Mid Cheshire Hospitals NHS Foundation Trust

Board of Directors

Thursday 25 March 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		**Staff Survey (p)** Director of Workforce & OD To note
4 9:45		**Draft Minutes of the Last Meeting – 28 January 2021 (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		**Board Workplan 2021/22 (d)** Chair To approve
6 09:55		**Chair's Opening Remarks (v)** • Governor Items
CONTEXT / OVERVIEW		
7		**BAF Heatmap (d)** Chief Executive For reference
8 10:05	**BAF13** **BAF6**	**Chief Executive's Report (d)** • **Hospital Redevelopment Programme Board Chair's Report – 11 February; 18 March 2021** • **Digital Clinical System Transformation Board Chair's Report – 6 March 2021** To note

No	BAF Risk	Item
9 10.15	**BAF19**	**Integrated Performance Report (Month 11 – February 2021) (d)** Chief Executive To note
QUALITY - Patient Safety, Clinical Effectiveness & Patient Experience		
10 10:15		**Quality & Safety Committee Chair's Assurance Reports (d) – 17 February; 17 March 2021** Committee Chair To note
		• **Learning from Deaths Q3 2020-21 (d)** Medical Director To note
11 10:25	**BAF 8**	**Serious Incidents (v)** Medical Director To note
PERFORMANCE		
12 10:35		**Performance & Finance Committee Chair's Assurance Reports (d) - 18 February; 18 March 2021** Committee Chair To note
WELL LED		
13 10:45		**Workforce & Digital Transformation Chair's Assurance Reports (d) - 22 February**; **22 March 2021** Committee Chair To note
	BAF12	• **People Practices Report 2020/21 (d)** Director of Workforce and OD To approve
	BAF12	• **Equality Delivery System 2020/21 (d)** Director of Workforce and OD To approve
14 11:00		**Trust Constitutional Changes (d)** Company Secretary To approve

No	BAF Risk	Item

15 11:05 **Request to Use the Trust Seal (d)**
Company Secretary
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** **Clinical Excellence Awards (d)**
  Medical Director

CONCLUDING BUSINESS

16 11:10 **Any Other Business**
Chair
To consider any other matters of business

17 **Items for the Risk Register/Changes to the Board Assurance Framework (BAF) (v)**
Chair
To identify any additional items for the Risk Register or changes to the BAF arising from discussions at this meeting

18 11:15 **Key Messages from the Board (v)**
Chair
To agree

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

MCHFT 2020

Staff Survey Results

Summary Indicators (Themes)

1) Equality, Diversity and Inclusion
2) Health and Wellbeing
3) Immediate Managers
4) Morale
5) Quality of Care
6) Safe Environment – Bullying and Harassment
7) Safe Environment – Violence
8) Safety Culture
9) Staff Engagement
10) Team Working

- Response Rates

2019	2020		Trust Performance
MCHFT	MCHFT	Acute or Combined Acute & Community Trust Average	
28%	44%	47.3%	
1246 people	2033 people		

- Corporate – 69%
- E&F – 28%
- DCSS – 41%
- CCICP – 53%
- S&C – 39%
- W&C – 46%
- MECD – 37%

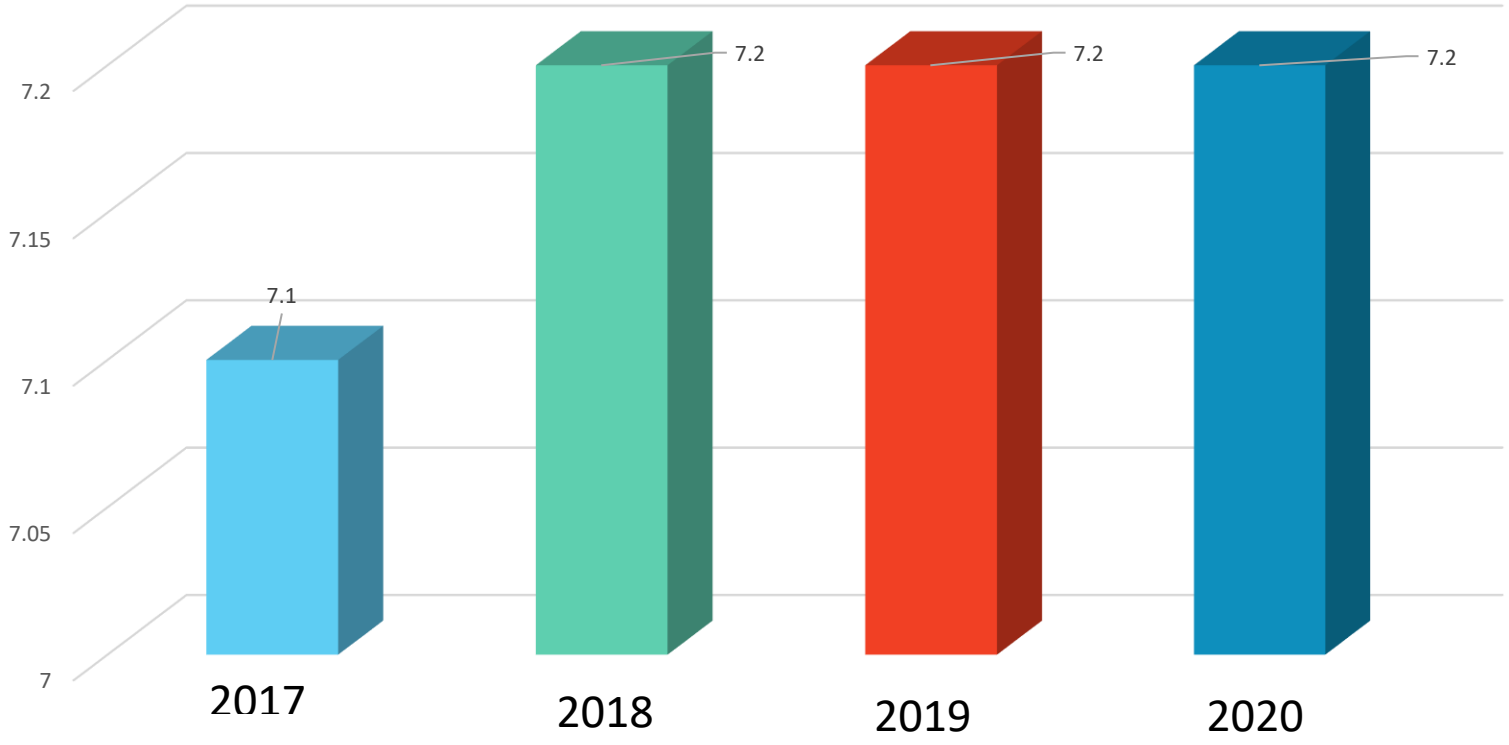
Occupational Group Response Rates 2020

	Sample Size	Number of Responses	%
Additional Prof Scientific and Technical	150	67	45%
Additional Clinical Services	1077	366	34%
Admin & Clerical	1034	630	61%
Allied Health Professionals	377	196	52%
Estates and Ancillary	383	90	24%
Healthcare Scientists	132	53	40%
Medical & Dental	260	109	42%
Nursing and Midwifery Registered	1259	522	42%

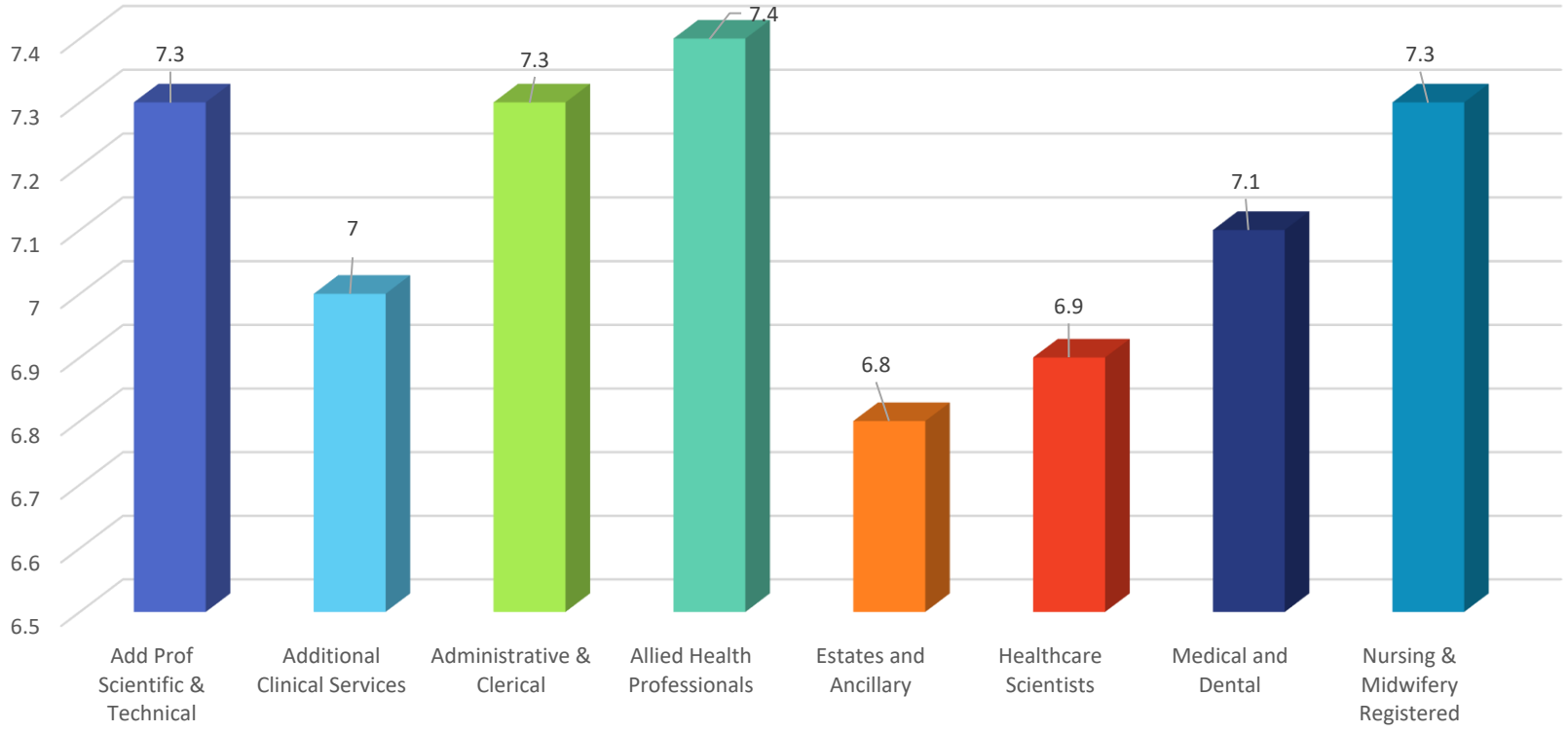
Staff Engagement Questions

Motivation	Recommendation of the organisation as a place to work or receive treatment.	Ability to contribute towards improvements
I look forward to going to work	Care of patients/service users is my organisation's top priority	There are frequent opportunities for me to show initiative in my role
I am enthusiastic about my job	I would recommend this organisation as a place to work	I am able to make suggestions to improve the work of my team/department
Time passes quickly when I am working	If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	I am able to make improvements happen in my area of work

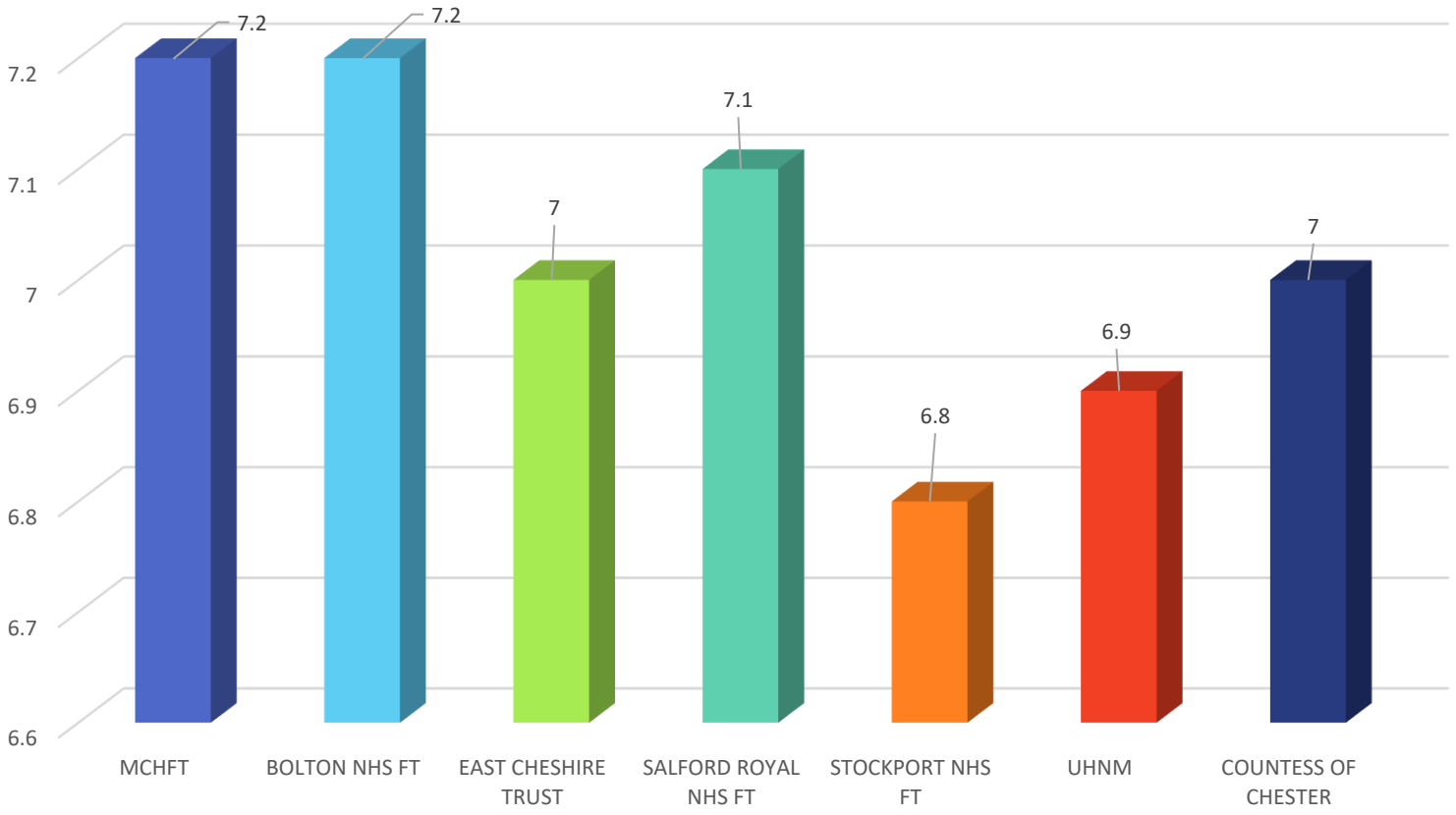
Our Staff Engagement Story



Staff Engagement by Occupational Group



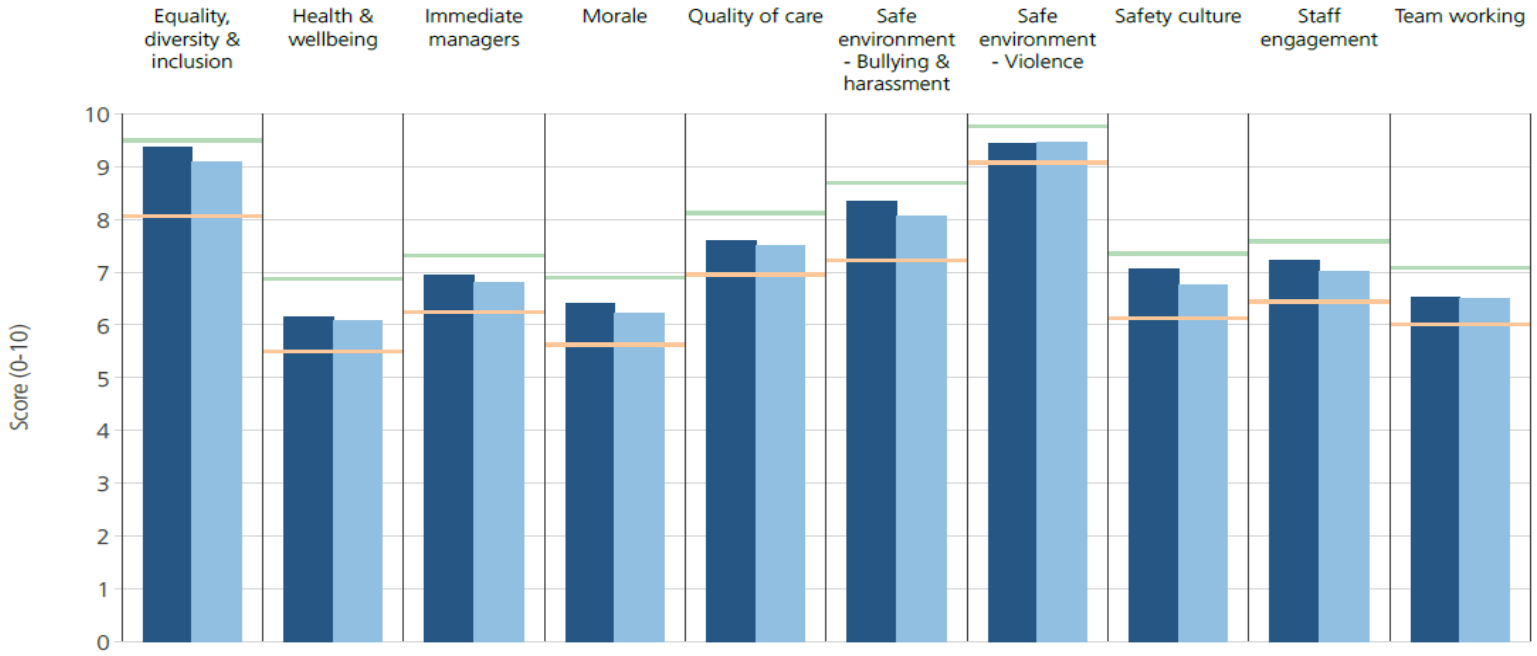
Staff Engagement Score Comparison



Survey Coordination Centre

2020 NHS Staff Survey Results > Theme results > Overview

NHS England



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.5	6.9	7.3	6.9	8.1	8.7	9.8	7.4	7.6	7.1
Your org	9.4	6.2	6.9	6.4	7.6	8.3	9.4	7.1	7.2	6.5
Average	9.1	6.1	6.8	6.2	7.5	8.1	9.5	6.8	7.0	6.5
Worst	8.1	5.5	6.2	5.6	7.0	7.2	9.1	6.1	6.4	6.0
Responses	1,956	1,961	1,966	1,940	1,740	1,911	1,953	1,952	2,001	1,975

How do we compare to the 2019 National Staff Survey Results?

Theme	2019 (Scores out of 10)	2020 (Scores out of 10)	+/-
Equality, Diversity and Inclusion	9.3	9.4	+0.1
Health and Wellbeing	6.0	6.2	+0.2
Immediate Managers	7.1	6.9	-0.2
Morale	6.4	6.4	=
Quality of Care	7.5	7.6	+0.1
Safe Environment – Bullying and Harassment	8.3	8.3	=
Safe Environment – Violence	9.5	9.4	-0.1
Safety Culture	6.9	7.1	+0.2
Staff Engagement	7.2	7.2	=
Team Working	6.7	6.5	-0.2

Theme Results MCHFT - Trends

Theme	2019 score	2019 respondents	2020 score	2020 respondents	Statistically significant change?
Equality, diversity & inclusion	**9.3**	1228	**9.4**	1956	Not significant
Health & wellbeing	**6.0**	1233	**6.2**	1961	Not significant
Immediate managers †	**7.1**	1236	**6.9**	1966	Not significant
Morale	**6.4**	1218	**6.4**	1940	Not significant
Quality of care	**7.5**	1025	**7.6**	1740	Not significant
Safe environment - Bullying & harassment	**8.2**	1226	**8.3**	1911	Not significant
Safe environment - Violence	**9.5**	1224	**9.4**	1953	Not significant
Safety culture	**6.9**	1227	**7.1**	1952	↑
Staff engagement	**7.2**	1242	**7.2**	2001	Not significant
Team working	**6.7**	1231	**6.5**	1975	↓

Theme Results by Division

Theme	MCHFT (2033)	Best Score (Nationally)	CCICP (370)	Corporate (293)	DCSS (390)	E&F (105)	MECD (303)	S&C (384)	W&C (188)
Equality, Diversity and Inclusion	9.4	9.5	9.6	9.5	9.4	9.1	9.1	9.2	9.6
Health and Wellbeing	6.2	6.9	6.5	6.7	6.0	6.3	5.4	6.3	6.0
Immediate Managers	6.9	7.3	7.6	7.3	6.5	6.3	6.8	7.1	6.4
Morale	6.4	6.9	6.9	6.3	6.2	6.2	6.2	6.6	6.2
Quality of Care	7.6	8.1	7.7	7.3	7.6	7.5	7.4	8.0	7.5
Safe Environment – Bullying and Harassment	8.3	8.7	8.9	8.9	8.3	8.7	7.7	8.2	8.2
Safe Environment – Violence	9.4	9.8	9.7	9.9	9.6	9.7	8.4	9.4	9.8
Safety Culture	7.1	7.4	7.2	7.0	7.0	6.6	7.1	7.2	7.1
Staff Engagement	7.2	7.6	7.4	7.3	7.0	6.8	7.1	7.4	7.2
Team Working	6.5	7.1	7.0	6.7	6.2	6.0	6.3	6.7	6.3

Theme Results Benchmarking

	MCHFT	East Cheshire Trust	Salford Royal NHS FT	Stockport NHS FT	Bolton NHS FT	UHNM	Countess of Chester NHS FT
Theme							
Equality, Diversity and Inclusion	9.4	9.1	9.2	9.1	9.3	9.1	9.1
Health and Wellbeing	6.2	6.0	6.1	5.9	6.2	5.9	6.0
Immediate Managers	6.9	6.9	6.9	6.8	7.0	6.5	6.7
Morale	6.4	6.2	6.3	6.0	6.5	6.0	6.2
Quality of Care	7.6	7.4	7.3	7.2	7.8	7.5	7.4
Safe Environment – Bullying and Harassment	8.3	8.1	8.4	8.1	8.3	8.0	8.1
Safe Environment – Violence	9.4	9.4	9.6	9.4	9.5	9.4	9.4
Safety Culture	7.1	6.6	6.8	6.6	7.1	6.7	6.6
Staff Engagement	7.2	7.0	7.1	6.8	7.2	6.9	7.0
Team Working	6.5	6.5	6.6	6.4	6.7	6.1	6.3

Key Areas of Focus for 2020/2021

- Reducing work related stress
- Improve Team Working – relationships, effectiveness and civility
- Reduce violence in the workplace

- 2020 Staff Survey results will also be linked to data from: Staff focus groups (including QI & Learning from COVID), Friends and Family test, and Stress survey

Next Steps

- “Staff Feedback Bundles” for Divisions & CCICP
- Targeted Support and Interventions to Divisions/CCICP
- Data broken down by areas such as ED&I, HWB, Civility and Psychological Safety and QI for subgroups to utilise
- Further analysis of available data sources
- Staff survey crossroads stand including examples of “You Said We Did”

Board Workplan 2021/22

			2021														2022	
			Board Dev. Day			Board Strategic Session	Board Dev. Day		Board Strategic Session		Board Dev. Day			Board Strategic Session	Board Dev. Day		Board Strategic Session	
Meeting Date	**Lead Dir**	**Frequency**	01-Apr	29-Apr	27-May	24-Jun	09-Jul	29-Jul	26-Aug	30-Sep	08-Oct	28-Oct	25-Nov	17-Dec	07-Jan	27-Jan	24-Feb	31-Mar
Patient Story	JT	M		✓	✓			✓		✓		✓	✓			✓		✓
Preliminary Business																		
Board Action Log	CK	M		✓	✓			✓		✓		✓	✓			✓		✓
Board Workplan 2020/21	CK	Q		✓				✓				✓				✓		
Chair's Report	DD	M		✓	✓			✓		✓		✓	✓			✓		✓
* Council of Governors Key Issues Report	CK	Q																
Context																		
BAF Report	JS	Q		✓				✓				✓				✓		
BAF Heat Map (when BAF report not submitted)	JS				✓					✓			✓					✓
Integrated Performance Report	JS	M		✓	✓			✓		✓		✓	✓			✓		✓
CEO Report	JS	M		✓	✓			✓		✓		✓	✓			✓		✓
* Hospital Redevelopment Programme Board				✓	✓			✓				✓				✓		
* Digital Clinical System Programme Board				✓	✓			✓		✓		✓	✓			✓		✓
* Consultant appointments	ML	ad hoc																
STRATEGY																		
Trust Strategy	JS	A		✓								✓						
Quality & Safety Improvement Strategic Plan	JT	A																
Risk Management Strategic Plan	JS/CK	A								✓								
Workforce Matters Strategic Plan	HB	A			✓													
Estates Strategic Plan	RF	A		✓														
Digital Strategic Plan	AF	A			✓													
QUALITY																		
Q&S Chair's Assurance Report	LM	M		✓	✓			✓		✓		✓	✓			✓		✓
Safeguarding Adults & Children Annual Report	JT	A						✓										
Health & Safety Report	RF	A								✓								
Nursing & Midwifery Staffing Report	JT	A										✓						
Serious Incidents	ML	M		✓	✓			✓		✓		✓	✓			✓		✓
Medical Revalidation Annual Report	ML	A								✓								
Clinical Negligence Scheme for Trusts	JT	A			✓													
Guardian of Safe Working Hours	HB	Q		✓				✓				✓				✓		
Learning from Deaths	ML	Q			✓					✓			✓					✓
Quality Account (date tbc)	JT	A																
National Inpatient Survey Results	JT	A								✓								
PERFORMANCE & FINANCE																		
PAF Chair's Assurance Report	TB	M		✓	✓			✓		✓		✓	✓			✓		✓
Corporate Trustees Assurance Report	RF/JC	6M		✓								✓						
Financial Plan	RF	A		✓														
Restoration and Recovery Plan																		
Capital Programme	RF	A		✓														
Winter Plan	OB	A										✓						
Emergency Planning																		
* Annual Report	OB	A											✓					

			Board Dev. Day			Board Strategic Session	Board Dev. Day		Board Strategic Session		Board Dev. Day			Board Strategic Session	Board Dev. Day		Board Strategic Session	
Meeting Date	**Lead Dir**	**Frequency**	01-Apr	29-Apr	27-May	24-Jun	09-Jul	29-Jul	26-Aug	30-Sep	08-Oct	28-Oct	25-Nov	17-Dec	07-Jan	27-Jan	24-Feb	31-Mar
* EPRR Assurances	OB	A											✓					
PEOPLE																		
WDT Committee Assurance Report	LB	M		✓	✓			✓		✓		✓	✓			✓		✓
WRES Data	HB	A											✓					
WDES Report	HB	A											✓					
Equality Delivery System	HB	A																✓
Equality, Diversity and Inclusion Annual Report	HB	A						✓										
Clinical Excellence Awards	ML	A																✓
HEE Self Assessment Report	HB	A								✓								
People Recovery Plan	HB	A		✓														
Medical Staffing Update	ML	ad hoc																
GOVERNANCE/WELL-LED																		
CQC Report & Action Plan	JT	6M						✓										
Annual Report & Accounts	RF/CK	A			✓													
Annual Plan	RF	A			✓													
Remuneration Committee Assurance Report	DD	Ad hoc																
Directors & Officers Liability Insurance Declaration	RF	A																
Corporate Governance																		
Audit Committee Assurance Report	LP	Q		✓	✓			✓		✓		✓	✓			✓		✓
NHS Provider Licence - Annual Self-Certification:	CK	A																
* General Condition 6/ Continuity of Services Condition 7					✓													
* Corporate Governance Statement					✓													
CQC:																		
* Registration Compliance	JT	A																
Board Self-Certification	RF/CK	A			✓													
Corporate Governance Handbook (SOs, SFIs, SoD)	CK/RF	A			✓													
Use of Trust Seal Annual Report	CK	A		✓														
Board Away Day Notes (tbc)	CK																	
Well-Led																		
National Staff Survey (Results & Improvement Plan)	HB	A																✓
Board of Directors' Self-Assessment/Evaluation	DD/CK	A		✓														
Evaluation of Board Committees Effectiveness/ToR	CK/NED Chairs	A			✓													
Board Development Plan	CK/HB	A		✓														
Accountability and Authority Framework *(tbc)*	*tbc*																	
Fit & Proper Person's Review	CK	A											✓					
Modern Slavery Strategy Statement	CK	A		✓														
Freedom to Speak Up Guardian	JS	Q		✓				✓				✓				✓		
Gender Pay Gap	HB	A														✓		
ITEMS IDENTIFIED IN YEAR																		

			Board Dev. Day			Board Strategic Session	Board Dev. Day		Board Strategic Session		Board Dev. Day			Board Strategic Session	Board Dev. Day		Board Strategic Session	
Meeting Date	**Lead Dir**	**Frequency**	01-Apr	29-Apr	27-May	24-Jun	09-Jul	29-Jul	26-Aug	30-Sep	08-Oct	28-Oct	25-Nov	17-Dec	07-Jan	27-Jan	24-Feb	31-Mar
Other Items (Ad Hoc in Year)																		
EVENTS / OTHER MEETINGS																		
Annual General Meeting												✓						
Board to Boards																		

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 = 12**
BAF2 Failure to manage risks to business continuity identified during Covid **Closed**	**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

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**8**	Date of Meeting: 25/03/2021
Report Title	**Chief Executive's Report March 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 latest position on Covid-19, performance and finance
- Senior appointments made

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 – 25 March 2021

Key Highlights

Senior Appointments

1. I am pleased that we have recently made the following appointments which demonstrate the successful development of our senior staff:

   - Mark Wilde, Director of Operations
   - Andrew Williams, DGM Surgery & Cancer Division

   We are out to advert for Andrew's current post, DGM of Women & Children's Division.

2. In February, we appointed Mr Sirhan Alvi, ENT consultant.

3. We also continue to be a Trust that is attractive to external candidates and have successfully appointed to the vacant Associate Director of Communication and Engagement post. Paul Newman is an experienced Director of Communications, having worked at The Peel Group, the Football Association and Liverpool's European Capital of Culture, and has previously been a news correspondent for BBC News, ITV and Sky News. Paul will join us on 6 April and his focus over the next few months will be on engaging with staff and wider stakeholders on our new Trust Strategy.

4. The collaborative of East Cheshire NHS Trust and ourselves have appointed Phillip James as the Digital Clinical Systems Programme Director. Phillip is a digital leader who has previously held senior positions at Warrington & Halton Teaching Hospitals, the Northern Care Alliance and North West Ambulance Service, having joined the NHS from the private sector in 2004. He has a range of delivery and support experiences with digital care schemes involving multiple organisations.

5. We are also seeing members of our staff getting involved on the national stage. Sarah Cain, a registered District Nurse and a member of our CCICP nursing team, has been chosen from over 500 applicants to join the National Shared Professional Decision-Making Council for Community Nursing to influence future community nursing services across England.

Covid-19

6. As at 16 March, there were 35 confirmed positive Covid-19 patients in the hospital compared to 209 at the peak of the current wave. This number is expected to continue to fall as the national lockdown and the continued success of the vaccination programme have an impact. Pressure within critical care has also abated and the unit is currently operating within baseline bed capacity. A roadmap has been developed to convert the majority of Covid-19 wards back to their original purpose and, by beginning of April, it is likely that only two wards will remain in place to manage Covid-19 patients, down from nine at the peak.

Infection Prevention & Control (IPC)

7. At the last Board meeting in January 2021, we reported that the number of nosocomial patients and outbreaks in the hospital had decreased following the after-action reviews undertaken. This position has improved as is evidenced in the relevant charts in the Integrated Performance Report.

Vaccination Programme

8. As part of the hospital hub programme, the Trust has now completed almost 23,000 first dose vaccines, far exceeding its initial plan of 7,200, to include MCHFT/CCICP and associated partner staff. The programme has successfully added capacity to the Cheshire system and increased the local supply of vaccine, enabling us to be on track to achieve our Cohorts 1-9 by the 15 April target.

9. Increased capacity is now available at both mass vaccination centres at Chester Racecourse and Alderley Park, as well as local pharmacies across Cheshire; the Trust will, therefore, now focus on providing 2nd doses to the 23,000 we have vaccinated and support the vaccination of higher risk groups of patients with allergies, who wish to be vaccinated in a safe environment i.e. within an acute hospital.

10. We have currently achieved 87.34% vaccinations to MCHFT/CCICP substantial staffing and 78% for our BAME colleagues (at 18/03/21). Occupational Health advisors are now contacting the remaining staff on a one-to-one basis to offer support and advice to encourage them to take the vaccine as soon as possible.

11. We remain very grateful to the staff who have taken up the vaccine offer, as well as the team who have provided the 7-day vaccine service on the Leighton site.

Covid-19 Restoration

12. The complex process of restoring services and activity is underway, alongside providing staff with the opportunity, space and support to recuperate and recover as the Trust exits the third wave of the pandemic. Most services have now started to resume more activity, including outpatients, routine electives and diagnostics; the full cancer elective programme is fully operational, and the routine elective programme resumed on 15 March. The restoration of services will be done in a planned, measured and phased approach, and it is vital that we continue to look after the health and wellbeing of staff throughout this next phase. It will also be important to embed and build on the innovation that the organisation has seen during the pandemic to ensure that we continue to embrace new ways of working in the provision of high-quality and reliable care.

13. The Trust is working with system partners to develop the plan and trajectories for restoring up to 100% of pre-pandemic activity levels during 2021/22. The focus of restoration will be on those patients whose clinical need is regarded as a priority and then followed by those who have waited over 52 weeks. A new governance structure has been established to oversee the development and implementation of the restoration and recovery programme in the Trust which is aligned to the Cheshire and Mersey system architecture.

14. The Chief Operating Officer will present a paper to the Board in April, outlining in detail the Trust's restoration and recovery plan and roadmap.

