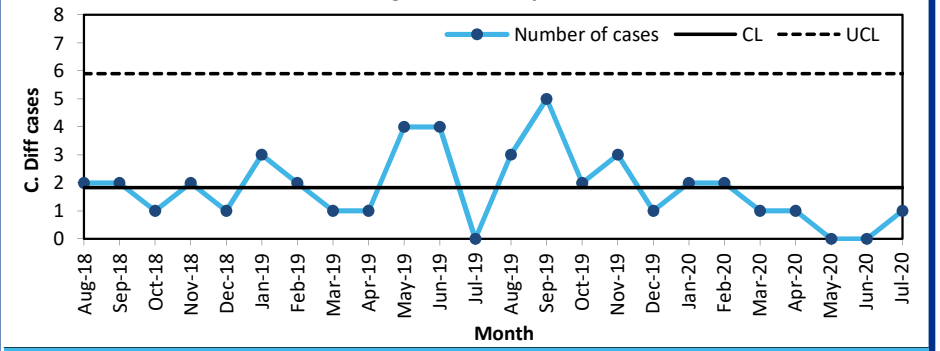
Key Narrative: There were no MRSAs in July 2020.

C. Diff Positive Cases

C-SPC Chart

Hospital Acquired C. Diff Cases Reported Within the Trust
August 2018 - July 2020

②

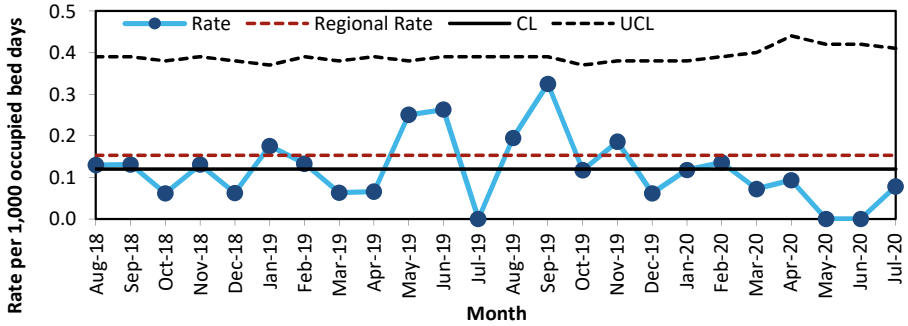


	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
Avoidable	0	0	0	0	0	0	0	0	0	0	0	0
Unavoidable	3	5	2	3	1	1	0	0	0	0	0	0
Awaiting Confirmation	0	0	0	0	0	1	2	1	1	0	0	1

U-SPC Chart

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

②



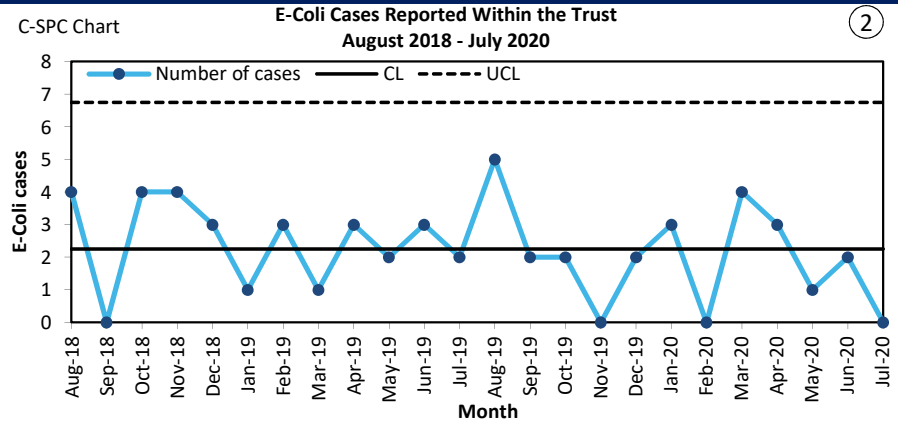
Accountable: Director of Nursing and Quality
Data Owner: Infection Prevention Control Team
Key Narrative: The Trust has to date not been given any set trajectories for C diff in 2020/21.
P-SPC charts adjust the control limits to take into account each month's denominator.

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

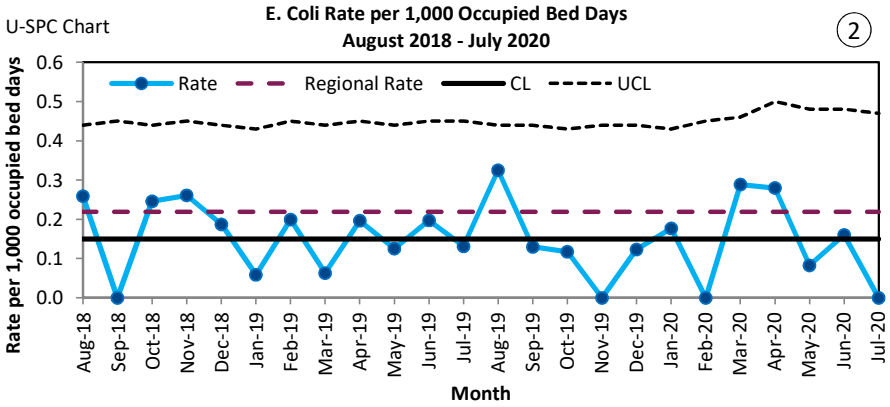
Board Papers - Quality, Safety & Experience - Infection Control

E-Coli Cases

C-SPC Chart



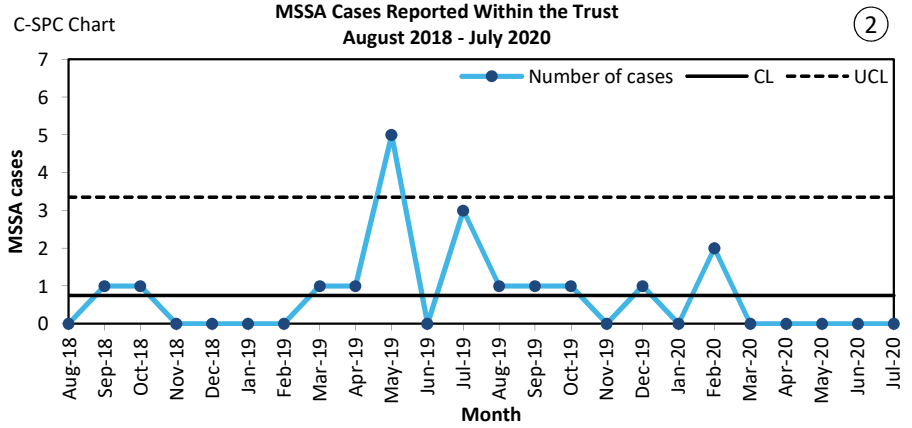
U-SPC Chart



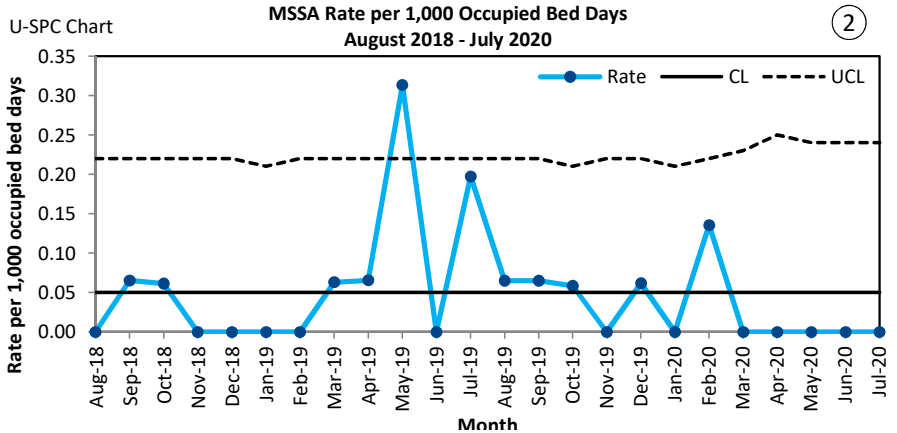
Accountable: Director of Nursing and Quality
Data Owner: Infection Prevention Control Team
Key Narrative: There were no E-Coli bacteraemia in July 2020. There is no set trajectory for E-Coli although there is a NHS Long Term Plan supporting a 50% reduction in gram-negative bloodstream infections (GNBSIs) by 2024/25.
To note: U-SPC charts adjust the control limits to take into account each month's denominator.

MSSA

C-SPC Chart



U-SPC Chart



Accountable: Director of Nursing and Quality
Data Owner: Infection Prevention Control Team
Key Narrative: There were no MSSAs in July 2020. There is no set trajectory for MSSA.
To note: U-SPC charts adjust the control limits to take into account each month's denominator.

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

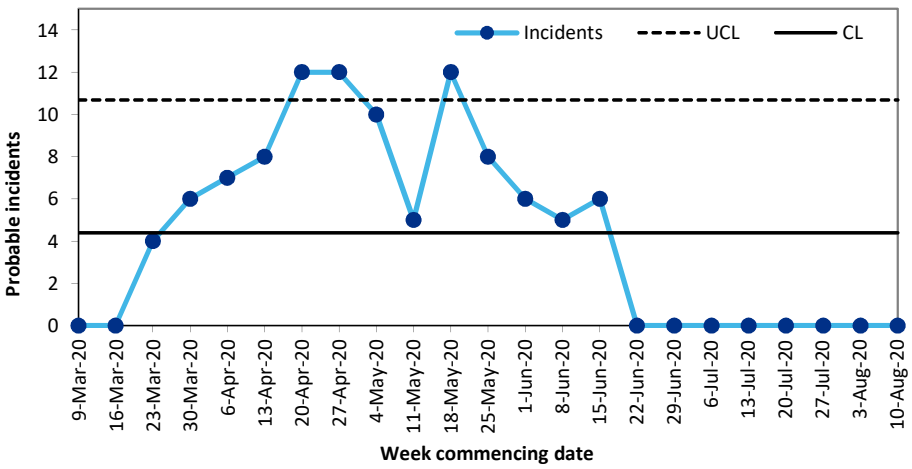
Board Papers - Performance

COVID-19 Healthcare Acquired Infections

C-SPC Chart

MCHFT Probable COVID-19 Incidents by Result Week
09 March 2020 - 16 August 2020

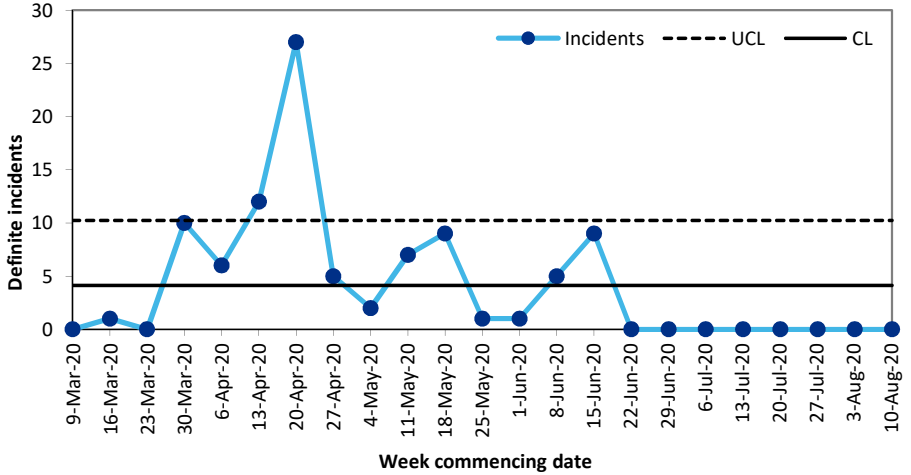
1



C-SPC Chart

MCHFT Definite COVID-19 Incidents by Result Week
09 March 2020 - 16 August 2020

1



Key Narrative: There have been no Covid-19 HCAI infections in July 2020.

Accountable: Director of Nursing and Quality
Data Owner: Information Services

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

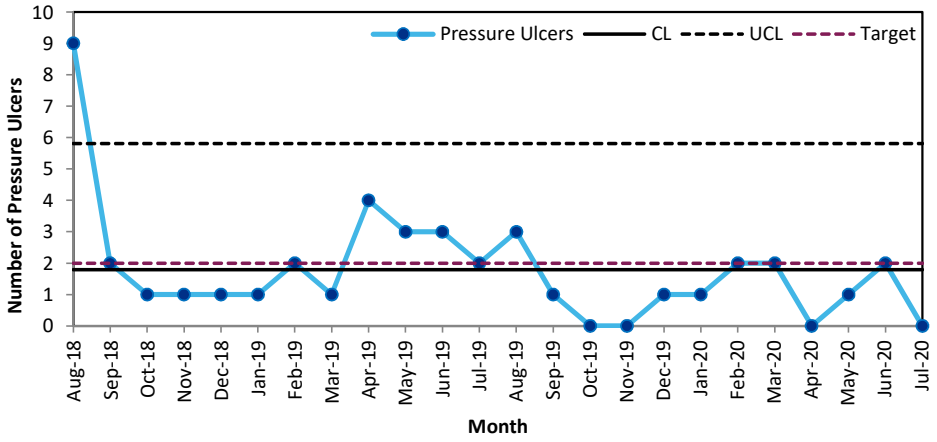
Board Papers - Quality, Safety & Experience

Acute Hospital Pressure Ulcers

C-SPC Chart

Acute Hospital Pressure Ulcers - Lapses in Care Identified
August 2018 - July 2020

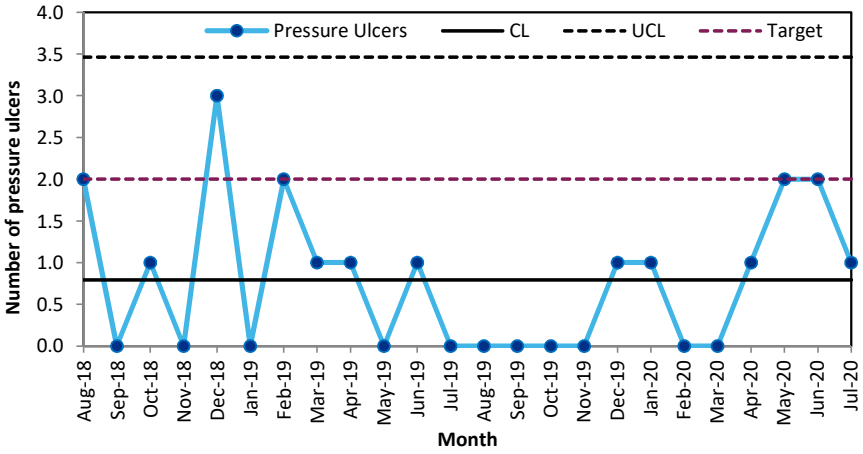
②



C-SPC Chart

Community Pressure Ulcers - Lapses in Care Identified
August 2018 - July 2020

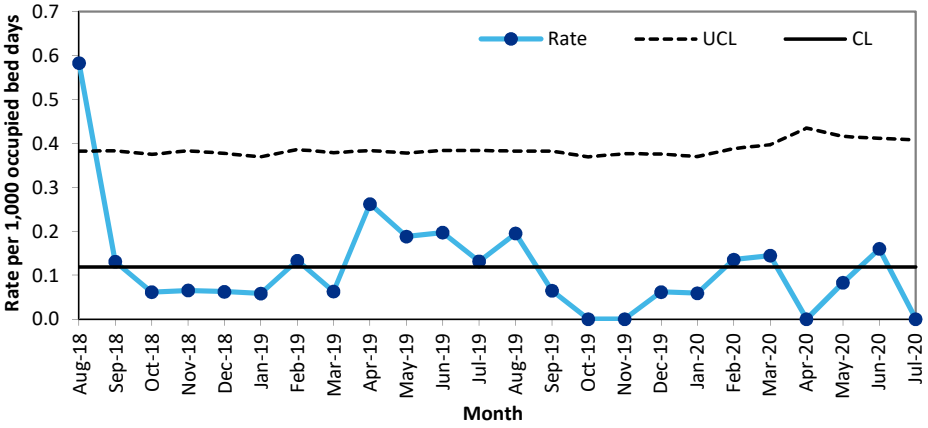
②



U-SPC Chart

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

②



To note: U-SPC charts adjust the control limits to take into account each month's denominator.

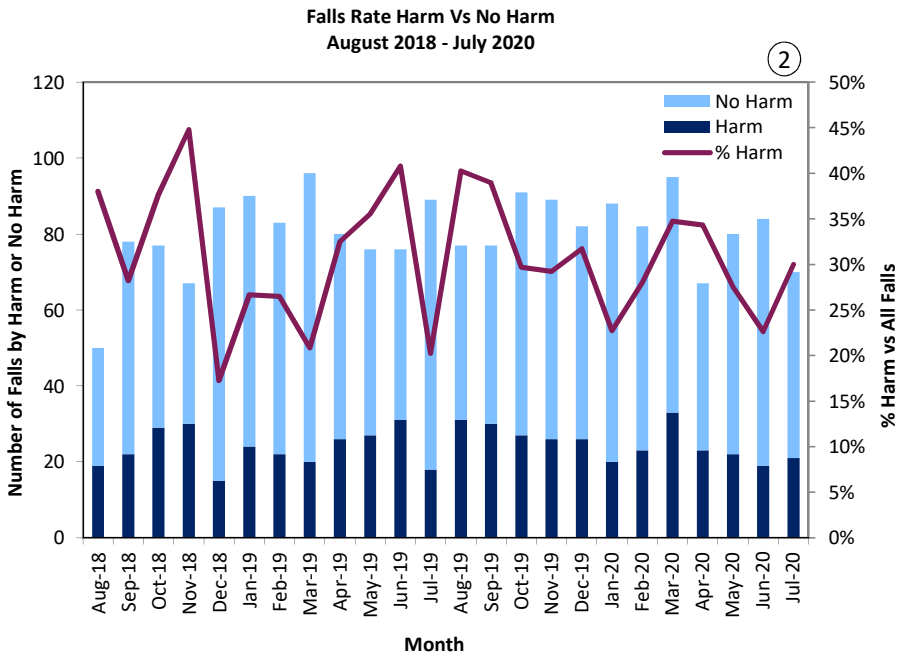
Accountable: Director of Nursing and Quality
Data Owner: Nursing Quality Team

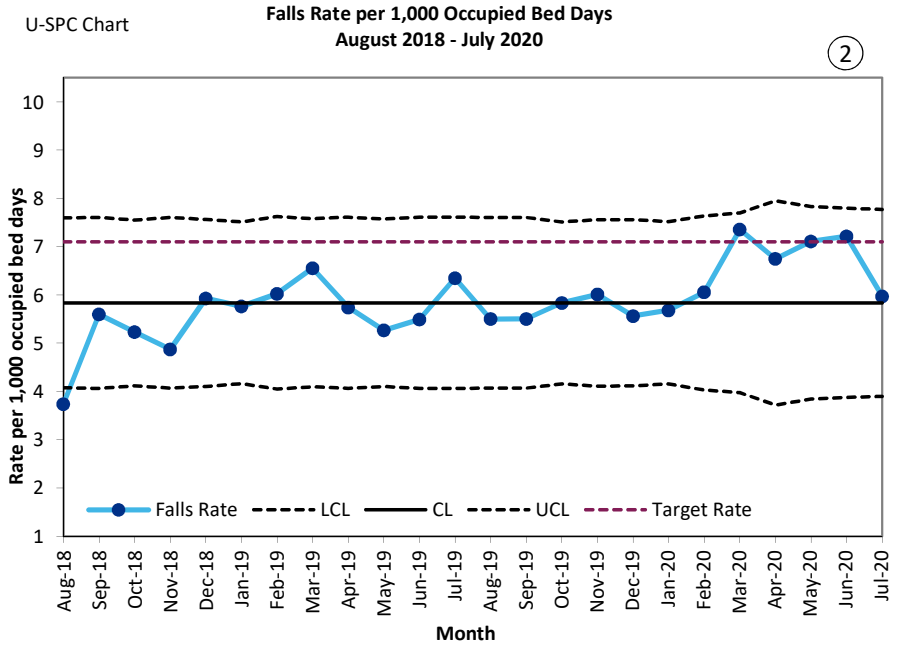
Key Narrative: A harmfree care study day (for 2020) is currently in its planning stages and will include lessons learned from the ongoing work to reduce skin damage.

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

Board Papers - Quality, Safety & Experience

Falls





Key Narrative: A harm free care panel will be set up and will incorporate both lessons learned and best practice from falls and pressure ulcers combined.

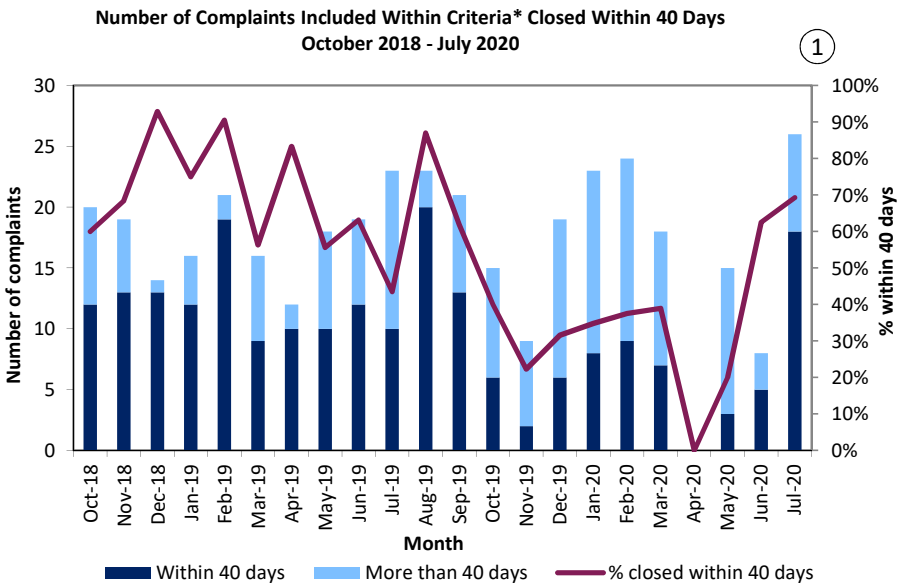
To note: U-SPC charts adjust the control limits to take into account each month's denominator.

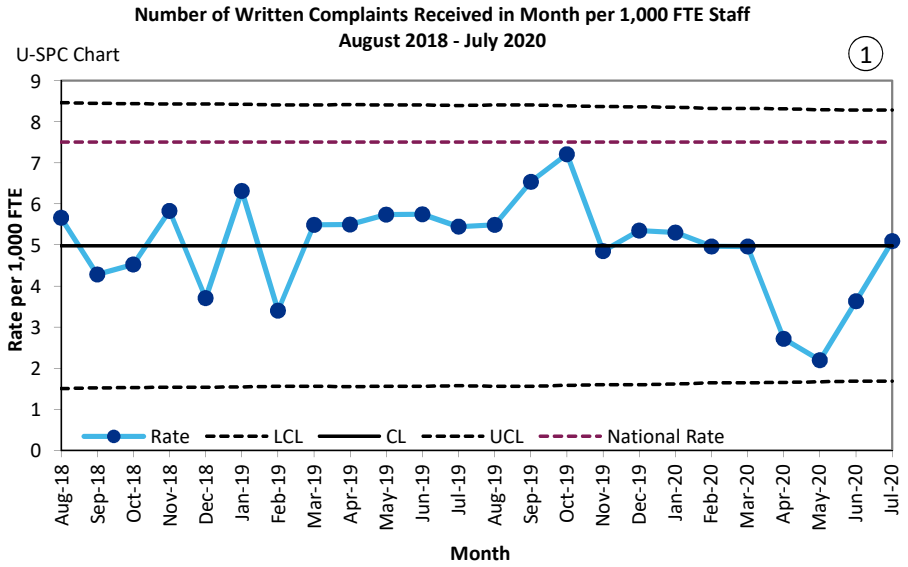
Accountable: Director of Nursing and Quality
Data Owner: Nursing Quality Team

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

Board Papers - Quality, Safety & Experience

Written Complaints





Key Narrative: One of the national key performance indicators for managing complaints is to have a response completed and closed within 40 working days. The Trust position had been improving up to August 2019, however this was not sustainable with changes in the team and delays in the process. An improvement plan has been put into place to ensure complainants receive a quality comprehensive response in agreed timeframes. The Trust has now recommenced all complaint responses, and the compliance against the 40 working day KPI increased for both June and July 2020 following the introduction of new processes and leadership.

Model hospital benchmark acute hospitals on complaints against a rate of per 1,000 WTE staff. Model hospital data published in December 2019 reported the Trust in the top quartile which gives some assurance that there is not a concern about quality of care. In April 2020 and May 2020 there was an expected reduction in complaints during the covid-19 pandemic and an expected increase has been seen through June and July 2020.

Accountable: Director of Nursing and Quality
Data Owner: Customer Care Team

**exclusion criteria includes, for example: complaints linked to an investigation, multi-agency and cross-divisional and complaints, withdrawn complaints, complaints put on hold during the COVID-19 period.*

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

Board Papers - Quality, Safety & Experience

Safer Staffing Divisional Analysis

①

Ward Name	Day				Night				Day		Night	
	Qualified		Unqualified		Qualified		Unqualified		Qualified	Unqualified	Qualified	Unqualified
	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Fill Rate	Fill Rate	Fill Rate	Fill Rate
MCHFT	**44,635.3**	**37,319.6**	**38,602.1**	**32,467.9**	**32,582.7**	**28,523.8**	**27,388.5**	**24,690.8**	**83.6%**	**84.1%**	**87.5%**	**90.2%**
Acute Medical Unit	1,894.0	1,750.0	2,218.3	2,109.3	1,320.0	1,212.0	1,476.0	1,500.0	92.4%	95.1%	91.8%	101.6%
Child & Adolescent Unit	3,392.7	2,329.9	1,493.3	1,367.5	2,162.0	2,089.3	713.0	701.5	68.7%	91.6%	96.6%	98.4%
Ward 15 Surgical/Gynae	1,998.0	1,716.0	2,137.0	1,680.5	1,164.0	1,008.0	1,704.0	1,479.5	85.9%	78.6%	86.6%	86.8%
Critical Care - Pod 1	4,039.0	3,490.6	675.0	549.0	3,852.0	3,284.0	36.0	81.0	86.4%	81.3%	85.3%	225.0%
Elmhurst	960.0	811.0	2,771.5	2,228.5	744.0	744.0	2,244.0	1,908.0	84.5%	80.4%	100.0%	85.0%
Maternity Unit (Ward 23)	1,295.0	1,156.7	1,083.7	1,003.7	744.0	732.0	744.0	729.3	89.3%	92.6%	98.4%	98.0%
Midwifery Led Unit	783.0	778.7	-	-	744.0	719.3	-	-	99.4%		96.7%	
NICU Ward 22	1,703.0	1,370.2	699.4	399.2	1,333.0	1,167.7	365.5	313.8	80.5%	57.1%	87.6%	85.8%
South Cheshire Surveillance	2,110.0	2,011.6	2,605.7	2,380.9	1,572.0	1,536.0	2,376.0	2,267.0	95.3%	91.4%	97.7%	95.4%
Ward 1 Coronary Care	2,049.0	2,032.5	1,294.0	1,228.5	1,512.0	1,501.0	876.0	852.0	99.2%	94.9%	99.3%	97.3%
Ward 10 Ortho Trauma	2,313.5	1,985.0	3,022.5	2,821.8	1,128.0	1,044.0	2,172.0	2,028.0	85.8%	93.4%	92.6%	93.4%
Ward 3 Surveillance	2,514.0	1,810.0	2,295.0	1,482.0	1,548.0	1,128.0	1,884.0	1,289.5	72.0%	64.6%	72.9%	68.4%
Ward 12 Surveillance	2,190.0	1,831.5	1,988.0	1,549.0	1,548.0	1,442.0	1,572.0	1,392.0	83.6%	77.9%	93.2%	88.5%
Ward 13 Elective	1,122.0	940.0	1,115.5	450.5	816.0	768.0	732.0	312.0	83.8%	40.4%	94.1%	42.6%
Ward 14 Gastroenterology	1,403.0	1,413.0	1,847.0	1,706.0	1,152.0	1,152.5	1,560.0	1,548.0	100.7%	92.4%	100.0%	99.2%
Ward 18 SAU	1,281.5	1,044.5	937.5	707.5	768.0	720.0	756.0	612.0	81.5%	75.5%	93.8%	81.0%
Ward 18 Surgical Speciality	1,109.8	701.8	968.3	750.3	744.0	408.0	552.0	433.0	63.2%	77.5%	54.8%	78.4%
Ward 21b Rehabilitation	1,185.0	1,113.0	2,295.0	2,153.0	792.0	786.0	1,182.0	1,243.0	93.9%	93.8%	99.2%	105.2%
Ward 26 Labour	3,023.9	2,835.6	619.2	582.2	2,591.7	2,520.5	324.0	385.2	93.8%	94.0%	97.3%	118.9%
Ward 4 Elderly	1,750.0	1,555.0	1,984.5	1,856.5	1,236.0	960.0	1,824.0	1,848.0	88.9%	93.6%	77.7%	101.3%
Ward 5 Respiratory	2,138.5	1,093.5	1,931.5	1,194.0	1,572.0	899.0	1,152.0	804.0	51.1%	61.8%	57.2%	69.8%
Ward 6 Rehab	1,886.5	1,786.5	2,094.0	1,910.0	1,620.0	1,394.5	1,476.0	1,356.0	94.7%	91.2%	86.1%	91.9%
Ward 7 Endocinology/Frailty	1,402.0	1,396.5	2,155.0	2,036.0	1,140.0	1,092.0	1,464.0	1,428.0	99.6%	94.5%	95.8%	97.5%
Ward 9 Orthopaedic Elective	1,092.0	366.8	371.5	322.2	780.0	216.0	204.0	180.0	33.6%	86.7%	27.7%	88.2%

Accountable: Director of Nursing and Quality
Data Owner: Information Services

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

Board Papers - Quality, Safety & Experience

Safer Staffing Divisional Analysis

Safe Staffing July 2020 Data

The Trust continued to response to Covid 19 during July, having passed the initial peak, MCHFT is now moving into recovery planning and re-establishing clinical services. Wards have moved but there has been a stabilisation of the ward model and moves are predominately to return wards to the original bed base and speciality. The demand for critical care beds has reduced and Pod 2 is now closed. 6 weekly Covid acuity reviews continue to be led by the Head of Nursing for Safer Staffing, based on the respiratory ward establishment model and professional judgement to ensure safe staffing throughout the post Covid period. Acuity reviews have established that a reduction in staffing has been possible in the post Covid period and wards are gradually returning to their pre Covid staffing requirements. Staffing numbers have continued to flex in a number of wards to meet patient demand which has fluctuated both in terms of acuity, nosocomial infection and reduced occupancy. Not all shifts have been required which is reflected in a lower fill rate in some wards. Staffing continued to be managed daily by the Senior Nursing teams and planned in response to acuity and demand.

