Mid Cheshire Hospitals NHS Foundation Trust

Board of Directors

Thursday 28 October 2021, 9.30am
Virtual (Teams) Meeting

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 – 30 September 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)** • Well Led Development Review Final Report - Executive Summary (d) • Council of Governors October 2021 Meeting Review To note
6 10:00	**BAF 11&12**	**Chief Executive's Report (d)** Chief Executive • Hospital Redevelopment Programme Board – 14 October 2021 (d) To note
7 10.20		**Board Assurance Framework Report Q2 2021/22 (d)** Chief Executive To note

No	BAF Risk	Item
8 10.30		**Integrated Performance Report Month 6 - (September 2021) (d)** Chief Executive To note
STRATEGY		
9 10.30		**Trust Strategy 2021-2026 (d)** Chief Executive To approve • Trust Strategy Progress Report Q2 2020/21 (d) Chief Executive To note
QUALITY - Patient Safety, Clinical Effectiveness & Patient Experience		
10 10:50	**BAF3**	**Quality & Safety Committee Chair's Assurance Report - 20 October 2021 (d)** Committee Chair To note • **Nursing and Midwifery Staffing Report (d)** Director of Nursing & Quality To note • **Serious Incidents Report (d)** Medical Director To note • **Learning from Deaths Report Q2 2021/22** Medical Director To note
PERFORMANCE & FINANCE		
11 11:15	**BAF7,11 &12**	**Performance & Finance Committee Chair's Assurance Report - 21 October 2021 (d)** Committee Chair To note
WELL LED		
12 11:30	**BAF2, 10, 13 & 14**	**Workforce & Digital Transformation Committee Chair's Assurance Report – 18 October 2021 (d)** Committee Chair To note

No	BAF Risk	Item

13 11:45
Freedom to Speak up Guardian Report Q2 2021/22 (d)
Freedom to Speak Up Guardian
To note

14 11.55
Audit Committee Chair's Assurance Report – 7 October 2021 (d)
Committee Chair
To note

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

- **BAF3** **Guardian of Safe Working Hours Report Q2 2021/22**

CONCLUDING BUSINESS

15 12:10
Any Other Business (v)
Chair
To consider any other matters of business

16
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

17
Key Messages from the Board (v)
Chair
To agree

Resolution

The Board is asked to resolve that in accordance with Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960, representatives of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudiced to the public interest.

consultOne
expertise . insight . improvement

Well-Led developmental review

Mid Cheshire Hospitals NHS FT

Executive Summary

October 2021

Introduction

The aim of this review was to assess the leadership and governance of the Trust as described in the Developmental reviews of leadership and governance using the well-led framework: guidance for NHS Trusts and NHS Foundation Trusts June 2017 and identify developmental actions to inform further targeted development work by the Trust to secure and sustain the Trust's future performance as part of continuous improvement.

We undertook the review in line with the well-led framework and considered existing and planned practice against the eight domains of the framework:

1. Leadership capacity and capability
2. Vision and strategy
3. Culture and engagement
4. Governance
5. Risk and performance management
6. Information, data and reporting
7. Stakeholder engagement; and
8. Innovation, learning and improvement

Our report is structured around the eight domains described above with each section detailing existing good practice, our findings and further developmental areas.

This was the first review undertaken by the Trust under the auspices of the Well Led Framework: guidance for NHS Trusts and NHS Foundation Trusts June 2017. The timing of the review was opportune in that the Trust is currently refreshing its strategy which allowed us to review the approach undertaken to date.

In other ways the timing was less opportune as the Trust is still to return fully to business as usual governance arrangements following the pandemic. Where necessary, we have taken account of this although equally there are instances where we feel that the Trust can and should return to 'business as usual' sooner or acknowledge the longer term nature of the pandemic impact and regularise new ways of working which allow oversight and governance to operate effectively.

Within the report we have set out areas of existing strength and areas for the Trust to consider focussing development on within the framework of being Well-Led.

Overview – summary of findings

Leadership Capacity and Capability

We found clear evidence and focus on compassionate leadership with a strong profile for staff health and wellbeing. Leadership has continued to move forward and develop strategically during COVID-19 including major commissions such as development of a new organisational strategy and a Strategic Outline Case for a new build hospital on the main Trust site.

Board members individually are credible with a good range of skills and experience with executives gaining experience of operating beyond their professional portfolios. However, as a whole we believe there is greater value to be unlocked from the Board.

Looking forward, the Trust recognises, and we share concerns, regarding the capacity of executives to maintain the pace and momentum over an extended period as expectations rise in relation to the recovery agenda and return to business as usual from a regulatory requirement perspective alongside continuing operational pressures.

Vision and Strategy

The Trust is in the process of refreshing its strategy with the new strategy pivoting its focus to ensure that the local population and their needs are central. The strategy headlines have been very well received both internally and externally and futureproofs the Trust's role in the move towards system and place-based working. There is now work to do to demonstrate wider ownership of the strategy and build out from the headlines into a fully formed strategy including deployment and engagement plans.

The timing of the new strategy and business case for the new hospital build appears to be causing some confusion as to the strength of reliance upon each other. It will be important for the Trust to clarify what, if any, elements of the strategy are reliant on the new build, given the nature of delays in NHS capital funding and approvals processes. This will help staff and stakeholders understand the impact on the organisation's strategy.

Organisational Culture

Organisational culture and the positive profile of this featured highly in our discussions and in interactions with the Trust. Feedback was consistent regarding the Trust being a 'great place to work' and the 'family feel' of the Trust along with the size of the Trust meaning that 'it's small enough to care'. We would also concur that, having spent time onsite during the course of our review, there is a positive and authentic feel to the Trust.

The values of the Trust were equally apparent and consistent throughout our interactions with the Trust. Recurring themes in discussions were reference to patient outcomes, population health and making the right decisions for patients.

Roles and System Accountabilities

In terms of the Council of Governors, we recognise that the Trust is in the midst of revising the ways of working for the group. Having reviewed the proposals and observed a recent Council meeting, we agree with the direction of travel and the detail within the proposals. In our view, this will bring the business of the Council much more into the formal Council of Governor meetings

Having observed a number of Board and Committee level meetings and reviewed the minutes of these over an extended period, the overriding sense is one of information provision as opposed to

oversight and scrutiny. We recognise that during the height of the pandemic, the Board stepped away to a degree and in effect were being briefed by executive management. However, as we normalise COVID-19 operations and focus on recovery, there is a need for the Board to revert to its oversight and scrutiny role.

At executive level, the recently implemented governance structure still needs embedding and ongoing support provided to help senior leaders understand the focus on risk and how the various groups align. This was evident in the focus groups with different understanding and mixed views on how well it was working although ERAG was viewed positively.

CCICP governance arrangements sit outside of divisional and executive governance arrangements to a large degree. Feedback from our interviews and focus groups evidenced a level of confusion in relation to the current arrangements and some frustrations in that it was felt that the current arrangements feel convoluted and result in community services being seen as an 'add on' to the Trust. There is a potential risk that this separation may dilute the benefits of having inhouse community services. From a governance perspective, we also note that the Partnership Board is chaired by a non-Trust person and yet the Board has delegated powers to agree priorities for investment and agreeing opportunities for new services amongst other duties.

Risk and performance management

Overall, we can see that the Trust has spent significant time and energy, during the pandemic, in revising its approach to risk management which is to be commended. Arrangements appear robust, reporting reflects good practice and there is evidence of Board scrutiny and discussion over risk. Looking forward we see that the Trust now needs to ensure that the balance of focus over risks and issues (performance) is appropriately balanced.

Performance management does not appear to receive the same level of focus as risk. The Trust has recognised that, at divisional level, divisional governance is not robust and requires strengthening which the Trust is in the process of undertaking. In our view, executive governance arrangements appear overly focussed on risk as opposed to risk and performance and at Board level we are of the view that scrutiny and challenge over performance could be strengthened.

ERAG appears to focus on high scoring operational risks (15+). Focussing on high scoring risks fails to recognise the role that risk appetite can play in helping to focus management attention on those risks where the Trust is exceeding its appetite. We understand that the Trust is currently reviewing all risks that exceed appetite and these will be scrutinised by executives prior to Board consideration on a regular basis even if not necessarily monthly.

Information

The recognised lack of a digital clinical system is seen as a blocker in terms of having timely, robust, and insightful clinical data. Interviewees described current arrangements as manual and labour intensive with existing systems unable to talk to each other. The Trust is aware of the current constraints and is in the process of procuring an electronic patient record.

Beyond this and in support of the Trust's new strategy, leadership has recognised the benefits to be had from investing in business intelligence and is partnering with a third party to build and implement a data warehouse to facilitate greater automation of data manipulation and build a forward look predictive analysis capability.

Staff members were positive in relation to some elements of Trust information such as quality and incident reporting data whereas they were less positive in relation to elements of workforce data. Mandatory training compliance reporting in particular was cited as inaccurate with managers keeping their own records as Trust-produced information was viewed as unreliable.

People, staff and external partners

Engagement levels with the governors is excellent. This was confirmed in our governor focus group where governors did not believe that there was anything that could or should be improved from an engagement perspective as they felt involved and informed. Equally, they all stated that they would feel able to share any concerns or ask questions without fear which helps evidence of an open and transparent culture.

Externally, partners were positive regarding the strengthening communications and engagement from the Trust out into the system. The Trust is seen as being more open and sharing than previously. Reference was made to a more outward facing CEO than the previous incumbent but partners also referenced the increased profile of other executives too with the COO in particular being referenced for their work with Primary Care Networks and Health and Wellbeing Boards. Partners commented that they would like medical leadership to be more visible and outward facing as system working and discussions increase.

Whilst positive and improving external relations exist, there was recognition that a more appropriate balance between engagement and communication is needed with a view that recent activities had tended to be more communicating with system partners as opposed to engaging with them. There was a sense that the Trust has embraced system working and moved more quickly than many in terms of embracing system working.

Learning, Continuous Improvement and Innovation

Despite COVID-19, there were a number of workforce investments and initiatives that have commenced within the last year. Feedback at focus groups was positive regarding the increased development opportunities than had previously been available.

We understand that the Trust has appointed an external partner to help embed QI methodology across the Trust and support the roll out of capabilities. Feedback from our focus groups referenced the presence of a Quality Improvement (QI) culture although it was described as “messy and pocketed” with the need for a focussed roll out programme and training schedule and therefore the appointment of a third party to increase capacity to support this is welcomed.

Whilst the Learning from Deaths programme was suspended nationally in March 2020, the Trust continued structured judgement reviews for deaths of patients with learning disabilities and all serious mental illness deaths. The report continues to be received by the Board on a quarterly basis.

Appendix I – Engagement Schedule

Interviews

Name	Role	Organisation
Dennis Dunn	Chair	Trust
James Sumner	CEO	Trust
Lesley Massey	NED	Trust
Lorraine Butcher	NED	Trust
Trevor Brocklebank	NED	Trust
Les Philpott	NED	Trust
Andy Vernon	NED	Trust
Manoj Agarwal	NED	Trust
Julie Tunney	Director of Nursing & Quality	Trust
Murray Luckas	Medical Director	Trust
Caroline Keating	Company Secretary	Trust
Amy Freeman	Chief Information Officer	Trust
Oliver Bennett	Chief Operational Officer	Trust
Heather Barnett	Director of Workforce & OD	Trust
Russ Favager	Deputy CEO and Director of Finance	Trust
Denise Frodsham	Cheshire East Place Director	Trust
Katherine Birch	Lead Governor	Trust
Paul Newman	Associate Director of Comms	Trust
Jackie Bene	CEO	Cheshire & Merseyside HCP
Alison Lee	Managing Director	Cheshire West ICP
Lynne McGill	Chair	East Cheshire NHS Trust
John Wilbraham	CEO	East Cheshire NHS Trust
Sian Axon	FTSU Guardian	Trust
Andrew Wilson	Chair	NHS Cheshire CCG
Susan Gilby	CEO	Countess of Chester NHS FT

Focus Groups

Name	Role	Division
Ali Barnes	Head of Nursing	Medicine & Emergency Care
Belinda Dean	Head of Nursing	Medicine & Emergency Care
Simon Dowson	Associate Medical Director	Women & Children's / Diagnostics and Clinical Support Services
Ruth Heaton	Head of Nursing	Diagnostics and Clinical Support Services
Rebecca Viggars	Deputy Divisional Director	Medicine & Emergency Care
Jenny Butters	Head of Midwifery & Paediatrics	Women & Children's / Diagnostics and Clinical Support Services
Sue Sarson	Head of Nursing	Surgery & Cancer
David Machin	Associate Medical Director	Medicine & Emergency Care
Andy Williams	Divisional General Manager	Surgery & Cancer
Emma Colgan	Divisional General Manager	Diagnostics and Clinical Support Services
Tony Mayer	Divisional General Manager	CCICP
Jo Bowen	Head of Nursing	CCICP

Name	Role	Division
Mark Wilde	Director of Operations	Trust wide
Katherine Birch	Governor	
Bob Pugh	Governor	
Valerie Pickford	Governor	
Tim Ashcroft	Governor	
Jan Roach	Governor	
Erica Morriss	Governor	
Pat Psaila	Governor	
Helen Piddock - Jones	Governor	

Meeting observations

Forum	Date
Trust Board meeting	29-Jul
Trust Board strategy session	26-Aug
Performance and Finance Committee	22-Jul
Quality and Safety Committee	21-Jul
Workforce and Digital Committee	19-Jul
Council of Governors	15-Jul
Executive Risk and Assurance Group	13-Jul
Executive Delivery and Performance Group	05-Aug

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**6**	Date of Meeting: 28/10/2021
Report Title	**Chief Executive's Report October 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)*

- ICS Update
- The impact of Urgent & Emergency Care Pressures
- Finance and workforce challenges but with positive work being undertaken on health & wellbeing

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 – 28 October 2021

Key Highlights

National / Regional Update

Cheshire & Merseyside (C&M) Integrated Care System (ICS)

1. The Interim Chair, David Flory, has agreed to remain in post until March to enable the Chair appointment process to be re-run in the New Year. The recruitment process is in train for the substantive Chief Executive of the ICS and it is hoped the outcome will be announced within the next few weeks.

New NHS System Oversight Framework 2021/22

2. Following consultation and feedback from local leaders and others, NHS England and NHS Improvement (NHSEI) announced implementation of the new framework which sets out a new approach to provide focused assistance to organisations and systems

3. The Trust has been placed in SOF Segment 2. According to the criteria, this means that we are considered to have plans in place to address areas of challenge and which have the support of system partners. Targeted support may be required to address specific identified issues.

4. What targeted support means in practice is that the regional team would work with us, as required, to access flexible support delivered through peer support, clinical networks, the NHSEI universal support offer e.g. Get it Right First Time (GIRFT), RightCare, pathway redesign, NHS Retention Programme or a bespoke support package via the regional improvement hubs.

5. The link to the SOF document is provided here (NHS England » NHS System Oversight Framework 2021/22) but will be emailed to Board members separately.

Trust Update

Community Diagnostic Hub

6. The Trust has now received confirmation of £1.7m capital investment in the development of a Community Diagnostic Centre (CDC) at Victoria Infirmary Northwich (VIN), which is excellent news for the people of Cheshire. The CDC will strengthen the services provided at VIN and will increase substantially the diagnostic capacity and capability and also will improve waiting times for critical tests, including CT and MR.

Consultant appointments:

Mr Jeremy Weetch, Obstetrics & Gynaecology Consultant (took up post on 1 October 2021)

Covid-19

7. At 20 October, there were 47 confirmed positive COVID-19 patients in the hospital compared to 31 reported in my last CEO report in September. The local infection rate is the highest it has been since the start of the pandemic and this, in turn, is resulting in growing hospitalisation. This has also led to a rise in COVID-19 admissions into Critical Care.

Vaccination Programme

8. The Trust is making reasonable progress with the administration of both the COVID-19 'booster' and seasonal flu vaccines to staff. As at 20 October, 48% of staff have had a 'booster' vaccine and 53% have had a seasonal flu jab.

Service Restoration

9. The recovery and restoration of core clinical services and activity continues to be a priority. Despite an improvement in elective and daycase activity in September, waiting lists continue to grow and the focus remains on patients with the highest clinical need and those that have waited the longest. Of those patients who require an operation within one month, we are still meeting this standard for nearly 8 in every 10 patients. Excellent progress has been made over several months to reduce the number of patients waiting over one year for surgery; however, because of recent pressures and the fact that we are not delivering the same level of activity compared to pre-pandemic, this has started to grow as the number of patients waiting 30-51 weeks is increasing rapidly. The Trust remains committed to a trajectory of improvement for long-waiters.

Trust 'Business as Usual'

Urgent and Emergency Care Pressures

10. Attendance levels are 14% higher than in 2019 (pre-pandemic). However, this is increasing admissions into hospital and, with significant flow pressures and challenges in discharging patients from hospital, is resulting in c.100 escalation beds being open.

11. The focus nationally remains on ambulance handover delays in excess of 60 minutes and the number of patients waiting a total time in the Emergency Department (ED) in excess of 12 hours. The Trust continues to perform well against the >60-minute ambulance handover standard.

12. I reported last month on the significant rise in the number of patients waiting more than 12 hours in ED compared to pre-pandemic levels. However, despite the rise, it remains one of the better positions when compared to other Trusts in C&M but there remains a significant amount of work to do to improve this experience for patients due to the demand issues described above.

13. The new urgent and emergency care improvement plan was presented to Performance & Finance (PAF) Committee in October 2021 and some headlines are included in the PAF Chair's assurance report. The new ED is due to open on 8 December.

Ward Accreditation Process

14. Due to the impact of Covid-19, ward accreditation visits were suspended during 2020/21; however, the Trust has re-launched the Ward Accreditation process in July 2021. The program has a new focus, with an identified ward accreditation team to undertake each accreditation. The use of this team has ensured a consistent and fair approach to the audit process, with outcomes being verified at an Executive lead verification panel.

15. To date, since commencing the accreditation program 4 wards have been accredited with a further 22 scheduled between October 2021 - April 2022.

Finance

Current position

16. The position at the end of month 6 (September) of the financial year is a £16k surplus. This position was achieved only after the Trust received a further £900k re-distribution of system monies from organisations with cumulative surpluses, following the collaborative financial agreement that all organisations in Cheshire & Merseyside would work together to achieve break even for every organisation. The system position was a surplus of £0.7m for H1 (April to September) against the system financial envelope with all organisations breaking even.

17. The Trust's £900k variance from the financial plan set by the Board was predominately due to two factors: 1) the impact of surging non-elective activity and 2) the reduction in Elective Recovery income and consequential non-achievement of the planned 'contribution' from this work factored into the financial plan (£300k).

H2 Financial Regime (October – March)

18. The Cheshire & Merseyside System's financial envelope for H2 has been confirmed as £2,745m (excluding Service Development Framework and Spending Review allocations); this represents a marginal (£51m) increase (c. 2%) in the equivalent envelope notified for H1. The national headlines are that the settlement is better than previously anticipated but there is a general efficiency requirement of c.2% and a reduction in COVID funding, non-NHS income (loss of car parking income etc) and an assumption that H1 efficiency was delivered recurrently, all of which will result in an overall efficiency requirement in the region of 2.5% - 3%.

19. Despite this increase in financial allocation, delivering financial balance for H2 (and hence the financial position for the whole of 2021/22) represents a considerable challenge for both the system and the Trust due to:

- The System currently estimates to suffer contribution loss of c. £30m due to the confirmed changes in the elective recovery funding (ERF) regime. For the Trust, this would be £2.3m
- The impact of the 3% pay award for 2021/22 is understood to not be fully funded. The extent of shortfall across the System is currently being assessed but, for the Trust locally, it is estimated as £600k
- Substantial reductions in funding for Covid-related costs (6%) and Provider 'Other income' support (totalling c.£10m), with no indication of associated abatement in expenditure/income recovery. Until the C&M system monies are agreed, it is unclear what impact this would have on the Trust
- Anticipated cost improvement delivery of c.2.5% (over £4m) as a minimum in H2

- Inflationary costs pressures within H2 (winter months) are anticipated to invariably outstrip the core level of growth funded within the envelope.

20. Whilst there are common areas of finance challenge across all trusts in C&M, locally there may be some variation in relation to the increased footprint of the new ED department and consequential staffing increases, general use of premium costs for vacancies and restoration and increased run rate from the winter plan. At the time of writing, negotiations are continuing within the system on allocations, funding flows and individual organisational positions, with scrutiny and challenge taking place internally around our own financial plans.

2022/2023 Timelines

21. As I have mentioned previously, guidance on next year (2022/23) is not expected until December 2021 at the earliest, with planning during the period January-March 2022 although, internally, we will be starting work on next year's financial plan earlier than that.

Workforce

People Recovery Plan

22. Staff Wellbeing Week was successfully delivered across MCHFT and CCICP during w/c 27 September to raise awareness of and how best to access wellbeing support, with exhibitors focusing on key areas of Physical, Psychological, Social & Financial Wellbeing. The event was supported by teams of Mental Health First Aiders and Volunteers visiting ward/frontline areas where the event could be accessed by staff unable to attend in person. Over 400 staff attended the event at Leighton with a further 900 branded flasks containing goodies and wellbeing information being distributed. Staff were able to sign up for free will writing services, speak to Union members, find out about support to quit smoking, how to access mental health support as well as a range of other wellbeing information and advice. Further wellbeing events will be delivered throughout October in other locations such as Infinity House and Elmhurst.

23. A Wellbeing calendar of events and activities has been approved by both the Health & Wellbeing Project Board and Executive Workforce & Assurance Group. The purpose is to focus resources on delivering key messages to staff across a variety of communication channels. Events have started to be delivered from October, including a smoking cessation event hosted by the CURE team in support of Stoptober; information and advice on musculoskeletal conditions as part of Back Care week and 'Bring a Piece of Fruit to Work Week'. Other key events to be supported during October will include World Mental Health, with a series of mental health sessions for staff during week commencing 11 October; menopause café to promote World Menopause day on 18 October as well as working with EDI colleagues to support Black History month.

24. The sickness rate for September 2021 was 4.7%, a 0.5% reduction from August 2021 and a continuing decline since July (5.8%). Sickness absence remains higher than this time last year, albeit only 0.2%. The top reason for absence is anxiety and stress which is reflective of the ongoing pressures the hospital faces. 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.

Offsite office moves

25. Consultation and engagement on off-site move concluded on 30 September after which formal contractual change letters were issued to relevant staff. Initial phases of the moves took place on 11 and 12 October. Initial staff feedback regarding the accommodation is positive, indicating that the move was successful with little 'down time' and the improved facilities have been very well received.

Cheshire International Recruitment Collaboration (CIRC)

26. The project continues to make good progress. 84% of offers (405/482) have now been made and the project has taken a total of 327 (68% of total) new International nurses to date. The remaining arrivals are planned throughout the year to ensure that there is enough capacity in the Practice Education Facilitators (PEFs) to maintain the excellent pass rates for the Objective Structured Clinical Exams (OSCE) that the project has been achieving. The pass rate so far is 76% on the first attempt. 232 nurses have now taken their OSCE and 177/232 have passed first time.

Leadership

27. The Trust's leadership programmes continue to progress well. The Clinical Talent programme is new this year, aimed at nurses and AHP colleagues wanting to develop into a service management role. The first cohort of 20 launched in September. During October the Senior Leadership programme for 2021-22 launched with 20 participants and the Intermediate and Foundation Leadership Cohorts (22 on each) will launch in November. The Clinical leaders programme is now mid-way through and is due to conclude in June 22. 16 Consultants are currently participating and feedback so far has been positive.

28. A review of the Shadow Board programme is currently underway and the outcome will be shared with Executives shortly. Initial indicators identify a positive experience and knowledge transfer.

29. Finally, a new self-compassion at work programme has been launched. The is open to all staff and there are currently 30 colleagues taking part. Participation has been targeted at teams requesting support for wellbeing.

Digital Clinical System (DCS) Update

30. The Programme Board did not meet in its entirety in September but delegated authority to the two Chief Executives and representative Non-Executive Directors of MCHFT and East Cheshire NHS Trust to consider the outcomes of the procurement process and approve the final decision regarding the preferred provider. This was duly undertaken and the decision taken to appoint Meditech IT Inc. We are working now with Meditech to inform and finalise the Full Business Case.

(Leighton) Hospital Redevelopment Programme Board (HRPB)

31. The HRPB met in October. The Chair's Assurance Report is appended to my report (Appendix I).

James Sumner, Chief Executive
September 2021

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

Report to	Board of Directors
Date	14 October 2021
Report from	James Sumner, Chief Executive
Report prepared by	Caroline Keating, Company Secretary
Executive Director	Russell Favager, Deputy Chief Executive
Meeting quoracy	Yes ☒ No ☐

KEY AREAS OF ASSURANCE

4 Ward Block – process in train to appoint preferred bidder in November. If funding obtained, governance structure to be revisited, together with the resource requirement, including a PMO. Discussions held with Divisions to enable final report including details of block occupancy to be agreed at end December. The design for the wards would be replicable for use by other Trusts.

RAAC capital spend - focus on ensuring achievement of £22m spend and having early sight of risk factors to potential slippage.

New ED Build – Practical handover date agreed as end November for opening date on 8 December. Work to be undertaken in parallel e.g. cleaning, room assessment and staff orientation to achieve opening date.

Bids for new hospitals – only one bid per ICS footprint required. Expression of Interest submitted with response expected Spring 2022. RAAC Risk Mitigation Works Cost Plan also submitted.

RAAC Planks work progressing with discussions taking place between Estates and Operations to address access issues.

KEY CONCERNS/RISKS

- Retaining labour and materials supply

Priority Areas: DECISIONS MADE

N/A

RECOMMENDATION

To note

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**7**	Date of Meeting: 28/10/2021
Report Title	**Board Assurance Framework Q2 2021/22**	
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)*

- BAF3 (*provide safest and best care*) score increased (12) following Board approval in September
- Board Committees (WDT, QSC and PAF) have each reviewed their delegated risks in October
- Review underway of high scoring operational risks and potential impact on Trust's Risk Appetite

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

- Executive Risk Leads to act on recommendations agreed during meeting
- Board to be advised of outcome of 15+ risks review and implications for Risk Appetite (November 2021)

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
Executive Team	Monthly	Executive Directors BAF Report	Company Secretary	Risks reviewed and updated as required
Board Committees (WDT, QSC, PAF)	October	BAF Report – Delegated BAF Risks	Executive Directors	Any comments incorporated into Board report

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). There has been one increase in year to BAF3 (cf Para 5 below). 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 – Current Position

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 (i.e. 15+). 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 score for BAF3 (*provide safest and best care*) was increased from 3x3=9 (Consequence x Likelihood) to 3x4=12 following approval at September Trust Board.

6. The Board Committees (Workforce & Digital Transformation (WDT); Quality & Safety Committee (Q&S); Performance & Finance (PAF)) discussed their delegated risks at their meetings in October, focussing on the assurance provided through substantive items. WDT highlighted BAF 2 *(Risk of reduction in workforce wellbeing and resilience)* in relation to the impact from current operational pressures, and workforce supply challenges impacting in turn on performance.

7. Changes made in 4Risk after 14 October (i.e. post submission to the Board Committees) are not reflected in the full 4Risk report.

8. The detail collated is subject to a continual quality assurance process, co-ordinated by Corporate Governance & Risk. The Executive Team monitors the completion of actions and discusses changes to the BAF on a monthly basis.

15+ Risks Review

9. The increase in the number of risks scored at 15+ was discussed at the Executive Risk & Assurance Group (ERAG) in early October. Corporate Governance & Risk has started to review these risks against local guidance to assess continuity of scoring. Discussions will now take place with the Divisions to explore their respective risks, including the scoring and

assurances to the controls, and the outcomes reported back to ERAG in the first instance.

10. Once the review is complete, and if any risks sit outside of the Trust's Risk Appetite, the Board will be asked to agree that these risks can be managed outside of the relevant appetite level and be advised of the timescale for managing these risks back to an acceptable level. The relevant Board Committees will be given the opportunity to comment on this position for those risks delegated to them prior to submission of the proposal to the Board.

Recommendations

11. To agree the current status of strategic risks and advise of any changes, note the associated operational risk profiles.

Chris McKeown, Corporate Risk & Assurance Manager
22 October 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 the previous report are 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**

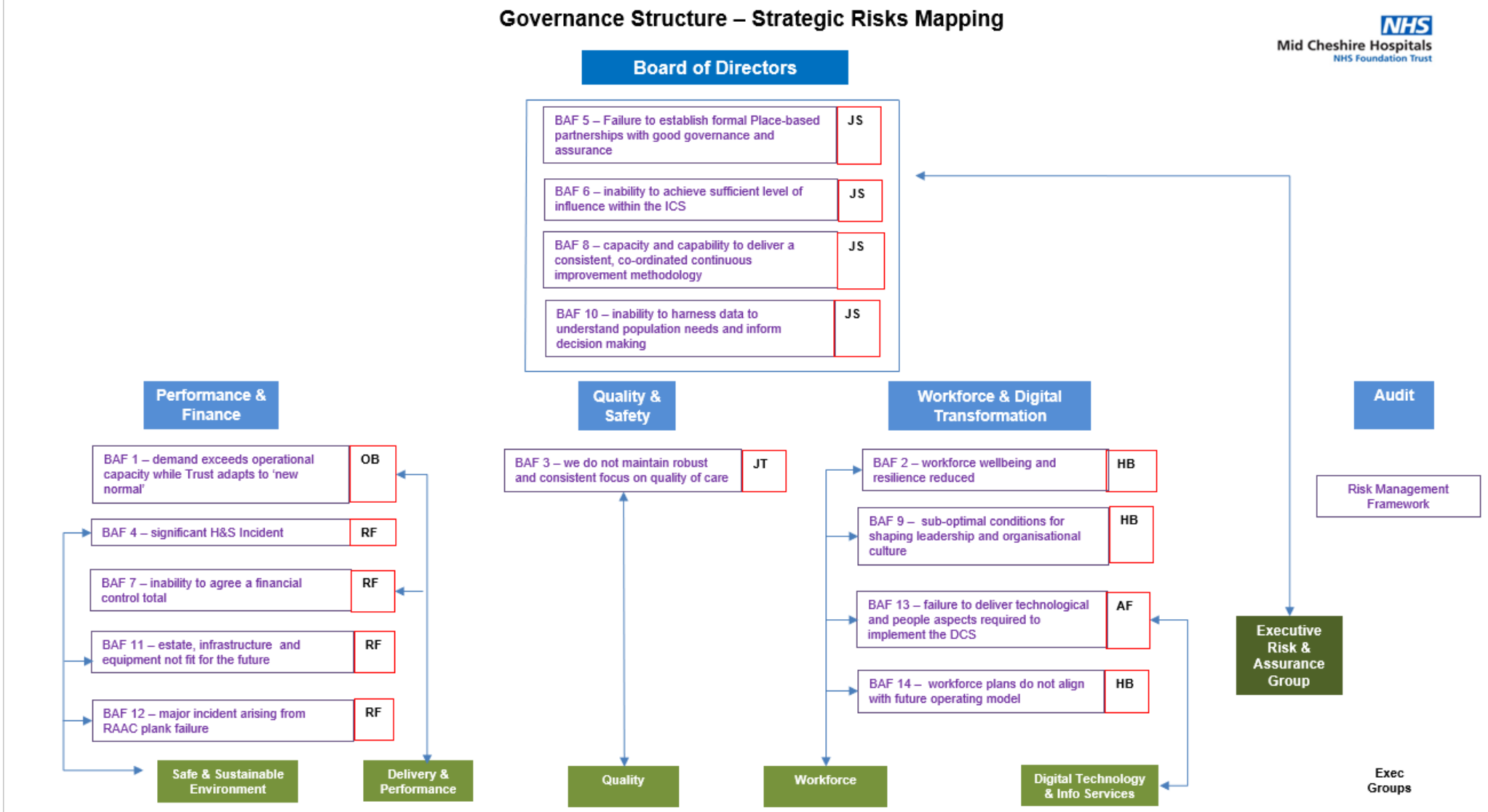
4. To ensure accuracy and consistency in risk scoring across the Trust, all risks should be scored against the risk impact and likelihood guidance included in the Risk Management Process Guide. The guidance is included in Appendix 4.

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 4 = 12***	**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**

***BAF3 score increased approved at September 21 Trust Board (previous 3x3=9)**

Appendix 2: BAF risks alignment to Board Committees



Appendix 3: 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

Strategic Risk	Title	Risk Score (IxL)
BAF1	Demand exceeds operational capacity while the Trust adapts to the 'new normal (**COO**)	**20 (4x5)**

Risk Reference	Title	Risk Score (IxL)
CORP1	Demand for outpatient care exceeding capacity	**16 (4x4)**
CORP4	Unable to deliver key cancer standards	**16 (4x4)**
CORP5	Waiting list size & long-waiters	**20 (4x5)**
CORP7	Unable to deliver urgent and emergency care in line with national standards	**20 (4x5)**
CORP9	Operational Flow	**16 (4x4)**
CORP10	Insufficient bed capacity	**16 (4x4)**
CORP13	Waiting list management	**20 (5x4)**
DG2	Histopathology Turnaround Times Provided	**20 (5x4)**
DGCH2	Unreliable Clinical Haematology Service	**20 (5x4)**
DGPH19	Lack of aseptic service at MCHFT	**15 (5x3)**
EC9	Shortages of medical staff in medicine	**20 (5x4)**

Risk Reference	Title	Risk Score (IxL)
EC13	Staffing levels across DMEC	**20 (5x4)**
ECAN4	Reduced anaesthetic sessions are available to deliver elective services	**20 (5x4)**
ECED6	ED capacity and delivery of core standards	**20 (4x5)**
EDED11	The emergency department corridor	**15 (5x3)**
SCEN6	Restricted access to Endoscopy Services during the COVID-19 national pandemic event	**16 (4x4)**
SC12	Impact of Covid-19 on the Elective Programme	**16 (4x4)**
WCGY3	Deterioration of Gynaecology elective services as a result of the Covid-19 pandemic	**15 (5x3)**
WCGY4	Lack of gynaecology oncology fail safe	**15 (5x3)**
WCMA17	Capacity of the fetal medicine unit	**15 (5x3)**
WCPAAC20	Potential surge in paediatric respiratory infections	**15 (5x3)**

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

Strategic Risk	Title	Risk Score (IxL)
BAF1	Demand exceeds operational capacity while the Trust adapts to the 'new normal (**COO**)	**20 (4x5)**

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 (21) are linked to this BAF associated with restoration of services. These risks are monitored monthly at the Executive Delivery & Performance Group
- The actions included on the BAF are designed to support staff and ensure that improvement plans are addressing the operational capacity issues that are influencing the increased demand.

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)
BAF2. Workforce wellbeing and resilience **(DW&OD)**	**16 (4x4)**
BAF3. We do not maintain robust and consistent focus on quality of care (**DN&Q / MD**)	**12 (3x4)**
BAF4. Significant Health & Safety incident (**DCEO/DF**)	**15 (5x3)**

Risk and controls commentary

- **BAF2** relates to the Workforce Matters Strategy and Health & Wellbeing Plan. A series of controls and actions are in place to support staff and the workforce.
- Monitoring of the quality of Trust services are included in the controls for **BAF3** that identify how the Trust ensures that patients are receiving the best care. These include strategies and policies that provide assurance of quality being delivered.
  - There are currently 6 high priority operational risks related to BAF3
- Within BAF3 the assurance of NICE guidance implementation has been increased from Low to Partial.
- **BAF4** controls identify that the groups, sub-groups and policies associated with Health & Safety (H&S) are providing good assurance of H&S management. Further Divisional engagement and completion of a Trust Stress Survey should provide further assurance of risk control.

