Mid Cheshire Hospitals NHS Foundation Trust

# Board of Directors

Monday 5 October 2020

9:30am

Virtual - via Microsoft Teams

# AGENDA

| No | BAF Risk | Item |
|---|---|---|
| **PRELIMINARY BUSINESS** | | |
| 1 | | **Welcome & Apologies (v)**<br>Chair |
| 2 | | **Declarations of Interest (v)**<br>Chair<br>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 | | **Patient Story (v)**<br>Director of Nursing & Quality<br>To note |
| 4 | | **Draft Minutes of the Last Meeting - 7 September 2020 (d)**<br>Chair<br>To approve the draft minutes of the last meeting of the Board of Directors, discuss any matters arising and review the action log |
| 5 | | **Chair's Opening Remarks**<br>• Governor's items (v)<br>• Annual Members' Meeting (v)<br>• Support from external organisations during Covid-19 (v)<br>To note<br>• Board Meetings' Schedule & Submissions (d)<br>To decide |
| **CONTEXT / OVERVIEW / RISK** | | |
| 6 | | **Chief Executive's Report (d)**<br>Chief Executive<br>To note |
| 7 | BAF19 | **Board Assurance Framework (BAF) Q2 2020/21 (d)**<br>Chief Executive<br>To note |
| 8 | BAF9 | **Integrated Performance Report (August - Month 5) (d)**<br>Chief Executive<br>To note |

| No | BAF Risk | Item |
|---|---|---|
| **QUALITY - Patient Safety, Clinical Effectiveness & Patient Experience** | | |
| **9** | | **Quality & Safety Committee (QSC) (14 September 2020) - Chair's Report (d)**<br>Committee Chair<br>To note |
| **10** | | **Quality Safety & Patient Experience Report**<br>Director of Nursing & Quality<br>To note |
| **11** | **BAF9** | **Serious Incidents (v)**<br>Medical Director<br>To note |
| **12** | **BAF14** | **Safer Staffing Report (Nursing & Midwifery) (d)**<br>Director of Nursing and Quality<br>To note |
| **PERFORMANCE** | | |
| **13** | | **Performance and Finance Committee (PAF) (24 September 2020) - Chair's Report (d)**<br>Committee Chair<br>To note |
| | **BAF7** | • **Winter Plan (d)**<br>Chief Operating Officer<br>To approve |
| **WELL LED** | | |
| **14** | | **Workforce & Digital Transformation (WDT) Committee (10 September 2020) Chair's Report (d)**<br>Committee Chair<br>To note |
| | **BAF12** | • **Workforce Race Equality Standards (d)**<br>• **Workforce Disability Equality Standard (d)**<br>Director of Workforce & OD<br>To approve |
| **GOVERNANCE** | | |
| **15** | | **Audit Committee (14 September 2020) – Chair's Report (d)**<br>Committee Chair<br>To note |

| No | BAF RISK | Item |
|---|---|---|

## CONCLUDING BUSINESS

**16** **Any Other Business**

Chair

To consider any other matters of business

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

Chair

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

**18** **Key Messages from the Board (v)**

Chair

To agree

**Time, Date and Place of Next Meeting**

Monday, 2 November 2020 @ 09:30 hours - virtually via Microsoft Teams

Action Log

| Agenda item | | Assigned to | Deadline | Status |
|---|---|---|---|---|
| Board of Directors 07/09/2020 6.1 Chief Executive's Report (d) | | | | |
| 191. | Draft Submission for restoration plan to be circulated to Board for comment. | Bennett, Oliver | 24/09/2020 | Pending |
| | *Explanation action item*<br>This needs to be before the submission deadline of 10 September. | | | |
| | *Explanation Bennett, Oliver*<br>Briefing sent to the Board. | | | |

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

# BOARD OF DIRECTORS

| | | |
|---|---|---|
| **Agenda Item** | **5.1** | Date of Meeting: 05/10/2020 |
| **Report Title** | Board Meetings' Schedule and Submissions | |
| **Executive Lead** | Caroline Keating, Company Secretary | |
| **Lead Officer** | Caroline Keating, Company Secretary | |
| **Action Required** | To approve | |

| | | | | | |
|---|---|---|---|---|---|
| ☐ | **Acceptable assurance**<br>General confidence in delivery of existing mechanisms / objectives | ☐ | **Partial assurance**<br>Some confidence in delivery of existing mechanisms / objectives | ☐ | **No assurance**<br>No confidence in delivery |

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

- Proposed introduction of formal and strategic Board sessions, with consent agendas
- Changes to Board Committee dates to allow scrutiny of data prior to Board
- Outline programme of Board development for 2020/21

**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 | ☐ | Proposal | |
| • Strategic/BAF Risk | ☐ | | |
| • Service Change | ☐ | | |

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

New schedule to be diarised and implemented from October 2020 (Board dates from January 2021)

**REPORT DEVELOPMENT**

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

# Board Meetings' Schedule & Submissions

## Introduction

1. Formal Board meetings take place on the first Monday of every month. In addition, there are five Board Away Days, normally scheduled for the final Monday of the months in which they are held. The programme for these days consists of Trust business and Board training, development and awareness raising.

2. The Board's formal business is managed through a workplan, approved by the Board at the beginning of each financial year. The terms of reference for the Board are included within the Corporate Governance Framework Handbook.

3. A Board Development Programme is in place, co-ordinated by the Company Secretary and Director of Workforce & OD in conjunction with the Chair and Chief Executive.

4. The NEDs are expected to give 2.5 days a month to Trust business; the Chair 2/3 days per week. It is clear that they all give time over and above this but it remains critical that their time adds value and is used efficiently.

## Proposal

5. The Board would continue to meet monthly but would not require as many formal meetings as are currently in place. A number would become informal strategic sessions to be used as an opportunity to explore strategic issues in more detail than is possible at formal meetings. If, however, for whatever reason, the Board had unexpected business to agree formally in those months a strategic session was being held, the Board would reserve the right to reconvene that session to a formal meeting, with the necessary notice given externally.

6. In addition to the eight formal meetings proposed in year, it is further proposed that each quarter throughout the financial year would include one strategic session and a development day; the latter to be used solely for Board training and development from January 2021 (the Away Day in December 2020 remains under the 'old' criteria to accommodate Board discussion on the Trust Strategy). Due to the dates for Board approval of regulatory submissions, it is not possible to alternate formal and informal meetings throughout the year.

7. The table overleaf outlines the structure of Board meetings throughout the financial year. It is based on a revised schedule of dates for the main groups within the Trust's Governance Structure to facilitate an effective flow of information from Executive-led Operational Groups to the Executive Risk & Assurance Group, Board Committees and the Board *(Appendix I)*. In this revised schedule, these entities take place in the same calendar month with the Board on the final Thursday of the month. Board Development Days would be scheduled for the beginning of the month in which a formal meeting is held. Dates have yet to be identified for these days and for the Executive Digital Technology & Information Services Group – this will be addressed shortly as will the exact times for all entities.

8. The new schedule contains a reduced number of Audit Committee meetings in year. In line with MIAA recommendations and other Trusts, there will be four quarterly meetings, with an additional one to agree the annual report and accounts, as opposed to the current seven. All are scheduled prior to Board meetings.

9. Council of Governors' meetings in 2021 will be moved from the final Thursday where they are currently scheduled. It is not anticipated this will be an issue as sufficient notice will be given of the revised dates.

10. The schedule of dates identified in Appendix I allows Corporate Governance to circulate papers within agreed timescales i.e. three working days + a weekend or four working days prior to the meetings. It also allows for the Chair's Assurance Reports from Board Committees to be written and agreed for onward circulation to Board, with the exception of the PAF Committee which is likely to be uploaded early in the week of the Board meeting.

| Quarter | Month | Formal Board Meetings/ Strategic Sessions | Board Development Days | Quarterly Retrospective Reports |
|---|---|---|---|---|
| 1 | April | Formal Board | | Q4 |
| | May | Formal Board | | |
| | June | Strategic Session | | |
| 2 | July | Formal Board | | Q1 |
| | August | Strategic Session | | |
| | September | Formal Board | | |
| 3 | October | Formal Board | | Q2 |
| | November | Formal Board | | |
| | December | Strategic Session | | |
| 4 | January | Formal Board | | Q3 |
| | February | Strategic Session | | |
| | March | Formal Board | | |

**Table 1: Board Meetings' Structure**

## Future Board Submissions

### Regular Reports

11. To ensure the Integrated Performance Report (IPR) is available for submission to Board Committees (Workforce & Digital Transformation, Quality & Safety, and Performance & Finance) and the Board, this report will contain unvalidated data with the Board/Board Committee advised verbally of any material changes following validation (it is not anticipated that this would be required on a regular basis). The narrative in the IPR will identify any statistical change in the data with Board Committees triangulating that information with the Executive Group Chair's Summary Report and verbal updates from the Executive Lead. The Board will, in turn,

triangulate the data in the IPR with the Chair's Assurance Reports (with the Board Committee agendas included in the appendix to these reports) from the Board Committees and headline key issues in the Chief Executive's Report.

12. All quarterly reports, including the Board Assurance Framework, will be submitted to Board the month after the quarter end e.g. Q1 would be considered in July, rather than the current position where some Q1 reports are taken in September.

13. Minutes of formal Board meetings will be taken as usual; the notes from the strategic sessions would be submitted to Part II of the next formal meeting. The Lead Governor would be invited to attend the Strategic Sessions.

14. The Integrated Performance Report and, potentially, the Finance Report would be circulated to the Board via email in advance of the Strategic Sessions. This would ensure that the Board maintains an overview of key issues each month. However, if any issues arising from these reports require Board discussion, the requirement should be alerted in advance to the Chair and Company Secretary who can amend the agenda for the day to accommodate this.

**Consent Agendas**

15. In order to maximise Board time, it is proposed that a Consent Agenda is adopted at formal Board meetings. A consent agenda groups those items, where the Board would normally accept the recommendation with little comment, into one agenda item which is then approved in one action. Transparency and accountability are key to ensuring a consent agenda is used appropriately, with all Board members having a responsibility to read and review the items and address any concerns prior to the meeting.

16. There are certain rules that apply:
    - At the beginning of the meeting, the Chair asks members if any of the consent agenda items should be moved to the regular discussion items
    - A member can request that an item be pulled from the Consent Agenda (normally via the Chair/Company Secretary two days in advance of the meeting) for clarification purposes, because he/she believes that the item requires clarification and further discussion before the Board decision or that he/she disagrees with the recommendation. The Chair will then decide whether to address the matter immediately or move it to the regular agenda as a discussion item. The remainder of the Consent Agenda items are accepted
    - When there are no items to be moved or if all requested items have been moved, the Chair identifies the remaining consent items and moves to adopt the Consent Agenda. Hearing no objections, he can announce that the recommendations on all items on the Consent Agenda have been accepted
    - The item details and recommendations that were adopted as part of the Consent Agenda are identified in the minutes.

17. This is an efficient system which facilitates greater focus on those items that require Board time and discussion. However, there is a risk that board members think they do not need to read those papers on the Consent Agenda and, therefore, approve them unread which can present issues for the Board at a later date.

18. Examples of items that would be included in the consent agenda are identified below:

- Corporate Governance Framework Handbook
- Use of the Trust Seal
- Fit & Proper Person's Review

19. What would *not* be included are:
    - Strategies
    - Annual Reports
    - Performance Reports
    - Statutory submissions

## Strategic Sessions

20. The main part of the programme would be on those items of requiring more focussed discussion e.g. Trust Strategy, Risk Appetite etc. It would also include mandatory training/awareness raising e.g. Health & Safety, Safeguarding, Cyber Security etc. Some of these sessions might involve an external facilitator.

21. It is anticipated that Strategic Sessions would not require reports (unless circulated in advance as background reading) but would predominantly be led by short presentations, setting the scene for in-depth exploration and discussion.

22. It may be that some discussions are on topics that will require a report to a subsequent Board for formal decision. This is not to have, or encourage, 'behind closed doors' discussions but rather to ensure the Board is fully informed about the item in question before being asked to take that final decision. Equally, the discussion at the strategic session might result in challenge to a position and this should be aired at the subsequent formal meeting and a response received.

## Board Development

23. Board Development Days would be focussed on moving the Board forward together towards becoming a High Performing Board and securing a positive Well Led Governance Review outcome in due course. Although individual Board members have, or are planning to have, external (e.g. NHS Providers) training in support of their role, it is suggested it might be advantageous for an early session to focus on achieving a collective understanding of roles and responsibilities, including constructive challenge within a unitary Board.

24. In the longer-term, masterclasses might be considered. Topics might include system-wide developments e.g. integrated care that might be impacted by a strategic direction set nationally etc.

25. The outline programme for 2020/21 is set out overleaf. The table also includes topics for future Strategic Sessions, including those items previously agreed in the Development Plan (*Board Away Day, June 2020*). (NB. it is hoped that the NHS Providers' Digital Development Training can be undertaken in November as a Board to Board with East Cheshire NHS FT – work is underway to identify a date). Further work is required on the Plan with a view to finalising it for Board agreement in December.

26. It is suggested that the November formal Board meeting may be rescheduled (in part or in its entirety) as a Strategic Session to accommodate an in-depth exploration of Quality Improvement

(the way forward, building on the outputs of the recent diagnostic) and the emerging Estates Strategy. The agenda items for the formal meeting have been reviewed and final checks are being undertaken to confirm if these can be deferred to the December formal Board meeting without causing any issues.

27. The rationale for the above rescheduling would be given to Governors expecting to attend the November Board meeting. As the Council of Governors takes place at end October, it is not considered that this would be an issue with Governors.

| Date | Board Away/Development Day | Strategic Session |
|---|---|---|
| **2020** | | |
| Mon 28 September | • ED&I (Enact)<br>• Risk Appetite | |
| Mon 2 November | | • Quality Improvement<br>• Estates (Infrastructure Review) |
| Mon 14 December | Trust Strategy (1) | |
| **2021** | | |
| Mon 11 January (*provisional date*) | Evaluation of Board Effectiveness (links to Well Led Governance Review) | |
| Thurs 25 February | | Trust Strategy (2) |
| April | | |
| Thurs 24 June | | |
| Early July | 'New' Board | |
| Thurs 26 August | | |
| October | | |
| Thurs 17 December | | |
| January | | |
| Thurs 25 February | | |

**Table 2: Board 'Informal' Meetings 2020/21 – 2021/22**

28. To enable the schedule of all meetings to work efficiently, and for final quality checks to be undertaken, papers will have to be submitted to Corporate Governance two working days before the circulation date identified on the schedule (Appendix 1) and to allow papers to be uploaded onto Ibabs. Corporate Governance will take responsibility for issuing invitations for all Board, Board Committee and ERAG meetings which will allow for more efficient management of these groups. Corporate Governance will also circulate the submission dates for papers for these groups to the Executive Team and Senior Managers.

## Recommendation

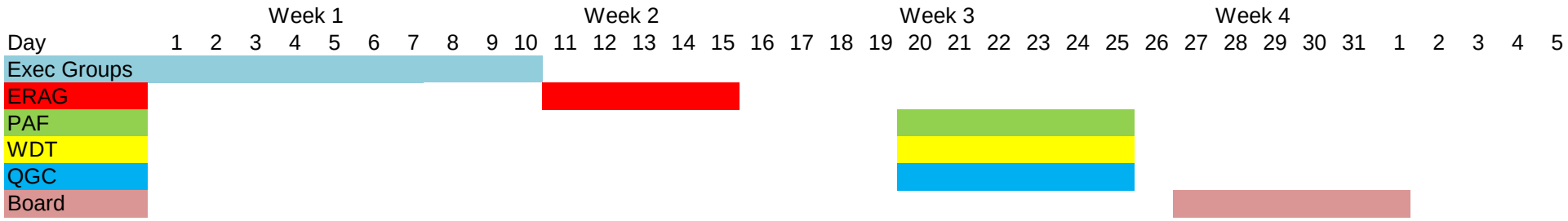
29. The Board is asked to approve the revised schedule of meetings and the introduction of a Consent Agenda from January 2021.

**Caroline Keating**
Company Secretary
25 September 2020

# Schedule of Key Meetings 2020-21

| September | October | November | December | January | February | March | April | May | June | July | August |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 Tu Execs | 1 Th | 1 Su | 1 Tu ESSEG | 1 Fri New Year's Day | 1 Mo | 1 Mo | 1 Th | 1 Sa | 1 Tu ESSEG | 1 Th | 1 Su |
| 2 We | 2 Fr | 2 Mo Board (S) | Execs | 2 Sa | 2 Tu ESSEG | 2 Tu ESSEG | 2 Fr Good Friday | 2 Su | Execs | 2 Fr | 2 Mo |
| 3 Th | 3 Sa | 3 Tu ESSEG | 2 We EQGG | 3 Su | Execs | Execs | 3 Sa | 3 Mo Bank Holiday | 2 We EQGG | 3 Sa | 3 Tu ESSEG |
| 4 Fr | 4 Su | Execs | EWAG | 4 Mo | 3 We EQGG | 3 We EQGG | 4 Su | 4 Tu ESSEG | EWAG | 4 Su | Execs |
| | 5 Mo Board (F) | 4 We EQGG | 3 Th EDRG | 5 Tu ESSEG | EWAG | EWAG | 5 Mo Easter Monday | Execs | 3 Th EDRG | 5 Mo | 4 We EQGG |
| 5 Sa | 6 Tu ESSEG | EWAG | 4 Fr | Execs | 4 Th EDRG | 4 Th EDRG | 6 Tu ESSEG | 5 We EQGG | 4 Fr | 6 Tu ESSEG | EWAG |
| 6 Su | Execs | 5 Th EDRG | 5 Sa | 6 We EQGG | 5 Fr | 5 Fr | Execs | EWAG | 5 Sa | Execs | 5 Th EDRG |
| 7 Mo Board (F) | 7 We EQGG | 6 Fr | 6 Su | EWAG | 6 Sa | 6 Sa | 7 We EQGG | 6 Th EDRG | 6 Su | 7 We EQGG | 6 Fr |
| 8 Tu ERAG | EWAG | 7 Sa | 7 Mo Board (F) | 7 Th EDRG | 7 Su | 7 Su | EWAG | 7 Fr | 7 Mo | EWAG | 7 Sa |
| Execs | 8 Th CEICP CCICP | 8 Su | 8 Tu ERAG | 8 Fr | 8 Mo | 8 Mo | 8 Th EDRG | 8 Sa | 8 Tu ERAG | 8 Th EDRG | 8 Su |
| 9 We EDRG | 9 Mo NEDs | Execs | 9 Sa | 9 Tu ERAG | 9 Tu ERAG | 9 Fr | 9 Su | Execs | Audit | 9 Mo | |
| 9 Fr | Audit | 9 We | 10 Su | Execs | Execs | 10 Sa | 10 Mo | 9 We | 9 Fr | 10 Tu ERAG | |
| 10 Th WDT | 10 Sa | 10 Tu ERAG | 10 Th | 11 Mo | 10 We | 10 We | 11 Su | 11 Tu ERAG | 10 Th | 10 Sa | Execs |
| 11 Fr | 11 Su | Execs | 11 Fr | 12 Tu ERAG | 11 Th | 11 Th | 12 Mo | Execs | 11 Fr | 11 Su | 11 We |
| 12 Sa | 12 Mo | 11 We | 12 Sa | Exec Away Day | 12 Fr | 12 Fr | 13 Tu ERAG | 12 We | 12 Sa | 12 Mo | 12 Th |
| 13 Su | 13 Tu ERAG | 12 Th | 13 Su | 13 We | 13 Sa | 13 Sa | Exec Away Day | 13 Th | 13 Su | 13 Tu ERAG | 13 Fr |
| 14 Mo Audit | Execs | 13 Fr | 14 Mo Board Away Day | 14 Th Audit | 14 Su | 14 Su | 14 We | 14 Fr | 14 Mo WDT | Execs | 14 Sa |
| Q&S | 14 We | 14 Sa | 15 Tu Execs | 15 Fr | 15 Mo WDT | 15 Mo WDT | 15 Th Audit | 15 Sa | 15 Tu Execs | 14 We | 15 Su |
| 15 Tu Execs | 15 Th | 15 Su | 16 We | 16 Sa | Exec Away Day | 16 Tu Execs | 16 Fr | 16 Su | 16 We QSC | 15 Th | 16 Mo WDT |
| 16 We | 16 Fr | 16 Mo WDT | 17 Th PAF | 17 Su | 16 Tu Execs | 17 We QSC | 17 Sa | 17 Mo WDT | 17 Th PAF | 16 Fr | 17 Tu Execs |
| 17 Th | 17 Sa | 17 Tu Execs | 18 Fr Exec Away Day | 18 Mo WDT | 17 We QSC | 18 Th PAF | 18 Su | 18 Tu Execs | 18 Fr | 17 Sa | 18 We Q&S |
| 18 Fr | 18 Su | 18 We QSC | 19 Sa | 19 Tu Execs | 18 Th PAF | 19 Fr Execs Pre Board | 19 Mo WDT | 19 We QSC | 19 Sa | 18 Su | 19 Th PAF |
| 19 Sa | 19 Mo WDT | 19 Th PAF | 20 Su | 20 We QSC | 19 Fr | 20 Sa | 20 Tu Execs | 20 Th PAF | 20 Su | 19 Mo WDT | 20 Fr |
| 20 Su | 20 Tu Exec Away Day | 20 Fr | 21 Mo WDT | 21 Th PAF | 20 Sa | 21 Su | 21 We QSC | 21 Fr Audit | 21 Mo | 20 Tu Execs | 21 Sa |
| 21 Mo | 21 We QSC | 21 Sa | 22 Tu Execs | 22 Fr Execs Pre Board | 21 Su | 22 Mo Exec Away Day | 22 Th PAF | Execs Pre Board | 22 Tu Execs | 21 We QSC | 22 Su |
| 22 Tu Execs | 22 Th PAF | 22 Su | 23 We QSC | 23 Sa | 22 Mo WDT | 23 Tu Execs | 23 Fr Execs Pre Board | 22 Sa | 23 We | 22 Th PAF | 23 Mo |
| 23 We | 23 Fr Execs Pre Board | 23 Mo | 24 Th | 24 Su | 23 Tu Execs | 24 We | 24 Sa | 23 Su | 24 Th Board (S) | 23 Fr Execs Pre Board | 24 Tu Execs |
| 24 Th | 24 Sa | 24 Tu Exec Away Day | 25 Fr Xmas Day | 25 Mo | 24 We | 25 Th Board (F) | 25 Su | 24 Mo | 25 Fr | 24 Sa | 25 We |
| 25 Fr PAF | 25 Su | 25 We | 26 Sa | 26 Tu Execs | 25 Th Board (S) | 26 Fr | 26 Mo | 25 Tu Execs | 26 Sa | 25 Su | 26 Th Board (S) |
| 26 Sa | 26 Mo | 26 Th | 27 Su | 27 We | 26 Fr | 27 Sa | 27 Tu Execs | 26 We | 27 Su | 26 Mo | 27 Fr |
| 27 Su | 27 Tu Execs | 27 Fr Execs Pre Board | 28 Mo Boxing Day | 28 Th Board (F) | 27 Sa | 28 Su | 28 We | 27 Th Board (F) | 28 Mo | 27 Tu Execs | 28 Sa |
| 28 Mo | 28 We | 28 Sa | 29 Tu Execs | 29 Fr | 28 Su | 29 Mo | 29 Th Board (F) | 28 Fr | 29 Tu Execs | 28 We | 29 Su |
| 29 Tu | 29 Th CoG | 29 Su | 30 We | 30 Sa | | 30 Tu Execs | 30 Fr | 29 Sa | 30 We | 29 Th Board (F) | 30 Mo |
| 30 We | | 30 Mo | 31 Th | 31 Su | | 31 We | 31 Sa | 30 Su | | 30 Fr | 31 Tu Execs |
| | 30 Fr | | | | | | | 31 Mo Bank Hol | | 31 Sa | |
| | 31 Sa | | | | | | | | | | |

September | October | November | December | January | February | March | April | May | June | July | August


Week 1
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Day
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 1 2 3 4 5
Exec Groups
ERAG
PAF
WDT
QGC
Board

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# BOARD OF DIRECTORS

| | | |
|---|---|---|
| **Agenda Item** | **6** | Date of Meeting: 05/10/2020 |
| **Report Title** | **Chief Executive's Report September 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
-

**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 | | | | |
| | | | | |
| | | | | |

# Chief Executive's Report
# Board Meeting – 5 October 2020

## National/Regional update

### Elective Restoration

1. The key focus nationally remains the restoration of elective activity and ensuring that Phase 3 plans are delivered. The main challenges are creating sufficient capacity, in particular in Endoscopy and Theatres, to deliver care to long-waiting patients and those referrals that have recommenced.

## Covid-19

### Performance

2. The increase in infection rates regionally is of significant concern and is replicated locally with rising admissions to Leighton Hospital. At the time of writing (29 September), there are 13 patients with confirmed Covid-19 in the hospital, two of whom are being treated in our Critical Care Unit. In response to these rising hospital admissions, and to ensure we do all we can to keep our patients and staff safe, we have re-designated two wards - one for Covid-19 surveillance, in addition to the South Cheshire Ward, and another for Covid-positive patients.

### Winter/Covid-19 Preparations

3. Winter preparations are well underway and the Trust has submitted its Winter Plan (Item 13.2 on today's agenda) to regulators.

### Restoration of Clinical Services

4. Restoration of non-Covid clinical services is making good progress and we are treating more patients than we did this time last month. This trajectory will continue notwithstanding the changing picture around Covid-19 infection rate and hospital admissions.

5. In September, the Trust submitted its final Phase 3 activity, performance and finance plan to Cheshire & Merseyside Healthcare Partnership which submitted the overall system plan to NHSE/I on 21 September. The Trust Plan identifies that, between now and March 2021, we will continue to increase activity toward pre-Covid levels; however, for elective/daycase services, restoration to 86% of pre-Covid activity levels is more likely, due to environment constraints and IPC and social distancing measures

6. The priority for the Trust remains the recovery of cancer services, firstly for those patients waiting for urgent treatment and then for those waiting the longest.

**Finance – Month 5 (August) 2020/21**

7. Following the agreed reimbursement process to end September, the Trust has received top-up payments in relation to Covid-19 expenditure up to the end of July (£5.6m) with only with more anticipated. The Trust has incurred £9.7m of costs (£1m non-recurrent) but only required £7.3m reimbursement to break even (the difference between the two mainly relates to underspends within planned care e.g. drugs and prosthetics). It is expected that the majority of these Covid-19 costs will continue for the rest of the financial year.

8. Financial Allocations – from 1 October, there will be a return to financial allocations, and the Trust has been notified of a nationally calculated baseline funding envelope which would result in a deficit of £9.8m for months 7-12 (October to March 2021). This replaces the £7.3m top up funding system referenced above (c. £8.4m for 6 months). Within the financial guidance issued, the Cheshire & Merseyside HCP has received non-recurrent funding to financially support this £9.8m shortfall to take the Trust to a break-even position, together with a further £160m for the Cheshire and Merseyside system to support additional Covid-19 costs (£132.5m) and growth (£28.3m).

9. The Trust has prepared and submitted its own internal forecast to C&M HCP which includes anticipated additional costs for Covid (£10m for the first six months and assumed similar levels for the second half of the year), premium costs associated with restoration and winter, expansion of the medical workforce and A&E and a Trust view that it will not return to 2019/20 non-patient income levels due to reduced footfall within the organisation (£2m). A decision on how the additional HCP system level financial support is to be distributed amongst providers and commissioners has yet to be made but it is a reasonable assumption to make that the Trust will receive a material amount from the £160m that should at least bring the Trust back in line with the financial plan that it initially set for 2020/21.

## Trust 'Business as Usual'

**Electronic Patient Record**

10. The Trust has received formal approval (25 September 2020) for the Digital Clinical Systems Outline Business Case from the Department of Health & Social Care and NHSI/E. This will enable us to move forward with the procurement process, in collaboration with East Cheshire NHS FT.

**Workforce**

11. **Mandatory Training and Appraisals compliance** – a task and finish group has been set up to explore different ways of tackling non-compliance with statutory and mandatory training as rates continue to be under target. The new Motiv8 appraisal programme is being rolled out across the Trust – it is anticipated that compliance will be achieved by December 2020 although this remains a risk due to workforce capacity likely to be affected over the coming months.

12. There were no reported HCA vacancies for a third consecutive month. 13 international nurses passed their OSCE (Objective Structured Clinical Examination) this week and will move to Band 5 vacancies imminently.

13. **Pathology** - consultation for the transfer of Pathology Services to the University Hospital of North Midlands (UHNM) commenced on 17 September 2020 with an effective TUPE transfer date of 1 December 2020. Joint briefing sessions (MCHFT and UHNM) are currently being held with the consultation closing on 17 October 2020.

**Author:** James Sumner, Chief Executive
**Date:** October 2020

# BOARD OF DIRECTORS

| | | |
|---|---|---|
| **Agenda Item** | **7** | Date of Meeting: 05/10/2020 |
| **Report Title** | Board Assurance Framework | |
| **Executive Lead** | James Sumner, Chief Executive | |
| **Lead Officer** | Caroline Keating, Company Secretary | |
| **Action Required** | To note | |

| | | | | | |
|---|---|---|---|---|---|
| ☐ | **Acceptable assurance**<br>General confidence in delivery of existing mechanisms / objectives | ☐ | **Partial assurance**<br>Some confidence in delivery of existing mechanisms / objectives | ☐ | **No assurance**<br>No confidence in delivery |

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

- Outputs from the controls and assurance mapping exercise presented
- Update on key operational risks

**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)*

Next full BAF report to the Board in January 2021.

Risk management procedures to be signed off by Audit Committee 9 November 2020.

Risk management training programme to commence with identified priority groups from December 2020.

Risk appetite to be developed as agreed at the Board Away Day 28 September 2020.

**REPORT DEVELOPMENT**

| Committee/ Group Name | Date | Report Title | Lead | Brief summary of key issues raised and actions agreed |
|---|---|---|---|---|
| Executive Team | 29/09/20 | Board Assurance Framework | Caroline Keating | Agreement of content of Board report and presentation from project team |
| | | | | |

# Board Assurance Framework

## Introduction

1. The Board Assurance Framework (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 previous reports. The new arrangements 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.

## BAF updates

3. Mapping of the full set of controls and assurances aligned with the principal risks has continued in consultation with Executive Risk Leads (ERLs). This report provides an update on current risk scores (see Appendix 1) and presents the BAF detail collated to date (Appendix 2). Good progress has been made in mapping the controls and assurance for all risks, and it is anticipated that the full set of inputs will be complete by the end of Q3 to include:
    - all available assurance ratings (acceptable/partial/low);
    - target risk scores;
    - actions to address control and assurance gaps.

4. The assurance mapping work includes identifying any relevant assurances submitted to date or due to be submitted for review by the Board and/or Board Committees. This includes any Internal Audit reports received and considered by the Audit Committee as external (3rd line) assurance. During the first half of this financial year, the following audits relating to BAF controls have been completed:
    - Incident Reporting (acceptable assurance) – BAF 8
    - Medical Devices (low assurance) – BAF 13

    A task & finish group has been set up to address the recommendations from the Internal Audit Report on Medical Devices. The action plan is due to be submitted to the Audit Committee in November.

5. BAF7 remains the highest priority risk, reflecting pressures across a number of services in the wake of Covid. The Trust's restoration plan to address activity, performance and finance

is considered to be robust and deliverable within the capacity and resources available, whilst also taking into account IPC and social distancing measures.

6. Given the current position regarding the Trust infrastructure, it is proposed that the risk score for BAF 13 is increased from a 12 (3 x 4) to a 15 (3 x 5) to reflect the number of high scoring operational risks in place. It is also proposed that the risk scoring for BAF 6 is reduced from a 12 (3 x 4) to an 8 (2 x 4) in light of the approval by the Department of Health & Social Care and NHSE/I of the Trust's Outline Business Case for the Electronic Patient Record.

7. The BAF Heatmap (Appendix I) includes directional arrows to indicate this anticipated risk movement over the next quarter.

8. The next quarterly BAF report is scheduled to be considered by the Board at its meeting in January 2021.

## Risk and assurance framework development – key updates

9. Work completed to date to improve the visibility of the Trust's risks, key controls and associated assurances includes:
    - the introduction of new-style agendas for the Board and all Board Committees, which facilitates identification of items relating to the BAF;
    - the inclusion of a BAF reference page, as a standing item, highlighting the principal risks assigned to each Committee;
    - submission of new-style summary reports to Board Committees from the Chairs of the Executive Groups highlighting key risks reviewed and associated risk management actions.

10. The first meeting of the new Executive Risk and Assurance Group (ERAG) was held on 8 September 2020. The Chief Executive set out the purpose of the Group and explained how it would work in practice. Members were also asked to view a recording of a presentation on risk management principles given by Conway Bloomfield Ltd, Risk & Governance Consultancy, adapted from the sessions held earlier in the year with the Executive Team and the Board. This is to ensure that a consistent message is cascaded throughout the organisation and to introduce senior leaders to a standardised risk language that will be adopted. It is acknowledged that further training is required and a plan has been developed to launch a training progamme, using interactive workshops, from December 2020 with senior leaders.

11. The Risk Management Procedures that underpin the Risk Management Strategy and set out how risk is managed at the Trust will be reviewed collaboratively by Corporate & Quality Governance and submitted to the Audit Committee in November for approval. These procedures will be used to reinforce the learning at the planned training workshops.

12. The Board began to develop its approach to risk appetite at its Away Day in September. The outputs of this discussion will be collated and next steps confirmed with the Board in October.

## Operational risk

13. With the enhanced focus on risk throughout the Trust's governance structure, the operational risk register will be subject to a high degree of scrutiny over the next few months to ensure that the risk records accurately reflect current risk profiles. This will include identifying gaps, moderating risk scores, and ensuring that there is transparency about decisions to manage or tolerate risks and the implications of doing so. The ERAG will drive these discussions and will be supported by a Risk Sub-Group to review the quality of risk management in more depth – this Sub-Group met for the first time 1 October 2020 to set out its priorities for the first six months. Executive Groups and Divisional Boards also play an important part in ensuring risks are appropriately assessed, managed and reviewed.

14. The following table provides an update on the key operational risks that were highlighted to the Board in September. The scores are unchanged but the next steps have been updated (highlighted in red) to reflect progress in managing these risks. A new risk (Medical Devices) has been added:

| Risk | Current score (LxC) | Next steps |
|---|---|---|
| Failure of a RAAC roof plank creating a critical risk to health and safety and/or business continuity | **4x5=20** | The Trust is progressing 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. |
| *NEW*: Medical devices may not be appropriately managed, tracked and disposed of to ensure patient information is secure and they may pose a security weakness to the Trust's wider network | **4x4=16** | Medical Devices Group established a Task & Finish Group to agree action plan to address issues and recommendations from Internal Audit report. Plan to October Exec Safe & Sustainable Environment Group (formerly EIDG) with progress reported back to Audit Committee in November |
| 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** | Capital monies agreed for the A&E extension into an Urgent Care Village. Work on-going with Design & Build company. Business case, completed and submitted nationally, identified |

| Risk | Current score (LxC) | Next steps |
|---|---|---|
| | | revenue consequences. Anticipated completion of ED expansion May 2021 |
| 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 | Outwith Trust control but due to delay in receiving bid approval, delayed completion to May 2021 considered realistic and helps mitigate the risks of rebuilding during winter. |
| 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 are to be undertaken. |
| 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 | Phase 3 restoration plan addresses capacity issues within available resource. |
| 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. |

## Conclusion

15. 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.

## Recommendation

16. 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: 25 September 2020**

## Appendix 1 BAF heatmap: current scores

| SO1<br>**Manage the impact of the Covid-19 pandemic and ensure safe recovery** | SO2<br>**Deliver outstanding care and patient experience** | SO3<br>**Deliver the most effective care to achieve best possible outcomes** | SO4<br>**Ensure MCHFT is the best place to work** | SO5<br>**Provide safe and sustainable healthcare to our population** | SO6<br>**Provide strong system leadership by working together** | SO7<br>**Be well governed and clinically led** |
|---|---|---|---|---|---|---|
| **BAF1** Inadequate arrangements for safe management of pandemic against national guidance<br>2 x 4 = 8 | **BAF3** Inability to close the nurse staffing vacancy gap<br>3 x 4 = 12 | **BAF7** Inability to provide sufficient capacity to meet demand and achieve operational standards<br>5 x 4 = 20 | **BAF10** Failure to attract, retain and support a high performing workforce<br>3 x 4 = 12 | **BAF13** Failure to provide modern, efficient, sustainable estate, infrastructure and equipment ⇧<br>3 x 5 = 15 | **BAF16** Failure to enable a successful Integrated Care Partnership and carry out its hosting responsibility<br>3 x 3 = 9 | **BAF19** Inappropriate governance systems to foster a risk assurance culture<br>4 x 3 = 12 |
| **BAF2** Failure to manage risks to business continuity identified during Covid<br>2 x 4 = 8 | **BAF4** The Trust's environments are not adequately safe and secure for staff, patients and visitors<br>3 x 4 = 12 | **BAF8** Insufficiently robust processes for clinical audit and quality improvement, learning and implementation of new practice<br>3 x 3 = 9 | **BAF11** Failure to harness the benefits of technology to integrate, streamline and improve systems of working<br>3 x 4 = 12 | **BAF14** Failure to adequately plan future workforce requirement<br>3 x 4 = 12 | **BAF17** Ineffective capacity across the Health and Social Care system<br>3 x 4 = 12 | **BAF20** Failure to establish appropriate governance and risk mitigation around existing and new collaborative models of working<br>3 x 3 = 9 |
| | **BAF5** The Trust's Quality Improvement approach does not help address the highest clinical challenges<br>3 x 3 = 9 | **BAF9** Failure to use high quality activity and patient outcome data to assess quality of care<br>4 x 3 = 12 | **BAF12** Failure to create the conditions for an effective organisational culture<br>2 x 4 = 8 | **BAF15** Inadequate financial management, budgetary controls, and efficiency planning<br>2 x 4 = 8 | **BAF18** The Trust fails to play its part in a successful Cheshire System<br>**Inactive*** | **BAF21** Failure to develop leadership capacity and capability throughout the organisation<br>3 x 4 = 12 |
| | **BAF6** Failure to proceed with EPR development and implementation ⇩<br>2 x 4 = 8 | | | | | |

| 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 report

Mid Cheshire Hospitals NHS
NHS Foundation Trust

| | |
|---|---|
| **Report Date** | 25 Sep 2020 |
| **Risk Status** | Open |
| **Risk Area** | Strategic Risks |

Mid Cheshire Hospitals NHS
NHS Foundation Trust

## Strategic Risks

| Risk Ref | Risk Title | Cause & Area of Impact | Risk Control | Control Assurance (1st Line Assurance) | 1st Line Assurance Assurance Level | Control Assurance (2nd Line Assurance) | 2nd Line Assurance Assurance Level | Control Assurance (3rd Line Assurance) | 3rd Line Assurance Assurance Level | 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<br>**Executive Risk Lead:** Oliver Bennett<br>**Last Updated:** 25 Sep 2020 | **Cause**<br>1. Limited leadership capacity and experience<br>2. Lack of agility and pace<br>3. Poor governance of decision-making<br>4. Lack of coordinated approach internally and system-wide<br>5. Insufficient use of evidence to inform plans<br>6. Inadequate communication, sharing information and engagement<br>**Areas of Impact**<br>1. Patient care and safety<br>2. Workforce safety and morale<br>3. Reputation<br>4. Regulatory | 1. Command and control structure to respond to and deliver all necessary plans and preparations in relation to pandemic management<br>**Control Owner:** Oliver Bennett | 1. Covid performance dashboard presented to each Silver Command meeting<br>2. Covid update standing item on PAF agenda<br>3. COO report submitted to PAF as interim measure prior to establishment of Executive Delivery & Restoration Group | | | | | | C = 4 L = 2 8 |
| | | | 2. SOPs to reflect National emergency planning and business continuity requirements<br>**Control Owner:** Oliver Bennett | Emergency Preparedness, Resilience and Response annual report to Board December 2020 | | | | CCG assurance expected end October 2020 | | |
| | | | 3. Process for systematic review of lessons learnt<br>**Control Owner:** Oliver Bennett | Learning from Covid report submitted to PAF August 2020 identified outputs from review process | | | | | | |
| | | | 4. Winter/COVID Plan - Trust-wide and system-wide (Cheshire) to be submitted to PAF and the Board for approval October 2020<br>**Control Owner:** Oliver Bennett | 1. Review including lessons learned on Board workplan for May/June 2021<br>2. Winter plan tracked and progress documented at the Winter Planning Group with updates documented at Silver Command and escalated to Gold if necessary. | | | | | | |
| | | | 5. Single point of contact (Director of Operations) for receipt of all national guidance with back-up in place to avoid single point of failure<br>**Control Owner:** Oliver Bennett | | | | | | | |
| 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<br>**Executive Risk Lead:** Russell Favager<br>**Last Updated:** 01 Sep 2020 | **Cause**<br>1. Poor risk management arrangements<br>2. Insufficient leadership capacity/capability<br>3. Resistance to change<br>4. Inadequate processes for learning from pandemic<br>**Areas of Impact**<br>1. Patient care and safety<br>2. Workforce safety and morale<br>3. Reputation<br>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)<br>**Control Owner:** Russell Favager | Lead Directors provide fortnightly updates to BCG | | 1. Fortnightly updates to Exec Team highlighting areas of concern / escalation (which informs CEO's monthly report to Board by exception)<br>2. Each Board Committee has a standing item and receives update on Covid-19 ISSUES applicable to them on a monthly basis | | | | C = 4 L = 2 8 |