Trust 'Business as Usual'

Finance – Month 11 (February) 2020/21

15. The Board will recall that, in order to provide stability in the short-term to the first wave of the pandemic, the NHS financial framework was amended for the first half of the year and all Trusts were put on a block contract, with an adjusting 'top-up' made retrospectively to bring the Trust to breakeven. All these top-up payments have now been received (although this may be subject to audit by NHSE/I) and thus the Trust was in a balanced financial position at the end of September 2020.

16. The financial regime for the second half of the year maintains the block payments to Trusts and, in addition, system-wide (Cheshire & Merseyside Health Care Partnership (HCP) funding has been allocated to each organisation within C&M, with the expectation that each manages their local costs, including Covid costs, within this control total.

17. The Trust has recently received funding of £3.2m to offset the loss of non-NHS income and is now forecasting a deficit of £6.9m (which is part of a C&M forecast deficit of £56m, recognised by NHSE/I).

18. At the end of February, the Trust has a cumulative deficit of £2.7m which is in line to deliver the £6.9m deficit above, once a provision for annual leave (not taken in 2020/21) of £3m is provided for in March.

19. The Trust is expecting, although not officially confirmed yet, that the annual leave accrual will be nationally funded (although the calculation will be based upon a national methodology). It is, therefore, expected that the Trust financial performance for the year will be in the region of a £3.9m deficit, compared to an initial plan of £15.2m deficit.

20. Official guidance is still awaited on 2021/22 planning but 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. The Director of Finance has been working to identify the Trust's underlying run-rates as a key step in developing financial plans for 2021/22. This was shared with the Performance and Finance Committee earlier in March 2021. This work will be refined as the national picture becomes more certain but, initially, interim budgets will be set for Divisions although, at this stage divisional efficiency targets will not be set.

21. It is clear that, next year, we will be faced with a unique and challenging operating environment and it is, therefore, essential that strong financial governance and control are maintained.

Workforce

The People Recovery Plan

22. The Health and Wellbeing and HR teams are currently working together to develop the Trust's People Recovery Plan. The initial phase of the project is to undertake a survey to ascertain how staff are feeling at this stage of the pandemic, to ensure our approach to people recovery is appropriately timed and measured, and to inform our approach to both the physical and mental health wellbeing needs of our staff. We are also in active discussion with Cheshire and Wirral Partnership NHS FT in relation to the design and delivery of a holistic risk assessment approach, which will be based around the needs of the individual staff member. The detail of

the People Recovery Plan will be presented to the Board in April 2021, alongside the Restoration and Recovery plan.

Cheshire International Recruitment Collaboration (CIRC)

23. Good progress is being made, with 260 offers of employment (74% of the first two additional CIRC cohorts planned) having been made. 114 (32%) new international nurses are now with us and further arrivals are planned throughout the year to smooth the demand and to match the capacity of the Practice Education Facilitators (PEFs) to train and get nurses through the Objective Structured Clinical Exams (OSCE). Strong pastoral support at each partner Trust is critical to support internationally recruited nurses to acclimatise so experienced nurses are in place to provide that. Pastoral Care Nurse resource will also support ward staff to understand cultural differences, enabling effective integration within clinical teams.

24. NHSI/E has recently allocated funding to us and the CIRC project to contribute to a national research study led by Huddersfield University to look at the retention of international nurses.

Appraisals

25. Feedback to date indicates that Motiv8 (the Trust's appraisal process) is impacting positively with quality performance/career discussions. However, the transition to Motiv8 and uptake of training has been impacted by COVID-related work pressures, resulting in a continued drop in appraisal compliance levels. Sensitive communications and engagement will be required to help aid transition over the coming months, with attention now turning to compliance at Divisional level with support from the HR team.

(Leighton) Hospital Redevelopment Programme Board (HRPB)

26. Two meetings of the HRPB have been held since the last formal Board meeting in January 2021. The Chair's Assurance Reports from both these meetings are appended to my report (Appendix I).

Digital Clinical System

27. The first meeting of the Digital Clinical System Programme Board was held on 8 March 2021. We are currently in the competitive procurement process, having completed the tender evaluations and client reference visits. The procurement process should be completed at the end of April with the full business case being for submission to the Trust Board in Q1.

28. The Chair's Assurance Report, jointly agreed with East Cheshire Trust, is appended to my report (Appendix II).

James Sumner, Chief Executive
March 2021

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

Report to	Board of Directors - 25 March 2021
Date	11 February 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 Caroline Keating, Company Secretary
Committee meeting quoracy	Yes ☐ No ☒

KEY AREAS OF ASSURANCE

- Design development phase for the Strategic Outline Case (SOC) complete to enable costing works to be completed in line with timetable. Will be further opportunity to make design adjustments after SOC stage
- All clinical workshops completed and feedback given to Medical Director
- Positive feedback received from three contractors who advised that building time could be reduced by up to 25%
- Links made between SOC and emerging Trust Strategy
- Final risk register design approved and top risks reported to HRPB
- Communications and Engagement Plan - further work on the stakeholder engagement matrix to be completed, plan will continue to flex and adjust through the project

KEY CONCERNS/RISKS

- New requirement in this bidding round to be zero carbon neutral is creating unprecedented challenges although Archus have confirmed this is deliverable

Priority Areas: DECISIONS MADE

- Project Initiation Document (PID) approved
- Risk Register approved
- Communications and Engagement direction of travel approved

Decisions to be ratified at the next meeting as not quorate.

RECOMMENDATION

To note

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

Report to	Board of Directors - 25 March 2021
Date	18 March 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

- Strategic Outline Case (SOC) is progressing well and on time with a number of elements and workshops being completed that would normally wait until the Outline Business Case stage
- Capital Costs have increased in the region of 10% due to inclusion of Net Zero Carbon requirements, further detailed work on the digital costs (which will generate revenue savings) and increase in floor area, specifically around FM and Automated guided vehicle (AGV). Linked revenue savings have not yet been accounted for. Costs have increased and the causes of this reviewed in detail by the Steering Group.
- Alternative uses of the new A&E building to be explored by the steering group
- The latest position on the SOC will be presented to the Board Strategic Session on 25 March for discussion, with the final SOC submitted to the April Board for approval

KEY CONCERNS/RISKS

- Increase in capital costs
- New risk to be added to the risk register around RAAC plank failure at another hospital

Priority Areas: DECISIONS MADE

None

RECOMMENDATION

To note

Digital Clinical System Transformation Board
Chair's Report
March 2021

Report to	Board of Directors
Date	8 March 2021
Report from	James Sumner – Chief Executive Officer
Report prepared by	Amy Freeman – Chief Information Officer
Executive Lead/s	Amy Freeman – Chief Information Officer
Committee meeting quoracy	Yes ☒ No ☐

KEY AREAS OF ASSURANCE

- Despite operational pressures on staff, the project remains on track against agreed milestones although future timescales were considered were ambitious.
- Benefits workshops have taken place to validate the benefits expected from the digital clinical system programme.
- DCS Programme Director will start in post on 15 March 2021.

KEY CONCERNS/RISKS

Concern/Risks Identified

Risk Register to be reviewed and scores reconsidered as identified as being low.

The following new risks were added to the Risk Register:

- Funding not secured - the procurement of the digital clinical system is dependent on being awarded capital funds from the Digital Aspirants Fund. In the event that the funding is not awarded, the Trusts will be unable to afford the solution resulting in non-delivery of the programme (Initial score of 5 x 4 = 20)
- Capital national regime not agreed - the procurement of the digital clinical system is dependent on being able to spend capital funds. The national regime on capital allocations is not yet clear and may restrict the ability for both Trusts to spend capital (Initial score of 4 x 4 = 16)
- National approval process not clear – NHSX becoming part of NHSI/E is leading to some ambiguity as NHSX were key approvers of the OBC. If the approval process is not clarified, this could lead to significant delays (up to 12 months) in the approval of the FBC (Initial score of 5 x 4 = 20)

DECISIONS MADE

- NHSI/E representative to be invited to become an attendee of DCSTB.
- Scope of the programme validated and remains unchanged.

- Governance arrangements to be revised to elevate the dependency and importance of organisational development and culture change.

- A number of decisions relating to the programme were made prior to the establishment of the DCSTB and these were ratified these included but not limited to:
    - Contract with PA Consulting for the development of the Outline Business Case
    - Contract with Apira for the development of the Full Business Case
    - Contract with Apira to support the procurement and evaluation process

RECOMMENDATION

- To note

Mid Cheshire Hospitals
NHS Foundation Trust

Board of Directors
Integrated Performance Report

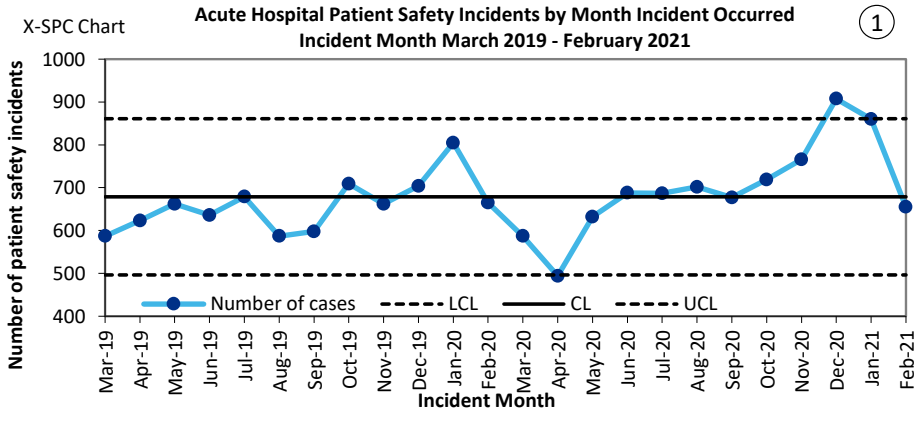
February 2021

"To Deliver Excellence in Healthcare through Innovation & Collaboration"

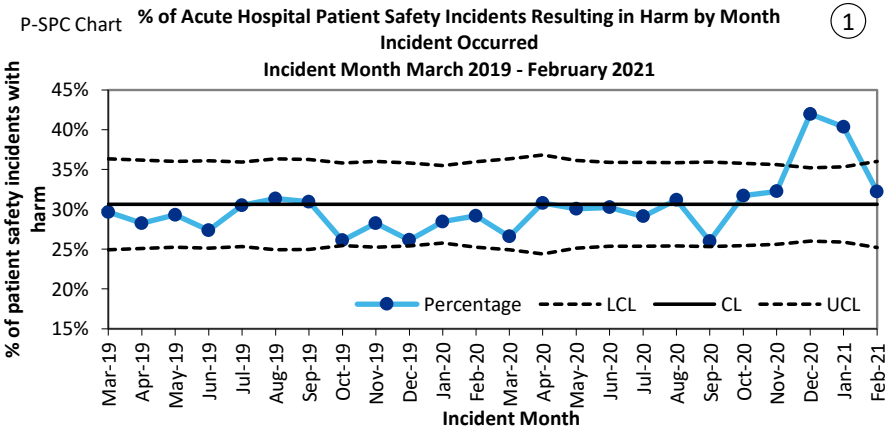
Quality, Safety & Patient Experience

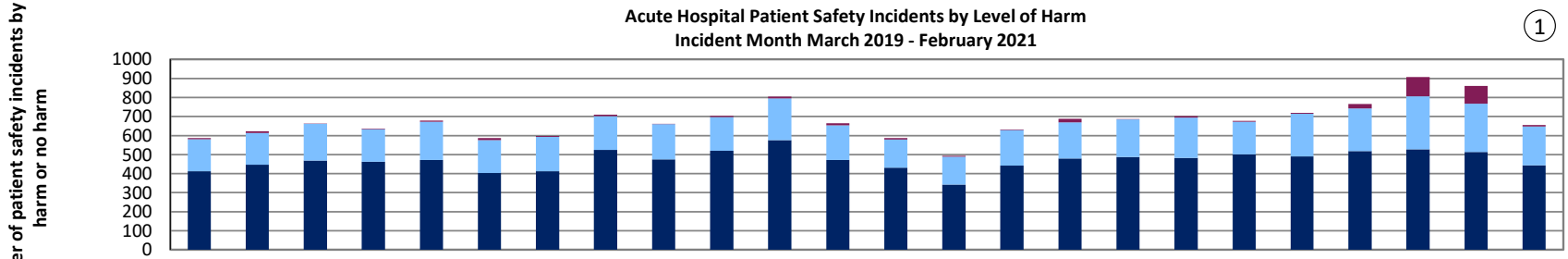
Acute Hospital Patient Safety Incidents (Excludes CCICP)

X-SPC Chart



P-SPC Chart





	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	Jan-21	Feb-21
Moderate and Above	6	10	1	3	6	11	5	7	2	6	9	12	8	5	3	19	2	8	5	5	24	102	92	8
Low Harm	168	166	193	171	201	173	180	178	185	178	220	182	148	147	187	189	198	211	171	223	223	279	255	203
No Harm	413	447	468	462	472	403	413	524	475	520	576	471	431	342	442	480	487	483	501	491	519	527	513	444

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: 655 incidents are currently shown for February 2021 of which 32% resulted in harm.

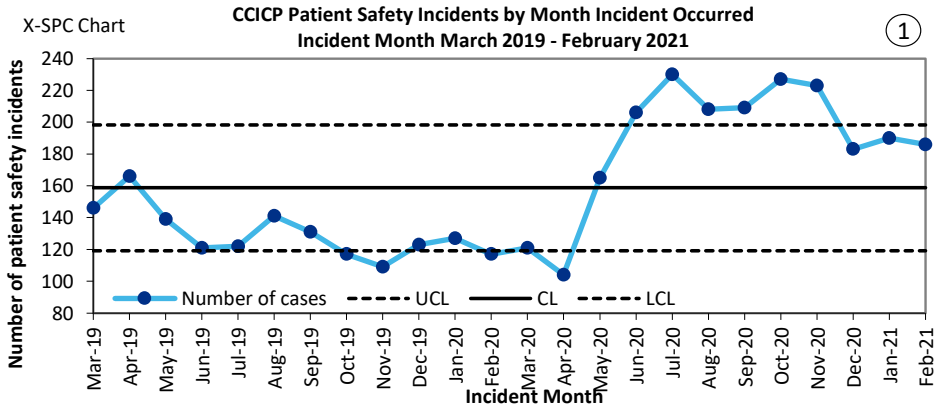
Low Harm 203, Moderate Harm 5, Serious Incident 3

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

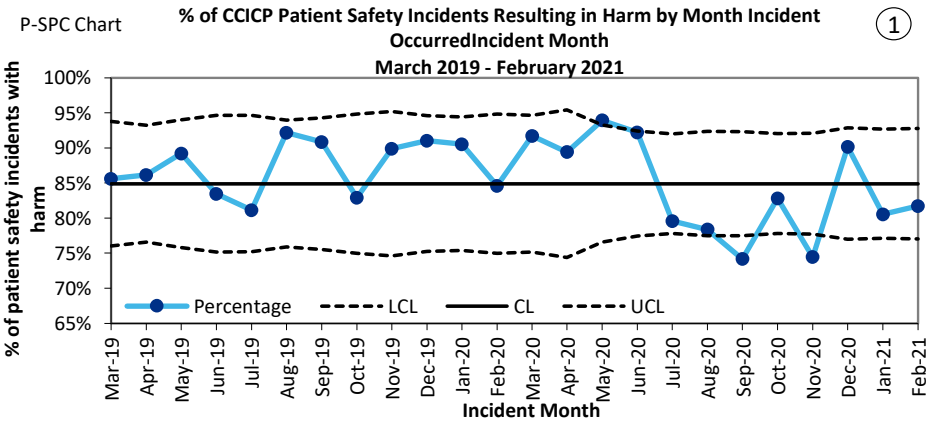
Quality, Safety & Patient Experience

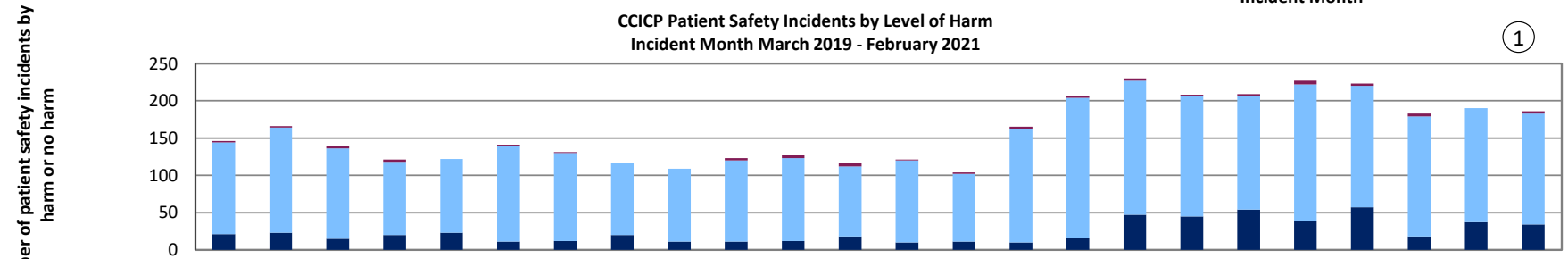
Central Cheshire Integrated Care Partnership (CCICP) Patient Safety Incidents

X-SPC Chart



P-SPC Chart





	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	Jan-21	Feb-21
Moderate and Above	2	2	3	3	-	2	1	-	-	3	4	5	1	2	3	2	3	1	3	5	3	4	-	3
Low Harm	123	141	121	98	99	128	118	97	98	109	111	94	110	91	152	188	180	162	152	183	163	161	153	149
No Harm	21	23	15	20	23	11	12	20	11	11	12	18	10	11	10	16	47	45	54	39	57	18	37	34

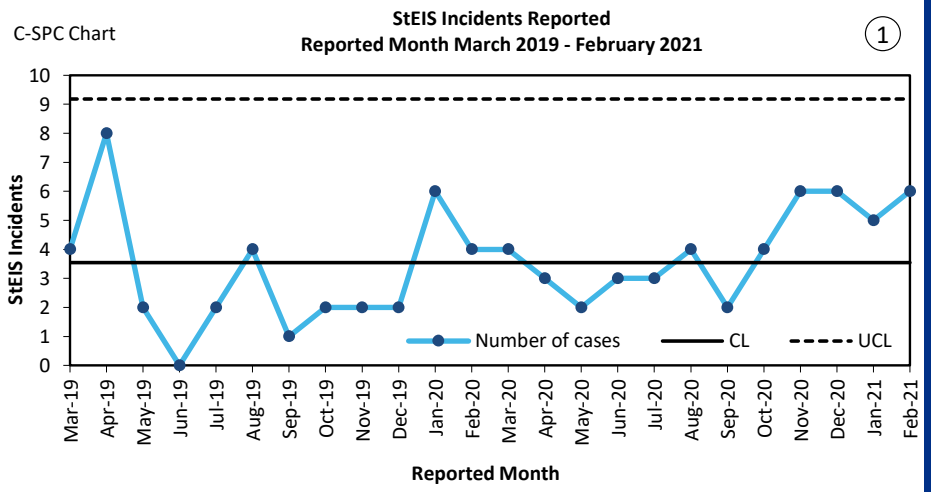
Accountable: Medical Director
Data Owner: Quality Governance
To note: P-SPC charts adjust the control limits to take into account each month's denominator.

Key Narrative: 186 CCICP patient safety incidents are currently shown for February 2021 of which 82% resulted in harm.

Low Harm 149, Moderate Harm 3, Serious Incident 0

Quality, Safety & Patient Experience

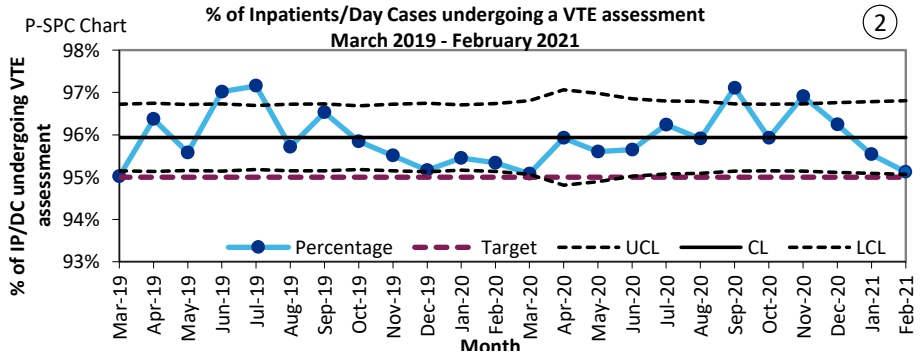
StEIS Incidents - Trust Total



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

Key Narrative: There were 6 serious incidents reported to StEIS in February 2021.

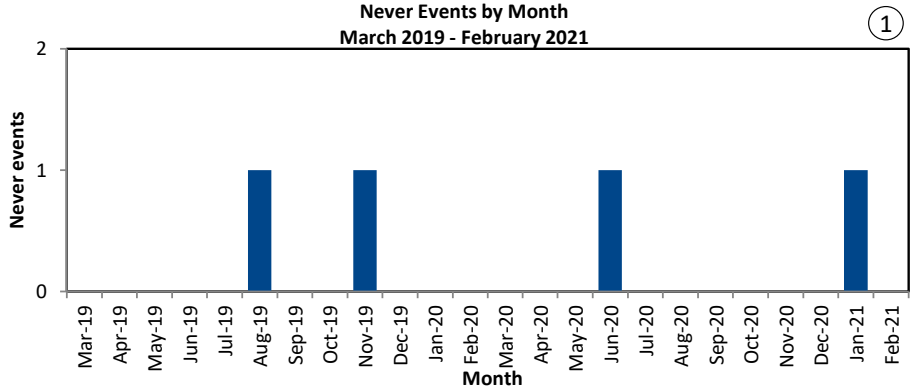
VTE



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

Key Narrative: The percentage of VTE assessments completed remains above target, achieving 95.1% in February 2021. 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 February 2021.

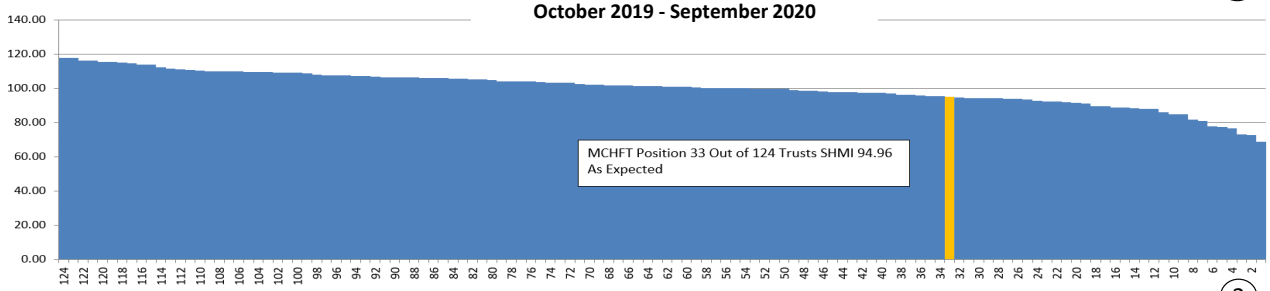
Quality, Safety & Patient Experience

Mortality

SHMI Position 12 Months

SHMI Position 12 months
October 2019 - September 2020

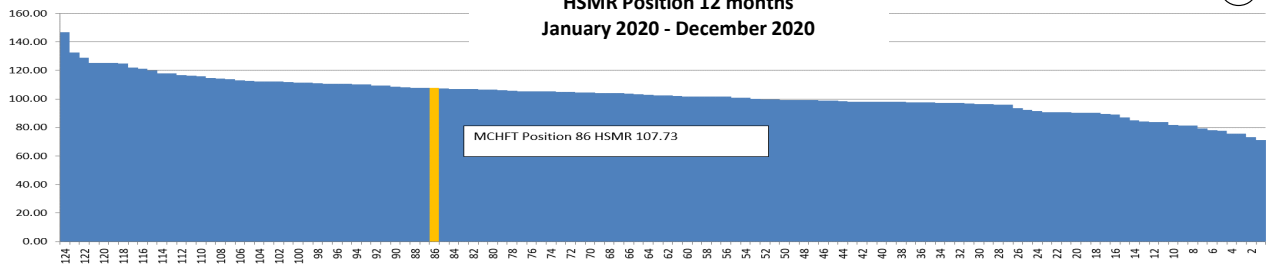
③



Key Narrative: The latest release of SHMI is 94.96 (rank 33) against the previous value of 96.45 (rank 37). 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

HSMR Position 12 months
January 2020 - December 2020

③

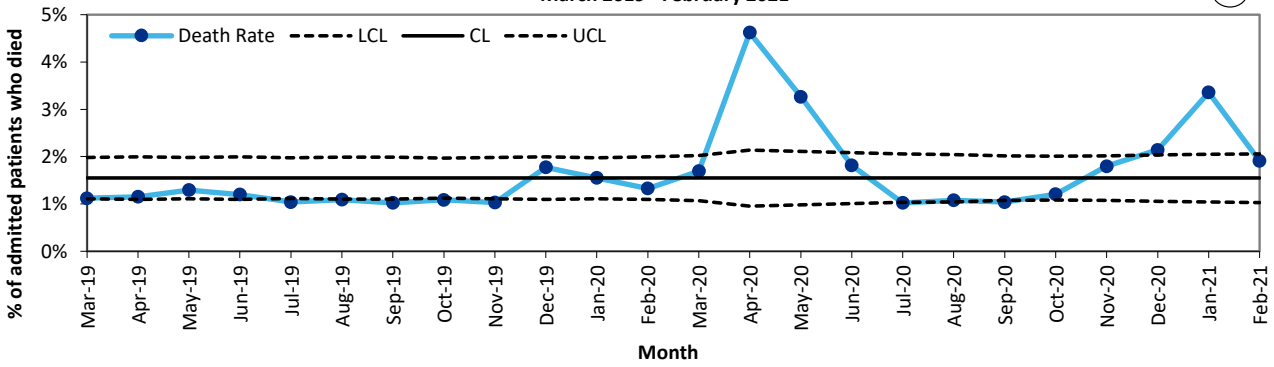


Key Narrative: The latest HSMR release is 107.73. Recent releases had shown an improvement in HSMR which is likely to be the result of improving rates of palliative coding (still low compared to other Trusts). This release shows a slight improvement. Please note that the Trust mergers in SHMI are reflected in this data.

P-SPC Chart

Crude Mortality - Percentage of In-Hospital Deaths by Total Discharges (excludes Community 30 days)
March 2019 - February 2021

②



Key Narrative: Crude mortality has remained largely consistent over the time period; exceptions are Dec 2019, March-May 2020, Dec 2020 & Jan 2021 where the rate increased and shows special cause variation on the chart. The latter 3 periods represent periods of increasing incidence of patients with Covid 19 in the Trust. February 2021 shows a return to normal

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

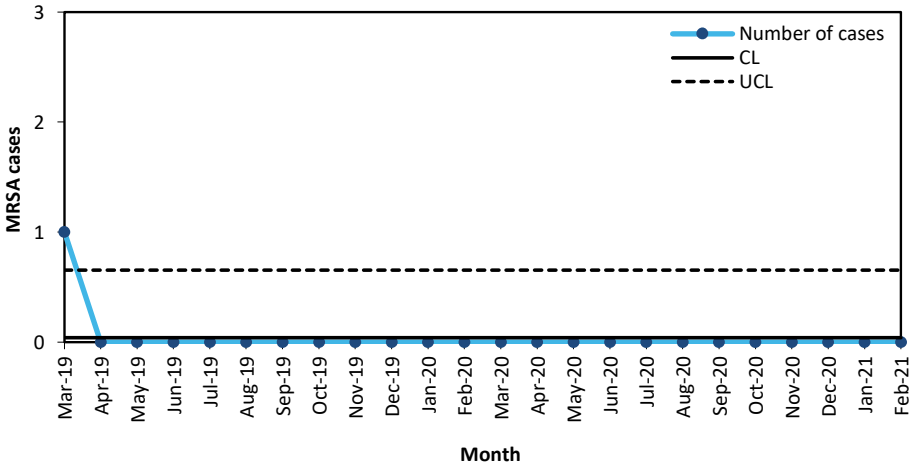
Quality, Safety & Patient Experience

MRSA

C-SPC Chart

MRSA Bacteraemia Cases Reported Within the Trust
March 2019 - February 2021

①



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

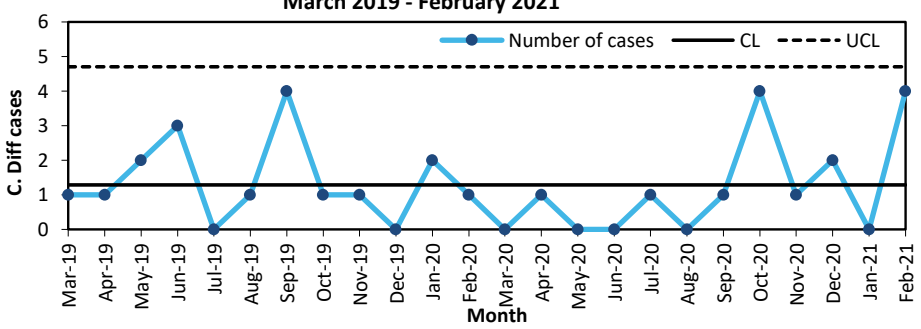
Key Narrative: There have been no MRSA bacteraemia cases reported since March 2019.

C. Diff Positive Cases

C-SPC Chart

Hospital Onset Healthcare Acquired C. Diff Cases
March 2019 - February 2021

①



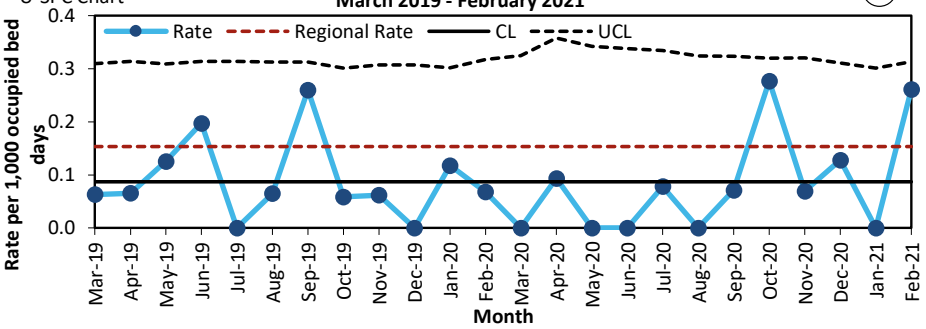
	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
Avoidable	0	0	0	0	1	0	0	0	0	0	0	0
Unavoidable	0	1	0	0	0	0	1	0	0	0	0	0
Awaiting Confirmation	0	0	0	0	0	0	0	4	1	2	0	4

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

U-SPC Chart

March 2019 - February 2021

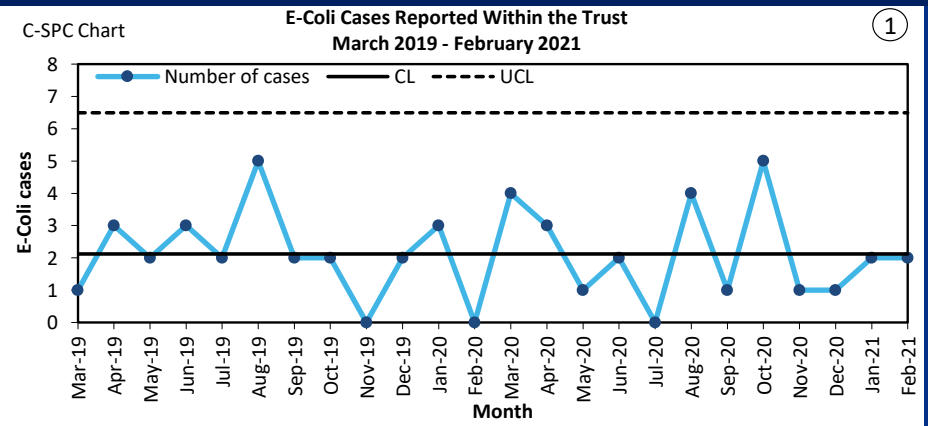
①

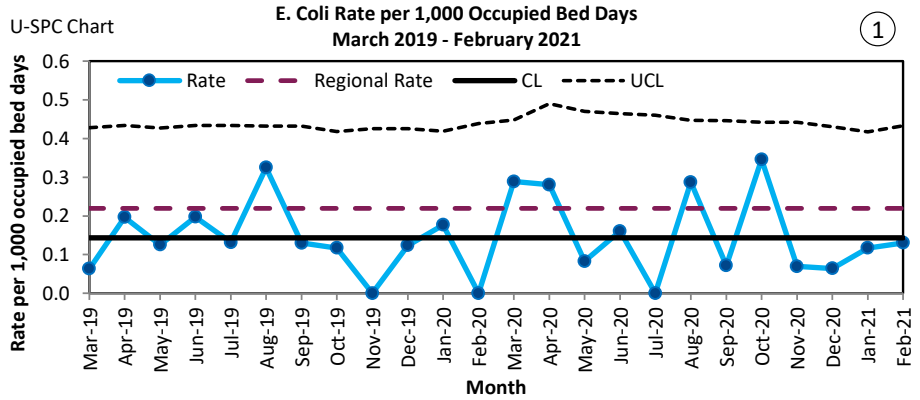


Accountable: Director of Nursing and Quality
Data Owner: Infection Prevention Control Team
Key Narrative: There were 4 hospital onset healthcare acquired C.Diff cases recorded in February 2021 with a rate of 0.26 per 1,000 occupied bed days, above the regional rate for the month. The year to date rate is currently 0.09. The P-SPC

Quality, Safety & Patient Experience

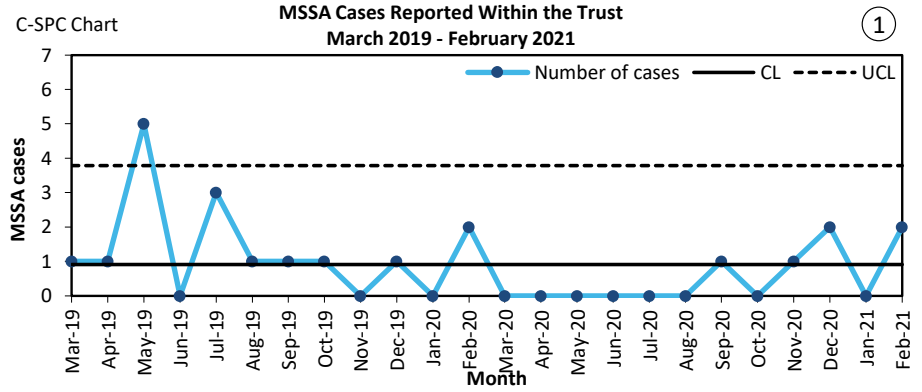
E-Coli Cases

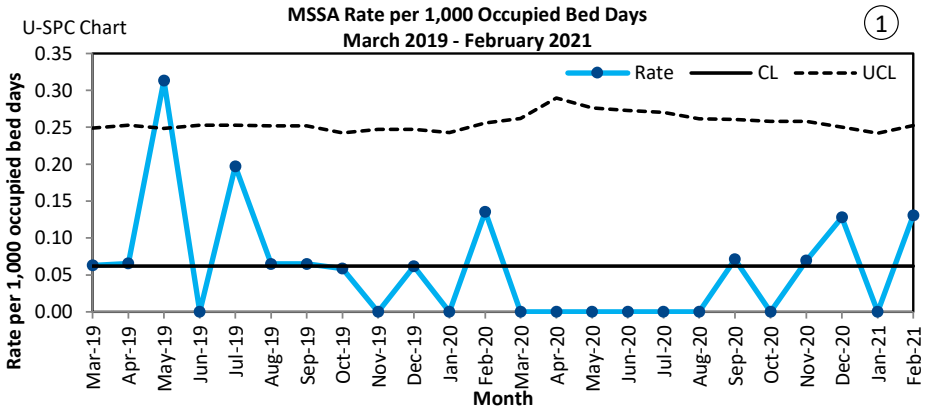




Accountable: Director of Nursing and Quality
Data Owner: Infection Prevention Control Team
Key Narrative: 2 E-Coli case were recorded in February 2021 with a rate of 0.13 cases per 1,000 occupied bed days, below the current regional rate. The U-SPC chart adjusts the control limits to take into account each month's denominator.