Divisional Analysis. (4 lowest fill rate wards)

Ward 9 Ortho Elective: Ward 9 remains merged with ward 10 this is not reflected in the data. Ward 9's staff were redeployed to Ward 10 and other Wards in the Divisions. This is reflected in the low percentage fill rate.

Ward 5: Ward has seen low occupancy with a reduction in Covid positive patients. Staffing levels have flexed to support patient acuity and occupancy this is reflected in a lower fill rate.

Ward 18 SAU and SSW: SAU and SSW merged and moved to ward 18 on a reduced bed base requiring a combined reduced staffing requirement, which is reflected in the low percentage fill rate on SAU and SSW. For operational purposes these rosters remained separate.

CAU: The Ward continues to have reduced Registered Nurse staffing on days due to increased sickness levels, shielding and uncovered maternity leave. Bank and agency are utilised to support the areas, night shifts are prioritised due to the availability of management to support day shifts. Recruitment is ongoing. Staffing resource has been moved across the unit to support operating two inpatient areas for Covid management. There has been additional requirement for a number of patients requiring 1:1 care.

Accountable: Director of Nursing and Quality **Data Owner:** Information Services

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

Mid Cheshire Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**12**	Date of Meeting: 07/09/2020
Report Title	Annual Board Report and Statement of Compliance on the Appraisal and Revalidation of Medical Practitioners at MCHFT	
Executive Lead	Murray Luckas, Responsible Officer/Medical Director	
Lead Officer	Nikki Phillips, Revalidation Support Manager	
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 Trust maintains a fit for purpose appraisal system that is operating effectively and satisfies the statutory requirements around revalidation

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)*

• Manage the impact of covid and ensure safe recovery	☐	• Provide safe and sustainable healthcare through our estate, infrastructure and planning	☐
• Deliver outstanding care and patient experience Deliver the most effective care to achieve best possible outcomes	✓	• Provide strong system leadership by working together	✓
• Ensure MCHFT is the best place to work	☐	• Be well governed and clinically led	✓

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)*

Statement of Compliance to be sent to NHS England Autumn 2020

REPORT DEVELOPMENT

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

Purpose of the Report

The purpose of this report for 2019 / 2020 is to provide assurance to the Board of Directors that the appraisal system for medical practitioners employed by Mid Cheshire Hospitals NHS Foundation Trust (MCHFT) is robust, supports the revalidation agenda and is operating effectively.

Background

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

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

The statutory duties of a RO include:

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

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

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

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

- A recommendation that the doctor is up to date and fit to practise and should be revalidated

- A request to defer the date of the RO's recommendation due to the doctor:

    - being engaged in the systems and processes that support revalidation, but about whom there is incomplete information on which to base a recommendation to revalidate (this will be where a doctor has not been able to gather all of the required supporting information by the time the submission date falls due)

- participating in an ongoing local human resources or disciplinary process, the outcome of which is material to the evaluation of the doctor's fitness to practice and that will need to be considered prior to making a recommendation.

- A notification of the doctor's non-engagement in revalidation, which should be made if a doctor has not engaged "sufficiently" with revalidation

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

Governance Arrangements

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and annexes A – G. Included in the seven annexes is the Annual Organisational Audit (annex C), Board Report (annex D) and Statement of Compliance (annex E), which although are listed separately, are linked together through the annual audit process.

In 2019 to ensure the FQA continued to support future progress in organisations and provide the required level of assurance both within designated bodies and to the higher-level Responsible Officer, a review of the main document and its underpinning annexes was undertaken with the priority redesign of the three annexes below:

Annual Organisational Audit (AOA):
The AOA has been simplified, with the removal of most non-numerical items. The intention is for the AOA to be the exercise that captures relevant numerical data necessary for regional and national assurance. The numerical data on appraisal rates is included as before, with minor simplification in response to feedback from designated bodies.

Board Report Template:
The Board Report template now includes the qualitative questions previously contained in the AOA. There were set out as simple Yes/No responses in the AOA but in the revised Board Report template they are presented to support the designated body in reviewing their progress in these areas over time. Whereas the previous version of the Board Report template addressed the designated body's compliance with the responsible officer regulations, the revised version now contains items to help designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance.

This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). The intention is to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. In this way the two regulatory processes become complementary, with the practical benefit of avoiding duplication of recording.

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore

a) help the designated body in its pursuit of quality improvement,
b) provide the necessary assurance to the higher-level responsible officer,
c) act as evidence for CQC inspections.

Statement of Compliance:
The Statement of Compliance has been combined with the Board Report for efficiency and simplicity as below

Section 1 – General:

The Board of Directors of Mid Cheshire Hospitals NHS Foundation Trust can confirm that:

1. The Annual Organisational Audit (AOA) for this year has been submitted.

Date of AOA submission: As per NHS England and GMC Guidance the AOA was not submitted this year due to Covid-19.
Action from last year: n/a
Comments: Due to the timing of Covid-19 the Trust were able to collate the data for the report, noting an overall achievement of 95.6% with a small number of Doctors unable to complete their documentation due to the ongoing Covid situation.
Action for next year: To ensure that appraisal compliance is maintained during the ongoing Covid-19 situation

2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: n/a
Comments: Mr Murray Luckas – Medical Director is the Responsible Officer, Dr Clare Hammell is the Deputy Responsible officer.
Action for next year: No changes anticipated

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes
Action from last year: n/a
Comments: At MCHFT the RO and Deputy RO roles are predominantly supported by the Revalidation Support Manager. However other members of the Medical Resourcing Team play an important role in ensuring that the RO and Deputy RO deliver their statutory duties around revalidation, particularly in relation to employing doctors and their pre-employment checks
Action for next year: No changes anticipated

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

Action from last year: n/a
Comments: The Trust uses the Allocate appraisal system for tracking and monitoring the Doctor's appraisals, alongside back-up manual processes to ensure that the system reflects the same information as held on GMC Connect.
Action for next year: To maintain the systems

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: n/a
Comments: Version 5 of the Consultant and SAS Doctor Appraisal Policy was ratified at the June 2018 Joint Local Negotiating Committee and Version 4 of the Consultant and SAS Remediation Policy was ratified in December 2019 by the Joint Negotiating Committee with review planned for December 2022.
Action for next year: Review and ratification of the Consultant and SAS Doctor Appraisal Policy due March 2021

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

Action from last year: n/a
Comments: A peer review was undertaken with Bolton NHS Foundation Trust and Salford Royal Foundation NHS Trust in August 2017. Areas for consideration for the Trust were suggested and an action plan developed and all objectives achieved by December 2017
Action for next year: To give due consideration to repeating the process depending on the resolution of Covid-19

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: n/a
Comments: Non-training grade Trust Doctors and Trust Doctors follow the same process as substantive Doctors - they are expected to undertake an Annual appraisal and have access to our appraisal system. The Medical Appraisal and Revalidation Entry Form, along with close working with Medical Resourcing means that upon starting these doctors are contacted with all the necessary information for them to carry out appraisal and 1:1 training with the Revalidation Support Manager is offered.
Agency doctors who are connected to the Agency as Designated Body – assurance of appraisal and revalidation dates on pre-employment checks.
Action for next year: To maintain the process.

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year: Maintain appraisal and revalidation processes during the transformation of the interim/new Senior Medical Team
Comments: Please see table below.
Action for next year: To maintain the processes.

Appraisal		**Number**
Completed	1	216
	1a	134
Missed / Incomplete	Approved	10
	Unapproved	0
Total		226
Appraisal Completion Rate (Category 1)		216/226 95.61%

The Trust's appraisal rates for the past 8 years have been:

	2012 /13	**2013 /14**	**2014 /15**	**2015 /16**	**2016 /17**	**2017 /18**	**2018 /19**	**2019 /20**
Number of Completed Appraisals (Category 1)	124	134	175	196	208	202	212	216
Missed / Incomplete Approved	NR	4	1	8	8	1	4	10
Missed / Incomplete Unapproved	NR	31	4	0	1	1	0	0
Total	166	169	180	204	217	204	216	226
Completion rate (%)	74%	79.2%	97.2%	96.1%	95.9%	99.01%	98.01%	95.6%

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: n/a
Comments: Please see the tables below
Action for next year: To maintain the processes

Appraisals completed but not classified as Category 1A
Reason
Appraisals not completed “3 months preceding the agreed date”
Appraiser did not sign off the appraisal within 28 days, due to information required for revalidation not included in the appraisal
Appraisee did not sign off the appraisal within 28 days, due to information required for revalidation not included in the appraisal

Missed / Incomplete Appraisals - Approved	
No of Appraisals	**Reason**
2	Maternity leave
4	Overseas
4	Appraisals not booked/completed due to Covid-19

Missed / Incomplete Appraisals - Unapproved
No of Appraisals
0

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board’s approval (or by an equivalent governance or executive group).

Action from last year: n/a
Comments: Please see Section 1.5
Action for next year: Please see Section 1.5

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: Train additional appraisers to ensure that the Trust has the required cohort of trained appraisers to manage the increased number of prescribed connections and natural appraiser turnover
Comments: The organisation trained an additional five Appraisers to ensure there were 33 trained Appraisers at the start of the appraisal year, however 2020 has seen an increase in the loss of Appraisers due to turnover.
Action for next year: To train additional appraisers and to consider bring the Appraiser Training in-house if possible.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Action from last year: n/a
Comments: Appraiser Meetings are held quarterly and the Appraisers are expected to attend two meetings per year. These meetings look at all aspects of the appraisal and revalidation processes, led by the Responsible Officer.
All appraisal summaries are reviewed by the Revalidation Support Manager using the PROGRESS tool and reports are provided to the Appraisers to include in their

Appraisal, along with the electronic Appraisee Feedback Questionnaires generated by the Allocate system.
Action for next year: To maintain the process.

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: Collate the outcomes and actions from 2019 – 2020 appraisals to meet the new requirement of the "NHS England Framework of Quality Assurance for Responsible Officers and Revalidation, Annex D – Annual Board report and Statement of Compliance"
Comments: As part of the quality assurance process around medical appraisals, the Revalidation Support Manager reviews all appraisals and appraisal summaries and then the RO randomly selects 20% of all medical appraisals undertaken each year for an in-depth review. The aims of this review include ensuring that the medical appraisals at the Trust are being undertaken in accordance with the Good Medical Practice framework and the Trust's Consultant and SAS Doctor Appraisal Policy. Compliance with a portfolio checklist of essential pieces of information to be discussed as part of the appraisal process is audited and the findings from this review are then presented to the Trust's appraisers as part of the drive to improve the standard of medical appraisals each year.
This board report is collated to comply with the new requirements.
Action for next year: To maintain the process.

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: Please see the table below
Comments: The Revalidation Overview and Assurance Committee (ROAC) meets monthly to discuss up-coming revalidation recommendations. The appraisal months for Doctors have been arranged to ensure that prior to these meetings the appraisal documentation can be quality audited by the Revalidation Support Manager to ensure, where possible, that all documentation is present and complete.
Please see table below
Action for next year: To maintain the process.

*Same Doctor, deferred twice in appraisal year

Recommendation	2019/20	2018/19	2017/18	2016/17	2015/16	2014/15
On Time	57	29	20	10	80	73
Late	0	0	0	0	0	0
Missed	0	0	0	0	0	0
Positive	54 (94.7%)	26 (90%)	18 (90%)	7 (70%)	74 (92.5%)	50 (68.5%)
Defer • Insufficient Information	1 (1.7%)	3(10%)	1 (5%)	3 (30%)	4 (5%)	15 (20.5%)
• On-going process	2 *	0	1 (5%)	0	1 (1.25%)	5 (6.9%)
Deferred for insufficient information and later revalidated	0	0	0	0	1 (1.25%)	3 (4.1%)
Non-engagement	0	0	0	0	0	0
Total	57	29	20	10	80	73

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: n/a
Comments: All recommendations are discussed in ROAC three months in advance to ensure that all documentation is reviewed and correct for recommendations to be made and that where required discussions can be held with the Doctor by the Responsible Officer, providing an action plan for the Doctor concerned.
Action for next year: To maintain the process.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: n/a
Comments: Appropriate clinical governance systems are in place and all Doctors are provided with Appraisal Portfolio Information containing Significant Events and Clinical Incidents for discussion and reflection in their appraisal
Action for next year: To maintain the process.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: n/a
Comments: Clinical Leads hold responsibility for identifying and managing concerns about all aspects of all performance, escalating them where it is felt that they may be serious.
Action for next year: To maintain the process.

3. There is a process established for responding to concerns about any licensed medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: n/a
Comments: The Trust's approach to identifying and responding to concerns includes regular case discussion meetings held by the Senior Medical Leadership Team in order to review progress on all open cases, which are also covered by the Trust's Disciplinary procedure and the Consultant and SAS Doctors Remediation Policy
Action for next year: To continue to follow our agreed policies and procedures

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.

Action from last year: n/a
Comments: There is a monthly report to Trust Board of significant cases involving doctors. The process and individual significant cases are independently scrutinised via the Root Cause Analysis process.
Action for next year: To maintain the process.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Action from last year: n/a
Comments: Transfer of Information is provided when requests are received. Requests are made using the Medical Appraisal and Revalidation Entry Form for all Doctors joining the organisation.

Action for next year: To maintain the process.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: n/a
Comments: All processes for responding to concerns are managed according to our Trust Policy. We have trained Case Investigators and Case Managers to ensure appropriate processes. Issues around potential bias and discrimination are considered by our Senior Team before any formal process is commenced.
Action for next year: We intend to increase our numbers of trained investigators

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: n/a
Comments: All doctors employed by the Trust are subject to the NHS mandatory pre-employment recruitment checks prior to appointment, including locum doctors by the Medical Resourcing Team
Action for next year: To continue to monitor compliance

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

General review of last year's actions.
As this is a new template introduced in June 2019 following a transition in the Responsible Officer role, the previous report was used and the objectives have been transferred, where appropriate, into this report and commented on. The report next year will allow for review of the actions listed in this report. Last year was an opportunity to review, refine and validate our current processes.

Actions still outstanding: None.

Current Issues/New Actions:
The focus in 2020-2021 will be to support the Doctors with the appraisal process through the pandemic, to increase the number of trained Appraisers and investigate providing in-house training for future new appraisers.

Overall conclusion: The Trust demonstrates compliance within the appraisal and revalidation processes whilst continuing to review and improve the overall quality of the appraisals and their content for the Doctors.

Section 7 – Statement of Compliance:

The Board of Mid Cheshire Hospitals NHS Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body
James Sumner
Chief Executive

Official name of designated body: Mid Cheshire Hospitals NHS Foundation Trust

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

PAF Committee
Chair's Assurance Report
August 2020

Report to	Board of Directors
Date	27 August 2020
Report from	Trevor Brocklebank, Non-Executive Director
Report prepared by	Katharine Dowson, Head of Corporate Governance
Executive Lead/s	Russell Favager, Deputy Chief Executive and Director of Finance Oliver Bennett, Chief Operating Officer
Committee meeting quoracy	Yes ☒ No ☐

KEY AREAS OF ASSURANCE

Impact of Covid-19 on Performance and Finance

- Registered Nursing Vacancy Plan: Committee was assured that the resource invested in international nursing recruitment is progressing towards delivering the strategic objective of closing the nursing staffing gap by December 2020. The strategic focus will now shift from recruitment to retention with an emphasis on embedding new nurses and supporting greater diversity in the workforce.
- Further financial guidance received 20 August in regard to the financial regime for Phase 3 from 1 September, outlining system of penalties and rewards for under and over delivery on a Cheshire & Merseyside activity control total, how this translates at organisational level is still unclear. PAF to review final forecast on activity levels at September meeting.
- Planning for a second wave acceptable assurance: clinical structures and command and control processes are in place, with learning from Covid-19 embedded and factored into winter planning. Strategic context to be provided by an upcoming external review on the organisational model which will inform the transformation programme

Performance

- Performance Report (July 2020): Delivery against all key access standards is a significant challenge following the effect of Covid on planned care. 4 hour A&E standard dropped below 95% as attendee numbers return; plans in place for urgent care for winter including potential A&E capital investment.
- Return to planned care activity levels is a key target but increased likelihood of deterioration in long waits before recovery is achieved
- Cancer treatment is a priority with significant decrease in backlog and plans in place for it to be cleared by December 2020. Recovery of Diagnostics waiting times supports this. Endoscopy remains a significant challenge; access to the independent sector or other providers will be required.

Finance

- Month 4 request for additional funding increased to £1.758m as previous cost savings made are reducing due to planned care resumption. A revised figure for block payments is expected.
- Capital slippage and programme may need to be reviewed if capital funding applications are successful and need to be managed between years. Slippage has allowed replacement of the fire alarm system to be brought forward.

HED Benchmarking Review

- Figures reviewed; divisions now to review actions required to improve areas where the Trust is an outlier, including A&E and neonatal readmissions. PAF to review proposal when ready.

Critical Infrastructure Risk Review

- Terms of Reference for an external review presented; final report to be submitted to Board in December 2020

KEY CONCERNS/RISKS

None raised

Priority Areas: DECISIONS MADE

No decisions made

RECOMMENDATION

To note

Board of Directors

Agenda Item	**13.1**	Date of Meeting: 07/09/2020
Report Title	Board of Directors Performance & Finance Report – July 2020	
Executive Lead	Russ Favager, Deputy CEO/Director of Finance & Oliver Bennett, Chief Operating Officer	
Lead Officer	Emma McGuigan, Director of Operations & Ros Davies, Deputy Director of Finance	
Action Required	To note	

☐	**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

- A&E attendances continue to increase since March 2020, overall Trust performance against the ED standard is positive and remains >90%
- Restoration of core services is gaining traction and a significant focus for the Trust to fully optimise current capacity. Compliance with IPC and socially distancing continues to constrain activity levels
- Strong performance against the Cancer rapid access appointments continues

Impact

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

Equality Impact Assessment

- Strategy ☐ Policy ☐ Service Change ☐

Strategic Objective(s)

• Manage the impact of covid and ensure safe recovery	✓	• Provide safe and sustainable healthcare through our estate, infrastructure and planning	✓
• Deliver outstanding care and patient experience Deliver the most effective care to achieve best possible outcomes	✓	• Provide strong system leadership by working together	☐
• Ensure MCHFT is the best place to work	☐	• Be well governed and clinically led	☐

Governance

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

Next Steps

No further steps.

REPORT DEVELOPMENT

Committee/ Group Name	Date	Report Title	Lead	Brief summary of key issues raised and actions agreed
Performance and Finance Committee	27 August 2020	Board Performance Report	As per this paper	Reviewed and forwarded to Board of Directors.

Mid Cheshire Hospitals
NHS Foundation Trust

Board of Directors Performance and Finance Report

July 2020

"To Deliver Excellence in Healthcare through Innovation & Collaboration"

Board Papers - Performance

Headline Measures

Organisational Delivery				
Indicator	**Standard**	**YTD**	**Jul-20**	
Cancer				
Rapid Access Referrals (%) (seen in 2 weeks)	93.00%	97.34%	97.93%	
Total Patients Seen		*4,016*	*1,062*	
Patients seen >14 days		*107*	*22*	
62 day GP Classic (%)	85.00%	69.98%	66.13%	*
Accountable Patients Treated		*272*	*62*	
No. of Breached Pathways (adjusted)		*82*	*21*	
62 day Screening (%)	90.00%	86.00%	100.00%	*
Accountable Patients Treated		*25*	*1*	
No. of Breached Pathways (adjusted)		*4*	*0*	
** Provisional figures subject to change depending on further validation or treatment outcome*				
Unplanned Activity				
4 Hour Access Standard (%)	95.00%	95.36%	92.71%	
A&E Attendances (LH/MIU/UUC) (% to plan)		59.68%	69.02%	
A&E Attendances LH & MIU (Vol)		*22,241*	*6,647*	
Planned Activity				
Incomplete Pathways <18wk (%)	92.00%	64.52%	53.77%	
>6wk Diagnostic Waits (%)	1.00%	50.03%	36.24%	
Total Patients Waiting for a First Outpatient Appointment			17,256	

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

Executive Summary

Performance across all measures is significantly different to recent months due to the pandemic. Where performance has previously been strong it has significantly reduced, albeit in line with national trend. The 4 hour A&E standard continues to achieve year to date. However, because A&E attendances have increased back up to near pre-covid levels, performance has deteriorated in July to 92.71% compared to 95% in the previous month.

In July the key metrics delivered were:

1. 2WW Rapid Access Cancer at 97.93% against a target of 93%
2. 62 Day Screening Cancer at 100% against a target of 90%

The key metrics not delivered were:

1. 62 Day Classic Cancer at 66.13% against a target of 85%
2. 4hr Emergency Access at 92.7% against a target of 95%
3. RTT Open Pathways at 53.77% against a target of 92%
4. Six weeks diagnostic at 36.24% against a 1% threshold

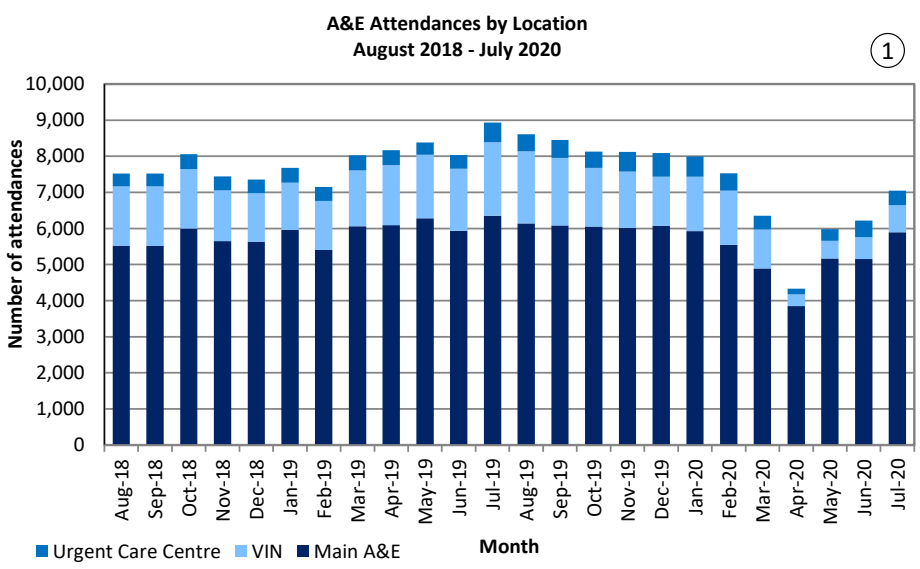
The resumption of critical services including routine elective operating and diagnostic imaging is gaining traction. Because of the requirement to comply with social distancing and other infection prevention and control measures, it will take time to resume near pre-covid activity levels.

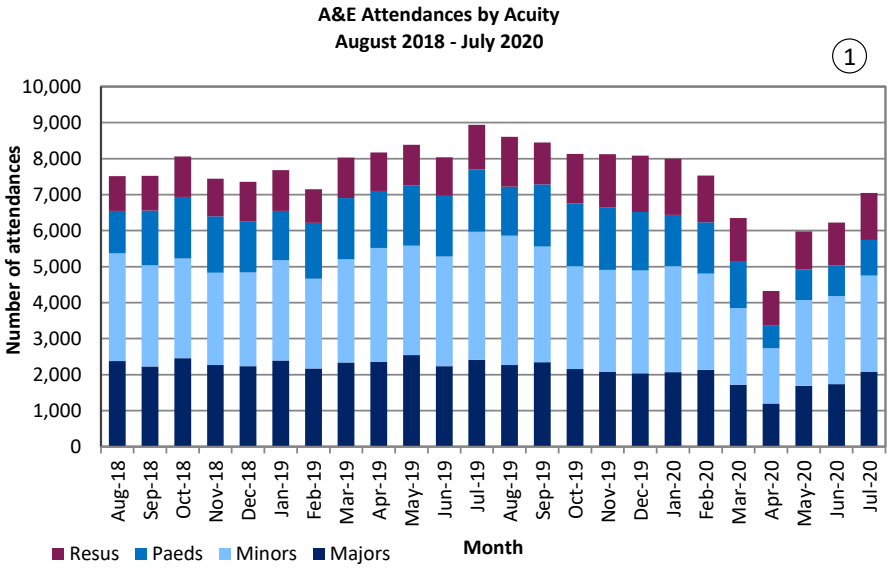
The reported position is break even, with the Trust expecting to receive £5.6m in additional Top Up funding from regulators. The expectation is that the Trust will meet a break even position will continue at least until the end of August and anticipated it will be extended to September.

At month 4 the Trust was £5.6m (£1.245m April, £1.405m May and £1.292m for June, July £1.758m excluding annual leave adjustments) 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 £5.6m 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 up to months 1-5.

Board Papers - Performance

A&E Activity





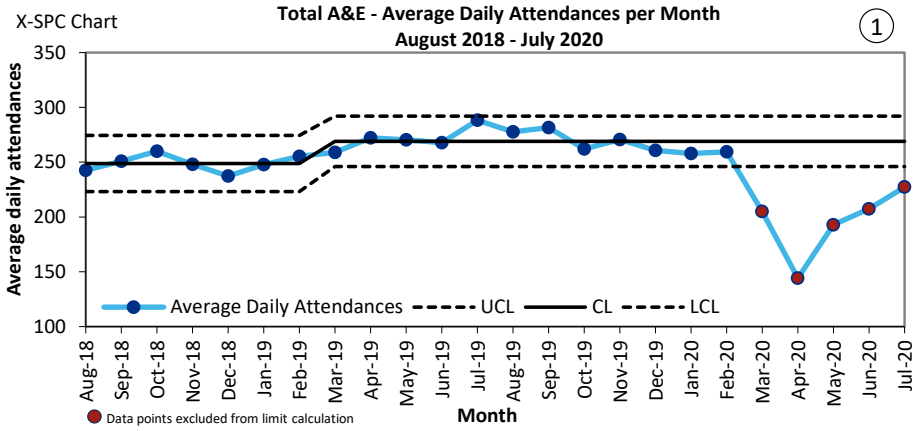
Accountable: Chief Operating Officer
Data Owner: Information Services

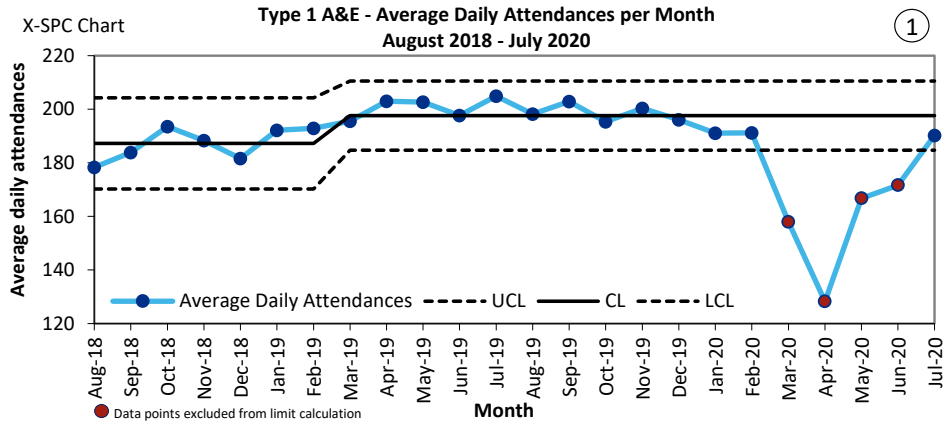
Key Narrative: The charts show the reduction in A&E attendances from March 2020 due to the impact of the coronavirus pandemic. Activity in May, June and July 2020 was still below the average monthly rate but continues to increase back towards normal pre-covid levels. Attendance rates at the Leighton emergency department have almost returned to pre-covid levels, with reduced attendance levels remaining at Victoria Infirmary Northwich (VIN). The Respiratory Assessment Unit (RAU) for patients presenting with covid-like symptoms remains in place and we continue to provide additional workforce out of hours. The Trust has recently been identified as a "fast-follower" site for the rollout of NHS111 First programme which will reduce A&E attendances by offering patients an appropriate alternative including bookable appointments in our ambulatory care services. The plan is to implement this new NHS111 First model in November/December 2020.