## Strategic Risks

| Risk Ref | Risk Title | Cause & Area of Impact | Risk Control | Control Assurance (1st Line Assurance) | 1st Line Assurance Assurance Level | Control Assurance (2nd Line Assurance) | 2nd Line Assurance Assurance Level | Control Assurance (3rd Line Assurance) | 3rd Line Assurance Assurance Level | Current Rating |
|---|---|---|---|---|---|---|---|---|---|---|
| BAF 3 | IF the widening nurse staffing vacancy gap is not closed THEN patient care could be detrimentally impacted<br>**Executive Risk Lead:** Julie Tunney<br>**Last Updated:** 01 Sep 2020 | **Cause**<br>1. National shortages<br>2. Competition between providers<br>3. Poor perception of pay and working conditions and the impact of COVID experience<br>4. Geographical location and transport access<br>5. Impact of Brexit on overseas workforce availability<br>6. Inability to secure international nurse recruits from overseas due to COVID<br>7. Inability to attract pre-registration nurses due to lack of bursaries<br>8. Failure to deliver UK Adaptation Programme<br>9. Failure to consider alternative opportunities to support nursing workforce<br>**Areas of Impact**<br>1. Patient care and safety<br>2. Financial: agency expenditure<br>3. Workforce morale<br>4. Reputation as employer / of nursing<br>5. Regulatory | 1. Closing the gap' plan 2023<br>**Control Owner:** Heather Barnett | | | 1. 'Closing the gap' report bi-monthly to EWAG<br>2. Safe Staffing reported monthly to Board | | CQC assessment | | C = 4 L = 3<br>12 |
| | | | 2. Multi-disciplinary clinical workforce plan includes 3 relevant workstreams: New Ways of Working, Recruitment and Retention, Maximising Potential<br>**Control Owner:** Heather Barnett | Monthly updates to Multi-disciplinary Clinical Workforce Group | | | | | | |
| | | | 3. Our Workforce Matters Strategy 2019 -21 (relevant aspects)<br>**Control Owner:** Heather Barnett | Our Workforce Matters annual report | | Nurse workforce metrics included in the Workforce Report reported via WDT to Board of Directors | | | | |
| | | | 4. Health & Wellbeing agenda (relevant aspects eg. sickness etc)<br>**Control Owner:** Heather Barnett | | | Health & Wellbeing quarterly report to EWAG | | NHSI/E Organisational Pulse Survey results reported to EWAG and to WTGC | | |
| | | | 5. Bank Incentive Schemes for RNs<br>**Control Owner:** Heather Barnett | Bank Incentive Scheme review report to AEMG | | | | | | |
| BAF 4 | IF the Trust does not ensure safe and secure environments for staff, patients and visitors THEN avoidable harm could occur<br>**Executive Risk Lead:** Russell Favager<br>**Last Updated:** 25 Sep 2020 | **Cause**<br>1. Inadequate focus on H&S<br>2. Water safety (legionella)<br>3. Ineffective security arrangements<br>4. Asbestos<br>6. Fire safety compliance<br>7. Contamination with dangerous substances<br>8. Slips, trips & falls<br>**Areas of Impact**<br>1. Health & Safety<br>2. Workforce morale<br>3. Reputation<br>4. Legal<br>5. Financial | 1. Fire Management Improvement Plan to 2023<br>**Control Owner:** Russell Favager | Workplace inspections - Fire Safety Assessments | | | | 1. Cheshire Fire & Rescue (CFR) Audit Programme Sept 2018 - Positive Audit Feedback<br>2. Annual audit by Authorising Engineer reported to Estates Divisional Board and H&S Group | Acceptable | C = 4 L = 3<br>12 |
| | | | 2. Asbestos Management Programme and register<br>**Control Owner:** Russell Favager | | | | | Annual audit by Authorising Engineer reported to Estates Divisional Board and H&S Group | | |
| | | | 3. H&S Policy and procedures<br>**Control Owner:** Russell Favager | Workplace inspections risk assessments | | Incident reporting to H&S Group (including RIDDOR) | | | | |
| | | | 4. Control of Substances Hazardous to Health (COSHH) register<br>**Control Owner:** Russell Favager | Compliance checks by H&S Manager | | | | | | |
| | | | 5. Management of Aggressive Behaviour Procedure (Security Team)<br>**Control Owner:** Russell Favager | Incident reporting via Ulysses | | | | | | |
| | | | 6. Water Safety Plan & Procedure<br>**Control Owner:** Russell Favager | Progress reports to Water Safety Group and Estates Divisional Board | | | | Annual audit by Authorising Engineer reported to Estates Divisional Board and H&S Group | | |

## Strategic Risks

| Risk Ref | Risk Title | Cause & Area of Impact | Risk Control | Control Assurance (1st Line Assurance) | 1st Line Assurance Assurance Level | Control Assurance (2nd Line Assurance) | 2nd Line Assurance Assurance Level | Control Assurance (3rd Line Assurance) | 3rd Line Assurance Assurance Level | 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<br>**Executive Risk Lead:** Julie Tunney<br>**Last Updated:** 01 Sep 2020 | **Cause**<br>1. QI methodoogy not embedded throughout organisation<br>2. Quality improvement not underpinned by evidence<br>3. Approach not developed in consultation with all relevant stakeholders<br>**Areas of Impact**<br>1. Patient care, safety and experience<br>2. Reputation as an employer for clinical staff<br>3. Regulatory<br>4. Public perception | 1. Quality & Safety Improvement Strategy 2020/21<br>**Control Owner:** Julie Tunney | | | 1. Quality, Safety & Experience Report to Q&SC monthly<br>2. Quality Account to Q&SC annually (April 2019) | | 1. CQC report May 2020<br>2. IA Quality Account internal audit – April 2019 (outcome?) | | C = 3 L = 3<br>9 |
| | | | 2. IPC Strategy (DIPC policies/procedures)<br>**Control Owner:** Julie Tunney | | | 1. IPC BAF Aug Board approved<br>2. IPC BAF updates 6 monthly to Q&SC | | 1. CQC inspections<br>2. MIAA audit 2018 | | |
| | | | 3. Ward accreditation programme<br>**Control Owner:** Julie Tunney | | | Annual Report to Q&SC | | 1. CQC full inspection<br>2. MIAA audit 2019 | | |
| | | | 4. Dedicated Quality Team deliver Q&SI strategy<br>**Control Owner:** Julie Tunney | | | | | | | |
| 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<br>**Executive Risk Lead:** Amy Freeman<br>**Last Updated:** 25 Sep 2020 | **Cause**<br>1. Insufficient financing<br>2. Inadequate business case to meet regulatory requirements<br>3. Business case approval process changing creating uncertainty<br>4. Relationship changes lead to affordability issues<br>**Areas of Impact**<br>Fall-back is status quo which is not sustainable and would negatively affect:<br>1. Patient care and safety<br>2. Reputation<br>3. Efficiency benefits<br>4. Running costs<br>5. Cyber security<br>6. Clinical audit | 1. Business case development process (with external support)<br>**Control Owner:** Amy Freeman | EPR update reports to W&DTC monthly | | | | Approval of the OBC from DoHSC and NHSEI 25/09/20 | Acceptable | C = 4 L = 3<br>12 |
| | | | 2. Regular engagement with NHSI/E<br>**Control Owner:** Amy Freeman | | | | | | | |
| | | | 3. Trust Systems Support Model self-assessment for EPR readiness<br>**Control Owner:** Amy Freeman | TSSM self-assessment results to DTIS Group 30/06/20 | Acceptable | | | | | |
| | | | 4. Five OGC gateway reviews<br>**Control Owner:** Amy Freeman | | | OGC gateway review included in Business Case approved by Board Jan 2019 | | | | |
| | | | 5. MoU with partners signed off by the Board Nov 2019<br>**Control Owner:** Amy Freeman | | | | | | | |
| | | | 6. Output based specification ready for procurement<br>**Control Owner:** Amy Freeman | | | | | | | |

## Strategic Risks

| Risk Ref | Risk Title | Cause & Area of Impact | Risk Control | Control Assurance (1st Line Assurance) | 1st Line Assurance Assurance Level | Control Assurance (2nd Line Assurance) | 2nd Line Assurance Assurance Level | Control Assurance (3rd Line Assurance) | 3rd Line Assurance Assurance Level | Current Rating |
|---|---|---|---|---|---|---|---|---|---|---|
| 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<br>**Executive Risk Lead:** Oliver Bennett<br>**Last Updated:** 25 Sep 2020 | **Cause**<br>1. Workforce gaps<br>2. IPC measures including social distancing<br>3. Changing patterns of demand<br>4. Access to the independent sector<br>5. Physical environment is restrictive<br>**Areas of Impact**<br>1. Patient care and experience<br>2. Patient outcomes<br>3. Reputation<br>4. Regulatory | 1.1. A&E: successful capital bid to build new A&E with 7 day operating<br>**Control Owner:** Oliver Bennett | | | | | | | C = 4 L = 5 20 |
| | | | 1.2. A&E: Urget Care Implementation Plan<br>**Control Owner:** Oliver Bennett | | | | | | | |
| | | | 1.3. A&E: NHS 111 Implementation Plan<br>**Control Owner:** Oliver Bennett | | | | | | | |
| | | | 2.1. RTT: Elective Care Restoration Plan submitted to PAF and Board September and October 2020 respectively<br>**Control Owner:** Oliver Bennett | | | | | | | |
| | | | 2.2. Outpatient Transformation Programme to reduce demand and change delivery - plan submitted to PAF (date?)<br>**Control Owner:** Oliver Bennett | | | | | | | |
| | | | 2.3. RTT: National contracts with independent sector to increase capacity<br>**Control Owner:** Oliver Bennett | | | | | ISP Utilisation Report identifies MCHFT uptake of available IS capacity | | |
| | | | 3.1. Diagnostics: Phase 3 Restoration Plan submitted to PAF and Board in September and October 2020 respectively<br>**Control Owner:** Oliver Bennett | | | | | | | |
| | | | 3.2. Diagnostics: independent sector capacity (national contracts)<br>**Control Owner:** Oliver Bennett | | | | | | | |
| | | | 4.1. Cancer Services: Restoration Plan<br>**Control Owner:** Oliver Bennett | | | | | | | |
| | | | 5. Winter/COVID Plan - Trust-wide and system-wide (Cheshire) that is submitted to PAF and the Board for approval October 2020<br>**Control Owner:** Oliver Bennett | 1. Review including lessons learned on Board workplan for May/June 2021.<br>2. Winter plan tracked and progress documented at the Winter Planning Group with updates documented at Silver Command and escalated to Gold if necessary. | | | | | | |

## Strategic Risks

| Risk Ref | Risk Title | Cause & Area of Impact | Risk Control | Control Assurance (1st Line Assurance) | 1st Line Assurance Assurance Level | Control Assurance (2nd Line Assurance) | 2nd Line Assurance Assurance Level | Control Assurance (3rd Line Assurance) | 3rd Line Assurance Assurance Level | 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<br>**Executive Risk Lead:** Murray Luckas<br>**Last Updated:** 25 Sep 2020 | **Cause**<br>1. Lack of coordinated approach<br>2. Poor dissemination of information<br>3. Complex Governance processes<br>**Areas of Impact**<br>1. Patient care and safety<br>2. Reputation<br>3. Regulatory | 1. Clinical Governance Team annual programme of work incorporating audit, research and QI faculty<br>**Control Owner:** Murray Luckas | 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<br>**Control Owner:** Murray Luckas | Divisional Governance monitoring of action plans and exception reporting to EQGG | | | | 1. CQC Good rating - May 2020<br>2. CQC Insight Report<br>3. HQUIP Audits<br>4. GIRFT | | |
| | | | 3. The Trust participates with the Advancing Quality programme (AQuA) and the implementation of recommendations is tracked<br>**Control Owner:** Murray Luckas | Advancing Quality workstream reports from QI Faculty? | | | | AQuA annual reports? | | |
| | | | 4. Arrangements for assessing compliance with NICE guidance<br>**Control Owner:** Murray Luckas | Compliance included in Divisional governance dashboards reported to EQGG | | | | | | |
| | | | 5. Incident reporting and investigation processes<br>**Control Owner:** Murray Luckas | | | | | Internal Audit 2020 - Incident Reporting | Acceptable | |
| 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<br>**Executive Risk Lead:** Murray Luckas<br>**Last Updated:** 25 Sep 2020 | **Cause**<br>1. Accessibility of data<br>2. Data quality<br>3. Inadequate data analysis capacity and capability<br>4. Inadequate data management software<br>5. Limited scope of existing data to surgical outcomes<br>**Areas of Impact**<br>1. Patient care<br>2. Reputation<br>3. Regulatory | 1. Learning from Deaths Policy & Mortality Review Process (Divisional & Corporate)<br>**Control Owner:** Murray Luckas | Divisional Mortality reports | | Quarterly Learning from Deaths Report to QSC and Board (September 2020) | Acceptable | 1. Nationally benchmarked mortality data<br>2. AQuA Quarterly Mortality Report | | C = 3 L = 4 12 |
| | | | 2. Action planning based on GIRFT findings<br>**Control Owner:** Murray Luckas | Departmental plans monitored locally | | | | GIRFT revisit? | | |
| | | | 3. Participation with Outcome Registries<br>**Control Owner:** Murray Luckas | Departmental plans monitored locally | | | | Annual registry reports | | |

## Strategic Risks

| Risk Ref | Risk Title | Cause & Area of Impact | Risk Control | Control Assurance (1st Line Assurance) | 1st Line Assurance Assurance Level | Control Assurance (2nd Line Assurance) | 2nd Line Assurance Assurance Level | Control Assurance (3rd Line Assurance) | 3rd Line Assurance Assurance Level | Current Rating |
|---|---|---|---|---|---|---|---|---|---|---|
| BAF 10 | IF the Trust cannot attract, retain and support a high performing workforce THEN quality of care is likely to deteriorate<br>**Executive Risk Lead:** Heather Barnett<br>**Last Updated:** 01 Sep 2020 | **Cause**<br>1. National shortages<br>2. Limited flexible working options<br>3. Competition between providers<br>4. Geographical location and transport access<br>5. Perception as an employer<br>6. Impact of Brexit on overseas workforce availability<br>7. Inadequate performance management and appraisal processes<br>8. Limited career pathways<br>9. Mismatch between skills and learning needs and education provision<br>10. Lack of University presence to attract students<br>11. Failure to embrace diversity & inclusion<br>12. Poor leadership<br>**Areas of Impact**<br>1. Workforce capacity & capability<br>2. Organisational resilience<br>3. Workforce morale<br>4. Reputation as an employer<br>5. Regulatory<br>6. Patient care and experience | 1. Our Workforce Matters Strategy 2019 -21<br>**Control Owner:** Heather Barnett | Our Workforce Matters annual report | | 'Medical staffing workforce metrics included in the Workforce Report reported via WDTC to Board of Directors | | | | 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<br>**Control Owner:** Heather Barnett | Multi-disciplinary Clinical Workforce Group report to EWAG | | | | | | |
| | | | 3. Health & Wellbeing Plan<br>**Control Owner:** Heather Barnett | | | 'Health & Wellbeing quarterly report to EWAG | | NHSI/E Organisational Pulse Survey results reported to EWAG and to WTGC | | |
| | | | 4. Annual Staff Survey process and action planning<br>**Control Owner:** Heather Barnett | | | Staff survey results reported to Board and WDTC, and also reported to JCNC | | Annual National Staff Survey results | | |
| | | | 5. Recruitment policies & process<br>**Control Owner:** Heather Barnett | | | MIAA Audit tool results reported to EWAG and WDT | | Internal Audit 2020 - vacancies | | |
| | | | 6. Apprenticeship Programmes<br>**Control Owner:** Heather Barnett | | | Apprenticeship levy usage report to EWAG and JCNC | | | | |
| | | | 7. ED&I Strategy<br>**Control Owner:** Heather Barnett | | | Annual ED&I report to WDTC and Board | | 1. National benchmarking WRES and WDES report to WTGC and Board<br>2. Gender pay gap results to WTGC and Board | | |
| | | | 8. Suite of HR policies that support management of high performing workforce<br>**Control Owner:** Heather Barnett | | | | | Internal Audits reported to WDTC - Electronic Staff Record 2019? | | |
| 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<br>**Executive Risk Lead:** Amy Freeman<br>**Last Updated:** 10 Sep 2020 | **Cause**<br>1. Insufficient financing<br>2. Inadequate business cases<br>3. Poor prioritisation processes<br>4. Low digital maturity<br>5. Limited ability to attract digital skills<br>**Areas of Impact**<br>1. Patient care, safety and experience<br>2. Reputation as provider and as an employer<br>3. Use of resources (efficiency, effectiveness, economy)<br>4. Workforce morale and productivity<br>5. Cyber security | 1. IT Strategy aligned with DIGIT@LL Strategy 2018-22 (refresh due April 2021)<br>**Control Owner:** Amy Freeman | Updates to DTIS and WDTC every two 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)<br>**Control Owner:** Amy Freeman | | | | | HIMSS report to WDTC with discussion about priorities | | |
| | | | 3. Horizon scanning events with suppliers to identify innovation in the sector<br>**Control Owner:** Amy Freeman | Updates to DTIS and WDTC | | | | | | |

## Strategic Risks

| Risk Ref | Risk Title | Cause & Area of Impact | Risk Control | Control Assurance (1st Line Assurance) | 1st Line Assurance Assurance Level | Control Assurance (2nd Line Assurance) | 2nd Line Assurance Assurance Level | Control Assurance (3rd Line Assurance) | 3rd Line Assurance Assurance Level | 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<br>**Executive Risk Lead:** James Sumner<br>**Last Updated:** 01 Sep 2020 | **Cause**<br>1. Poor leadership (tone from the top)<br>2. Misalignment of strategy and culture<br>3. Inadequate strategic focus on culture<br>4. Inadequate / inappropriate internal communications and cascade mechanisms<br>5. Poor understanding of overarching culture and sub-cultures<br>6. Insufficient focus on embedding culture at all levels<br>**Areas of Impact**<br>1. Workforce behaviours and morale<br>2. Patient care and experience<br>3. Reputation as an employer<br>4. Public perception<br>5. Regulatory | 1. Trust strategic priorities 2020-21 include culture<br>**Control Owner:** James Sumner | | | | | | | C = 4 L = 2 8 |
| | | | 2. Our Workforce Matters Strategy 2019 -21<br>**Control Owner:** Heather Barnett | Our Workforce Matters annual report | | Workforce metrics reporting and analysis reported to EWAG and via Integrated Performance Report to WDTC and Board | | | | |
| | | | 3. Communication and Engagement Strategy<br>**Control Owner:** Heather Barnett | Comms and Engagement bi-annual report to Workforce Group | | | | | | |
| | | | 4. Leadership Framework<br>**Control Owner:** Heather Barnett | Learning from Covid presentation | | | | | | |
| | | | 5. ED&I Strategy<br>**Control Owner:** Heather Barnett | | | Annual ED&I report to WDTC and Board | | 1. National benchmarking WRES and WDES report to WTGC and Board<br>2. Gender pay gap results to WTGC and Board | | |
| | | | 6. Annual Staff Survey Process and action planning<br>**Control Owner:** Heather Barnett | | | Staff survey results reported to Board and WDTC, and also reported to JCNC | | Annual National Staff Survey results | | |
| | | | 7. Quality Improvement strategy and action plan include culture elements<br>**Control Owner:** Heather Barnett | | | Internal OD Diagnostic reported to Execs and Board (organisational readiness assessment) | | Annual Patient Survey results includes culture of care and compassion to Board | | |

## Strategic Risks

| Risk Ref | Risk Title | Cause & Area of Impact | Risk Control | Control Assurance (1st Line Assurance) | 1st Line Assurance Assurance Level | Control Assurance (2nd Line Assurance) | 2nd Line Assurance Assurance Level | Control Assurance (3rd Line Assurance) | 3rd Line Assurance Assurance Level | 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<br>**Executive Risk Lead:** Russell Favager<br>**Last Updated:** 25 Sep 2020 | **Cause**<br>1. Old buildings / deteriorating physical environment<br>2. Ageing medical equipment<br>3. Competing priorities for investment<br>4. Lack of strategic approach to estates planning<br>5. Environmental sustainability considerations insufficiently embedded<br>6. Concrete (RAAC) roof planks<br>7. Unsupported IT systems and databases<br>**Areas of Impact**<br>1. Patient care, safety and experience<br>2. Workforce morale<br>3. Reputation<br>4. Regulatory | 1. Estates Strategy in place to 2020<br>**Control Owner:** Russell Favager | Estates & Facilities Divisional Assurance Framework reports to Divisional Board | | 1. Estates Annual report<br>2. Annual Sustainability report to Board? | | New Build Certification | | C = 4 L = 3 12 |
| | | | 10. Medical Devices maintenance and upgrade plans<br>**Control Owner:** Murray Luckas | | | | | Internal Audit 2020 - Medical Devices (operational and technical controls) | Low | |
| | | | 2. Capital programme expenditure agreed annually (Estates Infrastructure Development Group)<br>**Control Owner:** Russell Favager | Capital Exceptions report to IDG and Divisional Board (cost and programme) | | | | | | |
| | | | 3. 6 Facets survey includes environmental performance<br>**Control Owner:** Russell Favager | Self audits against NHS sustainability audit tool (every six months) | | | | | | |
| | | | 4. Compliance of Trust's environments with Equalities Act<br>**Control Owner:** Russell Favager | | | | | PLACE Assessments (members of the public) reported to Divisional Board (&?) before published nationally | | |
| | | | 5. Survey programme re RAAC beams<br>**Control Owner:** Russell Favager | | | | | | | |
| | | | 6. Cyber security action plan and risk register<br>**Control Owner:** Amy Freeman | Cyber report to DTIS every six months | | | | 1. Annual penetration tests<br>2. Internal Audit of cyber security processes 2020 | | |
| | | | 7. IT Strategy and plan reference priorities for maintenance and improvement of key systems<br>**Control Owner:** Amy Freeman | | | | | | | |
| | | | 8. IT contracts review process<br>**Control Owner:** Amy Freeman | | | | | | | |
| | | | 9. Backlog Maintenance planning<br>**Control Owner:** Russell Favager | | | Annual ERIC returns to NHSI provide information about the physical condition of the Estate (includes 6 Facets information) | | | | |

## Strategic Risks

| Risk Ref | Risk Title | Cause & Area of Impact | Risk Control | Control Assurance (1st Line Assurance) | 1st Line Assurance Assurance Level | Control Assurance (2nd Line Assurance) | 2nd Line Assurance Assurance Level | Control Assurance (3rd Line Assurance) | 3rd Line Assurance Assurance Level | 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<br>**Executive Risk Lead:** Heather Barnett<br>**Last Updated:** 01 Sep 2020 | **Cause**<br>1. Poor horizon scanning and forecasting<br>2. Poor understanding of expectations of young people entering workforce<br>3. Insufficient consideration of workforce in strategic planning<br>4. Misalignment of workforce planning, activity and finance<br>5. Lack of accurate and up-to-date workforce information and data<br>6. Lack of workforce planning capacity and capability<br>7. Poor communication between education providers / HEE / Providers<br>**Areas of Impact**<br>1. Sustainability of services<br>2. Workforce morale<br>3. Reputation as an employer<br>4. Regulatory<br>5. Patient care and experience | 1. Our Workforce Matters Strategy 2019 -21<br>**Control Owner:** Heather Barnett | Our Workforce Matters annual report | | Workforce metrics reporting and analysis reported to EWAG and via Integrated Performance Report to WDTC and Board | | | | C = 4 L = 3 12 |
| | | | 2. Annual Workforce Plan reviewed by EWAG and WDTC<br>**Control Owner:** Heather Barnett | Annual workplan report to WDTC | | | | Annual NHSI/E Workforce plan submission reported to WDTC | | |
| | | | 3. Workforce Systems Project group and action plan<br>**Control Owner:** Heather Barnett | Quarterly progress report to EWAG and 6 monthly to WDTC | | | | | | |
| | | | 4. E-roster project implementation plan<br>**Control Owner:** Heather Barnett | E-roster reporting on nursing / HCA staff groups | | E-roster report to EWAG | | | | |
| | | | 5. Recruitment Policies and Process<br>**Control Owner:** Heather Barnett | | | MIAA Audit tool results reported to EWAG and WDT | | Internal Audit 2020 - vacancies | | |
| | | | 6. Education Strategy<br>**Control Owner:** Heather Barnett | Education, Learning and OD report to EWAG quarterly | | | | HEE Self-Assessment Review (SAR) annual to Board | | |
| | | | 7. Apprentice Programme<br>**Control Owner:** Heather Barnett | | | Apprenticeship levy usage report to EWAG and JCNC | | | | |
| | | | 8. Volunteer plan<br>**Control Owner:** Heather Barnett | Volunteer annual report to WTDG | | | | | | |
| BAF 15 | IF financial management, budgetary controls and efficiency planning are not robust THEN the Trust may not deliver its financial targets<br>**Executive Risk Lead:** Russell Favager<br>**Last Updated:** 01 Sep 2020 | **Cause**<br>1. Inappropriate financial planning<br>2. Poor financial data<br>3. Low understanding of local budgetary responsibilities<br>4. Poor compliance with financial controls<br>5. Cash releasing savings plans that are not fully identified and may not be fully delivered<br>6. Cost pressures arising from the use of agency staff<br>7. The use of non-recurrent measures may also contribute to a risk to the Trusts longer term sustainability<br>8. Failure to agree control total with NHSI/E<br>9. Inability to invest in development of service<br>**Areas of Impact**<br>1. Regulatory<br>2. Sustainability of services<br>3. Reputation<br>4. Patient care | 1. Corporate Governance Handbook including Standing Financial Instructions and Scheme of Delegation (approved by Audit Committee and Board of Directors)<br>**Control Owner:** Russell Favager | | | Compliance with SFIs reported to Audit Committee on quarterly basis | | Annual Internal Audit Key Financial Controls | | C = 4 L = 2 8 |
| | | | 2. Budgetary Controls - each Division has a dedicated financial accountant<br>**Control Owner:** Russell Favager | Monthly divisional meetings with Accountant | | Monthly Finance reports to PAF and Board | | | | |
| | | | 3. Contracts with Commissioners<br>**Control Owner:** Russell Favager | Signed contract with Commissioners | | Monthly Contract financial reports to Commissioners | | | | |
| | | | 4. Financial plan<br>**Control Owner:** Russell Favager | Signed off by the PAF and the Board | | Monthly monitoring performance via Finance reports to PAF and Board | | Annual Use of Resources (External Audit) | | |
| | | | 5. Annual reference costs<br>**Control Owner:** Russell Favager | | | Signed off by PAF | | | | |
| | | | 6. End of year financial accounting processes<br>**Control Owner:** Russell Favager | | | Annual Accounts scrutinised and signed off by Audit Committee | | External Audited Annual Accounts | | |
| | | | 7. Collaboration at scale<br>**Control Owner:** Russell Favager | Directors of Finance meet fortnightly | | Monthly Cheshire meetings chaired by the CEO | | Head of Internal Audit Opinion | | |
| | | | 8. Information shared across divisions outlining benchmarking opportunities<br>**Control Owner:** Russell Favager | | | | | External Benchmarking information received by the Trust including Model Hospital | | |
| | | | 9. Cheshire System Financial Recovery Plan<br>**Control Owner:** Russell Favager | Monthly CEO and DOF meetings | | | | NHSI/E Performance Meetings | | |

## Strategic Risks

| Risk Ref | Risk Title | Cause & Area of Impact | Risk Control | Control Assurance (1st Line Assurance) | 1st Line Assurance Assurance Level | Control Assurance (2nd Line Assurance) | 2nd Line Assurance Assurance Level | Control Assurance (3rd Line Assurance) | 3rd Line Assurance Assurance Level | 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<br>**Executive Risk Lead:** Denise Frodsham<br>**Last Updated:** 01 Sep 2020 | **Cause**<br>1. Failure to overcome organisational politics<br>2. Senior capacity<br>3. Ineffective governance<br>4. Lack of agreement of shared goals and plans<br>5. Poor communication<br>6. Failure to have single data source across the system<br>**Areas of Impact**<br>1. Patient care and experience including inequality of provision<br>2. Reputation<br>3. Financial<br>4. Regulatory intervention | 1. Dedicated additional resource in place leading on partnerships<br>**Control Owner:** Denise Frodsham | | | | | | | C = 3 L = 3<br>9 |
| | | | 2. Local transformation funding to support the programme of work<br>**Control Owner:** Denise Frodsham | Task and Finish Groups report to Transformation Board (part of Cheshire East ICP governance structure) | | | | | | |
| | | | 3. CEICP Board includes CEO representation from MCHFT<br>**Control Owner:** James Sumner | Monthly risk reports to ERAG (from October) | | Monthly report to the Board of Directors from the Chair of the ICP | | | | |
| | | | 4. Cheshire East Place 5 year plan presented to Board October 2019<br>**Control Owner:** Denise Frodsham | | | Update reports go to Place Partnership Board | | | | |
| 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<br>**Executive Risk Lead:** Oliver Bennett<br>**Last Updated:** 25 Sep 2020 | **Cause**<br>1. Poor understanding of key failure points<br>2. Poor system-wide data<br>3. Parters not delivering on their commitments<br>4. Inadequate focus on embedding new ways of working<br>5. Poor communication<br>**Areas of Impact**<br>1. Hospital capacity<br>2. Patient care and experience<br>3. Reputation | 1. Plans for transformation & change programmes<br>**Control Owner:** Oliver Bennett | Key assurance documented in minutes of the weekly system wide capacity and flow group. Includes reps from Mid Cheshire, CCG, CoCH and East Cheshire and LA. | | | | | | C = 4 L = 3<br>12 |
| | | | 2. Winter/COVID Plan - Trust-wide and system-wide (Cheshire) that is submitted to PAF and the Board for approval October 2020<br>**Control Owner:** Oliver Bennett | 1. Review including lessons learned on Board workplan for May/June 2021.<br>2. Winter plan tracked and progress documented at the Winter Planning Group with updates documented at Silver Command and escalated to Gold if necessary. | | | | | | |
| | | | 3. Cheshire system-wide urgent care delivery board<br>**Control Owner:** Oliver Bennett | | | | | | | |
| 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<br>**Executive Risk Lead:** James Sumner<br>**Last Updated:** 25 Sep 2020 | **Cause**<br>1. Low openness to change<br>2. Low understanding of risk & assurance<br>3. Inability to effect culture change<br>4. Poor perception of governance requirement<br>5. Lack of senior buy-in<br>**Areas of Impact**<br>1. Governance<br>2. Regulatory<br>3. Reputation<br>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<br>**Control Owner:** Caroline Keating | Company Secretary holds weekly project meetings to review progress | | Monthly Audit Committee Task & Finish Group consultation sessions | | Internal Audit - Assurance Framework and Risk Management Policy Q4 2020-21 | | C = 3 L = 4<br>12 |
| | | | 2. Risk Management Strategy approved by the BoD August 2020 sets the overarching approach<br>**Control Owner:** Caroline Keating | | | | | | | |
| | | | 3. First version Assurance & Escalation Framework approved by the Audit Committee July 2020 documents key mechanisms<br>**Control Owner:** Caroline Keating | | | Internal compliance testing by Governance Team | | | | |
| | | | 4. CQC improvement planning and implementation<br>**Control Owner:** Julie Tunney | | | Must-dos reported quarterly to QSC | | | | |
| | | | 5. Redesigned Governance Structure<br>**Control Owner:** Caroline Keating | Annual evaluation of effectiveness of Exec Group, Board Committees and the Board of Directors | | | | Well-led governance reviews every 3 years | | |

## Strategic Risks

| Risk Ref | Risk Title | Cause & Area of Impact | Risk Control | Control Assurance (1st Line Assurance) | 1st Line Assurance Assurance Level | Control Assurance (2nd Line Assurance) | 2nd Line Assurance Assurance Level | Control Assurance (3rd Line Assurance) | 3rd Line Assurance Assurance Level | 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<br>**Executive Risk Lead:** James Sumner<br>**Last Updated:** 01 Sep 2020 | **Cause**<br>1. Low understanding of benefits of appropriate governance<br>2. Poor understanding of partnership risks<br>3. Ineffective communication between partners<br>4. Failure to learn and adapt to system -wide thinking<br>5. Lack of coterminosity<br>6. Failure to plan for partnership service changes<br>**Areas of Impact**<br>1. Governance<br>2. Reputation<br>3. Regulatory<br>4. Patient care<br>5. Financial | 1. CEO member of Cheshire East Leaders Group<br>**Control Owner:** James Sumner | Chief Executive's report to the BoD | | | | | | C = 3 L = 3<br>9 |
| | | | 2. CEO member of CE Place Partnership and ICP Boards. CEICP collaboration agreement to be signed off by BoD Sept 2020<br>**Control Owner:** James Sumner | Chief Executive's report to the BoD | | | | | | |
| | | | 3. DSP member of CWICP Board. Memorandum of Understanding approved by MCHFT Board June 2020<br>**Control Owner:** Denise Frodsham | | | | | | | |
| 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<br>**Executive Risk Lead:** Heather Barnett<br>**Last Updated:** 25 Sep 2020 | **Cause**<br>1. Inadequate planning of leadership requirement<br>2. Lack of clarity about development paths<br>3. Inadequate investment<br>4. Failure to address leadership culture<br>5. Low senior engagement<br>6. Low clinical leadership engagement<br>7. Lack of capacity to release staff for development<br>8. Lack of resources to deliver adequate development opportunities<br>9. Perceived or real cultural barriers for BAME staff<br>**Areas of Impact**<br>1. Leadership<br>2. Strategy<br>3. Change management<br>4. Culture<br>5. Workforce morale | 1. Leadership Framework<br>**Control Owner:** Heather Barnett | | | | | | | C = 4 L = 3<br>12 |
| | | | 2. Leadership Development matrix and implementation plan<br>**Control Owner:** Heather Barnett | Leadership development plan progress reports to Execs and EWAG | | | | | | |
| | | | 3. Our Workforce Matters Strategy<br>**Control Owner:** Heather Barnett | Our Workforce Matters annual report | | Workforce metrics reporting and analysis reported to EWAG and via Integrated Performance Report to WDTC and Board | | | | |
| | | | 4. Coaching & mentoring scheme<br>**Control Owner:** Heather Barnett | Education, Learning and OD report to EWAG quarterly | | | | | | |
| | | | 5. Medical leadership programme<br>**Control Owner:** Murray Luckas | Education Committee? | | | | | | |
| | | | 6. Talent Board is in place and succession planning process is aligned to the Divisions<br>**Control Owner:** Heather Barnett | | | | | | | |
| | | | 7. Staff Survey Process and action plans are in place<br>**Control Owner:** Heather Barnett | | | Staff Survey focus groups and action plan review includes feedback about leadership | | 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<br>**Control Owner:** Heather Barnett | | | Annual ED&I report to WDTC and Board September and October | | 1. WRES report to Board<br>2. WDES report to Board | | |

# Board of Directors

| | | |
|---|---|---|
| **Agenda Item** | **8** | Date of Meeting: 05/10/2020 |
| **Report Title** | Board of Directors Performance & Finance Report – August 2020 | |
| **Executive Leads** | Russ Favager, Deputy CEO/Director of Finance & Oliver Bennett, Chief Operating Officer | |
| **Lead Officers** | Emma McGuigan, Director of Operations, Ros Davies, Deputy Director of Finance | |
| **Action Required** | To note | |

| | | | | | |
|---|---|---|---|---|---|
| ☐ | **Acceptable assurance**<br>General confidence in delivery of existing mechanisms / objectives | ☐ | **Partial assurance**<br>Some confidence in delivery of existing mechanisms / objectives | ☐ | **No assurance**<br>No confidence in delivery |

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

- Restoration of clinical services continues to build momentum with more patients being treatment month on month.
- Performance against the A&E standard for the second month since the pandemic is delivering below the 95% standard which corresponds directly with increases in A&E attendances.
- RTT, cancer and diagnostic performance all remain a significant challenge and are not delivering against the required standard. The number of patients waiting >52 weeks for treatment continues to grow.
- More patients in August are being referred on a cancer pathway and attending A&E compared to the previous month and this continues to be an upward trend.
- The Trust has required a further top up of £1.7m this month, with the increase in expenditure relating the implementation of the restoration of planned care.
- The Trust has submitted a forecast for the final 6 months of the financial year, indicating a £25.3m increase in run rate net expenditure, as a result of expectations for restoration, Winter planning and changes to the top up re-imbursement.

**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 ☐<br>• Annual Business Plan Priority ☐<br>• Strategic/BAF Risk ✓<br>• Service Change ☐ | • Other ☐<br>*rationale for Board submission required:* |
| **Next Steps (***actions following agreement by Board/Committee of recommendation/s)* | |
| No further steps. | |

**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

# Board of Directors
# Integrated Performance Report

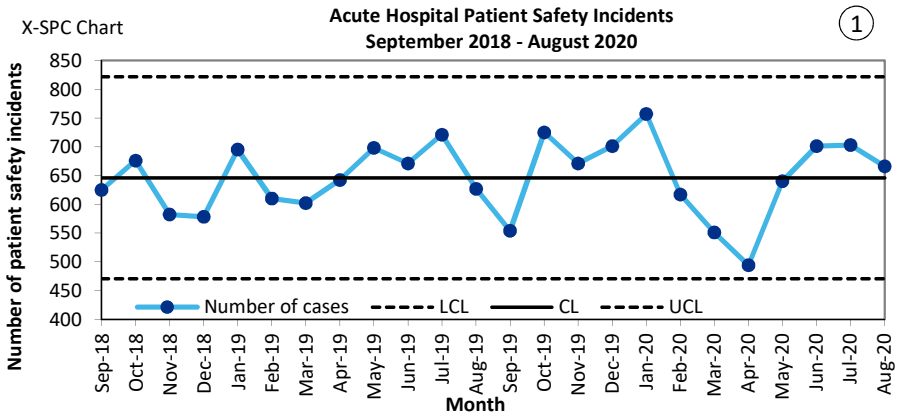
## August 2020

"To Deliver Excellence in Healthcare through Innovation & Collaboration"

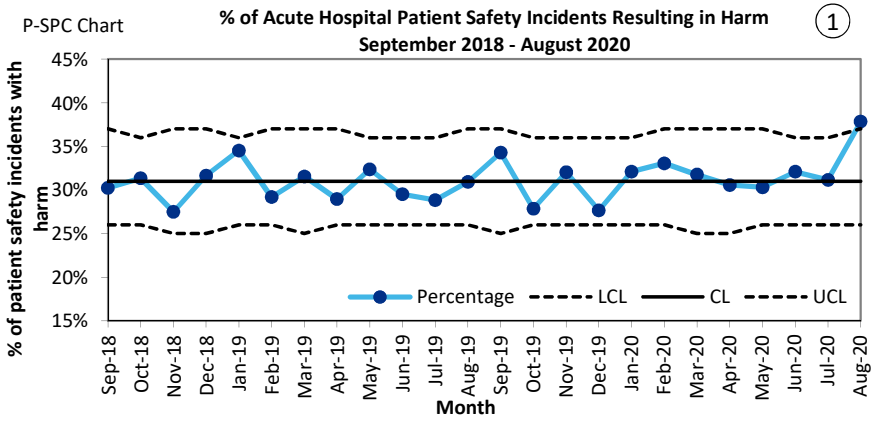
# Board Papers - Quality, Safety & Experience

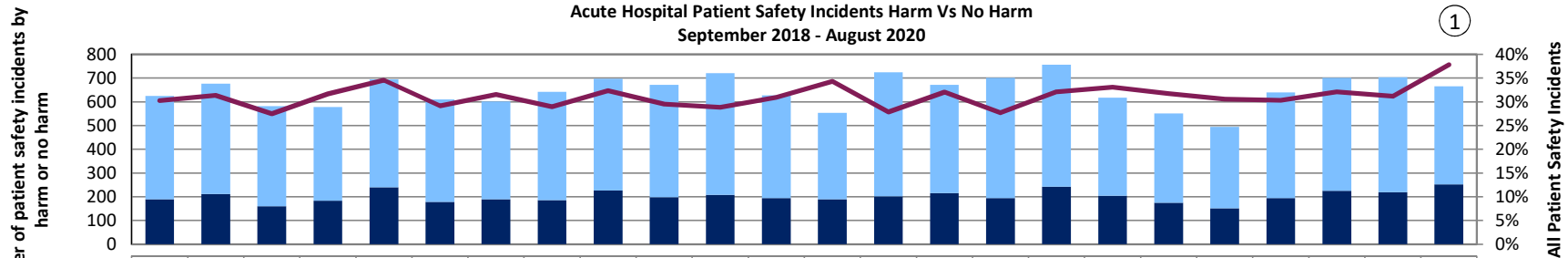
## Acute Hospital Patient Safety Incidents

X-SPC Chart




P-SPC Chart




| | 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 | Aug-20 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| No Harm | 436 | 464 | 422 | 395 | 455 | 432 | 412 | 456 | 472 | 473 | 513 | 433 | 364 | 523 | 456 | 507 | 514 | 413 | 376 | 343 | 446 | 476 | 484 | 414 |
| Harm | 189 | 212 | 160 | 183 | 240 | 178 | 190 | 186 | 226 | 198 | 208 | 194 | 190 | 202 | 215 | 194 | 243 | 204 | 175 | 151 | 194 | 225 | 219 | 252 |
| % Harm | 30% | 31% | 27% | 32% | 35% | 29% | 32% | 29% | 32% | 30% | 29% | 31% | 34% | 28% | 32% | 28% | 32% | 33% | 32% | 31% | 30% | 32% | 31% | 38% |

**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:** The total number of acute hospital patient safety incidents remains within normal variation. The percentage of acute patient safety incidents resulting in harm shows special cause variation in August 2020 with the measure breaching the upper control limit.

