Mid Cheshire Hospitals NHS Foundation Trust

Board of Directors

Thursday 28 January 2021
9.30am
Virtual – via Microsoft Teams

AGENDA

No	BAF Risk	Item
PRELIMINARY BUSINESS		
1 9:30		**Apologies (v)** Chair
2 9:32		**Declarations of Interest (v)** Chair To receive declarations of interest in agenda items and / or any changes to the register of directors' declarations of interest pursuant to Section 8 of Standing Orders
3 9:35	**BAF 9**	**MCHFT Covid-19 Mortality Review – Sharing Lessons (p)** Medical Director / Consultant in Critical Care and Emergency Medicine To note
4 9:45		**Draft Minutes of the Last Meeting – 7 December 2020 (d)** Chair To approve the draft minutes of the last meeting of the Board of Directors, discuss any matters arising and review the action log
5 09.50		**Chair's Opening Remarks (v)** • Governor Items
CONTEXT / OVERVIEW		
6 09:55		**Chief Executive's Report (d)** To note
	BAF13	• **Hospital Redevelopment Programme Board – 17 December 2020; 14 January 2021 (d)**
7 10.05	**BAF19**	**Board Assurance Framework Q3 2020/21 (d)** Chief Executive To note

No	BAF Risk	Item
8 10.15	**BAF19**	**Integrated Performance Report (Month 8 - November 2020) (d)** Chief Executive To note
QUALITY - Patient Safety, Clinical Effectiveness & Patient Experience		
9 10:20		**Quality & Safety Committee Chair's Assurance Reports (d) - 23 December 2020; 20 January 2021** Committee Vice Chair To note
	BAF19	• **CQC Improvement Plan Update (d)** Director of Nursing & Quality To note
10 10:30	**BAF 8**	**Serious Incidents (v)** Medical Director To note
11 10:35	**BAF 1**	**Infection Prevention and Control (IPC)** • **IPC Board Assurance Framework Update (d)** • **IPC 10-point Plan** Director of Nursing & Quality To note
12 10:45	**BAF 8**	**Transforming Perinatal Safety – Interim Response to the Ockenden Review (d)** Director of Nursing & Quality To note
PERFORMANCE		
13 10:55		**Performance & Finance Committee Chair's Assurance Reports (d) - 17 December 2020; 21 January 2021** Committee Chair To note
WELL LED		
14 11:05		**Workforce & Digital Transformation Chair's Assurance Reports (d)** • **21 December 2020**; **8 January 2021** Committee Chair To note

No	BAF Risk	Item
15 11:15	**BAF20**	**Cheshire East Integrated Care Partnership Transformation Strategy & Development Plan (d)** Director of Strategic Partnerships To note
16 11:25	**BAF12**	**Freedom to Speak up Guardian Q2 & Q3 2020/21 Report (d)** Freedom to Speak up Guardian To approve
17 11:35	**BAF21**	**Remuneration Committee Chair's Assurance Report – 7 December 2020 (d)** Chairman To note
18 11.40	**BAF12**	**Gender Pay Gap Report 2020 (d)** Director of Workforce and OD To approve

GOVERNANCE

19 11:45		**Audit Committee 14 January 2021 - Chair's Assurance Report (d)** Committee Chair To note
20 11:50	**BAF 6**	**Digital Clinical System Governance Structure (d)** Chief Information Officer To approve

CONSENT AGENDA (all items '*to note'* unless otherwise stated)

These items have been read by Board members and the minutes will reflect recommendations, unless an item has been requested to come off the consent agenda for debate; in this instance, these items will be identified at the start of the meeting

➢	**BAF 10**	**Guardian of Safe Working Hours Q2 & Q3 2020/21** Director of Workforce & OD
➢	**BAF 8**	**Learning from Deaths Q2 2020/21** Medical Director

No	BAF Risk	Item

CONCLUDING BUSINESS

21 12:00

Any Other Business

Chair

To consider any other matters of business

22 12:05

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

23 12:07

Key Messages from the Board (v)

Chair

To agree

Action Log Board of Directors **28 January 2021**

Agenda item		Assigned to	Deadline	Status
Board of Directors 07/12/2020 - Chief Executive's Report (d)				
346.	Circulate summary of the action plan against the 10 items in the IPC guidance	Tunney, Julie	19/01/2021	Pending Agenda Item 11
	Explanation action item Assigned to Sally Mann initially. A second version of the action plan was sent out by regulators, which then required rescoping of the work and so delayed circulation.			

BOARD OF DIRECTORS

Agenda Item	**6**	Date of Meeting: 28/01/2021
Report Title	**Chief Executive's Report January 2021**	
Executive Lead	James Sumner, Chief Executive	
Lead Officer	Caroline Keating, Company Secretary	
Action Required	To note	

☐ **Acceptable assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of controls

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

- Update on key issues including the Covid-19 vaccination programme, finance and performance
- Latest position regarding the risk relating to Reinforced Autoclaved Aerated Concrete (RAAC)

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

-

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

• Manage Covid response and recovery	☐	• Provide safe and sustainable services	☐
• Provide outstanding care/patient experience	☐	• Provide strong system leadership by working together	☐
• Deliver most effective care to achieve best possible outcomes	☐	• Be well governed and clinically led	✓
• Be the best place to work	☐		

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

• Quality	✓	• Compliance	✓
• Finance	✓	• Legal	☐
• Workforce	✓	• Risk/BAF Click here to select relevant risk	
• Equality	☐		

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

Strategy ☐ Policy ☐ Service Change ☐

REPORT DEVELOPMENT

Committee/ Group Name	Date	Report Title	Lead	Brief summary of key issues raised and actions agreed
Board of Directors	Monthly	CEO Report	Chief Executive	Noted

Chief Executive's Report
Board Meeting – 28 January 2021

Key Highlights

Reinforced Autoclaved Aerated Concrete (RAAC) Roof Planks

1. RAAC Roof Planks is considered a significant risk for the Trust on its Risk Register. There are 15 Trusts nationally that have some form of RAAC in their buildings but, in most of these cases, RAAC is only in a small section of the estate. Of the seven Trusts that are constructed more widely of RAAC planks, two of the seven are already included on the national Hospital Infrastructure Plan (HIP) for hospital replacements which leaves five Trusts, including Mid Cheshire, with a significant risk with no clear pathway to resolve.

2. The five Trusts have met twice in the last month to discuss sharing information to help address the safety concerns and as a result, the Trusts have written to senior officers at NHS Improvement (NHSI) and the Department of Health and Social Care to request clarity on how RAAC is being managed at a national level and the process for securing the necessary funding to address RAAC safety concerns to mitigate the risk in the medium and longer term.

Covid-19

3. As at 21 January, there were 189 confirmed positive Covid-19 patients in the hospital, which is a drop in the last few days although almost double what it was in the peak of wave one. It also represents a significant increase from last month. Hospital admissions for Covid-19 patients are starting to fall and the Trust expects this fall to continue over the coming weeks as the community infection rate decreases. Critical care is, however, likely to remain under significant pressure for a period longer than the rest of the hospital.

4. The recent significant increase in hospital admissions required staff to be redeployed to areas in the hospital that are under the most pressure and this impacted further on the elective programme, including the postponement of some cancer surgery. For those few patients that had their cancer operation postponed, the Trust sought 'mutual aid' from both the Greater Manchester and the Cheshire and Mersey Cancer Hubs to ensure that we could offer those patients an alternative date for their operation. The Trust has a robust plan to restart its full cancer programme from w/c 25 January, which is aligned to the falling number of Covid-19 admissions.

Infection Prevention & Control (IPC)

5. The IPC Board Assurance Framework (BAF), which also includes the IPC 10-point plan, has been updated and continues to be used as a monitoring tool for reducing nosocomial transmission. It is submitted for Board noting and Board members have been advised that the evidence embedded within the BAF cannot be accessed via Ibabs but is available on request.

6. The total numbers of IPC cases for December increased – this was mainly due to the volume of infected patients in the hospital and a rise in community rates, and not as a result of changes in clinical practice. We opened more wards for Covid-positive patients which made

adherence to the gold standard IPC guidance more challenging. To mitigate this, we developed the '**IPC guidance for the management of patient flow in high medium and low risk pathways'** for use across the Trust. It is also being considered for wider use across the Cheshire & Merseyside system.

7. As a result of the number of infection outbreaks, NHS England (NHSE) visited the Trust on 21 December to observe our practice and I am pleased to report that we have had some positive initial feedback and are currently awaiting their formal report. There were many areas of good practice identified, including IPC Champions monitoring patients wearing facemasks, ward helpers, additional cleaning, staff Lateral Flow Device (LFD) compliance and patient testing turnaround times; a couple of environmental improvements were suggested and these have been actioned. At the follow-up call with NHSE on 18 January, they confirmed the reduction in the number of nosocomial patients and outbreaks and were assured of all actions taken by the Trust, following the second after-action review in December

Staff Self-Screening

8. Over 95% of LFDs have been successfully distributed to over 4,000 staff. The impact on staff absences as a result of this testing has been less than expected and is helping to control the spread of the virus in the hospital. The Trust has requested another LFD consignment to enable staff to continue to self-test beyond the initial twelve-week period.

Covid-19 Vaccination

9. The Covid-19 vaccination programme is well underway with over 7,200 people (including 70% of our workforce) vaccinated (as at 21 January). In line with national guidance, the Trust will now be administering the second booster vaccination at week twelve, not at week three as the initial guidance mandated. The Trust continues to have capacity to vaccinate approximately 450 people per day, 7 days a week.

Restoration of Clinical Services

10. The Trust continues to sustain as many non-Covid clinical services as possible. However, because of the significant increase in Covid-19 positive patients being admitted to the hospital during December and in to January, the elective/planned care programme was scaled back in order to redeploy staff, capacity and resources to where the pressure is most significant, notably Covid-19 wards and Critical Care. This has resulted in a reduction in elective activity and a corresponding deterioration in the delivery of our Phase 3 plan. Notwithstanding, the Trust continues to deliver a significant proportion of its outpatient, diagnostic, endoscopic and daycase activity, including the bowel and breast screening programmes, which is different compared to wave one of the pandemic.

Trust 'Business as Usual'

Finance – Month 9 (December) 2020/21

11. The Trust has now received all national top-up payments for April – September 2020 (although this may be subject to audit by NHS Improvement) and thus was in a balanced financial position at the end of September.

12. As previously advised, there is a different financial regime for the second half of the financial year, based on financial allocations and a Cheshire & Merseyside Health Care Partnership (HCP) control total. The Trust is forecasting an expected £9.5m deficit for the second half of the financial year.

13. At the end of December, the Trust has a deficit of £3.3m which is £0.25m better than the forecast position.

14. The Trust has spent £15.5m to date on covid related costs during 2020/21 (excluding the loss of income). It is expected the majority of these circa £1.2m monthly costs will continue in the short term as they are key to supporting rotas, infection control etc, with a number expected to continue in the long term.

15. Although official guidance has not yet been received, it is expected that the financial regime which has operated in the second half of the current year (system level financial envelopes) will continue into the first quarter of 2021/22.

Workforce

16. **Health and Wellbeing:** we continue to support our staff with well-being initiatives, focusing on the immediate physical needs of our front line staff, such as providing hot food and supplying plenty of water to aid hydration. We are also working with the Trust's charity team to provide snacks and treats to areas under significant pressure to help with staff morale. The latest offer to our staff is the ability to access the Cheshire & Merseyside Resilience Hub, which is a regional service hosted by Mersey Care NHS Foundation Trust and is funded centrally from NHS England and Improvement. This service will provide additional support to our staff, ranging from self-help tools and techniques to complex psychological support for those staff who may begin to suffer potential psychological trauma as a result of their experience in coping through the pandemic".

17. A number of actions have been taken to ensure all clinical areas are maintained as safe as they can be. These actions include:

- Enhanced bank rates/ bank incentives
- Recruitment of increased numbers of international nurses
- Recruitment of additional Health Care Assistants
- Ward managers and coordinators temporarily based in clinical numbers
- Quality team/PEFs working clinically
- OPD and theatre work reduced- Staff re deployed to wards and critical care
- Reintroduction of ward helpers
- Buddy teams in critical care, including runners and non-clinical staff

Digital Clinical System

18. We continue to move forward with developing our Digital Clinical System (Electronic Patient Record and the proposed governance arrangements, developed with East Cheshire NHS Trust, are submitted for Board approval *(Item 20).*

Consultant Appointments

19. The following consultants have been appointed since October 2020:
    - Haseeb Chaudhary – Radiology
    - Gerard Dempsey – Anaesthetics and Critical Care
    - John Awad - Ophthalmology

Author: James Sumner, Chief Executive
Date: January 2021

Mid Cheshire Hospitals NHS Foundation Trust

Leighton Hospital Redevelopment Programme Board (HRPB)
Chair's Assurance Report
December 2020

Report to	Board of Directors
Date	17 December 2020
Report from	James Sumner, Chief Executive
Report prepared by	Katharine Dowson, Head of Corporate Governance
Executives	Russell Favager, Deputy Chief Executive/Director of Finance Caroline Keating, Company Secretary
Committee meeting quoracy	Yes ☐ No ☒

Meeting was inquorate due to the Medical Director being unable to attend.

KEY AREAS OF ASSURANCE

- Key documents and strategic plans have been developed to support the governance of the project and are in final draft stage, namely:
    - Project Initiation Document
    - Strategic Investment Objectives and Critical Success Factors
    - Risk Management Framework
    - Communications, Engagement and External Marketing Plan
- A first draft of the Draft Strategic Outline Case (SOC) will be available to the HRPB and Hospital Redevelopment Steering Group in early January. A final draft would be discussed by the Board in March
- Some of the clinical workshops had taken place but others were cancelled due to operational pressures. A plan was agreed to ensure clinical engagement in the SOC planning stage and a mixed approach, given the limited availability of clinical staff, would be taken to complete the workshops in January.

KEY CONCERNS/RISKS

- Timely engagement of clinical staff in SOC planning

Priority Areas: DECISIONS MADE

None.

RECOMMENDATION

To note

Leighton Hospital Redevelopment Programme Board (HRPB)
Chair's Assurance Report
January 2021

Report to	Board of Directors
Date	14 January 2021
Report from	James Sumner, Chief Executive
Report prepared by	Katharine Dowson, Head of Corporate Governance
Executives	Russell Favager, Deputy Chief Executive/Director of Finance Murray Luckas, Medical Director Caroline Keating, Company Secretary
Committee meeting quoracy	Yes ☒ No ☒

KEY AREAS OF ASSURANCE

- Despite operational pressures on Trust staff, the project remains on track against agreed milestones
- Majority of clinical workshops have been completed and staff feedback has not led to a significant change in the plan or size of building required
- Interim risk register discussed with full risk register to be completed by end of January
- Communications and Engagement Plan further work on the key messages with emphasis more on the case for change for Leighton. Phase 2 requirements need more detail with new media resources and stakeholder engagement

KEY CONCERNS/RISKS

- Timely engagement of clinical staff in Strategic Outline Case planning
- Further project support required as transformation team are focused on vaccination

Priority Areas: DECISIONS MADE

Provision for administration staff moved to Crewe Campus not built into the new redevelopment plan as move likely to be permanent move offsite.

RECOMMENDATION

To note

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

Board of Directors

Agenda Item	**7**	Date of Meeting: 28/01/2021
Report Title	**Board Assurance Framework Report Q3 2020/21**	
Executive Lead	James Sumner, Chief Executive	
Lead Officer	Caroline Keating, Company Secretary	
Action Required	To note	

☐ **Acceptable assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of controls

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

- The latest information relating to the Trust's principal risks is presented in this report alongside a summary of the key operational risks mapped to the current Strategic Objectives
- Proposed that BAF2 is closed; BAF19 score reduced from 12 (3x4) to 9 (3x3)
- The new Risk Management Process Guide has been issued and is being incorporated into practice.

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

- Executive Risk Leads to act on recommendations agreed during meeting
- Quality assurance process to be undertaken prior to Q4 submission; Executive Directors to monitor completion of actions and discuss changes to the BAF on a monthly basis

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

• Manage Covid response and recovery	☐	• Provide safe and sustainable services	☐
• Provide outstanding care/patient experience	☐	• Provide strong system leadership by working together	☐
• Deliver most effective care to achieve best possible outcomes	☐	• Be well governed and clinically led	✓
• Be the best place to work	☐		

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

• Quality	☐	• Compliance	☐
• Finance	☐	• Legal	☐
• Workforce	☐	• Risk/BAF **BAF19 Governance systems and risk assurance**	
• Equality	☐		

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

Strategy ☐ Policy ☐ Service Change ☐

REPORT DEVELOPMENT

Committee/ Group Name	Date	Report Title	Lead	Brief summary of key issues raised and actions agreed
Board of Directors	5 October 2020	Board Assurance Framework Q2 2020/21	James Sumner, CEO	Board advised of on-going development of the BAF. Changes in risk scores noted

Board Assurance Framework Report Q3 2020/21

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 was outlined to the Board in June and August 2020. 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.

3. This report presents the BAF in the new reporting format. It includes:
    - a Board Assurance Framework heatmap showing the current risk scores for the Trust's principal risks (Appendix 1),
    - a set of integrated risk dashboards showing the high scoring operational risks (15+) mapped to the principal risks and strategic objectives (Appendix 2),
    - a more detailed BAF report of the controls, assurances and actions mapped to the principal risks (Annex 1).

Revised Risk Management Process Guide

4. Following the Board's approval of the Trust's Risk Management Strategy in August 2020, a new Risk Management Process Guide was approved by the Audit Committee in November 2020 and supersedes a set of documents that were drafted at the end of 2019 but not formally adopted due to the planned review of the Trust's Risk Management Framework during 2020/21.

5. The refreshed guidance is set out in two sections. The first provides an introduction to risk management, risk registers, key responsibilities, and risk reporting arrangements. The second section provides practical process guidance and is structured around five key stages:

    1. Risk identification
    2. Risk assessment
    3. Planning risk response
    4. Implement the action plan
    5. Review the results

6. The document explains common terminology relating to risk management and includes an appendix glossary of terms. It aims to provide straightforward guidance about the Trust's risk management methodology and key considerations at each stage of the process.

7. The biggest changes compared to the previous methodology relate to risk assessment and prioritisation. A 5x5 scoring method for Likelihood and Impact has been retained with descriptions provided in tables to guide the scoring process. After consultation with the Executive Team, the Audit Committee Task & Finish Group, and the Quality Governance department, the prioritisation of risks based on overall risk score has been simplified – reducing from five priority levels ranging from 'Very Low' to 'Extreme' to three priority levels 'Low', 'Medium', and 'High'.

8. Included in the 'Medium' priority level are risks with a likelihood score of 1 ('Rare') and an impact score of 4 ('Major') or 5 ('Catastrophic'). These would previously have been classed as low priority risks but the new categorisation recognises the potentially significant impact on the Trust and helps ensure that such risks are not overlooked in decision-making and planning. The new priority categories are shown in the Addendum notes on page 7 of this report; the change does not alter the individual risk scores applied by risk owners.

9. Additional short sections have been added to provide guidance about closing risks and risks that materialise.

10. The Process Guide has been used to underpin the development of training materials for the risk management training programme which commenced in December (first sessions delivered by Conway Bloomfield Ltd for senior managers from Digital Technology and Information Services and Quality Governance). A training needs analysis is currently being undertaken to identify priority groups across all Divisions and Corporate areas with the aim of receiving training before the end of March 2021.

Executive Risk and Assurance Group

11. The monthly Executive Risk and Assurance Group (ERAG), chaired by the Chief Executive, was launched in September and provides a dedicated forum for the oversight of key risks across all areas of the Trust. This focus is helping to ensure that risk is prioritised in the Trust and that risk management plans are in place and monitored consistently. The ERAG reviews risk updates provided by Divisions and by the Chairs of Executive Groups where key operational risks are monitored and discussed in more detail on a monthly basis.

12. ERAG is supported by the monthly Risk Sub-Group launched in October, which provides a forum for detailed review of individual risk records, checking the quality of the information, advising senior managers on the application of risk management principles, and sharing learning. One of the early priorities for the Sub-Group is to review all high scoring operational risks that have been open on the risk register in excess of two years – this is being carried out through a series of 'deep-dives' following a prescribed structure where managers present their own review of longstanding risks. The deep-dives are generating valuable learning and have resulted in risks being re-evaluated in terms of articulation, relevance, scoring, duplication, oversight, accuracy of actions taken to date and clarity about next steps.

13. Despite the significant operational pressures currently being experienced by the Trust, it is to be commended that Divisional staff and senior management remain proactively engaged with the implementation of the revised Risk Management Framework, not only at ERAG but also at the Risk Sub-Group. This demonstrates a level of understanding and commitment to the cultural change required by the revised approach to risk management.

Principal risks

14. The mapping work to identify key controls and associated assurances is largely complete and the detail is presented in Annex 1. This work also included raising actions to address control and assurance gaps and proposing target risk scores. It should be noted that not all controls will require all three lines of assurance to be populated and it can be acceptable for some controls not to have direct assurance mechanisms.

15. The detail that has been collated will be subject to a thorough quality assurance process, co-ordinated by Corporate Governance, prior to submission of the Q4 BAF report to the Board Committees and Board in April 2021. The Executive Team will monitor the completion of actions and discuss changes to the BAF on a monthly basis.

16. BAF7 remains the highest priority risk, reflecting ongoing pressures during the Covid pandemic, and the SO3 dashboard on page 11 of this report shows specific operational capacity risks identified across the Trust.

17. It is proposed that BAF2 be closed. The Business Continuity Group was the key control for that risk and it has been disestablished as it has fulfilled its function and the risk is managed to an acceptable level. The workstreams monitored by the Business Continuity Group have been completed and closed or moved into relevant 'business as usual' areas for monitoring through established governance processes.

18. It is proposed that BAF19 should be reduced from 12 (3x4) to 9 (3x3) to reflect the progress made during 2020 to improve the Trust's risk management framework and its integration into corporate governance systems.

Operational risks

19. In October 2020, 12 operational risks were highlighted to the Board for particular attention. After being piloted at ERAG, integrated risk dashboards are provided as part of this report (Appendix 2) for the Board to be able to see all the operational risks that are current assessed at 'high' priority (scoring 15+). These operational risks are mapped to the principal risks to ensure they are considered during the assessment of principal risks.

20. Future BAF reports will include high level information about changes to the operational risk profiles so that the Board remains appraised of the strategic level view alongside the key operational level risks. The relevant sections to these dashboards and BAF assurances will also be submitted to Committees on a quarterly basis for scrutiny and to inform their work plans.

21. The data used to populate the risk dashboards was taken from the operational risk register on 4 January and reviewed at ERAG on 12 January 2021. It should be noted that current hospital pressures mean that there may be a delay in keeping risk records up to date in the

database; however, in such cases, updates are provided verbally and discussed at ERAG and records expected to be updated as soon as practicable.

Recommendations

22. To note the current status of principal risks and associated operational risk profiles. Executive Risk Leads will answer any questions relating to individual risks within their portfolios.

Author: Gilly Conway, Risk and Governance Consultant
Date: 21 January 2021

Addendum: notes relating to appendices – BAF heatmap and risk dashboards

1. The following appendices consist of a one-page summary of the current score for the Trust's principal risks included in the Board Assurance Framework, followed by a series of risk dashboards aligned to the Trust's strategic objectives. The dashboards provide a summary view of the key risks that would hinder achievement of strategic objectives by linking the principal risks from the BAF to the highest priority operational risks (rated 15+).

2. There is one dashboard for each strategic objective. Each page shows the Trust's principal risks in the table on the left and the associated operational risks in the table on the right. The principal risk records are held in 4Risk and the operational risks are held in Ulysses. The data is correct as at 4 January 2021.

3. The creation date is included in parentheses for all operational risks and appears in red if the duration of the risk has exceeded two years. It should be noted that all such longstanding risks are being prioritised for additional scrutiny through the Risk Sub-Group.

4. Movement in risk scores since the last report are denoted using arrows (⇑ increase ***/*** ⇓ decrease).

5. Risks are prioritised in accordance with the new Risk Management Process Guide as follows:

Impact / **Likelihood**	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
1 Rare	**1**	**2**	**3**	**4**	**5**
2 Unlikely	**2**	**4**	**6**	**8**	**10**
3 Possible	**3**	**6**	**9**	**12**	**15**
4 Likely	**4**	**8**	**12**	**16**	**20**
5 Almost certain	**5**	**10**	**15**	**20**	**25**

Appendix 1: BAF heatmap (current scores CxL)

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

Risk Rating	Priority
1 to 6 but excluding rare events with major or catastrophic impact	Green – Low
8 to 12 plus rare events with major or catastrophic impact	Amber – Medium
15 to 25	Red – High

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

Appendix 2: integrated risk dashboards (current scores)

Strategic Objective 1	**Manage the impact of the Covid-19 pandemic and ensure safe recovery** of the organisation post pandemic by using the established control structure

Principal risks	Risk score (CxL)
BAF1. Inadequate arrangements for safe management of pandemic against national guidance (**COO**)	**8 (4x2)**
BAF2. Failure to manage risks to business continuity identified during Covid (**DCEO/DF**)	**Closed**

Ref	High scoring operational risks (15+) (data from Ulysses)	Risk score (CxL)
TW0028	COVID-19 Pandemic (18/03/20)	**15 (5x3)**
IPC0006	Major outbreak of new or existing disease (17/01/19)	**15 (5x3)**
TW0031	Risk to patient safety if follow national COVID-19 guidance for swab testing of patients due to estate and workforce constraints (21/12/20)	**16 (4x4)**

Risk and controls commentary

- The controls in place for BAF1 aim to ensure adherence with national guidance. Monthly review of actions taken by Silver Command to be undertaken to gain assurance of compliance with national guidance and to continue to adapt Command and Control processes to ensure optimum effectiveness
- There are three operational risks rated 'high' aligned with BAF1. TW0031 was a short-term risk during December, a solution was found and the risk is to be closed.
- IPC0006 will be reassessed following COVID-19 management review (June 2021).
- BAF2 controls have been transitioned into business as usual and its closure is recommended to the Board.

Strategic Objective 2	**Deliver outstanding care and patient experience** focusing on staffing, standardisation and digitalisation

Principal risks	Risk score (CxL)
BAF3. Inability to close the nurse staffing vacancy gap (**DN&Q**)	**12 (4x3)**
BAF4. The Trust's environments are not adequately safe and secure for staff, patients and visitors (**DCEO/DF**)	**12 (4x3)**
BAF5. The Trust's Quality Improvement approach does not help address the highest clinical challenges (**DN&Q**)	**9 (3x3)**
BAF6. Failure to proceed with EPR development and implementation (**CIO**)	**8 (4x2)**

Ref	High scoring operational risks (15+) (data from Ulysses)	Risk score (CxL)
TW0004	Registered nurse staff shortage (02/01/13)	**16 (4x4)**
HSEF0004	Trustwide Fire Risk Assessment – Compliance with the Regulatory Reform (Fire Safety) Order 2005 (28/04/15)	**15 (5x3)**
EF0609	Clinical Waste Collection – Disruption (06/11/20)	**16 (4x4)**
SG0003	Liberty Protection Safeguards (LPS) risk assessment (23/06/20)	**16 (4x4)**
PA0308	Paediatric Audiology UKAS accreditation (13/05/20)	**15 (5x3)**

Risk and controls commentary

- There are workstreams in place to address BAF3 and a nurse vacancy project plan has been developed based on remodeling of the RN workforce and is to be discussed by the Executive Team during January.
- There is a suite of policies, processes and procedures in place to control the Health & Safety risks within the Trust's environments. Specific actions over the next quarter focus on ensuring all Fire Safety Management Assessments are completed across the Trust, implementing fire suppression improvements arising from the Critical Infrastructure Review, validating the asbestos register, and developing a violence reduction strategy to meet National requirements.
- Actions during this quarter relating to the Trust's Quality Improvement approach (BAF5) include implementing a quarterly Quality review process in the CCICP, ensuring all Quality actions from the 2019 CQC inspection have been completed, and developing a Quality Audit heatmap to incorporate into Quality reporting for 2021/22.
- EPR (BAF6) is now at Business Justification stage and the Digital Clinical System governance arrangements will be provided to the Trust Board for approval in January.
- There are currently five high scoring risks mapped to SO2.

Strategic Objective 3	**Deliver the most effective care to achieve the best possible outcomes** with the right capacity, latest learning and data driving decision making

Principal risks	Risk score (CxL)
BAF7. Inability to provide sufficient capacity to meet demand and achieve operational standards (**COO**)	**20 (4x5)**
BAF8. Insufficiently robust processes for clinical audit and quality improvement, learning and implementation of new practice (**MD**)	**9 (3x3)**
BAF9. Failure to use high quality activity and patient outcome data to assess quality of care (**MD**)	**12 (4x3)**

Risk and controls commentary

- There are a number of high scoring operational risks mapped to SO3, all of which are aligned with BAF7 and underpin the assessment of that principal risk as 'high' priority. This risk profile reflects the exacerbated pressures on services during COVID-19 and the uncertainties around resuming services.
- Aspects of the restoration plans approved by the Board in October have been superseded by the current wave of the pandemic and a revised restoration programme for elective work will be developed at the end of Q4. In addition, oversight of patient backlogs, clinical prioritisation and risks relating to delayed and cancelled treatments will be strengthened through the Performance and Finance Committee.
- There are no high operational risks associated with BAF8 and BAF9 at the present time; however, there are a number of risks recorded in Ulysses with a current score of 12. Plans will be developed for 2021/22 to guide the Quality Governance workstreams.

Ref	High scoring operational risks (15+) (data from Ulysses)	Risk score (CxL)
TW0001	Delivery of key Local and National Targets / standards, in particular the 4 hour standard in A&E (09/09/15)	**20 (5x4)**
EC0466	Lack of Out of Hours Upper GI Bleed Rota / Service (02/03/20)	**20 (5x4)**
DC1069	Clinical Haematology Service (04/12/19)	**20 (5x4)**
EC0464	Inadequate medical and senior nursing workforce to manage the on-going demands of COVID-19 (23/06/20)	**20 (5x4)**
SC0647	Restricted access to Endoscopy Services during the COVID-19 national pandemic (02/07/20)	**20 (4x5)**
SC0652	Impact of Covid-19 on the Elective Programme (01/09/20)	**16 (4x4)**
SC0636	Lack of surgical capacity for renal and ureteric stones cases (23/09/19)	**16 (4x4)**
DC1056	Lack of aseptic service at MCHFT (23/05/19)	**15 (5x3)**
SC0653	The impact of COVID-19 on national cancer screening programs (01/09/20)	**15 (5x3)**
SC0651	Lack of Theatre Staff impacting on the return to elective programme (01/09/20)	**15 (5x3)**
DC0887	Consultant Histopathologist Capacity (24/03/15)	**15 (5x3)**
GY0302	Deterioration of Gynaecology elective services as a result of the Covid-19 pandemic (09/11/20)	**15 (5x3)**
SC0626	Control of the backlog of patients awaiting routine follow-up surgery - General Surgery (31/12/18)	**15 (3x5)**
TW0007	Delayed routine outpatient follow-up (07/09/18)	**15 (3x5)**

Strategic Objective 4	**Ensure MCHFT is the best place to work** by meeting the needs of our staff better than anywhere else

Principal risks	Risk score (CxL)
BAF10. Failure to attract, retain and support a high performing workforce (**DW&OD**)	**12 (4x3)**
BAF11. Failure to harness the benefits of technology to integrate, streamline and improve systems of working (**CIO**)	**12 (4x3)**
BAF12. Failure to create the conditions for an effective organisational culture (**CEO**)	**8 (4x2)**

Ref	High scoring operational risks (15+) (data from Ulysses)	Risk score (CxL)
WOD0020	Workforce Planning (04/11/20)	**16 (4x4)**

Risk and controls commentary

- The majority of operational capacity risks that have been mapped to BAF7 on the previous page cite clinical staffing vacancies as causation factors, which also relate to BAF10. There are a range of initiatives in progress to help analyse, monitor, and respond to recruitment and retention challenges and to support the workforce during an intensely taxing time.
- A key action in relation to BAF11 is the refresh of the Digital Strategy which is due to be presented to the Workforce and Digital Transformation Committee in April before being submitted to the Trust Board.
- Actions relating to organisational culture (BAF12) over the next quarter include a review of the Equality, Diversity & Inclusion Strategy, analysis of the staff survey results, and recruitment of resource to deliver the Communications and Engagement Strategy.

Strategic Objective 5	**Provide safe and sustainable healthcare to our population** by ensuring our estate, infrastructure and planning focuses on the long term

Principal risks	Risk score (CxL)
BAF13. Failure to provide modern, efficient, sustainable estate, infrastructure and equipment (**DCEO/DF**)	**15 (5x3)**
BAF14. Failure to adequately plan future workforce requirement (**DW&OD**)	**12 (4x3)**
BAF15. Inadequate financial management, budgetary controls, and efficiency planning (**DCEO/DF**)	**8 (4x2)**

Ref	High scoring operational risks (15+) (data from Ulysses)	Risk score (LxC)
HSEF0007	Failure of RAAC planking at Leighton Hospital resulting in disruption to clinical services (09/03/20)	**20 (5x4)**
ITCYB0005	Oracle 10 out of support (04/11/20)	**20 (4x5)**
EF0505	Loss of Mechanical Infrastructure and associated Resources: Leighton Hospital (23/01/19)	**16 (4x4)**
EF0556	Infrastructure Pipeline Failure - Ward 1 (16/07/19)	**16 (4x4)**
EF0604	Missed medical devices planned preventative maintenance (PPM) (03/11/20)	**16 (4x4)**

Ref	High scoring operational risks (15+) (data from Ulysses)	Risk score (CxL)
TW0010	Medical Devices Running legacy Operating System Software (12/12/18)	**16 (4x4)**
EF0605	MRI 1, 2 and 3 failure to achieve temperature and humidity conditions (03/11/20)	**16 (4x4)**
ITCYB0001	Patching of CISCO kit (23/07/19)	**16 (4x4)**
EF0606	Inability to carry out key IT and Estate works to previous South Cheshire Hospital (04/11/20)	**16 (4x4)**
ITCYB0006	Network Access Control (11/11/20)	**16 (4x4)**
ITCYB0012	Windows Server 2008 (Clinical Servers) (11/11/20)	**16 (4x4)**
ITCYB0014	SQL 2008 (Clinical Servers) (11/11/20)	**16 (4x4)**
DC1044	Laboratory Information Management System (LIMS) for Pathology - End of Life (14/11/18)	**15 (5x3)**
EF0548	Critical Risk Adjusted Backlog Maintenance (25/01/19)	**15 (3x5)**
EF0603	Delivery of A&E rebuild in time for winter if capital allocation is delayed (03/11/20)	**15 (3x5)**
ITCYB0003	SQL 2005 out of support (04/11/20)	**15 (3x5)**
ITCYB0004	Windows Server 2003 out of support (04/11/20)	**15 (3x5)**

Risk and controls commentary

- There are currently seventeen high priority operational risks mapped to BAF13 which relate to equipment and aspects of the estate, critical infrastructure and IT systems. These underpin the high priority risk score for the principal risk.
- Key actions to note in relation to BAF13 are: the development of a new Estates Strategy (to be discussed at the Performance and Finance Committee in March and submitted to the Trust Board in April 2021), the action plan arising from the Critical Infrastructure Review, the development of the Strategic Outline Case for the Leighton Hospital re-development (due to be presented to the Board in March 2021), and the programme of RAAC beams surveys and ensuing 'make-safe' work.

Strategic Objective 6	**Provide strong system leadership by working together** in our place, our system and ICS

Principal risks	Risk score (CxL)
BAF16. Failure to enable a successful Integrated Care Partnership and carry out its hosting responsibility (**DSP**)	**9 (3x3)**
BAF17. Ineffective capacity across the Health and Social Care system (**COO**)	**12 (4x3)**
BAF18. The Trust fails to play its part in a successful Cheshire System (**CEO**)	**Inactive**

Ref	High scoring operational risks (15+) (data from Ulysses)	Risk score (CxL)
TW0006	Lack of pace in the significant transformational change required to deliver the Cheshire East Place Strategy and consequently the Health and Care Partnership (HCP) for Cheshire and Merseyside (09/08/18)	**16 (4x4)**
CP0115	Provision of ambulatory wound care within CCICP (07/02/20)	**15 (3x5)**

Risk and controls commentary

- There are two high operational risks relating to SO6 around challenges to integrating systems across the health and social care economy.
- In relation to BAF16, during this quarter the scope of devolved commissioning is due to be agreed by Trust Boards, and the ICP risk register will be incorporated within the MCHFT systems which will provide greater visibility of those risks and consistency of approach.
- In relation to BAF17, the Cheshire system-wide Urgent Care Delivery Board is now in place and chaired by the Chief Officer of the Cheshire CCG. Operationally the system-wide Winter/Covid plan has been enacted and an evaluation will be carried out after the end of the Winter period to ensure lessons are learned to inform future plans.

Strategic Objective 7	**Be well governed and clinically led** guided by the expertise and capable leaders with clear processes and practices

Principal risks	Risk score (CxL)
BAF19. Inappropriate governance systems to foster a risk assurance culture (**CEO**)	**9 (3x3)** ⇩
BAF20. Failure to establish appropriate governance and risk mitigation around existing and new collaborative models of working (**CEO**)	**9 (3x3)**
BAF21. Failure to develop leadership capacity and capability throughout the organisation (**DW&OD**)	**12 (4x3)**

Risk and controls commentary

- A focused programme of work to strengthen the Trust's governance and risk management systems has been underway during the first three quarters of 2020/21 and the risk score for BAF19 has been reviewed in light of the progress made (the likelihood score has reduced from 4 to 3). The appointment of a substantive Corporate Risk & Assurance Manager into a new post within the Corporate Governance team will assist with the next phase of work to embed and normalise improved approaches, and to ensure robust checking and tracking of risk assurance information.
- A key action in relation to BAF20 is to establish a Trust policy to guide the approach for entering into collaborative governance arrangements, using the recent Pathology agreement approved by the Board in November 2020 as a 'blueprint' for future agreements.
- Actions during this quarter relating to BAF21 focus on embedding ED&I into leadership development, and to evaluate the Shadow Board programme that has been running since August 2020.
- There are currently no high operational risks associated with SO7.

Board Assurance Framework (BAF)

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Report Date	22 Jan 2021
Risk Status	Open
Risk Area	1.Principal Risks
Control Status	Existing
Action Status	Outstanding

1.Principal Risks

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	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 Risk Score	Action Required	Target Risk Score
BAF 1	IF arrangements in place to ensure safe management of pandemic against national guidance are inadequate THEN patients and staff could be harmed **Executive Risk Lead:** Oliver Bennett **Risk Owner:** **Last Updated:** 22 Jan 2021	**Cause(s)** 1. Limited leadership capacity and experience 2. Lack of agility and pace 3. Poor governance of decision-making 4. Lack of coordinated approach internally and system-wide 5. Insufficient use of evidence to inform plans 6. Inadequate communication, sharing information and engagement **Consequence(s)** 1. Patient care and safety 2. Workforce safety and morale 3. Reputation 4. Regulatory	I = 4 L = 5 20	1. Command and control structure to respond to and deliver all necessary plans and preparations in relation to pandemic management **Control Owner:** Oliver Bennett	Covid 19 - Trust Response & Planning for Wave 2 reported to PAF August 2020	Acceptable					I = 4 L = 2 8	Continually review the effectiveness of Silver Command processes through the Executive Gold function and make alterations to ensure optimum effectiveness. **Action Owner:** Oliver Bennett **Target Implementation Date:** 26 Feb 2021	I = 4 L = 1 4
				2. SOPs to reflect National emergency planning and business continuity requirements **Control Owner:** Oliver Bennett	Emergency Preparedness, Resilience and Response annual report to Board November 2020	Acceptable			NHSE/I accepted Aug 2020 Trust assurance submission on the submission of EPRR Core Standards	Acceptable		Review that actions have been taken against national guidance through the Silver Command records on a monthly basis. **Action Owner:** Oliver Bennett **Target Implementation Date:** 30 Apr 2021	
				3. Winter/COVID Plan - Trust-wide and system-wide (Cheshire) approved by PAF and the Board October 2020 **Control Owner:** Oliver Bennett	Winter plan tracked and progress documented at the Winter Planning Group with updates documented at Silver Command and escalated to Gold if necessary.	Acceptable						Establish Executive Delivery & Performance Group (EDPG) oversight of covid plans and preparations in addition to the Command & Control structure **Action Owner:** Oliver Bennett **Target Implementation Date:** 30 Apr 2021	
												Review of Winter/Covid Plan including lessons learned on Board workplan for May/June 2021 **Action Owner:** Oliver Bennett **Target Implementation Date:** 30 Jun 2021	
												External review of Covid impact on quality, services and finances, together with lessons learned to inform Trust Strategy **Action Owner:** Oliver Bennett **Target Implementation Date:** 30 Sep 2021	
BAF 2	IF arrangements to deliver the mitigations to the risks identified to covid 19 recovery are inadequate THEN business continuity could be affected leading to loss of services **Executive Risk Lead:** Russell Favager **Risk Owner:** **Last Updated:** 01 Sep 2020	**Cause(s)** 1. Poor risk management arrangements 2. Insufficient leadership capacity/capability 3. Resistance to change 4. Inadequate processes for learning from pandemic **Consequence(s)** 1. Patient care and safety 2. Workforce safety and morale 3. Reputation 4. Regulatory	I = 4 L = 5 20	1. Business Continuity Group's programme of work takes a holistic view of COVID-related risks across the Trust (pre-mortem paper agreed by the Board April 2020) **Control Owner:** 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) 2. Each Board Committee has a standing item and receives update on Covid-19 ISSUES applicable to them on a monthly basis				I = 4 L = 2 8	**Action Owner:** **Target Implementation Date:**	

1.Principal Risks

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	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 Risk Score	Action Required	Target Risk Score
BAF 3	IF the widening nurse staffing vacancy gap is not closed THEN patient care could be detrimentally impacted **Executive Risk Lead:** Julie Tunney **Risk Owner:** **Last Updated:** 21 Jan 2021	**Cause(s)** 1. National shortages 2. Competition between providers 3. Poor perception of pay and working conditions and the impact of COVID experience 4. Geographical location and transport access 5. Impact of Brexit on overseas workforce availability 6. Inability to secure international nurse recruits from overseas due to COVID 7. Inability to attract pre-registration nurses due to lack of bursaries 8. Failure to deliver UK Adaptation Programme 9. Failure to consider alternative opportunities to support nursing workforce **Consequence(s)** 1. Patient care and safety 2. Financial: agency expenditure 3. Workforce morale 4. Reputation as employer / of nursing 5. Regulatory	I = 4 L = 5 20	1. Closing the gap' plan 2023 **Control Owner:** Heather Barnett	'Closing the gap' report bi-monthly to EWAG		1. NMC Registered Staff Group Vacancy Analysis submitted to PAF, WDT and Q&S Aug, Sept & Oct 2020 2. Safe Staffing reported annually to Board	Acceptable	CQC assessment		I = 4 L = 3 12	Driver diagram using QI methodology to be developed to address issue of maintaining 95% RN fill rate. Project scope to be submitted to EWAG **Action Owner:** Heather Barnett **Target Implementation Date:** 26 Feb 2021	I = 4 L = 2 8
				2. Workforce Supply Group workstreams: New Ways of Working, Recruitment and Retention, Maximising Potential **Control Owner:** Heather Barnett	Monthly updates to Multi-disciplinary Clinical Workforce Group							Deliver the Health & Wellbeing Phase 2 implementation plan **Action Owner:** Heather Barnett **Target Implementation Date:** 30 Jun 2021	
				3. Health & Wellbeing agenda (relevant aspects eg. sickness etc) **Control Owner:** Heather Barnett	1. Health & Wellbeing quarterly report to EWAG 2. Sickness Absence Analysis Report submitted to WDT Committee Dec 2020	Partial			NHSI/E Organisational Pulse Survey results reported to EWAG and to WTGC				
				4. Bank Incentive Schemes for RNs approved by the Executive Team and JCNC advised **Control Owner:** Heather Barnett	Incentive Scheme review outcomes presented to PAF March 2020	Acceptable							
				5. Nurse Vacancy Project Plan **Control Owner:** Heather Barnett									
				6. International Recruitment Programme **Control Owner:** Heather Barnett									

1.Principal Risks

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	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 Risk Score	Action Required	Target Risk Score
BAF 4	IF the Trust does not ensure safe and secure environments for staff, patients and visitors THEN avoidable harm could occur **Executive Risk Lead:** Russell Favager **Risk Owner:** **Last Updated:** 21 Jan 2021	**Cause(s)** 1. Inadequate focus on H&S 2. Water safety (legionella) 3. Ineffective security arrangements 4. Asbestos 6. Fire safety compliance 7. Contamination with dangerous substances 8. Slips, trips & falls **Consequence(s)** 1. Health & Safety 2. Workforce morale 3. Reputation 4. Legal 5. Financial	I = 4 L = 5 20	1. Fire Management Improvement Plan in place through to to 2023 **Control Owner:** Russell Favager	Workplace inspections - Fire Safety Assessments				1. Cheshire Fire & Rescue (CFR) Audit Programme Sept 2018 - Positive Audit Feedback 2. Annual audit by Authorising Engineer reported to Estates Divisional Board and H&S Group	Acceptable	I = 4 L = 3 12	Proposal for new COSHH management IT system to go to February ESSEG. **Action Owner:** Russell Favager **Target Implementation Date:** 27 Feb 2021	I = 4 L = 2 8
				2. Asbestos Management Plan (AMP) and Register of ACMs (Asbestos Containing Materials) **Control Owner:** Russell Favager					Annual audit by Authorising Engineer reported to Estates Divisional Board and H&S Group		Outstanding Fire Safety Management Assessments to be completed. **Action Owner:** Russell Favager **Target Implementation Date:** 31 Mar 2021	
				3. H&S Policy and procedures **Control Owner:** Russell Favager	Workplace inspections risk assessments		Incident reporting to H&S Group (including RIDDOR)					Prioritised actions from Critical Infrastructure Review: fire suppression system in switchboard (Leighton and VIN) to be reviewed and discussed at February Fire Safety Group. Capital Team aiming to complete work by end of March 2021. **Action Owner:** Russell Favager **Target Implementation Date:** 31 Mar 2021	
				4. Control of Substances Hazardous to Health (COSHH) register **Control Owner:** Russell Favager	Compliance checks by H&S Manager with outcomes reported to H&S Group							Asbestos register to be validated and formal appointments of Asbestos Authorising Person and Responsible Person. **Action Owner:** Russell Favager **Target Implementation Date:** 31 Mar 2021	
				5. Management of Aggressive Behaviour Procedure (Security Team) **Control Owner:** Russell Favager	Incident reporting via Ulysses							Violence reduction strategy needs to be in place by April 2021 to meet National Requirements. **Action Owner:** Russell Favager **Target Implementation Date:** 01 Apr 2021	
				6. Water Safety Group (WSG) is in place as required by HTM04. Responsible Person is formally appointed and is Head of Estates. There is an appointed external Authorising Engineer who produces an action plan following the annual audit which is monitored by WSG. **Control Owner:** Russell Favager	Progress reports to Water Safety Group and Estates Divisional Board				Annual audit by Authorising Engineer (September 2020) to Estates Divisional Board and H&S Group			Stress Survey to be undertaken, followed by improvements plans to be developed based on feedback from Focus Groups in identified hotspot locations. **Action Owner:** Russell Favager **Target Implementation Date:** 31 Dec 2021	
				7. Staff safety workstreams (HSE focus): - Stress Culture Survey undertaken bi-annually - Stress Management training available for managers - Managing Work Related Procedure in place - Proactive Preventative Psychology Well-being Improvement Plan **Control Owner:** Russell Favager	Workstreams monitored via Health & Safety Group and issues escalated to ESSEG								

1.Principal Risks

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	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 Risk Score	Action Required	Target Risk Score
BAF 5	IF the Trust does not introduce a Quality Improvement approach to its highest risk clinical challenges THEN it is less likely to resolve them **Executive Risk Lead:** Julie Tunney **Risk Owner:** **Last Updated:** 22 Jan 2021	**Cause(s)** 1. QI methodoogy not embedded throughout organisation 2. Quality improvement not underpinned by evidence 3. Approach not developed in consultation with all relevant stakeholders **Consequence(s)** 1. Patient care, safety and experience 2. Reputation as an employer for clinical staff 3. Regulatory 4. Public perception	I = 3 L = 5 15	1. Quality & Safety Improvement Strategy 2020/21 **Control Owner:** Julie Tunney			1. Quality & Safety metrics reported monthly to Committees and Board via IPR 2. Quality Account to Q&S and Board annually (Dec 2020)	Acceptable	1. CQC report May 2020		I = 3 L = 3 9	Implementation of formal quarterly quality review process in CCICP **Action Owner:** Julie Tunney **Target Implementation Date:** 29 Jan 2021	I = 3 L = 2 6
				2. IPC Strategy (DIPC policies/procedures) **Control Owner:** Julie Tunney			1. IPC BAF Aug Board approved 2. IPC BAF updates 6 monthly to Q&S (last submission Jan 2021; progress report due June 2021)	Partial	1. CQC inspections 2. MIAA audit 2018			Quality actions arising from CQC inspection report (September 2019) **Action Owner:** Julie Tunney **Target Implementation Date:** 26 Feb 2021	
				3. Ward accreditation programme including CCICP **Control Owner:** Julie Tunney			Annual Report to Q&SC		1. CQC full inspection 2. MIAA Internal Audit Report on Ward Quality Spot Checks (Sept 2019)	Acceptable		Monthly quality audit results heatmap to be included in Quality report for 2021/22 **Action Owner:** Julie Tunney **Target Implementation Date:** 31 Mar 2021	
				4. Self-assessment in response to Ockenden Report December 2020 (investigation into maternity services at Shrewsbury & Telford NHS Trust) **Control Owner:** Julie Tunney			Gap analysis report submitted to Q&SC and Board January 2021	Partial				Quality Improvement approach to be submitted to the Board following approval of the Trust Strategy in March **Action Owner:** Murray Luckas **Target Implementation Date:** 30 Apr 2021	
				5. Implementation of 'Falls Bundle' in response to analysis of falls trend data **Control Owner:** Julie Tunney			Effectiveness of initiative monitored by Falls Steering Group					All maternity services non-compliances to be addressed (ref Ockenden report) **Action Owner:** Julie Tunney **Target Implementation Date:** 30 Jun 2021	

1.Principal Risks

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	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 Risk Score	Action Required	Target Risk Score
BAF 6	IF the Trust is unable to proceed with EPR development and implementation THEN the Trust will be unable to improve safety to its desired standard **Executive Risk Lead:** Amy Freeman **Risk Owner:** **Last Updated:** 21 Jan 2021	**Cause(s)** 1. Insufficient financing 2. Inadequate business case to meet regulatory requirements 3. Business case approval process changing creating uncertainty 4. Relationship changes lead to affordability issues **Consequence(s)** Fall-back is status quo which is not sustainable and would negatively affect: 1. Patient care and safety 2. Reputation 3. Efficiency benefits 4. Running costs 5. Cyber security 6. Clinical audit	I = 4 L = 5 20	1. £250k NHSX funding received and external support contract in place with Apira to support development of the Full Business Case **Control Owner:** Amy Freeman	EPR update reports to W&DTC monthly				Approval of the OBC from DoHSC and NHSEI 25/09/20	Acceptable	I = 4 L = 2 8	Development of Digitial Clinical System governance arrangements for review by Board of Directors **Action Owner:** Amy Freeman **Target Implementation Date:** 28 Jan 2021	I = 4 L = 1 4
				2. Trust Systems Support Model self-assessment for EPR readiness **Control Owner:** Amy Freeman	TSSM self-assessment results to DTIS Group 30/06/20	Acceptable						OGC Gateway 1 (Business Justification) **Action Owner:** Amy Freeman **Target Implementation Date:** 31 Mar 2021	
				3. Five OGC gateway reviews **Control Owner:** Amy Freeman			1. OGC Gateway 0 review included in Business Case approved by Board Jan 2019					Programme Director to be in place and team recruited to deliver the programme **Action Owner:** Amy Freeman **Target Implementation Date:** 30 Jun 2021	
				4. MoU with partners signed off by the Board Nov 2019 **Control Owner:** Amy Freeman								Gateway Reviews to be reported to the Digital Transformation Programme Board when in place **Action Owner:** Amy Freeman **Target Implementation Date:** 30 Jun 2021	
				5. Procurement process documented in the OBC being undertaken by a joint Task & Finish Group (MCHFT, East Cheshire and Apira) **Control Owner:** Amy Freeman	T&F Group reports to DTIS				Independent assessment of procurement process by Apira				

1.Principal Risks

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	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 Risk Score	Action Required	Target Risk Score
BAF 7	IF the Trust does not provide sufficient capacity to meet demand and achieve operational standards THEN it may cause harm to its patients and be unable to meet its regulatory requirements **Executive Risk Lead:** Oliver Bennett **Risk Owner:** **Last Updated:** 22 Jan 2021	**Cause(s)** 1. Workforce gaps 2. IPC measures including social distancing 3. Changing patterns of demand 4. Access to the independent sector 5. Physical environment is restrictive **Consequence(s)** 1. Patient care and experience 2. Patient outcomes 3. Reputation 4. Regulatory	I = 4 L = 5 20	1.1. A&E: successful capital bid to build new A&E **Control Owner:** Oliver Bennett							I = 4 L = 5 20	NHS 111 (final) implementation plan and next steps to be submitted to PAF **Action Owner:** Oliver Bennett **Target Implementation Date:** 19 Feb 2021	I = 4 L = 3 12
				1.2. A&E: NHS 111 Implementation Plan **Control Owner:** Oliver Bennett	Highlight report included within COO Report on implementation to PAF Jan 2021 following soft launch Nov 2020							Ensure that PAF Committee has clear oversight of the backlog of patients, clinical prioritisation and risks emerging. **Action Owner:** Oliver Bennett **Target Implementation Date:** 30 Apr 2021	
				2.1. RTT: Elective Care Restoration Plan submitted to PAF and Board September and October 2020 respectively **Control Owner:** Oliver Bennett	Monthly update to PAF							Urgent Care Implementation Plan to be developed **Action Owner:** Oliver Bennett **Target Implementation Date:** 30 Apr 2021	
				2.2. RTT: National contracts with independent sector to increase capacity **Control Owner:** Oliver Bennett					ISP Utilisation Report identifies MCHFT uptake of available IS capacity			Deliver a revised restoration programme for elective work that is signed off by PAF Committee following Covid 3rd wave. **Action Owner:** Oliver Bennett **Target Implementation Date:** 30 Apr 2021	
				3.1. Diagnostics: Phase 3 Restoration Plan submitted to PAF and Board in September and October 2020 respectively **Control Owner:** Oliver Bennett			Monthly Integrated Performance Report provides performance data as evidence of progress against plan	Partial				Ensure that the overarching risk assessment around Covid Escalation provides adequate and effective information on how delayed and cancelled patients will be treated. **Action Owner:** Oliver Bennett **Target Implementation Date:** 30 Apr 2021	
				3.2. Diagnostics: independent sector capacity (national contracts) **Control Owner:** Oliver Bennett								Deliver the A&E build and new staffing model. **Action Owner:** Oliver Bennett **Target Implementation Date:** 30 Sep 2021	
				4. Cancer Services: Restoration Plan **Control Owner:** Oliver Bennett	Details of Cancer Services Restoration Plan within monthly Restoration Report submitted to PAF monthly	Acceptable							
				5. Winter/COVID Plan - Trust-wide and system-wide (Cheshire) approved by PAF and the Board October 2020 **Control Owner:** Oliver Bennett	1. Review including lessons learned to be submitted to BoD May 2021. 2. Winter plan tracked and progress documented at Winter Planning Group with updates documented at Silver Command and escalated to Gold if necessary.		Evidence of deviation from plan within the IPR and escalated by exception to PAF and Board via Chair's Assurance Report and potentially the CEO Report						
				6. International Recruitment programme **Control Owner:** Heather Barnett	International Recruitment of Medical Staff Report to December WDT Committee	Acceptable							

1.Principal Risks

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	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 Risk Score	Action Required	Target Risk Score
				7. LLPs providing additional clinical capacity **Control Owner:** Oliver Bennett									
BAF 8	IF the Trust does not have robust processes for audit, learning & implementation of new practice THEN it may hinder quality improvement and could be unable to meet regulatory requirements **Executive Risk Lead:** Murray Luckas **Risk Owner:** **Last Updated:** 22 Jan 2021	**Cause(s)** 1. Lack of coordinated approach 2. Poor dissemination of information 3. Complex Governance processes **Consequence(s)** 1. Patient care and safety 2. Reputation 3. Regulatory	I = 3 L = 5 15	1. Programme of National Audits and actions plans **Control Owner:** Murray Luckas	Divisional Governance monitoring of action plans with exception reporting to Trust Improvement Group and non-compliance escalated to EQGG		Clinical Audit and Effectiveness Annual Report 2019/20 to Audit Committee July 2020 - evidences delivery against the National Clinical Audit Patient Outcomes Programme	Acceptable	CQC review of compliance with national audits and implementation of action plans		I = 3 L = 3 9	Clinical Audit to report into Trust Improvement Group from February 2021 via quarterly report on national and local audits. **Action Owner:** Murray Luckas **Target Implementation Date:** 26 Feb 2021	I = 3 L = 2 6
				2. The Trust participates with the Advancing Quality programme (AQuA) and the implementation of recommendations is tracked (suspended due to pandemic) **Control Owner:** Murray Luckas			Benchmarked data and improvement plans reported quarterly					Advancing Quality Programme Group to be restarted and workplan refreshed. It will report into Trust Quality Improvement Group that will be established from February 2021 and chaired by the Deputy Medical Director. **Action Owner:** Murray Luckas **Target Implementation Date:** 31 Mar 2021	
				3. Arrangements for assessing compliance with NICE guidance and process for escalation of non-compliance **Control Owner:** Murray Luckas	Compliance included in Divisional governance dashboards		Exceptions reported to Trust Quality Improvement Group (from February 2021)					Clinical Audit Plan for 2021/22 to be developed to set out priorities for clinical audit and research. **Action Owner:** Murray Luckas **Target Implementation Date:** 28 May 2021	
				4. Incident Reporting, Management, Learning and Improvement Policy **Control Owner:** Murray Luckas					Internal Audit 2020 - Incident Management & Reporting submitted to Audit Committee Sept 2020 and Q&S Committee Oct 2020	Acceptable		Implementation of actions arising from CQC inspection to be evidenced **Action Owner:** Murray Luckas **Target Implementation Date:** 30 Jun 2021	
												Escalation process for non-compliance with NICE guidelines to be established to ensure Quality & Safety Committee agreement and Board sign-off **Action Owner:** Murray Luckas **Target Implementation Date:** 30 Jun 2021	
												Clinical Audit Policy refreshed and to be submitted to Trust Quality Improvement Group and Audit Committee. **Action Owner:** Murray Luckas **Target Implementation Date:** 30 Jul 2021	

1.Principal Risks

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	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 Risk Score	Action Required	Target Risk Score
BAF 9	IF the Trust does not use high quality activity and patient outcome data to assess the quality of its care THEN it may miss trends and signals and encounter less positive patient outcomes **Executive Risk Lead:** Murray Luckas **Risk Owner:** **Last Updated:** 22 Jan 2021	**Cause(s)** 1. Accessibility of data 2. Data quality 3. Inadequate data analysis capacity and capability 4. Inadequate data management software 5. Limited scope of existing data to surgical outcomes **Consequence(s)** 1. Patient care 2. Reputation 3. Regulatory	I = 4 L = 5 20	1. Learning from Deaths Policy & Mortality Review Process (Divisional & Corporate) **Control Owner:** Murray Luckas	Divisional Mortality reports		Quarterly Learning from Deaths Report to QSC and Board (September 2020)	Acceptable	1. Nationally benchmarked mortality data 2. AQuA Quarterly Mortality Report		I = 3 L = 4 12	Develop a business case for 7 day service for consultant ward rounds (Ockenden report action) **Action Owner:** Murray Luckas **Target Implementation Date:** 30 Sep 2021	I = 3 L = 3 9
				2. Action planning based on GIRFT findings (GIRFT on hold due to pandemic) **Control Owner:** Murray Luckas	Departmental plans monitored locally				GIRFT revisit to assess specialty action plans (date tbc)				
				3. Participation with Outcome Registries **Control Owner:** Murray Luckas	Departmental plans monitored locally				Annual registry reports				
				4. End of Life Care outcome measures (Strategic Collaborative for Palliative and End of Life Care in Cheshire) **Control Owner:** Julie Tunney					National Audit of Care at the End of Life reported to Q&S Committee January 2021	Partial			