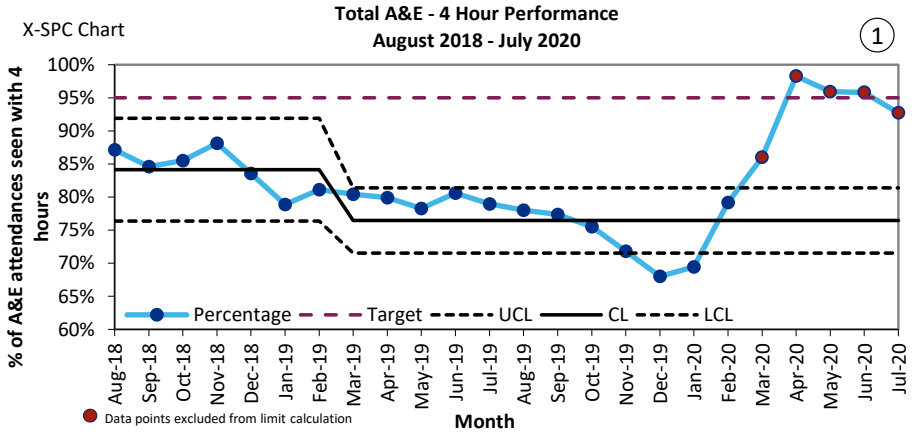
Data Rating: ①captured locally, ②system captured, ③published/benchmarked

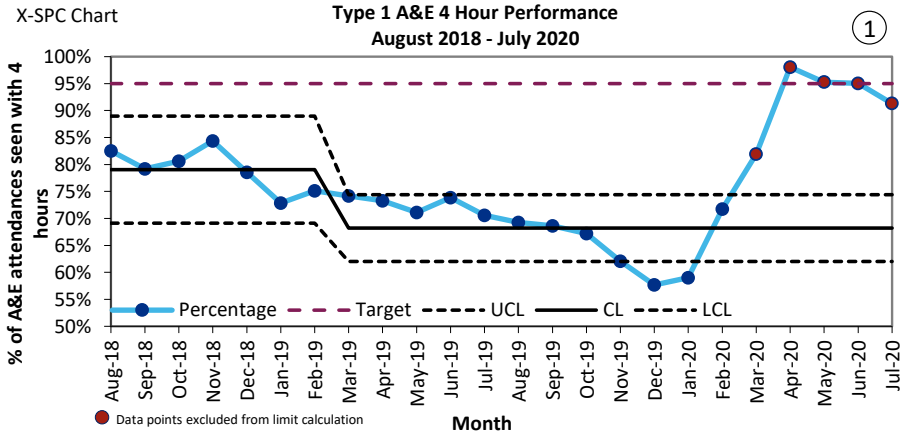
Board Papers - Performance

A&E Performance









Accountable: Chief Operating Officer

Data Owner: Information Services

Key Narrative: The 4 hour A&E standard was not delivered in July for the first time since the onset of the pandemic, with a performance of 92.71%. This performance correlates with the continued increase in A&E attendances. Type 1 attendances has returned to pre -covid levels, which is impacting on performance. However, performance continues to be better than pre-covid. It is expected that as attendances continue to increase, performance may continue to deteriorate. The focus is therefore on stabilising performance by tighter "grip and control", addressing workforce gaps and maintaining flow. There is a significant focus on preparing for winter.

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

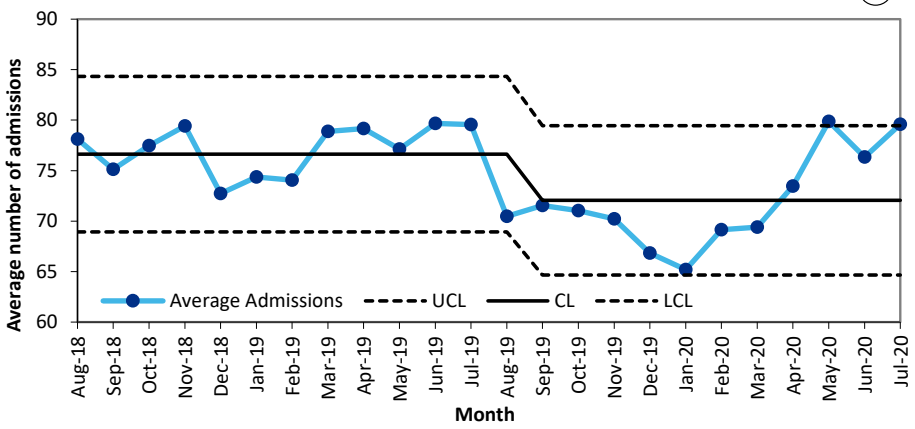
Board Papers - Performance

Unplanned Admissions

X-SPC Chart

Average Daily Admissions from A&E
August 2018 - July 2020

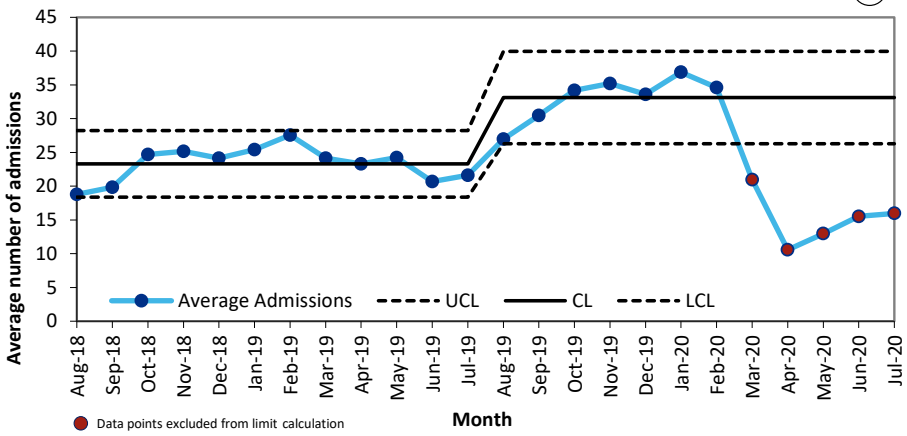
1



X-SPC Chart

Average Daily Admissions per Month - GP Referred
August 2018 - July 2020

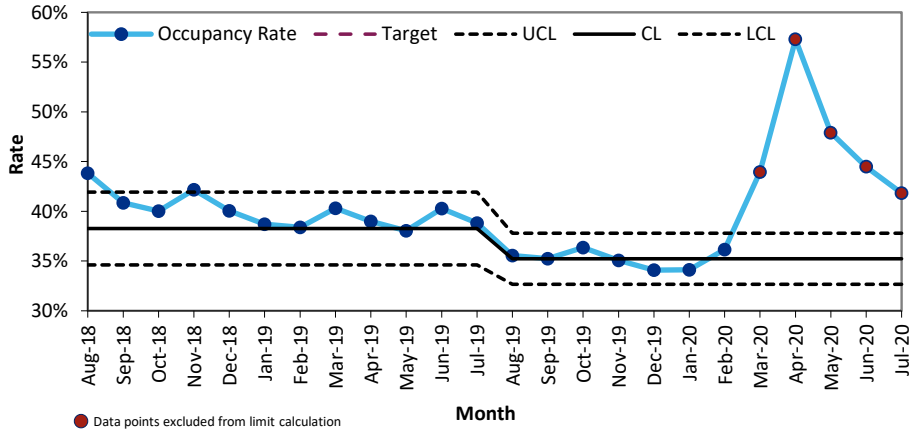
1



X-SPC Chart

Type 1 Attendance to Admissions Conversion Rate - Overall
August 2018 - July 2020

1



Accountable: Chief Operating Officer **Data Owner:** Information Services

Key Narrative: The activity over the last 5 months during the coronavirus pandemic shows:
- the number of admissions from GP decreased
- the conversion rate from A&E to admission increased, partly due to all attendances through RAU being classed as an admission.
- GP direct admissions have been slowly increasing from the lowest seen in April 2020 as primary care increases in activity this is expected to also increase. The Ambulatory Care Unit (ACU) was reopened in June 2020 and has been relocated to a larger footprint to allow for social distancing measures. The surgical ambulatory care unit has been relocated to the South Cheshire facility for increased physical footprint. The restarting of these ambulatory pathways will drive increased admissions
- As admissions continue to increase it is important to have a plan to match this with capacity in the hospital and therefore escalation capacity is a key feature of the 2020/21 winter/covid escalation plan.

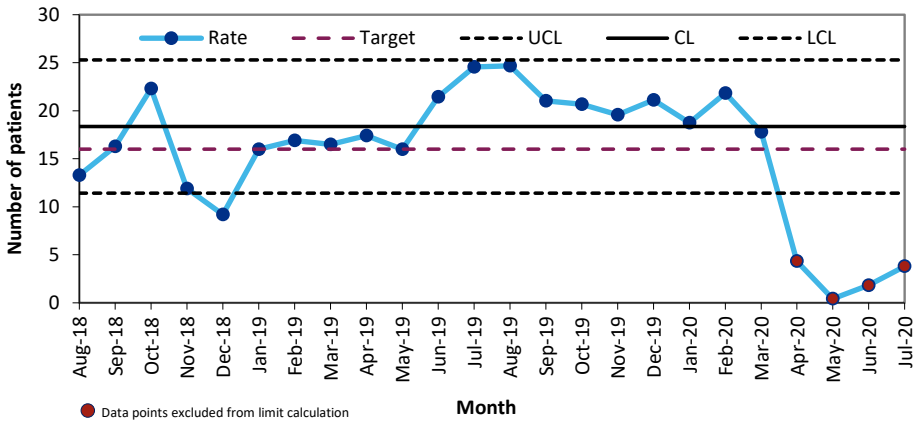
Data Rating: ①captured locally, ②system captured, ③published/benchmarked

Board Papers - Performance

Inpatient Metrics

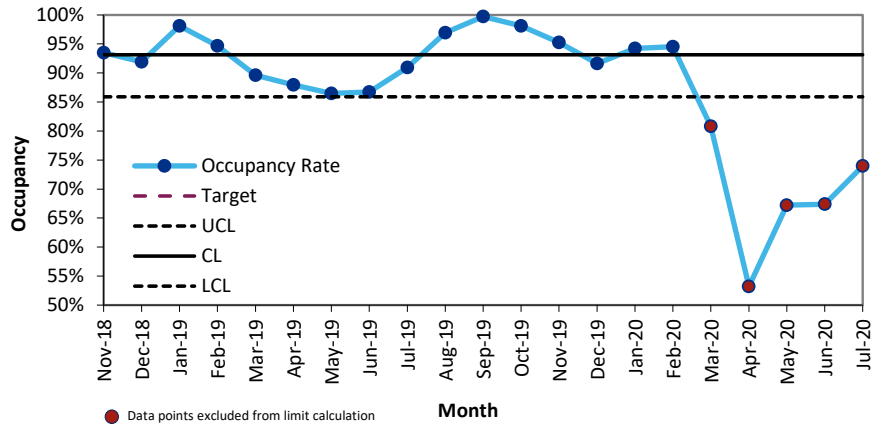
X-SPC Chart

Average Number of People Delayed per Day
August 2018 - July 2020



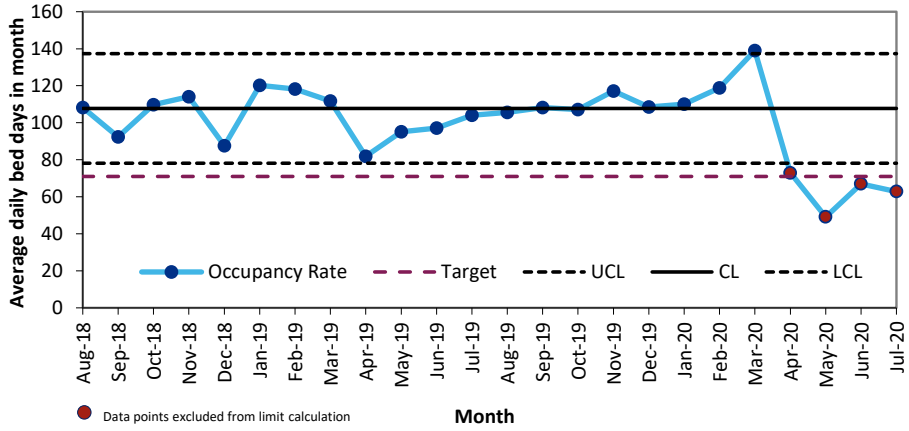
X-SPC Chart

Bed Occupancy
November 2018 - July 2020



X-SPC Chart

Super Stranded Patients
August 2018 - July 2020



Accountable: Chief Operating Officer **Data Owner:** Information Services

Key Narrative:

From April, and due to the impact of covid, there has been a reduction in the number of people delayed in hospital and the number of super stranded patients/days. This is reflective of good local system working with partner agencies in response to covid and a lower bed occupancy compared to pre-covid levels.

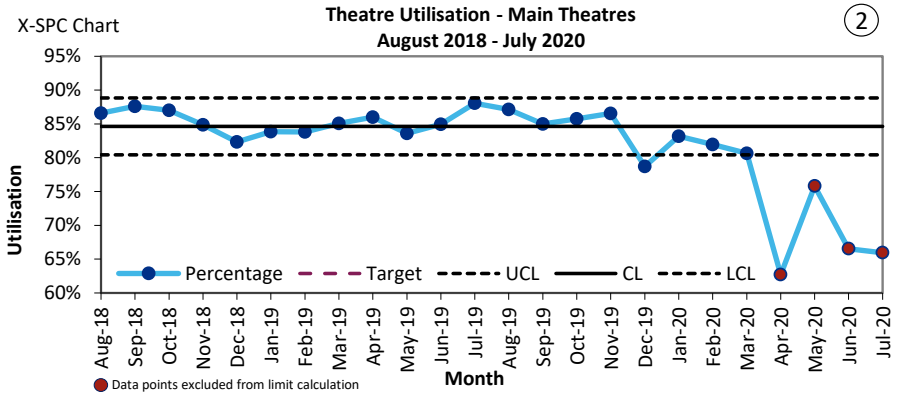
The delayed transfers of care do not include the patients who are waiting for test results or cannot be discharged due to infection control reasons. All patients that are discharged to nursing homes / care homes or with a community provision are tested for covid-19 before discharge.

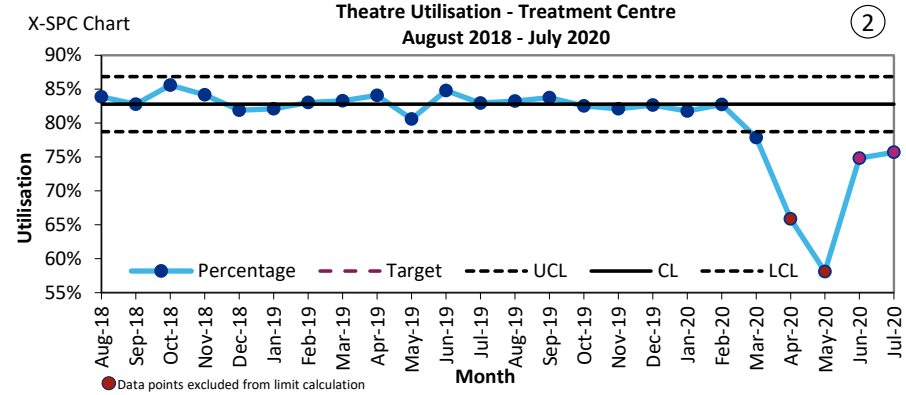
The Trust is working with system partners to maintain similar levels of out of hospital provision as during covid and the expectation is delayed transfer of care remain at May's position. Additional out of hospital capacity is in the winter plan.

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

Board Papers - Performance

Theatre Utilisation

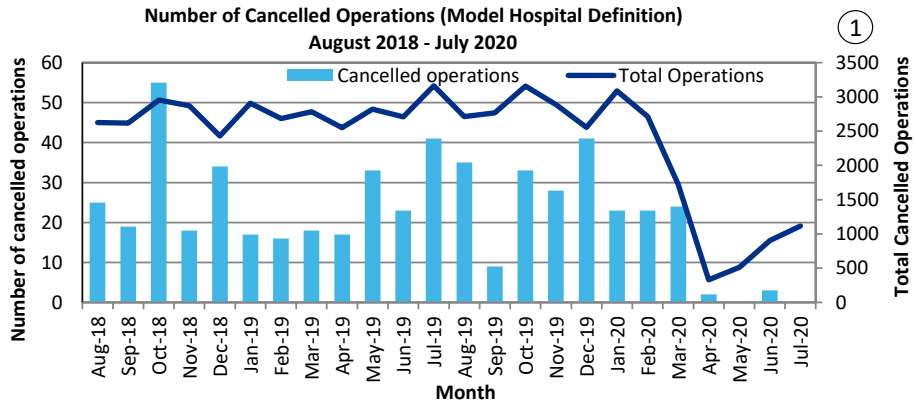


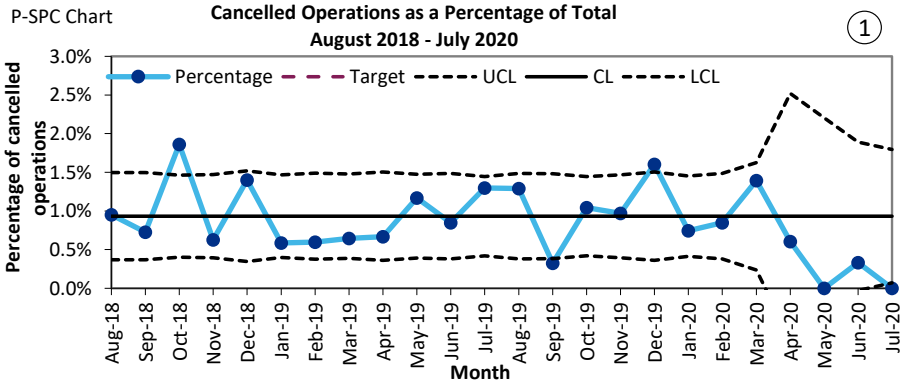


Accountable: Chief Operating Officer **Data Owner:** Information Services

Key Narrative: The number of theatre sessions planned in July 2020 was broadly maintained at June's level but still lower than pre-covid levels. A step up in the number of theatres operating occurred at the beginning of August. Theatre sessions are at pre-covid levels, however, due to IPC and social distancing factors, the number of patients being operated on per list is less. New NICE guidance will further support resumption of pre-covid activity levels and we are planning for a continued step change during August and over the next three-months. Ways to increase the theatre workforce are also being explored.

Cancelled Operations





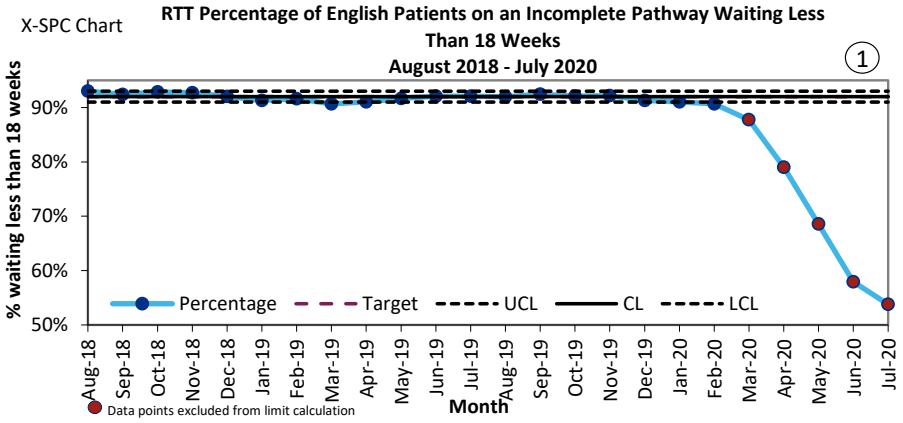
Accountable: Chief Operating Officer **Data Owner:** Information Services

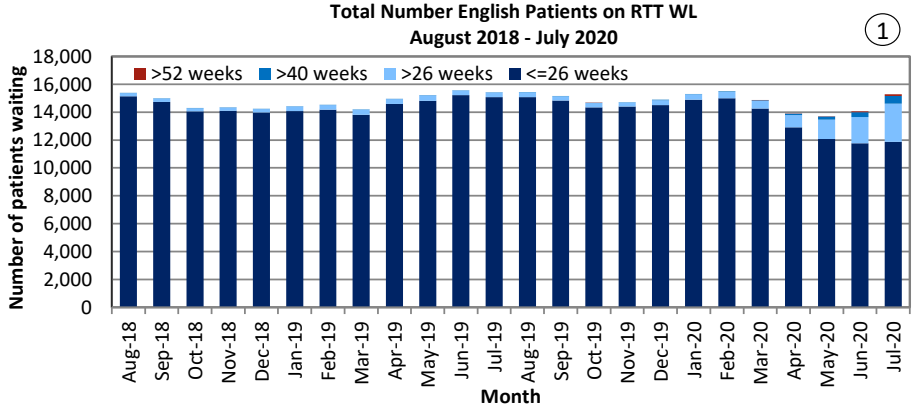
Key Narrative:
The significant reduction in cancelled operations from April 2020 reflects the reduced number of planned operations taking place due to Covid.

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

Board Papers - Performance

Referral to Treatment Waiting Times (RTT)

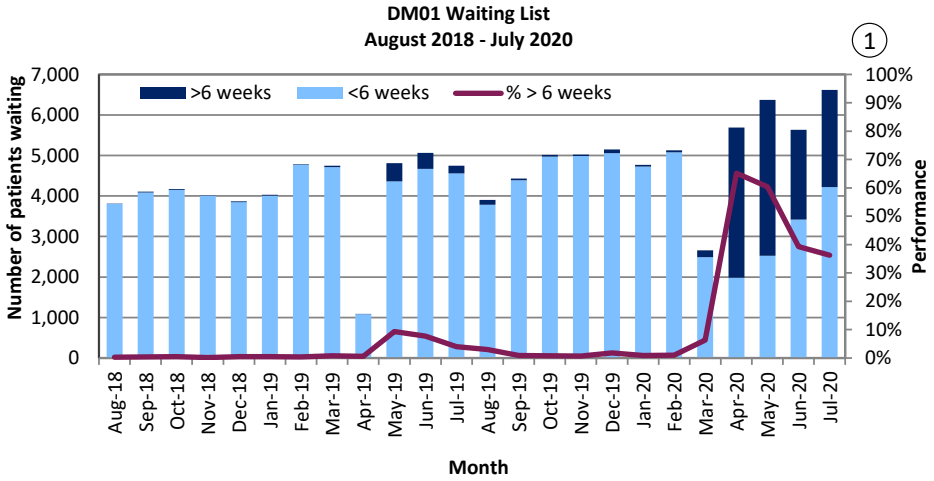




Accountable: Chief Operating Officer **Data Owner:** Information Services

Key Narrative: RTT performance for July 2020 is 53.8% with 115 52-week breaches, and 544 patients waiting between 40 and 52 weeks. Patients >52 weeks will continue to rise as the backlog of patients are treated and referral increases. Long-waiters is a significant focus of our restoration and a priority after clinical need. Restoration of our elective programme will improve this over time as will weekend operating and outsourcing to the ISP.

Diagnostic Waiting Times



Accountable: Chief Operating Officer **Data Owner:** Information Services

Key Narrative:

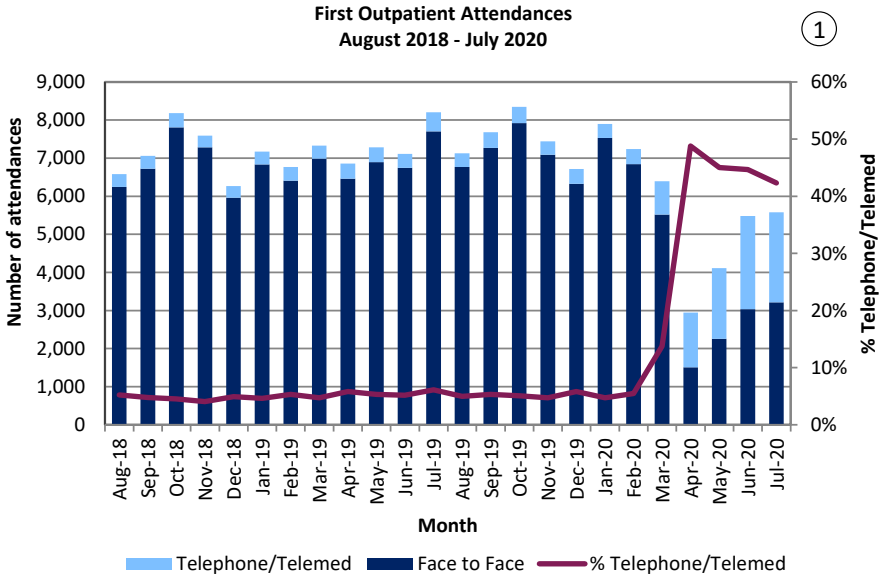
In July 2020, 2397 (36.2%) of patients waited longer than 6 weeks for their diagnostic tests, which is an improvement on the previous month. Resumption of near pre-covid activity levels will support further improvement. Installation of a third onsite CT scanner is planned for mid-November 2020 and a mobile MRI scanner planned in August. Further capacity is also be secured from the independent sector.

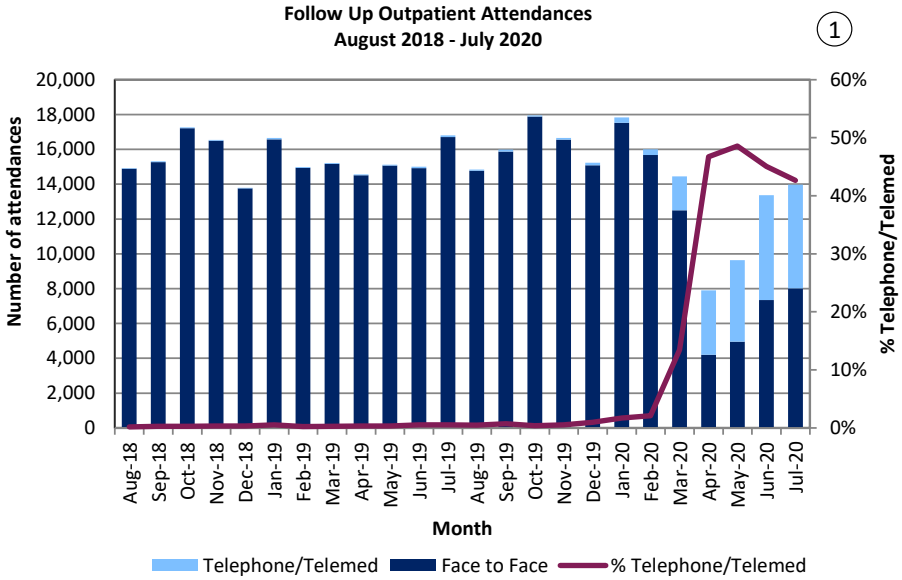
The resumption of the endoscopy programme is a significant challenge due to IPC measures. This is a major problem regionally/nationally. A plan is in place for a step up in the resumption of endoscopy activity in August and September, with the fifth endoscopy room being opened in August. The opportunity in the ISP is limited, however, we continue to try and secure independent sector capacity.

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

Board Papers - Performance

Outpatient Activity





Accountable: Chief Operating Officer **Data Owner:** Information Services

Key Narrative:

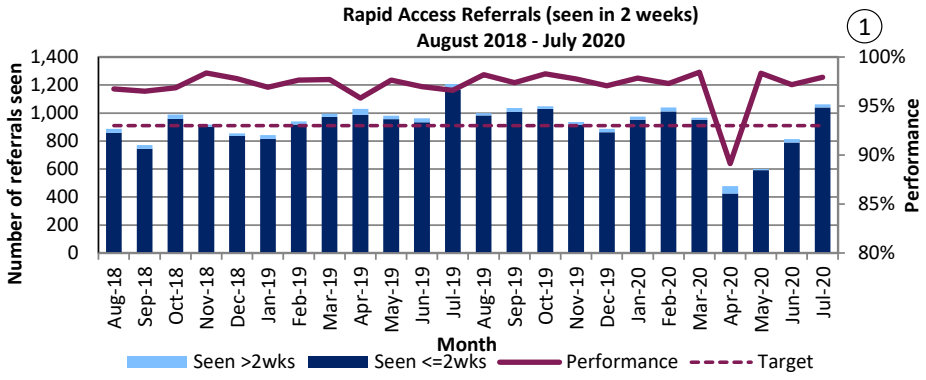
There continues to be a steady increase in outpatient activity to pre-covid levels, albeit the rate of improvement is slowing down in July. Both the total number and proportion of activity seen via telephone or telemedicine clinics has increased over the last 4 months. 42.3% of first outpatient attendances and 42.6% of follow up outpatient attendances seen remotely in July 2020. There is a comprehensive outpatient transformation programme underway with a weekly cross-divisional cell chaired by the DGM for Women's and Children's Division to lead the workstream, which is accountable to the Silver Restoration Group chaired by the COO.

