Mid Cheshire Hospitals NHS Foundation Trust

Board of Directors

Thursday 27 January 2022, 9.30am
Virtual (Teams) Meeting

AGENDA

No	BAF Risk	Item
PRELIMINARY BUSINESS		
1 9:30		**Apologies (v)** Chair
2		**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		**Patient Story (v)** Executive Director To note
4		**Victoria Infirmary Northwich (VIN) Update (p)** Non Executive Director (VIN Champion) To note
5		**Draft Minutes of the Last Meeting – 25 November 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		
6 10:00		**Chair's Report (v)** • **Council of Governors – 13 January 2022** Chair To note
7 10:10		**Chief Executive's Report (d)** • **Hospital Redevelopment Programme Board – 13 December 2021 (d)** • **Digital Clinical Systems Programme Board – 10 January 2022 (d)** Chief Executive To note

No	BAF Risk	Item
8 10.20		**Integrated Performance Report Month 9 – (December 2021) (d)** Chief Executive To note
9 10.20		**Board Assurance Framework (BAF) Q3 2021/22 (d)** Chief Executive To note
10 10.30		**Board Committees Assurance Report - January 2022 (d)** Company Secretary To note
STRATEGIC		
11 10.35		**Trust Strategy 2021-2026 Progress Report (d)** Chief Executive To note
QUALITY - Patient Safety, Clinical Effectiveness & Patient Experience		
12 10:45	**BAF3**	**Quality & Safety Committee Chair's Assurance Report – 22 December 2021 (d)** Committee Chair To note
13 10:55		**Serious Incidents Report (d)** Medical Director To note
14 11:00		**Getting It Right First Time (GIRFT) (d)** Medical Director To note
15 11:10		**Learning From Deaths Report (d)** Medical Director To note
PERFORMANCE & FINANCE		
16 11:20	**BAF7,11, 12**	**Performance & Finance Committee Chair's Assurance Report – 21 December 2021 (d)** Committee Chair To note

No	BAF Risk	Item
		• **Escalation Ward Business Case (Wards 13 & 19) (d)** Chief Operating Officer To note
17 11:35		**Finance Report (d)** Deputy CEO and Director of Finance To note
18 11:45		**H2 Operational Priorities and Elective Restoration Update (d)** Chief Operating Officer To note
PEOPLE		
19 11:55	**BAF1, 2,10, 13,14**	**Workforce & Digital Transformation Committee Chair's Assurance Report – 20 December 2021** Committee Chair To note
		• **Sickness Absence Improvement Plan (d)** Director of People To note
20 12:10		**Vaccination as a Condition for Deployment (d)** Director of People To note
21 12:20		**Gender Pay Gap (d)** Director of People To note
GOVERNANCE/WELL LED		
22 12:30		**Audit Committee Chair's Assurance Report – 14 January 2022 (d)** Committee Chair To note
23 12:40		**Freedom to Speak Up Q3 2021/22 Report (d)** Freedom to Speak Up Guardian To note
CONSENT AGENDA		

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

No	BAF Risk	Item
➢		**Guardian of Safe Working Hours (d)** To note
➢		**Fit and Proper Persons Report (d)** To note

CONCLUDING BUSINESS

24 12:45

Any Other Business (v)

Chair

To consider any other matters of business

25

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

26

Key Messages from the Board (v)

Chair

To agree

Date, Time and Venue of Next Meeting

- Thursday 31 March 2022 @ 09.30am via MS Teams

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.

Mid Cheshire Hospitals
NHS Foundation Trust

Victoria Infirmary Northwich (VIN)
Board Update

Karen Bowman – General Manager VIN
Manoj Agarwal – Non-Executive Director

27 January 2022

Because you matter

Victoria Infirmary Northwich (VIN) - Board Update

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

Current Service Provision at VIN

- Minor Injuries Unit (MIU) & GP Out of Hours
- Outpatient Department
- Endoscopy & Minor Operations
- Community Clinics
- Phlebotomy
- Cardio-Respiratory Testing
- Medical Imaging (plain x-ray, ultrasound & DEXA)
- Therapy Department (Physiotherapy including hydrotherapy & Occupational Therapy)

Victoria Infirmary Northwich (VIN) - Board Update

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

Community Diagnostic Centre Project

Phase 1

- Plain x-ray, DEXA and ultrasound services commenced CDC activity
- Minor works on-going in preparation for phase 2 services coming on-line
- Preparation and planning for CT modular build works - commencing January 2022
- Management of Change consultation undertaken with all relevant staff groups
- Recruitment process commenced across all services

Victoria Infirmary Northwich (VIN) - Board Update

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

Community Diagnostic Centre Project

Phase 2

- Additional CDC activity planned to go-live at the end of January 2022
  - Expansion of phlebotomy provision
  - Expansion of echocardiogram & ECG testing
  - Introduction of spirometry
  - CT (via additional Leighton capacity until CT modular build completed)
  - MRI (to be delivered via capacity at the main Leighton Hospital site)
- Completion of CT modular build works
- Following completion of phase 2, ramp up plans will be worked through to achieve full CDC implementation. This will see provision of an 08:00 – 20:00, 7-day service.

Because you matter

Victoria Infirmary Northwich (VIN) - Board Update

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

Improvements & Progress

- Response to CQC Inspection report
- Staff engagement and communication
- Staff wellbeing events and facilities
- Executive & senior level staff visits
- Development of Business Continuity Plans/Business Continuity exercise

Victoria Infirmary Northwich (VIN) - Board Update

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

Current Plans & Proposals

- Expansion of current outpatient utilisation – 6 month pilot for management of clinical rooms
- Centralisation of main reception services at VIN
- Introduction of a reception service and patient entrance in Verdin House
- Review of MIU hours in line with the Community Diagnostic Centre
- On-going review of current security arrangements

Victoria Infirmary Northwich (VIN) - Board Update

Mid Cheshire Hospitals
NHS Foundation Trust

Future Opportunities

- Development of a new Endoscopy & Day Surgery Unit
- Potential relocation and expansion of current Minor Injuries Unit
- Potential co-location of existing Medical Imaging services alongside the Community Diagnostic Centre
- Introduction of separate paediatric waiting area(s)
- Hydrotherapy pool utilisation

Board of Directors Part I
Action Log 27 January 2022

Agenda item		Assigned to	Deadline	Status
Board of Directors 29/07/2021 1 PRELIMINARY BUSINESS				
796.	DEFERRED Item - Digital Strategic Plan	Williams, Dylan	24/03/2022	Pending
	Explanation action item Deferred to October Board to allow incoming Chief Information Officer to influence its development Update: Deferred to Quarter 3 to follow Trust Strategy development - open deadline pending approval of the Trust Strategy in October 2021. Update: Deferred for completion by March 2022.			
	Explanation Williams, Dylan Update: Baselining of the existing portfolio of regional and local digital projects underway to develop the longer terms digital strategic plan. Update: Deferred for completion by March 2022.			
Board of Directors 30/09/2021 10.1 Performance & Finance Committee Chair's Assurance Reports - 17 August & 23 September 2021 (d)				
944.	Chairs' Assurance Reports to be reviewed	Keating, Caroline	07/01/2022	Complete
	Explanation action item Chairs' Assurance Reports to be reviewed			
	Explanation Keating, Caroline Update: Final draft completed. To be discussed with NEDs and Execs prior to submission to Audit Committee.			

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**7**	Date of Meeting: 27/01/2022
Report Title	**Chief Executive's Report January 2022**	
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 legislation delayed to July 2022; PLACE arrangements to be in shadow form from April 22
- Process in place for mandated vaccinations
- Operational pressures continue

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 – 27 January 2022

Key Highlights

National / Regional Update

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

1. Recruitment of Non-Executive Members and Executive Directors to the Integrated Care Board has and is taking place with NEDs appointed and interviews scheduled for Executive Directors. Further information will be made available to the Board when these positions are confirmed.

2. Although Integrated Care Systems were expected to be fully operational by April 2022, the move to put ICSs on a statutory footing has been delayed by three months to July 2022.

Progress on PLACE Plans

3. The development of proposed governance models for the East and West PLACE partnerships continues, despite the legislative delay, with both partnerships working through the various options for discussion with statutory Boards/Governing Bodies as soon as practicable. The aim is to set up the partnerships in shadow form from April 2022.

Digital Clinical System

4. The Boards of Mid Cheshire Hospitals NHS FT and East Cheshire NHS Trust approved the Full Business Case for the Digital Clinical System on 20 January 2022 and the submission of the FBC into the NHS England/Improvement Joint Investment Committee pipeline.

Maternity Services

5. In line with national requirements, the Trust took part in a national and regional review meeting of the safety of its maternity service in January 2022. Chaired by the Deputy Chief Midwifery Officer and attended by Board members, the review provided good assurance of care and safety whilst sharing ongoing lessons learnt and contribution to the local maternity/ neonatal services (LMNS) strategic direction.

Trust Update

Infection Prevention & Control

6. The Board and Council of Governors were both advised earlier in January that the Trust had been reporting a high level of nosocomial infection. However, internal investigation identified a data transfer issue and confirmation that our rate is c.50% of what the Trust has reported. Unfortunately, this confirmation was not obtained in time to influence an article in the Health Service Journal on 19 January 2022, identifying the Trust as the worst performer nationally for nosocomial infection. The Trust has engaged with relevant parties to advise them of the conclusive position. A report on the data issues is to be submitted to Gold Command.

COVID-19

7. Since my last report in November, COVID-19 infection rates have soared due to the Omicron variant which has led to a significant increase in hospitalisations and staff absences. The number of COVID-positive patients in the hospital (as at 18 January) is 132 compared to 31 in November 2021. Over one third of the general and acute bed capacity in the Trust is now occupied with COVID patients. Further capacity has been required to manage COVID and urgent and emergency care demand generally which has resulted in the re-purposing of the orthopaedic and the surgery elective wards. This has caused 17 patients having their surgery postponed in January (to date), including three patients on a cancer pathway, two of whom have been rescheduled for c/ 24 January.

8. As a result of Omicron transmitability, we have seen around a twofold increase in the staff absence rate over recent weeks which has placed considerable strain on the workforce. It is expected that the impact of COVID on services should start to abate middle to end of January as local infection rates start to fall.

Vaccination Programme

9. The Government announced last week that vaccination against Covid-19 will be made compulsory for health and care staff in England who are deployed to deliver CQC regulated activities. This will include roles which require face-to-face contact with patients or service users. It is expected that the new regulations will come into force on 1 April 2022.

10. Detail on the approach the Trust has taken to understand the position, including the number of our workforce impacted by this, is included in the substantive report submitted to Board (*Agenda Item 20*).

Quality Improvement

11. Due to operational pressures, some activity had to be deferred so the quarterly Progress Report due to be submitted to Board this month has been replaced with this update. However, all actions are on track, a cohort of improvement practitioner training is nearing completion and attending teams will continue to be supported through to completion of their projects.

12. A Board session in December 2021 was well received and resulted in a number of outputs. The initial priority is the need to develop a single, clear vision and statement around quality for the Trust. This will require engagement with a broad range of staff and involvement from Divisional leadership teams.

13. The Leadership Commitment Strategic Plan and operational delivery plan for Quality Improvement (QI) are in development and will be considered by the Executive QI Strategic Group in February, prior to submission to the Board for approval in March 2022.

Trust 'Business as Usual'

Urgent and Emergency Care

14. The system remains under significant pressure with demand remaining static above pre-pandemic levels. The key focus remains on ambulance handovers and the number of patients spending more than 12 hours in the Emergency Department (ED). Through the last month, performance against the former has remained relatively static, whilst the number of patients waiting over 12 hours in ED has increased, mainly as a result of significant increase in COVID hospitalisations. In December, 47 patients waited in ED over 12 hours following a decision to admit; this is one of the highest in C&M, with only Countess of Chester (219) and Southport and Ormskirk (85) having had more. A key driver resulting in longer ED waits is flow, currently hindered significantly by the number of patients (currently c.145) who are medically fit and no longer required to be in hospital. This situation arises from half of care homes in Cheshire East and Cheshire West being closed due to COVID outbreaks or workforce issues.

Delay to A&E build

15. The opening of the new Emergency Department is now scheduled for 9 February 2022. The A&E Building was handed over to the Trust by the contractors, MTX on Wednesday 19 January 2022 for the Trust to commence the 'clinical' clean. In addition, stocking and staff familiarisation visits will now take place with a planned occupation date of Wednesday 9 February 2022.

16. There is an operational 'move day' plan for 9 February, with a separate Command Team identified to oversee the move and ensure all patient safety and recording elements are facilitated.

17. The Critical Care expansion to provide 4 additional bed bays has been finished and the Unit was handed over on Tuesday 18 January. The extension to the staff areas will be completed in March.

Service Restoration

18. Despite recent challenges, the Trust has done well to maintain a significant proportion of its elective work, and reduction of backlogs remains a key priority. However, the overall RTT waiting list continues to grow (now almost double what it was at the start of the pandemic) and the number of patients waiting over 1 year for surgery is also rising. The Trust, however, continues to have one of the lowest 104-week backlogs in C&M. Further detail will be provided by the Chief Operating Officer (COO) in the H2 Operational Priorities and Elective Restoration Update (*Agenda Item 18*).

19. 2022/23 Priorities and Operational Planning guidance was published on 24 December. At this stage, revenue allocations have not been published. The COO will provide a summary report to the Performance and Finance Committee in February.

Finance

20. December's financial position was £0.2m over plan. The Board is reminded that the Trust expects to receive £7.9m additional system funding to achieve breakeven at year end. Further detail will be provided by the Deputy CEO/Director of Finance in the Finance Report (*Agenda Item 17*).

Workforce/Sickness Absence

21. According to local sickness absence data, colleague absences appeared to peak at end December/early January. Whilst some areas still experience higher than normal absence levels, there is an improving trend and the number of staff returning to work following COVID-19 absences is increasing. Silver Command monitors absence weekly and targeted support is being delivered through Workforce Business Partners. We remain one of the best performing trusts in the North West for sickness absence and isolation.

James Sumner, Chief Executive
January 2022

Appendices:

I Hospital Redevelopment Programme Board (13 December 2021)
II Digital Clinical Systems Programme Board (10 January 2022)

Redevelopment Programme Board (HRPB)
Chair's Assurance Report
December 2021

Report to	Board of Directors
Date	13 December 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 – alternative plan being considered should there be a funding shortfall. Plan to be identified as additional control to the relevant risk. As this is a replicable ward design, principles of future collaborative working, including clinical engagement, to be shared with the 5 RAAC Trusts.

Design Authority Group established, reporting into the HRPB, to provide a review and decision-making function. Ultimate approval of designs would remain with the HRPB.

2021/22 Works Progress – School of Nursing anticipated completion date now end January 2022 due to additional failsafe steel works required. Remaining Residences blocks due to be demolished by Christmas. Car Park to be completed by March 2022.

RAAC capital spend – RAAC capital in 2022/23 at least 50% more than £110m available nationally

New ED Build – handover date delayed to 23 December with challenges remaining, not least with obtaining cleaning contractors. Potential ministerial visit to officially open the new ED was being managed.

KEY CONCERNS/RISKS

- Funding shortfall (4Ward Block)
- ED completion date slippage

Priority Areas: DECISIONS MADE

RECOMMENDATION

To note

Digital Clinical System
DCS Transformation Board Assurance Report
January 2022

Report to	Board of Directors
Date	10 January 2022
Report from	Ged Murphy – Acting DCS Programme SRO
Report prepared by	Phill James – DCS Programme Director
Joint Chairs	Ged Murphy – Acting DCS Programme SRO James Sumner – DCS Programme SRO
Executive Lead/s	Dylan Williams – Chief Information Officer
Committee meeting quoracy	Yes ☒ No ☐

KEY AREAS OF ASSURANCE

The meeting focused upon the current plan to contract signature and the readiness of the Full Business Case for submission to Trust Boards.

The key steps to achieve a May 2022 contract signature were noted, articulating the relationship with the draft milestone payments plan including appropriately timed staff training and go-lives (i.e. avoiding holiday periods and winter pressures).

Members sought Full Business Case assurances in the areas of:

- Work to date to assure delivery timescales
- Strategy for dealing with staff pressures and sickness and the associated risks of additional costs
- The contractual ability to pause the programme without incurring costs.

It was noted that:

- FBC approval does not authorise contract signature but is a key step forward
- A number of assurances will be submitted to the March DCS Transformation Board including the draft contract schedules and Trust's Heads of Terms.

An action was recorded to ensure the covering Trust Board report would state key financial and contractual issues that remain unresolved at the time of FBC approval.

KEY CONCERNS / RISKS

- Total allocation of Capital PDC is not confirmed
- Total allocation of revenue support is not confirmed
- Any funding shortfall will be met by each Trust
- The business-as-usual impact from year 4 will be met by each Trust via additional Trust-wide cost reduction plans

- HM Treasury approval may be necessary due to the whole life cost being over £50m with a potential impact of up to 3 months of additional external scrutiny. The programme is liaising with DHSC/NHSEI to navigate this process by alternative means that avoids the delay.

DECISIONS MADE

- Supported the submission of the Full Business Case to the Trust Boards for approval at this point in the timeline.

RECOMMENDATION

- To note

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**8**	Date of Meeting: 27/01/2022
Report Title	**Integrated Performance Report – December 2021**	
Executive Lead	James Sumner, Chief Executive	
Lead Officer	Click here to enter text	
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)*

- IPR reported monthly to Board Committees, Board of Directors and made available to the Council of Governors

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 ☐

Mid Cheshire Hospitals NHS FT

REPORT DEVELOPMENT

Committee/ Group Name	Date	Report Title	Lead	Brief summary of key issues raised and actions agreed
Board Committees	Monthly	Integrated Performance Report	JSumner Chief Executive	Noted
Board of Directors	November 2021	Integrated Performance Report	JSumner Chief Executive	Noted

Mid Cheshire Hospitals
NHS Foundation Trust

Board of Directors
Integrated Performance Report

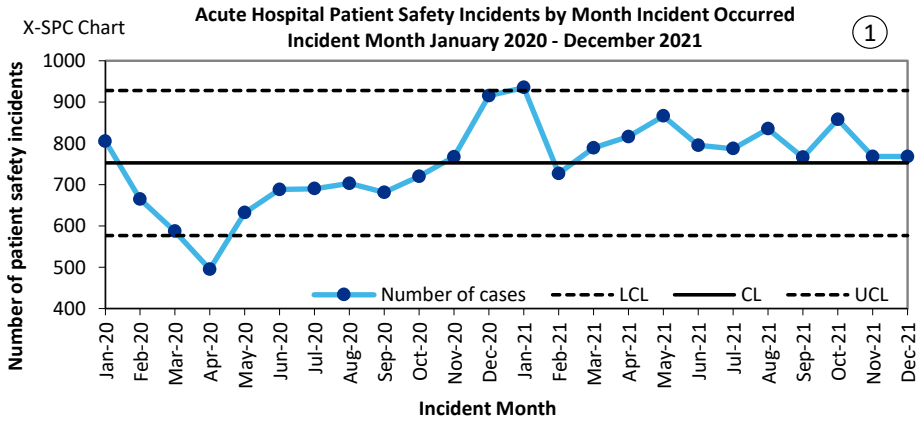
December 2021

Because you matter

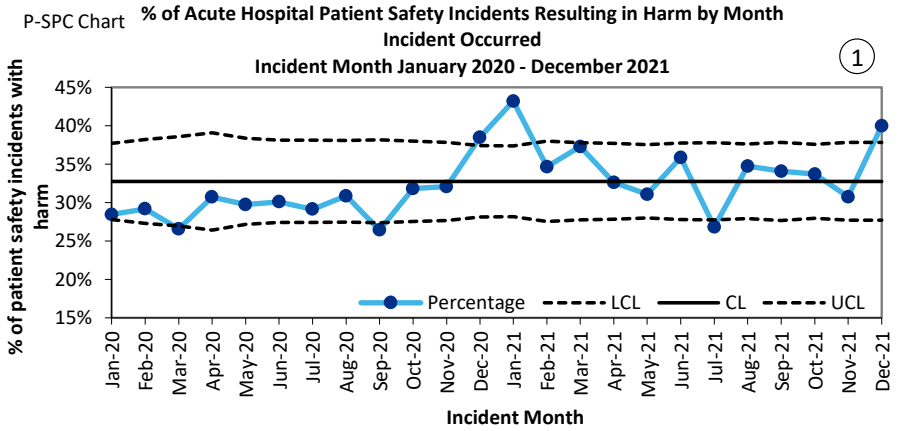
Quality, Safety & Patient Experience

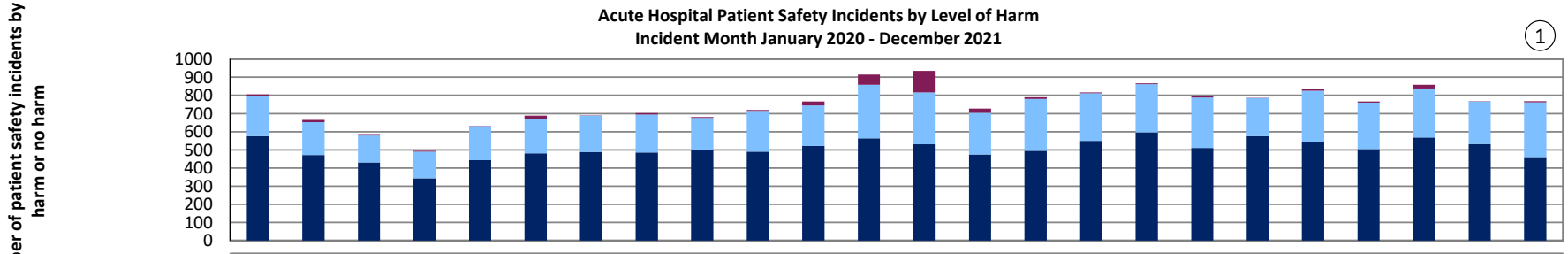
Acute Hospital Patient Safety Incidents (Excludes CCICP)

X-SPC Chart



P-SPC Chart





	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	Oct-21	Nov-21	Dec-21
Moderate and Above	9	12	8	5	1	20	2	8	5	5	22	56	118	23	8	5	5	7	2	9	6	20	2	7
Low Harm	220	182	148	147	187	187	199	209	175	224	224	296	286	229	286	261	264	278	209	281	255	269	234	300
No Harm	576	471	431	343	444	481	489	486	501	491	521	563	531	475	495	550	597	510	576	545	505	569	532	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.

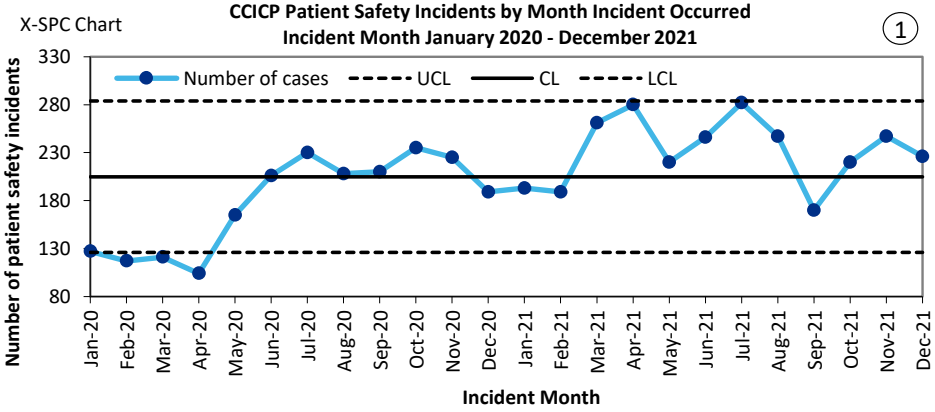
Key Narrative: 768 incidents are currently shown for December 2021 of which 40.0% resulted in harm.

Low Harm 300, Moderate Harm 7, Serious Incident 0

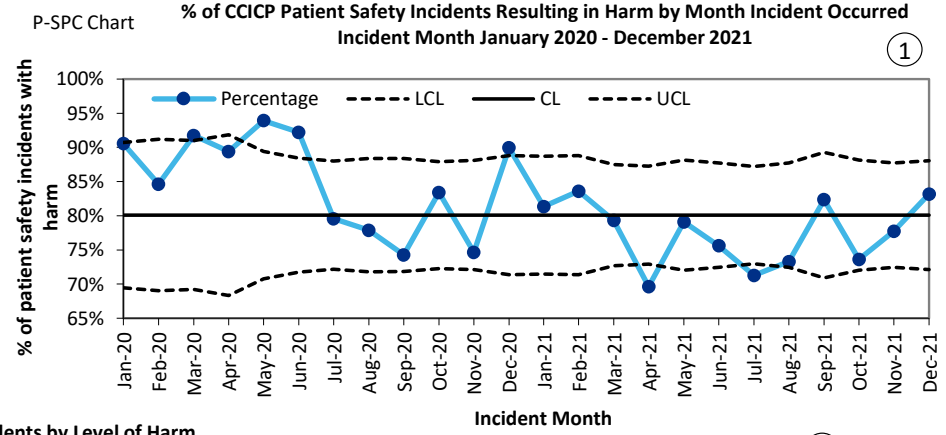
Quality, Safety & Patient Experience

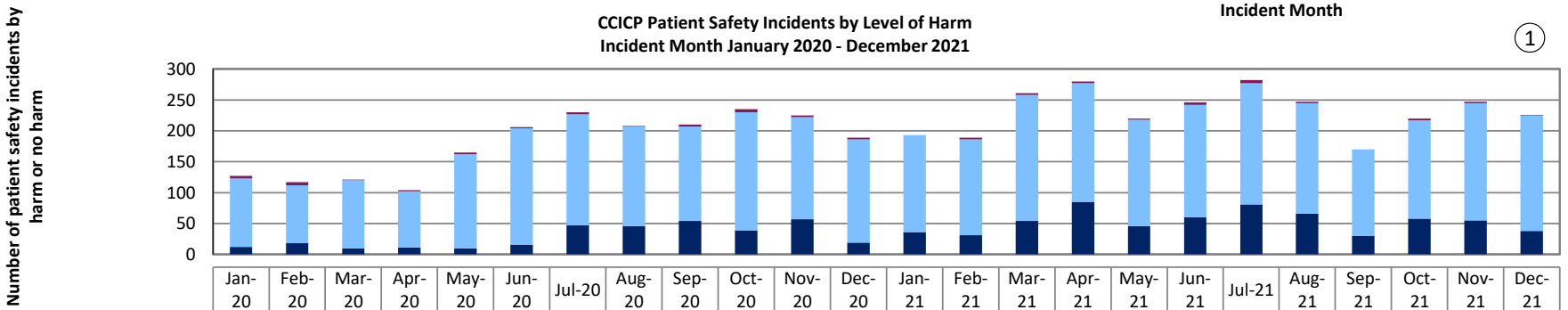
Central Cheshire Integrated Care Partnership (CCICP) Patient Safety Incidents

X-SPC Chart



P-SPC Chart





	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	Oct-21	Nov-21	Dec-21
Moderate and Above	4	5	1	2	3	2	3	1	3	5	3	3	-	3	3	3	2	4	5	2	-	3	2	1
Low Harm	111	94	110	91	152	188	180	161	153	191	165	167	157	155	204	192	172	182	196	179	140	159	190	187
No Harm	12	18	10	11	10	16	47	46	54	39	57	19	36	31	54	85	46	60	81	66	30	58	55	38

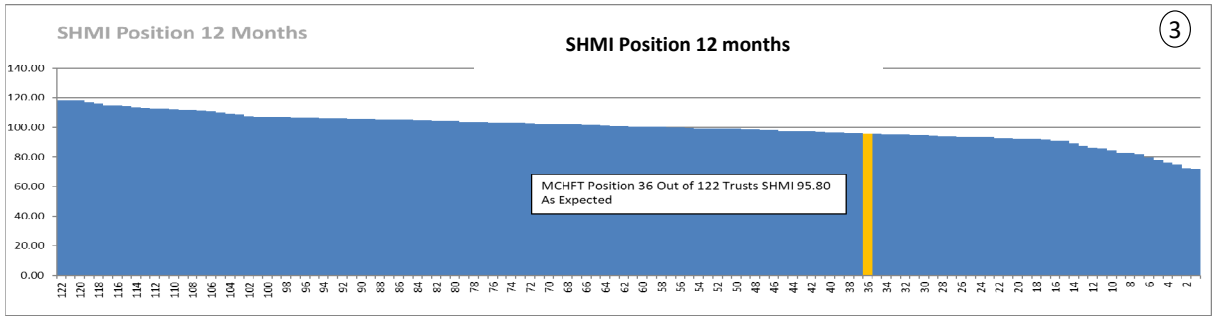
Accountable: Medical Director
Data Owner: Quality Governance
To note: P-SPC charts adjust the control limits to take into account each month's denominator.

Key Narrative: 226 CCICP patient safety incidents are currently shown for December 2021 of which 83.1% 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.

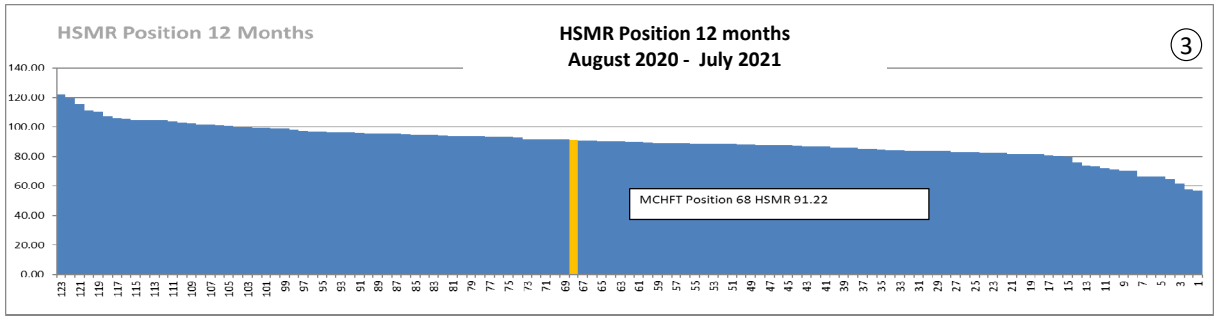
Low Harm 187, Moderate Harm 1, Serious Incident 0

Quality, Safety & Patient Experience

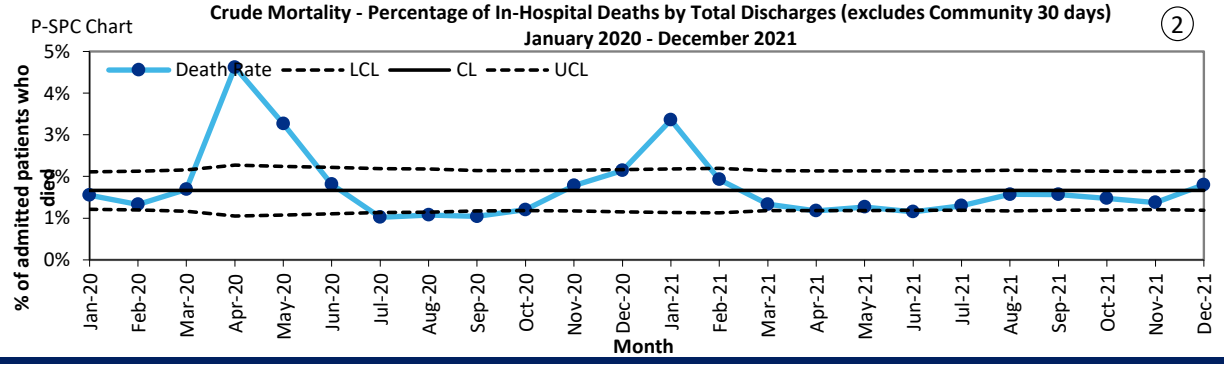
Mortality



Key Narrative: The latest release of SHMI is 95.80 (rank 36) against the previous value of 95.26 (rank 35). This is still in the 'as expected' range.



Key Narrative: The latest HSMR release is 91.22. 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.



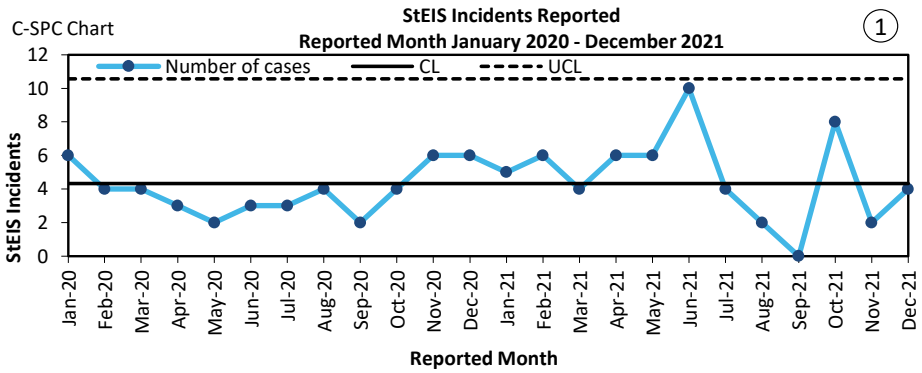
Key Narrative: Crude mortality has remained largely consistent over the time period except for peaks seen in April 2020, May 2020 and January 2021 related to an increase in COVID-19 patients within the Trust. December 2021 continues to show a return to pre-covid levels and is slightly lower than December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

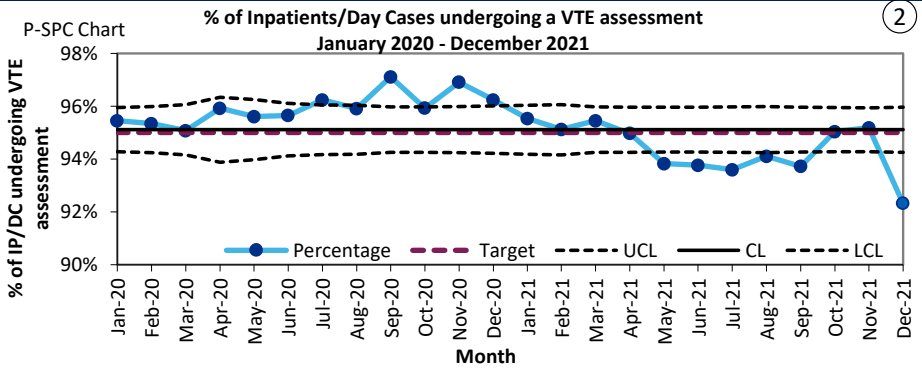
StEIS Incidents - Trust Total



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

Key Narrative: There were 4 serious incidents reported to StEIS in December2021.

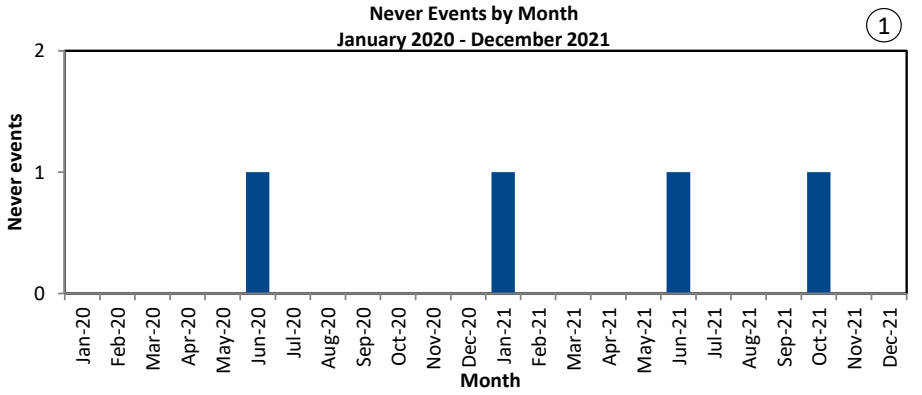
VTE



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

Key Narrative: The percentage of VTE assessments currently shown for December 2021 reduced to 92.3%, below the 95% target. The P-SPC charts adjust the control limits to take into account each month's denominator.

Never Events - Trust Total

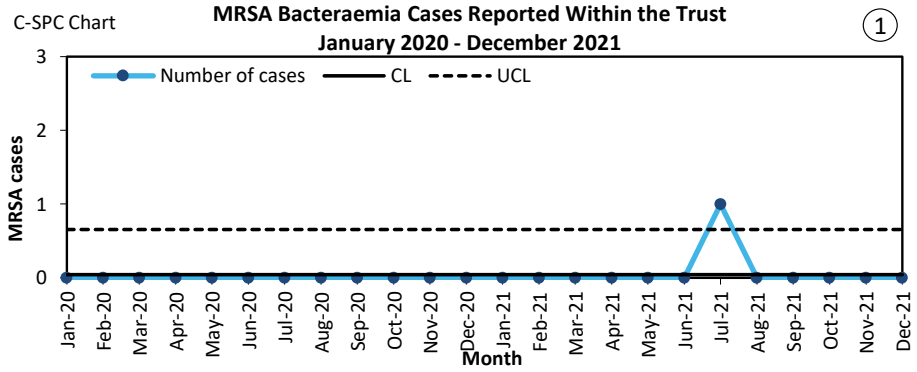


Accountable: Medical Director **Data Owner:** Information Services

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

Quality, Safety & Patient Experience

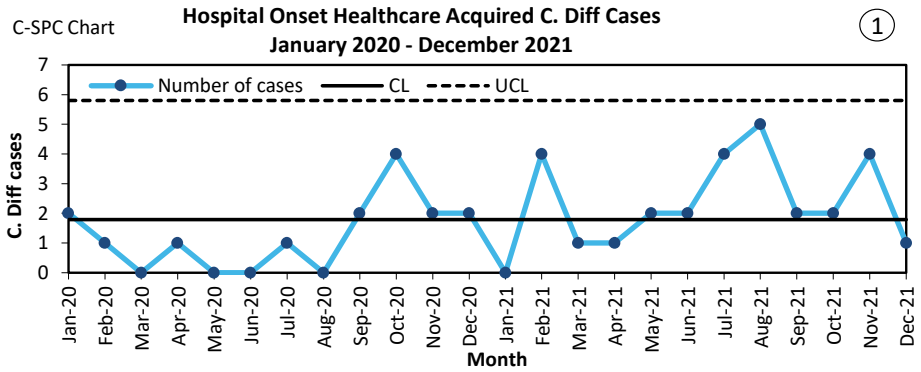
MRSA



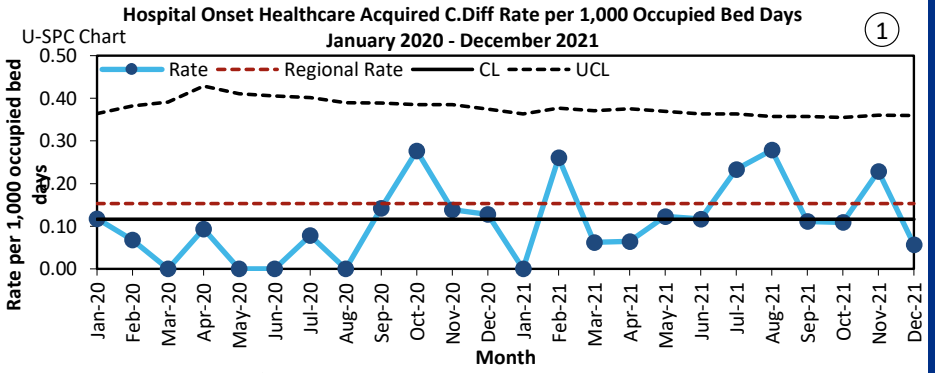
Accountable: Director of Nursing and Quality
Data Owner: Infection Prevention Control Team

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

C. Diff Positive Cases



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



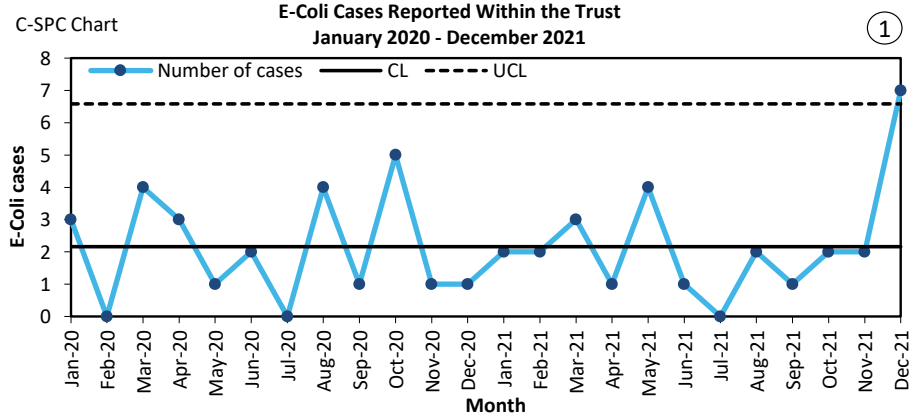
Accountable: Director of Nursing and Quality
Data Owner: Infection Prevention Control Team
Key Narrative: 1 hospital onset healthcare acquired C.Diff case was recorded in December 2021 with a rate of 0.06 per 1,000 occupied bed days. The P-SPC charts adjust the control limits to take into account each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

Current financial year reported cases subject to validation.

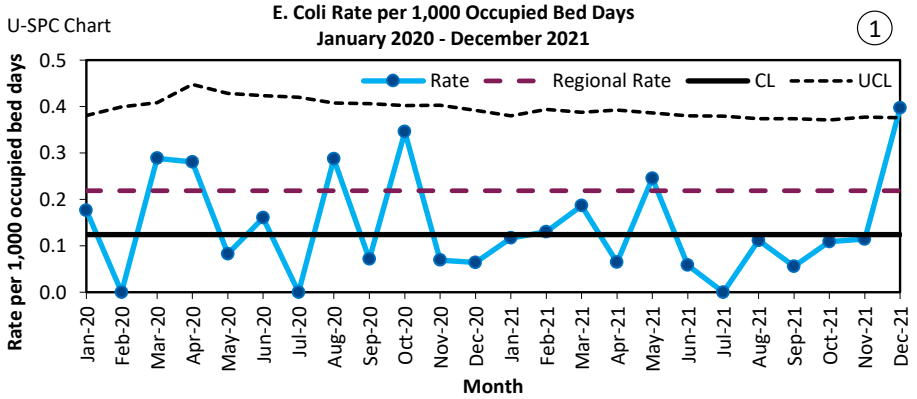
Quality, Safety & Patient Experience

E-Coli Cases

C-SPC Chart



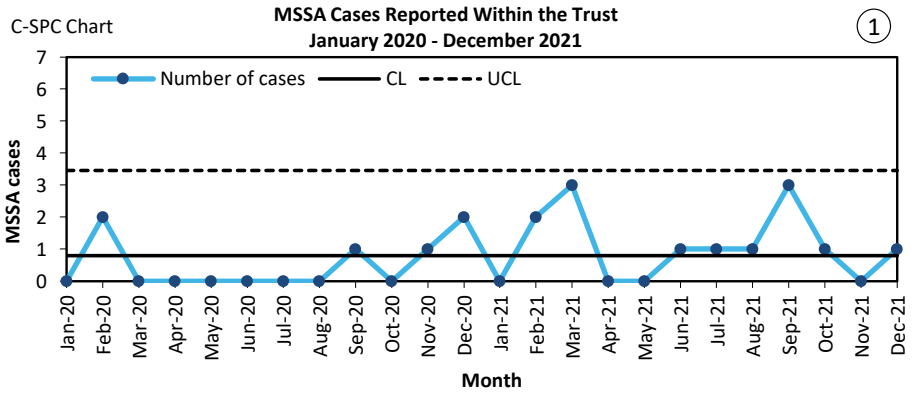
U-SPC Chart



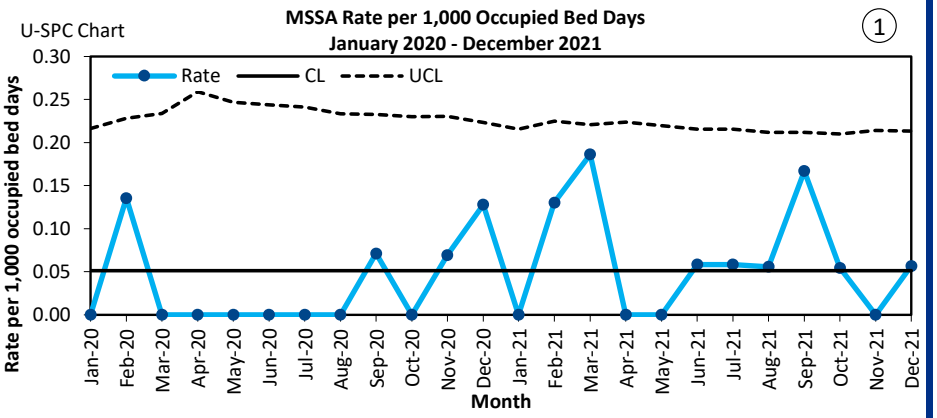
Accountable: Director of Nursing and Quality
Data Owner: Infection Prevention Control Team
Key Narrative: 7 E-Coli cases were recorded in December 2021 with a rate of 0.40 cases per 1,000 occupied bed days. The U-SPC chart adjusts the control limits to take into account each month's denominator.

MSSA

C-SPC Chart



U-SPC Chart

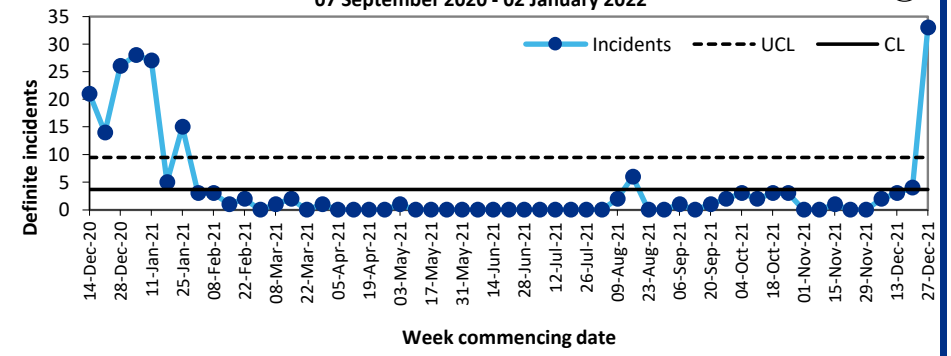


Accountable: Director of Nursing and Quality
Data Owner: Infection Prevention Control Team
Key Narrative: 1 MSSA case was reported in December 2021. The U-SPC chart adjusts the control limits to take into account each month's denominator.