Low Harm 245, Moderate Harm 5, Serious Incident 2

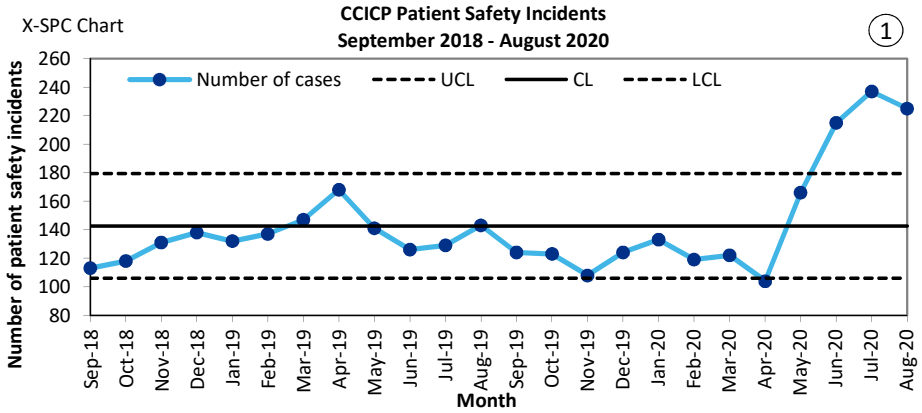


*Data Rating: ①captured locally, ②system captured, ③published/benchmarked*

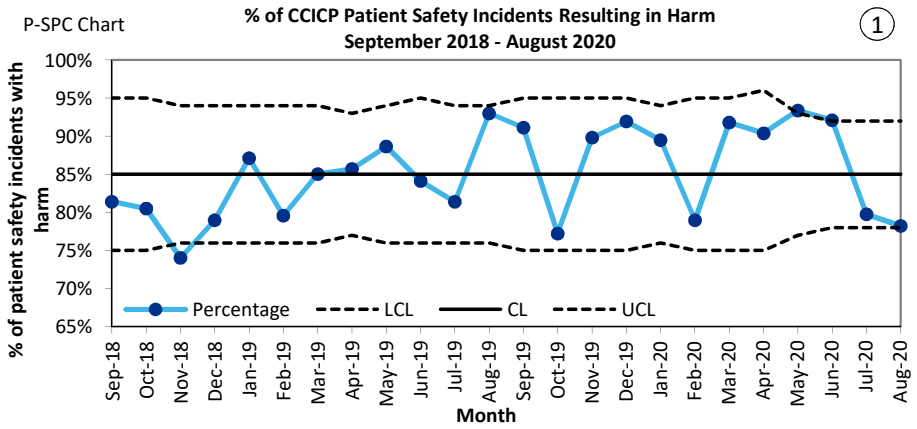
# Board Papers - Quality, Safety & Experience

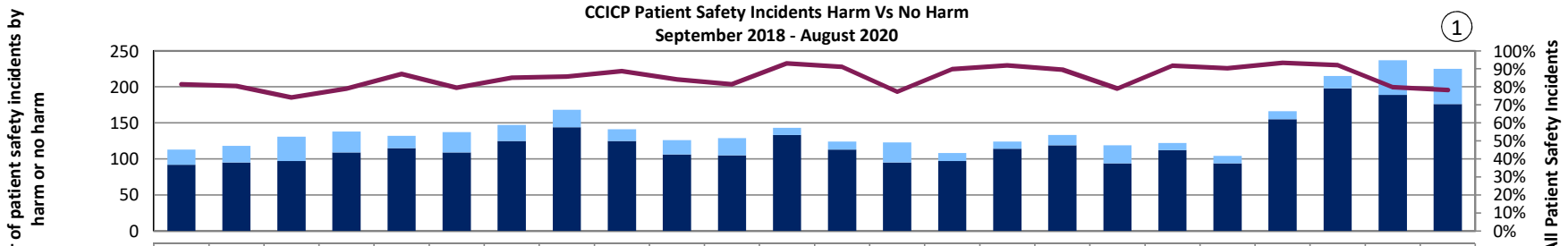
## Central Cheshire Integrated Care Partnership (CCICP) Patient Safety Incidents

X-SPC Chart




P-SPC Chart




| | 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 | Aug-20 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| No Harm | 21 | 23 | 34 | 29 | 17 | 28 | 22 | 24 | 16 | 20 | 24 | 10 | 11 | 28 | 11 | 10 | 14 | 25 | 10 | 10 | 11 | 17 | 48 | 49 |
| Harm | 92 | 95 | 97 | 109 | 115 | 109 | 125 | 144 | 125 | 106 | 105 | 133 | 113 | 95 | 97 | 114 | 119 | 94 | 112 | 94 | 155 | 198 | 189 | 176 |
| % Harm | 81% | 81% | 74% | 79% | 87% | 80% | 85% | 86% | 89% | 84% | 81% | 93% | 91% | 77% | 90% | 92% | 89% | 79% | 92% | 90% | 93% | 92% | 80% | 78% |

**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:** The total number of CCICP safety incidents shows special cause variation for the last 3 months where the upper control limit has been breached. The percentage of incidents resulting in harm breached the upper control limits in May 2020 and June 2020 and were close to the lower limits in the last 2 months reported.

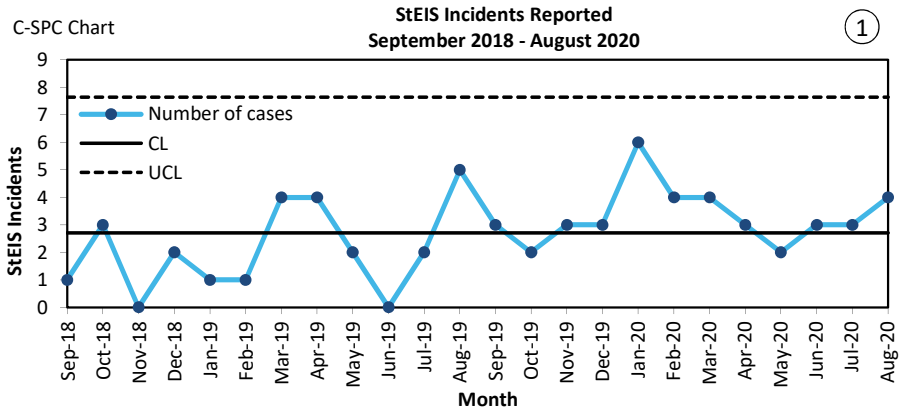
Low Harm 174, Moderate Harm 2, Serious Incident 0



*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:** The number of incidents reported remains within the expected variation.

There were 4 serious incidents reported to StEIS in August 2020.

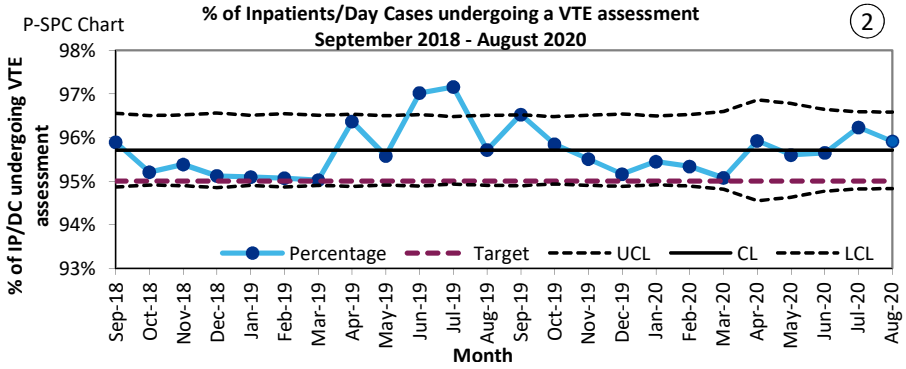
-A patient with a diagnosis of cirrhosis of the liver did not receive 6 monthly screening appointments. The patient developed a carcinoma.

-A patient with Hodgkins Lymphoma did not receive an appointment for a PET CT scan. He has since had a scan and has extensive disease.

-A baby required cooling and transfer to Liverpool womens hospital. There is a review of foetal monitoring underway.

-A patient had a delay in having emergency treatment for an ectopic pregnancy.

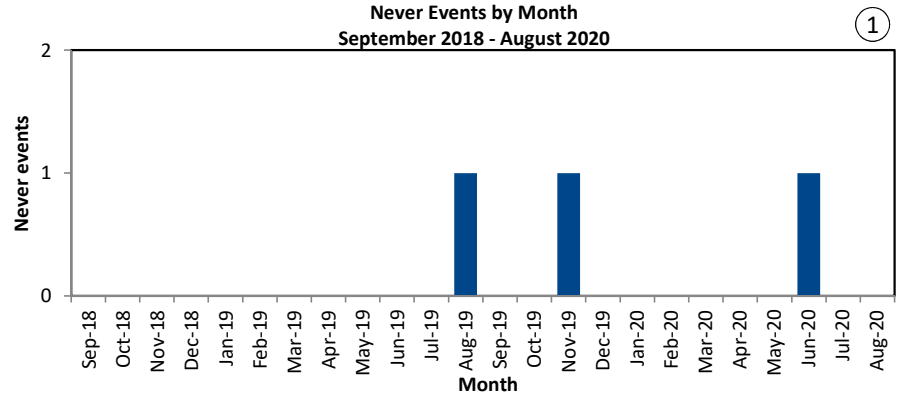
## VTE




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

**Key Narrative:** This measure has fallen within the expected range since October 2019 and remains above the target. 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

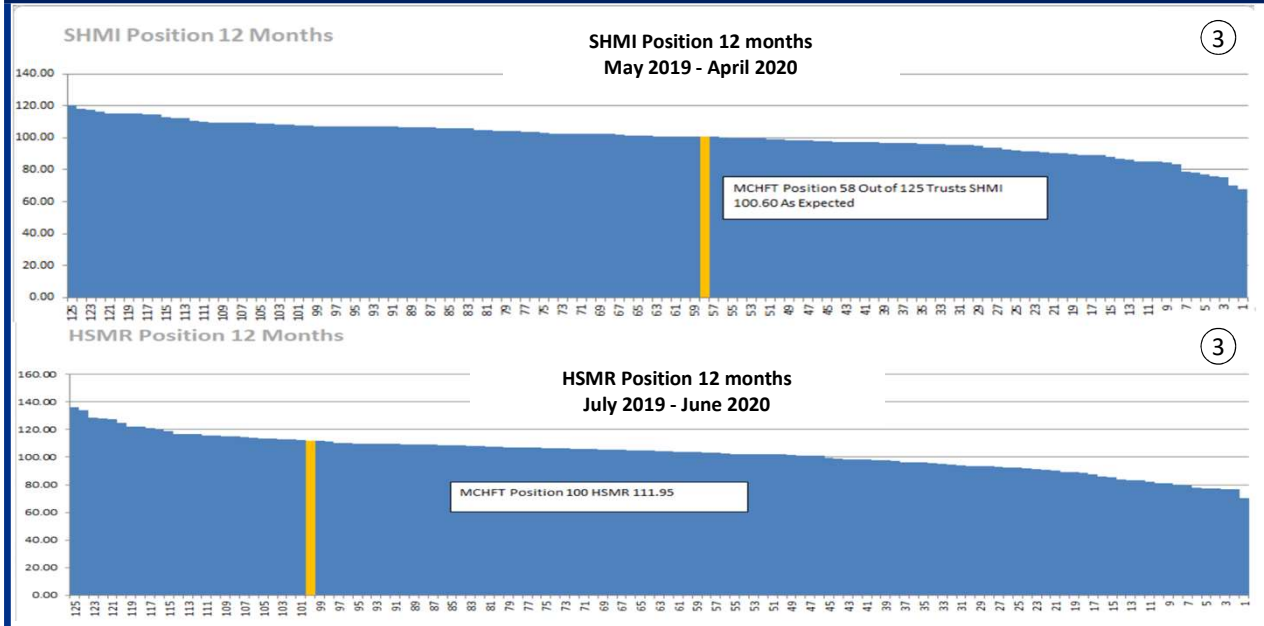
**Key Narrative:** There were no never events reported in August 2020.



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

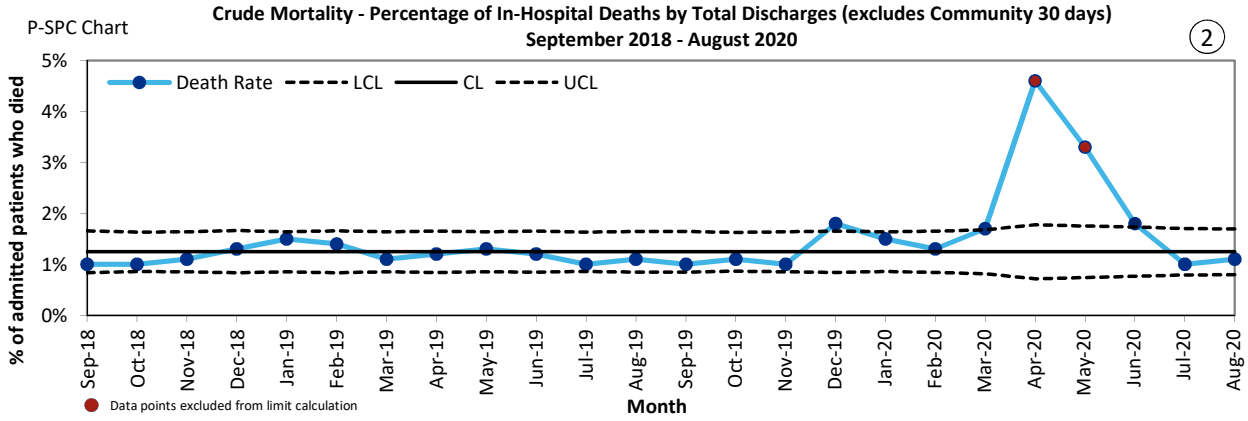
# Board Papers - Quality, Safety & Experience

## Mortality




3

3




2

**Key Narrative:** The latest release of SHMI is 100.60 (rank 58) against the previous value of 99.47 (rank 54). This is still in the 'as expected' range. 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.

**Key Narrative:** The latest HSMR release is 111.95. 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. Please note that the Trust mergers in SHMI are reflected in this data.

**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 August 2020 shows a return to a level similar to August 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*

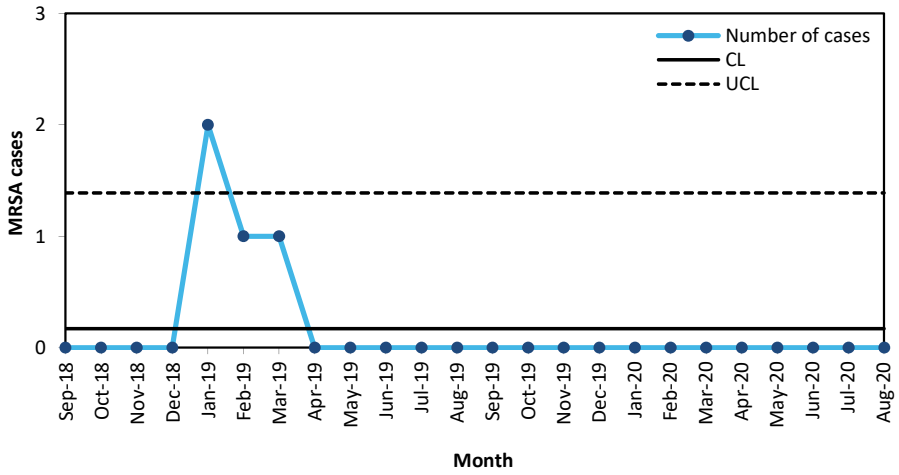
# Board Papers - Quality, Safety & Experience - Infection Control

## MRSA

C-SPC Chart

**MRSA Bacteraemia Cases Reported Within the Trust**
**September 2018 - August 2020**

②




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

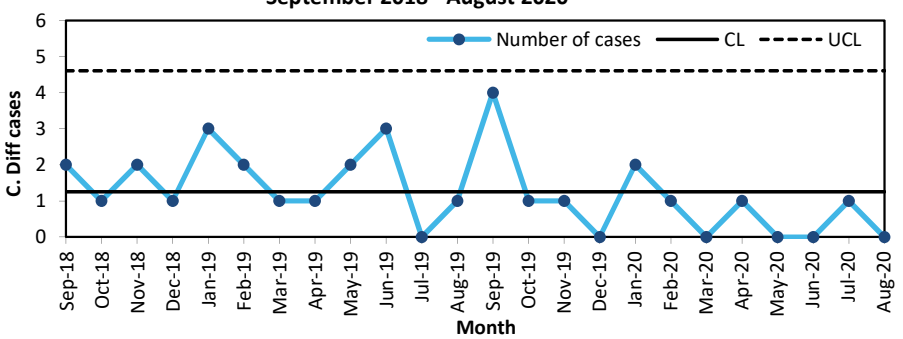
**Key Narrative:** There have been no MRSA bacteraemia cases reported since March 2019.

## C. Diff Positive Cases

C-SPC Chart

**Hospital Onset Healthcare Acquired C. Diff Cases**
**September 2018 - August 2020**

②

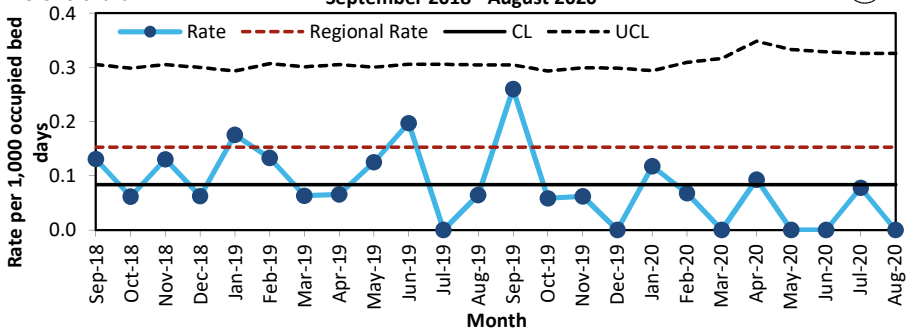



| | Sep-19 | Oct-19 | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Avoidable | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 |
| Unavoidable | 4 | 1 | 1 | 0 | 2 | 1 | 0 | 1 | 0 | 0 | 0 | 0 |
| Awaiting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

**Hospital Onset Healthcare Acquired C.Diff Rate per 1,000 Occupied Bed Days**
**September 2018 - August 2020**

U-SPC Chart

②




**Accountable:** Director of Nursing and Quality
**Data Owner:** Infection Prevention Control Team
**Key Narrative:** Hospital acquired C. Diff remains within expected variation with the last 6-months infection rate below the 24 month average. The P-SPC charts adjust the control limits to take into account each month's denominator.

*Historic C. Diff data refreshed.*

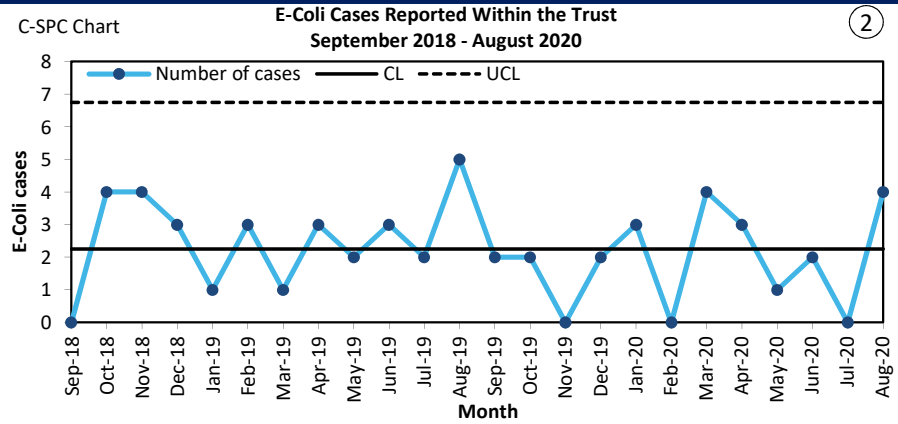


*Data Rating: ①captured locally, ②system captured, ③published/benchmarked*

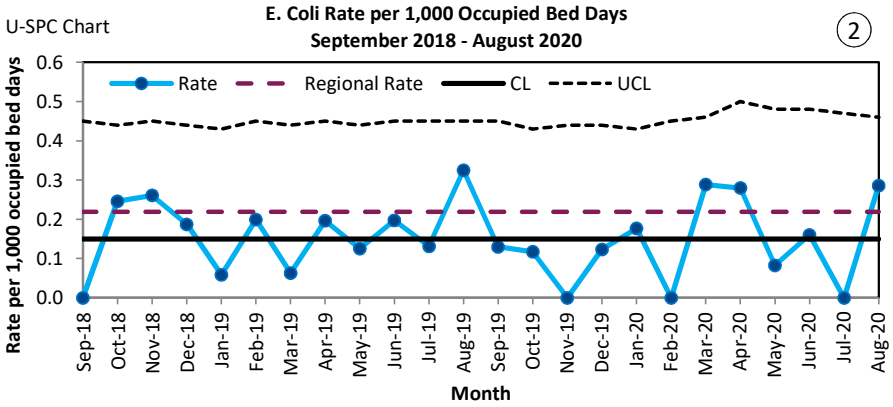
# Board Papers - Quality, Safety & Experience - Infection Control

## E-Coli Cases

C-SPC Chart



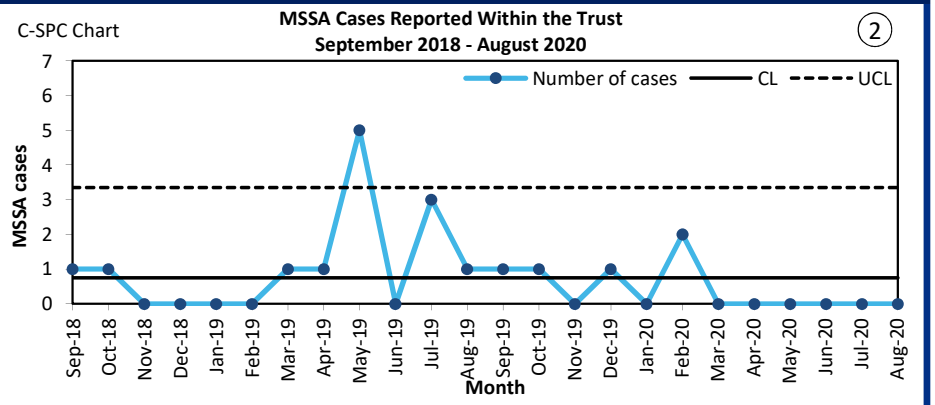

U-SPC Chart



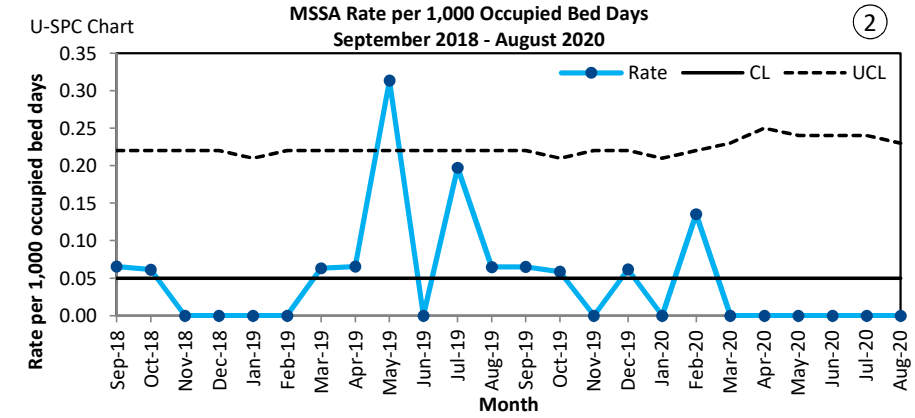

**Accountable:** Director of Nursing and Quality
**Data Owner:** Infection Prevention Control Team
**Key Narrative:** E-coli cases remain within expected variation. The U-SPC chart adjusts the control limits to take into account each month's denominator. There were 4 cases reported in August 2020.

## MSSA

C-SPC Chart




U-SPC Chart



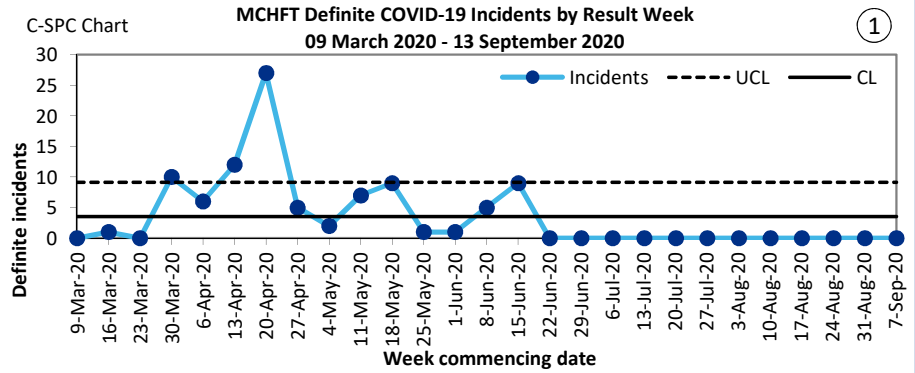

**Accountable:** Director of Nursing and Quality
**Data Owner:** Infection Prevention Control Team
**Key Narrative:** MSSA cases remain within expected variation with the exception of May 2019 which breached the upper control limit and July 2019 close to the upper limit. There have been no MSSA cases reported since February 2020. The U-SPC chart adjusts the control limits to take into account each month's denominator.

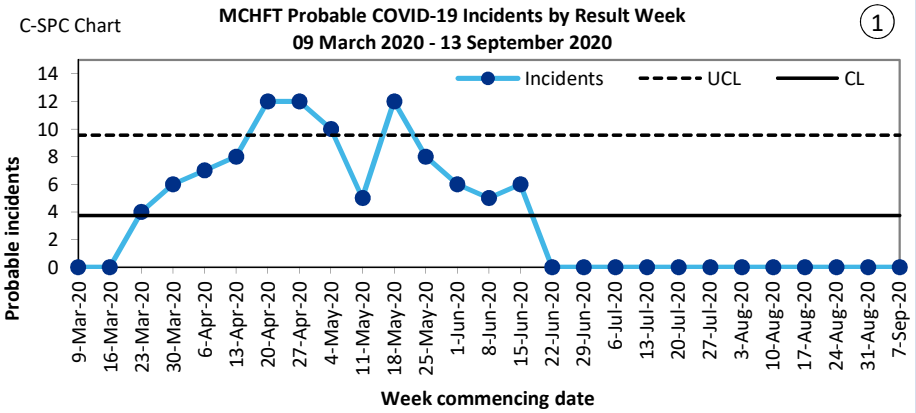


*Data Rating: ①captured locally, ②system captured, ③published/benchmarked*

# Board Papers - Quality, Safety & Experience

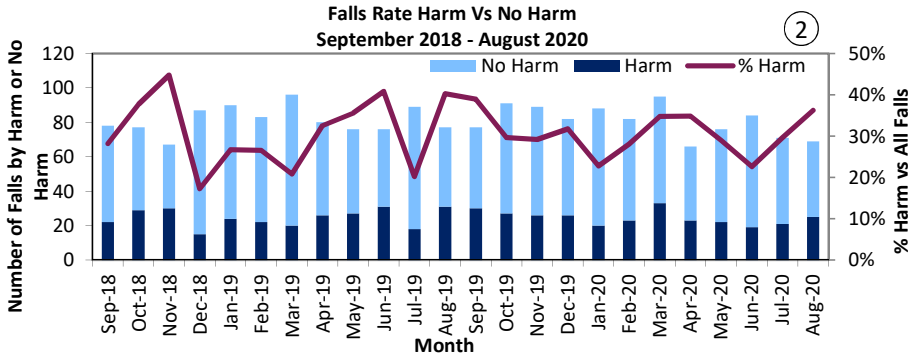
## COVID-19 Healthcare Acquired Infections

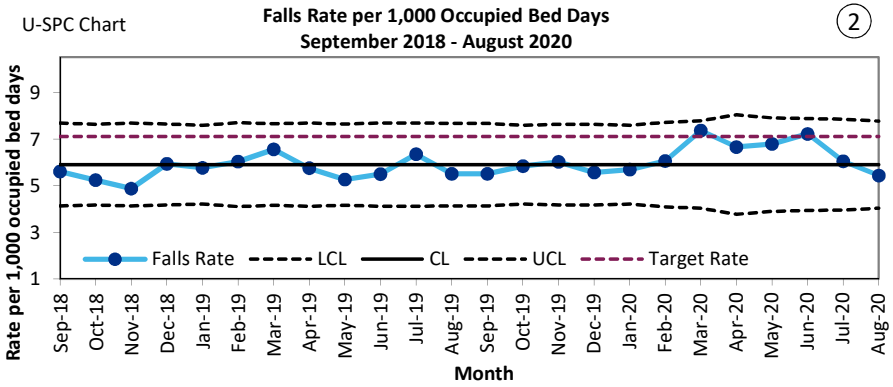



**Accountable:** Director of Nursing and Quality
**Data Owner:** Information Services
**Key Narrative:** The SPC charts show no hospital acquired incidents reported since 22nd June 2020.

## Falls




**Accountable:** Director of Nursing and Quality
**Data Owner:** Nursing Quality Team
**Key Narrative:** Falls cases per 1,000 occupied bed days remains within expected variation. March 2020 and June 2020 were close to the upper limit and above the target rate. The U-SPC chart adjusts the control limits to take into account each month's denominator.



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

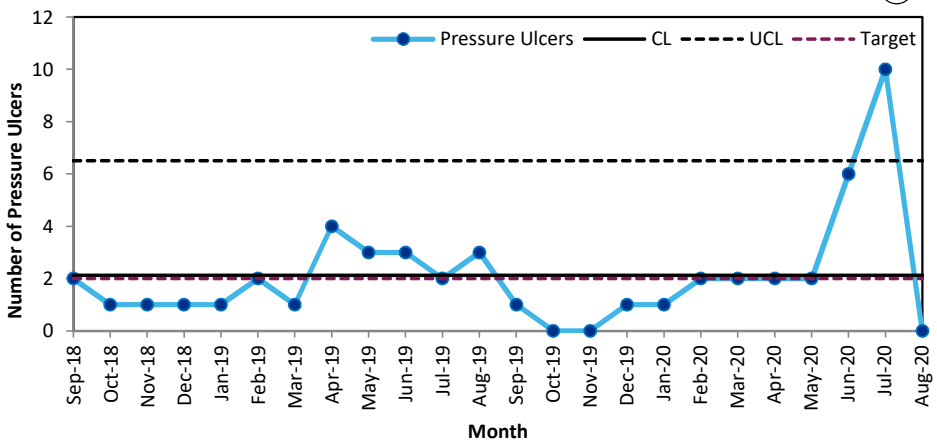
# Board Papers - Quality, Safety & Experience

## Acute Hospital Pressure Ulcers

C-SPC Chart

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

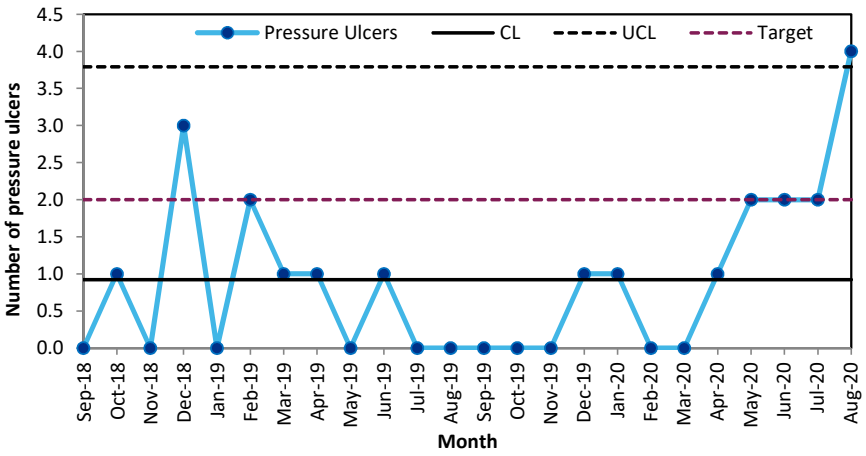
②




C-SPC Chart

**Community Pressure Ulcers - Lapses in Care Identified**
**September 2018 - August 2020**

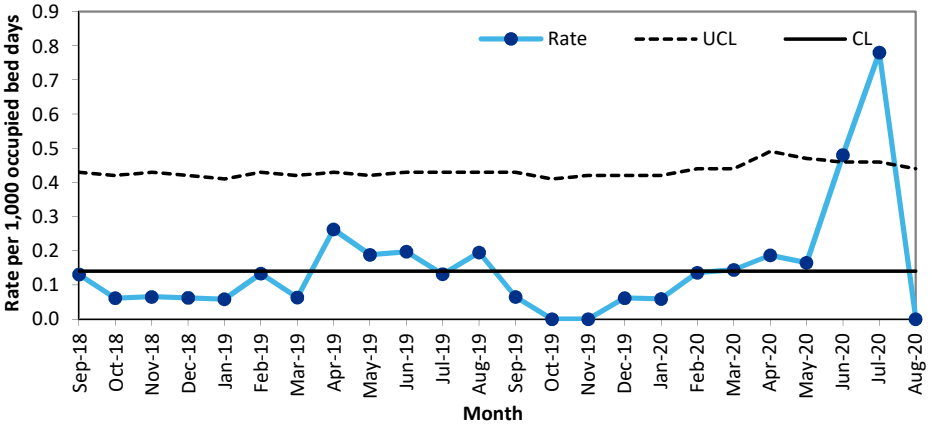
②




U-SPC Chart

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

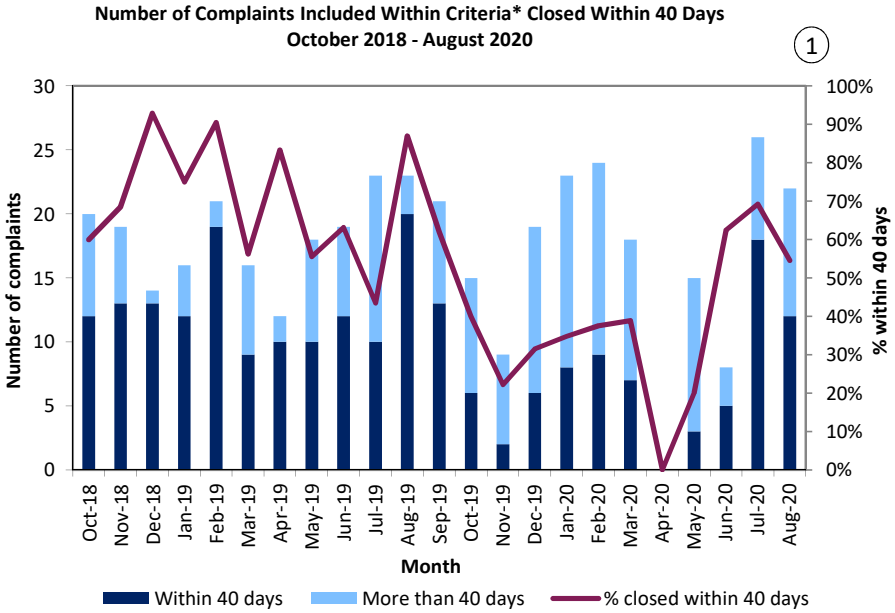
**Key Narrative:** Acute hospital pressure ulcers shows special cause variation in June 2020 and July 2020 returning to within expected range for the latest reported month. Community pressure ulcers identifies special cause variation in August 2020. The U-SPC chart adjusts the control limits to take into account each month's denominator.

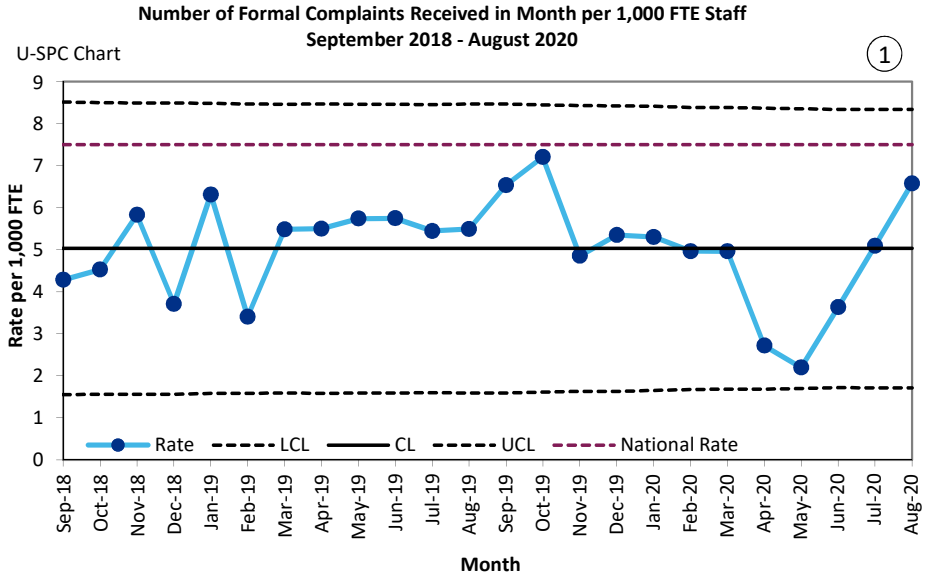


*Data Rating: ①captured locally, ②system captured, ③published/benchmarked*

# Board Papers - Quality, Safety & Experience

## Formal Complaints




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

**Key Narrative:** The number of written complaints received remains within expected variation and below the national rate.

**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 | **43,385.6** | **36,662.5** | **38,072.7** | **32,097.3** | **32,331.7** | **28,751.5** | **25,968.3** | **23,451.5** | **85.0%** | **84.0%** | **89.0%** | **90.0%** |
| Acute Medical Unit | 1,727.5 | 1,728.0 | 2,070.0 | 2,072.5 | 1,920.0 | 1,764.0 | 1,548.0 | 1,575.0 | 100.0% | 100.0% | 92.0% | 102.0% |
| Child & Adolescent Unit | 3,553.3 | 2,318.1 | 1,605.0 | 1,454.8 | 2,175.0 | 2,015.0 | 733.0 | 705.0 | 65.0% | 91.0% | 93.0% | 96.0% |
| Critical Care Unit (RED) | 4,211.3 | 3,683.8 | 552.0 | 406.0 | 3,804.0 | 3,372.0 | - | - | 87.0% | 74.0% | 89.0% | - |
| Elmhurst | 786.5 | 786.5 | 2,388.0 | 2,372.5 | 744.0 | 746.0 | 1,836.0 | 1,812.0 | 100.0% | 99.0% | 100.0% | 99.0% |
| Maternity Unit (Ward 23) | 1,329.1 | 1,142.8 | 1,104.7 | 983.8 | 744.0 | 732.0 | 744.0 | 680.7 | 86.0% | 89.0% | 98.0% | 91.0% |
| Midwifery Led Unit | 745.3 | 727.3 | - | - | 744.0 | 720.0 | - | - | 98.0% | - | 97.0% | - |
| NICU Ward 22 | 1,691.3 | 1,469.2 | 709.7 | 360.5 | 1,336.8 | 1,047.3 | 333.3 | 280.0 | 87.0% | 51.0% | 78.0% | 84.0% |
| South Cheshire Surveillance (AMBER) | 1,902.0 | 1,788.8 | 2,580.0 | 1,966.7 | 1,524.0 | 1,452.0 | 2,282.0 | 1,958.0 | 94.0% | 76.0% | 95.0% | 86.0% |
| Ward 1 Coronary Care | 2,143.5 | 2,131.5 | 1,200.0 | 1,141.0 | 1,488.0 | 1,486.5 | 744.0 | 744.0 | 99.0% | 95.0% | 100.0% | 100.0% |
| Ward 10 Ortho Trauma | 2,530.5 | 2,083.5 | 3,105.0 | 2,835.5 | 1,200.0 | 1,115.0 | 2,196.0 | 2,109.7 | 82.0% | 91.0% | 93.0% | 96.0% |
| Ward 11 Surgical/Gynae | 1,998.0 | 1,879.5 | 1,801.5 | 1,747.5 | 1,200.0 | 1,140.0 | 1,512.0 | 1,456.5 | 94.0% | 97.0% | 95.0% | 96.0% |
| Ward 12 SAU | 1,461.3 | 1,161.8 | 935.5 | 735.5 | 900.0 | 828.0 | 816.0 | 756.0 | 80.0% | 79.0% | 92.0% | 93.0% |
| Ward 12 Surgical Speciality | 1,133.5 | 794.3 | 1,008.0 | 887.0 | 744.0 | 444.0 | 624.0 | 612.0 | 70.0% | 88.0% | 60.0% | 98.0% |
| Ward 13 Elective | 1,220.0 | 962.0 | 1,116.0 | 431.0 | 744.0 | 744.0 | 732.0 | 384.0 | 79.0% | 39.0% | 100.0% | 52.0% |
| Ward 14 Gastroenterology | 1,325.0 | 1,307.0 | 1,626.5 | 1,584.5 | 1,152.0 | 1,128.0 | 1,236.0 | 1,200.0 | 99.0% | 97.0% | 98.0% | 97.0% |
| Ward 21b Rehabilitation | 1,133.8 | 1,104.3 | 2,634.5 | 2,513.0 | 768.0 | 768.0 | 1,272.0 | 1,236.0 | 97.0% | 95.0% | 100.0% | 97.0% |
| Ward 26 Labour | 3,027.9 | 2,758.8 | 575.3 | 562.5 | 2,604.0 | 2,533.8 | 324.0 | 360.7 | 91.0% | 98.0% | 97.0% | 111.0% |
| Ward 3 Surveillance (AMBER) | 3,676.5 | 1,991.0 | 4,051.5 | 2,099.0 | 2,352.0 | 1,355.5 | 3,384.0 | 2,052.0 | 54.0% | 52.0% | 58.0% | 61.0% |
| Ward 4 Elderly | 1,483.0 | 1,426.0 | 2,170.5 | 2,010.0 | 1,224.0 | 1,020.0 | 1,908.0 | 1,882.0 | 96.0% | 93.0% | 83.0% | 99.0% |
| Ward 5 Respiratory | 2,293.5 | 1,756.0 | 1,848.5 | 1,523.5 | 1,548.0 | 1,356.0 | 864.0 | 1,008.0 | 77.0% | 82.0% | 88.0% | 117.0% |
| Ward 6 Rehab | 1,852.0 | 1,729.0 | 2,044.0 | 1,924.5 | 1,536.0 | 1,320.5 | 1,224.0 | 1,140.0 | 93.0% | 94.0% | 86.0% | 93.0% |
| Ward 7 Endocinology/Frailty | 1,363.0 | 1,331.5 | 2,190.0 | 2,069.5 | 1,136.0 | 1,100.0 | 1,296.0 | 1,320.0 | 98.0% | 94.0% | 97.0% | 102.0% |
| Ward 9 Orthopaedic Elective | 798.0 | 602.0 | 756.5 | 416.7 | 744.0 | 564.0 | 360.0 | 180.0 | 75.0% | 55.0% | 76.0% | 50.0% |

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

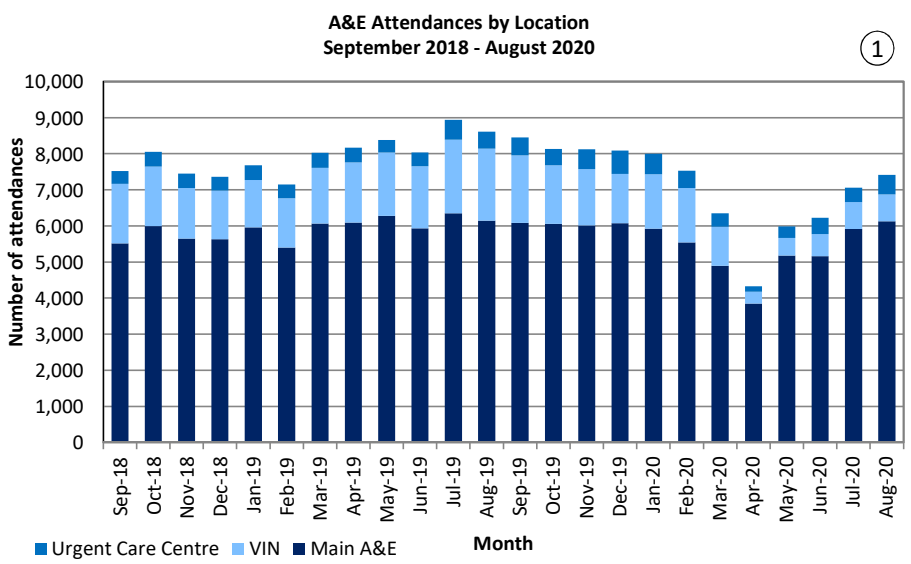
**Key Narrative:** The highlighted cells reflect wards where the qualified staffing rate is below the 85% target.