1.Principal Risks

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	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 Risk Score	Action Required	Target Risk Score
BAF 10	IF the Trust cannot attract, retain and support a high performing workforce THEN quality of care is likely to deteriorate **Executive Risk Lead:** Heather Barnett **Risk Owner:** **Last Updated:** 22 Jan 2021	**Cause(s)** 1. National shortages 2. Limited flexible working options 3. Competition between providers 4. Geographical location and transport access 5. Perception as an employer 6. Impact of Brexit on overseas workforce availability 7. Inadequate performance management and appraisal processes 8. Limited career pathways 9. Mismatch between skills and learning needs and education provision 10. Lack of University presence to attract students 11. Failure to embrace diversity & inclusion 12. Poor leadership **Consequence(s)** 1. Workforce capacity & capability 2. Organisational resilience 3. Workforce morale 4. Reputation as an employer 5. Regulatory 6. Patient care and experience	I = 4 L = 5 20	1. Our Workforce Matters Strategy 2019-21 approved by Trust Board Nov 2018 and delivered via an action plan monitored by WDTC **Control Owner:** Heather Barnett	Our Workforce Matters quarterly updates to WDT		Medical staffing workforce metrics included in the Workforce Report reported via WDTC to Board of Directors				I = 4 L = 3 12	Multi-disciplinary clinical workforce workstreams to be aligned into Workforce Supply Sub-Group Action Plan **Action Owner:** Heather Barnett **Target Implementation Date:** 29 Jan 2021	I = 4 L = 3 12
				10. Suite of HR policies that support management of high performing workforce (confirmed by the Workforce Governance Group to have been reviewed and in date) **Control Owner:** Heather Barnett					Internal Audits reported to WDTC - Electronic Staff Record 2019?			Initial analysis of staff survey results **Action Owner:** Heather Barnett **Target Implementation Date:** 31 Mar 2021	
				2. Education and Training Programme **Control Owner:** Heather Barnett	Training & Education Quarterly Report to WDTC		Self Assessment against Health Education England's priorities 2019/20	Acceptable				Review of ED&I Strategy and key objectives to ensure the implementation plan reflects Board and wider workforce feedback, and remains relevant within current social, political and environmental context **Action Owner:** Heather Barnett **Target Implementation Date:** 31 Mar 2021	
				3. Health & Wellbeing Plan **Control Owner:** Heather Barnett			Health & Wellbeing quarterly report to EWAG		NHSI/E Organisational Pulse Survey results reported to EWAG and to WTGC			Analysis of recruitment metrics from new recruitment trac.jobs system **Action Owner:** Heather Barnett **Target Implementation Date:** 31 Mar 2021	
				4. Annual Staff Survey process and action planning **Control Owner:** Heather Barnett			Action plans developed from analysis of the staff survey results presented to ?					Implement plans in key areas of focus identified from the Staff Survey for 2020/21: - reducing work related stress - staff engagement including morale and retention - reduce discrimination in the workplace - reduce violence in the workplace **Action Owner:** Heather Barnett **Target Implementation Date:** 31 Mar 2021	
				5. Workforce Supply Group monitors 4 workstreams: New Ways of Working, Recruitment and Retention, Maximising Potential, System Working **Control Owner:** Heather Barnett	Workforce Supply Group report to EWAG							Develop mental health support schemes for staff following Covid **Action Owner:** Heather Barnett **Target Implementation Date:** 30 Apr 2021	
				6. Apprenticeships **Control Owner:** Heather Barnett			Apprenticeship levy usage report to EWAG and JCNC					Review of Workforce Matters Strategy following approval of Trust Strategy - to be submitted to EWAG and WDTC **Action Owner:** Heather Barnett **Target Implementation Date:** 31 May 2021	
				7. ED&I Strategy 2020-24 **Control Owner:** Heather Barnett			Annual ED&I report to WDTC May 2020 and Board		1. National benchmarking WRES and WDES report to WDTC and Board 2. Gender pay gap results to WDTC and Board	Partial		Deliver Health & Wellbeing Implementation Plan **Action Owner:** Heather Barnett **Target Implementation Date:** 30 Jun 2021	
				8. Recruitment policies & process **Control Owner:** Heather Barnett	International Recruitment Medical Staff - update to WDT Committee Dec 2020	Acceptable	MIAA Audit tool (covers all elements of workforce for dealing with COVID) results reported to EWAG and WDT		Internal Audit - Vacancy Management (deferred from 2020/21 to 2021/22 audit plan)				

1.Principal Risks

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	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 Risk Score	Action Required	Target Risk Score
				9. Measures put in place to support BAME staff during the Covid-19 pandemic **Control Owner:** Heather Barnett	Detailed response submitted to NHSE/I in June 2020 re Trust compliance with risk assessments for at-risk staff groups. Board advised of 100% compliance via CEO Report & Workforce Report in July 2020	Acceptable						Implement and monitor new Agile Working Policy **Action Owner:** Heather Barnett **Target Implementation Date:** 31 Dec 2021	
BAF 11	IF the Trust fails to harness the benefits of technology to integrate, streamline and improve systems of working THEN this could lead to reduced productivity and safety **Executive Risk Lead:** Amy Freeman **Risk Owner:** **Last Updated:** 18 Jan 2021	**Cause(s)** 1. Insufficient financing 2. Inadequate business cases 3. Poor prioritisation processes 4. Low digital maturity 5. Limited ability to attract digital skills **Consequence(s)** 1. Patient care, safety and experience 2. Reputation as provider and as an employer 3. Use of resources (efficiency, effectiveness, economy) 4. Workforce morale and productivity 5. Cyber security	I = 4 L = 5 20	1. IT Strategy aligned with DIGIT@LL Strategy 2018-22 (refresh due April 2021) **Control Owner:** Amy Freeman	Updates to DTIS every two months						I = 4 L = 3 12	Launch of fortnightly meetings of the Digital Outpatients Group (mix of clinical and IT representatives) **Action Owner:** Amy Freeman **Target Implementation Date:** 31 Mar 2021	I = 4 L = 2 8
				2. Healthcare Information and Management Systems Society (HIMSS) Electronic Medical Record Adoption Model identifies gaps in systems for medical use (June 2020) **Control Owner:** Amy Freeman					HIMSS report to WDTC with discussion about priorities			Refreshed strategy to WDT Committee and Board of Directors **Action Owner:** Amy Freeman **Target Implementation Date:** 30 Apr 2021	
				3. Horizon scanning events with suppliers to identify innovation in the sector **Control Owner:** Amy Freeman	Updates to DTIS and WDTC							Decisions on investment and pressures list for 2021/22 **Action Owner:** Amy Freeman **Target Implementation Date:** 30 Jun 2021	

1.Principal Risks

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	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 Risk Score	Action Required	Target Risk Score
BAF 12	IF the Trust does not create the conditions for an effective organisational culture THEN this could affect quality, efficiency and workforce standards **Executive Risk Lead:** James Sumner **Risk Owner:** **Last Updated:** 18 Jan 2021	**Cause(s)** 1. Poor leadership (tone from the top) 2. Misalignment of strategy and culture 3. Inadequate strategic focus on culture 4. Inadequate / inappropriate internal communications and cascade mechanisms 5. Poor understanding of overarching culture and sub-cultures 6. Insufficient focus on embedding culture at all levels **Consequence(s)** 1. Workforce behaviours and morale 2. Patient care and experience 3. Reputation as an employer 4. Public perception 5. Regulatory	I = 4 L = 5 20	1. Trust strategic priorities 2020-21 include culture **Control Owner:** James Sumner							I = 4 L = 2 8	Review of ED&I Strategy **Action Owner:** Heather Barnett **Target Implementation Date:** 31 Mar 2021	I = 4 L = 2 8
				2. Our Workforce Matters Strategy 2019-21 **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					Initial analysis of staff survey **Action Owner:** Heather Barnett **Target Implementation Date:** 31 Mar 2021	
				3. Communication and Engagement Strategy **Control Owner:** Heather Barnett	Comms and Engagement bi-annual report to Workforce Group							Recruitment to ensure adequate resource in place to deliver Comms & Engagement Strategy **Action Owner:** Heather Barnett **Target Implementation Date:** 31 Mar 2021	
				4. Leadership Behaviours Framework **Control Owner:** Heather Barnett	Learning from Covid presentation							Identify and engage a Quality Improvement partner (third party) to embed QI methodology within the Trust **Action Owner:** Heather Barnett **Target Implementation Date:** 30 Jun 2021	
				5. ED&I Strategy 2020-24 **Control Owner:** Heather Barnett			Annual ED&I report to WDTC and Board		1. National benchmarking WRES and WDES report to WTGC and Board 2. Gender pay gap results to WTGC and Board			Define, raise awareness and embed leadership behaviours within current practice **Action Owner:** James Sumner **Target Implementation Date:** 31 Dec 2021	
				6. Annual Staff Survey Process and action planning **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 **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				

1.Principal Risks

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	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 Risk Score	Action Required	Target Risk Score
BAF 13	IF the Trust fails to provide modern, efficient, sustainable estate, infrastructure and equipment THEN this could lead to high cost business continuity issues in future **Executive Risk Lead:** Russell Favager **Risk Owner:** **Last Updated:** 18 Jan 2021	**Cause(s)** 1. Old buildings / deteriorating physical environment 2. Ageing medical equipment 3. Competing priorities for investment 4. Lack of strategic approach to estates planning 5. Environmental sustainability considerations insufficiently embedded 6. Concrete (RAAC) roof planks 7. Unsupported IT systems and databases **Consequence(s)** 1. Patient care, safety and experience 2. Workforce morale 3. Reputation 4. Regulatory	I = 5 L = 5 25	1. Estates Strategy in place to 2020 and is currently being updated with assistance from Property Consultants Archus **Control Owner:** Russell Favager	Estates & Facilities Divisional Assurance Framework reports to Divisional Board		1. Estates Annual report		New Build Certification		I = 5 L = 3 15	Medical Devices Action Plan to be submitted to January Audit Committee **Action Owner:** Russell Favager **Target Implementation Date:** 22 Jan 2021	I = 5 L = 3 15
				10. Cyber security action plan and risk register monitored by the Audit Committee **Control Owner:** Amy Freeman	Cyber report to DTIS and Audit Committee every six months	Partial			1. Annual penetration tests 2. Internal Audit of cyber security processes 2020	Acceptable		Critical Infrastructure Review action plan to be submitted to ESSEG **Action Owner:** Russell Favager **Target Implementation Date:** 26 Feb 2021	
				11. Medical Devices Group in place. Maintenance and upgrade plans form part of the overall capital planing process **Control Owner:** Russell Favager	Updates on action plan following Internal Audit report submitted to Audit Committee January 2021	Partial			Internal Audit 2020 - Medical Devices (operational and technical controls)	Low		New Estates Strategy to be presented to PAF and Board in March. **Action Owner:** Russell Favager **Target Implementation Date:** 25 Mar 2021	
				2. Capital programme expenditure agreed annually by Executive Safe and Sustainable Environment Group (ESSEG) and monitored by Performance and Finance Committee **Control Owner:** Russell Favager	Capital Exceptions report to IDG and Divisional Board (cost and programme)							IT investment for electronic tracking of medical devices business case to be developed **Action Owner:** Russell Favager **Target Implementation Date:** 31 Mar 2021	
				3. Six Facets Estate Survey database provided by NIFES and validated by Head of Estates will be used to inform the updated Estates Strategy **Control Owner:** Russell Favager	Self audits against NHS sustainability audit tool (every six months)							Premises Assurance Module (PAM) to be adopted for internal reporting and initial assessment to be complete by end of Mar 2021 **Action Owner:** Russell Favager **Target Implementation Date:** 31 Mar 2021	
				4. Compliance of Trust's environments with Equalities Act **Control Owner:** Russell Favager					PLACE Assessments (members of the public) reported to Divisional Board (&?) before published nationally			SOC to cover Leighton Hospital re-build to Trust Board **Action Owner:** Russell Favager **Target Implementation Date:** 28 May 2021	
				5. Survey programme re RAAC beams in progress **Control Owner:** Russell Favager								Relocation of VIN to Weaver Square is at feasibility stage and Business Case is due for completion by May 2021 **Action Owner:** Russell Favager **Target Implementation Date:** 31 May 2021	
				6. Backlog Maintenance planning (£6.5m of backlog maintenance risk to be addressed in 2020/21 utilising NHSE/I funding) **Control Owner:** Russell Favager			Annual ERIC returns to NHSI provide information about the physical condition of the Estate (includes 6 Facets information)					55% of RAAC beams surveys to be completed (63% including Residencies being 'moth-balled') by end of January. SOC to cover re-build of the areas affected by RAAC is due to go to the Trust Board in May 2021. **Action Owner:** Russell Favager **Target Implementation Date:** 31 May 2021	

1.Principal Risks

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	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 Risk Score	Action Required	Target Risk Score
				7. Hospital Redevelopment Programme provides long term sustainable solution to significant estate issues supported by a dedicated governance structure **Control Owner:** James Sumner	1. Monthly Programme Updates to Board via Chair's Assurance Report/CEO report 2. Highlight reports to BoD Part II as required							Estates environmental sustainability to be part of Corporate Social Responsibility Group to be led by the Director of Workforce & Organisational Development. It will include review of the NHS Environmental Assessment Tool (NEAT) and production of an action plan to improve performance in agreed key areas **Action Owner:** Russell Favager **Target Implementation Date:** 31 Dec 2021	
				8. IT Strategy and plan outline the priorities for maintenance and improvement of key systems **Control Owner:** Amy Freeman								
				9. IT contracts review process **Control Owner:** Amy Freeman									
BAF 14	IF the Trust does not plan its workforce requirement for the future THEN it is likely to create high cost expenditure and lead to workforce gaps which could impact standards of care **Executive Risk Lead:** Heather Barnett **Risk Owner:** **Last Updated:** 22 Jan 2021	**Cause(s)** 1. Poor horizon scanning and forecasting 2. Poor understanding of expectations of young people entering workforce 3. Insufficient consideration of workforce in strategic planning 4. Misalignment of workforce planning, activity and finance 5. Lack of accurate and up-to-date workforce information and data 6. Lack of workforce planning capacity and capability 7. Poor communication between education providers / HEE / Providers **Consequence(s)** 1. Sustainability of services 2. Workforce morale 3. Reputation as an employer 4. Regulatory 5. Patient care and experience	I = 4 L = 5 20	1. Our Workforce Matters Strategy 2019-21 approved by Trust Board Nov 2018 and delivered via an action plan monitored by WDTC **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				I = 4 L = 3 12	Workforce Plan to EWAG **Action Owner:** Heather Barnett **Target Implementation Date:** 06 Jan 2021 Workforce systems project team to be established **Action Owner:** Heather Barnett **Target Implementation Date:** 31 Mar 2021	I = 4 L = 2 8
				2. Workforce Plan 2020-23 (including volunteers) approved by WDTC December 2020 **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 **Control Owner:** Heather Barnett	Quarterly progress report to EWAG and 6 monthly to WDTC								
				4. E-roster project implementation plan **Control Owner:** Julie Tunney	E-roster reporting on nursing / HCA staff groups		E-roster report to EWAG						
				5. Recruitment Policies and Process **Control Owner:** Heather Barnett			MIAA Audit tool results reported to EWAG and WDT		Internal Audit - Vacancy Management (deferred from 2020/21 to 2021/22 audit plan)				
				6. Apprenticeships **Control Owner:** Heather Barnett			Apprenticeship levy usage report to EWAG and JCNC						
				7. Physician Associates in place as part of strategy to increase workforce **Control Owner:** Heather Barnett			Physicians Associate report submitted to EWAG December 2020						

1.Principal Risks

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	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 Risk Score	Action Required	Target Risk Score
BAF 15	IF financial management, budgetary controls and efficiency planning are not robust THEN the Trust may not deliver its financial targets **Executive Risk Lead:** Russell Favager **Risk Owner:** **Last Updated:** 18 Jan 2021	**Cause(s)** 1. Inappropriate financial planning 2. Poor financial data 3. Low understanding of local budgetary responsibilities 4. Poor compliance with financial controls 5. Cash releasing savings plans that are not fully identified and may not be fully delivered 6. Cost pressures arising from the use of agency staff 7. The use of non-recurrent measures may also contribute to a risk to the Trusts longer term sustainability 8. Failure to agree control total with NHSI/E 9. Inability to invest in development of service **Consequence(s)** 1. Regulatory 2. Sustainability of services 3. Reputation 4. Patient care	I = 4 L = 5 20	1. Corporate Governance Framework Manual including Standing Financial Instructions and Scheme of Delegation (approved by Audit Committee and Board of Directors) **Control Owner:** Russell Favager			Compliance with SFIs reported to Audit Committee on quarterly basis		Annual Internal Audit Key Financial Controls - report received High Assurance January 2021	Acceptable	I = 4 L = 2 8	Increase in senior post support for financial services to remove single points of failure, and ensure appropriate oversight, to be in place beginning of Q4 2020/21 **Action Owner:** Russell Favager **Target Implementation Date:** 29 Jan 2021	I = 4 L = 2 8
				2. Budgetary Controls - each Division has a dedicated financial accountant **Control Owner:** Russell Favager	Monthly divisional meetings with Accountant		Monthly Finance reports to PAF and Board					Current year operating under Cheshire/Merseyside financial envelope. Conversations ongoing with NHSI/E for forecast outturn for individual organisations. Awaiting national guidance on financial regime for 2021/22. **Action Owner:** Russell Favager **Target Implementation Date:** 31 Mar 2021	
				3. Contracts with Commissioners (suspended in 2020/21) **Control Owner:** Russell Favager	Signed contract with Commissioners		Monthly Contract financial reports to Commissioners						
				4. Financial plan **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)			Work with the collaboration at scale lead to ensure there is a clear plan going into 2021/22, to be completed as part of the annual planning process during Q4 2020/21 **Action Owner:** Russell Favager **Target Implementation Date:** 31 Mar 2021	
				5. Annual reference costs (cost improvement plans only being pursued during 2020/21 where no impact on patient services) **Control Owner:** Russell Favager			Signed off by PAF					
				6. End of year financial accounting processes **Control Owner:** Russell Favager			Annual Accounts scrutinised and signed off by Audit Committee		External Audited Annual Accounts			Updated training for budget holders to be rolled out Q4 2020/21 **Action Owner:** Russell Favager **Target Implementation Date:** 31 Mar 2021	
				7. Collaboration at scale (projects ongoing during 2020/21 but only for non patient facing services) **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 **Control Owner:** Russell Favager					External Benchmarking information received by the Trust including Model Hospital			Awaiting national guidance on the commissioning process for 2021/22 **Action Owner:** Russell Favager **Target Implementation Date:** 31 Mar 2021	
				9. Cheshire System Financial Recovery Plan (on hold - awaiting National guidance on financial regime for Cheshire/Merseyside system) **Control Owner:** Russell Favager	Monthly CEO and DOF meetings				NHSI/E Performance Meetings			Senior team review of key audit actions and timelines to ensure a robust year end process **Action Owner:** Russell Favager **Target Implementation Date:** 31 Mar 2021	
												PLICS data to be rolled out across targeted specialities, and linked with patient related outcomes in Q4 2020/21. **Action Owner:** Russell Favager **Target Implementation Date:** 31 Mar 2021	
												Annual report on financial benchmarking to be presented to PAF Q4 2020/21. **Action Owner:** Russell Favager **Target Implementation Date:** 31 Mar 2021	

1.Principal Risks

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	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 Risk Score	Action Required	Target Risk Score
												Revised SFIs and Scheme of Delegation incorporated into Corporate Governance Manual to be approved by the Audit Committee and Trust Board **Action Owner:** Russell Favager **Target Implementation Date:** 30 Apr 2021	
												Financial benchmarking data (reference cost) to be shared with the key divisional areas; corporate area to be reviewed for potential collaboration at scale opportunities. **Action Owner:** Russell Favager **Target Implementation Date:** 30 Apr 2021	
BAF 16	IF the Trust does not focus on enabling a successful Integrated Care Partnership and carry out its hosting responsibility THEN this could lead to substandard out of hospital care **Executive Risk Lead:** Denise Frodsham **Risk Owner:** **Last Updated:** 18 Jan 2021	**Cause(s)** 1. Failure to overcome organisational politics 2. Senior capacity 3. Ineffective governance 4. Lack of agreement of shared goals and plans 5. Poor communication 6. Failure to have single data source across the system **Consequence(s)** 1. Patient care and experience including inequality of provision 2. Reputation 3. Financial 4. Regulatory intervention	I = 3 L = 5 15	1. Local transformation funding to support the programme of work **Control Owner:** Denise Frodsham	Task and Finish Groups report to Transformation Board (part of Cheshire East ICP governance structure)						I = 3 L = 3 9	ICP Board development session to agree Board development programme for 2021 **Action Owner:** Denise Frodsham **Target Implementation Date:** 31 Dec 2020	I = 3 L = 2 6
				2. CEICP Board includes CEO representation from MCHFT **Control Owner:** James Sumner	Monthly risk reports to ERAG (from October)		Monthly report to the Board of Directors from the Chair of the ICP					Roadmap for devolvement of commissioning - agree scope for approval by Trust Boards **Action Owner:** Denise Frodsham **Target Implementation Date:** 28 Feb 2021	
				3. Cheshire East Place 5 year plan presented to Board October 2019 **Control Owner:** Denise Frodsham			Update reports go to Place Partnership Board					Costings to be provided to Director of Strategic Partnerships for independent supplier to write business cases for Business Intelligence and IT provision for ICP **Action Owner:** Amy Freeman **Target Implementation Date:** 31 Mar 2021	
				4. Memorandum of Understanding agree between health partners and agreed in principle with Local Authority **Control Owner:** Denise Frodsham							ICP risk register to be established and incorporated with MCHFT systems **Action Owner:** Denise Frodsham **Target Implementation Date:** 31 Mar 2021	
				5. ICP Strategy and Transformation Plan **Control Owner:** Denise Frodsham	Monthly highlight report for each workstream to ICP Transformation Board								

1.Principal Risks

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	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 Risk Score	Action Required	Target Risk Score
BAF 17	IF there continues to be Ineffective capacity and demand management across the Health and Social Care system THEN the risk to patients of being hospitalised unnecessarily will continue to increase **Executive Risk Lead:** Oliver Bennett **Risk Owner:** **Last Updated:** 14 Jan 2021	**Cause(s)** 1. Poor understanding of key failure points 2. Poor system-wide data 3. Parters not delivering on their commitments 4. Inadequate focus on embedding new ways of working 5. Poor communication **Consequence(s)** 1. Hospital capacity 2. Patient care and experience 3. Reputation	I = 4 L = 5 20	1. Winter/COVID Plan - Trust-wide and system-wide (Cheshire) approved by PAF and the Board October 2020 **Control Owner:** Oliver Bennett	1. Review including lessons learned on Board workplan for May/June 2021. 2. Winter plan tracked and progress documented at the Winter Planning Group with updates documented at Silver Command and escalated to Gold if necessary.						I = 4 L = 3 12	Ensure new Cheshire wide urgent care delivery Board in place **Action Owner:** Oliver Bennett **Target Implementation Date:** 31 Dec 2020	I = 4 L = 2 8
												Deliver a short-term action plan to ensure discharges are sufficient in the wider system to equalise the current Covid pressures. **Action Owner:** Oliver Bennett **Target Implementation Date:** 30 Jan 2021	
				2. Cheshire system-wide urgent care delivery Board **Control Owner:** Oliver Bennett									

1.Principal Risks

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	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 Risk Score	Action Required	Target Risk Score
BAF 19	IF the Trust does not have effective governance systems and processes in place to move to a risk assurance culture THEN it is less likely to manage its key risks, resulting in quality and financial challenges **Executive Risk Lead:** James Sumner **Risk Owner:** **Last Updated:** 22 Jan 2021	**Cause(s)** 1. Low openness to change 2. Low understanding of risk & assurance 3. Inability to effect culture change 4. Poor perception of governance requirement 5. Lack of senior buy-in **Consequence(s)** 1. Governance 2. Regulatory 3. Reputation 4. Patient care	I = 3 L = 5 15	1. Phase 1 Risk & Assurance project plan outputs July-Oct 2020 in place: - Risk Management Strategy & Process - Risk reporting through the governance structure with new reporting formats - ERAG and Risk Sub-Group set up and operational - BAF in 4Risk - Exec and Board training on BAF, assurance and risk appetite Design and delivery assisted by external expert resource **Control Owner:** Caroline Keating	Company Secretary holds weekly project meetings to review progress	Acceptable	Audit Committee Task & Finish Group consultation sessions	Acceptable	Internal Audit - Assurance Framework and Risk Management Process Q4 2020-21		I = 3 L = 4 12	Completion of all BAF assurance detail **Action Owner:** Caroline Keating **Target Implementation Date:** 21 Jan 2021 Initial risk maturity assessment by MIAA **Action Owner:** Caroline Keating **Target Implementation Date:** 31 Mar 2021 Training programme roll-out **Action Owner:** Caroline Keating **Target Implementation Date:** 31 Mar 2021	I = 3 L = 2 6
				2. Risk Management Strategy approved by the BoD August 2020 sets the overarching approach **Control Owner:** Caroline Keating									
				3. Final version Assurance & Escalation Framework agreed by the Audit Committee November 2020 and approved by Board December 2020 documents key mechanisms **Control Owner:** Caroline Keating			Internal compliance testing by Governance Team						
				4. CQC improvement planning and implementation **Control Owner:** Julie Tunney	Quality Summit reviews progress on actions		Must-dos reported quarterly to QSC						
				5. Redesigned Governance Structure approved by Board July 2020 **Control Owner:** Caroline Keating	Annual evaluation of effectiveness of Exec Groups, Board Committees and the Board of Directors				Well-led governance reviews every 3 years				
				6. Risk Management Process Guide approved by Audit Committee November 2020 and distributed to key groups sets out the risk management methodology to be followed by all staff **Control Owner:** Caroline Keating			Monthly Risk Sub -Group Workplan focuses on checking and challenging compliance with agreed process	Partial	Internal Audit Advisory Review of Compliance planned for Q4 2020/21				
				7. Data Security and Protection Toolkit (ICO requirement) **Control Owner:** Amy Freeman					Internal Audit May 2020	Acceptable			

1.Principal Risks

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	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 Risk Score	Action Required	Target Risk Score
BAF 20	IF the Trust fails to establish appropriate governance and risk mitigation around existing and new collaborative, system wide models of working THEN it may expose itself to risk of which it is unaware **Executive Risk Lead:** James Sumner **Risk Owner:** **Last Updated:** 13 Jan 2021	**Cause(s)** 1. Low understanding of benefits of appropriate governance 2. Poor understanding of partnership risks 3. Ineffective communication between partners 4. Failure to learn and adapt to system-wide thinking 5. Lack of coterminosity 6. Failure to plan for partnership service changes **Consequence(s)** 1. Governance 2. Reputation 3. Regulatory 4. Patient care 5. Financial	I = 3 L = 5 15	1. CEO member of Integrated Care Partnership Board and Trust is host of the new arrangements **Control Owner:** James Sumner	Chief Executive's report to the BoD						I = 3 L = 3 9	SLAs for UHNM clinical services to be approved by Boards of Directors **Action Owner:** James Sumner **Target Implementation Date:** 31 Mar 2021	I = 3 L = 2 6
				2. CEO member of CE Place Partnership. CEICP collaboration agreement to be signed off by BoD Sept 2020 **Control Owner:** James Sumner	Chief Executive's report to the BoD							Cheshire East breast screening integration **Action Owner:** Denise Frodsham **Target Implementation Date:** 30 Apr 2021	
				3. DSP member of CWICP Board. Memorandum of Understanding approved by MCHFT Board June 2020 **Control Owner:** Denise Frodsham								MCHFT governance guidance/policy for entering collaborative arrangements **Action Owner:** Caroline Keating **Target Implementation Date:** 30 Jun 2021	
				4. Blueprint for partnership agreements in place (cf Pathology agreement - approved by Board Nov 2020) **Control Owner:** James Sumner								Governance for ICP hosting **Action Owner:** Caroline Keating **Target Implementation Date:** 30 Sep 2021	

1.Principal Risks

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	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 Risk Score	Action Required	Target Risk Score
BAF 21	IF the development of leadership capacity and capability throughout the organisation is not a priority THEN the Trust's ambitions are unlikely to be met **Executive Risk Lead:** Heather Barnett **Risk Owner:** **Last Updated:** 18 Jan 2021	**Cause(s)** 1. Inadequate planning of leadership requirement 2. Lack of clarity about development paths 3. Inadequate investment 4. Failure to address leadership culture 5. Low senior engagement 6. Low clinical leadership engagement 7. Lack of capacity to release staff for development 8. Lack of resources to deliver adequate development opportunities 9. Perceived or real cultural barriers for BAME staff **Consequence(s)** 1. Leadership 2. Strategy 3. Change management 4. Culture 5. Workforce morale	I = 4 L = 5 20	1. Leadership Development matrix and implementation plan **Control Owner:** Heather Barnett	Leadership development plan progress reports to EWAG and WDT	Acceptable					I = 4 L = 3 12	Set up BAME Advisory Panel **Action Owner:** Heather Barnett **Target Implementation Date:** 29 Jan 2021	I = 4 L = 2 8
				2. Our Workforce Matters Strategy approved by Board of Directors November 2018 **Control Owner:** Heather Barnett	Quarterly updates to WDT committee. Last update mapped against 'We are the NHS: People Plan 2020/21"	Acceptable	Workforce metrics reporting and analysis reported to EWAG and via Integrated Performance Report to WDTC and Board					ED&I Strategy review **Action Owner:** Heather Barnett **Target Implementation Date:** 31 Mar 2021	
				3. Coaching & mentoring scheme **Control Owner:** Heather Barnett	Education, Learning and OD report to EWAG quarterly							Initial analysis of the staff survey results **Action Owner:** Heather Barnett **Target Implementation Date:** 31 Mar 2021	
				4. Medical leadership programme **Control Owner:** Murray Luckas	Education Committee?							Review of recruitment practices and establish diverse stakeholder panels for senior appointments **Action Owner:** Heather Barnett **Target Implementation Date:** 31 Mar 2021	
				5. Talent Board is in place and succession planning process is aligned to the Divisions **Control Owner:** Heather Barnett	Annual review of talent and succession plan to EWAG and WDTC							Evaluate the Shadow Board programme **Action Owner:** Heather Barnett **Target Implementation Date:** 31 Mar 2021	
				6. Staff Survey action plans relating to leadership are in place **Control Owner:** Heather Barnett			Staff Survey focus groups and action plan review includes feedback about leadership		Annual National Staff Survey results			Review Leadership Development Framework **Action Owner:** Heather Barnett **Target Implementation Date:** 30 Jun 2021	
												Annual review of the talent and succession plan **Action Owner:** Heather Barnett **Target Implementation Date:** 30 Sep 2021	

Mid Cheshire Hospitals
NHS Foundation Trust

Board of Directors
Integrated Performance Report

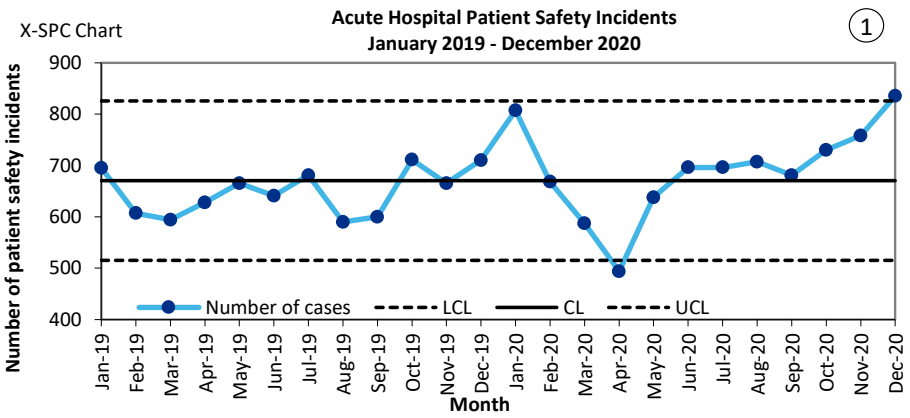
December 2020

"To Deliver Excellence in Healthcare through Innovation & Collaboration"

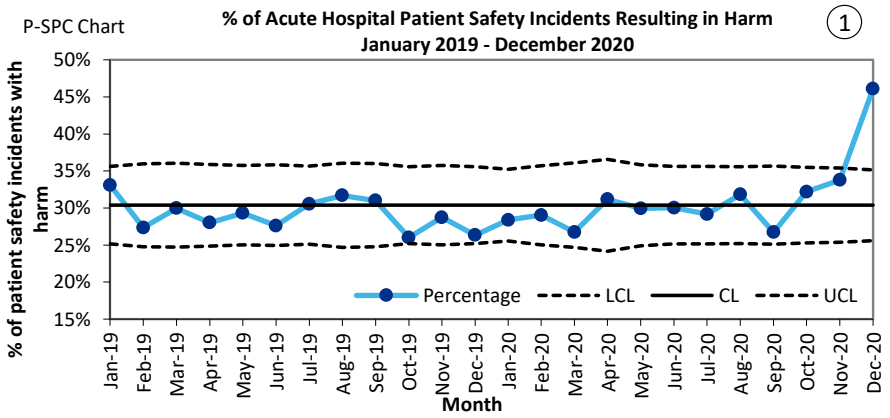
Quality, Safety & Patient Experience

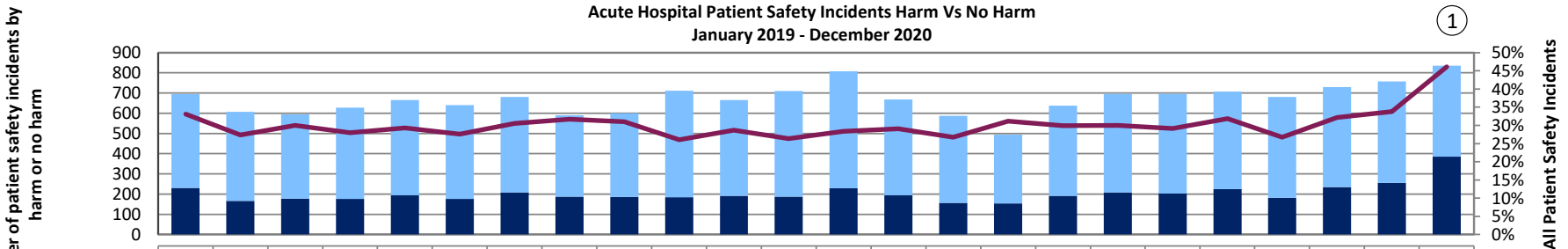
Acute Hospital Patient Safety Incidents (Excludes CCICP)

X-SPC Chart



P-SPC Chart





	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	Sep-20	Oct-20	Nov-20	Dec-20
No Harm	465	441	416	452	470	464	473	403	414	526	474	523	578	474	430	340	447	487	493	482	499	495	502	450
Harm	230	166	178	176	195	177	208	187	186	185	191	187	229	194	157	154	191	209	203	225	182	235	256	385
% Harm	33%	27%	30%	28%	29%	28%	31%	32%	31%	26%	29%	26%	28%	29%	27%	31%	30%	30%	29%	32%	27%	32%	34%	46%

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: 835 incidents were reported in December 2020 of which 46% resulted in harm. The total number of acute hospital patient safety incidents has remained above the 24-month average for the last 7 months reported.

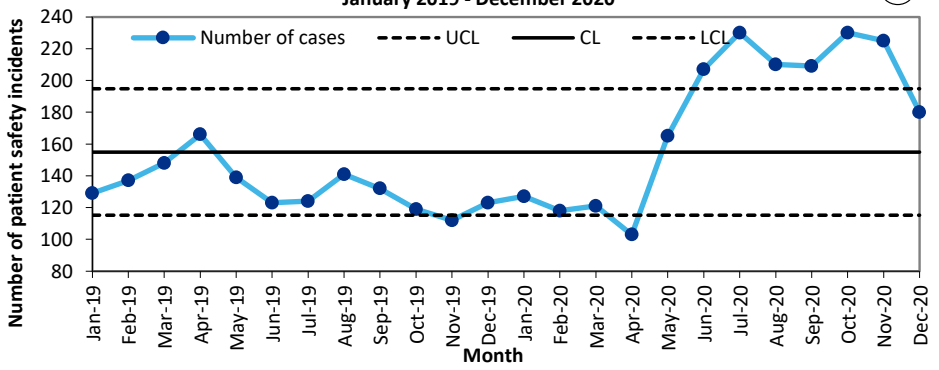
Low Harm 284, Moderate Harm 100, Serious Incident 1

Quality, Safety & Patient Experience

X-SPC Chart

CCICP Patient Safety Incidents
January 2019 - December 2020

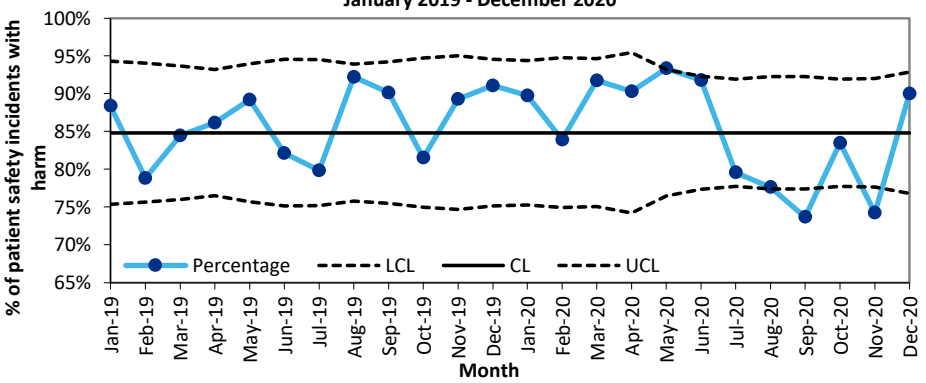
1



P-SPC Chart

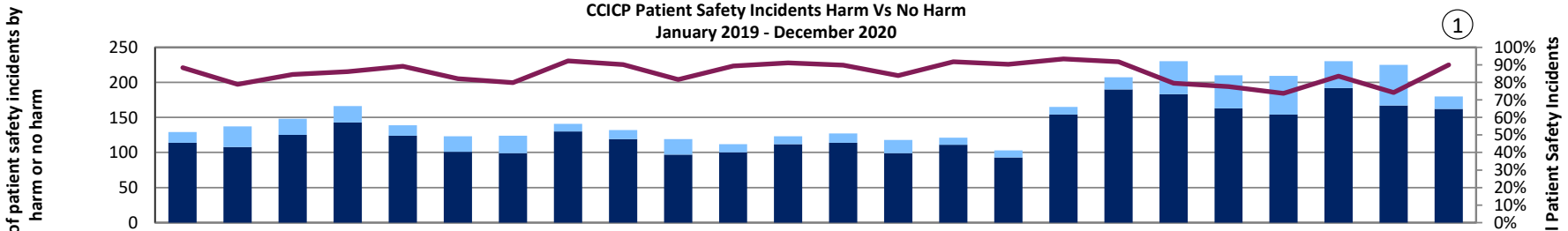
% of CCICP Patient Safety Incidents Resulting in Harm
January 2019 - December 2020

1



CCICP Patient Safety Incidents Harm Vs No Harm
January 2019 - December 2020

1



	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	Sep-20	Oct-20	Nov-20	Dec-20
No Harm	15	29	23	23	15	22	25	11	13	22	12	11	13	19	10	10	11	17	47	47	55	38	58	18
Harm	114	108	125	143	124	101	99	130	119	97	100	112	114	99	111	93	154	190	183	163	154	192	167	162
% Harm	88%	79%	84%	86%	89%	82%	80%	92%	90%	82%	89%	91%	90%	84%	92%	90%	93%	92%	80%	78%	74%	83%	74%	90%

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: 180 CCICP patient safety incidents were reported in December 2020, of which 90% resulted in harm. There was a 20% reduction in the numbers of safety incidents reported in December 2020 compared to the previous month.

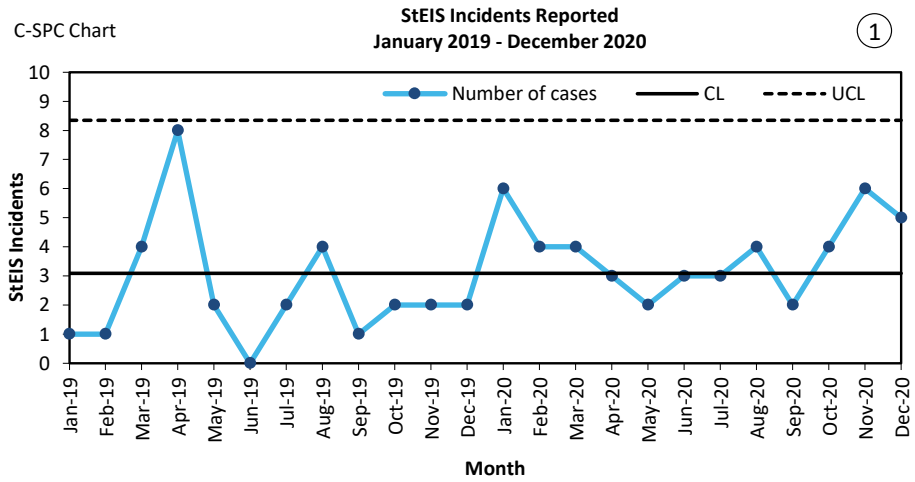
Low Harm 158, Moderate Harm 4, Serious Incident 0

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

Quality, Safety & Patient Experience

StEIS Incidents - Trust Total

C-SPC Chart

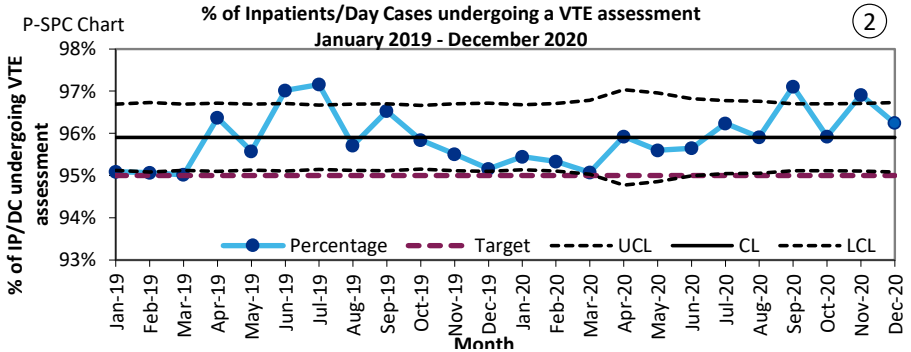


Accountable: Medical Director **Data Owner:** Quality Governance

Key Narrative: There were 5 serious incidents reported to StEIS in December 2020.

VTE

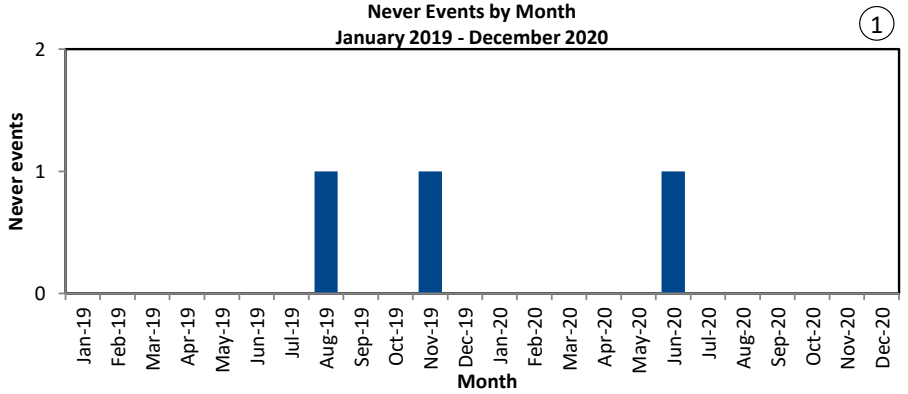
P-SPC Chart



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

Key Narrative: The percentage of VTE assessments completed remains above target, achieving 96.2% in December 2020. The P-SPC charts adjust the control limits to take into account each month's denominator.

Never Events - Trust Total



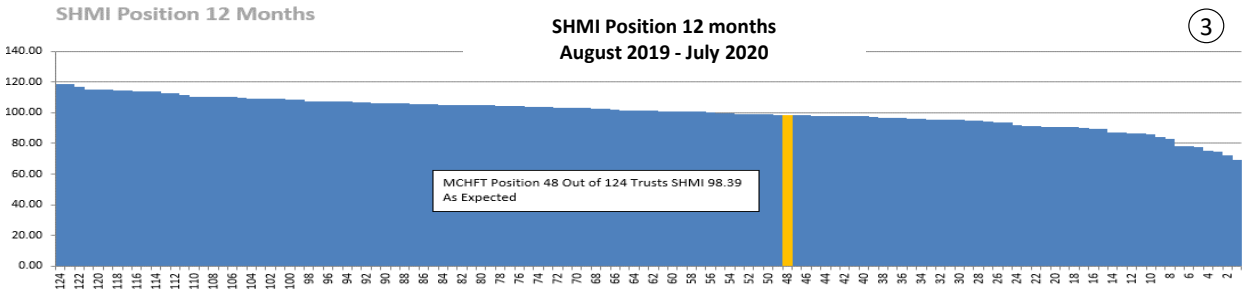
Accountable: Medical Director **Data Owner:** Information Services

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

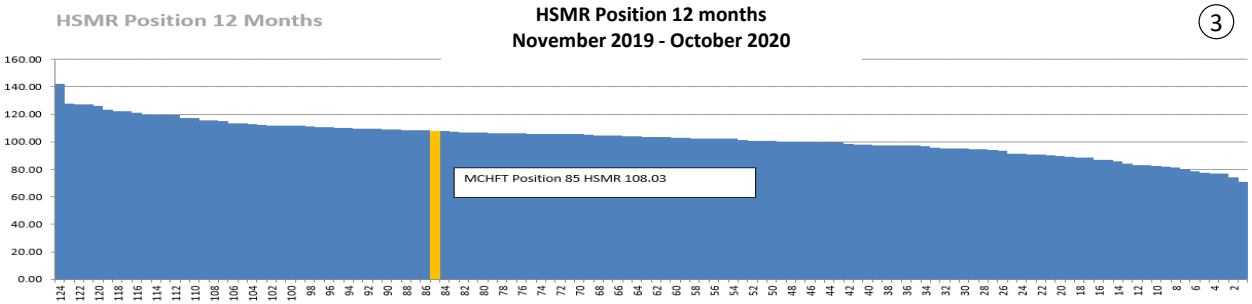
Data Rating: ①captured locally, ②system captured, ③published/benchmarked

Quality, Safety & Patient Experience

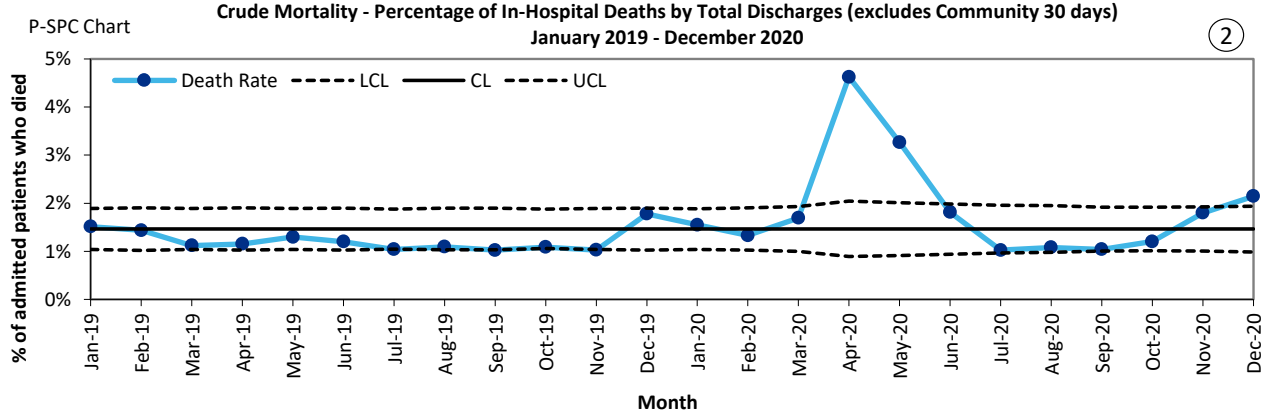
Mortality



Key Narrative: The latest release of SHMI is 98.39 (rank 48) against the previous value of 99.22 (rank 51). This is still in the 'as expected' range. Please note that the number of submitting Trusts has dropped from 129 to 124 due to Trust mergers that is now reflected in the data



Key Narrative: The latest HSMR release is 108.03. Recent releases had shown a deterioration in HSMR which is likely to be the result of low rates of palliative coding compared to other Trusts. This release shows a further slight improvement. 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-May 2020 & Dec 2020 where the rate increased and shows special cause variation on the chart. The latter 2 periods represent high alert levels for the Coronavirus pandemic, resulting in reduced numbers of inpatients in the Trust overall but increases in the severity of illness and resultant mortality amongst the inpatient cohort.
The most recent rate for December 2020 is rising due to increasing deaths against decreasing discharges.

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

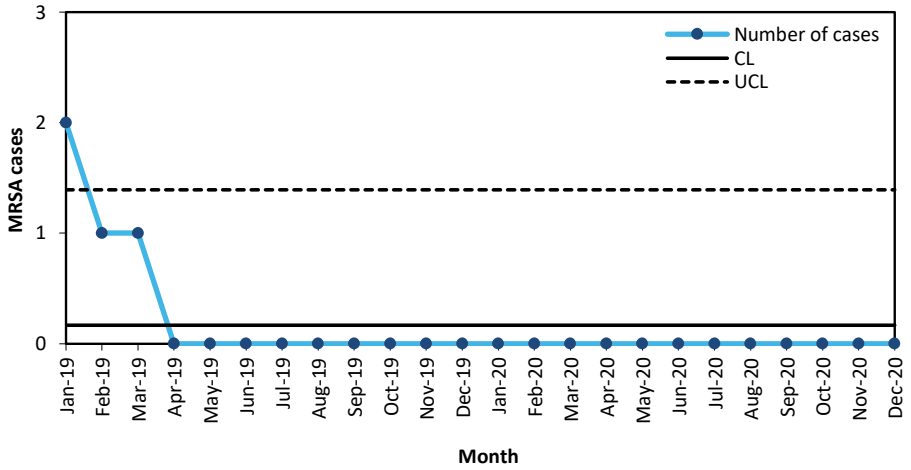
Quality, Safety & Patient Experience

MRSA

C-SPC Chart

MRSA Bacteraemia Cases Reported Within the Trust
January 2019 - December 2020

①



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

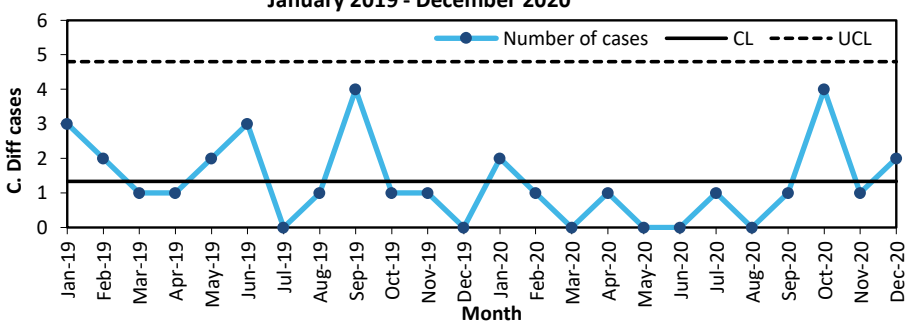
Key Narrative: There have been no MRSA bacteraemia cases reported since March 2019.

C. Diff Positive Cases

C-SPC Chart

Hospital Onset Healthcare Acquired C. Diff Cases
January 2019 - December 2020

①



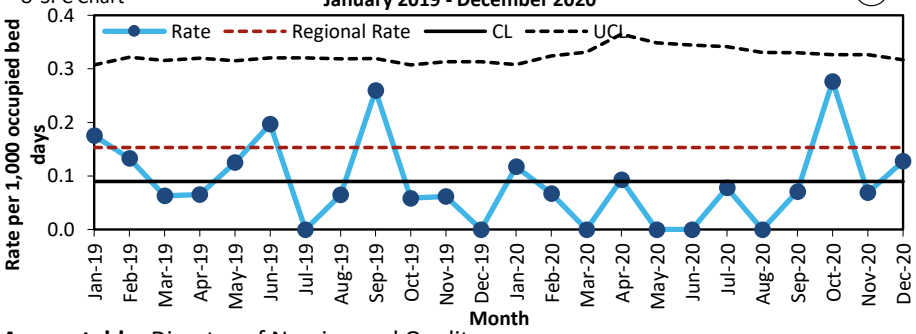
	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Avoidable	0	0	0	0	0	0	1	0	0	0	0	0
Unavoidable	2	1	0	1	0	0	0	0	1	0	0	0
Awaiting Confirmation	0	0	0	0	0	0	0	0	0	4	1	2

Hospital Onset Healthcare Acquired C.Diff Rate per 1,000 Occupied Bed Days

U-SPC Chart

January 2019 - December 2020

①

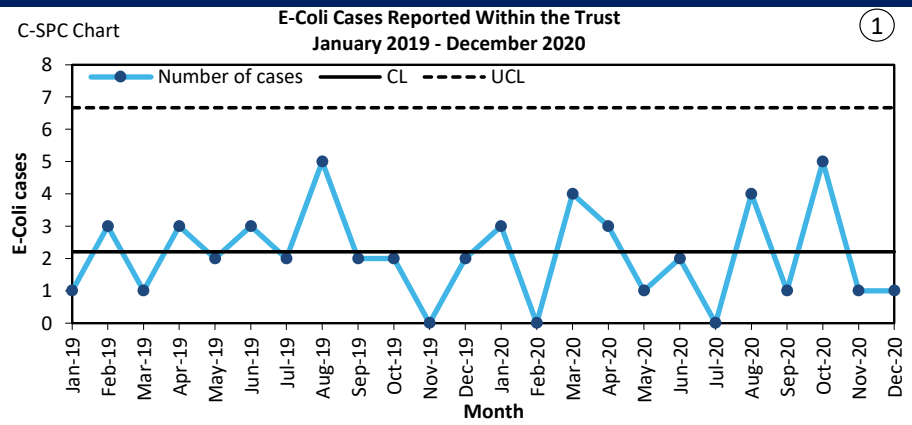


Accountable: Director of Nursing and Quality
Data Owner: Infection Prevention Control Team
Key Narrative: 2 hospital onset healthcare acquired C.Diff cases were recorded in December 2020, a rate of 0.13 cases per 1,000 occupied bed days, below the regional rate. The P-SPC charts adjust the control limits to take into account each month's denominator.

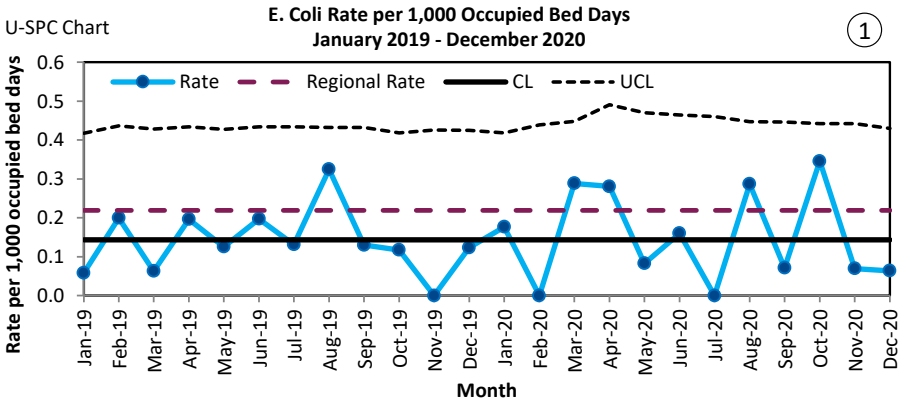
Quality, Safety & Patient Experience

E-Coli Cases

C-SPC Chart



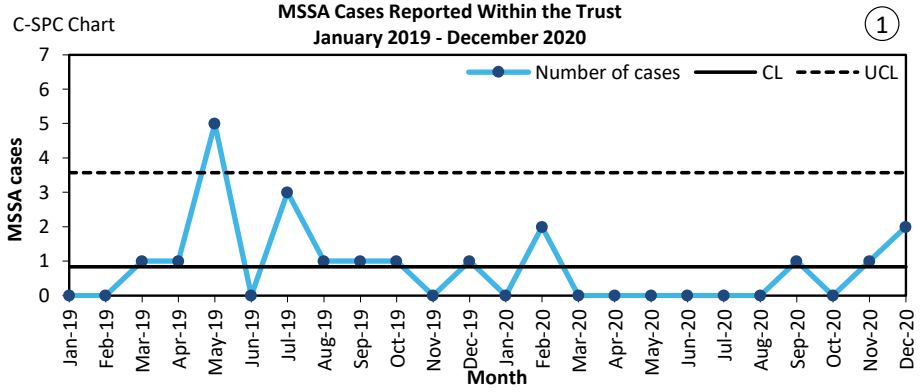
U-SPC Chart



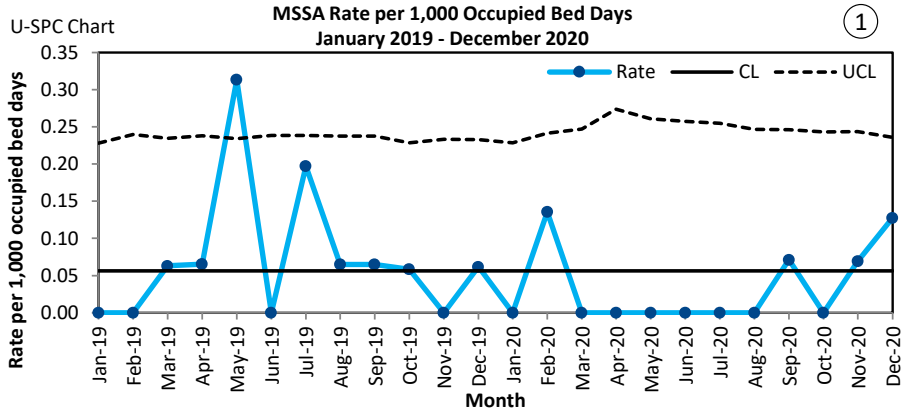
Accountable: Director of Nursing and Quality
Data Owner: Infection Prevention Control Team
Key Narrative: 1 E-Coli case was recorded in December 2020 with a rate of 0.06 cases per 1,000 occupied bed days, below the current regional rate. The U-SPC chart adjusts the control limits to take into account each month's denominator.

MSSA

C-SPC Chart



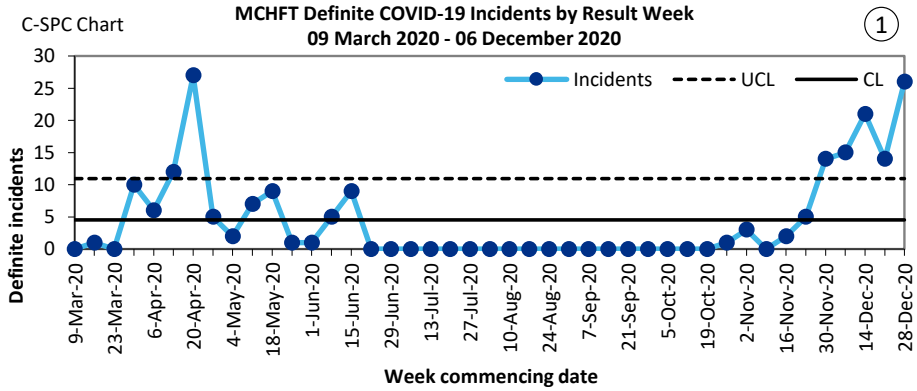
U-SPC Chart

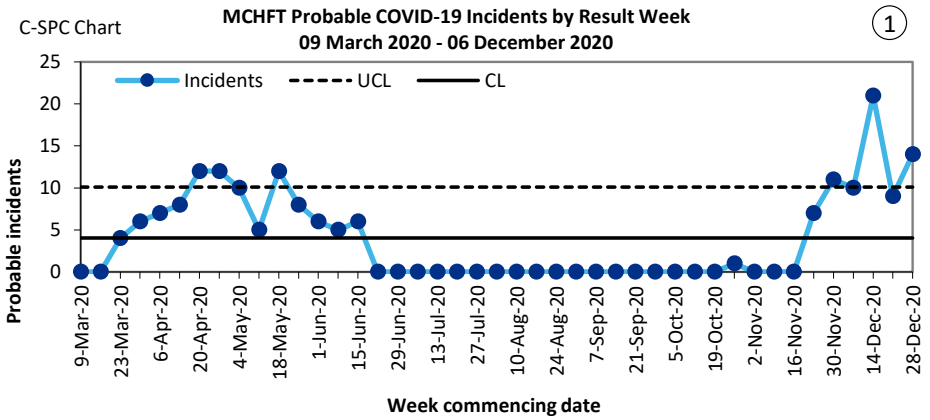


Accountable: Director of Nursing and Quality
Data Owner: Infection Prevention Control Team
Key Narrative: 2 MSSA case were reported in December 2020 with a rate of 0.13 cases per 1,000 occupied bed days. The U-SPC chart adjusts the control limits to take into account each month's denominator.

Quality, Safety & Patient Experience

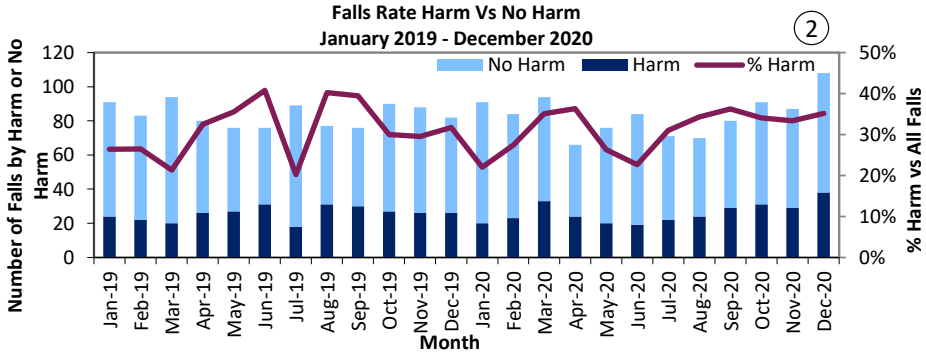
COVID-19 Healthcare Acquired Infections

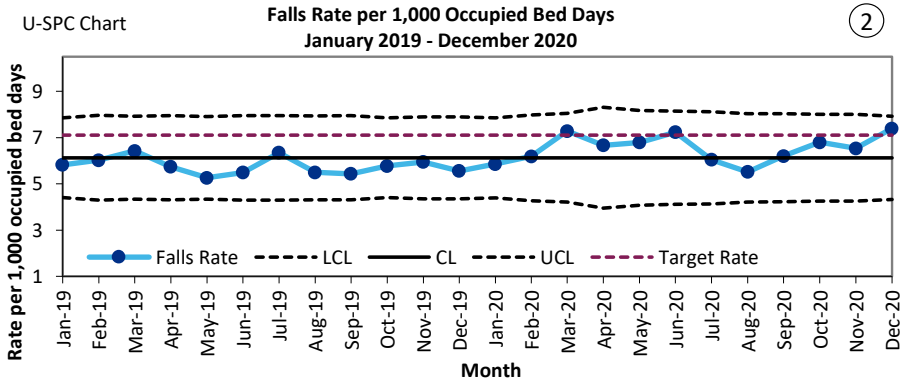




Accountable: Director of Nursing and Quality **Data Owner:** Information Services
Key Narrative: The latest week reported, week commencing 28th December 2020, shows 26 definite incidents, the highest since the start of the second wave of the coronavirus pandemic. 14 probable incidents shown in week commencing 28th December 2020 with the highest rate of 21 probable incidents seen in week commencing 14th December 2020.