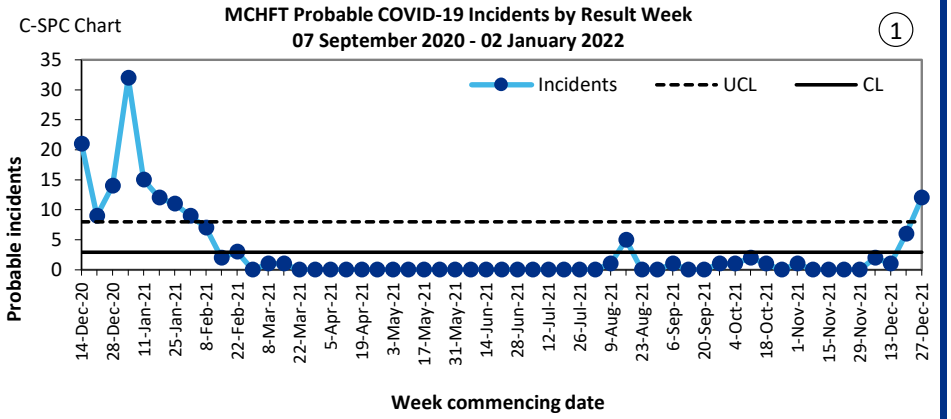
Quality, Safety & Patient Experience

COVID-19 Healthcare Acquired Infections

C-SPC Chart

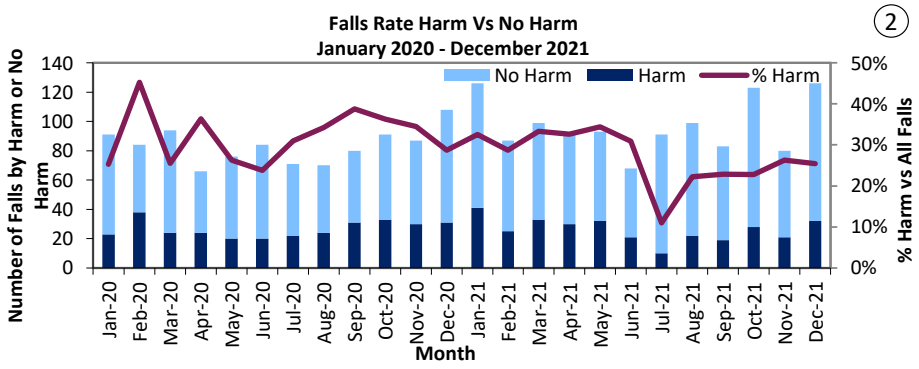


C-SPC Chart

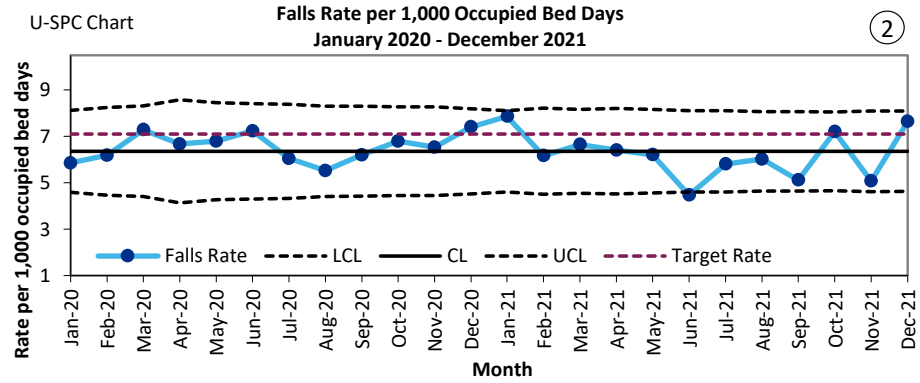


Accountable: Director of Nursing and Quality **Data Owner:** Information Services
Key Narrative: The latest week reported, week commencing 27th December 2021, shows 33 definite incidents and 12 probable incidents.

Falls



U-SPC Chart



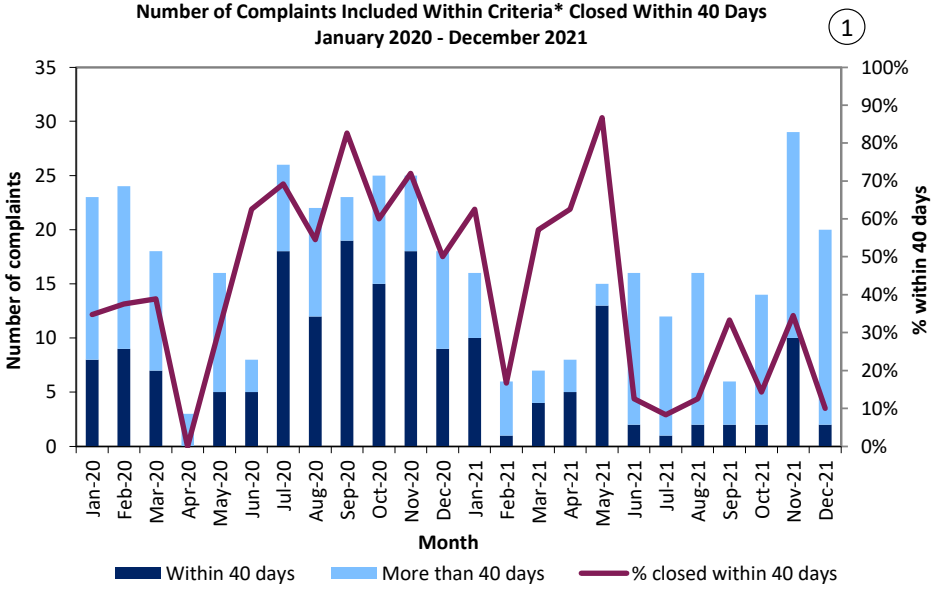
Accountable: Director of Nursing and Quality **Data Owner:** Nursing Quality Team
Key Narrative: 126 falls were reported in December 2021 with a rate of 7.1 per 1,000 occupied bed days, above the target rate of 6.6. 32 falls resulted in harm (25.4%). The U-SPC chart adjusts the control limits to take into account each month's denominator.

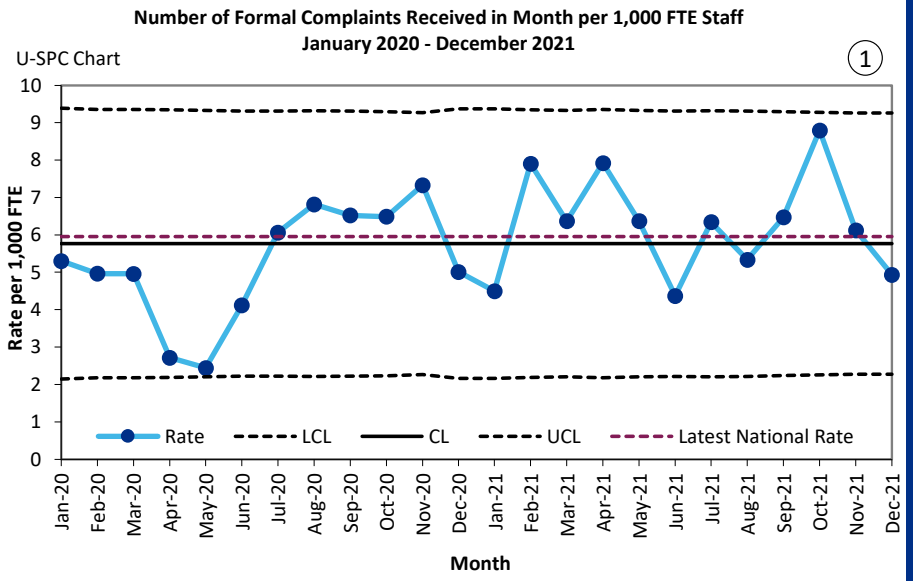
Data Rating: ①captured locally, ②system captured, ③published/benchmarked

Because you Matter

Quality, Safety & Patient Experience

Formal Complaints





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

Key Narrative: 20 complaints were closed in December 2021, of which 2 were closed within 40 days (10.0%). The rate of formal complaints received in December 2021 was 4.9 per 1,000 FTE staff, below the latest national rate.

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

The latest quarterly Model Hospital rate for written complaints is showing as 14.48 compared to a national median of 17.87 (March 2021 data, updated December 2021).

**exclusion criteria includes, for example: complaints linked to an investigation, multi-agency and cross-divisional and complaints, withdrawn complaints, complaints put on hold during the COVID-19 period.*

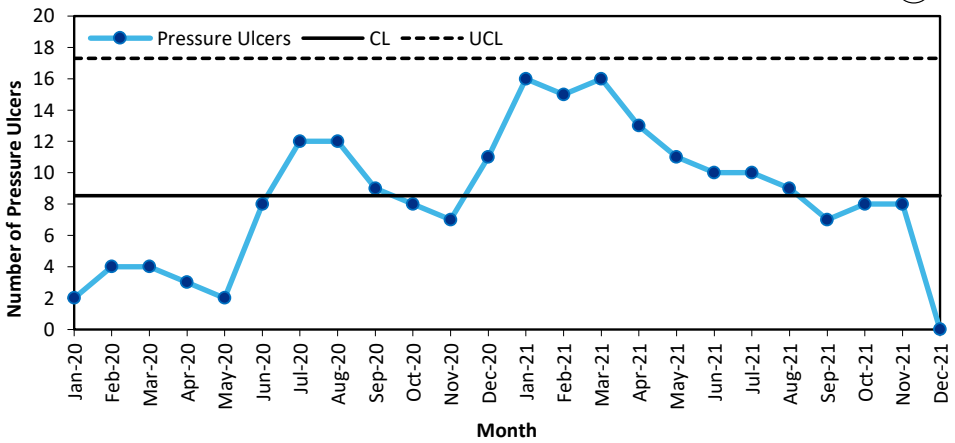
Quality, Safety & Patient Experience

Acute Hospital Pressure Ulcers

C-SPC Chart

Acute Hospital Pressure Ulcers - Lapses in Care Identified
January 2020 - December 2021

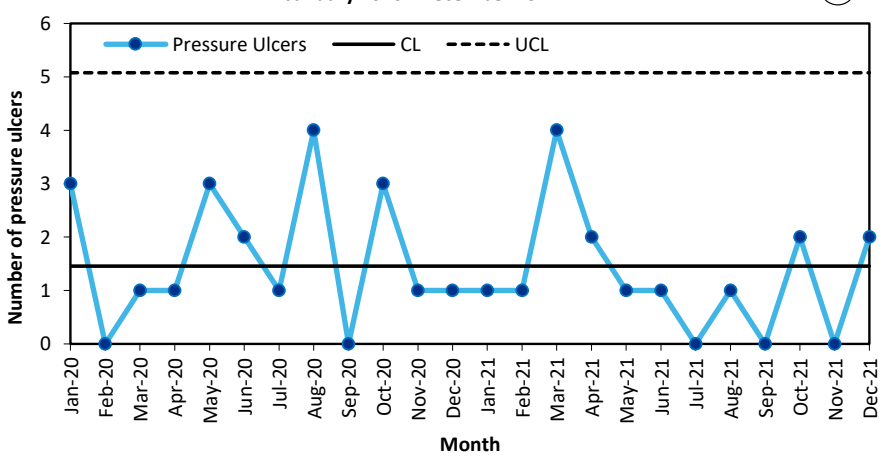
1



C-SPC Chart

Community Pressure Ulcers - Lapses in Care Identified
January 2020 - December 2021

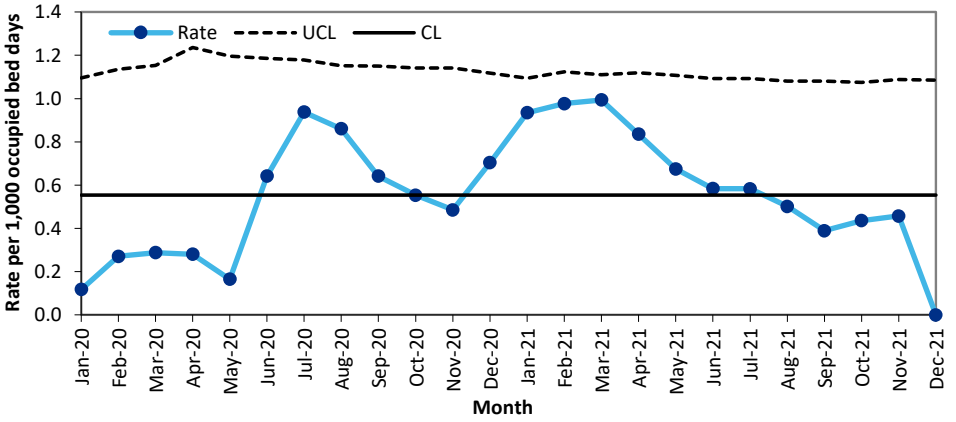
1



U-SPC Chart

Acute Hospital Pressure Ulcers - Lapses in Care Rate per 1,000 Occupied Bed Days
January 2020 - December 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: No acute hospital lapses in care have currently been identified in December 2021. Latest months data correct at time of reporting, however it will increase as the validation process for December 2021 data continues. There have been 76 acute lapses of care identified in the current financial year.

Community: Currently 2 community lapses of care have been identified in December 2021. There have been 9 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

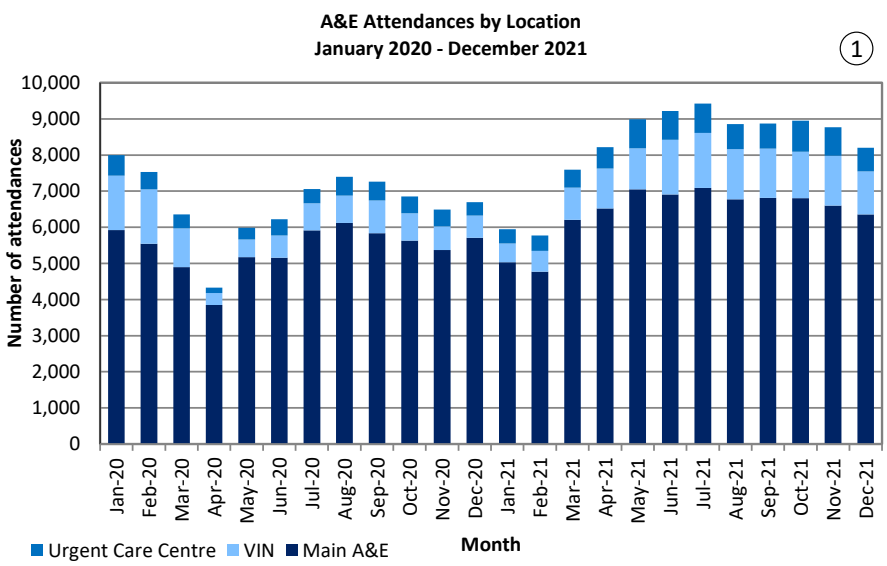
(1)

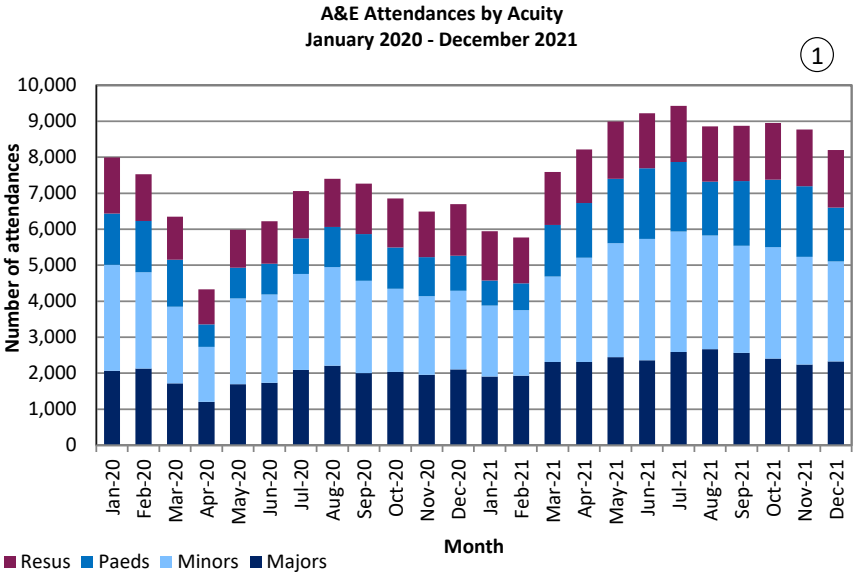
Ward Name	Day				Night				Day		Night	
	Qualified		Unqualified		Qualified		Unqualified		Qualified	Unqualified	Qualified	Unqualified
	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Fill Rate	Fill Rate	Fill Rate	Fill Rate
MCHFT	50108.8	42015.8	45358.8	36311.1	37520.7	32222.4	34048.5	29205.1	84%	108%	86%	106%
Acute Medical Unit	2160.8	1971.3	2055.0	1992.0	1968.5	1787.0	1512.0	1498.0	91.2%	96.9%	88.2%	99.1%
Child & Adolescent Unit	3381.0	2794.5	1292.0	1026.7	2268.0	2007.3	984.0	955.0	82.7%	79.5%	88.5%	92.4%
Critical Care Unit (HIGH)	4109.6	3230.8	654.0	448.5	4092.0	3153.5	984.0	192.0	78.6%	67.8%	77.1%	50.0%
Elmhurst	750.0	744.0	2716.0	2440.0	744.0	744.0	1962.0	1836.0	99.2%	89.8%	100.0%	93.6%
South Cheshire Surveillance (HIGH)	2452.0	2029.3	2818.5	2391.5	2256.5	1872.2	2533.5	2161.5	82.8%	84.9%	83.0%	85.3%
Ward 1 Cardiology Coronary Care	2093.5	1999.5	1248.0	1140.0	1536.0	1463.0	756.0	727.5	95.5%	91.3%	95.2%	96.2%
Ward 10 Orthopaedic Trauma	2808.0	2265.0	4104.5	3089.3	1608.0	1428.0	3072.0	2604.0	80.7%	75.3%	88.8%	84.8%
Ward 11 Surgical/Gynae	2166.8	1916.5	1646.0	1391.0	1260.0	1176.0	1284.0	1163.5	88.5%	84.5%	93.3%	90.6%
Ward 12 SAU	1282.5	1171.5	1309.6	967.7	828.0	696.0	1008.0	780.0	91.3%	73.9%	84.1%	77.4%
Ward 12 Surgical Specialties	1176.0	1004.5	1237.5	948.5	768.0	733.7	1214.5	1029.7	85.4%	76.6%	95.5%	84.8%
Ward 13 Medical Escalation	2144.0	1806.0	2309.8	1907.6	1236.0	1008.0	1932.0	1625.7	84.2%	82.6%	81.6%	84.1%
Ward 14 Gastroenterology	1343.5	1345.0	1587.5	1529.0	1169.5	1085.5	1272.0	1236.0	100.1%	96.3%	92.8%	97.2%
Ward 15 Medical	1905.5	1673.5	2174.5	1876.0	1188.0	1095.8	1944.0	1750.0	87.8%	86.3%	92.2%	90.0%
Ward 18 Elective	1498.0	1031.2	1521.0	1079.0	793.0	745.0	996.0	792.0	68.8%	70.9%	93.9%	79.5%
Ward 19 GP Led Stepdown	1681.0	1498.0	2407.5	2029.0	1212.0	1126.0	2028.0	1787.5	89.1%	84.3%	92.9%	88.1%
Ward 21b Rehabilitation	1182.0	1073.5	2854.0	2400.6	1116.0	1056.0	1872.0	1652.0	90.8%	84.1%	94.6%	88.2%
Ward 22 NICU	1932.8	1834.3	1262.3	538.3	1462.0	1383.5	666.5	305.8	94.9%	42.6%	94.6%	45.9%
Ward 23 Maternity	1301.7	1223.4	746.0	711.8	750.0	707.0	756.0	721.0	94.0%	95.4%	94.3%	95.4%
Ward 26 Labour	2897.0	2423.6	651.7	611.3	2591.7	2305.5	384.0	374.7	83.7%	93.8%	89.0%	97.6%
Ward 3 Respiratory	2404.5	2096.0	1840.5	1387.5	1692.0	1430.5	1068.0	989.0	87.2%	75.4%	84.5%	92.6%
Ward 4 Care of the Elderly	1437.8	1340.3	2073.5	1677.3	1200.0	960.0	1680.0	1655.5	93.2%	80.9%	80.0%	98.5%
Ward 5 Covid (HIGH)	2898.0	1367.5	1489.5	731.7	2220.0	1188.0	1488.0	840.3	47.2%	49.1%	53.5%	56.5%
Ward 6 Stroke / Rehab	1957.5	1705.5	2436.0	1944.3	1524.0	1359.5	1380.0	1279.0	87.1%	79.8%	89.2%	92.7%
Ward 7 Diabetes / General Medicine	1921.5	1673.2	2066.0	1635.8	1257.5	1113.5	1620.0	1432.0	87.1%	79.2%	88.5%	88.4%
Ward 9 Medical Escalation	1224.0	798.0	858.0	422.0	780.0	648.0	852.0	417.5	65.2%	49.2%	83.1%	49.0%

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

Performance

A&E Activity





Accountable: Chief Operating Officer
Data Owner: Information Services

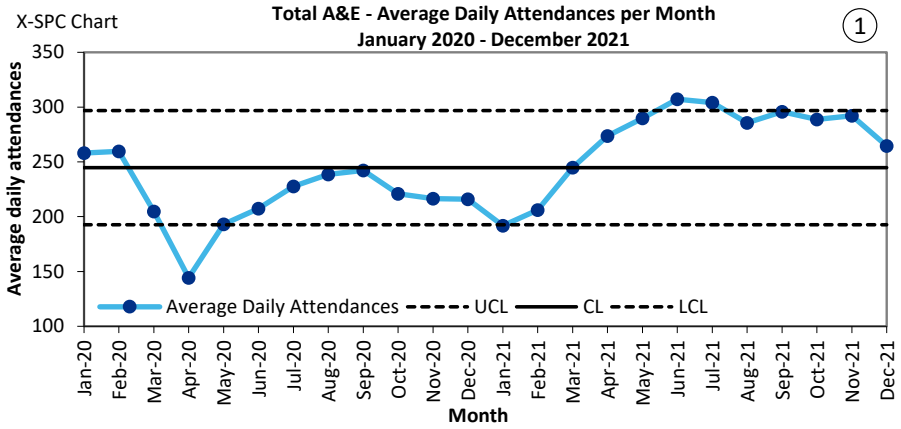
Key Narrative: There were a total of 8,203 A&E attendances across all locations in December 2021, a 6.4% decrease on the previous month . Recent activity remains above pre-pandemic levels.

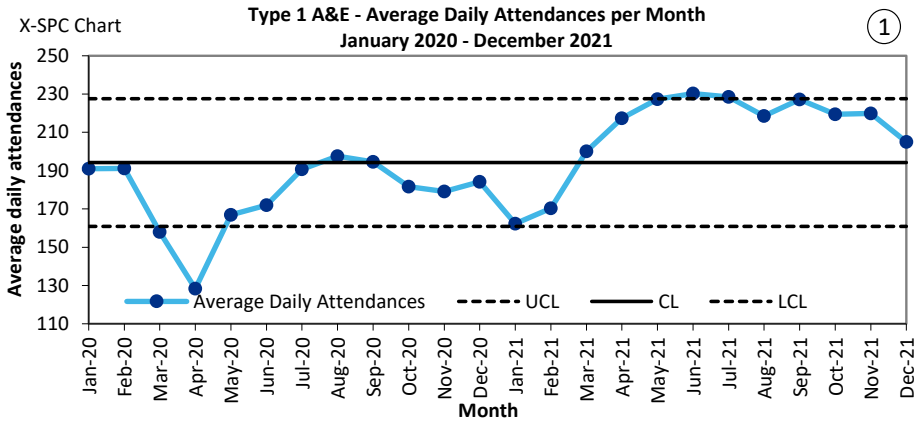
For the main A&E department at Leighton Hospital (Type 1), a similar pattern is shown, with 6,356 attendances reported in December 2021, 3.7% lower than the previous month.

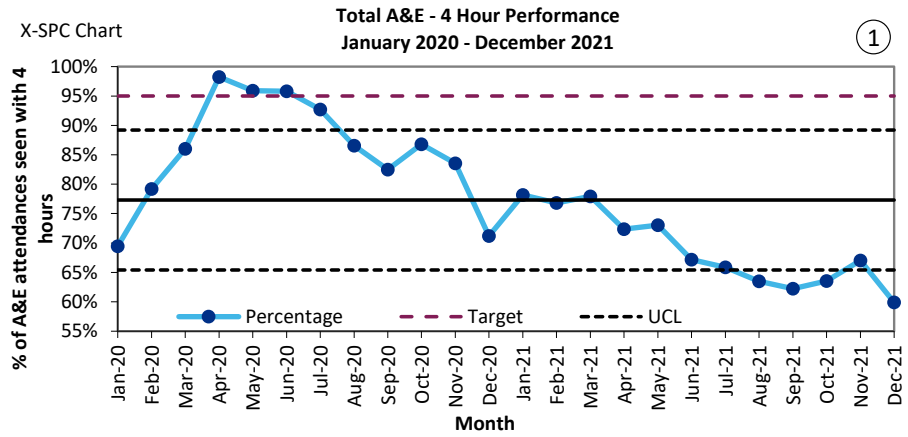
December 2021 activity variance compared to previous month by acuity: Majors +88, Minors -212, Paeds -472, Resus +31.

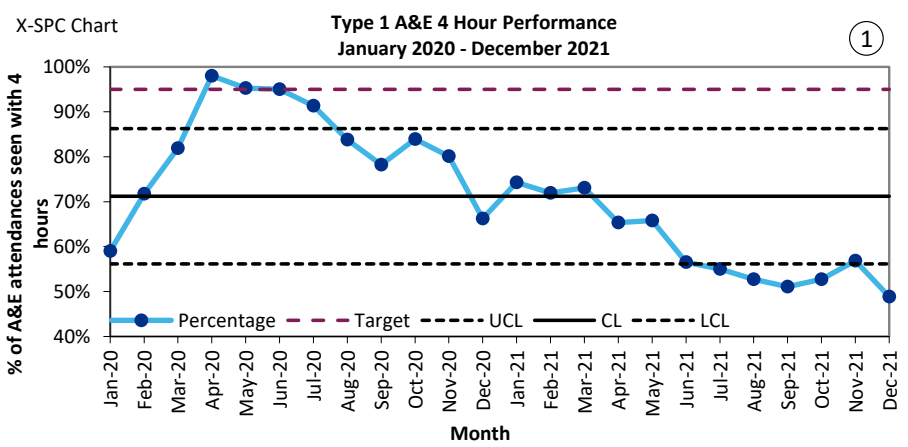
Performance

A&E Performance









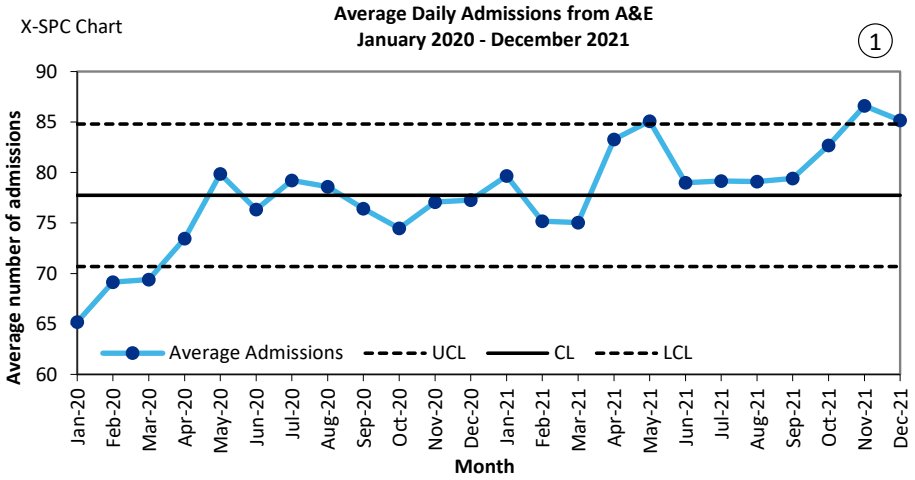
Accountable: Chief Operating Officer
Data Owner: Information Services

Key Narrative: The average total daily A&E attendances for December 2021 was 265 and below the November 2021 rate of 292, but remaining above pre-pandemic attendance rates. The average daily attendances for Type 1 follows a similar pattern with the December 2021 rate of 205, below the November 2021 rate of 220. As activity rates have remained high, this contributes to a lower performance, with a decrease in performance for both Total A&E Attendances and Type 1 of 59.9% and 48.9% respectively.

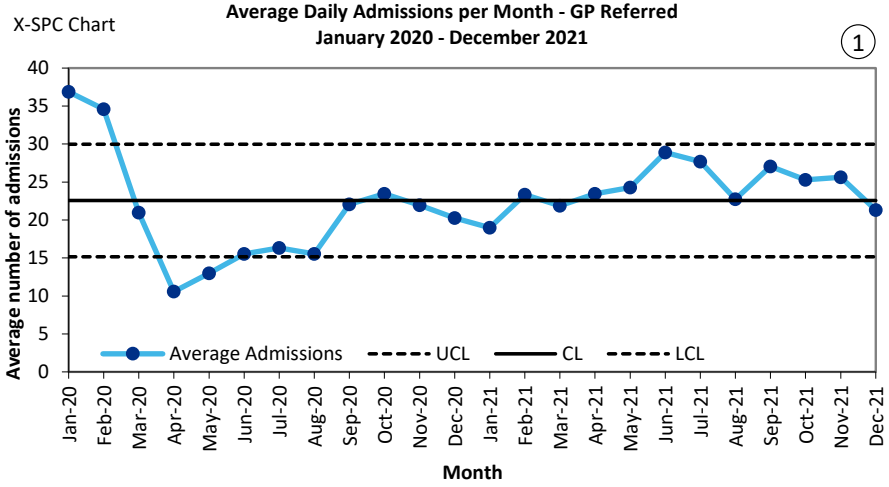
Performance

Unplanned Admissions

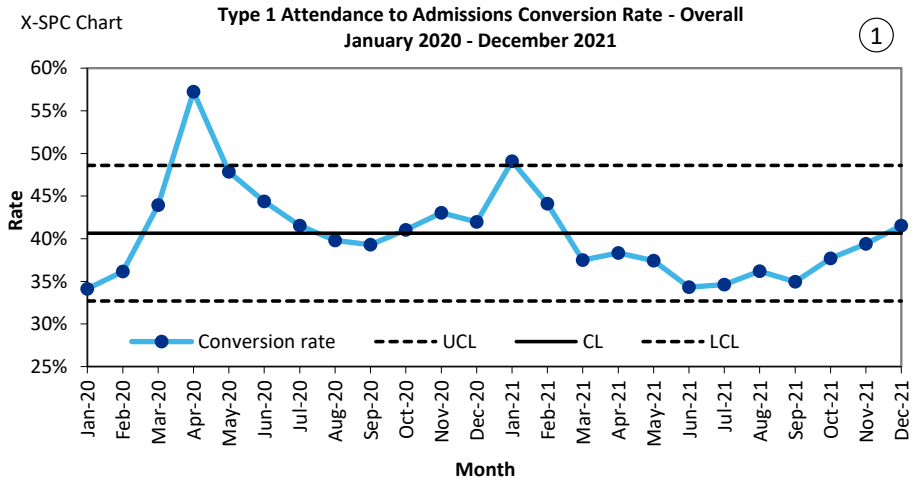
X-SPC Chart



X-SPC Chart



X-SPC Chart



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 and averaged 214 admissions per month during the period.

The average daily admissions from A&E for December 2021 was 85, below the rate shown for November 2021 (87).

The average daily admissions for GP-referred patients in December 2021 was 21, below the average admission rate for November 2021 (26). 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.

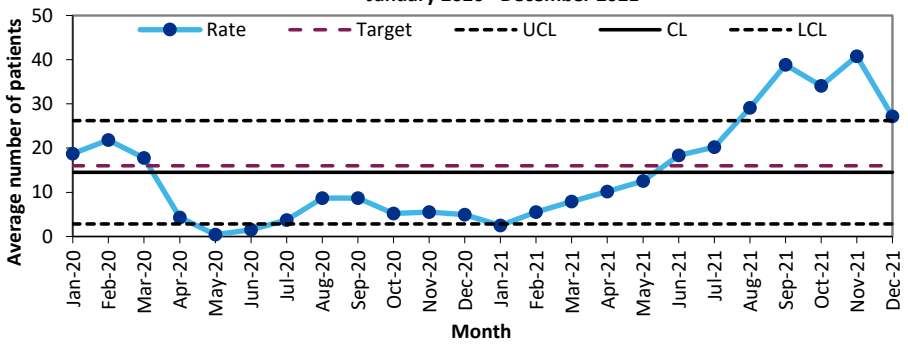
The type 1 admission conversion rate for December 2021 was 41.5%.

Performance

Inpatient Metrics

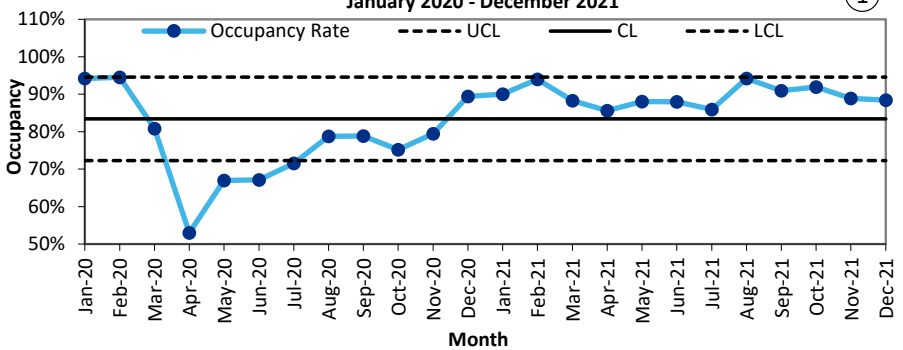
X-SPC Chart

Average Number of People Delayed per Day
January 2020 - December 2021



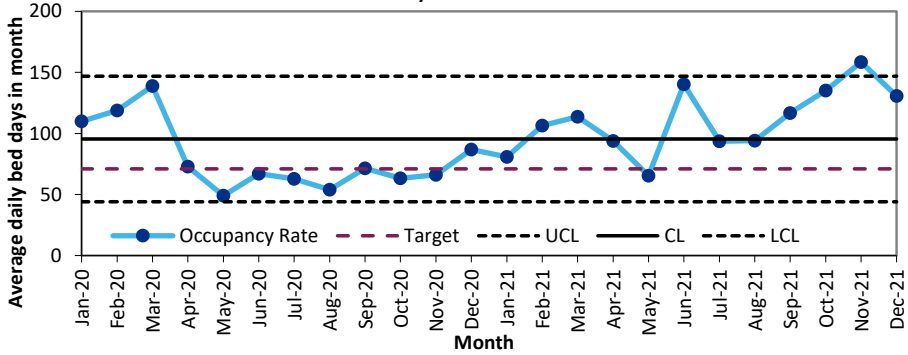
X-SPC Chart

Bed Occupancy
January 2020 - December 2021



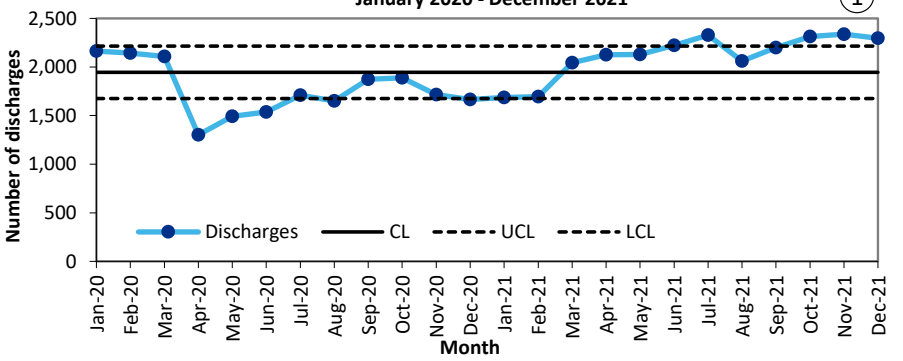
X-SPC Chart

Super Stranded Patients
January 2020 - December 2021



X-SPC Chart

Discharges from G&A Bed (Adult and Paeds) per Month
January 2020 - December 2021



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

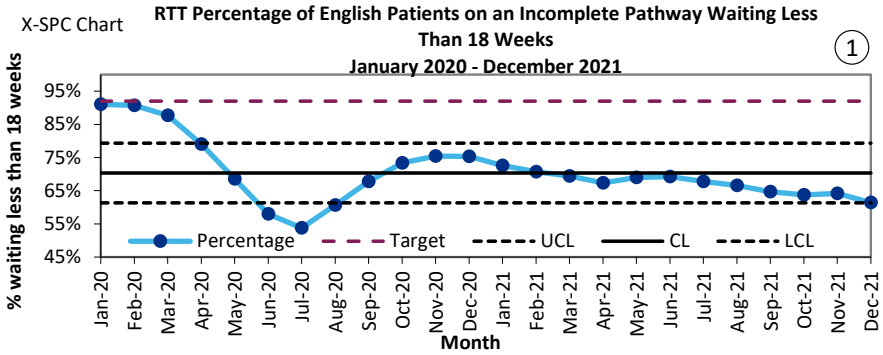
Key Narrative: The average number of people delayed per day during December 2021 was 27, a decrease on November 2021 (41). The average number of super stranded patients delayed per day in the hospital decreased from 158 in November 2021 to 130 in December 2021. The percentage bed occupancy rate for December 2021 was 88.4%, a slight decrease on the November 2021 occupancy rate of 88.7%. The bed occupancy figure reported does not exclude lost beds that are not suitable for patient admissions for infection prevention an control (IPC) reasons. There were 2,297 discharges from G&A beds in December 2021, a decrease against November 2021 (2,338).

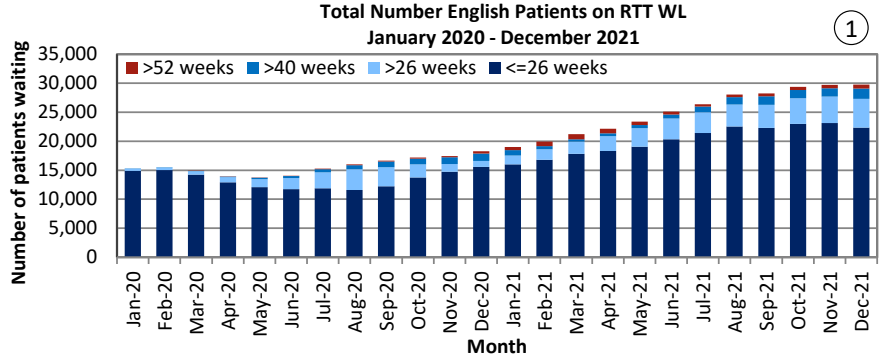
** bed stock numbers used to calculate the bed occupancy rate have been updated from July 2020 to reflect covid ward changes*

Mid Cheshire Hospitals NHS Foundation Trust

Performance

Referral to Treatment Waiting Times (RTT)





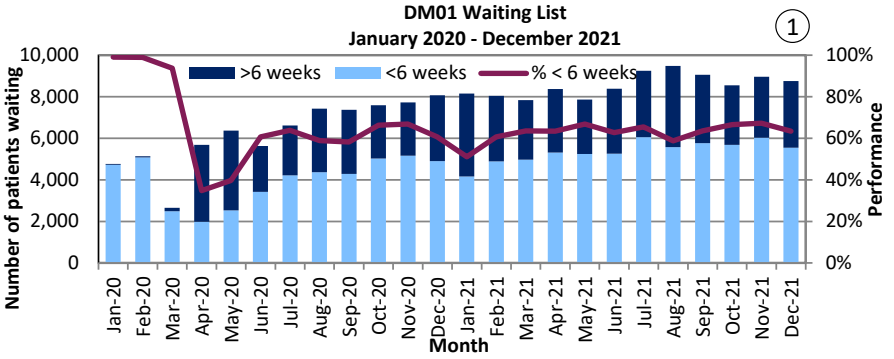
Accountable: Chief Operating Officer **Data Owner:** Information Services

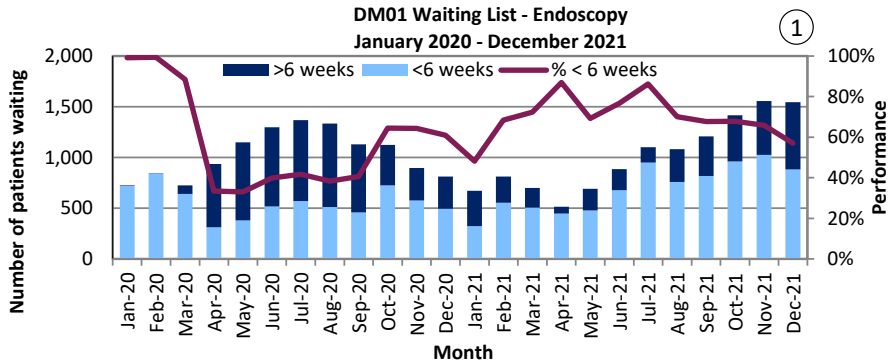
Key Narrative: The total number of patients on the RTT WL continues to grow with 29,751 patients waiting at the end of December 2021, of which 684 patients were waiting for more than 52 weeks, 84 more than reported in November 2021. December 2021 RTT performance shows 61.4% of patients waiting less than 18 weeks, lower than November 2021 (64.2%).

Reported RTT figures now include activity from the East Cheshire Dermatology service which moved over to Mid Cheshire in June 2021.

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, contributing towards waiting list growth.

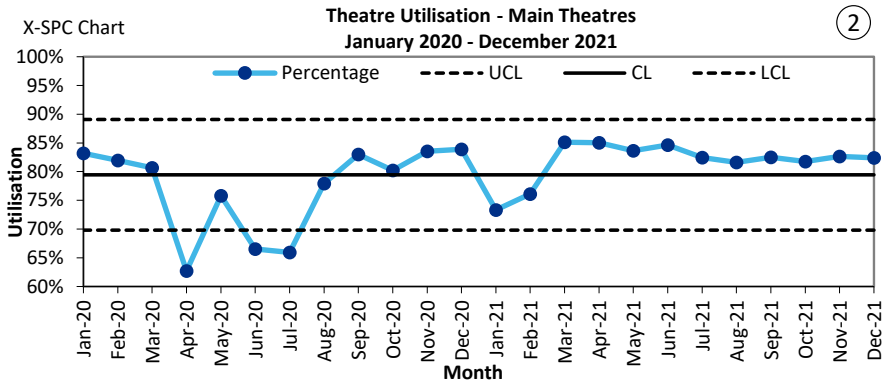
The total number of patients on the DM01 diagnostic waiting list for December 2021 was 8,749 and performance against the 6-week diagnostic standard was 63.4%. Performance for the Endoscopy DM01 modalities declined to 57.0% in December 2021.

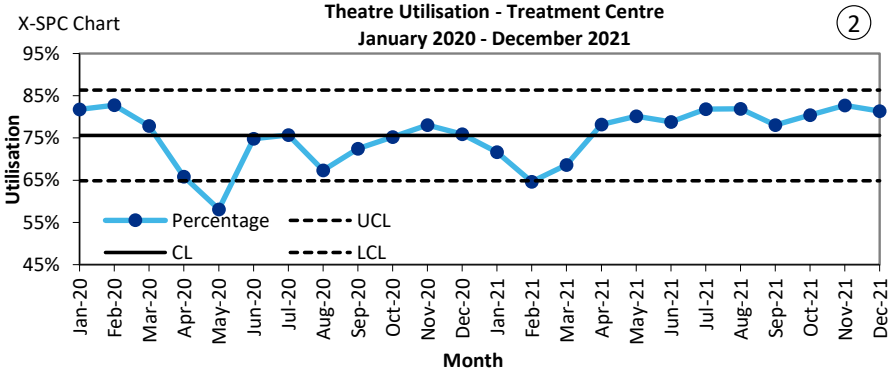
Data Rating: ①captured locally, ②system captured, ③published/benchmarked

Because you Matter

Performance

Theatre Utilisation



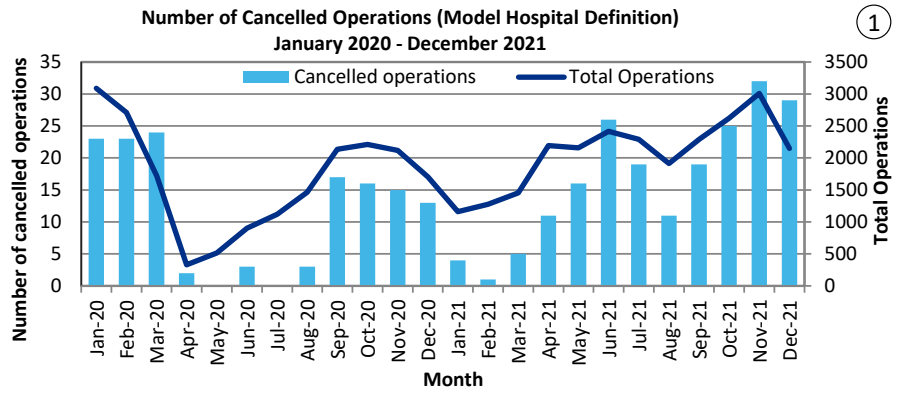


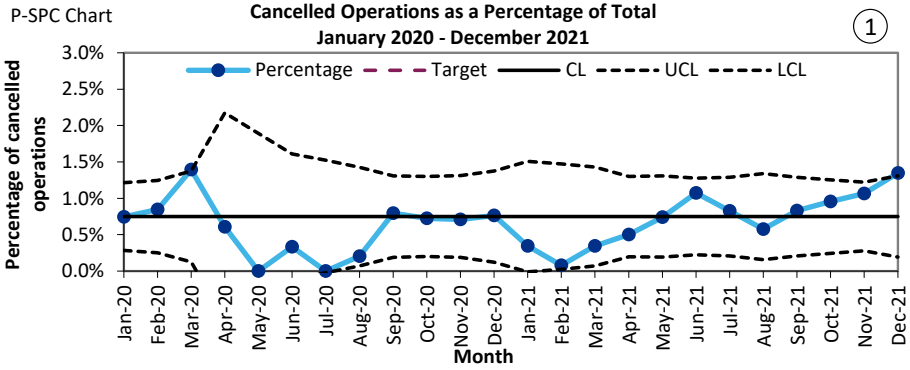
Accountable: Chief Operating Officer **Data Owner:** Information Services

Key Narrative: Theatre utilisation rate for December 2021 was 82.4% in Main Theatres, similar to the November 2021 position of 82.6%.

Theatre utilisation rate for the Treatment Centre in December 2021 was 81.4%, below the November 2021 position of 82.7%.

Cancelled Operations





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

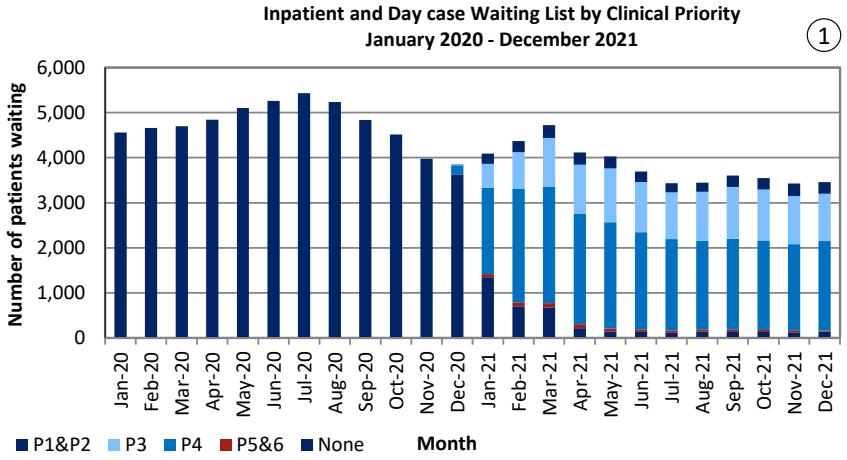
Key Narrative: 29 operations were cancelled on the day of admission by the hospital for non-clinical reasons in December 2021 (1.4%), slightly above the rate seen in November 2021 (1.1%).

