Mid Cheshire Hospitals NHS Foundation Trust

Board of Directors

Thursday 29 July 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		**Patient Story (v)** Executive Director To note
4 9:45		**Draft Minutes of the Last Meeting - 27 May 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
CONTEXT / OVERVIEW		
5 09.48		**Chair's Report (v)** To note • Council of Governors 15 July 2021 • Board Workplan
6 09:55		**Chief Executive's Report (d)** Deputy Chief Executive • Digital Clinical System Programme Board - 12 July 2021 • Hospital Redevelopment Programme Board - 14 July 2021 To note
7 10.05		**Board Assurance Framework (BAF) Q1 Report 2021/22 (d)** Company Secretary To note

No	BAF Risk	Item
8 10.15		**Integrated Performance Report Month 3 - (June 2021) (d)** Deputy Chief Executive To note
QUALITY - Patient Safety, Clinical Effectiveness & Patient Experience		
9 10:15		**Quality & Safety Committee Chair's Assurance Reports - 16 June & 20 July 2021 (d)** Committee Chair To note • **Analysis of Wave One Covid Inpatient Deaths (d)** Medical Director To note • **Learning from Deaths Q1 2021/22 (d)** Medical Director To note
10 10:25		**Serious Incidents (d)** Medical Director To note
PERFORMANCE & FINANCE		
11 10:30		**Performance & Finance Committee Chair's Assurance Reports - 17 June & 22 July 2021 (d)** Committee Chair To note
WELL LED		
12 10:50		**Workforce & Digital Transformation Chair's Assurance Reports - - 21 June & 19 July 2021 (d)** Committee Chair To note
13 11:00		**Care Quality Commission Report & Action Plan (d)** Director of Nursing & Quality To note
14 11:10		**Freedom to Speak Up Guardian Report Q1 2021/22 (d)** Freedom to Speak up Guardian To note

No	BAF Risk	Item

GOVERNANCE

15 11:20 — **Audit Committee Chair's Assurance Report – 7 July 2021 (d)**
Committee Chair
To note

- **Risk Management Strategic Plan** (d)
  Company Secretary
  To approve

16 11:30 — **Modern Slavery Act Trust Statement (d)**
Director of Workforce and OD
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

- **Guardian of Safe Working Hours Report Q1 2021/22 (d)**
  To note

- **Request to Use the Trust Seal (d)**
  To approve

CONCLUDING BUSINESS

17 11:40 — **Any Other Business (v)**
Chair
To consider any other matters of business

18 11:45 — **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

19 11:50 — **Key Messages from the Board (v)**
Chair
To agree

Board Workplan 2021/22

				2021														2022	
				Board Dev. Day			Board Strategic Session / Formal hybrid	Board Dev. Day		Board Strategic Session		Board Dev. Day			Board Strategic Session	Board Dev. Day		Board Strategic Session	
Meeting Date	**Part I/II**	**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	I	JT	M		✓	✓			✓		✓		✓	✓			✓		✓
Preliminary Business																			
Board Action Log	I	CK	M		✓	✓			✓		✓		✓	✓			✓		✓
Board Workplan 2020/21	I	CK	Q		✓				✓				✓				✓		
Chair's Report	I	DD	M		✓	✓			✓		✓		✓	✓			✓		✓
* Council of Governors Key Issues Report (tbc)		CK	Q																
Context																			
BAF Report	I	JS	Q		✓				✓				✓				✓		
BAF Heat Map (when BAF report not submitted)	I	JS				✓					✓			✓					✓
Integrated Performance Report	I	JS	M		✓	✓			✓		✓		✓	✓			✓		✓
CEO Report	I & II	JS	M		✓	✓			✓		✓		✓	✓			✓		✓
* Hospital Redevelopment Programme Board					✓	✓			✓				✓				✓		
* Digital Clinical System Programme Board						✓			✓		✓			✓			✓		✓
* Consultant appointments		JS	ad hoc		✓	✓			✓										
STRATEGY																			
Trust Strategy	II	JS	A		✓	✓	✓		✓				✓						
Quality & Safety Improvement Strategic Plan (tbc)	I	JT	A																
Risk Management Strategic Plan	I	JS/CK	A						✓										
* Risk Appetite Statement	I	CK	A			✓													
Workforce Strategic Plan	I	HB	A											✓					
Estates Strategic Plan	I	RF	A			✓			✓		✓								
Digital Strategic Plan	I	AF	A							✓	✓								
QUALITY																			
Q&S Chair's Assurance Report	I	LM	M		✓	✓			✓		✓		✓	✓			✓		✓
Safeguarding Adults & Children Annual Report	I	JT	A						✓		✓								
Health & Safety Report	I	RF	A								✓								
Nursing & Midwifery Staffing Report	I	JT	A										✓						
Serious Incidents	I	ML	M		✓	✓			✓		✓		✓	✓			✓		✓
Medical Revalidation Annual Report	I	ML	A								✓								
Clinical Negligence Scheme for Trusts	I	JT	A			✓													
Guardian of Safe Working Hours	I	HB	Q		✓				✓				✓				✓		
Learning from Deaths	I	ML	Q			✓			✓				✓				✓		
Quality Account	I	JT	A			✓	✓												
National Inpatient Survey Results	I	JT	A								✓								
PERFORMANCE & FINANCE																			
PAF Chair's Assurance Report	I	TB	M		✓	✓			✓		✓		✓	✓			✓		✓
Financial Plan	I	RF	A			✓													
Operational Plan	I	OB	6M			✓			✓				✓						
Capital Programme	I	RF	A			✓													
Winter Plan	I	OB	A										✓						
Emergency Planning																			

				Board Dev. Day			Board Strategic Session / Formal hybrid	Board Dev. Day		Board Strategic Session		Board Dev. Day			Board Strategic Session	Board Dev. Day		Board Strategic Session	
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* Annual Report	I	OB	A											✓					
* EPRR Assurances	I	OB	A											✓					
PEOPLE																			
WDT Committee Assurance Report	I	LB	M		✓	✓			✓		✓		✓	✓			✓		✓
WRES Data	I	HB	A											✓					
WDES Report	I	HB	A											✓					
Equality Delivery System	I	HB	A																✓
Equality, Diversity and Inclusion Annual Report	I	HB	A			✓													
Clinical Excellence Awards	I	ML	A																✓
HEE Self Assessment Report	I	HB	A								✓								
People Recovery Plan	I	HB	A			✓													
Medical Staffing Update	Part II	ML	ad hoc																
GOVERNANCE/WELL-LED																			
CQC Report & Action Plan	I	JT	6M						✓										
Annual Report & Accounts	I	RF/CK	A			✓													
Remuneration Committee Assurance Report	I	DD	Ad hoc		✓														
Corporate Governance																			
Audit Committee Assurance Report	I	LP	Q		✓	✓			✓		✓		✓	✓			✓		✓
NHS Provider Licence - Annual Self-Certification:	I	JS	A																
* General Condition 6/ Continuity of Services Condition 7						✓													
* Corporate Governance Statement						✓													
CQC:	I																		
* Registration Compliance	I	JT	A			✓													
Board Self-Certification	I	RF/CK	6 Monthly			✓							✓						
Corporate Governance Framework Manual (SOs, SFIs, SoD)	I	CK/RF	A		✓														✓
Trust Responsilble Persons	I	CK	A			✓													
Use of Trust Seal Annual Report	I	CK	A		✓														
Well-Led																			
National Staff Survey (Results & Improvement Plan)	I	HB	A																✓
Board of Directors' Self-Assessment/Evaluation	I	DD/CK	A	✓															
Evaluation of Board Committees Effectiveness/ToR	I	CK/NED Chairs	A		✓														
Board Development Plan	I	CK/HB	A			✓													
Fit & Proper Person's Review	I	CK	A											✓					
Modern Slavery Statement	I	CK	A			✓			✓										
Freedom to Speak Up Guardian	I	JS	Q		✓				✓				✓				✓		
Gender Pay Gap	I	HB	A														✓		
ITEMS IDENTIFIED IN YEAR																			
Heallth and Wellbeing Assessment	I	HB	A		✓														
Restoration Plan	I	OB	A		✓	✓													
Urgent and Emergency Care Improvement Plan	I	OB	A			✓													
Delegated Budgets	II	RF	A			✓													

				Board Dev. Day			Board Strategic Session / Formal hybrid	Board Dev. Day		Board Strategic Session		Board Dev. Day			Board Strategic Session	Board Dev. Day		Board Strategic Session	
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Other Items (Ad Hoc in Year)																			
Well Led Development Review Feedback	I	CK	A								✓								
Digital Clinical System Full Business Case	I	AF	ad-hoc			✓			✓		✓								
Request to Use the Trust Seal	I	JS	ad-hoc			✓			✓										
Use of South Cheshire Hospital	II	RF	A						✓										
EVENTS / OTHER MEETINGS																			
Annual Members' Meeting													✓						
Board to Boards																			
Board Development																			
Principal Risks				✓															
Risk Appetite Statement				✓															
Board Effectiveness Survey Results				✓															
Integrated Care Systems Briefing							✓												
Board Dynamics								✓											
Health and Safety Legal Briefing								✓											
Leadership Compact 'Our Leadership Way' (tbc)																			
National Cyber Security Centre Board Training												✓							
Health Inequalities																✓			
Quality Improvement															✓				
Well Led Development Review Feedback												✓							
Social Responsibility/ Sustainable Environmental Policy (tbc)																			

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**6**	Date of Meeting: 29/07/2021
Report Title	**Chief Executive's Report July 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)*

- Senior regional appointments in NHS England/Improvement and interim appointments to C&M Integrated Care System (ICS)
- Update on key issues including the latest Trust position regarding COVID-19 and urgent & emergency care pressures
- Workforce wellbeing support

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)*

• Provide safest and best care ☐	• Be the best place to work ☐
• Become a leading and sustainable health care system ☐	• Push boundaries in clinical, technology and digital innovation ☐

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 – 29 July 2021

Key Highlights

National / Regional Update

1. Following Sajid Javid's appointment as Secretary of State for Health and Social Care on 26 June 2021, there have been senior regional appointments, announced in July:

   - Dr Amanda Doyle, currently Chief Officer of Lancashire and South Cumbria ICS, succeeds Bill McCarthy as NHS England/Improvement (NHSE/I) NW Regional Director from 1 August following Bill McCarthy's retirement at end July
   - David Flory, currently Chair of Lancashire and South Cumbria Integrated Care System (ICS) will be the acting Chair on an interim basis for Cheshire & Merseyside ICS from 1 August
   - Sheena Cumiskey, Chief Executive at Cheshire & Wirral Partnership NHS Foundation Trust, will step into the post of Chief Officer on an interim basis for three months.

   The process for making substantive appointments is continuing.

2. There have recently been a number of key national policy announcements in relation to infection prevention and control, staff absences due to a COVID 'contact', the flu vaccination programme and changes to the maximum activity threshold for application of the Elective Recovery Fund (ERF):

   - All existing IPC measures will remain in place in the NHS to protect both patients and staff, despite the lifting of most lockdown restrictions on 19 July. Staff and visitors, therefore, will be expected to continue to wear face masks and socially distance where possible. However, some NHS staff who have been 'pinged' as a community contact, under certain conditions will be able to return to work and not self-isolate.

   - It is likely that this year's flu vaccination programme expected to commence in September will run in tandem with the COVID "booster" vaccination.

   - The maximum activity threshold for the application of the ERF changed on 1 July 2021 from 85% to 95%, creating a potential financial problem for both the system and the Trust.

3. There is growing concern regionally about the significant and sustained pressure on urgent and emergency care services with unprecedented levels of demand continuing and the rise in COVID hospitalisations (*cf. Para 10*). David Levy, NHSE NW Medical Director visited the Trust on 1 July to observe first-hand the pressures the NHS is facing and his feedback to some of the Executive Directors present was positive. He expressed his gratitude for the work the Trust is doing to keep services and patients safe.

4. At the beginning of July, Bill McCarthy, NHSE/I NW Regional Director visited Mid Cheshire to see the new Emergency Department currently under construction.

Trust Update

5. In my last report (May 2021), I advised the Board that, as part of its Duty of Candour obligations, the Trust was preparing to write to the families of patients who had sadly died from COVID or where it was a contributory factor and it was considered that they had contracted it in hospital. The review of these patients' records is on-going, with senior clinicians looking at infection prevention and control and the care the patient received. To date, few lapses in care have been identified and any learning is being collated and integrated into clinical care moving forward.

   Duty of Candour will be undertaken with all families and the correspondence is currently being reviewed prior to being sent out to identified next of kin.

Senior Appointments

6. The following appointments have recently been made:

   - Dr Z Mod Isa, Consultant Breast Radiologist (start date: 1 September 2021)
   - Mr Jeremy Weetch, Consultant Obstetrician & Gynaecologist (start date: 1 October 2021)

   - Susanne Crossley, Divisional Director, Division of Medicine & Emergency Care
   - Delyth Owen, Divisional Director, Women & Children's Division

COVID-19

7. At 19 July, there were 20 confirmed positive COVID-19 patients in the hospital compared to two reported in my last CEO report in May. Community infection rates have increased substantially as have hospitalisations, albeit at a lower rate than seen in the last wave. This has resulted in a second COVID-19 ward being redesignated for patients testing positive in addition to the South Cheshire Unit for surveillance patients only. Critical Care, at the time of writing this report, had eight COVID-positive patients (a significant escalation for this unit) and the unit has been converted for treating these patients. Further escalation is considered likely and we are planning for a continued increase in COVID cases which will inevitably impact on elective work.

Vaccination Programme

8. The Vaccination Centre is now closed; however, the Trust continues to provide vaccinations for people with known allergic reactions. To date, 86% of staff have had both COVID-19 injections.

COVID-19 Restoration

9. The Trust continues to make good progress with the resumption and restoration of all clinical services and activity; however, the backlog of patients waiting for care is significant and most waiting lists continue to grow. The priority for the last four months has been those waiting longer than one year for treatment and those patients whose surgery is required within one month; both are continuing to improve with the former ahead of trajectory. In May, the Trust delivered against the 'minimum' NHSEI activity threshold and ahead of the Trust plan. This

was the same for June, with the exception of daycase activity, which fell short of expectations. This was in part due to significant gaps in the consultant anaesthetic workforce, and the Executive Team and relevant clinical Divisions are working to improve the situation.

Trust 'Business as Usual'

Urgent and Emergency Care Pressures

10. The Trust continues to experience a significant and sustained pressure on its urgent and emergency care services. In June, more patients attended ED and were admitted to hospital compared to the average of the last four years, excluding the COVID year 2019/20 and activity has far exceeded pre-pandemic levels. Overcrowding remains a concern and the workforce continues to be stretched. This is a similar situation to most Trusts across Cheshire and Merseyside. Because of the ongoing pressures, the Trust has one of the lowest 4-hour A&E performances in the system and the Executive Team is focusing on performance and the safety of urgent and emergency care services on a weekly basis. Further assurance on the action being taken to respond to the sustained pressures on Urgent and Emergency Care services will be provided through the PAF Chair's Assurance Report.

Finance

Current position

11. The position at the end of the Q1 (June) of the financial year is broadly on plan with small deficit of £43k. Whilst the Trust is expecting to meet the break-even position for H1 (April-September), there are challenges ahead for Q2 as a result of the unplanned care pressures currently being experienced, which may also put pressure on the ability to deliver the elective recovery programme, and in turn access to the Elective Recovery Fund (ERF).

Forecast

12. The Trust is expecting to receive during August national guidance in relation to the funding for the second half of the financial year (H2, October - March), with an expectation to sign off plans during September. This will see continuation of the block payment arrangements but it is anticipated that there will be an increase in waste reduction (cost improvement) expectations, and some of the key non-recurrent sources of income such as COVID funding are expected to be reduced, which will put pressure on the financial regime across the whole of the healthcare partnership (HCP).

2022/2023 Timelines

13. Whilst guidance on next year is not expected until December 2021 at the earliest, nationally they are reviewing the NHS block payment and system top-up baselines by the end of November in time for the spending review in December. 2022/23 planning will be during the period January-March 2022.

Workforce

People Recovery Plan

14. Wellbeing Squads launched across the Trust at the beginning of June and have spent time with various teams offering a range of support. The Wellbeing Squads (HR, Occupational Health and Learning & OD team members, working alongside Mental Health First Aiders)

provide bespoke support to individuals and teams. They are applying a flexible approach to the support they offer to ensure maximum engagement and to make sure any offer of support is balanced with the current operational pressures upon our staff. A Wellbeing week is currently being planned with the aim of reaching as many staff as possible to provide immediate and appropriate support to those seeking wellbeing input. In response to the rising levels of pressure on our staff, a holistic staff wellbeing risk assessment has been completed to ensure that all current mitigations/controls are in place and to identify further areas of support for staff.

15. The sickness rate for June 2021 was 5.3% which reflects an increase since the last report. The top reason for absence is anxiety and stress which is reflective of the ongoing pressures the hospital faces as a result of the COVID-19 pandemic. We are continuing to work hard to provide support mechanisms to all our staff during this time to prevent a continued increase in sickness rates.

National Quarterly Pulse Survey (NQPS) Introduction at MCHT

16. From 1 July 2021, all NHS organisations are required to participate in the National Quarterly Pulse Survey (NQPS) which will replace the quarterly staff friends and family test (FFT). The People Pulse does not replace the representative data collected from the NHS Staff Survey, which will run as normal in October/November of this year; instead, it provides a more regular way of measuring employee engagement supporting the employee voice.

17. The link between engagement and high-quality care is well documented; King's Fund research highlights the link between engagement, patient satisfaction, mortality rates as well as general safety measures. Within the Trust, comms and engagement have been released to promote staff participation and at the end of each quarter, results will be shared with the Executive Workforce & Assurance Group subgroups for consideration and sense-checking with operational plans and a mechanism will be established to feedback to colleagues on what action has been taken as a result of their participation. Outputs from the surveys will also be reviewed at a national level to inform policy and prioritisation at both national and regional levels.

Staff Consultation and engagement: Offsite office moves

18. On 1 July, the Trust launched a consultation exercise with staff as part of its plans to relocate office space to allow for the redevelopment of the Leighton site. Staff were updated on the proposals and plans for that redevelopment, including the rationale for the requirement to change their location. Staff were also informed of how the ways of working which we have relied on and embraced over the last year will continue to help support staff with their work-life balance, with a clear message that we wish to encourage and enable agile working on all of our sites. Staff were also informed of the process for implementing these changes.

19. The consultation and engagement exercise will continue throughout July, August and September, with the expectation that staff moves will be done on a phased approach. Those staff who are moving off the Leighton site will be transitioning to the new building on Crewe Business Park at the beginning of October. The new offsite accommodation offers modern facilities with green space and local amenities close by. Staff visits to the new site will be arranged during July / August as part of the engagement and consultation exercise.

(Leighton) Hospital Redevelopment Programme Board (HRPB)

20. The HRPB met in July to discuss the RAAC Plank Business Case, the lessons learnt from the development of the Strategic Outline Case for Leighton Hospital Redevelopment and next steps. The Chair's Assurance Report is appended to my report (Appendix I).

Digital Clinical System (DCS)

21. The DCS Transformation Board met in July and considered the NHS Digital's Healthcheck Report. The Board has requested urgent written assurances against all recommendations and an additional Programme Board meeting has now been scheduled In August to consider these. The Chair's Assurance Report is at Appendix 2 to my report.

James Sumner, Chief Executive
July 2021

Digital Clinical System
DCS Transformation Board Assurance Report
July 2021

Report to	Board of Directors
Date	July 2021
Report from	James Sumner, DCS Programme SRO
Report prepared by	Phill James – DCS Programme Director
Executive Lead/s	Amy Freeman – Chief Information Officer
Committee meeting quoracy	Yes ☒ No ☐

The Digital Clinical Solution is a complex programme seeking significant investment on behalf of both Trusts.

The DCS Programme is committed to robust governance and is abiding by the OGC Gateway Review model. OGC Gateway reviews deliver a 'peer review', in which independent practitioners from outside the programme/project use their experience and expertise to examine the progress and likelihood of successful delivery of the programme or project. In anticipation of OGC Gateway 3, as the Full Business Case seeks approval, the programme commissioned an external healthcheck.

The DCS Transformation Board received the NHS Digital Trusts System Support Model Healthcheck Report on 28 June 2021. This gave the programme an amber rating – *"Successful delivery appears feasible but significant issues already exist requiring management attention. These appear resolvable at this stage and if addressed promptly, should not present a cost/schedule overrun".*

Challenges were highlighted in the following areas:
1. Market capability to meet resourcing demand
2. Pandemic pressures
3. Gap between current digital capability and DCS aspirations
4. Key stakeholders retiring or moving to other roles
5. Financial pressures
6. Limited visibility of business case and engagement progress within wider Nursing and Operations teams
7. Contract management arrangements
8. Supplier capacity
9. Communications
10. Patient flows with other organisations and interoperability.

The DCS Transformation Board received initial responses to the recommendations. The Transformation Board was not assured and actioned urgent written assurances against all recommendations. This will be provided in August 2021 at an additional Programme Board meeting (date tbc).

Recommendation

To note the report.

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

Report to	Board of Directors – 29 July 2021
Date	14 July 2021
Report from	James Sumner, Chief Executive
Report prepared by	Katharine Dowson, Head of Corporate Governance
Executives	Russell Favager, Deputy Chief Executive
Meeting quoracy	Yes ☐ No ☒

KEY AREAS OF ASSURANCE

RAAC Plank Business Case

- £22m funding for RAAC plank confirmed (spend by 31 March 2022)
- RAAC plank remedial works underway with 82% of site surveyed, a further 8% are in residencies and scheduled for demolition. Failsafe steelworks being installed as identified. Ward 10 (awaiting clinical decision) and ED (awaiting completion of new build) outstanding
- Emergency planning exercises for RAAC plank failure have tested emergency procedures
- Design team to be appointed to develop ward block design; Archus to support process
- Proposal to complete Ward 24 works as alternative ward space, if operational pressures do not allow vacation of South Cheshire area in time

Strategic Outline Case for Leighton Hospital Redevelopment

- Five RAAC plank Trusts meeting regularly through CEOs and Communications Leads; Estate Directors' meeting to be established
- Lessons Learnt paper reviewed with focus on successful project delivery and lessons to be embedded in Outline Business Case (OBC) stage
- Phased approach and risk register to be developed to prepare for bidding opportunities across all Trust sites
- External stakeholder engagement plan underway, including two planned MP visits

KEY CONCERNS/RISKS

- NHSI/E approval required to move South Cheshire Ward refurbishment resource to Ward 24 as part of £22m project
- Full design process, normally part of OBC, might not be complete before a first ward block is funded for development, therefore full design consultation and consideration may not be as in-depth as non-phased approach
- Partnership working may require some timelines to be amended to reflect wider stakeholder involvement'

Priority Areas: DECISIONS MADE (to be ratified as not quorate)

- Approval of appointment of Archus for work to develop ward block design (£27k)

RECOMMENDATION

- Recommendation to Board regarding use of South Cheshire funding and move of Ward 24 to the work plan as an alternative, noting NHS England /NHS Improvement approval required

To note

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**7**	Date of Meeting: 29/07/2021
Report Title	**Board Assurance Framework**	
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)*

- Current status of the newly agreed strategic risks mapped to the current Strategic Objectives
- Five risks have been scored at a high-risk priority level
- Controls, assurance of the controls and actions have been identified for all strategic risks

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

- Executive Risk Leads to act on recommendations agreed during meeting

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

• Provide safest and best care ☐ • Become a leading and sustainable health care system ☐	• Be the best place to work ☐ • Push boundaries in clinical, technology and digital innovation ☐

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

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

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

Strategy ☐ Policy ☐ Service Change ☐

Mid Cheshire Hospitals NHS FT

REPORT DEVELOPMENT

Committee/ Group Name	Date	Report Title	Lead	Brief summary of key issues raised and actions agreed
Executive Team	28/06/21	2021/22 Board Assurance Framework	Company Secretary	Each Executive to review current risk scores, controls and assurances
WDT, Q&S, PAF Committees	W/C 19/07/21	2021/22 Board Assurance Framework	Company Secretary	Reviewed and revisions to dashboard incorporated. Likelihood and Scoring guidance included in appendix

Board Assurance Framework

Introduction

1. The Board Assurance Framework (BAF) is an important component of the Trust's corporate governance and risk management framework. It is a monitoring tool used by the Board to assess the organisation's capacity to achieve its strategic objectives, and to ensure it has appropriate oversight of the Trust's risk profile and risk management arrangements. A properly used BAF will also drive the forward work plan and agendas for the Board and its Committees.

2. The Trust's strategic risks aligned with the strategic objectives were agreed with the Board of Directors in April 2021/22. Each strategic risk has been assigned either to the Board or a Board Committee for oversight. The Board receives a quarterly report of the full BAF.

3. This report provides an update in relation to current risk scores (see Appendix 1). Additional detail about the controls and assurances mapped to date for those strategic risks is provided in the 4Risk report in Annex 1.

Strategic Risks

4. Current risk scores (see Appendix 1) have been discussed and agreed by the Executive Team for all strategic risks. Five of the fourteen risks are rated within the high-risk priority level. These reflect the current pressures across services in the wake of the Covid pandemic crisis and the aged infrastructure of the Leighton Hospital site.

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

6. The detail that has been collated will be subject to a continual quality assurance process, co-ordinated by Corporate Governance. The Executive Team will monitor the completion of actions and discuss changes to the BAF on a monthly basis.

Recommendations

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

Chris McKeown, Corporate Risk & Assurance Manager
23 July 2021

Addendum: notes relating to appendix – BAF heatmap

1. The following appendix consist of a one-page summary of the current score for the Trust's strategic risks included in the Board Assurance Framework.

2. Movement in risk scores since will be reflected in future reports and be denoted using arrows (⇑ increase **/** ⇓ decrease).

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

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

4. To ensure accuracy and consistency in risk scoring across the Trust, all risks should be scored against the risk impact and likelihood guidance included in the Risk Management Process Guide. The guidance is included in Appendix 3.

Appendix 1: BAF heatmap showing current scores (Impact x Likelihood) 2021-22

SO1: Patient Experience & Quality of Services Provide safest and best care which is equitable and centred on the patient and their family's health, well-being and care needs	**SO2: New Ways of Working** Become a leading and sustainable health care system, providing seamless care to our local population in collaboration with our partners	**SO3: Best Place to Work** Be the best place to work, where our staff are empowered to innovate and provide consistently excellent care	**SO4: Build for the Future** Push boundaries in clinical, technology and digital innovation to provide the tools and infrastructure to deliver best possible care
BAF1: IF demand exceeds operational capacity while the Trust adapts to the 'new normal', THEN service restoration may be ineffective and impact negatively on patient care, outcomes and experience **4 x 5 = 20**	**BAF5:** IF we fail to establish formal place-based partnerships with good governance and assurance, THEN we are unlikely to deliver new ways of working across the health and social care system **4 x 3 = 12**	**BAF8:** IF we fail to develop the capacity and capability to deliver a consistent and coordinated continuous improvement methodology, THEN we will not deliver our strategic ambitions **3 x 4 = 12**	**BAF11:** IF our estate, infrastructure and equipment are not fit for the future, THEN we will fail to achieve our strategic ambitions **5 x 4 = 20**
BAF2: IF our workforce wellbeing and resilience are reduced, THEN our capacity to restore services and adapt to future challenges will be compromised **4 x 4 = 16**	**BAF6:** IF we are unable to achieve a sufficient level of influence within the ICS, THEN commissioning decisions may prevent us from achieving our strategic aims **4 x 3 = 12**	**BAF9:** IF the conditions for shaping leadership and organisational culture are sub-optimal, THEN our strategic ambitions will not be realised **4 x 3 = 12**	**BAF12:** IF a major incident occurs as a result of RAAC plank failure, THEN people may be harmed and the Trust could be subject to legal and regulatory investigation **5 x 4 = 20**
BAF3: IF we do not maintain a robust and consistent focus on the quality of care, THEN there may be a negative impact on patient safety, outcomes and experience **3 x 3 = 9**	**BAF7:** IF we are unable to agree a financial control total, THEN it could jeopardise delivery of strategy **3 x 3 = 9**	**BAF10:** IF we are unable to harness data to understand the needs of our population and inform our decisions, THEN we will fail to improve healthcare outcomes and address health inequalities **3 x 4 = 12**	**BAF13:** IF we fail to deliver the technological and people aspects required to implement Digital Clinical System, THEN intended benefits for patients may not be realised and the financial investment would be wasted **4 x 3 = 12**
BAF4: IF a significant H&S incident occurs within the Trust, THEN people may be harmed and the Trust could be subject to legal and regulatory investigation **5 x 3 = 15**			**BAF14:** IF workforce plans do not align with the future operating model, THEN it is likely that there will be increased costs and workforce gaps that could affect standards of care **3 x 4 = 12**

Appendix 2: integrated risk dashboards (current scores)

Strategic Objective 1	Provide safest and best care which is equitable and centred on the patient and their family's health, well-being and care needs

Principal risks	Risk score (IxL)
BAF1. Demand exceeds operational capacity while the Trust adapts to the 'new normal (**COO**)	**20 (4x5)**
BAF2. Workforce wellbeing and resilience (**DW&OD**)	**16 (4x4)**

Risk and controls commentary

- The controls in place for **BAF1** aim to ensure improvement plans are in place as part of the restoration. These include addressing backlogs in services, planning patient flow and surges and the recruitment of staff.
  - A number of high priority operational risks (10) are linked to this BAF associated with restoration of services
- The development and review of the plans are the actions required to ensure that services are being restored in a safe and most timely manner.
- **BAF2** controls relate to Workforce Matters Strategy and Health & Wellbeing Plan to ensure that staff and workforce are supported. A raft of actions to support staff are being implemented and reviewed for their effectiveness.

Ref	High scoring operational risks (15+)	Risk score (IxL)
TW0007	Delayed routine outpatient follow-up	**16 (4x4)**
TW0036	Unable to deliver key cancer standards	**16 (4x4)**
TW0037	Unable to deliver RTT performance and manage waiting times in line with national requirements	**20 (4x5)**
TW0039	Unable to deliver urgent and emergency care in line with national standards	**16 (4x4)**
TW0041	Suboptimal flow of patients	**16 (4x4)**
TW0042	Insufficient number of general, acute and critical care beds	**16 (4x4)**
TW0045	Inadequate processes and procedures to keep patients on waiting lists safe	**20 (5x4)**
SC0647	Restricted access to Endoscopy Services during the COVID-19 national pandemic event	**16 (4x4)**
SC0652	Impact of Covid-19 on the Elective Programme	**16 (4x4)**
GY0302	Deterioration of Gynaecology elective services as a result of the Covid-19 pandemic	**15 (5x3)**
TW0040	Unable to plan effectively for workforce changes and requirements	**20 (4x5)**
DC1086	Occupational Therapy staffing Levels	**16 (4x4)**
DC1087	Inpatient physiotherapy staffing resource	**16 (4x4)**

Strategic Objective 1 (continued)	Provide safest and best care which is equitable and centred on the patient and their family's health, well-being and care needs

Principal risks	Risk score (IxL)
BAF3. We do not maintain robust and consistent focus on quality of care (**DN&Q / MD**)	**9 (3x3)**
BAF4. Significant Health & Safety incident (**DCEO/DF**)	**15 (5x3)**

Risk and controls commentary

- The controls for **BAF3** identify how the quality of Trust services are monitored to ensure that patients are receiving the best care. These include strategies and policies that provide the assurance that quality is being maintained.
  - There are currently 12 high priority operational risks related to BAF3
- Actions for BAF3 include a process and operating procedure to ensure that implementation of NICE guidance can be evidenced as well as identifying learning from the Covid Wave 2.
- **BAF4** controls relate to the groups, sub-groups and policies associated with Health & Safety (H&S) which provide the assurance of good H&S management. Additional actions required will ensure a Violence & Aggression Strategic Plan is in place and a Stress Survey ii undertaken and acted upon.

Ref	High scoring operational risks (15+)	Risk score (IxL)
TW0053	Failure to identify and appropriately manage a deteriorating patient	**20 (5x4)**
WODLD9	Resus Training Capacity	**15 (5x3)**
CE0002	Failure to use LocSSIP before interventional procedure	**16 (4x4)**
SC0638	Lack of image capture within the Unisoft system	**20 (4x5)**
EC0466	Lack of Out of Hours Upper GI Bleed Rota / Service	**20 (5x4)**
EC0484	Shortages of medical staff in medicine	**20 (5x4)**
GY0303	Lack of gynaecology oncology fail safe	**15 (5x3)**
MS0179	Capacity of the foetal medicine unit	**15 (5x3)**
PA0308	Paediatric Audiology UKAS accreditation	**15 (5x3)**
PA0323	Potential surge in paediatric respiratory infections	**15 (5x3)**
DC1056	Lack of aseptic service at MCHFT	**15 (5x3)**
CP0115	Provision of ambulatory wound care within CCICP	**15 (3x5)**
HSEF0004	Regulatory Compliance with the Regulatory Reform (Fire Safety) Order 2005	**15 (5x3)**
HSEF0006	Estates and Facilities Alert EFA/2018/005 - Assessment of Ligature Points	**15 (5x3)**

Strategic Objective 2	Become a leading and sustainable health care system, providing seamless care to our local population in collaboration with our partners

Principal risks	Risk score (IxL)
BAF5. Failure to establish formal place-based partnerships with good governance and assurance (**CEO**)	**12 (4x3)**
BAF6. Inability to achieve sufficient level of influence within the ICS (**CEO**)	**12 (4x3)**
BAF7. Inability to agree a financial control total (**DCEO/DF**)	**9 (3x3)**

Ref	High scoring operational risks (15+)	Risk score (IxL)
TW0048	Ineffective contracting arrangements with commissioners (CCG/NHSE)	**16 (4x4)**
DC1069	Clinical Haematology Service	**20 (5x4)**

Risk and controls commentary

- **BAF5** controls relate to the partnership agreements and links the Trust has with other organisations to support new working. Actions are identified with further actions likely to be required as the partnership links evolve.
- **BAF6** controls are associated with both the development of the Trust's Strategy and that of the Board of Directors to ensure the Trust continues to be 'well led' and 'healthy' to enhance the ability to influence within the ICS.
- **BAF7** controls provide assurances of the financial management and agreement of financial plans. Once implemented, the actions are to provide further evidence of the financial control that is in place.

Strategic Objective 3	Be the best place to work, where our staff are empowered to innovate and provide consistently excellent care

Principal risks	Risk score (IxL)
BAF8. Capacity and capability to deliver a consistent, coordinated continuous improvement methodology (**CEO**)	**12 (3x4)**
BAF9. Sub-optimal conditions for shaping leadership and organisational culture (**DW&OD**)	**12 (4x3)**
BAF10. Inability to harness data to understand population needs and inform decisions (**CIO**)	**12 (3x4)**

Ref	High scoring operational risks (15+)	Risk score (IxL)
DQCC1	Temporary/Missing Casenotes	**15 (3x5)**
DQCC2	Bed Management System	**15 (3x5)**

Risk and controls commentary

- The controls for **BAF8** relate to the Executive Quality Improvement Group and Strategic Partner that has been appointed to support continuous improvement to deliver the strategic ambitions.
- **BAF9** controls include the strategies, plans and programmes that have been developed (such as Talent Board and Succession Planning and 'Our Leadership Way framework) that are in place or being developed to support the ambitions of shaping leadership and culture within the Trust. Actions identified will support the development of staff within the organisation.
- To understand the population needs, **BAF10** includes the current controls and actions required to ensure that a Data Warehouse is implemented to support decision-making in addressing healthcare outcomes and inequalities.
- There are currently no operational risks assessed as high priority relating to SO3.

Strategic Objective 4	Push boundaries in clinical, technology and digital innovation to provide the tools and infrastructure to deliver best possible care

Principal risks	Risk score (IxL)
BAF11. Estate, infrastructure and equipment not fit for the future (**DCEO/DF**)	**20 (5x4)**
BAF12. Major incident as a result of RAAC plank failure (**DCEO/DF**)	**20 (5x4)**
BAF13. Failure to deliver technological and people aspects required to implement the DCS (**CIO**)	**12 (4x3)**
BAF14. Workforce plans do not align with future operating model (**DW&OD**)	**12 (3x4)**

Ref	High scoring operational risks (15+)	Risk score (IxL)
MS0177	Maternity Theatre 1 IPC - improvements required	**15 (5x3)**
EF0548	Critical Risk Adjusted Backlog Maintenance	**20 (5x4)**
EF0606	Inability to carry out key IT and Estate works to previous South Cheshire Hospital	**16 (4x4)**
HSEF0007	Failure of RAAC Planking at Leighton Hospital resulting in disruption to Clinical services	**20 (5x4)**

Risk and controls commentary

- **BAF11** has 3 high priority associated risks and the controls are in place to ensure the Estates Strategic Plan is being implemented to support the continual development and management of the MCHT site. Actions being implemented to support the risk include ensuring cost benefit analysis is taking place with regard to current functions and that new Strategic Plans are developed.
- For **BAF12**, the survey, maintenance and redevelopment works in regard to the national RAAC plank identified concerns are in place and the continuation of these works is included in the action plan.
- Controls and actions for **BAF13** provide assurance on the ongoing work to ensure a Digital Records System can be implemented within the Trust
- The current recruitment and development work provides the assurance that staff are in place and fully supported to complete their role and progress when required. Actions identified will enhance this further whilst also analysing the recruitment process.

Appendix 3: Likelihood and impact scoring guidance

Likelihood scoring guidance

Likelihood	Description	Frequency (trend analysis)	Estimated Probability
5 Almost Certain	The indications are that the event will undoubtedly happen/recur.	A regular occurrence (at least weekly).	More than 90% chance of occurring
4 Likely	The event will probably happen/recur.	Occurs at least every two months.	60% to 90% chance of occurring
3 Possible	The event might happen or recur occasionally.	Has occurred intermittently (a few times a year).	40% to 60% chance of occurring
2 Unlikely	Not expected, but it is possible.	Has happened here or elsewhere within the past two years.	10% to 40% chance of occurring
1 Rare	There is a remote possibility of the event occurring in exceptional circumstances.	Has rarely happened (not in many years).	Less than a 10% chance of occurring

Impact scoring guidance

Impact					
Category	**1 Negligible**	**2 Minor**	**3 Moderate**	**4 Major**	**5 Catastrophic**
Patient, Staff or Public Safety	Superficial injury requiring no or minimal treatment	Minor injury or illness requiring minor intervention	Moderate harm requiring treatment Impact on small number of people	Serious injury or long-term effects	One or more fatalities Negative effects for large number of people
Legal / Regulatory	Minimal improvement required	Small number of minor recommendations	Wide-ranging recommendations requiring action	Enforcement action Critical report	Prosecution Severely critical report
Service disruption	Minor, very short interruption in a core service	Short-term, limited disruption to a core service	Temporary loss of ability to provide a core service	Sustained loss of service requiring contingency plans to be invoked	Permanent loss of a core service or sustained disruption to multiple services
Financial	Low financial loss <£750,000	Moderate loss >£750,000 <£1,500,000	High financial loss >£1,500,000 <£3,000,000	Major financial loss >£3,000,000 <£5,000,000	Severe financial loss >£5,000,000

Board Assurance Framework (BAF)

Report Date	21 Jul 2021
Risk Status	Open
Risk Area	01. Strategic Risks 2021/22
Control Status	Existing
Action Status	Outstanding

Mid Cheshire Hospitals NHS Foundation Trust

01. Strategic Risks 2021/22

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	Risk Control	Control Assurance (Internal Assurance)	Internal Assurance Assurance Level	Control Assurance (External Assurance)	External Assurance Assurance Level	Current Risk Score	Action Required	Target Risk Score

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	Risk Control	Control Assurance (Internal Assurance)	Internal Assurance Assurance Level	Control Assurance (External Assurance)	External Assurance Assurance Level	Current Risk Score	Action Required	Target Risk Score
BAF 1	IF demand exceeds operational capacity while the Trust adapts to the 'new normal', THEN service restoration may be ineffective and impact negatively on patient care, outcomes and experience **Executive Risk Lead:** Oliver Bennett **Risk Owner:** Oliver Bennett **Last Updated:** 21 Jul 2021 **Latest Review Date:** **Latest Review By:** **Last Review Comments:**	**Cause(s)** 1. Changing patterns of demand 2. Workforce gaps 3. Covid threat alters the operating environment indefinitely 4. Waiting list backlogs 5. Population health needs change due to long-term effects of Covid **Consequence(s)** 1. Ineffective restoration of services 2. Detrimental impact on patient care and experience 3. Poorer outcomes for patients 4. Regulatory and reputational impact 5. Health inequalities	I = 4 L = 5 20	01. Urgent and emergency care improvement plan, including development of the new A&E build, NHS111 'First' and 'Same Day Emergency Care (SDEC)'. **Control Owner:** Mark Wilde	Urgent & Emergency Care Improvement Plan, including high impact initiatives to improve performance, approved by PAF May 2021 Highlight report included within COO report on NHS111 implementation to PAF Jan 2021 following soft launch Nov 2020	Partial			I = 4 L = 5 20	Rollout programme for SDEC **Action Owner:** Denise Tokely-McNicholas **Target Implementation Date:** 31 Jul 2021	I = 4 L = 3 12
										Approved elective care improvement plan **Action Owner:** Andrew Williams **Target Implementation Date:** 31 Aug 2021	
										Robust monitoring of the delivery plan for the opening of the new A&E **Action Owner:** Rebecca Viggars **Target Implementation Date:** 30 Sep 2021	
				02.Backlogs - elective care restoration plan and investment. **Control Owner:** Mark Wilde	Monthly updates to PAF and Board.	Acceptable	Restoration Plan and trajectories submitted to NHSEI via C&M HCP April 2021. Final submission June 21.	Acceptable		Approved diagnostic improvement plan. including recovery of endoscopy services **Action Owner:** Emma Colgan **Target Implementation Date:** 30 Sep 2021	
				03.Elective care improvement plan. **Control Owner:** Andrew Williams	Plan updates taken to EDPG monthly	Partial				Agree priorities around the health inequalities agenda **Action Owner:** Oliver Bennett **Target Implementation Date:** 30 Sep 2021	
				04. Diagnostic services improvement plan and outsourcing to the independent sector. **Control Owner:** Emma Colgan	Monthly Integrated Performance Report provides performance data as a evidence of progress against plan	Partial				Approved Cancer Improvement plan **Action Owner:** Andrew Williams **Target Implementation Date:** 30 Sep 2021	
				05. Outpatient transformation plan. **Control Owner:** Leo Door	Monthly highlight report to EDPG	Acceptable				Seasonal Surge Plan to be approved **Action Owner:** Mark Wilde **Target Implementation Date:** 30 Sep 2021	
				06. Cancer services restoration and improvement plan. **Control Owner:** Andrew Williams	Details of Cancer Services Restoration Plan within monthly Restoration Report submitted to PAF. Included in July Cancer Highlights report to EDPG.	Partial				Agree a process to provide assurance on LLPs through to EDPG. **Action Owner:** Ros Davies **Target Implementation Date:** 30 Sep 2021	
				07. Seasonal surge plan. **Control Owner:** Mark Wilde	Covid Review including lessons learned submitted to BoD May/June 2021. Winter plan tracked and progress documented at Silver Command and escalated to Gold if necessary. Evidence of deviation from plan within the IPR and escalated by exception to PAF and Board via Chair's Assurance report and potentially the CEO Report.	Partial				Structure and framework to be agreed for workforce planning at Divisional level. Report to be taken to EDPG. **Action Owner:** Jenny Grant **Target Implementation Date:** 31 Oct 2021	
				08. Domestic and international recruitment programme. **Control Owner:** Jenny Grant	International Recruitment of Medical Staff Report to December WDT Committee	Partial					

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	Risk Control	Control Assurance (Internal Assurance)	Internal Assurance Assurance Level	Control Assurance (External Assurance)	External Assurance Assurance Level	Current Risk Score	Action Required	Target Risk Score
				09. Limited Liability Partnerships and other out/in sourcing arrangements **Control Owner:** Mark Wilde	Governance process in place for each contract along with contract management meetings	Low					

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	Risk Control	Control Assurance (Internal Assurance)	Internal Assurance Assurance Level	Control Assurance (External Assurance)	External Assurance Assurance Level	Current Risk Score	Action Required	Target Risk Score
BAF 2	IF our workforce wellbeing and resilience are reduced, THEN our capacity to restore services and adapt to future challenges will be compromised **Executive Risk Lead:** Heather Barnett **Risk Owner:** Heather Barnett **Last Updated:** 21 Jul 2021 **Latest Review Date:** **Latest Review By:** **Last Review Comments:**	**Cause(s)** 1. Increase in mental health issues post Covid 2. Staff with 'long Covid' 3. Staff burn-out 4. Further surges/new variants 5. Additional pressure due to restoration plans and increased activity 6. Inability to take time away from work 7. Inability to recruit to hard to fill roles (medical roles) 8. Additional work pressures as a result of restoration plans 9. Additional hours worked to achieve activity levels. **Consequence(s)** 1. Loss of goodwill and staff engagement 2. Fluctuating capacity 3. Increase in long-term sickness 4. Increased staff turnover 5. Disruption to services 6. Increased agency spend 7. Poor Mandatory training compliance 8. Poor Appraisal compliance 9. Reduction in release time for leadership / CPD / clinical skills training 10. Increase in stress related illness and potential rise in litigation claims	I = 4 L = 5 20	01. Our Workforce Matters Strategy **Control Owner:** Heather Barnett	Our Workforce Matters quarterly updates to Workforce & Digital Transformation (WDT). Medical staffing workforce metrics included in the Workforce Report reported via WDT to Board of Directors.	Partial			I = 4 L = 4 16	Implement the 'Wellbeing Squads' and review impact **Action Owner:** Bobby Sharma **Target Implementation Date:** 31 Jul 2021	I = 4 L = 3 12
										Develop the medical and wider clinical workforce gap trajectories **Action Owner:** Jenny Grant **Target Implementation Date:** 31 Jul 2021	
										Implement additional staff networks **Action Owner:** Heather Barnett **Target Implementation Date:** 30 Aug 2021	
				02. People Recovery Plan **Control Owner:** Jenny Grant	People Recovery Plan submitted to WDT June 2021	Acceptable				Develop Trust Workforce Strategic Plan to align with the People Plan and Trust Strategy aims. **Action Owner:** Heather Barnett **Target Implementation Date:** 31 Aug 2021	
				03. Health & Wellbeing Plan **Control Owner:** Bobby Sharma	H&WB Diagnostic tool completed and submitted to Board April 2021 - action plan in place to address gaps H&WB Project Board workstreams in place - WDT advised June 2021 Health & Wellbeing quarterly report to Executive Workforce Assurance Group; key issues escalated to WDT. Wellbeing /Serenity rooms, wellbeing conversations and vaccination programme.	Acceptable				Work with CWP and ECT to enhance OH and MH and wellbeing offer through the Cheshire Collaboration project **Action Owner:** Heather Barnett **Target Implementation Date:** 30 Sep 2021	
										Introduce financial wellbeing support as part of H&WB offer **Action Owner:** Bobby Sharma **Target Implementation Date:** 30 Sep 2021	
										Carry out skill mix review in Occupational Health **Action Owner:** Jenny Grant **Target Implementation Date:** 31 Oct 2021	
				04. Measures put in place to support BAME staff during Covid **Control Owner:** Bobby Sharma	ED&I Programme and National Priorities submitted to WDT June 2021. Appraisal data by ethnic group to go to WDT July 21.	Acceptable	Detailed response submitted to NHSE/I in June 2020 re Trust compliance with risk assessments for at risk staff groups. Board advised of compliance.	Acceptable			
				05. Occupational Health provision **Control Owner:** Bobby Sharma	Monthly Workforce Supply Group Chairs report to Executive Workforce Assurance Group including Occupational Health escalations when required.	Acceptable					
				06. National and Regional H&WB offers **Control Owner:** Bobby Sharma	Offers come from NHSI/E and are managed via the Health & Wellbeing Group	Acceptable					