Ref	High scoring operational risks (15+)	Risk score (IxL)
CORP8	Unable to plan effectively for workforce changes and requirements	**20 (4x5)**
DGIT1	Occupational Therapy staffing Levels	**16 (4x4)**
DGIT2	Inpatient physiotherapy staffing resource	**16 (4x4)**
ECAN5	Anaesthetic Workforce Levels	**20 (5x4)**
WODHW 3	Staff wellbeing whilst managing unprecedented demand / patient need	**16 (4x4)**
CPCN3	Provision of ambulatory wound care within CCICP	**15 (3x5)**
ECGA4	Lack of Out of Hours Upper GI Bleed Rota / Service	**20 (5x4)**
WCMA18	Failure to Provide Ockenden Consultant Ward Rounds in Obstetrics	**16 (4x4)**
QUCE3	Failure to use LocSSIP before interventional procedure	**16 (4x4)**
QUPS13	Failure to identify and appropriately manage a deteriorating patient	**15 (5x3)**
WODLD9	Resus Training Capacity	**15 (5x3)**
HS4	Regulatory Compliance with the Regulatory Reform (Fire Safety) Order 2005	**15 (5x3)**
HS6	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)**

Risk and controls commentary

- **BAF5** controls relate to the partnership agreements and developing links the Trust has with other organisations to support new working. The agreed plans are included within the risk controls. Actions are identified and further actions are likely to be required as partnership links evolve.
- The controls in **BAF6** provide assurance that development of the Trust's Strategy and Board Development Programme are supporting the Trust's ability to influence within the ICS.
- **BAF7** controls provide assurances of how financial control is being managed to support strategy. Once implemented, the actions are to provide further evidence of the financial control that is in place. When implemented the actions will provide further assurance of the risk being controlled following identification in areas such as benchmarking financial information and training with all senior teams with regard to finance.

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 the Strategic Partner that has been appointed to support continuous improvement to deliver the strategic ambitions. Actions have been developed to ensure that continual quality improvement methodology can used to develop the processes that are delivered at the Trust.
- **BAF9** controls provide assurance on how the strategies, plans and programmes that are in place will support the ambition of shaping leadership and culture within the Trust. A number of actions have been identified to further develop staff and leaders within the organisation.
- The Data Warehouse implementation plan, that will support decision-making to help address healthcare outcomes and inequalities is a control within **BAF10**. The implementation of the actions will support implementation of the Data Warehouse. . DQCC1 risk score reduced on 21 October to 12 (3 x 4) and approved by the CIO.

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)
WCMA15	Maternity Theatre 1 IPC - improvements required	**16 (4x4)**
ES48	Critical Risk Adjusted Backlog Maintenance	**20 (5x4)**
EF56	Inability to carry out key IT and Estate works to previous South Cheshire Hospital	**16 (4x4)**
HS7	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 good assurance for each of the risk controls is in place. Actions being implemented to support the continued development of the site's infrastructure have been agreed.
- For **BAF12**, the survey, maintenance and redevelopment work in regard to the national RAAC plank identified concerns are in place and the continuation of these works and implementation of new builds to support the work are included in the action plan.
- Controls and actions for **BAF13** provide assurance that the ongoing work to ensure a Digital Records System is implemented within the Trust. Further reviews to ensure readiness for the system are included in the actions.
- **BAF14** the current recruitment and development work provides good assurances that the controls are managing the risk. Actions identified include analysis of the recruitment process to study the effectiveness of the recruitment procedure.

Appendix 4: 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	14 Oct 2021
Risk Status	Open
Risk Area	01. Strategic Risks 2021/22
Control Status	Existing
Action Status	Outstanding

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	Progress Notes	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:** 12 Oct 2021 **Latest Review Date:** 13 Sep 2021 **Latest Review By:** Oliver Bennett **Last Review Comments:** Actions and controls updated and closed where applicable.	**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	Approved Endoscopy Plan **Action Owner:** Andrew Williams **Target Implementation Date:** 07 Oct 2021	**08 Oct 2021** **Oliver Bennett** Draft Improvement Plan presented to EDPG 8/10/21 - not approved as requires further work. Evidence that plan being implemented. To be considered at EDPG 4/11/21.	I = 4 L = 3 12
				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		Development of a transition/move plan for the new ED and a robust governance process for monitoring. **Action Owner:** Susanne Crossley **Target Implementation Date:** 11 Oct 2021		
				03.Elective care improvement plan. **Control Owner:** Andrew Williams	Plan updates taken to EDPG monthly	Partial				Approved Diagnostic Improvement plan. **Action Owner:** Emma Colgan **Target Implementation Date:** 04 Nov 2021	**06 Oct 2021** **Emma Colgan** Diagnostic recovery plan was presented to EDPG in July 21. Further detail including endoscopy and breast screening recovery to be added and plan presented at November EDPG (as per workplan)	
				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						
				05. Outpatient transformation plan. **Control Owner:** Leo Door	Monthly highlight report to EDPG	Acceptable						
				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.	Acceptable				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:** 30 Nov 2021	**20 Aug 2021** **Jenny Grant** Framework and toolkit agreed at EWAG, aligned to Trust business cycle. Planning to commence within Divisions in September.	
				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				Review the process for contract management providing assurance through EDPG, including LLPs. **Action Owner:** Ros Davies **Target Implementation Date:** 03 Jan 2022		
				08. Domestic and international recruitment programme. **Control Owner:** Jenny Grant	International Recruitment of Medical Staff Report to December WDT Committee	Partial				Agree priorities around the health inequalities agenda **Action Owner:** Oliver Bennett **Target Implementation Date:** 03 Jan 2022		
				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						

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	Progress Notes	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:** 30 Sep 2021 **Latest Review Date:** 30 Sep 2021 **Latest Review By:** Chris McKeown **Last Review Comments:** Actions updated / closed no change to current scores	**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.	Acceptable			I = 4 L = 4 16	Develop Trust Workforce Strategic Plan to align with the People Plan and Trust Strategy aims. **Action Owner:** Heather Barnett **Target Implementation Date:** 31 Oct 2021	**25 Aug 2021** **Chris McKeown** Target date moved to 31/10/2021. The Plan was approved at EWAG. A plan template is being developed to ensure that all W&OD strategic plans are consistent.	I = 4 L = 3 12
				02. People Recovery Plan **Control Owner:** Jenny Grant	People Recovery Plan submitted to WDT June 2021	Partial				Implement additional staff networks **Action Owner:** Heather Barnett **Target Implementation Date:** 31 Oct 2021	**25 Aug 2021** **Chris McKeown** Date extended to 31/10/21. LGBTQ+ network and Disabilities and Carers Networks are being established. Staff feedback was received via a questionnaire in July/August to identify how these will need to be set up effectively.	
				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				Carry out skill mix review in Occupational Health **Action Owner:** Jenny Grant **Target Implementation Date:** 31 Oct 2021	**30 Sep 2021** **Chris McKeown** Sue Coffee has been appointed via agency to review the current skill mix	
				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		Develop the medical and wider clinical workforce gap trajectories **Action Owner:** Jenny Grant **Target Implementation Date:** 31 Oct 2021	**20 Aug 2021** **Jenny Grant** Vacancy trajectories for all staff groups a rolling agenda item for the workforce supply group. Deep dive into Acute Med, Respiratory and Anesthetics medical workforce gaps completed and presented to ERAG in August	
				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				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:** 31 Dec 2021	**30 Sep 2021** **Chris McKeown** Project deliverables presented to Cheshire HRD network and progress will be monitored monthly. Project review date 3 months time, so target date updated to 31 Dec 21.	
				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				

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	Progress Notes	Target Risk Score
				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	Partial						
				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				
				13. Wellbeing Squads in place weekly to provide support to staff **Control Owner:** Bobby Sharma	Health & Wellbeing sub group provide updates to EWAG and this escalates to WDT when required.	Partial						

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	Progress Notes	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:** 13 Oct 2021 **Latest Review Date:** 04 Oct 2021 **Latest Review By:** Chris McKeown **Last Review Comments:** The score was increased from 3x3 to 3x4 following approval at Trust Board (September 21). The reason for the increase in score is because of the additional beds that have been opened on site and the resultant increase in agency staff required to support. Therefore the likelihood has increased from Possible (3) to Likely (4). Additional actions around increasing care observation audits, an after action infection control review and a maternity services culture review have been developed.	**Cause(s)** 1. Failure to monitor patient safety harm incidents 2. Patient safety incidents increasing 3. Lack of a Quality of Care Strategic Plan 4. Increase in in patient beds-stretching core staff **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 = 4 12	Process and Standard Operating Procedure for NICE guidance **Action Owner:** Hayley Cavanagh **Target Implementation Date:** 30 Nov 2021	**13 Oct 2021** **Chris McKeown** SOP to be approved at October TIG and then taken to November EQGG.	I = 3 L = 2 6
										IPC BAF to be presented to December QSC **Action Owner:** Becky Consterdine **Target Implementation Date:** 31 Dec 2021		
				02. Infection Prevention & Control Policy **Control Owner:** Julie Tunney	IPC BAF After Action Review May 2021. Submitted to QSC June 21	Acceptable				Culture survey to be completed for maternity services **Action Owner:** Jenny Butters **Target Implementation Date:** 31 Dec 2021		
				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		Covid Wave 2 Death Analysis **Action Owner:** Murray Luckas **Target Implementation Date:** 31 Dec 2021		
				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				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		
				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.	Acceptable						
				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				

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	Progress Notes	Target Risk Score
				07. NICE Compliance **Control Owner:** Clare Hammell	NICE programme to go to Trust Improvement Group following development of Process and SOP. Compliance status of all priority 1 guidance now known and no immediate cause for concern found. Ongoing issues with Divisional monitoring because of delayed implementation of Governance Structure.	Partial						
				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:** Julie Tunney	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 to QSC September 21.	Partial	National Audit of Care at End of Life. Strategic Collaborative Cheshire Plan for Palliative Care and End of Life.	Partial				
				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)	Acceptable	CNST3 to NHS Resolution (NHSR) submission by July 2021. Ockenden submission	Partial				
				12. Establishing the implementation of the GIRFT toolkit **Control Owner:** Clare Hammell	GIRFT was on hold but reinstated June 21	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	Progress Notes	Target Risk Score
				13. Ward observation audits to monitor and support ward areas identified as potential concerns **Control Owner:** Laura Egerton	Monthly agency report, any ward that is identified as a concern the corporate nursing perform a care observation audit . The result are taken to Divisional Board and Trust Quality Group. Any further concerns are to be taken to Executive Quality Governance Group and Quality and Safety Committee	Acceptable						
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:** 15 Sep 2021 **Latest Review Date:** 15 Sep 2021 **Latest Review By:** Russell Favager **Last Review Comments:** Risk has remained the same, action date amended for H&S engagement which is still work in progress	**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 Nov 2021	**01 Sep 2021** **Russell Favager** Discussions ongoing with Associate Director of Quality Governance, Director of Nursing and Deputy Medical Director to find a solution **07 Jul 2021** **Chris McKeown** A plan is being developed by the Divisional Director of Estates & Facilities and Head of Health & Safety.	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						
				03. Asbestos Management Plan **Control Owner:** Andrew Deakin	Included in Projects Chair's report taken to ESSEG	Acceptable						
				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						
				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:** Amanda Cartmill	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						
										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	**27 Jul 2021** **Wendy Astle-Rowe** Stress Survey commenced 1st June 2021 and will continue to 31st August 2021 regular communications being undertaken and progressing as per action plan	

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	Progress Notes	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:** 08 Oct 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	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		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				
				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				Digital Clinical System Programme Director / Dir of Corporate Affairs at ECT and Company Secretary to discuss draft Terms re: DCS at October meeting **Action Owner:** Caroline Keating **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				5 year plan to be realigned to match MCHT strategy **Action Owner:** James Sumner **Target Implementation Date:** 31 Oct 2021		
				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	Progress Notes	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:** 13 Sep 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 Oct 2021	**13 Sep 2021** **Chris McKeown** Engagement plan going to September Trust Board for approval	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:** 15 Sep 2021 **Latest Review Date:** 15 Sep 2021 **Latest Review By:** Russell Favager **Last Review Comments:** H2 planning dates updated. Roll out of training delayed due to operational pressures, revised timescale	**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:** Ros Davies **Target Implementation Date:** 31 Oct 2021	**07 Sep 2021** **Chris McKeown** Date extended two months as no benchmarking information has been received yet.	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:** Ros Davies	EDPG Chairs summary report submitted monthly to ERAG and PAF	Acceptable				H2 guidance has not yet been issued, expected 16 September 2022, although been confirmed will be a continuation of system envelopes. Final submissions of H2 forecast are expected early November with H1 and H2 being treated as a single financial period and organisations expected to achieve financial balance for the year as a whole **Action Owner:** Russell Favager **Target Implementation Date:** 30 Nov 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:** Duncan Goff	Corporate Governance Framework Manual agreed by Audit Committee and approved by Board April 2021	Acceptable				Training to be rolled out within divisional/corporate teams during H1 **Action Owner:** Ros Davies **Target Implementation Date:** 30 Nov 2021		
				04. Head of both Internal and External Audit opinions on the Trusts controls. **Control Owner:** Duncan Goff	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		SFIs revisions for 2022/23 proposed by Q4 **Action Owner:** Duncan Goff **Target Implementation Date:** 31 Mar 2022		
				05. Updated training for budget holders to be rolled out in H1 2021/22 **Control Owner:** Ros Davies	Training has begun but action in place to further roll out.	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	Progress Notes	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:** 30 Sep 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 from October 21				I = 3 L = 4 12	Communications & Engagement Plan for QI to be developed **Action Owner:** Clare Hammell **Target Implementation Date:** 30 Nov 2021		I = 3 L = 3 9
				02. AQUA appointed as Strategic Partner **Control Owner:** Clare Hammell	KPIs agreed in contract and will be reported to QI Strategy Group					Scoping of knowledge management work and QI system to be developed once completed **Action Owner:** Clare Hammell **Target Implementation Date:** 31 Dec 2021		
				03. Scope of knowledge management determined **Control Owner:** Clare Hammell	Scope to be presented to QI Strategy Group and taken to Board October 21.							
				04. Capability building plan developed for a 3 year period. **Control Owner:** Clare Hammell	To begin in Oct 2021					Director of QI to develop improvement model for Mid Cheshire **Action Owner:** Clare Hammell **Target Implementation Date:** 31 Jan 2022	**30 Sep 2021** **Chris McKeown** Director of QI not in post until December 21	

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	Progress Notes	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:** 30 Sep 2021 **Latest Review Date:** 30 Sep 2021 **Latest Review By:** Chris McKeown **Last Review Comments:** Actions updated and full evaluation of the shadow board is in progress and to go to Board.	**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	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	**29 Sep 2021** **Amy Oakes** Paper presented to WDT outlining progress made across all areas **12 Jul 2021** **Amy Oakes** Civility & Psychological Safety group has been established which specifically looks at actions to support safety culture	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						
				03. Coaching & mentoring scheme **Control Owner:** Amy Oakes	Education, Learning and OD Report to EWAG quarterly	Acceptable				Evaluate the Shadow Board programme **Action Owner:** Amy Oakes **Target Implementation Date:** 29 Oct 2021	**29 Sep 2021** **Amy Oakes** The timescales need to be amended for this as the original end date added was prior to the conclusion of the Shadow Board. The evaluation process is currently being developed and is anticipated will to go to EWAG in December **01 Jul 2021** **Chris McKeown** Evaluation to go to July EWAG	
				04. Medical leadership programme **Control Owner:** Amy Oakes	Learning & OD Group Chairs report to EWAG	Acceptable						
				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						
				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				Implement further staff networks for LGBQT+ and Disabled / carer staff **Action Owner:** Ian Howarth **Target Implementation Date:** 31 Oct 2021	**25 Aug 2021** **Chris McKeown** Date extended to 31/10/21. LGBTQ+ network and Disabilities and Carers Networks are being established. Staff feedback was received via a questionnaire in July/August to identify how these will need to be set up effectively.	
				07. Leadership Development Programme & investment, including investment in BAME leadership programmes **Control Owner:** Amy Oakes	Leadership Programme Report to WDT and EWAG April 2021	Acceptable						
				08. Leadership Compact / 'Our Leadership Way' Framework **Control Owner:** Amy Oakes	Framework developed and will be launched to the Executive Team August 21	Partial				Introduce the Leadership Compact at the Board development session **Action Owner:** Heather Barnett **Target Implementation Date:** 31 Oct 2021	**25 Aug 2021** **Chris McKeown** Date extended to 31/10/21 due to a National Delay. Scheduled for October Board Development session.	
				09. Communication & Engagement Strategy **Control Owner:** Paul Newman	Comms & Engagement bi-annual report to WDT and EWAG	Acceptable						
				10. ED&I Strategy **Control Owner:** Ian Howarth	Annual ED&I report to WDT and Board May 2021	Acceptable						
				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		

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	Progress Notes	Target Risk Score
				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				Carry out the Talent Board reviews for 2021 **Action Owner:** Amy Oakes **Target Implementation Date:** 21 Nov 2021	**30 Sep 2021** **Chris McKeown** Still to be completed for Executives and Senior Leadership roles and Corporate services therefore Target updated to November 21 **01 Sep 2021** **Amy Oakes** Talent Boards have now been completed in all clinical divisions and E&F	
				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				Develop further talent pathways for difficult to fill posts **Action Owner:** Nicola Madeley **Target Implementation Date:** 30 Nov 2021	**13 Sep 2021** **Nicola Madeley** Ongoing, HCA T&F group - HCA pathway poster developed, participating in AHP - Assistant Practitioner apprenticeships. SBAR submitted for new to care HCA apprenticeship and supporting cadet programme with Macclesfield College.	
				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		Review of recruitment practices and establish diverse stakeholder panels for senior appointments **Action Owner:** Susan Hossent **Target Implementation Date:** 31 Dec 2021	**30 Sep 2021** **Chris McKeown** The review has been completed and recommendations made as to how we will do this, but it isn't actually in place yet. Action plan in place and to monitor progress in 3 months.	
				17. Wellbeing Guardian and Wellbeing Ally **Control Owner:** Bobby Sharma	Progress to be included in Annual Report from Health & Wellbeing taken to EWAG.	Acceptable						
				18. Civility in the workplace awareness programme implemented and in place **Control Owner:** Amy Oakes	Progress to be included in Annual Report from Learning & Development taken to EWAG.	Acceptable				Set up BAME Advisory Panel **Action Owner:** Ian Howarth **Target Implementation Date:** 31 Dec 2021	**21 Jul 2021** **Chris McKeown** Original September date changed to December as if funding is received project can not be started until September and there will be a community stakeholder engagement involved with this one as well as work to ensure the scope of the BAME Staff Network is met.	
				19. Coaching Essentials sessions have been programmed in throughout the year for any level of MCHFT colleague to access to improve coaching leadership style **Control Owner:** Amy Oakes	Progress to be included in Annual Report from Learning & Development taken to EWAG.	Acceptable				Implement the national WRES model employer goals **Action Owner:** Ian Howarth **Target Implementation Date:** 31 Mar 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	Progress Notes	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:** Dylan Williams **Risk Owner:** Dylan Williams **Last Updated:** 01 Sep 2021 **Latest Review Date:** 01 Sep 2021 **Latest Review By:** Chris McKeown **Last Review Comments:** New CIO added as Risk Lead. Risk Reviewed with Head of Information & Performance. Control added following appointment of Data Warehouse Manager and Action updated pending review with new CIO in September 21.	**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	Scoping exercise being undertaken inline with Trust Strategy taking place with Trust Strategy Consultant **Action Owner:** Dylan Williams **Target Implementation Date:** 30 Sep 2021	**01 Sep 2021** **Chris McKeown** Actions are agreed from PA Consulting. New Data Warehouse Manager has started and current work is ongoing to review how best to deliver these actions. Action date extended to end of September and to be reviewed with new Chief Information Officer. **01 Sep 2021** **Chris McKeown** Actions are agreed from PA Consulting. New Data Warehouse Manager has started and current work is ongoing to review how best to deliver these actions. Action date extended to end of September and to be reviewed with new Chief Information Officer.	I = 3 L = 2 6
				02. Data Warehouse Manager started in August 21. **Control Owner:** Angela Wood	Data Warehouse Manager working with PA Consulting actions to establish how to deliver those identified. This will be monitored via Digital Technology & Information Services Group	Partial				Interoperability Manager to be appointed **Action Owner:** Angela Wood **Target Implementation Date:** 31 Dec 2021	**15 Jun 2021** **Chris McKeown** Job description, job matching and advert have all been written and submitted with the questionnaire to the Agenda For Change Panel	
										Influence and engage in the Cheshire and Merseyside Population Health solution. **Action Owner:** Dylan Williams **Target Implementation Date:** 30 Apr 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	Progress Notes	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:** 15 Sep 2021 **Latest Review Date:** 15 Sep 2021 **Latest Review By:** Russell Favager **Last Review Comments:** Revised date to end of November for Digital Strategic Plan as awaiting new CIO to start	**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 cost benefits to take place into the use of IT investment for electronic tracking of medical devices. **Action Owner:** Duncan Goff **Target Implementation Date:** 31 Oct 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				Revised Digital Strategic Plan to be developed **Action Owner:** Dylan Williams **Target Implementation Date:** 30 Nov 2021	**15 Sep 2021** **Russell Favager** Awaiting new CIO to start to develop Strategy and therefore target date moved to the end of November 2021	
				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				Review of the feasibility to relocate VIN to Weaver Square to be completed **Action Owner:** Russell Favager **Target Implementation Date:** 30 Nov 2021	**01 Sep 2021** **Russell Favager** Meeting with partner CEOs on 21st September to discuss feasibility of Weaver Square development. Phased approach re re-development of existing VIN site currently being worked up **07 Jul 2021** **Chris McKeown** Currently unaffordable and a business case is being completed to identify the next steps.	
				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				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		
				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:** Dylan Williams	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:** Dylan Williams	Cyber Security Operational Group Chair's report and risk report taken to DTIS monthly	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	Progress Notes	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:** 01 Sep 2021 **Latest Review Date:** 15 Sep 2021 **Latest Review By:** Russell Favager **Last Review Comments:** Reviewed and no amendments required	**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	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	**07 Jun 2021** **Chris McKeown** Business case submit and approved by NHSE&I. As above £15m requires approval at Investment Committee	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						
				03. ALARP Workshop held in 2020 & action plan produced. **Control Owner:** Russell Favager	Action plan monitored through ESSEG	Acceptable				RAAC beams surveys to be fully completed. **Action Owner:** Andrew Deakin **Target Implementation Date:** 30 Apr 2022	**27 Sep 2021** **Andrew Deakin** • Phase 6 complete. (82% of RAAC footprint + 8% is residences to be demolished) • Awaiting clinical decision on Ward 10. ED to be surveyed once decants into new facility **01 Sep 2021** **Russell Favager** Phase 6 complete, 82% complete + 8% residencies, no further progress. Ward 10, ED, part Ward 26 and part of residencies are left to survey. Ward 10 and South Cheshire, due to operational issues, both accepted may not be undertaken until Spring 22, meeting to be arranged with Cheshire Fire & Rescue re enforcement notice	
				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						

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	Progress Notes	Target Risk Score
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:** Dylan Williams **Risk Owner:** Dylan Williams **Last Updated:** 08 Oct 2021 **Latest Review Date:** 31 Aug 2021 **Latest Review By:** Chris McKeown **Last Review Comments:** Risk reviewed by Digital Clinical System Programme Director and updates to actions and controls identified.	**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:** Dylan Williams	Digital Clinical Systems (DCS) update reports to Workforce Digital Transformation Committee monthly	Acceptable			I = 4 L = 3 12	Digital Clinical System Programme Director / Dir of Corporate Affairs at ECT and Company Secretary to discuss draft Terms re: DCS at October meeting **Action Owner:** Caroline Keating **Target Implementation Date:** 31 Oct 2021	**31 Aug 2021** **Chris McKeown** Draft terms completed by Hill Dickinson. Meeting to agree in September 21.	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 taken to Transformation Board July 2021. Action plan being delivered.	Partial	NHS Digital TSSM assessment taking place as part of Programme Assurance Review to check progress against the TSSM.	Partial		Gateway Reviews to be reported to the Digital Transformation Programme Board when in place **Action Owner:** Dylan Williams **Target Implementation Date:** 31 Oct 2021	**31 Aug 2021** **Chris McKeown** Programme Assurance Review being completed by NHS Digital 7-9 September 21. Report expected September/October and expected to be available to go to Transformation Board in October 21. **01 Jul 2021** **Chris McKeown** Being presented at July Transformation Programme Board	
				03. Schedule in place to ensure Gateway 4 and Gateway 5 reviews **Control Owner:** Phillip James	Included in DCS project plan	Acceptable						
				04. MoU in place **Control Owner:** Dylan Williams	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						
				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				Increase in clinical time available for the Chief Clinical Information Officer to support the project. **Action Owner:** Dylan Williams **Target Implementation Date:** 30 Nov 2021	**31 Aug 2021** **Chris McKeown** Transformation Board approved time for Medics per month to support. Clinical Time for the Chief Clinical Information Officer still to be approved.	
										OGC Gateway 4 (Readiness for Service) Review **Action Owner:** Dylan Williams **Target Implementation Date:** 30 Jun 2024	**31 Aug 2021** **Chris McKeown** Gateway 4 as part of the plan is scheduled for review at the point DCS will go live. Therefore the date has been changed in line with this.	
										OGC Gateway 5 (Operational Reviews & Benefits Realisation) Review **Action Owner:** Dylan Williams **Target Implementation Date:** 25 Jun 2025	**31 Aug 2021** **Chris McKeown** Gateway 5 as part of the plan is scheduled for approximately 1 year after the DCS has gone live. Therefore the date has been changed in line with this.	

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	Progress Notes	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:** 30 Sep 2021 **Latest Review Date:** 27 Aug 2021 **Latest Review By:** Chris McKeown **Last Review Comments:** Review completed with Director for Workforce & Organisational Development. Progress against overdue actions entered and either new completion dates identified or if action was closed it has been entered as a new control. No changes in causes, consequences or scoring.	**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	Analysis of recruitment metrics from new recruitment trac.jobs system **Action Owner:** Jaz Mallan **Target Implementation Date:** 30 Sep 2021	**25 Aug 2021** **Chris McKeown** Target date changed to 30/09/21 as work still in progress.	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 Oct 2021	**25 Aug 2021** **Chris McKeown** Vacancy trajectories for all staff groups a rolling agenda item for the workforce supply group. Deep dive into Acute Med, Respiratory and Anesthetics medical workforce gaps completed and presented to ERAG in August	
				03. Workforce Systems Project **Control Owner:** Paul Cooper	Quarterly progress report to EWAG and 6 monthly to WDT.	Acceptable				Implement and monitor new Agile Working Policy **Action Owner:** Anna Bickerton **Target Implementation Date:** 31 Dec 2021		
				04. E-roster implementation plan developed in November 18. **Control Owner:** Helen Nutkins	E-roster reporting on nursing, midwifery and HCA staff groups. E-rostering project board monitor action plan. Plan on schedule and meeting NHSI levels of attainment.	Acceptable				Develop career pathways for Physician Associates **Action Owner:** Nicola Madeley **Target Implementation Date:** 31 Dec 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		Implementation of an e-roster system for medical staff **Action Owner:** Jaz Mallan **Target Implementation Date:** 31 Dec 2021	**21 Jul 2021** **Chris McKeown** Action target date changed from September to December as to implement will require a Business Case, seeking relevant approvals, setting up a working party and going through a procurement process.	
				06. Apprenticeships Strategic Plan **Control Owner:** Nicola Madeley	Apprenticeship levy usage report taken to July EWAG and August WDT.	Acceptable						
				07. Workforce Supply Group plus sub group workstreams **Control Owner:** Heather Barnett	Workforce Supply Group report to EWAG via Chair's reports	Acceptable						
				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						
				11. Appraisal system / career conversations **Control Owner:** Amy Oakes	Approval assurance report to WDT July 2021. Regular reports to EWAG.	Partial						

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	Progress Notes	Target Risk Score
				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

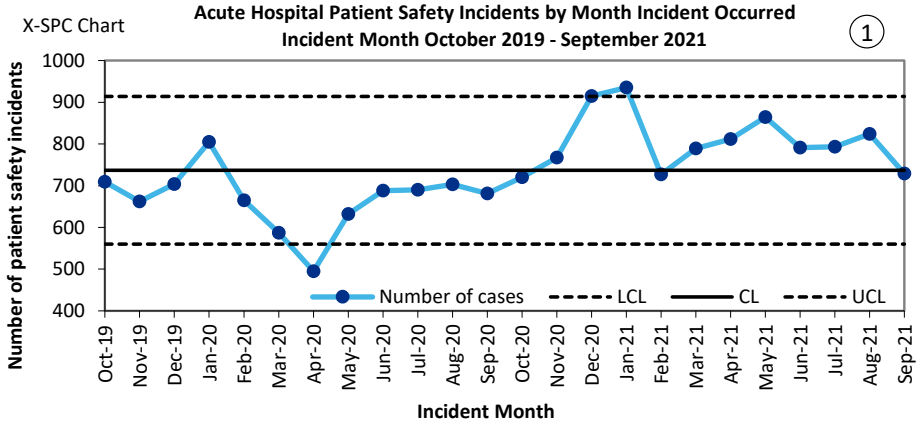
September 2021

"To Deliver Excellence in Healthcare through Innovation & Collaboration"

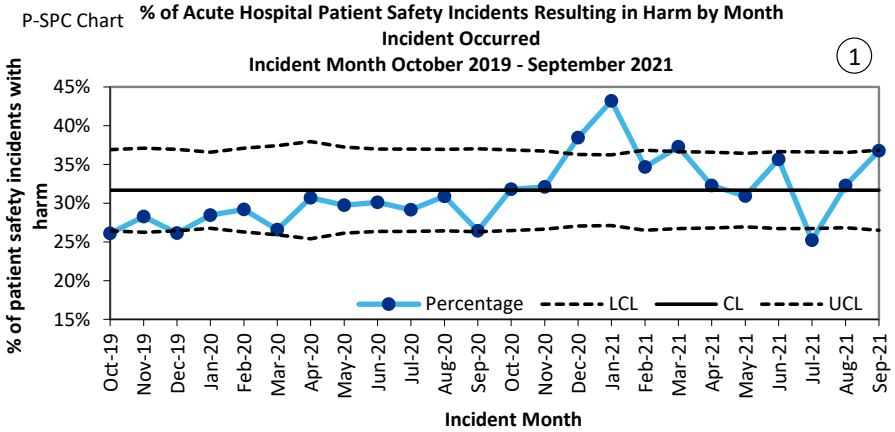
Quality, Safety & Patient Experience

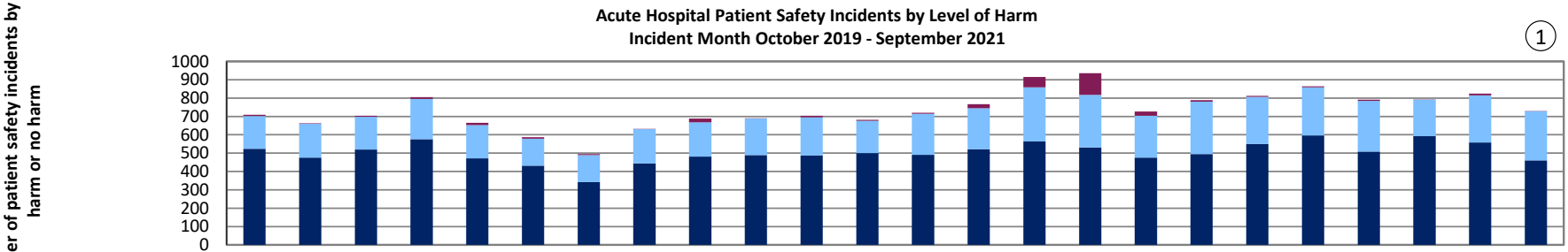
Acute Hospital Patient Safety Incidents (Excludes CCICP)

X-SPC Chart



P-SPC Chart





	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	Jul-21	Aug-21	Sep-21
Moderate and Above	7	2	6	9	12	8	5	1	20	2	8	5	5	22	56	118	23	8	5	5	7	2	9	1
Low Harm	178	185	178	220	182	148	147	187	187	199	209	175	224	224	296	286	229	286	257	262	275	198	257	267
No Harm	524	475	520	576	471	431	343	444	481	489	486	501	491	521	563	531	475	495	550	597	509	593	558	461

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: 729 incidents are currently shown for September 2021 of which 36.8% resulted in harm.

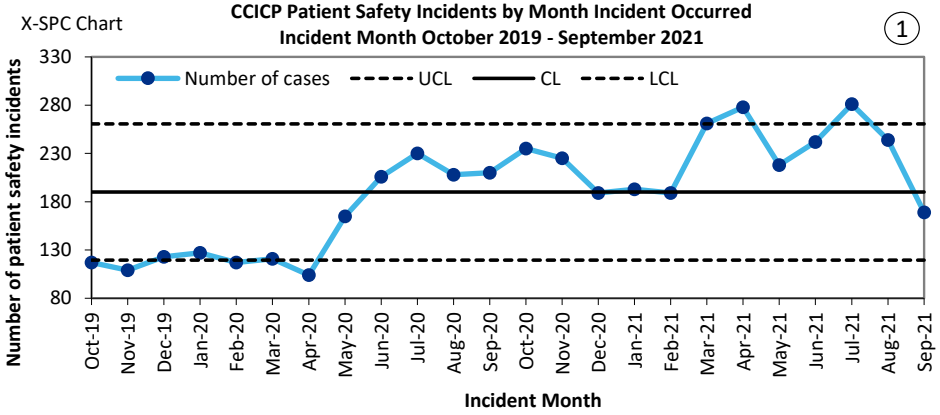
Low Harm 267, Moderate Harm 1, Serious Incident 0

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

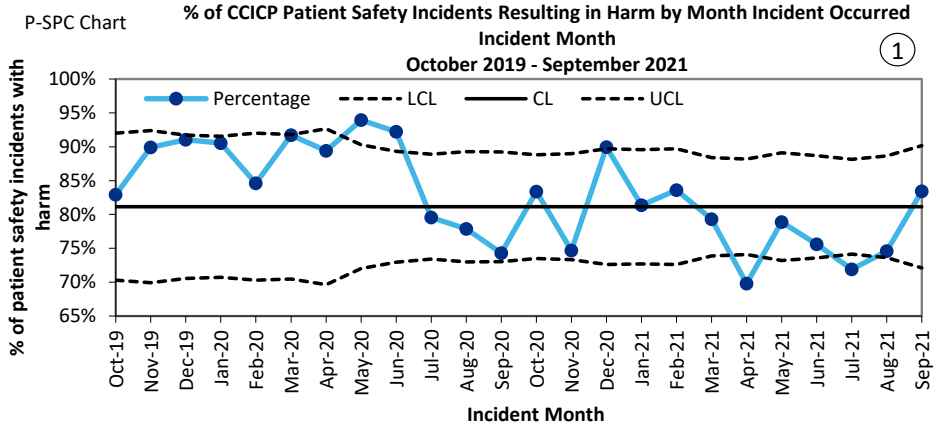
Quality, Safety & Patient Experience

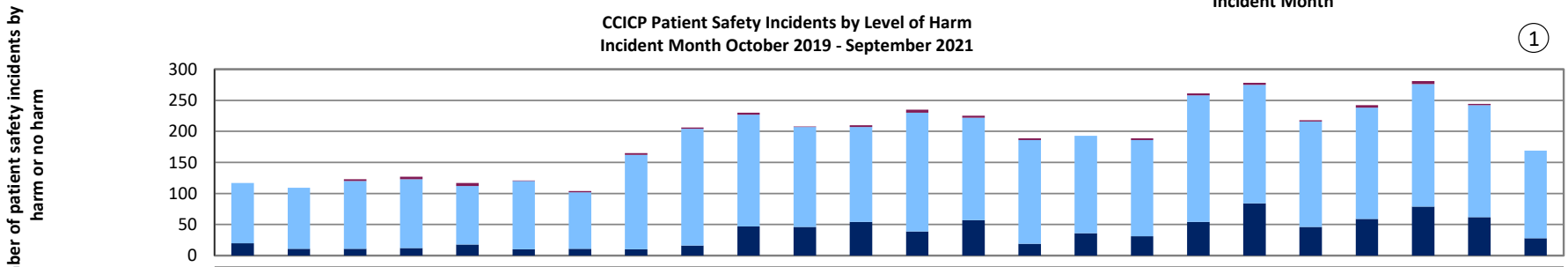
Central Cheshire Integrated Care Partnership (CCICP) Patient Safety Incidents

X-SPC Chart



P-SPC Chart





	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	Jul-21	Aug-21	Sep-21
Moderate and Above	-	-	3	4	5	1	2	3	2	3	1	3	5	3	3	-	3	3	3	2	4	5	2	-
Low Harm	97	98	109	111	94	110	91	152	188	180	161	153	191	165	167	157	155	204	191	170	179	197	180	141
No Harm	20	11	11	12	18	10	11	10	16	47	46	54	39	57	19	36	31	54	84	46	59	79	62	28

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

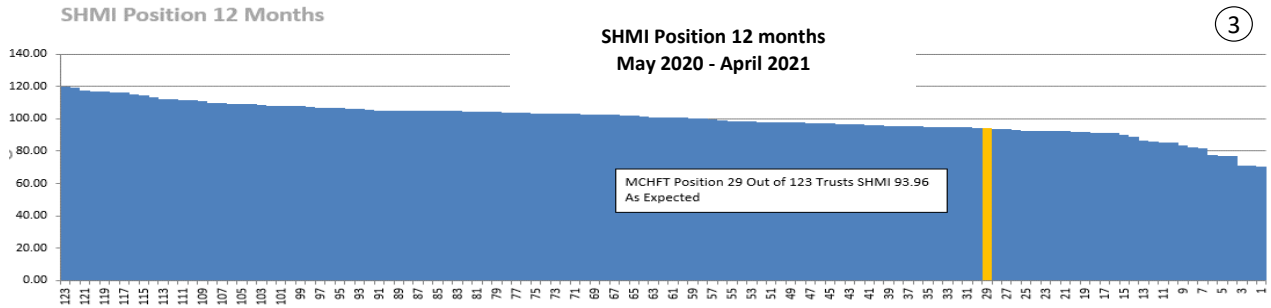
Key Narrative: 169 CCICP patient safety incidents are currently shown for September 2021 of which 83.4% resulted in harm. There was a step change in March 2020 where CCICP introduced incident reporting awareness sessions and this increased incident reporting from May 2020.