MSSA

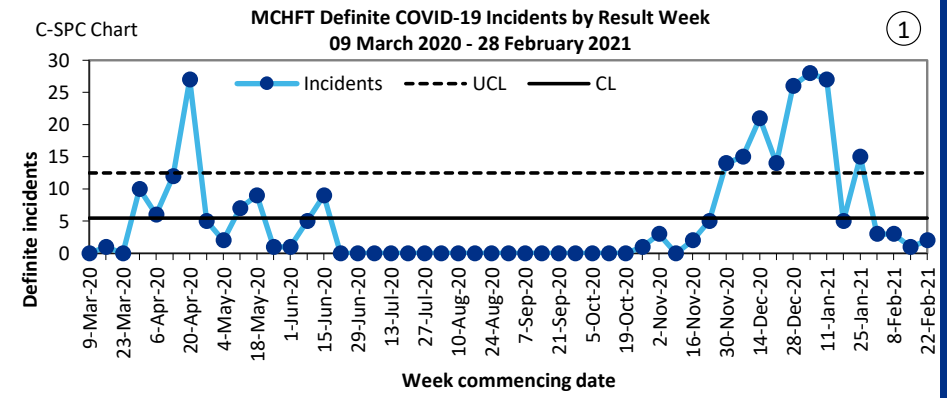


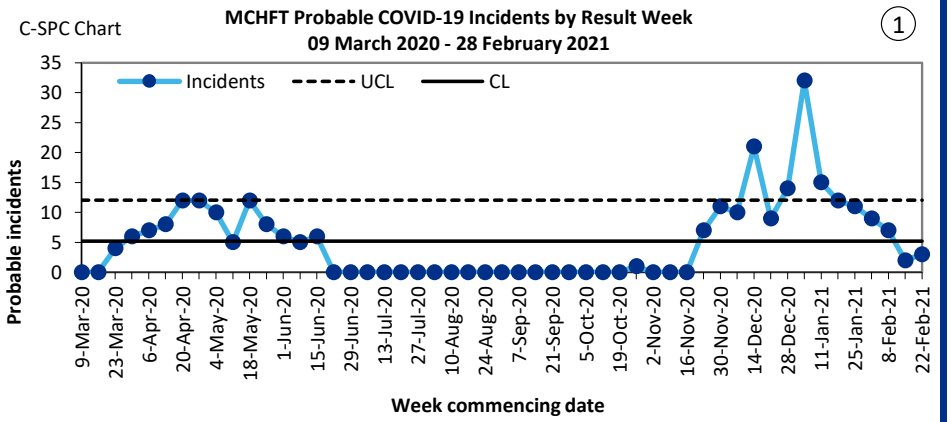


Accountable: Director of Nursing and Quality
Data Owner: Infection Prevention Control Team
Key Narrative: There were 2 MSSA case reported in February 2021 with a rate of 0.13 per occupied bed days. The U-SPC chart adjusts the control limits to take into account each month's denominator.

Quality, Safety & Patient Experience

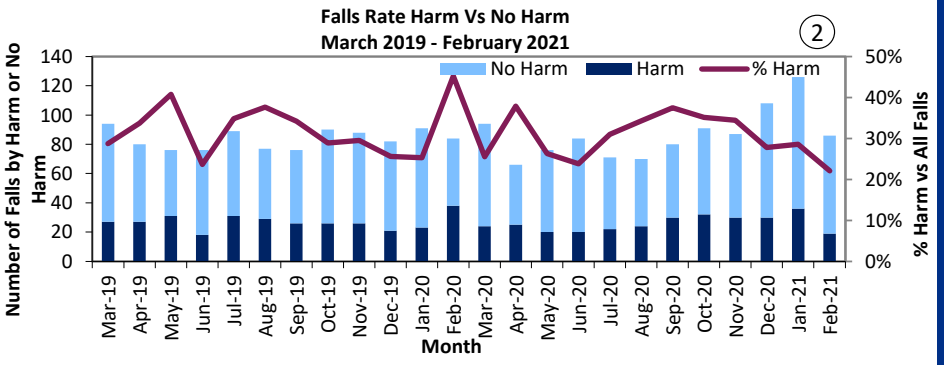
COVID-19 Healthcare Acquired Infections

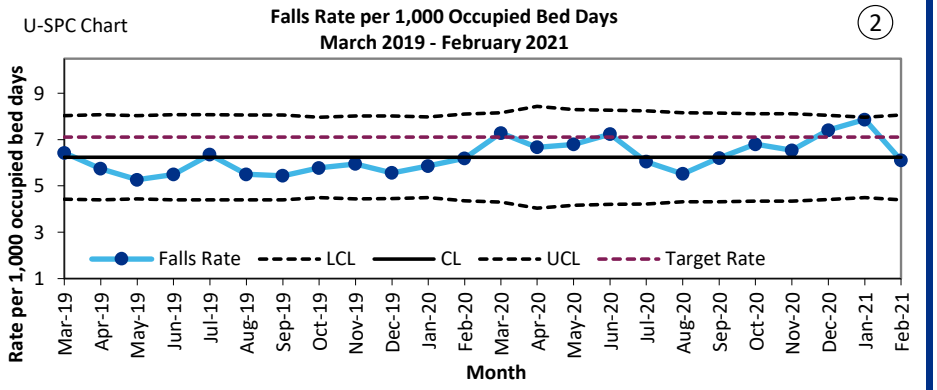




Accountable: Director of Nursing and Quality **Data Owner:** Information Services
Key Narrative: The latest week reported, week commencing 22nd February 2021, shows 2 definite incidents and 3 probable incidents.

Falls





Accountable: Director of Nursing and Quality **Data Owner:** Nursing Quality Team
Key Narrative: 86 falls were reported in February 2021 with a rate of 5.6 per 1,000 occupied bed days, below the target rate of 6.6. 19 falls resulted in harm (22%), of which 18 were low harm.
The U-SPC chart adjusts the control limits to take into account each month's denominator.

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

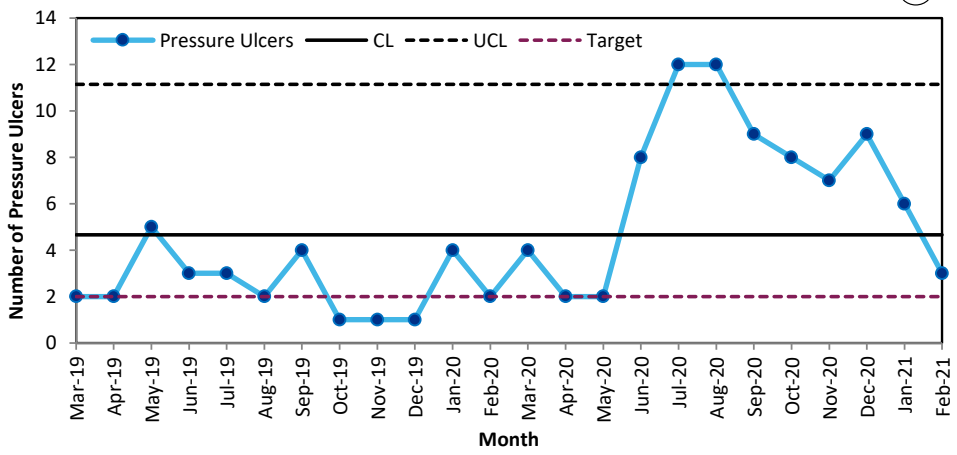
Quality, Safety & Patient Experience

Acute Hospital Pressure Ulcers

C-SPC Chart

Acute Hospital Pressure Ulcers - Lapses in Care Identified
March 2019 - February 2021

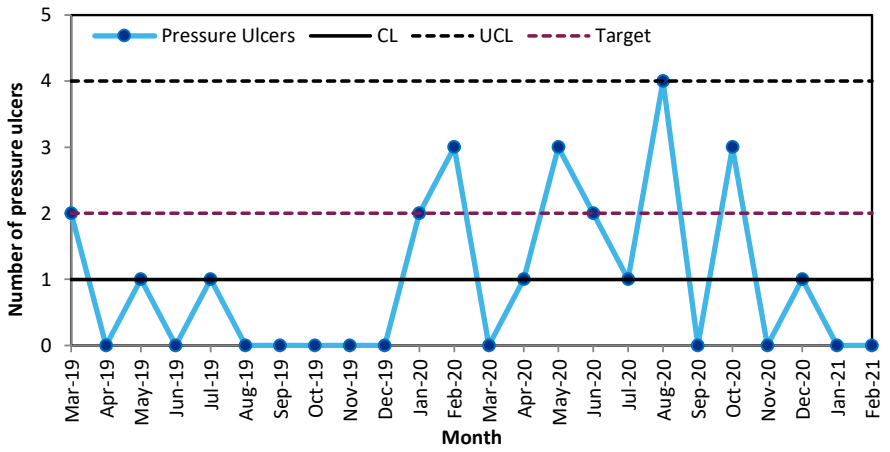
①



C-SPC Chart

Community Pressure Ulcers - Lapses in Care Identified
March 2019 - February 2021

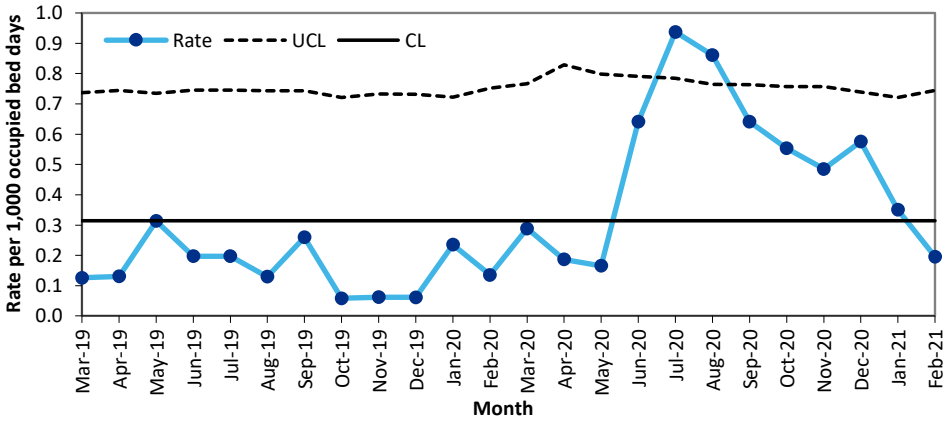
①



U-SPC Chart

Acute Hospital Pressure Ulcers - Lapses in Care Rate per 1,000 Occupied Bed Days
March 2019 - February 2021

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 3 acute hospital lapses in care identified in February 2021 with a rate of cases per 1,000 occupied bed days of 0.20. There have been 78 acute lapses of care reported in the current financial year against a target of 22.

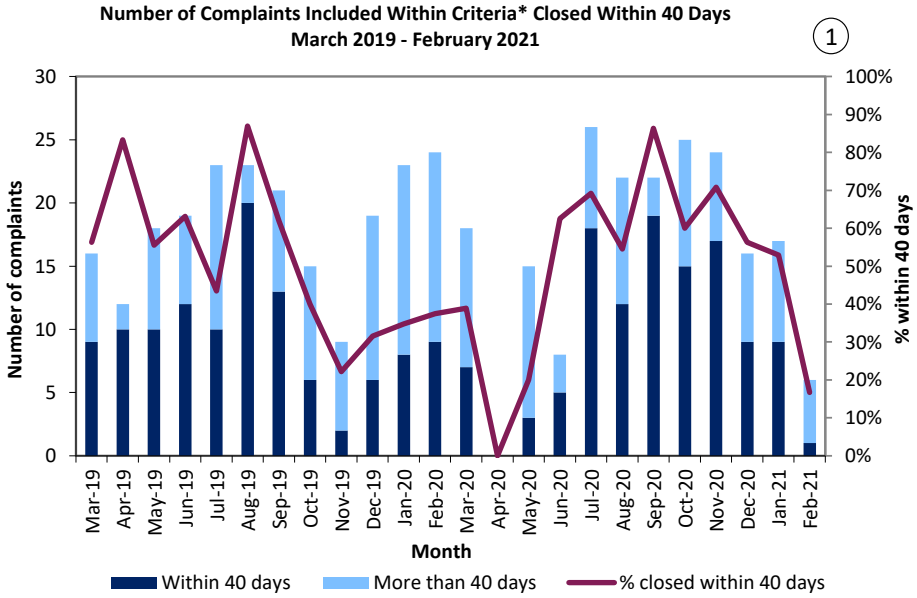
Community: There were no community lapses of care identified in February 2021. There have been 15 community lapses of care reported in the current financial year against a target of 18.

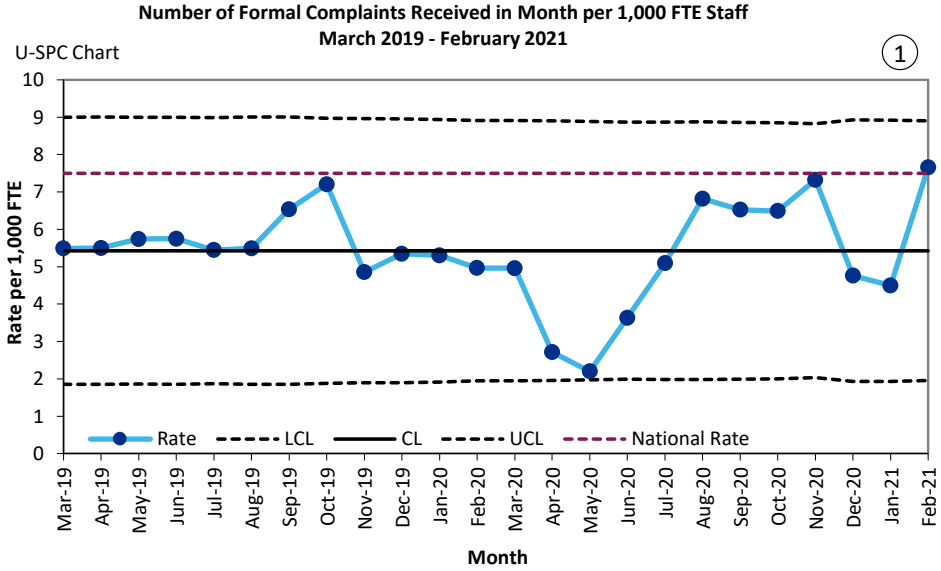
Current financial year reported cases subject to validation.

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

Quality, Safety & Patient Experience

Formal Complaints





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

Key Narrative: 6 complaints were closed in February 2021, of which 1 was closed within 40 days (16.7%). The rate of formal complaints received in February 2021 was 7.66 per 1,000 FTE staff, slightly above the national rate.

Due to the second wave of the covid pandemic, complaint responses were stood down from November 2020 to be recommenced in March 2021.

**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

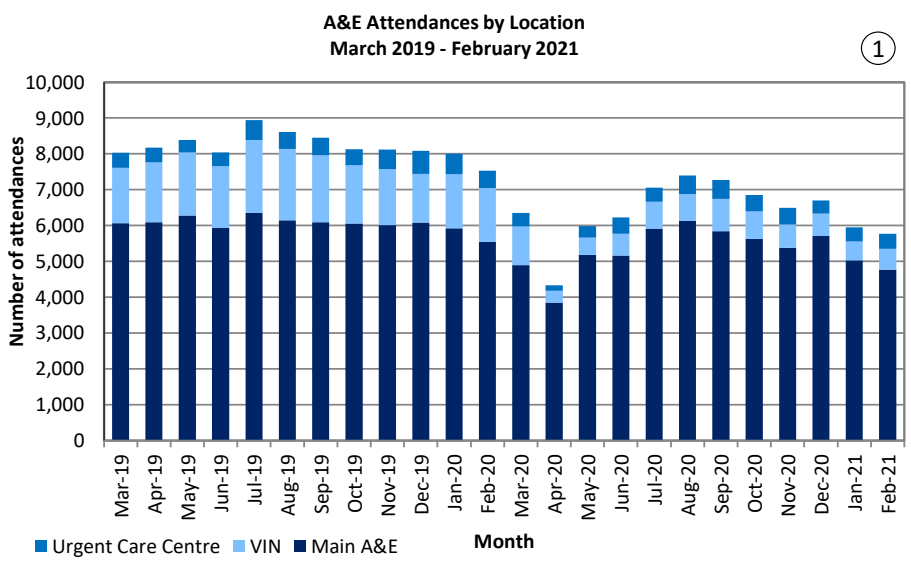
(1)

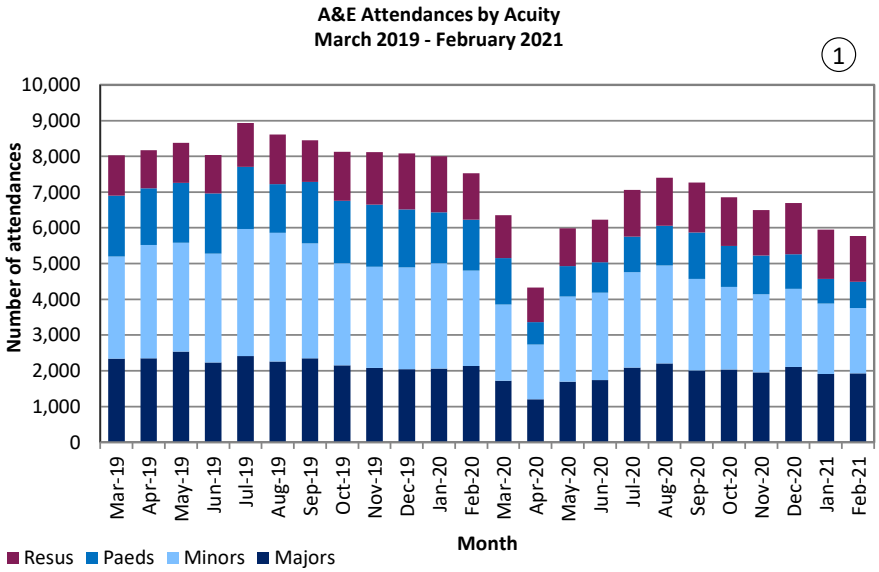
Ward Name	Day				Night				Day		Night	
	Qualified		Unqualified		Qualified		Unqualified		Qualified	Unqualified	Qualified	Unqualified
	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Fill Rate	Fill Rate	Fill Rate	Fill Rate
MCHFT	47783.5	40953.7	40829.1	33296.8	38040.3	34516.3	31288.0	25293.2	86%	100%	91%	91%
Acute Medical Unit	1724.5	1662.0	1811.0	1723.8	1788.0	1728.0	1344.0	1263.5	96%	95%	97%	94%
Child & Adolescent Unit	2377.7	2006.9	1047.8	732.5	2028.0	1945.0	492.0	490.0	84%	70%	96%	100%
Critical Care Unit (HIGH)	4674.5	4229.8	547.0	558.0	4452.0	4221.8	696.0	390.0	90%	102%	95%	56%
Elmhurst	684.0	680.5	2328.0	2100.0	708.0	672.0	1644.0	1476.0	99%	90%	95%	90%
Maternity Unit (Ward 23)	1222.9	1166.2	676.2	672.7	672.0	673.2	672.0	628.9	95%	99%	100%	94%
Midw ifery Led Unit	678.0	679.3	0.0	0.0	672.0	660.3	0.0	0.0	100%		98%	
NICU Ward 22	1657.7	1636.2	694.0	504.2	1204.0	1104.9	322.5	354.8	99%	73%	92%	110%
South Cheshire Surveillance (HIGH)	2170.8	1707.5	2455.5	2140.8	2064.0	1763.5	2352.0	1836.0	79%	87%	85%	78%
Ward 1 Coronary Care	1910.5	1816.5	1299.0	1142.0	1464.0	1427.5	1055.5	886.5	95%	88%	98%	84%
Ward 10 Ortho Trauma	1951.3	1294.8	2646.0	1592.5	1056.0	851.0	1740.0	1080.0	66%	60%	81%	62%
Ward 11 Surgical/Gynae	1826.5	1688.0	1710.0	1512.0	1176.0	1104.0	1380.0	1043.0	92%	88%	94%	76%
Ward 12 SAU	1266.0	1161.5	772.8	655.8	732.0	720.0	720.0	672.0	92%	85%	98%	93%
Ward 12 Surgical Speciality	1116.0	1031.5	822.0	610.5	744.0	673.5	792.0	540.0	92%	74%	91%	68%
Ward 13 Medical	1934.0	1520.5	2513.0	2114.0	1224.0	1088.2	2070.0	1577.5	79%	84%	89%	76%
Ward 14 Gastro	1743.5	1469.0	1632.0	1368.5	1368.0	1075.0	1452.0	1008.0	84%	84%	79%	69%
Ward 15 Medical	1866.0	1718.0	2521.5	2075.5	1260.0	1259.3	2136.0	1673.0	92%	82%	100%	78%
Ward 16 Medical	774.0	743.3	754.0	407.5	576.0	515.5	504.0	336.0	96%	54%	89%	67%
Ward 18 Surveillance	1246.5	1054.5	1572.8	1279.3	792.0	732.0	1068.0	998.0	85%	81%	92%	93%
Ward 19 Covid (HIGH)	1992.5	1298.3	1806.8	1482.3	1932.0	1329.0	1344.0	1094.5	65%	82%	69%	81%
Ward 21b Rehabilitation	1163.8	1048.4	2588.0	2223.5	1104.0	1031.5	1524.0	1344.0	90%	86%	93%	88%
Ward 26 Labour	2890.5	2758.0	499.1	451.6	2352.0	2314.9	336.0	336.0	95%	90%	98%	100%
Ward 3 Short Stay Medical	2249.5	1757.5	1968.0	1714.5	1464.0	1366.5	1440.0	1272.0	78%	87%	93%	88%
Ward 4 Surveillance	1388.0	1270.5	1771.0	1497.0	1032.0	803.5	1368.0	1236.0	92%	85%	78%	90%
Ward 5 Covid (HIGH)	2661.0	1841.0	1606.3	1303.8	2276.3	1915.8	1728.0	1356.0	69%	81%	84%	78%
Ward 6 Rehab	1634.0	1366.0	1951.0	1706.0	1428.0	1323.0	996.0	985.5	84%	87%	93%	99%
Ward 7 Surveillance (HIGH)	1959.0	1670.3	2164.5	1698.8	1704.0	1485.5	1428.0	1320.0	85%	78%	87%	92%
Ward 9 Elective Surgical	1021.0	678.0	672.0	30.0	768.0	732.0	684.0	96.0	66%	4%	95%	14%

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



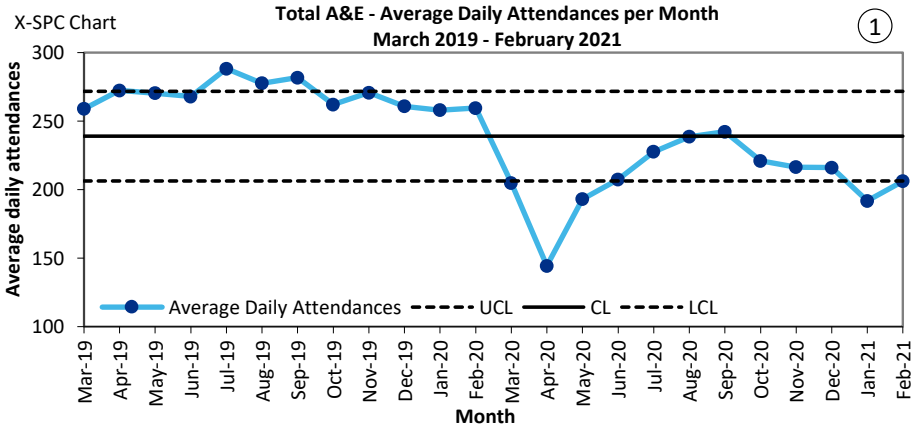


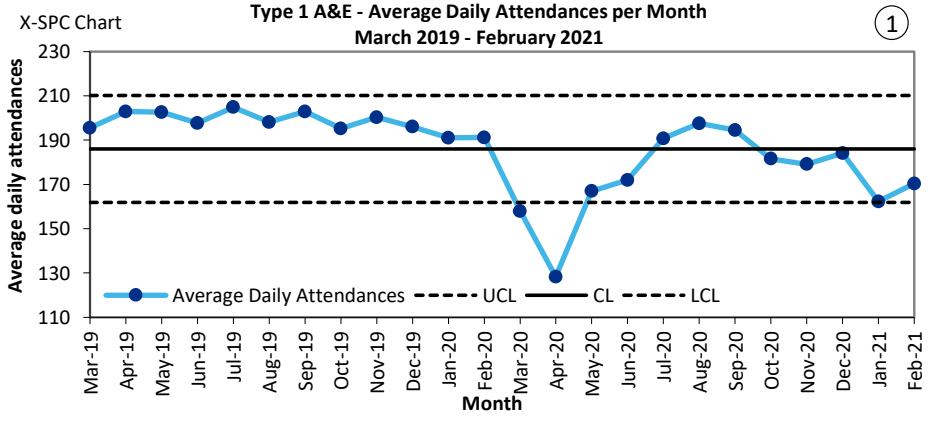
Accountable: Chief Operating Officer
Data Owner: Information Services

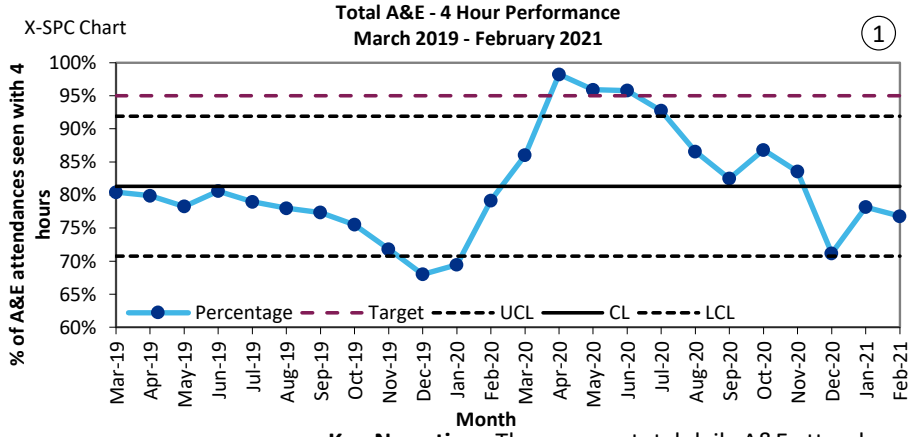
Key Narrative: February 2021 shows 5,772 total A&E attendances across all locations, 2.9% lower than the previous month. There were 4,771 attendances reported in February 2021 for the main A&E department at Leighton Hospital (type 1), 5.2% lower than the previous month. February 2021 activity variance compared to previous month by acuity: Majors +20, Minors -143, Paeds +43, Resus -94. To note: February 2021 has 11% fewer calendar days compared to January 2021.

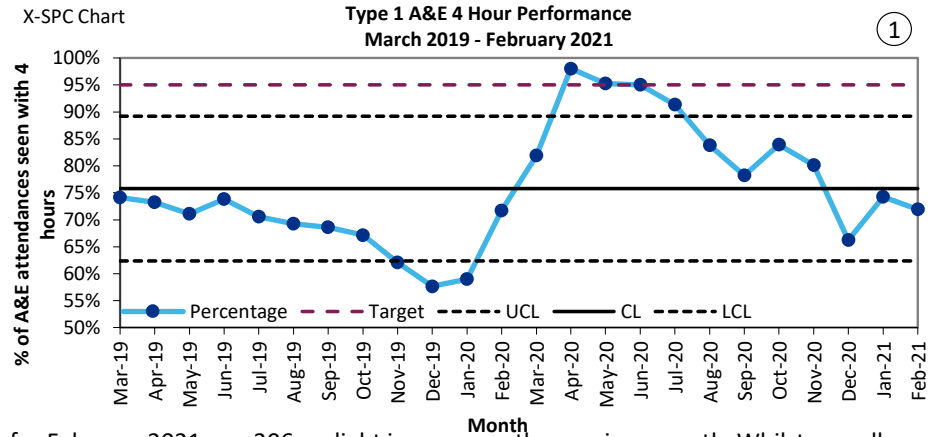
Performance

A&E Performance









Accountable: Chief Operating Officer
Data Owner: Information Services

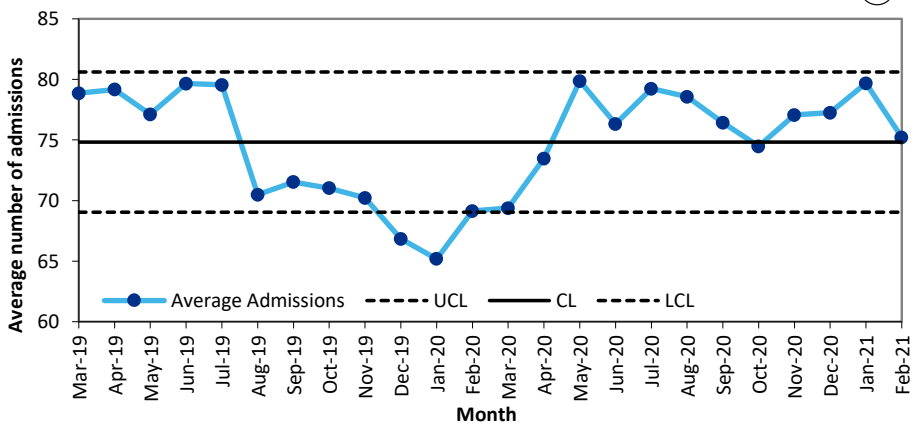
Key Narrative: The average total daily A&E attendances for February 2021 was 206, a slight increase on the previous month. Whilst overall attendances were reduced in February 2021, the daily average increased - this is due to February being a shorter month. Type 1 A&E average daily attendances follows a similar pattern . Attendances are lower when compared to the same period in the previous year (the previous year attendance were prior to the glabal pandemic and therefore not comparable). Performance for February 2021 Total and Type 1 was 76.8% and 71.9% respectively, which is a deterioration on the previous month.

Performance

Unplanned Admissions

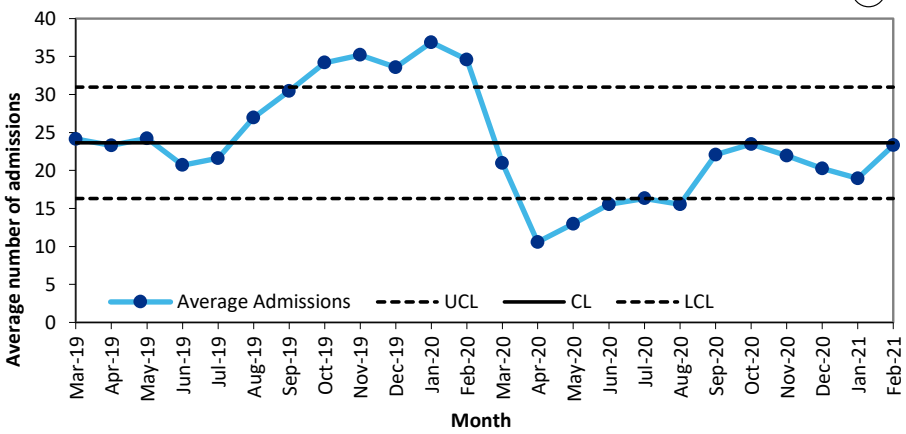
X-SPC Chart

Average Daily Admissions from A&E
March 2019 - February 2021



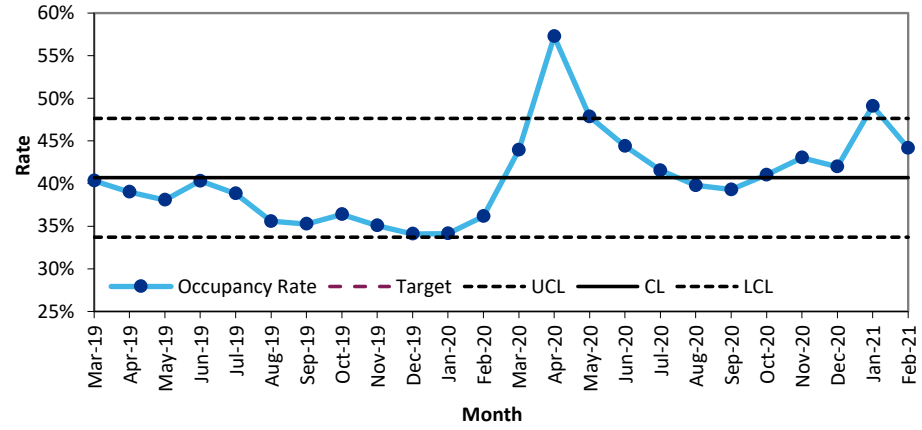
X-SPC Chart

Average Daily Admissions per Month - GP Referred
March 2019 - February 2021



X-SPC Chart

Type 1 Attendance to Admissions Conversion Rate - Overall
March 2019 - February 2021



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.