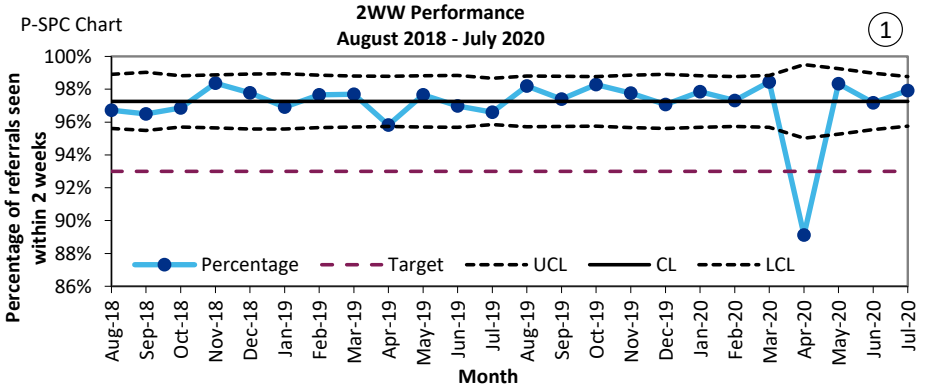
Data includes contracted specialties

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

Board Papers - Performance

Rapid Access Referrals





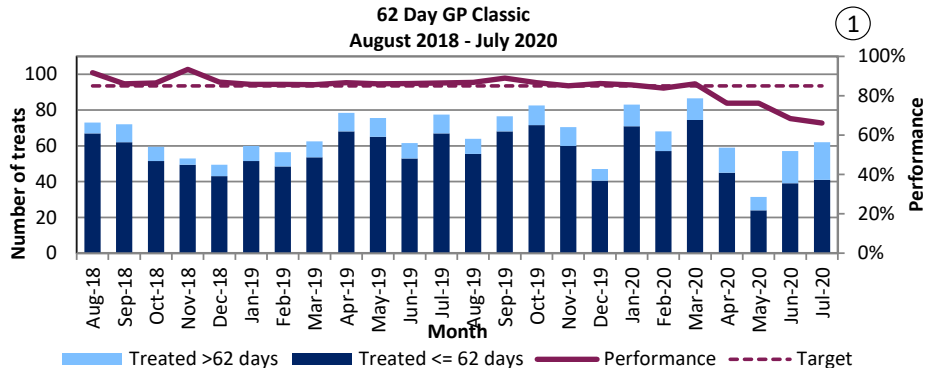
Accountable: Chief Operating Officer **Data Owner:** Cancer Performance

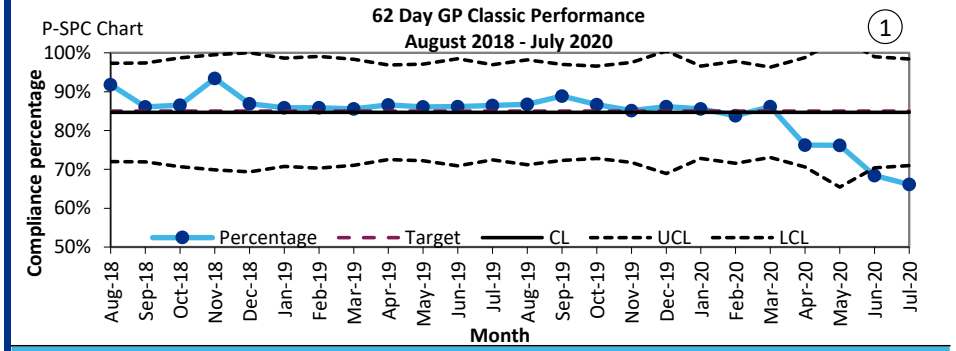
Key Narrative:

Delivery against the two-week rapid access cancer standard continues to perform well with a performance of 97.93 per cent in July, which is an improvement on the previous month. Referrals on a rapid access pathway continue to increase to near pre-covid levels.

The P-SPC chart adjusts the control limits to take into account the denominator. Latest month's data provisional.

62 Day





	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
104+day Confirmed Cancer	4	2	2	2	3	3	0	3	2	2	8	20

Accountable: Chief Operating Officer **Data Owner:** Cancer Performance

Key Narrative: Performance against the 62-day standard continues to be a significant challenge with a performance of 66.1% in July against a standard of 85%, which is a significant deterioration of pre-covid performance. Reduction in performance relates directly to diagnostic capacity, patient deferrals and surgical prioritisation and deferment during COVID-19. Improvement will focus on the resumption of diagnostics to pre-covid levels in addition to securing additional capacity (mobile scanners), and including the endoscopy programme.

The P-SPC chart adjusts the control limits to take into account the denominator. Latest month's data provisional.

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

Performance and Finance - Headlines July 2020

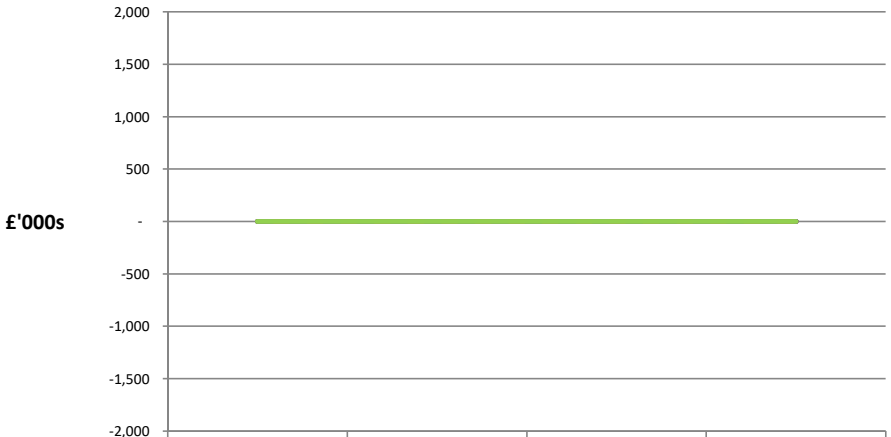
Current Position	Analysis	Forward View

The reported position is break even, with the Trust requiring £5.599m in additional Top up funding from regulators. The expectation that Trust will meet a break even position will continue at least until the end of September.

In prior months the additional expenditure incurred as a result of covid-19 measures has been offset by a number of underspends in planned care, which has begun a level of restoration – and this is the main driver behind the increase in requested top up for July.

The Use of Resources Ratings are suspended under the current financial regime.

Financial Performance 2020/21



	Apr	May	Jun	Jul
In Month Plan	0	-0	0	0
In Month Actual	-0	0	0	-0
In Month Variance	-1	0	0	-0
Cumulative Plan	0	-0	-0	0
Cumulative Actual	-0	-0	0	-0
Cumulative Variance	-1	-0	0	-0

	YTD Rating		YE Rating	
Indicator	**Plan**	**Actual**	**Forecast**	**Status**
Finance				
Use of Resource Rating				
Capital Service Capacity				
Liquidity				
I&E Margin				
Distance from Financial Plan				
Agency Spend				

The Top Up funding is based on costs over and above a baseline calculation that NHSI have made using a reference period of months 8-10 from the 2019/20 accounts. The fact that there were some key transactions that took place after this period is the main reason as to why the Trust requires the additional funding. It is expected that a review of the paper formally submitted to regulators will be reflected in the baselines that will be issued to Trusts for months 7-12.

The top up regime has been extended to August, and it is anticipated that September will also follow suit, however for the last 6 months of the year there will be a return to more usual financial management.

The Trust will be expected to forecast costs to the end of the year, and it is anticipated the Trust will be managed against a provider total, which will link in with a system expectation around the delivery of planned care. It is expected as part of this that there will be incentives for systems to exceed the expectations set out within the phase3 letter.

Performance and Finance - Income From Patient Care July 2020

Current Position

Income from Patient Care activity covers both contract income, Private Patient funding and Injury Cost Recovery Scheme income. This income is £946k below plan.

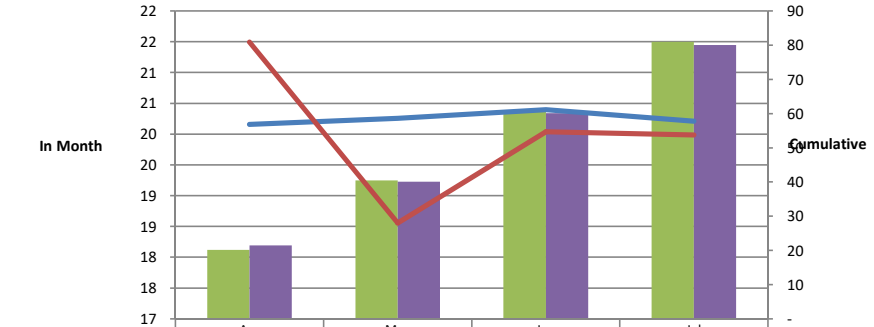
Contract income is £343k below plan which relates to non-contract/cross border flow activity as it is not currently being billed as part of the covid-19 guidelines.

The underlying PbR contract income position for activity seen to Month 4 is £18.3m less than received in the calculated block payments, as a result of reduced planned care.

Private patient and the Injury cost recovery scheme income is under plan by £604k year to date, as a result of the reduced activity within the hospital and social distancing measures in place.

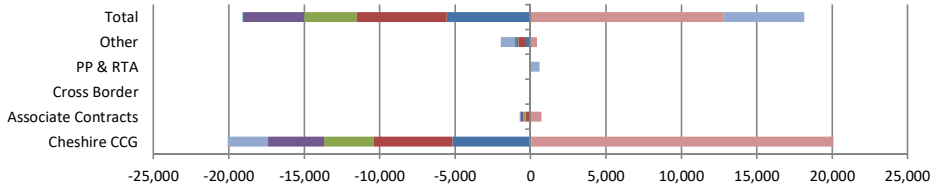
Analysis

Contract Income Performance 2020/21 £'m



	Apr	May	Jun	Jul
Cumulative budget	20	40	61	81
Cumulative actual	21	40	60	80
In month budget	20	20	20	20
In month actual	21	19	20	20

Cumulative Variance to Contract Income plan £'000s



	Cheshire CCG	Associate Contracts	Cross Border	PP & RTA	Other	Total
Unplanned Care	-5,176	-77	-6	-	-297	-5,556
Day case	-5,241	-240	-1	-	-496	-5,979
Elective	-3,267	-169	-1	-	-39	-3,475
Outpatients	-3,720	-201	-1	-	-116	-4,038
High cost drugs	68	0	2	-	-126	-56
COVID	20,010	728	-	-	421	12,771
Other Contracts	-2,674	-41	2	604	-891	5,386
Total	-0	0	-5	604	-1,545	-946

Forward View

The Trust has an agreement for a block value with all commissioners for April-September 2020/21, with additional 'top up' payments in place to support Trusts where costs exceed the regulator expectations.
The exact nature of the relationship that will exist between providers and commissioners will become clearer, with guidance expected at the end of August. Whilst the traditional, formal contracts are not expected - there will be an expectation to work to manage to a system total for October to March.

Performance and Finance - Pay Expenditure July 2020

Current Position

Cumulatively Pay is worse than the NHSI expectation by £4.2m, of which the response to Covid-19 has been the largest contributor of overspend.

The direct costs associated with covid-19 are broken down into the following areas:

- Bank incentive (£1m)

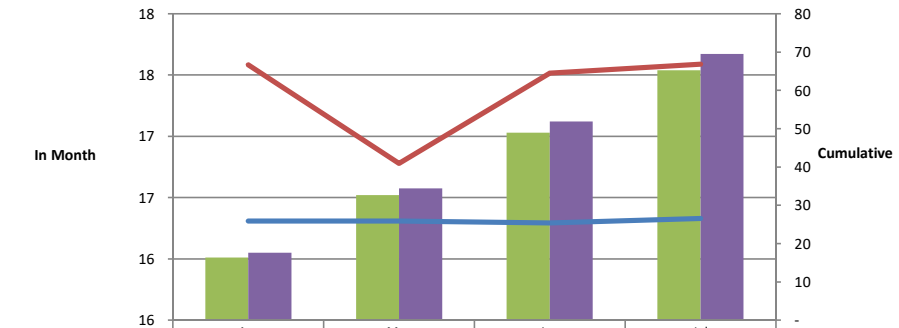
- Additional Medical costs including paid student placements (£0.9m)

- Increase in acuity pre-dominantly impacting nursing, and further paid student placements (£1.2m)

- Increased sickness levels (£1.5m)

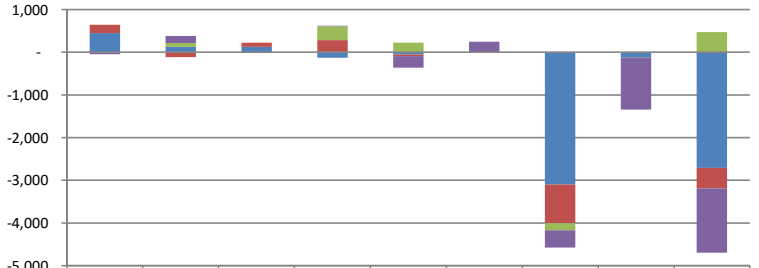
Analysis

Pay Expenditure 2020/21 £'m



	Apr	May	Jun	Jul
Cumulative budget	16	33	49	65
Cumulative actual	18	34	52	69
In month budget	16	16	16	16
in month actual	18	17	18	18

Pay Variances by Staff Group and Division £'000s



	DMEC	S&C	W&C	CSSD	CCICP	Estates	COVID	Other	Total
Total	602	272	206	496	-136	249	-4,572	-1,341	-4,225
Infrastructure Support Staff	-38	166	-12	15	-271	249	-406	-1,204	-1,502
Non Clinical Staff	-7	92	-2	328	227	-	-165	-5	468
Medical Staff	199	-111	96	281	-39	-	-901	-7	-482
Nursing Staff	448	125	125	-128	-53	-	-3,101	-125	-2,709

Forward View

There is significant pressure on the pay budgets as a result of measures put in place to support the Trust with the pandemic, which will impact Q2 of 2020/21. Some of these measures, such as the bank incentive have been reviewed by exective team and amended – but there are new emerging costs as planned care begins to restore which will be incurred.

The Trust has capitalised on the support for paid placements for nurses, and has looked to pro-actively offer roles to staff which will have an impact of reducing the current number of nursing vacancies. Elsewhere with projects to support workload – where there have been delays with the original plans – there are new schemes being developed

Performance and Finance - Non-Pay Expenditure July 2020

Current Position

Non Pay is £438k better than the expectations set out by NHSI regulators.

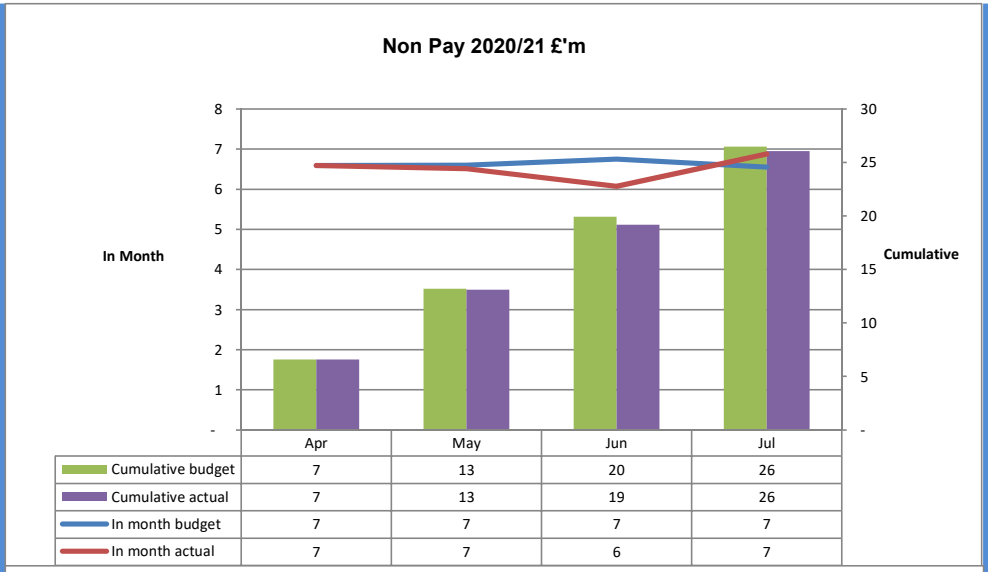
Whilst the costs associated with Covid-19 have been separately identified as being £3.456m there are a number of offsets associated with planned care which is significantly reduced at present.

The key expenditure within non pay for Covid-19, relates to PPE and increase consumables (£2m), temporary fixtures and enablement (£0.8m), decontamination (£0.5m) and IT costs (£0.5m).

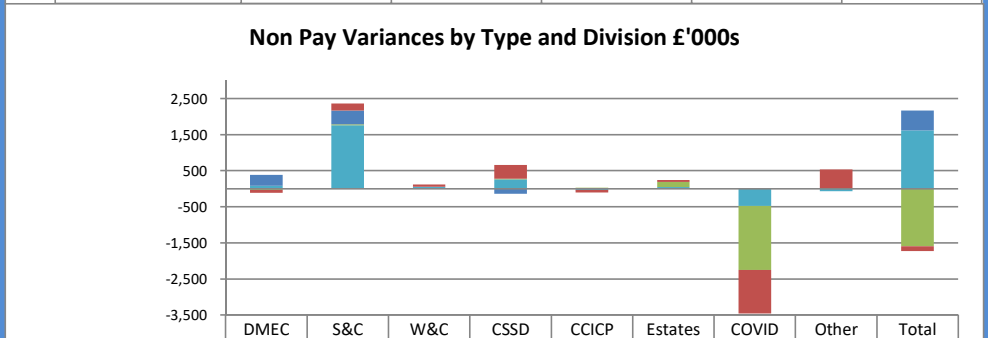
Whilst there has been a real reduction within planned care in areas such as drugs, July has seen an increase in activity (particularly within chemotherapy and ophthalmology) and the associated costs have increased.

Diagnostic activity has also seen an increase in the average run rate of costs as the outsourcing of activity has started to ramp up to tackle backlogs.

Analysis



	Apr	May	Jun	Jul
Cumulative budget	7	13	20	26
Cumulative actual	7	13	19	26
In month budget	7	7	7	7
In month actual	7	7	6	7



	DMEC	S&C	W&C	CSSD	CCICP	Estates	COVID	Other	Total
Total	273	2,359	114	520	-76	244	-3,456	461	438
Other Non Pay	-79	192	62	385	-74	56	-1,207	528	-137
Drugs	301	384	7	-138	-0	-0	1	2	556
Non Clinical Supplies	-34	25	-2	14	30	142	-1,771	1	-1,594
Clinical Supplies	85	1,758	47	259	-32	46	-479	-70	1,613

Forward View

There are considerable challenges associated with securing the supply of PPE, which presents a challenge when looking to forecast for the remainder of the year – particularly as the Trust looks to support the restoration of services.

At the end of the first quarter the Trust was underspending in key planned care areas by £1m. As this activity starts to ramp up, it is expected that these costs will revert back to their normal levels and the Trust will see an increase in the run rate to that value.

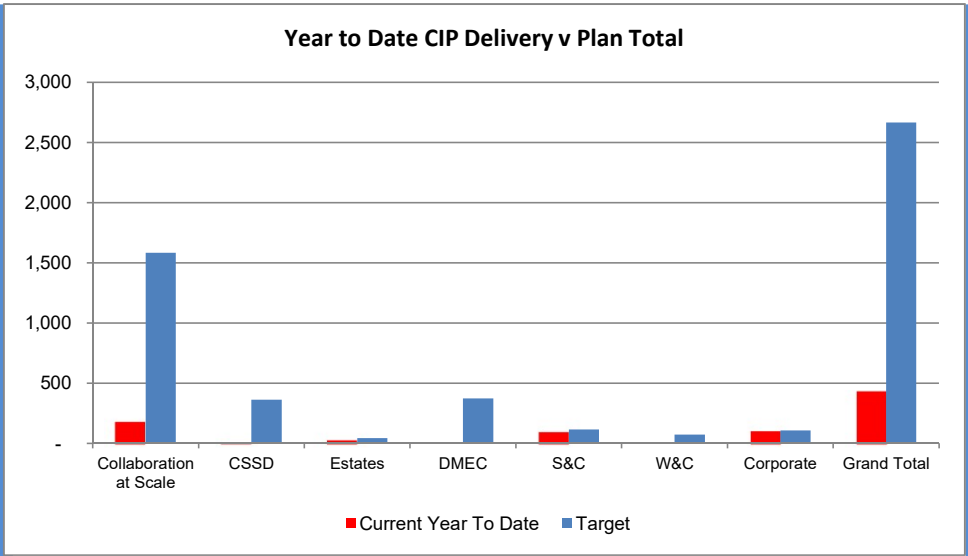
Performance and Finance - Cost Improvement Programme July 2020

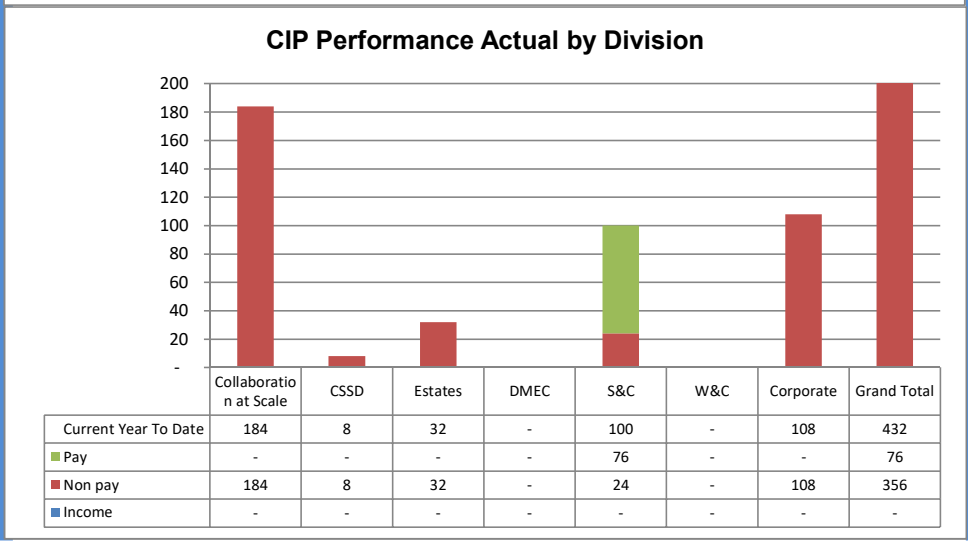
Current Position

The Trust is not currently being managed by regulators in terms of a cost improvement programme. The targets shown within the graph opposite illustrate the indicative cost savings expected in accordance with the draft plan.

However, the Trust is continuing to look to support either existing schemes or new schemes that can progress in areas of the hospital that have capacity to support focus around this, which is being managed via the monthly finance meetings.

Analysis





	Collaboration at Scale	CSSD	Estates	DMEC	S&C	W&C	Corporate	Grand Total
Current Year To Date	184	8	32	-	100	-	108	432
Pay	-	-	-	-	76	-	-	76
Non pay	184	8	32	-	24	-	108	356
Income	-	-	-	-	-	-	-	-

Forward View

Work that the collaboration at scale work stream has previously put forward for system wide opportunities will be reviewed both in terms of time frames in light of the impact of Covi-19 - but also their direct impact on the Trust.

Performance and Finance - Agency Spend July 2020

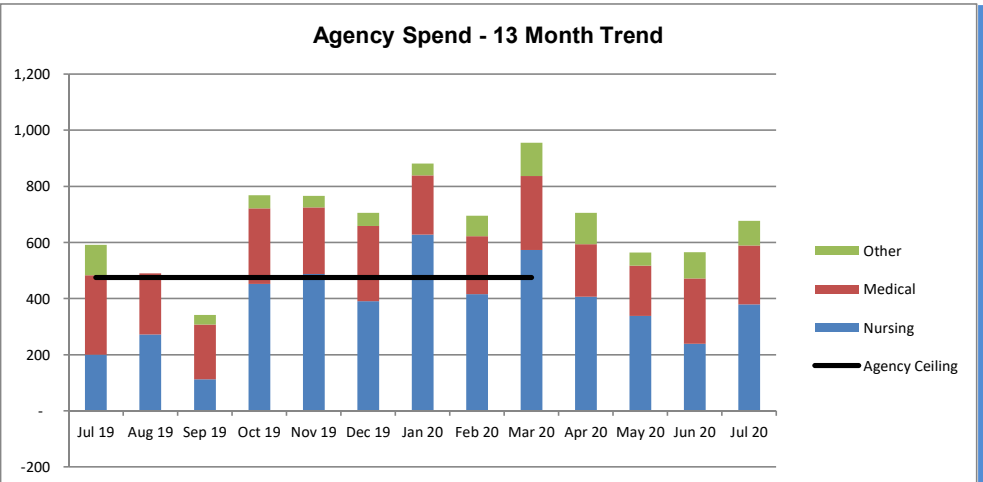
Current Position

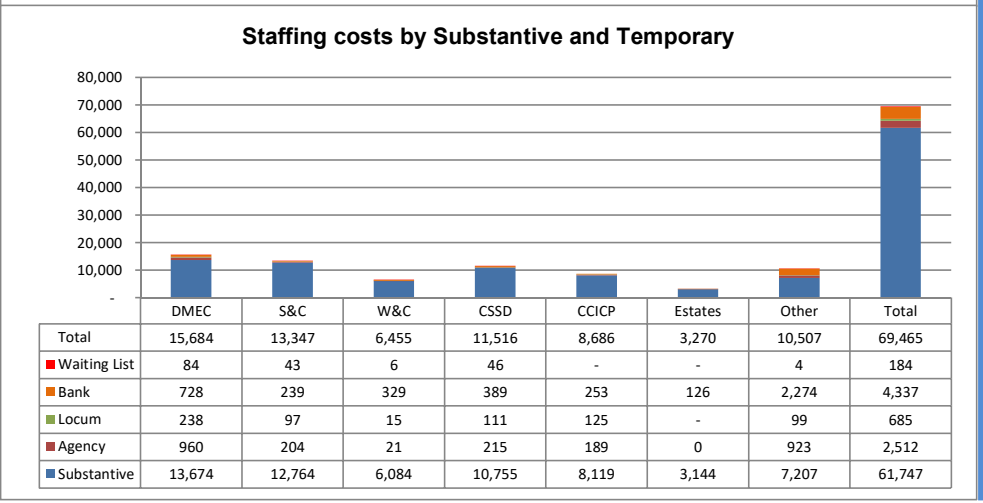
Agency expenditure has remained at a lower level again in July – however as nursing agency spend is reducing medical agency is increasing.
Nursing agency remains at a lower level than the trend over the past 12 months, which has come from an improvement in vacancies within the Trust.

There are some key areas within the Trust such as the Emergency Department which remain heavily reliant on the use of agency to support the additional measures for covid-19 that the Trust has had to make.

This is also reflected in the use of Thornbury nurses, where there have been only 8 used in July, however the reliance on Pulse particularly, within ED, presents a workforce challenge that will need to be addressed.

Analysis





	DMEC	S&C	W&C	CSSD	CCICP	Estates	Other	Total
Total	15,684	13,347	6,455	11,516	8,686	3,270	10,507	69,465
Waiting List	84	43	6	46	-	-	4	184
Bank	728	239	329	389	253	126	2,274	4,337
Locum	238	97	15	111	125	-	99	685
Agency	960	204	21	215	189	0	923	2,512
Substantive	13,674	12,764	6,084	10,755	8,119	3,144	7,207	61,747

Forward View

It is encouraging that the rates of agency expenditure are reducing, and the fill rates increasing for Registered nursing – despite the challenge that covid-19 has presented.

The next cohort of international nurses are with the Trust, and there has been a recent benefit with having the paid placement nurses – where the Trust has been able to recruit a number of nurses who will qualify for September. This is positive for the Trust, however it cannot be underestimated the level of challenge that the coming Winter is expected to bring.

There are challenges within the specialist areas within nursing, which is now where some of the focus needs to be with workforce planning along with the other specialisms such as medical workforce that will need to be reviewed.