Low Harm 141, Moderate Harm 0, Serious Incident 0

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

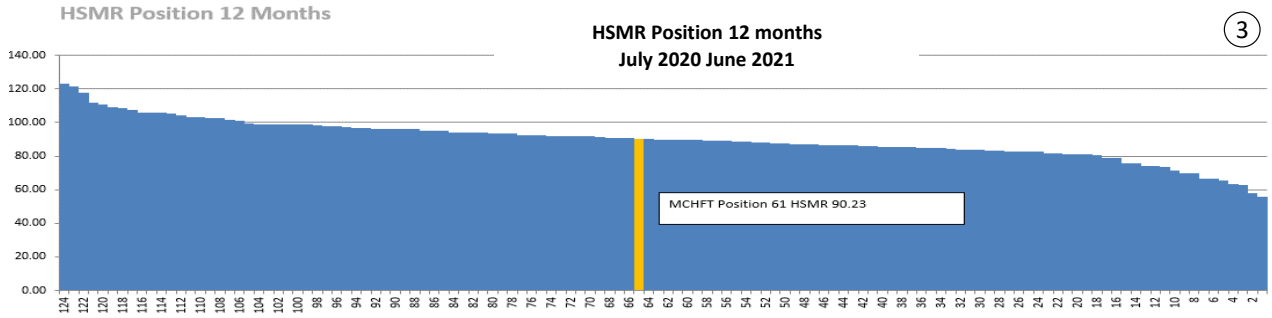
Quality, Safety & Patient Experience

Mortality



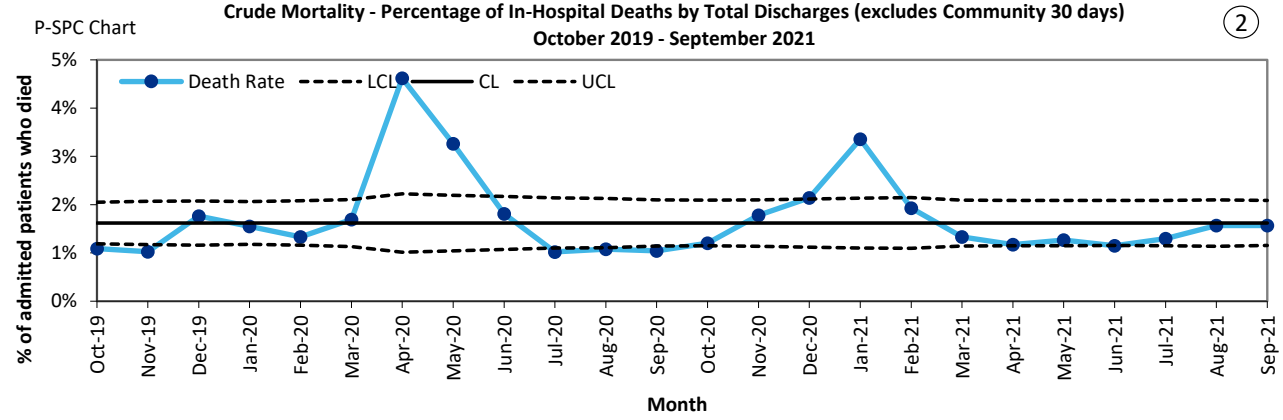
③

Key Narrative: The latest release of SHMI is 93.96 (rank 29) against the previous value of 94.30 (rank 30). This is still in the 'as expected' range. Please note that the number of submitting Trusts has dropped from 129 to 123 due to Trust mergers that is now reflected in the data.



③

Key Narrative: The latest HSMR release is 90.23. 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

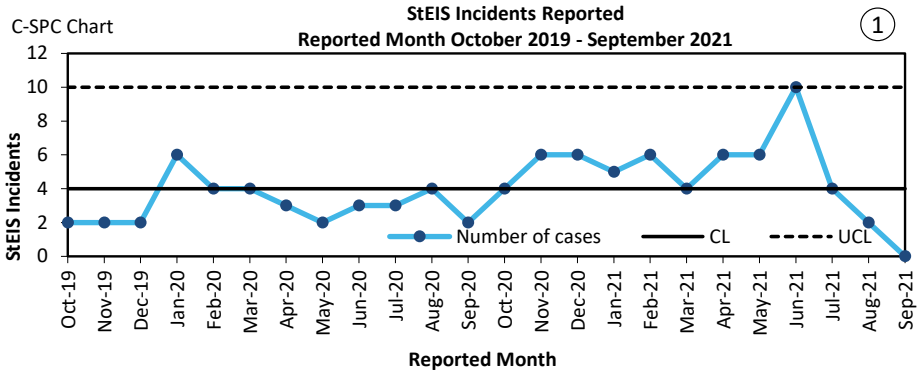
Key Narrative: Crude mortality has remained largely consistent over the time period except for peaks seen in April 2020, May 2020 and January 2021 related to an increase in COVID-19 patients within the Trust. September 2021 continues to show a return to pre-covid levels but is higher than September 2020, with more deaths & discharges recorded than in August 2020. September 2021 shows no change from August 2021.

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

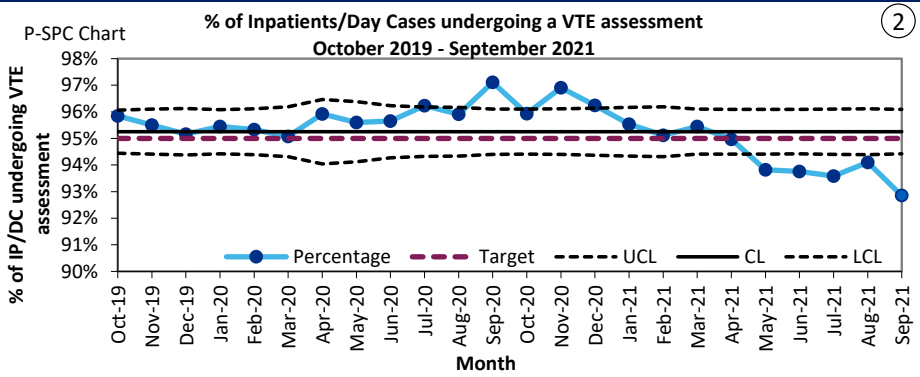
StEIS Incidents - Trust Total



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

Key Narrative: There were no serious incidents reported to StEIS in September 2021.

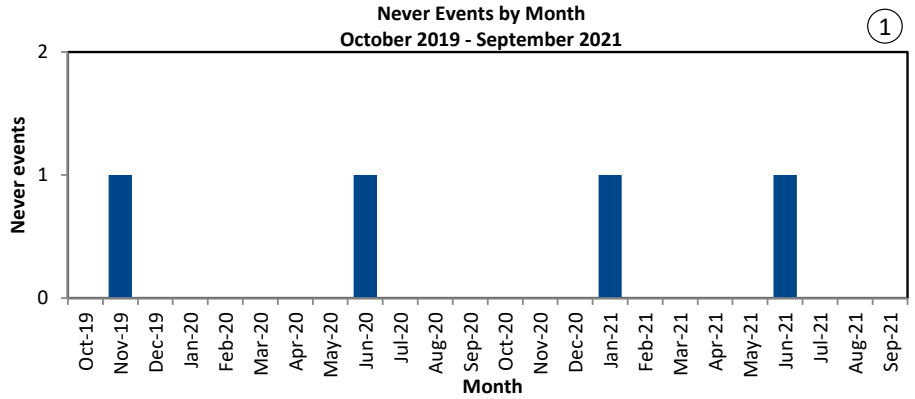
VTE



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

Key Narrative: The percentage of VTE assessments remains below target in September 2021 achieving 92.8%. The P-SPC charts adjust the control limits to take into account each month's denominator.

Never Events - Trust Total



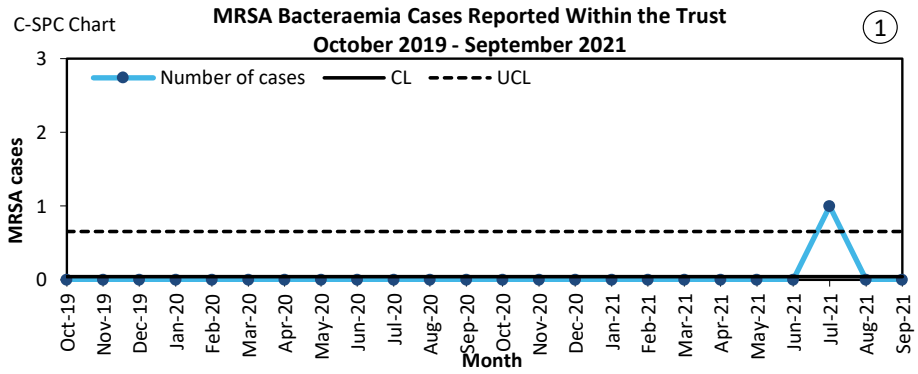
Accountable: Medical Director **Data Owner:** Information Services

Key Narrative: There were no never events reported in September 2021.

Quality, Safety & Patient Experience

MRSA

C-SPC Chart

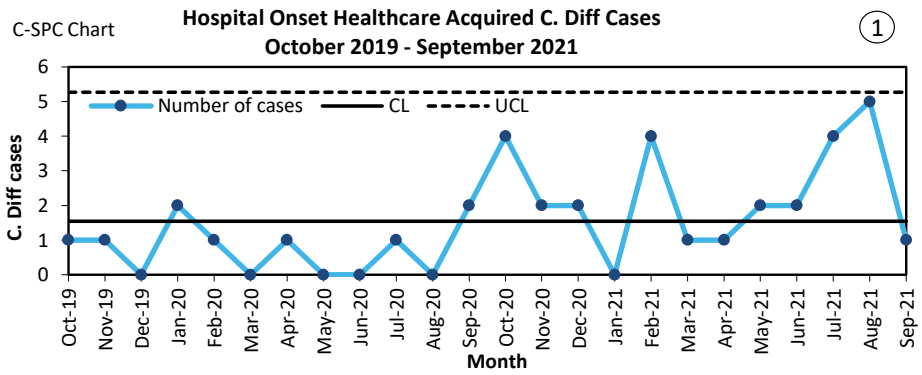


Accountable: Director of Nursing and Quality
Data Owner: Infection Prevention Control Team

Key Narrative: There were no MRSA bacteraemia cases reported in September 2021.

C. Diff Positive Cases

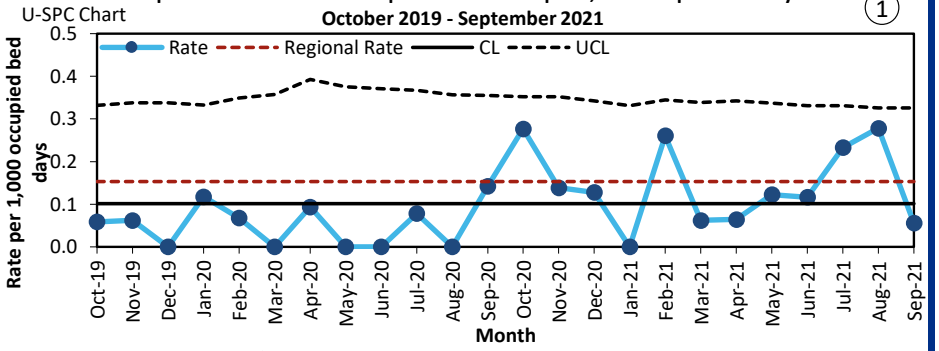
C-SPC Chart



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

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

U-SPC Chart



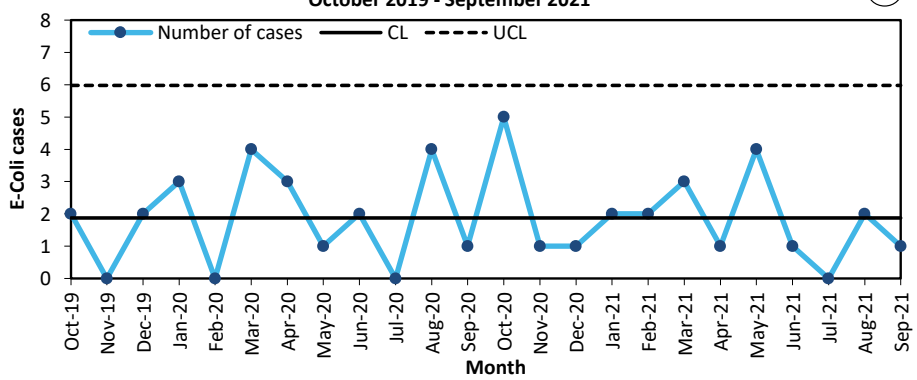
Accountable: Director of Nursing and Quality
Data Owner: Infection Prevention Control Team
Key Narrative: One hospital onset healthcare acquired C.Diff case was recorded in September 2021 with a rate of 0.06 per 1,000 occupied bed days, better than the regional rate for the month. The P-SPC charts adjust the control limits to take into account each month's denominator.

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

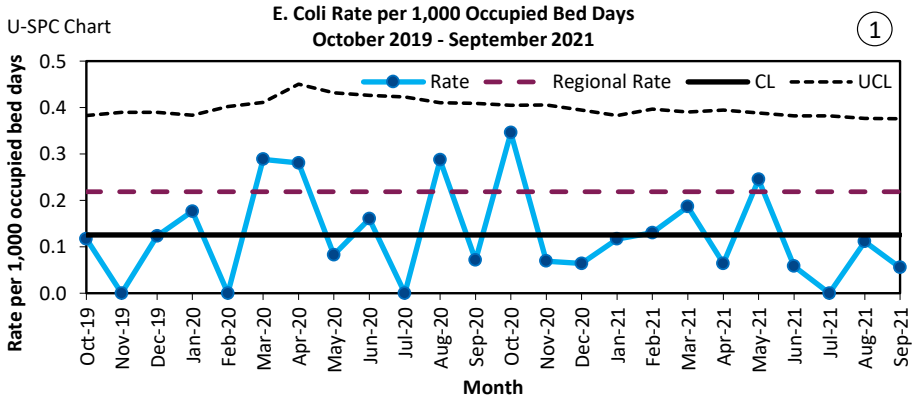
Quality, Safety & Patient Experience

E-Coli Cases

C-SPC Chart



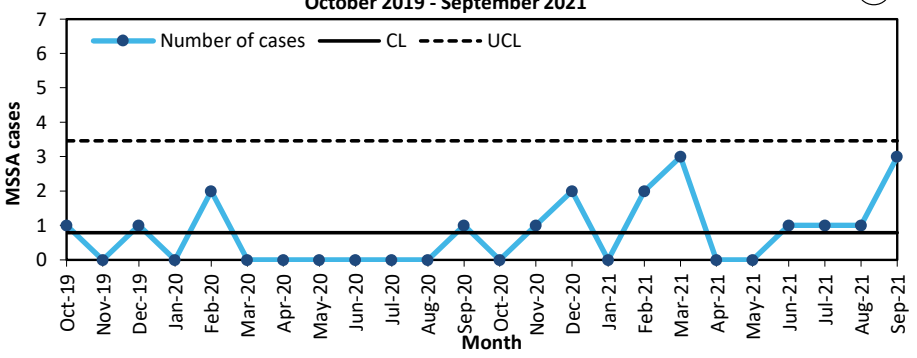
U-SPC Chart



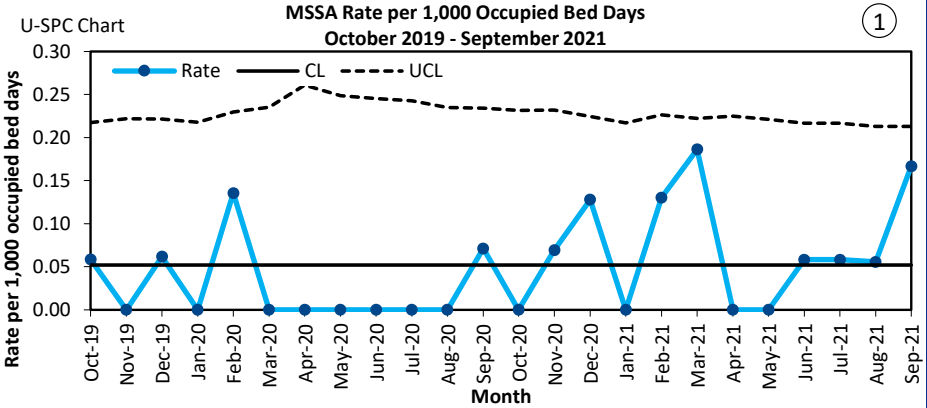
Accountable: Director of Nursing and Quality
Data Owner: Infection Prevention Control Team
Key Narrative: One E-Coli case was recorded in September 2021 with a rate of 0.06 cases per 1,000 occupied bed days, below the current regional rate. The U-SPC chart adjusts the control limits to take into account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

MSSA

C-SPC Chart



U-SPC Chart

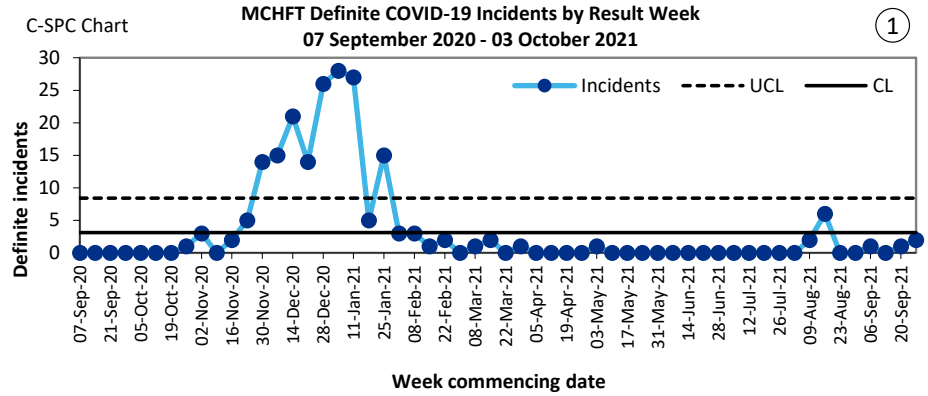


Accountable: Director of Nursing and Quality
Data Owner: Infection Prevention Control Team
Key Narrative: There were three MSSA cases reported in September 2021 with a rate of 0.17 per 1,000 occupied bed days. The U-SPC chart adjusts the control limits to take into account each month's denominator.

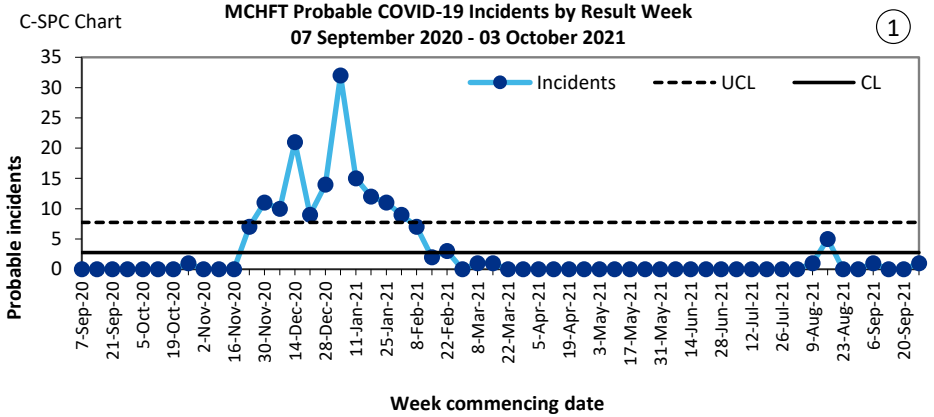
Quality, Safety & Patient Experience

COVID-19 Healthcare Acquired Infections

C-SPC Chart

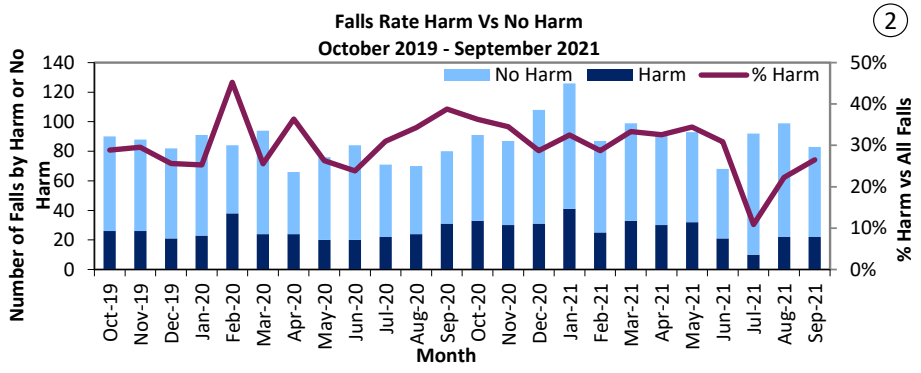


C-SPC Chart

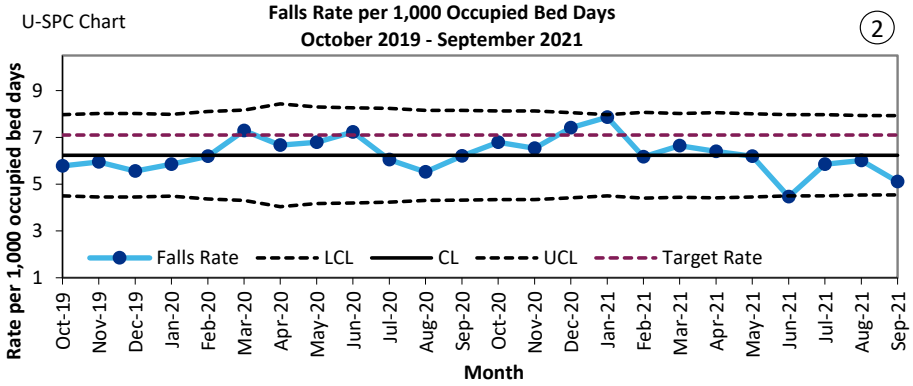


Accountable: Director of Nursing and Quality **Data Owner:** Information Services
Key Narrative: The latest week reported, week commencing 27th September 2021, shows 1 definite incidents and 2 probable incidents.

Falls



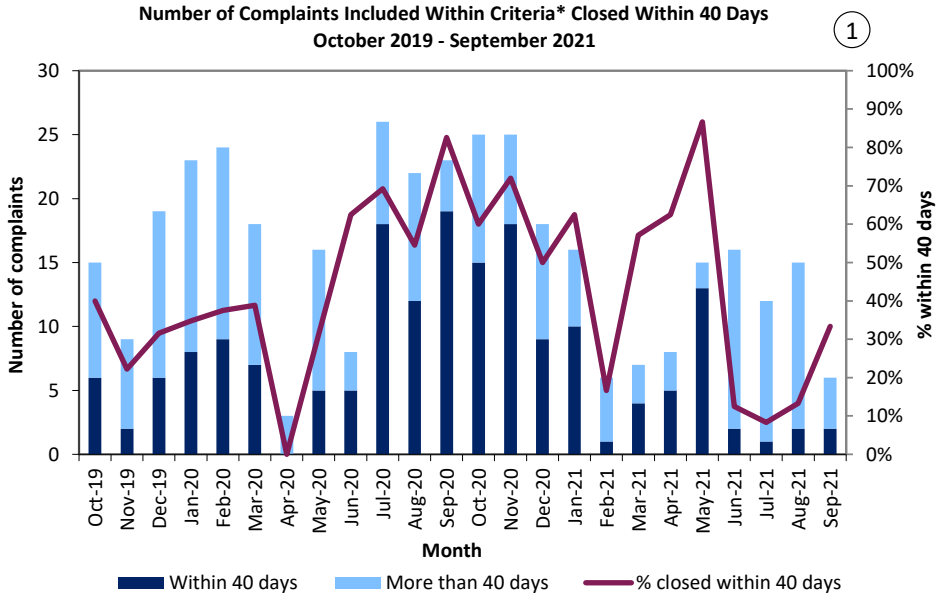
U-SPC Chart

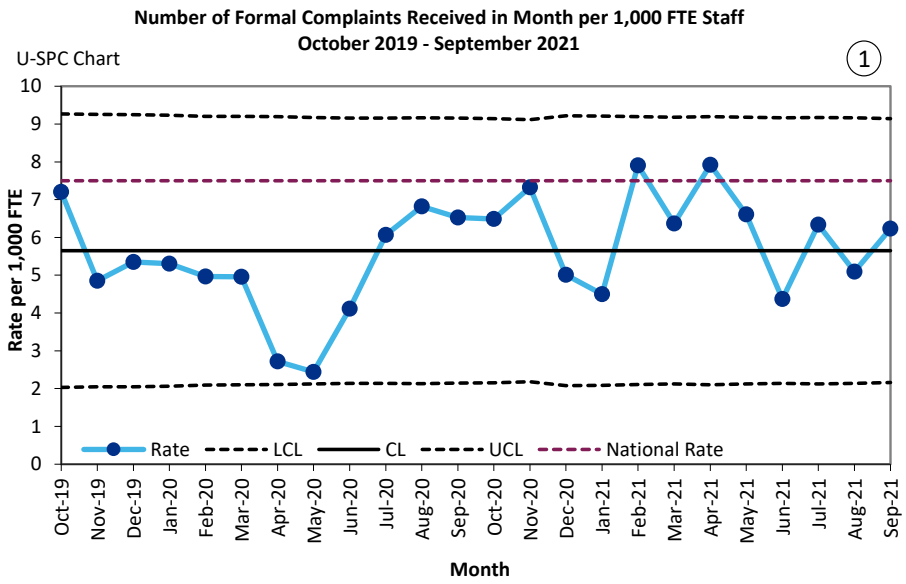


Accountable: Director of Nursing and Quality **Data Owner:** Nursing Quality Team
Key Narrative: 83 falls were reported in September 2021 with a rate of 4.6 per 1,000 occupied bed days, which is better than the target rate of 6.6. 22 falls resulted in harm (27%). The U-SPC chart adjusts the control limits to take into account each month's denominator.

Quality, Safety & Patient Experience

Formal Complaints





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

Key Narrative: 6 complaints were closed in September 2021, of which 2 were closed within 40 days (33.3%). The rate of formal complaints received in September 2021 was 6.23 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.*

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

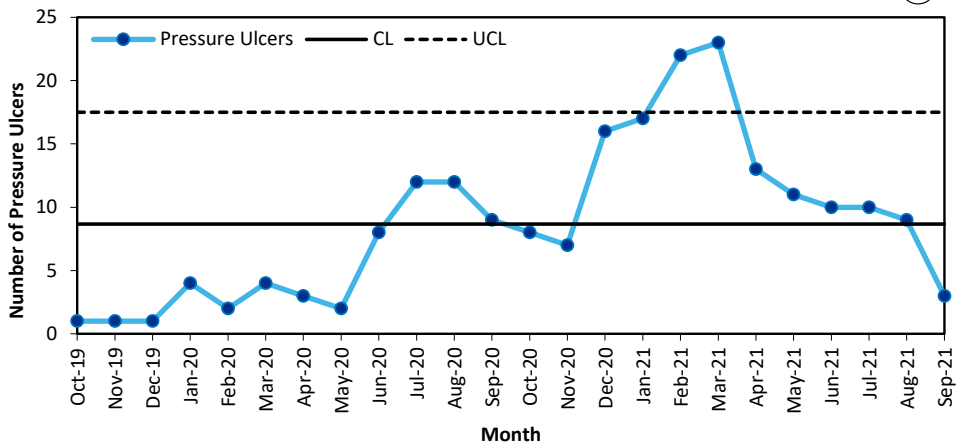
Quality, Safety & Patient Experience

Acute Hospital Pressure Ulcers

C-SPC Chart

Acute Hospital Pressure Ulcers - Lapses in Care Identified
October 2019 - September 2021

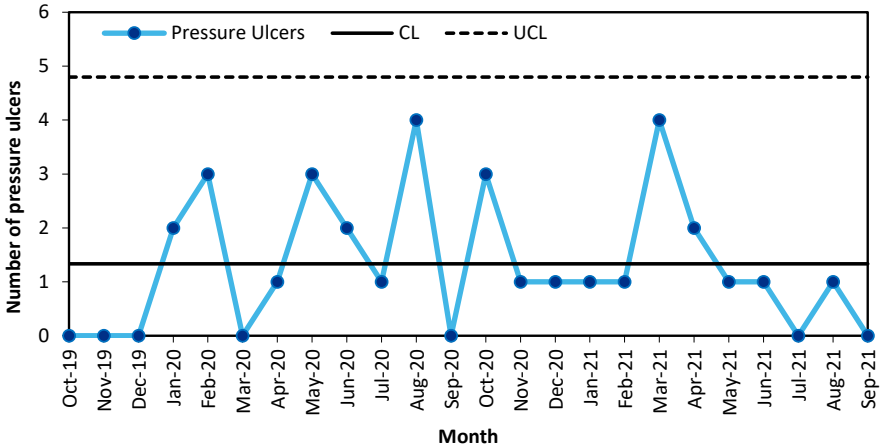
①



C-SPC Chart

Community Pressure Ulcers - Lapses in Care Identified
October 2019 - September 2021

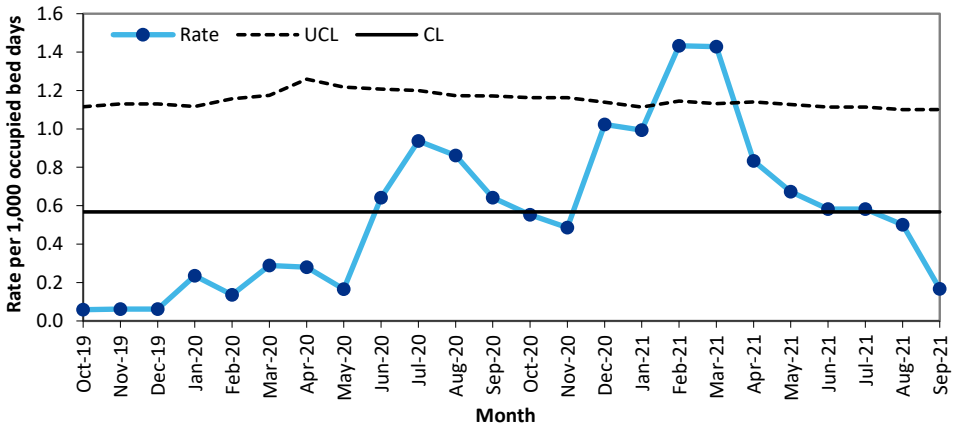
①



U-SPC Chart

Acute Hospital Pressure Ulcers - Lapses in Care Rate per 1,000 Occupied Bed Days
October 2019 - September 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: Three acute hospital lapses in care have currently been identified in September 2021 with a rate of cases per 1,000 occupied bed days of 0.17. Latest months data correct at time of reporting, however, will increase as the validation process for September 2021 data continues.