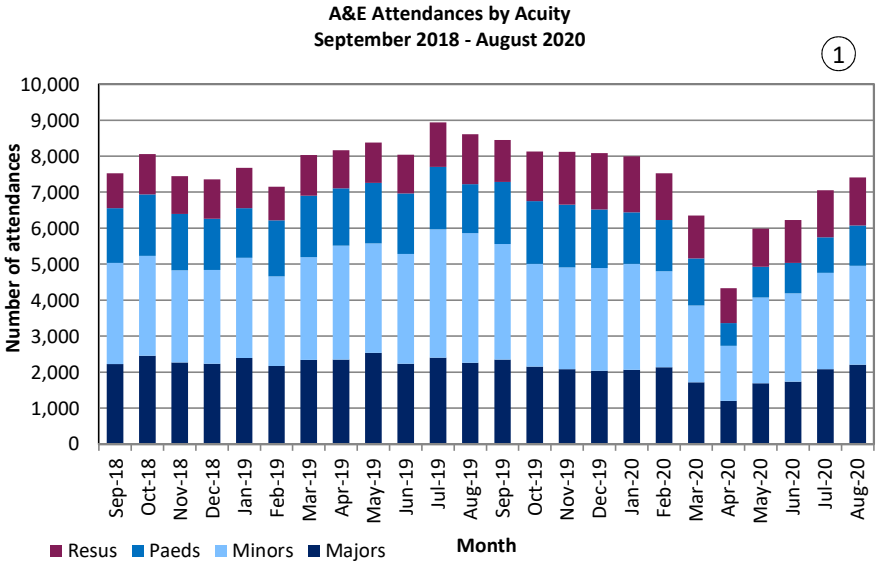


*Data Rating: ①captured locally, ②system captured, ③published/benchmarked*

# Board Papers - Performance

## A&E Activity




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

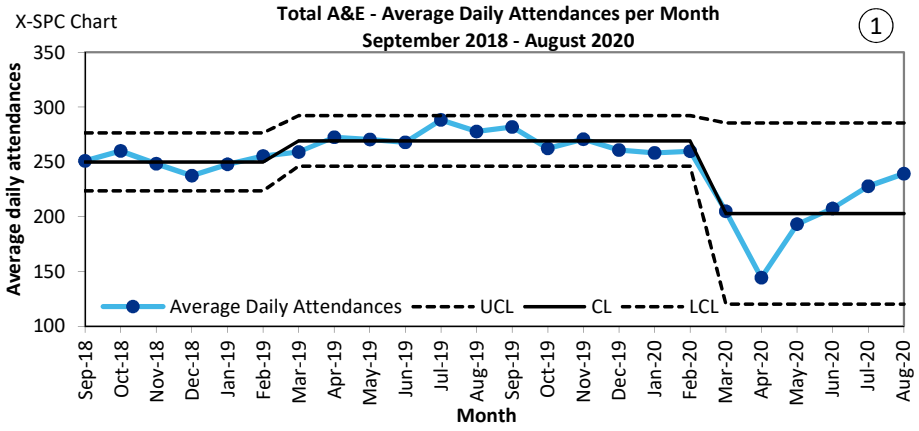
**Key Narrative:**
The charts show activity returning towards pre-covid levels with August 2020 reaching 92% of the 6-month average pre-covid based on September 2019 to February 2020 activity. Activity in the main A&E (type 1) at Leighton Hospital is back to pre-covid level if you compared August 2020 to the same month in the previous year (86% across all types). The reduced activity at Victoria Infirmary Northwich relates to the reduction in opening hours for the minor injuries unit at the weekend. Attendances in Majors and Resus in August 2020 are at near pre-covid levels if you compared it against the same month last year.

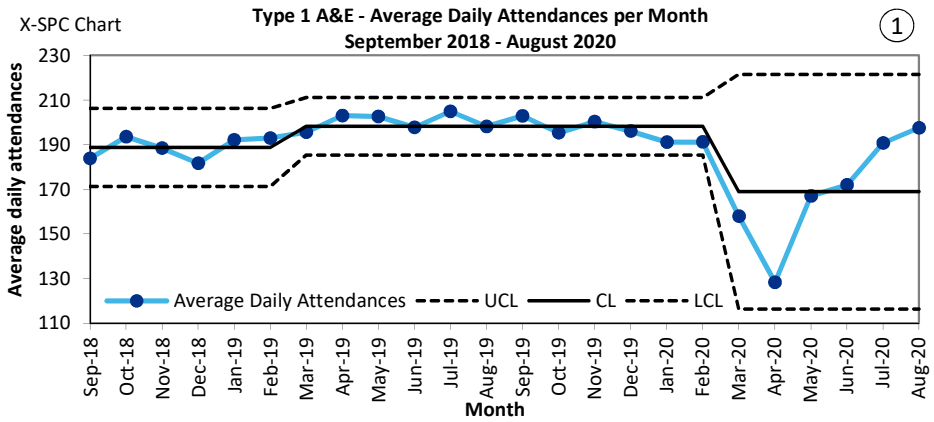


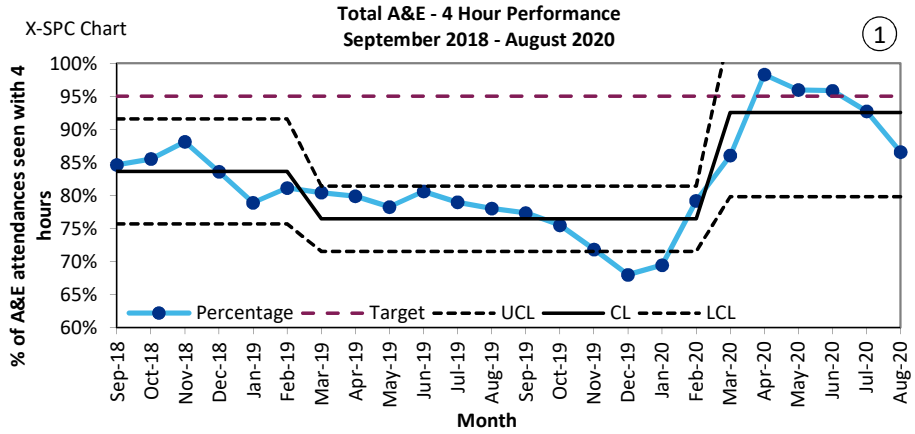
*Data Rating: ①captured locally, ②system captured, ③published/benchmarked*

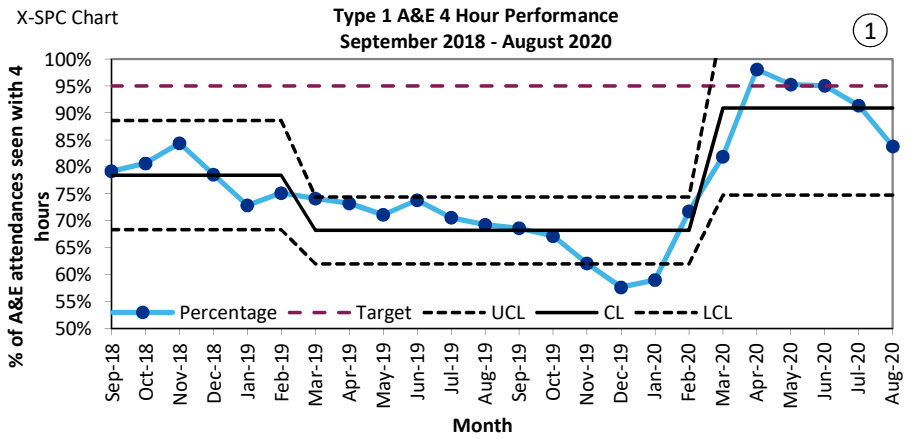
# Board Papers - Performance

## A&E Performance




**Accountable:** Chief Operating Officer

**Data Owner:** Information Services

**Key Narrative:** The SPC charts have been rebased from March 2019 to reflect a step change in demand, and from March 2020 to reflect changes related to the covid pandemic. Both total and type 1 attendances showed a process that was in control before the onset of the pandemic albeit not meeting the 4 hour standard, with decreased performance during the winter months November 2019 to January 2020. The wider control limits from March 2020 reflect the increased variation. The recent increase in activity towards pre-covid levels shows a corresponding decrease in performance and if this recent trend continues there will be high confidence that there is an underlying issue.



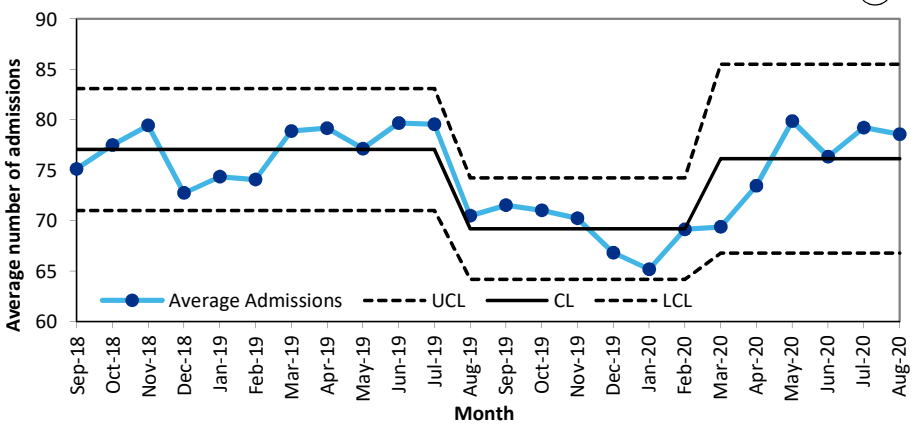
*Data Rating: ①captured locally, ②system captured, ③published/benchmarked*

# Board Papers - Performance

## Unplanned Admissions

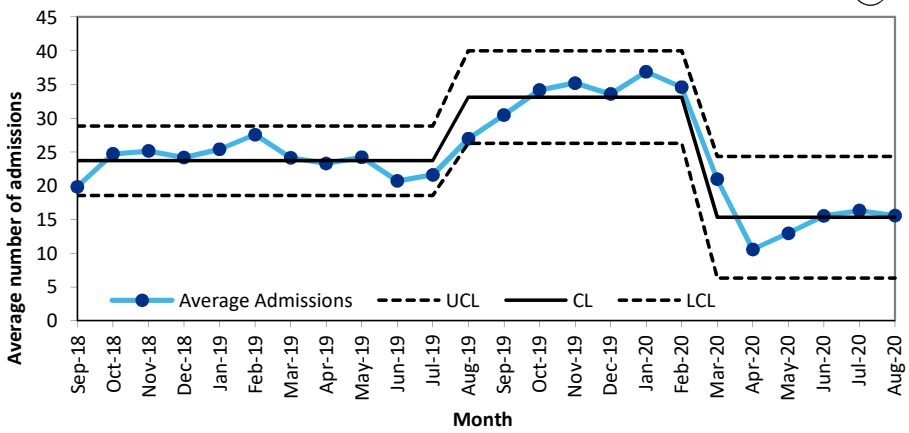
X-SPC Chart

**Average Daily Admissions from A&E**
**September 2018 - August 2020**



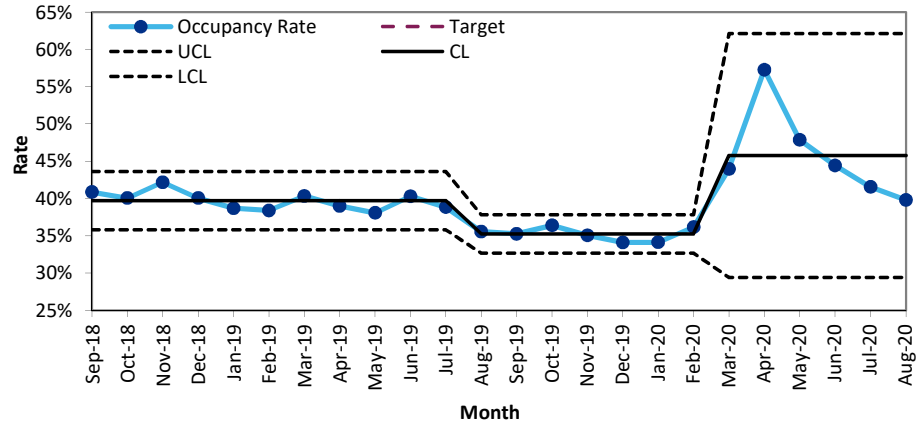

X-SPC Chart

**Average Daily Admissions per Month - GP Referred**
**September 2018 - August 2020**




X-SPC Chart

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




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

**Key Narrative:** The SPC charts have been rebased from August 2019 to reflect a change in recording of activity between admissions from A&E and via GP, and from March 2020 to reflect changes related to the covid pandemic. The wider control limits from March 2020 reflect the increased variation. The current conversion rates include the respiratory assessment unit (RAU), as an admissions area this is being reviewed.

Average daily admissions via A&E have continued to increase over the last five months since March, which corresponds with the increase in A&E attendances but remain within normal control limits.



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

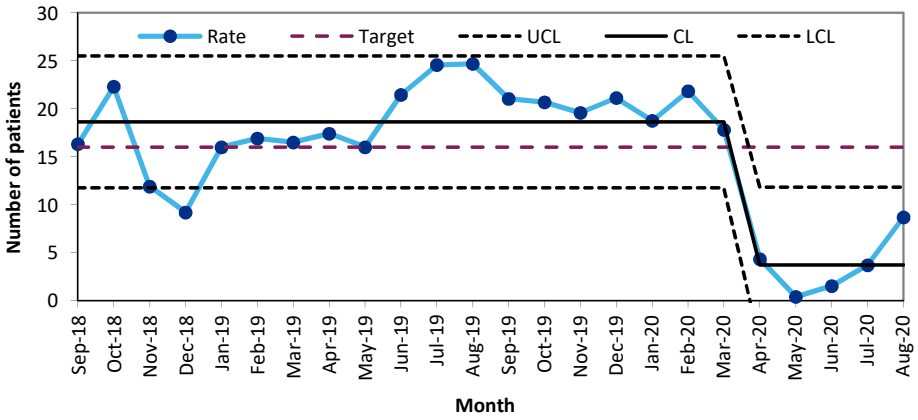
# Board Papers - Performance

## Inpatient Metrics

X-SPC Chart

**Average Number of People Delayed per Day**
**September 2018 - August 2020**

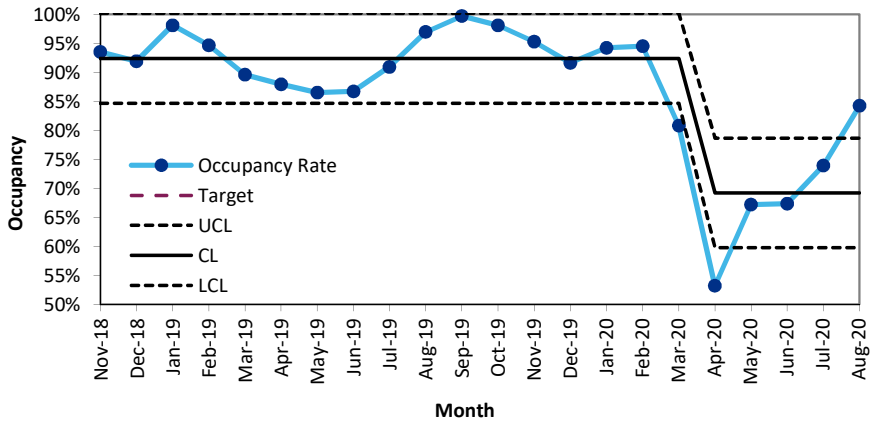
①




X-SPC Chart

**Bed Occupancy**
**December 2018 - August 2020**

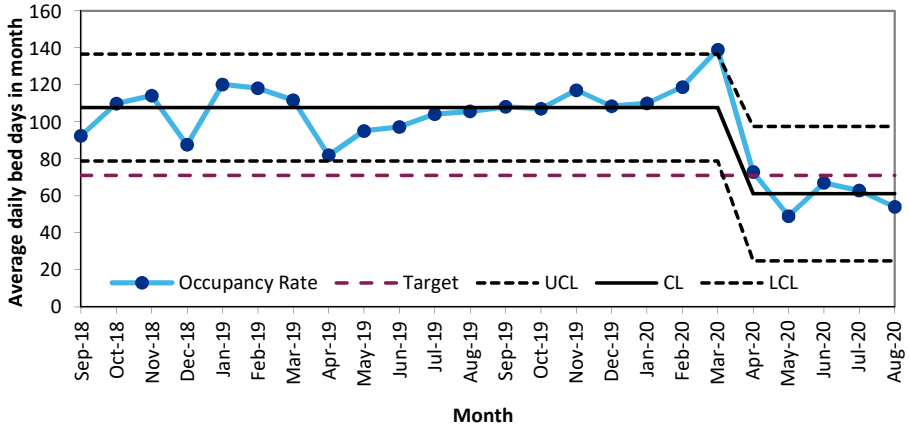
①




X-SPC Chart

**Super Stranded Patients**
**September 2018 - August 2020**

①




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

**Key Narrative:** The SPC charts have been rebased from April 2020 to reflect changes related to the covid pandemic. The average number of people delayed per day showed a run of 9 points above the mean from June 2019, and the number of super-stranded patients showed an increasing trend from April 2019 until the onset of the covid pandemic. The main areas of increasing length of stay are within our rehab areas (21B and Elmhurst) this is related to our increasing activity both elective and non-elective. Whilst the average number of patients delayed is increasing, overall the volume of system delays remains low throughout August. Across the Cheshire winter plan additional care and bed base services are being increased.

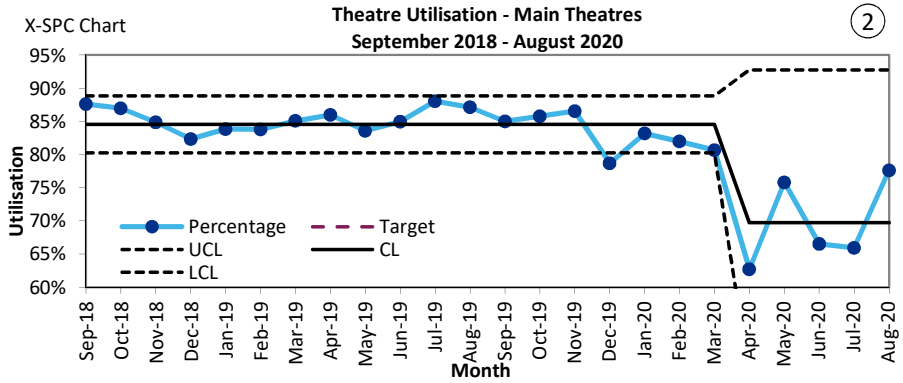
The percentage bed occupancy has not yet settled and shows an increasing trend towards pre-covid levels. Resumption of the elective programme, normal levels of type 1 A&E attendances and increasing transfer delays are contributing to the increased bed occupancy. Winter plans include expanding the bed base to match increased in demand.

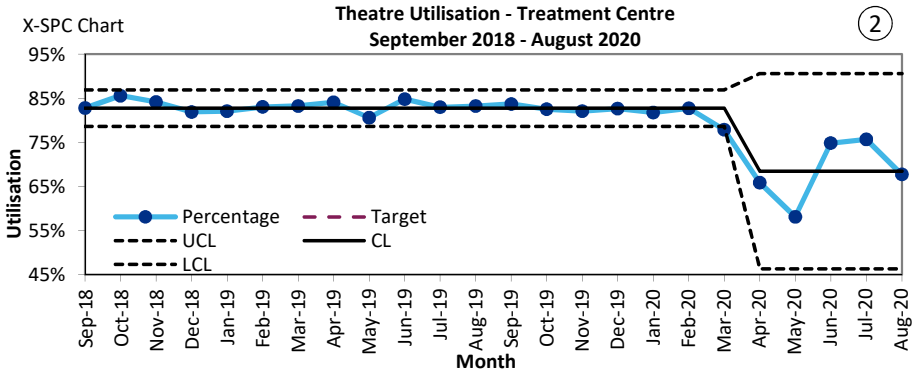


*Data Rating: ①captured locally, ②system captured, ③ published/benchmarked*

# Board Papers - Performance

## Theatre Utilisation

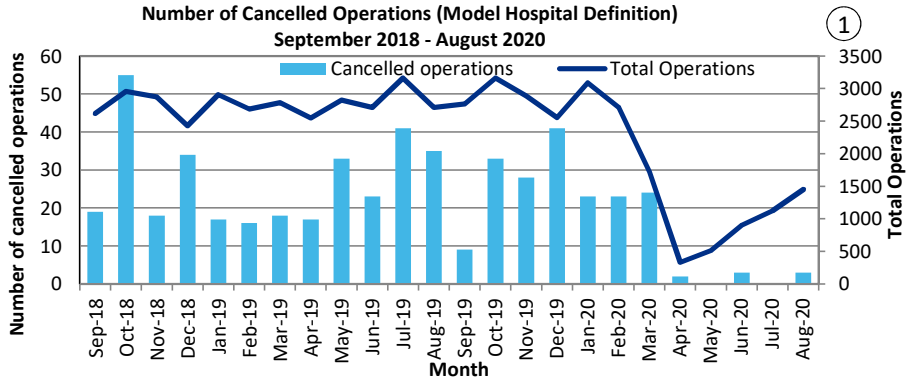


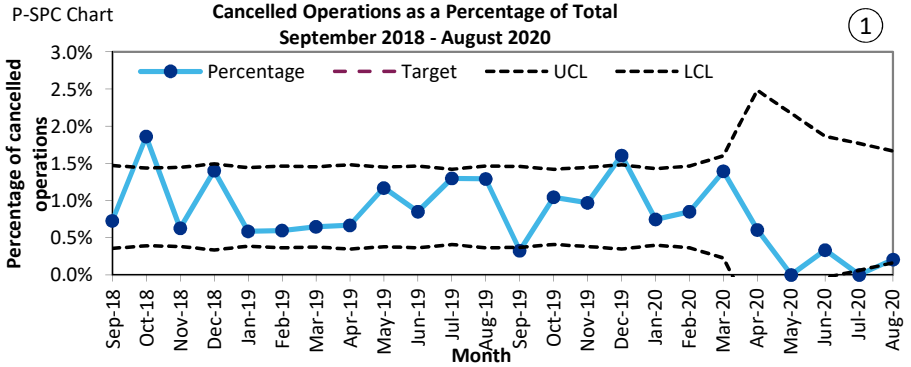




**Accountable:** Chief Operating Officer **Data Owner:** Information Services

**Key Narrative:** The SPC charts have been rebased from April 2020 to reflect changes related to the covid pandemic with the wider control limits from April 2020 reflecting the increased variation. Both processes were running within expected variances prior to the pandemic with the exception of Main Theatres which fell below the lower control limit in December 2019. Theatre utilisation in August was higher than in the previous month which reflects the step up in the restoration of our elective activity and 11% below the same period last year.

## Cancelled Operations




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

**Key Narrative:**

The P-SPC chart adjusts the control limits to take into account each month's denominator and shows the percentage of cancelled operations below the mean from April 2020.

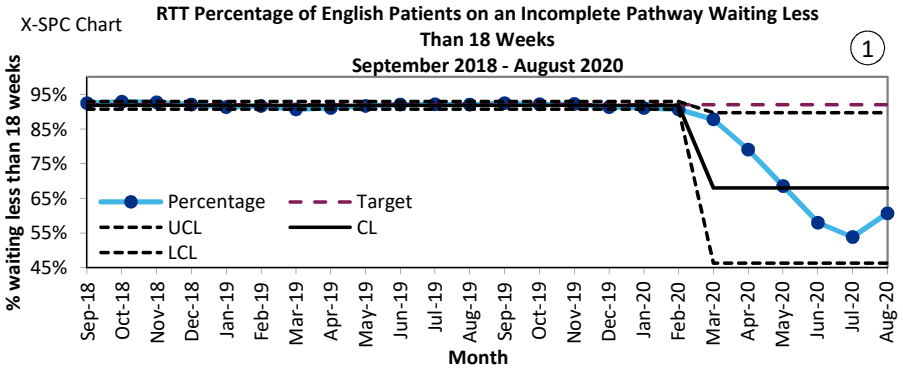


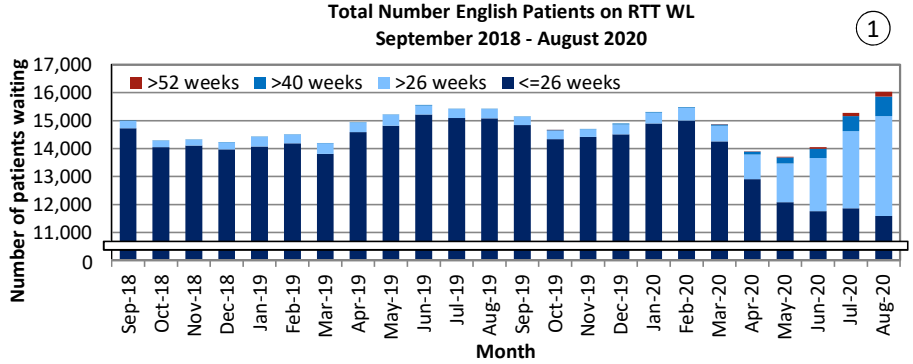
*Data Rating: ①captured locally, ②system captured, ③ published/benchmarked*

# Board Papers - Performance

## Referral to Treatment Waiting Times (RTT)

X-SPC Chart



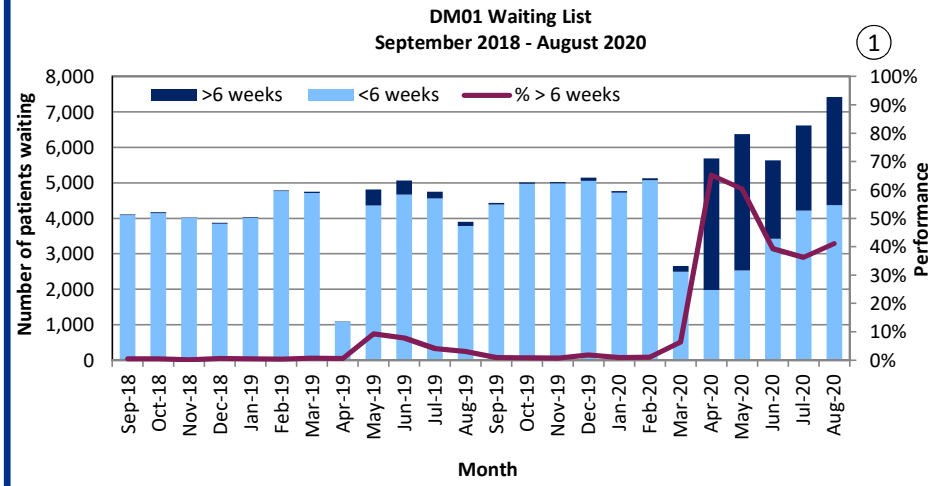




**Accountable:** Chief Operating Officer **Data Owner:** Information Services

**Key Narrative:** The SPC chart has been rebased from March 2020 to reflect changes related to the covid pandemic with the wider control limits reflecting the increased variation. Prior to covid, the process was in control with the exception of October 2018 which exceeded the upper control limit. Recent months show the increased waiting times with August 2020 showing an improvement to the previously reported period. The majority of patients over 52 weeks, of which there are 165, are related to the surgical services and the direct result of the suspension of the elective programme during the pandemic.

*Latest month's data provisional.*

## Diagnostic Waiting Times




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

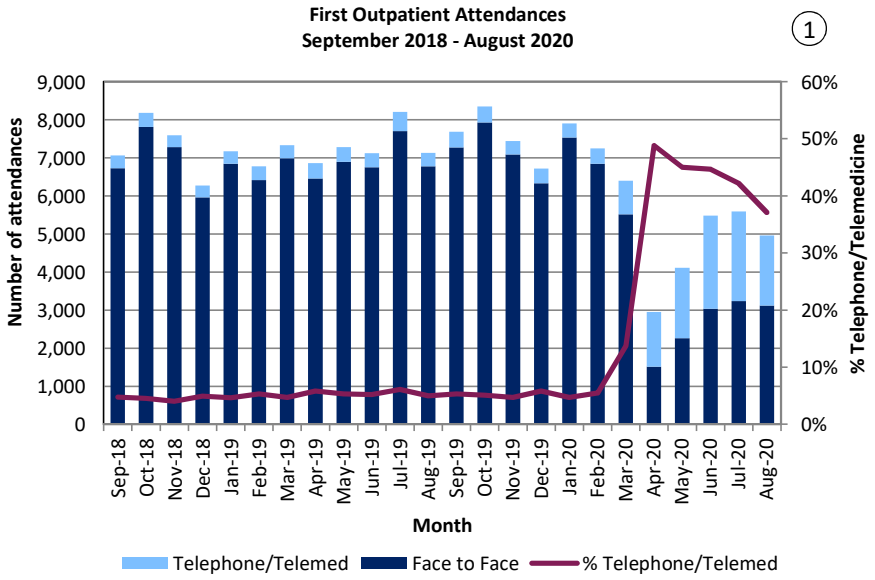
**Key Narrative:** The chart shows the total number of patients, and the proportion of patients waiting more than 6 weeks for a diagnostic has increased compared to pre-covid levels. More patients are also waiting in August compared to July. Issues with the MR scanners in August have extended MR waiting times for routine patients. However, diagnostic services continue to increase their activity levels back toward where they were pre-covid. Additional capacity has also been sourced by the commissioning on an additional CT scanner, which is in place for 10 weeks from September 2020. Endoscopy services remain the most challenged and there is a plan to increase activity levels in September.

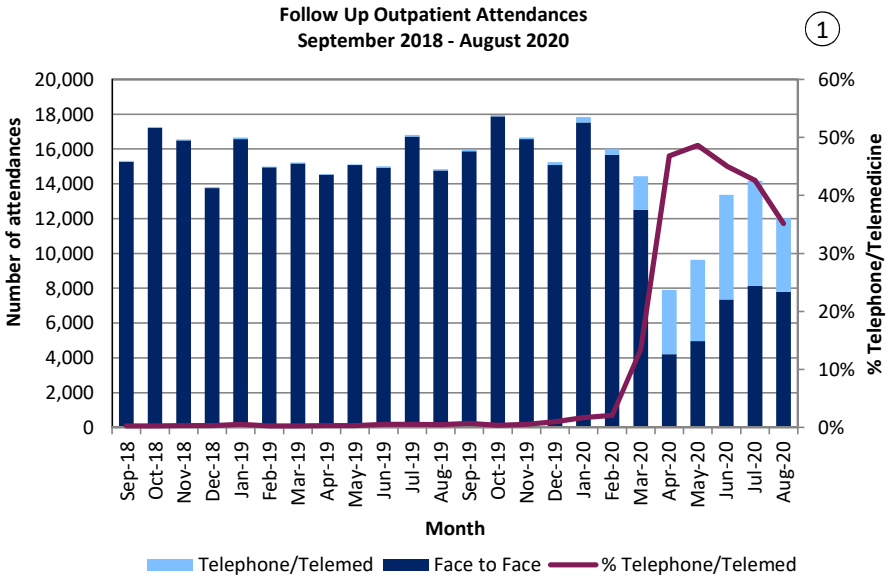


*Data Rating: ①captured locally, ②system captured, ③ published/benchmarked*

# Board Papers - Performance

## Outpatient Activity




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

**Key Narrative:**
The charts show lower activity levels following the start of the covid pandemic with an increased proportion of activity delivered via telephone and telemedicine appointments from April 2020. Although August 2020 is showing lower total activity than delivered in July 2020, the total outpatient activity is comparable when adjusted by the number of working days in the month (1% variance).

Activity levels across new and follow up appointments remains consistent. Use of virtual / telephone appointments has become well embedded within services. The outpatient transformation programme is currently focusing on improving advice and guidance services, rolling out patient initiated follow up pathways and supporting the divisions with the challenges related to social distancing in the resumption of activity.

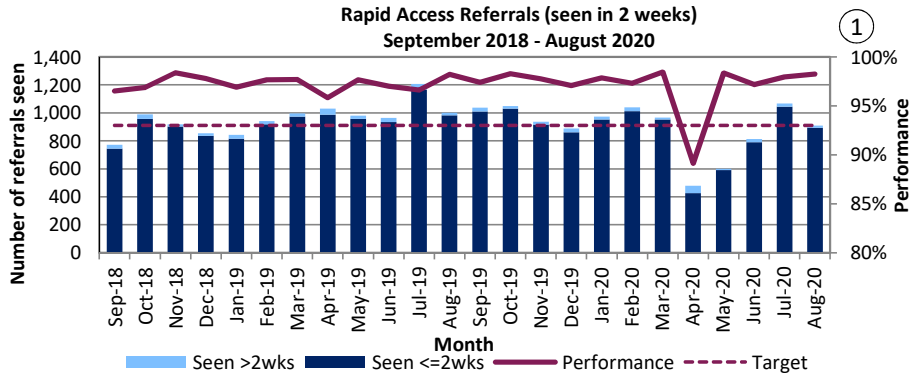
*Data includes contracted specialties.*

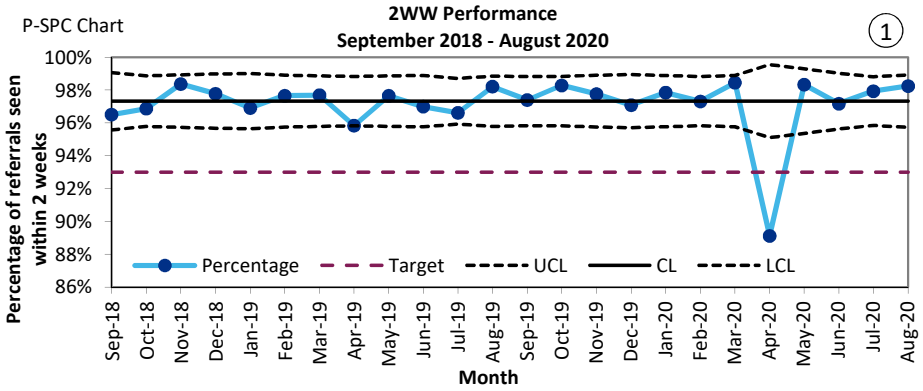


*Data Rating: ①captured locally, ②system captured, ③published/benchmarked*

# Board Papers - Performance

## Rapid Access Referrals



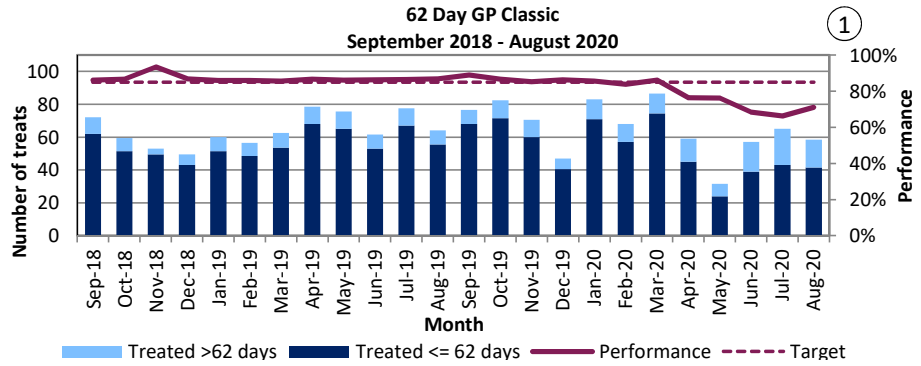



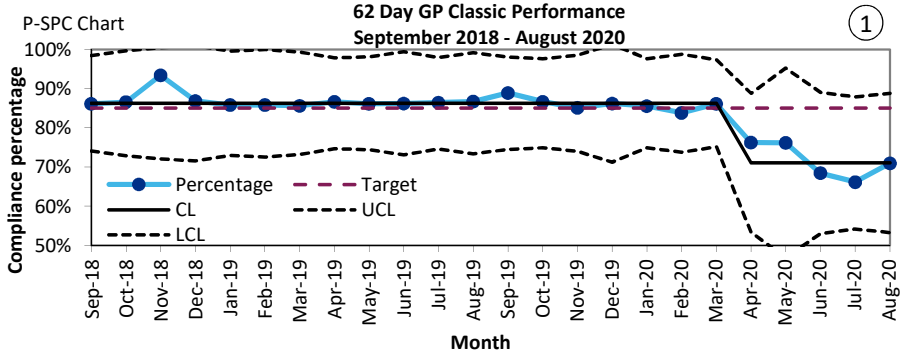

**Accountable:** Chief Operating Officer **Data Owner:** Cancer Performance

**Key Narrative:** The charts show activity has returned to near pre-covid levels. The P-SPC chart adjusts the control limits to take into account the denominator and shows the process remains within the expected range and consistently delivering above the standard. April 2020 is the only exception over the last 24-month period falling below the lower control limit and not delivering the standard. August's data remains provisional.

*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:** The P-SPC chart adjusts the control limits to take into account the denominator and has been rebased from April 2020 to reflect a step-change in compliance following the start of the covid pandemic. August's data is provisional. Delivery against the 62-day standard continues to remain a significant challenge and is performing below the standard and this is consistent for the last five months. However, the volume of patients waiting over 62 days for treatment reduces in August compared to the previous month.

*Latest month's data provisional.*



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

# Performance and Finance - Headlines August 2020

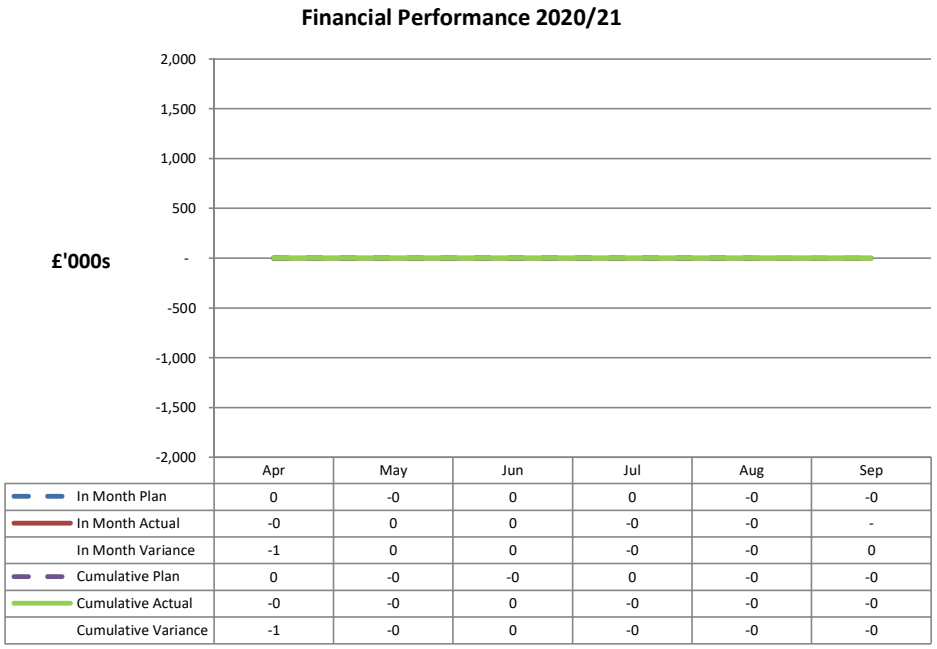
| Current Position | Analysis | Forward View |
|---|---|---|

**The reported position is break even, with the Trust requiring £7.3m in additional Top up funding from regulators. The expectation is that the Trust will meet a break even position until the end of September.**

**The Trust has had first quarter of the top up funding paid, and month 4 has been validated by regulators.**

**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 both July and August.**

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




| | Apr | May | Jun | Jul | Aug | Sep |
|---|---|---|---|---|---|---|
| In Month Plan | 0 | -0 | 0 | 0 | -0 | -0 |
| In Month Actual | -0 | 0 | 0 | -0 | -0 | - |
| In Month Variance | -1 | 0 | 0 | -0 | -0 | 0 |
| Cumulative Plan | 0 | -0 | -0 | 0 | -0 | -0 |
| Cumulative Actual | -0 | -0 | 0 | -0 | -0 | -0 |
| Cumulative Variance | -1 | -0 | 0 | -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, which the Trust is currently awaiting.**

**The top up regime has been extended to the end of September, however for the last 6 months of the year it is expected that there will be a return to more usual financial managements.**

**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. As part of the phase 3 planning, the Trust has submitted an expectation that it will spend £25.3m more than the current baselines that has been allocated to it.**

# Performance and Finance - Income From Patient Care August 2020

Current Position

Income from Patient Care activity covers both contract income, Private Patient funding and Injury Cost Recovery Scheme income. This income is £1.18m below plan.