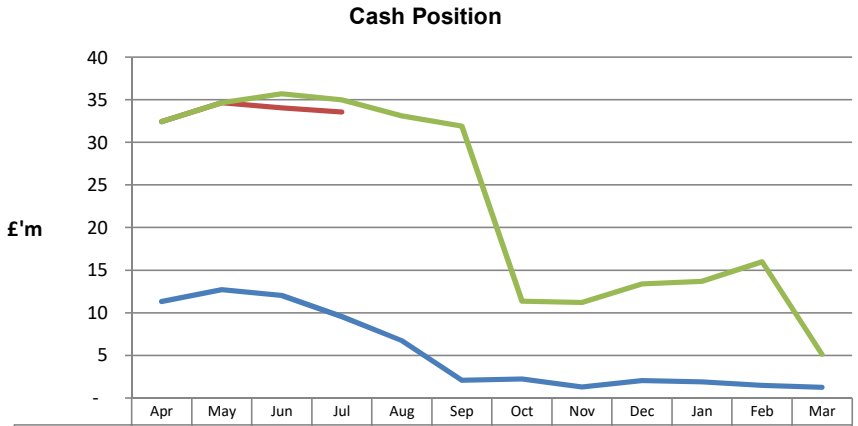
Performance and Finance - Cash July 2020

Current Position

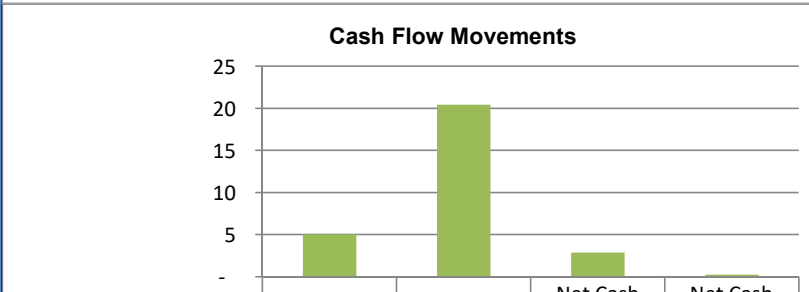
Cash Position
Cash is better than originally anticipated by £24m.

This is due to £20m of contract income being paid in advance to support cash flow during the COVID-19 pandemic. In addition, capital expenditure is behind plan by £5m.

Analysis



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Plan	11	13	12	10	7	2	2	1	2	2	1	1
Actual	32	35	34	34								
Forecast	32	35	36	35	33	32	11	11	13	14	16	5



	Operating Surplus / (Deficit)	Increase / (Decrease) in Working Capital	Net Cash Inflow / (Outflow) from Capital Expenditure	Net Cash Inflow / (Outflow) from Borrowings
Variance to Opening Balance	5	20	3	0

Forward View

Due to the COVID-19 situation, the Trust is not anticipating any problems with cash due to contract payments being received in advance from commissioners, and any additional COVID-19 costs are being reimbursed.

The forecast is based on the Going Concern exercise for the 2019/20 audit, which has been adjusted for actuals to July 2020.

Performance and Finance - Capital Expenditure July 2020

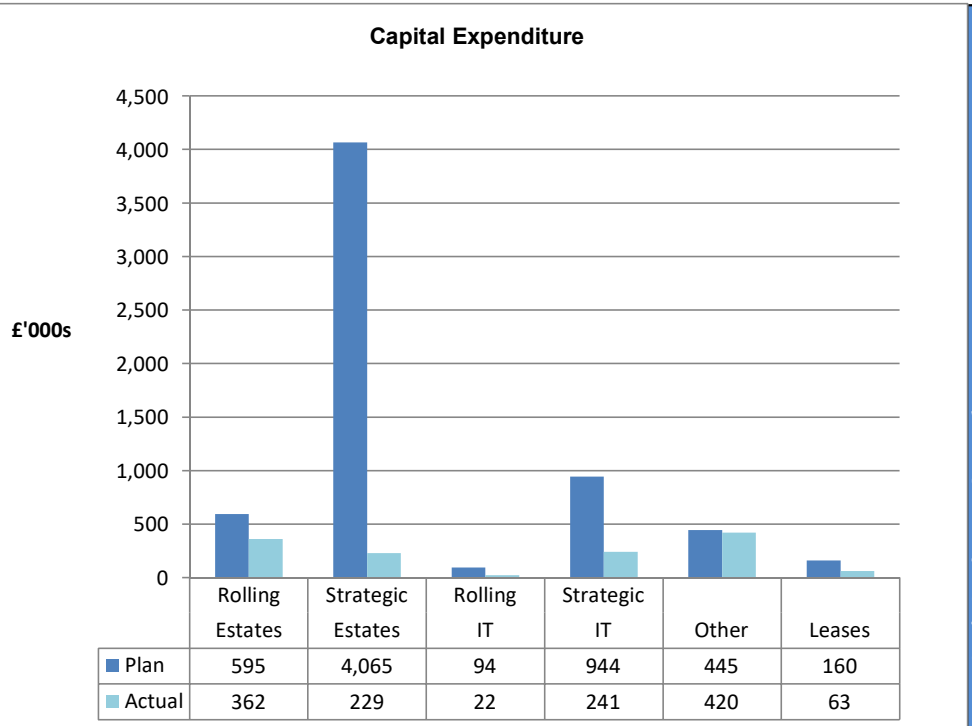
Current Position

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

(£1.1m) Car Park Expansion
(£0.9m) ICU Conversion
(£0.7m) Third CT Enabling
(£0.5m) Endoscopy Works
(£0.5m) Maintenance & Refurbishment
(£0.4m) Labcentre Upgrade

Lease expenditure is broadly inline with plan.

Analysis



		Year to Date £'000s			Year End £'000s		
		Plan	Actual	Variance	Plan	Forecast	Variance
Estates	Rolling	595	362	-233	4,292	4,292	0
Estates	Strategic	4,065	229	-3,836	8,223	7,223	-1,000
IT	Rolling	94	22	-72	353	353	0
IT	Strategic	944	241	-703	5,655	5,666	11
Other		445	420	-25	445	455	10
Leases		160	63	-97	3,679	3,679	0
		6,303	**1,338**	**-4,965**	**22,647**	**21,668**	**-979**

Forward View

We are awaiting national guidance on the Capital regime for 2020/21, therefore only essential and priority works will be progressed until this is received.

The forecast is based on information currently available, it is anticipated that there will be slippage on the refurbishment of South Cheshire Private Hospital.

Performance and Finance - Statement of Financial Position July 2020

Current Position | Analysis | Forward View

Assets Non-Current
The capital programme expenditure is £5m less than the anticipated plan, mainly due to slippage on the Car Park Expansion of £1.1m and ICU Conversion £0.9m.

Assets Current
Trade receivables have reduced by £3.4m compared to March 2020, mainly due to receiving payments for 19/20 PSF. Cash is better than expected due to £20m of contract income being paid in advance to support cash flow during the COVID-19 pandemic.

Current Liabilities
Trade Payables has reduced by £4.5m compared to March 2020, due to the increased frequency of payment runs. Deferred Income is £21m higher due to the additional contract payments to support COVID-19 cash flows.

Taxpayers Equity
Working Capital Loans and the Interim Capital Loans to the value of £13.2m are due to be converted to PDC in September.

	Position as at March 20 (£'000)	Actual Apr to July (£'000)	Variance (£'000)
Assets			
Assets, Non-Current	104,476	103,779	-697
Assets, Current	32,811	49,448	16,637
ASSETS, TOTAL	**137,287**	**153,227**	**15,940**
Liabilities			
Liabilities, Current	-39,717	-55,729	-16,012
Liabilities, Non Current	-8,655	-8,682	-27
TOTAL ASSETS EMPLOYED	**88,915**	**88,816**	**-99**
Taxpayers' and Others' Equity			
Taxpayers Equity	88,915	88,816	-99
TOTAL FUNDS EMPLOYED	**88,915**	**88,816**	**-99**

Over the coming months there are no significant changes anticipated to the Balance Sheet.

Cash flows are expected to remain consistent with regular cash coming in, and with regular payments being made to suppliers.

Performance and Finance - COVID Capital Schemes July 2020

Bid Month	Scheme Description	Scheme Rationale	Scheme Type	Bid Value	Year to Date £'000s			Year End £'000s		
				£'000s	Plan	Actual	Variance	Plan	Forecast	Variance
Apr-19	Voice over IP	Enables Switchboard virtual operator	IT	91	91	91	0	91	91	0
May-19	Upgrade of Oxygen Supply	To enable the use of CPAP and Ventilators	Infrastructure	56	56	56	0	56	56	0
May-19	Blood Gas GEM 5000	Additional required	Clinical Equipment	39	39	34	-5	39	39	0
May-19	IMPRIVATA: ONESIGN SINGLE	Single Sign on enablement	IT	109	109	109	0	109	109	0
May-19	Armstrong FD140 Vents	For CPAP	Clinical Equipment	90	45	45	0	90	90	0
May-19	Trilogy Ventilator	For CPAP	Clinical Equipment	31	31	31	0	31	31	0
May-19	Benevision N17 touch Elan	Patient Monitoring	Clinical Equipment	73	0	0	0	73	73	0
				489	**371**	**366**	**-5**	**489**	**489**	**0**

TAP Committee
Chair's Assurance Report
August 2020

Report to	Board of Directors
Date	6 August 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 Amy Freeman, Chief Information Officer Oliver Bennett, Chief Operating Officer
Committee meeting quoracy	Yes ☒ No ☐

KEY AREAS OF ASSURANCE

Impact of Covid-19 on Transformation & Workforce

- Nursing Vacancy Gap – BAF 3[1] : workforce modelling report to be reviewed before December across QGC, TAP and PAF committees due to impact across workforce, quality and finance.
- Workforce Update: Committee advised of new items for the workplan and it was agreed that the plan should be reviewed with the revised model submitted in September as the Committee is rebadged to Workforce and Digital Transformation.

Digital Transformation

- Reprioritisation of digital priorities in light of Covid - acceptable assurance: IT projects are considered against agreed scoring criteria across a number of elements, e. g. patient safety and quality, before being reprioritised
- Executive Digital Technology and Information Services Group to include a workforce representative to ensure staff impact is considered
- Digitally Enabled Clinical System Programme (EPR) BAF6[2]: current focus is in on interim solutions to mitigate the risk caused by the delay to Electronic Patient Record (EPR) approval.

Workforce

- Freedom to Speak Up Guardian (FTSUG) Annual report - acceptable assurance: the process was clarified in that concerns raised are discussed at Patient Safety Summit, at Board or with the CEO. Future reports to include examples of action taken and the impact. The new FTSUG starting on 1 September provides an opportunity to review FTSU processes.
- Black, Asian and Minority Ethnic (BAME) - acceptable assurance: further evidence provided that the actions taken for BAME staff identified as high or medium were appropriate. There were higher levels of disclosure of disability from staff than appear on ESR database; work is in

[1] BAF 3 Inability to close the nurse staffing vacancy gap
[2] BAF 6 Failure to proceed with EPR development and implementation

progress to support these staff. Links to BAF14 [3] and the importance of creating a knowledge base of lessons from Covid were discussed.

- Revised workforce report: intelligence provided is better but further improvement required e.g. training compliance cannot be linked to incidents and consequences easily. Deep dive into links between lack of manual handling training and musculoskeletal illness/absence delegated to EWAG.

Transformation

- GM Utilisation Report - partial assurance: The Transformation Team and Clinical Divisions are working to implement the key recommendations following the external review. The recommendations form a standard agenda within the Cheshire System Urgent Care Steering Group; compliance with the recommendations will be monitored via this group. The recommendations relating to predictive analysis and breach review are reliant upon a Trust EPR, which is currently not in place
- Next steps include ongoing assurance and monitoring via the Urgent Care Steering Group and an update back to this Committee in 3 months' time.

KEY CONCERNS/RISKS

- The number of ward moves during Covid 19 is providing an inaccurate picture at divisional level although Trust level data is accurate
- Capacity in the ED&I team is insufficient to deliver additional work on BAME and disability networks
- The delay to the EPR is impacting on other areas of business.

Priority Areas: DECISIONS MADE

No decisions made

RECOMMENDATION

To note the ongoing work to improve processes within the Emergency Department following receipt of the GM Utilisation Report.

[3] BAF 14 Failure to adequately plan future workforce requirement

BOARD OF DIRECTORS

Agenda Item	**15**	Date of Meeting: 07/09/2020
Report Title	Workforce Report – July 2020	
Executive Lead	Heather Barnett, Director of Workforce and OD	
Lead Officer	Melissa Oldham, Head of HR	
Action Required	To note	

☐	**Acceptable assurance** General confidence in delivery of existing mechanisms / objectives	X	**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)*

- Sickness has decreased since a peak in April 2020 but remains a concern
- Mandatory training is Red against target
- Appraisals are Red against target

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)*

• Manage the impact of covid and ensure safe recovery	✓	• Provide safe and sustainable healthcare through our estate, infrastructure and planning	☐
• Deliver outstanding care and patient experience Deliver the most effective care to achieve best possible outcomes	☐	• Provide strong system leadership by working together	✓
• Ensure MCHFT is the best place to work	✓	• Be well governed and clinically led	☐

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)*

N/A

REPORT DEVELOPMENT

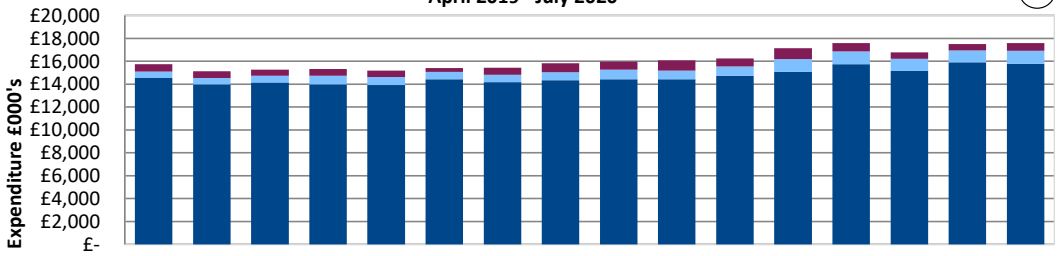
Committee/ Group Name	Date	Report Title	Lead	Brief summary of key issues raised and actions agreed

Board Papers - Performance

Finance and Costings

Workforce Expenditure by Month £000's
April 2019 - July 2020

(1)

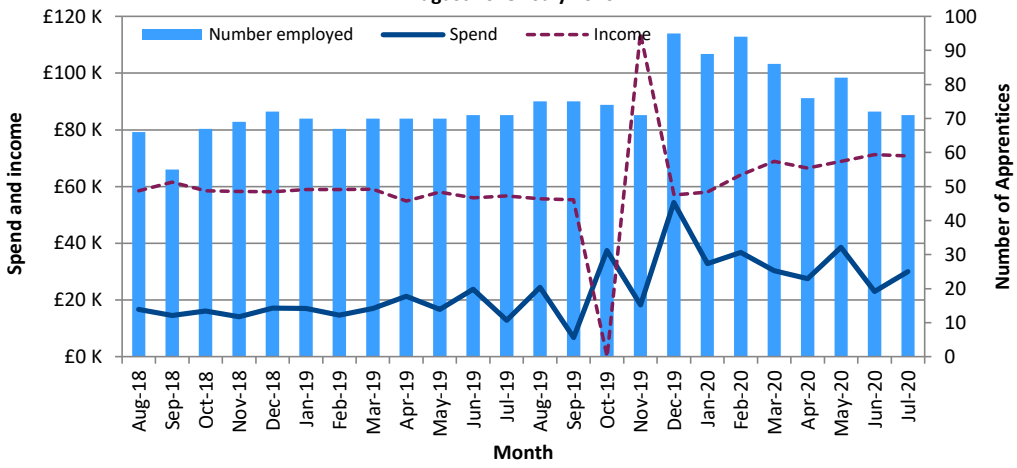


	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
Agency	£638	£570	£510	£591	£566	£341	£619	£765	£706	£881	£695	£955	£705	£565	£565	£677
Bank	£554	£556	£595	£761	£713	£646	£636	£711	£832	£750	£817	£1,127	£1,124	£1,052	£1,029	£1,132
Substantive	£14,55	£13,99	£14,15	£13,98	£13,91	£14,42	£14,18	£14,34	£14,42	£14,43	£14,73	£15,07	£15,75	£15,16	£15,92	£15,77

Month

Apprenticeship Spend by Month
August 2018 - July 2020

(1)



Accountable: Director of Workforce & Organisational Development
Data Owner: Workforce Directorate

Key Narrative:
Substantive expenditure has decreased in July, and both Bank and Agency spend have increased, when compared with June 2020. Bank and agency spend are higher than during the same month last year.

Cumulative Pay is worse than the NHSI expectation by £4.2m, of which the majority is associated with direct Covid-19 costs (£4.6m). Agency expenditure has remained at a lower level again in July – however as nursing agency spend is reducing medical agency is increasing. Nursing agency remains at a lower level than the trend over the past 12 months, which has come from an improvement in vacancies within the Trust.

Accountable: Director of Workforce & Organisational Development
Data Owner: Workforce Directorate

Key Narrative:
There has been a decrease in the number of Apprentices employed when compared with June 2020. However, numbers do fluctuate monthly depending on programme start and finish dates.

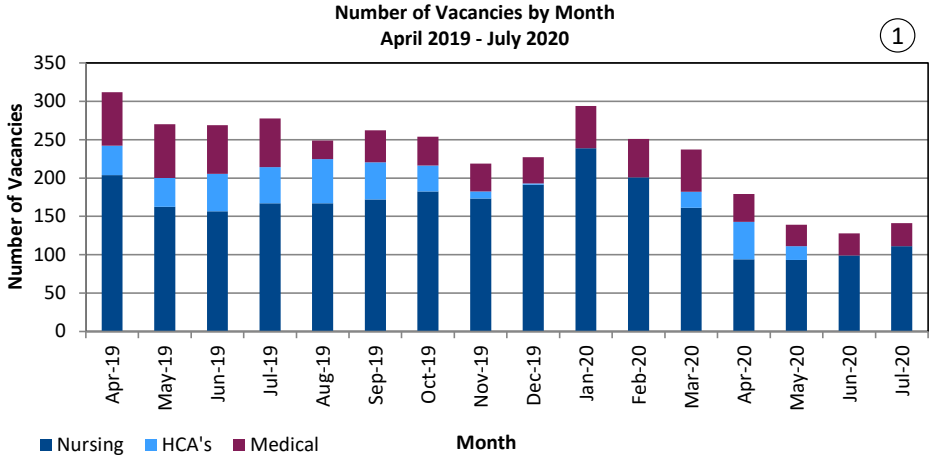
Although there has been a drop in spend in June and July 2020, the trajectory over the 2-year period has been increasing.

Income for October 2019 was received in November 2019, accounting for the drop and spike during that months.

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

Board Papers - Performance

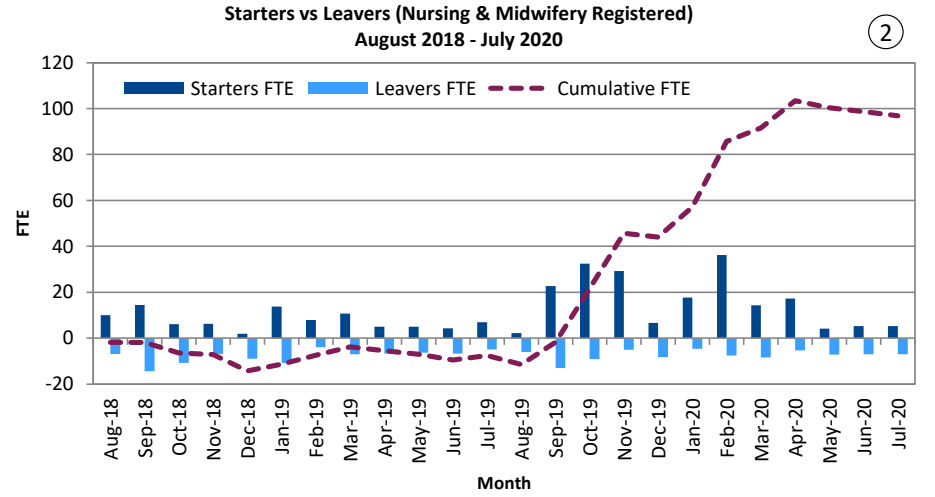
Vacancies



Accountable: Director of Workforce & Organisational Development
Data Owner: Workforce Directorate

Key Narrative:
The number of overall vacancies increased for the first time since January 2020, mainly due to an increase in nursing vacancies.

There were no recorded HCA vacancies for a second consecutive month and medical vacancies have remained stable for a fourth month in a row, following a decrease in Apr-20.



Accountable: Director of Workforce & Organisational Development
Data Owner: Workforce Directorate

Key Narrative:
July 2020 has been the third consecutive month since Dec-19 that the Trust has seen a higher number of leavers than starters. However, due to significant numbers of new starters in recent months (including International Recruitment and BMI), the cumulative FTE remains nearly 100 FTE above that of 2 years ago.

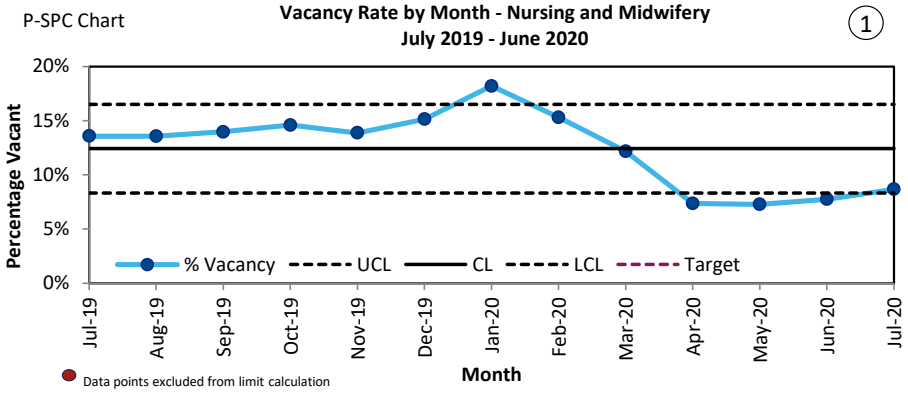
There has been an increase of over 100 FTE since August 2019.

The number of leavers each month remains stable.

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

Board Papers - Performance

Vacancies



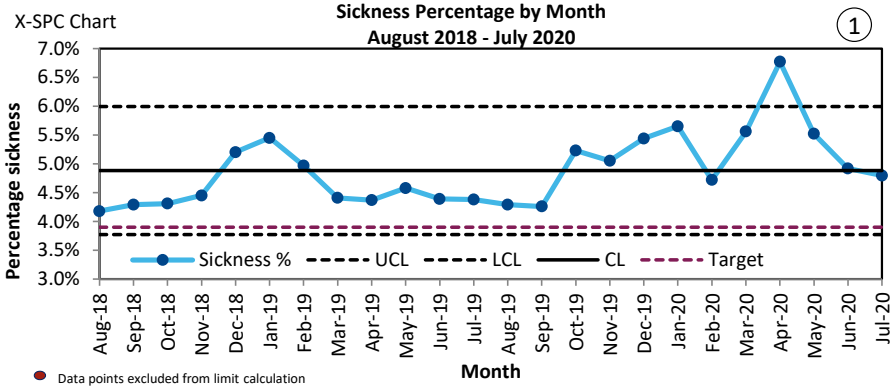
Accountable: Director of Workforce & Organisational Development
Data Owner: Workforce Directorate

Key Narrative:

The vacancy rate has slightly increased when compared with June 2020 but remains at the lower limit and is significantly lower than the average for the past 12 months. The vacancy rate had been decreasing significantly since January 2020 due to the impact of recruitment initiatives.

The vacancy rate is significantly lower than at the same point last year.

Sickness



Accountable: Director of Workforce & Organisational Development
Data Owner: Workforce Directorate

Key Narrative:

There has been another drop in sickness absence compared with June 2020. However, sickness during the period March 2020 to June 2020 was significantly higher than during the same months in previous years, due to the peak of the Covid-19 pandemic.

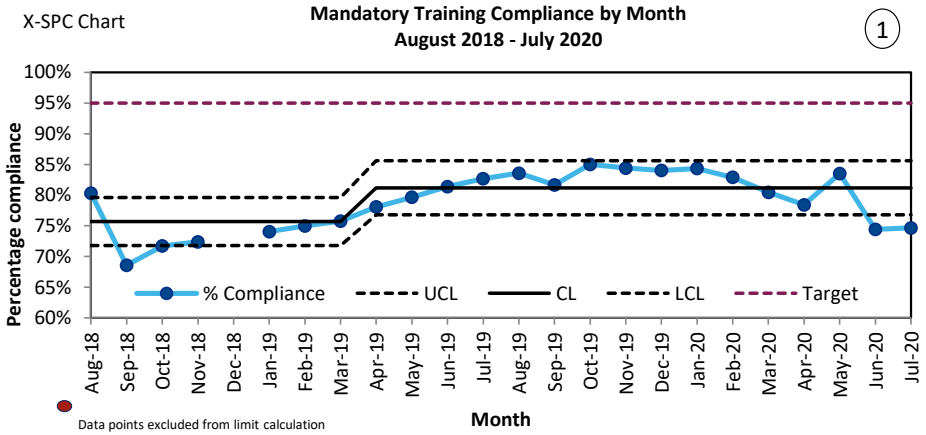
July 2020 is the first month since February 2020 that sickness absence levels have dropped below the 2-year mean average. The Covid-19 pandemic has followed the winter period where sickness levels do usually increase. Long term sickness absence has been decreasing month-on-month since April 2020 and short term absence has also increased for the first time since April 2020.

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

Board Papers - Performance

Training

X-SPC Chart

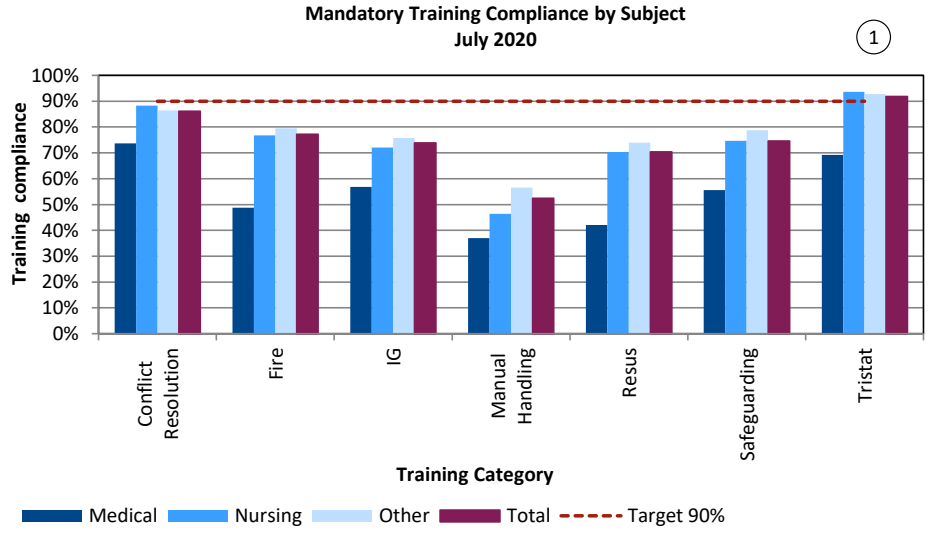


Accountable: Director of Workforce & Organisational Development
Data Owner: Workforce Directorate

Key Narrative:
Mandatory Training Compliance has slightly increased to **74.66% (RED)** from **74.40% (RED)** last month.

Compliance is also lower than at the same point last year (**81% AMBER**).

There was no data available during December 2018.



Accountable: Director of Workforce & Organisational Development
Data Owner: Workforce Directorate

Key Narrative:
Tri-Stat remains the only subject of Mandatory Training with compliance which is **GREEN (91.79%)**.

Conflict Resolution is **AMBER (86.17%)** and all other subjects are **RED**.

Mandatory Training compliance for Medical staff group is significantly lower than for other staff groups, across all training subjects.

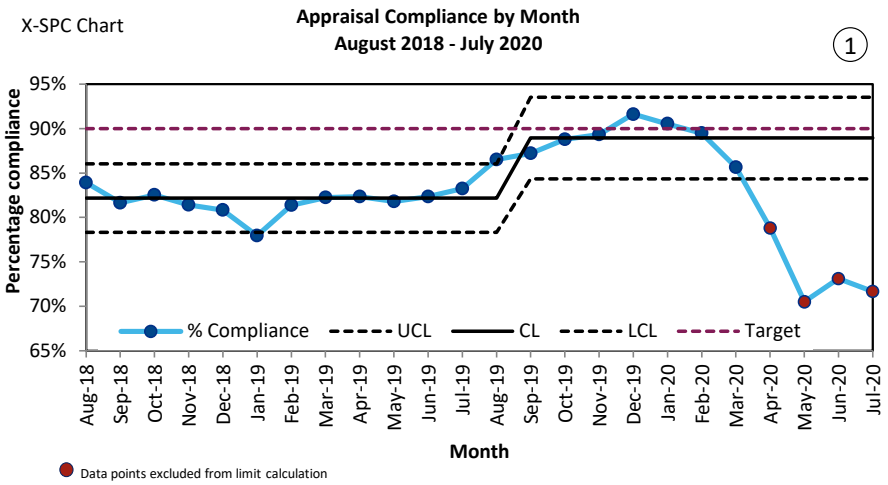
Compliance for all subjects is broadly similar across all other staff groups, with the exception for Manual Handling, where it is slightly lower for the Nursing staff group.