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	Risk Control	Control Assurance (Internal Assurance)	Internal Assurance Assurance Level	Control Assurance (External Assurance)	External Assurance Assurance Level	Current Risk Score	Action Required	Target Risk Score
				07. Cheshire & Merseyside Resilience Hub **Control Owner:** Bobby Sharma	C&M resilience hub provide additional Mental Health Support and is monitored via the Health & Wellbeing Group who repot to EWAG.	Acceptable					
				08. International recruitment programme **Control Owner:** Julie Mitchell	International Recruitment Medical Staff - update to WDT Committee Dec 2020. Quarterly update to WDT and escalated to EWAG if required.	Acceptable	Project Board for the Cheshire Collaborative meet monthly and international recruitment is monitored.	Acceptable			
				09. Workforce Supply Group **Control Owner:** Jenny Grant	Workforce Supply Group monitor key areas (workforce gaps, vacancy gaps, E-rostering) and report to EWAG.	Acceptable					
				10. Monthly workforce metric reporting **Control Owner:** Paul Cooper	Metrics such as sickness and turnover reported to EWAG. Divisional Deep Dives undertaken on an agreed schedule	Acceptable					
				11. Annual leave carry over entitlement **Control Owner:** Anna Bickerton	Carry over entitlement part of the Operational Recovery Plan	Acceptable	NHSI/E submission in April 21	Acceptable			
				12. Cheshire Collaborative Occupational Health project **Control Owner:** Heather Barnett			MCHT, East Cheshire and CWP are part of a monthly Cheshire HRD Group. A monthly Health Care Partnership meeting monitors this.	Acceptable			

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	Risk Control	Control Assurance (Internal Assurance)	Internal Assurance Assurance Level	Control Assurance (External Assurance)	External Assurance Assurance Level	Current Risk Score	Action Required	Target Risk Score
BAF 3	IF we do not maintain a robust and consistent focus on the quality of care, THEN there may be a negative impact on patient safety, outcomes and experience **Executive Risk Lead:** Julie Tunney **Risk Owner:** Julie Tunney **Last Updated:** 02 Jul 2021 **Latest Review Date:** **Latest Review By:** **Last Review Comments:**	**Cause(s)** 1. Failure to monitor patient safety harm incidents 2. Patient safety incidents increasing 3. Lack of a Quality of Care Strategic Plan **Consequence(s)** 1. Increased patient harm incidents 2. Poorer outcomes for patients 3. Quality standards not met 4. Lower CQC rating 5. Negative impact on patient experience 6. Reputational damage	I = 5 L = 4 20	01. Quality & Safety Improvement Strategy **Control Owner:** Julie Tunney	Q&S metrics reported monthly to Committees and Board via IPR Quality Account submitted to W&S and Board annually - approved by Board June 2021 CQC Compliance Report submitted to Board May 2021 Quarterly reporting to QSC and Board	Acceptable			I = 3 L = 3 9	Process and Standard Operating Procedure for NICE guidance **Action Owner:** Hayley Cavanagh **Target Implementation Date:** 31 Oct 2021 Development of Business Case for 7 day services **Action Owner:** Julie Tunney **Target Implementation Date:** 31 Dec 2021 End of Life process development. Training Programme and Communication with families of End of Life patients **Action Owner:** Liz Fullerton **Target Implementation Date:** 31 Dec 2021 Covid Wave 2 Death Analysis **Action Owner:** Murray Luckas **Target Implementation Date:** 31 Dec 2021	I = 3 L = 2 6
				02. Infection Prevention & Control Policy **Control Owner:** Julie Tunney	IPC BAF After Action Review May 2021. Submitted to QSC June 21	Partial					
				03. Ward Accreditation Programme including CCICP **Control Owner:** Julie Tunney	Annual Report to QSC. Monthly metrics taken to Trust Improvement Group.	Acceptable	CQC Inspection MIAA Internal Audit Report - Ward Quality Spot Checks (Sept 2019)	Acceptable			
				04. Reducing Harm Policies **Control Owner:** Julie Tunney	Falls and Pressure Ulcer Policies in place. Harm Free Care Panel reporting to Trust Quality Group. Escalation to EQGG if required. Falls Metrics within IPR submitted monthly to QSC and Board. Pressure Ulcer Groups (inpatients and CCICP), Skin Group, Falls Group. Deep Dives completed when potential issues identified.	Acceptable					

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	Risk Control	Control Assurance (Internal Assurance)	Internal Assurance Assurance Level	Control Assurance (External Assurance)	External Assurance Assurance Level	Current Risk Score	Action Required	Target Risk Score
				05. Clinical Audit and Effectiveness Plan **Control Owner:** Murray Luckas	Clinical Audit and Effectiveness Plan to Audit Committee July 2021. Annual Clinical Audit Programme forms part of plan and is included in annual Quality Account. Monthly Audit Days for Clinical staff to review quality of care and develop lessons learned and actions.	Partial					
				06. Advancing Quality Programme **Control Owner:** Clare Hammell	Trust Improvement Group and Quality Groups established and Chairs reports go to EQGG	Acceptable	Quarterly submission of data to partner (AQUA)	Acceptable			
				07. NICE Compliance **Control Owner:** Clare Hammell	NICE programme to go to Trust Improvement Group following development of Process and SOP.	Low					
				08. Incident Reporting, Management, Learning & Improvement Policy **Control Owner:** Murray Luckas	Incident Management & Reporting internal audit submitted to Audit Committee (September 2020) and Q&S Committee (October 2020). Incident Deep Dives completed when required.	Acceptable	Incident Reporting Internal Audit gave substantial assurance	Acceptable			
				09. Learning from Deaths & Mortality Review **Control Owner:** Murray Luckas	Learning from Deaths report submitted quarterly to Q&S and Board. Covid wave 1 death analysis submit to Q&S Committee in June 2021.	Acceptable					
				10. End of Life Outcome Measures **Control Owner:** Murray Luckas	National Audit of Care at End of Life and Strategic Collaborative Cheshire Plan for Palliative Care and End of Life reports submit to QSC Jan 21. Annual Report for End of Life to go tot QSC September 21.	Partial	National Audit of Care at End of Life. Strategic Collaborative Cheshire Plan for Palliative Care and End of Life.	Partial			

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	Risk Control	Control Assurance (Internal Assurance)	Internal Assurance Assurance Level	Control Assurance (External Assurance)	External Assurance Assurance Level	Current Risk Score	Action Required	Target Risk Score
				11. Maternity Services systems & processes **Control Owner:** Julie Tunney	Named NED Champion (LB). Quarterly Maternity Safety Report to QSC from July 21. Monthly maternity safety champions walkarounds, deep dives completed when required and monthly assurance of Local Maternity System (LMS)	Partial	CNST3 to NHS Resolution (NHSR) submission by July 2021. Ockenden submission	Partial			
				12. Action planning based on GIRFT findings **Control Owner:** Clare Hammell	GIRFT was on hold but reinstated June 21	Partial					
BAF 4	IF a significant H&S incident occurs within the Trust, THEN people may be harmed and the Trust could be subject to legal and regulatory investigation **Executive Risk Lead:** Russell Favager **Risk Owner:** Russell Favager **Last Updated:** 13 Jul 2021 **Latest Review Date:** **Latest Review By:** **Last Review Comments:**	**Cause(s)** 1. Low profile of H&S across Trust & lack of efficacy of the Health & Safety Group. 2. Legionella & other Water Safety risks arising from ineffective control measures. 3. Presence of asbestos & failure to fulfil 'Duty Holder' responsibilities. 4. Inconsistencies in security awareness amongst staff. 5. Failure to comply with the requirements of the RRO (Fire Safety) Regulations. 6. Contamination risk – dangerous substances. 7. Slips, trips and falls. **Consequence(s)** 1. Avoidable harm to persons. 2. HSE investigation and potential for prosecution/fines. 4. Disruption to services due to Enforcement Notices. 5. Reputational damage. 6. Claims against the Trust as a result of injury/death.	I = 5 L = 4 20	01. Trust H&S Group (HSG) & supporting Sub-Groups e.g. for Fire & Water Safety **Control Owner:** Russell Favager	Minutes from HSG go to ESSEG monthly.	Acceptable			I = 5 L = 3 15	Improved engagement of HSG with Divisions to ensure that H&S is embedded within day to day activities. **Action Owner:** Russell Favager **Target Implementation Date:** 30 Jul 2021	I = 5 L = 1 5
				02. Fire Management Plan **Control Owner:** Wendy Astle-Rowe	Workplace Inspections - Fire Safety Assessments. ESSEG Chairs report monthly to PAF includes risks.	Acceptable				Asbestos Register to be validated & training rolled out by 31/07/21 **Action Owner:** Andrew Deakin **Target Implementation Date:** 31 Jul 2021	
				03. Asbestos Management Plan **Control Owner:** Andrew Deakin	Included in Projects Chair's report taken to ESSEG	Acceptable				Management of Violence & Aggression Strategy will be in place by 30/06/21 in line with National Requirements. **Action Owner:** Dawn Pyatt **Target Implementation Date:** 31 Jul 2021	
				04. H&S policy and procedures **Control Owner:** Wendy Astle-Rowe	Workplace inspections and risk assessments and incident reporting to the Health & Safety Working Group (including RIDDOR). Escalations from HSG included in minutes taken to ESSEG.	Acceptable				Stress Survey to be undertaken, & action plan developed based on feedback, by 31/12/21 **Action Owner:** Wendy Astle-Rowe **Target Implementation Date:** 31 Dec 2021	
				05. COSHH register **Control Owner:** Wendy Astle-Rowe	Compliance checks by H&S Manager with outcomes reported to HSG. Minutes from HSG go to ESSEG.	Acceptable					
				06. Management of Violence & Aggression Policy **Control Owner:** Dawn Pyatt	Incident reporting via Ulysses and reported monthly to HSG. HSG minutes taken to ESSEG.	Acceptable					
				07. Water Safety Plan **Control Owner:** Craig Reid	Progress reports to Water Safety Group and Estates Divisional Board. EDB escalates to ESSEG	Acceptable					
				08. Appointment of Responsible/ Authorised (RP/AP) Persons within the Trust who have specific management responsibility for a specific area of compliance e.g. Head of Estates for Water safety **Control Owner:** Russell Favager	All RP/AP in place for Fire, Water, Electric, Asbestos etc. Annual Audits undertaken and presented to ESSEG.	Acceptable					

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	Risk Control	Control Assurance (Internal Assurance)	Internal Assurance Assurance Level	Control Assurance (External Assurance)	External Assurance Assurance Level	Current Risk Score	Action Required	Target Risk Score
BAF 5	IF we fail to establish formal place-based partnerships with good governance and assurance, THEN we are unlikely to deliver new ways of working across the health and social care system **Executive Risk Lead:** James Sumner **Risk Owner:** James Sumner **Last Updated:** 14 Jul 2021 **Latest Review Date:** 08 Jul 2021 **Latest Review By:** James Sumner **Last Review Comments:** Risk reviewed and controls updated	**Cause(s)** 1. Organisational politics 2. Senior capacity and relevant experience 3. New governance models required, including risk management 4. Development of Provider Collaborative and lack of shared goals and plans 5. Lack of single data sources across the system 6. Lack of accountability 7. Ineffective communication between partners **Consequence(s)** 1. Inequality of service provision 2. Disjointed care pathways 3. Poor patient experience 4. Failure to realise efficiencies 5. Failure to innovate 6. Reduced CQC rating 7. Reputational damage	I = 4 L = 4 16	01. CEICP governance and MOU in place with approval by all member organisations Boards. **Control Owner:** James Sumner			Monthly report to the Board of Directors from the Chair/Director of the ICP	Acceptable	I = 4 L = 3 12	Digital Clinical System Programme Director / Dir of Corporate Affairs at ECT and Company Secretary to discuss moving MOU to Heads of Terms re DCS. **Action Owner:** Caroline Keating **Target Implementation Date:** 31 Jul 2021	I = 4 L = 2 8
				02. Cheshire East Place 5 year plan **Control Owner:** James Sumner	CEO reports to formal boards and updates at Board Strategic Sessions	Acceptable	Update reports go to Place Partnership Board	Acceptable		Dermatology hosted by MCHFT under latter's provider contract. Work to be taken forward re risk sharing **Action Owner:** Russell Favager **Target Implementation Date:** 31 Aug 2021	
				03. CEICP Strategy & Transformation Plan **Control Owner:** James Sumner	Monthly highlight report for each workstream to ICP Transformation Board. CEICP Transformation Strategy submitted to Board January 2021. Referenced in Monthly CEO report to Board as required.	Acceptable				5 year plan to be realigned to match MCHT strategy **Action Owner:** James Sumner **Target Implementation Date:** 31 Oct 2021	
				04. CEO member of CE Place Partnership **Control Owner:** James Sumner	Updates on PLACE work through Chief Executive's report to the BoD monthly	Acceptable					
				05. Director for Strategic Partnerships member of CWICP Board + MoU in place **Control Owner:** James Sumner							
				06. Blueprint for partnership agreements in place (cf Pathology) **Control Owner:** James Sumner	North Midlands and Cheshire Pathology Service agreement approved by respective Boards (MCHFT & UHNM) November 2020	Acceptable					
				07. DCS Programme Board in place with on-going improvements being made to their risk management and links to respective BAFs. **Control Owner:** James Sumner	DCS Programme Board Chairs assurance report submitted to BoD	Acceptable	CEO's assurance reports (MCHFT & ECT) to respective Boards	Acceptable			
				08. DCS Governance structure in place aligned with structures of both MCHFT and ECT **Control Owner:** James Sumner	Governance structure approved by Trust Board January 2021. Reporting being strengthened with support of CoSec	Acceptable					

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	Risk Control	Control Assurance (Internal Assurance)	Internal Assurance Assurance Level	Control Assurance (External Assurance)	External Assurance Assurance Level	Current Risk Score	Action Required	Target Risk Score
BAF 6	IF we are unable to achieve a sufficient level of influence within the ICS, THEN commissioning decisions may prevent us from achieving our strategic aims **Executive Risk Lead:** James Sumner **Risk Owner:** James Sumner **Last Updated:** 14 Jul 2021 **Latest Review Date:** 08 Jul 2021 **Latest Review By:** James Sumner **Last Review Comments:** Reviewed. Some actions closed and reduction in risk rating associated with ICS strategy development	**Cause(s)** 1. Leadership capacity 2. Immature stakeholder strategy 3. New commissioning arrangements 4. Requirement to work within Provider Collaborative model 5. Challenge of selling MCHFT's vision and new strategy **Consequence(s)** 1. Loss of autonomy 2. Requirement to revise strategic ambitions 3. Financial uncertainty	I = 4 L = 3 12	01. Trust Strategy - developed to focus on Trust positioning in PLACE and ICS **Control Owner:** James Sumner	The Trust strategy has been developed through the Board of Directors aligned to the likely direction of travel that ICS' will take	Acceptable			I = 4 L = 2 8	AD Comms to complete a stakeholder engagement plan including DCS engagement with partners **Action Owner:** Paul Newman **Target Implementation Date:** 31 Jul 2021	I = 4 L = 2 8
				02. Board Development Programme **Control Owner:** Caroline Keating			Agreed at May 21 Board. Well Led Development review to be completed by October 2021.	Acceptable		Well Led Developmental Review outcomes to be submitted to Board Development Session October 2021 **Action Owner:** Caroline Keating **Target Implementation Date:** 31 Oct 2021	
BAF 7	IF we are unable to agree a financial control total, THEN it could jeopardise delivery of strategy **Executive Risk Lead:** Russell Favager **Risk Owner:** Russell Favager **Last Updated:** 08 Jul 2021 **Latest Review Date:** **Latest Review By:** **Last Review Comments:**	**Cause(s)** 1. Changes to the financial regime 2. Increased costs associated with pandemic and restoration 3. Inability to deliver nationally expected efficiencies and productivity improvements while managing restoration. **Consequence(s)** 1. Insufficient funding to deliver Trust strategy 2. Intense focus from regulators on Trust	I = 4 L = 3 12	01. Agreement of H1 and H2 plans with regulators and Trust board, with monthly reporting to the Trust board, Execs and Performance & Finance committee. **Control Owner:** Russell Favager	Financial Plan H1 went to PAF and Board in May 2021	Acceptable	Financial Plan H1 submitted to C&M HCP and NHSI May 2021	Acceptable	I = 3 L = 3 9	Financial benchmarking information to be reported to the operational finance group in line with national/local releases. **Action Owner:** Russell Favager **Target Implementation Date:** 30 Jul 2021	I = 2 L = 2 4
				02. Regular finance meetings with Corporate/Divisional teams to review financial performance, including budget holders and Senior leaders, which report into the Operational Finance Group, that in turn reports into the Exec Delivery & Performance Group **Control Owner:** Russell Favager	EDPG Chairs summary report submitted monthly to ERAG and PAF	Acceptable				Develop tool by end of Q1, for modelling and forecasting the in year financial position and also the ongoing recurrent financial structure. **Action Owner:** Russell Favager **Target Implementation Date:** 31 Aug 2021	
				03. Revised Standing Financial Instructions and Scheme of Delegation incorporated into Corporate Governance Manual approved by the Audit Committee and Trust Board **Control Owner:** Russell Favager	Corporate Governance Framework Manual agreed by Audit Committee and approved by Board April 2021	Acceptable				H2 guidance has not yet been issued with the timescale expected in Q2 2021/22. **Action Owner:** Russell Favager **Target Implementation Date:** 30 Sep 2021	
				04. Head of both Internal and External Audit opinions on the Trusts controls. **Control Owner:** Russell Favager	Substantial assurance given that there is a good system of internal control designed to meet the organisation's objectives. Head of Internal Audit Opinion included in Annual Report 2020/21	Acceptable	External Audit Opinion also. Accepted by Audit Committee and Board May 2021	Acceptable		2020/21 accounts audited with significant assurance. **Action Owner:** Russell Favager **Target Implementation Date:** 30 Sep 2021	
				05. Updated training for budget holders to be rolled out in H1 2021/22 **Control Owner:** Russell Favager	Training has begun but action in place to further roll out.	Partial				Training to be rolled out within divisional/corporate teams during H1 **Action Owner:** Russell Favager **Target Implementation Date:** 30 Sep 2021 SFIs revisions for 2022/23 proposed by Q4 **Action Owner:** Russell Favager **Target Implementation Date:** 31 Mar 2022	

Board Assurance Framework (BAF)

NHS Mid Cheshire Hospitals NHS Foundation Trust

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	Risk Control	Control Assurance (Internal Assurance)	Internal Assurance Assurance Level	Control Assurance (External Assurance)	External Assurance Assurance Level	Current Risk Score	Action Required	Target Risk Score
BAF 8	IF we fail to develop the capacity and capability to deliver a consistent and coordinated continuous improvement methodology, THEN we will not deliver our strategic ambitions **Executive Risk Lead:** James Sumner **Risk Owner:** James Sumner **Last Updated:** 14 Jul 2021 **Latest Review Date:** 08 Jul 2021 **Latest Review By:** James Sumner **Last Review Comments:** Record reviewed. New control added.	**Cause(s)** 1. QI methodology not embedded throughout organisation 2. Quality improvement not underpinned by evidence 3. Insufficient engagement from relevant stakeholders **Consequence(s)** 1. Failure improve ways of working and future-proof services 2. Failure to realise efficiencies 3. Failure to adapt to the changing health needs of the population and address inequalities	I = 3 L = 4 12	01. Executive QI Strategy Group in place and chaired by CEO and Deputy Medical Director. **Control Owner:** Clare Hammell	Quarterly assurance report to Board	Acceptable			I = 3 L = 4 12	**Action Owner:** **Target Implementation Date:**	I = 3 L = 3 9
				02. AQUA appointed as Strategic Partner **Control Owner:** Clare Hammell	Robust appointment process undertaken	Acceptable	Quarterly submission of data to be completed				
				Appointment of a Director of QI to lead the work programme **Control Owner:** Clare Hammell	The appointment of a Director to lead the QI work programme will provide additional control of the risk						

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	Risk Control	Control Assurance (Internal Assurance)	Internal Assurance Assurance Level	Control Assurance (External Assurance)	External Assurance Assurance Level	Current Risk Score	Action Required	Target Risk Score
BAF 9	IF the conditions for shaping leadership and organisational culture are sub-optimal, THEN our strategic ambitions will not be realised **Executive Risk Lead:** Heather Barnett **Risk Owner:** Heather Barnett **Last Updated:** 21 Jul 2021 **Latest Review Date:** **Latest Review By:** **Last Review Comments:**	**Cause(s)** 1. Cultural and leadership development required to adapt to system reforms and strategic ambitions 2. Tone from the top doesn't model desired cultural behaviours 3. Limited understanding of prevailing culture and sub-cultures 4. Insufficient focus on embedding culture at all levels and across all areas 5. Different cultures between partner organisations 6. Lack of staff and leadership engagement 7. Perceived or real cultural barriers for BAME staff **Consequence(s)** 1. Workforce behaviours don't support delivery of strategy 2. Workforce morale suffers 3. Poorer patient experience 4. Inability to adapt quickly enough to keep up with system reform 5. Ineffective leadership 6. Reputational damage 7. Inability to implement strategic changes 8. Poor staff engagement / loss of discretionary effort 9. Loss of key individuals to drive the strategy forward 10. Increased apathy and disbelief in the new strategy.	I = 4 L = 4 16	01. Leadership development matrix and implementation plan **Control Owner:** Amy Oakes	Leadership development plan progress reports to EWAG and WDT	Acceptable			I = 4 L = 3 12	Carry out the Talent Board reviews for 2021 **Action Owner:** Amy Oakes **Target Implementation Date:** 31 Jul 2021	I = 4 L = 2 8
				02. Our Workforce Matters Strategy **Control Owner:** Heather Barnett	Our Workforce Matters quarterly updates to Workforce & Digital Transformation. Medical staffing workforce metrics included in the Workforce Report reported via WDT to Board of Directors	Acceptable				Train additional internal coaches **Action Owner:** Amy Oakes **Target Implementation Date:** 31 Jul 2021	
				03. Coaching & mentoring scheme **Control Owner:** Amy Oakes	Education, Learning and OD Report to EWAG quarterly	Acceptable				Develop the roles of the Wellbeing Guardian and Wellbeing Ally - highlight via Comms **Action Owner:** Bobby Sharma **Target Implementation Date:** 31 Jul 2021	
				04. Medical leadership programme **Control Owner:** Amy Oakes	Learning & OD Group Chairs report to EWAG	Acceptable				Introduce a civility in the workplace awareness programme **Action Owner:** Amy Oakes **Target Implementation Date:** 31 Jul 2021	
				05. Talent Board and succession planning **Control Owner:** Heather Barnett	Annual review of talent and succession plan to EWAG and WDT. Progress Report to WDT June via the Chairs report.	Partial				Implement further staff networks for LGBQT+ and Disabled / carer staff **Action Owner:** Ian Howarth **Target Implementation Date:** 30 Aug 2021	
				06. Staff Survey action plans **Control Owner:** Amy Oakes	Staff Survey results reported to EWAG, WDT and Board April 21. Staff Survey focus groups and action plan review includes feedback about leadership.	Acceptable				Introduce the Leadership Compact at the Board development session **Action Owner:** Heather Barnett **Target Implementation Date:** 31 Aug 2021	
				07. Leadership Development Programme & investment, including investment in BAME leadership programmes **Control Owner:** Amy Oakes	Leadership Programme Report to WDT and EWAG April 2021	Partial				Review of recruitment practices and establish diverse stakeholder panels for senior appointments **Action Owner:** Susan Hossent **Target Implementation Date:** 30 Sep 2021	
				08. Leadership Compact / 'Our Leadership Way' Framework **Control Owner:** Amy Oakes	Framework developed and will be launched to the Executive Team August 21	Partial				Develop further talent pathways for difficult to fill posts **Action Owner:** Nicola Madeley **Target Implementation Date:** 30 Sep 2021	
				09. Communication & Engagement Strategy **Control Owner:** Paul Newman	Comms & Engagement bi-annual report to WDT and EWAG	Acceptable				Implement plans in key areas of focus identified from the Staff Survey for 2020/21: - reducing work related stress - improving team working - reduce violence in the workplace - further improve safety culture **Action Owner:** Amy Oakes **Target Implementation Date:** 30 Sep 2021	
				10. ED&I Strategy **Control Owner:** Ian Howarth	Annual ED&I report to WDT and Board May 2021	Acceptable				Embed talent management and succession planning into the appraisal system and workforce planning cycle **Action Owner:** Amy Oakes **Target Implementation Date:** 30 Sep 2021	
										Annual review of the talent and succession plan **Action Owner:** Amy Oakes **Target Implementation Date:** 30 Sep 2021	
										Evaluate the Shadow Board programme **Action Owner:** Amy Oakes **Target Implementation Date:** 29 Oct 2021	

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	Risk Control	Control Assurance (Internal Assurance)	Internal Assurance Assurance Level	Control Assurance (External Assurance)	External Assurance Assurance Level	Current Risk Score	Action Required	Target Risk Score
				11. Quality Improvement Strategy and action plan include culture elements **Control Owner:** Clare Hammell	Internal OD Diagnostics reported to Execs and Board. Report to QI Faculty and Chairs report taken to CEO Chaired Executive QI Strategy Group. External Partner (AQUA) identified.	Acceptable				Well Led Developmental Review outcomes to be submitted to Board Development Session October 2021 **Action Owner:** Caroline Keating **Target Implementation Date:** 31 Oct 2021	
				12. BAME staff network **Control Owner:** Natalie Wallace	Report to Equality, Diversity and Inclusion (EDI) Group. Overview of the BAME leadership development proposal was presented and agreed at May EDI. An EDI Chairs report taken to EWAG.	Acceptable				Set up BAME Advisory Panel **Action Owner:** Ian Howarth **Target Implementation Date:** 31 Dec 2021	
				13. Wellbeing Guardian role & NED Equality Champion providing challenge at Trust Board. **Control Owner:** Heather Barnett	Workforce and Wellbeing Diagnostic framework report approved by Board May 2021. H&WB Guardian role agreed by Board and NED appointed May 2021	Acceptable				Implement the national WRES model employer goals **Action Owner:** Ian Howarth **Target Implementation Date:** 31 Mar 2022	
				14. Shadow Board Programme **Control Owner:** Amy Oakes	Learning & Organisation Development report to EWAG and report provided to Trust Board	Acceptable					
				15. Executive Development **Control Owner:** James Sumner	TRANS2 programme completed. Individual coaching / mentoring in place also in support of Trust Strategy Development. Executive appraisals.	Acceptable					
				16. Board Development Programme **Control Owner:** Caroline Keating			Agreed at May 21 Board. Well Led Development review to be completed by October 2021.	Acceptable			

Board Assurance Framework (BAF)

Mid Cheshire Hospitals NHS Foundation Trust

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	Risk Control	Control Assurance (Internal Assurance)	Internal Assurance Assurance Level	Control Assurance (External Assurance)	External Assurance Assurance Level	Current Risk Score	Action Required	Target Risk Score
BAF 10	IF we are unable to harness data to understand the needs of our population and inform our decisions, THEN we will fail to improve healthcare outcomes and address health inequalities **Executive Risk Lead:** Amy Freeman **Risk Owner:** Amy Freeman **Last Updated:** 01 Jul 2021 **Latest Review Date:** 05 Jul 2021 **Latest Review By:** Amy Freeman **Last Review Comments:** Risk reviewed	**Cause(s)** 1. Lack of investment 2. Lack of staff capacity and right skills 3. Lack of coordinated partnership approach to develop a place-based system 4. Inconsistent and unreliable data quality **Consequence(s)** 1. Inability to address health inequalities 2. Failure to achieve duty to improve population health outcomes 3. Ineffective decision making 4. Misdirected resources 5. Failure to improve CQC rating	I = 3 L = 5 15	01. Data Warehouse project plan, developed and reviewed in collaboration with external consultants, to be implemented December 2021 **Control Owner:** Angela Wood	Plan is in place and monitored via Digital Technology and Information Services Group	Acceptable	PA Consulting review of the initial plan (April 2021)	Acceptable	I = 3 L = 4 12	Data warehouse Manager to be appointed **Action Owner:** Angela Wood **Target Implementation Date:** 31 Aug 2021 Scoping exercise being undertaken inline with Trust Strategy taking place with Trust Strategy Consultant **Action Owner:** Amy Freeman **Target Implementation Date:** 31 Aug 2021 Interoperability Manager to be appointed **Action Owner:** Angela Wood **Target Implementation Date:** 31 Dec 2021 Influence and engage in the Cheshire and Merseyside Population Health solution. **Action Owner:** Amy Freeman **Target Implementation Date:** 30 Apr 2022	I = 3 L = 2 6

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	Risk Control	Control Assurance (Internal Assurance)	Internal Assurance Assurance Level	Control Assurance (External Assurance)	External Assurance Assurance Level	Current Risk Score	Action Required	Target Risk Score
BAF 11	IF our estate, infrastructure and equipment are not fit for the future, THEN we will fail to achieve our strategic ambitions **Executive Risk Lead:** Russell Favager **Risk Owner:** Russell Favager **Last Updated:** 07 Jul 2021 **Latest Review Date:** **Latest Review By:** **Last Review Comments:**	**Cause(s)** 1. Old & functionally unsuitable buildings & a deteriorating physical environment. 2. Ageing medical equipment & lack of planned replacements. 3. Lack of coordinated approach to asset tracking and management. 4. Competing priorities for investment. 5. Lack of strategic approach to estates planning. 6. Environmental sustainability insufficiently embedded within the Trust. 7. Unsupported legacy IT systems and databases, with inherent security risk. **Consequence(s)** 1. Poor patient experience. 2. Poor staff morale. 3. Inefficient use of resources. 4. Exposure to cybersecurity threats. 5. Increased risk of harm to people. 6. Single Points of Failure with potential unplanned service interruptions. 7. Reputational damage. 8. Failure to improve CQC rating & PLACE scores.	I = 5 L = 4 20	01. Estates Strategic Plan **Control Owner:** Russell Favager	Estates & Facilities Divisional Assurance Framework reports to Divisional Board and escalates to ESSEG. Compliance of Trust's environments with Equality Act and Backlog maintenance programme included. Outline approved at PAF June 21. Full plan to July 21 PAF and Board.	Acceptable			I = 5 L = 4 20	Review of the feasibility to relocate VIN to Weaver Square to be completed by 31/07/21. **Action Owner:** Russell Favager **Target Implementation Date:** 30 Jul 2021 Review of the cost benefits to take place into the use of IT investment for electronic tracking of medical devices by 31/08/21. **Action Owner:** Russell Favager **Target Implementation Date:** 31 Aug 2021 Trust approval of new Estates Strategic Plan **Action Owner:** Russell Favager **Target Implementation Date:** 30 Sep 2021 Revised Digital Strategic Plan to be developed **Action Owner:** Amy Freeman **Target Implementation Date:** 30 Sep 2021 Estates environmental sustainability is part of the Corporate Social Responsibility Group, which is led by the Director of Workforce & Organisational Development (first meeting held 27/05/21) and will produce an action plan to improve performance in agreed key areas **Action Owner:** Russell Favager **Target Implementation Date:** 31 Dec 2021	I = 5 L = 2 10
				02. Capital Programme expenditure focused on risk reduction & functional improvements. **Control Owner:** Andrew Deakin	Capital Exceptions report to IDG and Divisional Board (Cost and programme). Capital Infrastructure Group provides a monthly report to ESSEG and PAF.	Acceptable					
				03. Six Facet Estate Survey database regularly updated (20% per annum). **Control Owner:** Craig Reid	Self audits against NHS sustainability audit tool (every six months). Audits taken to ESSEG from July 21.	Acceptable					
				04. Critical Infrastructure Review completed in 2020 & action plan being implemented **Control Owner:** Craig Reid	Action Plan implemented and submitted to ESSEG May 2021.	Acceptable					
				05. Hospital redevelopment SOC **Control Owner:** Russell Favager	Monthly programme updates to Board via Chair's assurance report / CEO report. Highlight reports to BoD as required	Acceptable					
				06. Medical Devices, H&S, & Space Utilisation Groups within Governance Structure **Control Owner:** Russell Favager	Updates on action plan following Internal Audit report submitted to Audit Committee January 2021. Monthly Estates report to ESSEG.	Acceptable					
				07. Capital Programme 2021/22 **Control Owner:** Russell Favager	submitted to PAF April 2021	Acceptable					
				08. Digital Strategy and Plan **Control Owner:** Amy Freeman	Current strategy submitted to WDT May 2021 with progress update. Plan includes Digital contracts. Progress taken to DTS in July 21	Acceptable					
				09. Cyber security action plan and risk register **Control Owner:** Amy Freeman	Cyber Security Operational Group Chair's report and risk report taken to DTIS monthly	Acceptable					

Board Assurance Framework (BAF)

Mid Cheshire Hospitals NHS Foundation Trust

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	Risk Control	Control Assurance (Internal Assurance)	Internal Assurance Assurance Level	Control Assurance (External Assurance)	External Assurance Assurance Level	Current Risk Score	Action Required	Target Risk Score
BAF 12	IF a major incident occurs as a result of RAAC plank failure, THEN people may be harmed and the Trust could be subject to legal and regulatory investigation **Executive Risk Lead:** Russell Favager **Risk Owner:** Russell Favager **Last Updated:** 08 Jul 2021 **Latest Review Date:** **Latest Review By:** **Last Review Comments:**	**Cause(s)** 1. Presence of concrete (RAAC) roof planks, which are the subject of a SCOSS Safety Alert dated May 2019. 2. Expected life of the RAAC planks has now been exceeded. 3. Lack of research regarding RAAC plank modes of failure & degradation rate. **Consequence(s)** 1. Potential for serious injuries/ fatalities in occupied spaces. 2. Loss of building. 3. Disruption to services. 4. Negative media attention. 5. Investigation and potential prosecution/ fines. 6. Reputational damage.	I = 5 L = 4 20	01. RAAC beams survey programme. **Control Owner:** Andrew Deakin	Programme reviewed at ESSEG July 21	Acceptable			I = 5 L = 4 20	RAAC beams surveys to be fully completed. **Action Owner:** Andrew Deakin **Target Implementation Date:** 31 Oct 2021	I = 5 L = 2 10
				02. Major Incident Evacuation Policy for RAAC. **Control Owner:** Craig Reid	Exercise Sykes event undertaken to simulate a plank failure. Report went to Hospital Redevelopment Board	Acceptable				Implement works comprising £22m capital bid made to NHSE&I for 2021/22, once proposed allocation is formally approved. **Action Owner:** Russell Favager **Target Implementation Date:** 31 Mar 2022	
				03. ALARP Workshop held in 2020 & action plan produced. **Control Owner:** Russell Favager	Action plan monitored through ESSEG	Acceptable					
				04. Installation of fail-safe steelwork as deemed necessary via the survey programme. **Control Owner:** Andrew Deakin	Monitored via monthly updates to ESSEG	Acceptable					
				05. SOC to cover re-build of the areas affected by RAAC now approved by the Trust Board. **Control Owner:** Russell Favager	Approved at Board April 21	Acceptable					
BAF 13	IF we fail to deliver the technological and people aspects required to implement the Digital Clinical System, THEN intended benefits for patients may not be realised and the financial investment would be wasted **Executive Risk Lead:** Amy Freeman **Risk Owner:** Amy Freeman **Last Updated:** 02 Jul 2021 **Latest Review Date:** 05 Jul 2021 **Latest Review By:** Amy Freeman **Last Review Comments:** Risk reviewed	**Cause(s)** 1. Insufficient funding 2. Poor planning 3. Lack of project capacity and skills 4. Low staff engagement 5. Changing partnership landscape **Consequence(s)** 1. Inability to achieve intended benefits for patient care and safety 2. Lost opportunity to modernise 3. Inefficient use of resources 4. Unsustainable operating costs 5. Exposure to cybersecurity threats 6. Reputational damage	I = 4 L = 4 16	01. NHSX funding received and external support contract in place with Apira to support development of the Full Business Case **Control Owner:** Amy Freeman	Digital Clinical Systems (DCS) update reports to Workforce Digital Transformation Committee monthly	Acceptable			I = 4 L = 3 12	Digital Clinical System Programme Director to attend July Medical Advisory Committee to raise the clinical awareness of processes and suppliers for the DCS programme **Action Owner:** Amy Freeman **Target Implementation Date:** 31 Jul 2021	I = 4 L = 2 8
				02. Trust Systems Support Model (TSSM) self-assessment for DCS readiness **Control Owner:** Phillip James	TSSM self-assessment results to DTIS Group 30/06/20. TSSM recommendations to be taken to Transformation Board July 2021 to be reviewed. Recommendations from the report that are agreed and new ones developed will be identified.	Partial	June 21 NHS Digital TSSM assessment Health Check Report from NHS Digital	Partial		Gateway Reviews to be reported to the Digital Transformation Programme Board when in place **Action Owner:** Amy Freeman **Target Implementation Date:** 31 Jul 2021	
										Digital Clinical System Programme Director / Dir of Corporate Affairs at ECT and Company Secretary to discuss moving MOU to Heads of Terms re DCS. **Action Owner:** Caroline Keating **Target Implementation Date:** 31 Jul 2021	
				03. Schedule in place to ensure Gateway 4 and Gateway 5 reviews **Control Owner:** Phillip James	Included in DCS project plan	Acceptable				TSSM report to be discussed at Transformation Programme Board and recommendations and actions to be agreed. **Action Owner:** Phillip James **Target Implementation Date:** 31 Jul 2021	
				04. MoU in place **Control Owner:** Amy Freeman	MoU with partners signed off by the Board Nov 2019	Acceptable					
				05. Procurement process documented in the Outline Business Case (OBC) being undertaken by a joint Task & Finish Group (MCHFT, East Cheshire and Apira) **Control Owner:** Phillip James	T&F Group reports on the project plan to DTIS.	Acceptable				Increase in clinical time available for the Chief Clinical Information Officer to support the project. **Action Owner:** Amy Freeman **Target Implementation Date:** 31 Aug 2021	
				06. IT Training course to ensure staff have basic IT skills to ensure they can use computers **Control Owner:** Ben Foster	A full schedule of dates on a rolling programmes is available and started. Training records will identify number of attendees.	Partial				OGC Gateway 5 Review **Action Owner:** Amy Freeman **Target Implementation Date:** 18 Feb 2022	
										OGC Gateway 4 Review **Action Owner:** Amy Freeman **Target Implementation Date:** 18 Feb 2022	

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	Risk Control	Control Assurance (Internal Assurance)	Internal Assurance Assurance Level	Control Assurance (External Assurance)	External Assurance Assurance Level	Current Risk Score	Action Required	Target Risk Score
BAF 14	IF workforce plans do not align with the future operating model, THEN it is likely that there will be increased costs and workforce gaps that could affect standards of care **Executive Risk Lead:** Heather Barnett **Risk Owner:** Heather Barnett **Last Updated:** 21 Jul 2021 **Latest Review Date:** **Latest Review By:** **Last Review Comments:**	**Cause(s)** 1. Poor horizon scanning and forecasting 2. Poor understanding of expectations of young people entering the workforce 3. Insufficient consideration of workforce in strategic planning 4. Misalignment of workforce planning, activity and finance 5. Lack of accurate and up-to-date workforce information and data 6. Lack of workforce planning capacity and capability 7. Poor communication between education providers **Consequence(s)** 1. Unsustainable services 2. Increased staff turnover 3. Widening vacancy gaps 4. Inability to plan capacity effectively 5. Reduced workforce morale 6. Poorer patient care and experience 7. Damage to reputation as an employer 8. Failure to improve CQC rating 9. Failure to deliver new models of care 10. Failure to adapt to new ways of working 11. Failure to embrace technological advancement in working practices	I = 4 L = 4 16	01. Our Workforce Matters Strategy **Control Owner:** Heather Barnett	Our Workforce Matters quarterly updates to Workforce & Digital Transformation. Medical staffing workforce metrics included in the Workforce Report reported via WDT to Board of Directors	Acceptable			I = 3 L = 4 12	Develop an Apprenticeship Strategic Plan and submit to WDT **Action Owner:** Nicola Madeley **Target Implementation Date:** 31 Jul 2021	I = 2 L = 4 8
				02. Trust Workforce Plan **Control Owner:** Jenny Grant	Closing the Nursing Workforce Gap report to EWAG. Annual workplan report to WDT. Reduction is risk score approved by Board April 2021. Physician Associate report submitted to EWAG December 2020	Acceptable				Develop the medical and wider clinical workforce gap trajectories **Action Owner:** Jenny Grant **Target Implementation Date:** 31 Jul 2021	
				03. Workforce Systems Project **Control Owner:** Paul Cooper	Quarterly progress report to EWAG and 6 monthly to WDT.	Acceptable				Analysis of recruitment metrics from new recruitment trac.jobs system **Action Owner:** Jaz Mallan **Target Implementation Date:** 31 Jul 2021	
				04. E-roster implementation plan **Control Owner:** Helen Nutkins	E-roster reporting on nursing / HCA staff groups. E-roster report to EWAG.	Partial				Further roll out e-roster **Action Owner:** Helen Nutkins **Target Implementation Date:** 30 Sep 2021	
				05. Recruitment policies and process **Control Owner:** Susan Hossent	International Recruitment Medical Staff - update to WDT Committee Dec 2020. Quarterly recruitment updates to EWAG and escalated to WDT if required.	Acceptable	MIAA Audit tool (covers all elements of workforce for dealing with COVID) results reported to EWAG and WDT	Acceptable		Implement and monitor new Agile Working Policy **Action Owner:** Anna Bickerton **Target Implementation Date:** 31 Dec 2021	
				06. Apprenticeships Strategic Plan **Control Owner:** Nicola Madeley	Apprenticeship levy usage report to EWAG and JCNC. To go to EWAG July 21	Partial				Develop career pathways for Physician Associates **Action Owner:** Nicola Madeley **Target Implementation Date:** 31 Dec 2021	
				07. Workforce Supply Group plus sub group workstreams **Control Owner:** Heather Barnett	Workforce Supply Group report to EWAG via Chair's reports	Acceptable				Implementation of an e-roster system for medical staff **Action Owner:** Jaz Mallan **Target Implementation Date:** 31 Dec 2021	
				08. Talent Board and succession planning **Control Owner:** Amy Oakes	Update submitted to WDT June 2021	Partial					
				09. Education and training programme **Control Owner:** Amy Oakes	Training & Education Quarterly Report to WDTC.	Acceptable	Self assessment against Health Education England's priorities 2019/20	Acceptable			
				10. ED&I Strategy **Control Owner:** Ian Howarth	Annual ED&I report to WDT and Board May 2021	Acceptable					

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	Risk Control	Control Assurance (Internal Assurance)	Internal Assurance Assurance Level	Control Assurance (External Assurance)	External Assurance Assurance Level	Current Risk Score	Action Required	Target Risk Score
				11. Appraisal system / career conversations **Control Owner:** Amy Oakes	Approval assurance report to WDT July 2021. Regular reports to EWAG.	Partial					
				12. Cheshire and Merseyside Workforce plan at ICS level **Control Owner:** Heather Barnett			Approved by Cheshire & Merseyside People Board	Acceptable			

Mid Cheshire Hospitals
NHS Foundation Trust

Board of Directors
Integrated Performance Report

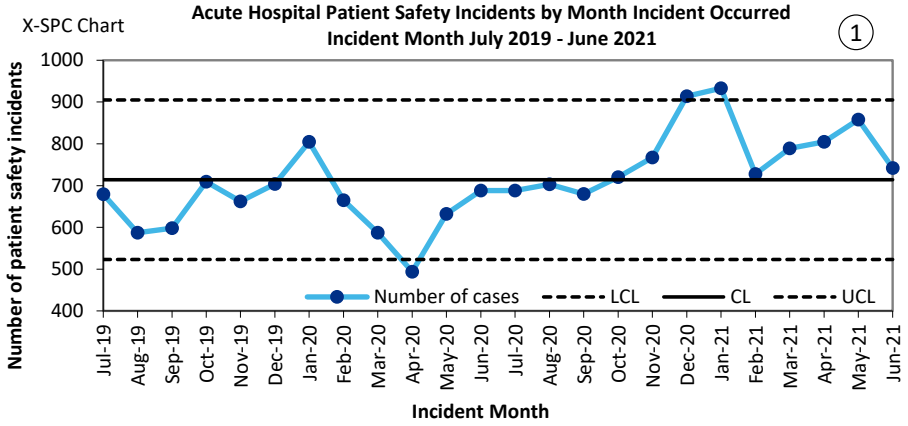
June 2021

"To Deliver Excellence in Healthcare through Innovation & Collaboration"

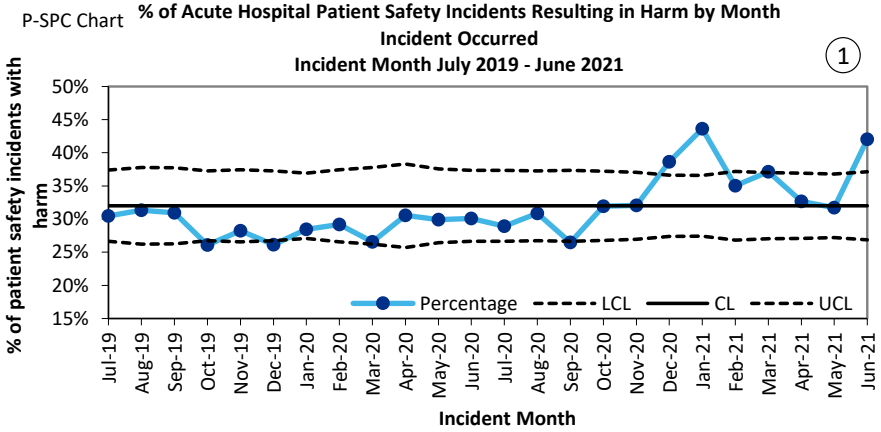
Quality, Safety & Patient Experience

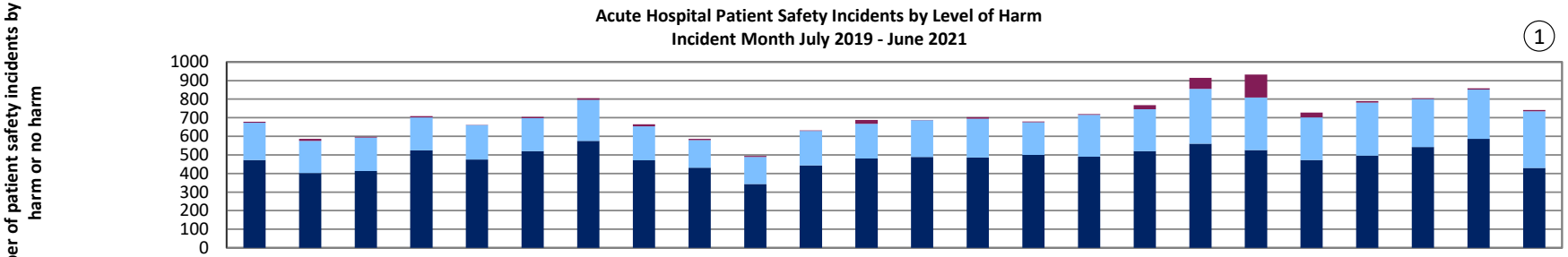
Acute Hospital Patient Safety Incidents (Excludes CCICP)

X-SPC Chart



P-SPC Chart





	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	Mar-21	Apr-21	May-21	Jun-21
Moderate and Above	6	11	5	7	2	6	9	12	8	5	3	20	2	8	5	5	22	58	124	26	8	5	6	7
Low Harm	201	173	180	178	185	178	220	182	148	146	186	187	197	209	175	225	224	295	283	229	285	258	266	305
No Harm	472	403	413	524	475	520	576	471	431	343	443	481	489	486	500	490	521	561	526	473	496	542	586	430

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: 742 incidents are currently shown for June 2021 of which 42% resulted in harm.