Community: Currently no community lapses of care has been identified in September 2021. There have been 5 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

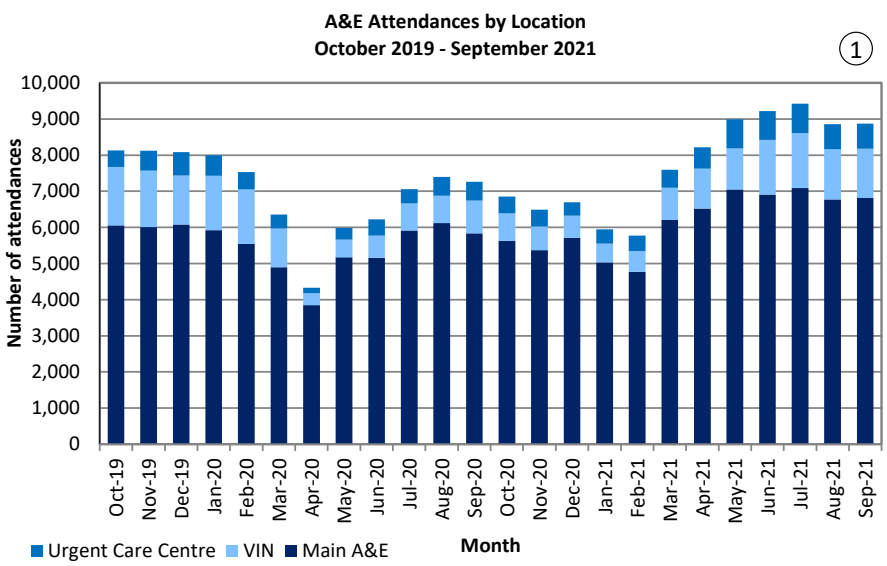
①

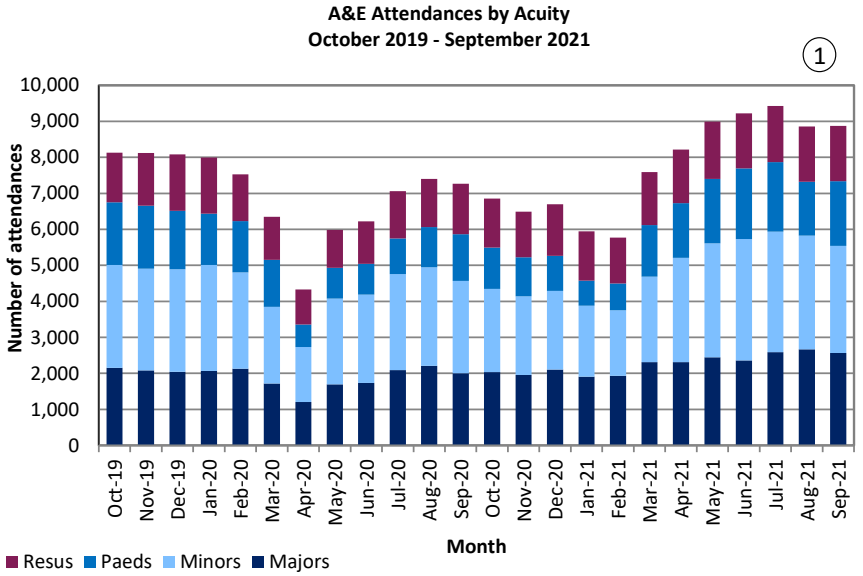
Ward Name	Day				Night				Day		Night	
	Qualified		Unqualified		Qualified		Unqualified		Qualified	Unqualified	Qualified	Unqualified
	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Fill Rate	Fill Rate	Fill Rate	Fill Rate
MCHFT	49272.9	42396.7	41762.7	33530.3	36817.0	31933.1	30475.5	27318.2	86%	99%	87%	95%
Acute Medical Unit	1965.5	1884.8	1934.5	1824.5	1809.0	1728.0	1476.0	1452.0	95.9%	94.3%	95.5%	98.4%
Child & Adolescent Unit	3350.8	2707.3	1411.5	990.2	1908.0	1748.9	432.0	313.3	80.8%	70.2%	91.7%	72.5%
Critical Care Unit (HIGH)	4282.1	3270.1	560.3	507.0	4680.0	3300.3	432.0	223.3	76.4%	90.5%	70.5%	51.7%
Elmhurst	727.5	726.5	2251.5	2060.5	720.0	720.0	1560.0	1536.0	99.9%	91.5%	100.0%	98.5%
South Cheshire Surveillance (HIGH)	2249.5	1807.0	2796.5	2173.0	2160.0	1753.0	2543.5	2024.9	80.3%	77.7%	81.2%	79.6%
Ward 1 Cardiology Coronary Care	1994.5	1961.3	1114.0	1034.0	1500.5	1404.0	720.0	720.0	98.3%	92.8%	93.6%	100.0%
Ward 10 Orthopaedic Trauma	2777.5	2379.0	3534.3	2909.8	1632.0	1476.5	2676.0	2508.0	85.7%	82.3%	90.5%	93.7%
Ward 11 Surgical/Gynae	2212.5	2039.5	1824.0	1517.0	1224.0	1116.0	1414.0	1354.0	92.2%	83.2%	91.2%	95.8%
Ward 12 SAU	1110.0	1050.5	868.0	719.3	768.0	696.0	804.0	745.0	94.6%	82.9%	90.6%	92.7%
Ward 12 Surgical Specialties	1155.5	1048.0	809.0	733.5	768.0	708.0	804.0	744.0	90.7%	90.7%	92.2%	92.5%
Ward 13 Medical Escalation	2358.3	1823.9	1709.0	1372.5	1260.0	1056.8	1632.0	1485.0	77.3%	80.3%	83.9%	91.0%
Ward 14 Gastroenterology	1353.8	1305.8	1547.0	1493.0	1128.0	1044.0	1260.0	1212.0	96.5%	96.5%	92.6%	96.2%
Ward 15 Medical Escalation	1898.5	1725.0	1733.0	1527.0	1164.0	1104.0	1452.0	1389.0	90.9%	88.1%	94.8%	95.7%
Ward 18 Elective	1547.0	1265.0	1256.0	983.0	720.0	721.0	756.0	684.0	81.8%	78.3%	100.1%	90.5%
Ward 19 Winter	1595.5	1407.3	1950.0	1488.0	1152.0	1068.0	1488.0	1370.5	88.2%	76.3%	92.7%	92.1%
Ward 21b Rehabilitation	1267.0	1171.9	2757.0	2170.0	1152.0	1020.5	1752.0	1581.8	92.5%	78.7%	88.6%	90.3%
Ward 22 NICU	1825.4	1769.8	1167.3	561.8	1311.5	1295.7	645.0	312.9	97.0%	48.1%	98.8%	48.5%
Ward 23 Maternity	1354.5	1199.8	716.7	652.0	720.0	714.8	727.0	694.3	88.6%	91.0%	99.3%	95.5%
Ward 26 Labour	2913.1	2452.8	728.5	687.8	2220.0	2047.2	360.0	352.9	84.2%	94.4%	92.2%	98.0%
Ward 3 Respiratory	2361.0	2056.0	1730.5	1345.0	1788.0	1503.5	756.0	756.0	87.1%	77.7%	84.1%	100.0%
Ward 4 Care of the Elderly	1477.0	1311.0	2163.0	1771.0	1236.0	1031.1	1788.0	1700.8	88.8%	81.9%	83.4%	95.1%
Ward 5 Covid (HIGH)	2881.0	2217.5	1647.8	889.8	2364.0	1759.0	1696.5	1353.5	77.0%	54.0%	74.4%	79.8%
Ward 6 Stroke / Rehab	1825.5	1654.0	2248.0	1869.0	1524.0	1356.0	1188.0	1093.0	90.6%	83.1%	89.0%	92.0%
Ward 7 Diabetes / General Medicine	1695.0	1582.0	2249.5	1876.3	1140.0	1105.0	1332.0	1296.0	93.3%	83.4%	96.9%	97.3%
Ward 9 Orthopaedic Elective	1095.0	581.0	1056.0	375.5	768.0	456.0	781.5	416.0	53.1%	35.6%	59.4%	53.2%

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



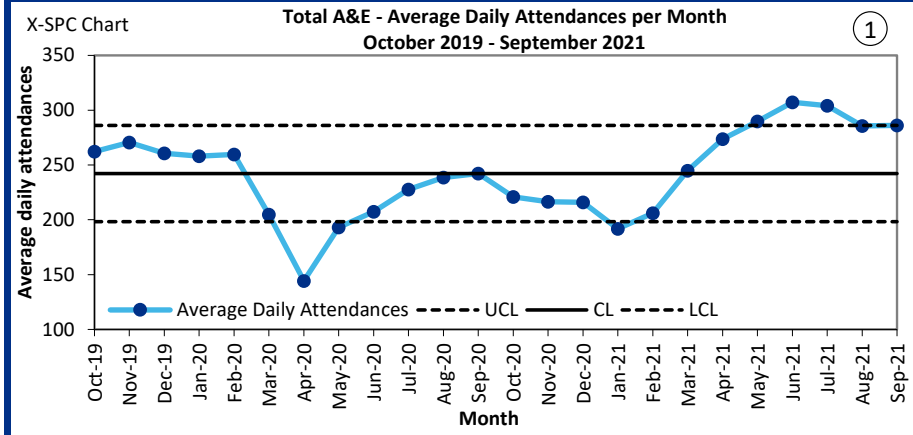


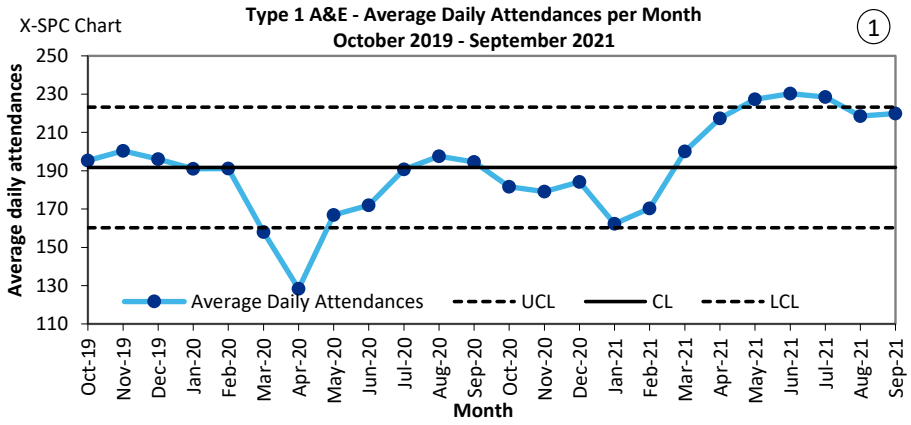
Accountable: Chief Operating Officer
Data Owner: Information Services

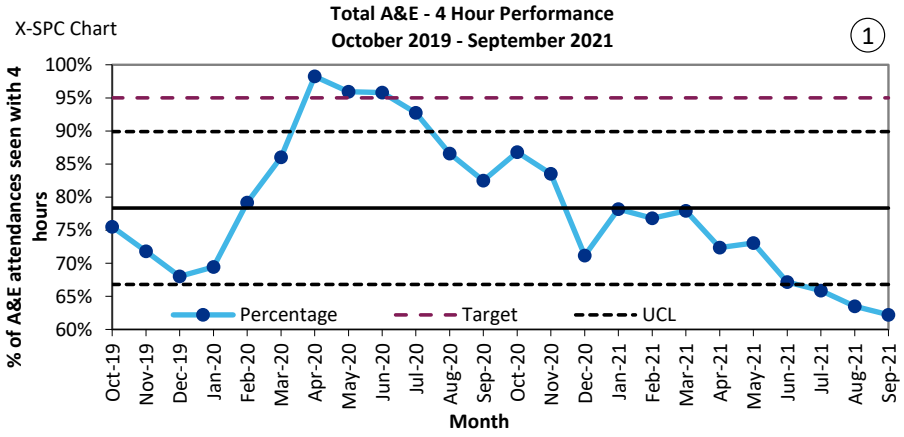
Key Narrative: There were a total of 8,873 A&E attendances across all locations in September 2021, a 0.2% increase on the previous month. There were 6,815 attendances reported in September 2021 for the main A&E department at Leighton Hospital (type 1), higher than pre-pandemic levels and above the 6,777 attendances in August 2021. September 2021 activity variance compared to previous month by acuity: Majors -101, Minors -183, Paeds 299, Resus 0.

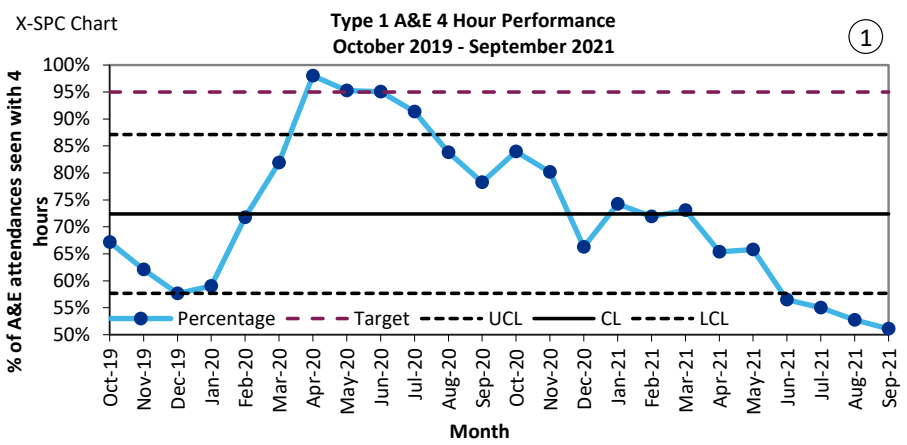
Performance

A&E Performance









Accountable: Chief Operating Officer
Data Owner: Information Services

Key Narrative: The average total daily A&E attendances for September 2021 was 286 and in line with the August 2021 rate of 286, remaining above pre-pandemic attendance rates. The average daily attendances for Type 1 follows a similar pattern with September 2021 rate of 220, in line with the August 2021 rate of 219. As activity rates have remained high there is a corresponding reduction in performance, with Total A&E Attendances achieving 62.2% and Type 1 achieving 51.1% in September 2021, which is lower than the previous month. There were 26 patients who spent longer than 12 hours in ED following a Decision to Admit in September.

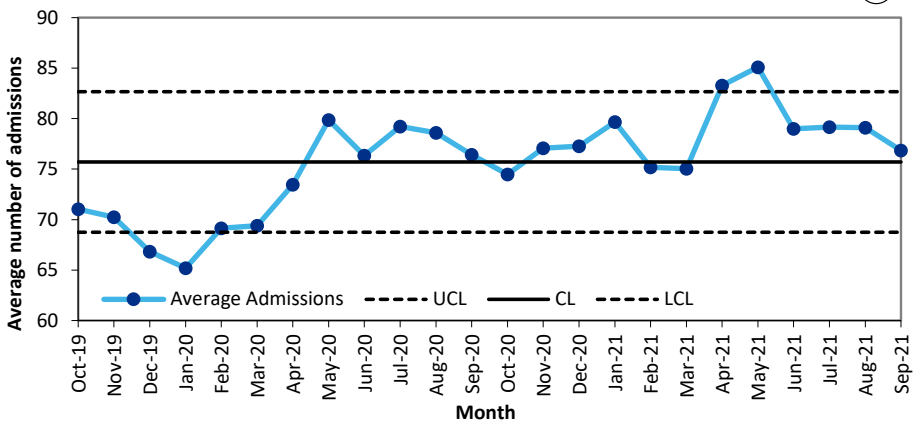
Performance

Unplanned Admissions

X-SPC Chart

Average Daily Admissions from A&E
October 2019 - September 2021

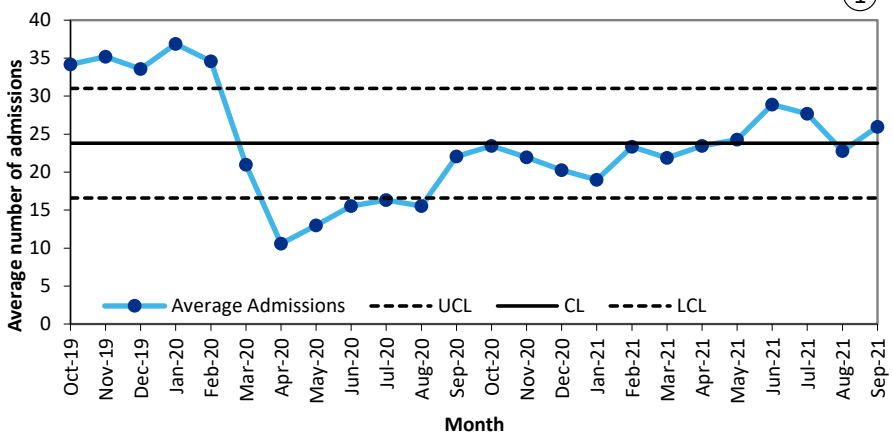
①



X-SPC Chart

Average Daily Admissions per Month - GP Referred
October 2019 - September 2021

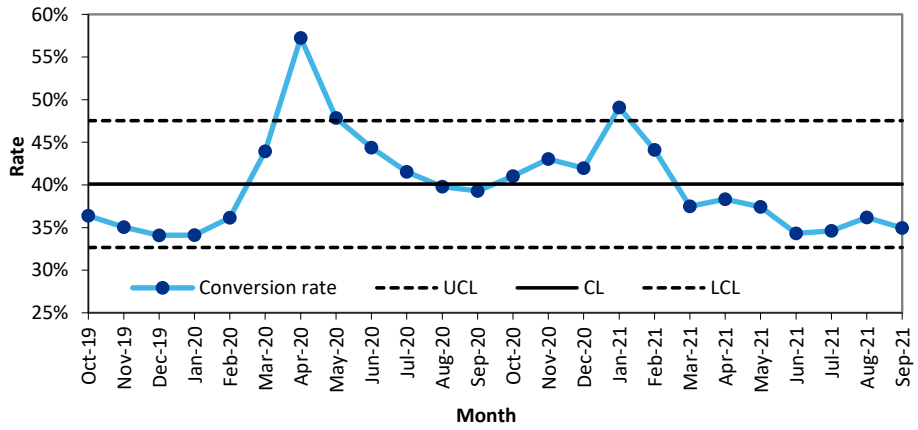
①



X-SPC Chart

Type 1 Attendance to Admissions Conversion Rate - Overall
October 2019 - September 2021

①



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

Key Narrative: 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.

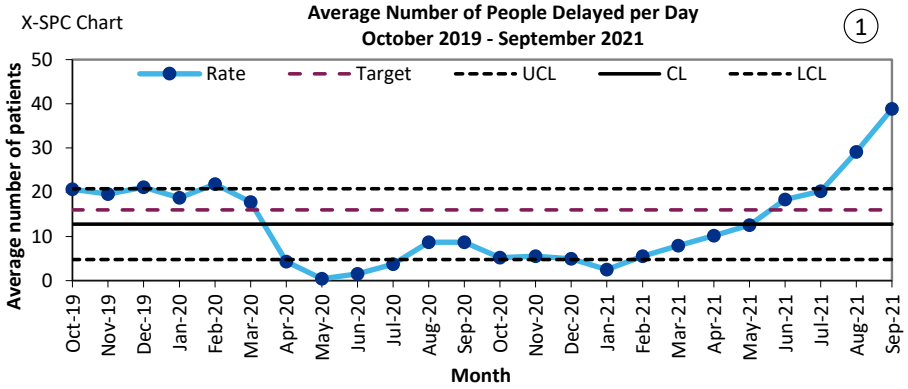
The average daily admissions from A&E for September 2021 was 77, slightly below the rate shown for August 2021 (79), above pre-pandemic levels.

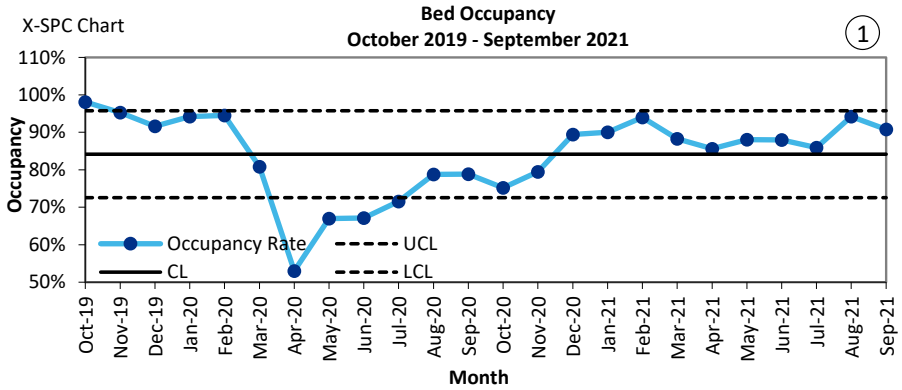
The average daily admissions for GP-referred patients in September 2021 was 26, an increase against the average admission rate for August 2021 (23). The reduction in GP referred admissions (compared to pre pandemic) is due to stricter admission criteria, based on Covid pathways, directing more patients to ED/RAU and a change in how patients present to ED following virtual GP appointments.

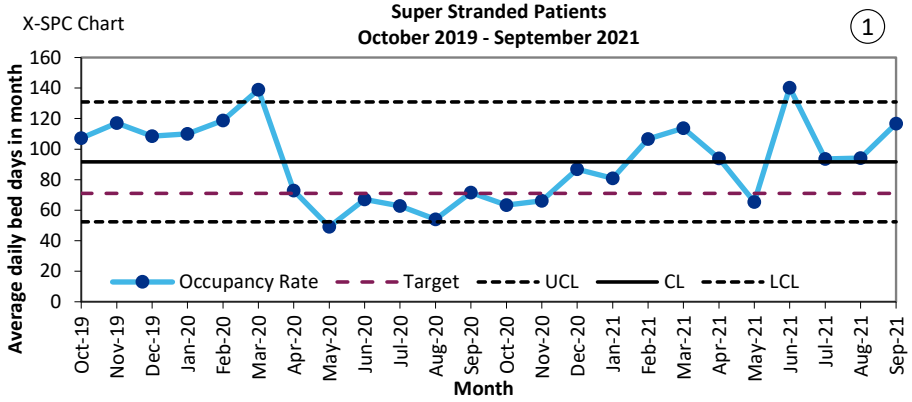
The type 1 admission conversion rate for September 2021 was 35.0%.

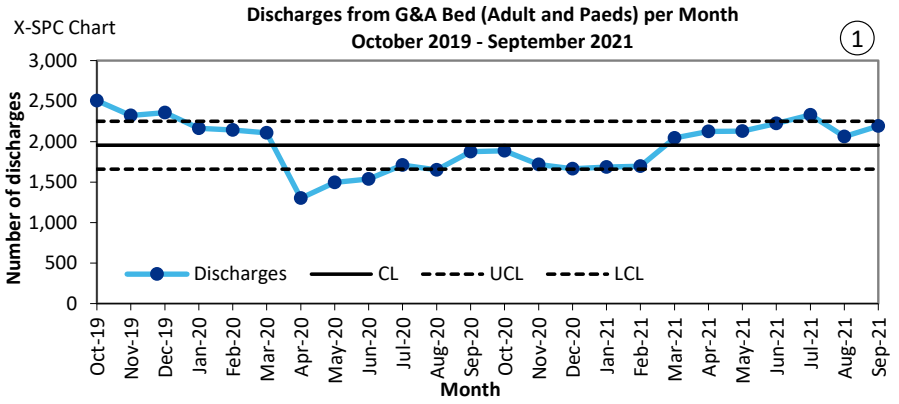
Performance

Inpatient Metrics









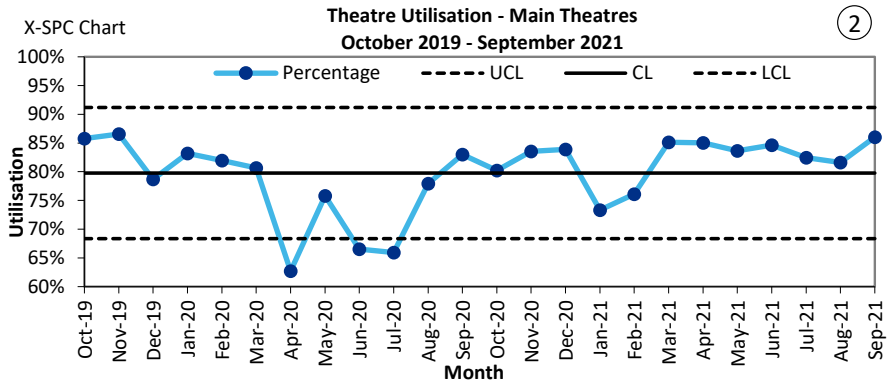
Accountable: Chief Operating Officer **Data Owner:** Information Services

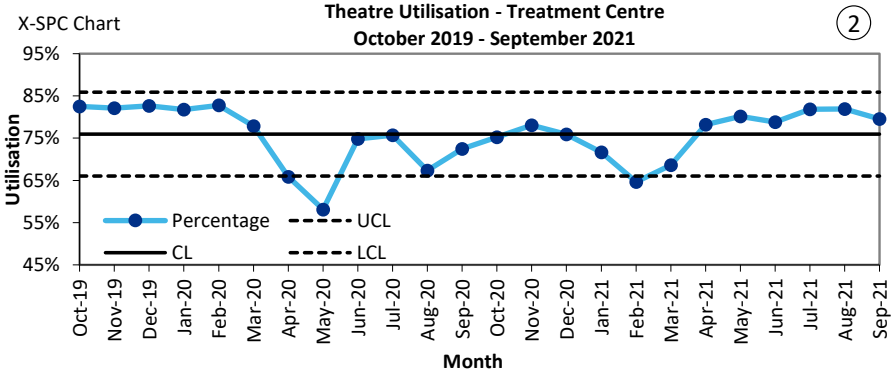
Key Narrative: The average number of people delayed per day during September 2021 was 39, an increase on August 2021 (29). The average number of super stranded patients delayed per day in the hospital increased from 94 in August 2021 to 117 in September 2021. The percentage b ed occupancy rate for September 2021 was 90.8%, a decrease on the August 2021 occupancy rate of 94.2%. The bed occupancy figure reported does not exclude lost be ds that are not suitable for patient admissions for infection prevention an control (IPC) reasons. There were 2,192 discharges from G&A beds in September 2021, which is an increase against August 2021 (2063).

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

Performance

Theatre Utilisation



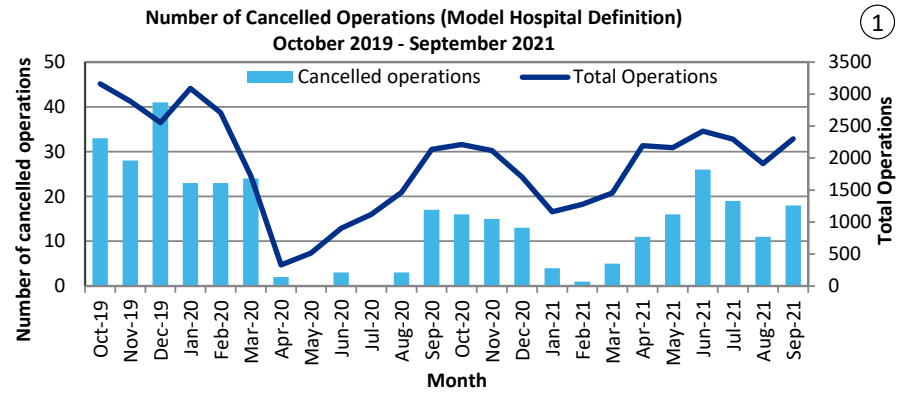


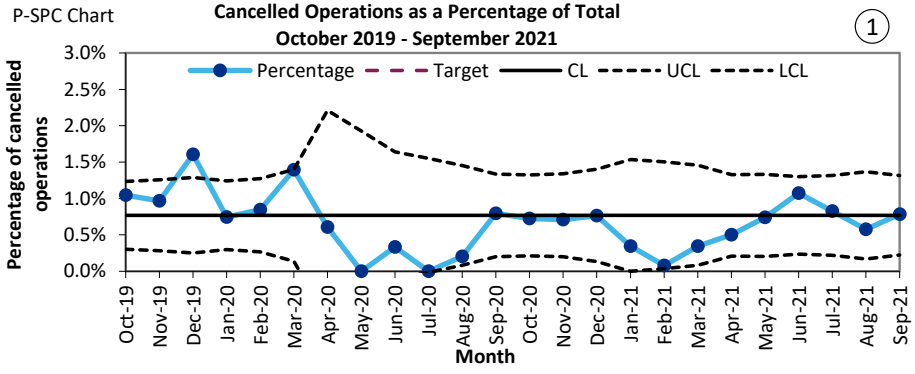
Accountable: Chief Operating Officer **Data Owner:** Information Services

Key Narrative: Theatre utilisation rate for September 2021 was 86.0% in Main Theatres, an increase on the August 2021 position of 81.6%.

Theatre utilisation rate for the Treatment Centre in September 2021 was 79.6%, below the August 2021 position of 81.9%.

Cancelled Operations





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

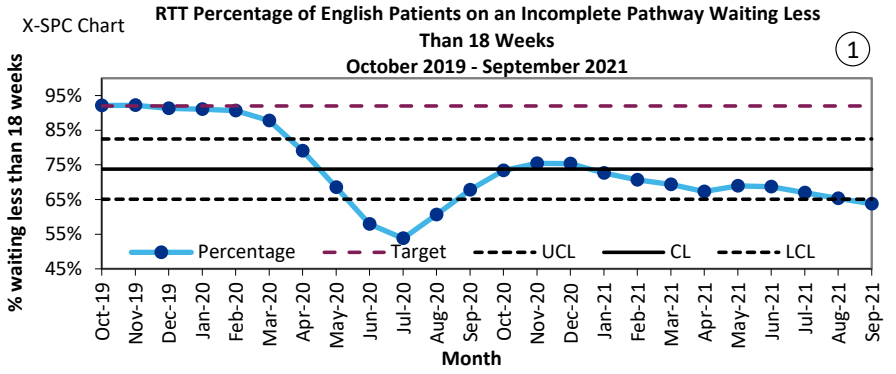
Key Narrative: 18 operations were cancelled on the day of admission by the hospital for non-clinical reasons in September 2021 (0.8%), an increase on the percentage of cancellations in August 2021 (0.6%).

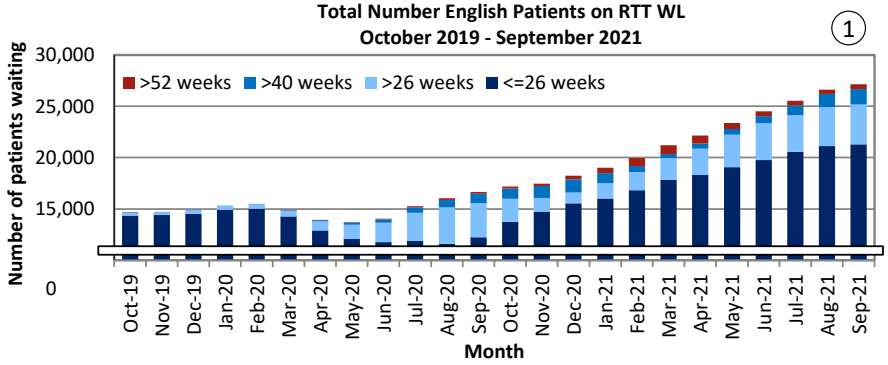
The P-SPC chart adjusts the control limits to take into account each month's denominator.

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

Performance

Referral to Treatment Waiting Times (RTT)





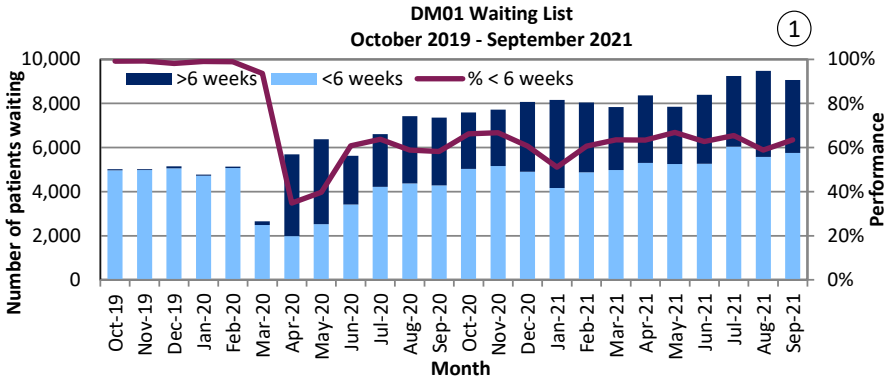
Accountable: Chief Operating Officer **Data Owner:** Information Services

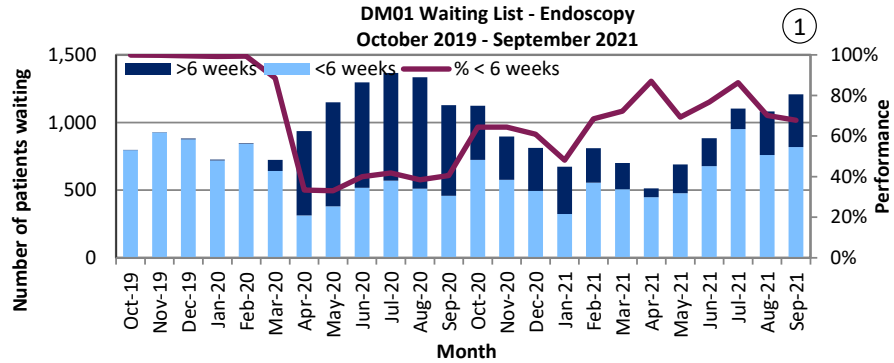
Key Narrative: The total number of patients on the RTT WL continues to grow with 27,163 patients waiting at the end of September 2021, of which 490 patients were waiting for more than 52 weeks, 66 more than reported in August 2021.

September 2021 RTT performance shows 63.7% of patients waiting less than 18 weeks, a decrease to the performance in August 2021 (65.3%).

Latest month's data provisional

Diagnostic Waiting Times





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

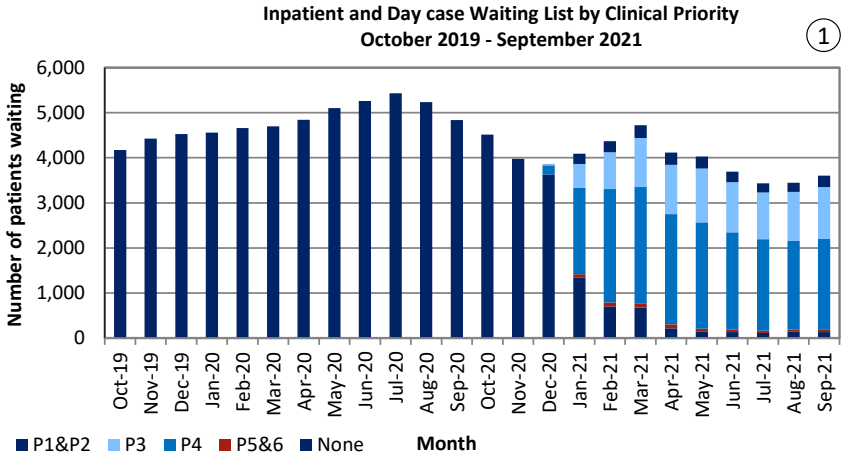
Key Narrative: Following a review of the DM01 guidance, there have been changes to the reporting logic from June 2021, which has led to an increase in the number of DM01 waiters reported alongside some waiting list growth.

The total number of patients on the DM01 diagnostic waiting list for September 2021 was 9,063 and performance against the 6 week diagnostic standard in September 2021 was 63.6%. Performance for the Endoscopy DM01 modalities reduced from 70.2% in August 2021 to 67.7% in September 2021.

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

Performance

Inpatient and Day Case Clinical Prioritisation

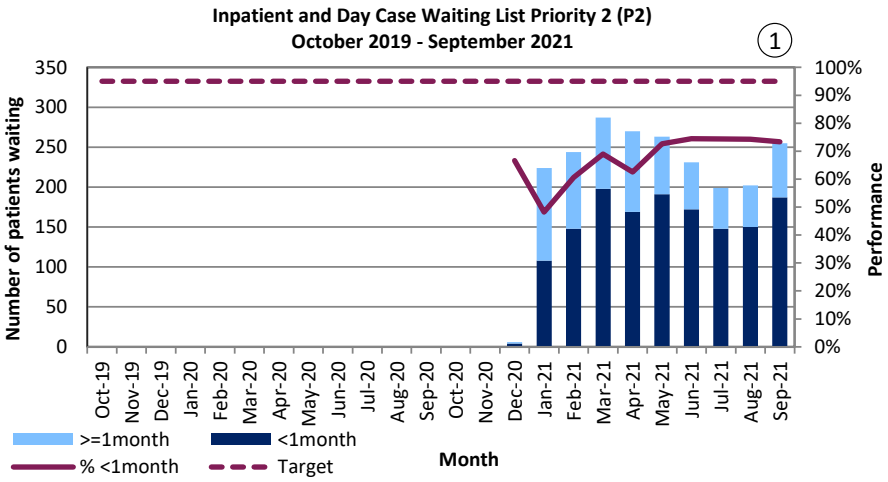


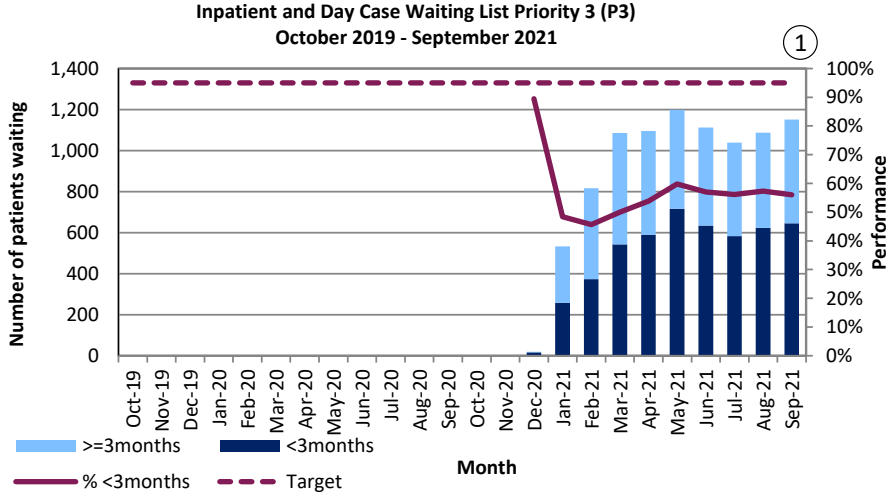
Accountable: Chief Operating Officer **Data Owner:** Information Services

Key Narrative: From December 2020, all patients on the inpatient waiting list are assigned a clinical priority code defining when they should undergo their operation. P1: 1-3 days, P2: <1 month, P3: <3 months. P5 and P6 relate to patients choosing to delay treatment for covid and non-covid reasons.

The waiting list at the end of September 2021 showed 255 patients had been categorised as P1 and P2; 1,151 as P3; 2,019 as P4.

In September 2021 the percentage of patients classified as P2 and currently waiting less than 4 weeks for treatment was 73.3%. The patients classified as P3 and waiting less than 3 months at the end of September 2021 was 56.0%.