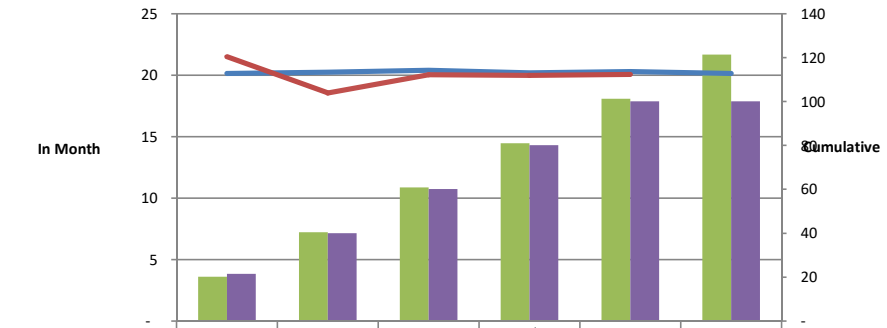
Contract income is £0.4m below plan which relates to non-contract/cross border flow activity as it is not currently being billed as part of the covid-19 guidelines.

The value of reduced activity as a result of COVID -19 is £24m year to date, this is received via the block and top up arrangements.

Private patient and the injury cost recovery scheme income is under plan by £0.8m year to date, as a result of the reduced activity within the hospital and social distancing measures in place.

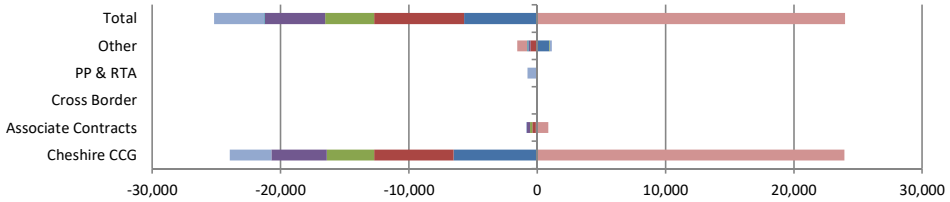
Analysis

**Contract Income Performance 2020/21 £'m**




| | Apr | May | Jun | Jul | Aug | Sep |
|---|---|---|---|---|---|---|
| Cumulative budget | 20 | 40 | 61 | 81 | 101 | 121 |
| Cumulative actual | 21 | 40 | 60 | 80 | 100 | 100 |
| In month budget | 20 | 20 | 20 | 20 | 20 | 20 |
| In month actual | 21 | 19 | 20 | 20 | 20 | - |

**Cumulative Variance to Patient Care Income Plan £'000s**




| | Cheshire CCG | Associate Contracts | Cross Border | PP & RTA | Other | Total |
|---|---|---|---|---|---|---|
| Unplanned Care | -6,514 | -96 | -14 | - | 941 | -5,684 |
| Day case | -6,196 | -284 | -2 | - | -537 | -7,018 |
| Elective | -3,680 | -185 | -1 | - | 52 | -3,813 |
| Outpatients | -4,329 | -247 | -1 | - | -138 | -4,715 |
| High cost drugs | 49 | 9 | 2 | - | -107 | -47 |
| COVID | 23,891 | 851 | -0 | - | -762 | 23,980 |
| Other Contracts | -3,222 | -48 | 3 | -767 | 146 | -3,888 |
| Total | 0 | 0 | -14 | -767 | -404 | -1,185 |

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.

From October onwards contract income values will be revised, there will be an expectation to work to manage to a system total for October to March.

Financial penalties have been set out if systems do not meet the activity restoration requirements set out for Phase 3. Where activity is below the expected value, 25% (for elective and outpatient procedure activity) and 20% (for outpatients) of the shortfall will be deducted from contract income. Based on the Trust forecast activity this will result in a reduction in income of £615k.

From October high cost drugs will not be on a block contract and will be charged to commissioners at cost.

# Performance and Finance - Pay Expenditure August 2020

Current Position

**Cumulatively Pay is worse than the NHSI expectation by £5.2m, 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 (£1.15m)**

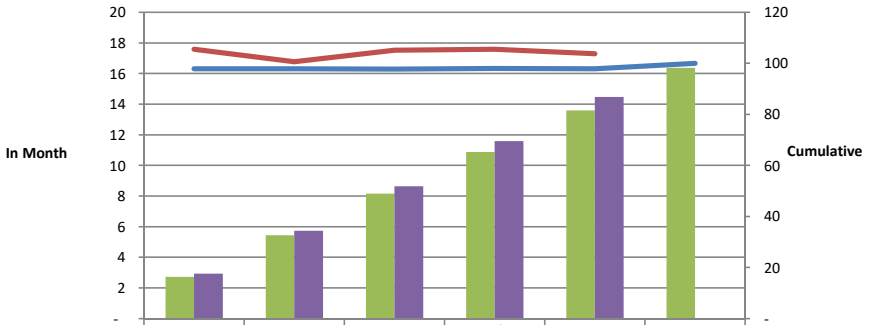
**- Additional Medical costs including paid student placements (£1m)**

**- Increase in acuity pre-dominantly impacting nursing, and further paid student placements (£1.5m)**

**- Increased sickness levels (£1.8m)**

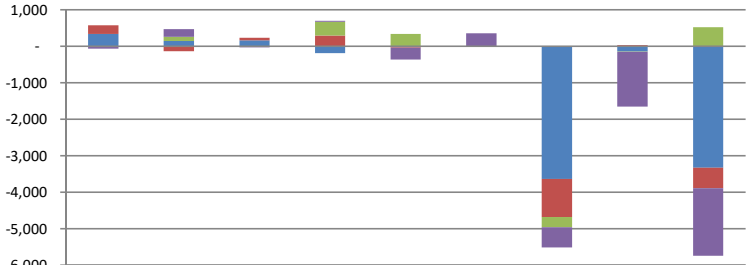
Analysis

## Pay Expenditure 2020/21 £'m




| | Apr | May | Jun | Jul | Aug | Sep |
|---|---|---|---|---|---|---|
| Cumulative budget | 16 | 33 | 49 | 65 | 82 | 98 |
| Cumulative actual | 18 | 34 | 52 | 69 | 87 | - |
| In month budget | 16 | 16 | 16 | 16 | 16 | 17 |
| in month actual | 18 | 17 | 18 | 18 | 17 | - |

## Pay Variances by Staff Group and Division £'000s




| | DMEC | S&C | W&C | CSSD | CCICP | Estates | COVID | Other | Total |
|---|---|---|---|---|---|---|---|---|---|
| Total | 521 | 341 | 202 | 522 | -20 | 356 | -5,511 | -1,626 | -5,214 |
| Infrastructure Support Staff | -52 | 219 | -27 | 32 | -325 | 356 | -554 | -1,506 | -1,857 |
| Non Clinical Staff | -9 | 107 | -3 | 373 | 345 | - | -281 | -5 | 529 |
| Medical Staff | 241 | -135 | 70 | 299 | -17 | - | -1,044 | 30 | -557 |
| Nursing Staff | 341 | 150 | 162 | -182 | -23 | - | -3,633 | -145 | -3,330 |

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 executive 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 – new schemes being developed.**

**Within the forecast for the second half of the year, there has been a level of premium cost built in to support an increase in outsourcing and others ways of increasing capacity to achieve the phase 3 restoration of services, however as all Trusts are pressured with delivering an increase in performance – this will be depended on availability of workforce.**

# Performance and Finance - Non-Pay Expenditure August 2020

Current Position

Non Pay is £139k better than the expectations set out by NHSI regulators, with a deterioration in month of £0.3m associated with increased planned care costs.

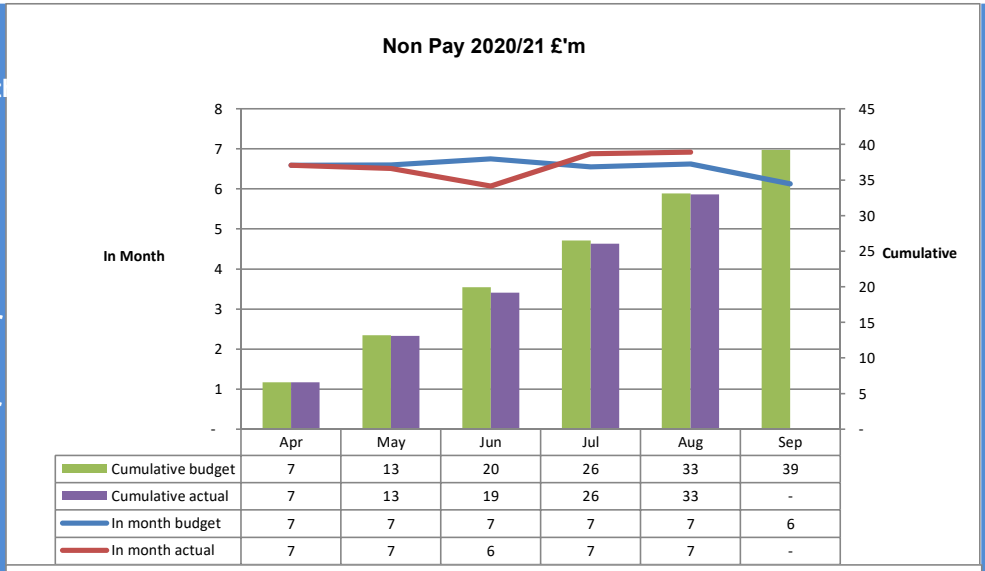
Whilst the costs associated with Covid-19 have been separately identified as being £4.229m there are a number of offsets associated with planned in the early months of the year which have offset this cost.

The key expenditure within non pay for Covid-19, relates to PPE and increased consumables (£2.2m), temporary fixtures and enablement (£0.9m), decontamination (£0.6m) and IT costs (£0.6m).

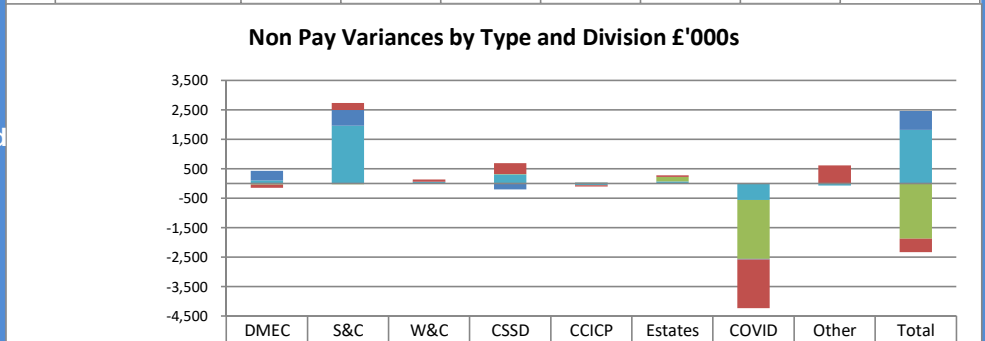
Whilst there has been a real reduction within planned care in areas such as drugs, and prosthetics costs in the early part of the financial year, July and August have seen an increase in activity (particularly within chemotherapy and surgical services) and the associated costs have increased.

Diagnostic activity has also seen an increase in the average run rate of costs in July and August as a result of increased activity in response to tackling backlogs that have built up during the early part of the pandemic.

Analysis




| | Apr | May | Jun | Jul | Aug | Sep |
|---|---|---|---|---|---|---|
| Cumulative budget | 7 | 13 | 20 | 26 | 33 | 39 |
| Cumulative actual | 7 | 13 | 19 | 26 | 33 | - |
| In month budget | 7 | 7 | 7 | 7 | 7 | 6 |
| In month actual | 7 | 7 | 6 | 7 | 7 | - |




| | DMEC | S&C | W&C | CSSD | CCICP | Estates | COVID | Other | Total |
|---|---|---|---|---|---|---|---|---|---|
| Total | 293 | 2,702 | 136 | 494 | -80 | 279 | -4,229 | 543 | 139 |
| Other Non Pay | -103 | 243 | 73 | 375 | -53 | 50 | -1,646 | 610 | -452 |
| Drugs | 330 | 525 | 10 | -203 | 1 | -0 | -25 | 2 | 641 |
| Non Clinical Supplies | -40 | -29 | -2 | 15 | 26 | 158 | -2,003 | 2 | -1,875 |
| Clinical Supplies | 105 | 1,965 | 54 | 306 | -54 | 72 | -555 | -69 | 1,824 |

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 a month. 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 August 2020

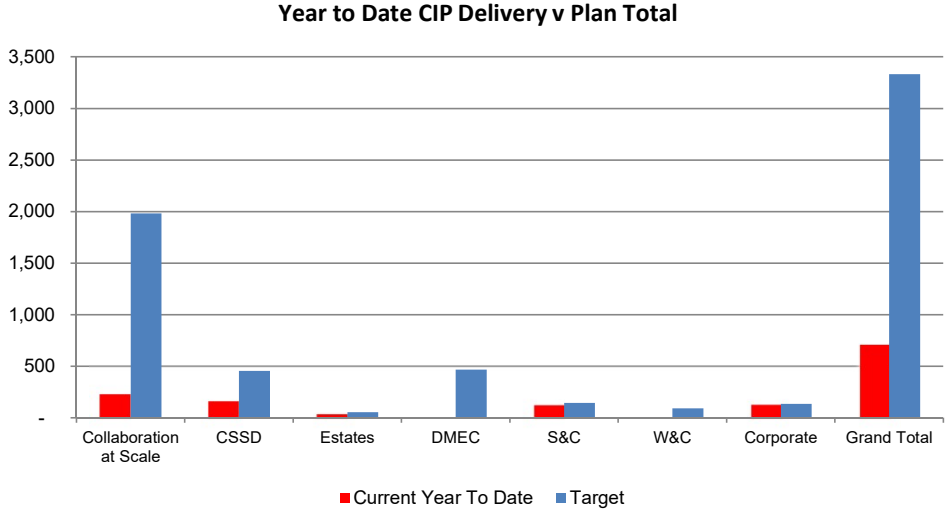
Current Position

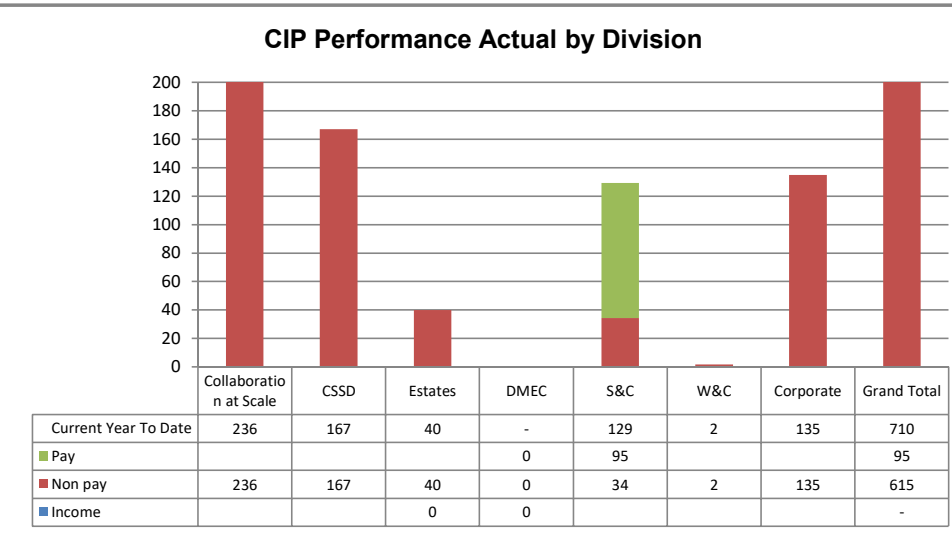
**The Trust is not currently being managed by regulators in terms of a cost improvement programme. The targets shown within the graph opposite illustrate the indicative cost savings expected in accordance with the draft plan.**

**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.**

**Saving schemes that will be progress this year, at present are focussed on having no or low patient impact.**

Analysis




| | Collaboration at Scale | CSSD | Estates | DMEC | S&C | W&C | Corporate | Grand Total |
|---|---|---|---|---|---|---|---|---|
| Current Year To Date | 236 | 167 | 40 | - | 129 | 2 | 135 | 710 |
| Pay | | | | 0 | 95 | | | 95 |
| Non pay | 236 | 167 | 40 | 0 | 34 | 2 | 135 | 615 |
| Income | | | 0 | 0 | | | | - |

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.**

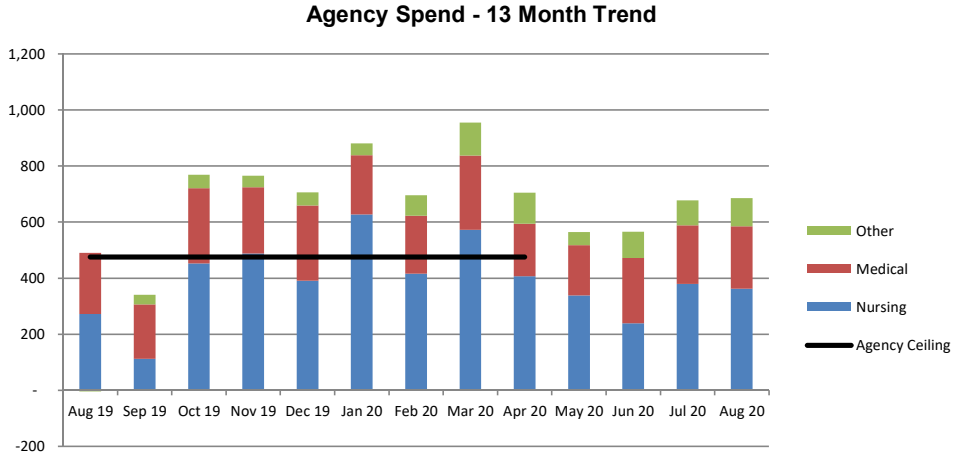
# Performance and Finance - Agency Spend August 2020

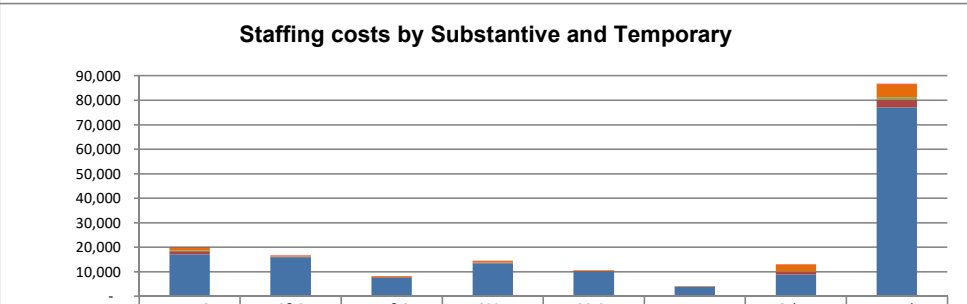
Current Position

Agency expenditure has sustained at a similar level for August as July.

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 for registered nurses. This is reflected in the use of the high cost agencies of Thornbury and Pulse, which has increased during August.

Analysis




| | DMEC | S&C | W&C | CSSD | CCICP | Estates | Other | Total |
|---|---|---|---|---|---|---|---|---|
| Total | 19,812 | 16,680 | 8,118 | 14,460 | 10,692 | 4,086 | 12,917 | 86,764 |
| Waiting List | 93 | 53 | 6 | 87 | - | - | 4 | 244 |
| Bank | 958 | 322 | 388 | 509 | 217 | 165 | 2,784 | 5,343 |
| Locum | 319 | 132 | 19 | 136 | 155 | - | 122 | 884 |
| Agency | 1,325 | 272 | 34 | 260 | 224 | 0 | 1,081 | 3,197 |
| Substantive | 17,118 | 15,900 | 7,669 | 13,468 | 10,096 | 3,920 | 8,925 | 77,096 |

Forward View

It is encouraging that the rates of agency expenditure are improving, 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 during 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 August 2020

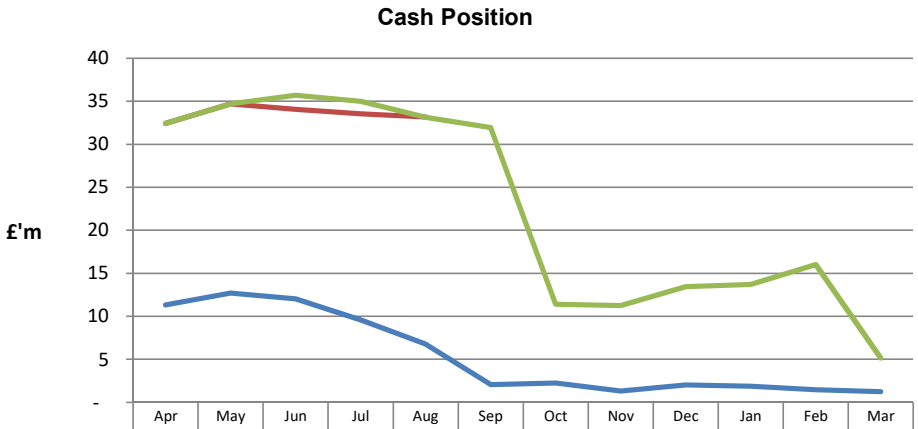
Current Position

**Cash Position**
**Cash is better than originally anticipated by £26m.**

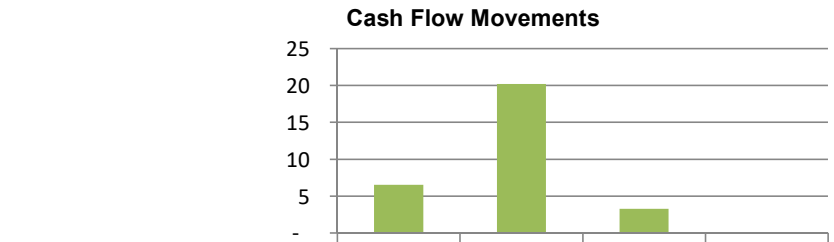
**This is due to £20m of contract income being paid in advance to support cash flow during the COVID-19 pandemic. In addition, capital expenditure is behind plan by £5.4m.**

**Additional COVID-19 top up payments have been validated and agreed by NHSI totalling £5.6m, of which £3.8m have now been received.**

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 | 33 | | | | | | | |
| 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 | 7 | 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 August 2020.**

# Performance and Finance - Capital Expenditure August 2020

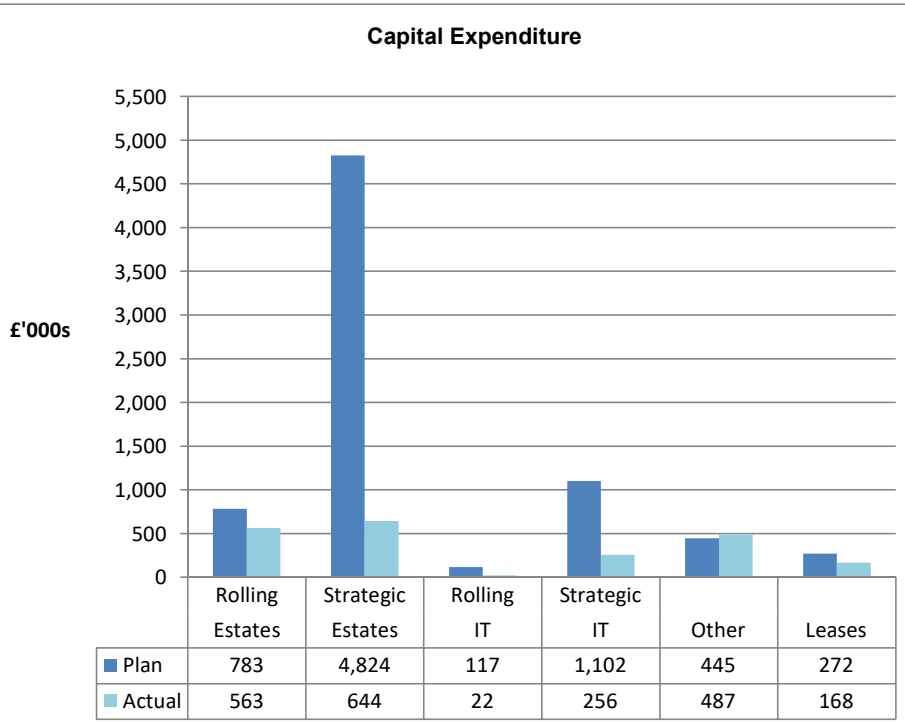
Current Position

**The capital programme (excluding leases) is £5.3m less than anticipated which is mainly due to:**

**(£1.4m) Car Park Expansion**
**(£0.8m) ICU Conversion**
**(£0.7m) Third CT Enabling**
**(£0.6m) Maintenance & Refurbishment**
**(£0.5m) Endoscopy Works**
**(£0.5m) 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 | 783 | 563 | -220 | 4,292 | 4,379 | 87 |
| Estates | Strategic | 4,824 | 644 | -4,180 | 8,223 | 7,083 | -1,140 |
| IT | Rolling | 117 | 22 | -95 | 353 | 353 | 0 |
| IT | Strategic | 1,102 | 256 | -846 | 5,655 | 5,666 | 11 |
| Other | | 445 | 487 | 42 | 445 | 83 | -362 |
| Leases | | 272 | 168 | -104 | 3,679 | 3,679 | 0 |
| | | **7,543** | **2,139** | **-5,404** | **22,647** | **21,243** | **-1,404** |

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 August 2020

Current Position | Analysis | Forward View

**Assets Non-Current**
The capital programme expenditure is £5.4m less than the anticipated plan, mainly due to slippage on the Car Park Expansion of £1.4m and ICU Conversion £0.8m.

**Assets Current**
Trade receivables have reduced by £1.6m compared to March 2020, mainly due to receiving payments for 19/20 PSF. Cash is better than expected due to £19m of contract income being paid in advance to support cash flow during the COVID-19 pandemic.

**Current Liabilities**
Trade Payables has reduced by £5.7m 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 August (£'000) | Variance (£'000) |
|---|---|---|---|
| **Assets** | | | |
| Assets, Non-Current | 104,476 | 104,073 | -403 |
| Assets, Current | 32,811 | 50,395 | 17,584 |
| **ASSETS, TOTAL** | **137,287** | **154,468** | **17,181** |
| **Liabilities** | | | |
| Liabilities, Current | -39,717 | -56,924 | -17,207 |
| Liabilities, Non Current | -8,655 | -8,752 | -97 |
| **TOTAL ASSETS EMPLOYED** | **88,915** | **88,792** | **-123** |
| **Taxpayers' and Others' Equity** | | | |
| Taxpayers Equity | 88,915 | 88,792 | -123 |
| **TOTAL FUNDS EMPLOYED** | **88,915** | **88,792** | **-123** |

**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.**

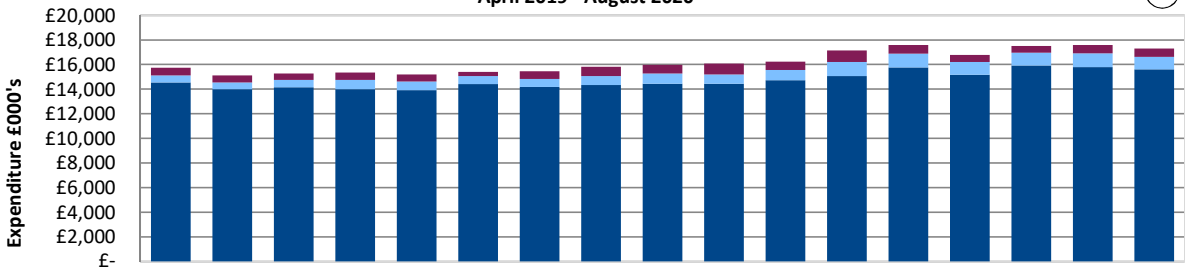
# Board Papers - Finance - COVID Capital Schemes August 2020

| 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 | 39 | 0 | 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 | 73 | 73 | 0 | 73 | 73 | 0 |
| | | | | | | | | | | |
| | | | | **489** | **444** | **444** | **0** | **489** | **489** | **0** |

# Board Papers - Workforce

## Finance and Costings

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



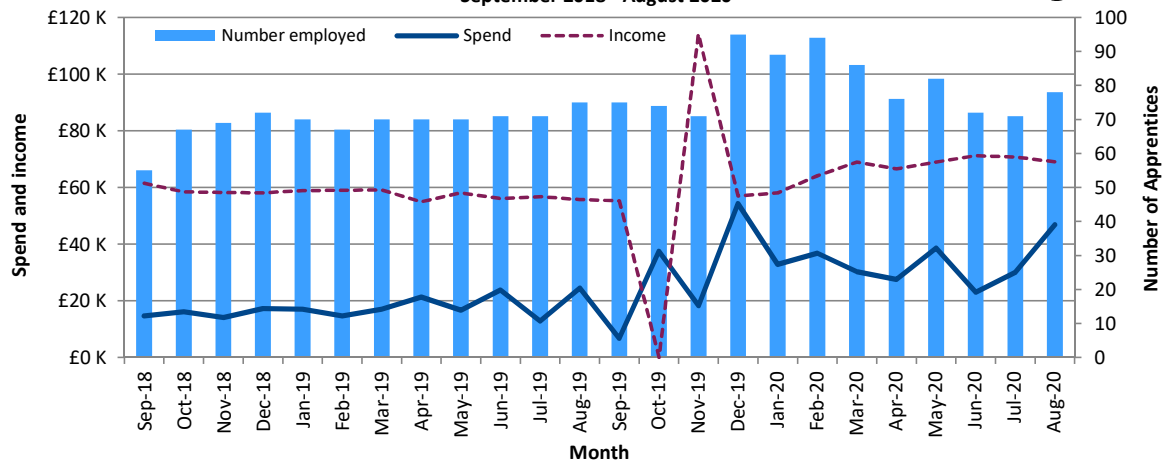

| | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Agency | £638 | £570 | £510 | £591 | £566 | £341 | £619 | £765 | £706 | £881 | £695 | £955 | £705 | £565 | £565 | £677 | £685 |
| Bank | £554 | £556 | £595 | £761 | £713 | £646 | £636 | £711 | £832 | £750 | £817 | £1,127 | £1,124 | £1,052 | £1,029 | £1,132 | £1,010 |
| Substantive | £14,553 | £13,995 | £14,154 | £13,988 | £13,914 | £14,421 | £14,189 | £14,344 | £14,427 | £14,439 | £14,733 | £15,071 | £15,754 | £15,161 | £15,921 | £15,779 | £15,604 |

Month

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

**Key Narrative:** Slight decrease in substantive workforce expenditure in August 2020 compared to the previous month's position. Bank and agency staff both higher in August 2020 compared to the same period last year.

**Apprenticeship Spend by Month**
**September 2018 - August 2020**




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

**Key Narrative:** The chart shows number of Apprentices employed has increase in August 2020 with spend running below income.

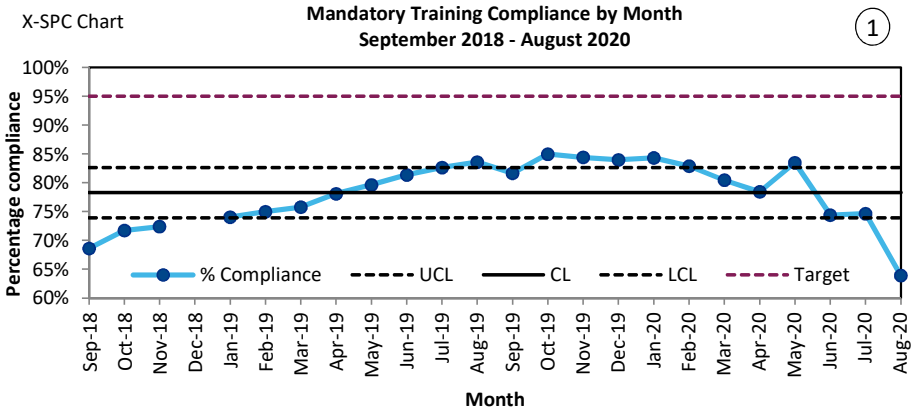


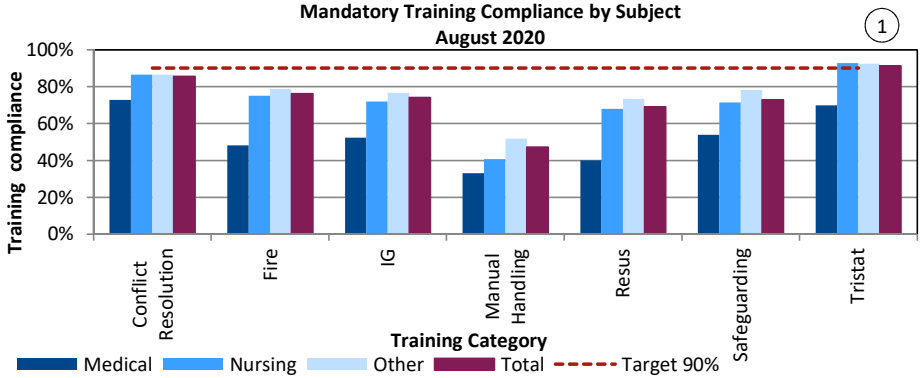
*Data Rating: ①captured locally, ②system captured, ③ published/benchmarked*

# Board Papers - Workforce

## Training

X-SPC Chart

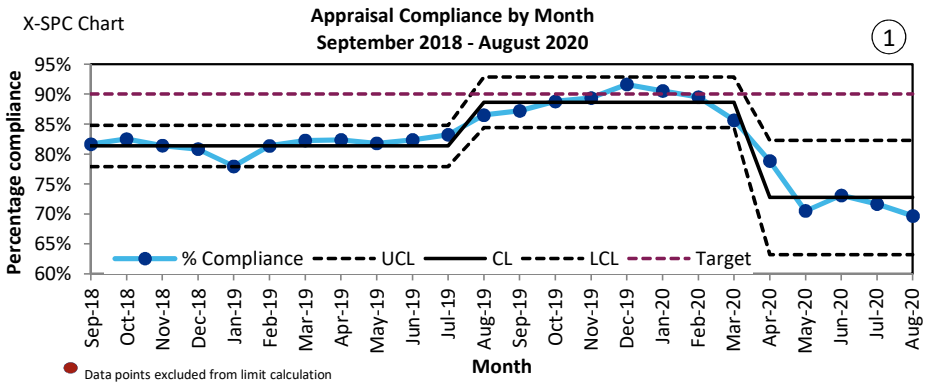


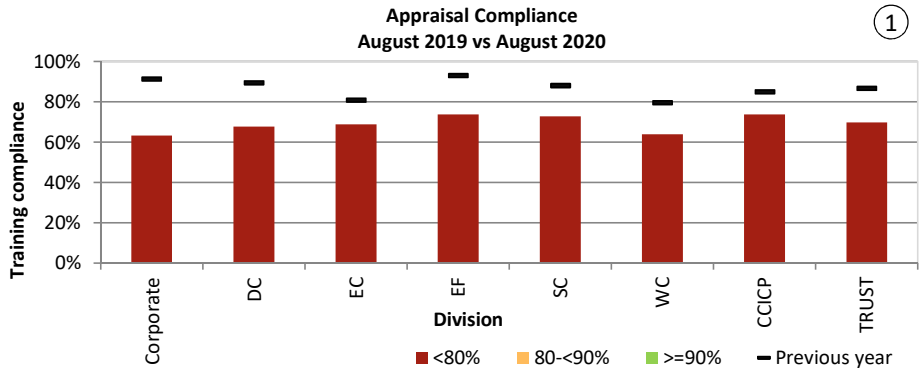




**Accountable:** Director of Workforce & Organisational Development
**Data Owner:** Workforce Directorate
**Key Narrative:** The SPC chart shows an increasing trend from September 2018 to August 2019 but remaining below the 95% target. There has been a decline in compliance in recent months with August 2020 having the lowest compliance.

## Appraisals

X-SPC Chart



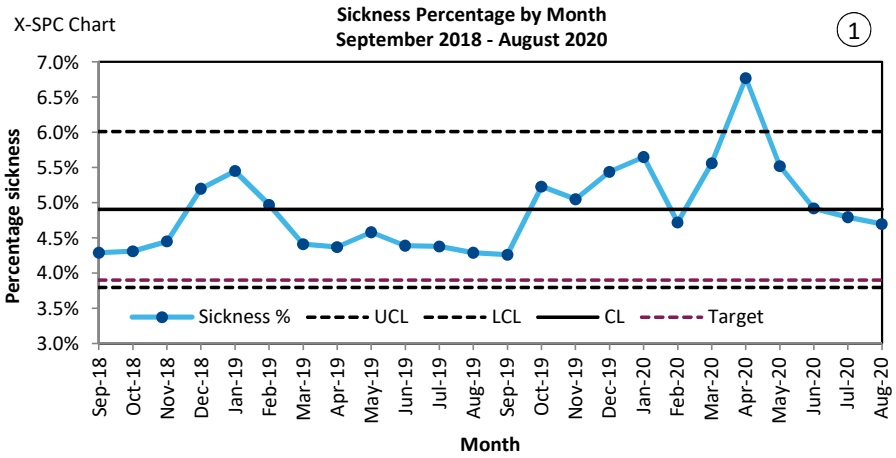

**Accountable:** Director of Workforce & Organisational Development
**Data Owner:** Workforce Directorate
**Key Narrative:** The SPC chart has been rebased from August 2019 to reflect a sustained improvement in compliance. The process showed normal variation for the following 8 months and the process was capable of meeting the target. A further rebase was set from April 2020 to reflect the decline in compliance since the start of the pandemic.



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

# Board Papers - Workforce

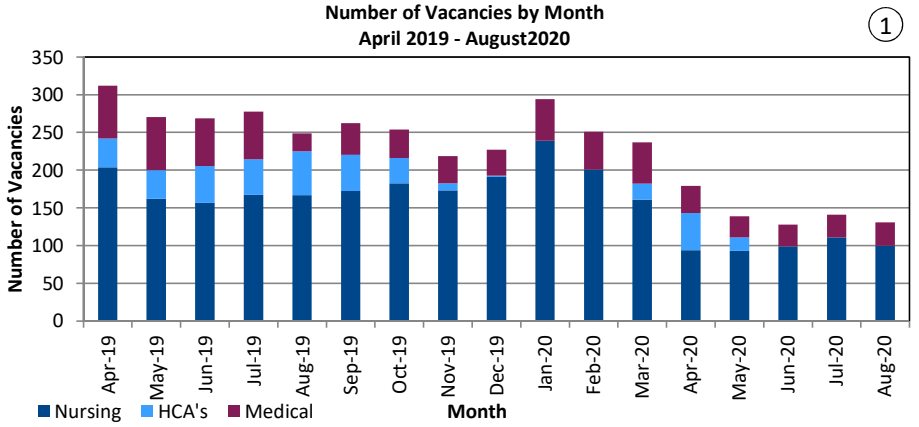
## Sickness

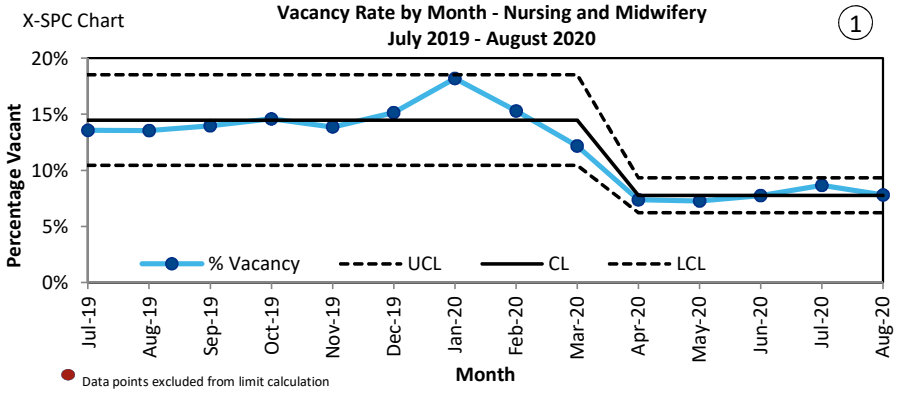



**Accountable:** Director of Workforce & Organisational Development
**Data Owner:** Workforce Directorate

**Key Narrative:** Over recent months, sickness rates remain within expected range with the exception of April 2020 which exceeded the upper control limit. The target has not been met over the 24-month period shown.

## Vacancies




**Accountable:** Director of Workforce & Organisational Development
**Data Owner:** Workforce Directorate
**Key Narrative:** The charts show a marked improvement in the number of vacancies from April 2020. The SPC chart has been rebased from this date to show the improved mean.