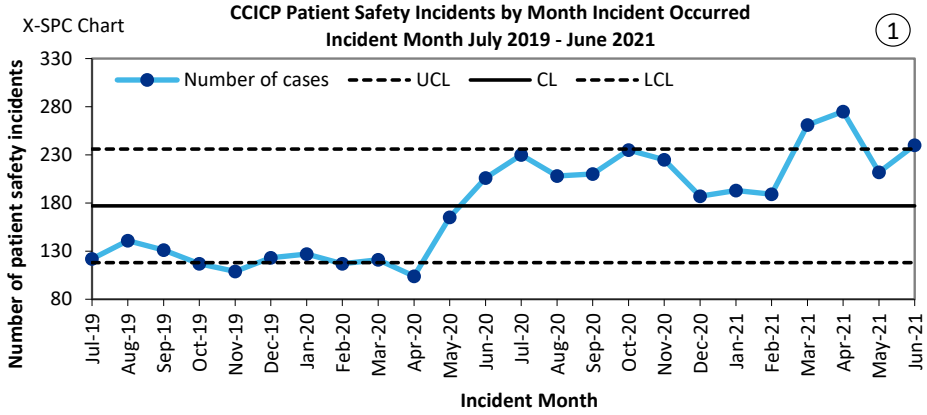
Low Harm 305, Moderate Harm 5, Serious Incident 2

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

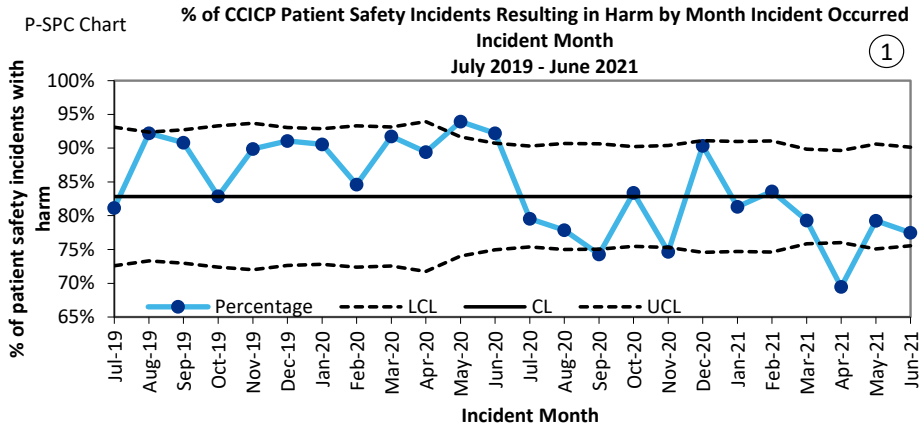
Quality, Safety & Patient Experience

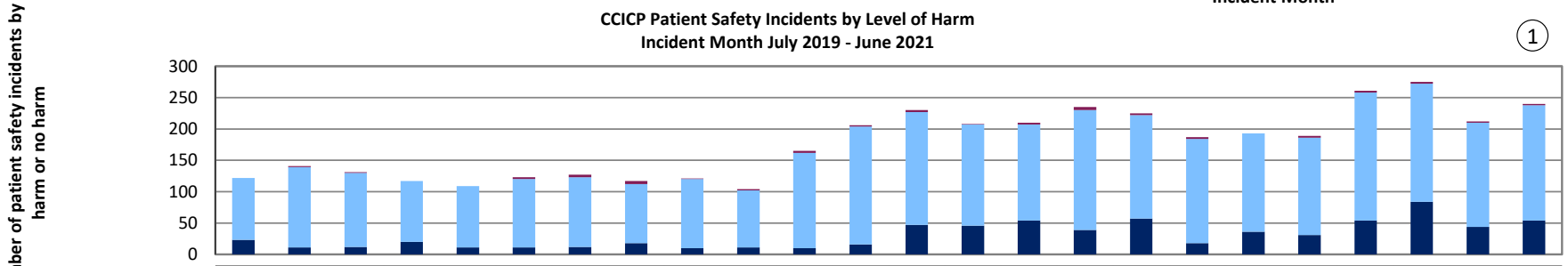
Central Cheshire Integrated Care Partnership (CCICP) Patient Safety Incidents

X-SPC Chart



P-SPC Chart





	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	Mar-21	Apr-21	May-21	Jun-21
Moderate and Above	-	2	1	-	-	3	4	5	1	2	3	2	3	1	3	5	3	3	-	3	3	3	2	2
Low Harm	99	128	118	97	98	109	111	94	110	91	152	188	180	161	153	191	165	166	157	155	204	188	166	184
No Harm	23	11	12	20	11	11	12	18	10	11	10	16	47	46	54	39	57	18	36	31	54	84	44	54

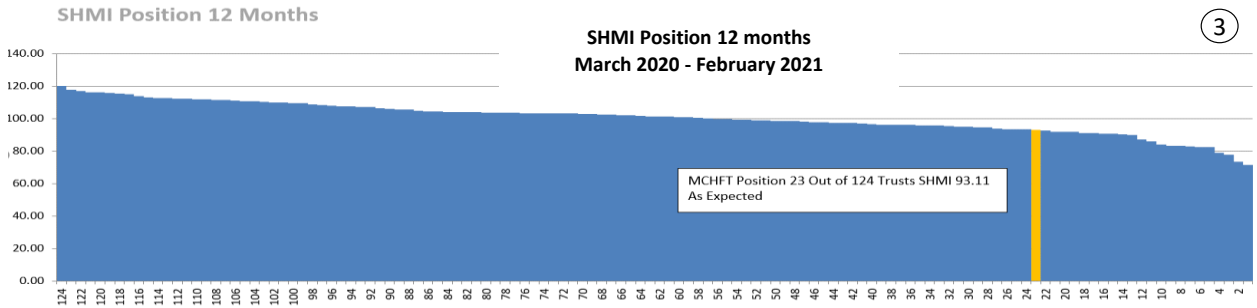
Accountable: Medical Director
Data Owner: Quality Governance
To note: P-SPC charts adjust the control limits to take into account each month's denominator.

Key Narrative: 240 CCICP patient safety incidents are currently shown for June 2021 of which 78% resulted in harm.

Low Harm 184, Moderate Harm 2, Serious Incident 0

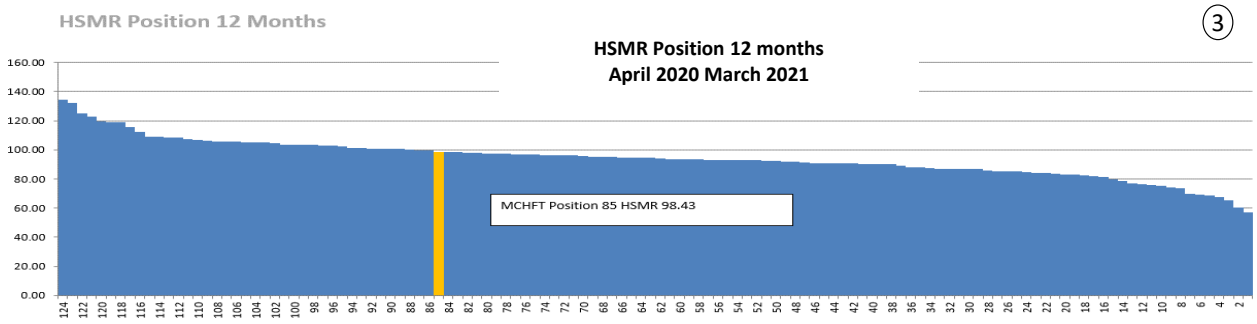
Quality, Safety & Patient Experience

Mortality



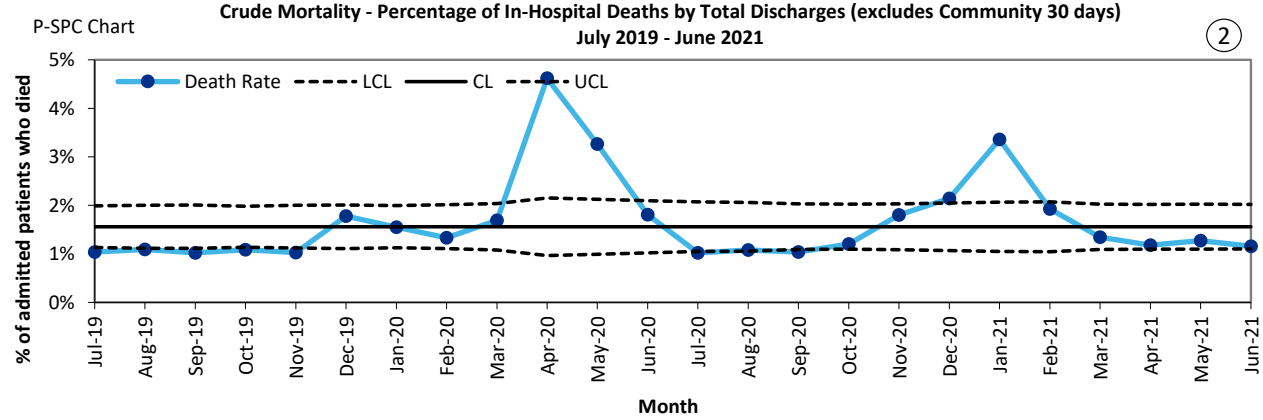
③

Key Narrative: The latest release of SHMI is 93.11 (rank 23) against the previous value of 94.93 (rank 31). 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.



③

Key Narrative: The latest HSMR release is 98.43. 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 another slight improvement. Please note that the Trust mergers in SHMI are reflected in this data.



②

Key Narrative: Crude mortality has remained largely consistent over the time period except for peaks seen in April 2020, May 2020 and January 2021 related to an increase in COVID-19 patients within the Trust. June 2021 continues to show a return to pre-covid levels and is lower than June 2020.

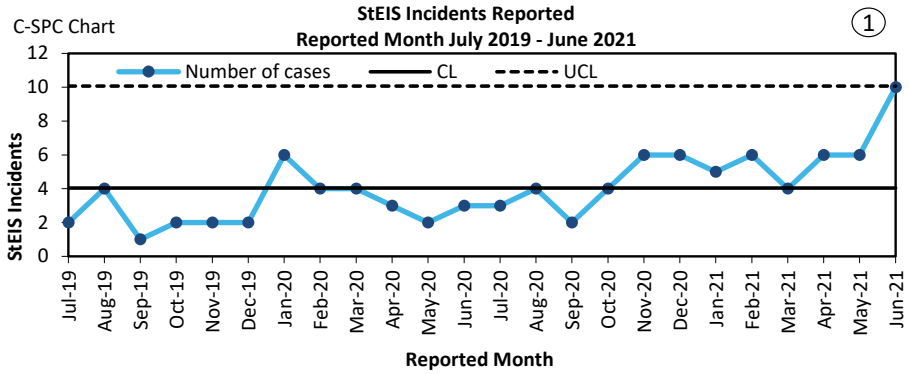
Accountable: Medical Director
Data Owner: Quality Governance
To note: P-SPC charts adjust the control limits to take into account each month's denominator.

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

Quality, Safety & Patient Experience

StEIS Incidents - Trust Total

C-SPC Chart

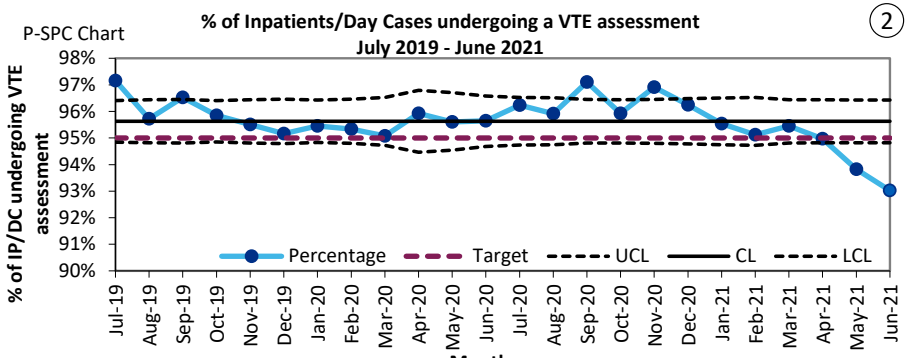


Accountable: Medical Director **Data Owner:** Quality Governance

Key Narrative: There were 10 serious incidents reported to StEIS in June 2021.

VTE

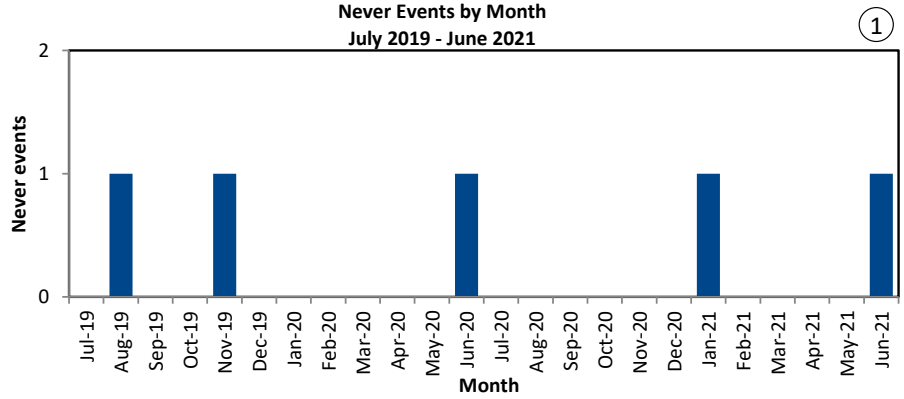
P-SPC Chart



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

Key Narrative: The percentage of VTE assessments remains below target in June 2021 achieving 93.0%. 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

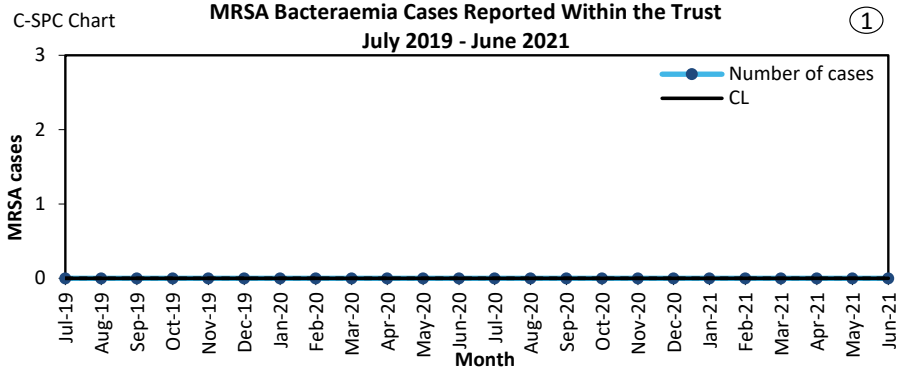
Key Narrative: There was one never event reported in June 2021.

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

Quality, Safety & Patient Experience

MRSA

C-SPC Chart

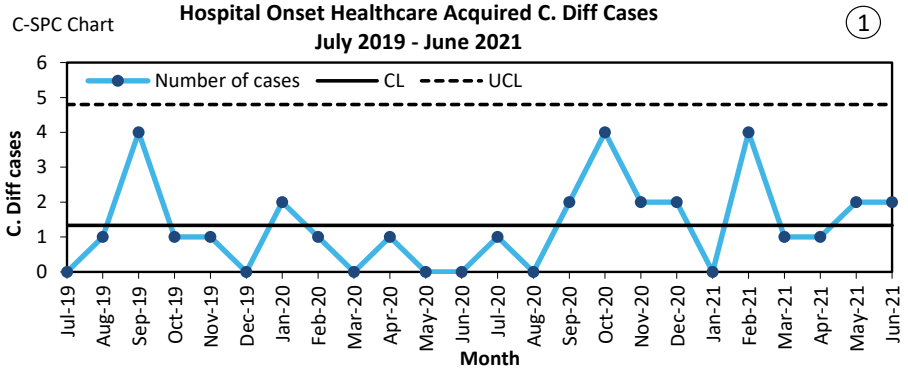


Accountable: Director of Nursing and Quality
Data Owner: Infection Prevention Control Team

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

C. Diff Positive Cases

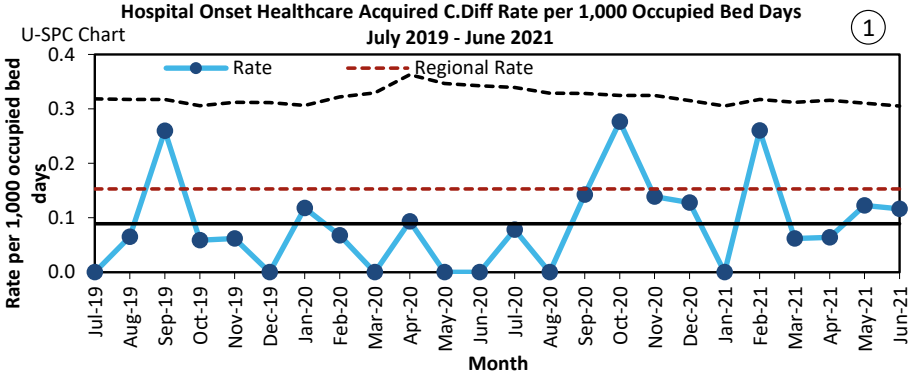
C-SPC Chart



	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
Avoidable	1	0	0	0	0	0	0	0	0	0	0	0
Unavoidable	0	0	1	4	1	0	0	1	1	0	0	0
Awaiting Confirmation	0	0	1	0	1	2	0	3	0	1	2	2

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

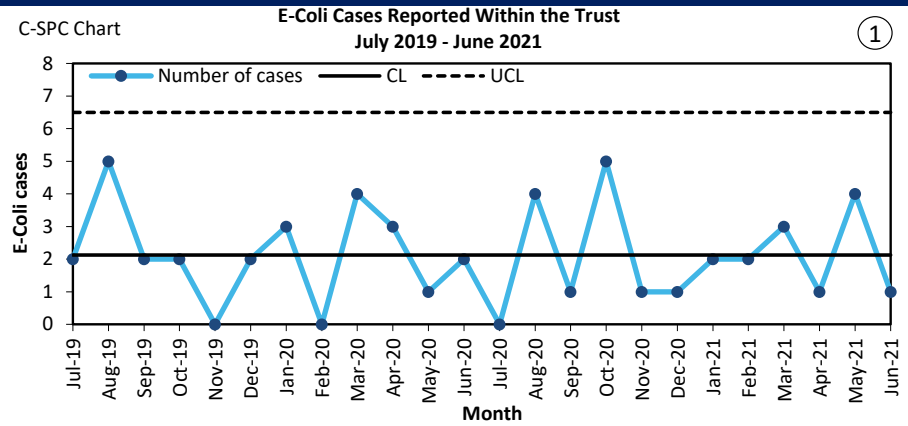
U-SPC Chart

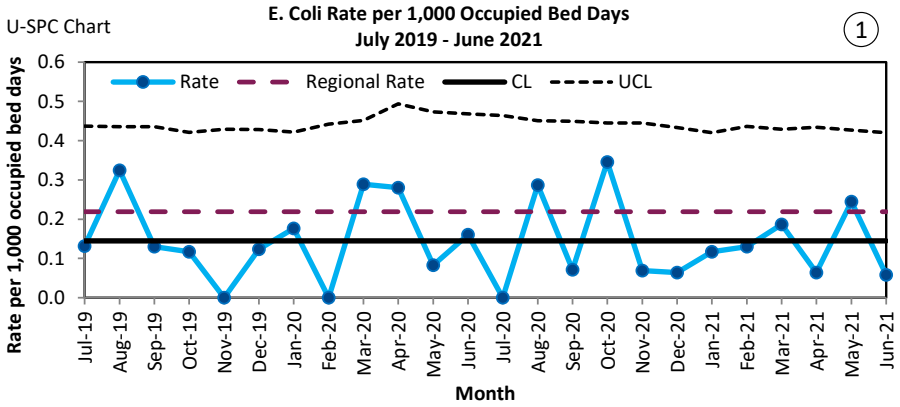


Accountable: Director of Nursing and Quality
Data Owner: Infection Prevention Control Team
Key Narrative: Two hospital onset healthcare acquired C.Diff cases was recorded in June 2021 with a rate of 0.12 per 1,000 occupied bed days, below the regional rate. The P-SPC charts adjust the control limits to take into account each month's denominator.

Quality, Safety & Patient Experience

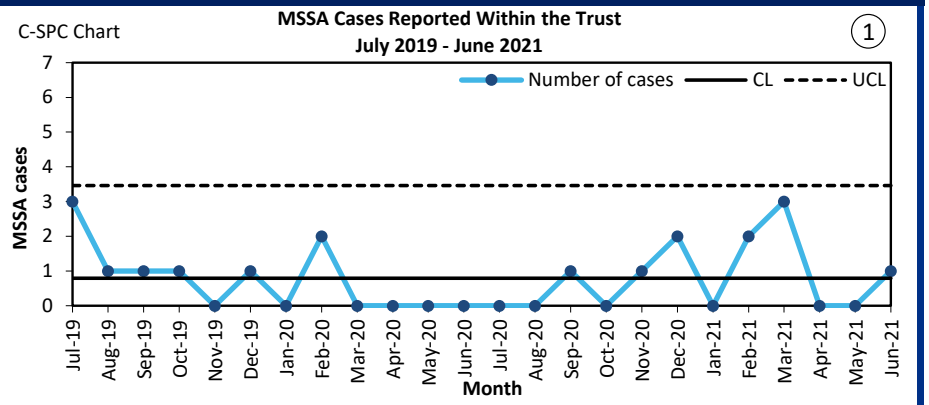
E-Coli Cases

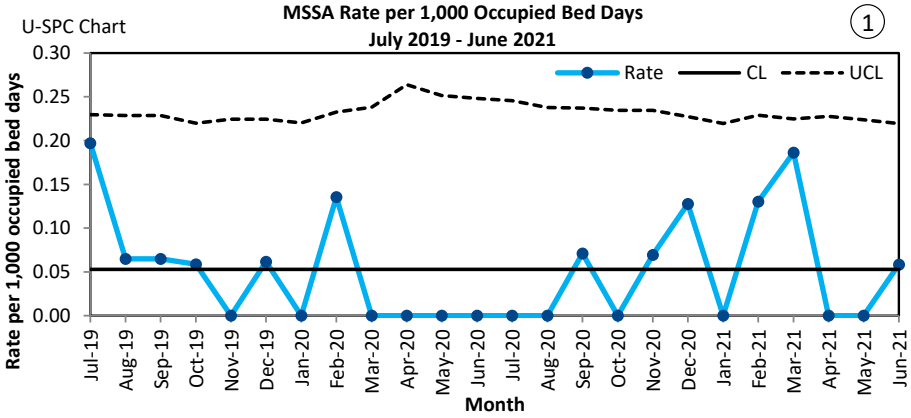




Accountable: Director of Nursing and Quality
Data Owner: Infection Prevention Control Team
Key Narrative: One E-Coli cases was recorded in June 2021 with a rate of 0.06 cases per 1,000 occupied bed days, below the current regional rate. The U-SPC chart adjusts the control limits to take into account each month's denominator.

MSSA





Accountable: Director of Nursing and Quality
Data Owner: Infection Prevention Control Team
Key Narrative: There was one MSSA case reported in June 2021. The U-SPC chart adjusts the control limits to take into account each month's denominator.

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

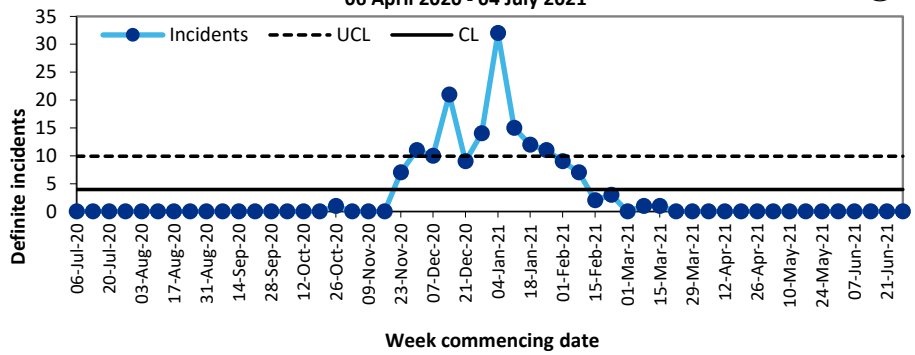
Quality, Safety & Patient Experience

COVID-19 Healthcare Acquired Infections

C-SPC Chart

MCHFT Definite COVID-19 Incidents by Result Week
06 April 2020 - 04 July 2021

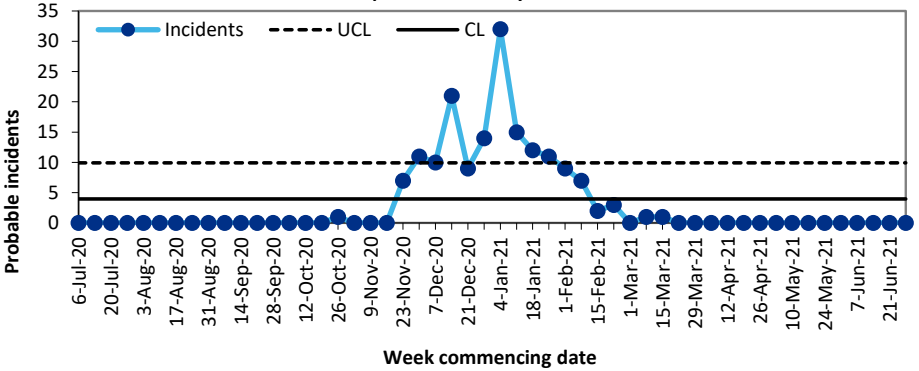
①



C-SPC Chart

MCHFT Probable COVID-19 Incidents by Result Week
06 April 2020 - 04 July 2021

①

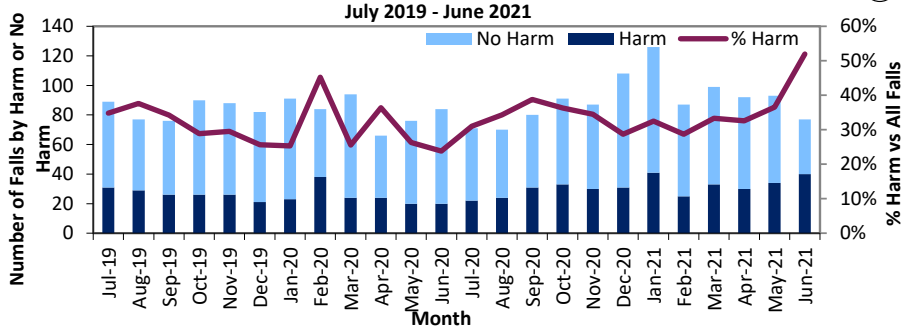


Accountable: Director of Nursing and Quality **Data Owner:** Information Services
Key Narrative: The latest week reported, week commencing 28th June 2021, shows 0 definite incidents and 0 probable incidents.

Falls

Falls Rate Harm Vs No Harm
July 2019 - June 2021

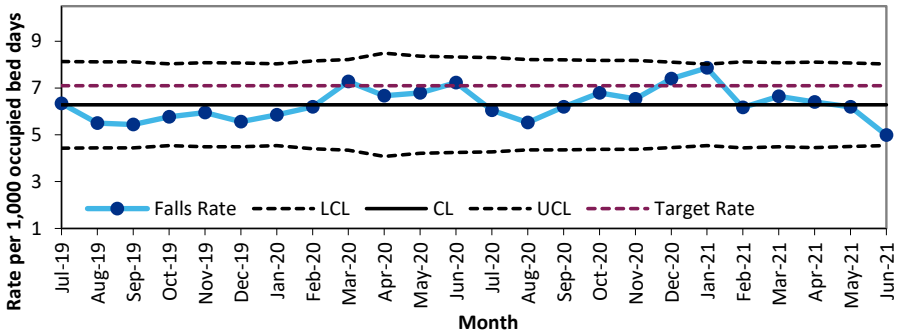
②



U-SPC Chart

Falls Rate per 1,000 Occupied Bed Days
July 2019 - June 2021

②

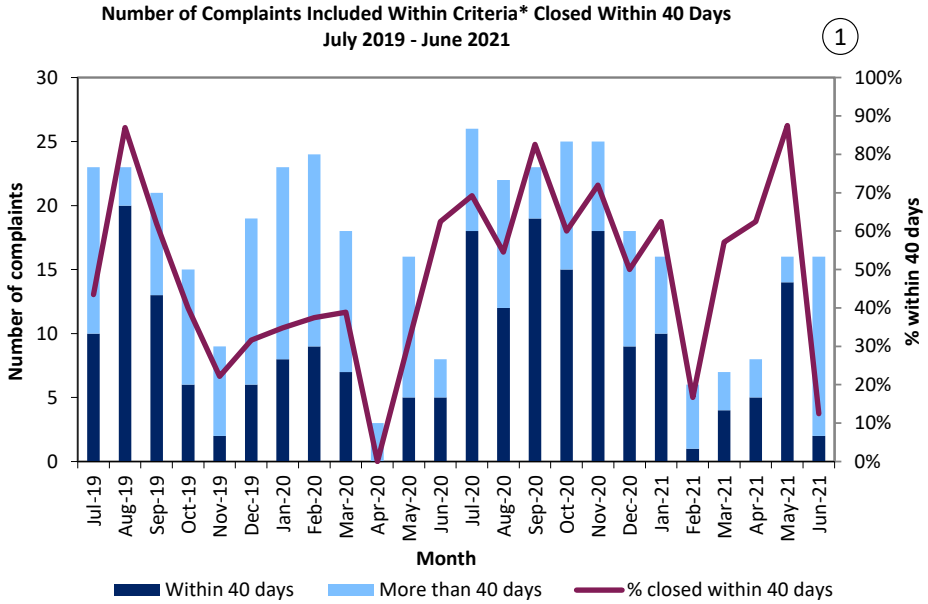


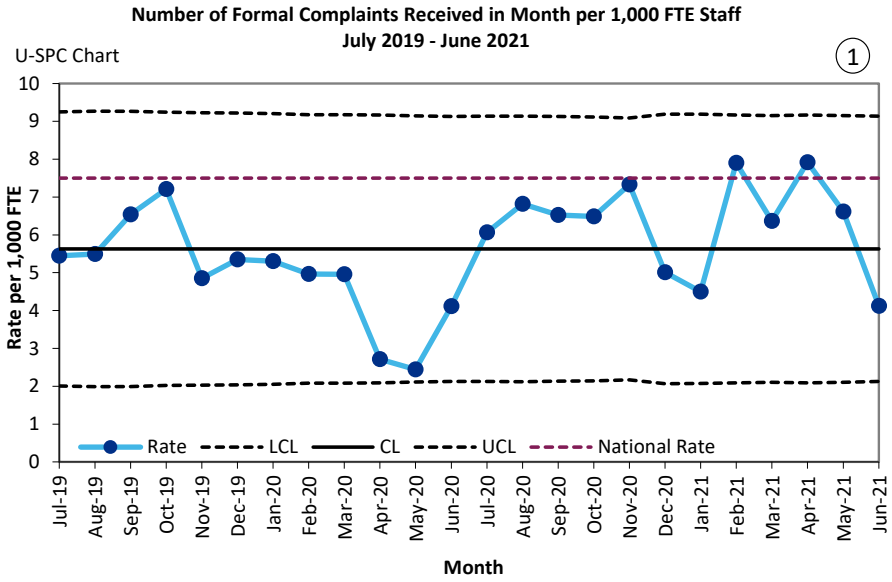
Accountable: Director of Nursing and Quality **Data Owner:** Nursing Quality Team
Key Narrative: 77 falls were reported in June 2021 with a rate of 4.5 per 1,000 occupied bed days, below the target rate of 6.6. 40 falls resulted in harm (52%), 94% of these were low or no harm. The U-SPC chart adjusts the control limits to take into account each month's denominator.

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

Quality, Safety & Patient Experience

Formal Complaints





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

Key Narrative: 25 complaints were closed in June2021, of which 2 were closed within 40 days (12.5%). The response rate deterioration is in line with workforce issues combined with the backlog where a significant amount of complaints have gone breached the deadline. The rate of formal complaints received in June 2021 was 4.13 per 1,000 FTE staff, below the national rate.

Due to the second wave of the covid pandemic, complaint responses were stood down from November 2020 and 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.*

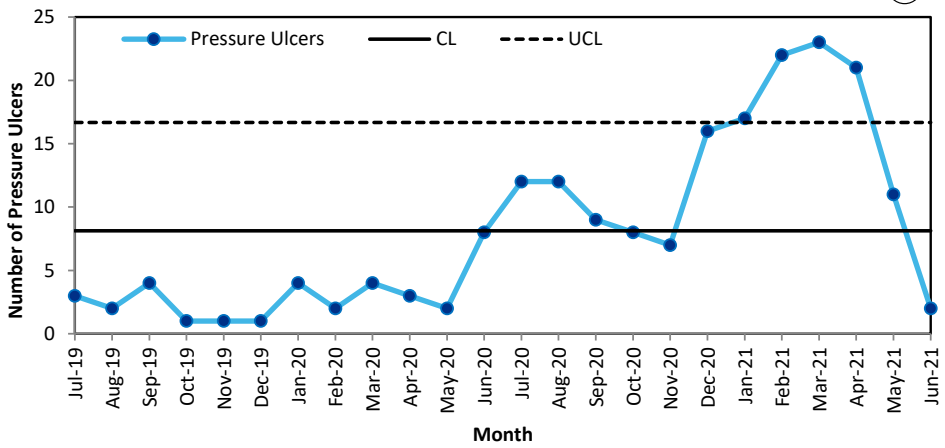
Quality, Safety & Patient Experience

Acute Hospital Pressure Ulcers

C-SPC Chart

Acute Hospital Pressure Ulcers - Lapses in Care Identified
July 2019 - June 2021

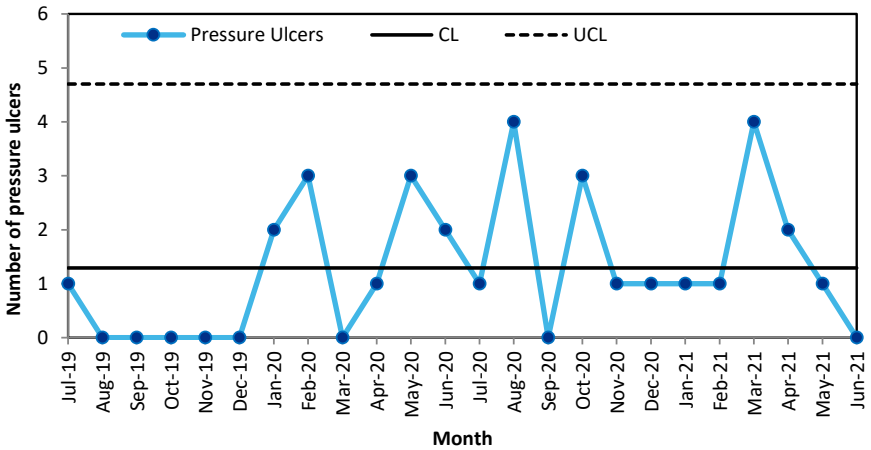
①



C-SPC Chart

Community Pressure Ulcers - Lapses in Care Identified
July 2019 - June 2021

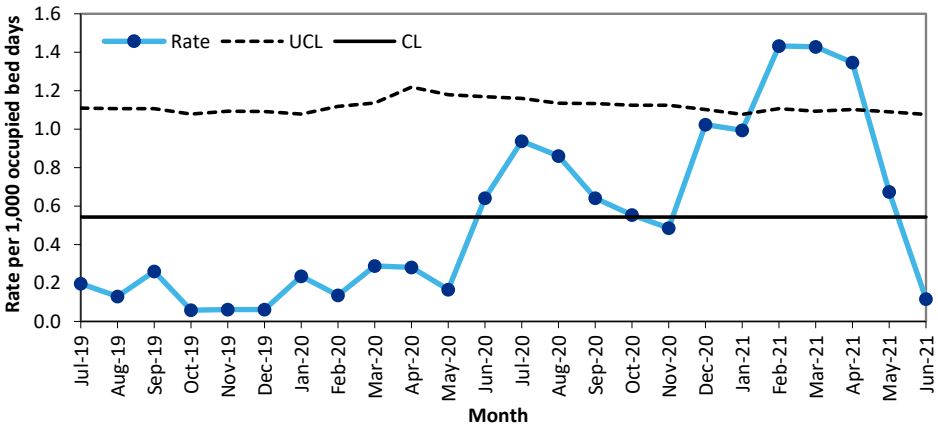
①



U-SPC Chart

Acute Hospital Pressure Ulcers - Lapses in Care Rate per 1,000 Occupied Bed Days
July 2019 - June 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: Two acute hospital lapses in care have currently been identified in June 2021 with a rate of cases per 1,000 occupied bed days of 0.12. Latest months data correct at time of reporting, however, will increase as the validation process for June 2021 data continues.

Community: No community lapses of care have currently been identified in June 2021. There have been 3 community lapses of care reported in the current financial year.

Current financial year reported cases subject to validation.

Quality, Safety & Patient Experience

Safer Staffing Divisional Analysis

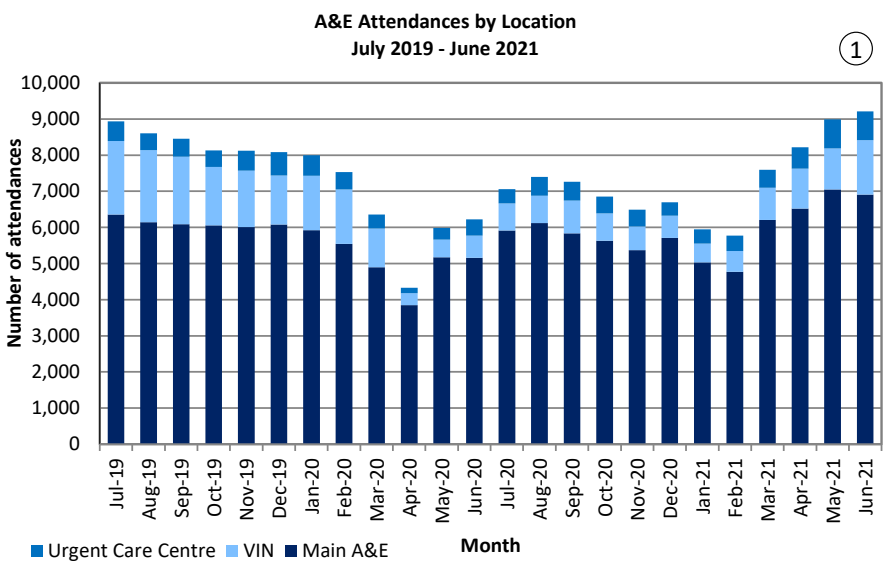
①

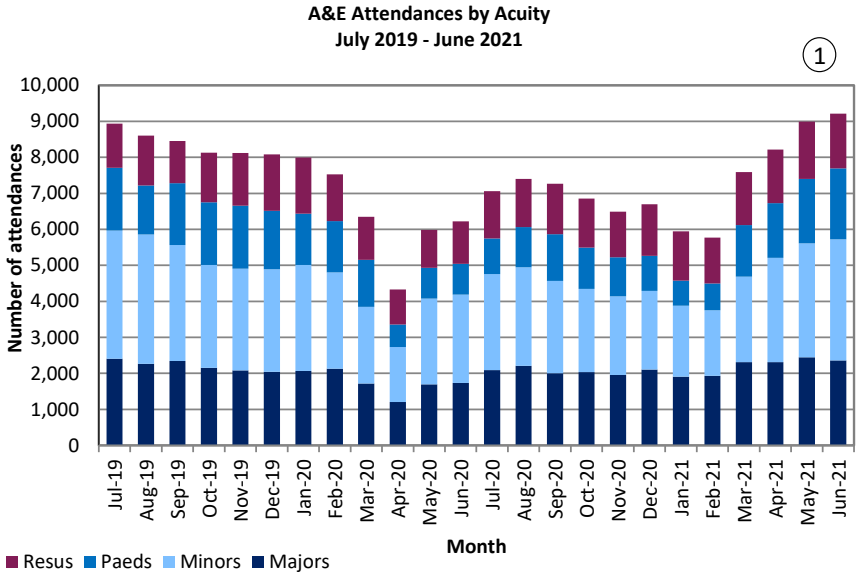
Ward Name	Day				Night				Day		Night	
	Qualified		Unqualified		Qualified		Unqualified		Qualified	Unqualified	Qualified	Unqualified
	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Fill Rate	Fill Rate	Fill Rate	Fill Rate
MCHFT	45762.2	39609.6	40901.8	33801.7	34355.8	31652.5	31239.1	26184.0	87%	103%	92%	99%
Acute Medical Unit	2019.0	1945.5	1799.8	1739.3	1968.0	1833.0	1476.0	1478.5	96%	97%	93%	100%
Child & Adolescent Unit	3351.8	2247.4	1204.3	980.6	1764.0	1686.0	384.0	369.8	67%	81%	96%	96%
Critical Care Unit (HIGH)	3822.0	3373.5	537.8	449.8	3748.0	3300.8	0.0	0.0	88%	84%	88%	
Elmhurst	741.5	730.0	2256.0	2184.0	732.0	722.0	1548.0	1500.5	98%	97%	99%	97%
South Cheshire Surveillance (HIGH)	2153.5	1720.0	2616.8	2042.8	2091.5	1731.5	2399.5	1703.5	80%	78%	83%	71%
Ward 1 Cardiology Coronary Care	1979.5	1926.5	1116.0	1056.0	1488.0	1453.5	792.0	780.0	97%	95%	98%	98%
Ward 10 Orthopaedic Trauma	2590.0	2150.0	3676.5	2854.5	1572.0	1235.0	2736.0	2444.5	83%	78%	79%	89%
Ward 11 Surgical/Gynae	2051.5	1804.5	1896.0	1574.0	1313.0	1179.5	1536.0	1428.0	88%	83%	90%	93%
Ward 12 SAU	1105.7	1029.4	768.0	692.5	792.0	756.0	792.0	720.0	93%	90%	95%	91%
Ward 12 Surgical Specialties	1132.5	1054.0	1001.3	844.8	804.0	708.0	804.0	612.0	93%	84%	88%	76%
Ward 13 Medical Escalation	2094.3	1861.8	2119.8	1547.0	1548.0	1379.5	2052.0	1584.0	89%	73%	89%	77%
Ward 14 Gastroenterology	1301.0	1283.0	1548.0	1464.5	1140.0	1068.0	1176.0	1128.0	99%	95%	94%	96%
Ward 15 Medical Escalation	2174.8	1755.8	2045.5	1867.3	1188.0	1116.0	1845.5	1677.0	81%	91%	94%	91%
Ward 18 Elective	1828.1	1198.1	1374.0	915.5	996.0	877.0	966.0	821.0	66%	67%	88%	85%
Ward 19 Winter	1544.0	1291.8	2452.9	1986.6	1140.0	1043.5	1848.0	1661.5	84%	81%	92%	90%
Ward 21b Rehabilitation	1159.7	1100.0	2716.5	2448.8	972.0	1080.0	1368.5	1287.5	95%	90%	111%	94%
Ward 22 NICU	1881.8	1744.1	1154.3	598.6	1299.0	1271.3	645.0	297.3	93%	52%	98%	46%
Ward 23 Maternity	1289.0	1219.6	725.8	677.5	720.0	711.0	918.2	817.2	95%	93%	99%	89%
Ward 26 Labour	2648.9	2399.8	557.8	546.2	2158.3	2099.3	360.0	359.8	91%	98%	97%	100%
Ward 3 Respiratory	3096.2	2530.4	1591.4	1322.9	2220.0	2028.0	1800.0	828.0	82%	83%	91%	46%
Ward 4 Care of the Elderly	1437.5	1421.0	2556.0	2050.0	1198.0	1135.3	2124.0	1846.0	99%	80%	95%	87%
Ward 6 Stroke / Rehab	1675.0	1489.5	2190.0	1880.0	1476.0	1296.0	1184.5	1112.0	89%	86%	88%	94%
Ward 7 Diabetes / General Medicine	1611.0	1511.5	2309.5	1887.3	1296.0	1235.0	1764.0	1548.0	94%	82%	95%	88%
Ward 9 Orthopaedic Elective	1074.0	822.5	688.0	191.5	732.0	707.5	720.0	180.0	77%	28%	97%	25%

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



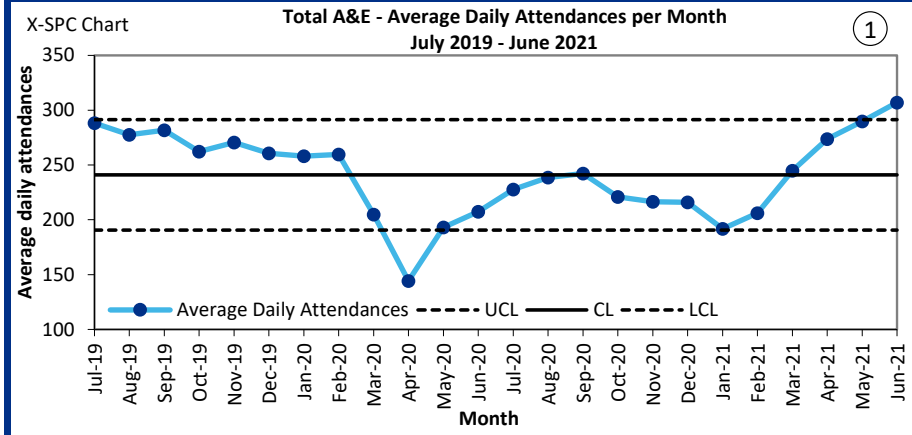


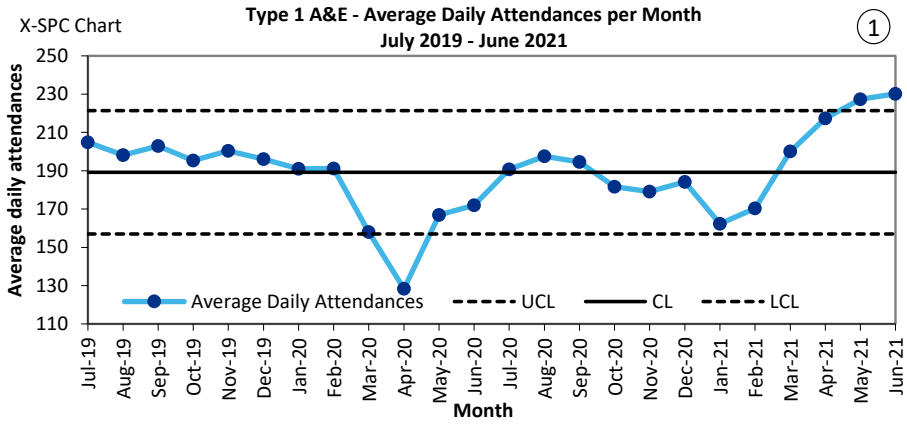
Accountable: Chief Operating Officer
Data Owner: Information Services

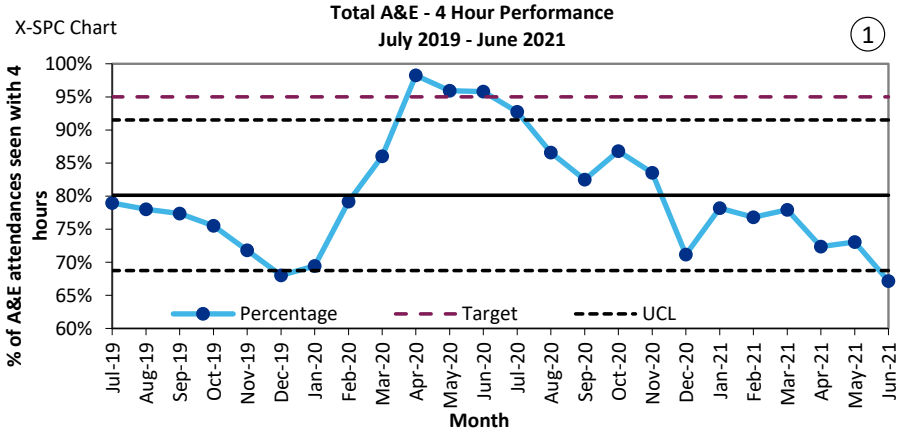
Key Narrative: June 2021 shows 9,211 total A&E attendances across all locations, a 2.5% increase on the previous month and above pre-pandemic levels. There were 6,906 attendances reported in June 2021 for the main A&E department at Leighton Hospital (type 1), higher than pre-pandemic levels, however, 2% lower than the previous month. June 2021 activity variance compared to previous month by acuity: Majors -93, Minors +208, Paeds +171, Resus -63.