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

Board Papers - Performance

Appraisals

X-SPC Chart

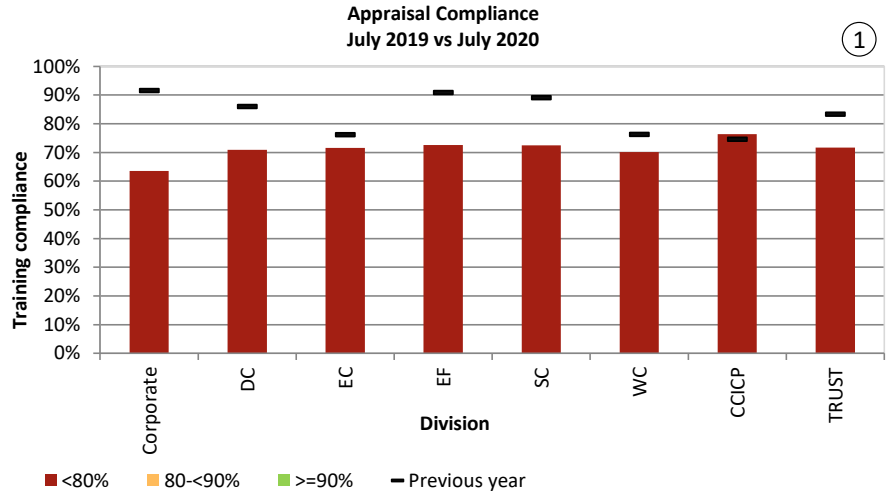


Accountable: Director of Workforce & Organisational Development
Data Owner: Workforce Directorate

Key Narrative:
Overall Appraisal compliance remains **RED** at **71.66%**, which is a slight drop when compared with June 2020 **(73.1%)**.

Compliance had been dropping month-on-month since December 2020 before an increase in May 2020.

July 2020 was the fourth consecutive month where compliance dropped below the lower limit, highlighting a cause for concern.



Accountable: Director of Workforce & Organisational Development
Data Owner: Workforce Directorate

Key Narrative:
All divisions have compliance which is **RED** falling below the **AMBER** target of **80%**.
The Trust position is lower than during the same month last year.

CCICP is the only division which has compliance higher than during the same month last year.

Business Continuity Group and Executive Workforce Assurance Group have commissioned work for each division to provide a plan providing assurance of an Appraisal compliance turnaround trajectory, both prior to and post Motiv8.

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

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**16**	Date of Meeting: 07/09/2020
Report Title	Health Education England (HEE) Self Assessment Report (SAR)	
Executive Lead	Heather Barnett, Director of Workforce and OD	
Lead Officer	Jack Fairhall, Medical Education Manager + Helen Ashley, Head of Education	
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 *(2/3 headlines only)*

- Overview assessment of Education at the Trust
- Quality Assurance document devised by the Quality Team at HEE (North)

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)*

• Manage the impact of covid and ensure safe recovery	☐	• Provide safe and sustainable healthcare through our estate, infrastructure and planning	☐
• Deliver outstanding care and patient experience Deliver the most effective care to achieve best possible outcomes	✓	• Provide strong system leadership by working together	☐
• Ensure MCHFT is the best place to work	✓	• Be well governed and clinically led	✓

Governance *(is the report a…?)*

• Statutory requirement	✓	• Other	✓
• Annual Business Plan Priority	☐	*rationale for Board submission required:*	
• Strategic/BAF Risk	☐	Board sign off required by HEE(North)	
• Service Change	☐		

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

For submission to HEE(North) Quality Team

REPORT DEVELOPMENT

Committee/ Group Name	Date	Report Title	Lead	Brief summary of key issues raised and actions agreed
Transformation and People Committee (TAP)	06/08/20	Health Education England (HEE) Self Assessment Report (SAR)	Heather Barnett, Director of Workforce and OD	To note at TAP. For Board to Approve

Self-Assessment Report (SAR) 2020

Declaration

Trust Name

Mid Cheshire Hospitals NHS Foundation Trust

Name of Board Level Director responsible for Education and Training within your organisation:

Heather Barnett, Director of Workforce and OD

Report compiled by (responsible for completion):

Jack Fairhall – Medical Education Manager
Helen Ashley – Head of Education
Dr Joanna Scott – Director of Medical Education

Date seen at or scheduled for Board meeting?

Dates need to be in the format 'DD/MM/YYYY', for example 27/03/1980.

07/09/2020

Approved by / on behalf of the trust Board (Name):

Date approved by/ on behalf of the trust Board:

Dates need to be in the format 'DD/MM/YYYY', for example 27/03/1980.

HEE Priorities

Please consider HEE's priorities for 2019/2020 for both medical and healthcare professionals.

HEE Domain 1 Learning Environment and Culture, HEE priority for 2019/20 reporting in this domain is:

In your organisation, in which clinical service areas does clinical workload regularly impact adversely on your ability to deliver clinical training?	For its location and size MCHT is busy with a heavy footfall that is increasing year on year. This has the advantage of giving trainees a great number of learning opportunities with a varied caseload. It is recognised that in several areas (foundation particularly) we are relatively under-doctored and whilst this has the potential to cause issues by and large this is not the case. There is recognition across the organisation of the importance of release of trainees for training and there has recently been recruitment of other clinical professionals such as Physician Associates (PA) and Advanced Nurse Practitioners (ANPs). Winter, as expected, is a very busy time for the Trust with constant service pressures in keeping with most acute healthcare providers. We have recognised this and postpone internal teaching sessions (GP and foundation) in January to accommodate this work load. The postponed sessions are relocated to other periods in the year. However, the consultant body is very proactive and maintains shop floor and experiential training in this period. As a Medical Education Team we are responsive to concerns raised by trainees either personally or via routes such as the GMC survey or exception reporting and strive to liaise with Service Managers, College Tutors and Departments to resolve any problems.

What strategies do you employ to maintain both clinical service and training on a daily basis?	The organisation has a strong culture of support and provision of education at all levels and this is generally reflected in survey outcomes. Despite the workload intensity learning is encouraged and opportunities such as consultant lead ward rounds are maximised. Within individual departments an array of sessions are provided on a regular basis to supplement shop floor learning. For example weekly lunch time paediatric teaching, fortnightly ED middle grade and junior slots, the daily trauma list review in orthopedics has a strong educational focus as do many of the MDT meetings.

HEE Domain 2 Educational Governance and Leadership, HEE priority for 2019/20 reporting in this domain is:

Many clinical services are undergoing review and change as part of the NHS Long Term Plan & People Plan, what governance steps have you put in place to ensure the required notification of any change in service is given to both HEE and the HEIs to ensure continued clinical placements within your organisation?	Bi-monthly partnership meetings take place between the Trust and each of its HEI partners. Placement quality and development of placement opportunities are standing agenda items to ensure that students gain the maximum educational benefit from placements with us and to ensure that new role such as Nursing Associates and Physician Associates are also places across the Trust. Regular progress reports are shared with HEE and attendance at regional forum meetings with HEE colleagues are mandatory. Senior HEE colleagues visit the Trust on an annual basis for detailed site visits.
Please describe how your organisation ensures the governance of education. Please email a copy of the organisational diagram or visual that describes the governance and team structures relating to education and training to the North Quality Analyst Team at nqat@hee.nhs.uk.	Education at MCHFT reports to the Board through the Executive Workforce Assurance Group. The DME has monthly meetings with the Deputy Medical Director ensuring any concerns, including TRES, departmental issues etc are brought to executive level attention. The core education team (DME, ADME MEM and Foundation team) meets fortnightly. There are quarterly Medical Education meetings involving the wider organisational education members including Trust Specialty Training Leads (TSTLs) and our patch Associate Dean to share practice and ensure any issues are raised and discussed. We have a robust system for Trainees Requiring Extra Support (TRES) both in terms of formal reporting and holistic support via the Educational Supervisor (ES) and Post Graduate team. The Medical Director also takes a keen interest in such cases and is informed of any issues.

HEE Domain 3 Supporting and Empowering Learners, HEE priority for 2019/20 reporting in this domain is:

Please describe how your organisation provides support to medical trainees who submit Exception Reports or Code of Practice concerns?	Exception Reports and Code of Practice concerns are initially analysed by Educational and Clinical Supervisors. They ensure issues are looked into and work with trainees and departments looking for solutions. Throughout this process the Guardian of Safe Work Hours (GOSWH) and DME are kept informed. If no solution is agreed, the issue is escalated to the GOSWH. The GOSWH has a slot at induction and ensures that all trainees know about, have access to the system and can submit Exception Reports.

How do you encourage trainees to identify Educational Exception Reports (e.g. loss of specific training session to cover clinical service gap) from ERs relating to working beyond regular hours?	There is a monthly Junior Doctors' Mess Meeting where trainees discuss issues affecting them. The GOSWH and DME attend these meetings and offer guidance and solutions. The importance of Exception Reports is stressed at these meetings and the trainees are ensured that Exception Reports will always be looked into seriously. The Medical Education Team has an open door policy. Trainees are able to 'drop-in' and discuss items related to their training.
How have you used the 'Rest Monies' allocated to you from central funding to support doctors in training?	The Mess Committee has used the 'Rest Monies' to upgrade and renovate the Doctors' Mess. Specific Junior Doctor IT equipment has also been purchased. The Mess Committee are still in discussions how to use the remainder of the funding. The Trust has agreed to carry it forward to the 2020-21 financial year to ensure the funding is spent most effectively.
Please describe how your organisation provides support to learners to ensure they can access rest facilities, IT resources and pastoral support during their placement.	There is a newly refurbished Doctors' Mess that is available to all junior doctors, physician associates and medical students to use. Some of the BMA Rest Monies have been used to improve the Mess; including reclining furniture, better kitchen facilities and upgraded technology. There are also a number of Wellbeing Rooms newly created across the Trust. Any member of staff can use these 24 hours a day. The JET Library has a dedicated IT Training Suite and a number of computers that can be accessed 24 hours a day. The Education Team has an open-door policy. Any learner can 'drop-in' at any time and discuss anything. The experienced team can deal with queries and questions or direct them elsewhere where appropriate. The Education Team are supported by a number of consultants and other senior staff eg. Director of Medical Education.
How do you support academic learners?	N/A

HEE Domain 4 Supporting and Empowering Educators, HEE priority for 2019/20 reporting in this domain is:

MEDICAL TRAINING: Please provide details of the specific SPA time you allocate to individual trainers undertaking the roles of named Educational and Clinical Supervisor. Job planned 'one hour per week per trainee under named supervision' is the accepted standard and this is covered by the placement tariff sent with the LDA. Does your organisation meet this standard; if not, what tariff do you apply?	Named Educational Supervisors are remunerated at 0.25 PAs for every trainee.
MULTIPROFESSIONAL TRAINING: Please provide details of the protected annual time for continued development you allocate to those providing educational roles over and above the time required annually for their continuing clinical development. What in house courses/support do you provide; what external courses do you regularly use?	The Trust runs an annual 'Supervisors Away Day.' The programme varies from year to year and is always well attended. Feedback is positive. There is a study leave budget for each supervisor. The supervisors aligned to the Education Team can be offered an enhanced study leave budget to support their educational requirements. Education Roles are formally reviewed in the organisation's Appraisal Process thus encouraging attendance at educational courses and events. Courses and conferences etc provided by HEE and other bodies are advertised to supervisors and we ensure all our supervisors have completed the training required to enable supervision.

HEE Domain 5 Delivering Curricula and Assessments, HEE priority for 2019/20 reporting in this domain is:

With the introduction of new workforce roles (e.g. Physicians Associates) and increased numbers of Advanced Practitioners in training, together with an increased reliance on Locally Employed Doctors on service rotas, how do you ensure that doctors in training receive their required curricular opportunities and where necessary how are these needs prioritised?	Rather than hindering the education of doctors in training the introduction of new workforce roles has enhanced our ability to release doctors for planned training sessions and also that the service is covered to release trainees for shop floor training opportunities. The potential impact on shop floor experiential learning is recognised and departments have put measures in place to minimise this. For example in ED the non-doctor (PA, ACP trainees, med students etc) trainees will be timetabled over the day to 'spread the load' both to ensure supervisors are not overwhelmed and that trainee doctors are ensured learning opportunities. The junior doctors are encouraged to share their experience with the other clinical roles to ensure a good learning environment is developed for all.

The NHS People Plan identifies the need for increased placement numbers to accommodate the planned growth in student numbers to meet future workforce demand. What plans do you have in place to accommodate increased student placements? What impact do you envisage this will have on your ability to maintain the learning experience provided to current students and to clinical service provision?	MCHFT already offers placements to learners from a number of different organisations. There is an appetite to always expand on these. Keele University Physician Associate Students recently started placements at MCHFT and initial talks with University of Buckingham Medical School are in progress, with a view to offering Medical Students placements at MCHFT. Careful consideration has taken place to ensure currently learners and service is not affected. Capacity for learners is a constant topic of discussion. Innovative methods of working support learners on placement.

HEE Domain 6 Developing a Sustainable Workforce, HEE priority for 2019/20 reporting in this domain is:

The People Plan identifies as a priority the need to tackle both 'The Nursing Challenge' (Chapter 3) and to create the workforce needed to deliver '21st Century Care' (Chapter 4). What plans for 2019-21 does your organisation have to meet these challenges from an educational and training perspective?	The Trust's multidisciplinary workforce group has committed to delivering on three key strands around workforce planning; staff retention and professional development opportunities. Our strategic plan includes professional development opportunities that are apprenticeship based to increase the available routes into nursing and CPD pathways that offer pathways to advanced clinical practice and nurse lead service delivery. Our robust connections with HEIs across the region enable us to collaborate in module design which is closely aligned to service transformation.

Organisation top three successes and top three challenges

Please use this section to summarise three high-level successes your organisation is most proud of achieving, and list any challenges or prominent issues that HEE should be aware of.

More info

	Description of success	Description of Challenge
1.	Introduction of Registered Nursing Apprenticeship programme (now in second year).	Over 100 candidates for 20 places in 2020/21 requires a review of capacity and funding models to enable more access to careers in the NHS.
2.	The organisation is in the early stages of developing a Trust wide Governance and Education strategy for Advanced Clinical Practitioners to ensure recognition and continued professional development of this role. This is multidisciplinary and aims to promote shared learning and the role across the organisation. This will fit in with the vision to ultimately provide multi role 'clinical education' not just medical education to create a cohesive learning environment across all disciplines.	Recognition of the advanced clinical practitioner role within the organisation and development of this role as a multispecialty group.
3.	Staff redeployment during initial stages of Covid-19 pandemic response.	To provide a strategy to ensure safe redeployment of staff in response to a change in service need during the Covid-19 pandemic whist maintaining trainee welfare and minimising disruption to training.

Please use this section to summarise three items of Best Practice your organisation is most proud of achieving, and the impact this has had within your organisation.
Please Note: Best Practice will be shared with other organisations.

	Description of Best Practice	Impact of Best Practice
1.	Integrated preceptorship programme, supporting newly qualified staff through the first year of professional practice and beyond.	Improved retention across all professions for first three years in practice linked to broader understanding of clinical co-workers across different disciplines.
2.	Medical Education Peer-to-Peer teaching programmes	Built foundations of an educational culture and supported teamworking, collaboration and communication.
3.	Mentor-led return to training programme	Bespoke programme designed to meet the specific requirements of doctors returning from significant periods away from training offer significantly faster reintegration into role.

Nursing and Midwifery Students (NMC)

Organisation assurance statement and exception reporting against HEE Quality Domains and Standards

*In this section, we are asking you to consider HEE Quality Domains and Standards and declare any areas where Standards are not met. Link to the **HEE Quality Framework 2019-2020***

If your organisation does not provide education and training to this professional group, please select 'Not Applicable' and move on to the next section.

- ○ Not Applicable
- ○ **Applicable - Yes**

Domain 1 Learning Environment and Culture,
*please see **HEE Quality Framework** page 9 & 10.*

Please don't select more than 2 answer(s) per row.

	Met	Not Met	Action Plan Available
1.1 Learners are in an environment that delivers safe, effective, compassionate care that provides a positive experience for service users.	☑	☐	☐
1.2 The learning environment is one in which education and training is valued and learners are treated fairly, with dignity and respect, and are not subject to negative attitudes or behaviours.	☑	☐	☐
1.3 There are opportunities for learners to be involved in activities that facilitate quality improvement (QI), improving evidence-based practice (EBP) and research and innovation (R&I).	☑	☐	☐
1.4 There are opportunities to learn constructively from the experience and outcomes of service users, whether positive or negative.	☑	☐	☐

1.5 The learning environment provides suitable educational facilities for both learners and educators, including space, IT facilities and access to quality assured library and knowledge.	☑	☐	☐
1.6 The learning environment promotes inter-professional learning opportunities.	☑	☐	☐

Domain 2 Educational governance and leadership,
*please see **HEE Quality Framework** page 11 & 12.*

Please don't select more than 2 answer(s) per row.

	Met	Not Met	Action Plan Available
2.1 The educational governance arrangements measure performance against the quality standards and actively respond when standards are not being met.	☑	☐	☐
2.2 The educational leadership uses the educational governance arrangements to continuously improve the quality of education and training.	☑	☐	☐
2.3 The educational governance structures promote team-working and a multi-professional approach to education and training where appropriate, through multi-professional educational leadership.	☑	☐	☐
2.4 Education and training opportunities are based on principles of equality and diversity.	☑	☐	☐
2.5 There are processes in place to inform the appropriate stakeholders when performance issues with learners are identified or learners are involved in patient safety incidents.	☑	☐	☐

Domain 3 Supporting and empowering learners, p*lease see **HEE Quality Framework** page 13 & 14.*

Please don't select more than 2 answer(s) per row.

	Met	Not Met	Action Plan Available
3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in their curriculum or professional standards to achieve the learning outcomes required.	☑	☐	☐
3.2 Learners are supported to complete appropriate summative and formative assessments to evidence that they are meeting their curriculum, professional standards or learning outcomes.	☑	☐	☐
3.3 Learners feel they are valued members of the healthcare team within which they are placed.	☑	☐	☐
3.4 Learners receive an appropriate and timely induction into the learning environment.	☑	☐	☐
3.5 Learners understand their role and the context of their placement in relation to care pathways and patient journeys.	☑	☐	☐

Domain 4 Supporting and empowering educators,
please see HEE Quality Framework page 15.

Please don't select more than 2 answer(s) per row.

	Met	Not Met	Action Plan Available
4.1 Those undertaking formal education and training roles are appropriately trained as defined by the relevant regulator or professional body.	☑	☐	☐
4.2 Educators are familiar with the curricula of the learners they are educating.	☑	☐	☐
4.3 Educator performance is assessed through appraisals or other appropriate mechanisms, with constructive feedback and support provided for role development and progression.	☑	☐	☐
4.4 Formally recognised educators are appropriately supported to undertake their roles.	☑	☐	☐

Domain 5 Delivering curricula and assessments, *please see HEE Quality Framework page 16.*

	Met	Not Met	Action Plan Available
5.1 The planning and delivery of curricula, assessments and programmes enable learners to meet the learning outcomes required by their curriculum or required professional standards.	☑	☐	☐
5.2 Placement providers shape the delivery of curricula, assessments and programmes to ensure the content is responsive to changes in treatments, technologies and care delivery models.	☑	☐	☐
5.3 Providers proactively engage patients, service users and learners in the development and delivery of education and training to embed the ethos of patient partnership within the learning environment.	☑	☐	☐

Please don't select more than 2 answer(s) per row.

Domain 6 Developing a sustainable workforce, *please see* ***HEE Quality Framework*** *page 17.*

Please don't select more than 2 answer(s) per row.

	Met	Not Met	Action Plan Available
6.1 Placement providers work with other organisations to mitigate avoidable learner attrition from programmes.	☑	☐	☐
6.2 There are opportunities for learners to receive appropriate careers advice from colleagues within the learning environment, including understanding other roles and career pathway opportunities.	☑	☐	☐
6.3 The organisation engages in local workforce planning to ensure it supports the development of learners who have the skills, knowledge and behaviours to meet the changing needs of patients and service.	☑	☐	☐
6.4 Transition from a healthcare education programme to employment is underpinned by a clear process of support developed and delivered in partnership with the learner.	☑	☐	☐

Where a standard is 'not met', please select which professional groups 'not met' relates to:

Please don't select more than 6 answer(s) per row.

	Domain 1	Domain 2	Domain 3	Domain 4	Domain 5	Domain 6
Adult Nursing	☐	☐	☐	☐	☐	☐
Child Nursing	☐	☐	☐	☐	☐	☐
Community Nursing	☐	☐	☐	☐	☐	☐
Health Visitors	☐	☐	☐	☐	☐	☐
Learning Disabilities Nursing	☐	☐	☐	☐	☐	☐
Mental Health Nursing	☐	☐	☐	☐	☐	☐
Midwifery	☐	☐	☐	☐	☐	☐
Nursing Associates	☐	☐	☐	☐	☐	☐

Medical Training (General Medical Council)

Organisation assurance statement and exception reporting against HEE Quality Domains and Standards

In this section, we are asking you to consider HEE Quality Domains and Standards and declare any areas where Standards are not met.
***HEE Quality Framework** 2019-2020.*

If your organisation does not provide education and training to this professional group, please select 'Not Applicable' and move on to the next section.

- ○ Not Applicable
- ○ **Applicable - Yes**

Domain 1 Learning Environment and Culture,
*please see **HEE Quality Framework** page 9 & 10.*

Please don't select more than 2 answer(s) per row.

	Met	Not Met	Action Plan Available
1.1 Learners are in an environment that delivers safe, effective, compassionate care that provides a positive experience for service users.	☑	☐	☐
1.2 The learning environment is one in which education and training is valued and learners are treated fairly, with dignity and respect, and are not subject to negative attitudes or behaviours.	☑	☐	☐
1.3 There are opportunities for learners to be involved in activities that facilitate quality improvement (QI), improving evidence-based practice (EBP) and research and innovation (R&I).	☑	☐	☐
1.4 There are opportunities to learn constructively from the experience and outcomes of service users, whether positive or negative.	☑	☐	☐

1.5 The learning environment provides suitable educational facilities for both learners and educators, including space, IT facilities and access to quality assured library and knowledge.	☑	☐	☐
1.6 The learning environment promotes inter-professional learning opportunities.	☑	☐	☐

Domain 2 Educational governance and leadership, *please see **HEE Quality Framework** page 11 & 12.*

Please don't select more than 2 answer(s) per row.

	Met	Not Met	Action Plan Available
2.1 The educational governance arrangements measure performance against the quality standards and actively respond when standards are not being met.	☑	☐	☐
2.2 The educational leadership uses the educational governance arrangements to continuously improve the quality of education and training.	☑	☐	☐
2.3 The educational governance structures promote team-working and a multi-professional approach to education and training where appropriate, through multi-professional educational leadership.	☑	☐	☐
2.4 Education and training opportunities are based on principles of equality and diversity.	☑	☐	☐
2.5 There are processes in place to inform the appropriate stakeholders when performance issues with learners are identified or learners are involved in patient safety incidents.	☑	☐	☐

Domain 3 Supporting and empowering learners, *please see **HEE Quality Framework** page 13 & 14.*

Please don't select more than 2 answer(s) per row.

	Met	Not Met	Action Plan Available

3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in their curriculum or professional standards to achieve the learning outcomes required.	☑	☐	☐
3.2 Learners are supported to complete appropriate summative and formative assessments to evidence that they are meeting their curriculum, professional standards or learning outcomes.	☑	☐	☐
3.3 Learners feel they are valued members of the healthcare team within which they are placed.	☑	☐	☐
3.4 Learners receive an appropriate and timely induction into the learning environment.	☑	☐	☐
3.5 Learners understand their role and the context of their placement in relation to care pathways and patient journeys.	☑	☐	☐

Domain 4 Supporting and empowering educators, *please see **HEE Quality Framework** page 15.*

Please don't select more than 2 answer(s) per row.

	Met	Not Met	Action Plan Available
4.1 Those undertaking formal education and training roles are appropriately trained as defined by the relevant regulator or professional body.	☑	☐	☐
4.2 Educators are familiar with the curricula of the learners they are educating.	☑	☐	☐
4.3 Educator performance is assessed through appraisals or other appropriate mechanisms, with constructive feedback and support provided for role development and progression.	☑	☐	☐
4.4 Formally recognised educators are appropriately supported to undertake their roles.	☑	☐	☑

Domain 5 Delivering curricula and assessments, *please see **HEE Quality Framework** page 16.*

Please don't select more than 2 answer(s) per row.

	Met	Not Met	Action Plan Available
5.1 The planning and delivery of curricula, assessments and programmes enable learners to meet the learning outcomes required by their curriculum or required professional standards.	☑	☐	☐
5.2 Placement providers shape the delivery of curricula, assessments and programmes to ensure the content is responsive to changes in treatments, technologies and care delivery models.	☑	☐	☐
5.3 Providers proactively engage patients, service users and learners in the development and delivery of education and training to embed the ethos of patient partnership within the learning environment.	☑	☐	☐

Domain 6 Developing a sustainable workforce, *please see* ***HEE Quality Framework*** *page 17.*

Please don't select more than 2 answer(s) per row.

	Met	Not Met	Action Plan Available
6.1 Placement providers work with other organisations to mitigate avoidable learner attrition from programmes.	☑	☐	☐
6.2 There are opportunities for learners to receive appropriate careers advice from colleagues within the learning environment, including understanding other roles and career pathway opportunities.	☑	☐	☐
6.3 The organisation engages in local workforce planning to ensure it supports the development of learners who have the skills, knowledge and behaviours to meet the changing needs of patients and service.	☑	☐	☐
6.4 Transition from a healthcare education programme to employment is underpinned by a clear process of support developed and delivered in partnership with the learner.	☑	☐	☐

Where a standard is 'not met', please select which professional groups 'not met' relates to:

Please don't select more than 6 answer(s) per row.

	Domain 1	Domain 2	Domain 3	Domain 4	Domain 5	Domain 6
Postgraduate	☐	☐	☐	☐	☐	☐
Undergraduate	☐	☐	☐	☐	☐	☐
Physicians Associates	☐	☐	☐	☐	☐	☐

Dental Training (General Dental Council)

If your organisation does not provide education and training to this professional group, please select 'Not Applicable' and move on to the next section.

- [ ] **Not Applicable - YES**
- [ ] Applicable

Organisation assurance statement and exception reporting against HEE Quality Domains and Standards

*In this section, we are asking you to consider HEE Quality Domains and Standards and declare any areas where Standards are not met. Link to the **HEE Quality Framework** 2019-2020.*

Domain 1 Learning Environment and Culture,
please see HEE Quality Framework page 9 & 10.

Please don't select more than 2 answer(s) per row.

	Met	Not Met	Action Plan Available
1.1 Learners are in an environment that delivers safe, effective, compassionate care that provides a positive experience for service users.	☐	☐	☐
1.2 The learning environment is one in which education and training is valued and learners are treated fairly, with dignity and respect, and are not subject to negative attitudes or behaviours.	☐	☐	☐
1.3 There are opportunities for learners to be involved in activities that facilitate quality improvement (QI), improving evidence-based practice (EBP) and research and innovation (R&I).	☐	☐	☐
1.4 There are opportunities to learn constructively from the experience and outcomes of service users, whether positive or negative.	☐	☐	☐

1.5 The learning environment provides suitable educational facilities for both learners and educators, including space, IT facilities and access to quality assured library and knowledge.	☐	☐	☐
1.6 The learning environment promotes inter-professional learning opportunities.	☐	☐	☐

Domain 2 Educational governance and leadership, p*lease see* ***HEE Quality Framework*** *page 11 & 12.*

Please don't select more than 2 answer(s) per row.

	Met	Not Met	Action Plan Available
2.1 The educational governance arrangements measure performance against the quality standards and actively respond when standards are not being met.	☐	☐	☐
2.2 The educational leadership uses the educational governance arrangements to continuously improve the quality of education and training.	☐	☐	☐
2.3 The educational governance structures promote team-working and a multi-professional approach to education and training where appropriate, through multi-professional educational leadership.	☐	☐	☐
2.4 Education and training opportunities are based on principles of equality and diversity.	☐	☐	☐
2.5 There are processes in place to inform the appropriate stakeholders when performance issues with learners are identified or learners are involved in patient safety incidents.	☐	☐	☐

Domain 3 Supporting and empowering learners, p*lease see* ***HEE Quality Framework*** *page 13 & 14.*

Please don't select more than 2 answer(s) per row.

	Met	Not Met	Action Plan Available

3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in their curriculum or professional standards to achieve the learning outcomes required.	☐	☐	☐
3.2 Learners are supported to complete appropriate summative and formative assessments to evidence that they are meeting their curriculum, professional standards or learning outcomes.	☐	☐	☐
3.3 Learners feel they are valued members of the healthcare team within which they are placed.	☐	☐	☐
3.4 Learners receive an appropriate and timely induction into the learning environment.	☐	☐	☐
3.5 Learners understand their role and the context of their placement in relation to care pathways and patient journeys.	☐	☐	☐

Domain 4 Supporting and empowering educators,
p*lease see **HEE Quality Framework** page 15.*

Please don't select more than 2 answer(s) per row.