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

# Quality & Safety (Q&S) Committee
# Chair's Assurance Report
# September 2020

| | |
|---|---|
| **Report to** | Board of Directors |
| **Date** | 14 September 2020 |
| **Report from** | John Church, NED Deputy Chair |
| **Report prepared by** | Katharine Dowson, Head of Corporate Governance |
| **Executive Lead/s** | Julie Tunney, Director of Nursing & Quality (apologies given)<br>Sally Mann, Interim Deputy Director of Nursing deputising<br>Murray Luckas, Medical Director (apologies given)<br>Clare Hammell, Deputy Medical Director deputising |
| **Committee meeting quoracy** | Yes ☐ No ☒ |

## KEY AREAS OF ASSURANCE

- **Board Assurance Framework –** The BAF matrix provided an overview of the Trust's strategic risk environment, including those risks being monitored by the Committee

- **Complaints Dashboard –** the first draft of the dashboard demonstrated that systems and processes were in place to allow for an overview of complaints and concerns, including trends, themes and lessons learnt in future iterations of the dashboard

- **Quality Improvement Faculty** - **acceptable assurance**: six workstreams are in place and making good progress to support the three objectives for the project: to build improvement capability, develop a QI infrastructure and build the right culture to promote psychological safety and innovation across the organisation

- **Quality Governance Oversight Report** - **acceptable assurance**: learning from recent incident reviews was shared and a five year look back review had been commissioned in response to two recent maternity incidents relating to foetal monitoring. The Quality Summit Matters bulletin was commended by the Committee

- **Clinical Negligence Scheme for Trusts Year 3 (CNST)** – **partial assurance:** 5 of 10 safety actions remain in progress with described actions in place. Full compliance planned for March 2021 (national submission paused due to Covid)

- **Organ Donation Annual Report** - **acceptable assurance**: a higher number of donors in 2019/20 than previous years, with referral and consent rates higher than national benchmarking. Challenge is to maintain this through a busy winter period as donor patients require an extended stay on the Critical Care Unit

## KEY CONCERNS/RISKS

Impact of Covid on capacity in CCU for potential organ donations

## Priority Areas: DECISIONS MADE

None.

## RECOMMENDATION

To note.

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

# BOARD OF DIRECTORS

| | | |
|---|---|---|
| **Agenda Item** | **10** | Date of Meeting: 05/10/2020 |
| **Report Title** | Quality, Safety and Patient Experience Report - August 2020 | |
| **Executive Lead** | Medical Director and Director of Nursing and Quality | |
| **Lead Officer** | Associate Director of Quality Governance | |
| **Action Required** | To Note | |

| | | | | | |
|---|---|---|---|---|---|
| X | **Acceptable assurance**<br>General confidence in delivery of existing mechanisms / objectives | ☐ | **Partial assurance**<br>Some confidence in delivery of existing mechanisms / objectives | ☐ | **No assurance**<br>No confidence in delivery |

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

- There have been 4 reportable StEIS incidents
- Incident reporting continues to improve to pre covid times
- There was an expected drop in the compliance for complaint response times
- There have been no transmitted covid cases since 18.06.2020

**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)*

NA

**REPORT DEVELOPMENT**

| Committee/ Group Name | Date | Report Title | Lead | Brief summary of key issues raised and actions agreed |
|---|---|---|---|---|
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## 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 August 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 August 2020 Trust wide dashboard containing:

- Patient safety incidents – Incident reporting continues to be reflective of pre COVID-19 times. The harm rate increased in August and following a deep dive into the incidents (presented to EQGG 16.09.2020) – there were no concerns raised. Increased pressure ulcer reporting of harm was discussed as being similar to the national picture – benchmarking data has been requested.
- There were 4 StEIS reportable incidents in August 2020
  - **Women's and Children's**
    - A baby required cooling and transfer to Liverpool Women's Hospital. There is a review of foetal monitoring underway.
    - A patient had a delay in having emergency treatment for an ectopic pregnancy.
  - **Division of Medicine and Emergency Care**
    - A patient with a diagnosis of cirrhosis of the liver did not receive six monthly screening appointments. The patient developed a carcinoma.
  - **Diagnostics and Clinical Support Services**
    - A patient with Hodgkins Lymphoma did not receive an appointment for a PET CT scan. He has since had a scan and has extensive disease.
- There were no never events in August 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 August 2019.
- There have been no MRSA cases reported for over 12 months.
- There were no cases of hospital acquired Clostridium Difficile reported.

- There were 4 cases of E-Coli reported in August 2020, all were investigated as unavoidable.
- There were no cases of MSSA.
- Inpatient pressure ulcers have come back into the expected range in August 2020.
- A cluster RCA was completed on CCICP pressure ulcers, there were no significant concerns. Incidental learning from the report has been implemented across the division.
- 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 continues to be monitored. There is an expected decrease in compliance in August 2020, this is due to the backlog from COVID-19 on overdue cases. The standard is expected to continue to improve to the stretched targets set in the recovery plan.

## 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 August 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: 22/09/2020**

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

# BOARD OF DIRECTORS

| | | |
|---|---|---|
| **Agenda Item** | **12** | Date of Meeting: 05/10/2020 |
| **Report Title** | Nursing and Midwifery Comprehensive Staffing Report | |
| **Executive Lead** | Julie Tunney Director of Nursing & Quality | |
| **Lead Officer** | Helen Nutkins Head of Nursing Safe Staffing and Workforce Utilisation | |
| **Action Required** | To decide | |

| | | | | | |
|---|---|---|---|---|---|
| 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)*

- Assurance of safe staffing levels across Nursing and Midwifery
- No investment required in Adult and Paediatric wards
- Investment required in Midwifery

**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)*

Implementation of Recommendations

**REPORT DEVELOPMENT**

| Committee/ Group Name | Date | Report Title | Lead | Brief summary of key issues raised and actions agreed |
|---|---|---|---|---|
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## 1. Executive Summary

This paper aims to provide assurance that Mid Cheshire Hospitals NHS Foundation Trust (MCHFT) plans safe nursing, midwifery and care staffing levels across all in-patient ward areas and that there are appropriate systems in place to manage the demand for nursing, midwifery and care staffing.

The Trust normally provides two updates to Board per year detailing the findings of strategic staffing reviews undertaken in line with the National Quality Boards (NQB) requirements (2013 & 2016) to review nursing and midwifery staffing as a quality and performance measure. Acuity reviews are undertaken in January and July.

Due to Covid 19, the ward configurations and staffing levels have been subject to constant review as the Trust has created covid positive, surveillance and covid free green wards. This constantly evolving situation has made the data collection process challenging, in that the normal acuity model cannot account for this in areas where wards have moved or changed use constantly during the Covid management plans.

During this year, whilst dealing with the pandemic, the Trust has instead carried out 6 weekly staffing and acuity reviews, using the professional judgement of its senior nursing team and continued to review the monthly safe staffing report at the Trust Board meeting though out the Covid-19 pandemic to ensure that there is line of sight into the issue.

This paper therefore sets out to give assurance that safe staffing processes were in place throughout those areas affected by Covid 19 (Medical and Surgical wards predominantly) but has still used a methodology to assess staffing requirements in those areas less affected such as Women's & Children's services. The Emergency Department is also looked at separately as during the period, there has been a physical extension of the department making it larger.

The papers shows that the two key areas for investment are the Emergency Department, however, this is based on its expansion with the development of the new build next year, and Maternity services which is based on the requirement to deliver the new continuity of care model mandated by NHSE.

There are no additional funding requirements for this financial year, however, the maternity continuity of care requirement will cost circa £420k and would need to be delivered via 2021/22 planning round.

## 2. Background

From March 2020 the COVID-19 pandemic created a workforce resourcing challenge across health and social care. Measures were introduced to free up as much capacity as possible to manage the response. COVID-19 has required health care professionals to be flexible in what they do, this entailed working in different clinical areas within their scope of practice. New models of care delivery have been utilised in the short and medium term to ensure workforce sustainability and maintain high-quality patient care. Simultaneously, there has been a high percentage of staff unavailability due to COVID-19 related absence.

Additional measures were introduced to support safe staffing during the COVID-19 pandemic. The Director and Deputy Director of Nursing and Quality along with Heads of Nursing implemented 6 weekly COVID-19 acuity reviews based on the respiratory ward establishment model and professional judgement to ensure safe staffing throughout the period, recorded through a safe staffing tracker. It is important to note there is no evidence based staffing tool developed for COVID-19 wards. The 6 weekly COVID-19 acuity reviews recognised that initially nurse staffing needed to

be increased in positive and surveillance wards, a gradual reduction was feasible as patient numbers reduced. Having passed the initial peak, MCHFT has moved into recovery planning and the majority of wards are returning to their pre COVID-19 staffing models.

## 3. Acuity results and actions by Division

### 3.1 Medicine and Emergency Care Division

### 3.2 Medical Ward areas

The latest Safer Nursing Care Tool acuity assessment, as previously mentioned, gives an unrealistic position for assurance purposes for the period assessed in July due to the Covid-19 changes to wards. However, as noted, the following procedures were in place during this period to ensure safe care on the wards:

- Daily staffing by the senior nursing team and redeployment of staff to meet acuity
- 6 weekly Covid-19 acuity reviews monitored through a safe staffing tracker

### 3.3. Emergency Department

The Emergency Department (ED) has seen significant growth in attendances over recent years. In December 2019 to support this growth the department expanded capacity through the addition of a modular unit, adding 8 major cubicles. Additional staffing was approved of 11.18WTE to deal with this.

An additional 29.97WTE staff was then put in place to bring the staffing levels in line with the Best acuity reviews via the workforce business case.

During the pandemic period, a respiratory assessment unit was established to take all ED attendances that had symptoms of Covid-19 and an additional 16.89WTE of temporary staffing was approved to ensure this was safely staffed.

The next phase of ED development is the £15m new development of the Urgent Care Village which has an additional staffing requirement which is currently being considered by the Board for approval prior to build.

ED has had several acuity and staffing reviews over the period of this reporting and is again being evaluated with reference to the new build. Like other areas, it was subject to 6 weekly reviews during the Covid-19 pandemic period and there is high confidence that staffing levels are appropriate.

### 3.4 Critical Care

Following last year's annual planning investment, Critical care received investment of 5.7 WTE Band 5 nurses to backfill band 7s to provide a supernumerary Registered Nurse Shift Coordinator as recommended by the Care Quality Commission (CQC) and Cheshire & Merseyside Critical Care Network and Royal College of Nursing Standards (2003).

This allowed the organisation to comply with the *Adult Critical care service specification,* NHS England May 2019 and *The Guidelines for the provision of Intensive care services V2 and The faculty for intensive care medicine & Intensive care society 2019*

During the Covid-19 pandemic Critical Care has been support through the redeployment of staff from theatres and wards, with critical care skills. Specialised teams were developed to work within

the unit using a bespoke workforce model, based on national guidance.

**3.5 Divisional actions agreed:**

- Review supernumerary co-ordinator role across all ward areas to come in line with other divisions, this has been delayed due to COVID-19
- ED continue with BEST acuity tool on a bi-annual basis
- To continue to actively recruit into all vacancies

## 4. Surgery & Cancer Division

**4.1 Surgical Ward areas**

The latest Safer Nursing Care Tool acuity assessment, as previously mentioned, is unreliable for assurance purposes for the period assessed in July due to the Covid-19 changes to wards. However, as noted, the following procedures were in place during this period to ensure safe care on the wards:

- Daily staffing by the senior nursing team and redeployment of staff to meet acuity
- 6 weekly Covid-19 acuity reviews monitored through a safe staffing tracker

**4.2 Divisional actions agreed:**

- Continue to remodel bed base to better support Elective and Emergency patient flow

## 5. Diagnostic and Clinical Support Services Division

The acuity tool outcome for July 2020 was accurate for the Diagnostic and Clinical Support Division as this was only for two areas that were less affected and not regularly changed unlike the medical and surgical wards.

This showed that the division has the right balance of funded establishment versus the findings of the acuity tool (72.34WTE establishment versus 73.17WTE acuity requirement).

Both Ward 21b and Elmhurst have seen an increase in acuity due to a change in patient cohort supporting the wider trust patient placement of non Covid patients.

There is increasing demand for beds for patients requiring assistance of 2 at Elmhurst requiring the support of an additional HCA on nights. This will be reviewed again in Jan 2021 to establish if this is a continuing trend.

**5.1 Divisional actions agreed:**

- Explore other acuity tools more aligned to a GP led ward and Elmhurst and rehabilitation

## 6. Women & Children's Division

**6.1 Paediatric Acuity**

The acuity tool used (STEAM tool) for Paediatrics was successfully reviewed in July 2020 and showed 98% of shifts as positively staffed. This is a significant improvement on previous reviews.

To support paediatric patients during COVID-19 Children's Assessment Unit separated into two 24 hour inpatient areas Red/Green. Due to the changing in the ward configuration an additional

temporary healthcare support on nights has been required. The results of the review highlighted the percentage of shifts positively staffed and has seen an improvement as a result.
The division reviews this data every 4 hours and alters the staffing requirements accordingly. The paediatric inpatient ward, although not positively staffed on all occasions was deemed to be safe using the skill mix of staff available.

### 6.2 Maternity

The results of the July 2020 review highlighted 98% of shifts positively staffed which is an improvement on last time

By proactively managing the workload these figures show that measures were put in place to maintain safe staffing on the labour ward areas for both low and high risk women

In addition to the Trusts own acuity data, Birthrate Plus® (BR+) provides an objective assessment of the complexity and risk of women during intrapartum care, in order to calculate the number of midwives required to achieve the agreed staffing standard of one midwife to one woman during labour and delivery. MCHFT commissioned an external BR+ assessment which was undertaken in July 2019, with the report available in November 2019. The assessment was based on 2018 annual birth rate of 2777. This suggests a need to move to a skill mix ratio of 90:10 qualified to unqualified.

To ensure we provide high quality and safe care to mothers and babies, it was recognised in November 2019 by the Trust that Midwifery staffing was not at the recommended level. There was no risk appetite to wait six months for 2021/2022 budgets to resolve this and therefore the establishment required to uplift existing 8.09 WTE band 2 HCA's to Band 3 maternity support workers was increased by £18.5k and managed within the overall financial position for 2020/2021. A robust training package will upskill this staff group. This will support a move towards a skill mix ratio of 90:10 Qualified to Unqualified staff as recommended by the BR+ external review.

#### 6.2.1 Maternity – Continuity Care Model

In February 2016 'Better Births', the report of the National Maternity Review, set out the five Year Forward View for NHS maternity services in England to become safer and more personal. At the heart of this vision is the idea that women should have continuity of the person looking after them during their maternity journey, before, during and after the birth.

This continuity of care and relationship between care giver and receiver has been proven to lead to better outcomes and safety for the woman and baby including reduced stillbirth, miscarriage and premature birth, improved perinatal mental health and successful breastfeeding, as well as offering a more positive and personal experience. Better Births also recommends pathways particularly focused on safety of women from the BAME community and those with any additional vulnerability.

Local Maternity Systems set out an expectation that each Trust, by October 2017, establish a shared vision and plan to implement Better Births by the end of 2020/21. These plans are expected to show how most women will receive continuity of the person caring for them during pregnancy, birth and postnatally.

Continuity of care is mandated by NHSE and MCHFT must achieve 35% compliance by March 2021 and subsequently 100% by the end of 2021, expected date to be confirmed. To enable delivery of a 1:36 caseload ratio required for a continuity of care model investment is required.

The Trust is currently in track to achieve the 35% compliance by March 2021, however, there will need to be further investment in 2021/22 to achieve the 100% target. This will cost circa £420k.

### 6.3 Neonatal Intensive Care Unit (NICU)

The July 2020 review showed 100% of shifts positively filled. The acuity and dependency on NICU varies throughout the year and there is no real pattern to assist with prediction of acuity however, the division reviews this data every 12 hours and alters the staffing requirements accordingly. NICU was positively staffed on all occasions it was deemed to be safe using the skill mix of staff available at the time.

### 6.4 Divisional actions agreed:

- Review of Paediatric ward model to support Covid-19
- The division plan to triangulate the data from STEAM with the RCN defining staffing levels for Children and Young People's services (2013).

## 7. Central Cheshire Integrated Care Partnership (CCICP)

The establishment and acuity for each Care Community was reviewed for April 2020. This is still a manual process undertaken by team leaders until the full implementation of the Malinko system which will give better assurance on staffing versus acuity.

The acuity review has highlighted that SMASH was the only Care Community where caseloads were not aligned to band 6 caseload managers, this was due to a number of vacant band 6 posts which have now been filled.

All teams demonstrated an increase in registered staffing numbers as compared to 2019. This is due to the frailty and bench post investments.

Registered nursing and therapy staff are increasingly required to undertake initial assessments and reviews due to an increase in demand for general nursing assistant (GNA) support packages of care for patients in the community. A recent review of this activity indicated that 46% of patients requiring packages of care supplied by general nursing assistants resided in the Crewe locality. A working group has been established in CCICP to ensure that resource alignment for GNA packages of care is in accordance with workload.

### 7.1 Divisional actions agreed:

- Alignment resource for GNA packages of care in accordance with workload
- Develop Malinko reporting to support identifying future establishment requirements

## 8. Strategic Staffing Reviews – Summary

The onset of Covid-19 in mid-March and the continued response has required reconfiguration of services and wards to create new capacity in Critical Care areas and to manage patient flow. These continuous changes have impacted on the validity of the data for July as many wards have moved or changed function. Therefore it is important to note the results of July acuity reviews for adult inpatient wards were not a true reflection and unlike previous reviews so other processes and professional judgement have been applied.

The key areas that the Trust needs to investment in additional staff are in the Emergency Department (which is being reviewed in a separate Board case) and Midwifery to apply a Continuity of Care model as mandated by NHS England.

The costs of the Midwifery investment for Continuity of Care are likely to be circa £420k and will

need to planned as part of the next financial year investments

The Trust will continue to review acuity and establishment routinely throughout this current year as it has throughout the Covid 19 pandemic and provide assurance to the Trust Board on a monthly basis through the safer staffing information.

## 9. Recommendations

The Board of Directors is asked to:-

- Note the work undertaken in relation to assurance of safe staffing across the wards as identified in the bi-annual reviews and the strategic staffing review during a period of a global pandemic.
- Note and support the required investment in Midwifery prior to the annual plan 2021-2022 following the bi-annual staffing reviews in July 2020.
- Support the recommendations that registered and unregistered nurse staffing levels need to be a continued area of incremental investment in line with evidenced based reviews.

Mid Cheshire Hospitals NHS Foundation Trust

# PAF Committee
# Chair's Assurance Report
# September 2020

| | |
|---|---|
| **Report to** | Board of Directors |
| **Date** | 24 September 2020 |
| **Report from** | Trevor Brocklebank, Non-Executive Director |
| **Report prepared by** | Katharine Dowson, Head of Corporate Governance |
| **Executive Lead/s** | Oliver Bennett, Chief Operating Officer<br>Russell Favager, Deputy Chief Executive and Director of Finance (*apologies given*)<br>Ros Davies, Deputy Director of Finance and Andrew Deakin, Head of Capital Development deputising. |
| **Committee meeting quoracy** | Yes ☒ No ☐ |

## KEY AREAS OF ASSURANCE

**Covid-19 (Exception Report)**

- Covid-19 infections are rising (doubling around every 7 days) and this is increasing attendances to RAU and admissions into Leighton Hospital. The Trust has responded to this and has re-designated two wards for covid-19 admissions
- Demand for testing has increased, probably in line with schools re-opening. Currently, demand is not exceeding available capacity; however, it could become a problem if demand continues to rise. Staff communication circulated regarding criteria for and availability of testing. The Trust continues to engage with the Pathology Network with regard to having onsite capability for rapid testing and a plan for a tenfold increase in rapid testing capacity; nationally, the intention is to have this capability in October/November

**Estates**

- Key programmes moving forward, including Critical Infrastructure Review (external consultants appointed), Medical Devices Internal Audit recommendations, a review of lessons learnt from MRI humidity issues and additional backlog maintenance, following successful bid for funding
- Estates Returns Information Collection (ERIC) – **acceptable assurance:** annual variance report identified costs in providing and maintaining the NHS Estate with assurances provided on each variance except Quality of Building rating, deteriorated due to roof planks risk

**Performance (August 2020)**

- Type 1 A&E attendances and non-elective hospital admissions have returned to pre-Covid-19 levels and the number of patients seen and treated within 4 hours is deteriorating. This is further impacted by the fact that A&E still has to function with Covid-19 safe areas. However, performance remains 10% better in August compared to the same period last year, despite attendances and admissions returning to normal levels
- New A&E build - business case for £15m capital funding submitted to NHS Improvement
- The increase in the number of patients waiting >52 weeks for treatment was noted as a going concern and will likely continue to deteriorate from now until March 2021

- Cancer treatment remains the top priority for the Trust and the number of patients waiting >63 and >104 days has significantly improved

**Finance**

- Covid-19 top-up Q1 request had been paid and July's had been validated and was awaiting payment to the Trust. To date, including August 2020, the Trust had submitted £7.3m of net costs to be reimbursed by regulators, which was the process to the end of September
- Within the financial year to date, the Trust had reported £9.7m of costs associated with the pandemic, of which only £1m was non-recurrent and, therefore, it was expected that the majority of those costs would continue for the rest of the financial year
- The difference between the reported Covid-19 costs and the top-up requested to regulators lies with underspends in key planned care areas, such as drugs and prosthetics which had increased in July/August in line with the restoration of services – which was why the top-up value had increased on the early part of the financial year
- A forecast of £25.3m additional spend was forecast for the final 6 months of the financial year, which including increased spend for restoration, Winter and further covid-19 expenditure. This was prior to the release of financial allocations

**Allocations (Oct 2020 to March 2021)** - **acceptable assurance**

- The financial allocations were released last week, and the calculated position prior to non-recurrent support funding was a deficit of £9.8m, which left a significant challenge against the draft forecast. This takes the previous forecast of £25m further costs, to a £30m deficit before non-recurrent funding is taken into consideration
- Some of the key elements of the guidance was the expectation of non-patient care income to return to pre-Covid-19 levels, which would include footfall income on site and that there was an expectation that a 1% cost improvement could be achieved – both of which would be extremely challenging for health economies at present
- In comparison to the draft plan, it was expected that the financial allocations may leave the Trust in a similar or potentially slightly better position than the original £15m deficit that was submitted; however, there was some work to be done in finalising the levels of non-recurrent support to healthcare providers which would determine this
- Trust's financial approach to be submitted to the HCP on 5 October with the aggregated position submitted nationally on 22 October

**Phase 3 Restoration Plan Submission**

Phase 3 restoration plan for the Trust was presented in detail and acceptable assurance received that the plan is robust and deliverable within the capacity and resources available and taking into account IPC and social distancing measures

**Winter Plan**

- Comprehensive winter plan presented and focused on implementation of NHS111 First programme to manage demand differently, increasing in-hospital bed capacity, improving the flow of patients out of the hospital in to a different care setting, working with system partners, and finally the health and wellbeing of our staff
- Concerns were noted about how the system is going to manage safely and effectively the likely significant increase in demand for children's urgent care services
- PAF endorsed the 2020/21 winter plan

## KEY CONCERNS/RISKS

- Prioritisation of Covid-19 testing to frontline staff if demand continues to increase into winter
- Increasing waiting lists and the time patients wait for treatment as referrals continue to increase and the fact that the Trust cannot resume 100% of pre-Covid-19 elective activity
- System response to management of paediatric cases in primary care during winter to prevent increase in A&E attendances

## Priority Areas: DECISIONS MADE

No decisions made

## RECOMMENDATION

To note

Mid Cheshire Hospitals NHS Foundation Trust

# Board of Directors

| | | |
|---|---|---|
| **Agenda Item** | **13.2** | Date of Meeting: 05/10/2020 |
| **Report Title** | **Mid Cheshire Winter Plan** | |
| **Executive Lead** | Oliver Bennett, Chief Operating Officer | |
| **Lead Officer** | Emma McGuigan, Director of Operations | |
| **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)*

- This is the Mid Cheshire Hospitals Winter Plan for 2020/21 and is not the system-wide plan.
- The plan has four main focus areas: reducing demand through implementation of NHS 111 First; increase in hospital bed capacity; improving exit flow through working with the wider Cheshire system and a request for support equivalent to 30 additional community beds; and finally, staff health and wellbeing, which includes a comprehensive flu campaign. There are also other schemes that were in place last year which proved effective as we plan to repeat this winter.
- PAF have endorsed the Winter Plan and investment of £3.5m, which is £0.5m more than in the previous year and is probably reasonable as preparations also include Covid-19 future planning.

**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)*

Submitted to the Cheshire CCG to form the system winter plan.

**REPORT DEVELOPMENT**

| Committee/ Group Name | Date | Report Title | Lead | Brief summary of key issues raised and actions agreed |
|---|---|---|---|---|
| Performance and Finance Committee | 24 Sept 2020 | | Oliver Bennett, Chief Operating Officer | Recommended for approval to Board |
| | | | | |

## *Mid Cheshire Hospitals NHS FT*

# Seasonal Winter Plan 2020/21

***Working in partnership:***
*Mid Cheshire Hospitals NHS Foundation Trust*
*Cheshire and Wirral Partnership NHS Foundation Trust*
*NHS South Cheshire Clinical Commissioning Group*
*NHS Vale Royal Clinical Commissioning Group*

# Seasonal Winter Plan 2020/21

## 1.0 Introduction

This paper will provide a reflection on winter 2019/20 as well as outlining the specific additional seasonal schemes that are being proposed as part of the Cheshire inter planning process. Unlike winter planning previously, the coronavirus pandemic means that we need to plan for surges in demand related to Covid-19 as well as the usual seasonal increase in activity throughout this period. It is imperative we continue to maintain infection prevention and control standards including social distancing. This places additional pressures on areas such as the emergency department, where previously there has been over crowding throughout the winter months. This will require a different configuration of wards and inpatient care. Within this winter 2020/21 plan, lessons learned both from previous years and throughout the first wave of coronavirus have been incorporated, including the effectiveness of the system-response in relation to patient flow which has been evident in the response to Covid-19. The key focus of the 2020/21 winter plan:

- Managing demand by signposting patients to alternative to acute trust based care provision.

- Preventing overcrowding in emergency departments.

- Timely and effective triage, decision making and treatment.

- Maintaining flow throughout the in-hospital and out of hospital system, ensuring that patient that are medically fit for discharge do not stay in hospital unnecessarily and care is safely transferred to alternative providers.

- The health and wellbeing of our workforce is also a critical element to the plan and therefore there will be a significant emphasis on a highly effective flu campaign right across the system.

The total values of the schemes within this plan are circa £3.5 million. These schemes will support the seasonal fluctuations in demand especially within the acute hospital setting. The plan is designed to allow the continuing delivery of safe and effective clinical services during winter.

The required outcomes of winter planning are to ensure that:-

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- A comprehensive winter plan is in place which recognises that demand on available services is likely to be at peak levels and identifies local areas of risk which need to be mitigated.
- Lesson learned from the first covid peak are incorporated into the winter plan and this plan for 2020/21 takes into account mitigation for fluctuations in the incidence covid-19 throughout winter
- Reduced overcrowding within the emergency departments
- Maintenance of the segregation of symptomatic and asymptomatic (CV19) patients

within the emergency department and wards
- An integration of the Trust as part of the overall local health and social care plans
- High quality services and excellent patient outcomes and experiences are maintained through periods of pressure.
- The impact of pressures on individual services, national performance standards and finances are managed effectively.
- A process is in place to meet the reporting requirements of NHS England and NHS Improvement.
- There are clearly quantifiable escalation arrangements in place with plans to provide additional capacity if required.
- Key risks and lessons learnt from previous years have been identified.

The plan is for the majority of schemes to commence from 1st November 2020 to March 31st 2021.

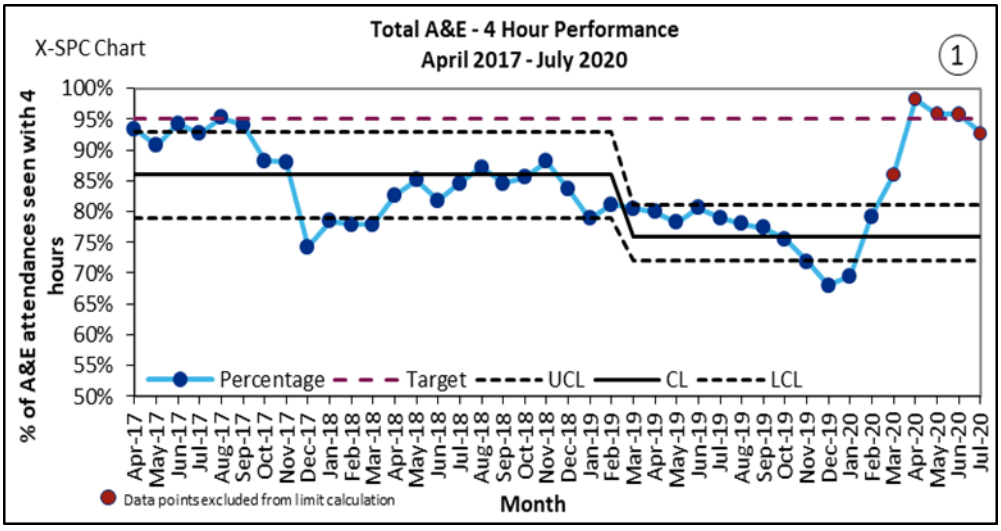
The seasonal schemes will be activated and stood down at different times depending on service demands. Some schemes will require fixed timescales, whereas others will be deployed when demand indicates they are necessary. All schemes will be monitored through the Cheshire System Flow Group and the Cheshire A&E Delivery Board (yet to be reinstated)

## 2.0 Context

### Performance and why winter is different

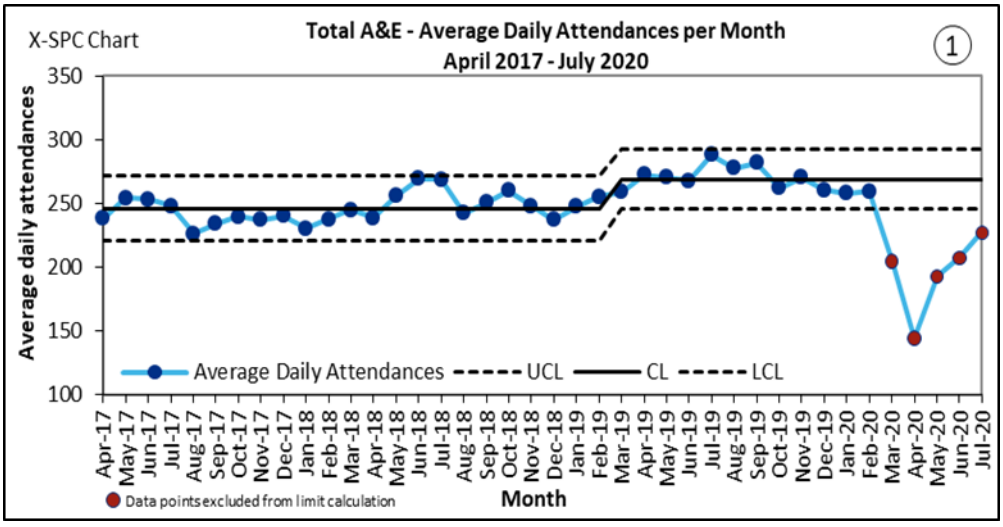
It is important to set out the context and the likely environment that the Trust and wider-system is likely to be operating in during winter 2020/21. The context will be given by presenting some of the performance trends over recent years and to provide the narrative around why winter is different and requires additionality.

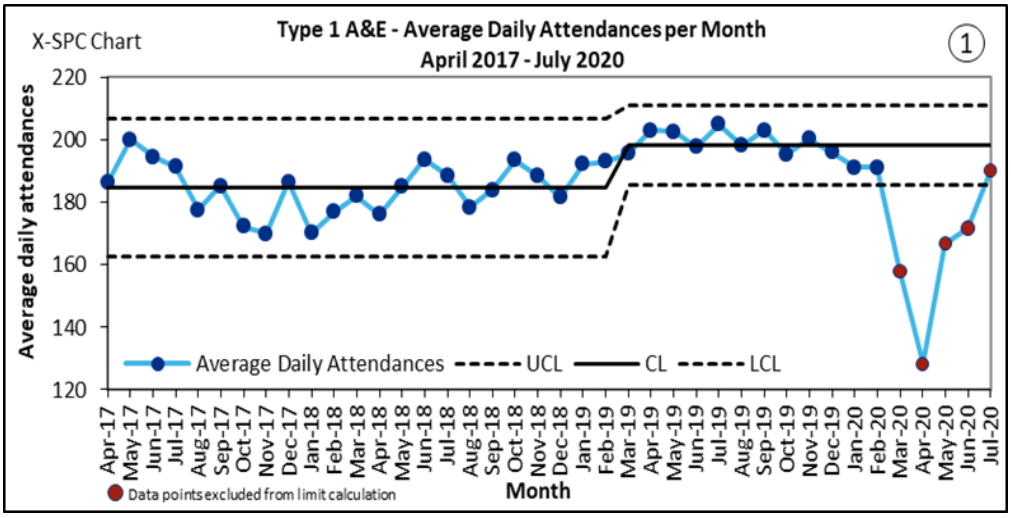
**A&E 4 Hour Standard**
Mid Cheshire Hospitals NHS Foundation Trust (MCHFT) is seen by regulators as performing comparatively well but with specific challenges related to the 4 hour emergency standard and more specifically an increase in ED attendances significantly higher than the national average. This has resulted in a lower performance against the 4 hour A&E standard during the winter as shown in the first graph below. However, performance sharply improved against this target from March onwards in 2020/21 as a result of the significant reduction in attendances as a result of the Covid-19 pandemic. There is thus a clear correlation between attendances and performance.




**A&E Attendances**

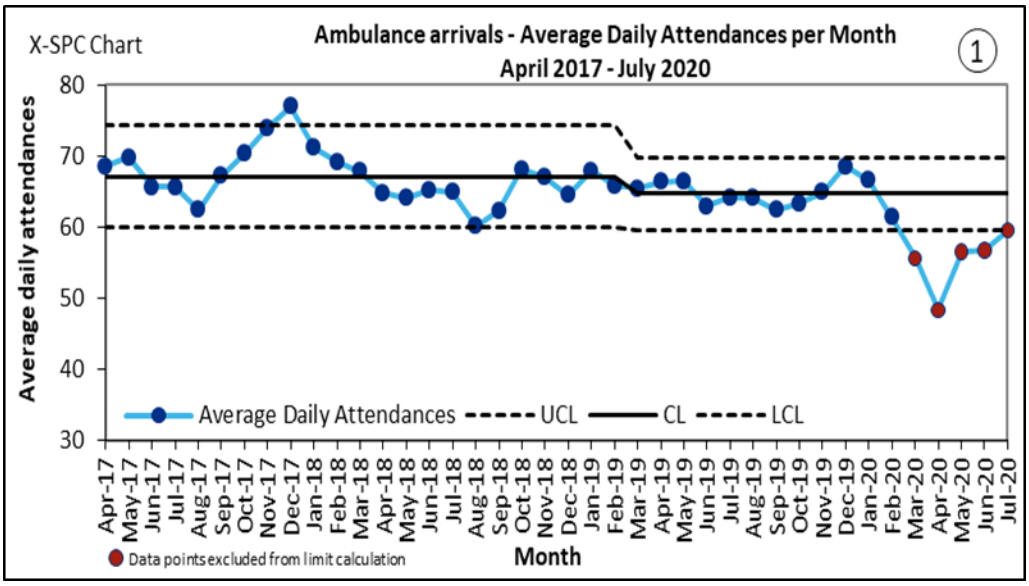
We know that attendances to A&E have risen, well above the national average, year on year for the last 3 years as shown in the graph below. Attendances in winter 2020/21 are likely to be around 6 per cent higher than in the previous year. As discussed above, demand for our urgent and emergency care services is probably the most significant driver of performance. The data shows a direct correlation between demand and A&E performance. It is difficult to model what the impact of any changes in the profile of Covid-19 will have on A&E attendances during winter.






**Ambulance Attendances**

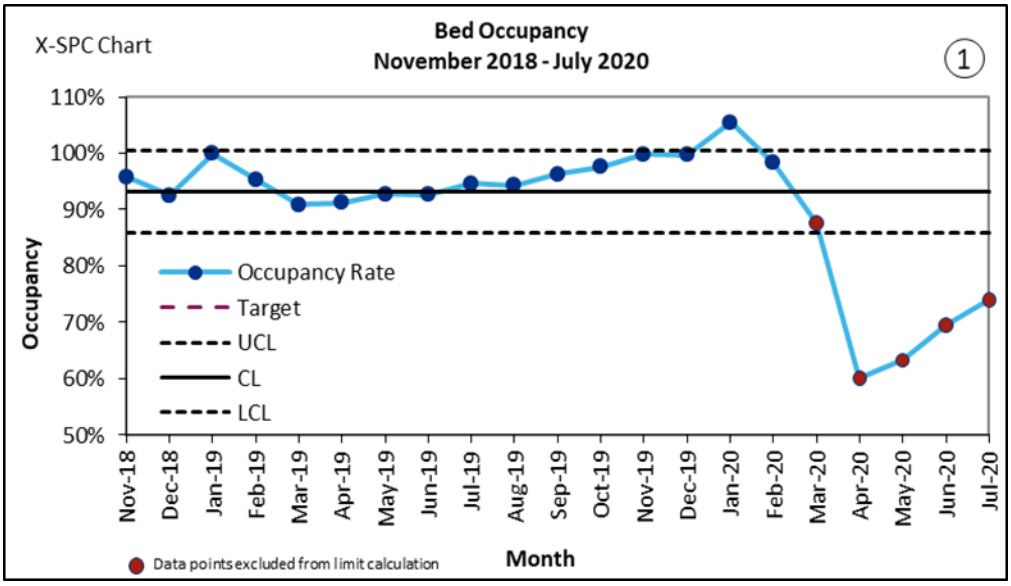
We know that a higher proportion of patients are attending A&E and are unwell. We also know that we see an increase in ambulance conveyances during winter. There is no signal that this trend won't abate and it is likely, especially given Covid-19 that more ambulances will come to our ED this coming winter compared to last.




**Bed Occupancy**

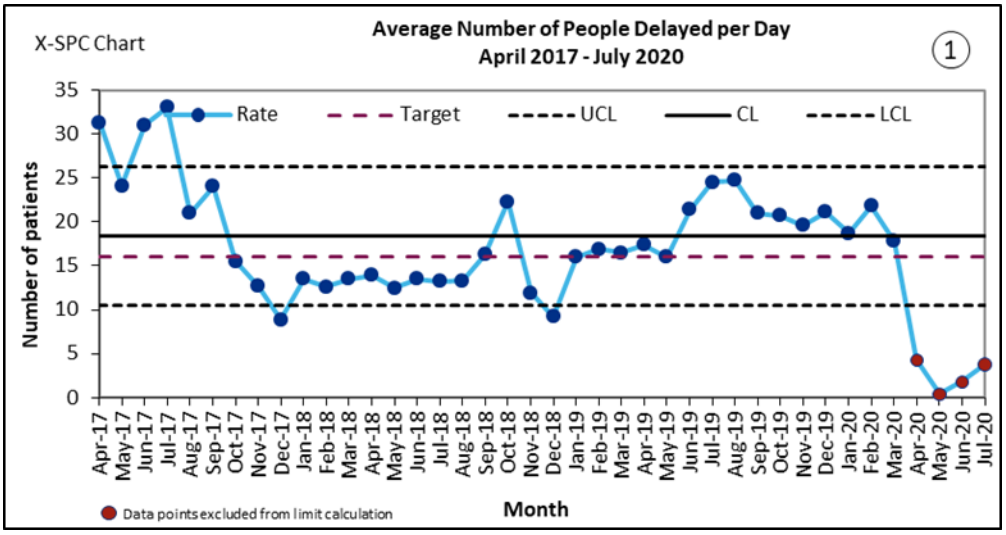
The graph below demonstrates, as expected, that bed occupancy increases during the winter months. Last winter all escalation beds were utilised at some point, albeit in an unplanned way, which injected further complexity in to an already challenging environment. There is no signal that bed occupancy will be any less than in the previous winter. Trusts this year are expected to maintain bed occupancy at 92% or less. This will be extremely challenging for the Trust or indeed any other Acute Trust within the region to meet. Forecasting shows that winter 2020/21 is likely to require additional beds if the Trust is to have enough capacity to maintain safe flow

throughout the organisation and the wider-system. There is further evidence in the next section, based on several scenarios, about the possible effects that Covid-19 will have on bed capacity all of which indicate a requirement for more beds. This will be exacerbated if Mid Cheshire is to maintain delivery of some of its routine elective services.




**Delayed Transfers of Care**

During any winter the whole care system experiences immense pressure. During winter 2019/20, performance against delayed transfers of care deteriorated more starkly than the previous year. This is probably indicative of the type of patients coming in to hospital, namely older patients with more underlying conditions/co-morbidities requiring more care outside of hospital. This resulted in more patients remaining in a general/acute hospital bed for longer than they required medically (delayed transfers of care). This in turn not only impacted on the experience of patients, but impacted on the flow of patients through the hospital system causing patients to reside in an acute bed, not necessarily the best place to deliver their care needs nor to provide the best people to provide that care.




## Lessons from winter 2019/2020

The winter plans through 2019/2020 were focused primarily on increasing the underlying workforce deficits within the emergency department. As outlined above, the type one attendances at Leighton hospital increased significantly throughout 2019 and the winter plan was dedicated to support the increasing attendances.

Winter 2019/2020 was very challenging for the organisation; an additional winter ward (32 beds) was opened in December 2019. The reactive opening of the ward led to a significant pressure within the organisation and challenges with workforce & recruitment. High agency usage was needed to support the ward. As we approach winter this year, it is imperative to support staff well-being and therefore earlier planning is essential. A planned approach to increasing the acute bed base will allow for substantive workforce to be recruited and embedded into the organisation, utilising our own workforce as much as possible is important for patient safety and staff morale. Early planning is crucial to the delivery of a safe winter plan.

## Impact of Covid-19

In addition to managing normal winter pressures and surges in demand on urgent and emergency care services in hospitals and across the system, winter 2020/21 is likely to be particularly challenging given the ongoing prevalence of Covid-19. The management of Covid-19 will further compound the challenges likely to be faced this coming winter. This winter plan has reflected on learning from the pandemic up until now and includes additional measures that will be taken to both manage winter alongside any changes in the prevalence of coronavirus.