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

Inpatient and Day Case Clinical Prioritisation

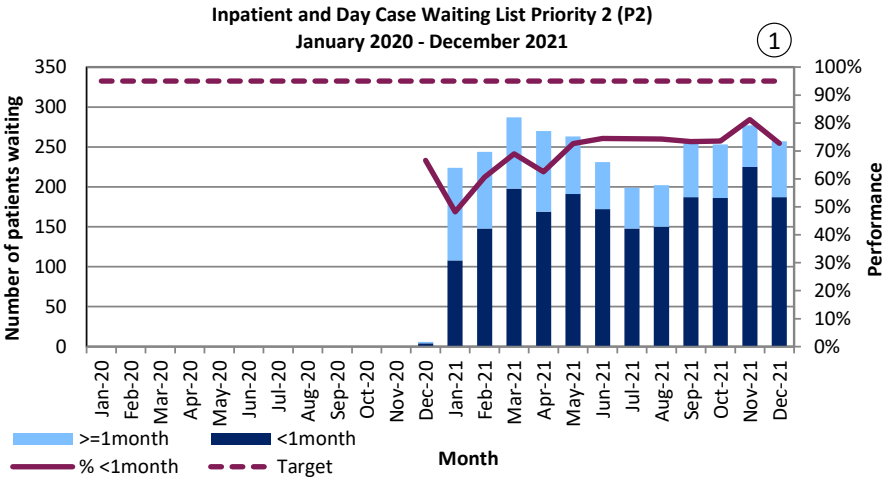


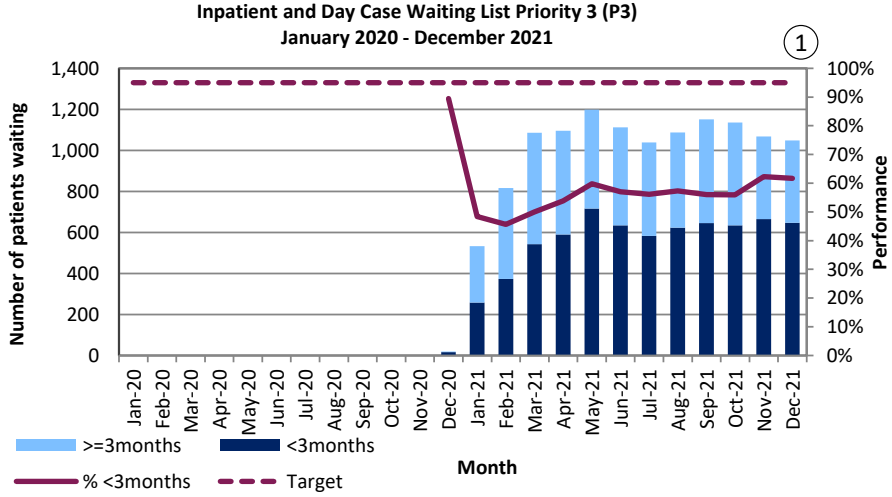
Accountable: Chief Operating Officer **Data Owner:** Information Services

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 December 2021 showed 257 patients had been categorised as P1 and P2; 1,049 as P3; 1986 as P4.

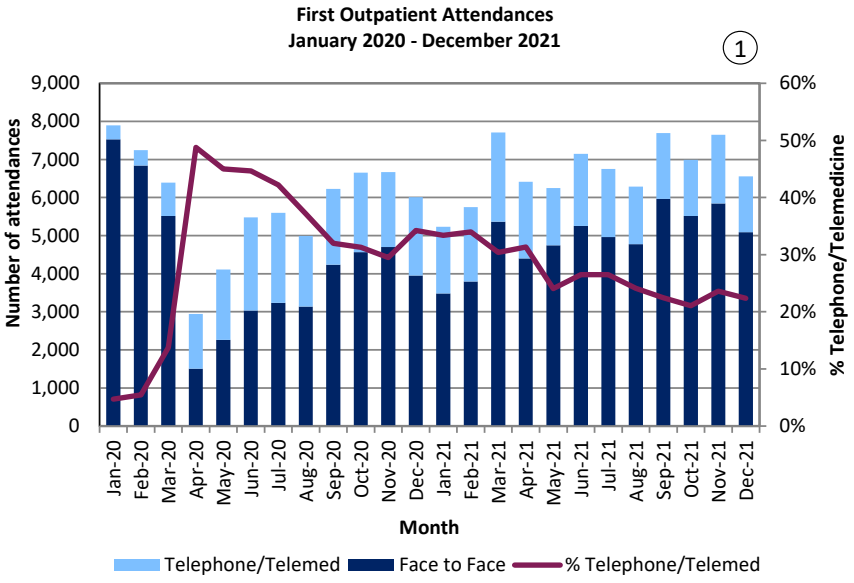
In December 2021 the percentage of patients classified as P2 and currently waiting less than 4 weeks for treatment was 72.8%. The patients classified as P3 and waiting less than 3 months at the end of December 2021 was 61.7%.

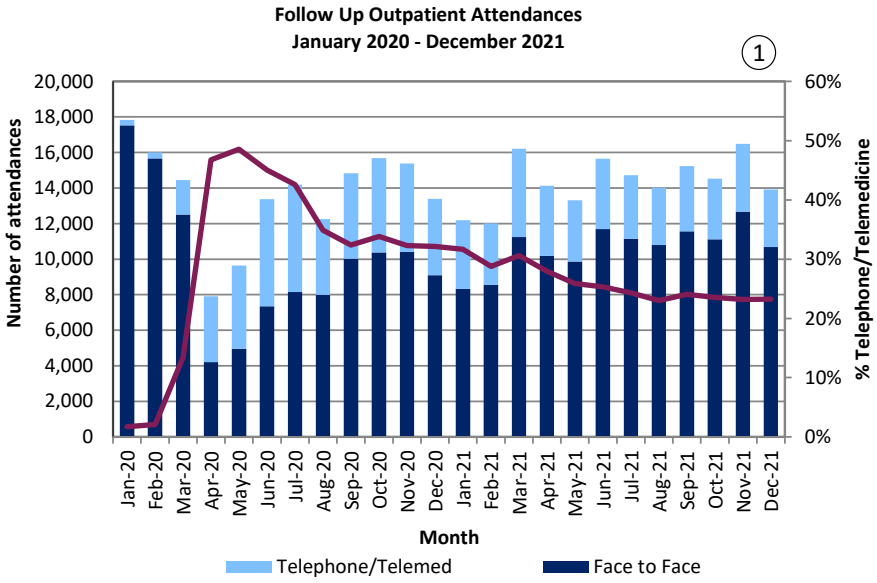




Performance

Outpatient Activity





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

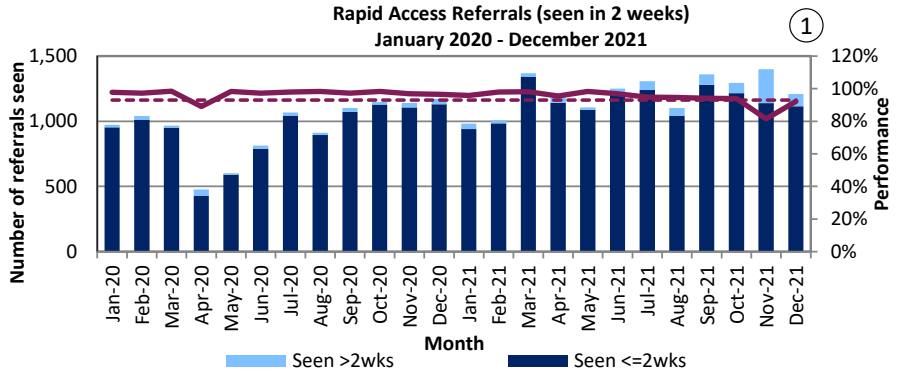
Key Narrative: 6,557 total first outpatient appointments were attended in December 2021, a decrease on both the total monthly position for November 2021 (7,652), and the average daily rate based on number of working days in the month. The proportion of non face to face appointments for December 2021 was 22.3%, below the rate seen in November 2021 (22.3%).

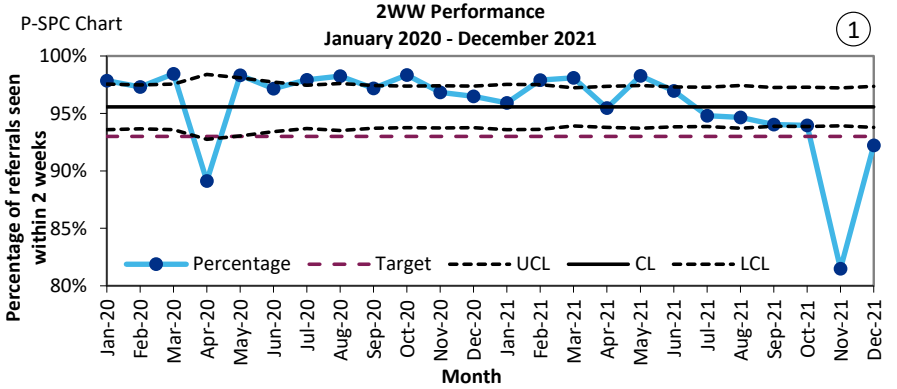
Total follow up outpatient activity followed a similar pattern with 13,923 attended in December 2021 compared to 16,490 seen in November 2021. The proportion of non face to face appointments for December 2021 was 23.3%, similar to the rate seen in November 2021 (23.3%).

Data includes contracted specialties.

Performance

Rapid Access Referrals





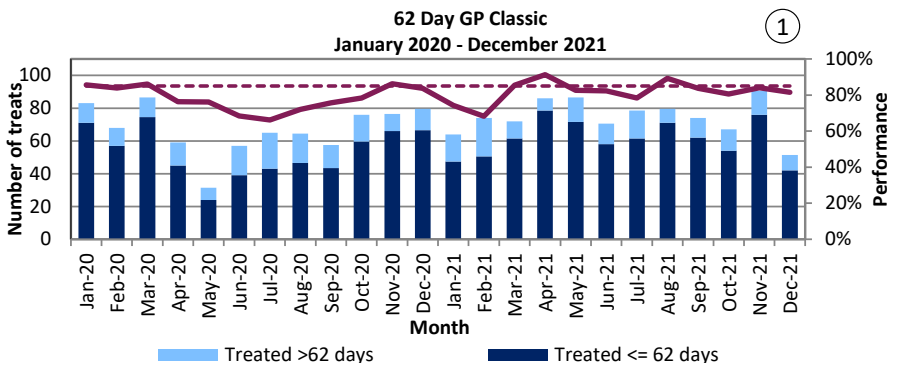
Accountable: Chief Operating Officer **Data Owner:** Cancer Performance

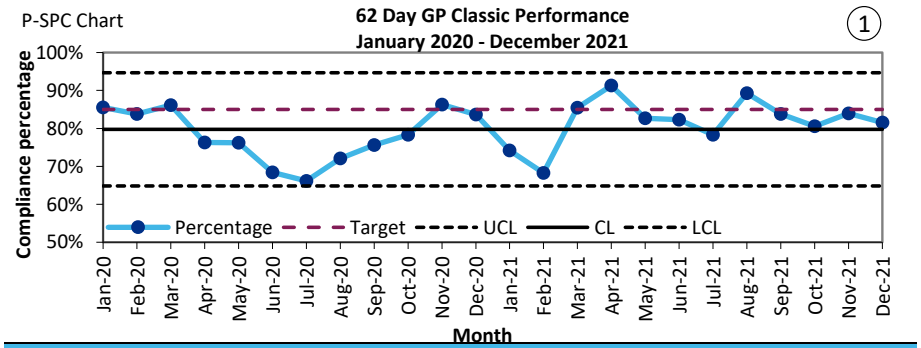
Key Narrative: 1,209 rapid access referrals were seen in December 2021, a decrease of 13.6% from the previous month.

The 2 week wait performance for December 2021 was 92.2%, remaining below the 93% standard.The P-SPC chart adjusts the control limits to take into account the denominator.

Latest month's data provisional.

62 Day





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

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

Key Narrative: Provisional performance against the 62-day standard for December 2021 currently reported at 81.6%. This is subject to validation of tertiary referrals and transfer dates, this is likely to improve.

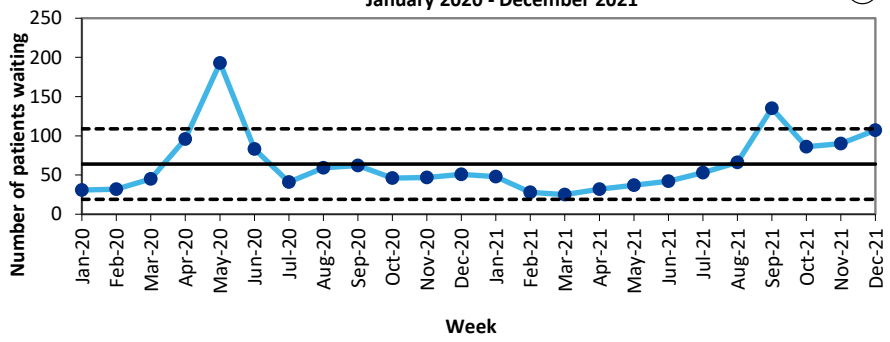
The P-SPC chart adjusts the control limits to take into account the denominator.

Performance

Cancer Waits Without DTT

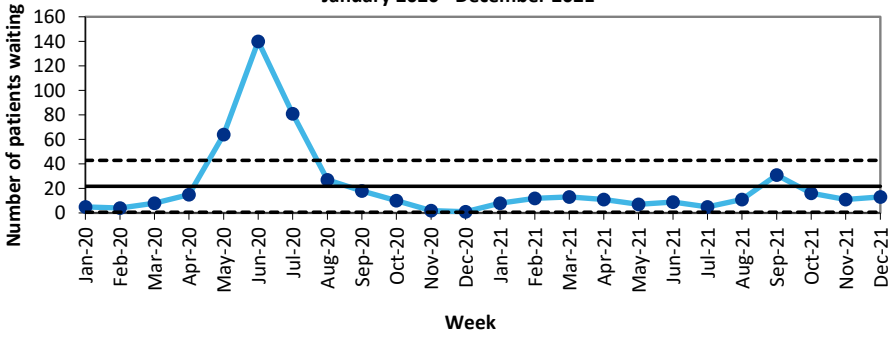
X-SPC Chart

Rapid Access GP Referrals waiting 63-104 days without a decision to treat
January 2020 - December 2021



X-SPC Chart

Rapid Access GP Referrals waiting more than 104 days without a decision to treat
January 2020 - December 2021



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

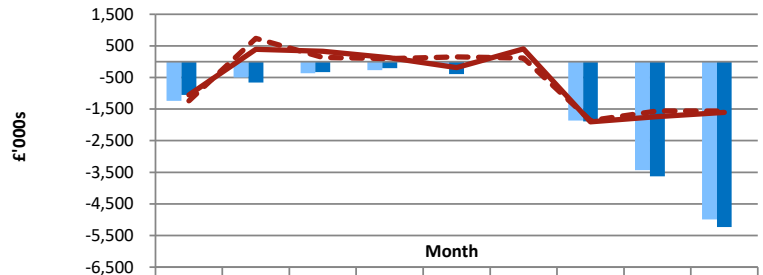
Key Narrative: There were 107 patients waiting between 63 and 104 days without a decision to treat (DTT) at the end of December 2021, and 13 patients waiting more than 104 days.

Data based on the last Monday of the month

Finance

Financial Performance

Financial Performance 2021/22



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Cumulative Plan	-1,235	-497	-366	-266	-116	-2	-1,866	-3,428	-4,991
Cumulative Actual	-1,054	-660	-328	-204	-388	16	-1,890	-3,632	-5,235
Cumulative Variance	181	-163	38	62	-272	17	-24	-204	-244
In Month Plan	-1,235	737	132	100	149	115	-1,864	-1,562	-1,563
In Month Actual	-1,054	393	333	124	-184	404	-1,903	-1,742	-1,605
In Month Variance	181	-344	201	24	-334	289	-39	-180	-42

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

Current view

The cumulative actual position at the end of December was off plan by £0.2m, with a small variance remaining due to the higher than expected drugs costs in November.

Whilst a number of measures were taken during December to support the Trust in light of the anticpated surge in activity, there were minimal additional costs in the financial position.

Forward view

The Trust is expecting to deliver a break-even position, however as this is reliant on the latest set of system discussions - and balances moving between organsiations, this not without a level of risk.

There are expected to be challenges ahead in relation to supporting the trust through the surge associated with the omnicron variant, particualrly around enhanced pay rates to support with improving the shift fill rates.

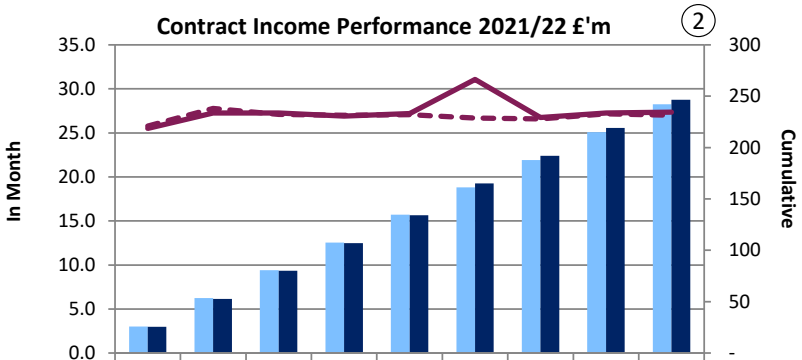
The guidance for 2022/23 planning has been issued, with the system capital allocations granted and the revenue values pending release.

	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				

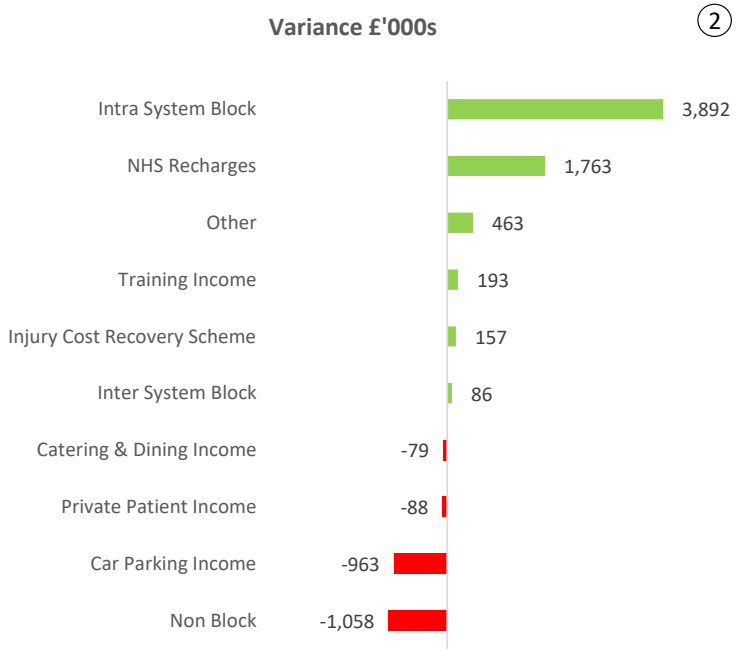
Data Rating: ①captured locally, ②system captured, ③published/benchmarked

Finance

Income



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Cumulative budget	26	54	81	108	135	161	188	215	242
Cumulative actual	26	53	80	107	134	165	192	219	247
In month budget	26	28	27	27	27	27	27	27	27
In month actual	26	27	27	27	27	31	27	27	27



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

Current View:

Overall income is above plan by £4.0m. The main drivers for this are additional income of £3.5m for H1 funding/pay award support, with provider to provider changes higher than planned particularly in relation the contract with The Christie where the charges mainly relate to pass through drugs costs.

Forward View:

There is a small amount of ERF funding for H2 being distributed within the system, October and November performance is currently being validated. The proposal for contract income in 22/23 is to be on an 'aligned incentive' arrangement - whereby there is an agreed fixed payment and a variable element for any under or over performance - this will replace ERF.

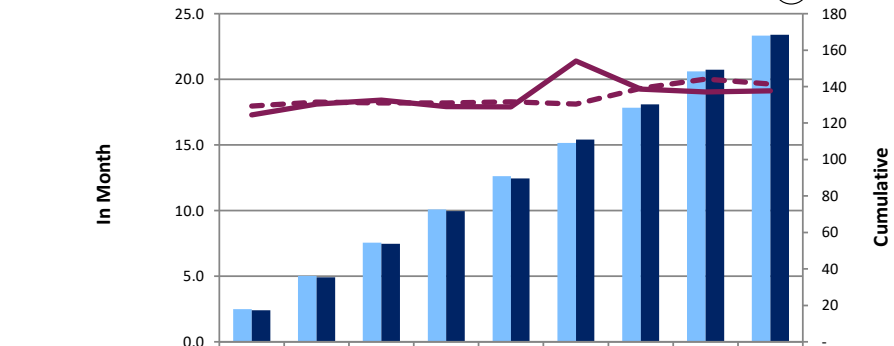
Data Rating: ①captured locally, ②system captured, ③published/benchmarked

Finance

Pay

Pay Expenditure 2021/22 £'m

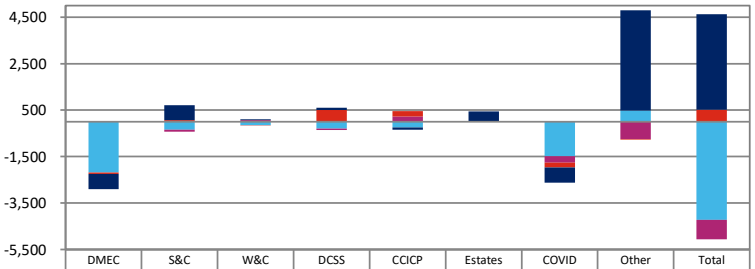
(2)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Cumulative budget	18	36	54	73	91	109	128	148	168
Cumulative actual	17	35	54	72	90	111	130	149	168
In month budget	18	18	18	18	18	18	19	20	20
in month actual	17	18	18	18	18	21	19	19	19

Pay Variances by Staff Group and Division £'000s

(2)



	DMEC	S&C	W&C	DCSS	CCICP	Estates	COVID	Other	Total
Total	-2,888	290	-52	246	115	442	-2,620	4,037	-429
Infrastructure Support Staff	-665	642	30	97	-93	436	-651	4,318	4,113
Non Clinical Staff	-55	74	-7	502	233	6	-212	-21	520
Medical Staff	19	-77	72	-58	221	-	-270	-745	-837
Nursing Staff	-2,187	-349	-146	-295	-246	-	-1,487	485	-4,225

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

Current View:

Pay is over budget YTD by £0.4m, which is a reflection of the underfunding of the pay award in H1.

In terms of H2- the pressures resulting from the expanded bed base being the most significant pressure, resulting is continue high use of agency, bank and Bedwatch costs.

£1.8m of the Annual Leave accrual has been used YTD to offset additional premium costs, associated with supporting staff with their leave.

Forward View:

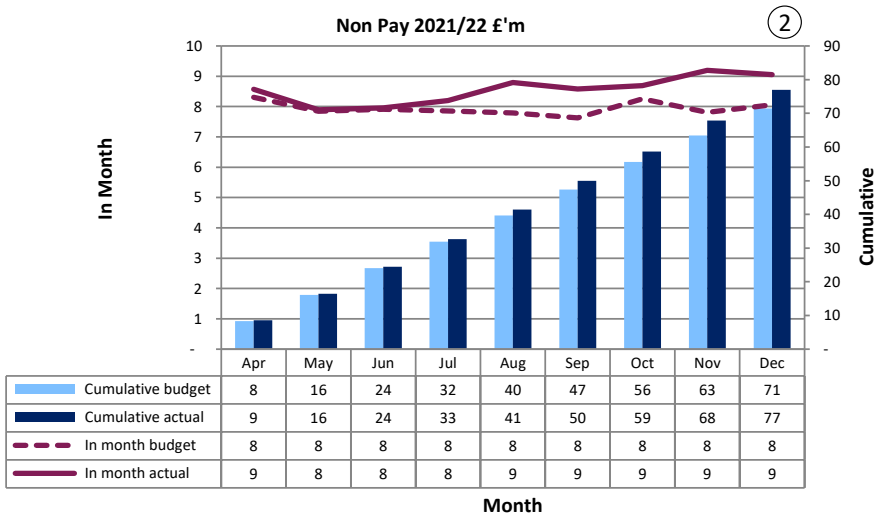
The pay bill will continue to experience pressure in H2, as the unplanned care demand continues as a result of Winter pressures and the Omnicron surge – with the escalation wards remain open, with an additional covid ward being opened in response.

In order to plan to mitigate the pressures expected over Winter, the further funding received for the Winter/UEC bids – will be utilised to support pressures in the Emergency Department, and key schemes that were identified from the 7 days no delays work.

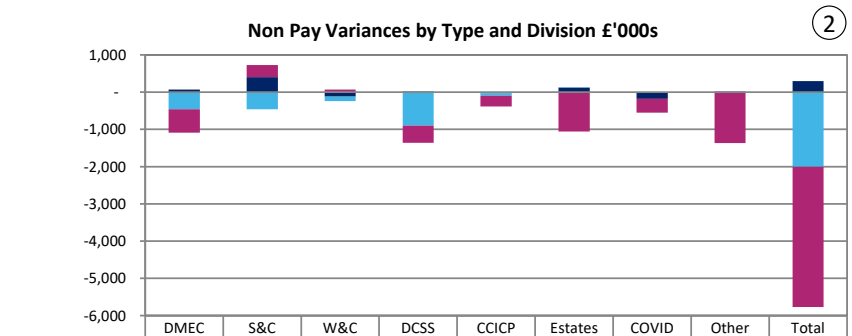
Data Rating: ①captured locally, ②system captured, ③published/benchmarked

Finance

Non-Pay



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Cumulative budget	8	16	24	32	40	47	56	63	71
Cumulative actual	9	16	24	33	41	50	59	68	77
In month budget	8	8	8	8	8	8	8	8	8
In month actual	9	8	8	8	9	9	9	9	9



	DMEC	S&C	W&C	DCSS	CCICP	Estates	COVID	Other	Total
Total	-1,014	267	-176	-1,342	-381	-938	-549	-1,344	-5,477
Other Non Pay	-624	322	68	-459	-284	-1,058	-368	-1,366	-3,768
Drugs	-462	-461	-121	-899	-66	0	-	6	-2,003
Clinical Supplies	72	406	-123	16	-31	120	-181	16	294

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

Current View:

Non-Pay is over budget YTD by £5.5m with the largest area of overspend is within the area of drugs – which is showing a £2.0m overspend. Whilst the majority of this relates to high cost drugs which are recoverable to commissioners or other providers such as The Christie – there is a variance of £1.2m, which is attributed to drugs within the block arrangements. This is undergoing a detailed review to ascertain whether the increase in a fluctuation in demand or a permanent change, which will need to be reflected in the forthcoming planning.

Other areas of increase relate to the use of outsourcing/insourcing of activity which is offset by pay vacancies.

The CIP for H2 is in the main un-allocated and the target sits within non pay, it is expected that as provisions are reviewed this will offset against this.

Forward View:

The trust has a 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, and look to reduce this dependency in the future. This is crucial in the future planning, given that there are signals that there will be a chance of direction on the blended tariff approach in relation to elective activity funding.

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

Finance

Income and Expenditure

2

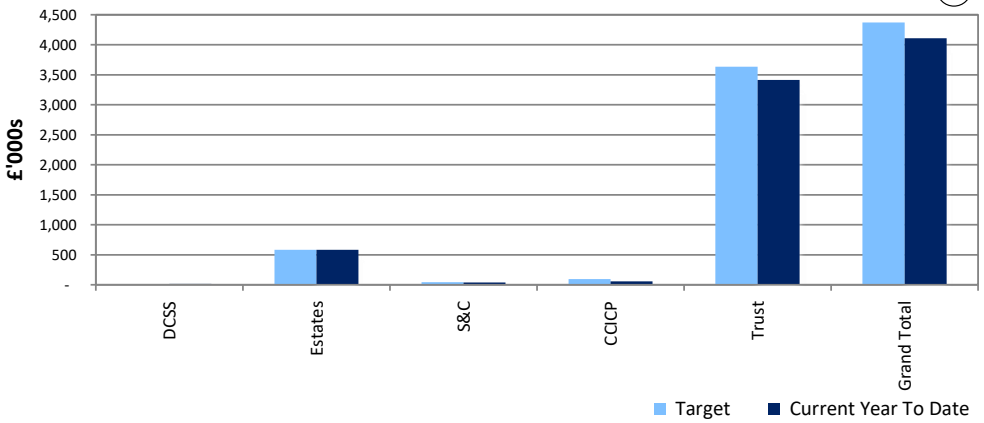
Budget FY		Month			Year to Date			Forecast FY
2021/22 (£'000)		Plan Dec (£'000)	Actual Dec (£'000)	Variance Dec (£'000)	Plan April to Dec (£'000)	Actual April to Dec (£'000)	Variance April to Dec (£'000)	2021/22 (£'000)
	Operating							
	Operating Income							
	Commissioning Income							
300,186	Inter System Block	1,249	1,162	(88)	12,450	12,537	86	301,086
0	Intra System Block	19,459	19,626	167	172,519	176,411	3,892	0
0	Non Block	4,059	4,344	285	39,911	38,853	(1,058)	0
814	RTA and Private Patient	68	97	29	611	680	69	814
	Other Operating Income							
0	Charitable Capital Income	0	0	0	0	21	21	0
30,842	Other Operating Income	2,184	2,114	(70)	16,683	18,040	1,356	30,842
331,842	**TOTAL OPERATING INCOME**	**27,019**	**27,342**	**323**	**242,174**	**246,541**	**4,367**	**332,742**
	Operating Expenses							
(227,405)	Employee Benefits Expenses (Pay)	(19,634)	(19,128)	506	(168,011)	(168,440)	(429)	(228,305)
(19,177)	Drugs	(1,711)	(2,189)	(478)	(14,044)	(16,047)	(2,003)	(19,177)
(15,994)	Clinical Supplies	(1,337)	(1,703)	(366)	(11,851)	(11,557)	294	(15,994)
(59,202)	Other operating expenses	(5,013)	(5,160)	(147)	(45,569)	(49,337)	(3,768)	(59,202)
(321,778)	**TOTAL OPERATING EXPENSES**	**(27,695)**	**(28,180)**	**(485)**	**(239,475)**	**(245,381)**	**(5,906)**	**(322,678)**
10,064	**EBITDA**	**(676)**	**(838)**	**(162)**	**2,699**	**1,160**	**(1,539)**	**10,064**
	Non Operating							
	Non Operating Income							
(379)	Interest	(32)	(25)	6	(284)	(114)	171	(379)
0	Asset disposal	0	0	0	0	0	0	0
	Non-Operating Expenses							
(6,985)	Depreciation & Finance Leases	(615)	(480)	135	(5,428)	(4,283)	1,145	(6,985)
0	Depreciation on Donated Assets	0	(26)	(26)	(0)	(277)	(277)	(377)
(2,700)	PDC Dividend Expense	(241)	(241)	(0)	(1,978)	(1,978)	(0)	(2,700)
0	**Net Surplus/(deficit) before Exceptional Items**	**(1,563)**	**(1,610)**	**(47)**	**(4,991)**	**(5,492)**	**(502)**	**(377)**
0	Remove capital donations/grants I&E impact	(0)	26	26	0	256	256	377
0	**Net Surplus/(Deficit) after Exceptional Items**	**(1,563)**	**(1,584)**	**(21)**	**(4,991)**	**(5,236)**	**(245)**	**0**

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

Finance

Cost Improvement Programmes (CIP)

Year to Date CIP Delivery v Plan Total ①



CIP Performance Actual by Division ②

	DCSS	Estates	S&C	CCICP	Trust	Grand Total
Current Year To Date	15	585	40	57	3,412	4,109
Pay		311			2,994	3,305
Non pay		275	40	57	418	789

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

Current View:

The total efficiency target for H1 was £2.3m. This target was met, with the largest savings relating to the procurement of laundry services, with additional non recurrent savings on recruitment delays and phasing difference in expected cost pressures.

The target for H2 is £4.0m which is currently under achieving by £0.26m due to the increased overall Trust spend impacting on the ability to meet the non recurrent efficiencies.

Forward View:

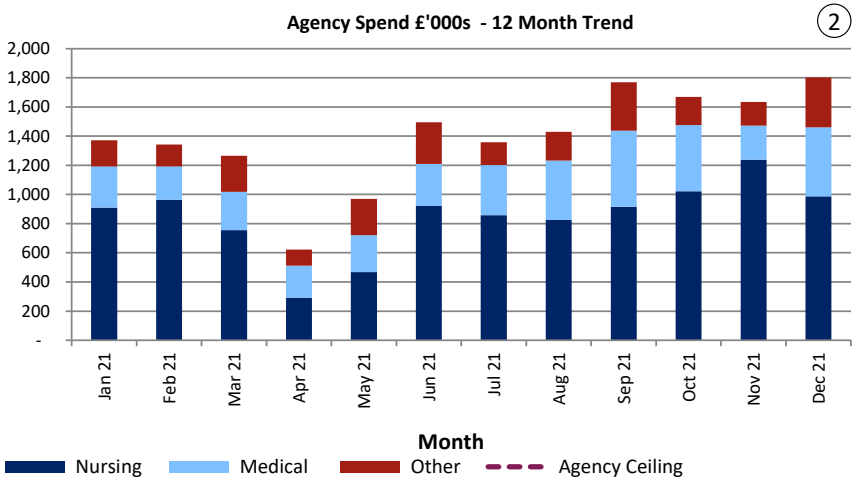
The Trust is beginning to focus on drawing up efficiencies plans for 2022/23 as it is anticipated the requirement for efficiencies will be greater next year.

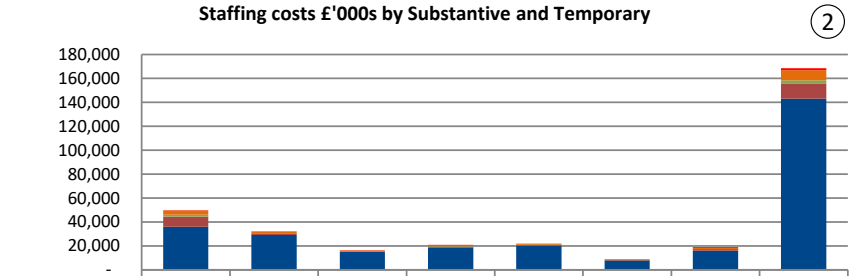
New efficiencies governance arrangements and documentation has been approved with a view to launching the efficiencies and value programme for 2022/23 in January.

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

Finance

Bank and Agency





	DMEC	S&C	W&C	DCSS	CCICP	Estates	Other	Total
Total	49,960	32,318	16,291	20,720	21,505	8,645	19,000	168,440
Waiting List	333	322	77	145	0	2	743	1,623
Bank	3,537	1,141	610	932	693	594	817	8,324
Locum	1,570	363	79	407	220	-	31	2,669
Agency	8,593	1,257	450	511	354	36	1,553	12,755
Substantive	35,928	29,235	15,075	18,724	20,237	8,013	15,856	143,068

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

Current View:

Agency expenditure was £1.8m in the month of December, which is an increase on the previous month, although nursing agency was less asa result of the reduced availability of staff.

The continued high levels of spend relate primiarily to continued unplanned care demands.

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.

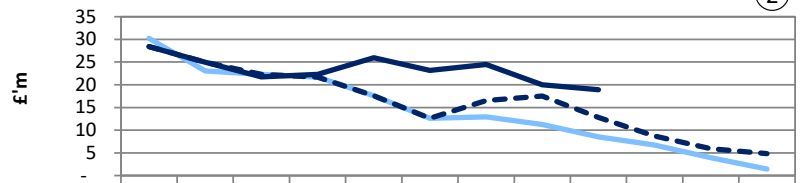
Data Rating: ①captured locally, ②system captured, ③published/benchmarked

Mid Cheshire Hospitals NHS Foundation Trust

Finance

Cash

Cash Position



	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	24	20	19			
Forecast	28	25	22	22	18	13	17	18	13	9	6	5

Cash Flow Movements

	Operating Surplus / (Deficit)	Increase / (Decrease) in Working Capital	Net Cash Inflow / (Outflow) from Capital Expenditure	Net Cash Inflow / (Outflow) from Borrowings
Variance to Opening Balance	0	9	2	-1

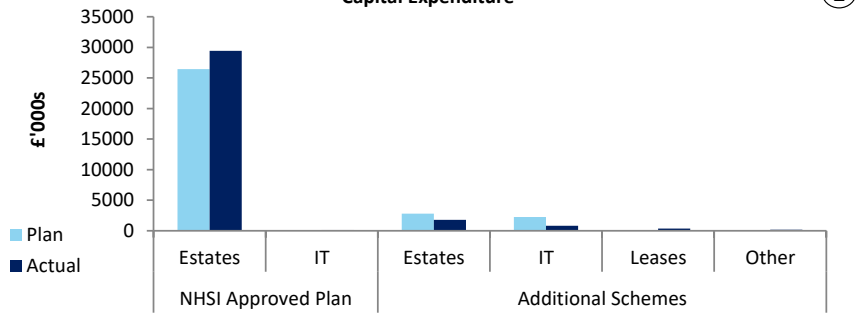
Accountable: Director of Finance **Data Owner:** Financial Services

Current View: Cash is higher than plan by £10.4m due to improvements in working capital linked to higher accruals and payables, and Education income received in advance.

Forward View: The cash position has improved due to slippage on the EPR project.

Capital

Capital Expenditure



	Year to Date £'000s			Year End £'000s		
	Plan	Actual	Variance	Plan	Forecast	Variance
NHSI Approved Plan						
Estates	29,284	32,230	2,946	37,909	39,145	1,236
IT	0	120	120	3,600	153	-3,447
NHSI Approved Total	**29,284**	**32,349**	**3,065**	**41,509**	**39,298**	**-2,211**
Additional Schemes						
Estates	2,955	2,224	-731	3,627	4,599	972
IT	2,402	950	-1,452	2,600	2,107	-493
Other	0	187	187	0	2,160	2,160
Leases	0	383	383	0	383	383
Total Capital Schemes	**34,641**	**36,093**	**1,452**	**47,736**	**48,547**	**811**

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

Current View: Capital is ahead of the NHSI approved plan by £3m, due to the nationally supported projects in ED, Critical Care and RAAC planks cumulatively.

Forward View: The Trusts capital plan is higher than the NHSI submitted plan, and the HCP have confirmed that capital limits will be adjusted within the system to support the additional schemes.

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

Finance

Statement of Financial Position December 2021

②

		Plan Apr to December (£'000)	Actual Apr to December (£'000)	Variance (£'000)
Assets	Assets, Non-Current	135,423	135,356	-67
	Assets, Current	22,570	31,518	8,948
ASSETS, TOTAL		**157,993**	**166,874**	**8,880**
Liabilities	Liabilities, Current	-31,454	-40,391	-8,937
	Liabilities, Non Current	-6,891	-7,240	-349
TOTAL ASSETS EMPLOYED		**119,648**	**119,243**	**-405**
Taxpayers' and Others' Equity				
	Taxpayers Equity	119,648	119,243	-405
TOTAL FUNDS EMPLOYED		**119,648**	**119,243**	**-405**

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

Current View:

Cash is higher than plan by £10.4m, mainly due to higher payables and capital creditors, and Education income received in advance.

Trade Payables are £2.2m above plan, mainly due to fewer payment runs in December. Capital Creditors are above plan by £1.5m. Accruals are £4m higher than plan due to an increase in agency and drugs costs.

Deferred Income is above plan by £1.5m due to Education income received in advance.

Public Dividend Capital is behind plan by £0.5m due to capital scheme slippage.

Forward View:

The Trust is due to receive PDC funding in relation to RACC Planks of £22m.

Finance

Balance Sheet

Current View:

Assets Non-Current
The capital programme is ahead of plan, driven by spend of RAAC plank schemes.

Assets Current
Cash is higher than plan by £10.4m due to increases in payables, accruals and education income received in advance.

Current Liabilities
Trade Payables are £2.2m above plan due to fewer payment runs in December, and Capital Creditors are above plan by £1.5m. Accruals are £4m higher than plan due to an increase in agency and drugs costs. Deferred Income is above plan by £1.5m due to education income received in advance.

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

	Plan Apr to December (£'000)	Actual Apr to December (£'000)	Variance (£'000)	Forecast 2021/22 (£'000)
Assets				
Assets, Non-Current	**135,423**	**135,356**	**-67**	**144,036**
Assets, Current				
Trade and other Receivables	6,555	3,621	-2,935	7,062
Other Assets (including Inventories & Prepayments)	7,511	8,986	1,475	6,662
Cash and Cash Equivalents	8,504	18,911	10,407	4,826
Total Assets, Current	**22,570**	**31,518**	**8,948**	**18,551**
ASSETS, TOTAL	**157,993**	**166,874**	**8,880**	**162,586**
Liabilities				
Liabilities, Current				
Finance Lease, Current	-614	-427	186	-1,010
Loans Commercial Current	-145	-145	0	-357
Trade and Other Payables, Current	-16,627	-20,570	-3,943	-18,713
Provisions, Current	-479	-734	-256	-226
Other Financial Liabilities	-13,590	-18,514	-4,924	-13,475
Total Liabilities, Current	**-31,454**	**-40,391**	**-8,937**	**-33,780**
Net Current Assets/(Liabilities)	**-8,884**	**-8,873**	**11**	**-15,230**
Liabilities, Non Current				
Finance Lease, Non Current	-2,095	-2,477	-382	-1,065
Loans Commercial Non-Current	-3,306	-3,306	0	-2,962
Provisions, Non-Current	-1,490	-1,457	33	-1,370
Trade and Other Payables, Non-Current	0	0	0	0
Total Liabilities Non-Current	**-6,891**	**-7,240**	**-349**	**-5,397**
TOTAL ASSETS EMPLOYED	**119,648**	**119,243**	**-405**	**123,409**
Taxpayers' and Others' Equity				
Taxpayers Equity				
Public dividend capital	136,332	135,832	-500	143,832
Retained Earnings	-28,774	-28,708	66	-32,513
Donated asset reserve	0	0	0	0
Revaluation Reserve	12,090	12,119	28	12,090
TOTAL TAXPAYERS EQUITY	**119,648**	**119,243**	**-405**	**123,409**
TOTAL FUNDS EMPLOYED	**119,648**	**119,243**	**-405**	**123,409**

Forward View: ②

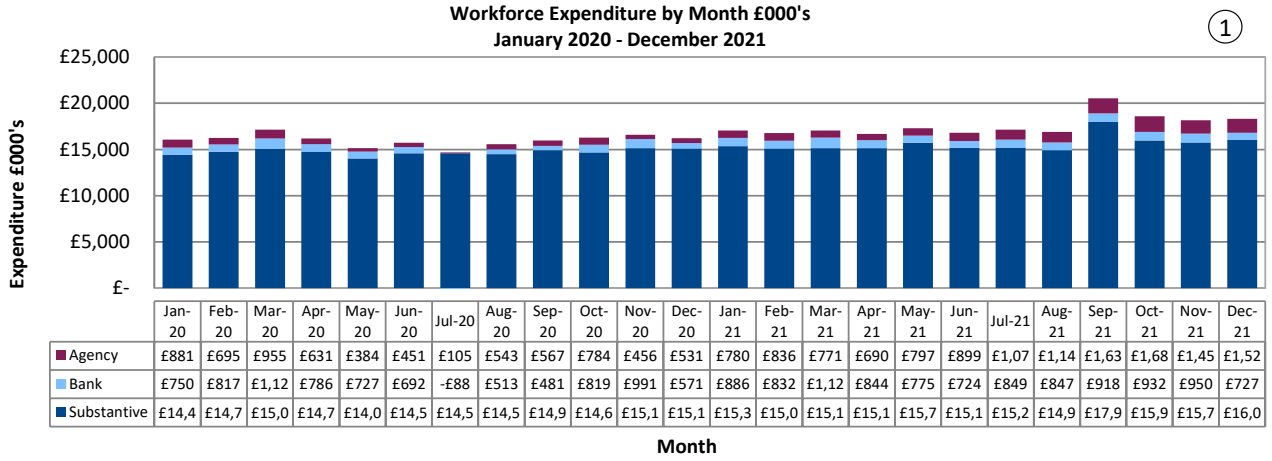
The forecast includes PDC funding and capital spend in relation to RACC Planks of £22m.

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.

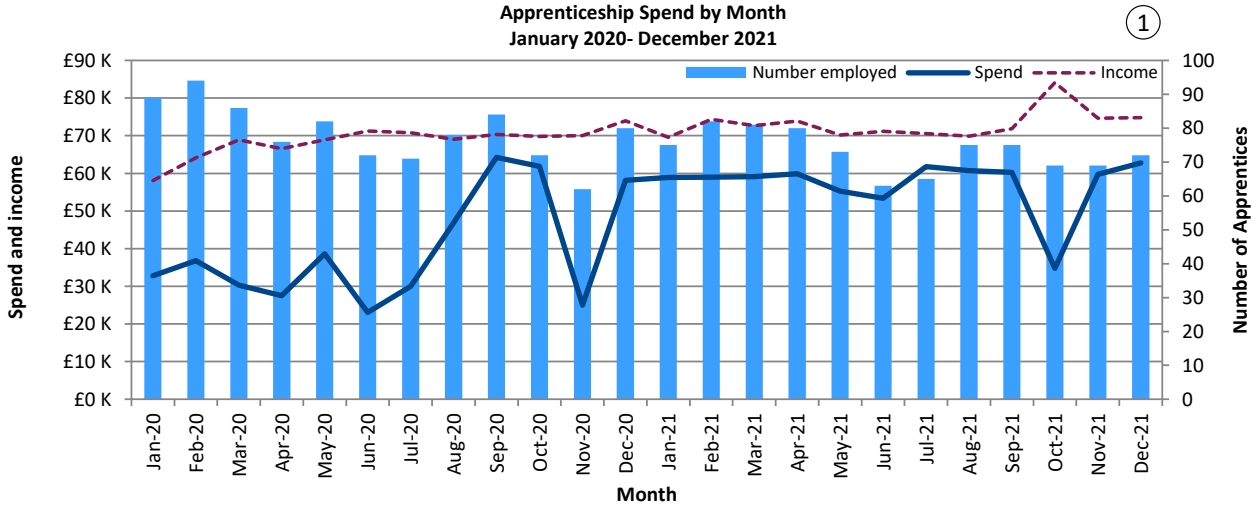
Data Rating: ①captured locally, ②system captured, ③published/benchmarked

Workforce

Finance and Costings



	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	Oct-21	Nov-21	Dec-21
Agency	£881	£695	£955	£631	£384	£451	£105	£543	£567	£784	£456	£531	£780	£836	£771	£690	£797	£899	£1,07	£1,14	£1,63	£1,68	£1,45	£1,52
Bank	£750	£817	£1,12	£786	£727	£692	-£88	£513	£481	£819	£991	£571	£886	£832	£1,12	£844	£775	£724	£849	£847	£918	£932	£950	£727
Substantive	£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	£17,9	£15,9	£15,7	£16,0



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

Key Narrative: Total workforce expenditure for December 2021 was £18,327k, 13% higher than December 2020. There has been an increase of £160k (0.9%) from the previous month.

Expenditure for December 2021 is £509k below budget (2.7%) and £453k below budget (0.3%) year to date.

October 2021 expenditure was impacted by the pay award (£2.8m) and Flowers back pay (£0.2m).

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

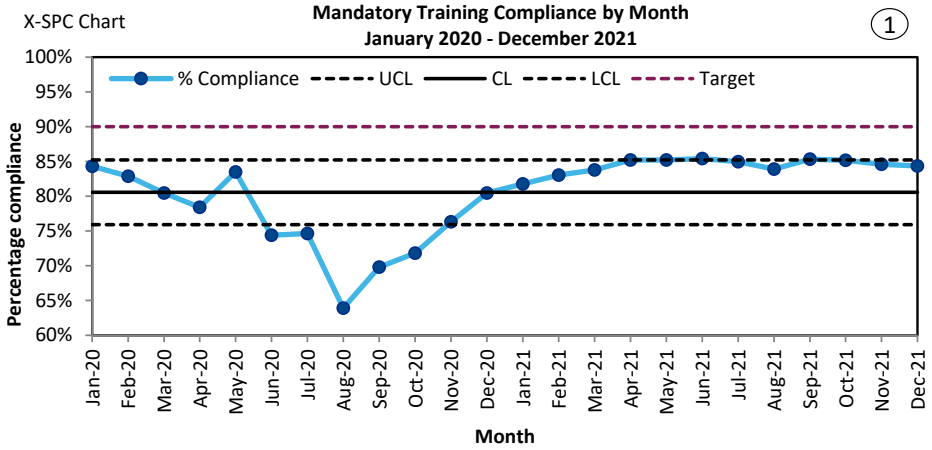
Key Narrative: The number of Apprentices employed in December 2021 was 72, an increase from the previous month (69) and lower than the number reported in December 2020 (80).