The average daily admissions for February 2021 was 75.2, below the average admission rate for January 2021 (79.7) and close to the 24-month average.

The average daily admissions for GP-referred patients in February 2021 was 23.3, above the average admission rate for January 2021 (19.0) and close to the 24-month average.

The type 1 admission conversion ratio for February 2021 was 44.1%.

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

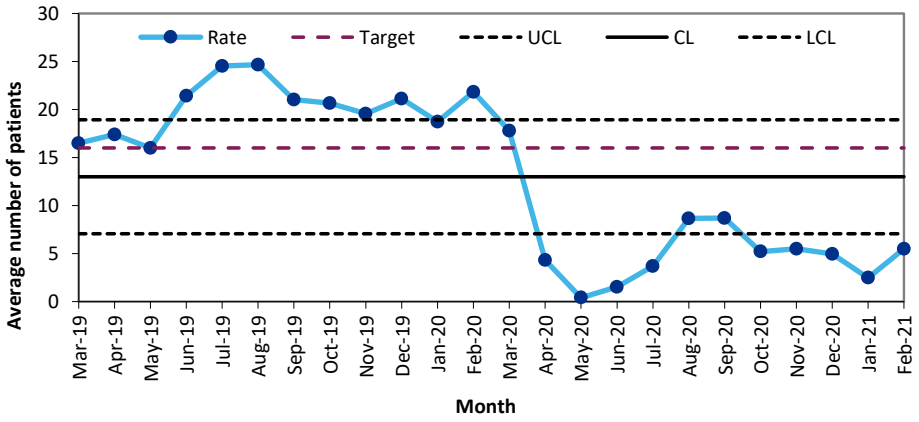
Performance

Inpatient Metrics

X-SPC Chart

Average Number of People Delayed per Day
March 2019 - February 2021

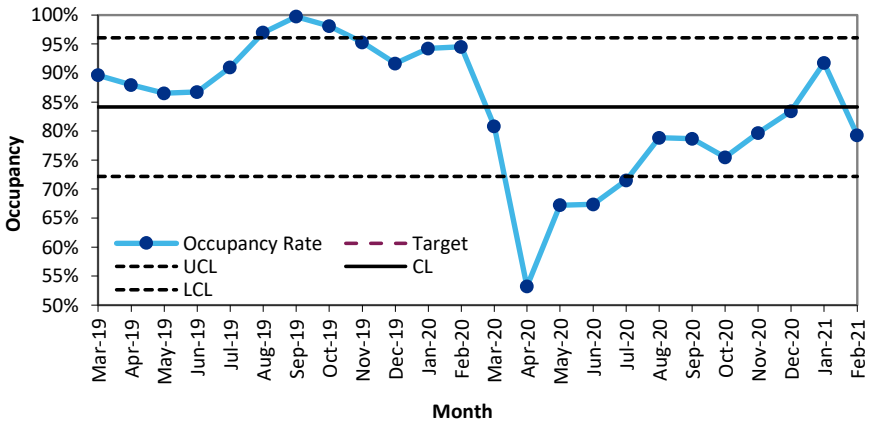
①



X-SPC Chart

Bed Occupancy
March 2019 - February 2021

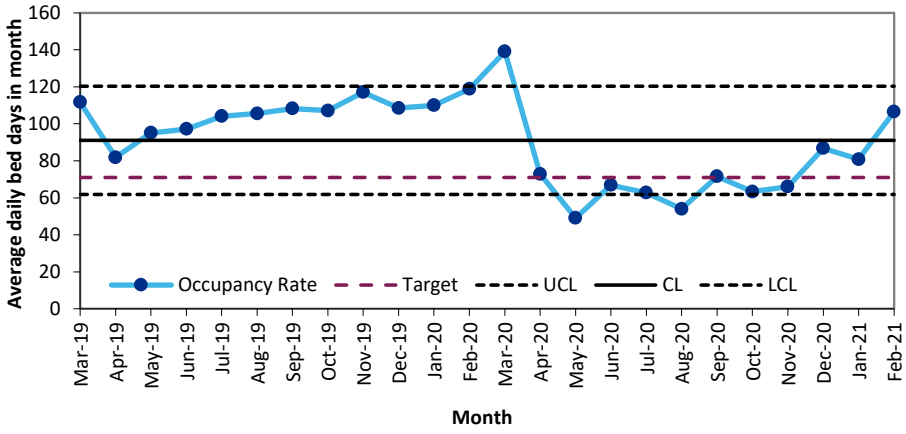
①



X-SPC Chart

Super Stranded Patients
March 2019 - February 2021

①



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

Key Narrative: The average number of people delayed per day during February 2021 was 5.5, similar to the recent months activity and has remained below target since the onset of the covid pandemic.

The average number of super stranded patients delayed per day in the hospital increased from 80.8 in January 2021 to 106.6 in February 2021.

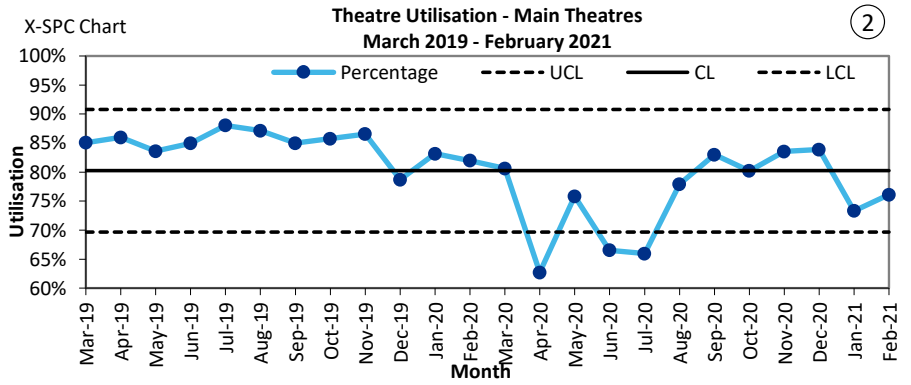
The percentage bed occupancy rate for February 2021 was 79.3%, a decrease on the January 2021 occupancy rate of 91.7%. The bed occupancy figure reported does not exclude lost beds that are not suitable for patient admissions for infection prevention and control (IPC) reasons.

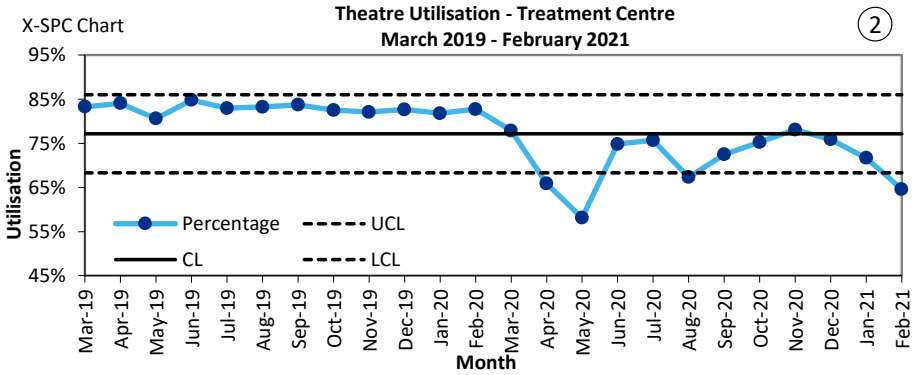
**bed stock numbers used to calculate the bed occupancy rate have been updated from July 2020 to reflect covid ward changes*

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

Performance

Theatre Utilisation



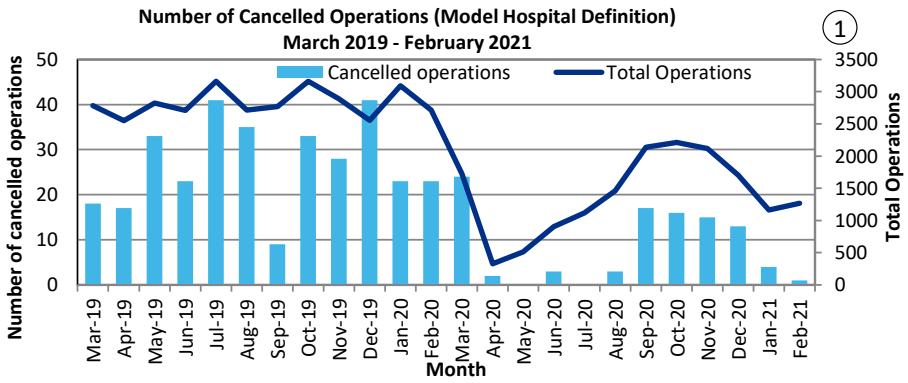


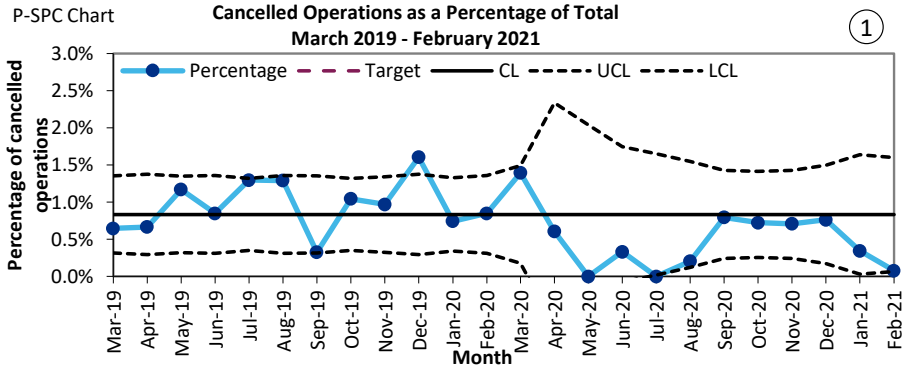
Accountable: Chief Operating Officer **Data Owner:** Information Services

Key Narrative: Theatre utilisation rate for February 2021 was 76.1% in Main Theatres, an increase on the January 2021 position of 73.3% but below the February 2020 position of 82.0%.

Theatre utilisation rate for the Treatment Centre in February 2021 was 64.6%, a decrease on the January 2021 position of 71.7%.

Cancelled Operations





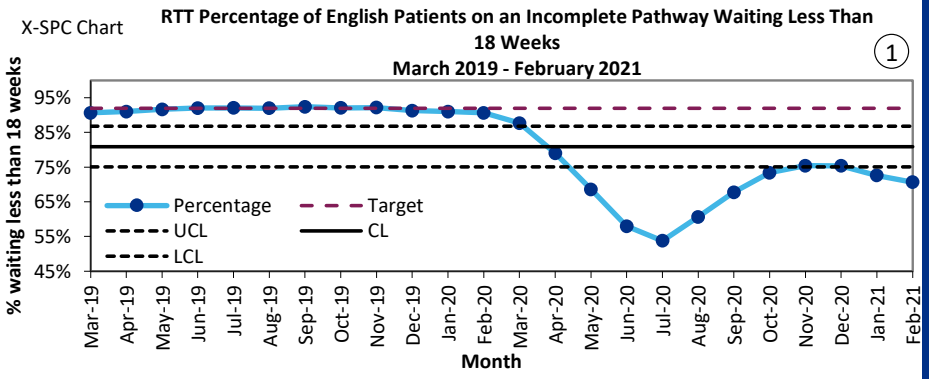
Accountable: Chief Operating Officer **Data Owner:** Information Services

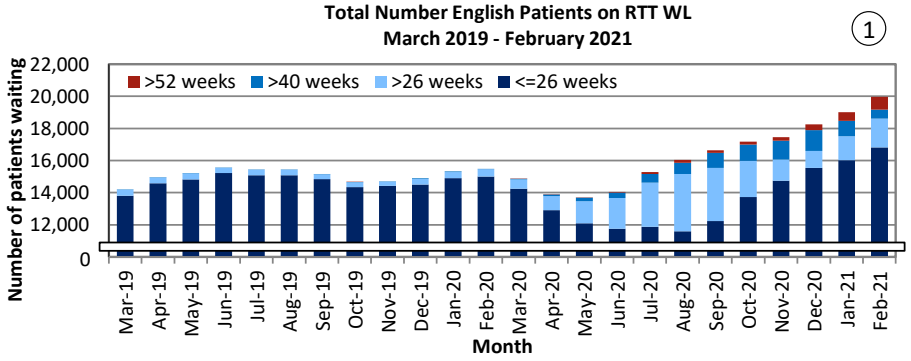
Key Narrative: One operation was cancelled on the day of, or after, admission by the hospital for non-clinical reasons in February 2021 (0.1%).

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

Performance

Referral to Treatment Waiting Times (RTT)



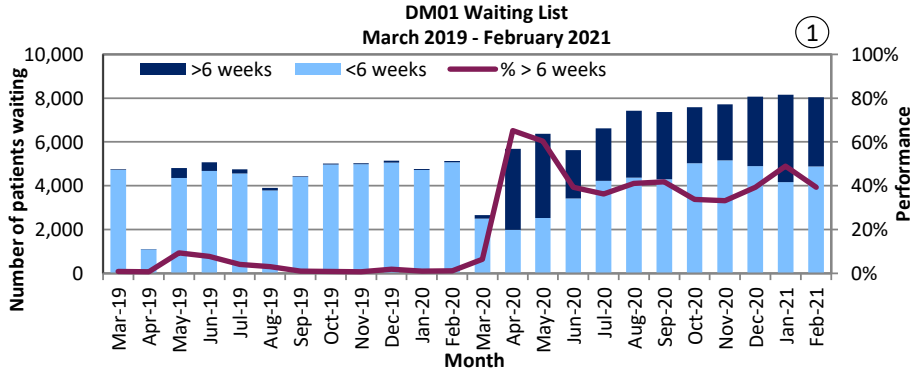


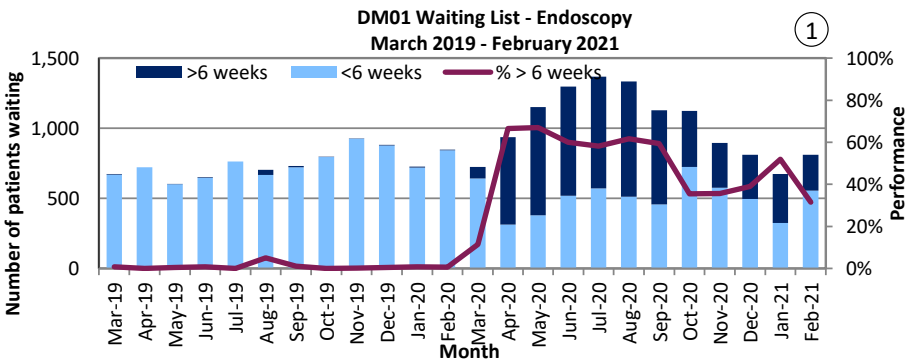
Accountable: Chief Operating Officer **Data Owner:** Information Services

Key Narrative: The total number of patients on the RTT WL continues to grow with 19,959 patients waiting at the end of February 2021, of which 788 patients were waiting for more than 52 weeks, 250 more than reported in January 2021.

February 2021 RTT performance shows 70.7% of patients waiting less than 18 weeks against a standard of 92%. This is a slight decline from January 2021 performance of 72.6%, overall the RTT position remains stable.

Diagnostic Waiting Times





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

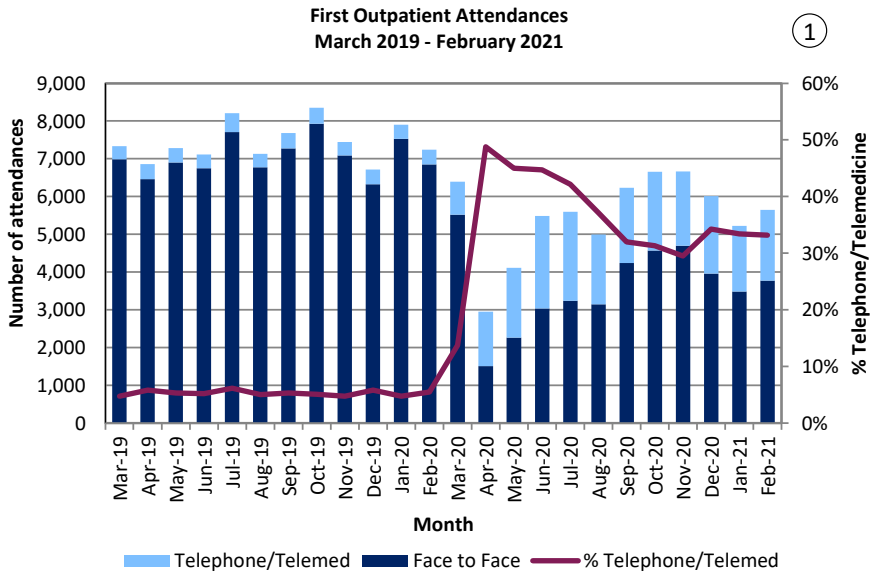
Key Narrative: The total number of patients on the DM01 waiting list for February 2021 was 8,046, 1.3% lower than January 2021's total of 8,155.

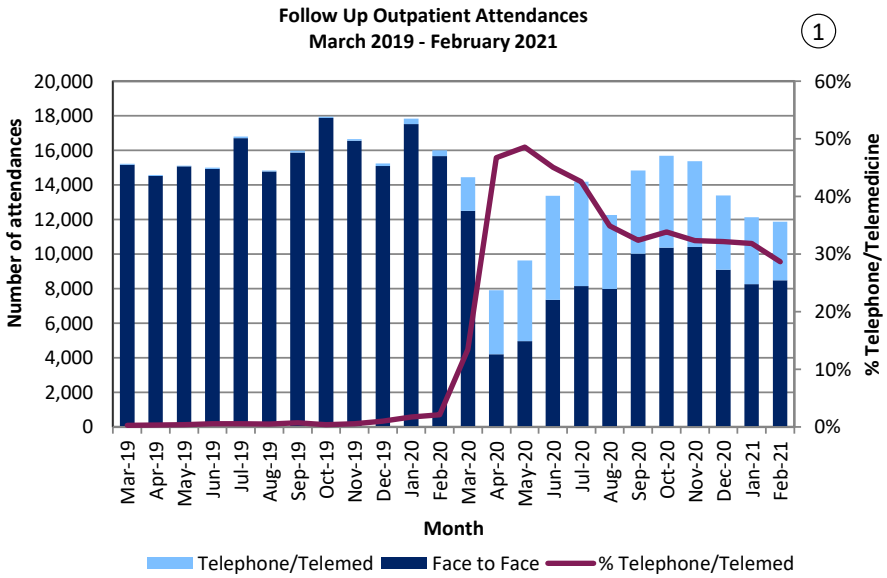
Performance against the 1% diagnostic standard improved from 48.9% in January 2021 to 39.3% in February 2021 but remains above the 1% target. There have been significant improvements with waiting times for imaging and endoscopy.

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

Performance

Outpatient Activity





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

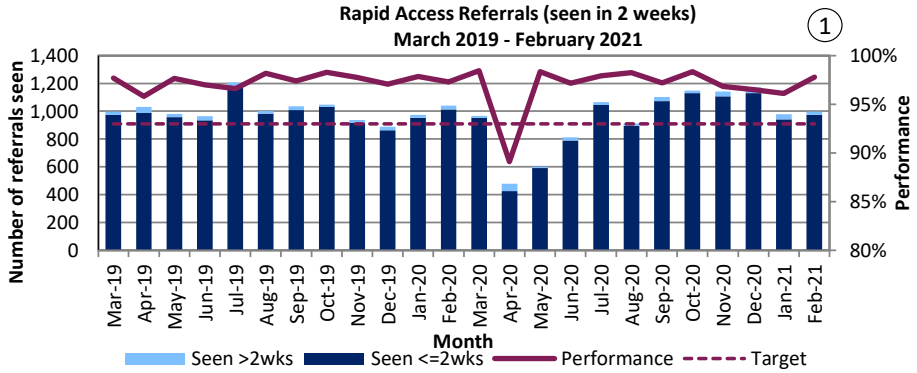
Key Narrative: 5,644 total first outpatient appointments were attended in February 2021, this is an increased from the previous month and 77.9% of activity compared to February 2020. The proportion of non face to face appointments for February 2021 was 33.2%, similar to the previous month.

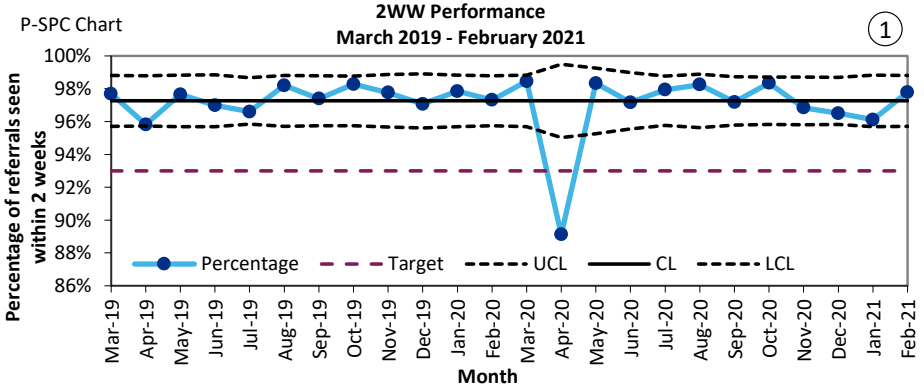
There were 11,879 total follow up outpatient appointments attended in February 2021, delivering 74.2% of February 2020. The proportion of non face to face appointments for February 2021 was 28.6%, slightly lower than the previous 4 months.

Data includes contracted specialties.

Performance

Rapid Access Referrals





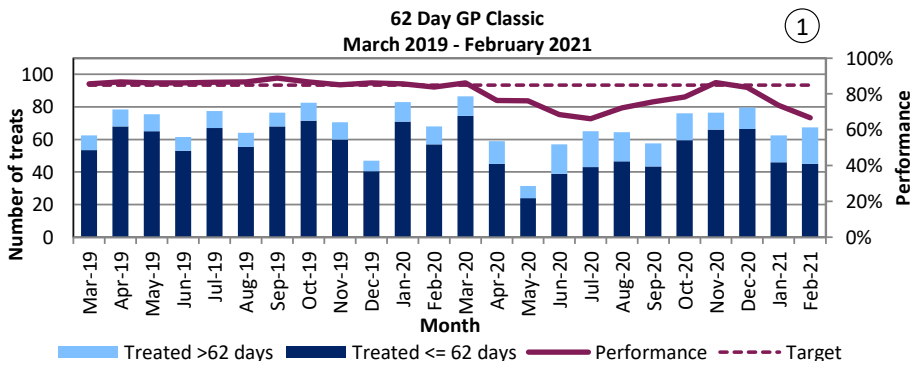
Accountable: Chief Operating Officer **Data Owner:** Cancer Performance

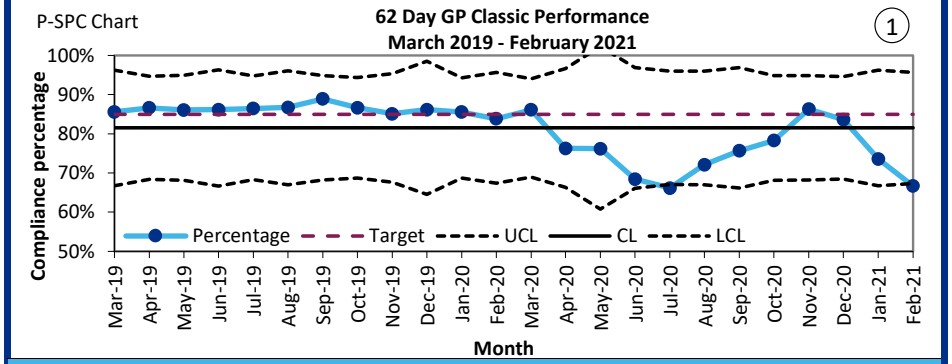
Key Narrative: 996 rapid access referrals were seen in February 2021, an increase of 1.8% from the previous month and above the 24-month average.

The 2 week wait performance has consistently delivered above the 93% standard with the exception of April 2020. February 2021 performance was 97.8%. The P-SPC chart adjusts the control limits to take into account the denominator.

Latest month's data provisional.

62 Day





	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
104+day Confirmed Cancer	0	3	2	1	8	20	7	2	3	3	5	4	2

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

Key Narrative: Provisional performance against the 62-day standard for February 2021 currently reported at 66.7% subject to validation of tertiary referrals and transfer dates, this is likely to improve.

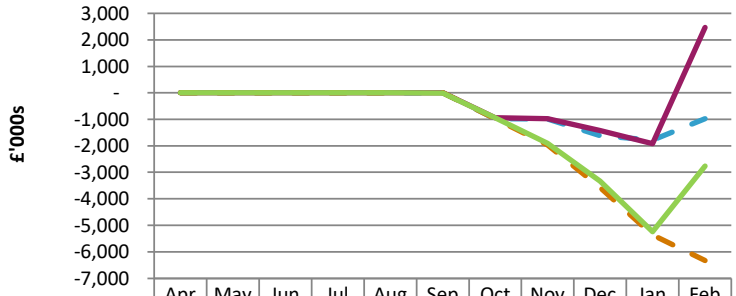
The P-SPC chart adjusts the control limits to take into account the denominator.

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	Jan	Feb
In Month Plan	-0	0	-0	-0	-0	-0	-979	-990	-1,6	-1,7	-975
In Month Actual	-1	0	-0	0	0	0	-936	-972	-1,4	-1,9	2,4
In Month Variance	-0	-0	-0	0	0	0	43	18	192	-135	3,4
Cumulative Plan	-0	-0	-0	-0	-0	-0	-979	-1,9	-3,5	-5,3	-6,3
Cumulative Actual	-1	-1	-1	-1	-1	-0	-936	-1,9	-3,3	-5,2	-2,7
Cumulative Variance	-0	-1	-1	-1	-1	-0	43	61	253	118	3,5

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 cumulative deficit at the end of February was £2.7m, and the Trust is in line to deliver a £6.9m deficit – which includes a provision for annual leave accrual of £3m.

The in-month surplus of £2.5m is better that the budgeted £1.0m deficit due to receipt of £2.7m compensation for lost non NHS footfall income, and additional other income receipts.

The previous forecast of £10.2m deficit has now been revised to £6.9m.

Forward view

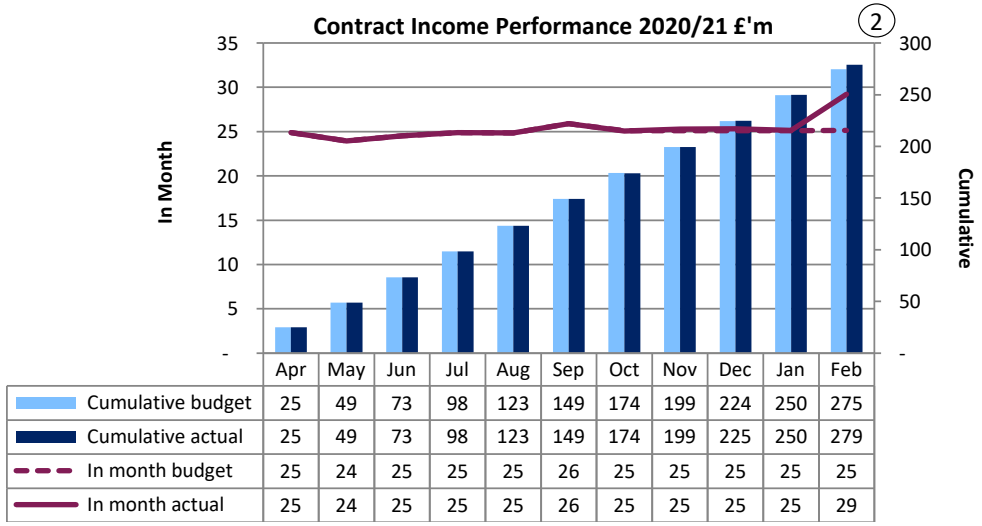
It is expected that the annual leave accrual will be funded, although the calculation will be based upon a national methodology. It is therefore expected that the Trust financial performance for the year will be in the region of a £3.9m deficit.

Looking ahead to 2021/22 – the first quarter of 2021/22 (April-June) will be an extension to the current financial arrangements of block payments to Trust with Covid top up funding being allocated at a C&M HCP system level for onward distribution. At the current time the financial figures for this first quarter are unknown.

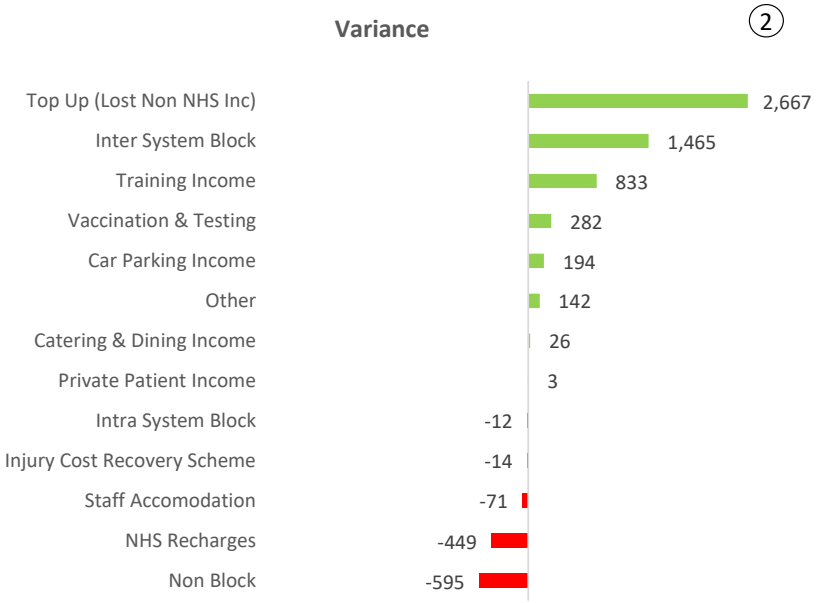
Planning guidance is expected in March to cover from the second quarter onwards.

Finance

Income



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Cumulative budget	25	49	73	98	123	149	174	199	224	250	275
Cumulative actual	25	49	73	98	123	149	174	199	225	250	279
In month budget	25	24	25	25	25	26	25	25	25	25	25
In month actual	25	24	25	25	25	26	25	25	25	25	29



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

Current View:

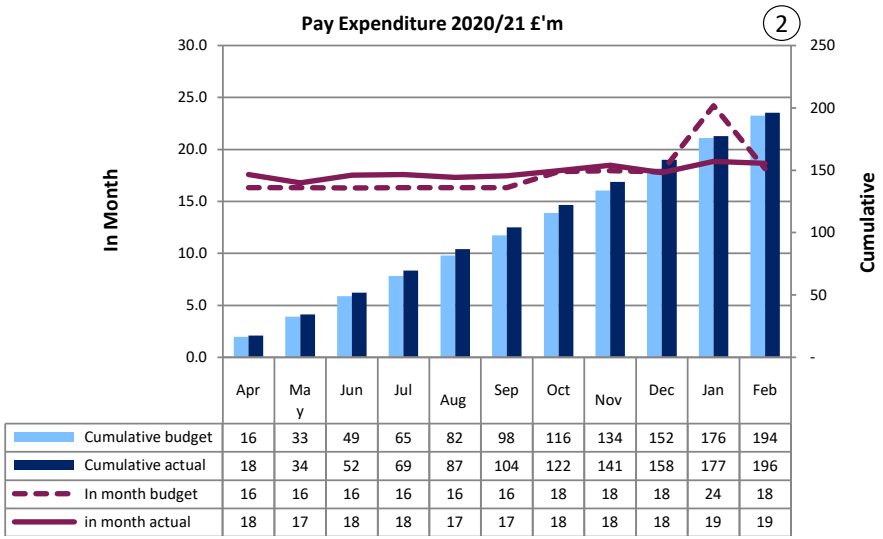
Income is £4.5m above plan, with the Trust receiving £2.7m in month for the loss of non NHS income. The other over performance relates to additional contract services including the PLACE funding and GP hot hubs, re-imbursement for vaccination, testing and increasing capacity contracts and additional training income.

Forward View:

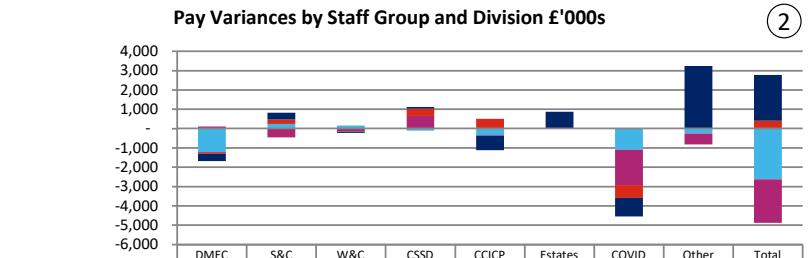
The regulatory expectation is organisations manage to a system control total into Q1 of 21/22. Above this there will be re-imbersements for expenditure relating to vaccination and testing costs which are expected to continue.