The Cheshire and Merseyside Health Care Partnership has commissioned PA Consulting to undertake number of scenario-based analysis in order to try and determine the likely impact

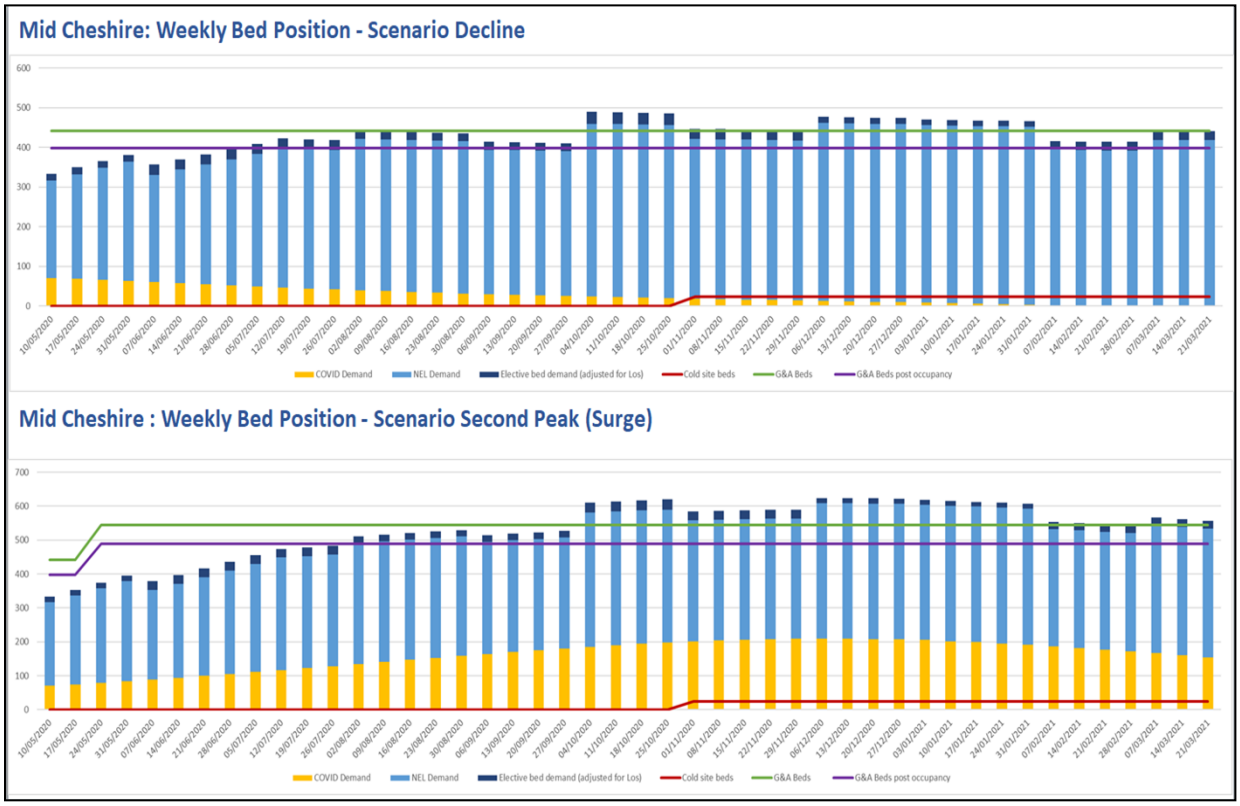
on services because of Covid-19 over the coming months and in to winter. This is intended to aid system-wide planning for any changes to the prevalence and profile of Covid-19.

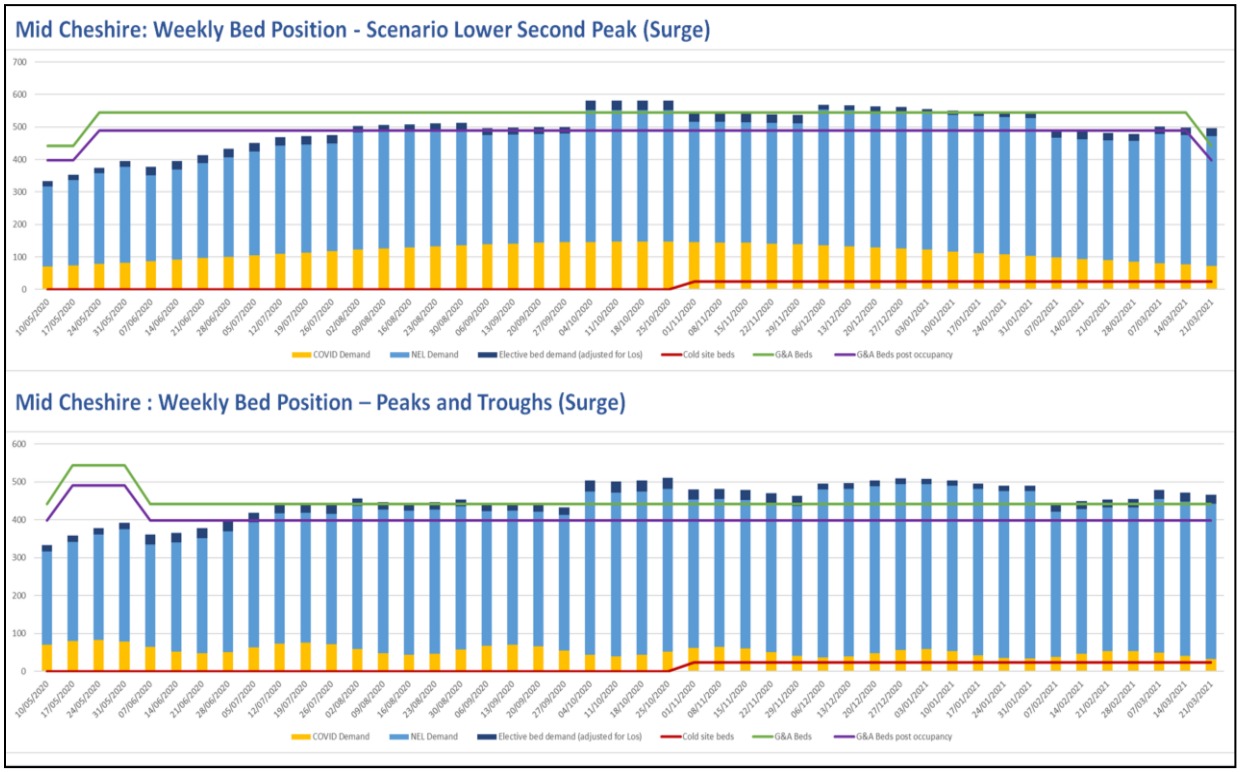
The following scenarios have been modelled for the Trust:

- **Decline** – in this scenario the covid-19 virus slowly burns out completely and over the course of winter the requirement for covid-19 bed base and separation is eventually not required.
- **Second Peak (R=1.7 or more)** – in this scenario, following the relaxation of lockdown measures the incidence of covid-19 begins to increase across the country and the rates and impact of coronavirus reaches a second peak similar to the initial first wave of covid-19.
- **Lower Second Peak (R=1.5-1.7)** – in this scenario, following the relaxation of lockdown measures the incidence of covid-19 increases however with the IPC measures now in place across the country (such as social distancing and face masks), the peak does not reach the levels of the first wave.
- **Peaks and Troughs** – in this scenario, the peaks are more localised and the virus rates increase and decrease at a local level. This may lead to local lockdowns and a more regional response to the pandemic across winter.

The modelling for each of the scenarios articulated above is presented graphically in this section. In each of these scenarios, it is clear that the impact of coronavirus and the winter non elective surge will have a significant impact on the hospital bed base. The purple line represents 92% bed occupancy. The figure targeted by NHS England. Achieving 92% bed occupancy at the Trust is highly unlikely without additional capital to support additional bed capacity above baseline and baseline plus escalation. From reviewing the modelling below, it is imperative that the hospital plans to at least open the same level of winter escalation capacity that was in place last year.

If we assume that we are to see a “decline” in Covid-19 cases, which is the assumption that NHSE/I have asked us to assume in our planning, then we are typically around 50 beds short of what would be required to manage demand on our urgent and emergency care services (assuming a 92% bed occupancy). On the assumption that we are to see an incidence of “peaks and troughs” in Covid-19 cases, then we will remain typically around 50 beds short to meet demand (but this doesn’t allow for a 92% bed occupancy, it would be more around 98% plus occupancy).


Mid Cheshire: Weekly Bed Position - Scenario Decline
COVID Demand
NEL Demand
Elective bed demand (adjusted for Los)
Cold site beds
G&A Beds
G&A Beds post occupancy
Mid Cheshire : Weekly Bed Position - Scenario Second Peak (Surge)
COVID Demand
NEL Demand
Elective bed demand (adjusted for Los)
Cold site beds
G&A Beds
G&A Beds post occupancy


Mid Cheshire: Weekly Bed Position - Scenario Lower Second Peak (Surge)
COVID Demand
NEL Demand
Elective bed demand (adjusted for Los)
Cold site beds
G&A Beds
G&A Beds post occupancy
Mid Cheshire : Weekly Bed Position – Peaks and Troughs (Surge)
COVID Demand
NEL Demand
Elective bed demand (adjusted for Los)
Cold site beds
G&A Beds
G&A Beds post occupancy

## 3.0 Winter Schemes

Normally the winter planning process would report to partners via the A&E Delivery Board (AEDB). However, the AEDB has been suspended due to coronavirus. The schemes described within this plan were therefore presented to the Cheshire System Flow Group on Monday 10th August. The deliverability, effectiveness and impact on patient outcomes were discussed. It was important that these proposals incorporated the lessons learned from Covid-19. To this end, the proposed schemes for winter 2020/21 have been developed following feedback from the Covid-19 Silver Command Group. A separate Winter Planning Group involving key clinicians and CCICP colleagues was established to develop and oversee implementation of the winter plan. Given the impact of the Covid-19 pandemic the winter planning process has been expedited.

The winter schemes have been developed after reviewing the following:

- Lessons learnt from the initial coronavirus response
- Greater Manchester utilisation review – external review of Emergency department performance
- Lesson learnt from the "perfect week" in January 2020
- PA consulting bed modelling
- Lesson learned from winter 2019/20

The winter plans have also incorporated a range of ideas from key stakeholders and were presented to the Trust Executive team on 11th August 2020. The main themes for the 2020/21 winter plan include:

- Reducing demand in A&E by providing patients with a safe alternative by implementing the NHS111 First programme and increasing capacity in the community rapid intervention service.

- Improving in hospital flow and capacity to meet expected levels of demand. This will include escalated bed capacity. The Trust has also submitted a national bid for capital for a new ED build.

- Improving exit flow so that patients are not in hospital unnecessarily and are transferred to a suitable alternative care setting, including their own home. This will require the commissioning of place-based care equivalent to an additional 30 out of hospital beds.

- Safeguard the health and wellbeing of our staff and keep levels of morale as high as possible. This will include a comprehensive flu campaign.

The full plan will require a non-recurrent investment of circa £4m (not all of which has been approved by the Trust Executive at the time of writing this plan). Just over £2.7m has been approved as per the below.

### *3.1 Overview of schemes for Winter 2020/21*

The below provides a summary of the approved winter schemes for Mid Cheshire. Further detail about each scheme is outlined below.

| Description | Value £000's |
|---|---|
| Winter Ward | (1,865) |
| Additional capacity/Escalation beds | (380) |
| Medical Workforce | (365) |
| Flu Campaign | (142) |
| Surgical Ambulatory Care Unit (SACU) | (127) |
| Therapy support | (125) |
| Paediatric Medical Cover | (100) |
| Paediatric Nursing | (100) |
| IDT Nurse | (53) |
| Point of Care | (50) |
| Portering / Transfer Team | (46) |
| Pharmacist | (45) |
| Discharge Co-Ordinators | (43) |
| Urgent Care -Triage Nurse | (21) |
| Admin 7 day | (12) |
| Phlebotomy | (10) |
| | |
| **Total** | **(3,484)** |

Whilst these schemes are focused on winter preparedness, there are a number of schemes that related to additional covid-19 pressures. The additional therapy and pharmacy posts are to support running dual rota's to maintain separation of staff working on covid and non covid areas. Additional resource has also been allocated for point of care testing, which is expected throughout winter to support the flu and covid clinical demand.

There are two schemes which require coordination across the system and should be included within the Central Cheshire winter plan, however the detail of these two schemes have not yet been finalised. The plans are supported by all partners for inclusion within the winter planning process:

- **System 7 days working**
  As part of the lessons learned throughout the coronavirus pandemic, the value of 7 day working for hospital discharge patients has been evident. It is recommended this is reinstated across the winter months; the full benefit of this scheme can only be achieved if all partners are involved. Within the schemes above the hospital is committed to ensuring transport and discharge co-ordinator support across winter.

- **Care home support**
  Throughout the pandemic the co-ordinated system response and communication to the care home sector has been significant. The CCG and Local Authority have provided

additional support clinically and financially to allow care homes in Cheshire to continue to operate. Because of the threat of Covid-19 within care homes, throughout the initial wave of the pandemic, both those homes and domiciliary care agencies only accepted negative testing patients. The hospital also utilised the Nightingale centres for medically optimised, asymptomatic Covid-19 positive patients. In the absence of the Nightingale centres this winter, it is clear that a plan for Covid-19 positive medically optimised patients is required. If those patients are to remain with the acute providers, then a further 30 community nursing beds are required within the Central Cheshire system. This also points to the modelling outlined above.

### 3.1.1 New Emegency Department Capital Build

In addition to the above, the Trust has submitted a bid to NHSE/I for circa £15 million capital to develop a new Emergency Department, with greater capacity and space to migitate the risk of overcrowding and to maintain social distancing and create a better environemnt for our staff. Any revenue implications of this new build is not factored in to this winter plan.

### 3.1.2 Critical Care

The Trust has also submitted a capital bid to support the expansion of critical care capacity during winter, if required, in order to respond to any surges in coronavirus. The revenue costs associated with any critical care escalation is not included in the winter plan, however, there is an acknowledgement that if escalation was required further staffing and other associated costs would be incured.

### 3.1.3 Implementation of NHS111 “First” to reduce demand

Prior to the coronavirus pandemic, the emergency department at Leighton Hospital was a national outlier for increasing attendances. Previous analysis had pointed to a high volume of walk in attendances of adults between 25 – 55 years old. Nationally an NHS 111 “First” pilot is aimed at ensuring patients access NHS 111 prior to attending ED thus allowing appropriate redirection to alternative services and/or enabled to book appointments straight into the hospital ambulatory care services. In the pilot sites this has reduced ED attendances by between 10 and 20 per cent. The Trust has been successfully chosen as a ‘fast follower’ site and we are planning to go live with this programme by November/December 2020. This will hopefully safely reduce the number of attendances through A&E by working differently and providing a safe and appropriate alternative pathway.

### 3.1.4 Capacity

Having sufficient capacity across the Cheshire system during winter will be critical. Because of social distancing and infection prevention and control measures, there has been a small reduction in the total number of beds in Leighton Hospital which at present stands at 433 general and acute beds.

As described in this document more capacity (beds) will be required both in and out of hospital during this winter. The winter plan proposes to plan to escalate in to and open up an additional

54 acute and general beds at Leighton Hospital (see table below). This will allow better flow throughout the hospital and manage the increase in non-elective admissions during winter. Additionally, up to another 30 community beds are being planned (see below). This will allow Leighton Hospital to discharge more patients, safely and quicker to another care setting. Escalation capacity has also taken in to consideration expected Covid-19 demand (based on scenarios presented above).

| **Bed Base** | |
|---|---|
| Medicine | 282 |
| Diagnostics | 24 |
| Surgery | 127 |
| Total baseline | 433 |
| Escalation above baseline | 54 |
| Total available beds | 487 |

At the time of writing, every effort and significant planning is being put in to the restoration of critical services across our hospitals. This is to ensure that we can start to treat more patients who have been waiting for routine elective care as a result of the pandemic. It is the intention of the Trust to continue to maintain as much routine elective care (inc. operations) as possible during the winter months. However, if demand exceeds expectations and/or the incidence of Covid-19 is greater than anticipated (i.e. second-wave/local outbreak), further capacity will almost certainly be required to support the urgent and emergency care pathway and the Covid-19 response. This may result in the loss of elective capacity to supporting these patients. If this scenario becomes a reality it is important the Trust is adequately prepared. Therefore, a plan is being drawn up that will outline the process for redistributing bed stock to support urgent and emergency care in the context of a second wave of Covid-19.

### 3.1.5 Staff health and wellbeing and flu campaign

The Trust and wider-system has an ambitious flu plan for winter. It will seek to go beyond last year's success and aims for the majority of staff to be vaccinated. The Trust is also considering what it can offer to staff throughout winter to support and look after their health and wellbeing. Alongside this will be the recognition of the importance of keeping staff morale and spirits as high as they possibly can, and again the Trust is considering ways this can be supported.

### 3.2 Approved Winter Schemes in more detail

| **Scheme** | **Winter Wards** |
|---|---|
| **Value of investment** | £1.865m |
| **Period Active** | Recruitment commenced in August 2020 |

| | |
|---|---|
| **Implementation lead** | MCHFT |
| **Summary Detail** | Additional workforce necessary to increase the hospital bed base to match the winter escalation beds in 2019/20. Based on the PA consulting modelling, the hospital needs to increase the bed base across the winter month. The Trust has decided to adopt elements of the Seacole model; however following guidance from CQC, the nursing rates were increased. This will create a 54 bedded winter ward within the Acute provide. This 54 bedded ward will have senior nursing leadership to ensure patient safety. Increased ventilation is planned for this ward in the evident of a significant second wave to ensure the ward can support high flow oxygen if necessary. |

| | |
|---|---|
| **Scheme** | **Additional Bed capacity** |
| **Value of investment** | 380k |
| **Period Active** | January 2021 |
| **Implementation lead** | MCHFT |
| **Summary Detail** | Increased escalation bed capacity to support the peak of winter. The previous escalation capacity within the James Cross unit is now utilised to ensure socially distancing and covid-19 separation in the emergency department, so the escalation capacity will be located elsewhere in the organisation – currently under review. |

| | |
|---|---|
| **Scheme** | **Medical workforce** |
| **Value of investment** | £365K |
| **Period Active** | Recruitment commenced August 2020 |
| **Implementation lead** | MCHFT/ CCICP |
| **Summary Detail** | A comprehensive medical model will be established to support the 54 bedded winter ward. This will incorporate the Seacole model and CCICP ACP staffing and a GP led component. |

| | |
|---|---|
| **Scheme** | **Paediatric Nursing** |
| **Value of investment** | 100k |
| **Period Active** | November 2020 |
| **Implementation lead** | MCHFT |
| **Summary Detail** | The Paediatric unit at MCHT was significantly busier in winter 19/20 and required high cost agency. The plans to increase the RN provision this year will enable an increase bed opening for the Children's Assessment Unit (CAU) and reduce the required for Paediatric diverts and |

| | |
|---|---|
| | transfer. The increase Paediatric nursing will support the emergency department and ensure timely flow from ED into CAU if required. |

| | |
|---|---|
| **Scheme** | **Porter/ Transfer Team** |
| **Value of investment** | 46k |
| **Period Active** | December 2020 |
| **Implementation lead** | MCHFT |
| **Summary Detail** | This was a recommendation from the GM Utilisation review; this is required to support the timely allocation of patients out of ED into the ambulatory care areas and other areas within the hospital. This scheme will also increase the transport provision at the weekend to ensure delivery of 7/7 services and an increase in the transfer team at weekends. |

| | |
|---|---|
| **Scheme** | **Discharge co-ordinators** |
| **Value of investment** | 43k |
| **Period Active** | October 2020 |
| **Implementation lead** | MCHFT |
| **Summary Detail** | Further support for the assessment areas in the Trust to support with complex discharges. The discharge coordinators are integral to work closely with social care and the integrated discharge team to allow for safe discharge for patients into their homes with additional support or another care setting. This provision will enable greater discharge co-ordinators across the weekend. |

All the above schemes will compliment all the existing social care, primary care and secondary care services that are already in place.

### 3.3 Better Care Fund (BCF)

In addition to the above proposed schemes for 2020/21, there are five ongoing schemes in place that are part of the wider BCF, these are care homes assessments, care package retention over seven days, Care sourcing team, additional social care staff to support D2A process, Care market sustainability. All BCF schemes are monitored monthly to ensure that they support the four national BCF targets. The CCGs are also jointly contracting care home and care at home provision.

## 4.0 Governance Structure

The Trust will introduce a command and control structure to co-ordinate and manage winter pressures in line with arrangements in place for managing Covid-19. Executive oversight will be via the weekly executive director group meeting and the weekly system-flow group.

## 5.0 Communications Strategy

The winter schemes will need to be communicated to all partner organisations within the local health economy and internally. Communicating our plans to staff is critical to give them assurance that we are suitably prepared for the winter.

A full winter communications plan will be developed for the wider health economy and partners will also participate in the development of the plan and subsequent reviews. This will also include specific messages to the public.

### 6.0 Safety Measures

The Trust does not hold ambulance crews on arrival to the ED, which enables NWAS colleagues to be able to respond promptly to emergency calls within the community. There was an increase in the ED physical footprint which has supported a reduction in corridor care. The Trust has implemented the ED Safety Checklist to be completed for all patients within the majors and resus area. The department's supernumerary Coordinator is in regular communication with the Clinical Site Manager. With covid-19, it is more important than ever to ensure a reduction in corridor care. The emergency departments will be significantly challenged throughout winter to maintain and ensure social distancing.

The coordination of the site is overseen by a Capacity Director who is responsible for planning and overseeing patient flow from the ED / Assessment Units to base wards and escalation areas. The progress of every patient on escalation wards and medical outliers is reviewed daily by the site team to ensure discharge dates are known and tracked. The system has a very successful IDT system which enables tracking and escalation of hospital discharges; this is available and updated by all partners.

### 7.0 Escalation Policy

The Trust has developed an Escalation and Full Capacity policy. These policies are currently under review to incorporate the significant changes required to continue to manage the pandemic it is current state and any possible future spikes/waves in Covid-19 cases. These escalation policies are critical for maintain the safety of our sites and patient care.

## 8.0 Key Deliverable and Conclusion

Last winter was extremely challenging for both the Trust and the whole of the "Cheshire System". Learning from last winter and from the pandemic to date, alongside close collaborative working with all partners, is essential to ensure the "system" is prepared for the challenges of the forthcoming winter.

The likely impact of any further escalation of the current pandemic and the impact it could have on the delivery of critical services during the most challenging months of the year (winter) is largely unknown. However, it is imperative that we take the learning and prepare for a "typical" winter coupled with the ongoing management of Covid-19 in our communities and hospitals, and any further escalation of the pandemic.

The plan and investment (circa £4m schemes of which £2.2m committed at the time of writing this document) set out in this document is focused on delivering safe, reliable and timely care during winter and recognising the importance of protecting and supporting our staff. By delivering what has been described in this winter plan should yield the following:

- **Reduction in ED attendances** (or stemming of the usual winter increase in demand) of between 10 and 20 per cent through implementation of NHS111 First, plus additional support and capacity from our community services and other partners. This could result in the signposting of around 25-50 patients per day from attending ED to other more appropriate services.

- A significant investment in **additional workforce**, particularly medical and nursing, but not exclusive to, to ensure our wards, departments and services are safe and we have added resilience across the organisation and across more of the week.

- **Additional capacity (more beds)**. At Leighton Hospital there is a plan to open up to 54 additional acute and general beds (broadly in line with the bed capacity available in winter 2019/20).

- Up to a further **30 additional community/out of hospital beds** which will reduce the number of patients who are delayed being transferred out of hospital to other care settings who are medically fit.

- A **plan and firm commitment to look after the health and wellbeing of our workforce** above and beyond what we would normally do, which includes an ambitious and comprehensive **flu campaign.**

- Submission of two capital bids to support extra critical care capacity with the main capital bid being for the development of a **new larger ED at Leighton Hospital**.

There will be regular updates to the Cheshire System Flow Group regarding progress against implementation and delivery of the winter plan and we will continue to work with partners across the “Cheshire System” to ensure that we are prepared for this winter and to ensure delivery of safe, reliable and timely urgent and emergency care for those patients that require us the most.

# Workforce and Digital Transformation Committee
# Chair's Assurance Report
# September 2020

| | |
|---|---|
| **Report to** | Board of Directors |
| **Date** | 10 September 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<br>Amy Freeman, Chief Information Officer<br>Oliver Bennett, Chief Operating Officer |
| **Committee meeting quoracy** | Yes ☒ No ☐ |

## KEY AREAS OF ASSURANCE

The Committee received the first Executive Group Chair report from Executive Workforce Assurance Group (EWAG) which provided a clear summary of issues and risks discussed and actions taken.

**Workforce Report:**

- A task and finish group has been set up to explore different ways of tackling non-compliance with mandatory training as rates continue to be under target. Next report to provide greater detail on medical workforce compliance
- Divisions have signed up to agreed trajectories to recover the appraisal position by December together with the launch of the new Motiv8 training programme
- Staff Survey to be launched at the end of September with a new provider and online options for completion. Communications are planned, to include outcomes of action plans from last year
- Initial Pulse survey results are within normal parameters; frequency of the survey is being reduced to minimise survey fatigue and encourage completion
- Flu campaign planning is underway, monitored by Executive Workforce Assurance Group (EWAG) with additional nursing resource to support this year. This year the flu campaign will be supported by an electronic system to aid swift and accurate reporting
- Six staff have been asked to isolate through Track and Trace

Given the discussion, the Committee considered they had a robust line of sight on the issues in the report and the report provided good intelligence about workforce and the measures being taken in response to the report.

**NHS People Plan 2020/21** - acceptable assurance: review against current policy and practice and a gap analysis completed; further work required to identify priority objectives, actions, review against Our Workforce Matters Strategy and BAF risks. Particular areas of focus are staff health and wellbeing, equality diversity and inclusion (ED&I), flexible and new ways of working, leadership development and workforce planning.

**Nursing Staff Group Vacancy Analysis -** acceptable assurance: Positive trajectory noted with recognition of challenge in specialist areas such as theatres and paediatrics and the need to move focus to retention. Committee requested evidence of the impact on nursing staff.

**Leadership Development** - acceptable assurance: new structured flexible programme for post-Covid training should provide the scope for development and wider experience with partners, with the aim of retaining leaders at the Trust.

**Communications and Engagement Update** - acceptable assurance: performance of Communications being integral to Covid was recognised through the variety and regularity of different communication channels which resulted in greater engagement with staff.

**Equality Diversity and Inclusion (ED&I)**

- Workforce Race Equality Standard (WRES) annual report: decline across a number of standards identified but actions in place to address this, including setting up a BAME advisory panel, review of recruitment practices and establishing diverse stakeholder panels for senior appointments. Capacity required to deliver the work required was raised as an issue

- Workforce Disability Equality Standard: worsening position noted, with a number of key similarities with the WRES workplan and actions proposed as part of an overall inclusion agenda. Committee considered that they had a good line of sight and noted that these reports required improvements in the organisational culture for all colleagues

**Electronic Patient Record (EPR)**

- NHSX provided recommendations about the proposed procurement process and digital training for the Board. In addition, NHSX requested an updated copy of the procurement schedule. NHSX have sent a letter to the Department of Health and Social Care recommending the outline business case for approval. The EPR procurement and implementation including staff training within a changing environment for the workforce will bring significant challenges particularly during Covid restoration and Winter.

## KEY CONCERNS/RISKS

- EPR BAF risk to be reviewed following submission of full business case to Board, as this will be a significant change programme which will bring risk and opportunities
- ED&I performance deteriorating and needs focused work to improve the experience of BAME and disabled colleagues
- An overall approach to transformation that aligns to the Trust Strategy is required to facilitate alignment with WDT's remit

## Priority Areas: DECISIONS MADE

No decisions made

## RECOMMENDATION

To note

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

# Board of Directors

| | | |
|---|---|---|
| **Agenda Item** | **14.1** | Date of Meeting: 05/10/2020 |
| **Report Title** | Workforce Race Equality Standard (WRES) Key Findings Annual Report and Action Plan | |
| **Executive Lead** | Heather Barnett, Director of Workforce and OD | |
| **Lead Officer** | Natalie Wallace, Senior Workforce Business Partner | |
| **Action Required** | To approve | |

| | | | | | |
|---|---|---|---|---|---|
| ☐ | **Acceptable assurance**<br>General confidence in delivery of existing mechanisms / objectives | X | **Partial assurance**<br>Some confidence in delivery of existing mechanisms / objectives | ☐ | **No assurance**<br>No confidence in delivery |

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

- The Workforce Race Equality Standard (WRES) is a set of specific metrics that enable NHS organisations to compare the experiences of white and black and minority (BAME) staff.
- A decline in outcomes has been identified against five metrics, one indicator found static outcomes where no overall improvements or changes were measured and improved outcomes against two of the indicators.
- An action plan has been developed in partnership with our BAME Staff Network to address the areas where improvements are required. This action plan will be regularly monitored and reviewed by the Equality, Diversity and Inclusion Group.

**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 | ☐ | NHS contract requirement | |
| • Service Change | ☐ | | |

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

Publication on the Trust Website.

**REPORT DEVELOPMENT**

| Committee/ Group Name | Date | Report Title | Lead | Brief summary of key issues raised and actions agreed |
|---|---|---|---|---|
| Workforce and Digital Transformation Committee | 10 Sept 2020 | | Heather Barnett, Director of Workforce and OD | Recommend for approval to Board of Directors |
| | | | | |
| | | | | |

Mid Cheshire Hospitals
NHS Foundation Trust

# Workforce Race Equality Standard (WRES) 2020

**Summary:**

There is considerable evidence that the less favourable treatment of BAME staff in the NHS, through poor treatment and opportunities, has a significant impact on staff well-being, patient outcomes and on the efficient and effective running of the NHS and that the measures needed to address such discrimination will benefit patient care and organisational effectiveness.

The Workforce Race Equality Standard (WRES) is a set of nine specific metrics that enable NHS organisations to compare the experiences of white and black and minority (BAME) staff. This information will then be used to develop a local action plan, and enable the Trust to demonstrate progress against the indicators of race equality.

The main purpose of the WRES is:

- to help local, and national, NHS organisations to review their data against the nine WRES indicators,
- to produce action plans to close the gaps in workplace experience between white and Black and Ethnic Minority (BAME) staff, and,
- to improve BAME representation at the Board level of the organisation.

**The WRES Metrics**

The 9 Metrics are confirmed as follows:

| Metric Number | Data source | Metrics |
|---|---|---|
| 1 | ESR | Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce |
| 2 | NHS Jobs | Relative likelihood of staff being appointed from shortlisting across all posts |
| 3 | Local HR database | Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation<br>(based on data from a two year rolling average) |
| 4 | Local training data | Relative likelihood of staff accessing non-mandatory training and CPD |
| 5 | Staff survey | Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months |

| | | |
|---|---|---|
| 6 | Staff survey | Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months |
| 7 | Staff survey | Percentage believing that trust provides equal opportunities for career progression or promotion |
| 8 | Staff survey | In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues |
| 9 | ESR | Percentage difference between the organisations' voting Board membership and its overall workforce |

Note: For the 2020 reporting period, only metrics 1-4 and 9 are required for submission to NHS England as part of the data collection process. The results from metrics 5-8 are still included in this report, however for comparison purposes, it is noted that the 2019 NHS Staff Survey was issued to **all** Trust staff, rather than a sample as seen in previous years.

97.74% of Trust staff have their ethnicity recorded on ESR.

**WRES Trust findings against the metrics**

**Metric 1-** Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (based on ESR data as at 31st March 2020)

**Non-clinical (AfC)**

| Band | % of BAME staff |
|---|---|
| Band 1 | 0% |
| Band 2 | 2.88% |
| Band 3 | 1.80% |
| Band 4 | 0.92% |
| Band 5 | 2.25% |
| Band 6 | 1.61% |
| Band 7 | 8.82% |
| Band 8a | 2.33% |
| Band 8b | 5.26% |
| Band 8c | 0.00% |
| Band 8d | 11.11% |
| Band 9 | 0.00% |
| VSM | 0.00% |

**Clinical (AfC)**

| Band | % of BAME staff |
|---|---|
| Band 1 | 0% |
| Band 2 | 7.55% |
| Band 3 | 7.19% |
| Band 4 | 3.94% |

| | |
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| Band 5 | 15.17% |
| Band 6 | 4.94% |
| Band 7 | 3.76% |
| Band 8a | 1.54% |
| Band 8b | 0.00% |
| Band 8c | 0.00% |
| Band 8d | 0.00% |
| Band 9 | 0.00% |
| VSM | 0.00% |

**Medical & Dental**

| Grade | % of BAME staff |
|---|---|
| Consultant | 35.55% |
| Non Consultant Career Grade | 45.31% |
| Trainee Grades | 38% |

**Key findings**

- BAME staff make up 2.38% of the non-clinical workforce (AfC banded posts only).
- BAME staff account for 7.77% of the overall clinical workforce (AfC banded posts only).
- 6.05% of the total workforce, **excluding** those in Medical and Dental posts, are from BAME backgrounds. This increases to 7.70% when Medical and Dental staff are included.
- Excluding Medical and Dental roles, the highest numbers of BAME staff are in Band 5 nursing posts. This is a trend seen over previous years. BAME staff numbers in this band have increased over 50% since the previous reporting period due to recent international nursing recruitment campaigns.
- The only posts where BAME staff outnumber white staff is in Non-Consultant Career Grade posts.

**Metric 2 -** Relative likelihood of staff being appointed from shortlisting across all posts

24.9% of all applications for posts during the 2019/20 period were from BAME applicants, compared to 21.5% the previous year. BAME applicants who were short listed accounted for 18.46% of all shortlisted applicants.

The findings show that white staff are 1.43 times more likely to be appointed from shortlisting compared to BAME staff.

This is a declining position compared to the previous year where white staff were 1.32 times more likely to be appointed compared to BAME staff.

Policies and guidance are available for all aspects of the recruitment and selection process providing comprehensive information and guidance for those undertaking recruitment and selection at the Trust. Recruitment and Selection training for managers' covers unconscious bias and all recruiting managers are to attend training prior to undertaking the recruitment and selection process. The Trust will continue to monitor detailed analysis of ethnicity patterns in recruitment at the Equality, Diversity & Inclusion Group.

**Metric 3 -** Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation

This indicator is measured over a 2 year period as defined in the WRES guidance.

Based on a 2 year period April 2018- March 2020 BAME staff were 0.54 times more likely than white staff to enter the formal disciplinary process. This is compared to 1.01 in the previous reporting period.

This metric has seen a year on year improvement, decreasing from 1.70 in 2017 and 1.65 in 2018.

The Trust continue to monitor staff that enter into the disciplinary process and provide an annual disciplinary by ethnicity profile report to the Equality, Diversity & Inclusion Group to determine any outlying trends.

**Metric 4 -** Relative likelihood of staff accessing non-mandatory training and CPD

It is noted that each staff member may have attended more than one training session and have several training sessions attributed to them. The figures have been calculated to ensure that only one period of training/CPD is taken into account.

White staff are 0.88 times more likely to access non-mandatory training than their BAME counterparts. This is a slightly worsening position when compared to the previous year when white staff were 0.86 times more likely to access non-mandatory training.

The Trust continues to monitor attendance at training and CPD events to ensure that such courses and opportunities for learning are available and accessible to all.

**Metric 5 -** Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

This metric has seen an increase since the previous year for BAME staff (28.4% in 2019 compared to 17.9% in 2018).

White staff reported a poorer experience for this metric in the 2018 NHS Staff Survey when compared to BAME staff; however this is no longer the case, with a decrease to 23.2% of staff in 2019, compared to 25.7% in 2018.

The Trust will continue to review all incidents relating to harassment, bullying or abuse from patients in line with the zero tolerance guidance.

**Metric 6 -** Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

The results from the 2019 NHS Staff Survey shows an improvement for this metric compared to the previous year with 22.4% of BAME staff reporting harassment, bullying or abuse from their colleagues. This is compared to 32.1% in the previous year.

22.2% of white staff reported that that they had experienced harassment, bullying or abuse from staff in 2019, a slight increase noted when compared to 20.2% in 2018. The

staff survey results show a relatively poor experience in relation to both white and BAME staff experiences.

The Trust will continue to review all reported incidents relating to harassment, bullying or abuse.

**Metric 7 -** Percentage believing that the trust provides equal opportunities for career progression or promotion

This metric reported a significant decline in 2019 with just 68.2% of BAME staff believing that the Trust provides equal opportunities for career progression or promotion. This is a declining position when compared to 2018 (86.4%).

White staff reported a slight decline for this metric in 2019 with 89.4% of staff believing that equal opportunities for career progression or promotion were provided, compared to 91.2% in the previous year.

The Trust will continue to promote equal access to career progression opportunities. Analysis of ethnicity patterns in training will be monitored at the Equality, Diversity & Inclusion Group.

**Metric 8 -** In the last 12 months have you personally experienced discrimination at work from any of the following?
- Manager/team leader or other colleagues

This metric reported an increase for BAME staff in the 2019 NHS Staffs Survey. 16.2% of BAME staff reported that they personally experienced discrimination compared to 10.3% of BAME staff in 2018.

In contrast, 4.9% of white staff reported that they experienced discrimination in 2019 compared to 4.4% in the previous year.

The Trust will continue to review all reported incidents relating to discrimination and will take appropriate action where this occurs.

**Metric 9 -** Percentage difference between the organisations' Board membership and its overall workforce (based on data as at 31st March 2020)

There has been no change to this indicator since the introduction of the WRES with the Board voting profile 100% white.

**Conclusion, data reporting and action planning**

When excluding metric one which relates to staffing numbers across each of the pay bands, a decline in outcomes has been identified against five metrics (relative likelihood of staff being appointed from shortlisting, relative likelihood of staff accessing non-mandatory training and CPD, percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public, percentage believing that the trust provides equal opportunities for career progression or promotion and staff experiencing discrimination at work from their manager/team leader or other colleagues.

One indicator found static outcomes where no overall improvements or changes were

measured (percentage difference between the organisations' Board membership and its overall workforce).

The Trust has measured improved outcomes against two of the WRES indicators (relative likelihood of staff entering the formal disciplinary process and percentage of staff experiencing harassment, bullying or abuse from staff).

Whilst some improvements have been noted, the findings still evidence that in some areas BAME staff still experience a poorer experience at work than white staff.

These findings from the WRES data will be reported to the Workforce and Digital Transformation Committee and Trust Board and will be published on the Trust website.

An action plan will be developed in partnership with our BAME Staff Network to address the areas where improvements are required. This action plan will be regularly monitored and reviewed by the Equality, Diversity and Inclusion Group.

Natalie Wallace
Workforce Business Partner/Equality, Diversity & Inclusion Lead
August 2020

Mid Cheshire Hospitals
NHS Foundation Trust

# Equality, Diversity & Inclusion
# Workforce Race Equality Standard (WRES)
# Action Plan 2020/21

Mid Cheshire Hospitals NHS Foundation Trust is committed to meeting the requirements of the Workforce Race Equality Standard (WRES).

The Trust aims to ensure that principles of equality, diversity and inclusion are embedded throughout every part of the organisation and improve its status as an organisation that leads the promotion of equality, diversity and inclusion, challenges discrimination wherever it happens, and promotes equality in service delivery and employment.

To achieve our aims the Trust is committed to:

- Promoting equality of opportunity for all
- Promoting an inclusive environment in which all persons are treated with respect
- Fulfilling all of our legal obligations under the equality legislation
- Regarding all breaches of equal opportunities as misconduct which could lead to disciplinary proceedings

This document outlines the actions required as a result of the Trusts Workforce Race Equality Standard (WRES) report from August 2020. The action plan will be monitored by the Equality, Diversity and Inclusion Group which meets on a quarterly basis.