Falls





Accountable: Director of Nursing and Quality
Data Owner: Nursing Quality Team
Key Narrative: 108 falls were reported in December 2020 with a rate of 6.9 per 1,000 occupied bed days, above the target rate of 6.6. 38 falls resulted in harm (35%), all of which were low harm.
The U-SPC chart adjusts the control limits to take into account each month's denominator.

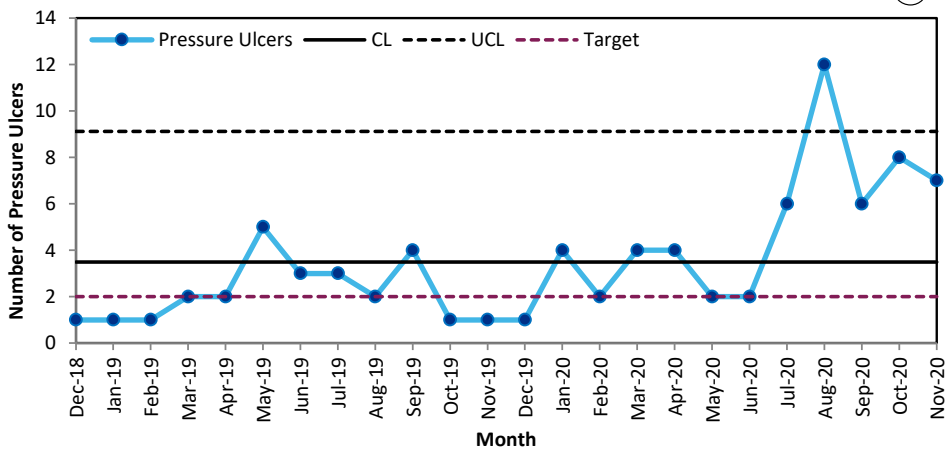
Quality, Safety & Patient Experience

Acute Hospital Pressure Ulcers

C-SPC Chart

Acute Hospital Pressure Ulcers - Lapses in Care Identified
December 2018 - November 2020

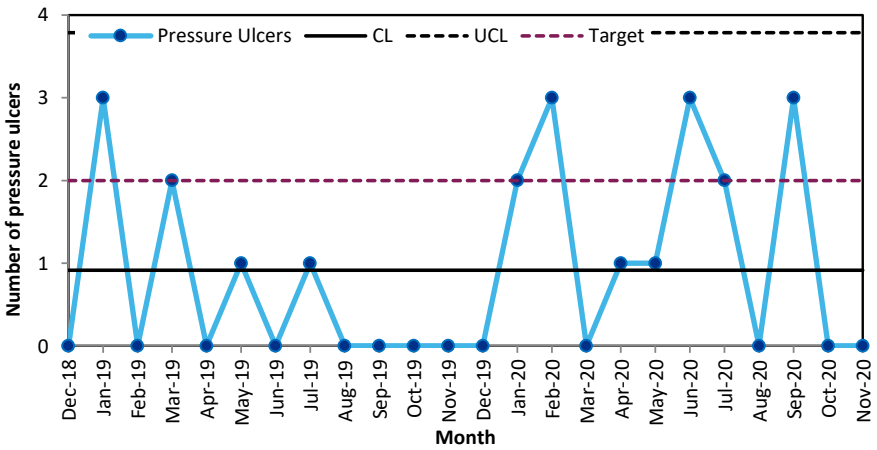
①



C-SPC Chart

Community Pressure Ulcers - Lapses in Care Identified
December 2018 - November 2020

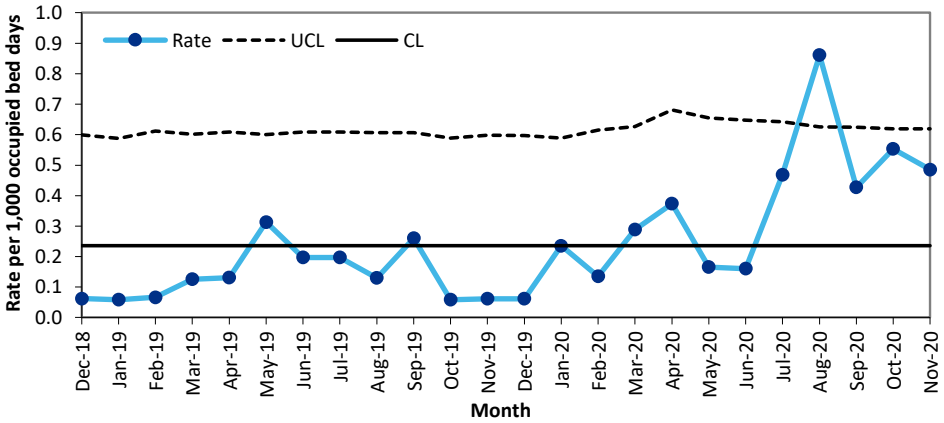
①



U-SPC Chart

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

①



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:

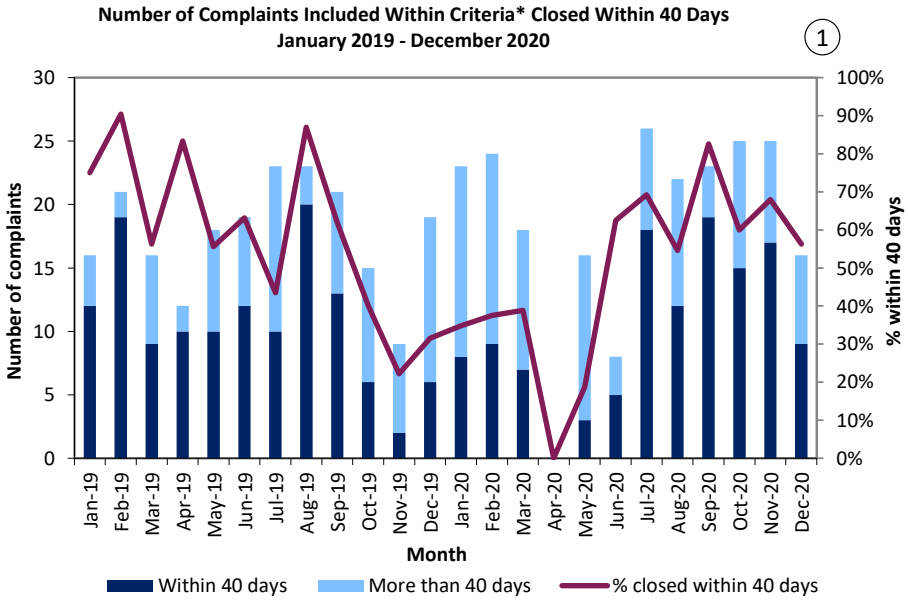
Acute: There were 7 acute hospital lapses in care identified in November 2020. The rate of cases per 1,000 occupied bed days was 0.49. There have been 47 acute lapses of care reported in the current financial year against a target of 16.

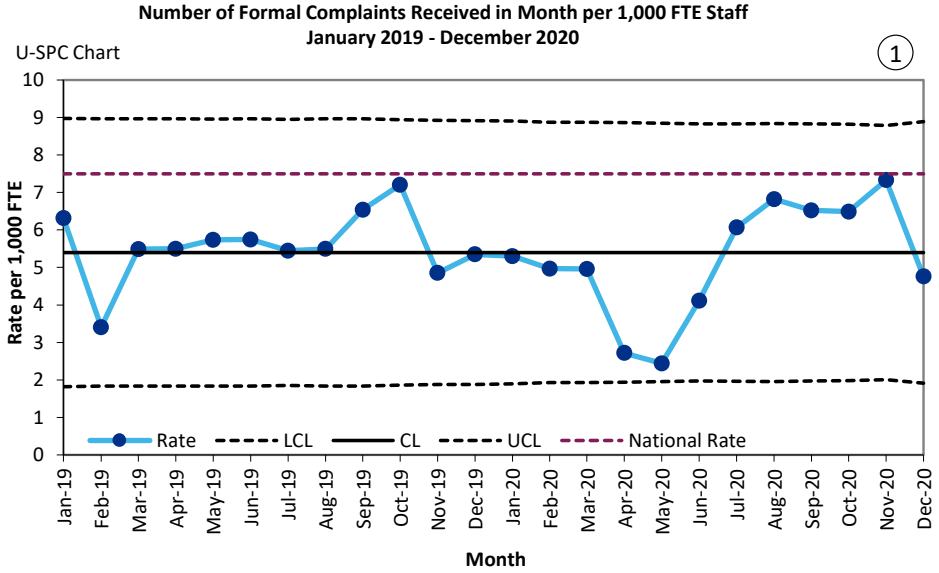
Community: There were no community lapses of care identified in November 2020. There have been 10 community lapses of care reported in the current financial year against a target of 16.

Current financial year reported cases subject to validation.

Quality, Safety & Patient Experience

Formal Complaints





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

Key Narrative: 16 complaints were closed in December 2020, of which 9 were closed within 40 days (56%). The rate of formal complaints received in December 2020 was 4.76 per 1,000 FTE staff, remaining 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.*

Quality, Safety & Patient Experience

Safer Staffing Divisional Analysis

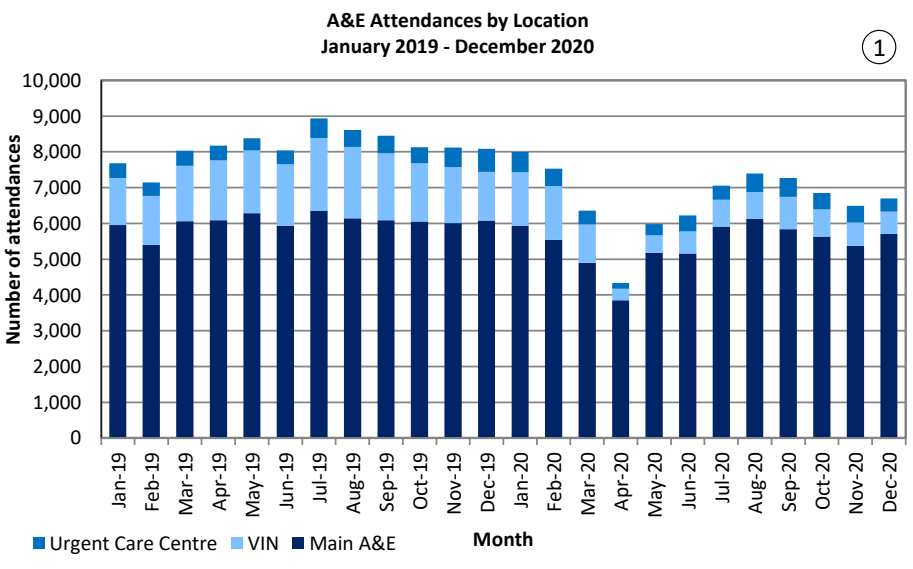
①

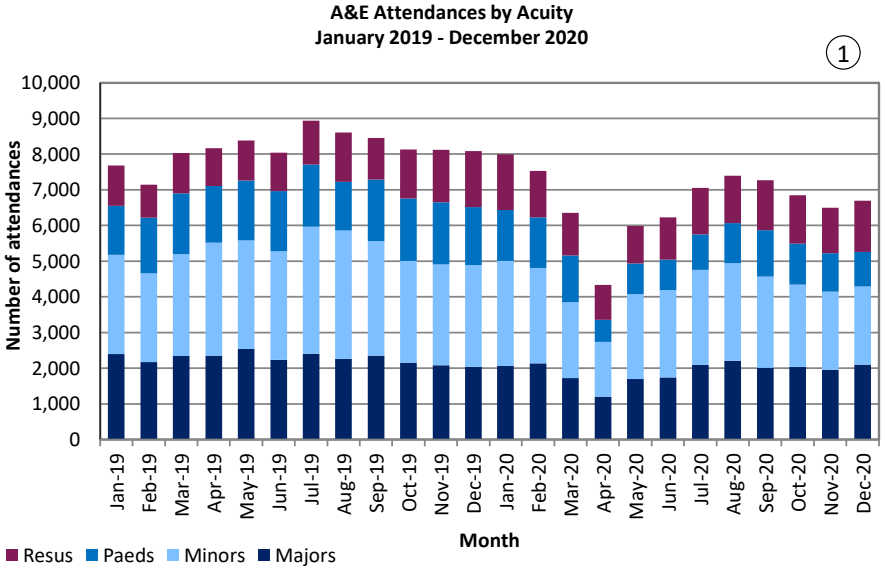
Ward Name	Day				Night				Day		Night	
	Qualified		Unqualified		Qualified		Unqualified		Qualified	Unqualified	Qualified	Unqualified
	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Fill Rate	Fill Rate	Fill Rate	Fill Rate
MCHFT	49632.9	41061.3	42745.0	33207.1	38067.3	33335.0	30993.8	24714.6	83%	104%	88%	93%
Acute Medical Unit	1629.3	1640.5	2034.0	2045.0	1860.0	1728.5	1452.0	1536.0	101%	101%	93%	106%
Child & Adolescent Unit	3817.2	2695.4	1665.8	1226.8	2580.8	2174.9	768.0	695.3	71%	74%	84%	91%
Critical Care Unit (HIGH)	4364.8	3925.8	715.5	601.5	4190.5	3816.5	504.0	355.0	90%	84%	91%	70%
Elmhurst	758.8	751.0	2682.0	2329.5	744.0	744.5	1989.0	1881.0	99%	87%	100%	95%
Maternity Unit (Ward 23)	1312.2	1243.7	743.3	670.9	744.0	694.3	744.0	707.2	95%	90%	93%	95%
Midwifery Led Unit	742.1	696.0	0.0	0.0	744.0	744.0	0.0	0.0	94%		100%	
NICU Ward 22	1825.8	1694.4	783.5	554.8	1333.0	1206.5	333.3	290.5	93%	71%	91%	87%
South Cheshire Surveillance (HIGH)	2209.5	1853.5	2995.8	2359.8	2256.0	1833.0	2627.0	1981.8	84%	79%	81%	75%
Ward 1 Coronary Care	2094.5	2136.0	1338.2	919.2	1524.0	1477.3	972.0	744.0	102%	69%	97%	77%
Ward 10 Ortho Trauma	2352.5	1773.0	3089.0	2474.5	1188.0	1116.0	1968.0	1608.0	75%	80%	94%	82%
Ward 11 Covid (HIGH)	1918.0	1600.0	1684.3	1313.0	1284.0	1140.0	1356.0	1128.0	83%	78%	89%	83%
Ward 12 SAU	1269.0	1058.7	866.5	668.5	804.0	744.0	840.0	720.0	83%	77%	93%	86%
Ward 12 Surgical Speciality	1313.5	1139.5	971.5	657.0	768.0	696.0	564.0	458.0	87%	68%	91%	81%
Ward 13 Medical	1396.4	833.1	1247.5	840.0	984.0	804.0	996.0	672.0	60%	67%	82%	67%
Ward 14 Gastroenterology	1454.5	1211.0	1684.5	1548.0	1116.0	924.0	1272.0	1037.8	83%	92%	83%	82%
Ward 15 Covid +Step Down (HIGH)	1825.5	1384.0	1695.5	1284.5	1260.0	1047.0	1428.0	922.0	76%	76%	83%	65%
Ward 21b Rehabilitation	1243.5	956.0	2192.5	1724.5	816.0	744.0	912.0	792.0	77%	79%	91%	87%
Ward 26 Labour	3146.0	2992.9	542.5	491.8	2612.0	2557.6	372.0	372.0	95%	91%	98%	100%
Ward 3 Short Stay Medical	2466.5	1753.3	1745.0	1446.0	1572.0	1295.5	1692.0	1344.0	71%	83%	82%	79%
Ward 4 Surveillance	1356.0	1154.8	2016.0	1488.0	1152.0	924.0	1500.0	1248.0	85%	74%	80%	83%
Ward 5 Covid (HIGH)	2427.0	1728.0	1810.5	1481.5	1724.5	1400.5	1860.0	1416.0	71%	82%	81%	76%
Ward 6 Rehab	1780.5	1490.0	2322.0	1969.0	1596.0	1344.0	1176.0	1032.0	84%	85%	84%	88%
Ward 7 Surveillance (HIGH)	2284.5	2003.0	2523.5	1780.0	1812.0	1512.0	1620.0	1320.0	88%	71%	83%	81%
Ward 9 Elective	1260.0	870.8	1254.0	456.0	876.0	788.5	827.0	315.5	69%	36%	90%	38%
Winter Ward 18	1426.8	1230.3	1741.0	1404.0	852.0	792.0	1344.0	1164.0	86%	81%	93%	87%
Winter Ward 19	1958.8	1246.8	2401.3	1473.3	1674.5	1086.5	1877.5	974.5	64%	61%	65%	52%

Accountable: Director of Nursing and Quality
Data Owner: Information Services
Key Narrative: The highlighted cells reflect wards where the qualified staffing rate is below 85% of planned levels.

Performance

A&E Activity



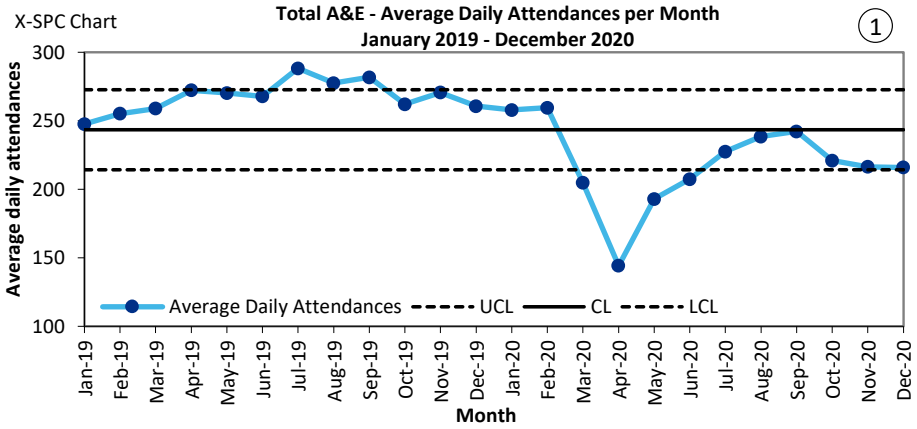


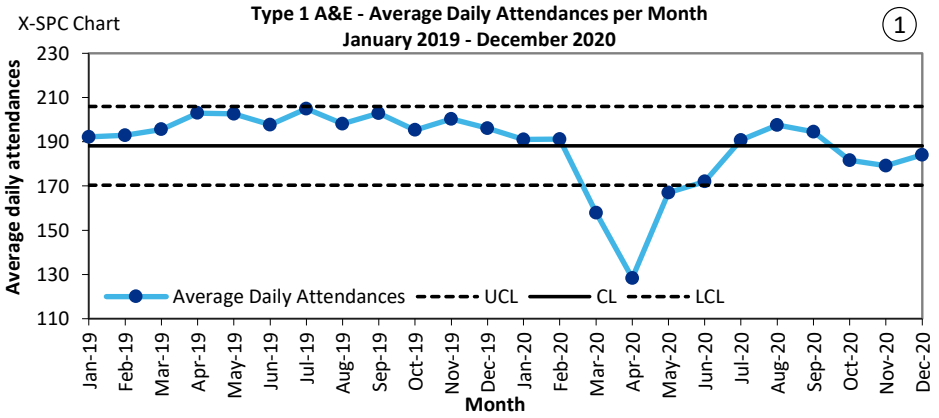
Accountable: Chief Operating Officer
Data Owner: Information Services

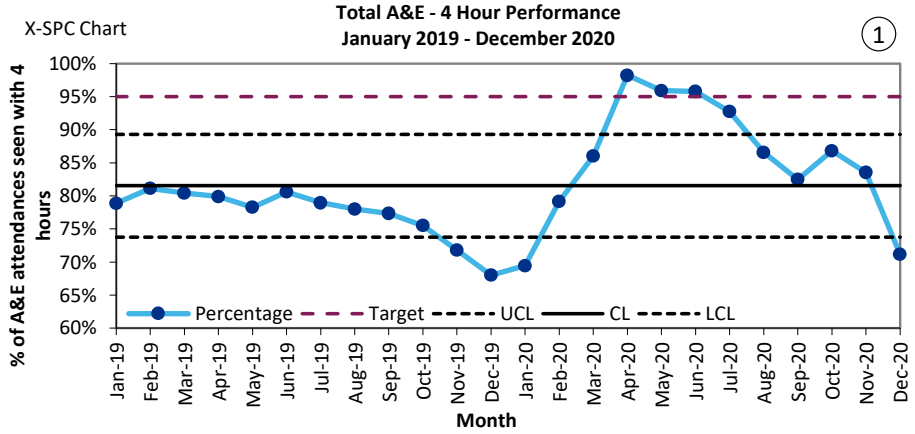
Key Narrative: December 2020 shows 6,696 total A&E attendances across all locations, similar to the previous month and 17.2% lower than December 2019. There were 5,705 attendances reported in December 2020 for the main A&E department at Leighton Hospital (type 1), 6.2% higher than the previous reported month and lower than the same period last year (93.9%). December 2020 activity variance compared to previous month by acuity: Majors +146, Minors -2, Paeds -108, Resus -167.

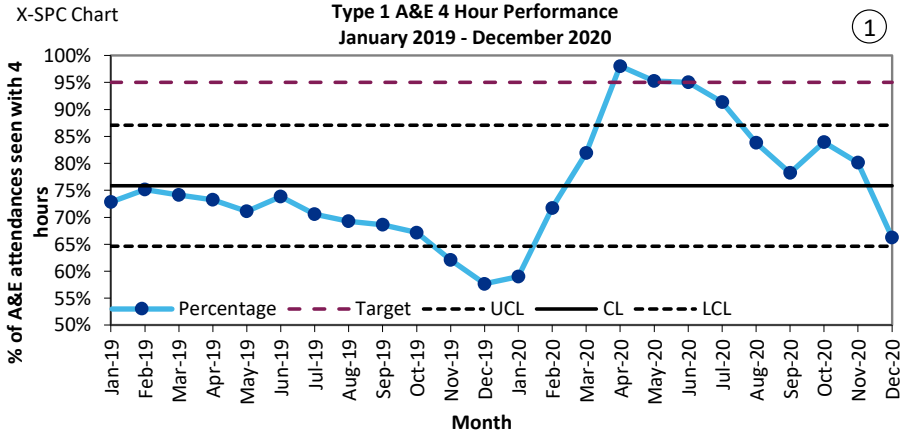
Performance

A&E Performance









Accountable: Chief Operating Officer

Data Owner: Information Services

Key Narrative: The average total daily A&E attendances for December 2020 was 216, similar to the previous two months and 17.2% lower than the same period in the previous year. Type 1 A&E average daily attendances follows a similar pattern with December 2020 2.7% higher than previous month and 6.1% lower than previous year. There was a significant fall in performance against the 4 hour urgent care access standard in December (71%) compared to previous months. But performance remained better compared to the same period last year (68%).

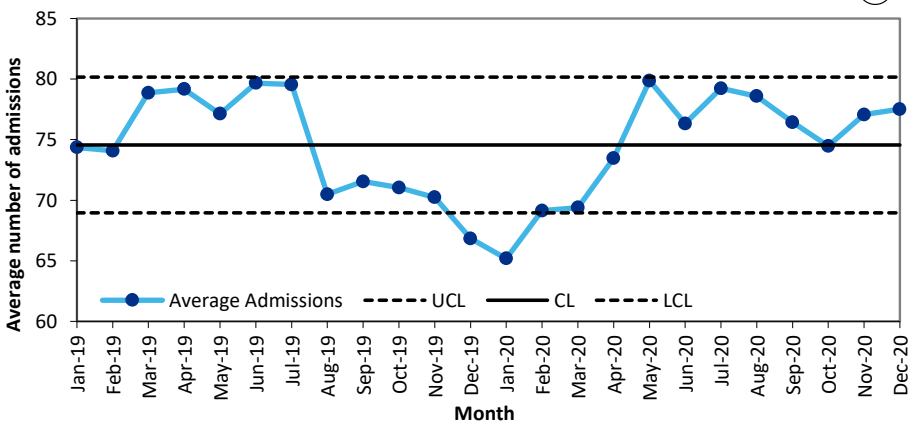
Performance

Unplanned Admissions

X-SPC Chart

Average Daily Admissions from A&E
January 2019 - December 2020

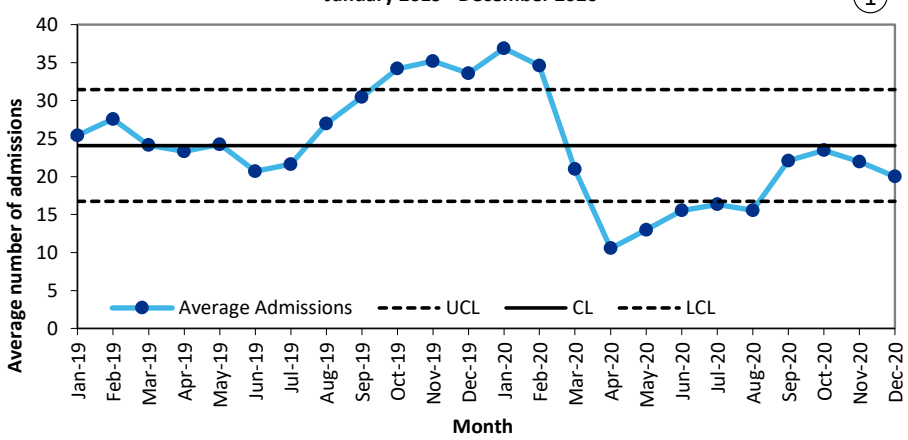
①



X-SPC Chart

Average Daily Admissions per Month - GP Referred
January 2019 - December 2020

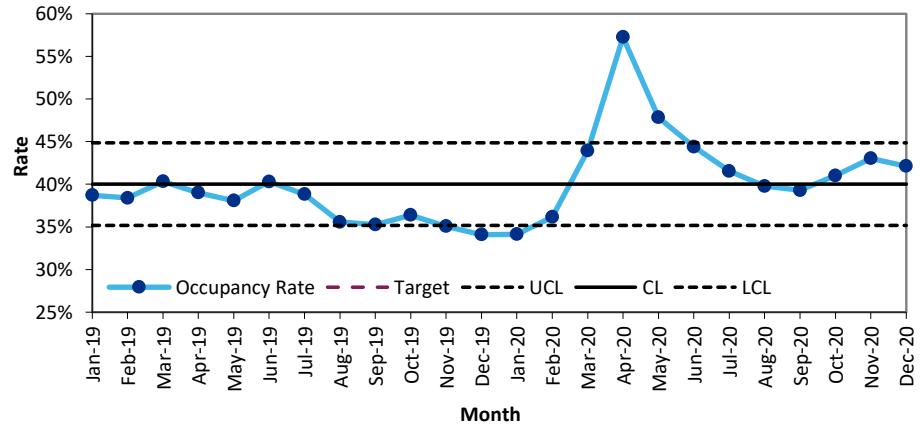
①



X-SPC Chart

Type 1 Attendance to Admissions Conversion Rate - Overall
January 2019 - December 2020

①



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

Key Narrative: There was a change in recording of activity between admissions from A&E and via GP from August 2019 driving some of the variation seen in the average daily admission charts from August 2019 until the onset of the covid pandemic. Activity from March 2020 to date includes admissions to RAU reflecting a new pathway designed to support the covid pandemic averaging 214 admissions per month, which has inflated the position.

Average daily admissions from A&E have increased since October. Average daily admissions via GP increased notably over the last 4 months since the lowest rates seen between April 2020 and August 2020.

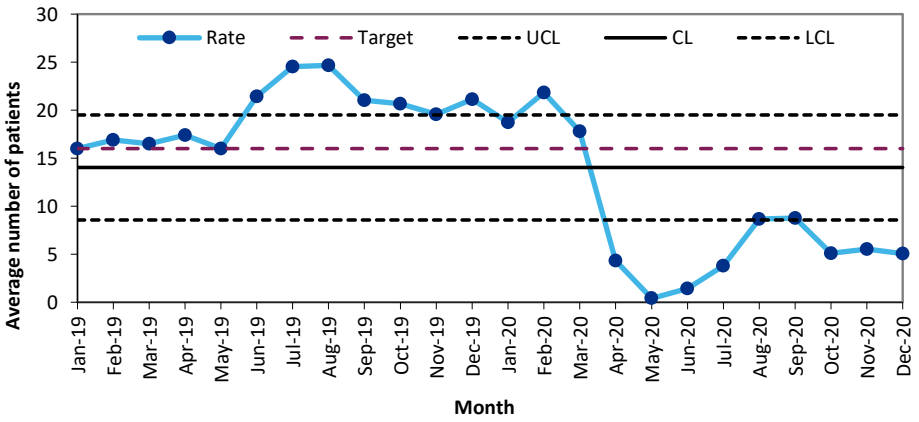
Performance

Inpatient Metrics

X-SPC Chart

Average Number of People Delayed per Day
January 2019 - December 2020

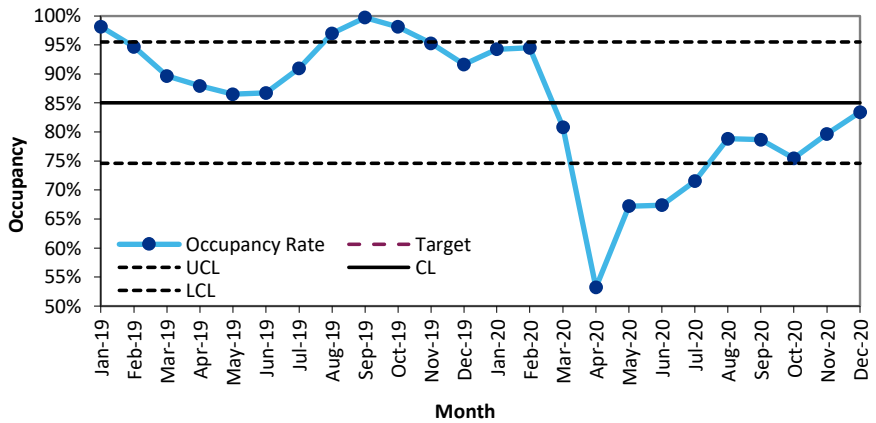
1



X-SPC Chart

Bed Occupancy
January 2019 - December 2020

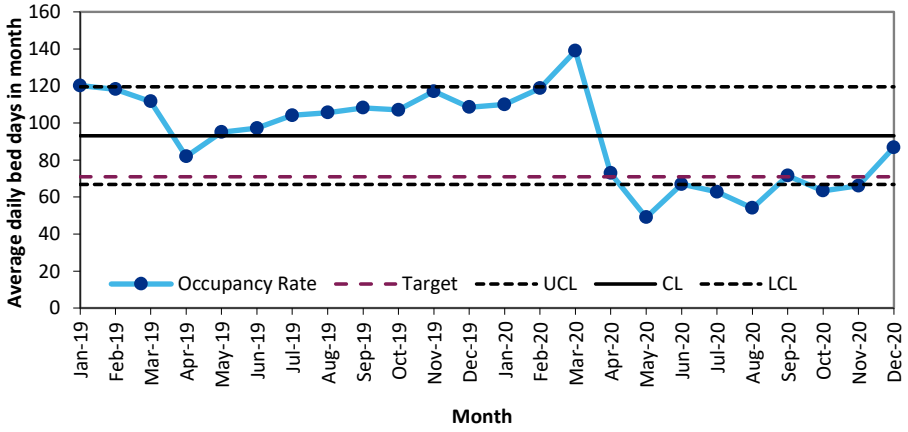
1



X-SPC Chart

Super Stranded Patients
January 2019 - December 2020

1



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

Key Narrative: The average number of people delayed per day during December 2020 was 5.1, similar to the recent months activity and has remained below target since the onset of the covid pandemic.

The number of super stranded patients in the hospital increased from 71 November to 87 in December.

The percentage bed occupancy rate for December 2020 was 83.4%, an increase on the November 2020 occupancy rate of 79.5% and the highest rate seen since the onset of the coronavirus pandemic. The bed occupancy figure reported does not exclude lost beds that are not suitable for patient admissions for infection prevention and control (IPC) reasons.

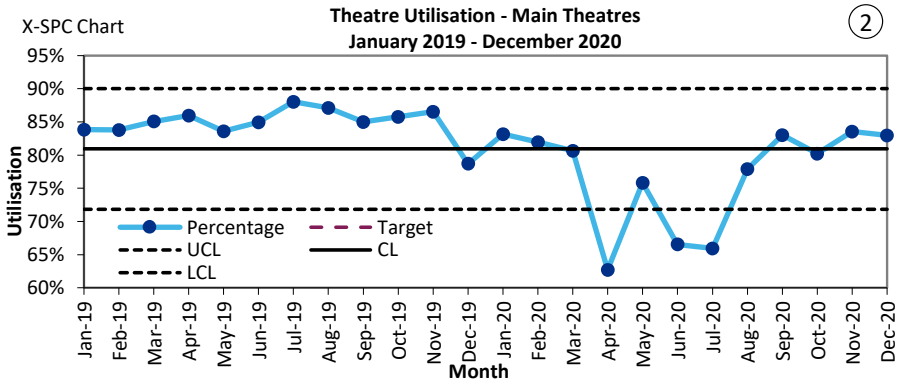
**bed stock numbers used to calculate the bed occupancy rate have been updated from July 2020 to reflect covid ward changes*

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

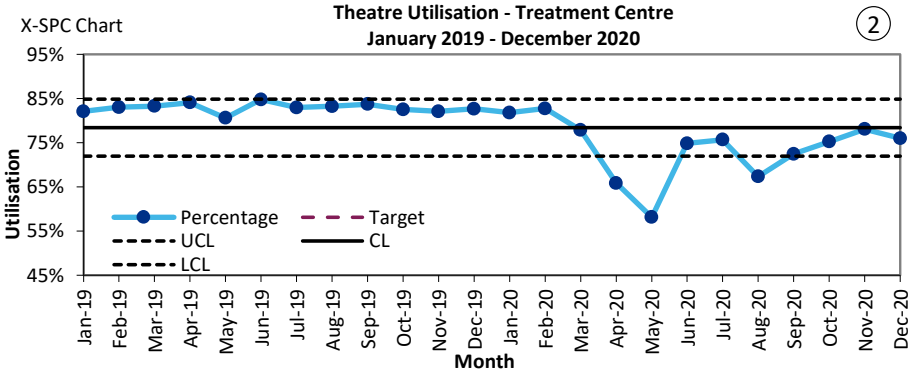
Performance

Theatre Utilisation

X-SPC Chart



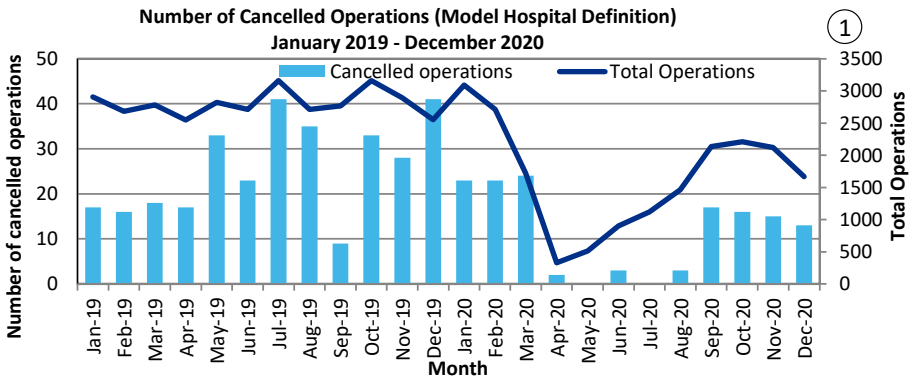
X-SPC Chart



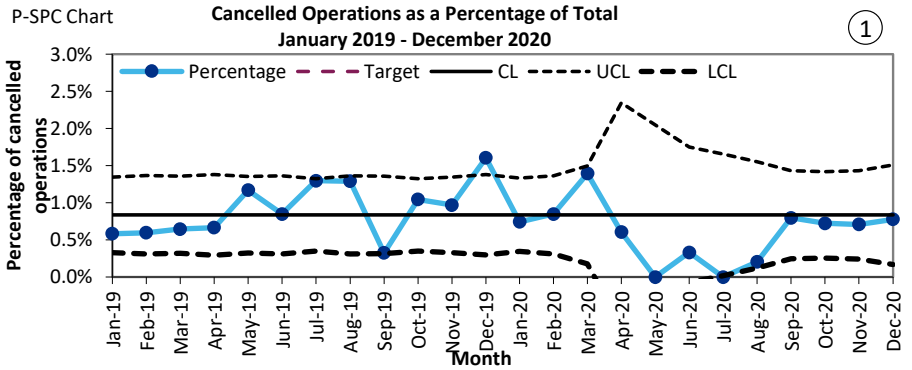
Accountable: Chief Operating Officer **Data Owner:** Information Services

Key Narrative: Theatre utilisation for main theatres in December 2020 was 83.0% and in-line with the previous month. Theatre utilisation in the treatment centre was 76.0%, close to the 24-month average, but lower than in the previous month.

Cancelled Operations



P-SPC Chart



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

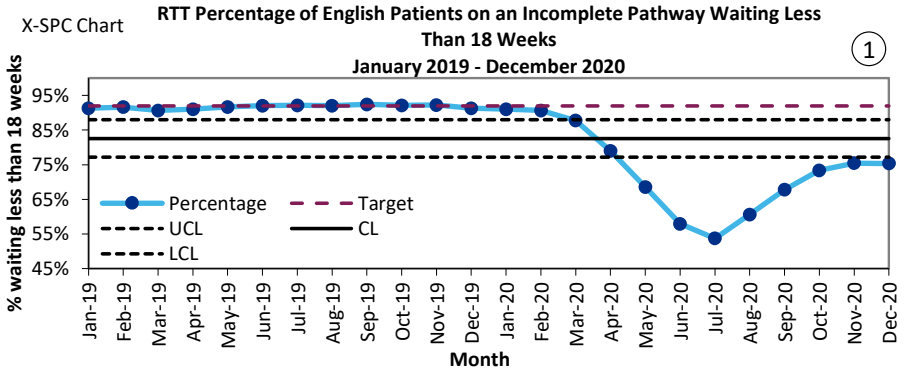
Key Narrative: 13 operations were cancelled on the day of, or after, admission by the hospital for non-clinical reasons in December 2020 (0.8%).

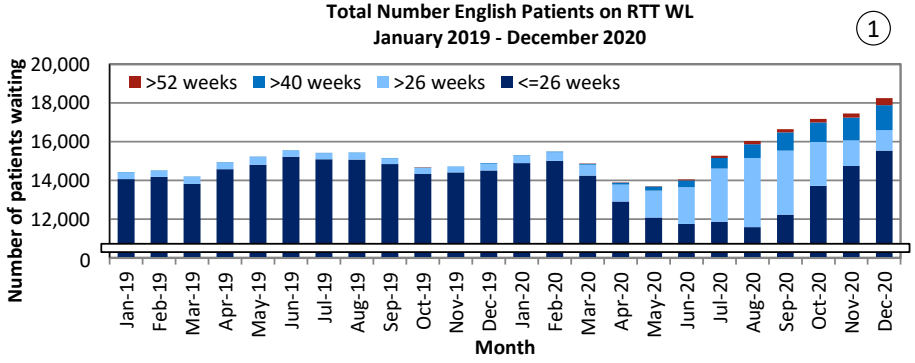
The P-SPC chart adjusts the control limits to take into account each month's denominator.

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

Performance

Referral to Treatment Waiting Times (RTT)



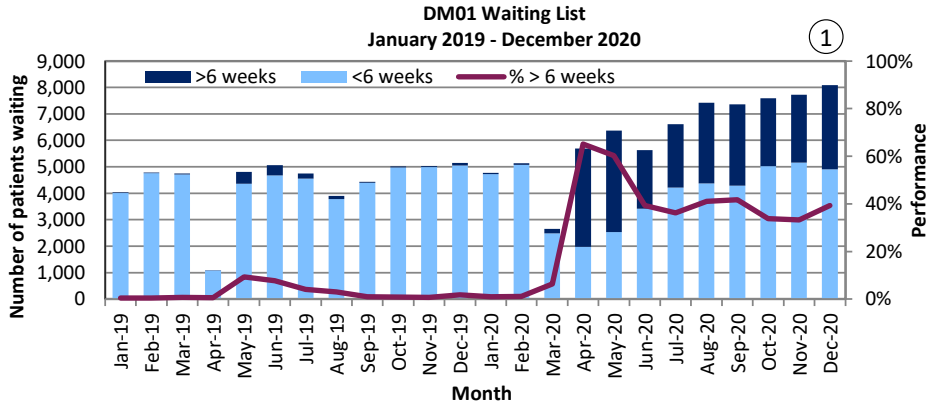


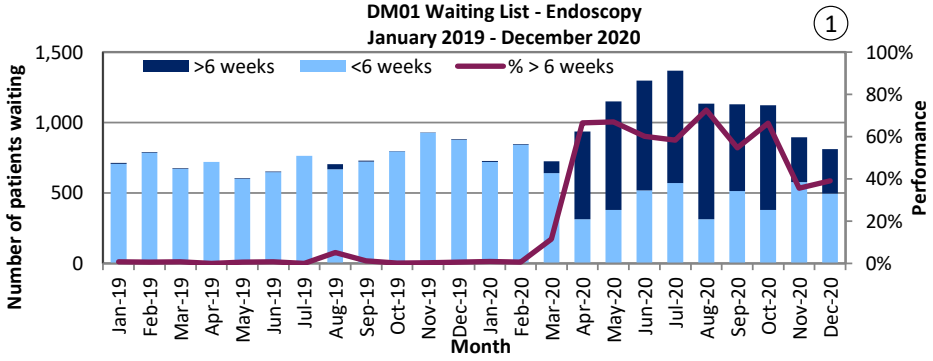
Accountable: Chief Operating Officer **Data Owner:** Information Services

Key Narrative: The total number of patients on the RTT WL continues to grow with 18,246 patients waiting at the end of December 2020, of which 358 patients were waiting for more than 52 weeks, 143 more than reported in November 2020.

Since July, RTT performance has continued to improve., but has plateaued in the last three months. Performance for December 2020 was 75.4%, similar to the previous month, against a standard of 92%.

Diagnostic Waiting Times





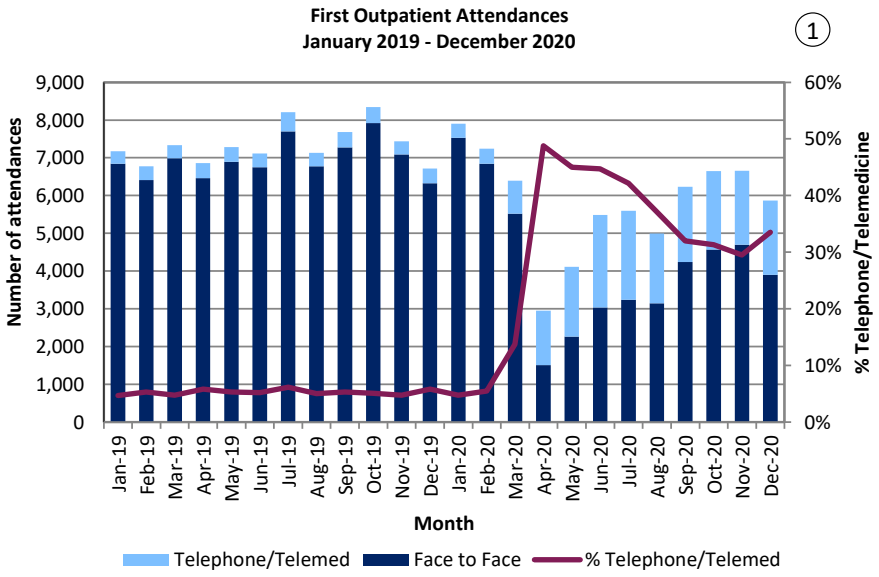
Accountable: Chief Operating Officer **Data Owner:** Information Services

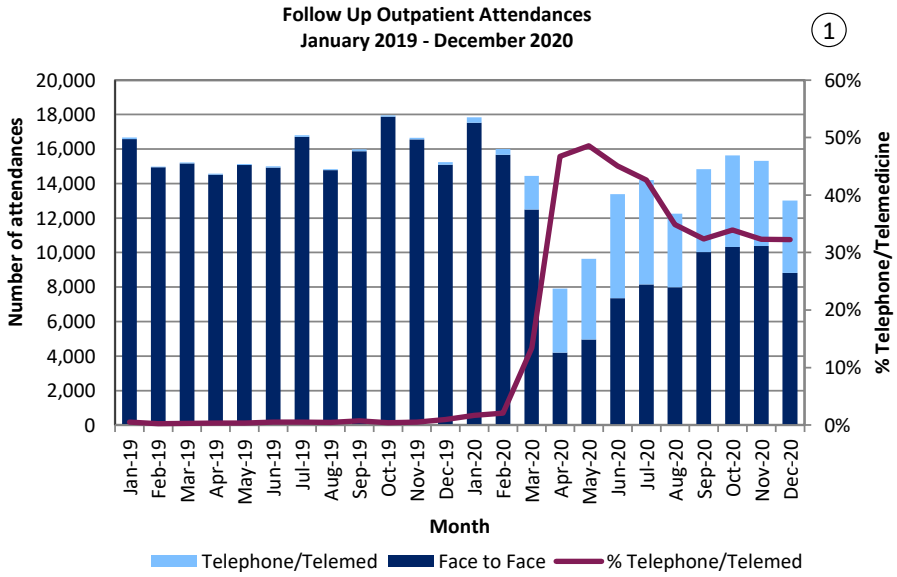
Key Narrative: Performance against t the 1% diagnostic standard continues to improve. However, the total DM01 waiting list is continuing to grow with December 2020 reaching 8,086, an increase of 363 on the previous month. The proportion of patients waiting <6 weeks in December 2020 was 60.7%, a slight improvement on the previous month.

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

Performance

Outpatient Activity





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

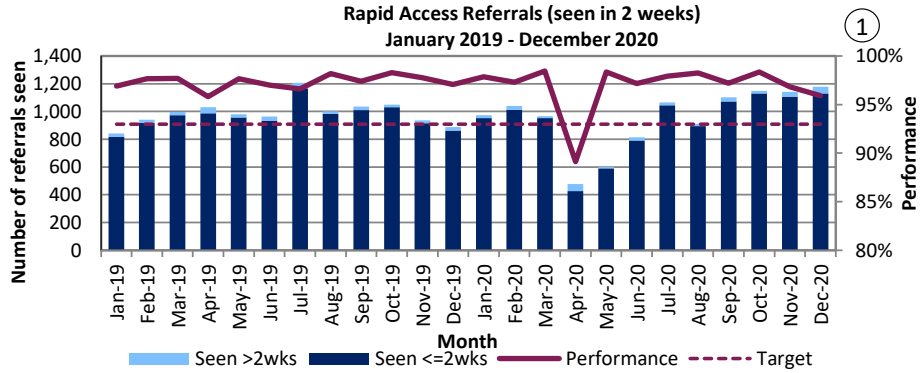
Key Narrative: There were 5,868 total first outpatient appointments attended in December 2020, 88.1% of the total first attendances the previous month and 87.4% of activity compared to December 2019. The proportion of non face to face appointments has increased slightly from the previous month with a rate of 33.5%.

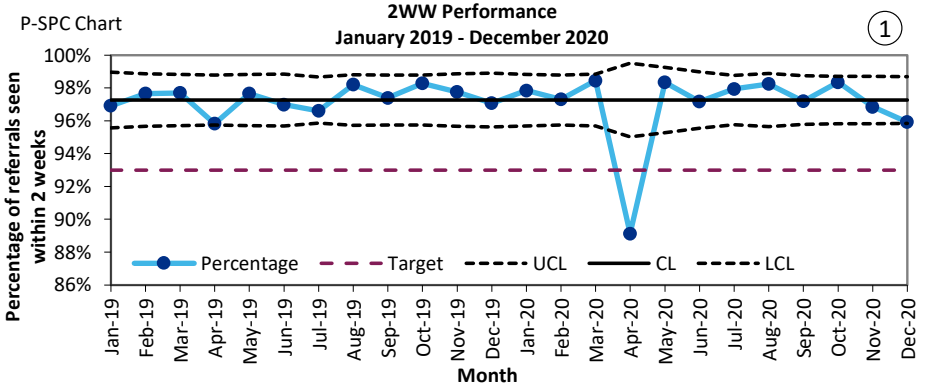
There were 13,017 total follow up outpatient appointments attended in December 2020, delivering 85.0% of November 2020 activity and 85.4% of December 2019. The proportion of non face to face appointments for December 2020 remains consistent at 32.3%.

Data includes contracted specialties.

Performance

Rapid Access Referrals



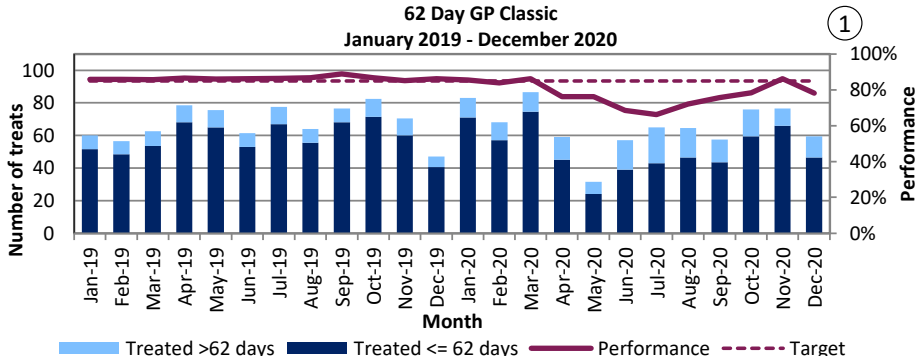


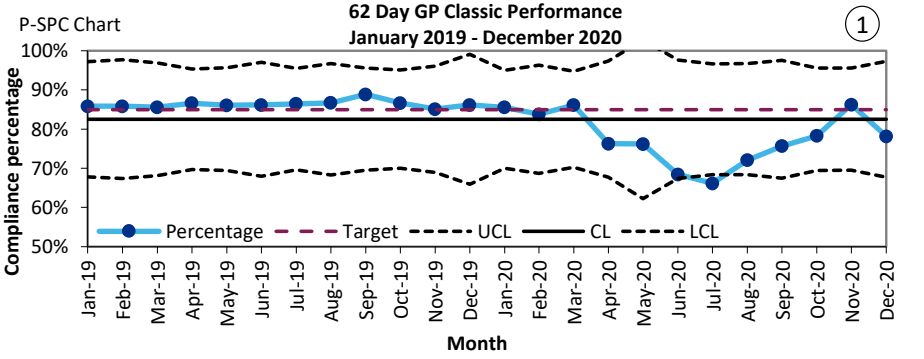
Accountable: Chief Operating Officer **Data Owner:** Cancer Performance

Key Narrative: 1,178 rapid access referrals were seen in December 2020, similar volume to the previous 3 months, and more than same period last year. The 2 week wait performance has consistently delivered above the 93% standard with the exception of April 2020. December 2020 performance was 95.9%. The P-SPC chart adjusts the control limits to take into account the denominator.

Latest month's data provisional.

62 Day





	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
104+day Confirmed Cancer	3	0	3	2	1	8	20	7	2	3	3	5

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

Key Narrative: Provisional performance against the 62-day standard for December 2020 currently reported at 78.2% subject to validation of tertiary referrals and transfer dates, this is likely to improve.

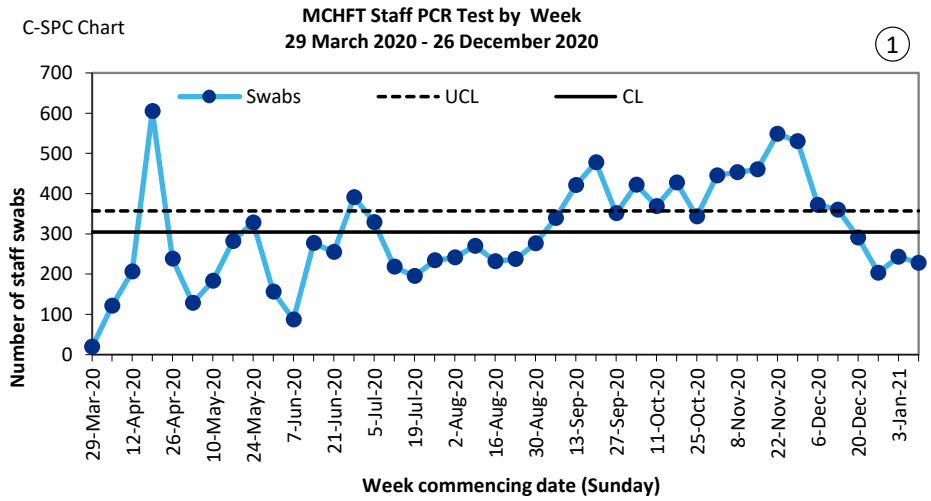
The P-SPC chart adjusts the control limits to take into account the denominator.

Latest month's data provisional.

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

Performance

COVID-19 Staff Swabbing



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

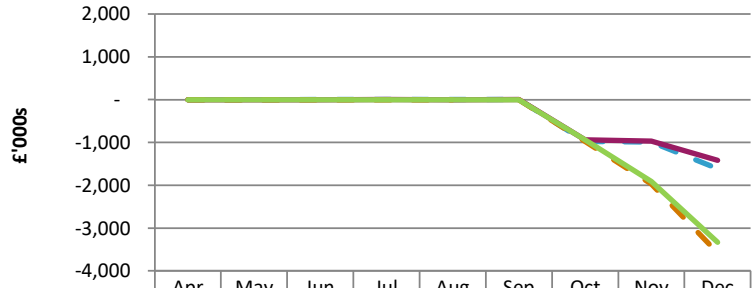
Key Narrative: The chart shows the number of PCR swabs taken for staff members by week start date.

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

Finance

Financial Performance

Financial Performance 2020/21



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
In Month Plan	-0	0	-0	0	-0	0	-979	-990	-1,611
In Month Actual	-1	-0	-0	0	0	0	-936	-972	-1,419
In Month Variance	-0	-0	-0	0	0	0	43	18	192
Cumulative Plan	-0	-0	-0	0	-0	-0	-979	-1,969	-3,580
Cumulative Actual	-1	-1	-1	-1	-1	-0	-936	-1,908	-3,327
Cumulative Variance	-0	-1	-1	-1	-1	-0	43	61	253

Month

	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				

Accountable: Director of Finance **Data Owner:** Finance Department

Current view

The first six months of the financial year saw the Trust operating under a national financial top up arrangement and thus achieved a break-even position, in line with national guidance. For the second six months of the year the Trust has received a financial allocation to balance, and the Trust is forecasting a £9.5m deficit an original forecast of £10.2m. The cumulative deficit at the end of December was £3.6m which is in line with the forecast.

The Trust has received all funding in terms of the top ups requested for the first half of the financial year.

Whilst there has been an increase in net cost within the month, compared to October/November - this is as expected within the phasing of the budget.

Forward view

Regulators are continuing to conduct regular reviews and scrutiny of the financial forecasts that Trusts have submitted, and therefore it is possible that the £9.5m deficit forecast could still change through either changes to allocations or operational pressures.

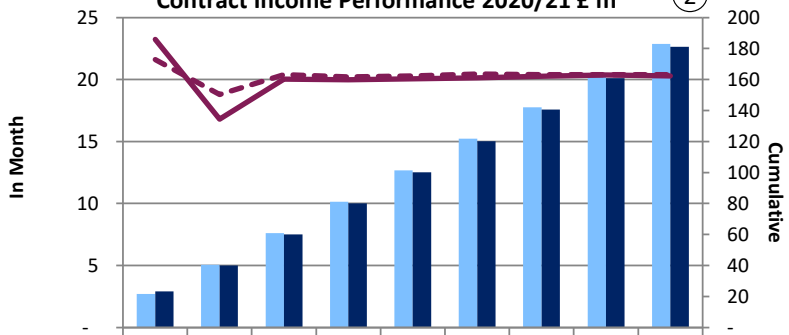
The forecast contains Winter planning, Phase 3 restoration forecast and continuing the support for covid-19 affected areas of the hospital.

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

Finance

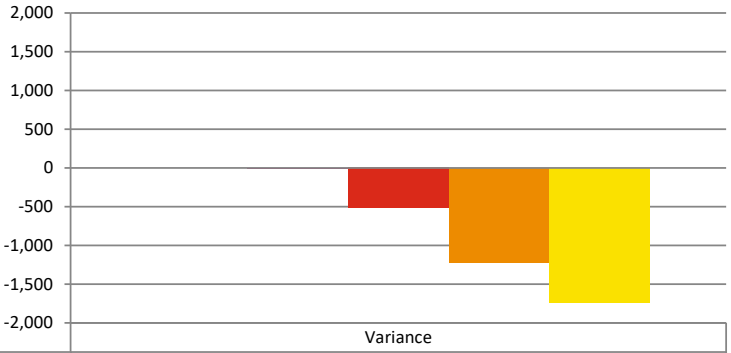
Contract Income

Contract Income Performance 2020/21 £'m ②



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Cumulative budget	22	40	61	81	101	122	142	163	183
Cumulative actual	23	40	60	80	100	120	141	161	181
In month budget	22	19	20	20	20	20	20	20	20
In month actual	23	17	20	20	20	20	20	20	20

Cumulative Variance to Patient Care Income Plan £'000s ②



	Variance
Inter System Block	-0
Intra System Block	-0
Non Block	-516
Other	-1,223
Total	-1,739

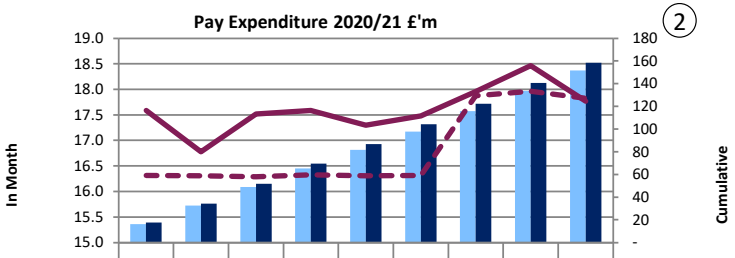
Accountable: Director of Finance **Data Owner:** Finance department

Current View:
Income from Patient Care activity is £1.7m below plan. Contract income is £0.5m below plan which relates to non-contract/cross border flow activity, not currently being billed as per covid-19 guidelines. Private patient and the ICRS income is under plan by £1.2m year to date, as a result of the reduced activity within the hospital and social distancing measures in place.

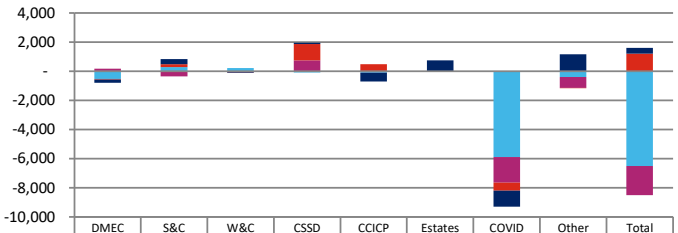
Forward View:
The regulatory expectation organisations manage to a system control total for October to March, with anticipated variations in respect of pandemic measure such as the GP hot hubs, and vaccinations. Contract guidance for 2021/22 is anticipated in the coming weeks.

Finance

Pay



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Cumulative budget	16	33	49	65	82	98	116	134	152
Cumulative actual	18	34	52	69	87	104	122	141	158
In month budget	16	16	16	16	16	16	18	18	18
in month actual	18	17	18	18	17	17	18	18	18



	DMEC	S&C	W&C	CSSD	CCICP	Estates	COVID	Other	Total
Total	-609	463	98	1,876	-222	751	-9,292	22	-6,914
Infrastructure Support Staff	-233	348	-47	92	-588	751	-1,101	1,174	396
Non Clinical Staff	-37	200	-4	1,127	472	-	-541	-16	1,201
Medical Staff	186	-361	-70	737	-4	-	-1,758	-730	-1,999
Nursing Staff	-524	281	219	-80	-102	-	-5,892	-406	-6,506

Accountable: Director of Finance **Data Owner:** Finance Department

Current View:

The cumulatively Pay is worse than the NHSI expectation by £6.9m, £6.4m of this relates to the first half of the year. The increase in pay costs were anticipated in the forecast and within month there is little variance against budget.

Whilst there is a key focus on the nursing expenditure, medical pay has also increase as a result of the need to cover more areas of the hospital. These areas of expenditure are closely monitored by the executive team in the form of regularly acuity reviews, which are documented and agreed.

The Pathology network transfer was completed on the 1st December and therefore there is an offsetting movement from pay to non pay of £0.9m.