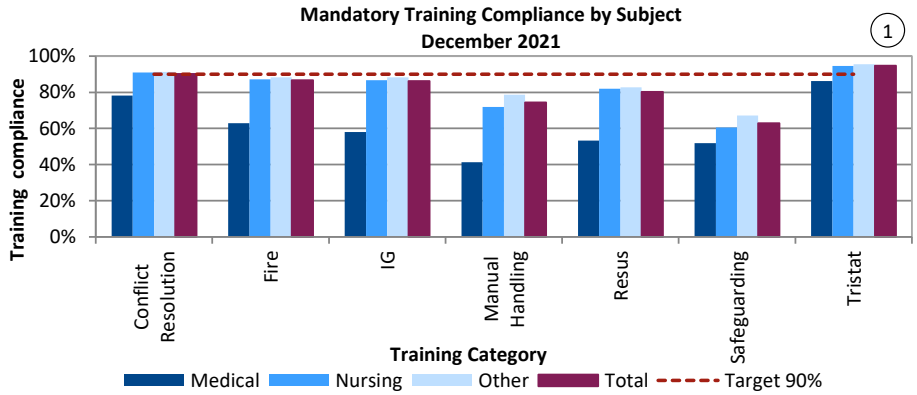
Apprenticeship spend remains below income.

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

Workforce

Training

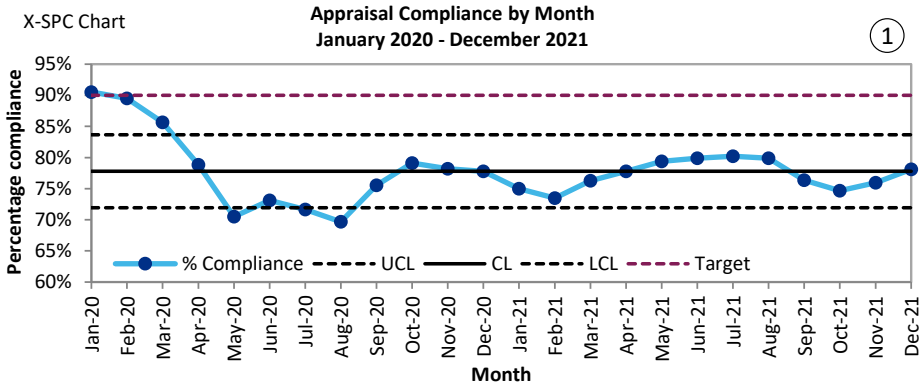


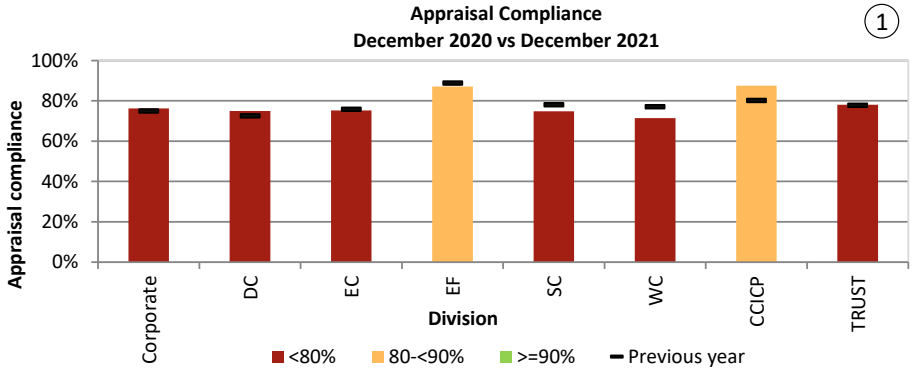


Accountable: Director of Workforce & Organisational Development
Data Owner: Workforce Directorate

Key Narrative: Mandatory training compliance remains stabile achieving 84.3% in December 2021. Training compliance remains below the 90% target.

Appraisals



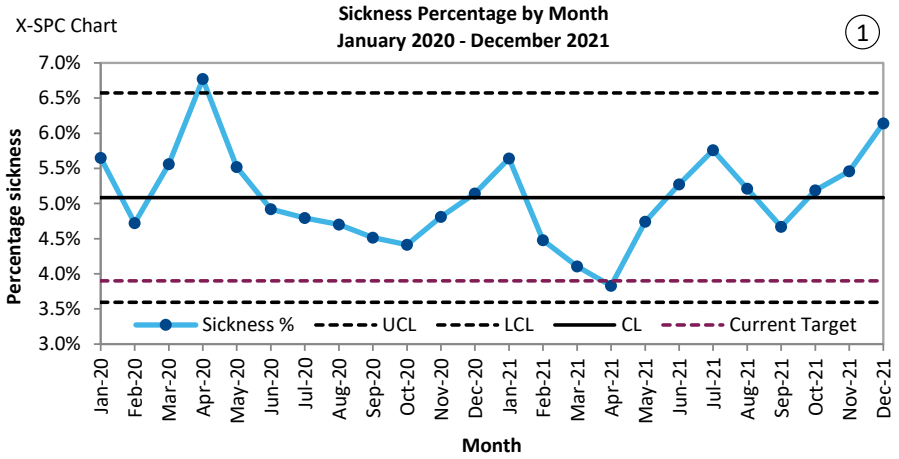


Accountable: Director of Workforce & Organisational Development
Data Owner: Workforce Directorate

Key Narrative: The reported appraisal compliance for December 2021 is 78.1%, an increase to the 76.0% compliance reported in November 2021. Appraisal compliance remains below the target rate of 90% which was only achieved in January 2020 over the 24-month period shown.

Workforce

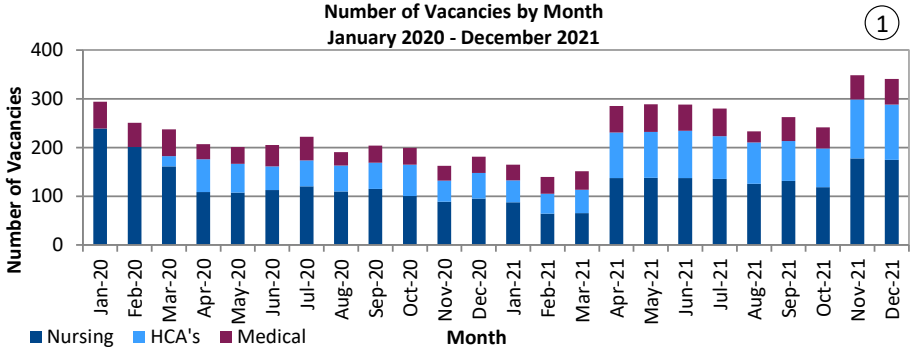
Sickness

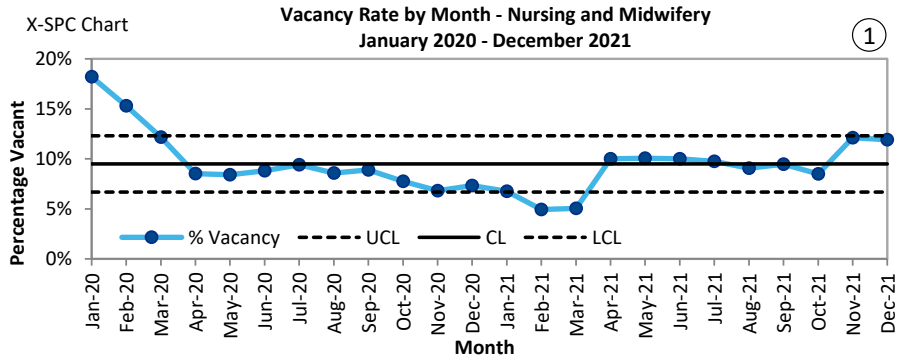


Accountable: Director of Workforce & Organisational Development
Data Owner: Workforce Directorate

Key Narrative: The sickness rate for December 2021 was 6.1%. This is an increase compared to the sickness rate reported for November 2021 (5.5%), and above the sickness for the same period last year (5.1%).

Vacancies





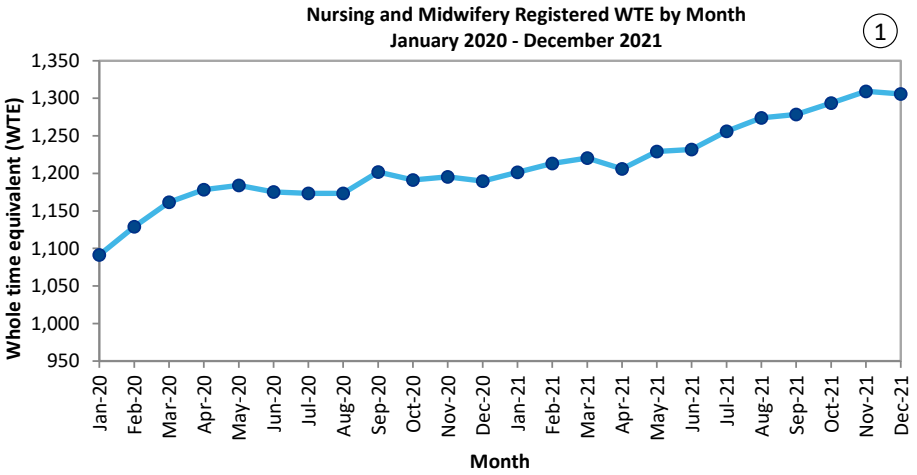
Accountable: Director of Workforce & Organisational Development
Data Owner: Workforce Directorate

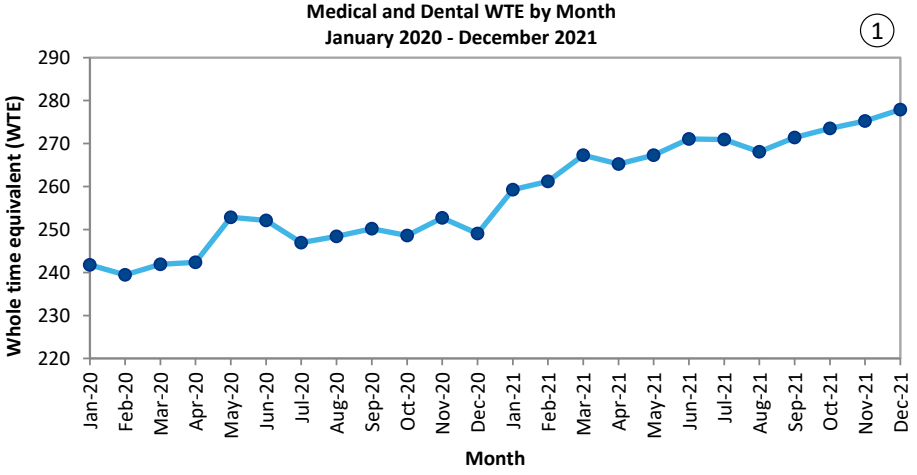
Key Narrative: The vacancy figures from April 2020 were restated to exclude International Recruitment, Nurse Apprentices and COVID.

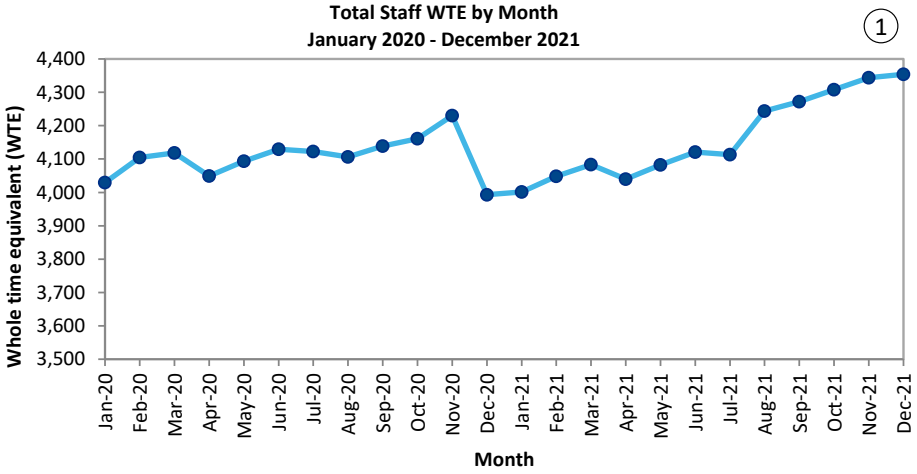
The vacancy rate for December 2021 has decreased to 11.9% from the 12.1% reported for the previous month and includes new budget for Escalation Ward 2. The vacancy rate since the beginning of the financial year has increased, mainly as a result of investments added to the Establishment at the beginning of 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 214.8 WTE (19.7%) over the 24-month period and Medical and Dental staff by 36.1 (14.9%).

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

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

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**9**	Date of Meeting: 27/01/2022
Report Title	**Board Assurance Framework Q3 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

- No proposed changes to Strategic Risk scores in Q3
- Review of controls and assurances submitted to Board Committees (PAF, QSC and WDT) in December with summary submitted to Audit Committee in January 2022. Work on-going with Executive leads in February and March
- 15+ operational risks demonstrate the Trust's risk exposure

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

- Executive Risk Leads to act on recommendations agreed during meeting

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

• Provide safest and best care	✓	• 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
Audit Committee	Jan 22	BAF Controls & Assurances	CKeating, Company Secretary	BAF controls and assurances would continue to be reviewed and updated with the Executive leads during February and March
Board & Board Committees	Nov 21	15+ Risk Review	JSumner, CEO/ CKeating, Company Secretary	Committees agreed reductions to risk scores
Board Committees	Dec 21	Board Assurance Framework Quality & Safety Committee delegated risks – controls & assurances	CKeating, Company Secretary	Request for detail on the changes made to BAF

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 workplan and agendas for the Board and its Committees.

2. The Trust's strategic risks and alignment 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, following scrutiny by the relevant Board Committee.

3. This report provides an update in relation to current risk scores (see Appendix 1). There has been one score change during the year (BAF3 increased from 9 to 12 during Q2). Additional detail about the controls and assurances mapped to date for the strategic risks is provided in the 4Risk report in Annex 1.

4. There has been no Board Committee scrutiny for this quarter's report from the Quality & Safety (QS), Performance & Finance (PAF) or Workforce & Digital Transformation (WDT) Board Committees as these were stood down in January due to operational pressures.

5. The report has been informed by the 15+ Risk Review that was submitted to Board and Board Committees in November 2021 and the BAF Controls & Assurances Review that was submitted to the aforementioned Board Committees in December 2021 and Audit Committee in January 2022.

Strategic Risks – Current Position

6. 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 and the aged infrastructure of the Leighton Hospital site. The Executive Team also monitors the completion of actions and discusses changes to the BAF on a monthly basis.

7. The detail collated is subject to a continual quality assurance process, co-ordinated by Corporate Governance & Risk. A review of the BAF risks' controls and assurances has been undertaken with the outcomes reported through to each Committee in December and to Audit Committee in January 2022. In addition, the Trust's internal auditors undertook a sampling exercise to assess the quality of assurances submitted as part of their mandated Assurance Framework review which provided that the organisation's Assurance Framework:

   - is structured to meet the NHS requirements
   - is visibly used by the Board and its Committees and Executive-led Groups
   - clearly reflects the risks discussed by the Board and its Committees and Executive-led Groups

(cf. Audit Committee Chair's Assurance Report, Agenda Item, Board of Director January 2022).

8. It was noted at Audit Committee in January 2022 that BAF controls and assurances would continue to be reviewed and updated with the Executive leads during February and March prior to the new BAF being agreed by the Board in April 2022. Corporate Governance & Risk will ensure any updates align with the Committee workplans for 2021/22 and are factored in to the 2022/23 workplans.

Changes to BAF risks within Q3

9. There were no changes in risk scores during Q3.

10. 69 amendments have been made to the BAF in the last quarter as outlined in Table 1 below. These changes demonstrate reasonable engagement with the BAF by Risk leads, owners and action owners. Figures in brackets () denote the number of changes made to that particular risk:

Amend type	Number of amends	BAF Risk
New cause added	1	BAF2
New controls added	3	BAF1; BAF6 (2)
Control/Assurance updated	11	BAF1 (3); BAF2; BAF3; BAF5 (3); BAF8; BAF9; BAF14
Control assurance added	2	BAF8 (2)
Control assurance changed	5	BAF1 (2); BAF2; BAF3; BAF13
Action completed	24	BAF1 (4); BAF2 (3); BAF3; BAF5 (2); BAF6 (2); BAF7; BAF9 (3); BAF11 (3); BAF13; BAF14 (3)
Action date extended	19	BAF1 (3); BAF2 (2); BAF3 (3); BAF4; BAF5; BAF7 (2); BAF8 (2); BAF9; BAF10; BAF13 (2); BAF14 (2)
New action	3	BAF2; BAF7; BAF14
Action changed	1	BAF10

Table 1: Amends to BAF in Q3

11. Following a request from the PAF Chair, the Corporate Governance & Risk Team is exploring how to highlight within the 4Risk report any changes made to the BAF in the quarter. This is a system issue and is being taken up with the system suppliers.

15+ Operational Risks Review

12. The Board was advised at its November 2021 meeting of the outcomes of a review into the high scoring risks (15+) by the Divisions and Corporate areas in accordance with the Trust's approved risk scoring guidance to ensure the scores were not only correct but applied consistently.

13. Since then, 8 additional 15+ risks have been added to the Risk Register and 1 has been reduced below 15, following approval by the relevant Executive Director, in line with the agreed approval process. There are, therefore, now 31 15+ risks that align to the BAF risks and these are highlighted in the Integrated Risk Dashboards (Appendix 3). These demonstrate the current risk exposure outside of appetite.

Recommendations

14. To agree the current status of strategic risks and advise of any changes; to note the associated operational risk profiles.

Author: Chris McKeown, Corporate Risk & Assurance Manager
Date: 19 January 2021

Addendum: notes relating to Appendix 1 – 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**

Table 2: Risk Prioritisation Matrix

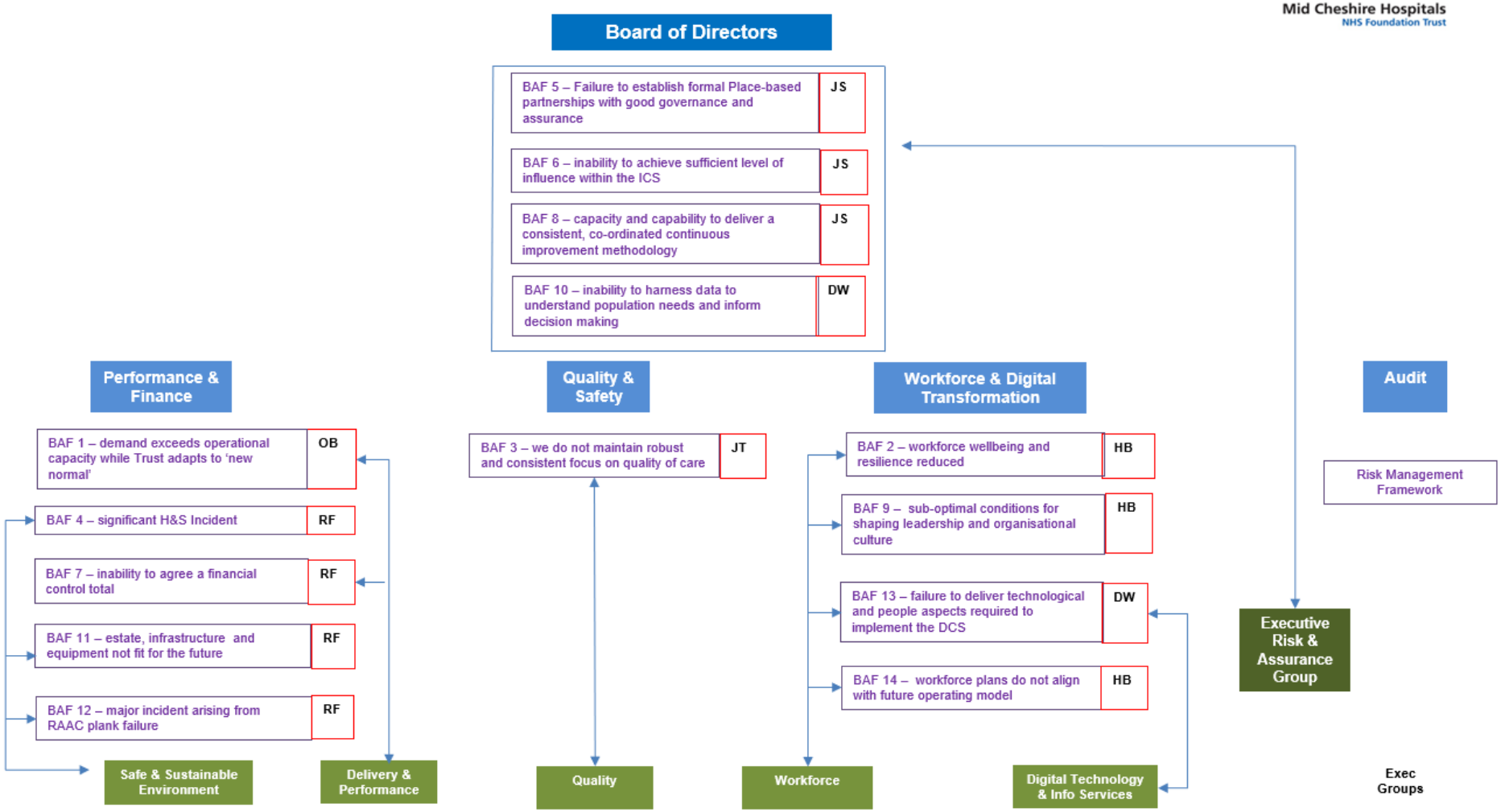
4. To ensure accuracy and consistency in risk scoring across the Trust, all risks should be scored against the risk impact and likelihood guidance included in the Risk Management Process Guide.

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**

Appendix 2: BAF risks alignment to Board Committees

Governance Structure – Strategic Risks Mapping



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	**15 (3x5)**
CORP4	Unable to deliver key cancer standards	**16 (4x4)**
CORP5	Waiting list size & long-waiters	**16 (4x4)**
CORP6	Diagnostic capacity to meet demand	**16 (4x4)**
CORP7	Unable to deliver urgent and emergency care in line with national standards	**20 (4x5)**
CORP9	Operational Flow	**20 (4x5)**
CORP10	Insufficient bed capacity	**15 (3x5)**
CORP13	Waiting list management	**16 (4x4)**

Risk Reference	Title	Risk Score (IxL)
DG2	Histopathology Turnaround Times Provided	**20 (5x4)**
DGCH2	Unreliable Clinical Haematology Service	**15 (5x3)**
ECED6	ED capacity and delivery of core standards	**16 (4x4)**
SC16	Capacity Challenges in Division of Surgery	**16 (4x4)**
WCHCT3	Paediatric Diabetes Service Provision	**16 (4x4)**
WCGY3	Deterioration of Gynaecology elective services as a result of Covid-19	**15 (5x3)**
WCGY4	Lack of Gynaecology oncology fail safe	**15 (5x3)**
WCMA17	Capacity of the fetal medicine unit	**15 (5x3)**

Risk and controls commentary

- The controls in place for **BAF1** aim to monitor the improvement plans developed as part of the restoration of services. These plans address backlogs in services, patient flow and surges and recruitment of staff.
  - A number of high priority operational risks (16) are linked to this BAF and are associated with demand and capacity risks that could impact safe care. These risks are monitored monthly at the Executive Delivery & Performance Group.
- The actions included on the BAF are designed to address the operational capacity issues that are influencing the increased demand through approving updated restoration plans, reviewing contractual processes, agreeing priorities around health inequalities and having an agreed workforce planning structure.

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 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 workforce resilience and controls and actions are in place related to the Workforce Matters Strategy and Health & Wellbeing Plan.
- The strategies and processes in place to monitor the quality of Trust services the controls within **BAF3** and identify how patients are receiving the best quality care.
  - There are currently 9 high priority operational risks related to BAF3
- Within BAF3 actions that provide further assurance of the quality of services have been identified.
- **BAF4** has controls in place to provide acceptable assurance of H&S management. Further Divisional engagement and action plans following the Trust Stress Survey will provide further assurance of the risk controls effectiveness.

Ref	High scoring operational risks (15+)	Risk score (IxL)
CORP8	Unable to plan effectively for workforce changes and requirements	**16 (4x4)**
CPCN5	Capacity issues within Community Nursing for complex patients	**15 (5x3)**
EC9	Shortages of medical staff in medicine	**15 (5x3)**
EC13	Staffing levels across DMEC	**20 (5x4)**
ECDI1	Web Based Monitoring of Blood Glucose	**16 (4x4)**
EDED11	The emergency department corridor	**15 (5x3)**
ECGA4	Lack of Out of Hours Upper GI Bleed Rota / Service	**15 (5x3)**
ECRE4	Delays in providing respiratory treatment	**16 (4x4)**
SCOR4	Ward 10 Escalation Beds	**16 (4x4)**
QUPS15	Quality Governance Team Staffing	**16 (4x4)**
HS4	Regulatory Compliance with the Regulatory Reform (Fire Safety) Order 2005	**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 controls have been agreed and assessed so that they have been managed supporting Trust strategy. Further actions have been developed to ensure future financial control can be achieved through submission of finance proposals, benchmarking and training for senior staff.

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)**

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. Assurance of the controls' effectiveness has been identified for two of the controls and work is ongoing to evidence the assurance level of the other controls. Actions have been developed to ensure that continual quality improvement methodology can used to develop the processes that are delivered at the Trust.
- **BAF9** relates to risks on shaping leadership and organisational culture. A number of actions have been completed that provide further assurance of the controls' effectiveness. Additional actions are still being implemented to ensure that evidence is available that current controls are mitigating the risk.
- The Data Warehouse implementation plan, that will support decision-making to help address healthcare outcomes and inequalities is a control within **BAF10**. The current actions planned will support implementation of the Data Warehouse.

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	**15 (5x3)**
ES56	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 acceptable assurance has been identified for each of the controls is in place. Actions have been implemented to support the continual development of the site's infrastructure.
- 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 system to provide an electronic patient record is implemented. The outstanding actions identified are associated with further work required that will ensure Trust readiness for the system.
- Within **BAF14** the current controls for recruitment and development are providing acceptable assurances that the controls are managing the risk. Other actions identified will provide further assurance that the controls are effective.

Annex 1 - Board Assurance Framework (BAF) as at 20 January 2022

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	Risk Control	Control Assurance (Internal Assurance)	Internal Assurance Assurance Level	Control Assurance (External Assurance)	External Assurance Assurance Level	Current Risk Score	Action Required	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:** 19 Jan 2022 **Latest Review Date:** 18 Jan 2022 **Latest Review By:** Oliver Bennett **Last Review Comments:** Actions updated and controls reviewed.	**Cause(s)** 1. Changing patterns of demand 2. Workforce gaps 3. Covid alters the operating environment indefinitely 4. Waiting list backlogs 5. Capacity and ability to restore pre-covid levels 5. Population health needs change due to long-term effects of Covid **Consequence(s)** 1. Ineffective restoration and recovery 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. Monthly UEC Performance to PAF Highlight report included within COO report on NHS111 implementation to PAF Jan 2021 following soft launch Nov 2020.	Partial			I = 4 L = 5 20	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:** 28 Jan 2022	**18 Jan 2022** **Jenny Grant** Presented to EDPG in January 2022. Review and lessons learnt to take place in Jan 2022 to support a revised framework for 2022-23 **08 Dec 2021** **Jenny Grant** Aggregated workforce plans completed. This is included for presentation on the EDPG agenda for January 2022	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		Agree priorities around the health inequalities agenda **Action Owner:** Oliver Bennett **Target Implementation Date:** 31 Jan 2022		
				03.Elective care improvement plan and maximising existing core capacity. **Control Owner:** Andrew Williams	Plan updates taken to EDPG monthly Restoration Planning (Elective Care) Chair's report taken to Nov PAF.	Partial						
				04. Diagnostic services improvement plan, mobile CT/MRI capacity, and outsourcing to the independent sector. **Control Owner:** Emma Colgan	Monthly Integrated Performance Report provides performance data as a evidence of progress against plan to EDPG	Acceptable						
				05. Outpatient transformation plan and maximising existing core capacity. **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 EDPG which is referenced in Chair's report to PAF.	Acceptable						
				07. Seasonal Surge / Winter plan. **Control Owner:** Mark Wilde	Covid Review including lessons learned submitted to BoD May/June 2021. Winter Plan went to Nov PAF Seasonal Surge / 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.	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
				08. Domestic and international recruitment programme. **Control Owner:** Jenny Grant	International Recruitment of Medical Staff Report to December WDT Committee	Partial						
				09. Limited Liability Partnerships and other out/in sourcing arrangements to provide additional elective capacity. **Control Owner:** Mark Wilde	Governance process in place for each contract along with contract management meetings. Managed via Operational Finance Meeting who report to EDPG.	Low						
				10. Establishment of a programme of work and group to look at ways of keeping patients informed and safe whilst on a waiting list. **Control Owner:** Andrew Williams	Restoration Planning Group provided verbal update to Dec EDPG	Low						

Board Assurance Framework (BAF)

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	Risk Control	Control Assurance (Internal Assurance)	Internal Assurance Assurance Level	Control Assurance (External Assurance)	External Assurance Assurance Level	Current Risk Score	Action Required	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:** 22 Dec 2021 **Latest Review Date:** 22 Dec 2021 **Latest Review By:** Chris McKeown **Last Review Comments:** Risk Reviewed with Director of Workforce & OD. Actions closed for the new sickness absence target trajectories and for review of appraisals. Control assurance for Metric Reporting updated following these being completed. Additional actions extended due to system delays and a new action to review OH provision included.	**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. 10. Prolonged opening of additional beds **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. Workforce Strategic Plan **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	Carry out a full risk assessment of Occupational Health Provision **Action Owner:** Jenny Grant **Target Implementation Date:** 31 Jan 2022	**18 Jan 2022** **Jenny Grant** Full OH risk assessment completed. Included on agenda for EWAG in February 2022	I = 4 L = 3 12
				02. People Recovery Plan **Control Owner:** Jenny Grant	People Recovery Plan submitted to WDT June 2021	Partial				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:** 28 Feb 2022	**22 Dec 2021** **Chris McKeown** Cheshire Wellbeing Collaborative Project paused until Jan / Feb 22 **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.	
				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 Mar 2022	**22 Dec 2021** **Chris McKeown** Completion date extended to March 22 due to unforeseen leadership issues that arose within the Occupational Health Department **29 Oct 2021** **Heather Barnett** Target date extended due to review being carried out currently by new Head of OH	
				04. Measures put in place to support BAME staff during Covid **Control Owner:** Bobby Sharma	ED&I Programme and National Priorities submitted to WDT June 2021. Appraisal data by ethnic group to go to WDT July 21.	Acceptable	Detailed response submitted to NHSE/I in June 2020 re Trust compliance with risk assessments for at risk staff groups. Board advised of compliance.	Acceptable				
				05. Occupational Health provision **Control Owner:** Bobby Sharma	Monthly Workforce Supply Group Chairs report to Executive Workforce Assurance Group including Occupational Health escalations when required.	Acceptable						
				06. National and Regional H&WB offers **Control Owner:** Bobby Sharma	Offers come from NHSI/E and are managed via the Health & Wellbeing Group	Acceptable						
				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 New Divisional targets agreed at WDT Dec 21 for sickness absence and to be in IPR from February 22	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. Reported to EWAG in October and approved - escalated in Chair's report to WDT.	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 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:** 20 Jan 2022 **Latest Review Date:** 13 Jan 2022 **Latest Review By:** Chris McKeown **Last Review Comments:** Reviewed by Director of Nursing and no changes to the risk identified.	**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:** Clare Hammell **Target Implementation Date:** 31 Jan 2022	**23 Dec 2021** **Chris McKeown** Approval of the SOP is scheduled for Jan TIG and EQGG. The NICE process that is in the SOP is already in place and embedded however. **13 Oct 2021** **Chris McKeown** SOP to be approved at October TIG and then taken to November EQGG.	I = 3 L = 2 6
				02. Infection Prevention & Control Policy **Control Owner:** Julie Tunney	IPC BAF After Action Review May 2021. Submitted to QSC June 21. IPC BAF went to Dec 21 QSC with Partial Assurance	Partial				Culture survey to be completed for maternity services **Action Owner:** Jenny Butters **Target Implementation Date:** 31 Mar 2022	**21 Dec 2021** **Chris McKeown** Survey completed by an external organisation who have advised results wont be available until 2022/23 financial year.	
				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 Mar 2022	**19 Jan 2022** **Chris McKeown** The target date has moved to March as the final paper is still in progress.	
				04. Reducing Harm Policies **Control Owner:** Murray Luckas	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						
				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. Quarterly GIRFT to EQGG & QSC, identifying compliance. Reports to TIG following GIRFT visits and reports.	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:** 07 Jan 2022 **Latest Review Date:** 07 Jan 2022 **Latest Review By:** Russell Favager **Last Review Comments:** Actions on stress survey implemented. Risk score reviewed but given current organisational operational pressures risk score remains the same	**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	**Action Owner:** **Target Implementation Date:**		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						

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:** 19 Jan 2022 **Latest Review Date:** 19 Jan 2022 **Latest Review By:** Chris McKeown **Last Review Comments:** The actions for work on the Head of Terms is ongoing and the aim is for a draft to go to DCS Transformation Board in March 22 so the target date has been changed to reflect this. The Dermatology risk sharing action has been completed following a contract variation letter being agreed.	**Cause(s)** 1. Organisational politics 2. Senior capacity and relevant experience 3. New governance models required, including risk management 4. Development of Provider Collaborative and lack of shared goals and plans 5. Lack of single data sources across the system 6. Lack of accountability 7. Ineffective communication between partners **Consequence(s)** 1. Inequality of service provision 2. Disjointed care pathways 3. Poor patient experience 4. Failure to realise efficiencies 5. Failure to innovate 6. Reduced CQC rating 7. Reputational damage	I = 4 L = 4 16	01. CEICP governance and MOU in place with approval by all member organisations Boards. **Control Owner:** James Sumner			Monthly report to the Board of Directors from the Chair/Director of the ICP	Acceptable	I = 4 L = 3 12	Digital Clinical System Programme Director / Dir of Corporate Affairs at ECT and Company Secretary to discuss draft Terms re: DCS at October meeting **Action Owner:** Caroline Keating **Target Implementation Date:** 31 Mar 2022	**19 Jan 2022** **Chris McKeown** Work on the Head of Terms is ongoing and the aim is for a draft to go to DCS Transformation Board in March 22	I = 4 L = 2 8
				02. Adoption of MCHFT strategy as basis the CE PLACE strategy **Control Owner:** James Sumner	CEO supporting adoption of new strategy in CE PLACE	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						
				04. CEO and NED members of CE Place Partnership Governance **Control Owner:** James Sumner	CEO and NED part of PLACE governance. Updates to Board through Chief Executive's report to the BoD monthly	Acceptable						
				05. CEO member of both East and West PLACE governance **Control Owner:** James Sumner	CEO on both partnership boards and executive groups in Cheshire East and West PLACEs							
				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:** 18 Jan 2022 **Latest Review Date:** 18 Jan 2022 **Latest Review By:** Caroline Keating **Last Review Comments:** Stakeholder Engagement Plan completed; work in progress with Executive Directors to refine engagement details	**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	**Action Owner:** **Target Implementation Date:**		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				
				03. Membership of and engagement in emerging Provider Collaboratives in C&M **Control Owner:** James Sumner	CEO is member of CMASH provider collaborative and Dir of Partnerships is member of Community focused provider collaborative							
				04. CEO central to PLACE developments in East and West PLACEs, influencing development of PLACE and ICS relationship **Control Owner:** James Sumner	CEO member of PLACE groups that are determining governance arrangements with ICS							

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 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:** 09 Dec 2021 **Latest Review Date:** 09 Dec 2021 **Latest Review By:** Russell Favager **Last Review Comments:** No change to risk score, benchmarking and training actions are iterative processes and impacted by covid in terms of staff availability and information availability	**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	Final H2 financial plan presented to Board and submitted to NHSE/I on 25th November with deficit of £7.9m, however there is an assumed C&M system re-allocation of system income of £7.9m per HCP letter of 18th November to produce a balanced H2 financial plan. Concern remains around process, timescales and transparency of the Trust receiving this 'Other Income' of £7.9m without which the Trust will be in a deficit position. System discussions continue to resolve this uncertainty **Action Owner:** Russell Favager **Target Implementation Date:** 31 Jan 2022	**25 Nov 2021** **Russell Favager** See presentation to Board 25/11/21 and letter from HCP	I = 2 L = 3 6
				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						
				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				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 Mar 2022	**09 Dec 2021** **Russell Favager** This action is an ongoing iterative process so the target date will constantly be moving **08 Dec 2021** **Ros Davies** Corporate benchmarking data, and the national cost collection have been presented to the operational finance group prior to submission, and when the national submissions for these collections are available, they will be shared with the group (not expected until Q4 21/22). An overview of the financial structure of the organisation using historic benchmarking metrics has also been presented to the operational finance group.	
				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				
				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				Training to be rolled out within divisional/corporate teams during H1 **Action Owner:** Ros Davies **Target Implementation Date:** 31 Mar 2022	**08 Dec 2021** **Ros Davies** Training has been commenced for corporate areas, and also Trust governors. For Divisional areas, this will be rolled out during Q4.	

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
										SFIs revisions for 2022/23 proposed by Q4 **Action Owner:** Duncan Goff **Target Implementation Date:** 31 Mar 2022		
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:** 06 Jan 2022 **Latest Review Date:** 05 Jan 2022 **Latest Review By:** Chris McKeown **Last Review Comments:** Controls have been updated where evidence of assurance is available. Evidence is still in the process of being developed to identify the assurance for the other controls. Actions have been extended due to further work being identified before these can be completed.	**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 November 21	Acceptable			I = 3 L = 4 12	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	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:** 28 Feb 2022	**05 Jan 2022** **Chris McKeown** Scoping work is underway and further work is required to be undertaken in relation to the improvement model.	
				03. Scope of knowledge management determined **Control Owner:** Clare Hammell	Scope to be presented to QI Strategy Group and taken to Board October 21.	Partial				Communications & Engagement Plan for QI to be developed **Action Owner:** Clare Hammell **Target Implementation Date:** 28 Feb 2022	**05 Jan 2022** **Chris McKeown** Date extended to Feb 22 following a session on Board Development Day.	
				04. Capability building plan developed for a 3 year period. **Control Owner:** Clare Hammell	Capability building plan has begun and is on track with QI training embedded into leadership development (positive feedback evidenced around people feeling that their skills had developed in relation to this), Board Development Programme Day 1 delivered and first improvement practitioner cohort delivered.							

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:** 23 Dec 2021 **Latest Review Date:** 23 Dec 2021 **Latest Review By:** Chris McKeown **Last Review Comments:** Reviewed with Director of Workforce & OD and actions for developing talent pathways, talent board reviews and reviewing appointment practices closed and action plans and monitoring included in controls.	**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 the national WRES model employer goals **Action Owner:** Ian Howarth **Target Implementation Date:** 31 Mar 2022		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				Set up BAME Advisory Panel **Action Owner:** Ian Howarth **Target Implementation Date:** 31 Mar 2022	**22 Dec 2021** **Chris McKeown** Action delayed to March 22 due to further establishment of staff networks in progress. **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.	
				03. Coaching & mentoring scheme **Control Owner:** Amy Oakes	Education, Learning and OD Report to EWAG quarterly	Acceptable						
				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 December via the Chairs report. Talent Board reviews for 2021 completed.	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						
				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 November 21	Partial						
				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 Review of recruitment practices undertaken and action plan in progress (monitored by ED&I committee) to establish diverse stakeholder panels for senior appointments	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
				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						
				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						
				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						
				14. Shadow Board Programme **Control Owner:** Amy Oakes	Learning & Organisation Development report to EWAG and report provided to Trust Board Report submitted to WDT in November	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 received in October 2021.	Acceptable				
				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						
				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						

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:** 19 Jan 2022 **Latest Review Date:** 19 Nov 2021 **Latest Review By:** Chris McKeown **Last Review Comments:** Review of Divisional Dashboards underway. Controls and actions updated and re-worded. Risk scoring remains the same.	**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	Digital Enabling Strategy to support the Trust's new Service Strategy in development. **Action Owner:** Dylan Williams **Target Implementation Date:** 31 Mar 2022	**19 Nov 2021** **Chris McKeown** Baseline and evidence gathering is currently in progress **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. Monitored workplan to deliver the PA Consulting Actions **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				Influence and engage in the Cheshire and Merseyside Population Health solution. **Action Owner:** Dylan Williams **Target Implementation Date:** 30 Apr 2022		
										Interoperability Manager to be appointed **Action Owner:** Angela Wood **Target Implementation Date:** 31 May 2022	**19 Jan 2022** **Dylan Williams** Appointment process delayed pending wider workforce review and . **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	

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:** 07 Jan 2022 **Latest Review Date:** 07 Jan 2022 **Latest Review By:** Russell Favager **Last Review Comments:** Risk scores reviewed, given current uncertainty around future Capital allocations which would mitigate some of the risk risk score remains the same	**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	Revised Digital Strategic Plan to be developed **Action Owner:** Dylan Williams **Target Implementation Date:** 31 Mar 2022	**07 Dec 2021** **Dylan Williams** New Digital Strategic Plan to be developed by March 2022. **15 Sep 2021** **Russell Favager** Awaiting new CIO to start to develop Strategy and therefore target date moved to the end of November 2021	I = 5 L = 2 10
				02. Capital Programme expenditure focused on risk reduction & functional improvements. **Control Owner:** Andrew Deakin	Capital Exceptions report to IDG and Divisional Board (Cost and programme). Capital Infrastructure Group provides a monthly report to ESSEG and PAF.	Acceptable						
				03. Six Facet Estate Survey database regularly updated (20% per annum). **Control Owner:** Craig Reid	Self audits against NHS sustainability audit tool (every six months). Audits taken to ESSEG from July 21.	Acceptable						
				04. Critical Infrastructure Review completed in 2020 & action plan being implemented **Control Owner:** Craig Reid	Action Plan implemented and submitted to ESSEG May 2021.	Acceptable						
				05. Hospital redevelopment SOC **Control Owner:** Russell Favager	Monthly programme updates to Board via Chair's assurance report / CEO report. Highlight reports to BoD as required	Acceptable						
				06. Medical Devices, H&S, & Space Utilisation Groups within Governance Structure **Control Owner:** Russell Favager	Updates on action plan following Internal Audit report submitted to Audit Committee January 2021. Monthly Estates report to ESSEG.	Acceptable						
				07. Capital Programme 2021/22 **Control Owner:** Russell Favager	submitted to PAF April 2021	Acceptable						
				08. Digital Strategy and Plan **Control Owner:** 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:** 22 Dec 2021 **Latest Review Date:** 07 Jan 2022 **Latest Review By:** Russell Favager **Last Review Comments:** Risk scores reviewed. Given uncertainty around future Capital allocations, which would further mitigate the risk, risk score remains unchanged	**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	**22 Oct 2021** **Andrew Deakin** As previously reported - no change **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	
				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:** 19 Jan 2022 **Latest Review Date:** 19 Jan 2022 **Latest Review By:** Dylan Williams **Last Review Comments:** Additional fixed term CCIO support being in place has been set at October 2022 as per the DCS business case. No further changes required to risks.	**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 Mar 2022	**19 Jan 2022** **Chris McKeown** Work on the Head of Terms is ongoing and the aim is for a draft to go to DCS Transformation Board in March 22 **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. Programme Assurance Review has been provided and been reported through DCR updates at DTIS, WDT and Board	Acceptable		Increase in clinical time available for the Chief Clinical Information Officer to support the project. **Action Owner:** Dylan Williams **Target Implementation Date:** 31 Oct 2022	**19 Jan 2022** **Dylan Williams** October 2022 is a realistic date for fixed term support for CCIO being in place as per the DCS business case. **07 Dec 2021** **Dylan Williams** CCIO time commitment for DCS and clinical advisory group is sound but further clinical capacity will be required for the implementation and beyond DCS - final resources for DCS to be agreed in the FBC in January 2022.	
				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				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:** 19 Jan 2022 **Latest Review Date:** 22 Dec 2021 **Latest Review By:** Chris McKeown **Last Review Comments:** Reviewed with Director of Workforce & OD. Recruitment metrics and appraisals actions completed and relevant controls updated. Agile Working policy approved at JCNC, action can be closed when detail on how implementation of the policy will be monitored. Extensions to additional actions due to system delays.	**Cause(s)** 1. Poor horizon scanning and forecasting 2. Poor understanding of expectations of young people entering the workforce 3. Insufficient consideration of workforce in strategic planning 4. Misalignment of workforce planning, activity and finance 5. Lack of accurate and up-to-date workforce information and data 6. Lack of workforce planning capacity and capability 7. Poor communication between education providers **Consequence(s)** 1. Unsustainable services 2. Increased staff turnover 3. Widening vacancy gaps 4. Inability to plan capacity effectively 5. Reduced workforce morale 6. Poorer patient care and experience 7. Damage to reputation as an employer 8. Failure to improve CQC rating 9. Failure to deliver new models of care 10. Failure to adapt to new ways of working 11. Failure to embrace technological advancement in working practices	I = 4 L = 4 16	01. Our Workforce Matters Strategy **Control Owner:** Heather Barnett	Our Workforce Matters quarterly updates to Workforce & Digital Transformation. Medical staffing workforce metrics included in the Workforce Report reported via WDT to Board of Directors	Acceptable			I = 3 L = 4 12	Develop career pathways for Physician Associates **Action Owner:** Nicola Madeley **Target Implementation Date:** 31 Jan 2022	**22 Dec 2021** **Chris McKeown** Action is In Progress and completion date extended to end of Jan 22.	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				Implement actions from the UEC programme to close medical workforce gaps within the UEC pathway **Action Owner:** Jenny Grant **Target Implementation Date:** 31 Jan 2022	**18 Jan 2022** **Jenny Grant** Action plans developed and approved at UEC Programme meeting Metrics agreed for monitoring progress and action delivery	
				03. Workforce Systems Project **Control Owner:** Paul Cooper	Quarterly progress report to EWAG and 6 monthly to WDT.	Acceptable				Implementation of an e-roster system for medical staff **Action Owner:** Jaz Mallan **Target Implementation Date:** 31 Mar 2022	**22 Dec 2021** **Chris McKeown** Action delayed pending approval and selection of e-rostering system **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.	
				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						
				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. Analysis of recruitment metrics from new recruitment trac.jobs system completed in Nov 21.	Acceptable	MIAA Audit tool (covers all elements of workforce for dealing with COVID) results reported to EWAG and WDT	Acceptable				
				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 to be submitted to WDT December 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				

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
				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. Motiv8 reviewed and aligned with H&WB career conversations. Appraisals review taken to WDT in Dec 21	Partial						
				12. Cheshire and Merseyside Workforce plan at ICS level **Control Owner:** Heather Barnett			Approved by Cheshire & Merseyside People Board	Acceptable				

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**10**	Date of Meeting: 27/01/2022
Report Title	**Board Committee Assurance Report**	
Executive Lead	Caroline Keating, Company Secretary	
Lead Officer	Click here to enter text	
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)*

- Board Committees stood down in January due to operational pressures, with exception of Audit Committee
- Items submitted direct to Board, due to suspension of delegated duties to Committee, identified
- Summary of information due to have been submitted to Board Committees in January identified (Appendix I)
- Full Chairs' Reports from Executive Groups included (Appendix 2)

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 ☐

Mid Cheshire Hospitals NHS FT

REPORT DEVELOPMENT

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

Board Committee Assurance Report

Introduction

1. Due to the significant operational pressures arising from the COVID Omicron variant, a decision was taken by the Chair and Chief Executive on 11 January 2022 to step down Board Committee meetings in January 2022. Effectively, this equated to a suspension in Board delegation to its Committees in January 2022 for one month only although this would be kept under review.