Finance

Pay



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Cumulative budget	16	33	49	65	82	98	116	134	152	176	194
Cumulative actual	18	34	52	69	87	104	122	141	158	177	196
In month budget	16	16	16	16	16	16	18	18	18	24	18
in month actual	18	17	18	18	17	17	18	18	18	19	19



	DMEC	S&C	W&C	CSSD	CCICP	Estates	COVID	Other	Total
Total	-1,580	371	-58	1,010	-616	871	-4,539	2,426	-2,116
Infrastructure Support Staff	-394	354	-64	73	-753	871	-955	3,239	2,370
Non Clinical Staff	-76	237	-7	388	505	-	-655	9	401
Medical Staff	105	-455	-147	657	-28	-	-1,828	-567	-2,262
Nursing Staff	-1,215	239	160	-108	-340	-	-1,101	-255	-2,621

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

Current View:

Cumulatively pay is above the October plan by £2.1m, which reflects the level of challenge on the workforce which has resulted from increase in covid admissions and requirement to increase the number of critical care beds and wards dedicated to medical admissions (and therefore increased acuity).

As the budgets have been re-aligned to reflect the October re-submitted plan – the key variances from the first 6 months have been consolidated with finalised top up payments, and agreement on plans.

Within the forecast the annual leave accrual has been calculated to be £3m, which is expected to be funded national although based upon a national methodology.

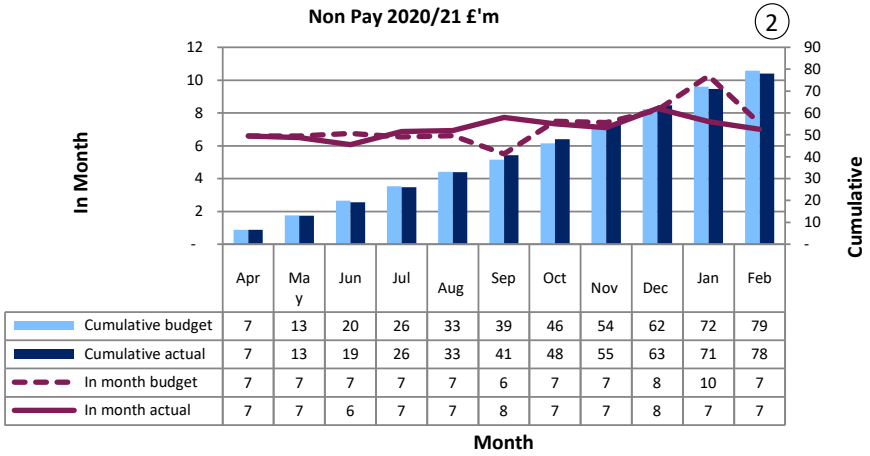
Forward View:

There is significant pressure on the pay budgets as a result of measures put in place to support the Trust with the pandemic during 20/21. Decisions the Trust has recently made around the incentive scheme will help ensure that some premium areas of cost will reduce from the 1st April.

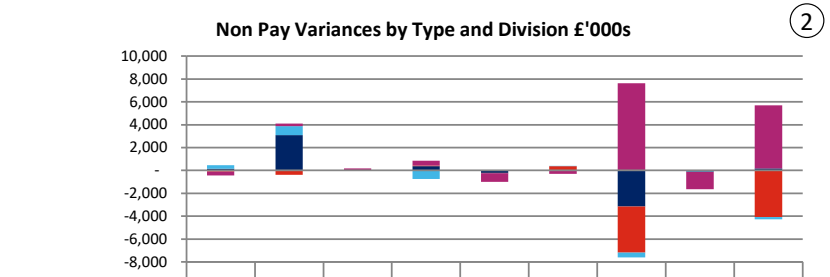
It is inevitable that a material element of the costs incurred this year will continue into next year, and therefore the key strategies that the Trust has had with recruitment such as the international nurse recruitment will be more important than ever in supporting a sustainable financial and workforce position.

Finance

Non-Pay



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Cumulative budget	7	13	20	26	33	39	46	54	62	72	79
Cumulative actual	7	13	19	26	33	41	48	55	63	71	78
In month budget	7	7	7	7	7	6	7	7	8	10	7
In month actual	7	7	6	7	7	8	7	7	8	7	7



	DMEC	S&C	W&C	CSSD	CCICP	Estates	COVID	Other	Total
Total	4	3,725	131	94	-1,000	81	-	-1,628	1,407
Other Non Pay	-347	240	149	397	-759	-300	7,615	-1,496	5,500
Drugs	290	775	-41	-747	-11	0	-438	-23	-195
Non Clinical Supplies	-99	-378	-6	56	-10	384	-4,037	2	-4,087
Clinical Supplies	160	3,088	28	388	-220	-3	-3,139	-111	190

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

Current View:

Non-Pay is better than plan by £1.4m, with the former overspends in the first 6 months of the year having been adjusted following receipt of months 1-6 top up payments.

There has been a continued regular supply of PPE from the national "push" stocks so it is expected that this trend will now continue to run at a reduced cost rate to the end of this financial year, which is a key part of the reduced expenditure. In other areas clinical supplies are better than budget, which is a result of the reduced planned care programme – leading to lower costs for surgical equipment.

Forward View:

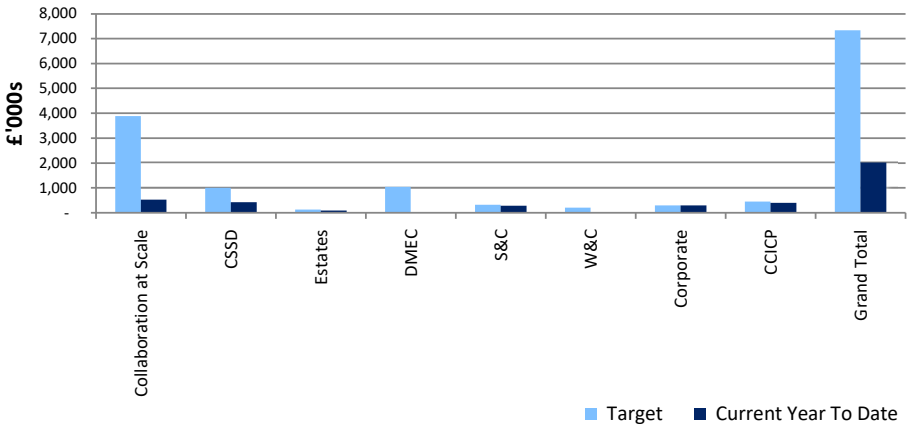
The balance and offsets of pay and non-pay is expected to continue into March whilst the peak of the pandemic subsides within the hospital.

Moving into the next financial year – it is anticipated that there will be an increase in the use of alternative providers as part of the restoration programme. The Trust will need to ensure appropriate governance frameworks are in place, and that the Trust looks to utilise the Increasing Capcity framework.

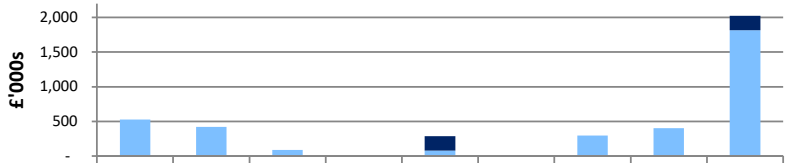
Finance

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	526	419	88		287	4	297	403	2,024
Pay					209				209
Non pay	526	419	88		78	4	297	403	1,815

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.

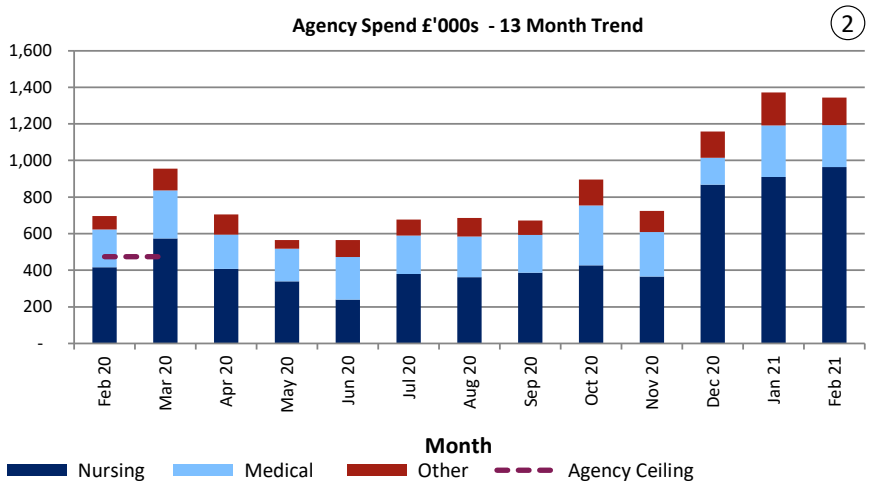
Forward View:

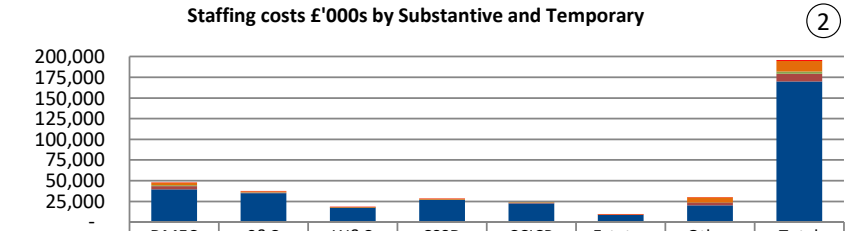
Work that the collaboration at scale work stream has previously put forward for system wide opportunities will be reviewed both in terms of time frames in light of the impact of Covid-19 - but also their direct impact on the Trust.

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	47,974	37,488	18,498	28,309	24,191	9,220	30,288	195,966
Waiting List	238	374	47	52	-	1	488	1,201
Bank	3,255	936	801	890	643	474	5,962	12,962
Locum	1,118	334	52	351	332	-	179	2,365
Agency	3,888	938	209	353	533	1	3,439	9,363
Substantive	39,474	34,905	17,389	26,662	22,682	8,743	20,219	170,075

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

Current View:

Agency expenditure was £1.4m in the month of February, reflecting the continuation of severe challenges from January - particularly within the nursing workforce.

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. Whilst the International Nurse Recruitment project has seen an additional 97 nurses to the Trust - the additional demand placed by the acuity and escalation beds has outstripeed this during 2020/21.

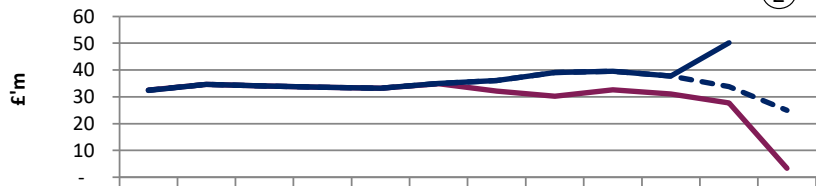
Forward View:

The Trust has been successful with securing additional funding to support recruitment of further international nurse recruits, as part of a Cheshire collaborative to increase workforce for the future. This will see an additional 68 nurses being recuirted to the Trust by the end of September 2021, and there are futher bids that the Trust is waiting on confirmation of.

Finance

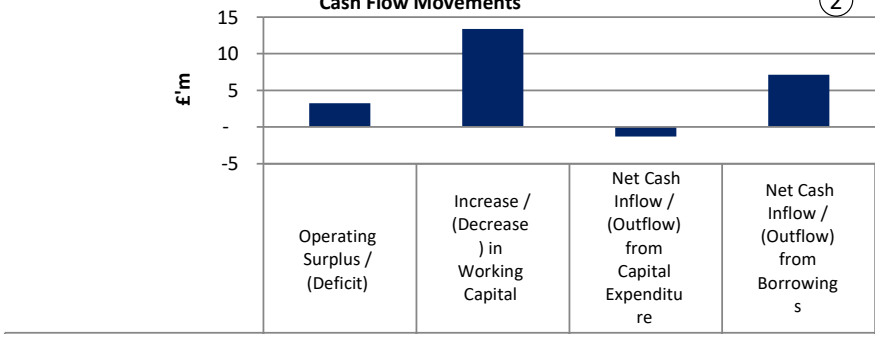
Cash

Cash Position ②



	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	38	50	
Forecast	32	35	34	34	33	35	36	39	40	38	34	25

Cash Flow Movements ②



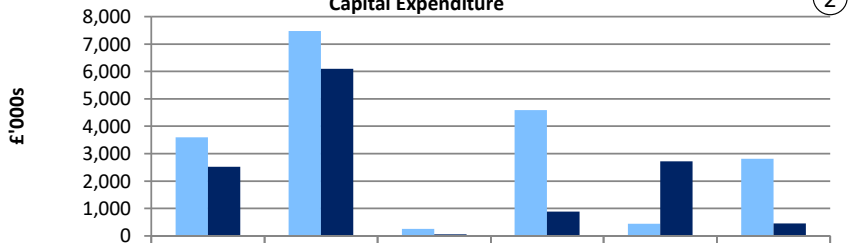
Accountable: Director of Finance **Data Owner:** Financial Services

Current View: Cash is better than anticipated by £22m. This is due to £6m drawdown of PDC funding for ED, lower Trade Receivables of £3.3m, £3.2m received for Non NHS Income, slippage on capital projects £1.3m and the receipt of £3.1m COVID top up, £0.8m Training income in advance, and a lower deficit than expected of £3.8m.

Forward View: The cash position includes £20m of contract income paid in advance, to be repaid in March 21. Cash is forecast to be £22m better than plan at year end, mainly due to an increase in capital creditors.

Capital

Capital Expenditure ②



	Rolling Estates	Strategic Estates	Rolling IT	Strategic IT	Other	Leases
Plan	3,599	7,478	257	4,584	445	2,814
Actual	2,521	6,095	52	884	2,714	451

②

		Year to Date £'000s			Year End £'000s		
		Plan	Actual	Variance	Plan	Forecast	Variance
Estates	Rolling	3,599	2,521	-1,078	4,292	4,879	587
Estates	Strategic	7,478	6,095	-1,383	8,223	6,784	-1,439
IT	Rolling	257	52	-205	353	52	-301
IT	Strategic	4,584	884	-3,700	5,655	1,483	-4,172
Other		445	2,714	2,269	11,152	10,517	-635
Leases		2,814	451	-2,363	3,679	591	-3,088
		19,177	**12,717**	**-6,460**	**33,354**	**24,306**	**-9,048**

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

Current View: The capital underspends are due to slippage on two major schemes, EPR Upgrade £2.2m and Maintenance & Refurbishment of £1.9m. Lease underspends of £2.4m are due to leases being assessed as Operating rather than Financial Leases.

Forward View: The EPR and EPMA schemes are expected to slip into 21/22 to the value of £3.1m. This is on the assumption that the full amounts will be utilised for

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

Finance

Statement of Financial Position February 2021

		Plan Apr to February (£'000)	Actual Apr to February (£'000)	Variance (£'000)
Assets	Assets, Non-Current	110,552	111,374	822
	Assets, Current	43,545	62,368	18,822
ASSETS, TOTAL		**154,097**	**173,742**	**19,644**
Liabilities	Liabilities, Current	-43,544	-53,705	-10,161
	Liabilities, Non Current	-9,547	-8,910	637
TOTAL ASSETS EMPLOYED		**101,006**	**111,127**	**10,121**
Taxpayers' and Others' Equity				
	Taxpayers Equity	101,006	111,127	10,121
TOTAL FUNDS EMPLOYED		**101,006**	**111,127**	**10,121**

② **Accountable:** Director of Finance **Data Owner:** Financial Services

Current View:
The main Balance Sheet movements are the improved cash position of £22m, and an increase is capital creditors of £3m due to work commencing on the ED expansion. Deferred Income remains high due to receiving a contract payments of £20m and COVID top ups of £3.2m in advance.

Taxpayers Equity is £6m higher than the original plan, due to the PDC Drawdown for the ED expansion .

Forward View:
For year end, the main movements expected are the increases in PDC Drawdown for ED and Critical Care capital schemes, as well as the

COVID Capital Schemes February 2021

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 and the funding has been received.

Finance

Income and Expenditure

Budget 2020/21 £'000			Month			Year to Date			Forecast
			Plan Feb (£'000)	Actual Feb (£'000)	Variance Feb (£'000)	Plan April to Feb (£'000)	Actual April to Feb (£'000)	Variance April to Feb (£'000)	2020/21 (£'000)
	Operating								
	Operating Income								
	Commissioning Income								
222,328		Inter System Block	18,682	19,012	330	203,646	204,659	1,012	222,328
19,555		Intra System Block	1,453	1,475	21	15,988	15,975	(12)	19,555
0		Non Block	249	188	(61)	2,092	1,498	(595)	0
241,883	**Total Commissioning Revenue**		**20,384**	**20,675**	**290**	**221,726**	**222,132**	**406**	**241,883**
21,185	*Other Operating Income*		1,438	2,211	774	28,703	19,803	(8,900)	21,185
263,068	**TOTAL OPERATING INCOME**		**21,822**	**22,886**	**1,064**	**250,429**	**241,934**	**(8,494)**	**263,068**
	Operating Expenses								
(211,667)		Employee Benefits Expenses (Pay)	(18,133)	(18,676)	(543)	(193,850)	(195,966)	(2,116)	(211,667)
(17,803)		Drugs	(1,230)	(1,667)	(437)	(16,070)	(16,265)	(195)	(17,803)
(19,388)		Clinical Supplies	838	(1,160)	(1,998)	(14,722)	(14,532)	190	(19,338)
(3,725)		Non Clinical Supplies	2,236	(341)	(2,577)	(1,820)	(5,907)	(4,087)	(3,385)
(48,664)		Other operating expenses	(9,223)	(3,843)	5,380	(46,749)	(41,249)	5,500	(49,264)
(301,248)	**TOTAL OPERATING EXPENSES**		**(25,513)**	**(25,687)**	**(174)**	**(273,210)**	**(273,920)**	**(709)**	**(301,458)**
(38,180)	**EBITDA**		**(3,691)**	**(2,801)**	**890**	**(22,782)**	**(31,985)**	**(9,204)**	**(38,390)**
	Non Operating								
	Non Operating Income								
(379)		Interest	110	(22)	(132)	(190)	(166)	24	(379)
0		Asset disposal	0	0	0	0	0	0	0
	Non-Operating Expenses								
(6,432)		Depreciation & Finance Leases	(376)	(480)	(104)	(5,739)	(5,375)	364	(6,332)
(2,160)		PDC Dividend Expense	(107)	(180)	(73)	(1,980)	(1,980)	(0)	(1,910)
(47,151)	**Adjusted Financial Performance surplus/(deficit)**		**(4,063)**	**(3,483)**	**581**	**(30,691)**	**(39,507)**	**(8,816)**	**(47,011)**
8,762		Baseline M1 - 6	0	0	0	8,762	8,762	0	8,762
9,665		COVID Top Up M1 - 6	0	0	0	0	9,665	9,665	9,665
9,798		Baseline M7-12	1,633	1,633	0	8,165	8,165	0	9,798
8,736		COVID Top Up M7 - 12	1,456	1,456	0	7,280	7,280	0	8,736
0		COVID Additional	0	2,869	2,869	0	2,869	2,869	3,200
(10,190)	**Net Surplus/(deficit) before Exceptional Items**		**(974)**	**2,475**	**3,450**	**(6,483)**	**(2,765)**	**3,718**	**(6,850)**
0		Donations for purchase of assets	0	0	0	0	50	50	0
0		Depreciation on Donated Assets	0	(25)	(25)	0	(274)	(274)	0
		Remove capital donations/grants I&E impa	0	25	25	150	223	73	0
0		Prior Period Adjustments	0	0	0	0	0	0	0
(10,190)	**Net Surplus/(Deficit) after Exceptional Items**		**(974)**	**2,475**	**3,450**	**(6,333)**	**(2,767)**	**3,567**	**(6,850)**

Finance

Balance Sheet

Assets Non-Current
The capital programme expenditure is £6.1m less than the anticipated plan, mainly due to slippage on the EPR upgrade of £2.2m and Maintenance & Refurbishment £1.9m. Finance Lease underspend of £2.4m due to leases being assessed as Operating Leases.

Assets Current
Cash is better than plan by £22m mainly due to £6m drawdown of PDC funding for ED, lower Trade Receivables of £3.3, £3.2m received for Non NHS Income, slippage on capital projects and the receipt of £3.1m COVID tip up and £0.8m Training 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
Trade Payables increase in month of £3m due to capital creditor for the ED build. 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.

Taxpayers Equity
Public Dividend Capital is higher than plan due to the drawndown of ED funding.

	Plan Apr to February (£'000)	Actual Apr to February (£'000)	Variance (£'000)
Assets			
Assets, Non-Current	**110,552**	**111,374**	**822**
Assets, Current			
Trade and other Receivables	9,816	6,496	-3,321
Other Assets (including Inventories & Prepayments)	5,961	5,676	-285
Cash and Cash Equivalents	27,767	50,196	22,428
Total Assets, Current	**43,545**	**62,368**	**18,822**
ASSETS, TOTAL	**154,097**	**173,742**	**19,644**
Liabilities			
Liabilities, Current			
Finance Lease, Current	-223	-16	208
Loans Commercial Current	-13	-7	6
Trade and Other Payables, Current	-12,040	-15,699	-3,659
Provisions, Current	-207	-355	-148
Other Financial Liabilities	-31,062	-37,629	-6,567
Total Liabilities, Current	**-43,544**	**-53,705**	**-10,161**
Net Current Assets/(Liabilities)	**1**	**8,663**	**8,662**
Liabilities, Non Current			
Finance Lease, Non Current	-3,948	-3,392	556
Loans Commercial Non-Current	-3,651	-3,651	0
Provisions, Non-Current	-1,948	-1,867	81
Trade and Other Payables, Non-Current	0	0	0
Total Liabilities Non-Current	**-9,547**	**-8,910**	**637**
TOTAL ASSETS EMPLOYED	**101,006**	**111,127**	**10,121**
Taxpayers' and Others' Equity			
Taxpayers Equity			
Public dividend capital	101,720	108,328	6,607
Retained Earnings	-17,999	-14,486	3,513
Donated asset reserve	0	0	0
Revaluation Reserve	17,285	17,285	0
TOTAL TAXPAYERS EQUITY	**101,006**	**111,127**	**10,121**
TOTAL FUNDS EMPLOYED	**101,006**	**111,127**	**10,121**

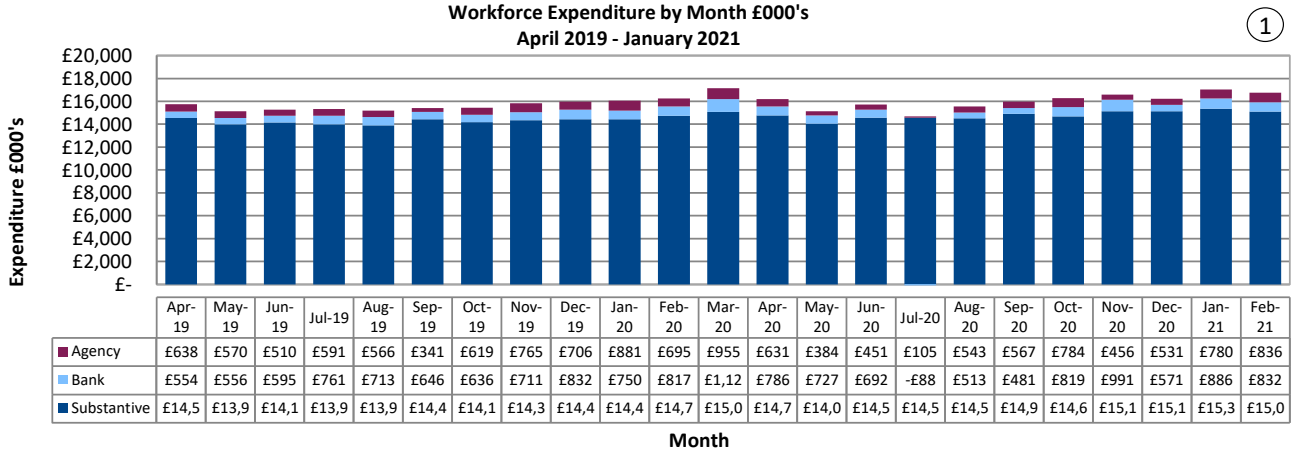
Forward View:

The forecast has been updated to include additional PDC funding and capital spend in relation to the ED build £9.4m, £2.1m Critical Care 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

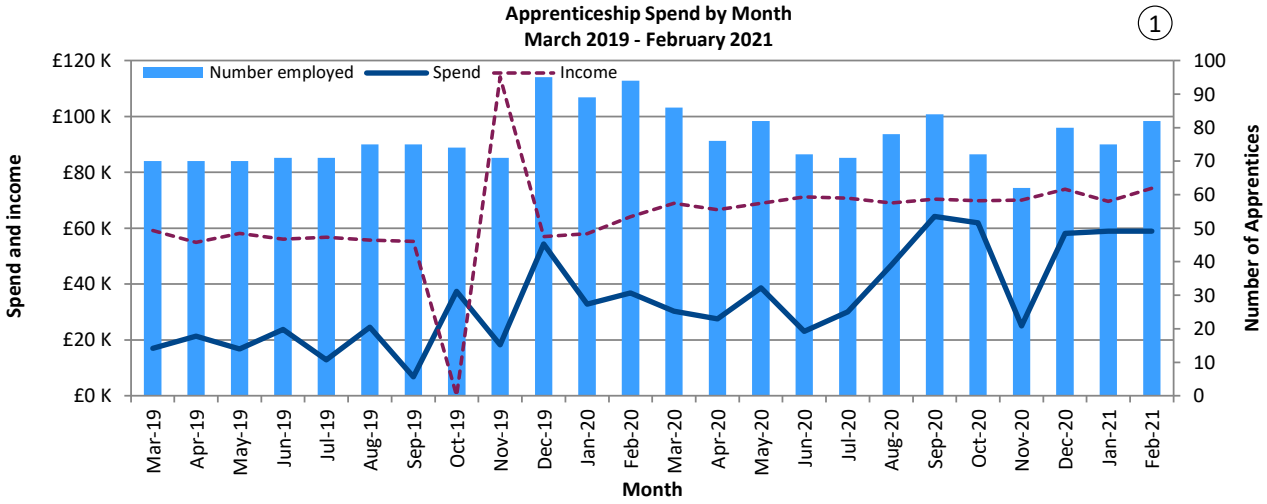
Finance and Costings



	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	Jan-21	Feb-21
Agency	£638	£570	£510	£591	£566	£341	£619	£765	£706	£881	£695	£955	£631	£384	£451	£105	£543	£567	£784	£456	£531	£780	£836
Bank	£554	£556	£595	£761	£713	£646	£636	£711	£832	£750	£817	£1,12	£786	£727	£692	-£88	£513	£481	£819	£991	£571	£886	£832
Substantive	£14,5	£13,9	£14,1	£13,9	£13,9	£14,4	£14,1	£14,3	£14,4	£14,4	£14,7	£15,0	£14,7	£14,0	£14,5	£14,5	£14,5	£14,9	£14,6	£15,1	£15,1	£15,3	£15,0

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

Key Narrative: Total workforce expenditure for February 2021 is £16,765k, a decrease of £270k (1.6%) from the previous month but 3.2% higher than February 2020. The year to date expenditure is £1,943k below budget (-1.1%).



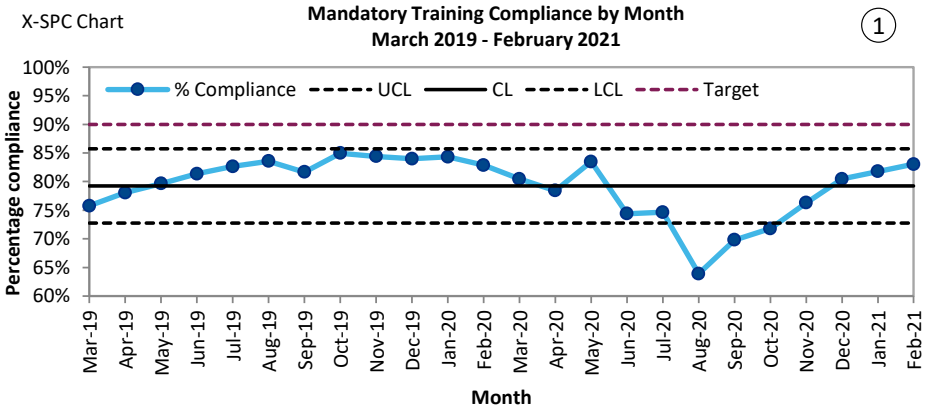
Accountable: Director of Workforce & Organisational Development
Data Owner: Workforce Directorate

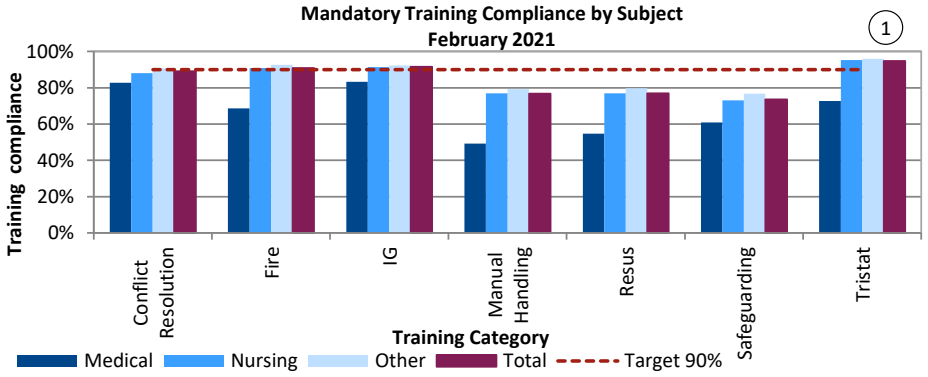
Key Narrative: The number of Apprentices employed in February 2021 was 82, 12.8% lower than the number employed in February 2020 (94).

Apprenticeship spend remains below income.

Workforce

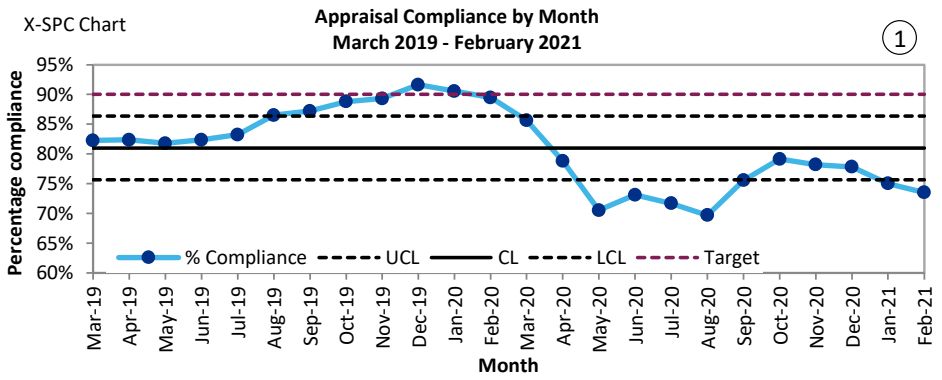
Training

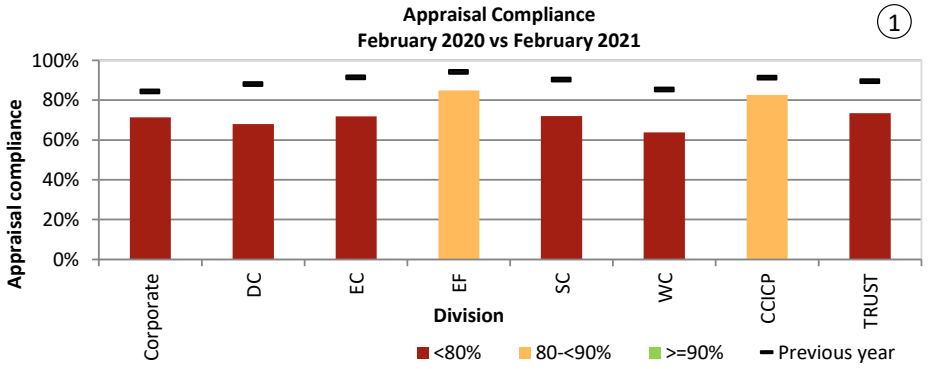




Accountable: Director of Workforce & Organisational Development
Data Owner: Workforce Directorate
Key Narrative: Mandatory training compliance has been improving over the last 6 months achieving 83.0% in February 2021 from the lowest compliance of 63.9% reported in August 2020. Training compliance remains below the 90% target.

Appraisals

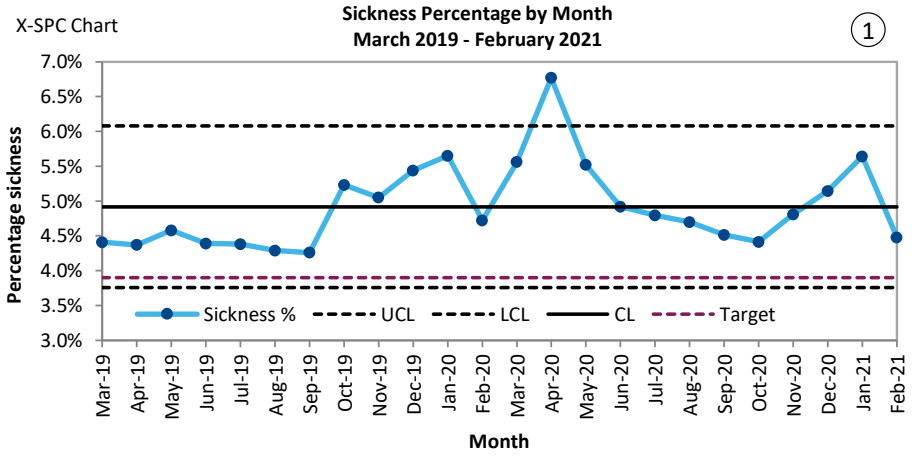




Accountable: Director of Workforce & Organisational Development
Data Owner: Workforce Directorate
Key Narrative: The reported appraisal compliance for February 2021 is 73.5%, a slight decline from the 75.0% compliance reported in January 2021. Appraisal compliance remains below the target rate of 90% which was only achieved in December 2019 and January 2020 over the 24-month period shown.