Forward View:

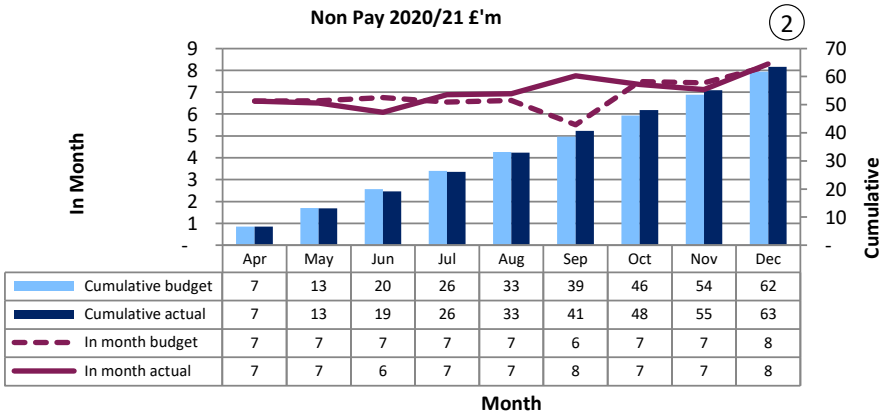
There is significant pressure on the pay budgets as a result of measures put in place to support the Trust with the pandemic, which will continue into Q4 of 2020/21.

The forecast takes into account the additional pressure expected over the winter period, which will increase the pay expenditure – however this does not take into account some of the extremely challenging scenarios currently being faced including opening additional critical care beds – this may mean that the pay forecast may well rise higher than expected, though some of these costs will be offset by the pausing of the restoration programme.

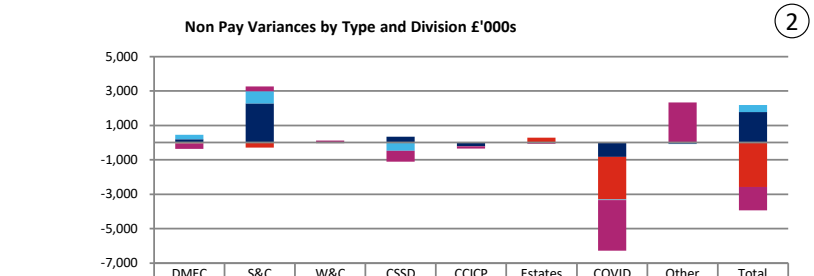
Looking beyond the short term, the trust has been supported with additional funding to increase substantive HCAs, and expand the International nurse recruitment programme.

Finance

Non-Pay



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Cumulative budget	7	13	20	26	33	39	46	54	62
Cumulative actual	7	13	19	26	33	41	48	55	63
In month budget	7	7	7	7	7	6	7	7	8
In month actual	7	7	6	7	7	8	7	7	8



	DMEC	S&C	W&C	CSSD	CCICP	Estates	COVID	Other	Total
Total	105	2,961	87	-752	-346	220	-6,279	2,251	-1,752
Other Non Pay	-298	279	94	-639	-141	-67	-2,940	2,342	-1,369
Drugs	256	696	-27	-462	-2	-0	-35	-21	405
Non Clinical Supplies	-56	-297	-6	-3	-9	276	-2,478	2	-2,571
Clinical Supplies	202	2,284	26	352	-194	11	-825	-71	1,784

Accountable: Director of Finance **Data Owner:** Finance Department

Current View:

Non-Pay was £1.7m worse than the expectations set out by NHSI regulators, with the majority of this overspend occurring during the first 6 months of the year.

This quarter has seen a reduction in PPE expenditure, reflected in the forecast which has resulted from the majority of PPE being distributed to Trusts centrally rather than purchased directly. There has been an increase in clinical supplies as a result of the increased number of patients attending the hospital.

The Pathology network transfer was completed on the 1st December and therefore there is an offsetting movement from pay to non pay of £0.9m.

Forward View:

The Trust has reflected changes to the costs associated with PPE and to a lesser degree restoration costs within the latest forecast to regulators.

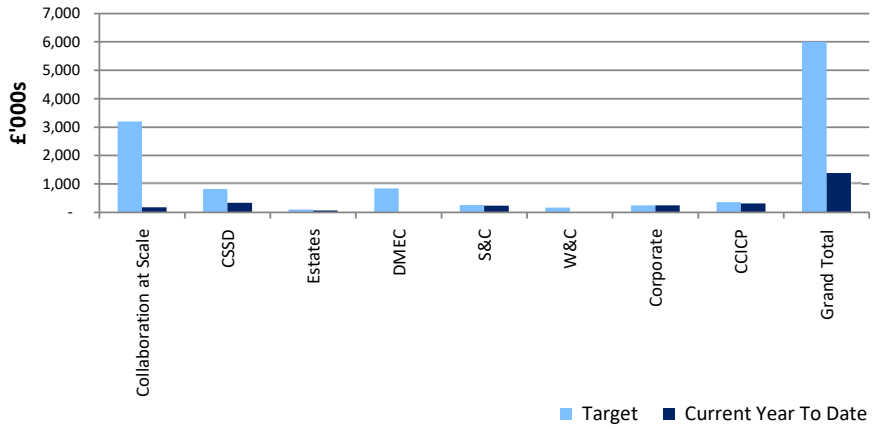
Whilst the Trust will continue to support the restoration of services, it is expected that there will be a reduction in the level of expenditure on planned care areas such as prosthesis and high cost drugs as the Trust will focus support on unplanned care. This will in part offset the expected increases in pay that this will bring in the form of premium agency and bank incentive costs.

Finance

Cost Improvement Programmes (CIP)

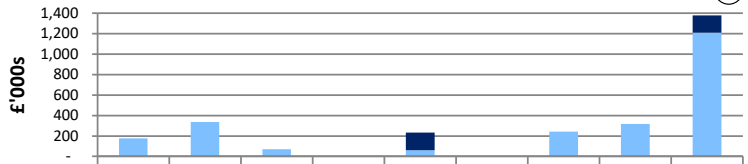
Year to Date CIP Delivery v Plan Total

(2)



CIP Performance Actual by Division

(2)



	Collaboration at Scale	CSSD	Estates	DMEC	S&C	W&C	Corporate	CCICP	Grand Total
Current Year To Date	176	335	72		232	3	243	319	1,380
Pay					171				171
Non pay	176	335	72		61	3	243	319	1,209

Accountable: Director of Finance **Data Owner:** Finance Department

Current View:

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, with a particular focus on collaboration at scale schemes that can be progressed.

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

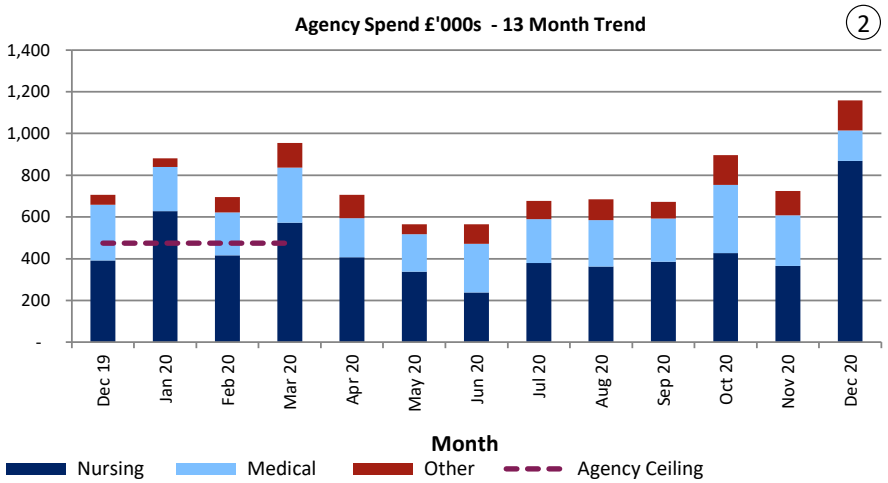
Forward View:

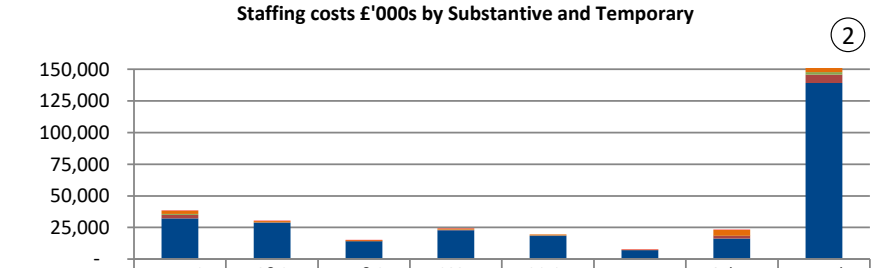
Work that the collaboration at scale work stream has previously put forward for system wide opportunities will be reviewed both in terms of time frames in light of the impact of Covid-19 - but also their direct impact on the Trust.

Schemes within medicines management, workforce, IT, estates and procurement are under development and being progressed in order to keep a level of momentum within collaboration at scale programme.

Finance

Bank and Agency





	DMEC	S&C	W&C	CSSD	CCICP	Estates	Other	Total
Total	38,507	30,442	14,974	24,171	19,495	7,454	23,385	158,428
Waiting List	196	292	31	38	-	1	400	958
Bank	2,490	744	646	683	401	378	4,394	9,735
Locum	793	272	45	297	288	-	146	1,842
Agency	2,936	570	136	293	410	2	2,301	6,648
Substantive	32,093	28,565	14,115	22,860	18,396	7,072	16,144	139,246

Accountable: Director of Finance **Data Owner:** Finance Department

Current View:

Agency expenditure was £1.2m in the month of December, reflecting the severe challenges that the trust faced during the month, particularly in staffing rotas with nursing.

Within registered nursing, the challenge with agency use lies within the increased Covid positive wards, which require a higher ratio of nursing staff, an expanded Critical care unit, Emergency Department, surveillance wards, and other key specialised areas such as the Child & Adolescent unit.

Forward View:

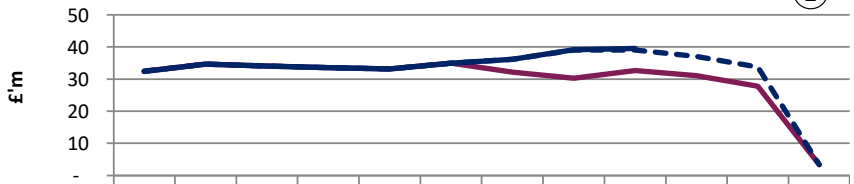
The international nurse recruitment programme continues, and the Trust is progressing the further International Nurse recruits as part of the Cheshire & Mersey Collaborative – which has been extended further this month.

In addition the Trust has been successful in a bid for support the rapid reduction of HCA vacancies within the Trust.

Finance

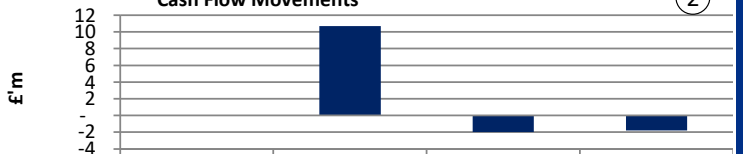
Cash

Cash Position



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Plan	32	35	34	34	33	35	32	30	33	31	28	3
Actual	32	35	34	34	33	35	36	39	40			
Forecast	32	35	34	34	33	35	36	39	39	37	34	3

Cash Flow Movements



	Operating Surplus / (Deficit)	Increase / (Decrease) in Working Capital	Net Cash Inflow / (Outflow) from Capital Expenditure	Net Cash Inflow / (Outflow) from Borrowings
Variance to Opening Balance	-0	11	-2	-2

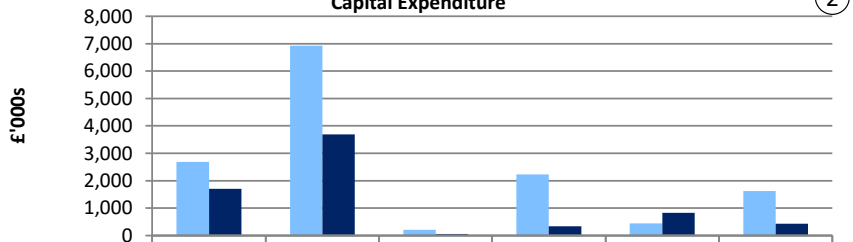
Accountable: Director of Finance **Data Owner:** Financial Services

Current View: Cash is better than anticipated by £7m. Due to a decrease in Trade Receivables of £4.5m mainly due to the payment of M6 Top-up (£2.4m), £3.1m received in advance for COVID Top-up, and reduction in Trade payables of £1m.

Forward View: The cash position includes £20m of contract income paid in advance to support cash flow during the COVID-19 pandemic, this is expected to be repaid in March 2021.

Capital

Capital Expenditure



	Rolling Estates	Strategic Estates	Rolling IT	Strategic IT	Other	Leases
Plan	2,690	6,928	210	2,225	445	1,625
Actual	1,703	3,694	52	334	831	425

		Year to Date £'000s			Year End £'000s		
		Plan	Actual	Variance	Plan	Forecast	Variance
Estates	Rolling	2,690	1,703	-987	4,292	6,379	2,087
Estates	Strategic	6,928	3,694	-3,234	8,223	7,535	-688
IT	Rolling	210	52	-158	353	305	-48
IT	Strategic	2,225	334	-1,891	5,655	1,732	-3,923
Other		445	831	386	11,152	11,096	-56
Leases		1,625	425	-1,200	3,679	2,500	-1,179
		14,123	**7,039**	**-7,084**	**33,354**	**29,547**	**-3,807**

Accountable: Director of Finance **Data Owner:** Financial Services

Current View: The capital underspends based on the original NHSI plan on are due to slippage on seven major schemes, notably Maintenance & Refurbishment of £2.0m and Car Park Expansion £1.0m.

Forward View: The EPR and EPMA schemes are expected to slip into 21/22 to the value of £3m. New schemes added to the plan and forecast for ED £9.4m and Endoscopy £0.8m.

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

Finance

Statement of Financial Position December 2020

		Plan Apr to December (£'000)	Actual Apr to December (£'000)	Variance (£'000)
Assets	Assets, Non-Current	107,145	106,838	-307
	Assets, Current	48,818	51,070	2,252
ASSETS, TOTAL		**155,963**	**157,908**	**1,945**
Liabilities	Liabilities, Current	-44,506	-48,123	-3,617
	Liabilities, Non Current	-8,987	-9,294	-308
TOTAL ASSETS EMPLOYED		**102,470**	**100,491**	**-1,979**
Taxpayers' and Others' Equity				
	Taxpayers Equity	102,470	100,491	-1,979
TOTAL FUNDS EMPLOYED		**102,470**	**100,491**	**-1,979**

(2)

Accountable: Director of Finance **Data Owner:** Financial Services

Current View:
The main Balance Sheet movements are a decrease in Trade Receivables of £4.5m, mainly due to receiving the M6 COVID Top-up. In addition, £3.1m of COVID Top-up funding has been received in advance. Both of which contribute to cash being £7m better than plan.

PDC of £1.9m has been received in November for Critical Infrastructure capital schemes.

Forward View:
Over the coming months the only significant changes anticipated to the Balance Sheet is the receipt of funding for the new ED build, and additional funding Endoscopy.

COVID Capital Schemes December 2020

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

(2)

Accountable: Director of Finance
Data Owner: Financial Services

Current View:
These capital schemes are now all spent, however to date the agreed funding has not yet been received.

Forward View:
Funding to be followed up with NHSI.

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

Finance

Income and Expenditure

Budget 2020/21 £'000		Month			Year to Date			Forecast
		Plan Nov (£'000)	Actual Nov (£'000)	Variance Nov (£'000)	Plan April to Nov (£'000)	Actual April to Nov (£'000)	Variance April to Nov (£'000)	2020/21 (£'000)
	Operating							
	Operating Income							
	Commissioning Income							
222,328	Inter System Block	18,787	18,658	(129)	167,923	166,743	(1,180)	222,328
19,555	Intra System Block	1,453	1,453	0	13,081	13,081	(0)	19,555
180	Non Block	143	172	28	1,910	1,353	(557)	180
242,063	**Total Commissioning Revenue**	**20,384**	**20,283**	**(101)**	**182,914**	**181,177**	**(1,737)**	**242,063**
12,616	*Other Operating Income*	1,650	1,966	316	21,675	21,901	225	12,616
254,679	**TOTAL OPERATING INCOME**	**22,034**	**22,249**	**215**	**204,590**	**203,078**	**(1,512)**	**254,679**
	Operating Expenses							
(205,373)	Employee Benefits Expenses (Pay)	(17,822)	(17,766)	56	(151,515)	(158,428)	(6,914)	(205,373)
(17,803)	Drugs	(1,481)	(1,543)	(61)	(13,359)	(12,954)	405	(17,803)
(19,388)	Clinical Supplies	(1,656)	(1,799)	(143)	(14,561)	(12,777)	1,784	(19,338)
(3,725)	Non Clinical Supplies	(314)	(425)	(110)	(2,756)	(5,328)	(2,571)	(3,385)
(46,634)	Other operating expenses	(4,733)	(4,520)	213	(31,035)	(32,405)	(1,369)	(46,634)
(292,924)	**TOTAL OPERATING EXPENSES**	**(26,007)**	**(26,053)**	**(46)**	**(213,226)**	**(221,891)**	**(8,665)**	**(292,534)**
(38,245)	**EBITDA**	**(3,973)**	**(3,804)**	**169**	**(8,637)**	**(18,814)**	**(10,177)**	**(37,855)**
	Non Operating							
	Non Operating Income							
(379)	Interest	(5)	(17)	(13)	(280)	(125)	155	(379)
0	Asset disposal	0	0	0	0	0	0	0
	Non-Operating Expenses							
(6,432)	Depreciation & Finance Leases	(535)	(508)	27	(4,829)	(4,437)	391	(6,332)
(2,248)	PDC Dividend Expense	(187)	(180)	7	(1,686)	(1,620)	66	(1,998)
(47,304)	**Adjusted Financial Performance surplus/(deficit)**	**(4,700)**	**(4,509)**	**190**	**(15,431)**	**(24,996)**	**(9,565)**	**(46,564)**
8,762	Baseline M1 - 6	0	0	0	8,762	8,762	0	8,762
9,818	COVID Top Up M1 - 6	0	0	0	0	9,818	9,818	9,818
9,798	Baseline M7-12	1,633	1,633	0	1,633	1,633	0	9,798
8,736	COVID Top Up M7 - 12	1,456	1,456	0	1,456	1,456	0	8,736
(10,190)	**Net Surplus/(deficit) before Exceptional Items**	**(1,611)**	**(1,420)**	**190**	**(3,579)**	**(3,327)**	**253**	**(9,450)**
0	Donations for purchase of assets	0	0	0	0	0	0	0
0	Depreciation on Donated Assets	0	(24)	(24)	0	(224)	(224)	0
0	Prior Period Adjustments	0	0	0	0	0	0	0
(10,190)	**Net Surplus/(Deficit) after Exceptional Items**	**(1,611)**	**(1,444)**	**166**	**(3,579)**	**(3,551)**	**29**	**(9,450)**

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

Finance

Balance Sheet

Assets Non-Current
The capital programme expenditure is £7.1m less than the anticipated plan, mainly due to slippage on the Maintenance & Refurbishment of £2.0m and Car Park Expansion £1.0m.

Assets Current
Cash is better than plan by £7m mainly due to lower Trade Receivables and the receipt of £3.1m additional income in advance. The cash balance includes £20m of contract income being paid in advance to support cash flow during the COVID pandemic.

Current Liabilities
Other Financial Liabilities are higher due to increased deferred Income due top up payments of £3.1m being paid in advance. Included in deferred income is £20m which has been paid in advance supporting cash flow during the COVID pandemic. Loans of £13.2m converted to PDC.

Taxpayers Equity
Working Capital Loans and the Interim Capital Loans to the value of £13.2m have been converted to PDC in September.

	Plan Apr to December (£'000)	Actual Apr to December (£'000)	Variance (£'000)
Assets			
Assets, Non-Current	**107,145**	**106,838**	**-307**
Assets, Current			
Trade and other Receivables	9,894	5,358	-4,535
Other Assets (including Inventories & Prepayments)	6,284	6,140	-144
Cash and Cash Equivalents	32,641	39,572	6,931
Total Assets, Current	**48,818**	**51,070**	**2,252**
ASSETS, TOTAL	**155,963**	**157,908**	**1,945**
Liabilities			
Liabilities, Current			
Finance Lease, Current	-419	-107	312
Loans Commercial Current	-156	-146	9
Trade and Other Payables, Current	-12,662	-11,828	834
Provisions, Current	-242	-277	-35
Other Financial Liabilities	-31,027	-35,765	-4,737
Total Liabilities, Current	**-44,506**	**-48,123**	**-3,617**
Net Current Assets/(Liabilities)	**4,312**	**2,947**	**-1,365**
Liabilities, Non Current			
Finance Lease, Non Current	-3,388	-3,696	-308
Loans Commercial Non-Current	-3,651	-3,651	0
Provisions, Non-Current	-1,948	-1,948	0
Trade and Other Payables, Non-Current	0	0	0
Total Liabilities Non-Current	**-8,987**	**-9,294**	**-308**
TOTAL ASSETS EMPLOYED	**102,470**	**100,491**	**-1,979**
Taxpayers' and Others' Equity			
Taxpayers Equity			
Public dividend capital	100,430	98,274	-2,156
Retained Earnings	-15,245	-15,068	177
Donated asset reserve	0	0	0
Revaluation Reserve	17,285	17,285	0
TOTAL TAXPAYERS EQUITY	**102,470**	**100,491**	**-1,979**
TOTAL FUNDS EMPLOYED	**102,470**	**100,491**	**-1,979**

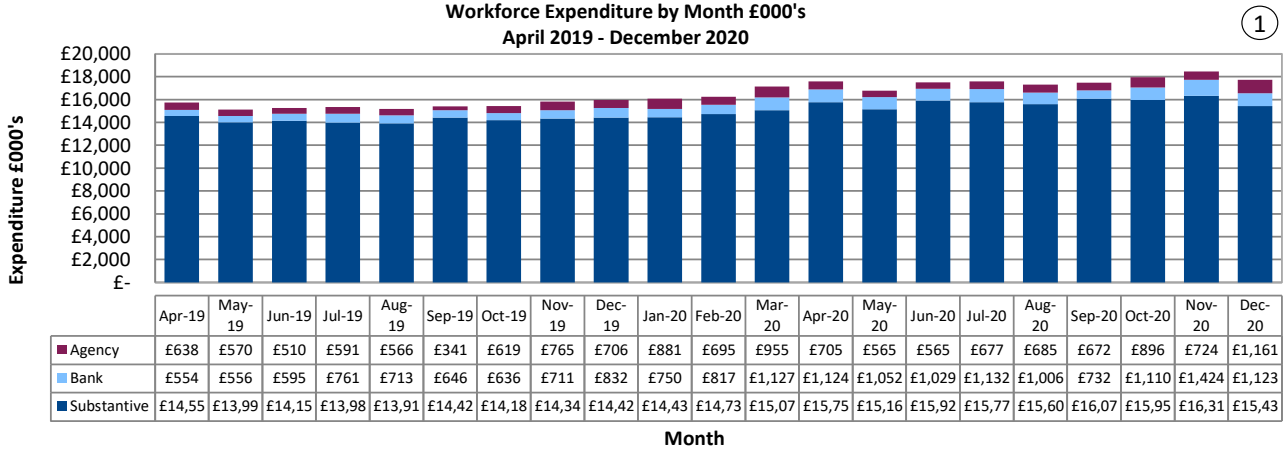
Forward View:

The forecast has been updated to include additional PDC funding and capital spend in relation to the ED build £9.4m and Endoscopy £0.8m.

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

Workforce

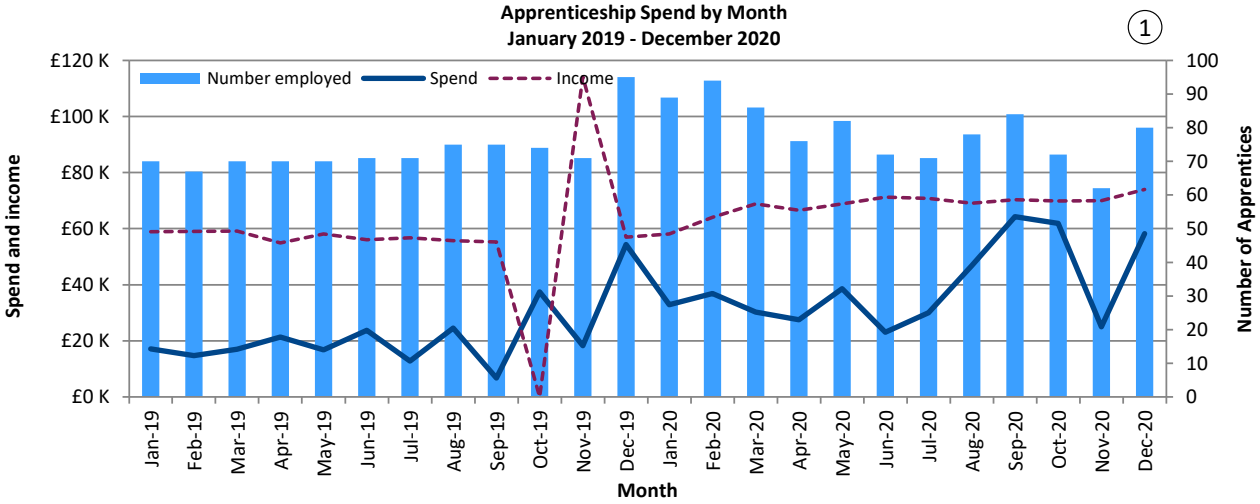
Finance and Costings



	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	Sep-20	Oct-20	Nov-20	Dec-20
Agency	£638	£570	£510	£591	£566	£341	£619	£765	£706	£881	£695	£955	£705	£565	£565	£677	£685	£672	£896	£724	£1,161
Bank	£554	£556	£595	£761	£713	£646	£636	£711	£832	£750	£817	£1,127	£1,124	£1,052	£1,029	£1,132	£1,006	£732	£1,110	£1,424	£1,123
Substantive	£14,55	£13,99	£14,15	£13,98	£13,91	£14,42	£14,18	£14,34	£14,42	£14,43	£14,73	£15,07	£15,75	£15,16	£15,92	£15,77	£15,60	£16,07	£15,95	£16,31	£15,43

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

Key Narrative: Total workforce expenditure for December 2020 is £17,716k, a decrease of £750k (4.1%) from the previous month but 11.0% higher than December 2019. The year to date expenditure is £7,718k above budget (5.1%).



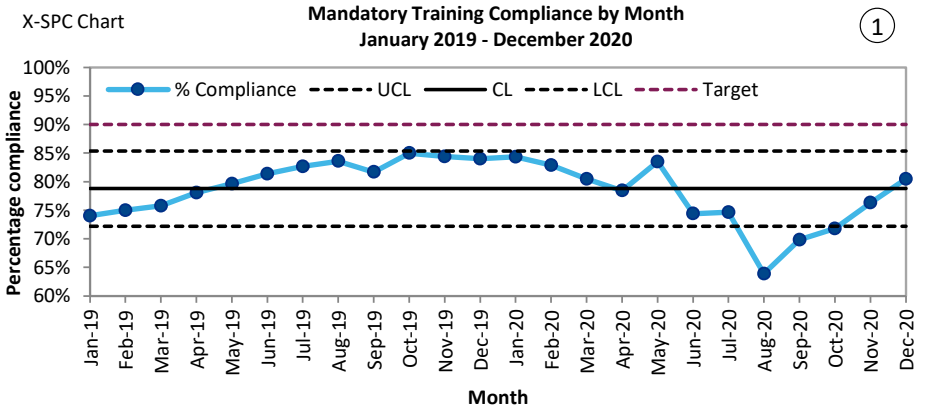
Accountable: Director of Workforce & Organisational Development
Data Owner: Workforce Directorate

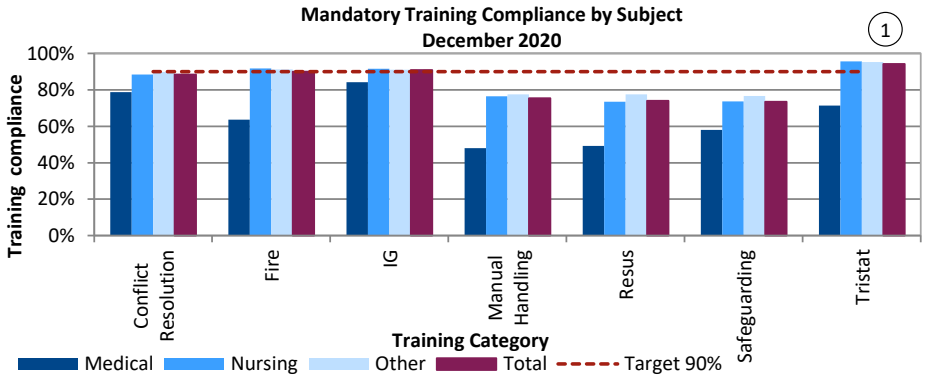
Key Narrative: The number of Apprentices employed in December 2020 was 80, 15.7% lower than the number employed in December 2019 (95).

Apprenticeship spend remains below income.

Workforce

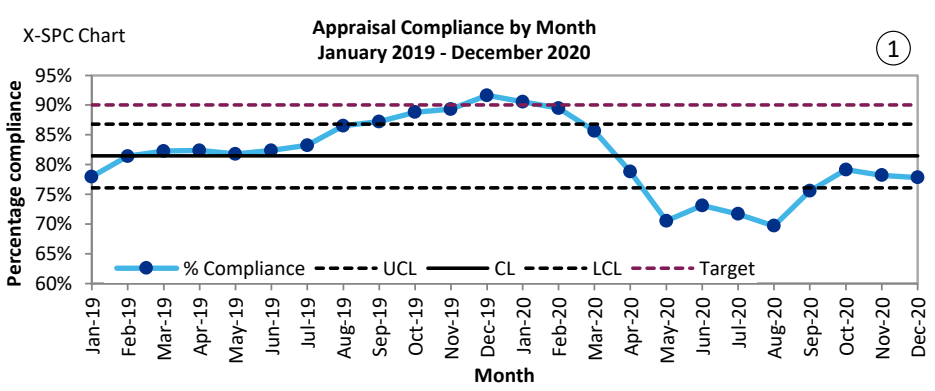
Training

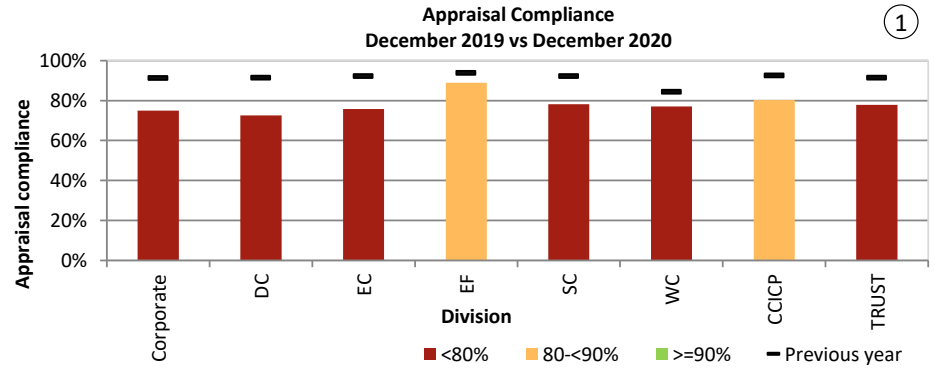




Accountable: Director of Workforce & Organisational Development
Data Owner: Workforce Directorate
Key Narrative: The SPC chart shows an increasing trend for the periods January 2019 to August 2019. August 2020 shows the lowest compliance at 63.9%. Compliance has increased over the last 4 months reaching 80.5% in December 2020 albeit remaining below the 90% target.

Appraisals

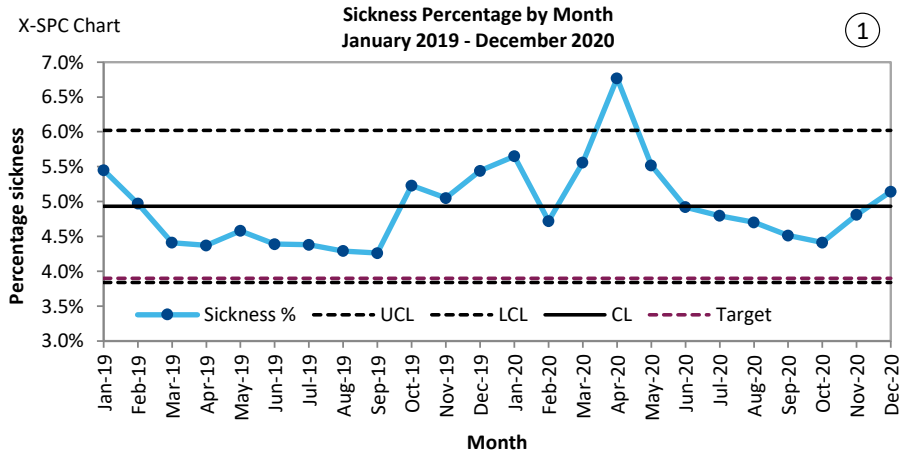




Accountable: Director of Workforce & Organisational Development
Data Owner: Workforce Directorate
Key Narrative: The SPC chart shows increasing compliance from June 2019 peaking in December 2019, 1 of only 2 months to meet the 90% target over the 24 month period. Appraisal compliance for December 2020 was 76.1%, similar to the previous 2 months and an improvement on the period May 2020 to August 2020.

Workforce

Sickness

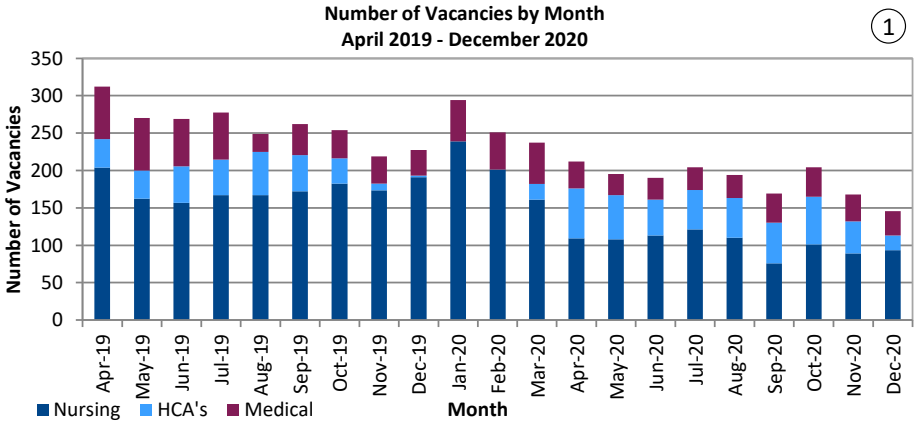


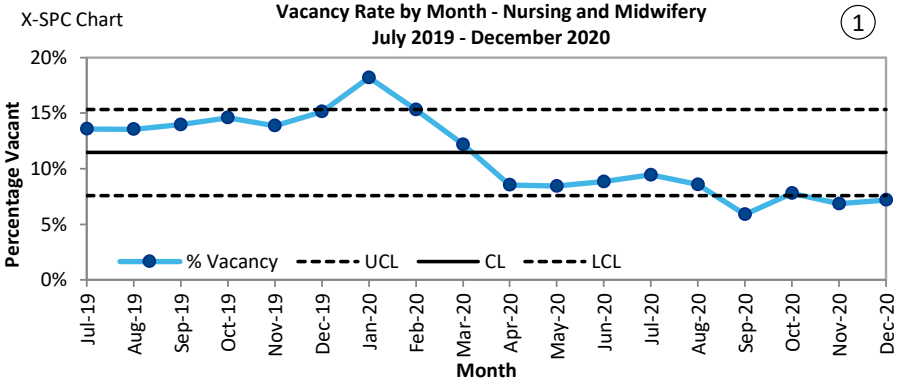
Accountable: Director of Workforce & Organisational Development
Data Owner: Workforce Directorate

Key Narrative: The sickness rate for December 2020 was 5.1%, an increase to the 4.9% sickness rate reporting for November 2020 but below December 2019 sickness rate of 5.4%.

The target has not been met over the 24-month period reported.

Vacancies



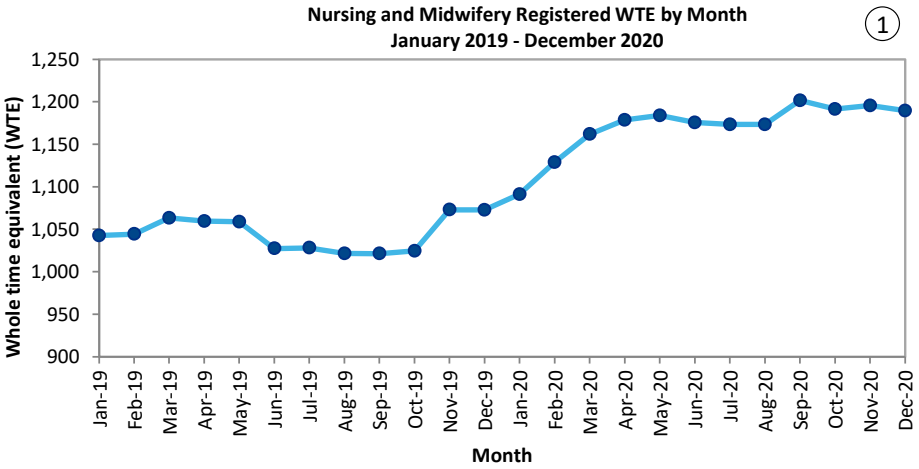


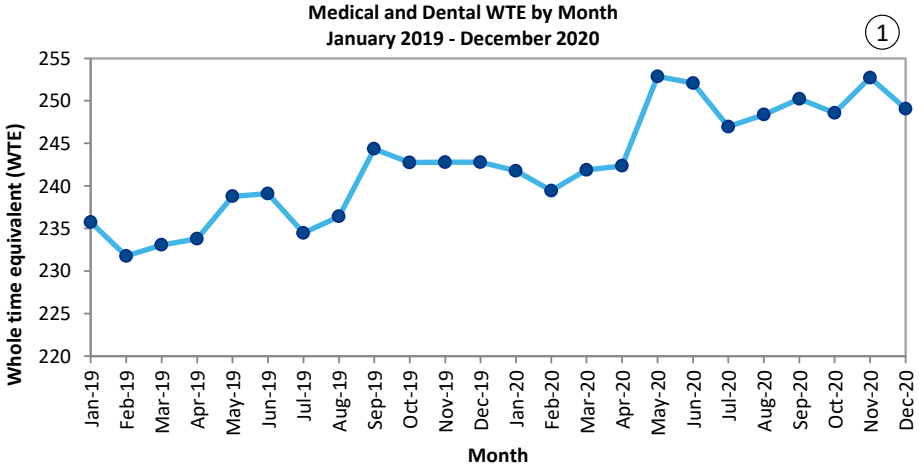
Accountable: Director of Workforce & Organisational Development
Data Owner: Workforce Directorate
Key Narrative: The vacancy figures for the current financial year have been restated to exclude International Recruitment, Nurse Apprentices and COVID. There has been a marked improvement in the number and percentage of vacancies in the current financial year with a vacancy rate of 7.6% in December 2020.

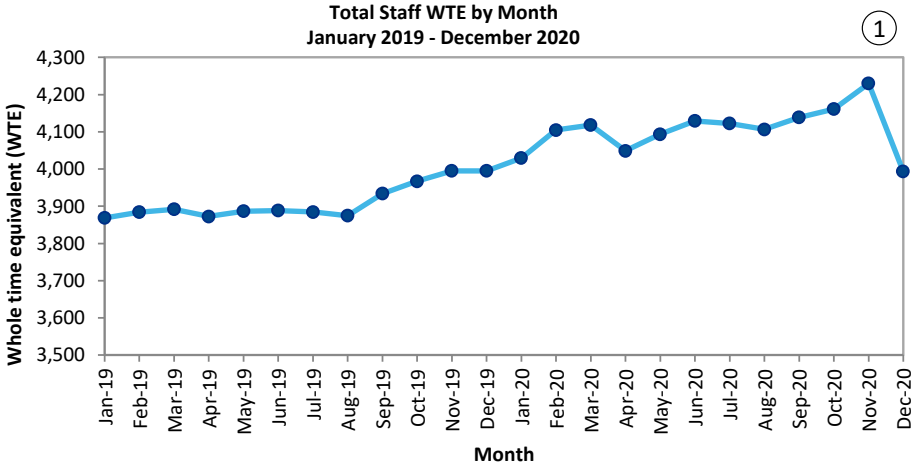
Data Rating: ①captured locally, ②system captured, ③ published/benchmarked

Workforce

Total Staff Whole Time Equivalent (WTE)







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

Key Narrative: Nursing and Midwifery staff have increased by 147 WTE (14.1%) over the 24-month periodand Medical and Dental staff by 13.

The Pathology Services transfered across to UHNM on the 1st December 2020 via a TUPE process, accounting for a drop in WTE of total staff.

Data from ESR report: Monthly staff in post (WTE)

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

Report to	Board of Directors
Date	23 December 2020
Report from	Lesley Massey, NED Chair
Report prepared by	Katharine Dowson, Head of Corporate Governance
Executive Lead/s	Julie Tunney, Director of Nursing & Quality Murray Luckas, Medical Director
Committee meeting quoracy	Yes ☒ No ☐

Meeting was streamlined due to operational pressures. A number of items deferred to 2021.

KEY AREAS OF ASSURANCE

Anticoagulation Incidents - acceptable assurance: deep dive completed following a rising number of incidents in relation to the administration of anticoagulant medication. Reduction achieved in November following education and communications; monitoring to continue through Safe Medicines Practice Group.

Mortality Review of Covid-19 Deaths (First Wave) - acceptable assurance: presentation of findings from a Critical Care and Emergency Medicine Consultant, reflecting a significant review into Covid deaths using Quality Improvement methodology. No major concerns found. Positive comments about end of life care and prompt decision making. Areas for improvement included nosocomial transmission, end of life care documentation and communication with families. Actions were implemented in response and shared with national and regional studies. Work is ongoing to include all Covid deaths in future reviews.

Covid-19:

- Vaccination is anticipated to arrive week commencing 28 December
- Nosocomial infection: area of maximum focus following November increase and further anticipated rise in December. External NHS England/ NHS Improvement review found no significant concerns with minor recommendations made; limitations due to ward space, capacity and flow recognised.

Integrated Performance Report

- Patient Safety Incidents leading to harm above control level; deep dive review linked increase to nosocomial Covid cases
- CCICP patient safety numbers now consistently above control level – latter to be reset following focus on encouraging incident reporting. % reported incidents resulting in harm decreasing, reflecting positive movement towards improved patient safety culture
- Crude Mortality rising in line with Covid.

Complaints, Concerns and Compliments Dashboard – partial assurance: revised and enhanced dashboard now includes themes from complaints and concerns. Communication

remains top theme. Further development to the dashboard to follow with engagement from Non-Executive Directors, to include information on upheld complaints.

Learning from Deaths report Q2 2020-21 - acceptable assurance: Medical Examiners now in place and leading strategic approach, working towards requirement of scrutinising all deaths in line with national deadlines.

Committee Workplan: items deferred due to operational pressures have implications for future agenda planning; Corporate Governance to agree priorities with Committee Chairs/Exec Leads.

KEY CONCERNS/RISKS

- Current operational pressures are unprecedented and the impact of nosocomial infection a considerable challenge
- Staff wellbeing is a matter of concern.

Priority Areas: DECISIONS MADE

Learning from Deaths Q2 and Review of Covid deaths to be reviewed at Board.

RECOMMENDATION

To note.

Quality & Safety (Q&S) Committee
Chair's Assurance Report
January 2021

Report to	Board of Directors
Date	20 January 2021
Report from	Lesley Massey, NED Chair
Report prepared by	Katharine Dowson, Head of Corporate Governance
Executive Lead/s	Julie Tunney, Director of Nursing & Quality Clare Hammell Deputy Medical Director representing Murray Luckas, Medical Director
Committee meeting quoracy	Yes ☒ No ☐

KEY AREAS OF ASSURANCE

Covid-19:

- Process in place to audit compliance with Infection Prevention and Control Policy and Practice (IPC) i.e. reported to Silver Command daily and actions put into place where concerns raised.

Integrated Performance Report (IPR):

- **Patient Safety Incidents:** on upward trajectory and above control level with spike in incidents resulting in harm in December. Review showed that spike due to increase in nosocomial incidents (Covid) and moderate harm incidents arising from clinical harm reviews on waiting list patients initially undertaken by a clinician. This resulted in a number of initial moderate harm ratings which can often be reduced following a more objective review by quality governance team.
- **Nosocomial acquired infection:** December rates increased; includes total numbers of cases in the trust in line with peers. Numbers started to reduce in line with peers and following re-energising of "Stop the Spread" campaign. As a result of second After Action Review, new role (supernumerary Infection Control Champion) introduced to audit wards daily and monitor mask wearing, ventilation etc. Following external review from NHSE/I, no new measures suggested
- **Pressure Ulcers**
  December figures to follow due to delay to Pressure Ulcer panel in December – to be updated next IPR.

Safe Staffing

Figures challenging to match to changing ward establishments as a result of covid 19. Agreed with peers qualified nursing ratios maintained except in extremis (managed on daily basis). Critical Care Unit (CCU) national agreement to reduce to 1:2 or 1:3 in extremis; Trust moved to 1:2 with temporary additional role of CCU helper introduced in support.

Executive Quality Governance Group (EQGG)

Key points highlighted from EQGG sub-groups as EQGG cancelled in December /January due to operational pressures. Non-compliance advised of Nutritional Advisory Group NICE guidance - no nutritional nurse with daily ward rounds; CCICP to take forward.

Interim Ockenden Report Update – Partial Assurance: Gap analysis against the new Maternity Services Assessment and Assurance tool showed good evidence of compliance. Partial compliance against three of ten actions, some overlap with CNST work. Completion of actions to be monitored by EQGG and Divisional Board (Women & Children's) & update provided to QSC.

CNST Update – Partial Assurance: two actions of ten challenging to complete with submission due March 2021; awaiting confirmation of national delay to this date from NHSIE. Written report to be submitted to QSC in March 2021 to provide assurance that work is on track.

Care Quality Commission (CQC) – Acceptable Assurance: All 'must do' actions completed from April 2020 CQC report (November 2019 inspection). 23 'should-do' actions making good progress with one overdue, five on-going. Monitored through Quality Summit.

Infection Prevention and Control (IPC) – Partial Assurance: significant areas of assurance provided on compliance with eight of the ten points in the plan and the amalgamated IPC Board Assurance Frameworks (IPCBAF May 2020 and October 2020). Two areas of non-compliance i.e. external reporting of the Use of Antimicrobials (non-compliant with CQUIN due to Covid) and testing all negative patients daily (feasibility of this challenged with NHSIE).

Patient Safety Incident Report – Acceptable Assurance: CCG confirmed satisfied with Serious Incident (SI) reporting and levels of SI (five SI in December). The fall resulting in fractured neck of femur will not be subject to full Root Cause Analysis as 48 hour review assessed as sufficient; CCG to sign off. All Covid deaths being reviewed in preparation for anticipated external scrutiny at a later date

End of Life Care

- Strategic Collaborative Cheshire (SCC) plan 2020-25 **– Partial Assurance:** innovative approach across providers. Focus on system leadership and advance planning processes. Good control, assurance to be provided by a regular update on implementation of plan and plan outcomes.
- National Audit of Care at End of Life (March 2020) **– Partial Assurance:** key findings generally positive; some scope for improvement in communication with patients which ties in with Trust complaints received. Next steps for development (i.e. specialist palliative care workforce to move to 7-day working, quality improvement work with families and adoption of Swan model) delayed by Covid.

KEY CONCERNS/RISKS

No items raised

Priority Areas: DECISIONS MADE

Response to the Ockenden Review and Maternity Services Assessment and Assurance Update Tool to be submitted to Board of Directors.

RECOMMENDATION

To note.

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**9.1**	Date of Meeting: 28/01/2021
Report Title	**CQC Action Plan update**	
Executive Lead	Julie Tunney, Director of Nursing and Quality	
Lead Officer	Sheila Kasaven, Associate director of Quality Governance	
Action Required	To note	

X **Acceptable assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of controls

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

- All 13 CQC 'must do' actions have been completed.
- Good progress seen against the 23 CQC 'should do' actions with only 6 remaining open.

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

- CQC to receive updated Improvement plans

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

• Manage Covid response and recovery	☐	• Provide safe and sustainable services	✓
• Provide outstanding care/patient experience	✓	• Provide strong system leadership by working together	☐
• Deliver most effective care to achieve best possible outcomes	✓	• Be well governed and clinically led	✓
• Be the best place to work	☐		

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

• Quality	✓	• Compliance	✓
• Finance	☐	• Legal	✓
• Workforce	☐	• Risk/BAF Click here to select relevant risk	
• Equality	☐		

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

Strategy ☐ Policy ☐ Service Change ☐

REPORT DEVELOPMENT

Committee/ Group Name	Date	Report Title	Lead	Brief summary of key issues raised and actions agreed
Quality Summit	25.09.20	CQC Improvement Plan (Must Do Actions)	Director of Nursing & Quality	
Quality & Safety Committee	20.01.21	CQC Action Plan Update	Director of Nursing & Quality	Reviewed and submitted to Board for sign off

CQC Action Plan Update

Introduction

1. Following the publication of the CQC inspection report April 2020, the Trust has made significant progress in both the response to requirements and recommendations made. Action plans were developed to address the 13 'must do's and 23 'should do's' and 81 actions to support achievement of full compliance and continued improvement were identified.

2. The Quality Summit provided scrutiny and progression of the CQC Action Plan on the must and should do actions and the Divisions have fully engaged to ensure that evidence could be matched with the actions.

3. This paper provides the Board with an update as to progress against the CQC action plan and highlights:
    - any overdue actions;
    - actions at risk

4. 75 actions have been completed, evidence has been provided to give assurance. There are currently:-
    - 0 'must do' actions overdue
    - 1 'should do' action overdue
    - 5'should do' actions in progress

5. Progress has been made against all of these actions, and where barriers have been identified these are being addressed.

Background and Analysis

6. The CQC inspected the Trust during November 2019 and the final report was published on April 2020.

7. The CQC inspection report highlighted 13 'must do's' and 23 'should do' recommendations.

8. Divisions, Corporate and Executive teams reviewed the CQC findings and developed action plans to address each must and should do as part of the Quality Summit group workplan. The quality improvement action plan (for Must do's) had 33 specific actions/work-plans for implementation by September 2020.

9. The quality improvement action plan (for Should do's) has 48 specific actions/work-plans for implementation on or before March 2021 (the EPR action has a longer date due to the complexity that action entails).

10. The CQC Action Plan provides the means of improving control over the risks highlighted following the CQC inspection and, reduces the risk that:

a. Service users are exposed to unacceptable levels of harm arising from inadequate compliance with CQC fundamental standards of care.
b. The Trust fails to comply with CQC Registration Regulations and has its certification of
registration revoked.

11. The CQC inspection report was utilised to support the Trusts consideration of which areas we need to improve. In developing the action plan the following areas of consideration were included:-

- What was the outcome we hoped to achieve (referencing the CQC must/should do's; regulatory requirements; clinical expertise) i.e. how can we improve safety and quality for our patients.
- What changes (actions) will lead to the improvement.
- How will we monitor the actions are being implemented.
- What resources will we require to make the change.

12. It is recognised that the completion of the identified actions is only one stage in the process of ensuring that the desired outcome has been achieved and sustained.

Conclusions

13. Following the publication of the CQC report in April 2020, the Trust has made significant progress in both the response to the requirements and recommendations made.
Improvement plans were developed to address the 13 'must dos' and 23 'should dos' and the 81 actions to support achievement of full compliance and continued improvement identified. Scrutiny of the actions and evidence submitted for assurance was provided through the Quality Summit and confirmation from Divisions that 75 actions were completed and assured.

14. The impact of the COVID-19 response has had some impact on timescales for completed actions however the sign off for the 'must dos' were met in time. It is also anticipated that COVID-19 has also impacted on the speed at which actions could be embedded due to changes in processes during the pandemic.

Recommendations

15. Board sign-off requested to note the latest position.

Author: Sheila Kasaven, Associate Director of Quality Governance
Date: 11/01/2021

Mid Cheshire Hospitals
NHS Foundation Trust

CQC Improvement Plan

Inspection Date – November / December 2019

Inspection Report Date – April 2020

'Delivering Excellence in Healthcare through Innovation and Collaboration'

1. Purpose of this document

Following the CQC inspection in November/December 2020, the trust was accredited with, and maintained its *"Good"* rating. This Improvement Plan addresses the findings following the inspection and included in the Inspection report and evidences the completion and ongoing monitoring, where required, of the "Must Do' actions required to improve services and patient safety within the Trust. This plan will be managed by the Quality Summit group and monitored at the Executive Quality Governance Group for assurance and escalation.

2. Process for monitoring and escalation of benchmark / gap analysis / improvement plan

The overall **Current Progress Rating** will be rated as follows, which shows our position against the improvement planned:

Current Progress Rating		
Colour	**Narrative**	**Description**
B	Blue "Complete/business as usual (BAU)"	Completed: Improvement / action delivered with sustainability assured.
G (a or b)	Green "On track"	Improvement on trajectory either: a) On track – not yet completed b) On track – not yet started)
A	Amber "Problematic"	Delivery remains feasible, issues / risks require additional intervention to deliver the required improvement e.g. Milestones breached.
R	Red "Delayed"	Off track / trajectory – milestone / timescales breached. Recovery plan required.

Introduction

This Improvement Plan addresses the findings following the CQC Inspection in November / December 2019 and evidences the completion and ongoing monitoring, where required, of the Must Do" actions required to improve services and patient safety within the Trust. This plan will be managed by the Quality Summit Group.