2. This decision applied to the meetings of Workforce & Digital Transformation (WDT), Quality & Safety (Q&S) and Performance & Finance (PAF) Committees. The exception to the above was the Audit Committee as papers had already been circulated for its meeting on 14 January 2022.

3. This decision was in line with guidance received from NHS England/Improvement in December 2021[1]

Implications for Board

4. Corporate Governance has reviewed the agendas of the relevant Committees and agreed with the Executive Leads and NED Committee Chairs those items which should be submitted direct to the January meeting of the Board and those items which can be deferred to the Committee meetings in February. In addition, information that would normally be provided to the Board Committees through the Executive Group Chair's Summary Reports have been collated into a Board Committee Assurance Report to provide oversight to the Board. The key messages have been mapped to the items in the December (NED) Chair Assurance Reports to ensure that the Board can triangulate the information with the quarterly report on the Board Assurance Framework and the Integrated Performance Report.

5. Items that would normally be on the Board agenda supported by assurance from Board Committee scrutiny (e.g. Board Assurance Framework Report; Integrated Performance Report) are retained.

6. The Board agenda for January has been revised accordingly.

Conclusion

7. The report provides assurance that the process for managing a suspension in delegated duties to Board Committees has been implemented robustly. Reports that would have been scrutinised by the relevant Board Committee are submitted direct to the Board for consideration or summary information, including any assurance that might have been proposed to the Board Committee, provided in the table in Appendix I, thereby enabling the Board to have an overview.

[1] C1518 Reducing the burden of reporting and releasing capacity to manage the COVID-19 pandemic: NHSEI 24 December 2021

8. The full Chairs' reports from the Executive Groups are included at Appendix 2 for information.

Recommendation

9. The Board is asked to note the report.

Author: **Caroline Keating, Company Secretary**
Date: **17 January 2022**

Appendix I

	Item (January)	Summary Detail	Proposed Assurance Level	January Board Agenda Item
Quality & Safety Committee				
1.	**Executive Quality Governance Group (EQGG) Chair's Summary Report (January 2022) – Key Messages**	• Despite operational pressures, all Quality and Safety metrics within control limits • Ward accreditation continues • Reduction in QUPS13 –(deteriorating Patient) to 10		
2.	**BAF Q3 2021/22**			✔
	Integrated Performance Report (December 2021)			✔
3.	**Serious Incidents**			✔
4	**Learning from Deaths**			✔
5.	**Get It Right First Time (GIRFT)**	*Included in Report History*	**Acceptable**	✔
Performance & Finance Committee				
1.	**Executive Development & Performance Group (EDPG) Chair's Summary Report (January 2022) – Key Messages**	• Long waits (circa. >1 year) for new patient appointment down from nearly 500 to around 200; remains a key focus. • >52-week waiters increasing due to operational pressures, and likely to have a small number of >104-week waiters at the end of March. • UEC pressures rising due to demand and growing Covid numbers and nearly all services are under significant pressure; resulting in 12-hour DTA breaches (47 in December; likely to exceed this in January). Well over 100 covid patients and likely to grow significantly.		

	Item (January)	Summary Detail	Proposed Assurance Level	January Board Agenda Item
		• As a result of a significant increase in breast 2WW referrals the rapid access cancer standard was not delivered in December; predicted to be recovered in January. Cancer 63-day backlog has grown but in line with H2 trajectory. • Histology turnaround times remain a significant problem and impacting on cancer pathways. • December's financial position was £0.2m over plan. [Post-ERAG note – The Trust expects to receive £7.9m additional system funding to achieve breakeven at year end]. • New Private Patient Policy approved in response to the situation in ophthalmology. • Several SBARs and a business case were approved.		
2.	**Covid 19 Update**			✔ **CEO Report**
3.	**BAF Q3 2021/22**			✔
4.	**Integrated Performance Report (December 2021)**			✔
5.	**H2 Restoration Plan Update**			✔
6.	**Executive Safe & Sustainable Environment Group (ESSEG) – January 2022**	Meeting cancelled due to scheduling and operational issues		
7.	**Capital Plan**	*Deferred to PAF in February*		
8.	**Finance Report**			✔
9.	**Emerging Efficiency Schemes**	*Within the Integrated Performance Report*		

	Item (January)	Summary Detail	Proposed Assurance Level	January Board Agenda Item
Workforce & Digital Transformation Committee				
1.	**Matters Arising:** • **Vaccination as a Condition of Deployment** • **Flowers Legal Case Update**	*Flowers Update deferred to WDT February*		✔
2.	**BAF Q3 2021/22**			✔
3.	**Integrated Performance Report (December 2021)**			✔
4.	**Digital Technology & Information Services (DTIS) Executive Group Chair's Report (January 2022)**	• Key projects such as Ward Enablement to be paused pending availability of front-line staff for engagement and training. • PACS system direct award option was discussed and recommended that the service should ensure it adheres to agreed business case governance process • Global supply chain issues could jeopardise delivery of capital items, including the Unified Tech Funding, within this financial year and the team are reviewing options with suppliers and Finance colleagues. • Whilst there is good assurance with respect to recent planned cyber work the Log4j incident has created a significant amount of additional remedial work for the remainder of the year.		
5.	**Executive Workforce Assurance Group (EWAG) Chair's Report (January 2022) – Key Messages**	• Medical and Dental Training Analysis Dec 21: 61.95% compliance with training competencies within the medical and dental staff group against a target completion rate of 90%. Hot spot areas have been highlighted and will be		

	Item (January)	Summary Detail	Proposed Assurance Level	January Board Agenda Item
		discussed within Divisional People and Finance Sub-Groups. • Trust People Plan Priorities: Trust people planning process aligned to Workforce Strategic plan and priorities. Further work next year to further align to activity and financial planning. Also needs to link to medical job plans. • ESR Data Project: Full establishment control now in place for Estates & Facilities. Project remains on track to expand to other Divisions. Report to be shared with WDT as up-date on project progress • Annual leave in ESR: Annual leave project remains on track. All leave requests will be digitalised for the 2022/23 leave year, with the exception of medical teams because of the proposed e-roster plans later this year. • Workforce Supply Sub-Group: New risk identified relating to mandated covid vaccination. Focused attention on AHP workforce plans. Nursing vacancy numbers have increased due to increase in number of substantive RN posts to support additional escalation beds. Key themes identified from Divisional workforce plans.		
6.	**Gender Pay Gap**			✔
7.	**ESR Data Project Update**	*Deferred to WDT February*		
8.	**Medical Workforce Gap Update**	*Deferred to WDT February*		
9.	**Workforce & OD Strategic Plan Q3 2021/22**	Following approval of the Workforce Strategic Plan at Board in November 2021, a quarter 3 progress report provided evidence of progress towards the year one objectives outlined within it.		

	Item (January)	Summary Detail	Proposed Assurance Level	January Board Agenda Item
		• **Nurse Vacancy Gap:** continues to be closed with 18 international nurses commencing in post in Q3 and a further 23 international nurses due to commence in post in Q4. • **Supporting Medical Capacity**: Improvements include the roll out of the regional Doctors in Training bank and expanded use of framework agencies for long-term locum positions and in-sourcing. Work will commence in Q4 on the appointment to the CESR consultant training pathway approved as a business case in Q3 • **Workforce Planning**: the 2022-23 workforce planning round was concluded in the last quarter and supplemented by delivery of the Q3 divisional talent boards. Outcomes from divisional workforce planning have been aggregated for the Trust and strategic deliverables identified to be translated into actions for year 2 of the Workforce Strategic plan during Q4. • **Workforce Supply/Resilience**: on-going risks due to operational pressures. • **Workforce Strategic Plan Metrics:** under development but expected to be finalised during Q4 to allow a baseline position to be established at the end of year 1 in preparation for quarterly monitoring throughout years 2-5.		

Appendix 2

Executive Group (EQGG; EDPG; DTIS; EWAG) Chair Summary Reports

Executive Quality Governance Group
Chair's Report

Report To:	Executive Risk Assurance Group 11 January 2022
Date of Executive Group Meeting:	04/01/2022
Chair's Name and Title:	Julie Tunney Director of Nursing & Quality
Key Messages:	• Despite operational pressures, all Quality and Safety metrics within control limits • Ward accreditation continues. • Reduction in QUPS13 –(deteriorating Patient) to 10

New Operational Risks Identified

Summary	Risk Owner Assigned (Responsible for assessment on risk register)	Risk Assessment Due
Lack of SALT capacity in CCICP	Jo Bowen	January 2022
Lack of agreed pathway for feeding tube patients who have been discharged and then develop complications	Jo Bowen/NAG	January 2022

Risks Reviewed

Risk Ref	Risk Title	Current risk (CxL=Score)	Direction of travel	BAF Ref	EQGG Update/Decision
EC9	There is a risk of patients not being treated in a timely manner as a result of shortages of medical staff in DMEC that could lead to patients' conditions deteriorating	5x3=15 (Reduced from 5x4)	⇨	BAF3	Unchanged
EC13	IF safe staffing levels are not maintained across Medicine and Emergency Care, THEN patients may come to harm	4x4=16	⇨	BAF3	Block booking of Thornberry to be included as an action
ECED11	IF patients in the Emergency Department are cared for on the corridor, THEN patients may come to harm	5x3 = 15	⇨	BAF3	Unchanged

Risk Ref	Risk Title	Current risk (CxL=Score)	Direction of travel	BAF Ref	EQGG Update/Decision
QUPS13	There is a risk of failure to identify and or escalate for appropriate treatment patients whose clinical condition deteriorates leading to avoidable patient harm.	5x2=10 (Previously 5x3)	⇩	BAF3	Reduced risk – excellent work.
QUPS15	If the staffing shortages, skill mix and experience within the Quality Governance Team are not addressed then patient safety, effective Quality Governance and reputational damage may occur	4x4=16	⇨	BAF3	To include OD work on 'fit for the future team' to be included.
ECGA 4	IF there is not a 24/7 in house UGI Bleed service, THEN patients who do not meet the criteria to be transferred to UHNM may result in harm whilst waiting for the next available 'in hours' slot at MCHFT	5x3= 15	⇨		Update on MOC required
CPCN 5	There is a risk that CCICP will not be able to meet the increasing care needs of patients by the community nurses due to the increasing complexity of patients and a lack of capacity within the Care Communities across CCICP.	5x3 =15	⇨		unchanged
ECRE 4	If patients are delayed in receiving respiratory treatment this could result in significant deterioration	4x4 = 16	⇨		unchanged
ECDI 1	There is a risk of patient deterioration as a result of not having a live system for patient's monitoring blood glucose that could result in additional patient harm due to a diabetic medical emergency not being identified	4x4 = 16	⇨		unchanged
SCOR4	Risk of patient safety and quality compromised due to 6 additional escalation beds on ward 10 and no increase in ward establishment which could result in long term harm to a patient.	4x4=16		BAF3	unchanged

Reports/Documents Reviewed

Title	Outcome (incl. whether approved for onward reporting to Committee or Board)	BAF Ref	Assurance Level (if applicable) Low / Partial / Acceptable
Quality dashboard	• All monitored metrics within control limits **Including VTE risk assessment** •		Full

Trust Quality Group Chair's Report	• Only circa 40% of Thornberry shifts currently filled • Ward accreditation continues despite operational pressures. Seven wards accredited. • Sign of process for CQC action plans agreed – empower divisions to sign of with corporate oversight.		Full
Trust Patient Safety Group Chair's Report	• S&C deep dive good assurance about Divisional review of risks and RCA action plans – all in date • Clinical harm Reviews now requiring significant clinical time reducing capacity for front line activity. • Histology TATs a significant risk.		Full
Trust Safeguarding Group Chair's Report	• Bed Watch requirements diminished – to report back impact on HCA bank shift requirements • Child Protection Medical Report – despite operational pressures no delay in undertaking medicals or reduction in capacity. • Safeguarding 'Star of the month' Rhiannon Evans (ED)		Full
Trust Improvement Group Chair's Report	• Cancelled due to operational pressure		NA
Deteriorating Patient (NEWS2) Task and Finish Group Chair's Report	• Audit continues to demonstrate reliability of escalation • Training package in place • Group recommends reduction in risk to 5x2 – approved by EQGG • Integration of AKI and sepsis steering group agreed.		Full
Cancer Board	• Door to needle time training in place for neutropenic sepsis • All cancer delays due to TAT monitored via CI reporting and harm review – integrated with Clinical Governance Team. • Bowel screening pathology capacity identified at Shrewsbury & Telford. • 62 day pathway backlog in line with Trust trajectory.		Full
GIRFT quarterly review	• Urology, Lung Cancer and COVID mortality visits undertaken. • Process of governance for quality issues established. • Need to clarify process for operational issues.		Partial

Mid Cheshire Hospitals NHS FT

Executive Delivery and Performance Group
Chair's Report
January 2022

Report to	**Executive Risk and Assurance Group**
Date of Executive Group Meeting	**January 2022**
Chair's Name & Title	**Oliver Bennett, Chief Operating Officer**
Key Messages	• Long waits (circa. >1 year) for new patient appointment down from nearly 500 to around 200; remains a key focus. • >52-week waiters increasing due to operational pressures, and likely to have a small number of >104-week waiters at the end of March. • UEC pressures rising due to demand and growing Covid numbers and nearly all services are under significant pressure; resulting in 12-hour DTA breaches (circa. 46 in December; likely to exceed this in January). Well over 100 covid patients and likely to grow significantly. • As a result of a significant increase in breast 2WW referrals the rapid access cancer standard was not delivered in December; predicted to be recovered in January. Cancer 63-day backlog has grown but in line with H2 trajectory. • Histology turnaround times remain a significant problem and impacting on cancer pathways. • December's financial position was £0.2m over plan. [Post-ERAG note – The Trust expects to receive £7.9m additional system funding to achieve breakeven at year end]. • New Private Patient Policy approved in response to the situation in ophthalmology. • Several SBARs and a business case were approved.

EDPG review all Corporate risks and Operational risks scored >15 monthly to ensure controls are in place and assurance provided. The below are the corporate risks to bring to ERAGs attention:

BAF Ref	Risk Ref	Risk Title	Description	Update/Next Action	Due Date	Score
BAF 1	TW0039	Unable to deliver urgent and emergency care in line with national standards	IF there is insufficient capacity and or a failure to reduce demand on the Emergency Dept.	• Delivery of UEC improvement plan underway and making reasonable progress. • '7 Days, No Delay's fully planned and went live 3 November. Evaluation completed.		4x5=20

			THEN patients will not receive timely care which may result in harm and an unsatisfactory experience, and failure to deliver the 4-hour A&E access standard	• More capacity converted to support UEC and Covid demand • Plan identified for creating further capacity in January if required.		
BAF 1	CORP4	Cancer delivery	IF there is insufficient capacity and or clinical pathways are not sufficiently robust, including screening programmes to assess, diagnose and treat patients on a cancer pathway within the required timescales THEN it may lead to patient harm.	• Histology results remains a significant risk to cancer delivery (new significant risk identified), but some progress in reducing the backlog evidenced. • Cancer Improvement Plan making good progress with a focus on delivering FDS across all tumour groups. • Focus on bringing the current 62+ day backlog down following spike. • 2WW wait a problem but likely to be recovered by January		4x4=16
BAF 1	CORP8	Workforce issues	IF the Divisions do not develop effective and robust workforce plans to address current and future workforce requirements and skill mix including gilling current workforce gaps THEN patient may come to harm	• Divisional workforce planning process underway expected to be completed December/January 2022.	January 2022	4x5=20
BAF 1	CORP9	Suboptimal flow	IF there is sub-optimal flow through the organisation or the safe transfer between organisations THEN patients may not receive the right care.	• Part of the UEC improvement plan – LLOS review now occurring reliably, however, going to shift to focusing on Pathway 0. • New “Plan B” arthroplasty unit now open and admitting patients. Ward 9 now non-elective.	Ongoing	4x4=16
BAF1	Corp 13	Effective management of waiting lists	IF wating lists are not effectively managed, THEN patient care may be delayed and could result in harm	• Emerging evidence that waiting lists across the organisation are being inconsistency managed with significant variation. • Programme of work to be developed to review waiting list management processes aligned to a review of the Patient Access Policy • New patient Helpline gone ‘live’		4x4=16

Mid Cheshire Hospitals NHS FT

Reports/documents reviewed

Title	**Outcome** (include whether approved for onward reporting to Committee or Board)	**BAF ref?**	**Assurance level** (if applicable)
SBAR – clinical coding bench	approved		
SBAR – ED workforce requirements (new ED)	Approved (retrospective approval) – already agreed by Executive Directors		
SBAR – BMJ Advertising subscription	Approved		
SBAR – Access control improvement for mortuary	Approved		
SBAR – VIN clinical room booking	Approved		
SBAR – RTT validations posts	Approved – Executive Directors for approval		
SBAR – VIN opening times	Approved – Executive Directors for approval		
Business case – NHS Grad Training scheme	Approved – Executive Directors for approval		
Trust People Plan	Considered		
Divisional Management Board Assurance Reports	Considered		
Private Patient Policy	Approved – Executive Directors for information only		
Cost Improvement & Efficiency Plan/structure	Approved		

New corporate risks identified

Summary	**Risk owner assigned** (responsible for assessment on risk register)	**Risk assessment due**
None		

Brief overview of other issues discussed
No other issues discussed

Deferred items *(with rationale for deferral and when they are likely to be submitted)*
None

Mid Cheshire Hospitals NHS FT

DTIS Executive Group
Chair's Report
5 January 2022

Report to	ERAG
Date of Executive Group Meeting	5 January 2022
Chair's Name & Title	Dylan Williams – Chief Information Officer
Key Messages	• Key projects such as Ward Enablement to be paused pending availability of front line staff for enagagement and training. • PACS system direct award option was discussed and recommended that the service should ensure it adheres to agreed business case governance proces. • Global supply chain issues could jeapordise delivery of capital items, including the Unified Tech Funding, within this financial year and the team are reviewing options with suppliers and Finance colleages. • Whilst there is good assurance with respect to recent planned cyber work the Log4j incident has created a significant amount of additional remedial work for the remainder of the year.

Risks reviewed

No risks over 15 reported. However, the challenge of releasing front line staff for engagement, training and digital meetings is causing concern.

Reports/documents reviewed

Title	Outcome	BAF ref?	Assurance level
Digital Clinical System Update	Digital Clinical System update confirmed full business case nearing completion and all required central funding bids have been submitted.	13	
IT Services & IT Programmes Operational Group Chair's Report (November)	Concerns regarding attendance at meeting and front line staff release continues to be a concern.	10.13	

Cyber Security Operational Group Chair's report – December 2021	Log4j mitigation and continued impact was notes.	13	
Data Security and Protection Toolkit Review 21/22 Draft Terms of Reference	Noted	13	
Network Penetration Testing Scope	Noted	13	
DTISEG Capital Programme – December 2021	Noted	13	

New operational risks identified

ISPOG 56 – There is a risk that as service move away from MCHT systems can duplicate demographic data leading to clinicians not seeing the full patient record	13	

Brief overview of other issues discussed

- Pharmacy system went live on time but experiencing reporting issues. This highlighted the need for better engagement with corporate services on impact of introducing new front line clinical systems and their impact departments such as Finance and BIU.
- The main Leighton Wifi network rollout is complete with the exception of the Theatres building which is pending delayed equipment delivery due to the global supply chain problems.
- Breast screening project went live in October 2021 and the Trust now uses the East Cheshire Instance.

Deferred items *(with rationale for deferral and when they are likely to be submitted)*

- N/A

Mid Cheshire Hospitals NHS FT

Executive Workforce Assurance Group
Chair's Report
January 2022

Report to	Executive Risk Assurance Group 11 January 2022
Date of Executive Group Meeting	05.01.22
Chair's Name & Title	Heather Barnett, Director of People
Key Messages	• **Medical and Dental Training Analysis Dec 21:** There is a 61.95% compliance with training competencies within the medical and dental staff group against a target completion rate of 90%. Hot spot areas have been highlighted and will be discussed within Divisional People and Finance Sub-Groups. • **Trust People Plan Priorities:** Trust people planning process aligned to Workforce Strategic plan and priorities. Further work next year to further align to activity and financial planning. Also needs to link to medical job plans. • **ESR Data Project:** Full establishment control now in place for Estates & Facilities. Project remains on track to expand to other Divisions. Report to be shared with WDT as up-date on project progress • **Annual leave in ESR:** Annual leave project remains on track. All leave requests will be digitalised for the 2022/23 leave year, with the exception of medical teams because of the proposed e-roster plans later this year. • **Workforce Supply Sub-Group:** New risk identified relating to mandated covid vaccination. Focused attention on AHP workforce plans. Nursing vacancy numbers have increased due to increase in number of substantive RN posts to support additional escalation beds. Key themes identified from Divisional workforce plans.

New operational risks identified:

Summary	**Risk owner assigned** (responsible for assessment on risk register)	**Risk assessment due**
There is a risk that the Trust will experience significant workforce shortages due to our staff choosing not to become fully vaccinated against covid 19 by 1st April 2022 resulting in a detriment to patient care, safety and experience: 3 x 3=9	Jenny Grant	31.01.22
Significant service and leadership challenges within Occupational Health resulting in increasing waiting lists and risk to increased absence and delay in appointment to posts. Draft risk assessment out for review to be agreed at Feb EWAG.	Jenny Grant	31.01.22

Risks reviewed: No risks over 15 to review.

Risk ref	BAF ref	Risk title	Update / decision	Next action	Due date	Current risk (CxL = score)

Reports/documents reviewed

Title	**Outcome** (incl whether approved for onward reporting to Committee or Board)	BAF ref	**Assurance level** (if applicable)
Workforce Metrics Report for EWAG	Metrics noted and key points of change discussed. Additional funded registered nursing posts for escalation beds highlighted as the reason for increased vacancies in RN posts.	2, 9, 14	Partial
Corporate Services Deep Dive in Workforce performance metrics	Sickness remains within target, although short term stress anxiety and depression is the highest sickness cause. Turnover has risen to over 11% for reasons of people leaving the Trust for promotion. MT remains positive at 90% compliance. Appraisal compliance remains a challenge and will be addressed as part of the wider Motiv8 performance improvement plan. Concern raised relating to corporate team burn out, and potential lack of internal career progression opportunities identified / lack of Motiv8 conversations.	2, 9, 14	Partial
Medical and Dental Training Analysis – Dec 21	There is a 61.95% compliance with training competencies within the medical and dental staff group against a target completion rate of 90%. Hot spot areas have been highlighted and will be discussed within Divisional People and Finance Sub-Groups.	3, 4, 9	Partial
Employee Relations Quarter 3 Performance Report	Case numbers have declined slightly in Q3, with most formal cases relating to sickness management. Generally, disciplinary and grievances cases appear to be fewer however more complex	2	Acceptable
WOD risks 15 and above report	Following mitigation and actions to manage all risks scored 15 and above, all risks have been reduced to below 15		N/A
Trust People Plan Priorities	Trust people planning process aligned to Workforce Strategic plan and priorities. Further work next year to align to activity and financial planning. Needs to link to job plans too.	9, 14	Acceptable

The Future of NHS HR and OD	Document discussed. Need to ensure outcomes are aligned to the Trust's Workforce Strategic Plan and actions outlined for 2022 are embedded within sub group work plans.		N/A
Health and Wellbeing Group Chair's Report	Onsite gym proposal options being progressed for ESSG review. 12-month extension given to Health Assured contract for continued counselling provision from April 22.	2	Acceptable
Trust People Recovery Plan	MIAA audit scheduled to report back at the end of January. Report back findings and recommendations to EWAG in March 22	2	Acceptable
Gender Pay Gap Report	To be submitted to WDT for comment / note and then on to Board by March 22	9	Acceptable
ESR Data Project	Fulll establishment control now in place for Estates & Facilities. Project remains on track to expand to other Divisions. Report to be shared with WDT as up-date on project progress	9, 14	Acceptable
Annual Leave in ESR	Annual leave project remains on track. All leave requests will be digitalised for the 2022/23 leave year, except for medical teams as a result of the proposed e-roster plans for later this year.	9, 14	Acceptable
Workforce Supply Group Chair's Report	New risk identified relating to mandated covid vaccination (see above). Focused attention on AHP workforce plans. Nursing vacancy numbers have increased due to increase in number of substantive RN posts to support additional escalation beds. Key themes identified from Divisional workforce plans.	2, 9, 14	Acceptable
Sustainable Development Group Chair's Report	Environmental and Social Responsibility Plan approved at Board in Nov 21; successful application of the Social Value Award; good cross sector / organisaitonl working on the sustainability agenda.	9, 10, 11, 14	Acceptable

Brief overview of other issues discussed - None

Deferred items – EDS2, ED&I Chairs report, Annual retention report, International Nurse Retention

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**11**	Date of Meeting: 27/01/2022
Report Title	**Trust Strategy – Progress Report Q3 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)*

- Schedule for development of enabling strategic plans on track with Workforce Strategic Plan approved by Board in November 2021
- Some delay in delivery of capabilities and system work during latest Covid wave but recoverable during the next quarter

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

- Development of remaining enabling strategic plans on track for submission to Board in March 2022

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
Q3 (October to December 2021)

Introduction

1. The Trust Strategy was launched in October supported by a series of promotional activities, led by the Chief Executive. Feedback to date from both external and internal stakeholders has been positive.

2. It has been a challenging period but we have moved things forward, albeit at a slower pace.

3. Work started in Q3 on assessing the current controls and actions on the Board Assurance Framework so that robust assurance on the delivery of the Trust Strategy can be presented to the Board. This work will be finalised during Q4 and aligns with the focus of the Cheshire East PLACE Governance Group on delegated authority into the future governance model. This will be discussed with the Board in due course.

Position Update – Progress and Challenges

National/regional developments

4. Changes to legislation to establish Integrated Care System have been deferred from April to July 2022. In Cheshire & Merseyside (C&M), the aim is to set up arrangements in shadow form from April 2022 and work is continuing to achieve this.

5. Graham Urwin has been appointed Chief Officer of the C&M ICS with the recruitment process for the Chair continuing. Appointments to the Medical Director and Finance Director posts have been made but as yet unannounced. The process for appointing Non-Executive and Executive Directors is currently being implemented.

30-60-90 Day Plans – Key Deliverables

6. Key areas of achievement in Q3 are highlighted below, with a summary overview at Appendix I:

7. **System innovation** – we have continued to develop conversations at the CE PLACE level. This will help with resource and capacity including the shared resources model (Commercial Management). We have also been working on co-developing a population analytics supporting the Joint Strategic Needs Assessment (JSNA) and the priority system issues.

8. **Development of capabilities** – progress has been made in talent management, launching Quality Improvement (QI), staff welfare (understanding and starting to address the appraisals challenge through a QI approach) and determining opportunities for rethinking future workforce (e.g. diabetes service). We have also initiated process mining[1] with Cancer

[1] Process mining is a method of analysis of operational processes based on event logs. The goal of process mining is to turn event data into insights and improvement actions

Services (improving patient experience and efficiencies) and are progressing the infrastructure upgrade on the estate and the Digital Clinical System. The Full Business Case for the latter was discussed and approved by the Boards of Mid- and East Cheshire on 20 January and is in the process of being submitted to the NHSEI Joint Investment Committee pipeline. The Heads of Terms will be finalised for Board approval in March 2022.

9. **Communication** – the communication toolkit and supporting materials were launched to support consistent and relevant messaging. National and regional media opportunities were taken forward in November, with a video posted on the Trust's YouTube channel (viewed 434 times as of 20 January) and interviews with James Sumner, CEO. We also shared the Strategy with our partners. Internally, staff were engaged through e-bulletins, Team Talk and social media. Feedback to date is provided below:

- Chief Executive Briefings issued to all staff (around 5,000)
- Social Media:
  - Tweet on Strategy launch - 2,546 impressions, with 60 people going on to view the Strategy web page. Separate post later in the day with the video had 517 impressions and 91 video views (11 November)
  - LinkedIn - post on strategy launch (11 November) has had 205 impressions
  - Facebook – two posts on Strategy launch (initial announcement reached 4,635 people, second post with video reached 1,460 people)
- Website:
  - Trust Strategy page has had 962 views since the page was updated on 11 November (182 of these on 11 November alone)
  - separate news article on Strategy launch has had 340 views since being published on 11 November

10. We commissioned an external agency, Frank Design, to deliver a new Trust website and plans will be shared with Board members in January/February.

11. **Enabling delivery units** - the Divisional governance arrangements aligned to the Trust priorities continue to evolve.

Challenges

12. We have made slower progress on certain areas for understandable reasons. These include divisional alignment/enablement, internal analytics capability, business planning and patient experience.

13. Given the capacity and capability constraints, we have also de-prioritised some activities such as knowledge management and delayed our knowledge exchange activities with the private sector e.g. Unilever although dates are being sought for these to take place later in the year.

Next Steps

14. The focus is on taking stock, realigning activity and simplifying our action plan, in preparation for the 2022/23 plans and how these influence system activities. The Trust is also in the process of aligning the enabling Strategic Plans to the Strategy. However, we will need to bolster our capacity and capability to carry out the transformation activities.

15. Following the Board discussion on the Q2 Trust Strategy Progress Report in October 2021, consideration has been given to re-positioning this report towards a more strategic overview of the Strategy 'staircase'. The revised format will be used for reporting to the Board in 2022/23.

Conclusion

16. Progress on delivery of the Trust Strategy continues to move forward but at a slower pace due to the significant operational pressures. 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

17. The Board is asked to note the report.

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

Date: **20 January 2022**

Appendix I

Strategic Staircase

Progress against plan

- Against the challenges of the pandemic, we have continued to make progress with the strategic transformation
- Good progress has been made in aligning and agreeing the PLACE agenda for Cheshire East
- Various capability development initiatives have progressed such as talent management and QI
- However, we have deprioritised some activities such Knowledge Management due to operational pressures
- We are looking to take stock and simplify the activities in building out the 22/23 plans.

Q3/Q4

New Ways of Collaborating

- PLACE (Cheshire East) strategic case and governance model developed
- Structured collaboration on joint capability development e.g. analytics, commercial management
- Social Value plan and priorities develop at system level

Build for the Future

- ED completion and handover activities
- Community Diagnostic Hub launched
- New Build business case and planning
- Integrated workforce ideation and planning
- DCS business case finalisation

An Inspiring Workplace

- Quality Improvement programme launched
- Talent management development – Motiv8, field visits planned, leadership programme evaluation
- Divisional Dashboards being launched
- PLACE analytics collaboration

Patient Experience and Quality of Service

- Process mining pilot started with Cancer (identify opportunities to improve patient experience)
- Future Occ Health provision reset across Cheshire and Wirral
- Staff Wellbeing offer enhanced with easier access for staff
- Digital Health plan on a page

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

Report to	Board of Directors
Date	December 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

Covid: visiting at the Trust stood down, with exception of compassionate visiting. Staff sickness absence across wards ranged from 4-15%.

Governance & Risk: Committee reviewed the strengthened controls and assurances supporting the BAF strategic risks delegated to QSC and the work undertaken to date to map the information flow to the Committee as identified in the workplan. Both provided **Partial Assurance** as they remain work in progress.

Integrated Performance Report (IPR) Month 6:

- **Pressure Ulcer Lapses in Care** – data to be amended as incorrect
- **Safe (Nurse) Staffing:** challenges remained but robust processes in place to ensure patients were being kept as safe as possible

Executive Quality Governance Group (EQGG) Chair's Report December 2021

- **15+ Operational Risks –** delay to receiving respiratory treatment increased to a score of 16 but actions in place to mitigate; risk of patient deterioration from lack of blood glucose monitoring system also increased to 16 – temporary staffing in place to mitigate. Significant work undertaken to address the Deteriorating Patient risk (reduced to 15 from 20) with potentially further reduction shortly.

Covid-19 Infection Prevention & Control Board Assurance Framework – Partial Assurance: full compliance with eight recommendations; two remain at partial assurance ('*use of appropriate antimicrobials'* and '*prompt identification of people at risk of developing an infection … to reduce the risk of transmitting infection')*. Compliance with the first has not been possible due to suspension of the CQUIN programme; compliance with the second was proving challenging to ensure patients adhere to face mask wearing, despite advice/education.

Serious Incidents Report - Acceptable Assurance:

- Two incidents reported – delay in diagnosis in ED of fracture leading to potential poor patient outcome; baby transfer for external cooling following delivery in poor condition. The first led to a

review of process for imaging report review in ED; the second was referred to Health Service Investigation Branch (HSIB) although not taken further (case did not meet HSIB criteria)

- Spike in moderate harm incidents due to reporting of nosocomial Covid infections during Covid Wave 2
- Discharge incidents a trend in complaints; further work to be undertaken.

2021 Mortuary Collection Submission – Partial Assurance: following NHSEI request, compliance review against existing guidance for mortuary and/or body stores and steps to be taken to improve mortuary security/staff monitoring. Small number of improvement actions identified; Trust position confirmed with NHSEI 16 November 2021

KEY CONCERNS/RISKS

Continuing operational pressures and impact on staff
Commencement of upper GI rota delayed due to ongoing Management of Change process underway.

Priority Areas: DECISIONS MADE

N/A

RECOMMENDATION

To note.

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**13**	Date of Meeting: 27/01/2022
Report Title	**Serious Incidents Report December 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 December there were four StEIS (Strategic Executive Information System) reportable incidents declared.

- One incident where a baby required transfer to a tertiary centre for active cooling.
- There has been a Never Event declared where a patient had the incorrect lesion removed.
- There has been a serious incident where a patient underwent surgery and the report used to direct the procedure had the incorrect area identified for where a tumour was situated.
- There has been a serious incident declared following a divert of maternity services

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

Serious Incidents Report December 2021

Introduction

1. This report provides the Board with details of serious incidents declared and closed during December 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 four serious incidents declared in December 2021

SI 2021/25441 (148703) Baby transferred externally for therapeutic cooling

A baby was born in unexpectedly poor condition requiring transfer to a tertiary unit for therapeutic head cooling. Following preliminary investigations, no lapses in care have been identified.
In line with National Guidance, the case has been referred for investigation by HSIB. In addition, a deep dive into maternity incidents, including babies referred for cooling, in the last three years has been undertaken, including comparator data with Maternity Units in the Region. The Trust is not an outlier for the number of babies referred for cooling and has very low levels for babies who subsequently develop brain injuries.

SI 2021/25441 (150322) Never Event – wrong site surgery

A patient undergoing a scar removal following a previous biopsy had the incorrect scar excised. The patient had multiple scars from previous excisions and a large tattoo covered the area. The patient was relisted and had the correct surgery completed within 48hours. An observational review of the procedure is to be undertaken to identify any gaps in barriers to ensure this does not reoccur.

SI 2021/ (150171) Unexpected complication following surgery

A patient underwent a bowel resection for a malignant polyp identified at colonoscopy. Unfortunately, the resected segment of bowel did not contain the polyp. Preliminary investigation has revealed that the colonoscopy report incorrectly identified the anatomical site of the polyp. An immediate action is to undertake a second colonoscopy at the time of surgery where the polyp site cannot be positively identified.

SI 2021/26075 (148972) Maternity Divert and neonatal closure

Following a review of services of 30/11/2021 by senior Trust managers a decision was made to divert maternity services due to lack of neonatal capacity. The closure resulted in two patients being diverted with no patient harm incurred. A de-escalation plan on 01/12/2021 enabled the neonatal unit to reopen timely.

Conclusions

5. The Trust has declared four 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 are 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: 29/12/2021

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**14**	Date of Meeting: 27/01/2022
Report Title	**GIRFT Report Q3 2021/22**	
Executive Lead	Murray Luckas, Medical Director	
Lead Officer	Clare Hammell, Deputy Medical Director	
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 national GIRFT programme re-commenced following its pause during the Covid-19 pandemic.
- Trust processes around GIRFT refreshed, with greater divisional engagement and corporate oversight.
- In this quarter, GIRFT deep dive visits took place for Lung Cancer, Urology and Covid-19.

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 **BAF3 Quality of care**
• Equality ☐	

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

Strategy ☐ Policy ☐ Service Change ☐

REPORT DEVELOPMENT

Committee/ Group Name	Date	Report Title	Lead	Brief summary of key issues raised, and actions agreed
Executive Quality Governance Group (EQGG)	04.01.21	GIRFT Q3 2021/22 Report	CHammell, Deputy Medical Director	• Urology, Lung Cancer and COVID mortality visits undertaken. • Process of governance for quality issues established. • Process for operational issues to be clarified.

GETTING IT RIGHT FIRST TIME (GIRFT) Q3 2021/22 REPORT

Introduction

1. The GIRFT programme is a national programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking and presenting a data-driven evidence base to support change.

2. Following a temporary cessation of the GIRFT programme during the initial waves of the Covid-19 pandemic, the national programme has now restarted with an ambitious programme of specialty reviews and the publication of regular national specialty reports.

3. At MCHFT, the approach and processes which support the GIRFT programme have been refreshed. In line with national recommendations, a centralised GIRFT team has been developed to co-ordinate all GIRFT activity within the Trust. This ensures that all deep dive visits are arranged in a timely manner with appropriate Executive attendance and also that the key messages and required improvements are captured centrally as well as at local specialty level.

4. Following a deep-dive GIRFT visit, and/or the publication of a relevant national GIRFT report, the key messages are presented to the Trust Improvement Group and to the relevant Divisional Quality & Safety groups. Necessary actions and progress with recommendations are monitored by the Divisional Quality & Safety groups and escalated to the Trust Improvement group as required. A quarterly summary report of all GIRFT activity will be presented to The Executive Quality Governance Group and to the Quality and Safety Committee.

Quarterly summary of GIRFT related activity at MCHFT (Q3)

5. Three specialties and/or areas at MCHFT have received a deep-dive GIRFT visit in the last 6 months:
   - Lung Cancer
   - Urology
   - Covid-19 GIRFT review

Lung Cancer

6. The Lung Cancer service is a joint service provided by MCHFT and Manchester University Foundation Trust (MFT). One of the Respiratory Consultants is a joint post between the two trusts to support this service. The GIRFT visit included representatives from MCHFT in addition to representatives from oncology and surgical services at MFT.

7. Areas of good practice identified during the GIRFT review were:
   - Patient support: provision of online information and well-established patient support group. An extensive package of support for smoking cessation as part of the CURE project. Recent introduction of a cancer care support worker role.
   - Clinical effectiveness: effective triage and access to diagnostics prior to first Consultant appointment. Excellent access to chemotherapy slots and the ability to begin this treatment within one week of a patient's clinic appointment. A high number of lung cancers are diagnosed at an early stage at MCHFT and there are excellent radical treatment rates.

- Lung Cancer Nursing team: offer an extensive portfolio of holistic support along with a wide range of nurse led clinics. All of the nurses have palliative care qualifications and/or experience and there are good links to the wider palliative care team.
- Governance: proactive cancer board and good engagement across divisions. Strong evidence of supportive working relationships between clinicians, managers and the local alliance.

8. Agreed areas for improvement noted with the MCHFT aspects of the service were:
   - Dedicated time for quality improvement and service development for the lead clinician.
   - Local audit of (i) lung biopsy practice to review numbers of patients undergoing more than one biopsy and (ii) surgical resection rates.
   - Improved governance around lung nodule service which includes automatic flagging by reporters and tracking software. This service needs to be adequately resourced with Consultant, administrative and radiology dedicated time.

9. In addition, concerns around histopathology turnaround times were identified, particularly since the merger of the service to become part of the North Midlands Pathology Network. This is not unique to lung cancer and is recognised as a risk on the Trust's risk register with mitigating actions and active monitoring being undertaken by the Trust's Cancer Board.

10. Improvement actions focused on the South Manchester aspects of the service delivery were related to improving waiting times for CT guided biopsy and for commencement of radiotherapy.

Urology

11. The virtual deep-dive Urology review was held on the 22nd October 2021. Urology is a core service provided at MCHFT with long standing clinical pathways for major oncological surgery provided jointly with Stepping Hill Hospital.

12. Areas of good practice identified from the review were:
   - Highly effective Consultant led triage of 2 week wait referrals.
   - Metrics for high volume, low complexity urology surgery are good , with better than national average day case rates for transurethral resection of bladder (TURBT), ureteroscopy and bladder outflow surgery.
   - Improvement in diagnostic services for men with possible prostate cancer via the development of a template biopsy service.
   - Well established and effective pathways with Stepping Hill for patients requiring major oncological surgery.
   - The unit is well supported by experienced Clinical Nurse Specialists.
   - Excellent feedback from Doctors in training about their training experience within the department (GMC survey).

13. Agreed improvement opportunities with the GIRFT team were:
   - Improve theatre access for emergency urological patients, particularly those needing 'hot' ureteroscopy. A move to a 'Consultant of the week' working model would facilitate this. This will require the appointment of a 6th Consultant Urologist within the department. There is a business case in progress to support this.
   - Expansion of clinical nurse specialists to support benign urology service.

- Greater system opportunities around aligning the provision of low volume services e.g., Percutaneous Nephrolithotomy (PCNL) provision.

14. In summary, the GIRFT team concluded that the review was productive with good clinician engagement. There was strong evidence of service improvement plans that were in line with national and GIRFT recommendations.

Covid-19 GIRFT review

15. The Trust was one of a few Trusts invited to take part in the national Covid-19 review process. This was driven by our outcomes (crude mortality) for patients admitted with Covid-19 having significantly improved between the first and second wave. The aim of the visit was for the GIRFT team to identify areas of our practice which may have contributed to this significantly improved and lower than average mortality rate in the 2nd wave.

	Wave 1	**Wave 2**
Adjusted mortality rate (Trust)*	31.3%	23.2%
Adjusted mortality rate (national)*	29.4%	23.7%
Standardised Mortality Ratio (SMR)	1.04	0.98

**Rates adjusted for age, sex, ethnicity, deprivation & comorbidities (Charlson co-morbidity index)*

16. Areas of good practice highlighted and shared with the national GIRFT team related to Covid-19 were:
    - The high percentage of inpatients with Covid-19 being offered entry into Covid-19 clinical trials testing the use of various clinical treatments, including dexamethasone and Tocilizumab which have since became mainstream treatments for Covid-19.
    - Clear clinical and flow pathways for patients presenting with symptoms of Covid-19
    - Establishment of enhanced respiratory care setting outside of Critical Care which delivered high flow oxygen and non-invasive ventilatory treatment.
    - Excellent collaborative working between Acute Physicians, Respiratory Physicians and Critical Care teams to support clinical decision making around escalation of care.
    - Supportive and effective local Critical Care network. MCHFT were able to support with the transfer in of patients from other units when their demand exceeded capacity.

Summary of Q3 activity

17. Three GIRFT visits have occurred as outlined above. In all visits, there was excellent engagement from the clinical teams involved. Improvement actions have been agreed between the GIRFT team and the respective clinical teams. Implementation of these actions will be monitored by Divisional Quality & Safety groups.

Recommendation

18. The Board is asked to note the report.

Dr. Clare Hammell, Deputy Medical Director
23/12/2021

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**15**	Date of Meeting: 27/01/2022
Report Title	Learning from Deaths Report Q3 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 Q3 2021/22 Report

Introduction

1. This report is the third 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 3 of 2021/22 (1 October to 31 December 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 3:

   - There were **305** deaths at MCHFT
   - **305** (100%) deaths were reviewed by a Medical Examiner
   - **37** (12%) deaths were subject to a Structured Judgement Review (SJR)
   - **20** completed SJRs were received in Q3
   - **No** deaths were felt to be potentially avoidable (more likely than not to be due to a problem in care)

   Of the **126** SJRs commenced in year, **68** 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 3:

   - **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.
   - **19** 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
110	94	5	3	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
299	276	20	29	0	1	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
891	1222	67	28	1	2	0	7

Mid Cheshire Hospitals
NHS Foundation Trust

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

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

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
2	1	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
6	3	0	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
12	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 (Q3) **N= 20**	17	3	0	0	0	0
This Year (21/22) **N= 68**	56	9	2	0	0	1

(Source: SJR database, 2022)

Total Deaths Reviewed by Overall Care Score (Completed SJRs)

	Excellent Care	Good Care	Adequate Care	Poor Care	Very Poor Care
This Quarter (Q3) **N= 20**	6	8	5	1	0
This Year (21/22) **N= 68**	14	35	17	2	0

(Source: SJR database, 2022)

Total SJR's completed for Quarter 3 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)
October 2021	**12**	0	0	12
November 2021	**3**	0	1	2
December 2021	**5**	0	0	5

(Source: SJR database, 2022)

Indication for SJR meeting criteria in Q3

	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	Elective death
October 2021	4	0	1	2	1	0	1	0	0	1 **(**Also LD)
November 2021	2	0	1 (Also ME referral)	0	1	0	0	0	0	0
December 2021	0	0	1	**3 (1** Also ME referral)	2	0	1	0	16	0
Total	**6**	**0**	**3**	**5**	**4**	**0**	**2**	**0**	**16**	**1**

(Source: SJR database, 2022)

Summary of Potentially Avoidable Deaths in Quarter 3 2021/22

Month	Incident number	Recorded Cause of Death	Speciality	Concerns and learning	SJR outcome
None identified in Q3					

(Source: SJR and SI database, 2022)

Update Summary of Potentially Avoidable Deaths from Previous Quarter – Quarter 2 2021/2022

Month	Incident number	Recorded Cause of Death	Speciality	Concerns and learning	SJR outcome
None identified in Q2					

(Source: SJR and SI database, 2022)

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

2 cases to report in quarter

Month	Incident number	Details	Review on target?	Details/Comments/Learning
October 2021	145555	A 3-month-old baby was brought into the Emergency Department (ED) not breathing. On arrival to the ED a cardiac arrest was confirmed, and resuscitation attempted before death was confirmed.	Internal review completed	No lapses in care identified
November 2021	147807	A 6-week-old baby was brought into the ED in cardiac arrest. On arrival to the ED cardiac arrest was confirmed and resuscitation attempted before death was confirmed.	Internal review completed.	No lapses in care identified

Inquest - Quarterly Update of Concluded Inquests

Month	Inquest number	Recorded Cause of Death	Coroners Verdict	Learning	Linked Trust Investigations or SJR
October	INQ/21/009	1a. Covid 19 Pneumonitis complicated by bronco-pleural fistula due to misplaced nasogastric (NG) tube.	The deceased died as a result of community acquired COVID-19 pnenmonitis which was complicated by a broncoplerual fistua, which was a direct consequnce of the misplacement of the NG tube	None highlighted for the Trust	Incident (132779) reported as a known complication of insertion of an NG tube. The incident was presented at PSS and no lapses in care were identified, however the case was referred for an SJR. The SJR concluded good overall care and LIKERT 1, definitely not preventable.
October	INQ/18/013	1a. Multi-organ failure 1b. Sepsis 1c. Necrotising pancreatitis and peri pancreatic tissue necrosis duodenal perforation at ERCP.	The deceased died as a result of life maintaining surgery that was both required and necessary. The risks were fully explained and understood and that conservative management was appropriate.	None highlighted for the Trust	3 incidents were reported during the inpatient period: Development in care of a grade 2 pressure ulcer (88110) The patient self-extricated their central line (88242) The patient self-extricated their central line (88396)

(Source: Ulysses, 2022)

Medical Examiner Quarterly Update

	October 2021	November 2021	December 2021
Number cases reviewed	81	107	117
Number cases referred to coroner	9	14	9
Number of cases referred for SJR	1	1	2

Learning Themes

15. During quarter 3, there were 4 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. During the ME reviews in quarter 3 potential learning was identified in relation to a patient that had a unified Do Not Attempt Cardiopulmonary resuscitation (uDNACPR) order in place. However when the patient went into cardiac arrest, resuscitation was initially commenced. An incident from was completed. Learning from the case was discussed at Patient Safety Summit (PSS) as part of the incident review and the learning shared Trust wide through Safety Matters, the PSS newsletter.