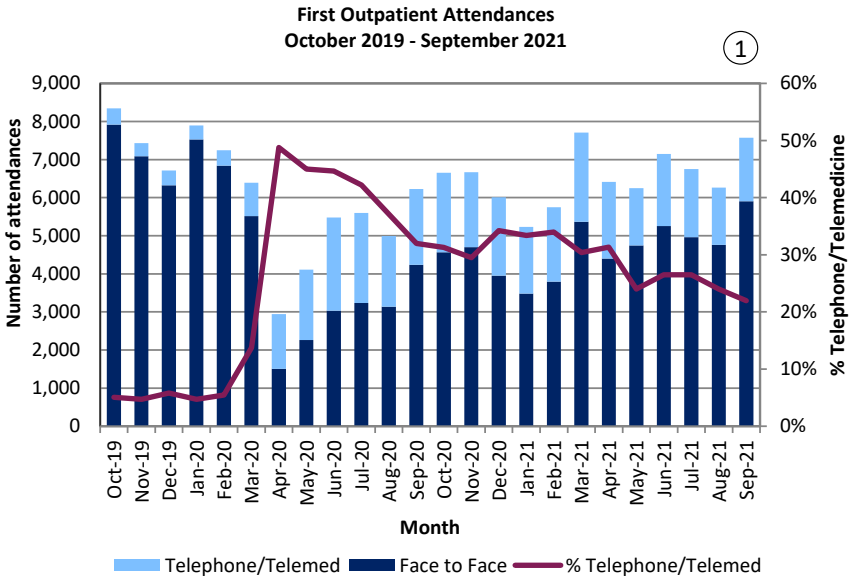


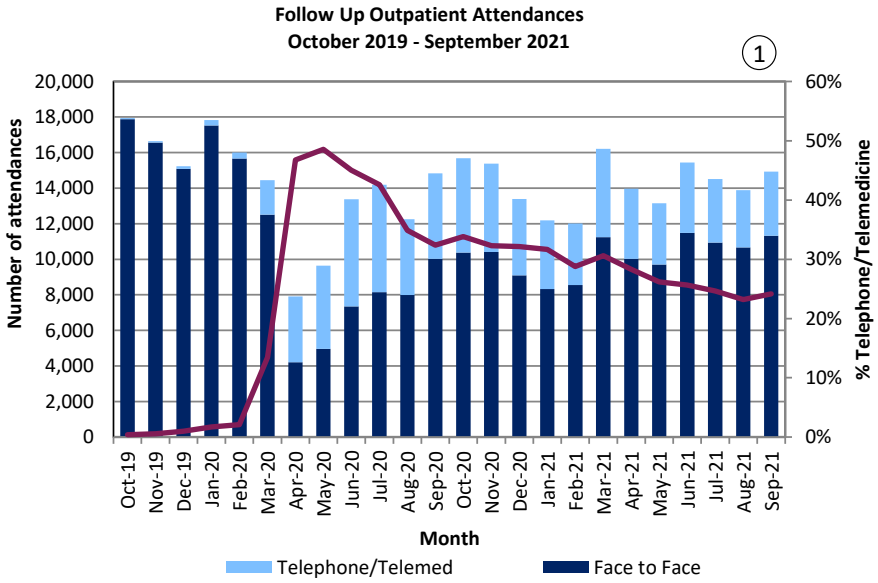


Data Rating: ①captured locally, ②system captured, ③published/benchmarked

Performance

Outpatient Activity





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

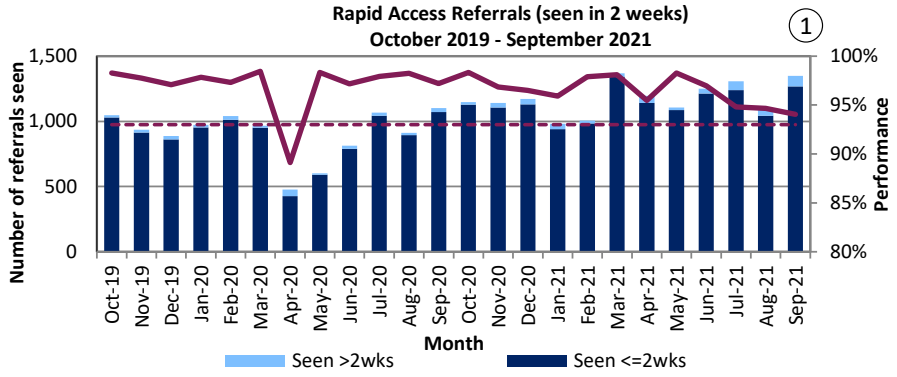
Key Narrative: 7,572 total first outpatient appointments were attended in September 2021, an increase of 20.8% of activity compared to August 2021. The proportion of non face to face appointments for September 2021 was 22.0%, below the rate seen in August 2021 (24.0%).

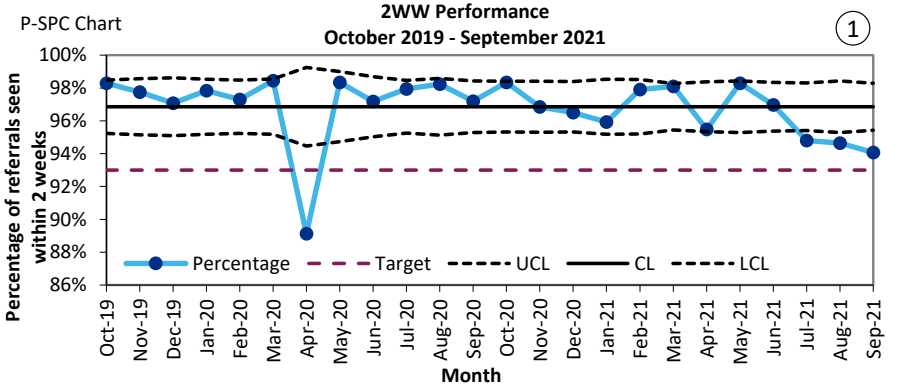
There were 14,934 total follow up outpatient appointments attended in September 2021, an increase of 7.6% of the activity compared to August 2021. The proportion of non face to face appointments for September 2021 was 24.2%, above the rate seen in August 2021 (23.2%).

Data includes contracted specialties.

Performance

Rapid Access Referrals





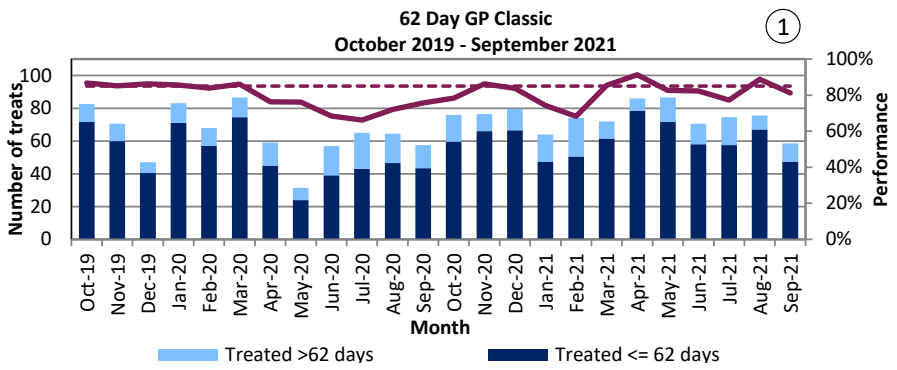
Accountable: Chief Operating Officer **Data Owner:** Cancer Performance

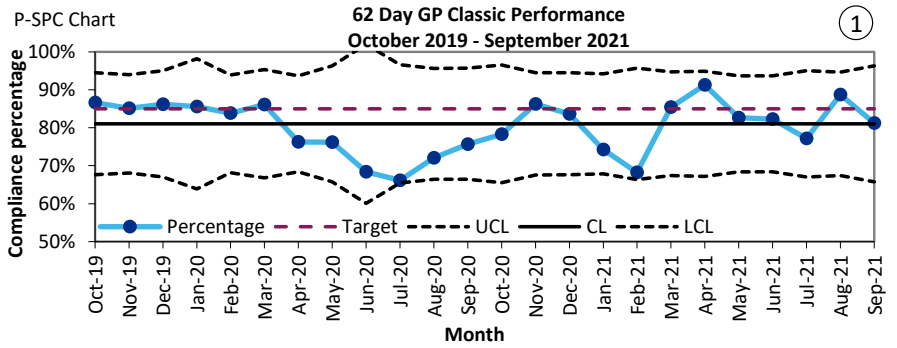
Key Narrative: 1,348 rapid access referrals were seen in September 2021, an increase of 22.2% from the previous month and above the 24-month average.

The 2 week wait performance has consistently delivered above the 93% standard. September 2021 performance was 94.1%. The P-SPC chart adjusts the control limits to take into account the denominator.

Latest month's data provisional.

62 Day





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

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

Key Narrative: Provisional performance against the 62-day standard for September 2021 currently reported at 81.2%. This is 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, ③published/benchmarked

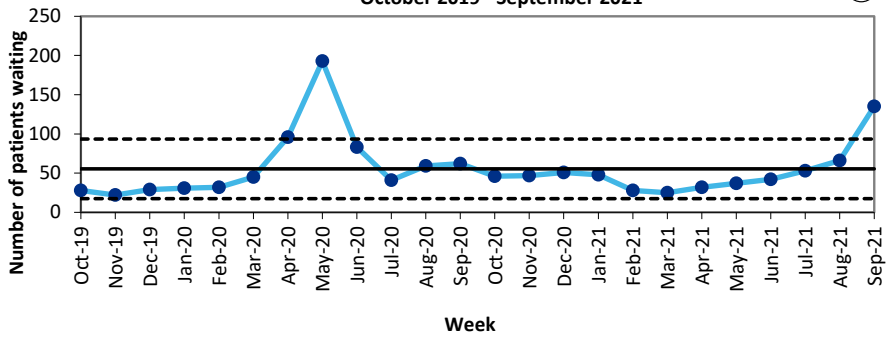
Performance

Cancer Waits Without DTT

X-SPC Chart

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

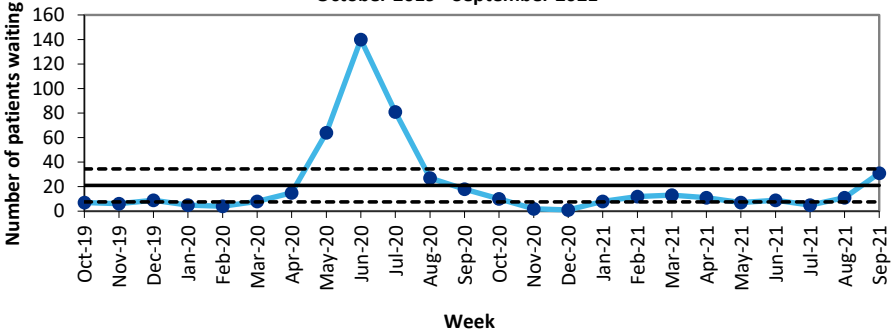
①



X-SPC Chart

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

①



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

Key Narrative: There were 135 patients waiting between 63 and 104 days without a decision to treat (DTT) at the end of September 2021, and 31 patients waiting more than 104 days, which is a rising trend.

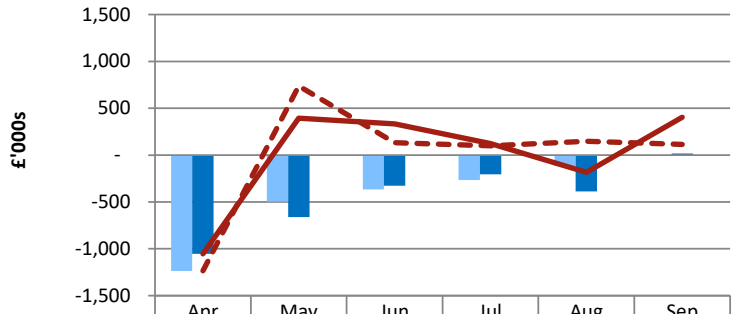
Data based on the last Monday of the month

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

Finance

Financial Performance

Financial Performance 2021/22



	Apr	May	Jun	Jul	Aug	Sep
Cumulative Plan	-1,235	-497	-366	-266	-116	-2
Cumulative Actual	-1,054	-660	-328	-204	-388	16
Cumulative Variance	181	-163	38	62	-272	17
In Month Plan	-1,235	737	132	100	149	115
In Month Actual	-1,054	393	333	124	-184	404
In Month Variance	181	-344	201	24	-334	289

Month

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

Current view

The cumulative actual position at the end of September (H1) was a slight surplus of £16k against budget. This is in line with the Healthcare Partnership (HCP) requirement for the system to breakeven and includes £0.9m of additional system support from other organisations.

The additional covid positive ward, and 2 escalation wards, continued to be fully operational in September contributing to the underlying adverse variance.

Forward view

The escalation beds are expected to remain open beyond H1 into Q3 & 4. The planning for Winter/surge capacity indicates that there will be further pressures to come to support key areas such as paediatrics, and additional escalation capacity.

Planning guidance for H2 (October-March) has been received and confirms a continuation of system envelopes and block contract payments that have been seen in H1.

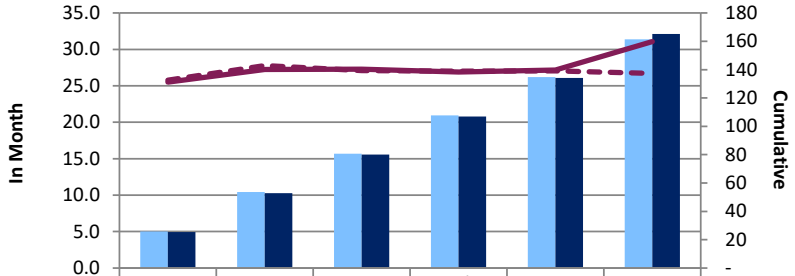
It is expected to be be a challenging second half of the year, with an increased efficency expectation offset continued unplanned care pressures. H1 and H2 will be treated as a single financial period with organisations expected to achieve financial balance for the whole year.

	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				

Finance

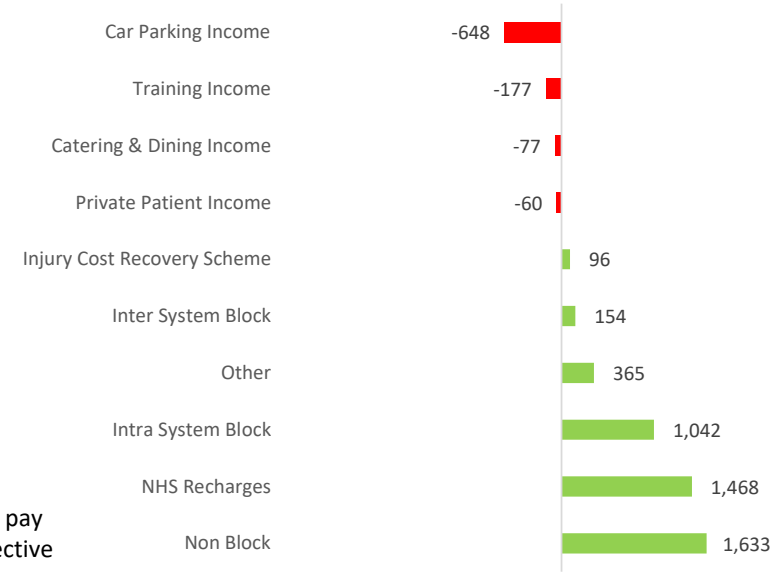
Income

Contract Income Performance 2021/22 £'m ②



	Apr	May	Jun	Jul	Aug	Sep
Cumulative budget	26	54	81	108	135	161
Cumulative actual	26	53	80	107	134	165
In month budget	26	28	27	27	27	27
In month actual	26	27	27	27	27	31

Variance £'000s ②



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

Current View:

Overall income is above plan by £3.7m. The main drivers for this are additional income of £2.6m for the pay award backpay and £0.9m income from the system to support the Trusts position to breakeven. The Elective Recovery Fund income underperformed by £0.3m due to the threshold increase in Q2.

There is also an under performance due to delays to services change eg East Cheshire Dermatology – which are offset by recharges above the plan associated with the vaccination, testing and final year student nurse placement funding.

Forward View:

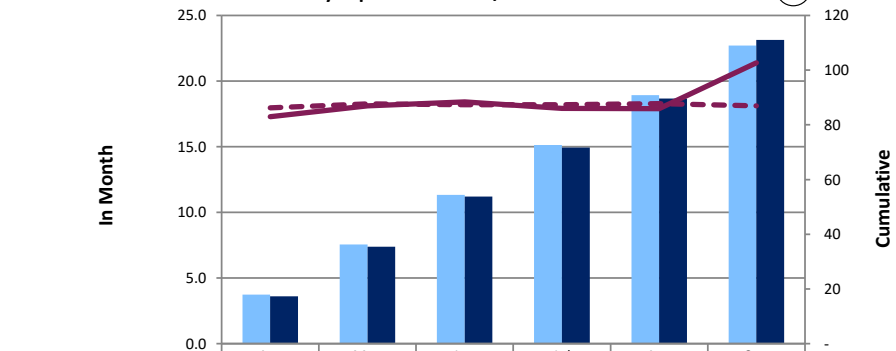
The funding and payment arrangements for H2 will be based on H1 with the addition of 1.16% for inflationary pressures, including pay award and an increase to the efficiency target of 0.82%. The Elective Recovery Fund (ERF) will be based on RTT completed pathway performance above the 19/20 threshold, although based on early planning this will be very difficult for the Trust to achieve and it is not expected that there will be significant ERF monies for H2. There will also be a Targeted Investment Fund available for schemes to increase capacity.

Finance

Pay

Pay Expenditure 2021/22 £'m

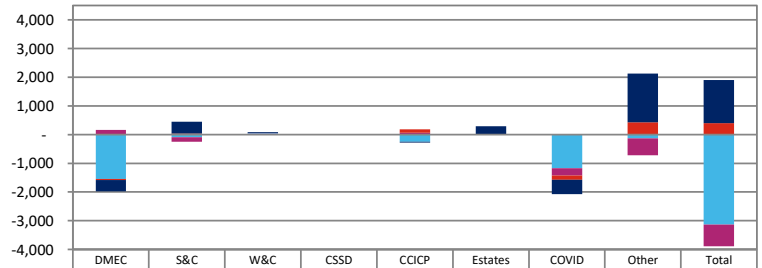
②



	Apr	May	Jun	Jul	Aug	Sep
Cumulative budget	18	36	54	73	91	109
Cumulative actual	17	35	54	72	90	111
In month budget	18	18	18	18	18	18
in month actual	17	18	18	18	18	21

Pay Variances by Staff Group and Division £'000s

②



	DMEC	S&C	W&C	CSSD	CCICP	Estates	COVID	Other	Total
Total	-1,814	195	86	-	-85	289	-2,073	1,412	-1,991
Infrastructure Support Staff	-398	406	33	-	-27	289	-497	1,694	1,500
Non Clinical Staff	-39	39	-3	-	120	-	-152	433	398
Medical Staff	166	-160	13	-	68	-	-255	-587	-755
Nursing Staff	-1,543	-89	42	-	-246	-	-1,170	-128	-3,134

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

Current View:

Pay is over budget YTD by £2.0m. The national Pay award was paid to staff in month backdated to April 2021 and amounted to circa. £2.8m. Based on the expected funding for the Trust via contract income block movements, there is expected to be a pressure of £0.3m which is expected to materialise in H2, in accordance with the guidance to trusts on this matter.

Costs continue to be high in month reflecting the continuation of the existing escalation wards and additional covid ward. This has in turn led to the continuation of a high level of nurse/HCA temporary shifts, however, this has been offset in part by the annual leave accrual being released from reserves.

Bedwatch security costs continue to be high in month with the continuation of additional beds.

Forward View:

The pay bill will come under significant pressure in H2 if the current levels of bed occupancy continue, whilst the Trust has forward planned with the international nurse recruits - the level of demand caused by further opening of a ward is such, that there will remain a high dependency on agency to staff wards within the hospital this Winter.

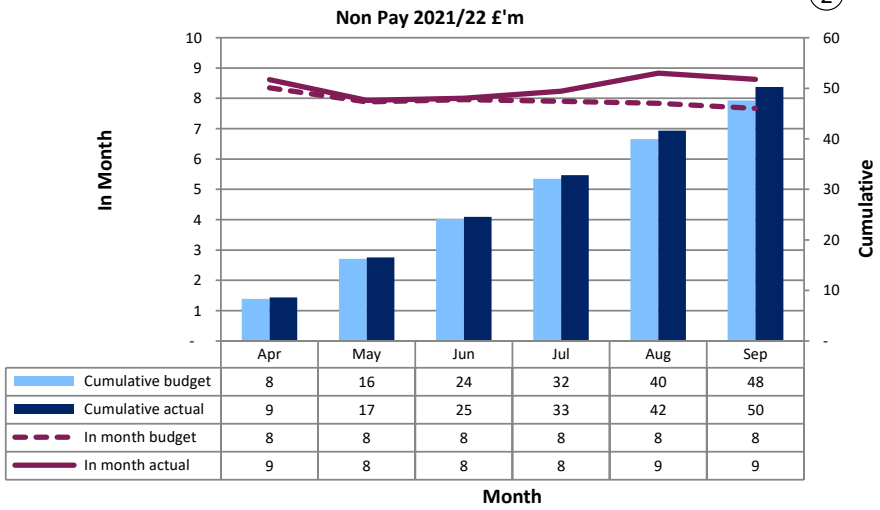
Escalation beds that were expected to close at the end of June 2021 remain open at a financial pressure to the Trust and are expected to remain open beyond September. In additional there are emerging pressures being identified as part of the Winter/surge planning which are likely to see a further increase in cost.

In response to this the Trust is supporting several strategies aimed at improving the urgent care flow – which has been at a high for a number of months.

Finance

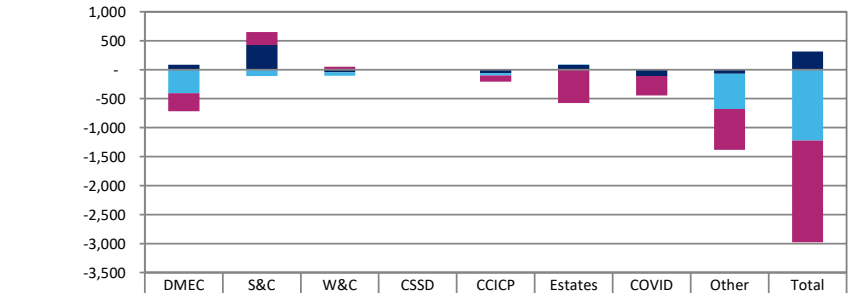
Non-Pay

②



	Apr	May	Jun	Jul	Aug	Sep
Cumulative budget	8	16	24	32	40	48
Cumulative actual	9	17	25	33	42	50
In month budget	8	8	8	8	8	8
In month actual	9	8	8	8	9	9

②



	DMEC	S&C	W&C	CSSD	CCICP	Estates	COVID	Other	Total
Total	-628	540	-54	-	-205	-486	-442	-1,384	-2,659
Other Non Pay	-309	222	50	-	-104	-574	-331	-708	-1,755
Drugs	-406	-108	-58	-	-39	0	-	-608	-1,220
Clinical Supplies	87	426	-46	-	-61	88	-111	-68	316

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

Current View:

Non-Pay is over budget YTD by £2.7m.

The largest area of overspend is within the area of high cost drugs, which is linked to an increase in activity – where those drugs are commissioned by NHSE, the Trust has seen a corresponding increase income.

Outsourcing costs and Clinical supplies have seen increases in month which area anticipated as part of the restoration recovery plan.

Forward View:

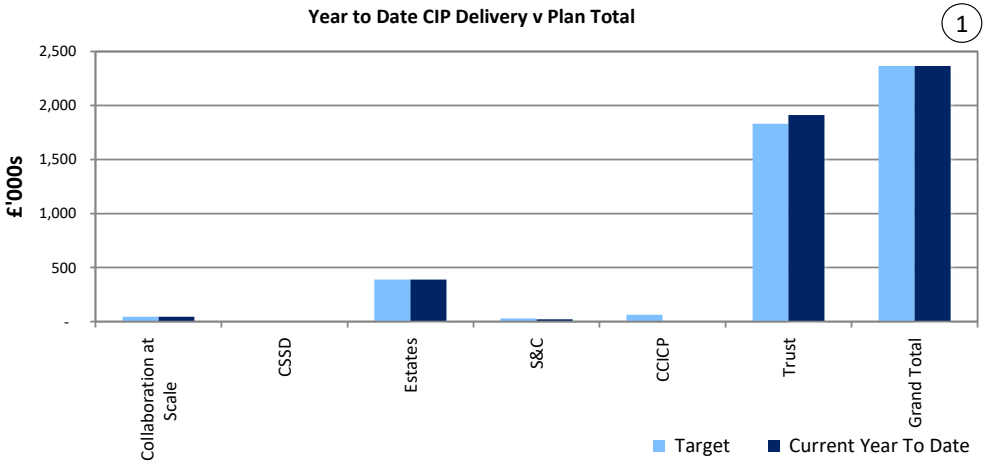
The trust has a growing reliance on outsource and insource companies to support the restoration of services, and also existing gaps - particularly with the medical workforce. Work is required to develop quality workforce plans that look to reduce this reliance in future and provide better stability for services.

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

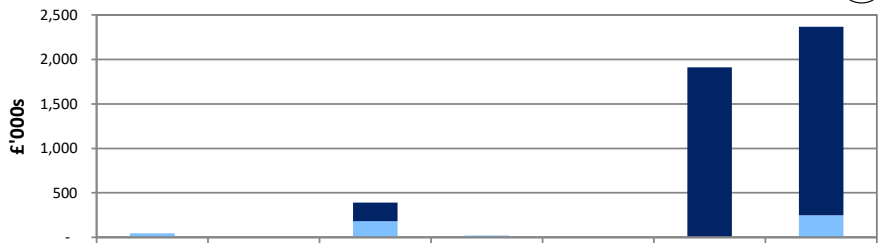
Finance

Cost Improvement Programmes (CIP)

1



2



	Collaboration at Scale	CSSD	Estates	S&C	CCICP	Trust	Grand Total
Current Year To Date	45		390	20		1,912	2,367
Pay			207			1,912	2,119
Non pay	45		183	20			248

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

Current View:
The national efficiency expectation for H1 was set at 0.28% (£0.4m), in addition the Trust has a C&M system efficiency target of £1.9m, giving a total target of £2.3m for H1. 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 national efficiency expectation for H2 is 0.82%, or £1.25m. 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, indications are it could be between 3 and 4% (£4.5 - £5.2m).

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

Finance

Income and Expenditure

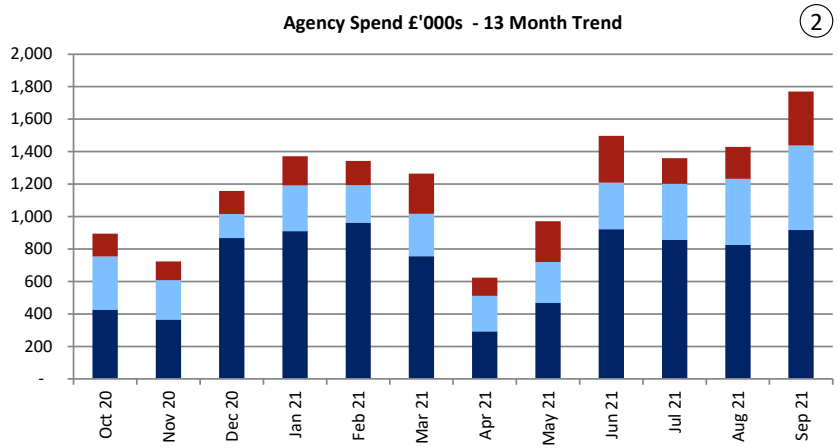
(2)

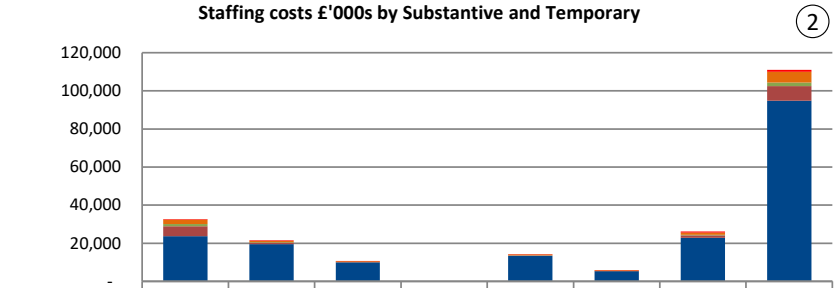
Budget H1		Month			Year to Date			Forecast H1
2021/22 (£'000)		Plan Sep (£'000)	Actual Sep (£'000)	Variance Sep (£'000)	Plan April to Sep (£'000)	Actual April to Sep (£'000)	Variance April to Sep (£'000)	2021/22 (£'000)
	Operating							
	Operating Income							
	Commissioning Income							
151,309	Inter System Block	1,468	1,445	(22)	8,702	8,856	154	152,209
0	Intra System Block	18,684	20,113	1,429	114,143	115,185	1,042	0
0	Non Block	4,779	7,344	2,565	28,076	29,709	1,633	0
407	RTA and Private Patient	68	97	29	407	444	36	407
	Other Operating Income							
0	Charitable Capital Income	0	0	0	0	0	0	0
10,066	Other Operating Income	1,700	2,072	371	10,076	11,007	931	10,066
161,782	**TOTAL OPERATING INCOME**	**26,699**	**31,071**	**4,372**	**161,404**	**165,201**	**3,797**	**162,682**
	Operating Expenses							
(109,534)	Employee Benefits Expenses (Pay)	(18,118)	(21,394)	(3,276)	(109,032)	(111,022)	(1,991)	(110,596)
(8,912)	Drugs	(1,485)	(1,818)	(333)	(8,912)	(10,131)	(1,220)	(8,912)
(8,311)	Clinical Supplies	(1,301)	(1,256)	46	(7,828)	(7,512)	316	(8,311)
(30,057)	Other operating expenses	(4,882)	(5,552)	(669)	(30,851)	(32,606)	(1,755)	(30,057)
(156,814)	**TOTAL OPERATING EXPENSES**	**(25,788)**	**(30,020)**	**(4,232)**	**(156,622)**	**(161,271)**	**(4,649)**	**(157,876)**
4,968	**EBITDA**	**912**	**1,051**	**140**	**4,782**	**3,930**	**(852)**	**4,806**
	Non Operating							
	Non Operating Income							
(190)	Interest	(32)	(14)	18	(190)	(69)	121	(190)
0	Asset disposal	0	0	0	0	0	0	0
	Non-Operating Expenses							
(3,522)	Depreciation & Finance Leases	(555)	(425)	131	(3,339)	(2,591)	748	(3,522)
0	Depreciation on Donated Assets	(0)	(26)	(26)	0	(162)	(162)	0
(1,256)	PDC Dividend Expense	(209)	(209)	0	(1,256)	(1,256)	0	(1,256)
0	**Net Surplus/(deficit) before Exceptional Items**	**115**	**377**	**262**	**(2)**	**(148)**	**(146)**	**(162)**
0	Remove capital donations/grants I&E impact	0	26	26	(0)	162	162	162
0	**Net Surplus/(Deficit) after Exceptional Items**	**115**	**403**	**288**	**(2)**	**14**	**16**	**0**

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

Finance

Bank and Agency





	DMEC	S&C	W&C	CSSD	CCICP	Estates	Other	Total
Total	32,672	21,568	10,624	-	14,247	5,777	26,134	111,022
Waiting List	230	278	56	-	0	0	530	1,095
Bank	2,420	748	382	-	450	375	1,157	5,532
Locum	1,105	250	47	-	165	-	305	1,871
Agency	5,155	744	127	-	263	23	1,337	7,649
Substantive	23,763	19,548	10,013	-	13,370	5,379	22,804	94,876

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

Current View:

Agency expenditure was £1.78m in the month of September, which is a step increase from August - reflecting the additional demand in shifts required to support the escalation areas of the hospital.

The continued high levels of spend relate to the escalation beds remaining open, and also support for the restoration programme.

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. There is work ongoing to develop the workforce plan for 22/23, of which the predicted requirement for further international nurse recruitment will be a key element.

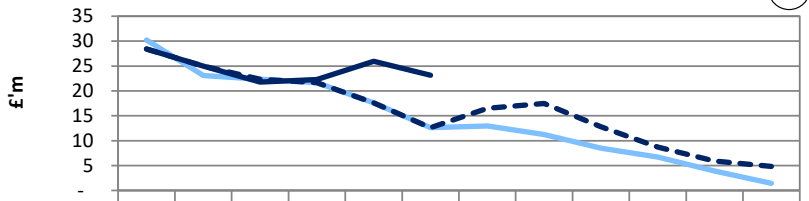
As the restoration plans progress there will be an increase in premium costs (agency/WLIs) for the medical workforce in order to support this return of planned care services.

Finance

Cash

Cash Position

(2)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Plan	30	23	22	22	18	13	13	11	9	7	4	1
Actual	28	25	22	22	26	23						
Forecast	28	25	22	22	18	13	17	18	13	9	6	5

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	6	9	-5

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

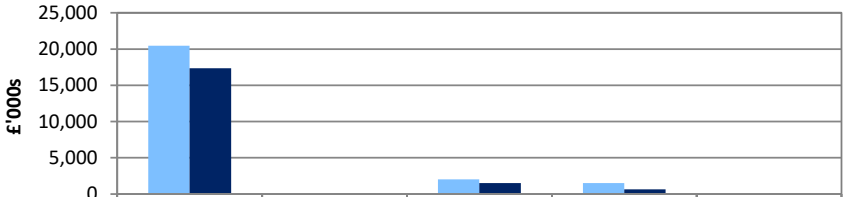
Current View: Cash is higher than plan by £10.5m due to improvements in working capital linked to higher accruals and payables, and slippage in capital projects.

Forward View: The cash position has improved due to slippage on the EPR project, however uncertainty remains around the income levels for H2.

Capital

Capital Expenditure

(2)



	Estates	IT	Estates	IT	Other
	NHSI Approved Plan		Additional Schemes		
Plan	20461	0	2043	1517	0
Actual	17360	85	1510	652	101

(2)

	Year to Date £'000s			Year End £'000s		
	Plan	Actual	Variance	Plan	Forecast	Variance
NHSI Approved Plan						
Estates	20,461	17,360	-3,101	37,909	38,728	819
IT	0	85	85	3,600	0	-3,600
NHSI Approved Total	**20,461**	**17,445**	**-3,016**	**41,509**	**38,728**	**-2,781**
Additional Schemes						
Estates	2,043	1,510	-533	3,627	5,303	1,676
IT	1,517	652	-865	2,600	2,396	-204
Other	0	101	101	0	202	202
Total Capital Schemes	**24,021**	**19,708**	**-4,313**	**47,736**	**46,629**	**-1,107**

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

Current View: Capital is behind plan by £4.3m, due to the A&E expansion of £2.6m, RAAC Planks £0.4m, Backlog Maintenance £0.5m and Labcentre £0.4m.

Forward View: The Trust is currently forecasting a £2.8m underspend against the NHSI Submitted Plan, due to the EPR project. The Trust is awaiting formal recognition from the HCP for the additional capital schemes.

Finance

Statement of Financial Position Sept 2021

2

		Plan Apr to Sept (£'000)	Actual Apr to Sept (£'000)	Variance (£'000)
Assets	Assets, Non-Current	125,670	120,734	-4,936
	Assets, Current	28,134	42,279	14,145
ASSETS, TOTAL		**153,804**	**163,013**	**9,210**
Liabilities	Liabilities, Current	-30,172	-43,702	-13,530
	Liabilities, Non Current	-6,921	-7,252	-331
TOTAL ASSETS EMPLOYED		**116,711**	**112,059**	**-4,652**
Taxpayers' and Others' Equity				
	Taxpayers Equity	116,711	112,059	-4,652
TOTAL FUNDS EMPLOYED		**116,711**	**112,059**	**-4,652**

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

Current View:

Cash is higher than plan by £10.5m, mainly due to higher payables and slippage on the capital programme. Trade Receivables are £3.3m higher than plan, due to accrued pay award income of £2.8m.

Trade Payables are £5.3m above plan, mainly due to £3.9m of UHNM Pathology invoices awaiting payment. Capital Creditors are above plan by £4.1m. Accruals are £3.9m higher than plan, driven by agency and drugs costs.

Public Dividend Capital is behind plan by £4.5m due to capital scheme slippage.

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 £4.3m, due to the A&E expansion of £2.6m, RAAC Planks £0.4m, Backlog Maintenance £0.5m and Labcentre Upgrade £0.4m.

Assets Current
Receivbables are £3.3m higher than plan, mainly due to accrued pay award income of £2.8m. Cash is higher than plan by £10.5m due to increases in payables and accruals.

Current Liabilities
Trade Payables are £5.3m above plan, mainly due to £3.9m of UHNM Pathology invoices awaiting payment. Capital Creditors are above plan by £4.1m. Accruals are £3.9m higher than plan due to an increase in agency and drugs costs.

Taxpayers Equity
Public Dividend Capital is behind plan, due to slippage in capital projects.