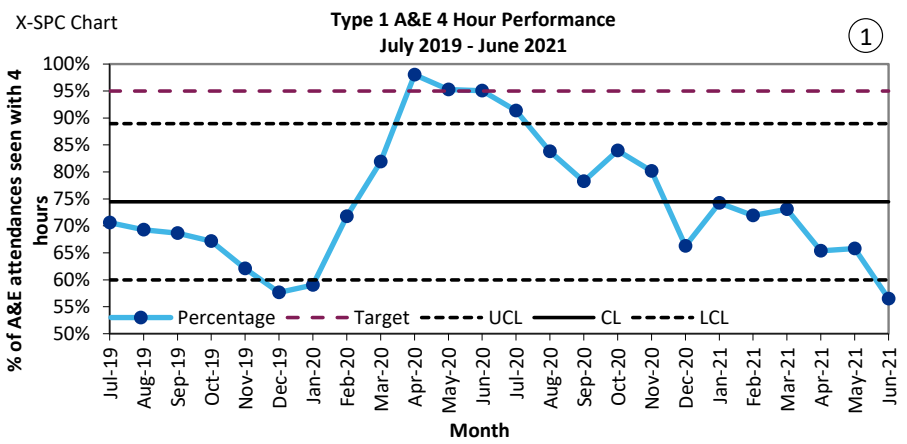
Performance

A&E Performance









Accountable: Chief Operating Officer
Data Owner: Information Services

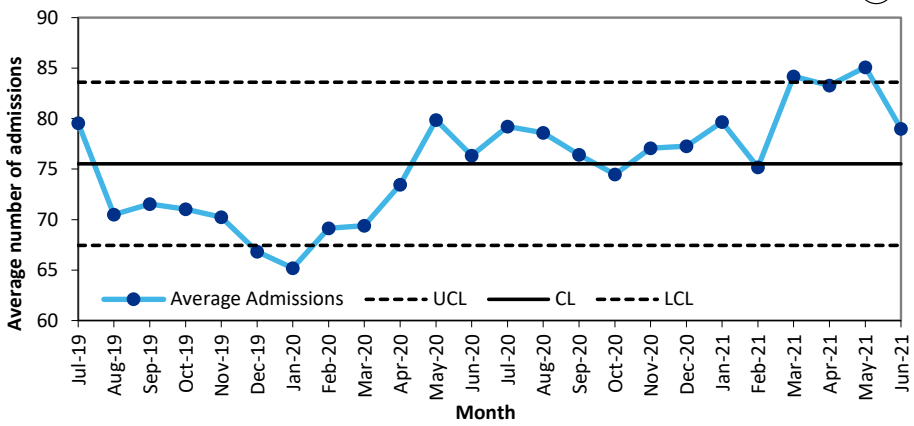
Key Narrative: The average total daily A&E attendances for June 2021 was 307, an increase on the previous month and the highest daily average across the 24 month period. The daily average attendances for Type 1 has increased significantly since March 21 and is more than pre-pandemic levels. It is above the upper control limit with June 2021 showing an average rate of 230 per day. Performance against the 4 hour standard in June 2021 was 67.2%, which is below performance for the the previous month at 73.0%, and 56.5% for type 1 performance.

Performance

Unplanned Admissions

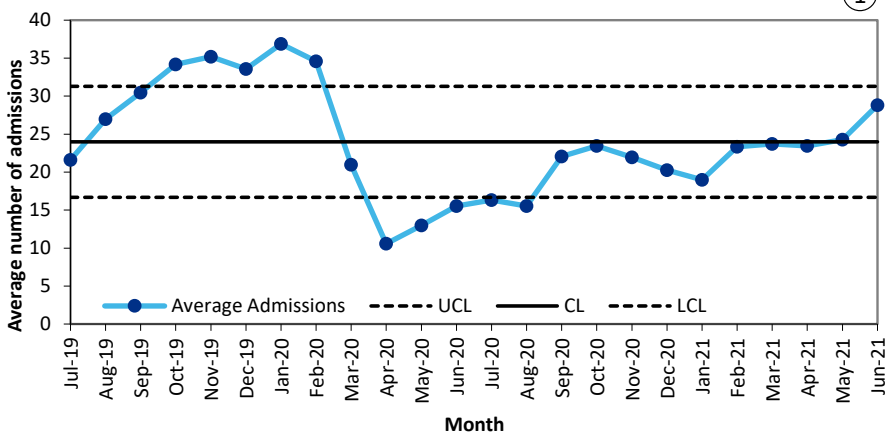
X-SPC Chart

Average Daily Admissions from A&E
July 2019 - June 2021



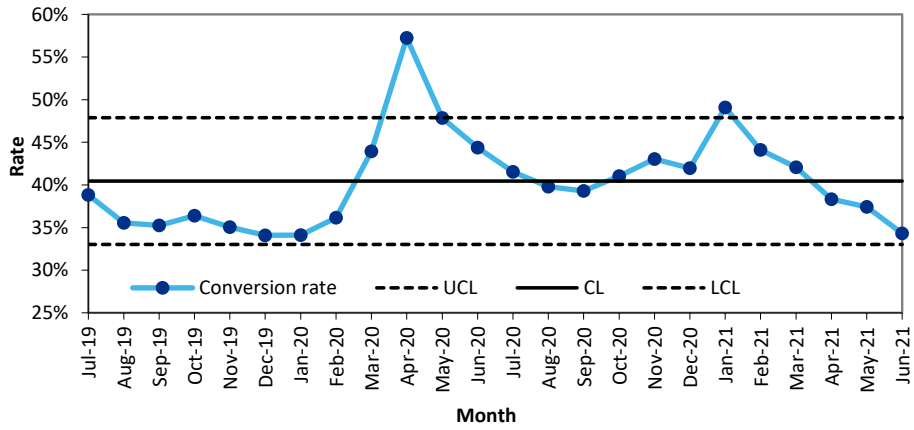
X-SPC Chart

Average Daily Admissions per Month - GP Referred
July 2019 - June 2021



X-SPC Chart

Type 1 Attendance to Admissions Conversion Rate - Overall
July 2019 - June 2021



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

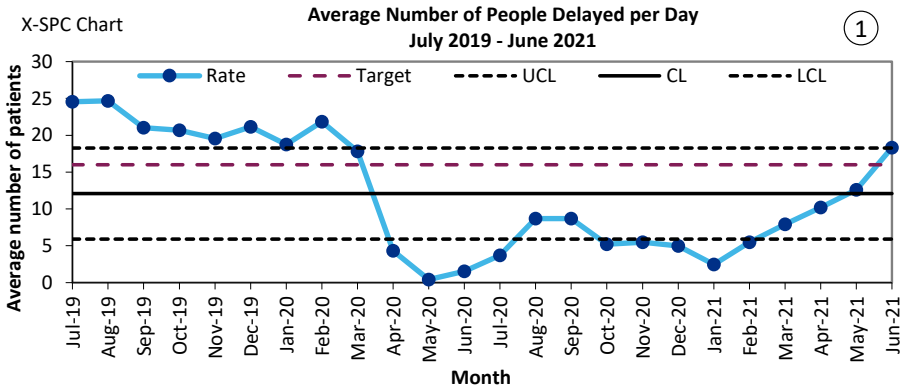
Key Narrative: There was a change in recording of activity between admissions from A&E and via GP from August 2019 driving some of the variation seen in the average daily admission charts from August 2019 until the onset of the covid pandemic. Activity between March 2020 and March 2021 included admissions to RAU reflecting a pathway designed to support the covid pandemic which has now closed and averaged 214 admissions per month during the period.

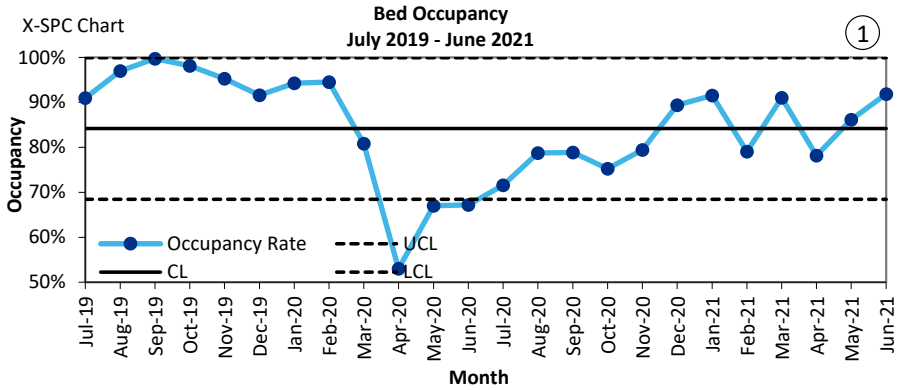
The average daily admissions from A&E for June 2021 was 79.0, which is a decrease on the average admission rate for May 2021 (83.2).

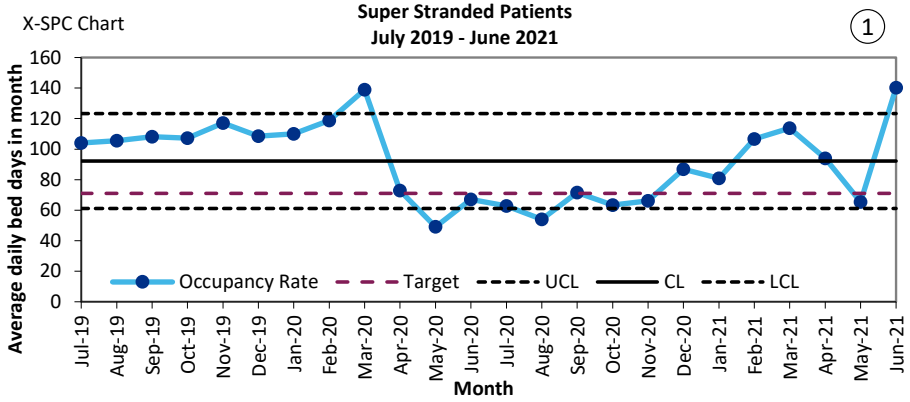
The average daily admissions for GP-referred patients in June 2021 was 28.8, an increase against the average admission rate for May 2021 (24.3). The reduction in GP referred admissions (compared to pre pandemic) is due to stricter admission critria, based on Covid pathways, directing more patients to ED/RAU and a change in how patients present to ED following virtual GP appointments. The type 1 admission conversion rate for June 2021 was 34.3%.

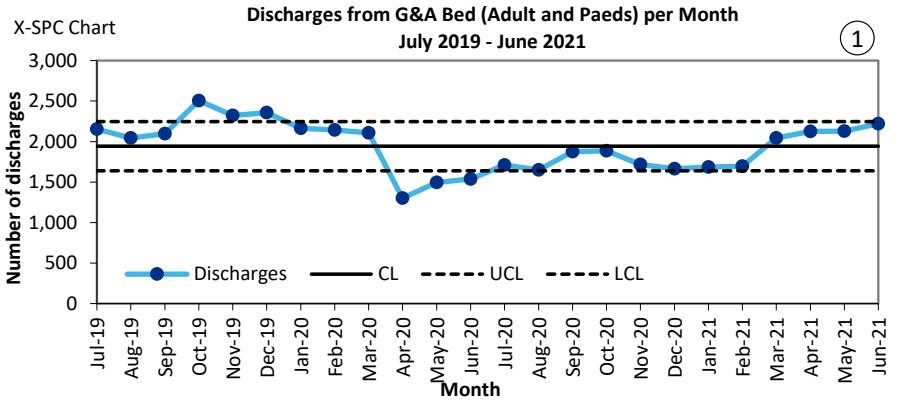
Performance

Inpatient Metrics









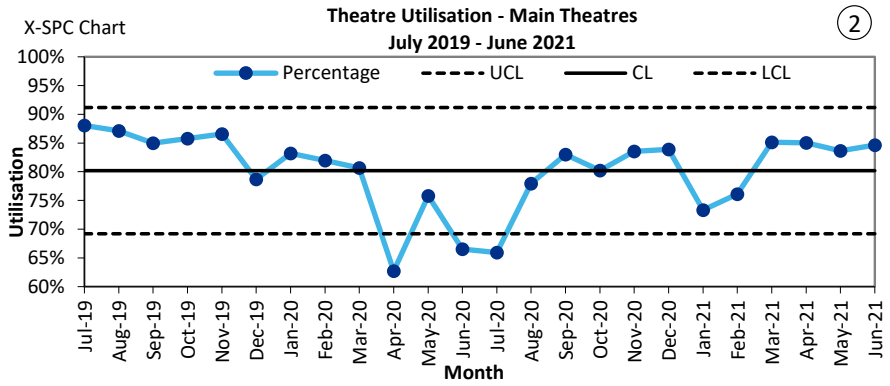
Accountable: Chief Operating Officer **Data Owner:** Information Services

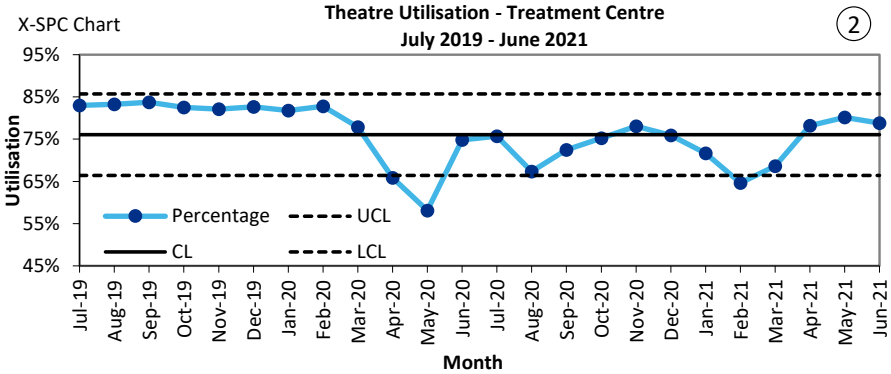
Key Narrative: The average number of people delayed per day during June 2021 was 18.3, an increase on May 2021 (12.6) and is now above the target. The average number of super stranded patients delayed per day in the hospital increased from 65.4 in May 2021 to 104.3 in June 2021. The percentage bed occupancy rate for June 2021 was 91.2%, an increase on the May 2021 occupancy rate of 86.1%. The bed occupancy figure reported does not exclude lost beds that are not suitable for patient admissions for infection prevention and control (IPC) reasons. There were 2,222 discharges from G&A beds in June 2021, which is a small increase on the previous month and an improving trend.

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

Performance

Theatre Utilisation



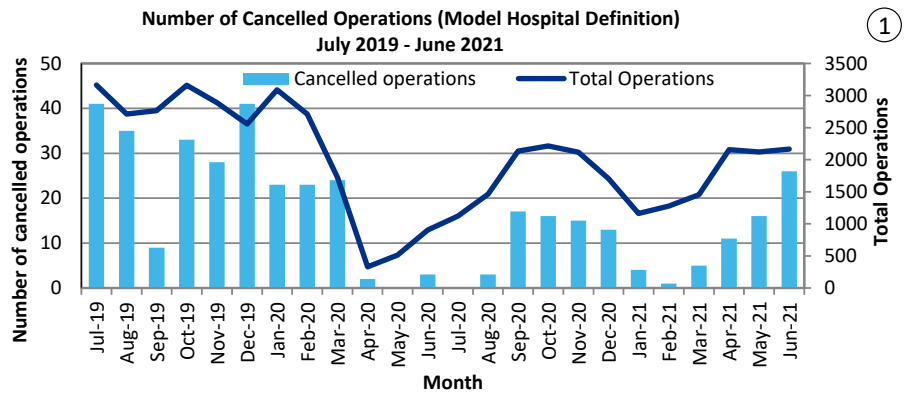


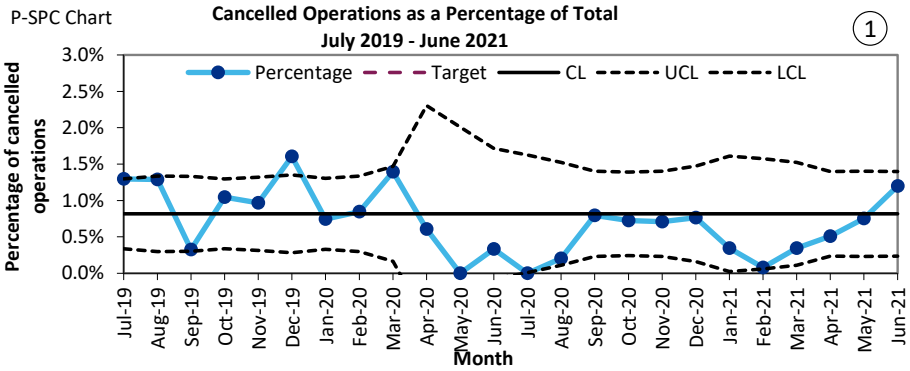
Accountable: Chief Operating Officer **Data Owner:** Information Services

Key Narrative: Theatre utilisation rate for June 2021 was 84.7% in Main Theatres, a small increase on the May 2021 position of 83.6%.

Theatre utilisation rate for the Treatment Centre in June 2021 was 78.8%, a small decrease on the April 2021 position of 80.1%.

Cancelled Operations





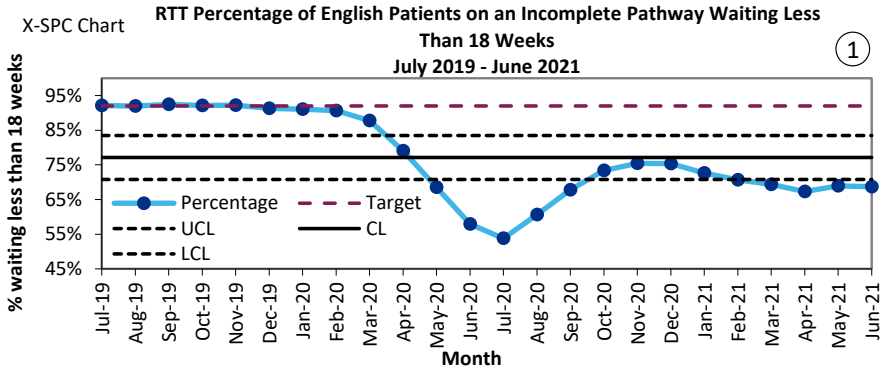
Accountable: Chief Operating Officer **Data Owner:** Information Services

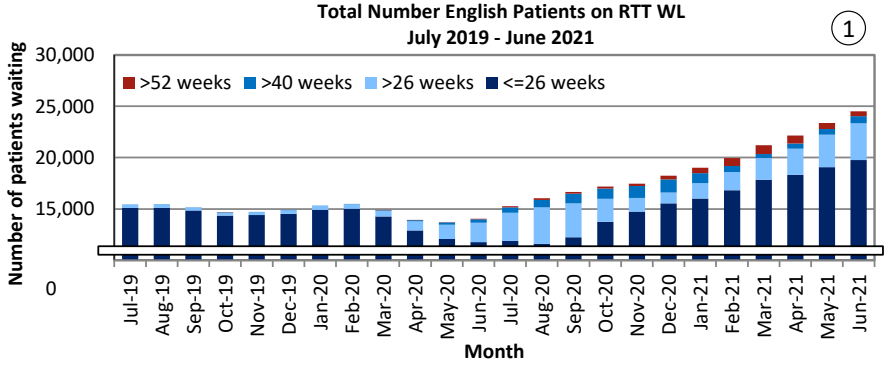
Key Narrative: 26 operations were cancelled on the day of admission by the hospital for non-clinical reasons in June 2021 (1.2%).

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

Performance

Referral to Treatment Waiting Times (RTT)





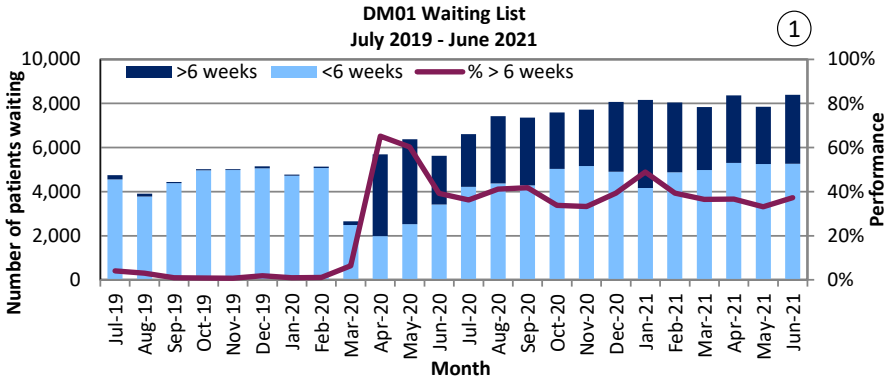
Accountable: Chief Operating Officer **Data Owner:** Information Services

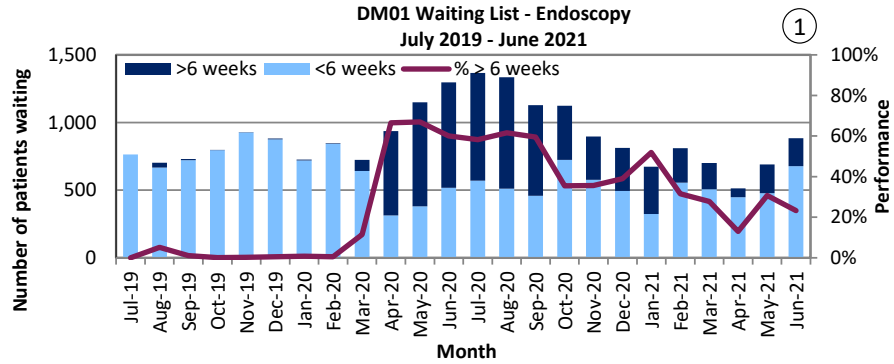
Key Narrative: The total number of patients on the RTT WL continues to grow with 24,511 patients waiting at the end of June 2021, of which 459 patients were waiting for more than 52 weeks, 126 fewer than reported in May 2021 and a continuous improvement in the last 4 months.

June 2021 RTT performance shows 68.6% of patients waiting less than 18 weeks. This is in line with May 2021 performance of 69.0%.

Latest month's data provisional

Diagnostic Waiting Times





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

Key Narrative: Following a review of the DM01 guidance, there have been changes to the reporting logic from June 2021, which has led to an increase in the number of DM01 waiters reported alongside some waiting list growth.

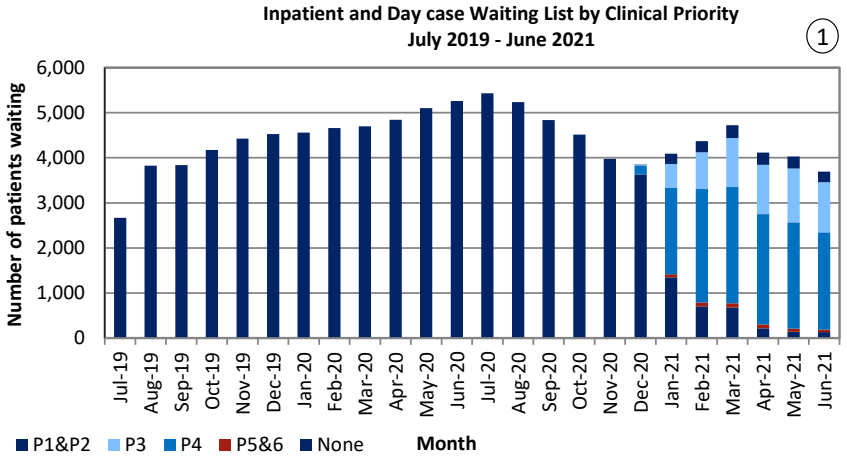
The total number of patients on the DM01 diagnostic waiting list for June 2021 was 8,389 and performance against the 6 week diagnostic standard in June 2021 was 37.3%. Performance for the Endoscopy DM01 modalities improved from 30.7% in May 2021 to 23.3% in June 2021.

Latest month's data provisional

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

Performance

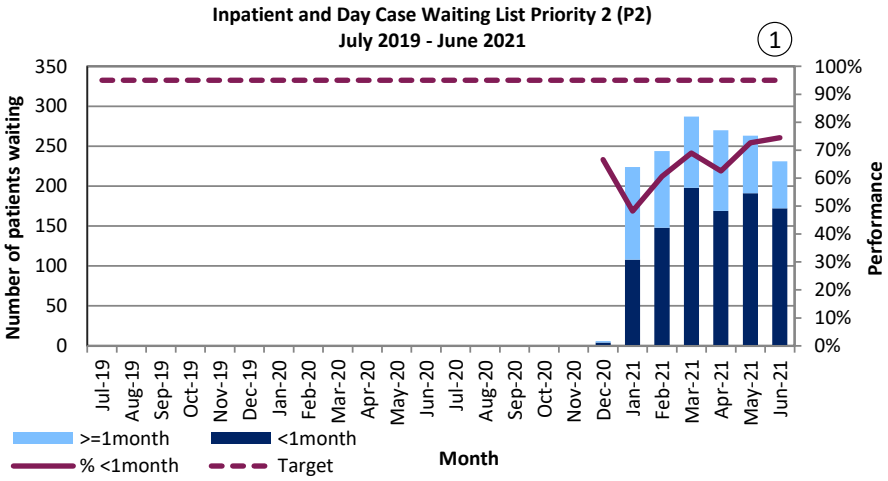
Inpatient and Day Case Clinical Prioritisation

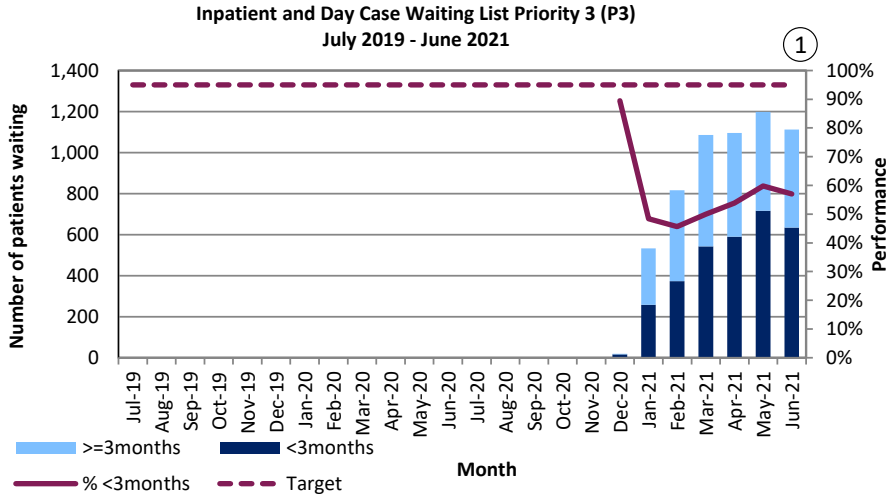


Accountable: Chief Operating Officer **Data Owner:** Information Services

Key Narrative: Since December 2021 all patients on the inpatient waiting list have now been assigned a 'priority' code defining when they should undergo their operation. P1 = 1-3 days, P2 = <1 month, and P3 = <3 months. P5&6 relate to patients who have chosen to delay treatment for covid and non-covid reasons. The waiting list at the end of June 2021 showed 232 patients had been categorised as P1 and P2, 1,113 as P3, 2,159 as P4 and 54 patients categorised as either P5 or P6.

In June 2021 the percentage of patients classified as P2 and currently waiting less than 4 weeks for treatment was 74.5% which is an imporving trajectory. For P3 patients it was 57.1% getting their operation in <3 months.

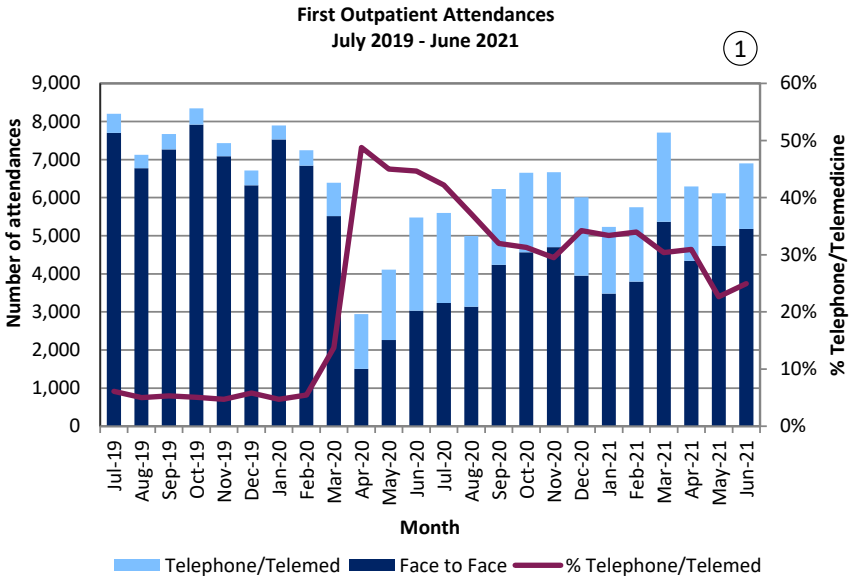


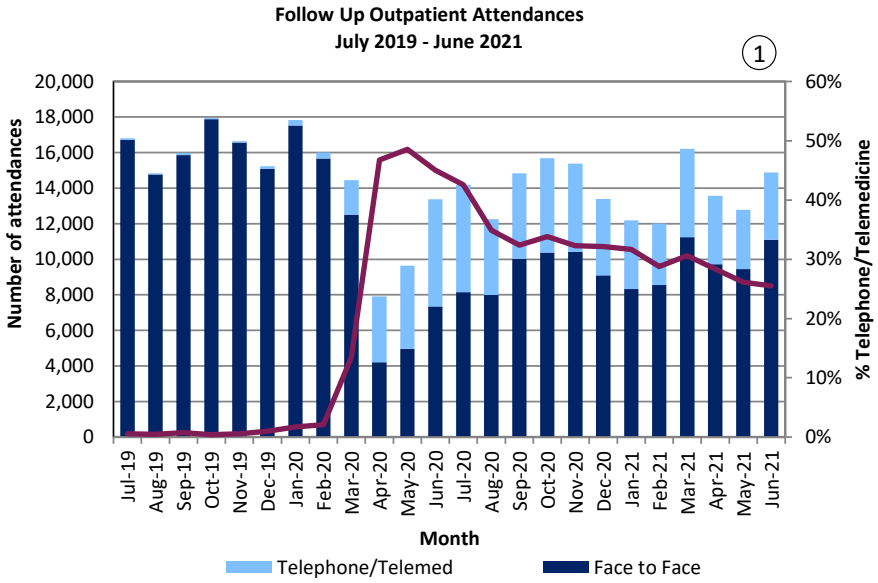


Data Rating: ①captured locally, ②system captured, ③published/benchmarked

Performance

Outpatient Activity





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

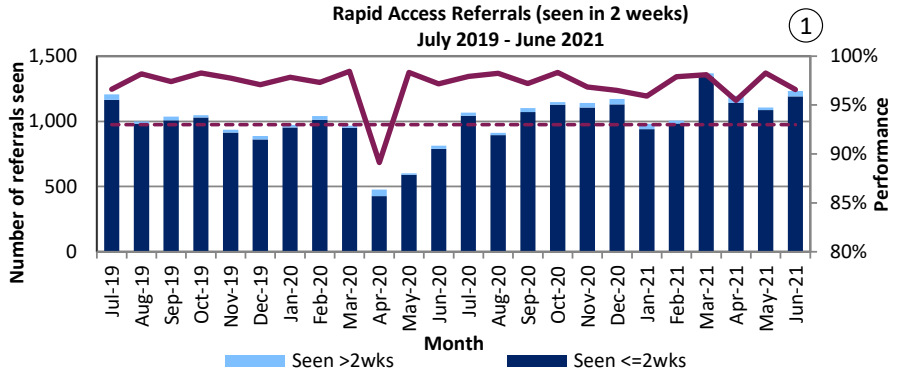
Key Narrative: 6,900 total first outpatient appointments were attended in June 2021, an increase of 12.8% of activity compared to May 2021. The proportion of non face to face appointments for June 2021 was 25.0%, an increase compared to 22.7% in May 2021.

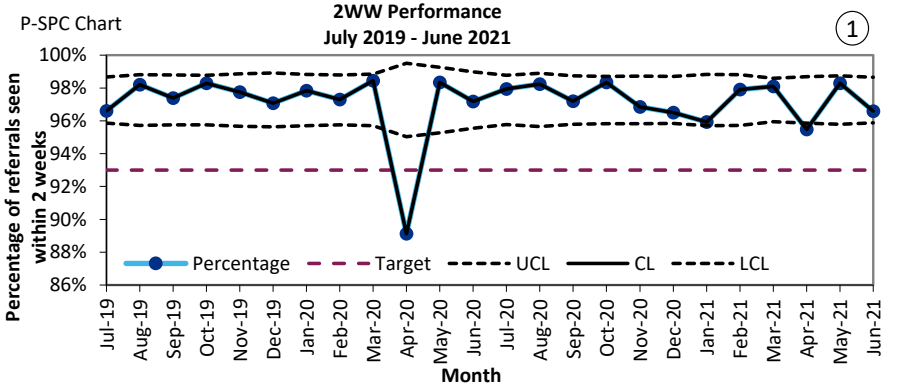
There were 14,888 total follow up outpatient appointments attended in June 2021, an increase of 16.4% of the activity compared to May 2021. The proportion of non face to face appointments for June 2021 was 25.5%.

Data includes contracted specialties.

Performance

Rapid Access Referrals





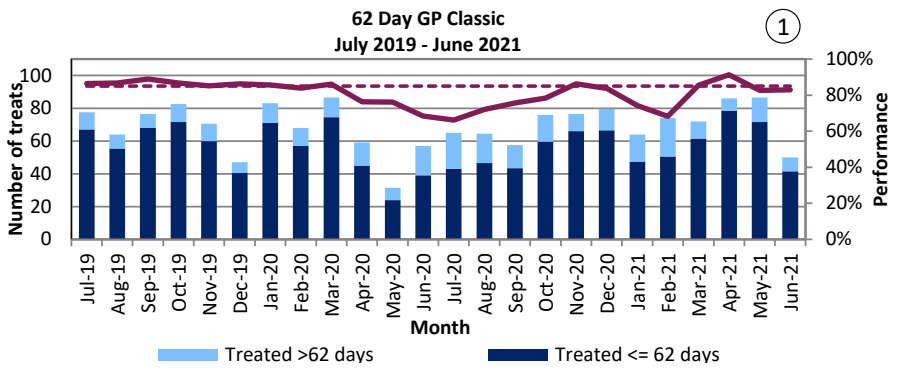
Accountable: Chief Operating Officer **Data Owner:** Cancer Performance

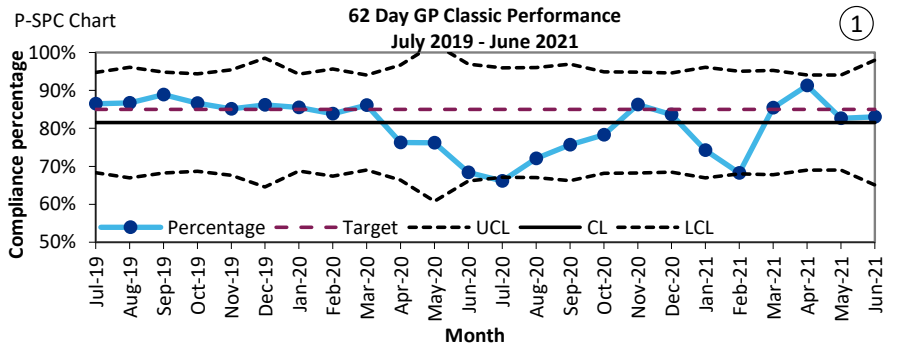
Key Narrative: 1,234 rapid access referrals were seen in June 2021, an increase of 11.6% from the previous month but in line with the 24-month average.

The 2 week wait performance has consistently delivered above the 93% standard with the exception of April 2020. June 2021 performance was 96.6%. The P-SPC chart adjusts the control limits to take into account the denominator.

Latest month's data provisional.

62 Day





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

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

Key Narrative: Provisional performance against the 62-day standard for May 2021 currently reported at 83.0% subject to validation of tertiary referrals and transfer dates, this is likely to improve.

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

Latest month's data provisional.

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

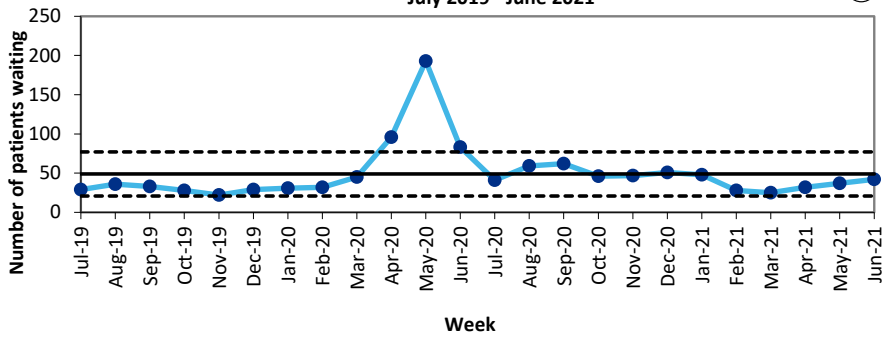
Performance

Cancer Waits Without DTT

X-SPC Chart

Rapid Access GP Referrals waiting 63-104 days without a decision to treat
July 2019 - June 2021

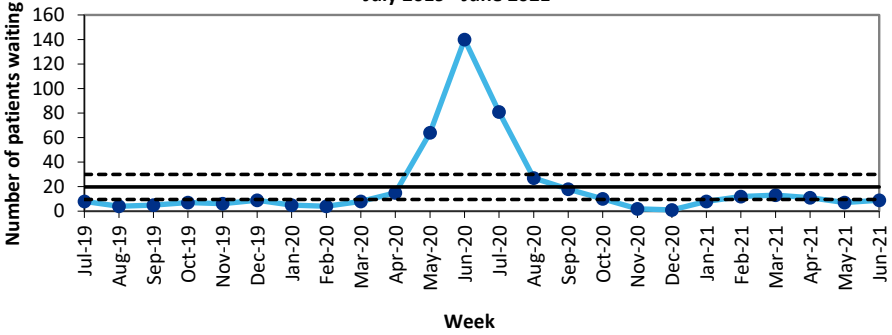
①



X-SPC Chart

Rapid Access GP Referrals waiting more than 104 days without a decision to treat
July 2019 - June 2021

①



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

Key Narrative: There were 42 patients waiting between 63 and 104 days without a decision to treat (DTT) at the end of June 2021, and 9 patients waiting more than 104 days.

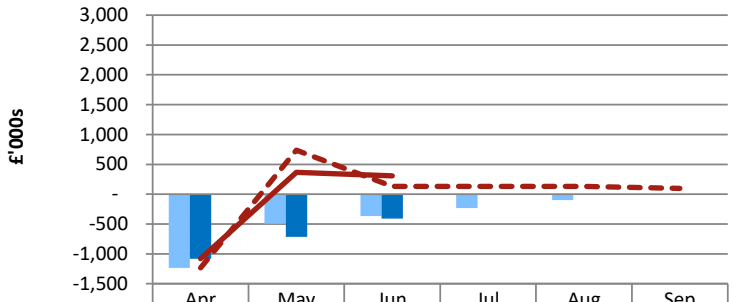
Data based on the last Monday of the month

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

Finance

Financial Performance

Financial Performance 2021/22



	Apr	May	Jun	Jul	Aug	Sep
Cumulative Plan	-1,235	-497	-366	-233	-101	-3
Cumulative Actual	-1,081	-715	-409			
Cumulative Variance	154	-218	-44	-176	-309	-406
In Month Plan	-1,235	737	132	132	132	97
In Month Actual	-1,081	366	306			
In Month Variance	154	-371	174	-132	-132	-97

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 actual position at the end of June was a £0.4m deficit, which was broadly in line with the plan to deliver a balanced budget for H1.

In month there is a small adverse variance to plan with an increase in pay costs due to increased unplanned care demands.

The level of expenditure of premium costs within nursing, including use of high cost agencies has increased in month reflecting these urgent care pressures, where there are material unfunded escalation areas opened within the hospital.

Forward view

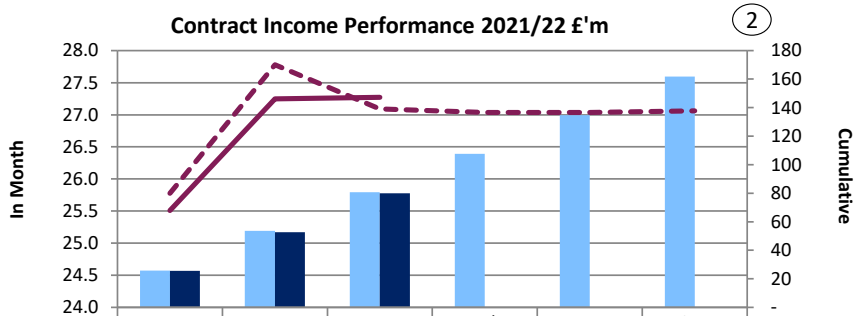
Escalation beds are expected to continue being open going into Q2. These beds were planned to close at the end of June 2021 and therefore the financial costs have not been included in the H1 plan and pose a risk of up to £1.9m if all current escalation areas remain open until the end of September.

In response to this the Trust is supporting several strategies aimed at improving the urgent care flow – which is at an unprecedented level for a Summer period.