Recommendations

18. The ME office will be undertaking the following in quarter 4:
    - Reviewing the office space as part of the ME community planning
    - Appointment of an additional MEO with interviews taking place in January 2021
    - The ME paperwork is to be streamlined as duplication has been identified
    - The ME's have raised concerns regards missing volumes of notes when completing their review. If a potential theme from one particular area is identified, it will be escalated to both the relevant Matron and Governance team for triangulation

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
December 2021

Report to	Board of Directors
Date	21 December 2021
Report from	Trevor Brocklebank, Non-Executive Director
Report prepared by	Caroline Keating, Company Secretary
Executive Lead/s	Russell Favager, Deputy Chief Executive and Director of Finance Oliver Bennett, Chief Operating Officer
Committee meeting quoracy	Yes ☒ No ☐

KEY AREAS OF ASSURANCE

Governance & Risk: The Committee reviewed the strengthened controls and assurances supporting the BAF strategic risks delegated to WDT and the work undertaken to date to map the information flow to the Committee as identified in the workplan. Both remain work in progress.

Executive Delivery and Performance Executive Group (EDPG) Chair's Assurance Report (December 2021)

- Omicron variant likely to have a significant impact on services and workforce availability given its transmitability. Pattern of admissions also likely to be different with more patients being hospitalised over a shorter period of time compared to previous waves. More staff are expected to be absent compared to previous waves.

Urgent and Emergency Care (UEC) Improvement Plan

- UEC services remained under significant and sustained pressure; positive progress against the Improvement Plan, with outcome from the '7 Days, No Delays' campaign noted.
- Rising Covid hospitalisations placing further strain on clinical services, impacting on patient care and performance.

H2 Restoration Update:

- In November, inpatient electives in-line with the H2 plan; daycases and outpatient activity all above H2 plan, with the latter delivering more activity compared to pre-pandemic levels.
- Most diagnostic modalities delivering greater levels of activity compared to pre-pandemic.

Finance:

- Final H2 financial position confirmed as a £7.9m deficit position, offset by system support to deliver a break-even position. £9.6m deficit previously report now moved due to additional system funding allocated to the Trust and an additional CIP increase. Mechanisms for additional system allocation yet to be agreed as a system but, given level of slippage expected and potential of using balance sheets for supporting the overall system, places challenge on the mechanism of movement rather than the substance behind the overall position.

- To end November, there was a £3.6m deficit compared to plan of £3.4m with main variance being related to an increase in drugs costs in month. Whilst there is a variance in month, forecast to end of the financial year end remains unchanged at this stage.
- As a result of the system capital forecast calculations, the Trust has had confirmation that MCHT's capital limit will be increased to reflect the full value of the schemes it is expected to deliver.

Executive Safety and Sustainable Environment Group (ESSEG) Chair's Assurance Report (December 2021)

- Due to on-going issues, new ED opening delayed further. Handover by contractor now confirmed as 18 January with the opening now on 9 February 2022.
- Alternative areas for additional beds explored to help manage the expected increase in Covid patients
- Completion of improvements to Victoria Infirmary Northwich slipped.

Estates Return Information Collection 2020/21 – Partial Assurance: explanations for nine exceptions noted. Data to be analysed against revised definitions prior to next submission.

KEY CONCERNS/RISKS

- Forecast year-end financial position to break-even dependent on further support from the Cheshire & Mersey system
- Ongoing and sustained pressure on Urgent and Emergency Care services with increased number of COVID-positive patients in December, which is likely to continue to rise.

Priority Areas: DECISIONS MADE

None

RECOMMENDATION

To note

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**16.1**	Date of Meeting: 27/01/2022
Report Title	**Escalation Wards Business Case (Wards 13 & 19)**	
Executive Lead	Oliver Bennett, Chief Operating Officer	
Lead Officer	Emma Colgan, Divisional Director for DCSS Susanne Crossley, Divisional Director for DMEC	
Action Required	To approve	

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

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

- The business case was signed off at the Executive Business Case meeting on Monday 13 December 2021 and presented and noted by PAF on 21 December 2021 as a sensible solution.
- The business case is a low financial risk solution to the high cost of agency staff currently being incurred and will provide stability and continuity in patient care, and is the safest solution given the situation.
- The business case is proposing recruitment to substantive and fixed term posts for two escalation wards (13&19) at a cost of £4m. Costs in excess of this are already being incurred to staff these wards via premium cost and the business case argues that should the escalation wards close there are sufficient current gaps on others wards across the organisation to consume the substantive staff.

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

- Recruitment to substantive posts identified in the business case
- Recruitment to fixed term posts identified in the business case
- Review the funding of the GP Staffing Model within the Trust to maximise cost effectiveness and longer- term sustainability of the service.

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 **BAF1 Demand and capacity**	
• 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
Please refer to business case.				

Business Case Number		**Date**	**08.11.21**
Business Case Title	**Funding for Escalation Wards (currently 13 and 19)**		
Executive Lead	Oliver Bennett, Chief Operating Officer		
Lead Officers	Emma Colgan, Divisional Director for DCSS & Susanne Crossley, Divisional Director for DMEC		

Key Messages of this Business Case

- Having escalation bed capacity is important to maintain patient flow from ED, and therefore patient safety. To open, or keep open, escalation beds require them to be staffed, via redeployment, from the current nursing, and other professional, establishments across all wards. This also impacts on patient safety as well as increases agency spend.

- The recommended option is to fund two Escalation Wards based on current configuration of Wards 13 &19 (62 beds) with a core team of substantive nursing and key support staff.

- This option provides a balance between investing in the nursing infrastructure to keep the escalation wards open but, based on the intention to close escalation wards in the future, not putting the full staffing infrastructure in on a permanent basis.

Key Financial Implications of the Business case

- **H2 Revenue:** The additional costs expected in H2 is £3.1m, which is composed on £2m of substantive recruitment and £1.1m of temporary posts/variable non pay costs.
- **22/23 Revenue:** The substantive recruitment and associated impacts is £4m – which assuming the escalation beds close, would be re-deployed to vacancies on other wards. If the escalation beds do not close for 22/23, then the recurrent costs will be £4m and the non-recurrent £2.2m – totaling £6.2m.
- **Capital:** There are no expected capital costs.

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

- Recruitment to substantive posts identified in the business case
- Recruitment to fixed term posts identified in the business case
- Review the funding of the GP Staffing Model within the Trust to maximise cost effectiveness and longer-term sustainability of the service.

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

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

Impact *(is there an impact arising from the report on the following?)*			
• Quality • Finance • Workforce • Equality	✓ ✓ ✓ ☐	• Compliance • Legal • Risk/BAF **BAF1 Demand and capacity**	☐ ☐
Equality Impact Assessment (*must accompany the following submissions)*			
Strategy ☐	Policy ☐	Service Change ☐	
Have all signatories signed the business case on the signatories' page?			☐

BUSINESS CASE APPROVAL ROUTE

Committee/ Group Name	**Date**	**Report Title**	**Lead**	**Brief summary of key issues raised and actions agreed**
D&CSS Divisional Board	15.9.21 1.12.21	**Funding for escalation Wards 13 and 19**	Emma Colgan	Concern regarding non-recurrent funding for medical, therapy and pharmacy staff if ward remain open in 2022/23.
DMEC Divisional Board	26.11.21	**Funding for escalation Wards 13 and 19**	Susanne Crossley	Concern regarding non-recurrent funding for medical staff if ward remain open in 2022/23.
Operational Finance Group	18.11.21	**Funding for Escalation Wards (currently wards 13 and 19)**	Emma Colgan	
Executive Delivery & Performance Group	2.12.21	**Funding for Escalation Wards (currently wards 13 and 19)**	Emma Colgan & Susanne Crossley	
Exec Business Case Group	20.12.21	**Funding for Escalation Wards (currently wards 13 and 19)**	Emma Colgan & Susanne Crossley	
Performance & Finance Committee	21.12.21	**Funding for Escalation Wards (currently wards 13 and 19)**	Emma Colgan & Susanne Crossley	Amended the financial tables to include the PDC figure of £106k onto the £3,026k consistently throughout the case

CONTENTS

1. Signatories

The business case must be signed by **all** the following signatories:

Deputy Director of Finance – Financial Services.....

Deputy Director of Finance - BIU.....

Director of Operations .....

Deputy Director of HR .....

Deputy Medical Director.....

Deputy Director of Nursing & Quality .....

Divisional Director of Estates & Facilities.....

Head of Digital .....

Head of Information and Performance.....

Signatories are responsible for communicating issues to relevant parties. For example:

- *Head of Operations should make all Divisional General Managers aware of the case.*
- *Deputy Director of Finance – Financial Services should make procurement aware.*

**This list is not exhaustive and other parties may need to sign the business case*

2. Executive Summary

Wards 18 / 19 opened in October 2020, with temporary funding as winter wards. Due to ongoing and unprecedented pressures on the Trust through 2020/21 the wards remain open as escalation capacity. (Note that Ward 18 moved to ward 13 with an increase of 8 beds).

- As neither ward has substantive funding, they are currently staffed by bank and agency staff, with a small cohort of staff redeployed cross divisionally.
- This results in a transient workforce, that lacks the consistency and teamwork required to deliver high quality, safe patient care.
- The divisions have highlighted the current situation as a risk with a scores of 16 for nurse staffing, 20 for medical staffing and 16 for support staff, with increasing concerns relating to the staffing fill rate for the wards; and increasing numbers of patient safety incidents.

The Trust has agreed that Ward 13 and 19 will remain as escalation wards during the 21/22 winter period, however the current staffing approach is not sustainable due to the fragility of staffing levels.

The options in the business case are: -

Option 1	**Do nothing** Escalation Wards staffed by Bank & Agency and cross divisional redeployment
Option 2	**Fund the Winter Model 2020/21** 54 beds - Funds 30 beds on Ward 19 and 24 Beds on Ward 13 - funding nursing and core ward staff recurrently and other professionals non-recurrently. Original staffing model.
Option 3	**Fund two Escalation Wards** 62 beds - Funds 30 Beds on Ward 19 and 32 Beds on Ward 13 - funding nursing and core ward staff recurrently and other professionals non-recurrently. Updated staffing model.
Option 4	**Close Wards two Escalation Wards (13 and 19)**

The Recommended Option is **Option 3: Fund two Escalation Wards based on current configuration of Wards 13 &19 – 62 beds**

This option will provide a more consistent level of patient care with the permanently recruitment to the nursing and core ward staff. It is planned that these posts will cover gaps in the workforce on existing wards if the escalation wards close in the future.

In addition, the non-recurrent funding will continue in H2 for the GP led ward model on Ward 19 and for other professional across the two wards. The GP led model has proved a highly effective means of supporting the Trusts medical staffing challenges and provides an innovative model for medically optimised/rehabilitation patients. However, the risks of these posts being non-recurrently funded, and so employed on a temporary basis, remain.

This option provides a balance between investing in the nursing infrastructure to keep the escalation wards open but, based on the intention to close escalation wards in the future, not putting the full staffing infrastructure in on a permanent basis.

The financial investment requested is £4.0m (pay and non-pay) recurrently in 2022/23 to allow the substantive recruitment of some staff groups. Within H2 the financial investment will be £3.1m

3. Background and Context

3.1 Change and Sustained Increase in Demand

Ward 18 / 19 opened in October 2020, with temporary funding as winter wards. Over the past 3-year period there has been less that a 6-week period when bed capacity has enabled the winter wards to shut; and currently with an additional 100plus escalation beds in the hospital there is no indication they can be reasonably be removed from the bed base.

Ward 18 moved to Ward 13 on the 28th June 2021, to give medicine an increase of 8 beds due to escalating demand. This move also supported the surgical Covid restoration plans by decreasing the Elective Surgical beds (on Ward 18) and so reduced the number of non-elective being placed there.

Ward 19 runs as a GP led 30 bedded ward for medically optimised patients, the ward focuses on discharge planning and the provision of short term rehab. The ward has a rapid turnover and can discharge up to 8 patients a day, supporting flow out of hospital.

The Trust has experienced a growth in ED attendances of 27.8%, when comparing the average attendances to ED in June over the last 4-years (excluding 2020/21 (Covid year)). ED attendances in 2021 have remained consistently higher than pre COVID with a weekly average of 1575 attendances, pre COVID this was 1388.

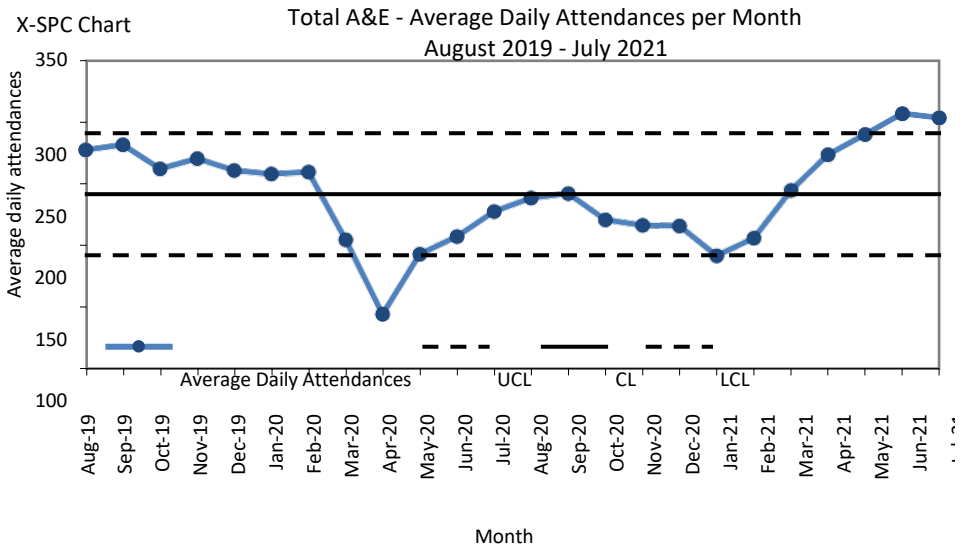


Figure 1: Emergency Department Attendances

This increase in demand is resulting in patients spending longer in the department with 5% of patients now spending longer than 12 hours in the department. Pre COVID this was at 1.3%. As well as an increase in 12 hour waits, the department is also seeing increased corridor waits. At current levels this is 235 patients per week spending longer than 30 minutes on the corridor, compared to 217 pre COVID. This is directly attributable to poor flow out of ED due to lack of available inpatient beds and is a significant risk to patient safety. GIRFT data confirms that mortality, morbidity and length of stay increases when patients spend time in an overcrowded ED.

Since January 2021 daily admissions have increased alongside the increase in ED attendances. During May and June some of the highest attendance levels recorded have been noted.

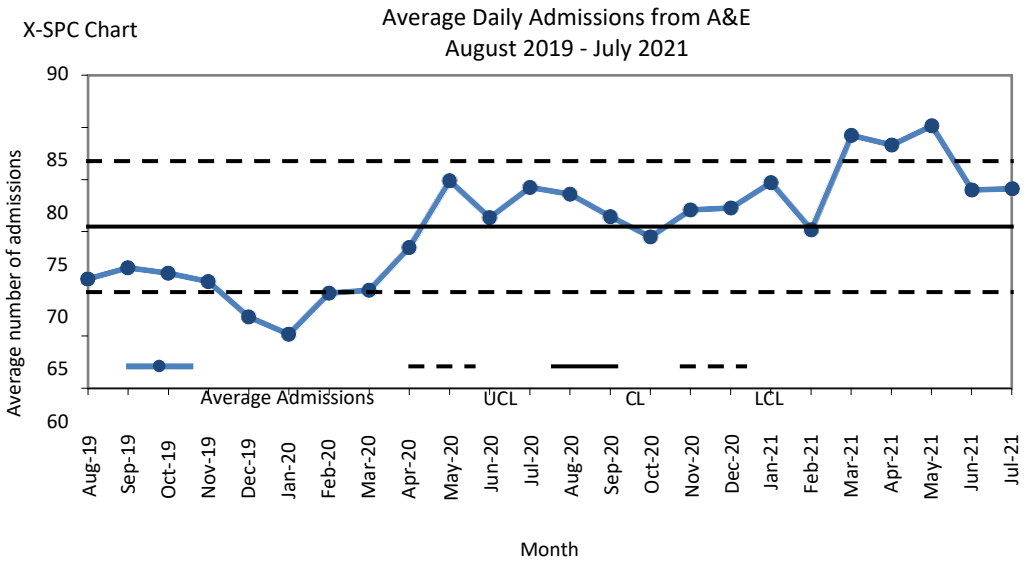


Figure 2: Average Daily Admissions From ED

Moving into the seasonal surge period when there are likely to be ongoing pressures relating to Covid, alongside flu and winter illnesses, it is not expected that a significant change will be experienced to enable ward closures.

3.2 Bed Model

Ward 13

Ward 13 is a 32 bedded ward that opened on the 28th June 2021 as a medical escalation ward. 24% of the ward is staffed with a cohort of staff from ward 18/19 and from across the wards in the Division of Medicine and Emergency Care. However, because the ward does not have substantive funding, 57% of shifts are staffed by bank and agency workers, with 19% remaining unfilled. The senior nursing team undertake a daily staffing review and will move staff across the division to support the skill mix and utilisation of agency nurses across the division.

Ward 19

Ward 19 first opened in December 2018 as part of the 18/19 winter schemes to target occupancy levels, delayed transfers of care and support ED performance. Due to medical staffing pressures, a new and innovative GP led model was developed, with the ward focusing on medically optimised patients, allowing GPs to use their clinical expertise and local knowledge alongside a multi-disciplinary team to facilitate safe and timely discharge planning. On-call cover was supported by the junior doctor rota from Medicine. The ward proved successful over the winter period, in reducing patient's length of stay, supporting flow of medically optimised patients, and introducing an alternative workforce model. The impact was acknowledged via the service winning the Forward Healthcare Award – Leading Healthcare in 2019, and the Trust Board approved recurrent financial support for the ward commencing from Winter 2019. Reconfiguration of the Medical ward base during Covid 19 has resulted in the reallocation of wards, including the opening of the South Cheshire Covid Surveillance Ward, and staffing. This required the review and re-establishment of Ward 19 as a GP Led, medically optimised stepdown ward, forming part of the escalation bed base.

In July 2021, Ward 19 was returned to the Division of Diagnostics and Clinical Support Services, who now manage the bed base for medical optimised patients via a GP led model, this includes Ward 21b and Elmhurst.
Based on the 3 months data average in September 2021, Ward 19 due to the lack of substantive funding, runs with a nursing workforce of 45% substantive staff redeployed from all 3 clinical divisions and 42% bank and agency staff, with 12% of shifts unfilled. The Trust KPI and recommended ratio for Agency versus substantive staff should be not more that 25% for safety reasons. Due to ongoing Trust staffing pressures, there is an increasing need to repatriate the substantive staff to their core wards, increasing the pressures on ward 19 and with increasing agency fill.

3.3 Workforce

Nursing Staff

Nurse staffing levels are actively managed daily by the senior nursing team to maintain safe staffing levels in line with National Quality Boards (NQB) safe staffing guidance (2013 & 2016) to maintain patient safety. However, without a core team of substantive staff on Wards 13 and 19, there is a requirement to redeploy from core wards cross divisionally, to ensure an appropriate skill mix in terms of experience and agency staff. Despite this intent, performance data from e-rostering (Tables 1 and 2) highlights an unacceptably high level of bank and agency usage in these wards, and Table 3 demonstrates the fill rates on the wards have consistently fallen in the 80% range. Fill rates below 85% trigger review and actions for improvement.

Ward 19	Bank/Agency Use%	Agency Use Hours%	Unfilled Roster%
May 21	41.46%	7.68%	7.50%
June 21	43.54%	10.56%	12.88%
July 21	42.09%	14.49%	16.73%

Table 1: Ward 19 Bank and Agency Usage

Ward 13	Bank/Agency Use%	Agency Use Hours%	Unfilled Roster%
July 21	54.58%	21.49%	18.96%

Table 2: Ward 13 Bank and Agency Usage

	Day				Night			
	Qualified		Unqualified		Qualified		Unqualified	
	Fill Rate		Fill Rate		Fill Rate		Fill Rate	
Ward	13	19	13	19	13	19	13	19
April 21	84%	86%	85%	87%	89%	89%	82%	92%
May 21	72%	86%	58%	86%	75%	96%	62%	89%
June 21	66%	84%	67%	81%	88%	92%	85%	90%
July 21	81%	89%	80%	83%	85%	82%	83%	87%

Table 3: Staffing fill April - July 2021

NB: Rates below 80% are reflective of ward 18 de-escalating beds to close/move to Ward 13 and staffing fill temporarily reducing in line.

Whilst Nurse staffing vacancies have significantly improved over the past 12 months due to an extensive programme of international recruitment, there are a high number of international nurses across the Trust still requiring significant support as they adapt to working in the UK. The international recruitment programme continues, with cohorts arriving up to March 2022, and this gives a level of confidence in being able to support substantive recruitment to wards 13 and 19.

Recruitment and retention of Healthcare Assistants has again been a core focus over the past 12 months, and a Task and Finish Group has been established to focus on supporting new initiatives to maintain a flow of new recruits and provide pastoral and developmental support for existing HCAs to improve retention rates.

Recent staff surveys have indicated that a key issue that impacts staff morale is the constant movement between wards; agency staff will frequently only work on the ward they have booked, resulting in increased movement of Trust staff. Substantive nurse staffing on Wards 13 and 19, will enable the establishment of 2 ward teams, enabling staff currently supporting the wards to be released back to their normal wards, and the reduced need to pull staff from across the Trust. This will release significant time spend by the senior nursing team and out of hours teams in managing nurse staffing levels.

Medical Staffing

Consultants

The lack of substantive medical Consultants with the Division of Medicine and Emergency Care is well known. Table 4 details some of the current staffing gaps:

Specialty	Funded WTE	Substantive WTE in Post	Variance
Acute Medicine	7.8	3.9	3.9
Respiratory	4.0	2.6	1.4
Gastroenterology	8.0	4.0	4.0
Total	19.8	10.5	9.3

Table 4: DMEC Consultant Staffing Gaps

This lack of substantive consultant workforce means that the Division is heavily reliant on Agency Consultants to manage the existing bed base within the Division.

The additional 107 escalation beds open within the Trust as a whole, only serves to exacerbate this situation further by having to stretch an already stretched workforce even more. In times of pressure, wards are opened at short notice with no time to recruit additional consultants and funding to support those wards is often only agreed for short periods of time initially, and then extended monthly. This has seen a myriad of Agency Consultants that have only been booked for 3 weeks at a time. This does not provide good patient care, lacks consistency and is hard to pre-plan. Non-recurrent funding, and temporary appointments of medical consultants, does not support safe and good quality patient care on the escalation wards and misses the benefits of providing ownership, responsibility, consistency, resilience to support leave and CPD sessions, on the escalation wards that substantive appointments afford.

In response to the medical staffing challenges, Ward 19 champions an alternative workforce model and is GP led, however, all GPs are currently on temporary or bank contracts and are the same GPs that work in the GP out of hours' service and the GP hub. Short term funding has resulted in days where there has been no GP cover due to not being able to cross cover annual leave. This presents a risk in terms of patient care and flow, as the ward juniors lack senior support to review unwell patients, support changes in management plans, and facilitate timely discharges.

Currently there is no dedicated Consultant overview for ward 19 which causes additional strain on the medical Consultants on the occasions where there is no GP cover identified, or where complex patients with delayed discharges require an overview.

Junior Doctors

In addition to lack of Consultant cover there are no deanery trainee junior doctors allocated to the escalation wards and therefore these are staffed by pulling from the existing pool of juniors or via the use of short-term bank/agency doctors. This impacts on the training of the existing juniors and the Divisions rely on the good will of the trainees to help provide ward cover at short notice. Given the ongoing pressures, this goodwill is dwindling as the doctors are tired and feeling 'burnout'.

Recently, non-recurrently funding for junior doctors has been secured which has meant that juniors have been block booked to work on the escalation wards. This has helped to provide some level of consistency; however, agency locums do not have to ask to take leave and so this still leaves the risk of understaffed wards at short notice.

Support for the junior doctors is well established within the division of Medicine and Emergency Care with structured supervision, governance, and development opportunities. However, Ward 19 sits in the Division of Diagnostics and Clinical support services and lacks divisional provision for junior doctors as they have not previously been hosted by the division. Juniors will continue to remain hosted by Medicine and Emergency Care to ensure the ability to provide assurance on effective governance of this workforce and creates resilience via a critical mass of juniors.

Conversely, the majority of the Trust's GP workforce sits with the Division of Diagnostics and Clinical Support Workforce, this will continue. But whilst GPs remain on temporary contracts it hampers any move to by the Division to review the associated governance required for this specialty workforce.

Support workforce

In addition to the Medical and Nursing workforce, there are significant numbers of support staff that require allocation to the escalation wards, including therapists and pharmacists.

These posts will require non recurrent funding until 31.3.22, to enable the services to seek recruitment to temporary posts and agency. The services will also review options to develop / extend the use of bench posts to support recruitment. However, there is a risk these posts will not be filled, as recruitment to temporary Pharmacy and Therapy posts historically has largely been unsuccessful. In this case there will be the need for staff to be reallocated from across other wards to cover, and the services will prioritise provision, with limits on the provision of routine care across the Trust.

This is seen in the inability to provide a comprehensive therapy service to all patients, with daily prioritisation to critically unwell patients, and those pending discharge. As a result, patients requiring therapy mobilization, are deconditioning, impacting on their health outcomes, length of stay and increasing support requirements on discharge. At the peak of recent pressures in June 21 over 200 patients were missing out on Therapy interventions in a week, due to the spread of resources across escalation areas.

3.4 Impact on Quality & Patient Safety

Figures 1 and 2 demonstrates the link between increasing bed occupancy and patient safety incidents. Triangulating this further with staffing data (Figure 3) demonstrates the clear link between incidents and staffing gaps/ agency staffing.

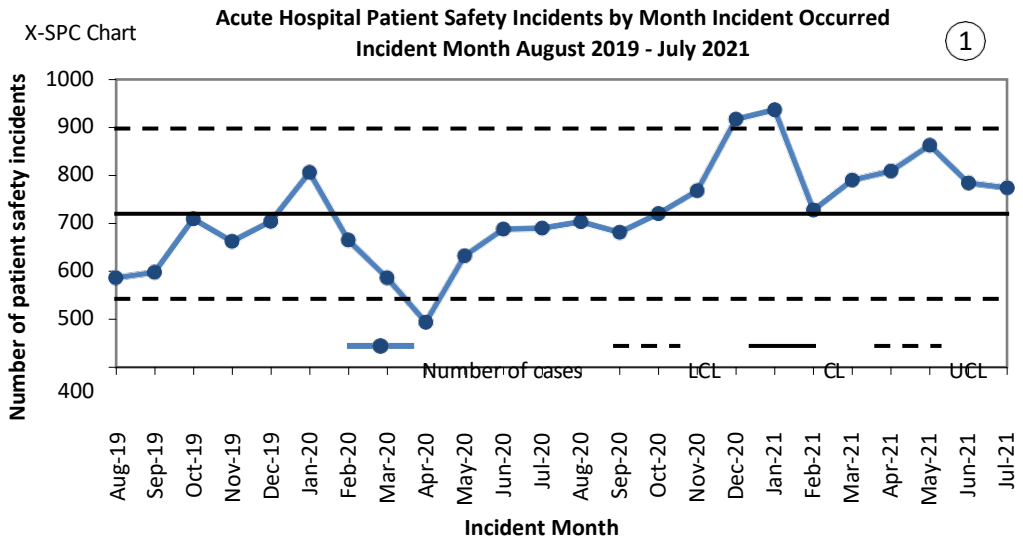


Figure 3: Patient Safety Incidents

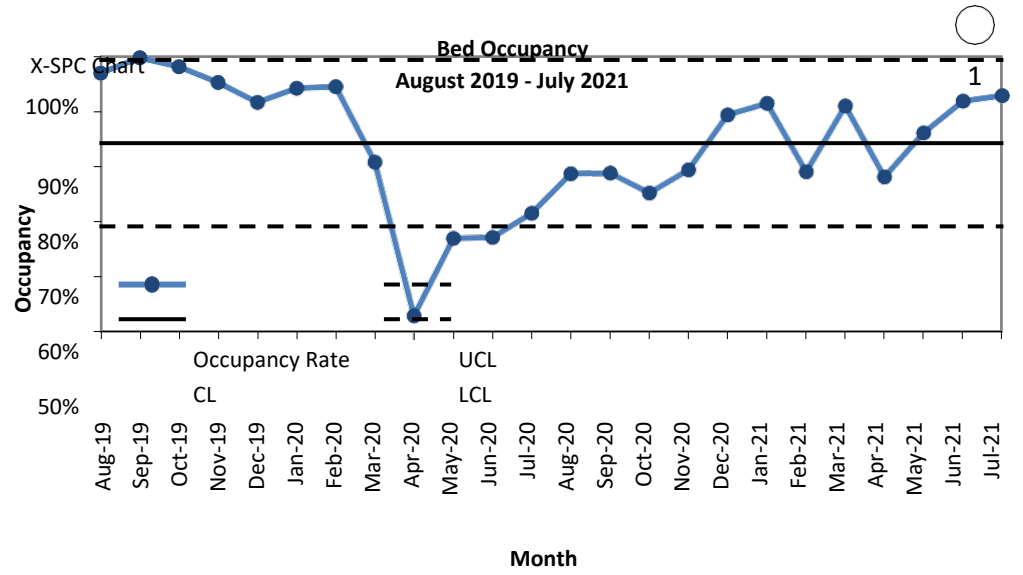
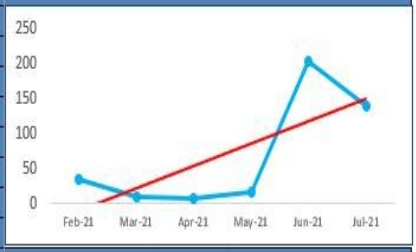


Figure 4: Bed Occupancy

Department	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Totals	Trajectory
Ward 13								
Total Concerns:	35	9	7	16	203	139	413	
Harm Incidents	15	6	1	1	0	8	31	
Complaints	0	3	0	3	0	2	8	
Delays in referral to Critical Care	0	0	0	0	0	0	0	
CQC Enquiries	0	0	0	0	0	0	0	
Agency Shifts	20	0	6	12	203	129	374	
RN Fill Rate Day			77%	76%	89%	81%		
RN Fill Rate Night			99%	96%	89%	85%		
Ward 18								
Total Concerns:	10	17	10	3	33	4	88	
Harm Incidents	8	16	6	3	7	2	42	
Complaints	1	0	4	0	0	1	6	
Delays in referral to Critical Care	0	0	0	0	0	0	0	
CQC Enquiries	0	0	0	0	0	0	0	
Agency Shifts	1	1	0	0	26	1	40	
RN Fill Rate Day			84%	72%	66%	72%		
RN Fill Rate Night			89%	75%	88%	98%		
Ward 19								
Total Concerns:	126	46	72	65	70	107	486	
Harm Incidents	8	2	8	15	6	14	53	
Complaints	0	2	0	1	1	2	6	
Delays in referral to Critical Care	0	0	0	0	0	0	0	
CQC Enquiries	0	0	0	0	0	0	0	
Agency Shifts	118	42	64	49	63	91	427	
RN Fill Rate Day			86%	86%	84%	89%		
RN Fill Rate Night			89%	96%	92%	82%		



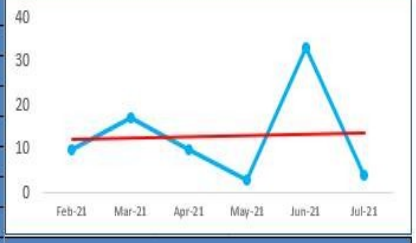


Figure 5: Incidents and Staffing Levels

NB Ward 18 has been included as the ward base in use for medical escalation, prior to the move to Ward13, hence the improved position in July as it moved to a substantively staffed core surgical ward. The variance in May reflects the attempts to wind the ward down and close it.

Of particular concern, is the wider impact and risk on all core wards, as the need to move staff to cover ward 13 and 19, is diluting the core staffing across the Trust. Wards are either dropped to minimum staffing levels to share the staffing gap risk or backfilled with agency staff unfamiliar with ward routines and protocols. Whilst this is a means of mitigating the risk on wards 13 and 19, in effect it widens the areas impacted and thus increases the overall risk to patient safety across the Trust. The latest ward metrics (Figure 4) demonstrates the impact across the organisation of current pressures, with the issues detailed above being a contributory factor to a decline in performance against quality metrics.

CQC Theme	Audit Topic	Apr 2021	May 2021	Jun 2021	Jul 2021
Safe	Patient Safety	95	96	95	93
Safe	Harm Free Care	92	93	92	94
Safe	Medication Safety	96	96	95	96
Safe	Infection Prevention & Control	103	102	101	101
Well Led	Record Keeping	94	95	96	93
Well Led	Well Led Team	91	93	95	91
Caring	Nutrition and Hydration	94	94	95	94
Caring	Toileting and Hygiene	94	95	96	94
Caring	Patient Experience	90	91	91	93
Responsive	Needs Specific Care - CYP	91	88	100	97
Responsive	Needs Specific Care - DEMENTIA	91	90	88	90
Responsive	Needs Specific Care - EOL	96	95	93	92
Responsive	Needs Specific Care - LD	95	93	94	94
Responsive	Pain Management	86	87	88	89
Responsive	Communication	92	94	93	92
Effective	Cleanliness	93	93	93	92
Effective	Discharge and Patient Flow	89	87	89	87
Overall	Overall Quality	93	93	92	92

Figure 6: Ward Safety Metrics

3.5 Risks

EC0484	Shortage of medical staffing in Medicine	20
EC0494	Insufficient Staffing within Inpatient Locations	12
DC1113	Staffing levels in DCSS Bed Based Services	16
DC1086	Occupational Therapy Staffing levels	16
DC1087	Physiotherapy Staffing Levels	16

To reflect the above issues the divisions have highlighted the current situation as a significant risk to patient care, with risk ratings of 16 – 20 in relation to medical, nursing and support workforce staffing.

4. Option Appraisal and Proposal Identification

4.1 Option Identification

The options identified for the staffing of two escalation wards (currently wards 13 & 19) are: -

Option 1 - Do nothing
Escalation Wards staffed by Bank & Agency and cross divisional redeployment

Option 2 - Fund the Winter Model 2020/21
54 beds - Funds 30 beds on Ward 19 and 24 Beds on Ward 13 - funding nursing and core ward staff recurrently and other professionals non-recurrently. Original staffing model.

Option 3 - Fund Two Escalation Wards
62 beds - Funds 30 Beds on Ward 19 and 32 Beds on Ward 13 - funding nursing and core ward staff recurrently and other professionals non-recurrently. Updated staffing model.

Option 4 – Close Two Escalation Wards (13 and 19)

4.2 Options Appraisal

Option 1: Do Nothing
Continue to staff the ward via bank/agency and cross divisional redeployment

Advantages	***Risks***
• Removes the need for recurrent funding • Removes requirement for recruiting substantively and associated resource required to support process • Avoids commitment to additional ward base	• Ongoing staffing shortfalls, staffing levels below NQB safe staffing guidance • Negative impact on patient safety and quality of care • Negative trust-wide impact supporting additional 62 beds without staffing resource • Continued additional resources to support the Bank team to fill demand 7 days a week. • Risk of having to shut ward if staffing levels become critical and resulting in insufficient bed base against current demand, and compromise of ED flow • GP led model may not be sustainable with staff securing permanent employment elsewhere • Poor staff morale and engagement • No Improvement to patient safety, quality of care and patient experience

Option 2: Fund the Winter Model 2020/21

54 beds - Funds 30 beds on Ward 19 and 24 Beds on Ward 13 - funding nursing and core ward staff recurrently and other professionals non-recurrently. Original staffing model.

Advantages	*Risks*
• Improved patient safety, quality of care and patient experience • Reduce risk of serious patient harm • Reduce current risk ratings linked to wards/staffing • Enables substantive recruitment for nursing, staff • Supports establishment of wards, enabling teamwork and ownership • Improved staff morale and engagement enhancing patient care and experience • Minimal requirement to move staff from other wards/divisions • Reduced reliance on bank/agency staff, reduced temporary staffing costs	• Leaves a shortfall, with staffing resources for 8 beds unfunded • Ward staffed not staffed in line with NQB safe staffing requirements • Significant resource required to recruit the required workforce. • Failure to increase staffing levels if recruitment is largely via internal movement • GP led model may not be sustainable with staff securing permanent employment elsewhere • Temporary Therapy, Pharmacy and Medical posts may not be filled, resulting in key functions not being delivered

Option 3: Fund Two Escalation Wards

62 beds - Funds 30 Beds on Ward 19 and 32 Beds on Ward 13 - funding nursing and core ward staff recurrently and other professionals non-recurrently. Updated staffing model.

Advantages	*Risks*
• Improved patient safety, quality of care and patient experience • Reduce risk of serious patient harm • Reduce current risk ratings linked to wards/staffing • Enables substantive recruitment for nursing, staff • Supports establishment of wards, enabling teamwork and ownership • Improved staff morale and engagement enhancing patient care and experience • Ward staffed in line with NQB safe staffing requirements • Minimal requirement to move staff from other wards/divisions • Reduced reliance on bank/agency staff, reduced temporary staffing costs	• Significant resource required to recruit the required workforce. • Failure to increase staffing levels if recruitment is largely via internal movement • GP led model may not be sustainable with staff securing permanent employment elsewhere • Temporary Therapy, Pharmacy and Medical posts may not be filled, resulting in key functions not being delivered

Option 4: Close Wards 13 and 19 and repatriate staff back to Core Wards

Advantages	*Risks*
• Improved patient safety, quality of care and patient experience on core wards as staff to established levels • Reduce risk of serious patient harm on core wards • Financial lower cost	• Leaves insufficient bed base to manage current demands • Inability to maintain flow from ED, resulting in compromised safety in ED • Unable to meet ED 4 and 12 hour wait targets, ambulance wait times, and extended corridor waits. • Site unsafe, resulting in unplanned and unstaffed opening of wards • Potential reduction in the elective programme to support site safety

4.3 Preferred Option – Key Features

Option 3: Fund Two Escalation Wards
62 beds - Funds 30 Beds on Ward 19 and 32 Beds on Ward 13 - funding nursing and core ward staff recurrently and other professionals non-recurrently.

This option provides a balance between investing in the nursing infrastructure to keep the escalation wards open but, based on the intention to close escalation wards in the future, not putting the full staffing infrastructure in on a permanent basis.

Workforce Model and Rationale

Ward 13

This model is in line with staffing for a general medical ward. This provides 1 Registered Nurse and 1 Unregistered Nurse for 8 patients on a day shift along with a supernumerary coordinator. On the night shift this provides 1 Registered Nurse for 10.66 patients and 1 unregistered Nurse for 8 patients. There is not a supernumerary coordinator at night.

This model also includes a fixed term 8a Matron. Matrons are vital to delivering high quality, safe care to patients and their relatives and are instrumental in promoting high standards of clinical within the Division of Medicine and Emergency care. This is done through visible leadership and engagement with staff, patients and their families.

WARD	Speciality	Number of Beds	Agreed Safe Staffing RN + HCA		Minimum Safe Staffing RN + HCA	Critical Staffing RN + HCA
13	Medical Escalation	32	Mon – Fri Long Day	5+4	5+4	4+4
			Weekend Long Day	5+4	5+4	4+4
			Nights	3+4	3+4	2+4

Table 5: Ward 13 Nurse Staffing Model

Description	Band	WTE	
Consultant	Agency		
Junior Doctor - F2 level	MED	2.50	Non Recurrent
General Practitioner	MED	0.00	Non Recurrent
Matron	Band 8a	0.50	Non Recurrent
Ward Manager	Band 7	1.00	Recurrent
Senior Registered Nurse	Band 6	2.81	Recurrent
Registered Nurse	Band 5	22.50	Recurrent
Health Care Assistant	Band 2	22.18	Recurrent
Ward Clerk	Band 2	1.00	Recurrent
Discharge Co-ordinator	Band 3	1.00	Recurrent
Housekeeper	Band 3	0.67	Recurrent
Domestics & Porters	Band 2	1.33	Non Recurrent
Pharmacist	Band 7	0.37	Non Recurrent
Pharmacy Technician	Band 5	0.50	Non Recurrent
Pharmacy ATO	Band 2	0.38	Non Recurrent
Occupational Therapist	Band 5	1.00	Non Recurrent
Speech and Language Therapist	Band 6	0.00	Non Recurrent
Physiotherapist	Band 6	0.50	Non Recurrent
Therapy Assistant	Band 3	1.50	Non Recurrent
Phlebotomist	Band 2	0.90	Non Recurrent
		60.65	

Table 6: Ward 13 Staffing Establishment (Recurrent and Non-recurrently Funded Posts)

Ward 19

Nursing Staff

The detailed nurse staffing model is in line with the National Quality Boards (NQB) safe staffing guidance (2013 & 2016) to maintain patient safety, for a cohort of medical optimised, but largely elderly frail patients who require varying level of support with personal care and mobility whilst their discharge plans are finalised. The Model on the day shift supports 1 RN for 10 patients, with 1 RN coordinating discharges, Monday – Friday. The bridging gap between the original model proposed in 2019, reflects staffing for 30 beds and the proposed model is in line with other medical wards with a comparable patient population and similar acuity/dependency

Healthcare assistant numbers for the ward are optimized due to the ward layout and issues relating to visibility when managing a cohort of patients at higher risk of falls, and with degrees of cognitive impairment.

The model includes an AHP matron/coordinator role, which is an additional role for the Division of Diagnostics and Clinical Support Services to support the existing divisional matron, but with an enhanced focus on rehabilitation, discharge and flow. This role will have a clear focus to ensure patients are appropriately allocated across the divisional bed base and timely discharge progressed.

The role will also lead on Trust-wide initiatives to reduce patient deconditioning, promote the PJ paralysis initiative. This post replaces the original ACP post, and allows options for a role with a wider remit, with options to develop the post holder as a non-medical prescriber to support clinically as required.

WARD	Specialty	Number of Beds	Agreed Safe Staffing RN + HCA		Minimum Safe Staffing RN + HCA	Critical Staffing RN + HCA
19	GP Led Short Stay	30	Mon – Fri Long Day	4+5	3+ 5	2+ 4
			Weekend Long Day	3+5	3+5	2+ 4
			Nights	3+4	2+4	1+4

Table 7: Ward 19 Nurse Staffing Model

Description	Band	WTE	
MEDICAL			
Consultant	MED		
Junior Doctor - F2 level	MED	2.50	Non Recurrent
General Practitioner	MED	0.67	Non Recurrent
NURSING			
AHP Matron/Co-ordinator	Band 8a	1.00	Recurrent
Ward Manager	Band 7	1.00	Recurrent
Senior Registered Nurse	Band 6	2.81	Recurrent
Registered Nurse	Band 5	18.88	Recurrent
Health Care Assistant	Band 2	24.96	Recurrent
Ward Clerk	Band 2	1.00	Recurrent
Discharge Co-ordinator	Band 3	1.00	Recurrent
Housekeeper	Band 3	0.67	Recurrent
OTHER SUPPORT			
Domestics & Porters	Band 2	0.65	Non Recurrent
Pharmacist	Band 7	1.20	Non Recurrent
Pharmacy Technician	Band 5	0.00	Non Recurrent
Pharmacy ATO	Band 2	0.00	Non Recurrent
Occupational Therapist	Band 6	1.00	Non Recurrent
Speech and Language Therapist	Band 6	0.33	Non Recurrent
Physiotherapist	Band 6	1.00	Non Recurrent
Therapy Assistant	Band 3	1.00	Non Recurrent
Phlebotomist	Band 2	0.30	Non Recurrent
		59.98	

Table 8: Ward 19 Staffing Establishment (Recurrent and Non-recurrently Funded Posts)

Medical Staff

The ward will have GP cover 5 mornings a week, providing a ward round to support the review of all patients, and progress discharge planning. The GPs are ideally placed to sign post patients to community services, and progress discharge with an understanding of the level of risk that can be managed in Primary care. The GP's will form part of a Divisional GP cohort, with oversight by the Divisional AMD, to ensure effective governance of this staff group.

The Junior Doctors will be managed by the Division of Medicine and Emergency Care and will form a cohort with Ward 21b juniors to rotate through care of the elderly, rehabilitation, and discharge wards to offer a wider range of experience. This will increase the attractiveness of these posts, which have traditionally not been easy to recruit to.

The attractiveness of the junior doctor posts, and the ability to create a Divisional GP cohort, will be limited by the non-recurrent funding and therefore tenure of these posts.

Support Staff Across Wards 13 and 19
The Pharmacy allocation includes non-recurrent/fixed term staffing to support an enhanced ward-based service, which is of key importance to promote timely TTO's ready for discharge.

Non-recurrent/fixed term therapy Staffing Provision will be based on therapists working across the 2 wards for a 5 day per week service, with an element of cross cover for leave and sickness absence.

A band 6 would be based on each ward, with cross cover as needed, in line with the therapy prioritisation matrix.

There will be a focus on improving flow by:

a. A consistent and regular therapy provision by therapy staff who know the patients and ward staff

b. Therapists leading on D2A including leading on complex discharge planning, partners in criteria led discharge and input to STTF for complex patients

c. Discharge home visits developed and led by senior OT and supported by therapy assistant

d. Assistants ensure that patients receive daily therapy for rehabilitation as needed and led by senior physio

e. Prevention of deconditioning – developed jointly with nursing/HCAS to encourage patients to remain active and mobile

5. Proposed Investment and Funding Profile

1. The table below indicates the associated costs to be incurred in running Wards 13 and 19, both in H2 21/22. The staffing figures are based on 21/22 average pay scales, including a 3% uplift for each category of staff. All pay costs are based on substantive recruitment and include all relevant enhancements for unsociable hours where applicable.

   Financial:
   - Pay - £2.5m for October to March 22.
   - Non-Pay - £0.5m October to March 22

	Annual	H2 only
Ward 19	2,740	1,370
Ward 13	3,525	1,762
	6,265	**3,132**

   Workforce:
   - 120.62 WTE

2. **Funding Sources to be identified**
   Internal – agreed as part of the H2 plan.

   For the substantive posts (amounting to £4.0m per annum) it is planned that these posts will cover gaps in the workforce on existing wards if the escalation wards close.

3. **Impact on current financial performance of Department and Trust**

   The financial regime for the H2 period is pre-dominantly focused on the run rate expenditure for organisations and is funded via a fixed allocation. As these wards have been opened throughout 2021/22, the majority of these costs are within the run rate – however it does need to be acknowledged that these costs do contribute to the overall expected deficit of the Trust, which will be incurred during 2021/22 in the second half of the financial year (H2). The impact on the H2 position is an expected increase on run rate costs of £0.3m associated with the wards.

   The original budget for 2021/22, which was presented to the Board in order to delegate authority for the full year – did include these wards for Q1, and the second half of the financial year. If they remain open as escalation areas, then the full year impact would be a requirement for a further £1.4m for 2022/23. The planning cycle for 2022/23 will need to take into account the expectation as to whether these escalation areas will remain open in full or part during the next financial year.