CQC Requirement		Improvement Required	Division / Core Service Executive Lead Operational Lead	Milestones/ Timescales (by end of)	Current Progress Rating	Assurance	Evidence
						(What evidence / assurance will be provided to demonstrate sustainable improvement?)	
1	The service must ensure that they have enough staff with the right qualifications, skills, training and experience to provide care and treatment to children and that staffing of children's nurses is in line with national guidance. Regulation 18 (1)	A Band 6 and a Band 5 Paediatric nurse have since been recruited. Both of these staff members will work 22.5 in ED and 15 hours on our paediatric ward. This will support the development of the rotation of staff between these areas.	DMEC – ED Director of Nursing & Quality Head of Nursing ED	Completed		• Reporting through Executive Working and Assurance Group and Divisional Board • Monthly review of ward and department vacancies at Head of Nursing performance meetings. • Divisional vacancy oversight by Head of Nursing • Divisional recruitment and retention plan by Head of Nursing • Acuity review meeting with Director of Nursing and Deputy Director of Nursing • Rotation of staff between ED and Paeds will commence from 3rd September 2020 • Paediatric study day took place on 13th August 2020 • Review of paediatrics attends by time over the last 12 months • Potential recruitment of newly qualified paediatric nurses • Plan to look at educational programme with support from CAU when needed • Audit of SOP • 2 additional paediatric nurses have been recruited which now brings the total to 5 paediatric nurses	• Completion of SOP - Management of Paediatric Patients in the Emergency Department 1. Management of Paediatric Patients in • Staffing plan on a Page - ED Plan on a page - ED.pdf • ED Vacancies September 2020 1. ED vacancies September.pdf • Links with School of Nursing re-established • Adult based competency booklet for paediatric staff (at printers) • ED Paediatric Nursing Improvement Plan 1. ED Paeds nursing improvement plan.pdf
		A Standard Operating Procedure that outlines the agreement to release paediatric staff from the paediatric ward to support the Emergency Department when required will be written.		Completed			
		Rotation of staff between Emergency Department and Paediatrics will be revisited by the Head of Nursing.		Completed			
		Bespoke paediatric study days for the Emergency Department Adult nurses will continue bi annually.		Completed			
		Paediatric nursing staff will complete adult based competencies		Completed			
		Review of the Care Quality Commission's Brief guide: Staffing in emergency departments that treat children		Completed			
2	The service must ensure that patients receive care in a timely way and work towards improving performance against national standards such as the time from arrival to treatment and median total time in the department. Regulation12 (2)	A service review and subsequent business case was approved in April 2019 for an investment in additional workforce with the primary benefits of: • increasing rota coverage at a senior level • Improved patient safety and quality due to improved staffing levels • Reduction in premium cost sessions and locums • Improved compliance against the four hour access standard As the required investment was significant	DMEC – ED Chief Operating Officer DMEC Divisional General Manager	Completed		• Investment in the infrastructure and workforce to meet demand • Regular review of workforce rota's to ensure changes in surges and peaks are met • On-going Emergency care performance meetings with key stakeholders present • Urgent care steering group agenda to support a wider system approach to demand management • Specialties continue to support flow through ED by taking more patients direct to service	• CQC Update for Quality Summit – Performance 2. CQC update for quality summit - perfc • Gap Analysis for Non-Elective Performance 2. Gap analysis for non-elective perform

CQC Requirement		Improvement Required	Division / Core Service Executive Lead Operational Lead	Milestones/ Timescales (by end of)	Current Progress Rating	Assurance	Evidence
						(What evidence / assurance will be provided to demonstrate sustainable improvement?)	
		it was approved over a phased five year period with the initial investment targeted at improving nursing levels to support improving safety and quality. The level of attendances during 2019/20 was forecast by March 2020 to increase by a further 6.9% compared to the previous year.				• Monthly updates at Quality Summit • Trust part of NHS111 pilot	• Performance Board Report June 2020_V4 Performance Board Report June 2020_V4
		The ECIST and BEST staffing modelling tools were repeated using the revised attendance data which identified a further requirement for workforce.		Completed		BEST Tool Acuity Results	• BEST Data ED BEST data Emergency Departme
3	The service must ensure that there are no time lapses between patient group directions expiring and new ones being authorised and signed by staff. Regulation 12 (2) (g)	A Patient Group Directive (PGD) nursing lead has been identified to work with the Patient Group Directive lead consultant. Bi annual Patient Group Directive training dates will be diarised to ensure that all new and existing staff have a regular opportunity to update. This will be monitored at Divisional board level	DMEC – ED Medical Director Practice Based Educator & Head of Nursing - ED	Completed		The interim practice based educator has developed a Patient Group Directive database to move away from paper records. This will enable more accurate oversight of expiry dates. Competency will also be discussed as part of the appraisal process. This will be monitored at monthly divisional board level by the senior management team. • Training will then continue twice a year to capture all staff	• 18 members of staff trained to date in Sepsis and Neutropenic Sepsis PGDs • 25 members of staff trained in Paracetamol and Ibuprofen PGD • PGD Training Log confirming staff training • PGD Training Database (PGD Review date pushed back to December 2020 by Pharmacy) PGD training log August 2020.xlsx
4	The service must ensure that audit information is up to date, accurate and properly analysed and reviewed by people with the appropriate skills and competence to understand its significance. When required, results should be escalated and appropriate actions taken to improve. Regulation 17 (2) (a)	Phase 2 of the ward quality metrics and accreditation process will include role out to the Emergency Department and Victoria Infirmary Northwich in May 2020. A suite of monthly quality metrics will provide a systematic approach to continually improve the quality of services and safeguard high standards of care, forming part of a strong governance structure within the organisation.	DMEC – ED Medical Director / Chief Operating Officer	Completed		• The audits will be reviewed by the Matron with any improvements required fed back to the staff. They will also be shared and monitored at the sub divisional governance meeting. • 1 member of the Divisional Senior Management Team will attend the sub divisional governance quarterly to ensure appropriate discussion and escalation. • Questions within quality metrics being amended for Emergency Department and Minor Injuries Unit • Consultant Lead identified for Clinical Audit • Rationalisation of clinical audit programme being undertaken by June 2020 • Updated action plan developed for previous audits • Gap analysis and action plans completed for high impact RCEM audits from 2019	• ED Metrics 4. ED metrics May.pdf • ED Accreditation Dashboard July 2020 ED accreditation dashboard July 2020. • VIN Accreditation Dashboard July 2020 VIN accrediation dashboard July 2020. • Divisional Governance Meetings • Missed Fractures Gap Analysis
		The service will review missed fractures and injuries as well as litigation and clinical incidents, oversight of which will be monitored through the monthly ED governance group with sharing of outcomes and lessons learnt to clinical staff members.	Matron & Clinical Lead / Deputy Medical Director	Completed	a		

CQC Requirement		Improvement Required	Division / Core Service Executive Lead Operational Lead	Milestones/ Timescales (by end of)	Current Progress Rating	Assurance	Evidence
						(What evidence / assurance will be provided to demonstrate sustainable improvement?)	
		RCEM Audits - actions to be progressed to show improvements		Completed		• Re-audit of missed fractures • 2127 Severe sepsis & septic shock 16-17 - improvement plan • 2128 Consultant Sign Off 16-17 - improvement plan • 2129 Moderate & Acute Severe Asthma 16-17 - improvement plan complete • 2369 Procedural Sedation in Adults 17-18 - improvement plan complete • 2370 Pain in Children 17-18 - improvement plan • 2371 Fractured NOF 17-18 - improvement plan • 2527 VTE risk in lower limb immobilisation 18-19 - improvement plan actions complete • 2528 Feverish children 18-19 - improvement plan done actions ongoing • 2529 Vital signs in adults 18-19 - improvement plan • 2742 Cognitive impairment in older people 19-20 - no report yet • 2743 Care of children in ED 19-20 - no report yet • 2744 Mental health 19-20 - no report yet	4 and 9. Missed Fracture Gap Analysis • Process for Missed Fractures Missed Fractures.docx • Action Plans from RCEM Audits 2127 RECM sepsis 2016-17.pdf 2128 RCEM Consultant Sign-off 2 2129 RCEM Asthma 2016-17.pdf 2369 RCEM Sedation in adults 2017-18.pdf 2370 RCEM Pain in Children 2017-18.pdf 2371 RCEM NOF 2017-18.pdf 2527 RCEM VTE 2018-19.pdf 2528 RCEM Feverish Children 2018-19.pdf 2529 RCEM Vital signs in adults 2018-
5	Take actions to improve staff compliance in mandatory training and safeguarding training. Regulation 18 (2) (a).	All Mandatory metrics including safeguarding are monitored and reported on a monthly basis, which is then fed back through to the Divisional Board for Medicine and Emergency care.	DMEC - Medicine Director of Nursing & Quality / Director of Workforce OD DMEC Divisional General Manager	Completed		• Reporting through Executive Working and Assurance Group and Divisional Board • Monthly review of ward and department vacancies at Head of Nursing performance meetings. • Divisional vacancy oversight by Head of Nursing • Divisional recruitment and retention plan by Head of Nursing • Acuity review meeting with Director of Nursing and Deputy Director of Nursing • Ward Performance Monthly Meetings	• Monthly reporting of mandatory training at Quality Summit • Training Performance – Medicine ACU Training performance Data 1s AMU Training performance Data 1s PIU Training performance Data 1s Ward 1 Training performance Data 1s Ward 3 Training performance Data 1s Ward 4 Training performance Data 1s
		It had been recognised that the monitoring and management of the staff training data base required more focused attention at a Divisional level this has led to the introduction of a support staff member whose role is to maintain and track the training data base.		Completed			
		This will be monitored monthly by the Senior Management Team and a quarterly compliance plan put in place.		Completed			

CQC Requirement		Improvement Required	Division / Core Service Executive Lead Operational Lead	Milestones/ Timescales (by end of)	Current Progress Rating	Assurance	Evidence
						(What evidence / assurance will be provided to demonstrate sustainable improvement?)	
							Ward 5 Training performance Data 1s Ward 6 Training performance Data 1s Ward 7 Training performance Data 1s Ward 14 Training performance Data 1s
6	Take actions to improve nurse staffing levels across all medical wards. Regulation 18 (1)	Excluding ED and Critical Care there are currently 15.17 RN vacancies across the Division. This is a significant improvement due to active recruitment both at home and internationally.	DMEC - Medicine Director of Nursing & Quality / Director of Workforce and OD Head of Nursing - Medicine	Completed		• Reporting through Executive Working and Assurance Group and Divisional Board • Monthly review of ward and department vacancies at Head of Nursing performance meetings. • Divisional vacancy oversight by Head of Nursing • Divisional recruitment and retention plan on a page by Head of Nursing – Completed • Acuity review meeting with Director of Nursing and Deputy Director of Nursing • Engagement session taking place to yield Band 5 recruitment	• Medicine Recruitment Plan on a Page Plan on a page - Medicine.pdf • Monthly reporting of vacancies at Quality Summit • Divisional Vacancy Projection 6. DMEC Vacancies.pptx • DMEC Vacancy RunChart Run charts DMEC Vacancies Apr19 Aug
		A divisional workforce retention plan will be implemented, and will be monitored through monthly workforce meetings with the HR manager and senior nursing team and will be monitored at Divisional board level		Completed			
		Additional rotational posts to be scoped following successful rotational posts between Respiratory Medicine and Intensive care it has been identified that a proportion of newly qualified nurses find rotational posts more attractive as it gives them further exposure to different specialties, posts between Emergency department and Paediatrics and Acute Medicine and Emergency department are also being reviewed		Completed			
7	The service must ensure that there is an effective process to safely escalate deteriorating patients. Regulation 17 (2) (b)	A Standard Operating Procedure (SOP) for the management of patients attending Minor injuries unit at Victoria Infirmary was implemented in November 2019, this document provides guidance on the following topics: • Patients requiring escalation • Patients who present and out of the sphere of competency of the ENP workforce • Patients who require X-ray out of hours • Patients who require analgesia in the event of a sole practitioner being on site • Patients with unplanned re-attendance with the same problem within 72 hours • Waiting time exceeds 2 hours • Paediatrics patients under 1 year of age	DMEC - VIN Medical Director / Chief Operating Officer Emergency Department Manager	Completed		• An IR1 will be completed for any patient that is escalated via this SOP. Each IR1 will be investigated with the outcome shared with the relevant staff members so lessons can be learned and improvements made. • Outcomes will be discussed at the Patient Safety Summit chaired by the Medical Director. • Audit SOP in September 2020 • Departmental Action Plan for VIN which is monitored at ED Governance • Lead clinician identified as point of contact for unplanned attendances • Newly appointed Service Manager for VIN (due to start approx Oct 2020) • The baton bleep will be given to Dr Griffin/Dr Kreutzer each day, and VIN ENP	• VIN Escalation SOP 7. MCHT VIN escalation.pdf • Survey completed with good staff awareness of SOP 7. ENP Survey Results.docx • Divisional Action Plan for VIN CQC Improvement plan VIN.pdf

CQC Requirement		Improvement Required	Division / Core Service Executive Lead Operational Lead	Milestones/ Timescales (by end of)	Current Progress Rating	Assurance	Evidence
						(What evidence / assurance will be provided to demonstrate sustainable improvement?)	
		• Patients who require specialty review which is not available at VIN				staff can contact the clinicians via the bleep for input and discussion on any cases required.	• Log of Calls from VIN to Lead Clinician 7. Log of advice calls from VIN.xlsx • All the incidents forms that are completed at VIN are discussed at VIN Governance (Evidence embedded in action9) • ENP Baton Bleep Poster ENP BATON BLEEP.docx
		Specific action in relation of unplanned re-attendances is for the ENP to discuss each case with the designated consultant shift leader at Leighton who will provide clinical advice and guidance on the appropriate management including any requirement for the patient to be transferred to Leighton for more senior input, with an IR1 form being completed for each incident.		Completed			
8	The service must ensure there are processes to seek medical input, particularly a process for medical approval for unplanned patient reattendances. Regulation 17 (2) (b)	Database for unplanned attendances created	DMEC – ED/VIN Chief Operating Officer / CIO Emergency Department Manager	Completed		• Outcomes will be discussed at Divisional Board • Database launch W/c 01/06/2020 • Departmental Action Plan for VIN which is monitored at ED Governance • Audit of Return Visits	• Return Visits VIN 8. Return visits VIN.XLSX • Divisional Action Plan for VIN (Evidence embedded in Action 7) • Minutes from VIN Governance meetings – May / June / July / August (Evidence embedded in action 9) • VIN Unplanned Attendances Unplanned re attendances MIU.doc 8. MiU unscheduled returns.pptx
9	The service must ensure that a regular schedule of local audit of patient outcomes is undertaken to improve the quality and safety of the service. Regulation 17 (2) (a)	The service will review missed fractures and injuries as well as litigation and clinical incidents, oversight of which will be monitored through the monthly ED governance group with sharing of outcomes and lessons learnt to clinical staff members.	DMEC – VIN Medical Director / Director of Nursing & Quality Matron & Clinical Lead	Completed		• The QI / audit action plans will be reviewed and monitored to completion via the sub divisional ED governance group. • The audits will be reviewed by the Matron with any improvements required fed back to the staff. They will also be shared and monitored at the sub divisional governance meeting. • Departmental Action Plan for VIN which is monitored at ED Governance • 1 member of the Divisional Senior Management Team will attend the sub divisional governance quarterly to ensure appropriate discussion and escalation.	• Minutes from VIN Governance meetings – May / June / July / August 9. VIN GOV May 20.docx 9. VIN GOV June 20.docx 9. VIN GOV july 20.docx ED VIN Governance Minutes August 20.dc • Divisional Action Plan for VIN (Evidence embedded in Action 7)

CQC Requirement		Improvement Required	Division / Core Service Executive Lead Operational Lead	Milestones/ Timescales (by end of)	Current Progress Rating	Assurance	Evidence
						(What evidence / assurance will be provided to demonstrate sustainable improvement?)	
						• Monitoring via VIN Governance meetings attended by Lead ENP	• Missed fractures gap analysis which is discussed at VIN Governance Meetings (Evidence embedded in action 4) • VIN Minor Injuries Audit Timetable VIN Minor Injuries Audit Timetable.docx • ENP Clinical Standards enpQA.XLSX • VIN Audit Dashboards VIN august 2020 dashboard.pdf 9. VIN TopicHeatmap.xlsx
10	The service must ensure that the risks to people who use services are escalated within the organisation. Regulation 17 (2) (b)	Regular monitoring of the risk register to be undertaken at the Emergency Department governance meeting which is held on a monthly basis, triangulated through feedback from the Emergency Nurse Practitioner (ENP) meetings and the Multi-Disciplinary Team (MDT) review of clinical outcomes meetings, with any areas of concern or identified outlier in terms of patient outcomes or volume of incidences reported to be raised at Divisional board.	DMEC - VIN Medical Director Senior Management Team	Completed		An IR1 will be completed for any patient that is escalated via this SOP. Each IR1 will be investigated with the outcome shared with the relevant staff members so lessons can be learned and improvements made. • Monitoring via VIN Governance meetings attended by Lead ENP • Departmental Action Plan for VIN which is monitored at ED Governance • Minutes from VIN Governance meetings • Monthly rota for Quality Governance Managers visiting VIN commencing from July 2020 • Quality Governance Manager weekly visits to VIN commenced which involves a walk round and talk to staff in the minor injuries unit and the outpatients departments and the general office. Support the MIU staff to report incidents and have escalated issues externally (eg: the issue of dressings patients being sent from an overbooked CCICP-run dressings clinic to MIU).	• Minutes from VIN Governance meetings – May / June / July / August (Evidence embedded in action 9) • Divisional Action Plan for VIN (Evidence embedded in Action 7) • VIN Risk Register VIN Risk Assessment Report 250820.pdf
		The Governance team will have visibility at the Victoria Infirmary to ensure that all staff are aware of the importance of incident reporting and escalation processes within the organisation.		Completed			
11	The trust must ensure they deploy sufficient number of suitably qualified, competent,	Adverts for ED nursing staff will continue bi monthly, bespoke ED recruitment events will be planned quarterly.	DMEC - VIN	Completed		• Divisional recruitment and retention plan by Head of Nursing • Departmental Action Plan for VIN which is	• VIN Divisional Action Plan (Evidence embedded in Action 7)

CQC Requirement		Improvement Required	Division / Core Service Executive Lead Operational Lead	Milestones/ Timescales (by end of)	Current Progress Rating	Assurance (What evidence / assurance will be provided to demonstrate sustainable improvement?)	Evidence
	skilled and experienced staff to ensure safe care and treatment is provided. Regulation 18 (1)	Internationally recruited nurses will continue to be supported in ED.	Director of Nursing and Quality	Completed		monitored at ED Governance • Staff development needs identified through appraisal process • 14 Nurses recruited which includes 6 International recruits recently appointed • 2 ENPs on every shift • Band 5's succession planning	
		Staff development needs will be identified and supported through the appraisal process.	Senior Management Team	Completed			
12	The service must ensure they hold a record of staff competencies that are up to date for all staff. Regulation 18 (2) (a)	Staff competencies will be discussed and reviewed as part of the appraisal process.		Completed		• Reporting through Executive Working and Assurance Group and Divisional Board • Monthly review of ward and department vacancies at Head of Nursing performance meetings. • Divisional vacancy oversight by Head of Nursing • Divisional recruitment and retention plan by Head of Nursing - completed • Acuity review meeting with Director of Nursing and Deputy Director of Nursing • Departmental Action Plan for VIN which is monitored at ED Governance • Monthly updates at Quality Summit	• ENP Appraisal Summary 12. ENP Appraisal form.docx • ENP Strategy 12. ENP strategy MCHT.docx • ENP Educational Agreement 12. ENP Educational Agreement.docx • ENP Competency Assessment Framework 12. ENPDOPS1.docx 12. ENPDOPS2.docx • ENP Teaching Programme 12. ENP Teaching Programme July.docx • VIN Training Performance VIN performance 24th Aug 2020.docx • VIN Divisional Action Plan (Evidence embedded in Action 7)
		Completed competencies will be held on a data base		Completed			
		ENP competency booklet will be reviewed and updated. Out of an establishment of 13 ENPS at the time of inspections, seven had completed the prescribing course. Since the inspection three further ENP's have successfully completed the non-medical prescribing course. One ENP is currently on maternity leave but will complete the course once she returns. Of the seven, six intention to prescribe forms were sent, the remaining one could not be located at the time. This compliance therefore was 87.5% not 50%. The Trust has now located the last form making this 100% compliant.	DMEC - VIN Medical Director / Director of Nursing and Quality	Completed			
		Staff competencies will be discussed and reviewed as part of the appraisal process.	Senior Management Team / Non-Medical Prescriber Lead	Completed			
13	The trust must ensure that all staff receive appropriate training for their role. Regulation 18 (2) (a)	Funding has been requested as part of the ED business case for a permanent Practice Based Educator. This post will support and coordinate the ED staff to	DMEC - VIN Director of Nursing &	Completed		• Reporting through Executive Working and Assurance Group and Divisional Board • Monthly review of ward and department vacancies at Head of Nursing performance	• Business Paper for Practice Based Educator in ED

CQC Requirement		Improvement Required	Division / Core Service Executive Lead Operational Lead	Milestones/ Timescales (by end of)	Current Progress Rating	Assurance	Evidence
						(What evidence / assurance will be provided to demonstrate sustainable improvement?)	
		receive the training that they require to undertake their roles.	Quality Senior Management Team			meetings. • Divisional vacancy oversight by Head of Nursing • Divisional recruitment and retention plan by Head of Nursing • Acuity review meeting with Director of Nursing and Deputy Director of Nursing • Departmental Action Plan for VIN which is monitored at ED Governance • ED training database • Rota in place for senior staff visiting VIN • Recruitment of senior manager to be based at VIN • Awaiting feedback from Execs on funding for Practice Based Educator for VIN/ED	13. Investments for UC COVID.docx • VIN Divisional Action Plan (Evidence embedded in Action 7) • Rota for Senior Staff visiting VIN 13. ED SMT VIN Rota.docx
		The ED training database will continue to be developed to ensure that accurate records are maintained		Completed			

NHS
Mid Cheshire Hospitals
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Board of Directors

Agenda Item	**11**	Date of Meeting: 28/01/2021
Report Title	**COVID-19: Infection Prevention and Control Board Assurance Framework**	
Executive Lead	Julie Tunney, Director of Nursing & Quality	
Lead Officer	Rebecca Consterdine, Interim Head of Nursing IPC	
Action Required	To note	

☐ **Acceptable assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	X **Partial assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of controls

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

- MCHT has reviewed IPC control measures and mitigations as outlined in the IPC Board Assurance Framework and has highlighted that there are many areas of good practice and systems in place

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

- Bi-monthly monitoring at the Trust Infection Prevention Control Group
- Review at Quality & Safety Committee quarterly
- 6 monthly review and presentation to Board

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

• Manage Covid response and recovery	✓	• Provide safe and sustainable services	☐
• Provide outstanding care/patient experience	✓	• Provide strong system leadership by working together	☐
• Deliver most effective care to achieve best possible outcomes	✓	• Be well governed and clinically led	✓
• Be the best place to work			

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

• Quality	✓	• Compliance	✓
• Finance	☐	• Legal	✓
• Workforce	☐	• Risk/BAF **BAF5 Quality Improvement approach**	
• Equality	☐		

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

Strategy ☐ Policy ☐ Service Change ☐

Mid Cheshire Hospitals NHS FT

REPORT DEVELOPMENT

Committee/ Group Name	Date	Report Title	Lead	Brief summary of key issues raised and actions agreed
Quality & Safety Committee	20/01/2021	Infection Prevention and Control Board Assurance Framework Update and 10-point Plan	Julie Tunney, Director of Nursing and Quality	To submit to Board following review

COVID-19 Infection Prevention and Control Board Assurance Framework

Introduction

1. The purpose of this paper is to provide the Board of Directors with information and assurance of how well the Trust is performing against the Infection Prevention and Control Board Assurance Framework (IPCBAF NHS England, May 2020 and October 2020), which has been developed by NHSE/I. The IPCBAF is largely specific to COVID 19 but also includes IPC practices in general.

2. NHS E/I developed Key Actions: Infection Prevention and Control testing, December 2020. NHS E/I state it is the Boards responsibility to ensure compliance against all 10 key actions that are intended to reduce the transmission of hospital acquired nosocomial infection. This paper also provides assurance to the Board of Directors of how well the Trust is performing against the Key Action: Infection Prevention and Control Testing, December 2020.

Background and Analysis

3. The national emergency response to the COVID 19 pandemic has produced vast amounts of information, guidance and control measures. These have had to be implemented rapidly to ensure the safety of patients, service users, casual workers, visitors and staff. This remains a continuous process due to emerging knowledge of the virus. Significant changes to the way teams work have to happen quickly and these are still being refined. We are now focusing on consistent application of practice across all areas.

4. The Trust responded to the pandemic by developing internal command structures to enable agile decision making and implementation.

5. In May 2020, the IPCBAF was released to Trusts as a self-assessment tool to provide information and assurance on IPC standards. Updated guidance was released in October 2020. The self-assessment against the 10 standards / KLOEs has produced a baseline review of the controls currently in place.

6. Of the 10 standards / KLOEs within the combined IPCBAF / Key Actions the following tables demonstrate significant assurance & partial assurance;

   8 areas of the IPCBAF were self-assessed to have **"Significant Assurance"**:

IPCBAF Standard/KLOE	
1	Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and risks posed by their environment and other service users.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

IPCBAF Standard/KLOE	
3.1	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion.
5	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
6	Provide or secure adequate isolation facilities
7	Secure adequate access to laboratory support as appropriate
8	Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections.
9	Have a system in place to manage the occupational health needs and obligation of staff in relation to infection

2 areas were considered to have **"Partial Assurance":**

IPCBAF Standard/KLOE	
3	The use of appropriate antimicrobials to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.

7. The IPCBAF will be monitored bi-monthly with progress reported to Trust Infection Prevention & Control Group then to Quality Governance Committee quarterly; a further formal update will be presented to the Quality Committee and Board of Directors in June 2021.

8. A review of the IPCBAF has highlighted a number of successes, including:

- Upskilling of clinical staff to enable flexibility in the workforce
- Full organisation environmental review to enable social distancing
- Implementation and review at pace of Standard Operating Procedures / policies, and procedures to ensure clear guidance is available (in line with national recommendations) and communicated.
- Full programme of training for PPE across multiple platforms (Trust Communications, intranet, facebook, twitter, floorwalkers, Be EquiPPEd campaign)
- Up to date training records for staff fit tested appropriately
- BAME Schwartz round listening event for staff completed
- Introduction of Donning and Doffing stations
- Trust communications daily to staff following Silver command with up to date national and local guidance – with video briefings from the Executive team and senior managers.
- Creation of color-coded wards and flexing of wards to meet the needs of the patient population

- Significant staff support mechanisms including mental health first aiders, wobble rooms, food distribution and Occupational Health extended out of hours
- Implementation of patient flow pathways for the management of patient flow in medium and high risk Covid pathways.
- Implementation of ward-based IPC champions and IPC checklist.

Conclusion

9. It is recognised that the staff have sustained resilience to the significant changes placed upon the Trust, which has continued in to wave 2 of the global pandemic.

10. Regular monitoring and reporting of progress against the 10 IPCBAF standards / KLOE will continue as described in this paper.

11. The IPCBAF evidences the significant work undertaken in the Trust, demonstrating good processes and systems in place. The evidence in this framework gives acceptable assurance to the Quality & Safety Committee.

Recommendations

12. The Quality & Safety Committee is asked to note the report and self-assessment and the level of assurance provided against the 10 standards / KLOE. A progress report will be provided in June 2021.

Author: Interim Head of Nursing Infection Prevention Control
Date: 13.01.2021

Benchmark / Gap Analysis / Improvement Plan

Template, Monitoring and Escalation

MCHFT Infection Prevention and Control Board Assurance Framework (Dec 2020) and 10 Key Actions: Infection Prevention Control & Testing

'Delivering Excellence in Healthcare through Innovation and Collaboration'

1. Purpose of this document

The purpose of this paper is to provide the Board of Directors with information and assurance of how well the Trust is performing against the Infection Prevention and Control Board Assurance Framework (IPCBAF NHS England, May 2020 and October 2020), which has been developed by NHSE/I. The IPCBAF is largely specific to COVID 19 but also includes IPC practices in general. The purpose of this paper is to also provide the Board of Directors with information and assurance of how well the Trust is performing against the Key Action: Infection Prevention and Control Testing, November 2020, which has been developed by NHS E/I. NHS E/I state it is the Boards responsibility to ensure compliance against all 10 key actions that are intended to reduce the transmission of hospital acquired nosocomial infection.

2. Process for monitoring and escalation of benchmark / gap analysis / improvement plan

The **Initial "BRAG" Rating** will be rated as follows – showing our position against the required standard / measure etc.

Key:	Universal Compliance	Compliant	Partially Compliant	Non – Compliant
	Adherence 100%	Adherence 90% - 99%	Adherence 80% - 89%	Adherence < 79%

The overall **Current Progress Rating** will be rated as follows, which shows our position against the improvement planned:

Current Progress Rating		
Colour	**Narrative**	**Description**
B	Blue "Complete/business as usual (BAU)"	Completed: Improvement / action delivered with sustainability assured.
G (a or b)	Green "On track"	Improvement on trajectory either: a) On track – not yet completed b) On track – not yet started
A	Amber "Problematic"	Delivery remains feasible, issues / risks require additional intervention to deliver the required improvement e.g. Milestones breached.
R	Red "Delayed"	Off track / trajectory – milestone / timescales breached. Recovery plan required.

Introduction

The national emergency response to the COVID 19 pandemic has produced vast amounts of information, guidance and control measures. These have had to be implemented rapidly to ensure the safety of patients, service users, casual workers, visitors and staff. This remains a continuous process due to emerging knowledge of the virus. Significant changes to the way teams work have to happen quickly and these are still being refined. We are now focusing on consistent application of practice across all areas. In May 2020 the IPCBAF was released to Trusts as a self-assessment tool to provide information and assurance on Infection Prevention Control standards. This document provides assurance against the updated IPCBAF released in October 2020.
In November 2020 a 10 point plan compliance document was released to Trusts to provide information and assurance on the key actions. The 10 point plan was then updated on the 23rd December 2020. The following plan also includes the analysis and assurance of the Trusts self-assessment against the 10 point plan.

Standard/Process/ Issue/Recommendation	'BRAG' Rating	Improvement Required (What does good look like?)	Responsible Lead	Milestones/ Timescales (by end of)	Current Progress Rating	Responsible Committee/ Group	Evidence (What evidence will be provided to demonstrate sustainable improvement?)
1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users.							
Systems and processes are in place to ensure: • Infection risk is assessed at the front door and this is documented in patient notes		All patients are assessed for their infection risk on arrival to the Emergency Department.	Divisional General Manager Division of Medicine & Emergency Care Head of Nursing Emergency Urgent & Emergency Medicine	Complete	BAU	Emergency Division Governance	ED Walk-in pathway 1.2 approved 09.06.2
Patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission		Ratification of patient flow policy by Silver Command	Director of Operations Matron – Site/Patient Flow	February 2021	BAU	Silver Command	Implementation of patient flow pathways for the management of patient flow in medium and high

Standard/Process/ Issue/Recommendation	'BRAG' Rating	Improvement Required (What does good look like?)	Responsible Lead	Milestones/ Timescales (by end of)	Current Progress Rating	Responsible Committee/ Group	Evidence (What evidence will be provided to demonstrate sustainable improvement?)
							risk Covid pathways. Flow Pathways Dec 2020 updated v2 FIN
Compliance with the national guidance around discharge or transfer of COVID-19 positive patients		Trust compliance with national guidance for positive patients being transferred or discharged from the Trust.	Director of Operations Matron – Site/Patient Flow	Sept 2020	BAU	Gold Command	Local agreement with Care Homes for negative swab 48 hours pre-discharge. Strategic care home conference call 08_0(Strategic care home conference call 27_05 This is being managed system wide across Cheshire for a full partner response and will support discharge to care homes and packages of care

Standard/Process/ Issue/Recommendation	'BRAG' Rating	Improvement Required (What does good look like?)	Responsible Lead	Milestones/ Timescales (by end of)	Current Progress Rating	Responsible Committee/ Group	Evidence (What evidence will be provided to demonstrate sustainable improvement?)
Patients being discharged to a care home must be tested 48 hours prior to discharge and must only be discharged when their test result is available. Care homes must not accept discharged patients unless they have that person's test result and can safely care for them. **NB. 10 Key Action. No 8e**		Care homes residents referred to Integrated Discharge Team (IDT) receive pre-discharge swab within 72hrs within transfer and will transition to 48 hours from 04/12/2020. Those unknown to IDT are managed by ward. Ward staff are responsible for documenting and communicating result with care home. IDT Swab HCA supports swabbing and following up of the results to ward staff and within IDT shared system to maximise flow.	Chief Operating Officer	March 2021	BAU	Silver Command	Local agreement with Care Homes for negative swab 48 hours pre-discharge. Strategic care home conference call 08_06 Strategic care home conference call 27_05 This is being managed system wide across Cheshire for a full partner response and will support discharge to care homes and packages of care
Monitoring of IPC practices, ensuring resources are in place to enable compliance with IPC practice		Trust compliance with Infection Prevention Control practice.	Nurse Consultant IPC and Decontamination Head of	December 2020	BAU	Trust Infection Prevention Control Group	IPC Environmental Visit Template V1.dc IPC Environmental Visit - Immediate Act

Standard/Process/ Issue/Recommendation	'BRAG' Rating	Improvement Required (What does good look like?)	Responsible Lead	Milestones/ Timescales (by end of)	Current Progress Rating	Responsible Committee/ Group	Evidence (What evidence will be provided to demonstrate sustainable improvement?)
			Nursing Infection Prevention & Control				IPC Environmental Visit - Initial feedba
Monitoring of compliance with PPE, consider implementing the role of PPE guardians/safety champions to embed and encourage best practice		Implementation of PPE champions to support compliance with IPC practice.	Head of Nursing Emergency Preparedness	March 2021	a)	Operational Infection Prevention Control Group	PPE Champions Trust Guidance.doc PPE audit v3.xlsx December 2020: Implementation of Ward Based IPC Champions and Staff IPC Checklist. nosocomial driver diagram Jan 2021 07
Staff testing and self-isolation strategies are in place and a process to respond if transmission rates of COVID-19 increase		Ensure robust procedure in place for staff who have been confirmed as COVID -19 positive and how associated contacts identified in the workplace will be managed.	Divisional General Manager Diagnostics & Clinical Services	December 2020	BAU	Silver Command	test and trace SOP - Version 6.pdf COVID TATs 30122020.xlsx

Standard/Process/ Issue/Recommendation	'BRAG' Rating	Improvement Required (What does good look like?)	Responsible Lead	Milestones/ Timescales (by end of)	Current Progress Rating	Responsible Committee/ Group	Evidence (What evidence will be provided to demonstrate sustainable improvement?)
			Service Manager Covid-19 Swabbing Services				If a member of staff or their household m SOP Symptomatic staff.pdf MCHFT Policy Lateral flow.doc
Implementation of twice weekly lateral flow antigen testing for NHS patient facing staff. Whilst lateral flow technology is the main mechanism for staff testing, this can continue to be used alongside PCR and LAMP testing. **NB 10 Key Action. No 7a**		Initially 2300 staff from the original allocation (2900) received lateral flow tests. A subsequent consignment of 1300 tests continue to be distributed. There is daily reporting through Silver Command on the numbers of staff taking up lateral flow testing. Staff are issues with lateral flow antigen test kits and management.	Medical Director	March 2021	BAU	Silver Command	3933 kits have been distributed to staff and assurance in place that they are being used. Once tested positive on LFD, staff attend for a PCR test. IPC checklist completed daily across the wards and reported to

Standard/Process/ Issue/Recommendation	'BRAG' Rating	Improvement Required (What does good look like?)	Responsible Lead	Milestones/ Timescales (by end of)	Current Progress Rating	Responsible Committee/ Group	Evidence (What evidence will be provided to demonstrate sustainable improvement?)
							silver.
If your trust has a high nosocomial rate you should undertake additional targeted testing of all NHS staff, as recommended by your local and regional infection prevention and control/Public Health team. Such cases must be recorded, managed and reported using agreed regional/national escalation systems. **NB 10 Key Action. No 7b.**		Where outbreaks of nosocomial infections have occurred, all staff attending the ward have been target tested. Most staff go through the staff self-testing asymptomatic referral route for any outbreaks and LFDs can be used to take pressure off PCR capacity. All positive PCRs are reported straight from the lab validating the result and daily outbreak reporting completed either by the Trust's Testing or IPC team.	Director of Nursing and Quality	March 2021	BAU	Silver Command	Minutes of the daily Outbreak meetings led by IPC services. COVID-19 Daily Outbreak Meeting Ag COVID-19 Daily Outbreak Meeting Ag
Training in IPC standard infection control and transmission-based precautions are provided to all staff		Trust wide education implementation for Infection Prevention Control.	Director or Nursing & Quality Deputy Director of Infection Prevention Control	December 2020	BAU	Trust Infection Prevention Control Group	HCA INDUCTION DATES FOR TRAININ HCA TRAINING-NEW VER
IPC measures in relation to COVID-19 should be		Trust wide education implementation for Infection	Head of Learning &			Silver	Appropriate social distancing

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included in all staff Induction and mandatory training		Prevention Control, including; • Staff Induction • Mandatory training	Organisational Development	December 2020	BAU	command	measures for face to face teaching have been implemented, including reduced class sizes/seating spacing. Face to face sessions have been restricted to essential only. Additional touch point cleaning between sessions has been introduced. Standard mask wearing guidelines and hand gels are in place. The IPC course on induction/TRISTAT has been updated to reference the additional measures needed in light of COVID-19 and signposting and links to current

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							guidance on the intranet along with donning and doffing video and hand hygiene video. The course also directs learners to discuss latest IPC measures with their line manager as a part of local induction. Local induction checklist has now been updated to specifically reference COVID measures.
All staff are regularly reminded of the importance of wearing face masks, hand hygiene and maintaining physical distance both in and out of work		Launch of a Be Safe Be EquiPPEd to ensure Trust wide implementation of PPE guidance.	Director of Nursing & Quality Medical Director Divisional General Managers	April 2021	a)	Operational Infection Prevention Control Group	Trust wide PPE guidance implementation as part of the Be Safe Be Equipped campaign.

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			Heads of Nursing				RISK - master poster.pdf Increased Executive Walk abouts implemented. Ward Walkaround Rota.docx IPC Exec Walk about.xlsx Implementation of Ward Based IPC Champions nosocomial driver diagram Jan 2021 07
All staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context;		Launch of a Be Safe Be EquiPPEd to ensure Trust wide implementation of PPE guidance.	Head of Nursing Emergency Preparedness	April 2021	a)	Silver Command	Trust wide PPE guidance implementation as part of the Be Safe Be Equipped campaign.

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and have access to the PPE that protects them for the appropriate setting and context as per national guidance							RISK - low.pdf RISK - medium.pdf RISK - high.pdf PHE_COVID-19_Donning_quick_guide.pdf PHE_COVID-19_Doffing_quick_guide.pdf PHE_COVID-19_Doffing_poster.pdf COVID-19_PPE_Donning_poster.pdf Series of videos,

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							briefing notes posters and cross road events available on the Trust Intranet used to promote correct use of PPE. Staff compliance measured through weekly PPE audits and monthly quality metrics.
National IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way		Ensure robust process in place for current national IPC guidance to be communicated Trust wide.	Head of Nursing Infection Prevention Control Associate Director of Communications and Engagement	April 2020	BAU	Daily Operational COVID Infection Control Group	Discussed at the Infection Prevention Strategic and Operational meetings three times a week during which "new guidance" is an agenda item, discussed and feedback is given to Silver Command.

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							Covid -19 Risk Assessment v11 05.0 5.3 Phase 3 Silver Workstream Leads.dc 4) Agenda 15.06.2020 Covid Ta Updated guidance is communicated to Trust staff via daily staff briefings, Be Safe, be EquiPPEd campaign, dedicated Coronavirus staff intranet page and staff video briefings. https://mchft.sharepoint.com/sites/intranet/Pages/Coronavirus.aspx https://web.microsoftstream.com/video/caa62c0a-eb5f-

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							4ec0-8d3b-daacee1e0920 The delivery of educational sessions e.g. Crossroads training, visits by Divisional infection prevention champions to increase the means by which guidance is communicated to Trust staff  List for Fit Testing.xlsx  Floor Walkers Rota May 2020.xlsx  Floor Walkers.doc December 2020: Introduction of IPC ward champions.

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							nosocomial driver diagram Jan 2021 07
Changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted		None required.	Chief Operating Officer Director of Nursing & Quality Medical Director	April 2020	BAU	Gold Command & Trust Board	Covid -19 Risk Assessment v11 05.0
Risks are reflected in risk registers and the board assurance framework where appropriate		The Board Assurance framework will be linked to the overarching risk for COVID-19. The overarching risk assessment is updated following silver command and has been presented to Gold command.	Associate Director of Quality Governance	April 2020	BAU	Silver Command	The risk assessment is regularly updated and actions have been closed. New IPC Risk assessments are presented & agreed at Silver Command. Covid -19 Risk Assessment v11 05.0

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							Covid19 Bed Capacity Risk Assess
Robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens		None required.	Consultant Microbiologist Head of Nursing Infection Prevention Control	April 2020	BAU	Trust Infection Prevention Control Group	Policies and procedures on the management of multidrug resistant organisms (MDRO's) are available to all Trust staff. http://lhintra/trust-info/policies-guidelines-sops-and-pathways/quick-links/infection-control/. IPC isolation policy advises on the isolation of patients with communicable diseases who require protective / source isolation

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							http://lhintra/easysiteweb/getresource.axd?assetid=1754&type=0&servicetype=1&filename=/Isolation_Policy_V1.pdf Management of patients is clearly documented by the IPCT on ICNet  Screen shot of ICNet webpage taken 04.0(Estates and facilities work to maintain a safe and clean patient environment.  Ward 4 C4C cleaning audit score sheet Jun  Ward 4 estates actions June 20.pdf

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							Cleaning policy.pdf
That Trust CEOs or the executive responsible for IPC approve and personally signs off, all data submissions via the daily nosocomial sitrep. This will ensure the correct and accurate measurement and testing of patient protocols are activated in a timely manner. **NB. 10 Key Actions. No 5.**		Daily submissions are signed off by the nominated Executive (Chief Operating Officer).	Chief Operating Officer Director of Nursing & Quality	March 2021	a)	Silver Command	COVID19DailySitRep V11 08012021 LEIC Re Daily COVID data 07.01.21.msg Nosocomial information is clinically validated Monday – Friday. Daily oversight of Sitrep sent to the Director of Nursing & Quality, Chief Operating Officer and Director of Operations.
		The Board Assurance Framework was submitted to board in July 2020 and is currently under review. This	Chief Executive Officer	February 2021	a)	Silver Command	Ruth May the Chief Nurse of England visited in October 2020 and reviewed

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		review is due to be reported on in January 2021.					all the systems described in the IPCBAF and described the Trust as being an exemplar organisation in these areas. IPCBAF was assessed by the CQC in July 2020, where good assurance was received.
Ensure Trust Board has oversight of ongoing outbreaks and action plans.		Escalation of outbreaks through Silver and Gold Command.	Director of Nursing & Quality	December 2020	BAU	Silver Command	Daily update of outbreak meetings provided to Silver command meetings when required.
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infection							
Systems and processes are in place to ensure: • Designated teams		Appropriate education and training provided for designated staff who care	Divisional General Manager,	April 2021	BAU		Fit Testing Database.xlsx

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with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas		and treat patients with Covid-19.	Division of Medicine & Emergency Care Head of Nursing, Medicine				https://www.bing.com/videos/search?q=donning+and+doffing+video&docid=608020228254337858&mid=8B4977AEA2280A8B02E28B4977AEA2280A8B02E2&view=detail&FORM=VIRE Copy of FFP2 Fit Check and PPE Educ NIV clinical fow.zip FW__Clinical_Criteria_for_use_of_CPAP_i NIV CPAP Training powerpoint.pptx

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							NIV flow protocol.docx NIV.ppt SOP CPAP.DOC Clinical Competency Assessr Risk assessment for CPAP outside of Crit PPE hand hygiene walkaround checklis 4) PPE - red area.pdf

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							5) PPE - leaving patient area (v2 upd PPE - AMBER v2 July 2020.pdf **Resus & PPE** PPE_for_Resuscitation_of_all_Patients_i
Designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas		Appropriate education and training provided for designated staff who are allocated to clean Covid-19 isolation or cohort areas.	Head of Facilities	May 2020	BAU	Trust Infection Prevention Control Group	Designated teams re-allocated to areas with the appropriate skills in place. All domestic staff trained on correct PPE requirements. All domestic staff trained in appropriate SSOW for COVID 19 and Cohort Wards

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							Refresher.pdf 20191224_medgar_3446_001.pdf
Decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance		Decontamination carried out in line with PHE and national guidance.	Head of Facilities	April 2020	BAU	Trust Infection Prevention Control Group	SSoW X (N) 0001d COVID - 19 Confirme SSoW X (N) 0001e COVID - 19 Un-Confi SSoW X (N) 0003 Mixing Tristel Fuse.xl
Increased frequency at least twice daily of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance		Increased cleaning is completed as set out in the PHE and other national guidance	Head of Facilities	March 2021	BAU	Trust Infection Prevention Control Group	Hours and resources are being reviewed to meet capacity demand and additional infection cleaning hours have been increased across the Trust in all

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							divisions. Additional funding has also been approved for an additional twilight cleaning team which has commenced early November 2020. Additional resources have been requested to support site services and clinical site managers with demands for infection cleans at night. Introduction of Cleaning checks action card to observe compliance with enhanced cleaning and to feedback to Silver Command.

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							nosocomial driver diagram Jan 2021 07
Cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses		Cleaning is completed with the appropriate disinfectant/detergent as per national guidance.	Head of Facilities	December 2020	BAU	Trust Infection Prevention Control Group	Cleaning Bundle including Matrix for cleaning Wipes Cleaning Bundle 23.12.20 KE.docx Gold Silver Bronze v3.docx
Manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/disinfectant solutions/products as per national guidance		• Safe Systems of Work • Staff Induction Training	Head of Facilities	December 2020	BAU	Trust Infection Prevention Control Group	SSoW X (N) Enhanced 01c Clean

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							SSoW X (N) Enhanced 01a Chan SSoW X (N) Enhanced 01d V3 C(SSoW X (N) Enhanced 01e COVI SSoW X (N) Enhanced 01 Cleani Consistent and reliable environmen
'Frequently touched' surfaces e.g. door/toilet handles, patient call bells, over bed tables and bed rails should be decontaminated more than twice daily and when known to be contaminated with secretions, excretions or body fluids		Implementation of Touch point campaign to ensure decontamination of frequently touched surfaces.	Head of Facilities	March 2021	a)	Trust Infection Prevention Control Group	Cleaning sheets include touch point cleaning twice per day by Domestic staff. Scan_Duplessis Kathryn (RBT) Mid Cl

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							Implementation of Let it Shine - Touchpoint Cleaning Let it shine - MCHFT - Wards.pdf Let it Shine Ward Manager Briefing - I Implementation of Ward Based IPC Champions to support Touch point cleaning. nosocomial driver diagram Jan 2021 07
Electronic equipment e.g. mobile phones, desk phones, tablets, keyboards should be cleaned a minimum of twice daily		Implementation of Touch point campaign to ensure decontamination of electronic equipment.	Head of Facilities	March 2021	a)	Trust Infection Prevention Control Group	All clinical and non-clinical staff help to regularly clean touchpoints as part of the 'Let it Shine' campaign

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							Clean environments brief (draft).pdf
Rooms/areas where PPE is removed must be decontaminated, ideally timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)		Enhanced cleaning schedules to ensure decontamination of donning and doffing areas.	Head of Facilities	April 2021	a)	Trust Infection Prevention Control Group	Enhanced Cleaning SSoW SSoW X (N) Enhanced 01c Clean Enhanced Cleaning Hours Review Reviewed Cleaning Hours November 20
Linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken		Compliance with national and local policy in the management of linen from possible and confirmed Covid-19 patients.	Head of Facilities	June 2020	BAU	Trust Infection Prevention Control Group	Infected Linen (Coronavirus).msg Patient Focus Report April 2020.xlsx Trust waste induction training presentation

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							Waste Trust Induction Training V4 Trust Induction Training V4.pptx Infection Control Training 2020.docx
Single use items are used where possible and according to single use policy		Compliance with the Trusts single use policy.	Head of Nursing Infection Prevention Control	April 2021	a)	Trust Infection Prevention Control Group	The Trust "Decontamination Policy" (expiry date April 2022) Decontamination Policy.pdf Infection Prevention and Control Cleaning policy (clinical areas) clarifies single use symbol. Cleaning Policy V3.pdf

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Reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance		Decontamination of reusable equipment in line with Trust policy.	Nurse Consultant Infection Prevention Control / Decontamination	April 2020	BAU	Trust Infection Prevention Control Group	Decontamination Policy.pdf Reusable equipment has continued to be decontaminated in the usual way; in accordance with the Trust's decontamination policy (follows national guidance). This includes processing in the sterile services department and the endoscopy unit. No disposable items of equipment have been subjected to Reprocessing eg. facemask/ ventilation
Ensure cleaning standards and frequencies are monitored in non-clinical		Maintain cleaning standards are achieved in non-clinical areas.	Head of Facilities	March 2021	a)	Trust Infection Prevention Control	Audits undertaken twice per day to provide assurance including Masking

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areas with actions in place to resolve issues in maintaining a clean environment						Group	station audits, communal area audits, stairs & corridors and public toilet audits. new toilet audit.docx Mask Station Audit 18-12-2020.docx
Ensure the dilution of air with good ventilation e.g. open windows, in admission and waiting areas to assist the dilution of air		Promotion and increased provision of air ventilation	Divisional Director of Estates & Facilities	March 2021	BAU	Silver Command	Ward Walkaround Checklist (002).docx Ward Areas that have received Oxygen pipework and upgrade on delivery have been fitted with further provision regarding air exchange ventilation units.

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							commercial_-_t-series_window.pdf FW Covid ward extract fans- list.msg Implementation of Ward Based IPC Champions to support ventilation. nosocomial driver diagram Jan 2021 07
There is evidence organisations have reviewed the low risk COVID-19 pathway, before choosing and decision made to revert to general purpose detergents for cleaning, as opposed to widespread use of disinfectants		Review of the low-risk Covid-19 pathway for use of general purpose detergents for cleaning.	Head of Facilities	March 2021	a)	Trust Infection Prevention Control Group	Implemented cleaning Bundle, Bronze Silver and Gold Standard Cleaning Cleaning Bundle 23.12.20 KE.docx

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							Gold Silver Bronze v3.docx
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance							
Systems and process are in place to ensure: • Arrangements around antimicrobial stewardship is maintained		Processes are in place to ensure antimicrobial stewardship is maintained.	Consultant Microbiologist	April 2020	BAU	Antimicrobial Stewardship Group (ASG)	ASG meetings action points October 2019.docx Approved annual work plan and annual antimicrobial stewardship programme submitted to TIPCG. Action Log October 2019.doc March 2020 virtual meeting action points

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							March 2020 virtual meeting outstanding Antimicrobial Stewardship Program October 2019.docx Annual report 2019-2020 v3.doc Link to guidelines: https://viewer.microguide.global/mcht/adult 11th cycle antibiotic audit in medicine repc 12th cycle antibiotic audit in surgery repor

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							Antibiotic Ward Round quarterly repo AMSG February NL final.pdf
Mandatory reporting requirements are adhered to and boards continue to maintain oversight		Quality assurance measures (e.g. CQUIN, UK 5 year action plan for antimicrobial resistance, National standard contract)	Director of Pharmacy	March 2021		Antimicrobial Stewardship Group (ASG)	CQUIN performance data submission for MCHFT to PHE. CQUIN CCG 1a. q3 data.docx CQUIN CCG 1b q3 data.docx Evaluation of consumption data using Define Rx-info Copy of NG139 Baseline Assessment

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							Copy of NG141 Baseline Assessment
3.1 Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion.							
Systems and processes are in place to ensure: • Implementation of national guidance on visiting patients in a care setting		No improvement required.	Director of Nursing & Quality	April 2020	BAU	Silver Command	The Trust provides advice to visitors in line with Public Health England advice. Visitor guidance poster - 31 March 20 https://www.mcht.nhs.uk/information-for-visitors/coronavirus-covid-19-information/visiting-us/ COVID 19 Visitors Guidance Trigger Too

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							Covid-19 In -Patient Visiting Good Practice In Pateint Visiting Guidance Letter v2.pd Code of Conduct Ward 23 Visiting (drat Ward 26 daily visiting v.1 3.9.20.docx nosocomial driver diagram Jan 2021 07
Areas in which suspected or confirmed COVID-19 patients are being treated in areas clearly marked with appropriate signage and have restricted access		Ensure restricted access to Covid-19 areas and appropriate signage in use.	Head of Estates & Facilities	April 2020	BAU	Daily Operational COVID Infection Control Group	The Trust security system (swipe access) restricts access into clinical areas. Amber & Red clinical areas have designated clearly visible PPE signage at the entrance to the

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							department. Amber PPE door poster picture.docx Red PPE door poster picture.docx Communications team have provided banners, posters, electronic communications regarding the correct PPE to be worn in each clinical area https://mchft.sharepoint.com/sites/intranet/Pages/Coronavirus.aspx POSTER - high risk areas (BESE2, 12 Octo

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							POSTER - low risk areas (BESE2, 12 Octo POSTER - low risk areas (BESE2, 12 Octo POSTER - medium risk areas (BESE2, 12 (
Information and guidance on COVID-19 is available on all trust websites with easy read versions		Staff and public have easy access to the most up to date information and guidance relating to COVID-19 in the most appropriate format for them.	Associate Director of Communications and Engagement	April 2020	BAU	Silver Command	Dedicated Coronavirus intranet site https://mchft.sharepoint.com/sites/intranet/Pages/Coronavirus.aspx as well as Coronavirus information hub on public facing website – https://www.mcht.nhs.uk/information-for-visitors/coronavirus-covid-19-

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							information/  COVID-19 PP Survey Results.pptx Information is also routinely provided through other established channels, such as Facebook, Twitter and through regular staff briefings.  Accessible Information flowchart Links given to national sites where alternative versions are available. Trust website "accessibility" provides some basic tools to support

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							patients/visitors with different communications requirements. This includes being able to change the graphics, text size and language of information on our website, including our 'coronavirus information hub' pages. https://www.mcht.nhs.uk/accessibility/
Infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved		Designated areas for admitting possible or confirmed COVID patients (Amber). Patients requiring speciality input isolated in non COVID areas advising on appropriate PPE/precautions/risk assessments.	Director of Operations Matron – Site/Patient Flow	June 2020	BAU	Bronze COVID operational group	Implementation of patient flow pathways for the management of patient flow in medium and high risk Covid pathways. Flow Pathways Dec 2020 AMENDEDEM.pl

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							Repatriation Request Form; Mid Cheshire Hospitals NHS Trust R BIU dashboard in place to support live status update of patients Screen shot of COVID-19 Portal 11.(
There is clearly displayed and written information available to prompt patients' visitors and staff to comply with Hands, Face, Space Campaign.		Implementation of Hands, Face, Space Campaign.	Associate Director of Communications and Engagement	April 2021	a)	Silver Command	POSTER - patient mask notice (BESE2, Patient packs leaflet.pdf Implementation of Ward Based IPC Champions to support with promotion of

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							Hands, Face, Space Campaign through the IPC Champion action card.  nosocomial driver diagram Jan 2021 07
4. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.							
Systems and processes are in place to ensure: • Screening and triaging of all patients as per IPC and NICE Guidance within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases.		All patients to be screened for Covid-19 as per NICE guidance.	Head of Nursing Infection Prevention Control Service Manager Covid-19 Screening	April 2020	BAU	Silver Command	 Key Actions; IPC control and testing.  COVID swabbing flow chart for 3 & 5
Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms		Covid-19 patients triaged and segregated from non-Covid 19 patients at all front door areas.	Divisional General Manager, Division of Medicine & Emergency	April 2020	BAU	Emergency Department Governance	Waiting room management has been agreed through Infection Prevention Control. Steps have been

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and to segregate from Non Covid-19 cases to minimise the risk of cross-infection as per national guidance			Care Head of Nursing, Urgent & Emergency Services				put in place to minimise the number of patients in the waiting room with a number of chairs being designated as not in use. Due to the high volume of attendances in Emergency Department and the variable nature of peaks, Infection Prevention Control have approved the use of face coverings to be issued to all patients on arrival to minimise risk. Once patients have been triaged and there is capacity in the relevant zone, patients are segregated into green and amber zones for the

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							remainder of their time in ED Waiting area management during
All emergency patients must be tested at emergency admission, whether or not they have symptoms **NB. 10 Key Actions No 8a**		All patients admitted to the Trust via the emergency department or any portal of entry is tested upon admission	Chief Operating Officer	March 2021	BAU	Silver Command	ED Flow chart COVID-19 Response - Adult Patient Flow F
Staff are aware of agreed template for triage questions to ask		Patients who are streamed/triaged have an assessment of C-19 risk recorded electronically in free text.	Divisional General Manager, Division of Medicine & Emergency Care Head of Nursing,	December 2020	BAU	Emergency Department Governance	Walk-in pathway 1.3.docx

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			Urgent & Emergency Services				
Triage undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible		All triage staff have received appropriate triage training and make an assessment of C-19 risk that is recorded electronically in free text.	Divisional General Manager, Division of Medicine & Emergency Care Head of Nursing, Urgent & Emergency Services	December 2020	BAU	Emergency Department Governance	Walk-in pathway 1.3.docx
Face coverings are used by all outpatients and visitors		Mask Stations and signage available at all outpatient entrances to ensure face coverings are used by all outpatient and visitors.	Divisional General Manager, Diagnostics & Clinical Services	December 2020	BAU	Silver Command	Introduction of Volunteer/security to man stations and ensure PPE guidance adhered to. Visiting poster for entrance v2.pdf
Face masks are		All patients to be provided	Head of	March 2021	a)	Silver	Implementation of

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available for patients with respiratory symptoms		with face masks.	Nursing, Infection Prevention Control Head of Nursing, Emergency Preparedness			Command	patient admission packs, including supply of surgical face masks and patient information leaflets. Patient Packs Leaflet.pdf Implementation of Patient face mask stations in ward bay areas. POSTER - patient mask notice (BESE2, Introduction of ward based IPC Champions to challenge patients non-compliant with face masks and provide appropriate education.

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							nosocomial driver diagram Jan 2021 07
Provide clear advice to patients on use of face masks to encourage use of surgical facemasks by all inpatients in the medium and high-risk pathways if this can be tolerated and does not compromise their clinical care		Implementation of Patient admissions packs, including supply of surgical face masks and patient information leaflets to promote the Hands, Face, Space Campaign.	Head of Nursing, Emergency Preparedness	March 2021	a)	Silver Command	Patient Packs Leaflet.pdf Implementation of Patient face mask stations in ward bay areas. POSTER - patient mask notice (BESE2, Introduction of ward based IPC Champions to challenge patients non-compliant with face masks and provide appropriate education. nosocomial driver diagram Jan 2021 07
Ideally segregation		Implementation of Step Back	Head of	March 2021	a)	Silver	

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should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff.		Campaign to promote 2m social distancing across the site and introduction in the use or Perspex screens.	Estates & Facilities			Command	Implementation of Step Back Campaign to promote 2m social distancing across the site. MCH - Social Distancing Campaig MCH - Social Distancing Campaig MCH - Social Distancing Campaig MCH - Social Distancing Campaig Implementation of Perspex screens where appropriate eg; ED waiting rooms, Main Entrance Help Desk, offices, Nursing Stations.

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Moving patients increases their risk of transmission of infection. For urgent and emergency care, hospitals should adopt pathways that support minimal or avoid patient bed/ward transfers for the duration of their admission (unless clinically imperative). The exception will be patients who need a period of care in a side room or other safe bed while waiting for their COVID test results. On occasions when it is necessary to cohort COVID or non-COVID patients because of bed occupancy, then reliable application of IPC measures must be implemented. It is also imperative that any vacated areas are cleaned as per guidance.		The Trust has two pathways into the hospital - symptomatic and asymptomatic. The asymptomatic patients remain inside rooms / step down ward until two negative tests. Where patients are admitted via the asymptomatic pathway, the patients remain on the admission wards until the first negative result (June 2020) Covid response patient flow was reviewed in December 2020 and a revised process was launched in December 2020 that meet the criteria.	Chief Operating Officer	February 2021	a)	Silver Command	Covid -19 Symptomatic and Asy COVID-19 Response - Adult Patient Flow F Flow Pathways Dec 2020 updated v2 FIN

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NB 10 Key Action No 4							
For patients with new-onset symptoms, isolation, testing and instigation of contact tracing is achieved until proven negative		All Patients with new on-set symptoms are isolated, tested and contact-traced as per the Cocid-19 flow pathway.	Head of Nursing, Infection Prevention Control	December 2020	BAU	Daily Operational COVID Infection Control Group	Flow Pathways Dec 2020 updated v2 FIN RAG House.pptx
Patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly		None required.	Head of Nursing, Infection Prevention Control Matron – Site/Patient Flow	May 2020	BAU	Daily Operational COVID Infection Control Group	Flow Pathways Dec 2020 updated v2 FIN RAG House.pptx
Those who test negative upon admission must have a retest on day 3 of admission, and again between 5-7 days post admission. **NB. 10 Key Actions. No 8c**		All patients admitted to the Trust are tested upon admission, at day 3 and at day 5. There is a dedicated team to support the wards ensuring this happens 7 days per week. Throughout the second wave we have introduced additional matron support to monitor this.	Director of Nursing & Quality Medical Director	March 2021	a)	Silver Command	Dedicated patient testing team in place. Daily performance against numbers of patients tested is reported and actioned at silver.

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Those who go on to develop symptoms of COVID-19 after admission must be retested at the point symptoms arise. **NB. 10 Key Action Point. No 8b**		Patient Flow Policy in place. This covers re-testing of symptomatic patients at the point of symptoms arising after admission.	Director of Nursing & Quality Medical Director	March 2021	BAU	Infection Prevention Control Outbreak Meeting	COVID-19 Daily Outbreak Meeting Ag COVID-19 Daily Outbreak Meeting Ag
Patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately.		Patients are asked COVID-19 screening questions prior to attending their outpatient appointment. Patients have their temperature checked, as a COVID-19 screen, prior to attending their outpatient appointment.	Divisional General Manager, Surgery & Cancer Division Head of Nursing, Surgery & Cancer Division	June 2020	BAU	Outpatient Planning Group (Transformation Meeting)	Screening questions are BAU in Outpatient areas outpatient screening questions chart.docx Temperature checks trialled in the Eye Care Centre. Proposed Enhanced Screening (Temperatı
Sites with high nosocomial rates should consider testing COVID negative patients daily. **NB. 10 Key Action. No**		Daily testing implementation for negative patients in areas of high nosocomial rates.	Chief Executive Officer Chief Operating	March 2021		Silver Command	Outbreak meetings; clinical decision made to retest all patients in areas of outbreak.

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8d			Officer Director of Nursing & Quality Medical Director				IPC group scoping national/regional response to daily testing of all negative patients.
5. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.							
Systems and processes are in place to ensure: • Separation of patient pathways and staff flow to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas		Segregated patient and staff pathways.	Head of Estates & Facilities Associate Director of Communications and Engagement	April 2020	BAU	Silver Command	Signage is on display across the Trust to create one way systems in areas of staff/ flow e.g. restaurant and cafe, restricted access to areas such as lifts, small communal spaces, clinic rooms etc. Segregation of staff and patient entrances across the Trust. BeSafeBequiPPEd posters are displayed to clearly

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							mark low, medium and high risk pathways. RISK - medium.pdf RISK - low.pdf MCH - Social Distancing Campaign RISK - high.pdf
Where bays with high numbers of beds are in use, these must be risk assessed, and where 2m can't be achieved, physical segregation of patients must be considered. The concept of 'bed, chair, locker' should be implemented. All wards should be effectively ventilated.		Risk Assessment completed by the IPC team – control measure includes enhanced cleaning, campaign for patients wearing masks and the use of enhanced ventilation, increased patient testing on day 3 and LFDs for staff. Introduction of ward based IPC Champions 04/01/2021	Chief Operating Officer	February 2021	a)	Silver Command	Social distancing Risk Assessment Forr IPC champions are also checking concept of bed, chair, locker repositioning, reporting transgressions to

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NB. 10 Key Action No 6.							silver.
All staff (clinical and non-clinical) have appropriate training, in line with latest national guidance to ensure their personal safety and working environment is safe		Launch of the Be EquiPPEd campaign across the Trust to demonstrate appropriate PPE usage. Training updates provided through the Be Safe Be Equipped 2 Campaign.	Head of Nursing, Infection Prevention Control Head of Nursing, Emergency Preparedness Head of Nursing Engagement & Wellbeing	May 2020	BAU	Silver Command	Daily crossroad events delivered, including demonstration of Red/Amber/Green PPE equipment required. Signature list of attendance documented. Trust communications 12.0(https://web.microsoftstream.com/video/caa62c0a-eb5f-4ec0-8d3b-daacee1e0920 List for Fit Testing.xlsx Display of posters/banners to support the campaign across the Trust/on

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							entrance to ward areas highlighting appropriate PPE usage for Red/Amber/Green environment. https://mchft.sharepoint.com/sites/intranet/Pages/Coronavirus.aspx Matron rota supporting PPE training during campaign launch. Late shifts covered to capture shift handover. Senior/executive walk abouts across inpatient ward areas to address staff concerns/issues with PPE usage Implementation of floor walkers to promote Be Equipped

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							campaign. Initial visits to inpatient wards followed by focus on non-clinical areas across the Trust Floor Walkers Rota May 2020.xlsx FFP3 fit test training sessions provided for staff required to undertake aerosol generating procedure. Database of staff training captured. List for Fit Testing - Excel data.xlsx COVID-19 Remobilisation Guida

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							Be safe Be EquiPPEd campaign key points.c
All staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to Don and Doff it safely		Launch of the Be EquiPPEd campaign across the Trust to demonstrate appropriate PPE usage. Training updates provided through the Be Safe Be Equipped 2 Campaign.	Head of Nursing, Infection Prevention Control Head of Nursing, Emergency Preparedness Head of Nursing Engagement & Wellbeing	May 2020	BAU	Silver Command	Staff have 1:1 and group training on the availability and use of PPE relevant to their clinical area. This is reinforced by the provision of education at Crossroads training & visits by Divisional infection prevention champions. List for Fit Testing.xlsx Posters / banners depicting PPE use in red, amber green, blue areas are available at the entrance to all ward areas with

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							banners being visible in corridor areas. Amber PPE door poster picture.docx Intranet educational support https://mchft.sharepoint.com/sites/intranet/Pages/Coronavirus.aspx
A record of staff training is maintained		For staff records to be accurately maintained. Relevant staff to be fit tested.	Head of Nursing, Infection Prevention Control Head of Nursing, Emergency Preparedness Head of Nursing Engagement & Wellbeing	May 2020	BAU	Trust Infection Prevention Control Group	Central log FFP2 & FFP3 testing kept on a live database on the Trust S drive. Database of staff trained during Be Safe Be EquiPPEd launch maintained. List for Fit Testing.xlsx

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Appropriate arrangements are in place that any reuse of PPE in line with the MHRA CAS Alert is properly monitored and managed		Appropriate equipment and alternative provision guidance is available for Divisional teams.	Head of Nursing, Emergency Preparedness Head of Nursing, Infection Prevention Control	Duration of the COVID pandemic	a)	Silver Command	Infection prevention provided a response to the alert on 05.05.20 Screen shot relating to PPE shortages.doc
Any incidents relating to the re-use of PPE are monitored and appropriate action taken		No incidents reported.	Associate Director of Governance	December 2020	BAU	Patient Safety Summit	Any incidents reported would be managed through the Patient Safety Summit. Minutes from the Summit and virtual huddle board via teams. Policy - Incident Investigation, Learning, Reporting and Improving Incident Reporting Management Learnin

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Adherence to PHE national guidance on the use of PPE is regularly audited		Implementation of weekly PPE audits, undertaken by the ward managers.	Head of Nursing, Infection Prevention Control	May 2020	BAU	Daily Operational COVID Infection Control Group	PPE Audit Tool DRAFT June-20 v3.d(
Staff wear the right level of PPE when in clinical settings, including use of face masks in non-clinical settings, with systems in place to monitor adherence. Movement of staff between Covid and Non-Covid areas is minimised. **NB. 10 Key Actions. No 3**		The PPE audit demonstrates very good compliance within all the clinical and non-clinical teams. Face masks worn by all staff in all areas, both clinical and non-clinical was introduced before the national mandate. Monitoring is done through the IPC champion and IPC checklist action cards. **No improvement required**	Director of Nursing and Quality Medical Director	March 2021	a)	Silver Command	PPE audit v3.xlsx nosocomial driver diagram dec 2020 v6 Daily safe staffing meetings in place, chaired by the Heads of Nursing to ensure staff are not moved between Covid and non-Covid wards.
Hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimise		IPC measures are available for all patients/individuals, staff and visitors to minimise Covid-19 transmissions.	Head of Nursing, Infection Prevention Control	March 2021	a)	Silver Command	Hygiene evidence one .docx

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COVID-19 transmission such as: -hand hygiene facilities including instructional posters -good respiratory hygiene measures -maintaining physical distancing of 2 metres wherever possible unless wearing PPE as part of direct care -frequent decontamination of equipment and environment in both clinical and non-clinical areas -clear advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas							MCH - Social Distancing Campaig RISK - master poster.pdf POSTER - patient mask notice (BESE2, Patient Packs Leaflet.pdf Visiting poster for entrance v2.pdf Introduction of ward based IPC Champions. nosocomial driver diagram Jan 2021 07
Staff regularly undertake hand hygiene and observe standard infection control		Completion of Monthly quality metric audits undertaken in ward areas. This includes audit of Infection Control	Head of Nursing, Infection	May 2020	BAU	Trust Infection Prevention Control	Independent hand hygiene audits are undertaken by hand hygiene

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precautions		standards and hand hygiene.	Prevention Control				champions based in clinical areas. Monthly hand hygiene audits undertaken by ward managers. In areas of outbreaks, daily hand hygiene audits completed.  Hand Hygiene scores 2020 - ward and outp Additional hand hygiene compliance monitored through the monthly quality metrics.  Mid Cheshire Trust_IPC_ Quality Met Hand hygiene compliance monitored by IPC

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							checklist.
Staff consistently practice good hand hygiene and all high touch surfaces, and items are decontaminated multiple times every day with systems in place to monitor assurance **NB. 10 Key action. No 1**		Ward areas undertake monthly staff hand hygiene audits. Attached are the results which give assurance on compliance. However, monitoring is undertaken by the IPC team. A suite of Quality Metrics is undertaken monthly. This includes auditing hand hygiene practice The "Let it Shine" cleaning Campaign is in progress and involves ward staff cleaning high contact areas four times daily.	Director of Nursing and Quality Director of Finance	March 2021	a)	Silver Command	Hand Hygiene scores 2020 - ward and outp Let it shine - MCHFT - Wards.pdf There is limited assurance that the touch points are being cleaned daily. The introduction of the IPC checklist is supporting the monitoring and the IPC champions support completion of the forms. nosocomial driver diagram dec 2020 v6

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The use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance		No action required.	Divisional Director of Estates & Facilities	December 2020	BAU	Trust Infection Prevention Control	There are no hand dryers within the clinical areas. Soft absorbent tissue dispensers are located next to all sinks outside of splash zones
Guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff areas		Clearly displayed guidance on hand hygiene, including hand drying.	Associate Director of Communications and Engagement	March 2021	a)	Trust Infection Prevention Control Group	Hygiene evidence one .docx
Staff understand the requirements for uniform laundering where this is not provided for on site		Staff will be compliant with Trust Uniform policy	Head of Nursing, Infection Prevention Control	April 2020	BAU	Trust Infection Prevention Control Group	The Trust uniform policy provides advice regarding the laundering of uniforms. This advice is reiterated by the IPCT.