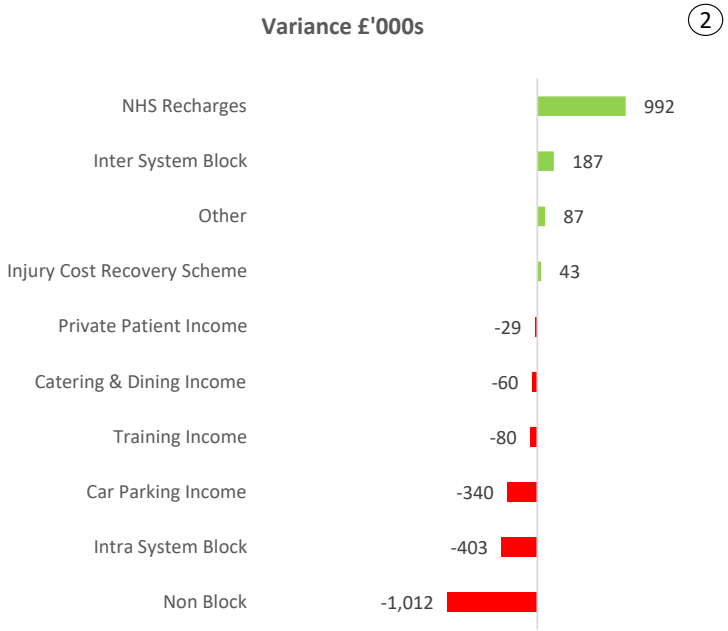
Planning guidance for H2 (October-March) has not yet been received but is expected shortly.

Finance

Income



	Apr	May	Jun	Jul	Aug	Sep
Cumulative budget	26	54	81	108	135	162
Cumulative actual	26	53	80			
In month budget	26	28	27	27	27	27
In month actual	26	27	27			



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

Current View:

Overall income is under budget by £0.6m, which is comprised of taking a prudent approach to the income earned from the Elective Recovery Fund (ERF), and delays to services change eg Dermaology – which are offset by recharges above the plan associated with the vaccination, testing and final year student nurse placement funding.

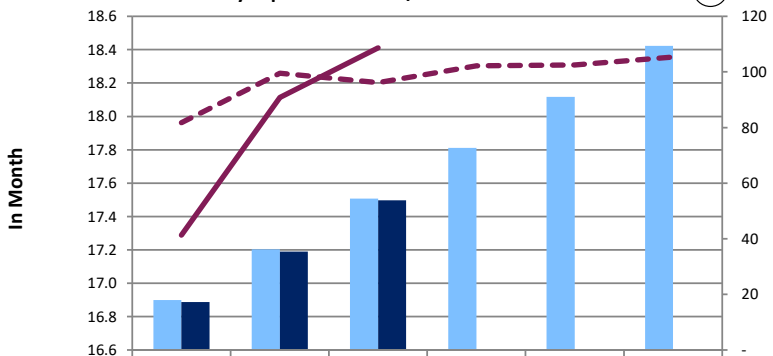
Forward View:

The ERF, has recently seen a change in criteria in that all Trusts will be expected to deliver 95% of 2019/20 pre-covid levels of activity (previously 85%) in order to earn the income from July onwards, this will see an expected reduction in forecast income of £150k, with the incentives to achieve this remain in place.

Finance

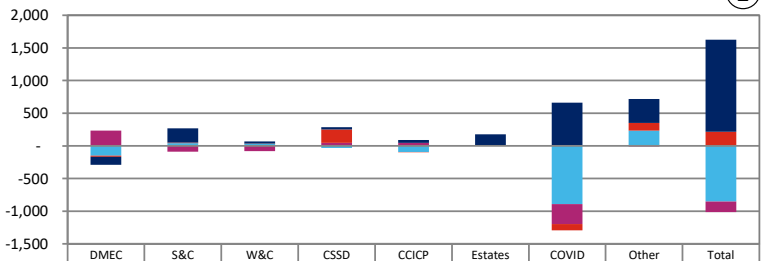
Pay

Pay Expenditure 2021/22 £'m ②



	Apr	May	Jun	Jul	Aug	Sep
Cumulative budget	18	36	54	73	91	109
Cumulative actual	17	35	54			
In month budget	18	18	18	18	18	18
in month actual	17	18	18			

Pay Variances by Staff Group and Division £'000s ②



	DMEC	S&C	W&C	CSSD	CCICP	Estates	COVID	Other	Total
Total	-56	181	-16	254	-2	175	-631	707	613
Infrastructure Support Staff	-122	219	29	31	45	175	662	369	1,408
Non Clinical Staff	-16	10	2	206	-2	-	-97	115	218
Medical Staff	233	-88	-82	47	47	-	-305	-12	-161
Nursing Staff	-150	40	35	-30	-92	-	-891	235	-853

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

Current View:

Pay is under budget YTD by £0.6m due to the delayed transfer of Dermatology services from the 1st June (offset by reduced income received), but in month the pay costs are overspent by £0.2m.

Additional wards and escalation beds remain open across the Trust, which has in turn increased the number of additional nurse/HCA shifts required. This has particularly impacted nursing agency costs which are £0.9m in month (circa. 50% with high cost agencies).

Bedwatch security costs are continuing to increase on a monthly basis with £0.3m expenditure YTD - almost equivalent to the full year cost for 20/21.

The Trust is continuing to see delays in the number of international nurse recruits that are arriving at the Trust, due to the continuing travel restrictons. The Trust is looking to support the nurses who have been affected by this, and will be looking to re-book flights when restrictions are lifted.

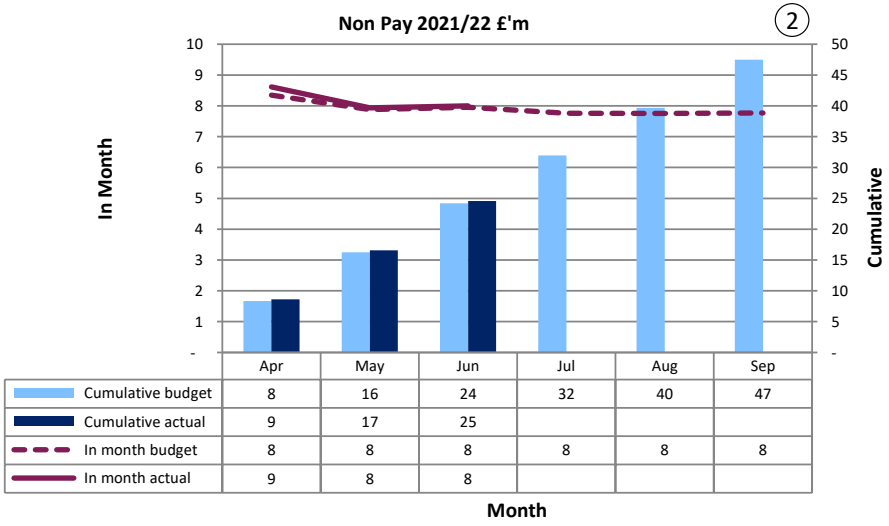
Forward View:

The pay bill will come under significant pressure particularly in Q2 if the current levels of bed occupancy continue, however the Trust has forward planned for additional international nurse recruits to start throughout the Summer in order to continue the support for staffing levels.

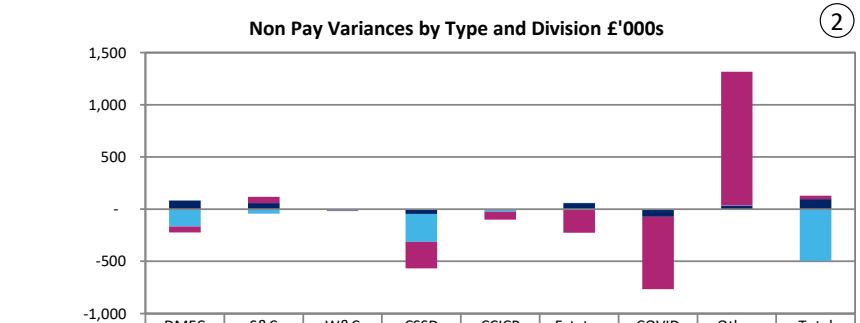
The Elective Recovery will impact significantly on the pay costs throughout 21/22, and it is expected for the first half of the year that there will be an increase in premium costs to support this.

Finance

Non-Pay



	Apr	May	Jun	Jul	Aug	Sep
Cumulative budget	8	16	24	32	40	47
Cumulative actual	9	17	25			
In month budget	8	8	8	8	8	8
In month actual	9	8	8			



	DMEC	S&C	W&C	CSSD	CCICP	Estates	COVID	Other	Total
Total	-140	75	-17	-567	-101	-167	-767	1,316	-367
Other Non Pay	-56	61	-0	-255	-79	-224	-695	1,280	31
Drugs	-166	-42	-4	-267	-18	0	-	1	-496
Clinical Supplies	82	57	-12	-46	-4	57	-72	35	98

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

Current View:

Non-Pay is over budget YTD by £0.4m

The largest area of overspend is within the area of high cost drugs, which is linked to an increase in activity. Outsourcing costs and Clinical supplies have seen increases in month which is anticipated as part of the people recovery plan.

Forward View:

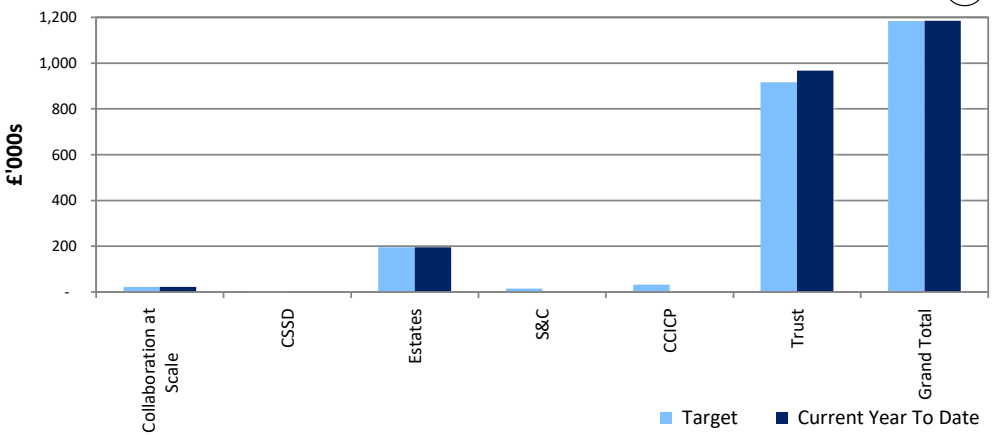
In the coming months it is anticipated that there will be an increase in the use of alternative providers as part of the restoration programme commences, which will be primarily sourced via the increasing capacity framework.

It is expected that from next month onwards the costs will begin to increase to reflect the plan to balance the restoration plan, with supporting staff coming out of the last wave of Covid within the hospital.

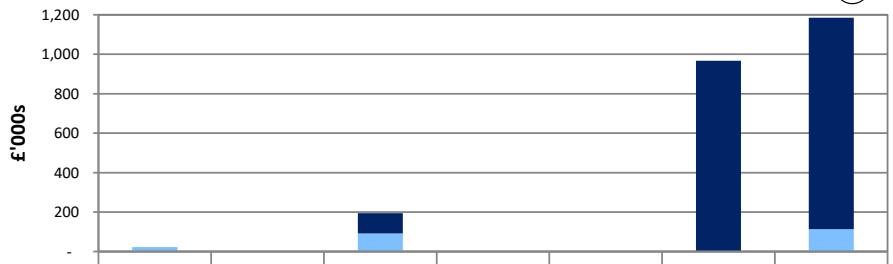
Finance

Cost Improvement Programmes (CIP)

Year to Date CIP Delivery v Plan Total ①



CIP Performance Actual by Division ②



	Collaboration at Scale	CSSD	Estates	S&C	CCICP	Trust	Grand Total
Current Year To Date	23		195	-		967	1,185
Pay			104			967	1,071
Non pay	23		91	-			114

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

Current View:
The national efficiency expectation for H1 is set at 0.28% which represents a target of £0.4m for the Trust, in addition to this the Trust has a C&M system efficiency target of £1.9m, giving a total target of £2.3m for H1. The target is predominantly phased over the next 4 months but year to date the CIP plan is being met, with the largest savings relating to the procurement of laundry services, with additional savings on recruitment delays and phasing difference in expected cost pressures.

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 schemes that can be progressed.

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

Forward View:
The efficiency target for H2, set nationally of 1.1% or £1.7m has been previously indicated -however indicators are that this may increase to 3%, which would equate to £4.6m for the Trust

Early indications are that for Cheshire & Merseyside healthcare partnership (HCP) there is likely to be a significant financial challenge to deliver a balanced system position for H2. The expectation is that there will be an increasing focus on Trust efficiency schemes with an expected efficiency target set above the national one, which would be on top of the 3% (£4.6m) indicated above.

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

Finance

Income and Expenditure

(2)

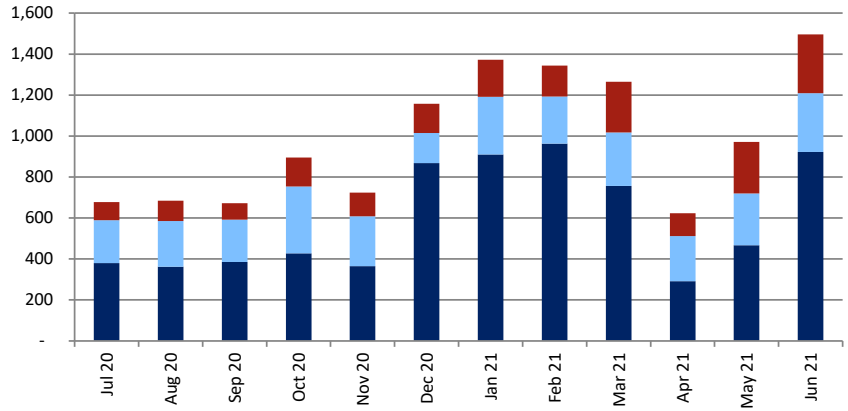
Budget H1			Month			Year to Date			Forecast H1
2021/22 (£'000)			Plan Jun (£'000)	Actual Jun (£'000)	Variance Jun (£'000)	Plan April to Jun (£'000)	Actual April to Jun (£'000)	Variance April to Jun (£'000)	2021/22 (£'000)
	Operating								
	Operating Income								
	Commissioning Income								
151,309		Inter System Block	1,450	1,571	121	4,350	4,537	187	151,309
0		Intra System Block	19,105	19,067	(38)	57,315	56,912	(403)	0
0		Non Block	4,779	4,416	(364)	13,738	12,726	(1,012)	0
407		RTA and Private Patient	68	50	(18)	204	218	15	407
0	*Other Operating Income*	Donations of Purchased Assets	0	0	0	0	0	0	0
10,066		Other Operating Income	1,687	2,168	481	5,039	5,638	599	10,066
161,782	**TOTAL OPERATING INCOME**		**27,090**	**27,272**	**183**	**80,646**	**80,031**	**(615)**	**161,782**
	Operating Expenses								
(109,534)		Employee Benefits Expenses (Pay)	(18,203)	(18,411)	(208)	(54,425)	(53,813)	613	(109,534)
(8,912)		Drugs	(1,485)	(1,763)	(278)	(4,456)	(4,952)	(496)	(8,912)
(8,311)		Clinical Supplies	(1,306)	(1,274)	32	(3,923)	(3,825)	98	(8,311)
(30,057)		Other operating expenses	(5,162)	(4,964)	198	(15,806)	(15,775)	31	(30,057)
(156,814)	**TOTAL OPERATING EXPENSES**		**(26,157)**	**(26,413)**	**(255)**	**(78,610)**	**(78,364)**	**245**	**(156,814)**
4,968	**EBITDA**		**932**	**860**	**(73)**	**2,036**	**1,667**	**(369)**	**4,968**
	Non Operating								
	Non Operating Income								
(190)		Interest	(32)	(29)	2	(95)	(61)	33	(190)
0		Asset disposal	0	0	0	0	0	0	0
	Non-Operating Expenses								
(3,522)		Depreciation & Finance Leases	(559)	(288)	272	(1,679)	(1,304)	375	(3,522)
0		Depreciation on Donated Assets	(0)	(27)	(27)	0	(82)	(82)	0
(1,256)		PDC Dividend Expense	(209)	(209)	0	(628)	(628)	0	(1,256)
0	**Net Surplus/(deficit) before Exceptional Items**		**132**	**306**	**175**	**(366)**	**(409)**	**(43)**	**0**
0		Remove capital donations/grants I&E impact	0	27	27	(0)	82	82	0
0	**Net Surplus/(Deficit) after Exceptional Items**		**132**	**334**	**202**	**(366)**	**(327)**	**39**	**0**

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

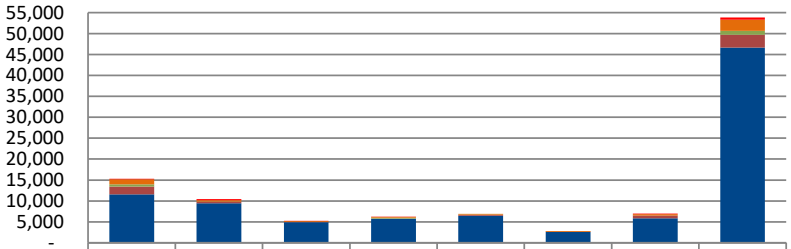
Finance

Bank and Agency

Agency Spend £'000s - 13 Month Trend (2)



Staffing costs £'000s by Substantive and Temporary (2)



	DMEC	S&C	W&C	CSSD	CCICP	Estates	Other	Total
Total	15,292	10,415	5,200	6,193	6,943	2,785	6,985	53,813
Waiting List	110	207	42	19	-	-0	144	522
Bank	1,201	341	165	206	224	164	347	2,649
Locum	535	114	19	160	84	-	-3	909
Agency	1,878	293	64	84	151	9	611	3,090
Substantive	11,567	9,459	4,911	5,724	6,484	2,613	5,886	46,643

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

Current View:

Agency expenditure was £0.9m in the month of June, which is an increase on the previous months especially within nursing agency costs.

This is reflective of the unplanned care challenges that the Trust is experiencing with additional escalation beds opened during June

Forward View:

It is expected that there will be increased pressure on agency expenditure as a result of the pressures that are being experienced with unplanned care.

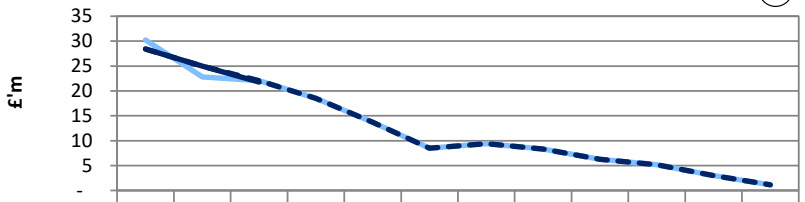
The Trust continues to work collaboratively across Cheshire to increase the International nurse recruitment in order to meet the key objective of minimal nurse vacancies.

As the restoration plans progress there will be an increase in premium costs (agency/WLIs) for the medical workforce in order to support this return of planned care services.

Finance

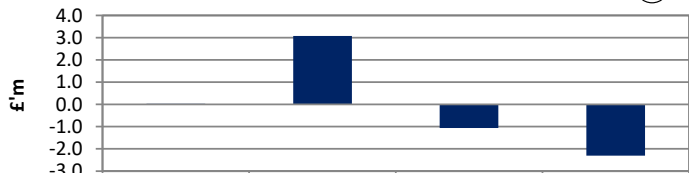
Cash

Cash Position ②



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Plan	30	23	22	18	14	8	9	8	6	5	3	1
Actual	28	25	22									
Forecast	28	25	22	18	14	8	9	8	6	5	3	1

Cash Flow Movements ②



	Operating Surplus / (Deficit)	Increase / (Decrease) in Working Capital	Net Cash Inflow / (Outflow) from Capital Expenditure	Net Cash Inflow / (Outflow) from Borrowings
Variance to Opening Balance	0	3	-1	-2

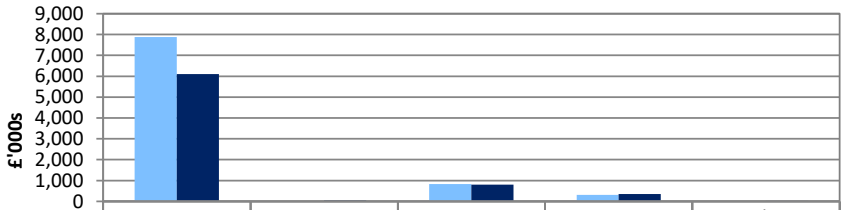
Accountable: Director of Finance **Data Owner:** Financial Services

Current View: Cash is lower than plan by £0.3m. Working capital has improved by £3m in June, this is partially offset by a slight delay in PDC drawdown.

Forward View: The cash position remains strong, however the forecast includes £7.3m of additional capital expenditure which is funded internally.

Capital

Capital Expenditure ②



	Estates	IT	Estates	IT	Other
	NHSI Approved Plan		Additional Schemes		
Plan	7880	0	830	313	0
Actual	6101	50	807	348	23

②

	Year to Date £'000s			Year End £'000s		
	Plan	Actual	Variance	Plan	Forecast	Variance
NHSI Approved Plan						
Estates	7,880	6,101	-1,779	37,909	38,832	923
IT	0	50	50	3,600	3,770	170
NHSI Approved Total	**7,880**	**6,151**	**-1,729**	**41,509**	**42,602**	**1,093**
Additional Schemes						
Estates	830	807	-23	3,627	3,787	160
IT	313	348	35	2,600	2,501	-99
Other	0	23	23	0	84	84
Total Capital Schemes	**9,023**	**7,329**	**-1,694**	**47,736**	**48,974**	**1,238**

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

Current View: The capital programme is behind plan by £1.7m, due to the A&E expansion scheme of £1.1m, and Backlog Maintenance £0.6m.

Forward View: We are currently forecasting a £1.1m overspend against the NHSI Submitted Plan. The Trust is awaiting formal recognition from the HCP for the additional capital schemes.

Finance

Statement of Financial Position June 2021

②

		Plan Apr to June (£'000)	Actual Apr to June (£'000)	Variance (£'000)
Assets	Assets, Non-Current	111,192	109,520	-1,672
	Assets, Current	40,373	38,517	-1,856
ASSETS, TOTAL		**151,565**	**148,037**	**-3,528**
Liabilities	Liabilities, Current	-37,337	-36,271	1,066
	Liabilities, Non Current	-6,931	-6,464	466
TOTAL ASSETS EMPLOYED		**107,297**	**105,302**	**-1,995**
Taxpayers' and Others' Equity				
	Taxpayers Equity	107,297	105,302	-1,995
TOTAL FUNDS EMPLOYED		**107,297**	**105,302**	**-1,995**

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

Current View:

Cash is lower than plan by £0.3m. Trade Receivables are lower by £1.6m due to continued prompt payments of SLA invoices.

Trade Payables is below plan by £1.9m, due to a lower capital creditors.

Public Dividend Capital remains unchanged in the month as funding was drawn down in March to support capital spend in Quarter 1

Forward View:

The Trust is due to receive PDC funding in relation to RACC Planks of £22m, and ED build £6m.

Finance

Balance Sheet

Current View:

Assets Non-Current
The capital programme is behind plan by £1.7m, due to the A&E expansion scheme of £1.1m, and Backlog Maintenance £0.6m.

Assets Current
Cash is lower than plan by £0.3m. Trade Receivables are lower by £1.6m due to continued prompt payments of SLA invoices.

Current Liabilities
Trade Payables is below plan by £1.9m, due to a lower capital creditors.

Taxpayers Equity
Public Dividend Capital remains unchanged in the month as funding was drawn down in March to support capital spend in quarter 1.

	Plan Apr to June (£'000)	Actual Apr to June (£'000)	Variance (£'000)	Forecast 2021/22 (£'000)
Assets				
Assets, Non-Current	**111,192**	**109,520**	**-1,672**	**147,436**
Assets, Current				
Trade and other Receivables	9,246	7,609	-1,637	7,062
Other Assets (including Inventories & Prepayments)	9,099	9,136	37	6,662
Cash and Cash Equivalents	22,028	21,771	-257	1,126
Total Assets, Current	**40,373**	**38,517**	**-1,856**	**14,851**
ASSETS, TOTAL	**151,565**	**148,037**	**-3,528**	**162,286**
Liabilities				
Liabilities, Current				
Finance Lease, Current	-1,119	-1,354	-235	-1,010
Loans Commercial Current	-318	-318	0	-357
Trade and Other Payables, Current	-20,203	-18,739	1,464	-18,713
Provisions, Current	-549	-676	-128	-226
Other Financial Liabilities	-15,149	-15,184	-36	-13,175
Total Liabilities, Current	**-37,337**	**-36,271**	**1,066**	**-33,480**
Net Current Assets/(Liabilities)	**3,036**	**2,246**	**-790**	**-18,630**
Liabilities, Non Current				
Finance Lease, Non Current	-2,155	-1,690	465	-1,065
Loans Commercial Non-Current	-3,306	-3,306	0	-2,962
Provisions, Non-Current	-1,470	-1,469	1	-1,370
Trade and Other Payables, Non-Current	0	0	0	0
Total Liabilities Non-Current	**-6,931**	**-6,464**	**466**	**-5,397**
TOTAL ASSETS EMPLOYED	**107,297**	**105,302**	**-1,995**	**123,409**
Taxpayers' and Others' Equity				
Taxpayers Equity				
Public dividend capital	118,832	116,832	-2,000	143,832
Retained Earnings	-23,625	-23,621	4	-32,513
Donated asset reserve	0	0	0	0
Revaluation Reserve	12,090	12,091	1	12,090
TOTAL TAXPAYERS EQUITY	**107,297**	**105,302**	**-1,995**	**123,409**
TOTAL FUNDS EMPLOYED	**107,297**	**105,302**	**-1,995**	**123,409**

(2)

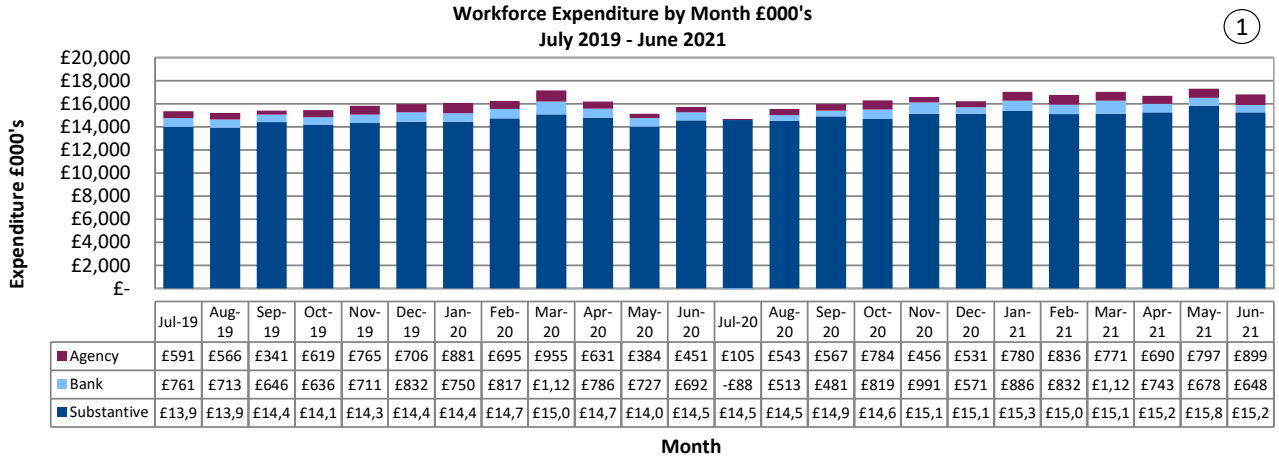
Forward View:

The forecast includes PDC funding and capital spend in relation to RACC Planks of £22m, and ED build £6m.

Cash balances are expected to reduce due to capital spends and a forecast deficit. At present, there are no plans to request cash support during the financial year.

Workforce

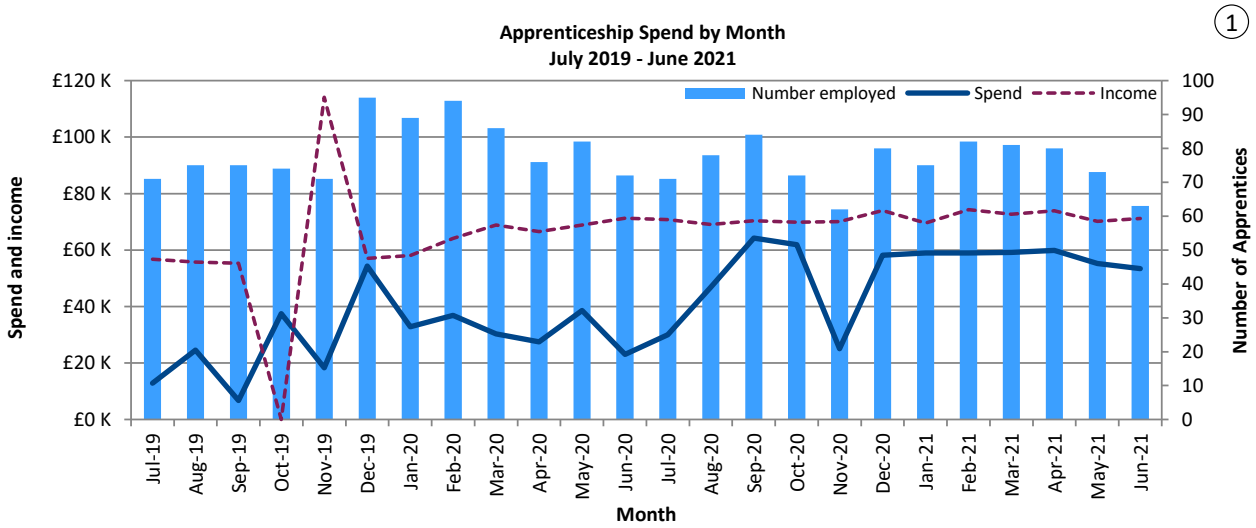
Finance and Costings



	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	Mar-21	Apr-21	May-21	Jun-21
Agency	£591	£566	£341	£619	£765	£706	£881	£695	£955	£631	£384	£451	£105	£543	£567	£784	£456	£531	£780	£836	£771	£690	£797	£899
Bank	£761	£713	£646	£636	£711	£832	£750	£817	£1,12	£786	£727	£692	-£88	£513	£481	£819	£991	£571	£886	£832	£1,12	£743	£678	£648
Substantive	£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	£15,1	£15,2	£15,8	£15,2

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

Key Narrative: Total workforce expenditure for June 2021 is £16,806k, a decrease of £500k (-2.9%) from the previous month and 6.9% higher than June 2021. Expenditure for June 2021 is £136k below budget (-0.8%).



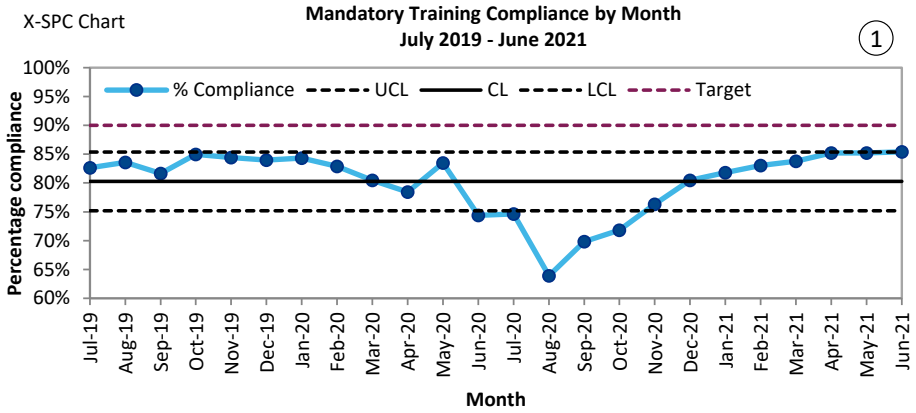
Accountable: Director of Workforce & Organisational Development
Data Owner: Workforce Directorate

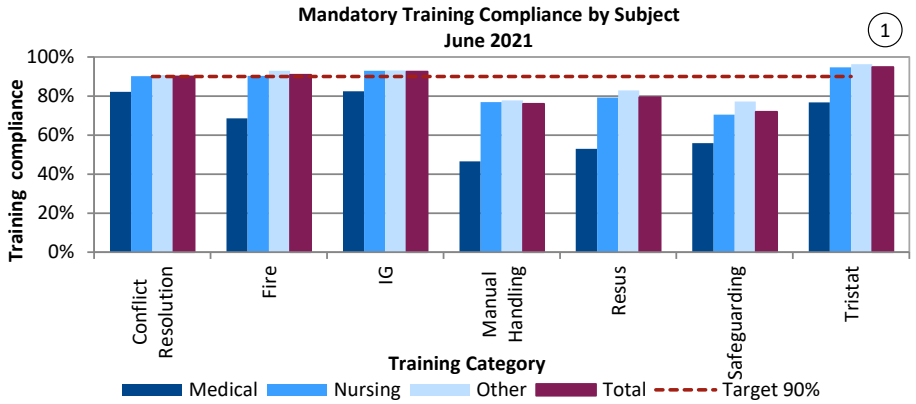
Key Narrative: The number of Apprentices employed in June 2021 was 63, 12.5% lower than the number employed in June 2020 (72).

Apprenticeship spend remains below income.

Workforce

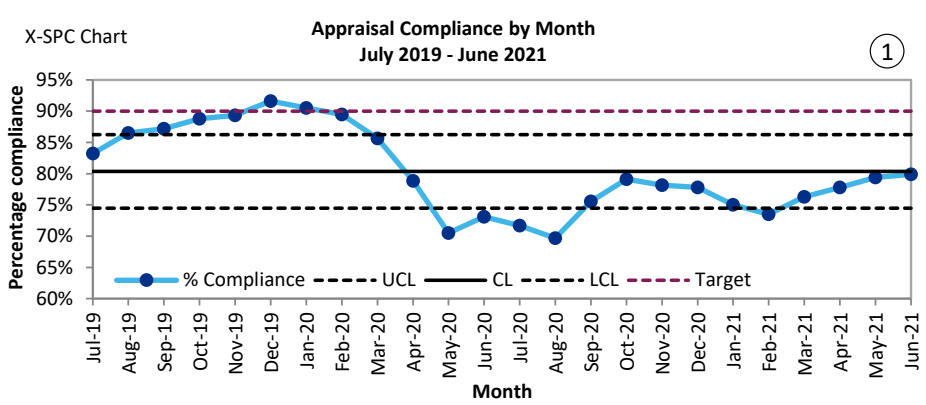
Training

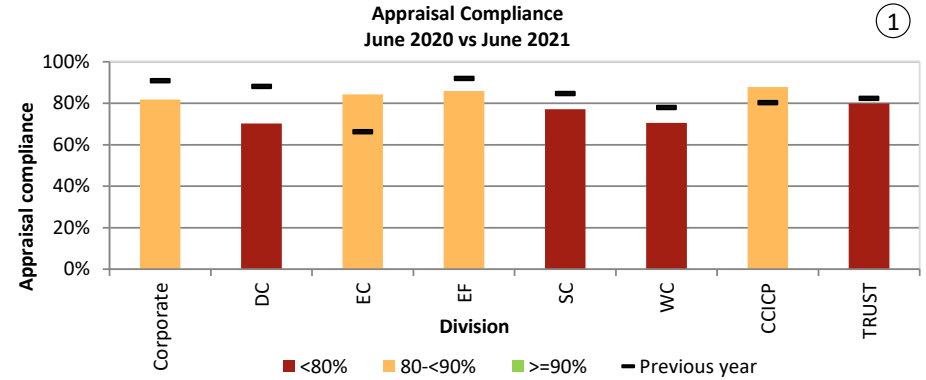




Accountable: Director of Workforce & Organisational Development
Data Owner: Workforce Directorate
Key Narrative: Mandatory training compliance has stabilised achieving at 85.4% in June 2021 . Previously there had been a month on month improvement from the lowest compliance of 63.9% reported in August 2020. Training compliance remains below the 90% target.

Appraisals

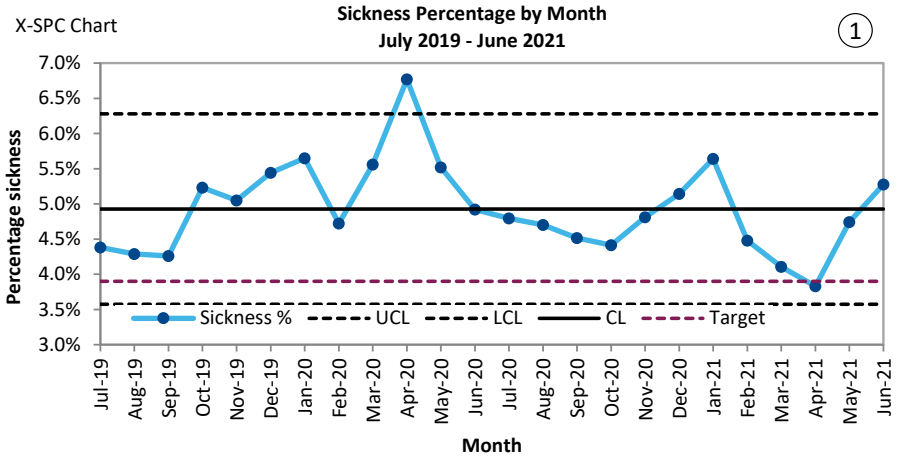




Accountable: Director of Workforce & Organisational Development
Data Owner: Workforce Directorate
Key Narrative: The reported appraisal compliance for June 2021 is 79.9%, which is in line with the 79.4% compliance reported in May 2021. Appraisal compliance remains below the target rate of 90% which was only achieved in December 2019 and January 2020 over the 24-month period shown.

Workforce

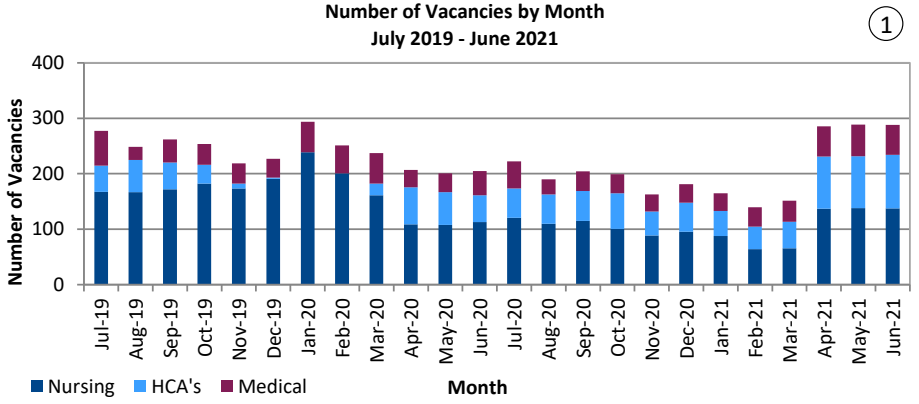
Sickness

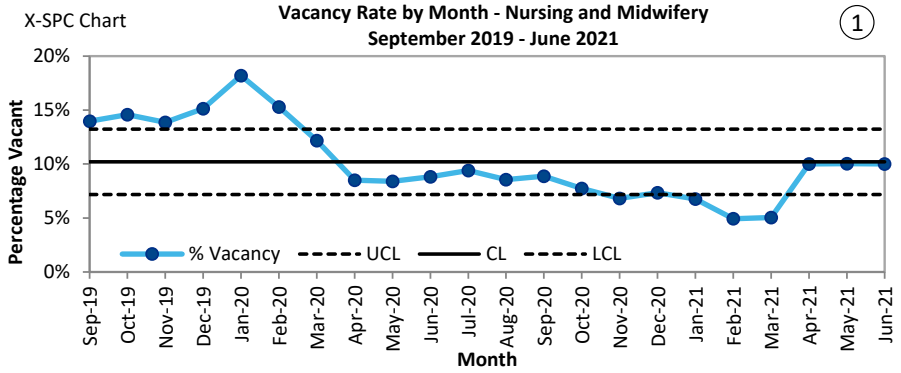


Accountable: Director of Workforce & Organisational Development
Data Owner: Workforce Directorate

Key Narrative: The sickness rate for June 2021 was 5.3%. This is an increase compared to the sickness rate reported for May 2021 (4.7%) and is due to a rise in short term absense. The sickness rate is above that reported the previous year for June 2020 which was 4.9%.

Vacancies



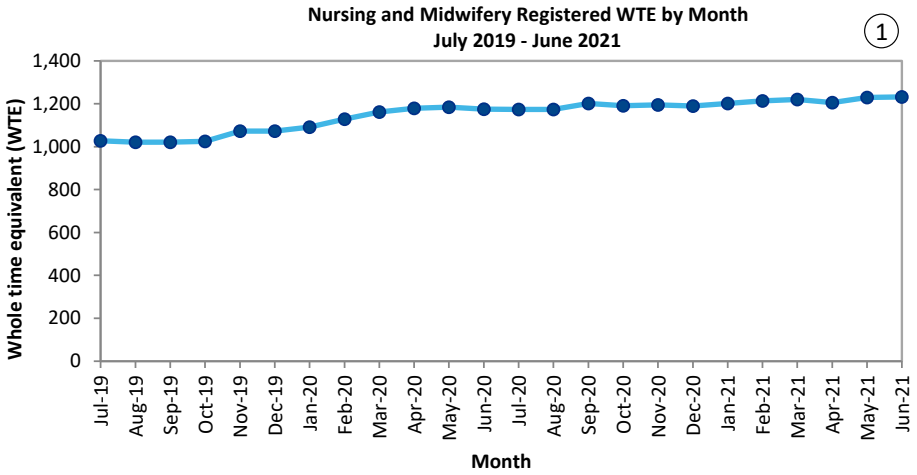


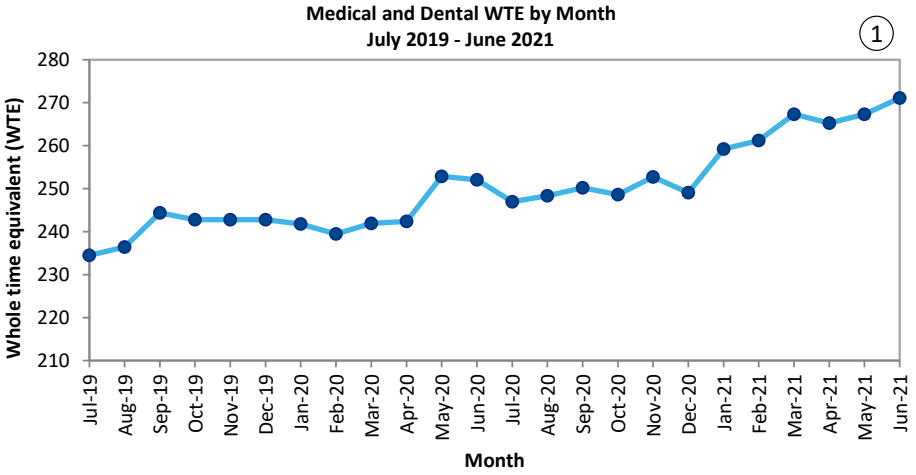
Accountable: Director of Workforce & Organisational Development
Data Owner: Workforce Directorate
Key Narrative: The vacancy figures from April 2020 were restated to exclude International Recruitment, Nurse Apprentices and COVID. The vacancy rate for June 2021 is at 10.0%. The vacancy rate has increased, mainly as a result of investments which have been added to the Establishment at the beginning of the 2021-22 Financial year.

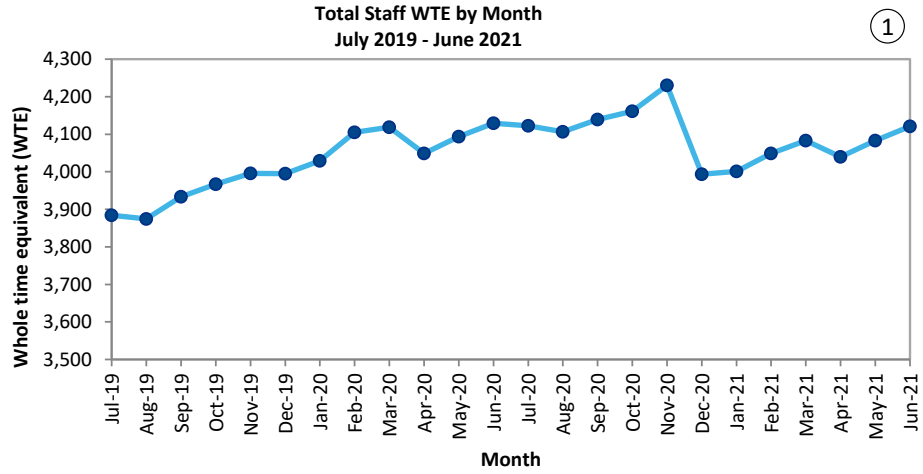
Data Rating: ①captured locally, ②system captured, ③ published/benchmarked

Workforce

Total Staff Whole Time Equivalent (WTE)







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

Key Narrative: Nursing and Midwifery staff have increased by 204.0 WTE (19.8%) over the 24-month period and Medical and Dental staff by 36.6 (15.6%).

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 from ESR report: Monthly staff in post (WTE)

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

Report to	Board of Directors
Date	29 July 2021
Report from	Lesley Massey, NED Chair
Report prepared by	Katharine Dowson, Head of Corporate Governance
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

Covid-19 Significant rise in community infections not currently mirrored by Hospital admissions Other North West providers now seeing rising hospital admissions.

IT Radiology Incident Update: All GP Practices now aware of issue and request to report patient harm, minimal incidents raised to date. Joint Root Cause Analysis (RCA) with Cheshire Clinical Commissioning Group (CCG) to be completed and reported to QSC later in September.

Integrated Performance Report (IPR):

- Sustained upward trend of patient safety incidents, vast majority of which are low and no harm
- Central Cheshire Integrated Care Partnership (CCICP) numbers of patient safety incidents reduced; level of harm incidents remains low
- StEIS control limits to be rebased following a statistical shift due to change in process.
- Improvement in 40 day complaints metric following opening following suspension, ongoing results will be variable as due to backlog
- Three month downward trend in pressure ulcer lapses of care following sustained efforts
- Further deterioration in Venous thromboembolism (VTE) assessment rates, largely due to operational pressures in organisation
- Trends in operational metrics in IPR impacting quality and safety:
    - Significant increase in arrivals at A&E, particularly of type 1 attendances
    - 4-hour A&E performance deteriorating as a result
    - Significant increase in admissions, some improvement in discharge rates but not keeping pace
    - Approximately 100 escalation beds in use (70 in normal winter peak). Concern about availability and resilience of staff to support this, increased use of agency staff. Raised as corporate risk
- Executive oversight of pressures in place, increase of same day emergency care planned, to avoid admissions for patients.

Executive Quality Governance Group Chair's Report

Scoring on nursing vacancy gap reduced to 8.