Workforce

Sickness

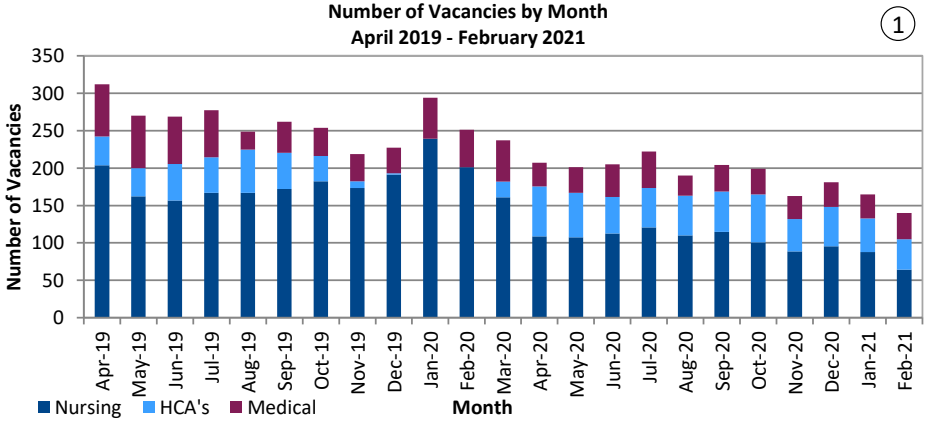


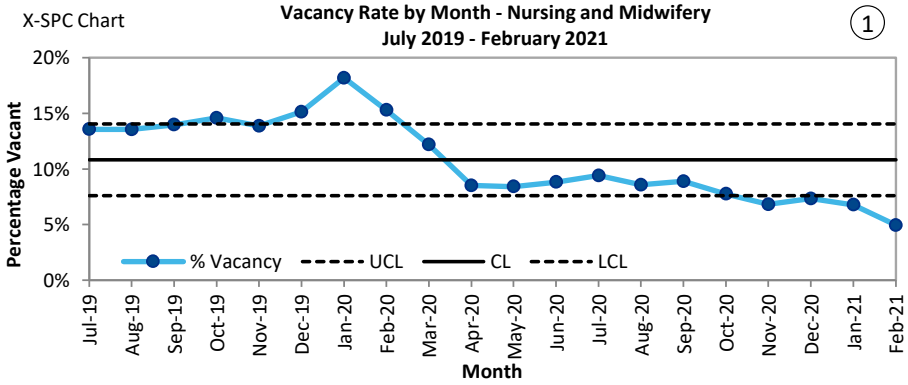
Accountable: Director of Workforce & Organisational Development
Data Owner: Workforce Directorate

Key Narrative: The sickness rate for February 2021 was 4.5%, a decrease to the 5.6% sickness rate reporting for January 2021 and similar to the sickness rate reported in February 2020 (4.7%).

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

Vacancies

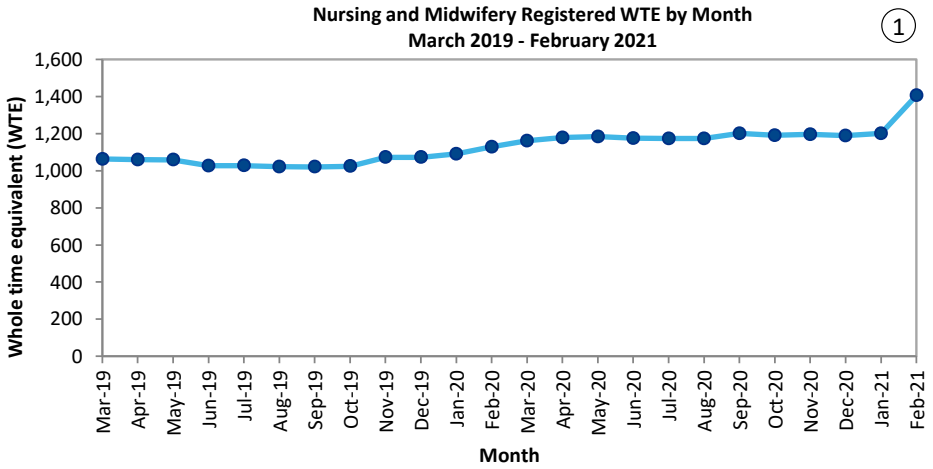


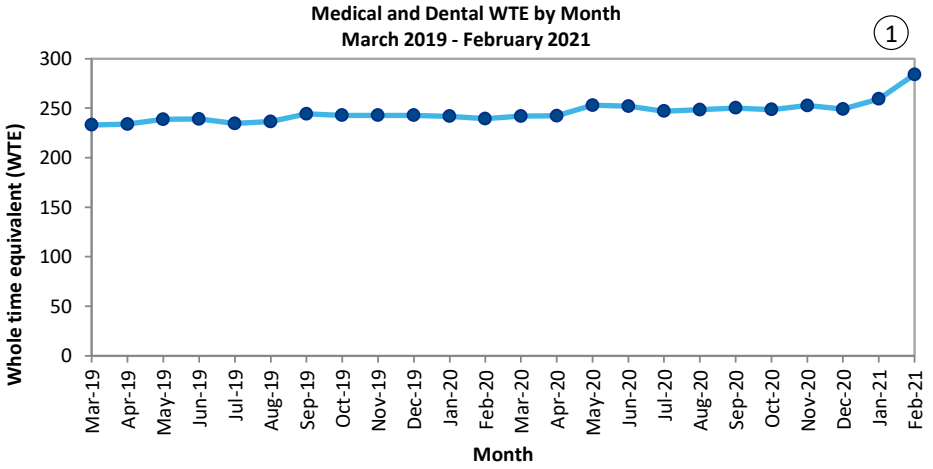


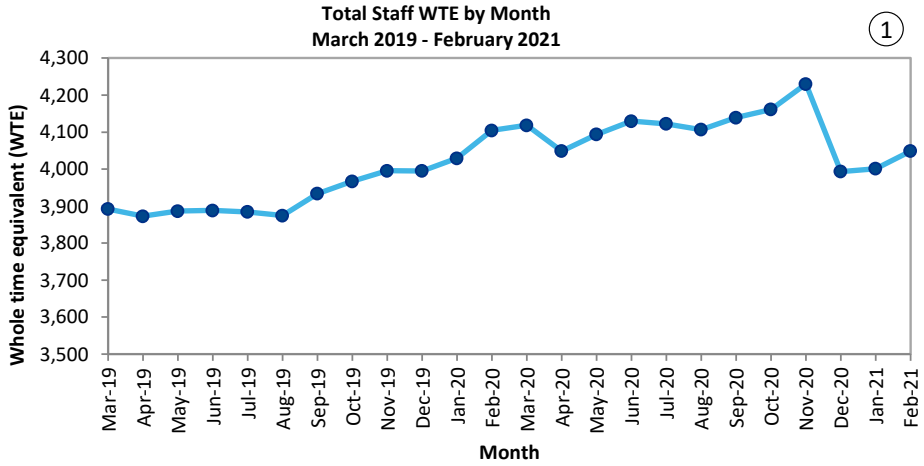
Accountable: Director of Workforce & Organisational Development
Data Owner: Workforce Directorate
Key Narrative: The vacancy figures for the current financial year have been restated to exclude International Recruitment, Nurse Apprentices and COVID. There has been a marked improvement in the number and percentage of vacancies in the current financial year with a vacancy rate of 4.9% in February 2021.

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 342.8 WTE (32.2%) over the 24-month period and Medical and Dental staff by 50.9 (21.9%).

The Pathology Services (~278 staff, 243.8 WTE) transferred across to UHNM on the 1st December 2020 via a TUPE process, accounting for a drop in WTE of total staff from December 2020.

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

Mid Cheshire Hospitals NHS Foundation Trust

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

Report to	Board of Directors
Date	17 February 2021
Report from	Lesley Massey, NED Chair
Report prepared by	Caroline Keating, Company Secretary
Executive Lead/s	Julie Tunney, Director of Nursing & Quality Murray Luckas, Medical Director
Committee meeting quoracy	Yes ☒ No ☐

KEY AREAS OF ASSURANCE

Effectiveness & Performance Review – Survey Outcomes: these identified the Committee was developing in its maturity and was in a good position to have a more strategic focus on its remit in 2021/22. The areas of potential focus for next year would be considered at the March meeting, in conjunction with the desk top review and consideration of the Terms of Reference.

BAF Q3 2020/21 Committee Delegated Risks: two BAF risks considered – BAF 3 and BAF 8. The approach to taking Quality Improvement (BAF8) forward within the Trust was under consideration by the Chief Executive. This might have implications for the ToR for the Quality and Workforce & Digital Transformation Committees.

The need for effective communication between Committees was considered crucial. BAF 3 was given as an example where the portfolios of two Exec Directors overlapped.

Integrated Performance Report (IPR): areas highlighted were the reduction in the community Covid-19 infection rate, the reduced number of Covid-19 positive patients currently in the hospital although patient acuity on Covid wards was high with complex needs; the relatively high number of patients on the Critical Care Unit; improved compliance with patients wearing masks on wards. Other areas included a significant reduction in acute patient safety incidents, due to fewer forms being completed – a review of data for incidents resulting in harm was being undertaken; pressure ulcer rates now in line with expectations; minor slippage in complaints responses performance with a remedial action plan in place

Q&S Improvement Strategy Q1 & 2 – Partial Assurance: quality meetings held with reduced frequency during the pandemic with focus on Preventing deterioration and sepsis; Medicines safety; Maternal and neonatal safety; and End of Life Care. The latter will be a dedicated priority programme in 2021/22.

Partial compliance relates to the Trust being an outlier in the NW for Post-Partum Haemorrhage (PPH) (where more than 1500 mls of blood was lost). Actions had been taken to improve compliance, including a PPH risk assessment and management checklist.

R&D Priorities: Committee approved the NIHR Covid Urgent Public Health studies, increasing the Department's visibility and accountability through the Trust's governance structure; better use of information and date; robust annual planning/governance cycle; focus on the team; development of a 3 year strategy.

Trauma Audit & Research Network (TARN): good progress demonstrated with key achievements cited as Paediatric nurse in ED 12 hours per day; on-going excellent data completeness, CT scanning. However, the Trust was not compliant with the standard of all patients receiving the CT scan within 60 minutes ('Time to CT'), due to increased use of CT during Covid and taken for staff to accompany a patient for each CT scan. The possible solution of a CT scanner in the Emergency Department was proposed; to be taken back to the Division for further consideration.

Serious Incidents January 2021 – Acceptable Assurance: overview provided of five StEIS incidents, including actions taken to prevent further occurrences. Positive feedback had been received from Cheshire Clinical Commissioning Group (CCG) relating to the level of assurance derived from the immediate actions. Committee assurance was taken that processes were in place to identify, investigate and learn from serious incidents.

Learning from Deaths Q3 – Acceptable Assurance: Trust mortality rates remain in a stable position. A more detailed report would be submitted in future, to include greater clinical detail and individual cases of potentially avoidable deaths.

Duty of Candour – a breach to compliance had resulted in the CCG requiring that the Board be sighted on the Duty of Candour [process]. The Q&S Committee had requested sight of the action plan in March 2021.

KEY CONCERNS/RISKS

No items raised

Priority Areas: DECISIONS MADE

R&D Priorities

RECOMMENDATION

To note.

Mid Cheshire Hospitals NHS Foundation Trust

Quality & Safety Committee (QSC)
Chair's Assurance Report
March 2021

Report to	Board of Directors
Date	17 March 2021
Report from	Lesley Massey, NED Chair
Report prepared by	Caroline Keating, Company Secretary
Executive Lead/s	Murray Luckas, Medical Director Sally Mann, Deputy Director of Nursing *(representing Julie Tunney, Director of Nursing & Quality)*
Committee meeting quoracy	Yes ☒ No ☐

KEY AREAS OF ASSURANCE

Annual Committee Effectiveness Evaluation - Acceptable Assurance: desk top review concluded Committee's focus in 2020/21 was focused correctly on those duties delegated to it by the Board through its Terms of Reference (ToR).

Terms of Reference/ Workplan: New ToR discussed and agreed. Workplan for 2021/22 broadly correct; further work to be undertaken to consider the assurance mechanisms for the more detailed duties identified in the ToR.

Integrated Performance Report (IPR): Patient safety incident graphs now distinguish those incidents resulting in moderate or higher harm separately from low harm. Review into increased harm incidents in December and January concluded this was due to nosocomial incidents which are required to be reported as moderate harm. Numbers subsequently improved in February. Decline in VTE (Venous thromboembolism) assessments is being monitored but remains within control limits. Incidents of Pressure Ulcers continue to vary month to month; outputs from a deep dive to be reported back to Committee.

Covid-19: 32 inpatients remain with minimal numbers of nosocomial infections being reported. After action review planned alongside mortality reviews using the Structured Judgement Review (SJR) process. Regional Medical Directors' approach is to focus on lessons learnt as well as avoidability.

Executive Quality Governance Group Chair's Report: risk approach being embedded in this group and its sub-groups. Committee challenged Upper GI bleed risk as reported as unchanged (risk score 20). Verbal update advised that this risk is being addressed through workforce investment which will in time result in repatriation of pathway and closure of the risk.

Serious Incidents February 2021 – Acceptable Assurance: Overview provided of six Strategic Executive Information System (StEIS) incidents, including actions taken to prevent recurrence and lessons learnt. A more open approach to StEIS reporting has led to greater reporting numbers over time, reflecting a positive learning culture and is an approach to be encouraged. Thematic bi-annual review of themes from serious incidents to be added to Committee 2021/22 workplan.

NWICC 4955 Limited implementation of measures to reduce nosocomial spread of COVID-19 in hip fracture patients in the NW of England: Audit response completed as requested by NHS Northwest to all Trusts. Four areas of compliance and three areas of non-compliance identified; latter challenging to achieve outside specialist orthopaedic units.

Clinical Negligence Scheme for Trusts 3 (CNST) Update - Partial Assurance: six areas compliant; four in progress. Plans are in place to achieve the remaining areas by submission date of 15 July 2021. Full report to be submitted to the Board in May.

Maternity and Neonatal Safety - Partial Assurance: review to be undertaken with assurance provided to Committee in April 2021.

Complaints and Concern: Dashboard to be reviewed to ensure QSC and the Board have sufficient oversight of complaints. Additional report under development.

KEY CONCERNS/RISKS

- Assurance on maternity and neonatal safety in light of the Ockenden report on maternal and baby safety.

Priority Areas: DECISIONS MADE

- Committee Terms of Reference agreed for submission to Audit Committee and subsequent approval by Board

RECOMMENDATION

To note.

BOARD OF DIRECTORS

Agenda Item	**10.1**	Date of Meeting: 15/03/2021
Report Title	**Learning from Deaths Report Q3 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 to Trust Board in line with national recommendations.

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	
• 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

Learning from Deaths Quarterly Report Q3 2020/21

January 2020

'Delivering Excellence in Healthcare through Innovation and Collaboration'

Contents

1.0 Introduction

Background

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

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

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

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

Purpose

This is the fourteenth iteration of our Learning from Deaths Report covering Quarter 3 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.

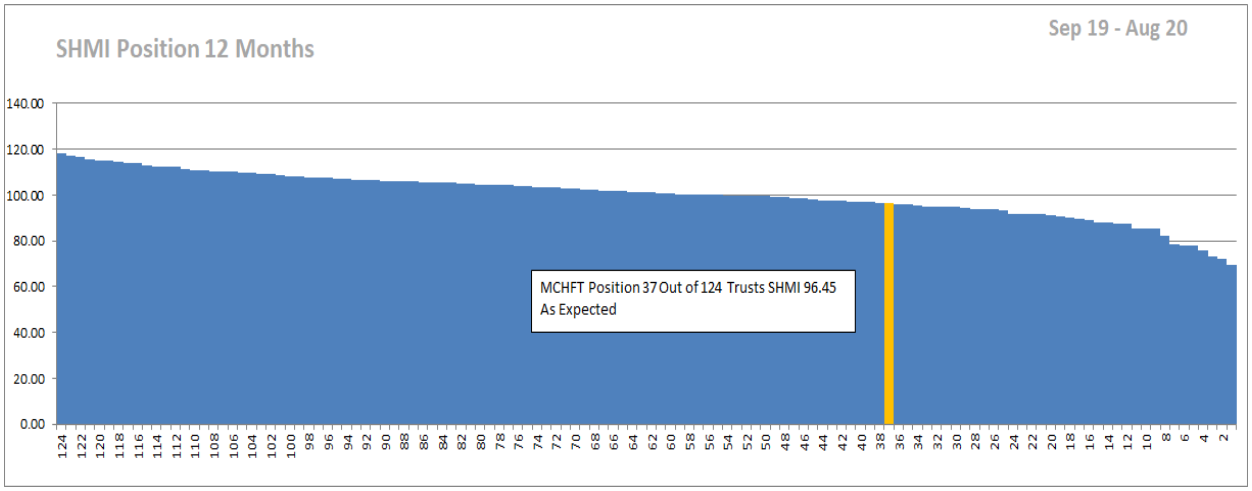
Appendices 6.2 and 6.3 provide a glossary of key terms.

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) September 2019 to August 2020

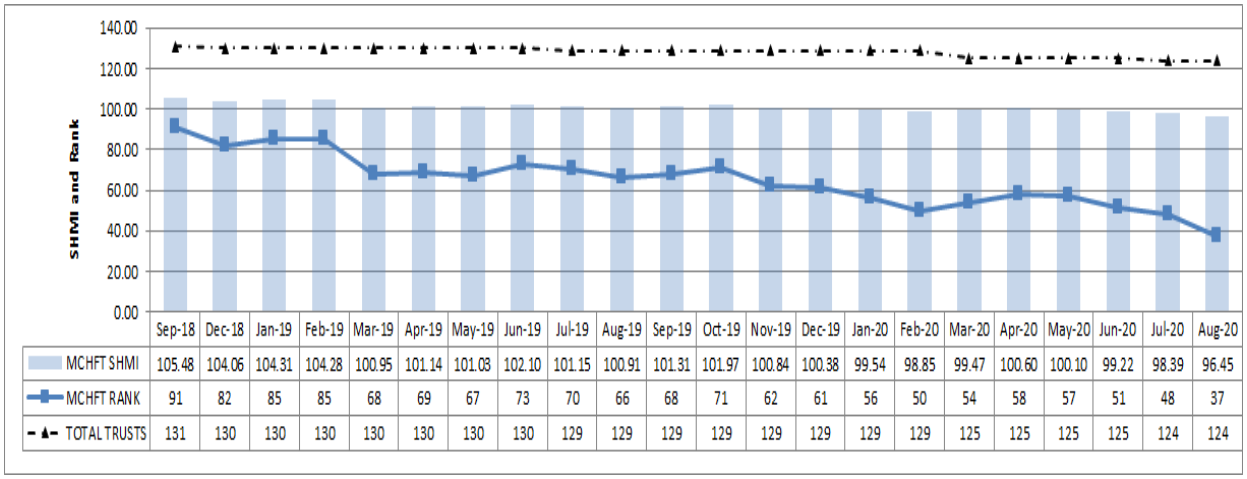
Chart 1 - SHMI Position



(Source NHS Digital, 2021)

Chart 1 demonstrates the SHMI position for the reporting period September 2019 to August 2020. The SHMI is currently 96.45 and is as 'expected'. This currently places the Trust 37 out of 124 Trusts, an improving position.

Chart 2 - 12 month rolling SHMI and position



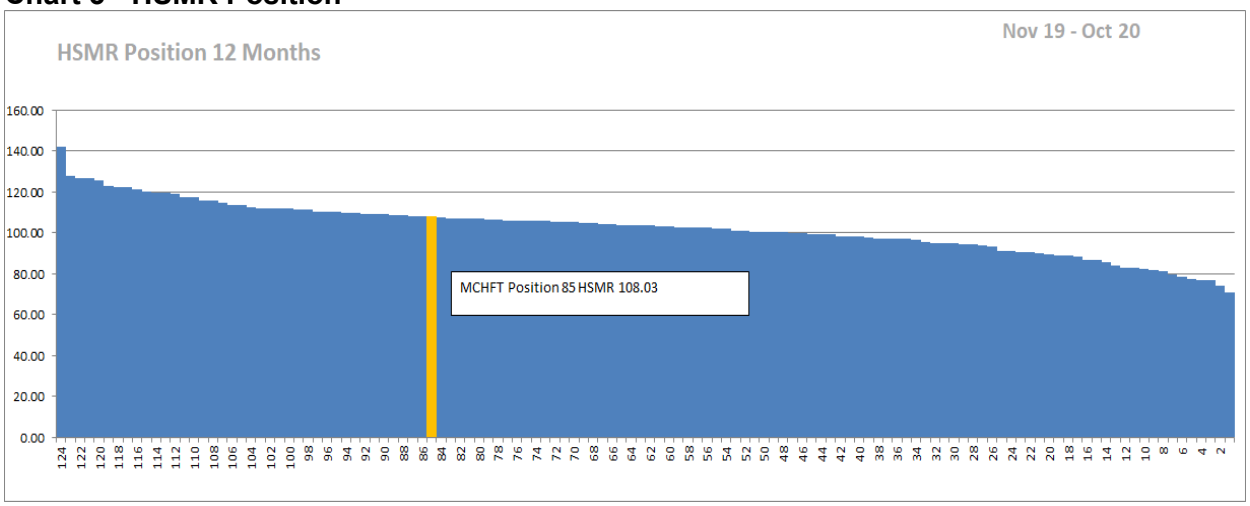
	Sep-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20
MCHFT SHMI	105.48	104.06	104.31	104.28	100.95	101.14	101.03	102.10	101.15	100.91	101.31	101.97	100.84	100.38	99.54	98.85	99.47	100.60	100.10	99.22	98.39	96.45
MCHFT RANK	91	82	85	85	68	69	67	73	70	66	68	71	62	61	56	50	54	58	57	51	48	37
TOTAL TRUSTS	131	130	130	130	130	130	130	130	129	129	129	129	129	129	129	129	125	125	125	125	124	124

(Source NHS Digital, 2021)

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

2.2 Hospital Standardised Mortality Rate (HSMR) November 2019 to October 2020

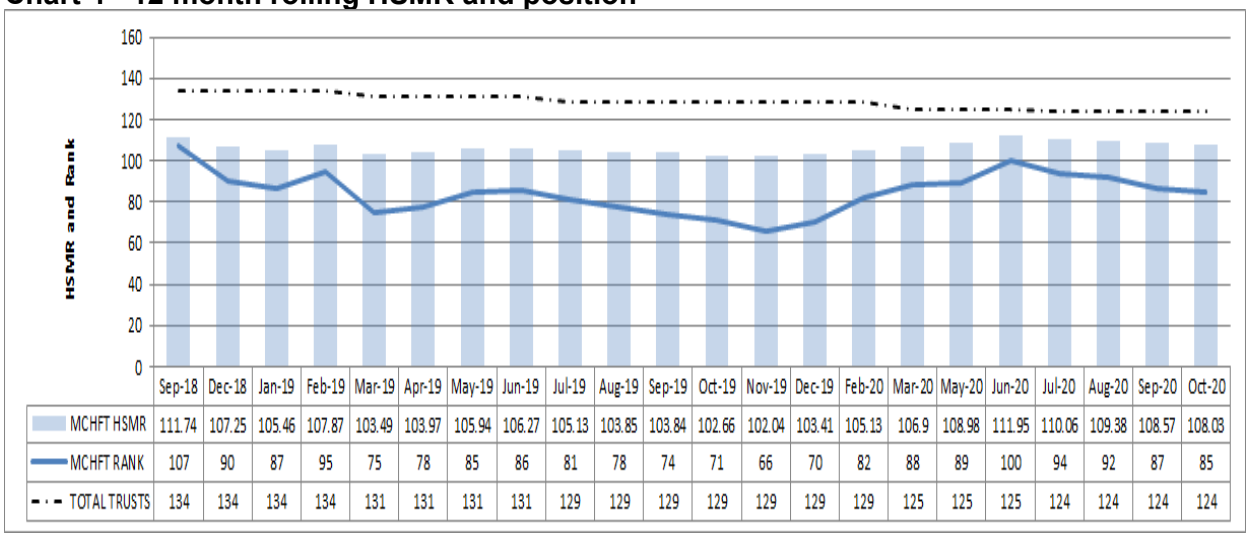
Chart 3 - HSMR Position



(Source HED, 2021)

Chart 3 demonstrates the HSMR position for the reporting period November 2019 to October 2020. The HSMR is currently 108.03 and is as 'expected, this places the Trust 85 out of 124 Trusts.

Chart 4 - 12 month rolling HSMR and position



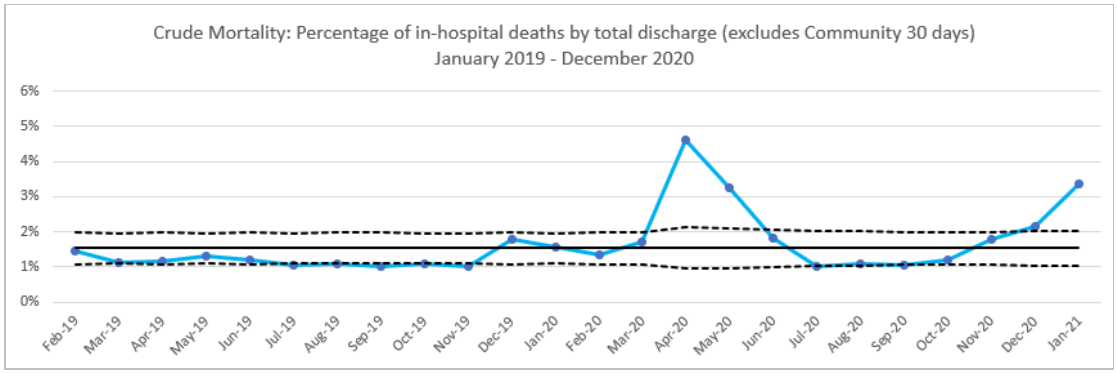
	Sep-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Feb-20	Mar-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
MCHFT HSMR	111.74	107.25	105.46	107.87	103.49	103.97	105.94	106.27	105.13	103.85	103.84	102.66	102.04	103.41	105.13	106.9	108.98	111.95	110.06	109.38	108.57	108.03
MCHFT RANK	107	90	87	95	75	78	85	86	81	78	74	71	66	70	82	88	89	100	94	92	87	85
TOTAL TRUSTS	134	134	134	134	131	131	131	131	129	129	129	129	129	129	129	125	125	125	124	124	124	124

(Source HED, 2021)

Chart 4 demonstrates the HSMR and rank of the Trust over time, up to the latest reporting period.

2.3 Crude Mortality – Rolling 12 months

Chart 5 - Crude Mortality



(Source HED, 2021)

Chart 5 demonstrates the crude death rate for the period up to January 2021. The in-hospital crude death rate has increased during the first and second waves of the Covid-19 pandemic which 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.

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
122	108	0	0	0	1	0	1	1	3
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
305	169	0	0	1	4	1	0	4	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
873	1033	0	621	5	129	1	0	6	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 4 learning disability deaths that have been reviewed to date in 2020/21 have been classed as definitely not preventable. Overall care was classed as good in three cases and adequate in the final case. Learning will be shared through the LfD Newsletter.

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
1	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
2	2	1	2	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
5	5	4	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 (10 January 2021). The Trust undertakes an in-depth case note review in response to any Mortality Outlier Alert.

Key Messages

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

Number of outlier alerts for this Trust as at 14 December 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 underwent 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.

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 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. These have however been on hold during the Covid-19 pandemic.

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 Associate Medical Director for Patient Safety. 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. However, the Trust have continued to undertake SJRs for,

- all learning disability deaths
- all patients who have been diagnosed with a severe mental health illness.
- incident reviews which have suggested an SJR is required
- all complaints received where the patient has died
- potentially avoidable nosocomial Covid-19 infections

4.2 Summary of potentially avoidable deaths in Q3 2020/21

One investigation from quarter 2 of 2020/21 has been escalated as a potentially avoidable death following the comprehensive investigation.

- Incident number: 122277
  Between 2016 and 2018 The Trust failed to arrange routine screening scans for a 54-year-old patient with alcohol related cirrhosis of the liver. This led to a delay in the diagnosis of liver cancer from which the patient subsequently died.
  Following a comprehensive investigation, an action plan has been enacted to include orientation of locum medical staff with local policies, a failsafe mechanism for patients who decline scans and confirmation that all patients with liver cirrhosis were on the correct follow up pathway.

Five potentially avoidable deaths have been identified in quarter 3 of 2020/21.

- Incident number: 127023
  In 2016, The Trust failed to arrange further investigations for a 75-year-old patient in whom a CT scan which demonstrated an incidental liver abnormality. This led to the delay in diagnosing a liver cancer. The patient subsequently died from a combination of the liver cancer and myasthenia gravis.
  Preliminary Investigation has confirmed that since 2018, a new reporting mechanism would have flagged this patient to the appropriate clinical team which in all probability would have prevented this delay in diagnosis.

- Incident number: 125740
  A patient was admitted with an upper gastrointestinal bleed. In accordance with our pathway, the patient was offered transfer to UHNM, which the patient declined. Local endoscopy was delayed because of concerns about the patient's covid status which resulted in the patient leaving the hospital against medical advice. He was subsequently admitted with a further bleed from which he sadly died despite emergency transfer.
  Preliminary investigation has confirmed that the Trust now employs front of house testing which together with a new pathway would have likely resulted in an earlier on-site endoscopy.

- Incident number: 115392
  An elderly patient with type 2 diabetes admitted with pancreatitis developed a rare complication of his diabetes. This was not recognised leading to a delay in treatment. Subsequently, the patient died due to a combination of his pancreatitis and diabetic complication.
  Following comprehensive investigation, number of actions have been taken including Trust wide training in the recognition and treatment of this condition together raised awareness about involving the diabetic specialist nurses with patients with pancreatitis.

- Incident number: 129572
  A patient was admitted shortly after major chest surgery for lung cancer with a diagnosis of pulmonary embolus. There was a failure to administer medication in a timely factor which may have prevented his demise from his pulmonary embolus.
  Following preliminary investigation, immediate actions include managing all complex patients on specialist wards and increased awareness of the importance of communicating prescribed medication to nursing staff.

- Incident number: 127371
  A 92-year-old patient admitted with a stroke contracted nosocomial Covid-19 following contact with a patient who had been admitted unscreened directly from clinic who had asymptomatic Covid-19 infection. Sadly the 92-year-old gentleman died from his nosocomial infection.
  Following investigation an immediate action was to expand the screening and subsequent cohorting of patients admitted to the Hospital to include all portals of entry including outpatient clinics .

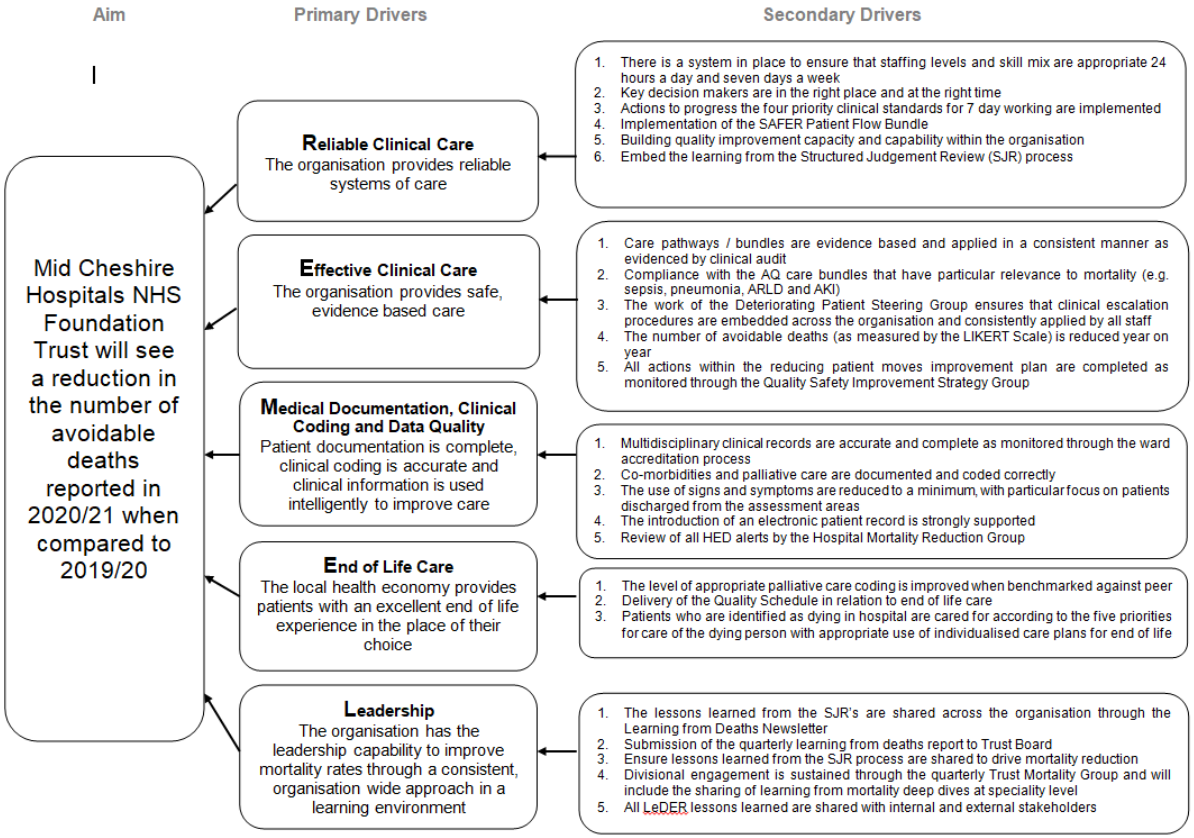
4.4 Next Steps

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's have now commenced reviewing a sample of all deaths and this will escalate to review all deaths during 2021.

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

5.0 Appendices

5.1 Appendix 1 Driver Diagram



5.2 Appendix 2 - Glossary

Healthcare Evaluation Data (HED)

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

Hospital Standardised Mortality Ratio (HSMR)

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

LIKERT Scale

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

LIKERT Scale

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

Summary Hospital-level Mortality Indicator (SHMI)

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

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

5.3 Appendix 3: Understanding the difference between SHMI and HSMR

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

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**11**	Date of Meeting: 25/03/2021
Report Title	Serious Incidents report for January and February 2021	
Executive Lead	Murray Lucas, Medical Director	
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)*

There have been 5 serious incidents reported in January 2021.
There have been 6 serious incidents reported in February 2021.