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							Uniform and Dress Code Policy.pdf FFP2 information sheet highlights laundering process COVID 19.docx
All staff understand the symptoms of COVID-19 and take appropriate action (even if experiencing mild symptoms) in line with PHE national guidance and other if they or a member of their household display any of the symptoms		None Required.	Head of Nursing, Infection Prevention Control Associate Director of Communications and Engagement Service Manager, Cheshire NHS Occupational Health Service	April 2020	BAU	Silver Command	Updated guidance (or signposting to national advice) is included in on the Trust's website (coronavirus information hub), staff intranet, and regular updates are provided as part of the Trust's coronavirus briefings. https://www.mcht.nhs.uk/information-for-visitors/coronavirus-covid-19-information/

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							https://mchft.sharepoint.com/sites/intranet/Pages/Coronavirus.aspx Occupational Health supporting the national initiative for track and trace  Ocupational Health SOP 09.06.20.docx
A rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals)		The following information is already readily available - Staff prevalence (however only available to IPC) - Hospital transmission – available to everyone - C&M transmission – available on Tableau - Local council rates – available on gov.uk	Director of Operations	December 2020	BAU	Silver Command	Information is available for Covid positive rates within the hospital and staff cases  Power BI Covid Dashboard.PNG Prevalence across Cheshire and Mersey available via GOLD command daily and shared with silver

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							command.
Positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported.		Positive cases will be reviewed through an outbreak investigation.	Associate Director of Governance Head of Nursing Infection Prevention Control	December 2020	BAU	Trust Infection Prevention Control Group	Post Infection Review.docx PIR Panel Agenda V2.doc PIR flowchart.docx TOR PIR Root Cause Analysis Terms of Re
Robust policies and procedures are in place for the identification of and management of outbreaks of infection		Implementation of daily outbreak meetings and adherence to Trust policy.	Head of Nursing Infection Prevention Control Nurse Consultant Infection Prevention Control / Decontamination	December 2020	BAU	Trust Infection Prevention Control Group	Daily Outbreak meetings held. Outbreak Info-National.docx COVID HOCI SOP1.7 090620pdf (3

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							COVID-19 Daily Outbreak Meeting A
Staff maintain social distancing (2m+) in the workplace, when travelling to work (including avoiding car sharing) and to remind staff to follow public health guidance outside of the workplace. **NB. 10 Key Actions, No 2**		Daily coronavirus briefings to all staff reminding them of national guidance, which includes key messages around care sharing, is distributed on an almost daily basis, and are also included on social media accounts; covering both Local and National information (example of briefing enclosed). In addition, there is specific guidance for those who do need to car share with regards to reducing the risks. **No improvement required**	Chief Operating Officer	March 2021	a)	Silver Command	STAFF BRIEFING Coronavirus update (STAFF BRIEFING Coronavirus update (i
6. Provide or secure adequate isolation facilities							
Systems and processes are in place to ensure: • Restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other		Pathway process has been designed and agreed by silver command Daily Flow Operational Group established to managed challenging patient placement queries and	Director of Operations	January 2021	a)	Silver command	Flow Pathways Dec 2020 AMENDEDEM.pl To ensure sustainable

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patients/individuals, visitors or staff		evolving situations. Senior attendance, oversee by the Chief Operating Officer. Increased comms to organisation required					improvement; Audit of compliance required January / February 2021
Areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas		Launch of Be Safe Be Equipped Campaign and Be Safe Be Equipped Campaign 2.	Divisional Director of Estates & Facilities Associate Director of Communications and Engagement	December 2020	BAU	Silver Command	BeSafe Be EquiPPEd posters are displayed to clearly mark low, medium and high risk areas and highlight appropriate PPE for those areas. RISK - medium.pdf RISK - high.pdf RISK - low.pdf
Patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or		None required.	Head of Nursing Infection Prevention	April 2020	BAU	Infection Control operation group	Flow Pathways Dec 2020 updated v2 FIN

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designated areas where appropriate			Control Matron -Site / Patient Flow				Mid Cheshire Hospitals NHS Trust R RAG House.pptx
Areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance		Infection Control environmental measures meet the requirements set out in PHE national guidance.	Head of Capitol Development	December 2020	BAU	Silver command	Several measures have been implemented; Permanent wash hand basins to ward entrances in wards 1. 4, 10, 13, 15, 18, 19 and Ward A in South Cheshire Hospital. Temporary / mobile wash hand basins – 2 fitted in Critical Care and 1 in South Cheshire Hospital and ordered for ward areas without permanent sink fixture.

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							Perspex screen fitted to x-ray reception desk, fracture clinic reception, ENT reception and Urology reception. Demountable partitions to form 2 isolation rooms in James Cross and partitions between ward 16 and 17. 2 temporary mortuaries COVID testing pod in front of Emergency Department Drive-in testing in front to of Emergency Department and South Cheshire Hospital.

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							Ventilation into wards 3 5 and 7. Increased oxygen supplies to wards 3, 5 7 and recovery Social distance signage erected. Additional Perspex screens throughout the hospital as required.
Patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement		None required	Head of Nursing Infection Prevention Control Nurse Consultant Infection Prevention Control / Decontamination	December 2020	BAU	Executive Infection Prevention Control Group	http://lhintra/trust-info/policies-guidelines-sops-and-pathways/quick-links/infection-control/
7. Secure adequate access to laboratory support as appropriate							
There are systems and processes in place to		Prioritisation of admission screens with reporting within	Divisional General	February 2021	a)	Testing	All patients swabbed on day of

Standard/Process/ Issue/Recommendation	'BRAG' Rating	Improvement Required (What does good look like?)	Responsible Lead	Milestones/ Timescales (by end of)	Current Progress Rating	Responsible Committee/ Group	Evidence (What evidence will be provided to demonstrate sustainable improvement?)
ensure: • screens taken on admission given priority and reported within 24hrs		24 hours.	Manager, Diagnostics and Clinical Services.			Advisory Group Silver Command Diagnostics & Clinical Services board	admission and Day 3, 5, 10 & 20. Not all swabs reported within 24 hours. However, Fast Swabs – all in house (8-8pm) – 12 Cepheid swabs – utilised be discharges/Critical Care/Key staff 50 Samba swabs – utilised by ED for admission.  Weekend plans Swab allocation.pptx Compliance monitored daily. Weekly meetings with UHNM in place to work towards improvements – limited by equipment and reagent capacity

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							(nationally controlled)  Covid testing procedures v2.1.docx
Regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available		None required.	Divisional General Manager, Diagnostics and Clinical Services.	December 2020	BAU	Testing Advisory Group Silver Command Diagnostics & Clinical Services board	 COVID TATs 30122020.xlsx TAT report produced daily providing both collection to validation and receipt to validation information. Meeting held 3 times per week with TATs on agenda
Regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data)		Cases reported in line with testing protocols.	Divisional General Manager, Diagnostics and Clinical Services.	December 2020	BAU	Testing Advisory Group Silver Command Diagnostics	 COVID TATs 30122020.xlsx We record and monitor that the date and time of collection has been

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						& Clinical Services board	added and the lab has a sample acceptance policy.
Screening for other potential infections takes place		IPC routine work undertaken daily.	Consultant Microbiologist Head of Nursing, Infection Prevention Control	December 2020	BAU	Pathology management committee	Routine laboratory work UKAS accreditation
8. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections							
Systems and processes are in place to ensure that: • Staff are supported in adhering to all IPC policies, including those for other alert organisms.		None Required.	Head of Nursing, Infection Prevention Control	April 2020	BAU	Trust Infection Prevention Control group	IPC policies are available on the IPC webpage Evidence of the advice given to staff in line with Trust policies is recorded on the IPC ICNet pathology system  Screen shot of ICNet webpage taken 04.0(

Standard/Process/ Issue/Recommendation	'BRAG' Rating	Improvement Required (What does good look like?)	Responsible Lead	Milestones/ Timescales (by end of)	Current Progress Rating	Responsible Committee/ Group	Evidence (What evidence will be provided to demonstrate sustainable improvement?)
							Infection Prevention Control Team deliver informal advice (ward based discussions) and formal training on the management of alert organisms
All clinical waste and linen/laundry related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance		SSOW in place for removal of clinical waste that meets PHE requirements in relation to Suspected or confirmed Covid 19. All staff Trained in relation the SSOW Audits undertaken to ensure compliance against SSOW and segregation of all clinical waste.	Head of Facilities	May 2020	BAU	Trust Infection Prevention Control Group	SSoW X (N) 0018 WASTE Collection of (SRCL Coronavirus waste guide.pdf Waste Flow Chart V2.docx Patient Focus Report April 2020.xlsx
Any changes to the PHE national guidance on PPE are quickly identified and effectively		Staff receive regular communication to ensure they remain aware of recommended PPE for their	Head of Nursing, Infection Prevention	April 2020	BAU	Daily Operational COVID Infection	National guidance updates highlighted at Daily Operational COVID

Standard/Process/ Issue/Recommendation	'BRAG' Rating	Improvement Required (What does good look like?)	Responsible Lead	Milestones/ Timescales (by end of)	Current Progress Rating	Responsible Committee/ Group	Evidence (What evidence will be provided to demonstrate sustainable improvement?)
communicated to staff.		use.	Control			Control Group	Infection Control Group for decision making. Escalated to Silver and Gold Command. Updated guidance is communicated to Trust staff via daily staff briefings, floor walkers, Be Safe, be EquiPPEd campaign, dedicated Coronavirus staff intranet page and staff video briefings. Floor Walkers Rota May 2020.xlsx
PPE stock is appropriately stored and accessible to staff who require it		All staff have appropriate PPE and there is a good supply stored centrally and can be accessed easily.	Deputy Director of Finance Receipts & Distribution Centre Manager	April 2020	BAU	Silver Command	A central supply of stock is held within Receipts & Distribution Centre and monitored by a computerised stock management system which records receipts

Standard/Process/ Issue/Recommendation	'BRAG' Rating	Improvement Required (What does good look like?)	Responsible Lead	Milestones/ Timescales (by end of)	Current Progress Rating	Responsible Committee/ Group	Evidence (What evidence will be provided to demonstrate sustainable improvement?)
			Head of Nursing, Emergency Preparedness				and issues. An appropriate stock holding is managed on key Wards/Departments determined by the individual status of the department, Trust policy and historical data (when available). Stock is replenished by Supplies staff on a regular basis Out of Hours PPE Access to Receipts ar PPE Burner spread sheet is also utilised to assist predictive stock usage.
9. Have a system in place to manage the occupational health needs and obligation of staff in relation to infection							
Appropriate systems and processes are in place to ensure: • Staff in 'at-risk' groups		None required.	Service Manager, Cheshire NHS Occupational	December 2020	BAU	Silver Command Health &	Fully automated/electronic staff risk assessment tool is

Standard/Process/ Issue/Recommendation	'BRAG' Rating	Improvement Required (What does good look like?)	Responsible Lead	Milestones/ Timescales (by end of)	Current Progress Rating	Responsible Committee/ Group	Evidence (What evidence will be provided to demonstrate sustainable improvement?)
are identified using an appropriate risk assessment tool and managed appropriately including ensuring their physical and wellbeing is supported			Health Service Head of HR			Wellbeing group	now in place for all staff with responses stored centrally. SOP Available here - http://lhintra/easysiteweb/getresource.axd?assetid=4977&type=0&servicetype=1&filename=/Covid-19_Staff_Risk_Assessments.pdf Documents are all available here - https://mchft.sharepoint.com/sites/intranet/Pages/Coronavirus.aspx under the COVID-19 Staff Risk Assessment – V7 November 2020 section. Wellbeing resources are available for all

Standard/Process/ Issue/Recommendation	'BRAG' Rating	Improvement Required (What does good look like?)	Responsible Lead	Milestones/ Timescales (by end of)	Current Progress Rating	Responsible Committee/ Group	Evidence (What evidence will be provided to demonstrate sustainable improvement?)
							staff to access https://mchft.sharepoint.com/sites/intranet/Pages/COVID-19-Health-and-Wellbeing-Resources.aspx and are included regularly in the comms
Staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained and held centrally		Record to show FFP fit check has been undertaken and staff are aware of the use of FFP2 as an enhanced surgical mask.	Head of Nursing, Emergency Preparedness	Duration of the pandemic	a)	Silver Command	EasiAir Hoods are currently the reusable Respirator available if staff member has failed FFP3 mask fit test SOP clean template EasiAir.doc Hood overview.docx EasiAir log. Checklistno watermar https://vimeo.com/4

Standard/Process/ Issue/Recommendation	'BRAG' Rating	Improvement Required (What does good look like?)	Responsible Lead	Milestones/ Timescales (by end of)	Current Progress Rating	Responsible Committee/ Group	Evidence (What evidence will be provided to demonstrate sustainable improvement?)
							32824939/71ee81e74b EasiAir Hood Video  Copy of Copy of EasiAir Powered Air H
That risk assessment(s) is (are) undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic (BAME) and pregnant staff		None Required.	Service Manager, Cheshire NHS Occupational Health Service Head of HR	December 2020	BAU	Silver Command	Fully automated/ electronic staff risk assessment tool is now in place for all staff with responses stored centrally. SOP Available here - http://lhintra/easysiteweb/getresource.axd?assetid=4977&type=0&servicetype=1&filename=/Covid-19_Staff_Risk_Assessments.pdf Documents are all available here - https://mchft.shar

Standard/Process/ Issue/Recommendation	'BRAG' Rating	Improvement Required (What does good look like?)	Responsible Lead	Milestones/ Timescales (by end of)	Current Progress Rating	Responsible Committee/ Group	Evidence (What evidence will be provided to demonstrate sustainable improvement?)
							epoint.com/sites/intranet/Pages/Coronavirus.aspx under the COVID-19 Staff Risk Assessment – V7 November 2020 section Wellbeing resources are available for all staff to access https://mchft.sharepoint.com/sites/intranet/Pages/COVID-19-Health-and-Wellbeing-Resources.aspx and are included regularly in the comms
Staff who carry out fit test training are trained and competent to do so		All fit test testers to be suitably trained.	Head of Nursing, Emergency Preparedness	March 2021	a)	Trust Infection Prevention Control Group	Fit testing register and master data base includes testing, education and logs from all pertinent staff areas.

Standard/Process/ Issue/Recommendation	'BRAG' Rating	Improvement Required (What does good look like?)	Responsible Lead	Milestones/ Timescales (by end of)	Current Progress Rating	Responsible Committee/ Group	Evidence (What evidence will be provided to demonstrate sustainable improvement?)
							fit test& train the trainer17320.xlsx LHRPS2_MFD3AF00793_0107_001.pdf Fit Testing Database.xlsx
All staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used		Ensure staff are fit tested on all models of FFP respirators to be used.	Head of Nursing, Emergency Preparedness	March 2021	a)	Trust Infection Prevention Control Group	Fit Testing Database.xlsx
A record of the fit test and result is given to and kept by the trainee and centrally within the organisation		Result of fit test logged on system and employee aware of fit testing failure at time of test. Paper copy for staff available.	Head of Nursing, Emergency Preparedness	March 2021	a)	Trust Infection Prevention Control Group	Quantitative test record held within 'Portacount system' also Paper copy for staff available. Fit Testing Database.xlsx

Standard/Process/ Issue/Recommendation	'BRAG' Rating	Improvement Required (What does good look like?)	Responsible Lead	Milestones/ Timescales (by end of)	Current Progress Rating	Responsible Committee/ Group	Evidence (What evidence will be provided to demonstrate sustainable improvement?)
For those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation of repeated testing on alternative respirators and hoods		Central database records held for fit testing.	Head of Nursing, Emergency Preparedness	March 2021	a)	Trust Infection Prevention Control Group	Fit Testing Database.xlsx Data base holds test attempts and failures. If fail, and working in an area requiring FFP3 then EasiAir hood is given as an alternative, logged out and education on use and user cleaning given: supported by video on Trust Intranet, and suite of documents
For members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with		Discussions to be held locally regarding any redeployment due to risk factors.	Head of Nursing, Emergency Preparedness	March 2021	a)	Trust Infection Prevention Control Group	Covid-19 risk assessment V7 - Final Any FFP3 masks that fail a fit test are fit tested to an alternative mask in line with HSE standards. If an alternative FFP3 cannot be found

Standard/Process/ Issue/Recommendation	'BRAG' Rating	Improvement Required (What does good look like?)	Responsible Lead	Milestones/ Timescales (by end of)	Current Progress Rating	Responsible Committee/ Group	Evidence (What evidence will be provided to demonstrate sustainable improvement?)
nationally agreed algorithm							and successfully passed re fit test process then the member of staff is issued a Hood respirator unit.  SOP clean template EasiAir.doc  Hood overview.docx  EasiAir log. Checklistno watermar
A documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health		No action required.	Head of Nursing, Emergency Preparedness	March 2021	BAU	Trust Infection Prevention	Resolution of this issue is achieved by the staff member being given a Respirator hood. All staff undergo workplace risk assessments with staff member and

Standard/Process/ Issue/Recommendation	'BRAG' Rating	Improvement Required (What does good look like?)	Responsible Lead	Milestones/ Timescales (by end of)	Current Progress Rating	Responsible Committee/ Group	Evidence (What evidence will be provided to demonstrate sustainable improvement?)
						Control Group	their manager these link to occupational health as required . Log of Hood education and distribution is actively maintained.  Copy of Copy of EasiAir Powered Air H
Following consideration of reasonable adjustments e.g. respiratory hoods, personal re-usable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational health service record		None required.	Head of Nursing, Emergency Preparedness	April 2020	BAU	Trust Infection Prevention Control Group	Resolution of this issue is achieved by the staff member being given a Respirator hood. Failure of fit test is as above, linked to the use of EasiAir hood. Staff Redeployment is linked to their personal risk

Standard/Process/ Issue/Recommendation	'BRAG' Rating	Improvement Required (What does good look like?)	Responsible Lead	Milestones/ Timescales (by end of)	Current Progress Rating	Responsible Committee/ Group	Evidence (What evidence will be provided to demonstrate sustainable improvement?)
							assessment.
Boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board		Oversight of fit testing through Trust Board.	Head of Nursing, Emergency Preparedness	March 2021	a)	Trust Infection Prevention Control Group	This BAF holds the information to inform the Board on the processes and systems in place regarding fit testing and the use of the Hood respirators, which applies across the organisation.
Consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency care pathways as per national guidance		All elective wards/ departments have designated roster for staff thus reducing movement between wards. Movement of staff between elective areas and Covid – 19 positive areas is not allowed. To maintain safe staffing levels staff are moved if necessary, for complete shift from elective to Medium Risk wards or vice versa. Staff complete LFD tests twice weekly to provide assurance on negative Covid status	Head of Nursing, Surgery & Cancer Division	December 2020	BAU	Silver Command	Embedded process for staff screening for elective pathways. This is also recently supported by staff Lateral Flow Testing.  SOP Elective Surgery and COVID Verion 4 Individual rosters available on Health Roster

Standard/Process/ Issue/Recommendation	'BRAG' Rating	Improvement Required (What does good look like?)	Responsible Lead	Milestones/ Timescales (by end of)	Current Progress Rating	Responsible Committee/ Group	Evidence (What evidence will be provided to demonstrate sustainable improvement?)
Elective patients must be tested within 3 days before admission and must be asked to self-isolate from the day of their test until the day of admission. **NB. 10 Key Action No 8f**		All elective admissions are swabbed 72 hours before admission and advised to self-isolate. The Trust cannot evidence if they have self-isolated but can evidence that patients have received information leaflet and verbally advised when contacted by their scheduler to arrange their surgery date. Policy attached for information.	Chief Operating Officer	March 2021	BAU	Silver Command	Elective Surgery Programme sop.pdf
All staff should adhere to national guidance on social distancing (2 metres) if not wearing a facemask and in non-clinical areas		None Required.	Head of Health & Safety	December 2020	BAU	Silver Command	MCH - Social Distancing Campaig MCH - Social Distancing Campaig MCH - Social Distancing Campaig MCH - Social Distancing Campaig

Standard/Process/ Issue/Recommendation	'BRAG' Rating	Improvement Required (What does good look like?)	Responsible Lead	Milestones/ Timescales (by end of)	Current Progress Rating	Responsible Committee/ Group	Evidence (What evidence will be provided to demonstrate sustainable improvement?)
							MCH - Social Distancing Campaig MCH - Social Distancing Campaig MCH - Social Distancing Campaig MCH - Social Distancing Campaig MCH - Social Distancing Campaig
Health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone • staff are aware of the need to wear facemask when moving through		Health & Care settings are Covid-19 secure work place.	Head of Health & Safety	March 2021	a)	Silver Command	Office space work-based risk assessments undertaken. Social distancing Step Back Campaign implemented, including Trust signage.

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COVID-19 secure areas.							Launch of Trust wide Be Safe Be EquiPPEd campaign (2) to ensure the use of face masks.
Staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing		Staff are able to access testing and supported in self-isolation and absence.	Service Manager, Cheshire NHS Occupational Health Service Head of HR Divisional Heads of Nursing Head of Nursing, Infection Prevention Control	April 2020	BAU	Workforce Group	IPC team liaise with the member of staff as required to signpost them to the relevant testing hub if required. Occupational health support as per the below guidance. https://www.gov.uk/government/publications/covid-19-management-of-exposed-healthcare-workers-and-patients-in-hospital-settings/covid-19-management-of-exposed-

Standard/Process/ Issue/Recommendation	'BRAG' Rating	Improvement Required (What does good look like?)	Responsible Lead	Milestones/ Timescales (by end of)	Current Progress Rating	Responsible Committee/ Group	Evidence (What evidence will be provided to demonstrate sustainable improvement?)
							healthcare-workers-and-patients-in-hospital-settings Ocupational Health SOP 09.06.20.docx
Staff who test positive have adequate information and support to aid their recovery and return to work		Guidance on Staff returning to work is available through Occupational Health.	Service Manager, Cheshire NHS Occupational Health Service Head of Nursing, Infection Prevention Control	April 2020	BAU	Trust Infection Prevention Control Group	Infection Prevention contacting staff by phone to inform them of their COVID-19 status and providing guidance in line with PHE recommendations. Occupational health support as per the below guidance. https://www.gov.uk/government/publications/covid-19-management-of-exposed-

Standard/Process/ Issue/Recommendation	'BRAG' Rating	Improvement Required (What does good look like?)	Responsible Lead	Milestones/ Timescales (by end of)	Current Progress Rating	Responsible Committee/ Group	Evidence (What evidence will be provided to demonstrate sustainable improvement?)
							healthcare-workers-and-patients-in-hospital-settings/covid-19-management-of-exposed-healthcare-workers-and-patients-in-hospital-settings Ocupational Health SOP 09.06.20.docx
Local Systems must assure themselves, with commissioners, that a trust's infection prevention and control interventions (IPC) are optimal, the Board Assurance Framework is complete, and agreed action plans are being delivered. **NB Key Action. No 9**		Existing external reporting mechanisms in place to provide assurance to commissioners.	Director of Nursing and Quality	March 2021	BAU	Relationship meetings with CCG/Director of Nursing and Quality	There are fortnightly calls with the commissioners to give assurance on managing the Covid situation and the IPC interventions that are taking place. Updated version of 10 point plan shared with CCG, along with IPC BAF

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							1&2.
Review system performance and data; offer peer support and take steps to intervene as required. **NB. Key Action. No 10**		The data and performance is discussed externally and internally.	Chief Operating Officer	March 2021	BAU	Operational Infection Prevention Control Group System Infection Prevention Control meetings	External systems - There is a Cheshire and Mersey Directors of Nursing weekly meeting to review IPC issues and discuss protocols and policies, along with system Gold Command, across the region. There is a sharing of how covid is being managed. Internal systems – 3 times weekly IPC meetings to review the data and performance. Heads of Nursing work together to ensure peer support into areas as required.

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**12**	Date of Meeting: 28/01/2021
Report Title	**Transforming Perinatal Safety Response to the Ockenden Report**	
Executive Lead	Julie Tunney Director of Nursing & Quality	
Lead Officer	Jenny Butters, Head of Midwifery	
Action Required	To note	

☐ **Acceptable assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	X **Partial assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of controls

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

- To inform the Board of Directors of progress against the Ockenden Report Immediate and Essential Actions (IEA)

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

- Continue to work towards achieving compliance with the seven immediate and essential actions (IEAs)
- Report progress against actions at Quality and Safety Committee on a monthly basis

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

• Manage Covid response and recovery	☐	• Provide safe and sustainable services	✓
• Provide outstanding care/patient experience	☐	• Provide strong system leadership by working together	☐
• Deliver most effective care to achieve best possible outcomes	✓	• Be well governed and clinically led	✓
• Be the best place to work	☐		

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

• Quality	✓	• Compliance	✓
• Finance	☐	• Legal	☐
• Workforce	☐	• Risk/BAF BAF9 Activity and patient outcome data	
• Equality	☐		

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

Strategy ☐ Policy ☐ Service Change ☐

REPORT DEVELOPMENT

Committee/ Group Name	Date	Report Title	Lead	Brief summary of key issues raised and actions agreed
Quality and Safety Committee	20/01/2021	Ockenden Report Update	Julie Tunney	Progress against the seven immediate and essential actions.

Transforming Perinatal Safety – Response to the Ockenden Report

Introduction

1. The Former Secretary of State Jeremy Hunt requested an independent review of the quality of investigations and implementation of their recommendations of a number of alleged avoidable neonatal and maternal deaths and harm at the Shrewsbury and Telford NHS Trust. The first report following 250 clinical reviews – "Emerging Findings and Recommendations from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust" otherwise known as the Ockenden Report was published in December 2020. The final report is expected later in 2021.

2. A letter was received into the Trust on 14th December from NHS E requesting confirmation from the CEO of implementation of the Immediate and Essential Actions (IEA) outlined in the Ockenden report. An initial confirmatory response from the Trust was returned to NHS E via the Local Maternity System (LMS) on 21st December.

3. NHSE have provided the Maternity Services Assessment and Assurance Tool as a framework to give structured support for trusts to critically evaluate their current position and identify further actions and support requirements. Within the framework the actions have been cross referenced with the Clinical Negligence Scheme for Trusts (CNST) 10 maternity incentive scheme safety actions where appropriate.

4. The tool is divided into two sections which is currently being worked through in detail to provide evidence and assurance and identify gaps where appropriate.

5. The framework consists of-
   - **Section 1** – Identifies a total of 7 Immediate and essential safety actions
   - **Section 2** – Identifies a total of 3 actions -Maternity Workforce planning, Midwifery Leadership, New Guidance related to Maternity.

6. The Deadline for the completed Maternity Service Assessment and Assurance tool and submission to NHSE is 15 February 2021.

Summary

7. This report is intended to provide the highlights and further detail is provided in the live assurance tool already submitted to the LMS on 21st December 2021

Section 1 - Immediate and Essential safety actions (7 actions)

8. *Action 1 Enhanced Safety* – implementation of the Perinatal Clinical Quality Surveillance Model (PCQSM) in progress.

This action focuses on strengthening trust level oversight for quality including building on the role of the maternity / neonatal Safety Champion, a key element throughout the report is the appointment of non – executive director to work alongside the board level perinatal safety champion a key element to A robust process is in place at the trust for ensuring all SI's are shared with Trust boards however a process is to be identified by the LMS is awaited to ensure shared with LMS boards. The introduction of a locally agreed dashboard is currently being created to enhance timely reporting.

MCHFT identifies itself as **partially compliant** as additional guidance is required from NHSE /LMS to support dashboard development and communication pathway.

9. *Action 2 Listening to Women and Families* – The Central Cheshire Maternity Voices Partnership (MVP) is maturing strengthening the relationship between MCHFT and the service users voice to support co - production of local maternity services.

There is a requirement from the Ockenden report that trusts create an independent senior advocate role which reports to both Trusts and the LMS boards – currently guidance from NHS E is awaited as to the specific requirements of the role we are therefore **partially compliant** due to this aspect of action 2.

10. *Action 3 Staff training and Working Together* – Evidence that multidisciplinary training and working can be provided and will be validated through the LMS 3 times per year, annual training plans are in place. MCHFT can evidence training plans and compliance awaiting confirmation of process for feedback to LMS.

Consultant led ward rounds twice daily seven days a week are required – short- and long-term plan in place to address gaps. Short term plan – a change in way of working for consultants is required and being worked through with clinical leads and Divisional General Manager, Standard Operating procedure to be introduced to support the action and audited. Long term plan may feature request for further investment. We currently grade MCHFT as **partially compliant** with this action.

11. *Action 4 Managing Complex Pregnancy* – All women with complex pregnancies booked at MCHFT have a named consultant lead.

Complex pregnancies identified must have specialist involvement and management plans agreed between woman and the team- MCHFT have care pathways in place to support women both locally and in conjunction with tertiary centres where required MCHFT are therefore **compliant** with this action.

12. *Action 5 – Risk Assessment throughout pregnancy* – all women must be formally risk assessed at each contact throughout the pregnancy pathway including intended place of birth. Facility included in maternity information system to record assessments – to be audited monthly. MCHFT are **compliant** with this action

13. *Action 6 Monitoring Fetal Well Being* – all services must have a dedicated Lead Midwife and lead Obstetrician with expertise to focus on and demonstrate best practice in fetal monitoring - MCHFT are compliant with both of these roles in place. This action is further strengthened in the Five elements of Saving Babies Lives Care Bundle Version 2 of which the Trust is largely compliant with the exception of confirmation of agreement from the CCG regarding deviation in relation to uterine doppler scanning for which there are robust amendments to the Detection of fetal Growth Restriction Guideline in place to mitigate the risk. Confirmation is awaited from

the CCG of acceptance of the mitigation in place. **Following receipt of confirmation from CCG this action will be compliant.**

14. *Action 7 Informed Consent* – Trusts must ensure women have ready access to accurate information to enable their informed choices of intended place of birth and mode of birth including maternal choice for caesarean section. MCHFT website provides information relating to care pathways, personalised care pathways in place to facilitate women's choice and provide information, this is audited monthly and provided to the LMS. MCHFT are **compliant** with this action.

Section 2 - Maternity Workforce Gap Analysis (3 actions)

15. MCHFT commissioned a full Birth rate plus assessment in 2019 and the findings escalated to executive board, investment rounds addressed the identified deficits, ongoing work to meet the recommendations of "Better Births" (National Maternity Review 2016) has resulted in further investment in midwifery staffing being required to deliver Continuity of Care models for women and this is detailed in the Annual Staffing Report undertaken by the Director of Nursing and the request will go forward as part of the Trust annual financial planning and investment.

16. Midwifery Leadership – Confirmation that the Director / Head of Midwifery is responsible and accountable to an executive Director and description of how the trust meets the maternity leadership requirements set out by the Royal College of Midwives (RCM) is required. At MCHFT the HOM is professionally responsible and accountable to the executive Director of Nursing and together will work through the 7 steps outlined by the RCM to agree a position for the Trust.

17. New Guidance Related To maternity – trusts are asked to review their approach to NICE guidelines in maternity and provide assurance that they are assessed and implemented where appropriate, MCHFT maternity services have a robust process in place that facilitates the review of NICE guidance and decisions to implement , this can be evidenced via obstetric governance committee minutes demonstrating multidisciplinary discussion and agreement and the communication pathway for disseminating any changes to staff. Any deviations will be risk assessed and mitigation put in place and escalated via the Trust Quality Governance process and CCG.

Conclusion and Next Steps

18. Of the 7 immediate and essential safety actions outlined in the Ockenden Report, MCHFT are compliant with actions 4, 5, 6 and 7. MCHFT are partially compliant with the remaining immediate and essential safety actions 1, 2 and 3. The actions to achieve compliance with 1 and 2 require further guidance awaited from NHSE and the LMS, action 3 requires a short and long term plan to achieve compliance in relation to achieving consultant ward rounds twice daily seven days a week and this is currently being worked on by the division.

19. To provide assurance to board the next steps are to report progress at the Executive Quality Governance Group and then to the Quality and Safety Committee on a monthly basis. The requirement to report compliance to NHSE is completion of the Maternity Assessment and Assurance Tool to be returned to NHSE by 15 February 2021.

Mid Cheshire Hospitals NHS FT

Author: Jenny Butters, Head of Midwifery/ Head of Nursing Paediatrics and Gynaecology
Date: 12.01.2021

Mid Cheshire Hospitals NHS Foundation Trust

PAF Committee
Chair's Assurance Report
December 2020

Report to	Board of Directors
Date	17 December 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 Russell Favager, Deputy Chief Executive and Director of Finance
Committee meeting quoracy	Yes ☒ No ☐

KEY AREAS OF ASSURANCE

This was a streamlined meeting to release Executive colleagues back to operational matters.

Covid 19
321 patients have been treated for Covid-19 and discharged since the start of the pandemic.

Pressures are significant with almost as many positive cases as at the Wave 1 peak. Management challenge is greater as restoration work is continuing and levels of A&E attendances have not decreased in the same way; staff are working hard to keep patients safe against the following key challenges:

- Increased bed occupancy rates
- More staff are isolating with fewer staff to redeploy
- Nosocomial infections – approx. 70% of positive patients are asymptomatic

Covid Testing

- Lateral flow testing rolled out to 70% of staff
- Vaccination programme ready to start once vaccine received
- Rapid testing now available on site (up to 20 per day)

Integrated Performance Report - Performance

- **Emergency Department** - performance deteriorated in month although improved position on November 2019
- **Cancer** - 62-day standard recovered in November (not yet validated) which is ahead of forecast. Performance ahead of plan
- **Referral to Treatment/ Diagnostics** - month on month improvement demonstrated

No evidence of higher levels of patient safety incidents despite pressures.

Phase 3 Restoration Update

- 70% (pre-Covid levels) of planned work remains in place despite some cancellations due to Covid. Position likely to deteriorate in January to divert resources to emergency work. Planning for Phase 4 expected to start in the new year.

Spend Above Envelope Case for Change - acceptable assurance: Trust rationale submitted to NHS Improvement North West (NHSI) to justify why forecast spend is above national expectations for restoration work (£1.7m) and Covid (£2.5m). Feedback awaited

Financial Position, Month 8 (September 2020): - **acceptable assurance:** Finances well-managed despite levels of uncertainty; end of year position likely to be acceptable with a modest deficit excluding annual leave provision and non NHS income, although material slippage on capital spend likely.

Collaboration at Scale - **acceptable assurance:** progress noted particularly in HR and IT schemes, but Estates capacity is limiting further contribution from the Trust. Funding received to support Trust-led international nurse recruitment programme with Cheshire and Warrington hospital trusts.

Executive Safety and Sustainable Environment Group (ESSEG) Chair's Assurance Report
Oversight of risks much improved following 6 Facet and Critical Infrastructure Reviews. Volume of Estates-related risks is clear but capacity of Estates to deliver is a challenge given the number of significant projects in progress, including the Leighton Hospital rebuild, A&E build. Move to Crewe Campus and Weaver Square in addition to the day to day covid challenges. To be discussed further by Executives 18 December.

KEY CONCERNS/RISKS

Capacity of the Estates team

Priority Areas: DECISIONS MADE

None.

RECOMMENDATION

To note

Mid Cheshire Hospitals NHS Foundation Trust

PAF Committee
Chair's Assurance Report
January 2021

Report to	Board of Directors
Date	21 January 2021
Report from	Trevor Brocklebank, Non-Executive Director
Report prepared by	Katharine Dowson, Head of Corporate Governance
Executive Lead/s	Oliver Bennett, Chief Operating Officer Russell Favager, Deputy Chief Executive and Director of Finance
Committee meeting quoracy	Yes ☒ No ☐

KEY AREAS OF ASSURANCE

Covid-19 Expenditure - acceptable assurance: audit of £15.5m 2020/21 Covid expenditure to end December completed, expected spend circa £20m. Expected that, of average £1.2m spend per month, significant element recurring infrastructure costs in future, (majority being ward support).

Covid-19 Performance

- Trust remains under significant pressure, but the committee is assured that the challenges are being dealt with in a structured, planned and pro-active manner.

Integrated Performance Report - Performance

- **Emergency Care:** Performance deteriorated in December due to increasing Covid-19 demand and challenges around flow; however, better position than December 2019. No delays in ambulance handover and zero 12 hour breaches
- **Discharge:** Significant pressure on wider system recently from NHSIE. Positive impact being seen through improvement in patient transfer to care homes/other care settings and overall discharges. A 'designated setting' (care home) to take Covid-positive patients opened 21 January.
- **Referral to Treatment (RTT)/ Restoration:** despite several months of improvement, RTT performance declined, particular concern around volume of patients waiting >52 weeks
- **Restoration programme –** on-going delivery of significant amount of non-Covid activity; however, large part of Phase 3 Covid Restoration Plan not being delivered
- **Cancer**: Overall performance remains good, with Endoscopy rates among best in Cheshire & Merseyside; patient backlog remains low and is being sustained. Screening programmes remain in operation. Cancer patients, with postponed operations due to Covid-19, referred to Greater Manchester Cancer Hub and either been treated or have a rescheduled date. Planning in place to reinstate cancer programme fully, w/c 25 January.

NHS 111

Greater impact than anticipated, leading to overall reduction in attendances. Majority of reduction moved to other Urgent Care services e.g. GP Out of Hours.

NHS Operational Priorities for Winter and 2021/22
PAF noted key messages set out in NHSIE letter (23 December 2020) regarding operational priorities for winter and 2021/22.

Executive Safety and Sustainable Environment Group (ESSEG) Chair's Assurance Report
Significant number of high risks in Estates remain but with actions and controls in place:

- **RAAC planks** – 55% surveyed by end of January, remaining more challenging to access; two areas identified for supportive steelworks
- **Critical Infrastructure Review** – number of high risk actions to be completed by March e.g. fire suppression systems
- **Fire Safety Assessments** – improved compliance with some clinical divisions at 100%; corporate areas lower than average, areas being chased up to complete (working from home hampering some completion).

Finance

- Cheshire & Merseyside system remains in deficit, but position improved and close to acceptable position with NHSI; Trust position remains broadly unchanged with £9.5m forecast deficit
- Pay costs continue to increase in real terms, including £1.2m of monthly Covid related costs. Challenge will be removing a number of these costs post Covid-19
- Planning for 2021/22 is behind normal Q4 process. Regulators deferred planning to Q1 2021/22; further guidance anticipated. Headline assumptions to be provided to March meeting.

Collaboration at Scale: **acceptable assurance –** most work stepped down; Trust-led international nursing recruitment praised by Cheshire system for ongoing activity.

EU Exit Overseas Visitor Implications – change to policy approved. Action plan developed against national guidance, including requirement for a dedicated post to become compliant.

KEY CONCERNS / RISKS

Significant number of high risks in Estates remain but with actions and controls in place.

Priority Areas: DECISIONS MADE

Updated Overseas Visitors Policy approved

RECOMMENDATION

To note

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

Workforce and Digital Transformation Committee
Chair's Assurance Report
December 2020

Report to	Board of Directors
Date	21 December 2020
Report from	Lorraine Butcher, Non-Executive Director
Report prepared by	Katharine Dowson, Head of Corporate Governance
Executive Lead/s	Heather Barnett, Director of Workforce and OD Amy Freeman, Chief Information Officer
Committee meeting quoracy	Yes ☒ No ☐

KEY AREAS OF ASSURANCE

Covid-19

- Workforce resilience remains a key concern; sickness rates increasing. Trust is responding with packages of immediate wellbeing support and further guidance for managers
- New 'task teams' mobilising at speed to support operational pressures focusing on six key areas e.g. ward helpers, infection control
- Preparations for vaccine programme in place, awaiting delivery date. 180 very vulnerable clinical staff to receive vaccine at Countess of Chester Hospital this week. 3,700+ staff completing twice weekly lateral flow testing, supported by IT designed app.

Integrated Performance Report

- Mandatory Training rates recovering due to focused work on data improvement
- Vacancy rate declining trend; additional staff signing up to bank.

Executive Workforce Assurance Group Chair's Report (EWAG) Key Messages

- Workforce priorities and risks developed and aligned to new Trust strategic priorities. Workforce groups established and getting underway
- Understanding of mandatory training issues increasing work underway to rectify data and recording issues
- ESR functionality requires further development to align with finance ledger.

EWAG and sub-groups submitting evidence of greater focus on assurance and risk, including review of operational risks.

Statutory and Mandatory Training Update December 2020 - **partial assurance:** Project progressing well, Trust forecast to be in amber by end of December. Data improvement and cleansing led to significant improvement with 4000+ training records brought through between September and November, compared to 577 people completing via learning portal.
Deep dive into resuscitation courses evidences low compliance and spaces on courses. Assurance project is delivering but further work to complete the work required.

Absence Analysis Report - **partial assurance:** Deep dive review requested by Committee into links between training compliance and musculoskeletal absence showed no clear findings. Further work required, combined with completion of work on data quality, to identify whether training is the issues as Estates and Facilities have highest compliance and highest absence rates.

Leadership Development Offer - acceptable assurance: foundation course start delayed to January due to Covid. Number of parallel programmes underway with planned winter pause built in; virtual aspects working well. Delay in appointing strategic partners for Quality Improvement (QI) programme impacting on senior leadership programme.

Workforce Plan: Committee considered this the right approach, although the need to align with new Trust Strategy recognised. Next steps are to reflect learning from Covid, review appropriate caseloads for different staff groups and increase references to volunteer groups

Motiv8 Progress update - partial assurance: broadly implemented and welcomed by staff but not yet embedded, mainly due to Covid pressures. Further communications required when Covid pressures have abated.

Executive Digital Transformation and Information Services Group (DTIS) Key Messages: AF provided summary of key risks and issues, as December meeting stood down. Backup options paper approved due to time constraints. New risk identified in relation to Freedom of Information capacity, as requests increasing in volume and complexity, mitigations being developed.

Update provided on key IT programmes of work including the Digital Clinical System. Committee agreed following Digital Board training on 11 January to develop a joint piece or work with OD about the transformation programme requirements

KEY CONCERNS/RISKS

- Resilience of workforce to deliver safe care under current winter and Covid pressures
- Overall pressure on IT team to deliver the Digital Clinical System, a key strategic transformation project over the next two years

Priority Areas: DECISIONS MADE

None

RECOMMENDATION

To note

Workforce and Digital Transformation Committee
Chair's Assurance Report
January 2021

Report to	Board of Directors
Date	18 January 2021
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 Oliver Bennett, Chief Operating Officer Amy Freeman, Chief Information Officer
Committee meeting quoracy	Yes ☒ No ☐

KEY AREAS OF ASSURANCE

Statutory and Mandatory Training Update December 2020 - partial assurance:
Improved to 80.46% (Amber), from 76.30% (Red) in November; further improvement anticipated as courses booked. Number of further measures close to completion e.g. new guide, local compliance tracking tool. Key blocker is availability on practical courses. Received reassurance of no links identified between missing refresher training and clinical incidents.

Motiv8 Appraisal System Update
Challenging to complete conversations/appraisals with current operational pressures - likely to continue for some weeks. Discussions with ESR to develop on online HTML solution for tracking rather than paper forms and tie into talent management tracking.

Covid-19

- Operational pressures remain significant but some positive signs of rate of admission is starting to slow down. Nearly 40% of General & Acute beds occupied by Covid patients. Critical Care Unit (CCU) likely to be under longer sustained pressure.
- Approximately 97% of lateral flow staff testing kits distributed, around 90% of staff are recording a result. Lower than expected levels of staff absences as a result of self-testing. Sickness levels remain lower than peers at just over 5%
- Vaccination programme well underway. Due to immense efforts by the vaccination team, over 6,000 people vaccinated (3,097staff out of 4,836 with another 476 staff booked in).
- Staff redeployment and volunteering levels significant to support CCU, Covid wards and Medicine, most routine elective work now stood down, including some small amounts of cancer activity, to support the effort. New temporary roles introduced e.g. Ward Helpers, have shown a significant benefit in freeing up nurses to focus on core nursing duties.
- Health and wellbeing support focused on short-term response to immediate needs / planning for medium and long-term effects on staff; may require significant support due to sustained period of heightened workloads and potential psychological trauma. Offer of support received from CWP
- Digital pressures of sitrep reporting out of hours and volume - new operational group set up under Silver Command to consider alternative approach.

Integrated Performance Report

- Establishment vacancy numbers continue to reduce, however, the impact of international recruitment is not being felt because of extra beds open. International recruitment work progressing with partner Trusts.
- Current challenge with triangulating data; senior managers visiting different areas and speaking to staff. Incident management systems remain in place.

Executive Workforce Assurance Group Chair's Report (EWAG) Key Messages

- Completed deep dive into sickness in Surgery & Cancer
- QI on hold, recruitment of strategic partner on hold
- Mandatory training compliance target operational risk reduced from 12 to 8

Gender Pay Gap - partial assurance:

Mean Gender Pay Gap showing a 2% deterioration on prior year to 23.2%; median 0.3% improvement. Further work to be completed by ED&I Group, reporting to EWAG to understand changes/ develop action plan.

Executive Digital Transformation and Information Services Group (DTIS) Key Messages:

Not met since the last WDT meeting. 4Risk pilot for cyber risks going well with positive benefits for staff who can input and own their own risk

Digital Cultural Programme

Developing an organisational development (OD) approach to delivering digital transformation essential for the success of the Digital Clinical System (DCS). Capacity to be secured to enable this to commence. Report back to WDT in March 2021.

KEY CONCERNS/RISKS

- Lack of capacity of IT teams, some additional interim staff being sought to support Covid work and complete data warehouse project, but long term, substantive solution required.
- Ensure learning from Covid continues to be captured and lessons learnt

Priority Areas: DECISIONS MADE

Recommend Board of Directors to approve the 2020 Gender Pay Gap report for publication on Trust website.

RECOMMENDATION

To note

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**15**	Date of Meeting: 28/01/2021
Report Title	**Cheshire East ICP Strategy and Transformation Plan**	
Executive Lead	Denise Frodsham, Director of Strategic Partnerships	
Lead Officer	Dr David Holden, GP	
Action Required	To note	

☐ **Acceptable assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	**Partial assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of controls

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

- First Strategy and Transformation plan for CEICP – covers period until April 2022
- Focuses on tackling health inequalities, preventing ill health, patient centred, community led
- 4 key priority themes – Respiratory, Cardiovascular, Children's Services, Health and Wellbeing

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

- ICP needs development and sustainable infrastructure
- Progress themes though ICP governance to understand shared accountability
- Develop future operating model for ICP to enable development of wider ICP role in commissioning as well as shared provider service delivery across health and care partnerships

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

• Manage Covid response and recovery	✓	• Provide safe and sustainable services	✓✓
• Provide outstanding care/patient experience	✓	• Provide strong system leadership by working together	✓
• Deliver most effective care to achieve best possible outcomes	✓	• Be well governed and clinically led	
• Be the best place to work	✓		

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

• Quality	✓	• Compliance	☐
• Finance	✓	• Legal	☐
• Workforce	✓	• Risk/BAF Click here to select relevant risk	
• Equality	✓		

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

Strategy ☐ Policy ☐ Service Change ☒

REPORT DEVELOPMENT

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

Cheshire East Integrated Care Partnership
ICP Strategy
And
Transformation Delivery Plan
September 2020 – March 2022

Cheshire East Place Vision

"Our vision is to enable people to live well for longer;
to live independently and
to enjoy the place where they live. "

Contents

Executive Summary

Cheshire East Integrated Care Partnership (ICP) is within the Cheshire East Place. One of the key challenges is how to work differently and how to engage partners and colleagues differently and effectively across our local health and care system.

There are multiple drivers for change: The health inequalities in the population we serve are increasing; There is not enough capacity or finance to deliver the same model of health and social care with an ageing and expanding local population; there is national impetus for change for example with the NHS Long Term Plan; we are required to meet a challenging financial deficit to achieve system financial balance. There are instability and capacity issues in all of our services and particularly in primary and social care.

There are multiple ways of meeting this challenge and various health and care systems around the world can demonstrate where they have been successful in this regard.

We have set out on the journey to have 8 "Care Communities" as our hubs and focus for local care delivery and we are working towards putting structures in place to provide the partnership working, with a common purpose, commensurate autonomy and enablers for them to be effective.

There is a further challenge to ensure that as a system we have a consistency of offer to our population that allows for large scale improvement in health and outcomes to be delivered across the place and allowing innovation and rapid testing of good ideas that will enable our Care Communities to flourish.

The National Association of Primary Care (NAPC) Primary Care Home programme "is about delivering care for patients as locally as we can to them that is sensitive to their needs". This was how the Care Communities were initially intended to function and our transformation programme will support this aim. The Primary Care Home model moves away from a reactive model of care to a proactive, preventative approach to health using a biopsychosocial model.

By April 2021, The ICP Board will ensure that their role is to improve health and wellbeing, by using all of our assets to support the development of care closer to home, will have developed at a board level to take into account population health and look strategically at care needs and delivery for Cheshire East population. We will have dissolved some silos, developed the partnership and begun the process of reducing unwarranted variation and ensuring consistency of offer across primary, community, mental health and social care to an agreed minimum offer.

Care Communities will be more robust with an identified cost centre, indicative budget and with identified enablers. Their core team will be visible and baseline assessment of community assets and maturity will have been completed in order to understand the sum of their constituent resources and estates. Each will have access to a dashboard showing key metrics "at a glance" to allow rapid interpretation and responsive action.

Each Care Community will have developed a social prescribing offer and this will be available to the whole Cheshire East population. There will be a mental health first offer in development and assessment of wellbeing including formal assessment where necessary as routine in all long term condition reviews. Each Care Community will have completed or be undertaking a quality improvement project in cardiovascular and respiratory health. There will be two established Children's hubs in Crewe and Macclesfield with advice and guidance for parents on common childhood conditions. Childhood immunisation uptake will be improved.

Public Health colleagues will work with the ICP teams to being to tackle the wider determinants of health. Communities of practice will share learning from all of these projects and test and spread using a quality improvement approach.

By April 2022, Care Communities will be at the heart of care delivery for all of our major providers. Community care team capacity will increase to enhance the offer. We will be making use of technology to enhance monitoring of health and embedding point of care testing. People will be supported to stay safe well and independent in their communities. Hand in hand with the community and voluntary sector we will be working with local authority colleagues to further develop community groups and assets to support wellbeing and keep people as well as possible for as long as possible before needing our health and care services.

Innovation and improvement methodology will be embedded and further local projects encouraged. Community diagnostics and access to rapid specialist advice will become the norm. Care services will respond rapidly to escalation of need and provide an intervention from within the team
The ICP will be taking more responsibility for the local budget and working in partnership with a strategic commissioner to tackle the wider determinants of health and care needs, ensuring that we make inroads into these in order to keep our population well.

Public and service users will be vital partners in this journey and their voice will be heard throughout the ICP structure.

Cheshire East Integrated Care Partnership

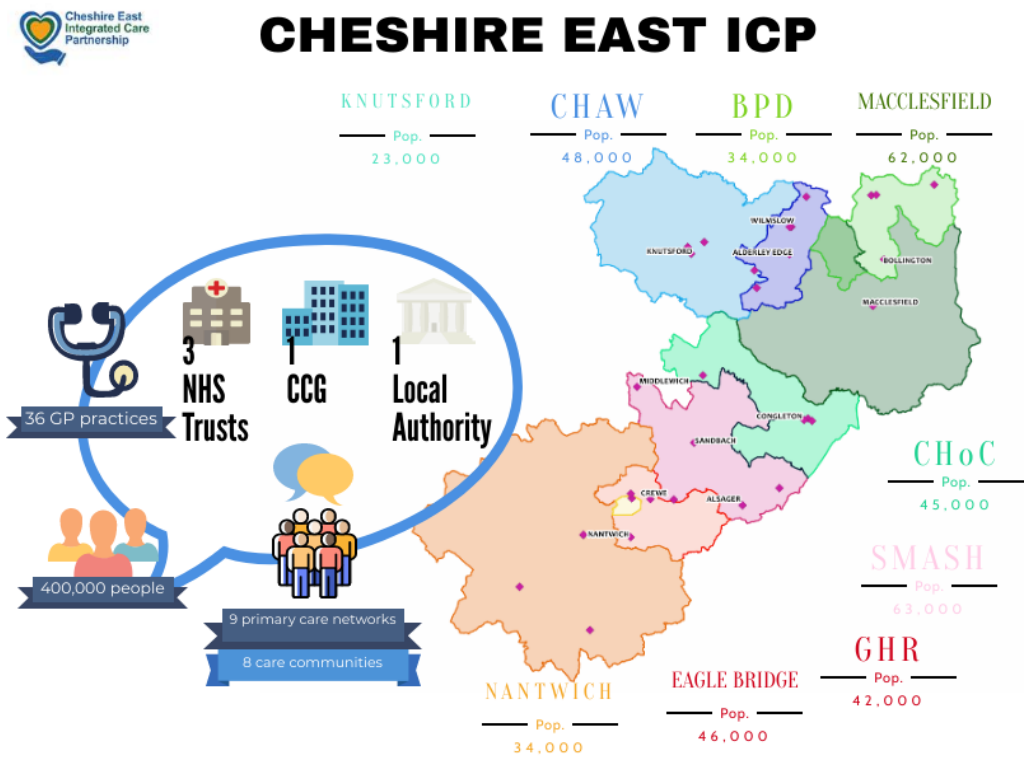


Fig1: Cheshire East ICP

The Cheshire East ICP serves a population of ~400,000 people. Figure 1 describes how it is divided into its constitutional geographies of 8 “Care Communities” and 9 Primary Care Networks (PCNs) within one

Cheshire East Council boundary. In the main the Care Communities and PCNs are coterminous with the exception being Crewe Care Community which contains two PCNs within it.

Since 2017 the Clinical Commissioning Groups (CCGs) had encouraged the local formation of Care Communities. These were collaborations of local provider teams with development support and basic funding provided to encourage them to develop shared aims and take a local view of health and care in their neighbourhood.

During this time they have been supported but have been limited in their overarching co-ordination and scope. This is in part due to not being able to access the funding and resources required to develop further.

Care services have come a long way since the inception of the NHS and evidence based medicine and care has done much to increase life expectancy, healthy years and quality of life. As a result of this we have entered a new era of people living longer with multiple conditions, with multiple medications and family units that are generally more spread across the country. This new challenge requires an additional focus on the individual and for local populations to provide expert generalism and support around people and the communities they live in. For this reason our health and care services need to evolve to maintain this excellence in quality but also provide the support needed in later years to keep people safe, well and independent.

Despite our best efforts inequalities have increased over the last 10 years and these need addressing within our approach. The wider determinants of health and wellbeing will be at the forefront of the ICP plan and in line with the NHS long term plan, the local 5 year plan and our CCG's commissioning intentions.

The advent of the NHS long term plan and the emergence of PCNs have further strengthened commitment to local, functional, robust teams and the resources allocated to these are significant. As an ICP we wish to build on this foundation and wrap the care we provide around this to create functional teams which anchor the ICP in communities directly and we invite specialists and advice in rather than refer out.

Health and care systems are complex, as are individual people and the systems their lives create. We will attempt to create an environment and care system which is flexible enough to meet these needs while still providing assurance on quality and equity of service, access and parity of esteem for all of our population groups.

Cheshire East Place Vision and Strategic Goals

Cheshire East Place Vision - Focus Areas:

- Tackling inequalities, the wider causes of ill-health and the need for social care support through an integrated approach to reducing poverty, isolation, housing problems and debt
- Prevention of ill health, early intervention, health improvement and creating environments that support and enable people to live healthily
- Ensuring our actions are centred on the individual, their goals, and the communities in which they live and supporting people to help themselves
- Having shared planning and decision making with our residents

Cheshire East Place Strategic Goals:

- To develop and deliver a sustainable, integrated health and care system
- To create a financially balanced system
- To create a sustainable workforce
- To significantly reduce the health inequalities

Principles

There are multiple examples of care systems around the world which have found ways of working that have shown benefit. Similar to the model in Jonkoping, Sweden we will use a fictional patient to map our system and look at where the pinch points are in the system for high cost patients, delayed transfers of care and overall public experience.

Realising the benefits of and achieving the Place vision will take some time. However, there are principles that we could all adhere to across the Cheshire East Place in order to demonstrate commitment and support this. Some of these have been set out previously in other documents – but broadly **we should be**:

- Improving the resident and patient experience and the quality of care provided
- Reducing unwarranted variation in care and outcomes ensuring equity of service for our population
- Using system resources effectively, driving value for money and having a single agreed information set to measure and monitor our programme of work
- Using evidence based approaches where possible
- Improving resource utilisation and reducing waste
- Demonstrating a willingness to allow innovation and to follow through with test, prove and implement at scale approach
- Look at high frequency attenders and how they interact with the system
- Improving interactions within teams and between and across providers

To do this we need:

- Access to good and current business intelligence (BI) – not just data but analysis that informs improvement and that we can standardise
- Resources and flexibility
- Strong and effective clinical and practitioner leadership
- A 'One Team Around A Population' ethic
- Shared outcomes
- Alignment of purpose from partner organisations to allow our current workforce to work flexibly and with a united purpose
- Increased improvement capability

Lastly there is a need to understand the competing financial drivers and desire for return on investment. Some interventions particularly population health measures may not deliver an in-year return and we need to understand how we facilitate this longer term approach in the current environment of financial restraint.

Scope and Duration of Plan

This document is intended to describe the transformation of the Cheshire East ICP from its inception to the end of the 2022 financial year. The intention is to set the direction of travel and roadmap for the next 18 months for the ICP and the outputs that are expected.

Transformation Themes

The selected transformation themes are key in the development of the ICP and its move towards a sustainable working arrangement. One of the challenges to overcome is that essentially the ICP covers two historically distinct healthcare systems divided by the M6 motorway. The population of the previous East Cheshire CCG footprint with patient flows into and out of Macclesfield Hospital (East Cheshire Trust) and East Cheshire Trust community services and the previous South Cheshire CCG with patient flows into and out of Leighton Hospital (Mid Cheshire Trust) and CCICP community services. Social Care services have also been delivered as a South and East in recognition of this situation

There are issues of sustainability of services to address and also sharing of learning across these historic footprints. One of the first orders of business for the ICP is to bring these two health and social care economies together and develop a shared purpose and team.