Infection Prevention Control Board Assurance Framework - Partial Assurance: Recommendation 4 now met - identifying patients at risk of infection following implementation of dedicated testing team and new outbreak management process among other measures. Significant assurance in eight further measures maintained. Recommendation 3 - **Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance,** not within the Trust's gift to achieve compliance due to suspension of National CQUIN programme

Serious Incidents May 2021 - Partial Assurance: Six Strategic Executive Information System (StEIS) incidents. One incident related to a cluster nosocomial Covid review. Three incidents unlikely to identify any lapses in care. Two historic incidents of delay in diagnosis, due to gaps in follow up of potential cancers. Challenging to identify in advance other potential cases. QSC requested further assurance that new processes implemented since then would pick up similar cases. (October QSC)

Coronial Work - Partial Assurance: Work restarted in April following Covid suspension. Unprecedented number of inquests impacting capacity. New process to track and manage inquests in place, additional substantial support from solicitors. Five inquests concluded since April with no Regulation 20 - Preventing Future Deaths (PFD) reports. One case of neglect, Coroner content with actions already put into place through RCA.

Quality Account 2020/21 - Acceptable Assurance: Reviewed through governance routes, including external stakeholders. Wide scope of information and significant work to compile report noted. Change in approach to reporting from 2021/22, will incorporate report into Annual Report.

Quality Matters Newsletter - Acceptable Assurance: Comprehensive description of work of Quality Summit. More numbers, measures of success and impact would enhance newsletter. QSC asked for an update (September 2021) on how learning to be spread through organisation, measuring impact and scaling up as part of QI approach.

Analysis of Inpatient Deaths related to Covid-19 Infection during the First Wave - Acceptable Assurance: Report included post-infection review plus mortality report previously reviewed at QSC and Board. Focus on lessons learnt for Wave 2 (to be confirmed 2021). Availability of testing was limiting factor in Wave 1. Low level of concerns about standards of care. Escalations and Do Not Resuscitate orders were appropriate and individualised.

Never Event
Recent Never Event in surgery (June) raised. QSC requested assurance on application of checklists in theatre and of culture and approach to these. Cultural safety survey suggested - update to be provided in July.

KEY CONCERNS/RISKS

- High pressures on Emergency Department and rise in emergency admissions
- Unprecedented number of inquests listed between May and July. Risk raised due to increased workload on Legal Services Team and potential impact of PFD reports received

Priority Areas: DECISIONS MADE

- Recommended approval to the Board of the Quality Account 2020/21
- Review of Wave 1 deaths analysis to be submitted to the Board

RECOMMENDATION

To note.

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

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

KEY AREAS OF ASSURANCE

Covid-19:
Community rates high, resulting in growing admissions to Trust. Critical Care moving to 'low surge' capacity, redeployment of staff being planned. Paediatric admissions high. Increased Urgent and Emergency Care attendances and admissions, and restoration work all adding to pressure

Board Assurance Framework (BAF) 2021/22 Quarter 1 Report
Robust discussion and review of BAF with key points noted:

- Overall risk score for BAF 3 - *Quality of Care* is 9, despite a number of high scoring operational risks. Corporate Risk team undertaking review of risk scoring from a corporate context
- Deteriorating patient escalation risk scoring to be reviewed, following implementation of controls and completion of actions
- New risk relating to recruitment of Anaesthetists escalated via Executive Risk and Assurance Group (ERAG) in July. Current controls no longer sufficient, due to sickness in department and availability of locums. Risk assessment to be reviewed. Task and finish group set up to focus on recruitment of Anaesthetists, Respiratory and Acute Medical Consultants
- Patients on waiting list being reviewed by clinically-led Waiting List Surveillance Group. Clinical Harm Reviews taking place to review potential harm caused by delays to treatment
- Low Assurance on NICE compliance -actions in place but controls are not sufficient. Process under review to improve oversight of exceptions through governance process to Board. Report on proposed programme of work to be submitted to QSC in August.

Integrated Performance Report (IPR): Key points raised were:

- Hospital Patient Safety Incidents remain above average but within control limits. Data is currently seen as total number of incidents and does not take into account additional inpatient activity levels. Majority of incidents identified as low harm, deep dive being undertaken to understand themes
- Venous thromboembolism (VTE) assessments, deteriorating trend for four months - reflective of pressures in hospital and increased use of short-term staff despite local induction process. No rise in related incidents. Divisions will have greater oversight of this when the divisional dashboards are developed in the coming months

- Increase in falls, 94% low or no harm – controls and actions in place. Potential indicator of a pressurised workforce and corresponding reduction in levels of care. Actions in place to address this in key wards
- Complaints numbers within control limits for number of complaints received - closed complaints' rate down as expected following restart of responding to complaints in May. Significant backlog and review of team capacity to compile responses underway
- Safe staffing - all wards at all times staffed as safely as can be, with robust processes in place
- Staff sickness levels up - focus on getting staff back and supporting staff with Wellbeing Squads.

Executive Quality Governance Group (EQGG) Chair's Report
All risks scoring 15 or over reviewed. Capacity for Resuscitation training flagged by Executive Workforce Assurance Group (EWAG) to EQGG to enable impact on quality to be reviewed.

IT Radiology Incident Update:
Three incidents of potential harm reported from GPs, all low harm due to delay in referral. Joint Root Cause Analysis (RCA) with Clinical Commissioning Group (CCG) being planned.

Maternity Safety Report Quarter 1 2021/22 - Partial Assurance
First of regular quarterly overview report. Improvements requested by EQGG include triangulation with Serious Incidents and other data. Good links established with NED Maternity Champion to be reflected in next iteration of report. Best practice on maternity dashboards being explored.

Serious Incidents June 2021 – Acceptable Assurance: Ten Strategic Executive Information System (StEIS) incidents recorded, including one Never Event regarding wrong implant insertion during surgery which had resulted in no harm to the patient - positive debriefing session held with excellent engagement from all staff. Checklists redesigned and cultural survey to be repeated in theatres. Incident of a baby born in unexpectedly poor condition, requiring resuscitation and a transfer for cooling - possible lapses of care identified, immediate actions taken. Another similar incident occurred in July. Although Trust within benchmark for referring for cooling, further work required to strengthen the human factor team working aspects within the department.

Learning from Deaths
One potentially avoidable death not previously identified through Trust safety and quality processes, now under review. Another case was identified as having poor care and was referred for a second review which considered that care overall was good and no lapses in care had occurred. Three deaths of patients with learning difficulties in Q1. All will be reviewed through the national review process, but no lapses of care identified through local review. The percentage of deaths reviewed by a medical examiner is increasing steadily within the Trust.

KEY CONCERNS/RISKS

Capacity of staff to manage patient care and all role requirements due to operational pressures.

Priority Areas: DECISIONS MADE

- Committee workplan approved
- Clinical Audit Report deferred to next meeting due to timing constraints

RECOMMENDATION

To note.

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**9.3**	Date of Meeting: 29/07/2021
Report Title	Analysis of In-Patient Deaths Related to Covid-19 Infection During the First Wave	
Executive Lead	Murray Luckas, Medical Director	
Lead Officer	Richard Lowsby, Consultant in Intensive Care Medicine / Karen Egan, Nurse Consultant for Infection Prevention and Control	
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

- The review, using an SJR (Structured Judgement Review) methodology that is nationally recognised alongside a PIR (Post Infection Review), found in 85.6% of cases that care was of a good standard
- No evidence found of a 'blanket' application of DNACPR (Do not attempt resuscitation) forms
- Within wave one, testing and guidance for managing nosocomial infections was either not in place or in its infancy; this subsequently improved in wave two
- A number of lessons learned were highlighted changes introduced in the second wave.
- The audit found no evidence of amenable deaths
- Report compiled in the format of a scientific paper

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

- Wave Two analysis to be completed by the end of 2021

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

• Provide safest and best care	✓	• Be the best place to work	☐
• Become a leading and sustainable health care system	☐	• Push boundaries in clinical, technology and digital innovation	☐

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

• Quality	✓	• Compliance	✓
• Finance	☐	• Legal	☐
• Workforce	☐	• Risk/BAF **BAF3 Quality of care**	
• Equality	☐		

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

Strategy ☐ Policy ☐ Service Change ☐

REPORT DEVELOPMENT

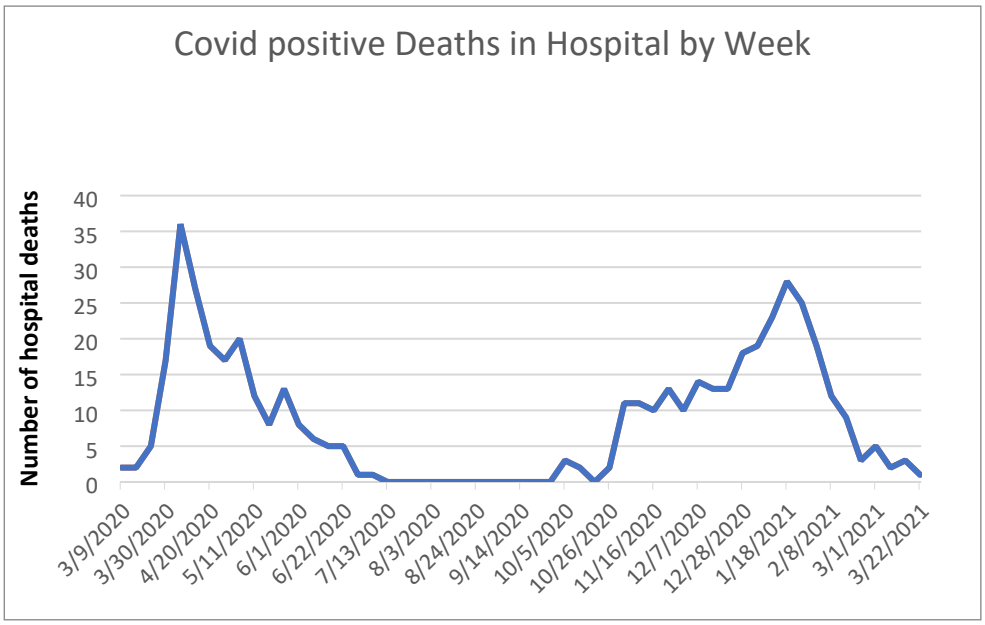
Committee/ Group Name	Date	Report Title	Lead	Brief summary of key issues raised and actions agreed
Executive Quality Governance Group (EQGG)	02 June 2021	Analysis of In-Patient Deaths Related to Covid-19 Infection During the First Wave	Murray Luckas, Medical Director	Noted

An analysis of in-patient deaths related to Covid-19 infection during the first wave of the Pandemic at Mid Cheshire Hospitals NHS Foundation Trust

1. Introduction

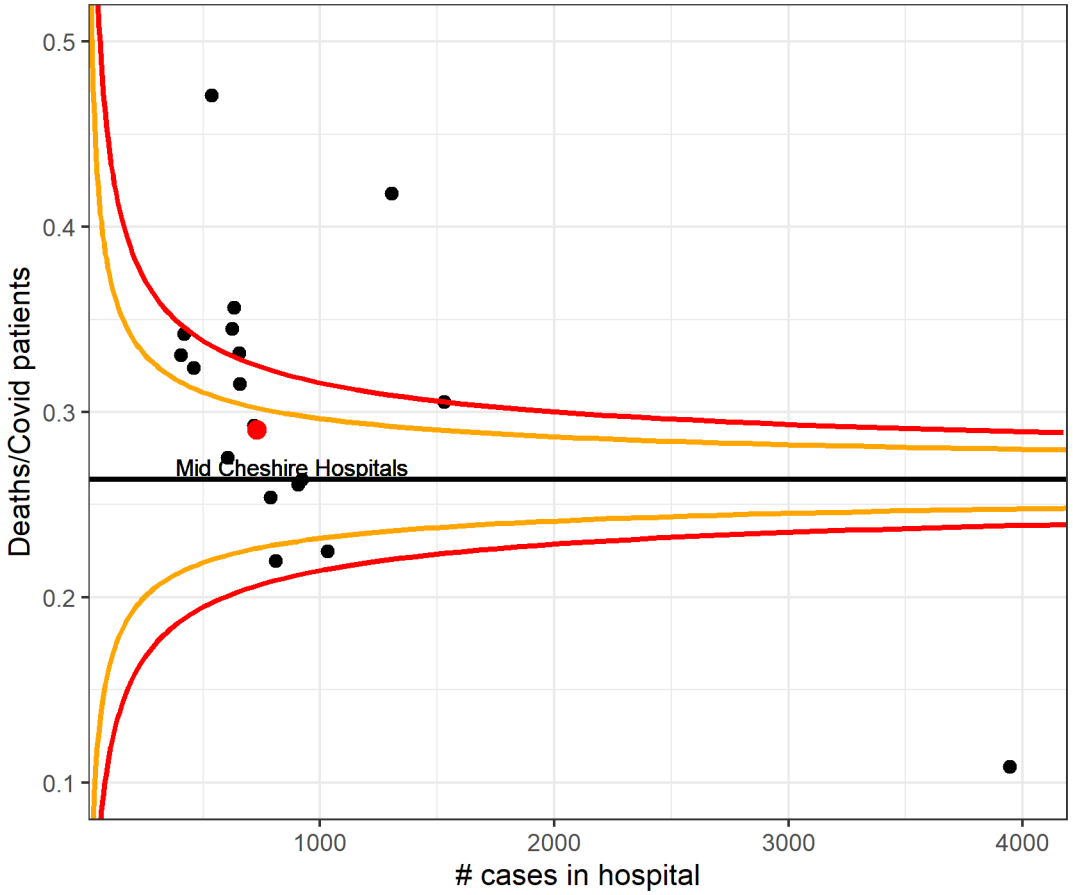
Since the start of the COVID-19 pandemic (March 2020), the Trust has admitted and cared for a significant number of patients affected by the disease. To date, local infection rates have seen two distinct waves of in-patients with Covid-19 referred to as wave one (March to the end of June 2020) and wave two (October 2020 onwards). Unfortunately, these waves have been closely mirrored by in-patient deaths in which Covid -19 was either directly responsible or a significant factor (see graph 1) or the patient had tested positive within 28 days of dying.

Graph 1 In-patient deaths demonstrating wave 1 and wave 2.



Whilst in-patient deaths during the first wave were within normal limits (see Graph 2), it is important that these deaths were scrutinised to identify any lessons to improve future care. This paper details the process and the findings of that work.

Graph 2 Covid related deaths related to the number of infected in patients for North West Acute Trusts



2. This paper looks specifically at wave one from early March to the end of June 2020. During this time, 201 patients died with Covid-19 being reported on the Medical Certificate of Cause of Death (MCCD) as either the main cause or a significant contributor to the patient's demise or the death occurred within 28 days of a positive test. It draws together the audit of the clinical care provided to a sample of 146 patients who succumbed during this first wave and a subsequent Post Infection Review (PIR) for those cases identified as potentially nosocomial infections.

   It is important to highlight that national guidance relating to the definition and management of nosocomial cases (infection acquired within hospital) was in its infancy and that for large parts of the first wave, the capacity to test for coronavirus was significantly limited.

   As the knowledge base in relation to the routes of transmission of coronavirus grew, it became apparent towards the second wave that the airborne route of transmission was perhaps more significant than first anticipated.

3. Methodology

3.1 Audit

A retrospective audit of the case notes of patients who had died from Covid-19 or when Covid-19 was identified as a contributory factory on the MCCD. The audit was undertaken by pairs of clinicians combing Intensive Care Physicians and General Physicians who participated in the

General Internal Medicine on-call rota. Pairings did not examine cases in which they had contributed significantly to the clinical care given. The audit used an electronic form for data collection with particular reference to treatment escalation plans (TEP), Do not attempt resuscitation forms (DNA-CPR), Critical care referrals, End of Life care plans (EOL). In addition, the pairings judged the quality of care according to the National Confidential Enquiry into Perioperative Deaths (NCEPOD) definitions described in table 2:

Table 2 NCEPOD definitions of quality of care

Score	Grade	Example
1	Good practice	A standard that you would accept from yourself, your trainees and your institution
2	Room for improvement in clinical care	Aspects of clinical care that could have been better
3	Room for improvement in organisational care	Aspects of organisational care that could have been better
4	Room for improvement in both clinical and organisational care	Aspects of both clinical and organisational care that could have been better
5	Less than satisfactory	Several aspects of clinical and/or organisational care that were well below that you would accept from yourself, your trainees and your institution

Lastly, pairings were asked to score the 'avoidablility' of the death (due to lapses or omissions in the clinical care given) according to a Nationally recognised scoring system, the Hogan (Likert Score described in table 3. The definition of an avoidable death used in the audit again conforms to National Standards and is one more likely than not to have resulted from problems in healthcare and therefore to have been potentially avoidable (Hogan scores 4-6).

Table 3 Hogan score of avoidability of death

Hogan score	Descriptor
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

Any cases identified by the pairings with a NCEPOD score of 2 or above, and or a Hogan score of 3 and above were subject to a case conference within the Division of Medicine and Emergency Care in order to confirm the scorings and to disseminate any lessons learned.

3.2 Post Infection Review

A post infection review (PIR) was undertaken on all the cases of potential nosocomial transmission of the virus identified by the above audit. The PIR was undertaken by a Nurse Consultant in Infection Control and utilised the standard Trust PIR process which included looking at patient journeys and any environmental factors as well as test results and case notes.

The aim of the PIR was to establish whether the SARS-CoV-2 infection was attributed to transmission within the hospital (nosocomial); and if so, whether any lapses or omissions in IPC processes could be identified. The definition of a healthcare acquired COVID-19 case was taken from the nationally agreed definition, which became available at the end of June; namely:

- Probable nosocomial: First identification of infection between day 8-14 of admission
- Definite nosocomial: First identification of infection on day 15+ of admission

For both the audit and the PIR, the overarching emphasis was to identify any lessons learned.

4. Results

4.1 Audit

A total of 146 patients were included in the audit comprising 72.6% of patients who perished from or whose death was related to Covid-19. The average age of patients 79 with the youngest being 44 and the oldest 98. Of these patients, 129 (88%) had a Treatment Escalation Plan documented in the notes of which the vast majority (127) were judged to be of a good standard.

A total of 111 patients were not escalated for consideration of critical care support. Of these, only 1 was felt, by the reviewers to have warranted escalation but they did feel it unlikely that this would have changed the outcome. The audit found no evidence of failure to escalate to critical care being based on a patient's age or mental state alone.

Most patients (140/146, 95.6%) had DNA CPR form completed. Only 6 of these forms were not discussed with either the patient or next of Kin. In all these it was documented that this was due to a rapid decline in the patient's condition. The audit found no evidence of blanket application of DNA CPR forms based on patient age etc. In each case they had been undertaken on an individual basis. A documented End of Life Pathway was documented in 103 (70.5%) of cases.

One hundred and twenty-five (85.6%) of the cases were graded as NCEPOD 1 for the quality of care provided indicating good practice. A further 17 (11.6%) were given a grade of 2 to 3 indicating an improvement in clinical or organisational care or both could have been achieved. These related to deficient EOL care planning and lack of documented escalation plans. Four cases (2.7%) were graded as less than satisfactory (grade 5) due to concerns about potential nosocomial transmission of virus. No cases were graded as less than satisfactory for the clinical care provided.

A Hogan score of 1 was given to 128 cases (87.7%) indicating that they were definitely not preventable. 11 (7.5%) were graded as Hogan 2, and 4 (2.7%) Hogan 3; based entirely on the potential for nosocomial infection. Three cases were ungraded.

All cases where the NCEPOD score was 4 and or the Hogan score 3 or more were subject to case conference at which in all cases, the grading was confirmed.

4.2 Post Infection Review

A total of 35 (24%) out of the 146 cases included in the audit were identified as being potentially nosocomial and underwent a PIR. Of these 35 cases, the PIR concluded that 11 (7.5%) were likely to be Hospital acquired infections (HAI) based on the evidence available in that they occurred in individuals admitted with non-respiratory conditions.

It was impossible to draw a conclusion on a further 12 cases because of the absence of admission testing and or the possibility of symptoms on admission representing Covid-19. One of these patients could not be appropriately assessed in terms of acquisition, as the SARS-CoV-2 laboratory test was inconclusive.

Twelve cases were felt to be likely to be community acquired infections, due to clear respiratory symptoms on admission.

5. Conclusions

It is pleasing to note that the care of almost three quarters of all in-patient deaths related to Covid-19 during the first wave has undergone scrutiny. Whilst not using a Structured Judgement Review (SJR) form, the methodology utilised in the audit was based on the SJR process, recognised nationally.

The care provided for the vast majority (85.6%) of these cases was judged to be of a good standard. Whilst disappointing to note that care could have been better in 11.6% of cases, this was confined to issues surrounding EOL care and treatment escalation plans. Only four cases (2.7%) involved care deemed to be less than satisfactory, this being solely due to the possibility of nosocomial infection. No cases were felt to have received less than satisfactory clinical care otherwise. It was particularly reassuring to note that the audit found no evidence of ‘blanket’ application of DNA CPR forms being applied nor of decisions about escalation to critical care being based on patients age or mental ability alone.

Of the 35 cases referred for a PIR following the audit, 11 (7.5% of the total cases examined) were thought to be due to HAI and in a further 12 cases (8.2%) a HAI could not be reasonably excluded giving a combined total of likely and possible HAI as 15.7%. Recent analysis of the North West data following further waves of the pandemic suggests that around 22% of in-hospital covid-19 deaths arose in patients with nosocomial infection. It is entirely feasible, due to a combination of relying on historical records and the lack of comprehensive testing, that the audit and therefore the PIR failed to identify all cases of HAI.

As indicated above, it is important to remember that for large parts of the first wave, there was extremely limited access to testing for the virus. As a consequence, the Trust, like the rest of the Country, could not employ testing for all patients at the point of entry to the Hospital.

It has subsequently become apparent that patients with Covid-19 can present with a constellation of different symptomatologies and indeed infection is common in asymptomatic individuals. Subsequent data has confirmed that relying on clinical diagnosis of Covid-19 without testing will only identify approximately half of infected individuals. This knowledge underpins the current local and national policy of testing all patients on admission to the Hospital and also repeat testing

during in-patient stays to facilitate early detection of infected individuals and prevent cross-infection of unaffected patients.

It is highly likely that this paucity of comprehensive testing of patients and the lack of understanding about the complexity of presentation of Covid-19 during the first wave was a major contributor to the burden of nosocomial infection.

It is arguable that all deaths following nosocomial infection are preventable, however The North West Regional Mortality Cell has now recognised that the complexities in relation to contributory factors (patient risk factors, transmissibility risks, variant risks, environmental risks, behavioural factors that influence IPC compliance, community prevalence, hospital burden of Covid etc which impact of HAI) mean that application of these criteria is too simplistic. Instead the recommendation from the cell is that the focus is on amenable deaths (ones that could have been avoided through timely and effective healthcare) and the lessons learned with particular reference to the PIR. The audit found no evidence of amenable deaths using the above categorisation.

6. Lessons Learned:

6.1 The Audit

- The mortality audit highlighted a number of areas of existing good practice including timely referrals to critical care, good communication around end-of-life decision making and involvement of the palliative care team.
- The importance of early decision making with regards to escalation plans, documentation of DNA CPR discussions and use of end-of-life care plans were highlighted to both the Division and wider Trust through the QI process.
- Revisiting DNA-CPR discussions with patients and their next-of-kin was identified as an area to work on going forward, especially prior to discharge.

In addition, the following changes were introduced prior to the second wave:

- The majority of patients with Covid-19 were offered the opportunity to participate in national portfolio research trials.
- Evidence from these studies was introduced rapidly into practice and protocols were embedded into clinical care pathways.
- The critical care MDT team was strengthened by the addition of regular respiratory team input.
- Communication between the medical and critical care teams was improved via a daily morning meeting with MDT involvement to facilitate rapid decision making.

6.2 PIR

- The PIR review has only been capable of providing an ‘observation’ in relation to any potential lapses in care for nosocomial cases, largely due to the timing of the cases. COVID-19 knowledge and its associated evidence base was limited at the start of the pandemic and testing was grossly restricted. Community testing was not in place.
- There were occasions (11), whereby the patient met the case definition for swabbing, but a SARS-CoV-2 swab was either not available or not sanctioned. This is particularly evident up to the end of March; after which improvement is noted.

- Knowledge, guidance and evidence has evolved considerably since the start of the pandemic, therefore, subsequent PIRs are capable of identifying greater detail with regard to any potential lapses in care, or any other contributory factors.
- Potential lapses in care need to be framed in accordance with national/local guidance and policies and also be reflective of historic epidemiology. Without adequate and appropriate testing, robust guidance identifying how patients should be managed and how routes of transmission should be mitigated, the certainty of a 'lapse' is not reliable.
- Any potential lapse associated with the first wave, unfortunately represents the infancy of the national testing programme in terms of availability, turnaround times and potentially lack of knowledge in relation to how long a patient may test positive for and what that pattern might look like. In the absence of community-based testing, it is highly likely that some patients admitted may well have been previously positive and further deteriorating at the point of admission.

7. Terminology

'SARS-CoV-2' represents the most recent term for a coronavirus capable of causing SARS (Sudden Adult Respiratory Syndrome).

'COVID-19' relates to the disease caused by coronavirus; first identified in 2019.

Mr Murray Luckas, Medical Director

Dr Richard Lowsby, Consultant in Intensive Care medicine

Miss Karen Egan Nurse Consultant in Infection Control

Date: June 2021

Mid Cheshire Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**9.4**	Date of Meeting: 29/07/2021
Report Title	**Learning from Deaths Report Q1 2021/22**	
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 reported potentially avoidable deaths
- To note the progress of the Medical Examiners Programme

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)*

• Provide safest and best care	✓	• Be the best place to work	☐
• Become a leading and sustainable health care system	☐	• Push boundaries in clinical, technology and digital innovation	☐

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

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

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

Strategy	☐	Policy	☐	Service Change	☐

REPORT DEVELOPMENT

Committee/ Group Name	Date	Report Title	Lead	Brief summary of key issues raised and actions agreed
Quality and Safety Committee (QSC)	20.07.21	Learning from Deaths report Q1 2021/22	Murray Luckas, Medical Director Rebecca Shenton, Patient Safety Lead	Noted

Learning From Deaths Q1 Report 2021/22

Introduction

1. This report is the first iteration of the new quarterly report to the Board of Directors on the deaths of patients under the care of Mid Cheshire Hospitals NHS Foundation Trust (MCHFT), as required by the Trusts Learning from Deaths Policy[1]. The policy was developed in accordance with National Guidance first published in 2017[2]. This report covers quarter1 of 2021/22 (1st April – 30 June 2021).

2. Since April 2017, acute hospital trusts have been required to collect and publish specified information on deaths. This should be through a paper and an agenda item to a public Board meeting in each quarter, to set out publication of the data and learning points. The data should include the total number of inpatient deaths (including Emergency Department deaths for acute trusts) and those deaths that have been subjected to case record review. Of the deaths subjected to case record review, trusts need to provide estimates of how many deaths were judged more likely than not to have been due to problems in care.

Executive Summary

3. In quarter 1:

   - There were **216** deaths at MCHFT
   - **119** (55%*)* of deaths were reviewed by a Medical Examiner
   - **41** (19%) of deaths were subject to a Structured Judgement Review (SJR)
   - **1** (0.5%) deaths was felt to be potentially avoidable (more likely than not to be due to a problem in care)
   - Of the **41** SJRs commenced, **11** have been completed at the time of the report being written.

4. Of the deaths reviewed using the SJR methodology in quarter 1:

   - **1** was classed as category 1 and was therefore potentially avoidable (LIKERT 4 or above)
   - **None** were classed as category 2, where poor care was identified but the death was unavoidable (LIKERT 1-3, poor or very poor care)
   - **10** were classed as category 3 and were unavoidable with average or better care identified

Learning from Deaths Process

5. The process is fully outlined in the Trust's Learning from Deaths policy[1]. The following narrative is a brief overview of the system currently in place.

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

7. 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 (see Appendix 1). 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.

8. 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.

9. 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 via clinical incident reports
    - All learning disability deaths
    - All deaths of patients who have a diagnosed serious mental health illness
    - Outlier data deaths (Liver disease and CCF Non hypertensive)
    - Medical Examiner concerns (all in-patient deaths will be scrutinised by a Medical Examiner)
    - Divisional Review Concerns

10. Where an SJR identifies a potentially avoidable death and or poor care, a report is obtained from both the consultant responsible for the case and their clinical lead or Associate Medical Director addressing the issues raised by the SJR and any lessons learned. In addition, a peer review SJR is undertaken. In the event of a discrepancy between the initial SJR and the peer review SJR, a final judgement is made at HMRG.

11. Subsequent 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.

12. 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 provide additional support for the SJR reviewers.

13. Learning from the reviews is shared through several other forums including at Grand Rounds, Divisional Quality Improvement Sessions and Medical Training Sessions.

14. 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.

Trust Data Analysis

Learning from Deaths Dashboard - Part 1

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 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
70	76	4	7	1	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
216	349	11	22	1	1	0	1
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
216	1222	11	28	1	2	0	7

Mid Cheshire Hospitals
NHS Foundation Trust

Learning from Deaths Dashboard - Part 2 (Learning Disability deaths)

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

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	2	0	1	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
3	6	1	4	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
3	11	1	9	0	0

Total Deaths Reviewed by LIKERT Score (Completed SJRs)

	Definitely not preventable	Slight evidence for preventability	Possibly preventable but not very likely, less than 50-50	Probably preventable, more than 50-50	Strong evidence for preventability	Definitely preventable
This Month	2	1	0	1	0	0
This Quarter	7	2	1	1	0	0
This Year	7	2	1	1	0	0

(Source: SJR database, 2021)

Total Deaths Reviewed by Overall Care Score (Completed SJRs)

	Excellent Care	Good Care	Adequate Care	Poor Care	Very Poor Care
This Month	0	0	3	1	0
This Quarter	1	5	4	1	0
This Year	1	5	4	1	0

(Source: SJR database, 2021)

Total SJR's completed for Quarter 1 2020/21

Month	Total	Category 1 (Potentially avoidable with a LIKERT 4 or above)	Category 2 (Poor care was identified but the death was unavoidable. LIKERT 1-3, poor or very poor care)	Category 3 (Unavoidable death with adequate or better care identified)
April 2021	0	0	0	0
May 2021	7	0	0	7
June 2021	4	1	0	3

(Source: SJR database, 2021)

Indication for SJR

	Deaths where families, carers or staff raise concerns	Deaths where concerns are raised by the Coroner	Learning Difficulty Deaths	Patients who have a diagnosed Serious Mental Health Illness Deaths	Deaths where concerns are raised at the Patient Safety Summit	Outlier data deaths	Medical Examiner concerns	Divisional Review Concerns	Covid-19 Nosocomial Death
April 2021	0	0	0	1	0	0	0	0	1
May 2021	2	0	1	2	1	0	1	0	11
June 2021	4	0	3	1	1	0	1	0	11
Total	**6**	**0**	**4**	**4**	**2**	**0**	**2**	**0**	**23**

(Source: SJR database, 2021)

Please note the patient level information for the outlier deaths has not been available until July 2021 due to a change in the Business Intelligence Unit (BIU) information system. The outlier deaths for quarter 1 will be reviewed during quarter 2.

Summary of Potentially Avoidable Deaths in Quarter 1 2021/22

Month	Incident number	Recorded Cause of Death	Speciality	Concerns and learning	SJR outcome
June 2021	139717	The cause of death was recorded as: 1a. Community Acquired Pneumonia, 2. Decompensated alcoholic liver disease.	Gastroenterology	Lapses in care regarding the management of the patient's hypokalaemia have been identified. The incident has been recorded as a potentially avoidable death and reported on StEIS. A concise review will be completed to pull together the learning from the SJR and root cause analysis investigation. Immediate actions include direct feedback to both the team & individuals concerned.	LIKERT 4 – Probably preventable Overall poor care

(Source: SJR and SI database, 2021)

Update Summary of Potentially Avoidable Deaths From Previous Quarter – Quarter 4 2020/2021

Month	Incident number	Recorded Cause of Death	Speciality	Concerns and learning	SJR outcome
January 2021	131471	The cause of death was recorded as: 1a. Covid-19 pneumonia 2. Parkinson's	General Medicine	There was a failure to identify and correctly escalate the patient's deterioration. Comprehensive investigation is ongoing. Immediate actions included a Task and Finish Group, led by the Head of Nursing for Emergency Care being developed.	LIKERT 5 - Strong evidence for preventability Overall poor care

(Source: SJR and SI database, 2021)

Unexpected and/or Unexplained Child Deaths that have been cared for at MCHFT

None to report in quarter

Month	Incident number.		Details	Review on target?	Details/Comments/Learning
	Unexpected?	Unexplained?			

Inquest Quarterly Update

Month	Inquest number	Recorded Cause of Death	Coroners Verdict	Learning	Linked Trust Investigations or SJR
May 2021	INQ/21/005 Cardiology	1a. Ischaemic and Hypersensitive heart disease. 1b. Coronary Artery Atheroma and Hypertension 2. Type 2 Diabetes Mellitus, Sildenafil usage	Natural causes with background of complications of the acceptable risk of the use of Sildenafil	None identified -Coroner recorded narrative verdict- natural causes with background complications of acceptable risks of use of Sildenafil	Incident completed and reviewed as low harm- 132249
May 2021	INQ/19/048 Urology	1a. Massive Haemorrhage 1b. Bladder perforation 1c. Complex Prolonged surgical procedure	Complex surgery in a frail patient – contributed to by neglect	Coroner confirmed death was as a result of a complication of a complex prolonged surgical procedure which was contributed to by neglect. 1.Undertake a urology service review with regard to undertaking urgent cystoscopy and taking over the management of ward referrals - Complete 2.Review the use of theatre lists to prevent additions without Consultants prior agreement – Complete 3.Create a standard Operating procedure for time limits and planned procedures in theatre - Complete	Potential Claim - POT/21/002 Comprehensive Investigation completed - 113177

Month	Inquest number	Recorded Cause of Death	Coroners Verdict	Learning	Linked Trust Investigations or SJR
				4. To share the lessons learnt and the outcome of the review at the Urology Mortality group and Divisional mortality group - Complete	
June 2021	INQ/19/055 Gastroenterology	1a. Neutropenic Sepsis 1b. Pancytopenia 1c. Chemotherapy for Cholangiocarcinoma 2. Type 2 Diabetes – Hypertension	The Coroner concluded that the death was caused by a recognised risk of treatment that was intended to prolong life and was contributed to by her pre-existing medical condition.	Nutritional and hygiene care - addressed in RCA and felt more of a concern than contributing to death.	Potential Claim POT/21/040 Concise investigation completed - 114747
June 2021	INQ/21/001 General Surgery	1a. Multi Organ Failure 1b. Necrotising Fasciitis 2. Coagulopathy	The Coroner concluded that the patient died as a result of multi organ failure due to necrotising fasciitis and coagulopathy contributed. The following factors contributed- firstly there was a delay in diagnosing necrotising fasciitis despite evidence it was more likely than not present. Secondly following identification of necrotising fasciitis there was a delay in taking him to theatre to operate. Thirdly there were shortcomings in communication between the on-site and off duty senior surgical team along with an under estimation of the urgency required.	1. Educational session regarding necrotising fasciitis- Complete 2. Ongoing training on management of necrotising fasciitis - Complete 3. Expansion of case based discussion training - Complete 4. Incident presented at grand round teaching session - Complete 5. Trust wide review of the escalation of the deteriorating patient - Underway	Claim – CN/21/009 Comprehensive Investigation - 113282
June 2021	INQ/20/001 General Surgery	1a. Vomiting and aspiration of bowel contents 1b. Intestinal obstruction	The Coroner concluded that the death was caused by a recognised risk of life maintaining treatment contributed to by neglect	1. Imaging to be reviewed by senior clinician and at handover - Complete 2. Reflection by clinician involved - Complete	Claim – CN/20/033 Comprehensive Investigation - 113191

Month	Inquest number	Recorded Cause of Death	Coroners Verdict	Learning	Linked Trust Investigations or SJR
		1c. Adhesion to site of mesh umbilical hernia repair operation			

(Source: Ulysses, 2021)

Medical Examiner Quarterly Update

	April 2021	May 2021	June 2021
Number cases reviewed	**26**	**38**	**55**
Number cases referred to coroner	**1**	**6**	**6**
Number of cases referred for SJR	**1**	**1**	**0**

Learning Themes

15. During quarter 1, there were two cases referred for an SJR by the ME office in line with the Learning from Deaths Policy.

16. One case identified as potential learning relates to a patient that developed a pulmonary embolism and died following surgery for a fractured hip.

17. The second case has been referred following a complaint being raised by a family regards care and treatment in relation to a lack of medical imaging and communication with the family.

    SJRs will be completed for both cases and any learning identified shared through the Hospital Mortality Reduction Group.

Recommendations

18. The ME office will be undertaking the following in quarter 2:

- Commence the gradual roll out within the community setting
- Recruit two additional Medical Examiners
- Arrange for a Medical Examiner to attend the next End of life and Bereavement Group meeting to give an overview of the ME Service
- Trial electronic ME paperwork in the Emergency department

References

1. Learning from Deaths version 2 December 2020 *MCHFT Trust Intranet*

2. National Guidance on Learning from Deaths, National Quality Board, March 2017

Appendix 1 Structured Judgement Scoring Systems

Quality of care:

1. Very poor care
2. Poor care
3. Adequate care
4. Good care
5. Excellent care

LIKERT preventability scale:

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

On the above scale, LIKERT 4 and above satisfies the national definition of a potentially avoidable death, namely a death more likely than not to be due to a problem in care provided.

Appendix 2 Care Quality Commission (CQC) Mortality Outlier Alerts

The information below is sourced from the latest version of the CQC Insight document (*May 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 2021

	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

-

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

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**10**	Date of Meeting: 29/07/2021
Report Title	**Serious Incidents Report June 2021**	
Executive Lead	Murray Luckas, 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 ten StEIS (Strategic Executive Information System) reportable incidents declared.

- Four serious incidents reported to cover cluster investigations of nosocomial transmitted infections where patients have sadly died
- Three inpatient falls resulting in a fractured neck of femurs on different wards
- A patient experienced a delay in treatment causing harm
- The insertion of a wrong sided joint replacement which satisfies the requirement of a Never Event
- A baby was born in poor condition requiring resuscitation and a transfer.

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)*

• Provide safest and best care	✓	• Be the best place to work	☐
• Become a leading and sustainable health care system	☐	• Push boundaries in clinical, technology and digital innovation	☐

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

• Quality	✓	• Compliance	✓
• Finance	☐	• Legal	☐
• Workforce	☐	• Risk/BAF **BAF3 Quality of care**	
• 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
TPSG	16/07/2021	Serious Incidents June report	Associate Director of Quality Governance	Paper reviewed
Quality and Safety Committee	20/07/21	Serious Incidents June report	Deputy Medical Director	Paper reviewed

Serious Incidents Report June 2021

Introduction

1. This report provides the Committee with details of serious incidents declared and closed during June 2021, and an oversight of learning gained through the patient safety summit discussions. 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. See attached Appendix 1 for the Serious Incident Report slides

4.1 There have been ten serious incidents declared in June 2021.

SI 2021/12564 (139276), SI 2021/13726 (139503) and SI 2021/13187 (139595) Fractured neck of femurs

Three patients suffered in-patient falls resulting in fractured femurs. These occurred on separate ward areas and preliminary investigation has not revealed any lapses in care.

SI 2021/12214 (129501) Ward 12, SI 2021/13006 (133594) Elmhurst, SI 2021/13012 (134420) Ward 10, SI 2021/13187 (143293) Ward 13 Nosocomial infection

There have been four separate outbreaks of Covid which have occurred in the organisation and sadly a number of patients with the infection have subsequently died. In line with recent National /Recommendations, the Trust has reported each separate outbreak together with any associated deaths as one incident. As a result of immediate learnings, the Trust has implemented a number of campaigns to reduce the risk of transmission of infection including the BeEquiPPEd and Stop the Spread campaigns.

SI 2021/12836 (139170) Never Event

A patient had a wrong sided implant inserted into their knee. This was detected before the end of the procedure, corrected and did not result in patient harm. It does however satisfy the threshold for a never event. Immediate actions include redesign of the intraoperative checklists and real time auditing of the safety culture in theatre.

SI 2021/12760 (137791) Delay in follow up
There was a failure to arrange follow up treatment and appointments for a rheumatology patient in line with national guidance. It is likely that the patient has permanent damage to her hand joints as a result.

SI 2021/13725 (139942) External transfer for treatment
A baby was born in unexpectedly poor condition requiring transfer to a tertiary unit. Preliminary investigations have revealed a failure to adequately monitor the baby during the labour and delivery. Immediate actions include a full team debrief to identify human factors as well as an individual debrief of the clinicians involved.

In line with national guidance this has been reported to HSIB, who have yet to confirm they will undertake the investigation.

Conclusions

5. The Trust has declared ten serious incidents; immediate actions to prevent further occurrences happening have been instigated. Four incidents relate to nosocomial outbreaks that have been through the post infection review process, three relate to fractured neck of femurs with no lapses in care.

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

Recommendations

7. The Committee is asked to decide whether it is sufficiently assured that the Trust has processes in place to identify, investigate and learn from serious incidents.

Author: Sheila Kasaven, Associate Director of Quality Governance
Date: 01/07/2021

Mid Cheshire Hospitals NHS Foundation Trust

PAF Committee
Chair's Assurance Report
17 June 2021

Report to	Board of Directors
Date	29 July 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

Executive Safety and Sustainable Environment Group (ESSEG) Chair's Assurance Report
Substantial additional capital investment in 2021/22 of over £40m in the last 12 months. Hospital Redevelopment Programme Board (HRPB) to continue to monitor spend of the £22m for RAAC plank work. Update on Tatton House, Weaver Square and staff relocation projects noted.

Estates Strategic Plan
2021-2026 plan was developed in parallel with pending Trust Strategy as required for Strategic Outline Case (SOC) for hospital redevelopment. Plan to be regularly reviewed in light of emerging Trust Strategy. Executive Summary commended by Committee, greater linkages to Integrated Care System (ICS) and patient benefit suggested by PAF, following which Executive Summary recommended for approval to Board as appendix to the Trust Strategy.

Executive Delivery and Performance Executive Group (EDPG) Chair's Assurance Report

- Urgent and Emergency Care (UEC) services are under significant pressure. In May, attendances up by nearly 25% at Leighton Hospital and down 33% at Victoria Infirmary, based on the average of the last four years. In turn, emergency admissions increased by just under 22%. Average length of stay for emergency admissions increased, however, discharges have improved. Because of the growth in the last two months, there are nearly 100 extra beds open. This pressure is stretching the workforce even further. As a result of sustained growth and pressure, performance against the A&E standard is the most challenged in the C&M system. Over the coming weeks, the Trust will be focusing efforts on preventing admission to hospital by providing an alternative to patients who require diagnosis and treatment planning which will focus further expansion of 'Same Day Emergency Care (SDEC)'
- The overall Referral to Treatment (RTT) waiting list continues to grow and will likely continue to do so for a number of months. Number of patients waiting over one year continues to reduce and is currently ahead of trajectory. The number of patients who require their operation within one month ("P2" patients) is behind trajectory and unlikely to achieve the 95% threshold by end of June.
- Significant growth in the outpatient follow up backlog, which has doubled in size since the pandemic
- Cancer performance is stable, despite increase in referrals, and improvement in diagnostic performance continues

Restoration Plan Update
Outpatient (new and follow-up) and elective inpatient activity has exceeded both the NHSEI minimum thresholds and the Trust's trajectory in May. Daycase activity, underperformed, mainly attributed to the endoscopy service not resuming levels of activity expected. A change in the daycase trajectory by circa. 5 per cent as a result of changes to casemix in the baseline year of 2019/20, where the plan and not the baseline has been changed at system-level. It was agreed, however, that internally performance will be assessed against the daycase trajectory approved by the Trust Board in May and not the recent amended version.

Financial Position 2021/22 – Month 2 (May 2021)
On plan against revised trajectory to achieve balanced position in H1 of 2021/22 as approved by Board. Cost Improvement Programme on track including HCP additional £1.9m over six months. Risk to trajectory of growth in costs associated with unfunded escalation beds, staffed at premium cost. Restoration costs remain in line with plan. Expected additional Elective Recovery Fund income at month 2 not yet included as first national calculation expected at end of June and methodology and against which plan still not clear.

Emerging Efficiencies Schemes
Schemes to meet national and HCP requirements for H1 (April -September 2021) in place. H2 requirements not yet known. Priority to ensure savings do not impact patient care and add to pressures on staff. Three areas of focus:

- Collaboration at Scale - procurement, back office etc. continuing with established workstream
- Premium Costs – review of how to spend money better by investing in recruitment to fill vacances more quickly, divisional plans for workforce will support this.
- Transformation – Operational Finance Group established as Subgroup of EDPG to identify savings

Treasury Policy Review
Internal Auditor provided good assurance on systems and financial controls at year end. Trust bankers remain as A+, new tender for banking services will commence shortly. Mid Cheshire Hospitals Charity increase of £66k income through investment partner following change of risk appetite.

KEY CONCERNS/RISKS

- The sustained pressure on urgent and emergency care resulting in a significant escalation of bed capacity placing further strain on an already stretched workforce. Balancing urgent and emergency care pressures, with restoration of elective services along with the wellbeing of staff is a challenge.
- Unfunded escalation bed costs from July onwards putting pressure on H1 breakeven financial plan

Priority Areas: DECISIONS MADE

- Estates Strategic Plan Executive Summary approved
- Treasury Policy Approved

RECOMMENDATION

To note

PAF Committee
Chair's Assurance Report
July 2021

Report to	Board of Directors
Date	22 July 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

Board Assurance Framework (BAF) Q1 2021/22
Controls and assurance in place for PAF delegated strategic risks, assurance provided on all high level operational risks through the meeting. Clarification on risk scoring criteria requested to understand the differential between a risk score of 15 and that of 20.

Integrated Performance Report (Month 3) – June 2021
Key issue not covered elsewhere in the meeting:

- Data quality exercise on reporting of DM01 diagnostic metric to regulators, to ensure in line with national guidance. Number of corrections made resulting in a small growth in the size of the waiting list.

Executive Safety and Sustainable Environment Group (ESSEG) Chair's Assurance Report
Key issues highlighted:

- RAAC plank survey ongoing; two remaining areas - Ward 10, awaiting clinical decision, and Emergency Department (ED) - to take place following decant to new building
- South Cheshire risks to be considered at Board as unable to release space for refurbishment
- Approved plan to remove baths from wards. Capital funding approval required
- ED build at risk of further 2 week delay due to re-routing of medical gases; situation to be confirmed
- Critical infrastructure action plan progressing; monitoring two outstanding actions
- MRI risk score reduced by Executive Risk Assurance Group (ERAG) as works completed. Current hot weather has not resulted in a repeat of overheating issues
- Premises Assurance Model covering all aspects of estates work submitted to NHS Improvement. Full report to PAF once benchmarking report received.