	Met	Not Met	Action Plan Available
4.1 Those undertaking formal education and training roles are appropriately trained as defined by the relevant regulator or professional body.	☐	☐	☐
4.2 Educators are familiar with the curricula of the learners they are educating.	☐	☐	☐
4.3 Educator performance is assessed through appraisals or other appropriate mechanisms, with constructive feedback and support provided for role development and progression.	☐	☐	☐
4.4 Formally recognised educators are appropriately supported to undertake their roles.	☐	☐	☐

Domain 5 Delivering curricula and assessments, *please see **HEE Quality Framework** page 16.*

Please don't select more than 2 answer(s) per row.

	Met	Not Met	Action Plan Available
5.1 The planning and delivery of curricula, assessments and programmes enable learners to meet the learning outcomes required by their curriculum or required professional standards.	☐	☐	☐
5.2 Placement providers shape the delivery of curricula, assessments and programmes to ensure the content is responsive to changes in treatments, technologies and care delivery models.	☐	☐	☐
5.3 Providers proactively engage patients, service users and learners in the development and delivery of education and training to embed the ethos of patient partnership within the learning environment.	☐	☐	☐

Domain 6 Developing a sustainable workforce, *please see **HEE Quality Framework** page 17.*

Please don't select more than 2 answer(s) per row.

	Met	Not Met	Action Plan Available
6.1 Placement providers work with other organisations to mitigate avoidable learner attrition from programmes.	☐	☐	☐
6.2 There are opportunities for learners to receive appropriate careers advice from colleagues within the learning environment, including understanding other roles and career pathway opportunities.	☐	☐	☐
6.3 The organisation engages in local workforce planning to ensure it supports the development of learners who have the skills, knowledge and behaviours to meet the changing needs of patients and service.	☐	☐	☐
6.4 Transition from a healthcare education programme to employment is underpinned by a clear process of support developed and delivered in partnership with the learner.	☐	☐	☐

Where a standard is 'not met', please select which professional groups 'not met' relates to:

Please don't select more than 6 answer(s) per row.

	Domain 1	Domain 2	Domain 3	Domain 4	Domain 5	Domain 6
Dentists	☐	☐	☐	☐	☐	☐
Dental Therapists	☐	☐	☐	☐	☐	☐
Dental Technicians	☐	☐	☐	☐	☐	☐
Dental Nurses	☐	☐	☐	☐	☐	☐
Dental Hygienists	☐	☐	☐	☐	☐	☐

Pharmacy Training (General Pharmaceutical Council)

If your organisation does not provide education and training to this professional group, please select 'Not Applicable' and move on to the next section.

- ○ Not Applicable
- ○ **Applicable - Yes**

Organisation assurance statement and exception reporting against HEE Quality Domains and Standards

In this section, we are asking you to consider HEE Quality Domains and Standards and declare any areas where Standards are not met.

Domain 1 Learning Environment and Culture,
*please see **HEE Quality Framework** page 9 & 10.*

Please don't select more than 2 answer(s) per row.

	Met	Not Met	Action Plan Available
1.1 Learners are in an environment that delivers safe, effective, compassionate care that provides a positive experience for service users.	☑	☐	☐
1.2 The learning environment is one in which education and training is valued and learners are treated fairly, with dignity and respect, and are not subject to negative attitudes or behaviours.	☑	☐	☐
1.3 There are opportunities for learners to be involved in activities that facilitate quality improvement (QI), improving evidence-based practice (EBP) and research and innovation (R&I).	☑	☐	☐
1.4 There are opportunities to learn constructively from the experience and outcomes of service users, whether positive or negative.	☑	☐	☐

1.5 The learning environment provides suitable educational facilities for both learners and educators, including space, IT facilities and access to quality assured library and knowledge.	☑	☐	☐
1.6 The learning environment promotes inter-professional learning opportunities.	☑	☐	☐

Domain 2 Educational governance and leadership, *please see **HEE Quality Framework** page 11 & 12.*

Please don't select more than 2 answer(s) per row.

	Met	Not Met	Action Plan Available
2.1 The educational governance arrangements measure performance against the quality standards and actively respond when standards are not being met.	☑	☐	☐
2.2 The educational leadership uses the educational governance arrangements to continuously improve the quality of education and training.	☑	☐	☐
2.3 The educational governance structures promote team-working and a multi-professional approach to education and training where appropriate, through multi-professional educational leadership.	☑	☐	☐
2.4 Education and training opportunities are based on principles of equality and diversity.	☑	☐	☐
2.5 There are processes in place to inform the appropriate stakeholders when performance issues with learners are identified or learners are involved in patient safety incidents.	☑	☐	☐

Domain 3 Supporting and empowering learners, *please see **HEE Quality Framework** page 13 & 14.*

Please don't select more than 2 answer(s) per row.

	Met	Not Met	Action Plan Available

3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in their curriculum or professional standards to achieve the learning outcomes required.	☑	☐	☐
3.2 Learners are supported to complete appropriate summative and formative assessments to evidence that they are meeting their curriculum, professional standards or learning outcomes.	☑	☐	☐
3.3 Learners feel they are valued members of the healthcare team within which they are placed.	☑	☐	☐
3.4 Learners receive an appropriate and timely induction into the learning environment.	☑	☐	☐
3.5 Learners understand their role and the context of their placement in relation to care pathways and patient journeys.	☑	☐	☐

Domain 4 Supporting and empowering educators,
*please see **HEE Quality Framework** page 15.*

Please don't select more than 2 answer(s) per row.

	Met	Not Met	Action Plan Available
4.1 Those undertaking formal education and training roles are appropriately trained as defined by the relevant regulator or professional body.	☑	☐	☐
4.2 Educators are familiar with the curricula of the learners they are educating.	☑	☐	☐
4.3 Educator performance is assessed through appraisals or other appropriate mechanisms, with constructive feedback and support provided for role development and progression.	☑	☐	☐
4.4 Formally recognised educators are appropriately supported to undertake their roles.	☑	☐	☐

Domain 5 Delivering curricula and assessments, *please see **HEE Quality Framework** page 16.*

Please don't select more than 2 answer(s) per row.

	Met	Not Met	Action Plan Available
5.1 The planning and delivery of curricula, assessments and programmes enable learners to meet the learning outcomes required by their curriculum or required professional standards.	☑	☐	☐
5.2 Placement providers shape the delivery of curricula, assessments and programmes to ensure the content is responsive to changes in treatments, technologies and care delivery models.	☑	☐	☐
5.3 Providers proactively engage patients, service users and learners in the development and delivery of education and training to embed the ethos of patient partnership within the learning environment.	☑	☐	☐

Domain 6 Developing a sustainable workforce, *please see **HEE Quality Framework** page 17.*

Please don't select more than 2 answer(s) per row.

	Met	Not Met	Action Plan Available
6.1 Placement providers work with other organisations to mitigate avoidable learner attrition from programmes.	☑	☐	☐
6.2 There are opportunities for learners to receive appropriate careers advice from colleagues within the learning environment, including understanding other roles and career pathway opportunities.	☑	☐	☐
6.3 The organisation engages in local workforce planning to ensure it supports the development of learners who have the skills, knowledge and behaviours to meet the changing needs of patients and service.	☑	☐	☐
6.4 Transition from a healthcare education programme to employment is underpinned by a clear process of support developed and delivered in partnership with the learner.	☑	☐	☐

Where a standard is 'not met', please select which professional groups 'not met' relates to:

Please don't select more than 6 answer(s) per row.

	Domain 1	Domain 2	Domain 3	Domain 4	Domain 5	Domain 6
Pharmacy Technicians	☐	☐	☐	☐	☐	☐
Pharmacists	☐	☐	☐	☐	☐	☐
Pharmaceutical Scientists	☐	☐	☐	☐	☐	☐

All Other Learners

If your organisation does not provide education and training to this professional group, please select 'Not Applicable' and move on to the next section.

- ○ Not Applicable
- ○ **Applicable - YES**

Organisation assurance statement and exception reporting against HEE Quality Domains and Standards

In this section, we are asking you to consider HEE Quality Domains and Standards and declare any areas where Standards are not met.

Domain 1 Learning Environment and Culture,
*please see **HEE Quality Framework** page 9 & 10.*

Please don't select more than 2 answer(s) per row.

	Met	Not Met	Action Plan Available
1.1 Learners are in an environment that delivers safe, effective, compassionate care that provides a positive experience for service users.	☑	☐	☐
1.2 The learning environment is one in which education and training is valued and learners are treated fairly, with dignity and respect, and are not subject to negative attitudes or behaviours.	☑	☐	☐
1.3 There are opportunities for learners to be involved in activities that facilitate quality improvement (QI), improving evidence-based practice (EBP) and research and innovation (R&I).	☑	☐	☐
1.4 There are opportunities to learn constructively from the experience and outcomes of service users, whether positive or negative.	☑	☐	☐

1.5 The learning environment provides suitable educational facilities for both learners and educators, including space, IT facilities and access to quality assured library and knowledge.	☑	☐	☐
1.6 The learning environment promotes inter-professional learning opportunities.	☑	☐	☐

Domain 2 Educational governance and leadership, p*lease see* ***HEE Quality Framework*** *page 11 & 12.*

Please don't select more than 2 answer(s) per row.

	Met	Not Met	Action Plan Available
2.1 The educational governance arrangements measure performance against the quality standards and actively respond when standards are not being met.	☑	☐	☐
2.2 The educational leadership uses the educational governance arrangements to continuously improve the quality of education and training.	☑	☐	☐
2.3 The educational governance structures promote team-working and a multi-professional approach to education and training where appropriate, through multi-professional educational leadership.	☑	☐	☐
2.4 Education and training opportunities are based on principles of equality and diversity.	☑	☐	☐
2.5 There are processes in place to inform the appropriate stakeholders when performance issues with learners are identified or learners are involved in patient safety incidents.	☑	☐	☐

Domain 3 Supporting and empowering learners, p*lease see* ***HEE Quality Framework*** *page 13 & 14.*

Please don't select more than 2 answer(s) per row.

	Met	Not Met	Action Plan Available

3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in their curriculum or professional standards to achieve the learning outcomes required.	☑	☐	☐
3.2 Learners are supported to complete appropriate summative and formative assessments to evidence that they are meeting their curriculum, professional standards or learning outcomes.	☑	☐	☐
3.3 Learners feel they are valued members of the healthcare team within which they are placed.	☑	☐	☐
3.4 Learners receive an appropriate and timely induction into the learning environment.	☑	☐	☐
3.5 Learners understand their role and the context of their placement in relation to care pathways and patient journeys.	☑	☐	☐

Domain 4 Supporting and empowering educators, *please see **HEE Quality Framework** page 15.*

Please don't select more than 2 answer(s) per row.

	Met	Not Met	Action Plan Available
4.1 Those undertaking formal education and training roles are appropriately trained as defined by the relevant regulator or professional body.	☑	☐	☐
4.2 Educators are familiar with the curricula of the learners they are educating.	☑	☐	☐
4.3 Educator performance is assessed through appraisals or other appropriate mechanisms, with constructive feedback and support provided for role development and progression.	☑	☐	☐
4.4 Formally recognised educators are appropriately supported to undertake their roles.	☑	☐	☐

Domain 5 Delivering curricula and assessments, *please see **HEE Quality Framework** page 16.*

Please don't select more than 2 answer(s) per row.

	Met	Not Met	Action Plan Available
5.1 The planning and delivery of curricula, assessments and programmes enable learners to meet the learning outcomes required by their curriculum or required professional standards.	☑	☐	☐
5.2 Placement providers shape the delivery of curricula, assessments and programmes to ensure the content is responsive to changes in treatments, technologies and care delivery models.	☑	☐	☐
5.3 Providers proactively engage patients, service users and learners in the development and delivery of education and training to embed the ethos of patient partnership within the learning environment.	☑	☐	☐

Domain 6 Developing a sustainable workforce, *please see* ***HEE Quality Framework*** *page 17.*

Please don't select more than 2 answer(s) per row.

	Met	Not Met	Action Plan Available
6.1 Placement providers work with other organisations to mitigate avoidable learner attrition from programmes.	☑	☐	☐
6.2 There are opportunities for learners to receive appropriate careers advice from colleagues within the learning environment, including understanding other roles and career pathway opportunities.	☑	☐	☐
6.3 The organisation engages in local workforce planning to ensure it supports the development of learners who have the skills, knowledge and behaviours to meet the changing needs of patients and service.	☑	☐	☐
6.4 Transition from a healthcare education programme to employment is underpinned by a clear process of support developed and delivered in partnership with the learner.	☑	☐	☐

Where a standard is 'not met', please select which professional groups 'not met' relates to:

Please don't select more than 6 answer(s) per row.

	Domain 1	Domain 2	Domain 3	Domain 4	Domain 5	Domain 6
Clinical Psychology	☐	☐	☐	☐	☐	☐
Dieticians	☐	☐	☐	☐	☐	☐
Estates (i.e. clinical engineers)	☐	☐	☐	☐	☐	☐
Healthcare Scientists: Life Sciences, Physiological Sciences, Physical Sciences, Clinical Bioinformatics	☐	☐	☐	☐	☐	☐
Occupational Therapy	☐	☐	☐	☐	☐	☐
ODP	☐	☐	☐	☐	☐	☐
Orthotists and Prosthetists	☐	☐	☐	☐	☐	☐
Ophthalmologists	☐	☐	☐	☐	☐	☐
Orthoptists	☐	☐	☐	☐	☐	☐
Other Apprentice	☐	☐	☐	☐	☐	☐
Other Therapist (art, drama, music etc.)	☐	☐	☐	☐	☐	☐
Paramedics	☐	☐	☐	☐	☐	☐
Physiotherapy	☐	☐	☐	☐	☐	☐
Podiatry	☐	☐	☐	☐	☐	☐
Radiography Diagnostic	☐	☐	☐	☐	☐	☐
Radiography Therapeutic	☐	☐	☐	☐	☐	☐
Sexual Health Advisors	☐	☐	☐	☐	☐	☐
Sonographers	☐	☐	☐	☐	☐	☐
Speech and Language Therapy	☐	☐	☐	☐	☐	☐

19/20 Financial Accountability Report

Details of LDA Funding

A separate copy of the LDA Financial Section (Schedule E) was included in the email sent with the SAR. In this section please describe how the trust has utilised the HEE funding received via LDA payments.

I can confirm that funding listed in the LDA (Schedule E) has been utilised for it's intended purpose? (Y/N)

Yes

If you selected No, please specify:

Additional in year funding already provided

Have you received any further funding not included in the LDA?

No

In this section please list any additional funding received from HEE, for example any regional or national funding received outside of the LDA payments. Please state the amount received, provide a high-level description of what this additional funding is for and please describe how the trust has utilised this funding.

	Please state the amount received	Please describe what this additional funding was for?
1		
2		
3		
4		
5		

SAR 2020 Staff, Associate Specialist, and Specialists Doctors

Page 1: Declaration

Trust Name

Mid Cheshire Hospitals NHS Foundation Trust

Report signed off by (name):

Mr Mohammed Ali Kazem, SAS Lead

Date signed off:

Dates need to be in the format 'DD/MM/YYYY', for example 27/03/1980.

30/07/2020

(dd/mm/yyyy)

Page 2: 2020 Staff, Associate Specialist and Specialty Doctors (SAS) and Locally Employed Doctors (LEDs)

Use of funding to Support Staff, Associate Specialist and Specialty Doctors (SAS) and Locally Employed Doctors (LEDs) Faculty development

Please provide answers to the following questions. You may wish to include funding details, as required. For further information in relation to LEDs please review the following NACT document LEDs across the UK http://www.nact.org.uk/documents/national-documents/.

It is recommended that if the trust has a nominated lead for SAS doctors and/ or LEDs, they should complete this section.

1. Nominated leads for SAS doctors and LEDs

Name of nominated lead for SAS doctor development (*if there is no nominated lead, state "None"):*

Mr Mohammed Ali Kazem

Name of nominated lead for LED development (*if there is no nominated lead, state "None")*:

None

2. Number of SAS doctors and LEDs in the trust

	Answer
Number of Specialty Drs:	29
Number of Associate Specialists:	4
Number of Staff Grades:	1

TOTAL number of SAS doctors:	33
Number of LEDs (e.g. Trust Grade, Clinical Fellow):	20

3. Study leave budgets

	Amount (£)
Trust study leave funding allocation per SAS doctor (£):	There is no limit on the study leave allocation.
Trust study leave funding allocation per LED (£):	As above.

How do these allocations compare to the study leave funding allocation for consultants?

Your answer should be no more than 3000 characters long.

Both consultants and SAS doctors have similar funding allocation and both groups are included in the same study leave policy

Please outline any examples of good practice or challenges regarding study leave budget allocations:

Your answer should be no more than 3000 characters long.

There is no limit on the study leave budget to SAS doctors this is left to MD discretion.

4. HEE SAS Development Funding received during the financial year 2018/19

	Amount (£)	Details (if req)
SAS Development Fund – Individual courses (£):	-	

SAS Development Fund – Trust-hosted courses (£):	-	
Funding for SAS tutor/ lead role (£):	£9198	
Funding for SAS administrator role (£):	£29122	
Any other funding received from SAS Development Fund (please give details):	-	
TOTAL funding received from HEE (£):	£38320	No other SAS funding received via LDA, 2018/19.

5. Identification of SAS doctor development needs

	Development needs:
Please describe the process by which the development needs of SAS doctors within your organisation were individually and collectively identified:	All SAS doctors have appraisal on yearly basis and PDP`s are agreed during that process. This influences the individual development needs. As a SAS group, collective needs are assessed through direct contact with the group and suggestions as well as through findings of questionnaires circulated to the group.

How were priorities decided in regard to applications to the HEE SAS Development Fund?	During last year we did not decline any SAS fund requests. The main criteria for going ahead with the development fund application was for the intended course or degree not funded by the Trust (for example higher degree)

6. CESR

	Answer
Number of doctors currently being supported by the trust to work towards CESR application:	4
Number of doctors who completed a successful CESR application during the year April 2018 to March 2019:	0 (one was granted May 2020)

7. SAS doctors as Clinical and Educational Supervisors

	Answer
Number of SAS doctors who are GMC-approved Clinical Supervisors:	1
Number of SAS doctors who are GMC-approved Educational Supervisors:	1 (a course planned to accredit SAS doctors)

Who decides which trainees have a SAS doctor as their named Clinical or Educational Supervisor?

Your answer should be no more than 3000 characters long.

Educational team in the postgraduate medical Centre allocate trainees to educational supervisors available on the list of supervisors

What governance arrangements are in place for SAS doctors who are Clinical and Educational Supervisors?

Your answer should be no more than 3000 characters long.

The governance arrangements for SAS doctors are similar to the consultant colleagues

8. SAS doctors in leadership roles

	Answer
Number of SAS doctors who are in leadership roles:	0
Please give details of the roles being undertaken:	

9. Has the SAS Charter been implemented in the trust?

Yes, No, Partially (Please select one of the options)
Partially implemented

Please give details of any examples of good practice or challenges in implementing the SAS Charter:

	Good Practice	Challenge
1	All SAS doctors have appraisals with agreed PDPs and All SAS Doctors have an annual job plan review	Access to Mentors
2	Template “model contract” from NHS Employers has been implemented	Mechanisms for coding of patients ensures attribution of clinical activities to SAS doctors

3	Study Leave Process is in line with Consultant colleagues	

10. Please give details of any programmes or initiatives in place to support the development of LEDs:

Your answer should be no more than 3000 characters long.

LEDs are able to attend Grand Rounds, Schwartz Rounds, Departmental teaching etc.

Please outline any examples of good practice in developing SAS doctors or LEDs which you would like to highlight:

	Good Practice - Please outline any examples of good practice in developing SAS doctors or LEDs which you would like to highlight:	Challenges - Please outline any particular challenges in developing SAS doctors or LEDs:
1	Voluntary ARCP process in place to support SAS doctors who are interested in going through CESR.	Occasionally there is conflict between the service needs and SAS doctors development needs. This is been addressed on individual basis.
2	Education supervisor training capacity increased targeting SAS doctors to increase number of supervisors within the group.	The need for further experience to fulfil CESR requirement is challenging for some SAS doctors especially if the training not available locally.
3	SAS doctors are encouraged and supported to apply for SAS fund to help them develop new skills and develop.	
4		

Any other comments you would like to make regarding development of SAS doctors & LEDs:

Your answer should be no more than 3000 characters long.

SAR 2020 Library Quality Process

Page 1: Organisation Details

Trust Name:

Mid Cheshire Hospitals NHS Foundation Trust

Report signed off by (name):

Susan Smith, Senior Librarian

Date signed off:

Dates need to be in the format 'DD/MM/YYYY', for example 27/03/1980.

27/07/202

(dd/mm/yyyy)

Page 2: Library Quality Process

We recommend that you consult with your Library and Knowledge Services Manager or Lead to complete this section. Please provide narrative and evidence (for 1, 3 and 4) on the following 4 areas for your Library and Knowledge Service. Please also highlight any issues or concerns, including any areas which are not being met. If your Library and Knowledge Service is provided via a service level agreement, please consult with the providing Library and Knowledge Services Manager. Additional prompts have been added under each heading.

1. Describe how your Trust is implementing the ***HEE Library and Knowledge Services Policy*** ***https://www.hee.nhs.uk/sites/default/files/documents/NHS%20Library%20and%20Knowledge%20Services%20in%20England%20Policy.pdf*** namely: To ensure the use in the health service of evidence obtained from research, Health Education England is committed to:

Enabling all NHS workforce members to freely access library and knowledge services so that they can use the right knowledge and evidence to achieve excellent healthcare and health improvement.	The Library works in partnership with the University of Chester and East Cheshire NHS Foundation Trust to support all NHS staff, learners and all people across the Cheshire Health System with access to high quality information. We offer access through Sconul and an NHS access scheme from across the North of England. Through centralisation of the Library & Knowledge Service Leads, the library has lost funding to support the role of the Community Outreach Librarian from March 2020. Working on the recommended ratio of qualified librarians 1:1,250 WTE, we will be down 1 WTE for supporting MCHFT, without taking into consideration the support of GPs, local authority health works, patients and public. This is leading us to review our services with a view to withdraw support to community-based staff. We will therefore be unable to deliver to the policy going forward into 20/21. Resource wise we have implemented a new Resource Discovery service to streamline access to our collection and provide training, literature search support and evidence synthesis services for our users. This year we have been working to strengthen our support of knowledge mobilisation within the organisation. The library has a number of resources aimed at facilitating virtual meetings (conferencing kits, headphones, speakerphones, lap tops, Surface Hub). All of which has been used to move staff over to new virtual ways of working. We lend equipment, but have also optimised library spaces to allow for online collaboration. It has raised profile of the library within the organisation and made us more accessible to many staff.

Developing NHS librarians and knowledge specialists to use their expertise to mobilise evidence obtained from research and organisational knowledge to underpin decision-making in the National Health Service in England.	Library staff have had the benefit of participating in a number of local training sessions within the Trust, webinars, participation in educational activities across the north of England, conferences as well as self-directed learning. This has been put to good practice in change practices and delivering innovative solutions to the Trust.

Prompt: We advise you to consult with your Library and Knowledge Services Manager or Lead when compiling your response. You could provide evidence from your Library and Knowledge Services' strategy or annual action/implementation/business/service improvement plan.

2. HEE's ***Library and Knowledge Services Policy is*** delivered primarily through local NHS Library and Knowledge Services.

Please identify the budget allocated to your Library and Knowledge Service in the current financial year.	£144,551.00 (for 2019-20) £111,393 in current year
If possible please identify the sources of this funding, differentiating for example between educational tariff funding and any contribution from your organisation.	2019-20 period: £113,181 tariff, £1.940 SIFT, 28,960 HEE Library development fund. Some staff, stationary, furniture and print resources have been funded by the University of Chester. We do not currently have the figures for this contribution, in the past it has been slightly below the NHS income 20-21 period: £109,065 tariff, £2,328 SIFT

Prompt: Your Finance department and/or your Library and Knowledge Service Manager should be able to supply this information.

3. Please tell us about any areas of Library and Knowledge Services good practice that you would like to highlight.

Prompt: We advise you to consult with your Library and Knowledge Services Manager or Lead when compiling your response. You could provide evidence of impact on clinical practice, impact on management decision-making (including cost savings) and any innovation submissions originating from your Library and Knowledge Service.

Latest activities and impact statements from Covid work are available is this presentation delivered to the Northern Library Managers: https://www.lksnorth.nhs.uk/media/2258/library-managers-susan-smith.pdf

Many of these build on the activities highlighted for 2019-20:

The JET Library won a silver award in the Library & Health Network North West for our work around the Menopause. This was a library driven initiative to work with the health & wellbeing group to raise awareness of the issues. The library developed a local support leaflet, wrote a Trust policy, held awareness sessions and Menopause Cafes and received funding from the Library Development Fund to develop emergency menopause boxes for departments.

The library has been supporting information sharing and collaboration through the introduction of group conferencing and live events. This has been used to deliver 'Live Events' to stream CEO briefings, teaching sessions and system wide leadership course.

This year we started to work with the hospital radio volunteers, local public library writers group and authors to create a new storytelling show. We have had local guest authors join the show, staff contributions and professional author short stories. Some podcasts are shared on the staff network. Due to limitations of the radio station, we have no way of gathering listener feedback or volunteers to review feedback.

We routinely try to collect impact case studies from literature searches. A couple of examples which have been submitted to the national database have been included.

4. The Learning and Development Agreement that Health Education England has with your organisation states that for 2018- 19 the LKS should have achieved a minimum of 90% compliance with the national standards laid out in the NHS Library Quality Assurance Framework. **LKS that scored below 90% submitted an action plan to Health Education England in March 2019 describing their planned improvements. If you submitted an action plan, please describe the improvements you have made against the plan.**

N/A

SAR 2020 Patient Safety, Simulation and Human Factors

Page 1: Organisation Details

Trust Name:

Mid Cheshire Hospitals NHS Foundation Trust

Report signed off by (Name):

Helen Ashley, Head of Education

Date signed off:

Dates need to be in the format 'DD/MM/YYYY', for example 27/03/1980.

01/09/2020

(dd/mm/yyyy)

Page 2: Patient Safety

1. Who is the Lead for Patient Safety in your organisation?

Hayley Cavanagh

What support do they receive in delivering this role? e.g. job-planned time, resources etc.

Head of Patient Safety is a full-time substantive role.

2. Please advise up to three areas relating to patient safety agenda that you have worked on in the last two years and you are most proud of? Could these be applied regionally and be shared with HEE?

	Answer
1	Improvements to our Trianglulation processes (complaints/claims/incidents)
2	Increased Executive oversight on trends, themes and exception reports related to serious incidents
3	Introduction of Daily Patient Safety Huddles

3. In which areas would you like support from HEE? e.g. educational events, funding, specific areas of training such as quality improvement.

Page 3: Simulation

Prompt: we advise you to consult with your Simulation Manager or Lead when compiling your response.

1. What is the governance structure in place within your organisation with regard to simulation-based education training?

Simulation is aligned to the Education Forum, which Is a sub-committee of the Executive Workforce Assurance Group. There is also a dotted line to the Medical Education Committee

Who is the responsible Simulation Lead within the organisation?

Dr Chiara Mosley

2. Please describe your process for accessing education funding received for simulation and/or TEL bids and who is responsible for this?

Bids are managed by Helen Ashley, Head of Workforce Transformation and are accessed through HEE, North.

3. Does your Trust offer multidisciplinary faculty training including specific simulation-based education debriefing in line with ASPiH standards?

Yes. Our programmes and trainers are accredited by ASPiH

4. Which directorates or inter-professional groups are actively engaged with simulation-based education within your organisation?

Medicine and Emergency Care, Surgery and Cancer and Womens and Childrens Divisions all regularly participate in inter-professional simulation based education.

How do you encourage equitable access to simulation for all staff? Add how is this monitored?

The Trust's Education Forum has Simulation as a standing agenda item, programmes and equal access are monitored by this group.

5. Please describe strategic engagement and representation in simulation activity in the organisation i.e. board level, clinical governance, patient safety, incident reviews, quality improvement?

Simulation is included in emergency preparedness activities, serious incident reviews and as part of emerging quality improvement activities.

Page 4: Human Factors

Who is the Lead for Human Factors in your organisation?

Dr Chiara Mosley

What support do they receive in delivering this role? e.g. job-planned time, resources etc.

This role forms part of a broader simulation lead function.

Please describe the extent to which your HF training covers the following domains:

People – the individual & teamwork	This is the main focus of our Human Factors activity, both simulation based and classroom based activities are scheduled for teams and for professional group based training.
Environment – the physical aspects of a workspace	This is not yet a focus of our activity, however our high fidelity simulations include careful reference to workspace elements appropriate to participants.
Equipment and technology	Equipment, technology and systems are core elements of our training design. We simulate system and equipment failures regularly as part of our curriculum.
Tasks and processes	We frequently run simulations based on new processes to support their evaluation before formal implementation.
Organisation	The Trust usually schedules two or three organisation wide simulations per year to investigate key issues and scenarios to support system change and emergency preparedness.

Ergonomics and research methods	This is not yet a focus of our activity.