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

For information

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
EQGG	1.3.21	Serious incident report	SK	Report Noted
QSC	17.03.21	Serious incident report	SK	Report Noted

Introduction

1. This report provides the Committee with details of serious incidents declared during January and February 2021.
The report reflects a key control for the strategic objectives to deliver outstanding care and patient experience and deliver the most effective care to achieve best possible outcomes.

Background and Analysis

2. Serious Incidents in health care are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified. The national Serious Incident Framework (NHS England, 2015) describes the circumstances in which such a response may be required and the process and procedures for achieving it, to ensure that Serious Incidents are identified correctly, investigated thoroughly and, most importantly, learned from to prevent the likelihood of similar incidents happening again.

3. Serious Incidents include acts or omissions in care that result in; unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm - including those where the injury required treatment to prevent death or serious harm, abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services

4. **Incidents reported in Month**

4.1 There have been five serious incidents declared in January 2021:

1) SI 2021/2339 (131646) Fall resulting in a fractured neck of femur
A 75 year old gentleman had an unwitnessed fall resulting in a fractured neck of femur. From the initial investigation no lapses in care were identified.

2) SI 2021/1744 (130856) Treatment delay resulting in a potentially avoidable death
A patient was admitted with a working diagnosis of a pulmonary embolism (PE) and following this, the appropriate administration of drugs was delayed. The patient subsequently died with the cause of death identified as PE. The initial investigation confirmed missed opportunities to give the first and subsequent doses. The opportunity to have given these may or may not have changed the outcome, however this was a clear lapse in care. A number of actions have been taken within the area of the occurrence and Trust wide learning shared.

3) SI 2021/806 (120681) Treatment delay
In 2018, a 70 year old patient with a history of treated recurrent cancer was not followed up when she should have been. The patient was referred back to the Trust by her GP with a further recurrence of the cancer. The patient has received chemotherapy however she is now receiving end of life care. Actions including independent opinion on the outcome, systems to review follow ups and a Trust wide high risk patient follow up process have been implemented.

4) SI 2021/1307 (131094) Never Event – wrong site surgery

A patient attended the Eye Care Centre for laser surgery to their right eye. The case notes used by the team were the case notes of a separate patient with the same name who was also attending that day for laser surgery to her left eye. As a result, inadvertently the patient had laser to the left eye. It should be noted that whilst this does reach the definition of wrong site surgery, the patients left eye did in fact need laser treatment which would have been undertaken at a later date. However, this remains a Never Event despite no patient harm. A full action plan has been established including a Trust wide review of LocSSIPs (Local Safety Standards for Invasive Procedures) will be led by the Associate Medical Director of Patient Safety.

5) SI 2021/2352 (131471) Patient death – delay in taking observations

A 45 year old gentleman with Parkinson's disease was admitted with covid-19. He subsequently deteriorated and died on a ward. There was a failure to identify and correctly escalate this deterioration. As a result a review of the ward care was undertaken by the Critical Care Outreach lead and Matron and a number of additional actions put in place by Head of Nursing.

4.2 There have been six serious incidents declared in February 2021:

1) SI 2021/3843 (132652) Fall resulting in a fractured neck of femur

An 83 year old lady had a unwitnessed fall which resulted in a spiral femoral fracture. The patient was under the care of the Orthopedic team and underwent successful surgery.
From the initial investigation there are no lapses in care identified.

2) SI 2021/2612 (131784) Treatment Delay

A patient underwent ERCP (Endoscopic Retrograde Cholangio-Pancreatography) whilst an inpatient. The initial review has found lapses in care. A known complication of ERCP was suspected (bowel perforation), and a CT scan was performed which confirmed this. There was an overnight delay in identifying the CT findings due to human error. Review has confirmed that this did not lead to significant patient harm, however actions have been taken to ensure learning

3) SI 2021/2853 (132130) Covid 19 Nosocomial death

A 66 year old lady was admitted to the Trust with a deterioration of her serious cardiac condition. She was stabilised over a number of days allowing her to be discharged home. She was subsequently readmitted shortly afterwards with symptomatic COVID -19 from which she subsequently died. This case has now undergone both a formal Post infection and Structured Judgement Review which have confirmed that although the Covid infection was nosocomial (acquired in hospital), there were no lapses in the infection control processes. Sadly, it is recognised that despite these controls, the transmission of a highly infectious disease in the hospital environment cannot be completely eradicated.

4) SI 2021/3499 (132484) Delay in treatment

A woman underwent a complicated breech delivery of a second twin directly undertaken by a consultant obstetrician and the baby required transfer to the specialist hospital as a result. Initial review confirmed a significant delay in delivery of the baby due to the complex nature of the birth. The case has been reported to HSIB (Healthcare Safety Investigation Branch) who will undertake a thorough investigation and support has been given to the consultant involved.

5) SI 2021/ (132903) Delay in treatment

A 78 year old woman was incorrectly discharged in 2015 following the partial removal of a complex bowel polyp. She has now re-presented with bowel cancer that has required bowel resection. The initial investigation has identified that in 2018, a complex polyp multidisciplinary team (MDT) meeting instituted in the Trust which would have in all likelihood prevented this incident.

6) SI 2021/4317 (132795) Intra uterine fetal death

A patient with a complex pregnancy being monitored for severe fetal growth restriction suffered an intrauterine fetal death at 28 weeks of gestation which was unlikely to have been avoided. However, the review highlighted that the interval of monitoring arrangements did not conform to national guidance, therefore a number of actions have been taken including a revised Standard Operating Procedure.

Conclusions

5. The Trust has declared eleven serious incidents in the reported period, January and February 2021; immediate actions to prevent further occurrences happening have been instigated.

6. The Trust continues to demonstrate ongoing learning from incidents and ensures these are disseminated widely within the organisation.

Recommendations

7. The Board of Directors to note the assurance that the Trust has processes in place to identify, investigate and learn from serious incidents.

Author: Sheila Kasaven, Associate Director of Quality Governance
Date: 11/03/2021

PAF Committee
Chair's Assurance Report
February 2021

Report to	Board of Directors
Date	18 February 2021
Report from	Trevor Brocklebank, Non-Executive Director
Report prepared by	Caroline Keating, Company Secretary
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 Performance

- number of Covid-positive patients decreasing although Critical Care Unit (CCU) beds in use still above establishment.
- Approximately 17k people vaccinated to date; inpatients' vaccination programme underway with priority for those undergoing surgical or cancer treatment.

Effectiveness & Performance Review

- new approach worked well with Committee members viewing it positively
- areas of potential focus for next year would be considered at the March meeting, in conjunction with the desk top review and consideration of the Terms of Reference
- 'time-out' session proposed for April to enable the Committee to discuss its approach for 2021/22

BAF

- report confirmed what the Committee would receive in future through the quarterly reports on the delegated risks
- BAF 13 (*Failure to provide modern, efficient, sustainable estate, infrastructure and equipment*) – increased score from 16 to 20 proposed, due to the high number of operational risks scoring at 20. Committee to agree recommendation to Board at its March meeting
- BAF17 (*Ineffective capacity across the Health and Social Care system*) – Trust ownership of this risk was queried and would be addressed through the refresh of the BAF risks

Integrated Performance Report – Performance (January 2021)

- ED attendances decreased with increase in Covid-19 and respiratory demand
- theatre staff relocated to CCU, resulting in significant reduction in theatre activity and corresponding increase in longer-wait patients

Chief Operating Officer's Report

All patients to be allocated a Priority code related to a clinically appropriate timeline. This national requirement for managing waiting lists currently being implemented on inpatient surgical waiting list, with potential significant impact on diagnostics and outpatient waiting lists going forward.

Restoration

- phase 4 activity plan to replace Phase 3.
- "road-map" for recovery developed to restart services for those that were ready for restarting and to provide a break for those members of staff who required that.

NHS 111

Trust's approach of a soft launch and early implementation proceeding as expected provided assurance that Phase 2 would proceed optimally, particularly when it was rolled out into primary care

Executive Safety and Sustainable Environment Group (ESSEG) Chair's Assurance Report

- RAAC Plank Incident Response Plan approved.
- simulation exercise to be undertaken in April 2021

Finance – acceptable assurance:

- current forecast of £10.2m deficit will reduce to £7m when NHS income is received and may reduce to circa £4m if annual leave accrual is funded (national calculation).
- 2021/22 national planning delayed until March/April 2021 which will impact on the financial regime for 2021/22, first quarter continuation of current regime.
- current assessment of underlying expenditure run rate could be up to circa £38m deficit based upon assumptions on new 2020/21 additional costs continuing into 2021/22 and national income funding continuing at similar levels (unconfirmed at current time)

Capital Plan - **acceptable assurance:** the ambition of the capital plan and the significant amount of work involved was recognised. Further work is being undertaken to prioritise the plan, recognising it is likely to be above the Capital Resource limits set by the C&M Healthcare Partnership.

KEY CONCERNS/RISKS

Wheelchair Service, Congleton Hospital – lack of mitigation, to be taken forward with East Cheshire NHS Trust Chief Executive.

Priority Areas: DECISIONS MADE

N/A

RECOMMENDATION

To note

Mid Cheshire Hospitals NHS Foundation Trust

PAF Committee
Chair's Assurance Report
March 2021

Report to	Board of Directors
Date	18 March 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

Annual Committee Effectiveness Evaluation - Acceptable Assurance: desk top review concluded the Committee's work in 2020/21 was focused correctly on those duties delegated to it by the Board through its Terms of Reference (ToR) and that the Committee had moved in year into a strategic space.

Terms of Reference/ Workplan: New ToR including update to membership agreed. Workplan to be further developed to consider assurance mechanisms for all duties described in the ToR.

Operational Performance

- Covid positive numbers continue to fall and only two Covid wards (out of nine) remain.
- Urgent and emergency care (A&E) performance has deteriorated and below the England average.
- RTT waiting list continues to grow and there is a significant increase in patients waiting 52+ weeks.
- Cancer waiting time backlogs continue to be the lowest in Cheshire and Mersey.
- Routine elective activity has resumed.
- Service restoration and recovery plan following the third wave of the pandemic will be presented to the PAF Committee and Board in April.

Cheshire Medical Imaging LLP Briefing

The Committee can assure the Board that a comprehensive review of the contractual arrangements currently in place with CMI LLP have been reviewed; a clear set of recommendations have been agreed and are being implemented, with the majority expected to be completed by May 2021. Conflicts of interests have been considered fully by the Trust and the LLP with support from the Trust's legal advisors. There are no service delivery or quality concerns to note.

Executive Safety and Sustainable Environment Group (ESSEG) Chair's Assurance Report

- Proposed that BAF13 currently scored at 15 should be increased to 20; Board approval required
- All Estates and Health and Safety high-scoring risks reviewed; no new risks identified

Estates Strategic Plan 2021-2026 - Acceptable Assurance: Risks, challenges and opportunities reviewed prior to Board approval in April. Renewed strategic focus and leadership for Estates recognised; challenge of backlog and ambition acknowledged. PAF requested Board sighted on presentation of strategic plan before April Board meeting.

Finance – Acceptable Assurance: £3.2m footfall lost income has been received. End of year forecast is £6.9m deficit; if £3m annual leave accrual funding is received, deficit will reduce to c. £4m. This is a significantly better position than the £15m deficit (based upon delivery of £8m CIP) forecast at start of year and below the external auditors' level of materiality. Cheshire & Merseyside HCP System position has improved but remains with a forecast £56m deficit.

Draft 2021/22 Financial Plan

Trust and system financial allocations for 2021/22 not expected until 26 March. Block funding arrangements with system top-ups to continue for Q1 and potentially Q2; consequently, Trust cannot finalise its 2021/22 budget as would normally be the case under Standing Financial Instructions (SFIs). Interim expenditure-based budgets have been developed; once income is known, the financial gap will drive the efficiency requirement. A number of assumptions still remain and decisions on level of Cost Improvement Plans and investments need to be agreed. The Committee commended the approach, given ambiguity in the system and noted the interim budgets, which will be subject to revisions based upon final national guidance, with a further budget presented back to Committee and Board in due course. Audit Committee to receive this paper for information.

Emerging Efficiencies/Collaboration at Scale

HR Collaboration at Scale project continuing; most others paused due to wider system discussions about future approach. Efficiency projects (non-patient facing areas only) have delivered this year to the value of £2m. Efficiencies to be monitored through EDPG in future.

KEY CONCERNS/RISKS

- Restoration of activity to address waiting lists, while allowing workforce to recover from Covid

Priority Areas: DECISIONS MADE

- Covid-19 standing agenda item to be removed from workplan as covered under Operational Performance
- Board to be asked to approve an increase of the risk score of BAF 13 from 15 to 20 – due to the high risk items identified from the Critical Infrastructure Review and 6 facet survey
- Financial Plan for 2021/22 noted

RECOMMENDATION

To note

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

Report to	Board of Directors
Date	22 February 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

Gender Pay Gap Update: Change in the number of male employees compared to female is due to an increase in the number of female employees not a reduction in male employees.

MIAA Covid-19 Governance – People: Acceptable Assurance – Audit checklist repeated, minimal gaps identified. Next step is a People Recovery Plan, this will be the strategic focus.

Committee Survey

- Results of survey welcomed and acknowledged as a fair picture of Committee performance
- Need for greater focus on strategic rather than operational
- Move to a risk-based approach remains a work in progress; Committee needs to be clear where assurance is required and that this is reflected in its agendas and workplan
- Executive Group (EG) and Subgroups workplans need to be clearly linked into key operational risks which feed into BAF strategic risks. EG Chair's reports need to be centred on risk reporting
- Digital transformation strategy is required to set the scene – pending the launch of the new Trust Strategy
- Task and finish group to be formed to meet before next meeting to bring results and discussion together and develop revised Terms of Reference

Board Assurance Framework

First review of full BAF report - Executive Groups to ensure BAF risks are used to frame discussions and provide the focus. Discussions on each BAF including:

- BAF 6 *Failure to proceed with EPR development and implementation*. Insufficient detail about the risks that could take project off track. Agreed further work to ensure controls are correct and key operational risks described.
- BAF21 *Failure to develop leadership capacity and capability throughout the organisation*. Leadership development will need to be reframed through Trust Strategy and more reference to the inclusion agenda included
- BAF11 *Failure to harness the benefits of technology to integrate, streamline and improve systems of working.* Workforce capacity needs to be built up to be ready to harness the benefits

of digital development, ensure staff can access new technology. Discussions to follow from launch of Trust Strategy

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

- Statutory and mandatory training project improved compliance and ESR data. Reflected in 6-month upward trend in Integrated Performance Report (IPR) metrics. Monitoring by Executive Workforce Assurance Group (EWAG) in future as risk score moved from 12 to 8
- Workforce Plan to be implemented across divisions, to include workforce planning to reduce vacancies
- New interim report developed to allow closer insight across a number of EWAG metrics - to enable a focus in coming months e.g. Apprentice Levy

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

- Working with ATOS as potential partner to develop the Digital Hospital plan for new hospital development and build technology into the fabric of the building. Initial meeting highlighted a small number of elements not already identified by Trust and further debate required on the extent of digital ambition

Covid-19 People Recovery Plan in development, to be linked to Trust Strategy, important balance between restoration and staff recovery time.

Equality Delivery Systems 2 (EDS) – Partial Assurance
Plan for approach to EDS submission agreed, Healthwatch Cheshire supporting. Element regarding Shaping and Commissioning of Services needs to be linked to key external partners.

People's Practice Report: Acceptable Assurance agreed (partial assurance stated on the paper). Response to Harding report in May 2019 completed and signed off by EWAG in September. Board oversight of disciplinary process required. WDT agreed future quarterly updates across this and a number of other areas not included in IPR.

Items for Internal Audit Plan
E-Rostering, Vacancy Management and Disciplinary process suggested.

KEY CONCERNS/RISKS

- Challenging to understand strategic direction for Digital Transformation and workforce until the Trust Strategy is launched to provide context as these are two key enabling workstreams

Priority Areas: DECISIONS MADE

- People's Practice Report to be reviewed at Board of Directors

RECOMMENDATION

To note

BOARD OF DIRECTORS

Agenda Item	**13.1**	Date of Meeting: 25/03/2021
Report Title	**People Practices Review**	
Executive Lead	Heather Barnett – Director of Workforce and OD	
Lead Officer	Anna Bickerton – Acting Head of HR	
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)*

- Actions have been taken by the Trust to review and improve investigation and Disciplinary Processes in line with NHS England recommendations.
- Whilst the Trust meets the criteria, additional actions have been identified which will further support our compliance against the recommendations and further improve the experience of those involved in investigation procedures.

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

- KPI development for ER cases to provide assurance to the Board that decisions are made fairly and in a timely manner, cases are managed swiftly and themes on lessons learnt.
- Workforce Business Partner team to progress additional actions identified and provide assurance through EWAG and WDT.

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
Workforce and Digital Transformation Committee	22/2/21	People's Practice Report	Anna Bickerton, Interim Head of HR	Minor revisions requested before submission to Board.
Executive Workforce Assurance Group	03/02/21	People's Practices - Verbal Update	Anna Bickerton, Interim Head of HR	Request that all NHS Trusts review disciplinary procedures and that these be formally discussed at a Public Board or equivalent.
Executive Workforce Assurance Group	30/9/20	People's Practice Action Plan	Anna Bickerton, Interim Head of HR	Action plan completed.
Executive Workforce Assurance Group	25/6/20	People's Practice Action Plan	Anna Bickerton, Interim Head of HR	Update provided on status of actions.

People Practices Review

Introduction

1. Following a request by NHS England, this paper provides assurance that investigation and disciplinary processes have been reviewed and amended in line with the recommendations provided by Baroness Harding in May 2019.

Executive Summary

2. NHS England requested a tangible and timely review of disciplinary processes be completed by the end of the financial year and that this review is discussed at a Public Board meeting.

3. The review has been conducted in line with the recommendations provided by Baroness Harding in 2019. The group is asked to take note of the review which has been detailed under the following headings.

- Adhering to best practice
- Applying rigorous decision-making methodology
- Ensure people are fully trained and competent to carry out their role
- Assigning sufficient resources
- Decisions relating to the implementation of suspensions/exclusions
- Safeguarding people's health and wellbeing
- Board-level oversight

4. It is recognised that continuous improvements can and should be made to our processes and recent closed case reviews have indicated that we can make further developments in the following areas:

- Development of a Just Culture Decision Tree as part of a preliminary investigation checklist
- Consider implementation of an investigation decision panel to ensure that a multi-disciplinary approach is taken when deciding whether a full disciplinary investigation is required
- Continued promotion of the supportive employee and manager guides; ensuring the information provided remains up to date.

Background and Analysis

5. On 23rd May 2019, Baroness Harding issued a letter to all NHS Trust Chairs and Chief Executives, sharing the outcomes of work undertaken by an NHS Improvement task and finish advisory group. The work was focused around exploring the failings and procedural errors that occurred throughout an investigation and disciplinary process which led to a NHS London Trust member of staff taking their own life.

6. The purpose of the task and finish group was to explore whether the failings found in this case were unique to that Trust or whether they were more widespread across the NHS, and what learning could be applied.

7. The key themes identified were:

- Poor framing of concerns and allegations
- Inconsistency in the fair and effective application of local policies and procedures
- A lack of adherence to best practice guidance
- Variation in the quality of investigations
- Shortcomings in the management of conflicts of interest
- Insufficient consideration and support of the health and wellbeing of individuals
- Over-reliance on the immediate application of formal procedures, rather than consideration of alternative responses to concerns.

8. In response, a gap analysis was undertaken by Mid Cheshire Hospitals NHS Foundation Trust against current processes and practices and a corrective action plan was developed. The action plan was monitored on a quarterly basis at the Executive Workforce Assurance Group (EWAG) and formally closed in September 2020. A copy of this action plan has been appended for information.

9. During December 2020, all NHS Trust Chairs and Chief Executives were written to again and asked to undertake a review of all disciplinary procedures against the recommendations and that these be formally discussed at a Public Board or equivalent. The request was that this is repeated on an annual basis.

Recommendations

10. Baroness Harding provided seven recommendations relating to the management and oversight of local investigation and disciplinary procedures. For the purpose of this report, a review has been undertaken under each recommendation and any key learning as well as changes to practice have been summarised.

Adhering to best Practice

11. The Trust Disciplinary Policy and Procedure has been written in line with ACAS ‘code of practice on disciplinary and grievance procedures’ and in partnership with Trade Union colleagues. The Policy is reviewed in line with Trust timescales and updated on an ad-hoc basis to reflect changes to legislation or ACAS guidance. Any changes to the policy are approved in partnership via Policy Group and JCNC.

12. Advice from Hill Dickinson has been sought regarding the framing of allegations and Divisions are asked to involve the workforce business partner team in this process to ensure a consistent approach is applied.

13. Investigating Officers (IO) are provided with comprehensive training

14. IOs are appointed outside of immediate teams ensuring there is no conflict of interest. Where individuals have raised concerns, i.e. a previous working relationship, the reallocation of an appropriate IO has been considered/actioned.

15. A monthly review of all Disciplinary cases is undertaken by the Acting Head of HR to track progress and ensure cases do not experience unnecessary delays.

16. The HR team have introduced a process to internally review closed cases on a quarterly basis to discuss any learning points or best practice. Any areas for development are discussed amongst the Workforce Business Partner team and actions agreed and progressed where appropriate.

Applying rigorous decision-making methodology

17. The Disciplinary Policy includes three stages of the procedure:

    I. Informal Disciplinary Action (Informal Counselling) - Cases of misconduct will wherever possible, be managed informally, with the aim being to resolve problems quickly and confidentially.
    II. Fast Track Process - In cases of alleged misconduct where dismissal is not expected to be an outcome, and where the individual does not contest the allegations, the case may be dealt with via a fast-track route. Cases can only be fast-tracked with the relevant member of staff's agreement that they do not wish to proceed with a full investigation and disciplinary hearing.

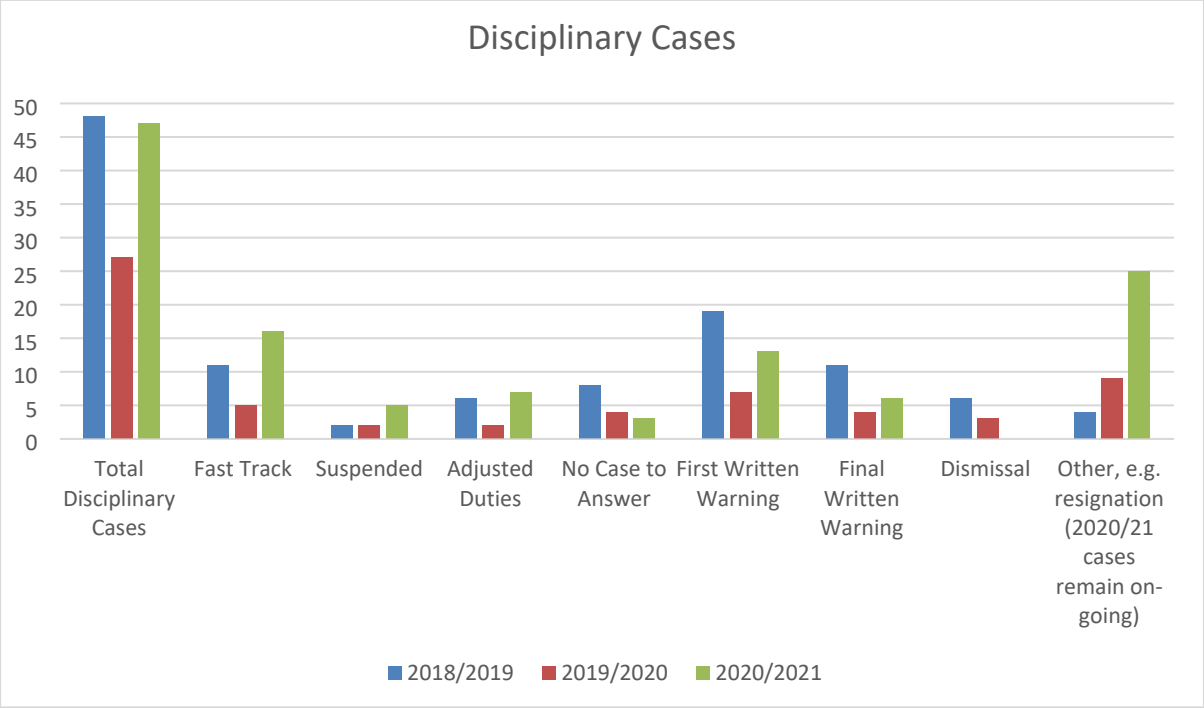
    III. Formal Disciplinary Action - Formal action is only considered if informal action has already taken place in respect of similar act of misconduct or if the alleged misconduct is sufficiently serious as to warrant immediate formal action. The manager, in conjunction with HR, decides if it is appropriate to launch a formal investigation.

18. HR use the relevant Trust policies as well as knowledge of previous cases and sanctions to advise on the most appropriate course of action.

19. An initial review of our internal processes did identify an inconsistent approach in relation to how we responded to Information Governance breaches. Work was therefore undertaken with the Head of Information Governance and a guidance document was produced for the HR team to review when determining the appropriate approach. This action has since provided greater clarity and consistency.

20. Table 1 below shows the total number of disciplinary cases which have been completed during 2018/2019, 2019/2020 and 2020/2021 and the number of these which have been through a Fast Track process. The table also indicates the outcomes of investigations. Positively this demonstrates that whilst a small number of cases have resulted in no case to answer, these have reduced indicating that cases have been appropriate progressed under the Disciplinary Process.

Table 1



Ensure people are fully trained and competent to carry out their role

21. An additional 29 Investigating Officers (IO's) have been trained since May 2019; in addition to this, quarterly IO Network Meetings have been developed. These sessions have provided an opportunity for ongoing development and have also allowed IO's to discuss their experiences and share learning with each other. This forum has provided a useful mechanism to share and discuss updates to legislation, policies, processes or documentation.

22. A HR representative is allocated to all IO's during formal investigation processes to ensure appropriate processes are followed.

Assigning sufficient resources

23. Prior to an investigation commencing discussions are held with the relevant DGM/equivalent manager to discuss the importance of the timely completion of the investigation, ensuring an appropriate IO is allocated and can be released to undertake the investigation.

24. IO's are provided with a 'Terms of Reference' to explain the scope of the investigation. Any supporting documentation or information is shared with the IO at this time. The gap analysis undertaken identified that unrealistic deadlines had been included in these documents and it was agreed that these should now be agreed collaboratively between the commissioning manager, IO and HR; considering the size of the investigation, workload and any pre-booked annual leave.

25. Workload and availability of the IO and witnesses has continued to be an issue in the timely completion of investigations; this has been compounded during the pandemic. The Trust has where necessary, appointed external investigations when the scope of the investigation has been too large to allocate to an internal IO.

Decisions relating to the implementation of suspensions/exclusions

26. In cases where the allegations potentially amount to gross misconduct, consideration may be given to the suspension of the individual. Suspension should only be considered where there is a risk identified either to the individual or to the organisation. Alternatives to suspension are always explored; this may include a temporary removal from clinical duties or a temporary move into another department.

27. The Trust Policy provides detailed guidance regarding suspensions to ensure that all appropriate considerations are made. Suspensions are reviewed on a frequent basis and individuals are provided with regular updates and support during this time.

28. Table 1 shows how many suspensions have taken place during 2018/2019, 2019/2020 and 2020/2021. Whilst the number of suspensions has increased during 2020/2021 there has also been an increase in the number of individuals whose duties have been adjusted. This demonstrates that more discussion is taking place when determining initial action to be taken.

Safeguarding people's health and wellbeing

29. The gap analysis undertaken identified that there was more we could do to support individuals and line managers through this process.

30. As a result, a number of supportive guidance documents have now been produced and are issued, as appropriate. A "Colleague Support Guide" and "Manager Support Guide" are issued at the commencement of an investigation process. These documents explain the process which will be followed and aims to answer frequently asked questions. Both documents provide details of health and wellbeing support available and explain the responsibilities of both staff and managers.

31. If a case then proceeds to a formal disciplinary hearing, a guidance booklet has been produced in recognition that most individuals will be unaware of what to expect during this process.

32. Where required, additional pastoral support is now also allocated to individuals; this may be in the form of a dedicated Mental Health First Aider or a support buddy to ensure an individual has the appropriate level of support required throughout what we know can be an incredibly difficult process.

33. A communication checklist has also been developed to provide guidance to managers and IO's as to how and when they should make contact with individuals; this is particularly relevant where a suspension or adjusted duties have been applied.

Board Oversight

34. Detailed, anonymised, case work information is reviewed at EWAG for assurance purposes. The Workforce Business Partner team are developing a tool to analyse casework trends which can then be submitted to EWAG and Workforce and Digital Transformation Committee on a quarterly basis, and assurance provided to Board on a frequency to be agreed.

Conclusions

35. Significant improvements have been made to our internal processes both to avoid formal investigation processes where appropriate alternatives are available and to improve support and communication mechanisms.

36. It is recognised that continuous improvements can and should be made to our processes and recent closed case reviews have indicated that we can make further developments in the following areas:

- Implementation of a Just Culture Decision Tree as part of a preliminary investigation checklist.
- Consider implementation of an investigation decision panel to ensure that a multi-disciplinary approach is taken when deciding whether a full disciplinary investigation is required.
- Continued promotion of the supportive employee and manager guides; ensuring the information provided remains up to date.
- KPI development for ER cases to provide assurance to the Board that decisions are made fairly and in a timely manner, cases are managed swiftly and themes on lessons learnt.
- Training for HR team and Investigating Officers on cases being managed through the Maintaining High Professional Standards processes.
- Development of additional guidance documents for commissioning/case manager emphasising their role in decision making and regularly reviewing progress.

Recommendations

37. In line with the recommendations within the letter dated 1 December 2020, this report be escalated and discussed at a public Board meeting.

38. The Trust commits to review compliance/progress on an annual basis.

39. Workforce and Digital Transformation Committee to monitor performance on a quarterly basis on behalf of the Board.

Author: Lucy Brownlee, Workforce Business Partner
Date: 12 February 2021

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**13.3**	Date of Meeting: 25/03/2021
Report Title	**Equality Delivery System (EDS2) 2021**	
Executive Lead	Heather Barnett, Director of Workforce and OD	
Lead Officer	Ian Howarth, Equality Diversity & Inclusion Lead	
Action Required	To approve	

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)*

- Summary position shared with Internal stakeholder group which consisted of: Staff side Chair, Patient Experience Team, BAME Staff Network Lead, UNITE Regional Officer
- Stakeholder validation has confirmed the Trust is achieving in respects of EDS Goals 1 -Better Health Outcomes, and Goal 4 Inclusive Leadership.
- Stakeholder validation led to the inclusion of additional credible examples of how we meet the standard being included. Notably, the EDI considerations in the new Emergency Department design & build, and how The Trust support addressing health inequalities through our commitment to the Cheshire East Partnership

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

- Review with Health Watch has been postponed until 19th March owing to ill health of HealthWatch representative
- WDT required to approve report for onward submission to and approval by Exec Board before reporting our position publicly on the Trust website.

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 **BAF21 Leadership capacity and capability**	
• 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
EDI Steering Group	17-02-21	EDS 2	Ian Howarth	Suggestions provided for additional key contributors
EWAG	13-03-21	EDS 2	Ian Howarth	Endorsed rating of 'Achieving' and onward subsequent presentation of position to Stakeholder Group, HealthWatch & WDT
WDT	22.03.21	EDS 2	Ian Howarth	tbc

Equality Delivery System
(EDS2)
Annual Report 2020/21

Introduction

1. The Equality Delivery System forms part of the Trust's commitment and obligations in respect of the Public Sector Equality Duty. Comprising of four goals broken down into a further 18 competencies, an annual review must be undertaken of progress against the standard and a rating ratified by independent validators.

   This paper summarises the approach taken in preparing the submission, internal governance and assurance sought along the way and culminates in a summary of the endorsed rating.

   Following authorisation from the Trust Executive board the final position has to be reported publicly via the Trust website.

Background and Analysis

2. All NHS Trusts are given the option to focus their annual review each year on two of the goals so as to not to become over burdened with sourcing evidence and losing sight of the real purpose of the review which is to evidence performance and present a summary to independent validators. Approaching the review this way allows for meaningful discussion and review into specific competencies throughout the validation cycle, as opposed to a transactional exercise of reviewing every single competency without ever really presenting an opportunity for challenge or debate.

3. In evaluating each competency those involved with preparing the review and those evaluating the rating are required to consider each element in the context of seeking confirmation of equality of opportunity, accessibility and their ability to benefit from such services in line with each of the nine protected characteristics under the Equality Act 2010.

4. Goals identified for review during this cycle are as follows:

   - **Better Health Outcomes**
     - This is about ensuring services are commissioned and designed with the health needs of local communities in mind. That individual health needs are considered, their safety prioritized and health promotion activities reach all local communities.
   - **Inclusive Leadership**
     - This is about the board and senior leaders acting responsibly in terms of seeking assurances and supporting governance processes which ensure equality risks both in terms of our workforce and patients are given due consideration. Seeking evidence of a leadership team which is culturally diverse both in terms of its makeup and in terms of its influences and role model similar behavior for others across the trust to follow.

5. In preparing for the review summary presentations on approach and requests for supporting evidence have been shared with:

- Equality Diversity & Inclusion Steering Group
- Executive Workforce Assurance Group
- Workforce & Digital Transformation Committee
- HealthWatch

6. Evidence has been sourced against each competency specifically drawing attention examples where we can actively demonstrate equal consideration is given to members of the local community irrespective of whether they identify with one or more of the protected characteristics.

7. An example of the Trust position against each of the two competencies are:

Goal One – Better Health Outcomes

1.3 - Transitions from one service to another, for people on care pathways, are made smoothly with everyone well informed.

Partnerships
CCICP is currently working with our partners within CWP, East Cheshire Hospice and the End-of-Life Partnership to develop a Palliative Care in Partnership model of providing end of life care to patients identified within the last 12 weeks of life. If successful, this will enable patients who choose to spend their end-of-life phase at home being supported consistently across Cheshire by unregistered staff that are highly trained and skilled in providing end of life care.