	Plan Apr to Sept (£'000)	Actual Apr to Sept (£'000)	Variance (£'000)	Forecast 2021/22 (£'000)
Assets				
Assets, Non-Current	**125,670**	**120,734**	**-4,936**	**144,036**
Assets, Current				
Trade and other Receivables	7,235	10,528	3,293	7,062
Other Assets (including Inventories & Prepayments)	8,268	8,588	321	6,662
Cash and Cash Equivalents	12,631	23,163	10,531	4,826
Total Assets, Current	**28,134**	**42,279**	**14,145**	**18,551**
ASSETS, TOTAL	**153,804**	**163,013**	**9,210**	**162,586**
Liabilities				
Liabilities, Current				
Finance Lease, Current	-841	-702	139	-1,010
Loans Commercial Current	-185	-185	0	-357
Trade and Other Payables, Current	-16,804	-26,175	-9,372	-18,713
Provisions, Current	-514	-656	-143	-226
Other Financial Liabilities	-11,829	-15,985	-4,155	-13,475
Total Liabilities, Current	**-30,172**	**-43,702**	**-13,530**	**-33,780**
Net Current Assets/(Liabilities)	**-2,038**	**-1,423**	**615**	**-15,230**
Liabilities, Non Current				
Finance Lease, Non Current	-2,125	-2,477	-352	-1,065
Loans Commercial Non-Current	-3,306	-3,306	0	-2,962
Provisions, Non-Current	-1,490	-1,469	21	-1,370
Trade and Other Payables, Non-Current	0	0	0	0
Total Liabilities Non-Current	**-6,921**	**-7,252**	**-331**	**-5,397**
TOTAL ASSETS EMPLOYED	**116,711**	**112,059**	**-4,652**	**123,409**
Taxpayers' and Others' Equity				
Taxpayers Equity				
Public dividend capital	127,832	123,332	-4,500	143,832
Retained Earnings	-23,211	-23,363	-153	-32,513
Donated asset reserve	0	0	0	0
Revaluation Reserve	12,090	12,091	1	12,090
TOTAL TAXPAYERS EQUITY	**116,711**	**112,059**	**-4,652**	**123,409**
TOTAL FUNDS EMPLOYED	**116,711**	**112,059**	**-4,652**	**123,409**

(2)

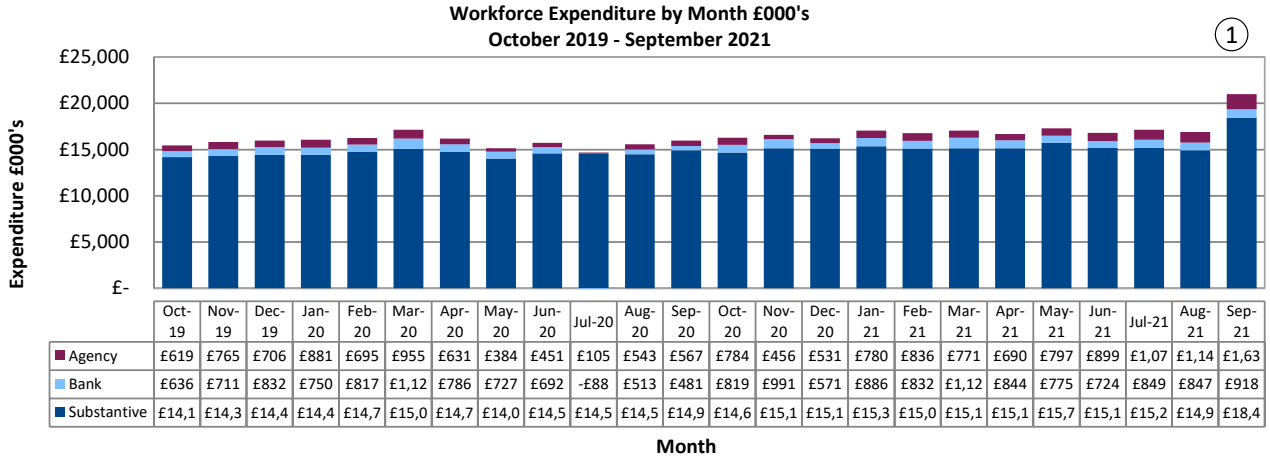
Forward View:

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

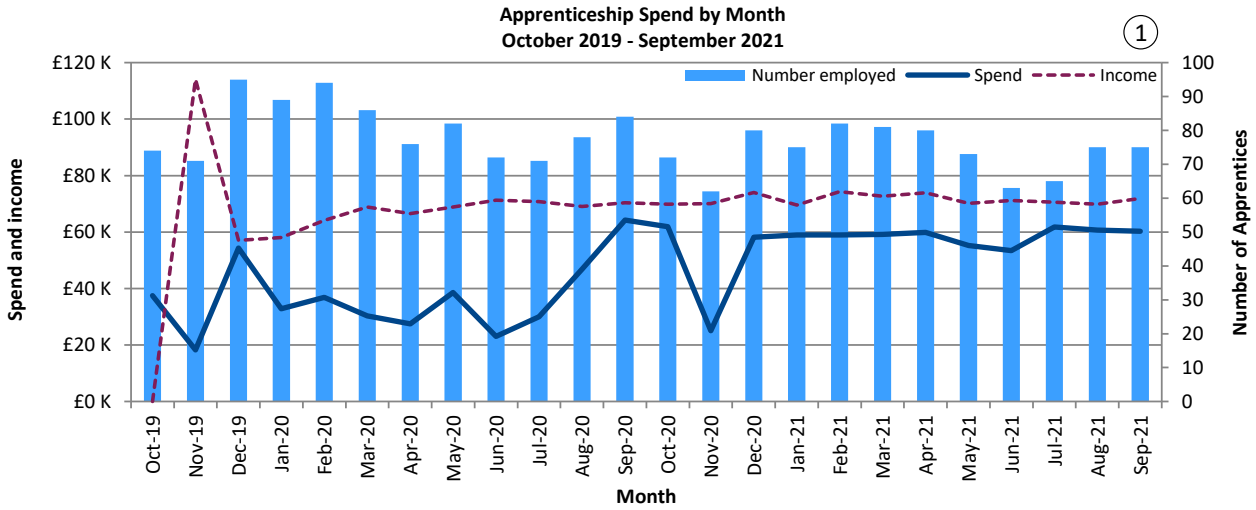
Finance and Costings



	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	Jul-21	Aug-21	Sep-21
Agency	£619	£765	£706	£881	£695	£955	£631	£384	£451	£105	£543	£567	£784	£456	£531	£780	£836	£771	£690	£797	£899	£1,07	£1,14	£1,63
Bank	£636	£711	£832	£750	£817	£1,12	£786	£727	£692	-£88	£513	£481	£819	£991	£571	£886	£832	£1,12	£844	£775	£724	£849	£847	£918
Substantive	£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	£15,1	£15,7	£15,1	£15,2	£14,9	£18,4

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

Key Narrative: Total workforce expenditure for September 2021 is £20,984k, an increase of £266k (24.2%) from the previous month and 31.4% higher than September 2020. This increase is due to the pay award (£2.8m) and Flowers back pay (£0.2m). Expenditure for September 2021 is £3,605k above budget (17.2%) and £1,464k above budget (1.4%) YTD.



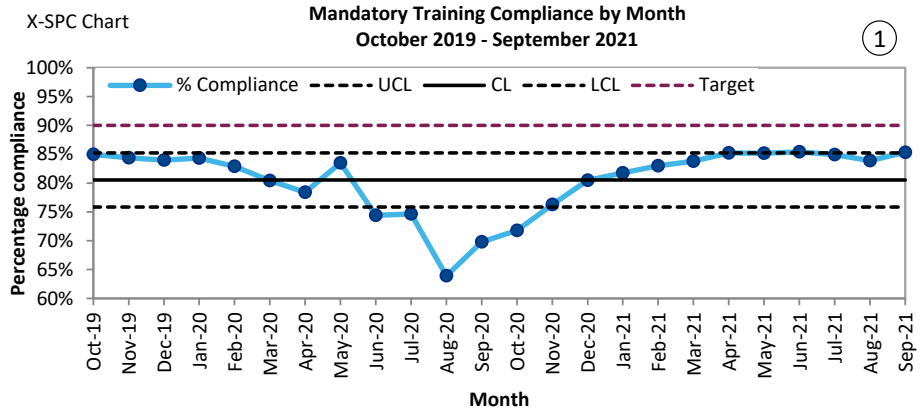
Accountable: Director of Workforce & Organisational Development
Data Owner: Workforce Directorate

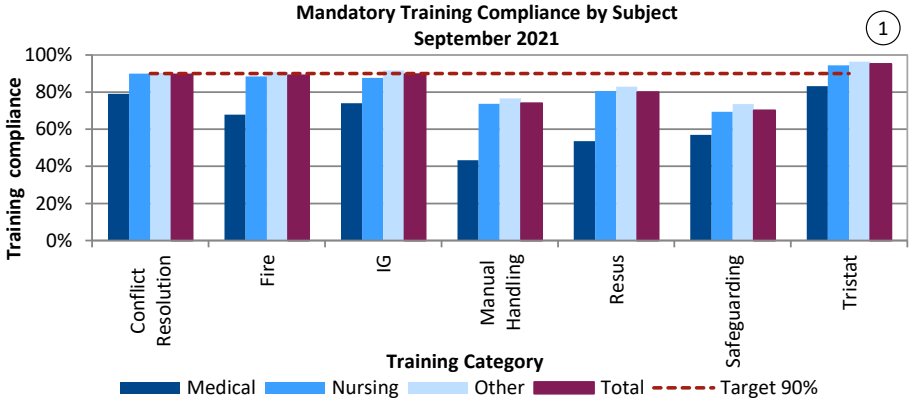
Key Narrative: The number of Apprentices employed in September 2021 was 75, 10.7% lower than the number employed in September 2020 (84).

Apprenticeship spend remains below income.

Workforce

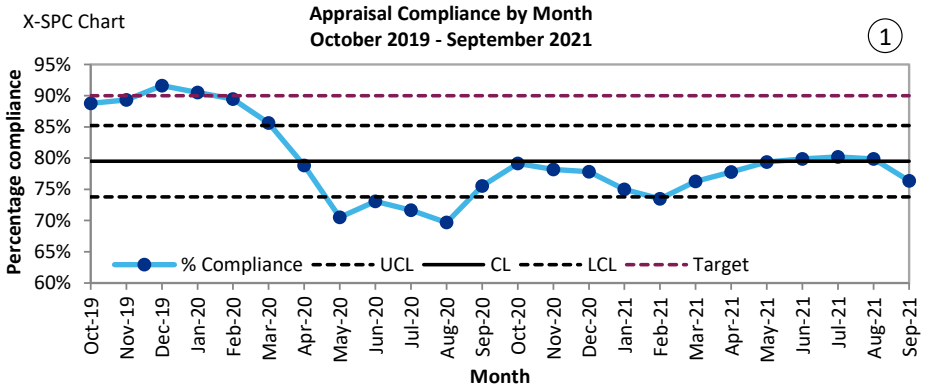
Training

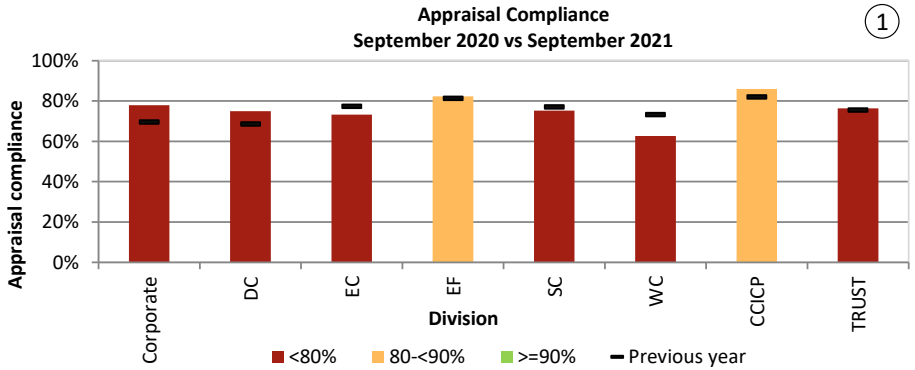




Accountable: Director of Workforce & Organisational Development
Data Owner: Workforce Directorate
Key Narrative:
Mandatory training compliance has stabilised achieving at 85.4% in September 2021 and is an improvement on the compliance reported in August 2021 at 83.9%. Training compliance remains below the 90% target.

Appraisals

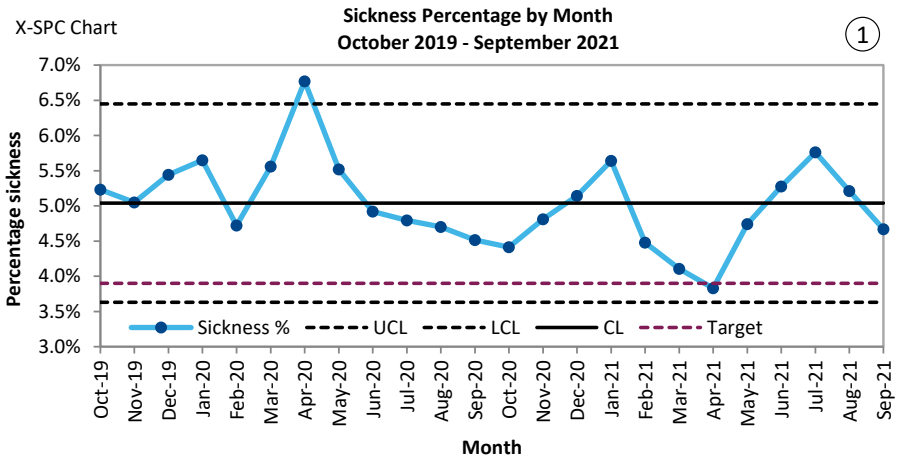




Accountable: Director of Workforce & Organisational Development
Data Owner: Workforce Directorate
Key Narrative: The reported appraisal compliance for September 2021 is 76.4%, which is below the 79.9% compliance reported in August 2021. Appraisal compliance remains below the target rate of 90% which was only achieved in December 2019 and January 2020 over the 24-month period shown.

Workforce

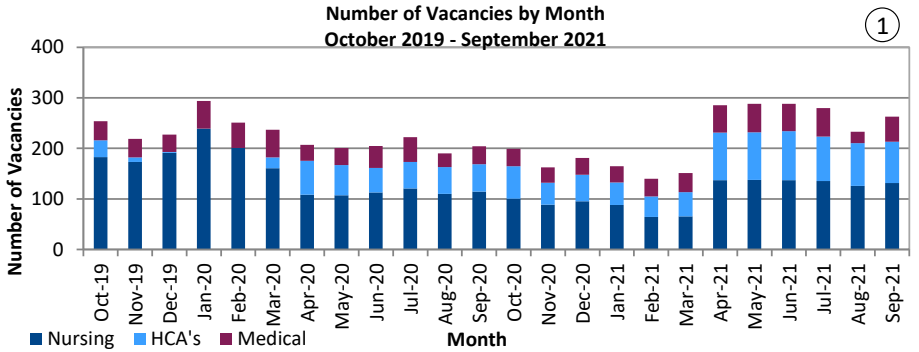
Sickness

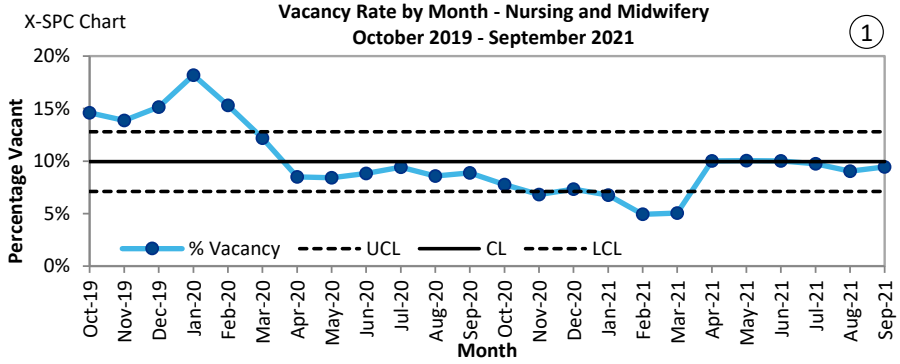


Accountable: Director of Workforce & Organisational Development
Data Owner: Workforce Directorate

Key Narrative: The sickness rate for September 2021 was 4.7%. This is a decrease compared to the sickness rate reported for August 2021 (5.2%). The sickness rate is slightly above that reported the previous year for September 2020 which was 4.5%.

Vacancies



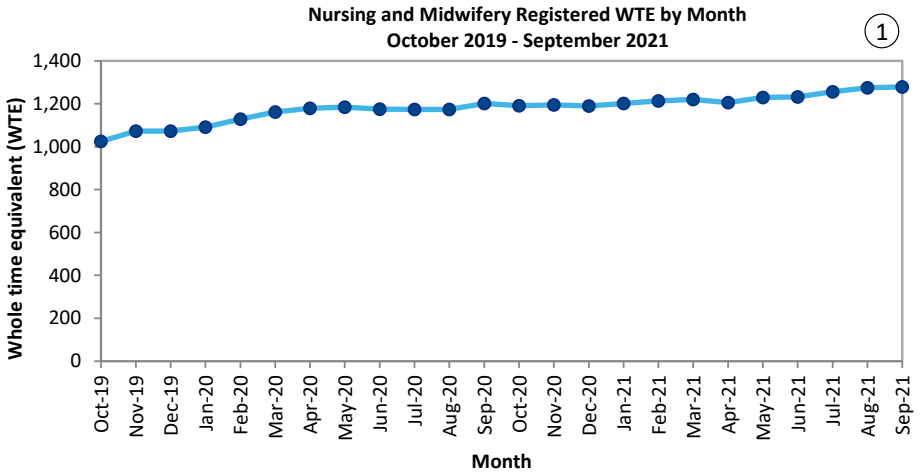


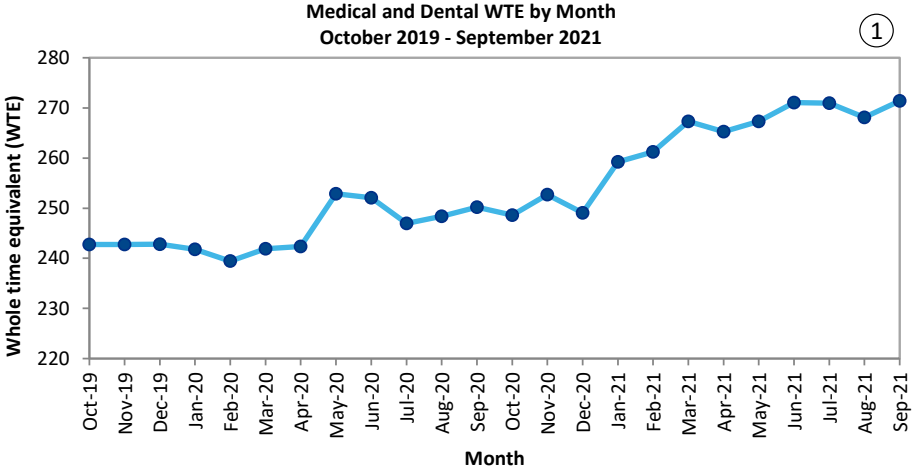
Accountable: Director of Workforce & Organisational Development
Data Owner: Workforce Directorate
Key Narrative: The vacancy figures from April 2020 were restated to exclude International Recruitment, Nurse Apprentices and COVID.

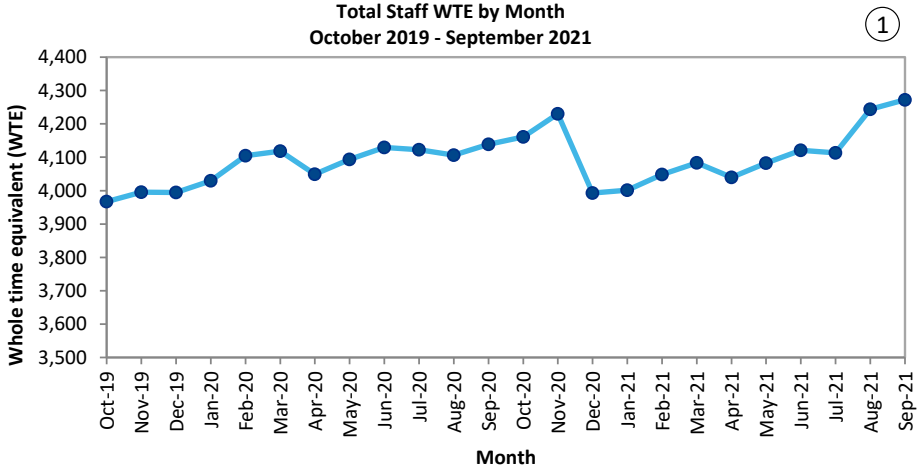
The vacancy rate for September 2021 has increased slightly to 9.5% compared to previous month. The vacancy rate since the beginning of the financial year has increased, mainly as a result of investments which have been added to the Establishment at the beginning of the 2021-22.

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 254.1 WTE (25%) over the 24-month period and Medical and Dental staff by 28.6 (11.8%).

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)

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

BOARD OF DIRECTORS

Agenda Item	**9**	Date of Meeting: 28/10/2021
Report Title	**Trust Strategy 2021-2026**	
Executive Lead	James Sumner, Chief Executive	
Lead Officer	Paul Newman, Associate Director Comms & Engagement	
Action Required	To decide	

☐ **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)*

- Strategy booklet revised to incorporate comments from Board members

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	Sept 2021	Strategy document	James Sumner, CEO	Agreed subject to minor revisions

NHS

Mid Cheshire Hospitals

NHS Foundation Trust

Our Strategy

2021-26

Enter

Because you matter

Contents

Foreword

The National Health Service has endured a uniquely challenging period since the spring of 2020 and there is no doubt the impact of Covid-19 will be long-lasting. At Mid Cheshire Hospitals NHS Foundation Trust, our top priority remains to provide the highest quality care and experience for our patients and to ensure the wellbeing of our dedicated staff, who have been exemplary throughout the pandemic.

Against a complex backdrop, the Trust has developed a new exciting five-year strategy for all the patients we serve, working closely with our staff and our highly valued healthcare partners. Our strategy aligns well with the significant changes across the NHS, with a revised approach to system working and emerging legislative requirements.

Through this document, we are sharing with you the strategic vision that will guide us from now until 2026.

We have reviewed how we can create clinically and financially sustainable services that are best able to meet the changing and growing needs of the local population.

There is no single answer but, working with our partners, we will collaborate in new and innovative ways so that we can truly transform the way we operate as a health and care system.

With patients at the heart of everything we do, we will harness the benefits of digital technology, maintain investment in enhancing our infrastructure via our new-build programme and empower our staff to continue to provide the very best care possible.

Over the coming months, we will provide further updates on the evolution of these strategic initiatives. Our future success will ultimately be built on the pooling of great ideas, shared ambition and the resilience and determination to deliver.

The Trust Board, Council of Governors and staff remain unequivocal in our ethos: the needs of our patients come first.

Dennis Dunn MBE JP DL
Chairman

James Sumner
Chief Executive Officer

Our mission

To inspire hope and provide unparalleled care for the people and communities of Cheshire, helping them to enjoy life to the fullest.

Our values

We put you first

involving you in decisions which affect you and making time to learn from what you tell us to get it right for patients and staff every time.

We strive for more

setting ourselves high standards, encouraging innovation and sharing best practice to be the best we can be and deliver great quality, safe care.

We respect you

embracing diversity and treating everyone with understanding, dignity and compassion to support and care for the people we work with and for.

We work together

with colleagues and partners to go beyond traditional boundaries and deliver care which truly benefits our patients and meets their individual needs and wants.

...Because you matter

About us

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

Leighton Hospital, Crewe

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.

We employ almost 5,000 members of staff, have 500 hospital beds, with a range of services including accident and emergency, maternity, outpatients, therapies, and children's health.

Reception at Victoria Infirmary, Northwich

Elmhurst Intermediate Care Centre, Winsford

The Trust is also responsible for the provision of a range of community services for people across South Cheshire and Vale Royal, working in partnership with local GPs and Cheshire and Wirral Partnership NHS Foundation Trust.

During the pandemic, the Trust was recognised nationally for its 'Be Safe Be EquiPPEd' campaign, which aimed to make the Trust as safe as possible for staff and patients, through supporting the correct use of PPE.

The results of the 2020 national NHS Staff Survey showed 92% of respondents from the Trust, felt their role made a difference to our patients. We were also recognised nationally for our workforce health and wellbeing initiatives.

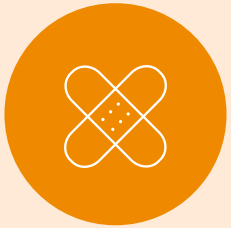
At Mid Cheshire, we really value our staff and appreciate that in order to give our patients the best quality, compassionate care, we also need to look after our colleagues.

"It doesm't feel like a job to me, it's very rewarding working within a great team which makes a huge difference for patients."

Sam, Health Care Assistant

Trust facts and figures

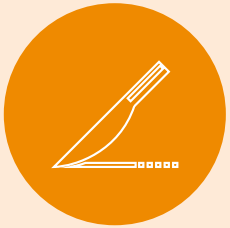
450,576
Total number of patients seen in a year



233,688
Number of outpatients seen

169,330
Medical imaging requests

4,899
Number of staff



16,105
Procedures performed

77,610
Visits to our A&E Department

3,127
Births

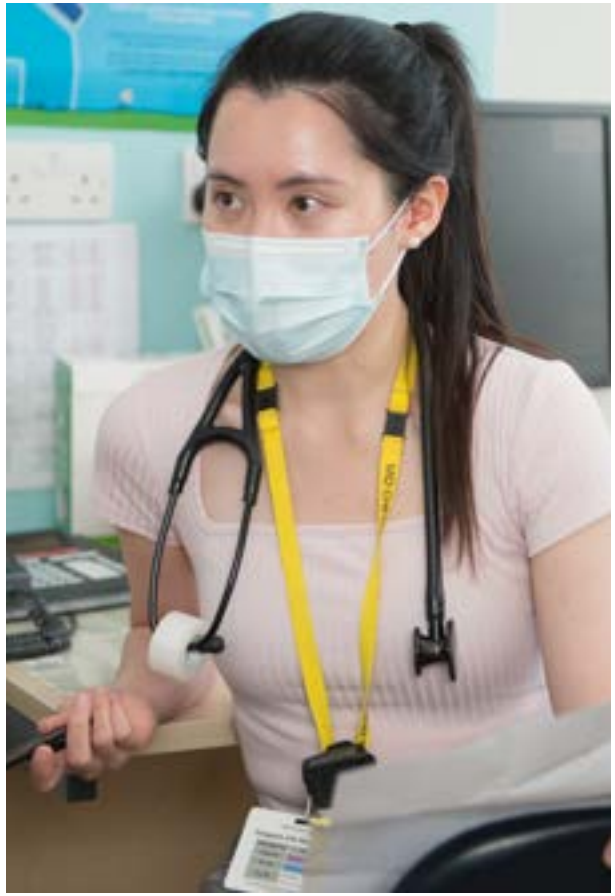
500
Number of beds

£19.8m
Invested in building and infrastructure projects

£323.1m
Turnover

9,570
Number of Foundation Trust Members

Developing our strategy



Why we did it

With the social and economic effects of Covid-19 still impacting hugely on people's lives, this is a pivotal moment to assess our future health and social care needs, in the face of a high level of uncertainty.

A shared ambition with our partners is to improve the health outcomes of people within our local population, reduce health inequalities and deliver the right kind of care at the right time in the right place to every person within the area we serve.

We believe now is the time for significant change in how care is delivered for our population.

A combination of complex care needs, people with multiple health conditions and the increasing reliance on social care, are all part of the success story of people living longer. Our population is increasing and care needs are changing, as is the modern technologically savvy world around it.

However, the way care is delivered in our communities and hospitals has not changed at the same pace, leading to crowded hospitals and pressure on all aspects of the health and care system.

In our view we need a reset; a new proposition that will help us deliver the high-quality care our population requires, when they need it most. We recognise we cannot do this alone. We will be developing our strategy with many others across health and social care, as part of the emerging place-based partnerships, to help realise this new approach.

Essentially, to provide outstanding care that is sustainable and continues to meet the changing needs of the people of Cheshire, we need to think completely differently about how we do that, given the environment in which we are operating.

How we did it

Our strategy has been determined through obtaining a deep understanding of the needs of our local population - an innovative analysis of the requirements and health conditions of our population, combined with a detailed look at how they are currently served.

We started with a focus on the population across the whole of Cheshire and North Staffordshire and analysed the following:

- **Need** – in-depth research and assessment of the views of patients to understand their requirements, expectations of their care and how this is likely to change in the future
- **Behaviours** – how people currently use our services and where they go for care
- **Service use** – how we meet existing demands and whether they are on the increase
- **Acuity** – (health of the population) where we combined several research sources to analyse and model future demand. These included the Joint Strategic Needs Analysis which our local authorities and public health departments use, NHS data, Office of National Statistics data, quality data and several other established data sources.

We took all of the above and combined it with an innovative methodology to divide the population we serve into ten different segments. Unlike the previous way of assessing people by age or clinical condition, this approach looks more holistically at population needs and what services are required to meet them.

The next diagram shows how our population breaks down into segments and what proportion they represent e.g. one in every two people are healthy and do not need our input at present.

Population breakdown

1. Carefree	2. Well mother and baby	3. Consult and follow-up	4. Urgent need	5. Quick fix
Relatively healthy people supported in the community.	People using maternity services only, including both mothers and babies.	People feeling unwell and looking for a diagnosis and short-term treatment.	People requiring urgent attention, generally in A&E without needing other services.	People with known issues requiring a one-off inpatient treatment which is usually short stay.
1 in 2	1 in 50	1 in 13	1 in 12	1 in 40

6. Unwell high consumer	7. Living with it	8. Intense need	9. Complex elderly	10. End of life
People with no previous diagnosis or long-term conditions with high level of service usage.	People with long-term health conditions, mostly self-managing but needing ongoing support.	People with long-term health conditions and a high level of service need.	People with multiple long-term health conditions currently spending a lot of time in hospital.	People with gradual decline and toward the end of their life.
1 in 8	1 in 36	1 in 17	1 in 300	1 in 450

For each of our segments we have a very detailed profile, including which areas people live in, their age, the services they access and how this is catered for in our organisation. It also helps us to understand the resources going into their care.

What we know from this is there are several segments of our population where the current way we deliver care does not work as well for them e.g. it involves them attending or being admitted to hospital when it may not have been necessary if other alternative services were in place.

We also know that for those with complex care needs, hospitals are often the wrong place for their ongoing care, and we need to maintain their independence at home wherever possible, with enough of the right care and support in place.

"I had an Ultrasound Scan at the Victoria Infirmary, Northwich, and wanted to thank the two members of staff who saw me. They showed compassion and kindness which was very much appreciated. Thank-you."

When we have looked at all the needs our population have, and how they want to access services, there are some key commonalities within the different segments i.e. people with different health conditions but with similar needs in terms of how to access care or the timescales in which they need it.

We have concluded four different care models are required to cater for the population we serve. These are:

Hospital-based care for emergency and planned situations – fix me

There will always be a need for specialist care for our population. However, from our analysis we can do more to improve their care and experience of services and deliver better outcomes. This is going to be vital as we address the waiting list backlog caused by Covid.

Diagnostic and treatment planning – what's wrong with me?

Some of our population have a particular need to understand what is wrong with them. Perhaps they are unwell at that moment and need to know quickly, or they are seeking help from their GP or community services and need a specialist opinion. Many people end up coming into hospital unnecessarily and we want to reduce this.

Helping people stay well

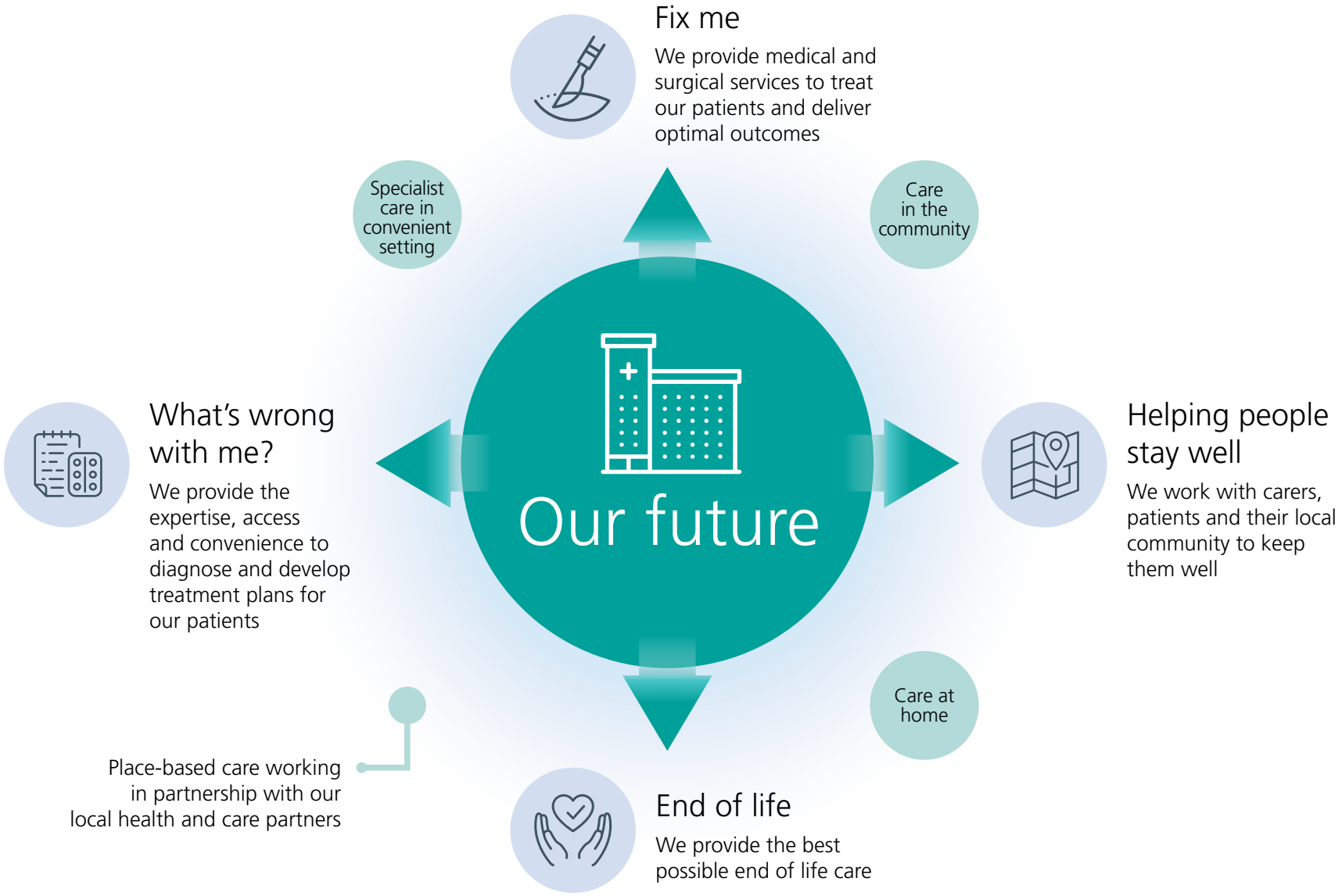
Whether elderly with complex needs, or coping with chronic conditions, everyone needs better support to stay well. This should come from a range of health and social care services and be much more proactively delivered to support people in their own homes wherever possible.

End of life care

A segment of our population, at the end of life, need our support and care more than ever. We need to focus on working with other sectors and organisations to provide the best support for both those who wish to die at home, as well as those spending their last days in hospital.

"I would like to pass on my thanks to the staff in the Treatment Centre and Endoscopy. I came for a procedure and was impressed by the efficiency and kindness shown. I understand how difficult it is in these current times with social distancing, availability of rooms and staffing levels, however, this did not affect my visit today, which was met only with kindness and efficiency."

Four care models



What happens next?

We will work with our partners to develop four new care models using what we have learned about our population and working with our local communities.

The decision-making and design will be based around care communities (populations of 30-50,000 people reflecting a local area). Our population analysis shows different areas require different services, tailored to their respective needs.

To succeed, we must enhance our skills and abilities. Locally, we will bring together our collective resources to assess where they are best deployed and how we deliver the best possible value for every Cheshire pound.