**WRES action plan**

| Objective | Specific Action | Lead | Timeframe | WRES 2020 submission | Indicator of improvement | Progress |
|---|---|---|---|---|---|---|
| **Leadership & Culture** | | | | | | |
| **Staff will work in an environment free from bullying, harassment and discrimination** | Develop a culture of dignity and respect for all staff - develop a campaign to ensure professional behaviours in the Workplace.<br><br>Introduce a Civility in the Workplace programme<br><br>Review of zero tolerance campaign – report to evidence number of incidents reported relating to patient abuse and overview of actions taken. | ED&I Lead<br><br>Head of OD<br><br>Security Manager<br><br>Communications Lead | March 2021 | Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months - reported increase since the previous year for BAME staff (28.4% in 2019 compared to 17.9% in 2018).<br><br>Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months - an improvement was noted for this metric with 22.4% of BAME staff reporting harassment, bullying or abuse from their colleagues compared to 32.1% in the previous year, however improvement is still required.<br><br>In the last 12 months have you personally experienced discrimination at work from any of the following?<br>- Manager/team leader or other colleagues - 16.2% of BAME staff reported that they personally experienced discrimination compared to 10.3% of BAME staff in 2018. | Fewer complaints of bullying and harassment with appropriate actions taken where incidents do occur.<br><br>Staff confident to raise incidents – increase in reporting<br><br>Civility in the Workplace programme rolled out<br><br>Improvement in staff survey results relating to discrimination and staff experiencing harassment, bullying and abuse. | |

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| **Ensure ethnicity diversity balance on decision making forums** | Review all board committees / decision making forums to assess whether staff from protected groups sit on decision making boards – explore implementation of a BAME advisory group.<br><br>Ensure that decision making groups are reviewing equality impact assessments prior to any strategic decision making | ED&I Lead<br><br>Director of Workforce and OD | December 2020 | | Forum in place for staff with protected characteristics to be involved in decision making.<br><br>Agreed and robust system in place to ensure that EIAs are reviewed prior to decision making. | |
| **Recruitment, Retention & Resourcing** | | | | | | |
| **Ensure that recruitment and selection practices are inclusive for BAME staff and prospective applicants** | Work with Trust communications to ensure that we present an inclusive picture to potential job applicants<br><br>Develop a selection process for senior Trust | ED&I Lead<br><br>Recruitment Manager | March 2021 | 24.9% of all applications for posts during the 2019/20 period were from BAME applicants.<br><br>White staff are 1.43 times more likely to be appointed from shortlisting compared to BAME staff. | Noted improvement in conversation rates for BAME staff.<br><br>Evidence to support whether BAME staff are not applying for promotional | |

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| | posts with a clear focus on selecting for talent and reducing unconscious bias - include use of psychometric testing and diverse stakeholder panels for senior appointments band 8a and above.<br><br>Enhance recruitment training so focus is on reducing unconscious bias at all stages of selection<br><br>Expand and mandate diversity of all selection panels – proposal paper to ED&I Group in October 2020<br><br>Analyse trend data in relation to Band 6 nursing vacancies and | | | | opportunities or whether are not successful for promotion at interview stage – further actions will be required to address the outcome. | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | appointments to determine progression opportunities for Band 5 staff. | | | | | |
| **Employee Voice** | | | | | | |
| **Examine issues facing BAME staff and improve working experience** | Develop/enhance the profile of the newly formed BAME Staff Network – additional communication to raise awareness. Branding exercise of the network required.<br><br>Share stories from BAME staff regarding their experiences in the workplace – to become standard practice | ED&I Lead<br><br>BAME staff network Chair | December 2020 | 7.70% of the total workforce are from BAME backgrounds. | Regular events to promote BAME network and celebrate BAME contribution<br><br>Committed and engaged BAME staff network in place with clear progress against objectives identified. | |
| **Education and Learning** | | | | | | |
| **To have strategies in place to equip and support BAME staff to progress** | Explore implementation of a reverse mentoring programme – scoping exercise to be undertaken to explore requirements, | ED&I Lead<br><br>Head of Education | March 2021 | White staff are 0.88 times more likely to access non-mandatory training than their BAME counterparts. This is a slightly worsening position when compared to the previous year when white staff were 0.86 times more likely to access non-mandatory training. | Improvement in staff survey results relating to progression and promotion | |

| | | | | | | |
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| | what this entails and expected outcomes.<br><br>Explore implementation of a mentorship programme for BAME staff - scoping exercise to be undertaken to explore requirements, what this entails and expected outcomes.<br><br>Survey to BAME staff to gain in-depth views on career progression opportunities - identification of whether feel are barriers and if feel supported etc.<br><br>Improvement in training communications regarding availability of development | | | | | |

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| | sessions/training – widen reach to ensure awareness.<br><br>Implement BAME development programme for Band 5 staff to support aspirations to move into higher banded posts.<br>. | | | | | |
| **Close the gap between the percentage difference between the organisations' Board membership and its overall workforce** | Explore implementation of a Board Apprenticeship programme | ED&I Lead<br><br>Director of Workforce and OD | December 2020 | No BAME representation at Board level - there has been no change to this indicator since the introduction of the WRES with the Board voting profile 100% white. | Board is representative of the overall workforce – robust plans in place to support/develop this. | |

NHS
Mid Cheshire Hospitals
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# Board of Directors

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|---|---|---|
| **Agenda Item** | **14.1** | Date of Meeting: 05/10/2020 |
| **Report Title** | Workforce Race Equality Standard (WRES) Key Findings Annual Report and Action Plan | |
| **Executive Lead** | Heather Barnett, Director of Workforce and OD | |
| **Lead Officer** | Natalie Wallace, Senior Workforce Business Partner | |
| **Action Required** | To approve | |

| | | | | | |
|---|---|---|---|---|---|
| X | **Acceptable assurance**<br>General confidence in delivery of existing mechanisms / objectives | ☐ | **Partial assurance**<br>Some confidence in delivery of existing mechanisms / objectives | ☐ | **No assurance**<br>No confidence in delivery |

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

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**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)*

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| • 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 | ✓ |
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**Governance** *(is the report a…?)*

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| • Annual Business Plan Priority | ☐ | *rationale for Board submission required:* | |
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**Next Steps (***actions following agreement by Board/Committee of recommendation/s)*

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**REPORT DEVELOPMENT**

| Committee/ Group Name | Date | Report Title | Lead | Brief summary of key issues raised and actions agreed |
|---|---|---|---|---|
| Workforce and Digital Transformation Committee | | | | |
| | | | | |
| | | | | |

Mid Cheshire Hospitals
NHS Foundation Trust

# Workforce Race Equality Standard (WRES) 2020

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**WRES Trust findings against the metrics**

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**Key findings**

- BAME staff make up 2.38% of the non-clinical workforce (AfC banded posts only).
- BAME staff account for 7.77% of the overall clinical workforce (AfC banded posts only).
- 6.05% of the total workforce, **excluding** those in Medical and Dental posts, are from BAME backgrounds. This increases to 7.70% when Medical and Dental staff are included.
- Excluding Medical and Dental roles, the highest numbers of BAME staff are in Band 5 nursing posts. This is a trend seen over previous years. BAME staff numbers in this band have increased over 50% since the previous reporting period due to recent international nursing recruitment campaigns.
- The only posts where BAME staff outnumber white staff is in Non-Consultant Career Grade posts.

**Metric 2 -** Relative likelihood of staff being appointed from shortlisting across all posts

24.9% of all applications for posts during the 2019/20 period were from BAME applicants, compared to 21.5% the previous year. BAME applicants who were short listed accounted for 18.46% of all shortlisted applicants.

The findings show that white staff are 1.43 times more likely to be appointed from shortlisting compared to BAME staff.

This is a declining position compared to the previous year where white staff were 1.32 times more likely to be appointed compared to BAME staff.

Policies and guidance are available for all aspects of the recruitment and selection process providing comprehensive information and guidance for those undertaking recruitment and selection at the Trust. Recruitment and Selection training for managers' covers unconscious bias and all recruiting managers are to attend training prior to undertaking the recruitment and selection process. The Trust will continue to monitor detailed analysis of ethnicity patterns in recruitment at the Equality, Diversity & Inclusion Group.

**Metric 3 -** Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation

This indicator is measured over a 2 year period as defined in the WRES guidance.

Based on a 2 year period April 2018- March 2020 BAME staff were 0.54 times more likely than white staff to enter the formal disciplinary process. This is compared to 1.01 in the previous reporting period.

This metric has seen a year on year improvement, decreasing from 1.70 in 2017 and 1.65 in 2018.

The Trust continue to monitor staff that enter into the disciplinary process and provide an annual disciplinary by ethnicity profile report to the Equality, Diversity & Inclusion Group to determine any outlying trends.

**Metric 4 -** Relative likelihood of staff accessing non-mandatory training and CPD

It is noted that each staff member may have attended more than one training session and have several training sessions attributed to them. The figures have been calculated to ensure that only one period of training/CPD is taken into account.

White staff are 0.88 times more likely to access non-mandatory training than their BAME counterparts. This is a slightly worsening position when compared to the previous year when white staff were 0.86 times more likely to access non-mandatory training.

The Trust continues to monitor attendance at training and CPD events to ensure that such courses and opportunities for learning are available and accessible to all.

**Metric 5 -** Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

This metric has seen an increase since the previous year for BAME staff (28.4% in 2019 compared to 17.9% in 2018).

White staff reported a poorer experience for this metric in the 2018 NHS Staff Survey when compared to BAME staff; however this is no longer the case, with a decrease to 23.2% of staff in 2019, compared to 25.7% in 2018.

The Trust will continue to review all incidents relating to harassment, bullying or abuse from patients in line with the zero tolerance guidance.

**Metric 6 -** Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

The results from the 2019 NHS Staff Survey shows an improvement for this metric compared to the previous year with 22.4% of BAME staff reporting harassment, bullying or abuse from their colleagues. This is compared to 32.1% in the previous year.

22.2% of white staff reported that that they had experienced harassment, bullying or abuse from staff in 2019, a slight increase noted when compared to 20.2% in 2018. The

staff survey results show a relatively poor experience in relation to both white and BAME staff experiences.

The Trust will continue to review all reported incidents relating to harassment, bullying or abuse.

**Metric 7 -** Percentage believing that the trust provides equal opportunities for career progression or promotion

This metric reported a significant decline in 2019 with just 68.2% of BAME staff believing that the Trust provides equal opportunities for career progression or promotion. This is a declining position when compared to 2018 (86.4%).

White staff reported a slight decline for this metric in 2019 with 89.4% of staff believing that equal opportunities for career progression or promotion were provided, compared to 91.2% in the previous year.

The Trust will continue to promote equal access to career progression opportunities. Analysis of ethnicity patterns in training will be monitored at the Equality, Diversity & Inclusion Group.

**Metric 8 -** In the last 12 months have you personally experienced discrimination at work from any of the following?
- Manager/team leader or other colleagues

This metric reported an increase for BAME staff in the 2019 NHS Staffs Survey. 16.2% of BAME staff reported that they personally experienced discrimination compared to 10.3% of BAME staff in 2018.

In contrast, 4.9% of white staff reported that they experienced discrimination in 2019 compared to 4.4% in the previous year.

The Trust will continue to review all reported incidents relating to discrimination and will take appropriate action where this occurs.

**Metric 9 -** Percentage difference between the organisations' Board membership and its overall workforce (based on data as at 31st March 2020)

There has been no change to this indicator since the introduction of the WRES with the Board voting profile 100% white.

**Conclusion, data reporting and action planning**

When excluding metric one which relates to staffing numbers across each of the pay bands, a decline in outcomes has been identified against five metrics (relative likelihood of staff being appointed from shortlisting, relative likelihood of staff accessing non-mandatory training and CPD, percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public, percentage believing that the trust provides equal opportunities for career progression or promotion and staff experiencing discrimination at work from their manager/team leader or other colleagues.

One indicator found static outcomes where no overall improvements or changes were

measured (percentage difference between the organisations' Board membership and its overall workforce).

The Trust has measured improved outcomes against two of the WRES indicators (relative likelihood of staff entering the formal disciplinary process and percentage of staff experiencing harassment, bullying or abuse from staff).

Whilst some improvements have been noted, the findings still evidence that in some areas BAME staff still experience a poorer experience at work than white staff.

These findings from the WRES data will be reported to the Workforce and Digital Transformation Committee and Trust Board and will be published on the Trust website.

An action plan will be developed in partnership with our BAME Staff Network to address the areas where improvements are required. This action plan will be regularly monitored and reviewed by the Equality, Diversity and Inclusion Group.

Natalie Wallace
Workforce Business Partner/Equality, Diversity & Inclusion Lead
August 2020

Mid Cheshire Hospitals
NHS Foundation Trust

# Equality, Diversity & Inclusion
# Workforce Race Equality Standard (WRES)
# Action Plan 2020/21

Mid Cheshire Hospitals NHS Foundation Trust is committed to meeting the requirements of the Workforce Race Equality Standard (WRES).

The Trust aims to ensure that principles of equality, diversity and inclusion are embedded throughout every part of the organisation and improve its status as an organisation that leads the promotion of equality, diversity and inclusion, challenges discrimination wherever it happens, and promotes equality in service delivery and employment.

To achieve our aims the Trust is committed to:

- Promoting equality of opportunity for all
- Promoting an inclusive environment in which all persons are treated with respect
- Fulfilling all of our legal obligations under the equality legislation
- Regarding all breaches of equal opportunities as misconduct which could lead to disciplinary proceedings

This document outlines the actions required as a result of the Trusts Workforce Race Equality Standard (WRES) report from August 2020. The action plan will be monitored by the Equality, Diversity and Inclusion Group which meets on a quarterly basis.

**WRES action plan**

| Objective | Specific Action | Lead | Timeframe | WRES 2020 submission | Indicator of improvement | Progress |
|---|---|---|---|---|---|---|
| **Leadership & Culture** | | | | | | |
| **Staff will work in an environment free from bullying, harassment and discrimination** | Develop a culture of dignity and respect for all staff - develop a campaign to ensure professional behaviours in the Workplace.<br><br>Introduce a Civility in the Workplace programme<br><br>Review of zero tolerance campaign – report to evidence number of incidents reported relating to patient abuse and overview of actions taken. | ED&I Lead<br><br>Head of OD<br><br>Security Manager<br><br>Communications Lead | March 2021 | Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months - reported increase since the previous year for BAME staff (28.4% in 2019 compared to 17.9% in 2018).<br><br>Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months - an improvement was noted for this metric with 22.4% of BAME staff reporting harassment, bullying or abuse from their colleagues compared to 32.1% in the previous year, however improvement is still required.<br><br>In the last 12 months have you personally experienced discrimination at work from any of the following?<br>- Manager/team leader or other colleagues - 16.2% of BAME staff reported that they personally experienced discrimination compared to 10.3% of BAME staff in 2018. | Fewer complaints of bullying and harassment with appropriate actions taken where incidents do occur.<br><br>Staff confident to raise incidents – increase in reporting<br><br>Civility in the Workplace programme rolled out<br><br>Improvement in staff survey results relating to discrimination and staff experiencing harassment, bullying and abuse. | |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Ensure ethnicity diversity balance on decision making forums** | Review all board committees / decision making forums to assess whether staff from protected groups sit on decision making boards – explore implementation of a BAME advisory group.<br><br>Ensure that decision making groups are reviewing equality impact assessments prior to any strategic decision making | ED&I Lead<br><br>Director of Workforce and OD | December 2020 | | Forum in place for staff with protected characteristics to be involved in decision making.<br><br>Agreed and robust system in place to ensure that EIAs are reviewed prior to decision making. | |
| **Recruitment, Retention & Resourcing** | | | | | | |
| **Ensure that recruitment and selection practices are inclusive for BAME staff and prospective applicants** | Work with Trust communications to ensure that we present an inclusive picture to potential job applicants<br><br>Develop a selection process for senior Trust | ED&I Lead<br><br>Recruitment Manager | March 2021 | 24.9% of all applications for posts during the 2019/20 period were from BAME applicants.<br><br>White staff are 1.43 times more likely to be appointed from shortlisting compared to BAME staff. | Noted improvement in conversation rates for BAME staff.<br><br>Evidence to support whether BAME staff are not applying for promotional | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | posts with a clear focus on selecting for talent and reducing unconscious bias - include use of psychometric testing and diverse stakeholder panels for senior appointments band 8a and above.<br><br>Enhance recruitment training so focus is on reducing unconscious bias at all stages of selection<br><br>Expand and mandate diversity of all selection panels – proposal paper to ED&I Group in October 2020<br><br>Analyse trend data in relation to Band 6 nursing vacancies and | | | | opportunities or whether are not successful for promotion at interview stage – further actions will be required to address the outcome. | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | appointments to determine progression opportunities for Band 5 staff. | | | | | |
| **Employee Voice** | | | | | | |
| **Examine issues facing BAME staff and improve working experience** | Develop/enhance the profile of the newly formed BAME Staff Network – additional communication to raise awareness. Branding exercise of the network required.<br><br>Share stories from BAME staff regarding their experiences in the workplace – to become standard practice | ED&I Lead<br><br>BAME staff network Chair | December 2020 | 7.70% of the total workforce are from BAME backgrounds. | Regular events to promote BAME network and celebrate BAME contribution<br><br>Committed and engaged BAME staff network in place with clear progress against objectives identified. | |
| **Education and Learning** | | | | | | |
| **To have strategies in place to equip and support BAME staff to progress** | Explore implementation of a reverse mentoring programme – scoping exercise to be undertaken to explore requirements, | ED&I Lead<br><br>Head of Education | March 2021 | White staff are 0.88 times more likely to access non-mandatory training than their BAME counterparts. This is a slightly worsening position when compared to the previous year when white staff were 0.86 times more likely to access non-mandatory training. | Improvement in staff survey results relating to progression and promotion | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | what this entails and expected outcomes.<br><br>Explore implementation of a mentorship programme for BAME staff - scoping exercise to be undertaken to explore requirements, what this entails and expected outcomes.<br><br>Survey to BAME staff to gain in-depth views on career progression opportunities - identification of whether feel are barriers and if feel supported etc.<br><br>Improvement in training communications regarding availability of development | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | sessions/training – widen reach to ensure awareness.<br><br>Implement BAME development programme for Band 5 staff to support aspirations to move into higher banded posts.<br>. | | | | | |
| **Close the gap between the percentage difference between the organisations' Board membership and its overall workforce** | Explore implementation of a Board Apprenticeship programme | ED&I Lead<br><br>Director of Workforce and OD | December 2020 | No BAME representation at Board level - there has been no change to this indicator since the introduction of the WRES with the Board voting profile 100% white. | Board is representative of the overall workforce – robust plans in place to support/develop this. | |

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# Board of Directors

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|---|---|---|
| **Agenda Item** | **14.2** | Date of Meeting: 05/10/2020 |
| **Report Title** | Workforce Disability Equality Standard (WDES) Key Findings Annual Report and Action Plan | |
| **Executive Lead** | Heather Barnett, Director of Workforce and OD | |
| **Lead Officer** | Natalie Wallace, Senior Workforce Business Partner | |
| **Action Required** | To approve | |

| | | | | | |
|---|---|---|---|---|---|
| ☐ | **Acceptable assurance**<br>General confidence in delivery of existing mechanisms / objectives | X | **Partial assurance**<br>Some confidence in delivery of existing mechanisms / objectives | ☐ | **No assurance**<br>No confidence in delivery |

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

- The Workforce Disability Equality Standard (WDES) is a set of specific metrics that enable NHS organisations to compare the experiences of disabled and non-disabled staff.
- A decline in outcomes has been identified against eight areas including all areas relating to staff experiencing harassment, bullying or abuse, two indicators found static outcomes where no overall improvements or changes were measured and improved outcomes against just two of the indicators
- An action plan has been developed to address the areas where improvements are required. This action plan will be regularly monitored and reviewed by the Equality, Diversity and Inclusion Group.

**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 | ☐ | NHS contract requirement | |
| • Service Change | ☐ | | |

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

Publication on the Trust website.

**REPORT DEVELOPMENT**

| Committee/ Group Name | Date | Report Title | Lead | Brief summary of key issues raised and actions agreed |
|---|---|---|---|---|
| Workforce and Digital Transformation Committee | 10 Sept 2020 | | Heather Barnett, Director of Workforce and OD | Recommend for approval to Board of Directors |
| | | | | |
| | | | | |

Mid Cheshire Hospitals
NHS Foundation Trust

# Workforce Disability Equality Standard (WDES) 2020

**Introduction:**

The Workforce Disability Equality Standard (WDES) is a set of ten specific measures (metrics) that enable NHS organisations to compare the experiences of Disabled and non-disabled staff. Research has shown that Disabled staff have poorer experiences in areas such as bullying and harassment and attending work when feeling ill, when compared to non-disabled staff. The metrics are measured using a using a combination of data from ESR and other HR databases including responses from the national NHS Staff Survey.

This information is then used to develop a local action plan, and enable the Trust to demonstrate progress against the indicators of disability equality.

The WDES first came into force on 1st April 2019 is mandated through the NHS Standard Contract. This report outlines the findings for the Trusts second WDES submission.

**Data quality**

All of the data required for WDES reporting is already collected through ESR, the NHS National Staff Survey, NHS Jobs or via the HR Employee Relations databases. The reporting of disability on ESR is low as noted below:

| MCHFT staff | ESR March 2019 | ESR March 2020 |
|---|---|---|
| Disabled - Yes | 2.6% | 2.78% |
| Disabled - No | 79.7% | 81.23% |
| Not declared/prefer not to answer/unspecified | 17.7% | 15.99% |

**Reasons for this may include:**

- New starters not feeling confident to report during the recruitment process.
- ESR not being updated when staff becoming disabled in service.
- Staff fear of disability reporting affecting their work /career
- Staff not understanding the legal definition of disability & what it includes, which may cause many hidden disabilities and mental health issues to be unreported.

**The WDES Metrics**

The 10 Metrics are confirmed as follows:

| Metric Number | Data source | Metrics |
|---|---|---|
| 1 | ESR data | Percentage of staff in AfC paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce. |
| 2 | NHS Jobs data | Relative likelihood of Disabled staff compared to non-disabled staff being appointed from shortlisting across all posts. |
| 3 | Local HR database | Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure. |
| 4 | Staff survey | Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:<br>i. Patients/service users, their relatives or other members of the public<br>ii. Managers<br>iii. Other colleagues<br>b) Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it. |
| 5 | Staff survey | Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion. |
| 6 | Staff survey | Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties. |
| 7 | Staff survey | Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work. |
| 8 | Staff survey | Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work. |
| 9 | Staff survey<br>Local information | a) The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.<br>b) Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (Yes) or (No) |
| 10 | ESR | Percentage difference between the organisation's Board voting |

| | | |
|---|---|---|
| | | membership and its organisation's overall workforce, disaggregated:<br>• By voting membership of the Board.<br>• By Executive membership of the Board |

Note: For the 2020 reporting period, only metrics 1-3 and 9b - 10 are required for submission to NHS England as part of the data collection process. The results from metrics 4-9a are still included in this report, however for comparison purposes, it is noted that the 2019 NHS Staff Survey was issued to all Trust staff, rather than a sample as seen in previous years. Any NHS Staff Survey comparisons are made from the 2018 survey results.

## WDES findings against the metrics

**Metric 1-** Percentage of staff in AfC paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce

Non-clinical (AfC)

| Banding | Disabled | Non-disabled | Not known |
|---|---|---|---|
| Cluster 1 (Band 1-4) | 5.2% | 80.8% | 14% |
| Cluster 2 (Band 5-7) | 3.2% | 82.7% | 14.1% |
| Cluster 3 (Band 8a-8b) | 1.6% | 92.1% | 6.3% |
| Cluster 4 (Band 8c-8d and VSM) | 3.2% | 83.9% | 12.9% |

Clinical (AfC and Medical & Dental grades)

| Banding | Disabled | Non-disabled | Not known |
|---|---|---|---|
| Cluster 1 (Band 1-4) | 2.84% | 83.03% | 14.13% |
| Cluster 2 (Band 5-7) | 3.48% | 80.94% | 15.57% |
| Cluster 3 (Band 8a-8b) | 1.44% | 76.26% | 22.30% |
| Cluster 4 (Band 8c-8d and VSM) | 0% | 100% | 0% |
| Cluster 5 Consultant | 1.32% | 81.58% | 17.11% |
| Cluster 6 Non-consultant career grade | 0% | 59.38% | 40.63% |
| Cluster 7 Trainee grades | 2% | 84% | 14% |

## Key findings

- The largest proportion of staff with a disability are in cluster 1 for non-clinical staff and cluster 2 for clinical staff. These groups have the largest staffing numbers.
- Staff in cluster 4 for clinical staff do not report any disabilities, however it is the small headcount of staff in this cluster is noted.
- Over 40% of staff in non-consultant career posts chose not to confirm whether or not they have a disability. This trend remains the same as seen in the previous year.
- Over 14% of staff in both clinical and non-clinical roles bands 1 to 7 chose not to confirm whether or not they have a disability.
- The findings indicate that non-clinical managers in bands 8a and 8b are more likely to report whether or not they have a disability than those in clinical posts of the same band.

**Metric 2 -** Relative likelihood of Disabled staff compared to non-disabled staff being appointed from shortlisting across all posts.

3.80% of all applications received for Trust positions during 2019/20 were from candidates who indicated that they had a disability. 3.70% of candidates who were shortlisted for interview reported that they had a disability and 2.30% of those appointed to post had a disability.

The findings show that ***non-disabled staff are 1.63 times more likely*** to be appointed from shortlisting than disabled staff. This is compared to 1.26 times more likely in the previous year.

The Trust offer the guaranteed interview scheme for staff who self-report that they are disabled. In addition, the Trust are also recognised as being a 'Disability Confident' employer.

**Metric 3 -** Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure

This metric was voluntary in the first year of WDES completion however was made compulsory during 2020. This metric is based on a 2 year rolling average for the period 1st April 2018 to 31st March 2020 and uses the performance management procedure to constitute capability procedures rather than ill health capability. Findings are therefore calculated as such.

The findings show that ***disabled staff are no more likely*** to be subjected to formal capability procedures that non-disabled staff. This metric has seen no change since the previous year.

It is noted that a low number of capability procedures are undertaken across the Trust in comparison to other types of employment relations casework.

**Metric 4 -** Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse.

**From patients /public** – disabled staff reported a higher percentage of harassment bullying and abuse from patients, service users or the public at 30% compared to 22% of non-disabled staff. Both disabled and non-disabled staff have seen a slight decrease since the previous year; 34% and 23% respectively.

| Patient/public Score | Disabled staff | Non-disabled staff |
|---|---|---|
| Staff Survey 2019 | 30% | 22% |
| Staff Survey 2018 | 34% | 23% |

**From their manager** – This metric has seen a decline in the experience of disabled staff. 15% of disabled staff reported that they had experienced harassment, bullying or abuse from their manager, compared to 9% of non-disabled staff. This is compared to 10% of disabled staff and 8% of non-disabled staff in the previous year.

| Manager Score | Disabled staff | Non-disabled staff |
|---|---|---|
| Staff Survey 2019 | 15% | 9% |
| Staff Survey 2018 | 10% | 8% |

**From colleagues** – A higher proportion of disabled staff reported experiencing harassment, bullying or abuse from a colleague (28%) compared to their non-disabled

counterparts (14%), and therefore double. This is compared to 25% for disabled staff with no change for non-disabled staff (14%) in the previous year.

| Colleagues Score | Disabled staff | Non-disabled staff |
|---|---|---|
| Staff Survey 2019 | 28% | 14% |
| Staff Survey 2018 | 25% | 14% |

**Reporting –** This metric has seen a significant decline for disabled staff who have reported incidents of bullying, harassment or abuse where such an incident occurred. Only 37% of disabled staff confirmed that they reported the incident, compared to 55% in the previous year.

This metric has also seen a reduction in non-disabled staff reporting incidents of harassment, bullying or abuse, 47% this year, compared to 52% in the previous year.

| Reporting Score | Disabled staff | Non-disabled staff |
|---|---|---|
| Staff Survey 2019 | 37% | 47% |
| Staff Survey 2018 | 55% | 52% |

**Metric 5 -** Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.

| Equal Opportunities | Disabled staff | Non-disabled staff |
|---|---|---|
| Staff Survey 2019 | 80% | 90% |
| Staff Survey 2018 | 85% | 92% |

The staff survey results showed that 80% of disabled staff felt the Trust provides equal opportunities for career progression or promotion compared to 90% of non-disabled staff. This is compared to 85% for disabled staff and 92% for non-disabled staff in the previous year, and therefore a decline across both groups of staff.

**Metric 6 -** Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.

| Pressure Score | Disabled staff | Non-disabled staff |
|---|---|---|
| Staff Survey 2019 | 28% | 18% |
| Staff Survey 2018 | 29% | 20% |

28% of disabled staff felt under pressure from their managers to attend work when they were not well enough to perform their duties. This significantly reduces to 18% for non-disabled staff. This is a very slight improvement on the previous year's data for both staff groups (29% of disabled staff and 20% of non-disabled staff).

**Metric 7 -** Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work

| Sense of being valued Score | Disabled staff | Non-disabled staff |
|---|---|---|
| Staff Survey 2019 | 40% | 53% |
| Staff Survey 2018 | 43% | 50% |

40% of disabled staff reported that they were satisfied with the extent to which their work was valued compared to 53% of non-disabled staff.

Whilst this metric has seen a decline for disabled staff when compared to the previous reporting period (43% in the 2018 staff survey), a 3% improvement has been noted for non-disabled staff in the 2019 staff survey results when compared to the previous year (50%).

**Metric 8 -** Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work

72% of all disabled staff respondents who required adjustments felt that these were adequately made to enable them to carry out their work. This is compared to 70% in the previous year.

**Metric 9 - a)** The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.

| Engagement Score | Disabled staff | Non-disabled staff |
|---|---|---|
| Staff Survey 2019 | 6.7 | 7.4 |
| Staff Survey 2018 | 6.9 | 7.3 |

The staff survey highlighted that non-disabled staff reported higher levels of engagement (score of 7.4 out of 10) than disabled staff (6.7). When compared to the previous year, disabled staff have recorded a slight decrease in the engagement score, with a slight improvement recorded for non-disabled staff.

**Metric 9 b)** Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard?

A staff focus group took place in 2019 to further explore staff experiences of having a disability at work. As a result of discussions and feedback received, a health passport has been produced to support staff with disabilities in their role and this is currently in the process of being rolled out across the Trust.

Following the recent successful launch of a BAME staff network in July 2020 following a series of forums and Schwartz Rounds as a direct response to issues highlighted by Covid, a similar approach is being taken to explore launching a disability staff network. It is anticipated that the first disability forum to share staff experiences will take place in September 2020, with the longer term view of forum members engaging to develop a staff network.

**Metric 10 -** Percentage difference between the organisation's Board voting membership and its organisation's overall workforce

2.78% of the total workforce report that they have a disability, a slight increase from 2.60% the previous year. When reviewing Trust Board members, no disabilities are reported. 54% of Board members report that they do not have a disability and 46% have not declared or prefer not answer. This outcome remains the same as noted in the previous WDES report.

**Conclusion, data reporting and action planning**

The below conclusions have been drawn from metric indicators 2 to 9a and 10 (including metrics 4a – 4d), a total of 12 areas.

It is disappointing to note that a decline in outcomes has been identified against eight areas including all areas relating to staff experiencing harassment, bullying or abuse.

Two indicators found static outcomes where no overall improvements or changes were measured (relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process and the percentage difference between the organisation's Board voting membership and its organisation's overall workforce).

The Trust has measured improved outcomes against just two of the WDES indicators (percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work and the percentage of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work).

These findings from the WDES data will be reported to the Workforce and Digital Transformation Committee and Trust Board and will be published on the Trust website.

Whilst some improvements have been noted, the findings still evidence that in some areas disabled staff still experience a poorer experience at work than non-disabled staff. An action plan is being developed to address the areas where improvements are required. This action plan will be regularly monitored and reviewed by the Equality, Diversity and Inclusion Group with input from staff feedback from planned disability staff forums.

Natalie Wallace
Workforce Business Partner/ Equality, Diversity and Inclusion Lead
August 2020

Mid Cheshire Hospitals
NHS Foundation Trust

# Equality, Diversity & Inclusion
# Workforce Disability Equality Standard (WDES)
# Action Plan 2020/21

Mid Cheshire Hospitals NHS Foundation Trust is committed to meeting the requirements of the Workforce Disability Equality Standard (WDES) and this is our second publication against this standard.

The Trust aims to ensure that principles of equality, diversity and inclusion are embedded throughout every part of the organisation and improve its status as an organisation that leads the promotion of equality, diversity and inclusion, challenges discrimination wherever it happens, and promotes equality in service delivery and employment.

To achieve our aims the Trust is committed to:

- Promoting equality of opportunity for all
- Promoting an inclusive environment in which all persons are treated with respect
- Fulfilling all of our legal obligations under the equality legislation
- Regarding all breaches of equal opportunities as misconduct which could lead to disciplinary proceedings

This document outlines the actions required as a result of the Trusts Workforce Disability Equality Standard (WDES) report from August 2020. The action plan will be monitored by the Equality, Diversity and Inclusion Group which meets on a quarterly basis.

**WDES action plan**

<table>
<tr><th>Objective</th><th>Specific Action</th><th>Lead</th><th>Timeframe</th><th>WDES 2020 submission</th><th>Indicator of improvement</th><th>Progress</th></tr>
<tr><td colspan="7">Leadership & Culture</td></tr>
<tr><td>Staff will work in an environment free from bullying, harassment and discrimination</td><td>Develop a culture of dignity and respect for all staff - develop a campaign to ensure professional behaviours in the Workplace.<br><br>Introduce a Civility in the Workplace programme</td><td>ED&I Lead<br>Head of OD</td><td>March 2021</td><td>National staff survey for % of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:<br><br>Patients /public<br><br>
<table>
<tr><th>Patient/public Score</th><th>Disabled staff</th><th>Non-disabled staff</th></tr>
<tr><td>Staff Survey 2019</td><td>30%</td><td>22%</td></tr>
<tr><td>Staff Survey 2018</td><td>34%</td><td>23%</td></tr>
</table>
<br>From their manager<br><br>
<table>
<tr><th>Manager Score</th><th>Disabled staff</th><th>Non-disabled staff</th></tr>
<tr><td>Staff Survey 2019</td><td>15%</td><td>9%</td></tr>
<tr><td>Staff Survey 2018</td><td>10%</td><td>8%</td></tr>
</table>
</td><td>Fewer cases of conflict going through formal processes compared to previous reporting periods<br><br>Fewer complaints of bullying and harassment<br><br>Disabled staff reporting less incidents of harassment bullying and abuse and feeling confident about reporting incidences of bullying and harassment – notable</td><td></td></tr>
</table>

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<tr>
<td></td>
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<td></td>
<td>From colleagues<br><br>
<table>
<tr><th>Colleagues Score</th><th>Disabled staff</th><th>Non-disabled staff</th></tr>
<tr><td>Staff Survey 2019</td><td>28%</td><td>14%</td></tr>
<tr><td>Staff Survey 2018</td><td>25%</td><td>14%</td></tr>
</table>
<br>Reporting where it occurs<br><br>
<table>
<tr><th>Reporting Score</th><th>Disabled staff</th><th>Non-disabled staff</th></tr>
<tr><td>Staff Survey 2019</td><td>37%</td><td>47%</td></tr>
<tr><td>Staff Survey 2018</td><td>55%</td><td>52%</td></tr>
</table>
</td>
<td>improvements recorded in future NHS staff survey</td>
<td></td>
</tr>
<tr>
<td>Ensure disability diversity balance on decision making forums</td>
<td>Review all board committees / decision making forums to assess whether staff from protected groups sit on decision making boards – develop a plan to address this.<br><br>Ensure that decision making</td>
<td>ED&I Lead<br><br>Director of Workforce and OD</td>
<td>December 2020</td>
<td>2.78% of the total workforce report that they have a disability. When reviewing Trust Board members, no disabilities are reported.<br><br>54% of Board members report that they do not have a disability and 46% have not declared or prefer not answer.</td>
<td>Forum in place for staff with protected characteristics to be involved in decision making.<br><br>Agreed robust system in place to ensure that EIAs are reviewed prior to decision</td>
<td></td>
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| | | | | | | |
|---|---|---|---|---|---|---|
| | groups are reviewing equality impact assessments prior to any strategic decision making | | | | making. | |
| **Recruitment, Retention & Resourcing** | | | | | | |
| **Ensure that recruitment and selection practices are inclusive for disabled staff and prospective applicants** | Work with Trust communications to ensure that we present an inclusive picture to potential job applicants<br><br>Develop a selection process for senior Trust posts with a clear focus on selecting for talent and reducing unconscious bias - include use of psychometric testing and diverse stakeholder panels for senior appointments | ED&I Lead<br><br>Recruitment Manager | March 2021 | 3.80% of all applications received for Trust positions during 2019/20 were from candidates who indicated that they had a disability. 3.70% of candidates who were shortlisted for interview reported that they had a disability and 2.30% of those appointed to post had a disability.<br><br>The findings show that non-disabled staff are 1.63 times more likely to be appointed from shortlisting than disabled staff. | Noted improvement in conversation rates for disabled applicants | Disability Confident Employer<br><br>Guaranteed Interview Scheme offered |

| | | | | | | |
|---|---|---|---|---|---|---|
| | band 8a and above.<br><br>Enhance recruitment training so focus is on reducing unconscious bias at all stages of selection<br><br>Expand and mandate diversity of all selection panels – proposal paper to ED&I Group in October 2020 | | | | | |
| **Examine issues facing disabled staff and have strategies in place to support** | Explore via way of staff forums what barriers staff have faced in relation to adjustments being made to the workplace and develop a plan based on feedback to address this.<br><br>Explore the | ED&I Lead | December 2020 | 72% of all disabled staff respondents who required adjustments felt that these were adequately made to enable them to carry out their work. | Disabled staff feel their physical, mental and psychological needs are met<br><br>Noted improvement in staff survey results | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | culture amongst managers in relation to making adjustments in the workplace – Survey to department managers in addition to gathering feedback from managers who have implemented adjustments | | | | | |
| **Employee Voice** | | | | | | |
| **Examine issues facing disabled staff and improve working experience** | Introduce forums to start staff discussions in relation to disability | ED&I Lead | October 2020 | No disability staff network in place at present | Series of successful staff forum sessions to generate conversations regarding disabilities<br><br>Disabled staff feel engaged and listened to<br><br>Successful launch of disability staff network | First staff disability forum scheduled for Sept 2020 |
| **Examine issues** | Create a | ED&I Lead | December | No disability staff network in place at | An engaged | |

<table>
<tr>
<td>facing disabled staff and improve working experience</td>
<td>disability Staff Network to support staff with a disability</td>
<td></td>
<td>2020</td>
<td>present</td>
<td>and productive disability staff network in place – improved engagement score in the staff survey for disabled staff.</td>
<td></td>
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<tr>
<td>All disabled staff have confidence in declaring their disability on ESR</td>
<td>Develop a communication campaign so that staff feel confident about self-recording their disability on ESR.<br><br>Increased promotion of Trust as a ‘Disability Confident’ employer both internally and via recruitment social media sites<br><br>Share stories from disabled staff regarding their experiences in the workplace</td>
<td>ED&I Lead<br><br>Recruitment Manager</td>
<td>December 2020</td>
<td>
<table>
<tr><th>MCHFT staff</th><th>ESR March 2019</th><th>ESR March 2020</th></tr>
<tr><td>Disabled - Yes</td><td>2.6%</td><td>2.78%</td></tr>
<tr><td>Disabled - No</td><td>79.7%</td><td>81.23%</td></tr>
<tr><td>Not declared/prefer not to answer/unspecified</td><td>17.7%</td><td>15.99%</td></tr>
</table>
</td>
<td>Reduce not declared/prefer not to answer responses to 12% by March 2021.</td>
<td>Health Passport developed - to be rolled out</td>
</tr>
</table>

<table>
<tr><th colspan="7">Education and Learning</th></tr>
<tr><td rowspan="2">To have strategies in place to equip and support disabled staff to progress</td><td>Develop a Disability Confident Training Package for managers to cover reasonable adjustments.<br><br>Encourage managers (via training, ongoing education and coaching conversations) to have health and well-being discussions with staff about what reasonable adjustments can be made.</td><td>ED&I Lead</td><td>December 2020</td><td colspan="2">72% of all disabled staff respondents who required adjustments felt that these were adequately made to enable them to carry out their work.</td><td>Improvement in staff survey results in relation to reasonable adjustments and 4% improvement in disability reporting rates</td><td>Health Passport developed - to be rolled out</td></tr>
<tr><td>Review development opportunities available to Staff (both formal and informal) which</td><td>ED&I Lead<br><br>Head of OD<br><br>Head of Education</td><td>March 2021</td><td colspan="2"><table><tr><th>Equal Opportunities</th><th>Disabled staff</th><th>Non-disabled staff</th></tr><tr><td>Staff Survey 2019</td><td>80%</td><td>90%</td></tr><tr><td>Staff Survey</td><td>85%</td><td>92%</td></tr></table></td><td>Improvement in staff survey results relating to progression and promotion for disabled staff.</td><td></td></tr>
</table>

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<tr>
<td></td>
<td>would support promotion and career progression using feedback from disability forums (exploring themes in relation to barriers to accessing)</td>
<td></td>
<td></td>
<td>
<table>
<tr><td>2018</td><td></td><td></td></tr>
</table>
The staff survey results showed that 80% of disabled staff felt the Trust provides equal opportunities for career progression or promotion compared to 90% of non-disabled staff. This is compared to 85% for disabled staff in the previous year.
</td>
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<tr>
<td></td>
<td>Promote relevant awareness days across the Trust to show support for staff members with both short term and long term disabilities – such as Dyslexia Week and International Day for People with Disabilities.</td>
<td>ED&I Lead</td>
<td>March 2021</td>
<td>40% of disabled staff reported that they were satisfied with the extent to which their work was valued compared to 53% of non-disabled staff.
<table>
<tr><th>Sense of being valued Score</th><th>Disabled staff</th><th>Non-disabled staff</th></tr>
<tr><td>Staff Survey 2019</td><td>40%</td><td>53%</td></tr>
<tr><td>Staff Survey 2018</td><td>43%</td><td>50%</td></tr>
</table>
</td>
<td>Improved engagement score in the staff survey for disabled staff.</td>
<td></td>
</tr>
</table>

# Audit Committee
# Chair's Assurance Report
# October 2020

| | |
|---|---|
| **Report to** | Board of Directors |
| **Date** | 14 September 2020 |
| **Report from** | Les Philpott, Non-Executive Director |
| **Report prepared by** | Katharine Dowson, Head of Corporate Governance |
| **Executive Lead/s** | Russell Favager, Deputy Chief Executive and Director of Finance |
| **Committee meeting quoracy** | Yes ☒ No ☐ |

## KEY AREAS OF ASSURANCE

**Report of Board Committees:** the Committee queried the purpose of this report and whether it provided necessary assurance on the work and focus of Board Committees. A review will be undertaken by the Corporate Governance Team.

**Conformance report:** assurance was sought that the plan to promote 'no Purchase Order, no Pay' was sufficiently robust. Requested that the plan be revised to increase the pace of compliance and that the criteria for exceptions are laid out clearly.

**Internal Audit:** The plan for 2020/21 is now underway, with three audits completed and work on the E-booking review started. The plan remains unchanged although audits are now aligned to strategic objectives and BAF risks.

**Internal Audit Reports**

- **Incident Management and Reporting:** Substantial Assurance

- **Medical Devices Reports:** Limited Assurance

Two separate audit reports on Medical Devices were presented - technical controls and operational controls. Following discussion, the Committee agreed that the limited assurance opinion was a valid opinion and the Executive lead highlighted the following key points:

- The Executive Team had identified Medical Devices as an area for investigation by Internal Audit in order to receive recommendations and external opinion
- There were mitigating factors, including Covid impacting on delayed maintenance and monitoring
- Leadership has been changed and the governance is under review as part of a new approach to asset management
- An action plan with key milestones will be submitted to EDIG, and the Audit Committee. A new task and finish group has been established to review and action the recommendations of the report

- Audit Committee will receive an update at the November meeting at which point a potential date for a follow-up review will be agreed with internal auditors and incorporated into the 2021/22 internal audit plan

## KEY CONCERNS/RISKS

Medical Devices, as above

## Priority Areas: DECISIONS MADE

None made

## RECOMMENDATION

To note