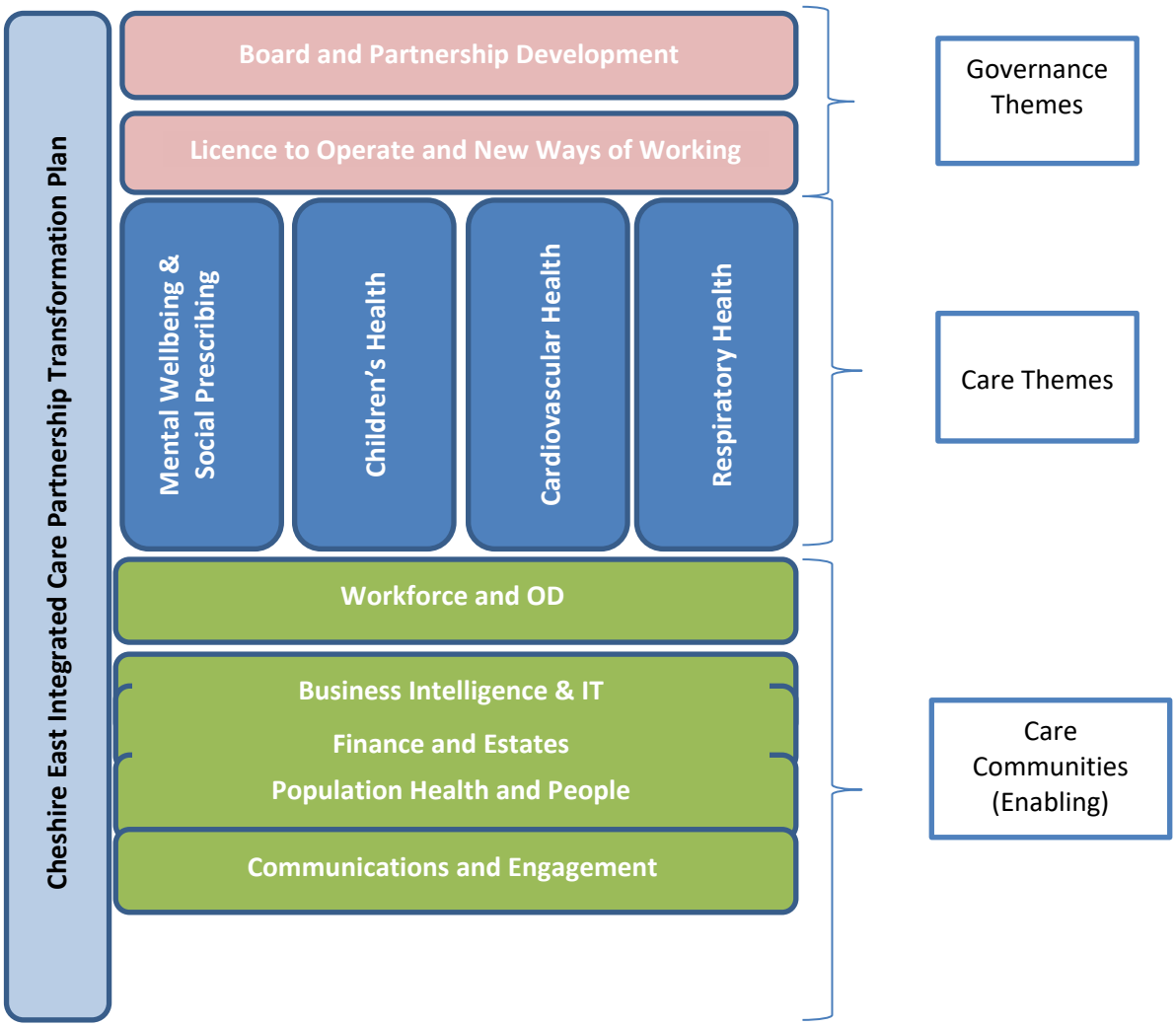
Given the historic differences in services offered, the ICP will spend time until April 2021 understanding and reducing inequity of community services across the new ICP footprint and ensuring that the stage is set to develop these further moving into 2021/22 financial year.

The care themes allow an opportunity to test new ways of working and develop new services.

In December 2019 a development workshop was held at South Cheshire College. Work was done in small groups with representatives from multiple stakeholders to be able to give feedback about how they believed the ICP should develop and what was needed to make this attempt at developing a local integrated care model successful.

The feedback has been collated and supports this transformation document. In summary, the ask was to ensure that Care Communities were supported to develop with recurrent resource and that the population data was readily available to the teams working in those areas. There was also an expressed need to develop infrastructure and governance arrangements to enable devolution of resources and accountability. Lastly there was the issue of trust and how we develop this both in governance sense to share resource risk, clinical risk and accountability, which will only occur through communication and engagement.

For this reason Care Community development is considered separately to the overall ICP development in this plan.



Corporate/Governance Theme

Within this theme is board development and ensuring that the partnership works. Developing trust is essential to working together especially when it comes to sharing risk and reward. To April 21 there will be time and resource dedicated to this and ensuring the governance arrangements facilitate the working we need to see across teams in Care Communities.

Within this theme there will also be a need to look at contracting arrangements, regulation, relationship with the new strategic CCG and how resource is transferred.

A communications plan that is regular and robust also sits within this theme and is currently in development.

Teams need time to coalesce around the Care Community footprints and in the main are aligned. Time will be given to considering how to allow team members to operate at the top of their licence in the interests of the populations they serve.
As part of developing understanding to April 21, a mapping exercise will be undertaken to establish the assets and offers available across both previous CCG footprints and commence the process of ensuring equity of services up in line with this.

A summary of activities is listed in the table below.

Care Themes

Our evidence, which is a combination of public health data, Marmot reviews, Rightcare data, JSNA and local system intelligence shows that key starting areas to develop some of the principles of the ICP with are:

- Cardiovascular Health
- Respiratory Health
- Mental Wellbeing and Social Prescribing
- and Children's Health (in the form of setting up Children's Hubs)

These areas were selected as there was a perceived need, evidence that we are outliers in this area in our Place and an opportunity to demonstrate the kind of working and thinking that will help our ICP flourish.

There are some specific asks within the clinical areas and an explanation of why these were selected is outlined below.

There are many other areas that would have been suitable all with valid claims, for instance care of older adults and frailty (which we will add as a theme in 2022). However, there are already programmes of work underway in these areas and so to make a start on how we want to work we considered the below.
Care communities may have other local priorities to work on and this will continue to be supported with the 80:20 principle, with 80% consistent offer for the population across the Place and 20% local variation and innovation responsive to local need.

All initiatives and improvement plans will be required to demonstrate the impact they are expected to have in the short, medium and long term. Project support for each care community will be available through the ICP and will assist in the setting of outcomes and the monitoring and reporting of progress.

The four areas of activity are not exclusive nor are they a comprehensive plan for the delivery of our ICP in time. They are intended to test and prove some of the ideas discussed in this document.

Children's Health

The potential scope here in children's health and wellbeing is broad. We have for the time being elected to keep safeguarding and child safety out of scope.

Need: Cheshire East Council 'Tartan Rug' – high rates of admissions to hospital across the place for under the age of 4.

Proposed Intervention:

1) Child Health Hubs based on the Imperial Model
2) Potential to expand these to include Women's and Families Health also

Evidence:
https://www.cc4c.imperial.nhs.uk/child-health-gp-hubs
https://www.kingsfund.org.uk/sites/default/files/media/imperial-child-health-general-practice-hubs-kingsfund-oct14.pdf
https://www.england.nhs.uk/integratedcare/case-studies/child-health-hubs-see-patients-closer-to-home-and-reduce-unnecessary-hospital-trips/

In one hub 39% of hospital appointments were avoided altogether, further 42% were seen by a GP, 19% decrease in sub-speciality referrals, 17% reduction in admissions and 22% decrease in A&E attendance.

Resources Identified:
Funding received from the Cheshire and Merseyside Health and Care Partnership for this programme for Year 1. We undertook a successful bidding process and have commenced development of two child health hubs initially.

Plan:
Initially work has commenced with the aim of implementing child health hubs in Crewe Care Community and Macclesfield Care Community first.

There is a lead Paediatrician attached to this piece of work. Initially work will look at 0-4yrs and urgent care including frequent attenders (mainly respiratory issues, gastrointestinal issues and infant feeding).

Medicines management will be looking at data and prescribing behaviour in this cohort to help us understand the need.

Data will also drive where there are gaps in social/community support (eg housing, parenting support, health visitor services).

The hub will aim to be initially staffed by APNPs using current resource with aims to improve upon this over time.

A second strand will look at the use and roll out of the CATCH App – which will help parent signposting.

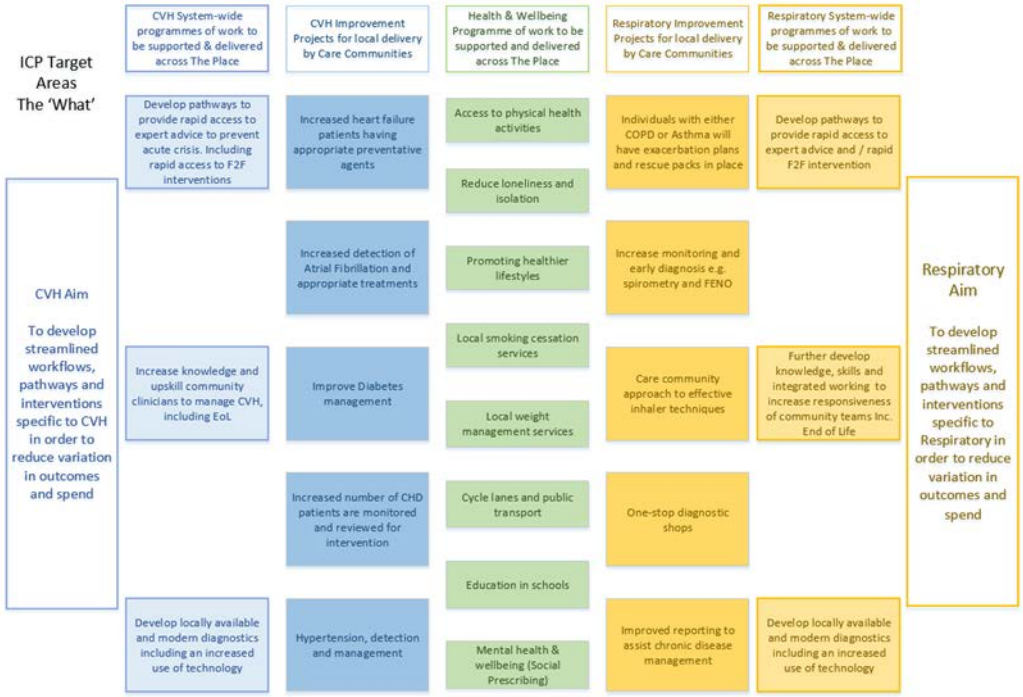
Following this, there will be a move to look at long term illnesses. The work will be based on local data and prescribing information alongside audit of admissions and pathways followed.

The hub approach involves specialists moving into the community to provide rapid access to expert advice and to improve the skills and confidence for clinicians (and families) to manage these conditions without the need for hospital interventions. The development will also identify how to signpost families to non-health support to address the wider determinants impacting on the children and their families. This will

demonstrate this way of working and hopefully provide a platform to be able to do the same for other clinical areas.

Cardiovascular Health

There is some overlap between the Cardiovascular and Respiratory Health Themes in terms of preventative measures. The diagram below illustrates how they overlap in the ICP plan.



Need:
In the Rightcare Packs for both Eastern and South Cheshire CCGs we are outliers for non-elective spend and mortality in the under 75s from CVD in comparison with our 10 most similar CCGs. This is a high cost area for the CCG and ICP. Cardiology services are struggling with sustainability issues. There are multiple population interventions that are possible which will allow us to embed a biopsychosocial approach rather than traditional model of care.

In terms of circulatory health alone Rightcare have identified potential opportunities of ~£2.2million for elective conditions and ~£4.1million for non-elective spend compared with the best of our 10 most similar peers. Circulatory conditions are an underlying cause of death in 25.1% of deaths nationally and Cheshire East is broadly similar to this.

The Rightcare data also shows that increased amounts of elective spend seems to correlate to a reduction in non-elective activity. There are also opportunities to streamline workflows, pathways and interventions to be more efficient in how we use our existing resources.

Proposed Interventions:
Several proposed methods of improvement to reduce variation in spend and outcomes have been discussed. Project Charters are being created and items for improvement will be discussed and approved at ICP transformation board. The intention for this area is that a 'menu of options' approach will allow Care Community teams to scrutinise their own data and implement methodology and plans that will address their local needs whilst remaining in line with the ICP plan.

Examples of interventions:

Public Health Intervention and Wider Determinants:-

1) Easy access to physical health activities/exercise
2) Reducing loneliness and isolation
3) Promoting healthier lifestyles
4) Effective and local smoking cessation services
5) Effective and local weight management services
6) Council encouragement to live healthily – provide cycle lanes, good public transport
7) Education in schools
8) "Know your numbers" and "Every Contact Counts" campaign – Hypertension and Atrial Fibrillation screening in all healthcare settings eg Pharmacy, Dentist, Optometrist when appropriate.

Managing Chronic Disease as effectively as possible:

1) Ensuring that all Heart Failure patients have appropriate preventative agents started and titrated to max tolerated dose (equating to 40% reduction in relative risk of long term mortality and hospital admission)
2) Ensuring that all patients with Atrial Fibrillation are encouraged to consider Anticoagulation where appropriate and then appropriately monitored
3) Improve Diabetes management - including local access to current effective treatments such as Libre testing kits and insulin pumps to improve compliance and ease of management
4) Ensuring that CHD (Coronary Heart Disease) patients are appropriately monitored and reviewed for intervention
5) Integrating Mental Health, Social Care and End of Life teams into clinical pathways.

Plan for acute deterioration/Exacerbation:

1) Exacerbation plans for Heart Failure patients including sick day rules
2) Provide rapid access to expert advice in case of deterioration to prevent acute crisis
3) Explore community rapid access for those in need of rapid face to face intervention

Providing Rapid Access to Expert Advice:

1) Provision of Community Clinics and urgent specialist review
2) Education and MDT working
3) Consultants working in and with the community to educate upskill and contribute to MDTs
4) Using technology to bridge the Primary/Secondary care divide.

Providing Rapid Access to Community Diagnostics and reducing waste:

1) More locally available diagnostic services with reporting and advice that will allow community clinicians to continue to manage them in their own area
2) QI expertise and methodology to be applied to current workflow with a view to significantly reducing waste in terms of patient footfall, spend and activity both elective and non-elective

Review of Acute and Secondary Care services to ensure best use of local resource across providers.

Evidence:

All the above interventions have evidence of reduction in morbidity and mortality from various trials and pilots elsewhere. Based on local data it may be that the largest benefit will be from smoking cessation in one area and chronic disease management in another. Care Communities will prioritise interventions with

the greatest impacts. The list is not exhaustive and the Charters and Working Group will establish more formal plans.

Resources Identified:
Some of the activity will be in streamlining usual care. Resources for transformation are to be identified as part of the work plan.

This Care Theme gives us an opportunity to show how our Place can work in different ways, streamline clinical pathways, reduce waste and unwarranted variation and our commitment to doing this across Care Pathways

Respiratory Health

Need:
In the Rightcare Packs for both Eastern and South Cheshire CCGs we are outliers for non-elective spend and mortality. This is a high cost area for the CCG and ICP and the Respiratory services are struggling with sustainability. There are multiple population interventions that are also possible here.

Rightcare have identified opportunities for savings of ~£554K in elective conditions and ~£2.4million for non-elective conditions. Activity for Respiratory conditions is increasing across the Place over the last 5years.

Smoking levels have reduced across the Place over the last few years but still remain high in pockets.

Performance across the place for diagnosis confirmed/monitored with Spirometry for COPD is below our peers and also admissions for COPD in particular are on the rise.

Proposed Intervention:
There are several interventions to improve outcomes/spend and reduce unwarranted variation.
Project Charters are being created and items for improvement to be discussed and approved at ICP transformation board.

Public Health Intervention and Wider Determinants:

1) Reducing loneliness and isolation
2) Promoting healthier lifestyles
3) Effective and local smoking cessation services
4) Effective and local weight management services
5) Council encouragement to live healthily – provide cycle lanes, good public transport
6) Education in schools
7) Actions to improve air quality.

Managing Chronic Disease as effectively as possible:

1) Ensuring patients with COPD and Asthma have medications appropriate to their condition and a care plan
2) Ensuring people with COPD/Asthma have effective inhaler technique
3) Monitoring and diagnosis are supported for example with Spirometry and FENO testing and appropriate step up and step down management implemented
4) Increasing provision of and access to pulmonary rehabilitation
5) Access to secondary care advice where there is diagnostic uncertainty

6) Ensuring the IAPT and LTC offer is embedded into Care communities
7) Ensure effective end of life care planning for those with end stage disease.

Plan for acute deterioration/Exacerbation:

1) Exacerbation plans for those with COPD and Asthma.
2) Rescue packs in place where appropriate
3) Responsive community teams to be able to deal with deterioration – eg Integrated Respiratory Team, Advanced Community Practitioners and Paramedics.

Providing Rapid Access to Expert Advice:

1) Provision of Community Clinics
2) Education and MDT working
3) Consultants working in and with the community to educate upskill and contribute to MDTs
4) Using technology to bridge the Primary/Secondary care divide.

Providing Rapid Access to Community Diagnostics and reducing waste:

1) Locally available diagnostics including advice on distinguishing between conditions and when to step up to specialist care
2) One-stop diagnostic shops for symptoms where conditions may overlap (for example breathlessness)
3) Improved reporting to assist chronic disease management for all community team members.

Review of Acute and Secondary Care services to ensure best use of local resource across providers.

Evidence:
The above interventions have evidence of reducing morbidity and mortality from various trials and pilots elsewhere. Using local data it may be that the largest benefit/impact will be from smoking cessation in one area and chronic disease management in another. The list is not exhaustive and the Charters and Working Group will establish more formal plans.

Resources Identified:
Some of the activity will be in streamlining usual care. Resources for transformation are to be identified as part of the work plan.

The CURE project in place at MCHfT could also be supported out into the community in terms of smoking cessation and lung cancer care. There is also potential for spread across secondary care providers.

The Clinical Areas give us an opportunity to show how our Place can work in different ways, streamlines clinical pathways, reduce waste and unwarranted variation and our commitment to doing this across Care Pathways

Mental Wellbeing and Social Prescribing

Need:
There is a national recognised method of improving community resilience and increasing capacity in the voluntary sector. Evidence from Frome has also demonstrated impact on reduced need for GP appointments and ED attendances. A service is needed to cater for all aspects of mental wellbeing but in particular needs to address lower level mental wellbeing and social isolation as these impacts negatively on other aspects of health and social interaction.

The transfer of appropriate work into Primary Care cannot occur without a further transfer of work from Primary Care which is better supported by the community and via self-care.

Interventions:

1) Introduction of social prescribers via PCNs – curation and activation of the local community and voluntary sectors
2) Linking with the mental health forward view and providing first contact mental health practitioners with a particular focus on wellbeing at key (and early) points in all pathways providing an obvious first contact and support
3) Council connected communities project to link with ICP programmes and help provide infrastructure for voluntary sector (in conjunction with CVS)
4) The expansion of IAPT in line with the Mental Health Forward view.

Evidence:
Multiple national examples of where this has been successful in reducing workload across the whole system including A&E admissions and Primary Care activity. Strategic Development Group looked in particular at the Frome Model and how this model could be implemented locally.

Resources Identified:

1) PCNs have been funded for social prescribers at 100% to allow their introduction into primary care.
2) Council Connected Communities project is helping curate the local community
3) Need to develop a directory of services – examples of this are available locally
4) Improve links to 3rd Sector and
5) Mental Health forward view and Mental Health first pilots.

Plan:
To discuss as a Care Community how to best utilise this resource locally.

Work already underway in Care Communities:
Nantwich and Rural Care Community have already made significant strides curating a local directory of services and volunteer recruitment. Other projects are underway in Macclesfield and SMASH also.

The aim is to support this work and help develop the approach across all 8 Care Communities. Residents of Cheshire East should have access to a social prescribing service of some kind by April 2021. These will be mapped across the Place and enhanced in line with the intentions set out above and in keeping with need.

Mental Wellbeing:
Within this theme is also mental wellbeing and we will be looking to implement a mental health first model. We will aim to encourage wellbeing practitioners in Care Communities to enable rapid access and turnaround to support wellbeing in line with the mental health five year forward view.

We will look to embed assessment of mood and/or depression screening in all long term condition pathways and address inequalities and parity of esteem for all mental health conditions.

Local Innovation

There is also a method for allowing rapid testing, innovation and pursuing projects that address local need.

In doing this we need to ensure that we:

1) Use proven risk stratification tools/BI
2) Adopt an experiential learning approach
3) Adopt a QI approach
4) Improve Capability
5) Identify the aim of each project – some may be releasing capacity, others return on investment, others innovation

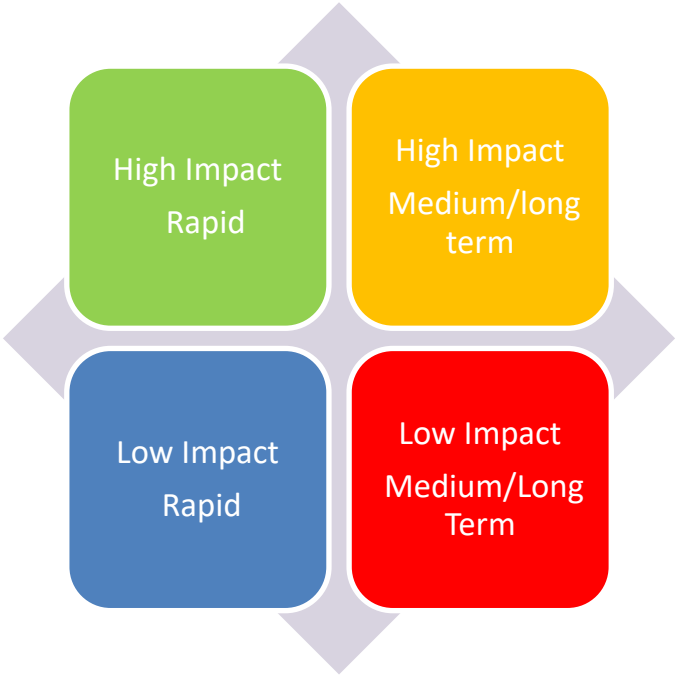
Each project should be commenced with a project initiation document which has been developed and then assessed against an agreed framework to allow development.

Each Care Community should be encouraged to bring their plans for peer critique. If approval for implementation is granted, there will be assistance from the ICP to plan for how this is possible to implement rapidly in other areas if it is relevant.

As a system we should favour plans which address:

1) Increasing GP access
2) Improving long term condition management/planned care
3) Escalating need in the community
4) Early Intervention of those with known needs, using risk stratification
5) Prevention
6) Wider determinants of health.

We will map activities across the Kaizen chart (below) in order to select the most relevant but ultimately this will be down to local determination within the allocated budget constraints.

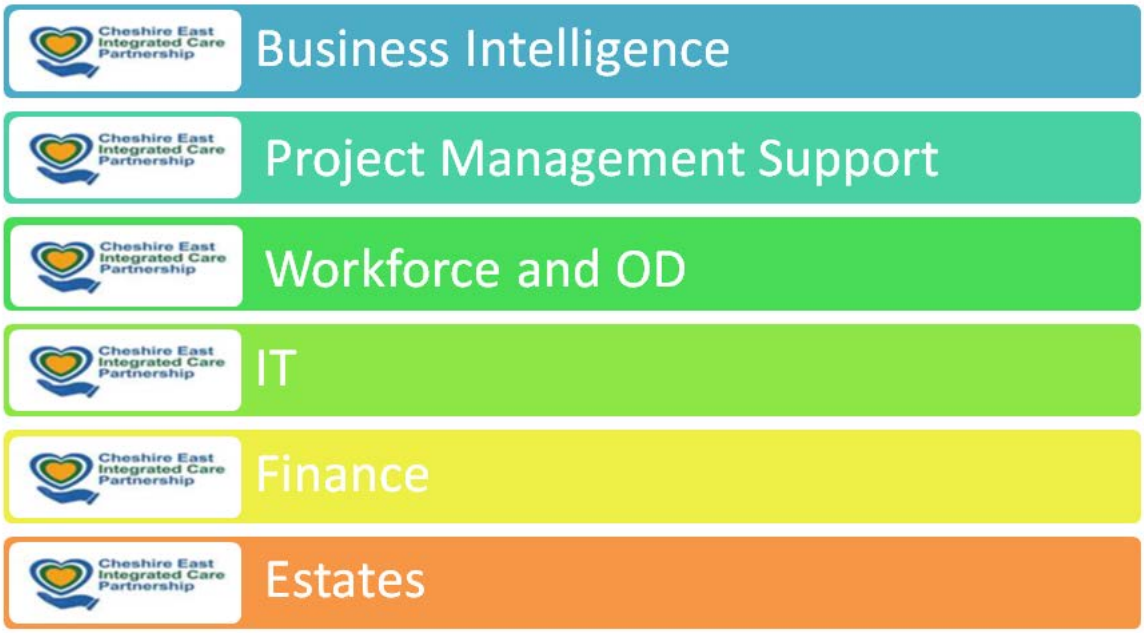


Care Communities Theme

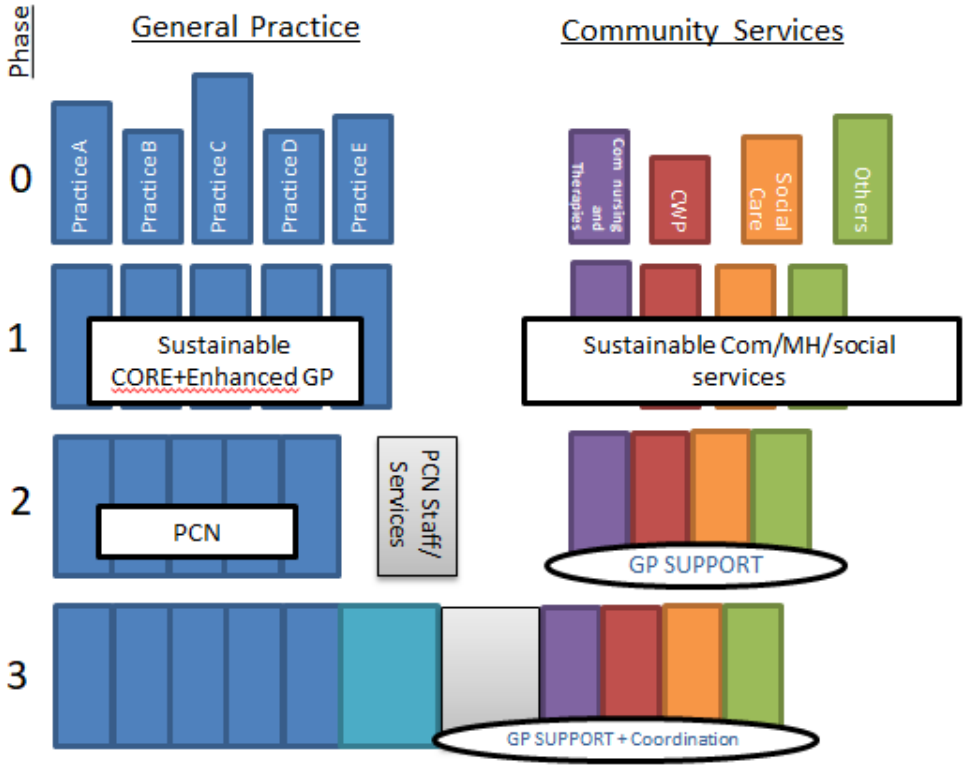
The development of the Care Community itself is of paramount importance in developing the ICP's way of working. All Care Communities are at varying stages of development and maturity.

We have developed an agreed maturity matrix to measure progress along this journey and allow support and enablers to be introduced that will support this process.

By April 2021 every Care Community should be able to identify a named individual responsible for their Care Community for several enabling themes listed below as a minimum:



In terms of functional development, the diagram below illustrates the different stages of development. There needs to be a gradual move from the considerable variation of offer across different areas to a consistent approach. Formation of PCNs will aid this process. In line with this and the work set out above we will level up the other partners' services. The ICP will aim to have all Care Communities working towards phase 3 by April 2022.



Primary Care Stability and Sustainability:
The current building blocks of Care Communities are General Practice and wider Primary Health, Social and Community care. All of these are under unprecedented pressure locally and the capacity of the few individuals that are currently working within each Care Community Team is not large enough to take on the kind of large scale transformational programme that is required. At present there has been temporary resource for clinical leadership but beyond that there is little incentive for practices to engage fully in the ICP mechanism as there is limited capacity.

Capacity:
Within Care Communities there has been provision for leadership but otherwise there is precious little resource (especially resource to be able to effect the changes that are needed, building in improvement and transformation capability). The idea that teams can free capacity to deliver large scale projects from within their current budget and human resource is not feasible and will likely lead to disengagement if not addressed.

Motivation and Engagement:
There needs to be an agreement from executives of Partner organisations to allow teams to flourish and self-determine but also to action change in a way that is meaningful for the populations the teams serve. There needs to be a framework of delegation from partner organisations to support teams and Care Communities to implement change that is required locally.

Teams need to feel they are doing the right thing, based on evidence, have adequate time and resource and have a degree of autonomy in order to be able to flourish in this new model – this is a challenge within the current regulatory frameworks with competing drivers, outcomes, targets and quality measures both local and national.

Estates:
Community estates and sourcing of sites for hubs and teams to work is a priority. We need to give due consideration also about how to bring specialist care into the community without breaking up

communities of practice that exist in secondary care and maintain excellent acute and specialist services for when they are called upon.

Suggestion:
There needs to be an immediate focus for the ICP on the stability and sustainability of Primary Care and in particular General Practice.

It will need to be based on a reciprocal arrangement and acknowledgement that providing services and systems that help General Practice will help the Care Communities and in turn the ICP. This will also create the capacity for them to take on more appropriate work in the revised pathways of care.

Dialogue needs to occur with local populations and third sector organisations to support communities to care for themselves when appropriate both in terms of self-care and communities supporting one another which will free capacity in primary and community care to serve those most in need.

Care Community Teams need access to good business intelligence and potentially be able to rapidly implement and test ideas to foster the idea of team working.

An indicative budget would also go towards making Care Communities more real, with a level of autonomy.

Further ideas for development

CCICP have demonstrated the benefits of working in different ways. They have organised co-located teams around a single point of access with teams that look after a local population rather than a condition group.

There is a shared IT system which is in common with GP practices. Reduced waste by looking at visiting load, reducing the need for duplicate visits and introducing innovative technology like Malinko which is making a real difference in terms of productivity and mapping demand.

The teams are interacting with General Practice to reduce home visiting workload and thinking about reducing waste in professional prescribing areas for example in Stoma Care has both improved care quality and reduced spend.

There have been projects across East Cheshire Trust which have also supported Care Community and team working successfully for example Frailty teams, Buurtzorg working, joint working between practice nurses and community nurses and developments in home visiting for those in crisis

However we need to go further and:

1) Expand the community offer
2) Bring specialist experience into the community providing rapid if not instant advice
3) Break down barriers between teams and reduce silo working, the Jonkoping approach
4) Understand the pressure points across the system and work collaboratively to resolve them
5) Reduce unwarranted variation across providers and ensure equity of services to all our population
6) Provide rapid access to diagnostics, guidance and advice
7) Invest in a population health approach
8) Invest in education and health promotion

9) Population education about how best to use services and when and how to access appropriate care
10) Utilise MDTs, the 3rd sector and assets in the community where possible
11) Look at high frequency attenders and high risk groups with an eye on equity of access, equality and parity of esteem for vulnerable groups
12) Reduce waste from multiple contacts for the same problem
13) Develop and invest in Primary Care and General Practice
14) Integrate Mental Health, Community and Social Care colleagues more effectively
15) Identify areas that improve experience for all care professionals in the system
16) We need to look at high cost pathways across the system and see where we can improve efficiency or transform work patterns.

Work needs to be done on engagement with General Practice. GPs are a large part of the senior clinical presence in primary care. As a system we would benefit from them supporting other community based clinicians and dealing with complex care and cases.

To allow this we need to explore ways of removing work from them that could be performed by other team members. GPs will need in return to reduce their unwarranted variation and agree to be part of the system working in line with agreed local pathways and guidance to provide seamless patient journeys and transitions between teams.

We need to avoid unintentional consequences of actions and understand the impact of plans – for example bringing resource into the community and unintentionally destabilising secondary care provision.

Impact for Secondary Care Clinicians

Working in this ICP will require Consultant colleagues and other specialists in secondary care to support community teams in a different way. We will need to blur the boundaries between Primary and Secondary Care to provide seamless transfers of care and advice for our local population.

We will need to use their expertise to see the most complex individuals who really need their expert care and we will rely on them to provide subject leadership and insight into which evidence based interventions would benefit our population most.

We need them to provide advice and guidance to community teams and work with them to help upskill the entire workforce through experience and over time reduce the reliance on attending hospital for interventions that could be provided in the community. This will mean that “routine care” is provided in the Community with the hospital being reserved for only those most at need.

This will mean working in a different way. The ICP recognises that secondary care have Communities of Practice and the benefit that working in clusters with other specialists brings. Integrating specialist care in the community would need to be done without deconstructing functions that work well and we need to be mindful of this as a system. We need to protect them and use their time wisely.

Impact for Community Teams

Community Teams can expect to expand in numbers, scope and skill. There are members of the Community who traditionally in our local area have not been part of mainstream care. There will be increased integration with Dentists, Optometrists, Pharmacies, Paramedics as well as Social Care and Mental Health colleagues.

There will need to be an increased skill mix with teams having more members (for example respiratory/heart failure nurses) and working with more support and advice from colleagues.

Access to rapid expert advice and point of care testing will mean an increased ability to manage conditions locally without the need to transfer to other care environments.

We will aim to improve satisfaction and team morale by making it easy for staff to do the right thing for the local population and see the benefit of their new way of working.

Impact for the Population & Individual

There will be increased stability of local health and care services. There will be an understanding of "the local offer" and more care away from hospital settings and in the local community.

We will have responsive local health and care teams that are working to help people stay safe, well and independent in their communities and providing care close to them when their health or wellbeing deteriorates. There will be an overall increased level of confidence in living with long term conditions and support provided from early years until the end of life.

Individuals will experience care delivery which is much more streamlined, easier to access and focussed on the individual's health and wellbeing. The Jonkoping approach to improving care coordination and the experiences of particularly elderly individuals will be central to developments in the Community.

Impact for General Practice

GPs provide the senior clinical resource in the community. The ICP will work with local practices and PCNs to form the foundation for the Care Communities and ensure that in line with secondary care clinicians we respect and protect that vital infrastructure.

We hope to encourage them to contribute to the development and leadership of the Care Communities. Over time as the workforce expands and the new care models develop they will be able to provide support and guidance to community teams and support multi-disciplinary working in mutual benefit for our local population.

Resources and Allocation

It is recognised that the investment required to deliver significant transformation through a new models of care programme will be substantial. This aligns with current and historical understandings of local need

to fully develop proposals for service change that meets the future health and care requirements of our population. It is acknowledged that some funds will be released from changing the way services are currently provided but others need to be prioritised from new investment through robust business cases and commissioning support.

The ICP does have a limited amount of non-recurrent funding available for this year to support the initiation of our transformation plan. This will encourage the high trust system that we aspire to. Each Care Community will receive some small amount of funding directly as an indicative budget with an intent for the ICP to find a way to continue to invest in this if teams generate/demonstrate a value return (not merely in cash terms). The remainder of the non-recurrent funding for this year will be allocated to support ICP wide projects as set out in this plan and to deliver the business cases for the service redesign proposals.

The aim is to be ambitious and innovative. We will continue to apply to be part of national and HCP schemes which will enable us to achieve delivery of our theme areas and that will attract investment and benefit for our local population.

Summary

The purpose of the ICP is to improve population health and individual person centred outcomes, to reduce variation in those outcomes across the Place and to maximise our productivity. That is, do as much as we can with the money we have, and at the same time develop a programme of investment which is clear and agreed across our whole system.

There is not enough capacity in Primary Care or Care Communities to do whole system change alongside current service delivery. We need to increase capacity and sustainability in Primary Care and Care Communities which will improve the clinical capacity and ability to do other things.

The four Care Themes present an opportunity to demonstrate:

- Reduction in waste and clinical variation
    - via the Cardiovascular and Respiratory themes
- Reducing the need for specialist hospital services by introducing new ways of working (leading to improved primary care capacity)
    - via the Social Prescribing and Mental Wellbeing theme
- Providing access to specialist advice and bringing the specialist into the community for support and education
    - via the Children's Health Hubs

The learning from these target areas will allow us to develop our approach as an ICP and move towards defining our operating model going forward.

Future Plans and Evolution

As the ICP evolves in maturity we will expand the remit of Care Communities and the resources that are made available to them. The system will develop a shared accountability for the care of the population, no matter which parent organisation they originate from.

In terms of the care themes, we will add an “Older People’s Health” theme in 2021/22 to ensure that the care of older adults remains in focus for our ICP. This will allow us to build on the work completed at that time and fold in the work going on across multiple sectors on frailty and ageing well.

As we improve our coding, business intelligence and system working, the intelligence picture we gather will lead our plans into 2023 and beyond and we will keep the populations needs at the heart of this. Population health and tackling the wider determinants of problems will ensure that we make our system sustainable into the future and we continue to measure the impact of our plans.

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**16**	Date of Meeting: 28/01/2021
Report Title	**Freedom to Speak Up – Quarter 2 & 3**	
Executive Lead	James Sumner Chief Executive Officer	
Lead Officer	Sian Axon – Freedom to Speak up Guardian	
Action Required	To note	

X **Acceptable assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of controls

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

- Sian Axon, Head of Nursing Emergency Preparedness commenced in post on 1 September 2020
- 12 concerns raised and met the Freedom to Speak up Criteria (5 in Quarter 2 & 7 in Quarter 3)
- Concerns related to Covid-19, safety issues & non-patient safety Issues

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

- Robust communication and engagement over the coming months to ensure staff are aware of the change in Guardian
- Continued programme of works to encourage staff to speak out
- Roving Open door Freedom to Speak Up (FTSU) days

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

• Manage Covid response and recovery	☐	• Provide safe and sustainable services	✓✓
• Provide outstanding care/patient experience	✓	• Provide strong system leadership by working together	✓
• Deliver most effective care to achieve best possible outcomes	✓	• Be well governed and clinically led	
• Be the best place to work	✓		

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

• Quality	✓	• Compliance	☐ ☐
• Finance	☐	• Legal	
• Workforce	✓	• Risk/BAF BAF12 Organisational culture	
• Equality	☐		

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

Strategy ☐ Policy ☐ Service Change ☐

REPORT DEVELOPMENT

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

Mid Cheshire Hospitals NHS FT

FREEDOM TO SPEAK UP GUARDIAN QUARTERLY REPORT
July - Sept & Oct - December 2020 (Quarters Two & Three)

Introduction

1. Speaking up at the earliest opportunity can protect patients, improve the experience of the NHS workforce and help the Trust embed a culture of continuous learning and improvement.

2. The Freedom to Speak Up Guardian's role is to provide staff with someone to go to if they have a concern about a patient safety risk, a wrong-doing or malpractice. The role also includes a requirement to report to the Board on all speaking up matters (including whistleblowing) and support the organisation in developing an open and transparent culture.

3. During the first two months of quarter two the Guardian role at the Trust was undertaken by the Director of Nursing and Quality. Sian Axon, Head of Nursing Emergency Preparedness commenced in post on 1st September 2020.

4. This report provides an update on the current position during quarter two and three in relation to speaking up and raising concerns.

Analysis of Quarter 2

5. During the period 1st July – 30th September 2020, 5 new concerns were raised using the various Freedom to Speak Up reporting mechanisms. All 5 of these concerns met the Freedom to Speak Up criteria and therefore will be reported to the National Guardians Office as required. This compares to 6 concerns being raised during the previous quarter and 2 concerns highlighted during quarter two in 2019-2020.

6. The concerns raised during Quarter 2 are set out below:

Staff Group	Method of reporting	Patient Safety issue	Actions taken	Issue closed and feedback reported
Nursing	email	Staff safety	Dealt with by HON EP & IPC	Issue closed & feedback given
AHP	email	Staff safety	Signpost to HR	Issue closed & feedback given
Nursing	Incident report	Yes	Dealt with by the Division	Issue closed & feedback given
Admin	email	Staff safety	Dealt with by the Division / IPC	Issue closed & feedback given
Nursing	email	Yes	Dealt with by HON EP	Issue closed & feedback given

7. No particular themes were identified in relation to staff groups where concerns were raised, however all of the safety concerns raised related to Covid-19.

8. Promotion of the importance of speaking up has continued during the quarter with regular reminders issued in Trust communications.

Analysis of Quarter 3

9. During the period 1st October – 31st December, 7 new concerns were raised using the various Freedom to Speak Up reporting mechanisms. All 7 of these concerns met the Freedom to Speak Up criteria and therefore will be reported to the National Guardians Office as required. This compares to the previous Quarter 2 with 5 concerns raised. A Teams Talk event was undertaken involving the Guardian, NED for FTSU and Workforce Business Partner, during FTSU Month, this may have influenced the increase in concerns raised.

10. The concerns raised during Quarter 3 are set out below:

Staff Group	Method of reporting	Patient Safety issue	Actions taken	Issue closed and feedback reported
Allied Health Professionals	FTSU Email	Staff safety	Dealt with by the divisional HON	Issue, reviewed responded to & closed
Healthcare Support	FTSU guardian email	Non patient safety	Dealt with by the division following signposting	Issue closed and feedback given
Healthcare Support Bank	FTSU guardian email	Non patient safety	Signposted to Division and HR	Feedback given
Estates and Ancillary	Telephone call to FSTU Guardian	Non patient safety & Potential Patient safety Issue	Dealt with by division & Issue raised by FSTU guardian and action relayed at Patient safety summit	Staff member feedback given by FTSU; further dissatisfaction issue raised at feedback remains on-going
Estates and Ancillary	Telephone call to FSTU Guardian	Non patient safety & Potential Patient safety Issue	Same issue raised by FSTU guardian at Patient safety summit	Meeting Scheduled with Division- on going
Nursing & Midwifery	FTSU guardian email	Potential patient safety	Dealt with by the Deputy Director Nursing & Quality	Issue closed and feedback given
Estates and Ancillary	FTSU Email	Non patient safety	Dealt with by Workforce Business Partner & Signpost to Union	Feedback given and Issue closed

Conclusion

11. Quarter two has seen a slight decrease in the number of concerns raised compared to the previous reporting period, compared to Quarter three yielding a small increase. It is recognised that quarterly returns have remained fairly static over the previous year and additional work is required to further encourage staff to speak up. Where concerns are identified, staff are actively utilising the wide variety of reporting mechanisms available to them.

12. In addition, historically the majority of concerns raised originated from Nursing and Midwifery staff and it is therefore encouraging to note that other staff groups, such as AHPs, Admin and Estates & Ancillary are seen in Quarter two and three, becoming increasingly confident to raise concerns where identified.

Recommendations

13. The data included in this report will be shared with the National Guardians Office for the Quarter 2 returns to ensure compliance and national learning.

14. Robust communication and engagement is required over the coming months to ensure staff are aware of the change in Guardian, including with those community based colleagues.

Remuneration Committee
Assurance Report to Board

Date	28 January 2021
Date of Committee Meeting	7 December 2020
Chair's Name & Title	Dennis Dunn, Chairman
Executive Lead	James Sumner, CEO

Summary

The Remuneration Committee continues to receive reports and provides assurance to the Board of Directors against its work programme via a summary report submitted to the Board after each meeting. Full minutes and enclosures are made available on request.

Key Issues

Executive Directors - Summary of Appraisal Outcomes

Appraisals had been undertaken for all members of the Executive Team, except for the Chief Operating Officer and the Company Secretary who had only recently joined the Trust. These would be undertaken in due course.

The CEO provided a verbal summary of each individual's performance and development plans. Following input from Committee members, the Chairman noted the positive signs of the effectiveness of the Executive Directors. He recognised the significant change in the Team over the last two years and supported the on-going aspiration of the Executive Directors.

Chief Executive – Summary of Appraisal Outcomes

The Chairman reported a positive appraisal which covered the eighteen months since the CEO's appointment – a significantly challenging time with a CQC Well-Led Inspection and the onset and continuation of Covid-19. During this period, the CEO has demonstrated committed and effective leadership, establishing productive relationships both internally and externally. His early decision to focus on supporting staff and maintaining their resilience has been well-received and has contributed to the Trust's ability to manage through this pandemic.

Decisions Made

- N/A

Recommendation

The Board is asked to note the report.

BOARD OF DIRECTORS

Agenda Item	**18**	Date of Meeting: 28/01/2021
Report Title	**Gender Pay Gap Report 2020**	
Executive Lead	Heather Barnett- Director of Workforce & OD	
Lead Officer	Ian Howarth – Workforce Equality Diversity & Inclusion Lead	
Action Required	To approve	

☐ **Acceptable assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	X **Partial assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of controls

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

- MEAN (AVG) Gender Pay Gap 23.2%, a 2% deterioration on prior year
- Median (Mid point) Gender Pay Gap is 10% representing a 0.3% improvement on prior year
- Gender imbalance in workforce has increased on prior year - F 85.2% (80.4%), M 14.8% (19.6%)

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

- Deep dive into attrition, are we losing male colleagues at lower end of AfC spectrum?
- Understand how Female talent is being recognised and supported into senior roles
- Evaluate candidate attraction programmes, males into healthcare profession AfC B1-5 in particular

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

• Manage Covid response and recovery	☐	• Provide safe and sustainable services	☐
• Provide outstanding care/patient experience	☐	• Provide strong system leadership by working together	✓
• Deliver most effective care to achieve best possible outcomes	☐	• Be well governed and clinically led	☐
• Be the best place to work	✓		

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

• Quality	☐	• Compliance	✓
• Finance	☐	• Legal	☐
• Workforce	✓	• Risk/BAF BAF12 Organisational culture	
• Equality	✓		

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

Strategy ☐ Policy ☐ Service Change ☐

REPORT DEVELOPMENT

Committee/ Group Name	Date	Report Title	Lead	Brief summary of key issues raised and actions agreed
Workforce Development Committee	18/01/21	Gender Pay Gap Report 2020	H Barnett	Recommended for approval to Board
Executive Workforce Assurance Group	06/01/21	Gender Pay Gap Report 2020	R Bather	Recommended for approval to WDT

Mid Cheshire Hospitals
NHS Foundation Trust

Gender Pay Gap Report 2020

Introduction

Mid Cheshire's Hospitals NHS Foundation Trust' services are committed to ensuring that everyone has an equal chance to live a long and healthy life, regardless of age, disability, gender identity, marital / civil partnership status, pregnancy / maternity, race, religion or belief, sex, or sexual orientation.

It is essential, therefore, that we take steps to ensure that we are a good employer which values and welcomes different ideas and skills of our staff. Our goal is to recruit, engage, develop and retain outstanding people who reflect the communities we serve and who work together to deliver our common aims and objectives.

Gender pay gap legislation was first introduced in April 2017 which required all organisations with 250 or more employees to publish their gender pay gap annually as of 31 March 2017. The information must be published on the organisations website in addition to a government website.

The gender pay gap shows the average difference in the average pay between men and women. Gender pay gap reporting is a valuable tool for assessing levels of equality in the workplace, female and male participation, and how effectively talent is being maximised.

This differs from equal pay which looks at the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value.

Job Evaluation

The Trust's pay and grading system and policies are in line with the NHS Agenda for Change (AFC) terms and conditions. Agenda for Change is underpinned by a tailored job evaluation scheme which is a pay and grading system for all NHS staff with the exception of doctors, dentists and some very senior managers.

The job evaluation scheme was specifically developed for the NHS across the UK and it determines the basic pay of all staff covered by the Agenda for Change terms and conditions. This is done by evaluating each job across a range of factors and allocating relevant levels to each factor according to the job role being considered. Each of these levels has an allocated points score; the points total for a job determines the appropriate pay band for that job. This allows jobs in different professions but with overall equal value to be appropriately measured. All new job roles are evaluated under the job evaluation scheme to ensure that they are graded fairly and objectively without gender bias or any other form of discrimination. All evaluated jobs are then placed onto a pay band.

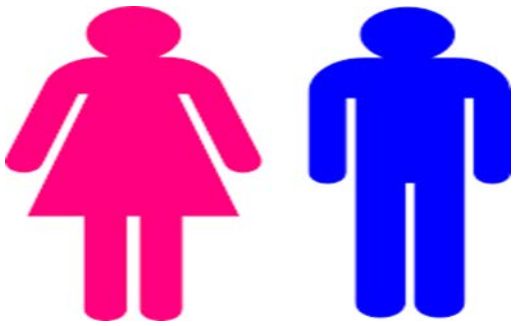
Material Factors Influencing Pay Levels

A number of factors can influence pay levels, which occur within the scope of an organisation's pay policies, these are known as material factors and can be used to objectively justify pay and pay variations. Material factors include:

- Length of service;
- Starting pay, pay protection and progression;

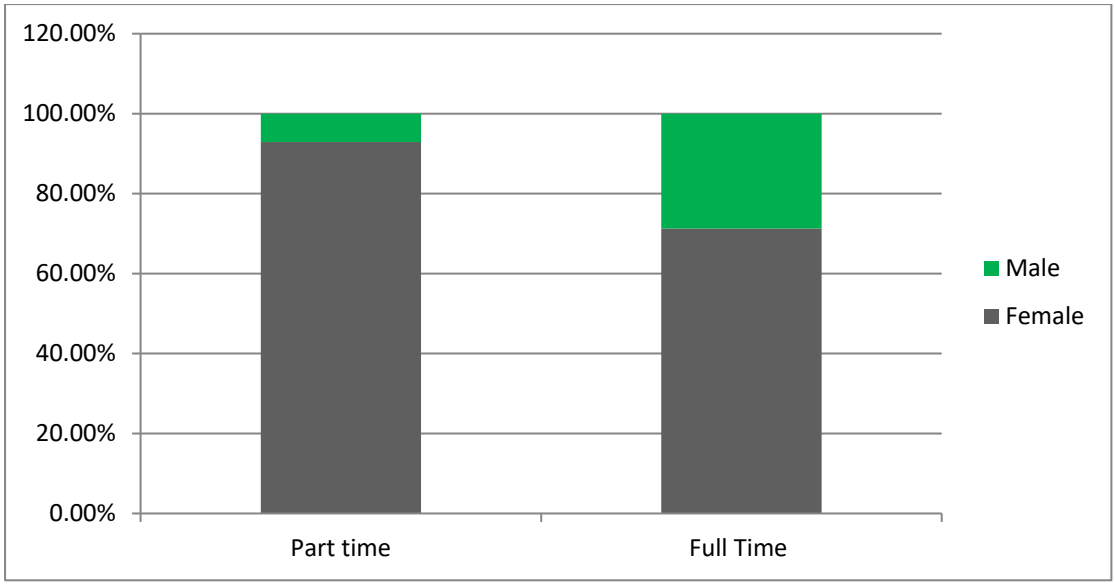
Overall, pay variances between males and females within an organisation can also be influenced by the proportion of males and females within each pay band, i.e. a higher number of females in the lower pay bands would result in a larger overall pay gap between overall total average pay for male staff and female staff within an organisation. The gender gap remains at a national level due to different ways man and women participate in the labour market. This may be due to choice of occupations and caring responsibilities

Pay and benefits based on length of service are covered specifically by the Equality Act 2010. It permits benefits to be awarded on length of service up to and including five years.



85.2% 14.8%

As at 31st March 2020 the gender make up of Mid Cheshire Hospitals NHS Foundation Trust consisted of 85.2% female and 14.8% male. This is an increase of women in the workforce as compared to last year (80.40% female compared to 19.60% male).



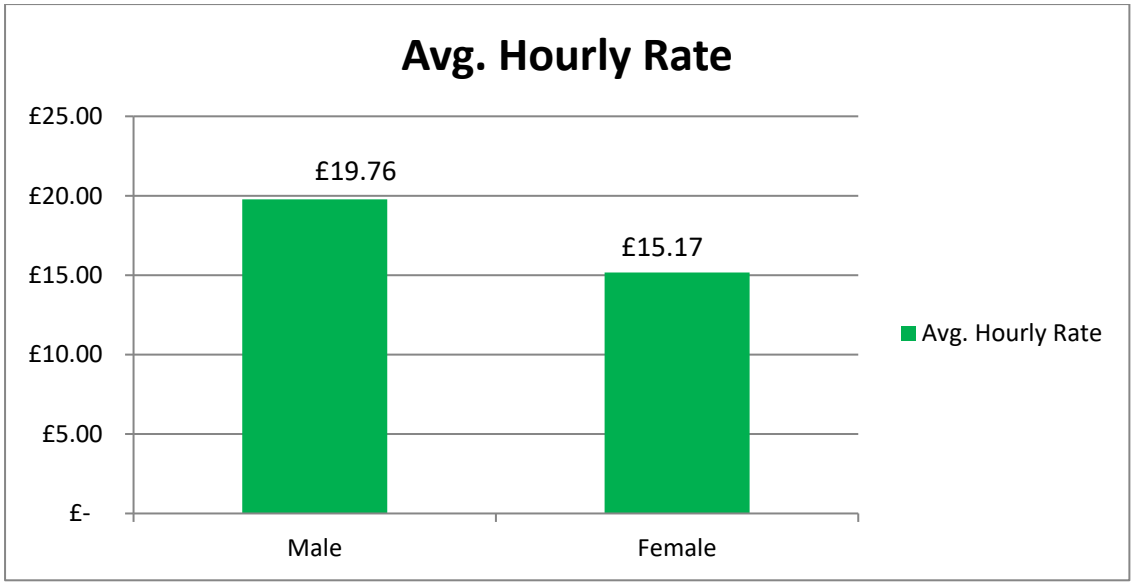
The above graph shows the gender split between full time and part time working. Just fewer than 53% of the workforce work part time hours, a decrease compared to the previous year (60%). This is made up of 49.19% of females and 3.76% of males. There has been a decrease across both groups of part time working with 51.88% of females working part time in 2019 and 7.75% of males.

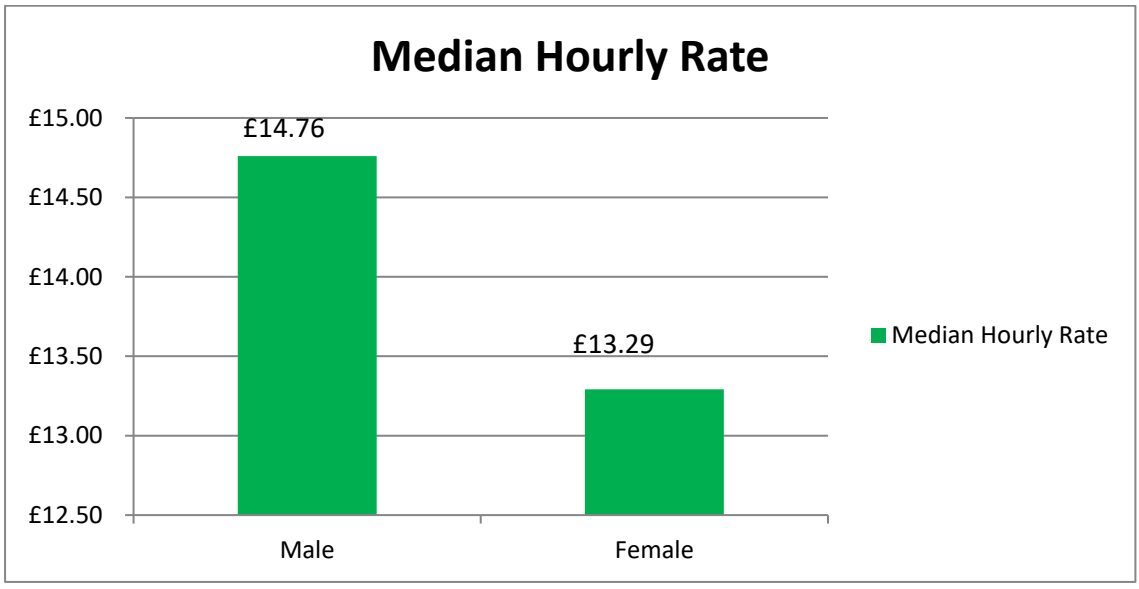
For full time working the rates are 33.53% and 13.5% respectively. Both groups have seen an increase in full time working on 2019 figures (28.56% female and 7.75% male).

Rates of Pay

The average rate of pay is calculated from a specific pay period; in this case a snap shot date of March 2020 has been used. The data includes both staff on Agenda for Change and staff on non-Agenda for Change terms and conditions. The hourly rate is calculated for each employee based on 'ordinary pay' which includes basic pay, allowances and shift premium pay. The hourly rate for staff has been calculated using the total monthly hours worked. Any overtime payments have been excluded. The median rate is calculated by selecting the average hourly rate at the mid-point for each gender group.

Gender	Avg. Hourly Rate	Median Hourly Rate
Male	19.7695	14.7601
Female	15.1731	13.2914
Difference	4.5964	1.4687
Pay Gap %	23.2498	9.9506





The above shows that the current gap between male and female average hourly pay rates is £4.59 less for females. When comparing the median hourly rate the gap decreases with a difference of £1.47.

Quartile	Female	Male	Female %	Male %
1	1016.00	196.00	83.83	16.17
2	1020.00	192.00	84.16	15.84
3	995.00	181.00	84.61	15.39
4	959.00	290.00	76.78	23.22

Note: Q1 low, Q4 high

In order to create the quartile information all staff are sorted by their hourly rate of pay. This list is then split into 4 equal parts.

The information shows that whilst males make up just under 15% of the Trust population, the largest proportion of male staff are paid in the higher quartile (24% male compared to nearly 76% female in this quartile). 33.7% of all male employees at the Trust are in the higher quartile indicating a greater distribution of male employees employed at the Trust in higher paid roles.

Bonus Pay Gap

As an NHS organisation the only pay elements that fall under the bonus criteria are Clinical Excellence Awards (CEA's) and Discretionary Points which are only applicable to certain groups of medical staff.

The Clinical Excellence Awards (CEA) scheme is intended to recognise and reward those consultants who contribute most towards the delivery of safe and high quality care to patients and to the continuous improvement of NHS services. In particular, awards are made to consultants who demonstrate sustained commitment to patient care and wellbeing, sustain high standards of both technical and clinical aspects of service while providing patient-focused care and those through active participation in clinical governance contribute to continuous improvement in service organisation and delivery.

The pay elements that are used in this calculation are awarded as a result of recognition of excellent practice over and above contractual requirements.

Gender	Avg. Pay	Median Pay
Male	11,776.34	6,032.04
Female	11,293.59	6,032.04
Difference	482.75	0.00
Pay Gap %	4.10	0.00

The information shows that there is a 4.10% bonus gap for average pay bonus payments between males and females. Considering that around only a fifth of the Trust workforce are male, a higher proportion of the male workforce receive bonus payments in comparison to their female counterparts (3.79% of males compared to 0.18% of females). There is a greater distribution of male employees on the Medical and Dental contract than females. This is not unusual as this depicts a trend that is usually reflected across the NHS nationally.

Conclusion

A gender pay gap has been identified and when comparing the figures to our previous reporting periods we can see that whilst the gap showed a 4.66% improvement over a 2 year period from March 2017 to March 2019, it increased in March 2020 by 2% (to 23.24%).

The gender pay gap will continue to be monitored via the Equality, Diversity and Inclusion Group and further detailed analysis exploring the results and a corresponding action plan will be developed over the coming months.

The Trust will continue to publish gender pay gap reports on an annual basis.

Statement

I confirm that Mid Cheshire Hospitals NHS Foundation Trust is committed to the principle of gender pay equality and has prepared its 2020 gender pay gap results in line with mandatory requirements.

Heather Barnett
Director of Workforce and Organisational Development

Audit Committee
Chair's Assurance Report
January 2021

Report to	Board of Directors
Date	28 January 2021
Report from	Les Philpott, Non-Executive Director
Report prepared by	Katharine Dowson, Head of Corporate Governance
Executive Lead	Russell Favager, Deputy Chief Executive and Director of Finance
Committee meeting quoracy	Yes ☒ No ☐

KEY AREAS OF ASSURANCE

Medical Devices Internal Audit Action Plans - Partial Assurance:

- Good progress demonstrated on delivery against action plan to address recommendations of Internal Audit reports, partial assurance as action plan not yet complete. Follow-up review to be included in 2021-22 Internal Audit Plan
- Medical Equipment Group meeting in January to approve new medical devices policy and related processes

External Audit Plan - Acceptable Assurance:

Process for approach to external audit for 2020/21 outlined; risks consistent with last year. Aspects to consider:

- Valuation of land and buildings - desk top exercise this year; consideration of Leighton Hospital redevelopment plan required to ensure consistency with current model
- Revenue Recognition - risk lower compared to previous years due to National Covid financial arrangements. Focus likely to be on providing assurance in regard to allocations and top ups through the Integrated Care System
- Expenditure Recognition - break even to month 6, now operating to ICS control total. Procedures in place to explore/identify key risks related to expenditure and/or management override of controls e.g. unusual treatments on PPE
- Going Concern - period goes into 2023 although current guidance issued to 2021-22 only
- Value for Money - increased level of scrutiny in this area from 2021, limited management guidance available. Work on risk assessment started; update to be provided to next meeting.

Report of Board Committees - Acceptable Assurance:

Board Committees stepped down in November due to operational pressures; items deferred to December/January. Committees working in line with Terms of Reference and agreed workplans.

Conformance report - Acceptable Assurance: 'no Purchase Order, no Pay' fully implemented with measured improvement to only 3% of total invoices paid (excluding pre-October legacy activity) being non PO invoices. Procurement rules remain in place following EU Exit, no changes anticipated. More detail requested for next meeting on clinical negligence claims and the process for monitoring these with lessons learnt advised to Quality and Safety Committee.

Cyber Security Progress Report - Partial Assurance:
Progress highlights include hardware upgrade of patient administration system (PAS) by end of February. Number of risks outstanding with work ongoing to mitigate but some solutions long-term as part of Digital Clinical System implementation. Progress to be reviewed in April due to high level of risk.

Internal Audit:

- **Internal Audit Governance Review of Trust Cyber Action Plan - Acceptable Assurance:** Scope of review limited to implementation of nine recommendations; high assurance reported as strong level of internal control demonstrated. Auditors confident no limitations or gaps in the work. Committee challenged whether cyber champion for Board should be CIO as recommendation that champion should be an Audit Committee member (i.e. a Non-Executive Director) - to be considered further
- **Internal Audit Finance Systems Key Controls Review - Acceptable Assurance:** Internal Audit confirmed high level of assurance
- Approved deferment of review of Vacancy Management to 2021-22 due to operational pressures.

Committee Terms of Reference
Draft using NHS Providers model terms of reference agreed, to be signed off by Board of Directors as part of the Corporate Governance Framework Manual.