Goal Four- Inclusive Leadership
4.1 Boards and senior leaders routinely demonstrate their commitment to promoting equality-related impacts including risks, and say how these risks are to be managed

Management of risk
The Board adopts BAF (Business Assurance Framework) approach to delivery which is disseminated throughout the organisation. Requires a structured approach through governance committee's with each Chair being responsible for summarising key points to the board and where appropriate bring reports for sign off.

8. Key findings

A review with internal stakeholders, including the Chair of our BAME staff network, StaffSide Chair, Unite Regional Officer and our Patient Engagement Team resulted in no challenges and an endorsement that the Trust is achieving across all 9 competencies linked to the two goals under review.

This stakeholder review proved useful and provided additional credible examples of equality being a key consideration in the provision of services following an open discussion about the approach to establishing the new Emergency Department and a greater insight into our involvement with the Cheshire East Partnership.

A subsequent review with HealthWatch was schedule for the 15th March but didn't go ahead owing to the HealthWatch representative being unwell on the day. This has been rescheduled for the 19th March.

Conclusions

9. The Trust has been recognised as Achieving in respect of all competencies aligned to Goals 1 & 4 of the Equality Delivery System.

EDS2 GRADING OF OUTCOMES		
	Undeveloped	staff members or people from all protected groups fare poorly compared staff members or people overall
	Developing	staff members or people from only some protected groups fare as well as staff members or people overall
	Achieving	staff members or people from most protected groups fare as well as staff members or people overall
	Excelling	staff members or people from all protected groups fare as well as staff members or people overall

Recommendations

The Board of Directors are asked to approve this report.

Following Board approval, the report will be uploaded as a summary paragraph with accompanying excel tracker outlining the endorsed rating against each competency to the Equality Diversity & Inclusion page on the Trust website.

Author: Ian Howarth –Equality Diversity & Inclusion Lead
Date: 16th March 2021

Goal	Number	Description of outcome	Supporting Evidence	Sources of evidence	Provisional rating	Endorsed rating	
					MCHT Rating	Stakeholder Group	HealthWatch
Better Health Outcomes	1.1	Services are commissioned, procured, and **designed and delivered** to meet the health needs of local communities	**Integration and Design of Services** CCICP work alongside community partners to ensure that all services are integrated and designed around the needs of patients. This includes attended at Care Community meetings which are attended by Patients, GPs, Local Authority, Social Care, Health watch and Volunteer Groups to discuss service development and priorities.	CQC Patient Survey Report 2019 'your care and treatment' section. National Inpatient Survey 2019 presentation - Trust has maintained essential clinical support for patients with 2,111 video consultations completed.	Achieving		
			Catering provision Menus are nutritionally coded and assessed against the dieticians analysis tool. The choices for patients on low fibre diets has been reviewed and all options are available in a low fibre version. A new selection of children's sandwiches are also available. The Catering Manager or the Lead Chef will speak to Patients on the ward with any specific dietary needs due to religion and produce an agreed menu.	National Inpatient Survey - 95% of patients felt that they were offered a choice of food.	Achieving		
	1.2	Individual people's health needs are assessed and met in appropriate and effective ways	**Spiritual Services** The Trust provides Chaplaincy, Pastoral and Spiritual Care services for patients. This recognises and affirms the increasing engagement with the spiritual healthcare agenda. The Trust also has a Chaplaincy Team who provide support to patients and relatives. The hospital also has a designated Prayer Room and a Mosque onsite.	Chaplaincy, Pastoral and Spiritual Care Guidelines. Hospital Chaplaincy Team leaflet National Inpatient Survey - Trust has supported patient contact with friends and family during restricted visiting.	Achieving		
			Access to Information Patient information leaflets are available in various formats (Braille and large Print). Information is also available in other languages. Recent requests have been for Bulgarian, Russian, Slovakian and Romanian. The Trust also uses the Bigword translation service for telephone as well as face to face interpreting. A trial with Language Line is also being undertaken in Maternity and the Treatment Centre using a video on demand service. (Accessible Information Standard)	http://lhcs2:100/documents/F2F%20A4%20-%20NHS%20-%203100.pdf	Achieving		
	1.3	Transitions from one service to another, for people on care pathways, are made smoothly with everyone well informed.	**Partnerships** CCICP is currently working with our partners within CWP, East Cheshire Hospice and the End-of-Life Partnership to develop a Palliative Care in Partnership model of providing end of life care to patients identified within the last 12 weeks of life. If successful, this will enable patients who choose to spend their end-of-life phase at home being supported consistently across Cheshire by unregistered staff that are highly trained and skilled in providing end of life care. CCICP already undertake this as part of a pilot project for all patients whose care is transferred from hospice to home. The proposed model will enable all patients to access this service including those patients being discharged from hospital or currently within the community setting.	CQC Patient Survey Report 2019 'your care and treatment' section.	Achieving		
			CCICP use EPaCCS which is an electronic care coordination system. This enables Community Nurses, Macmillan, GPs and Hospices to record a patients end of life plan. EPaCCs supports the patient to have an advanced care plan in place, to have discussions about their chosen place of care and death, having a DNACPR decision recorded and documented and promotes the discussions around patients' choices and future care provision. **Cancer Care Pathway** Pathway for Non-specific Symptoms where GPs refer directly if patients present to them with symptoms that could suggest cancer or another disease (non-specific in nature). Trust virtually review the referral and organise relevant diagnostics to speed up pathway and to avoid patients being referred to multiple specialties. Results are then coordinated into an MDT and patient is referred to appropriate specialty. Up to 20% of patients with NSS die within 12 months and streamlining referrals for prompt management is key. Supported by a Navigator and Clinical Nurse Specialist.	Palliative Patient Care Story which demonstrates integrated working across primary and secondary care. Provided by Jo Bowen, Head of Quality, Nursing and Professional Leadership.	Achieving		
	1.4	When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse	**Policies and Procedures to ensure Safety** The Trust has an Incident Reporting, Investigation and Learning policy that sets out how and when staff need to report any type of incident. It describes how learning is formed from an investigation process and shared within the organisation and with families and patients affected. There is also a Being Open and Duty of Candour policy that sets out how to inform and update patients on any areas of harm. It also sets out how learning is shared with patients and families. Interpreter services and translation of reports can be completed if required. The Trust has robust safeguarding vulnerable adults' procedures in place, underpinned by the Safeguarding Vulnerable Adults Policy The Trust has a Domestic Abuse Policy and has an Independent Domestic Abuse Advisor.	External Alerts and Internal Safety Alerts Procedure and Management Policy Being Open and Duty of Candour Incident Reporting, Investigation, Learning and Improvement Policy	Achieving		
	1.5	Screening, vaccination and other health promotion services reach and benefit all local communities	**Community Vaccinations** CCICP supports the annual flu vaccination campaign ensuring that all patients can access the service including hour bound and vulnerable patient groups. CCICP have also supported the COVID vaccination programme which has included the vaccination of the homeless community and traveller communities. CCICP support health promotion working with other organisations e.g. Community Stroke service commission the stroke association to undertake 6 month patient reviews which include health screening and secondary prevention alongside wellbeing and working support.		Achieving		
Inclusive Leadership	4.1	Boards and senior leaders routinely demonstrate their commitment to promoting equality-related impacts including risks, and say how these risks are to be managed	**Health Inequalities Lead** Oliver Bennett - Chief Operating Officer is also the Trust Boards lead on Health Inequalities The trust works with other health providers, to improve indicators of health in the local community whilst reducing indicators of health inequalities.		Achieving		
			Management of risk The Board adopts BAF (Business Assurance Framework) approach to delivery which is disseminated throughout the organisation. Requires a structured approach through governance committee's with each Chair being responsible for summarising key points to the board and where appropriate bring reports for sign off. Example - Gender Pay Gap (23.2%) - Partial Assurance flagged to Board on account of identified risks associated to demographics and GPG which can't be fixed overnight *(controls are still maturing and further action required to improve their effectiveness)*	Examples - Gender Pay Gap report, Equality & Diversity annual report, EDS report EWAG Chair's report for GPG to WDT Committee and onto Trust Board			
			Covid-19 Board approved free Vitamin D for all BAME staff for 3 months in response to known disproportionate impact of Covid-19 on BAME communities Board requested reporting and impact analysis of risk assessments undertaken for BAME staff 21 BAME Doctors, resulting in adjustments for all including but not restricted to: Exclusion from Covid-19 areas, Enhanced PPE, Undertaking telephone clinics, Adjusted clinical pathways to minimise risk of exposure to Covid+, provision of own office.				
			EDI Steering Group EDI Lead commissioned a review of (Feb-21) of the EDI steering group membership on account of perceived lack of patient facing / clinical contributions. There was a risk retaining existing members the group became a governance body only, lacked influence at grass roots levels so a well informed debate but lack of activists or sponsors. Risk to be managed within the group Target April-21	Membership listing by role			
			EDI Lead appointed The Board identified a risk in strategic support for advancing EDI within the trust following internal progression and realignment of role for incumbent. EDI Lead appointed in collaboration with East Cheshire NHS. Critical to the appointment was the acknowledged rise in demand and strategic importance of addressing inequalities within the workforce and patient services, a demand that could be better served through synergies with two trusts working to the same national agenda, but with a focus on addressing local inequalities faced in both trusts, BAME progression above B5, Female representation in senior clinical roles.	**EDI Strategy review** East & Mid Cheshire combined BAME Leadership Development course Addressing national EDI priorities			
	4.2	Papers that come before the Board and other major Committees identify equality related impacts including risks, and say how these risks are to be managed	**Risk governance** Board have been stringent in ensuring existing risk structure remained in place despite operational pressures from responding to Covid-19 Every Board Paper summary report has to clearly articulate the risk / BAF reference number which ensures every piece of work we do contributes to reducing risk exposure for the trust and patient services Board Level BAF has two key BAF risks relating to a high performing workforce and impact on quality of care as week as creating an effective organisational culture (BAF 10 & 12 respectively)	**MCHFT Risk Governance Structure** Red circles denote Equality related risks being managed	Achieving		
			Ownership of risk EDI risks owned at an Exec Level by Director for HR & Organisational Development Risks are owned at an operational level for workforce by the Trust EDI Lead and for patient services by the respective service lead. For workforce risks are reviewed with the EDI Steering Group, and Executive Workforce Assurance Group (EWAG) For patient services, every policy, procedure or management of change must come accompanied by an Equality Impact Assessment	**EDI Risks** WOD0020 - Lack of operational hearing loops in public spaces and clinical areas WOD0014 - Improvement of diversity in recruitment processes to improve cultural competence and planning for patient services WOD0016 - Underrepresented staff WOD0013 - BAME Covid-19 Risk Assessments BAF 10- & 12 linked to Strategic Objective #4			
			Equality Training The Board underwent Equality Impact Training - October 2020 Designed to support the Board in getting comfortable being uncomfortable talking about race, the live session delivered by actors played out workplace inequalities with a safe space for bias to be discussed openly, the impact on the individual to be discussed and to align Course focused on race but many of the principles are applicable when viewed through an intersectional lense, i.e.) how insensitive comments about ethnicity would be received is similar for say someone being subjected to inappropriate comments about faith or sexuality and so the learning reaches across multiple protected characteristics	Board summary feedback paper			

	4.3	Middle managers and other line managers support their staff to work in culturally competent* ways within a work environment free from discrimination	WRES WDES findings help inform the trust around the impact of our work and training to reduce bullying & harassment but these reports don't cover all protected characteristics. WRES & WDES doesn't offer us an insight into how we can ensure managers are training and supporting their staff around inappropriate behaviour and their efforts to reducing bullying say in relation to religion or sexual orientation.	More work to be done here:	Achieving		
			Culturally Competent EDS preparation threw up a need to define what we mean by this Text will accompany wider trust EDI briefings to help further educate Managers	Definition			
			International Nurse recruitment & on boarding Managers demonstrate cultural competence by the manner in which International Nurses are on boarded. Provision of pastoral care, buddying new arrivals up with peers from same cultural heritage. Support registering with GP's dentists, shopping Gradual on boarding into Wards - Mixed feedback still work to do. Not all international nurses continue to receive the same welcoming experience once they begin operating full time. Do our staff really understand and respect the contributions of International Nurses, why they are required? Support overcoming any language, cultural barriers for existing staff? Preceptorship Course for all newly qualified nurses. Includes a module on Vulnerable Adults and also diabetes specifically addressing health inequalities and helping to tailor care provision to those identified as vulnerable helping to ensure they receive equivalent healthcare to those fully able in society.	Quote from International Nurse…. *'Arriving in the United Kingdom gave me culture shock…… Most especially in the area of interpersonal relationship….. It was very difficult for me to adjust but, I'm used to it now'* *'I felt so much confident now as compared to when I first resumed as an international Nurse in this Trust. I now have a sense of belongingness and I now feel at home with almost everyone'* Preceptorship Course summary Feb 2020 Feedback from Sophie's questions to International Nurses Summary of conversation with Julie Mitchell - Medical Resourcing Manager			
	4.3	Middle managers and other line managers support their staff to work in culturally competent* ways within a work environment free from discrimination	**Stat and Mandatory training** Continued learning & professional development is encouraged, respect for others is key and the trust is currently working on a Civility in the Workplace programme which strips back some of the more legal positioning behind principles which underpin EDI and concentrates very much on the values and principles of treat others as you yourself would like to be treated	Completion rates - requested from Amy	Achieving		
			Rainbow Badge Campaign Individual pledges made throughout 2020 Aligned with celebrations in respect of LGBT+ Pride and LGBT+ History Month Support and attendance at key events from COO Departmental pledges being offered for 2021 but awaiting on the re-set of the programme nationally before investing any significant resource - anticipated Q3 2021	Images available			

Goal	Number	Description of outcome	Provisional rating		Endorsed rating	
			MCHT Rating		Stakeholder Group	HealthWatch
Better Health Outcomes	1.1	Services are commissioned, procured, and designed and delivered to meet the health needs of local communities	Achieving	Stakeholder discussion & review	Achieving	
	1.2	Individual people's health needs are assessed and met in appropriate and effective ways	Achieving		Achieving	
	1.3	Transitions from one service to another, for people on care pathways, are made smoothly with everyone well informed.	Achieving		Achieving	
	1.4	When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse	Achieving		Achieving	
	1.5	Screening, vaccination and other health promotion services reach and benefit all local communities	Achieving		Achieving	
Inclusive Leadership	4.1	Boards and senior leaders routinley demonstrate their commitment to promoting equality-related impacts including risks, and say how these risks are to be managed	Achieving		Achieving	
	4.2	Papers that come before the Board and other major Committees identify equality related impacts including risks, and say how these risks are to be managed	Achieving		Achieving	
					Achieving	
	4.3	Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination	Achieving		Achieving	
	4.3	Middle managers and other line managers support their staff to work in culturally competent* ways within a work environment free from discrimination	Achieving		Achieving	

EDS2 GRADING OF OUTCOMES	
Undeveloped	staff members or people from all protected groups fare poorly compared staff members or people overall
Developing	staff members or people from only some protected groups fare as well as staff members or people overall
Achieving	staff members or people from most protected groups fare as well as staff members or people overall
Excelling	staff members or people from all protected groups fare as well as staff members or people overall

*** Being Culturally Competent is about:**

….your ability to be curious, a willingness to be open and learn, and an understanding that we are all shaped by our own upbringing and life experiences about different cultures. Our own perspective on something is exactly that, our perspective.

Everyone's views are valuable and an ability to recognise our own biases coupled with a commitment to acquiring cultural knowledge will help us all be the best in our roles at work and in society as a whole'

BOARD OF DIRECTORS

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

Agenda Item	**14**	Date of Meeting: 25/03/2021
Report Title	Trust Constitutional Changes	
Executive Lead	Caroline Keating, Company Secretary	
Lead Officer	Katharine Dowson, Head of Corporate Governance	
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)*

- Constitutional changes to widen geographical boundaries to provide opportunity for greater diversity among Non-Executive Director candidates
- Proposed change to Noon-Executive Director eligibility criteria impacts on membership constituencies and Governors

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

- Ratification of the updated Constitution at the next Council Meeting on 8 April and at the Annual Members Meeting in October
- Members to be informed of agreed changes

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
Council of Governors	14/01/21	Trust Constitution – Constituency Changes	Head of Corporate Governance	Further discussion with Governors required and exploration of different options
Membership and Communications Committee	08/02/21	Membership Approach & Strategy	Head of Corporate Governance	Agreement of Membership approach in 2020/1
Council of Governors (Extra Ordinary)	02/03/21	Trust Constitution – Constituency Changes	Corporate Head of Governance	Paper responding to Governor feedback approved.

Mid Cheshire Hospitals
NHS Foundation Trust

Trust Constitution – Constituency Changes

Introduction

1. At a Board Away Day in 2020, the Board of Directors explored and agreed that the Trust should have a greater focus on diversity. Board membership was seen as a proactive means for the Board to demonstrate its leadership and commitment to this strategic direction.

2. In December 2020, the Nominations and Remuneration Committee recommended to the Council of Governors that the eligibility for Non-Executive Director (NED) appointments should be widened so that candidates from outside of Cheshire could also be considered. This proposal was approved by Governors at an Extra Ordinary meeting on 2 March.

3. Approval is also required from the Board of Directors to this proposal.

Background

4. It is a legal requirement to pay attention to diversity and equality. Furthermore, it promotes a culture of engagement which encourages the active and positive contribution of individuals to maintain and enhance the performance of organisations in supporting and encouraging high-quality and efficient care. Despite this, the number of chairs and non-executives from diverse backgrounds on the boards of NHS organisations has steadily declined since the early 2000s. A number of Trusts have changed their constitution in recent years to address the diversity challenge to good effect.

5. To include NEDs from outside Cheshire, changes to the constituency boundaries are required because, as mandated within the 2012 Health and Social Care Act, NEDs must be members of the foundation trust and, therefore, a membership constituency would have to be created or widened. This would impact the areas that Governors represent but would not alter the role of the Governor or their responsibilities.

6. This proposal allows future NED candidates to be drawn from a wider, although still controlled, geographical area which would include neighbouring larger urban areas. Local representation remains paramount so rather than creating a new ‘out of Cheshire’ constituency which would require an ‘out of Cheshire’ Governor, the proposal is to extend the Congleton border to create a much wider constituency. Members from anywhere in this area could choose to stand as a Governor but the expectation would be that there would naturally be more interest from those members who live closer to the Trust sites. The majority of Governors and Members would still be from the catchment areas of South Cheshire and Vale Royal.

Membership

7. At the Council of Governors meeting in January 2021 when the proposal was first discussed, some concerns were raised about how Governors would represent the membership across these wider areas. This was explored in some detail by the Membership and Communications

Committee in February who agreed that the current strategy should be maintained which was to have an inclusive membership offer to all eligible residents. This would be via the Alltogether newsletter and the new virtual events that have been introduced during Covid; alongside a face-to-face offer when social distancing restrictions allow. The virtual aspects could easily encompass digitally enabled Members from the new areas, although most engagement would continue to be focused on the areas around the Trust sites in South Cheshire and Vale Royal.

8. The Trust understands that the majority of people become Members to support their local Trust which is why the strategy has always been to focus on those who live more locally and who use the Trust's services. Events such as 'Meet Your Governor' are held in local areas and not taken further into Cheshire even though currently Members can come from that wider area. The current approach would continue.

9. A Governor's duty is to listen to Members and be available to them, but it is not necessary for Governors to go out and seek their views other than in their regular activities. It would not be expected that Governors would need to actively seek out the views from people living in the new areas outside of Cheshire any more than they currently do for residents living in the northern edges of Cheshire. It should be noted that there are already 60 Members who live outside of Cheshire who are clearly affiliated to the Trust in some way and 40 of these would be incorporated into the new constituency under this proposal.

Proposal

10. The Trust also wishes to remove the artificial constituency boundary between public and patient/carer Governors which was optional when the Trust first became a Foundation Trust. As it is a statutory duty for all Governors to represent the interests of the members of the corporation as a whole and the interests of the public (which includes patients), it is considered sensible to remove the distinction, particularly as it is confusing for Members and potential Governors at election time. Also, Healthwatch has a statutory role to gather and champion the views of users of health and social care services and the Council now has a partnership Governor from Healthwatch. All public Governors would, therefore, represent a geographical constituency in the future.

11. The implications for Governors and the basis of their representation has not been under-estimated. While the changes will not alter their duties, the basis on which they were elected will change and some Governors may feel unsettled by the changes.

12. Under the proposal, no Governor would find themselves without a post; however, Governors will be impacted by the following changes:

- The electoral basis on which they were voted in as Governors
- Changes to their current constituency and electorate
- Move to a geographical representation for patient/carer Governors

13. The number of public Governors would stay at 16, which remains the majority of the Council.

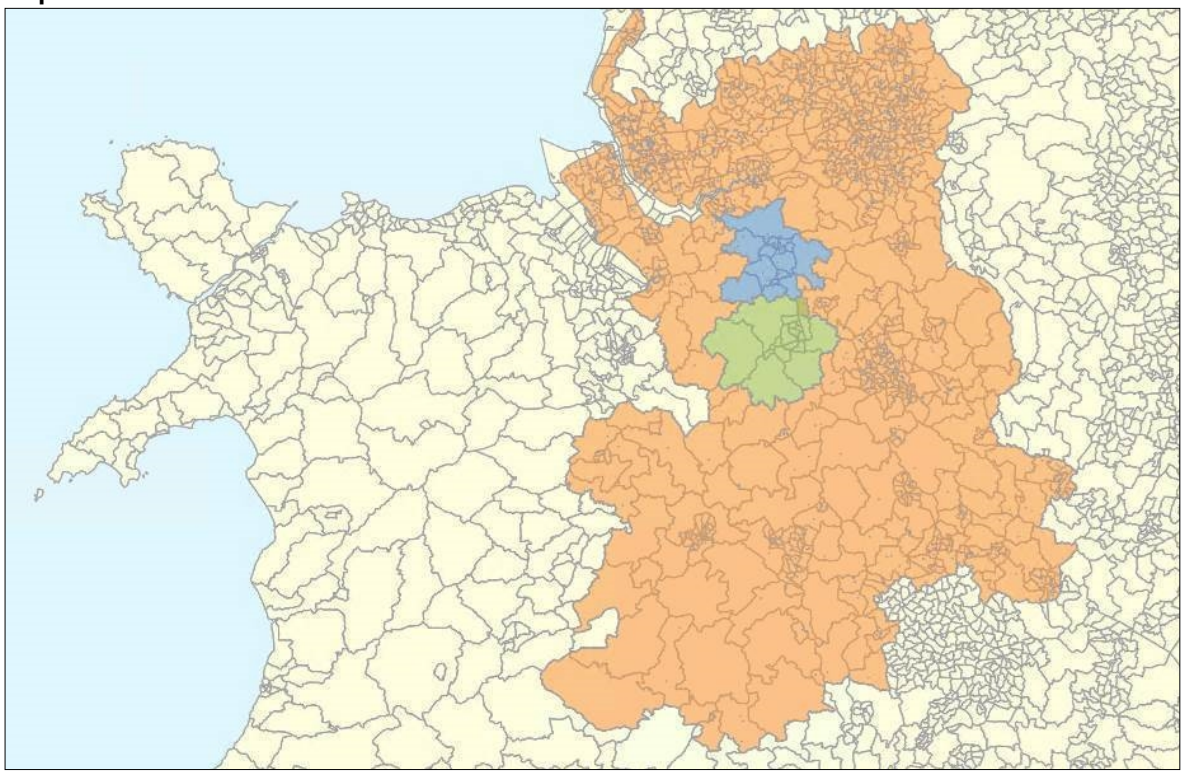
14. There would be no changes to appointed (partnership) or staff Governors.

Table 1 – Draft Allocation of Governors/ Members

Current Constituencies	Number of Governors Currently	Number of current Public Members (and minimum requirements)	New Constituency	Number of Governors Proposed	Estimated new Membership (and new minimum requirements)
Public & Carer	6	-	-	0	0
Crewe & Nantwich	4	1,787 (1,100)	Crewe & South Cheshire	8	1,787 (1,100)
Vale Royal and Cheshire West & Chester	4	1,365 (1,200)	Northwich & Region	6	1,335 (1,000)
Congleton	2	800 (450)	Cheshire Borders	2	870 (650)
Out of Trust Area	-	60	Out of Trust Area	-	20

15. Governors would move into their new constituencies only at the next election, so there would be a transition period to March 2023. The current patient/carer Governors would also move to geographic constituencies at this point so representation would increase in those areas closest to the Trust. Those Governors in their third term of office would not be eligible to stand in the new constituency at the next election.

Map 1 MCHFT New Constituencies



Key: Green = Crewe & Nantwich; Blue = Northwich & Region; Orange = Cheshire Borders

16. The Crewe & Nantwich constituency would remain across the same geographic area but increase its Governor representation from four to eight8 and be renamed **Crewe & South Cheshire**.

17. Vale Royal would be split from Cheshire West and Chester wards and become a smaller **Northwich & Region** area (see Map 2). The number of seats would go from four to six.

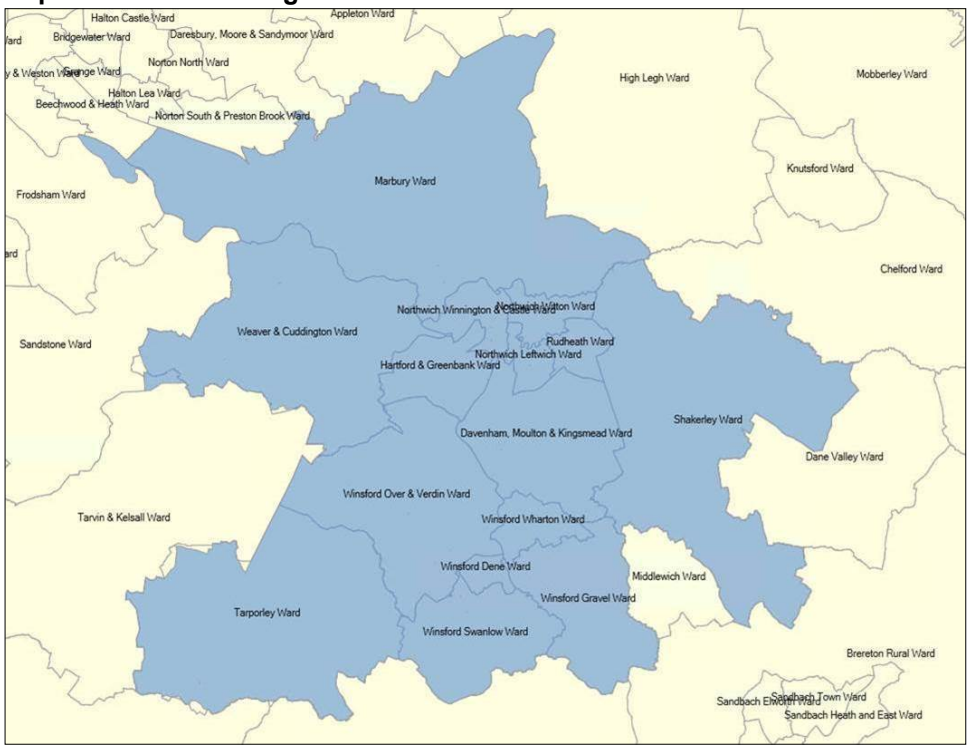
18. Cheshire West and Chester wards would join with the current Congleton wards and circle the edges of Cheshire, together with the surrounding counties of Shropshire, Staffordshire, Stoke-on-Trent, Merseyside, Liverpool City Region and Greater Manchester/Stockport to become **Cheshire Borders** (Map 3). It would be anticipated that Governor representation would be likely to stay from within Cheshire, but Members from outside counties would be eligible to stand.

19. These constituencies have been mapped out below and representation agreed against local populations by Civica which manages the Trust's Membership database. These would be confirmed if Board approval is given.

Crewe & South Cheshire

20. There would be no change to the current map for this constituency. However, implications for existing Governors are:
    - Four existing Crewe & Nantwich Governors would be unaffected.
    - The four current patient and carer Governors who live in this area would be eligible to stand in this constituency at the next election.

Map 2 Northwich & Region



Northwich & Region

21. Implications for existing Governors are:
    - Four existing Vale Royal Governors would be unaffected

- One patient and carer Governor would be eligible to stand in this constituency at the next election, so five of the six seats would potentially be filled by existing Governors in future elections
- There is one current public vacancy (patient and carer) which would translate to this new constituency.

Cheshire Borders

22. Implications for existing Governors are:
    - One Congleton Governor would be eligible to stand in the new Cheshire Borders constituency; the other Governor is in their third term so would not be able to stand again

Map 3 Cheshire Borders

Next Steps

23. If approved, the changes would come into effect from 1 April 2021, ahead of the approval of the appointment of the next NED at the Council of Governors on 8 April 2021. Ratification would need to take place at the next Annual Members Meeting in the Autumn.

24. All public Members will be advised of the change to constituencies (approx. 4,500 people). This would also be an opportunity to check their details in line with good practice[1] and encourage Members to supply their email address which will save resource in the future. This can be done between April and June 2021 ahead of the next election process starting in July. The Membership database would be updated by Civica which manages the database on behalf of the Trust.

Recommendations

25. The Board is asked to approve:

- The changes to Membership constituencies to increase diversity in NED recruitment and strengthen the membership of the Board
- The removal of the Patient/Carer constituency with those Governors moved into geographic constituencies
- The updated Constitution reflecting these changes to be ratified at the next Council of Governors and Board of Directors in April

Author: Katharine Dowson, Head of Corporate Governance
Date: 18 March 2021

[1] General Data Protection Regulation (GDPR) 2018

BOARD OF DIRECTORS

Agenda Item	**15**	Date of Meeting: 25/03/2021
Report Title	**Request to Use the Trust Seal**	
Executive Lead	Caroline Keating, Company Secretary	
Lead Officer	Katharine Dowson, Head of Corporate Governance	
Action Required	To Approve	

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)*

- Board approval required to apply the Trust Seal to 2 legal documents:
  - Deed of Surrender for the lease of the former School of Nursing
  - NEC Building Contract for the Emergency Department Expansion

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

- Seal to be applied and contracts signed

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
NA				

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Estates & Facilities Division

Capital Procedures

Form CF13 – Request to affix Trust Seal
(Version 1.0 – February 2013)

In line with the provisions Trust Standing Order Section 17 (Sealing of Documents), we request approval to affix the Trust Seal to the following document –

Type of Documents – Deed of Surrender

Title of Document – A Deed of Surrender of the lease between Mid Cheshire Hospitals Foundation Trust and the University of Chester, Faculty of Health and Social Care

Reason for Trust Seal – Engrossment of the Deed of Surender for the leasehold premises of 1263.9 sqm which was formally the School of Nursing.

Please note - this document is a request to affix the Trust Seal, the content of the Agreement has been agreed and authorised

Number of copies to be sealed – One copy of the Deed of Surrender

The seal is to be applied to – Page 4

Parties to Agreement - The parties are Mid Cheshire Hospitals NHS Foundation Trust and the University of Chester, Faculty of Health and Social Care

Value – N/A

Andrew Deakin
Head of Capital Development

Date: 15.03.2021

To be completed by Trust Secretary

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

Seal Applied *(date)*_____

Seal Number _____

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Estates & Facilities Division

Capital Procedures

Form CF13 – Request to affix Trust Seal
(Version 1.0 – February 2013)

In line with the provisions Trust Standing Order Section 17 (Sealing of Documents), we request approval to affix the Trust Seal to the following document –

Type of Documents – NEC Building Contract

Title of Document – NEC Building Contract between Mid Cheshire Hospitals Foundation Trust and MTX Contracts Limited

Reason for Trust Seal – Engrossment of the NEC Building Contract for the ED Expansion Scheme

Please note - this document is a request to affix the Trust Seal, the content of the Agreement has been agreed and authorised

Number of copies to be sealed – **Three** copies of the NEC Contract

The seal is to be applied to – Page 3

Parties to Agreement - The parties are Mid Cheshire Hospitals NHS Foundation Trust and MTX Contracts

Value – £13,114,825

Andrew Deakin
Head of Capital Development

Date: 15.03.2021

To be completed by Trust Secretary

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

Seal Applied *(date)*_____

Seal Number _____

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**Consent**	Date of Meeting: 25/0/21
Report Title	**Advisory Committee on Clinical Excellence Awards 2019/2020**	
Executive Lead	Murray Luckas Medical Director	
Lead Officer	Julie Mitchell Head of Resourcing	
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)*

- 116 Consultants eligible to apply for LCEAs in 2019.
- 24 Awards allocated
- £78,416 distributed

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

- For information

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 **BAF21 Leadership capacity and capability**	
• 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
JLNC (Joint Local Negotiating Committee)	4 March 2021	Clinical Excellence Awards Annual Report 2019	Julie Mitchell	Report noted

Clinical Excellence Awards 2019/20

Introduction

1. This paper gives a fiscal breakdown of the Clinical Excellence Awards distributed in 2019/2020. Board is asked to receive the Trusts Local Clinical Excellence Awards (LCEA) report. This report is for the LCEA's round that took place in October 2020 (for April 2019). The report is in line with the Local Clinical Excellence Awards Guidance 2018-2021.

Background

2. The Local Clinical Excellence Awards Guidance states that Local Clinical Excellence Awards: 'recognise and reward NHS Consultant's in England who perform over and above the standard expected of their role. Awards are given for quality and excellence, acknowledging exceptional personal contributions.

3. To be considered for an award, eligible doctors must demonstrate achievements in developing and delivering hight quality patient care and commitment to the continuous improvements of the NHS.

4. The 2018 -2021 guidance requires organisations to share an annual report with trust board, the following report must contain the following information:
    - The number of consultants eligible for a LCEAs
    - The total spent on LCEAs
    - The number of awards granted
    - The number of award holders

Trust Annual Report 2019/20

Number of eligible Consultants	116
Number of applicants	20
Number of awards allocated	24
Amount available for investments	£104,956
Amount carried over from 2018	£36,268
Amount invested	£78,416

Overall number of award holders (including 2019 awards).

Consultants in academic posts	None
Women Consultants	14
Black, Minority & Ethnic Consultants	44
Age Range	35 - 65
Full time	52
Part time	13
Appeals Received	0