For the training delivered in the reporting period please also consider and describe the following:

The audience to which HF training is being delivered, including details of multi-professional staff.	Cohorts made up of foundation doctors, physician associates, advanced clinical practitioners, and groups of midwives, paediatric specialist nurses and paramedics.
Frequency of training, or whether ad hoc events.	We schedule 12 sessions per year.
Who are the faculty that deliver the training? Please describe their “HF expertise”, professional background, specialty, whether they have job-planned time to deliver HF training.	Dr Chiara Mosley has a PhD in simulation based education and is ASPiH accredited. She is an RN and advanced practitioner in neonatal nursing.
What is the wider Trust context within which HF training is delivered. Is there a link between patient safety incidents, SI investigations, root cause analysis?	Links are developing across the Trust.
To what extent is HF training seen as part of a wider patient quality and safety agenda or integrated into clinical governance structure/process?	Awareness and understanding are developing and becoming more integrated with clinical governance.

What Human Training requirements do you have as a Trust?

HF training is developing across the Trust and awareness is growing. Additional resources will be required in time so support the fully matured model.

SAR 2020 Equality & Diversity

Page 1: Organisation Details

Trust Name:

Mid Cheshire Hospitals NHS Foundation Trust

Report signed off by (name):

Natalie Wallace, Senior Workforce Business Partner

Date signed off:

Dates need to be in the format 'DD/MM/YYYY', for example 27/03/1980.

02/09/2020

(dd/mm/yyyy)

Page 2: Equality and Diversity

The HEE Quality Framework states clearly that education and training opportunities should be based on principles of diversity and inclusion.

The HEE equality, diversity and inclusion strategy reflects HEE's commitment to this important area of work and features strategy for HEE employees, as well as the opportunity to gather regional activity and influence wider. An example of this is the HEE workforce strategy, used to inform our work in developing a comprehensive system-wide understanding of workforce needs for the future. Diversity and inclusion will be integral in how we look to influence the healthcare system to achieve greater representation and social mobility.

As well as applying these principles across all professional groups, there is also a specific work stream and duty to consider and capture information for doctors in training. The GMC continue their work in equality and diversity, reflecting their standards; promoting excellence.

For medical education, the GMC and local offices continue to consider differential attainment; different rates of attainment between different groups of doctors. This work includes ethnicity and country of primary medical qualification.

Prompt: In the responses below, please consider:

- *Organisation wide themes*
- *Examples of good practice from across professional groups*
- *As well as specific consideration and comment on differential attainment for doctors in training*

Name of Trust Equality, Diversity and Inclusion Lead (or equivalent):

Natalie Wallace

1. How do you ensure that learners with different protected characteristics are welcomed and supported into the trust, demonstrating that you value diversity as an organisation?

Specific inductions packages are in place e.g. international nurse recruitment. 1:1 support is available and appropriate adjustments are made to provide support where required which will be based on individual need. We have recently launched a BAME staff network and are hosting a number of disability forums for staff, with a longer term view of implementing a disability network. The Trust has an engaged ED&I group which meet on a regular basis to discuss all matters relating to ED&I.

2. How do you liaise with your trust Equality, Diversity and Inclusion Lead to:

	Answer
• Ensure trust reporting mechanisms and data collection take learners into account?	n/a
• Implement reasonable adjustments for disabled learners?	Reasonable adjustments are put into place on an individual basis with support available from the HR team/ED&I Lead where required.
• Ensure your policies and procedures do not negatively impact learners who may share protected characteristics?	All Trust policies are required to have a completed equality impact assessment (EIA) to ensure those with a protected characteristic are not at a disadvantage. All services including employment services also have a completed EIA.
• Analyse and promote awareness of outcome data (such as exam results, assessments, ARCP outcomes) by protected characteristic?	Additional work is required in relation to this and has been identified in the WRES/WDES submissions with actions identified to explore this further, particularly in relation to recruitment and progression.

3. How do you support learners with protected characteristics to ensure that known barriers to progression can be managed effectively?

Any actions would be taken on an individual basis, e.g. reasonable adjustments, additional or alternative equipment etc. Individual action plans etc. We are currently rolling out a health passport.

4. How do you educate learners on equality and diversity issues that may relate to themselves, their colleagues, or the local population of the trust?

All Trust employees undertake equality, diversity and inclusion training as part of the statutory and mandatory training.

5. How do you support your educators to develop their understanding of, and support for, learners with protected characteristics?

We have identified that additional work is required on this and it is therefore in our action plans in relation to additional manager training on unconscious bias and supporting reasonable adjustments.

6. Is there monitoring or strategies in place to look at those accessing progression opportunities, and those progressing into more senior roles?

Work is currently underway to explore this in further detail as a result of the recent WDES/WRES.
We are currently exploring implementation of specific development programmes to encourage and support those with protected characteristics in to more senior posts, ensure diverse stakeholder/recruitment panels are in place and are developing reports to review progression.

What is the Trust view on data on progression in the trust?

The WRES, WDES and staff survey suggest that BAME and disabled staff are not satisfied with the opportunity to progress. Additional work is required to understand whether staff with protected characteristics are not applying for progressional posts or whether they are not successful at interview. A report into this has been commissioned and will be reviewed once available at the Trust ED&I Group.

Are there any responses or resulting objectives to data held by the Trust?

An increase to BAME staff numbers, poor WRES results and impact of Covid has led to the development of a BAME staff network.

7. Does the Trust invest in additional Equality and Diversity training for some or all staff (i.e. more than statutory training)?

This is done on an ad-hoc basis where a particular need is identified by a division.
Training is provided to the GP trainers approx. twice a year on equality, diversity and inclusion.

Are there any training or initiatives (in place or being considered) to learn from cases that have an E&D theme?

We are currently developing a ‘civility in the workplace’ session for staff to develop a culture of dignity and respect for all due to reported incidents. Disability staff forums are also scheduled to understand why staff feel there are barriers to workplace adjustments being made.

SAR 2020 Incidents and Coroner's Case Support

Page 1: Organisation Details

Trust Name:

Mid Cheshire Hospitals NHS Foundation Trust

Report signed off by (name):

Dr Joanna Scott, DME

Date signed off:

Dates need to be in the format 'DD/MM/YYYY', for example 27/03/1980.

01/09/20

(dd/mm/yyyy)

Page 2: Supporting Learners at Coroners' Court and following Serious Incidents

To help HEE better understand how your organisation supports learners please complete the questions below.

Clinical Incidents

What system is used for reporting clinical incidents?

Ulysses

How is feedback on an incident given to the reporter?

Via email, feedback is created on Ulyesses and auto-sent to reporter.

What system is used for reporting Serious Untoward Incidents/ Never Events?

Ulysses, ranked as moderate or severe.

Support for learners involved in a Serious Incident:

How does the Trust identify learners involved in a serious incident?	Via electronic database held by Medical Education Team. Informed by ES, Ulysses, and trainees.
What is the target timescale for identifying learners involved in a serious incident?	20 days
Who in the education team is notified about a learner involved in a serious incident (e.g. DME, FPD, ES, names CS, Clinical Lead, etc...)?	DME, ADME, Clinical Leads, ES
Who offers support to a learner involved in a serious incident (e.g. DME, FPD, ES, Named CS, Clinical Lead, Manager, PALS, Trust Legal Team, etc...)?	ES and clinical team. DME adds support where necessary.
Describe briefly how support to a learner involved in a serious incident is delivered?	Face to face.

Describe briefly arrangements for debriefing/ support for other staff involved in a serious incident?

Hot and Cold debriefs to give initial support with further meetings following formal investigation outcome.

Does your Trust hold Schwartz rounds of similar events?

- **Yes**
- No

What guidance does the Trust offer about reflection on serious incidents?

Trainees are advised to reflect on incidents via portfolio and ARCP framework.

Writing statements and giving evidence

Who advises and supports learners in the following:

Writing statements for an inquiry into a serious incident, root cause analysis, complaint, etc?	Clinical team, ES and Legal Team if needed.
Giving evidence to an inquiry into a serious incident, root cause analysis, complaint, etc?	Clinical Team, ES and Legal Team.

Coroner's statement and inquests

Support for learners involved in a Coroner's case:

How does the Trust identify learners involved in a Coroner's case?	Via Clinical Teams and Medical Directors Office.

Who in the education team is notified about a learner involved in a Coroner's case (e.g. DME, FPD, ES, names CS, Clinical Lead, etc...)?	DME, ADME
Who offers support to a learner involved in a Coroner's case (e.g. DME, FPD, ES, Named CS, Clinical Lead, Manager, PALS, Trust Legal Team, etc...)?	ES and clinical team. DME adds support where necessary.
Describe briefly how support to a learner involved in a Coroner's case is delivered?	Clinical Team involved will meet with trainee prior to court date and a representative will usually accompany the trainee. There is also input from the Trust Legal Team.
Who offers advises and supports learners in writing statements for a Coroner's case (e.g. ES, DME, Trust Services, Legal Department, etc...)?	As above.
Who advises and supports learners in giving evidence to a Coroner's case?	As above.
How do the answers to the previous questions differ if the learner has moved to another Trust?	The trainee is still supported using the Trust networks.

Do you publicise the advice about Coroner's hearings on the HEE Website?

No, currently.

What training does your Trust offer on Duty of Candour?

Mandatory training modules.

Thank you

Thank you for completing the Self-Assessment Report.

Key for selection options

1 - Trust Name

- Aintree University Hospital NHS Foundation Trust
- Airedale NHS Foundation Trust
- Alder Hey Children's NHS Foundation Trust
- Barnsley Hospital NHS FT
- Blackpool Teaching Hospitals NHS Foundation Trust
- Bolton NHS Foundation Trust
- Bradford District Care NHS Foundation Trust
- Bradford Teaching Hospitals NHS FT
- Bridgewater Community Healthcare NHS Foundation Trust
- Calderdale & Huddersfield NHS FT
- Cheshire and Wirral Partnership NHS Foundation Trust
- City Health Partnerships
- Countess of Chester Hospital NHS Foundation Trust
- Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust
- East Cheshire NHS Trust
- East Lancashire Hospitals NHS Trust
- Greater Manchester Mental Health NHS Foundation Trust
- Harrogate & District NHS FT
- Hull University Teaching Hospitals NHS Trust
- Humber NHS Foundation Trust
- Lancashire & South Cumbria NHS Foundation Trust
- Lancashire Teaching Hospitals NHS Foundation Trust
- Leeds and York Partnerships NHS FT
- Leeds Community Healthcare NHS Trust
- Leeds Teaching Hospitals NHS Trust
- Liverpool Heart & Chest Hospital NHS Foundation Trust
- Liverpool University Hospitals NHS Foundation Trust
- Liverpool Women's NHS Foundation Trust
- Manchester University NHS Foundation Trust
- Mersey Care NHS Foundation Trust
- Mid Cheshire Hospitals NHS Foundation Trust

Mid Yorkshire Hospitals NHS Trust
Noble's Hospital, Isle of Man
North Cumbria University Hospitals
North West Boroughs Healthcare NHS Foundation Trust
Northern Lincolnshire and Goole NHS Foundation Trust
Pennine Care NHS Foundation Trust
Rotherham Doncaster and South Humber NHS Foundation Trust
Royal Liverpool and Broadgreen University Hospitals NHS Trust
Sheffield Children's Hospital NHS FT
Sheffield Health and Social Care NHS Foundation Trust
Sheffield Teaching Hospitals NHS Foundation Trust
South West Yorkshire Partnership NHS Foundation Trust
Southport and Ormskirk Hospital NHS Trust
St Helens and Knowsley Teaching Hospitals NHS Trust
Stockport NHS Foundation Trust
Tameside and Glossop Integrated Care NHS Foundation Trust
The Christie NHS Foundation Trust
The Clatterbridge Cancer Centre NHS Foundation Trust
The Rotherham NHS Foundation Trust
The Walton Centre NHS Foundation Trust
University Hospitals of Morecambe Bay NHS Foundation Trust
Warrington and Halton Teaching Hospitals NHS Foundation Trust
Wirral University Teaching Hospital NHS Foundation Trust
Wrightington, Wigan And Leigh NHS Foundation Trust
York Teaching Hospital NHS Foundation Trust

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**17**	Date of Meeting: 06/07/2020
Report Title	Health and Safety Annual Report	
Executive Lead	Russ Favager, Deputy CEO and Director of Finance	
Lead Officer	Wendy Astle-Rowe, Head of Health and Safety	
Action Required	To approve	

☐	**Acceptable assurance** General confidence in delivery of existing mechanisms / objectives	X	**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 Health and Safety Team achieved the annual objectives and actions from the local delivery plan
- There are a number of recommendations which if approved and implemented would significantly improve compliance for the Trust

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)*

• Manage the impact of covid and ensure safe recovery	✓	• Provide safe and sustainable healthcare through our estate, infrastructure and planning	✓
• Deliver outstanding care and patient experience Deliver the most effective care to achieve best possible outcomes	☐	• Provide strong system leadership by working together	☐
• Ensure MCHFT is the best place to work	✓	• Be well governed and clinically led	☐

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)*

Share approved recommendations at Health and Safety Group and agree actions to implement them, monitor progress via Health and Safety Group

REPORT DEVELOPMENT

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

Mid Cheshire Hospitals NHS Foundation Trust

Annual Report – Health and Safety

Introduction

1. This purpose of this paper is to provide an update to the Board of Directors of Trust Health and Safety arrangements and performance for the period 1st April 2019- 31st March 2020.

Executive Summary

2. The report focuses on the agreed objectives for the Trust's Health and Safety Team ("the Team") 2019/20 and the key deliverables as outlined in the Health and Safety Team Local Delivery Plan 2018-21, the elements of which are bulleted below and detailed in the body of the report:

- Health and Safety Group
- Fire Safety Management Group
- Violence and Aggression Forum
- Estates Strategy Implementation Group
- Risk Systems
- Stress
- Workstation Assessments (Display Screen Equipment)
- Moving and Handling
- Incident reviews and Root Cause Analysis (RCA) investigations
- Royal Society for the Prevention of Accidents (RoSPA) submission

3. The Health and Safety Team is available to provide advice and support to divisions via the Health and Safety Group, divisional Quality Governance/ Compliance Managers and to all management and staff on a needs basis. The Estates and Facilities Division report to the Board separately on Estates-related compliance issues based on their activities including contractor management, asbestos management and legionella management.

4. Areas recommended for action:

- Review the composition of the Health and Safety Group to ensure that it continues to meet the needs of the organisation
- Appoint an external Authorised Fire Engineer to undertake a review of Trust systems to provide independent assurance, this is scheduled for September 2020
- All Fire Safety Management Assessments not reviewed in period are to be brought back in Date by November 2020 and a regular divisional report will be developed to provide divisions with regular updates on position
- Explore options to centrally monitor the completion of fire drills in non-sleeping risk locations required to be undertaken by management
- All COSHH past their review date will be brought up to date by Dec 2020 and the review of COSHH Management systems to provide recommendations for improvement will be completed by March 2021

- Develop a draft Strategy for Violence Reduction in line with the NHS proposed Strategy which is likely to be finalised within 2020/21
- Review the management of Bariatric Equipment within the Trust based on draft paper
- Continue to support the Trust in relation to Covid-19 safe workplaces

Background and Analysis

Health and Safety Group

5. The purpose of the Group is to provide assurances to the Executive Quality Governance Group concerning the development and monitoring of Health and Safety policies, procedures and plans to comply with current legislation and to facilitate the attainment of a safe environment for staff, patients, visitors and all others affected by the activities of the Trust. The group has an annual work plan which is monitored on a quarterly basis with any exceptions being reported to the Executive Quality Governance Group (EQGG) and, in addition, provides an annual report outlining how it has achieved its terms of reference. The group met on four occasions in 2019/20 - 25/04/2019, 25/07/2019, 24/10/2019 and 23/01/2020.

6. Reports monitored by the group include: -

   a) Updated Policies and Procedures
   b) RIDDOR and RCA report which includes breached actions
   c) Workstation Safety Plus Report
   d) 1/4ly Report which includes incident trends, monitoring of unwanted fire signal trends and RIDDOR reporting compliance
   e) 1/4/y divisional incident trends
   f) Annual divisional health and safety plans
   g) Health and Safety Risk Register
   h) Health and Safety Assurance Framework
   i) Management System Audit
   j) Moving and Handling Audit
   k) COSHH Audit
   l) Training needs
   m) Violence and Aggression Forum Action Points

   Items e) – m) provide detail on the main activities during 2019/20.

7. The Health and Safety Assurance Framework provides a six monthly view on key areas in relation to compliance/gaps in compliance and this is monitored by the group and escalated to EQGG.

   It is recognised that the TOR need to be reviewed to ensure that the group is meeting the needs of the organisation particularly due to changing roles with the group and the Trust.

Fire Safety Management Group

8. The Group is responsible for providing information and assurances to the Estates Infrastructure Development Group (EIDG) via the Estates Strategic Infrastructure Group (ESIG) concerning fire safety performance in order to comply with current legislation and

improvement notice 741 issued by the Cheshire Fire Authority (CFA) in 2009. This is reported by exception to EIDG. Main activities in year were:

- Ensuring ongoing compliance with the outstanding enforcement notice 741 (2009), liaising with the Estates Team and Cheshire Fire Authority (CFA) to agree an extension to timeframes due to winter pressures and lately Covid-19 and potential second wave. The enforcement notice has been extended to 2023 to complete the remaining four wards, however since the original notice the Trust has acquired South Cheshire Hospital and this has been added to the programme.
- Facilitating and supporting fire drills within the wards sleeping risk locations - 100% compliance was achieved. Drills in non-sleeping risk areas are the responsibility of department managers and are not currently centrally monitored.
- Review of the Trust's overarching Fire Risk Assessment was completed. In total there are 103 locations requiring a localised fire risk assessment and these are undertaken on a risk-based approach over a three year programme for sleeping risk locations and a five year programme for non-sleeping risk locations in line with the Cheshire Fire Authority Audits. The compliance rate for 2019/20 for sleeping risk locations was 97% and 45% for nonsleeping risk locations. The out-of-date assessments (99% of locations have a FSMA) are being pursued.
- Facilitation Cheshire Fire Authority (CFA) Audit of Elmhurst, Victoria Infirmary and Leighton Hospital of CFA Audits at Leighton Hospital, Victoria Infirmary were undertaken and no recommendations were made. CFA reported that the Trust's arrangements for the management of fire safety appeared to be of a high standard.
- Work to reduce unwanted fire signals (false alarms) - there was a reduction of 14.6% (down from 41% in the previous year to 35%). There were three small fires compared to two in the previous year (one was a patient setting light to paper and two were suspected arson attempts where two laundry bags were found to be smoldering).
- 15 Fire Warden Courses completed.
- Producing an annual fire safety report for EIDG which reports through to PAF.
- The group recommended the need for an external audit to be undertaken by an Authorised Fire Engineer. This is scheduled for September 2020.

Violence and Aggression Forum

9. The purpose of the Forum is to provide updates to the Health & Safety Group (HSG) concerning the systems in place for monitoring national compliance and monitoring incident trends in relation to Violence and Aggression. Main activities in year were: -

- Development and implementation of Trust Violence Reduction Improvement Plan
- Specific Plan for Ward 14 which identified issues including Detox which were supported and monitored
- Improvement to specific Violence and Aggression incident analysis report which included further scrutiny of sanctions applied
- Pilot approved for 6 sessions of Breakaway training De-escalation/Behavioral training
- Ongoing training funds agreed to provide Breakaway and De-escalation/Behavioral training annually

Estates Strategy Implementation Group

10. **Reporting**

- The Fire Safety Management Group reports into the Estates Strategy Implementation Group (ESIG) and escalates the Action Points and any exceptions
- The Head of Health and Safety is a member of ESIG.

Embedding New Risk Systems

11. The team assisted with embedding the Workplace Inspection and Risk Assessment (WIRA) documentation within Central Cheshire Integrated Care Partnership and provided ongoing support to ward and department managers for the completion of WIRAs, monitoring compliance and feeding back divisionally. Compliance with updating assessments was variable by division from approximately 30% in Diagnostics up to 100% in Estates and Facilities. CCICP achieved 66.6%.

Management System Audits

12. The Team completed a number of Management Systems reviews within CCICP in line with HSG65 and aligned to OHSAS18001. Two care community teams within CCICP Crewe and Northwich had a management systems review undertaken in 2019/20 which scored 77% and 75% respectively; elements identified where most improvement was made included training and risk assessment. The requirement for further development of the divisional annual plan for Health and Safety was also noted.

Further Develop Systems which lead to high levels of absence

Stress

13. There was a re-run of the Stress Management Survey using the HSE Stress Management Standards Questionnaire in line with the Trust's Risk Management Strategy which requires the Stress Survey and Safety Culture Survey to be undertaken in alternate years. 2019/20 is the next planned Stress Survey which is focused around six potential stressors:
    - Role
    - Demands
    - Control
    - Management Support
    - Relationships
    - Change

14. The questionnaire went out in hard copy with wage slips and was available electronically on the intranet. 735 staff responded to the survey and the audit department assisted in analysing the results:

    - Divisional trends identified that 'Demands' triggered as an area for improvement in CCICP and the Division of Medicine and Emergency (DMEC), 'Management Support' triggered in Diagnostics Division and DMEC, and all divisions triggered for 'Change'.

- 11 departments triggered as 'hotspots' in one or more of four of the six potential stressors of demands, management support and control. No departments triggered for relationships or role.
- Departments were offered focus groups to assist identifying practical solutions to be implemented locally and included in local Improvement Plans
- Focus groups were held within the Emergency Department, Domestics Services and Medical Records, Estates Maintenance and Sterile Services Departments - the programme was interrupted in March 2020 by the Covid-19 pandemic.

Musculoskeletal Injuries from Postural Stress and or Moving and Handling

15. Main activities are outlined below:

Workstation Assessments (as required by the Display Screen Equipment Regulations 1992, as amended)

- Reporting on levels of DSE compliance at Health and Safety Group
- Display Screen Equipment Follow-up Assessors course was undertaken
- Inclusion of requirement for DSE Assessment was added to appraisal guidance
- Review of the Trust system to remove leavers and add new starters to the Cardinus system was undertaken
- Identification of laptop kits for use in community for agile workers and a pilot was undertaken within CCICP
- A 'Chair' project was undertaken in liaison with the Trust Supplies Team where a number of suppliers were invited to submit chairs for evaluation. The Clinical Coding team assessed the chairs provided. The result of the project was that three standard chairs have now been agreed for DSE purposes for the Trust to ensure suitability, reduce costs and reduce variation.

Moving and Handling

- There was a re-appointment of a trainer/adviser to support CCICP
- Introduction of 22 Link Workers within CCICP to assist with assessments of local needs
- Combined CCICP and MCHFT Moving and Handling Procedure developed and approved
- Delivery of a one day Bariatric Equipment Workshop was undertaken with good attendance of clinical staff
- Finalising the outstanding project relating to bulk handling of patient records Trust wide was completed by ensuring the provision of suitable equipment to key areas including Medical Records and Portering
- Development and approval of business case to replace all Trust hoists which are now obsolete due to age and monitoring progress with implementation
- Development of draft paper to propose options for better management of Trust Bariatric Equipment

Control of Substances Hazardous to Health

16. Main activities in 2019/20 included:

- An audit of COSHH inventories within the Trust - 99% of products were found to have an assessment, 43% were found to be in date (August 2020 position is 66%). The report went to the HSG for information and feedback for the divisions. The main area of non-compliance for COSHH related to E&F but all of their assessments have since been updated, trialing the Ulysses system. The 2019/20 figures compared to an audit result of 71% in place and in date in the previous year
- An additional COSHH Assessors course was delivered
- An action was taken to review options to improve systems for management of COSHH Assessments including evaluating commercial systems

Incident Reviews and Root Cause Analysis Investigations

17. Health and Safety incidents are monitored via the Ulysses system. Incidents are reviewed by local management and the relevant Quality Governance/Compliance Manager for the division. Incidents rated as Moderate or above are reviewed by the Head/Deputy Head of Health and Safety and are considered for Root Cause Analysis investigation and in relation to the requirement to report under the reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). All health and Safety incidents which are confirmed as Moderate or above are reportable under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

18. In 2019/20 there were 19 staff incidents reportable to the Health and Safety Executive (HSE) as required by RIDDOR; two of these were late reports from the previous year and 4 of the incidents related to a member of staff working for Central Cheshire Integrated Care Partnership (CCICP). This compared to 12 reported RIDDOR incidents in 2018/19, 3 of which related to a member of staff working for CCICP. There was one patient incident reported under RIDDOR in 2019/20 compared to none in the previous year.

19. The number of Health and Safety incidents relating to staff reported in 2019/20 increased by approximately 14.9% compared to the previous year (from 1493 to 1558) and for CCICP increased by 24.4% (from 45 to 56). There was an approximate 11.2% increase in the number of 'No Harm' incidents reported for the Trust compared to the previous year (from 1120 to 1218) and an increase of 84.6% for CCICP (from 13 to 24). The rate of staff 'Harm' incidents reported decreased by approximately 3.7% for the Trust compared to the previous year (from 373 to 340) and for CCICP it remained the same as in the previous year (32).

20. All RIDDOR incidents were investigated - one had a local investigation undertaken and all others were Root Cause Analysis (RCA) investigations. The actions identified from the RCA review meeting were monitored by the Health and Safety Group.

21. The main trends for Health and Safety 'Harm' incidents were as below for 2019/20: -

Violence and Aggression - Annual figures were down 15.8% Acute (171 to 144) and down 50% CCICP (3 to 2). There were, however, increased numbers of Moderate incidents up from zero to five for the year

Moving and Handling - showed a 4.9% decrease for the Acute staff (down from 41 to 39) and CCICP increased 160% (up from 5 to 13). The increase for CCICP is believed to be related to improvements in reporting

Staff Slips trips and falls - Acute staff incidents were up 3.3% (from 30 to 31), CCICP remained the same (8) as in the previous year

Contact with Contaminated Sharps - Annual figures showed a reduction of 20.8% down from 48 to 38.

Training

22. The following training was delivered across the Trust:

- IOSH Managing
- COSHH
- Breakaway training pilot
- Moving and Handling
- DSE follow up course
- Stress Management
- Resilience (in collaboration with the Organisational Development Team, Occupational Health and Learning and Development)

Submission of RoSPA Application

23. The fourth Trust submission to the Royal Society for the Prevention of Accidents (RoSPA) awards was completed. This is undertaken to obtain an external view on the systems and processes within the Trust for the management of health and safety compared with other organisations as a benchmarking exercise. There are two levels of awards - the Achievement Awards which allocate Bronze, Silver or Gold recognition awards and Industry Awards which compare organisations with those in a similar industry and award 'commended', 'highly commended' and 'winner'. These are not automatically awarded each year if RoSPA consider the submissions do not merit the award for the industry.

24. The submission is the same whether you are submitting for the Achievement Award or the Industry Awards; however, you can submit for one or the other. The assessing panel is made up of Industry 'experts', RoSPA, IOSH and NEBOSH panelists.

25. The Trust was awarded Gold recognition awards in 2017, 2018, 2019 and 'Highly Commended' in 2020. Each award is issued for the previous year's performance.

Conclusions

26. The Team completed the objectives and key deliverables from the agreed plans. Achievements included:
    - Work from the Violence and Aggression Forum including the development of an improvement plan relating to the NHS Violence Reduction Strategy and starting the implementation, securing funding for the Breakaway training pilot and ongoing training, supporting implementation of the Detox pathway
    - Agreeing further extension of the refurbishment programme with Cheshire Fire Authority and receiving positive feedback on the annual Fire Audit
    - Introducing the concept of Link Workers for Moving and Handling for CCICP to improve compliance

- Obtaining agreeance for continued funding for IOSH Managing Safely licenses and Executive training
- Acceptance of Hoist Replacement paper and funding
- RoSPA Industry Standard 'Highly Commended' Award (which does not suggest that we have everything in place but recognises our performance and systems against other organisations)

Recommendations

27. The following recommendations are made for implementation within the Trust based on 2019/20 performance and review for continued improvement: -

- Review the composition of the Health and Safety Group to ensure that it continues to meet the needs of the organisation and the links to divisional boards
- All Fire Safety Management Assessments not reviewed in period are to be brought back in Date by November 2020 and a regular divisional report will be developed to provide divisions with regular updates on position
- Appoint an external Authorised Fire Engineer to undertake a review of Trust systems to provide independent assurance, this is scheduled for September 2020
- Explore options to centrally monitor the completion of fire drills in non-sleeping risk locations required to be undertaken by management
- All COSHH past their review date will be brought up to date by Dec 2020 and the review of COSHH Management systems to provide recommendations for improvement will be completed by March 2021
- Develop a draft strategy for Violence Reduction in line with the NHS proposed Strategy which is likely to be finalised within 2020/21
- Review the management of Bariatric Equipment within the Trust based on draft paper
- Continue to support the Trust in relation to Covid-19 safe workplaces

28. This report is submitted to the Board of Directors for noting. Implementation of the recommendations should enable the overall performance and compliance of the Trust in respect of Health and Safety to be improved.

Author: Wendy Astle-Rowe, Head of Health and Safety
Date: 27/08/2020