Board Committee Effectiveness & Performance Review
Review of new process for annual evaluation of committees approved to be trialled for this year's process. New approach to encourage debate at committee and consideration of areas of focus/improvements for the forthcoming year before approval by Board. Audit Committee evaluation using HfMA self-assessment tool to remain.

KEY CONCERNS/RISKS

- Growing cyber security threat externally could lead to a threat before controls to address cyber security risks are in place

Priority Areas: DECISIONS MADE

- Approved trialling new approach for annual performance review of Board Committees
- Agreed new draft Terms of Reference
- Agreed Workplan for 2021/22
- Change to Risk Management Process Guide to reflect new finance prioritisation categorisation to a % impact with Catastrophic being set at £5m at Trust level. *Decision made on verbal recommendation, future changes to be supported with a short written case to ensure audit trail.*

RECOMMENDATION

To note

BOARD OF DIRECTORS

Agenda Item	**20**	Date of Meeting: 28/01/2021
Report Title	**Digital Clinical System Programme - Governance Arrangements**	
Executive Lead	Amy Freeman – Chief Information Officer	
Lead Officer	Click here to enter text	
Action Required	To approve	

☐ **Acceptable assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of controls

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

- Robust governance structure to provide necessary oversight and management of the programme
- Sufficiently agile structure to facilitate its development as the Trust moves through the approvals and implementation process
- Structure facilitates effective and timely reporting to the Board

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

- Governance structure to be put in place with the Transformation Board and Steering Group operational from February 2021
- Formal reporting to the Board from March 2021

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

• Manage Covid response and recovery	☐	• Provide safe and sustainable services	☐
• Provide outstanding care/patient experience	✓	• Provide strong system leadership by working together	☐
• Deliver most effective care to achieve best possible outcomes	☐	• Be well governed and clinically led	☐
• Be the best place to work	☐		

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

• Quality	☐	• Compliance	☐
• Finance	☐	• Legal	☐
• Workforce	☐	• Risk/BAF **BAF6 EPR**	
• Equality	☐		

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

Strategy ☐ Policy ☐ Service Change ☐

Mid Cheshire Hospitals NHS FT

REPORT DEVELOPMENT

Committee/ Group Name	Date	Report Title	Lead	Brief summary of key issues raised and actions agreed
MCHFT Company Secretary	11/12/2020	Digital Clinical System Governance Arrangements	CIO	Professionally reviewed

Digital Clinical System Programme
Governance Arrangements

Introduction

1. East Cheshire NHS Trust (ECT) and Mid Cheshire Hospitals NHS Foundation Trust (MCHFT) have embarked on an ambitious strategy to procure and implement a clinical transformation programme, underpinned by a digital clinical system which aims to ensure the NHS' hospital clinical systems enable the provision of world-class healthcare services. The Trust's intentions are to implement new digitally-enabled clinical practices which will take into consideration the overall Integrated Care System requirements for system-wide health and social care improvement.

2. This is a significant undertaking and highly complex due to both organisations being involved and which requires a robust governance structure through which the programme will be overseen and managed, enabling the Trust Boards to be provided with acceptable assurance on the controls in place and the progress in delivery.

Executive Summary

3. A Digital Clinical System Programme Director has been appointed to plan, monitor and manage the systems and processes required to deliver the programme's aims, aligned to a clear timetable. In the first instance to conduct a procurement and develop a Full Business Case (FBC) to help the Trusts gain approval from NHS England/Improvement (NHSE/I) to award the contract. In addition, the FBC will support the Trust's application to become NHSX Digital Aspirants along with the associated financial award. It is envisaged that this phase will be completed for Board approval by May 2021.

4. The governance structure outlined in this paper is designed to be as agile as possible, linking with both Trusts' current structures, such as MCHFT's Workforce and Digital Transformation Committee, but able to evolve as the programme becomes more intensive as the Trusts move through the regulatory approvals process and into implementation. It facilitates timely and efficient reporting to both Trust Boards through regular updates aligned to reports from the Board Assurance Framework (BAF).

5. Should additional scrutiny or assurance be required by the main Board on a specific area, the relevant organisation's Board Committee may be asked to consider and action.

Background and Analysis

6. The governance structure (Appendix I) identifies the main decision-making bodies for the programme – the Digital Clinical System Transformation Board (DCSTB) supported by the Digital Clinical System Steering Group (DCSSB). The main purpose of the DCSTB, chaired jointly by the Chief Executives of the two Trusts as the Senior Responsible Officers, is to ensure that the digital clinical system programme is completed successfully; specifically, that the primary objectives and benefits are delivered safely, to time and on budget.

DCSTB members are detailed in table 1 and are identified in the Terms of Reference for the DCSTB at Appendix II. It is suggested that there should be some flexibility in attendance for those individuals attending both the Transformation Board and the Steering Group and that certain roles might represent the position of both Trusts, if agreed in advance. This would require robust and effective communication between these individuals and confirmation of what would be in scope to agree on each other's behalf and what would be out of scope. This would require effective chairing and minute taking to support this approach.

DCSTB	
East Cheshire NHS Trust	**Mid Cheshire Hospitals NHS FT**
Chief Executive Officer (Co-Chair)	Chief Executive Officer (Co-Chair)
Head of Informatics	Chief Information Officer
Director of Finance	Deputy CEO/Director of Finance
Medical Director	Medical Director
Director of Nursing & Quality	Director of Nursing & Quality
Chief Operating Officer	Chief Operating Officer
Director of HR & Organisational Development	Director of Workforce and Organisational Development
Non-Executive Director	Non-Executive Director
DCS Programme Director	
Supplier Representative	
In Attendance:	
Programme Management Office	
Communications and Engagement Lead	
For Advice:	
Director of Corporate Affairs and Governance (ECT) representing both Trusts	

Table 1: DCSTB membership

7. The DCSTB will report to the respective Boards of Directors which will be provided with regular updates at its formal meetings (the programme will be included on Board agendas as a substantive item). In addition, for MCHFT the Board will be provided with information on the key risks to the programme via BAF reporting, as the Electronic Patient Record is one of the key mitigations to reducing BAF Risk 9 – *Failure to proceed with EPR development and implementation.*

8. The DCSSG will be jointly chaired by the Chief Information Officer (MCHFT) and Head of Informatics (ECT), with administrative support provided by the Programme Management Office (PMO), The Programme Director will be responsible for co-ordinating the work required to deliver the key areas of the programme. Initially, it has been decided not to set up separate workstreams to address those key areas until the supplier and solution have been selected as the solution selected will directly impact the workstreams required.

9. Members of the DCSSG Group are detailed in the table overleaf and identified in the Terms of Reference for the Group at Appendix III.

DCSSG	
East Cheshire NHS Trust	**Mid Cheshire Hospitals NHS FT**
Head of Informatics (Co-Chair)	Chief Information Officer (Co-Chair)
Chief Clinical Information Officer (Co-Deputy Chair)	Chief Clinical Information Officer (Co-Deputy Chair)
Deputy Director of Finance	Chief Nurse Information Officer
Head of Information	Deputy Director of Finance
Associate Director of Service Transformation	Head of Information and Performance
Divisional Associate Director	Head of Transformation
Deputy Director of HR Services	Operations Director
	Head of Organisational Development
DCS Programme Director	
Supplier Representative	
In Attendance:	
Deputy Director of Corporate Affairs and Governance (ECT) representing both Trusts	
Programme Management Office	
Communications and Engagement Lead	

Table 2: DCSSG membership

10. The risk register for the programme will be monitored by the DCSSG with key risks and exceptions escalated to the DCSTB as the body responsible for managing the overall risk of the programme. In addition, notable risks will be brought to the Board of Directors' attention as part of the regular BAF reporting process[1], thereby enabling the Board to receive assurance about actions taken to manage the risks.

11. Any issues that might arise through the process that require additional scrutiny and assurance will be referred to the Trust's established governance structures, including the Executive Risk & Assurance Group and, for ECT, their Clinical Management Board.

12. The Clinical Advisory Group is a source of independent and strategic advice to DCSTB and DCSSG as well as to workstreams as they are established. The group is a diverse and multi-professional forum providing access to a broad range of health and care professions who can provide opinion and guidance of digital clinical system matters.

13. The Clinical Advisory Group will take a specific interest and ownership in the clinical safety of new ways of working using a digital clinical system, in line with the information standards

[1] Reporting to Part II of the Board together with other significant risks that, for clear and acceptable reasons, cannot be made public

notice DCB0160 Amd 25/2018 - Clinical Risk Management: its Application in the Deployment and Use of Health IT Systems, 2018 Update.

14. The Clinical Advisory Group will be jointly chaired by the Chief Clinical Information Officers. The membership of the group will include medical, nursing, allied health professional and midwifery staff.

15. A register of decisions and advice provided by the Clinical Advisory Group will be maintained by DCSSG and the PMO.

Conclusion

16. The proposed governance structure:

- is sufficiently robust to provide the scrutiny and assurance necessary for successful delivery of the overall programme
- has the required Executive focus to ensure successful oversight and management of the programme
- will be subject to independent audits
- can evolve as necessary as the programme progresses
- links the management of the programme risks to the Trust's risk management framework, including reporting to the Board via the BAF
- facilitates timely reporting to the Board.

Recommendation

17. To approve

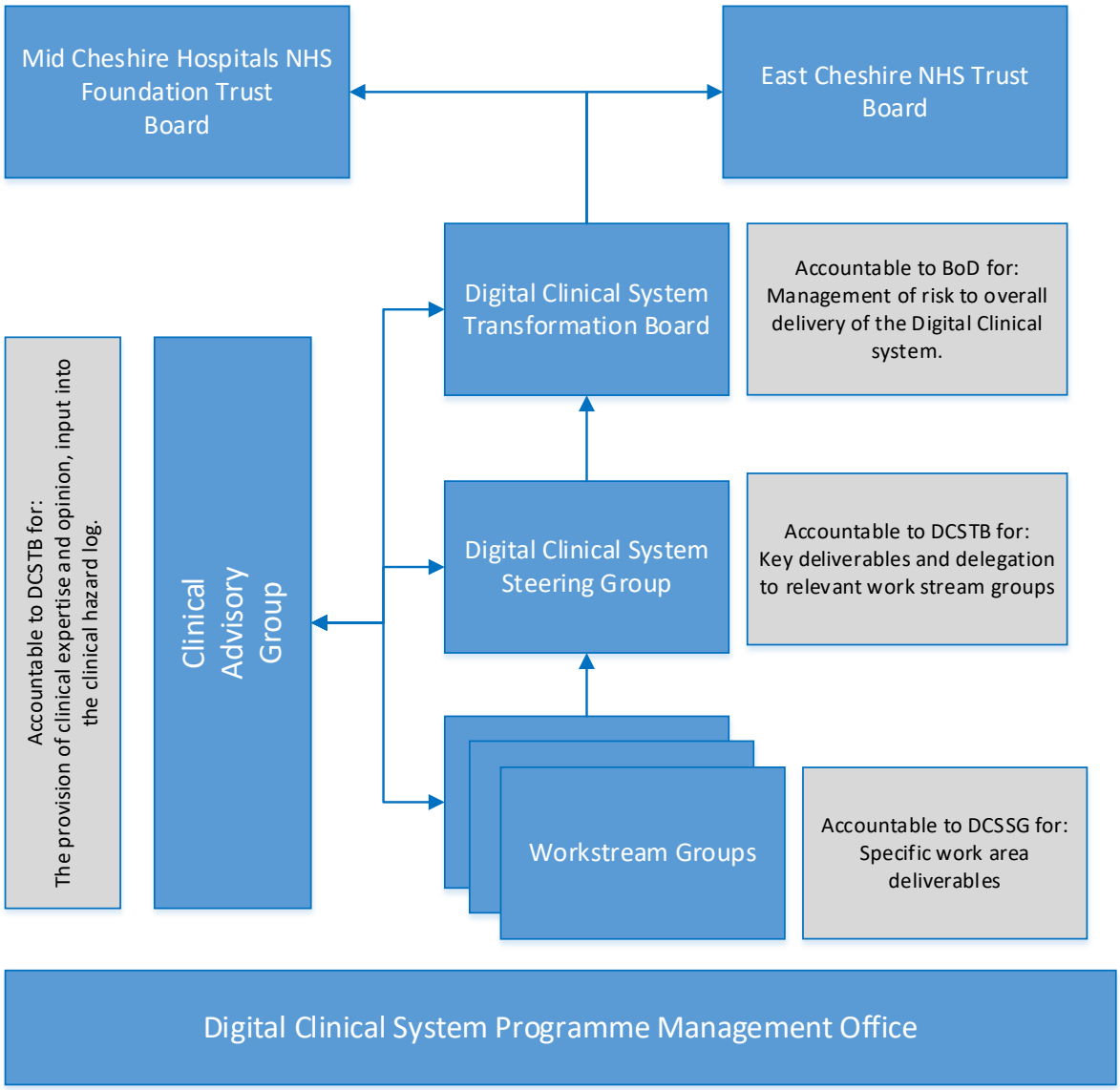
Author: **Amy Freeman, Chief Information Officer, MCHFT**
Date: **11 December 2020**

Appendix I

NHS East Cheshire NHS Trust

NHS Mid Cheshire Hospitals NHS Foundation Trust

Digital Clinical System Governance Structure



Appendix II

Digital Clinical System Transformation Board
Terms of Reference

Authority/Constitution

1. The Digital Clinical System Transformation Board (DCSTB) is authorised by the Board of Directors from East Cheshire NHS Trust (ECT) and Mid Cheshire Hospitals NHS Foundation Trust (MCHFT) to act within its terms of reference as a senior decision-making body.

2. The DCSTB has no executive powers other than those specifically delegated in these Terms of Reference.

3. The DCSTB has the authority to oversee and take decisions relating to programme activities which also support the achievement of the organisation's objectives.

4. The DCSTB is authorised to request specific reports from individual functions within the organisation and to seek any information it requires from any member of staff in order to perform its duties.

5. The DCSTB is authorised to request external assurance reports including but not limited to internal audit, Office of Government Commerce (OGC) gateway reviews, NHS Digital Electronic Patient Record (EPR) Readiness and Healthcare Information and Management Systems Society (HIMSS) assessments.

6. The DCSTB is authorised to create operational sub-groups, advisory or working groups as are necessary to fulfil its responsibilities within its terms of reference. The Group may not delegate executive powers and remains accountable for the work of any such group. Any of these groups will report directly to the DCSTB who will oversee their work or via the Digital Clinical System Steering Group.

Purpose

7. The aim of the DCSTB is to ensure that the digital clinical system programme is completed successfully; specifically, that the primary objectives are delivered safely, to time and on budget.

8. The DCSTB has a key role in supporting the Senior Responsible Owners (SRO) in making decisions and providing both challenge and approval on issues affecting the progress of the programme.

9. The SROs have executive responsibility for providing approvals and taking decisions affecting programme process and delivery throughout the programme. To fulfil these responsibilities,

the DCSTB will set the direction for the programme, support the SROs in decision-making and oversee the overall progress of the programme.

Membership

10. The DCSTB shall be comprised of the following members:

DCSTB	
East Cheshire NHS Trust	**Mid Cheshire Hospitals NHS FT**
Chief Executive Officer (Co-Chair)	Chief Executive Officer (Co-Chair)
Head of Informatics	Chief Information Officer
Director of Finance	Deputy CEO/Director of Finance
Medical Director	Medical Director
Director of Nursing & Quality	Director of Nursing & Quality
Chief Operating Officer	Chief Operating Officer
Director of HR & Organisational Development	Director of Workforce and Organisational Development
Non-Executive Director	Non-Executive Director
DCS Programme Director	
Supplier Representative	
In Attendance:	
Programme Management Office	
Communications and Engagement Lead	
For Advice:	
Deputy Director of Corporate Affairs and Governance (ECT) representing both Trusts	

11. The DCSTB will be deemed quorate when the Chair or Deputy Chair plus two additional members including the Medical Director and the Non-Executive Director are present. Members may only nominate a deputy to attend on their behalf if they have sufficient understanding of the area they are representing to be able to contribute effectively to the Board's business; however, this should only be in exceptional circumstances and should be agreed with the Chair. Deputies will count towards the quorum.

12. Other staff or external advisers may be co-opted or requested to attend for specific agenda items as necessary.

Requirements of Membership

13. Members must attend at least 75% of all meetings each financial year but should aim to attend all scheduled meetings. Attendance will be recorded and monitored.

14. Conflicts of Interest – the Companies Act 2006 defines a conflict of interest as arising when the interests of directors or 'connected persons' are incompatible or in competition with the interests of the organisation. DCSTB members are required to exercise judgement and to declare such interests as there is a risk of implied improper conduct. The relevant interest, once declared, will be recorded in a register of interests, maintained by the Company Secretary.

Duties

15. In order to fulfil its role and obtain the necessary assurance, the DCSTB will:

- oversee the management of the delivery of the digital clinical system procurement process
- oversee the management and delivery of the Full Business Case (FBC) for the digital clinical system
- champion the system implications and benefits with internal and external stakeholders
- provide approval for the creation of workstreams and task and finish groups
- confirm the scope of the programme and sign off the Programme Initiation Document
- approve a robust Programme Plan
- ensure the requirements for business case approval are met, including ensuring appropriate business case approvals
- monitor progress from workstreams associated with the development of the digital clinical system and clinical transformation
- receive and assess reports from the Digital Clinical Steering Group, Clinical Advisory Group and other task and finish groups as required
- ensure that Delivery Plans, including objectives, key milestones, resource plans, process, performance monitoring arrangements and all major deliverables associated with the programme aim are in place
- sign off key milestones and agree progression through the programme phases
- ensure that governance and assurance systems operate effectively and underpin programme delivery
- resolve any issues escalated to the DCSTB, in addition to identifying and monitoring any corrective actions where identified
- refer any decision required to be made that does not fall within the authority of the DCSTB to the relevant Committees of the Trust and/or the Boards of Directors for example the MCHFT Workforce and Digital Transformation Committee and the Clinical Management Board for ECT
- ensure that there is effective identification and management of the risks associated with the aims of the Programme Board by ensuring that relevant assurances are sought with respect to the effectiveness of risk controls and that future actions are focused on managing risks to an acceptable level
- prioritise work associated with the aim of the Programme Board, identifying and agreeing those areas which will not be progressed until later dates in the programme including after the new ways of digital working have been delivered
- provide leadership, advice and decision-making support to the Digital Clinical System Steering Group
- ensure that the Steering Group is sufficiently resourced to deliver successfully within the agreed scope time, cost and quality parameters

- ensure that each workstream has accountable representation and that they deliver in line with the Programme Plan
- act as an approving body for decisions and recommendations presented by the Steering Group
- ensure there is an integrated, comprehensive and effective Communications Plan in place which is approved by the DCSTB to ensure all stakeholders (internal and external) are informed and involved throughout the process
- identify whether any fundraising opportunities are available for this programme and action accordingly
- receive, assess and approve changes to the programme within the parameters detailed within the Project Initiation Document (PID)
- ensure all programme evaluation and lessons learned reports are prepared in accordance with the agreed Post Programme Evaluation Strategy.

16. The DCSTB is committed to protecting and respecting data privacy. The DCSTB will have regard to the EU General Data Protection Regulation (Regulation (EU) 2016/679) (GDPR) and demonstrate, where applicable, compliance with data protection legislation, in particular the Data Protection Act 1998 (DPA).

Equality, Diversity & Inclusion

17. In conducting its business, the DCSTB will at all times seek to promote its commitment to equality and diversity by the creation of an environment that is inclusive for both our workforce, patients and service users, including those who have protected characteristics and vulnerable members of our community.

18. Throughout the life of the Programme, specific consideration will be given to turning digital exclusion into digital inclusion ensuring patients and carers without access to the internet and connected devices are not disadvantaged.

Reporting

19. The DCSTB will be accountable to the Boards of Directors. The Boards will be informed of DCSTB's work through an assurance report from the Chair submitted following each meeting every 2 months.

20. Assurance reports will be received from the Digital Clinical System Steering Group as a standing agenda item at the DCSTB (Appendix I) with other reports on key areas as required.

Administration of Meetings

21. Meetings shall be held bi monthly with additional meetings held on an exception basis at the request of the Chair or any three members of the DCSTB.

22. The Programme Office will make arrangements to ensure that the DCSTB is supported administratively. Duties in this respect will include development and monitoring of a Workplan,

agenda setting, taking minutes of the meeting and providing appropriate support to the Chair and DCSTB members.

23. Agendas and papers will be circulated at least 4 working days in advance of the meeting.

24. A record of the meeting will be circulated to members for comment as soon as is reasonably practicable.

Review

25. The Terms of Reference shall be reviewed at each stage of the programme (next review date May 2021).

Appendix III

Digital Clinical System Steering Group
Terms of Reference

Authority/Constitution

1. The Digital Clinical System Steering Group (DCSSG) is authorised by the Digital Clinical System Transformation Board (DCSTB) to act within its terms of reference as a decision-making body of East Cheshire NHS Trust (ECT) and Mid Cheshire Hospitals NHS Foundation Trust (MCHFT).

2. The DCSSG has no executive powers other than those specifically delegated in these Terms of Reference.

3. The DCSSG has the authority to oversee and take decisions relating to the organisation's activities which also support the achievement of the organisation's objectives.

4. The DCSSG is authorised to request specific reports from individual functions within the organisation and to seek any information it requires from any member of staff in order to perform its duties.

Purpose

5. The aim of the DCSSG is to ensure that the digital clinical system programme is completed successfully; specifically, that the primary objectives are delivered safely, to time and on budget.

6. The DCSSG has a key role in supporting the DCSTB in making decisions and providing both challenge and approval on issues affecting the progress of the programme.

Membership

7. The DCSSG shall be comprised of the following members:

DCSSG	
East Cheshire NHS Trust	**Mid Cheshire Hospitals NHS FT**
Head of Informatics (Co-Chair)	Chief Information Officer (Co-Chair)
Chief Clinical Information Officer (Co-Deputy Chair)	Chief Clinical Information Officer (Co-Deputy Chair)
Deputy Director of Finance	Chief Nurse Information Officer
Head of Information	Deputy Director of Finance

Associate Director of Service Transformation	Head of Information and Performance
Divisional Associate Director	Head of Transformation
Deputy Director of HR Services	Operations Director
	Head of Organisational Development
DCS Programme Director	
Supplier Representative	
In Attendance:	
Deputy Director of Corporate Affairs and Governance (ECT) representing both Trusts	
Programme Management Office	
Communications and Engagement Lead	

8. The DCSSG will be deemed quorate when the Chair or Deputy Chair plus three additional members from each Trust are present. Members may only nominate a deputy to attend on their behalf if they have sufficient understanding of the area they are representing to be able to contribute effectively to the Group's business; however, this should only be in exceptional circumstances and should be agreed with the Chair. Deputies will count towards the quorum.

9. Other staff or external advisers may be co-opted or requested to attend for specific agenda items as necessary.

Requirements of Membership

10. Members must attend at least 75% of all meetings each financial year but should aim to attend all scheduled meetings. Attendance will be recorded and monitored.

11. Conflicts of Interest – the Companies Act 2006 defines a conflict of interest as arising when the interests of directors or 'connected persons' are incompatible or in competition with the interests of the organisation. DCSSG members are required to exercise judgement and to declare such interests as there is a risk of implied improper conduct. The relevant interest, once declared, will be recorded in a register of interests, maintained by the Company Secretary.

Frequency

12. Members will meet every 1 month and will last for 90 minutes.
13. The meeting will be held either face to face or over Microsoft Teams.

Duties

14. In order to fulfil its role and obtain the necessary assurance, the DCSSG will:

- manage the digital clinical systems procurement process
- manage the delivery of the Full Business Case (FBC) for the digital clinical system ensuring the FBC is developed in accordance with the Government 5 case model
- deliver and update the Programme Initiation Document, seeking approval from the DCSTB as required
- deliver and update the Programme Plan with approval by the DCSTB as required
- monitor progress from key areas associated with the development of the new digitally-enabled clinical delivery models
- ensure that Delivery Plans, including objectives, key milestones, resource plans, process, performance monitoring arrangements and all major deliverables associated with the programme aim are delivered
- ensure that there is effective identification and management of the risks associated with the aims of the Steering Group by seeking relevant assurances with respect to the effectiveness of risk controls and that future actions are focused on managing risks to an acceptable level
- identify and manage interdependencies between the DCS Programme and other organisational projects and programmes
- prioritise work associated with the aim of the Steering Group, identifying and agreeing those areas which will not be progressed until later dates in the programme including after the new ways of digitally-enabled clinical working have been delivered
- identify and establish workstreams and task and finish groups as agreed by DCSTB
- ensure that the Steering Group delivers its objectives successfully within the agreed scope time, cost and quality parameters
- ensure that each key area has accountable representation and that they deliver in line with the Programme Plan
- develop and implement an integrated, comprehensive and effective Communications Plan to ensure all stakeholders (internal and external) are informed and involved throughout the process
- seek advice from specialist groups such as the Clinical Advisory Group as required
- ensure the programme controls in use across workstreams, task and finish groups, programme group and DCSTB are appropriate and proportionate
- develop and manage the Clinical Safety Framework DCB0160 and DCB0129 thorough the life of the programme to ensure clinical safety of the new ways of digitally-enabled clinical working
- develop an effective Post Programme Evaluation and Benefits Realisation Strategy
- assure the integrity of the benefits profile and benefits realisation strategy.

15. The DCSSG is committed to protecting and respecting data privacy. The DCSSG will have regard to the EU General Data Protection Regulation (Regulation (EU) 2016/679) (GDPR) and demonstrate, where applicable, compliance with data protection legislation, in particular the Data Protection Act 1998 (DPA).

Equality, Diversity & Inclusion

16. In conducting its business, the DCSSG will at all times seek to promote its commitment to equality and diversity by the creation of an environment that is inclusive for both our workforce,

patients and service users, including those who have protected characteristics and vulnerable members of our community.

17. Throughout the life of the Programme, specific consideration will be given to turning digital exclusion into digital inclusion ensuring patients and carers without access to the internet and connected devices are not disadvantaged.

Reporting

18. The DCSSG will be accountable to the Digital Clinical System Transformation Board. The DCSTB will be informed of DCSSG's work through a report from the Chair, submitted following each meeting.

19. Reports may be received from the key areas (Appendix I) as required.

Administration of Meetings

20. Meetings shall be held monthly with additional meetings held on an exception basis at the request of the Chair or any three members of the DCSSG.

21. The Programme Office will make arrangements to ensure that the DCSSG is supported administratively. Duties in this respect will include development and monitoring of a Workplan, agenda setting, taking minutes of the meeting and providing appropriate support to the Chair and DCSSG members.

22. Agendas and papers will be circulated at least 4 working days in advance of the meeting.

23. A record of the meeting will be circulated to members for comment as soon as is reasonably practicable.

Review

24. The Terms of Reference shall be reviewed at each stage of the programme (next review date March 2021).

Appendix IV

Clinical Advisory Group
Terms of Reference

Authority/Constitution

1. The DCS Clinical Advisory Group (DCSCAG) is authorised by the Digital Clinical System Transformation Board (DCSTB) to act within its terms of reference as a decision-making body of East Cheshire NHS Trust (ECT) and Mid Cheshire Hospitals NHS Foundation Trust (MCHFT).

2. The DCS Clinical Advisory Group has no executive powers other than those specifically delegated in these Terms of Reference.

3. The DCS Clinical Advisory Group has the authority to take clinical decisions and offer clinical advice relating to the programmes activities which also support the achievement of the organisation's objectives.

4. The DCS Clinical Advisory Group is authorised to request specific reports from individual functions within the organisation and to seek any information it requires from any member of staff in order to perform its duties.

Purpose

5. The aim of the DCS Clinical Advisory Group is to ensure that the digital clinical system programme is completed successfully; specifically, that the new ways of working are clinically safe and efficient for staff and patients.

6. The DCS Clinical Advisory Group has a key role in supporting the DCSTB and DCSSG in making decisions and providing both challenge and approval on issues affecting the progress of the programme.

Membership

7. The DCS Clinical Advisory Group shall be comprised of the following members:

DCSCAG	
East Cheshire Trust	Mid Cheshire Hospitals NHS Foundation Trust
Chief Clinical Information Officer	Chief Clinical Information Officer
Chief Nurse Information Officer	Chief Nurse Information Officer
TBC	TBC
DCS Programme Director	

Supplier
In Attendance:
Programme Management Office

8. The DCS Clinical Advisory Group will be deemed quorate when the Chair or Deputy Chair plus two additional members from each Trust are present. Members may only nominate a deputy to attend on their behalf if they have sufficient understanding of the area they are representing to be able to contribute effectively to the Group's business; however, this should only be in exceptional circumstances and should be agreed with the Chair. Deputies will count towards the quorum.

9. Other staff or external advisers may be co-opted or requested to attend for specific agenda items as necessary.

Requirements of Membership

10. Members must attend at least 75% of all meetings each financial year but should aim to attend all scheduled meetings. Attendance will be recorded and monitored.

11. Conflicts of Interest – the Companies Act 2006 defines a conflict of interest as arising when the interests of directors or 'connected persons' are incompatible or in competition with the interests of the organisation. DCSCAG members are required to exercise judgement and to declare such interests as there is a risk of implied improper conduct. The relevant interest, once declared, will be recorded in a register of interests, maintained by the Company Secretary.

Frequency

12. Members will meet every 1 month and will last for 90 minutes.
13. The meeting will be held either face to face or over Microsoft Teams.

Duties

14. In order to fulfil its role and obtain the necessary assurance, the DCS Clinical Advisory Group will:

- provide clinical evaluation of the digital clinical systems procurement process`
- provide input into the quality and safety benefits of the Full Business Case (FBC) for the digital clinical system
- monitor progress from key clinical areas associated with the development of the new digitally enabled clinical delivery models
- ensure that there is effective identification and management of the clinical risks and hazards associated with the aims of the Steering Group by seeking relevant assurances with respect to the effectiveness of risk controls and that future actions are focused on

managing risks to an acceptable level and offering alternative approaches to overcome clinical hazards

- recommend to DCSSG the clinical risk appetite including risk thresholds for the programme and its constituent projects
- offer a clinical advisory service and access to clinical expertise to provide opinion, guidance and decisions on clinical matters
- part of the go no go arrangements ensuring hazards are managed before go live
- work with transformation colleagues on cultural and business change
- ensure that each key area has accountable clinical representation and that they deliver in line with the Programme Plan
- champion the digital clinical systems programme with clinical colleagues acting as an advocate for new safer ways of working
- input into the clinical safety framework DCB0160 and DCB0129 thorough the life of the programme to ensure clinical safety of the new ways of digitally enabled clinical sign off.
- input into the Benefits Realisation Strategy.

15. The DCS Clinical Advisory Group is committed to protecting and respecting data privacy. The Clinical Advisory Group will have regard to the EU General Data Protection Regulation (Regulation (EU) 2016/679) (GDPR) and demonstrate, where applicable, compliance with data protection legislation, in particular the Data Protection Act 1998 (DPA).

Equality, Diversity & Inclusion

16. In conducting its business, the DCS Clinical Advisory Group will at all times seek to promote its commitment to equality and diversity by the creation of an environment that is inclusive for both our workforce, patients and service users, including those who have protected characteristics and vulnerable members of our community.

17. Throughout the life of the Programme, specific consideration will be given to turning digital exclusion into digital inclusion ensuring patients and carers without access to the internet and connected devices are not disadvantaged.

Reporting

18. The Clinical Advisory Group will be accountable to the Digital Clinical System Transformation Board. The DCSTB will be informed of Clinical Advisory Groups work through the decisions and advice register submitted following each meeting.

Administration of Meetings

19. Meetings shall be held monthly with additional meetings held on an exception basis at the request of the Chair or any three members of the DCS Clinical Advisory Group.

20. The Programme Office will make arrangements to ensure that the DCS Clinical Advisory Group is supported administratively. Duties in this respect will include development and

monitoring of an agenda setting, maintaining the actions, decisions and advice register and providing appropriate support to the Chair and members.

21. Agendas and papers will be circulated at least 4 working days in advance of the meeting.

22. A record of the meeting will be circulated to members for comment as soon as is reasonably practicable.

Review

23. The Terms of Reference shall be reviewed at each stage of the programme (next review date March 2021).

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**Consent Agenda**	Date of Meeting: 28/01/2021
Report Title	Guardian of Safe Working Hours Report (Q2&3)	
Executive Lead	Heather Barnett, Director of Workforce and OD	
Lead Officer	Douglas Robertson, Guardian of Safe Working Hours	
Action Required	To note	

X **Acceptable assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of controls

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

- The Trust continues to implement the 2016 national contract for doctors in training.
- Service pressures because of Covid19 appears to have reduced reporting rates.
- Actions to ensure that systematic under-reporting does not occur are being put in place.

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

- None

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

• Manage Covid response and recovery	☐	• Provide safe and sustainable services	☐
• Provide outstanding care/patient experience	☐	• Provide strong system leadership by working together	☐
• Deliver most effective care to achieve best possible outcomes	☐	• Be well governed and clinically led	☐
• Be the best place to work	☐		

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

• Quality	☐	• Compliance	☐
• Finance	☐	• Legal	☐
• Workforce	☐	• Risk/BAF BAF12 Organisational culture	
• Equality	☐		

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

Strategy ☐ Policy ☐ Service Change ☐

REPORT DEVELOPMENT

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

Report from the Guardian of Safe Working Hours

1 July 2020 – 31 December 2020 (Q2, Q3)

Introduction

1. This is a report to the Board on progress with the 2016 junior doctors contract and the work of the Guardian of Safe Working Hours (GoSWH), who is required to provide it on a quarterly basis summarising exception reports made, fines levied, and ensuring that the Trust take appropriate action to address any issues identified.

Current Position

2. Since the new Junior Doctor's Contract commenced in October 2016, the Trust has assimilated Doctors in Training onto the contract in accordance with the schedules set out in the final agreement. There are over 150 'training grade' posts, all are on 2016 Terms and Conditions of Service (TCS).

3. During the increased demands and staff sickness caused by the Covid19 pandemic there have been challenges to fully staff rotas for Junior Doctors. However, the gaps are filled with locums and trainees who were redeployed from elective specialties or brought back "in house" from GP practices. During the most intense periods, there have been very few exception reports received.

Exception Reporting

4. Exception reporting is a contractual mechanism for junior doctors in training to report any unsafe working practices. This mechanism enables junior doctors to report patient safety, rostering and training concerns which should be dealt with in the required timescales.

- Q1: From **1st April to 30th June** there were no exception reports submitted
- Q2: During the period **1st July to 30th September** there were **32** exception reports from **10** individuals, all but 2 after the rotations of junior doctors in August 2020
- Q3: From **1st October to 31st December 2020** there were **11** exception reports from **7** individuals.

5. The main themes were late finishing of shifts in General Surgery FY1 doctors on call, and in General Medicine on call at several grades. Some FY2 trainees in Medicine felt that their opportunities for self-directed learning were limited, two individuals generated 12 Exception reports for this reason. These results have been discussed with the relevant clinical and service managers.

6. A trainee's Educational Supervisor should respond to exception reports within 7 days of a report being submitted, in order to review and discuss the reasons with the trainee. This

timescale was not well adhered to, and several Education Supervisors needed reminding to meet.

7. The most common outcome is time off in lieu (TOIL) or payment for hours worked if not possible. Fines are levied under the 2016 TCS on breach of one or more of the following provisions:

   a) The 48 hour average weekly working limit
   b) Contractual limit on a maximum of 72 hours worked within a 7 day consecutive period.
   c) Minimum of 11 hours rest between shifts.
   d) Where meal breaks are missed on more than 25% of occasions during a rota cycle.

	Fine Costs
Running Total Fines to Date for Q1- Q3	£0.00

Additional Actions

8. The role of GoSWH was taken up by Dr Douglas Robertson on 1 June 2020. He has attended the virtual regional meetings of Guardians monthly since then. It is notable that the local picture of low exception reporting is not universal. To assure the Board that there is not a culture of systematic under-reporting and to be aware of potential areas of concern the following actions have been taken:

   - Individual emails were sent to each trainee to thank them for their hard work in the Covid-19 outbreak and ask for informal feedback of any concerns and encouragement given to generate exception reports as appropriate. A small number of responses were received with informal identification of areas to watch, but despite resumption of national terms of service, only two exception reports were received prior to the rotation date in August.

   - The GoSWH and Director of Medical Education (DME) attended Induction in August to promote exception reporting to the new trainees and seek several specific Forum representatives as suggested in the BMA draft constitution. At the same time Educational Supervisors were reminded of the process and timelines of exception reporting.

   - To improve trainee engagement, a more representative Junior Doctor Forum meeting was envisaged. Using a template Junior Doctor Forum constitution obtained from the BMA, a draft Terms of Reference has been developed. This has been discussed widely with trainees and will be brought to JLNC for approval. This requires the Forums to be at two-monthly intervals, using virtual meeting technology, with wider representation to improve access for trainee representatives and ensure educational aspects of the 2016 TCS are adequately covered.

   - Junior Doctor Forum meetings have now been relaunched with a formal agenda and minutes with these Terms of reference. They have occurred in July, September, and November 2020 (January meeting postponed) jointly with Postgraduate Centre staff to ensure regular feedback from trainees and discussion of concerns. Between meetings,

the Guardian is kept informed of workload concerns and discusses them with appropriate service managers and lead clinicians.

- The Mess President and BMA representatives, supported by the Guardian, have surveyed their colleagues because of likelihood of underreporting of contractual exceptions, and concerns about hidden but avoidable breaching of contracted working hours, and potential effects on trainee morale. They have followed on with an awareness-raising program with the trainees.

- The ‘second wave’ of Covid19 activity has brought increased workload as ward cover has been further stretched, and there are concerns about resilience of all medical staff. However, as in the first wave, the frequency of exception reporting has fallen. A discussion in January 2021 with the Director of Medical Education has led to a plan to jointly re-launch awareness of exception reporting (and incident reporting for non-training doctors) specifically to monitor these concerns, and to assist operational teams to identify and address concerns. The emphasis will be on recognition of high workload, acknowledgement, and support to juniors, emphasising TOIL and avoiding burnout.

Conclusions & note.

9. This is the fifteenth report on the 2016 contract by the Guardian of Safe Working Hours. The Trust continues to take appropriate steps to implement the contract and its amendments for the junior doctors in training, with reporting rates falling over time.

10. However, there has been a marked reduction in the amount of exception reports submitted compared to the same periods as last year, particularly during times with high Covid19 admissions. This is not apparent in other Trusts, so a culture of under-reporting at Mid Cheshire was suspected to occur.

11. A programme of raising awareness of exception reporting was carried out by the Mess President supported by the Guardian from July onward. After that, the exception reports increased, reflecting difficulties scheduling self-directed learning time for Foundation Year 2 doctors, and workload in areas previously noted to have generated exception reports in the past.

12. However, there are again high levels of activity on the Trust with Covid19 admissions, absence of staff through sickness, self-isolation and consequent workload related stresses impacting on juniors. Again, a lower-than-expected rate of exception reporting has occurred since November.

13. Additional actions have recently been put in place between DME and GoSWH to address this and assure the Board that trainee concerns are sought, and where identified, are referred to the relevant operational teams, so that support can be given to juniors.

Douglas Robertson
Guardian of Safe Working Hours

17.01.21

BOARD OF DIRECTORS

Agenda Item	**CONSENT AGENDA**	Date of Meeting: 28/01/2021
Report Title	Learning from Deaths Report Q2 2020/21	
Executive Lead	Murray Luckas, Medical Director	
Lead Officer	Rebecca Shenton, Patient Safety Lead	
Action Required	To note	

X **Acceptable assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of controls

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

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

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

- To escalate report to Board in line with national guidance

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

• Manage Covid response and recovery	☐	• Provide safe and sustainable services	☐
• Provide outstanding care/patient experience	☐	• Provide strong system leadership by working together	☐
• Deliver most effective care to achieve best possible outcomes	✓	• Be well governed and clinically led	☐
• Be the best place to work	☐		

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

• Quality	✓	• Compliance	☐
• Finance	☐	• Legal	☐
• Workforce	☐	• Risk/BAF BAF8 Clinical audit, learning and implementation of new practice	
• Equality	☐		

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

Strategy ☐ Policy ☐ Service Change ☐

REPORT DEVELOPMENT

Committee/ Group Name	Date	Report Title	Lead	Brief summary of key issues raised and actions agreed
Quality and Safety Committee	23/12/20	As above	Medical Director	Submit to Board of Directors

Learning from Deaths Quarterly Report Q2 2020/21

October 2020

'Delivering Excellence in Healthcare through Innovation and Collaboration'

Contents

1.0 Introduction

Background

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

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

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

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

Purpose

This is the thirteenth iteration of our Learning from Deaths Report covering Quarter 2 of 2020/21.

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

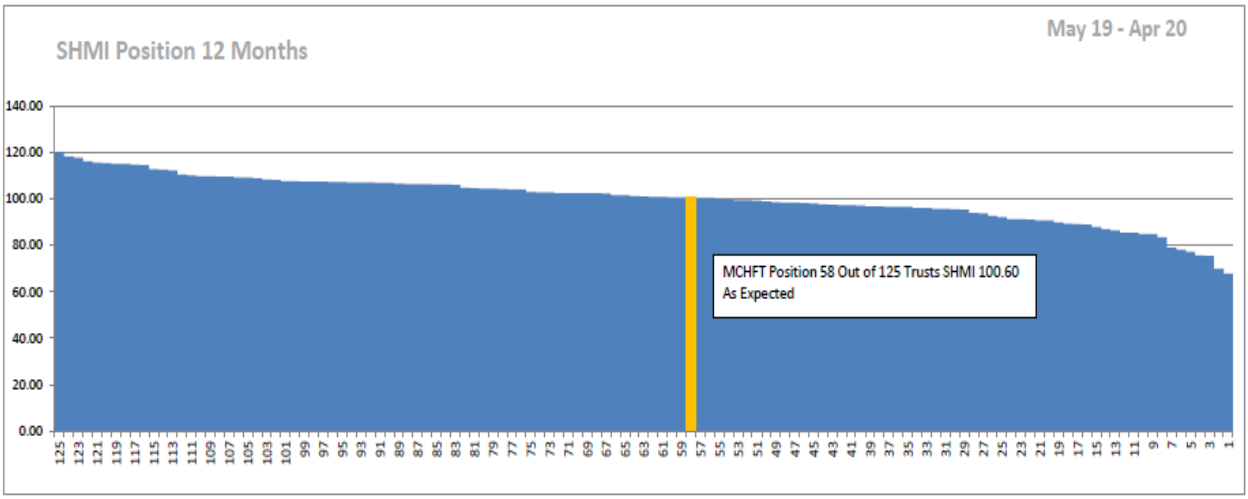
Appendices 6.2 and 6.3 provide a glossary of key terms.

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

2.0 Trust Mortality Data

2.1 Summary Hospital-level Mortality Indicator (SHMI) May 2019 to April 2020

Chart 1 - SHMI Position

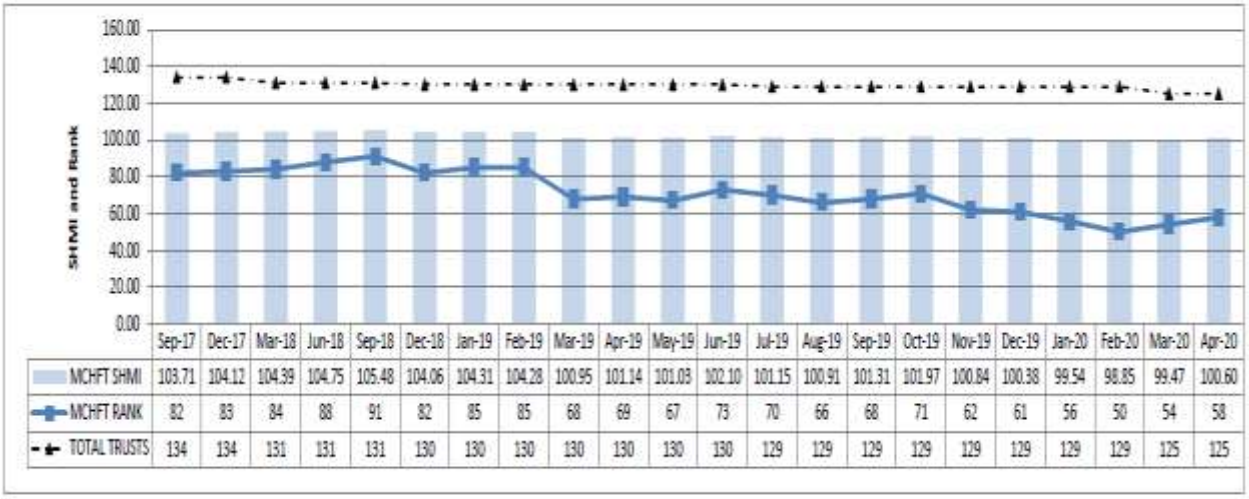


(Source NHS Digital, 2020)

Chart 1 demonstrates the SHMI position for the reporting period May 2019 to April 2020. The SHMI is currently 100.60 and is as 'expected'. This currently places the Trust 58 out of 125 Trusts, a stable position**.**

Chart 2 - 12 month rolling SHMI and position

(Source NHS Digital, 2020)

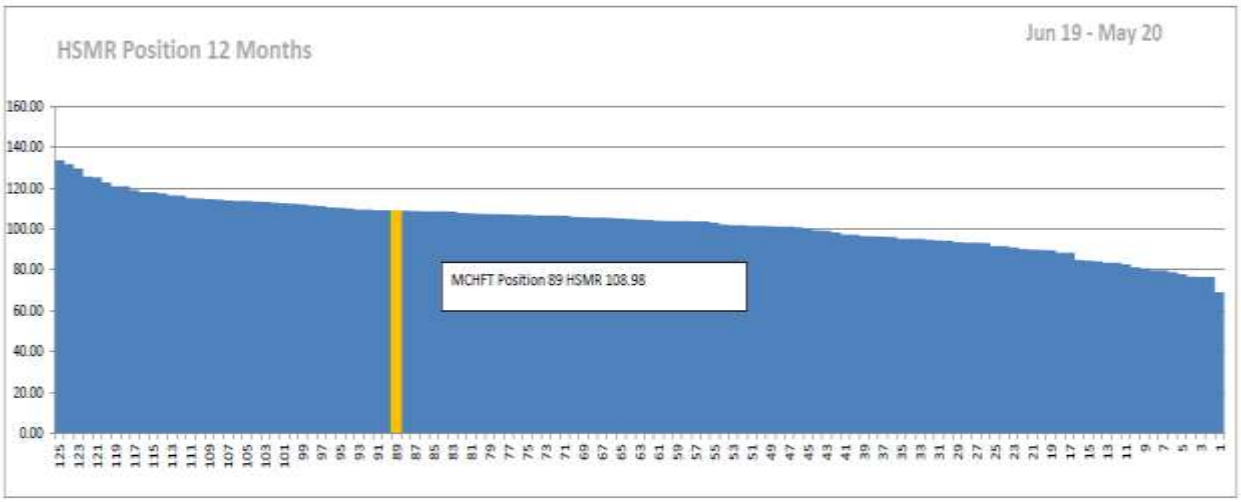


	Sep-17	Dec-17	Mar-18	Jun-18	Sep-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
MCHFT SHMI	103.71	104.12	104.39	104.75	105.48	104.06	104.31	104.28	100.95	101.14	101.03	102.10	101.15	100.91	101.31	101.97	100.84	100.38	99.54	98.85	99.47	100.60
MCHFT RANK	82	83	84	88	91	82	85	85	68	69	67	73	70	66	68	71	62	61	56	50	54	58
TOTAL TRUSTS	134	134	131	131	131	130	130	130	130	130	130	130	129	129	129	129	129	129	129	129	125	125

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

2.2 Hospital Standardised Mortality Rate (HSMR) June 2019 to May 2020

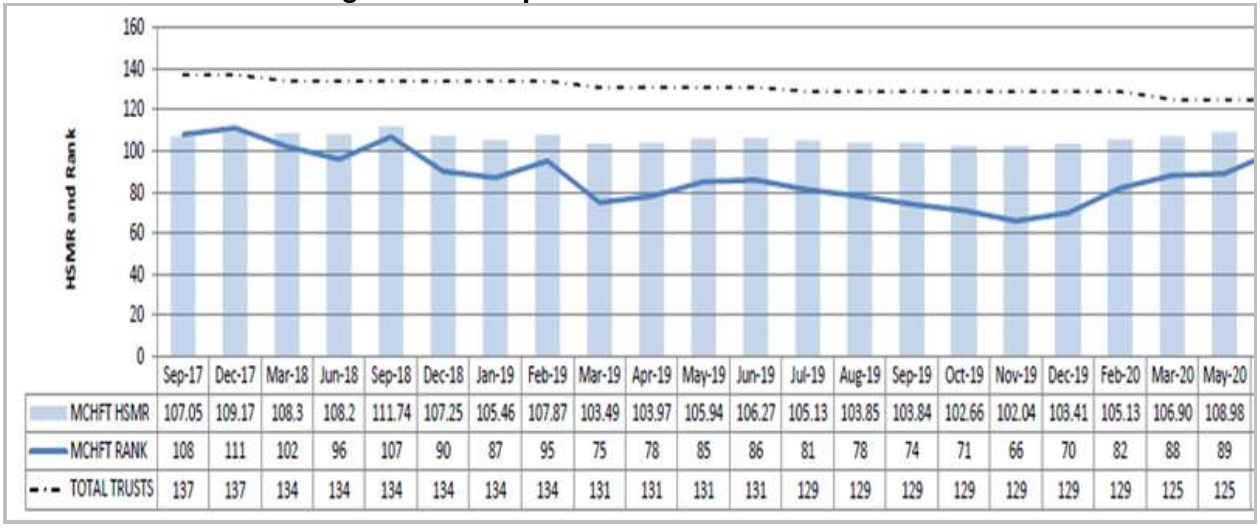
Chart 3 - HSMR Position



(Source HED, 2020)

Chart 3 demonstrates the HSMR position for the reporting period June 2019 to May 2020. The HSMR is currently 108.98 and is as 'expected, this places the Trust 89 out of 125 Trusts.

Chart 4 - 12 month rolling HSMR and position



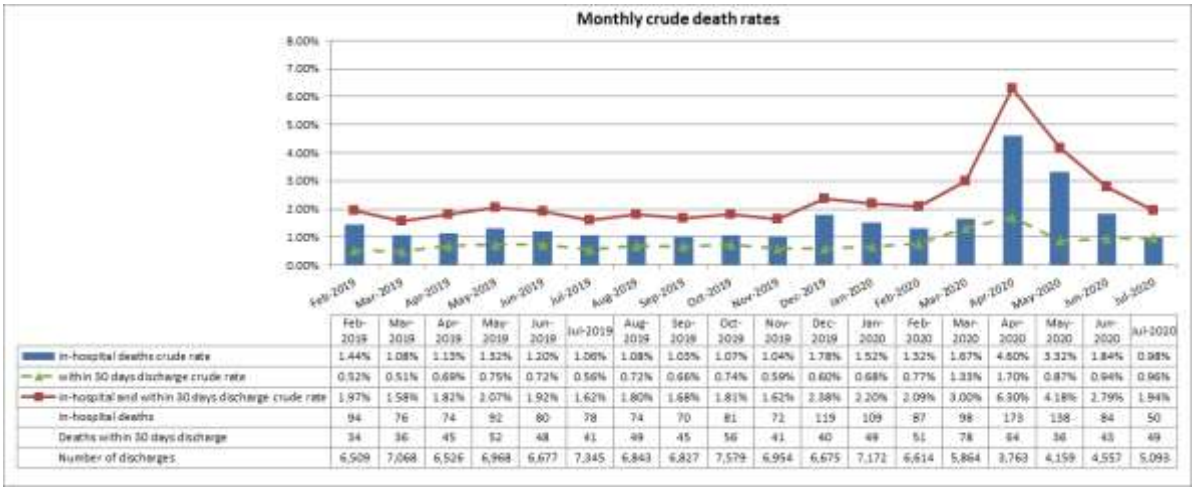
	Sep-17	Dec-17	Mar-18	Jun-18	Sep-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Feb-20	Mar-20	May-20
MCHFT HSMR	107.05	109.17	108.3	108.2	111.74	107.25	105.46	107.87	103.49	103.97	105.94	106.27	105.13	103.85	103.84	102.66	102.04	103.41	105.13	106.90	108.98
MCHFT RANK	108	111	102	96	107	90	87	95	75	78	85	86	81	78	74	71	66	70	82	88	89
TOTAL TRUSTS	137	137	134	134	134	134	134	134	131	131	131	131	129	129	129	129	129	129	129	125	125

(Source HED, 2020)

Chart 4 demonstrates the HSMR and rank of the Trust over time, up to the latest reporting period. The Trust HSMR has increased over the last 12 months. Unlike SHMI, HSMR includes palliative care coding in the model. In effect this means that if a patient is coded as receiving palliative care, they will have a higher *'risk of dying'* thereby reducing their HSMR. We have undertaken a deep dive on HSMR and the deterioration in our HSMR can be wholly accounted for by a reduction in our palliative care coding. A case note analysis has demonstrated that patients are still receiving the same level of palliative care; however these episodes are not being recorded in the case notes in a manner that allows them to receive a palliative care code. A task and finish group is now working with clinicians and coders to rectify this.

2.3 Crude Mortality – Rolling 12 months

Chart 5 - Crude Mortality



	Feb-2019	Mar-2019	Apr-2019	May-2019	Jun-2019	Jul-2019	Aug-2019	Sep-2019	Oct-2019	Nov-2019	Dec-2019	Jan-2020	Feb-2020	Mar-2020	Apr-2020	May-2020	Jun-2020	Jul-2020
in-hospital deaths crude rate	1.44%	1.08%	1.15%	1.32%	1.20%	1.06%	1.08%	1.05%	1.07%	1.04%	1.78%	1.52%	1.32%	1.67%	4.60%	3.32%	1.84%	0.98%
within 30 days discharge crude rate	0.52%	0.51%	0.69%	0.75%	0.72%	0.56%	0.72%	0.66%	0.74%	0.59%	0.60%	0.68%	0.77%	1.33%	1.70%	0.87%	0.94%	0.96%
in-hospital and within 30 days discharge crude rate	1.97%	1.58%	1.82%	2.07%	1.92%	1.62%	1.80%	1.68%	1.81%	1.62%	2.38%	2.20%	2.09%	3.00%	6.30%	4.18%	2.79%	1.94%
In-hospital deaths	94	76	74	92	80	78	74	70	81	71	119	109	87	98	173	138	84	50
Deaths within 30 days discharge	34	36	45	52	48	41	49	45	56	41	40	49	51	78	64	36	43	49
Number of discharges	6,509	7,068	6,526	6,968	6,677	7,345	6,843	6,827	7,579	6,954	6,675	7,172	6,614	5,864	3,763	4,159	4,557	5,093

(Source HED, 2020)

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

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

2.4 Learning from Deaths Dashboard – Part 1

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

A review of all Covid related deaths is currently underway and will be presented to the Organisation in October.

The 2 deaths that have been reviewed to date in 2020/21 were both classed as definitely not preventable. Overall care was classed as good in one case and excellent in the second.

Please note: The Learning from Deaths programme remains suspended due to the Covid-19 Pandemic

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

Total Number of Deaths in Scope		Total Deaths Reviewed using the Trust Mortality Tool		Total Deaths reviewed using SJR		Total Number of deaths considered to have been potentially avoidable (RCP<=3) using SJR		Total Number of deaths considered to have been potentially avoidable via alternative source (e.g. incident investigation)	
This Month	Last Month	This Month	Last Month	This Month	Last Month	This Month	Last Month	This Month	Last Month
61	56	0	0	0	2	0	0	1	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
169	399	0	0	2	0	0	0	1	1
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
568	1033	0	621	2	129	0	0	2	9

2.4 Learning from Deaths Dashboard – Part 2

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

The 2 learning disability deaths that have been reviewed to date in 2020/21 were both classed as definitely not preventable. Overall care was classed as good in both cases.

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

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
2	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
4	1	1	1	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
5	5	2	5	0	0

3.0 Care Quality Commission (CQC) Mortality Outlier Alerts

The information below is sourced from the latest version of the CQC Insight document (15 September 2020). The Trust undertakes an in-depth case note review in response to any Mortality Outlier Alert.

Key Messages

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

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

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

Mortality Outliers – Active Alerts

Cases under consideration by the Outlier Panel

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

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

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

Cases for review by inspection team

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

Maternity Outliers – Active Alerts

Cases under consideration by the Outlier Panel

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

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

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

Cases for review by inspection team

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

4.0 Learning from Deaths and Improvements

The Trust's Learning from Deaths Policy outlines the process for reviewing all in-hospital deaths. The policy has had a full review and was approved in quarter 2 of 2020/21.

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

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

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

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

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

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

4.1 Learning from Deaths Programme

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

4.2 Summary of avoidable deaths in Q2 2020/21

One potentially avoidable death has been reported by the Trust in quarter 2 of 2020/21.

- A patient was admitted from home on 4 September 2020, with a presenting complaint of shortness of breath and leg swelling. The patient was assessed on admission as having a complex medical history and their mobility had deteriorated over recent weeks. A falls risk assessment was completed and the patient was transferred to Ward 1. The falls risk assessment was not reviewed following transfer to the ward. A bed rail assessment was completed on 10 September 2020, and this identified that bed rails were required. On 15 September 2020, the patient had an unwitnessed fall in the ward bay. An urgent CT scan was undertaken and an acute subdural haematoma was apparent. The patient died on 17 September 2020.
  The investigation is currently ongoing. Lessons learned will be shared following the investigation review.
  There has been immediate learning with the clinical team in relation to:
  The Ward Manager has overseen the review of falls risk assessments for all patients on the ward.

4.4 Next Steps

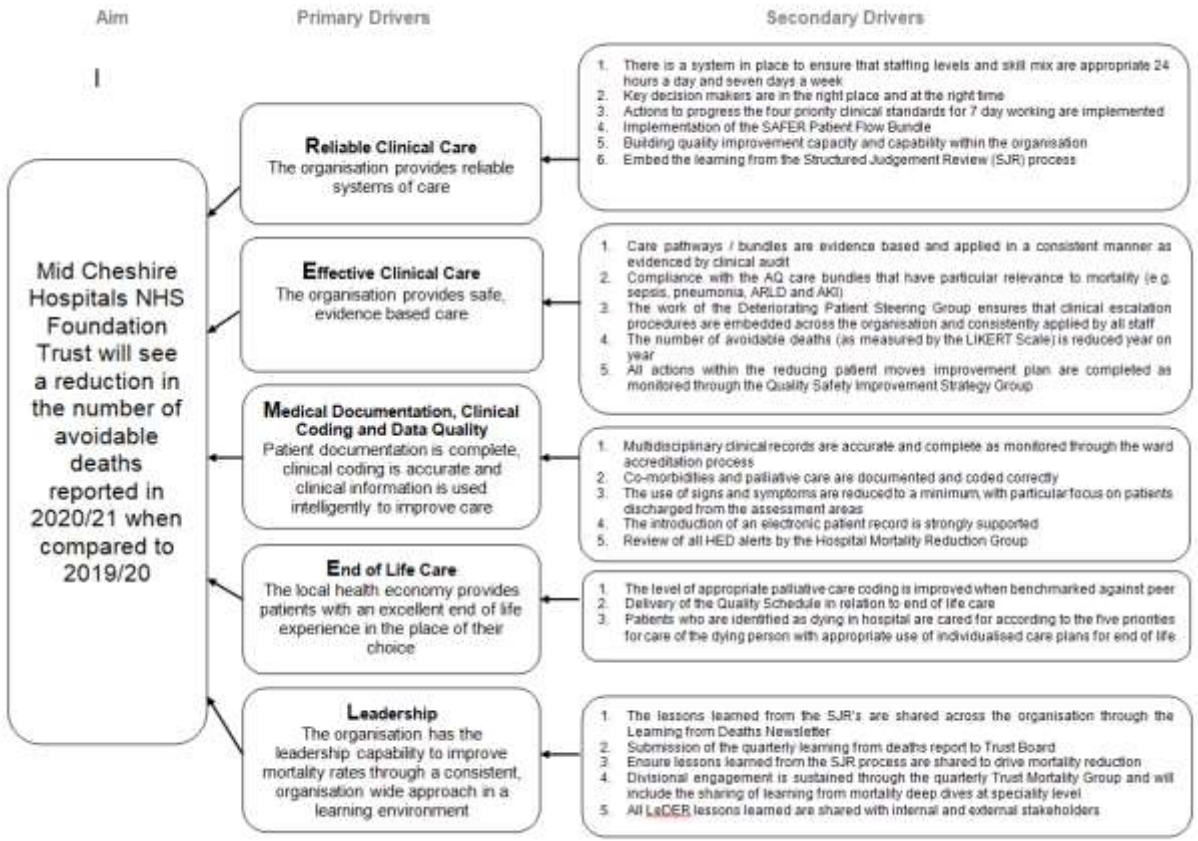
The Learning from Deaths policy has been reviewed in line with changes to national guidance and the introduction of the Medical Examiners (ME) role to the Trust. The policy was approved at the September 2020 Hospital Mortality Reduction Group. The ME began to review a small number of sample deaths in September escalating to review all deaths by 2021.

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

A review of deaths which occurred during the first wave of the Covid-19 pandemic is being undertaken and will include all deaths related to Covid-19. The review will be presented at the October 2020 Quality Improvement Session. Learning will be shared from the review in line with the Learning from Deaths Policy.

5.0 Appendices

5.1 Appendix 1 Driver Diagram



5.2 Appendix 2 - Glossary

Healthcare Evaluation Data (HED)

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

Hospital Standardised Mortality Ratio (HSMR)

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

LIKERT Scale

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

LIKERT Scale

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

Summary Hospital-level Mortality Indicator (SHMI)

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

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

5.3 Appendix 3: Understanding the difference between SHMI and HSMR

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