   The impact of this investment on budget and underlying performance is that DMEC and CSSD will no longer report an overspend associated with escalation beds and both divisions will operate within their funding envelope. However, there is a risk that the divisions will incur premium costs while in the process of substantive recruitment, particularly within nursing and medical posts which are often hard to fill. There is a potential financial risk of circa £0.5m in the first 12 months associated with premium costs.

Profit & Loss	Year 1	Year 2	Year 3	Year 4	Year 5
	£'000	£'000	£'000	£'000	£'000
Total Income	**0**	**0**	**0**	**0**	**0**
Non-recurrent Expenditure	(1,087)	0	0	0	0
Recurrent Expenditure	(2,046)	(4,015)	(4,015)	(4,015)	(4,015)
Total Expenditure	**(3,132)**	**(4,015)**	**(4,015)**	**(4,015)**	**(4,015)**
Operating Profit/(Loss)	**(3,132)**	**(4,015)**	**(4,015)**	**(4,015)**	**(4,015)**
Depreciation	0	0	0	0	0
Interest receivable/payable	0	0	0	0	0
Net Profit/(Loss)	**(3,132)**	**(4,015)**	**(4,015)**	**(4,015)**	**(4,015)**
Existing Budget	0	4,015	4,015	4,015	4,015
Additional Budget Required	**(3,132)**	**0**	**0**	**0**	**0**
Current Annual Actual Spend	0	0	0	0	0
I&E Impact - Spend Increase/(Saving)	**3,132**	**4,015**	**4,015**	**4,015**	**4,015**
Capital Expenditure Required	**0**	**0**	**0**	**0**	**0**
Net Cash Flow	**3,132**	**4,015**	**4,015**	**4,015**	**4,015**

6. Management Arrangements

Procurement Arrangements
This case will not require any formal tendering or procurement processes.

Implementation Team

The implementation of this case will be led by:

- Divisional Directors – Medicine and Emergency Care / Diagnostics and Clinical Support Services
- Deputy Divisional Director – Medicine and Emergency Care
- Associate Medical Directors – Medicine and Emergency Care / Diagnostics and Clinical Support Services
- Head of Nursing – Medicine and Emergency Care
- Head of Nursing / Healthcare Professions - Diagnostics and Clinical Support Services
- Matrons - Medicine and Emergency Care / Diagnostics and Clinical Support Services

This case will not require any consultation or TUPE, all posts will be recruited to via normal Trust Recruitment processes.

Implementation Timescales

	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	Sept 22
Business case appraisal and approval by Trust Board							
Recruitment of Nursing Staff							
Commencement of Nursing Staff							
Commencement of Medical Staff	Bank, agency, and fixed term appointments						
Commencement of Support Staff	Bank, agency, and fixed term appointments						
Benefit Realisation paper							

Risks

- The inability to recruit to the substantive nursing workforce model identified in this case.
- Increased cost pressure of ongoing/increased reliance on agency staff. There is a risk that the divisions will incur premium costs while in the process of substantive recruitment. There is a potential financial risk of circa £500k in year 1 associated with premium costs.
- If the two escalation wards remain open throughout 2022/23 then there is a £2.2m risk to non-recurrently fund the medical, therapy and pharmacy staff required to support these wards.
- There is a risk that further escalation beds may need to be opened over and above the funded 2 wards
- The lack of GP permanent posts creates the risk that we loss the existing GPs to other Trusts / services.

Query	Weighting	Option 1	Option 2	Option 3	Option 4	Preferred Option Commentary
Does this involve hard to recruit staffing?	40	No	Yes	Yes	No	Chances of successful recruitment are low
Does this option rely on training staff up?	35	No	Yes	Yes	No	Staff could leave after 12 months
Does this involve a procurement?	5	No	No	No	No	
Does this involve any savings that assumptions that need to be worked through?	10	No	No	No	No	
Does this involve collaboration with other Trust or Party?	0	No	No	No	No	
Does this involve any income that has not been confirmed?	10	No	No	No	No	
Total Financial Risk Score	**100**	**0**	**75**	**75**	**0**	

Benefits Realisation

The Benefits of the case will be measured by:

i. Substantive Nurse Staffing Establishment on Wards 13 and 19
ii. Reduced Agency fill
iii. Improved nurse staffing fill rates as monitored via e-roster
iv. Reduced number of patient incidents/concerns/complaints
v. Improved patient safety triangulation
vi. Ward occupancy rates
vii. Discharge rates from Ward 19

Management Structure

The Divisional Boards of DMEC and DCSS will monitor and drive the implementation of this business case. Both divisional boards will report progress to the Executive Delivery and Performance Group.

7. Recommendation

The recommendations are:

1. Approval of Option 3: Fund Two Escalation Wards
62 beds - Funds 30 Beds on Ward 19 and 32 Beds on Ward 13 - funding nursing and core ward staff recurrently and other professionals non-recurrently. Updated staffing model.

2. Review the funding of the GP Staffing Model within the Trust to maximise cost effectiveness and longer-term sustainability of the service.

Appendix I

1. Summary of Options

Financial Summary of Options	Option Number			
	1	2	3	4
	£'000	£'000	£'000	£'000
Recurrent Trading Position				
Income Receivable	0	0	0	0
Expenditure	0	(2,839)	(4,015)	0
Recurrent Operating Profit/(Loss)	**0**	**2,839**	**4,015**	**0**
Recurrent Additional Budget Required	**0**	**2,839**	**4,015**	**0**
Current Actual Spend	0	0	0	0
Annual Spend Increase/(Saving)	**0**	**(2,839)**	**(4,015)**	**0**
Initial Outlay				
Non-recurrent Revenue Costs	(4,540)	(701)	(1,087)	0
Capital Outlay Required	0	0	0	0
Total Initial Outlay	**(4,540)**	**(701)**	**(1,087)**	**0**

Note – Option 1 has been modelled on Option 3 plus an additional 50% to account for premium cost of bank and agency. This is a very conservative figure to account for the availability of the nursing staff from these sources and could be upwards of this figure.

Option 3 – Preferred option detailed breakdown

Detailed Income & Expenditure Impact		Year 1	Year 2	Year 3	Year 4	Year 5
		£'000	£'000	£'000	£'000	£'000
Income						
Total Income		**0**	**0**	**0**	**0**	**0**
Expenditure	**WTE**					
Consultant	0.00	137	0	0	0	0
General Practitioner	0.67	160	0	0	0	0
Junior Doctor - F2 level	5.00	26	0	0	0	0
Matron	1.50	45	60	60	60	60
Ward Manager	2.00	54	109	109	109	109
Senior Registered Nurse	5.63	142	284	284	284	284
Registered Nurse	41.38	904	1,808	1,808	1,808	1,808
Health Care Assistant	47.14	741	1,483	1,483	1,483	1,483
Ward Clerk	2.00	24	48	48	48	48
Discharge Co-ordinator	2.00	26	52	52	52	52
Housekeeper	1.34	18	35	35	35	35
Domestics & Porters	1.98	24	0	0	0	0
Pharmacist	1.57	43	0	0	0	0
Pharmacy Technician	0.50	9	0	0	0	0
Pharmacy ATO	0.38	5	0	0	0	0
Occupational Therapist	2.00	40	0	0	0	0
Speech and Language Therapist	0.33	7	0	0	0	0
Physiotherapist	1.50	34	0	0	0	0
Therapy Assistant	2.50	33	0	0	0	0
Phlebotomist	1.20	14	0	0	0	0
	120.62					
Total Pay Expenditure		**2,486**	**3,879**	**3,879**	**3,879**	**3,879**
Drugs		342	0	0	0	0
MASE - Consumables		74	0	0	0	0
Catering & Hotel Services		125	0	0	0	0
Total Non Pay Costs		**541**	**0**	**0**	**0**	**0**
Total Revenue Costs		**3,026**	**3,879**	**3,879**	**3,879**	**3,879**
of which non-recurrent		***1087***	***0***	***0***	***0***	***0***
of which recurrent		***1940***	***3879***	***3879***	***3879***	***3879***
Operating Profit/(Loss)		**(3,026)**	**(3,879)**	**(3,879)**	**(3,879)**	**(3,879)**
Capital Costs	**Asset Life**					
Total Capital Costs		**0**	**0**	**0**	**0**	**0**
Public Dividend Capital		(106)	(136)	(136)	(136)	(136)
Net Profit/(Loss)		**(3,132)**	**(4,015)**	**(4,015)**	**(4,015)**	**(4,015)**

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**17**	Date of Meeting: 27/01/2022
Report Title	**Financial Position – Month 09**	
Executive Lead	Russell Favager, Deputy Chief Executive and Director of Finance	
Lead Officer	Rosalyn Davies, Deputy Director of Finance	
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)*

- At end December 2021 (month 9) the Trust is reporting a deficit of £5.2m compared to the financial plan of £5.0m
- The Trust's year-end forecast position is break-even but this is dependent upon the Trust receiving £7.9m additional income from the C&M system
- There is a C&M HCP/DOFs meeting on Friday 28 January to discuss the arrangements for the transaction of resources moving around the system

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

Financial Position – Month 09

Overview

1. At the end of December 21 (month 9) the Trust is reporting a deficit of £5.2m compared to the financial plan of £5.0m, with the variance relating to prior months and relates to additional pressures that the Trust has experienced with drug costs.

£'000s	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	21/22 Total
Plan	(1,235)	737	132	100	149	115	(1,864)	(1,562)	(1,563)	**(4,991)**
Actual	(1,054)	393	333	124	(184)	404	(1,903)	(1,742)	(1,605)	**(5,236)**
Variance to Contract Total	**181**	**(344)**	**201**	**24**	**(334)**	**289**	**(39)**	**(180)**	**(42)**	**(245)**

2. The year-end forecast position is that of break-even, however this does depend on the Trust receiving £7.9m of additional income support from the Healthcare Partnership – this is planned for receipt in month 12.

3. In terms of providing assurance around the Trust receiving this £7.9m attached to this report in Appendix 1 is the response from the HCP DOF to the letter sent by the Chief Executive (Appendix 2) following the November Board meeting when the submission of a balanced plan was discussed.

4. The Directors of Finance within the Healthcare partnership are schedule to review the Cheshire & Merseyside (C&M) forecast position compared to the overall system plan at a facilitated workshop on Friday 28th January in order to confirm the arrangements for the transaction of resources moving around the system in line with the principles for shared system financial accountability agreed amongst C&M organisations (included in Appendix 1).

5. The 2022/23 planning guidance has been issued, with the indicative capital allocations for the next 3 years for the system included, this includes indicative values for 2022/23 for Mid Cheshire of £8.1m for digital and £11.1 for RACC planks, revenue allocations are still to be received. The guidance states a return to Trust 'agreements' which will be negotiated by CCGs.

Analysis of Spend Month 09 (December)

6. Pay was comparable with November's expenditure, noting that none of the annual leave accrual were used in month to offset costs due to the potential for a re-assessment of the use of this in light of the Omicron variant surge costs.

Actual Expenditure £'000s	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep***	**Oct**	**Nov**	**Dec**	**21/22 Total**
Commissioning Income	23,805	25,484	25,104	25,301	25,501	29,000	24,527	24,531	25,228	**228,480**
Other Income	1,704	1,766	2,168	1,614	1,683	2,072	2,222	2,718	2,093	**18,040**
Pay	(17,288)	(18,113)	(18,411)	(17,919)	(17,896)	(21,394)	(19,262)	(19,027)	(19,128)	**(168,440)**
Non Pay	(8,574)	(7,895)	(7,961)	(8,199)	(8,791)	(8,585)	(8,691)	(9,196)	(9,052)	**(76,942)**
Depreciation	(478)	(621)	(329)	(479)	(465)	(465)	(475)	(491)	(480)	**(4,283)**
Internal Recharges	0	0	(1)	1	0	0	0	0	0	**0**
Finance charges	(222)	(229)	(239)	(196)	(216)	(223)	(224)	(277)	(266)	**(2,092)**
Total	**(1,054)**	**393**	**333**	**124**	**(185)**	**404**	**(1,903)**	**(1,742)**	**(1,605)**	**(5,236)**
* Backdated pay award paid										

7. Whilst overall non pay also remained in line, there were increases in clinical supplies in the month in order to prepare for the holiday period which were offset by general reductions in other areas of spend.

Forward Look

8. The Trust will be required to submit a plan for 22/23 in April to regulators, which should mean that the first draft would be review in PAF in February – however this will be dependent on the timing of the revenue allocations announcement.

9. In expectation of the requirement for a challenging financial environment, the Trust has reviewed it's efficiencies programme and a new proposed framework has been proposed and supported by the operational teams in advance of 22/23, this will be presented to PAF in February. The scheduled start date for this new programme, termed "Efficiency and Value Programme" has been delayed as a result of the current operational challenges – this work is ready to be advanced in support of the planning timeframes and in Appendix 3 a draft implementation timeline is shown.

Author: Russell Favager
Date: 19/01/2022

APPENDIX 1

Cheshire and Merseyside
Health and Care Partnership

James Sumner
Chief Officer
Mid Cheshire Hospital NHS Foundation Trust
Leighton Hospital
Crewe
CW1 4QJ
James.sumner@mcht.nhs.uk

Thursday 9th December 2021

Dear James

Thank you for your letter dated 26th November 2021 regarding the H2 financial forecast and particularly for the decision taken by your Board to plan for breakeven on 31 March 2022. It was important that as a system we were able to make this happen, but we all recognise that there is still a considerable amount of work to be done by all to land it.

As regards the first point in your letter, I attach a paper previously circulated around the FD / CFO community which hopefully demonstrates that the principles of equity and collective 'buy in' have been the main stay of C&M's approach to allocating out the limited system resources we have at our disposal.

As regards landing breakeven for every organisation in H2, significantly this will require the system working as one. I believe there will be enough resource in the system as a whole; but it will need to be shared to ensure every organisation achieves breakeven. Positively we moved resources around in 20/21 and in H1 to achieve the same goal, so despite the size of the challenge being greater in H2, I still believe it is achievable. At a FARG (Finance Advisory and Reference Group) meeting prior to the H2 submission, it was acknowledged there was currently a financial gap but that by all Trusts working collaboratively we would have the ability to close this gap and that this would also mean moving resources around organisations. As has been acknowledged, individual organisations will have differing pressures - dependent upon their capacity for elective recovery (generating Income) and non-elective pressures - so it is critical that there is a collective commitment from the provider collaboratives and FD / CFO community to manage all the finance resources at our disposal to land break even for each organisation. The creation of 'system assets' during the Covid response has compounded this new, emerging financial landscape so the resources need to be viewed as system resources in the same way as our clinical capacity and facilities. Equally I appreciate that culturally this may seem a big ask but it is the only way of working from here on given the Bill and the move to ICB's. The challenge for the CEO's, Finance Directors and indeed Boards as whole, is to quickly agree the principles and mechanisms to make this happen. To this end the absolute financial gap in each organisation is being collated and will be shared openly to ensure we are all sighted on where we have 'gaps' that cannot be closed by organisations on their own, and by association therefore, where we need to direct I+E / Cash support.

In terms of being able to provide assurance, since submission, work has escalated to strengthen the transparency across all organisations and formalise the governance required to ensure every organisation achieves breakeven. Specifically, defined work streams have now been set up, all to be led by a CFO / FD from the system.

Although this may seem a small step, I cannot overstate its significance in terms of demonstrating collective responsibility and commitment. These groups, highlighted below, will require independent review of expenditure run rates and real openness and transparency. It should highlight where surpluses are being generated and allow for Income and cash to be redirected. (Success is only real success if every organisation is financially stable). The two critical programme areas are as follows:

1. Review of Individual Organisations' H2 financial plans to provide assurance to all that there is consistency of approach e.g. visibility of the balance sheet, CIP delivery expectations and assumed income levels. Equity is the key point here.

2. Review of H1 to H2 Expenditure run rates - this will require full transparency and open book from each organisation, so will be supported by independent enquiry from PA Consulting.

We should not underestimate the cultural challenge in this and hence the commitment to making this a success needs to be signed up to by the Provider collaboratives as well as the finance community. To aid this it has been suggested at the ICS Finance Committee that there is a joint meeting with CEO's and Finance Directors so that the underlying risks, options to mitigate and mechanisms to physically transact the financial flows can be discussed.

Finally, we have to be realistic in terms of when the movement of resources will physically happen, given the above actions need to be signed up to by all and mobilised, but once again I reiterate that at FARG there was the acknowledgement that there are options available to us to close the gap and hence ensure break even for all.

In summary, I hope this response provides some tangible evidence that there is commitment to close the underlying gap for Mid Cheshire, and indeed for other organisations in a similar position at the time of planning H2. Similarly, if you have any additional reflections as to how we can galvanise the hearts and minds of system colleagues to embed the approach being driven here then I am very willing to speak further and work with you to deliver the right result position for the whole of the Cheshire and Merseyside system.

Yours sincerely

Keith Griffiths
Executive Director Finance & Resources
Cheshire and Merseyside Health and Care Partnership

1. Introduction

1.1. This purpose of this paper is to set out the methodology adopted for the distribution of System monies received as part of the Cheshire and Merseyside Healthcare system's financial envelope for the second half of 2021/22 (i.e. "H2"). In doing so, the paperalso describes the underpinning principles which have been endorsed by the System's Financial Advisory Reference Group and which relate to financial matters wider than simply the distribution of funding. These are set out in the appendix to this paper.

1.2. Importantly, the approach to be taken for H2 can only be incremental from that deployed in H1, in order to ensure we do not destabilise the complete 21/22 financial landscape for all. Alongside this, success remains that of ensuring every organisation achieves breakeven at 31 March 2022, and with the approach taken to allocate system monies in H1, we did achieve this objective of breakeven for all for H1.

1.3. Alongside the above, the following 4 key objectives informed the methodology, namely:

- *Equity* – as far as possible, the principles should be equitable across individual organisations or impact on the least number of organisations to the least extent. Equity does not necessarily mean equal share, and also gives consideration to a multiplicity of financial and non-financial factors such as the need to address health inequalities issues and prospective financial challenges.
- *Transparency* – the methodology should be both simple and clear and readily replicable. To this end, the methodology needed to be based on criteria which are explicit. objective, evidence-able and reasonable/fair.
- *Expediency* – the distribution of System monies is intended to support, rather than detract from, wider collaborative working across the system in order to combat population health issues and inequalities. The methodology needs to enable (and not inhibit) timely flow of system monies to organisations.
- *Consistency* – the methodology needs to be applied consistently from one period to another, insofar as it remains relevant and appropriate.

1.4. This methodology covers the distribution of the following (non-recurrent) system 'top-up' funding allocations:

- *System Top-up*
- *System Covid; and*
- *System Growth.*

2. Basis of allocation of system monies

2.1. The bases of allocating the three system 'top-up' allocations has been locally determined as follows:

System 'pot'	Basis of allocation
Top-up	Apportion entirely between Providers, given that this element is funding is directly linked to NHS Provider contracts.
Covid	COVID allocation to be apportioned between Providers and CCGs on fair basis to reflect legitimate COVID costs reasonably expected to be incurred and which will need to be funded from the envelope.
Growth	Growth to go entirely to CCGs, allocated on basis of CCG allocation. Any deployment to Providers will be part of existing block contract regime.

3. Overview of methodology for H2

3.1. The final distribution of system monies for H1 was used as the template for the provisional distribution for H2 system monies; this was done to ensure that available funding was assigned to organisations as soon as possible following formal notification, to enable organisations some degree of certainty as early as possible and thus give the maximum amount of time within which to plan/manage its finances for H2.

3.2. Given that the ultimate (dual) aims of collective and organisational breakeven at the end of the period, the distribution of H1 system monies:

- involved identifying opportunities for 'equalising' the impact of the current financial regime, by 'smoothing' initial deficits and surpluses between organisations; and
- was informed by analysis of the H1 Plan position of individual organisations to identify which components should be supported by system funding and which should be covered by the organisations themselves. Primarily, expenditure assessed as being discretionary in nature (e.g. unfunded investments) was not backed by system monies.

3.3. Furthermore, adjustment was also made (in H1) for the estimated impact of the elective recovery fund (ERF) income to prevent organisations from inadvertently going into surplus; had this not happened, the period would have also ended with some organisations correspondingly in deficit. Thus the distribution needs to reflect the commitment to re-distribute any residual surpluses after expected impact of ERF to ensure every organisation achieves breakeven.

3.4. Changes to the ERF regime from July 2021 are recognised as disproportionately impacting on specialist Providers and therefore continuation of the H1 methodology into H2 would be financial disadvantageous to that group. The recent announcement of additional funding streams to the region (e.g. £100m elective recovery pump-priming fund and £25m Winter bed capacity expansion – of which the C&M fair share is c£36m and £9m respectively) may effectively reduce any impact arising from this basis of distribution, but if it fails to do this, then H2 system monies will need to be used to stabilise these organisations.

3.5. As in H1, the distributable amount of system 'top-up' funding for H2 has been reduced nationally by an efficiency factor which reflects the distance to organisational FIT (financial improvement trajectory) targets across the System as well as other movements outlined in the official financial guidance for the period. Total system top-up funding for H2 is therefore £325k (compared with £332k for H1), which represents c 12% of the financial envelope for H2 (i.e. £2,745m excluding national funding for Service Development Framework and Spending Review programmes).

3.6. Finally for H2, Capacity funding (£15.8m) and the residual of the reserve for system-wide infrastructural commitments (i.e. currently £10.0m) will be allocated. The latter is primarily required to support those organisations who host large scale digital infrastructure programmes on behalf of all system partner organisations in order to ensure they are not financially disadvantaged as a consequence of doing so.

4. Further revisions proposed to the H2 distribution methodology

4.1. Effectively, therefore, the only revisions to the H1 methodology that will be deployed for H2 centre on the deployment of the Capacity fund plus any residual from the IT and Infrastructure reserve highlighted above. There are a few specific issues which these funds should seek to address, namely:

- Rectification of the funding shortfall in respect of agenda for change staff on local authority commissioned contracts – the impact of this is potentially limited to 4 Providers (i.e. Bridgewater, CWP, Mersey Care and Wirral Community) and is likely to be circa £1.0m. The correction is necessary as this pressure would not have been included within the national 1.16% uplift to NHS contracts.
- Ongoing specific Provider cash/liquidity issues (affecting Liverpool Women's and Southport & Ormskirk NHS Trust primarily);
- Compensating for the loss of income (suffered by specialist Providers primarily) due to changes in the ERF regime and as a consequence of retaining a distribution methodology based in H1 positions. Paragraph 3.4 above explains how this issue has effectively been addressed and therefore removed from present consideration.

4.2. It would be recognised that the cash issue would be difficult to resolve substantively by the proposed distribution alone, or even complete re-distribution for H2 given the root cause is likely to have a structural diagnosis. Any distribution would therefore be seen to offer short-term support and may also have consequences for the I&E performance of the organisations concerned. As a result, the proposal is to repeat the level of associated support to these providers as was agreed in H1, whilst the national arrangements for accessing PDC are hopefully corrected. This effectively means partner organisations support the above two organisations with cash, not income, temporarily. In this way, H2 system monies remain available, and equity is maintained.

4.3. As mentioned above, rather than revisiting the entire distribution of H2 system monies, which would significantly destabilise the positions of many organisations, the proposal is that the distribution of the residual monies will be used to respond to any further equity issues as far as possible, namely:

	Capacity funding £m	IT & Infrastructure Reserve £m	Total retained £m
Capacity funding (not yet distributed)	15.8		15.8
Reserve for IT & Infrastructural commiments (net of H1 Provider BackPay paid in Month 7)		10.0	10.0
Less: Retained System Reserve (to enable management of risk for remainder of H2)		(1.0)	(1.0)
Total resources for distribution	15.8	9.0	**24.8**

4.4. For transparency purposes and to ensure equitability, the following order of prioritisation is proposed for the distribution of all remaining System monies (net of a small retained system-level risk management fund):

	£m
i. 100% coverage of existing system-level commitments (namely the revenue consequences of HSLI and CIPHA) plus MedTech funding commitment;	4.1
ii. Rectification of the H2 funding shortfall in respect of agenda for change staff on local authority commissioned contracts (at 100%);	1.0
iii. Compensation of Specialist Providers for the impact of the ERF contribution loss on H1 eventual distribution – this is calculated at 100% of the net loss in ERF income over H1 and H2;	7.0
iv. Distribution of the remaining balance amongst <u>all</u> Providers in proportion to Total Operating income from patient care services as per H2 Finance Plan.	12.7
Total distribution	24.8

4.5. In summary, we need to stabilise financial plans across H1 and H2 and give as much certainty as possible. Where there have been obvious impacts due to changes in national policy that have adversely affected specific organisations then these should be the first call on available resources. Equally, it must be honestly recognised that the learning from H1 is that what one organisation may see as equitable another will not, and that this debate should not overshadow the fact that every organisation did achieve breakeven in H1. This should be our collective ambition and commitment for H2.

Keith D Griffiths

Executive Director of Finance and Resources

15 November 2021.

Appendix 1

Financial Planning Principles for H2

1. We put the patient first and will maintain a focus on reducing health inequalities equally across the Cheshire and Mersey footprint. This applies to immediate restoration and non-elective pressures as it does to long term health improvement.

2. We accept the DUTY (as per the 'Bill') we all have to think and work on behalf of the Cheshire and Mersey System.

3. Every organisation must be supported to ensure breakeven on 31st March 2022.

4. Every organisation commits to an open and transparent peer to peer review of individual expenditure run rates, balance sheets, and sharing the detail on fortuitous savings (non-recurrent or recurrent). This process must be explicitly evidenced at sub-system and sector level, prior to the issue of draft organisational plans.

5. We will reflect locally the National Allocative methodology as closely as is practically possible.

6. Differential CIP / QIPP targets will apply, reflecting the pre-COVID deficits in organisations as well as stretching those organisations at Breakeven or Surplus to go further.

7. All service developments and non-delivery of H1 CIPs /QIPPs are to be signed off by the whole finance community through a process of peer-to-peer review.

8. Throughout H2 we aim to collectively maximise the elective capacity in NHS or IS organisations throughout Cheshire and Merseyside and operate in an agnostic manner to manage the available financial resources towards where the need is greatest.

9. Valid System commitments and obligations, including those carried forward from H1, to be considered as a first charge against the H2 envelope.

10. All organisations should act in a way so as to minimise leakage of the financial envelope out of the System, even where this benefits an individual organisation.

11. System monies distributions must be regarded as non-recurrent and should not to be used to support recurrent pressures without development of a plan for underlying sustainability. The final distribution methodology adopted will be primarily aimed to achieve organisational breakeven (re-distributing any operating surpluses and deficits).

12. Organisations will be expected to deliver I&E surpluses where it is clear that this is achievable.

APPENDIX 2

Mid Cheshire Hospitals
NHS Foundation Trust

26th November 2021

Office of the Chief Executive
Mr James Sumner

Leighton Hospital
Middlewich Road
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Cheshire
CW1 4QJ

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charmaine.morris-marshall@mcht.nhs.uk

Private & Confidential
Mr K Griffiths
Executive Director of Finance & Resources
Cheshire & Merseyside HCP

Delivery via Email

Dear Keith,

I wanted to update you on the position of the Mid Cheshire Board following our meeting yesterday. The Board discussed the current H2 plan and the ambition to break even as an ICS footprint and of course were supportive of that approach. However, there was significant concern around the Mid Cheshire £7.9m deficit position in that whilst we have a clear plan to control costs, the increase (£2.6m) being due to urgent care pressures or uncontrollable expenditure, the significant gap in income (£5.3m) in order to achieve balance is obviously out of our control and therefore the Board stated that they could not agree to this plan without some key assurances. These are:

1. Clarity on the process to get to the current point – i.e., the timeline of revisions made to the positions of the Trusts and what assumptions or formulas were used so that there is a clear and transparent record of how each organisation got to the current point. You acknowledged in your letter the issues of non-elective capacity requirements and mutual aid will land differently within organisations but it is unclear how this has or will be going forward addressed to ensure a holistic view is taken of organisations to safeguard the equity, but not necessarily equal, approach is taken.

2. Stronger assurance that the Trust will receive the external income required to balance the position than we have to date.

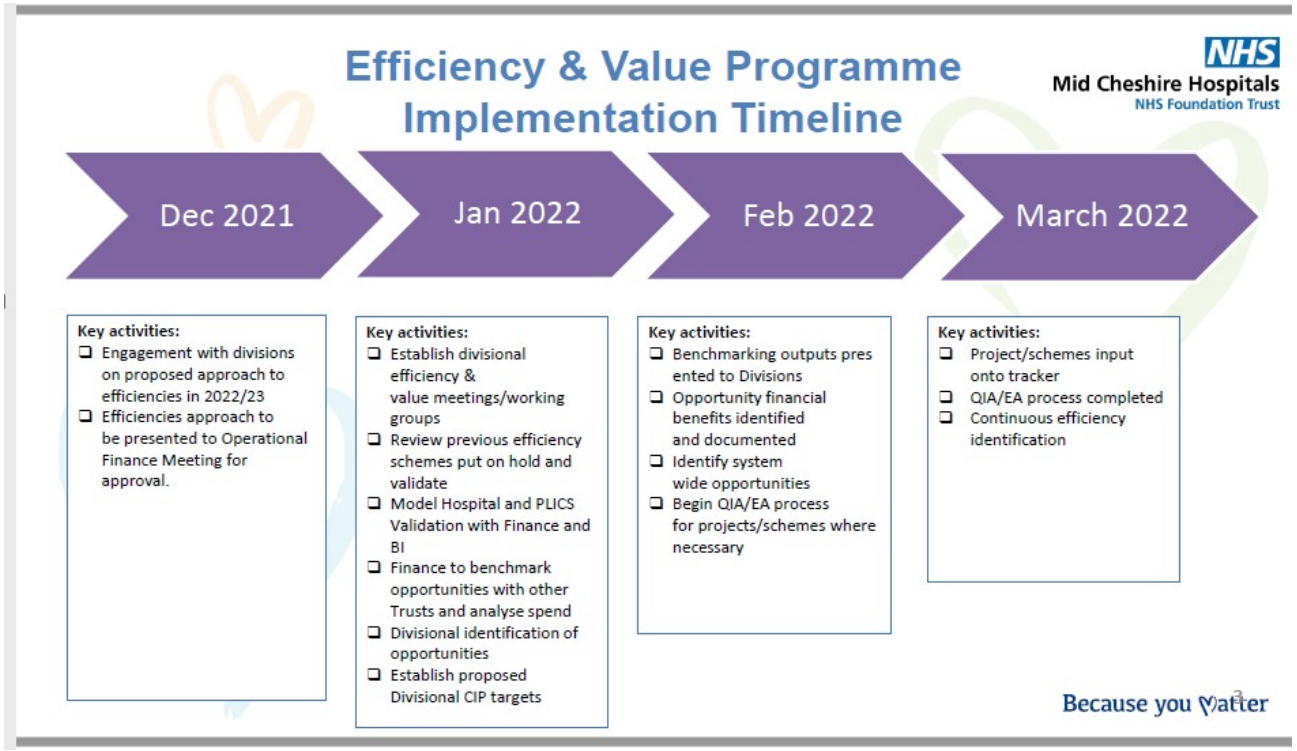
The H2 submission was made at 12pm yesterday in our Part 2 Board meeting half an hour later so I informed the Board that the current submission has been made on the basis of our collective ambition rather than strong assurance on the income at that point. The Board, and in particular the Audit Committee members, would like further assurance before they feel they can agree to this plan.

As you know, we will continue to help in any way we can to obtain that stronger level of certainty and assurance, but I needed to write and inform you that it will be unlikely that I can continue to obtain full Board support for the current plan as we move forward without this.

Yours sincerely,

James Sumner
Chief Executive Officer

APPENDIX 3


Efficiency & Value Programme Implementation Timeline
NHS
Mid Cheshire Hospitals
NHS Foundation Trust
Dec 2021
Jan 2022
Feb 2022
March 2022
Key activities:
❑ Engagement with divisions on proposed approach to efficiencies in 2022/23
❑ Efficiencies approach to be presented to Operational Finance Meeting for approval.
Key activities:
❑ Establish divisional efficiency & value meetings/working groups
❑ Review previous efficiency schemes put on hold and validate
❑ Model Hospital and PLICS Validation with Finance and BI
❑ Finance to benchmark opportunities with other Trusts and analyse spend
❑ Divisional identification of opportunities
❑ Establish proposed Divisional CIP targets
Key activities:
❑ Benchmarking outputs pres ented to Divisions
❑ Opportunity financial benefits identified and documented
❑ Identify system wide opportunities
❑ Begin QIA/EA process for projects/schemes where necessary
Key activities:
❑ Project/schemes input onto tracker
❑ QIA/EA process completed
❑ Continuous efficiency identification
Because you matter

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**18**	Date of Meeting: 27/01/2022
Report Title	**H2 Operational Priorities & Elective Restoration Update**	
Executive Lead	Oliver Bennett, Chief Operating Officer	
Lead Officer	Mark Wilde, Director of Operations	
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)*

- Overall progress is being made against the H2 operational priorities and restoration work across the Trust. Inpatient elective activity has exceeded pre-pandemic levels and outpatient activity is at near pre-pandemic levels, both are exceeding plan.
- Key priorities for urgent and emergency care performing relatively well and amongst the best in C&M, particularly around ambulance handovers. However, the number of patients waiting over 12 hours, including 12 hours DTAs in the Emergency Department is increasing because of Covid and operational pressures.
- Cancer referrals are increasing, and performance is below expectation, but the Trust is not an outlier in C&M.
- Daycase activity, the rising number of >52-week waiters and the growing RTT waiting list backlog remains a problem for the Trust.

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 **BAF1 Demand and capacity**
• 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

H2 Operational Priorities & Elective Restoration Update

Introduction

1. This paper provides an update against the H2 Operational Priorities and the elective restoration programme.

Executive Summary

2. Good progress is being made against the H2 Operational Priorities and restoration work across the Trust:

- Inpatient elective activity has exceeded pre-pandemic levels and outpatient activity is at near pre-pandemic levels, both are exceeding the H2 plan/trajectory.
- Key priorities for urgent and emergency care performing relatively well and amongst the best in C&M, particularly around ambulance handovers. However, the number of patients waiting over 12 hours in the Emergency Department is increasing because of Covid and operational pressures.
- Cancer referrals are increasing, and performance against key metrics is below plan, but the Trust is not an outlier in C&M and improvement over the coming months is expected.
- Daycase activity, the rising number of >52-week waiters and the growing RTT waiting list backlog remain the main concerns for the Trust.

Operational Priorities

Urgent and Emergency Care

3. Ambulance handovers and the number of patients waiting a total time of over 12 hours in Emergency Departments (ED) remain the key national priorities for urgent and emergency care. The expectation is that no ambulance waits longer than 60 minutes to handover; at the Trust in December over 99% of patients were handed over within this timeframe which remains one of the best performances in C&M, and over 86% are handed over within 30 minutes.

4. More patients waiting longer than 12 hours in December compared to November; from 4.5% to 8.7% of total attendances due to significant operational pressures. The Trust is not an outlier in C&M. However, the Trust in December was an outlier for the number of patients who waited over 12 hours in the ED after a decision to admit (DTA) was made. 47 patients in December waited over 12 hours following a DTA; only two other Trusts in C&M had more than this (Countess of Chester and Southport & Ormskirk).

5. Another UEC priority is to reduce length of stay for patients in hospital over 21 days. The Trust demonstrated an improvement against this metric in December compared to the previous month, and it remains a key focus.

Elective Care

6. Elective activity in December improved significantly with 168% of ordinary inpatient electives compared to same period in 2019 and exceeds the H2 plan. This is the result of maintaining most of the elective programme in month which hasn't been the case in previous years. 72% of daycase activity compared to pre-pandemic levels was delivered in December which is below the H2 plan. The Trust is still waiting confirmation of a baseline adjustment requested before Christmas to reflect changes to clinical pathways that has reduced the level of daycase activity planned to be delivered. Inpatient elective activity is above the C&M average and daycase is below.

7. Outpatient activity is nearly 95% of pre-pandemic levels and has exceeded the H2 plan in December. 23% of this activity was delivered virtually, below the 25% standard expected nationally.

8. CT and MRI activity are both exceeding pre-pandemic levels of activity by some way; 147% and 167% respectively, and both are achieving better than plan. Non-obstetric ultrasound is 100% of pre-pandemic activity but below the H2 plan set. Echocardiology is delivering 95% of pre-pandemic activity and is above plan. Gastroscopies are 87% and colonoscopies 85% of pre-pandemic levels, the former is better than plan and the latter below plan.

9. Eliminating patients waiting over 104 weeks is a top priority nationally. The Trust has one of the lowest rates in C&M. However, the number of patients waiting over 52 weeks is increasing and now stands at nearly 700, which is higher than the H2 plan, and 85 more compared to the previous month. This remains a significant priority, but likely to continue to rise due to current operational pressures, and a lot of work is underway to protect elective procedures as much as possible despite Covid and other operational pressures.

10. The national expectation is that the overall RTT waiting list does not grow beyond the position it was in September 2021 (28,231) by March 2022. As at December, the RTT waiting list at was 29,751 therefore exceeding the September 2021 position and is likely to continue to grow due to demand and operational pressures. The Trust is planning, over the coming months, to undertake a comprehensive validation of the RTT backlog to provide assurance that open pathways are correct. At least 89% of pathways should be closed in month compared to the same period in 2019. In December, the Trust achieved 87% and therefore fell short of the standard.

11. 1.5% of total outpatient appointments should transfer on to a 'patient initiated follow up' pathway. This is a significant challenge for the Trust despite a comprehensive plan being in place, with only 0.6% currently being achieved.

Cancer

12. The H2 plan for the number of patients who have waited over 62 days for their cancer treatment was 78 and the Trust currently has 85 in the backlog as at December 2021. The Trust is, however, not an outlier in C&M. A comprehensive improvement plan is in place to reduce the backlog in line with the H2 trajectory. The Trust treated 66 patients (31-day definitive treatment

standard) which was 89% of the number delivered in the same period in 2019 before the pandemic.

13. The Trust has historically performed well seeing most patients (>93%) referred to us on a cancer pathway within 2 weeks. However, in December the Trust fell short of this standard achieving 92%; driven by a significant increase in referrals particularly in breast. 37% increase in cancer referrals in December 2021 compared to the same period in 2019. An improvement plan is in place and the standard is expected to be delivered in January.

2022/23 Operational Priorities

14. On the 24 December 2021, NHS England/Improvement published the 2022/23 Operational Priorities and planning guidance. The guidance is currently being considered by the Executive Directors and a briefing will be provided to the Performance and Finance Committee in February.

Conclusion

15. The paper has provided a comprehensive update against the key operational priorities and despite the significant operational pressures, reasonably good progress is being made against many of the standards. Rising elective backlogs and patients waiting over one year for surgery are key areas of concern along with the amount of daycase activity being delivered which is an ongoing issue.

Recommendation

16. To note

Oliver Bennett
Chief Operating Officer
January 2022

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

Report to	Board of Directors
Date	December 2021
Report from	Lorraine Butcher, Non-Executive Director
Report prepared by	Caroline Keating, Company Secretary
Executive Lead/s	Heather Barnett, Director of Workforce and OD Dylan Williams, Chief Information Officer (CIO) Mark Wilde, Director of Operations *(deputising for OBennett, Chief Operating Officer*
Committee meeting quoracy	Yes ☒ No ☐

KEY AREAS OF ASSURANCE

Governance & Risk: The Committee reviewed the strengthened controls and assurances supporting the BAF strategic risks delegated to WDT and the work undertaken to date to map the information flow to the Committee as identified in the workplan. Both remain work in progress.

Integrated Performance Report: key trends identified:

- Agency spend and increase in staff vacancies – latter seen as wider than HR process issue, i.e. timely approval of vacancies (financial perspective) and management capacity to complete the necessary administration
- Safeguarding training compliance
- Rise in sickness absence

Digital Clinical System – Acceptable Assurance: full business case on track for joint Board meeting between MCHFT and East Cheshire Trust.

Future of NHS HR and OD Review: Trust sighted on all themes. Assurance provided that the strategic direction of travel for the Workforce Directorate aligned to the future vision for HR and OD functions. Immediate focus for the Trust and the Integrated Care System would be a focus on 'Prioritising the health and wellbeing of all our people', through the presenteeism vs absenteeism work and 'supporting and developing the people profession', through development of people teams.

Digital Technology & Information Services Group (DTIS) Chair's Report – December 2021: challenge identified in releasing ward staff for engagement and training (Ward Digital Enablement). Under review by senior maangement.

Executive Workforce Assurance Group Chair's Report – December 2021:

- Occupational Health Service – capacity and leadership issues to be addressed. Cheshire Wellbeing programme currently paused due to capacity issues and required review of objectives
- Staff wellbeing – internal audit review on the People Recovery Plan in progress

Sickness Absence Improvement Plan – Partial Assurance: Committee supported the proposal to replace the current overarching 3.9% internal 'stretch' target with an improved key performance indicator to demonstrate improving absence rates at Divisional level, using a Quality Improvement approach.

Appraisals' compliance – Partial Assurance: incremental steps to be taken to improve compliance with the improvement plan with monitoring of metrics through the Executive Workforce Assurance Group.

Stress Survey Summary Results – **Partial Assurance:** 730 staff responded with lower scores than previous years across all six stressors. Plan to be developed for support to departments scoring poorly. Results to be triangulated with Staff Survey initial raw data.

KEY CONCERNS/RISKS

- Occupational Health Service
- Increased sickness absence due to Omicron variant
- Health & Wellbeing impact through the BAF, i.e, consideration whether increasing levels of absence due to Omicron, coupled with challenges in Occupational Health and apparent workforce strain across all disciplines might impact on BAF2.

Priority Areas: DECISIONS MADE

- Sickness absence internal 'stretch' target – Committee agreed to remove the target in favour of improving the trajectory over the next 12 months using a quality improvement approach. Board approval to be sought.

RECOMMENDATION

To note

BOARD OF DIRECTORS

Agenda Item	**19.1**	Date of Meeting: 27/01/2022
Report Title	**Sickness Improvement Plan**	
Executive Lead	Heather Barnett, Director of People	
Lead Officer	Anna Bickerton, Acting Head of HR	
Action Required	To note	

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

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

- The Trust is consistently not achieving its sickness absence target of 3.90%.
- An improvement target, by division, is the fairest and most consistent way of supporting the organisation to move towards its absence target over the next 12 months.
- Targets for improvements in stress, anxiety and depression and MSK absences will help the Trust monitor the success of wellbeing initiatives implemented by the Health & Wellbeing Project Board and identify whether further work is required.
- WDT supported the proposal to remove the sickness absence target, and to recommend to Board for approval. Attached report submitted to WDT December 2021, included here for background information.

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

- WDT to take forward as indicated in the attached paper.

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 **BAF2 Workforce wellbeing and resilience**	
• 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
WDT Committee	20.12.2021	Sickness Improvement Plan	H. Barnett Director of People	Agreed with approval to be sought by the Board.

Sickness Improvement Plan

1. Introduction

1.1 The Trust target for sickness absence is 3.90%; this has been the target since April 2019.

1.2 Unfortunately, the Trust has consistently not achieved this target in the preceding 24-month period up to September 2021 and therefore this paper sets out the options which will allow for targeted improvements of this KPI over the next 12 months.

2. Background and Analysis

2.1 The Trust has consistently not achieved its sickness target of 3.90% in 24 months. The average rate of absence between October 2019 and September 2021 was 5.00% and in the preceding 12 months, October 2020 to September 2021, this was 4.88%. Appendix 1 provides a summary of the in-month sickness rates, by division, over the last 24 months.

2.2 It can be noted from Appendix 1 that sickness has started to steadily increase across most divisions since April 2021 suggesting that staff resilience/wellbeing may be deteriorating post-pandemic. Sickness absence attributed to stress, anxiety and depression accounted for 1.34% of total absence in the preceding 12-month period and Musculoskeletal absences for 0.91% over the same period.

2.3 Divisional sickness absence targets are in place; these were implemented in April 2019 along with the new Trust target of 3.90%. These targets were calculated based on their contribution towards the Trust's overall rate of absence and historic absence rates. Divisional achievement of targets has been mixed; CCICP, Women's and Children's, Corporate and Surgery & Cancer Divisions have all managed to achieve their targets in some months. Medicine & Emergency Care, Diagnostics & Clinical Support Services and Estates & Facilities have however found it more difficult to achieve compliance.

2.4 Appendix 2 provides sickness absence information for the Cheshire & Mersey region. This regional dataset places average rates of absence across the Cheshire & Mersey footprint for September 2021 at 6.16%. This information also shows that Trusts across Cheshire & Mersey have taken the decision to increase their sickness targets in light of the pandemic recovery period with targets across the region now averaging 5.13%.

2.5 There appears to be two options available; move towards focused divisional stretch targets or retain the Trust target of 3.9%. A brief options appraisal of these two options is detailed below.

2.6 **Option 1** – Remove/suspend the Trust absence target of 3.90% and instead set an improvement trajectory and target for all divisions to achieve by Sept 2022 based on their mean (R12M) absence rate between September 2020 and October 2021.

2.7 The table below details a proposed 10% divisional improvement target based on the mean (R12M) absence position for October 2020 to September 2021. Achievements of these proposed divisional targets would reduce the overall Trust Sickness absence rate to 4.4% by December 22.

		Oct-20 to Sep-21			PROPOSAL		
	Target	Absence FTE	Available FTE	Absence FTE %	Absence FTE	Available FTE	Absence FTE %
412 L4 Central Cheshire Integrated Care Partnership (CCICP) - Div	3.90%	8,830.98	219,052.25	4.03%	7,951.60	219,052.25	3.63%
412 L4 Cheshire East Integrated Care Partnership (CEICP) - Div	3.40%	172.45	1,936.50	8.91%	155.11	1,936.50	8.01%
412 L4 Corporate - Div	2.40%	3,648.13	160,755.32	2.27%	3,279.41	160,755.32	2.04%
412 L4 Diagnostics and Clinical Support Services - Div	3.70%	11,321.23	231,794.15	4.88%	10,198.94	231,794.15	4.40%
412 L4 Estates and Facilities - Div	4.30%	9,156.12	130,303.44	7.03%	8,235.18	130,303.44	6.32%
412 L4 Medicine and Emergency Care - Div	4.30%	19,134.29	340,091.75	5.63%	17,208.64	340,091.75	5.06%
412 L4 Surgical and Cancer - Div	4.15%	16,496.10	318,541.47	5.18%	14,844.03	318,541.47	4.66%
412 L4 Women and Childrens - Div	4.10%	6,007.93	128,141.85	4.69%	5,407.59	128,141.85	4.22%
Grand Total	3.90%	74,767.22	1,530,626.33	4.88%	67,280.50	1,530,626.33	4.40%

2.8

Benefits

- Ambitious divisional targets in place
- Divisional improvement trajectories will provide focus on reducing absence in a manageable way and recognises challenges with post-pandemic rates of absence
- Improvement targets can be set fairly across all divisions, irrespective of divisional targets, by using a % improvement calculation
- Targeted improvements can be set for absence reasons where targeted support is being delivered through the Health & Wellbeing Project Board (e.g. stress/anxiety/depression and musculoskeletal)
- Progress can be monitored at a Trust, Divisional and targeted absence reason level

Risks

- Mean (R12M) absence rates can be distorted by a handful of high in-month figures
- Trust may be viewed as a regional outlier in respect of its absence target

2.9 **Option 2** – Retain the Trust target of 3.9%. This would be a significant stretch target and this option requires acknowledgement that achievement of the current target is ambitious and attainment of the target in 12 months is unlikely.

2.10 Benefits

- Organisational stretch target remains in place
- Consistency in trajectory and reporting.
- Straightforward monitoring of overall Trust absence rates

Risks

- Retaining the target may not result in improved performance/ attendance
- Attainment of the target is unlikely

- Outlier in Cheshire and Merseyside for sickness absence target

2.11 Taking into consideration the risks and benefits of the two options above, it is recommended that Option 1 is pursued with a target improvement date of December 2022.