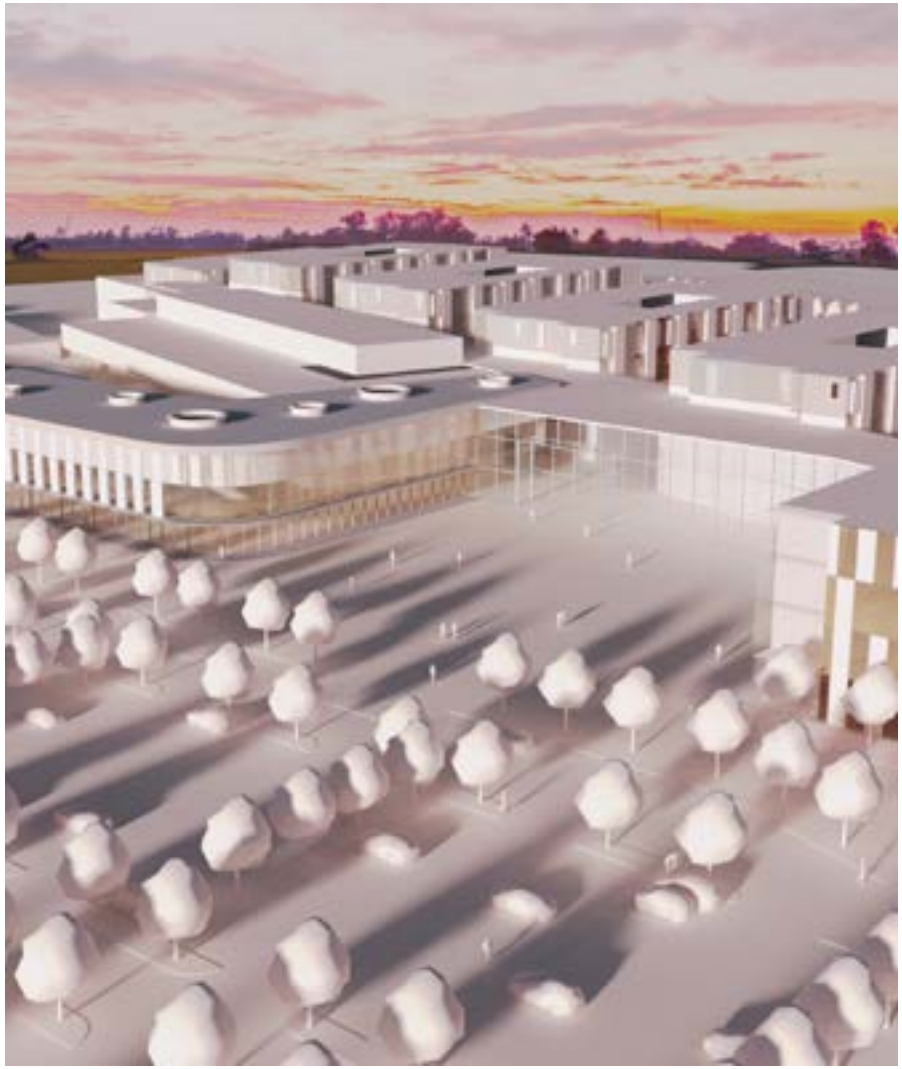
"Why would I work anyhwere else? The staff here supoorted me through difficult times, they celebrated my achievements with me, they kept me going when I was struggling most, and they were genuinely happy for me when I finally achieved my goal."

Carol Darlington, Emergency Department

How we will deliver

Key areas of development to support our new strategic direction:

1. Build back healthier
2. Embrace digital technology
3. Inspire the workplace
4. Champion partnerships
5. Leadership commitments

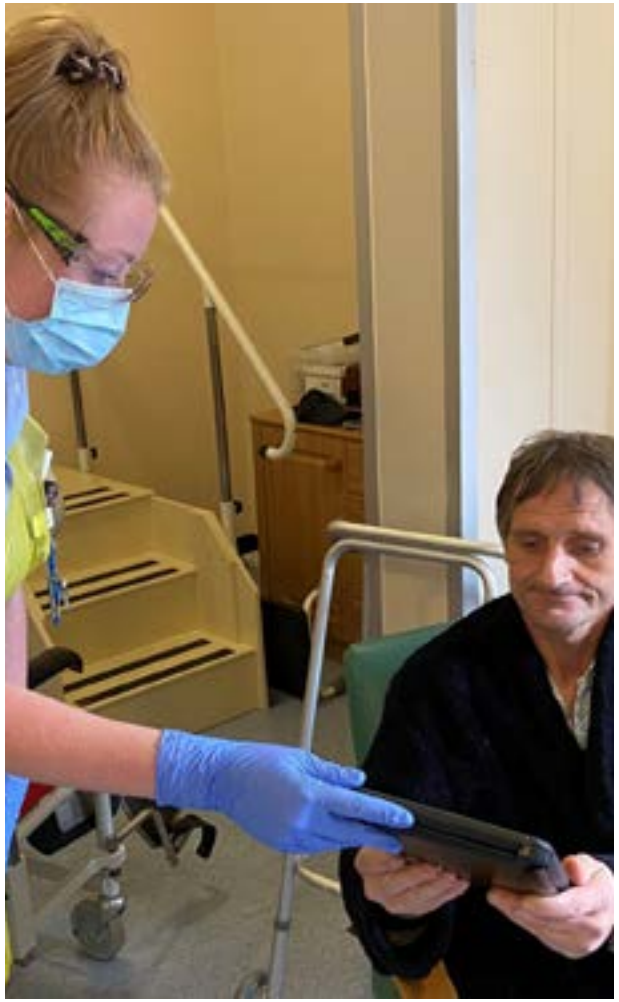


1. Build back healthier

Vision for a new Leighton

At the heart of our strategy to invest in quality infrastructure, our vision for a new Leighton is to deliver a net zero carbon hospital that transforms the quality of healthcare for the people of Cheshire and across the North West of England. In short, a vibrant hospital which sits at the heart of the communities it serves, supporting a network of partners. We believe the case for change is potent:

- Failing infrastructure, clinical risk, inadequate accommodation
- Opportunity – cost-effective, digital innovation to support new services, first class patient experience, sustainable purpose-built design
- Track record of improving facilities – investment in a new Emergency Department and Critical Care Unit at Leighton and ambitious plans for Victoria Infirmary, Northwich
- New offsite corporate facilities and a review of our community estate to support the new models of care.



2. Embrace digital technology

During the pandemic, we have all experienced the power of technology and how it can enhance the quality of care by connecting patients, carers and professionals. In the past, our investment in digital has been constrained due to the challenges of the hospital estate. Now, however, we have plans to upgrade our infrastructure and develop digital health solutions.

Our proposals for a new Leighton give us the opportunity to create a truly digitally enabled organisation, linking people, processes and technology. This will enable our staff to work in new and more efficient ways and support the improvement in quality of care. We are finalising plans for a hospital-wide electronic patient record, known as the Digital Clinical System. We are also working on a programme with national partners looking at the use of innovative and future-proof technologies.

We want to enhance the experience via digital health apps and solutions. Our work continues with partners to develop better patient access to services, allowing them to have more control over their care.

From our population analysis, we understand the use and knowledge of technology varies. We recognise it can never replace the human touch when most needed, but we believe it will be a critical aid.

"Being a nurse is very rewarding, helping patients to recover from illness and traumatic injuries, as well as being a patient advocate. It's sometimes challenging and extremely busy, but being a nurse is full of variety and achievement."

Julie Hutton, Advanced Clinical Practitioner

3. Inspire the workplace

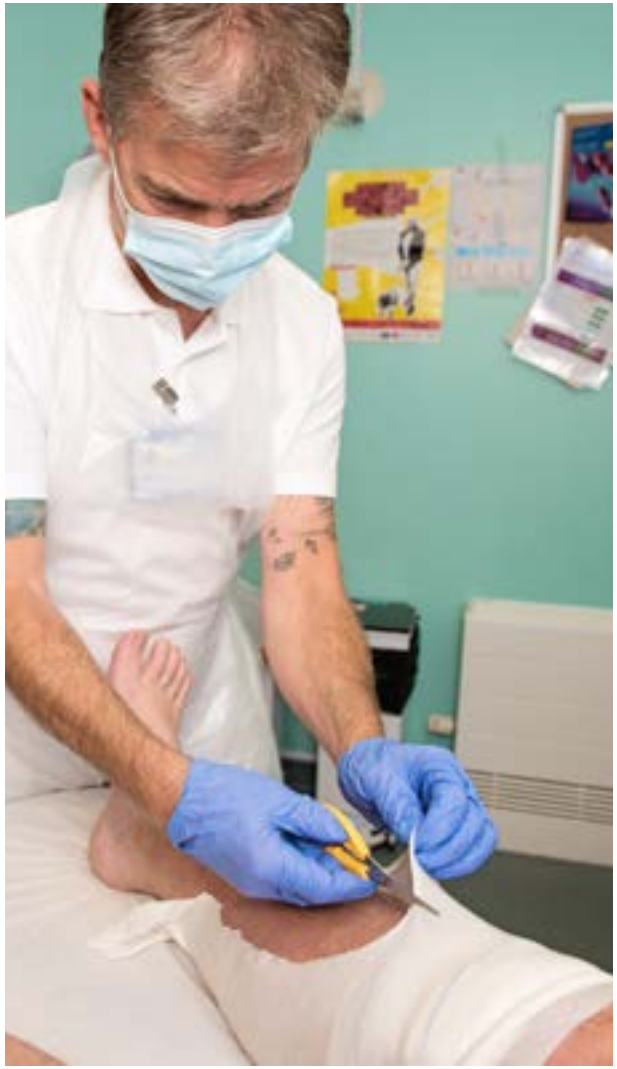
We will foster an environment in which people feel empowered to make decisions, guided by information which supports our drive for continuous quality improvement. We want to attract and retain the best and most diverse talent – people with ideas and ambition who will enable the organisation to develop its future skills and capabilities. We will create a workplace where staff are healthy, happy and productive, and where the safety and quality of patient care benefits from the positive wellbeing of our staff.

In conjunction with our network of partners, we will review the design and structure of our future workforce, so we have the right people with the right skills in the right place to deliver the appropriate care and treatment for our patients. Together, we will be agile, responsive and supportive in the face of challenges to come.

4. Champion partnerships

We are proud to work alongside so many valued partners, as part of the Cheshire and Merseyside Integrated Care System (ICS). The Trust is a key partner with two local collaboratives, Cheshire East and Cheshire West. We work with local authorities, acute NHS providers, Clinical Commissioning Group, Mental Health Trust, GPs and voluntary groups.

We will be part of two collaborations of providers across the whole of Cheshire and Merseyside. The premise of one of these is how acute and specialist hospitals can work together to enable less variation in patient care, reduce inequalities and adopt best practice. The other is focused on mental health, learning disabilities and community services with a similar agenda.



5. Leadership commitments

The global pandemic and the ongoing pressures to restore services to a 'new normal' present enormous challenges for all health and social care professionals. At Mid Cheshire, we believe it also creates an opportunity to adopt a different way of working, firmly rooted in our values and an imperative for compassionate and inclusive leadership.

"I enjoy job satisfaction through the daily patient interactions and seeing the value that my patients and colleagues find in what I do."

Julie Powell, Pharmacy Technician

Our expectations are reflected in the leadership commitments we adhere to, with the aim of ensuring the highest quality and most effective patient services:

Visibility – leaders must be seen by staff to be present around the organisation and should strive to understand challenges, while supporting colleagues to deliver solutions.

Improvement – we must continuously improve, with a focus on a deeper understanding of current challenges and a commitment to using improvement methodology to solve problems. We will train all staff in our approach.

Expertise – leaders will ensure they harness the expertise of colleagues, patients and partner organisations to enable sound decision-making based on professional advice, clear evidence and patient experience.

Measuring success – leaders must ensure they have a thorough understanding of data to drive the highest quality and standards we can achieve for our patients. We will train staff in how to understand and utilise data to best drive change.

Emotional intelligence – compassionate leadership and being aware of the issues affecting individuals and teams are prerequisites. We want to reaffirm a culture which supports improvement, innovation and empowers all staff to speak up. Diversity and equality will be cherished, and we will lead with kindness and compassion. We will recruit with such qualities in mind and staff will be supported to develop these skills.

The funding challenge

Even before the pandemic, there was significant financial pressure across our local health and care system. The reality is we cannot continue providing services the way we are now.

Even additional funding and continued efficiency saving programmes will not be enough. We believe we need to be radical and reimagine services around our population's needs.

Our strategy will require investment and we have gone through a thoughtful process to prioritise and sequence what is required, so it is not only affordable but delivers value for the taxpayer. Along with our partners, we will also look to reprioritise and reallocate resources where possible but also examine new ways of funding in addition to national support. Our aim is to innovate to

"Thank you to the whole team linked with the Covid Vaccination Clinic at Leighton Hospital. The administration staff and manager, the reception team, volunteers, the vaccinator and others too. Staff instinctively showed compassion, discretion and kindness towards my partner and myself and the speed in which our needs were met. You are all a credit to yourselves and our amazing NHS. You are truly appreciated."

A foundation for the future

Our collective response to Covid-19 across Cheshire and Merseyside demonstrated we can achieve great things if we break down organisational silos, empower staff and reduce bureaucracy. With the planned changes to the NHS and, indeed, funding, still in a state of flux, there is clear agreement that collaboration is the only way to meet the health and care needs of the population.

We believe our strategy embraces and builds on these principles, and provides a platform for even stronger partnerships, a transformation of services and a patient-focused approach. Working together, our shared aspirations will play a crucial role in shaping a new and sustainable future for healthcare in Cheshire.

Find out more – www.mcht.nhs.uk

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

Mid Cheshire Hospitals NHS Foundation Trust
Middlewich Road,
Crewe, Cheshire
CW1 4QJ

01270 255141

communications@mcht.nhs.uk

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**9.1**	Date of Meeting: 28/10/2021
Report Title	**Trust Strategy – Progress Report Q2 2021/22**	
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)*

- Key deliverables of 30-60-90 day plans largely achieved for Q2 (July – Sept) and identified for Q3 (Oct to Dec)
- A small number of deliverables were repositioned to a more realistic timescale with robust delivery plans in place
- Agreement from AOs of Cheshire East (CE) to adopt MCHFT's Population Analysis and Care Models as CE Strategy moving forward; discussions underway with Cheshire West
- Comms Plan being delivered in support of Strategy Launch

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

- Enabling strategic plans currently being drafted for submission to Board from Q3

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 Hospitals NHS FT

REPORT DEVELOPMENT

Committee/ Group Name	Date	Report Title	Lead	Brief summary of key issues raised and actions agreed
Board of Directors	Sept 2021	Trust Strategy Update	CEO	Noted
		Comms Narrative	CEO	Approved
Board of Directors	July 2021	Trust Strategy	CEO	Approved

Trust Strategy
Progress Report
Q2 (July to September 2021)

Introduction

1. The Trust Strategy was approved by the Board in July 2021 and the narrative for the e-booklet agreed in September 2021. Other supporting materials have been developed to support the key messages of the Strategy (Appendix 1).

2. The Board was provided with an update on ICS developments at its Board Development Day in early October and noted the implications for the Trust Strategy.

3. The capabilities have been considered from a risk perspective and all map to the strategic risks in the Board Assurance Framework (BAF) (Appendix 2). Work is underway to assess current controls and ascertain whether further controls and actions are required to provide robust assurance to the Board via the BAF on delivery of the Trust Strategy.

Background and Analysis

National/regional developments

4. Discussions are continuing at pace across the C&M system to move all organisations closer to compliance with national guidance for PLACEs.

5. The Interim ICS Chair (now in place until March 2022) and Chief Officer are supportive of the Trust Strategy and its direction of travel within the Cheshire East PLACE. Further discussions are continuing within Cheshire West as to how the strategy links to the PLACE plan.

6. As the governance becomes clearer, the Board will need to discuss areas of delegated authority into whichever governance model is determined.

30-60-90 Day Plans – Key Deliverables

7. The key deliverables for Q2 (July – September) for the majority of the 17 capabilities outlined as part of the strategy development have largely been achieved. Board Committee members will be familiar with a number of these as they are part of business-as-usual and will increasingly become that as we move forward in implementing the Strategy.

8. Key areas of achievement in Q2 are highlighted below:

9. **System innovation** - Significant progress has been made in sharing the strategic vision with partners. As a result, the Accountable Officers of Cheshire East (CE) partners i.e. East Cheshire NHS Trust, Cheshire East Council, the Clinical Commissioning Group and Cheshire & Wirral Partnership NHS FT have agreed to adopt the analysis and four care

models as the PLACE strategy, subject to agreement with governing bodies. Further work is continuing as to how we adapt the capabilities into the PLACE plans.

10. **Quality Improvement** – An Associate Director of QI has been appointed and the first cohort for our Quality Improvement Practitioner training has commenced. The Quality Improvement Board Development Programme is currently being designed with our strategic partner, AQUA.

11. **Applied Intelligence** – Further work on expanding the Integrated Performance Report through to Divisional level is continuing. A working group looking at how to bring new population intelligence across the Cheshire East PLACE has commenced and will become part of the new CE PLACE governance.

12. **Enabling delivery units** - New Divisional governance arrangements are commencing in November which are aligned to the Trust priorities. Investments have been agreed in additional Clinical Governance Leadership to support the new risk-based approach.

    The Trust's leadership offer has been refreshed to reflect the new strategic priorities and ICS collaboration. Selection of delegates for the 2021/22 leadership programmes has been finalised.

13. **Workforce welfare and capacity** - A number of initiatives have been put in place to support the wellbeing of our staff. We have also carried out workforce modelling for critical clinical roles in the Trust and established a strategic workforce group to focus on recruitment and succession plans for these key specialties.

14. **Infrastructure optimisation** - The Estates Strategic Plan was approved by the Board in July 2021 and we continue to move forward at pace. The new Emergency Department will be opened in December and we have recently been successful in securing funding for the Community Diagnostics Hub at Victoria Infirmary, Northwich. This will align with the phased redevelopment of the site and a business case is currently being drafted.

    We have moved a number of our staff to a new Corporate Headquarters at Infinity House in Crewe providing first class accommodation for staff and enabling works to continue the redevelopment of the Leighton site.

15. **Future Workforce** - The first draft of the Workforce Strategic Plan has been completed. This will be finalised over the coming weeks and will focus heavily on the requirements for new roles and competencies, as well as recruitment and retention.

16. Inevitably, there have been a few exceptions to our delivery plans, namely:

    - Service Portfolio Optimisation – this is a time-consuming review of service provision and was unable to commence during the last quarter due to operational pressures
    - Applied Intelligence - it was agreed that Q2 deliverables would move to Q3 to align with the start of the Trust's new Chief Information Officer.
    - Talent Management – the Motiv8 appraisal system will now be adapted in Q3 to align with the review on appraisal. There is also still work to do on succession plans for Board and Senior Leadership.

- Digital Operating Model – Heads of Terms have been drafted for the Digital Clinical System and will now be finalised, following approval of the preferred supplier, prior to submission to the respective Boards.

17. The above were accepted as being reasonable delays and plans are in place with agreed dates for delivery.

18. The plans for Q3 have been identified and work is underway to deliver these. The Executive Team have regular sessions dedicated to monitoring on-going work and providing a forum for escalation of key issues so that these can be addressed holistically.

19. Work is underway on the financial planning for 2022/23 and Strategy key deliverables will play an integral role in driving investments. National planning guidance, however, is not expected until December at the earliest and this will have an impact.

Communication & Engagement

20. As previously agreed with the Board, we will be promoting awareness of the Strategy via a wide range of internal and external meetings between now and the end of the year. A range of materials is being produced to support executives and senior managers in the roll out of the strategy through clear, concise messaging and a compelling narrative. Communication materials, including a PowerPoint slide pack, video and other briefing documents are being finalised for distribution. Internal channels, such as e-bulletins, Team Talk and social media will be used to articulate our strategic ambitions and direct staff to the website to download the full document.

21. Communications and engagement colleagues in partner organisations across Cheshire and Merseyside are being briefed on the background to the strategy and the plans for its wider public dissemination. A formal announcement about the publication of the strategy, will be made following the October Board meeting and posted on the Trust website. There are a number of national and regional media opportunities to be followed up in November, with requests to discuss the strategy in 1:1 interviews with James Sumner, CEO. These will build on the extensive coverage of the new build announcement in September and enable us to focus on the broader patient-focused strategic messages and strong partnership working.

22. Design work on a new Trust website is now underway, with presentations from invited agencies due to take place in early November. More detail on content workshops will be outlined in due course, once an agency has been selected.

Conclusion

23. Progress on delivery of the Trust Strategy is moving forward, despite significant operational pressures. Any exceptions are being managed appropriately. Risks to the delivery of the Trust Strategy will be monitored through the Board Assurance Framework, enabling Board and Board Committees to receive assurance.

Recommendation

24. The Board is asked to note the progress report.

Author: **James Sumner, CEO**
Caroline Keating, Company Secretary

Date: **22 October 2021**

Top level messages

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

We are **transforming** from a hospital focus to a **community anchor organisation** serving our local population, providing **seamless integrated care** - a borderless organisation. This is in line with the national and regional strategy for developing place-based care.

We will be operating **four distinct but inter-related business models** to meet the needs of our population. Services will be provided seamlessly across different care settings, working together with our partner ecosystem.

We will be **embracing innovation such as digital**, building on the opportunities from COVID recovery, upgrading our infrastructure such **as the new build programme**, investing in our people, and creating greater focus on our population needs.

For patients, we will be their local champion, **trusted care provider,** giving them faster and better experience with more control of their care. They will have a **seamless and integrated care** experience.

Staff will be **empowered** to provide the best care possible. They are the engineers of the change and will have the headroom to respond to changes/disruptions.

Patient Experience and Quality of Service	Listening and responding to our population and provide the **safest and best care** which is equitable, inclusive and centred on the patient and their family's health, wellbeing and care needs
New Ways of Collaborating	Become a leading and **sustainable health and care system** providing seamless care to our local population in collaboration with our partners
An Inspiring Workplace	Be the **best place to work** where our staff are empowered to innovate and provide consistently excellent care
Build for the Future	Push boundaries in **clinical, technology and digital innovation** to provide the tools and infrastructure to deliver the best possible care

Appendix 2

Trust Strategy - Risks to Delivery Q2 2021/22

(*Reference numbers to aid 4Risk recording)*

Theme	Linked BAF Risks	Phase 1 (Q2)
1. New Ways of Collaborating (JS)		
A - New Business Model Shifting from our current organisation model to operating in the 'new way' through the four distinct models of working: fix me, help me stay well, what's wrong with me and end of life. One 'organisation' providing optimised care to the population of Cheshire	**BAF 5 (PBP)** **BAF 6 (ICS Influence)**	**AP1 Agree business model approach with partners and map services** · AP1.1 Agree business model approach with partners in Cheshire East PLACE · AP1.2 Seek to move towards formal agreement · AP1.3 Map current services across Cheshire East PLACE to business models and determine inter-dependencies · AP1.2 Set out internal engagement programme
B - Optimising our portfolio of services Improve the relative performance of services to ensure patient care can be delivered through a sustainable portfolio of services. Triangulating analysis to determine relative performance and corrective actions	**BAF 1 (Demand & Capacity)** **BAF 5 (PBP)**	**BP1 Refresh analysis** · BP1.1 Commence analysis of services and refresh the strategic portfolio analysis · BP1.2 Evaluate and sense-check analysis with relevant stakeholders · BP1.3 Determine strategic/tactical options/actions around portfolio of services
C - System Innovation To move MCHFT and the local PLACEs to a new way of working that delivers PLACE based care by aligning our objectives and coalescing	**BAF 5 (PBP)** **BAF 8 (QI)** **BAF 10 (Harnessing data)** **BAF 14 (DCS)**	**CP1 Shared system vision + quick wins** · CP1.1 Agree strategic vision with Cheshire East PLACE i.e. segmentation and four business models

on a single vision of the four new business models together		· CP1.2 Agree capabilities at a system level in Cheshire East i.e. how do we plan QI as a system, how do we align our community contribution efforts etc.
D. Community Contribution Establishing a community anchor organisation. Connecting people, organisations, employers, educators, volunteers and communities to improve health and wellbeing. Doing 'good' and supporting the sustainable environment agenda	**BAF 5 (PBP)** **BAF 6 (ICS Influence)** **BAF 11 (Estates Infrastructure)**	**DP1 Develop and agree objectives, aligning priorities within PLACE** · DP1.1 Develop and agree objectives and measures for becoming a community anchor, aligning priorities within the PLACEs to concentrate on same objectives · DP1.2 Agree internal Social Responsibility/Value Plan including identified programmes · DP1.3 Start implementing local programmes with clear roles and responsibilities
E. Commercial Management Embedding a combination of capabilities needed to develop and manage the health and care ecosystems, partners and the regulators; from business development, marketing, strategic planning, deal making to account management	**BAF 5 (PBP)** **BAF 6 (ICS Influence)**	**EP1 Evaluate and co-build capabilities across PLACE; develop transition plan** · EP 1.1 PLACE leads in Cheshire East to discuss how this can be developed as a key PLACE capability · EP1.2 Conduct an evaluation of what all partner/place organisations have and don't have in terms of the required capability · EP1.3 Determine how we can co-build these capabilities and roles, and how we transition (e.g. consolidate marketing and communications)

2. An Inspiring Workplace (HB)		
F. Applied Intelligence Embed insight-led decision-making across the organisation with advanced use of data science and analytics to support the strategic and operational management of the organisation, and improve the patient experience	**BAF 10 (Harnessing data)** **BAF 14 (Future workforce planning)** **BAF 13 (DCS)**	**FP1 Develop automated dashboards; prioritise strategic areas; assess and build system capability/data intelligence** · FP1.1 Develop automated divisional dashboards for new divisional governance (connecting different dimensions e.g. quality, performance, resources, workforce, activity and segments) · FP1.2 Use data to measure impact on service provision and patient experience · FP1.3 Commence strategic plan for applied intelligence including capability development (new CIO to lead in first 3 months) · FP1.4 Begin work with Cheshire PLACEs on insight-led analytics based on population segmentation and creating single version of the truth, aligned to our strategy
G. Quality Improvement Implement formal quality improvement methods and tools, developing knowledge and skills among all staff to improve quality of care and to work safely and effectively, as part of a team across the system; build a culture supportive of improvement and innovation throughout the organisation and wider system	**BAF 8 (QI)** **BAF 3 (Quality of Care)**	**GP1 Establish QI Team, prioritise approach, and develop Cheshire methodology** · GP1.1 Recruit to Associate Director of Quality Improvement role and align existing resources within the transformation team · GP1.2 Identify key priorities for first collaborative – using analytics to determine 'low hanging fruits' · GP1.2 Bespoke methodology aligned to a Cheshire approach · GP1.4 Commence process of developing a centralised repository for knowledge sharing in relation to QI · GP1.5 Determine required capabilities and agree communications rollout plan · GP1.6 Scope cultural improvement opportunities
H. Enabled Delivery Units Giving greater autonomy to teams for the management of services and performance	**BAF 7 (Financial control)** **BAF 9 (Shaping leadership)** **BAF 10 (harnessing data)**	**HP1 Implement Divisional governance and create dashboards** · HP1.1 Implement new Divisional governance meeting structure

including their own financial management, requiring upskilling and the foundational capabilities to execute. Evolved from current divisions to new business model delivery units		· HP1.2 Agree how corporate teams integrate further into divisions · HP1.3 Determine measurement and performance evaluation framework – baseline · HP1.4 Support the evaluation and adoption of the divisional dashboards
I. Talent Management Implement consistent management of talent across the organisation and the PLACE to nurture and develop the current workforce. Key focus will be to attract, retain, develop and motivate staff to deliver the strategic objectives	**BAF 9 (shaping leadership)** **BAF 14 (Future workforce planning)**	**IP1. Implement talent foundations** · IP1.1 Comms and engagement activity for career/talent conversations and succession planning · IP1.2 Review and re-test adapted talent review boards for 2021/22 · IP1.3 Development of supporting documentation/resources to for career conversations · IP1.4 Refresh leadership offer · IP1.5 Introduce scope for growth (August Board Strategic Session)
J. Knowledge Management Implementing a systematic approach to developing and sharing the cumulative learning and knowledge across the organisation to achieve greater efficiency and effectiveness, and to propagate innovation in care delivery	**BAF 8 (QI)** **BAF 10 (Harnessing Data** **BAF 3 (Quality of Care)**	**JP1 Central repository system/QI platform** · JP1.1 Scope opportunities for development of central repository system/QI platform for sharing knowledge · JP1.2 Analysis and formation of plan · JP1.3 Field visits around knowledge management

3. Patient Experience and Quality of Service (OB)		
K. Backlog and Restoration Addressing the backlog of activity created by COVID in a safe and efficient way, leveraging new and transformative approaches in line with the PLACE strategy. Balancing workforce wellbeing, capacity and demand, and building capability to respond to future surges	**BAF 1 (capacity & demand)** **BAF 3 (quality of care)** **BAF 5 (PBP)**	**KP1 Dynamic predictive tool to prioritise restoration work** · KP1.1 Develop dynamic predictive modelling tool to inform future restoration planning, targeting key backlog and waiting time risks. · KP1.2 Create a clear resource and capacity view • KP1.3 Work with partners on short-term solutions to maximise capacity
L. Workforce Welfare and Capacity Work with staff to ensure there is sufficient support and care provision to maintain their welfare and wellbeing. Key focus is to ensure the Trust has the staff capacity and capability to respond to the backlog and deliver the changes needed to implement the new models of working	**BAF 2 (Workforce Resilience)** **BAF 5 (PBP)**	**LP1 Capacity solution and wellbeing** · LP1.1 Wellbeing squads and appoint visible leadership wellbeing champions · LP1.2 Develop the 'modelling' to support the intuitive thinking – creating an objective view based on Applied Intelligence · LP1.3 Implement rapid interventions to start to address critical workforce gaps (e.g. anaesthetics, acute medicine and respiratory) · LP1.4 Continue to promote the wellbeing support available
M. Patient Access, Flow and Equality Creating a customer/patient centric organisation. Developing new capabilities, implementing the new ways of working, coaching and development staff and working practices to elevate patient experience and consistent quality of service	**BAF 1 (capacity & demand)** **BAF 13 (DCS)**	**MP1 Immediate workforce priority identification** · MP1.1 Identify key areas/hotspots of concern currently resulting in a poor patient experience e.g. quality of complaints' handling; particular service areas · MP1.2 Commence work on above areas · MP1.3 Determine, using analytics/modelling, actions/interventions required to address issues of inequality, including poor service provision etc · MP1.4 Determine how and where digital can help to improve patient experience
N. Digital Health	**BAF 10 (data harnessing)** **BAF 5 (PBP)** **BAF 13 (DCS)**	**NP1 Capability evaluation and priority setting**

Enhance the customer/patient experience through digital workflows and services where applicable. Empowering patients though better access to services and helping clinicians and staff to optimise care delivery		· NP1.1 Evaluate current capability and determine what we need to do to build the capability to develop digital health solutions to improve the patient experience. · NP1.2 Based on the priority segment patient experience mapping, explore how we use digital to improve patient experience and flow e.g. potential for developing use of electronic Cheshire Care Record for patients
4. Build for the Future (RF)		
O. Infrastructure Optimisation Provide safe and fit for purpose buildings and infrastructure to deliver care in line with the strategy. Optimising our estate to provide care in the most appropriate setting for the patient, improving the quality of care and experience	**BAF 11 (Site infrastructure)** **BAF 1 (capacity & demand)** **BAF 4 (Health & Safety)** **BAF 12 (RAAC Planks)**	**OP1 Baseline and agree Strategic Plan; bid and implement** · OP1.1 Board agrees Estates Strategic Plan · OP1.2 New ED Build and IT fit out · OP1.3 VIN development plans finalised · OP1.4 Commencement of enabling works for Leighton phase 1 · OP1.5 Delivery of offsite accommodation · OP1.6 Bid to be one of the 8 new hospital re-builds (national)
P. Future Workforce Developing the future workforce, re-imagining professional roles and responsibilities, resourcing alternate professional development models to deliver the new ways of working. Closely collaborating with the wider Cheshire community and partnerships to enable the delivery of the new way of working	**BAF 2 (Workforce Resilience)** **BAF 14 (Future workforce planning)**	**PP1 Analysis, baseline workforce modelling** · PP1.1 Agree Workforce Strategic Plan · PP1.2 Prioritisation Plan for closure of current vacancy gaps in key areas (respiratory, acute medicine, anaesthetics) · PP1.3 Continue implementation of the CIRC (Cheshire International Recruitment Collaboration) programme · PP1.4 Develop Apprenticeship Strategic Plan aligned to new model of working

		· PP1.5 Expand routes in health & social care roles
Q. Digital Operating Model Creating a digital first PLACE, linking people, process and technology through digital workflows with greater emphasis on placing the patient at the core. Enabling the organisation to leverage the latest digital innovations in an agile and rapid way, building on innovative digital architecture, culture and governance	**BAF 5 (PBP)** **BAF 10 (Harnessing Data)** **BAF 13 (DCS)**	**QP1 Evaluate, baseline and identify gaps and opportunities** · QP1.1 Commence Atos Digitally Enabled Hospital Programme - baseline current capability, gaps and opportunities · QP1.2 A review of current operating model and identify areas for improvement · QP1.3 Sign Heads of Terms with East Cheshire NHS Trust

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

Report to	Board of Directors
Date	28 October 2021
Report from	Lesley Massey, Non-Executive Director Chair
Report prepared by	Caroline Keating, Company Secretary
Executive Lead/s	Murray Luckas, Medical Director Julie Tunney, Director of Nursing & Quality
Committee meeting quoracy	Yes ☒ No ☐

KEY AREAS OF ASSURANCE

Radiology Incident Root Cause Analysis Action Plan - Acceptable Assurance: actions arising from the RCA to be monitored via Divisional Governance meetings with escalations through the governance structure.

Covid-19: New Infection Prevention Control (IPC) guidance on testing, cleaning, isolation and social distancing for patients coming in for planned care procedures. Winter planning guidance on a single respiratory pathway may impact positively on patient flow, with patients being screened using multiplex for Covid and Flu and, for paediatrics, Respiratory Syncytial Virus.

Board Assurance Framework (BAF) Q2 2021/22: controls and actions discussed under substantive items.

Integrated Performance Report (IPR) Month 6:

- VTE assessments (93%): deep dive undertaken and compliance with recording identified as an issue. Improvement plans in place. Funding agreed to recruit divisional clinical governance leads which would support the Associate MDs in this. It remains the case that this reduction in risk assessment being completed has not resulted in an increase in incidents of VTE.
- Post-infection reviews started to identify cause for three Methicillin resistant staphylococcus aureus (MSSA) cases. 17 CDifficile cases reported, an increase from this time last year; assurance taken from a deep dive report.
- Staffing: use of agency staff under constant review; focus also on staff wellbeing and stress. Observation of practice audit of one ward that had a high usage of agency provided positive assurance of ward performance.

Executive Quality Governance Group (EQCG) Chair's Report

- Upper Gastrointestinal (GI) Bleed rota – EQGG only partially assured on actions undertaken to date on consultant recruitment although subsequent discussion at the Executive Risk & Assurance Group demonstrated progress was being made. Successful Gastroenterology recruitment will enable the consultant on-call rota to commence from January 2022
- Safeguarding training 90% target – this had not been achieved as there were issues with data recording. Discussions with EWAG re solutions in place

Maternity Safety Report Q2 2021/22 - Acceptable Assurance:

- Good compliance with Maternity Safety Actions (Ockenden Report). The Trust also benchmarks well against neighbouring Trusts, as evidenced through the North West Coast dashboard
- Despite investment in maternity services, vacancies and sickness absence remain with impact for the wards and on implementation of the Continuity of Care (COC) model. As a result, the latest (third) COC team has been paused to ensure safety on the labour ward.

Serious Incidents Report - Acceptable Assurance: No Serious Incidents reported in September; 10 SIs in October.

Nursing & Midwifery Comprehensive Staffing Report - Acceptable Assurance:

- The annual safe staffing establishment reviews outline four key ward areas that require further investment. The establishment gaps will be addressed by the redistribution of the additional permanent staff currently working on an escalation ward.

Learning from Deaths Report Q2 2021/2022 - Acceptable Assurance:

- 92% of the 279 deaths had been scrutinised by the Medical Examiner –
- 45 (16% - National Target 10%) of deaths underwent Structure Judgement Review (SJR) process with no potentially avoidable deaths identified. One case was considered to have provided poor care and was referred back to the Division for further review and reflection
- Due to capacity issues, no SJRs currently being undertaken for historical outlier alerts.

Complaints Report 2021/22 Q1 and Q2 – Partial Assurance:

- KPIs impacted by Covid but recovery plan in place to improve the response times
- Quality of complaint response identified as a Governor concern; M Agarwal to look at a complaint on a quarterly basis and feedback to the Committee.

KEY CONCERNS/RISKS

- GI Bleed Rota – successful recruitment to enable consultant on-call rota from January 2022

Priority Areas: DECISIONS MADE

N/A

RECOMMENDATION

To note.