Estates Strategic Plan
Recommended for submission to Board for approval in September. Executive Summary to be submitted to Board in July for noting and agreeing to its inclusion as appendix to the Trust Strategy. Previous feedback had been applied to amend the Key Performance Indicators (KPIs); further consideration to be given to whether achievement of each KPI would equate to successful completion of programme on time and to budget.

Finance
H1 (Mar-Sep 2021) forecast on track for breakeven position, risk to position is unfunded operational pressures on pay and Elective Recovery Fund (ERF) income. Submission to C&M HCP on best, most likely and worst financial position forecast for H1. Clarity awaited on financial framework for second half of year (H2).

Restoration spending in line with recovery plan, £400k underspend identified, actions in place to address this. Impact of threshold changes nationally for Elective Recovery Fund (ERF) being evaluated; new expectation of 95% of activity to access ERF rather than 85% previously stated. Cost Improvement Projects (CIP) on track, focus on backroom efficiencies, not frontline patient care.

Benefits Realisation Template
New template adopted for consistent approach to benefits realisation 12 months post-investment (over £500k). Inclusion of non-financial factors such as stakeholder engagement. PAF to review if over £1m. PAF requested periodic overview of trends and learning.

Contracts Management – Partial Assurance: initial report by new Head of Contracts illustrated need for overhaul of contracts management to include contract review, provision of advice and guidance, contract repository and training and development. Robust discussion on assurance that could be provided at this stage. Existing corporate risk to be reviewed to capture broader issues under BAF1 and progress to be reviewed in three months.

COVID 19
The significant increase in the COVID infection rate resulting in a rise in hospitalisations, which is particularly impacting on critical care, was noted together with the sustained increase in non-COVID patients attending the Emergency Department likely to impact on elective work. The impact of the current environment and conditions on the workforce was also noted.

Executive Delivery and Performance Executive Group (EDPG) Chair's Assurance Report
- A delay in starting a fully comprehensive 24/7 UGI bleed service due to workforce issues was noted.
- A significant risk with the haematology service backlog was noted and reassurance provided that a number of actions were being taken by the Executive Team in collaboration with partners.
- A number of new significant risks in the Women and Children's Division with controls in place was noted.

Restoration Plan Update
- Reasonable progress against the Restoration Plan continues to be made despite operational pressures
- Long waiters continue to reduce and is ahead of trajectory although overall waiting list continues to grow
- Patients waiting <1 month (P2) for urgent surgery continues to improve but remains behind plan. Number of actions to address this were highlighted
- Activity delivery remained largely on plan with the exception of daycase activity which continued to be a problem, mainly driven by endoscopy and the shortage of anaesthetists. Actions being taken to address these two problems were noted and have Executive oversight
- Cancer backlogs remained low, however starting to grow due to referrals exceeding pre-pandemic levels. Most patients still being seen within two weeks.

Emergency Planning Strategy – Acceptable Assurance: The Emergency Planning Strategy which is a framework for how the Trust will deliver its emergency planning obligations was noted.

Urgent and Emergency Care (UEC) Update

Committee noted the significant and unpresented increase in attendances to the Emergency Department (ED) resulting in higher admissions. 28% increase in attendances and 17% more emergency admissions in June compared to 4 year average. There are similar pressures on out of hospital services both in community services and primary care. Discharges increased in response to demand. Trust one of the lowest ED 4-hour performance in the system and there were four patients in June that waited longer than 12 hours in ED following a decision to admit. Ambulance handover delays (>60 minutes) remained at virtually zero, which was a key metric and is receiving significantly more focus by regulators. Assurance was provided around a series of actions being taken to respond to the situation and ongoing work with system partners. Reassurance was provided that there is a focus on quality and patient safety. External expert support is been sourced to support improvement.

KEY CONCERNS/RISKS

- Growing tension between urgent and emergency care, restoration of elective services and increasing COVID hospitalisation is of significant concern. High risk that some elective services may be curtailed as staff may need to be redeployed to critical parts of the Trust.
- Trust wide position on contracts remains an area of work in progress to understand risk

Priority Areas: DECISIONS MADE

- Committee Workplan approved

RECOMMENDATION

To note

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

Report to	Board of Directors
Date	21 June 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 Amy Freeman, Chief Information Officer Oliver Bennett, Chief Operating Officer *(to item 11 only)*
Committee meeting quoracy	Yes ☒ No ☐

KEY AREAS OF ASSURANCE

Integrated Performance Report (IPR)
Key metrics not discussed elsewhere:

- Spike in sickness; predominantly due to short-term absence
- Vacancy Gap increased in April/May because new investment posts added to establishment
- Urgent and Emergency Care (UEC) pressures significant, making a challenging working environment for workforce. 25% increase in average UEC attendances, 20% more admissions
- Concern with the rising community infection rate is not about increases in hospitalisation, but impact on staffing levels and further pressures on workforce. This is being actively monitored.

Executive Workforce Assurance Group Chair's Report
Mandatory Training compliance stabilised at 85% but a number of issues raised regarding this:

- Resus Capacity and Demand Exercise - **low assurance** provided about the capacity to provide sufficient training in-house for all those who need it. Additional immediate training resource implemented, longer-term plan in development. Referred to Executive Quality Governance Group (EQGG) and Executive Risk and Assurance Group (ERAG). New operational risk also raised
- Particular focus required on medical workforce compliance, potential link to appraisals
- Linkage of pay progression to completion of mandatory training and appraisal being implemented. Staff and managers being supported to ensure compliance. New operational risk raised
- Low compliance in Adults Safeguarding, shown significant improvement since modules moved to internal training platform, from 11% to 59%
- Safeguarding children modules requires further work to understand low compliance.

Further work required to manage staffing risk in occupational health, skills mix review proposed to modernise service and ensure can meet demand and requirements of People Recovery Plan.

Digital Transformation and Information Services (DTIS) Executive Group – Chair's Report
Cyber Security exercise completed by Trust, WDT requested repeated at least every six months. Confidentiality Policy approved at DTIS which prohibits use of WhatsApp for patient identifiable

data. Substantial Assurance for Clinical Coding Audit Assignment Report received from internal auditors. Three new risks identified by Group, poor change control in Malinko system (Community Services), data protection requirements for all contracts with suppliers and the role, training and identification of Information Assessed Owners. Two existing substantial risks reviewed following upgrading of systems, risks now reduced. WDT asked that this report is linked through to the Board Assurance Risks and reflects new controls and actions in the future.

Strategic Planning
Updates on development of Workforce Strategic Plan and Digital Strategic Plan presented. Both Plans in progress, pending launch of Trust Strategy. Digital Plan also subject to several national reviews due out in July. Direction of travel agreed.

Cheshire & Merseyside Digital Strategy Review – Integrated Care System (ICS) Shared Care Record - Acceptable Assurance: ICS framework now provides clarity on where digital projects will be driven, at ICS, Place or Trust level. Shared care record to be at ICS level so work on Cheshire Care Record will need to be integrated to wider system over next 3-4 years. Likely to be a similar solution and functionality, will be a challenge particularly for those invested in the Cheshire solution.

People Recovery Plan / Health and Wellbeing Project Board - **Acceptable Assurance:** In response to a request from Board, summary of packages of support for staff and for managers presented. Four workstreams: psychological, physical, social and financial wellbeing. Activity includes online resources and Wellbeing Squads. More work on signposting and raising awareness to be completed, particularly given operational pressures in some areas. Listening to what staff are saying and responding is crucial to success.

Equality, Diversity & Inclusion (ED&I) Programme Update & National Priorities - Acceptable Assurance: Priorities for year ahead outlined which tie in national requirements: Overhaul of recruitment practices, progress against Model Employer goals, establishment of high performing networks. Limited resources may require prioritisation of work. Staff engagement pending regarding new disability and carers network and LGBTQ network. WDT requested evidence in the future of how staff networks can have an impact on decision making.

Employee Relations - Partial Assurance:
First sight of report on Employees Relations Casework which was helpful. Number of employee relation cases reported reflecting grievance, capability, sickness, disciplinaries bullying and harassment cases over last three months. Report gives helpful insight (triangulated with other evidence) of culture and leadership. Important to triangulate with the wider context in which staff are functioning. Board oversight of suspensions required to satisfy requirements in Dido Harding letter.

Flowers v East of England Ambulance Trust - Acceptable Assurance: Trust on target to meet requirements for corrective payments by September 2021. Calculations for 2021/22 need to be decided locally as national scheme via ESR scheduled for launch in April 2022. C&M group working through approach. Supreme Court decision on 22 June will decide implications for other staff groups. PAF are sighted from a financial perspective and funding for last two years received.

Appraisal Assurance Report - Partial Assurance: remains a concern, two areas: Corporate and Women and Children's worsened, overall rate slightly improved. Likelihood of compliance by

August is low. Leads meeting with divisions, managers to be held to account, recognising pressures on time. Escalated to Executive. WDT requested review of compliance via ethnic group to understand if British, Asian and Minority Ethnic groups were being impacted more.

Talent Management Update - Partial Assurance:
Developed over last 18 months. Talent Boards in place with agreed focus on Deputy-Executives and Clinical Leadership roles, guidance expected from region. Divisional Boards taking place currently. WDT requested further data on what is known about retention of senior staff and opportunities.

KEY CONCERNS/RISKS

- Impact of high operational pressures on staff wellbeing
- Resuscitation training capacity is inadequate, external resource being utilised
- ED&I balance to find between national requirements and locally identified priorities as limited resources
- Appraisal compliance rates are not improving and declining in some areas

Priority Areas: DECISIONS MADE

None

RECOMMENDATION

To note

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

Report to	Board of Directors
Date	19 July 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 Amy Freeman, Chief Information Officer Oliver Bennett, Chief Operating Officer *(to item 11 only)*
Committee meeting quoracy	Yes ☒ No ☐

KEY AREAS OF ASSURANCE

Integrated Performance Report (IPR)
Three significant drivers causing operational pressures all of which are impacting on workforce:

- Unprecedented levels of demand on Urgent and Emergency Care (UEC), resulting in nearly 100 escalation beds open
- Delivery of the Restoration programme and elective work
- Increasing numbers of COVID patients in the hospital particularly in Critical Care.

Safe Staffing metric does not sufficiently reflect position, particularly when escalation beds open, to be discussed by Executives.

Board Assurance Framework (BAF) Quarter 1 2021/22
WDT BAF risks reviewed. BAF2 *Workforce wellbeing and resilience* (risk score 16) - controls/actions reviewed. Overarching risk assessment (RA) for staff health and wellbeing to be presented to Silver Command Group to ensure controls are in place and gaps in controls have actions to address them. RA will also be considered within the H&WB Group and Executive Workforce Assurance Group (EWAG). Immediate support to workforce still required in areas such as A&E, due to operational pressures, different staff groups are requiring different support.

Resuscitation training capacity (risk score 15) not reflected on BAF due to timing of BAF development; controls established and actions underway. No actions or significant risks outstanding under BAF 10, 13 or 14.

Executive Workforce Assurance Group Chair's Report
Mandatory training compliance by medical workforce at 61% is of concern. Particular hotspots identified, with recommendations/actions in place to address. Bank team hours extended to support start of night shifts and weekends. People Recovery Plans discussed in detail, noting continued pressure on staff. National quarterly pulse survey replacing staff Friends and Family Test from 1 July 2021.

Workforce Supply Group and an aligned task and finish group focusing on three high risk medical recruitment areas - Anaesthetics, Respiratory and Acute Medicine, to report back to Executive Risk and Assurance Group (ERAG) and EWAG in August. Allied Health Professional (AHP) vacancies also identified for further focus as emerging risk.

Digital Transformation and Information Services (DTIS) Executive Group – Chair's Report
Committee advised of reduced scoring on two key risks: Out of support system software. One server remains unsupported, due to complexity of upgrading, segmented from rest of network to minimise risk. Data Security and Protection Toolkit met all requirements, independent assurance provided by internal auditors. Number of new risks added following internal penetration testing, none above 15 and several actioned and closed.

Development of Digital Strategic Plan and engagement with operational teams in progress. New Chief Information Officer (CIO) will take this forward from September. Robust handover plan in place for CIO role.

Workforce and OD Quarterly Update Report Q1 2021/22 – Acceptable Assurance
First time report summarising all workforce items expected to evolve further following new Trust Strategy and associated Workforce Strategic Plan, to identify highlights and exception report format. Inclusion of digital thread and matrix approach to work noted.

Freedom to Speak up Guardian Annual Report (FSUG) 2020/21 – Acceptable Assurance
Increase in reporting compared to previous years shows embedding of role and greater understanding by staff. Themes identified were kindness and civility issues – task and finish group established in response. Evaluation process in progress and plan to embed further. FSUG diagnostic tool for Board to be reviewed and included in Board Development Plan.

Appraisal Assurance Report - Partial Assurance: 0.83% improvement since 1 June, 9 of 11 areas improved. Corporate increased compliance to 87% from 71% following targeted work that identified many conversations had taken place, but not logged. Approach in Divisions is more targeted given clinical pressures. WDT requested inclusion of compliance against protected characteristics (Black, Asian, Minority Ethnic (BAME) and disability characteristics). No Trust wide
disparity in likelihood of receiving an appraisal based solely on ethnicity. However, gender link was noted, 7% more likely to have had appraisal if male. Contributory link to gender pay gap to be explored further.

KEY CONCERNS/RISKS

- Staff wellbeing work focused on increased operational pressures and growth in COVID cases as well as supporting restoration.

Priority Areas: DECISIONS MADE

- Committee Workplan agreed.

RECOMMENDATION

To note

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	13	Date of Meeting: 29/07/2021
Report Title	CQC Improvement Plan update July 2021	
Executive Lead	Julie Tunney, Director of Nursing and Quality	
Lead Officer	Sheila Kasaven, Associate Director of Quality Governance	
Action Required	To note	

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

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

- All 'must do' and 'should do' actions closed
- Process for monitoring 175 areas established to gain assurance on sustainability of improvements.

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

- Provide full action areas updated database and analysis in 6 months.

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

• Provide safest and best care	✓	• Be the best place to work	☐
• Become a leading and sustainable health care system	☐	• Push boundaries in clinical, technology and digital innovation	☐

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

• Quality	✓	• Compliance	✓
• Finance	☐	• Legal	✓
• Workforce	✓	• Risk/BAF **BAF3 Quality of care**	
• Equality	✓		

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

Strategy ☐ Policy ☐ Service Change ☐

Mid Cheshire Hospitals NHS FT

REPORT DEVELOPMENT

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

CQC Report and Improvement Plan

Introduction

1. This paper will provide an update on the Care Quality Commission (CQC) improvement plan devised in April 2020 following the Trust inspection in November 2019.

2. The paper will focus on the next steps following the closure of the 'must dos' and 'should dos' raised from the inspection.

Background and Analysis

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

4. Divisions, Corporate and Executive teams reviewed the CQC findings and developed actions to address each must and should do as part of the Quality Summit group workplan. The improvement action plan (for must do's) had 33 specific actions/work-plans for implementation by September 2020 and these were achieved in time.
The improvement action plan (for should do's) had 48 specific actions/work-plans for implementation on or before March 2021 and these were all closed on time.
The CQC have received both improvement plans.
The CQC improvement plan provided the means of improving control over the risks highlighted following the CQC inspection and, reduces the risk that;
    - Service users are exposed to unacceptable levels of harm arising from inadequate compliance with CQC fundamental standards of care.
    - The Trust fails to comply with CQC Registration Regulations and has its certification of registration revoked.

5. The CQC inspection report was utilised to support the Trusts consideration of which areas we need to improve. In developing the action plan the following areas of consideration were included: -
What was the outcome we hoped to achieve (referencing the CQC must/should do's; regulatory requirements; clinical expertise) i.e. how can we improve safety and quality for our patients.
    - What changes (actions) will lead to the improvement.
    - How will we monitor the actions are being implemented?
    - What resources will we require to make the change.

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

6. Following the closure of all the 'must do' and 'should do' actions, the Medical Director, Director of Nursing and Quality and the Associate Director of Quality Governance met to review the next steps. Both Appendix documents from the previous two inspections were examined. All the points both subtle and directive were taken and put into a spreadsheet. 175 areas for action were identified, these covered all aspects of the Trust including quality, workforce, estates, performance and technology.

7. All the actions were subsequently assessed to which Executive Group would monitor these areas, not focusing on the specific detail but providing assurance on systems wide sustainability of improvement work either in progress or already completed.
For example if the CQC had picked up on a ward/department having storage issues – the Executive Group that is assigned this action would ensure there was a system or process in place that gave assurance that all areas had sufficient storage – that equipment etc is not stacking up in inappropriate/unsafe areas.

8. Each Executive Group have now received a number of areas to monitor and report through the group on progress, escalating to the Executive Risk Assurance Group (ERAG) any areas that do not give assurance. The below shows the amount of areas attributed to each Executive Group:
    - Executive Quality Governance Group – 98
    - Executive Workforce and Assurance Group - 26
    - Executive Safe and Sustainable Environment Group -15
    - Executive Delivery and Performance Group -22
    - Executive Digital and Information Services Group - 8

9. The Executive Quality Governance Group (EQGG) received the most areas to monitor covering 56% of the 175 areas. As a result, the Quality Summit has continued. The areas have been put into a plan for each divisional Head of Nursing to progress through divisional governance and report into the Trust Quality Group.

10. In September 2021 the Quality Summit will be replaced with a quarterly meeting '*Being Good, Becoming Outstanding Group'*. This group will monitor all CQC activity for the organisation including CQC actions from the Executive groups, CQC enquiries, CQC insight report analysis, inspections and mock inspections, annual statement of purpose review, outcomes from CQC engagement meetings. The group will also take the lead in changes coming out of the new CQC strategy.

Conclusion

11. The Trust has completed all the 'must do' and 'should do' actions following the CQC inspection in 2019, the process to gain assurance on the sustainability of those actions and those areas highlighted in the last two CQC inspection appendices has been described.

Recommendation

12. To note the direction on the management of the CQC actions and process established for 2021-22.

Author: Associate Director of Quality Governance
Date: 20/07/2021

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**14**	Date of Meeting: 29/07/2021
Report Title	**Freedom to Speak Up Guardian Report Quarter 1 2021/22**	
Executive Lead	James Sumner, Chief Executive	
Lead Officer	Sian Axon, FTSU Guardian	
Action Required	To note	

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

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

- 7 concerns were raised during Quarter one via differing routes
- CCICP & Victoria Infirmary 'Open Door' drop-in sessions have been held
- Evidence of triangulation of staff issues into Trust structure & processes

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

- Develop training opportunities

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

• Provide safest and best care	✓	• Be the best place to work	☐
• Become a leading and sustainable health care system	☐	• Push boundaries in clinical, technology and digital innovation	☐

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

• Quality	☐	• Compliance	☐
• Finance	☐	• Legal	☐
• Workforce	☐	• Risk/BAF **BAF9 Leadership and organisational culture**	
• Equality	☐		

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

Strategy ☐ Policy ☐ Service Change ☐

Mid Cheshire Hospitals NHS FT

REPORT DEVELOPMENT

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

Mid Cheshire Hospitals NHS FT

Freedom to Speak up Guardian Q1 2021/22

Introduction

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

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

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

Analysis of Quarter 1

4. During the period 1st April 2021 to 30th June 2021, 7 new concerns were raised using the various Freedom to Speak Up reporting mechanisms. 6 of these concerns met the Freedom to Speak Up criteria and therefore will be reported to the National Guardians Office as required. This compares to 9 concerns being raised during the previous quarter and 8 concerns highlighted during quarter one in 2020-2021.

5. The concerns raised during Quarter four are set out below:

Month reported	Staff Group	Method of reporting	Type of concern	Actions taken	Issue Closed and feedback reported
April 2021	Ancillary staff	In person	Workload	Feed back to Division	Issue closed & feedback given
April 2021	Pharmacy	email	Staff safety / wellbeing	Signpost to HR for resource	Issue closed & feedback given
April 2021	Ancillary Staff	In person ' open door'	? fraud & Staff wellbeing & HR	Dealt with by the Division & referral to regional Fraud officer	Issue partially closed, further feedback to be given
April 2021	Ancillary	In person ' open door'	? fraud & Staff & wellbeing & HR	Dealt with by the Division & REFERRAL TO Fraud officer	Issue partially closed, further feedback to be given

May 2021	HCA (Nursing & Healthcare)	FTSU 'staff email'	Patient safety	Raised @Pt. safety summit, HON & Email coms to all Matrons and ward managers	Issue closed & feedback given
May 2021	Student Nurse	FTSU 'staff email'	Professional Issues patient safety re communication	Divisional Team informed of concerns who actioned with individuals. L&D informed of student concern	Feedback offered to student not taken up.
June 2021	Ancillary Staff	In person	Wellbeing & relates to existing investigation	Incident form completed H R manager feedback to Divisional Management	Ongoing

6. Evidence of triangulation of staff issues and how these have been supported by the Guardian can be seen in examples where issues have been raised by a member of staff, the Guardian on their behalf then raising this to the Division in which they work for feedback, this has then triggered change or improvement. There are also examples of staff concerns which have been fed back to the Guardian that have safety implications; from this feedback the Guardian has been able to raise the concern at the Patient Safety Summit. Subsequent actions to resolve or change processes have been taken and with feedback and thanks to the staff member raising the concern.

7. As previously reported the role needed to be promoted in community settings. During Quarter one 'open door' sessions were held at Leighton, Eaglebridge Medical Centre (May) and Victoria Infirmary Northwich (June). Though the latter two venues did not yield lots of concerns from staff it enabled the Guardian to meet and talk to staff about the role and promote the FTSU service.

8. Freedom to Speak Up training via E- learning is currently being scoped in conjunction with the Head of Learning and Development. E- Learning for Health offer a package of 'Speak - Up 'Core training for all workers and 'Listen - Up' Training for all Managers. The plan to incorporate into staff induction and management training would be the preferred medium of delivery to staff, with further scoping into recording this training on completion via the staff ESR system.

9. A review tool from NHS England / Improvement linked to 'Guidance for Boards on Freedom to Speak Up in NHS Trusts and NHS Foundation Trusts' is currently being scoped and this will inform and promote the FTSU agenda.

10. The FTSU Guardian reports to the Chief Executive and meets monthly. Meetings with the Non-Executive Director aligned to support and promote the Freedom to Speak Up role and culture within the organisation have also occurred on a monthly basis. Thanks are extended to John Church, NED for FTSU for his support and commitment to the FTSU Guardian prior to his retirement; also for his championing of the FTSU service across the organisation. A welcome is extended to Lorraine Butcher who takes on the role of Non-Executive Director aligned to support and promote the FTSU role providing links into the Trust Board.

Conclusion

11. Regular FTSU sessions are now being set for the coming months which will continue to cover multiple venues across the organisation.

12. Further awareness through training and promotion of an open and transparent culture where staff are encouraged and thanked for speaking up is planned.

13. The role and service of FTSU will be further promoted in coming months with the aid of Learning and Development, Communication Team, Guardian 'Open Door' events and Guardian attendance at relevant groups, events and meetings.

Next Steps

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

15. Further work continues by the Freedom to Speak up Guardian to promote and raise the profile of the role and service offered across the Organisation.

Recommendation

16. To note

Report Author: Sian Axon, Freedom to Speak up Guardian
Date: 19 July 2021

Mid Cheshire Hospitals NHS Foundation Trust

Audit Committee
Chair's Assurance Report
July 2021

Report to	Board of Directors
Date	7 July 2021
Report from	Les Philpott, Non-Executive Director
Report prepared by	Katharine Dowson, Head of Corporate Governance
Executive Lead	Russell Favager, Deputy Chief Executive and Director of Finance
Committee meeting quoracy	Yes ☒ No ☐

KEY AREAS OF ASSURANCE

Risk Management Strategic Plan
Reviewed and recommended to Board for approval. Tested process of embedding risk appetite in governance structures. Executive Risk and Assurance Group challenged to test application of risk appetite through regular reporting. Requested addition of review points for five year priorities.

Cyber Security: Acceptable Assurance - Assurance moved from partial, based on evidence presented. Reporting to return to six-monthly.

Data Security and Protection Toolkit (DSPT): Acceptable Assurance - Mersey Internal Audit Agency (MIAA) end of year report rated, 'Substantial Assurance'. Robust challenge on levels of evidence included in report which support rating; sufficient assurance received from Chief Information Officer and MIAA.

Clinical Audit Effectiveness Annual Report 2020/21: Acceptable Assurance – Good level of compliance with national audits through the year. As suspended work restarted, gaps in team structure are a risk to future compliance - previously highlighted in last Care Quality Commission (CQC) report. Actions in place to address resource issues.

Declaration of Interests Annual Report 2020/21 Partial Assurance – levels of compliance and delay to development of App preventing full assurance. Considered levels of compliance achieved in year reasonable, particularly from 'decision-makers'. App in final testing stages to automate process and improve compliance. Committee emphasised the importance of interests being declared throughout the Trust as necessary and, while acknowledging the in-year challenges to this, set an expectation of improved performance going forward in the light of the initiatives the Trust management had set in train.

KEY CONCERNS/RISKS

- Visibility of essential work undertaken by Clinical Coding teams on clinical risk
- Capacity/sustainability of Clinical Audit team to deliver national audit requirements

Priority Areas: DECISIONS MADE

- Approved Anti-Fraud, Bribery and Corruption Policy

RECOMMENDATION

To note

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**15.1**	Date of Meeting: 29/07/2021
Report Title	**Risk Management Strategic Plan**	
Executive Lead	Caroline Keating, Company Secretary	
Lead Officer	Click here to enter text	
Action Required	To approve	

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

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

- The Risk Management Strategic Plan has been updated to reflect the evolution of the Trust's Risk Management Framework; an Equality Impact Assessment accompanies the submission
- Material changes from the previous iteration (approved by the Board in August 2020) identified in Document Change History and also highlighted in red for ease of reference
- Inclusion of new sections covering progress to date and future priorities

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

- To publish on Trust intranet.

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

• Provide safest and best care ☐	• Be the best place to work ☐
• Become a leading and sustainable health care system ☐	• Push boundaries in clinical, technology and digital innovation ☐

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 ☐

Mid Cheshire NHS FT

REPORT DEVELOPMENT

Committee/ Group Name	Date	Report Title	Lead	Brief summary of key issues raised and actions agreed
Board of Directors	August 2020	Risk Management Strategy	Company Secretary	Approved

Risk Management Strategic Plan 2021-2024

Author	Company Secretary		
Approval	Board of Directors	**Approval Date**	
Publication date	July 2021	**Review**	July 2024
Related documents:	• Trust Strategy • Risk Management Process Guide • Assurance & Escalation Framework • Health & Safety Policies		
Equality, Diversity & Inclusivity	An Equality Impact Assessment has been carried out: no impact has been identified on any Equality Target Group.		
Accessibility	This document can be made available in a range of alternative formats on request e.g. large print, Braille etc.		

Document Change History: changes from previous issues of document (if appropriate)

Version number	Page	Changes made with rationale and impact on practice	Date
1		New strategy	07/07/20
2	3	Replacement of previous executive summary with the Board's Risk Management Statement	01/07/21
	5	Scope explicitly references patient safety	
	4-6	Inclusion of new sections covering progress to date and future priorities	
	9	Refreshed risk appetite statement approved by the Board May 2021	
	10	Inclusion of diagram to show the five stages of the risk management process	
	12-14	Inclusion of risk hierarchy diagram and new 'corporate risk' level	
	15	Inclusion of 3 lines of defence model	
	19	Reference to place-based commissioning and Integrated Care System (ICS)	

Contents

1. Risk Management Statement

Mid Cheshire Hospitals NHS Foundation Trust is committed to delivering outstanding care and patient experience. Our long-term strategies aim to ensure sustainable healthcare for our local population and our operations are focused towards achieving the best possible outcomes safely and effectively. The Trust recognises that effective and proactive risk management helps keep our patients, visitors and staff safe, protects the Trust's assets and resources, improves organisational performance, and enhances its reputation.

Managing risk is a key organisational responsibility and an integral part of the Trust's governance arrangements. The Trust is committed to implementing the principles of good governance, defined as:

> *The system by which the organisation is directed and controlled to achieve its objectives and meet the necessary standards of accountability, probity and openness.*

The Trust will ensure that the principles of governance are supported by consistent risk management systems and processes that aid the achievement of its strategic objectives. To this end, the consideration of risk information should be an important driver in decision-making at all levels.

The Trust recognises that the provision of healthcare and the activities associated with the treatment and care of patients, employment of staff, maintenance of premises and managing finances by their nature incur risks. It is not appropriate nor practical to avoid or eradicate all risks and, where relevant, greater exposure to risk will be explored and accepted by the Trust in order to achieve certain objectives or outcomes. Considered risk taking is encouraged, together with experimentation and innovation within authorised limits. The Board provides clarity about the level of risk it is willing to take by defining and reviewing regularly its risk appetite in relation to key risk themes and the Trust's strategic objectives.

The Trust is committed to developing its risk maturity and creating the necessary conditions for fostering a confident and proactive risk management culture at all levels that underpins and supports the business of the Trust. The aim is for risks to be identified, evaluated, acted upon and monitored in such a way as to provide appropriate assurance to regulators, stakeholders and the public that the Board has a comprehensive view of the Trust's risk profile, and that informed decisions are taken about the prioritisation of resources for the treatment of risk.

Chairman …….. Chief Executive ……

July 2021

2. Introduction

This Risk Management Strategic Plan for MCHFT takes into account the strategic context of the organisation. The Trust's strategic direction is driven by a need to transform healthcare provision locally and nationally to provide high quality, sustainable, patient-focused services underpinned by seamless care pathways across the health economy. Embracing innovation and collaboration is critical to improving delivery and sustainability for the long term, working with strategic partners across Cheshire and beyond to meet the changing needs of the communities we serve. The Trust accepts that transformational change through innovation and inter-organisational collaboration carries greater short-term risks than incremental change, however, the benefits in securing the long-term sustainability of services and improved patient experience are clear. The on-going backdrop to this context is the COVID-19 pandemic, which has rapidly altered key aspects of our lives and has required monumental adaptation and resilience in the healthcare sector.

Given the nature and range of services provided by the Trust, it has a complex risk environment. It is therefore essential that the Trust has in place dynamic and consistent risk management systems and practices across the Trust, aiming to promote a balanced view of risk. This means using resources appropriately and proportionately to manage uncertainty to an acceptable level, mitigate threats and minimise compliance risks, while ensuring there is adequate scope for risk-taking in the pursuit of opportunities aligned to defined objectives. In this way, risk management supports the improvement of quality, safety and effectiveness of our services. The Trust sets out its stance on acceptable levels of risk through its risk appetite statement (see section 6).

In recognition of the Trust's strategic ambitions and the challenges and heightened uncertainty inherent in the current operating environment, the MCHFT Board is committed to improving the Trust's risk maturity. This requires continuous evolution of the Trust's Risk Management Framework to ensure that it is underpinned by sound principles, that there is improved visibility of and communication about risk, a positive learning environment and a risk aware culture, and good discipline applied to the risk management process. The aim of this is to create the conditions for risk to drive agendas and inform decision-making, and for appropriate risk treatment plans to be developed and implemented in a timely manner and monitored for effectiveness. The outcome should be to minimise the potential for harm to patients, staff and visitors, loss of assets and damage to reputation, while ensuring that the benefits of experimentation, collaboration and innovation may be harnessed.

MCHFT takes an integrated approach to risk management across the organisation which takes account of all types of risk. The Trust is committed to understanding all risks that may impact the achievement of its objectives, applying a proactive risk-based approach to all aspects of its undertakings, its activities and condition of its estate. This will be achieved using defined methodologies and processes to identify, evaluate and respond to risk. The Board of Directors takes overarching responsibility for determining the strategic governance arrangements for the Trust, creating an environment and structure for risk management to operate effectively, and addressing issues in compliance with the agreed risk management methodology.

3. Key Principles

3.1 Purpose of the Risk Management Strategic Plan

The purpose of this Strategic Plan is to describe and set the direction for the key components of the Risk Management Framework that support and sustain risk management throughout the organisation, i.e. the way the Trust evaluates, controls and monitors the risks to its key functions in carrying out its strategic plans and operations. This Strategic Plan underpins the Trust's reputation and performance and is fully endorsed by the Board of Directors.

3.2 Scope

The Trust recognises that risk management must be applied across all types of risk and at all levels of the organisation. This includes change and innovation initiatives conducted though projects and programmes and extends to collaborative working with external parties. Consideration of risk should be incorporated into all decision-making. All members of staff are responsible for making sure that risks associated with the activities and assets for which they are responsible are identified, assessed and managed, in accordance with the Trust's risk management system and processes. The Trust Board commits to providing the necessary support to help people carry out these responsibilities by ensuring adequate resourcing of risk and compliance functions, good communication systems, and fostering a mature risk culture.

The overarching risk management framework provides a consistent methodology and common system that is flexible enough to accommodate differences between the various professional functions that support the Trust's business. This differentiation will be reflected in how the principles of risk management are communicated to staff operating at different levels and in how staff are trained within their own functional areas about the specific risk and controls they manage on a day-to-day basis.

Risk management is considered by the Trust to be a key driver in ensuring patient safety. A proactive approach is required where findings from the investigation of incidents and near misses are used to identify and control future risks before they (re)occur. This contributes to the continuous improvement of day-to-day practices, greater risk awareness amongst staff when learnings and actions are well communicated, and ultimately a safer culture and safer systems.

The Trust's risk management arrangements must comply with relevant legislation, and the terms of its Provider Licence and CQC registration. The legislative and regulatory context provides an overarching framework that directs the Trust's risk management responsibilities and informs the design of the Trust's internal control environment. This includes topics such as health & safety, employment, data protection, equalities, etc.

3.3 Good Governance

Corporate governance is the system by which an organisation is directed and controlled at its most senior level to achieve the Trust's objectives and meet the standards of accountability and probity.

Risk management is a component of good governance and the Trust has adopted an integrated governance approach, which ensures that the Board and its Committees have appropriate visibility of all aspects of governance e.g. information, financial, clinical etc. Integrated governance is defined as:

> "*the systems, processes and behaviours by which we lead, direct and control our functions in order to achieve our organisational objectives and the safety, quality and value for money of services as they relate to patients and carers, the wider community and partner organisations".*[1]

The Trust is required to demonstrate that it is doing '*its reasonable best to manage risk'.* In practice, this means having systems and processes in place to identify, assess, evaluate and assign responsibilities to manage risks within the Trust. Oversight of risk is incorporated into the Trust's assurance and escalation processes and structures – Appendix 1 sets out the Trust's governance structure and Appendix 2 summarises the risk reporting approach through the governance hierarchy. In addition, the Trust promotes a consistent approach to the investigation of, and learning from, risks and incidents.

3.4 Trust Objectives

The Board recognises that the implementation of an effective risk strategy and risk management process, underpinned by a positive learning environment and a risk aware culture, is key to the delivery of the Trust's objectives. The Board uses a Board Assurance Framework (BAF) as one of the main tools to facilitate the evaluation and monitoring of the strategic risks that would hinder achievement of the strategic objectives (see section 6.2.1). In addition, corporate and operational risks are aligned to strategic objectives so that the Board may understand where lie the greatest challenges to achieving corporate strategy. In this way, the Board considers a top-down and bottom-up view of the Trust's risk profiles.

4. Progress during 2020-21

A key focus for the Trust has been to review the existing risk management arrangements to ensure:

- they represent contemporaneous information about best practice,
- the flow of risk information and monitoring arrangements are integral with the corporate governance structures and processes,
- there is an evidence-based approach to risk assurance,
- senior management and the Board have clear sight of the most important and urgent risks,
- risk management is integrated into every manager's skill set.

A programme of work has delivered the following:

- a clear set of strategic risks aligned with the Trust's strategic objectives,
- a new structure and improved approach for the Board Assurance Framework,
- pilot of new risk information software,
- clearer reporting of risk through the governance hierarchy,
- a new Risk Management Process Guide for managers and risk owners at all levels,
- launch of a training programme, starting with senior leaders,
- creation of a new Executive Risk and Assurance Group chaired by the Chief Executive,
- alignment of Board, Committee and Executive Group business to the Board Assurance Framework.

[1] Department of Health (2006) *Integrated Governance, A handbook for executives and non-executives in healthcare organisations*

At the end of the 2020-21 financial year, the Trust's internal auditors undertook a high-level review of the Trust's 'risk maturity', which was assessed as 'Level 4 – Enabled', in recognition of the changes implemented. The levels are numbered 1 to 5 with 5 being the highest.

5. Priorities for 2021-24

Priority	Why is it important?	How will it be done?
1. Sustainability and continuous improvement of risk management practices	The Board recognises that the improvements to the Trust's risk management arrangements are still relatively new and will need refining and embedding at all levels to become a core part of day-to-day practice.	• Benchmarking and sharing of good practice with other organisations through membership of ALARM, a professional public sector risk management association • Continued training roll-out for all management levels • Introduction of divisional Risk Groups as part of enhancements to clinical divisional governance
2. Focus on risk assurance	A focus on evidence-based assurance has been incorporated in the improved BAF; the Board is keen to ensure assurance information is subject to robust scrutiny and challenge in order to continuously test the effectiveness of key controls. A wider understanding of risk assurance needs to be developed so that the Trust can record and monitor systematically evidence about the effectiveness of operational controls.	• Board development to focus on good practice application of assurance principles to risk management • Consistent use of the assurance fields in the new risk database for all types of risk • Divisional management 'good governance' principles to be developed and communicated for Divisional Boards
3. Roll out and embed new risk software	The Trust has made a commitment to transfer all its risk records to a new system that will enhance the approach to risk assurance, action tracking, reporting and management oversight. The transition requires dedicated focus to manage the change, support staff to adapt, and ensure good data quality.	• Project plan with regular working group and Executive oversight • System training for all relevant staff • Review of regular risk reports to make use of enhanced reporting functionality • Regular QA of risk information
4. Evaluation of risk management	The Board should be able to demonstrate to stakeholders and regulators that it has effective risk management systems in place. Structured and repeatable means of evaluating the overall effectiveness of risk management will provide assurance to the Board as well as inform continuous improvement and increased risk maturity.	• Risk maturity benchmarking through ALARM • Development of a set of risk management key performance indicators to be monitored by the Audit Committee • Trend analysis of the Trust's overall risk exposure

Priority	Why is it important?	How will it be done?
5. Partnership risk	With changes in the place-based commissioning and partnership arrangements for health and social care coming into effect from April 2022, the Trust will need to ensure a strong understanding of the emerging risks to the organisation and its strategic objectives, as well as contribute actively to the identification and control of risks to shared partnership objectives.	• Proactive contribution to shaping governance and risk management arrangements at ICS level • Regular Board horizon scanning and review of relevant strategic risk intelligence • Regular engagement with legal advisors on ICS and Place governance arrangements

6. Risk Appetite

The Trust recognises that it is impossible and not always appropriate to eliminate all risks. Systems of control must be balanced in order that innovation and the use of limited resources are supported when applied to healthcare. Additionally, the Trust may be willing to accept a certain level of risk when the cost of treating the risk is disproportionately high in comparison to the potential impact and the likelihood of it occurring.

The Board recognises that the long-term sustainability of the Trust depends upon the delivery of its strategic objectives and its relationships with its patients, staff, local community and strategic partners. To be successful, the Trust must take risks, but in a managed way and to a level which is deemed acceptable. The Board sets out its attitude to risk in an annual risk appetite statement, which will act as a point of reference for strategic and operational decision-making.

Risk appetite statement 2021/22 (approved by the Board 25 May 2021)

The risk appetite set by the Board of Directors of Mid Cheshire Hospitals NHS Foundation Trust is necessarily more open than in previous years. This reflects the unprecedented challenges that the NHS has, and is, experiencing, the healthcare reforms taking place at national and local levels, and fast-paced societal and technological changes. In addition, a new Trust strategy is currently being developed by the Board which sets out clear ambitions focused on improving population health outcomes and providing the best healthcare.

During this time of change and increased uncertainty, we will continue to protect the safety of care and minimise risks that have potential to cause harm to people, whether they be patients, staff or visitors.

We acknowledge that the restoration and reconfiguration of services may be challenging as capacity continues to be prioritised across our healthcare system and as we adapt our models of working to the 'new normal'. With this in mind, we will take a cautious approach to risks that may affect the patient experience or that may have a negative regulatory impact.

We have a more open attitude to risk in relation to innovation, finance, and our workforce.

Our strategic plans are underpinned by improvements to our estate and we accept that investing in and managing such programmes carries higher levels of risk.

Investment decisions will reflect our desire to be innovative where the benefits for patients justify risk-taking. The digital agenda will underpin clinical innovation and the drive for services to become more efficient and effective. While we are prepared to accept higher levels of risk to implement changes for longer term benefit, we will ensure that data protection is a priority.

Improving services to ensure their future sustainability will require changes in staffing models and an agile, resilient workforce. We will support our people to adapt and thrive during change.

In recognition of the national policy drive for collaborative working across health and social care systems, we have a risk-seeking approach to partnerships. We will seek the opportunities that healthcare reform may present; we have a keen desire to take a leading role in the collaborative arena and implement new ways of working through a range of partnerships.

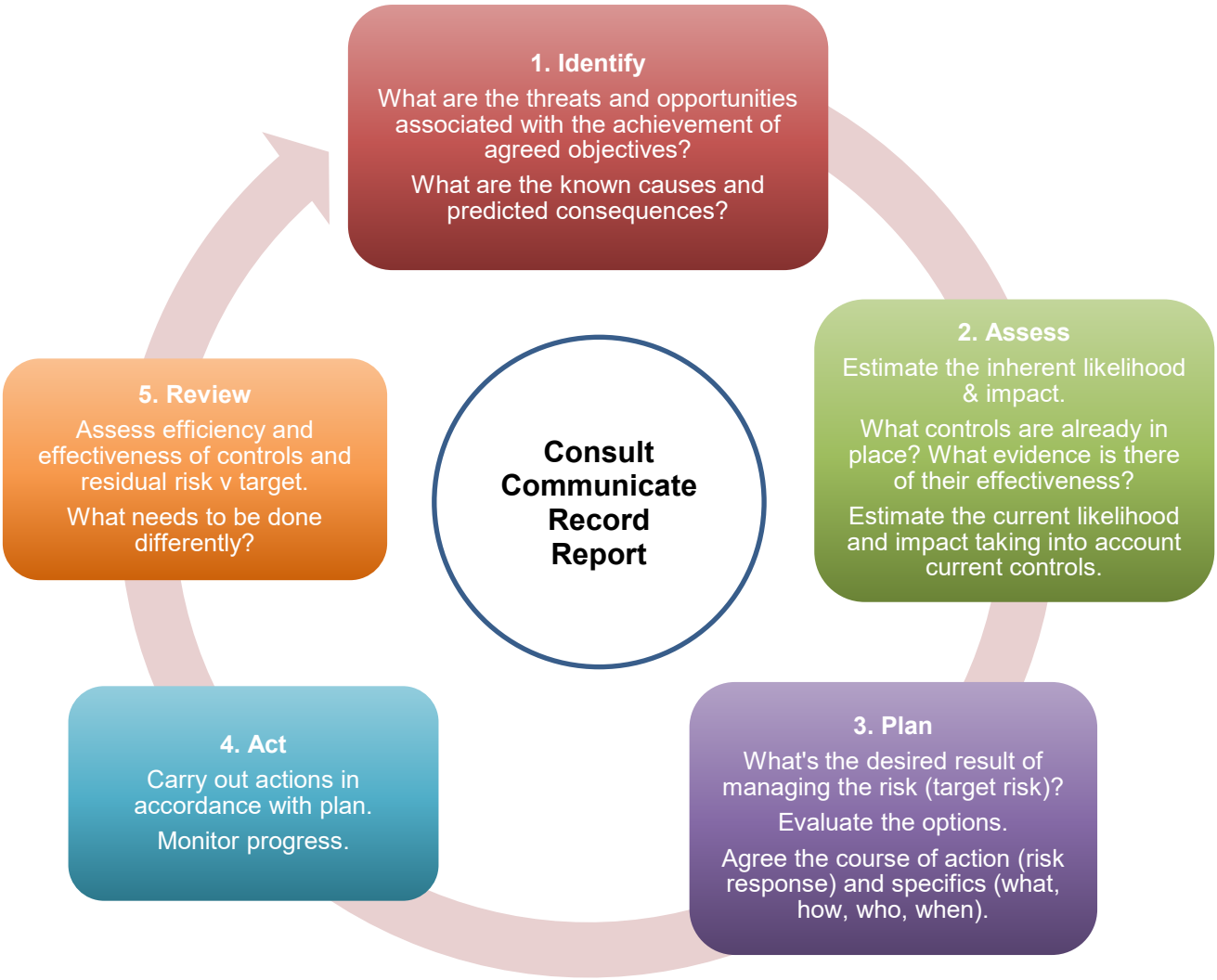
7. Risk Management Process

The Trust's risk management process is embedded at all levels as an integral part of MCHFT's Risk Management Strategic Plan and will be supported by a robust training programme.

Throughout the Trust's hierarchy, there are systems in place to identify, assess and prioritise risks, and develop plans to manage and control them. Risks to which the Trust may be exposed are managed and controlled at an appropriate level within the organisation with scrutiny and oversight provided through the Trust's governance structure (Appendix 1). Decisions relating to the treatment of risks may be escalated through the governance structure in accordance with the Assurance and Escalation Framework.

The methodology for identifying, assessing, recording and treating risks is defined in the Trust's Risk Management Process Guide. The Trust's agreed methodology is used proactively and consistently to:

- identify foreseeable risks,
- ensure they are evaluated and prioritised, taking account of existing control measures,
- identify further action to be taken to manage risks to an acceptable level, and
- review the effectiveness of controls implemented.



Communication and consultation are important at all stages of the risk management process to ensure that the right people are involved at key stages, including identification, assessment, planning and decision-making. The Trust's risk register consists of detailed risk records which are maintained to facilitate the tracking, monitoring and reporting of risks, and are useful sources of assurance about the effectiveness of the Trust's risk management arrangements.