2.12 The above proposal (Option 1) would aim to reduce the Trust's mean (R12M) sickness absence position by almost 0.5 percentage points by December 2022 (down to 4.40%) whilst applying a fair and consistent target across all divisions.

2.13 Specific improvement targets for stress, anxiety and depression and MSK absences are detailed below. These have been calculated using the same 10% improvement methodology.

	Oct-20 to Sep-21			PROPOSAL		
	Absence FTE	Available FTE	Absence FTE %	Absence FTE	Available FTE	Absence FTE %
Anxiety / Stress / Depression	20,516.01	1,530,626.33	1.34%	18,520.58	1,530,626.33	1.21%
MSK	13,895.78	1,530,626.33	0.91%	12,551.14	1,530,626.33	0.82%

2.14 Monitoring of reduction in stress, anxiety and depression targets will also be included within the divisional and EWAG reports.

3. Conclusions

3.1 The Trust is consistently not achieving its sickness absence target of 3.90%.

3.2 A percentage improvement target, by division, is the fairest and most consistent way of supporting the organisation to move towards its absence target over the next 12 months.

3.3 Targets for improvements in stress, anxiety and depression and MSK absences will help the Trust monitor the success of wellbeing initiatives implemented by the Health & Wellbeing Project Board and identify whether further work is required.

4. Recommendations

4.1 To agree the proposed divisional improvement targets in line with option 1

4.2 To bring 3 monthly updates on divisional and Trust level progress back to EWAG for assurance and support as necessary.

4.3 Senior Workforce Business Partners to discuss approach to targeted reduction in absence rates with SMTs and the new People, Culture & Finance Committees

Author: Anna Bickerton, Acting Head of HR
Date: 25 October 2021

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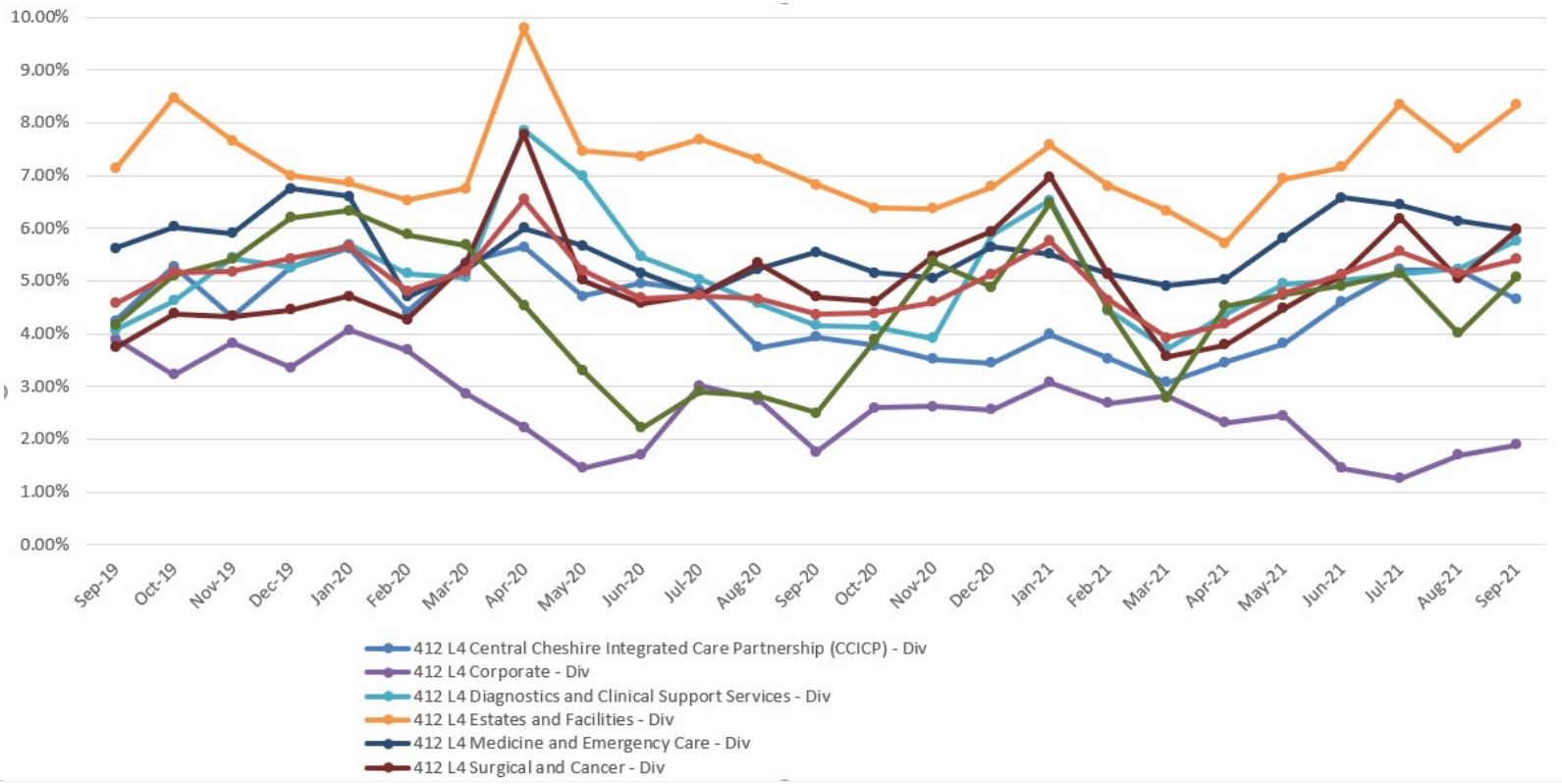
Appendix 1

Monthly Sickness Absence Rates by Division – Sep 2019 to Sep 2021

Division	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
412 L4 Central Cheshire Integrated Care Partnership (CCICP) - Div	4.25%	5.28%	4.32%	5.26%	5.62%	4.41%	5.35%	5.64%	4.71%	4.96%	4.81%	3.74%	3.94%	3.77%	3.51%	3.44%	3.98%	3.53%	3.07%	3.46%	3.82%	4.59%	5.22%	5.20%	4.64%
412 L4 Cheshire East Integrated Care Partnership (CEICP) - Div																						9.00%	10.63%	13.50%	2.26%
412 L4 Corporate - Div	3.90%	3.22%	3.82%	3.36%	4.07%	3.69%	2.87%	2.23%	1.45%	1.71%	3.01%	2.75%	1.76%	2.59%	2.62%	2.56%	3.08%	2.68%	2.82%	2.31%	2.45%	1.45%	1.25%	1.70%	1.89%
412 L4 Diagnostics and Clinical Support Services - Div	4.07%	4.63%	5.44%	5.25%	5.69%	5.14%	5.07%	7.86%	6.98%	5.46%	5.03%	4.57%	4.16%	4.13%	3.91%	5.88%	6.52%	4.44%	3.71%	4.36%	4.94%	5.00%	5.13%	5.23%	5.76%
412 L4 Estates and Facilities - Div	7.13%	8.47%	7.66%	6.99%	6.86%	6.52%	6.75%	9.78%	7.47%	7.36%	7.68%	7.30%	6.83%	6.38%	6.36%	6.79%	7.58%	6.80%	6.33%	5.71%	6.93%	7.15%	8.35%	7.50%	8.33%
412 L4 Medicine and Emergency Care - Div	5.62%	6.03%	5.90%	6.76%	6.60%	4.70%	5.22%	6.00%	5.67%	5.15%	4.75%	5.23%	5.54%	5.15%	5.05%	5.64%	5.51%	5.14%	4.91%	5.03%	5.82%	6.58%	6.44%	6.14%	5.96%
412 L4 Surgical and Cancer - Div	3.74%	4.38%	4.33%	4.45%	4.71%	4.26%	5.33%	7.78%	5.01%	4.57%	4.74%	5.34%	4.70%	4.61%	5.47%	5.94%	6.97%	5.11%	3.56%	3.79%	4.48%	5.11%	6.19%	5.04%	5.97%
412 L4 Women and Childrens - Div	4.16%	5.10%	5.41%	6.20%	6.33%	5.88%	5.68%	4.54%	3.31%	2.22%	2.90%	2.82%	2.50%	3.88%	5.36%	4.88%	6.48%	4.45%	2.79%	4.53%	4.73%	4.90%	5.16%	4.01%	5.07%
MCHFT	**4.58%**	**5.16%**	**5.17%**	**5.43%**	**5.65%**	**4.80%**	**5.18%**	**6.54%**	**5.21%**	**4.67%**	**4.73%**	**4.65%**	**4.37%**	**4.39%**	**4.59%**	**5.13%**	**5.75%**	**4.63%**	**3.92%**	**4.18%**	**4.77%**	**5.13%**	**5.55%**	**5.14%**	**5.41%**



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Appendix 2

Workforce KPI Benchmarking Dashboard for Cheshire & Wirral NHS Trusts

		CWP	COCH	ECT	MCHFT	WCT	WUTH	Cheshire & Wirral Position
Reporting Date - 31 August 2021		01-Sep-21	01-Sep-21	01-Sep-21	01-Sep-21	01-Sep-21	01-Sep-21	01-Sep-21
1	**Sickness Absence**							
	Target (in-month) %	5.39%	6.00%	5.50%	3.90%	5.00%	5.00%	**5.13%**
	In-month Position %	8.12%	5.32%	5.44%	4.67%	6.78%	6.62%	**6.16%**
	Target (12 m) %	5.33%	6.00%		3.90%	5.00%	5.00%	**5.05%**
	Rolling 12m %	6.65%	4.73%	5.36%	4.85%	5.81%	6.21%	**5.60%**

Appendix 3

Mean Average (R12M) Divisional Sickness Absence Rates
October 2019 – September 2021

	Oct-19 to Sep-21			Oct-19 to Sep-20			Oct-20 to Sep-21			PROPOSAL		
	Absence FTE	Available FTE	Absence FTE %	Absence FTE	Available FTE	Absence FTE %	Absence FTE	Available FTE	Absence FTE %	Absence FTE	Available FTE	Absence FTE %
412 L4 Central Cheshire Integrated Care Partnership (CCICP) - Div	18,540.77	420,121.50	4.41%	9,709.79	201,069.25	4.83%	8,830.98	219,052.25	4.03%	7,951.60	219,052.25	3.63%
412 L4 Cheshire East Integrated Care Partnership (CEICP) - Div	172.45	1,936.50	8.91%				172.45	1,936.50	8.91%	155.11	1,936.50	8.01%
412 L4 Corporate - Div	7,567.61	299,720.49	2.52%	3,919.47	138,965.18	2.82%	3,648.13	160,755.32	2.27%	3,279.41	160,755.32	2.04%
412 L4 Diagnostics and Clinical Support Services - Div	26,662.53	513,975.17	5.19%	15,341.30	282,181.02	5.44%	11,321.23	231,794.15	4.88%	10,198.94	231,794.15	4.40%
412 L4 Estates and Facilities - Div	18,287.17	252,537.53	7.24%	9,131.05	122,234.09	7.47%	9,156.12	130,303.44	7.03%	8,235.18	130,303.44	6.32%
412 L4 Medicine and Emergency Care - Div	36,275.34	645,015.07	5.62%	17,141.05	304,923.32	5.62%	19,134.29	340,091.75	5.63%	17,208.64	340,091.75	5.06%
412 L4 Surgical and Cancer - Div	32,635.80	643,292.71	5.07%	16,139.71	324,751.24	4.97%	16,496.10	318,541.47	5.18%	14,844.03	318,541.47	4.66%
412 L4 Women and Childrens - Div	11,473.55	253,235.29	4.53%	5,465.61	125,093.44	4.37%	6,007.93	128,141.85	4.69%	5,407.59	128,141.85	4.22%
Grand Total	151,615.21	3,029,843.87	5.00%	76,847.99	1,499,217.54	5.13%	74,767.22	1,530,626.33	4.88%	67,280.50	1,530,626.33	4.40%

Mean Average (R12M) Absence Rates for Anxiety/Stress/Depression and MSK
October 2019 – September 2021

	Oct-19 to Sep-21			Oct-19 to Sep-20			Oct-20 to Sep-21		
	Absence FTE	Available FTE	Absence FTE %	Absence FTE	Available FTE	Absence FTE %	Absence FTE	Available FTE	Absence FTE %
Anxiety / Stress / Depression	40,296.20	3,029,843.87	1.33%	19,780.19	1,499,217.54	1.32%	20,516.01	1,530,626.33	1.34%
MSK	24,598.18	3,029,843.87	0.81%	10,702.40	1,499,217.54	0.71%	13,895.78	1,530,626.33	0.91%

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**20**	Date of Meeting: 27/01/2022
Report Title	**Vaccination as a Condition of Deployment**	
Executive Lead	Heather Barnett, Director of People	
Lead Officer	Click here to enter text	
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)*

- National guidance received.
- Scope of regulations to apply to front line clinical and non-clinical workers who have face to face contact with patients, and as at 18 January 2022, 347 staff, 119 bank staff and 170 volunteers were recorded without a full vaccination record.
- Project implementation group established to ensure compliance with new regulations from 01 April 2022.

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

- Finalising of scope principles to ensure roles, which fall in and out of scope, are clearly identified and documented for CQC reporting purposes.
- Content of local standard operating procedure to be agreed with Trade Union colleagues, to provide supportive framework within which to manage colleagues who remain unvaccinated by the implementation date.

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 **BAF2 Workforce wellbeing and resilience**	
• 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
Exec Directors	17-01-22	Vaccination as a condition of deployment	Heather Barnett	Definition of scope and the meaning of incidental contact discussed and updated within the context of the national guidance and principles of application discussed and advised prior to wider engagement with TU colleagues.

Vaccination as a Condition of Deployment

Introduction

1. The Health and Social Care Act 2008 (Regulated Activities) (Amendment) (Coronavirus) (No.2) Regulations 2022, were made on 06 January 2022, and state that, from 01 April 2022, registered CQC providers can only employ or otherwise engage a person in respect of a CQC regulated activity, if the person provides evidence that they have been vaccinated with a complete course of an authorized vaccine against Covid-19, subject to specific exemptions. The scope of the regulations includes front line workers, as well as non-clinical workers not directly involved in patient care, but who nevertheless may have direct, face to face contact with patients, such as receptionists, ward clerks, porters and cleaners.

2. In order to receive both doses by the 01 April 2022 implementation date, colleagues will need to have received their first Covid-19 vaccine by 03 February 2022.

3. Recent data, as at 18 January 2022, confirms that the Trust has 347 employees who do not have a full Covid-19 vaccination record (2 doses). Of these, 85 (24.5%) are recorded as having received one dose. There are also 119 bank workers without full vaccination records and 170 volunteers whose records require review to comply with the regulations.

Current Position

4. A colleague's vaccination record may not be showing as complete for a number of reasons:

- They have been fully vaccinated however their details in ESR do not match the details held for them in NIMs.
- They have received one dose of the vaccine and are awaiting their second dose.
- They are exempt from receiving the Covid-19 vaccination.
- They have not received any Covid-19 vaccinations through personal choice.

5. In direct response to the new regulations, the Trust has established a project implementation group with governance aligned to Silver and Gold Command, as well as Executive Workforce Assurance Group to ensure the Trust will be compliant with the new regulations, with effect from 01 April 2022.

6. The project group has progressed the following key actions:

- Reviewed both phase 1 and phase 2 national guidance and has developed robust action plans to deliver
- Articulated a Trust level risk assessment in respect of future workforce supply. This has been added to the Trust's risk register and will have a direct impact on BAF2.
- Published an update to the Trust's Privacy Notice and has sought advice from the Trust's Data Protection Officer, to ensure the Trust remains complaint with GDPR responsibilities.
- Developed a robust process of data validation and recording using ESR and NIMs in advance of the National solution.

- Established a weekly sit-rep reporting process
- Ensured that colleagues who do not have a full Covid-19 vaccination record, have received access to dedicated support and advice. This has been achieved through a combination of personal calls from the Trust's vaccination centre, a supportive letter from the Occupational Health Clinical Lead, and through the commencement of informal line manager discussions.
- Developed a Trust wide communications plan including regular communication and consultation with Trade Union colleagues.
- Added vaccination status to the Trust's Covid-19 risk assessment.
- Commenced discussions with on and off framework agencies to gain assurance on their compliance processes.
- Drafted an Equality Impact Assessment for consultation.
- Commenced alignment of our Trust recruitment processes to the new regulations.

7. The project group is now focusing on:

- Finalising a set of 'scope' principles to ensure the Trust is clear which roles fall in and out of scope, clearly documenting this for CQC reporting purposes.
- Agreeing with Trade Union colleagues, the content of the local SOP which will provide The supportive framework within which to manage colleagues who remain unvaccinated by 01 April 2022 implementation date.

Recommendation

8. The Board is requested to note the report.

Author: Heather Barnett, Director of People
Date: 19 January 2022

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**21**	Date of Meeting: 27/01/2022
Report Title	**Gender Pay Gap Report 2021**	
Executive Lead	Heather Barnett, Director of People	
Lead Officer	Ian Howarth, ED&I Strategic Lead	
Action Required	To approve	

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

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

- Gender pay gap of 21.2% identified between the average hourly earnings of males and females. Trust Gender Pay Gap, however, reduced by 2% between 2021 and the gender pay gap figure reported in 2020. There is still a greater distribution of male staff in the upper earnings quartile.
- Bonus pay gap for 2021 is 17.71%, a negative increase of 13.61% on 2020 (4.10%) and largely attributable to male colleagues deferring CEA payments from previous years into 2021.
- 2021 data shows an increase in males within the workforce and a decline of women in the workforce (5.2%); also increase seen in both male and female employees reported as working part time hours.

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

- Gender Pay Gap Report to be discussed at JCNC 28 January 2021.
- Published report to reflect that data and findings have been shared with key workforce groups
- Gender Pay Gap report data to be submitted via the Government Reporting Portal before 30 March 2022 and subsequent publication on the Trust's website.

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

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

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

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

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

Strategy ☐ Policy ☐ Service Change ☐

Mid Cheshire Hospitals NHS FT

REPORT DEVELOPMENT

Committee/ Group Name	Date	Report Title	Lead	Brief summary of key issues raised and actions agreed
EWAG	01-12-21	GPG Annual Report	Becky Bather Ian Howarth	GPG accepted as a true reflection Bonus pay gap challenged on account of awards in 2021 being all the same Further exploration advised and any updates to be taken back through EDI Steering Group before bringing back to EWAG in Jan 2022
ED&I Steering Group	21-12-21	GPG Annual Report	Becky Bather Ian Howarth	Issue of bonus payments being deferred from previous years resulting in a 17% difference male to female in 2021 despite all awards in this year being equal irrespective of gender
EWAG	05-01-22	GPG Annual Report	Becky Bather Ian Howarth	Agree to recommend for approval by the Board.
JCNC	28-01-22	GPG Annual Report	Becky Bather Ian Howarth	Pending

Gender Pay Gap

Introduction

1. This paper summarises the findings of the 2021 Gender Pay Gap Report and data collection. The reference period for the Gender Pay Gap is 1 April 2020 to 31 March 2021. The data is taken from ESR. There is a national requirement to report Gender Pay Gap information for It requires all organisations with 250 or more employees to publish their gender pay gap annually as of 31 March 2017.

Executive Summary

2. A gender pay gap of 21.2% has been identified between the average hourly earnings of males and females based on data as of 31 March 2021.

3. The Trust Gender Pay Gap has reduced by 2% between 2021 and the gender pay gap figure reported in 2020.

4. The pay gap percentage for Median hourly pay is 7.72%. This has decreased positively by 2.22% on last year's figure.

5. The bonus pay gap – based on Clinical Excellence Awards (CEA) has increased from 4.10% in 2020 to 17.1% in 2021.

6. The average difference in bonus payment between male and female colleagues has increased to £1,826 in 2021 from £482.75 in 2020.

Background and Analysis

Workforce Demographics

7. The gender make-up of Mid Cheshire Hospitals NHS Foundation Trust consists of 80% female and 20% male. This is an 5.2% increase of men in the workforce as compared to last year (85.2% female compared to 14.8% male).

8. 50% of the workforce work part time hours which is a 3% decrease compared to the previous year. 56% of women and 22% of men are recorded as working part time hours. There has been an increase of both males and females working part time in 2021 (18.24% increase in males and 6.8% females).

Average Hourly Rate

9. The average hourly rate of pay for females was £15.71 and males £19.84. There is a difference of £4.22 between the hourly rate of pay for females and males. This has decreased positively on last year's figure when the difference was £4.59. The pay gap percentage for Average hourly pay is **21.2%** (this is the nationally reported figure). This has decreased positively by 2% on last year's figure.

Median Hourly Rate

10. The median hourly rate of pay for females is £13.79 and males £14.95. There is a difference of £1.15 between the median hourly rate of pay for females and males. This has decreased positively on last year's figure where the difference was £1.46. The pay gap percentage for Median hourly pay is 7.72%. This has decreased positively by 2.22% on last year's figure.

Quartiles

11. Male employees make up 20% of the Trust population. The largest proportion of male staff are in the highest paid quartile (22.72%). Quartile 4 has the lowest number of female staff (77.28%). There is a greater distribution of male employees at the Trust in higher paid roles. The position has improved on 2020, however, when 23.22% of males and 76.78% of females were in the higher quartile.

Bonus

12. As an NHS organisation the only pay elements which fall under the bonus criteria are the Clinical Excellence Awards (CEA). The pay elements that are used in this calculation are awarded as a result of recognition of excellent practice over and above contractual requirements. The Bonus pay gap for 2021 is 17.71%. This is a negative increase of 13.61% on 2020 (4.10%).

13. In 2021, the average male bonus payment was £1,826 more than the average female bonus. This has increased since 2020 where the difference between male and female bonus payments was £482.75.

14. For 2021, all eligible Consultants received an equal payment on account of the impact responding to the pandemic has had on the ability for eligible consultants to submit entries and for the scheme to be administered by host employers. This would typically have led to a neutralised gender bonus pay gap. However, a number of consultants had awards paid that were part of the 3 year pay deal from 2019. These payments have impacted the overall bonus pay gap position in 2021

Action Plan

GPG – Action Plan

Action	Measure	Date
Develop an approach for sharing GPG findings with workforce. Beginning with presenting to JCNC 28/01/21 to engage with staff and to gain feedback which can be fed into the action plan	GPG action plan	Jan-22
Complete deep dive analysis into the data to identify areas of concern such as AfC Vs Medical and Dental terms and conditions that could be influencing GPG	Increase in Women in 3rd & 4th quartile on 2022 gender pay gap report	Jan-22

Explore the Clinical Excellence Award scheme to understand the reasons for the significant increase in bonus pay gap on prior year	Decrease in Bonus Pay Gap in 2022	Dec-21
Facilitate focus groups with female consultants to explore CEA awards and any specific gender barriers to achieving. Findings to feed into the trust action plan	Reduced Median Bonus GPG in 2022 and 2023	Mar-22

Conclusion

15. Mid Cheshire Hospitals NHS Foundation Trust is committed to addressing the findings of the Gender Pay Gap Report for 2021 and welcomes the opportunity to align the action plan with the support from colleagues from across the Trust against those areas identified in order to further reduce the Gender Pay Gap.

    The Gender Pay Gap will continue to be monitored via the Equality Diversity and Inclusion Steering Group. Further detailed analysis of the results and any corresponding actions will be developed over the coming months. The Trust will continue to publish Gender Pay Gap Reports on an annual basis.

Recommendation

16. To approve.

Author: Rebecca Bather, Workforce Business Partner, ED&I
Ian Howarth, Equality Diversity & Inclusion Lead
Date: 21st January 2022

Mid Cheshire Hospitals
NHS Foundation Trust

Gender Pay Gap Report

Summary Findings and action plan
2020 – 2021

Annual Report prepared by
Rebecca Bather, Workforce Business Partner, Equality, Diversity and Inclusion

Executive Summary

Mid Cheshire Hospitals NHS Foundation Trust services are committed to ensuring that everyone has an equal chance to live a long and healthy life, regardless of age, disability, gender identity, marital / civil partnership status, pregnancy / maternity, race, religion or belief, sex, or sexual orientation.

It is essential, therefore, that we take steps to ensure that we are a good employer who values and welcomes different ideas and skills of our staff. Our goal is to recruit, engage, develop and retain outstanding people who reflect the communities we serve and who work together to deliver our common aims and objectives.

Mid Cheshire NHS Foundation Trust is committed to the principle of gender pay equality and has prepared its 2021 gender pay gap results in line with mandatory requirements.
The Gender Pay Gap report is based on a snapshot of data as of 31st March 2021 taken from ESR (Electronic Staff Record).

The 2021 report shows a reduction in the Trusts Gender Pay Gap of 2% on 2020 figures (based on average hourly pay) however the Bonus Pay Gap of 17% (based on Clinical Excellence Awards) has increased by 13% on 2020's figure.

What is the Gender Pay Gap?

Gender pay gap legislation was first introduced in April 2017.

It requires all organisations with 250 or more employees to publish their gender pay gap annually as of 31 March 2017.

The gender pay gap differs from equal pay which looks at the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value.

Mid Cheshire Hospitals NHS FT

What is the purpose of the Gender Pay Gap?

The gender pay gap shows the average difference in the average pay between men and women.

Gender pay gap reporting is a valuable tool for assessing levels of equality in the workplace, female and male participation, and how effectively talent is being maximised

The information must be published on the organisation's website in addition to a government website.

Gender Pay Gap – Key Observations – workforce demographics

Gender make-up
The gender make-up of Mid Cheshire NHS Foundation Trust consisted of 80% female and 20% male.

This is a 5.2% increase of men in the workforce compared to last year (85.2% female compared to 14.8% male).

Employment Type
50% of the workforce work part time hours which is a 3% decrease compared to the previous year.
56% of women and 22% of men are recorded as working part time hours.
There has been an increase of both males and females working part time in 2021 (18.24% increase in males and 6.8% females).

Gender Pay Gap – Key Observations – Hourly Pay

Average Hourly Rate (Appendix One for detail)

The average hourly rate of pay for females was £15.71 and males £19.84.

There is a difference of £4.22 between the hourly rate of pay for females and males.

This has decreased positively on last year's figure when the difference was £4.59.

The pay gap percentage for Average hourly pay is 21.2% (this is the nationally reported figure).
This has decreased positively by 2% on last year's figure.

Median Hourly Rate

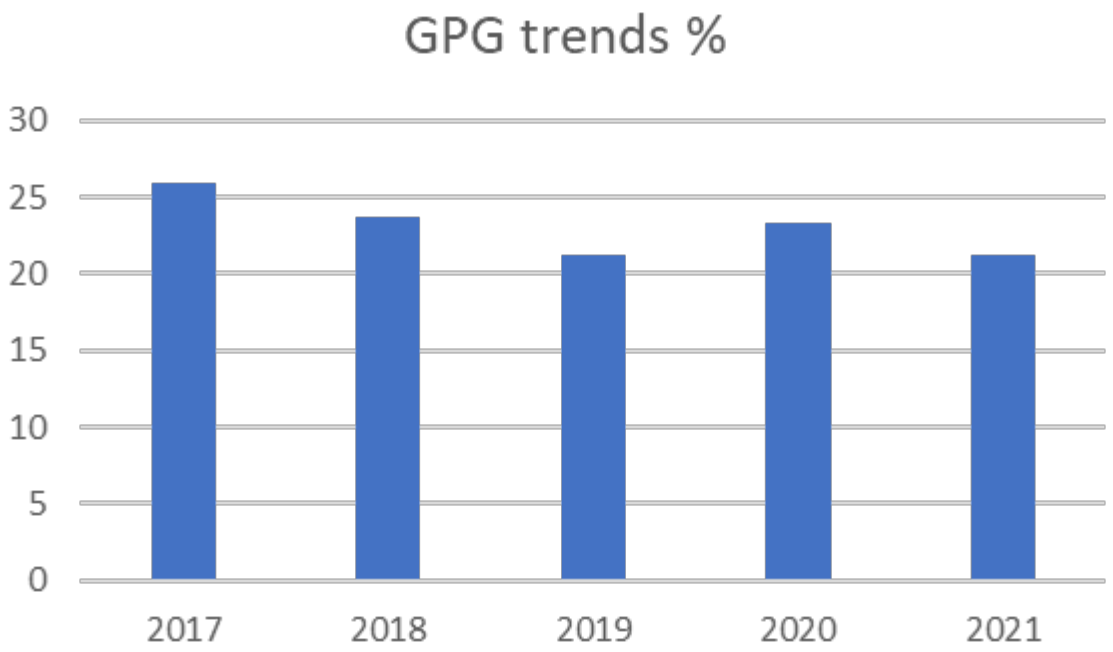
The median hourly rate of pay for females is £13.79 and males £14.95.

There is a difference of £1.15 between the median hourly rate of pay for females and males.

This has decreased positively on last year's figure where the difference was £1.46.

The pay gap percentage for Median hourly pay is 7.72%.

This has decreased positively by 2.22% on last year's figure.



Gender Pay Gap – Higher and additional pay

Quartiles
Male employees make up 20% of the Trust population.

The largest proportion of male staff are in the highest paid quartile (22.72%).

Quartile 4 has the lowest number of female staff (77.28%).

There is a greater distribution of male employees at the Trust in higher paid roles.

The position has improved on 2020 however when 23.22% of males and 76.78% of females were in the higher quartile.

Pay Quartiles (Q4 highest and Q1 lowest)

Quartile	Female	Male	Female%	Male%
1	1040	206	83.47	16.53
2	1063	188	84.97	15.03
3	1062	188	84.96	15.04
4	966	284	77.28	22.72

Mid Cheshire Hospitals NHS FT

Bonus (Appendix One for detail)

As an NHS organisation the only pay elements which fall under the bonus criteria are the Clinical Excellence Awards (CEA).

The pay elements that are used in this calculation are awarded as a result of recognition of excellent practice over and above contractual requirements.

The Bonus pay gap for 2021 is 17.71%. This is negative increase of 13.61% on 2020 (4.10%).

In 2021 the average male bonus payment was £1,826 more than the average female bonus. This has increased since 2020 where the difference between male and female bonus payments was £482.75.

For 2021 all eligible Consultants received an equal payment. However, a number of consultants had awards paid that were part of the 3 year pay deal from 2019.

Note: Please see appendix two for the calculation of the LCEA payments based on national guidance.

Conclusion

There has been a positive decrease in the Gender Pay Gap in terms of average hourly pay and median hourly pay. However there has been a significant increase in the Bonus Pay Gap.

Mid Cheshire Hospitals NHS Foundation Trust is committed to addressing the findings of the Gender Pay Gap Report for 2021 and welcomes the opportunity to align the action plan with the support from colleagues from across the Trust against those areas identified.

The Gender Pay Gap will continue to be monitored via the Equality Diversity and Inclusion Steering Group.

Further detailed analysis of the results and any corresponding actions will be developed over the coming months.

The Trust will continue to publish Gender Pay Gap Reports on an annual basis.

Mid Cheshire Hospitals NHS FT

Appendix One

GPG Metrics Report – Data taken as of 31 March 2021

Average hourly rate and median rate of pay

Gender	Avg Hourly Pay Rate (£)	Median Pay Rate (£)
Male	19.93	14.94
Female	15.70	13.79
Difference	4,22	1.15
Pay Gap %	21.20%	7.72

Bonus

Gender	Avg pay	Median Pay
Male	10,314.78	6032.04
Female	8,487.91	6032.04
Difference	1826.87	0
Pay Gap %	17.71	0

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Appendix Two

Calculation of LCEA award

https://www.nhsemployers.org/articles/local-clinical-excellence-award-lcea-arrangements

- Q4. How should employers calculate the investment pot for 2021? UPDATED JULY 2021
- The steps we advise employers to take to calculate the value of the investment pot for 2021-22 are:
- calculate the number of eligible* consultants (FTE)** as at 1 April 2021
- multiply the number of eligible consultants (FTE) by 1.242 (the cumulative investment ratio as set out in the recently published **joint statement)**
- multiply that figure by the unit value of an award (currently £3,092, as set out in the **Pay and Conditions circular 2/2020,** published by NHS Employers. The figure will be confirmed following the Government's response to DDRB's 49th report: 2021 and subsequently via an updated pay circular, expected to be published in September 2021)
- deduct the cost of any time limited awards that remain in payment from the 2018 and 2019 award rounds (on costs should be excluded)
- add/deduct any underspend/overspend carried over from previous award round

Audit Committee
Chair's Assurance Report
14 January 2022

Report to	Board of Directors
Date	27 January 2022
Report from	Les Philpott, Non-Executive Director
Report prepared by	Caroline Keating, Company Secretary
Executive Lead	Caroline Keating, Company Secretary (*deputising for Russell Favager, Deputy Chief Executive and Director of Finance*)
Committee meeting quoracy	Yes ☒ No ☐

KEY AREAS OF ASSURANCE

Risk Management Framework:

- **Risk Management Key Performance Indicators:** work not yet finalised due to delay in system (4Risk) upgrade; aligning KPIs to improvements in patient survey under discussion with Quality Governance. Added value of KPIs to be revisited.
- **BAF Controls and Assurances:** quality assurance process underway with a gap analysis completed and shared with Executive Risk Leads and Board Committees. Focus now on assurance of controls effectiveness. Internal Auditor's Assurance Framework review involved sampling a small number of assurances received from the Board Committees and Executive Risk & Assurance Group; all were considered acceptable.
- **Board Committee Workplans – Partial Assurance:** information flow mapping exercise reviewed submissions against Terms of Reference and BAF controls and assurances. Amends to 2021/22 workplans being made to provide robust baseline for evaluation of Committee effectiveness in 2021/22 and development of 2022/23 workplans.

Report of Board Committees – Acceptable Assurance: assurances accepted by Board Committees now included in the report, providing a succinct read-across for the last quarter. Receipt of national and regional guidance also now included, providing Audit Committee with line of sight. Actions required:

- WDT to amend wording to state that the Committee agreed to recommend approval to the Board to remove the sickness absence internal metric and replace with an improvement trajectory
- Committee Chairs to be aware of committee limits of authority according to their terms of reference.

Board Committee Effectiveness Evaluation Process: process agreed. Audit to adopt more detailed HfMA survey as accepted industry standard; Good Governance Institute survey to be considered by the incoming Audit Committee Chair.

Financial Conformance Report - Acceptable Assurance: increase in single tender waivers noted.

Cyber Security Update - Acceptable Assurance: significant level of work noted to improve the Trust's cyber security position. The risk to the Trust arising from the regular changes to the threat landscape was noted.

Internal Audit (IA):

- **Key Financial System Review – Substantial Assurance (IA rating):** the Trust has a good system of internal control designed to meet the system objectives; controls are generally being applied consistently
- **Assurance Framework (AF) Review:** IA opinion received as:
    - The organisation's AF is structured to meet the NHS requirements
    - The AF is visibly used by the Board, its Committees and Executive-led Groups
    - The AF clearly reflects the risks discussed by the Board, its Committees and Executive-led Groups
- **Internal Audit Plan 2021/22**: Audit Committee agreement to delay internal audit reviews to be reinforced
- **Internal Audit Tracker - Partial Assurance:** review of 2022/23 tracker to be undertaken.

External Audit Plan 2021/22: planned audit approach agreed. Audit Committee agreed to start negotiations regarding extension of contract. Cost clarification to be included in report to next Audit Committee meeting. Governor involvement with final agreement to be explored.

Anti- Fraud Progress Report - Acceptable Assurance: work undertaken across strategic governance, awareness raising, prevention and deterrence, and investigation. No issues identified to date with plan delivery.

KEY CONCERNS/RISKS

- Cyber Security – regular changes to threat landscape

Priority Areas: DECISIONS MADE

- None

RECOMMENDATION

To note

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**23**	Date of Meeting: 27/01/2022
Report Title	**Freedom to Speak Up Guardian Report Quarter 3 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)*

- A user Survey for Freedom to Speak Up has been constructed
- 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 with a rising number of users.

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

- Scope & trial FTSU Walkabouts
- Roll out FTSU user feedback survey to begin within quarter 4.
- Develop the FTSU Trust page, enhancing content and graphic design

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 Q3 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 3 in relation to speaking up and raising concerns.

4. '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, (359 staff have completed to date).

5. Formulation of the Service questionnaire for users has been progressed and will be ready to pilot in quarter 4.

Analysis of Quarter 3

6. During the period 1 October to 31 December 2021, nine new concerns were raised using the various Freedom to Speak Up reporting mechanisms. Seven of these concerns met the Freedom to Speak Up criteria and have been reported to the National Guardians Office as required. This compares to eight concerns being raised during the previous quarter and five concerns highlighted during quarter one in 2020/21.

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

Month reported	Staff Group	Method of reporting	Type of concern	Actions taken	Issue Closed and feedback reported
October 2021	Administrative & Clerical	In Person	Intimidation Worker wellbeing	Service Manager taking local actions Diagnostic and Clinical Support	Ongoing

Month reported	Staff Group	Method of reporting	Type of concern	Actions taken	Issue Closed and feedback reported
October 2021	Health Care Support Worker	In Person	Intimidation Worker wellbeing	Local actions Women & Children's Division	Ongoing
October 2021	Manager & Allied Health Professional	In person	Safety	Surgery & Cancer Division and Human Resources Action & Investigation	Ongoing
October 2021	Allied Health Professional	E- mail	Safety	Actioned by HON Diagnostic and Clinical Support	Closed
November 2021	Nurse	In Person	Patient safety & Staff wellbeing	Surgery & Cancer Division and Human Resources Action & Investigation	Ongoing
November 2021	Nurse	In person	Patient safety & Staff wellbeing	Surgery & Cancer Division and Human Resources Action & Investigation	Ongoing
November 2021	Nurse	E- mail	Patient safety & Staff Wellbeing	Corporate Division & Management	Closed

Division	Number of concerns raised Q3
Surgery and Cancer	3 (same case)
Medicine and Emergency Care	0
CCICP	0
Corporate	1
Diagnostic and Clinical Support	2
Estates and Facilities	0
Women & Children's	1
Not Given	0

8. Feedback from quarter 3 show a mixed grouping of themes: intimidation, safety and the impact of this on worker / team wellbeing was reported to the Guardian. If more than one person raises the same concern together, this is logged as a separate FTSU concern in line with National Guardians Office guidance. In Surgery and Cancer feedback from two staff members and a manager related to the same situation with some variance on the context / impact given on the issues raised. There were no issues raised from Estates and Facilities. Feedback in relation to past issues from staff who had raised concerns within this Division has been fed back positively to the Guardian, this is based on the improvements seen, better working relationships and atmosphere. Focused work within the Division had been commissioned.

9. Workload has not been cited in feedback as an issue as previously experienced in the last Guardian's report. Within this quarter intimidation from manager has been fed back from two of the cases (each within different divisions). This may be reflective of operational challenges; local measures are being actioned and the Guardian has raised with the relevant Human Resource leads.

10. Promotion of the Freedom to Speak up Champion's role continues, open door events have occurred, although 'walkabouts' have been curtailed with current pressures and in line with Infection Prevention control measures. These will resume when possible.

11. Formulation of an electronic questionnaire has occurred during this quarter with a plan to pilot and adopt over quarter 4. Each member of staff using the FTSU service will be sent an electronic survey to complete which will provide user feedback. A QR code and paper version will also be available. This will provide data to feed back to the Guardians office and other qualitive information on the service.

Conclusion

12. Themes do vary across each quarter; however, there appears to be some correlation of themes that link to the current state within the Trust; for example, Personal Protective Equipment (PPE) during the high prevalence of Covid, Workforce civility as staff tiring and facing increasing challenges. Triangulation of themes into workstreams can be promoted through the Freedom

to Speak Up Guardian, this may include patient safety Summit, Psychological Safety & Civility group.

13. The Freedom to Speak Up Guardian works closely with Divisions, Workforce Business Partners, resources, and staff representatives to support the staff voice and individual concerns. Further promotion, resources links and the feedback from the user questionnaire will help to focus FTSU work moving forward into the coming months ahead.

Next Steps

14. The data included in this report has been shared with the National Guardians Office for the Quarter 3 returns to ensure compliance and national learning.

Recommendation

15. To note

Report Author: Sian Axon, Freedom to Speak up Guardian
Date: 14 January 2022

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**CON1**	Date of Meeting: 27/01/2022
Report Title	Guardian of Safe Working Hours Report (Q3 2021-2022)	
Executive Lead	Heather Barnett, Director of People	
Lead Officer	Douglas Robertson, Guardian of Safe Working Hours	
Action Required	To note	

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

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

- Junior doctor contract exception reporting rates remain low despite severe workload pressures.
- Actions to promote increase exception reporting have been tried, with limited success
- Explicit self-directed learning time for Foundation trainees is now mandated from February 2022

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	
Junior Doctor Forum	21.01.22	Report from GoSWH	Douglas Robertson	

Mid Cheshire Hospitals NHS FT

Report from the

Guardian of Safe Working Hours

1st October 2021 – 31st December 2021 (Q3)

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), provided on a quarterly basis summarising exception reports made, fines levied, and identifying action to address 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 in the Trust to fully staff rotas for Junior Doctors which continue for all specialities 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 in the face of these difficulties raised concerns that this process does not function well, and that trainees' confidence in the system had been affected.

An issue which has come to the fore has been the mandating by Health Education England (HEE) of 2 hours per week of Self-Directed Learning time (SDL) for Foundation trainees, which has been difficult to ensure is taken consistently with the informal arrangements currently in place and has raised concerns with HEE and the BMA. This problem is not unique to Mid Cheshire.

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 often occur, and supervisors cite difficulties of unfamiliarity with the system or that it 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 October to 31st December 2021 there were 7 exception reports submitted by 4 individuals, 6 are awaiting a supervisor response and 1 was declined by the educational supervisor.
Of these reports, 5 were related to hours of work, 2 around trainee concerns about work patterns and 3 about inability to achieve breaks during a shift.
Another 2 were related to inability to attend educational sessions, but none related to missed SDL time. However informal feedback to GoSWH identified significant concerns about SDL amongst foundation trainees, and similar concerns raised elsewhere in the NW Guardians' network.

4. GoSWH Actions

To address systematic under-reporting and to be aware of potential areas of concern outside of exception reports, the following actions were 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 internal surveys, most recently in March 2021. They raised concerns about persisting poor morale and poor motivation to submit exception reports, particularly with the Foundation trainees. Further awareness raising has been promoted by the Mess President using BMA materials from September 2021.

3. Given the 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 in clinical areas. Actions to improve engagement in, and confidence with, exception reporting include:

    - Reminding trainees of the purpose and benefits of exception reporting in improving their working lives, to encourage an increase in reporting.
    - Awareness raising and training of educational and clinical supervisors emphasising need for signing off exception reports promptly. Individual prompts are given, but educator training days were paused in 2020 and have not yet re-started.
    - Ensuring better access to computers or a phone app to allow timely exception reporting.
    - Suggesting when TOIL is awarded, that rota coordinators formally record it and when it is taken, and if not taken, payment should be automatically generated.
    - The mandating of explicit Self-Directed Learning (SDL) time to be identified in Foundation trainees' work schedules from February 2022.
    - Ensuring a new exception reporting system to facilitate the above functions within the e-rostering systems currently being explored for doctors by medical resourcing.

5. Conclusions & to note.

This is the nineteenth 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 had been a marked reduction in exception reporting despite increasing workload pressures related to Covid19 admissions. Exception reports received do always identify areas of pressure or concern. Survey and informal feedback identified additional concerns around SDL and reduced trainee confidence in the Trust's response to exception reports.

Areas of particular concern from trainees include accessibility and usability of exception reporting software and difficulty in reliably taking Foundation SDL time in clinical rotas with heavy workloads, particularly in Medicine.

The GoSWH has discussed these themes and concerns with the relevant clinical and service managers, with the Director of People, Director of Medical Education, Foundation Lead and Deputy Medical Director. SDL is now to be made explicit in Foundation trainees' workplans, and the Trust is pursuing a better system to support submitting exception reporting and actioning them.

Douglas Robertson
Guardian of Safe Working Hours 21.01.22

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**CON2**	Date of Meeting: 27/01/2022
Report Title	**Fit and Proper Persons Annual Report 2021**	
Executive Lead	Caroline Keating, Company Secretary	
Lead Officer	Click here to enter text	
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)*

- No concerns were raised during the annual Fit and Proper Persons checks

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

- Checks have been filed centrally in Directors' personal files

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
NA				

Fit and Proper Persons Requirements

Introduction

1. Regulatory standards for the Fit and Proper Persons requirements for directors (Appendix I) came into force for all NHS provider organisations from 27 November 2014. This was a direct response to the Francis Inquiry into Mid-Staffordshire NHS Foundation Trust and reflected growing requirements, both within the NHS and in the corporate sector about the standards of conduct required for Board Directors.

Fit and Proper Persons Requirements (FPPR) Checks

2. The annual checks include a review of national registers for insolvency, bankruptcy and disqualified directors, with no findings of concern.

3. All Directors completed a self-declaration stating that they continue to comply with the FPPR.

4. A checklist has been completed and signed by the Chairman for each MCHFT Director which ensures all required FPPR checks are documented and available for Care Quality Commission Well Led inspections.

Partnership Boards

5. In February 2018 the Kirkup report, which focused on the failings in leadership at Liverpool Community Health NHS Trust was published. The Trust reviewed the recommendations and found the Trust's processes to be compliant; however, through the gap analysis it was agreed that the same levels of scrutiny should apply to all Trust directors including the Central Cheshire Integrated Care Partnership (CCICP) Board. Since 2018, all GP Alliance representatives have completed an annual declaration and were subject to a check against the national registers. DBS checks were confirmed as in progress.

6. The same provisions are recommended for the Cheshire East Integrated Care Partnership Board. Assurances have been received from East Cheshire Hospitals NHS Trust that their members have been checked in the past year.

Recommendations

7. To note that the Board of Directors, CCICP Partnership Board, GP and Cheshire East Council representatives on the Cheshire East Integrated Care Partnership Board remain compliant with the FPPR and have completed their annual checks.

Author: **Caroline Keating, Company Secretary**
Date: **13 January 2022**

Appendix I

FPPR Requirements

The requirements are defined in Schedule 4 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

A Trust must not appoint a person to a Director level post unless:

- they are of good character;
- they have the necessary qualifications, competence, skills and experience;
- they are able by reason of their health, after reasonable adjustments are made, properly to perform their work;
- they have not been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement in the course of carrying on a regulated activity; and
- none of the grounds of unfitness specified in Part 1 of Schedule 4 of the 2014 Regulations apply to them.

In assessing good character, consideration must be given to:

- whether the person has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence; and
- whether the person has been erased, removed or struck off a register of professionals maintained by a regulator of health care or social work professionals.

The grounds of unfitness specified in Part 1 of Schedule 4 of the 2014 Regulations are:

- The person is an undischarged bankrupt or a person whose estate has had a sequestration awarded in respect of it and who has not been discharged;
- The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland;
- The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986;
- The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it;
- The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006,
  or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland;
- The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.

Appendix II

Recommendations of the Kark Review 2018

None of the recommendations made below should remove from the Trust Board the overarching responsibility for good corporate governance and the overall responsibility of the Boards of Trusts to protect those working in the hospitals and to protect their patients.

1. **All directors (executive, non-executive and interim) should meet specified standards of competence to sit on the board of any health providing organisation. Where necessary, training should be available.**

2. **That a central database of directors should be created holding relevant information about qualifications and history**

3. The creation of a mandatory reference requirement for each Director

4. The FPPT should be extended to all Commissioners and other appropriate Arms-Length Bodies (including NHSI and NHSE)

5. The power to disbar directors for serious misconduct (through a new regulatory organisation, potentially hosted by NHSI)

6. We recommend that, in relation to Regulation 5 (3) (d) of the Regulations, the words “been privy to” are removed.