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**10.1**	Date of Meeting: 28/10/2021
Report Title	Nursing and Midwifery Comprehensive Staffing Report	
Executive Lead	Julie Tunney Director of Nursing & Quality	
Lead Officer	Helen Nutkins Head of Nursing Safe Staffing and Workforce Utilisation	
Action Required	To note	

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

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

- The annual establishment review process for nursing and midwifery staffing has been undertaken in line with agreed acuity methodology
- Challenges in undertaking reviews due to the significant reconfiguration of wards because of the pandemic
- Investment required to support an operating and staffing model for established wards for the period ahead which is clinically safe, operationally, and financially sustainable
- The paper is here to note, as the staffing investment for an additional ward (ward 13) has already been make at risk, if ward 13 does not close this will continue as a financial pressure

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

- The report will be finalised following the meeting and the required investment included the annual plan 2022-2023

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
Quality and Safety Committee	20th Oct 2021	Nursing and Midwifery Comprehensive Staffing Report	Julie Tunney	Recommendations agreed
Trust Board	28th Oct 2021	Nursing and Midwifery Comprehensive Staffing Report	Julie Tunney	

1. Executive Summary

This paper aims to provide assurance that Mid Cheshire Hospitals NHS Foundation Trust (MCHFT) has arrangements in place to review the nursing and midwifery establishments in line with regulatory requirements.

It details the outcome of the bi-annual acuity reviews for March 2021 and August 2021 based on the configuration of wards/units and clinical pathways currently in place, which have been subject to significant change over the past 12 months due to the Covid-19 pandemic.

This paper provides the position against which current staffing levels are assessed, using nationally recognised acuity tool methodology. The wards continued to move, and additional bed capacity is open, however this paper is based on the established bed capacity and acuity. The additional bed base is managed separately through winter planning. The staffing for the additional beds continues to be managed through the 6 weekly Covid-19 acuity reviews by the senior nursing team.

The need to be responsive to the different phases of the pandemic throughout 2021 has required and continues to require rapid staff deployment and redeployment. The senior nursing team continues to carry out 6 weekly Covid-19 acuity reviews, using professional judgement and the monthly safe staffing report is reviewed at the Trust Board meeting to ensure that there is line of sight. This approach has enabled a tactical response to the Covid-19 pandemic demand, flexing staffing levels to meet the changing requirements. It is expected that staff movement and deployment will continue to be necessary as we move through the different phases of the pandemic. However, every effort has been made to minimise staff movements where possible.

The bed configuration and expansion is a dynamic activity to meet expected and unexpected capacity requirements. Changes to the ward bed base and patient pathways has affected the staffing requirements. Going forward, work is now required to review the ward configuration and clinical pathways to ensure that there is an operating and staffing model for the period ahead which is clinically, operationally, and financially sustainable.

As a result of the March 2021 and August 2021 acuity reviews, this paper outlines four key areas that require funding in adult inpatient wards, Ward 4, Ward 14, Ward 10, and Ward 21b due to increased patient acuity and to achieve 1:8 registered nurse to patient ratio. This will cost circa. £330k. The Trust has already committed to permanently establish Ward 13 which is a temporary ward and committed to flexibly establish to support the international nurse pipeline. Therefore, when Ward 13 closes in April 2022 the established staff will need to be redistributed to support the acuity and ratio gaps.

For this review, there are no acuity funding requirements in ED, Critical Care, Paediatrics and Maternity for this financial year.

2. Background

The purpose of this paper is to provide the Board of Directors with an overview of Registered Nurse and midwifery staffing capacity and compliance with the National Institute for Clinical Excellence (NICE) safe staffing and National Quality Board (NQB) standards. It is a requirement that every Board receives an annual establishment report with a further review on a biannual basis (National Quality Board, 2016).

Data acquired from using the evidence-based tools is triangulated with the professional judgement of senior nurses to determine the right level and skill mix of nursing staff for each clinical ward area. Nurse sensitive indicators are used as part of the review to inform the establishment setting process.

During this period (2020-21) acuity review meetings were held with Director of Nursing, Deputy Director of Nurse, Heads of Nursing and Matrons to ensure professional scrutiny is applied to the establishment setting process.

Safer Nursing Care Tool (SNCT) data collection for adult inpatient wards is usually undertaken in January and July, this was delayed until March and August in 2021 as the wards were dealing with the second wave of Covid-19. Two fully validated data collections were completed for all adult inpatient wards.

For Women's and Children's acuity, data collection from the System to Escalate and Monitor (STEAM) the paediatric approved tool, BAPM (British Association of Perinatal Medicine) tool for Neonatal Intensive care and Birth-rate Plus® (BR+) intrapartum acuity tool was completed in March and August in 2021 in line with adult wards.

The establishment setting review process for 2021 has been impacted by the Covid-19 pandemic. The frequent reconfiguration of wards has affected the collection of two full datasets of SNCT for wards that have changed function between March and August. In a small number of wards, it was necessary to use the previous years' establishment data alongside professional judgement and patient outcomes to inform the position on 2021 establishments.

Acuity review outcome summary by Division

Below summarises the proposed nursing establishments following the divisional acuity review meetings held in 2021. An account of each Ward SNCT data together with current agreed establishment is available on request.

The resulting gap in the ward establishments are primarily due to increased patient acuity and to achieve a 1:8 registered nurse to patient ratio.

3. Medicine and Emergency Care Division

3.1 Medical Ward areas

Ward	Proposed compared to current establishment	Further comment	Costs
Ward 4 Care of the Elderly	Increase RN on days by 2.8 WTE	To achieve RN 1:8 patient ratio on day shifts	£126,378
Ward 14 Gastroenterology	Increase RN on days by 2.8 WTE	To achieve RN 1:8 patient ratio and acuity increase	£126,378

3.2 Emergency Department

The Emergency Department (ED) continues to see significant growth in attendances. There have been considerable changes to layout and patient pathways in response to the pandemic which have impacted on the nursing workforce.

The next phase of ED development, the Urgent Care Village will open by the end of the year. Additional staffing was funded via the in 2020 workforce business case with a 135.46 WTE staffing model planned to deliver clinical care. This model will bring staffing levels in line with the Best acuity reviews.

ED has undertaken an acuity review in March 2021 using the BEST tool and like other areas, it is subject to 6 weekly Senior Nurse reviews. A new ED Safer Nursing Care Tool will be launched in mid-September by the Shelford Group. The new acuity tool will support:

- Establishment setting using annual attendance as well as acuity and dependency
- Care hours to contact metrics on the current and recommended establishments
- A deployment arm showing an hourly staffing requirement aligned to acuity

3.3 Critical Care

During the Covid-19 pandemic the Critical Care bed configuration and expansion has been dynamic to meet capacity requirements, this has been supported through bank, specialist agency, and the redeployment of staff from theatres, with critical care skills. Staffing requirements have flexed to meet the care requirement of level 2 and level 3 patients to comply with Guidelines for the Provision of Intensive Care Services (GPICS).

In addition, Critical Care building extension commenced in 2021. Each bed commissioned will require an additional 5.7 WTE registered nurses and funding will need consideration through Trust governance processes. An incremental bed increase will be required to allow for recruitment.

4. Surgery & Cancer Division

4.1 Surgical Ward areas

Ward	Proposed compared to current establishment	Further comment	Costs
Ward 10 Ortho Trauma	Increase RN on weekend days by 0.8 WTE	To achieve RN 1:8 patient ratio at Weekends (Historical reduction at weekends)	£36,108

5. Diagnostic and Clinical Support Services Division

5.1 Diagnostics Ward areas

Ward	Proposed compared to current establishment	Further comment	Costs
Ward 21B Rehabilitation	Increase HCAs on Early shift by 1.37 WTE	Acuity scoring shows staffing below SNCT tool	£40,769

6. Women & Children's Division

6.1 Paediatric Acuity

The acuity tool used (STEAM) for Paediatrics was reviewed in March 2021 and August 2021. August data demonstrates negative acuity of 74% and 26% of shifts as positively staffed. This is a significant change from the previous review in March 2021 which demonstrated 100% positive acuity.

Acuity was high in August due to increased occupancy in HDU. The expected surge in respiratory infections in children has affected CAU intermittently throughout August combined with an increase in children and young people requiring admission due to emotional and mental health issues (CAMHS) this has made an impact on usual activity for August.

Actions to maintain safe staffing levels were taken including anticipating extra requirements in times of high acuity and maternity leave. The play specialist role is being reviewed to incorporate more support for the older child /young person with emotional and mental health issues.

Staffing has been managed proactively at the daily huddle with issues escalated and staff redeployed to support. There were no moderate or above incidents reported where staffing was a contributory factor. The paediatric inpatient ward, although not positively staffed on all occasions was deemed to be safe using the skill mix of staff available.

6.2 Maternity – Labour ward

An external Birth-rate Plus® (BR+) assessment was commissioned in 2019 and a refresh was completed in July 2021. The trust is currently awaiting the outcome report.

The results of the March 2021 and August 2021 acuity review highlighted 92% and 88% of shifts were positively staffed. By proactively managing the workload these figures show that measures were put in place to maintain safe staffing on the labour ward areas for both low and high-risk women.

Following the publication and actions required within the Ockenden Report (2020) the Trust received funding for 4.9 WTE registered midwives.

Maternity continues to work towards a continuity of care model and are achieving approx. 32% of women on a continuity pathway following investment as a result of the 2019-2020 acuity review.

6.3 Ward 23 – Maternity ward

Ward 23 have introduced the Birth rate Plus® postnatal Application (App) in May 2021. Patient acuity data is entered into the App three times a day at the start of each shift and is based on predictive workload for the next 8 hours, relating to admissions and discharges. Dependency is categorised to ascertain the number of care hours required.

The first data presented in August 2021 data demonstrates negative acuity of 72%. However, the results require professional judgement as the App only features a red or green status with no amber where the predicted workload may be of a lower acuity. The control in place is that senior Midwifes undertake a workload huddle every 6 hours and staff are redeployed across maternity to address any shortfalls due to increased workload or acuity.

6.4 Neonatal Intensive Care Unit (NICU)

The August 2021 review showed 78% of shifts positively filled. The acuity and dependency on NICU varies throughout the year and there is no real pattern to assist with prediction of acuity however, the division reviews this data every 12 hours and alters the staffing requirements accordingly. NICU was positively staffed and was deemed to be safe using the skill mix of staff available at the time.

7. Central Cheshire Integrated Care Partnership (CCICP)

The establishment and acuity for each Care Community was reviewed in June 2021 with specific reference to the Community Nursing service focusing on aspects of capacity, caseload management and care provision. The acuity review has again confirmed that there is still no ability to easily collate data following the rollout of the Malinko scheduling tool. The data obtained for the 2021 review has again relied on team leaders manually retrieving data.

CCICP's Community Nursing service saw an increase in activity during 2020-2021 which can be

attributed to the additional provision of ambulatory wound care services from April 2020 but also the understandable shift in requirement to provide more care to patients within their own homes. The service has also attended many more patients with multiple complex health concerns.
The Acuity Review evidenced caseload managers in all Community Nursing teams effectively undertaking regular caseload reviews to manage caseload sizes.

All Care Community teams demonstrated an increase in registered staffing numbers as compared to 2020. This is attributed to the additional funding provided for Ambulatory Wound Care Service.

Nantwich Community Care and Winsford Community Care teams' staffing levels per 1000 population were higher than those in the other Care Communities, however, other quality indicators such as caseload size, pressure ulcer management demands, and sickness absence levels all indicate that these staffing levels were required to support quality patient care and staff wellbeing.

8. Strategic Staffing Reviews – Summary

There has been a continued need to be responsive in terms of acuity and dependency to the different phases of the Covid-19 pandemic throughout 2021. The bed reconfiguration and expansion are a dynamic activity to meet expected capacity requirements. Changes to the ward bed base and patient pathways have affected the staffing requirements, to ensure we meet the nationally recommended safe staffing ratios and patient safety. Work is continually required to review the ward configurations and clinical pathways to ensure that there is an operating and staffing model for the period ahead which is clinically, operationally, and financially sustainable.

Based on the 2021 acuity reviews the key areas that the Trust needs to consider investment in is likely to be circa. £330k. The Trust has already committed to permanently establish Ward 13 which is a temporary ward and committed to flexibly establish to support the international nurse pipeline. Therefore, when Ward 13 closes in April 2022 the established staff will need to be redistributed to support the acuity gaps.

In addition to this work for the established bed base the Trust will continue to review acuity and establishment routinely throughout this current year and every 6 weeks as it has throughout the Covid-19 pandemic and provide assurance to the Trust Board monthly through the safer staffing information.

9. Recommendations

The Board of Directors is asked to: -

- Note that the annual establishment review process for nursing and midwifery staffing has been undertaken in line with agreed acuity methodology.

- Note the required investment prior to the annual plan 2022-2023.

- Note the staffing requirements taking into account the investment already made for the additional ward. If this additional ward is unable to close this will be carried as a financial pressure for 2022-2023.

- Support the recommendations that registered and unregistered nurse staffing levels need to be a continued area of incremental investment in line with evidenced based reviews.

BOARD OF DIRECTORS

Agenda Item	**10.2**	Date of Meeting: 28/10/2021
Report Title	**Serious Incidents Report September 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)*

In September there were no StEIS (Strategic Executive Information System) reportable incidents declared.

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

For information at EQGG, Report to be tabled at QSC and BoD

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	12/10/2021	Serious Incidents September report	ADQG	Meeting yet to be held

Serious Incidents Report September 2021

Introduction

1. This report provides the Committee with details of serious incidents declared and closed during September 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 no serious incidents declared in September 2021, all incidents rated as moderate are above have been investigated and monitored through the daily Patient Safety Huddle and reported up to the Patient Safety summit.

Conclusions

5. The Trust has declared no serious incidents.
6. The Trust continues to demonstrate ongoing learning from incidents and ensures these are disseminated widely within the organisation.

Recommendations

7. The Board 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: 06/10/2021

Mid Cheshire Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**10.3**	Date of Meeting: 28/10/2021
Report Title	**Learning from Deaths Report Q2 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 ☐

Learning from Deaths Q2 2021/22

Introduction

1. This report is the second 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 quarter 2 of 2021/22 (1 July – 30 September 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 2:

   - There were **279** deaths at MCHFT
   - **257** (92%*)* deaths were reviewed by a Medical Examiner
   - **45** (16%) deaths were subject to a Structured Judgement Review (SJR)
   - **29** completed SJRs were received in Q2
   - **No** deaths were felt to be potentially avoidable (more likely than not to be due to a problem in care)

   Of the **83** SJRs commenced in year, **42** have been completed at the time of the report being written.

   SJRs for the two mortality outliers of Liver disease and Congestive Cardiac Failure (non-hypertensive) have been suspended due to capacity within the SJR teams.

4. Of the deaths reviewed and completed using the SJR methodology in quarter 2:

   - **None** were classed as category 1 and therefore potentially avoidable (LIKERT 4 or above)
   - **1** was classed as category 2, where poor care was identified but the death was unavoidable (LIKERT 1-3, poor or very poor care). A divisional action plan has been developed to ensure learning from the SJR is captured.

- **28** 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) – suspended
    - 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 Hospital Mortality Reduction Group.

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
99	93	13	8	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
276	216	29	13	0	1	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
492	1222	42	28	1	2	0	7

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
1	2	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
3	3	0	1	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
6	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 Quarter (Q2) N=29	24	5	0	0	0	0
This Year (21/22) N=42	34	6	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 Quarter (Q2) N=29	4	16	8	1	0
This Year (21/22) N=42	6	22	12	2	0

(Source: SJR database, 2021)

Total SJR's completed for Quarter 2 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)
July 2021	8	0	0	8
August 2021	8	0	0	8
September 2021	13	0	1	12

(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
July 2021	0	0	2	2	1	14	1	0	9
August 2021	1	0	0	0	0	0	0	0	1
September 2021	1	0	2	1	1	0	5	0	4
Total	**2**	**0**	**4**	**3**	**2**	**14**	**6**	**0**	**14**

(Source: SJR database, 2021)

Summary of Potentially Avoidable Deaths in Quarter 2 2021/22

Month	Incident number	Recorded Cause of Death	Speciality	Concerns and learning	SJR outcome
None in quarter					

(Source: SJR and SI database, 2021)

Update Summary of Potentially Avoidable Deaths from Previous Quarter – Quarter 1 2021/2022

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 is underway to collate 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)

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

1 case to report in quarter

Month	Incident number.		Details	Review on target?	Details/Comments/Learning
	Unexpected?	Unexplained?			
August 2021	142929		Neonatal death at 30-week gestation. Following an amniotic fluid leak in early pregnancy, the baby was born prematurely because of maternal bleeding. Sadly, the babies lungs were not developed enough to support life.	Investigation completed	No lapses in care identified

Inquest Quarterly Update

Month	Inquest number	Recorded Cause of Death	Coroners Verdict	Learning	Linked Trust Investigations or SJR
July 2021	INQ/21/006 General Surgery	1a. Complication's post ERCP 1b. ERCP 1c. Cholangitis 2. COVID-19	The deceased died as the result of complcations arising out of a necessary surgical procedure. COVID-19 which was also naturally occuring contributed to their death.	Since 2019 the Trust has introduced a number of actions to improve the management of the deterorating patient. This includes by improving/introducing an acute care team, training, commuications, review and audit. A thermatic review of ERCP incidents has been completed.	Incident: 131784 A root cause analysis was completed. The incident was downgraded to no harm as no lapses in care were identified from the investigation. An SJR was completed which identified good overall care and LIKERT 1. A post infection review was completed which found no lapses in IPC measures.
August 2021	INQ/21/010	1a. Pneumonia 1b Hypoxic Cerebral damage 1c. Ligature suspension	The deceased had a Mental health diagnosis. Whilst an in-patient, the individual committed an act which was not intended to result in death, but sadly did	The outcome of the Inquest was misadventure and there was no learning for the Trust.	N/A

(Source: Ulysses, 2021)

Medical Examiner Quarterly Update

	July 2021	August 2021	September 2021
Number cases reviewed	73	77	107
Number cases referred to coroner	13	10	13
Number of cases referred for SJR	1	1	4

Learning Themes

15. During quarter 2, there were six cases referred for an SJR by the ME office in line with the Learning from Deaths Policy.

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

17. One case identified potential learning in relation to a unified do not attempt cardiopulmonary resuscitation (uDNACPR) not being in place for a patient that was stepped down from Critical Care. Consultants had confirmed the patient would not be suitable for readmission to critical care. The patient sadly had a cardiac arrest on the ward and was resuscitated, however, a uDNACPR would have been appropriate for this patient. This case was presented to the Trust Patient Safety Group.

Recommendations

18. The ME office will be undertaking the following in quarter 3:

- Continue the planning of the roll out within the community setting
- Interviews to take place in the coming weeks for the additional Medical Examiner post
- Pilot electronic ME paperwork on a designated area

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 (*August 2021*). The Trust undertakes an in-depth case note review in response to any Mortality Outlier Alert.

Key Messages

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

Number of outlier alerts for this Trust as at 14 December 2020

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

Mortality Outliers – Active Alerts

Cases under consideration by the Outlier Panel

- Acute cerebrovascular disease (Dr Foster, Nov 19) - New case - pending consideration (ON HOLD AS OF 26/03/20 DUE TO COVID-19)

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

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

Cases for review by inspection team

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

Maternity Outliers – Active Alerts

Cases under consideration by the Outlier Panel

-

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

PAF Committee
Chair's Assurance Report
21 October 2021

Report to	Board of Directors
Date	28 October 2021
Report from	Trevor Brocklebank, Non-Executive Director
Report prepared by	Caroline Keating, Company Secretary
Executive Lead/s	Russell Favager, Deputy CEO & Director of Finance Oliver Bennett, Chief Operating Officer
Committee meeting quoracy	Yes ☒ No ☐

KEY AREAS OF ASSURANCE

Board Assurance Framework (BAF) Q2 2021/22
High scoring risks (15+) reviewed and challenge around potential over-scoring. Outcomes of on-going review available November.

Integrated Performance Report (Month 6) September 2021
Committee advised of key areas, triangulating with BAF and Executive Delivery & Performance Group report.

Executive Delivery & Performance Group Chair's Report 7 October 2021

- Significant pressure remains on the urgent and emergency care pathway with attendances to ED remaining above pre-pandemic levels (15% growth since 2019 in line with year-on-year growth seen over last few years). Problem remains with the number of patients stranded in hospital. Urgent & Emergency Care (UEC) improvement Plan specifically targets these areas and working closely with system partners to help with hospital discharge continues.
- 26 breaches of 12-hour DTA (Decision to Admit) standard noted.
- Waiting list backlogs continue to grow; likely to be some time before this trend reverses due to capacity and referral levels almost back to pre-pandemic levels (96%).
- Cancer 62+ day backlog grown significantly in the last month. PAF reassured that this problem is understood, and remedial action agreed to recover the position within the next month or so.

Urgent and Emergency Care Improvement Plan - Acceptable Assurance
New plan based on reducing ED attendances, admission avoidance, improving flow and workforce development. 5 key workstreams each sponsored by an Executive Director with a new governance structure accountable for delivery. PAF keen to understand key milestones and risks associated with delivering the plan. PAF agreed that it was important that the Trust committed to the plan over the longer term to ensure successful delivery and changes are fully embedded as BAU.

Restoration Plan Update

- Elective, day case and outpatient activity improved in September compared to previous month but remains behind trajectory.
- Number of patients waiting between 44-51 weeks increasing due to delivery of less 'core' activity compared to 2019; may result in increase in 52+ week waiters; situation being closely managed.

- Noted that business case to develop a Community Diagnostic Centre at VIN confirmed.

New NHS Priorities and Operational Planning guidance Oct 2021 to March 2022 ("H2") published. Trust submitted first draft activity and performance plan to C&M HCP; final draft due and submitted to PAF Nov 2021.

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

- ED build delayed for multiple reasons including supply chain issues; now planned to open 8 December 2021; reassurance provided that a detailed move plan is being developed.
- Successful completion of Infinity House which is now occupied.

Finance Report (Month 6) September 2021

- Month 6 financial break-even position required £0.9m system support. Trust financial position significantly influenced by additional wards and no access to ERF (Elective Recovery Fund). Recent pay award an anticipated pressure of £0.6m which will materialise in H2
- Outlook for H2 financial position (Oct 2021 to March 2022) extremely challenging. Whilst the C&M HCP have had £51m additional funding, which is better than was expected, it is difficult to see the system balancing. Providers are continuing with a similar level of expenditure for H2 restoration; however, they are unlikely to be able to access the ERF, of which the system received £54m during H1. For H2 planning purposes, principles have been agreed for providers to comply with – so that H2 plan first draft meets submission of 25 October.
- Organisational allocations of income provisionally released; however, detailed calculations that reconcile commissioner contracts of income to providers have yet to be released. This will mean that the initial draft will, inevitably, require a further revision before the system submission in November. For the Trust, the particular cost increases relate mainly to seasonal pressures related to unplanned care; however, the biggest challenge will lie with delivering a cost improvement plan for the second half of the year.

KEY CONCERNS/RISKS

- Urgent and emergency care pressures and performance remain a significant challenge.
- Elective activity is improving but likely to be impacted by forthcoming seasonal pressures.
- H1 financial break-even required system support and H2 financial position remains uncertain but likely to be a significant challenge to deliver a break-even position by March 2022.
- Opening of the new ED by 8 December will require an ongoing significant effort to ensure delivery.
- Growing waiting list backlogs.

Priority Areas: DECISIONS MADE

None.

RECOMMENDATION

To note

Workforce and Digital Transformation (WDT) Committee
Chair's Assurance Report
18 October 2021

Report to	Board of Directors
Date	28 October 2021
Report from	Lorraine Butcher, Non-Executive Director
Report prepared by	Caroline Keating, Company Secretary
Executive Lead/s	Oliver Bennett, Chief Operating Officer Dylan Williams, Chief Information Officer (CIO) Jenny Grant *(representing HBarnett, Director of Workforce and OD)*
Committee meeting quoracy	Yes ☒ No ☐

KEY AREAS OF ASSURANCE

Board Assurance Framework (BAF) Q2 2021/22 – WDT Delegated Risks – BAF 2 *(Risk of reduction in workforce wellbeing and resilience)* highlighted in relation to the impact from current operational pressures, and workforce supply challenges impacting in turn on performance. Work underway in key areas starting to make positive progress although it would be some time before the scale of risk would reduce. Transformation and workforce risks where digital implementation might mitigate the impact would be looked into.

Integrated Performance Report: Significant challenges and associated risks remained in relation to the ability to discharge patients in a timely manner. Sickness absence was reducing and an improved position seen in September. Static compliance with statutory and mandatory training was discussed.

Executive Workforce Assurance Group Chair's Report – 06 October 2021 - Wellbeing calendar of events for next 12-months aligned with ED&I agenda. Deep dive into long-term sickness absence identified increase due to anxiety, stress and depression cases. Covid risk assessment compliance was good although there had been a shift with new starters and BAME colleagues' compliance which would be monitored by the H&WB Group. Medical workforce gap driver diagram provided identification for key areas of focus.

ESR Workforce Systems – **Partial Assurance:** Phase 2 completed; Phase 3 commenced with divisional consultation. On target in digitising key processes around training, access and budget allocation.

Workforce and OD Quarterly Update Report (2021/22 Q2): collective metrics (i.e. alignment of workforce and the digital agenda) to be identified following approval of strategic plans.

Vacancy Gap Update - Acceptable Assurance: the gap had been closed for substantive wards and beds base; however escalation wards remaining open are currently impacting on this position, leaving a gap. Work underway with Operations to review benefits realisation of the international nursing workforce to revise and work up the next model.

Appraisal Update Report - Partial Assurance: continuing challenge regarding appraisal compliance. To be escalated as an area of concern for the Committee.
Staff Wellbeing - Acceptable Assurance: staff survey and Pulse survey outcomes alignment with staff wellbeing updates to be considered. .

Digital Technology & Information Services Group (DTIS) Chair's Report – 01 October 2021 - reviews undertaken on bed cases and missing case notes risks. Tactical opportunities regarding the Cheshire Care record being discussed across a wider footprint. Bid to the Unified Tech Fund implemented.

Digital Clinical Systems (DCS) Update: Preferred supplier confirmed; Comms involved regarding announcement. Discussions underway regarding phasing and what was in scope of the full business case (FBC). FBC date of 4 November not considered viable. Maternity element remained a challenge and needed to be addressed. DCS operating model being considered by Mid and East Cheshire Trusts.

Cheshire & Merseyside Digital Programme Update - Meetings held with Integrated Care System (ICS) leads to obtain a baseline of regional and local issues and challenges.

Digital Programmes – IT Project Update: although projects were being monitored effectively, a more strategic approach was considered necessary.

KEY CONCERNS/RISKS

- Appraisals

Priority Areas: DECISIONS MADE

- N/A

RECOMMENDATION

To note

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**13**	Date of Meeting: 28/10/2021
Report Title	**Freedom to Speak Up Guardian Report Quarter 2 2021/22**	
Executive Lead	James Sumner, Chief Executive	
Lead Officer	Sian Axon, Freedom to Speak Up Guardian	
Action Required	To note	

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

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

- Further 'Open Door' event, occurred September 2021 with BAME Network Representative in attendance
- Evidence of triangulation of staff issues into Trust structure & processes can be evidenced
- E- Learning for staff; 'Speak Up' and Managers ' Listen Up' has been adding to the Trust's e-Learning platform

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

- Freedom to Speak Up Month October Promotion / coms across Organisation
- Embed further FTSU strategies -Board to floor
- Scope & trial FTSU Walkabouts
- Develop FTSU user feedback survey

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 ☐

REPORT DEVELOPMENT

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

Freedom to Speak up Guardian Q2 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 two in relation to speaking up and raising concerns.

4. Promotion of the Speaking Up agenda continues with Freedom to Speak Up E-learning. 'Speak Up' and 'Listen – Up' training has been made available for organisations.

5. 'Speak Up' training has been added to all staff induction, and 'Listen – Up' training is part of management training here at Mid Cheshire. Both training packages are available for staff to access.

Analysis of Quarter 2

6. During the period 1st July to 13th September 2021, x 8 new concerns were raised using the various Freedom to Speak Up reporting mechanisms. X 8 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 7 concerns being raised during the previous quarter and 5 concerns highlighted during quarter one in 2020/21.

   The concerns raised during Quarter 2 are set out below:

Month reported	Staff Group	Method of reporting	Type of concern	Actions taken	Issue Closed and feedback reported
July	Nursing	Telephone & Email	Intimidation Worker safety	HON Division took local actions	Closed with good feedback
July	Manager	In person	Intimidation Worker wellbeing	Human Resources & Divisional actions	Ongoing

July	Supervisor	In person	Intimidation Worker wellbeing	Human Resources & Divisional actions	Ongoing
August	Nursing	Meeting	Safety & Well being	Under action with relevant Leads	Ongoing
August	Allied Health Professional	In Person	Safety & Workload- wellbeing	Under action within Division	Ongoing
August	Allied Health Professional	In person	Patient safety & Workload- well being	Under action within Division	Ongoing
August	Nursing	Via CCICP Senior Team	Patient safety & Workload	Actions in place from Division	Awaiting final update
September	Nursing	Open door event	Staff wellbeing safety impact	Actions in place from Division	Actioned

Division	Number of concerns raised Q2
Surgery and Cancer	0
Medicine and Emergency Care	2
CCICP	3
Corporate	0
Diagnostic and Clinical Support	0
Estates and Facilities	2
Not Given	1

7. Themes that manifest from the table are based around workload, intimidation and impact of wellbeing. If more than one person attends raising the same concern together this is logged as a separate FTSU concern in line with National Guardians office guidance. Feedback has been received from groups within CCICP and Estates and facilities.

8. Workload has been raised as a concern; this possible safety impact has been raised by the FTSU Guardian at the patient safety summit. The specific concerns are being addressed by the Divisions involved, however this also links into the Organisational active recruitment and retention strategies and development of new roles and ways of working. The FTSU Guardian actively participates in these groups. Themes from FSTU helping to represent a form of feedback, for e.g. workload impact on wellbeing.

9. Promotion of the Freedom to Speak up Champion's role continues with attendance at the BAME network meeting in August from this meeting a BAME network representative supported the FTSU 'open door' event at Leighton site at the end of September. As part of the FTSU month there is also a series of FTSU walkabouts taking place, BAME network volunteers will be supporting this also.

Conclusion

10. The role and services of the FTSU Guardian will be further promoted moving forward. The Freedom to speak up should highlight, inform and improve the skills, knowledge and capability of workers; floor to board, Board to floor to speak up and support others to do so: Speak Up, Listen Up, Follow Up.
    With FTSU month in October, further communication events, walkaround and open-door events are planned.

Next Steps

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

Recommendation

12. To note

Report Author: Sian Axon, Freedom to Speak up Guardian
Date: 20 October 2021

Audit Committee
Chair's Assurance Report
7 October 2021

Report to	Board of Directors
Date	28 October 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

Report of Board Committees - Acceptable Assurance: Report noted as good practice by External Audit to enable review of how Board Committees are fulfilling agreed terms of reference and delegated responsibilities from Board. Committee noted the following points for consideration:

- Workforce and Digital Transformation (WDT) Committee to consider how the Digital Transformation agenda was addressed more clearly through the meetings now new Chief Information Officer in post
- Further focus needed on review and assurance across Committees to mitigate risk of possible straying into operational matters.

Financial Conformance Report - Acceptable Assurance: Strong management responses received on management of single tender waiver requests and IR35 process and compliance.

Risk Management Key Performance Indicators (KPI)
Work in progress linked to upgrade of 4Risk system. Strongly supported initiative. Proposal to be brought to next meeting on implementation and how to link KPIs to demonstrable improvements in patient safety and experience.

Whistle Blowing FTSU Assurance Report - **Acceptable Assurance:** Policy and processes of internal controls in place. Increasing numbers of concerns reflects greater awareness of Freedom to Speak Up Guardian (FSUG) following refresh and more communications. Majority of contacts are not anonymous which reflects positive reporting culture. National Guardian's Office FSU checklist in progress ahead of presentation to Board.

Internal Audit Report Update Acceptable Assurance: Bank and Agency Processes Internal Audit (IA) follow up review to 2019/20 report which resulted in Limited Assurance - Substantial Assurance now reported. Actions from first review all implemented and strong systems of internal control and good practice highlighted. Focus was on processes, not impact of temporary staff on patient care or finances. WDT Committee to be asked to consider patient care aspect with reference as appropriate to the Quality and Safety (QS) Committee.

Internal Audit Tracker - Partial Assurance: All actions completed or underway. Two delayed actions for Bribery Act Compliance training due to programming of Board and senior management training. Three overdue actions, relating to E-referral IA report, primarily due to changing national guidance. MIAA to conduct follow up review, review recommendations and report back to next Audit Committee.

Clinical Coding Update of Risks - Acceptable Assurance: Forward vision for Clinical Coding presented as part of Digital Transformation Workforce Plan to be developed before 2022/23. Key risks relate to workforce - short-term plans in place to mitigate this and future consideration of automation to manage risk long-term.

Medical Devices Review: Acceptable Assurance: Significant improvement in Trust position and rating of Substantial Assurance from Mersey Internal Audit Agency (MIAA) review. Some areas still in progress – reassuring update provided by Chief Information Officer (CIO) on progress against these. Network segmentation plan to isolate higher risk medical devices is an ongoing programme. New processes in place through procurement to ensure that backlog of devices not secured does not increase and asset register is correct.

KEY CONCERNS/RISKS

- Assurance received on system of internal control relating to bank and agency staff - WDT and QS Committees asked to consider quality issues and potential risks to patient care
- Evidence of Digital Transformation agenda at WDT is limited but this is a known issue to be explored with the CIO

Priority Areas: DECISIONS MADE

- None

RECOMMENDATION

To note

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**CONSENT AGENDA 1**	Date of Meeting: 28/10/2021
Report Title	Guardian of Safe Working Hours Report Q2 2021/22	
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 promote confidence with exception reporting have been tried, with limited success

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 continuing
- Exception reporting now considered in 'E-rostering for doctors' workstream in Medical Resourcing

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 July 2021 – 30th September 2021 (Q2)

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. 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 pandemic. The very low number of exception reports received, has raised concerns that this process does not function well, and confidence in the system has been affected. Currently, an e-rostering system for doctors is being explored withing Medical Resourcing, which may address some of these issues.

3. 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.

A trainee's Educational Supervisor is required to respond to exception reports within 7 days of a submission, to review and discuss the reasons with the trainee. This does not always occur, and supervisors cite difficulties of unfamiliarity or that the system does not reliably work for them.

The most common outcome is time off in lieu (TOIL) or payment for hours worked if that is not possible within a month. However, trainees find it hard to take TOIL under sustained workload pressure, need to specifically request payment, and missed training is hard to recover.

From **1st July to 30th September** there were **5** exception reports submitted and **3** supported. Of these all were related to hours of work. There were stays of more than an hour after the working day for two Foundation Year 1 (FY1) trainees in Medicine. The other was from a senior trainee in Orthopaedics who was resident on call for 24 hours, with insufficient rest. **A statutory fine (yet to be calculated) is likely to be levied in this period in respect of the orthopaedic senior trainee**.

4. GoSWH Actions

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

1. 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 service managers and lead clinicians.

2. 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. Further awareness raising is in progress using BMA materials.

3. There has been feedback from both trainees and educational supervisors that the current exception reporting system is difficult to use, with reliability problems and does not allow mobile phone access, so requires desktop and laptop access, which can be limited on the wards.

4. Actions to improve engagement in, and confidence with, exception reporting:

    - Re-launching exception reporting for trainees with positive messages from GoSWH and DME at every induction and at each rotation between clinical supervisors.
    - Awareness raising and training of educational and clinical supervisors emphasising need for signing off exception reports promptly. Educator training days were paused in 2020.
    - Ensuring better access to computers or a phone app to allow timely exception reporting.
    - 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, and if not taken, payment automatically generated
    - Considering a new exception reporting system to facilitate these functions within the e-rostering systems currently being explored for doctors

5. Conclusions & to note.

This is the eighteenth 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 &2021, there has been a marked reduction in exception reporting despite increasing workload pressures related to Covid19 admissions. Survey and informal feedback identified reduced trainee confidence in the Trust's response to exception reports.

Areas of concern from trainees include difficulty in integrating the new Foundation educational requirements for self-directed learning into rotas and persisting heavy workloads on the wards, particularly in Medicine.

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 Medical Director. In turn, we have significant concerns about junior doctors' risk of burnout with these unprecedented workload pressures.

Douglas Robertson
Guardian of Safe Working Hours 19.10.21