7.1 Risk identification

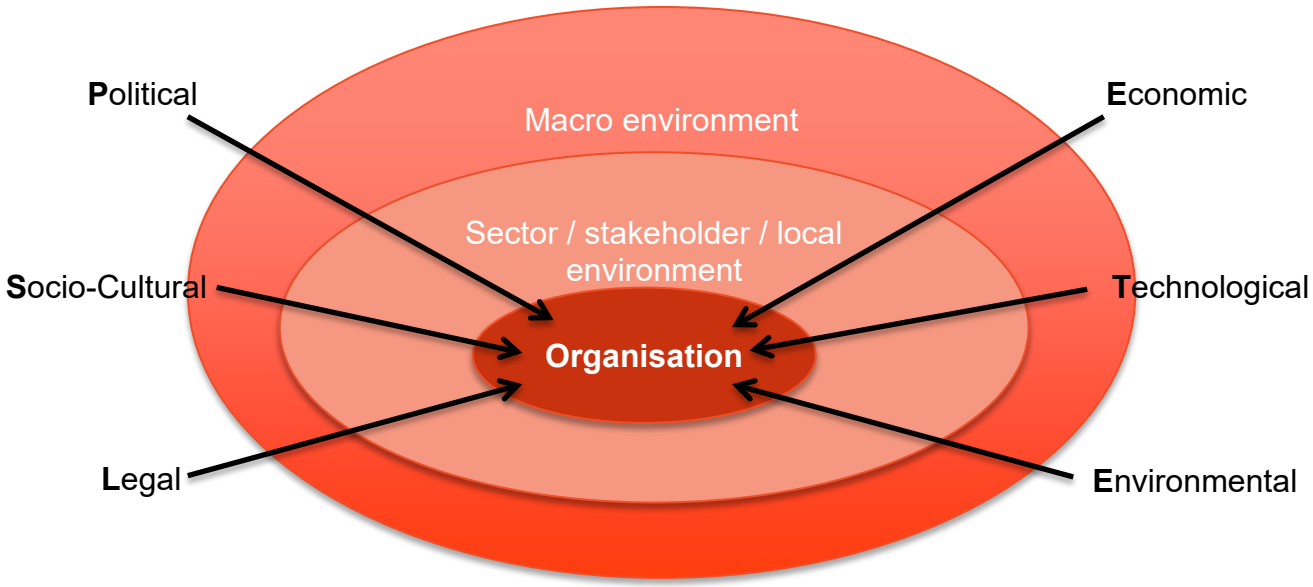
Risks may be identified on a day to day basis by any member of staff, service users, visitors, suppliers, partner organisations, etc. The Trust implements engagement and feedback mechanisms to encourage open communication and to promote a culture of learning. Risks may be identified from a range of different information sources and indicators, and the Trust puts in place systems to aid the early identification and ongoing monitoring of risk.

The following are examples of sources of information about operational risk:

- Incident and near miss reporting
- Incident investigations
- Claims, complaints and concerns
- Consultation with service users and staff
- Patient feedback
- Inspection reports
- Benchmarking
- Peer reviews
- Safety alerts
- Compliance with regulatory targets
- NICE guidelines
- Routine risk assessments
- Performance reporting

Horizon scanning is a method employed to identify, evaluate and adapt to changes and uncertainty in an organisation's operating environment; it is a proactive means of alerting the organisation to emerging risks. As well as identifying potential threats, horizon scanning can identify positive areas for the Trust to develop its business and services, taking opportunities where these arise. The Trust will work collaboratively with partner organisations and statutory bodies to horizon scan and be attentive and responsive to the changing environment.

The Trust will adopt formal mechanisms for horizon scanning as part of its annual business planning process and to inform the development of corporate strategy. Relevant matters will be reviewed in the context of the BAF and may be considered for inclusion in the Trust's strategic risk register and emergency response planning. The approach also considers ongoing risks to services and implications for business continuity arrangements. This means that the Trust will be better placed to respond to changes and uncertainties in a structured and coordinated way. The figure below illustrates a model for scanning the risk landscape using a thematic approach to structure the analysis of relevant information:



The scope of horizon scanning covers, but is not limited to:

- Legislation and regulatory environment
- Government white papers
- Government consultations
- Socio-economic trends
- Trends in public attitude towards health
- International developments
- NHS Improvement/England publications
- Local health economy strategies
- Local demographics
- Stakeholder views
- Innovations in Healthcare
- National and local risk assessments

7.2 Trust risk register

During the first half of 2021, the Trust is migrating all its risk records into a single database. Managerial oversight of individual risks and action plans operates through management reporting lines. Monitoring and reporting of risk is included in the Trust's Assurance and Escalation Framework and is an integral part of the organisation's governance arrangements (see Appendix 2).

The Trust has segmented its risk register into three levels: strategic, corporate, and operational. This enables the Board to take a holistic view of the Trust's risk profile through assessment of risk across the Trust as well as taking a 'bottom-up' perspective from local operational areas. Through the scoring methodology set out in the Risk Management Process Guide, the Board is able to prioritise its attention on those risks that have the greatest potential to impact the Trust's strategic direction.

7.2.1 Strategic risk

The strategic risks are those that are deemed to have a Trust-wide impact with potential to affect one or more strategic objectives. They are agreed annually by the Board and kept under regular review using a Board Assurance Framework (BAF). The BAF is an important component of the Trust's corporate governance and risk management framework. It is a monitoring tool used by the Board to assess the organisation's capacity to achieve its strategic objectives, and to ensure it has appropriate oversight of the Trust's risk profile and key controls. It aids transparency and is used to inform the Annual Governance Statement as a means of monitoring the robustness of the systems of internal control. A properly used BAF will also drive the forward work plan and agendas for the Board and its Committees.

The structure of the BAF has been developed based on the following key steps that reflect the original Board Assurance guidance from the Department of Health[2]:

[2] Department of Health (2003) *Building the Assurance Framework: A Practical Guide for NHS Boards*

- identify a set of high-level risks aligned to the strategic objectives,
- list the mechanisms in place that control each of the risks, and
- identify the sources of evidence that can demonstrate how effectively the risks are being controlled (assurance).

The diagram below shows the alignment between strategic objectives, principal risks, key controls and assurance information.

The information mapped through the BAF allows the Board to question the evidence about the effectiveness of the Trust's key controls.

The Audit Committee, which has responsibility for ensuring that the Trust's risk management framework remains effective, will undertake a review of the BAF process at least annually. The BAF directly underpins the Annual Governance Statement (AGS) and is the subject of annual enquiry by Internal and External Audit.

7.2.2 Corporate risks

Corporate risks are 'big-ticket' risks with potential for cross-cutting impact on operations. They require decision-making and direct oversight at the Executive Director level with reporting to relevant Committees of the Trust Board. A corporate risk may be identified by reviewing groups of operational risks that, when considered in aggregate, represent a higher level of risk exposure for the Trust than the individual risks would suggest when considered in isolation. This enables a coordinated, centralised response to be taken and helps ensure that related and interdependent risks are well understood and have visibility at the appropriate level.

7.2.3 Operational risks

Operational risks are those that are specific to individual areas of the Trust carrying out the day to day activities relating to service delivery. This includes quality and clinical risks as well as those relating to financial management, workforce, estates, etc. Operational risks are assigned to a risk lead and generally managed at a local level with detailed oversight through assurance groups and Executive Groups (EGs). The Executive Risk and Assurance Group has a responsibility for considering the potential impact of operational risk on the Trust's strategic objectives; significant operational risks (those scored as 15 or more) are monitored monthly at meetings of the Risk and Assurance Group.

7.3 System of control – 3 lines of defence

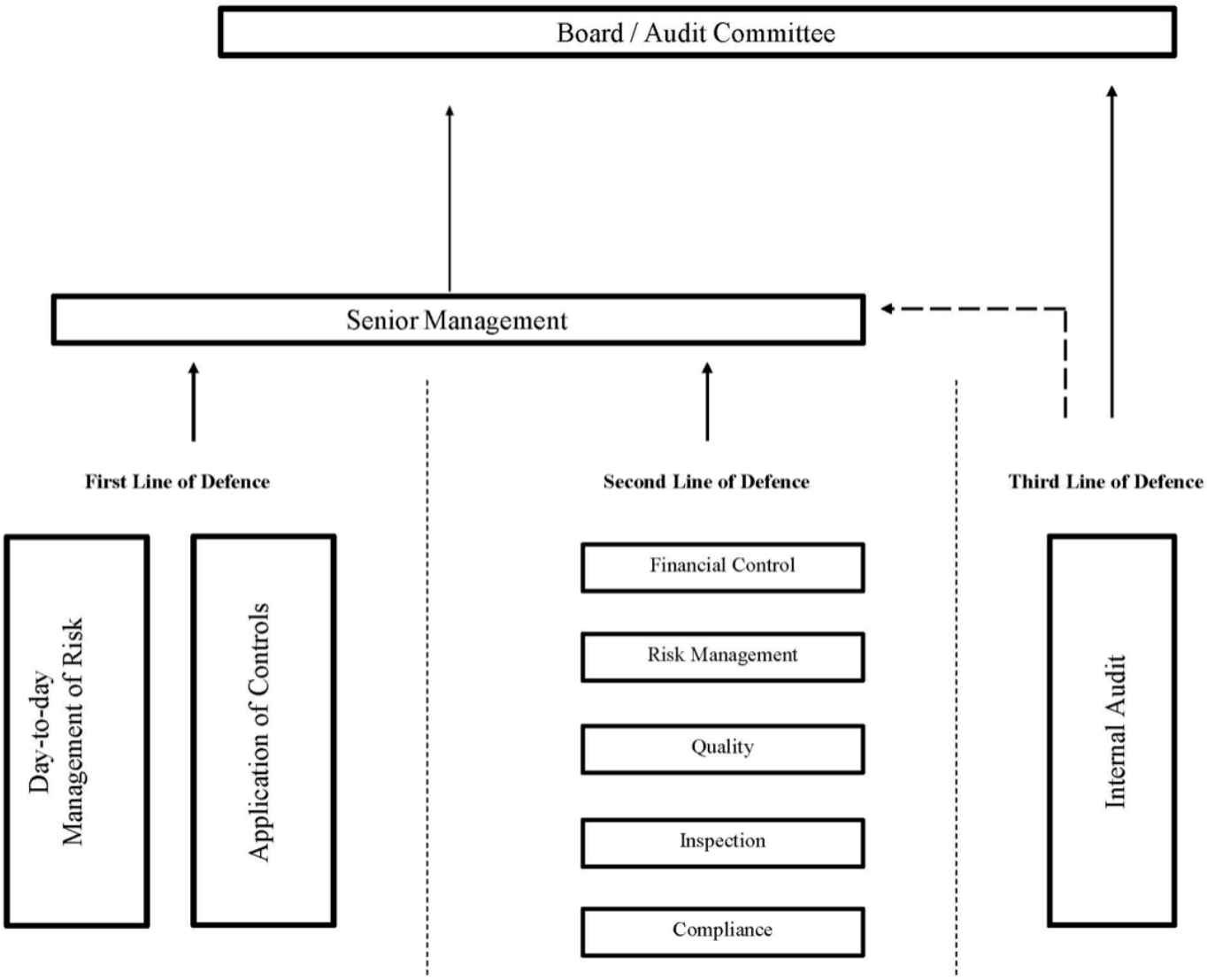
The Trust operates the 'three lines of defence' model in relation to risk management. This means that there are checks and balances in place to ensure that different types of risk are managed robustly across the Trust.

The diagram below illustrates how this works (source: Chartered Institute of Internal Auditors).

The first line of defence are functions that own and manage risk – it is formed by managers and staff who are responsible for identifying and managing risk as part of their accountability for achieving objectives. Collectively they should have the necessary knowledge and skills, information, and authority to operate relevant policies and procedures of risk control.

The second line of defence consists of functions that oversee or who specialise in compliance or the management of specific types of risk – it provides the policies, frameworks, tools, techniques and support to enable risk and compliance to be managed at the first line, conducts monitoring to judge how effectively they are doing it, and helps ensure consistency in the application of risk controls.

The third line of defence are functions that provide independent assurance, for example internal audit. The Trust commissions an annual risk-based programme of internal audit reviews to ensure the first two lines are operating effectively. This provides an evaluation of the effectiveness of risk management and internal controls to the Trust Board.



8. Responsibilities

8.1 Board and Committees

The Board of Directors is ultimately accountable for ensuring that the Trust is complying with the terms of its Provider Licence, which includes its arrangements for integrated governance and effective risk management. The Chairman and Non-Executive Directors exercise a key role for the promotion of risk management through participation in the Trust Board and its Committees. They are responsible for scrutinising systems of governance and for ensuring that the Chief Executive and Executive Directors are held to account for their risk management responsibilities.

The Trust operates a risk monitoring and reporting system to ensure that there is clear ownership of risk at the appropriate hierarchical levels and robust scrutiny and oversight of how risks are managed (see Appendices). The responsibilities in relation to the oversight of risk management for the respective Board Committees are outlined in the table below:

Title	Responsibilities
Audit Committee	The primary function of the Audit Committee is to assess the adequacy and effectiveness of the Trust's systems of integrated governance, the internal control environment and risk management across the whole of the Trust's activities (clinical and non-clinical) both generally and in support of the annual governance statement.
Quality & Safety Committee	The Quality & Safety Committee is responsible for providing the Trust Board with assurance on the standards of quality and safety for clinical care and effectiveness and patient experience, and the implementation of the Trust's risk management strategy in relation to those areas. The Committee oversees and monitors the Trust's compliance with all legal, regulatory and other obligations such as the Trust's compliance with CQC Essential Standards of Quality and Safety.
Remuneration & Nominations	The Remuneration & Nominations Committee is responsible for a range of duties relating to Board (Executive) appointments, remuneration, appraisal and succession planning. The Committee appraises the Board of any risks relating to the recruitment and employment of senior staff, as well as the structure, size and composition of the Board.
Performance & Finance	The Performance & Finance Committee is responsible for the oversight of financial and operational performance and delivery against planned budgets. The Committee ensures all risks related to finance and performance are properly scrutinised and to give oversight to the development of appropriate financial strategy.
Workforce & Digital Transformation Committee	Responsible for providing assurance to the Board in relation to the delivery of the Trust's Workforce Strategic Plan, ensuring delivery of statutory objectives and compliance with legislation. The Committee provides scrutiny of risks relating to the Trust's workforce risks and its capacity and capability to deliver the Trust's objectives. In addition, this Committee has oversight of the Trust's Digital Transformation initiatives and monitors assurances that relevant risks are managed effectively.

Title	Responsibilities
Charitable Trustees	Delegated authority from the Board of Directors to oversee that the Charity is administered effectively and its spending is in accordance with the objectives set by the Board/Corporate Trustees.

8.2 Executive Leadership

The Chief Executive has overall responsibility for risk management and for ensuring that the Board is appraised of the most significant risks relating to the Trust's operations and strategic objectives. The Chief Executive delegates to Executive Risk Leads responsibility for managing risk pertaining to their individual portfolios. This involves working with specialist corporate functions as appropriate to ensure that all types of risk identified within their portfolios are properly assessed and managed, for example quality, clinical, workforce, budgetary, maintenance, safety, etc.

The following Executive Groups (EG) are responsible for providing oversight and scrutiny of risk within their span of control and providing advice and assurance to Board Committees and the Executive Risk and Assurance Group as summarised in the reporting diagram in Appendix 2:

- Safe & Sustainable Environment
- Performance & Delivery
- Quality Governance
- Workforce Assurance
- Digital, Technology & Information Services

At the operational level, each Division and corporate function should have in place a reporting structure responsible for overseeing the management of risks identified within their specialist areas. Significant risks (scoring 15+), and those scored below 15 that have a wider impact on the Trust or cannot be controlled at the operational level, are escalated to the relevant EG for review and decisions about appropriate risk treatment. The terms of reference for the Executive Risk and Assurance Group outline its responsibility for considering the potential impact of operational risk on the Trust's strategic objectives. To facilitate the discharge of this duty, it receives reports on a monthly basis, which summarise key matters relating to significant operational risk alongside the BAF risks for each strategic objective.

The following table outlines specific risk management roles assigned to individual executives:

Title	Responsibilities
Chief Executive	Overall responsibility for risk management. This includes: • ensuring that employees and the public are properly protected against exposure to risks arising out of or as a result of the Trust's activities, and • ensuring that the appropriate arrangements are in place to manage risks within the organisation. As Accounting Officer[3], the Chief Executive has responsibility for maintaining a sound system of internal control that supports the achievement of the Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets. The Chief Executive is also responsible for ensuring that the Trust is administered prudently and economically and that resources are applied efficiently and effectively. The Chief Executive signs the Annual Governance Statement in the Annual Report and Accounts on behalf of the Board.
Medical Director	Nominated by the Chief Executive as the Executive Director responsible for the management of risk relating to clinical effectiveness, clinical governance, patient safety, research & development and professional responsibility for medical practice within the Trust. The Medical Director is also responsible for developing and implementing the systems and processes for clinical risk management and ensuring a risk-based approach to patient safety. The Medical Director is nominated Caldicott Guardian with responsibility for the safety of patient data.
Director of Nursing & Quality	Nominated by the Chief Executive as the Executive Director responsible for the management of risk relating to quality improvement, patient experience, safeguarding vulnerable adults & children as well as professional responsibility for nursing and allied health professionals.
Deputy CEO/Director of Finance	Nominated by the Chief Executive as the Executive Director responsible for the management of risk relating to systems of financial control, standards of business conduct and counter fraud, financial governance and associated risks. The Director of Finance is also the lead Director responsible for the management of risk relating to health & safety as well as the hospital's physical environment. The Director of Finance is nominated Senior Risk Information Officer (SIRO) with responsibility for ensuring that information risk is managed appropriately and effectively across the organisation and for any services contracted for by the organisation.
Chief Operating Officer	Nominated by the Chief Executive as the Executive Director responsible for the management of risk relating to organisational operational issues, lead for service improvement and transformation across the Clinical Divisions as well as emergency preparedness, resilience and response.

[3] NHS Foundation Trust Accounting Officer Memorandum

Title	Responsibilities
Director of Workforce & OD	Nominated by the Chief Executive as the lead Director responsible for the management of risk relating to the Trust's workforce, employer responsibilities and associated policies.
Chief Information Officer	Nominated by the Chief Executive as the lead Director responsible for the management of risk relating to information technology, information governance risk assessment and management processes.
Director of Strategic Partnerships	Nominated by the Chief Executive as the lead Executive responsible for the management of risk relating to operational issues, service improvement and transformation across community and Integrated Care Partnership hosted services.[4]
Company Secretary	Responsibility for all corporate governance arrangements that might affect the Trust to ensure that the Board is fully briefed on these matters and has regard to them when taking decisions. Lead officer for the Risk Management Framework with responsibility for developing the Trust's Risk Management Strategic Plan, Process Guide, and Board risk and assurance reporting processes e.g. the BAF.

8.3 Third Party Organisations

The way organisations work together to deliver place-based health and social care is changing. The management of risk across organisational boundaries is complex and creates its own challenges where it can be difficult to ascertain clarity about responsibilities and accountabilities for those risks. Mid Cheshire NHS FT will play a key role in a range of partnerships and will support the establishment of a common set of principles for managing risk across the Integrated Care Systems. Risk management will be integral in governance arrangements set in place for all partnerships with other organisations. Relevant risks identified by the Trust will be documented and shared with partner organisations. Likewise, the Trust expects that any relevant risks identified by partners will be shared with the Trust.

9. Evaluation and Review

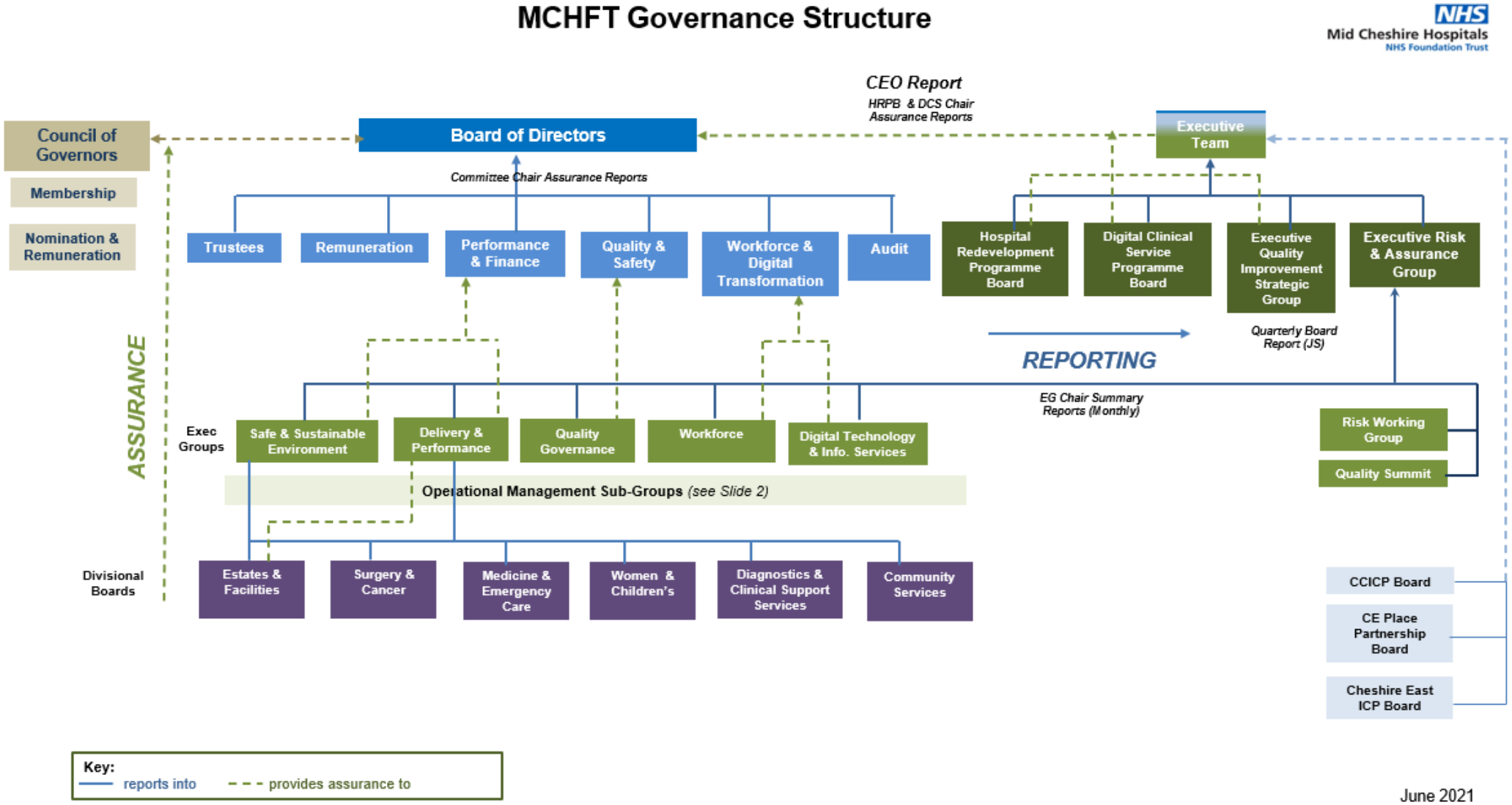
This Strategic Plan will be reviewed at least every three years, taking into account changes in the Trust's operating context, progress in implementing the priorities identified, and evidence of compliance with the Trust's Risk Management processes. In addition, analysis of the Trust's risk registers will be used to evaluate how risks have been managed across the Trust and understand how effectively current risk management arrangements have been implemented. Feedback from risk practitioners will be sought to update guidance for staff and to inform future training plans.

The Trust will undertake a regular risk maturity assessment to obtain a structured view of the adequacy of the components of its Risk Management Framework. This will inform the setting of future goals for evolving the Trust's risk management arrangements and improving consistency of practice across all areas.

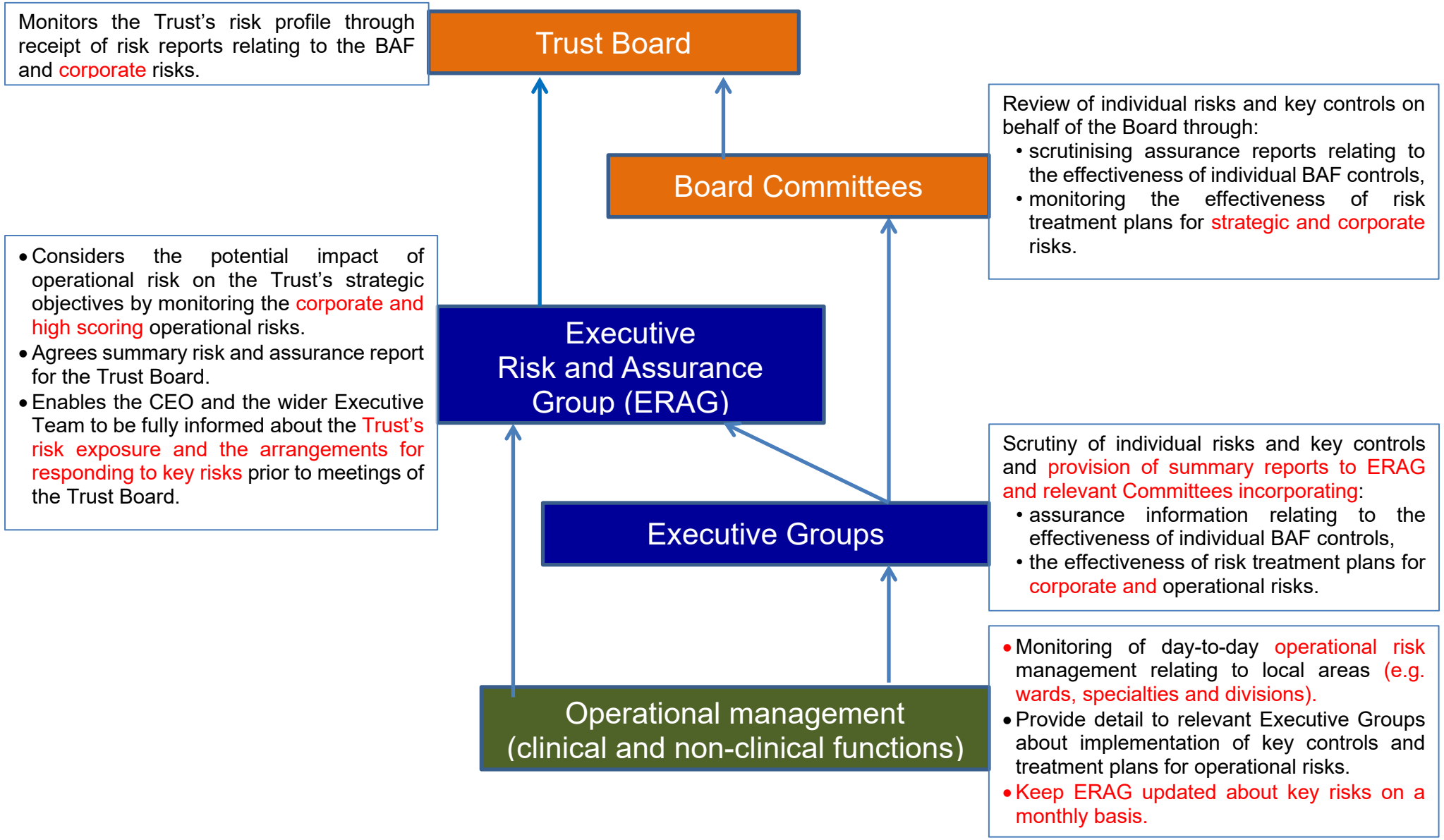
[4] The Director of Strategic Partnerships reports to the CEO on these areas through the Central Cheshire Integrated Care Partnership, hosted by the Trust

Appendix 1:

MCHFT Governance Structure



Appendix 2: Risk monitoring and reporting



NHS
Mid Cheshire Hospitals
NHS Foundation Trust

Equality Impact Assessment

Please read the Guide to Equality Impact Assessment before completing this form.
The completed assessment is to form part of the policy/proposal/business case appendices when submitted to governance-policies@mcht.nhs.uk for consideration and approval.

POLICY/DOCUMENT/SERVICE…Risk Management Strategic Plan…

SECTION A

A	Does the document, proposal or service affect one group less or more favourably than another on the basis of:	Yes/ No	Justification & data sources. Include nature of impact. Also record provisions already in place to mitigate impact.
1	Race, ethnic origins (including gypsies and travellers) or nationality	No	
2	Sex	No	
3	Transgender	No	
4	Pregnancy or maternity	No	
5	Marriage or civil partnership	No	
6	Sexual orientation including lesbian, gay and bisexual people	No	
7	Religion or belief	No	
8	Age	No	
9	Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
10	Economic/social background	No	
B	**Human Rights – are there any issues which may affect human rights**		
1	Right to Life	No	
2	Freedom from Degrading Treatment	No	
3	Right to Privacy or Family Life	No	
4	Other Human Rights (see guidance note)	No	

Date…010721 …….. Name…Caroline Keating

Signature  **Job Title…..Company Secretary**

Where an impact has been identified in Section A, please outline the actions that have been agreed to reduce or eliminate risks in Section B.
If there are no impacts identified in Section A, completion of Section B is not necessary.

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**16**	Date of Meeting: 29/07/2021
Report Title	**Modern Slavery Act Trust Statement**	
Executive Lead	Heather Barnett, Director of Workforce & OD	
Lead Officer	Ian Howarth, Workforce 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)*

- Proposed statement is compliant with Trust's obligations in respect of the Modern Slavery Act 2015 with strengthened wording
- Paper and associated recommendations have been shared with Procurement as part of the evaluation
- Improvements identified to raise staff awareness in respect of Modern Slavery regarding how and where to flag any concerns

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

- Revised Modern Slavery Act Trust Statement to be published on the Trust website
- Actions to be followed through with Procurement and Freedom to Speak up Guardian

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

• Provide safest and best care	☐	• Be the best place to work	✓
• Become a leading and sustainable health care system	☐	• Push boundaries in clinical, technology and digital innovation	☐

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

• Quality	☐	• Compliance	✓
• Finance	☐	• Legal	☐
• Workforce	✓	• Risk/BAF **BAF9 Leadership and organisational culture**	
• Equality	✓		

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

Strategy ☐ Policy ☐ Service Change ☐

Mid Cheshire NHS FT

REPORT DEVELOPMENT

Committee/ Group Name	Date	Report Title	Lead	Brief summary of key issues raised and actions agreed
WDT	18-05-2021	Modern Slavery Act (viewed within context of annual ED& Human Rights report)	Heather Barnett	Strengthening of wording to move the Trust's position from 'we aim to' to 'We ensure' Agreed to take forward to Board on basis of acceptable assurance

Modern Slavery Act Trust Statement

Introduction

1. Section 54 of the Modern Slavery Act 2015 requires organisations such as NHS Trusts to have (and review annually) a modern-day slavery and human trafficking statement. This statement sets out what steps the organisation takes to ensure modern slavery is not taking place in their business or supply chains.

2. Employers must act responsibly and adopt a robust approach in respect of eradicating and mitigating against slavery and human trafficking. This includes an obligation to inform the Home Office should the Trust ever have any concerns around Modern Slavery in respect of our corporate activities and provision of healthcare services.

3. All obligations on the Trust through the Modern Slavery Act extend beyond our immediate substantive workforce and reach right through our procurement processes, supply chain and partners.

4. The Trust's current Modern Slavery Act Trust Statement is publicly accessible through the Trust website. (https://www.mcht.nhs.uk/about-us/reports-and-publications/modern-slavery-act/). This paper puts forward a revised statement that confirms Trust compliance more strongly than the current version.

Current position

5. An annual review has been undertaken by the Trust Equality Diversity & Inclusion Team. The review was undertaken in accordance with an Employers Guide from Personnel Today which requires consideration to be given to each aspect of the statement. This was reviewed by Workforce and Digital Transformation Committee in May.

6. In preparing this review and associated recommendations, similar statements from neighbouring NHS provider organisations were considered including evaluating best practice from other public sector organisations including this proactive approach by Stoke City Council. (https://www.stoke.gov.uk/directory_record/333552/modern-day_slavery_and_human_trafficking_statement/category/19/your_council_your_city)

7. The Head of Procurement has supported this review and confirmed:
   - Any significant award of business follows Trust Standing Financial Instructions and uses a national framework which has Modern Slavery due diligence embedded within it by the framework creator
   - Where the Trust undertakes its own tenures, Modern Slavery is referenced within terms and conditions which suppliers must accept before an award is made
   - Gathering / obtaining Modern Slavery statements and public commitments from suppliers is not currently requested on supplier set up. This will be addressed as part of the work being undertaken to improve the Trust's contracting arrangements.

Review Outcomes

8. Key findings from the review are outlined overleaf:

- The Trust's current Modern Slavery Act statement is compliant with its obligations under Section 54 of the Modern Slavery Act; however, the wording reflects a future state rather than current compliance and this should be addressed
- Examples of Modern Slavery are included in Freedom to Speak Up (FTSU) awareness and training content
- Examples of Modern slavery are included in the Trust's whistleblowing policy to help provide context around the type of scenarios colleagues should consider appropriate for raising through that policy
- Two recommendations for change are highlighting links to relevant employment policies and also the provision of training and awareness programmes. Neither of these are deemed essential for compliance, but are evidence of best practice
- Discretionary spend outside of any formal Trust tender process cannot be governed and, therefore, poses a risk in terms of potential exposure around modern slavery within the Trust's supply chain, albeit typically for one-off engagements i.e. training providers.

9. The above points were taken into consideration for the revised Trust Statement and this is attached at Appendix 1. The revised Statement addresses the points raised by the WDT Committee and provides the Board with a stronger compliance position.

Next Steps

10. The following steps will be taken to ensure Trust compliance with the Modern Slavery Act 2015 continues to be strengthened:

- Procurement will seek individual supplier validation of their Modern Slavery Statement as part of any Trust tender
- Relevant employment links will be included within the statement
- Statement to be supported by the articulation/pictorial representation of major supply chains
- Standards of business conduct to be reviewed and a direct reference to Modern Slavery to be included

Recommendation

11. The Board is asked to:

- note compliance with the Trust's obligations in respect of the Modern Slavery Act
- approve the Modern Slavery Act Statement for subsequent publication on the Trust website

Author: **Ian Howarth**
Date: **July 2021**

Appendix 1

Proposed Modern Slavery Trust Statement

Introduction

This statement sets out the steps that Mid Cheshire Hospitals NHS Foundation Trust has taken, and is continuing to take, to ensure that modern slavery or human trafficking is not taking place within our business or supply chain.

About the organisation

Mid Cheshire Hospitals NHS Foundation Trust (MCHFT) provides good quality, safe and effective healthcare to the people of Cheshire and beyond.

The Trust, which manages Leighton Hospital in Crewe, Victoria Infirmary in Northwich, and Elmhurst Intermediate Care Centre in Winsford, was established as an NHS Trust in April 1991 and became a Foundation Trust in April 2008.

It employs nearly 5,000 members of staff, has around 540 hospital beds, and provides a range of services including emergency and elective care service, intermediate care and maternity services.

The Trust is also part of Central Cheshire Integrated Care Partnership (CCICP), a local health partnership that provides a range of community health services for people across South Cheshire and Vale Royal.

Our policies on slavery and modern trafficking

We are aware of our responsibilities towards patients, service users, employees and the local community and expect all suppliers to the Trust to adhere to the same ethical principles. We are committed to ensuring that there is no modern slavery or human trafficking in our supply chains or in any part of our business. Any identified concerns would be escalated as part of the organisational safeguarding process and in conjunction with partner agencies, such as the Local Authority and Police.

We operate a number of internal policies and processes to ensure that we are conducting business in an ethical and transparent manner. These include:

- **Recruitment policy** – we operate a robust recruitment policy which includes conducting employment checks for all directly employed staff and staff employed on our temporary staffing Bank. This adheres to the national NHS Employment Check Standards which includes Identity and Right to Work checks, suitable references, Disclosure and Barring checks and Occupational Health clearance. Additionally, Trust Executive Directors are assessed against the Fit and Proper Person Regulations to ensure they are compliant prior to taking up their positions. Where agencies are used, these are via the approved frameworks which are audited to provide assurance that pre-employment clearance has been obtained, to safeguard against human trafficking or individuals being forced to work against their will.
- **Equal opportunities** – we have a range of controls to protect staff from poor treatment and/or exploitation, which complies with all respective laws and regulations. These include fair pay rates and terms and conditions and access to training and development opportunities.

- **Training** – reference is currently made to slavery and modern trafficking within the Trust's Mandatory Safeguarding programmes. Examples of Modern Slavery are included in Freedom To Speak Up (FTSU) awareness and training content
- **Safeguarding policies** – audits are undertaken for safeguarding referrals. In addition, we adhere to the policies in our safeguarding policies and provide clear guidance so that our employees are clear on how to raise safeguarding concerns.
- **Whistleblowing policy** – we operate a whistleblowing policy so that employees are aware that they can raise concerns without fear of reprisals. Additionally, we give our employees a platform to raise concerns about poor working practices via the Trust Grievance, Complaints and Disputes (staff) incorporating Dignity at Work policy and procedure. We have a Freedom to Speak up Guardian who supports staff to speak up when they feel they are unable to do so through other routes.
- **Standards of business conduct** – this explains the manner in which we behave as an organisation and how we expect our employees and suppliers to act.
- **Contract management** – NHS Standard Contract Terms and conditions include specific clauses relating to the Modern Slavery Act and associated Guidance. The Trust, as a provider of healthcare services, is committed to adhering to these for all main acute and community services. When offering sub-contract arrangements for any of these services, these also align to the same conditions.

We will:

- Include modern slavery conditions or criteria in specification and tender documents wherever possible
- Evaluate tenders based on modern slavery commitments
- Not award contracts where suppliers do not demonstrate their commitment to ensuring slavery and human trafficking are not taking place in their own business or supply chains
- Expect supply chain/framework providers to demonstrate compliance with their obligations in their processes
- Ensure that employees liaise with the Procurement department when looking to work with new suppliers so appropriate checks can be undertaken

This statement is made pursuant to Section 54(1) of the Modern Slavery Act 2015 and constitutes our organisations modern slavery and human trafficking statement for the 2018/19 financial year.

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**CONSENT 1**	Date of Meeting: 29/07/2021
Report Title	Guardian of Safe Working Hours Report (Q1)	
Executive Lead	Heather Barnett, Director of Workforce and OD	
Lead Officer	Douglas Robertson, Guardian of Safe Working Hours	
Action Required	To note	

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

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

- Junior doctor contract exception reporting rates remain low despite severe workload pressures.
- Actions to specifically promote exception reporting are being put in place.

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

- Broader steps to engage and support junior doctors under pressure are being discussed

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

• Provide safest and best care ☐	• Be the best place to work ✓
• Become a leading and sustainable health care system ☐	• Push boundaries in clinical, technology and digital innovation ☐

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
N/A				

Mid Cheshire Hospitals NHS FT

Report from the Guardian of Safe Working Hours

1st April 2021 – 30th June 2021 (Q1)

1. Introduction

This is a report to the Board on progress with the 2016 junior doctors contract and the work of the Guardian of Safe Working Hours (GoSWH), who is required to provide it on a quarterly basis summarising exception reports made, fines levied, and ensuring that the Trust take appropriate action to address any issues identified.

2. Exception Reporting

Exception reporting is a contractual mechanism for junior doctors in training to report unsafe working practices and loss of training opportunities. This mechanism enables junior doctors to report patient safety, rostering and educational concerns which should be dealt with in the required timescales.

Q1: From **1st April to 30th June** there were only **2** exception reports submitted. One was related to missed educational opportunities for a Foundation Year 1 (FY1) trainee in Surgery. The other was also from an FY1, unable to leave promptly in Medicine. **No fines were levied in this period**.

A trainee's Educational Supervisor is required to respond to exception reports within 7 days of a submission, in order to review and discuss the reasons with the trainee. This occurred for one of these reports. The other is outstanding after 4 weeks.

The most common outcome is time off in lieu (TOIL) or payment for hours worked if not possible. However, trainees find it hard to take TOIL under sustained workload pressure, and missed training is often impossible to recover. Juniors comment that exception reporting is 'not worth the trouble'.

3. Current Position

There are over 150 training grade posts on 2016 Terms and Conditions of Service (TCS). There have been historic challenges to fully staff rotas for Junior Doctors which continue on both Medical and Surgical wards, despite the use of nurse practitioners and physician associates, and exacerbated by exceptionally high workload during and after the various waves of the pandemic. The very low number of exception reports received, has raised concerns that this process does not function well, and there might be a culture of under-reporting.

4. GoSWH Actions in 2020-21

To address any systematic under-reporting and still to be aware of potential areas of concern the following actions have already been taken:

1. Individual emails to thank trainees, inviting informal feedback of concerns.

2. The GoSWH and Director of Medical Education (DME) promoted exception reporting at Induction in August 2020 to the new trainees. At the same time Educational Supervisors were reminded of the process and timelines of exception reporting by email. This was repeated in February 2021.

3. To improve trainee engagement, a more representative quarterly Junior Doctor Forum meeting was formally relaunched, so that the Guardian is kept informed of concerns by trainee representatives and discusses them with appropriate service managers and lead clinicians. Initially well-attended, this has not been quorate in recent meetings.

4. A programme of raising awareness of exception reporting was carried out by the Mess President and BMA trainees representatives supported by the Guardian from July 2020, including three waves of surveys, most recently in March 2021. They have raised concerns about persisting poor morale and poor motivation to submit exception reports, particularly with the Foundation trainees. They have followed on with a further program to encourage trainees to report hours of work concerns but have asked the GoSWH for support in improving the responsiveness and assisting improving trainee confidence in the system.

5. Further actions considered to improve confidence with exception reporting:

    - Continue to use the Junior Doctor Forum as an opportunity for making their voices heard.
    - Re-launching exception reporting for trainees with positive messages from GoSWH and DME at every induction and at each rotation between clinical supervisors.
    - Ensuring better access to computers or a phone app to allow timely exception reporting.
    - Awareness raising of educational and clinical supervisors to emphasise need for signing off reports promptly. Educator training days were paused in 2020 but are being restarted.
    - Encouraging service managers and clinical leads in Medicine & Surgery to ensure Foundation trainees' self-directed learning time is explicit in rotas.
    - Suggesting when TOIL is awarded, that rota coordinators formally record it and when it is taken, as currently done for annual leave, to identify pressures that prevent taking TOIL.
    - Schwartz Round type 'Team Talks' to give an opportunity for junior doctors to discuss work pressures and support each other with facilitation.

5. Conclusions & to note.

This is the seventeenth quarterly report by the Guardian of Safe Working Hours. The Trust continues to take steps to implement the 2016 contract and its amendments for junior doctors in training.

In 2020, there was a marked reduction in exception reporting in the first wave of Covid19 admissions. This was not apparent in other Trusts, so a culture of under-reporting at Mid Cheshire was suspected. Feedback was sought by review of subsequent exception reporting and trainee survey and identified issues related to trainee confidence in the Trust's ability to respond to exception reports.

Particular areas of concern from trainees include difficulty in integrating new Foundation educational requirements into rotas and persisting heavy and fragmented workloads on the wards, leading to isolation and risk of burnout.

The GoSWH has discussed these themes and concerns with the relevant clinical and service managers, with the Director of Workforce and OD, Director of Medical Education, Foundation Lead and Deputy Medical Director. Some of these can addressed with the Trust's overarching Health & Wellbeing strategy but demonstrating responsiveness to workload and education concerns through effective exception reporting, service managers ensuring jobs are not fragmented or impossibly busy, access to support on the wards and responsive informal communication needs to continue.

Douglas Robertson
Guardian of Safe Working Hours 19.07.21

BOARD OF DIRECTORS

Agenda Item	**CONSENT 2**	Date of Meeting: 29/07/2021
Report Title	**Use of the Trust Seal**	
Executive Lead	Russ Favager, Deputy Chief Executive and Director of Finance	
Lead Officer	Andrew Deakin, Head of Capital Development	
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)*

- Request to use the Trust Seal for three contracts:
  - Works for RAAC Project at Leighton Hospital
  - Deed of Variation for Renal services car parking spaces
  - Licence to occupy rooms at Alderley Edge GP Practice for Dermatology Services

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

- To affix the seal to the contracts prior to signing in accordance with the SFIs

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

• Provide safest and best care ☐ • Become a leading and sustainable health care system ☐	• Be the best place to work ☐ • Push boundaries in clinical, technology and digital innovation ☐

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

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

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 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 Document – Form of Agreement by Deed

Title of Document – Form of Agreement by Deed between Mid Cheshire Hospitals NHS Foundation Trust and Willmott Dixon Construction Limited.

Reason for Trust Seal – Engrossment of a Form of Agreement by Deed detailing the Works Encompassing the RAAC Project at Leighton Hospital, Crewe.

Number of copies to be sealed – Two copies of the Form of Agreement by Deed.

The seal is to be applied to – Page 4 (numbered 3)

Parties to Agreement - The parties are Mid Cheshire Hospitals NHS Foundation Trust and Willmott Dixon Construction Limited.

Value – £19,016,984.00

Andrew Deakin
Head of Capital Development

Date: 19th July 2021

To be completed by Trust Secretary

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

Seal Applied *(date)*_____

Seal Number _____

Mid Cheshire Hospitals 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 Document – Deed of Variation

Title of Document – Deed of Variation between Mid Cheshire Hospitals NHS Foundation Trust and Fresenius Medical Care Renal Services Limited relating to premises at Leighton Hospital.

Reason for Trust Seal – Engrossment of a Deed of Variation detailing the change in car parking allocation for the Renal Unit.

Number of copies to be sealed – One copies of the Deed of Variation

The seal is to be applied to – Page 5

Parties to Agreement - The parties are Mid Cheshire Hospitals NHS Foundation Trust and Fresenius Medical Care Renal Services Limited.

Value – N/A

Andrew Deakin
Head of Capital Development

Date: 14th July 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

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 Document – Licence to Occupy

Title of Document – Licence to Occupy between Mid Cheshire Hospitals NHS Foundation Trust and Dr V.J.Taylor, Dr P.G.Speake, Dr H.L.Hayes, Dr T.G.J.Hunsley, Dr A.A.T.Garvey & Dr L.Vital relating to premises at Alderley Edge Medical Practice, Alderley Edge Medical Centre, Alderley Edge.

Reason for Trust Seal – Engrossment of a Licence to Occupy detailing the use of treatment rooms at Alderley Edge Medical Practice by the East Cheshire Dermatology Service.

Number of copies to be sealed – One copies of the Licence to Occupy.

The seal is to be applied to – Page 14

Parties to Agreement - The parties are Mid Cheshire Hospitals NHS Foundation Trust and Dr V.J.Taylor, Dr P.G.Speake, Dr H.L.Hayes, Dr T.G.J.Hunsley, Dr A.A.T.Garvey & Dr L.Vital.

Value – £3,510 per annum.

Andrew Deakin
Head of Capital Development

Date: 14th July 2021

To be completed by Trust Secretary

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

Seal Applied *(date)*_____

Seal Number _____